EAST SUSSEX HEALTHCARE NHS TRUST

ANNUAL GENERAL MEETING

The Annual General Meeting of East Sussex Healthcare NHS Trust will be held on Tuesday, 26th September 2017, commencing at 13:30 in the Hastings Centre, The Ridge, Hastings TN34 2SA

AGENDA

			Lead:
1.	Welcome and Apologies for Absence		Chair
2a.	Minutes of the East Sussex Healthcare NHS Trust Annual General Meeting held on 3rd August 2016	A	Chair
b.	Matters Arising		
3.	East Sussex Healthcare NHS Trust Year in Review: Receive 2016/17 Annual Report and Quality Account 3.1 Successes & Challenges 3.2 Clinical & Quality 3.3 Finances	B	CEO DN DF
4.	The Future & ESBT Pathways		Chair
5.	Questions from members of the public		Chair

David Clayton-Smith

David Clayton-Smith

Chairman

24th August 2017

Key:	
Chair	Trust Chairman
CEO	Chief Executive
DN	Director of Nursing
DF	Director of Finance
MD	Medical Director

EAST SUSSEX HEALTHCARE NHS TRUST

ANNUAL GENERAL MEETING

The Annual General Meeting of East Sussex Healthcare NHS Trust was held in public on Wednesday 3rd August 2016 at 13:45 in the Ashdown Room, Uckfield Civic Centre

1. Welcome and Apologies for Absence — Action

Mr Clayton-Smith welcomed members of the Board and the public to ESHT's Annual General Meeting. He explained that prior to the previous year's Annual General Meeting Sue Bernhauser had become chair at extremely short notice and thanked her for stepping in so competently.

He reported that apologies for absence had been received from:

Sue Bernhauser, Non-Executive Director
Mike Stevens, Non-Executive Director
Mrs Catherine Ashton, Associate Director of Strategic Development
Dr David Hughes, Medical Director
Mr Jonathan Reid, Director of Finance
Dr Andrew Slater, Director of Clinical Information & Strategy

He noted that Dr David Walker would be beginning his role as Medical Director at the start of September, and thanked Drs Hughes and Slater for the work with the Board.

Mr Clayton-Smith explained that the previous 12 months had been a time of great change for the Trust, noting that the annual report covered the financial year from April 2015 to March 2016.

He explained that the annual report provided the opportunity to review what the Trust had achieved during the previous year. He explained that the Trust would not be able to provide the service it did without the support it received from the local community, and the huge amount of much appreciated support from the Leagues of Friends.

2a. Minutes

The minutes of the Annual General Meeting (AGM) held on 30th September 2015 were agreed as an accurate record.

2b. Matters Arising

There were no matters arising from the previous AGM.

3.

a) Finance

Mr Astell reported that between 2014/15 and 2015/16 the Trust's position had moved from enjoying a small surplus to having a deficit of £48million. He explained that a number of factors had led to the deficit, including the loss of income support, the loss of community services, an efficiency tariff requirement and significant operational pressures leading to an increase in agency costs. He noted that the Trust had also had to significantly increase its clinical negligence scheme contributions. He explained that £9.2 million of cost improvements were delivered during the year, and that significant investment was also made in order to improve quality and safety. He noted that cash support had been received for £35.2million during the year.

Mr Astell reported that key capital projects had been completed during the course of the year and that these had included:

- Refurbishment of the Pevensey Unit at EDGH
- Centralising health records storage
- Modernisation of inpatient facilities
- Replacement of Conquest operating tables
- Refurbishment of Conquest fluoroscopy room

Mr Astell said that significant help had been received during the course of the year from the various Leagues of Friends, explaining that the support they provided to the Trust was invaluable.

Mr Astell explained that the Trust aimed to pay 95% of invoices within 30 days, and that this position had worsened during the previous year due to the shortfall in cash that had been experienced.

He reported that the Trust's financial outlook for 2016/17 had an initial planned deficit of £48million but that a revised control total of £31.3 million had been agreed with NHSI which would require further financial improvement from the Trust before it could be realised. He explained that the Trust would have access to cash support of £31.3million during the year.

Mr Astell said that achieving the financial plan for 2016/17 would be challenging, but that the Trust was committed to delivering financial improvement. He reported that measures being introduced included extended functionality of the staff rostering system in order to improve the management of staffing requirements and a recruitment drive to reduce the Trust's reliance on agency staff. He said that the cap in agency rates, and the development of the existing staff bank, would help to provide the Trust with a more flexible workforce and that agency costs had been greatly reduced during the first quarter of 2016/17.

He reported that procurement processes within the Trust had been improved, and that the Trust had strongly engaged with the Lord Carter

productivity review and expected to see significant efficiencies delivered as a result. Mr Astell reported that work was being undertaken to try to avoid unnecessary admissions of patients and to improve patient pathways in order to reduce associated costs. He said that an unprecedented level of operational and quality measures had been addressed during 2015/16, and that the outlook for 2016/17 would remain extremely challenging.

b) Quality Account

Mrs Webster explained that the Trust's Quality Improvement Priorities were aligned to patient experience, patient safety and effectiveness. She explained that these had been chosen by listening to the views of the Trust's staff, noting a change from 2015/16 when the views of stakeholders had been used as priorities.

She explained that the 2015/16 priorities had included challenges from the CQC, and that number of those challenges had been met. She noted that work would continue on meeting all of these challenges into 2016/17.

Mrs Webster reported that the Trust had seen a significant reduction in falls during 2015/16 following the introduction of post fall reviews, greatly reducing incidents of harm to patients. She said that safer staffing monitoring of nurses was taking place to ensure that the right person was in the right place at the right time, and noted the Trust's continued focus on improving clinical effectiveness.

Mrs Webster noted that the Trust had run a very successful "Hello my name is" campaign during 2015/16, and that the campaign had made a big difference to patients. She explained that a Butterfly Scheme for patients with dementia had been introduced, ensuring that staff were more aware of the need for extra support for patients with dementia, and reported that a Dementia Care Champions Course had been very well received.

Mrs Webster reported that the Trust's priorities for 2016/17 included:

- Duty of Candour
- Outpatient appointments
- End of Life Care
- Patient and staff transport issues between sites
- Recognition and treatment of sepsis
- Medicines management
- Reduction of ward moves.

c) Overview

Dr Bull explained that he had taken up his role with the Trust in in April 2016 and so had no personal experience of the Trust in 2015/16. He said that 2015/16 had been a difficult year for the Trust, and noted how hard staff had worked in order to keep the Trust stable and lay the groundwork

for the improvements that could now be seen.

He explained that the provision of community services in High Wealds, Lewes and Haven had been lost during the year, but that the Trust continued to work alongside that CCG. Dr Bull said that the Trust's aim was to provide safe, quality services for the people of East Sussex. He noted that one of biggest challenges to the organisation was the recruitment of staff at all levels and of all types, to ensure a stable and professional workforce.

Dr Bull noted that the CQC inspections of the Trust had taken place in March 2015, with the final reports being published in September 2015, following which Trust was put into special measures. A number of weaknesses were highlighted within the reports, including the concern that the organisation was reluctant to acknowledge and own its weaknesses, and therefore to address them, and he said that the Trust had made significant progress in improving this. Dr Bull noted that there had been significant changes to the Trust at Board level, and that there would be three further executive directors appointed during the coming months, following the appointment of the new Chief Executive and Director of Finance.

Dr Bull explained that he felt that the Trust had now set out a clear goal of what needed to be done to provide a service that would give confidence to the people of East Sussex, and one where staff would be proud and happy to work. He said that key priorities had been set out for improvements in quality and safety, and the Trust would ensure that the voices of public and patients were heard when implementing new plans.

Dr Bull reported that the Trust was developing strategies for care pathways that included the entire organisation and ensured that community services appreciated their importance to the organisation. He explained that the Trust's strategy for the next five years included work that would be carried out within the Sustainability and Transformation Plan and with East Sussex Better Together (ESBT) in order to build a clear view of the shape of the organisation into the future, conducted in collaboration with key stakeholders.

He said that the Trust had worked in conjunction with social services throughout the year, and that joint locality teams had been established, under ESBT, which were led by health and social service managers to bring health and social care services together.

Dr Bull explained that the Leagues of Friends had provided support to the Trust on a large number of initiatives during the course of the year and thanked them for the help that they provided. He explained that ongoing work to increase public engagement continued and that the Trust hoped to embed a systematic programme of involvement and engagement at all levels of the organisation. He thanked Healthwatch for their support during the previous year.

Dr Bull reported that work to improve health records and clinical

administration within the Trust had taken place, noting that the clinical administration teams had undergone radical turnaround activity two years previously and explaining that resolving the issues caused by this period had taken a significant amount of time. He explained that the transition to a centralised medical record service had begun, and that staff were beginning to embrace the change. He reported that the clinical administration teams were also beginning to feel the benefit of the work taking place to rebuild the service.

Dr Bull said that the ambition of the organisation was to ensure that anyone could speak up about any issues which compromised the quality or safety of services for patients without fear, and said that he had reiterated this to the new intake of junior doctors who had started that morning. He noted that the Trust had appointed a Speak Up Guardian to help with this work.

Dr Bull explained that the Trust would continue to work hard in order to improve in a number of different areas. He explained that the Trust's 2020 strategy would continue to be embedded within the organisation, and that focus would remain on improving the Trust's finances. He noted that improved patient flow out of the organisation would help to address financial issues, explaining that it was in the best interests of patients to be discharged when they were fit to do so.

Dr Bull explained that the Trust's strategy for the next five years would focus on working more closely with primary care providers and CCGs to provide greater support for primary care. He said that the Trust would be ensuring that the population of East Sussex were put at the forefront of the organisation's thinking and said that changes would not be made to services if they were not in patients' best interests. He said that it was important that services within the major hospitals were as accessible as possible. He explained that community services needed to be linked into acute care in as seamless a fashion as possible in order to prevent deterioration of patients with long term illnesses prior to any admission to hospital.

Dr Bull explained that the CQC would be inspecting the Trust in October 2016. He said that the ambition of the Trust was to re-establish itself as an organisation in which patients had confidence and where staff were happy and proud to work. He noted that the inspection was a milestone in the Trust's improvement journey and hoped that the work that had already been undertaken to make improvements would be reflected in the outcome of the inspection. Dr Bull said that the CQC would approach staff, patients and stakeholders for their opinions on the Trust, and explained that staff would be encouraged to be open and honest about their opinions.

The Board formally adopted the Annual Report and Summary Financial Statements and Quality Account for 2015/16.

4. Questions from Members of the Public

i) Duty of Candour

Mr Campbell asked whether Duty of Candour was linked to process definition or to process ownership? Mrs Webster explained that the process was not necessarily defined by either of those factors, but noted that if a patient should fall over the incident would be investigated, and the Trust would still apologise.

ii) Big Conversations

Mr Campbell asked whether the Trust would be holding further Big Conversations in the future? Dr Bull said that he felt that the conversations had been useful, but that they would not be included in their current form in the Trust's strategy and plan for communicating with the public. He explained that the Trust was exploring different methods of ensuring that the views the public, patients and their carers could be received by the organisation.

iii) Patient Transport

Mr Campbell asked about the processes that the Trust had for informing patients about their options for patient transport. He explained that he had been unable to find information on the Trust's website. Mr Clayton-Smith noted that the criteria for eligibility for patient transport was set at a national level, and not locally. Mrs Webster agreed that the Trust needed to improve information available on website, but noted that patients could get information about patient transport from their GP. She explained that discussions had taken place within the Trust about whether information could be sent out with appointment letters to patients.

iv) Interhospital Bus Service

Mr Campbell asked whether the Trust was considering providing an interhospital bus service for patients. Mrs Webster noted that a feasibility study had been carried out, but that the results of this were not yet available. Dr Bull noted that a comprehensive transport review was being conducted by the Trust, including reviewing on-site parking, the possibility of shuttle buses from stations and whether staff could use electric pool cars to move between sites. He said that the findings would be presented to the Board as part of 2016/17's programme of work. Miss Humber noted that staff side were included in this review of transport.

v) Friends and Family Tests

Mr Campbell explained that his wife had recently been in hospital and had been given a Friends and Family Test to complete. He suggested that the Trust could station Non-Executive Directors in outpatient departments in order to encourage completion of the tests and to receive feedback directly about what patients thought of the Trust.

vi) Ambition of ESHT

Ms Walke said that she hoped that ESHT would consider extending their ambition to become the provider of choice and employee of choice throughout East Sussex. She noted that this would involve greater expenditure, but said that she felt that patients who lived in East Sussex

should be treated in East Sussex.

vii) Ambition of ESHT

Ms Walke explained that she felt that the staffing provision within the Trust had never been adequate. Mr Clayton-Smith noted that the additional expenditure on staff during 2015/16 had been due to the necessity of providing escalation beds for much of the year, and in ensuring that these were safely staffed. He said that he expected the caps on agency fees, and the introduction of weekly pay for bank staff to help to reduce staffing costs during 2016/17..

viii) Core Services

Ms Walke reiterated her desire, and that of the Save the DGH Campaign, to see core services at both of the Trust's main hospitals.

ix) Public Engagement

Ms Walke suggested that public engagement should be carried out in conjunction with the CCG in order to save money.

x) Sepsis Awareness

Ms Walke said that she was pleased about the Trust's focus on sepsis awareness.

xi) Patient Transport

Ms Walke explained that the issues that existed with patient transport were having a huge impact on patients. She said that the criteria for patient transport had not been consistently applied by the previous provider, and as a result patients who had previously been eligible for transport had now found the service had been withdrawn. Dr Bull replied that the issue was a very serious one for the organisation, and that the care of patients had been compromised as a result of the change in provider of patient transport. He reported that the Chair of the Quality and Safety Committee had formally written to the CCG to lodge the Trust's concerns.

Ms Walke asked whether the Trust would be recompensed by the CCG for their expenditure in resolving the issues, and Dr Bull replied that the costs of alternative transport would be recompensed, but that the Trust would not receive compensation for any lost revenue or time lost as a result of patients missing appointments.

5. Close of Meeting

Mr Clayton-Smith thanked everyone for their attendance at the ESHT's Annual General Meeting.

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS
NHS Trust

Quality Account

2016 - 2017

Contents

Part 1 - Introduction

Statement on Quality from the Chief Executive

I am delighted to introduce the Quality Account for East Sussex Healthcare NHS Trust (ESHT). The Account summarises the Trust's quality achievements and successes during 2016/17. It also identifies areas for further improvement and sets out our quality priorities for 2017/18.

During October 2016 ESHT was inspected by the Care Quality Commission (CQC) and assessed as "requires improvement". This was a significant improvement from the previous year when the Trust had been rated 'inadequate'. The CQC highlighted a number of areas of outstanding practice and commented that there had been a 'transformation' in culture and attitude. Surgery and theatres were upgraded from 'inadequate' to 'good'. Community Services and Medicine were already rated 'good'. The Trust was commended on its improved systems of clinical governance. The Trust overall was rated as "good" for caring and "requires improvement" for the other domains (effective, well-led, safe and responsive). Further improvement is required to resolve the patient flow through the Emergency Departments, reduce the financial deficit and become rated as 'good' at the next inspection. The decision was made to keep the trust in special measures on the basis that the improvements had not yet had time to bed-in. The CQC will re-inspect the Trust in the autumn, at which time we aim to further improve our rating.

The Trust has made good progress on the priorities set out within this Quality Account, many of which will continue within programmes over the following year.

ESHT has continued to work in partnership with the Clinical Commissioning Groups across East Sussex. The Trust has joined the partnership between local CCGs, primary care, and East Sussex County Council as part of East Sussex Better Together, in the development of an Accountable Care Organisation for the populations of Eastbourne, Hailsham and Seaford and Hastings and Rother CCGs. This represents a significant advance in the way in which services will be developed and provided for patients across the area.

The Trust's close relationship with Healthwatch East Sussex has continued to provide a valuable resource to understand patient experience when treated at the Trust. These findings are shared with the Patient Experience Group to set priority improvements each year.

ESHT maintains the desire to improve the quality and safety of care for the patients it serves through the delivery of improvement schemes and developing the workforce. There is a particular focus on ensuring that the culture and behaviours across the

Trust are fully consistent with our stated values. These behaviours make an important contribution to the safety and quality of the care that we provide, ensuring that the Trust provides and open and collaborative environment which encourages learning from events, incidents, and comments from patients and members of staff.

We have set out our goals for the next five years in The ESHT 2020 Strategy. They are challenging but achievable and progress to date is a testament to the continued hard work, commitment and compassion of colleagues across the organisation.

Dr Adrian Bull MD
Chief Executive

About us and the services we provide

East Sussex Healthcare NHS Trust employs around 6,800 committed, skilled, caring and professional staff who deliver healthcare to a population of approximately 525,000 people living within the communities of East Sussex.

Our population is spread across urban, rural and semi-rural areas which are demographically diverse, with areas of significant deprivation, health inequalities and chronic disease.

We are an integrated Trust which provides healthcare within acute and community hospitals, including various clinics from health centres, children's centres and GP surgeries. We also provide community nursing and therapy services within patients' own homes.

Our hospitals and the services provided from these are:

- **Eastbourne District General Hospital (EDGH)**
  Emergency and Urgent Care, Diagnostics and Clinical Support, Critical Care, Specialist Medicine, Surgery, Outpatients, midwifery led birthing service and short stay children's Assessment Unit

- **Conquest Hospital**
  Emergency and Urgent Care, Diagnostics and Clinical Support, Critical Care, Specialist Medicine, Surgery, Outpatients, acute child and maternity services

- **Bexhill Hospital**
  Outpatients, Day surgery, Rehabilitation and Intermediate Care and Radiology

- **Uckfield Community Hospital**
  Outpatients and Day Surgery

- **Rye, Winchelsea and District Memorial Hospital**
  Outpatients and inpatient intermediate care services

- **Firwood House**
  Inpatient Intermediate Care services jointly run with Adult Social Care (East Sussex County Council)

- **Lewes Victoria Hospital**
  Physiotherapy services

Our Vision, Strategic Objectives and Values

Our Vision

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.

Our Strategic Objectives

1. 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.

2. All ESHT's employees will be valued and respected. They will involve in decisions about the services they provide and offered the training and development that they need to fulfil their roles.

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

4. We will operate efficiently and effectively, diagnosing and treating patients in timely fashion and expediting their return to health.

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

In 2016/17 we developed a framework of objectives and actions to support us in becoming a high performing organisation. The framework encompasses five key areas of focus aligned to our strategic objectives:

- ***Quality and safety***

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

- ***Leadership and culture***

Involve our people in decisions about the services they provide and offer training and development they need to fulfil their roles. We respect and value all our employees.

- ***Clinical strategy***

Work closely with commissioners, local authorities, and other partners to prevent ill-health and to plan and deliver services that meet the needs of our local population in conjunction with other care services. We believe in working in partnership.

- ***Access to services and operational delivery***

Deliver our services efficiently and effectively, diagnosing and treating patients in a timely way to optimise their health. We all have a role to play in delivering excellence.

- ***Financial control and capital development of our facilities and infrastructure***

Use our resources efficiently and effectively for the benefit of our patients and their care, and to ensure our services are clinically, operationally, and financially sustainable. Clinical quality and financial good health go hand in hand.

Strategic plans for each clinical speciality have been developed that focus on what 'Outstanding' means for each service, how we will know we have achieved this by 2020/2021 and the opportunities and challenges that we need to prioritise to achieve this vision.

Values

People across the organisation were involved in the identification of the values which we wish to characterise the way we work. These are:

Staff Achievements and Successes

We celebrate the work of our staff in a number of ways:

- Each month we have a monthly staff/team award, which is given to an individual/team who lives the Trust values

- We have a People's Choice Award where the public can nominate an individual staff member/team

- Each year we host Our Unsung Hero event to celebrate the fabulous work of those staff working behind the scenes

- We hold an annual Trust Awards ceremony to celebrate a range of achievements of our staff. We had over 400 nominations from a range of services last year

- We have introduced 'Listening Conversation' sessions where staff get the opportunity to generate ideas to improve patient care
- Examples of good practice are shared in the Director of Nursing's weekly bulletin

- We have introduced a ‘what have you done to make a difference’ campaign which encourages all staff to reflect on a small thing they have done that has made a difference. This is shared through posters and screensavers

- We hold events such as International Nurses Day, Dignity Day and Health and Safety Roadshows to recognise the good response and share the work teams do

- We received over 1,750 letters and cards complimenting the services we provide with many more captured via the Friends and Family Test (FFT) questionnaires

- A team responsible for the development and implementation for a new one stop Swallowing Disorder Clinic led by Anita Smith has been shortlisted for two Advancing Healthcare Awards. ESHT is the only Trust in the country to be shortlisted for two awards

- The Trust’s Doctors Assistants project has been shortlisted for a national British Medical Journal Award

- Mr Raj Harshen Consultant General Surgeon and the Richard Ticehurst Surgical Unit team have been named best for surgical training across Kent, Surrey and Sussex Deanery

- We have introduced the opportunity for any staff member to thank and acknowledge the work of #ourmarvellousteams in all parts of the Trust. This is communicated via the Trust website and is included in the regular bulletins to the public and staff

Our Improvement Journey

There has been significant improvement made in the quality care we deliver since the Care Quality Commission Inspection report published in September 2015 rated the Trust as “Inadequate” overall. Our recent inspection in October 2016 showed improvements and rated us as “Requiring Improvement”, which although there is work to be done to reach the “Outstanding” rating by 2020, it is a significant improvement in a short timescale.

During the year we have developed the Quality and Safety Strategy to detail the quality improvements required to support our 2020 Strategy. This includes a number of aims and deliverables such as the development of the ward accreditation scheme and improving patient flow through the hospitals with the Red2Green Project.

To support the delivery of our 2020 strategy, governance and staffing structures were changed during the year to ensure clear monitoring, accountability, assurance, escalation and communication through Trust wide and Clinical Division structures. The clinical leadership was revised and strengthened through increasing the senior nursing and medical management within each Division. The governance structure is detailed in the Risk and Quality Delivery Strategy produced in 2016.

Improvements achieved:

- Incident reporting numbers have continued to increase with 80.3% of these as no harm or near miss which is above the national average of 73% and an indicator of a good reporting culture
- Reporting and monitoring systems were revised and enhanced to ensure robust and timely investigations with clear tracking from actions and testing they are embedded in practice
- The previous backlog on the completion of serious incidents was cleared by October 2016 and has remained within the timescales for all investigations. The quality of these investigations, subsequent findings and resultant actions has improved our learning from events
- Our complaints backlog has significantly reduced to ensure we respond to complainants in a timely manner. Feedback on how we provide services is important to us and therefore we will be continuing to improve our responses and actions to complaints. During 2016 we began to seek and record feedback from complainants on the actual process to enable us to enhance the complaints system
- Our Patient Experience Steering Group now includes four patient representatives and representation from Healthwatch East Sussex who work

with us and provide healthy challenge to patient experience information and involvement in planning improvement activities

- Specific improvement work identified through this Quality Account and the Sign up to Safety Campaign has continued to develop and improve safety, including a reduction in patient falls, reduction in hospital acquired pressure ulcers, improvements in End of Life Care Pathway and improving awareness, identification and early treatment of patients with sepsis
- The Clinical Outcomes Group and the Clinical Effectiveness Group continue to drive the reduction in mortality metrics through tracking specific clinical outcomes and investigating potential outlier conditions to provide assurance safe and effective care is being provided
- During the course of the year we have been supported by our partners Healthwatch with their Enter and View activity. This activity has been in many places but with specific focus on the following areas – Dementia, Maternity – *From special measures to Special Moments* and a look at all of our services from Outpatients to A&E over a 24 hour period – *Round the clock care*. Each visit results in a report, that makes recommendations for improvement, and also highlight good things about the service. This helps the Trust to develop services ensuring that the patient's voice is heard and the experience for patients is improved

We know there is further improvement required and that many of our new systems and structures need time to embed. However, our staff is committed to achieving this and during 2017/18 we will continue to address the plans outlined in the Quality and Safety Strategy.

One of our greatest challenges is to manage effective patient flow through the organisation to ensure the specific clinical pathway/patient journey allows timely investigation, treatment and appropriate discharge without delay to the most suitable place once the acute care has been completed. This is integral to our improvement journey, therefore we will continue to address our internal pathways and work with partner organisations to establish clear and effective admission and discharge processes and capacity.

Purpose of a Quality Account

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

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

How the report was produced

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

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

30th June 2017		Chairman
30th June 2017		Chief Executive

Part 2 - Priorities for Improvement and Statement of Assurance from the Board

Our Quality Improvement Priorities for 2017/18

Our Quality and Safety Strategy describes all the main improvement schemes we will be working on during the next three years.

We are currently developing a Quality Improvement Hub which will support the staff with improvement skills trained through NHS Elect. We started training the first cohort of staff in 2016/17 and will continue in 2017/18 with the aim of increasing improvement awareness and capacity. Our new Improvement Group will record and track the Trust improvement schemes, programmes and projects underway and will manage the prioritisation for new initiatives. This is to manage the resources available and consider unintended consequences as a result of some small improvement schemes that require minimal resource. Many initiatives will have a start and end date in 2017/18, but some will continue over a number of years.

The following describes some examples of our continuous improvement priorities and details the key priorities we will report on within the this Quality Account to demonstrate our commitment to enhancing the care our patients receive.

Continuous Improvement Priorities:

Although this account identifies new priorities detailed below there are a number of on-going quality measures the organisation will continue to address. These are as follows:

- **Harm free Care**

The NHS Patient Safety Thermometer is used where 1 day every month a Trust wide audit is undertaken on all patients on each ward to identify if they have suffered one or more harms from:

- Hospital acquired pressure ulcers
- Catheter associated urinary tract infections
- Avoidable venous thromboembolism (VTE)
- Harm from falls

It distinguishes between harms that have occurred prior to admission and those that have occurred since admission, known as ‘new harms’. The Safety Thermometer audit during 2015/16 found 94% of our patients received harm free care. Although our ultimate goal is to provide 100% harm free care, our aim in 2016/17 was to achieve 96%. We achieved 93% in 2016/17.

Our Goal: Our ultimate aim is to provide 100% harm free care to all our patients. Our target in 2017/18 is to achieve a minimum of 97% harm free care.

- **Reducing mortality**

We will continue to monitor our mortality data and ensure through our review of deaths (part of the main priorities below) that we identify and act on trends or themes in care provision. To ensure we provide safe and effective care that also relates to mortality, we track progress and effectiveness with compliance to Venous Thromboembolism (VTE), Sepsis and Acute Kidney Injury, Urinary Tract Infections, Chronic Obstructive Pulmonary disorder (COPD) and any other potential condition identified for analysis by the Clinical Outcomes Group. Our aim in 2016/17 was to reduce our Summary Hospital Mortality Indicator (SHMI) to be within the normal range. We have achieved this with the latest data based on October 15 to September 16 currently at 1.10. This now leaves the Trust within the "as expected" range. The lower limit is 0.89 and the upper limit is 1.12.

Our Goal: To reduce our Summary Hospital Mortality Indicator (SHMI) to 1.00.

- **Improving patient experience**

Understanding and acting on patient feedback is essential for the organisation to identify areas to improve care. We have systems in place to capture patient experience information but we can increase the quantity of feedback internally through the Friends and Family Test (FFT) and inpatient questionnaires.

During 2016/17 we changed our Patient Experience Steering Group to include increased patient representation and ensured regular patient experience reports were received and discussed covering all aspects from Healthwatch reviews and feedback, complaints, FFT data, Inpatient questionnaires and NHS Choices. In addition to this, we changed some of the FFT systems, and questionnaires and provided increased feedback of results to the departments to re-engage them to request feedback from patients. League tables on response rates and scores were shared at the Divisional meetings to alert managers to low and high compliance.

Our goal in 2016/17 was to increase the response rate for Accident & Emergency (A&E) and inpatient areas and the scores. Although we changed the A&E system to assist them in data collection, there has been no change in response rates (currently around 7%) but the inpatient areas has increased from 14% in April 2016 to 32% in March 2017.

Our Goal: To increase patient feedback response rates for A&E to a minimum of 12% and for inpatient areas to continually increase each month with a demanding target of 50% by the end of 2017/18.

➢ Sign up to Safety

We reviewed our Sign up to Safety Pledges and agreed to include reducing patient falls, reducing hospital acquired pressure ulcers, improving Duty of Candour compliance and improving compliance to the Sepsis 6 Care Bundle following effective screening to identify potential sepsis. For each of these areas we have produced specific measures that were and will continue to be tracked on a monthly basis. This monitoring will continue with specific improvement work conducted where required to increase compliance or reduce harm from falls or pressure ulcers.

Progress to each can be seen below:

- **Duty of Candour**

Saying sorry when things go wrong is important for the patient, their family and carers as well as supporting the Trust to learn from and improve patient safety. The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to harm.

The Trust is committed to being open and transparent when things go wrong and at the start of 2016/17 we changed the system for determining, recording and investigating moderate and serious incidents that included robust tracking for Duty of Candour. Our compliance to the system has increased significantly since last year due to an effective tracking system now in place. Our compliance by the end of March 2017 is:

- Verbal apology provided for all moderate and above harm - 85% Compliance
- Written apology provided for all moderate and above harm – 84% compliance
- Findings of investigation shared with patient or next of kin – 89% Compliance

Our Goal: We will continue to improve compliance with this requirement for 2017/18.

- **Reducing Patient Falls**

We have continued to work on reducing patient falls through the falls Group and providing training and awareness for staff. We have changed our focus to a small number of wards with higher prevalence of falls to deep dive into the main causes and work on eliminating these wherever possible.

Regular reporting will continue and the figures compared to the previous year are detailed below:

Patient falls reported in 2016/17:

- 1,837 total falls
- Falls causing harm – 556 (2 Severe, 37 moderate)
- Falls with no harm – 1,281
- 6.2 total falls per 1,000 bed days

Although still higher than we aim for, this is an improvement from 2015/16 where there were:

- 1981 total falls
- Falls causing harm – 679 (4 Severe, 31 moderate)
- Falls with no harm – 1302
- 6.7 total falls per 1000 bed days

Our Goal: Zero harm from patient falls. We aim for a reducing trend each year with a minimum target to reduce the rate of falls causing harm per 1,000 bed days from 1.9 to 1.5.

- **Pressure Ulcer Prevention**

The aim is to have zero tolerance to attributable category 3 or 4 pressure ulcers and a reduction in attributable category 2 pressure ulcers. In 2016/17 a new 'Purpose T' tool was introduced and a targeted approach to highest areas with hospital acquired pressure ulcers was taken. Also a new patient information leaflet was developed and all avoidable pressure ulcers investigated with learning shared. We surpassed the target set for a 10% reduction of grade 2 community acquired pressure ulcers and only just missed the same target for the acute acquired. For grade 3 and 4 pressure ulcers, we did not achieve our overall aim of zero but saw a significant reduction in occurrences from 73 in 2015/16 to 49 in 2016/17.

Our Goal: To continue to reduce the attributable category grade 3 and 4 pressure ulcer to reach zero and to further reduce the grade 2 pressure ulcers.

- **Sepsis awareness and reduction in harm**

Sepsis is a common but life threatening condition triggered by infection. New National Institute of HealthCare and Excellence (NICE) guidance was published in 2016, which highlighted the improved outcomes if sepsis was identified and treated early.

A sepsis screening tool which included the 'Sepsis 6 Care Bundle' was launched following a national 'Sock it to sepsis' campaign' implemented along with an education programme for clinical staff.

An audit programme has been established to monitor compliance with sepsis screening and treatment. The audit to date has shown a slow but steady improvement in compliance.

Our Goal: to continue to provide education on sepsis management and improve compliance.

In addition to our continuous improvements the following initiatives have been implemented in departments and eight have been determined as the **key Quality Improvement Priorities (QIP) for 2017/18** which are aligned to the Quality and Safety Strategy to further improve Patient Experience, Patient Safety, Clinical Effectiveness and Staff engagement and wellbeing.

Examples of Departmental Quality Improvements in 2016/17

One Stop Swallow Disorder Clinic

The Consultant Speech and Language Therapist, Anita Smith, and her team have developed and implemented a one stop swallow disorder clinic. The aim of the clinic is to facilitate the patients being seen by the professional groups during one clinic appointment rather than the five appointments they needed previously. This has significantly reduced waiting times, treatment times as well as improved patient safety and satisfaction.

The Consultant Speech and Language Therapist won a national Advancing Practice Award for Collaboration work for this innovative service.

Nurse-led Fibroscan clinic

In February 2017 a nurse-led Fibroscan clinic was started in General Outpatients, EDGH. A Health Care Assistant has been trained to use the Fibroscan and works alongside the Nurse Specialist for Hepatitis C. The Fibroscan is a non-invasive way of assessing the condition of the liver. For patients, it is a quick and painless procedure that provides immediate results. It now means that patients can potentially avoid having an invasive liver biopsy or having to travel to another hospital for a Fibroscan. A second nurse is due to be trained to provide extra resource to ensure the scans can be undertaken during periods of leave.

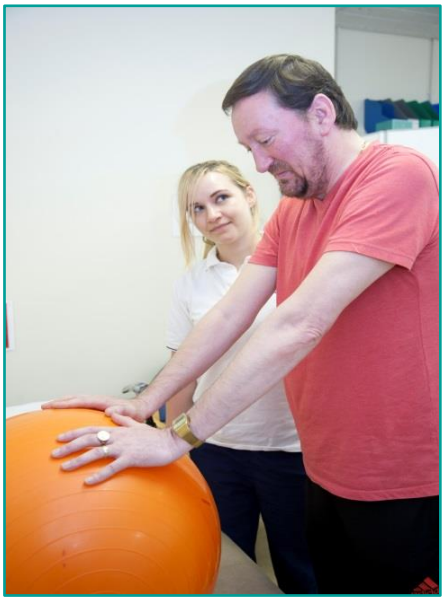
Stroke services

The Stroke services at ESHT continue to make significant progress on improving the quality since single siting the services to EDGH in 2013. The Trust participates in the Sentinel Stroke National Audit Programme (SSNAP) that collates data for 12 domains of care for stroke patients, that if achieved will contribute to improved outcomes. The latest data published is for August – November 2016 and when compared to the first audit in 2013, the following key indicators show significant improvement:

- The proportion of patients scanned within 1 hour has increased from 55.5% to 91.5%. This has led to ESHT being one of the top trusts in the country for this indicator
- Patient directly admitted to the Stroke Unit within 4 hours has improved from 71% to 87%
- The proportion of patients staying at least 90% of their stay on the Stroke Unit has risen from 87% to 99%
- Patients seen by a stroke consultant within 24 hours of admission had improved from 59% to 93% and to be seen by a stroke specialist nurse from 92% to 98%. A stroke consultant is now available 7 days a week.
- 92% of patients who are appropriate receive a swallow screen within 4 hours of admission compared to 54% in 2013

How these improvements have continued in 2016/17:

- Collaborative work with South East Coast Ambulance NHS Foundation Trust to enhance and disseminate the scanning and thrombolysis pathways across both organisations
- Implementation of a multidisciplinary team (MDT) education programme accessed by any staff working in stroke across the pathways and consisting of fortnightly ward update MDT sessions
- Formal stroke study days have been held involving MDT stroke staff across the pathway with involvement from the voluntary sector.
- Practical education sessions to help staff understand and improve their clinical knowledge on interpreting x-rays, cardiac tracings, swallowing assessments and improving communication with patients who have had their speech affected



The 8 Key Quality Improvement Priorities for 2017/18

Patient Safety

- **Introduction and development of Safety Huddles across the Trust**
- **Introduction of Departmental Accreditation Programme**
- **Learning from the review of deaths**

Clinical Effectiveness

- **Continue with the End of Life Care Improvement work**
- **To improve patient flow and reduce hospital length of stay for non-elective patients**

Patient Experience

- **Develop patient feedback forums where experiences of care can be shared**
- **To respond to all complaints within 30 days for non-complex or 45 days for complex complaints**

Staff Engagement and Wellbeing

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

An outline of each priority is given in the following section. Although the aim will remain the same during the year, the process may change and therefore associated measures may also be different from those indicated as the projects evolve.

Priority 1: Introduction and development of Safety Huddles across the Trust

Why we have chosen this priority

Conducting Safety Huddles on a daily basis in clinical areas provides a useful pause to discuss the current situation and identify key concerns or clinical status of patients between all health professionals. This improvement scheme is required as part of the Quality and Safety Strategy to deliver the 2020 plan and has already been rolled out in a number of wards. It requires further investment in time and resource to fully embed the process and culture on each ward across the Trust.

What we are going to do

- We will continue to roll out across the Trust and support the wards in conducting the Safety Huddles.
- We will assess the quality of the Safety Huddles that are taking place.

What will success look like?

- Safety Huddles will be conducted every day on every ward across both sites and in the community.
- The membership of the Safety Huddles will be multidisciplinary. Patients should notice a common approach to their care across professions so they receive constant messages about their care.
- Delays in pathways will be reduced.

How will we monitor progress?

- We will gather data on the number of wards conducting safety huddles
- The quality of huddles will be reviewed to assess attendance and points covered within basic requirements (there is a basic structure for wards to follow).

Priority 2: Introduction of Departmental Accreditation Programmes

Why we have chosen this priority?

In the past we have collected information on wards through incidents, patient feedback and audits. However, it has not been fully integrated into a user friendly dashboard for the ward teams to use in identifying areas requiring improvement. Through using the information to act and demonstrate positive change in reducing harm and improving patient and staff experience the ward will become recognised through an agreed accreditation system. This will increase staff morale, improve leadership and ultimately have more time to provide care as there will be efficiency savings through getting things right first time.

What we are going to do?

We will work with a few wards initially to design and develop the accreditation scheme through establishing a user friendly dashboard containing core measures, an accreditation scheme and ensure clear leadership capabilities with support provided where required. Each of these stages will be reviewed once trialled and adapted prior to rolling out to other wards.

What will success look like?

