East Sussex Healthcare
NHS Trust

Quality Account
2017-2018

WHAT **MATTERS** TO YOU
MATTERS TO US ALL

Contents

Part 1 – Introduction

Statement of Quality from the Chief Executive

I am pleased to introduce the Quality Account for East Sussex Healthcare NHS Trust (ESHT). The Account reports the progress that the Trust has made in improving safety and quality during 2017/18 and sets out the priorities that have been adopted by the organisation in 2018/19.

The foundations of quality and safety are for the organisation to listen to feedback from patients and families on the quality of care that we provide, to encourage an open reporting culture in which members of staff are able to raise concerns and report incidents for review and investigation, and to ensure that we adopt the improvements that are identified as a result.

We have continued to strengthen the investigation and reporting of complaints and reported incidents. We have reinforced the importance of clinical reviews of all deaths and complications of care. The findings and conclusions of these reviews are reported through the organisation and ultimately to the Quality and Safety Sub Committee of the Board.

We have focused on encouraging a higher response rate from patients in all areas of the Trust to the Family and Friends Test surveys and we continue to be encouraged by the improved response rates and the high levels of satisfaction that are reported.

We continue to reinforce the importance of participation of all clinical services in the national clinical audit programmes. We are proud that in many clinical areas our results feature in the highest levels of performance in the country.

The report describes the significant progress that the Trust has made in priority areas such as the care of patients reaching the end of their life. This has been supported by the significant improvements in our operational performance against important national standards.

All of this work is underpinned by the development we have made alongside our partners as part of East Sussex Better Together (ESBT). Through ESBT we are aligning primary, secondary, community and specialist services in a way that will drive the transformations necessary to meet future health needs of our populations. Working together we are developing new models of care and integrated pathways to deliver high quality services.

We will strive to continue to improve all aspects of the care we provide to our patients.

Dr Adrian Bull
Chief Executive

Some of our achievements in 2017/18

Awards and recognition for our achievements

The Trust's One Stop Swallow Disorder Clinic won two national awards in recognition of its innovative and collaborative approach which has reduced waiting times from 24 to just five weeks.

East Sussex Better Together, a pioneering partnership between health and social care in the county, won the improved partnerships between health and local government category at the Health Service Journal Awards.

The Doctor's Assistant Team and Danii Clark, Equality and Human Rights Assistant, both won Skills for Health's Our Health Heroes Awards, celebrating unsung healthcare heroes from across the UK.

The Trust was praised for having the most improved quarterly performance in A&E by Secretary of State for Health, Jeremy Hunt. The quarterly percentage of patients treated and either admitted or discharged within four hours increased by nearly nine percentage points, from 80.7% between March and May to 89.4% between June and August.

Care of cancer patients at the Trust was again highly praised in a national survey of patients who were diagnosed with the disease.

The Trust's Heart Failure Team won two awards at the regional Heart Failure Collaborative Event, held in partnership with the British Heart Foundation. Conquest Hospital won the Top Performing Acute Service award, with Eastbourne DGH named the Most Consistent Improver.

The nurseries at Conquest Hospital and Eastbourne DGH both received a 'good' rating following inspections by Ofsted.

The Trust has moved from the bottom 10% to the top 10% nationally on the Medical Engagement Scale, which assesses the level of engagement of the medical workforce with the goals of the organisation in which they work.

In the last national survey of inpatients, the Trust was better or equal to the national average in almost 80% of the questions asked.

The Trust's UroGynaecology unit was the first in Sussex to attain national accreditation from the British Society of UroGynaecology, making it one of only 22 units nationally to gain this status.

Project SEARCH, for which the Trust is the host employer, was recognised for its success in gaining young people with learning difficulties or disabilities paid employment.

The Trust's Audiology services have received national accreditation in recognition of the high quality of care they provide. The Improving Quality in Physiological Services (IQIPS) accreditation is given to services that can demonstrate the highest levels of quality of service, care and safety for patients.

Improvements to our services

Women who have just become pregnant can now self-refer to the midwifery service by completing a form on the Trust's website.

Over 500 people were seen by the new Frailty Practitioner Service in its first year.

A new state-of-the-art CT scanner at Eastbourne DGH became fully operational in January. The scanner was substantially funded by a £500,000 donation from the Friends of Eastbourne Hospital.

Patients attending the main Outpatient Departments at Conquest Hospital and Eastbourne DGH can now check in for their appointment using self-service check-in kiosks.

Medication Passports, which were kindly funded by the Friends of Conquest Hospital, have been launched to help people keep track of their medicines.

Paper patient notes will soon be a thing of the past with the implementation of electronic patient records almost complete.

Innovation in our services

A new procedure, Endobronchial Ultrasound, has been introduced to speed up lung cancer diagnosis and reduce travel for patients who previously had to go to either Brighton or London for the procedure.

An Eastbourne patient was the first in the UK to be implanted with an innovative cardiac device to modulate the heart's beat.

A new state of the art simulation training laboratory now gives clinical staff the opportunity to practice their skills and procedures in an educationally safe environment.

Doctors at the Trust are the first in the south east to use an innovative ultrasound scanner that combines MRI images to improve the detection of prostate cancer.

A state of the art digital mammography machine has been installed at Eastbourne DGH to improve the diagnosis of patients with suspected breast cancer.

Improving our buildings and facilities

Work to expand the Emergency Departments at Conquest Hospital and Eastbourne DGH was completed in November/December, helping improve the flow of patients through the department.

An expanded Ambulatory Emergency Care (AEC) unit opened at Eastbourne DGH in December, providing same day medical care for ambulatory patients to avoid overnight admission.

The courtyard of the Kipling Children's ward at Conquest Hospital was re-opened following refurbishment.

A new £500,000 Orthopaedic Outpatients and Fracture Clinic opened at Conquest Hospital in September.

Valuing our workforce

The Health and Wellbeing of our staff remains a priority. In the past year:

- 72% of our frontline staff had the flu vaccine, significantly higher than the 53% uptake the previous year
- 850 members of our staff who are over 40 have received a free health check
- Roadshows promoting staff Health and Wellbeing were attended by 180 staff
- Schwartz Rounds continue to run on site each month, providing emotional support for all staff.

The Employee Support Team is a unique service that recognises that family responsibilities can sometimes be complex and stressful for some staff. The team provides advice and guidance on:

- Childcare
- Carers Support
- Maternity Support Group
- Flexible working

The Trust has recognised the work of our staff in a variety of ways during the past year:

- 220 staff attended our Annual Awards
- Over 300 staff attended our Unsung Heroes roadshows or attended the celebration event where we recognised the work of those staff working behind the scenes
- 80 staff attended our Mentorship Awards which recognises the important part that mentors play in the development of staff
- Each month we have a month staff award
- The introduction of #ourmarvellousteams has also proved very popular with the public and other staff members in providing positive feedback on their experience of using our services.

The Trust is committed to ensuring all our staff have access to Learning and Development to support them in doing their job to the best of their ability and also for those who wish to further develop. This includes:

- Internal learning opportunities linked to patient safety
- Apprenticeships
- Leadership development
- Access to clinical courses run by our local universities.

Charitable funds have been made available to staff to make small improvements in their work areas, for the benefit of colleagues and/or patients. Improvements made in the last year include:

- A revamped bereavement garden for the Emergency Department at Eastbourne DGH
- Plants for the maternity entrance at Conquest Hospital
- Elite Community Nurse bags for the Frailty team
- Hot water boilers for porters
- Wall mounted fans in the Ear, Nose and Throat waiting area.

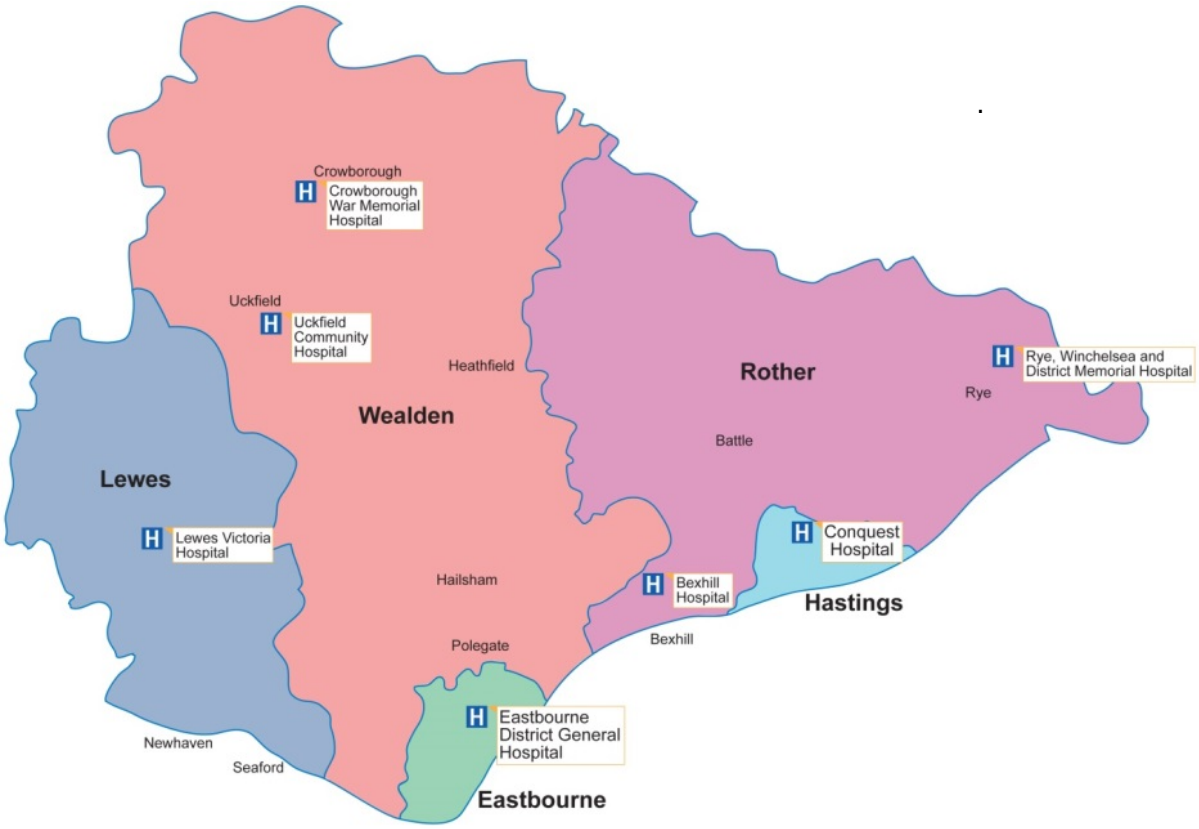
About us and the service we provide

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, staff come from 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 approximately 80 other sites ranging in scale from shared community based premises to community hospitals; we provide services from Bexhill Hospital; Crowborough War Memorial Hospital; Lewes Victoria Hospital; Rye, Winchelsea and District Memorial Hospital; and Uckfield Community Hospital.



Around 525,000 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

Outstanding by 2020 – Our Vision, Values and Ambition

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.

ESHT 2020 sets out **Our Ambition** to be an outstanding organisation by the year 2020 and provides the framework for how we will achieve this.

Our objectives encompass our commitment to provide clinical services that achieve and demonstrate the best clinical outcomes and provide an excellence experience for patients.

These are:

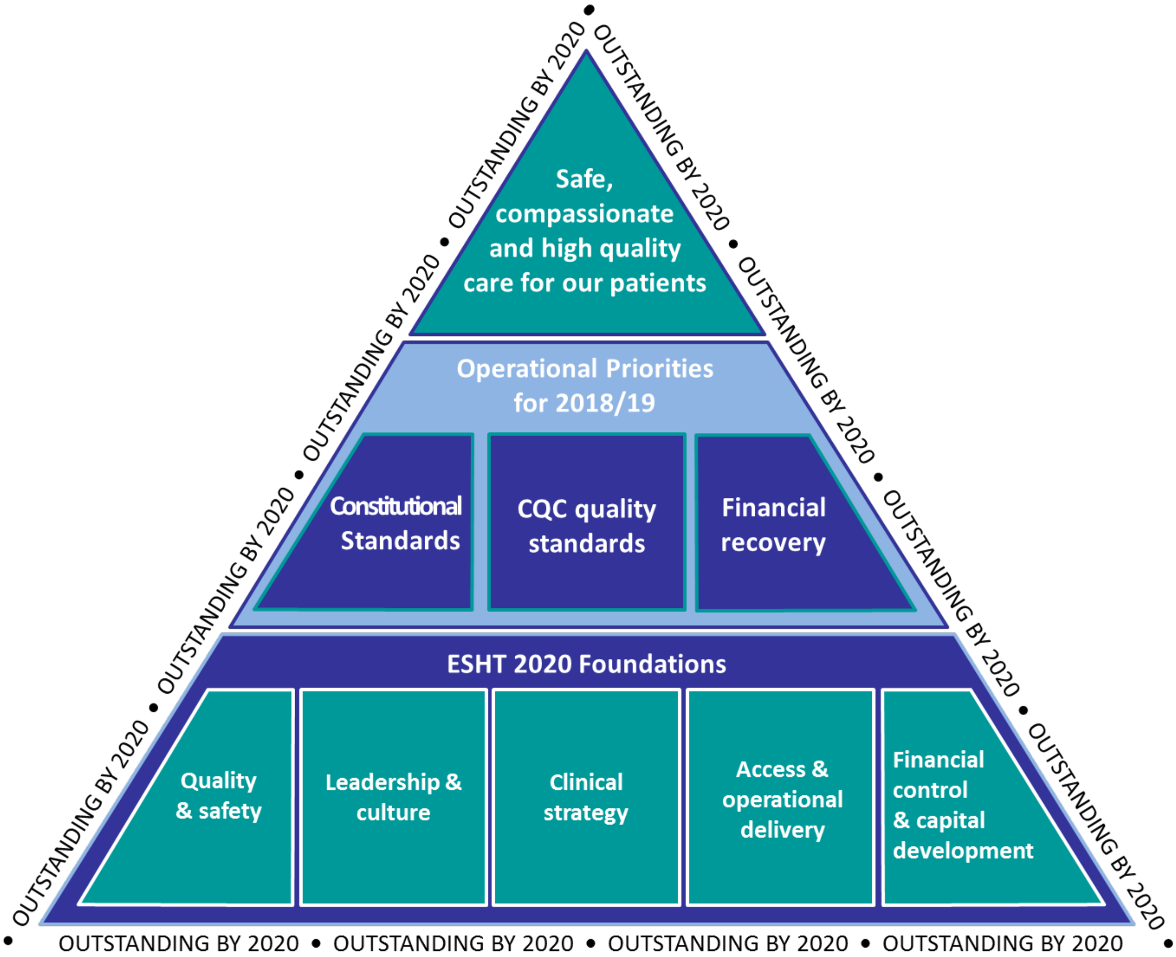
- **Safe patient care is our highest priority**
  We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.

- **All our employees will be valued and respected**
  They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.

- **We will work closely with commissioners, local authority and other partners…**
  …to plan and deliver services that meet the needs of our local population, in conjunction with other care services.

- **We will operate efficiently and effectively…**
  …diagnosing and treating patients in timely fashion and expediting their return to health.

- **We will use our resources efficiently and effectively for the benefit of our patients and their care**…
…to ensure our services are clinically, operationally, and financially sustainable.



Our partnerships and collaboration

East Sussex Better Together (ESBT) Alliance

We are a key partner, with Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG and East Sussex County Council in the East Sussex Better Together (ESBT) Alliance.

ESBT is a transformation programme aiming to integrate health and social care in our area in order to deliver high quality and sustainable services to our local population. Our shared vision is that by 2020/21 there will be a joined-up, sustainable health and care system in East Sussex that ensures people receive proactive care, supporting them to live as well and as independently as possible, with care delivered close to home.

Together we are building a new model of care that integrates our whole system: primary prevention, primary and community care, social care, mental health, acute and specialist care so that we can demonstrably make the best use of the £850m that is spent each year to meet the health and care needs of the people of East Sussex. Working as one health and care system in East Sussex will mean we plan, pay for and provide services together in a way that makes best use of our joint budget and resources.

ESBT works very closely with GP practices, providers in the independent care sector and voluntary sector, local people, patients, clients and carers.

Sustainability and Transformation Partnership (STP)

We have been fully engaged with the development of the Sussex and East Surrey Sustainability and Transformation Partnership and have actively contributed to the various work-streams including digital, workforce, finance and acute hospitals. ESBT is one of four local plans within Sussex and East Surrey STP. The STP is clearly aligned to our local ESBT plans for place based care and we will continue to contribute to the work streams.

Healthwatch

As part of a national network, there is a local Healthwatch in every local authority area in England. Healthwatch East Sussex works with the public of East Sussex to ensure that health and social care services work for the people who 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. Healthwatch acts as a critical friend to ESHT, providing objective assessment and constructive criticism where appropriate. This year Healthwatch undertook two reviews of our emergency services, with teams of volunteers observing our care of patients as part of their listening tour and separately over a 24 hour period. The feedback supports 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 some of 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, through roadshow events and by providing opportunity for staff to put forward their ideas for improvement in 2018/19. We have also undertaken a public/patient forum, a drop in and an outreach event to help shape our patient experience priorities.

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

29th June 2018		Chairman
29th June 2018		Chief Executive

Part 2 – Priorities for Improvement in 2018/19

Our Quality and Safety Strategy (2017 - 2020) outlines the improvements required to achieve the Trust's ambition to become an **outstanding organisation by 2020.**

Throughout 2017/18 we have monitored and reviewed the progress of all the areas within our strategy via the Trust's Patient Safety and Quality Group.

There has been significant improvement in a number of areas including our improvement priorities outlined in the previous Quality Account. We also recognise, however, that there is still scope and need for further improvement.

Therefore for 2018/19 we have developed a set of priorities informed by the review of work undertaken in 2017/18 and also from local or national sources which require focused improvement.

The table below describes the improvement priorities for 2018/19 with further detail in the pages that follow including; the rationale for choosing these areas, what we are planning to do, how we monitor progress and how we will demonstrate our success.

Quality Domain	Priority for Improvement 2018/19
Patient Safety	Improving the early recognition, escalation and management of the deteriorating patient
	Continue to reduce the number of avoidable falls
	Continue our focus on reducing avoidable Grade 3 and 4 pressure ulcers
Clinical Effectiveness	Working towards providing consistent high quality care for our patients seven days per week
	Continued implementation of the Excellence in Care Programme
	Safe and effective discharge and improving our patients' experience of getting home
Patient Experience	Continue to improve End of Life Care by improving processes and documentation
	Improving the experience of young people in hospital

Patient Safety Improvement Priorities 2018/19

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

Why we have chosen this

Early detection and treatment of physiological deterioration has been shown to improve the clinical outcomes for patients.

We have made considerable improvements in the monitoring and detection of patient deterioration using an electronic observation system. We will embed and build on this work to further improve our escalation processes to ensure consistent early recognition of deterioration and that patients are assessed and treated with ongoing care planned appropriately.

Amongst the main causes of deterioration are Sepsis and Acute Kidney Injury (AKI):

- **Sepsis** is a common and potentially life threatening condition which arises when the body's response to an infection injures its own tissues and organs. This can lead to shock, multi organ failure and death therefore early detection and treatment is essential. We have made improvements, both on our wards and in our emergency departments, and want to continue our focus on this. In addition we want to provide our community teams and hospitals the clinical tools to support the early recognition and escalation of suspected Sepsis in these areas.

- **Acute Kidney Injury** means that the kidneys suddenly stop working as well as they were. This often happens as a complication of other serious illness and for a variety of reasons including severe dehydration, Sepsis and side effects of medications. We want to improve early detection by alerting clinical teams and pharmacists to patients who have AKI and improve the pathway of care they receive.

What are we going to do?

We will develop a clinically led improvement group to oversee and drive improvement in the three areas of:

- Improving escalation processes
- Sepsis recognition and prompt treatment
- AKI alerting and treatment

Escalation pathways

We will work with frontline staff through improvement workshops to understand where current systems and processes can be improved and involve them in shaping the new pathways.

Sepsis

We will continue to support our frontline teams to embed consistent screening and early treatment of Sepsis. We will implement a community Sepsis screening tool and continue to

raise awareness of Sepsis in a variety of ways, providing training, education and online resources for our staff to access.

Acute Kidney Injury
We will revise and improve the Acute Kidney Injury pathway through working with frontline staff. We will also raise awareness of the importance of early recognition and prompt treatment and develop an alert to our pharmacy teams to trigger review of medications which may be contributing to the onset of the condition.

What will success look like?

- Revised and improved escalation pathway developed and implemented
- Reduction in cardiac arrests associated with suboptimal management of physiological deterioration
- Increased percentage of patients screened for Sepsis in our acute hospitals
- Increased percentage of patients with Sepsis who receive antibiotics within one hour of diagnosis
- Implemented a Sepsis screening tool in our community hospitals and teams
- Revised and improved AKI pathway implemented
- Implemented a pharmacy medication review alerting process

How we will monitor progress?

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

2. Continue to reduce the number of avoidable falls

Why we have chosen this

Injury to patients from a fall whilst in hospital can be at worst catastrophic, and at best can result in further pain and suffering with potential increased length of stay and delayed recovery. Although we acknowledge patients must mobilise to enable recovery which may create an increased risk of falling, we know from investigating serious and moderate incidents there are occasions when we could have done more to try and prevent the fall from occurring. We need to provide assurance we did everything possible to prevent a patient from falling. The number of patient falls has reduced each year over the last three years and we will continue on this improvement journey.

What are we going to do?

We will continue to roll out the new assessment and care plan to all wards and raise the profile of falls prevention through education, leadership and challenge.

We will support effective leadership on the wards and clinical areas to ensure robust assessments are completed with clear prevention plans that are documented and checked on a daily basis. This will further reduce falls and subsequent harm to patients. To achieve this we will ensure education programmes are in place and continue to roll out the Excellence in Care programme to support the leadership on falls reductions.

What will success look like?

Our aims are to:

- 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 we will monitor progress?

Progress will be tracked and reported on a monthly basis through the Sign up to Safety report to the Patient Safety and Quality Group (PSQG).

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

Why we have chosen this

Many patients are at risk of developing a pressure ulcer. This increases for patients who are acutely ill, have impaired mobility or nutrition or those who have conditions that affect the flow of blood through the body such as diabetes.

Pressure ulcers occur when an area of the body is subject to prolonged pressure. The increased pressure affects the blood flow causing the skin to be starved of oxygen and nutrients which leads to break down of the skin and surrounding tissues leading to ulcer formation.

We have chosen this as priority in 2018/19 as although we have made a number of improvements, we recognise there is more to do. Our focus is to reduce the number of avoidable grade 3 and 4 pressure ulcers with the ultimate aim of eliminating these entirely. Prevention of skin damage is an integral part of the care we provide at ESHT. Therefore a collaborative multidisciplinary approach, where each member of the healthcare team takes responsibility for the early identification of skin damage through assessment and on-going management, is required.

What are we going to do?

Develop our annual improvement plan which includes the following actions:

Understanding the key themes and share the learning

- Through the monthly Pressure Ulcer Review Group (PURG) we will continue to review all Grade 3 and 4 pressure ulcers
- Using the Department of Health definition, we will categorise whether the pressure ulcer was avoidable or unavoidable
- If it is found that our Trust policy has not been followed and the pressure was avoidable, it may be necessary to raise an incident under the Serious Incident process for full investigation
- Analysis will be undertaken so themes and trends are clearly identified with actions identified and learning shared

Training, education and improving awareness

- Introduce ‘Pressure Ulcer prompt cards’ to all our hospital and community staff to raise awareness and provide accessible information on prevention and management
- Continue to provide formal and informal training and education to our staff
- Support and develop our newly formed Pressure Ulcer Ward and Community Team Champions so they are able to support improvement in their areas

Measuring for improvement

- Review our existing measures of improvement and develop a set of measures which we will monitor regularly so we can track if improvement is being made
- Revise our monthly ward/team audits to ensure we track our compliance with key standards such as assessment using the Purpose T tool and the SSKIN bundle
- Provide support to teams or wards where our compliance could be improved

What will success look like?

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

How we will monitor progress?

We will monitor progress through the Pressure Ulcer Steering Group (PUSG) and if required, also to the Serious Incident Review Group (SIRG).

The Pressure Ulcer Steering Group (PUSG) is a bi-monthly multi-disciplinary meeting chaired by the Deputy Director of Nursing. It reviews findings and actions from the Pressure Ulcer Review Group (PURG) and tracks the progress of the pressure ulcer improvement plans and improvement measures.


Clinical Effectiveness Improvements 2018/19

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

Why we have chosen this

There is a national drive to improve access to emergency care 24 hours a day, 7 days a week. A large programme of work has been established by NHS England and NHS Improvement with early adopter Trusts including Oxford and Southampton.

Ten core standards were identified by the 'NHS Services, Seven Days a Week Forum' in 2013, which were based on the Royal College of Physicians' guidance on acute and emergency admissions. They apply only to emergency admissions and not planned care.

The original ten standards are still in place; however, there are four core standards that need to be delivered by the Trust by 2020/21:

- Core Standard 2 – patients wait no longer than 14 hours to initial consultant review after admission
- Core Standard 5 – patients get access to diagnostic tests with a 24 hour turnaround Emergency Department study opened in collaboration with SECAMB and Sussex Police time. For urgent requests, this drops to 12 hours and for critical patients, one hour.
- Core Standard 6 – patients get access to specialist, consultant-directed interventions
- Core standard 8 – patients with high-dependency care receive twice daily consultant review and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds

What are we going to do?

We acknowledge the need to achieve the four core standards by 2020/21; as such we plan to approach this three year scheme in a phased approach.

In 2018/19 we will initially focus on the first phase. This will include:

Monitoring

- Completing and responding to mandatory audits and benchmarking achievements against national peers
- Reviewing automated data capture systems with a view to reducing administrative overheads

Communications and Engagement

- Leading by example to increase awareness and improve services across the Trust; improving clinical safety and achievement of core standards
- Improving internal communications to enable sufficient access to out of hours services
- Liaising with, and learning from, early adopter sites
- Networking with other NHS Trusts to share best practice

Proof of Concept

- Putting changes in clinical practice in place in our local health economy in response to lessons learnt both internally and nationally
- Using an improvement methodology to enable initiatives to be positively adopted, tested and adjusted in anticipation of Trust-wide roll out.

Staffing

- Baselining existing workforce for acute and emergency admission areas and clinical support areas
- Comparing existing workforce to requirements for seven day services achievement
- Producing plans to identify solutions as to how the gaps will be filled

What will success look like?

We will end the first phase with an:

- Improvement on core standard delivery, resulting in audit results as follows by March 2019:
    a. Core Standard 2 = 80%
    b. Core Standard 5 = 77%
    c. Core Standard 6 = 90%
    d. Core Standard 8 = 50%
- Development of specialty or divisional level plans for further improvement
- Automated data capture solution identified, and implementation plans agreed

How we will monitor progress?

A number of workstreams will be established to focus on the key areas of work, reporting into the Project Steering Group, which subsequently is accountable to the Clinical Effectiveness Group, chaired by the Assistant Medical Director.

5. Continued implementation of the Excellence in Care Programme

Why we have chosen this

In the past we have collected information on ward performance through incidents, patient feedback and numerous audits and data collection. These have been collated and reported from different systems in varied ways, making it difficult for wards to easily access, review and analyse the information to identify areas for improvement or to celebrate the high quality care they are providing.

The Excellence in Care Programme was developed in response to our Trust commitment to continuous improvement, empowering teams to lead change. It clearly identifies key measures collated from all the different systems into a user friendly dashboard and highlights areas which require improvement. This enables staff to make changes to further improve the quality and delivery of the care they provide.

The dashboard enables wards to measure the desired improvement as a consequence of the positive action and changes they make to reduce harm, improve outcomes and improve patient and staff experience, contributing to overall quality improvement across the Trust.

What are we going to do?

We will continue to roll out the Quality and Safety Dashboard which is currently within ten wards to **all** our acute inpatient ward areas. Monthly reports will be available to enable review of information to identify areas for improvement. We will also roll out the Leadership and Culture dashboard in the same way, and work on the Access and Delivery dashboard, which will be trialled on a number of wards during the year.

We will develop a set of process and outcome measures to assess our performance in the domains of Access and Delivery and Leadership and Culture and aim to test these on two wards.

What will success look like?

- The Quality and Safety measures dashboard will be available to all inpatient wards across the Trust by 31st March 2019. Monthly reports will be available to enable review of information to identify areas for improvement
- Improvement measures for the other domains of Access and Delivery and Leadership and Culture will be developed, agreed and piloted with the aim of rolling out to at least 50% of wards

How we will monitor progress?

The Excellence in Care Project Board is responsible for monitoring and guiding the delivery of the Excellence in Care programme. Overall progress is monitored by the Trust's Patient Safety and Quality Group (PS&QG).

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

Why we have chosen this

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

What are we going to do?

We will design and implement a system for the communication and provision of information for patients and their families or carers prior to and during their discharge from hospital by the end of September 2018. This will be achieved through engagement with patients and staff on one ward in each division to review the current systems in place and identify the gaps to re-design an effective communication system for verbal and written information. Once improvement can be demonstrated and the system is effective it will be rolled out to other wards. We will work with ESBT and system partners to ensure a comprehensive and collaborative approach.

We will also design and implement a review process for potentially avoidable readmissions within 30 days to identify themes or lapses to determine what improvements can be made. This will involve a clinical audit of a snapshot of patients. We will also design a clinical audit system to review the number of readmissions each quarter to determine any themes or areas for improvement.

What will success look like?

Improved feedback from the people who use our services about the discharge process, firstly about communication and secondly about information regarding the discharge process. We also aim to see more positive feedback from our staff. A system will be designed and in place for reviewing (a snapshot of) potentially avoidable readmissions within 30 days. This will be similar to the work on learning from deaths and will be a snapshot audit.

How we will monitor progress?

Improvement will be monitored through the inpatient questionnaire via two questions about the discharge process, one about communication and one about information regarding the discharge process. The National Inpatient Survey will be used but is unlikely to show improvement in the 2018 survey due to the focus work with individual wards. We will also look to survey a number of staff involved in the process.

We will also hope to see a clinical audit in place with information regarding potentially avoidable readmissions within 30 days to provide themes and improvement work going forward.

Patient Experience Improvements 2018/19

7. Continue to improve end of life care by improving processes and documentation

Why we have chosen this

We have made a number of improvements in the care we provide to patients at the end of their life during 2017/18 which we have outlined in a later section of the Quality Account. Although we have achieved this we also recognise that there are a number of improvements required in some of our processes and documentation. Therefore this year we will focus on specific areas where improvement in systems and process is a key enabler to enhancing the overall experience of care we provide.

What are we going to do?

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

ReSPECT is a process that creates personalised recommendations for a person's clinical treatment in a future emergency in which they are unable to make or express choices. It provides healthcare professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment.

The plan is created through conversations between a person and healthcare professionals and recorded on a form which includes their personal priorities for care and agreed clinical recommendations about care and treatment that could help to achieve the outcome that they would want, that would not help, or that they would not want.

We plan to start implementation of ReSPECT in August 2018, initially within our acute hospitals. We will provide training to undertake the ReSPECT process to key members of staff within our acute and community teams, raise awareness through a number of mechanisms and provide information and training resources for staff to access.

End of life care for Neonates and Children and Young People

In recognising the different requirement for our patients and staff, we will develop with patients and parents a specific End of Life Care Strategy for Neonates, Children and Young People.

We will, as part of our year one improvement plan, introduce 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.

Measuring for improvement

In 2017/18 we developed a range of indicators to measure the improvements we are expecting as a consequence of the planned improvement actions we have implemented. This includes how well we are documenting the care we provide in the Last Hours and Days of Life Care Plan.

We will continue to monitor this on a monthly basis in 2018/19 and also review the information we gain through the Voices Survey which bereaved relatives and friends complete to give us feedback on the care experience of their loved one and of their own experience of the services we have provided.

What will success look like?

- ReSPECT advocates from our acute and community teams will be identified and trained and will be able to provide ReSPECT process training to colleagues in their clinical areas
- The ReSPECT process and document will be implemented within our acute hospitals
- We will see improvement in the documentation of last days and hours of life care

How we will monitor progress?

The End of Life Care Steering Group provides oversight of the full end of life care programme of work and the measures of improvements. The group reports into the Clinical Outcome Group (COG) which is chaired by our Medical Director.

8. Improving the experience of young people in hospital

Why we have chosen this

Results of the National Children and Young People survey highlighted areas that young people were not happy with during their stay as an inpatient. 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?
- Were you involved in decisions about your care and treatment?
- 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?

Our improvement priority is to work with the Patient Experience Lead and team and the Associate Director of Communications and Engagement 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.

What are we going to do?

We will develop a questionnaire that will be available as both an online and paper survey which will ask young people and their families about their recent hospital experience.

We will undertake the survey over a three month period and use the information gained to develop a plan of improvements on our children's wards. We will implement the changes in the later part of the year.

We will work with the patient experience team to break down the Friends and Family Test (FFT) responses by age groups so we are able to monitor and track the experience of care and the ward environment for all age groups. We may also add a specific question to the FFT questions to test if our actions are having the desired effect for the focus age group. The results of the FFT are reviewed monthly by the ward Matrons and Heads of Nursing and improvements made accordingly.

What will success look like?

Success will be measured by:

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

How we will monitor progress?

Progress will be monitored monthly by the Matrons and Heads of Nursing by regularly reviewing the patient experience data available including FFT, plaudits and complaints.

The Trust's Patient Experience Steering Group will monitor overall progress of the improvement priority.

Part 2.1

Statement of Assurance from the Board of Directors

Review of Services

During 2017/18 East Sussex Healthcare NHS Trust provided and/or sub-contracted 75 NHS services.

East Sussex Healthcare NHS Trust has reviewed all the data available to them on the quality of care in all 75 of these NHS services.

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of NHS services by East Sussex Healthcare NHS Trust for 2017/18.

Participation in Clinical Audit and National Confidential Enquiries

Overview of clinical audit at ESHT

We use clinical audit to aid improvements in the delivery and quality of patient care, and it is viewed as a tool to facilitate continuous improvement. It is effectively the review of clinical performance against agreed standards, and the refining of clinical practice as a result.

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

We follow 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.

National Audit and National Confidential Enquiries Programme

We participated in 98% of National Clinical Audits and 100% of National Confidential Enquiries during 2017/18. Details of those we were eligible to participate in during 2017/18 can be found in Appendix 1.

The list in Appendix 2 shows 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.

We also participated in six additional (non-mandated) national audits in 2017/18 which can be found in Appendix 3.

Non participation – Endocrine and Thyroid Audit

We were unable to participate in the 2017/18 round of this national audit as the eligible Consultants were unable to secure the necessary resources required (time and administrative support) due to significant staffing shortages within the department. This national audit is not mandated for the Trust in 2018/19.

National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD)

NCEPOD issued two reports in 2017/2018, these were:

- 'Inspiring Change – Acute Non Invasive Ventilation' published July 2017
- 'Each and Every Need – Chronic Neuro-disability' published March 2018

These have been reviewed by the Medical Director and Director of Nursing and a Lead Consultant has been identified to implement the recommendations.

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.

The Women, Children and Sexual Health Division continues to report:

- All late foetal losses between 22+0 and 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 seven 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 seven 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 2017-18 include:

- Amniotic Fluid Embolism (0 cases reported)
- Anaphylaxis in pregnancy (0 cases reported)
- Aspiration in pregnancy (0 cases reported)
- Breast Cancer in pregnancy (1 case reported)
- Cystic fibrosis in pregnancy (0 cases reported)
- Epidural Haematoma or Abscess Study (0 cases reported)
- Epilepsy in pregnancy (1 case reported)
- Gastric Bypass Surgery in pregnancy (0 cases reported)
- Pulmonary Embolism in pregnancy (0 cases reported)
- Vasa Praevia (1 case reported)

National Clinical Audit Reports in 2017/18

The reports of 46 national clinical audits were reviewed by the provider in 2017/18. 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.

Five of these completed national clinical audits are detailed below with the associated actions that East Sussex Healthcare NHS Trust intends to take to improve the quality of healthcare provided:

Paediatric Pneumonia Audit

Overview

Pneumonia (and other lower respiratory tract infections) is a leading cause of death worldwide - it is a common condition and associated with significant morbidity and mortality, therefore proper diagnosis, correctly recognising any complications or underlying conditions and appropriately treating patients is extremely important.

The United Nations Children's Fund (UNICEF) estimates that three million children die worldwide each year from Pneumonia. These deaths occur almost exclusively in children with underlying conditions, such as chronic lung disease of prematurity, congenital heart disease and immunosuppression. Although most fatalities occur in developing countries, pneumonia remains a significant cause of morbidity across the developed world.

This national audit will be used to assess compliance with the British Thoracic Society (BTS) Guidelines and to identify trends over time thus helping to determine baseline demographics and identify areas for improvement in the management of childhood community acquired pneumonia (CAP).

Lessons Learnt

Overall this audit has confirmed that the Trust is managing childhood CAP well, although documentation of clerking could improve to aid a more accurate assessment of severity in a child with possible pneumonia. Furthermore a local teaching session on the guidelines may reduce unnecessary investigations in some cases of CAP.

ESHT Actions following the audit

1. Conduct a departmental teaching session on the importance of accurate documentation and the management of chest infections in accordance with the national BTS guideline for the management of CAP – **complete**
2. Review antibiotic guidance in the Trust's local guideline, involving microbiology, local pharmacy and senior clinicians – **complete**

National Diabetic Foot-care Audit

Overview

The National Diabetes Foot Care Audit (NDFA) is a measurement system of care structures, patient management and outcomes of care for people with active diabetic foot disease. In 2014/15 the annual cost of diabetic foot disease to the NHS in England was estimated at £1 billion, in addition to the personal/social costs of reduced mobility and sickness absence.

This national audit seeks to address three key questions:

- Are NICE recommended care structures in place for the management of diabetic foot disease?
- Does treatment of active diabetic foot disease comply with national recommended guidelines?
- Are the outcomes of diabetic foot disease optimised?

Lessons Learnt

New foot ulcers should be referred for expert assessment as soon as possible - people with diabetes who have an active foot problem should be referred to a specialist team within one working day and be triaged within two working days. When the time to first expert assessment is delayed, ulcers are more likely to be severe.

ESHT Actions following the audit

1. Create simple and rapid referral pathways to facilitate rapid, expert assessment - **complete**
2. Continue to participate in the NDFA to collaborate in the nationwide drive to improve the outcomes for diabetic foot disease and boost local recruitment – **ongoing**
3. Provision of a Diabetes specialist foot-care team through collaboration with East Sussex Better Together – **current staffing issues have been noted, details have now been added to the Trust's Risk Register**

Moderate and Severe Asthma

Overview

There are approximately 5.4 million people in the UK who suffer from asthma, with one in five households being affected. Of greater concern is that every 10 seconds someone is having a potentially life threatening asthma attack and despite remarkable efforts by NHS staff, three people will die of acute asthma every day in the UK. The purpose of this national audit is to monitor documented care against the Royal College of Emergency Medicine (RCEM) standards published in 2016. The audit is designed to drive clinical practice forward by helping clinicians to examine the work they do day-to-day and benchmark against their peers, but also to recognise excellence.

Lessons Learnt

Identifying derangement in vital signs and peak flow early is a very important part of good asthma care as it guides treatment and therefore leads to a reduction in morbidity and mortality. Better sharing of working practices is needed and rapid cycle quality improvement work will raise standards where possible. The results of this audit show that many departments are finding it challenging to adhere to the time standards set by the British Thoracic Society and RCEM. It is thought that this, in part, reflects the increasing demands on Emergency Departments with higher volumes of patients with increasingly complex health needs.

ESHT Actions following the audit

1. Share the results of this audit across the Trust, ensuring full discussions and review at a local level. This will help clinical staff to understand and engage with the actions required to improve compliance – **complete**
2. Develop an education programme to roll out across the Emergency Departments; this will help to educate clinicians following the recommendations from the RCEM - to include psychological aspects – **complete**
3. Adopt or design a new proforma, incorporating the recommendations identified in this audit - this will help to improve documentation and act as an aide memoire for assessment, discharge/admission criteria and dosing of medication – **complete**
4. Design an information leaflet to provide to patients upon discharge – **complete**

National Audit of Dementia

Overview

Dementia has remained a key national priority for health services since the outset of audit in 2008. Governments in England and Wales have restated the need to improve dementia care in hospitals, other care settings and the community.

The National Audit of Dementia (care in general hospitals) measures the performance of general hospitals against criteria relating to care delivery which are known to impact upon people with dementia while in hospital. These criteria have been derived 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.

