EAST SUSSEX HEALTHCARE NHS TRUST

ANNUAL GENERAL MEETING

The Annual General Meeting of East Sussex Healthcare NHS Trust will be held on Tuesday, 6th August 2019, commencing at 14:00 in Oak Room, Hastings Centre

AGENDA

1.	Welcome and Apologies for Absence		Chair
2.	Minutes of the Annual General Meeting held on 7th August 2018	A	
3.	East Sussex Healthcare NHS Trust Year in Review: Receive 2018/19 Annual Report and Quality Account	B	CEO
4.	Key Improvements: • Achieving the 4 hour standard • Treating Sepsis • Managing Frailty		Dr Kate Murray Dr James Wilkinson Dr Elena Mucci
5.	Questions from members of the public		Chair

Key:	
Chair	Trust Chairman
CEO	Chief Executive

Steve Phoenix
Chairman

3rd July 2019

EAST SUSSEX HEALTHCARE NHS TRUST

ANNUAL GENERAL MEETING

Minutes of a meeting of the Annual General Meeting held in public on Tuesday, 7th August 2018 at 13:00 in the Hydro Hotel, Eastbourne.

Present:
Mr David Clayton-Smith, Chairman
Mr Barry Nealon, Vice Chairman
Mrs Sue Bernhauser, Non-Executive Director
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Mrs Miranda Kavanagh, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Dr Adrian Bull, Chief Executive
Ms Catherine Ashton, Director of Strategy
Ms Vikki Carruth, Director of Nursing
Mrs Joe Chadwick-Bell, Chief Operating Officer
Ms Monica Green, Director of Human Resources
Mrs Lynette Wells, Director of Corporate Affairs

In attendance:
Dr James Wilkinson, Assistant Medical Director
Miss Saba Sadiq, Deputy Director of Finance
Mrs Angela Ambler, NHSI Next NED Programme (observing)
Mr Pete Palmer, Assistant Company Secretary (minutes)

1 **Welcome**

Mr Clayton-Smith welcomed everyone to the Annual General Meeting.

Apologies for Absence
Mr Clayton-Smith reported that apologies for absence had been received from:

Dr David Walker, Medical Director and Dr Wilkinson was attending on his behalf.
Mr Jonathan Reid, Director of Finance and Miss Sadiq was attending on his behalf.
Mr Christopher Langley, Financial Improvement Director, NHSI
Mr Mark Friedmann

2. **Minutes**
The minutes of the Annual General meeting held on 26th September 2017 were considered and agreed as an accurate account of the discussions held. The minutes were signed by the Chairman and would be lodged in the Register of Minutes.

3. **Matters Arising**
There were no matters arising from the previous Annual General Meeting.

4. **East Sussex Healthcare NHS Trust Year in Review**

Dr Bull, Ms Carruth and Miss Sadiq made presentations highlighting the challenges and progress made by the Trust during 2017/18.

The Board formally adopted the Annual Report, Summary Financial Statements and Quality Account for 2017/18.

5. **Questions from members of the public**

Questions to the Board from members of the public were received. Topics included:

- Trust finances and deficit
- Length of stay for patients
- Thanks for support from the local community
- Staff welfare
- End of Life Care
- Bed occupancy rates
- Trust's role within ESBT and Alliance
- Control of the Trust's budget
- Bullying of staff and measures to address this
- PWC report into the underlying reasons for the Trust's deficit
- CCG funding
- Ensuring that every patient is treated as an individual

6. **Close of Meeting**

Mr Clayton-Smith noted that the meeting marked Mrs Bernhauser's final meeting for ESHT, as she was retiring from her role as a Non-Executive Director. He thanked her for her contribution to the Trust, including the time she had spent as acting Chair during a very difficult period for the Trust. He explained that she had been a stalwart of the Board, contributing enormously, and thanked her for her hard work in improving the Quality and Safety Committee.

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

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Annual Report 2018-2019

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

Contents

Welcome and overview

The year that we celebrated the 70th anniversary of the NHS was also a landmark year for the Trust. We are pleased to present some of the highlights from the year in our 2018/19 annual report and accounts.

We began the year with the publication of our most recent Care Quality Commission (CQC) report. The CQC rated almost every service they inspected as 'good' or 'outstanding' – it was the first time the Trust has received 'outstanding' ratings for some of its services. The CQC noted the marked improvement in the quality of our care and concluded that the Trust no longer needed to be in special measures for quality. The CQC acknowledged that on the basis of the inspection in March, the Trust's rating would be 'good', however the Trust's overall rating remains as 'requires improvement' because not all services were inspected.

Since then our quality improvements have continued apace. One of our biggest successes has been the increase in recognition and prompt treatment of sepsis, which has led to a significant decrease in sepsis mortality. Alongside this, our new approach to the treatment of pressure ulcers meant we saw a 76% reduction in reported category 3 and 4 ulcers amongst our patients. We took action to reduce foot amputations and have seen a reduction of 70% since the introduction of our multidisciplinary Diabetic Foot Clinics. We introduced three community midwifery teams to increase the number of women seeing the same small team throughout their pregnancy, birth and post-natal care. We exceeded the national target of 20% of women receiving this kind of care this year.

At the same time, patients continue to give us positive feedback about their care. This was reflected in the ratings of our two acute hospitals on the NHS website – both have improved and are now rated as 4.5 stars out of five. Over the last two years, the number of complaints we receive reduced by 15% and we received 65 compliments for every complaint.

This year we invested in refurbishing the Maxillofacial and Orthodontic department and Special Care Baby Unit. We saw the opening of two new CT scanners and our new robotic hoist. Work began on our new Urology Investigation Suite and the build of a new MRI suite for two new MRI scanners – which has included a major upgrade of the power infrastructure at the Conquest Hospital. Digital technology underpinned some our most ambitious developments this year. We introduced Live Bed State which manages patient flow in our acute hospitals and rolled out new technology in the community. We have moved completely from paper to electronic GP referrals, enabling patients to book their own appointments online. We also began the development of a Patient Portal which will allow patients access to their health records and a new electronic prescribing and administration system.

We faced growing patient need in our hospitals and in our community services. Despite this, we are, for the most part, meeting demand and providing high quality care in a timely fashion. We continue to improve our ability to see, treat and discharge or admit patients within four hours in our Emergency Departments – which is an important marker of how the health and care system works as a whole. At the year end, we were achieving a performance of 93% which puts us among the group of leading trusts nationally. We have

seen improvements in our ability to meet other national standards like referral to treatment time and access to diagnostics and cancer referral times. Our community services also generally met the increased demand placed on them for their services, which will be increasingly important as we see more and more care provided by members of staff in community settings and in people's own homes.

A number of excellent services were recognised this year including gaining national accreditation for our Pathology Departments, our Endoscopy Units, our Paediatric and Adult Audiology services and our UroGynaecology Unit, which was the first in Sussex to get accreditation from the British Society of UroGynaecology. Many other members of staff and teams were also recognised at Trust, local and national awards, with three members of staff receiving New Year's or Queen's Birthday Honours for their services to health and care.

In March this year, we received the results of the annual NHS staff survey which some 53% of us completed - one of the best return rates in the country. Looking back over three years, the results show some encouraging improvements. There has been a 25% increase in those members of staff saying they would recommend our care and a 47% increase in those who would recommend the Trust as a place to work.

We have made financial improvements at the same time as improving operational performance, quality of care and the experience of patients and members of staff. We achieved our ambitious financial target in 2018/19, reducing our financial deficit to under £45m. This was an improvement of over £10m on last year. We have also decreased our underlying monthly deficit by over £2m a month since 2016. To make sure these improvements are maintained, we have put in place stronger controls, improved our reporting, and strengthened our planning. An independent report into our governance published last November noted the Trust's improved financial governance and performance. Next year's financial target will be challenging, but we are confident of achieving it.

In January the NHS Long Term Plan was published, which asked all health and care providers to think differently about the way they provide care for their local population. We are working with our health and social care partners locally to make sure that our priorities for next year meet this challenge and build on the progress we are already making.

Every member of staff across our Trust has had a part to play in the improvements we have seen, building our reputation and making our Trust an organisation in which we can all be proud. On behalf of the Trust Board we would like to thank members of staff for their efforts to deliver safe and effective care for our patients. Our Board continues to play a crucial role and we extend our thanks for their commitment, support and challenge. We would also like to thank our small army of volunteers who provide support and assistance to patients in a wide variety of ways and settings. Finally, we would like to offer thanks to the Friends of our Hospitals, our Charitable Trust, and local people for their continued generosity and support throughout the year.

Dr Adrian Bull
Chief Executive

Steve Phoenix
Chairman

About us

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

This means working in partnership with commissioners, other providers, members of staff and volunteers as part of a locally focused and integrated health and social care network. We are one of the largest organisations in East Sussex, employing nearly 7,100 dedicated staff with an annual turnover of £410 million. Our teams are proud to provide acute hospital and community health services for the 550,000 people living in East Sussex.

We also offer an essential emergency service to the many seasonal visitors to the county every year. We operate two district general hospitals, Conquest Hospital and Eastbourne District General Hospital (EDGH), both of which have Emergency Departments and provide care 24 hours a day. Between them they offer a comprehensive range of surgical, medical and maternity services, supported by a full range of diagnostic and therapy services.

We have around 800 beds and over 110,000 inpatient spells each year. During 2018/19, there were close to 130,000 attendances at our Emergency departments and there were over 410,000 outpatient attendances. At Bexhill Hospital we offer outpatients, day surgery, rehabilitation and intermediate care services. Outpatient services, rehabilitation and inpatient intermediate care services are also provided at Rye, Winchelsea and District Memorial Hospital. We also provide day surgery and outpatient care at Uckfield Hospital. We provide rehabilitation services jointly with East Sussex County Council Adult Social Care from Firwood House in Eastbourne and Bexhill Health Centre.

We also deliver services which focus on people living in the community through our Integrated Locality Teams working with district and community nursing teams. Other services focus on people with long term conditions such as the Bladder and Bowel Service, Community Heart Failure, Tissue Viability and the Diabetes Specialist Nursing team. Respiratory, Parkinson's Disease and MS Nurse Specialists provide further support to our patients in the community. We provide a range of more specialist services in the community and these include the Community Dental Service, Medicines Management, and the Pharmacy Team.

Members of staff also provide care to patients in their homes and from a number of clinics, health centres and GP surgeries. Services based outside our hospitals include Health and Social Care Connect (HSCC), the Integrated Night Service, Community Nutrition and Dietetics, Speech and Language Therapy Service for Adults, Occupational Therapy, Physiotherapy, Podiatry, Diabetic Retinopathy and Sexual Health including contraception services. Services for children are offered, including Health Visiting and the Safeguarding Children Team and Looked after Children Team.

Our year in numbers

- Our Emergency Departments were used **130,000 times**, an increase of 9% on last year. 91% of people using our EDs were seen, treated and either discharged or admitted, within four hours
- **3,053** children were born in our hospitals. This includes **332** children born at Eastbourne Midwifery Unit, an increase of nearly 16% on last year
- **54,000** people had planned surgery, 87% of these were day cases
- **21,800** cancer referrals were made to us, an increase of 8.5% on last year
- There were **414,000** outpatient appointments, nearly **300,000** of these were consultant-led
- **283,000** X-ray and scans were carried out
- We had 42,000 new referrals to our community nursing teams, with 6,500 responded to within 24 hours.
- **7m** pathology tests were performed.
- **40.1 million m2** of flooring were cleaned
- **470,000** medicines were dispensed
- **896,000** meals were delivered to patients

Our Vision, Values, Ambition – to be Outstanding and Always Improving

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

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

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

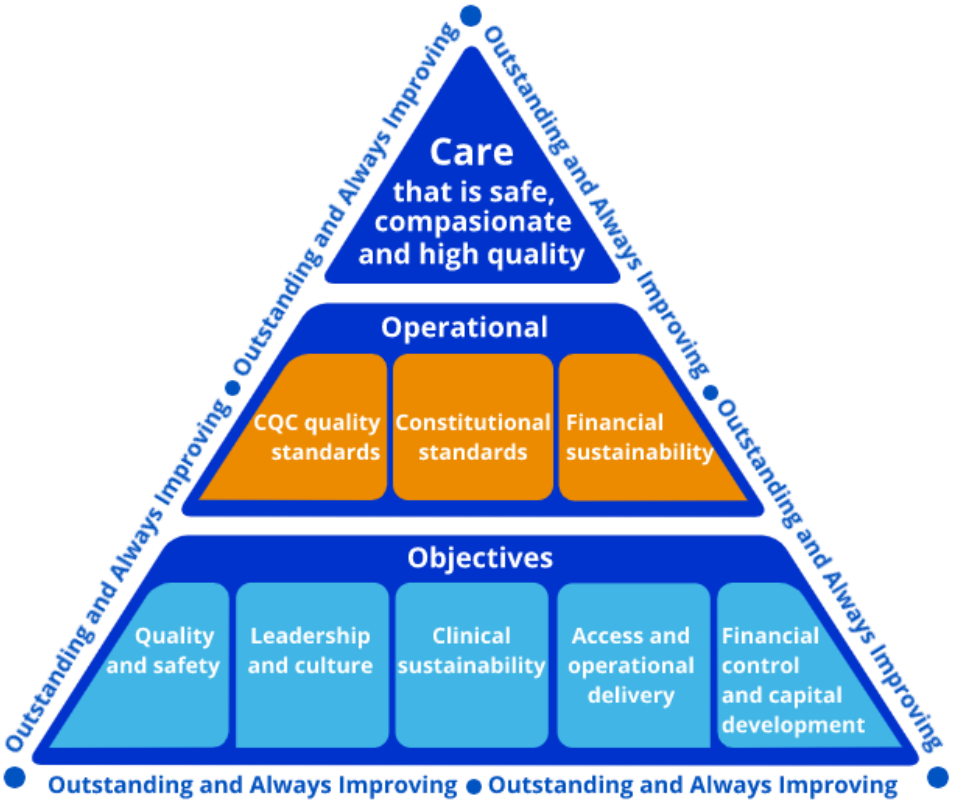
Operational priorities:

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

Our Objectives:

- **Safe patient care is our highest priority:** Delivering high quality services that achieve and demonstrate the best outcomes and provide an excellent experience for patients
- **All members of staff will be valued and respected**: Members of staff will be involved in decisions about the services they provide and offered training and development to fulfil their roles and help them progress
- **Our clinical services will be sustainable**: Working with commissioners, our local authority and other stakeholders we will plan and deliver health and care services that meet the needs of our local population now and in the future

- **We will operate efficiently and effectively:** Diagnosing and treating patients in a timely fashion that supports their return to health
- **We will use our resources efficiently and effectively:** Ensuring our services are financially sustainable for the benefit of our patients and their care



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

Going Concern

As in previous years, the Trust has prepared its 2018/19 Annual Accounts on a going concern basis.

The Trust is planning to deliver a deficit in 2019/20 of £34.0m, assuming delivery of a £20.6m cost improvement programme. If this deficit is delivered, the Trust will receive £24m of funding from the Department of Health and Social Care, meaning that the year end position will be a £10m deficit.

As at 31 March 2019, the Trust had a cash balance of £2.1m with a cash forecast for the end of each month during 2019/20 ranging from £2.1m to £4.5m. The cash balances assume achievement of the forecast position including delivery of the cost improvement programme and receipt of £23.9m and cash support from the Independent Trust Financing Facility through application to the Department of Health and Social Care via NHS Improvement.

Despite the risk and uncertainty associated with future cash flow projections, management are of the view that whilst challenging, they will be able to deliver against the cost improvement programme and achieve the agreed forecast outturn. However at this stage, there is no certainty that the cost improvement programme will be achieved. If it is not achieved, cash resources would be consumed within the next 12 months and the Trust would require further cash support to meet its liabilities as these fall due. DHSC has not confirmed, at the certification date of the accounts, that they will provide cash support to the Trust in 2019/20.

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

Notwithstanding the need for additional cash support, the Trust does not have any evidence indicating that the going concern basis is not appropriate. The Trust has not been informed by NHS Improvement that there is any prospect of reconfiguration or dissolution within the next 12 months. In terms of the sustainable provision of services, there has been no indication from the Department of Health and Social Care that the Trust will not continue to be a going concern. Furthermore, continuity of service provision in the future can be demonstrated by signed contracts and future commissioning intentions with commissioners, and through the financial and operational plans described in the Trust Strategy, the Sussex and East Surrey Sustainability and Transformation Plans and the East Sussex Better Together (ESBT) Alliance. In 2018/19 the Trust has worked with system partners to achieve system financial balance. This work will continue to be progressed at pace in 2019/20.

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

Performance analysis

The operational performance at ESHT is measured against key access targets and outcome objectives set out in the single oversight framework drawn up by NHS improvement (NHSI). These are:

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

Alongside the performance standards above, ESHT 2020 contains a set of five overarching 'foundations' that will enable us to deliver our vision and to be recognised as an 'Outstanding' organisation by 2020. Our 2018/19 Integrated Business Plan sets out our priorities under each of these strategic objectives for the year. These priorities provide an additional means of measuring progress, which in turn supports us to deliver our long-term vision of providing safe, compassionate, and high quality care to improve the health and wellbeing of the people of East Sussex.

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

Oversight of performance is from 'floor to board'. Performance is discussed at all levels of the organisation. This review process is underpinned by business intelligence that analyses our performance data, highlighting any deviation from anticipated outcomes, as well as potential drivers for change and improvement, such as changing demand for services.

Progress against the national standards, and our 18/19 Integrated Business Plan, are set out over pages 12 to 31.

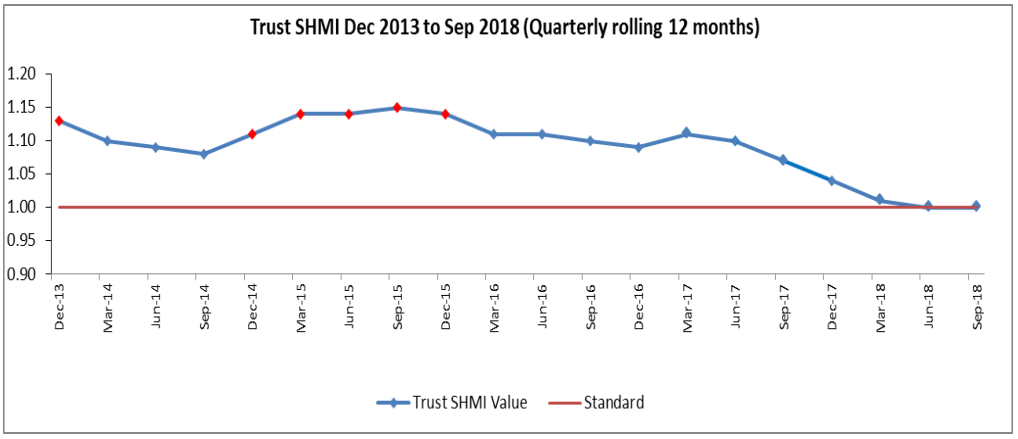
1: Safe patient care is our highest priority

Summary of performance

Indicator	Detail	17/18	18/19
Mortality	RAMI SHMI Crude mortality	78 (Feb to Jan) 107 (Oct to Sept) 1.8% (Feb to Jan)	74 (Feb to Jan) 100 (Oct to Sept) 1.5% (Feb to Jan)
Patient falls	Falls total Per 1000 bed days Resulting in harm Falls assessment compliance	1,624 5.7 19 84.6%	1,514 5.8 9 91.4%
Pressure ulcers (3/4)	Total	33	8
Patient infections	Cdif MSSA MRSA	34 9 3	51 18 2
Serious incidents		48	44
Never events		4	1
Patient complaints	All Per 1000 bed days	562 1.95	557 2.15
FFT	Inpatient A&E Maternity Community Outpatients	97.1 90.4 98.3 97.5 96.6	97.5 92.5 97.9 98.2 97.1

Mortality and review of deaths

Our mortality rates are monitored by three separate indices, all considering slightly different factors. These all provide evidence that we have seen significant improvements and are within the expected range for our peer group. These significant improvements are due to better reporting and recording within the Trust, and the significant improvements that we have made to the number of patients being screened for sepsis and then receiving treatment within one hour.



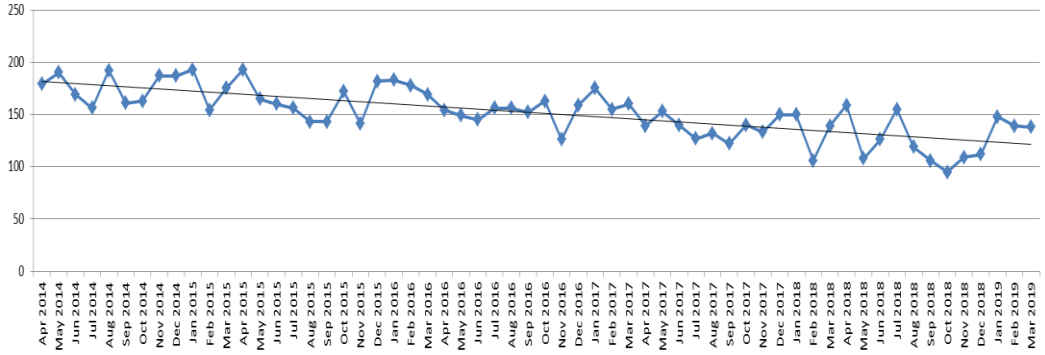
The requirements set out in the Care Quality Commission Learning from Deaths review have been incorporated into Trust policy. The mortality database reflects the new review process and all plaudits and care concerns raised by family or carers of the deceased are recorded.

A higher percentage of deaths are now being reviewed within the three month timescale and the backlog of deaths outstanding for review has decreased. Medical Examiner posts are being recruited to at both ESHT sites and the new review process will commence in April 2019.

Reducing falls, pressure ulcers and infections

The number of patient falls reported across the Trust per 1000 bed days has stayed around the same: 5.8 in 2017/18 compared to 5.7 in 2018/19. However we have seen a drop in the total number of falls, down from 1624 to 1514. We also saw a reduction in the number of falls leading to harm, with nine reported in 2018/19 down from 19 the year before. The Trust has rolled out a multifactorial risk assessment and care planning tool which provides a more holistic approach to assessing the risk of falls.

Total number of reported falls per month (April 2014 – March 2019)



We have seen a significant reduction in the number of category 3/4 pressure ulcers, down by 76%, from 33 in 2017/18 to eight in 2018/19.

We have however seen a rise in the number of Clostridium Difficile infections reported, from 34 in 2017/18 to 51 in 2018/19. The Trust has a significant action plan in place to address the rise in infections. The plan has been discussed with Public Health England (PHE) and

they have not raised any significant concerns about the rise in infections. We also saw a small rise in the number of MSSA cases, and small drop in the number of MRSA cases.

Serious Incidents and never events

This year, we have maintained and improved on the reduction we saw last year in the number of serious incidents reported. The number reported this year fell slightly again from 48 in 2017/18 to 44 in 2018/19. An improved process for managing Serious Incidents has proved effective, with no overdue incidents reported. Never events fell from four reported last year to one reported this year.

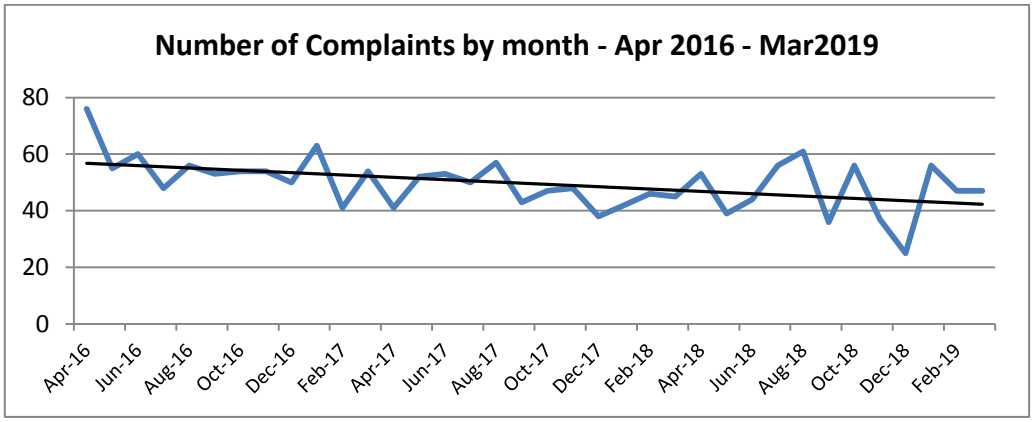
We have seen a small reduction in the number of patient safety incidents reported per 1000 admissions, from 43 to 41 (a reduction in total from 5339 to 4870). Although we have seen a small increase in the number of incidents that resulted in severe harm (from 7 incidents in 17/18 to 12 incidents in 18/19).

Mixed sex accommodation

Following new reporting guidelines, the Trust reported significantly more breaches of mixed sex accommodation. This is mainly because areas like Critical Care do not have the capacity to have single sex accommodation. We have joined a national collaborative to support a reduction of breaches and a number of improvements have been put in place already, for example identifying the number of male and female beds empty or likely to be empty and allocating these to those awaiting admission.

Patient feedback

Complaints: We have maintained the improvements to complaints processes and have had a near zero rate of overdue complaints this year. This year we received 557 complaints (2.15 per 1000 bed days) compared to 562 in 2017/18 (1.95 per 1000 bed days). The average number of complaints we received each month during the year to date was 46.4.



PALS: Our Patient Advisory and Liaison Service continues to support patients who might need confidential advice and support to help address any concerns about the care we provide. The number of contacts that PALS has continues to be high, but this year we saw a small reduction in contacts from 7282 in 2017/18 to 6802 in 2018/19

Friends and Family Test and feedback: Our friends and family response rate for in-patients has remained broadly static at 42%, although we have increased the response rate for our Emergency Departments from 12% to 14%. Our overall score from patients saying that they would recommend our services has remained predominantly above 97%. These responses provide valuable feedback to allow us to continue to improve our services.

Reviews: We have developed a robust system of monitoring the NHS website and Patient Opinion websites and welcome feedback given using these routes. We have received an increased number of positive comments on these sites compared to 2017/18. Both Conquest and Eastbourne Hospitals have a rating of four and a half stars out of five on the NHS website.

Seven day services

The aim of 7 Day Hospital Services is to deliver improvements for patients by tackling the variation in outcomes for patients admitted to hospitals in an emergency. Overall, there are ten clinical standards, of which four have been made priorities for delivery.

ESHT submitted an initial self-assessment in February 2019. Overall, ESHT met the standard for access to consultant-directed diagnostics (clinical standard 5), however the Trust self-assessment from February 2019 indicated that the Trust had not met the standards overall for initial consultant assessment (clinical standard 2), access to interventions (clinical standard 6), and ongoing consultant-directed review (clinical standard 8).

Clinical Standard	**Service**	**Weekday**	**Weekend**	**Overall Score**
Clinical Standard 2 (initial consultant review)	Consultant review within 14 hours of admission	Yes	No	Not Met
Clinical Standard 5 (access to diagnostics and interventions)	Microbiology	Yes	Yes	Met
	Computerised Tomography (CT)	Yes	Yes	
	Ultrasound	Yes	Yes	
	Echocardiography	Yes	Yes	
	MRI	Yes	Yes	
	Upper GI endoscopy	No	No	
Clinical Standard	**Service**	**Weekday**	**Weekend**	**Overall Score**
Clinical Standard 6 (access to diagnostics and	Critical Care	Yes	Yes	Not Met
	Interventional Radiology	Yes	Yes	

interventions)	Interventional Endoscopy	No	No	
	Emergency Surgery	Yes	Yes	
	Emergency Renal Replacement Therapy	Yes	Yes	
	Urgent Radiotherapy	Yes	Yes	
	Stroke Thrombolysis	Yes	Yes	
	Percutaneous Coronary Intervention	Yes	Yes	
	Cardiac Pacing	Yes	Yes	
Clinical Standard 8 (ongoing review)	Daily review of IP	Yes	No	Standard Not Met
	Twice daily in critical care	Yes	Yes	

Plans have been developed to improve delivery against the remaining three priority standards, with the Trust expected to be compliant with access to interventions (clinical standard 6) by the end of April 2019.

The Trust also continues to develop divisional improvement plans for improving compliance against clinical standards 2 and 8 (first consultant review within 14 hours, and ongoing consultant review).

Excellence in Care and Essential Care Standard

We have made good progress in reviewing the clinical effectiveness of our services through the development of the Excellence in Care dashboard, which is designed to enable clinical departments to see clear outcomes and the drivers to achieving these. This has now been rolled out across all inpatient areas, with plans to implement it in specialist areas such as Emergency Departments, Critical Care and Paediatrics.

To enhance this, this year the Trust developed a set of care standards to ensure that all clinical staff understand what is expected of them and how to achieve the CQC rating of 'outstanding'. These standards include: end of life care, nutrition and hydration, dementia, falls, pressure ulcers, documentation, hygiene, continence, patients experience, medication safety, deteriorating patient and consent. These are designed to be practical aids to support members of staff. The standards have been co-written by specialist nurses and rollout and embedding of these standards will be a focus for next year.

Research participation

The Trust acts as a participating site for national and international research studies. This means we recruit patients to studies that have been developed elsewhere. Currently, we are supporting over 70 clinical research trials.

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2018/19 who were recruited to participate in research approved by a research ethics committee, was 911. This is a slight increase from the previous year when 890 patients were recruited to participate in research studies. At the beginning of this year, the Trust pledged to recruit 511 patients into trials.

- Gastroenterology has been a novel specialist area that has grown significantly during this year. This is due to the collaboration with a Specialist Nurse who has taken the role of Principal Investigator for a genetic registry study. This team received an award as Highly Commended from the Clinical Research Network Kent Surrey and Sussex (CRN KSS) for 'Best Contribution to Non-Commercial Research'.
- The Head of Research also received a CRN KSS award for 'Involving Patients in Research' and this too was Highly Commended. This was due to a whole team effort in relation to the Patient Research Experience Survey. ESHT patients contributed the largest number of responses across KSS (17.7%). We are in the process of examining the responses to further improve our research offering and patient experience.
- To help recognise the role of research in delivering quality patient care and to strengthen the assessment of research activity, a new assessment guidance and indicators have been developed under the CQC's well-led domain.

Improvements in National Audit

A number of national audit reports published throughout 2018/19 confirm that the Trust is performing above the national average in many clinical areas and is achieving (or exceeding) best practice clinical standards, delivering consistently good clinical outcomes for our patients.

- **Trauma and Research Network (TARN):** TARN is a mandated national audit that enables us to assess our performance in managing and treating trauma patients. Conquest Hospital was the fourth best in terms of survival outcome, with Eastbourne Hospital 22nd. The Trust's TARN Coordinator recently won the national 'TARN Coordinator of the year' Award.
- **National Audit of Dementia Quality Review:** The National Audit of Dementia examines and measures the performance of general hospitals against criteria relating to care delivery which are known to impact people with dementia while in hospital. The Trust participated in round four of this nationally mandated audit in 2018/19; cases were submitted to the Royal College of Psychiatrists who then randomly selected the Trust for a snapshot quality review of results to check accuracy. It was concluded that patients' notes were clear and well formulated. The notes 'flowed well' with frequent updates and entries and were easy to follow. Discharge summaries to GPs were extremely thorough particularly from the Orthopaedic Department.