- There will be a completed dashboard with a clear accreditation process in place with 10 wards on the scheme by the end of March 2018
- Wards should achieve a constant high standard across the Trust

How will we monitor progress?

- We will track the milestones for the project through the Improvement Group and the number of wards commencing the scheme.
- We will review the benefits and effects of the wards on the scheme through reduced incidents causing harm, reduction in complaints, improved patient experience with increased FFT response rates and scores.
- As part of the design, measures will be developed further with the wards involved.

Priority 3: Learning from the review of deaths

Why we have chosen this priority

Although we currently have a system in place for recording and reviewing the care and treatment of all deaths at ESHT we want to improve this by ensuring we are listening to relatives and those closest to the deceased if they have raised concerns, and aligning our policy and processes to meet the recommendations outlined by the National Guidance on Learning from Deaths.

It is important that we learn from any care provided to patients that could have been improved. We already identify and act on cases following reported incidents, complaints, claims, inquests or clinical audit. However, there could be learning that has not been raised through these routes such as following an unexpected death of a patient. Relatives or others closest to the deceased patient may have raised concerns about the care provided or the condition resulting in the death could be one causing higher mortality rates and therefore requires further exploration.

What we are going to do?

Align the Trust Morbidity and Mortality policy and associated processes with National Guidance and implement these for all Inpatient deaths. This will include:

- Listen to concerns raised at the time of death or immediately after and conduct a review;
- Review deaths using the new recommended national review tool produced by the Royal Colleges;
- Provide regular reporting on deaths and learning from them to the Trust Board
- Improve the timeliness of reviewing deaths:
- Review deaths for all conditions or patient groups recommended by the Care Quality Commission or identified by our own monitoring and governance processes.

What will success look like?

- A revised policy will be developed by September 2017 which meets the national requirements. Deaths will be reviewed within three months of the month of death.

How will we monitor progress?

Progress of the improvements and the new processes will be monitored through the Trust Clinical Outcomes Group including the percentage of deaths reviewed within one month.

Priority 4: Continue with the End of Life Care Improvement work

Why we have chosen this priority?

ESHT is committed to improving End of Life Care (EoLC) and ensuring people and their families are able to access the care they need, and being supported to die with dignity in their preferred setting of care.
During 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.
However, we acknowledge that further improvement is required and this has been highlighted by the CQC visits to ESHT. Therefore, an improvement plan is being taken forward by our project management governance structure. The aim is that:

- Adults approaching End of Life will have access to consistent care that meets the national best practice standards
- We will reduce unwarranted variation in care delivery across ESHT for people approaching End of Life and/or requiring specialist palliative care

What we are going to do?

We are developing a new five year strategy that will set out the vision and direction for EoLC services. It will integrate the latest national guidance and the key themes from the strategy. It is imperative that this strategy is developed with users and so we shall be consulting with the public in forums to establish how they would like to see EoLC services improved.
In 2017/18 we will focus on improving the acute services and strengthen relationships with community services to plan how to align them in the future.
We will be utilising the 'Ambitions for Palliative and End of Life Car: a national framework for local action 2015-2020' to support the approach we are taking and set clear plans for improvement.
There will also be a focus on workforce and education to support healthcare professionals who have a responsibility for EoLC.

What will success look like?

- **We will know who is in the last days or hours of life ensuring appropriate care can be given**
- **We will see an improvement across the year with all patients who are in the last days or hours of life having a clearly identifiable individualised plan of care**
- **We will understand patients and relatives views in relation to the experience of EoLC services at ESHT through the 'Voices' survey**
- **We will track progress against the six ambitions set out in the national**

framework for Palliative and EoLC

- **All patients who expressed a desire for spiritual support will have been seen by chaplain**
- **There will be a mechanism in place for ensuring the patient's wishes for a preferred place of care is achieved**
- **All nursing staff will have attended the 'Care of the dying' Programme**
- **Implementation of a flowchart aimed at reducing variation in access to local hospice services**
- **Learning from complaints and incidents associated with EoLC can be demonstrated**

How will we monitor progress?

- An audit programme will be established that will cover aspects such as:
  - Compliance against national standards for EoLC
  - Audit of Do Not Resuscitate Request forms completed
  - Compliance with spiritual needs
- Key Performance Indicators will be developed alongside the project plans

Priority 5: To improve patient flow and reduce the hospital length of stay for non-elective patients

Why we have chosen this priority

We have chosen this priority to support improved patient flow throughout the Trust, and have initiated a Discharge Improvement workstream as part of the Trust's Urgent and Emergency Care Project. Also aiming to improve the hospital's effectiveness, patient benefits and meet the 4 hour A&E standard.

The aim is to deliver improvements in discharge planning and process which include;

- Implementation of Red2Green (SAFER patient flow bundle) – a standardised way of managing patient flow through hospitals
- Implementation of revised discharge process and procedures
- Development of a discharge to assess model of care
- Development of Integrated Discharge Teams

What we are going to do?

- **Red2Green**

We are rolling out the SAFER patient bundle flows across all adult inpatient wards (excluding maternity) in all acute and community settings under the branding of Red2Green by 31st July 2017. The SAFER patient flow bundle is a practical tool which provides a set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients. The SAFER patient flow bundle works particularly well when it is used in conjunction with the red and green days approach.

Discharge Process and Procedures

A Discharge Procedures, Pathways and Policy Group has been established and it will be reviewing the policies and clinical pathways. A workplan will be implemented that will include a review of the usage of the discharge lounge and the 'Let's get you home' policy.

- **Discharge to Assess and Integrated Discharge Teams**

The working group is reviewing various models of delivery in order to provide a recommendation on the model to be implemented together with implementation plan by 31st July 2017.

What will success look like?

- Discharges will be appropriately planned with an increased number taking place before midday and with increased use of the Discharge Lounge
- Length of stay and delayed transfers of care will be reduced and support improved patient flow

How will we monitor progress?

A weekly urgent care performance report is being developed which will measure the following in respect of patient flow:

- Average length of stay (target reduction)
- Number of stranded patients, i.e. those patients whose stay in hospital is over 7 days (target reduction)
- Number of patients whose Expected Date of Discharge is more than 2 days (target reduction)
- Number of patients discharged before midday (target 33%)

In addition, as part of Red2Green, further Key Performance Indicators are being measured at a ward level via an audit tool.

Priority 6: Develop patient feedback forums where experiences of care can be shared

Why we have chosen this priority

We have made improvements with our Patient Experience Steering Group to involve more patient representatives and have continued our close relationship with Healthwatch East Sussex, but we are seeking to involve public and patients more in shaping and designing our services such as quality improvement schemes and pathways. This will provide us with external insights and enable patient views to be part of any change.

What we are going to do?

We will produce a Public and Patient Engagement Strategy outlining how we will deliver this priority and in addition we will set up forums during the year to scope new initiatives such as the ward accreditation project.

What will success look like?

- There will be a strategy in place and public/patient voice and views incorporated into quality improvement

How will we monitor progress?

We will monitor the number of public/patient forums that have taken place for new designs and the number that have taken place to provide feedback on current services.

Priority 7: To respond to all complaints within 30 days for non-complex or 45 days for complex complaints

Why we have chosen this priority

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 remains a backlog of complaints that have become overdue and although this has decreased considerably we want 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.

What we are going to do?

We will continue to embed the new complaints process and will revisit the improvements already made to ensure they are effective and embedded. We will ensure that new actions are specific, have a person responsible for completing the action identified and a timescale.

There will be deep dive sessions into the complaints themes with each division to identify common sub themes with the aim of developing action plans to improve.

What will success look like?

- There will be no more than 5 overdue complaints in the system for any month. This will demonstrate that the system is fully embedded and working effectively. Although we would like no overdue complaints due to the complexity and at times the need to work with other organisations, there will at times be a delay.
- We will have less than 100 actions in the system by the end of March 2018 as this will provide assurance we are acting swiftly on findings from the complaint.

How will we monitor progress?

We will continue to monitor and record progress through monthly key performance indicators. Overdue complaint actions will be reported to each Division's Governance Meeting to ensure they are followed up and completed. Specific measures will be:

- Number of overdue formal complaints
- Number of formal complaints reported per month
- Number of outstanding actions on Datix.

Priority 8: To identify and improve three corporate priorities highlighted in the National Staff survey to ensure ESHT is a good place to work

Why we have chosen this priority

We believe that by ensuring that 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/experience. Following analysis of the National Staff Survey, the following corporate priorities have been identified:

1. To reduce the number of staff experiencing bullying and harassment
2. To continue to improve good communication between management and staff
3. To continue to develop ESHT as a good place to work and that patient care is the organisation's top priority

What we are going to do?

- Develop a staff engagement action plan that will focus on the three corporate priorities
- Establish a health and wellbeing programme to support both the physical and psychological needs of staff
- Further embed the values and behaviours expected through the introduction of a behavioural framework
- Continue to promote the role of the Speak Up Guardian
- Complete the Management Essentials programme and introduce management induction programme so that all new managers are clear of our expectations of them.

What will success look like?

- Improvement in the staff survey results with agreed targets
- The continued development of a culture where staff feel engaged
- Staff feel they have adequate resources to do their job
- Staff enjoy coming to work and seeing the difference they make to the people who use our services.

How will we monitor progress?

- Regular pulse and staff FFT surveys
- Informal staff feedback through the Quality Walks and External visits
- Reviewing the themes raised by the Speak Up Guardian.

Statement of assurance from the board

Review of Services

During 2016/17 the East Sussex Healthcare NHS Trust provided and/or sub-contracted 65 NHS services.

The East Sussex Healthcare NHS Trust has reviewed all the data available to them on the quality of care in all 65 of these NHS services.

The income generated by the NHS services reviewed in 2016/17 represents 100% of the total income generated from the provision of NHS services by the East Sussex Healthcare NHS Trust for 2016/17.

Clinical Audit

Quality Improvement snapshot reviews are undertaken by the Clinical Effectiveness Team on a monthly basis. These reviews assess the improvements that have taken place following a clinical audit, highlighting the changes that have been made and flagging up any remaining risks for escalation.

Aims of the Quality Improvement Reviews:

To assess and review the completeness of clinical audit action plans, ensuring actions have been fully embedded in practice;

To provide evidence of robust implementation and track continuous improvement in patient care;

To identify any areas of non-compliance or concern to the appropriate speciality or division for monitoring and further actions as appropriate;

To mitigate any identified risks to patient and staff safety, sharing lessons learnt across the Trust.

National Clinical Audit and National Confidential Enquiries

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust was eligible to participate in during 2016-2017 are as follows:

National Confidential Enquiries (NCE)

The Trust participated in 100% of applicable National Confidential Enquiries in 2016-2017

	National Confidential Enquiries	ESHT Eligible	ESHT Participation
1	Maternal infant and perinatal mortality (MBRRACE-UK)	**Y**	**Y**
2	Acute Pancreatitis (NCEPOD)	**Y**	**Y**
3	Physical and Mental Healthcare (NCEPOD)	**Y**	**Y**
4	Non-invasive Ventilation (NCEPOD)	**Y**	**Y**
5	Young Peoples Mental Health (NCEPOD)	**Y**	**Y**

6	Chronic Neuro-disability (NCEPOD)	**Y**	**Y**
7	Cancer in Children, Teens and Young Adults (NCEPOD)	**Y**	**Y**

National Clinical Audit

The Trust participated in 98% of all applicable National Clinical Audits / Audit programmes in 2016-2017.

	National Clinical Audit	ESHT Eligible	ESHT Participation
1	Neonatal Intensive and Special Care (NNAP)	**Y**	**Y**
2	Falls and Fragility Fractures Audit Programme (FFFAP)	**Y**	**Y**
3	Adult Critical Care Audit (Case mix programme - ICNARC)	**Y**	**Y**
4	National Joint Registry (NJR)	**Y**	**Y**
5	Bowel Cancer Audit (NBCA)	**Y**	**Y**
6	National Audit of Breast Cancer in Older Patients (NABCOP)	**Y**	**Y**
7	National Prostate Cancer Audit	**Y**	**Y**
8	National Lung Cancer Audit (NLCA)	**Y**	**Y**
9	National Oesophago-gastric Cancer Audit (NOGCA)	**Y**	**Y**
10	Head and Neck Cancer Audit (DAHNO) / HANA	**Y**	**Y**
11	Major Trauma (TARN)	**Y**	**Y**
12	Coronary Angioplasty / PCI	**Y**	**Y**
13	Cardiac Rhythm Management (CRM)	**Y**	**Y**
14	National Heart Failure Audit	**Y**	**Y**
15	Acute Coronary Syndrome / Acute MI Audit (MINAP)	**Y**	**Y**
16	National Cardiac Arrest Audit (NCAA)	**Y**	**Y**
17	National Inflammatory Bowel Disease Audit	**Y**	**Y**
18	National Emergency Laparotomy Audit (NELA)	**Y**	**Y**
19	National Paediatric Diabetes Audit (NPDA)	**Y**	**Y**
20	National Pregnancy in Diabetes (NPID) Audit	**Y**	**Y**
21	National Adult Diabetes Inpatient Audit (NADIA)	**Y**	**Y**
22	National Diabetes Foot Care Audit (NDFA)	**Y**	**Y**
23	National Diabetes Adult Audit	**Y**	**N**
24	Stroke National Audit (SSNAP)	**Y**	**Y**
25	National Audit of Dementia	**Y**	**Y**
26	Elective Surgery (National PROMs Programme)	**Y**	**Y**
27	Adult Asthma	**Y**	**Y**

28	National COPD Audit Programme	**Y**	**Y**
29	Paediatric Pneumonia	**Y**	**Y**
30	National Maternity and Perinatal Audit (NMPA)	**Y**	**Y**
31	National Comparative Audit of Blood Transfusion Programme	**Y**	**Y**
32	Asthma care in Emergency Departments	**Y**	**Y**
33	Severe Sepsis and Septic Shock care in Emergency Departments	**Y**	**Y**
34	National Ophthalmology Audit	**Y**	**Y**
35	Serious Hazards of Transfusion (SHOT)	**Y**	**Y**
36	British Society of Urological Surgeons (BAUS) – Cystectomy Audit	**Y**	**Y**
37	British Society of Urological Surgeons (BAUS) – Nephrectomy Audit	**Y**	**Y**
38	British Society of Urological Surgeons (BAUS) – Radical Prostatectomy Audit	**Y**	**Y**
39	British Society of Urological Surgeons (BAUS) – PCNL Audit	**Y**	**Y**
40	British Society of Urological Surgeons (BAUS) – Stress Urinary Incontinence Audit	**Y**	**Y**
41	British Society of Urological Surgeons (BAUS) – Urethroplasty Audit	**Y**	**Y**
42	Endocrine and Thyroid National Audit	**Y**	**Y**
43	British Society of Urogynaecology Audit Database	**Y**	**Y**

- **National Adults Diabetes Audit - Reason for non-participation by ESHT**

The Trust was unable to participate in the 2016-2017 National Adult Diabetes Audit as the Diabetes Department do not have the required specialist software. The Trust considers participation in this national audit a priority and as a result the Trust is now in a position to participate in the National Audit.

NCEPOD issued two reports in 2016/2017:

'Acute Pancreatitis: Treat the Cause' was published in June 2016.
18 recommendations were made by NCEPOD; the Trust is in the process of reviewing these recommendations against current process to assess compliance. Remedial action plans will be developed where non-compliance has been identified.

'Mental Health in General Hospitals Treat as One' was published in January 2017.
21 recommendations were made by NCEPOD; the Trust is in the process of reviewing these recommendations against current process to assess compliance. Remedial action plans will be developed where non-compliance has been identified.

MBRRACE-UK: Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (the current definitions are as follows)

The Women's Health Division continues to report:

- All late foetal losses between 22+0 - 23+6 weeks gestation.
- Terminations of pregnancy – resulting in a pregnancy outcome from 22+0 weeks gestation onwards.
- Stillbirths - the baby is delivered showing no signs of life after 24+0 of pregnancy
- Neonatal deaths - 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) occurring 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 Division contributes, where possible, to their studies. The studies undertaken during the period 2016-17 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)

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust participated in, *and for which data collection was completed during 2016-17*, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title	Number of Cases submitted	% submitted of those required (where requested)
Adult Asthma	11 cases Conquest 5 cases EDGH	100% Conquest 100% EDGH (All eligible cases submitted)
National Adult Diabetes Inpatient Audit	58 cases Conquest 56 cases EDGH	100% Conquest 100% EDGH (All eligible cases submitted)
National Paediatric Diabetes Audit	111 cases Conquest	100% Conquest
National Pregnancy in Diabetes Audit	14 cases Conquest	100 % Conquest
National Audit of Dementia	50 cases Conquest 53 cases EDGH	100% Conquest 100% EDGH
Asthma Care in Emergency Departments	100 cases Conquest 69 cases EDGH	100% Conquest 69% EDGH
Severe Sepsis and Septic Shock – care in Emergency Departments	100 cases Conquest 126 cases EDGH	100% Conquest 100% EDGH
National Comparative Audit of Red Cells and Platelets in Adult Haematology Patients	25 cases Conquest 33 cases EDGH	100% Conquest 100% EDGH

National Comparative Audit of Patient Blood Management in Scheduled Surgery	34 cases Conquest 11 cases EDGH	100% Conquest 100% EDGH
Mental Health in General Hospitals - NCEPOD	7 x Clinical Questionnaires 9 x Case Notes 3 x Organisational Questionnaires	78% of required Clinical Questionnaires 100% of required Case Notes 100% of required Organisational Questionnaires
Non-Invasive Ventilation - NCEPOD	4 x Clinical Questionnaires 5 x Case Notes 2 x Organisational Questionnaires	80% of required Clinical Questionnaires 100% of required Case Notes 100% of required Organisational Questionnaires

The reports of 32 national clinical audits were reviewed by the provider in 2016/17.

Six of these 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:

British Thoracic Society Royal College of Physicians	**Pulmonary Rehabilitation (National COPD Audit)**

Overview

The National Pulmonary Rehabilitation Audit is run by the National COPD Audit Programme and provides a comprehensive overview of Pulmonary Rehabilitation (PR) service provision and treatment outcomes across England and Wales. This is the first time PR services have been audited at a national level. All patients with a primary diagnosis of COPD who attended an initial assessment for PR were included in the audit.

Identified recommendations:

- There is a need for greater awareness of the benefits of PR in primary and secondary care.
- Commissioners and providers should ensure that all patients receive an offer to start PR treatment within the recommended 3 months following their referral
- Cohort programmes particularly should address how waiting times are managed

- Referrers and patients should be provided with up-to-date and clear written information about the benefits of attending and completing PR.

ESHT Action plan:

- ESHT PR leaflet – completed
- Yearly financial PR plan – completed
- Maintaining accurate ESHT PR database – on going
- Work collaboratively with the Kent, Surrey and Sussex PR Network Group – on going
- Regular updates and meetings held with the CCG's, Service Managers, Consultant Lead and PR lead - on going.

National Heart Failure Audit

Overview

The National Heart Failure Audit collects data on patients with an unscheduled admission to hospital in England and Wales who are discharged with a primary diagnosis of heart failure.

The audit aims to drive up the quality of the diagnosis, treatment and management of heart failure by collecting, analysing and disseminating data, and eventually to improve mortality and morbidity outcomes for heart failure patients.

Lessons Learnt

- If you identify a patient with heart failure you must bleep the specialist nurse.
- Best practise is to do an echo within 48 hours of admission.

ESHT Actions following the audit

- Laminated posters are now displayed on each ward and include contact details for the heart failure specialist team, making referrals quick and easy for staff.
- B-type natiuretic peptide (BNP) tests are only good if the patient has no history of heart failure; it is not a useful test if the patient is in Atrial Fibrillation.
- Need to identify heart failure as soon as possible in front line Medical Admission Unit.

Procedural Sedation in Adults

Overview

The delivery of safe sedation is a key component of the skill-set of any emergency medicine physician, the audit was designed to drive clinical practice forward by helping clinicians examine the work they do day-to-day and benchmark against their peers but also recognise excellence.

Lessons Learnt

Clear and accurate documentation is key – all staff must be aware of the importance of good documentation (it is considered that poor documentation impacted on the results of

this audit).

Recommendations / Actions to take forward

- All staff giving sedation should attend Safe Sedation training.
- The Trust should now investigate and address the reasons why sedations are being performed outside of the resuscitation room or rooms with dedicated resuscitation facilities.
- A pro-forma should be used for procedural sedation and analgesia (PSA) as a checklist and as a record of the procedure. A safe sedation pro-forma has been developed by RCEM and the department must implement this (or develop a local version) prior to the re-audit.
- The sedation pro-forma should be stored with the drugs; doctors shouldn't be able to access the drugs without completing the pro-forma.
- Ensure that the recommendations for Emergency Department sedation described in *Safe Sedation of Adults in the Emergency Department* (RCoA and RCEM, Nov 2012) are met and adhered to.
- Emergency Department clinicians must ensure adequate documentation of pre-procedural assessment and of patients' informed consent.
- Emergency Department clinicians must ensure adequate documentation of monitoring during procedural sedation and that an accurate record of the event is completed.
- Emergency Department clinicians must ensure adequate documentation of formal assessment of suitability for discharge.
- Hospitals must support adverse event recording using the World Society of Intravenous Anaesthesia (*SIVA*) reporting tool.
- Network / link with other trusts to share ideas and review practice.

Progress of actions:

All actions have been completed.

BASHH

British HIV Association BHIVA

The British Association for Sexual Health and HIV (BASHH) 2016 national audit: Sexually Transmitted Infection (STI)/Human Immunodeficiency Virus (HIV) screening and risk assessment

Overview

STIs and HIV, although preventable, present an individual and a population health problem, with high clinical, psychosocial, and economic costs. There are marked inequalities in the distribution of these infections across the life-course and between different ethnic groups, sexual orientations, and geographic locations. This national pilot audit was conducted with the aim of improving patient outcomes and reducing STI and HIV transmissions, specifically:

- Limit the impact and transmission of STIs
- Mitigate against the development of antimicrobial resistant gonorrhoea

- Reduce late diagnosis of HIV

ESHT Actions / response following the audit

- Local training for all clinical staff to use the appropriate electronic template for all new attendees for sexual health episodes where the offer of STI testing recording continues to be mandatory. In addition we further plan to add a mandatory field within the 'general template' that asks "STI screen required – yes/no".
- Enquiries about chemsex and other high risk practices are now built into the electronic 'male template'.
- Awareness and training for all clinical staff about chemsex has been arranged.
- All clinical staff are able to offer fingerprick point of care HIV testing, the electronic templates have been adapted to include as a mandatory field the offer of an HIV test, reason for refusal and whether or not the patient was offered a point of care test.
- HIV testing updates to be provided as part of rolling programme of clinician education.

National Hip Fracture Database (NHFD)

Overview

The NHFD is a national clinical audit project and part of the Falls and Fragility Fracture Audit Programme (FFFAP). It allows care to be audited against six evidence-based standards on the care of patients with fragility fracture; and enables local health economies to benchmark their performance in hip fracture care against national data.

Lessons Learnt

The Conquest Hospital is performing well compared to the national average for best practice; however the 30 day mortality rate is around 8-9% and needs to be improved. Overall, Trust mortality has improved over the past 5 years however the Department must be flexible and manage resources appropriately.

Actions

- The Trust's NHFD Lead encourages staff to get involved with the audit – staff should contact him if they require any further information / data access etc.
- The Trust has now appointed a new Ortho-geriatrician who will work closely with the Department; a focus will be placed on improving these results.

7 Day Services Audit

Providing a consistent 7 day a week NHS for emergency patients has been identified by Sir Bruce Keogh and supported by the Academy of Medical Royal Colleges as a significant means of improving the quality and safety of healthcare. Patients should get the same high quality, safe care on a Saturday and Sunday as they do on a weekday. This means having enough consultants available to assess and review patients, providing access to important diagnostic tests and ensuring that consultants are there to make crucial clinical judgements.

NHS England led a nationwide audit in 2016 to assess Trust compliance against ten key

'7 day service' core standards.

ESHT Actions / recommendations following the audit

- The Divisions must note the results of the audit and incorporate compliance with the priority standards into their strategic work plan. Networking with neighbouring Trusts would be beneficial.
- Emphasis should be placed on accurate documentation, clearly stating that a consultant review has occurred, the time of that review and comment on what was discussed with the patient or relatives.
- Job plans should be reviewed to ensure that review of emergency patients within 14 hours of admission and daily thereafter is possible.
- The rapid roll-out of the SAFER programme across the Trust will support several aspects of the 7 day working standards (notably 3, 8 and 9).
- Consideration should be given to expressly stating in the notes if appropriate that "no further consultant review is required unless clinical condition changes".
- It must be recorded in the notes that treatment has been discussed with the patient and carers/family where appropriate.
- Consideration should be given to implementing an electronic white board system in Medical Admissions Unit/Surgical Admissions Unit to enable easier identification of admitted patients, and recording of when they have been reviewed.
- Clear and readily available information on how to access those diagnostic services currently perceived as unavailable at the weekend/out of hours would increase their accessibility.
- The 7 day working steering group acts as a multidisciplinary oversight group to deal with cross-cutting issues.
- A resource needs to be identified to conduct future rounds of the Audit.

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.

171 local clinical audit reports were reviewed by the Trust in 2016-17. Five of these local 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:

Endocrinology: Use of Variable Rate Insulin Infusion (VRII) in Pregnant Women with Diabetes (3728)

Background / Aims:

This audit was carried out to observe peripartum control of diabetes with the use of "Variable Rate Insulin Infusion", to reduce the risk of neonatal hypoglycemia which is associated with poorly controlled maternal hyperglycemia in labour. The NICE guidelines recommend that the capillary blood glucose of labouring diabetic women should be maintained between 4-7

mmol/L. ESHT department protocol is to initiate insulin infusion if capillary blood glucose (CBG) is >7 mmol/L, which is monitored hourly.
The aim of this audit is to assess compliance with our local protocol, assess blood glucose control during labour, and ensure appropriate use of variable rate insulin infusion during labour and incidences of neonatal hypoglycemia.

Lessons Learnt:

- Insulin infusion is likely to prevent neonatal hypoglycemia.
- Clear and accurate documentation is essential.
- Retrospective audits pose a problem with attaining files and notes – takes longer to undertake.
- If any risk factors are recognised (at any time) a patient should have a Glucose Tolerance Test (GTT). A repeat GTT should be performed if there are any concerns - if results show glucose++ repeat the GTT, but if another 'new' risk factor appears seek advice from the Consultant.

Recommendations / Actions following the audit:

- Conduct teaching sessions on Capillary Blood Glucose (CBG) monitoring and starting VRII. -
- Develop and implement a sticker to flag diabetic team visits.
- Develop and implement a sticker or form for hourly CBG monitoring.
- Update Diabetes guidelines – these will need to be reviewed by all staff as there is a change in the diagnostic criteria.
- Re-audit

Progress of actions:

All actions have been completed with the exception of the stickers. The re-audit is currently being completed.

Radiology: MRI Accuracy in Staging of Prostate Cancer (3931)

Background / Aims:

This audit was recommended by the Urology Tumour Group for quality assurance purposes to assess local Magnetic Resonance Imaging (MRI) accuracy in the staging of prostate cancer by comparing with the histological stage following radical prostatectomy.

Lessons Learnt:

A retrospective review of images showed missed findings in 8% of cases, mostly regarding seminal vesicle invasion and misinterpretation of normal central zone of the prostate for T3a/b disease.
Focal or microscopic extracapsular extension that cannot be detected on MRI appears to play a significant role.
Bad image quality/post biopsy haemorrhage and increased time interval between MRI and radical prostatectomy (>6 months) contributed little to the final results.

Recommendations:

- Regarding MRI protocol: repeat sequences where movement artefact is present, consider emptying rectum prior to examination.
- Regarding MRI reporting: alert reporting radiologists to pitfalls in mpMRI imaging of the

prostate, careful evaluation for Seminal Vescicle invasion in all sequences, ensure up to date training as concepts in mpMRI of the prostate are continuously evolving.

- Re audit in 1 year.

Trust-Wide: Annual Audit of Consent (3729)

Background / Aims:

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore essential to all forms of health care, from provision of personal care to undertaking major surgery. Seeking consent is also a common courtesy between a patient and health professional.

For written consent to be valid a patient needs to have been given: time to understand the procedure, the risks and benefits of the procedure, written information, and the opportunity to ask questions and consider options.

Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is evidence that the patient has given consent, but is not proof of valid consent.

Lessons Learnt:

Clear, concise and detailed documentation is key for the Consent process to be meaningful and to ensure the patient is fully informed prior to the procedure.

Recommendations / Actions following the audit:

To review all areas where the audit team considered there was concern, as below:

- A review of the recording of leaflet provision and ensure this decision is communicated to all staff.
- To review the training programme and update staff currently trained to consent patients in order to ensure staff are clear that consent must be confirmed and that patients must retain a copy of their consent form.
- To ensure staff who take consent are aware that risks and benefits must be recorded on the consent form or signposted on the form to where they are recorded within the patients personal records.
- Staff to be reminded not to use abbreviations within the consenting process and the reasons behind this.
- A regular programme of audits needs to be developed.

Progress of actions:

Audit report is currently being drafted along with the action plan.

Trust-Wide: Audit to review staff knowledge and practice in regards to the Mental Capacity Act and Deprivation of Liberties (3693)

Background / Aims:

This was a baseline audit to assess staff competence with recording care given to patients in relation to Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLs).

The objectives of this audit were to:

1. To raise staff awareness of MCA and DoLs requirements as well as learn from any deficiencies identified as a result of the audit, ensuring that staff have support to address action plans arising from the audit.
2. To demonstrate evidence of MCA implementation for both Care Quality Commission (CQC)

and NHS Litigation Authority (NHSLA).
3. To enable staff to find out how effectively they are meeting the standards set by legislation, Professional bodies and Trust's policies and procedures relating to MCA Patient Documentation and Record Keeping.

Lessons Learnt:

Documentation and evidence of decision specific testing is still poor, there has been no real improvement since the last audit was undertaken. Robust action and implementation of identified recommendations is now required to drive improvements forward.
Staff receive regular MCA and DoLs training however there needs to be a method of regular re-enforcement.

Recommendations / Actions following the audit:

- More robust documentation is required around specific decisions and interventions so that there is greater clarity.
- Review of a patient's mental capacity must be ongoing and documented as such.
- The audit has uncovered a disconnect between training and practice, the Safeguarding Team now need to consider alternative training methods to bridge this gap.
- Increase ward visibility from the Safeguarding Team to help educate staff 'on the job'.

Progress of actions:

- MCA/DoLs training is now a mandatory three yearly requirement. Workbooks have been designed to assist with this as well as an e-learning package. They were launched in April 2017, initially targeting matrons with a plan to roll out to other staff;
- The DoLs Care plan has been reviewed and is being trialled with a new DoLs authorisation. This care plan will be mandatory when caring for a patient with a DoLs authorisation;
- The Safeguarding team visit wards/departments/units with offers to advise or debrief on cases relevant to the ward/area.

General Surgery / Anaesthetics: IV Fluid Audit – Is prescribed, goal directed fluid therapy being given appropriately to inpatients? (3628)

Background / Aims:

Intravenous (IV) fluid prescribing is often performed by the most junior members of the medical team; some studies suggest 90% of the time. NICE introduced guidelines for fluid prescribing in December 2013; these were produced on the back of the NCEPOD report (1999) that revealed the majority of fluid prescribed outside theatres and critical care was inappropriate in type and volume. It is likely that as many as 1 in 5 patients on IV fluids suffer complications or morbidity due to their inappropriate administration.

Recommendations / Actions following the audit:

- Several education sessions were conducted by all participants of this audit. These sessions were mostly directed to junior doctors. Flow charts were created to summarise the goal directed fluid therapy protocol as per NICE guidelines and made available in doctors folders on the wards. A sticker was produced to encourage documentation on the drug chart.
- To incorporate training in induction for all junior doctors

Woman's Health: Re-audit of the management of severe hypertension, pre-eclampsia and eclampsia (3740)

Background / Aims:

The incidence of eclampsia and its complications has decreased significantly in the UK since 1992 following the introduction of management guidelines for eclampsia and pre-eclampsia. From 2006 - 2008 22 women died from pre-eclampsia in the UK (CMACE 2011). Of these deaths, 20 demonstrated substandard care; in 14 of these deaths this was classed as major – these were avoidable deaths.

Pre-eclampsia management was flagged up as an area of concern by the CQC, therefore this audit was highlighted as a way in which the Trust could review current practice and identify recommendations for improvement as necessary.

Lessons Learnt

- There needs to be increased senior Obstetric involvement in the care of women with severe pre-eclampsia.
- Staff need to be reminded and educated on the necessity of following the guidelines in blood pressure monitoring, fluid management and documentation in Modified Early Obstetric Warning Score (MEOWS) charts.

Recommendations

The criteria for considering women to have severe pre-eclampsia is not well defined, hence it is possible that there has been an overestimation of cases for this audit. The guidelines need to be reworded to provide clarity - if a women meets the criteria as outlined in the guideline they should immediately be discussed with the Consultant on call and a plan should be documented in the case-notes

Actions

- Guidelines need to be closely followed in blood pressure monitoring, fluid management and use of the MEOWS chart in women identified to have severe pre-eclampsia – Divisional Management to write to doctors and midwives and inform of the results of the audit, reinforcing the need to follow the guidelines closely.
- Women on Magnesium Sulphate to have monitoring including reflex checks as per the guideline – Consultant Lead to arrange a joint teaching session on diagnosis and management of pre-eclampsia and a presentation of guideline.

Progress of actions:

Audit results have been presented to midwives to increase awareness and there is some evidence that compliance with guidance has improved. Considering another audit cycle to formally assess this.

Commissioning for Quality and Innovation (CQUIN)

East Sussex Healthcare NHS Trust like all NHS trusts, are required to make a proportion of their income conditional on achieving quality improvement and innovation goals, through the Commissioning for Quality and Innovation (CQUIN) payment framework. The baseline value for CQUIN is 2.5% of contract values which is approximately £7.1 million. If milestones and goals are not fully achieved a proportion of CQUIN monies would be withheld. During 2015/16 East Sussex Healthcare NHS Trust undertook four national schemes, nine locally agreed schemes with commissioners and eight specialised service schemes agreed with NHS England.

Further details of the agreed goals for these schemes for 15/16 and the following 12 month period are available on request from the Trust.

	Scheme	Value	Milestones Achieved
National CQUIN	1. Physical Health – Acute Kidney Injury	£716,766	Achieved
	2a. Sepsis Screening	£358,383	Partial achievement
	2b. Antibiotic administration	£358,383	Partial achievement
	3a. Dementia FAIRI	£238,684	Achieved
	3b. Dementia Training	£238,682	Achieved
	3c. Dementia Carers Survey & Support	£238,682	Achieved
	4. Reducing avoidable emergency admissions	£1,433,530	Partial achievement
Locally agreed CQUINs	5. Maintenance of GP Practice Data	£169,391	Achieved
	6. Provision of generic medicines for Ophthalmology Patients	£195,212	Achieved
	7. Access Policy	£814,934	Achieved
	8. Medication Safety Thermometer	£298,934	Achieved
	9. Transfer of Medication Information via Electronic Discharge Summary	£298,499	Achieved
	10. Implement process to provide A&E discharge notes electronically to GP practices	£298,499	Achieved
	11. Implement process for all Outpatient Departments to receive electronic referrals from GPs	£556,717	Achieved
	12. Clinical Correspondence with Community Services	£298,499	Achieved

	13. Summary Care Record Access in Community Services	£298,499	Achieved
NHS England	14. Adult Critical Care Bed Management	£52,460	Partial achievement
	15. Prevention of Hypothermia in pre term babies	£58,289	Partial achievement
	16. Systemic Anti-Cancer Therapy	£66,061	Partial achievement
	17. Oncotype DX testing for breast cancer	Per patient	N/A
	18. Health Visiting	£51,660	Partial achievement
	19. Hep B Immunisation in high risk babies	£42,543	Partial achievement
	20. Diabetic Eye Screening Programme	£42,543	Achieved
	21. Dental Dashboard	£53,179	Achieved

Research

Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. 'Clinical research' means research which has received a favourable opinion from a research ethics committee within the National Research Ethics Service (NRES).
In April 2016 the Health Research Authority (HRA) rolled out a new single approval process. HRA Approval is the new process for the NHS in England that brings together the assessment of governance and legal compliance, and is undertaken by dedicated HRA staff, with the independent REC opinion provided through the UK Health Departments' Research Ethics Service (UKREC).
It replaces the need for local checks of legal compliance and related matter by each participating organisation in England. This allows participating organisations to focus their resources on assessing, arranging and confirming their capacity and capability to deliver the study. More information is available via www.hra.nhs.uk/about-the-hra/our-plans-and-projects/assessment-approval/#sthash.HZPrMuWP.dpuf.
Therefore, many research governance processes currently in operation within Research and Development (R&D) has required change and development. New policies and Standard Operating Procedures are being compiled by ESHT R&D to support new ways of working. This has included development of the ways in which the Trust engages with research activity. Processes are being developed to further enhance the involvement of Division structures now in place.
The number of patients that were recruited to research studies during 2016/2017 to participate in research approved by a research ethics committee was 837 with many more being offered the opportunity to take part. This is an increase in participation from the previous year which neared 600 participants and above the target of 827.
Participation in clinical research demonstrates ESHT's commitment to improving the quality of care we offer and to making our contribution to wider

health improvement. Our clinical staff will be able to participate in good quality research that can offer the latest possible treatments. Active participation in research leads to successful patient outcomes as demonstrated in the following paper detailing research activity and the association with mortality. http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0118253

ESHT was involved in conducting 29 interventional and 37 observational clinical research studies in 15 medical specialties during the year. The priority this year was to achieve the recruitment target set for the Trust by the Clinical Research Network, Kent, Surrey and Sussex of 836. This has been achieved and is a significant increase in past performance.
There are approximately eight whole time equivalent (WTE) Clinical Research Nurses, supported by three WTE administrative roles. There was a total of 55 clinical staff participating in research approved by a research ethics committee during 2016/17.