Lessons Learnt

Inconsistency in what is recorded and communicated with regards to delirium may affect clinical care and thereby increase a person with dementia's risk of developing delirium. Robust mechanisms must be in place for assessing delirium in people with dementia including:

- At admission, a full initial delirium assessment, whenever indicators of delirium are identified
- Cognitive tests administered on admission and again before discharge
- Delirium screening and assessment fully documented in the patient's notes (regardless of the outcome).
- Care offered in concordance with the delirium evidence-based recommendations when the assessment indicates symptoms of delirium

- Results recorded on the electronic discharge summary
- Ensure staff receive training in delirium and its relationship to dementia, manifestations of pain and behavioural and psychological symptoms of dementia

Carer satisfaction should be seen as a marker of good care. Ward managers should be supported to ensure carers supporting patients should not be asked to leave at mealtimes/stopped from helping with meals (this excludes emergency and urgent care and treatment).

A Dementia champion should be available to support staff 24 hours per day, 7 days per week. This could be achieved through ensuring that people in roles such as Site Practitioners have expertise in Dementia care.

ESHT Actions following the audit

Staff communication

1. The Outreach Specialist Team to attend gateway areas within the acute setting - *Service Change Proposal devised to support the development of shared care wards on each site* – **In progress**
2. Key documents to be made available and used appropriately within the patient's notes – **Ongoing**
3. "This is Me"/ "Reach out to Me" documents – *ensure that these are displayed in clear plastic wallets at the end of the patient's bed for all staff (including housekeeping) to refer to as required* – **Ongoing**
4. Ensure calls are made in a timely manner to the Dementia Care Team for early assessment and therapeutic intervention or to support carers and staff as appropriate – *Education of staff, especially in relation to general comprehension of this growing cohort of patients to ensure that management is respectful and empathy is shown to the needs of patients and carers* – **Ongoing**

Discharge

1. Development of improved multidisciplinary working – **In progress**
2. Specialist Teams to undertake continuous evidence-based assessments – *Education of staff about the National Audit requirements for documentation to support evidencing of intuitive observation, robust care and improved discharge planning* – **Ongoing**

Assessment

1. Comprehensive Geriatric Assessment tool to be included in a booklet for frail patients and those over 65 years old – **Underway**
2. Staff training and education regarding accurate assessment and clear documentation within the Trust's Integrated Care Pathway – **Ongoing**
3. Delirium – requires an assessment on admission by Medical Teams – **Under review**
4. Conduct a local audit on pain assessment for Dementia patients – **Complete**

Carer Communication

1. Development of a supplementary information document for Dementia care – this will help support the service moving forward and improve patient/carer communication – **In development**
2. Butterfly scheme in situ (Butterfly stickers should be placed on the patient's notes and in all referral documents if they have Dementia) – *maintain uptake and ensure all staff implement the scheme, this will require education through the Matrons* – **Ongoing**
3. Carers Respite Emergency Card – increased education and involvement from South East Coast Ambulance Service (SECAMB) and South Central Ambulance Service (SCAS) –

Ongoing

4. Continue to work closely with the catering department to increase and widen the use of blue (and/or red) plates – **Ongoing**

Public Health England	**Prevention of Surgical Site Infection**

Overview

Public Health England's Healthcare Associated Infection and Antimicrobial Resistance Department runs the Surgical Site Infection Surveillance Service (SSISS) – this service 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. The SSISS supports the mandatory surveillance of surgical site infection (SSI) in four categories of Orthopaedics:

- hip replacements
- knee replacements
- repair of neck of femur
- reduction of long bone fracture

Lessons Learnt

Factors increasing SSI risks can be related to patient characteristics and certain pre-operative factors. Implementation of national evidence based guidelines and standards provide a means of achieving an effective patient safety culture.

- Yearly comparison of data is better than the quarterly comparison for a more reliable and accurate reflection of the SSI rate
- Any high outlier notifications are dealt with by the multidisciplinary team approach to find the cause and work towards correcting it
- Patients are informed about their post-operative role in wound management and 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

ESHT Actions following the audit

1. Provide a single room for patients identified as MRSA positive and prevent any unnecessary bed movements post-surgery – *work towards reducing bed shortages by carefully planning and improving the timely discharge of patients* – **Ongoing**
2. Continue to screen all patients for MRSA pre-operatively – **Ongoing**
3. Continue to ensure decolonisation treatment is given to all patients identified as MRSA positive – **Ongoing**
4. Source and provide information leaflets to patients about Surgical Site Infections and the resources available to them – **Complete / Ongoing**
5. Educate and ensure relevant staff understand and comply to NICE Guideline CG74 - *Surgical site infections: prevention and treatment* and to the local Trust Policy – **Ongoing**

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

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.

159 local clinical audit reports were developed in 2017/18. Five 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

Endocrinology

Are we effectively investigating & managing hyponatremia in our patients?

WINNER of the 2017/18 Trust Clinical Audit Awards

Background

Hyponatraemia affects 15-20% of emergency admissions to hospital, it is a dangerous problem associated with increased mortality and length of stay in hospital. Rapid changes in serum sodium levels or severely low levels can result in vomiting, seizures, coma and cardio-respiratory arrest. Despite the consequences and implications of low sodium levels it is a poorly recognised problem which is often inadequately investigated and managed.

Aims and objectives

- To establish whether, amongst those patients presenting to the acute assessment unit with hyponatraemia, it is being recognised as a problem
- To assess whether the recommended investigations are being carried out to determine the cause of the hyponatraemia
- To assess whether the correct management is being undertaken to correct the hyponatraemia
- To evaluate the length of stay, rate of re-admission and mortality rates amongst patients with hyponatraemia

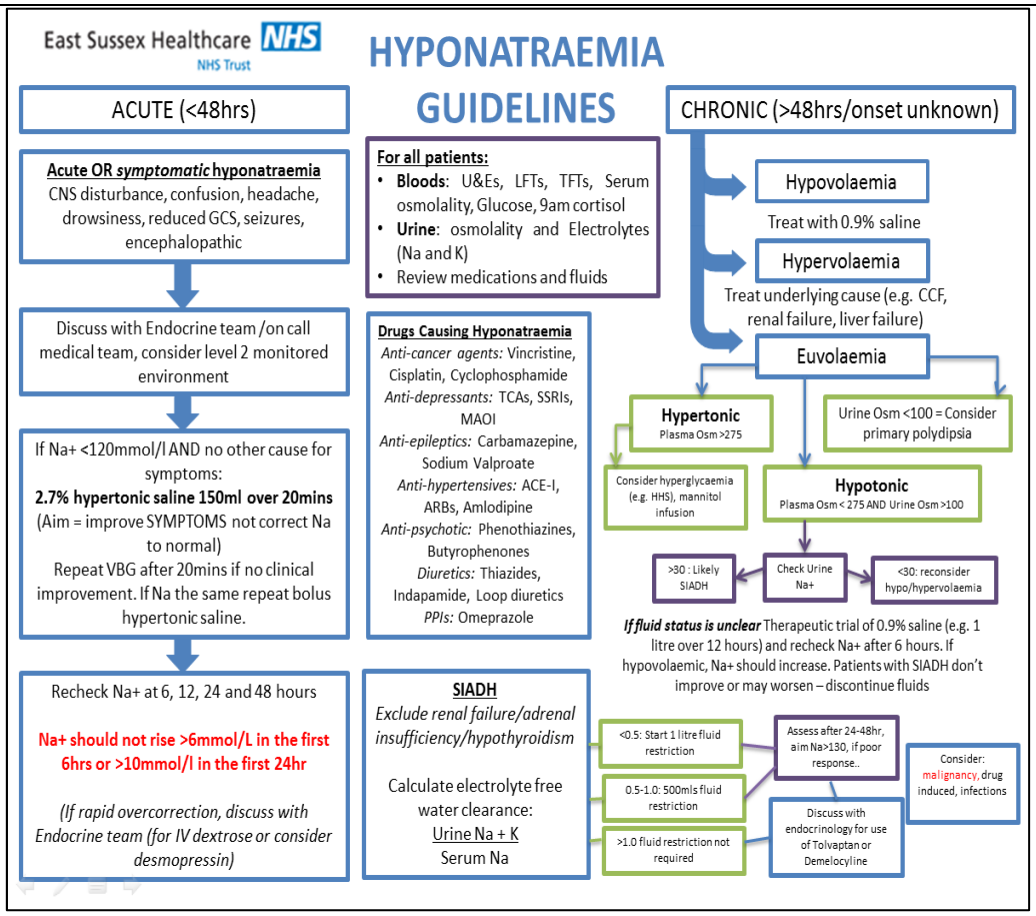
Discussion and Lessons Learnt

This audit has demonstrated primarily that hyponatraemia is not being adequately investigated and managed in the Acute Assessment Unit. In addition the evidence of increased length of stay, re-admission and mortality rates amongst these patients reiterates the need for this problem to be correctly managed.

Actions following the audit

1. Re-education of doctors in the assessment and management of hyponatraemia – **ongoing and reiterated via Grand Round**
2. Provide an outline of how to manage hyponatraemia – **Complete**

Following this audit, the auditor developed a poster outlining how hyponatraemia must be managed; this has been displayed appropriately across key clinical areas. Alert stickers have also been developed for use in patient notes.



Accident & Emergency

Consultant sign off in patients with traumatic chest pain aged 30 years or older and abdominal pain aged 60 years or older

Background

The crucial role of Middle Grade staff and particularly Consultants in A&E departments helps to improve clinical outcomes, reduce waiting times and length of stay and ensures that patients are only admitted to hospital if there is no reasonable alternative.

The Royal College of Emergency Medicine is currently advocating an increase in the number of Consultants present within A&E departments to provide a higher standard of care to patients and invaluable support to Junior Doctors and other medical practitioners. Chest pain and abdominal pains are very commonly encountered in A&E – most cases are straightforward in nature and managed appropriately, however, a number of these patients may have underlying life-threatening health conditions and are being discharged by Junior Doctors who have not discussed the patient with a Consultant or Middle Grade Doctor (against best practice recommendations). In many cases these discharged patients will re-present to A&E again at some point in the near future in a worsened state, increasing the risk of mortality.

Aims and objectives

- To identify the proportion of this patient group who are assessed by a Consultant/Middle Grade Doctor prior to discharge

- To recognise and implement improvement methods to ensure a rising trend of these patients being reviewed by a Consultant (or a Middle Grade Doctor in the absence of a Consultant) prior to discharge

Discussion and Lessons Learnt

More than 50% of patients presenting to the Emergency department were neither seen nor reviewed by a Consultant or a Middle Grade Doctor.

There is a notable lack of awareness amongst Junior Doctors with regards to the importance of Consultant and Middle Grade patient sign off. Despite the presence of a Middle Grade doctor on the A&E shop floor at all times during the audit, the number of Middle Grade sign offs were considerably low. To optimise patient safety, Junior Doctors must be educated and encouraged to approach Middle Grade Doctors working in the department to review patients in the absence of a Consultant. The use of posters displayed around the department, Consultant sign-off stamps, educational seminars and meetings will help to circulate the message to all staff members working in the department.

Actions following the audit

1. Make alterations to the Consultant rotas to ensure a greater proportion of time is spent working on the 'shop floor' – **Complete**
2. Increase recruitment of Middle Grade doctors by developing employment opportunities within the department – assistance from Managers to advertise job posts – **Ongoing**
3. Increase awareness amongst Junior Doctors regarding the importance of Consultant/ Middle Grade sign offs and Royal College standards by conducting educational seminars, displaying posters and using sign off stamps. Department staff (including Doctors, Nurses and Paramedic staff) must take an active role in educational activities and seminars to raise awareness of this issue. **Ongoing** – *Posters are now displayed on the A&E Doctors' noticeboard, sign off stamps are available for use and trainee teaching sessions are being used to educate staff regarding the need for Consultant/Senior grade patient sign offs.*

Obstetrics

Category 1 caesarean section – Decision to delivery interval and neonatal outcomes

Background

Category 1 caesarean sections are undertaken in situations where there is an immediate threat to the mother or foetus, and should be initiated within 30 minutes of 'decision to delivery' (DDI). Certain clinical situations will require a much quicker DDI than 30 minutes and units should work towards improving their efficiency. Undue haste to achieve a short DDI can introduce its own risk, both surgical and anaesthetic, with potential harm caused to mother and foetus.

Aims and objectives

This audit was conducted as a baseline study to evaluate Trust practice and identify any factors leading to a delay in delivery or adverse outcome for the mother or baby.

Discussion and Lessons Learnt

A category 1 caesarean section is an obstetric emergency and has to be acted on quickly involving a multi-disciplinary team of Obstetricians, Midwives, Theatre Team, Anaesthetists and Neonatologists. This audit evidenced good multidisciplinary team involvement and all patients had been discussed with the Consultant on call. No specific risks were identified in

this study, seven cases did not achieve the 30 minute target but all babies were delivered safely with good outcomes.

- If the decision is made to delay the delivery beyond the 30 minute target, full details must be clearly documented in the patient's notes and on the Trust's electronic system 'E3'.

Actions following the audit

1. Ensure that each caesarean section category is clearly documented on E3 – Inform the PROMPT (Practical Obstetric Multi-Professional Training) Lead of the need to highlight this at every course – **Ongoing**
2. Consider a prospective future re-audit for accurate data collection – (if deemed necessary) **to be confirmed**
3. Discussion to take place with the Anaesthetic Lead regarding the use of a second theatre for Category 1 caesarean sections, and the frequency of requirement – **complete**
4. Improve documentation for any category 1 caesarean sections performed >30 minutes from DDI – Discuss with E3 system coordinator to generate an information box to be completed by the surgeon involved – **complete**

Pharmacy

Compliance with East Sussex Healthcare NHS Trust Guideline on Pharmacological Treatment of Inpatient Acute Anxiety and Insomnia in Adults

Background

Hypnotic and anxiolytic drugs are respectively used to help restore normal sleep behaviour and to reduce anxiety-linked symptoms. The use of hypnotics and anxiolytics may cause drowsiness, falls, forgetfulness, confusion, depression, irritability, aggression, impulsivity, cognitive and psychomotor impairment, in addition to problems of tolerance and dependence and therefore correct management for these drugs is essential.

Aims and Objectives

To assess whether the treatment of acute anxiety and insomnia in adults at Eastbourne DGH and Conquest Hospital is according to the ESHT guideline.

Discussion and Lessons Learnt

Staff are not complying with the ESHT guideline for the acute treatment of anxiety and insomnia in adults:

- Patients are at risk of being treated unnecessarily and inappropriately for these conditions
- Non-pharmacological measures are not in place and followed as a first step before initiating pharmacological treatments.

Prescribers, pharmacists and nurses should be educated regarding the available guidance and where this can be located. The inclusion of pathways for acute treatment of anxiety and insomnia in the drug charts would be helpful to staff and boost compliance.

Cognitive Behavioural Therapy for insomnia and anxiety (CBTI) has been shown to be beneficial where it affects everyday life. CBTI is not currently available locally and so the introduction of this therapy may be beneficial.

Actions following the audit

1. Disseminate the results of this audit and the associated guideline widely across the Trust to educate staff and increase awareness, the guideline is available for all staff to review via the extranet – **complete**

2. Pharmacists to challenge sleep disturbance in accordance with the formulary and guidelines. Audit to be presented at clinical pharmacist meeting and all staff reminded of guidance and formulary status – **complete** *(audit to be repeated after suitable time lapse)*
3. The Pharmacy Department to review medicines as part of the *'Falls and Polypharmacy review'* – **complete**. A process has been created however it is currently unclear how widespread practice is. The model of practice in Pharmacy has been reworked around clusters and it is expected that this work will form a new model of care within Pharmacy. Work around this includes the creation of referral criteria and tools to simplify review.

Pathology

Anaerobic blood stream infections in East Sussex Healthcare Trust

Background

Anaerobic bloodstream infections (BSI) are uncommon in the community and in hospital patients, though one study from the USA has reported the re-emergence of anaerobic bacteraemia. The isolation of anaerobes from blood culture is usually associated with high mortality and can lead to multi-organ failure. The majority of patients with anaerobic BSI do not receive appropriate antimicrobial treatment as this infection remains unsuspected on clinical basis, often leading to an adverse outcome. Antibiotic susceptibility testing on anaerobic organisms is rarely carried out as it is technically difficult to perform, expensive and the results take significant time to become available due to the slow growth of anaerobes.

Aims and Objectives

The main objective was to examine the prevalence and antibiotic susceptibility pattern of anaerobic organisms causing BSI and evaluate the efficacy of empirical antimicrobial therapy.

Discussion and Lessons Learnt

Anaerobic BSIs are rare in hospitalised patients, however several risk factors such as recent abdominal surgery, cancer, intensive cancer therapy, bone marrow transplant, old age or pre-existing heart, kidney and liver disease have been identified for this infection. The incidence of anaerobic BSI in this audit was low - there could be several reasons for this such as routine bowel preparation before surgery, appropriate use of antibiotic prophylaxis and use of empirical antibiotics which are effective against anaerobes.

This study highlights a low rate of anaerobic bacteraemia at ESHT over the past ten years. 76% of episodes occurred in the over 60 age group and 40% of all episodes occurred in the Emergency Department, therefore empirical agents active against anaerobes should be considered in patients presenting with bacteraemia in this location.

Low level resistance to the antibiotics used was identified; therefore the empirical antibiotic guidelines for Sepsis issued by the Trust are confirmed to be extremely effective.

The auditors recommend periodic epidemiology and resistance surveillance in anaerobic bacteraemia to guide empirical antibiotic therapy.

Actions following the audit

1. Re-audit again in five years to evaluate the effectiveness of empirical antibiotics against anaerobic blood stream infections
2. Share the audit's findings with the Antimicrobial Stewardship Group and the Microbiology department to assure staff that the Trust's antimicrobial guidelines are effective against anaerobic blood stream infections

Participation in Research

Participation in clinical research demonstrates our commitment to improving the quality of care and services we provide.

Research is a core part of the NHS, enabling the improvement of the current and future health of the people it serves. The Health Research Authority (HRA) defines research as 'The attempt to derive generalizable or transferable new knowledge to answer questions with scientifically sound methods'.

In April 2016 the HRA rolled out a new single approval process bringing together the assessment of governance and legal compliance. Under this umbrella the independent Research Ethics Committee (REC) opinion is provided through the UK Health Departments' Research Ethics Service (UKRES) therefore participating sites can be confident that patients are being offered research opportunities that meet the regulatory and statutory requirement for national and international studies. This is a positive outcome for patients.

This has led to a shift in focus for the Clinical Research Department requiring exploration of new ways of working to support varied specialties. This has given us opportunities to work closely with nursing and AHP specialists, who are experts in their field, whilst we can support as specialists in the research requirements.

This has included developing strategies to enable Trust engagement with research activity. Chiefs of Division receive regular updates of current recruiting studies and details of Principle Investigators involved in providing research opportunities to patients. The Head of Research is now a member of Senior Leaders Forum, Clinical Effectiveness Group and Education Steering Group.

Activity

The number of patients that were recruited to research studies during 2017/18 is currently 834 with many more being offered the opportunity to take part. This is a similar number to the previous year. The final figure will be available at the end of May 2018 and is expected to exceed the 2016/17 total.

During 2017/18 we have been involved in conducting 70 clinical research studies and this is an increase from the previous year.

The clinical research team seeks to work closely with specialist teams, supporting Principle Investigators, Clinical Nurses Specialists and Allied Health Professionals in a number of specialties.

Achievements 2017/18

- Audiology study opened – Hearing Aids for Music project
- Ophthalmology study opened - National survey of prosthetic eye users
- Emergency Department study opened in collaboration with SECAMB and Sussex Police – ENHANCE (Enhancing Mental Health Awareness in Emergency Services)

- Fluid Optimisation in Emergency Laparotomy (FLO ELA) – Conquest is joint 4th in recruiting to this national study
- A renal denervation study for hypertension (RADIANCE HTN) which is available on Facebook with Conquest Hospital Doctors being cited, and is the only participating site in the Kent Surrey and Sussex region
- Improved working with CNS's who run nurse led clinics – including Gastroenterology, Urology, Rheumatology, Cardiology
- Continued alignment with the five year Research and Development Strategy
- Reconfiguration of the team to provide admin support and clinical trial co-ordinator posts. This is positive and enables flexibility to support a wide variety of research activity

Commissioning for Quality and Innovation (CQUIN)

Like all NHS Trusts, East Sussex Healthcare is required to make a proportion of our 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.

2017/18 schemes are summarised in the table below with indication as to whether all quality milestones were achieved.

	Scheme	Improvement milestones achieved
National	Staff Health & Wellbeing	Partially achieved
CQUIN	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Partially achieved
	Improving service for people with mental health needs who present to A&E	Full achievement
	Offering Advice & Guidance	Full achievement (against revised milestones)
	NHS e-Referrals	Full achievement (against revised milestones)
	Supporting Proactive & Safe Discharge	Full achievement
NHS England CQUIN	Patient Activation Measures (HIV)	Full achievement
	Dose Banding IV SACT	Full achievement
	Diabetic Eyes Screening Programme	Full achievement
	CHIS – Unimmunised Children	Full achievement

Statements from the Care Quality Commission

The Trust is registered with the Care Quality Commission (CQC) to carry out eight legally regulated activities from 17 registered locations with no conditions attached to the registration.

In March 2018 the CQC carried out inspections at the Conquest Hospital and Eastbourne District General Hospital. They rated everything they inspected as 'good' or 'outstanding'; the Emergency Department at Eastbourne was rated good for well led and caring but 'requires improvement' for safe, effective and responsive. The CQC noted a marked improvement in the quality of our care and concluded that the Trust no longer needed to be in special measures for quality and this recommendation was accepted by NHS Improvement.

The CQC acknowledged that on the basis of the inspection in March, the Trust's rating would be 'good'; however the overall rating remains as 'requires improvement' because not all services were inspected. It is explained in the report that whilst the aggregated rating for the core services inspected would have brought the Trust to good overall, the impact of the core services they did not re-inspect leaves it as requires improvement overall.

For the first time 'outstanding' ratings were received in three categories. Care across the Trust continued to be rated as 'good' and the CQC noted that the staff they spoke to across the Trust placed compassion and empathy as integral to providing good care, and they found evidence that many 'went the extra mile'.

The Trust aims to be an outstanding organisation by 2020, providing excellent healthcare for the people of East Sussex, and where people are happy and proud to work. The report is clear evidence that good progress is being made.

Conquest Hospital (Arrows indicate progress since last report)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑↑ Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Outstanding ↑↑ Jun 2018	Good ↑ Jun 2018
Medical care (including older people's care)	Good ↑ Jun 2018	Good →← Jun 2018	Outstanding ↑ Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018
Surgery	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Outstanding ↑ Jun 2018	Good →← Jun 2018
Critical care*	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Maternity	Good ↑ Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Good →← Jun 2018
Services for children and young people*	Requires improvement Oct 2016	Good Oct 2016	Good Oct 2016	Requires improvement Oct 2016	Good Oct 2016	Requires improvement Oct 2016
End of life care *	Good Oct 2016	Requires improvement Oct 2016	Good Oct 2016	Good Oct 2016	Requires improvement Sept 2016	Requires improvement Oct 2016
Outpatients*	Requires improvement Oct 2016	N/A	Good Oct 2016	Requires improvement Oct 2016	Requires improvement Oct 2016	Requires improvement Oct 2016
Overall*	Requires improvement →← Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018

*Critical care, services for 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

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↑ Jun 2018	Requires improvement →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Good ↑ Jun 2018	Requires improvement →← Jun 2018
Medical care (including older people's care)	Good ↑ Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018
Surgery*	Good Oct 2016	Good Sept 2016	Good Oct 2016	Requires improvement Oct 2016	Good Oct 2016	Good Oct 2016
Critical care *	Good Oct 2016	Good Oct 2016	Good Oct 2016	Requires improvement Oct 2016	Good Oct 2016	Good Oct 2016
Services for children and young people*	Requires improvement Oct 2016	Good Oct 2016	Good Oct 2016	Requires improvement Oct 2016	Good Oct 2016	Requires improvement Oct 2016
End of life care*	Good Oct 2016	Requires improvement Oct 2016	Good Oct 2016	Requires improvement Oct 2016	Requires improvement Sept 2016	Requires improvement Oct 2016
Outpatients	Good ↑ Jun 2018	N/A	Good →← Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2017
Overall*	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Good ↑ Jun 2018	Requires improvement →← Jun 2018

*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

Overall Ratings

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Good ↑ Jun 2018	Requires improvement →← Jun 2018

The full reports and ratings are available at www.cqc.org.uk/provider/RXC

Data Quality

During 2018/19 we will be taking the following actions to maintain and improve data quality:

- Service improvement to support moving towards the 2020 national digital roadmap
- Complete a review of process and function to ensure expert resource is used in the best way
- Staffing – increase establishment and management to better support the Trust in recognition of the importance of data quality
- Analyse and identify data quality issues within new systems/services to the Trust e.g. SystmOne and Evolve
- Undertake a re-audit of completeness of NHS Numbers to ensure continued progress
- Validate correct attribution on the Patient Administration System of GP Practice through the national register (SPINE)
- Visit other Trusts' Data Quality departments to gain an understanding of how other units operate and to bring back and apply good practice
- Engage with the divisions to gain understanding of how these operate and also identify areas for data quality improvement
- 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
- Identify long term data issues and determine actions to overcome these
- Work closely with training staff to ensure training materials and scripts are accurate and support good data quality practice
- Establish a Data Quality steering group to address wider issues and to provide better governance

NHS Number and General Medical Practice Code Validity

East Sussex Healthcare NHS Trust submitted records during April 2017 to January 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:

- 99.6% admitted patient care
- 99.8% outpatient care
- 98.3% accident and emergency care

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

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

Information Governance toolkit attainment levels

The Information Governance Toolkit (IGT) is an existing approved Information Standard. It is an online performance tool developed by the Department of Health to support organisations to measure their performance against information governance requirements. The Care Quality Commission uses the results to triangulate their findings.

All organisations, including ESHT, are mandated to carry out self-assessments of their compliance against the IG requirements. The Trust has 45 requirements over the following six areas:

- Information governance management
- Confidentiality and data protection assurance
- Information security assurance
- Clinical information assurance
- Secondary use assurance
- Corporate information assurance

ESHT's IGT assessment score for 2017/18 was 73% and was graded as **Green** or satisfactory. This is a self-assessment with external review to provide assurance of accuracy to the Trust.

Out of the 45 requirements, 36 were assessed as at the required level 2, and 9 were at the higher level 3. For 2017/18 the Trust internal auditor's report gives 'reasonable assurance' that the Trust's submission is robust.

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 Information Governance (IG) Audit conducted by a Clinical Classifications Service Registered Auditor.

Results of the IG Audit

We have achieved Level 2 in primary diagnosis, primary procedure and secondary procedure fields and achieved level 3 in secondary diagnosis field. Attainment levels are below.

Information Governance Toolkit – Levels of attainment – percentage accuracy targets

Levels of attainment – percentage accuracy target areas	Level Two	Level Three
Primary diagnosis	≥ 90%	≥ 95%
Secondary diagnosis	≥ 80%	≥ 90%
Primary procedure	≥ 90%	≥ 95%
Secondary procedure	≥ 80%	≥ 90%

The percentage accuracy for the latest IG Audit by CCS approved external auditor is:

Primary diagnosis	Secondary diagnosis	Primary procedure	Secondary procedure
92.65%	94.02%	92.79%	86.38%

This indicates an overall accuracy percentage of 91.46% highlighting 8.54% error rate.

In conclusion, the general standard of Clinical Coding was noted as very good with national standards for clinical coding being followed well. Some mandatory comorbidities, current conditions, peri and post procedural complications and relevant symptoms without definitive diagnosis had been omitted however.

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

Part 3 - Review of Quality Indicators and our Priorities for Improvement in 2017/18

Patient Safety Improvement priorities 2017/18

Introduction and development of Safety Huddles across the Trust

Significantly improved

What is a Safety Huddle?

A Safety Huddle is a multi-disciplinary meeting which gives frontline teams the opportunity to discuss specific patient safety risks and collectively develop plans to address these.

Generally, the huddles are held mid-way through the shift, ensuring effective communication and a chance for the team to re-group and discuss any concerns or issues.

The huddle always ends with the nurse-in-charge checking on the team's health and well-being and ensuring they have all had the opportunity to take a break.

Our aim

- Safety huddles will be conducted every day on every ward across both sites and in the community
- Membership of the safety huddle will be multidisciplinary
- Delays in pathways will be reduced

How have we done?

- At the beginning of 2017/18, no wards held a safety huddle daily, this has now increased to 97% at the end of March 2018
- At the beginning of 2017/18, no wards held a safety huddle twice a day, this has now increased to 94% at the end of March 2018

Whilst it is difficult to quantify the impact that Safety Huddles are having in isolation, alongside additional focussed pieces of work, we are seeing:

- A steady decrease in the severity of harm being reported
- A reduction in the severity of falls

Amongst the benefits that staff have reported as a direct result of the introduction of Safety Huddles are:

- An opportunity to develop action plans to address safety issues and to foster a culture of safe care
- Dedicated time to ensure the health and well-being of staff
- Time to share important messages at the earliest opportunity

- A vehicle for ward teams to continually learn and improve together
- Supported personal development and increased confidence as all trained staff are given the opportunity to lead a Safety Huddle
- Patients and relatives reassured by the introduction of the huddles

Further improvements identified for 2018/19

- Additional support for the wards to embed the safety huddle into twice daily practice
- Continue to improve multidisciplinary participation in safety huddles

Introduction of a departmental accreditation programme - Excellence in Care

Progress made (continued priority in 2018/19)

What is the 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 and departments to deliver high quality care through effective leadership and improvement culture.

This will bring together the quality assurance and robust actions for improvement. It will also provide recognition for wards and departments delivering continuously safe and effective care enabling other areas to learn from them.

Our aim

- Completed dashboard with a clear accreditation process
- 10 wards on the scheme by end of March 2018
- Wards should achieve a constant high standard across the Trust

How have we done?

We initially designed the Quality and Safety measures with a ward to identify outcomes and effective measures and then the drivers required to achieve these. Eight outcomes were identified for the Quality and Safety measures and these were then collected on a monthly basis from quality audits, patient experience feedback and risk management data such as incidents.

Rolling out to four wards who received the information in a dashboard format allowed a clear review of the outcomes to determine if within the thresholds. If over the threshold the outcome will flag as red and the ward can then drill down to the drivers that will impact on the outcome to identify where they can improve.

This was tested and trialled until February and in March 2018 we rolled out to another six wards that have started to use the system.

In addition we have procured a new system to enable electronic recording and the ability to see all the domains of Quality and Safety, Leadership and Culture, Access and Delivery and Finance and Efficiency in a dashboard. The other domains have also been developed but need to be tested and established on the system before rolling out to the trial wards.

We made the decision to use the system to collect and define a standard threshold for the wards to work towards. This will allow us to know what good looks like and identify if the wards are achieving this. Where they are not achieving, the wards can establish their own improvement schemes to increase the quality of care delivered

Further improvements identified for 2018/19

- Identify how to collect and record the outcomes and drivers for Access and Delivery and Leadership and Culture domains
- Continue to roll out the system to further wards on a rolling programme
- Ensure monthly reports sent to the wards to enable review of information to identify areas for improvement

Learning from the review of deaths

Progress made

It is important that we learn from care provided to our patients which could have been better. We already have a system and process in place for recording consultant review of deaths but we wanted to improve this by making changes to meet the National Guidance on learning from deaths. We also wanted to ensure any care or treatment raised by bereaved relatives/carers/friends will initiate a clinical review and discussion at a multidisciplinary meeting so we can learn and make changes to practice if required.

Our aim

- A revised Morbidity and Mortality Policy will be developed by September 2018 which meets the national requirements
- Deaths will be reviewed within three months of the month of death

How have we done?

- We have developed and implemented a mechanism where concerns raised by relatives/friends at time of death are investigated and actions taken where necessary
- We have changed the way we review all deaths which have occurred in the Trust to meet the new National Guidelines on Learning from the Review of Deaths
- Our Out of Hospitals Division now reviews all deaths which have occurred in our community hospitals and ensure that any learning from these is used to improve care of the services we provide
- We continue to strive to review all acute hospital deaths where possible within a three month timeframe.
- We review and investigate where necessary any pathway or condition where there is a concern identified through local or external data, for example, CQC
- We report information on deaths and any associated learning to the Trust Board on a quarterly basis.
- Our Medical Director hosted a Mortality Summit for all Trust Consultants to drive improvement in patient outcomes and improve mortality review processes and learning
- The Trust actively participates in the KSS AHSN Mortality Community of Interest, represented by the Assistant Medical Director

Further improvements identified for 2018/19

- We continue to support our consultants to review all deaths within a three month timeframe
- We are considering whether alternative models for systematic learning from deaths might increase the independence, rigour and timeliness of review

Mandatory Disclose of Information - Learning from Deaths 2017/18

No.	Requirement	Mandatory wording for QA
27.1	The number of patients who have died within the reporting period	During April 2017 – March 2018, 1,957 of East Sussex Healthcare NHS Trusts (ESHT) patients died. This comprises the following number of deaths which occurred in each quarter of that reporting period: • 436 in first quarter • 411 in second quarter • 486 in third quarter • 624 in the fourth quarter **The following reporting is based on number of deaths from April – December 2017 as deaths in Q4 are still subject to the review and investigation processes set out by the Trust policy for reviewing deaths.** **During April – December 2017, 1,333 of ESHT in-hospital patients died.**
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure	By 29th May 2018, 1,085 case record reviews and 78 investigations have been carried out in relation to 1,333 of the deaths included in item 27.1. In 73 cases a death was subjected 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 was: • 384 in the first quarter • 342 in the second quarter • 364 in the third quarter
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the	7 representing 0.525% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: • 1 representing 0.229% for the first quarter

	provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	• 2 representing 0.487% for the second quarter • 4 representing 0.823% for the third quarter 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, Inquests, Complaints and Quarterly Mortality Review Audits.
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	The predominant themes from learning have been: improved recognition of Sepsis, improved falls assessment and prevention practice, improved handover (SBAR) information, improved DNACPR documentation, improved pain recognition, the need for more robust checks when n-g tubes are inserted, and improved referral processes.
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	The Trust has a Sepsis improvement programme, with the steering group driving improvements in prompt recognition and treatment of Sepsis, via a programme of education aimed at both frontline and ward staff. Falls assessment training is ongoing and documentation audited. The Trust is trialling an improved assessment tool, for which evidence suggests a higher sensitivity. Training of staff and audit of completion of DNACPR forms continues. We are introducing, together with the CCGs, the national ReSPECT documentation throughout East Sussex, both in the acute hospitals and the community, during 2018 and a programme of education is under way for this. Training is ongoing both in the Emergency departments and on the wards on pain recognition and severity assessment. New processes are being introduced, to increase the robustness of safety checks when inserting n-g tubes. The Trust has recently incorporated electronic referral systems in some areas. The specification for the upcoming electronic patient record and clinical information systems will include this universally.
27.6	An assessment of the impact of the actions described in item 27.5 which	The Sepsis Improvement Programme has resulted in a substantial and ongoing decrease in the mortality from Sepsis over the course of 2017/18.

	were taken by the provider during the reporting period.	The new falls assessment programme is anticipated to reduce further the number of patient falls, as should the increased emphasis on re-assessing falls risk when a patient's condition changes or when they transfer between wards or hospitals. The introduction of RESPECT documentation will create an advance care planning framework much more responsive to patients' wishes, incorporating ceilings of care and DNACPR components. The increased education in pain recognition and assessment will improve the responsiveness of staff to patients suffering pain and enable more prompt and effective management of it. The more robust checks of n-g tube position should avoid incidents of inappropriate position with the associated risk of aspiration of fluid into the respiratory tract. The electronic referral systems, once established, will greatly improve the speed and reliability of inpatient referrals, ensuring more appropriate and timely specialist advice and better outcomes (mortality, morbidity and length of stay).
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period	As this is the first Learning from Deaths report in quality accounts there is no previous relevant reporting period.
27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	As this is the first Learning from Deaths report in quality accounts there is no previous relevant reporting period. Our previous mortality review system was different and it would be difficult to compare the two.

27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8	As this is the first Learning from Deaths report in quality accounts there is no previous relevant reporting period. Our previous mortality review system was different and it would be difficult to compare the two.

Clinical Effectiveness Improvements 2017/18

Continue with the End of Life Care Improvement work

Progress made (continued priority in 2018/19)

End of life care was chosen for the Quality Account in recognition that there is only one chance to get it right for end of life care patients and their families.

In 2016/17 we developed and completed a number of actions to comply with the five Priorities of Care as outlined by the Leadership Alliance for the Care of Dying People. We concentrated on adults, in their last days and hours of life, in the acute sector. The CQC had rated end of life care as requiring improvement. In 2017/18 we broadened our improvements to include the last year of life, services provided in the community and how we coordinate care for patients.

Our aims

- We will know who is in the last days or hours of life
- We will see improvement in the use of an individualised care plan for patients in the last days/hours of life
- We will understand patients' and relatives' views and experience of EOLC services
- We will track progress against the six ambitions set out in the national framework for Palliative and End of Life Care
- All patients who express a desire for spiritual support will be seen by the chaplain
- A mechanism will be in place for ensuring patient's wishes for a preferred place of care is achieved
- All nursing staff will have attended the 'care of the dying' programme
- A flow chart will be implemented aimed at reducing variation in access to the local hospice
- We will be able to demonstrate learning from complaints of incidents associated to EOLC

How did we do?

We have developed a robust governance process for EOLC which includes seven workstreams. Each has a lead responsible for providing regular reports to the EOLC Improvement Group.

1. Streamlining care through sharing information
2. Improving staff capability through learning and development
3. Communication and patient engagement (staff newsletters, engaging with the public and carers)
4. Improving patient care through clinical effectiveness (a programme of audits, learning from incidents and complaints)
5. Developing the East Sussex Better Together EOLC strategy for last year of life
6. Care of the dying (adults) and Care of the dying (children, young people and infants)
7. Care after death (verification, certification, mortuary processes, organ and tissue retrieval

Achievements

- Access to the Specialist Palliative care team is standardised across the two sites, with a clear process for referral
- We have developed a process for ensuring that when consultants and nurses on the wards identify someone as in their last days of life, they alert the Supportive and Palliative Care Team and the Chaplains
- The Last Days of Life Personalised Care Plan is in version 2 and is audited every month by a MDT team of auditors
- We have developed a VOICES (Views of Informal Carers' Experience of Services) questionnaire for patients who die in the acute sector. This is given to the bereaved and asks about their view of the care provided. A similar questionnaire is being developed in the community in collaboration with the hospices who provide hospice at home services
- We are tracking all complaints and looking for any concerns around EOLC, and putting in place an action plan
- A basic leaflet with key messages about end of life care will be shared with ALL ESHT staff with the March payslip. From April 2018 EOLC training will be mandated for all staff that have face to face contact with patients at end of life. All nursing, AHPs and other clinical staff who have face to face contact with people at end of life will attend intermediate training, with specialists receiving advanced training
- The EOLC improvement board oversees and monitors performance through audits and monthly data analysis

Development of the strategy

ESHT has played a key role in the development of the East Sussex Better Together (ESBT) End of Life Strategy for adults, children and babies (2018 - 2021). The strategy is for the last year of life and will support ESBT in achieving the five ambitions. It has three main aims:

- To improve the quality of end of life care for people in East Sussex by coordinating care and integrating where possible
- To improve access to individualised end of life care, by improving identification of people in their last year of life and having conversations about death and dying early and recording these for use by the whole system
- To improve the skills, confidence and capability of those who care for people at the end of life by providing training and learning opportunities to staff across the whole health system.

To develop the strategy we engaged with the public, carers and learned from the views of the bereaved. We held workshops with relevant partners including patients, GPs, hospices, and social care to set a vision for excellent end of life care.

"Across East Sussex high quality, individualised end of life care is effectively coordinated and integrated and provided to all those who need it, regardless of diagnosis or age. Where appropriate we have conversations about death and dying at an early stage, supporting people to make plans and communicate these with those who are important to them. This care extends beyond death to include bereavement and support for families"

Further improvements identified for 2018/19

Detailed implementation plans have been developed with partners for adults, children and babies. A brief summary is described below:

Coordination of care

- Information sharing across the health and care system
- Better utilising Health and Social Care Connect to become a single hub, with single phone number to take on the keyworker role for patients at end of life
- Improving communication between paediatricians and primary care
- Improving communication between midwives, health visitors and primary care
- Improving processes of caring for patients after death

Improving access to individualised care

- Implement Advance Care Planning for adults and children at an early stage to identify what is most important to them
- Changing attitudes to death and dying
- Improving transition services for young people moving from children's to adults services
- Improving care after the death of a baby by increasing parental choice of where they spend time with their baby

Improving the skills, confidence and capability of those who care for people at end of life

- Implement the ESHT training programme
- Developing reciprocal training arrangements with the hospices (Inc. children's)
- Consider roles of lead paediatrician and lead GP for end of life care for children
- Standardise the debrief processes to support staff when a child or baby has died

Improve patient flow and reduce hospital length of stay for non-elective patients

Significantly improved

There is considerable evidence that poor patient flow through hospital and discharge can have a negative impact on the quality of patient experience, clinical outcomes and the length of time a patient stays in hospital. Delayed discharge can seriously impact on the healthcare system, creating financial pressures, delays in patients moving through the emergency departments in a timely way and increased costs to Trusts and the wider health economy.