2: All our employees will be valued and respected

Summary of performance

Indicator	Detail	17/18	18/19
Recruitment	Fill rate all staff Vacancies medical staff Vacancies registered nurses and midwifes Vacancies unregistered nurses AHPs	92.2% 4.1% 8.3% 11.9% 13.5%	90.6% 11.0% 8.2% 11.3% 12.6%
Turnover		11%	10.9%
Bank usage % total FTE		9.1%	8.9%
Agency usage % total FTE		1.9%	1.5%
Annual sickness		4.5%	4.2%
Appraisal	Medical staff AfC staff	100% 78.8%	100% 78.8%
Front line staff having the flu vaccine		72%	76%
Staff completing the NHS annual staff survey		49%	53%

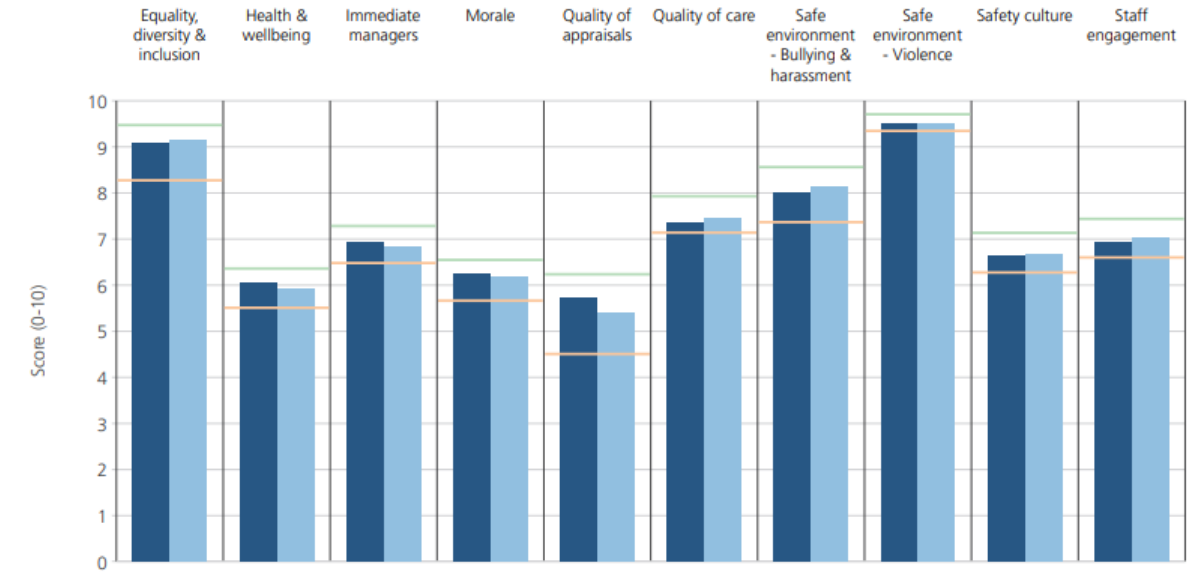
Staff surveys

NHS staff survey: The response rate to our annual NHS staff survey continues to improve with 53% of our staff sharing their views about different aspects of working at the Trust, an increase from 49% in 2017/18. This compares with a national response rate for similar organisations of 41%.

In many areas there is a marked trend of year-on-year improvement. The survey shows progress has been made in the quality of appraisals, our safety culture and on addressing bullying and harassment. Members of staff feel more supported and valued by their managers and more people feel able to raise issues of concern with confidence that they will be addressed. Importantly, more members of staff within the organisation would recommend ESHT as a place to work and receive care.

The survey shows where we have further work to do as part of the continuing improvement towards becoming an outstanding organisation. For example, staff engagement and involving members of staff in decisions that impact on them, supporting the safety of

members of staff working directly with patients and encouraging everyone to demonstrate behaviours that reflect our values, especially respect and compassion towards each other and patients.



Best	9.5	6.4	7.3	6.5	6.2	7.9	8.6	9.7	7.1	7.4
Your org	9.1	6.0	6.9	6.2	5.7	7.4	8.0	9.5	6.6	6.9
Average	9.2	5.9	6.8	6.2	5.4	7.4	8.1	9.5	6.7	7.0
Worst	8.3	5.5	6.5	5.7	4.5	7.1	7.4	9.3	6.3	6.6

GMC National Trainee Survey: The overall Trust results for the General Medical Council (GMC) 2018 National Trainee Survey showed an improvement from the 2017 results. The Trust has gone from 33 red flags in 2017, to 25 in 2018. Although we saw a small drop in the number of green flags from 16 in 2017 to 14 in 2018, we saw an increase in the number of light green flags from 7 in 2017 to 13 in 2018.

Recruitment

During 2018/19, our permanent workforce remained stable with an average of 6200 full time equivalents throughout the year. This was a reduction of 0.5% from the previous year. Our overall vacancy rate fell to 9.4%.

Thirty nine newly qualified UK student nurses joined us in 2018/19. International recruitment of hard to recruit staff continued. We went to the Philippines and the Indian sub-continent for Medical and Allied Health Professional staff, successfully recruiting 16 nurses who are due to join the Trust by July 2019.

We have had success with recruiting to positions which have been hard to fill in the past, including in Haematology, Ophthalmology and Radiology.

Safe staffing : Effective rostering practices ensure that our wards have safe levels of staffing. We introduced Safecare as part of our electronic rostering system to support this. This makes live staffing information available on iPads; the information is reviewed during twice-daily staffing meetings on each site to continuously monitor staffing levels. Twice yearly safe

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

Retention

The Trust works hard to retain the high quality staff that we have. During the past year, we have worked to improve our understanding of the reasons why staff may leave us. We have found that our turnover rates are lower than many other NHS trusts; 61% of our staff who complete the Staff Family and Friends Test recommend us as a place to work.

We expect all our staff to receive a good induction into the organisation and to receive regular feedback from their manager on their performance. We are particularly pleased that our most recent staff survey highlighted improvements in the quality of appraisals.

We are participating in a national programme linked to the retention of nursing staff which has shared best practices from around the country. Utilising this information, we have developed an action plan focussing on supporting the wellbeing of our nurses by developing more flexible working patterns and exploring different career pathways.

Our Allied Health Professionals have developed and piloted 'stay interviews'. Conversations take place with members of staff who are considering leaving the Trust and options identified which may influence them in staying. As a result of this pilot programme, we are now rolling out the interviews across the organisation. We have also been piloting talent conversations to ensure that we are clear about the career aspirations of all our staff and how we can support them in achieving their ambitions.

Positive environment and open culture

We are committed to maintaining a culture that is open and honest, where staff are confident that they can safely raise their concerns.

No harm/near miss incidents comprise 79% (slightly down on 80% in 2017/18) of all our reported patient safety incidents, which is an excellent indicator of a good reporting culture. Nationally, no harm/near miss incidents comprise 73% of all reported patient safety incidents. Our Freedom to Speak Up Guardian provides a valuable role in supporting staff to freely raise concerns, and is fully supported by the Trust Board.

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

- Colleagues from across the Trust have the opportunity to meet Senior Leaders on a regular basis to share their views and influence decisions that impact on their service. These opportunities include quality walks, quarterly meetings with senior and junior doctors, monthly visits to services by executives and a range of staff networks.
- Each division has developed its own approach to improving staff engagement. Inventive measures have included 'Breakfast with the Boss', regular newsletters, open meetings and staff suggestion schemes.

- Our Out of Hospital Division runs regular 'Embedded Learning Events' where they focus on an issue that members of staff have raised, and generate a joint solution.
- Our Leadership Briefings ensure that the 160 leaders in the organisation are briefed directly by Executives about performance and planning.

Health and Wellbeing

The emotional and physical wellbeing of members of staff is a priority for the organisation and this year we launched our staff health and wellbeing strategy.

- **Health checks:** This year, over 1000 eligible staff (aged between 40-74) received a free health check at work. The check is intended to spot early signs of stroke, kidney disease, heart disease, diabetes and dementia. This programme has supported many staff in reviewing their health and wellbeing, seeking further advice from their GP where necessary and making lifestyle changes.
- **Flu vaccine:** 76% of our frontline staff had the flu vaccination compared to 72% in 2017/18. This kept both our staff and patients safe and reduced the risk of a flu outbreak.
- **Employee support:** One hundred and forty members of staff have been supported with a range of issues linked to flexible working, childcare and financial wellbeing.
- **Physical wellbeing:** We provide a range of opportunities for staff to improve their physical wellbeing. This includes pilates, lunch break walks, take a break campaign, staff discounts at local fitness centres, and support for those staff who want to use healthy alternatives to travel to work.
- **Emotional wellbeing:** We recognise that working in a healthcare setting is both emotionally rewarding and challenging. We want to look after the emotional wellbeing of members of staff and have a number of ways we do this. Everyone has access to a range of support including pastoral support, counselling and psychology services, Schwartz rounds and various training events.
- **Celebrating success:** The Trust continues to recognise the work of colleagues. In 2018, 250 staff members came together to celebrate the 70th Anniversary of the NHS and the individual and team achievements at the Trust Annual Staff awards. More members of staff than ever are being nominated for our monthly staff awards.

Leadership Development

In 2017, we launched our Leadership Pathway. Leaders play a key role in ensuring the people who use our services receive high quality patient care. The pathway is intended to provide a range of development opportunities to support leaders from throughout the organisation in their work. The programmes have included:

- Managers' Essentials Programme highlighting the importance of induction, regular one to ones, team meetings and a well thought out appraisal process, allowing time for conversations
- Leading Excellence Programme which focused on how to lead change successfully

3: We will work closely with commissioners, other providers and health and care partners to create sustainable clinical services

Sustainability Plan (3+2 plan)

This year the Trust developed a five year sustainability plan. The plan examines what we must prioritise as a Trust and as a system to create a sustainable model for services over the next five years (and beyond). Our six sustainability programmes address these priorities. Our long term financial plan and projections are driven by the programmes.

1. **Productive planned care:** To make our planned services, like outpatients and planned surgery, as high quality and efficient as possible
2. **Becoming the best at managing frailty:** To help those who have frailty stay well for longer, with better quality of life, and reduce their need for hospital services
3. **Creating a sustainable model for urgent care:** To meet urgent demand more quickly and with the most efficient resources
4. **Integrating community services:** To make sure our out of hospital and in hospital services and teams can work seamlessly, sharing information and practices
5. **Implementing sustainable service models:** To find the right configuration across our sites or the right partners to ensure all our services are high quality and sustainable
6. **Business processes and cost control:** To ensure our corporate functions are fully equipped to help our services manage themselves efficiently and effectively and deliver the changes needed for the future

Quality Improvement (QI)

We are committed to transforming the culture of the organisation and creating clinically sustainable services through continuous improvement. Our Quality Improvement (QI) Strategy sets out what we are doing to ensure there is a constant focus on improving the quality of care that we provide, and describes the approach we are taking to embed our improvement approach at the Trust. Our strategy involves:

- Building quality into our services, systems and processes from the outset
- Engaging and involving our staff in the work of improving their day-to-day practice
- Developing quality improvement capacity and capability so that staff at all levels are skilled in making incremental improvements over time

In 2018/19, we established a new Quality Improvement team to support the delivery of our QI strategy. The support provided by the QI team includes:

- **Developing and coordinating training opportunities:** A range of QI training courses are being introduced to increase awareness and develop capability for improvement and transformation across the organisation. Our range of QI training courses differ in duration

and depth of content, and are targeted to individuals working in different roles and at different levels.

- **Ensuring support is available to design systems and processes that lead to clinical, service and quality improvements:** Our QI team provide support and guidance on how to sustainably implement and embed improvement and transformation work in the organisation.
- **Bringing together improvement expertise from across the organisation to share learning:** We are creating a network of individuals from within our organisation who are skilled in managing change and improvements. Our QI team are involved in planning and coordinating events to engage and involve staff in sharing learning and expertise.

We have also established a dedicated improvement hub, based at Eastbourne DGH. In addition to being used as a venue for training, workshops and events, the improvement hub is a multifunctional space where our workforce can access guidance and support on how to implement quality and service improvements.

All of these improvements will contribute to supporting our health and social care workforce to deliver services in new and innovative ways, with genuine integration at the very heart of service delivery. Our approach to improvement will also contribute to tackling unwarranted variation in clinical care, reduce waste, and ensure that our services continue to have quality, safety, and patient care as our primary focus.

Working with partners and our local communities

We are committed to working in partnership with our local communities to provide health and care services in which our local communities can be proud.

Place-based alliance: East Sussex Healthcare NHS Trust, East Sussex County Council and our East Sussex Clinical Commissioning Groups have been working closely together through East Sussex Better Together (ESBT) and Connecting 4 You (C4Y) to break down barriers between health and social care to deliver the right services, in the right places, at the right time.

To strengthen this work, and following a review of the Health and Wellbeing Board, the Trust are now full partners in this strategic group working alongside commissioners including High Weald Lewes Havens CCG, and other providers, to lead a single health and care transformation programme for East Sussex.

We will continue to develop our established projects, initiatives and services, and we will also work on new ideas to further improve the health and wellbeing of local people right across East Sussex.

By working in such a joined-up way, we believe we are able to serve the whole of East Sussex much more effectively. This approach aligns closely with the priorities set out in the NHS Long Term Plan.

Sustainability and Transformation Partnership (STP): We have been fully engaged with the development of the Sussex and East Surrey Sustainability and Transformation Partnership and have actively contributed to the various work-streams including digital,

workforce, finance and acute hospitals. The STP is clearly aligned to our local plans for place based care and we will continue to contribute to the work streams.

Healthwatch: As part of a national network, there is a local Healthwatch in every local authority area in England. Healthwatch East Sussex works with the public of East Sussex to ensure that health and social care services work for the people who use them. Their focus is on understanding the needs, experiences and concerns of people of all ages who use services and to then speak out on their behalf. Their role is to ensure that local decision makers and health and care services put the experiences of people at the heart of their work and decision making. They do this by gathering people's experiences and identifying issues that are important to them and, when addressed, which will make services better for everybody. This year we supported Healthwatch to undertake a great deal of activity at the Trust, including a review of maternity services and teams of volunteers who observed our care of patients as part of their listening tour and also over a continuous 24 hours period. The feedback supports us with the continuing improvement of our processes.

Public engagement: The Trust will only achieve its vision by working in collaboration with those people and communities affected by the care we provide. We want to enable the public to input into and improve our organisation, the clinical care we provide and their own experience at the hospital or in a community setting.

We are encouraging a greater diversity of people to get involved with the Trust via Trust Membership. We currently communicate regularly with our 2000 members, contacting them with news and information, and opportunities for them to let us know what they think about local health and care services.

Using our membership as a base, we are developing a group of 'super' members who are willing to get more involved in our work. These members are mainly recruited as ESHT volunteers and as such have a formal role within the Trust.

Over the last year we have involved members in the Excellence in Care project, the front entrance redesign, the End of Life Care project, and have members who sit on our Patient Experience and Public Engagement Group. We have also facilitated groups looking at the care of children with shorter lives, and wayfinding around Eastbourne Hospital. The latter two groups have included experts by experience in the development of the project.

Over the last year, we have held two member forums at which we talk to up to 50 members of the public about projects, asking for feedback about their design and next steps. Members have fed into the Excellence in Care programme, the management of complaints, patient booklet, outpatients transformation, communication and discharge processes.

Via the Patient Experience and Public Engagement Group, we have encouraged members to take part in a 'sit and see' programme, where they spend two hours in a department or service noting down their observations and feeding back their thoughts and recommendations to the group and the service/ward.

Volunteering: We offer varied, rewarding and highly valued volunteering opportunities at the Trust. We have over 500 volunteers across Eastbourne and Conquest Hospitals, Bexhill and Rye, all of whom make a valuable contribution to the services we offer our patients and visitors.

Our Volunteer Satisfaction Survey results show that overall satisfaction amongst our volunteers is high at 96%.

Along with local partners, we have been successful in the application to the Pears #iwill Fund. Our aim is to develop more volunteering roles for young people (16-25) by creating a specific Youth Volunteering Manager post funded by the Pears #iwill Fund. The new post will sit within the ESHT Voluntary Service Team and will be supported by statutory and voluntary sector stakeholder organisations that are committed to learning how to increase youth volunteering opportunities in other health and social care settings across the county.

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

Summary of performance

Indicator	Detail (national standard)	17/18	18/19
Standards	Four hour A&E (95%)	87.5%	90.9%
	RTT (92%)	91.2%	89.9%
	Cancer 62 days urgent referral (85%)	75.9%	72.4%
	Cancer 62 day Screening Standard (90%)	68.3%	68.5%
	Diagnostics (99%)	97.6%	98.8%
DToC (delayed transfers)	3.5%	3.9%	3.0%
Length of Stay	Acute elective (days)	2.7	3.0
	Non-elective (days)	5.2	4.4
	Bexhill (days)	30.1	27.4
	Rye (days)	20.3	18.4
Super stranded (21 days or more)		68	54
Community (seen within 13 weeks)	Podiatry	100%	100%
	Dietetics	99%	100%
	Speech and language	100%	87%
	Adult therapy	93%	100%
	Neurological physio	76.2%	71.2%
	MSK (H&R)	-	50%
Community nursing	Rapid Response within two hours	2,760	1,608
	Urgent Referrals Seen on the Same Day	1,713	1,953
	24 Hour Referrals	5,801	6,482

Regulatory standards

We use an extensive framework to monitor our performance against these standards and to ensure sustained delivery. This supports scrutiny, assurance, and where necessary, further action and follow up. Oversight of performance is from ‘floor to board’. Performance is discussed at all levels of the organisation. This review process is underpinned by business intelligence who analyse our performance data, highlighting any deviation from anticipated outcomes, as well as potential drivers for change and improvement, such as changing demand for services.

A&E standard: A&E maximum waiting time of four hours from arrival to admission/transfer/discharge

During 2017/18, the Trust undertook an in-depth analysis of its patient flow and emergency department performance and work began on changing the medical model, improving the Emergency Departments (ED) and discharge of patients to meet the standard of seeing and either treating or admitting 95% of ED patients within four hours. That year we achieved an average of 87.5% compliance against this standard, which was a significant increase on the year before (80.3% in 2016/17).

In 2018/19 we improved this performance again to 91%, consolidating the improvements that we made the year before. At year end, we were achieving performance of 93% which puts us among the group of leading Trusts nationally.

This performance improvement is despite increasing activity levels. Comparing last year with this year, A&E attendances were up 9%.

The sustained improvements that we have seen in our Emergency Departments reflect the hard work that has been going on across the organisation to improve patient care, quality and flow. It is also a result of effective joint working with East Sussex County Council and our local commissioners. This improvement has been supported by a transformation in our urgent care departments and the development of important new services.

An Ambulatory Care Unit and extended assessment ward opened at Eastbourne Hospital, to provide same day emergency care for ambulatory patients who do not require an overnight stay in hospital. This means that when appropriate, patients are assessed, diagnosed, treated and can go home the same day – without the need for an overnight stay. Nearly 23% of patients coming to Eastbourne's A&E are now seen through this service.

The unit offers patients rapid access to diagnostic tests and review by hospital consultants in a single place. It provides safe care designed around the needs of patients, providing them with a better experience and preventing unnecessary hospital admissions. A similar unit is planned for the Conquest Hospital in 2019/20.

RTT standard: Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate

The Trust broadly maintained its delivery of the referral to treatment (RTT) standard in 2018/19. We achieved 91.0% in 2018/19 against the national standard of 92%. This was slightly down on 91.2% compliance in 2017/18.

We have reduced the total number of people on our waiting list from over 28,000 to under 27,000. There are currently no patients waiting more than 52 weeks for their treatment, and we have seen a 26% reduction in those waiting over 35 weeks. This compares well against the performance of our peers. We have focused on out-patient and theatre productivity to better manage demand and capacity.

Diagnostic standard: Maximum 6-week wait for diagnostic procedures
The diagnostics standard of 99% was broadly achieved by the Trust this year (98.8%). This was an improvement on last year (97.6%) where achieving the diagnostic standard was a challenge. Towards the end of the year, the Trust significantly improved, performing above the 99% target.

Cancer standard: All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer and NHS cancer screening service referrals
Although we continued to achieve the two week cancer standard and 31 day cancer standard, compliance against the standard of seeing 85% of patients within 62 days continued to be challenging for the Trust. This has been exacerbated by the continued increase in referrals (8.5% increase on last year), which has placed services under considerable pressure. In 2018/19 the Trust achieved 72.4% compliance against the 62 day standard, compared to 75.9% in 2017/18.

Following a dip in performance in September, the Trust took steps to realign its focus on this standard and build a recovery plan with a trajectory to meet the standard by July 2019. Since September the Trust has been able to demonstrate improvement, despite an anticipated reduction in performance during the busy winter period:

- October 18: 66.3%
- November 18: 69.8%
- December 18: 80.7%
- January 19: 72.9%
- February 19: 80.3%
- March 19: 80%

Some of the improvements that we have seen put in place have included:

- In February 2019, work started on a new £1.3 million Urology Investigation Suite which will offer a dedicated one stop urology clinic. The new development is expected to be completed by June and will co-locate all urology services at Eastbourne DGH, creating a modern, fit for purpose Urology Investigation Unit. The unit will have double the current capacity, helping to meet the increasing demand, enabling many more than the current 7,000 patients a year to be treated
- 28 day lower Gastrointestinal pathway implemented (FIT and straight to test) with primary care
- Booking of Radiology appointments straight from clinic
- Plans to develop a local working group with Primary Care and GPs in order to understand the on-going increases in two week referrals
- MRIs are no longer outsourced, reducing the time that patients wait for their scan

Community services

Referrals to our community services have continued to increase, putting many teams under heavy pressure. For example, the number of patients seen by Speech and Language Therapists, Dietitians and Neurophysiotherapists has increased by 30%, 22% and 37% respectively. Even so, we have broadly maintained the percentage of patients seen within the 13 week target for each therapy.

Length of Stay

Despite the increase that the Trust has seen in activity levels, non-elective length of stay has decreased from 5.2 days to 4.4 days. Supporting the continued flow of patients through our hospitals has enabled us to sustain our improved performance against the four hour standard.

The Trust's intermediate care services at Irvine Rehabilitation Unit (Bexhill) and Rye, Winchelsea and District Memorial Hospital, have also seen a reduction in the length of stay by an average of almost 10 days (figures for three months February to April 2018 compared to November 2018 to January 2019).

This has helped to enhance patient flow through our acute hospitals, support our Emergency Departments in treating patients within the four hour target and reduce the number of acute stranded patients.

Patient flow

A number of initiatives to support a patient's journey through our hospitals have been developed this year.

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

SAFER: We have also continued our work to embed "SAFER". This included the establishment of effective daily board rounds, all patients being given an expected discharge date within 14 hours of admission and multi-disciplinary review of all patients who have been in hospital for 7 days or more. Let's Get You Home, Red2Green and EndPJParalysis are some of the initiatives forming part of this work.

Integrated pathways: Home First (also referred to as Discharge to Assess or D2A) is an initiative that aims to get patients out of hospital more quickly and back to their own home wherever possible. It involves staff in acute settings working closely with community health and social care staff to make the best possible decisions when a patient is ready to leave the acute setting; and community staff working together, across agencies, to support the patients and develop their independence once they are in a community setting (ideally returning to their own home).

Since November 2018, we have been trialling two specific pathways when patients are discharged from hospital. These are:

1. Discharging patients back to their own home and then assessing their community needs once they are in a familiar setting.
2. Discharging patients who are likely to need on-going nursing home care to a temporary nursing home placement and carrying out an assessment of their longer term needs once they have had some time to 'recover' from their time in hospital.

To date, the numbers of patients using these pilot pathways has been relatively small but the outcomes for these patients have been overwhelmingly positive. We are learning from the pilots and adapting and refining processes as we go. We will use this learning to design how integrated working, and in particular the interface between acute and community service, can be even better.

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

Meeting our financial plan

We set ourselves an ambitious financial target in 2018/19 of reducing our financial deficit to £45m. We achieved this target, ending the year with a reported deficit of £44.8m, an improvement of £10.1m from last year's deficit of £54.982m.

In 2016, our underlying monthly deficit was over £5m a month. By the end of 2018/19, we had reduced this to around £3m a month. To make sure these improvements are maintained into the future, we have put in place stronger financial controls, improved our reporting, and strengthened our financial planning. An independent report into our governance published last November noted the Trust's improved financial governance and performance. We have also introduced a staff-led process (T3) that carefully scrutinises all requests for expenditure to ensure that they are required, cost effective, and appropriate.

Cost improvement

We made efficiency savings during the year through our Cost Improvement Programme (CIP) without reducing quality or safety of the care we provide – our CIP programme is based on the Model Hospital and GIRFT programmes, so is aimed at improving quality and safety, which deliver efficiencies. We set ourselves a CIP target for the year of £19.2m – our teams delivered £19.3m.

We achieved these savings by reducing our use of expensive agency staff, embracing new technology such as the management of medical notes, reducing unnecessary lengths of stay in hospital and making efficiencies in medicine management. We have also seen theatre efficiency increase and cancellations decrease. These changes have significantly reduced the amount we spend, whilst also providing better care and outcomes for our patients. Identifying and realising recurrent savings is key to continued sustainable financial improvement. During 2018/19, 74% of the savings that were achieved through CIPs were from recurrent schemes that will continue to save the Trust money year after year.

Capital development

As the Trust has been in deficit for a number of years, this has led to significant constraints on being able to generate internally funded capital and investing in our estates and facilities. However, we now have a strategic capital investment plan and an associated capital cash management plan in line with our local investment priorities. As a result, we anticipate that investment will continue to grow in future years.

In 2018/19, our key capital projects have included:

- the building of a dedicated MRI suite at Conquest Hospital to house two state of the art scanners which will serve our local population and improve immeasurably the service

and quality of care we can provide. The £5m cost of the building represents the largest single capital project undertaken by the Trust in the last decade;

- building the housing for a CT scanner at Eastbourne Hospital;
- issuing our community staff with mobile devices to ensure that they provide the best possible patient care within the community setting;
- improving our electronic document management system which involves converting patient case notes into electronic format so they can be viewed on screen at the point of care; and
- introducing electronic prescribing and medicine administration which will reduce potential medication errors and also free up staff time to focus on patient care.

Looking forward to 2019/20, we are planning major capital investment projects which will transform the care that we are able to provide such as the Urology Investigation Suite at Eastbourne and the Ambulatory Care Unit at Conquest. We will continue to seek more capital investment to make the transformational changes we believe are necessary to provide the best possible care to our local population now and in to the future.

Influences on performance

The principle issues and risks facing the organisation during 2018/19 are outlined below.

Care Quality Commission (CQC) rating

In March 2018, the CQC carried out inspections at the Conquest Hospital and Eastbourne Hospital; they published their full report in June 2018. The CQC rated everything they inspected as 'good' or 'outstanding', apart from the Emergency Department at Eastbourne which was rated as 'requires improvement', but 'good' for well led and caring. The CQC noted that there had been a marked improvement in the quality of the care we deliver and concluded that the Trust no longer needed to be in special measures for quality.

The CQC acknowledged that, on the basis of the inspection in March, the Trust's rating would be 'good' overall; however our overall rating remained as 'requires improvement' because not all services were inspected. They explained this in the report saying that "Whilst the aggregated rating for the core services inspected at this inspection visit would have brought the Trust to good overall, the impact of the core services we did not re-inspect leaves it as requires improvement overall."

For the first time 'outstanding' ratings were awarded in three categories, care across the Trust continued to be rated as 'good' and the CQC noted that the staff that they spoke to during the inspection placed compassion and empathy as integral to providing good care, and it was evident that many "went the extra mile".

EDGH

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

Conquest

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

Increased demand

Our hospitals and community services continue to get busier every year as demand for our services increases. This places ever greater pressure on our staff and requires us to work more efficiently and think of innovative ways to ensure that we meet the changing needs of our population. Even so, we are broadly maintaining and in some cases improving the time people are waiting to be seen.

Indicator	2017/18	2018/19	Increase
Inpatient	105,262	110,036	4.5%
Elective	54,187	53,980	-0.4%
Non-Elective	51,075	56,056	9.8%
Outpatient	411,279	413,516	0.5%
A&E Attendances	118,846	129,380	8.9%
Cancer Referrals	20,094	21,807	8.5%
Ambulatory Care Unit (EDGH) Admissions	15,344	18,824	22.7%

We continue to work closely with our adult social care and commissioner partners to plan for increases in demand.

Winter

Winter periods continue to be very busy for the Trust, and we also see a surge in use over the summer period. Attendances to our Emergency Departments over the Christmas week were up 3% compared to the same period last year, however performance against the four hour standard improved by 5.9%. Our performance was supported by advance system-wide planning that took place. Robust staffing plans were agreed and enhanced pathways introduced to avoid overcrowding in the Emergency Departments and reduce the need for unplanned escalation.

Aging population

The population that the Trust cares for is relatively elderly (East Sussex has a relatively low birth rate and high inward migration amongst elderly age groups). Demographic trends in East Sussex indicate that pressure on health and social care services may increase more quickly in the future. Our over 85 population is also projected to grow at 3.5% per annum.

In populations that are over 75 (and more so in those over 85), certain factors tend to markedly increase the need for hospital or community based healthcare. More people are living with 'frailty' and older people are also more likely to have multiple, ongoing health problems (like high blood pressure, angina, diabetes, emphysema) which means that they are more likely to become ill and need hospital attention.

We are focused on becoming the best at managing frailty in the country, and know that we need to make the 'acute' phase of someone's illness as short as possible, address frailty and the risks of frailty outside hospital, and manage ongoing health conditions as well as possible.

Our ability to manage this trend as a Trust and as a system – in particular the impact of an increase in those living with frailty – will be a key priority over the next five to ten years to create a sustainable system.

Trust finances

We remain in financial special measures and our financial position remains challenging, but has improved and we have delivered our financial plan. We are developing service by service improvement plans, swiftly addressing those services which can be improved operationally, and taking a methodical approach to those services which require more

significant change. All plans are subject to a full quality impact assessment by our Medical and Nursing Directors. The plans are translated into detailed budgets covering activity, cost, revenue, and workforce for the individual divisions and clinical specialties. Assurance of performance against these plans will be measured throughout the year during integrated performance review meetings.

Recruitment and staffing

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

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

Meeting national standards

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

Innovating and improving

April – June 2018

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

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

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

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

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

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

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

Trust leads national project for people with swallowing difficulties
The Trust has implemented a new way of classifying modified foods and fluids for people who have swallowing difficulties. In line with recommendations from the Royal College of Speech and Language Therapists (RCSLT), ESHT is an early implementer, spearheading the one-year phased implementation which will be adopted nationally by all healthcare providers by 2019.

New endocrine drug is first to be prescribed in UK
The Trust became the first in the UK to prescribe a new endocrine drug called Natpar, a recombinant parathyroid hormone.

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

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

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

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

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

July - September 2018

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

Diabetes Nurses achieve accreditation for educational programme
Our Diabetes Specialist Nurses achieved accreditation to deliver their educational programme supporting people living with Type 1 diabetes. The education programme called SADIE (Skills for Adjusting Diet and Insulin in East Sussex) was approved by the Quality Institute for Self-Management in Education and Training (QISMET) for another three years.

Young adults with a Learning Difficulty or Disability graduate from Project SEARCH

In July 2018, eight young people with a Learning Difficulty or Disability graduated from Project SEARCH, a supported internship programme designed to give young people skills to gain competitive paid employment. Project SEARCH has been running since September 2014.

Endoscopy Units recognised for high quality care

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

Number of births at Midwifery Unit increases by over 25%

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

NHS Heroes recognised at Trust Award Ceremony

Local NHS heroes were recognised at the Trust's Annual Awards Ceremony in July 2018. The winners of 12 awards categories were announced along with recognition for members of staff with over 40 years NHS service.

October – December 2018

Patients give excellent feedback on their cancer care

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

Trust's Pathology Departments achieve national accreditation

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

Trust improves its rating for Emergency Response

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

High quality trauma care at Trust

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

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

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

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

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

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

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

New staff Extranet launched
Members of staff at ESHT now have access to the Trust's new extranet. The new platform will help to support better staff engagement and involvement, facilitate collaboration and initiate a shift in staff culture towards active knowledge.

January – March 2019

Trust shows improvement in maternity services
A national survey on maternity services undertaken on behalf of the Care Quality Commission (CQC), found that maternity care at the Trust had improved across a number of areas. Twenty one of the questions showed an improvement or remained the same, when compared to the same survey undertaken in 2017.

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

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

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

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

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

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

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

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

Finance

Important Financial Results

The following tables show a range of financial performance values taken from the accounts.

Accounts Highlights	2018/19 £000	2017/18 £000
Deficit for year	(44,781)	(54,982)
Public Dividend Capital Dividend Payable	875	2,920
Value of Property, Plant and Equipment	223,584	215,699
Value of borrowings (including loans)	202,815	157,211
Cash at 31st March	2,100	2,100
Creditors - trade and other	23,230	37,740
Debtors - trade and other	19,655	35,341
Revenue from patient care activities	375,387	350,246
Clinical negligence costs	10,117	14,615
Gross employee benefits	292,871	284,737

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	119,305	169.057	128,709	158,861
Total non-NHS trade invoices paid within target	82,432	129,104	24,188	43,923
Percentage of non-NHS trade invoices paid within target	69.0%	76.4%	18.8%	27.6%
NHS Payables				
Total NHS trade invoices paid in the year	3,179	32,831	2,698	35,381
Total NHS trade invoices paid within target	2,668	32,058	845	29,352
Percentage of NHS trade invoices paid within target	83.9%	97.6%	31.3%	83.0%

Operating and Financial Review

In 2018/19, we set ourselves an ambitious target of reducing our deficit from £54.9m to £45.0m. We outperformed this target, ending the year with a deficit of £44.8m, an improvement of £10.1m from our 2017/18 deficit. This achievement is set against a backdrop of continued significant improvements in safety and quality, and strengthened delivery of national performance standards.

