Western Sussex Hospitals
NHS Foundation Trust

# Meeting of the Board of Directors

09:30 to 12:50 on Thursday 25 July 2019

Mickerson Hall, Chichester Medical Education Centre, St Richard's Hospital, Spitalfield Lane, Chichester, PO19 6SE

## AGENDA – MEETING IN PUBLIC

| | | | | |
|---|---|---|---|---|
| 1. | 09:30 | **Welcome and Apologies for Absence**<br>To note | Verbal | Chair |
| 2. | 09:30 | **Declarations of Interests**<br>To note | Verbal | All |
| 3. | 09:30 | **Minutes of Board Meeting held on 30 May 2019**<br>To approve | Enclosure | Chair |
| 4. | 09:35 | **Matters Arising from the Minutes**<br>To note | Enclosure | Chair |
| 5. | 09:40 | **Report from Chief Executive**<br>To receive and note overview of the Trust's activities | Enclosure | Marianne Griffiths |
| | | **INTEGRATED PERFORMANCE REPORT** | | |
| 6. | 09.50 | **Introduction from Chief Executive**<br>To receive and note overview of the Trust's activities | Enclosure | Marianne Griffiths |
| 7. | 10:00 | **Quality Improvement**<br>To receive and agree any necessary actions | Enclosure | George Findlay<br>Maggie Davies |
| 8. | 10:10 | **Systems and Partnerships**<br>To receive and agree any necessary actions | Enclosure | Amanda Fadero |
| 9. | 10:20 | **Sustainability**<br>To receive and agree any necessary actions | Enclosure | Karen Geoghegan |
| 10. | 10:30 | **Our People**<br>To receive and agree any necessary actions | Enclosure | Denise Farmer |
| | | **ASSURANCE REPORTS FROM COMMITTEES** | | |
| 11. | 10:40 | **Report from Finance and Performance Chair**<br>To receive assurance from Committee and recommendations from the Committee | Enclosure | Lizzie Peers |
| 12. | 10:50 | **Report from Audit Committee Chair *including Annual Report***<br>To receive assurance from Committee and recommendations from the Committee | Enclosure | Joanna Crane |

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| 13. | 11:00 | **Report from Quality Assurance Committee Chair**<br>To receive assurance from Committee and recommendations from the Committee | Enclosure | Joanna Crane |
| 14. | 11:10 | **Board Assurance Framework**<br>To approve for publication on the web site | Enclosure | Glen Palethorpe |
| | | **SERVICE PRESENTATION** | | |
| 15. | 11:20 | **A&E Service Presentation**<br>To receive assurance over application of patient first processes | Presentation | Medicine Division |
| 16. | 11:35 | **Annual Organ Donation Report 2018/19**<br>To receive | Presentation | Andrew Hetreed |
| | | **OUR PEOPLE** | | |
| 17. | 11:50 | **Annual Workforce Race Equality Survey Results**<br>To approve | Enclosure | Denise Farmer |
| 18. | 12:00 | **Annual Workforce Diversity Equality Survey Results**<br>To approve | Enclosure | Denise Farmer |
| | | **QUALITY** | | |
| 19. | 12:10 | **Annual Adults & Children's Safeguarding Report ****<br>To receive activity information for 2018/19 | Presentation | Maggie Davies |
| 20. | 12:20 | **CNST Maternity Standards**<br>To approve | Enclosure | Maggie Davies |
| | | **WELL LED & COMPLIANCE** | | |
| 21. | 12.30 | **Annual Medical Appraisal and Revalidation Report 2018/19**<br>To approve | Enclosure | George Findlay |
| 22. | 12:30 | **Company Secretary Report**<br>To note | Enclosure | Glen Palethorpe |
| | | **OTHER** | | |
| 22. | 12:40 | **Any Other Business**<br>To receive and action | Verbal | Chair |
| 23. | 12:40 | **Questions from the public**<br>To receive and respond to questions submitted by the public | Verbal | Chair |
| 24. | 12:50 | **Date and time of next meeting:**<br>The next meeting in private of the Board of Directors is scheduled to take place at **10:30** on **26th September 2019** in the John Bull Conference Room, WHEC, Worthing Hospital. | Verbal | Chair |

**To resolve to move to into private session**

*The Board now needs to move to a private session due to the confidential nature of the business to be transacted*

** Hard copies of these reports are available on request via email to tanya.humphrys@wsht.nhs.uk

**Trust Board of Directors Quoracy**

A meeting of the Board shall be quorate and shall not commence until it is quorate.

Quoracy is defined as meaning that at least half of the Board must be present, including one Non-executive Director and one Executive Director. This means that at least 6 voting members must be present. A Director shall be deemed as present if he joins the meeting by telephone or other means, provided that he can hear and be heard by all other Directors present at the meeting

Western Sussex Hospitals
NHS Foundation Trust

Minutes

**Minutes of the Board of Directors meeting held in Public at 10.30am on Thursday 30 May 2019, John Bull Conference Room, Worthing Health Education Centre, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH.**

| | | |
|---|---|---|
| **Present:** | Alan McCarthy | Chairman |
| | Patrick Boyle | Non-Executive Director |
| | Mike Rymer | Non-Executive Director |
| | Joanna Crane | Non-Executive Director |
| | Lizzie Peers | Non-Executive Director |
| | Jon Furmston | Non-Executive Director |
| | Martin Sinclair | Non-Executive Director Adviser |
| | Dame Marianne Griffiths | Chief Executive |
| | George Findlay | Chief Medical Officer & Deputy Chief Executive |
| | Karen Geoghegan | Chief Financial Officer |
| | Denise Farmer | Chief Workforce and OD Officer |
| | Maggie Davies | Chief Nurse |
| | Amanda Fadero | Managing Director |
| **In Attendance:** | Alison Ingoe | Finance Director |
| | Jennie Shore | Human Resources Director |
| | Oliver Philips | Group Director of Strategy and Planning (For Item 6) |
| | Rowena Remorino | Chief of Service – Women and Children (For Item 14) |
| | Lynn Woolley | Head of Midwifery (For Item 14) |
| | Lisa Ekinsmyth | Quality Matron (For Item 17) |
| | Glen Palethorpe | Group Company Secretary [joined the meeting from the end of the Integrated Performance Report] |
| | Tanya Humphrys | Board Administrator |