Research Achievements 2016/2017

- R&D department reconfiguration continues to demonstrate a positive and flexible response to research needs, supporting development of research opportunities which can respond in new areas. For example, this has enabled 531 patients to take part in research studies in musculoskeletal research including rheumatology and physiotherapy, anaesthesia and critical care, surgery, orthopaedics and occupational therapy
- The department aims to provide a specialist research service, supporting clinicians and practitioners in providing research opportunities for the benefit of patients. The department has the specialist knowledge to guide the set up and management of research within the Trust, while supporting clinicians and practitioners to gather research data as part of the patient's care pathway
- To facilitate this further, investment has been made in administrative support to the research nurse teams to ensure activity is role appropriate
- We have joint appointments with clinical nurse specialist roles to enable research activity as part of care. This has been evaluated this year to assess the impact this has on research recruitment opportunities of patients.
- R&D 5 year strategy – current until 2019
- Recruitment has increased in 2016/2017 in relation to the previous performance, developing from 424 recruited in 2014/15, to 836 participants

Data Quality

During 2017/18 we will be taking the following actions to maintain and improve data quality:

- Service improvement to support heading towards the 2020 national digital roadmap.
- A review of process and function to ensure the 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.
- To analyse and identify data quality issues within new systems/services to the Trust e.g. SystmOne, Electronic Document Management.
- Undertaking a re-audit of completeness of NHS Numbers to ensure continued progress
- Validating 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.
- Identifying 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.

NHS Number and General Medical Practice Code Validity

East Sussex Healthcare NHS Trust has submitted records to the Secondary Users Service for inclusion in the Hospital Episode Statistics 2016/2017.
The latest published data includes the period April 2016 to December 2016.

The percentage of records in the published data:

- Which included the patient's valid NHS number:
  - 99.6% admitted patient care (national rate 99.2%)
  - 99.8% outpatient care (national rate 99.5%)
  - 98.3% accident and emergency care (national rate 96.6%)
- Which included the patient's valid General Medical Practice Code:
  - 100% admitted patient care (national rate 99.9%)
  - 100% outpatient care (national rate 99.8%)
  - 100% accident and emergency care (national rate 98.9%)

Clinical Coding Error Rate

There is an on-going internal audit process that is carried out within the Clinical Coding Department by the Clinical Coding Data Quality and Audit Manager. This looks at inpatient coding and ensures that areas of concern are checked and that clinical coding training needs are highlighted for appropriate attention. Compliance with the Information Governance Toolkit requirements (v.14) is essential and has been reviewed by the Trust's independent internal auditors on a regular basis.

Levels of attainment – percentage accuracy targets

Area	Level Two	Level Three
Primary Diagnosis	≥ 90%	≥ 95%
Secondary Diagnosis	≥ 80%	≥ 90%
Primary Procedure	≥ 90%	≥ 95%
Secondary Procedure	≥ 80%	≥ 90%

Source: Acute Trust Information Governance Toolkit Requirement 14-505

Trust Internal Audits have looked at Quality Coding Review with clinician validation of the coded data. Results below:

The accuracy percentages for an ACC Coder were as follows:

Primary Diagnosis %	Secondary Diagnosis %	Primary Procedure %	Secondary Procedure %
96.70%	**95.20%**	**96.00%**	**97.80%**

This makes an overall accuracy percentage of 96.43%. This includes a small element of non-coder error. It was noted that the source documentation for several patient episodes was found to be untidy and difficult to navigate at audit but the episodes coded by the coder were not particularly taxing.

There were no episodes where the errors resulted in an incorrect Healthcare Resource Groups (HRGs) and therefore no errors affecting funding.

ESHT achieved Level 3 on all the fields.

- Death in Low Risk Diagnosis groups – on-going throughout year
- Quality Control – Clinical Coders –90% accuracy audits on-going
- Stroke Validation – on-going

We now also have a new Audit tool called Data Quality Analytics Solution (DQA) from Medicode since November 2016. We are running the coded data through DQA which will highlight the errors and then we can quickly correct the errors and also feedback the findings to the coders.

Coders will then put into practice and code correctly so that the Trust's data is of high quality. Financial returns based on this will be accurate as well for the treatments we have provided.

Information Governance

The 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 finds.

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 2016/17 was 71% and was graded as **'green'** or satisfactory. Out of the 45 requirements 39 are at the required level 2 and 6 are at the higher level 3. For 2016/17 the Trust internal auditor's report gives 'substantial assurance' that the Trust's submission is robust.

What the CQC says about us

The Trust is registered with the CQC to carry out eight legally regulated activities from 19 registered locations with no conditions attached to the registration. The CQC undertook an unannounced inspection of the organisation in March 2015 and the reports were published in September 2015. The reports identified concerns in a number of areas and the Trust was rated overall as 'Inadequate' and subsequently placed in special measures.

A re-inspection took place in October 2016 and the reports were published in January 2017. The reports recognised significant improvements since the last inspection and the CQC rating moved to 'Requires Improvement'.

The CQC gave the organisation a total of 114 ratings of which 52 were 'Good' and two were 'Inadequate', this compares to 11 'Good' and 23 'Inadequate' in 2015. Within the reports the CQC commended 15 areas for outstanding practice. The reports also identified some areas where further improvements were required

and included two ‘must do’ actions, relating to play services in paediatrics and staffing in the A&E departments and 34 ‘should do’ actions. Both hospitals were rated ‘Inadequate’ for the safe domain of Urgent Care, although Urgent Care was rated ‘Requires Improvement’ overall. There have been no enforcement actions taken against the Trust during this reporting period.

CQC Ratings for East Sussex Healthcare Trust

Safe	Effective	Caring	Responsive	Well-led		Overall
Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement		Requires Improvement

CQC Ratings for the Conquest Hospital

	Safe	Effective	Caring	Responsive	Well-led		Overall
Urgent and Emergency Services	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement		Requires Improvement
Surgery	Good	Good	Good	Requires Improvement	Good		Good
Maternity and Gynaecology	Requires Improvement	Good	Good	Requires Improvement	Good		Requires Improvement
Services for Children and Young People	Requires Improvement	Good	Good	Requires Improvement	Good		Requires Improvement
End of Life care	Good	Requires Improvement	Good	Good	Requires Improvement		Requires Improvement
Outpatients and Diagnostic Imaging	Requires Improvement	Not rated	Good	Requires Improvement	Requires Improvement		Requires Improvement
Overall	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement		Requires Improvement

**Medicine and Critical Care were not inspected in 2016 but received ‘Good’ ratings at the previous inspection*

CQC Ratings for the Eastbourne District General Hospital

	Safe	Effective	Caring	Responsive	Well-led		Overall
Urgent and Emergency Services	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement		Requires Improvement
Surgery	Good	Good	Good	Requires Improvement	Good		Good
Maternity and Gynaecology	Good	Requires Improvement Good	Good	Requires Improvement	Good		Requires Improvement
Services for Children and Young People	Requires Improvement	Good	Good	Requires Improvement	Good		Requires Improvement
End of Life care	Good	Requires Improvement	Good	Requires Improvement Good	Requires Improvement		Requires Improvement
Outpatients and Diagnostic Imaging	Requires Improvement	Not rated	Good	Requires Improvement	Requires Improvement		Requires Improvement

Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement		Requires Improvement

**Medicine and Critical Care were not inspected in 2016 but received 'Good' ratings at the previous inspection*

There is a robust programme of work and governance framework in place to support delivery of continued improvement. The improvement plan is reviewed both internally and externally at monitoring meetings with key stakeholders. The Trust remains in special measures and as a result will benefit from professional and financial support. A CQC re-inspection is expected later in 2017.

The reports and our improvement plan are available at http://www.esht.nhs.uk/about-us/cqc-report/

Part 3: Review of 2016/17 quality improvement priorities

During 2016/17 the Trust worked hard to address the quality concerns raised within the 2015/16 CQC inspection report to ensure there were demonstrable improvements for the 2016/17 inspection as previously described in this quality account. This required significant investment in time and focus however we continued to work on the priorities detailed below. We have managed to achieve a number of elements within each priority as described below.

Patient Experience

Priority 1: Improve the availability and timeliness of outpatient appointments

Why we chose this priority

A priority for the Trust is to ensure patients are seen in a timely manner. Our patients have raised concerns regarding the quality and timeliness of their appointment letter. Some patients are also keen to use alternative media such as texts or email to manage their outpatient appointment(s).

Effective communication with our patients regarding their outpatient appointment(s) is paramount to ensure they are able to attend and have adequate notice. This in turn enables the Trust to maximise utilisation of clinics and reduce Did Not Attend (DNA) rates, reducing the waiting time to receive care and treatment for all patients.

Improvement delivered throughout the year

Work has continued on improving communication to our patients regarding their outpatient appointment(s). We have reviewed our outpatient appointment letters, tested them and then implemented them in May 2017. The letters provide consistency in format, information and increased options on contacting us to discuss the appointment i.e. via email address; we have extended our opening hours, which include a Saturday morning.

We have continued to expand the use of the text/call reminder service which has seen our DNA rates reduce during the year. The content of our text messages have been reviewed and now include information to patients on the cost of an NHS appointment for DNAs.

Goals set for 16/17 – *Partially Achieved*

- Following the review of the quality of outpatient letters, there were 4 months with no formal complaints and an average of 1 per month. There were 41complaints in 2015/16 and reduced to 13 in 2016/17.
- Despite some fluctuation, the DNA rate has reduced by almost 1%.
- An email address has been added to our new Outpatient appointment letters for patients to contact us along with the Booking Team opening for longer hours and on a Saturday morning. We are exploring technology opportunities to advise patients of their outpatient appointments and will be looking to undertake a pilot of this in 2017.

Future plans

Further work is required to reduce the Trust's DNA rate in order to consistently achieve our KPI target in this area. We have achieved or exceeded our KPI on some weeks but have not been able to sustain it throughout the year, although the industrial action and issues with Patient Transport impacted on performance during this financial year. As the NHS e-referral service expands, this is increasing patient choice as the patient logs onto the system and makes their own outpatient appointment. Also we are piloting calling patients in a couple of areas where the DNA rate is higher to make their outpatient appointment with them.

Priority 2: Improving End of Life Care

Why we chose this priority

There is only one chance for ESHT services to provide the best care for a person and those most important to them at the end stage of their life. End of life can be described as being the last 12 months of a person's life, however in the last days and hours of life it is even more crucial that we 'get it right'. There were a number of key publications in 2015, the recommendations of which will form the basis of our overarching strategy. In addition to our own CQC report and the NICE guidelines, there is a national framework for local action called *Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020*. Success can be measured by linking outcomes to these ambitions.

For our quality improvement work for 2016/17, we chose to focus on care in the last days and hours of life so that we can be sure that the patient's symptoms will be controlled and that those most important to them are also supported and cared for. We also want to ensure that every person is treated with privacy, dignity and compassion.

Improvement delivered throughout the year

- Development and adoption of an End of Life (EoLC) Care Strategy. Now working with our "East Sussex Better Together" colleagues to produce a vision that spans across East Sussex
- Review and revision of all policies and procedural documents that relate to end of life care
- Production and implementation of a 'Last days of Life Personalised Care Plan'
- Implementation of an EoLC training programme for staff. Leaflets to raise awareness of EoLC distributed to all staff
- Patient and carer questionnaire pilot
- Allocation of full time project support to support improvements in end of life care
- Team building activities for the Palliative Care Team with revised working arrangements to reduce unwarranted variation
- Improved governance arrangements
- Approval for funding of consultant training in the 5 priorities of care for the dying person
- Established medical leadership for Specialist Palliative Care.
- Focussed weekly audits to ensure that the quality of care is good
- Improved processes around the sharing of information using the Summary Care Record
- A review of current services with an opportunity to consider other models of care
- Revised labels for the T34 syringe drivers
- Community Quality Measures are now regularly audited in the community setting
- Poster presentation at Kent, Surrey and Sussex EoLC Workshop

Goals set for 16/17 – Partially achieved

- We have set up monitoring processes that demonstrate the Trust is correctly identifying all patients who are in the last days or hours of life and ensuring that support and care are given.
- We have introduced a personalised care plan onto all the wards within the organisation with appropriate focussed training on its use. Monthly monitoring has indicated high compliance with 81% in March 2017 of all individuals having a personalised care plan. This is an increase from 58% in January 2017.
- On our way to achieving the Quarter 4 target of 80% of all ESHT staff who come into contact regularly with patients who require End of Life Care receive training in the key aspects of good end of life care.
- Continue to explore options in how to understand people's views in relation to their experience of ESHT End of Life services.

Future plans

There is still further improvement work to be undertaken. Future plans include continued collaboration with our partners to develop an East Sussex wide vision on how we will deliver the best End of Life Care for our communities. Further recruitment and service redesign is being explored that will enable access to Specialist Palliative Care 7 days a week. We will seek opportunities to work with the voluntary sector to improve companionship for those in the last hours/days of life. ESHT will continue to participate in national programmes of work such as *Living well to the very end – patient and family-centred care (PFCC) programme.*

We wish to work more closely with the public to understand people's experience of care that they receive. Together with a more robust governance programme this will enable us to continue to understand fully how we can improve the services that we deliver. We will continue to explore methods of how to collect, record and manage future scenarios that incorporate people's wishes and involve them in making shared decisions.

Priority 3: Understand the scale of the transport issues between sites experienced by our patients and staff

Why we chose this priority

The lack of available transport between sites has been raised by patients and staff at a number of forums and through letters to the Chief Executive. Therefore, the Trust committed to scoping the scale of the problem to enable future planning and decision making.

Improvement delivered throughout the year

- In the first quarter, a Board paper was drafted outlining Health Travel Options, the results of a recent public and staff survey and scoping of various initiatives and options.
- Meetings were held with staff representatives to consider the survey outcomes and how best to manage, promote and refresh a variety of improvements for public and staff. Some examples given included access to information on cycling and walking, improved internet information and discounted travel schemes.
- The travel survey saw interviews conducted with 2,428 patient/visitors to establish mode of transport, travel choices and travel to other sites. At the time, EDGH conducted 20,003 outpatient appointments per month and the Conquest 15,371. 33% of those interviewed had travelled to the other site at some stage. Only 10% travelled monthly. The majority would consider using a shuttle bus service if it was free.
- Initial discussions were held with operators and it was apparent that an annual cost in excess of £500,000 was likely. This would

require users to travel to the site and catch the service to the opposite hospital. This would increase parking pressures on site. An additional link to each town centre increased the cost to £725,000. As the cost would not be subsidised and would be funded from patient care, it was decided that alternative options may help reduce cross site travel.

Targets set for 16/17 – ***Achieved***

- The feasibility of a shuttle bus service was determined
- A review of staff travel patterns and costs have been completed
- A search is ongoing for possible park and ride solutions in Hastings
- Commenced a pilot pool car system for staff using hybrid vehicles
- Achieved the scoping of Transport provision and cost of additional parking facilities on both sites, but recognise more work need to be done to resolve transport issues
- Set up a cross Borough Transport Forum to review transport options both towns and across boroughs
- Completed a series of Travel alternative Roadshows

Future plans

From the work undertaken in 2016/17, the following key areas will be taken forward in the next year:

- Use the Transport Forum to engage with bus operators and the County Council to lobby for improved services.
- Create a patient leaflet that will go to all outpatients, highlighting how to get to each site and the various options available.
- Invest in personal travel planning software for public and staff.
- Use the Internet to improve the information and links offered.
- Review parking needs on site and consider reallocation of parking.
- Identify land for additional parking spaces.
- Consider working in partnership to create decked parking facilities.
- Investment in tele/video conferencing facilities to reduce the need for travel between sites.

Patient Safety

Priority 4: Improving Medicines Management

Why we chose this priority

Medicines Management within the organisation was highlighted by the CQC as a cause for concern. Much work has been undertaken to improve this with strengthened governance processes around medicines management at ward and department level and a more integrated service has been introduced. Key Performance Indicators and a medicines optimisation dashboard are under development by the Medicines Management Committee to provide oversight of this work.

As part of this work three key areas have been identified within Patient Safety that can have a positive impact on improving patient outcomes and experience. These are:

- A focus on reducing omitted or delayed doses of medicines
- Improving the extent of Medicines Reconciliation on admission into hospital
- Improving the accuracy of information provided about medicines during transfers of care to another provider (at discharge).

Omitted and delayed doses of medicines can occur for a number of reasons. Some of these are legitimate clinical reasons; however there are two, potentially three markers which may indicate poor care. These are:

- Doses that are not signed for (undocumented), which could lead to overdose or omission of a critical medicine
- Doses that are not administered due to medicine unavailability
- Potentially doses that are not administered because a patient is absent or route not available.

Obtaining an accurate medication history and undertaking Medicines Reconciliation on a patient's admission to hospital is an important step in their care. It underpins on-going treatment and ensures accurate information is provided during transfers between care settings. Additionally NICE recommends that a pharmacist is involved in medicines reconciliation as soon as possible after admission.

During an admission to hospital, medicines may change as a result of review by clinicians in the context of their care. It is therefore essential that if the benefits of the changes are to be seen by the patient, providing accurate information about medicines at the transfer of care must be provided to the new provider, such as a GP or other care setting. Having pharmacist involvement during the transfer of care

ensure the information is safe, accurate and a true reflection of the current medication record.

Improvement delivered throughout the year

A range of measures have been introduced to deliver robust systems for medicines management, including:

- Restructuring of pharmacy department involving the integration of staff within common teams and cross site management of specialties. Clinical team structure has been realigned to support Clinical Divisions.
- Revision of internal Pharmacy governance arrangements. A Pharmacy Leadership Group has been created to ensure effective collaboration decision making/ownership and monitoring of internal KPI's
- Improvement of medicines security by the installation of 13 automated medicine cabinets across the Trust, targeted at high risk areas. There is a new process for ambient temperature monitoring and audit. Secure medicine return bins have been introduced.
- Medicines Management Committee has been reformed as the Medicines Optimisation Group (MOG) with revised terms of reference to ensure robust arrangements for medicines governance. A Medication Safety Officer has been appointed.
- Strong processes are now in place for audit of medicines security/controlled drugs and reporting mechanism through Quality and Finance Performance Group and Clinical Division meetings established for escalation of required actions.

Targets set for 16/17 – ***Partially achieved***

- On average, 1.15% of doses of critical medicines are either undocumented or not administered due to supply issues in the population sample per month. This is below the original target of 2%.
- There has been an average of 74% of patients who have had their medicines reconciled by pharmacy within 24 hours in the population sample. The target set was 75%.
- We set out to ensure that all discharge letters from acute medical wards via the Integrated Clinical Environment (ICE) discharge summary system would be submitted to pharmacy for review and checked for safety and accuracy by a pharmacist prior to discharge. However, due to technical issues, it did not prove possible to directly extract data from the ICE system. This will be addressed in future plans.

Future plans

In order to meet the original goal of improving the quality of medication related information to GPs, a comprehensive revised plan is now being implemented which will:

- Identify all acute medical wards currently using the ICE discharge system
- Assess current level of compliance on each ward and barriers to implementation
- Review pharmacy processes at discharge to ensure thorough screening of discharge prescriptions, streamlined workflow and minimised delay
- Ensure medical staff on target wards are aware of “submit to pharmacy” function in ICE discharge and provide training as required
- Starting with pilot wards for the SAFER project, implement the revised process with full use of “submit to pharmacy” function
- Monitor compliance rates on pilot wards and assess effectiveness of new process
- Modify as necessary and roll out to remaining areas during 2017.

Priority 5: Reduce the transfer of patients for non-clinical reasons between our wards

Why we chose this priority

Ward moves can have an adverse impact on patient experience and a change of environment for patients can lead to confusion and an increased risk of falls.

Improvement delivered throughout the year

It has been difficult to deliver improvements for this priority due to the unprecedented challenges of patient flow that the Trust has experienced. However, progress has been made on the following:

- There was inconsistency with how information was being captured on data systems. This is now been addressed following collaboration with the Business Intelligence team.
- A draft Standard Operating Procedure and new policy regarding ward moves has been developed

Goals set for 16/17 – *Not Achieved*

- We planned to achieve a reduction in the number of monthly ward moves but this has been difficult to achieve with significant variation in the number of moves that have taken place. Some of the data may be inaccurate prior to improvement with the consistency of data captured.
- It has not been possible to determine if there has been a reduction in patient safety incidents related to transfer due to data not being robust initially.

Future Plans

During 2017/18, there will be a Trust project that will be focused on patient flow across the Trust and out to Community/Adult Social Care services. Therefore, this priority will be incorporated into the new project.

Clinical Effectiveness

Priority 6: Improving the recognition and treatment of sepsis

Why we chose this priority

Sepsis is a common and potentially life threatening condition triggered by an infection. It affects patients of all ages, but is most common in the elderly and very young. In 2014, approximately 123,000 people in England suffered from sepsis with an estimated 37,000 deaths per year associated with it.

When a patient has sepsis the body's immune system goes into overdrive, setting off a series of widespread inflammation, swelling and blood clotting which can lead to decreased blood pressure and therefore reduce blood supply to vital organs starving them of oxygen. If not recognised and treated quickly, sepsis can lead to multiple organ failure and death.

We have undertaken actions to improve sepsis recognition and treatment at ESHT however we know we can do more to improve the outcomes for our patients.

Improvement delivered throughout the year

- A new Trust sepsis screening tool, which includes the delivery of the Sepsis 6 Care Bundle, was introduced in October 2016 during the 'Sock it to Sepsis' campaign.
- The audit process was established to monitor compliance with screening and from patients with a red flag sepsis indicator, how many elements of the Sepsis 6 Care Bundle have been delivered
- Monthly audits for inpatients and those admitted via Emergency Department have

been completed demonstrating a slow but steady improvement in compliance
- Ongoing education and training provided to a variety of healthcare professionals

- Established a Sepsis Steering Group
- Achievement of national CQUIN for Sepsis for 2016/17

Goals set for 16/17 – *Partially Achieved*

- We set out to achieve consistency and improvement in screening compliance across the acute part of the Trust. The sepsis screening tool and ongoing education has resulted in a steady increase in screening compliance from 8% in September 2016 to 30% in March 2017
- There is Trust Sepsis Clinical Guidance in place
- Improvement in the delivery of the Sepsis Care Bundle has been more challenging with compliance varying within the Trust from 13% to 33%
- KPI's were established, monitored through monthly audit and reviewed by the Sepsis Steering Group
- An education/training programme has been implemented for junior doctors and nurses via a variety of sessions such as 1:1's, group teaching, incorporated into induction programmes, specific sepsis sessions

Future Plans

- Focussed support to inpatient areas on the use of the screening tool and the Sepsis 6 Care Bundle
- Review and refine the education programme
- Amend the audit process to meet the CQUIN requirements and continue to audit monthly
- Review and draft KPIs and share data with the Clinical Divisions
- Support learning by sharing any sepsis related serious incidents
- Consider rolling out sepsis screening tool to Community Rapid Response Team

Review of Quality Performance

Integrated Performance Dashboard – Apr 2016 to Mar 2017

Safety and Quality

Indicator Description	Target	Previous Months											Current Month			VTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	This Yr	Last Yr	Var	
Total patients safety incidents reported	M	1054	1078	1012	1499	1799	1786	1396	1241	1396	1307	1236	1247	978	27.5%	16051	10868	32.3%	
% Patient safety incidents with no harm or near miss	70.0%	64.4%	67.0%	72.5%	84.1%	86.5%	84.5%	82.7%	80.7%	84.5%	82.3%	79.8%	82.4%	67.8%	14.6%	80.3%	66.9%	13.3%	
% Patient safety incidents causing severe harm or death	0	0.2%	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.3%	0.2%	0.7%	-0.6%	0.1%	0.3%	-0.2%	
Total Non-ESHT patients safety incidents reported	M	319	243	148	168	145	164	136	130	151	177	150	148	85	74.1%	2079	1322	36.4%	
No of never events reported	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	4	-3	
No of serious incidents reported	M	7	0	3	8	8	4	3	6	2	6	7	5	14	-9	59	124	-65	
No of moderate incidents reported	M	6	5	11	3	6	9	9	9	4	12	12	4	2	2	90	9	90.0%	
Total Falls per 1000 beddays	7	6.0	6.0	6.0	6.3	6.3	6.2	6.4	5.0	6.4	6.5	6.4	6.3	6.1	0.2	6.2	6.7	-0.5	
Total falls reported	M	152	149	144	152	156	152	160	124	159	174	155	160	169	-5.3%	1837	1981	-7.8%	
No of falls no harm	M	97	101	99	109	116	92	115	80	113	130	107	122	118	3.4%	1281	1302	-1.6%	
No of falls minor/moderate	M	55	48	45	43	40	59	45	44	46	44	47	38	51	-25.5%	554	675	-21.8%	
No of falls major/catastrophic	M	0	0	0	0	0	1	0	0	0	0	1	0	0	0	2	4	-2	
Falls Assessment Compliance	M	92.2%	93.9%	89.6%	91.4%	92.5%	85.2%	90.3%	85.6%	85.3%	90.9%	88.9%	91.8%			90.2%			
No of pressure ulcers grade 3 & 4 (trust acquired)	R	6	5	2	2	4	0	5	3	5	5	7	5	5	0	49	73	-24	
No of pressure ulcers grade 2 (trust acquired)	R	62	45	51	32	46	53	54	53	46	56	66	64	73	-9	628	697	0	
Pressure Ulcer Assessment Compliance	M	93.4%	86.0%	87.5%	92.0%	86.7%	94.0%	91.2%	95.8%	94.4%	96.3%	93.2%	92.1%			91.5%			
No of medication administration incidents	M	29	25	16	32	24	31	33	28	37	25	36	16	17	0	332	253	0	
Medication errors causing severe harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Observations completed on time (per protocol)	M	79.7%	80.7%	83.4%	82.5%	84.2%	83.2%	81.2%	82.1%	83.2%	83.1%	83.3%	84.3%	76.8%	7.5%	82.6%	72.1%	10.5%	
No of Cardiac Arrest calls		1	8	1	1	1	4	0	3	1	2	1	9	0	0	32	0	1	
No of MRSA cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	-4	
No of CDI cases	4	2	7	7	2	6	3	4	2	0	0	2	0	5	-5	35	48	-13	
No of MSSA cases	M	2	0	2	1	0	4	1	1	0	0	0	0	1	-1	11	7	4	
Safety thermometer overall score	92.0%	93.0%	93.6%	94.0%	95.4%	93.0%	95.0%	93.3%	93.6%	93.4%	92.7%	92.5%	91.7%	94.0%	-2.2%	6.6%	6.2%	0.4%	
% of VTE risk assessments completed	95.0%	95.2%	97.9%	98.1%	97.9%	96.8%	97.0%	95.4%	97.0%	96.2%	96.7%	96.9%	96.8%	94.8%	2.0%	96.8%	95.3%	1.5%	
Emergency C-Section rate	9.0%	15.4%	13.4%	14.5%	12.6%	11.9%	17.4%	14.6%	16.0%	25.8%	15.2%	13.1%	12.4%	12.8%	-0.5%	15.1%	15.0%	0.0%	
Mixed sex accomodation breaches	0	0	7	0	0	0	0	0	0	0	20	0	0	0	0	27	130	-103	
Inpatient FFT Response rate	45.0%	14.01%	13.94%	16.97%	17.31%	14.89%	14.00%	21.37%	27.60%	24.31%	26.76%	31.77%	32.42%	13.3%	19.1%				
Inpatient FFT Score (% positive)	96.0%	98.26%	97.29%	96.70%	96.75%	96.13%	96.61%	97.02%	97.07%	97.26%	96.74%	97.35%	96.47%	95.5%	1.0%				
A&E FFT Response rate	22.0%	8.96%	9.91%	8.40%	7.69%	5.98%	6.98%	7.91%	6.40%	8.01%	7.47%	7.52%	6.70%	6.5%	0.2%				
A&E FFT Score (% positive)	88.0%	87.97%	83.69%	84.11%	82.00%	81.91%	81.73%	82.80%	84.57%	87.96%	83.60%	82.68%	86.11%	80.1%	6.0%				
Outpatients FFT Score (% positive)	M	96.02%	96.08%	95.41%	97.06%	96.02%	94.96%	94.59%	96.54%	92.27%	96.39%	95.56%	95.64%	95.4%	0.3%				
Maternity FFT Response rate	45.0%	29.19%	11.59%	33.21%	25.25%	29.03%	30.25%	26.70%	46.40%	24.31%	37.12%	39.79%	38.88%	24.2%	14.7%	29.3%	24.4%	4.9%	
Maternity FFT Score (% positive)	96.0%	90.21%	92.45%	93.72%	96.65%	92.86%	94.84%	96.08%	92.57%	96.94%	93.81%	96.68%	96.04%	92.9%	3.1%	94.2%	94.9%	-0.7%	
No of complaints reported	R	75	55	58	46	56	53	53	54	50	62	41	55	55	0.0%	658	703	-6.8%	
All ward moves	M	2303	2344	2265	2313	2304	2280	2210	2194	2316	2389	2114	2317	2331	-0.6%	27349	27325	0.1%	
Night ward moves	M	470	434	409	416	445	399	375	407	433	391	407	387	512	-24.4%	4973	5422	-9.0%	
Crude Mortality Rate	M	2.0%	1.7%	1.5%	1.4%	1.4%	1.4%	1.9%	1.5%	2.1%	2.7%	2.1%	1.7%	2.3%	-0.6%	1.8%	1.8%	0.0%	
HSMR (CHKS)	100	104	104	102	102	101	100	99	97										
SHMI (CHKS)	100	77	80	75	85	72	74	64											
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	10.0%	8.0%	7.6%	7.3%	6.9%	6.5%	6.8%	6.8%	7.1%	7.2%	7.9%	7.2%	8.0%	8.1%	-0.1%	7.3%	7.3%	-0.1%	

Access and Delivery

Indicator Description	Target	Previous Months											Current Month			VTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	Yr	Last Yr	Var	
RTT Incomplete (%achievement)	92.0%	90.2%	90.7%	89.5%	88.5%	87.5%	86.7%	85.7%	85.6%	85.6%	88.9%	89.3%	90.8%	90.5%	0.3%	88.2%	93.0%	-4.8%	
RTT Backlog (number of patients waiting over 18 weeks)	M	2936	2931	3399	3791	4239	4534	4809	4714	4425	3243	3131	2680	2823	-5.1%	334530	303304	9.3%	
RTT 52 Week waiters	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	1	
Diagnostic performance (% patients waiting over 6 weeks	1.0%	2.9%	2.7%	2.6%	2.2%	3.0%	2.5%	0.9%	1.6%	0.8%	0.9%	1.2%	1.4%	6.7%	-5.3%	98.1%	97.6%	0.5%	
Cancer 2WW standard	93.0%	96.0%	95.6%	96.5%	97.1%	97.3%	97.1%	97.2%	98.7%	98.0%	97.1%	98.4%		96.9%		97.2%	91.7%	5.5%	
Cancer 2WW standard (Breast Symptoms)	93.0%	93.2%	98.5%	96.9%	95.8%	95.8%	96.9%	97.2%	98.2%	97.3%	95.5%	98.8%		90.0%		96.8%	89.6%	7.2%	
Cancer 31 Day standard	96.0%	98.5%	99.4%	98.3%	97.7%	99.1%	98.8%	98.7%	99.5%	98.3%	99.5%	98.8%		99.3%		98.8%	97.6%	1.2%	
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%	
Cancer 31 Day subsequent surgery	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	100.0%	100.0%	100.0%	100.0%	94.1%		100.0%		98.6%	100.0%	-1.4%	
Cancer 62 day urgent referral standard	85.0%	67.6%	68.3%	82.3%	75.3%	79.5%	72.6%	82.5%	78.3%	84.1%	78.6%	69.9%		79.4%		76.5%	75.1%	1.3%	
Cancer 62 day screening standard	90.0%	100.0%	66.7%	62.5%	100.0%	88.9%	85.7%	91.7%	100.0%	100.0%	92.6%	66.7%		42.9%		88.0%	78.5%	9.5%	
Urgent operations cancelled for a 2nd time	0	0	0	0	0	0	0	0	1	0	0	0	0	1	-1	1	6	-5	
Proportion of patients not re-booked within 28 days of las	0.0%	0.0%	0.0%	0.0%	2.4%	0.0%	3.8%	3.8%	0.0%	0.0%	0.0%	2.7%		9.4%		1.4%	3.7%	-2.3%	
Delayed Transfer of Care	3.5%	5.3%	5.7%	7.0%	7.7%	8.0%	9.7%	9.7%	7.6%	7.1%	7.6%	7.6%	7.6%	9.4%	-1.8%	7.5%	7.6%	0.0%	
Outpatient appointment cancellations < 6 weeks	R	14	29	47	34	37	30	41	44	64	27	44	46	18	155.6%	457	371	18.8%	
Outpatient appointment cancellations > 6 weeks	R	1121	1033	1289	1438	1530	1302	1271	1250	1251	1184	1130	1385	1551	-10.7%	15184	14777	2.7%	

Leadership and Culture

Indicator Description	Target	Previous Months											Current Month			VTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	Yr	Last Yr	Var	
Trust Turnover rate	10.0%	10.3%	10.0%	10.0%	10.0%	9.8%	9.7%	9.9%	9.5%	9.7%	9.8%	10.0%	10.3%	10.6%	-0.3%	9.9%	12.2%	-2.3%	
Trust total sickness rate	33.0%	4.2%	3.9%	3.8%	4.1%	4.0%	4.0%	4.7%	4.5%	4.6%	4.8%	4.4%	4.0%	4.8%	-0.9%	4.3%	4.5%	-0.3%	
Trust vacancy rate	10.0%	9.8%	9.3%	9.8%	8.1%	8.0%	8.3%	8.0%	8.3%	7.5%	7.6%	6.9%	6.2%	5.8%	0.4%	91.9%	91.9%	0.0%	
Temporary costs and overtime as a % of total paybill	10.0%	15.0%	14.7%	15.5%	15.0%	16.2%	17.1%	16.6%	15.9%	14.9%	14.0%	14.8%	15.0%	18.7%	-3.8%	15.4%	16.9%	-1.5%	
Proportion of staff with up to date annual appraisal	85.0%	88.5%	89.8%	88.1%	86.3%	87.0%	83.2%	81.7%	79.3%	78.5%	78.8%	79.1%	79.0%	87.3%	-8.3%	83.2%	79.0%	4.3%	

Activity/Effectiveness

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	Yr	Last Yr	Var	
Primary Referrals	M	9249	9047	9551	8859	9169	9205	8989	9328	7665	8726	8653	10151	9169	10.7%	108592	106195	2.2%	
Cons to Cons Referrals	M	1406	1422	2006	1648	1448	1500	1438	1480	1321	1516	1414	1773	1294	37.0%	18372	17327	5.7%	
First OP Activity	M	9853	9876	10839	9868	10706	10989	11653	12491	10644	10913	10570	11834	10076	17.4%	130236	122534	5.9%	
Subsequent OP Activity	M	23216	23403	24446	22052	23389	23933	22845	25167	21863	24899	23351	26981	23716	13.8%	285545	279171	2.2%	
New:FU Ratio	M	2.4	2.4	2.3	2.2	2.2	2.2	2.0	2.0	2.1	2.3	2.2	2.3	2.4	-0.1	2.2	2.1	0.0	
Elective IP Activity	M	596	697	656	715	649	670	682	717	619	642	644	716	627	14.2%	8003	7888	1.4%	
Elective DC Activity	M	3521	3839	4119	4036	4199	4207	3932	4164	3755	4086	3826	4430	3785	17.0%	48114	45259	5.9%	
Non-Elective Activity	M	4038	3772	3791	3879	3801	3663	3721	3789	3966	3719	3494	4075	4077	0.0%	45708	47015	-2.9%	
A&E Attendances	M	8715	9573	9239	10144	9711	9470	9397	8989	9136	8771	7951	9442	9398	0.5%	110538	106876	3.3%	
Admissions Via A&E	M	2357	2398	2363	2409	2302	2215	2381	2416	2620	2464	2241	2622	2433	7.8%	28788	28005	2.7%	
Ambulance Conveyances	M	2848	3068	2995	3133	3092	3051	3138	3163	3331	3223	2886	3156	3084	2.3%	37084	35370	4.6%	
Average LOS Elective	M	2.7	3.4	3.0	3.1	2.4	3.1	2.7	2.5	3.1	2.6	2.9	3.5	3.0	0.5	2.92	2.99	-0.1	
Average LOS Non-Elective	M	6.1	5.8	5.5	5.6	5.9	6.1	6.1	5.9	6.1	6.3	6.5	6.2	6.0	0.2	6.01	5.62	0.4	

Community

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	Yr	Last Yr	Var	
Community Nursing Referrals	M	3902	3768	3962	3994	3975	4100	4157	4182	3997	4714	4281	4520	3840	17.7%	49552	38475	22.4%	
Community Nursing Total Contacts	M	33652	35504	36021	33717	34998	32851	33544	33436	33070	36718	34092	37895	34518	9.8%	415498	408176	1.8%	
Community Nursing Face to Face Contacts	M	19125	20065	19520	19055	19684	18734	19426	19244	18956	20342	18506	21259	19535	8.8%	233916	233333	0.2%	
% Patient Facing Time	60.0%	56.8%	56.5%	54.2%	56.5%	56.2%	57.0%	57.9%	57.6%	57.3%	55.4%	54.3%	56.1%	56.6%	-0.5%	56.3%	56.2%	0.1%	
Community Nursing ALOS	42.0	24.5	23.1	20.3	18.6	19.0	17.7	15.7	14.7	13.7	10.9	8.8	5.6	26.2	-20.6	15.77	31.55	-15.8	
SALT WL <13 Weeks %	85.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	0	90.6%	100.0%	-0.09409	
Podiatry WL <13 Weeks %	85.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	0	88.7%	100.0%	-0.11332	
Dietetics WL <13 Weeks %	85.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.7%	100.0%	100%	0	91.6%	100.0%	-0.08438	
MSK WL <13 Weeks %	85.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	81.0%	96.5%	100%	-0.035188	98.2%	98.5%	-0.00285	
SALT Total WL	M	146	160	0	176	202	182	149	130	140	128	133	139	117	22	1685	690	995	
Podiatry WL Total WL	M	841	830	0	998	842	942	633	418	293	284	284	380	749	-369	6745	4204	2541	
Dietetics WL Total WL	M	73	32	0	43	65	54	30	64	39	43	74	69	146	-77	586	1400	-814	
MSK WL Total WL	M	101	101	0	1922	1922	105	1641	1265	1938	2087	434	2029	211	1818	13545	4201	9344	
IP ALOS (including Irvine Stroke Unit)	M	30.6	33.3	25.8	30.9	36.0	28.5	27.0	26.9	32.3	35.0	33.8	38.0	31.1	6.9	31.42	26.35	5.1	
IP Activity (including Irvine Stroke Unit)	M	92	97	85	85	85	81	84	93	85	69	75	85	89	-4.5%	1016	1523	-49.9%	

Review of 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.