The Trust made significant progress in improving its financial governance in 2018/19, including understanding and acting on the key drivers of the underlying deficit and in stabilising the overall financial performance. In 2016, our monthly deficit was over £5m a month. By 2018/19 we had reduced this to around £3m a month. To make sure these improvements are maintained, we have strengthened further our financial controls, strengthened our financial planning and improved our reporting. An independent report into our governance published in November 2018, noted the Trust's improved financial governance and performance.

We delivered efficiency savings through our Cost Improvement Programme (CIP) of £19.3m against a target of £19.2m. Identifying and realising recurrent savings is vital to our continued sustainable financial improvement. During 2018/19, 74% of the savings that were achieved through CIPs were from recurrent schemes that will continue to save the Trust money year after year. Our savings focused on reducing expensive agency staff, use of new technology, reducing lengths of stay in hospital, and efficiencies in medicine management. In addition, theatre efficiency has increased, whilst cancellations have decreased, therefore reducing spend and providing better care and outcomes for our patients.

The Trust has a plan to return to breakeven along with a clinical strategy which will ensure clinical and financial stability across all of our key services. We have used the national Model Hospital toolkit, Getting it Right First Time (GIRFT) initiative, other benchmarking tools, and worked with NHS Improvement and the Financial Special Measures team to help us develop and address the issues driving our deficit. The 2018/19 financial plan, and the associated Cost Improvement Plan, were based around these drivers, income recovery, service sustainability, workforce costs, infrastructure costs and technology requirements, and have been where we have focused our attentions in helping us to reduce the deficit.

The Trust has continued to work within a local and regional health economy with significant financial challenges. During 2018/19, the two key local Clinical Commissioning Groups – Eastbourne, Hailsham & Seaford CCG and Hastings and Rother CCG – entered Legal Directions, and the Sussex and East Surrey STP Region (within which the Trust sits) also continued to report a significant financial deficit. The Trust has continued to work in close partnership with the STP to develop system-wide financial plans to improve operational, clinical and financial performance.

The Trust has also continued to work with and alongside key partners including the CCGs and East Sussex County Council to strengthen local plans for the improvement of health outcomes for the East Sussex population. The local health economy faces financial challenges and the management of these financial challenges is being addressed on a

system wide basis. This includes joint working on key change programmes, including supporting the development of primary care and the community services to provide support and care closer to home.

During the year, activity and demand levels were significantly higher than planned, particularly in our Accident and Emergency Departments. In addition, throughout the year, non-elective activity was very high. The Trust, working with its partners, is developing a range of interventions to reduce levels of demand for urgent care.

Elective care (planned procedures) and outpatient activity levels were below the planned levels and therefore associated income levels were also below plan. In part, this is a reflection of the continued work within the Trust to focus on day case activity and delivering follow-up procedures to support the management of waiting lists. Whilst this has had an adverse impact on planned income, it has led to an improved performance against national waiting times standards and improved the management of the bed base for the hospital. This has improved flow through the hospitals resulting, in a reduced average length of stay for urgent and planned care.

In 2018/19, NHS Improvement and NHS England asked the Trust and two local CCGs to work together to develop a sustainable system financial recovery plan. We have made huge strides in progressing this work, but recognise there is still much to do in 2019/20. To achieve financial balance the system must

- realise more recurrent cost improvement plans for the Trust and quality, innovation, productivity and prevention (QIPP) plans for the CCGS;
- significantly reduce recent increases in demand trends in our Accident and Emergency Departments as well as reducing non-elective demand;
- change the pattern of investment with more investment in out of acute settings, front loading clinical capacity at the acute 'front door' clinical services and reducing unnecessary or lower planned care interventions and acute outpatient services; and
- transform the system's operating model to one with a lower cost base per head.

All of this must be achieved within a constrained capital and revenue investment environment and in the context of high growth in our over 85 population – the patient cohort most in need of support.

To ensure that the system financial recovery plan was fit for purpose and progressed at pace there has been:

- regular discussion between our Chief Executive and the CCGs;
- our Trust Board and the CCGs' Governing Body have met twice in 2018/19 to discuss and approve the system financial recovery plan;
- a refreshment and enhancement of joint system governance and delivery processes; and
- submission of the system financial recovery plan to NHS Improvement and NHS England as our and the CCG's regulators.

To help facilitate some of this work, we reached an income settlement with our two local CCGs for 2018/19. This has allowed the Trust and CCGs to work together on progressing system financial sustainability. In 2019/20, we will build upon this work, including further

development of our system financial recovery plan to ensure that our patients receive the highest quality care in an appropriate setting to their needs.

In 2018/19, the Trust has continued to strengthen its cash flow management procedures, with a more robust set of forecasting and tracking tools in use to enable a more targeted approach to payment of suppliers. The Trust remains committed to supporting local suppliers and routinely reviews its creditor position to ensure that delays in payment are minimised.

Capital investment has remained constrained as a result of our financial position, which adversely impacts on the experience for both patients and staff. In 2018/19, we have used alternative forms of capital funding (e.g. leasing) to make improvements across our sites. In addition, the generosity of the Friends must be noted as these donations directly improve patient care and experience – these donations have continued across the year and are welcomed by our staff. In 2018/19, we spent £15.4m of capital expenditure on making improvements across our infrastructure, IT and medical equipment. Looking forward to 2019/20, we will be looking to maximise every opportunity of obtaining capital funding to supplement our own internal capital plan of c.£13m. Our capital budget, which has more demands on it than funds available, will support the much needed investment in infrastructure, IT and equipment across the organisation.

In 2019/20 we will continue to use Service Line Reporting and Patient Level Information Costing as tools to increase clinical engagement in understanding and improve our cost drivers and profitability, as well as providing management with better information on which to make business decisions. The Trust is fully engaged in the national Operational Productivity programme, led by NHS Improvement, and the Getting It Right First Time clinical improvement programme. These programmes help the Trust understand the links between clinical activity and cost across the organisation and, working with our partners within the local health economy, to ensure that the right models of care are put in place to ensure that we continue to deliver high quality care to all of our patients.

The Trust Board gains assurance on financial matters through the Finance and Investment Committee, which ensures that all material financial risks and developments are closely scrutinised and that senior management is properly held to account for the Trust's 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 appropriate action taken.

Looking ahead to 2019/20, the Trust has agreed a control total of £34.0m and submitted an operating plan to NHS Improvement on this basis. The Trust is aiming to secure efficiency savings through our cost improvement programme of £20.6m – detailed work is already in train to ensure that CIP schemes are robust and deliverable. If we achieve our control total, we will be able to access £24.0m of central funding, thereby reducing our deficit to £10.1m. Achieving this plan carries significant risk but we are already developing mitigations, both on a Trust and system wide basis, against this.

One of our key objectives for 2019/20 is to exit financial special measures. Achieving our 2018/19 financial plan, the first time that we have done this in a number of years, is a key building block in our journey to exit financial special measures. Every member of staff is working hard to help the Trust achieve this objective whilst maintaining delivery of safe and high quality patient care.

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, £363,000 was donated or bequeathed to our charitable funds. We utilise this funding to improve our clinical services, enhance patient outcomes and contribute to the development and welfare of our staff. Examples of major purchases made by the charity during 2018/19 include:

- Items to promote healthy lifestyles for children in the Trust's nurseries at Eastbourne Hospital and Conquest Hospital
- Computers on Wheels for Pevensey Ward to allow patient assessments to be recorded at the bedside
- A Stellar Ventilator for the respiratory team for use by motor neurone disease patients at the end of their lives
- New furniture for the playroom on Friston Ward
- A system to allow presentations to be made to patients attending cardiac rehabilitation programmes
- A slit lamp and stand for ophthalmology outpatients at Eastbourne Hospital
- Funding the Annual Trust Awards for staff
- Funding for the Arts in Healthcare project

The charity continues to operate a lottery to raise funds to support the Trust, open to staff and members of the public. Details of the lottery can be found at www.esht.nhs.uk/lottery

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

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

Friends of our hospitals

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

During 2018/19:

The Friends of Bexhill Hospital donated a second MRI scanner, costing £800,000, to the Trust.

This was in addition to purchasing other items for the Trust, including:

- 2 Cirrus 500 OCT scanners for the ophthalmology unit
- 2 Raizers, to help patients get off the floor following a fall
- Replacement dialysis chairs for Bexhill Renal Unit

- Refurbishment of the gardens of Bexhill Irvine Unit

Sadly, the Chair of the Friends of Bexhill Hospital, Stuart Earl, passed away in 2018. He was a passionate supporter of both Bexhill Hospital and the Trust and he will be greatly missed.

The Friends of the Conquest Hospital successfully raised £1m to purchase a state-of-the-art MRI scanner for the hospital, replacing the existing 13 year old scanner. This is expected to become operational in July 2019.

The Friends also purchased other items for the Trust, including:

- A Glidescope videolaryngoscope system, to aid difficult intubations in theatres
- 4 Raizers, to help patients get off the floor following a fall
- Air conditioning for the physiotherapy gym.
- Funding for a sensory garden for critical care patients, paid for in partnership with Bexhill's Friends.

The Friends of Eastbourne Hospital raised £250,000 for a trio of special projects:

1. £52,000 for a fibreoptic endoscope for the Swallowing Disorder Clinic
2. £98,000 for an echocardiography machine for the Cardiology Department
3. £100,000 for the replacement of dental surgery equipment for Maxillofacial and Orthodontic Department

This was in addition to purchasing other items for the Trust, including:

- 4 Raizers, to help patients get off the floor following a fall
- A Lucas 3 mechanical CPR device for the resuscitation department
- 2 tympanometers for the Audiology Department
- Bladder scanners for the frailty practitioner service
- Continued support for the therapeutic garden at Eastbourne

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

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

Capital and Our Estate

Investing in our Estate

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

In 2018/19, at Eastbourne Hospital we refurbished our CT suite, installing two new CT scanners, one of which was donated by the Friends of Eastbourne Hospital. The new suite offers an enhanced patient experience, improving privacy and dignity with better disabled access. With two scanners together, rather than in separate areas of the hospital, the radiology team can work more efficiently helping them to cope with rising demand.

Construction of a new MRI suite commenced at the Conquest Hospital in September 2018; it is due to be completed in July 2019. The facility will house two new MRI scanners, replacing the single 14 year-old MRI scanner at the hospital. The scanners were donated by the Friends of Bexhill Hospital and the Friends of Conquest Hospital. The £5m cost of the building represents the largest single capital project undertaken by the Trust in the last decade.

In April 2018, with the support of the Friends of Eastbourne Hospital, the Trust began work on a new Urology Investigation Suite at Eastbourne Hospital. The new facility will be opened in May 2019 and will enable the Trust to offer patients a one-stop urology clinic, speeding up diagnosis and the commencement of treatment.

Other areas of investment during the year have included:

- Refurbishment of anaesthetic rooms
- Hydrotherapy pool repairs
- Refurbishment of the staff changing rooms
- Installation of automatic booking terminals for outpatient areas at Eastbourne Hospital
- Installation of a new medical air plant at Eastbourne Hospital

Patient environment

Catering

The catering teams at the Trust continue to work hard to ensure that all our patients are provided with nutritious and wholesome food that meets a wide range of nutritional requirements and tastes. In 2018/19, we provided over 846,000 meals to patients across our four in-patient sites.

The catering department work closely with our Dieticians and Clinical teams to look at further improving nutrition and hydration for our patients; this is part of a national initiative supported by NHS Improvement. As part of this programme, the catering team worked with the

Speech and Language therapists to adopt The International Dysphagia Diet Standardisation Initiative (IDDSI). This standardises terminology and definitions describing texture modified foods and thickened liquids used for individuals with dysphagia of all ages, in all care settings and all cultures.

Cleanliness
The Trust has a duty to ensure high standards of cleanliness are being achieved and maintained. These standards are measured against the National Specification of Cleanliness in the NHS Guidelines.

Our housekeeping teams work closely with the Infection, Prevention and Control teams to ensure that cleanliness standards are maintained at a high level in all of our premises. Rigorous and robust monitoring procedures are in place with our Trust National Specification of Cleanliness scores consistently achieving an average overall compliance score of 96.45% against the Trust target of 92.96%.

In 2018/19, our housekeeping teams cleaned over 100,000 square metres each day and undertook over 4,833 deep cleans and 670 Hydrogen Peroxide cleans.

Portering
Our portering teams provide essential support to our clinical teams. In 2018/19, the porters completed over 150,000 tasks, including patient transfers, movement of patient notes, and specimen collection and delivery.

Site Security
Crime and assaults continued to fall across the Trust; we have a proactive security culture, promoted by our security team who cascade advice to staff through roadshows, training and induction. Our quarterly “Securitywise” information letter is now in its 20th year.

Personal attack alarms are available to many staff. Frontline staff benefit from mandatory conflict resolution training. Staff also receive training in how to maintain security within their departments, and how to look after patients’ property.

The Trust has a good relationship with Counter Terrorism Officers and regularly offers staff awareness training.

Our sites have 110 CCTV cameras and a number of stand-alone units, managed by control rooms on both acute sites. The control rooms also manage a number of other alarms including those for medical gases, blood banks, lifts and fire systems. All our staff wear an official identity badge, with a clear portrait, name and job title.

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

Emergency Preparedness, Resilience and Response (EPRR)

The role of the EPRR Team is to ensure our Trust is as resilient as possible, able to offer patients our services without interruption, no matter what challenges we may face.

The NHS England 'Core Standards for EPRR' represents an audit of 70 standards against which the EPRR performance of NHS organisations is judged. In October 2018, the Trust was acknowledged by NHS England and our Clinical Commissioning Groups (CCGs) to have risen from being 'partially' to 'substantially' compliant with the standards. NHS England said "*ESHT has made significant progress following the appointment of a full-time EPRR Lead earlier this year with a comprehensive work plan in place to address continued improvement*".

Over the past year, the significant progress made has included:

- We reviewed all of the Trust's EPRR plans.
- We updated the EPRR training program; this now includes regular Major Incident courses, and practical training days for On-Call staff.
- We enhanced the Trust's incident response capability by introducing a smartphone and desk-top app 'Rainbow', which together telephone and instant messaging capabilities.
- The Trust participated fully in a large multi-agency exercise on 28th November 2018, testing Sussex Major Trauma Network plans.
- Two Incident Coordination Centres (ICCs) were moved to more suitable locations at both acute sites.
- Planning for a potential no-deal Brexit.

Work will continue to make the organisation more resilient, including:

- Continued enhancement of the EPRR training programme.
- Updates to the Trust's 'Incident Response Plan' and 'Major Incident Plan for Casualties' following feedback from incident and exercise de-briefings.

- Equipping our ICCs with enhanced equipment.
- Further test exercises will be arranged; these may include tests of hospital evacuation arrangements and of a failure of water supply.
- Moving towards full compliance with the EPRR 'Core Standards' audit in autumn 2019

The EPRR Team provides ESHT links to multi-agency partnerships, including the 'Sussex Resilience Forum' (Civil Contingencies Act 2004), the Sussex 'Local Health Resilience Partnership (Health & Social care Act 2012), and also represents the organisation at East Sussex event 'Safety Advisory Groups' organised by East Sussex local authorities.

Sustainability

Care Without Carbon – Delivering Sustainable Healthcare at ESHT

Throughout 2018/19, we have continued to build on the work kick-started by our Sustainable Development Management Plan (SDMP), Care Without Carbon (CWC) in 2015. Through this we are working towards three key aims:

1. long term financial sustainability;
2. minimising our impact and even having a positive impact on the environment; and
3. supporting staff wellbeing to enable a healthy, happy, productive workforce;

whilst at the same time aligning our work on sustainability with the Trust's clinical objectives and the improvement of quality, safety and operational standards.

CWC sets out the actions we need to take across seven elements of the organisation to ensure a co-ordinated approach. The seven elements are designed to integrate sustainable thinking and planning into core operational activities so that it becomes part of business as usual, and key to the way the Trust functions.

Our impact on the environment as a trust, as well as our performance in 2018-19 against each of the elements of Care Without Carbon are detailed below.

Our environmental impact

Our environmental impact is measured by our carbon footprint. This is made up from our operations including: the energy used to heat our premises, the electricity we consume; the water we use; and emissions from Trust owned vehicles and from our business travel or "grey fleet" mileage which includes the miles driven in staff-owned vehicles. Our carbon footprint in 2018/19 is illustrated using figures 2 and 3 below.

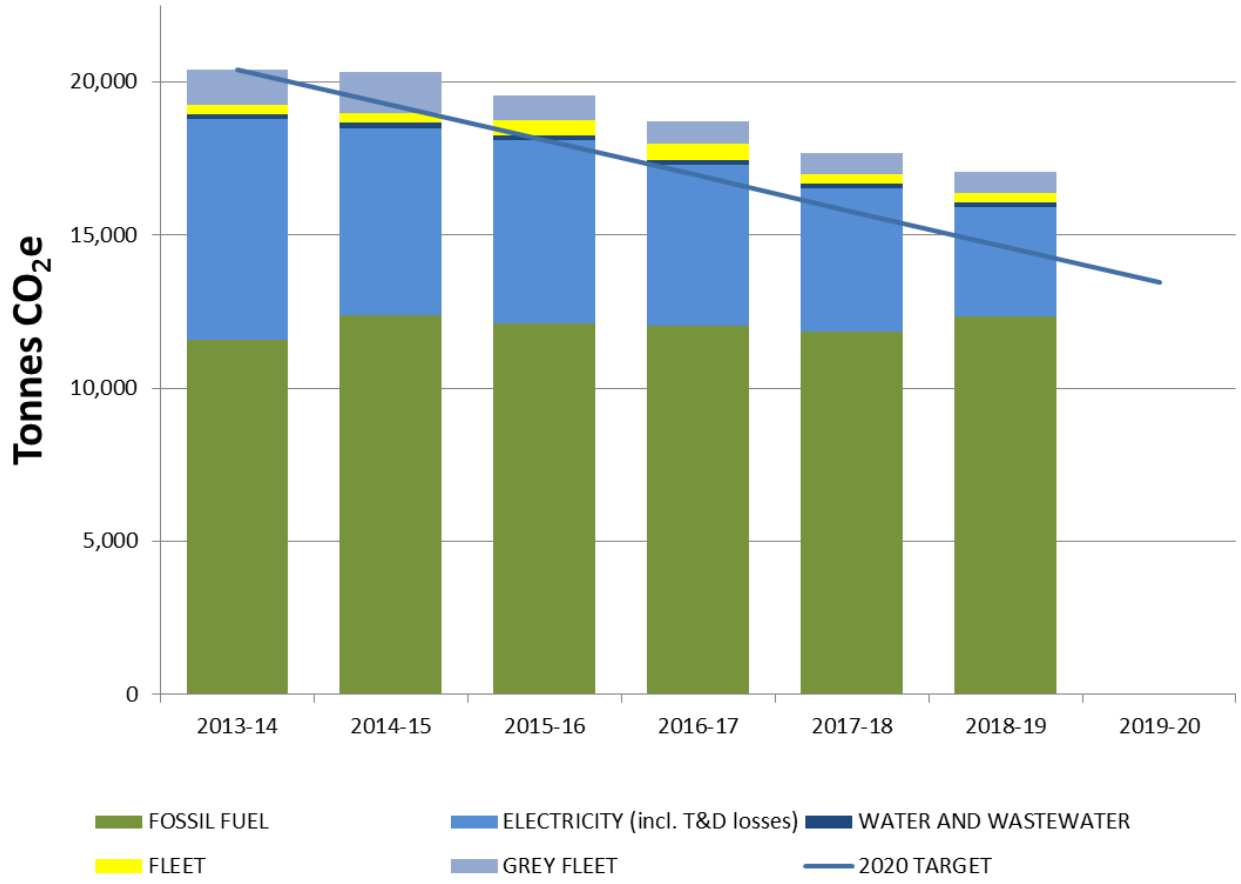


Figure 2: ESHT Carbon emissions against 2020 target **(DRAFT)**

EMISSION SOURCE	BASE YEAR (2013-2014)	2017-18	2018-19
ESHT Carbon Footprint – tonnes CO_2e[1]			
Fossil Fuels	11,585	11,825	12,343
Trust Vehicles	313	314	295
Electricity (incl. transmission and distribution losses)	7,183	4,685	3,548
Water and Wastewater	182	156	175
Business Mileage	1,131	699	692
TOTAL	**20,394**	**17,678**	**17,053**

Figure 3: ESHT Carbon Footprint

The Trust's carbon footprint has reduced by 3,341 tonnes CO_2e since 2013/14 and our 2020 target is a 34% reduction which equates to a reduction of 6,934 tonnes CO_2e as detailed in

Figure 2. Our current performance is falling short of our 2020 target. This is a key area we are working on, in particular through our Energy Performance Contract (EPC) which will help us drive down our emissions significantly over a number of years (see highlights below). In 2018/19, we have reported emissions from oil consumption as a significant amount has been burnt to rundown reserves at Conquest Hospital ahead of infrastructure change as part of the EPC. Previously, a nominal amount of oil was consumed for backup generation purposes so was not reported separately.

Our journeys are also measured using our carbon footprint and, whilst we have reported that our business mileage has reduced since we first started measuring our footprint in 2013/14, during 2019/20 we will improve how we report Trust fleet and grey fleet mileage and update the footprint as appropriate, as we believe there to be some anomalies within the data that require further investigation.

We also measure and monitor the waste we generate at our five main sites (see Fig. 3). Between 2017/18 and 2018/19 there was a reduction in the total waste generated by the Trust of 59.40 tonnes which equates to 3%. The amount of reusable sharps containers used across the Trust has increased and healthcare waste in general has decreased significantly between 2017/18 and 2018/19.

Highlights this year

- **Buildings:** we are continuing to drive our EPC project, with the implementation of a number of large scale carbon reduction projects starting in 2019/20. Projects in phase one of the EPC include: the implementation of Combined Heat and Power (CHP) at Conquest Hospital and associated plant; installing LED lighting across the Trust; and a raft of other energy efficiency measures. The benefits of the project include a significant reduction in the Trust's carbon footprint, a reduction in EPC backlog maintenance, and financial savings from reduced utility costs over the fifteen year contract term. The Trust moved onto a renewable electricity contract on the 1 April 2018 and we are currently investigating a better way to reflect this in the reporting of our electricity emissions. As a result of this procurement decision, emissions from our electrical consumption when using our contract-specific emissions factor were 213 tonnes CO_2e, whilst when applying the grid average factor they were 3,270 CO_2e.
- **Journeys:** the ESHT Making Every Contact Count (MECC) Team expanded the number of pool cars available to staff to eight in October 2018 and also successfully trialled the offer of a minibus for large meetings in July 2018. ESHT have also been promoting active travel throughout 2018/19 and have carried out projects including improving cycle shelters and running a programme to help staff get back into cycling in conjunction with Sustrans.
- **Circular economy:** the Trust started seperating out all cardboard from its dry mixed recycling scheme in 2018/19. This has allowed the cardboard to be balled and collected seperately which generates income for the Trust. In 2019/20 the effective recycling of disposible coffee cups and patient wash bowls will be investigated, with the aim of finding a suitable scheme and introducing recycling facilities for these items.
    - **Governance:** the delivery, monitoring and reporting of our Sustainability Development Management Plan is supported by Sussex Community NHS Foundation Trust's Sustainability and Environment Team. The team assists with implementing key aspects of the programme working alongside teams within in the

Trust and feeding into the Trust's Board lead for sustainability, Jonathan Reid, Director of Finance. We are in the process of reviewing our governance arrangements. In 2019/20, we are aiming to set up a Sustainability Steering Group to support the delivery of Care Without Carbon more formally, and to agree our approach post 2020.

- **Culture:** the Trust is commencing a pre-engagement programme to understand how best to engage staff at ESHT on sustaianbility, aiming to implement an engagement campaign in 2019/20
- **Wellbeing:** the MECC Team at ESHT has taken considerable action in the area of wellbeing, a Health and Wellbeing Policy was published and its messages are promoted to ESHT staff via targeted events and communications. Looking to 2019/20, the MECC team will be working to improve the eating areas within the Trust and aims to create a staff wellbeing garden outside Eastbourne Hospital's canteen. They are also planning to investigate the potential to replicate this at the Conquest.
- **Future:** The Trust will support joint working within our STP, for example through an STP wide review of its courier services. The Trust took part in a joint waste tender with other trusts in the STP in 2018/19 for non-healthcare waste. This method of jointly tendering delivered economies of scale and best value for the Trust. The Trust is also working on a further joint tender for clinical waste collection from home patients which will be completed in early 2019.

This performance report was approved by the board on 24 May 2019 and signed on its behalf by:

Signed  Chief Executive

Date 24/05/2019

Accountability Report

Director's Report

Trust Board

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

Board members as of 31st March 2019	
Chair Steve Phoenix	 Chair of Trust Board Member of Remuneration Committee
Chief Executive Dr Adrian Bull	
Non-Executive Directors	
Jackie Churchward-Cardiff	Chair of Quality and Standards Committee Member of Finance and Investment Committee Member of People and Organisational Committee Member of Remuneration Committee
Miranda Kavanagh	Chair of People and Organisational Committee Member of Finance and Investment Committee Member of Remuneration Committee
Karen Manson	Member of Quality and Standards Committee Member of People and Organisational Committee
Barry Nealon	Vice Chair of Trust Board Senior Independent Director Chair of Finance and Investment Committee Chair of Remuneration Committee Member of Audit Committee
Nicola Webber	Chair of Audit Committee Member of Finance and Investment Committee
Executive Directors and Officers	
Joanne Chadwick-Bell, Chief Operating Officer	
Jonathan Reid, Director of Finance	
Dr David Walker, Medical Director	
Vikki Carruth, Director of Nursing	
Monica Green, Director of Human Resources*	
Catherine Ashton, Director of Strategy*	
Lynette Wells, Director of Corporate Affairs *	

** Non-voting Board member/officer*

Board changes during the year are outlined below:

Name	Role/Position	Dates of Change
David Clayton-Smith	Chair	Resigned 31.01.19
Steve Phoenix	Chair	Appointed 01.02.19
Susan Bernhauser, OBE	Non-Executive Director	Term Ended 31.08.18
Michael Stevens	Non-Executive Director	Term Ended 10.09.18
Karen Manson	Non-Executive Director	Appointed 01.09.18
Nicola Webber	Non-Executive Director	Appointed 27.09.18

Attendance at board meetings 2018/19

Name and Position	Attendance at Trust Board meetings 2018/19
David Clayton-Smith Chairman until 31.01.19	**5/5**
Steve Phoenix Chairman from 01.02.19	**1/1**
Barry Nealon Vice-Chairman Non-Executive Director	**6/6**
Susan Bernhauser Non-Executive Director until 31.08.18	**2/3**
Jackie Churchward-Cardiff Non-Executive Director	**5/6**
Miranda Kavanagh Non-Executive Director	**5/6**
Karen Manson Non-Executive Director from 01.09.18	**1/3**
Michael Stevens Non-Executive Director until 10.09.18	**3/3**
Nicola Webber Non-Executive Director from 27.09.18	**2/3**
Dr Adrian Bull Chief Executive	**6/6**
Vikki Carruth Director of Nursing	**6/6**
Joanne Chadwick-Bell Chief Operating Officer	**6/6**
Jonathan Reid Director of Finance	**5/6**
Dr David Walker Medical Director	**4/6**
Catherine Ashton* Director of Strategy	**4/6**
Monica Green* Director of Human Resources	**6/6**
Lynette Wells* Director of Corporate Affairs	**6/6**

** Non-voting Board member/officer*

Trust Board Register of Interests

Non-Executive Directors	David Clayton-Smith	• Advisory Board Member, Coffee Assurance Services, Bonn • Chair, Kent, Surrey and Sussex Academic Health Science Network • Independent Chair, East Sussex Better Together • Independent Chair, East Sussex Better Together Clinical Leadership Forum • Epsom, St Helier Acute Sustainability Programme Board, Surrey Downs CCG • Independent Chair, Surrey Priorities Committee, Surrey Downs CCG
	Steve Phoenix	• Wife is senior manager at SECAMB; Chair of Sussex Beacon and Sussex Audiology; Director of Phoenix 2 Solutions Ltd.
	Barry Nealon	• Chairman of Rye, Winchelsea & District Memorial Hospital.
	Susan Bernhauser	None
	Jackie Churchward-Cardiff	• Owner and director of Clinical Strategies
	Miranda Kavanagh	None
	Karen Manson	• Director of Manson Associates (Global) Limited (MAGL) • Owner of MAGL • Shareholding in Johnson & Johnson
	Michael Stevens	None
	Nicola Webber	None
Executive Directors	Dr. Adrian Bull	None
	Vikki Carruth	None
	Joanne Chadwick-Bell	None
	Jonathan Reid	• Chair of Final Audit Committee for South Downs College (April 2018) • Co-opted Member of Finance Committee of East Sussex College (April-September 2018)
	Dr. David Walker	• Trustee of Parchment Trust • Private Cardiology Practice at Spire Sussex Hospital
	Catherine Ashton	None
	Monica Green	None
	Vikki Carruth	None
	Lynette Wells	Director and Shareholder of Chalkman Limited

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

The following table outlines the notice periods for Directors and Officers in post at 31st March 2019:

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

For statements on salary and pension benefits for all senior management who served during 2018/19, please see tables on pages 77-78

Trust Committees

Audit Committee
The Audit Committee was chaired by Mike Stevens until 10th September 2018, and was then chaired by Nicola Webber. The Committee met on five occasions during 2018/19.

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

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

The Trust's external auditor is Grant Thornton UK LLP appointed for a period of three years in 2018.

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

Committee Attendance during 2018/19 was as follows:

	Audit	Finance & Investment	People & Organisational Development	Quality & Safety
Sue Bernhauser	1/2	-	-	2/2
Jackie Churchward-Cardiff	1/1	10/12	2/7	5/6
Miranda Kavanagh	-	5/7	7/7	-
Karen Manson	-	1/1	2/4	2/4
Barry Nealon	4/5	10/12	-	-
Mike Stevens	2/2	4/5	-	-
Nicola Webber	3/3	6/7	-	-

All of the meetings of the Trust's Committees during 2018/19 were quorate, with the exception of the Audit Committee meeting on 28th March where no decisions were made.

Modern Slavery and Human Trafficking Act 2015 Annual Statement

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

Anti-Bribery and Anti-Corruption

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

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

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

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

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

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

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

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

Signed  Chief Executive

Date 24.05.2019

Governance Statement 2018/19

1. **Scope of responsibility**

   As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 NHS 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.

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

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

   The system of internal control is based on an ongoing 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 internal control has been in place in East Sussex Healthcare NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

3. **Capacity to handle risk**

   There are robust processes in place throughout the organisation to enable identification and management of current risk and anticipation of future risk. Leadership arrangements for risk management are clearly documented in the Trust's Risk Management Strategy which 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.

   Leadership starts with the Chief Executive having overall responsibility, with delegation to named Executive Directors and Divisional and clinical leaders. The leadership is further embedded by ownership at a local level by managers taking responsibility for risk identification, assessment and analysis. Terms of reference clearly outline the responsibilities of committees for risk management.

   All new members of staff are required to attend a mandatory induction that encompasses key elements of risk management. This is further supplemented by local induction. The organisation provides mandatory and statutory training that all staff must complete, and in addition to this, specific training to individuals' responsibilities is also provided. There are many ways that the organisation seeks to learn from good practice and this includes

incident reporting procedures and debriefs, complaints, claims and pro-active risk assessment. This information is filtered to frontline staff through incident reporting feedback, team meetings and briefings, the extranet and newsletters.

4. 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 a robust governance process which includes 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 risk 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's risk appetite has been defined by the Board and indicates how much, or little, risk the Trust wishes to accept when reviewing service changes or investment.

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.

Data security is reported at each meeting of the Audit Committee and through the Trust's Information Governance Steering group risks are highlighted and mitigating actions scrutinised.