We therefore planned and implemented a number of initiatives and improvements during 2017/18 to ensure patients move through their pathway of care without unnecessary delay, leading to a timely, effective and safe discharge.

Our aim

- Discharges are appropriately planned with an increased number taking place before midday (target 33%)
- Increased use of the discharge lounge
- Length of stay and delayed transfers in care will be reduced

How have we done?

We have introduced the SAFER patient flow bundle, which is a practical tool to reduce delays for inpatients on our wards. SAFER combines five elements of best practice which together have cumulative benefits. This includes all patients having an expected date of discharge planned within 14 hours of admission and multidisciplinary review of all patients who have been in hospital for seven days and longer.

Other initiatives we have introduced are

- Let's get you home – improved joint working with our adult social care colleagues to ensure patients have the right care they need to return home
- Red2Green – an initiative which works alongside SAFER to identify and eliminate wasted time in a patient's journey
- End PJ Paralysis – an initiative to raise awareness of the benefits for patients getting dressed as soon as possible within their hospital stay.

We have reviewed our discharge process and procedures and introduced a discharge to assess service provided through our Crisis Response Team. This service supports patients to stay at home and enables them to be supported when returning home when they are medically fit for discharge.

We have also expanded our Ambulatory Care (AC) Unit at Eastbourne DGH which provides rapid access to diagnostic tests and consultant review. The service is designed around the needs of the patient providing an improved experience and preventing unnecessary hospital admissions. A similar project to increase the size of the AC Unit at Conquest Hospital is now underway.

Through this work we have seen the following improvements:

- We have reduced the number of delayed transfers of care from 8% to almost 1.3% (March 2018)
- We have reduced non elective length of stay in our acute hospitals by 1.5 days and by five days in our intermediate care beds
- We have reduced by almost 20% the number of patients who spend seven days or more in our acute hospitals
- We have increased the number of patients discharged before midday and increased the use of the discharge lounge. We are improving the process of data capture on our information systems so we can measure and track our progress

Further improvements identified for 2018/19

We have further work to undertake during 2018/19 to robustly embed the changes we implemented during 2017/18. We want to ensure SAFER is used consistently across all wards and patient experience of discharge is improved. This is a Trust priority for 2018/19.

Other focused Improvement initiatives are:

- Improving the length of hospital stay for non-weight bearing patients
- Development of an electronic bed management system
- Development of the Ambulatory Care Unit at Conquest
- Continued improvement of the frailty pathway
- Improving our discharge to assess processes

Patient & Staff Experience Improvements 2017/18

Develop patient feedback forums where experiences of care can be shared

Fully achieved

ESHT will only achieve its 2020 vision by engaging those members of the public and patients who are affected by the care we provide. By working together, we can develop services that are better targeted, more effective and more likely to meet the expectations of the people who use them.

Our aim

- A Public and Patient Engagement strategy will be developed
- Public and patients' views will be incorporated into quality improvement

How have we done?

- We developed a Public Engagement and Patient Experience strategy and work plan to guide our work until 2020
- We held two well attended public forums, seeking input from members of the public about patient information, hospital access and end of life care
- We held two well attended open days in cardiology and ophthalmology
- We have revived our membership database and are regularly in contact with our two thousand members by email
- We are developing a small public panel of volunteers who sit on projects, service redesign schemes or within service governance. We also have a small number of volunteers who sit on local Public Participation Groups as ESHT members
- We have engaged with local organisations and are actively involved with our local Healthwatch
- Through East Sussex Better Together (ESBT) and our local Sustainability and Transformation Partnership (STP) we are engaging with members of the public in a broader way, talking about their experiences of health and social care as a whole

Further improvements identified for 18/19

- Further development of member database and regular newsletter to our members, with opportunities to engage and input into our work
- Two more departmental open days held
- Six-monthly focus groups
- Development of new "Ask the Board" sessions
- Further development of public panel and embedding public/lay governance within our ESHT structures
- Coordination through ESBT and our local STP with public engagement work
- Development of specific engagement campaigns (co-production where appropriate) such as young people's experience in hospital, wayfinding and access and discharge

Respond to all complaints within 30 days for non-complex or 45 days for complex complaints

Fully achieved

Good quality complaints handling is vital to ensuring continuous improvement in the quality and safety of care we provide. Complaints provide essential feedback from which to learn.

There was a backlog of complaints that had become overdue and although this has decreased considerably, we wanted to reduce this further and fully embed the new processes to ensure they are sustained over the year.

Actions that arise from complaints are now logged and tracked for implementation but this is a new system that requires robust monitoring.

Our aim

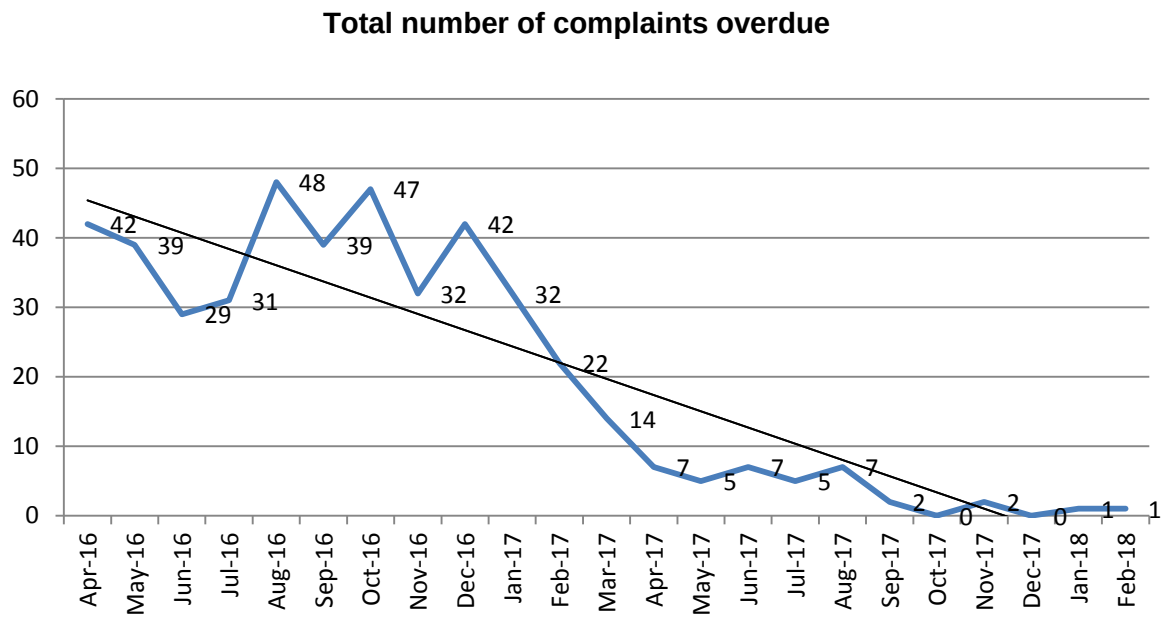
- No more than five overdue complaints in the system for any month
- Less than 100 actions in the system by the end of March 2018

How have we done?

The complaints process was revised to increase the focus on the triage of the complaint and identify exactly who needs to respond to each individual point. We also requested the patient's health records when the complaint was first received to reduce delays in waiting for them. The final change was to establish a clear escalation process to act prior to a complaint becoming overdue.

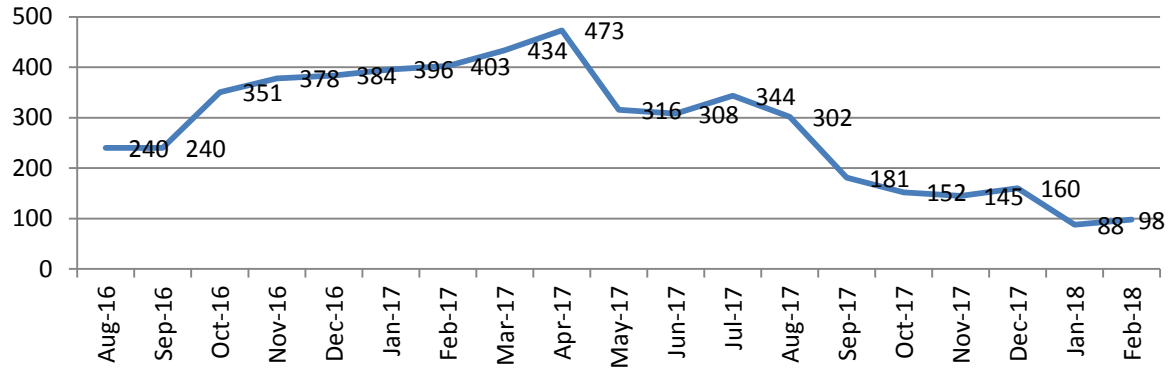
Actions were tracked on the Datix system and support provided with divisions to review and complete the actions.

As shown below we have improved and continued to manage complaints within the timescales:



As shown below we have recorded all complaint actions on Datix which explains the rise in numbers and now reduced the number to below 100.

Number of outstanding complaint actions on Datix system



Further improvements identified for 2018/19

We will continue to manage complaints within the agreed timescales and will further work on completing the complaint actions with a further system to test on a rolling basis if the action has been embedded in practice.

Identify three corporate priorities for improvement following publication of the 2016 National staff survey to ensure ESHT is a good place to work

Progress made

We believe that ensuring our staff are engaged and involved in decisions that impact on them, and empowering them to feel that they can raise concerns safely will lead to high morale and motivation which in turn leads to better patient outcomes and experience of care. Therefore we chose to focus on improving the following:

Reduce the number of staff experiencing bullying and harassment

- To ensure all staff are aware of the organisation's policy and process for raising concerns about unsafe clinical practice and are provided with reassurance about how these would be handled to encourage and reassure staff that their concerns will be treated seriously and with transparency
- Continue to improve awareness of the need to report incidents of harassment, bullying and abuse and ensure that staff are aware of the process

Continue to improve good communication between management and staff

- Consider what can be done to improve communication, reduce conflicting pressures and eliminate barriers to effective communication
- Ensure that the pathways to jobs with greater responsibility are clear to all staff and that the training and support mechanisms to support job and personal development are signposted plainly to all staff.

- To ensure that ESHT vision and values are clearly communicated to all staff through a range of leadership programmes

Continue to develop ESHT as a good place to work

- We wanted to prioritise the issue of reported physical deterioration and stress at work and analyse ways in which ESHT can support staff through a range of Health & Wellbeing programmes

Our aims

- Improve the Staff Survey 2017 key finding results for the above
- Continued development of a culture where staff feel engaged
- Staff feel they have adequate resources to do the job
- Staff enjoy coming to work and seeing the difference they make to the people who use our services

How did we do?

Staff survey 2017 results

The table below provides the results related to the aims for 2017/18. These show a small improvement in the three priority areas:

Key Finding (KF)	2015	2016	2017	2017 National Average
KF26 – Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	32%	27%	27%	24%
KF6 – Percentage of staff reporting good communications between senior management and staff (higher is better)	19%	32%	33%	33%
KF1 - Staff recommendation of ESHT as a place to work or receive treatment (1 to 5, where 5 is best)	3.36	3.63	3.66	3.75

Achievements

Reduce the number of staff experiencing bullying and harassment

We are disappointed that we have not seen any improvement on our target to improve the response of some staff linked to bullying and harassment but believe that we have taken the issue very seriously and there is a lot of work going on to improve in this area. We recognise that it will take some time to bring about a real change in this area.

We are already beginning to see those green shoots of improvement. The last two CQC visits have commented positively on the change of culture within the Trust.
Some of the work that we are doing to make this improvement includes:

- Working closely with the Speak Up Guardian to understand and identify the root causes of bullying and harassment and take action to address poor behaviour
- Reviewing our approach for dealing with bullying and harassment and wherever possible dealing with concerns in a more timely way. We have introduced mediation instead of immediately defaulting to a more formal process
- We have introduced a behavioural framework which outlines our approach to values based behaviour and are rolling this out across the Trust
- Supporting our leaders to deal with some entrenched behaviours in a fair and compassionate way

Continue to improve good communication between management and staff

- Clarified what is expected from our leaders through the Management Essentials training programme, 1:1s, team meetings, induction and appraisal
- Development and circulation of Communication Toolkit to all managers
- Introduced a leadership development pathway with a range of courses linked to good communication, handling change and compassionate leadership
- Continued with our programme of Board member visits to services, so they gain a better understanding of the issues being faced at the frontline.

Continue to develop ESHT as a good place to work

- 1,080 members of our staff who are over 40 have received a free health check
- Continued to offer interventions to support the emotional and physical wellbeing of our staff through initiatives such as Emotional resilience training, Schwartz rounds, Compassion without burnout workshops, Healthy Weights, Pilates
- Visual feedback to staff by divisions/services through “You said, We did” posters
- Developed a staff handbook for new doctors and introduced a pastoral support group for junior doctors

Further improvements identified for 2018/19

Based on the recommendations we are proposing to set three corporate priorities that link to the key findings and recommendations:

- To ensure all our staff demonstrate values based behaviour and to develop a range of interventions that will embed the behaviours we expect to see
- To identify the main causes of stress at an individual, team and organisation level and identify how we can work with staff to reduce/eliminate stress so they feel valued and supported
- To support and involve our staff in continuous improvement to deliver outstanding care to the people who use our services

Other improvement initiatives in 2017/18 and Sign up to Safety pledges

In last year's Quality Account, we also identified some of the other improvement initiatives we have been working on which are part of our Trust Quality and Safety Improvement Strategy. This included our 'Sign up to Safety' pledges for 2017/18.

Our progress and achievement for these areas is identified below.

Sign up to Safety plan - Reduce patient falls
Our goal was to reduce the amount of falls causing harm to 1.5 per 1,000 bed days.

We have reduced the total amount of falls from 6.1 per 1,000 bed days in 2016/17 to 5.6 per 1,000 bed days in 2017/18 and reduced the number causing harm from 1.8% to 1.4%

Although we have made significant improvements we recognise that there is still more work to be done to reduce harm, therefore we have made this one of our Trust priority areas for improvement in 2018/19 as well continuing to be one of our Sign up to Safety pledges.

Sign up to Safety – Reduce pressure ulcers
Our goal was to reduce grade 3 and 4 pressure ulcers to zero and reduce the number of grade 2 pressure ulcers from 2016/17.

We have had nearly 100 fewer Category 2 pressure ulcers in 2017/18 compared to 2016/17. Although we have also seen a small reduction in the number of Category 3 and 4s, we have not yet met our aim to reduce these to zero. Therefore we have made this a Trust improvement priority for 2018/19

Sign up to Safety - Improving Sepsis recognition and treatment
Our goal was to continue to provide education on Sepsis management and improve compliance with screening and administration of antibiotics within one hour.

Education, training and support to our wards and departments from the clinical improvement team has continued through the year leading to improved Sepsis screening rates from 39% in April 2017 to 77% in March 2018 and administration of antibiotics within one hour have also increased from 50% to 85% for the same period.

Although we have made significant improvements in a number of areas, we recognise that there is still more work to be done therefore we have made this one of our priority areas for improvement in 2018/19 as part of the patient deterioration improvement programme.

Sign up to Safety - Duty of Candour (DoC)
Our goal was to improve our compliance from 2016/17 which we have done and identified below.

	Verbal DoC average % over the year	Written DoC	Shared findings with patient/family
2016/17	82% average over six months	79% average over six months	37% average over six months
2017/18	86% average % over the year	89% average % over the year	87% average % over the year

Harm Free Care
Our goal was to achieve 97% harm free care measured by the NHS Safety Thermometer tool.

The harm free care data is a snapshot in time on one day per month. It provides an approximate measure of quality that can be used alongside many other metrics to determine safe care. Our results have remained broadly similar over the last two years however we haven't achieved the 97% target. To gain a broader understanding of quality and safety we are using new measures for quality monitoring at ward level through our Excellence in Care work.

Reduced mortality rates
Our goal was to reduce the Trust Summary Hospital level Mortality Indicator (SHMI) to 1.00.

Although we have not achieved the challenging goal of 1.00, we have seen a significant decrease from last year's value of 1.10 to 1.07 for the latest data period published. Actions continue to be taken to improve our SHMI and other mortality indicator positions.

Improve patient experience
Increase patient response rate for the Friends and Family Test (FFT) to 50% for inpatients and 12% for our Emergency Departments.

We have increased the inpatient response rate from 21% in 2016/17 to 40% during 2017/18, however our Emergency Departments has remained static at 8%. We continue to drive improvement in the response rate for the FFT through a number of actions which are tracked by the patient experience steering group.

Sign up to Safety 2018/19 pledges

We are committed to improving the quality and safety of care we provide and thus continue to drive improvement in 2018/19 through the following Sign up to Safety priorities:

- Reduce patient falls
- Reduce pressure ulcers
- Improve Sepsis recognition and treatment
- Improve Duty of Candour (DoC)
- Reduce mortality rates
- Improve patient experience

Part 3.1 - Review of our Quality Indicators

Amended regulations from the Department of Health require Trusts to include a core set of quality indicators in the Quality Account. These 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.

Indicator	2017/ 18 (April 2017 to Dec 2017)	National average (Acute Trusts)	Best performer (Acute Trusts)	Worst performer (Acute Trusts)	2016/ 17 data	2015/ 16 data	2014/ 15 data
Percentage of admitted patients risk-assessed for Venous Thromboembolism (VTE)	96.27%	95.20%	100.00%	51.38%	96.77%	96.30%	97.42%

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

- A weekly monitoring email communication is generated and sent directly to the relevant clinical leads highlighting the compliance rate for individual areas falling below the 95% national goal. 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
- The Clinical Improvement Lead also monitors compliance and escalates any area falling below the target to the Clinical Outcomes Group
- The key mechanism for monitoring and ensuring accountability at divisional and specialty levels is through the Integrated Performance Review process
- Compliance with standards is supported by training for new junior doctors which is included in the Trust's Doctors' e-induction programme and training in the prescribing of thromboprophylaxis which is included in the Pharmacy Doctors' prescribing induction
- Ward Clerks are given training to enter the VTE Risk Assessment data onto the OASIS/PAS team. The Clinical Improvement Lead provides operational support to the ward Clerks on an ad hoc basis to minimise problems with data entry

- VTE Risk Assessment has been included in the procurement specification for the Trust's Electronic Prescription and Medicines Administration (ePMA) project and it is anticipated that electronic VTE Risk assessment as part of ePMA will improve both compliance rates, appropriate prescribing of thromboprophylaxis and patient safety of those assessed as at high risk of Hospital Associated Thrombosis
- We conduct 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)
- In 2018 regular audit of VTE prevention measures is also planned as a key improvement metric included in the Trust's Excellence in Care ward accreditation scheme

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.

Indicator	2016/17 (final)	National average	Best performer	Worst performer	2015/ 16 data	2014/ 15 data	2013/ 14 data
Rate of C. difficile Infection per 100,000 bed days (aged 2 or over)	17.6	13.2	0.0	82.7	19.2	23.7	16.4

Source: NHS Digital

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

- Monitoring trends from the Post Infection Review (PIR) and acting on findings
- Introducing a checklist for treating every patient with CDI as a Period of Increased Incidence with enhanced cleaning of inpatient environment with hypochlorite solution, additional hand hygiene auditing and additional education of staff on the ward involved
- Each ward displays their CDI rates
- All PIRs to be signed off and completed within the expected timeframe
- All HAI samples to be sent for ribo-typing as routine to exclude cross infection
- Share lessons learnt from PIRs with other departments via the Infection Control Link system
- Improved antimicrobial prescribing including recent update of the antimicrobial guidelines, reduction in Tazocin usage, embedding the use of Microguide app and monthly auditing of antimicrobial prescribing

- Introduction of a diarrhoea assessment tool to facilitate assessment of patient's need for isolation, stool specimen and ongoing assessment of risk of CDI
- Hydrogen peroxide vaporisation as standard terminal cleaning following diagnosis of CDI. Enhanced cleaning of inpatient environment with hypochlorite solution

Rate of patient safety incidents reported per 100 admissions and the proportion of patient safety incidents they have reported that resulted in severe harm or death

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

Indicator – NRLS Data	ESHT 2017/18	National average	Best performer	Worst performer	2016/17	2015/16
	01/04/17 – 30/09/17				01/04/16 – 30/09/16	01/04/15 – 30/09/15
Rate of patient safety incidents reported per 1,000 admissions	43.02 (5,339 incidents reported)	**Rate not provided by NRLS** (average of 5,265 incidents reported)	111.69 (10,016 incidents reported)	23.47 (3,085 incidents reported)	59.97 (7,503 incidents reported)	39.3 (4,489 incidents reported)
% 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	Severe 0.1% (7 incidents)	Severe 0.3% (Total of 1,821 incidents)	Severe 0.0%	Severe 1.5%	Severe 0.2% (12 incidents)	Severe 0.4% (18 incidents)
	Death 0.0% (No incidents)	Death 0.1% (Total of 661 incidents)	Death 0.0%	Death 0.5%	Death 0.0% (2 incidents)	Death 0.1% (5 incidents)

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

- The management and investigation of serious incidents has been centralised and since this process was embedded the Trust has seen an improvement in the quality of investigations
- Serious incidents are all managed in accordance with national timescales and the Trust has no overdue investigation reports
- Actions resulting from serious incidents and amber investigations are being closely monitored with updates on the number outstanding provided to the Patient Safety and Quality Group each month

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.

Indicator	Oct 2016 – Sept 2017	Oct 2015 - Sep 2016	Oct 2014 – Sep 2015	Oct 2013 - Sep 2014	Oct 2012 - Sep 2013	Oct 2011 - Sep 2012
SHMI value	1.07	1.10	1.15	1.08	1.14	1.05
Banding	2 (as expected)	2 (as expected)	1 (higher than expected)	2 (as expected)	1 (higher than expected)	2 (as expected)
% of patient deaths with palliative care coding by speciality and/or diagnosis	20.2	18.8	18.05	22.4	18.2	14.8
% of patient deaths with palliative care coding by speciality and/or diagnosis (national average)	31.5	29.7	26.6	25.3	20.9	18.9

The most recent SHMI value for the data period October 2016 to September 2017 shows an improvement in the indicator and the Trust remains in the national “expected” range.

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

- Improved Consultant staffing in our emergency units and acute medicine departments so we can provide optimum care when patients are acutely ill

- Improvement in the recognition and treatment of Sepsis which has reduced the mortality indicators across the year
- Improvement groups working on pneumonia, COPD and Acute Kidney Injury (AKI)
- The above groups are now amalgamated into a Deteriorating Patient Improvement Group
- Multidisciplinary daily board rounds, led by the consultant, now provide timely senior decision making at ward level
- VitalPAC is operational in nearly all inpatient areas in the acute hospitals, with work ongoing on installing it in the Emergency Departments at both Conquest Hospital and Eastbourne DGH. This flags up patients whose observations are deteriorating, alerts ITU outreach and supports ward nursing staff in making the correct responses to deterioration
- 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 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
- Improved 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 this data is as described because the Trust has robust data quality assurance processes in place.

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 outcome of their surgical intervention and compare themselves to other Trusts nationally.

The Trust undertakes minimal varicose vein surgery therefore no data is available for this procedure.

Indicator	Index	2017/18	2016/17 Adjusted Average Health Gain (Provisional Data)	2016/17 - National Adjusted Average Health Gain (Provisional Data)	2016/17 Adjusted Average Health Gain Provisional Data (Best performer)	2016/17 Adjusted Average Health Gain Provisional Data (Worst performer)	2015/16	2014/15
Patient Reported Outcome Measures Adjusted Average Health Gain Hip Replacement (primary)	EQ-5D	Not available	0.495	0.445	0.536	0.31	0.463	0.451
	EQ-VAS	Not available	14.22	13.40	20.15	8.52	12.53	11.49
	Oxford Hip Score	Not available	22.79	21.8	25.06	16.42	23.38	22.58
Patient Reported Outcome Measures Adjusted Average Health Gain Knee Replacement (primary)	EQ-5D	Not available	0.33	0.324	0.40	0.24	0.325	0.312
	EQ-VAS	Not available	4.80	7.00	14.50	1.00	2.17	5.28
	Oxford Knee Score	Not available	16.32	16.50	19.87	12.50	16.76	16.38

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

The NHS Digital Score Comparison Tool is based on modelled records which are records that link to an episode, have both questionnaires completed fully and correctly and they also need to have other information in there in order to have the case mix adjusted scores calculated (such as adjusted average health gain).

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.

Indicator	ESHT 2017/18 (Apr 2017 to Jan 2018)	National average	HES Acute Peer 5th Percentile	HES Acute Peer 95th Percentile	2016/17	2015/16 data	2014/15 data
Emergency readmissions to hospital within 28 days of discharge Age 0-15	12.35%	8.10%	2.37%	12.96%	12.84%	13.37%	11.82%
Emergency readmissions to hospital within 28 days of discharge Age 16+	7.99%	7.39%	5.67%	9.41%	7.10%	7.46%	7.60%

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

- We have improved our multidisciplinary discharge processes through the implementation of SAFER on our wards.
- We hold daily operational executive calls to identify system issues and put actions into place to support effective discharge home
- We hold twice weekly ‘enhanced discharge’ meetings with the discharge manager and social care to coordinate complex patient discharges from our hospitals. This ensures patients have the right care and resources in place to minimise the need for readmissions
- 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.

Indicator	2017/18	National average	Best performer	Worst performer	ESHT 2016/17	2015/16 data
Percentage of patients who would recommend the trust to friends or family needing treatment (inpatient)	**97%**	**96%**	**100%**	**76%**	**97%**	**97.8%**
Percentage of patients who would recommend the trust to friends or family needing treatment (A&E)	**90%**	**86%**	**100%**	**51%**	**86%**	**90.1%**

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

- Addressing the response rate has been a high priority for the Patient Experience and Engagement Steering Group
- We collect more experience information than the standard Friends and Family question within the questionnaire so the suitability of these questions was reviewed and altered in line with results from the national survey and the Excellence in Care work which has been undertaken
- Additional support has been provided to departments to ensure they have suitable and well printed questionnaire forms, with electronic collection devices available
- Feedback reports provided at ward and divisional level to share the data collected continue to be fed back to the teams to show the scores and individual comments (positive and negative)
- A league table and regular reporting by ward on response rate and score was provided within the Patient Experience monthly reports and divisional reports and reinforced at the relevant meetings
- We continue our aim to achieve to a minimum of 50% overall response rate for inpatients

Our Emergency Departments have taken the following actions:

- We share the feedback (both positive and negative) in our weekly team brief to ensure shared learning
- We discuss at the multidisciplinary governance meetings

- Our Paediatric Emergency Department nurses aim to give two FFT cards out where possible, one for the child and one for the parent/carer
- We are starting cross-site quarterly clinical supervision which is booked for June. We would like to invite the patient experience team to come and meet the teams and talk to them about ways in which we can improve our compliance

Responsiveness to inpatients' personal needs

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

Indicator	ESHT 2017 CQC weighted score	National average	Best performer	Worst performer	ESHT 2015 CQC weighted score	ESHT 2016 CQC weighted score
Responsiveness to inpatients' personal needs; CQC national inpatient survey score	67	69	86	58.2	67.9	67

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

The national inpatient survey full report has not yet been published, however the headlines report has been published and highlighted that discharge for our patients is an issue. This has been discussed at our Patient Experience and Engagement Steering Group where each division has been asked to feedback to the group on their plans to address this.

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.

Indicator	ESHT 2017	National average *For acute and community Trusts*	Best performer	Worst performer	2014 data	2015 data	2016 data
Percentage of staff who would recommend the Trust to friends or family needing treatment	65%	69%	89%	48%	52%	54%	62%

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

Using the ESHT staff FFT results as a source of intelligence to inform and signpost us to areas for improvement in staff working life, wellbeing, conditions and work environment. We also monitor staff responses three times a year through an internal mechanism.

Overall, it is felt that part of the Trust's success in staff engagement lies in its overall approach in analysing 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 mini action plans, giving local control and power back to staff to make effective change.

Continue to develop ESHT as a good place to work
Through cultural support workshops, the Medical Education Team aims to increase the awareness of UK culture among doctors joining the NHS from overseas or doctors who may need some additional support where necessary with their written and spoken English language skills. It is hoped this will create a social and professional support and learning network with emphasis on student led interactivity. A dedicated Cultural Support Facilitator has put together some helpful information for new doctors to the UK and the new working environment.

Supporting staff
The Trust appointed a full time, independent Speak Up Guardian who reports directly to the Chief Executive. Staff are encouraged to phone, email or book an appointment with the Speak Up Guardian to confidentially discuss any issues or concerns they may have. The

independence of the role has been highly successful in encouraging openness and transparency between the ward and Trust Board.

Following an idea developed in America, the Trust holds a Schwartz Round forum each month where an independent panel are invited to talk about a topic that would better enable staff to deal with some of the emotional and psychological impacts of their work. Topics have included 'When you have to care for a colleague in the healthcare environment'.

We have continued to embed a culture that is open and honest, where staff feel confident to raise their concerns. This work includes:

- Continuing to tackle poor behaviour through formal HR processes
- Continuing promotion of the role of the Speak Up Guardian, who encourages and supports staff to raise concerns and ensures that the voice of the frontline is heard clearly at a senior level
- Robust review of Datix incidents with HR for clinical units and SUG
- Addressing conduct and behaviour issues with learning identified
- Review of violence and aggression poster
- A number of workshops held with local teams which focus on behaviour linked to our Trust values
- Additional support in place from the Occupational Health & Wellbeing department for all staff experiencing harassment
- Divisional action plans identified and included specific actions to address bullying and harassment where it was identified as one of their lowest five scores in the national staff survey

Continue to improve communication between management and staff

- Clarified what is expected from our leaders through the Management Essentials training programme, 1:1s, team meetings, induction and appraisal
- Development and circulation to all managers of the Communication Toolkit
- Held Communicating with Influence workshops
- Introduced a leadership development pathway with a range of courses linked to good communication, handling change and compassionate leadership
- Continued with our programme of Board member visits to services, so they gain a better understanding of the issues being faced at the frontline

Additional activities

- Continued to offer interventions to support the health and wellbeing of staff e.g. healthy weights clinics, Pilates, workshops tailored to supporting staff wellbeing sessions such as Compassion Without Burnout and support to stop smoking
- Supported the emotional wellbeing of staff through a range of initiatives such as emotional resilience training and Schwartz rounds
- Developed a staff handbook for new doctors and introduced a pastoral support group for junior doctors
- Continued to promote a range of benefits to staff including discounts at local retailers
- Celebrated the achievements of colleagues at award ceremonies held throughout the year

- Continued to provide a comprehensive range of learning and development opportunities provided both in-house and through contracts with local providers
- Celebrating success through Trust Awards, Mentorship Awards and Unsung Hero Awards
- Monthly Networks and engagement sessions developed by divisions
- Visual feedback to staff by division/service through “You Said, We Did” posters
- Continue to develop and promote employee services, for example, carers support and maternity support group

Staff Survey 2017 Results

Based on the recommendations from the Staff Survey 2017 we are proposing to set three corporate priorities that link to the key findings and recommendations:

- To ensure all our staff demonstrate values based behaviour and to develop a range of interventions that will embed the behaviours we expect to see
- To identify the main causes of stress at an individual, team and organisation level and identify how we can work with staff to reduce/eliminate stress so they feel valued and supported
- To support and involve our staff in continuous improvement to deliver outstanding care to the people who use our services

The full results of the Staff Survey 2017 are available on the Trust’s website.

Integrated Performance Report

Safety and Quality

Indicator Description	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Month Comparison Mar-17	Month Comparison Mar-18	Month Comparison Var	YTD Comparison 2016/17	YTD Comparison 2017/18	YTD Comparison Var	Rolling 12 month avg	Trend
Total patient safety incidents reported	M	1064	1150	1113	1066	1086	998	1104	1142	1098	1188	1082	1179	1247	1179	-5.5%	16051	13270	-17.3%	1106	
% Patient safety incidents with no harm or near miss	70.0%	84.9%	82.3%	83.9%	85.6%	82.3%	84.3%	84.5%	83.4%	83.3%	81.1%	81.9%	81.2%	83.2%	81.2%	-2.1%	80.5%	83.2%	2.7%	83.2%	
% Patient safety incidents causing severe harm or death	0.0%	0.2%	0.3%	0.1%	0.1%	0.1%	0.3%	0.4%	0.4%	0.3%	0.0%	0.2%	0.6%	0.2%	0.6%	0.4%	0.1%	0.2%	0.1%	0.2%	
Number of medication administration incidents	M	22	35	28	32	42	42	40	43	37	33	36	41	16	41	56.3%	332	431	29.8%	36	
Number of Serious Incidents reported	M	3	5	5	3	8	4	2	6	3	0	3	5	5	5	0	57	47	-10	4	
Number of moderate incidents reported	M	9	12	6	12	8	9	12	9	13	16	8	4	5	4	-1	93	118	25	10	
Never Events	0	0	1	1	0	0	1	1	0	0	0	0	0	0	0	0	1	4	3	0	
Total falls	M	136	152	139	125	129	122	135	133	149	150	105	138	160	138	13.8%	1837	1613	12.2%	134	
Number of no-harm falls	M	104	115	104	94	80	87	98	104	114	112	79	109	123	109	11.4%	1282	1200	6.4%	100	
Number of minor/moderate falls	M	32	37	35	31	48	34	36	25	34	38	25	28	36	28	22.2%	551	403	26.9%	34	
Number of major/catastrophic falls	0	0	0	0	0	1	1	1	4	1	0	1	1	1	1	0	4	10	6	1	
All patient falls per 1000 Beddays	5.5	5.7	6.1	6.2	5.5	5.6	5.4	5.8	5.9	6.3	5.9	4.6	5.5	6.3	5.5	-0.8	6.2	5.7	-0.47	5.4	
All patient falls with harm per 1000 Beddays		1.3	1.5	1.6	1.4	2.1	1.5	1.6	1.3	1.5	1.5	1.1	1.1	1.5	1.1	-0.3	1.9	1.4	-0.48	1.4	
Falls assessment compliance	M	90.1%	90.4%	88.5%	90.3%	88.9%	92.9%	92.9%	88.4%	75.3%	73.3%	51.0%	69.3%	91.8%	69.3%	22.5%	90.2%	83.5%	6.6%	83.5%	
Total grade 2 to 4 pressure ulcers per 1000 Beddays	M	2.5	2.3	2.0	1.7	2.2	1.6	1.4	1.9	1.9	2.4	2.1	2.8	2.4	2.8	18.9%	2.2	2.0	-9.8%	2.1	
Number of grade 2 pressure ulcers	M	56	53	40	37	50	32	30	39	44	57	46	70	56	70	25.0%	617	554	10.2%	46	
Number of grade 3 to 4 pressure ulcers	M	4	4	4	1	1	4	3	5	2	3	3	1	4	1	-3	36	35	-1	3	
Pressure ulcer assessment compliance	M	89.4%	85.9%	88.5%	90.3%	89.5%	96.4%	93.6%	85.2%	96.9%	90.2%	0.0%	73.1%	92.1%	73.1%	19.0%	91.5%	82.2%	9.3%	82.2%	
Safety Thermometer overall score	92.0%	93.2%	92.6%	90.8%	92.2%	91.2%	92.4%	93.8%	93.6%	93.0%	92.0%	92.0%	92.8%	91.7%	92.84%	1.1%	93.4%	92.5%	0.9%	92.5%	
VTE Assessment compliance	95.0%	96.7%	97.2%	96.8%	96.3%	96.0%	95.3%	96.6%	95.9%	94.1%	94.1%	94.7%	94.9%	97.3%	94.9%	2.3%	97.1%	95.7%	1.4%	95.7%	
% Observations completed on time	M	85.4%	85.2%	84.6%	84.1%	83.9%	84.2%	82.0%	82.7%	82.5%	82.1%	82.6%	79.5%	84.3%	79.5%	4.8%	82.6%	83.2%	0.6%	83.2%	
Number of MRSA Cases	0	0	0	0	1	0	0	0	1	0	1	0	0	0	0	0	0	3	3	0	
Number of Cdiff cases	4	1	5	1	4	6	0	4	3	5	1	1	3	2	3	1	43	34	-9	3	
Number of MSSA cases	M	0	0	0	1	2	1	1	2	1	1	0	0	0	0	0	11	9	-2	1	
Emergency Re-Admissions within 30 days	10.0%	10.1%	10.1%	10.2%	10.3%	9.5%	10.6%	9.4%	10.6%	10.4%	10.0%	9.5%	8.5%	10.3%	8.5%	1.7%	9.3%	9.9%	0.7%	9.9%	
Crude Mortality Rate	M	1.8%	1.7%	1.4%	1.4%	1.4%	1.6%	1.5%	1.5%	2.1%	2.3%	2.0%	2.1%	1.7%	2.1%	0.5%	1.8%	1.7%	0.0%	1.6%	
HSMR (CHKS)	M	103	101	99	98	97	96	93	93	91	88										
SHMI (NHS Digital)	M	1.13	1.11	1.1	1.1	1.08	1.07														

Indicator Description	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Month Comparison Mar-17	Mar-18	Var	YTD Comparison 2016/17	2017/18	Var	Rolling 12 month avg	Trend
Number of complaints received	M	41	52	52	50	57	43	45	48	38	42	46	45	55	45	18.2%	658	559	15.0%	47	
Inpatient FFT response rate	45.0%	30.9%	34.8%	36.2%	43.0%	44.9%	45.6%	41.8%	42.4%	38.7%	41.1%	40.3%	43.3%	32.9%	43.3%	10.3%	21.0%	40.3%	19.2%	40.3%	
Inpatient FFT score	96.0%	97.0%	97.1%	97.4%	97.0%	96.2%	96.8%	97.6%	97.4%	96.7%	98.1%	97.8%	97.2%	96.5%	97.2%	0.7%	97.2%	97.2%	0.0%	97.2%	
A&E FFT response rate	22.0%	8.3%	8.3%	7.8%	10.9%	13.3%	9.8%	7.0%	11.0%	7.3%	6.6%	4.5%	3.9%	6.7%	3.9%	-2.8%	7.6%	8.3%	0.7%	8.3%	
A&E FFT score	88.0%	90.0%	87.0%	85.4%	87.6%	90.1%	90.1%	88.1%	90.8%	93.4%	93.1%	94.1%	86.4%	86.1%	86.4%	0.3%	86.8%	89.5%	2.7%	89.5%	
Outpatient FFT Score	M	95.3%	96.0%	96.3%	95.5%	95.2%	97.1%	97.7%	96.3%	97.0%	98.2%	97.1%	96.0%	95.6%	96.0%	0.4%	95.7%	96.1%	0.4%	96.1%	
Maternity FFT response rate	45.0%	43.3%	42.0%	37.3%	32.8%	29.3%	32.5%	17.6%	30.4%	36.3%	24.7%	30.6%	21.5%	38.9%	21.5%	17.4%	32.9%	31.4%	-1.5%	31.4%	
Maternity FFT score	96.0%	98.2%	99.1%	97.4%	97.7%	96.1%	97.7%	98.0%	100.0%	100.0%	98.5%	100.0%	96.6%	97.1%	96.6%	-0.5%	94.8%	98.3%	3.5%	98.3%	
Accommodation and Moves																					
Mixed Sex Accommodation breaches	0	0	6	0	0	0	0	7	0	0	0	144	87	0	87	87	27	244	217	20	
All ward moves	M	2106	2226	2107	2221	2335	2228	2437	2384	2418	2457	2170	2516	2304	2516	9.2%	27099	27605	1.9%	2300	
Night ward moves	M	367	370	379	413	450	436	443	415	498	474	454	498	384	498	29.7%	4910	5197	5.8%	433	