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 and review the quality of care provided by the Trust. We also look at Hospital Standardised Mortality Ratio (HSMR) the Risk Adjusted Mortality indicators as well as crude rates and associated local metrics.

Indicator	Oct 15-Sep 16	Oct 14 –Sep 15	Oct 13-Sep 14	Oct 12-Sep 13	Oct 11- Sep 12
SHMI value	1.10	1.15	1.08	1.14	1.05
Banding	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	18.8	18.05	22.4	18.2	14.8
% of patient deaths with palliative care coding by speciality and/or diagnosis (national average)	29.7	26.6	25.3	20.9	18.9

The most recent SHMI value for the data period October 15 to September 16 shows a reduction in the indicator. The Trust has moved into the 'as expected' range, SHMI band 2.

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

- All specialties conduct morbidity and mortality (M&M) meetings.
- All adult deaths are reviewed on the Trust mortality database. The Trust policy is that this occurs within 3 months of the date of death. There is a programme of quarterly quality control review of entries on the Trust's electronic database.
- Deaths in "Low Risk Groups" are reviewed at Divisional M&M Meetings. Learning from these is included in the Governance meetings for the Divisions.
- Coding systems reviewed and amended to improve recording of primary condition
- The Clinical Outcomes Group monitors the Trust's mortality indicators and identifies areas for further scrutiny and review. This group monitors progress to mortality drivers such as Sepsis, Acute Kidney Injury, Venous Thromboembolism.
- Trust Mortality Review Group meets monthly. This Group reviews trends and variances, triangulating this with other quality indicators (e.g. complaints, Clinical Incidents, SIs,) and reviews unexpected deaths in which care might have been contributory to the death.

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 the patient reported outcomes of surgical interventions and compare themselves to other trusts nationally.

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

	Percentage Improving						
Indicator	**ESHT 16/17 * April 2016 – September 2016** *Provisional data	**National Average**	**Best performer**	**Worst performer**	**15/16 data** *Provisional data	**14/15 data**	**13/14 data**
Patient Reported Outcome Measures/scores (PROMS) for Hernia surgery	EQ-5D Index 65.1% EQ-VAS 46.5%	EQ-5D Index 50.9% EQ-VAS 40.5%	EQ-5D Index 87.5% EQ-VAS 83.3%	EQ-5D Index 0.0% EQ-VAS 5.6%	EQ-5D Index 51.7% EQ-VAS 45.4%	EQ-5D Index 53.5% EQ-VAS 40.4%	EQ-5D Index 56.1% EQ-VAS 39.1%
Patient Reported Outcome Measures/scores (PROMS) for Hip replacement	EQ-5D Index 100.0% EQ-VAS 46.2%	EQ-5D Index 89.7% EQ-VAS 67.8%	EQ-5D Index 100.0% EQ-VAS 100.0%	EQ-5D Index 50.0% EQ-VAS 22.2%	EQ-5D Index: 90.2% EQ-VAS: 62.0%	EQ-5D Index 86.8% EQ-VAS 63.3%	EQ-5D Index 88.8% EQ-VAS 59.3%
Patient Reported Outcome Measures/scores (PROMS) for Knee replacement	EQ-5D Index 85.7% EQ-VAS 28.6%	EQ-5D Index 82.1% EQ-VAS 59.4%	EQ-5D Index 100.0% EQ-VAS 90.0%	EQ-5D Index 44.4% EQ-VAS 25.0%	EQ-5D Index 74.4% EQ-VAS 44.5%	EQ-5D Index 82.6% EQ-VAS 58.7%	EQ-5D Index 83.6% EQ-VAS 51.5%

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

- Ensuring our pre assessment teams distribute and collect the PROMS questionnaire.
- Reviewing the data within our Governance and quality meetings

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 16/17 April to January	National Average	HES Acute Peer 5th Percentile	HES Acute Peer 95th Percentile	15/16 data	14/15 data	13/14 data
Emergency readmissions to hospital within 28 days of discharge Age 0-15	12.83%*	9.02%	3.57%	14.00%	13.37%	11.82%	11.19%
Emergency readmissions to hospital within 28 days of discharge Age 16+	7.01%	7.21%	5.53%	9.11%	7.46%	7.60%	7.47%

* Paediatric admissions are high due to neonates going to specialist centre and then returning back to ESHT and coded as a readmission. Data source: CKHS (data included in the Quality Account 2015/16 was obtained from NHS Digital. Data no longer available so 16/17 obtained from CKHS).

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

- The readmission rates are reviewed by divisions and specialities during governance meetings and the Individual Performance Reviews with the Chief Executive.
- Readmission cases that have resulted in harm are raised and discussed within the division/speciality audit meetings.
- If the readmission results in harm it is also included in the incident reporting process and investigated.

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 2016 CQC weighted score	National Average	Best performer	Worst performer	ESHT 2015 CQC weighted score	ESHT 2014 CQC weighted score
Responsiveness to inpatients' personal needs; CQC national inpatient survey score	67	68.5	83.7	60.3	67.6	67.9

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

- This indicator will be reviewed at the Patient Experience Steering Group in July 2017, along with the key findings from the Inpatient Survey published in June 2017. Any recommendations made will be implemented thereafter.

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 2016	National Average *For acute and community trusts*	Best performer	Worst performer	2015 data	2014 data
Percentage of staff who would recommend the trust to friends or family needing treatment	62%	68%	91%	48%	54%	52%

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

Use ESHT staff FFT data as a source of intelligence in informing and signposting the Trust to areas for improvement in staff working life, wellbeing, conditions and work environment. The Trust also monitors staff responses three times a year through an internal mechanism.

- The Trust has taken the opportunity to ask additional questions using the staff FFT and regular Pulse surveys to seek feedback on various staff engagement/wellbeing initiatives such as the Take Break campaign and the role of the Speak Up Guardian.
- The Trust has improved how we involve and engage staff on how to deliver our services, set standards and listened to their feedback about what it feels like to be an employee of ESHT.
- Many of the services have looked at different ways to deliver services such as the introduction of daily safety huddles, regular team meetings, regular roadshows where managers go and meet staff and holding listening conversations with staff to identify staff improvements to services.

- There are over 250 staff from all levels of the organisation who have volunteered to be “ESHT viners”, who communicate our themes of the week through their formal and informal networks.
- A new appraisal system has supported every staff member in knowing that their role counts and they make a difference by lining their appraisal to the Trust values.
- We have been sharing and celebrating success through monthly staff awards and Trust award ceremonies.

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.

The NHS Friends and Family Test (FFT) was introduced in 2013 and asks patients whether they would recommend or not recommend the Trust hospital wards, A&E departments and maternity services to their friends and family if they needed similar care or treatment.

Indicator	ESHT 16/17	National Average	Best performer	Worst performer	15/16 data
Percentage of patients who would recommend the trust to friends or family needing treatment (inpatient)	97%	*96%*	100	80	97.8%
Percentage of patients who would recommend the trust to friends or family needing treatment (A&E)	86%	*87%*	100	46	90.1%

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

Addressing the poor response rate has been a high priority for the Patient Experience Steering Group. During the year we conducted a review of the current system and explored what was in place at other organisations. Following this review the Trust confirmed the systems in place were suitable but improved awareness and compliance was required through the developing the culture of requesting feedback.

We collect more experience information than the standard Friends and Family question within the questionnaire so the suitability of these questions were reviewed and altered.

Additional support was provided to departments to ensure they have suitable and well printed questionnaire forms, electronic collection devices available and the system was cleansed to align the departments to the correct FFT category (inpatient, outpatient, Accident and Emergency, Maternity).

Finally we developed the feedback reports provided at Ward and Divisional level to ensure the data collected was fed back to the teams to show the scores and individual comments (positive and negative). As the majority of comments were extremely positive our approach was for this to be useful to motivate staff and use as part of their professional revalidation. A league table and regular reporting by ward on response rate and score was provided within the Divisional reports from October 16 and reinforced at the relevant meetings.

Response rates for in-patients has improved each month since October with the Trust aiming to try and achieve a minimum of 50% overall inpatient response rate.

The A&E response rate has not improved although the system was changed to a simplified postcard questionnaire as requested by the department. This will continue to be addressed during 17/18 through support and challenge with the leadership team for the department.

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

East Sussex Healthcare NHS Trust considers that this data is as described for the following reasons: the Trust has a new process in place for measuring VTE risk assessments of patients which will be further reviewed in 2017/18.

This data capture is a retrospective paper based system, with pharmacists auditing the risk assessment for the ward area they cover.

Indicator	ESHT 16/17	National Average	Best performer	Worst performer	15/16 data	14/15 data	13/14 data
Percentage of admitted patients risk-assessed for Venous Thromboembolism (VTE)	96.8%	95.69%	100%	79.14%	96.30%	97.42%	97.05%

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

- All adult in-patients admitted to ESHT are required to have an individual VTE and bleeding Risk Assessment carried out on admission or within a maximum of

24 hours of admission. The nationally agreed goal is currently 95%. Previously the Trust reported compliance against the VTE and bleeding Risk Assessment having been carried out during the care episode as with many other trusts.

- During the recent CQC inspections and as highlighted by both internal and external audits, it was found that some patients were being risk assessed late in the care episode, rather than as part of the admission process. This created risks to patient safety and organisational reputational risk as compliance was being reported at above 95% yet patients were not always being risk assessed in a timely manner.
- The Trust has addressed this by implementing changes to the current paper based VTE risk assessment data capture process. The Ward clerks, who enter the risk assessment data are now required to enter specifically whether the risk assessment has been recorded by the doctor within 24 hours of admission to be compliant with the national requirements. If the patient has been risk assessed outside of this timeframe it will no longer be recorded as compliant or reported in the compliance figures via UNIFY.
- The paper based tool contained in the Integrated Patient Documentation was altered to ensure that date and time of assessment is clearly recorded. Ward clerks and staff involved in VTE Risk Assessment were engaged and updated in these process changes. .
- Following the most recent audits and recommendations from tiaa, an electronic weekly compliance monitoring email is generated which is distributed to relevant senior leaders and divisional managers to aid divisional and ward based monitoring of compliance with the process.
- In the longer term, the Trust plans to implement electronic VTE and bleeding risk assessment as part of the procurement of a Trust wide E-prescribing programme (EPMA) and this has been factored into the project management discussions currently taking place as part of the Lord Carter recommendations.
- The advantages of integrating VTE Risk Assessment into the EPMA include: increased patient safety as there are prompts and ‘hard stops’ to prescribe appropriate thromboprophylaxis to patients who are identified as at high risk of VTE.
- An electronic process also removes the need for manual data entry by ward clerks and will support audit and continued monitoring of both risk assessment compliance together with thromboprophylaxis provision in line with NICE guidance and Trust policy.

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	ESHT 16/17 (Trust data*)	National Average	Best performer	Worst performer	15/16 data	14/15 data	13/14 data
Rate of C. Difficile Infection per 100,000 bed days	18.4	N/A	N/A	N/A	15.44	17.7	16.4

***The national data for 2016/17 has not been published at the time of this Quality Account. ESHT data has been provided for 2016/17.

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

- Trust wide enhanced cleansing using chlorine based cleaning solution
- All areas where patients with *Clostridium difficile* infection have been are deep cleaned using chlorine based cleaning solution and additional Hydrogen Peroxide Vapour treatment
- Environmental audits are undertaken using the National Specification of cleanliness guidance to ensure that standards are being maintained and any non-compliances addressed by the wards and divisions
- Introduction of Infection Prevention and Control electronic monitoring system (VitalPac) to improve the prompt identification and management of patients presenting with potentially infectious diarrhoea
- Continued surveillance and monitoring of cases of *Clostridium difficile* infections to identify and manage increased rates and possible outbreaks
- Introduction of the revised diarrhoea assessment tool to facilitate the early detection of patients with potentially infectious diarrhoea
- All cases of hospital acquired *Clostridium difficile* infections are investigated through a Post Infection Review which is undertaken by the clinicians involved in the patients care and signed off by the commissioners. Any lapses in care are identified and lesson learned shared
- Additional compliance monitoring for hand hygiene, use of personal protective equipment and environmental cleanliness is undertaken to provide assurance of the standards being achieved and maintained
- Antimicrobial policy has been reviewed to minimise the use of broad spectrum antibiotics associated with increased risk of *Clostridium difficile* infections

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

We are committed to learning from patient safety incidents in order to improve the overall quality of patient care and to ensure robust strategies are put in place to prevent recurrence. The Trust is focused on promoting high levels of reporting as a positive attribute to a culture of openness and transparency. A total of 16051 patient safety incidents were reported on Datix in 2016/17 against 10868 incidents which were reported in 2015/16 thereby recording an increase of 5183 incidents or 68%. This includes all incidents reported by our staff that may not be attributable to East Sussex Healthcare.

It should be highlighted that a rise in the number of incidents reported is a good marker of the Trust's commitment to a culture of openness which encourages reporting in ensuring lessons are learnt in preventing recurrence and promoting patient-centred safer care.

The following table reflects our annual performance on two key indicators against national standards.

Indicator	ESHT 16/17	National Average	Best performer	Worst performer	15/16 data	14/15 data
	01/04/2016 - 30/09/2016				01/04/2015 - 30/09/2015	01/04/14 - 31/03/15
Rate of patient safety incidents reported per 1000 admissions	59.97	40.02 (median reporting rate)	71.81	21.15	39.3	36.92
% of patient safety incidents reported that resulted in severe harm or death – This is the National and Reporting and Learning system Data between 1st April 2016 and 30th September 2016 **	0.2	0.4	0.0	1.7	0.5	0.3

** Please note: This was data submitted (uploaded) to the National reporting and Learning System during the stated time period which had a final date for updating incident severity following investigation outcomes on the 30th November. Some of the incidents involving major and catastrophic cases were still under investigation or

were not re-uploaded and therefore subsequently changed the final severity grading. This is a difference of 6 incidents in the severe and death category but there is an audit trail for all. There were 6 resulting in severe harm rather than 12 originally uploaded to NRLS. The final figure for the Trust at the end of the financial year for this time period is:

Overall indicator for % of patient safety incidents reported that resulted in severe harm or death - 0.1% (severity 4 = 0.1% and severity 5 = 0%).

Data Reporting

All incidents are reported on the Trust incident reporting system (Datix). These remain as a permanent record. The initial grade of an incident is determined by the reporter. However the grade may change following investigation which can take a few weeks after the incident has been uploaded to the national reporting and learning system.

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

The serious and moderate incident reporting process was redesigned in March 2016 and introduced in April 2016 to provide more support and expertise to the clinical staff with undertaking investigations and identifying the learning from the events. This new process has improved the quality of investigations and cleared the backlog of outstanding serious incidents.

In addition staff are encouraged to report incidents through training and by embedding a reporting culture to report within the organisation. The Trust has recorded and tracked actions from serious and moderate incidents to ensure they are being completed and we have established a system to test the robustness of completed actions on a rolling review.

Staff Survey Results

The NHS Staff survey has been completed by NHS organisations annually since 2003; its purpose is to collect staff views about working in their local NHS trust. The CQC uses the staff survey as part of the on-going monitoring of registration compliance.

The survey helps ESHT to assess the effectiveness and application of policies and strategies, for example, training, flexible working and safety at work. The survey also monitors performance against the four staff pledges of the NHS Constitution: these pledges clarify what the NHS expects from its staff and what staff can expect from the NHS as an employer. Feedback from the surveys helps inform us as a Trust on areas for development and improvement.

The survey was conducted between September and December 2016 and the results published in February 2017.

46% of staff at East Sussex Healthcare NHS Trust took part in the survey which is in line with the National response rate and an increase of 6% from 2015.

There are two ways of scoring responses to questions:

1. 5 scores which indicate the percentage of staff giving a particular response to a question or a series of questions
2. Scale summary scores which convert staff responses to questions into scores, with the minimum being one and the maximum being five

The following tables summarises the Trust's top and bottom ranking scores:

Top scores (* denotes lower score is better)

Key Finding	ESHT score	National average
KF27. Percentage reporting most recent experience of harassment, bullying or abuse	**49%**	**46%**
KF24. Percentage reporting most recent experience of violence	**70%**	**68%**
KF9. Effective team working	**3.78**	**3.77**
KF29. Percentage reporting errors, near misses or incidents witnessed in last month	**92%**	**91%**
*KF16. Percentage working extra hours	**70%**	**71%**

Bottom scores (* denotes lower score is better)

Key Finding	ESHT score	National average
*KF18. Percentage attending work in last 3 months despite feeling unwell because they felt pressure	**62%**	**55%**
KF3. Percentage agreeing that their role makes a difference to patients/service users	**89%**	**91%**
KF31. Staff confidence and security in reporting unsafe clinical practice	**3.56**	**3.69**
KF2. Staff satisfaction with the quality of work and care they are able to deliver	**3.87**	**3.92**
*KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	**27%**	**22%**

The following table outlines the largest improvements since 2015 (* denotes lower score is better)

Key Finding	ESHT score 2016	ESHT score 2015
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	**3.69**	**3.41**
KF10. Support from immediate managers	**3.73**	**3.54**
KF19. Organisation and management interest in and action on health and wellbeing	**3.62**	**3.34**
KF31. Staff confidence and security in reporting unsafe clinical practice	**3.56**	**3.30**
KF27. Percentage reporting most recent experience of harassment, bullying or abuse	**49%**	**39%**

The following section presents each of the 32 Key Findings, using the data from the Trust's 2015 survey, and compares theses with other integrated Trusts in England and to the Trust's performance in the 2014 survey.

	ESHT 2016	ESHT 2015	National Average 2016
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.63	3.36	3.71
KF2. Staff satisfaction with the quality of work and patient care they are able to deliver	3.87	3.73	3.92
KF3. % agreeing that their role makes a difference to patients / service users	89	88	91
KF4. Staff motivation at work	3.89	3.77	3.93
KF5. Recognition and value of staff by managers and the organisation	3.45	3.23	3.47
KF6. % reporting good communication between senior managements and staff	31	19	19
KF7. % able to contribute towards improvements at work	68	63	71
KF8. Staff satisfaction with level of responsibility and involvement	3.87	3.79	3.91
KF9. Effective team working	3.78	3.62	3.77
KF10. Support from immediate managers	3.73	3.54	3.75
KF11. % appraised in last 12 months	83	82	86
KF12. Quality of appraisals	3.13	2.93	3.10
KF13. Quality of non-mandatory training, learning or development	4.04	3.97	4.07
KF14. Staff satisfaction with resourcing and support	3.25	3.12	3.29

KF15. % of staff satisfied with the opportunities for flexible working patterns	51	47	51
* KF16. % working extra hours	70	72	71
* KF17. % suffering work related stress in last 12 months	36	40	36
* KF18. % feeling pressure in last 3 months to attend work when feeling unwell	62	66	55
KF19. Org and management interest in and action on health / wellbeing	3.62	3.34	3.62
* KF20. % experiencing discrimination at work in last 12 months	13	12	10
KF21. % believing the organisation provides equal opportunities for career progression / promotion	86	83	87
* KF22. % experiencing physical violence from patients, relatives or the public in last 12 months	15	13	13
* KF23. % experiencing physical violence from staff in last 12 months	2	2	2
KF24. % reporting most recent experience of violence	70	65	65
* KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	30	33	26
* KF26. % experiencing harassment, bullying or abuse from staff in last 12 months	27	32	22
KF27. % reporting most recent experience of harassment, bullying or abuse	49	39	46
* KF28. % witnessing potentially harmful errors, near misses or incidents in last month	30	29	28
KF29. % reporting errors, near misses or incidents witnessed in last month	92	87	91
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.69	3.41	3.73
KF31. Staff confidence and security in reporting unsafe clinical practice	3.56	3.30	3.69
KF32. Effective use of patient / service user feedback	3.61	3.42	3.69

Staff survey Comments from our Chief Executive

It is encouraging to see that improvements have been made in many important areas since the previous year's survey, marking the progress we continue to make together on our journey to be outstanding by 2020.

Although we should be pleased with significant improvement that this survey shows, there is more that we can do to create an environment in which everyone is proud and happy to work, confident of their contribution and able to raise issues and report issues of concern without reprisal or recrimination.

The results show an increased sense of confidence in reporting incidents and in the sense of value we place in our work, with an increase in people recommending our organisation as a place in which to work or receive treatment.

In the previous year's survey, our results showed that we were a long way behind the average position of other organisations. We are glad to say that this year's survey shows that we have significantly closed that gap. Despite this progress, there are still many areas where we are showing as below average when compared to other trusts similar to us.

Our goal is to be an organisation which 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. There is growing research that demonstrates that when we are better in our workplace and are proud of our contribution, we see better patient outcomes and experience.

During this coming year we want to continue to build upon the improvement seen across the organisation and respond directly to the messages that are coming from this survey. We need to work together to address the common themes and issues highlighted in the staff survey. This is our opportunity to make things better and improve the working experiences of everyone who works at the Trust.

ANNEX

1. Statements from Commissioners, Healthwatch and HOSC
2. Independent Accountant Limited Assurance report
3. Equality Impact assessment
4. Glossary

Annex 1 - Statements from Commissioners, Healthwatch and HOSC

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

During 2016/17 HOSC has welcomed the Trust's positive engagement on a number of issues including its response to the HOSC report on the Trust's Quality Improvement Plan (QIP).

We consider the follow-up Care Quality Commission (CQC) inspection report, published in January 2017, to have shown considerable improvement and welcome the Trust's revised rating of 'requires improvement'. However, there is still much work to be done before the Trust reaches its goal of an 'outstanding' rating by 2020, particularly as the Trust remains in special measures.

HOSC welcomes the work so far of ESHT's new 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 to help elevate the Trust out of special measures. We are also glad that ESHT has agreed to work collaboratively with Healthwatch East Sussex to strengthen the Trust's patient and public engagement.

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 the progress of ESHT's QIP over our last few meetings and will scrutinise the urgent care and patient flow, and end of life care projects at future meetings.

We also hope that the Trust remains focused on addressing the long term and systemic cultural and leadership issues in order that ESHT staff are given the support and encouragement they need to succeed at work, and provide excellent care to their patients. We agree with the CQC that staff and patient satisfaction are intrinsically linked. Until staff survey results improve there will be a lack of evidence that services are really where they need to be. It is therefore encouraging that we were informed that in the most recent NHS Staff Survey all measures of staff satisfaction– including staff morale – have improved or stayed the same, and a number are now at the national average. We also noted that ESHT is showing improvement in areas such as communication between management and staff, communication between staff, and staff being able to identify and report if they are

being bullied or harassed. We expect to see a continuation in this upward trend this year.

2016/17 Quality Priorities

Given the scale of challenges facing the Trust since 2015 it is perhaps understandable that most priorities were partially achieved. However, the failure to reduce the transfer of patients for non-clinical reasons between wards is disappointing, and we hope that its incorporation into the patient flow priority for 2017/18 helps to rectify this issue.

2017/18 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 – improving patient flow and reducing hospital length of stay, and improving end of life care for patients. We will be considering both of these issues at future committee meetings.

It is also good to see that ESHT is prioritising reducing the number of staff experiencing bullying and harassment, and improving the communication between management and staff, given the importance of staff satisfaction to patient care.

The development of a Quality Improvement Hub for staff is welcome as a way of ensuring that improvement priorities are delivered, and so too is the new Improvement Group to monitor the delivery of priorities. We would hope ESHT can demonstrate their value to the improvement process.

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.

Healthwatch East Sussex Commentary on East Sussex Healthcare NHS Trust (ESHT) Quality Account 2016/2017

Collectively, Local Healthwatch across the region have provided responses for NHS Trusts Annual Quality Account report for the public by means of a generic response. However, on this occasion Healthwatch East Sussex (HWES) has also provided a detailed response to reflect the strong relationship, level of engagement and involvement with the Trust throughout the year and most importantly to support the improvement statements using the evidence HWES has gathered.

Healthwatch East Sussex continues to build strong relationships with the Trust at all levels. We have welcomed invitations from the Trust to be involved in events celebrating staff successes and other more focussed activities where the Trust bring staff together, as appropriate; reinforcing their commitment to involve external stakeholders in an open and transparent way. Examples include; invitation to join Schwartz Rounds, Quality Night Walks with the Director of Nursing and attendance at the launch of the Clinical Administration Leadership programme.

Our volunteers and staff alike have consistently noted considerable improvement in their positive interactions with staff throughout the Trust.

Other areas where improvement has been noted include:

Priority 1 Introduction and Development of Safety Huddles across the Trust

On numerous enter and view visits and engagement activities HWES provided; our volunteers observed ‘Safety Huddles’ in action and reported that they can see a direct link to improved patient and staff experiences on wards where safety huddles were common practices and would want to see the practice grow consistently across the Trust.

Priority 7 Responding to Complaints

HWES supports this priority and is pleased to again report the progress made by the Trust in addressing some of the concerns identified following its own independent review of the Trust Complaints Process. HWES look forward to having continued input into the processes the Trust are developing around conducting internal lay reviews and we will monitor externally through the Patient Experience Group.

Featured elsewhere in the account are the NHS England national audit compliances with ten key ‘7 Day Services’ core standards, HWES engagement with patients, families and carers included this in its 24-hour activity and unplanned visits over the weekend periods. This evidence provided valuable insight to the Trust and the public on how the outcomes of more formal audits, translates in to patient and family experiences around the clock.

Consolidating collaborative working

HWES continue to value the strong collaboration that has developed with East Sussex Healthcare Trust and the Care Quality Commission (CQC) since the decision was made for the Trust to be placed in special measures. It is also delighted to see

how our work has positively impacted on the Trust's overall ratings following the latest CQC inspections. Whilst there are still further improvements to be made, the excellent partnerships that have developed between the Trust, the regulator and HWES will be a priority to continue going forward.

Healthwatch East Sussex
May 2017

Statement from Clinical Commissioning Groups

Commissioner statement on ESHT Quality Account (2016/17)

East Sussex Healthcare NHS Trust (ESHT) has worked hard during the 2016/17 year to improve the quality and safety of services provided to the residents of East Sussex and this Quality Account reflects improved outcomes in many areas as a result.

In particular, the Trust has improved its safety culture and this has been evidenced by the following:

- increased reporting of incidents on to the trust DATIX system;
- a focus upon fostering a culture of openness and inclusion in relation to areas affecting staff culminating a suite of bespoke trust corporate values;
- an increase in the number of staff members who undertook the NHS Staff Survey (2016) when compared with 2015;
- a focus upon improving the experience of inpatients and resolving complaints;
- an improvement across a range of mortality indicators which has the seen the trust move to reporting the expected number of deaths rather than previously being an outlier;
- a revised system of governance which has led to ensuring that lessons learned as a result of serious incidents are embedded in practice;
- a significant improvement in the implementation of the Duty of Candour where required; and,
- an overall improvement in avoidable pressure damage and the falls rate per 1,000 bed days.

The Trust has demonstrated improvements in the provision of safe and effective services for patients that has seen the organisation Care Quality Commission (CQC) rating improve from "Inadequate" to that of "Requires Improvement" during the 2016/17 year. However, there remains further work for the Trust to undertake. The 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 lessons are learnt from hospital acquired Clostridium Difficile (CDI) infections;
- ensuring that national guidance is met in relation to the identification, management and escalation of Sepsis in patients;
- ensuring that patients are risk assessed upon admission for Venous Thromboembolism (VTE);
- ensuring that the emergency department (ED) Friends and Family Test (FFT) test response improves;
- ensuring that inpatient personal needs are attended to in a more responsive manner; and,
- ensuring improvement work in relation to falls and hospital acquired pressure damage continues.

It is the view of the CCG that the Quality Account presented by ESHT is an accurate reflection of the organisation's position in relation to their quality improvement programme during the 2016/17 year, and the CCG looks forward to continuing to work collaboratively with the Trust as the East Sussex Better Together Alliance further develops.

Yours sincerely

Allison Cannon
Chief Nurse

Annex 2 - Independent Accountant's Limited Assurance Report

Independent Chartered Accountant's Limited Assurance Report to the Directors of East Sussex Healthcare NHS Trust on the Annual Quality Account

We have been engaged by 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 2017 ("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 Accounts) Regulations 2010, the National Health Service (Quality Accounts) Amendment Regulations 2011 and the National Health Service (Quality Accounts) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

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

We refer to these two indicators collectively as "the indicators".

Directors' responsibilities

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health 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 guidance.

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

Our responsibilities

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") as supplemented by the Quality Accounts: Reporting Arrangements 2016/17 letter dated 6 January 2017; 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 to 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 2016 to June 2017;
- papers relating to quality reported to the Board over the period April 2016 to June 2017;
- feedback from the Commissioners as included within the Annex to the Quality Account;
- feedback from Healthwatch East Sussex as included within the Annex to the Quality Account;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social
  Services and NHS Complaints (England) Regulations 2009, in respect of 2016/17;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey for 2016;
- the latest national staff survey for 2016;

- the Head of Internal Audit's annual opinion over the trust's control environment in respect of 2016/17;
- the annual governance statement dated 1June 2017.

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.

This report, including the conclusion, is made solely to the Board of Directors of East Sussex Healthcare NHS Trust as a body in accordance with the terms of our engagement letter dated 6 June 2017. Our work has been undertaken so that we might state to the Directors those matters we have agreed with them in our engagement letter and for no other purpose.

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 or for the conclusions we have formed save 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;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to 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 which can result in materially different measurements and can impact 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 thereof, 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. 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 assurance work has not included governance over quality or non-mandated indicators which have been determined locally by East Sussex Healthcare NHS Trust.

Basis for qualified conclusion

Based on our testing of a sample of 40 cases, the indicator reporting the percentage of admitted patients risk-assessed for Venous Thromboembolism (VTE) does not meet two of the six dimensions of data quality for validity and completeness because:

- Two of our sample cases were incorrectly recorded as being cohorted, which means that these patients have been incorrectly included in the numerator (number of adults admitted to hospital as inpatients who have been risk assessed for VTE according to the criteria in the national VTE risk assessment tool, during the reporting period)
- Five of our sample cases were incorrectly excluded from the numerator (number of adults admitted to hospital as inpatients who have been risk assessed for VTE according to the criteria in the national VTE risk assessment tool, during the reporting period).

Qualified conclusion

Based on the results of our procedures, with the exception of the matters 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 2017:

- 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 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.

BDO LLP

BDO LLP

Chartered Accountants

London, UK

30 June 2017

Annex 3 - Equality Impact Assessment

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

Care Quality Commission	The Care Quality Commission (CQC) replaced the Healthcare Commission and Mental Health Act Commission for Social Care Inspection in April 2009. The 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
Care Pathway	This is an anticipated care plan that a patient will follow, in an anticipated time frame and is agreed by a multi-discipline team (i.e. a team made up of individuals responsible for different aspects of a patient's care).
Clinical Audit	Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.
Clinical Coding	Clinical Coding Officers are responsible for assigning 'codes' to all inpatient and day case episodes. They use special classifications which are assigned to and reflect the full range of diagnosis (diagnostic coding) and procedures (procedural coding) carried out by providers and enter these codes onto the Patient Administration System. The coding process enables patient information to be easily sorted for statistical analysis. When complete, codes represent an accurate translation of the statements or terminology used by the clinician and provide a complete picture of the patient's care.
Clostridium difficile or C. Difficile / C.Diff	Clostridium Difficile also known as 'C.Difficile' or 'C. diff', is a gram positive bacteria that causes 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. People are most often nosocomially infected in hospitals, nursing homes, or other institutions, although C. Difficile infection in the community and outpatient setting is increasing.
Commissioning for Quality and Innovation	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 East Sussex Healthcare NHS Trust introduced an electronic incident reporting software known as DatixWeb. Incidents are reported directly onto the system by any employee of the organisation, about incidents or near missing occurring to patients, employees, contractors, members of the public. The data provided by DatixWeb assists the organisation to trend the types of incidents that occur, for learning lessons as to why they occur and to ensure that these risks are minimised or even eliminated by the action plans that we put in place. DatixWeb is also used to comply with national and local reporting requirements.
Department of Health	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.
ESHT Accreditation Programme	Department based system used for ensuring hihg quality standard of care throughout.
End of Life Care	Healthcare for patients in the final hours or days of their lives, or for those with a terninal illness or terminal condition that has become advanced, progressive and incurable.
Friends and Family Test	An NHS 'friends and family' test was implemented by Prime Minister David Cameron in April 2013 to improve patient care and identify the best performing hospitals in England. Patients are asked a simple question: whether they would recommend hospital wards, accident and emergency units to a friend or relative based on their treatment. Publishing the answers allows the public to compare healthcare services and clearly identify the best performers in the eyes of patients – and drive others to take steps to raise their standards.
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	Hospital Standardised Mortality Ratio (HSMR) is an indicator of whether death rates are higher or lower than would be expected.
Key Performance Indicators (KPIs)	Key Performance Indicators, also known as KPI help an organisation define and measure progress toward organisational goals. Once an organisation has analysed its mission, identified all its stakeholders, and defined its goals, it needs a way to measure progress toward 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.
Medicine reconcilliation	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.
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 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 East Sussex Healthcare NHS Trust participate in national enquiries and review the published reports to make sure any recommendations are put in place.
National Institute for Health and Clinical excellence	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 has 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 Safety Thermometer	The NHS 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 and simple method for surveying patient harms and analysing results so that we can measure and monitor local improvement and harm free care.
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.
Patient Reported Outcome Measures (PROMs)	Assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre and post-operative surveys.
Providers	Providers are the organisations that provide NHS services, e.g. NHS trusts and their private or voluntary sector equivalents.
Registration	From April 2009, every NHS trust that provides healthcare directly to patients must be registered with the Care Quality Commission (CQC).

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.
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.
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.
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 on hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern.
Speak Up Guardian	A person who supports staff to raise concerns.
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 was 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.
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.
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.

Feedback on this document is welcome…

Please email us at:

esh-tr.enquiries@nhs.net

Or write to us at:

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East Sussex Healthcare NHS Trust
Eastbourne DGH
Kings Drive
Eastbourne
BN21 2UD

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Accessibility

The Trust can provide information in other languages when the need arises. Furthermore, to assist any patient with a visual impairment, literature can be made available in Braille or on audio tape.

For patients who are deaf or hard of hearing a loop system is available around our hospitals and a British Sign Language service can be arranged. Information on these services can be obtained via the Patient Advice and Liaison Service (PALS).

NHS
East Sussex Healthcare
NHS Trust

Annual Report 2016/17

and summary financial statements

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

PERFORMANCE REPORT
OVERVIEW WELCOME

The purpose of this section of the Annual Report it to provide a short summary that allows the reader to understand our organisation, its purpose, key risks to the achievement of our objectives and how we have performed during the year.

Welcome

Welcome to our annual report for 2016/17, a year that has seen improvement and progress thanks to the dedication and professionalism of the people who work at East Sussex Healthcare NHS Trust.

We both joined the Trust at around the start of the year with a shared goal for this organisation; to provide care in which the people of East Sussex can be fully confident and an environment in which people are happy and proud to work. The first is dependent on the second. So from the outset we have made it our business to meet those who deliver care or support the delivery of care across the organisation. We have been deeply impressed by the commitment of everyone to do their best for patients. There is a real energy and dedication with our colleagues and partners to make improvements in the quality of care we are delivering for our patients.

This improvement was recognised by the Care Quality Commission with the publication, in January, of our October 2016 inspection report. The report highlighted that the Trust was no longer rated 'inadequate' and is now rated as 'Requires improvement'. Importantly we were rated as 'good' for care, with fifteen areas of 'outstanding practice' highlighted.

However, we remain in special measures pending our next inspection only because inspectors want to make sure the changes they saw are sustained and embedded.

The CQC report echoed the summary from an inspection by a General Medical Council team in October. That report said that the organisation was unrecognisable from the picture painted by previous surveys, thanks to the hard work and commitment of everyone who works with and supports our junior doctors.

Patients have noted improvement as well. The CQC inpatient survey results published in June 2016, identified improvements in four out of five areas, with a number of areas of the survey showing significant improvement. In fact we were one of the most improved Trusts in the country. This is reiterated by our improved four star (out of five) rating on NHS Choices.

Some 3,000 members of staff (46%) responded to the NHS national staff survey last autumn. The results said that peoples' confidence in reporting incidents, feeling able to contribute towards improvements, and willingness to recommend the Trust as a place to work or receive treatment had all improved significantly.

While we recognise there is still work to do, and we must not be complacent, these reports all show that we are no longer an 'inadequate' organisation. Importantly, there are areas of practice across the Trust which rank amongst the best in the country.

Our ambition is to be rated 'outstanding' by the CQC by 2020 and we have set out a clear plan to achieve this, focusing on five key areas for improvement; quality and safety, leadership and culture, clinical strategy, access to services and operational delivery and financial control.