All risks are routinely reviewed at Divisional Governance Meetings and Team Meetings and discussed at Integrated Performance Reviews (IPR) which take place monthly and involve divisions and the executive team. The High Level Risk Register is also presented to the Audit and Quality and Safety 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 Board Assurance Framework (BAF) was regularly reviewed and revised by the Board and by the Audit and Quality and Safety Committees. Gaps in control and assurance related to workforce and finance were also considered by the People and Organisational Development Committee and Finance and Investment Committee. As part of the Trust's ongoing governance review it held a seminar in July 2018 to consider whether the Board had identified the principle strategic risks to the organisation and that these risks were effectively controlled and mitigated in order for the Trust to achieve its strategic aims and objectives

Internal audit gave 'Reasonable Assurance' over the Board Assurance Framework and Risk Management processes in May 2019.

NHS Provider Licence Conditions: The Trust Board completes an annual self-certification to confirm the organisation can meet the obligations set out in the NHS provider licence and has complied with governance requirements.

As outlined in this document the Trust is in Financial Special Measures and co-operates fully with regulators to support its delivery of an improved financial position. The Trust monitors compliance with statutory and regulatory requirements and agrees and reviews actions. Compliance with the 62 day cancer waiting time standard has been challenging over the year and a recovery plan has been developed. This is captured on the Trust's Board Assurance Framework.

Workforce Safeguards : A comprehensive set of national guidelines on workforce planning 'Developing workforce safeguards' was introduced in 2019 and includes recommendations on reporting and governance approaches to support safe, sustainable and productive workforce planning.

The Trust has developed a 3 + 2 (5 year) sustainability to support the delivery excellent care within the available resources and this provides the framework for the short, medium and long term strategic and tactical workforce plan. It dovetails with the STP Workforce Strategic priorities; maintaining workforce through retention, boosting workforce supply through recruitment, meeting demand differently through skill mix/

transformation and reducing temporary staff usage through efficiency to ensure we maintain the right staff, with the right skills in the right place at the right time.

Ensuring that staffing processes are safe, sustainable and effective is paramount as the Trust implements its strategy. A robust governance framework is in place to facilitate this; including workforce governance and quality and safety governance policies, effective systems and processes, with the People and Organisational Development Committee and the Quality and Safety Committee scrutinising a broad range of detailed information to provide assurance, oversee the mitigation of risk and focus on achieving excellent patient and staff outcomes. The Trust Board receives quality, performance, workforce and financial information in the Integrated Performance Report at each public meeting. This is being further supplemented throughout the organisation with the implementation of the 'Excellence in Care' dashboard which brings together workforce, quality, outcomes, productivity and financial information together as a whole.

Annual staffing establishment reviews are aligned to the business planning process which includes short term workforce planning and budget setting. Where available, clinical staffing establishments are developed using evidence based tools as well as guidance, professional judgement and outcomes. There is variability in the robustness with which this triangulated approach is applied, when reviewed by professionally registered staff group, as there is national variation in the tools and guidance available to support the Trust. Where the tools and guidance are available they are used to support establishment setting. The consistency of information is being strengthened across all staff groups and provided to the clinical leads to support the establishment review process with professional judgement and consideration of patient and staff outcomes by specialty. The Trust is revising its workforce governance and introducing a skills group to ensure it can optimise opportunities for staff to work across settings, organisational boundaries and traditional professional boundaries to benefit patients.

Staff deployment through e-rostering is in place with further development of e-job planning to ensure coverage of medics, Specialist Nurses and AHP's. This supports efficient deployment and identification of opportunities for improving productivity and the elimination of waste, focusing on freeing up clinicians time with patients. Reliance on agency staff has decreased in 2018/19 with an increase in substantive staffing. This focus will continue as it is well evidenced that this leads to improved quality of care. Through the Excellence in Care dashboard and the Integrated Performance Report work is underway to strengthen visibility of staff deployment across all staff groups. Care Hours Per Patient Day (CHPPD) is in place for nursing staff however there is an absence of any national metrics for other professional staff groups, work is therefore underway to use fill rates for actual v planned staffing and develop this further. Policies for safe staffing and escalation are being expanded to all professional staff groups, with operational practices being standardised across divisions and settings.
Following a comprehensive gap analysis the Trust is partially compliant with the Developing Workforce Safeguards recommendations and has an action plan in place to reach full compliance.

Care Quality Commission (CQC): The Trust is fully Compliant with the registration requirements of the Care Quality Commission. On the 6th and 7th March 2018 the CQC carried out a core service inspection at both acute hospital sites followed by a 'well led' inspection on the 20th and 21st March. The reports were published in June 2018 and the CQC rated the Trust as 'Good' or 'Outstanding' in almost all of the services they inspected and noted the marked improvement in the quality of care.

The Trust remained as 'Requires Improvement' overall as the rating included the ratings carried forward from services not inspected during the March inspection. The CQC concluded that the Trust no longer needed to be in special measures for quality and NHS Improvement accepted this recommendation.

The CQC made 22 recommendations which included 1 'must do'; an action plan was developed and this has been monitored by the Trust's Quality and Safety Committee. Another inspection is anticipated in the Autumn of 2019.

Register of Interests: The Trust has published an up to date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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.

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. Equality impact assessments are completed for all Trust policies, significant projects and service redesign to identify and address existing or potential inequalities.

Climate Change: The Trust has undertaken risk assessments and has a sustainable development management in place in accordance with emergency preparedness and civil contingency requirements which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5. Review of the effectiveness of risk management and internal control

The Trust has a robust process in place for incident reporting and investigation, complaints handling and the Board Assurance Framework. There is a programme of training for root cause analysis and risk, and incident reporting and duty of candour are embedded across the organisation. Training and awareness of reporting has continued and this has led to the Trust have an effective incident reporting culture, although levels of incidents 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 45 Serious Incidents during 2018/19. Each incident was investigated and actions agreed and implemented. The Trust had one Never Event in 2018/19 (also included in the SI figures); this related to a retained suture needle which was subsequently removed. These incidents were investigated to ensure learning and change of practice were identified to prevent reoccurrence and an independent review of theatres commissioned to test systems and controls.

The Trust has a Duty of Candour 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.

A recommendation from the Deloitte review of Board leadership, governance and culture was for the Trust to introduce a more explicit accountability framework which clearly sets out expectations regarding roles, responsibilities and accountability; the leadership model at all levels; and the Trust operating structure down to ward level. This is being reviewed and addressed.

6. Governance Framework

The Trust has agreed Standing Orders (SOs), a Scheme of Matters Reserved to the Board, a Scheme of Delegation to officers and others and Standing Financial Instructions. These documents with policies set by the Board provide the regulatory framework for the business conduct of the Trust and define its ways of working. 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 2018. It was agreed to seek external internal audit review of the documents in 2019 to ensure they remain in line with best practice.

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 changes to the non-executive members of the Board during the period. David Clayton-Smith stepped down as Chairman on 31 January 2019 and Sue

Bernhauser and Mike Stevens completed their terms of office on 31 August 2018 and 10 September 2018 respectively. Steve Phoenix joined the Trust as Chairman on 1 February 2019 and Karen Manson and Nicola Webber as non-executive Directors in September 2018.

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

The Trust has nominated a non-executive director, Barry Nealon, as Vice Chairman and 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 Board has a tailored seminar programme in place to support the development of Board knowledge and allow in depth discussion and exploration of key issues. The Board completed a self-assessment of its effectiveness in April 2018 and this was considered at a Board Seminar the following month with the aim of supporting improvements and planning future Board development activities. A tailored Board development day took place in June that encompassed analysis of potential Board collective behaviours and dynamics when under pressure and a participative review of strategic challenges with action planning. A non-NHS speaker attended to provide a different perspective on transformational organisational change.

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.

The Board commissioned Deloitte in May 2018 to undertake a review of Board leadership, governance and culture across the Trust. The final report was considered at the December 2018 public Board meeting and commended the "impressive progress" to improve quality, culture and performance under a well-respected leadership team. It noted the comprehensive financial governance structure and progress made in respect of the financial agenda. The report outlined the need for a greater focus on strategy and also recommended improvements to financial scrutiny, management information and strengthening the accountability framework throughout the organisation. The report contains 17 recommendations, 4 of which were rated high. An action plan was developed and progress will be monitored by the Board.

Committee Structure: The Trust Board meets bi-monthly in public and also holds 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

Information Governance: In May 2018 the General Data Protection Regulations (GDPR) and Data Protection Act 2018 (DPA) came into force. At the same time the NHS Information Governance Toolkit (IGT) was replaced by the Data Security and Protection Toolkit (DSPT). The DSPT is an online self-assessment tool which comprises 40 assertions to measure performance against the National Data Guardian's ten data security standards. The DSPT provides assurance that the Trust is practising god data security and that personal information is handled correctly. The self-assessment score for 2018/19 was that the Trust fully met all of the 100 standards. This DSPT was independently audited and given reasonable assurance over the Trust's IGT self-assessment.

A data flow mapping (DFM) exercise was also undertaken with 200 DFMs being recorded. The legislation outlines the two legal basis for using information and 98% of Trust processing is undertaken by the organisation as a public authority. The Trust is required to justify the use of special information – this is usually health or staff information and approximately 85% of processing is carried out for direct healthcare purposes. A paper detailing all DFMs was considered by the Audit Committee in November 2018.

During 2018/19 staff reported 126 IG incidents, 124 of these were scored against the Trust's incident scoring as either 'negligible or none' for severity, one was scored as 'low or minor' and one incident was scored as 'medium or moderate'. This indicates that the majority of incidents had minimal impact upon information security. All incidents are investigated and actions implemented to prevent reoccurrence. Three incidents were reported on the Data Security and Protection Toolkit, but none of them reached the threshold for onward reporting to the Information Commissioner's Office.

The Trust received 699 Freedom of Information requests in 2018/19, of these (676 - 97%) were responded to within the 20 working day timeframe. This was an increase on 2017/18 when the Trust received 646 requests (585 - 91% were responded to in time).

7. Review of economy, efficiency, effectiveness of the use of resources.

The Trust was placed in financial measures by NHS Improvement in October 2016. This was as a result of a significant negative variance against the Trust's financial control total plan and because of the significant deficit forecast for 2016/17. A financial recovery plan was developed and the Trust put in place a number of enhanced control measures. Financial governance arrangements are reviewed by internal and external audit to provide assurance of economic, efficient and effective use of resources.

The Trust ended the 2017/18 financial year with a £57.4m reported deficit and a movement against the initial plan of £20.4m. In 2018/19 a plan for a deficit of £44.5m was set and delivered. In addition, the Cost Improvement Programme (CIP) for 2018/19 was delivered, although some elements were non-recurrent. Lessons from 2018/19 are being applied in 2019/20 to ensure full delivery on a recurrent basis. A five year financial model has been developed with local Clinical Commissioning Groups aimed at delivering a route-map to system financial sustainability. As a result of using this model, the Trust and Commissioners have a shared financial plan for 2019/20 and an agreed contract which includes jointly recognised Quality, Innovation, Productivity and Prevention (QIPP) schemes. The Trust remains in Financial Special Measures, and the CCG remains in Legal Direction. However, the responsibility for regulatory oversight has moved to the Regional NHS Improvement and NHS England team and the level of scrutiny and assurance required has reduced to a once monthly joint regulatory meeting as the Trust and the CCG continue to move towards financial sustainability. The Trust is working towards an application to exit from Financial Special Measures in 2019/20.

8. 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 2018/19 has been developed in line with relevant national guidance and priorities were developed following feedback from patients, staff and external stakeholders.

Quality is a core component of our strategy to be Outstanding by 2020 and through the hard work and commitment of our staff we continue to deliver safe, effective and high quality services whilst at the same time targeting priority areas for improvement. Quality is considered through our divisional governance structure and this feeds up to the Quality and Safety Committee.

Directors have taken steps to satisfy themselves that the content of the Annual Quality Account is consistent with internal and external sources of information and feedback from 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 Safety and Audit Committees.

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.

External auditors offered a limited assurance opinion, qualified on the basis of testing of the Venous thromboembolism (VTE) indicator. There is potentially a further qualification of the C.Difficile indicator if concerns about its calculation are not resolved.

9. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Quality and Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The review of effectiveness of the system of internal control is informed by the work of the Trust's internal auditor, TIAA, who deliver a risk based annual plan of audits over a wide range of areas and track progress on implementing agreed recommendations arising from their work. A range of assurances were given over key areas covered in the 2018/19 Internal Audit Plan, with two "Substantial", eight "Reasonable", three "Limited" assurance reports, and one "No" assurance report. During the year TIAA made a number of important recommendations to improve controls over specific areas; in particular the management of Medical Devices, Waiting List Initiatives and Delayed Transfers of Care. For the reporting period, TIAA gave an overall opinion of "Reasonable assurance" on the adequacy of the Trust's risk management, control and governance processes. The report acknowledged the continuing positive progress made by management in the year to enhance the adequacy and effectiveness of controls in many areas, maintaining the overall "Reasonable" assurance opinion delivered in 2017/18 which followed "Limited" assurance opinions delivered in 2016/17 and in 2015/16.

My review of the effectiveness of the systems of internal control has also 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 and risk management within their discrete portfolios.

The Board and its sub-committees maintain continuous oversight of the effectiveness of the Trust's risk management and internal control systems. The Board meets every other month in public and holds seminars in the month where there are not public meetings. 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.

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 need to provide assurance on controls in place in relation to cybersecurity, transition to meet the requirements of the General Data Protection Regulations and updates on the work of both internal and external audit and counter fraud have been reviewed by the Committee.

During the year the Committee reviewed the Annual Plan for Clinical Audit and received progress updates at each meeting. Good progress was noted in national and local audits although further work was required to ensure that the loop was closed on completed audits. Alongside the Audit Committee, the Finance and Investment Committee provides support to the Trust Board in regard to understanding the financial challenges, risk and opportunities for the Trust and oversight of the effectiveness of the Trust's financial governance.

The Quality and Safety 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. During the year, the Quality and Safety Committee reviewed and endorsed the Trust's quality improvement priorities for subsequent publication in the Quality Account. It undertook "deep dive" reviews of areas highlighted through external review and internal risk management processes such as ophthalmology, radiology, pressure ulcers and medication related incidents.

Strategic oversight of workforce development, planning and performance is within the People and Organisational Development Committee remit. It provides 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.

10. Conclusion

In line with the guidance on the definition of the significant internal control issues, I have not identified any significant control issues.

Dr Adrian Bull
Chief Executive

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 HM 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, the 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.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy

By order of the Board

24.05.2019 Date  Chief Executive

24.05.2019 Date  Finance Director

Remuneration and Staff Report

Remuneration Report

The Remuneration and Appointments Committee is a non-executive subcommittee of the Board and oversees the appointments of the Chief Executive and Executive Directors and agrees the parameters for the senior appointments process. The Committee agrees and reviews the Trust policies on the reward, performance, retention and pension matters for the executive team and any relevant matters of policy that affect all staff.

The Committee is chaired by the Senior Independent Non-executive Director and membership also comprises the Chairman of the Board and two other non-executive directors. The Chief Executive, Human Resources Director and Director of Corporate Affairs 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 or, in his absence, the Trust 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 2018/19 included:

- Chief Executive’s report on individual Directors’ performance and objectives
- Annual performance review for Chief Executive
- Review of Senior NHS Salaries
- Approval of relevant appointments and terminations
- Clinical Excellence Awards

Due to nature of the business conducted, Committee minutes are considered confidential and are therefore not in the public domain. The Chair of the Committee draws to the Board's attention any issues that require disclosure to the full Board or require Executive action.

A) Salary and Pension entitlements of senior managers - Single total figure table – audited

EAST SUSSEX HEALTHCARE NHS TRUST - Annual Accounts 2018/19

5.3 Salary and Pension entitlements of senior managers

A) Single total figure table

Name and Title	2018.19						2017.18					
	Salary (bands of £5,000) £'000	Expense payments (taxable) to nearest £100 £'00	Performance pay and bonuses (bands of £5,000) £'000	Long Term Performance pay and bonuses (bands of £5,000) £'000	All pension-related benefits (bands of £2,500) £'000	**TOTAL (bands of £5,000) £'000**	Salary (bands of £5,000) £'000	Expense payments (taxable) to nearest £100 £'00	Performance pay and bonuses (bands of £5,000) £'000	Long Term Performance pay and bonuses (bands of £5,000) £'000	All pension-related benefits (bands of £2,500) £'000	**TOTAL (bands of £5,000) £'000**
David Clayton-Smith (Left 31st January 2019) Chairman	30 - 35	3**	0	0	0	**35 - 40**	35 - 40	2**	0	0	0	**40 - 45**
Steve Phoenix (Started 1st February 2019) Chairman	5 - 10	0	0	0	0	**5 - 10**	0	0	0	0	0	**0**
Barry Nealon Vice Chairman	5 - 10	0	0	0	0	**5 - 10**	5 - 10	0	0	0	0	**5 - 10**
Dr Adrian Bull Chief Executive	185 - 190	4**	0	0	0	**185 - 190**	180 - 185	3**	0	0	0	**185 - 190**
Joanne Chadwick-Bell Chief Operating Officer	130 - 135	2**	0	0	20 - 22.5	**150 - 155**	130 - 135	3**	0	0	0	**130 - 135**
Catherine Ashton Director of Strategy	110 - 115	2**	0	0	25 - 27.5	**135 - 140**	115 - 120	2**	0	0	60 - 65	**180 - 185**
Victoria Carruth Director of Nursing	115 - 120	0	0	0	65 - 67.5	**185 - 190**	55 - 60	0	0	0	70 - 75	**130 - 135**
Monica Green Director of Human Resources	120 - 125	1**	0	0	85 - 87.5	**205 - 210**	110 - 115	1**	0	0	15 - 20	**130 - 135**
Jonathan Reid Director of Finance	130 - 135	35***	0	0	27.5 - 30	**160 - 165**	130 - 135	0	0	0	45 - 50	**175 - 180**
David Walker Medical Director *	50 - 55*	4**	0	0	0	**50 - 55**	50 - 55*	4**	0	0	0	**50 - 55**
Lynette Wells Director of Corporate Affairs	100 - 105	0	0	0	32.5 - 35	**130 - 135**	95 - 100	0	0	0	20 - 25	**115 - 120**
Susan Bernhauser (Left 31st August 2018) Non-Executive Director	0 - 5	0	0	0	0	**0 - 5**	5 - 10	0	0	0	0	**5 - 10**
Jackie Churchward-Cardiff Non-Executive Director	5 - 10	3**	0	0	0	**5 - 10**	5 - 10	4**	0	0	0	**5 - 10**
Miranda Kavanagh Non-Executive Director	5 - 10	0	0	0	0	**5 - 10**	5 - 10	0	0	0	0	**5 - 10**
Karen Manson (Started 1st September 2018) Non-Executive Director	0 - 5	1**	0	0	0	**0 - 5**	0	0	0	0	0	**0**
Michael Stevens (Left 10th September 2018) Non-Executive Director	0 - 5	0	0	0	0	**0 - 5**	5 - 10	0	0	0	0	**5 - 10**
Nicola Webber (Started 27th September 2018) Non-Executive Director	0 - 5	0	0	0	0	**0 - 5**	0	0	0	0	0	**0**

**- David Walker, non-Board related salary for the full year of £175k.*
*** - represents reimbursement of travel costs incurred subject to UK income tax and disclosed to nearest £100*
**** - represents leased car net benefit, subject to UK income tax and disclosed to nearest £100*
There were no Performance pay or bonuses paid in either 2017/18 or 2018/19.

B) Pension Benefits

Name and Title	Real increase in pension at pension age (bands of £2500) £'000	Real increase in pension lump sum at pension age (bands of £2500) £'000	Total accrued pension at pension age at 31 March 2019 (bands of £5000) £'000	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5000) £'000	Cash equivalent transfer value at 1 April 2018 £'000	Real increase in Cash Equivalent Transfer value £'000	Cash equivalent transfer value at 31 March 2019 £'000	Employer's contribution to stakeholder pension £'000
Dr Adrian Bull Chief Executive ***	0	0	0	0	0	0	0	0
Joanne Chadwick-Bell Chief Operating Officer	0 - 2.5	0	35 - 40	90 - 95	555	79	670	0
Jonathan Reid Director of Finance	0 - 2.5	0	20 - 25	35 - 40	271	50	349	0
David Walker Medical Director	0	0	0	0	0	0	0	0
Victoria Carruth Director of Nursing	2.5 - 5	2.5 - 5	35 - 40	80 - 85	487	109	628	0
Catherine Ashton Director of Strategy	0 - 2.5	0	20 - 25	40 - 45	334	53	415	0
Monica Green Director of Human Resources	2.5 - 5	12.5 - 15	45 - 50	145 - 150	928	178	1,152	0
Lynette Wells Director of Corporate Affairs	0 - 2.5	0	15 - 20	0	184	45	248	0

**** - As Dr Bull has reached the normal pension age, cash equivalent transfer value will not be shown*
As non-executive members do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive members.

Cash Equivalent Transfer Values
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 200826.

The Government Actuaries Department has revised the NHS Pension Scheme's CETV factors following HM Treasury's published change to the discount rate used for calculating CETVs. The impact of the change in the discount rate is to increase all CETV factors. This does not affect the calculation of the real increase in pension benefits, column (a) and (b) of Table 2, or the Single total figure table, column (e) of Table 1.

Real Increase in CETV
This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Payments to Past Directors
No payments to past directors were made during the year 2018/19.

Payment for Loss of Office (audited)
No payments for loss of office were made during the year 2018/19.

Note on Pension-related benefits (Table A)

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Factors determining the variation in the values recorded between individuals include but are not limited to:

- A change in role with a resulting change in pay and impact on pension benefits
- A change in the pension scheme itself
- Changes in the contribution rates
- Changes in the wider remuneration package of an individual.

Pay Ratios (audited)

Pay Ratios (audited)	2018/19	2017/18
Band of Highest Paid Director	£225 - £230k	£215 - £220k
Median Total Remuneration	£29,073	£26,933
Ratio	1 : 7.83	1 : 7.96

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 the Trust in the financial year 2018/19 was £225-230k (2017/18, £215k-£220k). This was 7.83 times (2017/18 - 7.96) the median remuneration of the workforce, which was £29,073 (2017/18, £26,933).

In 2018-19 there were 12 (an increase on four employees in 2017/18) employees/agency workers received remuneration in excess of the highest-paid director. Of these, seven were consultants and four were locums. Remuneration ranged from £5,009 to £467,705 (2017/18 £365-£362,318).

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 pensions.

It should be noted that the changes in ratio between financial years have arisen principally due to the application of the national NHS wage settlements for all staff groups, but particularly those in the Agenda for Change grades.

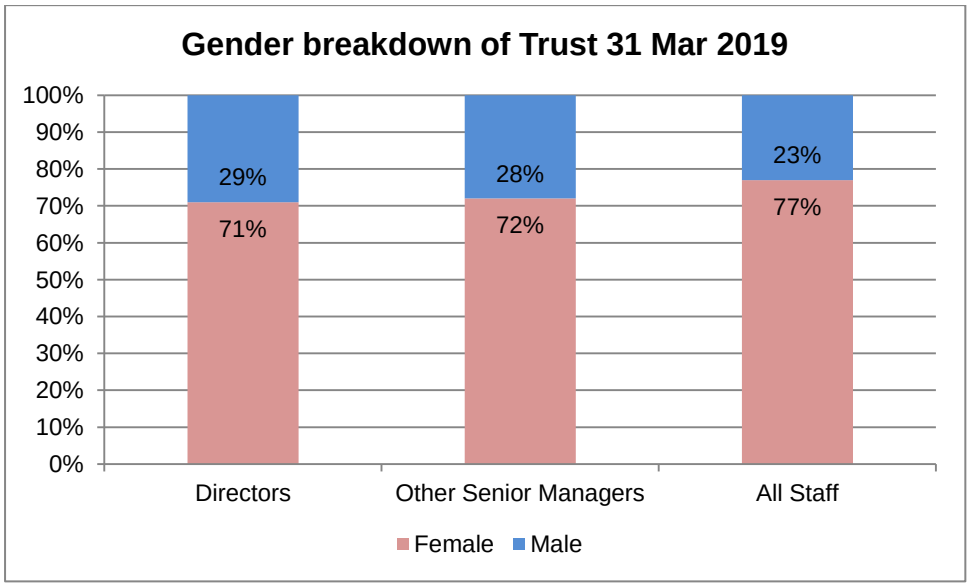
Staff Report

Number of Senior Managers by band at 31st March 2019

Senior Managers	FTE
Directors	7.0
Other Senior Managers (Ad Hoc payscales)	0.6
Agenda for Change Band 9	7.0
Agenda for Change Band 8d	10.0
Agenda for Change Band 8c	35.2
Agenda for Change Band 8b	52.6
Agenda for Change Band 8a	174.2

(NB FTE Full-time Equivalent)

Gender distribution by Directors, Other Senior Managers & Staff



Senior Managers includes all staff on Agenda for Change Bands 8a-8d.

Gender pay gap report

Along with other organisations with over 250 employees, ESHT has published its gender pay gap report which includes data alongside actions identified to investigate any differences in pay.

The report identifies that there is a gender pay gap of 21.5% in relation to the mean hourly rate within the Trust, for the year to 31 March 2018. This is a reduction of 0.9% compared to the previous year. When this is broken down, it identifies that the largest difference exists within the medical workforce, whilst for other staff mean hourly pay is higher for female staff.

Further analysis of the differences will be undertaken and an action plan will be agreed as part of the Trust's Strategic Workforce Group agenda.

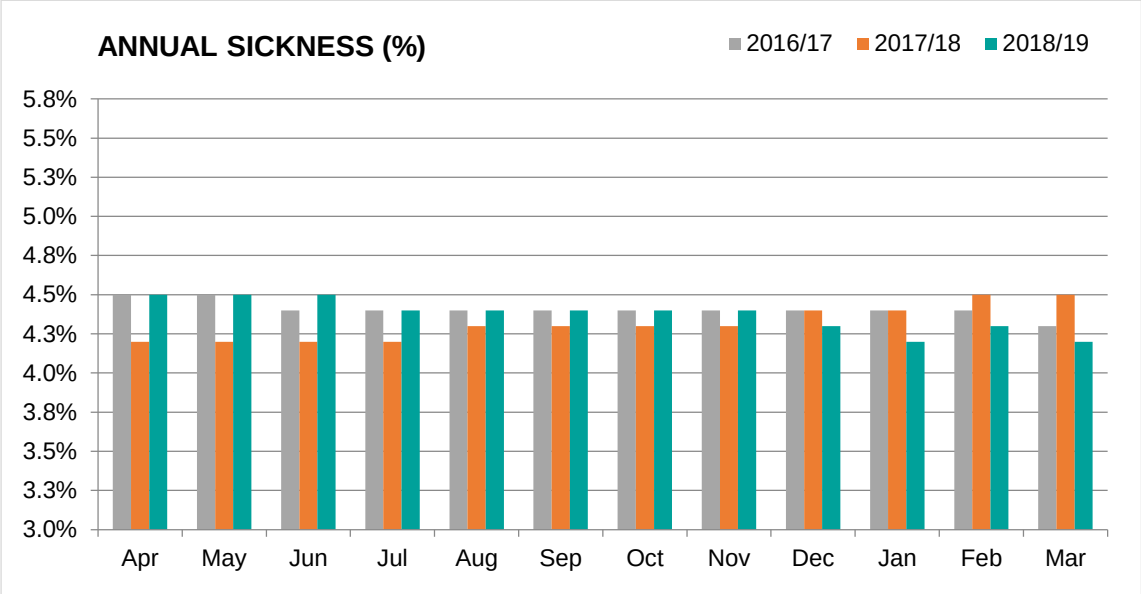
Staff fact file

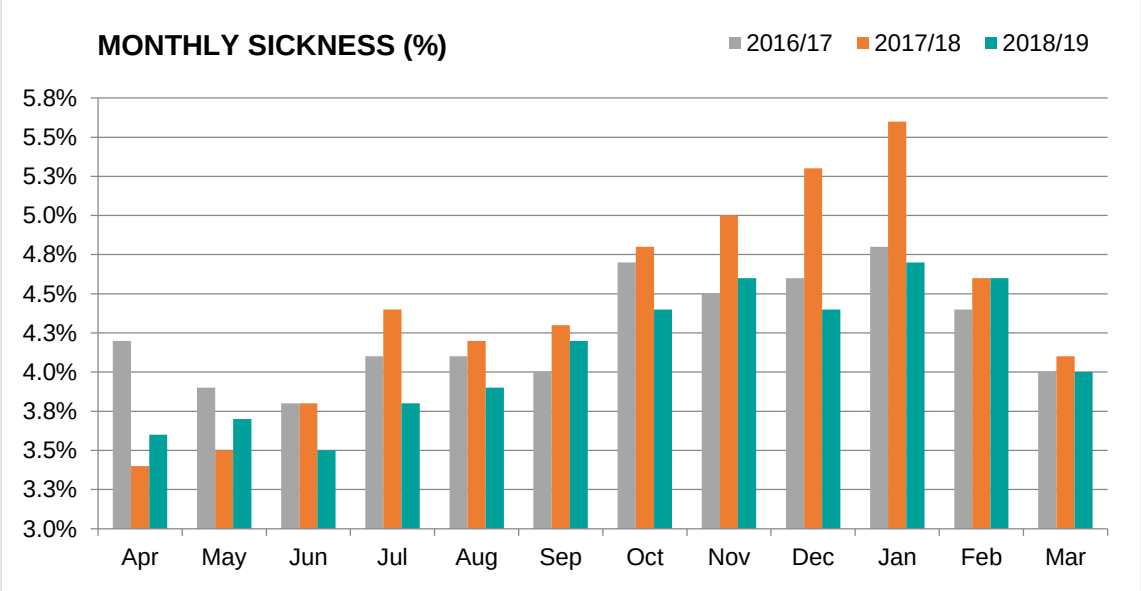
As of 31st March 2019:

- Just over 77% of our staff were female
- 40.4% of all staff work part-time
- 35.6% of staff are over 50 years old
- Just under 3.3% of staff identified themselves as disabled and just under 1.7% identified themselves as either gay, lesbian or bisexual
- Just under 13.4% of staff are from a black or minority ethnic (BME) origin

Staff Absence Data

Our annual sickness rate has decreased during the year from 4.5% to 4.2%.The average working days lost due to sickness per member of staff during the year to 31st March 2019 was 9.9.





Staff Policies

We aim to ensure that vacancies for positions within the Trust are advertised both internally & externally, through our Trust website and NHS Jobs2. Applicants with a disability are encouraged to apply through the 'Positive about Disability' scheme indicator which enables managers to ensure that all applicants with a disclosed disability, who meet the minimum requirements as set out in the person specification, are called for interview under our guaranteed interview scheme. We treat internal and external applicants in exactly the same way.

We support disabled employees in maintaining their training and career development by undertaking an annual Personal Development Review, with a 6 month follow-up to ensure that agreed actions have been undertaken. Our Learning and Development service gives all our staff access to personal development training, and staff also have the support of the Occupational Health Service. Disabled staff will also have the opportunity to join the ESHT Disability Staff Network which aims to support implementation of the new Workforce Disability Equality Standard (WDES) and promote inclusive practices across the Trust.

When necessary, our Human Resources Department will provide support for staff and for line managers to ensure that, wherever possible, staff seeking alternative posts due to health issues are supported to identify alternative suitable employment. Support is made available from the Occupational Health Department, the Equality & Diversity Team and Local Disability Advisors as required.

Our Equality, Diversity and Human Rights Manager takes the lead in ensuring that disability awareness is embedded throughout our Trust's policies, practices and overall culture. All of our staff undergo equality training and have the option of doing this online or face to face. All new staff attend a face to face session. We further ensure that equality is embedded throughout the Trust via Personal Development Reviews, team briefings, and within a variety of Trust communications.

Relevant policies are presented to the Staff Networks to ensure staff with protected characteristics are involved in decision making processes across the Trust.

Other Employee Matters

We aim to treat all staff fairly in relation to all employee matters; all of our policies and processes are monitored in terms of equality and diversity and equal treatment. Staff are not treated differently because of any role or position they hold and all policies are reviewed regularly to ensure they adhere to current legislation.

Equality, Diversity and Human Rights

2018/19 has been another busy year for Equality & Diversity with dedicated staff rising to challenges to ensure equal access to services for patients, staff and visitors.

This year we have focused of improving engagement with protected groups of staff and patients through networks and meetings with stakeholder involvement.

Engagement included involving local charities in the development of the new wayfinding signs at Eastbourne Hospital; listening to the views and challenges experienced by local Deaf people; engaging with staff on accessibility around the Trust, resulting in a full access audit that will be reviewed and improvements made throughout 2019/20.