**TB/05/19/01 Welcome and Apologies**

1.1 The Chair welcomed all those present to the meeting.

1.2 Apologies were received from Jon Furmston and Lizzie Peers.

**TB/05/19/02 Declarations of Interests**

2.1 There were no declarations of interest.

**TB/05/19/03 Minutes of Board Meeting held on 28 March 2019**

3.1 The Board received the minutes of the meeting held on 28 March 2019.

3.2 **The Board resolved that the minutes of the Board meeting held on 28 March 2019, would be approved as a correct record of the meeting and signed by the Chairman.**

**TB/05/19/04 Matters arising from Minutes**

4.1 The Matters Arising from previous meetings were received.

4.2 All Matters Arising related to items on the agenda or were on a forward agenda plan.

**TB/05/19/05 Chief Executive's Report**

5.1 Dame Marianne Griffiths introducted the Chief Executives report and highlighted the following key areas.

5.2 **Celebrations**
**10 years of Western Sussex** – The Trust celebrated a decade of achievements and improvements on its 10th birthday in April, 10 years after the Trust was formed on 1 April 2009. Within four years, Western Sussex Hospitals won Foundation Trust status and in April 2016 it became the first multi-site hospital trust to be rated "Outstanding" by the Care Quality Commission. Marianne noted that the Trust had celebrated with cake for staff at St Richard's, Worthing and Southlands hospitals.

5.3 **Patient First STAR Awards** – Marianne explained that the Trust has just launched its tenth annual event which is a real celebration of everything that is great and good about the Trust and its staff. Last year there were over 600 nominations, the Board was advsied that the deadline for nominations was 31 May 2019.

5.4 **Top 10 A&E performance & multi-million pound bonus –** In 2018/19 WSHT had the ninth best type 1 A&E performance in England, the Trust finished the year with 95% of A&E patients in Worthing and St Richard's seen, treated, admitted or discharged within four hours. In addition to this the Trust delivered a surplus of £1.194m, which together earned the Trust an additional £27million Sustainabilty Funding which the Trust is seeking to use for capital investment. Marianne commended all those involved in delivering this fantastic achievement.

5.5 Marianne went onto to advise the Board about a number of other achievements that had taken place within the Trust in the previous months, including the Multi-million pound radiology investment, £8.5 million endoscopy investment, Improving patient catering, Leadership development programme for Matrons and Band 7's.

5.6 Marianne went on to draw the Boards attention to the following diary highlights:
- Meetings with partner organisations
- Sustainability and Transformation Partnership
- Sharing our improvement story:
    - Lean Academic Conference
    - KPMG Improvement event
- Clinical Director Induction Day
- Consultant engagement meeting
- Acute Network
- Staff briefings

5.7 Looking ahead Marianne advised the Board that the Trust was starting to prepare for the impending CQC inspection, it was noted that the Trust had received notifcation that the CQC intended to inspect the Trust this summer and that it was anticipated to take place some point before the end of July.

**TB/05/19/06 2019/20 Operational Plan**

6.1 Oliver Philips introduced the Trusts 2019/20 Operational Plan explaining that the Operational Plan is a key document which, for 2019/20 demonstrates how the Trust plans to sustain its outstanding CQC rating and continue with its improvement journey.

6.2 The revised Strategic Initiatives will ensure long term improvement in the face of a range of complex demands across performance, productivity, finance, quality and system development, this year's Corporate Projects have been refreshed and include Western 'Outstanding', Clinical Strategy Delivery, Delivery of Seven Day Services, Reducing Abusive Behaviours, and the Facilities and Estates Response to the '6 Facet' Survey

6.3 Oliver explained that the Operational Plan sets out how during 2019/20 the Trust will achieve its ambitions and was submitted to NHS Improvement in April 2019.

6.4 Amanda Fadero advised the Board that looking back on the previous year, whilst it was extremely busy but noted that the Trust had remained in the top quartile nationally for its performance and went on to highlight the Trusts target to be achieved in 2019/20:

- A&E less than 4 hour waits - 95%;
- RTT – 92%;
- RTT 52 week waits – 0;
- Diagnostics more than 6 weeks – less than 1.0%;
- Cancer - First treatment following GP referral < 62 days – 85%

6.5 George Findlay explained that WSHFT was already a Trust that was proud of the high quality of care it provides to its patients with the best outcomes for patients at the forefront of all it does but noted that this needed to be maintained and as part of the Operational Plan the following targets would support that ethos:

- Preventable Mortality target: HSMR Top 20%;
- Avoidable Harm target: 99% Harm Free Care;
- Patient Satisfaction target: >97%

6.6 Denise Farmer introduced the Workforce slide noting that the Trust has previously performed well in the Annual Staff Survey but noted that the Trust would like to be the best nationally when it comes to Staff Engagement and supporting our staff. Denise explained that the following areas were key to helping the Trust achieve that aspiration:

- Develop new roles and ways of working to support workforce supply challenges;
- Align workforce plans and Clinical Strategy;
- Delivery of improvements in staff engagement, ability of staff to make improvements, reduction in abusive behaviours and Patient First Improvement System (PFIS) including – develop leadership skills to deliver performance.