Indicator Description	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Month Comparison Mar-17	Mar-18	Var	YTD Comparison 2016/17	2017/18	Var	Rolling 12 month Avg	Trend
Four hour standard	95.0%	80.1%	81.4%	88.0%	87.7%	92.5%	87.8%	92.1%	94.1%	86.7%	86.7%	86.8%	85.5%	80.7%	85.5%	4.8%	80.3%	87.5%	7.1%	87.5%	
12 Hour DTAs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	-3	0	
Unplanned re-attendance to Emergency Department	5.0%	3.0%	3.2%	2.9%	2.9%	2.5%	2.7%	2.7%	2.3%	2.7%	3.3%	2.5%	2.7%	3.1%	2.7%	-0.4%	3.0%	2.8%	-0.3%	2.8%	
% Patients waiting less than 15 minutes for assessment in ED	M	80.9%	80.8%	85.4%	85.6%	83.9%	80.0%	84.0%	85.2%	83.0%	81.4%	78.7%	83.3%	79.7%	83.3%	3.6%	89.5%	82.7%	-6.8%	82.7%	
% Patients waiting less than 60 minutes for treatment in ED	M	41.1%	40.4%	46.0%	39.1%	44.5%	40.7%	52.2%	52.6%	46.4%	54.8%	52.6%	45.0%	43.0%	45.0%	2.1%	41.3%	46.2%	4.9%	46.2%	
% Patients waiting less than 120 minutes for treatment in ED	M	68.5%	67.3%	75.4%	68.3%	75.4%	71.4%	82.1%	84.1%	76.0%	84.1%	83.0%	74.9%	72.8%	74.9%	2.1%	68.6%	75.8%	7.2%	75.8%	
% Patients that left without being seen in ED	M	1.5%	1.4%	1.1%	1.6%	2.1%	2.2%	1.7%	1.4%	1.9%	1.9%	1.7%	2.5%	1.2%	2.5%	1.2%	1.5%	1.8%	0.3%	1.8%	
% Patients admitted from ED (Conversion rate)	M	26.4%	26.0%	26.6%	27.6%	28.3%	28.5%	28.4%	30.8%	31.0%	32.3%	33.0%	31.3%	27.5%	31.3%	3.8%	25.6%	29.1%	3.5%	29.1%	
Number of ambulatory care admissions with zero length of stay	M	628	689	719	846	925	742	742	883	917	898	810	1022	639	1022	383	6826	9821	2995	818	
% of ambulatory care admissions with zero length of stay	M	54.5%	51.9%	56.0%	55.4%	59.5%	52.9%	53.4%	57.6%	58.4%	55.7%	56.9%	58.8%	50.9%	58.8%	7.9%	50.1%	56.1%	6.0%	56.1%	
RTT Incomplete standard	92.0%	90.8%	92.3%	92.2%	92.0%	92.0%	91.3%	91.4%	91.5%	90.0%	90.4%	90.2%	89.9%	90.8%	89.9%	-0.8%	88.2%	91.2%	3.0%	91.2%	
RTT Backlog (Number of patients waiting over 18 weeks)	M	2794	2401	2351	2315	2385	2629	2623	2573	2929	2767	2777	2839	2680	2839	159	2680	2839	159	2620	
RTT 52 week waiters	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	1	2	1	0	
RTT 35 week waiters	M	331	277	236	201	172	157	164	141	165	174	165	213	302	213	29.5%	302	213	29.5%	200	
Diagnostic standard (% patients waiting more than 6 weeks)	1.0%	5.0%	2.3%	1.6%	1.7%	2.3%	2.5%	2.8%	1.8%	2.3%	2.8%	1.9%	1.4%	1.4%	1.4%	0.0%	1.9%	2.4%	0.4%	2.4%	

Indicator Description	Target	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Month Comparison Feb-17	Feb-18	Var	YTD Comparison 2016/17	2017/18	Var	Rolling 12 month Avg	Trend
Cancer 2WW Standard	93.0%	98.1%	96.8%	96.0%	96.0%	95.4%	94.7%	96.4%	94.9%	97.4%	98.2%	95.8%	96.4%	98.4%	96.4%	-2.0%	97.3%	96.1%	-1.1%	96.1%	
Cancer 62 day urgent referral standard	85.0%	76.3%	76.0%	72.4%	73.4%	74.7%	81.6%	80.8%	77.4%	75.4%	80.2%	65.5%	76.6%	69.9%	76.6%	6.7%	76.4%	75.7%	-0.7%	75.7%	
Cancer 2WW Standard (breast symptoms)	93.0%	98.7%	96.7%	97.6%	93.8%	96.8%	94.2%	96.7%	96.0%	95.0%	96.2%	94.4%	97.7%	98.8%	97.7%	-1.1%	97.0%	95.9%	-1.1%	95.9%	
Cancer 31 day standard	96.0%	97.1%	98.1%	96.8%	98.9%	95.3%	97.7%	96.8%	98.0%	98.3%	96.3%	95.6%	99.3%	98.8%	99.3%	0.5%	98.7%	97.3%	-1.3%	97.3%	
Cancer 31 day subsequent drug treatment	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Cancer 31 day subsequent surgery	94.0%	94.1%	100.0%	100.0%	100.0%	100.0%	94.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	100.0%	5.9%	98.1%	98.4%	0.3%	98.4%	
Cancer 62 day screening standard	90.0%	85.7%	80.0%	78.6%	83.3%	55.6%	92.3%	66.7%	70.0%	62.5%	80.0%	66.7%	40.0%	66.7%	40.0%	26.7%	87.8%	71.9%	15.9%	71.9%	

Indicator Description	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Month Comparison Mar-17	Mar-18	Var	YTD Comparison 2016/17	2017/18	Var	Rolling 12 month Avg	Trend
Delayed transfer of care national standard	3.5%	8.6%	6.3%	4.9%	4.4%	4.0%	4.4%	2.8%	2.3%	2.0%	1.3%	1.7%	1.1%	7.3%	1.1%	-6.1%	7.5%	3.7%	-3.9%	3.7%	
Cancellations																					
Urgent operations cancelled for a second time	0	0	0	1	0	0	0	0	0	0	0	0	1	2	1	-1	9	2	-7	0	
Proportion of last minute cancellations not rebooked within 28 days	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.6%	3.0%	0.0%	6.3%	0.0%			1.3%	1.3%	0.0%	98.7%	
Outpatient appointment cancellations <6 weeks	M	51	37	46	51	38	36	53	47	43	31	49	52	46	52	13.0%	458	534	16.6%	45	
Outpatient appointment cancellations >6 weeks	M	1246	1386	1345	1421	1607	1277	1307	1223	1370	1413	1362	1484	1383	1484	7.3%	15195	16441	8.2%	1370	

Leadership and Culture

Indicator Description	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
														Mar-17	Mar-18	Var	2016/17	2017/18	Var		
Trust turnover rate	10.0%	11.0%	11.0%	11.0%	11.2%	11.2%	11.6%	11.3%	11.3%	11.3%	11.2%	11.1%	11.0%	10.3%	11.0%	0.7%	9.9%	11.2%	1.3%	11.2%	
Trust total sickness rate	3.3%	3.4%	3.5%	3.8%	4.4%	4.2%	4.3%	4.8%	5.0%	5.3%	5.6%	4.6%	4.1%	4.0%	4.1%	0.1%	4.3%	4.4%	0.1%	4.4%	
Trust vacancy rate	10.0%	12.0%	11.7%	11.7%	10.6%	10.6%	11.0%	9.6%	9.2%	9.0%	8.6%	8.0%	7.8%	6.2%	7.8%	1.6%	8.1%	10.0%	1.9%	10.0%	
Temporary costs and overtime as a % of total payroll	10.0%	14.2%	14.1%	15.1%	13.8%	13.6%	14.6%	16.1%	14.2%	13.6%	15.3%	11.6%	13.3%	15.0%	13.3%	-1.7%	15.4%	14.1%	-1.3%	14.1%	
Proportion of staff with up to date annual appraisal	85.0%	79.3%	81.8%	81.1%	81.6%	82.0%	82.3%	82.4%	81.5%	81.4%	81.8%	81.4%	80.0%	79.0%	80.0%	1.0%	83.2%	81.4%	-1.8%	81.4%	

Activity and Effectiveness

Indicator Description	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Month Comparison Mar-17	Mar-18	Var	YTD Comparison 2016/17	2017/18	Var	Rolling 12 month Avg	Trend
Emergency Department attendances	M	9571	10063	10050	10596	10476	9859	9911	9579	10065	9454	8652	10570	9442	10570	11.9%	110537	118846	7.5%	9904	
Ambulance conveyances	M	3211	3279	3106	3219	3187	3123	3183	3237	3527	3327	2945	3386	3156	3386	7.3%	37083	38730	4.4%	3228	
Admissions via A&E	M	26.4%	26.0%	26.6%	27.6%	28.3%	28.5%	28.4%	30.8%	31.0%	32.3%	33.0%	31.3%	27.5%	31.3%	3.8%	25.6%	29.1%	3.5%	29.1%	
Primary Referrals	M	8020	9316	9022	8287	8526	8187	8958	8813	6750	8188	7665	8203	10268	8203	-20.1%	108785	99935	-8.1%	8328	
Consultant to Consultant referrals	M	1469	1714	1685	1740	1786	1774	1880	2006	1693	2037	1812	1724	1819	1724	-5.2%	18498	21320	15.3%	1777	
2WW Referrals	M	1443	1768	1825	1730	1756	1569	1764	1641	1297	1701	1657	1796	1888	1796	-4.9%	19744	19947	1.0%	1662	
Elective spells	M	586	665	612	591	614	629	618	651	507	529	589	658	715	658	-8.0%	8002	7249	-9.4%	604	
Day Cases	M	3511	4194	4163	3953	3904	3795	4044	4223	3390	4164	3705	3858	4438	3858	-13.1%	48133	46904	-2.6%	3909	
Elective Beddays	M	1579	1852	1520	1850	1765	1468	1581	1783	1375	1303	1503	2143	2136	2143	0.3%	23035	19722	-14.4%	1644	
Total Non-Elective Spells	M	3750	4040	4027	4163	4267	4046	4242	4432	4520	4552	4123	4899	4077	4899	20.2%	45708	51061	11.7%	4255	
Number of Emergency spells	M	3106	3422	3430	3534	3670	3463	3553	3841	3927	3929	3560	4261	3418	4261	24.7%	38240	43696	14.3%	3641	
Number of Maternity spells (ante and post partum)	M	357	332	319	331	319	304	381	323	319	336	308	343	351	343	-2.3%	4020	3972	-1.2%	331	
Number of other non-elective spells (Births/Transfers from other hospitals)	M	287	286	278	298	278	279	308	268	274	287	255	295	308	295	-4.2%	3448	3393	-1.6%	283	
Non-Elective beddays	M	22149	23000	20749	21342	21307	21132	21781	20971	22329	23970	21117	23444	23183	23444	1.1%	274689	263291	-4.1%	21941	
LOS																					
Elective Average Length of Stay	M	2.7	2.8	2.5	3.1	2.9	2.3	2.6	2.7	2.7	2.5	2.6	3.3	3.0	3.3	0.3	2.9	2.7	-0.2	2.7	
Non-Elective Average Length of Stay	M	5.5	6.1	5.8	5.0	5.0	5.1	5.2	4.9	4.9	5.1	4.9	4.9	6.2	4.9	-1.4	6.0	5.2	-0.8	5.2	
Inpatient Average Length of Stay at intermediate care units	M	29.8	37.1	29.7	28.6	24.7	26.0	26.1	26.7	26.0	24.7	30.1	32.0	36.7	32.0	-4.7	30.7	28.5	-2.2	28.5	
Outpatients																					
First outpatient attendances	M	8653	10070	11191	9554	9778	9332	10503	10556	8596	10384	9578	9969	11844	9969	-1875	143112	128842	-14270	9847	
Follow-up outpatient attendances	M	21336	25102	25847	24043	24549	23745	26075	27417	20854	26242	23118	24662	27111	24662	-2449	313748	320198	6450	24416	
First outpatient DNA rate	M	8.3%	8.6%	7.9%	9.0%	8.5%	9.0%	8.2%	7.9%	8.9%	7.8%	7.6%	7.8%	8.7%	7.8%	-0.9%	9.0%	8.3%	-0.7%	8.3%	
New to follow up ratio	M	2.5	2.5	2.3	2.5	2.5	2.5	2.5	2.6	2.4	2.5	2.4	2.5	2.3	2.5	0.2	2.2	2.5	0.3	2.5	
Community Nursing																					
Community nursing referrals	M	3743	4318	4238	4165	4039	4003	4188	4366	3674	4640	4002	4175	4518	4175	-343	49537	49551	14	4129	
Community nursing total contacts	M	33274	36727	35439	35940	36036	33723	36142	37163	33056	38143	33040	35312	37911	35312	-2599	415441	423995	8554	35333	
Community Nursing face-to-face contacts	M	19159	20792	20150	20416	20314	19078	19981	20425	18717	20127	17942	18863	21249	18863	-2386	233726	235964	2238	19664	
Community nursing ALOS	M	20.0	20.2	19.3	19.3	18.5	16.9	15.9	14.2	13.1	11.1	8.5	5.6	19.9	5.6	-14	23.6	15.2	-8.4	15	
Waiting Times																					
% SALT patients waiting less than 13 weeks	M	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Total SALT patients waiting	M	153	146	141	107	143	123	154	153	145	121	159	159	139	159	20	1860	1704	-156	142	
% Podiatry patients waiting less than 13 weeks	M	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Total podiatry patients waiting	M	335	305	255	259	188	212	292	238	183	244	236	223	380	223	-157	7607	2970	-4637	248	
% Dietetics patients waiting less than 13 weeks	M	98.6%	100.0%	100.0%	93.8%	97.8%	97.8%	97.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	99.9%	98.6%	-1.3%	98.6%	
Total dietetics patients waiting	M	141	50	46	90	45	45	40	39	41	75	53	101	69	101	32	730	766	36	64	
% MSK patients waiting less than 13 weeks	M	94.5%	86.6%	96.2%	93.9%	99.9%	100.0%			77.9%	38.4%	52.4%	48.1%	96.5%	94.5%	-2.0%	98.5%	71.3%	-27.2%	71.3%	
Total MSK patients waiting	M	1388	1570	1062	1021	1041	170	0	0	1713	448	1018	1836	2029	1836	-193	13661	11267	-2394	939	

Appendix 1

National clinical audits and national confidential enquiries we were eligible to participate in during 2017-2018

National Confidential Enquiries	ESHT Eligible	ESHT Participation
Maternal, newborn and infant and perinatal mortality (MBRRACE-UK)	Y	Y
Acute Heart Failure (NCEPOD)	Y	Y
Perioperative Diabetes (NCEPOD)	Y	Y
Young Peoples Mental Health (NCEPOD)	Y	Y
Chronic Neuro-disability (NCEPOD)	Y	Y
Cancer in Children, Teens and Young Adults (NCEPOD)	Y	Y
National Clinical Audit	**ESHT Eligible**	**ESHT Participation**
National Maternity and Perinatal Audit (NMPA)	Y	Y
Neonatal Intensive and Special Care (NNAP)	Y	Y
Adult Critical Care Audit (Case mix programme - ICNARC)	Y	Y
Falls and Fragility Fractures Audit Programme (FFFAP)	Y	Y
National Joint Registry (NJR)	Y	Y
Bowel Cancer Audit (NBCA)	Y	Y
National Audit of Breast Cancer in Older Patients (NABCOP)	Y	Y
National Prostate Cancer Audit	Y	Y
National Lung Cancer Audit (NLCA)	Y	Y
National Oesophago-gastric Cancer Audit (NOGCA)	Y	Y
Head and Neck Cancer Audit (HANA)	Y	Y
Major Trauma (TARN)	Y	Y
Coronary Angioplasty / PCI	Y	Y
Cardiac Rhythm Management (CRM)	Y	Y
National Heart Failure Audit	Y	Y
Acute Coronary Syndrome / Acute MI Audit (MINAP)	Y	Y
National Cardiac Arrest Audit (NCAA)	Y	Y
National Inflammatory Bowel Disease Audit	Y	Y
National Emergency Laparotomy Audit (NELA)	Y	Y
Elective Surgery (National PROMs Programme)	Y	Y
National Paediatric Diabetes Audit (NPDA)	Y	Y
National Pregnancy in Diabetes (NPID) Audit	Y	Y
National Adult Diabetes Inpatient Audit (NADIA)	Y	Y
National Diabetes Foot Care Audit (NDFA)	Y	Y
National Diabetes Adult Audit	Y	Y
National Diabetes Transition Audit	Y	Y
Stroke National Audit (SSNAP)	Y	Y
Learning Disability Mortality Review Programme (LEDER)	Y	Y
National Audit of Intermediate Care (NAIC)	Y	Y
UK Parkinson's Audit	Y	Y
National COPD Audit Programme - Pulmonary Rehabilitation	Y	Y
National COPD Audit Programme - Secondary Care	Y	Y
National Comparative Audit of Blood Transfusion Programme - Red Cells and Platelets in Adult Haematology Patients	Y	Y
Audit of the management of patients at risk of Transfusion Associated circulatory overload (TACO)	Y	Y

Fractured Neck of Femur - Emergency Departments	Y	Y
Pain in Children - Emergency Departments	Y	Y
Procedural Sedation in Adults – Emergency Departments	Y	Y
National Ophthalmology Audit	Y	Y
British Society of Urological Surgeons (BAUS) – Cystectomy Audit	Y	Y
BAUS – Nephrectomy Audit	Y	Y
BAUS – Radical Prostatectomy Audit	Y	Y
BAUS – PCNL Audit	Y	Y
BAUS – Stress Urinary Incontinence Audit	Y	Y
BAUS – Urethroplasty Audit	Y	Y
Endocrine and Thyroid National Audit	Y	N

Appendix 2

Participation and cases submitted – Mandatory Clinical Audits

Mandatory National Audit	Number of cases submitted by Trust	% submitted of those required
National COPD Audit Programme - Pulmonary Rehabilitation	21 cases	100% (No specific number required)
National Audit of Intermediate Care (NAIC)	Service User Questionnaire – 176 Patient Reported Experience Measure – 107	100% (all available data submitted)
Red Cells and Platelets in Adult Haematology Patients	CONQ – 21 cases EDGH – 24 cases	100% (all available data submitted)
Audit of the management of patients at risk of Transfusion Associated circulatory overload (TACO)	CONQ – 38 cases EDGH – 33 cases	100% (all available data submitted)
UK Parkinson's Audit	87 cases	100% (No specific number required)
National Adult Diabetes Audit	2842 cases	Unknown – 2017/18 was the first year the Trust participated and only a partial return was possible due to the development of a new data collection system. A full return is planned for 2018-19.
National Adult Diabetes Inpatient Audit	CONQ – 48 cases EDGH – 51 cases	100% (all available data submitted)
National Pregnancy in Diabetes Audit	CONQ – 11 cases EDGH – 14 cases	100% (all available data submitted)
Fractured Neck of Femur – Emergency Departments	CONQ – 100 cases EDGH – 100 cases	100%
Pain in Children - Emergency Departments	CONQ – 100 cases EDGH – 50 cases	100%
Procedural Sedation in Adults – Emergency Departments	CONQ – 50 cases EDGH – 53 cases	100%
Acute Heart Failure (NCEPOD)	9 x Clinical Questionnaires 9 x Case notes	100%
Young Peoples Mental Health (NCEPOD)	5 x Clinical Questionnaires 5 x Case notes 2 x Organisational Questionnaires	100%
Chronic Neuro-disability (NCEPOD)	4x Clinical Questionnaires 4 x Admission Questionnaires 4 x Case notes	100%

Appendix 3

Other non-mandated National Clinical Audits

National Clinical Audit	Specialty
The Second UK Sprint National Anaesthesia Project: Epidemiology of Critical Care provision after Surgery (SNAP-2: EpiCCS)	Anaesthetics
Clinical management of Complicated intra-Abdominal Infection (CABI) in UK hospitals	General Surgery
National Small Bowel obstruction Audit	General Surgery
National Right Iliac Fossa pain Treatment (RIFT) Audit	General Surgery
National Audit of Cardiac Rehabilitation	Cardiology
BHIVA National Clinical Audit 2017: Psychological well-being and support, and use of alcohol and recreational drugs.	Sexual Health

Annex 1 Statements from the Commissioners, Healthwatch and HOSC

Commissioner statement on ESHT Quality Account 2017/18

East Sussex Healthcare NHS Trust (ESHT) in 2017/18 has continued to improve the quality and safety of services provided to the residents of East Sussex. The Quality Account demonstrates the improvement in outcomes for the population who access services at ESHT. A recent Care Quality Commission inspection was undertaken in March 2018 and Eastbourne, Hailsham and Seaford (EHS) Clinical Commissioning Group (CCG) and Hastings and Rother (HR) CCG will continue to support ESHT in providing high quality care during 2018/19.

EHS and HR CCGs have reviewed the ESHT Quality Account for the 2017/18 year and consider it to be a fair and accurate reflection of the organisations' performance during the year.

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

- significantly improved reduction in the number of falls occurring (particularly in relation to the number of falls per 1,000 bed days and those resulting in harm)
- significantly improved compliance with the component elements of the Duty of Candour
- significantly improved reduction in open complaints and elimination of backlog of cases
- improved mortality indices which continues to see the Trust perform in line with peer organisations
- improved inpatient and maternity Friends and Family Test (FFT) returns
- improved Emergency Department (ED) national Four Hour Wait standard monthly returns
- improved Delayed Transfer of Care (DTOC) rates
- reduced Clostridium difficile Infections against national objectives

The 2018/19 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:

- ensuring consistent access to high quality care for patients 7 days per week
- ensuring that national guidance continues to be met in relation to the identification, management and escalation of Sepsis in patients
- ensuring that all patients continue to be risk assessed upon admission for Venous Thromboembolism (VTE)
- ensuring that all patient deaths are reviewed within the national standard of three months post event
- ensuring that the ED Friends and Family Test (FFT) response improves together with compliance with the four hour standard
- ensuring that inpatient personal needs are attended to in a more responsive manner
- ensuring that there is sustained and ongoing improvement in relation to falls and hospital acquired pressure damage

Both EHS and HR CCGs look forward to continuing to work collaboratively with the Trust during the 2018/19 year and ensuring that the residents of East Sussex continue to receive safe and optimum service provision via the East Sussex Better Together programme.

Healthwatch East Susssex statement on ESHT Quality Account 2017/18

Healthwatch East Sussex (HWES) continues to work with East Sussex Healthcare NHS Trust on its quality improvement programme and is very pleased to provide this statement based on our engagement with patients, their families, the staff and Board members during 2017/18.

It is very reassuring for Healthwatch East Sussex to see one of the continued priorities for the year and going forward is to listen to feedback from patients and families on the quality of care they provide; HWES strongly supports this priority and is delighted the evidence and insight that it gathers on patient experiences is used by the Trust as part of their continuous improvement programme.

We have continued our engagement during the year at all levels with frontline staff, at executive level and with Board members and have confidence and trust in the leadership team as it grows. HWES welcomed the appointment of the new Director of Nursing and continues to build strong relationships with her team.

The improvement priorities for 2017/18 reflected the learning the Trust needed to embed to continue its quality improvement programme, especially around the introduction of safety huddles, developing patient feedback forums where experiences can be shared, learning from review of deaths and responding to complaints. Our engagement in these areas continues to report patients and families experiences are improving significantly. It is also very encouraging to see the increase in patients completing the Trust's own patient feedback surveys and Friends and Family Test (FFT) responses.

Going forward, the priorities for 2018/19 reflect what matters to patients, safe and effective discharge, improving patients' experience of being on a ward and getting home and early recognition and treatment of the deteriorating patient, all again HWES would support alongside the remaining priorities identified. We will continue to engage with the Trust throughout 2018/19 and are planning collaboratively a programme of activity that allows trained members of the public into the Trust to view for themselves the quality of care patients receive. These activities are very reassuring for the local community as they help to build confidence in the services the Trust provide. For HWES our priority for 2018/19 is to look at the out of hospital services the Trust provide and we look forward to another successful year working together.

Health Overview and Scrutiny Committee (HOSC) statement on ESHT Quality Account 2017/18

During 2017/18 HOSC has welcomed the Trust's positive engagement with the Committee as evidenced by the very senior officers who attend HOSC meetings, including the Chief Executive.

The report of the fourth Care Quality Commission (CQC) inspection, published in June 2018, shows that the Trust has once again made considerable improvements. We welcome the Trust receiving 'good' or 'outstanding' ratings in all areas inspected by the CQC, apart from urgent and emergency services at Eastbourne District General Hospital (EDGH), and we recognise that the Trust's overall rating has only remained at 'requires improvement' due to the fact that not all areas of the Trust were re-inspected. We would expect to see the Trust achieve at least a 'good' rating when the remaining areas are re-inspected during 2019/20.

The fact that urgent and emergency services are still rated as 'requires improvement' at the EDGH is disappointing, although it is clear that the service has improved since the last inspection. The CQC identified one 'must do' and 12 'should do' actions in relation to urgent and emergency care, mainly at the Eastbourne site, and we understand that the Trust is developing an action plan to address these actions. We would expect this plan to have clear and deliverable actions to improve urgent and emergency services contained within it.

We see the recommendation by the CQC that ESHT is removed from special measures for quality as evidence of major improvements at the Trust since 2015. We congratulate the commitment of every member of staff in achieving that goal. We hope, however, that the Trust is also able to come out of financial special measures before too long.

HOSC welcomes the continued work of ESHT's leadership team, which has been forthright in its admission of the scale of the issues facing the Trust, and has responded by developing a programme of quality improvement that has helped to elevate the Trust out of special measures for quality. The CQC stated that there had been a significant improvement in organisational culture; we are very glad to hear that this is the case given that it was an area of major concern to this Committee in previous years, and we hope to see further improvements when the well led domain is re-inspected during 2019/20.

HOSC, alongside many in East Sussex, remains focused on working where we can to identify and support the improvements in quality that patients and their families deserve. We have considered improvements being made in both end of life care and maternity services over the past year and will look to identify opportunities for further scrutiny following consideration of the CQC report at our next meeting at the end of June.

2017/18 Quality Priorities

We are glad that ESHT at least made progress in all of its quality priorities during 2017/18 and that it made significant improvements or fully implemented more than half of them.

Improving patient flow and reducing hospital length of stay for non-elective patients was an area HOSC identified as one we wished to see improved, and we welcome the fact that the Trust has made significant improvements in this area.

End of Life care improvement has been an area of interest for the Committee and we welcome that progress was made in this area during 2017/18 and that it is due to continue as a quality priority during 2018/19.

It is, however, disappointing that there has not been much progress in reducing the number of staff experiencing bullying and harassment, given the importance of staff satisfaction to patient care, and we hope that the work the Trust is doing to make improvements this year are more successful.

2018/19 Quality Priorities

We are pleased to see the inclusion of quality priorities based on areas identified by the CQC as requiring 'should do' action and which need addressing, for example, improving young people's experience of being in hospital wards. We also welcome plans to deliver the four core standards for emergency admissions by 2020/21 as part of the priority of working towards providing consistent high quality care for patients 7 days per week, particularly because of the CQC's concerns about emergency care at EDGH.

HOSC looks forward to working with the Trust over the coming year and will continue to monitor progress on behalf of local people, working closely with CQC, NHS Improvement and local Healthwatch.

Annex 2 Independent Practitioner's Limited Assurance report

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 2018 ("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 2018 subject to the limited assurance engagement consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE);
- Percentage of reported patient safety incidents resulting in severe harm or death.

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 April 2017 to 28 June 2018;

- papers relating to quality reported to the Board over the period April 2017 to 28 June 2018;
- feedback from East Sussex County Council dated 1 June 2018 and each of Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCGs, both dated 1 June 2018;
- feedback from local Healthwatch organisations dated 20 June 2018;
- feedback from the Overview and Scrutiny Committee dated 21 June 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated May 2018;
- the national patient survey dated 13 June 2018;
- the local patient surveys dated 17 October 2017 and 30 January 2018;
- the national staff survey dated 17 January 2018;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 8 May 2018;
- the annual governance statement dated 24 May 2018; and
- the Care Quality Commission's inspection report dated 6 June 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 the percentage of patients risk-assessed for venous thromboembolism (VTE) did not meet the six dimensions of data quality in the following respects:

- Validity/Accuracy – Our testing identified 12 errors in relation to the validity and accuracy of the indicator population. Specifically, 3 cases were incorrectly recorded as having not been subject to a risk assessment and 2 cases which were out of scope of the indicator were incorrectly included in the indicator population; all of which led to an understatement of the indicator. In addition, our testing identified 7 cases that had been incorrectly recorded as having been subject to a risk assessment, leading to an overstatement of the indicator.

Conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- 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

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Chartered Accountants
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28 June 2018

Annex 3 Equality Impact Assessments

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

Annex 4 Glossary

Acute Kidney Injury (AKI)	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 Care (AC)	Ambulatory Care (AC) or outpatient care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention and rehabilitation services. This care can include advanced medical technology and procedures, even when provided outside hospitals.
Anaerobic bloodstream infections (BSI)	An anaerobic bloodstream infection is caused by anaerobes, which are bacteria that cannot grow in the presence of oxygen.
British Thoracic Society (BTS)	The British Thoracic Society (BTS) was formed in 1982 by the amalgamation of the British Thoracic Association and the Thoracic Society. It is a registered charity and a company limited by guarantee. The BTS exists to improve standards of care for people who have respiratory diseases and to support and develop those who provide that care.
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
Childhood Community Acquired Pneumonia (CAP)	Pneumonia is an infection in one or both lungs. Pneumonia can be caused by viruses or bacteria. Viruses are more common in children younger than two years old. It is called community-acquired as the infection started outside the hospital (in the community).
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).
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.

Cognitive Behavioural Therapy for Insomnia and Anxiety (CBTI)	Cognitive behavioural therapy (CBT) is a talking therapy that can help someone manage problems by changing the way they think and behave. It is most commonly used to treat anxiety and depression but can be useful for other mental and physical health problems.
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/
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
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.
Decision to Delivery (DDI)	Decision to Delivery (DDI) is the time period between the clinical decision that a caesarean section is required and when the procedure is carried out.
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, nurisng 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
East Sussex Better Together (ESBT)	East Sussex Better Together is an alliance of commissioners and providers in East Sussex, working together to reshape the way health and social care services are provided in East Sussex. ESBT is working towards a fully integrated health and social care system that ensures every patient or service user enjoys proactive, joined up care that supports them to live as independently as possible and achieve the best possible outcomes.
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.
Electronic Prescription and Medicines Administration (ePMA)	Electronic Prescribing and Medicines Administration (ePMA) is the "utilisation of electronic systems to facilitate and enhance the communication of a prescription or medicine order, aiding the choice, administration and supply of a medicine through information and decision support and providing a robust audit trail for the entire medicines use process". The aim is to improve patient safety by reducing prescribing and administration errors that could result in medication errors and adverse drug events.
Enhancing Mental Health Awareness in Emergency Services (ENHANCE)	ENHANCE (Enhancing Mental Health Awareness in Emergency Services) is an Emergency Department study opened in collaboration with SECAMB and Sussex Police

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.
Fluid Optimisation in Emergency Laparotomy (FLO ELA)	Fluid Optimisation in Emergency Laparotomy Trial (FLO-ELA) is the Fluid Optimisation in Emergency Laparotomy trial. It is a large pragmatic clinical trial which aims to find out whether cardiac-output guided haemodynamic therapy given to patients during and shortly after emergency bowel surgery could save lives, when compared with usual care. The trial is being run in 100 UK hospitals and will study nearly 8,000 patients. The project is funded by the National Institute for Health Research Technology Assessment Programme (project number 15/80/54).
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.
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.
Hyponatraemia	Hyponatraemia is defined as a serum sodium concentration of less than 135 mmol/L. It is the most common electrolyte disorder encountered in clinical practice and is usually an incidental finding on routine blood tests.

Information Governance Toolkit (IGT)	Information Governance Toolkit (IGT) is an existing approved Information Standard. It is an online performance tool developed by the Department of Health (DH) to support organisations to measure their performance against information governance requirements. The Care Quality Commission uses the results to triangulate their findings.
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.
Kent Surrey Sussex Academic Health Science Network (KSS AHSN) Mortality Community of Interest	The Learning from Mortality Community of Practice (MCoP) was formed in January 2017 by six convening members. The group's first activity was a survey of medical directors across Kent, Surrey and Sussex. None of the respondents felt that there was comprehensive or well-structured training for staff undertaking mortality reviews. However, more than 75% felt that mortality governance was a top priority for their Trust board, and that sharing of experiences and learning from mortality reviews across the region would be beneficial. Ambition: To build relationships between organisations to improve the standards of mortality reviews and enrich learning for safer care. Our community: A community from Kent, Surrey and Sussex closely involved in mortality and committed to going beyond effective screening and mortality reviews to become a community of trust, where learning is shared through working together with carers and families.
Medicine reconciliation	The process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated.
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 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 Diabetes Foot Care Audit (NDFA)	The National Diabetes Footcare Audit (NDFA) is a measurement system of care structures, patient management and outcomes of care for people with active diabetic foot disease. In 2014/15 the annual cost of diabetic foot disease to the NHS in England was estimated at £1 billion, in addition to the personal/social costs of reduced mobility and sickness absence.
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
Near miss	An event not causing harm, but having the potential to cause injury or ill health.
Never Event	A Never Event is a type of Serious Incident (SI). These are defined as 'serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'.
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.
Patient Safety Thermometer	The NHS Patient Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of harm once a month from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE (venous thromboembolism - deep vein thrombosis and pulmonary embolism). It provides a quick, simple method for surveying patient harms and analysing results so that we can measure and monitor local improvement and harm free care.
Practical Obstetric Multi-Professional Training (PROMPT)	PROMPT (PRactical Obstetric Multi-Professional Training) is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working.
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.
RADIANCE HTN	RADIANCE-HTN is a randomised, double-blind, sham controlled, 2-cohort study (TRIO and SOLO) designed to demonstrate efficacy and document the safety of the Paradise Renal Denervation System in two distinct populations of hypertensive subjects.
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.
SAFER patient flow bundle	A combined set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients.
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.
Schwartz Rounds	Schwartz Centre Rounds, a multidisciplinary forum designed for all staff, both clinical and non-clinical, to come together once a month to discuss and reflect on the emotional and social challenges associated with working in healthcare. Rounds provide a confidential space to reflect in and share experiences.
Sepsis	The body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure and death.

Sepsis Care Bundle	A selected set of elements of care that, when implemented as a group, have an effect on outcomes beyond implementing the individual elements alone.
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. For 2017/18 the Trust has signed up to four safety pledges which are: • Reducing harm from patient falls • Compliance with Duty of Candour • Pressure ulcer prevention • Improved compliance with Sepsis screening and delivery of the Sepsis 6 Care Bundle
South Central Ambulance Service (SCAS)	South Central Ambulance Service NHS Foundation Trust (SCAS) is the authority responsible for providing NHS ambulance services in Buckinghamshire, Oxfordshire, Berkshire and Hampshire excluding North East Hampshire.
South East Coast Ambulance Service (SECAmb)	South East Coast Ambulance Service NHS Foundation Trust (SECAmb) is the authority responsible for providing NHS ambulance services for south-eastern England, covering Kent (including Medway),West Sussex and East Sussex (including Brighton and Hove). It also covers a part of north-eastern Hampshire. The service was made an NHS Foundation Trust on 1 March 2011.
Speak Up Guardian	A person who supports staff to raise concerns.

Spine	The Spine is a set of national services used by the NHS Care Record Service. These include: • The Personal Demographics Service (PDS) which stores demographic information about each patient and their NHS number. Patients cannot opt-out from this component of the Spine, although they can mark their record as 'sensitive' to prevent their contact details being viewed by 831,000 staff • The Summary Care Record is a summary of patients' clinical information, such as allergies and adverse reactions to medicine • The Secondary Uses Service (SUS) which uses data from patient records to provide anonymised and pseudonymised business reports and statistics for research, planning and public health delivery.
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 SHMI value, Trusts are banded between 1 and 3 to indicate whether their SHMI 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 (SSIS) 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.
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.
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.

UK Health Departments' Research Ethics Service (UKRES)	The UK Research Ethics Service (UKRES) is committed to enabling and supporting ethical research in the NHS, protecting the rights, safety, dignity and wellbeing of research participants. It is one of the core functions of the Health Research Authority (HRA) which is an executive non-departmental public body of the Department of Health in the United Kingdom.
United Nations Children's Fund (UNICEF)	The United Nations Children's Fund (UNICEF) was established in 1946 by the United Nations to meet the emergency needs of children in post-war Europe and China. Its purpose as mandated by the United Nations General Assembly is to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential.
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.
Views of Informal Carers' Experience of Services (VOICES)	VOICES is a questionnaire for patients who die in the acute sector. This is given to the bereaved and asks about their view of the care provided.
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.

Contents

Welcome and overview

We are pleased to present our annual report which looks back on our work and achievements over 2017/18. The Trust has implemented many changes and improvements over the last 12 months and there is a growing confidence within the organisation in our ability to achieve important national standards and our ambition to be an outstanding Trust by 2020.

We have made great progress in delivering the target of assessing and treating or referring 95% of patients within four hours in our emergency departments. This is an important national standard and is an indicator of how well our organisation is working. It is also a reflection of how the whole health and care system works together, from social care, to primary care through to community and acute services. We are now regularly exceeding 90%, and are in the top 30 Trusts in the country.

Together we are transforming the way we provide urgent and emergency care, embedding quality management systems, better identifying and supporting those patients at the end of their life, reducing patient falls and pressure ulcers and effectively detecting and managing infections. In February 2018 Jeremy Hunt, Secretary of State for Health, visited the Trust and told us that he was "impressed by the excellent work to focus on mortality rates and falls". There is much of which to be proud.

These improvements are set in the context of unprecedented demand. We have seen a 9% increase in attendances at our Emergency Departments – this was significantly higher over winter. However, our work to create integrated care across East Sussex through East Sussex Better Together (ESBT) and more widely across Sussex and East Surrey through our local Sustainability and Transformation Partnership (STP), has helped us to manage the continued increase, whilst improving our services. Our partnership with East Sussex County Council and our commissioners has helped us manage demand during a very busy winter period. We bucked the trend nationally, with only a handful of operation cancellations because of bed space. Our ESBT work is being recognised nationally and we were proud to win a high profile HSJ partnership award.

Referrals to our community services have also continued to increase, putting these teams under heavy pressure. Colleagues, particularly in community and district nursing and community child health, have shown great resilience and determination to maintain core standards of care in these challenging circumstances.

Throughout the year, our patients have continued to rate their experiences of our care very highly. Our patient experience scores have improved and our two hospitals have four and four and a half star ratings on NHS Choices. We are also seeing more plaudits about the care we offer and fewer complaints.

Our goal is to be an organisation that provides care in which the people of East Sussex can be fully confident, and one in which people are happy and proud to work. The first is dependent on the second, therefore looking after our staff and making sure that they have

the support they need is very important to us. During 2017/18 we reduced our vacancy rate, recruiting to a number of nationally 'hard to recruit to' posts. We have also seen a reduction in staff turnover and sickness. In the 2017 NHS Staff Survey, we maintained the significant improvements that we saw in the 2016 survey and saw further improvements in many important areas. We are now one of the best performing trusts in the south east. This improvement was borne out in improved results from the Medical Engagement Scale and the GMC junior doctor survey.

We continue to value innovation and research as a way to provide high quality patient care. Over the last year, the Trust has worked with patients, universities, industry and others to take the best new ideas and use them to care for our patients in the most effective way. ESHT members of staff have supported many advances over the years, including pioneering treatments and technology that are now routinely used in hospitals throughout the UK.

This year the Trust's finances remained challenging and we ended the financial year with a deficit of £57.4m. This figure is far larger than we wanted and more than the ambitious target we set ourselves at the start of this year. While we improved our underlying financial position and made £22.3m in financial savings, we did not do enough to reach our financial targets. We have a duty to our local community to be financially sustainable while continuing to make the significant improvements to quality and safety that we have seen over the last 12 months. We are identifying ways to further reduce our costs in 2018/19 and beyond, through building effective and efficient services while maintaining safe and high quality care for our patients.

In March the CQC inspected our Trust. In their initial feedback, the inspection team particularly commented on the good reception they were given by members of staff. They were impressed by the openness with which people discussed their service and the enthusiasm and commitment they saw to providing high quality care. We are awaiting the inspection results and are hopeful our continued improvements will be recognised.

Every member of staff across our Trust has supported the improvements being realised. On behalf of the Trust Board we would like to thank members of staff for their efforts to deliver safe and effective care for our patients. Thank you for the hard work that you do across the organisation, in all your various responsibilities and areas of work, to ensure that the care we provide for our patients is as efficient and good as it can be.

Our Board has continued to play a crucial role and we extend our sincerest thanks for their continued commitment, support and constructive challenge. We would also like to thank our 600 volunteers and everyone else involved in providing care to our patients and making our Trust an organisation in which we can all be proud. Finally we would like to extend a thank you to the Friends of our Hospitals and our Charitable Trust whose voluntary work and fundraising have supported our patients and members of staff in many ways.