The Accessible Information team continued to provide information in accessible formats ensuring information and patient leaflets are accessible to patients and staff with a communication barrier, arising from a disability or language barrier.

ESHT LGBT+ STAFF NETWORK

The Trust funded two members of staff to attend a training day at Canterbury Hospital in partnership with other surrounding Trusts to develop their understanding of Transgender communities and develop a wider supportive network. The ESHT Staff LGBT+ Network plans to develop new ways of engaging with local LGBT+ people and staff to ensure the Trust is providing inclusive practices of LGBT+ people.

ESHT DISABILITY STAFF NETWORK

The Staff Disability Network is Chaired by the Associate Director of Estates and Facilities and the Trust's Equality & Human Rights Lead. The Disability network meetings provide a safe place for staff to discuss workplace issues, share ideas, meet new people and identify training/career development opportunities. A key area the network has been working to improve is the process of making reasonable adjustments for staff requiring adaptations or support due to a disability. The improved process aims to be rolled out in 2019.

ESHT BME STAFF NETWORK

The Trust Black & Minority Ethnic (BME) staff Network has continues to provide a safe place for staff to seek support, meet people with shared interests, raise awareness, identify training and development opportunities. The Network has benefited from motivational speeches from highly respected BME Leaders from NHS England other Trusts as well as career development workshops.

A full report on all of the Trust's equality activities is published in the EDS2 report; a framework that continues to support us in meeting our legal obligation to eliminate unlawful discrimination, advance equality of opportunity and to foster good relations, as per the Equality Act 2010.

Other Highlights

- Following the end of a contract for the supply of interpreting and translation services in November 2017 the Trust's contracts were successfully awarded to:
    - Language line for access to instant telephone interpreters and video interpreting including British and American Sign Language.
    - ABSOLUTE Interpreting for the supply of face to face interpreters of foreign spoken community languages.
- British Sign Language (BSL) continues to be successfully provided by a local supplier to our Deaf patients

Analysis of Staff & Costs for 2018/19 (audited)

Staff costs

	Permanent	Other	2018/19 Total	2017/18 Total
	£000	£000	£000	£000
Salaries and wages	232,477	-	**232,477**	222,615
Social security costs	22,327	-	**22,327**	21,093
Apprenticeship levy	1,172	-	**1,172**	1,121
Employer's contributions to NHS pensions	26,913	-	**26,913**	25,991
Termination benefits	266	-	**266**	118
Temporary staff	-	9,716	**9,716**	13,799
Total gross staff costs	**283,155**	**9,716**	**292,871**	**284,737**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**283,155**	**9,716**	**292,871**	**284,737**
Of which				
Costs capitalised as part of assets	512	-	**512**	441

Average number of employees (WTE basis)

	Permanent	Other	2018/19 Total	2017/18 Total
	Number	Number	Number	Number
Medical and dental	587	98	**685**	665
Ambulance staff	-	-	**-**	-
Administration and estates	1,228	57	**1,284**	1,315
Healthcare assistants and other support staff	1,790	293	**2,082**	2,118
Nursing, midwifery and health visiting staff	1,780	132	**1,912**	1,923
Nursing, midwifery and health visiting learners	14	-	**14**	22
Scientific, therapeutic and technical staff	551	41	**592**	582
Healthcare science staff	137	12	**149**	142
Other	7	-	**7**	8
Total average numbers	**6,093**	**634**	**6,726**	**6,775**
Of which:				
Number of employees (WTE) engaged on capital projects	11	-	**11**	13

Exit Packages (audited)

	2018-19					
Exit Package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
	Whole Numbers only	**£000s**	**Whole Numbers only**	**£000s**	**Whole Numbers only**	**£000s**
Less than £10,000	0	0	6	38	6	38
£10,000 - £25,000	3	51	1	12	4	63
£25,001 - £50,000	3	112	0	0	3	112
£50,001 - £100,000	1	52	0	0	1	52
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
> £200,000	0	0	0	0	0	0
Totals	**7**	**215**	**7**	**50**	**14**	**265**

	2017-18					
Exit Package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
	Whole Numbers only	**£000s**	**Whole Numbers only**	**£000s**	**Whole Numbers only**	**£000s**
Less than £10,000	0	0	3	10	3	10
£10,000 - £25,000	0	0	2	24	2	24
£25,001 - £50,000	1	48	1	37	2	85
£50,001 - £100,000	0	0	0	0	0	0
Totals	**1**	**48**	**6**	**71**	**7**	**119**

Table 2 Analysis of Other Departures

	2018-19		2017-18	
	Agreements Number	Total Value of Agreements £'000	Agreements Number	Total Value of Agreements £'000
Mutually Agreed resignations (MARS) contractual costs	0	0	0	0
Contractual payments in lieu of notice	6	45	5	34
Exit payments following employment tribunals or court orders	1	5	1	37
Total	7	50	6	71

Expenditure on Consultancies

During 2018/19, the Trust's total spending on consultancies was £985,000 (see Accounts, note 6)

Off-payroll Engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2019	5
Of which, the number that have existed:	
for less than one year at the time of reporting	3
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	1
for 4 or more years at the time of reporting	0

Table 2: New Off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1st April 2018 and March 2019, for more than £245 per day and that last for longer than six months

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	6
Of which	
No. assessed as caught by IR35	3
No. assessed as not caught by IR35	3
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year.	1
No. of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll board member/senior official engagements Off-payroll engagements Table 3

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

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 officers with significant financial responsibility”, during the financial year. This figure must include both on payroll and off-payroll engagements.	18

This accountability report was approved by the Board on 24th May 2019 and signed on its behalf by:

Signed  Chief Executive

Date 24.05.2019

Certificate on summarisation schedules

Trust Accounts Consolidation (TAC) Summarisation Schedules for East Sussex Healthcare NHS Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2018/19 have been completed and this certificate accompanies them.

Finance Director Certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:

    - the financial records maintained by the NHS trust
    - accounting standards and policies which comply with the Department of Health and Social Care's Group Accounting Manual and
    - the template accounting policies for NHS trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.

2. I certify that the TAC schedules are internally consistent and that there are no validation errors.

3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Trust.

Jonathan Reid, Director of Finance Date: 24.05.2019

Chief Executive Certificate

1. I acknowledge the attached TAC schedules, which have been prepared and certified by the Finance Director, as the TAC schedules which the Trust is required to submit to NHS Improvement.

2. I have reviewed the schedules and agree the statements made by the Director of Finance above.

Adrian Bull, Chief Executive Date: 24.05.2019

ESHT: Annual Accounts 2018/2019

Independent auditor's report to the Directors of East Sussex Healthcare NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of East Sussex Healthcare NHS Trust (the 'Trust') for the year ended 31 March 2019, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. 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 Department of Health and Social Care Group Accounting Manual 2018-19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Material uncertainty relating to going concern

We draw attention to note 1.1.2 in the financial statements, which indicates that the Trust is forecasting a deficit in 2019/20 of £34 million, assuming delivery of a challenging £20.6 million cost improvement programme. If this deficit is delivered, the Trust will receive £24 million of funding from the Department of Health and Social Care (DHSC), meaning that the year-end position will be a £10 million deficit. The Trust forecasts that its cash balances at the end of each month during 2019/20 will range from £2.1m to £4.5m. This forecast assumes achievement of the planned deficit, including delivery of the cost improvement programme and receipt of £23.9 million of cash support from the Independent Trust Financing Facility through application to the DHSC via NHS Improvement.

As stated in note 1.1.2, there is no certainty that the cost improvement programme will be achieved. If it is not achieved, cash resources would be consumed within the next 12 months and as such would mean the Trust would require further cash support to meet its liabilities as these fall due. The Department of Health and Social Care has not confirmed, at the date of our report, that they will provide cash support to the Trust in 2019/20. These events or conditions, along with the other matters as set forth in note 1.1.2, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19 and the requirements of the National Health Service Act 2006; and

- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's

arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters, except on 10 May 2018 we referred a matter to the Secretary of State under section 30(a) of the Local Audit and Accountability Act 2014 in relation to East Sussex Healthcare NHS Trust's planned breach of its break-even duty for the three year period ending 31 March 2019.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

The Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, because of the significance of the matters described in the basis for adverse conclusion section of our report, we are not satisfied that, in all significant respects, East Sussex Healthcare NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for adverse conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- the Trust was placed in NHS Improvement's financial special measures regime in (month) (year) and remained in this regime throughout 2018/19;
- the Trust reported an adjusted financial performance deficit of £44.8 million in 2018/19 and its cumulative deficit at 31 March 2019 totalled £215.4 million;
- the Trust's financial plan for 2019/20 forecasts a deficit of £10 million, which assumes delivery of a challenging £20.6 million cost improvement programme and consequent receipt of an additional £24 million of funding from the Department of Health and Social Care (DHSC); and
- the Trust is heavily reliant on borrowing from DHSC and had loans outstanding of £202.8 million with DHSC at 31 March 2019.

These matters identify weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures due to the current configuration of services. They are evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable deliver of strategic priorities and maintain statutory functions.

Responsibilities of the Accountable Officer

The Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of East Sussex Healthcare NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Darren Wells

Darren Wells, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Crawley

28 May 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	375,312	350,246
Other operating income	4	33,471	37,688
Operating expenses	6, 8	(445,974)	(448,947)
Operating surplus/(deficit) from continuing operations		**(37,191)**	**(61,013)**
Finance income	12	62	20
Finance expenses	13	(6,491)	(4,509)
PDC dividends payable		(875)	(2,920)
Net finance costs		**(7,304)**	**(7,409)**
Other gains / (losses)	14	100	-
Surplus / (deficit) for the year from continuing operations		**(44,395)**	**(68,422)**
Surplus / (deficit) for the year		**(44,395)**	**(68,422)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	-	(10,249)
Revaluations	18	3,486	-
Other recognised gains and losses		-	(112)
May be reclassified to income and expenditure when certain conditions are met:			
Total comprehensive income / (expense) for the period		**(40,909)**	**(78,783)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(44,395)	(68,422)
Remove net impairments not scoring to the Departmental expenditure limit		-	14,423
Remove I&E impact of capital grants and donations		(386)	121
CQUIN risk reserve adjustment (2017/18 only)		-	(1,104)
Adjusted financial performance surplus / (deficit)		**(44,781)**	**(54,982)**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	15	1,902	1,948
Property, plant and equipment	16	223,584	215,699
Receivables	20	1,795	1,311
Total non-current assets		**227,281**	**218,958**
Current assets			
Inventories	19	6,827	7,301
Receivables	20	19,655	35,341
Cash and cash equivalents	21	2,100	2,100
Total current assets		**28,582**	**44,742**
Current liabilities			
Trade and other payables	22	(23,230)	(37,740)
Borrowings	24	(59,240)	(35,694)
Provisions	26	(488)	(551)
Other liabilities	23	(1,311)	(1,729)
Total current liabilities		**(84,269)**	**(75,714)**
Total assets less current liabilities		**171,594**	**187,986**
Non-current liabilities			
Borrowings	24	(143,575)	(121,517)
Provisions	26	(2,095)	(2,304)
Total non-current liabilities		**(145,670)**	**(123,821)**
Total assets employed		**25,924**	**64,165**
Financed by			
Public dividend capital		159,013	156,345
Revaluation reserve		97,697	94,449
Income and expenditure reserve		(230,786)	(186,629)
Total taxpayers' equity		**25,924**	**64,165**

The notes on pages 6 to 43 form part of these accounts.

Name Dr Adrian Bull
Position Chief Executive
Date **24 May 2019**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**156,345**	**94,449**	**(186,629)**	**64,165**
Surplus/(deficit) for the year	-	-	(44,395)	**(44,395)**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(226)	226	**-**
Revaluations	-	3,486	-	**3,486**
Transfer to retained earnings on disposal of assets	-	(12)	12	**-**
Public dividend capital received	2,668	-	-	**2,668**
Taxpayers' equity at 31 March 2019	**159,013**	**97,697**	**(230,786)**	**25,924**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**153,562**	**104,708**	**(118,105)**	**140,165**
Surplus/(deficit) for the year	-	-	(68,422)	**(68,422)**
Impairments	-	(10,249)	-	**(10,249)**
Transfer to retained earnings on disposal of assets	-	(10)	10	**-**
Other recognised gains and losses	-	-	(112)	**(112)**
Public dividend capital received	2,783	-	-	**2,783**
Taxpayers' equity at 31 March 2018	**156,345**	**94,449**	**(186,629)**	**64,165**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve represents the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(37,191)	(61,013)
Non-cash income and expense:			
Depreciation and amortisation	6	12,393	12,719
Net impairments	7	-	14,423
Income recognised in respect of capital donations	4	(1,297)	(773)
(Increase) / decrease in receivables and other assets		14,875	5,438
(Increase) / decrease in inventories		474	(1,106)
Increase / (decrease) in payables and other liabilties		(13,627)	(15,126)
Increase / (decrease) in provisions		(274)	(141)
Net cash generated from / (used in) operating activities		**(24,647)**	**(45,579)**
Cash flows from investing activities			
Interest received		62	20
Purchase of intangible assets		(372)	(443)
Purchase of property, plant, equipment and investment property		(17,161)	(14,607)
Sales of property, plant, equipment and investment property		162	112
Receipt of cash donations to purchase capital assets		1,297	773
Net cash generated from / (used in) investing activities		**(16,012)**	**(14,145)**
Cash flows from financing activities			
Public dividend capital received		2,668	2,783
Movement on loans from the Department of Health and Social Care		44,525	63,996
Interest on loans		(6,131)	(3,676)
Other interest		(8)	(48)
PDC dividend (paid) / refunded		(395)	(3,331)
Net cash generated from / (used in) financing activities		**40,659**	**59,724**
Increase / (decrease) in cash and cash equivalents		**-**	**-**
Cash and cash equivalents at 1 April - brought forward		**2,100**	**2,100**
Cash and cash equivalents at 31 March	21	**2,100**	**2,100**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern
These accounts have been prepared on a going concern basis.

The Department of Health and Social Care 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.

The Trust is planning to deliver a deficit in 2019/20 of £34.0m, assuming delivery of a £20.6m cost improvement programme. If this deficit is delivered, the Trust will receive £24m of funding from the Department of Health and Social Care, meaning that the year-end position will be a £10m deficit.

As at 31 March 2019 the Trust has a cash balance of £2.1m with a cash forecast for the end of each month during 2019/20 ranging from £2.1m to £4.5m. This forecast assumes achievement of the planned deficit, including delivery of the cost improvement programme and receipt of £23.9m of cash support from the Independent Trust Financing Facility through application to the DHSC via NHS Improvement.

Despite the risk and uncertainty associated with future cash flow projections, management are of the view that whilst challenging, they will be able to deliver against the cost improvement programme and achieve the agreed forecast outturn. However at this stage, there is no certainty that the cost improvement programme will be achieved. If it is not achieved, cash resources would be consumed within the next 12 months and the Trust would require further cash support to meet its liabilities as these fall due. DHSC has not confirmed, at the certification date of the accounts, that they will provide cash support to the Trust in 2019/20.

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

Notwithstanding the need for additional cash support, the Trust does not have any evidence indicating that the going concern basis is not appropriate. The Trust has not been informed by NHS Improvement that there is any prospect of reconfiguration or dissolution within the next 12 months. In terms of the sustainable provision of services, there has been no indication from the Department of Health and Social Care that the Trust will not continue to be a going concern. Furthermore, continuity of service provision in the future can be demonstrated by signed contracts and future commissioning intentions with commissioners and through the financial and operational plans described in the Trust Strategy, the Sussex and East Surrey Sustainability and Transformation Plans and the East Sussex Better Together (ESBT) Alliance. In 2018/19 the Trust has been working with system partners to achieve system financial balance. This work will continue to be progressed at pace in 2019/20.

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

Note 1 Accounting policies and other information (continued)

Note 1.2 Critical accounting judgements and key sources of estimation uncertainty
In the application of the NHS Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.2.1 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Charitable Funds
The Non-Executive Directors of the Trust act as Trustees of the East Sussex Healthcare NHS Trust Charitable Fund. However, these are not consolidated with the Trust accounts on the grounds of materiality.

Alternative Site Valuation
In 2015/16 the Trust adopted the Alternative Site valuation for its main acute hospital sites. The revaluation is on the basis of:
- single siting of the main acute sites
- removal of all accommodation buildings including admin space
- removal of St Anne's House
- removal of the Education Centre
- removal of all Commercial Services buildings
- removal of the Crèche (at Eastbourne DGH)

See note 18

Note 1.2.2 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Property, Plant and Equipment valuations
The District Valuer has valued land and buildings using the Alternative Site methodology. See note 18

Asset Lives
Each year the Trust reviews all of its plant and equipment assets to ensure that the existing asset lives are accurate, this review results in both increases and decreases in lives at an asset level and the subsequent depreciation charge for those assets.

Part Completed Spells
Partially completed spells for inpatient services are accounted for by accruing the income due to 31 March 2019. This is calculated by applying the reference cost per bed day to the number of bed days by inpatient at midnight on 31 March 2019. Bed stays over 70 days are ignored and then a 72% collection rate is assumed based on previous years' amounts billed under PBR tariff arrangements once patients are discharged.

Note 1.3 Revenue from contracts with customers
Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office for National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for healthcare services. A performance obligation relating to delivery of a spell of healthcare is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but these affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from non-NHS contracts - SMSKE Partnership
The Trust receives income for Musculoskeletal Services from a non-NHS commissioner. This uses the same contracting arrangements as NHS contracts. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the non-NHS commissioner but the customer benefits as services are provided to the patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its Commissioner including how care is provided to patients. The CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from non-NHS contracts - Local Authority
The Trust receives income for two distinct services - provision of healthcare services and provision of staff. The healthcare service uses a similar contracting arrangements as the NHS contract. A performance obligation relating to delivery of an episode of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner but the customer benefits as services are provided to the patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with the delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer.

For the provision of staff, revenue is recognised as and when performance obligations are satisfied during the period covered by the recharge.

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of a multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Non-patient care services to other bodies
The Trust supplies a range of staff and goods to a range of customers, and also rents out facilities. For these services, revenue is recognised as and when performance obligations are satisfied during the period covered by the recharge.

Note 1.4 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.5 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition
Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.6.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where, it would meet the location requirements of the service being provided, an alternative site can be valued.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

Note 1.6.3 Donated assets
Donated non-current assets are capitalised at current value in existing use. If they will be held for their service potential or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

Note 1.7 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first-in first-out methodology, however, the Pharmacy system uses the weighted average cost formula so drugs are valued this way. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.8 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.9 Financial assets and financial liabilities

Note 1.9.1 Recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.
This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Note 1.9.2 Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The Trust does not normally recognise expected credit losses in relation to other NHS bodies.
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.9.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.
Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.10 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.10.1 The trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.11 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 26.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.12 Contingencies
Contingent liabilities are not recognised, but are disclosed in note 26.2, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.13 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated assets (including lottery funded assets),

(ii) average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and

(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.14 Value added tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.15 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.16 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the Health Service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the Losses and Compensations Register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.17 Intangible Assets

Note 1.17.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

The Trust's intangible assets comprise internally generated software. Purchased software is capitalised as part of the relevant item of property, plant and equipment. Intangible assets are assessed for impairment when they are first brought into use.

Note 1.17.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at current value in existing use.

Note 1.17.3 Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.18 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.19 Standards, amendments and interpretations in issue but not yet effective or adopted

- IFRS 14 Regulatory Deferral Accounts: applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable
- IFRS 16 Leases: Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FreM therefore early adoption is not permitted
- IFRS 17 Insurance Contracts: Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FreM therefore early adoption is not permitted
- IFRIC 23 Uncertainty over Income Tax Treatments: Application required for accounting periods beginning on or after 1 January 2019 but not applicable to the Trust

Note 2 Operating Segments

The Trust has considered IFRS8: Operating Segments and has taken the view that its activities should be reported as a single entity rather than in a segmental manner. Although financial performance is reported to the Executive Board members at a divisional level, the key financial information for decision making purposes is based on the single entity as a whole. Furthermore, the Trust's business is the delivery of acute and community healthcare across a single economic environment. No separate reportable segments have therefore been identified.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	**2018/19 £000**	**2017/18 £000**
Elective income	51,218	51,013
Non elective income	112,358	102,257
First outpatient income	15,718	14,758
Follow up outpatient income	25,565	26,775
A & E income	17,766	16,046
High cost drugs income from commissioners (excluding pass-through costs)	34,062	31,137
Other NHS clinical income	68,566	60,389
Community services income from CCGs and NHS England	28,259	29,299
Income from other sources (e.g. local authorities)	10,872	12,254
Private patient income	2,132	2,011
Agenda for Change pay award central funding	5,055	-
Other clinical income	3,741	4,307
Total income from activities	**375,312**	**350,246**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2018/19 £000**	**2017/18 £000**
NHS England	43,677	44,454
Clinical commissioning groups	299,719	278,451
Department of Health and Social Care	5,055	70
Other NHS providers	39	48
NHS other	372	709
Local authorities	10,078	10,705
Non-NHS: private patients	2,132	2,011
Non-NHS: overseas patients (chargeable to patient)	195	9
Injury cost recovery scheme	961	649
Non NHS: other	13,084	13,140
Total income from activities	**375,312**	**350,246**
Of which:		
Related to continuing operations	375,312	350,246

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2018/19	2017/18
	£000	£000
Income recognised this year	195	9
Cash payments received in-year	69	42
Amounts added to provision for impairment of receivables	26	-
Amounts written off in-year	9	2

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	540	493
Education and training (excluding notional apprenticeship levy income)	9,114	9,005
Non-patient care services to other bodies	13,445	14,297
Provider sustainability / sustainability and transformation fund income (PSF / STF)	-	3,534
Income in respect of employee benefits accounted on a gross basis	1,441	1,409
Other contract income	7,330	7,957
Other non-contract operating income		
Receipt of capital grants and donations	1,297	773
Charitable and other contributions to expenditure	304	220
Total other operating income	**33,471**	**37,688**
Of which:		
Related to continuing operations	33,471	37,688

Note 5 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	1,729

Note 5.1 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2018/19	2017/18
	£000	£000
Income	1,567	1,559
Full cost	(1,979)	(1,875)
Surplus / (deficit)	**(412)**	**(316)**

Note 6 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	9,943	6,709
Purchase of healthcare from non-NHS and non-DHSC bodies	6,271	4,816
Staff and executive directors costs	292,093	284,296
Remuneration of non-executive directors	78	78
Supplies and services - clinical (excluding drugs costs)	35,419	35,279
Supplies and services - general	4,599	4,656
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	44,281	42,933
Consultancy costs	985	592
Establishment	7,852	6,233
Premises	14,279	14,639
Transport (including patient travel)	691	1,130
Depreciation on property, plant and equipment	11,975	12,364
Amortisation on intangible assets	418	355
Net impairments	-	14,423
Movement in credit loss allowance: contract receivables / contract assets	60	-
Movement in credit loss allowance: all other receivables and investments	-	(309)
Increase/(decrease) in other provisions	-	245
Change in provisions discount rate(s)	(32)	24
Audit fees payable to the external auditor		
audit services- statutory audit	75	61
other auditor remuneration (external auditor only)	10	10
Internal audit costs	201	184
Clinical negligence	10,117	14,615
Legal fees	154	185
Insurance	362	383
Education and training	908	871
Rentals under operating leases	1,645	1,159
Redundancy	266	-
Hospitality	26	47
Other	3,298	2,969
Total	**445,974**	**448,947**
Of which:		
Related to continuing operations	445,974	448,947

Note 6.1 Other auditor remuneration

	2018/19	2017/18
	£000	£000
Other auditor remuneration paid to the external auditor:		
Other non-audit services	10	10
Total	**10**	**10**

Note 6.2 Limitation on auditor's liability

In accordance with the terms of engagement with the Trust's external auditors, Grant Thornton UK LLP, it's members, partners and staff (whether contract, negligence or otherwise) in respect of services provided in connection with or arising out of the audit shall in no circumstances exceed £2 million in the aggregate in respect of all such services.

Note 7 Impairment of assets

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	-	14,423
Total net impairments charged to operating surplus / deficit	**-**	**14,423**
Impairments charged to the revaluation reserve	-	10,249
Total net impairments	**-**	**24,672**

Note 8 Employee benefits

	2018/19	2017/18
	Total	Total
	£000	£000
Salaries and wages	232,477	222,615
Social security costs	22,327	21,093
Apprenticeship levy	1,172	1,121
Employer's contributions to NHS pensions	26,913	25,991
Termination benefits	266	118
Temporary staff (including agency)	9,716	13,799
Total gross staff costs	**292,871**	**284,737**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**292,871**	**284,737**
Of which		
Costs capitalised as part of assets	512	441

Note 9 Retirements due to ill-health

During 2018/19 there was one early retirement from the Trust agreed on the grounds of ill-health (none in the year ended 31 March 2018). The estimated additional pension liabilities of thIS ill-health retirement is £54k.

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 10 Pension costs
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as at 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

c) National Employees Savings Trust (NEST)
The Trust participates in the National Employees Savings Trust (NEST) scheme as an alternative for those employees who are not eligible to join the NHS Pension Scheme. This came into effect in July 2013 for this Trust as part of the auto-enrolment requirements introduced by the Government. NEST is a defined contribution scheme with a phased employer contribution rate, set at 2% for 2018/19 (1% for 2017/18). Trust contributions under the NEST scheme for the 2018/19 financial year totalled £37k (£18k 2017/18).

Note 11 Operating leases

Note 11.1 East Sussex Healthcare NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where East Sussex Healthcare NHS Trust is the lessee.

The leases relate to cars, medical equipment, buildings and photocopiers. Lease periods range from 3 to over 5 years.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	1,645	1,159
Total	**1,645**	**1,159**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,719	1,226
- later than one year and not later than five years;	3,123	1,947
- later than five years.	256	237
Total	**5,098**	**3,410**

Note 12 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19	2017/18
	£000	£000
Interest on bank accounts	62	20
Total finance income	**62**	**20**

Note 13 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	6,481	4,455
Interest on late payment of commercial debt	8	48
Total interest expense	**6,489**	**4,503**
Unwinding of discount on provisions	2	6
Total finance costs	**6,491**	**4,509**

Note 13.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims under this legislation	8	48

Note 14 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	100	-
Total gains / (losses) on disposal of fixed assets	**100**	**-**
Total other gains / (losses)	**100**	**-**

Note 15 Intangible assets - 2018/19

	Internally generated information technology	Development expenditure	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**95**	**3,092**	**3,187**
Additions	-	372	**372**
Reclassifications	(95)	95	**-**
Valuation / gross cost at 31 March 2019	**-**	**3,559**	**3,559**
Amortisation at 1 April 2018 - brought forward	**95**	**1,144**	**1,239**
Provided during the year	-	418	**418**
Reclassifications	(95)	95	**-**
Amortisation at 31 March 2019	**-**	**1,657**	**1,657**
Net book value at 31 March 2019	**-**	**1,902**	**1,902**
Net book value at 1 April 2018	**-**	**1,948**	**1,948**

Note 15.1 Intangible assets - 2017/18

	Internally generated information technology	Development expenditure	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**95**	**2,649**	**2,744**
Additions	-	443	**443**
Valuation / gross cost at 31 March 2018	**95**	**3,092**	**3,187**
Amortisation at 1 April 2017 - as previously stated	**95**	**789**	**884**
Provided during the year	-	355	**355**
Amortisation at 31 March 2018	**95**	**1,144**	**1,239**
Net book value at 31 March 2018	**-**	**1,948**	**1,948**
Net book value at 1 April 2017	**-**	**1,860**	**1,860**

Note 16 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**14,072**	**171,353**	**-**	**-**	**70,047**	**251**	**25,174**	**4,245**	**285,142**
Additions	-	5,618	-	4,021	2,508	-	4,151	139	**16,437**
Revaluations	1,900	1,586	-	-	-	-	-	-	**3,486**
Disposals / derecognition	-	-	-	-	(1,280)	(23)	(1,037)	-	**(2,340)**
Valuation/gross cost at 31 March 2019	**15,972**	**178,557**	**-**	**4,021**	**71,275**	**228**	**28,288**	**4,384**	**302,725**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**-**	**-**	**-**	**50,553**	**251**	**15,569**	**3,070**	**69,443**
Provided during the year	-	5,552	-	-	3,890	-	2,324	209	**11,975**
Disposals / derecognition	-	-	-	-	(1,217)	(23)	(1,037)	-	**(2,277)**
Accumulated depreciation at 31 March 2019	**-**	**5,552**	**-**	**-**	**53,226**	**228**	**16,856**	**3,279**	**79,141**
Net book value at 31 March 2019	**15,972**	**173,005**	**-**	**4,021**	**18,049**	**-**	**11,432**	**1,105**	**223,584**
Net book value at 1 April 2018	**14,072**	**171,353**	**-**	**-**	**19,494**	**-**	**9,605**	**1,175**	**215,699**

Note 16.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**27,027**	**187,190**	**13,393**	**-**	**66,815**	**259**	**22,882**	**3,955**	**321,521**
Additions	-	7,679	-	-	5,402	-	2,324	307	**15,712**
Impairments	(12,955)	(82)	(11,635)	-	-	-	-	-	**(24,672)**
Revaluations	-	(23,434)	(1,758)	-	-	-	-	-	**(25,192)**
Disposals / derecognition	-	-	-	-	(2,170)	(8)	(32)	(17)	**(2,227)**
Valuation/gross cost at 31 March 2018	**14,072**	**171,353**	**-**	**-**	**70,047**	**251**	**25,174**	**4,245**	**285,142**
Accumulated depreciation at 1 April 2017 - as previously stated	**-**	**17,739**	**1,411**	**-**	**48,661**	**258**	**13,421**	**2,896**	**84,386**
Accumulated depreciation at 1 April 2017 - restated	**-**	**17,739**	**1,411**	**-**	**48,661**	**258**	**13,421**	**2,896**	**84,386**
Provided during the year	-	5,695	347	-	3,977	1	2,162	182	**12,364**
Revaluations	-	(23,434)	(1,758)	-	-	-	-	-	**(25,192)**
Disposals / derecognition	-	-	-	-	(2,085)	(8)	(14)	(8)	**(2,115)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**-**	**50,553**	**251**	**15,569**	**3,070**	**69,443**
Net book value at 31 March 2018	**14,072**	**171,353**	**-**	**-**	**19,494**	**-**	**9,605**	**1,175**	**215,699**
Net book value at 1 April 2017	**27,027**	**169,451**	**11,982**	**-**	**18,154**	**1**	**9,461**	**1,059**	**237,135**

Note 16.2 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	15,972	168,744	-	4,021	15,082	-	11,394	762	**215,975**
Owned - donated	-	4,261	-	-	2,967	-	38	343	**7,609**
NBV total at 31 March 2019	**15,972**	**173,005**	**-**	**4,021**	**18,049**	**-**	**11,432**	**1,105**	**223,584**

Note 16.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	14,072	167,106	-	-	17,010	-	9,528	888	**208,604**
Owned - donated	-	4,247	-	-	2,484	-	77	287	**7,095**
NBV total at 31 March 2018	**14,072**	**171,353**	**-**	**-**	**19,494**	**-**	**9,605**	**1,175**	**215,699**

Note 17 Donations of property, plant and equipment
The following organisations donated assets to the Trust during 2018/19

- Friends Of The Eastbourne Hospital - £1,009,231 (2017/18 £134,000)
- The League Of Friends Of The Bexhill Hospital CIO - £164,072 (2017/18 £329,000)
- The League Of Friends Of The Conquest Hospital - £73,184 (2017/18 £227,000)
- East Sussex Healthcare NHS Trust Charitable Fund - £50,025 (2017/18 £6,000)
- Friends of Lewes Victoria Hospital - £0 (2017/18 £17,000)
- The League of Friends of Uckfield Community Hospital - £0 (2017/18 £61,000)

Note 18 Revaluations of property, plant and equipment
The Trust first adopted the "alternative site valuation" methodology in 2015/16. In 2018/19 this methodology was reviewed and the District Valuer instructed to complete the revaluation on the basis of:

- single siting of the main acute sites
- removal of all accommodation buildings including admin space
- removal of St Anne's House
- removal of the Education Centre
- removal of all Commercial Services buildings
- removal of the Crèche (at Eastbourne DGH)

The Trust instructed the District Valuer (Mr Oliver Gronow MSc, MRICS, FAAV) to conduct a full revaluation of the Trust's land and buildings as at 31 March 2019.