6.7 Karen Geoghegan explained that the Trust started the year in a positive position after delivering a surplus position for the previous 3 years, including the delivery of the efficiency programme in excess of 4% of the cost base for the last 3 years. Karen noted the financial targets that the Trust has set out as part of the 2019/20 Operational Plan:

- Deliver a control total (including Provider Sustainability Fund and Marginal Rate Emergency Tariff ) of £14.062m surplus for 2019/20 and the efficiency requirement of £11.7m;
- Improved Theatre and Outpatient Productivity;
- Diagnostic demand management (incl. primary care);
- Support the delivery of New Models of Care;
- Deliver medical workforce redesign project;
- Take an active part within the Integrated Care Provider Pathfinder Development.

6.8 The Chairman thanked the Executive Team for all the hard work that had

been put into developing the Operational Plan.

6.9 The Board **NOTED** the 2019/20 Operational Plan.

**TB/05/19/07 Integrated Performance Report**

7.1 Dame Marianne Griffiths introduced the Integrated Performance Report explaining that Patient First is the Trust's methodology and how it aligns its processes and governance, highlighting that there are three key streams of work that feed into the Trust's Patient First True North; Breakthrough Objectives, Corporate Projects and Strategic Initiatives. Marianne explained that the new Integrated Performance Report supported reporting to the Board in line with the patient first approach, highlighting the Trust's True North for each of the 5 domains.

7.2 **Quality**
George Findlay noted the key messages from the Quality section of the report noting that for HMSR the Trust has deteriorated to the 31st percentile when compared nationally, due to the 12 month rolling figure increasing to 92.5.

7.3 George explained that the change had been driven by the following factors; coded case-mix has changed at a different rate than seen nationally for Sepsis and Pneumonia with a greater fall in the proportion and activity. Allied with an increase in zero day non-elective admissions with a potential impact on the expected mortality rate, particularly at St Richard's. George assured the Board that this was not a patient outcome issue, purely coding.

7.4 Maggie Davies advised the Board that the Trust had experienced an outbreak of Norovirus at both St Richard's and Worthing sites, it was noted that in addition to this the Trust observed an increased incident of vomiting and on 09 May and a D&V outbreak was promptly declared. Maggie assured the Board that all corresponding risk mitigations were in place and extra support for the clinical areas affected, including weekend working by the IP&C team, was provided and the outbreak was formally closed on 15 May 2019.

7.5 Jon Furmston asked if our coders were quicker to adopt the change of coding for Sepsis and Pneumonia and did the Trust believe that the drop in activity would correct itself. In response George explained that it was expected to balance out but confirmed that it was absolutely the correct change to make.

7.6 **Operational Performance**
Amanda Fadero drew out the following key points for the Trust's Operational Performance for April 2019:

- A&E 4hr target performance April-19 was 91.9%, compared to 85.1% National Average performance.
- RTT (Referral to Treatment) compliance was static at 83.3%, compared to 86.7% National Average (March) with Zero patients waiting over 52 weeks.
- Cancer provisional performance April-19 was 82.1 % of patients treated within 62 days from referral as per the Trust's recovery plan and was delivered in the context of continued significant increased demand, compared to 79.75 National Average(March).
- Diagnostic performance was compliant (0.81% not achieved) for the 16th consecutive month despite demand pressures, compared to National Average (March) of 2.5%

7.7 Marianne reminded the Board that for 2018/19 activity was not commissioned to meet the RTT target of 92%, but to show a reduction in the total waiting list size for 2018/19 which was achieved. Marianne confirmed that for 2019/20 the activity to deliver the RTT target has been commissioned.

7.8 Amanda went on to explain that there was particular focus on Outpatient and Theatre improvement programmes, with new plans in place to look at different ways of scheduling theatre lists. George added that there had been added focus on Ophthalmology to reduce waiting lists, noting that there had been a significant reduction in the waiting list for Glaucoma patients.

7.9 **Financial Performance**
Karen Geoghegan noted that the Trust is exactly in line with the plan it has set itself. Karen explained that at the end of Quarter 1 the Trust needs to deliver a surplus of £1.0m in order to earn £1.25m of Provider Sustainability Fund (PSF) income. In 2019/20 there are no performance or access targets associated with the payment of PSF income.

7.10 The Board was advised that the delivery of the control total will require the close management of elective and non-elective capacity and control of the Trust's cost base, particularly in relation to medical pay, which is a break-through objective for 2019/20.

7.11 Karen went on to note that the Trust has been able to identify Efficiency opportunities to meet all of the £1.1m efficiency plan savings at the end of Month 1 and that the Capital Programme is ambitious and as it is in excess of the plan it will have to be closely managed.

7.12 **Workforce**
Denise Farmer highlighted the key areas from the Workforce section of the integrated performance report, noting that the Trust remains on track overall in relation to staff engagement.

7.13 It was noted that the Equality, Diversity and Inclusion strategy had been developed and that there was a programme of work in relation to that and how it is translated into changing behaviours of both staff and patients and their visitors.

7.14 The Board was advised that there had been some changes to the Agenda for Change contract, namely a change from manager led to employee led appraisal and the phasing out of the Band 1 role.

7.15 Denise explained that the Finance and Performance Committee had discussed workforce capacity in its earlier meeting with a particular focus on the implementation of new medical roles, where it had been agreed the Quality Assurance Committee would provide oversight on the quality risk of its implementation in particular with respect to changing junior doctor roles.

**ACTION: QAC to provide oversight and support on the implementation of the new Junior Doctor roles.** **DF**

7.16 The Board **NOTED** the Integrated Performance Report.

**TB/05/19/08 Report from the Finance and Performance Committee Chair**

8.1 Lizzie Peers presented the report from the Finance and Performance Committee and explained that the role of the Committee is to receive assurance and scrutinise the data on behalf of the Board.