The past year has been challenging for many NHS trusts in England particularly in terms of finances and performance. We were no exception. As you will read, the Trust recorded a financial deficit of £43.9 million, and struggled to meet national targets such as the maximum four hour wait in accident and emergency and some of our elective (18 week) elective targets. We are working hard to address these challenges and have started to make improvements in these areas of performance.

As we move forward we will continue to deliver our plans around quality, safety, performance and finance. We need to make improvements to the way we work for our patients and begin to transform our approach to the way we manage the movement of urgent care patients around and out of hospital, back to their home. By working more effectively together with our partners in Adult Social Care and our local Clinical Commissioning Groups (CCGs) we will find the best health and care solutions for our population.

On 1st April 2017, we joined with these partners to become the East Sussex Better Together Alliance. We will work to integrate our whole health and care system: primary prevention, primary and community care, social care, mental health and acute and specialist care. Working together we can build on the improvements we have already made and tackle our financial sustainability across health and social care in East Sussex.

Another key part to solving our financial position is reducing the money spent on agency and locum staff. We have seen real improvement in the recruitment of nurses

both from home and abroad. Our senior nursing staff have successfully recruited a number of nurses from the Philippines, Spain, Croatia and Romania. We also have has great success in recruiting Healthcare Assistant with over 100% vacancies filled. Our overall vacancy rate has reduced.

We hope that this report gives you an insight into the successes and challenges we have experienced over the past year, as well as an appreciation of what lies ahead.

We are confident that with the continued dedication, commitment and professionalism of our colleagues we can sustain our improvement journey. Our priority is that the residents of East Sussex receive safe, high quality healthcare throughout our hospitals and community services.

We are immensely proud to lead an organisation with so many hard-working colleagues who provide such important services.

Through an initiative introduced this year called #ourmarvellousteams colleagues have highlighted the great work of many teams within our organisation and this report will showcase some of them.
Thank you to all our staff for their continuing dedication to delivering high quality care. Thanks also goes to our army of over 1,000 volunteers who support all our activities.

We are grateful for the ongoing support we have received from East Sussex Healthwatch, in particular the 24 hour A&E reviews they have carried out over the past year, to help give us greater insight into our patients' experience.

Moreover, we would like to thank everyone in our local community who donates and raises money for the Trust's charitable funds and for the Friends of our hospitals who support us in so many ways.

We hope that you find this report informative and that it demonstrates to you just how hard we are working to really focus on what matters to our patients.

For more information about our organisation visit our new website at www.esht.nhs.uk

David Clayton-Smith
Chairman

Dr Adrian Bull
Chief Executive

#ourmarvellousteams

"General Surgery Team - They work efficiently together and are helpful and proactive in thinking of ways to help the patient. Helping on the hot gallbladder turn around to efficiently treat inpatients with gallstone disease."

ABOUT THE TRUST

Patients come first at East Sussex Healthcare NHS Trust. 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, our staff and volunteers as part of a locally focused and integrated network of health and social care in the county.

We are proud to provide acute hospital and community health services for people living in East Sussex. We also provide an essential emergency service to the many seasonal visitors to the county every year.

Around 525,000 people live in East Sussex and we are one of the largest organisations in the county. We employ around 6,800 dedicated staff with an annual turnover of £379.307million.

We operate two district general hospitals, Conquest Hospital in Hastings and Eastbourne District General Hospital, 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.

At Bexhill Hospital we provide 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 and outpatient services at Crowborough War Memorial Hospital and Lewes Victoria Hospital.

We provide intermediate care services jointly with East Sussex County Council Adult Social Care at Firwood House in

Eastbourne. We 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.

Our staff also provide care in patients' 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.

We offer 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.

#ourmarvellousteams

"Nursing Staff - Benson Trauma, Surgery, Trauma and Orthopaedics - When faced with a crisis on the ward the night staff worked hard to reassure patients and manage the issue. No panic or overreaction they just got on with the shift. Same for the day team who had to organise and manage a very different day. Good Team work, calm in a crisis, good communication and generally great attitude."

OUR YEAR IN NUMBERS 2016/17

78,000 We treated 78,000 patients in our Emergency Departments

3,144 women became mothers by delivering 3,182 babies **3,182**

54,422 There were 54,422 elective primary procedures carried out and of these 46,470 were undertaken as day cases.

145,000 people attended outpatient appointments with us **145,000**

15,870 Our community nurses supported 15,870 patients

We performed more than 290,000 radiological examinations and therapeutic procedures **290,000**

6,000,000 Over 6 million pathology tests were carried out

Our Highlights in 2016/17

New Sexual Health Service Launched

On 1st April 2016 we launched our new integrated Sexual Health and HIV treatment and care services across East Sussex offering improved access to service users and new developments. We were successful in winning a contract to continue to be the provider of integrated Sexual Health and HIV treatment and care services in East Sussex for the next three years. Around 3,000 people use the sexual health service each month across East Sussex. Specialist sexual health services in East Sussex are provided from two main bases at Station Plaza, Hastings and Avenue House, Eastbourne, with sessional outreach specialist services provided on a variety of days and evenings in six community locations across the county.

New nurses start work at the Trust

During the year we welcomed around 350 new nurses from the UK, European Union and overseas including the large number of nurses from the Philippines to take up staff nurse positions across the organisation.

The new nurses are part of our sustained recruitment campaign to increase the number of registered nurses in the Trust. New overseas nurses spend a week being introduced into the organisation before they start working on the wards, initially, as unregistered nurses whilst they undertake training to pass the Nursing and Midwifery Council (NMC) exam for their full NMC registration.

New service to help frail people live independent lives

As part of East Sussex Better Together, a new frailty service started aimed at supporting frail people to live independent and healthy lives out of hospital. The new service, run by a team of Frailty Practitioners, coordinates the care of frail people so they can be supported to live independently at home. The frailty service is wrapped around the needs of the patient with the team working closely with the community and hospital workforce. This service helps to reduce the number of frail elderly people in hospital who could be cared for more effectively in the community, or avoids admission to hospital altogether due to the having robust preventative services in place.

New Crisis Response Service launched

A new crisis response service was launched as part of the East Sussex Better Together programme to prevent unnecessary hospital admission by providing urgent assessment and provision of community nursing care, in people's own homes. The service is made up of a team of Nurse Practitioners, Healthcare Assistants, Occupational Therapists, Physiotherapists and night sitters. Working together they help people who are unwell and who may have previously been admitted to hospital to stay at home. By the person staying at home, it allows them to be cared for in a familiar environment without the added stress and anxiety of being admitted to hospital. This ensures the person receives the right care in the right setting at the right time, one of the fundamental principles of East Sussex Better Together."

Window dedicated in memory of colleagues

A specially made stained glass window has been dedicated to the memory of colleagues who have sadly passed away. The window, opposite the Chapel at Conquest Hospital, was unveiled by our Director of Nursing, Alice Webster, at an emotional ceremony. The idea for the commemorative originated from a very difficult period experienced during the year when we sadly lost a number of colleagues, in a short period of time with whom we had been working with and we wanted to be able to remember them. The window is intended to be a point of connection for us all to remember all of our colleagues who are no longer with us.

Radiology areas upgraded

The radiology reception and waiting areas at Conquest Hospital and Eastbourne DGH have been expanded and upgraded offering enhanced privacy and dignity when patients are booking into a clinic or waiting for radiology examinations such as an X Ray or scan. This upgrade work is part of an overall development programme. The radiology improvements, costing £1.2 million, include a reconfigured ultrasound suite, new disabled toilets and baby change facilities, waiting and changing areas and a new recovery area on both sites. At Eastbourne District General Hospital the Interventional Radiology facilities have also been refurbished to improve privacy and dignity along with the installation of two new CT scanners in a new CT scanner suite.

Building work starts on Radiotherapy Centre at Eastbourne DGH

Building work started on a new £15 million Radiotherapy Centre at Eastbourne DGH. The new radiotherapy centre will significantly reduce the need for cancer patients to travel outside East Sussex for vital radiotherapy treatment. Prior to the unit's opening, patients who live in East Sussex have to travel to Brighton or Maidstone in Kent for radiotherapy treatment. The £15m investment, funded by Brighton and Sussex University Hospitals NHS Trust provides two linear accelerator machines used to deliver radiotherapy within a modern, fully equipped radiotherapy facility at Eastbourne.

Hospital is a national site for Cardiology simulation training

Eastbourne DGH is one of only eight approved hospitals in the United Kingdom to offer simulation training for new specialist cardiac doctors to improve their skills with heart procedures. Doctors are able to learn and practice procedures in a simulated situation using high-tech mannequins and IT training devices. We are delighted to be taking part in this new improved form of training for cardiac doctors and proud that Eastbourne DGH is one of only a few hospitals in the UK to be involved. Simulation training has been around a long time in the aviation industry but it is relatively new in medicine. This training uses high-tech mannequins and simulators to help junior doctors learn and develop their technique so that they are safe and prepared before they perform these procedures on patients.

New high tech drugs cabinet introduced in Emergency Department

New secure drugs cabinets with high tech fingerprint security were introduced in the Emergency Department at Eastbourne District General Hospital. The cabinets have all the medicines required by Emergency Department staff in a computer controlled user ID and fingerprint access security system only allowing the correct medicine required by a doctor or nurse to be dispensed. The cabinet is linked by computer to pharmacy to ensure stock levels are maintained. We have 13 of these secure drugs cabinets on wards across the Trust.

New investment in pathology services providing faster test results

New pathology laboratories with the latest advanced diagnostic equipment opened at Conquest Hospital and Eastbourne DGH. The new equipment was part of an £18 million, seven year contract with Roche Diagnostics Ltd to provide some of the most advanced pathology equipment available. The pathology laboratories at both Conquest Hospital and Eastbourne DGH have been significantly upgraded and refurbished into large open plan spaces where new modern robotic analysers and equipment installed. An estimated 70 to 80% of all healthcare diagnoses and decisions are directly influenced by pathology test results. This new equipment will make a significant positive impact on pathology reporting helping to ensure we provide a better service to our patients.

256 beds replaced at Conquest Hospital and Eastbourne DGH

We invested more than £350,000 in replacing all of the 256 mechanical beds at Conquest Hospital and Eastbourne DGH. The new beds have removable panels which are easy to clean, separate handsets so that both the patient and staff can adjust the height and back support provided and a night light on the underside of the bed to improve the patient's awareness of their surroundings. The beds are also extremely light, making them easy to manoeuvre, yet have increased weight capacity to support a 30 stone patient and can also be extended to accommodate taller patients. The provide the optimum combination of safety, performance and functionality.

First NHS Trust in Sussex and Kent to offer innovative new treatment for enlarged prostate

The Trust was the first in Sussex and Kent to offer the innovative UroLift System to treat an enlarged prostate, at Eastbourne DGH. This new minimally invasive treatment acts like curtain tie-backs to hold open the lobes of an enlarged prostate to create a channel from the bladder. Patients experience rapid symptom relief, recover from the procedure quickly, and return to their normal routines with minimal downtime. An enlarged prostate places pressure on the bladder and urethra (the tube through which urine passes) making it difficult to urinate. It is a very common condition for males over 50. This procedure is a true breakthrough offering men an alternative to drug therapy or more invasive surgery. It was treatment is one of six innovations hand-picked by the Government as a strategically important product for the future of the NHS, as one of a handful of revolutionary healthcare technologies that can improve the UK's public healthcare system, in a new report and funding mechanism for innovations by the UK Government released in October 2016.

CQC praises significant improvements at ESHT and issues improved rating

The Care Quality Commission (CQC) recognised significant improvements upgrading our rating to 'requires improvement' having previously rated the organisation 'inadequate' in September 2015. Care across the Trust was rated as 'good'. Following the publication of their report we remained in special measures to support our continuing improvement. The CQC recognised the progress that has been made since our last inspection. It is testament to the hard work and commitment of people across the organisation who continually seek to provide good care for our patients. We have a talented and professional workforce and the rating of 'good' for being caring is recognition of this. However, we still have a lot of work to do to ensure we provide consistently high standards of care across all of our services. We must continue to seek out every opportunity to make improvements to achieve our ambition of becoming outstanding. Our aim is to be an organisation which provides excellent healthcare for the people of East Sussex, and one in which people are happy and proud to work.

New role of Doctors' Assistants starts at East Sussex

We have pioneered the new role of Doctors' Assistant with six Doctors' Assistants undertaking admin work and essential duties alongside doctors. They help junior doctors with core tasks to free up their time so they spend less time on admin duties but the Doctor Assistants' have no duties with medication or independent decision-making. Several national studies show that doctors in their first four years spend 50% of their time on admin. The Trust was successful in a bid for £80,000 from Health Education England to run a six-month pilot of Doctors' Assistants. The project has been shortlisted into the final six for a prestigious national award, the "BMJ Award for Clinical Leadership" and show-cased in an edition of the British Medical Journal.

UroGynaecology Unit is first in Sussex to attain national accreditation

Our UroGynaecology unit is the first in Sussex to attained national accreditation from the British Society of UroGynaecology following a recent inspection. It is one of only 22 units all over 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. Attaining this national accreditation is a major achievement for our Gynaecology department and marks us as one of the best units in the country. Local women can be assured of the quality of the service we offer which, thanks the drive, ambition and expertise within the team, we will continue to build upon.

Local Cardiology Consultant appointed as Visiting Professor

Cardiology Consultant Dr Nikhil Patel was appointed as a Visiting Professor and PhD research supervisor at the Institute of Medical Science at Canterbury Christ Church University. Professor Nikhil Patel has made a significant contribution to the Cardiology Department's education and research development since joining the Trust as a Consultant Cardiologist in 1998. His recent appointment as a visiting professor accentuates his commitment to develop education and research into cardiac devices. Professor Nikhil Patel becomes our second Professor alongside Professor David Howlett. We are committed to providing opportunities for clinical research and development. Developing a research active culture brings a host of benefits for patients, clinicians and the NHS. It drives innovation, gives rise to better and more cost effective treatments, creates opportunities for staff development and encourages the recruitment of talented professionals.

Local Stroke Services highlighted as one of the best

Our stroke services were highlighted in a Stroke Association report for being one of the best in the country. The report compared stroke services across the country in key performance areas. It rated our service as the quickest for scanning suspected stroke patients within one hour (81%) and fourth best in the country for scanning within 12 hours (98.2%). The report also had local services the fifth best in the country for admitting patients to a stroke unit within 4 hours (80.5%). In July 2013, stroke services across East Sussex consolidated to provide both hyper acute and acute stroke care on one site at Eastbourne DGH. The Stroke Association report is further evidence that the consolidated stroke service is helping to save and improve more lives.

ESHT 2020
Our journey to be outstanding by 2020

In 2016 we developed a framework of objectives and actions to support us in becoming a high performing organisation. The framework encompasses five key areas of focus aligned to our strategic objectives

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

- **Leadership and culture**
  Involve our people in decisions about the services they provide and offer the training and development they need to fulfill their roles. We respect and value all our employees.

- **Clinical strategy**
  Work closely with commissioners, local authorities, and other partners to prevent ill-health and to plan and deliver services that meet the needs of our local population in conjunction with other care services. We believe in working in partnership

- **Access to services and operational delivery**
  Deliver our services efficiently and effectively, diagnosing and treating patients in a timely way to optimise their health. We all have a role to play in delivering excellence.

- **Financial control and capital development of our facilities and infrastructure**
  Use our resources efficiently and effectively for the benefit of our patients and their care, and to ensure our services are clinically, operationally, and financially sustainable. Clinical quality and financial good health go hand in hand.

Strategic plans for each clinical specialty have been developed that focus on what 'Outstanding' means for each service, how we will know we have achieved this by 2020/ 2021 and the opportunities and challenges that we need to prioritise to achieve this vision.

Key issues and risks facing the organisation

The principle issues and risks facing the organisation during 2016/17 are outlined below.

We remain in quality special measures following our CQC inspection in October 2016. Significant improvements were noted by the regulator but there is still more to do. CQC 'should' and 'must' dos are being addressed and there are programmes of work in place for Urgent Care and End of Life Care. A robust governance framework is in place to monitor and assure progress of implementing the actions.

We have a number of risks in meeting contractual and constitutional standards; most notably the achievement of the A&E standard that 95% of patients should be seen, diagnosed and treated or discharged in under four hours and that patients should wait no longer than 18 weeks from GP referral to treatment. The Trust is working with the wider health economy to develop solutions and a number of actions are in place to improve performance. These include focus and programmes of work around A&E management, development of a new medical model and improved discharge.

Our emergency departments require reconfiguration to support effective patient assessment-treatment time and subsequent discharge to other specialist/bed areas. The Department of Health confirmed in April 2017 that Conquest Hospital and Eastbourne DGH have been allocated £985k and £700k respectively.

This money will be used to build facilities to provide primary care streaming for patients who arrive in our emergency departments with minor illnesses and conditions. A funding bid has also been submitted for the wider Urgent Care Programme which, if successful, will support the development of the Departments.

There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties. This presents a number of challenges in effectively managing vacancies and appointing to "hard to recruit specialties" for example A&E consultants and middle grades and histopathology staff. We are addressing this through innovation in recruitment activity and the creation of new roles such as doctor's assistants and Physician Associates.

Throughout the financial year there were concerns over the provision of patient transport services when a new provider took over the services. The service problems had a detrimental impact on patient care and experience and there was increased non-attendance rates and loss of procedure time due to failure to collect patients and late arrivals. We worked closely with commissioners and also put in place our own contingency plans to minimise the impact on our patients. A new provider took over in March 2017 and the service has improved and is being monitored.

As outlined in this document, our financial position is challenging and we reported a deficit of £43.792m for 2016/17.

The organisation was placed in Financial Special Measures in October 2016. A financial recovery plan has been developed and we are being supported by NHS Improvement and a newly appointed Director of Financial Improvement to assist us in delivery of this.

Performance summary

A number of challenges exist in respect to achieving referral to treatment timescales and A&E performance.

During the year the Trust experienced increased operational pressures; notably a 2.2% increase in primary care referrals and A&E attendances were up by 4.6%, particularly those arriving by ambulance.

In addition, there were more than 1,000 more admissions to the hospitals than last year, with the biggest increase being in the number of day cases.

The increase in the number of attendances and patients contributed to a decline in the performance of the A&E 4 hour standard of 95% from 88.1% last year to 80.3% this year.

A number of key actions have been implemented including better directing of patients in A&E and improved triaging processes. For elective care, despite an increase in the number of elective admissions, the number of patients waiting more than 18 weeks increased in comparison to 2015/16.

The increase was mainly seen in the first part of the year with an improvement in performance from November onwards.

Referrals for patients on the 2 week wait cancer pathway increased by more than 12% although the Trust has consistently met all the cancer targets with the exception of the 62 day wait.

This increasing demand is compounded by skill shortages in some specialties. The Trust is implementing recovery plans and targeted recruitment campaigns where required and working with commissioners to develop a system wide approach to improving performance. The Trust has additional resources in place to support patient flow and has been supported externally by the Emergency Care Intensive Support Team.

Going concern assessment

The Trust has prepared its 2016/17 Annual Accounts on a going concern basis. After making enquiries the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future.

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 Sussex and East Surrey Sustainability and Transformation Plan.

Access to cash continues to be available through application to Department of Health via NHS Improvement from the Independent Trust Financing Facility. For this reason they continue to adopt the going concern basis in preparing the accounts.

PERFORMANCE ANALYSIS
QUALITY AND SAFETY

A number of projects have supported the delivery of our Quality Improvement aims.

These projects are more fully detailed in our Annual Quality Account and have included:

- Reduce patient falls
- Reduce hospital acquired pressure ulcers
- Improve the End of Life Care Pathway
- Improve awareness, identification and treatment of patients with Sepsis.

Mortality

Despite new technology and medical breakthroughs of recent years, people do die in hospital – every day, every month and every year.

Most of the time, these deaths are unavoidable – the consequences of major trauma such as road traffic accidents, as well as other serious conditions like heart attacks.

Some people die because their illness is incurable; yet others have just come to the end of their natural life and the most important thing is that they have a dignified and respectful death, ideally at home surrounded by their loved ones.

We measure mortality rates as they help us better understand the risks of hospital treatments for individual patients, changes in patterns over time can pinpoint where improvements may need to be made.

They can also help those people wishing to make a choice about the hospital where they may want to have their treatment. Accurate mortality data matters – to doctors and nurses, as well as to their patients.

When it comes to measuring mortality rates, there are three main statistics used:

- Crude mortality rate - produced locally by the Trust itself
- Hospital standardised mortality rate (HSMR) - published nationally by Dr Foster Intelligence.
- Summary hospital-level mortality indicator (SHMI) - published nationally by the Health and Social Care Information Centre (HSCIC)

Our Clinical Outcomes Group and the Clinical Effectiveness Group continue to drive the reduction in mortality metrics through tracking specific clinical outcomes and investigating potential outlier conditions to provide assurance that safe and effective care is being provided.

Our mortality metrics are within the expected ranges and we aim to undertake reviews of all deaths that happen whilst patients are in our care.

Analysis of main causes identifies pneumonia as the highest cause.

Safe staffing

We continue to review the usage of e-rostering to ensure that there is adequate central support available in recognition of the fact that effective rostering ensures adequate and safe staffing on our wards.

Twice yearly establishment reviews have continued to be carried out which have resulted in increases in staffing numbers where necessary in order to ensure we have sufficient colleagues to deliver safe patient care.

We continue to have difficulty in recruiting staff to some areas within the Trust including Medical (Doctors and Consultants) as well as Registered Nurses. This reflects the national position of shortages in these areas. We continue to recruit from both the EU and Internationally for these posts, in order to meet our requirements.

We have also carried out workforce reviews to establish and create new job roles to provide support for both Doctors (Doctors Assistants) and Matrons (Matrons Assistants). Both these roles release colleagues to spend more quality time with patients by covering the administrative aspect of the positions. We will continue to examine the option of new roles within the Trust to support patient care.

Governance

We are committed to ensuring we continually learn from past events, fully adopt evidenced based standards and policies of safe practice and ensure operational resilience for the future.

To facilitate this the Trust's governance structure has been strengthened and a review of committees and groups undertaken, to ensure clear lines of accountability and escalation processes for managing and delivering on concerns and celebrating success.

Reporting and monitoring systems have been revised and enhanced to ensure that we deliver robust and timely investigations of incidents with clear tracking from actions and testing they are embedded in practice. We previously had a backlog on the completion of serious incidents and this was cleared by October 2016 and has remained within the timescales for all investigations.

The quality of these investigations, subsequent findings and resultant actions has improved our learning from events. Although not fully resolved, our previous delay and backlog in responding to patient experience through complaints has continued to reduce significantly to now provide timely feedback with identified actions tracked on our monitoring systems. The CQC noted the improved governance across the Trust following the October 2016 inspection.

Patient and Public Involvement

We will only achieve our 2020 ambitions 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.

We continue to take forward work that measures, reports and improves patient engagement and experience and actively involve patients and the public in this process. Our intention is to ensure that the involvement of patients and families in making improvements to our services, becomes part of everyday practice.

We have organised departmental open days, and have played a more active role within the community, speaking at a number of public facing external meetings, introducing local people to the work of the trust and answering their questions. Following the Big Conversation events we are developing a three year public engagement strategy and annual implementation plan to take this work forward.

As part of the East Sussex Better Together Alliance, we have held joint workshops and events with members of the public asking them about their expectations of care services in East Sussex, what matters to them and how we can better engage them in our work.

Our patient experience team continues to support individual services in engaging with service users, carer groups and staff, A public engagement event was held where we sought feedback on the proposed Quality Account Priorities for 2017/18. 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 from 93.23% in 2015/16 to 94.45% in 2016/17.

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 all of these issues. We have developed a robust system of monitoring the NHS Choices and Patient Opinion websites and welcome feedback via these routes. We have received a higher number of positive comments on these sites during 2016/17 than we did during the previous year.

We have increased our engagement with the public and patients especially by involving members of Healthwatch East Sussex within our Patient Experience Group to understand the issues and shape the work required for the year ahead to deliver on further improvements.

Healthwatch

Healthwatch East Sussex made a commitment to local people that it would provide opportunities for patients and members of the public to be actively involved in the scrutiny of their local acute and community trust.

This commitment to strengthening patient and public involvement involved:

- The recruitment of approx. 50 volunteers from across the county to support the trust's Improvement Plan
- Engaging with over 750 patients about the quality of care they received, including engagement activities over two 24 hour periods
- Unplanned visits to surgical wards
- Speaking and listening to over 300 women's views about their experiences of using local maternity services; and
- Distributing leaflets to patients and visitors informing them about how to give feedback on the care they receive

This activity has been supported by staff from Healthwatch East Sussex attending a range of meetings to ensure patient feedback remains at the heart of the Trust's improvement agenda. We have also engaged with wider partner and stakeholder networks, making sure quality assurance systems and processes are robust and reflect the best interests of local people.

Our involvement with the Trust on this part of their journey was very positive and we extend our thanks to all the staff for their cooperation and support in delivering innovative approaches to patient engagement. We look forward to the next phases of work as the trust continues its improvement priorities for patients in hospital and in the community.

Julie Fitzgerald, Director
Healthwatch East Sussex

During 2016/17, Healthwatch undertook a programme of 'Enter and View activities'. These included:

Special measures, to special moments - an overview of maternity services

It was really important for us to have an independent review of maternity services and Healthwatch East Sussex (HWES) were asked to gather the views of women and their families who use local maternity services as part of an ongoing support package for the Trust. Trained volunteers visited maternity services, and spoke directly with 50 patients and/or their partners about their experiences noting their observations of the service over a three day period.

Notable observations and findings were that women on both units at the time of the visit shared mostly positive experiences about their interactions with nursing and midwifery staff. The midwife led unit at Eastbourne was very highly rated by women and their partners, and described by some as a 'gold standard service'. Areas for improvement were also identified, which will be focused on in 17/18.

24 hours in East Sussex acute hospitals, the patients' view

Healthwatch were asked to visit the Trust for a 24 hour period to observe and feedback to us about how patients saw our services throughout the day. Healthwatch East Sussex volunteers, trained as authorised representatives, spent 24 hours in both acute hospitals in April 2016, and again in November 2016. They talked with patients, carers, relatives and some staff to gather their views and experiences. They asked people to rate the care and treatments they received, about whether their care met their expectations and how well they were communicated with.

Notable observations and findings were that patients' and relatives' experiences of care during the 24 hours were largely

reported in a complimentary and positive fashion. Authorised representatives' observations of care during the 24 hours were also positive and complimentary. Areas for improvement were also identified, which will be focused on in 17/18.

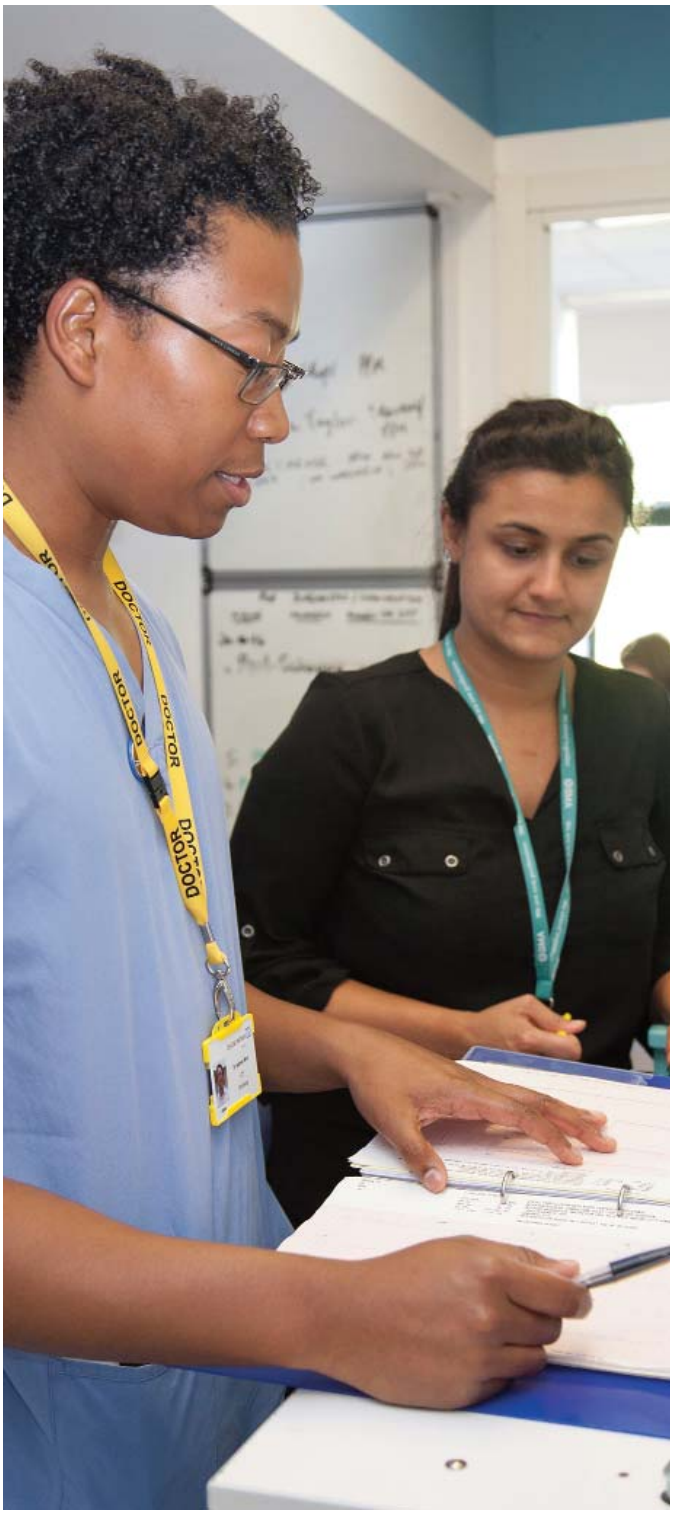
The Pathway to Urgent Care - Turning Up Where The Light Is On

HWES planned a short activity, conducted over a two week period by HWES volunteers, to undertake a series of short, semi structured interviews with patients, using a questionnaire to gather their views and experiences. This was completed over a two week period in August 2016, with volunteers attending urgent care departments between 10:00 - 22:00 every day, including on weekends and a bank holiday. A total of 623 people took part across the major Accident & Emergency Departments (A&E), Minor Injury Units (MIU) and Walk In Centres (WIC).

The supplementary information and elements of the questionnaire showed that less than 15% of people were found to have been waiting for more than 2 hours across all departments. Many people commented positively about their interactions with the staff and their treatment in the A&E departments. For MIU, all comments received were positive, with those relating to staff being the most significant in number. In conclusion, many people had a positive experience when they arrived at an urgent care department within East Sussex Healthcare NHS Trust. Areas for improvement were also identified, which will be focused on in 17/18.

The Trust would like to acknowledge the time and effort that has been put into this valuable programme and for the subsequent constructive reports presented to the Trust. We thank all those who participated in the development of this programme. These reports acknowledge that whilst there has been improvement in our services we still have further work to do.

A critical part of this will be for the Trust to continue to work with Healthwatch on gathering and responding to feedback on our services. We meet with Healthwatch on a monthly basis and we are very grateful to them for the commitment and support that they provide. This helps us to provide a more meaningful and positive patient experience and patient environment.



Care Quality Commission

The CQC inspected the acute services of the Trust (Eastbourne District General Hospital and Conquest Hospital) in October 2016 and reviewed services against the five domains of safe, effective, caring, responsive and well-led.

The reports were published in January 2017 (available at www.esht.nhs.uk/about-us/cqc-report/) and they recognised significant improvements since the previous inspection in 2015. The CQC rating moved from 'Inadequate' to 'Requires Improvement'.

The CQC gave the organisation a total of 112 ratings; these included 58 'Good' ratings and 2 'Inadequate' ratings for the Safe domain of Urgent Care on both sites. Within the reports the CQC commended 15 areas for outstanding practice. The reports also identified some areas where further improvements were required and included two 'must do' actions, relating to play services in paediatrics and staffing in the A&E departments and 35 'should do' actions.

Improvements identified during the inspection included:

- Improved surgery at all hospitals, with services at both Conquest Hospital and Eastbourne DGH upgraded to 'Good' overall from 'Inadequate'.
- All services rated 'Good' for caring, with very positive feedback from patients with respect to the caring nature of staff.
- Improved leadership with a coherent and consistent view of strategic, operational issues and risk.
- A 'transformed' organisational culture
- Significant improvements in out-patients and clinical administration.
- Critical care rated as 'Good' across the organisation.
- Improved infection control and cleanliness with significant improvements in hand hygiene compliance across the Trust with the organisation noted as a largely clean environment
- Maternity services rated as 'Good' for caring and well led having previously been rated as 'Inadequate' overall.

There is a robust programme of work and governance framework in place to support delivery of continued improvement. The improvement plan is reviewed both internally and externally at monitoring meetings with key stakeholders. The Trust remains in special measures until improvements are seen to be fully embedded, and as a result will benefit from ongoing support.

We know there is a great deal more to be done in all areas of quality and safety to ensure we deliver the aim of becoming rated as an outstanding organisation by 2020 and the plan for this is detailed within the Patient Safety and Quality Strategy.

The Risk and Quality Delivery Strategy for the organisation outlines the structure and systems to deliver this. One of our greatest challenges is to manage effective patient flow through the organisation to ensure the specific clinical pathway/patient journey ensures timely investigation, treatment and appropriate discharge without delay to the most suitable place once hospital care has been completed.

This is integral to our 2020 strategy and requires work within the organisation and collaboration with external partners.

CULTURE AND LEADERSHIP

Celebrating our Staff Achievements

We have worked hard to celebrate and share individual and staff achievements during the year.

The introduction of #OurMarvellousteams by our communications department has been a great way to hear about the work of the teams across the organisation.

Alongside the Trust awards we have held a number of celebration events recognising the work of staff and volunteers. These included the Unsung Hero week, showcasing the work of staff who work behind the scenes, International nurses day, a Volunteer celebration event and Mentorship awards.

Clinical Leadership

We are committed to placing clinical leadership at the forefront of our organisation, and improving communication, decision making and accountability.

Following feedback about our clinical unit structure we evolved the existing structure into the following Clinical Divisions:

- Medicine
- Diagnostics, Anaesthetics and Surgery
- Women's, Children's and Sexual Health
- Out of Hospital
- Emergency Care will remain a Clinical Unit pending further review.

Each Division is led by a leadership team comprising the medical Chief of Division, General Manager, and Assistant Director of Nursing. The Out of Hospital Division is headed up by a broader management team, chaired and led by the General Manager and includes a Senior Medical Adviser and Senior Nurse.

We have also strengthened the operational management of the two hospitals and surrounding support services by establishing a Hospital Director at each main site supported by an Associate Medical Director and Deputy Director of Nursing. Newly appointed Specialty Leads have led to increased accountability and significantly strengthened medical leadership under the medical Chiefs of Division.

#ourmarvellousteams

"**The Out of Hospital teams** - This Division is demonstrating how using social media is supporting cross team health and well-being. Competition and conversations are happening on @ESHT_OOH twitter across the county showing the positive and creative attitudes of our truly marvellous teams! The teams themselves are creating and growing a sense of togetherness and support that is growing by the minute. We are so proud of the teams joining in with the spirit of our Out of Hospital Olympics. They have also been sharing good news stories in their teams and this is what makes coming to work so much more enjoyable."

STAFF DEVELOPMENT, ENGAGEMENT AND WELLBEING

Clinical Education and Learning and Development

We continue to work closely with Health Education England (Kent, Surrey, and Sussex) who have supported and funded the majority of our externally provided training.

We commission professional education placements at our local Higher Education Institutes (HEIs), and also ensure that the skills and knowledge of our workforce are maintained and developed through providing continuous professional development.

During the year we have aligned our education provision with service need and divisional business plans. We have been working with East Sussex Better Together to support the development and training for new roles within health and social care and ESHT.

Internally, we have provided induction training for all new staff including additional induction programmes for health care assistants and overseas nurses to support our recruitment drives in these areas.

A range of mandatory training opportunities are continually provided for staff with a range of role specific training options. Ongoing training has been provided for overseas nurses to support them in their roles and ensure that they achieve their Nursing and Midwifery Council registration.

We are achieving a success rate of over 90% with the completion of OSCE (Oral Structured Clinical Examinations) for the overseas nurses. Mandatory training compliance is on an upward trajectory and the team are working closely to support the business units in maintaining and improving compliance.

Our established in-house programmes continue to be delivered and well received and during 16/17 we offered additional training identified by the Senior Management Team. This included Introduction to Coaching, Management Essentials Training, and Conflict Resolution Training for doctors.

In conjunction with the staff engagement team a new leadership programme is being developed for managers.

Achievements during 2016/17 include:

- Supporting new job roles in the organisation, such as doctors' assistants, for which the trust has been nominated for a national award.
- In preparation for the Apprenticeship Levy, which comes into effect from April 2017 we have worked with the business units to identify staff to undertake a range of clinical and non- clinical apprenticeship programmes. These staff were mainly from bands 1 to 4.
- During the year 27 staff commenced a non-clinical apprenticeship and 17 staff commenced a clinical apprenticeship.
- The apprenticeship role, supported by Health Education England through widening participation funding, has been very successful and a second HR post has been introduced to support the ongoing apprenticeship agenda.
- We have worked with the business units to provide team training that fits around the clinical commitments.
- An apprenticeship role in Learning and Development to support e-learning has been very successful and will continue for a further 12 months.
- A significant amount of additional bespoke training for staff undertaking appraisals was provided during the year in the form of a masterclass. This has supported the implementation of the new Appraisal policy and improved appraisal compliance.
- Significant preparation has been done towards the implementation of Clinical Supervision for nursing.
- Both the clinical education and learning and development teams remain focused and committed to providing support through education and training for the ESHT workforce.