As a result of the revaluation carried out at 31 March 2019, the Trust's assets were revalued upwards by £3,486k. Of this, £226k related to assets previously impaired through the Statement of Comprehensive Income and the reversal of these impairments was credited to the I&E Reserve.

Standard lives for property, plant and equipment and Intangibles are adopted as follows:

- buildings, as per the District Valuer between 10 and 90 years
- plant and equipment, 3 to 80 years
- motor vehicles, 4 to 7 years
- furniture, 3 to 70 years
- IT equipment, 3 to 15 years
- IT - In House Software (intangibles), 5 to 7 years

The annual review of asset lives resulted in an in-year reduction in depreciation of £116,975 (2017/18 £92,237). Extending asset lives reduces in-year depreciation costs but increases the number of years in which depreciation is charged for individual assets.

The gross carrying amount of all fully depreciated tangible assets still in use is:

Purchased £31.9m (2017/18 £28.7m)
Donated £13.1m (2017/18 £12.8m)

Note 19 Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	3,004	2,382
Consumables	3,653	4,749
Energy	170	170
Total inventories	**6,827**	**7,301**

Inventories recognised in expenses for the year were £59,562k (2017/18: £59,044k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 20 Trade receivables and other receivables

	31 March 2019	31 March 2018
	£000	£000
Current		
Contract receivables*	17,015	-
Trade receivables*	-	21,384
Capital receivables	262	157
Accrued income*	-	9,900
Allowance for impaired contract receivables / assets*	(127)	-
Allowance for other impaired receivables	-	(145)
Prepayments (non-PFI)	1,698	2,419
PDC dividend receivable	-	432
VAT receivable	680	835
Other receivables	127	359
Total current trade and other receivables	**19,655**	**35,341**
Non-current		
Contract receivables*	2,001	
Allowance for impaired contract receivables / assets*	(206)	-
Allowance for other impaired receivables	-	(151)
Other receivables	-	1,462
Total non-current trade and other receivables	**1,795**	**1,311**
Of which receivables from NHS and DHSC group bodies:		
Current	11,028	22,038

* Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 20.1 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward	-	296
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	296	(296)
New allowances arising	65	-
Reversals of allowances	(5)	-
Utilisation of allowances (write offs)	(23)	-
Allowances as at 31 Mar 2019	**333**	**-**

Note 20.2 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	
Prior period adjustments	621
Allowances as at 1 Apr 2017 - restated	**621**
Increase in provision	17
Amounts utilised	(16)
Unused amounts reversed	(326)
Allowances as at 31 Mar 2018	**296**

Note 20.3 Exposure to credit risk

As the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

Note 21 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	**2,100**	**2,100**
At 31 March	**2,100**	**2,100**
Broken down into:		
Cash at commercial banks and in hand	48	27
Cash with the Government Banking Service	2,052	2,073
Total cash and cash equivalents as in SoFP	**2,100**	**2,100**
Total cash and cash equivalents as in SoCF	**2,100**	**2,100**

Note 21.1 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2019	31 March 2018
	£000	£000
Monies on deposit	5	19
Total third party assets	**5**	**19**

Note 22 Trade and other payables

	31 March 2019	31 March 2018
	£000	£000
Current		
Trade payables	6,444	6,766
Capital payables	2,305	3,029
Accruals	9,616	17,806
Social security costs	1,104	3,077
Other taxes payable	446	5,672
PDC dividend payable	48	-
Accrued interest on loans*	-	729
Other payables	3,267	661
Total current trade and other payables	**23,230**	**37,740**
Of which payables from NHS and DHSC group bodies:		
Current	5,634	6,680

Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 24. IFRS 9 is applied without restatement therefore comparatives have not been restated

Note 23 Other liabilities

	31 March 2019	31 March 2018
	£000	£000
Current		
Deferred income: contract liabilities	1,311	1,729
Total other current liabilities	**1,311**	**1,729**

Note 24 Borrowings

	31 March 2019	31 March 2018
	£000	£000
Current		
Loans from the Department of Health and Social Care	59,240	35,694
Total current borrowings	**59,240**	**35,694**
Non-current		
Loans from the Department of Health and Social Care	143,575	121,517
Total non-current borrowings	**143,575**	**121,517**

Note 25 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Total
	£000	£000
Carrying value at 1 April 2018	**157,211**	**157,211**
Cash movements:		
Financing cash flows - payments and receipts of principal	44,525	**44,525**
Financing cash flows - payments of interest	(6,131)	**(6,131)**
Non-cash movements:		
Impact of implementing IFRS 9 on 1 April 2018	729	**729**
Application of effective interest rate	6,481	**6,481**
Carrying value at 31 March 2019	**202,815**	**202,815**

Note 26.2 Contingent liabilities

	31 March 2019	31 March 2018
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(2)	-
Employment tribunal and other employee related litigation	(216)	(113)
Gross value of contingent liabilities	**(218)**	**(113)**
Net value of contingent liabilities	**(218)**	**(113)**

Contingent Liabilities relating to NHS Resolution are for legal claims which are currently being pursued against the Trust. Contingent Liabilities relate to Employment Tribunal and other employee related litigation. For both of these classes of contingent liability, the timings, the amounts involved and the outcomes are uncertain.

Note 27 Contractual capital commitments

	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	2,305	3,029
Total	**2,305**	**3,029**

Note 28 Financial instruments

Note 28.1 Financial risk management
Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with NHS Healthcare Commissioners and the way the latter bodies are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health and Social Care (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 29 Carrying values of financial assets
IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**
Trade and other receivables excluding non-financial assets	17,372	**17,372**
Cash and cash equivalents at bank and in hand	2,100	**2,100**
Total at 31 March 2019	**19,472**	**19,472**

	Loans and receivables	Assets at fair value through the I&E	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**
Trade and other receivables excluding non-financial assets	33,549	-	**33,549**
Cash and cash equivalents at bank and in hand	2,100	-	**2,100**
Total at 31 March 2018	**35,649**	**-**	**35,649**

Note 29.1 Carrying value of financial liabilities
IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	
Loans from the Department of Health and Social Care	**202,815**
Trade and other payables excluding non-financial liabilities	**21,189**
Total at 31 March 2019	**224,004**

	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39	
Loans from the Department of Health and Social Care	**157,211**
Trade and other payables excluding non-financial liabilities	**37,740**
Total at 31 March 2018	**194,951**

Note 29.2 Fair values of financial assets and liabilities
The fair value of receivables and cash is consistent with the carrying value in the Statement of Financial Position. Receivables comprise amounts to be collected within 1 year and the non-current receivables for Injury Cost Recovery Income. Non-current receivables are not discounted as the difference to carrying values is not considered material. Cash is available on demand.

Payables arising under statutory obligations such as payroll taxes are not classified as financial liabilities. The fair value of payables is consistent with the carrying value in the Statement of Financial Position. Payables comprise amounts to be paid within 1 year and are valued using discounted cash flows.

Note 29.3 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	80,429	73,434
In more than one year but not more than two years	95,773	119,042
In more than two years but not more than five years	45,976	974
In more than five years	1,826	1,501
Total	**224,004**	**194,951**

Note 30 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	121	99	86	93
Bad debts and claims abandoned	41	17	26	16
Total losses	**162**	**116**	**112**	**109**
Special payments				
Ex-gratia payments	41	21	53	18
Total special payments	**41**	**21**	**53**	**18**
Total losses and special payments	**203**	**137**	**165**	**127**

Note 31 Initial application of IFRS 9
IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £729k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £1,311k.

Note 31.1 Initial application of IFRS 15
IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 32 Related parties
Details of related party transactions with individuals are as follows:

Payments to Winchelsea and District Memorial Hospital Ltd £281,125 (2017/18: £314,766)
Related party: Barry Nealon, Non-Executive Director who is Chairman of the above organisation

Payments to Sussex Downs College £13,000 (2017/18: £11,639)
Income from Sussex Downs College: £33,671 (2017/18: £29,259)
Related party: Jonathan Reid, Director of Finance who was a Governor of the above organisation

Payments to Chalkman Films £0 (2017/18: £570)
Related party: Lynette Wells, Company Secretary who is a Director of the above organisation

Income from South East Coast Ambulance NHS Foundation Trust £47,195
Related party: Steve Phoenix, Chairman (from 1 February 2019 of the Trust) whose wife is a senior manager of South East Coast Ambulance NHS Foundation Trust

Payments to Johnson & Johnson £1,378,237
Related party: Karen Manson, Non-Executive Director who is a shareholder

Income from Kent, Surrey and Sussex Academic Health Science Network: £7,672 (2017/18: £14,913)
Related party: David Clayton-Smith, Chairman (up to 31 January 2019 of the Trust) who is Chairman of the above organisation

Income from Spire Sussex Hospital £1,258,928 (2017/18: £1,205,184)
Related party: David Walker, Medical Director who has a private practice operating out of Spire Sussex Hospital

Payments to Clinical Strategies £2,357 (2017/18: £0)
Related party: Jackie Churchward-Cardiff, Non-Executive The Department of Health and Social Care is regarded as a related party. During 2018/19 East Sussex Healthcare NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. The bodies listed below have entered in to income or expenditure transactions with the Trust over £500,000:

Brighton and Hove CCG
Brighton and Sussex University Hospitals NHS Trust
Coastal West Sussex CCG
Eastbourne, Hailsham and Seaford CCG
Hastings and Rother CCG
Health Education England
High Weald Lewes Haven CCG
NHS England
NHS Pensions Agency
NHS Property Services
NHS Resolution
NHSE Wessex
Oxford Health NHS Foundation
Queen Victoria Hospital NHS Foundation Trust
South East CSU
South East Commissioning Hub
South East Local Office
Surrey Downs CCG
Surrey & Sussex Healthcare NHS Trust
Sussex Community NHS Trust
The NHS Blood and Transplant Agency
West Kent CCG

In addition, the Trust has had transactions over £500,000 with the following government body:

East Sussex County Council

The Trust has also received revenue and capital payments from East Sussex Healthcare NHS Trust Charitable Fund, whose Board comprises members of the Trust Board. The amount received was £62,364 (2017/18 £762,000), comprising donations of assets amounting to £50,025 (2017/18 £6,000) and cash support of £12,339 (2017/18 £756,000).

The Trust has had a number of transactions over £500,000 with central government bodies:

HM Revenue and Customs
National Health Service Pension Scheme

Note 33 Events after the reporting date
There were no adjusting events after the reporting period.

Note 34 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	119,305	169,057	128,709	158,861
Total non-NHS trade invoices paid within target	82,342	129,104	24,188	43,923
Percentage of non-NHS trade invoices paid within target	69.0%	76.4%	18.8%	27.6%
NHS Payables				
Total NHS trade invoices paid in the year	3,179	32,831	2,698	35,381
Total NHS trade invoices paid within target	2,668	32,058	845	29,352
Percentage of NHS trade invoices paid within target	83.9%	97.6%	31.3%	83.0%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 35 External financing

The Trust is given an external financing limit against which it is permitted to underspend:

	2018/19 £000	2017/18 £000
Cash flow financing	**47,193**	**66,779**
Finance leases taken out in year		
External financing requirement	**47,193**	**66,779**
External financing limit (EFL)	47,194	66,780
Under / (over) spend against EFL	**1**	**1**

Note 36 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	16,809	16,155
Less: Disposals	(63)	(112)
Less: Donated and granted capital additions	(1,297)	(773)
Charge against Capital Resource Limit	**15,449**	**15,270**
Capital Resource Limit	15,467	15,277
Under / (over) spend against CRL	**18**	**7**

Note 37 Breakeven duty financial performance

	2018/19 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(44,781)
Breakeven duty financial performance surplus / (deficit)	**(44,781)**

Note 38 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		350	(4,704)	87	522	(23,094)	88	(47,997)	(43,792)	(53,878)	(44,781)
Breakeven duty cumulative position	1,745	2,095	(2,609)	(2,522)	(2,000)	(25,094)	(25,006)	(73,003)	(116,795)	(170,673)	(215,454)
Operating income		282,807	299,623	385,281	387,400	364,240	384,876	356,152	379,307	387,934	408,783
Cumulative breakeven position as a percentage of operating income		0.7%	(0.9%)	(0.7%)	(0.5%)	(6.9%)	(6.5%)	(20.5%)	(30.8%)	(44.0%)	(52.7%)

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

East Sussex Healthcare NHS Trust

Quality Account 2018-2019

Contents

Part 1 – Introduction

Statement of Quality from the Chief Executive

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

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

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

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

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

We know that the key to maintaining and improving the quality of our services, care for our patients and the experience of our staff is listening to feedback and ensuring that we make changes and embed improvements based on the feedback we receive. For our patients this means better two-way communication during every step of their care journey and ensuring that they are fully informed and involved in decisions relating to their care. For members of the public this means ensuring that we embed a culture of experience based co-design when redesigning services or care pathways. For members of staff it means continuing to

encourage an open reporting culture so that they feel safe and able to raise concerns, We were pleased to see this reflected in some of the improvements we saw in the NHS staff survey published in March this year.

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

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

Dr Adrian Bull
Chief Executive
24 June 2019

About us and the service we provide

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

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

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

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

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

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

- Diagnostics, Anaesthetics and Surgery
- Medicine
- Out of Hospitals
- Urgent Care
- Women, Children and Sexual Health

Our Vision, Values and Ambition – to be Outstanding and Always Improving

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

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

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

Operational priorities:

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

Our Objectives:

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

- **We will use our resources efficiently and effectively:** Ensuring our services financially sustainable for the benefit of our patients and their care

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

Some of our achievements in 2018/19

April – June 2018

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

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

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

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

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

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

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

Trust leads national project for people with swallowing difficulties
The Trust has implemented a new way of classifying modified foods and fluids for people who have swallowing difficulties. In line with recommendations from the Royal College of Speech and Language Therapists (RCSLT), ESHT is an early implementer, spearheading the one-year phased implementation which will be adopted nationally by all healthcare providers by 2019.

New endocrine drug is first to be prescribed in UK
The Trust became the first in the UK to prescribe a new endocrine drug called Natpar, a recombinant parathyroid hormone.

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

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

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

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

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

July - September 2018

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

Diabetes Nurses achieve accreditation for educational programme
Our Diabetes Specialist Nurses achieved accreditation to deliver their educational programme supporting people living with Type 1 diabetes. The education programme called SADIE (Skills for Adjusting Diet and Insulin in East Sussex) was approved by the Quality Institute for Self-Management in Education and Training (QISMET) for another three years.

Young adults with a Learning Difficulty or Disability graduate from Project SEARCH

In July 2018, eight young people with a Learning Difficulty or Disability graduated from Project SEARCH, a supported internship programme designed to give young people skills to gain competitive paid employment. Project SEARCH has been running since September 2014.

Endoscopy Units recognised for high quality care

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

Number of births at Midwifery Unit increases by over 25%

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

NHS Heroes recognised at Trust Award Ceremony

Local NHS heroes were recognised at the Trust's Annual Awards Ceremony in July 2018. The winners of 12 awards categories were announced along with recognition for members of staff with over 40 years NHS service.

October – December 2018

Patients give excellent feedback on their cancer care

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

Trust's Pathology Departments achieve national accreditation

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

Trust improves its rating for Emergency Response

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

High quality trauma care at Trust

Data published by the Trauma Audit and Research Network (TARN) highlighted the high quality of trauma care provided at Conquest Hospital and Eastbourne DGH. The data looked at the whole trauma patient journey from the Emergency Department through the hospital and showed that Conquest Hospital was the fourth best in terms of survival outcome with Eastbourne DGH 22nd out of all the

country's hospitals that provide a similar level service.

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

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

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

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

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

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

New staff Extranet launched
Members of staff at ESHT now have access to the Trust's new extranet. The new platform will help to support better staff engagement and involvement, facilitate collaboration and initiate a shift in staff culture towards active knowledge.

January – March 2019

Trust shows improvement in maternity services
A national survey on maternity services undertaken on behalf of the Care Quality Commission (CQC), found that maternity care at the Trust had improved across a number of areas. Twenty one of the questions showed an improvement or remained the same, when compared to the same survey undertaken in 2017.

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

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

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

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

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

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

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

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

Our partnerships and collaboration

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

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

As part of a national network, there is a local Healthwatch in every local authority area in England. Healthwatch East Sussex works with the public of East Sussex to ensure that health and social care services work for the people who use them. Their focus is on understanding the needs, experiences and concerns of people of all ages who use services and to then speak out on their behalf. Their role is to ensure that local decision makers and health and care services put the experiences of people at the heart of their work and decision making. They do this by gathering people's experiences and identifying issues that are important to them and, when addressed, which will make services better for everybody. This year Healthwatch undertook a great deal of activity at ESHT, including a review of maternity services and teams of volunteers observing our care of patients as part of their listening tour and separately over a 24 hours period. The feedback supports us with the continuing improvement of our processes.

Purpose of the Quality Account and how it was developed

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

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

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

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

Part 2.1 – Priorities for Improvement in 2019/20

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

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

Table 1: Priorities for improvement in 2019/20

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

1. Continue to improve the management of the deteriorating patient

Why this has been chosen as priority

Early detection and treatment of physiological deterioration has been shown to improve the clinical outcomes for patients, and was made an improvement priority for the Trust in 2018/19. The priority in 2018/19 focused specifically on supporting the early recognition and prompt treatment of suspected sepsis, acute kidney injury (AKI) and improving processes for escalation.

As part of the work completed in 2018/19, the Trust has made considerable improvements, including introduction of a new Treatment Escalation Planning (TEP) tool to assist clinical staff with appropriate planning of ongoing care.

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

What we are going to do

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

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

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

What will success look like?

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

How we will monitor progress

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

We will continue to monitor and report VitalPAC: clinical observations undertaken on time and time taken to perform and record clinical observations led by the Critical Care Outreach Team.

We will also continue to monitor improvement and embed sepsis screening and implementation of the sepsis 6 pathway across our acute care areas.

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

Why this has been chosen as priority

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

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

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

What we are going to do

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

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

What will success look like?

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

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

How we will monitor progress

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

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

Why this has been chosen as priority

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

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

What we are going to do

- We will provide support and training to our ward teams and departments to use the information to make improvements and celebrate success.
- Agree standards for all domains with the domain leads.
- Align the KPIs to the standards.
- Confirm the data source of information that will be automatically populated into the dashboard.
- Amend the audit questions to reflect the KPIs and provide staff with data that they can use for improvement.

- Agree the number of audits required per clinical area.
- Agree phase 2 areas to include following the initial roll out.

What will success look like?

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

How we will monitor progress

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

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

Why this has been chosen as priority

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

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

What we are going to do

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

What will success look like?

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

How we will monitor progress

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

Part 2.2 – Statements of Assurance from the Board of Directors

Services provided and income

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

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

The income generated by the NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of NHS services by East Sussex Healthcare NHS Trust for 2018/19.

Participation in Clinical Audit and National Confidential Enquiries

Clinical audit is used within East Sussex Healthcare NHS Trust to aid improvements in the delivery and quality of patient care, and is viewed as a tool to facilitate continuous improvement. Clinical audit involves the review of clinical performance against agreed standards, and the refining of clinical practice as a result. The importance of this is also described in the ESHT Quality Strategy (2019).

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

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

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

National Audit and National Confidential Enquiries Programme

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

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

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

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

National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD)

NCEPOD issued four reports in 2018/19:

- 'Common Themes' was published in November 2018.
- 'Acute Heart Failure – Failure to Function' was published in November 2018.
- 'Cancer in Children, Teens and Young Adults: On the Right Course?' was published in December 2018
- 'Perioperative Diabetes: High and Lows' was published in December 2018

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

The Women and Children's division continues to report:

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

UKOSS UK Obstetric Surveillance System

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

The studies undertaken during the period 2018/19 include:

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

Successes in National Audit

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

Trauma and Research Network (TARN) National Audit

One such example is the ongoing Trauma and Research Network (TARN) mandated national audit – a 'must do' for the Trust, this audit enables us to assess our performance in managing and treating trauma patients. Through the audit we can directly compare our results on a national scale and identify improvements to optimise clinical outcomes. The Trust's TARN Coordinator, Kelly Tuppen, was named ESHT 'Employee of the Month' in October 2018 and in February 2019 Kelly won the national 'TARN Coordinator of the year' Award!

Over the past 16 months with great determination and perseverance, Kelly has successfully turned around Trust performance (in terms of the number of cases reported to TARN) from 22% in 2016-17, to 100% in 2018!

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

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

National Audit of Dementia Quality Review

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

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

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

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

Many aspects of the routine nursing and medical assessment documentation help to facilitate the good care of people with dementia. The admission clerking proforma includes the 4AT delirium assessment, the multidisciplinary record ensures that people with dementia routinely have assessments of continence, skin care, functional independence and nutrition (the latter invariably including a calculation of the patient's BMI). The Trust's snapshot review confirmed accurate data submission.

National Clinical Audit Reports in 2018/19

The reports of 42 national clinical audits were reviewed in 2018/19. The Trust scrutinises each set of results to benchmark the quality of care provided, identify successes for celebration and / or identify any risks for mitigation. Recommendations for local improvement and change are considered and tracked via a central clinical audit action plan.

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

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

Actual and Potential Deceased Organ Donation Audit

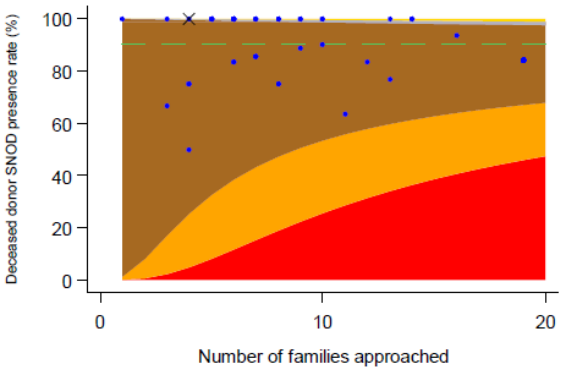
NHS Blood and Transplant

Overview:

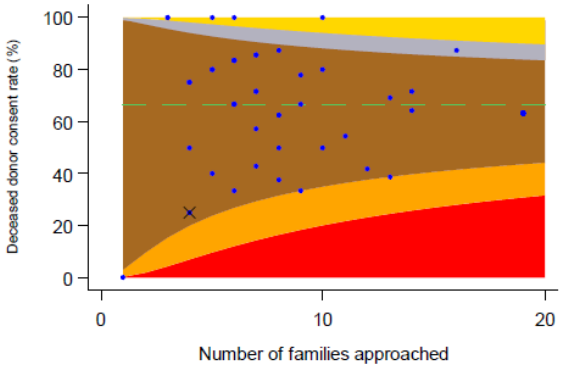
The potential donor audit commenced in 2003 as part of a series of measures to improve organ donation. Information is gathered for each patient that dies in a critical care unit (intensive care or emergency department) in all UK hospitals; this data is gathered by the Specialist Nurse for Organ Donation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

Key Results:

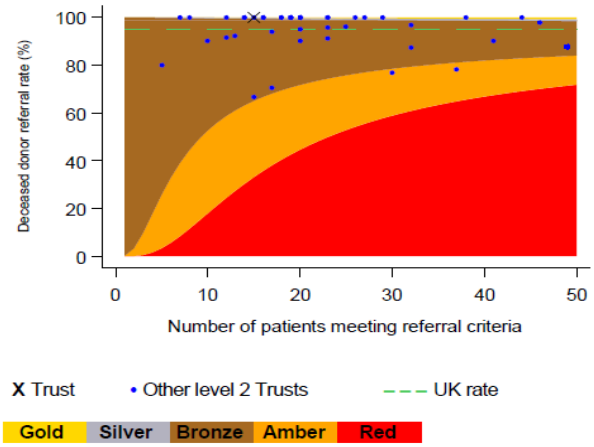
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.



Goal: The agreed 2017/18 national targets for Donation after Brainstem Death and Donation after Circulatory Death consent rates are 73% and 67%, respectively



Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service as per NICE CG135 and NHS Blood and Transplant Best Practice Guidance on timely identification and referral of potential organ donors.



Conclusions:

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

No specific actions were required following publication of the national report.

Surgical Site Infection (SSI) Surveillance in Orthopaedic Surgery

Public Health England

Overview:

Active orthopaedic SSI surveillance commissioned by the PHE Surgical Site Infection Surveillance Service remains a requirement of the Department of Health. This is endorsed by the NHS litigation authority which advocates using surveillance and reporting for compliance with national requirements and as formation of a learning system to be used by Trusts to improve performance and outcome.

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

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

Key Results:

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

	Total number of patients	Number of SSI	SSI %
Conquest	139	2	1.4
EDGH	115	0	0.0
ESHT Total	**254**	**2**	**0.8**
National Average (Apr-12 to Mar-17)	**198,180**	**1,264**	**0.6**

Knee Prosthetic Replacement Surgery including resurfacing and revision but excluding 1st stage revision where a spacer implant is used

	Total number of patients	Number of SSI	SSI %
Conquest	179	0	0.0
EDGH	174	1	0.6
ESHT Total	**353**	**1**	**0.3**
National Average (Apr-12 to Mar-17)	**206,994**	**1,155**	**0.6**

Conclusions:

During the period from 01/04/16 – 31/12/16 the Trust's SSI rate for Hip prosthetic surgery was higher than the national benchmark at 0.8% (however the knee prosthetic surgery SSI

rate remained low at 0.3%). A high outlier notification was sent to ESHT; the relevant Consultants in Orthopaedics and Microbiology reviewed the cases and determined that there were no particular causal trends, and that each case was managed appropriately.

Lessons Learnt and recommendations

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

ESHT Actions following the audit

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

The Trauma and Orthopaedic Consultants are currently reviewing recent cases of infection and will liaise with Microbiology and Infection Control to devise a further plan of action.

Pain in Children – Care in Emergency Departments

The Royal College of Emergency Medicine

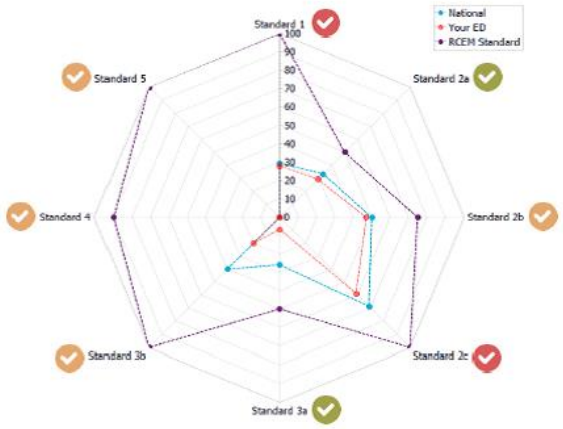
Overview:

A significant proportion of children attend the Emergency Department (ED) due to injuries and fractures to their arms and legs. These injuries are painful and distressing, and children require analgesia and review in a timely fashion.

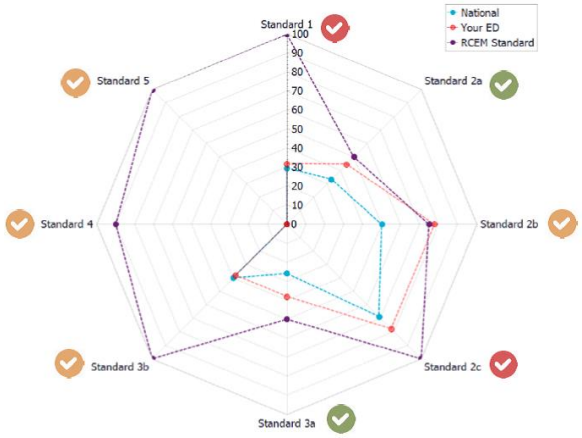
This audit was conducted for the seventh time to continue the work of the 2009/10 and 2011/12 data collections. It identifies current performance against RCEM clinical standards, showing the results in comparison with other departments.

Key Results:

Conquest



EDGH



Lessons Learnt and Recommendations

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

ESHT Actions following the audit

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

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

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

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

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

National COPD Audit Programme – Secondary Care Unit

Royal College of Physicians

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

Key Results:

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

Lessons Learnt and Recommendations

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

ESHT Actions following the audit:

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

Local Clinical Audit

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

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

Obstetrics & Gynaecology: Re-audit Management of Hyperemesis in Early Pregnancy; are we managing patients in accordance with the local policy?
WINNER of the 2018-19 Trust Clinical Audit Awards

Background

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

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

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

Aims and objective

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

Results

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

	% compliance 2017	% compliance 2015
Vital parameters	100%	55%
Lying/standing blood pressure	0%	-
Weight	85%	-
Urinalysis	82%	-
Blood tests: urea and electrolytes, full blood count, liver function tests	88%	86%
Fluid balance chart	65%	-

Doctors standards – a number of areas of poor compliance were noted:

- The Pregnancy-Unique Quantification of Emesis/Nausea (PUQE) score was used for less than 30% of patients.
- Documentation of initial hydration status.
- Formal re-assessment at 6 hours.

	% compliance 2017	% compliance 2015
PUQE score assessment admission & at 6 hour review	42%	-
Hydration status	34%	32%
Clinical examination	76%	-
Medication review; stop exacerbating medication e.g. iron	-	-
Blood tests for re-admissions: amylase, TFT's	46%	-
Request TVUSS if not already performed in current pregnancy	84%	36%
Vitamins prescribed	86%	68%
VTE prophylaxis	96%	77%
Review of patient after 6 hours of initial treatment	52%	45%
IV fluid regimen: 2-4L/day	86%	82%
Regular and PRN antiemetic prescribed	88%	45%
Discharge medication: 2 week supply of PO antiemetics + vitamins	72%	-
Patient information leaflet	0%	N/A

Good practice identified

Good performance was evidenced with regard to fluid resuscitation, anti-emetic and VTE prescriptions.

Identified risks or concerns

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

Lessons Learnt

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

Actions following the audit

1. Formal teaching on appropriate HG management at departmental induction – **Ongoing for each cohort.**
2. Develop and use a joint nursing-doctor proforma – **Complete.**
3. Update the Trust's local 2014 guideline and incorporate the recommendations specified in the RCOG national guidance – **Complete.**
4. Set-up of a hyperemesis outpatient suite; invest-to-save project – **A business case is in development.**

Emergency Department: Re-Audit of Severe Sepsis & Septic Shock in Adults (EDGH) (4187)

Background

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

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

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

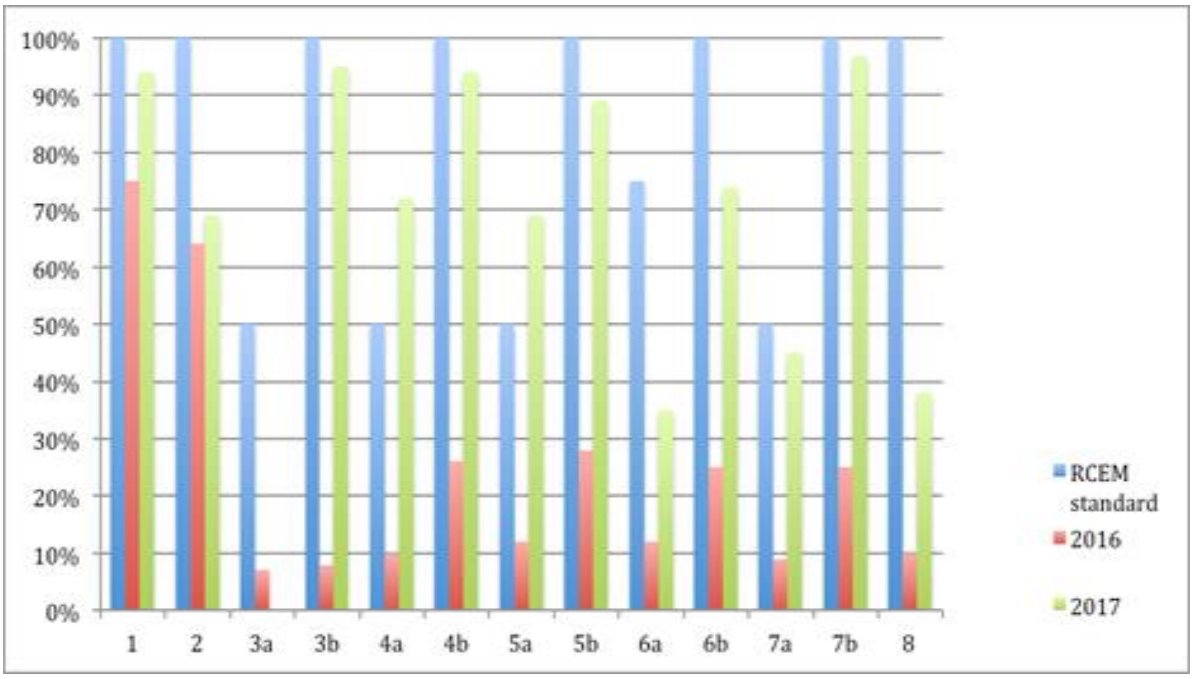
The first cycle of this audit was completed in 2016 when our sepsis pathway results were evaluated against the RCEM standards of best practice. Areas of poor compliance were identified and measures put in place to facilitate improvement.