8.2 Lizzie noted that Marianne had already reflected on a very positive year-end result, whilst at the same time delivering good outcomes in A&E, Diagnostics, Capital Investments, and Cash Management. Lizzie went on to highlight that the Committee had been greatly assured by the delivery of the Efficiency Programme again last year.

8.3 The Board was advised that the Committee had discussed the 2019/20 Efficiency Programme noting that it was well matured but that it contained some potentially very high risk schemes, due to it being more transformational this year.

8.4 It was noted that the Committee had discussed the gaps in workforce and new models of care and the implementation of new roles and as mentioned earlier will be looking to the Quality Assurance Committee to test out the quality assurance in relation to these changes

8.5 Lizzie summed up by advising that Operational Performance had largely been within the set plan to deliver the constitutional targets.

8.6 The Board **NOTED** the Report from the Finance and Performance Committee Chair.

**TB/05/19/09 Report from the Audit Committee Chair**

9.1 Jon Furmston presented the Chairs report from the Audit Committee and highlighted the findings of an Internal Audit Advisory Report the Committee had received in relation to Medical Workforce expenditure in the Medical Division. Jon noted that there had been months where finances weren't as expected and as a result the Trust requested internal audit (BDO) take a more in-depth look into the reasons for the overspend. Jon explained that positively the auditors confirmed that the Trust was already addressing the correct areas and that the action plan put together by BDO, would be used to support the other Divisions not only Medicine.

9.2 The Board was advised that the Committee received the Annual Report and Accounts for 2018/19; Ernst & Young commented that it had been a much smoother process than in previous years and were able to deliver their opinion on time.

9.3 The Committee received a post project evaluation on the Docman referral system which provided a number of learning points that would be beneficial for the delivery of future projects and business cases.

9.4 The Board **NOTED** the Report from the Audit Committee Chair.

**TB/05/19/10 Women's and Children's Service Presentation**

10.1 Rowena Remorino introduced the Women's and Children's service presentation and began by explaining to the Board that in 2018/19 WSHFT Maternity Service supported 4888 women to have their babies and delivered 5012 babies.

10.2 The Board was advised that the Maternity Department was aiming to maintain its Outstanding service rating as noted in the previous CQC inspection and more recently from the feedback provided by the CQC in

their engagement visit.

10.3 Rowena drew the Board's attention to slide 4 of the presentation which highlighted feedback from patients and family, noting that the departments Family and Friends Test (FFT) recommend rate is 98%, which is significantly better than the national average.

10.4 The Board heard about some of the areas where the team have worked closely with families that have used the service, working to create the Maple Suite for families that have suffered the loss of a baby, Baby basics for mothers that have nothing, a local charity provides basic supplies to help them get started.

10.5 Lynn Woolley highlighted to the Board some of the innovative projects within the department, in particular balloon inductions which are midwifery led, which have seen higher rates of patient satisfaction and reduced time to delivery.

10.6 The Board heard about the co-design of Maternity services with the women that use the service in particular with the Continuity of Carer project, in addition that there had been the recent appointment of a Chair and co-Chair of the Maternity Voices partnership, offering a sound forum to discuss service improvements.

10.7 The Chair thanked Rowena and Lynn for their presentation and asked what other challenges there were; within the service Rowena explained that workforce sustainability continues to be a challenge but positively added that recently they have had a period of stability.

10.8 The Board **NOTED** the Women's and Children's Service Presentation on Maternity.

**TB/05/19/11 Equality, Diversity and Inclusion**

11.1 Jennie Shore presented the Equality, Diversity and Inclusion paper and drew out the following key points, explaining that the paper sets out the Trusts strategy for improving equality, diversity and inclusion together with an improvement plan that sets out measurable objectives that meet WSHFT's legal and social responsibilities and continues to shift the Trusts culture to one that embraces difference.

11.2 The Board was advised that the Trust has a number of schemes in place to support the Trusts vision and drew the Boards attention to the current position detailed in the paper.

11.3 The Trust's improvement plan and focus over the next two years was explained noting the following actions:

- Embedding the strategy throughout the Trust
- Facilitating the ongoing conversations with the staff from differing protected characteristic groups about their experience and satisfaction
- Continuing to support the staff networks to actively contribute to this agenda and support the delivery of these priorities
- Providing training to enable staff to have productive conversations in areas of race, disability, sexual orientation and bullying/harassment
- Increasing the number of staff providing full information on ESR, especially for Disability, Sexual Orientation and Religion or Belief
- Carrying out a review of the recruitment and selection process to determine the reason for the differences between White and BME staff being shortlisted for positions

- Reviewing the data provided in the annual reports such as the Equality Annual Report, WRES, WDES and Gender Pay Gap to enable the annual priorities to be determined
- Supporting the development of the team that supports the delivery of the EDI agenda
- Ensuring that communication of the agenda and workstreams supporting these plans are regularly shared across the organisation and externally to ensure that staff and the community are aware of our commitment to true equality and inclusion.

11.4 Dame Marianne Griffiths commented that one of the Trust's Corporate Projects for 2019/20 was tackling Violence and Aggression towards staff as it continues to be one of the biggest challenges that the hospitals experience, so it is hoped that the actions as part of the improvement plan will help to reduce the number of cases that are reported.

11.5 The Board **ENDORSED** the actions set out within the improvement plan in the Equality, Diversity and Inclusion plan.