Looking ahead towards 2018/19 we are looking forward to another landmark year with the implementation of further innovations and improvements, CQC feedback following our March inspection and celebrating the NHS 70th birthday in July.

We look forward to sharing our work with you as the year progresses.
Adrian and David

About us

Patients come first at East Sussex Healthcare NHS Trust (ESHT). Our vision 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.

This means working in partnership with commissioners, other providers, and members of staff and volunteers as part of a locally focused and integrated network of health and social care as part of East Sussex Better Together.

We are one of the largest organisations in the local community, employing nearly 7,000 dedicated staff with an annual turnover of £400million. Our teams are proud to provide acute hospital and community health services for the 525,000 people living in East Sussex. We also offer an essential emergency service to the many seasonal visitors to the county every year.

We operate two district general hospitals, Conquest Hospital and Eastbourne District General Hospital (EDGH), both of which have Emergency Departments and provide care 24 hours a day. Between them they offer a comprehensive range of surgical, medical and maternity services supported by a full range of diagnostic and therapy services.

We have around 800 beds and over 100,000 inpatient spells each year. During 2017/18, there were close to 119,000 attendances at our Emergency departments and there were over 449,000 outpatient attendances.

At Bexhill Hospital we offer outpatients, day surgery, rehabilitation and intermediate care services. Outpatient services and inpatient intermediate care services are also provided at Rye, Winchelsea and District Memorial Hospital. We also provide day surgery and outpatient care at Uckfield Hospital.

We provide intermediate care services jointly with East Sussex County Council Adult Social Care at Firwood House in Eastbourne. We also deliver services which focus on people living in the community through our Integrated Locality Teams. Other services focus on people with long term conditions such as the Bladder and Bowel Service, Community Heart Failure, Tissue Viability and Diabetes Specialist Nursing team. Respiratory and MS Nurse Specialists provide further support to our patients in the community.

We provide a range of more specialist services in the community and these include the Emergency Dental Service, Medicines Management, Pharmacy Team and Special Care Dental Service.

ESHT members of staff care for patients in their homes and from a number of clinics, health centres and GP surgeries. Services based outside our hospitals include Health and Social Care Connect (HSCC), the Integrated Night Service, Community Nutrition and Dietetics,

Speech and Language Therapy Service for Adults, Occupational Therapy, Physiotherapy, Podiatry, Diabetic Retinopathy and Sexual Health including contraception services.

Services for children are offered including Health Visiting and the Safeguarding Children Team and Looked after Children Team.

ESHT 2020 – Vision, Values, Ambition

We are committed to providing seamless high quality services across our hospitals and community settings. We are an ambitious organisation that aspires to be excellent and we are focused on delivering outstanding services by 2020. Our vision, values and objectives have been developed to support the achievement of this ambition.

Our vision at East Sussex Healthcare 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.

ESHT 2020 sets out **Our Ambition** to be an outstanding organisation by the year 2020 and provides the framework for how we will achieve this.

Our objectives encompass our commitment to provide clinical services that achieve and demonstrate the best clinical outcomes and provide an excellence experience for patients. These are:

- **Safe patient care is our highest priority**
  We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.

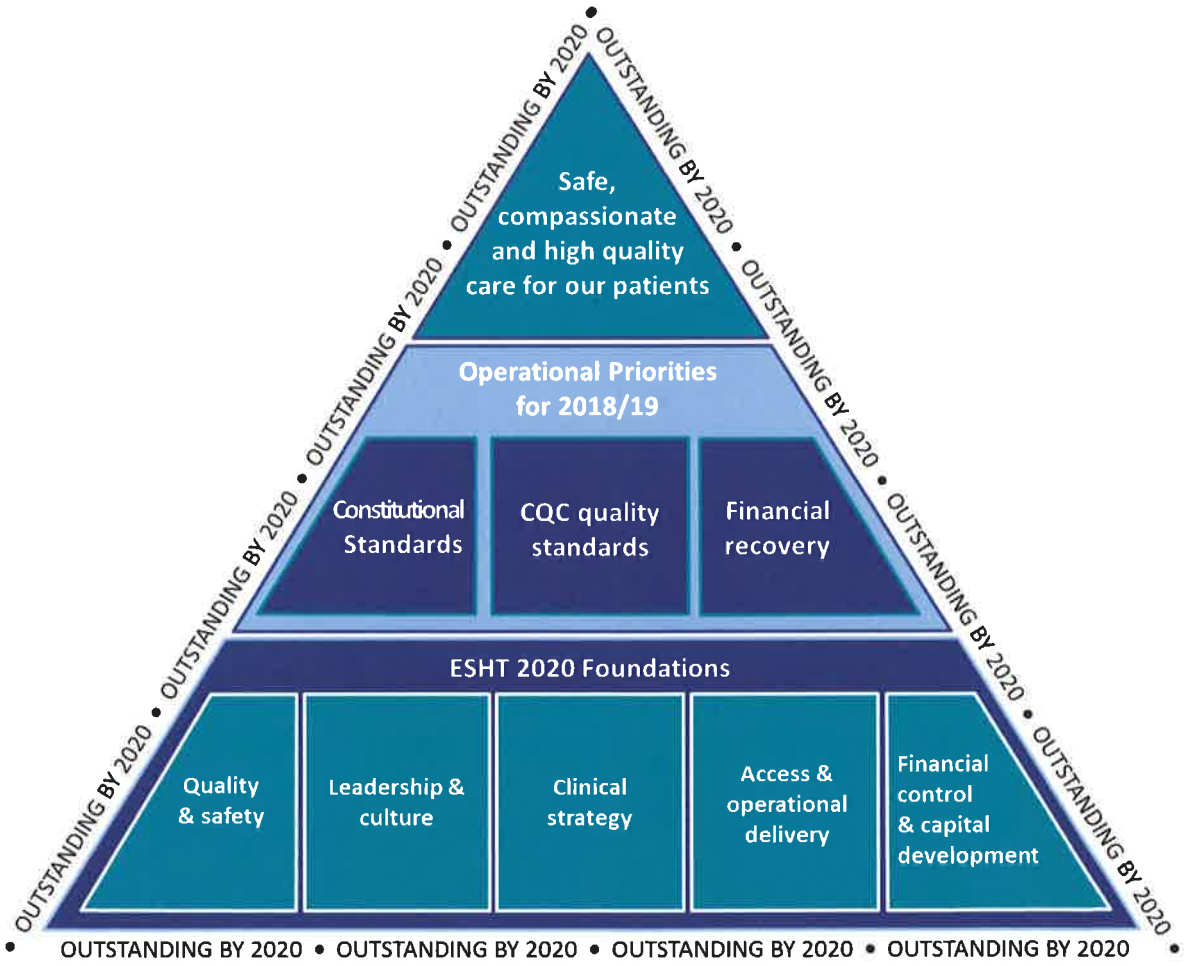
- **All our employees will be valued and respected**
  They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.

- **We will work closely with commissioners, local authority and other partners…**
  …to plan and deliver services that meet the needs of our local population, in conjunction with other care services.

- **We will operate efficiently and effectively…**
  …diagnosing and treating patients in timely fashion and expediting their return to health.

- **We will use our resources efficiently and effectively for the benefit of our patients and their care…**
  …to ensure our services are clinically, operationally, and financially sustainable.

The 2020 vision and our strategic objectives have been embedded across the organisation and translated into individual work programmes in Divisions, corporate services, and cross-organisation initiatives. 2020 is the reference document for personal objectives, internal communications, and external communication with partner organisations and other stakeholders.



Going Concern

The Trust has prepared its 2017/18 Annual Accounts on a going concern basis. The Trust is forecasting a deficit in 2018/19 of £47,853,000, assuming delivery of a £18,000,000 cost improvement programme. As at 31 March 2018 the Trust has a cash balance of £2,100,138 with a cash forecast for the end of each month during 2018/19 ranging from £2,100,000 to £4,692,000. The cash balances assume achievement of the forecast position including delivery of the cost improvement programme and cash support from the Independent Trust Financing Facility through application to the Department of Health via NHS Improvement.

Despite the risk and uncertainty associated with future cash flow projections, management are of the view that whilst challenging, they will be able to deliver against the cost improvement programme and achieve the agreed forecast outturn. However there is no certainty that the cost improvement programme will be achieved, which would consume the available cash resources within the next 12 months and as such would mean the Group and Trust would require further cash support to meet its liabilities as these fall due.

These matters indicate the existence of a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Notwithstanding the need for additional cash support, the Trust does not have any evidence indicating that the going concern basis is not appropriate. The Trust has not been informed by NHS Improvement that there is any prospect of reconfiguration or dissolution within the next 12 months. In terms of the sustainable provision of services, there has been no indication from the Department of Health that the Trust will not continue to be a going concern. Furthermore, continuity of service provision in the future can be demonstrated by signed contracts and future commissioning intentions with commissioners and through the financial and operational plans described in the Trust Strategy and the Sussex and East Surrey Sustainability and Transformation Plans. The Trust Board has set a strategic objective of reaching break-even in five years, and a long-term financial model to secure this objective is under development for review by the Trust Board in July 2018.

Taking the above into account, the directors believe that it is appropriate to prepare the financial statements on a going concern basis.

Performance analysis

Regulatory standards

The operational performance of ESHT is measured against key access targets and outcome objectives set out in the Single Oversight Framework drawn up by NHS Improvement, the organisation responsible for overseeing NHS trusts.

These are:

- **A&E standard:** A&E maximum waiting time of four hours from arrival to admission/transfer/discharge
- **RTT Standard:** Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway
- **Cancer standard:** All cancers – maximum 62-day wait for first treatment from:
  - Urgent GP referral for suspected cancer
  - NHS cancer screening service referrals
- **Diagnostic Standard:** Maximum 6-week wait for diagnostic procedures

Oversight of performance

We use an extensive framework to monitor and interrogate our performance against these standards and to ensure sustained delivery. This supports scrutiny, assurance, and where necessary, further action and follow through.

Oversight of performance is from 'floor to Board'. Performance is discussed at all levels of the organisation. This review process is underpinned by business intelligence that highlights outcomes and any deviation of outcomes, but also the drivers and potential changes, such as changing demand profiles.

Performance

	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Average
Four hour standard	95.0%	80.1%	81.4%	88.0%	87.7%	92.5%	87.8%	92.1%	94.1%	86.7%	86.7%	86.8%	85.5%	87.4%
RTT standard	92.0%	90.8%	92.3%	92.2%	92.0%	92.0%	91.3%	91.4%	91.5%	90.0%	90.4%	90.2%	89.9%	91.2%
Diagnostic standard	99.0%	95.0%	97.7%	98.4%	98.3%	97.7%	97.5%	97.2%	98.2%	97.7%	97.2%	98.1%	98.6%	97.6%
Cancer 62 day urgent referral standard	85.0%	76.0%	72.4%	73.4%	74.7%	81.6%	80.8%	77.4%	75.4%	80.2%	65.5%	76.6%	78.0%	76.0%
Cancer 62 day screening standard	90.0%	80.0%	78.6%	83.3%	55.6%	92.3%	66.7%	70.0%	62.5%	80.0%	66.7%	40.0%	47.6%	68.6%
Cancer 2WW Standard	93.0%	96.8%	96.0%	96.0%	95.4%	94.7%	96.4%	94.9%	97.4%	98.2%	95.8%	96.4%	95.2%	96.1%

A&E standard and improved patient flow

During 2016/17, the Trust undertook an in-depth analysis of its patient flow and emergency department performance and work began on changing the medical model, improving the Emergency Departments and discharge of patients. In May 2017 we began a four week, cross-organisation rapid improvement of our four hour standard. In April, 80.1% of patients were seen in four hours against a national standard of 95%. This steadily increased to 94.1% in November.

The Trust achieved an average of 87.5% compliance against this standard in 2017/18, an improvement on an average of 80.3% in 2016/17. ESHT now performs within the top third, and often the top quartile, of trusts for A&E delivery, in contrast to 2016/17 when we were performing in the lowest quartile of trusts. In October 2017 we received a letter from the Secretary of State commending us on our improved performance.

This improvement has been set against a backdrop of sustained increased demand for our urgent care provision. We have seen an 7.52% increase in attendances at our Emergency Departments in 2017/18.

This improvement is a significant achievement for members of staff working across the entire organisation and highlights the impact of effective joint working with East Sussex County Council and our local commissioners through East Sussex Better Together. This standard is reliant on all parts of our health and care system working effectively together, maintaining people in their homes where appropriate and ensuring patient flow through hospital and community beds.

This improvement has been supported by a transformation in our urgent care departments and the development of important new services.

An Ambulatory Care Unit and extended assessment ward opened at EDGH, to provide same day emergency care for ambulatory patients who do not require an overnight stay in hospital. In addition, work to expand the Emergency Departments at Conquest Hospital and EDGH has been completed, helping to improve the flow of patients through the departments. The work included additional consulting rooms for primary care streaming along with improved patient waiting areas and improvements to reception areas.

We also introduced a Discharge to Assess Service, provided via crisis response. This supports patients to stay at home, preventing admission for patients who do not need to be in an acute hospital. The service also supports patients in going home as soon as they are medically fit for discharge.

RTT standard

The Trust improved delivery of the referral to treatment (RTT) standard in 2017/18. We achieved 91.2% compliance against the national standard of 92%. This compared well to our performance of 88.0% during 2016/17 and to the performance of our peers. We have focused on out-patient and theatre productivity to better manage demand and capacity.

Diagnostic standard
Achievement of the diagnostics standard of 99% remained a challenge for the organisation. The Trust achieved 97.6% compliance against this standard during 2017/18, compared to 98.1% in 2016/17, although performance improved towards the end of the year.

We are undertaking a review of our radiology services with a focus on capacity and demand, with the intention of reducing waiting times for patients who require CT and MRI scans.

Cancer standard
Although we achieved the two week cancer standard and 31 day cancer standard, achieving the 62 day cancer standard was challenging this year. The Trust achieved 75.7 % compliance against the 62 day standard in 2017/18, compared to 76.4% in 2016/17. The Trust is continuing to implement improvements in cancer care pathways to ensure that patients are seen and treated appropriately. The 62 day cancer standard will be a focus for the organisation in 2018/19.

Achievement against our 2017 - 19 business plan

Alongside the performance standards that we are required to meet, ESHT 2020 contains a set of five overarching internal strategic objectives that will enable us to deliver our vision and to be recognised as an 'Outstanding' organisation by 2020.

Our integrated Business Plan and Quality Account set out our priorities under each of these strategic objectives. These priorities provide an additional means of measuring progress, which in turn supports us to deliver our long-term vision of providing safe, compassionate, and high quality care to improve the health and wellbeing of the people of East Sussex.

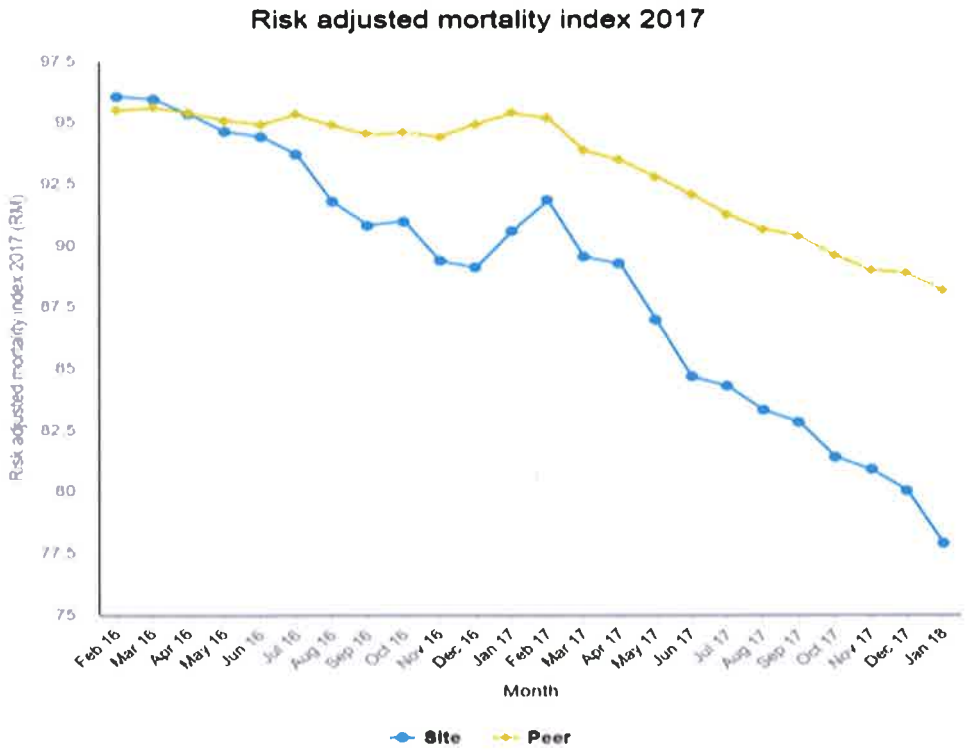
To measure our progress against these strategic objectives we have set out high level targets. Progress towards these is monitored on an ongoing basis using quantitative and qualitative measures

Strategic objective 1: Safe patient care is our highest priority

Mortality

Our mortality rates are monitored by three separate indices, all considering slightly different factors. These all provide evidence that that we have either improved or are within the expected range for our peer group.

- Risk Adjusted Mortality Index (RAMI) performance from February 2017 to January 2018 (rolling 12 months) is 78 compared to 91 for the same period last year. Our position has improved both in absolute terms and relative to our peer comparator group.
- Summary Hospital-level Mortality Indicator (SHMI) for the period October 2016 to September 2017 is the latest published and is 1.07 which puts us within the expected range.
- Crude mortality shows February 2017 to January 2018 at 1.76% compared to 1.89% for February 2016 to January 2017.



The requirements set out in the Care Quality Commission Learning from Deaths review have been incorporated into Trust policy. Our mortality database has been updated to reflect the new review process and now includes a record of all plaudits and care concerns raised by family or carers of the deceased.

The importance of reviewing deaths within the 3 month timescale ensures that reporting is accurate and enables the Trust to identify and learn from deaths that were actually or potentially avoidable.

Reducing falls, pressure ulcers and infections
The number of patient falls reported across the Trust has reduced from 6.2 per 1000 bed days in 2016/17 to 5.7 per 1000 bed days in 2017/18. The Trust trialled a new combined assessment tool which reviewed the risk of falls and associated care plans for patients. We aim to rolled this assessment tool out across the whole Trust during 2018/19.

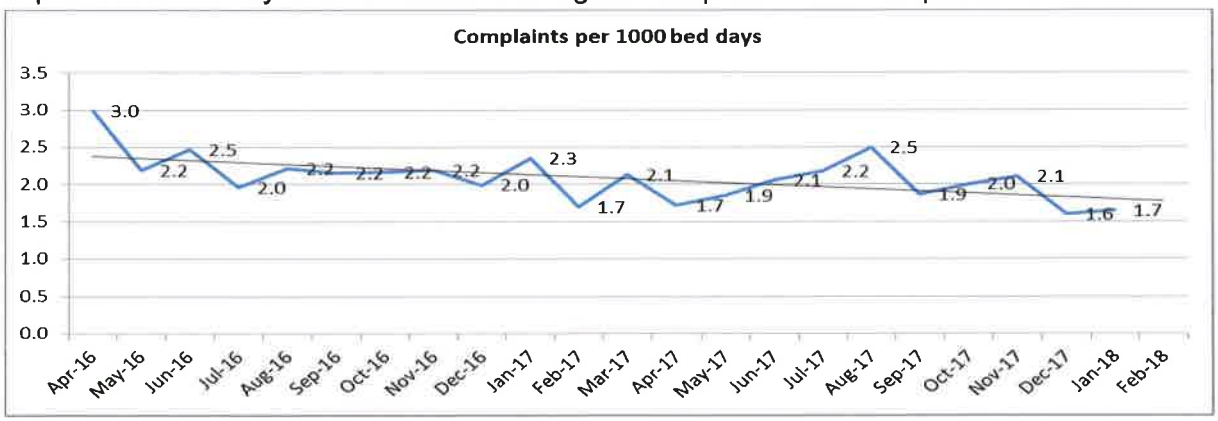
This year we aimed to reduce Category 2 Pressure ulcers occurring in our care by 10%. We worked in partnership with Kent, Surrey and Sussex Quality and Safety Collaborative and NHS Improvement on a new risk assessment tool called PURPOSE T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) and the SSKIN bundle initiative.

We have seen a reduction in the number of Clostridium Difficile Infections reported, from 43 in 2016/17 to 34 in 2017/18 and a reduction in the number of MSSA cases from 11 in 2016/17 to 9 in 2017/18. However we also saw an increase in the number of reported MRSA cases from zero in 2016/17 to three in 2017/18.

Patient complaints
System improvements were made to first reduce and then sustain improvements in the complaint response backlog from 63 overdue complaints in April 2016 to zero overdue in August 2017. The maximum number of overdue complaints during any month since August 2017 was one complaint.

The number of complaints received during the year reduced by 15% from 658 in 2016/17 to 559 in 2017/18. The average number of complaints we received each month during the year to date was 47.

We have continued to implement our 4C approach (Complaints, Concerns, Comments and Compliments) to enhancing patient experience. This includes having systems and processes in place to effectively address issues and regular 'deep dives' into complaints received.



Friends and Family Test and feedback
Our patient experience team continues to support individual services in engaging with service users, carer groups and staff and patient experience feedback continues to be an important quality measure in terms of score and response rate.

As part of our Friends and Family Test, our scores for both patient experience and our overall score from patients saying that they would recommend our services have improved.

Our response rate for inpatients has risen from 19.9% in 2016/17 to 40.2% in 2017/18. These response provide valuable feedback to allow us to continue to improve our services.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total	
Meridian feedback compliment	2391	2860	2711	2920	3390	2922	3216	3370	2569	2583	2556	2560		
Formal written thank you	51	41	44	41	47	31	42	41	20	55	50	55		
Informal - Thank you cards	104	138	114	95	140	157	152	196	249	180	125	163		
Totals	2546	3039	2869	3056	3577	3110	3410	3607	2838	2818	2731	2778	36379	

RECOMMEND	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Average 17/18	Average 16/17
FFT % recommend Inpatient	97.00%	97.00%	97.00%	97%	96.00%	96.80%	97.00%	97.41%	96.81%	98.10%	98.00%	97.20%	97.11%	97.3%
FFT % recommend A&E	90%	87%	85%	88%	90.00%	90.10%	88.00%	90.79%	93.38%	93.08%	94.00%	86.40%	90.42%	89.6%
FFT % recommend Maternity	98%	97%	96%	98%	96.30%	97.70%	98.00%	99.41%	100%	98.46%	100%	96.60%	98.27%	94.5%
FFT % recommend Community													97.5%	97.4%
FFT % recommend Outpatients													96.5%	95.7%

RESPONSE	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Average 17/18	Average 16/17
FFT response Inpatient	31.00%	35.00%	36.00%	43%	45.00%	45.60%	41.80%	42%	38%	41.07%	40.30%	43.26%	40.20%	19.9%
FFT response A&E	8.00%	9.00%	8.00%	11%	13.00%	9.80%	6.90%	11%	7.26%	6.56%	4.49%	3.92%	8.20%	7.7%
FFT response Maternity	43%	42%	44%	33%	25.70%	32.50%	17.60%	30%	36.33%	24.71%	30.57%	21.53%	27.99%	32.4%

We have developed a robust system of monitoring the NHS Choices and Patient Opinion websites and welcome feedback given using these routes. We have received a increased number of positive comments on these sites compared to 2016/17. EDGH has a four star rating while the Conquest is rated at four and a half stars out of five.

Serious Incidents

The number of Serious Incidents reported has reduced from 57 in 2016/17 to 47 in 2017/18. An improved process for managing Serious Incidents has proved effective with no overdue incidents reported. Ensuring patients and families are informed of harm and the reasons why harm has occurred is a requirement outlined within the Duty of Candour legislation. Compliance with this duty had continued to improve with 90% compliance across all areas.

Learning from events and feedback is crucial to improving quality and therefore we have been developing "closing the loop" reviews and reports to our Patient Safety and Quality Group. The reviews test whether actions identified following a Serious Incident have been completed and embedded and the process will be expanded in 2018/19 to encompass actions identified following complaints.

Improvements in National Audit: A number of national audit reports published throughout 2017-18 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.

The 2017 National Lung Cancer Audit (NLCA) confirmed that 72.5% of our lung cancer patients with advanced disease, but a 'good' performance status, received treatment. The national average for this measure was 62.5% and the target set by the NLCA was 65%. ESHT is above the national average and target goals set by the NLCA in all parameters of performance.

The National Bowel Cancer Audit shows the Trust's Bowel Cancer services to be the best in the South East. The audit showed the Trust to have the lowest mortality rates and second lowest readmission rate in the region, with these indicators significantly better than the national average.

Data published by the National Emergency Laparotomy Audit (NELA) in 2017 confirms that the Trust is above the national average for all process measures, and excels in ensuring that a Consultant Surgeon is present in theatre when the risk of death is greater than 5%. The national average for this process measure was 92.9%, with the Trust achieving 100% compliance.

Other quality indicators

- Our detection and management of sepsis has improved. RAMI from sepsis has fallen from 122 to 80 since the introduction of the sepsis screening program in September 2016.
- Postoperative Pulmonary Embolism and Deep Vein Thrombosis rates have improved, resulting in the Trust moving from being an outlier against these measure to being below the national average. Over the last 18 months our postoperative rates have fallen from 0.071% to 0.024%. The national average now is around 0.033%.
- 71% of new admissions to our hospitals were reviewed by a Consultant within 14 hours during February and March 2017, up from 36% in September 2016.
- We have greatly improved our tracking of medical records following the introduction of bar codes and scanners. We hold over 700,000 medical records and now see only 0.1% of records unable to be found for patient appointments.
- 87% of our inpatient wards now hold a daily Safety Huddle and 77% of wards hold them twice a day.

Strategic objective 2: All our employees will be valued and respected

2017 Staff Survey

The results of the 2017 national NHS staff survey showed that the improvements staff reported in 2016 were maintained. This has led to ESHT being one of the best performing trusts in the South East in 2017.

We saw an increase in the number of staff who participated in the survey in 2017, with a response rate of 49% compared to 46% in 2016. Other comparable trusts' average response rates were 45%.

The results of our staff survey demonstrated that continuous improvements we are making at ESHT and showed increasing numbers of our staff recommending the Trust as a place to work or receive treatment. Our 2017 results showed that five key findings were significantly improved from 2016. We continue to see high levels of confidence amongst staff in reporting incidents, harassment and abuse and we have also seen greater recognition and support from managers, better team working and action on health and wellbeing. Gratifyingly, these improvements align with the priorities that we set ourselves following the 2016 staff survey.

No key findings showed a significant decline and eleven key findings were significantly better than the national average. A further six key metrics all showed improvements against 2016's results, but all remain significantly worse than the national average.

Medical Engagement Scale

The Medical Engagement Scale (MES) results, published in 2017, showed clear improvements in the engagement of ESHT medical colleagues when compared to the previous survey. ESHT consultants were 'strongly engaged' in six of the ten criteria and were 'positively engaged' in the four other criteria.

We still have work to do to improve further. Few SAS Doctors completed the survey, and reported that they were less engaged that consultant colleagues. Seven of the ten criteria were rated as 'low' and the other three rated as 'medium'.

GMC National Trainee Survey

The overall Trust results for the General Medical Council (GMC) 2017 National Trainee Survey showed a significant improvement from the 2016 results. The Trust has gone from 49 red flags in 2016, to 33 in 2017, while increasing the number of green flags from 8 in 2016 to 16 in 2017.

Our number of lime green flags (which are likely to indicate that trainees' perceptions are positive), have gone from 4 in 2016 to 7 in 2017. Clinical Radiology and cardiology both achieved three green flags and no red flags.

Recruitment and retention

During 2017/18 we saw a net increase of 5% in our workforce. Our overall vacancy rate fell to 9% and all areas have shown a reduction in vacancy trend between August 2017 and January 2018. A targeted approach to medical vacancies, in particular in our Emergency

Departments, has seen a reduction in these vacancies from over 14% in April 2017 to 5% in February 2018. We have also seen a reduction in staff turnover to 9.5%.

International recruitment is continuing in the Philippines and the Indian sub-continent for Medical and Allied Health Professional staff groups and 31 international nurses will join the Trust by August 2018. We have also had success with recruiting to hard to fill microbiology, histopathology and physiotherapy posts. Twenty newly qualified UK student nurses joined us in February 2018..

The Trust scores highly for appraisals and training undertake with staff appraisals levels for March 2018 at 81.8%, and mandatory training at 88.8%

Safe staffing
Effective rostering practice ensure that our wards have appropriate levels of safe staffing. In support of this, the roll out of Safecare as part of the electronic rostering system has been successfully completed. This allows live staffing information to be accessed on iPads and information is reviewed during twice daily staffing meetings on each site to monitor staffing levels.

Twice yearly safe staffing establishment reviews are carried out and these have resulted in increases to staffing numbers when necessary.

Openness and transparency
We are committed to maintaining a culture that is open and honest, where staff are confident that they can safely raise their concerns. No harm/near miss incidents comprise 80% of all our reported patient safety incidents, which is an excellent indicator of a good reporting culture. Nationally , no harm/near miss incidents comprise 73% of all our reported patient safety incidents.

Our Freedom to Speak Up Guardian provides a valuable role in supporting staff to freely raise concerns, and is fully supported by the Trust Board.

Good leadership and open culture
The Trust continues to listen to members of staff through a range of forums and conversations and makes improvements based on their feedback. This ensures that staff remain involved and engaged in the work of the Trust.

- Colleagues from across the Trust have the opportunity to meet Senior Leaders on a regular basis to share their views and influence decisions that impact on their service. These include quality walks, quarterly meetings with senior and junior doctors, monthly visits to services and a range of staff networks.
- Each division has developed their own approach to improving staff engagement. Inventive measures had included Breakfast with the Boss, regular newsletters, open meetings and staff suggestion schemes.
- Our Out of Hospital Division run regular Embedded Learning Events where they focus on an issue that the staff have raised and generate a joint solution.

- Following feedback from colleagues about burnout and resilience, we held Grand Rounds at both sites on 'compassion without burnout'. These workshops were very well attended by junior doctors, medical students and consultants and the feedback was positive.
- We continue to recognise the great work of colleagues through our Annual Trust Awards, Unsung Hero Awards and our monthly staff awards.
- We have introduced a leadership development pathway with a range of courses linked to good communication, handling change and compassionate leadership and a range of opportunities to support and develop our leaders.

Health and wellbeing of members of staff

There was an impressive uptake from frontline and non-frontline staff in having the flu vaccine over the winter period. 72% of our front line staff had the vaccine which was significantly higher than the 53% uptake seen the previous year.

180 members of staff attended our roadshows promoting staff health and wellbeing and almost 850 members of staff who are over 40 received a free health check. Schwartz rounds were held across the Trust on a monthly basis providing emotional support for all staff.

Strategic objective 3: We will work closely with commissioners, local authority and other partners

East Sussex Better Together (ESBT) Alliance

We are a key partner, with Eastbourne Hailsham and Seaford CCG, Hastings and Rother CCG and East Sussex County Council in the East Sussex Better Together (ESBT) Alliance, a transformation programme to fully integrate health and social care in order to deliver high quality and sustainable services to our local population. Our shared vision is to ensure that people receive proactive, joined up care, supporting them to live as independently as possible and achieve the best possible outcomes. Together we are building a new model of care that integrates our whole system: primary prevention, primary and community care, social care, mental health, acute and specialist care so that we can demonstrably make the best use of the £850m that is spent each year to meet the health and care needs of the people of East Sussex.

In April 2017 we strengthened the Alliance when we established the ESBT Alliance agreement in order to support the committed and collective leadership.

Sustainability and Transformation Plan (STP)

We have been fully engaged with the development of the Sussex and East Surrey Sustainability and Transformation Plan and have actively contributed to the various work-streams including digital, workforce, finance and acute hospitals. The STP is clearly aligned to our local ESBT plans for place based care and we will continue to contribute to the work streams.

Healthwatch

As part of a national network, there is a local Healthwatch in every local authority area in England. Healthwatch East Sussex works with the public of East Sussex to ensure that health and social care services work for the people who 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.

Public engagement

Public engagement and involvement is a vital part of our improvement journey at the Trust. We will only achieve our 2020 ambitions by engaging with those members of the public and patients who are affected by the care we provide.

This year we introduced a Trust Public Engagement and Patient Experience Strategy and work plan to guide our work until 2020. We continue to take forward work that measures, reports and improves patient engagement and experience and more actively involve patients and their families in making improvements to our services. In 2017/18:

- We held two well attended public forums, seeking input from members of the public about patient information, hospital access, and end of life care.
- We held two well attended open days in cardiology and ophthalmology.

- We have revived our membership database and are regularly in contact with our two thousand members by email.
- We are developing a small public panel of volunteers who sit on projects, service redesign schemes or within service governance. We also have a small number of volunteers who sit on local Public Participation Groups as ESHT members.
- We have engaged with local organisations and are actively involved with our local Healthwatch.
- We have refreshed our Public Engagement and Patient Experience Steering Group membership to ensure increased public representation and to better understand any issues that might exist and shape the work required for the year ahead and to deliver on Public Engagement and Patient Experience Strategy.

We have further improvements identified for 2018/19, including the development of our member database and regular newsletter to our members, further opportunities to engage including the development of new "Ask the Board" sessions, embedding public / lay governance within our ESHT structures and the development of specific engagement campaigns, co-produced where appropriate, such as young people's experience in hospital, wayfinding and access and discharge

Volunteering

We offer varied, rewarding and highly valued volunteering opportunities at ESHT. We have over 600 volunteers across EDGH, Conquest Hospital, Bexhill and Rye all of whom make a valuable contribution to the service we offer our patients and visitors.

Our Volunteer Satisfaction Survey results show that overall satisfaction with our volunteering opportunities is high at 89%.

We have developed new volunteering roles such as Patient Support Volunteers who provide assistance to patients on the ward as directed by the matron or nurse in charge. A pilot has begun on one ward

The volunteer library service is starting a dedicated children's trolley service. Parents and children will be able to buy or borrow books in the same way as the adult service and a trolley for the service has been ordered.

Strategic objective 4: We will operate efficiently and effectively diagnosing and treating patients

SAFER care bundle

A number of initiatives to support a patient's journey through our hospitals have been developed this year. "SAFER" is the overarching way we describe these, combining five elements of best practice. These include all patients being given an expected discharge date within 14 hours of admission and multi-disciplinary review of all patients who have been in hospital for 7 days or more. Let's Get You Home, Red2Green and EndPJParalysis are some of the initiatives forming part of this work.

Excellence in Care

The Excellence in Care project will support wards and departments to agree a set of localised standards aligned to Trust strategy and national requirements. This year we have designed a dashboard which will enable leaders to monitor their ward/department's progress towards consistently achieving these standards through local improvement work. Standards will cover topics such as end of life care, hand hygiene, patient environment, patient safety and workforce. Through co-production, colleagues will be engaged and empowered to co-design and create an accreditation process for ESHT, supporting us to reduce unwarranted variations in care.

The initial standards and dashboard development work was piloted on four wards over the summer, with workshops held to involve and support colleagues on these wards. Learning from the pilot wards will be used to inform the roll-out to further wards later in the year. We also started procurement of an electronic system to enable staff to access data and results.

Transforming our Emergency Departments

An Ambulatory Care Unit and extended assessment ward opened at EDGH, to provide same day emergency care for ambulatory patients who do not require an overnight stay in hospital. This led to a 44% increase in ambulatory care admissions with zero length of stay, reducing the pressure on the rest of the hospital and improving patient flow.

The unit offers patients rapid access to diagnostic tests and review by hospital consultants in a single place. It provides safe care designed around the needs of patients, providing them with a better experience and preventing unnecessary hospital admissions. A similar unit is planned for the Conquest Hospital in 2018/19.

End of Life Care improvement

The End of Life Care (EoLC) project has focused on making improvements in the care we offer patients in the last year of their life. This work has been supported by the Supportive and Palliative Care Team, which now works as a single team across the Trust. We now have standardised care pathways and access criteria for specialist palliative care and end of life support services

We have established improved identification and notification of patients who are approaching end of life and we have a developed system for receiving feedback both about care we give to EoLC patients and for service improvements. A survey of relatives six weeks post death has been introduced.

Staff training has been revised and will be mandatory for all clinical staff from April 2018. Over 1,000 members of staff have already received this training during 2017/18.

This work is overseen through a clear embedded governance structure which includes a patient representative who now sits on the End of Life Care Steering Group. We have also established a dashboard to measure and monitor improvement developed.

An End of Life Care strategy for last year of life is in development for adults, children and babies. Four public events have been held to inform this, supported by patient and public engagement.

Cancellations

We have seen a reduction in the number of urgent operations cancelled for a second time from 9 in 2016/17 to 2 in 2017/18. We effectively managed our elective workload during the winter months to increase bed space and reduce elective surgeries. This planning allowed us to continue with planned activity, most of which was day surgery, with virtually no operations cancelled due to a lack of bed space.

Delayed Transfers of Care

Working with our partners in East Sussex Better Together we have seen a significant drop in the number of Delayed Transfers of Care. Since October 2017 we have achieved the national target of under 3.5% for Delayed Transfers of Care. Since December 2017 this has been below 2%.

Length of Stay

Despite the increase that the Trust has seen in activity levels, non-elective bed days have reduced by 4.1% and Length of Stay has decreased by 0.8 days. Length of Stay in the community has decreased by 1.6 days. In total we used 14,654 fewer acute bed days than in 2016/17 which supported the continued flow of patients through our hospitals and enabled us to sustain our improved performance against the 4 hour standard.

Community services

Referrals to our community services have continued to increase, putting many teams under heavy pressure. However we have broadly maintained the percentage of patients seen within the 13 week target for each therapy as follows:

Community Service	2016/17	2017/18
Podiatry	100%	100%
Dietetics	99%	99%
Speech and Language Therapy	100%	100%
Women and Men's Therapy	100%	97.5%
Neurological Physiotherapy	100%	85.9%
MSK Hastings and Rother	90%	86.6%

Percentage of patients seen within 13 weeks

Strategic objective 5: We will use our resources efficiently and effectively for the benefit of our patients and their care

Trust finances

Our financial position remains challenging. At the beginning of the financial year, we set ourselves an ambitious financial plan to reduce our deficit to £36.4m. The Trust's deficit in 2017/18 is £57.4m but the underlying deficit is £54m. Although the overall deficit has deteriorated from last year (£46m), we have improved on last year's underlying position (£57m).

The outturn this year was worsened because of a number of factors including adverse settlement of contract disputes of some £10m with the CCG, the increased costs of some drugs and clinical equipment and reduced income because of lower than planned elective activity.

We were however able to make £22.3m of efficiency savings against a target of £28.4m. We have made significant improvements to the control of temporary staff costs, with substantial moves of staff from agency to locum, bank or direct engagement. Our much improved operational efficiencies, including reduced Length of Stay, have led to significant cost reductions.

Members of staff across the organisation have worked hard to achieve these savings, while making significant improvements to our standards, quality and safety, and patient experience. The provision of safe and effective care for our patients is our absolute focus and we have worked with our commissioners and adult social care to make sure patients are treated by the right person, in the right place, at the right time. It is this that will ensure we achieve financial sustainability in the long term.

We are confident that work we have undertaken during 2017/18 will allow us to develop a detailed financial plan for 2018/19 with the correct balance between ambition and achievability. This will support us in achieving our goal of financial sustainability across the system with our partners in East Sussex Better Together.

Clinical Strategy 2017/18

Our Clinical Strategy was developed in 2017/18 with the engagement of the staff who provide services and the patients who use those services. All services have developed a strategic ambition that describes what an excellent service will look like in five years' time and have outlined at a high level the steps that need to be taken to achieve this ambition. Clinical teams will be expected to review their strategies, refresh their operational plans and recommit to delivery each year so we can to continue to meet the needs of our population.

We worked collaboratively with our Clinical Commissioning Groups (CCGs) and primary care providers using a range of methodologies to develop these strategies. We identified ten workstreams where a whole system approach has been taken to developing and redesigning end to end pathways. This has process has involved collaboration with all the services that a patient engages with during that pathway. A further twenty specialties were developed with ESHT practitioners and wherever possible, the CCG and primary care.

Improvement Hub

In order to deliver our five strategic objectives and our broad, ambitious programme of change, we recognise that we need to be able to master both improvement and transformation, including introducing new services and new models of care. The improvement and transformation methodology and the team to support both, has been introduced incrementally over the course of 2017/18 and has included the following:

- Continued investment in a bespoke NHS Elect Improvement training programme. The first cohort of staff were trained in 2016/17 and there were three further cohorts in 2017/18.
- We established an improvement hub, improvement forum and Trustwide Improvement Group to ensure alignment of improvement initiatives.