Aims and objectives

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

Results

	RCEM standard	2016	2017
1 Vital signs	100%	75%	94%
2 Senior R/V	100%	64%	69%
3a O2 sats 1hr	50%	7%	95%
3b O2 sats 4hr	100%	8%	95%
4a Lactate 1hr	50%	10%	72%
4b Lactate 4hrs	100%	26%	94%
5a Cultures 1hr	50%	12%	69%
5b Cultures 4hrs	100%	28%	89%
6a IV Fluids 1hr	75%	12%	35%
6b IV Fluids 4hrs	100%	25%	74%
7a Abx 1hr	50%	9%	45%
7b Abx 4hrs	100%	25%	97%
8 Urine output	100%	10%	38%



Good practice identified:

Following the interventions made in 2016, all aspects of the sepsis pathway have now improved at the EDGH Emergency Department.

Average completion standard across all fields is 83% by RCEM standards. The most improved standard was the 'administration of oxygen delivery within 4 hours' (3b) which increased by 87% equating to a 12 fold improvement.

Identified risks or concerns:

'Monitoring of urine output' was poor – only 38% compliance to the standard was noted.

The least improved standard was the 'involvement of a Senior clinician before leaving the Emergency Department'; only a 5% increase in compliance was evidenced between 2016 and 2017.

Conclusions and Lessons learnt

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

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

Actions following the audit

1. Education of Emergency Department Junior Doctors regarding the importance of informing a senior clinician early - Include Sepsis 6 and the departmental protocol in the induction training for all new staff. **Complete / ongoing for every new batch of trainees.**
2. Improve completion of the Sepsis 6 screening proforma - Nominate an individual to track and review completion of the forms, individual training needs can then be identified and targeted to improve compliance. **Complete / ongoing – the Trust's Sepsis Link Nurse is now responsible for this.**
3. Addition of a sepsis pack with blood cultures included as a dropdown menu on the eSearcher Pathology interface – Discussion with Laboratory staff and IT, this will help to ensure appropriate investigations are done. **Complete.**

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

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

Background

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

Aims and objectives

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

Results

True Pneumonia

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

Hospital stay

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

Co-morbidities (COPD, Heart Failure or Asthma

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

comorbidity was COPD.

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

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

Antibiotics
All 48 patients received antibiotics.

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

Good practice identified

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

Identified risks or concerns

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

Conclusions and Lessons learnt

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

The average length of stay was similar between the entire 'coded' cohort and those with 'true' pneumonia - a mean difference of 2 days. This could suggest that incorrectly diagnosed Pneumonia caused Physicians to delay discharge as they monitored for a suitable decrease in the infective markers (WCC and CRP) for pneumonia with antibiotic treatment.

Furthermore, despite 100% of patients receiving antibiotics only 58% had blood cultures taken. This represents a poor initiative in targeted antibiotic therapy. Junior Doctors should be encouraged to take blood cultures in suspected infections and preferably prior to antimicrobial therapy.

In addition, the prevalence of sputum cultures was also disappointing. These results would

allow for targeted sensitive antibiotic therapy, quicker eradication, a quicker drop in white cell count (WCC) and c-reactive protein (CRP) and a quicker relief of symptoms / discharge.

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

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

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

Actions following the audit

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

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

Participation in Clinical Research

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

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

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

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

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

Achievements 2018/19

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

experience. Together these awards attracted £500 and will be utilised to increase our capacity to deliver effective research opportunities for patients

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

Commissioning for Quality and Innovation (CQUIN)

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

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

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

Table 2: CQUIN priorities 2018/19

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

* Awaiting confirmation of outcome from commissioners

Further details of the agreed goals for the following 12 month reporting period are available electronically at: https://www.esht.nhs.uk/wp-content/uploads/2019/05/Commissioning-for-Quality-and-Innovation-CQUIN.pdf

Statements from the Care Quality Commission

East Sussex Healthcare NHS Trust is registered with the Care Quality Commission (CQC) to carry out eight legally regulated activities from 17 registered locations with no conditions attached to the registration. The Trust has not participated in any special reviews or investigations by the CQC in the reporting period.

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

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

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

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

Overall Ratings (Arrows indicate progress since last report)

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

Conquest Hospital

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

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

Eastbourne District General Hospital

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

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

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

Data Quality

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

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

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

NHS Number and General Medical Practice Code Validity

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

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

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

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

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

Data Security & Protection Toolkit attainment levels

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

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

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

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

Clinical Coding Error Rate

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

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

Results of the DSPT Audit

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

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

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

Table 4: Overall Audit Results Summary – November 2018

Primary diagnosis	Secondary diagnosis	Primary procedure	Secondary procedure
97.01%	95.02%	93.79%	92.98%

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

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

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

Learning from Deaths

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

Most deaths are unavoidable and would be considered to be 'expected', however there will be cases where sub-optimal care in hospital may have contributed to the death. The Trust is keen to take every opportunity to learn lessons to improve the quality of care for our patients and families, and is committed to fully implementing the national guidance on learning from deaths.

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

Number of patients who died

Between January and December 2018, 1819 East Sussex Healthcare NHS Trust patients died. Table 5 summarises the number of deaths which occurred in each quarter of that reporting period:

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

Reporting period	Number of deaths
Q4 2017/18: January 2018 to March 2018	624
Q1 2018/19: April 2018 to June 2018	432
Q2 2018/19: July 2018 to September 2018	371
Q3 2018/19: October 2018 to December 2018	392
Total: January 2018 to December 2018	**1819**

Number of case record reviews or investigations

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

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

Reporting period	Number of case record reviews or investigations
Q4 2017/18: January 2018 to March 2018	555
Q1 2018/19: April 2018 to June 2018	414
Q2 2018/19: July 2018 to September 2018	359
Q3 2018/19: October 2018 to December 2018	362

3 representing 0.16% of the patient deaths between January and December 2018 are judged to be more likely than not to have been due to problems in the care provided to the patient. The numbers relating to each quarter is outlined in table 7.

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

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

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

Summary of lessons learnt

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

Clinical Treatment

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

Communication and Documentation

- Poor quality of patient documentation
- Improved communication on handover between wards
- Advance Care Planning and documentation of amendments to these
- Importance of documenting & sharing treatment escalation plans/ceilings of care
- Need for discussion between ITU and patient consultant when ITU admission felt inappropriate by ITU
- Inaccurate image reporting

- Accuracy of cause of death – need for junior to discuss with consultant/senior doctor before completing
- Confusion between palliative care and end of life care.

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

Description of actions taken during 2018/19

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

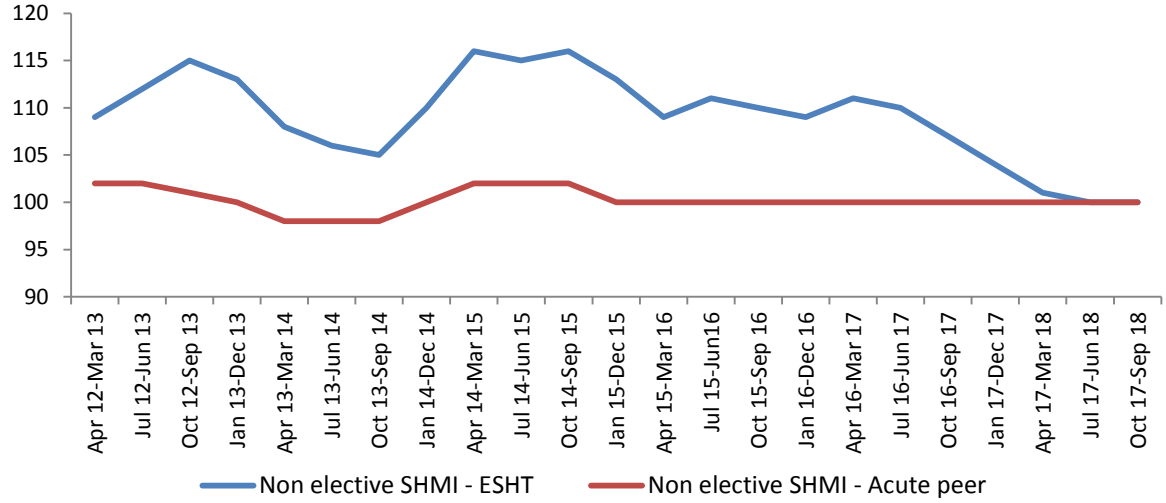
Description of proposed actions to take during 2019/20

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

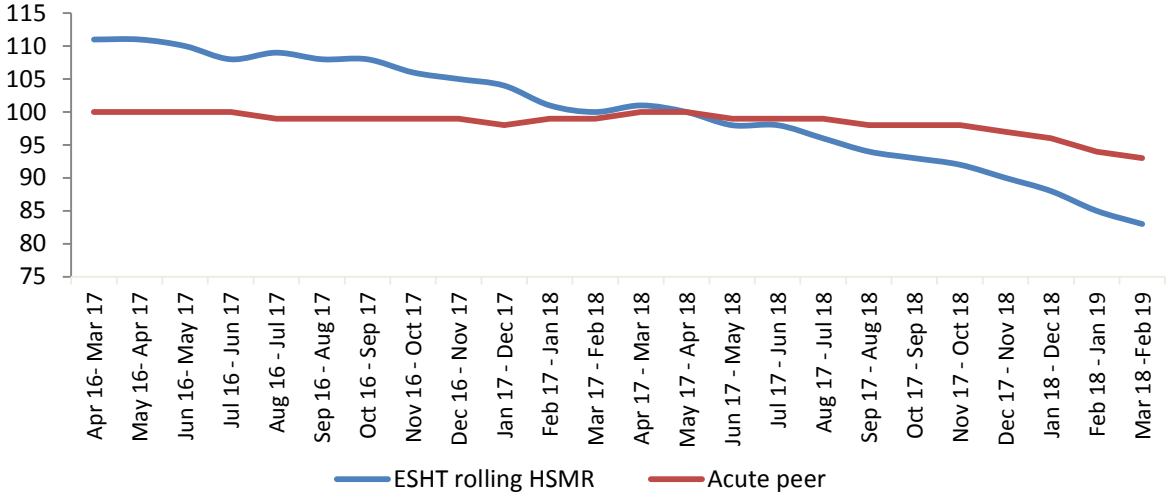
Assessment of the impact of actions taken

Overall the many changes instituted have contributed to a continuing reduction in all the risk adjusted mortality indices, including the Standardised Hospital-level Mortality Indicator (SHMI), Risk Adjusted Mortality Indicator (RAMI), Hospital Standardised Mortality Ratio (HSMR), and in crude mortality (unadjusted for risk factors and co-morbidities). At the same time we have also been able to reduce the average length of stay for patients admitted to the Trust.

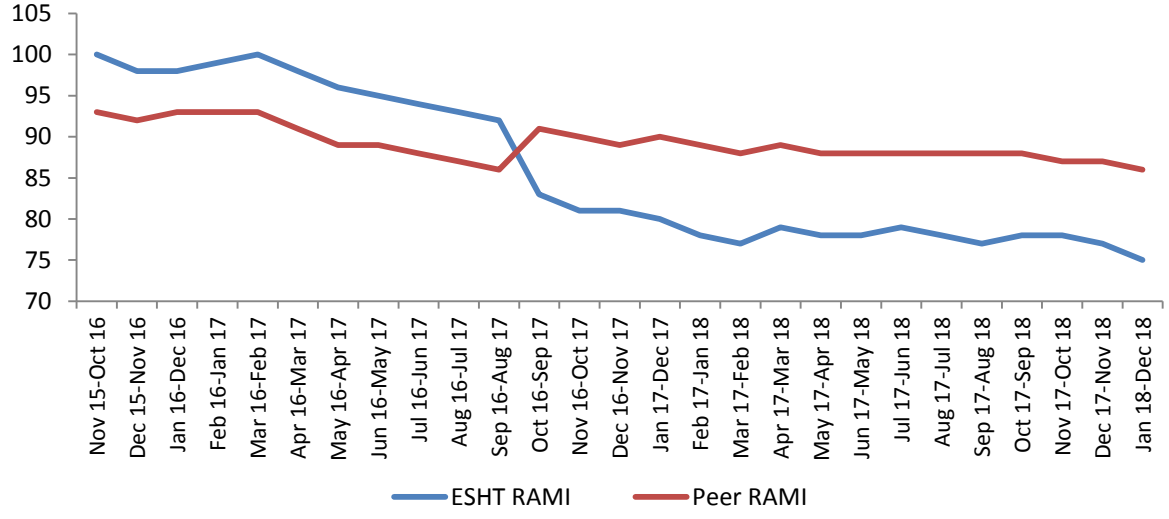
Non-elective SHMI (12 month rolling) to Sep 2018 *(source: CHKS)*



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



RAMI rolling 12 months to Dec 2018 *(source: CHKS)*



Reviews and investigations which relate to deaths in the previous reporting period

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

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

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

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

Seven Day Hospital Services

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

The priority clinical standards are:

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

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

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

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

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

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

Rota Gaps

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

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

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

Table 8: Meetings attended by the GOSWH

Group	Frequency
People and Organisation Development (POD) Group	Quarterly
Trust Local Faculty Group (LFG)	Every 4 months
Oversight Group Meeting	Every 4 months
Junior Doctors Forum	Quarterly
Junior Doctors Inductions	Three times a year
CEO Junior Doctors Forum	Every 4 months
Local Negotiating Committee	Monthly

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

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

Staff who speak up

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

How staff can speak up

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

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

Staff can report something they are concerned about either to:

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

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

How feedback is given to those who speak up

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

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

How we ensure staff who speak up do not suffer detriment

- Fear of reprisal is discussed and it is recognised that it is may not be easy to speak up in certain posts or areas. The Speak Up Guardian reports to the Chief Executive,

and staff are reassured with this reporting line. Any concerns of reprisal would be raised immediately and can be managed down a formal route. Records are made of staff who feel that they have faced reprisal and this is escalated.

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

Staff Survey 2018 Results

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

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

Staff engagement and staff survey

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

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

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

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

Living our Values

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

Leadership Development

In 2017 we launched our Leadership Pathway. The pathway outlines the leadership, management and coaching development provided in the Trust for aspiring, new and experienced leaders from all staff groups and provides continual professional development for those staff in Leadership roles.

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

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

Table 9: Leadership development programmes at ESHT

Programme Name	Number of staff that have attended training
Business Essentials *Focus on budget management, contracting, data and information, business cases and business planning*	51
Management Essentials *Workshop to refocus managers on the basic/essential expectations of their role to promote a common experience of management for all staff across the Trust*	397
First Line Managers *Development of core leadership skills including effective communication as a manager and managing organisational change*	149
Leading Service *Refreshing core and advanced leadership skills including: leading self, leading others, understanding change, leading into the future*	55
Leading Community Together *Aimed at the leads of Community nursing services, covering a range of leadership and management skills*	29
New Managers Orientation *Overview of ESHT 2020 / ESBT strategies, management behaviours, ESHT values, qualities of a manager, knowledge sources for managers*	47
Systems Wide Leadership *Programme 1 – Sussex & East Surrey Systems Leadership Programme* *Programme 2 – OD Practitioner Programme*	20

Health and Wellbeing

The emotional and physical wellbeing of our staff is really important to us and this year we launched our staff Health and Wellbeing strategy which outlines 7 priorities to help us support staff's wellbeing. Some of the work that has taken place so far:

- **Free Health checks for Staff** – The wellbeing team delivered health checks for 1069 eligible staff (aged between 40 and 74).
- **Physical wellbeing** – Staff have been offered the opportunity to improve their physical wellbeing with Pilates, lunch break walks, take a break campaign, staff discount at local fitness centres and support for those staff who want to use healthy alternatives to travel to work.
- **Emotional wellbeing** – All of our staff have access to a range of support including pastoral support, counselling and psychology services Schwartz round and various training events e.g. Compassion without Burnout workshops, Mindfulness.
- **Employee support** – 140 staff have been supported with a range of issues linked to flexible working, childcare and financial wellbeing.

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

Part 3 - Review of Quality Indicators and our Priorities for Improvement in 2018/19

Part 3.1 – Our Priorities for Improvement in 2018/19

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

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

Table 10: Priorities for improvement 2018/19

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

Patient Safety Improvements 2018/19

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

Why we chose this priority

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

Our aims

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

How have we done?

Revised and improved escalation pathway developed and implemented

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

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

To address these challenges, we have introduced the following:

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

to include more clinical areas, and the final version of the TEP was introduced across the Trust at the beginning of April 2019.

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

Reducing cardiac arrests associated with suboptimal management of physiological deterioration

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

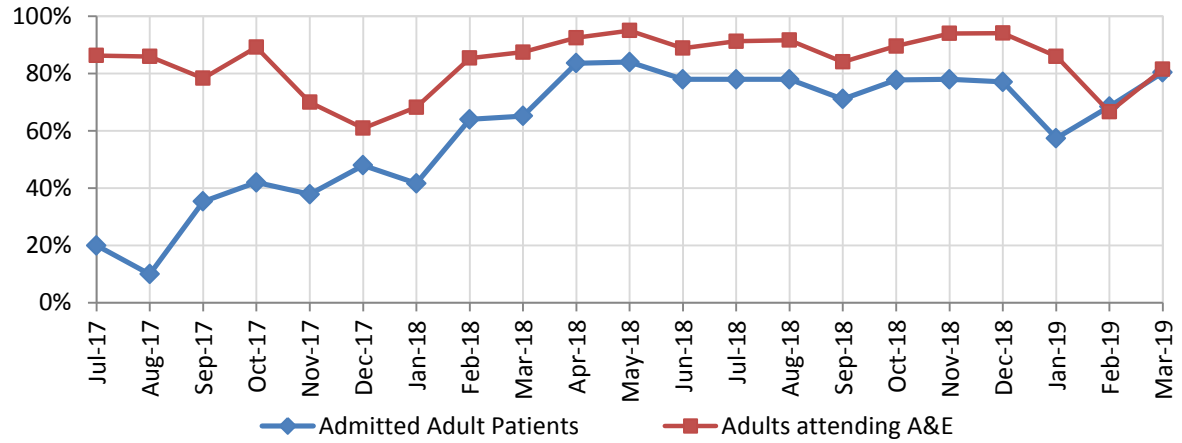
Improving the recognition and management of Sepsis in our acute hospitals

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

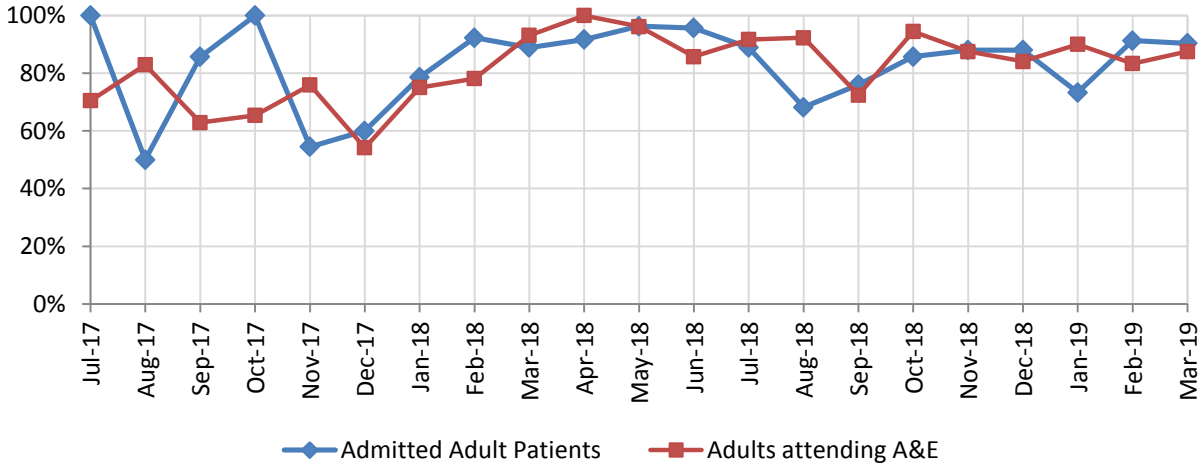
- We reviewed and re-launched our screening tools and clinical guidelines for sepsis.
- We introduced a 'live' audit process to enable more timely feedback for clinical teams on their practice of identifying patients who meet the criteria for sepsis screening in our acute in-patient areas. This live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

As a result of these actions, we have increased the percentage of patients screened for sepsis in our emergency departments and ward areas, and where patients are identified with red flag sepsis, we have increased the percentage of patients who receive antibiotics within 1 hour. This has led to significant improvements in the recognition, diagnosis and treatment of sepsis, which has also positively impacted on reducing our mortality rates related to sepsis at ESHT.

Percentage (%) of eligible patients that were screened for sepsis



Percentage (%) of patients with sepsis who receive antibiotics within 1 hour of diagnosis



Revised and improved AKI pathway

A snapshot clinical audit completed in October 2018 identified several areas for improvement in the recognition and management of AKI. The results of the audit guided us to introduce the following improvements:

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

Further improvements identified for 2019/20

Whilst the TEP has been implemented within the Trust embedding a new process into clinical practice can take some time and changing the behaviour regarding planning for

escalation may also be challenging. This is why we have identified the embedding of the TEP process as a key priority for the Trust in 2019/20, which has been outlined earlier in this report.

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

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

2. Continue to reduce the number of avoidable falls

Why we chose this priority

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

Our aims

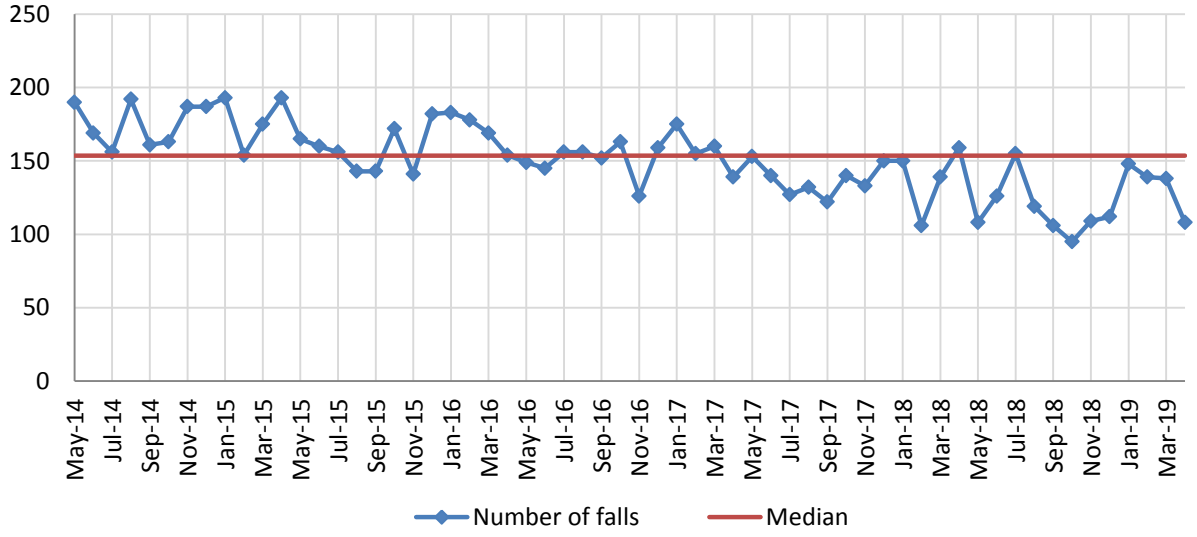
- Meet the challenging target of no more than 5 falls per 1,000 bed days compared with 5.6 in 2017/18
- Continue to reduce the total number of falls occurring within the Trust from the 1,624 reported in 2017/18

How have we done?

Throughout 2018/19, the Trust falls rate has averaged at 5.8 falls per 1,000 bed days, ranging from a high of 6.89 falls per 1,000 bed days in April 2018, to a low of 4.51 falls per 1,000 bed days in October 2018. Although we have not achieved our ambitious target of having no more than 5 falls per 1,000 bed days, or reduced our average falls rate compared with 2017/18, we have seen:

- A decline in the total number of falls incidents in 2018/19 compared with previous years. During 2018/19 there were a total of 1,514 falls incidents reported on the Trust Datix incident reporting system. This is a reduction from the 1,624 reported falls during the previous fiscal year (2017/18).
- A significant reduction in the number of serious incidents relating to falls (9 serious incidents relating to falls in 2018/19 compared with 19 in 2017/18).

Falls Incidents May 2014 - Apr 2019



Throughout 2018/19 we have introduced the following:

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

divisions and is also shared widely at the Falls Steering Group which has representation Trustwide.

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

Further improvements identified for 2019/20

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

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

Why we chose this priority

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

Our aims

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

How have we done?

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

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

Table 11: Number of PUs by with contributory lapses

Reporting period	Category 3	Category 4	Total
Q1 2018/19: April 2018 to June 2018	1	0	1
Q2 2018/19: July 2018 to September 2018	1	0	1
Q3 2018/19: October 2018 to December 2018	0	1	1
Q4 2018/19: January 2019 to March 2019	0	0	0
Total	**2**	**1**	**3**

Our improvement plan included the following actions:

Understanding the key themes and sharing learning

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

Training, education and improving awareness

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

Measuring for improvement

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

Further improvements identified for 2019/20

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

Clinical Effectiveness Improvements 2018/19

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

Why we chose this priority

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

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

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

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

Our aims

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

How have we done?

In November 2018, NHSE and NHSI introduced a new measurement system and process for providers to self-assess compliance against the 7DS standards. Overall ESHT has met the standard for access to consultant-directed diagnostics (standard 5). However the Trust self-assessment from February 2019 also indicates that the Trust had not fully met the standards for initial consultant assessment (standard 2), access to interventions (standard 6), and ongoing consultant-directed review (standard 8).

Standard 2 – time to first consultant review

- Our self-assessment of compliance against standard 2 indicated that the Trust was not fully compliant overall. Although the Trust has arrangements in place across our medical and surgical specialities to deliver first consultant review within 14 hours during weekdays, the formalised arrangements for consultant cover in a number of surgical specialities currently provide insufficient cover to consistently deliver review within 14 hours at weekends.
- To assist with monitoring compliance against the standards at ESHT, we have monitored delivery against standard 2, the time to first consultant review within 14 hours, by ward, on a monthly basis as part of our Excellence in Care programme. The overall compliance rate for November – February has been 91-92%, with a further increase in March to 96%. However, we are currently unable to confirm that performance over Saturday – Sunday is at the same level as that for Monday – Friday. Data collected from Excellence in Care highlights a number of areas where we could make improvements, and we are using this information to target our interventions. From May 2019 this data will allow comparison of performance on weekday and weekend admissions.

Standard 5 – Access to consultant-directed interventions

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

Standard 8 – Ongoing consultant-directed review

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

Further improvements identified for 2019/20

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

Additionally:

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

5. Continued implementation of the Excellence in Care Programme

Why we chose this priority

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

Our aims

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

How have we done?

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

Further improvements identified for 2019/20

The Excellence in Care dashboard is now being used regularly by our clinical teams to monitor performance and compliance with clinical standards. However we recognise that improvements could be made to refine and streamline the amount and type of information

that is generated, so that it is an effective tool for clinical teams to monitor consistency of care and identify areas for improvement. This is why we have identified the continued implementation and development of Excellence in Care as a priority for the Trust in 2019/20.

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

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

Why we chose this priority

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

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

Our aims

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

How have we done?

- A new bedside booklet has been produced on 'Information about your stay in hospital'
- Following the result of the 2017 National Inpatient Survey results, the Trust inpatient survey was amended to include the questions which had scored lower in the national survey in order to capture more local results

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

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

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

Further improvements identified for 2019/20

Admissions, transfer and discharge policy to be reviewed in 2019/20, in collaboration with ESCC to reflect the system-wide Let's Get You Home policy

7. Continue to improve End of Life care by improving processes and documentation

Why we chose this priority

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

Our aims

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

How have we done?

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

To support the roll out and embedding of ReSPECT, we have:

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

Our strategy for End of Life Care has been developed with our partners, and includes a specific End of Life Care Strategy for Neonates, Children and Young People. We have

established an End of Life Care Improvement Group to take forward our improvements, and over the past year we have:

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

Further improvements identified for 2019/20

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

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

8. Improving the experience of young people in hospital

Why we chose this priority

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

- Were there enough things for you to do in hospital?
- Did hospital staff play with you or do any activities with you while you were in hospital?
- When the hospital staff spoke with you, did you understand what they said?
- Did the hospital staff answer your questions?
- Was it quiet for you to sleep when needed in the hospital?
- If you had any worries, did a member of staff talk with you about them?
- Before the operations or procedures, did hospital staff explain to you what would be done?
- Afterwards, did staff explain to you how the operation or procedures had gone?
- If you wanted, were you able to talk to a doctor or nurse without your parents or carer being there?

In 2018/19, we committed to undertake engagement events and communications to consult with young people and their families around what can be done to improve the experience they have.

Our aims

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

How have we done?

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

Based on feedback we have received from young people, we have introduced the following:

- Games consoles are now available in our inpatient areas, that can be used by the bedside if requested.
- The recently redesigned playroom on the children's (Kipling) ward includes a specific area for young people.

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

Further improvements identified for 2019/20

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

Part 3.2 - Sign up to Safety pledges

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

Our progress and achievement for these areas is outlined below:

Sign up to Safety – Reduce patient falls

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

Sign up to Safety – Reduce pressure ulcers

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

Sign up to Safety - Improving Sepsis recognition and treatment

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

Sign up to Safety - Duty of Candour (DoC)

Our ambitious goal for 2018/19 was to achieve 100% of verbal and written feedback. At the time of the writing the report the Trust is reviewing the duty of candour data collection and

completing an audit. Therefore the trust does not have accurate information to report for 2018/19.

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

Sign up to Safety - Reduced mortality rates

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

Sign up to Safety - Improve patient experience

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

Sign up to Safety 2019/20

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

Part 3.3 – Review of our Quality Indicators

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

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

Patient Safety Indicators

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

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

Indicator	ESHT 15/16	ESHT 16/17	ESHT 17/18	ESHT 18/19 (April 2018 to Dec 2018)	National average (Acute Trusts)	Best performer (Acute Trusts)	Worst performer (Acute Trusts)
Percentage of admitted patients risk-assessed for Venous Thromboembolism (VTE)	96.30%	96.77%	95.83%	**95.83%**	95.20%	100.00%	77.80%

Source: NHS Digital

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

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

- VTE Risk Assessment is embedded and continues to be reported nationally on a quarterly basis

Rate of C. Difficile Infection

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

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

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

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

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

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

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

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

Indicator – NRLS Data	ESHT 16/17	ESHT 17/18	ESHT 18/19	National average	Best performer	Worst performer
	01/04/16 – 30/09/16	01/04/17 – 30/09/17	01/04/18 – 30/09/18			
Rate of patient safety incidents reported per 1,000 admissions	59.97 (7503 incidents reported)	43.02 (5339 incidents reported)	40.68 (4870 incidents reported)	Rate not provided by NRLS (average of 5458 incidents reported)	51.9 (23692 incidents reported)	13.1 (556 incidents reported)
% of patient safety incidents reported that resulted in severe harm or death – This is the National and Reporting and Learning System Data between 01/04/2017 and 30/09/2017	Severe 0.2% (12 incidents)	Severe 0.13% (7 incidents)	Severe 0.23% (11 incidents)	Severe 0.2%	Severe 0.3%	Severe 0.5%
	Death 0.03% (2 incidents)	Death 0.0% (no incidents)	Death 0.02% (1 incident)	Death 0.1%	Death 0.1%	Death 0.0%

Source: NHS Digital

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

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

Clinical Effectiveness Quality Indicators

Summary Hospital-level Mortality Indicator (SHMI)

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

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

Indicator	ESHT Oct 12 - Sep 13	ESHT Oct 13 - Sep 14	ESHT Oct 14 - Sep 15	ESHT Oct 15 - Sep 16	ESHT Oct 16 - Sept 17	ESHT Oct 17 - Sep 18
SHMI value	1.14	1.08	1.15	1.10	1.07	1.00
Banding	1 (higher than expected)	2 (as expected)	1 (higher than expected)	2 (as expected)	2 (as expected)	2 (as expected)
% of patient deaths with palliative care coding by speciality and/or diagnosis	18.2	22.4	18.1	18.8	20.2	29.9

Source: NHS Digital

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

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

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

- Providing timely senior decision making at ward level through multidisciplinary daily board rounds, led by the consultant.
- Improving handover for acute teams. We have also purchased Nerve Centre: a handover, task allocation, and patent tracking tool. The first components of this are currently being introduced and others rolled out across the hospitals.
- Increasing recognition of frailty, with specific documentation of this in the Integrated Patient Document (IPD).
- Implementing a 24/7 acute GI bleeding service, which will be fully operational from mid-April 2019.
- VitalPAC is used across acute inpatient areas to identify patients whose observations are deteriorating. The system is used to record and share the information ensuring clinicians have full visibility of a patient's observations and can respond at the earliest opportunity. The system will be upgraded in July 2019 with new functionality available including NEWS2, fluid management charts and falls assessment.
- The Trust's Deteriorating Patient Improvement Group (DPIG) is working on improved documentation of agreed interventions for frail patients with multiple comorbidities, with clarity on ceilings of care and treatment escalation.
- We continue to track and review all benchmarked mortality indicators, trends and themes in other mortality and quality data on a monthly basis through the Trust Mortality Review Group (MRG). Actions or investigations are taken or recommended when there is variation or any concern identified.
- Overview of Trust mortality indicators is provided by the Clinical Outcome Group (COG) which is chaired by the Medical Director. The group also drives improvement in a number of workstreams to improve outcomes for patients.
- An additional quarterly review group reviews the case notes of all deaths graded at M&M review as having poor quality of care, deaths involving serious clinical incidents or complaints, to re-assess avoidability and promote learning.
- We are moving to an independent Medical Examiner system in 2019, as recommended by the Royal College of Physicians (RCP) and the Department of Health (DOH).
- The Trust Board is sighted on our mortality performance with formal quarterly reporting, including the number of avoidable deaths.
- Improving clinical coding of patient information to ensure mortality indicators are based on accurate clinical information.