#ourmarvellousteams

"**Speech and Language Therapy** - Everyone works together really well to do the best for our patients. We have excellent team spirit and high morale to help us through any challenging times. We have an excellent leader in Anita Smith. I am admin so I am here to support Anita and the clinicians – and they support me too. They are very appreciative of the input I give the team which makes me feel valued. I genuinely look forward to coming to work because of my colleagues. Their professionalism, skills and enthusiasm improve the quality of life for our patients. They get lovely plaudits, verbal and written that come back from patients. The initiatives they come up with and the team response to these for example our recent very successful Swallowing Awareness Day – Anita was responsible for setting it up but the whole team got behind the idea and contributed to a fantastic day of promoting awareness about how swallowing difficulties affect people and what help is available."

Staff Engagement and Wellbeing

Our goal is to be an organisation which provides care in which the people of East Sussex can be fully confident, and one which people are proud to work.

We know that if the people who work for us are engaged and involved then patient experience/outcomes are better

Our recent CQC inspection, Staff Survey Results, and the Staff Family and Friends tests demonstrated significant improvements in staff engagement during the past year. This has been further demonstrated by the results of the regular pulses surveys where we seek staff feedback

The improvements are a result of everyone working together to identify areas for improvement and solutions.

Following feedback from staff in last year's national staff survey we agreed to address three priorities. These were:

- improving communication between managers and staff
- developing a health and wellbeing service for our staff
- addressing areas where behaviours were not acceptable resulting in staff feeling undermined.

A number of pieces of work then followed:

- The introduction of a management essentials programme, championed by the Chief Executive, clarified expectations for all our managers in terms of staff engagement. This was further supported by the introduction of an engagement and communications toolkit to support managers in the engagement of staff.
- The clinical administration service commissioned a bespoke programme for all levels of leaders to focus on how they could improve staff engagement.

#ourmarvellousteams

"**The Infection Prevention and Control Team** - During the last 3 months whilst I have been out of the Trust on secondment to another organisation the Infection Prevention & Control team members have worked together to deliver some significant service and quality improvements including; co-ordinated World Hand Hygiene day events including gain pledges form staff to commit to hand hygiene, improved the process for RCAs of healthcare associated infections (HCAIs), revised and implemented some key polices, developed a program of work, focused on strategies for prevention of infection, recruited new team members into new roles for development and held a successful one day conference for Infection Control Link Facilitators. Particular praise must go to Lesley Smith for taking on the role of Interim Lead ICN during this time but most importantly all the team members have demonstrated the improvements that can be achieved through the genuine and sincere application of all of the Trust values in everything they do."

- Increased visibility of our senior leaders through staff forums, regular events, quality walkabouts and regular visits to wards and departments. Staff have commented on how they have welcomed the opportunity to showcase their work
- Our staff wellbeing service has introduced a number of programmes to look after both the physical and physiological wellbeing of our staff. These include the introduction of health checks for staff between the age of 40 to 70, healthy weights programme, stop smoking surgeries, introduction of Pilates classes, emotional resilience and Schwartz

rounds. A monthly wellbeing newsletter is distributed containing a list of available activities, healthy eating recipes and tips and techniques to improve health and wellbeing.

- Work linked to our values and behaviours is ongoing to ensure that we demonstrate these during our everyday interactions with both the people who use our services and the people who work here. Staff are encouraged to raise concerns linked to undermining behaviour through their line management structure.

Each division has a staff engagement plan; linked to their own local priorities; many have made considerable improvements this year.

We continue to listen to staff feedback in a range of different ways including formal and informal meetings and engagement with the Joint Staff Committee, regular short pulse surveys to staff and Listening Conversations with our staff about areas where they would like improvements to be made. Feedback from quality walkabouts by Board members is discussed at every Trust Board meeting. The Chief Executive holds regular "meet and greet" meetings with a range of different staff to hear their views

We have also continued to review how we communicate with staff. In September last year we developed the ESHT Vine which consists of over two hundred staff who help communicate and reinforce key messages through the theme of the week to their informal/formal networks

We continue to run a scheme enabling staff to bid for allocated charitable funds money which enables them to make small improvements within their departments that will make improvements to patient care or to their working lives. Examples include the development and publication of a guide for new fathers which explains about their baby's development, items for bereavement areas and improvement to the waiting areas at Hailsham Health Centre.

Staff Survey Results

The NHS Staff Survey has been carried out annually within NHS organisations since 2003.

The CQC use the staff survey as part of the ongoing monitoring of registration compliance.

The purpose of the survey is to collect staff views about working in their NHS organisation. The data will be used to improve local working conditions and ultimately to improve patient care. The survey has been designed to replace organisations' own annual staff surveys as well as those run by the Department of Health, and CQC reviews.

The survey is administered annually so that staff views can be monitored over time. It also allows for comparison of experiences of staff from similar organisations to our own, and to compare the experiences of staff in a particular organisation with the national picture.

46% of our staff took part in the survey which is above the average response rate for combined acute and community trusts in England and increase of 6% from the previous year. The responses of individual members of staff are entirely confidential.

Our priorities for 2016

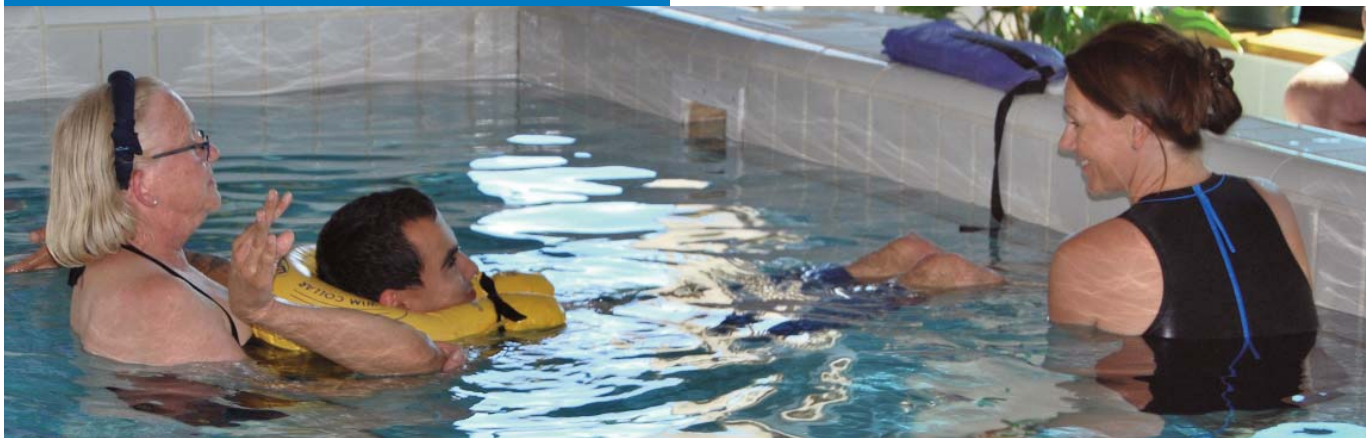
Following the results of the 2015 survey, three priorities were set by our Board for 2016:

1. Improving communication between senior management and staff
2. Reducing bullying and harassment
3. Improving health and wellbeing of staff

It was encouraging to see that significant improvements were made in each of these areas.

The survey asks 30 multi-part questions which are grouped into 32 Key Findings (KFs). 24 KFs demonstrated a positive change, and no KFs showed a negative change since the previous survey. However, when compared to comparable Trusts in England 13KFs were average and 19KFs were below average.

We were extremely pleased to see the improvements that have been made in many areas of our staff survey results compared to those of the previous year, particularly as there is a direct correlation between staff engagement and patients' experiences and outcomes. We will work hard to build on the tremendous progress that has been made during 2016.
The tables below set out some of the key findings from the staff survey.



Improving communication between senior management and staff

Area	2015	2016	Comparable Trust Average
Overall staff engagement (1 to 5, where 5 is best)	3.55	3.73	3.80
Good communications between senior management and staff (higher is better)	19%	32%	32%
Effective team working (higher is better)	3.62	3.78	3.78
Support from immediate managers (higher is better)	3.52	3.72	3.74

Reducing bully and harassment

Area	2015	2016	Comparable Trust Average
Those experiencing harassment, bullying or abuse from staff in the last 12 months (lower is better)	32%	27%	23%
Fairness and effectiveness of procedures for reporting errors, near misses and incidents (higher is better)	3.41	3.69	3.73
Confidence and security in reporting unsafe clinical practice (higher is better)	3.30	3.56	3.68
Those reporting most recent experience of harassment, bullying or abuse (higher is better)	37%	48%	45%
Those reporting most recent experience of violence (higher is better)	64%	69%	67%
Those reporting errors, near misses or incidents witnessed in the last month (higher is better)	87%	91%	91%

Improving health and wellbeing of staff

Area	2015	2016	Comparable Trust Average
Organisation and management interest in, and action on, health and wellbeing (higher is better)	3.33	3.61	3.61
Those working extra hours (lower is better)	72%	70%	71%
Those attending work in the last 3 months despite feeling unwell, because they felt pressured (lower is better)	66%	62%	55%

Other highlights

Area	2015	2016	Comparable Trust Average
Those agreeing that their role makes a difference to patients/service users (higher is better)	88%	89%	91%
Staff recommend ESHT as a place to work or receive treatment (1 to 5, where 5 is best)	3.36	3.63	3.71
Satisfaction with the quality of work and the care they are able to deliver (higher is better)	3.72	3.87	3.92

OUR VOLUNTEERS

We now have approximately 700 volunteers in service across our sites. Our service diagrams below detail where these volunteers are placed.

Over the last 12 months Volunteer services has transformed its training, recruitment and engagement in line with national guidelines. All our volunteers are now DBS checked, fully referenced and attend training which now includes safeguarding , equality and diversity, infection control, fire safety and manual handling.

We have established links into the community providing information and resources and enabling people wishing to volunteer an easy access to information.

The new 2017 SMILE magazine was produced and distributed which details our recruitment process in full and as well as being available in our hospitals is also available to view online.

The team have also set up a twitter account which is @ESHTVolunteers which provides updates and news. We also publish regular newsletters which all the volunteers receive.

We celebrate and value our volunteers at ESHT, each year our Long service awards take place for those that have reached milestones in their volunteering career.

At Christmas we held a thank you buffet at each site and these were well attended with over 100 guests at each one.

As part of national volunteer's week (June) last year we arranged 'thank you' lunches at each of the hospital sites as well as certificates for our volunteers, this year there are celebration events taking place at both Eastbourne and Hastings during Volunteers week.

We are now successfully placing volunteers in more supported roles throughout the hospital, responding to the changing face of volunteering and those seeking experience/ references etc.

New roles are being developed all the time but some of our roles currently being placed include

- Front of house reception and Wayfinding
- Patient Library and book sales service
- Hand-care Teams
- Ward and Division Administration
- Chaplaincy
- Hospital Radio
- League of Friends
- Pathology
- HSDU
- Breastfeeding Support
- Macmillan Counselling
- Cardiac Rehab
- Ward helpers

In 2017 we also sent our first annual 'Survey' to all volunteers giving them the chance to provide feedback and for us to address any issues or actions the results and actions are below.

How Are We Doing?

Thank you to all of you who completed and returned your annual surveys.

Your Views matter to us, we have followed up the comments made by some of you and actioned them. Aside from the annual survey you can always speak to your local teams for any suggestions or advice.

The Overall Satisfaction Rating for our service from 332 responses was

Not Satisfied	Neutral	Satisfied
2%	7%	91%

From the comments & feedback received we have also identified some areas for improvement

You Said	We Did
'It's sometimes difficult to access the volunteer services team'	We are a small team, often lone working back to back and covering 6 sites between us, we have ensured that our offices if closed explain our whereabouts, signpost you to our email (which all the team access even when offsite) voicemails (accessed daily) and ensured emergency contact numbers are also available.
'We did not receive regular updates from the volunteer team'	It became apparent that some of our volunteers were not receiving their newsletters, our next one is Easter 2017, we will do a physical delivery to all volunteer areas, a postal delivery to those unwell or on hold, and in areas such as chaplaincy and the Friends (DGH & Conquest) we will individually address them and deliver to the shops/ chaplaincy areas to ensure that they get to you

Becoming a Volunteer

The full recruitment process is outlined on our website: www.esht.nhs.uk/volunteers

Our volunteer services teams can talk you through the process and what's available. We always aim to be able to place most enquiries and if there is not a suitable placement we can refer onto one of the community agencies who can assist.

Contact details for the volunteer teams:

Eastbourne
Tel: 01323 417400 Ext 4880
Email: esh-tr.voluntaryservices-eastbourne@nhs.net

Hastings
Tel: (01424) 696955 Ext 8496
Email: esh-tr.voluntaryservices-hastings@nhs.net

Equality, Diversity and Human Rights

2016/17 has seen many positive changes across the organisation with Equality and Diversity being no exception.

The Trust's nomination as a finalist at the Health Education Kent, Surrey Sussex (HEKSS) Leadership and Innovation awards for being an 'Inclusive Leader' is a clear demonstration of our continued commitment to staff in ensuring that Equality is at the heart of all we do.

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.

During 2016/17 the Equality and Human Rights Department have implemented many equality initiatives and engagement events that have ensured people's needs are at the heart of service delivery, change, improvement and development. Some of the highlights of 2016/17 include:

- The Trust has welcomed the new 'Accessible information Standard' with implementation across the organisation well under way. This standard has assisted the Trust in developing a streamlined process for ensuring people with a communication barrier, arising from a disability, have access to the support they need.
- A new contract for the supply of interpreting and translation services commenced in September 2016 which 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 containing many resources for patients, carers and service users with communication needs were delivered to the elderly wards at Bexhill, Conquest and Eastbourne hospitals. The boxes included digital listeners which help to support elderly patients with reduced hearing to be fully involved in their care and decisions about their care as well as improving social interaction.
- Staff involved in organising or using interpreters were provided with training on working with interpreters and using the new system. Training is also included in induction training for all new staff in patient facing roles.
- Two new staff networks were formed; Lesbian, Gay, Bisexual, Transgender and any non-conforming (LGBT+) member of staff and Black and Minority Ethnic (BME) staff. The networks aim to provide a safe place for staff to seek support, meet people with similar interest, raise awareness, identify training and development opportunities.
- A staff disability network is currently being developed. The first meeting will take place in summer 2017.
- Project Search continued to work with local colleges providing internships for young people with learning disabilities.
- Equality, diversity and human rights training continued to be rolled out for doctors, nurses, therapists, ancillary and administrative staff to support the development and spread of inclusive practices.
- Tailored equality, diversity and human rights training delivered to clinical units to support staff in meeting the needs of their patients, carers and service users.
- Sexual Health continued to promote support for Lesbian, Gay, Bisexual and Transgender (LGBT) patients, carers and service users with drop in clinics and male only weekly clinics.
- Successful retention of the Disability Positive Employer ("two ticks") status which recognises our commitment to supporting disabled job applicants, including through a guaranteed interview scheme.

- EDS2 continued to enable us to meet our legal obligation to eliminate unlawful discrimination, advance equality of opportunity and to foster good relations, as per the Equality Act 2010.
- Equality impact assessments continued to be carried out by all staff, ensuring equality and diversity continued to be embedded within each policy document and that each protected characteristic is assessed at every stage, ensuring 'due regard' is integral to every process.
- Health Visitors continued to support local migrants with access to interpreters and advocates to promote "Accessing NHS Services through the correct pathways", ensuring new migrants understand how to access NHS services appropriately
- The Equality and Diversity webpage continues to provide further communication resources to support The Accessible Information Standard and people who do not use spoken English as their first language. Resources include an online form for patients to advise of their communication preferences; language identification chart, common phrases in many languages, bilingual appointment letters and the Hospital Communication Booklet which provides pictorial support.

#ourmarvellousteams

"Cuckmere Ward - I have been nursing for 30 years but I have never worked such a genuinely supportive team, the patient is a 100% centre of everything they, this has to be one of the most stressful wards to work on yet the staff always manage a smile, a joke or a tear, but most importantly they all have each other backs, from matron to housekeeper they are one."

ACCESS AND DELIVERY

We are committed to operating efficiently and effectively, diagnosing and treating patients in timely fashion and expediting their return to health.

This commitment is underpinned by a number of Key Performance Indicators (KPIs) which are detailed below. They are monitored via various forums and accountability reviews such as:

- Weekly Patient Tracking List (PTL) meetings for Referral To Treatment (RTT), Diagnostics and Cancer performance
- Monthly Executive led integrated performance reviews with each Clinical Division. A performance report is presented at each of these meetings
- A Trustwide integrated performance report which is presented at Finance and Investment Committees and to the Trust Board
- Monthly Contract Performance reviews with the CCGs
- Monthly Oversight meetings with NHS Improvement

We have also introduced an Elective Care Delivery Board, a Cancer Care Delivery Board, an Urgent Care Delivery Board, and a Maternity Care Delivery Board. These committees are led by clinicians and oversee the cross-organisation operational arrangements to ensure the efficient achievement of operational standards for these areas of care.

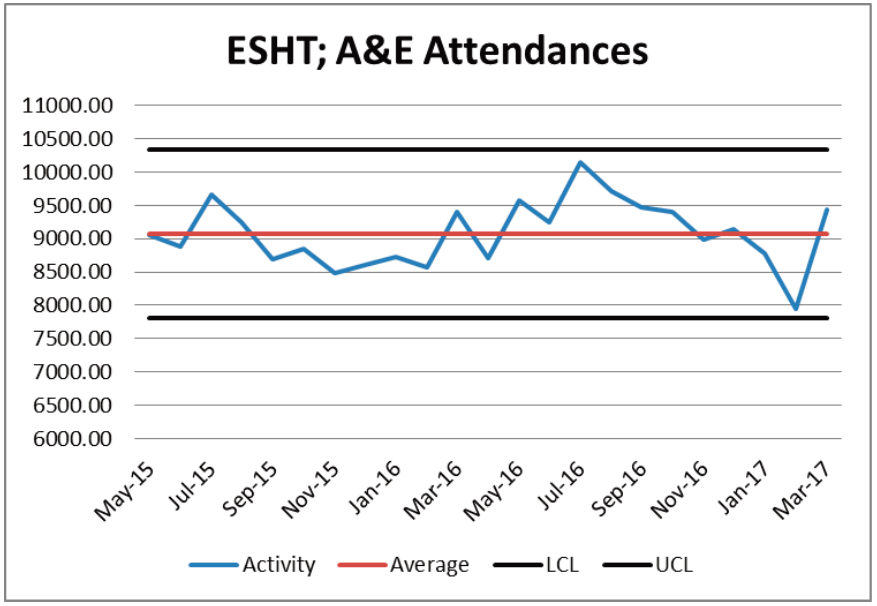
An information suite provides managers and clinicians with monitoring information. It provides both historical and forward views which allow clinical units to monitor performance against KPIs. Examples of information that we monitor include live PTL booking data, daily clinic and theatre utilisation data, live cancer performance and booking tools, Did Not Attend (DNA) rates and RTT performance.

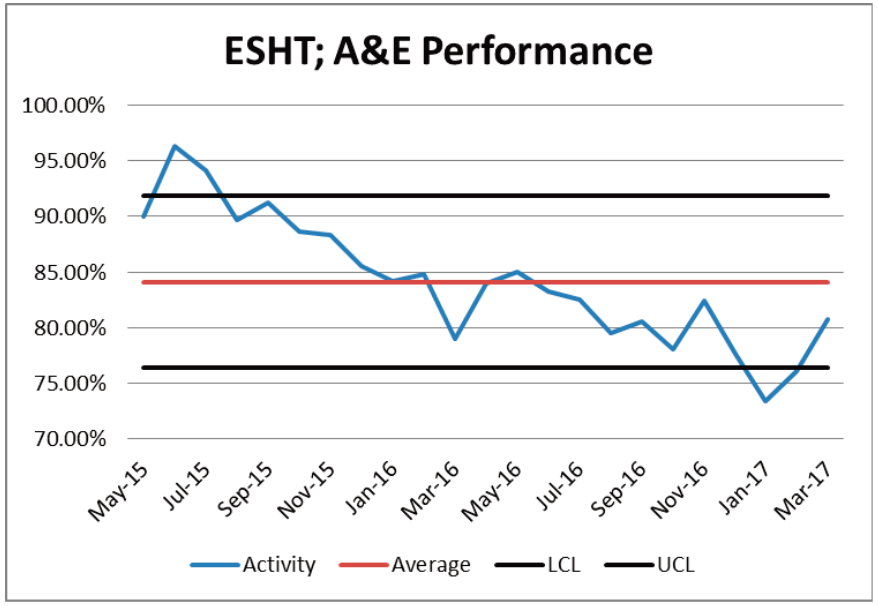
Access and Responsiveness: Emergency Department – 2016/17

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	Yr	Last Yr	Var	
A&E Performance (4 hour wait)	95.0%	83.9%	85.0%	83.2%	82.6%	79.5%	80.5%	78.1%	82.4%	77.6%	73.4%	76.1%	80.7%	79.0%	1.7%	80.3%	88.1%	-7.8%	
A&E 12 Hour trolley waits	0	0	0	0	0	1	0	2	0	0	0	0	0	0	0	3	1	2	

Commentary

- Year to date attendances are up by 3662 (3.3%)
- The Trust did not achieve the 4 hour target during 2016/17.
- Increased attendances, particularly for patients attending via ambulance has had a major impact.
- Recruitment to key posts within the Emergency Department continues to be challenging. As such, there has been a reliance on locum and agency staff to cover some vacancies.
- A number of initiatives are now in place to improve flow through the A&E department and the hospital. This will provide a greater opportunity to meet the 4 hour target.
- The Trust has stabilised the position over the final months of the year. Performance is now showing signs of improvement.





Access and Responsiveness: Referral to Treatment and Diagnostics – 2016/17

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	Yr	Last Yr	Var	
RTT Incomplete (%achievement)	92.0%	90.2%	90.7%	89.5%	88.5%	87.5%	86.7%	85.7%	85.6%	85.6%	88.9%	89.3%	90.8%	90.5%	0.3%	88.2%	93.0%	-4.8%	
RTT Backlog (number of patients waiting over 18 weeks)	M	2936	2931	3399	3791	4239	4534	4809	4714	4425	3243	3131	2680	2823	-5.1%	334530	303304	10.3%	
RTT 52 Week waiters	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	1	
Diagnostic performance (% patients waiting over 6 weeks	1.0%	2.9%	2.7%	2.6%	2.2%	3.0%	2.5%	0.9%	1.6%	0.8%	0.9%	1.2%	1.4%	6.7%	-5.3%	98.1%	97.6%	0.5%	

Commentary

- The overall aggregate score for the Referral to Treatment (RTT) Incomplete was 88.2% against a target of 92%
- The Trust did not achieve the Incomplete standard in 2016/17.
- The main challenges include increase in demand across the Trust (particularly 2 Week Wait referrals), together with reduced capacity due to emergency pathways.
- The Trust is working hard to increase capacity to reduce waiting times.
- Improvements have been seen month on month since November 2016
- The Trust reported one 52 week wait in January 2017.
- Diagnostic performance against the 6 week time standard has continued to be very challenging for the Trust, though improvements have been seen in the second half of the year. Increased capacity within Endoscopy service has contributed to improvements .
- Capacity within Cardiac CT and Ultrasound has limited further improvements.

Access and Responsiveness: Cancer – 2016/17

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	Yr	Last Yr	Var	
Cancer 2WW standard	93.0%	96.9%	96.0%	95.6%	96.5%	97.1%	97.3%	97.1%	97.2%	98.7%	98.0%	97.1%	98.4%		96.9%		97.2%	91.7%	5.5%	
Cancer 2WW standard (Breast Symptoms)	93.0%	90.0%	93.2%	96.5%	96.9%	95.8%	95.8%	96.9%	97.2%	98.2%	97.3%	95.5%	98.8%		90.0%		96.8%	89.6%	7.2%	
Cancer 31 Day standard	96.0%	99.3%	96.5%	99.4%	98.3%	97.7%	99.1%	98.8%	98.7%	99.5%	98.3%	99.5%	98.6%		99.3%		98.8%	97.6%	1.2%	
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%	100.0%	0.0%	
Cancer 31 Day subsequent surgery	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	100.0%	100.0%	100.0%	100.0%	94.1%		100.0%		98.6%	100.0%	-1.4%	
Cancer 62 day urgent referral standard	85.0%	78.4%	67.6%	68.3%	82.3%	76.3%	79.5%	72.6%	82.5%	78.3%	84.1%	78.6%	69.9%		79.4%		76.5%	75.1%	1.5%	
Cancer 62 day screening standard	90.0%	42.9%	100.0%	66.7%	62.5%	100.0%	88.9%	85.7%	91.7%	100.0%	100.0%	92.6%	66.7%		42.9%		88.0%	78.5%	9.5%	

Commentary

- Final Cancer performance for March will be published in May
- Urgent (2 Week Wait) referrals have increased over 10% from the previous year
- Despite this, the Trust has been able to achieve 2WW Cancer performance throughout 2016/17. This is a significant improvement from the 2015/16 position.
- The 'Live' Cancer PTL implemented by the Trust last year has ensured a greater focus on delays and is a major contributing factor to the improved position.
- The Trust has not achieved the 62 Day urgent referral standard in 2016/17

Activity and Effectiveness - 2016/17

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	Yr	Last Yr	Var	
Primary Referrals	M	9249	9047	9551	8859	9169	9205	8989	9328	7665	8726	8653	10151	9169	10.7%	108592	106195	2.3%	
Cons to Cons Referrals	M	1406	1422	2006	1648	1448	1500	1438	1480	1321	1516	1414	1773	1294	37.0%	16372	17327	6.0%	
First OP Activity	M	9853	9876	10839	9868	10706	10989	11653	12491	10644	10913	10570	11834	10076	17.4%	130236	122534	6.3%	
Subsequent OP Activity	M	23216	23403	24446	22052	23389	23933	22845	25167	21863	24899	23351	26981	23716	13.8%	285545	279171	2.3%	
New:FU Ratio	M	2.4	2.4	2.3	2.2	2.2	2.2	2.0	2.0	2.1	2.3	2.2	2.3	2.4	-0.1	2.2	2.1	0.0	
Elective IP Activity	M	696	697	656	715	649	670	682	717	619	642	644	716	627	14.2%	8003	7888	1.5%	
Elective DC Activity	M	3521	3839	4119	4036	4199	4207	3932	4164	3755	4086	3826	4430	3785	17.0%	48114	45259	6.3%	
Non-Elective Activity	M	4038	3772	3791	3879	3801	3663	3721	3789	3966	3719	3494	4075	4077	0.0%	45708	47015	-2.8%	
A&E Attendances	M	8715	9573	9239	10144	9711	9470	9397	8989	9136	8771	7951	9442	9398	0.5%	110538	106876	3.4%	
Admissions Via A&E	M	2357	2398	2363	2409	2302	2215	2381	2416	2620	2464	2241	2622	2433	7.8%	28788	28005	2.8%	
Ambulance Conveyances	M	2848	3068	2995	3133	3092	3051	3138	3163	3331	3223	2886	3156	3084	2.3%	37084	35370	4.8%	
Average LOS Elective	M	2.7	3.4	3.0	3.1	2.4	3.1	2.7	2.5	3.1	2.6	2.9	3.5	3.0	0.5	2.92	2.99	-0.1	
Average LOS Non-Elective	M	6.1	5.8	5.5	5.6	5.9	6.1	6.1	5.9	6.1	6.3	6.5	6.2	6.0	0.2	6.01	5.62	0.4	

Indicator Description	Target	Previous Months											Current Month			YTD			Trend
		Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Mar-16	Var	Yr	Last Yr	Var	
Community Nursing Referrals	M	3840	3902	3768	3962	3994	3975	4100	4157	4182	3997	4714	4281	4520	3840	17.7%	49552	38475	22.4%	
Community Nursing Total Contacts	M	34518	33652	35504	36021	33717	34998	32851	33544	33436	33070	36718	34092	37895	34518	9.8%	415498	408176	1.8%	
Community Nursing Face to Face Contacts	M	19535	19125	20065	19520	19055	19684	18734	19426	19244	18956	20342	18506	21259	19535	8.8%	233916	233333	0.2%	
% Patient Facing Time	60.0%	56.6%	56.8%	56.5%	54.2%	56.5%	56.2%	57.0%	57.9%	57.6%	57.3%	55.4%	54.3%	56.1%	56.6%	-0.5%	56.3%	56.2%	0.1%	
Community Nursing ALOS	42.0	26.2	24.5	23.1	20.3	18.6	19.0	17.7	15.7	14.7	13.7	10.9	8.8	5.6	26.2	-20.6	15.77	31.55	-15.8	
SALT WL <13 Weeks %	85.0%	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	100.0%	100.0%	0	
Podiatry WL <13 Weeks %	85.0%	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	100.0%	100.0%	0	
Dietetics WL <13 Weeks %	85.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.7%	100.0%	100%	0	99.9%	100.0%	-0.00137	
MSK WL <13 Weeks %	85.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	81.0%	96.5%	100%	-3.5%	98.5%	98.5%	-0.00038	
SALT Total WL	M	117	146	160	175	176	202	182	149	130	140	128	133	139	117	22	1860	690	1170	
Podiatry WL Total WL	M	749	841	830	862	998	842	942	633	418	293	284	284	380	749	-369	7607	4204	3403	
Dietetics WL Total WL	M	146	73	32	144	43	65	54	30	64	39	43	74	69	146	-77	730	1400	-670	
MSK WL Total WL	M	211	101	101	116	1922	1922	105	1641	1265	1938	2087	434	2029	211	1818	13661	4201	9460	
IP ALOS (including Irvine Stroke Unit)	M	31.1	30.6	33.3	25.8	30.9	36.0	28.5	27.0	26.9	32.3	35.0	33.8	38.0	31.1	6.9	31.42	26.35	5.1	
IP Activity (including Irvine Stroke Unit)	M	89	92	97	85	85	85	81	84	93	85	69	75	85	89	-4.5%	1016	1523	-49.9%	

Commentary

- Both primary referrals and consultant to consultant referrals increased 2.3% and 6.0% respectively. The Trust has noted a significant increase in referrals for suspected cancer across al specialties.
- Primary referrals appear to have increased primarily within medical specialties. This is impacting significantly on RTT and diagnostic waiting lists, putting additional pressure on the ability of the Trust to meet these constitutional standards.
- Outpatient activity has increased across the trust. Initial and follow-up appointments are up 6.3% and 2.3% respectively.
- Elective activity has increased 1.5% against the previous year. Whilst a greater increase in activity would have supported further improvements in RTT performance, capacity challenges prevented this, particularly in the winter months. It should also be noted that day case activity has increased over 6% on last year, indicating a shift in some areas.
- Non Elective occupied beddays have stayed at similar levels to the previous year. The average length of stay for non elective pathways has increased, whilst non elective activity has reduced.
- In both EHS and HAR localities the community nursing referral rate remains significantly higher than expected.
- EHS Community Nursing teams are continuing to maintain a consistent response time performance in all categories.
- Face to Face contacts are increasing following a downward trend at the end of 2015/16. The community IT system, is now fully implemented in the community nursing teams. A number of initiatives have successfully ensured data input practices are following necessary guidelines. The result is a far more accurate dataset.
- Whilst length of stay remains above the standard, it has been adversely affected across all community sites by Non-Acute Delayed Transfers of Care. This is primarily due to patients awaiting packages of care prior to being discharged.

STRATEGIC DEVELOPMENT

We work closely with the local Clinical Commissioning Groups, the Surrey and Sussex Area team of NHS England, NHS Improvement and the Health and Wellbeing Board of East Sussex County Council.

We also continue to work closely with Brighton and Sussex University Hospitals NHS Trust, Sussex Partnership NHS Foundation Trust, South East Coast Ambulance NHS Foundation Trust, East Sussex County Council Adult Social Care, Sussex Police, East Sussex Fire and Rescue Service, NHS Direct and the local district, borough and county councils.

We are grateful for the support received from all these organisations during 2016/17. We particularly value the scrutiny role and support for the Trust and the wider local NHS provided by the local Health Overview and Scrutiny Committee of East Sussex County Council and Healthwatch East Sussex.

Over the last year we have continued our engagement with East Sussex Better Together, an Alliance of all those involved in health and care throughout East Sussex. By working closer together we aim to better meet the needs of the people of East Sussex by transforming health and social care, bringing together prevention work, primary and community care, social care, mental health, acute and specialist care. April 2017 marks the beginning of our shadow year to test out the most effective ways of working together.

The Alliance is made up of five local partners Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG, East Sussex County Council, East Sussex Healthcare NHS Trust and Sussex Partnership NHS Foundation Trust.

We also work closely with GP practices and other organisations providing health and care to our local populations. Together we have already begun to make significant improvements in care pathways across health and social care, such as Health and Social Care Connect (HSCC) and integrated locality teams.

To allow for the transformation we are building a new model of accountable care – through the ESBT Alliance. We are working closely with commissioners and other providers to develop integrated care pathways across all specialties and undertaking a number of whole system pathway reviews which will ensure that only the processes that provide value to patients are in place and patients receive safer healthcare with fewer delays.

The Trust has also been fully engaged with the development of the Sussex and East Surrey Sustainability and Transformation Plan and have been actively contributing 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.

Chief Executive
1st June 2017

FINANCE

Important Financial Results

The following table shows a range of financial performance values taken from the accounts.

Accounts highlights	2016/17	2015/16
Deficit for year	(43,792)	(47,997)
Public Dividend Capital Dividend Payable	4,968	6,940
Value of Property, Plant and Equipment	237,135	231,172
Value of borrowings (including Loans)	93,215	39,198
Cash at 31st March	2,100	2,100
Creditors - trade and other	53,034	39,830
Debtors - trade and other	40,806	17,184
Revenue from patient care activities	339,788	323,874
Clinical negligence costs	13,286	12,078
Gross employee benefits	269,971	258,087

Better payment practice code	2016/17		2015/16	
	Number	Value	Number	Value
% of non-NHS trade invoices paid within target	26.28%	37.69%	57.26%	65.15%
% of NHS trade invoices paid within target	29.59%	79.57%	61.24%	83.67%

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.

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 2016/17. Access to cash is available through

application to Department of Health via NHS Improvement, the value of the in-year deficit was drawn and additional exceptional working capital was applied for and utilised during the year.

Although these challenges represent a material uncertainty that may cast doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have a reasonable expectation that the Trust will have access to adequate resources to continue in operational existence for the foreseeable future.

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.

#ourmarvellousteams

“

Eastbourne Town Health Visiting Team - I began working with this team last week and they could not have been more welcoming. I can already see how efficient and organised they are. We have had open discussions regarding the way working with children and families in this team is going and I am very excited to be able to be a part of this going forward. Good management from team lead Helen. Very supportive of each other. Excellent learning and development opportunities offered to me. Respectful of each other's opinions.

”

OPERATING AND FINANCIAL REVIEW

In 2016/17, the Trust resolved to improve the underlying financial position for the organisation.

Having ended 2015/16 with a deficit of £48m, the Trust committed to a control total (a planned deficit) of £41.7m, £10.4m of national sustainability and transformation funding was available to the Trust, on delivery of both the financial plan and the national performance standards.

The Trust also agreed with clinical commissioners to move to a payment by results-based contract, moving away from the previous cap and collar arrangements. The change in contract arrangements was driven by a desire to improve the quality and robustness of reporting on patient activity and interventions, and this has led to an improvement in data quality across the Trust.

During the year, levels of activity and demand were significantly greater than planned. The Trust has made significant progress in the year, and has delivered a financial outcome which is an improvement on 2015/16, but was not in line with the aspiration at the start of the year. The financial statements for the Trust show an outturn operational deficit of £46.4m, and receipt of STF funding of £2.6m, leading to a reported deficit of £43.792m.

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. Similarly, the CQC has improved its assessment of the Trust to 'requires improvement' from 'inadequate' following the October inspection. Significant investments in resourcing, quality and safety have been agreed by the Trust Board, including increased substantive staffing, additional support for ward-based staff, minor improvements to the infrastructure, and investment in clinical support staff. This has created additional pressure on the constrained resources available to the organisation, but has been essential in starting the journey to sustainable and continued clinical improvement.

Over the year, the Trust's financial position initially deteriorated, with the monthly 'run-rate' (the difference between income and expenditure) moving out to £6m deficit in month. As the financial position for the Trust started to improve, additional support was provided by the NHS Improvement Financial Special Measures regime, into which the Trust entered in October 2016.

The Trust remains within the FSM programme and receives weekly and monthly support and challenge to work towards an improvement in the overall sustainability of the organisation. By the end of the financial year, the underlying run rate for the Trust had improved by £3m/month - although this was predominantly through an increase in income rather than a decrease in cost, which creates affordability challenges for the local health economy – which is a testament to the focused work of staff across the organisation in seeking to manage within available resources.

A Trust with a significant deficit has additional challenges in managing cash flow, and this has created additional pressure for staff and suppliers throughout the last financial year. To support cashflow, 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. The level of cash borrowing available was not fully sufficient to address the underlying financial challenges for the Trust, and in consequence, the balance sheet shows a significant increase in creditors and payables.

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. During the year, the Trust has been able to explore alternatives and additional forms of capital funding, including leasing and partnership funding.

This work will continue into 2017/18, and 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. The Trust will be working with the Sussex and East Surrey Sustainability and Transformation Programme as part of the shared plan to ensure clinical and financial sustainability across local and regional health and care services.

The Trust continues to strengthen its working relationships with customers, suppliers, other NHS organisations and key supporters such as the League of Friends. The support of these organisations – and in particular, donations from League of Friends received throughout the year – have been invaluable to the Trust's patients and staff over the year.

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. In addition the Trust remains fully engaged in the Lord Carter review of efficiency that has been initiated by the DH.

The Board continues to gain additional 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 agreed and submitted to NHS Improvement a financial plan for 2017/18 in line with the control total deficit issued of £36.5m, excluding a proposal for STF. This is after planned cost improvements of £28.7m, which is a challenging target and for which plans are being developed.

The Trust's main contract with three local CCGs will be again based on national tariff, where applicable, without any 'cap and collar' arrangement. 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.