**TB/05/19/12 Learning From Deaths Quarter 4**

12.1 George Findlay presented the Quarter 4 Learning from Deaths report and highlighted the following key areas; George noted that this report detailed Quarter 3 data as the process for screening is limited, it looks at historic data and this can lead to delays in the reporting. The Trust continues to aspire to move toward a daily review process and will be piloting this during Q1 2019-20.

12.2 It was noted that there had been some progress in the last Quarter and that there had been an increase in capacity with the recruitment of the new Learning from Deaths Manager, who was leading the review of the current screening and structured judgement review process, which it is hoped will enable the Board to be kept up to date in a more timely fashion.

12.3 George drew the Board's attention to Appendix 1 CQC Learning from Deaths – Driving Improvement Report, highlighting the 5 key areas that support Trusts putting the learning from Deaths guidance into practice, noting that the Trust is meeting these recommendations within our processes.

12.4 Mike Rymer commented that he had recently attended the End of Life summit in May which had been very positive; in addition that he felt it was the right decision to amalgamate the Mortality Steering Group with the End of Life Board. George concurred explaining this was to ensure a coordinated strategic plan is delivered and to broaden the membership of both groups.

12.5 The Board **NOTED** the Quarter 4 Learning from Deaths Report.

**TB/05/19/13 Annual Patient Experience Report**

13.1 Maggie Davies introduced Lisa Ekinsmyth, Quality Matron who attended the meeting to present the Patient Experience Annual Report.

13.2 The Board was advised that the report provided a review of the Patient Experience data collected through the Friends and Family Test (FFT), the real time survey system, National Surveys as well as themes from PALS enquiries and formal complaints received the Trust for 2018/19.

13.3 Lisa explained that at the beginning of the year the patient experience strategy was launched and set out the Trusts improvement goals with the top two being, to "**Make feedback business as usual**" and "**Improve timely responses to concerns and complaints**".

13.4 The Board was advised that in relation to FFT the Trust is performing well in all areas:

- A&E – WSHT was at 95% satisfaction compared to 87% nationally;
- Inpatients – The Trust scored 97% satisfaction compared to 93% nationally;
- Outpatients – 96.8% satisfaction in comparison to a score of 93.5% nationally;
- Maternity was the standout area for FFT scoring 97% satisfaction compared to 96% nationally, with a response rate of 50.8% compared to the national average of 20.9%.

13.5 Lisa advised the Board that the Trust gets lots of positive comments from patients through FFT and highlighted some of these within the presentation.

13.6 The Boards attention was drawn to the Real Time Surveys section of the presentation highlighting that 6,730 patients were surveyed in 2018, with 3 key improvement themes being noted, reduction in the noise at night, improved discussions regarding discharge and to improve inpatient food.

13.7 Lisa explained that the PALS and Complaints Service handled 11,588 cases in 2018/19, noting the trend of an increase in PALS cases which is reflected in the reduction of patients and families having to formally raise complaints.

13.8 Lizzie Peers reflected that the positive comments were all around behaviours and the areas highlighted as needing improvement are processes and environmental factors all things that the Trust can change relatively easily which is a really encouraging position and a testament to the Trust's staff.

13.9 The Board **NOTED** the Annual Patient Experience Report for 2018/19.

**TB/05/19/14 Annual Provider Licence Self-Certifications**

14.1 Glen Palethorpe presented the Annual Provider Licence Self-Certifications, explaining that as part of the Trust's provider licence the Trust is required to make a self-declaration against a number of the licence specific conditions. The Trust's self-declarations must be published on its website.

14.2 NHS improvement provide a template for these declarations where explanations are required if the Trust cannot provide a compliant declaration.

14.3 It was noted that the Trust is compliant for each element within the annual required declarations, detailed within the report.

14.4 The Board **APPROVED** the Annual Provider Licence Self-Certifications for submission to NHSI.

**TB/05/19/15 Other Business**

15.1 There was no other business to discuss.

**TB/05/19/16** The Chair formally closed the meeting

**TB/05/19/17 Questions from Members of the Public**

17.1 John Thompson commented that nominations for this year's STARS were very important and that he hoped the Trust would draw on the positive stories portrayed within many of the reports presented today.

17.2 John went on to acknowledge the new Integrated Performance Report and complimented the style of reporting; in addition he noted that the Diversity and Inclusion paper was a very interesting read.

17.3 Anita Mackenzie asked whether an OCT scan in Ophthalmology was part of routine examinations. George Findlay explained that this was not routine and was only used for specific conditions and routinely providing such tests is not encouraged or clinically directed.

**TB/05/19/18 Resolution into Board Committee**

18.1 The Board resolved to meet in private due to the confidential nature of the business to be transacted.

**TB/05/19/19 Date of Next Meeting**

19.1 It was noted that the next Board Meeting would take place on **Thursday 25 July 2019** in **Mickerson Hall, CMEC, St Richard's Hospital, Chichester.**

Tanya Humphrys
**Board Administrator**
May 2019

Signed as a correct record of the meeting

……
Chair
……
Date

# MATTERS ARISING
## Trust Board

**Agenda Item: 4**

| Meeting | Minute Ref | Action | Responsible Person | Deadline | Status |
|---|---|---|---|---|---|
| 28 March 2019 | **TB/03/19/10.6** | **CNST Action Plan:** Quality Assurance Committee to take lead oversight of the CNST ATAIN Action Plan and report up to Board. | Glen Palethorpe | **Completed** | Item 20 on the agenda. |
| | | | | | |
| 30 May 2019 | **TB/05/19/7** | **Integrated Performance Report – Workforce:** Quality Assurance Committee will provide oversight of the implementation of the new Junior Doctor roles. | Denise Farmer | **Completed** | Referred to the Quality Assurance Committee for their ongoing support and oversight. |