All of these improvements will support our health and social care workforce to deliver services in new and innovative ways with genuine integration at the very heart of service delivery and patients being our primary focus. It will also reflect our system wide approach to tackling unwarranted variations in clinical care, reducing waste, becoming more patient and carer focussed and ensuring that quality and safety remain a priority for the Trust.

Influences on performance

The principle issues and risks facing the organisation during 2017/18 are outlined below.

Trust finances
We remain in special measures and our financial position is challenging. With the support of NHSI's financial special measures team, we are putting together a recovery plan which will be implemented over the next three years. This plan draws heavily on the rich information we have received from Model Hospital and Lord Carter data.

We are developing service by service improvement plans, addressing early those services which can be improved operationally, and more methodically those services which require re-configuration or other significant change. All plans are subject to a full quality impact assessment by our Medical and Nursing Directors. The plans are being translated into detailed budgets covering activity, cost, revenue, and workforce for the individual divisions and clinical specialties. Assurance of performance against these plans will be measured throughout the year during integrated performance review meetings.

CQC rating
The Trust was placed in Quality Special Measures in September 2015. In October 2016, the CQC undertook an inspection and recognised the significant improvements made since the 2015 inspection. The CQC's overall rating for the Trust was improved to 'Requires Improvement'. The Trust was re-inspected in March 2018 for core services on the acute sites and separately for the Well Led Domain. We are awaiting the results of this inspection and are hopeful that our continued improvement will be recognised.

Increased demand
Our hospitals and community services continue to get busier every year as demand for our services increases. This places ever greater pressure on our staff and requires us to work more efficiently and think in innovative ways to ensure that we meet the changing needs of our population.

We saw increased activity in comparison to the previous year, with a 7.5% increase in attendances and an 11.7% increase in non-elective spells. Ambulance conveyances increased by 4.4% compared to the previous year.

Like many other trusts, we saw even greater demand for our services over the winter period. We saw an 11% increase in attendances at our emergency departments when compared to the same time in 2016/17. We also saw patients with more severe symptoms and during the winter period the number of patients being admitted to our hospitals increased. Our staff did a fantastic job in maintaining their professional standards during a period when they found themselves working under huge pressure and at full capacity.

We continue to work closely with our adult social care and commissioner partners to plan for increases in demand. Our new Emergency Department front entrance management, which includes our Ambulatory Care Unit, has meant that we are better able to manage

attendances and admittances. In conjunction with adult social care, we have worked to support patients to stay at home where appropriate. We have also worked together to reduce delayed transfers of care and support the discharge of patients from hospital once they are medically stable.

Recruitment and staffing

While recruitment and retention has improved and we have recruited to a number of 'hard to recruit' posts, like many other NHS trusts, we still face staff shortages in some areas. This is due to an aging workforce and a national shortage in some specialities. The use of temporary staff presents a number of challenges both in terms of cost and quality and consistence in our care.

We have sought external help in order to fill difficult to recruit medical posts. We are developing Return to Practice incentives to support nurses in returning to work as well as offering incentives to encourage existing staff to work on the Trust Bank. A Workforce Resourcing Group is being established which will develop a longer term strategy to meet workforce requirements, taking into account the age profile of the population and will look at new roles and skill mixes to meet patient demand. We are also supporting staffing innovation and have created and developed new roles such as physician's assistants, matron's assistants and nurse injectors.

Meeting national standards

While we have made significant strides in meeting the 4 hour standard and the RTT standard, the cancer and diagnostic standards remain challenging. The Trust is working with the wider health economy to develop solutions and a number of actions are in place to improve performance in these areas.

Innovating and improving

Clinical innovation

- **UroLift treatment for enlarged prostate:** EDGH was the first NHS hospital in Sussex and Kent to offer the innovative UroLift System to treat an enlarged prostate.
- **Children's ward clinical monitoring system:** We were one of the first Trusts in the country to use paediatric VitalPAC clinical monitoring system on children's wards.
- **Procedure to lower blood pressure:** Patients at the Conquest Hospital were the first in the South East to be offered a new procedure to lower blood pressure called Renal Denervation Ultrasound.
- **New mammography machine:** A new and state of the art digital mammography machine, a GE Pristina Senograph, has been installed at EDGH to improve the diagnosis of patients with suspected breast cancer. It is one of only three of its kind in the UK.
- **New Simulation Training Laboratory:** A new state of the art simulation training laboratory has been opened to improve the development of healthcare workers' clinical skills.
- **Bobble hat care bundle**: A new way of identifying babies requiring extra support following delivery, called the 'The Bobble Hat Care Bundle', has been introduced on the maternity unit at Conquest Hospital. The use of these bobble hats has reduced the number of unnecessary admissions into the Special Care Baby Unit (SCBU).
- **Improve detection of Prostate Cancer:** Doctors at the Trust were the first in the South East to use an innovative ultrasound scanner that combines MRI images to improve the detection of Prostate Cancer.
- **New innovative heart device:** An Eastbourne patient was the first in the UK to be implanted with an innovative Cardiac device to modulate the heart's beat.
- **Trust launched new service to improve mouth care:** A new service to improve the oral care of patients in hospital was been launched called Mouth Care Matters. It aims to ensure that every patient who is in hospital for more than 24 hours has a mouth care risk assessment and that all healthcare professionals who are involved in providing mouth care to patients have had appropriate training.
- **Faecal Immunochemical Testing:** ESHT will be implementing a Faecal Immunochemical Test (FIT) and positive FIT Straight to Test (STT) in the colorectal pathway in ESHT in April 2018.
- **Support for research:** The Clinical Research Department supports clinicians and enables patients to take part in national and multi-national research studies in many specialties across ESHT.

Corporate improvements

- **Ophthalmology Nurse Injectors:** Two Nurses in Ophthalmology, along with two Orthoptists, have been trained to provide regular injections to patients with Age Related Macular Degeneration.

- **Matrons' Assistants:** The role of Matrons' Assistant was introduced to reduce the time Matrons spend on administration.
- **AHP Research Escalator:** This interactive platform enables AHPs to support their development and capability to use research as part of everyday practice.
- **Electronic patient notes**: The implementation of electronic patient records is now well underway. The first five phases of the £7million project are complete.

Patient experience improvements

- **Self Service Check-in:** Self-service check-in kiosks for patients attending the main Outpatient Departments were introduced.
- **Breakfast in the discharge lounge:** A Breakfast Club at EDGH providing breakfast for patients leaving hospital in the discharge lounge is helping to free up beds on the wards earlier in the day.
- **Maternity self-referral service launched:** Women who have just become pregnant can self-refer to the midwifery service at ESHT.
- **End of Chemotherapy Treatment Bell:** The Judy Beard Day Unit at Conquest Hospital has installed a bell for patients to ring when they finish their course of chemotherapy treatment, giving them hope and strength for the future.
- **Medication Passports:** Medication Passports have been launched at EDGH and Conquest Hospital to help people keep track of their medicines.
- **New children's play area**: A new play area for Kipling Ward at Conquest Hospital was created out of a disused courtyard thanks to the generous support of Colleen's Tenderheart Charity, Darvell Bruderhof Community, Parker and Sons and Skinners Sheds.
- **New Trust website:** The Trust launched an improved website, with the aim of both modernising it and making it easier to navigate to help patients find the information they need as easily as possible.

Awards and recognition

- **National recognition for high quality of Audiology services:** Audiology services at ESHT received national accreditation in recognition of the high quality of care they provide. The Improving Quality in Physiological Services (IQIPS) accreditation is given to services that can demonstrate the highest levels of quality of service, care and safety for patients undergoing physiological diagnostics and treatment. Both adult and paediatric services at the Trust have received the accreditation, making ESHT the first Trust in the south east to have full IQIPS accreditation across both its Audiology services.
- **Trust UroGynaecology Unit is first in Sussex to attained national accreditation:** The Trust's UroGynaecology unit was the first in Sussex to attained national accreditation from the British Society of UroGynaecology following an inspection. It is one of only 22 units in the country to gain this status. Accreditation status is given to the units for the high quality UroGynaecology service offered to patients and a strong governance framework including multidisciplinary team input.
- **Project SEARCH wins award for 100% placement success:** Project SEARCH is a supported internship programme designed to give young people with learning difficulties or disabilities the skills to gain competitive paid employment. This year Project SEARCH was recognised for its success in gaining paid employment for young people with learning difficulties or disabilities. In the last three years, 32 young people with learning difficulties or disabilities have completed the Project SEARCH programme with a further 8 currently on the project this year.
- **Maternity improvements noted in CQC survey:** A national survey on maternity services undertaken on behalf of the Care Quality Commission (CQC), found that maternity care at ESHT had improved across a number of areas. All but five questions showed an improvement when compared to the same survey undertaken in 2015 and six questions showed significant improvement
- **Special Care Baby Unit scores well in reducing avoidable admissions:** The Special Care Baby Unit (SCBU) at Conquest Hospital scored well in a national initiative (ATAIN) to reduce avoidable admission of full term babies to Neonatal units.
- **ESBT wins HSJ partnership award:** Our East Sussex Better Together partnership, bringing together health and social care in East Sussex won the improved partnerships between health and local government award at the Health Service Journal Awards, a prestigious national award. East Sussex Better Together was praised by judges for the 'breadth and scope' of the 'extremely ambitious' partnership.
- **Success at Skills for Health's Our Health Heroes Awards.** Our Doctors Assistant Team won the Gold Award in the Workforce Planning Team of the Year category. Danii Clark, Equality and Human Rights Assistant won the regional Operational Services Support Worker of the Year. These awards, sponsored by Health Education England, celebrate the unsung healthcare heroes from across the UK that go above and beyond in their roles every day.
- **One Stop Swallow Disorder clinic wins 'Project Recognition Award' at the Zenith Global Healthcare Professionals Awards:** The Swallow Disorder Clinic is an innovative, collaborative approach between Ear, Nose and Throat and Speech and Language Therapy teams which has improved patient experience and outcomes. The

clinic has reduced treatment times from 24 to 5 weeks and improved patient safety and satisfaction.

- **Trust's Heart Failure Team picks up two regional awards:** The Trust's Heart Failure Team picked up two awards at the regional Heart Failure Collaborative "Enhancing the Quality of Heart Failure Care".

Finance

Important Financial Results

The following table shows a range of financial performance values taken from the accounts (see pages 88 to 119)

Accounts Highlights	2017/18	2016/17
Deficit for year	(54,982)	(43,792)
Public Dividend Capital Dividend Payable	2,920	4,968
Value of Property, Plant and Equipment	215,700	237,135
Value of borrowings (including Loans)	157,211	93,215
Cash at 31st March	2,100	2,100
Creditors - trade and other	37,487	53,034
Debtors - trade and other	35,088	40,806
Revenue from patient care activities	350,246	339,788
Clinical negligence costs	14,615	13,286
Gross employee benefits	284,296	269,971

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	128,709	158,861	119,039	130,851
Total non-NHS trade invoices paid within target	24,188	43,923	30,662	49,321
Percentage of non-NHS trade invoices paid within target	18.79%	27.65%	25.76%	37.69%
NHS Payables				
Total NHS trade invoices paid in the year	2,698	35,381	2,656	46,757
Total NHS trade invoices paid within target	845	29,352	786	37,205
Percentage of NHS trade invoices paid within target	31.32%	82.96%	29.59%	79.57%

Operating and Financial Review

2017/18 marked a year of significant transition for the Trust. Significant improvements in safety and quality, and strengthened delivery of national performance standards, were not matched by an equivalent and direct improvement in financial performance. However, over the financial year, the Trust has made significant progress in strengthening financial governance, in understanding the key drivers of the underlying deficit, and in stabilising overall financial performance.

In 2016/17, the Trust ended the year with a reported operational deficit of £46.4m, excluding Sustainability and Transformation Funding. A review by KPMG indicated that the underlying deficit – driven by the exit run-rate – for the Trust in 2016/17 was £58m. In 2017/18, the Trust ended the year with a reported operational deficit, excluding STF, of £57.3m. This was not the planned financial performance – excluding STF, the Trust was aiming to deliver a deficit of £36.4m and it did not meet this target. Delivery of Cost Improvements was at less than planned levels, a number of cost pressures emerged in the year and impacted on the financial position, and the Trust entered into an income agreement with local commissioners which was below the level forecast based on activity and demand. However, significant efficiency savings were delivered by staff across the organisation, and the accurate recording of activity and collection of associated income improved over the year. Strengthened controls were put in place around the use of high cost temporary resourcing – and the Trust did meet its agency spending cap over the year without an identified impact on quality and safety.

However, it is important that the Trust starts to reduce the overall deficit. A plan to return to breakeven over a three year period is in development, alongside the development of a detailed Clinical Strategy which will ensure clinical and financial stability across all of our key services. Using the national Model Hospital toolkit, and working with NHS Improvement and the Financial Special Measures team, the Trust now has a much greater understanding of the underlying issues which are driving the deficit. The financial plan for 2018/19, and the associated Cost Improvement Plan are based around these drivers – income recovery, service sustainability, workforce costs, infrastructure costs and technology requirements – and the Trust is seeking to significantly reduce the operational deficit in 2018/19.

The Trust is working within a local and regional health economy with significant financial challenges. During 2017/18, the two key local Clinical Commissioning Groups – Eastbourne, Hailsham & Seaford CCG and Hastings and Rother CCG – moved into deficit for the first time, and the Sussex and East Surrey STP Region (which the Trust sits within) also reported a very significant financial deficit. The Trust is working in close partnership with the STP to develop system-wide financial plans to improve operational, clinical and financial performance. Locally, the Trust continues to work within the East Sussex Better Together programme, alongside key partners including the CCGs and East Sussex County Council, to strengthen local plans for the improvement of health outcomes for the population of East Sussex. Management of the system financial challenge is a key local priority and is supported by joint working on the key programmes of change, including supporting the

development of primary care and the development of key community services to support care closer to home.

During the year, levels of activity and demand were significantly greater than planned – particularly in urgent care. Levels of activity at our Accident and Emergency Departments, and levels of non-elective activity more generally – were exceptionally high. However, the Trust has put in place a series of measures to support the management of this demand for urgent care, and during the year opened an Ambulatory Care Unit at EDGH, and commenced pilots of Primary Care Streaming at the front door at both EDGH and Conquest Hospital. Working within East Sussex Better Together, the Trust and local partners have also developed a series of community-based interventions to reduce levels of demand for urgent care, and to support care closer to home.

Elective Care – planned procedures – and outpatient activity levels remained high, although activity and associated income were below the planned levels. In part, this reflects work within the Trust to move towards day case activity, and a greater focus on delivering follow-up procedures to support the management of waiting lists. Whilst this has had an adverse impact on planned income, it has led to an improved performance against national waiting times standards, and a very significant reduction in cancelled operations through improved management of the bed base for the hospital. Indeed, flow across the hospital has significantly improved, supported by both internal initiatives such as 'Red to Green' and by strengthened joint working with key partners including social care. The level of 'delayed transfers of care' has significantly reduced in the last year, reflecting a much greater shared focus on helping patients to get home at the earliest opportunity. There is further work to do – but the improved performance across the system has resulted in a reduced average length of stay within the hospital for both urgent and planned care.

During the year, the Trust has made progress across a range of areas – performance against national targets is not yet meeting the required standards, but has improved over the past twelve months. At the end of 2016/17, the CQC improved its assessment of the Trust to 'requires improvement' from 'inadequate' following the October 2016 inspection. The CQC revisited the Trust in early 2018, and the results of this inspection are awaited. During the year, significant investments in resourcing, quality and safety have been agreed by the Trust Board, including increased staffing in key priority areas, additional administrative support for ward-based staff, minor improvements to the infrastructure, and investment in clinical support staff. This has created additional pressure on the resources available to the organisation – and has inevitably impacted on financial performance - but this investment remains a key element of the Trust's progress to sustainable and continued clinical improvement. Each investment that the Trust makes passes through a rigorous and robust business case process. The Trust is also tracking the investments to ensure that a financial return is secured in time – and improved efficiencies from investments in prior years are starting to flow through into the efficiency programme for 2018/19.

A Trust with a significant deficit has additional challenges in managing cash flow, and this has created pressure for staff and suppliers throughout the last financial year. To support cash flow, the Trust has had access to a Working Capital Facility (WCF) from the Department of Health (DH), which was used throughout the year to meet the cash impact of the deficit. During the year the Trust applied to DH for a series of loans to meet the balance of the Trust's cash pressures and these are fully described within the financial accounts.

With the support of NHS Improvement, the Trust secured additional loan financing in year to restructure the debt on the balance sheet and this has led to a reduction in the level of outstanding trade creditors at the end of the financial year. During the year, the Trust has also undertaken work to strengthen its own cash flow management procedures, with a strengthened set of forecasting and tracking tools in use to enable a more targeted approach to payment of suppliers. The Trust remains committed to supporting local suppliers, and recognises that delays in payment can create cash flow challenges, and will continue to work to improve its processes to enable early and reliable payment where possible.

Capital investment in the Trust has been constrained in recent years as a result of the financial position, which has adverse impacts on the experience for patients and staff. However, during the year, the Trust has been successful in drawing down capital loans and public dividend capital to secure much-needed infrastructure improvements. The Trust has been able to use alternative forms of capital funding to invest, including leasing and partnership funding. And, as ever, the generosity of the Friends must be noted – donations which directly improve patient care and experience have continued across the year and are welcomed by staff across the organisation. Taken together, the refreshed approach to capital management by the Trust has enabled capital investment to increase to £15.2m in 2017/18. For 2018/19, the Trust has developed a detailed capital plan which seeks to supplement the national challenges around availability of capital and to provide the much-needed investment in infrastructure, IT and equipment across the organisation.

Service Line Reporting and Patient Level Costing are key tools which are increasingly being used to engage clinicians in improving understanding of cost drivers, profitability and for providing management with better information with which to make business decisions. The Trust has a deep understanding of the costs of service delivery, and is an 'exemplar' Trust in the national Costing Transformation Programme. The Trust is fully engaged in the national Operational Productivity programme, led by NHS Improvement, and the Getting it Right First Time clinical improvement programme. Both programmes are key in helping the Trust understand the links between clinical activity and cost across the organisation, and in working with partners within the local health economy to ensure the right models of care are delivered over time.

The Trust Board gains assurance on financial matters through the Finance and Investment Committee, which ensures that all material financial risks and developments are closely scrutinised and that senior management is properly held to account for financial performance. Clinical representation at this committee helps to ensure that clinical quality and patient safety issues are always considered alongside financial performance and risk.

In addition to the scrutiny provided by the Finance and Investment Committee, key financial risks form part of the Trust-wide high-level corporate risk register, which is regularly updated and assessed by the Audit Committee and referred onwards to the Trust Board where significant risks are considered and acted upon.

Looking ahead the Trust has submitted to NHS Improvement an initial financial plan for 2018/19 of £47.9m, excluding STF. This is not in line with the issued control total for the Trust, but it represents an improvement in the underlying financial position and the Board will continue to seek options to improve this position. This approach will mean that the Trust is not eligible for STF funding in year, although it has received an 'offer' of £14.4m STF if it is

able to deliver the control total and securing this funding remains an aspiration for the Trust over time. The Trust is aiming to secure £23.5m of efficiency savings in year, and detailed work is in train to ensure that these schemes are robust, deliverable and are assessed through our The Trust's main contract with three local CCGs will be again based on national tariff, where applicable. The Trust will initially use the interim WCF for its cash requirements in 2016/17 but this will need to be replaced with loan funding under arrangements yet to be advised.

Each director has confirmed that as far as he/she is aware there is no relevant audit information of which the Trust's auditors are unaware and he/she has taken all the steps that he/she ought to have taken as a director in order to make himself/herself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

Fundraising

We are extremely grateful for the efforts of a wide range of charities and individuals whose generosity supports our work. Over the year £295,000 was donated or bequeathed to our charitable funds. We utilise this funding to improve our clinical services, enhanced patient outcome and contribute to the development and welfare of our staff. Examples of major purchases made by the charity during 2017/18 include:

- 2 Prismaflex Dialysis machines for Critical Care
- Virtual Dementia Tour training to enable 1,000 members of staff to experience the symptoms of dementia
- Refurbishment of doctors' accommodation at EDGH and Conquest Hospital
- Funding the Annual Trust Awards for staff
- Training equipment for the Resuscitation team

At the start of 2018, the charity launched a lottery, open to staff and members of the public, in order to continue to raise funds to support the Trust. Details of the lottery can be found at www.esht.nhs.uk/lottery

You can donate to ESHT's Charitable Funds in a number of ways:

- Online at www.esht.nhs.uk/about-us/donate/
- Send us a cheque, addressed to Charitable Funds, St Anne's House, 729 The Ridge, St Leonards-on-Sea TN37 7PT
- Cash, via the Cashier's Offices at EDGH or Conquest Hospital

Friends of our hospitals

We receive a huge amount of support from the Friends of our hospitals, and they have again been hugely generous throughout the year. They continue to purchase equipment which improves the care and support that the Trust is able to offer to patients and the Trust is incredibly grateful for the generosity of the Friends' support.

During 2017/18:

The Friends of the Conquest Hospital pledged to celebrate twenty five years since the hospital opened by raising £1million to provide a state-of-the-art MRI scanner, in order to replace the 13 year old scanner currently in use. This was in addition to purchasing other items for the Trust, including:

- An ultrasound/echo machine for the cardiology department
- Omnicell medicines management systems
- An ultrasound machine for the delivery suite
- Dentistry equipment for disabled patients (in partnership with Bexhill's Friends)

The Friends of Eastbourne Hospital raised £500,000 which substantially funded a new state-of-the-art CT scanner for EDGH and further £386,000 to purchase a CT scanner for EDGH's new radiotherapy unit. This was in addition to purchasing other items for the Trust, including:

- An echoendoscope for the Endoscopy Unit
- A cardiovascular ultrasound machine for the cardiology department
- A video laryngoscope for the anaesthetics department
- A flexible cystoscope for the women's health team

The Friends of Bexhill Hospital continued their generous support of the Ophthalmology department at Bexhill Hospital, purchasing a range of specialist equipment. This included approving funding for cataract and OCT scanners, a tonometer and a focimeter. This was in addition to purchasing other items for the Trust, including:

- An Andago walking hoist
- An operio-sterile air zone unit
- Dentistry equipment for disabled patients (in partnership with Conquest's Friends)
- A foot orthoses/insole grinding and finishing station

If you would like to support or become involved with the Friends please contact:

Friends of Bexhill Hospital	Tel: 01424 217449
Friends of the Conquest Hospital	Tel: 01424 755820
Friends of Crowborough War Memorial Hospital	Tel: 01892 664626
Friends of the Eastbourne Hospital	Tel: 01323 417400 ext 4696
League of Friends Lewes Victoria Hospital	Tel: 01273 474153
Friends of Rye Hospital	Tel: 01797 223810
Uckfield Community Hospital League of Friends	Tel: 01825 767053

Capital and Our Estate

Investing in our Estate

We continued to undertake capital investment in the Trust in order to improve quality and safety, reduce risks associated with backlog maintenance and to adapt and remodel our estate to provide more efficient services.

Primary Care Streaming by GPs at both acute sites provides new patient pathways which reduce the demands on our Emergency Departments by allowing the treatment of patients by GP's when appropriate. Extensive remodelling at both sites was undertaken to allow these services to be sited next to Emergency Departments.

An Ambulatory Care Unit (ACU) has been constructed at EDGH which provides an alternative care pathway for patients who have been referred by GPs, walked in or attended by ambulance. An ACU will be built at Conquest Hospital during 2018.

Other areas of investment during the year have included:

- New theatre lights.
- New doors for the Irvine Unit to facilitate deep cleans.
- New flooring and doors within wards and outpatient areas.
- Refurbishing bathrooms to provide new showers.
- New roof finishes at both acute sites.
- New mains electrical supply at EDGH.
- We continue to address fire compartment issues at EDGH

We have developed a five year Estates Strategy which will be flexible enough to respond to the developing service requirements of both the Trust and the local health economy in East Sussex. This will us to maintain and improve our high quality services, efficiency and effectiveness while continuing to ensure good value for money.

Patient Environment

Catering

The catering teams at the Trust ensure that all our patients are provided with nutritious and wholesome food that meets a wide range of nutritional requirements and tastes. In 2017/18 we provided over 900,000 meals to patients, working closely with Dieticians and Clinical teams to ensure our menus meet the needs of our patients. We have introduced an improved finger food menu, which supports individuals with Dementia and manual dexterity issues, and a picture menu which helps patients to identify the dishes that are available.

We aim to act as a role model in reducing the number of foods that are high in fat, sugar and salt that we offer to patients, staff and visitors. The catering team undertook a review of the food and drink options that were available which has led to the introduction of drinks with less sugar and food with less fat and salt.

We work closely with our suppliers to ensure that the food we offer is CQUIN compliant and meets the National Government Directives.

Future Developments

We are working closely with the Speech and Language Team to review our Dysphagia menu to ensure it meets the changes being implemented nationally.

Cleanliness

The Trust has a duty to ensure high standards of cleanliness, which are measured against the National Specification of Cleanliness (NSC) in the NHS Guidelines.

In order to provide assurance that these standards are being met, monthly audits are undertaken by our NSC auditing team. Results of these are discussed at monthly Patient Environmental Auditing Group Meetings which are attended by Nursing, Infection Control, Estates and Housekeeping representatives. Any areas of concern are discussed and action plans formulated to address and assist with improvements.

To ensure compliance with the NSC, our NSC audit team carry out regular audits throughout the year. In 2017/18 we achieved an average NSC score of 95.36% against the Trustwide NSC cleanliness target score average of 92.96%.

During 2017/18 our housekeeping teams cleaned over 100,000m^2 of our hospitals every day and undertook over 5,200 deep cleans.

Future Developments

A review of all cleaning materials and consumables we use will be undertaken to ensure that products are effective, environmentally sound and offer the best possible value.

Portering

In May 2017 we introduced a new Portering task management system. This assists the Portering team in efficient allocation and performance monitoring of tasks, including patient transfers, transport of goods and specimen and blood collections.

Future Developments

We will be reviewing our two way radio communication with a view to transferring analogue systems to a new digital radio system.

Social, community and human rights issues

We recognise the need to forge strong links with the communities we serve and pride ourselves on having a proactive and engaging communications teams. The work of the team is far reaching and covers community engagement, event organisation, media and social media management, internal and external marketing and communication, GP liaison and patient and staff information. We work closely with HealthWatch to undertake research into the experiences of patients and carers in using our services and to develop services incorporating the views and feedback of those that have experienced our care.

The Department of Health produced a guide in 2013/14 on 'Human Rights and Healthcare', setting out scenarios where the Human Rights Act might apply and we are committed to meeting our obligations in respect of the human rights of our staff and patients. These commitments are closely aligned to the NHS Constitution and to our own Trust values. NHS trusts are public bodies and it is therefore unlawful for us to act in any way that is incompatible with the European Convention on Human Rights Policy unless required by primary legislation.

The Trust has an Equality, Diversity and Human Rights Policy which guides our approach to manging social, community and human rights issues. The policy is regularly reviewed to ensure that it continues to be effective and that the Trust's approach on Equal Opportunities is compliant with legal and best practice standards and that our practice in this area is exemplary.

Anti-Bribery and Anti-Corruption

One of the basic principles of public sector organisations is the proper use of public funds. The majority of people who work in the NHS are honest and professional and they find that fraud and bribery committed by a minority is wholly unacceptable as it ultimately leads to a reduction in the resources available for patient care.

The Trust Board is committed to maintaining high standards of honesty, openness and integrity within the organisation. It is committed to the elimination of fraud, bribery and corruption within the Trust, and to the rigorous investigation of any suspicions of fraud, bribery or corruption that arise.

The Trust has procedures in place that reduce the likelihood of fraud, bribery or corruption occurring. These include Standing Orders, Standing Financial Instructions, authorised signatories, documented procedures, procurement procedures, disclosure checks, and "Whistleblowing". Additionally, the Trust, aided by its Local Counter Fraud Specialist (LCFS), attempts to ensure that a risk (and fraud) awareness culture exists within the organisation.

The Trust adopts a zero tolerance attitude to fraud and bribery within the NHS. The aim is to eliminate all fraud and bribery within the NHS as far as possible.

Site Security

The Trust is fully compliant with Secretary of State Directives concerning security and safety in hospitals. We have used these guidelines, to develop a proactive security culture which has seen crime fall across our sites over the last three years.

Our security team work closely with colleagues, regularly engaging through roadshows, security and personal safety presentations and during Trust inductions. Our quarterly newsletter, "Securitywise", is now in its 19th year.

Personal attack alarms are available to many staff which can be used at home or outside the hospital. Conflict resolution training is a mandatory requirement for all front line staff, supplemented by optional Breakaway Training. Staff also receive training in how to maintain security within their departments, and how to look after patients' property.

The Trust has around 106 CCTV cameras and a number of stand-alone units which are managed by control rooms on both acute sites. The control rooms also manage a number of other alarms including those for medical gases, blood banks, lifts and fire systems. All staff wear an official identity badge, with a clear portrait, name and job title, which integrates into our swipe card system which manages and restricts movement across the Trust.

Security offices were refurbished recent improvements to main reception and A&E and are now more prominent than previously. This has an added benefit of allowing our local Police to use the offices when needed.

Our car parks at Conquest Hospital and EDGH have retained their accreditation under the national "Park Mark" scheme, which recognises their continued high standards of security and safety.

Emergency Preparedness, Resilience and Response (EPRR)

The Trust acknowledges its duties as a 'Category 1 responder' under the Civil Contingencies Act 2003, and the requirements of the NHS EPRR Framework 2015. These require the organisation to:

- Assess the risk of emergencies occurring and use this to inform planning;
- Put in place emergency plans;
- Put in place Business Continuity Management arrangements;
- Put in place arrangements to warn and inform the public about civil protection matters (which impact on the organisation);
- Share information and co-operate with other local responders.

In August 2017 we participated in the multi-agency response to the 'Birling Gap' gas-cloud 'major incident'. Over 130 people were decontaminated at the EDGH, the largest known response of this type in recent years.

In October 2017, the Trust's compliance with the annual 'NHS England EPRR Core Standards' audit dropped from 'Substantially' to 'Partially' compliant. In February 2018 a 2nd EPRR practitioner joined the organisation with the aim of raising the profile of EPRR and ensuring that it became embedded into the Trust's culture. A large program of work has been started to ensure that the Trust is resilient at all times.

The Trust values its engagement with both the Sussex Resilience Forum (SRF) and the Local Health Resilience Partnership (LHRP). It has participated in exercises at both a regional and local level, and is represented across the range of SRF working groups, and event 'Safety Advisory Groups' organised by East Sussex local authorities.

Future plans include updating risk-specific plans, including business continuity plans, on an annual basis. Staff will receive additional training to ensure that Trust responses are in line with those of the emergency services and multi-agency partners.

Exercises will be held to test that responses are effective.

The EPRR team is committed to ensuring that the organisation has a greater understanding of 'emergency preparedness' arrangements across all sites, leading to improved Trust resilience.

Sustainability

Care Without Carbon – delivering sustainable healthcare at ESHT

Our ambition is to become a sustainable organisation that provides safe, compassionate and high quality care to improve the health and wellbeing of the people in East Sussex while:

- Working towards long-term financial sustainability
- Minimising our impact and having a positive impact on the environment and natural resources
- Supporting staff wellbeing to enable a happy, healthy and productive workforce

Since 2015 we have been working to achieve this through our Sustainable Development Management Plan (SDMP), Care Without Carbon (CWC). This is focussed around a seven step action plan (see Figure 1), which aims to integrate sustainable development principles into our core operational activities, linked into our work to improve quality, safety and operational standards.

Figure 1: our seven steps to sustainability

How we deliver CWC at ESHT – programme governance

The SDMP was originally approved by our Trust Board in 2015. A refreshed SDMP was approved by the Board in January 2018, setting out a programme of targets and actions to further integrate sustainability into core business through a programme of staff engagement.

The delivery, monitoring and reporting of the SDMP is supported by the Sussex Community NHS Foundation Trust Environment and Transformation team who help implement key aspects of the programme.

Sustainable healthcare across Sussex and East Surrey

The annual carbon footprint of the healthcare system within Sussex and East Surrey, (including the seven main NHS provider trusts) is around 100,000 tonnes CO_2e, costing an estimated £32m per annum. NHS provider partners in our STP area of Sussex and East Surrey have initiated three collaborative projects:

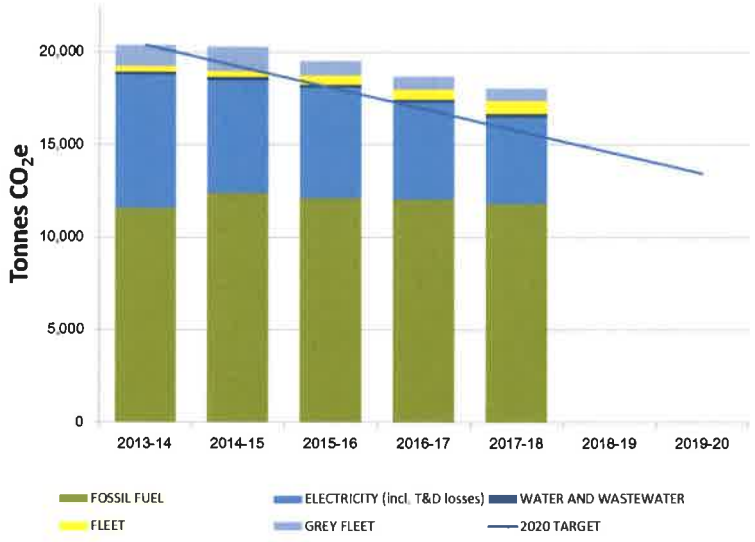
- a joint Energy Performance Contract (EPC) procurement;
- a Courier Services Review
- a joint waste tender with five of the STP trusts.

These projects aim to create economies of scale and delivering better value and to enable organisations to share best practice, encourage innovation and improve system-wide planning and management of sustainability impacts.

Summary of our environmental performance

In delivering our services we consume a significant amount of energy and water and produce a large volume of waste. We also transport Trust staff, patients and goods, and purchase a large range of medical and other equipment and services. All of these activities generate carbon dioxide (CO_2) emissions, which are linked to climate change, and can be collectively summarised as our carbon footprint.

Since our baseline year of 2013/14 we have reduced our absolute carbon footprint by 2328 tonnes CO_2e[1] (11%) (see figures 2 and 3 below). Our target for 2020 is a 34% reduction, in line with national NHS requirements. Whilst our work to achieve this is consistently resulting in reductions in our carbon footprint, we are currently falling short of the overall target. This highlights the need to accelerate the rate of progress with key aspects of our SDMP, in particular targeting our highest areas of impact through energy conservation and travel reduction opportunities, discussed later.



[1] CO_2e is the standard unit for measuring carbon footprints. It reflects the impact of all six greenhouse gases that cause global warming including carbon dioxide and methane. This is important as some of the gases have a greater warming effect than carbon dioxide.

Figure 2: ESHT carbon emissions against 2020 target

SCOPE	Emission Source (tCO_2e)	Base Year	2014-2015	2015-2016	2016-2017	2017-2018
1	Fossil Fuel	11,585	12,364	12,127	12,048	11,794
	Trust Vehicles	313	312	477	527	700
2	Electricity	7,183	6,125	5,963	5,222	4,694
3	Water	182	182	170	179	180
	Business Mileage	1,131	1,323	814	716	699
TOTAL		**20,394**	**20,306**	**19,550**	**18,693**	**18,066**

Figure 3: ESHT carbon emission figures by source

In addition to our carbon footprint, in delivering our services to patients we produce a significant quantity of waste – in 2017/18 this amounted to just over 1990 tonnes for our five main sites (see figure 3). Our segregation of non-infectious (tiger bag) waste has improved and is up from last year to 63%. Our recycling rate, however is still relatively low, at 34% and is an opportunity for improvement in 2018/19.

Waste source	Tonnes
Healthcare waste	969.2
Reusable sharps	117.9
General / Commercial waste	595.4
Recyclable waste	307.8
TOTAL	**1990.2**

Figure 4: ESHT waste produced from five main sites

Staff business travel also affects our environmental with over 3 million miles travelled by our staff each year, with associated cost and carbon impacts.

Key aspects to note in relation to our environmental data:

- *Due to the date of publication of the annual report, 2017-18 all figures are subject to final validation as they contain some estimated data.*
- *Scope 3 emissions for waste disposal and procurement (supply chain) not currently included in our carbon footprint due to lack of reliable conversion factors.*
- *Waste figures include our five main sites (EDGH, Conquest Hospital, Bexhill, Rye Hospital and Arthur Blackman Clinic) only, as we no longer manage waste at other sites and data was not available.*

This performance report was approved by the board on 24th May 2018 and signed on its behalf by:

Signed J Chadwick Self on behalf. Chief Executive
Chief operating officer - Acting CEO.

Date 24-5-18

Accountability Report

Director's Report

Trust Board

The Board of Executive and Non-Executive directors manage the Trust, with the Chief Executive being responsible for the overall running of our healthcare services as the Accountable Officer.

Board members as of 31st March 2018	
Chairman David Clayton-Smith	Chairman of Trust Board Chairman of Remuneration Committee
Chief Executive Dr Adrian Bull	
Non-Executive Directors	
Susan Bernhauser OBE	Chair of Quality and Standards Committee Member of Audit Committee Member of Remuneration Committee
Jackie Churchward-Cardiff	Member of Finance and Investment Committee Member of People and Organisational Committee Member of Quality and Standards Committee
Miranda Kavanagh	Chair of People and Organisational Committee
Barry Nealon	Vice Chairman of Trust Board Chair of Finance and Investment Committee Member of Audit Committee Member of Remuneration Committee
Michael Stevens	Chair of Audit Committee Member of Finance and Investment Committee Member of Remuneration Committee
Executive Directors and Officers	
Joanne Chadwick-Bell, Chief Operating Officer	
Jonathan Reid, Director of Finance	
Dr David Walker, Medical Director	
Vikki Carruth, Director of Nursing	
Monica Green, Director of Human Resources*	
Catherine Ashton, Director of Strategy*	
Lynette Wells, Director of Corporate Affairs *	

** Non-voting Board member/officer*

Board changes during the year are outlined below:

Name	Role/Position	Dates of Change
Alice Webster	Director of Nursing	Resigned 30.07.17
Hazel Tonge	Acting Director of Nursing	Acting up period 01.08.17 to 01.10.17
Vikki Carruth	Director of Nursing	Appointed 02.10.17

Attendance at Board meetings 2017/18

Name and Position	Attendance at Trust Board meetings 2016/17
David Clayton-Smith Chairman	**5/5**
Barry Nealon Vice-Chairman Non-Executive Director	**3/5**
Susan Bernhauser Non-Executive Director	**3/5**
Jackie Churchward-Cardiff Non-Executive Director	**5/5**
Miranda Kavanagh Non-Executive Director	**5/5**
Michael Stevens Non-Executive Director	**5/5**
Dr Adrian Bull Chief Executive	**5/5**
Joanne Chadwick-Bell Chief Operating Officer	**5/5**
Jonathan Reid Director of Finance	**4/5**
Dr David Walker Medical Director	**4/5**
Catherine Ashton* Director of Strategy	**4/5**
Monica Green* Director of Human Resources	**5/5**
Alice Webster Director of Nursing until 30.07.18	**1/1**
Hazel Tonge* Acting Director of Nursing from 01.08.18 to 01.10.18	**1/2**
Vikki Carruth Director of Nursing from 02.10.18	**1/2**
Lynette Wells* Director of Corporate Affairs	**5/5**

** Non-voting Board member/officer*

Trust Board Register of Interests

Non-Executive Directors	David Clayton-Smith	• Advisory Board Member, Coffee Assurance Services, Bonn • Chair, Kent, Surrey and Sussex Academic Health Science Network • Independent Chair, East Sussex Better Together • Independent Chair, East Sussex Better Together Clinical Leadership Forum • Independent Chair, East Sussex Better Together Clinical Leadership Forum • Epsom, St Helier Acute Sustainability Programme Board, Surrey Downs CCG • Independent Chair, Surrey Priorities Committee, Surrey Downs CCG
	Barry Nealon	• Chairman of Rye, Winchelsea & District Memorial Hospital.
	Susan Bernhauser	None
	Jackie Churchward-Cardiff	• Owner and director of Clinical Strategies • Chair, Avante Carer Support
	Miranda Kavanagh	None
	Michael Stevens	• Council Member & Treasurer, St George's, University of London
Executive Directors	Dr. Adrian Bull	None
	Joanne Chadwick-Bell	None
	Jonathan Reid	• Chair - Audit Committee, Sussex Downs College (until March 2018)
	Dr. David Walker	• Trustee of Parchment Trust
	Catherine Ashton	None
	Monica Green	None
	Alice Webster	None
	Hazel Tonge	None
	Vikki Carruth	None
	Lynette Wells	• Director and Shareholder of Chalkman Limited

Each director has confirmed that as far as he/she is aware there is no relevant audit information of which the Trust's auditors are unaware and he/she has taken all the steps that he/she ought to have taken as a director in order to make himself/herself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

The following table outlines the notice periods for Directors and Officers in post at 31st March 2018:

Name	Start Date	Notice period
Dr. Adrian Bull Chief Executive	April 2016	6 months
Joe Chadwick-Bell Chief Operating Officer	November 2016	6 months
Dr. David Walker Medical Director	September 2016	6 months
Jonathan Reid Director of Finance	June 2016	6 months
Catherine Ashton Director of Strategy	August 2016	6 months
Vikki Carruth Director of Nursing	October 2017	6 months
Monica Green Director of Human Resources	June 2002	6 months
Lynette Wells Director of Corporate Affairs	February 2012	6 months

For statements on salary and pension benefits for all senior management who served during 2017/18, please see tables on pages 71-73

Trust Committees

Audit Committee

The Audit Committee is chaired by Mike Stevens and met on six occasions during the past year.