Patient Reported Outcome Measures /Scores (PROMS)

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

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

NHS England undertook a consultation on the national PROMs programme in 2016. As a result of the findings of that consultation, NHS England has now taken the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections.

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

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

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

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

- Reviewing and sharing the data through our divisional Quality and Governance mechanisms.

Emergency readmissions to hospital within 28 days of discharge

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

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

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

Source: NHS Digital

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

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

Patient and Staff Experience Indicators

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

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

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

Source: https://www.england.nhs.uk/publication/friends-and-family-test-data-november-2018/ https://www.england.nhs.uk/fft/friends-and-family-test-data/fft-data-historic/

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

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

- We continue our aim to achieve to a minimum 50% overall response rate for inpatients. This was a challenge during our changeover of systems.

Our Emergency Departments have taken the following actions:

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

Responsiveness to inpatients' personal needs

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

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

*CQC National Inpatient survey was published in June 2018.

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

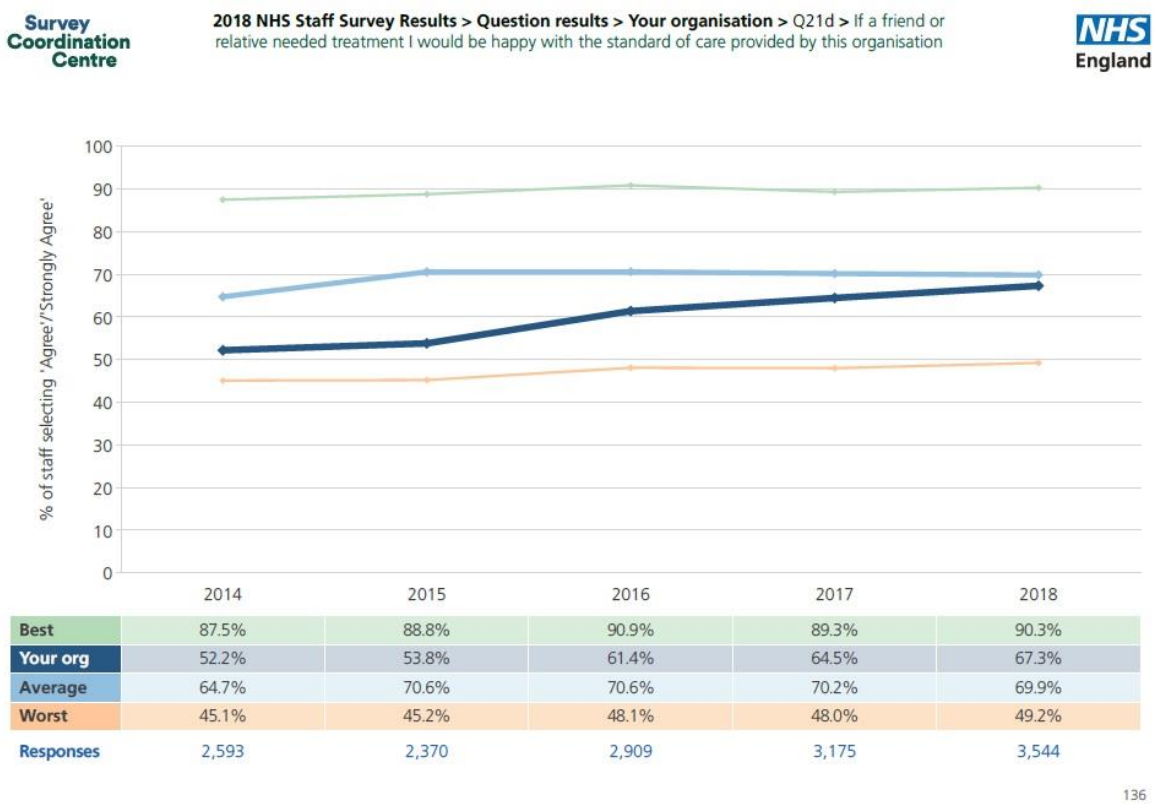
- For the 2017 results, the questions with the lowest scores were reviewed and added to the Trusts inpatient survey to gain further data
- The results of the 2017 survey was provided to teams for areas of improvement to be addressed
- The results were used alongside other feedback as part of the data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

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

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

Indicator	ESHT 2015	ESHT 2016	ESHT 2017	ESHT 2018	National average *For acute and community Trusts*	Best performer	Worst performer
Percentage of staff who would recommend the Trust to friends or family needing treatment	54%	62%	65%	67.3%	69.9%	90.3%	42.2%

Source: NHS Digital



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

- Analysing the NHS Staff Survey results and using the information to identify key priorities for the whole organisation to focus on. To deliver those priorities effectively

across the Trust, each division was tasked to create and implement action plans, giving local control and enabling staff to make effective change.

- Using staff FFT results as a source of intelligence to inform and signpost to areas for improvement in staff working life, wellbeing, conditions and work environment. Staff responses are also monitored three times a year through an internal mechanism.
- Launching a Leadership Pathway to develop and support aspiring, new and experienced leaders from all staff groups, including providing continual professional development for those staff in leadership roles.
- The Staff Engagement and Wellbeing Team are working with the Strategy, Innovation and Planning Team to promote Quality Improvement (QI) sessions aimed at all members of staff, to increase awareness and develop capability for continuous improvement across the Trust.

Annexes

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

Statement from Commissioners

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

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

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

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

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

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

- All relevant recommendations into the "Gosport War Memorial Hospital: The Report of the Gosport Independent Panel (2018)" are reviewed and implemented where required;

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

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

Yours sincerely

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

Statement from Healthwatch East Sussex

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

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

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

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

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

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

A further area HWES is keen to strengthen for the future is the relationship and engagement with the executive board and non-executive members and looks forward to progressing these discussions in 2019/2020.

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

HOSC has welcomed the Trust's positive engagement with the Committee as evidenced by the attendance of the Chief Executive and other senior officers at each meeting.

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

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

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

2018/19 Quality Priorities

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

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

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

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

2019/20 Quality Priorities

It is reassuring to see continuity in quality priorities, with three of the four priorities having been brought forward from 2018/19. The Committee also welcomes the fact that the quality priorities are based on a Quality and Safety Strategy designed to realise the ambition to become an outstanding organisation by 2020. This shows that the trust is operating with focus and a clear goal in mind.

In terms of individual quality priorities, the embedding of the new Treatment Escalation Plan (TEP) and ReSPECT tools into clinical practice across the trust are welcomed as they will help to raise a better, more consistent offer of care to patients from ESHT clinicians.

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

HOSC looks forward to working with the Trust over the coming year and will continue to monitor progress on behalf of local people.

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

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

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

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

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

By order of the Board

Dr Adrian Bull
Chief Executive

24 June 2019

Steve Phoenix
Chairman

24 June 2019

Annex 3: Independent Practitioner's Limited Assurance Report on the Quality Account

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

Scope and subject matter

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

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

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

Respective responsibilities of the directors and Practitioner

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

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

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

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

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period 1 April 2018 to 24 June 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 24 June 2019;
- feedback from commissioners dated 06/06/2019;
- feedback from local Healthwatch organisations dated 04/06/2019;
- feedback from the Overview and Scrutiny Committee dated 29/05/2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated June 2019;
- the national patient survey dated 14/06/2019;
- the national staff survey dated 27/02/2019;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 15/05/2019;
- the annual governance statement dated 24/05/2019; and
- the Care Quality Commission's inspection report dated 06/06/2018.

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

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

This report, including the conclusion, has been prepared solely for the Board of Directors of East Sussex Healthcare NHS Trust. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the

fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and East Sussex Healthcare NHS Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

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

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

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

Our audit work on the financial statements of East Sussex Healthcare NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as East Sussex Healthcare NHS Trust’s external auditors. Our audit reports on the financial statements are made solely to East Sussex Healthcare NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to East Sussex Healthcare NHS Trust’s directors those

matters we are required to state to them in an auditor's report and for no other purpose. Our audits of East Sussex Healthcare NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than East Sussex Healthcare NHS Trust and East Sussex Healthcare NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Basis for qualified conclusion

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

- Validity and Accuracy – Our testing identified one case which had been incorrectly excluded from the numerator as risk assessments had been completed in the patient notes, but had not been recorded as compliant on PAS.
- Validity and Accuracy – Our testing identified one case which had been incorrectly included in the numerator as it should have been recorded as non-compliant because the assessment had not been completed within 24 hours.

Qualified conclusion

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

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

Grant Thornton UK LLP

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Chartered Accountants

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Crawley

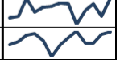
RH10 1HS

25 June 2019

Appendices

Appendix 1 – Integrated Performance Report

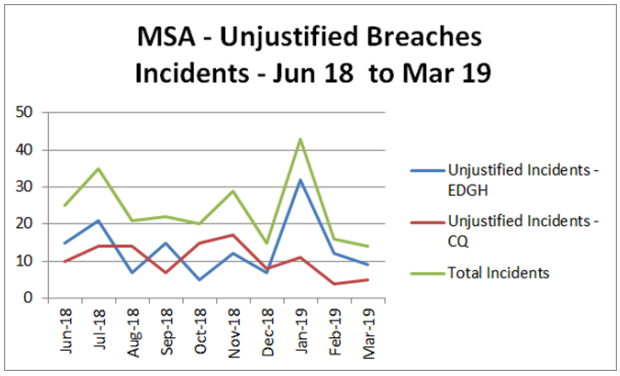
Safety and Quality

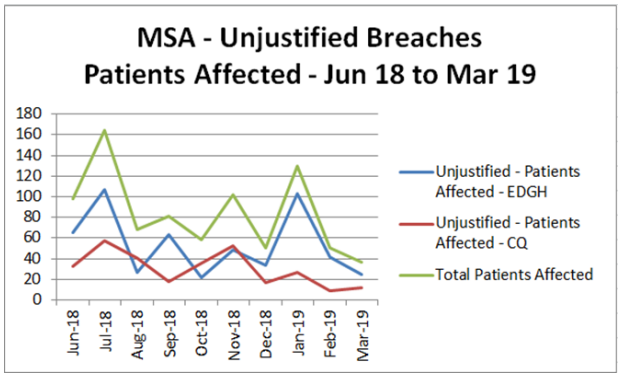
Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Mar-18	Mar-19	Var	2017/18	2018/19	Var		
Total falls	M	137	140	2.2%	1612	1508	-6.5%	126	
Number of no-harm falls	M	109	105	-3.7%	1200	1109	-7.6%	92	
Number of minor/moderate falls	M	27	35	29.6%	402	391	-2.7%	33	
Number of major/catastrophic falls	0	1	0	-1	10	8	-2	1	
All patient falls per 1000 Beddays	5.5	5.4	6.3	0.9	5.7	5.7	0.01	5.5	
All patient falls with harm per 1000 Beddays		1.1	1.6	0.5	1.5	1.5	0.05	1.4	
Falls assessment compliance	M	69.3%	95.4%	26.1%	83.5%	91.9%	8.3%	91.9%	
Total grade 2 to 4 pressure ulcers per 1000 Beddays	M	2.3	1.9	-18.9%	2.1	2.2	3.6%	2.2	
Number of grade 2 pressure ulcers	M	58	41	-29.3%	556	562	1.1%	47	
Number of grade 3 to 4 pressure ulcers	M	1	1	0	35	10	-25	1	
Pressure ulcer assessment compliance	M	73.1%	89.8%	16.7%	82.2%	82.6%	0.4%	82.6%	
VTE Assessment compliance	95.0%	95.4%	96.5%	1.1%	95.3%	95.9%	0.5%	95.9%	

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Mar-18	Mar-19	Var	2017/18	2018/19	Var		
Number of MRSA Cases	0	0	1	1	3	2	-1	0	
Number of Cdiff cases	4	3	2	-1	34	51	17	4	
Number of MSSA cases	M	0	4	4	9	18	9	2	
Emergency Re-Admissions within 30 days	10.0%	10.5%	9.9%	-0.6%	10.1%	10.8%	0.6%	10.8%	
Crude Mortality Rate	M	2.1%	1.5%	-0.6%	1.7%	1.4%	-0.3%	1.3%	

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Mar-18	Mar-19	Var	2017/18	2018/19	Var		
Number of Serious Incidents	M	5	4	-1	47	45	-2	4	
Number of Never Events	0	0	0	0	4	1	-3	0	
Number of medication administration incidents	M	41	34	-17.1%	431	373	-13.5%	31	

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Mar-18	Mar-19	Var	2017/18	2018/19	Var		
Inpatient FFT response rate	45.0%	43.3%	48.7%	5.4%	40.3%	44.1%	3.8%	44.1%	
Inpatient FFT score	96.0%	97.2%	97.5%	0.4%	97.2%	97.5%	0.3%	97.5%	
A&E FFT response rate	22.0%	3.9%	6.8%	2.9%	8.4%	5.3%	-3.1%	5.3%	
A&E FFT score	88.0%	86.4%	90.7%	4.3%	89.5%	92.5%	3.0%	92.5%	
Outpatient FFT Score	M	96.0%	96.2%	0.2%	96.7%	97.5%	0.8%	97.5%	
Maternity FFT response rate	45.0%	21.5%	16.9%	-4.6%	32.3%	14.7%	-17.6%	14.7%	
Maternity FFT score	96.0%	96.6%	97.4%	0.8%	98.3%	97.2%	-1.2%	97.2%	





Access and Delivery

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Mar-18	Mar-19	Var	2017/18	2018/19	Var		
Four hour standard	95.0%	85.4%	93.1%	7.7%	87.5%	90.9%	3.5%	90.9%	
A&E Minor Performance	98.0%	97.3%	98.6%	1.2%	97.6%	98.9%	1.3%	98.9%	
Four hour standard (Local System)	95.0%	89.3%	94.7%	5.4%		93.0%			
12 Hour DTAs	0	0	0	0	0	0	0	0	
Unplanned re-attendance to Emergency Department	5.0%	2.8%	3.5%	0.7%	2.8%	3.5%	0.7%	3.5%	
% Patients waiting less than 15 minutes for assessment in ED	M	83.2%	84.1%	0.9%	82.7%	85.8%	3.1%	85.8%	
% Patients waiting less than 60 minutes for treatment in ED	M	45.0%	44.6%	-0.4%	46.2%	47.6%	1.4%	47.6%	
% Patients waiting less than 120 minutes for treatment in ED	M	74.9%	78.1%	3.2%	75.8%	79.7%	3.9%	79.7%	
% Patients that left without being seen in ED	M	2.6%	1.7%	-0.9%	1.8%	2.1%	0.3%	2.1%	
% Patients admitted from ED (Conversion rate)	M	31.4%	32.2%	0.8%	29.1%	30.2%	1.0%	30.2%	
Emergency Department attendances	M	10571	11387	7.7%	118846	129380	8.9%	10782	
Ambulance conveyances	M	3388	3344	-1.3%	38731	38447	-0.7%	3204	

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Mar-18	Mar-19	Var	2017/18	2018/19	Var		
RTT Incomplete standard	92.0%	89.9%	91.2%	1.3%	91.2%	89.9%	-1.3%	89.9%	
RTT Backlog (Number of patients waiting over 18 weeks)	M	2839	2381	-458	2839	2381	-458	2832	
RTT Total Waiting List Size	28221	28221	27157	-1064	28221	27157	-1064	28128	
RTT 52 week waiters	0	0	0	0	2	0	-2	0	
RTT 35 week waiters	M	213	158	-25.8%	213	158	-25.8%	181	

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Feb-18	Feb-19	Var	2017/18	2018/19	Var		
Cancer 2WW Standard	93.0%	96.4%	96.3%	0.0%	96.0%	94.0%	-2.0%	94.1%	
Cancer 62 day urgent referral standard	85.0%	76.6%	80.3%	3.8%	75.9%	72.4%	-3.5%	72.8%	
Cancer 2WW Standard (breast symptoms)	93.0%	97.7%	97.8%	0.1%	95.8%	95.9%	0.0%	95.8%	
Cancer 31 day standard	96.0%	99.3%	98.4%	-0.8%	97.2%	94.7%	-2.5%	94.9%	
Cancer 31 day subsequent drug treatment	98.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Cancer 31 day subsequent surgery	94.0%	100.0%	100.0%	0.0%	98.6%	86.8%	-11.8%	88.0%	
Cancer 62 day screening standard	90.0%	40.0%	83.3%	43.3%	68.3%	68.5%	0.1%	66.1%	

Activity and Effectiveness

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Mar-18	Mar-19	Var	2017/18	2018/19	Var		
Emergency Department attendances	M	10571	11387	7.7%	118846	129380	8.9%	10782	
Ambulance conveyances	M	3388	3344	-1.3%	38731	38447	-0.7%	3204	
Elective spells	M	656	585	-10.8%	7246	6635	-8.4%	553	
Day Cases	M	3868	4104	6.1%	46941	47357	0.9%	3946	
Elective Beddays	M	2081	1714	-17.6%	19581	20203	3.2%	1684	
Total Non-Elective Spells	M	4909	5076	3.4%	51075	56057	9.8%	4671	
Number of Emergency spells	M	4270	4490	5.2%	43709	48987	12.1%	4082	
Number of Maternity spells (ante and post partem)	M	344	316	-8.1%	3973	3745	-5.7%	312	
Number of other non-elective spells (Births/Transfers from other hospitals)	M	295	270	-8.5%	3393	3325	-2.0%	277	
Non-Elective beddays	M	23433	20404	-12.9%	263310	243715	-7.4%	20310	
LOS									
Elective Average Length of Stay	M	3.2	2.9	-0.2	2.7	3.0	0.3	3.0	
Non-Elective Average Length of Stay	M	4.9	4.1	-0.8	5.2	4.4	-0.8	4.4	
Inpatient Average Length of Stay at intermediate care units	M	31.6	25.3	-6.3	28.4	25.3	-3.1	25.3	

Leadership and Culture

TRUST													
WORKFORCE CAPACITY	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend line
Budgeted fte	6,859.1	7,060.0	6,981.2	6,993.4	7,031.1	6,941.3	6,914.1	6,915.7	6,915.1	6,906.1	7,031.9	7,033.8	7,033.8	
Total fte usage	6,875.5	6,910.5	6,681.7	6,707.4	6,755.4	6,667.0	6,679.1	6,622.4	6,737.3	6,655.5	6,575.2	6,682.6	6,841.9	
Variance	16.4	-149.5	-299.5	-286.0	-275.7	-274.3	-235.0	-293.3	-177.8	-250.6	-456.7	-351.2	-191.9	
Substantive vacancies	527.6	644.6	605.2	651.3	663.5	641.2	611.9	576.4	556.6	595.9	693.2	659.1	641.4	
Fill rate	92.2%	90.5%	91.0%	90.4%	90.3%	90.5%	90.9%	91.4%	91.7%	91.1%	89.8%	90.3%	90.6%	
Bank fte usage (as % total fte usage)	9.1%	10.1%	7.3%	8.1%	8.3%	7.8%	8.1%	6.8%	7.9%	7.6%	7.7%	7.1%	8.9%	
Agency fte usage (as % total fte usage)	1.9%	1.6%	1.9%	1.8%	1.7%	1.6%	1.4%	1.2%	1.4%	1.2%	1.2%	1.5%	1.5%	
Turnover rate	11.0%	10.9%	11.0%	10.9%	11.1%	11.0%	10.8%	10.7%	11.0%	11.1%	11.1%	10.9%	10.9%	
Stability rate	92.7%	92.1%	91.9%	89.5%	92.0%	92.0%	91.8%	91.4%	91.0%	90.9%	89.8%	91.1%	91.3%	
SICKNESS ABSENCE														
Annual sickness rate	4.5%	4.5%	4.5%	4.5%	4.4%	4.4%	4.4%	4.4%	4.4%	4.3%	4.2%	4.3%	4.2%	
Monthly sickness rate (%)	4.1%	3.6%	3.7%	3.5%	3.8%	3.9%	4.2%	4.4%	4.6%	4.4%	4.7%	4.6%	4.0%	
Short term sickness (<28 days)	57.5%	45.9%	42.8%	46.0%	41.2%	45.0%	42.6%	50.1%	55.1%	51.3%	60.7%	59.1%	52.0%	
Monthly long term sickness (28 days+)	42.5%	54.1%	57.2%	54.0%	58.8%	55.0%	57.4%	49.9%	44.9%	48.7%	39.3%	40.9%	48.0%	
MANDATORY TRAINING & APPRAISALS														
Appraisal rate	79.6%	79.5%	79.2%	78.1%	78.2%	79.7%	80.1%	79.5%	80.6%	81.3%	80.9%	79.8%	79.5%	
Fire	86.6%	86.2%	87.4%	87.1%	86.6%	87.6%	87.2%	88.2%	87.9%	87.2%	87.5%	87.2%	87.3%	
Moving & Handling	90.1%	89.4%	89.9%	89.8%	88.7%	89.2%	89.2%	90.2%	90.4%	90.3%	91.1%	91.2%	91.9%	
Induction	94.8%	94.4%	95.0%	94.3%	94.8%	96.2%	95.5%	91.3%	90.8%	91.1%	92.0%	92.1%	92.2%	
Infec Control	90.2%	89.9%	90.5%	90.1%	89.6%	90.0%	89.7%	90.9%	91.0%	91.0%	90.7%	90.6%	91.4%	
Info Gov	86.3%	85.8%	85.1%	83.8%	84.7%	84.0%	82.5%	82.0%	80.5%	79.3%	79.1%	76.2%	77.4%	
Health & Safety	88.0%	88.8%	89.1%	88.6%	89.4%	88.7%	88.2%	88.3%	87.6%	88.2%	87.6%	88.0%	88.3%	
MCA	95.8%	95.8%	96.1%	96.1%	96.5%	96.5%	95.7%	95.7%	95.1%	95.6%	95.6%	95.5%	95.6%	
DoLs	96.4%	96.4%	96.8%	96.9%	97.2%	96.7%	94.9%	94.9%	93.9%	94.4%	95.0%	95.0%	95.4%	
Safeguarding Vulnerable Adults	84.7%	84.2%	85.8%	86.0%	86.7%	86.6%	86.3%	87.2%	86.8%	87.2%	87.6%	87.5%	87.7%	
Safeguarding Children Level 2	85.3%	84.7%	86.4%	87.4%	87.6%	87.8%	87.5%	88.2%	88.0%	88.4%	88.5%	87.3%	88.3%	

Appendix 2 – National Clinical Audit and National Confidential Enquiries Programme

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

National Confidential Enquiries	**ESHT Eligible**	**ESHT Participation**
Maternal, newborn and infant and perinatal mortality (MBRRACE-UK)	**Y**	**Y**
Child Health Clinical Outcome Review Programme	**Y**	**Y**
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Pulmonary Embolism	**Y**	**Y**
NCEPOD - Perioperative Management of Diabetes	**Y**	**Y**
NCEPOD - Acute Bowel Obstruction	**Y**	**Y**
National Clinical Audit	**ESHT Eligible**	**ESHT Participation**
Adult Community Acquired Pneumonia	**Y**	**Y**
Mandatory Surveillance of Bloodstream Infections and C. Diff infection	**Y**	**Y**
National Audit of Care at the End of Life	**Y**	**Y**
National Audit of Dementia	**Y**	**Y**
National Audit of Intermediate Care	**Y**	**Y**
National Audit of Seizures and Epilepsies in Children & Young People (Epilepsy 12)	**Y**	**Y**
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	**Y**	**Y**
National Maternity and Perinatal Audit (NMPA)	**Y**	**Y**
Neonatal Intensive and Special Care (NNAP)	**Y**	**Y**
Adult Critical Care Audit (Case mix programme - ICNARC)	**Y**	**Y**
Falls and Fragility Fractures Audit Programme (FFFAP) – Fracture Liaison Service Database	**Y**	**Y**
FFFAP – Inpatient Falls	**Y**	**Y**
FFFAP – National Hip Fracture Database	**Y**	**Y**
National Joint Registry (NJR)	**Y**	**Y**
National Gastrointestinal Cancer Audit Programme	**Y**	**Y**
National Audit of Breast Cancer in Older Patients (NABCOP)	**Y**	**Y**
National Prostate Cancer Audit	**Y**	**Y**
National Lung Cancer Audit (NLCA)	**Y**	**Y**
Surgical Site Infection Surveillance Service	**Y**	**Y**
Major Trauma (TARN)	**Y**	**Y**
National Audit of Coronary Angioplasty / PCI	**Y**	**Y**
Cardiac Rhythm Management (CRM)	**Y**	**Y**
National Heart Failure Audit	**Y**	**Y**
Acute Coronary Syndrome / Acute MI Audit (MINAP)	**Y**	**Y**
National Audit of Cardiac Rehabilitation	**Y**	**Y**
National Cardiac Arrest Audit (NCAA)	**Y**	**Y**
National Inflammatory Bowel Disease Programme	**Y**	**Y**
National Emergency Laparotomy Audit (NELA)	**Y**	**Y**
Elective Surgery (National PROMs Programme)	**Y**	**Y**
National Paediatric Diabetes Audit (NPDA)	**Y**	**Y**
National Pregnancy in Diabetes (NPID) Audit	**Y**	**Y**
National Adult Diabetes Inpatient Audit (NADIA)	**Y**	**Y**
NADIA Harms Audit	**Y**	**Y**
National Diabetes Foot Care Audit (NDFA)	**Y**	**Y**
National Diabetes Adult Audit	**Y**	**Y**

National Diabetes Transition Audit	**Y**	**Y**
Stroke National Audit (SSNAP)	**Y**	**Y**
Learning Disability Mortality Review Programme (LEDER)	**Y**	**Y**
Seven Day Services self-assessment survey	**Y**	**Y**
National COPD Audit Programme - Pulmonary Rehabilitation	**Y**	**Y**
National COPD Audit Programme - Secondary Care	**Y**	**Y**
National COPD Audit Programme – Adult Asthma	**Y**	**Y**
Non-Invasive Ventilation – Adults	**Y**	**Y**
Management of Massive Haemorrhage (Blood Transfusion Programme)	**Y**	**Y**
Serious Hazards of Transfusion (SHOT)	**Y**	**Y**
Feverish Children - Emergency Departments	**Y**	**Y**
Vital Signs in Adults - Emergency Departments	**Y**	**Y**
VTE Risk in lower limb immobilisation – Emergency Departments	**Y**	**Y**
National Ophthalmology Audit	**Y**	**Y**
British Society of Urological Surgeons (BAUS) – Cystectomy Audit	**Y**	**Y**
BAUS – Nephrectomy Audit	**Y**	**Y**
BAUS – Radical Prostatectomy Audit	**Y**	**Y**
BAUS – PCNL Audit	**Y**	**Y**
BAUS – Stress Urinary Incontinence Audit	**Y**	**Y**
Reducing the Impact of serious infections – Antibiotic Consumption	**Y**	**Y**
Reducing the Impact of serious infections – Antibiotic Stewardship	**Y**	**Y**

Appendix 3 – Participation in Mandatory Clinical Audits

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

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

Appendix 4 – Other Non-Mandated National Clinical Audits

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

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

Appendix 5 – 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

Appendix 6 – Glossary

A

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

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

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

C

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

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

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

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

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

Clostridium difficile or C. difficile / C.diff
Clostridium difficile (also known as 'C. difficile' or 'C. diff') is a gram positive bacteria causing diarrhoea and other intestinal disease when competing bacteria in a patient or person's gut are wiped out by antibiotics. C. difficile infection can range in severity from asymptomatic to severe and

life-threatening, especially among the elderly.

Commissioning for Quality and Innovation (CQUIN)
High Quality Care for All included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Visit: www.dh.gov.uk/en/

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

D

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

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

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

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

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

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

Division
A group of clinical specialities managed within a management structure.

Each has a clinical lead, nursing lead and general manager.

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

- Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered
- Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators
- Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it

E

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

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

F

Friends and Family Test (FFT)
The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for patients to give their views after receiving care or treatment.

G

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

Guardians of Safe Working Hours (GOSWH)
GOSWHs champion safe working hours for junior doctors. The roles are independent from the Trust management structure and are supported by

the British Medical Association (BMA) to:

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

H

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

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

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

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

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

I

Integrated Performance Review (IPR)
Meeting attended by members of Trust board, senior leads from the division, Finance, HR, Knowledge Management

K

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

M

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

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

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

N

National Audit of Dementia
The National Audit of Dementia is commissioned on behalf of NHS England and the Welsh Government. They measure the performance of general hospitals against standards relating to delivery of care which are known to impact people with dementia while in hospital. The standards are from national and professional guidance, including NICE Quality Standards and guidance, the Dementia Friendly Hospitals charter and reports from the Alzheimer’s Society, Age Concern and Royal Colleges.

National Clinical Audit Patient Outcomes Programme (NCAPOP)
Set of national clinical audits, registries and confidential enquiries which measure healthcare practice on specific conditions against accepted standards. These projects give healthcare providers’ benchmarked reports on their performance, with the aim of improving the care provided.

National Confidential Enquiry into Patient Outcome and Death – NCEPOD The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reviews clinical practice and identifies potentially remediable factors in the practice of anaesthesia and surgical and medical treatment. Its purpose is to assist in maintaining and improving standards

of medical and surgical care for the benefit of the public. It does this by reviewing the management of patients and undertaking confidential surveys and research, the results of which are published.
Clinicians at ESHT participate in national enquiries and review the published reports to make sure any recommendations are put in place.

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

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

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

P

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

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

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

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

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

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

R

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

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

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

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

Root Cause Analysis (RCA)
RCA is a method of problem solving that tries to identify the root causes of faults or problems that cause operating events. RCA practice tries to solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. By focusing correction

on root causes, problem recurrence can be prevented.

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

S

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

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

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

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

Sign up to Safety
Sign up to Safety is a campaign that aims to make the NHS the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group. The ambition is to halve avoidable harm in the NHS over the next three years and save 6,000 lives as a result.
By signing up to the campaign, organisations commit to listening to patients, carers and staff, learning from what they say when things go wrong and taking action to improve patient safety, helping to ensure patients get harm free care every time, everywhere.
Chief Executives of NHS England, The Care Quality Commission, the NHS Trust Development Authority, Monitor, NHS Improving Quality and the NHS Litigation Authority have all signed up to align their work with this campaign.

Speak Up Guardian
A person who supports staff to raise concerns.

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

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

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

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

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

T

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

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

U

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

V

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

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