Western Sussex Hospitals
NHS Foundation Trust

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| **Agenda Item:** | 5 | **Meeting:** | Trust Board | **Meeting Date:** | 25 July 19 |
| **Report Title:** | Chief Executive Report | | | | |
| **Sponsoring Executive Director:** | Dame Marianne Griffiths, Chief Executive | | | | |
| **Author(s):** | Jonathan Keeble, Director of Communications & Engagement | | | | |
| **Report previously considered by and date:** | N/A | | | | |
| **Purpose of the report:** | | | | | |
| Information | ✓ | | Assurance | ☐ | |
| Review and Discussion | ☐ | | Approval / Agreement | ☐ | |
| **Reason for submission to Trust Board in Private only (where relevant):** | | | | | |
| Commercial confidentiality | ☐ | | Staff confidentiality | ☐ | |
| Patient confidentiality | ☐ | | Other exceptional circumstances | ☐ | |
| **Link to Trust Strategic Themes:** | | | | | |
| Patient Care | ✓ | | Sustainability | ✓ | |
| Our People | ✓ | | Quality | ✓ | |
| Systems and Partnerships | ☐ | | | | |
| **Any implications for:** | | | | | |
| Quality | | | | | |
| Financial | | | | | |
| Workforce | | | | | |
| **Link to CQC Domains:** | | | | | |
| Safe | ☐ | | Effective | ☐ | |
| Caring | ✓ | | Responsive | ☐ | |
| Well-led | ✓ | | Use of Resources | ☐ | |
| **Communication and Consultation:** | | | | | |
| | | | | | |

**Executive Summary:**

This report provides an overview for the Trust's activities for the months of June and July.

**Key Recommendation(s):**

The Board is asked to NOTE this report.

# Chief Executive's Report

## July 2019

Western Sussex Hospitals
NHS Foundation Trust

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- Looking outwards
- Looking ahead

# Headlines

## Sussex NHS unites for Pride

Staff and volunteers from Western Sussex joined colleagues from Sussex Partnership, Sussex Community NHS trusts and Unite at Worthing Pride this month to celebrate the diversity of our organisations and the people we serve.

July also saw the launch of Rainbow Warrior initiative at the trust enabling staff to show their support for LGBTQ+ patients, carers, visitors and colleagues. The initiative originated at the Evelina London Children's Hospital and is now spreading across the NHS as other organisations borrow the idea 'with pride'! The aim is to make a positive difference by promoting a message of inclusion to the LGBT+ community, with Rainbow Warriors prominently wearing their rainbow lanyards or pin badges.

## E&D conference:  Day Two of our annual conferences

The second of our annual staff conferences took place on 13 June. The conference theme this year is *Diverse, Inclusive and Together* and is part of a wider strategy of celebrating diversity in our hospitals as we continue to improve the services we provide.

## Successful Maternity voices group launched

More than 40 people have joined the Western Sussex Maternity Voices Partnership mailing list following its successful launch on 10 June at St Richard's.
Led by practice development midwife, Anita Clarke, MVP chair Emma Johnson and co-chair Nicky Sheppard, staff and members of the public shared ideas and their own stories of maternity care.


The Western Sussex MVP is a maternity group that works with families to develop a service that meets their needs, giving them the best possible care during pregnancy, birth and beyond. If you are interested in joining the mailing list, contact them through their social media channels on Twitter @WestSussexMVP and Facebook www.facebook.com/westsussexMVP/. Or, you can email westsussexmvp@gmail.com.

# Headlines

## Frailty Intervention Teams working in A&E

New Frailty Intervention Teams (FIT) have been established to provide more specialist support for older and more frail patients in the trust's emergency departments.
The teams, which include a frailty practitioner, supported by a consultant geriatrician, see patients in minors, majors, resus and the clinical decisions unit, depending on patient need.  They work alongside the A&E medics, nurses and occupational therapists to provide specialist care for elderly patients who have been triaged in A&E as being frail.

## Top hospital award for Western Sussex


Western Sussex has been named as one of the country's top hospitals at this year's CHKS Top Hospitals Awards in London on Wednesday (12 June).
The trust was also ranked among the very best hospitals for the quality of experience our patients receive at St Richard's, Worthing and Southlands. .

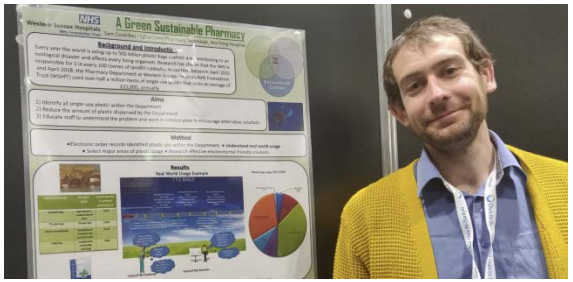
## Junior doctors win excellence awards


Junior doctors were recognised for their achievements at the trust's inaugural Trainee Doctor Excellence Awards in Arundel on 21 June. The event was held in conjunction with an educational conference which focussed on wellbeing and resilience.
The event included the award of the Sophie Spooner Cup, presented by Laurel and Richard Spooner in memory of their daughter, who was working at Western Sussex when she died in 2017.

The cup recognises the trainee who has contributed most to the culture of the organisation, through their personal values, attitude and behaviour. The first winner was specialist registrar in Acute Medicine, Dr Christopher Chandler. Chris's achievement was all the more significant as nearly 170 nominations for the award were received.

# Headlines

## Pharmacist's plastic-cutting project




An improvement project led by pharmacy technician Sam Coombes will stop the trust using nearly 70,000 single-use plastic bags a year. Sam's vision for "a green sustainable pharmacy" was showcased at the 2019 Clinical Pharmacy Congress in London (7-8 June), where colleagues from around the country commended his improvement project.