The Committee is responsible for providing the Board with advice and recommendations on matters which include:

- the effectiveness of the framework of controls within the Trust
- the adequacy of arrangements for managing risk and how these are implemented
- the adequacy of plans of internal and external audits and how they perform against these
- the impact of changes to accounting policy
- the review of tenders and waivers issued by the Trust
- the review of the annual report and accounts

Until 2017/18, the Trust's External Auditors were appointed by the Audit Commission and its successor bodies. From 2017/18, Trusts were required to form an Audit Panel, and to appoint external auditors through a procurement process. The Audit Committee was designated as the Audit Panel for the Trust, and with the support of the Committee, the Trust undertook a tendering exercise which approved the appointment of Grant Thornton UK LLP for a period of three years commencing with the 2017/18 financial year.

Committee Attendance

Non-Executives form the Audit Committee, Finance and Investment Committee, People and Organisational Development Committee and Quality and Safety Committee.

Committee Attendance during 2017/18 was as follows:

	Audit	Finance & Investment	People & Organisational Development	Quality & Safety
Barry Nealon	6/6	11/13	-	-
Sue Bernhauser	4/6	-	-	6/6
Jackie Churchward-Cardiff	-	13/13	4/5	5/6
Miranda Kavanagh	-	-	5/5	-
Mike Stevens	6/6	11/13	-	-

All of the meetings of the Trust's Committees during 2017/18 were quorate.

Modern Slavery and Human Trafficking Act 2015 Annual Statement

The Trust's income does not reach the £36million threshold at which we are required to prepare an annual slavery and human trafficking statement.

Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

I confirm that, as far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed ..... on behalf.
Chief Executive

Date 24-5-18

Governance Statement

1. **Scope of responsibility**

   As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the duties and obligations assigned to me.

   I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum. The governance framework outlined in this documentation ensures there are adequate arrangements in place for the discharge of statutory functions that these have been checked for any irregularities and are legally compliant.

2. **The purpose of the system of internal control**

   The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

   The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of East Sussex Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

   The system of control has been in place in East Sussex Healthcare NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

3. **Capacity to handle risk**

   I am responsible for risk management across all organisational, financial and clinical activities. This includes responsibility for ensuring that processes are in place to enable identification and management of current risk and anticipation of future risk. The Risk Management Strategy provides a framework for managing risks across the organisation which is consistent with best practice and Department of Health guidance. The Strategy provides a clear, systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, management and financial processes across the organisation. It was reviewed and revised in the financial year.

4. Governance Framework

The Trust has agreed Standing Orders (SOs) for the regulation of proceedings and business. The Trust SOs are designed to translate the statutory requirements set out in the National Health Service Trusts (Membership and Procedures) Regulations 1990 (1990/2024) into day to day operating practice, and, together with the adoption of a Scheme of Matters Reserved to the Board; a Scheme of Delegation to officers and others; and Standing Financial Instructions, they provide the regulatory framework for the business conduct of the Trust and define its ways of working. These documents, together with the range of policies set by the Board make up the Governance and Accountability Framework. The Standing Orders, Scheme of Delegation and Standing Financial Instructions have been periodically updated to account for alterations in year and were last reviewed, updated and approved by the Trust Board in December 2017.

Best practice in governance states that the Board should be of sufficient size that the balance of skills, capability and experience is appropriate for the requirements of the business. The Trust Board has a balance of skills and experience appropriate to fulfilling its responsibilities and is well balanced with a Chairman, five non-executive directors and five voting executive directors. In line with best practice there is a clear division of responsibilities between the roles of Chairman and Chief Executive. The Board complies with the HM Treasury/Cabinet Office Corporate Governance Code where applicable.

The Trust has a stable Board and there was only one change during the year; Alice Webster resigned as Director of Nursing on 30 July 2017, the position was filled on an interim basis by Deputy Director of Nursing Hazel Tonge until Vikki Carruth joined the Trust on 2 October 2017.

In addition to responsibilities and accountabilities set out in terms and conditions of appointment, Board members also fulfil a number of "Champion" roles where they act as ambassadors for matters including health and safety, business continuity, dementia and organ donation.

The Trust has nominated a non-executive director, Barry Nealon, as Vice Chairman and another, Sue Bernhauser, as the Senior Independent Non-Executive Director (SID). The role of the SID is to be available for confidential discussions with other directors who may have concerns which they believe have not been properly considered by the Board, or not addressed by the Chairman or Chief Executive, and also to lead the appraisal process of the Chairman. The SID is also available to staff in case they have concerns which cannot, or should not, be addressed by the Chairman, Executive Directors or the Trust's Speak Up Guardian as outlined in the Trust's Raising Concerns (Whistleblowing) Policy.

The Trust has a Fit and Proper Persons Policy and processes to ensure that people who have director level responsibility for the quality and safety of care, and for meeting the

Care Quality Commission fundamental standards are fit and proper to carry out their roles. Directors and officers complete an annual declaration that they remain 'Fit and Proper Persons' to be directors.

4.1 Board Effectiveness

All Board members participate in the annual appraisal process and objectives are agreed and evaluated. During the year the SID undertook an appraisal of the Chairman on behalf of the Board.

The Board has a tailored seminar programme in place to support the development of Board knowledge and allow in depth discussion and exploration of key issues. The Board completed a self-assessment of its effectiveness in April 2017 to support planning of future Board development activities Board development activity encompassed leading improvement, team dynamics, leadership behaviours and learning styles.

Board members also undertake 'quality walks' to develop their understanding of the organisation and the organisation's understanding of the Board. These visits add to and complement the assurance provided to the Board through regular reporting on compliance with local, national and regulatory quality standards. They are not one off events but part of a continuing cycle of improvement where outcomes are fed back to staff, patients and others and, if required, actions are taken. Board members feedback on the outcome of their quality walks at each public board meeting.

4.2 Committee Structure

The Trust Board meets bi-monthly in public and also holds informal seminars covering key issues and Board development in the month where there is no public Board meeting. Committees of the Board include Audit, Remuneration and Appointments, Finance and Investment, Quality and Safety and People and Organisational Development. All Committees are chaired by a Non-Executive Director of the Trust and membership of the Audit and Remuneration and Appointments Committees comprise only Non-Executive Directors. Terms of reference outline both quoracy and expected attendance at meetings and the Board receives a report from the Committee Chair at each Board meeting. Functions of these Committees are outlined below.

4.2.1 Audit Committee

The Audit Committee supports the Board by critically reviewing the governance and assurance processes on which the Board places reliance. This encompasses: the effectiveness of Trust governance, risk management and internal control systems; the integrity of the financial statements of the Trust, in particular the Trust's Annual Report; the work of internal and external audit and any actions arising from their work; compliance by the Trust with relevant legal and regulatory requirements. The Committee meets at least quarterly.

The Committee has aimed to perform its duties during the year as delegated by the Trust Board and mandated through governance requirements. It has ensured compliance with and further developed good practice through continuous self-assessment and review of its effectiveness; and assessing itself against the checklist in the Audit Committee Handbook. The Committee has been chaired by a non-executive director with a financial background, and membership consists of himself and 2 non-executive directors. Executive directors are invited to attend. The Committee met on 6 occasions throughout the financial year, was well attended and all meetings were quorate.

The Committee has oversight of the completeness of the risk management system. Divisional and Corporate representatives have attended the Committee on a rotational basis to present their risk registers and mitigating actions.

As one of the key means of providing the Trust Board with assurance that effective internal control arrangements are in place, the Audit Committee requests and receives assurances and information from a variety of sources to inform its assessments. This process has also included calling managers to account, when considered necessary, to obtain relevant assurance and updates on outcomes. The Committee also works closely with executive directors to ensure that assurance mechanisms within the Trust are fully effective, and that a robust process is in place to ensure that actions falling out of internal audits and external reviews are implemented and monitored by the Committee.

The Committee's remit includes oversight of the effectiveness of Clinical Audit arrangements. During the year the Committee reviewed the Annual Plan for Clinical Audit and received progress updates at each meeting. In addition Divisions attended the meeting on a rotational basis to update on the clinical audits in their area. Good progress was noted and it was recommended that the number of clinical audits be reduced due to the high number abandoned. The Committee received assurance that the Trust would be compliant with the national diabetes audit after a number of years of failing to participate due to a lack of appropriate software.

The Audit Committee Chairman updates the Trust Board at each meeting with both minutes and a verbal update, and an annual report is also presented. Highlights have included the points outlined above; notably assurance on the risk management system and internal controls monitored by the Committee, the need to provide assurance on controls in place in relation to cyber security, preparation to meet the requirements of the General Data Protection Regulations and updates on the work of both internal and external audit and counter fraud.

4.2.2 Finance and Investment Committee

The Finance and Investment Committee provides support to the Trust Board in regard to understanding:

- the future financial challenges and opportunities for the Trust
- the future financial risks of the organisation
- the integrity of the Trust's financial structure
- the effectiveness and robustness of financial planning
- the effectiveness and robustness of investment management
- the robustness of the Trust's cash investment approach
- the investment and market environment the Trust is operating in,
- the financial and strategic risk appetite that is appropriate for the organisation
- the process for business case assessments and scrutiny and the process for agreeing or dismissing investment decisions depending on the above

The Committee is scheduled to meet quarterly, but has met monthly during 2017/18 due to the Trust being in Financial Special Measures. This provides sufficient time to review, scrutinise and monitor Trust plans.

4.2.3 Quality and Safety Committee

The Committee's prime function is to ensure that the Trust is providing safe and high quality services to patients supported and informed by effective arrangements for monitoring and continually improving the safety and quality of care. It meets bi-monthly to provide an objective review of all aspects of quality, safety and standards in support of getting the best clinical outcomes and experience for patients. The Committee assists the Board in being assured that the Trust is meeting statutory quality and safety requirements and to gain insight into issues and risks that may jeopardise the Trust's ability to deliver quality improvement. It held 6 meetings during the financial year. During the year the Quality and Safety Committee undertook a review of effectiveness and revised its terms of reference and adapted its work plan accordingly.

The Committee reviewed and endorsed the Trust's quality improvement priorities for subsequent publication in the Quality Account. It undertook "deep dive" reviews of areas highlighted through external review and internal risk management processes such as end of life care, radiology and plan film reporting and pressure ulcers.

4.2.4 People and Organisational Development Committee

The People and Organisational Development Committee convene quarterly, to provide strategic oversight of workforce development, planning and performance. Its remit includes providing assurance to the Board that the Trust has the

necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting the Trust objectives and organisational success. It met 5 times during the year, and has a broad membership including senior managers, staff-side and equality and diversity representatives.

Further details of the Remuneration and Appointments Committee can be found in the Remuneration Report section of the Annual Report.

5. Risk and Control Framework

The Trust has in place an ongoing process to:

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives;

- Evaluate the likelihood of those risks being realised and the impact should they be realised and to manage them efficiently, effectively and economically;

- Ensure lessons are learnt from concerns and incidents in order to share best practise and prevent reoccurrence.

Risk management requires participation, commitment and collaboration from all staff. Risks are identified, analysed, evaluated and controlled through the Trust's Datix incident reporting and information system. Risks are identified through incident reporting, risk assessment reviews, clinical audits and other clinical and non- clinical reviews with a clearly defined process of escalation to risk registers. The registers are real-time documents which are populated through the organisation's risk assessment and evaluation processes. This enables risks to be quantified and ranked. A corporate high level risk register populated from the risk registers of divisions and departments is produced and establishes the organisational risk profile.

The Trust manages its financial risks using a wide range of management tools. Performance against budgetary targets is recorded, analysed and reported monthly. This information is monitored and challenged both internally and externally. In addition to performance assessment, financial control and management is continually assessed by internal and external audit, and counter fraud teams. Reports from these parties are presented to the Audit Committee. Operational management, finance, purchasing and payroll teams are segregated to reduce conflicts of interest and the risk of fraud. Segregation is enhanced and reinforced by IT control systems which limit authority and access.

Risks are routinely reviewed at Divisional Quality Meetings and Team Meetings and discussed at Integrated Performance Reviews (IPR) which take place monthly and involve divisions and the executive team.. The High Level Risk Register is also

presented to the Audit and Quality and Standards Committees at each meeting and there is a rolling programme for each Division to present their risk register to the Audit Committee.

The Trust's Board Assurance Framework provides assurance that a robust risk management system underpins the delivery of the organisation's principal objectives. It clearly defines the:

- Trust's principal objectives and the principal risks to the achievement of these objectives.
- Key controls by which these risks can be managed
- Independent and management assurances that risks are being managed effectively
- Gaps in the effectiveness of controls and assurance
- Actions in place to address highlighted gaps.

The principal risks recorded on the Assurance Framework during the year are outlined below:

- We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies.

- We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.

- There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.

- We are unable to develop and maintain collaborative relationships based on shared aims, objectives and timescales with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.

- We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.

- We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we may not be the provider of choice for our local population or commissioners

- We are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.

- In running a significant deficit budget we may be unable to invest in delivering and improving quality of care and patient outcomes. It could also compromise our ability to make investment in infrastructure and service improvement.

- We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan

- We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.

- We are unable to effectively recruit our workforce and to positively engage with staff at all levels.

- If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.

The Board Assurance Framework has been regularly reviewed and revised by the Board and by the Audit and Quality and Standards Committees. As part of the Trust's ongoing governance review it held a seminar in June 2017 to consider the key risks, risk appetite and how this feeds into the Board Assurance Framework.

Internal audit gave 'Reasonable Assurance' over the Board Assurance Framework (BAF) and Risk Management processes. TIAA stated that the Trust has an effective Board assurance framework and risk management process and noted the development and progress that has been and continues to be made during the year in these areas.

5.1 Review of the effectiveness of risk management and internal control

Over the year the Trust has continued to strengthen risk management including incident reporting and investigation, complaints handling and the Board Assurance Framework. There is a programme of training for root cause analysis, risk and incident reporting and duty of candour. Increased training and awareness of reporting has continued and this has led to the Trust being in top quartile for incident reporting, although levels of incident relating to patient harm remain low.

Categories of serious Incidents are outlined in a national framework and include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

The Trust reported 47 serious incidents during 2017/18, a reduction of 10 when compared to 2016/17. Each incident was investigated and actions agreed and

implemented. The Trust had 4 never events in 2017/18; 3 related to theatres which despite being in different areas demonstrated a potential weakness in controls. The fourth never event was a misplaced naso-gastric tube. These incidents were investigated to ensure learning and change of practice were identified to prevent reoccurrence and an independent review of theatres commissioned to test systems and controls.

The review of the effectiveness of the system of internal control is informed by the work of the internal auditor, TIAA. For the reporting period, TIAA gave an overall opinion of Reasonable Assurance on the adequacy of the Trust's risk management, control and governance processes with the exception of the Trust's ability to deliver their planned financial control total.

6. Review of economy, efficiency and effectiveness of the use of resources

The Trust was placed in financial measures by NHS Improvement in October 2016. This was as a result of a significant negative variance against the Trust's financial control total plan and because of the significant deficit forecast for 2016/17. A financial recovery plan was developed and the Trust put in place a number of enhanced control measures.

In 2016/17 the Trust did not meet its control total but delivered a deficit of £46.2m which was better that the £48m position agreed by the Board at the start of the year. The underlying deficit in 2016/17 was £57m. In 2017/18 the Trust Board accepted a control total of a £37m deficit before Sustainability and Transformation Funding (STF). At Month 9, and following extensive dialogue with NHS Improvement and a series of mediation sessions with East Sussex CCGs due to contractual challenges of £11m, the Trust Board agreed a revised forecast outturn for the year of £57.4m (before STF funding) with a confirmed final income figure for the year from the CCGs of £257.1m. A full briefing on the crystallisation of risk within the position was reviewed with the Finance and Investment Committee and the Trust Board submitted a formal reforecast to NHSI, following completion of the required template. Risk remained within the position in respect of managing the financial consequences of winter pressures, agreeing an appropriate valuation basis for the Trust asset base at the end of the financial year, and delivery of the cost improvements agreed through the Trust-wide confirm and challenge process. The financial planning process for 2018/19 took account of the lessons from 2017/18

Financial governance arrangements are reviewed by internal and external audit to provide assurance of economic, efficient and effective use of resources.

7. Performance against the national priorities set out in the NHS Improvement Accountability Framework 2016/17

Performance against the NHS Improvement Accountability Framework is detailed more fully in the Performance Section of the Annual report.

The Trust made significant improvements to achieving constitutional standards such as referral to treatment timescales and A&E performance during the year and further detail can be found in the Annual Report.

The Trust assures the quality and accuracy of elective waiting time data and the risks to the quality and accuracy of this data. The quality of performance information is continually assessed by the Trust in regular meetings and forums as well as through quality assurance audits, including external review by TIAA audits and other external companies. Patient tracking lists (PTL), including those on the 'Referral To Treatment' pathway, are scrutinised in detail at weekly PTL and performance meetings.

8. Compliance and Regulation

8.1 Patient and Public Involvement

Section 11 of the Health and Social Care Act 2012 places a duty on the NHS to consult and involve patients and the public in the planning and development of health services and in making decisions affecting the way those services operate. The Trust has continued to strengthen working relationships with stakeholders and a number of public engagement events have taken place throughout the year; for example to develop Quality Improvement Priorities.

Healthwatch and their volunteers have actively supported the Trust and undertaken a number projects to improve patient experience. These have included a "round the clock care" review to follow patients over a 24 hour period in the Trust. Further details are provided in the main body of the Annual Report.

8.2 Equality and Diversity

Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with. The Trust has an Equality Strategy which details how the Trust will eliminate discrimination, advance equality and foster good relations between people who share certain characteristics and those who do not. The Board also consider an Annual Equality Information Report and progress against delivering the outcomes of the Equality Delivery System and Workforce Race Equality Standards

8.3 Information Governance

The Trust is compliant with the requirements of the NHS Information Governance Toolkit (IGT) attaining level 2. This was independently audited to assess the adequacy of policies, systems and operational activities to complete, approve and submit the IGT scores. The auditors gave 'Reasonable Assurance' over the Trust's IGT self-assessment.

During 2017/18 staff reported 76 IG incidents, 71 of these were scored against the Trust's incident scoring as either 'negligible or none' for severity, 3 were scored as 'low or minor' and the remaining 2 incidents were scored as 'medium or moderate'. This indicates that the majority of incidents have no impact upon information security. The number of incidents reported is lower when compared with 2016/17, with no identified reason for the decrease of 95 to 76. All incidents are investigated and actions implemented to prevent reoccurrence. One incident was reported to the Information Commissioner's Office, following investigation the ICO closed the incident with no actions for the Trust.

8.4 Freedom of Information Requests

The Trust received 646 Freedom of Information requests in 2017/18, of these (585 - 91%) were responded to within the 20 working day timeframe. This was comparable to 2016/17 when the Trust received 645 requests (584 - 91% were responded to in time).

8.5 NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

8.6 Climate Change

The Trust has undertaken a climate change risk assessment and developed an Adaptation Plan, to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met.

8.7 Duty of Candour

The introduction of a statutory Duty of Candour was a recommendation made in the Francis Report. The Duty was included in the Standard NHS Contract from 1st April 2014 and subsequently strengthened as a Care Quality

Commission regulatory requirement from 1st October 2014.

The intention of the regulation is to ensure that providers are open and honest with service users and other 'relevant persons' (people acting lawfully on the behalf of service users) when things go wrong with care and treatment, and that they provide them with reasonable support, truthful information and a written apology. As a result of training and increased awareness across the organisation compliance with the duty has improved to 90% across all areas.

The Trust has a Being Open Policy and ensures that, as part of any investigation into Serious Incidents or complaints, there is clear, open and honest communication with patients and their families/carers and that a process for shared learning is in place.

8.8 Counter fraud and anti-bribery arrangements

Under the NHS Standard Contract all organisations providing NHS services are required to have appropriate anti-fraud arrangements in place. The NHS Counter Fraud Authority publish 'Standards for Providers: Fraud, Bribery and Corruption' ("the Standards") to assist organisations with this process. It incorporates a requirement that the Trust employs or contracts a qualified person or persons to undertake the full range of anti-fraud work, and that it produces a risk based workplan that details how it will approach anti-fraud and corruption work.

The Trust is committed to ensuring fraud, bribery and corruption does not proliferate within the organisation. The organisation is fully compliant with the directions issued by the Secretary of State in 1999, the NHS Standard Contract (2012) and the NHS Counter Fraud and Corruption Manual.

The Trust's Counter Fraud Service is provided by TIAA Limited. The accredited Local Counter Fraud Specialist (LCFS) reports to the Director of Finance and attends the Audit Committee meetings to report on the work achieved. The LCFS works to ensure that counter fraud is integrated into all Trust activity in a positive way.

Throughout the past financial year there has been continued work to embed the counter fraud and anti-bribery culture, and work is undertaken against the Standards, comprising the area of Strategic Governance and the three key principals of Inform and Involve, Prevent and Deter, and Hold to Account.

Reactive investigations comply with legislative requirements and with the NHS Counter Fraud and Corruption Manual. The LCFS liaises with other LCFS personnel and relevant external bodies for investigations, as

appropriate. The LCFS is available to receive referrals and to report on the results of any investigations to the Director of Finance and the Audit Committee. All sanctions available to the Trust are considered following a reactive investigation, together with efforts to recover losses incurred.

8.9 Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. The Annual Quality Account for 2017/18 has been developed in line with relevant national guidance and priorities were developed following feedback from patients, staff and external stakeholders.

The Quality Account has been reviewed through external audit processes and comments have been provided by local stakeholders including commissioners, Healthwatch and the Health Overview and Scrutiny Committee. Internal oversight has been undertaken by the Senior Leaders Forum, and the Quality and Standards and Audit Committees.

External auditors issued a qualified opinion on the Quality Account. This was due to issues identified by Internal Audit's testing in relation to the Venous Thromboembolism (VTE) indicator; specifically in relation to accuracy, validity and completeness of the data. A sample of 40 patient notes was tested to check the validity of the data submitted in November and December 2017. The sample comprised 30 recorded as compliant and 10 recorded as non-compliant. Overall, 12 errors were found in the sample tested. Actions to improve data quality are already in place.

8.10 Care Quality Commission (CQC)

The Trust is registered with the Care Quality Commission to carry out eight legally regulated activities from 18 registered locations. The Trust was placed in Special Measures in September 2015 and in October 2016 the CQC undertook an inspection and recognised significant improvements since the previous 2015 inspection. The CQC's overall rating for the Trust was improved to 'Requires Improvement'. The Trust was re-inspected in March 2018 for core services on the acute sites and separately for the Well Led Domain. At the time of writing the reports were pending but the Trust is hoping that continued improvement will be recognised.

9. Conclusion

My review of the effectiveness of the systems of internal control has taken account of the work of the Executive Management team within the organisation, which has responsibility for the development and maintenance of the internal control framework within their discreet portfolios. In line with the guidance on the

definition of the significant internal control issues, I have not identified any significant control issues other than the financial and performance matters highlighted in sections 5-7 above.

Dr Adrian Bull
Chief Executive

Statement of Director's Responsibilities in Respect of the Accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

24-5-18 Date Chief Executive

24/5/18 Date Finance Director

Remuneration and Staff Report

Remuneration Report

The Remuneration and Appointments Committee is a non-executive subcommittee of the Board and oversees the appointments of the Chief Executive and Executive Directors and agrees the parameters for the senior appointments process. The Committee agrees and reviews the Trust policies on the reward, performance, retention and pension matters for the executive team and any relevant matters of policy that affect all staff.

The Committee is chaired by the Senior Independent Non-executive Director and all non-executive directors are able to attend. The Chief Executive, Human Resources Director and Company Secretary attend meetings in an advisory capacity except when issues relating to their own performance, remuneration or terms and conditions are being discussed.

Quoracy for the meeting is three members of which one must be the Committee Chairman. . Under delegated authority from the Trust Board, the Committee determines the appropriate remuneration and terms of service for the Chief Executive and Executive Directors having proper regard to national arrangements and guidance.

The Committee also advises on, and oversees, the appropriate contractual arrangements with the Chief Executive and Executive Directors, including the proper calculation and scrutiny of termination payments, taking account of national guidance as appropriate.

The remuneration rates are determined by taking into account national benchmarking and guidance in order to ensure fairness and proper regard to affordability and public scrutiny. The remuneration of the Chief Executive and Executive Directors are set at base salary only without any performance related pay. In line with national guidance, remuneration for all new executive directors includes an element earn back pay related to achievement of objectives. The earn back figure is included in the base salary. Treasury approval for "Very Senior Managers" pay exceeding the Prime Minister's salary is also required.

In addition, the Committee monitors the performance of the Chief Executive and Executive Directors based on their agreed performance objectives.

Matters considered in 2017/18 included:

- Chief Executive's report on individual Directors' performance and objectives
- Annual performance review for Chief Executive
- Review of Senior NHS Salaries
- Approval of relevant appointments and terminations
- Clinical Excellence Awards

Due to nature of the business conducted Committee minutes are considered confidential and are therefore not in the public domain. The Chair of the Committee draws to the Board's attention any issues that require disclosure to the full Board or require Executive action.

A) Salary and Pension entitlements of senior managers - Single total figure table - audited

Name and Title	2017.18						2016.17					
	Salary (bands of £5,000) £'000	Expense payments (taxable) to nearest £100 £'00	Performance pay and bonuses (bands of £5,000) £'000	Long Term Performance pay and bonuses (bands of £5,000) £'000	All pension-related benefits (bands of £2,500) £'000	**TOTAL** (bands of £5,000) £'000	Salary (bands of £5,000) £'000	Expense payments (taxable) to nearest £100 £'00	Performance pay and bonuses (bands of £5,000) £'000	Long Term Performance pay and bonuses (bands of £5,000) £'000	All pension-related benefits (bands of £2,500) £'000	**TOTAL** (bands of £5,000) £'000
David Clayton-Smith Chairman	35 - 40	2***	0	0	0	40 - 45	35 - 40	9**	0	0	0	35 - 40
Barry Nealon Vice Chairman	5 - 10 -	0 -	0 -	0 -	0 -	5 - 10	5 – 10 -	0 -	0 -	0 -	0 -	5 – 10 -
Susan Bernhauser Non-Executive Director	5 - 10	0	0	0	0	5 - 10	5 – 10	1**	0	0	0	5 – 10
Michael Stevens Non-Executive Director	5 - 10	0	0	0	0	5 - 10	5 – 10	0	0	0	0	5 – 10
Miranda Kavanagh Non-Executive Director	5 - 10	0	0	0	0	5 - 10	5 – 10	0	0	0	0	5 – 10
Jackie Churchward-Cardiff Non-Executive Director	5 - 10	4***	0 -	0 -	0	5 - 10	5 – 10	5**	0	0	0	5 – 10
Dr Adrian Bull Chief Executive	180 - 185	3***	0	0	0	185 - 190	175 - 180	4**	0	0	0	175 – 180
Joanne Chadwick-Bell Chief Operating Officer	130 - 135	3***	0	0	0	130 - 135	45 - 50	1**	0	0	47.5 - 50	95 – 100
Jonathan Reid Director of Finance	130 - 135	0	0	0	45 - 50	175 - 180	100 - 105	0	0	0	85 - 87.5	190 - 195
David Walker Medical Director	50 - 55*	4***	0 -	0 -	0	50 - 55	25 - 30	3**	0	0	0	25 - 30
Alice Webster (Left 30th July 2017) Director of Nursing	35 - 40	1***	0	0	20 - 25	50 - 55	110 - 115	1**	0	0	70 - 72.5	185 - 190
Victoria Leivers-Carruth (Started 2nd October	55 - 60	0	0	0	70 - 75	130 - 135	0	0	0	0	0	0

2017) Director of Nursing												
Hazel Tonge (From 1st August 2017 until 1st October 2017) Acting Director of Nursing	15 - 20**	0	0	0	15 - 20	35 - 40	0	0	0	0	0	0
Catherine Ashton Director of Strategy	115 - 120	2***	0 -	0 -	60 - 65	180 - 185	75 – 80	1**	0	0	50 - 52.5	125 - 130
Monica Green Director of Human Resources	110 - 115 -	1*** -	0	0	15 - 20 -	130 - 135	105 - 110 -	1** -	0 -	0 -	82.5 – 85 -	190 - 195 -
Lynette Wells Director of Corporate Affairs	95 - 100 -	0 -	0 -	0 -	20 - 25 -	115 - 120	95 - 100 -	0 -	0 -	0 -	60 - 62.5 -	155 - 160 -

**- David Walker, non-Board related salary for the full year of £164k.*
*** - Hazel Tonge, non-Board related salary for the full year of £85k.*
**** - represents reimbursement of travel costs incurred and leased car benefits, subject to UK income tax and disclosed to nearest £100*

	2017/18	2016/17
Band of Highest Paid Director	£215 - £220k	£200 - £205k
Median Total Remuneration*	£26,933	£27,832
Ratio	01:07.96	01:07.25

* The Median calculation is based on a starting point of the lowest paid employee up to the highest paid, including agency costs ,less the highest paid director.

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

This is set out in the table above.

B) Pension Benefits

Name and Title	Real increase in pension at pension age (bands of £2500) £'000	Real increase in pension lump sum at pension age (bands of £2500) £'000	Total accrued pension at pension age at 31 March 2018 (bands of £5000) £'000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5000) £'000	Cash equivalent transfer value at 1 April 2017 £'000	Real increase in Cash Equivalent Transfer value £'000	Cash equivalent transfer value at 31 March 2018 £'000	Employer's contribution to stakeholder pension £'000
Dr Adrian Bull **** Chief Executive	0	0	0	0	896	0	0	0
Joanne Chadwick-Bell Chief Operating Officer	0	0	25 - 30	65 - 70	396	0	377	0
Jonathan Reid Director of Finance	2.5 - 5	0 - 2.5	15 - 20	35 - 40	221	48	271	0
David Walker Medical Director	0	0	0	0	0	0	0	0
Alice Webster (Left 30th July 2017) Director of Nursing	0 - 2.5	0 - 2.5	40 - 45	120 - 125	660	21	730	0
Victoria Leivers-Carruth (Started 2nd October 2017) Director of Nursing	0 - 2.5	5 - 7.5	30 - 35	75 - 80	402	40	487	0
Hazel Tonge (From 1st August 2017 until 1st October 2017) Acting Director of Nursing	0 - 2.5	0 - 2.5	20 - 25	70 - 75	448	9	491	0
Catherine Ashton Director of Strategy	2.5 - 5	2.5 - 5	15 - 20	40 - 45	262	69	334	0
Monica Green Director of Human Resources	0 - 2.5	2.5 - 5	40 - 45	130 - 135	842	78	928	0
Lynette Wells Director of Corporate Affairs	0 - 2.5	0	15 - 20	0	154	28	184	0

**** - *As Dr Bull has reached the normal pension age, cash equivalent transfer value will not be shown.*

As non-executive members do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive members.

For detailed values on employee benefits and staff numbers please see Note 8 in the Annual Accounts and the Staff Report within the Annual Report

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 200826.

Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement.

Payment for to Past Directors

No payments to past directors were made during the year 2017/18.

Payment for Loss of Office (audited)

No payments for loss of office were made during the year 2017/18.

Pay Ratios (audited)

	2017/18	2016/17
Band of Highest Paid Director	£215 - £220k	£200 - £205k
Median Total Remuneration	£26,933	£27,832
Ratio	1 : 7.96	1 : 7.25

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director/member in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in East Sussex Healthcare NHS Trust in the financial year 2017/18 was £215-220k (2016/17, £200 - 205k). This was 7.96 times (2016/17, 7.25) the median remuneration of the workforce, which was £26,933 (2016/17 £27,832.

In 2017/16, 4 (2016/17, 8) employees received remuneration in excess of the highest paid director. Remuneration ranged from £365 to £362,318.03 (2016/17 £15,142 to £250,818).

Total remuneration includes salary, non-consolidated performance related pay, benefits in kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pension.

It should be noted that the changes in ratio between financial years have arisen due to :-

- Application of the national NHS wage settlements for all staff groups
- In addition the remuneration of the most highly paid individual has increased due to payments in taxable allowances.

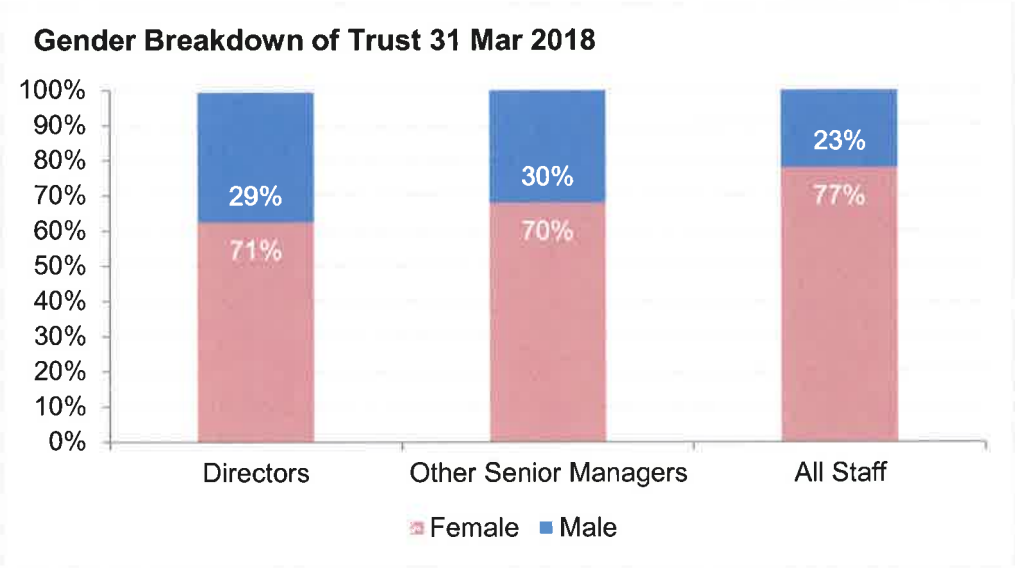
Staff Report

1. Number of Senior Managers by band at 31st March 2018

Senior Managers	Full-time Equivalent
Directors	7.0
Other Senior Managers (Ad Hoc payscales)	2.0
Agenda for Change Band 9	5.0
Agenda for Change Band 8d	15.0
Agenda for Change Band 8c	27.2
Agenda for Change Band 8b	51.8
Agenda for Change Band 8a	165.7

(NB FTE Full-time Equivalent)

2. Gender distribution by Directors, Other Senior Managers & Staff



Senior Managers includes all staff on Agenda for Change Bands 8a-8d.

3. Gender pay gap report

Along with other organisations with over 250 employees, ESHT has published a gender pay gap report which includes data alongside actions identified to investigate any differences in pay.

The report identifies that there is a gender pay gap of 22.6% in relation to the mean hourly rate within the Trust. When this is broken down, it identifies that the largest difference exists within the medical workforce. This is similar to other Trusts and it is subject of further review to identify the underlying reason for this difference.

At ESHT a working group will be established to look at the detailed data, there will be deep dive analysis to identify key areas for targeted improvement and an action plan will be developed.

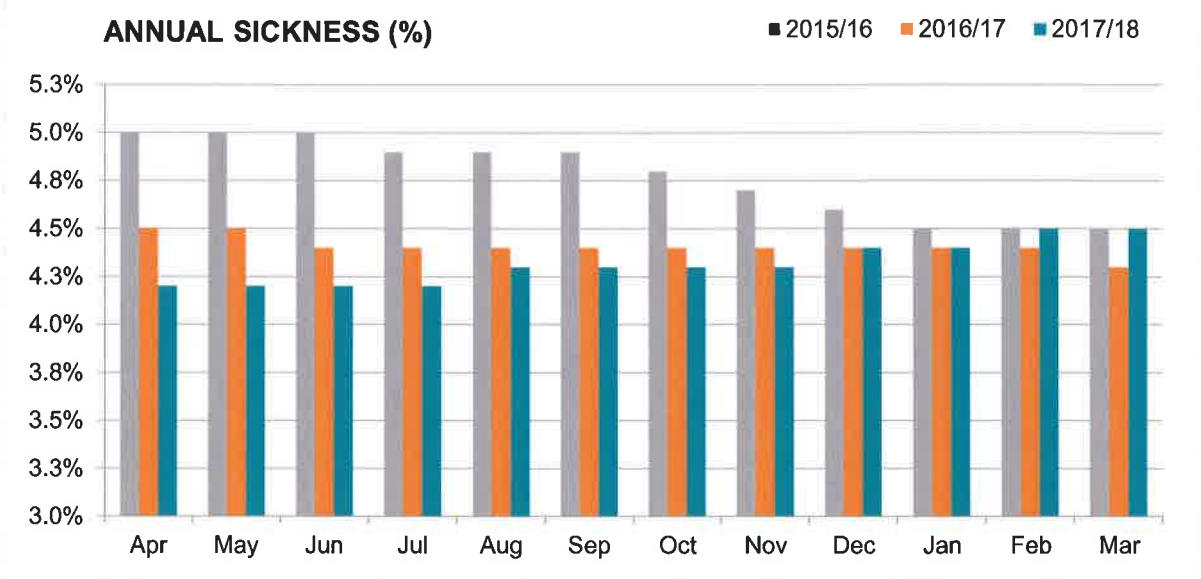
Staff fact file*

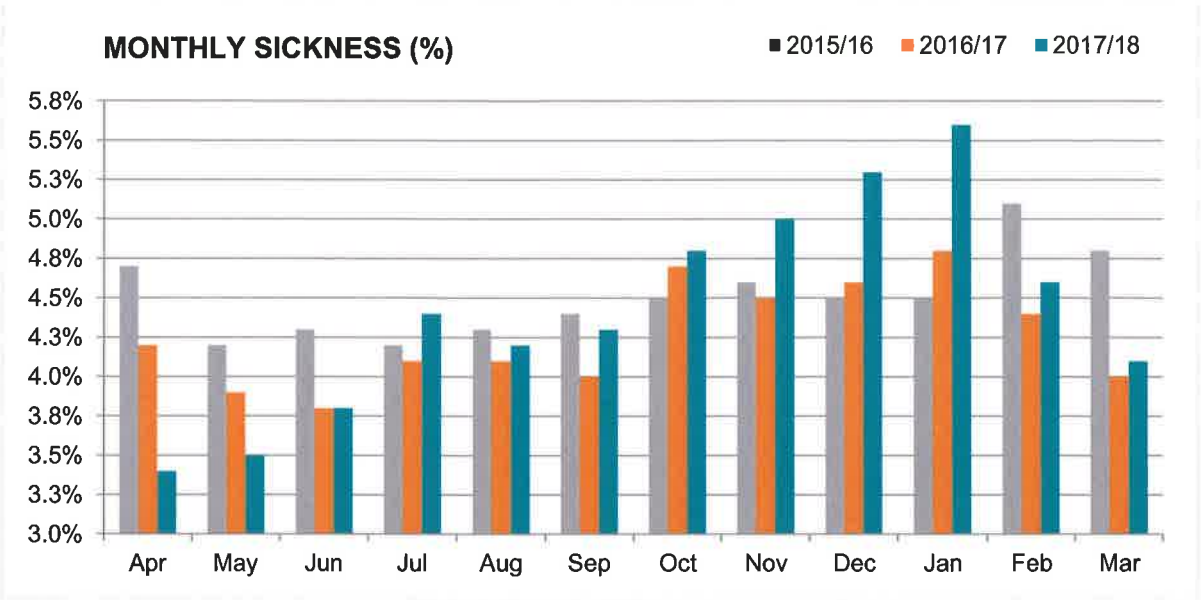
As of 31st March 2018:

- Just over 77% of our staff were female
- 38.7% of all staff work part-time
- 35.8% of staff are over 50 years old
- Just under 2.7% of staff identified themselves as disabled and just under 1.4% identified themselves as either gay, lesbian or bisexual
- 12.8% of staff are from a black or minority ethnic (BME) origin

4. Staff Absence Data

Our annual sickness rate has increased during the year from 4.3% to 4.5%.The average working days lost due to sickness per member of staff during the year to 31st March 2018 was 10.6.