The Trust is engaged in wider initiatives with a view to transforming the way services are provided. This includes

involvement in the 'East Sussex Better Together' programme across two local CCGs and the Sustainability and Transformation Plan (STP) being developed across Sussex and East Surrey.

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 £352,000 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.

We receive a huge amount of support from the Friends of our hospitals, and they have again been hugely supportive throughout the year. They have funded the purchase of equipment to improve the care and support that we are able to offer to patients throughout the Trust.

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

- Online at www.esht.nhs.uk/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 Conquest Hospital and Eastbourne DGH.

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 Hospitals - 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

Capital investment during 2016/17 focused on four work streams:

- Adapting and improving the Radiology departments
- Clinical environment projects
- Reducing risks associated with backlog maintenance
- Enabling projects to facilitate future works in the Emergency Departments and the Front Entrances.

To overcome privacy and dignity issues we undertook a redesign of our two Radiology departments which enabled us to revise patient flows through the department by separating Outpatient and Inpatient waiting areas.

Projects that had a direct clinical focus during the year, supporting the focus on controlling the spread of infection or patient experience, included:

- Replacement of theatre lights.
- Provision of new flooring and doors within wards and outpatient areas.
- Refurbishment of exiting showers, wc and utility areas.
- Replacement of macerators.
- Refurbished nurse bases.

Additionally we invested capital in improving the non-clinical areas within the estate, for patients, visitors and staff.

Projects within the main entrance at the Conquest have seen new improved café and shop areas; this will be replicated in Eastbourne in the spring/summer of 2017.

The Conquest nursery was partially refurbished and a new hot desk area was provided within the Eastbourne Restaurant, whilst an asbestos removal programme was implemented.

To improve our backlog maintenance issues, ten projects invested £2 million pounds in external envelope repairs and mechanical and electrical upgrades. The projects included:

- New roof finishes at both acute sites.
- Replacement boiler chimneys.
- Main circulatory pump replacements.
- Statutory works across eight statutory requirements including, legionella, asbestos and lifts.
- BMS replacements to improve energy usage.

All the above projects aligned with the aspirations set out within the Estates Strategy and importantly we have set the foundation for future works within the Conquest Emergency Department and Eastbourne front entrance area.

Patient Environment

Each year we are required to assess our facilities in line with national PLACE (Patient Led Assessment of the Care Environment) guidelines issued by The Health and Social Care Information Centre.

Inspections are carried out by a multidisciplinary in-house team, which also includes patient representatives from Healthwatch.
In 2016 additional inspection categories were added reviewing Organisation Food, Ward Food and Disabled Patient Accessibility. The full PLACE scores for the individual categories in 2016 are below.

The table below sets out full PLACE scores for the individual categories in 2016 with the national average for comparison. These scores show improvement on the 2015 scores especially in cleanliness where the Trust is above the national average for all sites except for Bexhill where it is slightly below.

A patient information video has been produced and is available to view on bedside televisions at the Conquest and Eastbourne DGH. This video tries to prepare patients for their stay in hospital by giving an insight into life on the ward, the types of staff that they will meet, the various facilities available and the importance of hand washing and infection control precautions for visitors and staff.

Site	% Cleanliness	% Food	% Organisation food	% Ward food	% Privacy, Dignity and Wellbeing	% Condition, Appearance and Maintenance	% Dementia	% Disability
Bexhill	98.04	76.99	80.05	73.42	71.09	92.51	71.69	71.68
Conquest	98.73	91.10	85.83	93.02	81.04	93.77	69.14	80.49
Eastbourne	98.66	88.21	85.83	89.23	77.57	93.22	67.67	77.95
Firwood	98.76	95.19	96.84	93.42	80.00	92.35	77.41	85.06
Rye	100	91.06	85.50	98.47	84.21	98.68	90.26	87.12
National average	98.06	88.24	87.01	88.96	84.16	93.37	75.28	78.84

Hospital Cleanliness

To better support service delivery we have implemented new staff rosters and made changes to a number of cleaning practices as part of a housekeeping modernisation plan supported by the Department of Health.

These reforms will help us to meet changes within our clinical strategy and to plan cleaning services to ensure that they are compliant with the National Specification for Cleanliness (NSC) 2007.

To ensure compliance with the NSC 2007 our NSC audit team carried out 3637 audits during the year and we achieved an average NSC score of 95.77% against the Trustwide NSC cleanliness target score average of 93.36%.

Weekly quality group meetings take place at Conquest Hospital and Eastbourne DGH to look at outcomes from NSC audits, and to address any issues. A monthly multidisciplinary meeting of the Patient Environment Audit Monitoring group looks at overall standards of cleanliness.

Large pieces of cleaning equipment were introduced into numerous areas within the organisation as part of the modernisation of housekeeping enabling housekeeping to provide better quality and a more efficient cleaning service. We also continue to engage with housekeeping staff through our Productive Cleaning Workshops to improve procedures / equipment in line with staff feedback and service requirements.

We are committed to maintaining our Intensive and Rapid Clean Service which operates 24 hours a day in order to facilitate specialist cleaning, enhanced decontamination cleans and Hydrogen Peroxide Vapour (HPV) treatment which help to reduce the number and spread of infections.

There is a 24 hour cleaning presence within both Conquest Hospital and Eastbourne DGH Emergency Departments, and increased cleaning hours within the main operating theatre suite at Conquest Hospital to support the higher patient activity and ensure that the environment is clean and maintained to the highest standards.

We continue to develop the ward housekeeping roles at both acute sites to support nurses in providing care to patients and aim to improve patient experiences by having fully trained lead housekeepers liaising with Ward Matrons on standards of cleanliness and nutrition.

Staff received additional training during 2016/17 on core cleaning standards and this has been embedded as part of an annual training programme for all housekeeping staff to ensure that they maintain and update their knowledge on a regular basis.

Patient Catering

The level of patient satisfaction continues to be high with in excess of 95% of patients who were asked about catering indicating that they were happy with the quality of food provided.

All patients were extremely satisfied with the level of choice available to them.

Our extended choice menu range continues to be extremely popular and provides a choice of over 16 hot main meal dishes, five hot light bite options (including 10 meat dishes, two fish dishes and seven vegetarian dishes, two of which are suitable for vegans). It also includes a range of salads and sandwiches, along with a range of hot and cold desserts including fresh fruit options.

The menu is refreshed every six months to reflect winter and summer variations.

To help us to decide which dishes are available on our menus, we work closely with Dieticians, Speech and Language Therapists, Ward Co-ordinators and Patient representative groups.

An extended choice menu for people requiring a texture modified diet, providing a range of dishes with different consistencies to support their special dietary requirements is also offered.

We have reviewed our specialist finger food menu and increased the choices that are available. This has been developed to support patients with dementia or those who are unable to feed themselves using cutlery but who still want some independence whilst eating.

The catering team are always happy to visit patients to discuss any concerns or ideas they may have in order to improve our services.

Site Safety

We do all we can to ensure that all visitors and staff are safe while they are in our hospitals and other buildings.

We have a proactive security culture which aims to keep our sites and all those in them safe. There is a regular cross-site security meeting and our quarterly newsletter 'Securitywise' is now in its 18th year.

We continue to work closely with local Police Officers and 2016/17 has seen several roadshows and exhibitions which have focussed on crime prevention and what staff can do both at home and at work to prevent crime. There have also been a series of counter terrorism training events run in conjunction with Regional Counter Terrorism Officers.

We have seen more sanctions and redress, which are positive indicators of good crime prevention, detection and investigation.

We have around 98 CCTV cameras and a number of stand-alone units. There are control rooms on both acute sites which manage the cameras along with a range 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. The badge integrates into our swipe card access system which manages and restricts movement across different areas of our sites.

Our car parks at Conquest Hospital and Eastbourne DGH have retained their accreditation under the national "Park Mark" scheme, recognising high standards of security and safety.

#ourmarvellousteams

"

Community Stroke Rehabilitation Service - Our team is unique in many ways, they are all kind caring and supportive of one another. They go above and beyond to help and assist clients. This is witnessed by myself on a daily basis while working as Administration Assistant within the service. We have a good lone working policy within the Community to help keep each other safe. Staff are supportive of each other both professionally and personally, and our team lead is a shining example of that. When an urgent matter of a client to be seen staff go out of their way to juggle work load and make it happen. They are all very good and adapting and changing to different situations. We are all good at listening and discussing lesson learnt and continue to improve our service on a daily basis. They are the best!!!. And I love and am extremely proud to be part of it.

"

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

The Trust is subject to the requirements of the Civil Contingencies Act 2004, and has statutory responsibilities as a Category 1 responder.

As a Category 1 responder, we are required to have sufficient Emergency Preparedness processes, policies and plans in place, and are required to be able to show that these are updated regularly and exercised appropriately.

We are required to evidence that our staff are trained appropriately, according to the role and function they hold during major incidents or business continuity incidents. Our training is aligned to the National Occupational Standards (NOS) for Operational, Tactical and Strategic leaders. During the year we have undertaken training delivered by external trainers, to ensure the correct standards are attained.

Training and Exercising within the Trust must continue to be developed, so that the Trust is resilient 24 hours per day, 365 days per year.

The Emergency Planning practitioner establishment remains at 0.8 of a whole time equivalent which has continued to make it very challenging to ensure that Emergency Preparedness and Business Continuity Planning have been maintained across both acute and community sectors.

As a direct result the Trust compliance with NHS England EPRR Core Standards has dropped from 'Substantially' to 'Partially' compliant. It has continued to impact on our ability to ensure that staff have access to suitable training to enable them to respond effectively to both a Major Incident or a Critical Incident (Business Continuity).

Our Emergency and Business Continuity Plans have, where required, been reviewed and updated during the year.

The Trust remains fully engaged with the Sussex Resilience Forum (SRF) and has participated in exercises at both a Regional and local level during the year. The Trust is represented at a number of working groups within the SRF as well as in event Safety Advisory Groups organised by Local Authorities across East Sussex.

We continue to enjoy a good working relationship with our multi-agency partners.

SUSTAINABILITY

East Sussex Healthcare NHS Trust is firmly committed to enhancing the sustainability of the healthcare services we provide to our local community.

To achieve sustainability we need to meet the needs of today without compromising the needs of tomorrow. In essence, sustainability is shorthand for effective management of our resources, both now and in the future.

Whilst there is understandably a strong focus on financial sustainability in the NHS at present, we believe that to be a truly sustainable organisation we need to recognise and take account of a broader range of resources upon which the Trust activity depends. In particular we acknowledge the Trust's impact on the natural environment as well as our relationship with our local communities, including our staff. We view these as complimentary objectives that together will directly support our efforts to deliver the best possible outcomes for our patients.

the environment and support personal health and wellbeing. The seven action areas are illustrated in the graphic below.

SUSTAINABILITY PROGRAMME GOVERNANCE AT ESHT

Our overarching sustainability objectives and priorities are defined by our Sustainable Development Management Plan (SDMP).

The plan was approved by our Trust Board in 2015 and sets out a programme of targets and actions to 2020. The SDMP also outlines the main drivers for this work programme for our Trust and, in doing, underlines the strategic value of the SDMP to our forward plans and ambitions.

The SDMP identifies seven key areas where we need to take action to ensure that the services we deliver are not only effective and efficient, but minimise our impact on

Each of the seven action plans has a nominated Trust lead and progress towards the objectives set is to be reported to our Board every six months. The Trust's Executive lead for sustainability is Jonathan Reid, our Director of Finance. Jonathan's role is to provide executive oversight of the plan, ensuring sustainability principles are fully represented in Board decision making and that the SDMP is effectively aligned to other key Trust strategies, programmes and plans.

In addition we carry out regular monitoring and reporting of our CO2 emissions and associated financial performance through a programme of monthly Key Performance Indicators (KPIs). These are also reported to our Board as part of our routine Trust assurance process.

ENVIRONMENTAL PERFORMANCE SUMMARY 2016/17

In common with other NHS organisations, the primary metric we use to measure and report on our Trust's environmental impact is what we refer to as our carbon footprint (measured in tonnes carbon dioxide equivalent, or CO2e).

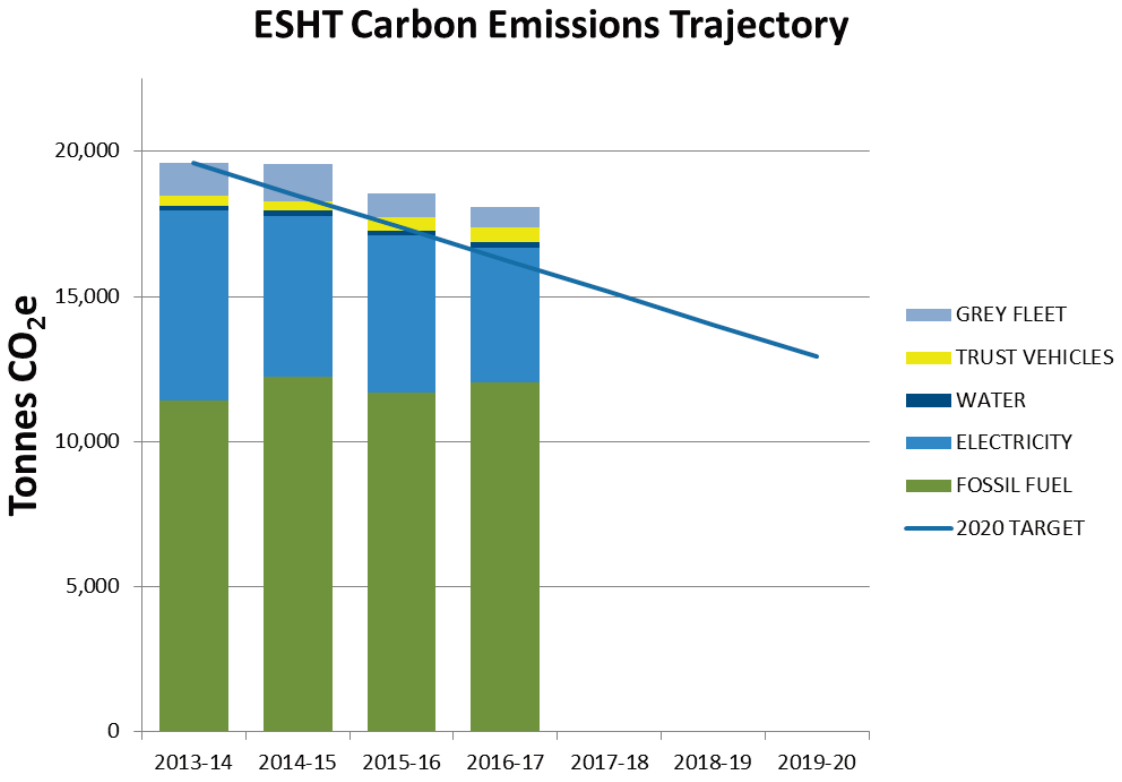
Carbon dioxide (CO2) is a known Greenhouse Gas that is strongly linked to Climate Change.

CO2 is released when we consume fossil fuels, for example when we heat and power our buildings and when we move people and materials around by motorised transport. There is also "embedded" CO2 in the goods and services we purchase from other organisations and in the resulting waste we produce. CO2 is therefore an effective way of capturing the Trust's overall impact on the environment using a single metric.

Our carbon footprint baseline (2013/2014) is 19,583 tonnes CO2, against which we have set a Trust-wide carbon reduction target of 34% by 2020, as set out in our SDMP. This commitment is in line with the national NHS carbon reduction target.

We have undertaken a comprehensive baseline adjustment exercise during the current reporting period. This takes into account a number of key changes in the Trust's structure and operations and includes a number of key improvements in the methodology we use to account for our emissions of CO2. Further detail on these changes is given below.

After adjustments are taken into account, our carbon footprint has reduced by 1,490 tonnes CO2e, 7.6%, since our base year (see graph below). Whilst this progress is encouraging and demonstrates the



effectiveness of the measures we have undertaken so far to achieve our CO2 reduction goal, we also recognise that our performance currently lags behind the trajectory required to achieve our target of 34% absolute reduction by 2020. This simply highlights the need to accelerate the rate of progress with key aspects of our SDMP, in particular the introduction of a robust capital investment programme targeting energy conservation opportunities that have already been identified. These plans are discussed further below.

Emission source	Base Year	2014/15	2015/16	2016/17
Fossil fuel	11,434	12,249	11,677	12,026
Electricity	6,530	5,522	5,412	4,654
Water	176	176	163	179
Trust vehicles	313	312	477	518
Business mileage	1,131	1,323	814	716
Total	**19,583**	**19,581**	**18,544**	**18,093**

Please note: figures for 2016/17 contain estimated data and are subject to final validation.

Key aspects to take note in relation to our CO2 reduction performance:

- Energy and water data have been re-baselined and adjusted annually to take account of the loss of the High Weald Lewes and Havens (HWLH) community services in 2015
- Business mileage emissions are now included and adjusted for HWLH values back to base year
- New emissions calculation method developed for Eastbourne DGH, backdated to base year and based on data available in each year. This has involved removing the Department of Psychiatry (occupied by Sussex Partnership NHS Foundation Trust) and the Sports and Social Club and apportionment of consumption based on occupancy of remainder of outlying buildings.
- All water figures for NHS Property Services sites occupied by the Trust currently based on benchmarks
- Most energy data for NHS Property Services sites occupied by the Trust is estimated for quarter 4 2016-2017
- Floor areas and occupancy details have been updated for 2016-2017
- Scope 3 emissions for waste disposal and procurement (supply chain) not currently included due to lack of reliable conversion factors. Waste management impacts discussed below.

In addition to our carbon footprint we produced an estimated 2,269 tonnes of waste in 2016-2017 including general waste and healthcare waste (figures for March 2017 have been estimated). This is broken down as follows:

Waste source	Tonnes
Healthcare waste	1,019
Reusable sharps	112
General/commercial waste	718
Recyclable waste	420
Total	**2,269**

Note: Figures contain estimated data and are subject to final validation.

Our overall waste volume reduced slightly over the last 12 months (estimated data show a 3.12% reduction between 2015-2016 and 2016-2017). Our use of reusable sharps containers has increased significantly by nearly 60% - this is potentially a better environmental option for the Trust as it avoids the need to incinerate single-use containers.

Around 55% of our bagged healthcare waste is segregated and disposed of as non-infectious (tiger bag), which is a preferable environmental option to incineration and alternative treatment (steam sterilisation). By contrast our recycling rate (as a proportion of all non-healthcare waste) is still below 40% and this is an opportunity for improvement going forward. Further information regarding our plans for waste management improvements is given in the Procurement section.

SDMP HIGHLIGHTS AND PRIORITIES FOR THE YEAR AHEAD

BUILDINGS

As the carbon footprint breakdown above illustrates, the energy we use to heat, cool and power our buildings is the most significant contributor to our Trust's carbon footprint.

It is also a significant cost to the Trust. We continue to roll out a programme of no and low cost energy conservation initiatives, which to date have helped to achieve most of the CO2 savings outlined above. Current and ongoing workstreams include:

- Review of our Building Management System to identify further opportunities to make savings through improved control strategies
- Developing a new metering strategy for our main acute sites to improve energy utilisation, reporting and control
- Advancing our investigation into increasing borehole utilisation at Eastbourne District General Hospital to increase resilience and reduce cost and emissions from supplied water
- Creation of new Carbon Roadmap to define future energy conservation investment opportunities at our acute sites. The most significant opportunity we have to reduce our carbon footprint and achieve the target we have set for 2020 is the implementation of this new Carbon Roadmap. We are finalising a business case for investment in a new Combined Heat and Power system at Conquest Hospital and as part of this exploring opportunities for third-party financing to facilitate the investment required. We aim to move forward with this programme later in 2017.

JOURNEYS

Trust travel, which includes business mileage (staff using their own vehicles for Trust business) and the Trust's own fleet of commercial and pool vehicles, is the third largest component of our carbon footprint.

We continue to develop a programme of initiatives to deliver a reduction in CO2, cost and staff time associated with business travel, informed by a Trust-wide travel survey undertaken in 2015 and establishment of a Healthy Travel Group (see Wellbeing). As a result of initiatives undertaken over the past 18 months we have already seen a reduction in Trust business mileage between 2015/16 and 2016/17.

Key activities we are currently working on and moving forward with in 2017/18 include:

- Trial of low-emission (hybrid) pool cars to reduce travel between our two acute sites
- Relaunched community transport forum to seek local improvements for cyclists, walkers and bus users
- Introduction of parking controls to reduce demand and promote healthy travel alternatives
- Developing our "Travel Alternatives" information page on the staff Intranet. All existing schemes were relaunched at Roadshows in November and this focus will continue. Improvements are underway and include: including travel alternatives information in staff induction planner; providing improved travel information for patients; investing in personal travel planning software so staff and visitors can obtain better information

about hospital access; implementing site Staff Travel Groups to identify projects and allocate funding; improving information and access to video- and teleconferencing.

PROCUREMENT

Our Procurement action plan takes a whole-life view of the goods and services we purchase as a Trust and the end-of-life (waste disposal) implications of these purchasing decisions.

It also recognises the ethical implications of our procurement activity, guided by the Social Values Act 2012.

This is an area that will receive greater attention during 2017. We will be reviewing our Procurement Policy to ensure it supports the objectives of the SDMP – in particular that sustainability, social responsibility and whole-life costing considerations are a business-as-usual feature of our procurement activity.

We will also continue to identify and implement measures to reduce waste at source and minimise the impact of any waste we do produce. To measure progress we intend to introduce a new waste performance reporting approach in 2017/18, which will support moves to improve waste segregation and implement more sustainable disposal options.

Our aim is to minimise the volume of waste we send for incineration and alternative treatment (steam sterilisation) and increase the volume we send for recycling, reprocessing and reuse, as well as moving towards a zero landfill model.

As part of our new waste programme we will also work with other NHS Trusts in Sussex to investigate opportunities to implement a county-wide reuse scheme for materials that could potentially be repurposed, including furniture.

CULTURE

Culture is another area that will receive further attention during 2017/18. We will be refreshing and relaunching our SDMP during the summer of 2017.

As part of this relaunch we intend to develop a new communications and engagement strategy to raise awareness of the SDMP and its aims and benefits and encourage staff to take action to support its delivery.

WELLBEING

Workplace health and wellbeing is an important component in our SDMP, since there are very clear synergies between our environmental objectives and our desire to improve the health and wellbeing of our staff - a healthy lifestyle is also a sustainable one and vice versa.

The Trust has significantly increased its focus and activity in this area over the past 12 months, primarily through the work of the reformed Health and Wellbeing Group. Key activities include:

- Review of healthy food options at restaurants at both acute sites as well as Trust coffee outlets. This will include broadening the number of healthy options available to staff and targeting high calorie/ high sugar items, removing these altogether in some cases.
- Alignment and integration of health and wellbeing objectives with the Making Every Contact Count programme at ESHT.
- Establishment of Healthy Travel Group, with representation from the Health and Wellbeing Group. Both groups are working together to maximise benefits for staff. Joint activities include development of safe walking and cycling routes and further development and promotion of the cycle to work scheme.

The four key focus areas for 2017/18 are healthy food, healthy travel, motivational skills and smoking cessation.

ADAPTATION

We are finalising a template for carrying out Climate Change Impact Risk Assessments and aim to trial this with 10 departments across the Trust during 2017/18.

This will help to ensure that our services understand and are resilient to potential disruptions that might be caused by anticipated future climate impacts. In addition, we intend to develop closer working relationships with external stakeholders to identify likely changes to service requirements resulting from climate change.

SDMP GOVERNANCE

We have established the primary programme governance structures and mechanisms required to deliver the SDMP, including incorporation of CO2 emissions into our monthly KPI reporting process and establishment of a programme governance structure with named action plan leads.

We are updating our SDMP in 2017 to take into account progress made so far as well as a number of important changes to the Trust's strategy and operations since the original version was written. The updated SDMP will be made available on the Trust's website and will be launched in summer 2017.

This accountability report was approved by the board on 31st May 2017 and signed on its behalf by:

Chief Executive
1st June 2017

ACCOUNTABILITY REPORT
DIRECTORS' REPORT

Trust Board

There were a number of Board changes during the year and these are outlined below:

Catherine Ashton	Director of Strategy	Appointed 01/08/16
Philip Astell	Acting Director Finance	Acting up period 01/04/16 to 15/06/16
Dr Adrian Bull	Chief Executive	Appointed - 11/04/16
Pauline Butterworth	Acting Chief Operating Officer	Acting up period ceased - 13/11/16
Joe Chadwick-Bell	Chief Operating Office	Appointed - 14/11/16
Dr Sally Herne	Improvement Director	Left - 22/12/16
Dr David Hughes	Medical Director (Governance)	Resigned - 06/09/16
Jonathan Reid	Director of Finance	Appointed - 13/06/16
Dr Andrew Slater	Medical Director (Strategy)	Resigned - 06/09/16
Richard Sunley	Deputy Chief Executive/Chief Operating Officer/Acting Chief Executive	Resigned - 10/04/16
Dr David Walker	Medical Director	Appointed - 07/09/16

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"Diabetic Eye Screening - The team have faced some recent challenges, but have continued to work tirelessly and support each other through them. Over the last few months the programme has been subject to an external Quality Assurance Inspection from the PHE Screening QA Service, and whilst we are still awaiting the final report the provisional feedback provided was that we were rated a 'good' programme and with a few changes could be 'excellent' this is all down to the teams continued hard work. Since December we have experienced high levels of long term sickness absence: at times 60% of our screening workforce has been off sick at any one time. The staff have supported the many changes I have had to put in place to ensure the continuation of the service during this time and have not once questioned the reasons behind it or stated they are not happy with the changes etc., they have been very supportive. Grading staff have their own workload. Due to staff sickness they have taken on additional screening duties to support continuity of service even though this has been detrimental to their own workload. Admin team has worked hard within tight timescales updating protocols and SOP's to provide as evidence for Quality Assurance supporting evidence. Recent Quality Assurance inspection feedback stated that our programmes pathway for pregnant patients was one of the best they had seen - the team work very hard at this and I am proud they have received the recognition they deserve."

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 2017

David Clayton-Smith
Chairman

Chairman of Remuneration Committee

Sue Bernhauser OBE
Non-Executive Director
Chair of Quality and Standards Committee
Member of Audit Committee
Member of Remuneration Committee

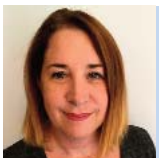
Jackie Churchwood-Cardiff
Non-Executive Director
Member of Finance and Investment Committee
Member of People and Organisational Committee
Member of Quality and Standards Committee

Miranda Kavanagh
Non-Executive Director
Chair of People and Organisational Committee

Barry Nealon
Non-Executive Director
Vice Chairman of Trust Board
Chair of Finance and Investment Committee
Member of Audit Committee
Member of Remuneration Committee

Michael Stevens
Non-Executive Director
Chair of Audit Committee
Member of Finance and Investment Committee
Member of Remuneration Committee

Dr Adrian Bull
Acting Chief Executive



Joanne Chadwick-Bell
Chief Operating Officer

Jonathan Reid
Director of Finance

Dr David Walker
Medical Director

Alice Webster
Director of Nursing

Catherine Ashton*
Director of Strategy

Monica Green*
Director of Human Resources

Lynette Wells*
Company Secretary

*Non-voting board member/officer

Attendance at board meetings 2016/17

Directors and Officers	Number of Trust Board meetings attended in 2016/17	Number of Trust Board meetings could have attended in 2016/17
Catherine Ashton Director of Strategy (from 01/08/16)	4	5
Philip Astell* Acting Director of Finance (Acting up period 01/04/16 until 15/06/16)	2	2
Sue Bernhauser* Non-Executive Director	5	7
Dr Adrian Bull* Chief Executive (From 11/04/16)	7	7
Pauline Butterworth* Acting Chief Operating Officer (Until 13/11/16)	4	4
Joanne Chadwick-Bell* Chief Operating Officer (From 14/11/16)	3	3
Jackie Churchwood-Cardiff* Non-Executive Director	7	7
David Clayton-Smith* Chairman	7	7
Monica Green Director of Human Resources	7	7
Dr David Hughes* Medical Director (Governance) (Until 24/09/16)	2	3
Miranda Kavanagh* Non-Executive Director	7	7
Barry Nealon* Vice Chairman Non-Executive Director	7	7
Jonathan Reid* Director of Finance (From 13/06/16)	4	5
Dr Andy Slater* Medical Director (Strategy) (Until 24/09/16)	1	3
Mike Stevens* Non-Executive Director	5	7
Dr David Walker* Medical Director (From 07/09/16)	2	4
Alice Webster* Director of Nursing	6	7
Lynette Wells Director of Corporate Affairs	7	7

* Voting Director of the Board

Audit Committee

The following Non-Executives form the Audit Committee. Attendance during 2016/17 was as follows:

- Sue Bernhauser 5/6
- Barry Nealon 4/6
- Mike Stevens, Chair of the Audit Committee 6/6

Other Committees

The Trust's other main Committees are the Finance and Investment Committee, the People and Organisational Development Committee and the Quality and Safety Committee.

	Audit	Finance and Investment	People and Organisational Development	Quality and Safety
Meetings held	6	13	4	7
Sue Bernhauser	5	n/a	n/a	7
Jackie Churchward-Cardiff	n/a	11	4	5
Miranda Kavanagh	n/a	n/a	4	n/a
Barry Nealon	4	11	n/a	n/a
Mike Stevens	6	12	n/a	n/a

All of the meetings of the Trust's Committees during 2016/17 were quorate.

REGISTER OF INTERESTS

Non-Executive Directors

Sue Bernhauser	None
Jackie Churchward-Cardiff	Owner and director of Clinical Strategies, a consultancy firm working within healthcare
David Clayton-Smith	Independent Chair for the East Sussex Better Together (ESBT) Programme Board, transitioning into the ESBT Alliance Governing Board during 2017 Independent Chair for the ESBT Leadership Forum. (Both roles above are contracted by East Sussex County Council) Chair, KSS Academic Health Science Network Chair, Thames Valley Housing Association Chair, Surrey Priorities Committee Chair, ESBT Programme Board
Miranda Kavanagh	None
Barry Nealon	Chairman of Rye, Winchelsea and District Memorial Hospital. A voluntary position in the Charity that owns Rye Hospital
Michael Stevens	Council Member and Treasurer, St George's, University of London

Executive Directors

Philip Astell	None
Joanne Chadwick-Bell	None
Dr Adrian Bull	None
Pauline Butterworth	None
Dr David Hughes	10.2% Shareholding in BMI Sussex Diagnostics
Jonathan Reid	Governor - Sussex Downs College
Dr Andrew Slater	None
Dr David Walker	Trustee of Parchment Trust
Alice Webster	None

Non-voting board member

Catherine Ashton	None
Monica Green	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.

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of NHS Improvement, in his capacity as the Accounting Officer (AO) for the NHS Trust Development Authority (operating as NHS Improvement) legal entity, requires NHS trust Accountable Officers to give him assurance about the stewardship of their organisations. The Chief Executive of the NHS Improvement has designated that the Chief Executive should be the Accountable Officer to the trust.

The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of NHS Improvement. 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 with the approval of the Treasury 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.
NB: sign and date in any colour ink except black

Chief Executive
1st June 2017

STATEMENT OF DIRECTORS' 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.

Chief Executive
1st June 2017

Director of Finance
1st June 2017

GOVERNANCE STATEMENT

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 responsibilities 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.

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 2017 and up to the date of approval of the annual report and accounts.

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.

Governance Framework

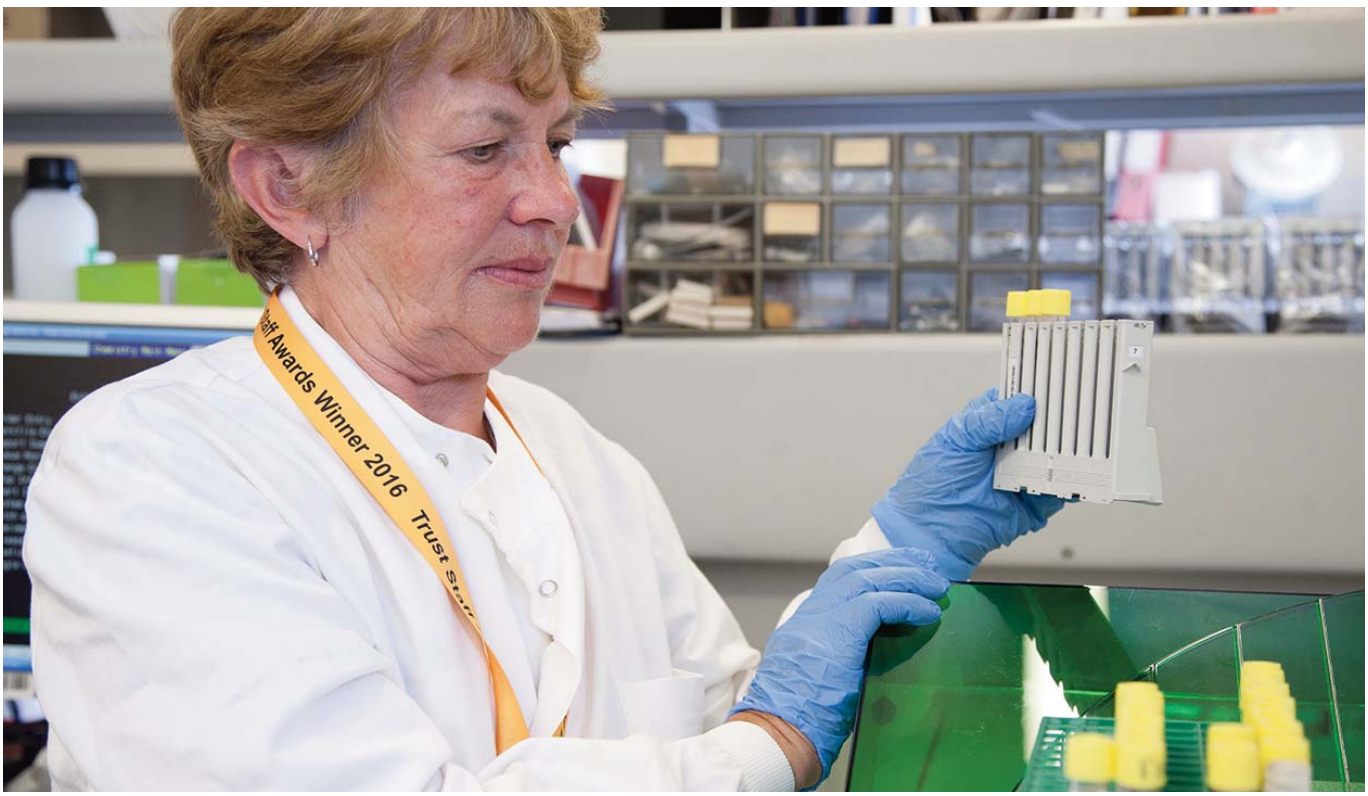
The Trust has agreed Standing Orders (SOs) for the regulation of proceedings and business. The Trust SOs are designed to translate the statutory requirements set out in the National Health Service Trusts (Membership and Procedures) Regulations 1990 (1990/2024) into day to day operating practice, and, together with the adoption of a scheme of matters reserved to the Board; a scheme of delegations 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 2016.

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.

There were a number of Board changes during the year including the appointment of the Chief Executive. These are outlined below:

Catherine Ashton	Director of Strategy, Improvement and Innovations	Appointed - 01/08/16
Philip Astell	Acting Director of Finance	Acting up period ceased - 01/04/16 to 15/06/16
Dr Adrian Bull	Chief Executive	Appointed - 11/04/16
Pauline Butterworth	Acting Chief Operating Officer	Acting up period ceased - 13/11/16
Joanne Chadwick-Bell	Chief Operating Officer	Appointed - 14/11/16
Dr David Hughes	Medical Director (Governance)	Resigned - 24/09/16
Jonathan Reid	Director of Finance	Appointed - 13/06/16
Richard Sunley	Chief Operating Officer Acting Chief Executive	Resigned - 10/04/16
Dr David Walker	Medical Director	Appointed - 07/09/16



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, complaints, dementia and organ donation committee.

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.

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 Trust Board also completed a self-assessment of its effectiveness in March 2017 to support planning of future Board development activities. The assessment recognised the changes in Board membership and improvements in the effectiveness of the Board and quality of agenda items. It was agreed to further explore the successful elements of a Unitary Board and that greater focus would be given to assuring progress on performance and delivery.

The CQC report published in March 2015 found the Trust to be Inadequate in the 'Well Led Domain' and there were subsequently a number of changes to membership of the Board including the Chairman and Chief Executive. The Trust commissioned a capability and capacity leadership review which commenced in March 2016 and the outcome of this piece of work was received in June 2016. It highlighted the need to develop a clear clinically led strategy for the organisation and to improve staff and stakeholder engagement and empower clinical leadership across the Trust. A capability assessment workshop also took place which focussed the Board on change architecture, change structure and change resonance.

A CQC re-inspection took place in October 2016 and the report, published in January 2017, moved the Trust to Requires Improvement. The report commended the Trust for its improved governance, cultural transformation and acknowledged the strengthened senior leadership. There were areas identified for improvement and these are detailed further in section 8.10 of this report.

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. Quality Improvement Board development sessions have also taken place, facilitated by NHS Elect.

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.

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.

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. Clinical Unit 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. Concern was expressed about the continued non-compliance with the national diabetes audit as the Trust did not have the required software and the Committee escalated this to the Board.

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 improve compliance with Clinical Audit processes and updates on the work of both internal and external audit and counter fraud. During the year the Committee managed the appointment process for external auditors.

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 2016/17 due to the Trust's deficit financial position. This provides sufficient time to review, scrutinise and monitor Trust plans.

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 the risk management process such as patient transport, maternity, urgent care pathways and mortality and morbidity.

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 4 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.

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. The Senior Leaders Forum, which comprises members of the executive team and clinical leaders, reviews the High Level Risk Register at each meeting. 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 2016 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.