Using the Patient first approach, Sam used data to identify the causes of the waste and used it to develop solutions. These include replacing throw-away fridge bags with reusable canvas bags with an antimicrobial coating.

## Wishing colleagues a happy retirement


Lead nurse for cancer and end-of-life care Tim Hutson (pictured) retired on May 31 after 40 years working for the trust.

Housekeeping senior supervisor Denise Darbinean has retired after 44 years at Southlands.

Consultant rheumatologist Dr Mike Chard retired on 31 May after 29 years working at Worthing and Southlands Hospitals.

## Thanks and congratulations to our volunteers

Congratulations for The Friends of Chichester Hospitals as they celebrated receiving the highest honour a voluntary group can be given. The Friends' receipt of The Queen's Award for Voluntary Service in recognition of their outstanding charitable work at St Richard's was applauded at a special lunch held at CMEC as part of the trust's Volunteers Week celebrations.

# Diary highlights

- Meetings with partner organisations
- Sustainability and Transformation Partnership
- Acute Network
- Healthcare Women Leaders Network
- NHS Providers Quality Conference
- NHS Confederation Annual Conference
- Clinical Director ‘s meeting
- Consultant engagement meeting
- Staff Conference Day 2
- Nursing and Midwifery Board Away Day
- Staff briefings
- Medical Education Conference
- Volunteers Summer tea party
- Council of Governors meeting
- Band 7 leadership programme

# Looking ahead

## Care Quality Commission inspection

The inspection of our trust began in June with a review of our Use of Resources, carried out by NHS Improvement. Inspections are now formed of three parts and our Well-led assessment and core, unannounced inspection are expected to take place before the end of August.

We were last inspected in December 2015, which resulted in the publication of our “Outstanding” CQC report in April 2016. Patient First was just beginning then and we have much to be proud of, using its approach to build on our rating, making significant improvements across the organisation.

## Our STAR awards

With more than 800 nominations for this year’s STAR awards, our judging panel meets on August 1 to decide on our shortlist. The shortlist will be shared with the organisation as part of preparations for the event on 26 September. Thank you again to all those who made nominations – both public and staff.