Staff Policies

We aim to ensure that vacancies for positions within the Trust are advertised both internally & externally, through our Trust website and NHS Jobs2. Applicants with a disability are encouraged to apply through the 'Positive about Disability' scheme indicator which enables managers to ensure that all applicants with a disclosed disability, who meet the minimum requirements as set out in the person specification, are called for interview under our guaranteed interview scheme. We treat internal and external applicants in exactly the same way.

We support disabled employees in maintaining their training and career development by undertaking an annual Personal Development Review, with a 6 month follow-up to ensure that agreed actions have been undertaken. Our Learning and Development service gives all our staff access to personal development training, and staff also have the support of the Occupational Health Service. Disabled staff will also have the opportunity to join the ESHT Disability Staff Network which aims to support implementation of the new Workforce Disability Equality Standard (WDES) and promote inclusive practices across the Trust.

When necessary, our Human Resources Department will provide support for staff & for line managers to ensure that, wherever possible, staff seeking alternative posts due to health issues are supported to identify alternative suitable employment. Support is made available from the Occupational Health Department, the Equality & Diversity Team and Local Disability Advisors as required.

Our Equality, Diversity and Human Rights Manager takes the lead in ensuring that disability awareness is embedded throughout our Trust's policies, practices and overall culture. All of our staff undergo equality training and have the option of doing this online or face to face. All new staff attend a face to face session. We further ensure that equality is embedded throughout the Trust via Personal Development Reviews, team briefings, and within a variety of Trust communications.

Relevant policies are presented to the Staff Networks to ensure staff with protected characteristics are involved in decision making processes across the Trust.

Other Employee Matters

We aim to treat all staff fairly in relation to all employee matters; all of our policies and processes are monitored in terms of equality and diversity and equal treatment. Staff are not treated differently because of any role or position they hold and all policies are reviewed regularly to ensure they adhere to current legislation.

Equality, Diversity and Human Rights

2017/18 was another busy year with positive changes improving Equality & Diversity across the whole organisation.

We continue to actively identify and remove barriers eliminating unlawful discrimination to ensure that we provide equal access to Healthcare services, employment opportunities and any function delivered by the Trust.

A highlight of the year for the Equality & Diversity team was Danii Clark, our Equality & Human Rights Assistant, winning the Skills for Health Regional award for 'Operational Support Worker of the Year 2017.

A dedicated team within the Equality & Diversity department continues to promote the 'Accessible information Standard' across the organisation. Dedicated staff provides direct access and support to accessible information and interpreters to patients and staff with a communication barrier, arising from a disability or language barrier.

The Accessible Information standard was promoted throughout the Trust during Equality Week 2017. The Equality team provided cream teas to staff, patients and visitors at EDGH, Conquest Hospital and Bexhill hospitals in exchange for wearing visual impairment simulation goggles and ear plugs. This enabled people to experience some of the barriers experienced by people with visual impairments and hearing loss.

The LGBT+ Network, recruitment team and the Sexual Health team promoted the Trust at both Eastbourne and Hastings 2017 Gay Pride celebrations. Sexual health testing, advice and support to local LGBT communities and promoting ESHT as a great place to work were all proudly offered by dedicated staff.

Other Highlights

- Following the end of a contract for the supply of interpreting and translation services in November 2017 the Trust's Accessible Information Team has provided easy access to instant telephone interpreters, face to face interpreters and translated material for patients who do not use spoken English as their primary communication method.

- Communication boxes continue to provide resources for patients, carers and service users with communication needs on the elderly wards at EDGH, Conquest Hospital

and Bexhill hospitals. Donations of whiteboards were received on Folkington ward to further support communication needs.

- The Trust Black & Minority Ethnic (BME) staff Network has continued to grow and go from strength to strength. The network aims to provide a safe place for staff to seek support, meet people with shared interests, raise awareness, identify training and development opportunities. During Equality week, catering staff delivered a menu from around the world with a different theme each day to promote the diverse cultures.

The Trust's EDS2 report, which sets out all of the Trust's equality activities is available on our website. This provides us with a framework to support us in meeting our legal obligation under Equality Act 2010 to eliminate unlawful discrimination, advance equality of opportunity and to foster good relations.

Analysis of Staff & Costs for 2017/18 (audited)

Staff costs

	Permanent	Other	2017/18 Total	2016/17 Total
	£000	£000	£000	£000
Salaries and wages	222,615	-	**222,615**	192,349
Social security costs	21,093	-	**21,093**	18,716
Apprenticeship levy	1,121	-	**1,121**	-
Employer's contributions to NHS pensions	25,991	-	**25,991**	23,960
Pension cost - other	-	-	-	-
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	118	-	**118**	405
Temporary staff		13,799	**13,799**	35,178
Total gross staff costs	**270,938**	**13,799**	**284,737**	**270,608**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**270,938**	**13,799**	**284,737**	**270,608**
Of which				
Costs capitalised as part of assets	441	-	**441**	637

Average number of employees (WTE basis)

	2017/18	2016/17

	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	559	105	**665**	605
Ambulance staff	-	-	**-**	-
Administration and estates	1,226	89	**1,315**	1,252
Healthcare assistants and other support staff	1,760	359	**2,118**	2,029
Nursing, midwifery and health visiting staff	1,778	146	**1,923**	1,903
Nursing, midwifery and health visiting learners	22	-	**22**	22
Scientific, therapeutic and technical staff	536	46	**582**	559
Healthcare science staff	132	10	**142**	130
Social care staff	-	-	**-**	-
Other	8	-	**8**	7
Total average numbers	**6,021**	**754**	**6,775**	**6,507**
Of which:				
Number of employees (WTE) engaged on capital projects	13	-	**13**	16

Exit Packages (audited)

			2017-18					
Exit Package cost band (including any special payment element)			Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
			Whole Numbers only	**£000s**	**Whole Numbers only**	**£000s**	**Whole Numbers only**	**£000s**
Less than £10,000			0	0	3	10	3	10
£10,000 - £25,000			0	0	2	24	2	24
£25,001 - £50,000			1	48	1	37	2	85
Totals			**1**	**48**	**6**	**71**	**7**	**119**

			2016-17					
Exit Package cost band (including any special payment element)			Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
			Whole Numbers only	**£s**	**Whole Numbers only**	**£s**	**Whole Numbers only**	**£s**
Less than £10,000					2	7,243	2	7,243
£10,000 - £25,000			1	18,400	4	58,498	5	76,898
£25,001 - £50,000			2	63,090	0	0	2	63,090
£50,001 - £100,000			1	51,777	3	176,810	4	228,586
Totals			**4**	**133,266**	**9**	**242,551**	**13**	**375,817**

Table 2 Analysis of Other Departures

	2017-18		2016-17	
	Agreements Number	Total Value of Agreements £'000	Agreements Number	Total Value of Agreements £'000
Mutually Agreed resignations (MARS) contractual costs	0	0	1	64
Contractual payments in lieu of notice	5	34	7	167
Exit payments following employment tribunals or court orders	1	37	1	12
Total	6	71	9	243

Expenditure on Consultancies

During 2017/18, the Trust's total spending on consultancies was £592,000 (see Accounts, note 6)

Off-payroll Engagements

Off-payroll engagements Table 1

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	6
Of which, the number that have existed:	
for less than one year at the time of reporting	6
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Off-payroll engagements Table 2

Where the reformed public sector rules apply, entities must complete Table 2 for all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and March 2018, form more than £245 per day and that last for longer than six months:

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	6
Of which	
No. assessed as caught by IR35	2
No. assessed as not caught by IR35	4
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year.	6

No. of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll engagements Table 3

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	1
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements.	16

This accountability report was approved by the board on 24th May 2018 and signed on its behalf by:

Signed Chadwick DCU on behalf.

Chief Executive

Date 24.5.18.

Certificate on summarisation schedules

Trust Accounts Consolidation (TAC) Summarisation Schedules for East Sussex Healthcare NHS Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2017/18 have been completed and this certificate accompanies them.

Finance Director Certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:
   - the financial records maintained by the NHS trust
   - accounting standards and policies which comply with the Department of Health and Social Care's Group Accounting Manual and
   - the template accounting policies for NHS trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.

2. I certify that the TAC schedules are internally consistent and that there are no validation errors*.

3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Trust

Jonathan Reid, Director of Finance

24th May 2018

Chief Executive Certificate

1. I acknowledge the attached TAC schedules, which have been prepared and certified by the Finance Director, as the TAC schedules which the Trust is required to submit to NHS Improvement.

2. I have reviewed the schedules and agree the statements made by the Director of Finance above.

Adrian Bull, Chief Executive

24th May 2018

** If you are unable to eliminate validation errors after discussions with your auditors and contacting NHS Improvement then amend this accordingly.*
*** Please insert the 'except for' clause only if applicable.*

Independent auditor's report to the Directors of East Sussex Healthcare NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of East Sussex Healthcare NHS Trust (the 'Trust') for the year ended 31 March 2018, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and Notes to the Accounts, including Accounting policies and other information. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty relating to going concern

We draw attention to note 1.1.2 in the financial statements, which indicates that the Trust is forecasting a deficit in 2018/19 of £47.853 million assuming delivery of a £23.5 million cost improvement programme. The cash balances in the cash flow forecast for 2018/19 assume achievement of the forecast deficit, including delivery of the cost improvement programme and cash support from the Independent Trust Financing Facility. As stated in note 1.1.2, there is no certainty that the cost improvement programme will be achieved which would consume the available cash resources within the next 12 months and mean the Trust would require further cash support to meet its liabilities as these fall due. These events or conditions, along with the other matters explained in note 1.1.2, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report excluding, the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006; and

- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or

- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we have made a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 10 May 2018 we referred a matter to the Secretary of State under section 30(b) of the Local Audit and Accountability Act 2014 in relation to East Sussex Healthcare NHS Trust's breach of its break-even duty for the three year period ending 31March 2018.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities set out on page 69, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, because of the significance of the matter described in the basis for adverse conclusion section of our report, we are not satisfied that, in all significant respects, East Sussex Healthcare NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for adverse conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matter:

The Trust reported a deficit of £54.98 million in 2017/18, compared to a planned deficit of £36.500 million, following significant deficits in previous years. The Trust's 2018/19 draft financial plan shows a forecast deficit of £47.853 million for the 2018/19 financial year.

This identifies weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures due to the current configuration of services. This matter is evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of East Sussex Healthcare NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Darren Wells
Director
for and on behalf of Grant Thornton UK LLP

2nd Floor
St Johns House
Crawley
RH10 1HS

Date: 24 May 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	350,246	339,788
Other operating income	4	37,688	39,519
Operating expenses	6, 8	(448,947)	(416,746)
Operating deficit from continuing operations		**(61,013)**	**(37,439)**
Finance income		20	17
Finance expenses	11	(4,509)	(1,795)
PDC dividends payable		(2,920)	(4,968)
Net finance costs		**(7,409)**	**(6,746)**
Deficit for the year		**(68,422)**	**(44,185)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(10,249)	-
Revaluations	14	-	6,569
Other recognised gains and losses		(112)	-
Total comprehensive expense for the period		**(78,783)**	**(37,616)**
Financial Performance for the year			
Retained deficit for the year		(68,422)	(44,185)
Impairments (excluding IFRIC 12 impairments)		14,423	(5)
CQUIN Risk Reserve adjustment		(1,104)	-
Adjustments in respect of donated asset reserve elimination		121	398
Adjusted retained deficit		**(54,982)**	**(43,792)**

Statement of Financial Position

	Note	31 March 2018 £000	Restated 31 March 2017 £000
Non-current assets			
Intangible assets		1,948	1,860
Property, plant and equipment	12	215,699	237,135
Trade and other receivables	16	1,311	1,308
Total non-current assets		**218,958**	**240,303**
Current assets			
Inventories	15	7,301	6,195
Trade and other receivables	16	35,341	40,806
Cash and cash equivalents	17	2,100	2,100
Total current assets		**44,742**	**49,101**
Current liabilities			
Trade and other payables	18	(37,740)	(51,773)
Borrowings	20	(35,694)	(427)
Provisions	21	(551)	(502)
Other liabilities	19	(1,729)	(1,261)
Total current liabilities		**(75,714)**	**(53,963)**
Total assets less current liabilities		**187,986**	**235,441**
Non-current liabilities			
Borrowings	20	(121,517)	(92,788)
Provisions	21	(2,304)	(2,488)
Total non-current liabilities		**(123,821)**	**(95,276)**
Total assets employed		**64,165**	**140,165**
Financed by			
Public dividend capital		156,345	153,562
Revaluation reserve		94,449	104,708
Income and expenditure reserve		(186,629)	(118,105)
Total taxpayers' equity		**64,165**	**140,165**

The notes on pages 97 to 119 form part of these accounts.

Chief operating officer - Acting CEO.

Dr A Bull
Chief Executive on behalf.
24 May 2018

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**153,562**	**104,708**	**(118,105)**	**140,165**
Deficit for the year	-	-	(68,422)	**(68,422)**
Impairments	-	(10,249)	-	**(10,249)**
Transfer to retained earnings on disposal of assets	-	(10)	10	-
Other recognised gains and losses	-	-	(112)	**(112)**
Public dividend capital received	2,783	-	-	**2,783**
Taxpayers' equity at 31 March 2018	**156,345**	**94,449**	**(186,629)**	**64,165**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**153,562**	**98,247**	**(74,028)**	**177,781**
Deficit for the year	-	-	(44,185)	**(44,185)**
Other transfers between reserves	-	(108)	108	-
Revaluations	-	6,569	-	**6,569**
Taxpayers' equity at 31 March 2017	**153,562**	**104,708**	**(118,105)**	**140,165**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS trust, is payable to the Department of Health as the public dividend capital dividend.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS Trust.

Revaluation Reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating deficit		(61,013)	(37,439)
Non-cash income and expense:			
Depreciation and amortisation	6	12,719	12,406
Net impairments	7	14,423	(5)
Income recognised in respect of capital donations	4	(773)	(539)
(Increase) / decrease in receivables and other assets		5,438	(24,109)
(Increase) / decrease in inventories		(1,106)	277
Increase / (decrease) in payables and other liabilties		(15,126)	14,728
Decrease in provisions		(141)	(5)
Net cash used in operating activities		**(45,579)**	**(34,686)**
Cash flows from investing activities			
Interest received		20	17
Purchase of intangible assets		(443)	(505)
Purchase of property, plant, equipment and investment property		(14,607)	(12,465)
Sales of property, plant, equipment and investment property		112	-
Receipt of cash donations to purchase capital assets		773	-
Net cash used in investing activities		**(14,145)**	**(12,953)**
Cash flows from financing activities			
Public dividend capital received		2,783	-
Movement on loans from the Department of Health and Social Care		63,996	54,017
Other interest paid		(3,724)	(1,761)
PDC dividend paid		(3,331)	(4,617)
Net cash generated from financing activities		**59,724**	**47,639**
Movement in cash and cash equivalents		**-**	**-**
Cash and cash equivalents at 1 April - brought forward		**2,100**	**2,100**
Cash and cash equivalents at 31 March	17	**2,100**	**2,100**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis.

The Department of Health Group Accounting Manual sets out the interpretations of "going concern" for the public sector. An NHS body would not need to have concerns about its "going concern" status unless there is a prospect of services ceasing altogether. For the Trust there are no uncertainties in this respect as continuity of service provision in the future can be demonstrated by signed contracts and future commissioning intentions with and from Commissioners.

In accordance with IAS 1, management have made an assessment of the Trust's ability to continue as a going concern considering the significant financial challenges faced by the Trust in 2017/18. Notwithstanding the need for additional cash support, the Trust does not have any evidence indicating that the going concern basis is not appropriate. The Trust has not been informed by NHS Improvement that there is any prospect of reconfiguration or dissolution within the next 12 months. In terms of the sustainable provision of services, there has been no indication from the Department of Health that the Trust will not continue to be a going concern. Furthermore, continuity of service provision in the future can be demonstrated by signed contracts and future commissioning intentions with commissioners and through the financial and operational plans described in the Trust Strategy and the Sussex and East Surrey Sustainability and Transformation Plans. The Trust Board has set a strategic objective of reaching break-even in five years, and a long-term financial model to secure this objective is under development for review by the Trust Board in July 2018.

For the reasons above, they continue to adopt the going concern basis in preparing the accounts and the financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Note 1.2 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Notes to the Accounts

Note 1 Accounting policies and other information (continued)

Note 1.2.1 Critical judgements in applying accounting policies (continued)

Note 1.2.1 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Charitable Funds
The Non-Executive Directors of the Trust act as Trustee's of the East Sussex Healthcare NHS Trust Charitable Fund, however, these are not consolidated with the Trust accounts on the grounds of materiality.

Alternative Site Valuation
In 2015/16 the Trust adopted the Alternative Site valuation for its main acute hospital sites. In 2017/18 this methodology was reviewed and the District Valuer instructed to complete the revaluation on the basis of:
- single siting the main acute sites
- removal of all accommodation buildings including admin space
- removal of St Anne's House
- removal of the Education Centre
- removal of all Commercial Services buildings
- removal of the Crèche (at Eastbourne DGH)

See note 13

Note 1.2.2 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Property, Plant and Equipment valuations
The District Valuer has valued land and buildings using the Alternative Site methodology. See note 14

Asset Lives
Each year the Trust reviews all of its plant and equipment assets to ensure that the existing asset lives are accurate, this review results in both increases and decreases in lives at an asset level and the subsequent depreciation charge for those assets.

Part Completed Spells
Partially completed spells for inpatient services are accounted for by accruing the income due to the 31 March 2018. This is calculated by applying the reference cost per bed day to the number of bed days by inpatient at midnight on 31 March 2018. Bed stays over 70 days are ignored and then a 72% collection rate is assumed based on previous years amounts billed under PBR tariff arrangements once patients are discharged.

Note 1.3 Income
Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Notes to the Accounts

Note 1 Accounting policies and other information (continued)

Note 1.4 Expenditure on employee benefits (continued)

Note 1.4 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.6.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Notes to the Accounts

Note 1 Accounting policies and other information (continued)

Note 1.6 Property, plant and equipment (continued)
All assets are measured subsequently at valuation. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
- Land and non-specialised buildings - market value for existing use
- specialised buildings - depreciated replacement cost, modern equivalent asset basis.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from the current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Notes to the Accounts

Note 1 Accounting policies and other information (continued)

Note 1.6 Property, plant and equipment (continued)

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.6.3 Donated assets
Donated non-current assets are capitalised at current value in existing use. If they will be held for their service potential or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

Note 1.7 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first-in first-out methodology, however, the Pharmacy system uses the weighted average cost formula so drugs are valued this way. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.8 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.9 Financial instruments and financial liabilities

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets are categorised as loans and receivables.

Notes to the Accounts

Note 1 Accounting policies and other information (continued)

Note 1.9 Financial instruments and financial liabilities (continued)

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Financial liabilities
Financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Note 1.10 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.11 Value added tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Notes to the Accounts

Note 1 Accounting policies and other information (continued)

Note 1.12 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.13 Transfers of functions to other NHS bodies
For functions that the trust has transferred to another NHS body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net gain corresponding to the net assets transferred is recognised within income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Note 1.14 Standards, amendments and interpretations in issue but not yet effective or adopted

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

- IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating Segments

The Trust has considered IFRS8: Operating Segments and has taken the view that its activities should be reported as a single entity rather than in a segmental manner. Although financial performance is reproted to the Executive Board members at a divisional level, the key financial information for decision making purposes is based on the single entity as a whole. Furthermore, the Trust's buiness is the delivery of acute and community healthcare accross a single economic environment. no seperate reportable segmants have therefore been identified.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2017/18 £000	2016/17 £000
Acute services		
Elective income	51,013	53,786
Non elective income	102,257	84,686
First outpatient income	14,758	15,563
Follow up outpatient income	26,775	23,547
A & E income	16,046	13,321
High cost drugs income from commissioners (excluding pass-through costs)	31,137	29,098
Other NHS clinical income	60,389	71,589
Community services		
Community services income from CCGs and NHS England	29,299	30,201
Income from other sources (e.g. local authorities)	12,254	12,078
All services		
Private patient income	2,011	2,232
Other clinical income	4,307	3,687
Total income from activities	**350,246**	**339,788**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	44,454	40,590
Clinical commissioning groups	278,451	269,808
Department of Health and Social Care	70	-
Other NHS providers	48	91
NHS other	709	124
Local authorities	10,705	10,956
Non-NHS: private patients	2,011	2,232
Non-NHS: overseas patients (chargeable to patient)	9	62
NHS injury scheme	649	963
Non NHS: other	13,140	14,962
Total income from activities relating to continuing operations	**350,246**	**339,788**

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18 £000	2016/17 £000
Income recognised this year	9	62
Cash payments received in-year	42	10
Amounts added to provision for impairment of receivables	-	44
Amounts written off in-year	2	18

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	493	609
Education and training	9,005	9,286
Receipt of capital grants and donations	773	539
Charitable and other contributions to expenditure	220	272
Non-patient care services to other bodies	14,297	13,995
Sustainability and transformation fund income	3,534	2,600
Income in respect of staff costs where accounted on gross basis	1,409	1,319
Other income	7,957	10,899
Total other operating income related to continuing operations	**37,688**	**39,519**

Other income above is made up of:

	2017/18	2016/17
	£000	£000
Car Parking	1,330	1,428
Catering	398	380
Property	654	515
Staff Accommodation Rental	1,406	1,469
Creche Services	577	695
Other Income Generation Schemes	1,973	1,525
Other Income	1,619	4,887
Total	**7,957**	**10,899**

Note 5 Fees and charges

	2017/18	2016/17
	£000	£000
Income	1,559	1,666
Full cost	(1,875)	(1,951)
Deficit	**(316)**	**(285)**

The income and expenditure values summarised above relate to the Michelham Unit, the Trust's private patient centre. In 2017/18 its financial objective was to generate a £179,000 operating surplus. Actual performance resulted in a £316,000 deficit. In 2016/17 the unit made a deficit of £285,000 against a target surplus of £143,000. The unit also provides care for NHS patients but that income is not recognised in the figures above.

Note 6 Operating expenses

	2017/18 £000	Restated 2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	6,709	6,770
Purchase of healthcare from non-NHS and non-DHSC bodies	4,816	6,181
Staff and executive directors costs	284,296	269,971
Remuneration of non-executive directors	78	75
Supplies and services - clinical (excluding drugs costs)	35,279	35,221
Supplies and services - general	4,656	3,881
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	42,933	40,498
Consultancy costs	592	993
Establishment	6,233	5,298
Premises	14,639	12,019
Transport (including patient travel)	1,130	1,572
Depreciation on property, plant and equipment	12,364	12,111
Amortisation on intangible assets	355	295
Net impairments	14,423	(5)
Increase/(decrease) in provision for impairment of receivables	(309)	99
Increase in other provisions	245	-
Change in provisions discount rate	24	203
Audit fees payable to the external auditor		
audit services- statutory audit	61	105
other auditor remuneration (external auditor only)	10	-
Internal audit costs	184	184
Clinical negligence	14,615	13,286
Legal fees	185	270
Insurance	383	425
Education and training	871	732
Rentals under operating leases	1,159	1,512
Hospitality	47	-
Other	2,969	5,050
Total related to continuing operations	**448,947**	**416,746**

Note 6.1 Limitation on auditor's liability

In accordance with the terms of engagement with the trust's external auditors, Grant Thornton UK LLP, its members, partners and staff (whether contract, negligence or otherwise) in respect of services provided in connection with or arising out of the audit shall in no circumstances exceed £2 million in the aggregate in respect of all such services.

Note 7 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating deficit resulting from:		
Changes in market price	14,423	303
Other	-	(308)
Total net impairments charged to operating deficit	**14,423**	**(5)**
Impairments charged to the revaluation reserve	10,249	-
Total net impairments	**24,672**	**(5)**

Note 8 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	222,615	192,349
Social security costs	21,093	18,716
Apprenticeship levy	1,121	-
Employer's contributions to NHS pensions	25,991	23,960
Termination benefits	118	405
Temporary staff (including agency)	13,799	35,178
Total staff costs	**284,737**	**270,608**
Of which		
Costs capitalised as part of assets	441	637

Note 8.1 Retirements due to ill-health

During 2017/18 there were no early retirements from the trust agreed on the grounds of ill-health (8 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £0k (£695k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period. In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

Note 10 East Sussex Healthcare NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where East Sussex Healthcare NHS Trust is the lessee.

The leases relate to cars, medical equipment, building and photocopiers. Lease periods range from 3 to over 5 years

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	1,159	1,512
Total	**1,159**	**1,512**

	2018 £000	2017 £000
Future minimum lease payments due:		
- not later than one year;	1,226	1,681
- later than one year and not later than five years;	1,947	2,864
- later than five years.	237	292
Total	**3,410**	**4,837**

Note 11 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18 £000	2016/17 £000
Interest expense:		
Loans from the Department of Health and Social Care	4,455	1,743
Interest on late payment of commercial debt	48	18
Total interest expense	**4,503**	**1,761**
Unwinding of discount on provisions	6	34
Total finance costs	**4,509**	**1,795**

Note 12.1 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2017 - brought forward	**27,027**	**187,190**	**13,393**	**66,815**	**259**	**22,882**	**3,955**	**321,521**
Additions	-	7,679	-	5,402	-	2,324	307	**15,712**
Impairments	(12,955)	(82)	(11,635)	-	-	-	-	**(24,672)**
Revaluations	-	(23,434)	(1,758)	-	-	-	-	**(25,192)**
Disposals / derecognition	-	-	-	(2,170)	(8)	(32)	(17)	**(2,227)**
Valuation/gross cost at 31 March 2018	**14,072**	**171,353**	**-**	**70,047**	**251**	**25,174**	**4,245**	**285,142**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**17,739**	**1,411**	**48,661**	**258**	**13,421**	**2,896**	**84,386**
Provided during the year	-	**5,695**	**347**	**3,977**	**1**	**2,162**	**182**	**12,364**
Revaluations	-	(23,434)	(1,758)	-	-	-	-	**(25,192)**
Disposals / derecognition	-	-	-	(2,085)	(8)	(14)	(8)	**(2,115)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**50,553**	**251**	**15,569**	**3,070**	**69,443**
Net book value at 31 March 2018	**14,072**	**171,353**	**-**	**19,494**	**-**	**9,605**	**1,175**	**215,699**
Net book value at 1 April 2017	**27,027**	**169,451**	**11,982**	**18,154**	**1**	**9,461**	**1,059**	**237,135**

Note 12.2 Property, plant and equipment financing - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2018								
Owned - purchased	14,072	167,106	-	17,010	-	9,528	888	**208,604**
Owned - donated	-	4,247	-	2,484	-	77	287	**7,095**
NBV total at 31 March 2018	**14,072**	**171,353**	**-**	**19,494**	**-**	**9,605**	**1,175**	**215,699**

Note 12.3 Property, plant and equipment - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**25,279**	**176,720**	**12,104**	**66,943**	**264**	**20,898**	**3,581**	**305,789**
Additions	-	6,148	19	2,971	-	1,988	374	**11,500**
Impairments	-	5	-	-	-	-	-	**5**
Revaluations	1,748	4,184	1,403	-	-	-	-	**7,335**
Reclassifications	-	133	(133)	-	-	-	-	**-**
Disposals other than for resale	-	-	-	(3,099)	(5)	(4)	-	**(3,108)**
Valuation/gross cost at 31 March 2017	**27,027**	**187,190**	**13,393**	**66,815**	**259**	**22,882**	**3,955**	**321,521**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**11,615**	**941**	**47,622**	**262**	**11,453**	**2,724**	**74,617**
Provided during the year	-	**5,513**	**315**	**4,138**	**1**	**1,972**	**172**	**12,111**
Revaluations	-	611	155	-	-	-	-	**766**
Disposals other than for resale	-	-	-	(3,099)	(5)	(4)	-	**(3,108)**
Accumulated depreciation at 31 March 2017	**-**	**17,739**	**1,411**	**48,661**	**258**	**13,421**	**2,896**	**84,386**
Net book value at 31 March 2017	**27,027**	**169,451**	**11,982**	**18,154**	**1**	**9,461**	**1,059**	**237,135**
Net book value at 1 April 2016	**25,279**	**165,105**	**11,163**	**19,321**	**2**	**9,445**	**857**	**231,172**

Note 12.4 Property, plant and equipment financing - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2017								
Owned - purchased	27,027	164,312	11,982	15,581	1	9,351	859	**229,113**
Owned - donated	-	5,139	-	2,573	-	110	200	**8,022**
NBV total at 31 March 2017	**27,027**	**169,451**	**11,982**	**18,154**	**1**	**9,461**	**1,059**	**237,135**

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Note 13 Donations of property, plant and equipment

The following organisations donated assets to the Trust during 2017/18:
ESHT Charitable Funds - £6,000 (2016/17 £39,000)
EDGH League of Friends - £134,000 (2016/17 £188,000)
Bexhill League of Friends - £329,000 (2016/17 £174,000)
Conquest league of Friends - £227,000 (2016/17 £90,000)
Lewes Victoria Hospital League of Friends - £17,000 (2016/17 £15,000)
Uckfield League of Friends - £61,000 (2016/17 £0)

Note 14 Revaluations of property, plant and equipment

Depreciation, impairments and valuation assessments
The Trust first adopted the "alternative site valuation" methodology in 2015/16. In 2017/18 this methodology was reviewed and the District Valuer instructed to complete the revaluation on the basis of:
- single siting the main acute sites
- removal of all accommodation buildings including admin space
- removal of St Anne's House
- removal of the Education Centre
- removal of all Commercial Services buildings
- removal of the Crèche (at Eastbourne DGH)

The Trust instructed the District Valuer (Mr Oliver Gronow MSc, MRICS, FAAV) to conduct a full revaluation of the Trust's land and buildings as at 31 March 2018.

As a result of the Revaluation carried out at 31 March 2018, assets previously impaired increased in value by £14.423m (2016/17 £0.308m).

Standard lives for property, plant and equipment are adopted as follows:
- buildings, as per the District Valuer between 3 and 56 years
- short life plant and equipment, 5 to 7 years
- medium life plant and equipment, 10 years
- long life plant and equipment, 15 years
- motor vehicles, 4 to 7 years
- furniture, 5 to 10 years
- IT equipment, up to 15 years

The annual review of asset lives for plant and machinery, furniture and IT equipment resulted in an in year reduction in depreciation of £92,237 (2016/17 £220,086 reduction). Extending asset lives reduces in-year depreciation costs but increases the years depreciation is charged for individual assets.

The gross carrying amount of all fully depreciated assets still in use is:
Purchased - £28.7m (2016/17 £24.4m)
Donated - £12.8m (2016/17 £12.4m)

Note 15 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	2,382	2,122
Consumables	4,749	3,900
Energy	170	173
Total inventories	**7,301**	**6,195**

Inventories recognised in expenses for the year were £59,044k (2016/17: £58,296k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

Note 16.1 Trade receivables and other receivables

	31 March 2018 £000	Restated 31 March 2017 £000
Current		
Trade receivables	21,384	29,103
Capital receivables (including accrued capital related income)	157	8
Accrued income	9,900	8,555
Provision for impaired receivables	(145)	(232)
Prepayments (non-PFI)	2,419	2,517
PDC dividend receivable	432	21
VAT receivable	835	375
Other receivables	359	459
Total current trade and other receivables	**35,341**	**40,806**
Non-current		
Provision for impaired receivables	(151)	(389)
Other receivables	1,462	1,697
Total non-current trade and other receivables	**1,311**	**1,308**
Of which receivables from NHS and DHSC group bodies:		
Current	22,038	29,094

Note 16.2 Provision for impairment of receivables

	2017/18 £000	2016/17 £000
At 1 April as previously stated	**621**	**620**
Increase in provision	17	99
Amounts utilised	(16)	(98)
Unused amounts reversed	(326)	-
At 31 March	**296**	**621**

Note 16.3 Receivables past their due date but not impaired

	31 March 2018 £000	31 March 2017 £000
By up to three months	4,153	4,262
By three to six months	2,203	55
By more than months	3,664	1,364
Total	**10,020**	**5,681**

Note 17 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 31 March	**2,100**	**2,100**
Broken down into:		
Cash at commercial banks and in hand	27	42
Cash with the Government Banking Service	2,073	2,058
Total cash and cash equivalents as in SoFP	**2,100**	**2,100**
Total cash and cash equivalents as in SoCF	**2,100**	**2,100**

Note 17.1 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Monies on deposit	19	3
Total third party assets	**19**	**3**

Note 18 Trade and other payables

		Restated
	31 March 2018	31 March 2017
	£000	£000
Current		
Trade payables	6,766	28,013
Capital payables	3,029	1,924
Accruals	17,806	16,594
Social security costs	3,077	2,744
Other taxes payable	5,672	2,225
Accrued interest on loans	729	273
Other payables	661	-
Total current trade and other payables	**37,740**	**51,773**
Of which payables from NHS and DHSC group bodies:		
Current	6,680	7,017
Included above		
- outstanding pension contributions	3,444	6,624

Note 19 Other liabilities

	2018 £000	Restated 2017 £000
Current		
Deferred income	1,729	1,261
Total other current liabilities	**1,729**	**1,261**

Note 20 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health and Social Care	35,694	427
Total current borrowings	**35,694**	**427**
Non-current		
Loans from the Department of Health and Social Care	121,517	92,788
Total non-current borrowings	**121,517**	**92,788**

Note 21.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs £000	Legal claims £000	Other £000	Total £000
At 1 April 2017	**2,709**	**154**	**127**	**2,990**
Change in the discount rate	24	-	-	**24**
Arising during the year	28	111	125	**264**
Utilised during the year	(231)	(52)	(127)	**(410)**
Reversed unused	-	(19)	-	**(19)**
Unwinding of discount	6	-	-	**6**
At 31 March 2018	**2,536**	**194**	**125**	**2,855**
Expected timing of cash flows:				
- not later than one year;	232	194	125	**551**
- later than one year and not later than five years;	857	-	-	**857**
- later than five years.	1,447	-	-	**1,447**
Total	**2,536**	**194**	**125**	**2,855**

Note 21.2 Clinical negligence liabilities

At 31 March 2018, £123,064k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of East Sussex Healthcare NHS Trust (31 March 2017: £81,346k).

Note 22 Financial instruments

Note 22.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with NHS Healthcare Commissioners and the way the latter bodies are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 22.2 Carrying values of financial assets

	Loans and receivables
	£000
Trade and other receivables excluding non financial assets	33,549
Cash and cash equivalents at bank and in hand	2,100
Total at 31 March 2018	**35,649**
Trade and other receivables excluding non financial assets	41,143
Cash and cash equivalents at bank and in hand	2,100
Total at 31 March 2017	**43,243**

Note 22.3 Carrying value of financial liabilities

	Other financial liabilities
	£000
Borrowings excluding finance lease and PFI liabilities	157,211
Trade and other payables excluding non financial liabilities	37,740
Total at 31 March 2018	**194,951**
	£000
Borrowings excluding finance lease and PFI liabilities	93,215
Trade and other payables excluding non financial liabilities	46,533
Total at 31 March 2017	**139,748**

Note 22.4 Fair values of financial assets and liabilities

The fair value of receivables and cash is consistent with the carrying value in the Statement of Financial Position. Receivables comprise amounts to be collected within 1 year and the non-current receivables for Injury Cost Recovery Income. Non-current receivables are not discounted as the difference to carrying values is not considered material. Cash is available on demand.

Payables arising under statutory obligations such as payroll taxes are not classified as financial liabilities. The fair value of payables is consistent with the carrying value included in the Statement of Financial Position. Payables comprise amounts to be paid within 1 year and are valued using discounted cash flows.

Note 23 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	86	93	121	183
Bad debts and claims abandoned	26	16	-	-
Total losses	**112**	**109**	**121**	**183**
Special payments				
Ex-gratia payments	53	18	50	86
Total special payments	**53**	**18**	**50**	**86**
Total losses and special payments	**165**	**127**	**171**	**269**

Note 24 Related parties

Details of related party transactions with individuals are as follows:

Payments to Winchelsea and District Memorial Hospital Ltd: £314,766 (2016/17: £294,227)
Related party: Barry Nealon, Non-executive Director who is Chairman of the above organisation.

Payments to Sussex Down College: £11,639 (2016/17 : £7,722)
Income from Sussex Down College: £nil (2016/17: £28,760)
Related Party: Jonathan Reid, Director of Finance who is a Governor of the above organisation.

Payments to Chalkman Films: £570 (2016/17: £972)
Related party: Lynette Wells, Company Secretary who is a Director of the above organisation.

Payments to Kent, Surrey and Sussex Academic Health Science Network: £nil (2016/17: £32,700)
Income from Kent, Surrey and Sussex Academic Health Science Network: £14,913 (2016/17: £20,771)
Related party: David Clayton-Smith, Chairman who is Chairman of the above organisation.

Payments to Mr Ian Miller: £311,077 (2016/17 £nil)
Related Party: Ian Miller was a Trust appointed Financial Improvement Director, paid via payroll under IR35 rules.

The Department of Health is regarded as a related party. During 2017/18 East Sussex Healthcare NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. The bodies listed below have entered into income or expenditure transactions with the Trust of over £500,000:

Brighton And Hove CCG
Brighton and Sussex University Hospitals NHS Trust
Coastal West Sussex CCG
Eastbourne, Hailsham and Seaford CCG
Hastings and Rother CCG
Health Education England
High Weald Lewes Havens CCG
NHS England
NHS Property Services
NHSE Wessex
Oxford Health NHS Foundation Trust
Queen Victoria Hospital NHS Foundation Trust
South East CSU
South East Commissioning Hub
South East Local Office
Surrey & Sussex Healthcare NHS Trust
Sussex Community NHS Trust
Sussex Partnership NHS Foundation Trust
The NHS Blood and Transplant Agency
The NHS Litigation Authority
The NHS Pensions Agency
West Kent CCG

In addition, the Trust has had transactions over £500,000 with the following local government body:

East Sussex County Council

The Trust has also received revenue and capital payments from East Sussex Healthcare NHS Trust Charitable Fund for which some of the trustees are also members of the Trust board. The amount received was £762,000 (2016/17 £392,000), comprising of donations of assets amounting to £6,000 (2016/17 £39,000) and cash support of £756,000 (2016/17 £353,000).

The Trust has had a number of transactions over £500,000 with central government bodies:

HM Revenue and Customs
National Health Service Pension Scheme

Note 25 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	128,709	158,861	119,039	130,851
Total non-NHS trade invoices paid within target	24,188	43,923	30,662	49,321
Percentage of non-NHS trade invoices paid within target	18.79%	27.65%	25.76%	37.69%
NHS Payables				
Total NHS trade invoices paid in the year	2,698	35,381	2,656	46,757
Total NHS trade invoices paid within target	845	29,352	786	37,205
Percentage of NHS trade invoices paid within target	31.32%	82.96%	29.59%	79.57%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 26 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	66,779	54,017
External financing requirement	**66,779**	**54,017**
External financing limit (EFL)	66,780	54,017
Underspend against EFL	1	-

Note 27 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	16,155	12,005
Less: Disposals	(112)	-
Less: Donated and granted capital additions	(773)	(539)
Charge against Capital Resource Limit	15,270	11,466
Capital Resource Limit	15,277	11,467
Underspend against CRL	7	1

Note 28 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance deficit (control total basis)	(54,982)
Remove CQUIN risk reserve adjustment	1,104
Breakeven duty financial performance deficit	(53,878)

Note 29 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		350	(4,704)	87	522	(23,094)	88	(47,997)	(43,792)	(53,878)
Breakeven duty cumulative position	1,745	2,095	(2,609)	(2,522)	(2,000)	(25,094)	(25,006)	(73,003)	(116,795)	(170,673)
Operating income		282,807	299,623	385,281	387,400	364,240	384,876	356,152	379,307	387,934
Cumulative breakeven position as a percentage of operating income		0.74%	-0.87%	-0.65%	-0.52%	-6.89%	-6.50%	-20.50%	-30.79%	-44.00%

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.