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 taken place and this has led to a continued increase in the number of incidents reported, 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 59 serious incidents during 2016/17. Each incident was investigated and actions agreed and implemented. The Trust had 1 never event in 2016/17 which related to wrong route administration of medication. This incident was investigated and learning and change of practice identified to prevent reoccurrence.

The Trust did have a backlog of closure for serious incidents and this has been significantly reduced and focus is being given to timely reporting of incidents and sharing outcomes and learning.

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 "limited assurance" on the adequacy of the Trust's management and internal control processes in respect of achievement of its objectives. The auditors noted however that positive progress was made by management in the second half of the year to improve the adequacy and effectiveness of controls in many areas.

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 has been developed and was submitted to NHS Improvement in November 2016 and the Trust was closely monitored against this.

As part of the initial response to financial special measures the Trust put in place a number of enhanced control measures. These included a reduction in the number of authorised signatories, the introduction of a vacancy control panel and a non-pay review group, a revision to the process of approving waiting list initiatives as well as the creation of a temporary workforce board that scrutinises agency expenditure. The year-end position was a £46.4m deficit (£43.792m after receipt of Sustainability

Transformation Funding), this was against an initial internal budget of £48m which was adjusted to a control total of £41.7m deficit required by NHS Improvement (the deficit and control total exclude sustainability and transformation funding).

Financial governance arrangements are reviewed by internal and external audit to provide assurance of economic, efficient and effective use of resources. As a result of the Trust being in cumulative deficit since 2010/11, which exceeds the five year breakeven period, and in accordance with the requirements of Section 30 of the Local Audit and Accountability Act (2014) our external auditors, BDO LLP, notified the Secretary of State that the Trust had breached its financial statutory duty. The referral related particularly to section 30(b) in respect of a breach of the breakeven duty in 2016/17 and section 30(a) in respect of a planned deficit in 2017/18. Actions are being developed to meet the 2017/18 control total, agreed with NHS Improvement, of a £36.5m deficit.

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.

A number of challenges exist in respect to achieving referral to treatment timescales and A&E performance. During the year the Trust experienced increased operational pressures; notably a 2.2% increase in primary care referrals and A&E attendances were up by 4.6%, particularly those arriving by ambulance. In addition, there were more than 1,000 more admissions to the hospitals than last year, with the biggest increase being in the number of day cases.
The increase in the number of attendances and patients contributed to a decline in the performance of the A&E 4 hour standard of 95% from 88.1% last year to 80.3% this year. A number of key actions have been implemented including better directing of patients in A&E and improved triaging processes. For elective care, despite an increase in the number of elective admissions, the number of patients waiting more than 18 weeks increased in comparison to 2015/16. The increase was mainly seen in the first part of the year with an improvement in performance from November onwards.

Referrals for patients on the 2 week wait cancer pathway increased by more than 12% although the trust has consistently met all the cancer targets with the exception of the 62 day wait.

This increasing demand is compounded by skill shortages in some specialties. The Trust is implementing recovery plans and targeted recruitment campaigns where required and working with commissioners to develop a system wide approach to improving performance. The Trust has additional resources in place to support patient flow and has been supported externally by the Emergency Care Intensive Support Team.

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.

Compliance and Regulation

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. These have included reviews of maternity, review of complaints, "round the clock care" and the urgent care pathway. The Trust participated in the Healthwatch 'red bus' engagement tour.

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

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 'Substantial Assurance' over the Trust's IGT self-assessment.

During 2016/17 ESHT staff reported 95 IG incidents, 92 of these were scored against the Trust's incident scoring as either 'negligible or none' for severity, the remaining 3 incidents were scored as 'low or minor'. This indicates that the majority of incidents have no impact upon information security. The number of incidents reported increased in comparison to the 80 reported in 2015/16; this increase was attributable to raised awareness of incident reporting requirements and information governance across the organisation. All incidents are investigated and actions implemented to prevent reoccurrence. No incidents met the criteria to report to the Information Commissioner's Office during 2016/17.

Freedom of Information Requests

The Trust received 645 Freedom of Information requests in 2016/17, of these 584 (91%) were responded to in time. This compared to 522 (461 - 88% were responded to in time) in 2015/16.

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.

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.

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. A significant amount of training has been undertaken during 2016/17 to raise awareness of the processes and requirements of the duty of candour.

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.

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. In 2015, NHS Protect published '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.

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 2016/17 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.

Care Quality Commission (CQC)

The Trust is registered with the Care Quality Commission to carry out eight legally regulated activities from 18 registered locations. Following the Trust's CQC visit in March 2015 the Trust was rated as 'Inadequate'. A re-inspection took place in October 2016, and the associated report was published in January 2017. The latest report recognised significant improvements since the 2015 inspection, and the CQC's overall rating for the Trust was improved to 'Requires Improvement'.

Of note, the CQC ratings of services identified 58 'good' and two 'inadequate' domains. Within the reports the CQC commended 15 areas for outstanding practice. The reports also identified some areas where further improvements were required and included two 'must do' actions, relating to play services in paediatrics and staffing in the A&E departments and 35 'should do' actions. Both hospitals were rated Inadequate for the safe domain of Urgent Care, although Urgent Care was rated 'needs improvement' overall.

There is a robust programme of work and governance framework in place to support delivery of continued improvement. The improvement plan is reviewed both internally and externally at monitoring meetings with key stakeholders. The Trust remains in special measures and as a result will benefit from professional and financial support. A further CQC re-inspection is expected later in 2017.

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. Notably, the Trust's year end deficit position of £43.792 million which exceeded the deficit budget and control total and the challenges in respect to achieving referral to treatment timescales and A&E performance.

Chief Executive

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 2016/17 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.

The following table outlines the notice periods for Directors and Officers in post at 31st March 2017:

Directors and Officers	Start date	Notice period
Catherine Ashton Director of Strategy	August 2016	6 months
Joanne Chadwick-Bell Chief Operating Officer	November 2016	6 months
Dr Adrian Bull Chief Executive	April 2016	6 months
Monica Green Director of Human Resources	June 2012	6 months
Jonathan Reid Director Finance	June 2016	6 months
Dr David Walker Medical Director	September 2016	6 months
Alice Webster Director of Nursing	May 2012	6 months
Lynette Wells Company Secretary	February 2012	3 months

For statements on salary and pension benefits for all senior management who served during 2016/17, please see tables.

Salary entitlements of senior managers

2016/17

Single total figure table - audited

Name and title	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
Susan Bernhauser Non-Executive Director	5-10	1**	0	0	0	5-10
Jackie Churchwood-Cardiff Non-Executive Director (appointed 01/03/16)	5-10	5**	0	0	0	5-10
David Clayton-Smith Chairman (appointed 11/01/16)	35-40	9**	0	0	0	35-40
Miranda Kavanagh Non-Executive Director (appointed 09/11/15)	5-10	0	0	0	0	5-10
Barry Nealon Non-Executive Director	5-10	0	0	0	0	5-10
Michael Stevens Non-Executive Director	5-10	0	0	0	0	5-10
Catherine Ashton Director of Strategy (commenced 01/08/16)	75-80	1**	0	0	50-52.5	125-130
Dr Adrian Bull Chief Executive (appointed 11/04/16)	175-180	4**	0	0	0	175-180
Joanne Chadwick-Bell Chief Operating Officer (appointed 14/11/16)	45-50	1**	0	0	47.5-50	95-100
Monica Green Director of Human Resources	105-110	1**	0	0	82.5-85	190-195
Jonathan Reid Director of Finance (appointed 13/06/16)	100-105	0	0	0	85-87.5	190-195
Dr David Walker Medical Director (appointed 07/09/16)	25-30	3**	0	0	0	25-30
Alice Webster Director of Nursing	110-115	1**	0	0	70-72.5	185-190
Lynette Wells Director of Corporate Affairs	95-100	0	0	0	60-62.5	155-160

2015/16

Name and title	£'000	£'00	£'000	£'000	£'000	£'000
Susan Bernhauser Non-Executive Director	10-15	1**	0	0	0	10-15
Jackie Churchwood-Cardiff Non-Executive Director (appointed 01/03/16)	0-5	1**	0	0	0	0-5
David Clayton-Smith Chairman (appointed 11/01/16)	5-10	0	0	0	0	5-10
Miranda Kavanagh Non-Executive Director (appointed 09/11/15)	0-5	0	0	0	0	0-5
Barry Nealon Non-Executive Director	5-10	0	0	0	0	5-10
Michael Stevens Non-Executive Director	5-10	5**	0	0	0	5-10
Catherine Ashton Director of Strategy (commenced 01/08/16)	0	0	0	0	0	0
Dr Adrian Bull Chief Executive (appointed 11/04/16)	0	0	0	0	0	0
Joanne Chadwick-Bell Chief Operating Officer (appointed 14/11/16)	0	0	0	0	0	0
Monica Green Director of Human Resources	100-105	1**	0	0	5-7.5	105-110
Jonathan Reid Director of Finance (appointed 13/06/16)	0	0	0	0	0	0
Dr David Walker Medical Director (appointed 07/09/16)	0	0	0	0	0	0
Alice Webster Director of Nursing	105-110	1**	0	0	35-37.5	140-145
Lynette Wells Director of Corporate Affairs	75-80	0	0	0	15-17.5	90-95

For key for Salary and Pension entitlements of senior managers tables please see page 85.

Salary entitlements of senior managers (continues)

2016/17

Single total figure table

Name and title	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
Philip Astell Director of Finance (from 01/04/16 to 15/06/16)	25-30	1**	0	0	62.5-65	90-95
Pauline Butterworth Acting Chief Operating Officer (started 01/09/15, seconded out 14/11/16)	75-80	2**	0	0	80-82.5	155-160
Professor Jon Cohen Non-Executive Director (left 31/10/15)	0	0	0	0	0	0
Charles Ellis Non-Executive Director (left 31/01/16)	0	0	0	0	0	0
Darren Grayson Chief Executive (left 31/01/16)	0	0	0	0	0	0
Vanessa Harris Director of Finance (left 30/09/15)	0	0	0	0	0	0
Amanda Harrison Director of Strategic Development and Assurance (left 30/09/15)	0	0	0	0	0	0
Sally Herne Improvement Director (left 22/12/16)	0	0	0	0	0	0
David Hughes Medical Director (Governance) (ceased 06/09/16)	35-40	1**	0	0	22.5-25	60-65
David Meikle Interim Director of Finance (left 31/03/16)	0	0	0	0	0	0
Maggie Oldham Improvement Director (left 23/12/1523/12/15)	0	0	0	0	0	0
Andrew Slater Medical Director (Strategy)(ceased 06/09/16)	35-40	2**	0	0	0	35-40
Richard Sunley Deputy Chief Executive /Chief Operating Officer (Left 10/10/16)	80-85	1**	0	0	0	80-85
Stuart Welling Chairman (left 30/09/15)	0	0	0	0	0	0

2015/16

Name and title	£'000	£'00	£'000	£'000	£'000	£'000
Philip Astell Director of Finance (from 01/04/16 to 15/06/16)	0	0	0	0	0	0
Pauline Butterworth Acting Chief Operating Officer (started 01/09/15, seconded out 14/11/16)	50-55	1**	0	0	50-52.5	100-105
Professor Jon Cohen Non-Executive Director (left 31/10/15)	0-5	1**	0	0	0	0-5
Charles Ellis Non-Executive Director (left 31/01/16)	5-10	1**	0	0	0	5-10
Darren Grayson Chief Executive (left 31/01/16)	145-150	23**	0	0	75-77.5	225-230
Vanessa Harris Director of Finance (left 30/09/15)	65-70	0	0	0	0	65-70
Amanda Harrison Director of Strategic Development and Assurance (left 30/09/15)	55-60	10**	0	0	0-2.5	55-60
Sally Herne Improvement Director (left 22/12/16)	0	0	0	0	0	0
David Hughes Medical Director (Governance) (ceased 06/09/16)	220-225*	1**	0	0	25-27.5	250-255
David Meikle Interim Director of Finance (left 31/03/16)	125-130	0	0	0	0	125-130
Maggie Oldham Improvement Director (left 23/12/1523/12/15)	0	0	0	0	0	0
Andrew Slater Medical Director (Strategy)(ceased 06/09/16)	195-200	4**	0	0	30-32.5	225-230
Richard Sunley Deputy Chief Executive /Chief Operating Officer (Left 10/10/16)	155-160	0	0	0	65-67.5	225-230
Stuart Welling Chairman (left 30/09/15)	10-15	2**	0	0	0	10-15

For key for Salary and Pension entitlements of senior managers tables please see page 85.

Pension benefits (Audited)

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 2017 (bands of £5000) £'000	Lump sum at pension age related to accrued pension at 31 March 2017 (bands Of £5000) £'000	Cash equivalent transfer value at 1 April 2016 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash equivalent transfer value at 31 March 2017 £'000	Employer's contribution to stakeholder pension £'000
Catherine Ashton Director of Strategy (commenced 01/08/16)	0-2.5	0-2.5	15-20	35-40	220	28	262	0
Dr Adrian Bull Chief Executive (appointed 11/04/16)	0	0	35-40	115-120	960	0	896	0
Joanne Chadwick-Bell Chief Operating Office (appointed 14/11/16)	0-2.5	2.5-5	25-30	75-80	375	8	396	0
Monica Green Director of Human Resources	2.5-5	12.5-15	40-45	120-125	734	108	842	0
Jonathan Reid Director of Finance	2.5-5	5-7.5	15-20	35-40	158	50	221	0
Dr David Walker Medical Director (appointed 05/09/16)	0	0	0	0	0	0	0	0
Alice Webster Director of Nursing	2.5-5	10-12.5	35-40	115-120	581	79	660	0
Lynette Wells Director of Corporate Affairs	2.5-5	0	12.5-15	0	111	43	154	0
Philip Astell Director of Finance (from 01/04/16 to 15/06/16)	0-2.5	0-2.5	35-40	60-65	685	13	746	0
Pauline Butterworth Acting Chief Operating Officer (started 01/09/15, seconded out 14/11/16)	2.5-5	0	15-20	0	124	36	182	0
David Hughes Medical Director (Governance) (Ceased 24/09/16)	0-2.5	2.5-5	60-65	180-185	1233	33	1309	0
Andrew Slater Medical Director (Strategy) (commenced 01/11/15 - ceased 24/09/16)	0	0	55-60	165-170	1003	0	1003	0
Richard Sunley Deputy Chief Executive /Chief Operating Officer (left 10/10/16)	0	0	50-55	165-170	1298	0	0	0
Sally Herne Improvement Director (started 04/01/16 - left 22/12/16)	0	0	0	0	0	0	0	0

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.

Key for Salary and Pension entitlements of senior managers tables

* David Walker, non-Board related salary for the full year of £167k.

* David Hughes, non-Board related salary for the full year of £164k.

* Andrew Slater, non-Board related salary for the full year of £137k.

* Catherine Ashton., non-Board related salary for the full year of £32k.

** represents reimbursement of travel costs incurred and leased car benefits, subject to UK income tax and disclosed to nearest £100

Richard Sunley left the Trust on 10th April 2016 and was undertaking project work for NHS Improvement until 10th October 2016

Salary costs for Maggie Oldham and Sally Herne were incurred by the Trust and recovered from the NHSi

##The amount included in the column headed "all pension related benefits" represents the annual increase (expressed in £2,500 bands) in pension entitlement. This amount represents pension benefits accruing to executive directors.

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 pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme.

They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).and uses common market valuation factors for the start and end of the period.

Payment for Loss of Office (audited)

Philip Astell (Acting Director of Finance 01/04/16 to 15/06/16) received compensation for loss of office during the year 2016/17.

The gross amount of this settlement was £53,811, this payment was in lieu of working a notice period, including annual leave, and no additional contractual payments were made.

Pay ratios (audited)

	2016/17	2015/16 Restated
Band of Highest Paid Director	£200-205k	£220-225k
Median Total Remuneration	£27,832	£28,180
Ratio	1 : 7.25	1 : 7.85

In 2016/17 the Trust calculated the median pay based upon the full time equivalent staff at the 31st March 2017 on an annualised basis, including agency costs, whilst in 2015/16 the Trust calculated the median pay without the agency costs. The 2015/16 values have been restated to reflect the new methodology.

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 2016/17 was £200k-£205k (2015/16, £220-225k). This was 7.25 times (2015/16, 7.95) the median remuneration of the workforce, which was £27,832 (2015/16 £28,180).

In 2016/17, 8 (2015/16, 2) employees received remuneration in excess of the highest paid director. Remuneration ranged from £15,142 to £250,818 (2015/16 £15,099 to £238,860).

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 reduced due to a reduction in taxable allowances.

STAFF REPORT

Our workforce at the end of 2016/17 consisted of 6,867 members of staff (6,012 full time equivalents).

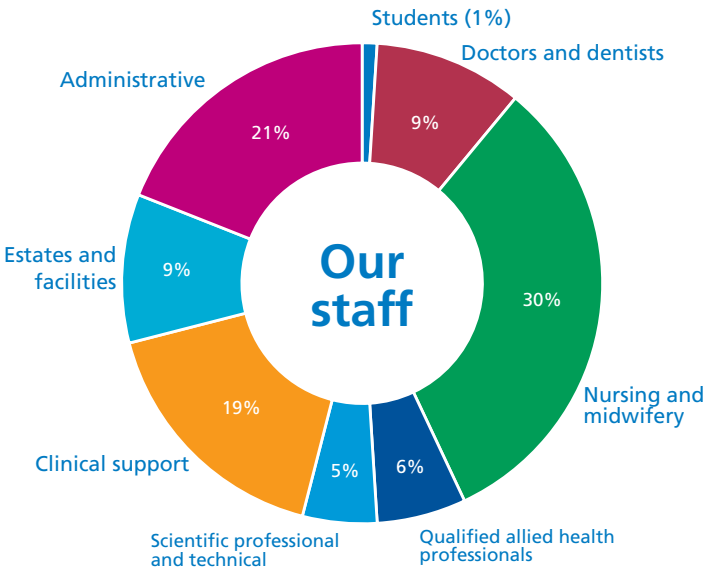
The analysis below is for staff employed at the end of the year only.

Analysis of Staff Numbers

Number of senior managers by band as at 31st March 2017.

	FTEs as of 31/03/17
Directors	8.00
Agenda for change Band 9	3.00
Agenda for change Band 8d	12.00
Agenda for change Band 8c	25.93
Agenda for change Band 8b	50.15
Agenda for change Band 8a	154.22

Our staff are made up as follows:



#ourmarvellousteams

“Heathfield Goodstart Health Visiting Team -
Everyone in the team is mindful of each other and our individual strengths and vulnerabilities. We know we are not perfect and we have a laugh. We provide a good service and do our best and we are learning every day. We appreciate the training and change our practice and try to be constant in changing and challenging times. Together I believe we are making a difference to mothers, children and families. Katy, our CNN, is a mine of information and always helps without us having to ask. Elspeth is clever and methodical and very thorough and tells great jokes. Julie, our admin, is very experienced and responds to our requests efficiently despite our interrupting her numerous tasks with too little time to do everything. Gill coordinates the team and fits everything in in her relaxed and respectful way and our students have been great. We miss them all. Tracey, very new member of the team as a CNN is welcome and no doubt will add her own ingredients to the mix. I feel privileged to work alongside them all.”

Employee benefits - Gross Expenditure 2016/17

	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000s	£000s	£000s	£000s	£000s	£000s
Salaries and wages	**227,527**	186,454	41,073	220,413	181,938	38,475
Social security costs	**18,716**	17,235	1481	14,660	13,837	823
Employer contributions to NHS BSA - Pensions Division	**23,960**	22,064	1896	23,444	22,128	1,316
Termination benefits	**405**	405	0	13	13	0
TOTAL - including capitalised costs	**270,608**	226,158	44,450	258,530	217,916	40,614
Employee costs capitalised costs	**637**	548	89	443	396	47
Gross Employee Benefits excluding capitalised costs	**269,971**	225,610	44,361	258,087	217,520	40,567

Average staff numbers

	Total YTD	Permanently Employed	Other	Total Prior Year	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	**605**	516	89	600	514	86
Administration and estates	**1,252**	1,146	106	1,139	1,039	100
Healthcare assistants and other support staff	**2,029**	1,665	364	1.853	1,473	380
Nursing, midwifery and health visiting staff	**1,903**	1,750	153	1,881	1,722	159
Nursing, midwifery and health visiting learners	**22**	22		26	26	
Scientific, therapeutic and technical staff	**559**	496	63	550	495	55
Healthcare Science staff	**130**	130		131	131	
Other	**7**	7		88	88	
Total	**6,507**	**5,732**	**775**	6,268	5,488	780
Of the above - staff engaged on capital projects	**16**	14	2	15	13	2

Exit packages (audited)

Exit package cost band (including any special payment element)	2016/17 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**

Exit package cost band (including any special payment element)	2015/16 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
	Numbers	£s	Numbers	£s	Numbers	£s
Less than £10,000	0	0	7	11,957	7	11,957
Totals	**0**	**0**	**0**	**11,957**	**7**	**11,957**

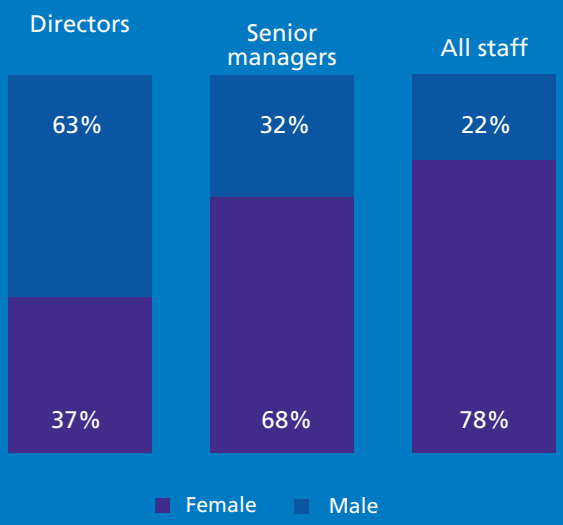
Analysis of Other Departures

	2016/17 Agreements Number	Total value of Agreements £000s	2015/16 Agreements Number	Total value of Agreements £000s
Mutually agreed resignations (MARS) contractual costs	1	64	1	0
Contractual payments in lieu of notice	7	167	6	12
Exit payments following employment tribunals or court orders	1	12	0	0
Totals	**9**	**243**	**7**	**12**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pensions. Exit Costs in this note are accounted for in full in the year of departure. Where ESHT has agreed early retirements, the additional costs are met by ESHT and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

Gender distribution by directors, other senior managers and staff

Gender breakdown of Trust - 31st March 2017



Senior Managers includes all staff on Agenda for Change Bands 8a-8d.

Staff fact file*

As of 31st March 2017:

- Just under 78% of our staff were female
- 38.6% of all staff work part-time
- 35.2% of staff are over 50 years old
- Just over 2.3% of staff identified themselves as disabled and just over 1.2% identified themselves as either gay, lesbian or bisexual
- 12.3% of staff are from a black or minority ethnic (BME) origin. This compares to 14.6% nationally (England, 2011 Census) and just over 8.3% in East Sussex (December 2012)

* Source: ESR (comparative ethnic info from 2011 Census and East Sussex in Figures).

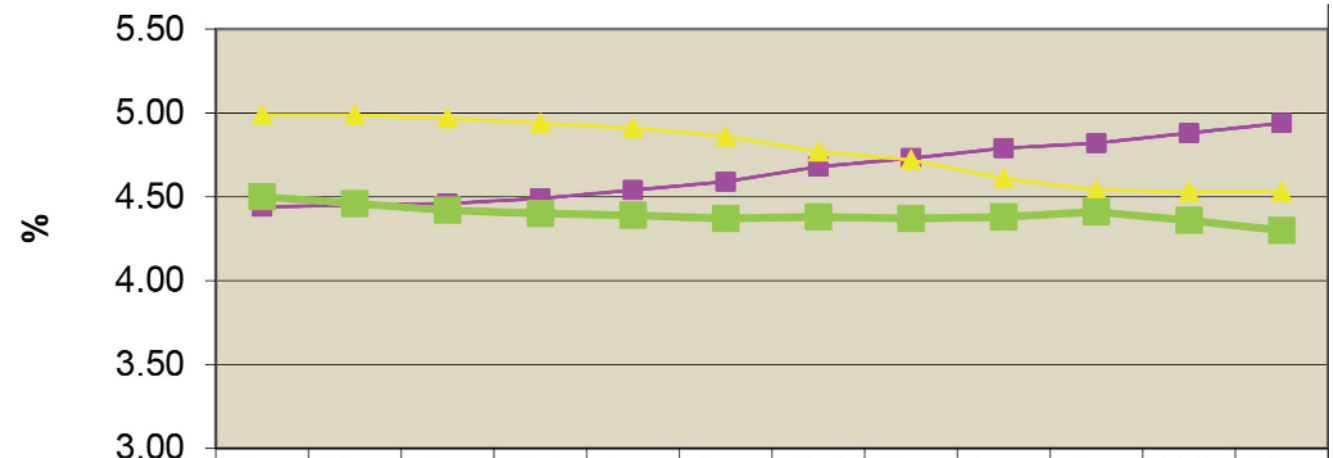
#ourmarvellousteams

“**Conquest A&E, AAU and IV team** - I am a 3rd year registrar in Radiology at Barts and The London NHS trust. I also have a rare medical condition (a mitochondrial disease) that requires specialist in patient care when I become unwell with intercurrent illness. I completed my F1 jobs at Conquest Hospital. I recently was admitted to the Conquest AAU, via A&E, my parents live locally and I became ill whilst staying with them and was not able to get into London to get the treatment I normally have. I just wanted you to know how impressed and grateful I was for the care I received. In particular the nursing and HCA staff in both A&E and AAU who took care of me and were always so prompt with my requests. The doctors were great and in fact the consultant on call that weekend (Dr Nadeem Rahman) was actually my registrar when I was an F1. I was amazed at how many people recognised me from my time there which was 10 years ago. In particular I wanted to flag up what a superb service the IV team is. This is something that I do not have access to in London and wish I did. They were absolutely brilliant and were there so quickly when issues arose with my portacath and that not only helped me get my treatment quicker but also massively reduced my anxiety around having a central venous access device in a strange hospital. Support and hold on to that service, you have no idea how much stress was relieved by having them there, not only for me as a patient but I'm sure for the clinical staff too. I appreciate what a great job is being done at the Conquest.”

Staff Absence Data

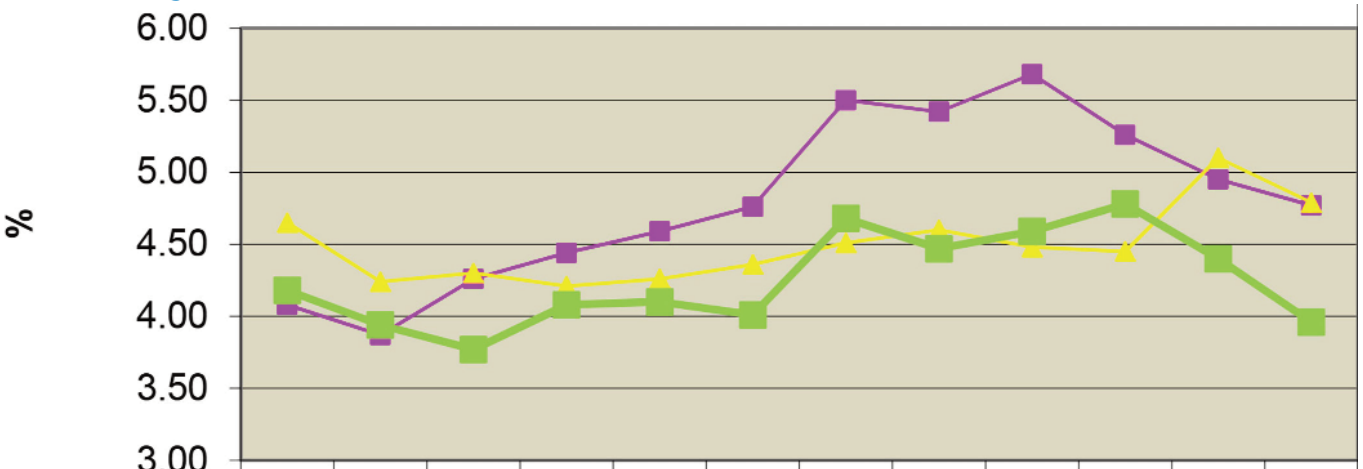
Our annual sickness rate has reduced during the year from 4.50% to 4.30%.
The average working days lost due to sickness per member of staff during the year to 31st March 2016 was 10.16.

Annual sickness rate



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	4.44	4.45	4.46	4.49	4.54	4.59	4.68	4.73	4.79	4.82	4.88	4.94
2015/16	4.99	4.99	4.97	4.94	4.91	4.86	4.77	4.72	4.61	4.54	4.53	4.53
2016/17	4.50	4.46	4.42	4.40	4.39	4.37	4.38	4.37	4.38	4.41	4.36	4.30

Monthly sickness rate



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	4.08	3.87	4.26	4.44	4.59	4.76	5.50	5.42	5.68	5.26	4.95	4.77
2015/16	4.65	4.24	4.30	4.21	4.26	4.36	4.51	4.6	4.48	4.45	5.10	4.79
2016/17	4.18	3.94	3.77	4.08	4.10	4.01	4.68	4.47	4.59	4.78	4.4	3.96

Staff Policies

We ensure that all vacancies for positions within the Trust are advertised both internally and externally, through our Trust website and NHS Jobs2.

Applicants who disclose a disability are given an automatic 2 ticks indicator which is visible during the shortlisting process, and 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.

When necessary, our Human Resources Department will provide support for staff and for line managers to ensure that, wherever possible, staff needing to find an alternative post due to health issues are helped to identify suitable alternative employment. Support is made available from the Occupational Health Department 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 culture. All of our staff undergo equality training and have the option of doing this online or face to face. We further ensure that equality is embedded throughout the Trust via Personal Development Reviews, team briefings, and within a variety of Trust communications.

Expenditure on Consultancies

During 2016/17, the Trust's total spending on consultancies was £993,000.

Off-payroll Engagements

	Number
Number of existing engagements as of 31/03/17	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
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

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	2
Of which, the number that have existed:	
Number of new engagements which include contractual clauses giving East Sussex Healthcare NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	2
Number for whom assurance has been requested	0
Of which:	
assurance has been received	0
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

Two contracts were arranged through HR and for these the term was included. However, for the contracts which were developed outside HR during a time of organisational change, the Trust cannot confirm that these are included and as a result is reporting non-compliance. The individual who agreed the contracts and who were the subject of the contracts have now left the organisation. Processes have been in place to ensure HR involvement for contracts since then.

Off-payroll engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1st April 2016 and 31st March 2017.

	Number
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 should include both on payroll and off-payroll engagements.	15

Modern slavery

Note: The Trust income does not reach the level at which we are required to prepare an annual slavery and human trafficking statement.

This accountability report was approved by the board on 31st May 2017 and signed on its behalf by:

Chief Executive
1st June 2017

SUMMARY FINANCIAL STATEMENTS

Independent Auditor's Report to the Directors of East Sussex Healthcare NHS Trust

We have audited the financial statements of East Sussex Healthcare NHS Trust (the Trust) for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014.

The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes.

The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2016-17 Government Financial Reporting Manual (the 2016/17 FReM) as contained in the Department of Health Group Accounting Manual 2016/17 (the 2016-17 GAM) and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is described in that report as having been audited.

This report is made solely to the Board of Directors of East Sussex Healthcare NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited.

Our audit work has been undertaken so that we might state to the Directors of the Trust 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 Board of Directors of the Trust, as a body, for our audit work, this report, or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the Statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

We are required under section 21(3)(c), as amended by 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. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed
- the reasonableness of significant accounting estimates made by the Directors; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Statement of comprehensive income for the year ended 31st March 2017

	2016/17 £000s	2015/16 £000s
Gross employee benefits	**(269,971)**	(258,087)
Other operating costs	**(146,775)**	(138,083)
Revenue from patient care activities	**339,788**	323,874
Other operating revenue	**39,519**	32,278
Operating deficit	**(37,439)**	(40,018)
Investment revenue	**17**	29
Other gains	**0**	29
Finance costs	**(1,795)**	(859)
Deficit for the financial year	**(39,217)**	(40,819)
Public dividend capital dividends payable	**(4,968)**	(6,940)
Transfers by absorption - losses	**0**	(29,260)
Retained deficit for the year	**(44,185)**	(77,019)
Other comprehensive income	**2016/17 £000s**	2015/16 £000s
Impairments and reversals taken to the revaluation reserve	**0**	(262)
Net gain/(loss) on revaluation of property, plant and equipment	**6,569**	(10,877)
Total comprehensive income for the year	**(37,616)**	(88,158)
Will not be reclassified to income and expenditure		
Financial performance for the year		
Retained deficit for the year	**(44,185)**	(77,019)
Impairments (excluding IFRIC 12 impairments)	**(5)**	(411)
Adjustments in respect of donated government grant asset reserve elimination	**398**	173
Adjustment re absorption accounting	**0**	29,260
Adjusted retained deficit	**(43,792)**	(47,997)

Statement of financial position as at 31st March 2017

	31/03/17 £000s	31/03/16 £000s
Non-current assets:		
Property, plant and equipment	**237,135**	231,172
Intangible assets	**1,860**	1,650
Trade and other receivables	**1,308**	1,193
Total non-current assets	**240,303**	234,015
Current assets:		
Inventories	**6,195**	6,472
Trade and other receivables	**40,806**	17,184
Cash and cash equivalents	**2,100**	2,100
Total current assets	**49,101**	25,756
Total assets	**289,404**	259,771
Current liabilities:		
Trade and other payables	**(53,034)**	(39,830)
Provisions	**(502)**	(253)
DH capital loan	**(427)**	(427)
Total current liabilities	**(53,963)**	(40,510)
Net current liabilities	**(4,862)**	(14,754)
Total assets less current liabilities	**235,441**	219,261
Non-current liabilities:		
Provisions	**(2,488)**	(2,709)
DH revenue support loan	**(89,662)**	(35,218)
DH capital loan	**(3,126)**	(3,553)
Total non-current liabilities	**(95,276)**	(41,480)
Total assets employed	**140,165**	177,781
Financed by:		
Public dividend capital	**153,562**	153,562
Retained earnings	**(118,105)**	(74,028)
Revaluation reserve	**104,708**	98,247
Total taxpayers' equity	**140,165**	177,781

The summarised financial statements on pages 97 to 100 were approved by the board on 31st May 2017 and signed on its behalf by

Chief Executive
1st June 2017

Statement of cash flows for the year ended 31st March 2017

	2016/17 £000s	2015/16 £000s
Cash flows from operating activities		
Operating deficit	**(37,439)**	(40,018)
Depreciation and amortisation	**12,406**	12,665
Impairments and reversals	**(5)**	(411)
Donated assets received credited to revenue but non-cash	**(539)**	(947)
Decrease in inventories	**277**	127
(Increase)/Decrease in trade and other receivables	**(24,109)**	2,271
Increase in trade and other payables	**14,728**	11,817
Provisions utilised	**(405)**	(467)
Other movement in non cash provisions	**400**	250
Net cash outflow from operating activities	**(34,686)**	(14,713)
Cash flows from investing activities		
Interest received	**17**	29
Payments for property, plant and equipment	**(12,465)**	(10,159)
Payments for intangible assets	**(505)**	(583)
Proceeds of disposal of assets held for sale (PPE)	**0**	6
Net cash outflow from investing activities	**(12,953)**	(10,707)
Net cash outflow before financing	**(47,639)**	(25,420)
Cash flows from financing activities		
Gross temporary and permanent PDC received	**0**	32
Loans received from DH - new capital investment loans	**0**	441
Loans received from DH - new revenue support loans	**54,444**	66,633
Loans repaid to DH - capital investment loans repayment of principal	**(427)**	(427)
Loans repaid to DH - working capital loans/revenue support loans	**0**	(31,415)
Capital element of payments in respect of finance leases	**0**	(335)
Interest paid	**(1,761)**	(859)
PDC Dividend paid	**(4,617)**	(7,558)
Net cash inflow from financing activities	**47,639**	26,512
NET INCREASE IN CASH AND CASH EQUIVALENTS	**0**	1,092
Cash and cash equivalents at beginning of the period	**2,100**	1,008
Cash and cash equivalents at year end	**2,100**	2,100

Interest Paid and PDC Dividend Paid were shown as Operating activities in 2015/16, these are now accounted for as Financing Activities.

Better payment practice code

	2016/17		2015/16	
	Number	£000s	Number	£000s
Non-NHS payables				
Total non-NHS trade invoices paid in the year	**119,039**	**130,851**	131,962	144,870
Total non-NHS trade invoices paid within target	**31,288**	**49,321**	75,556	94,383
Percentage of non-NHS trade invoices paid within target	**26.28%**	**37.69%**	57.26%	65.15%
NHS payables				
Total NHS trade invoices paid in the year	**2,656**	**46,757**	2,619	22,572
Total NHS trade invoices paid within target	**786**	**37,205**	1,604	18,886
Percentage of NHS trade invoices paid within target	**29.59%**	**79.57%**	61.24%	83.67%

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 a valid invoice, whichever is later.

Accessibility

We can provide information in other languages when the need arises. Furthermore, to assist any patient with a visual impairment, literature can be made available in Braille or on audio tape.
For patients who are deaf or hard of hearing a loop system is available around our hospitals and a British Sign Language service can be arranged.

If you require any of the Trust leaflets in alternative formats, such as large print or alternative languages, please contact the Equality and Human Rights Department.

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Freedom of Information

The Trust is required under the Freedom of Information Act 2000 to make certain information public. The information available can be found in the Trust's Publication Scheme available on our website at **www.esht.nhs.uk/foi**

Alternatively write to: Freedom of Information Manager, Eastbourne District General Hospital, Kings Drive, Eastbourne, East Sussex, BN21 2UD.