# Integrated Performance Report

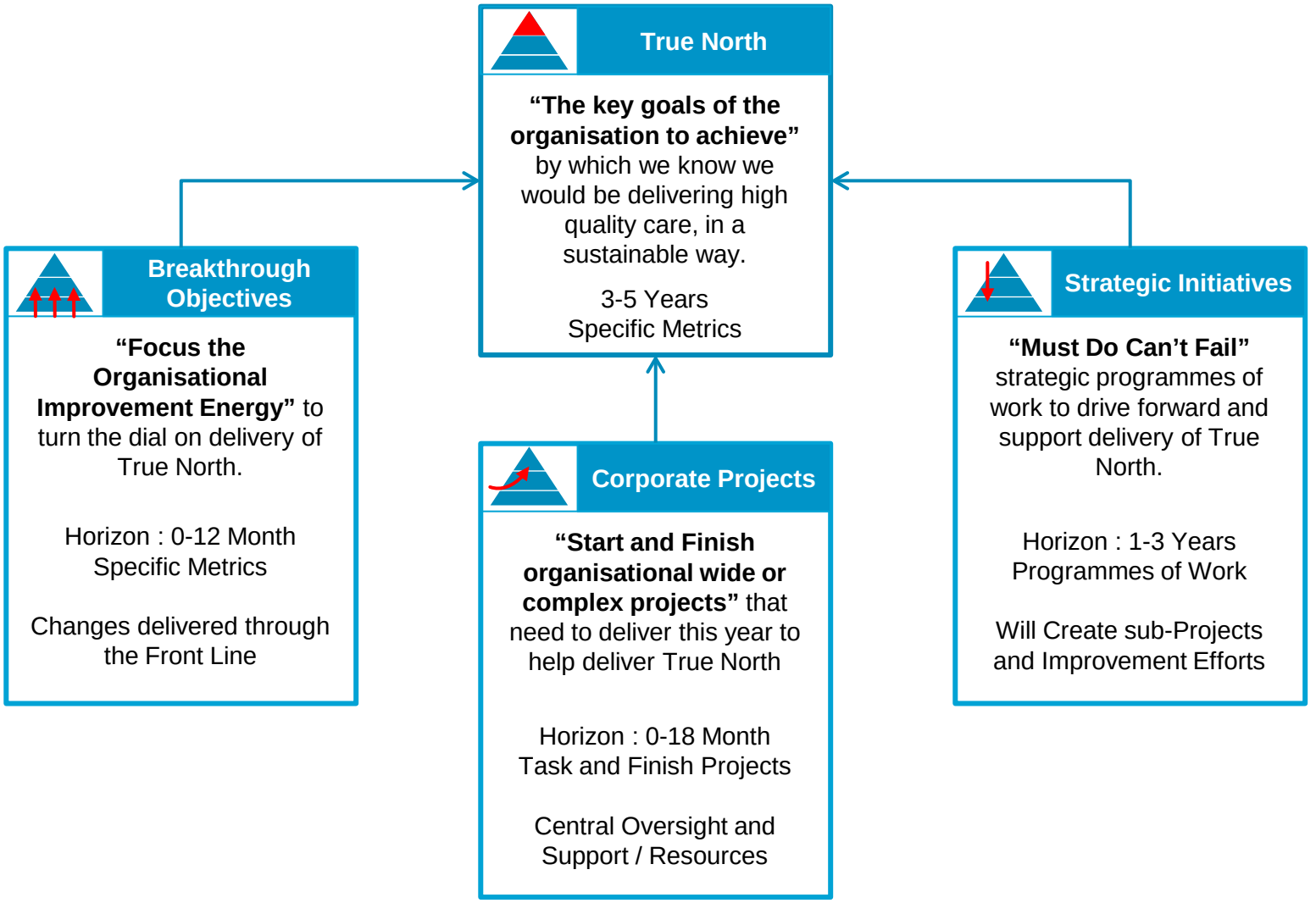
# July 2019

NHS
Western Sussex Hospitals
NHS Foundation Trust

# Contents

Structure of the report

# Patient First Strategy Deployment Framework



# Patient First True North

**Key Goals** for the Organisation to achieve sustainably

## Patient

**Patient Satisfaction**

**Target: Family & Friends Recommend Rate >96%**

## Sustainability

**Financial Management**

**Target: Break Even**

## People

**Staff Engagement**

**Target: Engagement Score Top in the Country**

## Quality

**Preventable Mortality**

**Target: HSMR Top 20% in the Country**

**Avoidable Harm**

**Target: Patient Safety Thermometer 99% Harm Free Care**

## Systems & Partnerships

**Non Elective Care**

**Target: A&E 95% <4hrs**

**Elective Care**

**Target: RTT 92% <18wks**

# Quality Performance - Effectiveness

| Quality |
| --- |
| **Preventable Mortality** |
| **Target: HSMR Top 20% in the Country** |
| **Avoidable Harm** |
| **Target: Patient Safety Thermometer 99% Harm Free Care** |

## Key messages for Board

**Effectiveness:** Mortality-Analysis of the rise in HMSR: the Trust rolling 12 month HMSR now includes data for March 2019 and has risen to 94.2. There has been an accompanying deterioration to the 38th Percentile when compared nationally. The Trust remains statistically significantly low in terms of both the HSMR and SMR with an increasing trend in the point value of the HSMR itself.

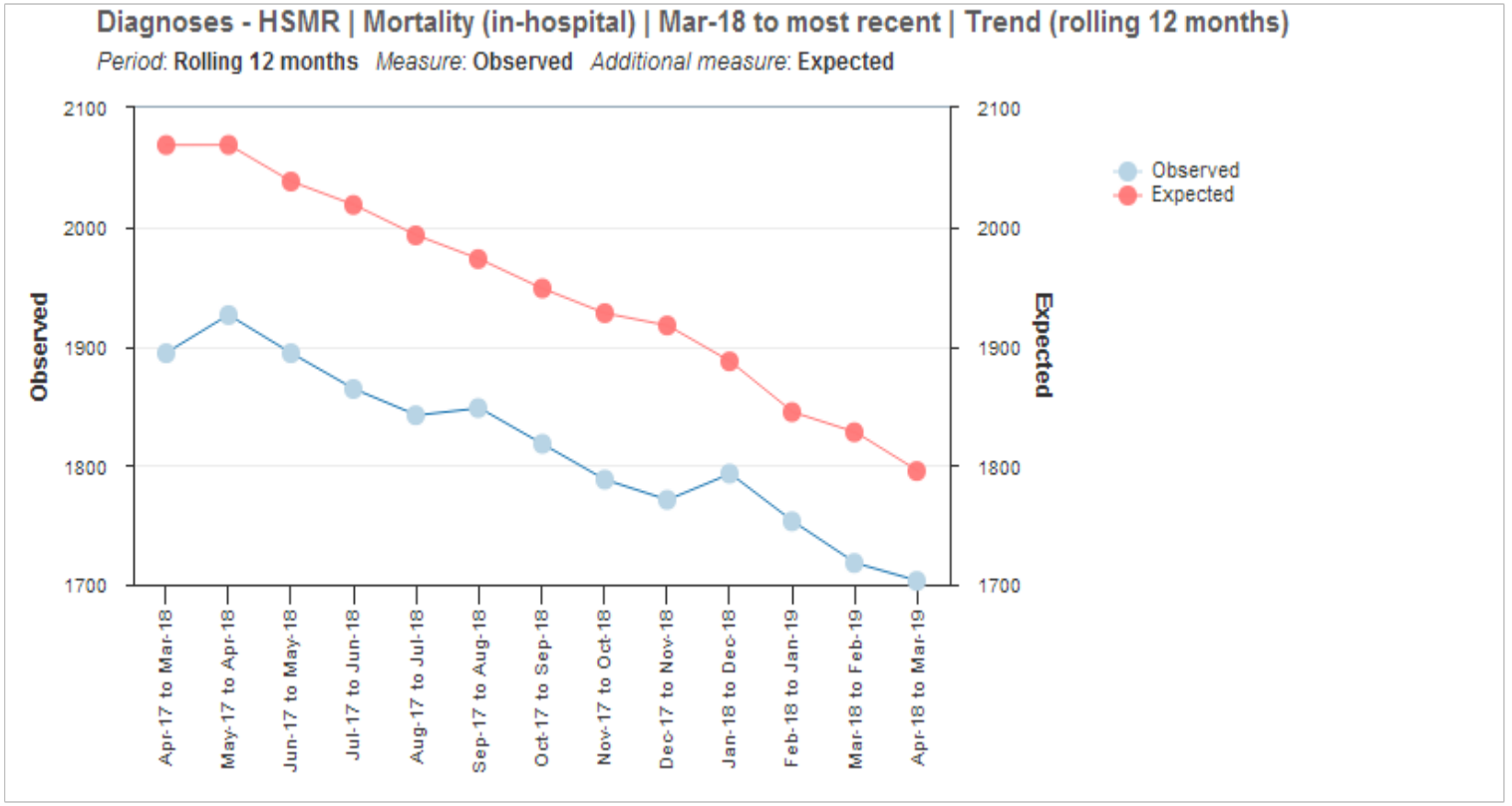
The causes for the rising HMSR have been investigated and the 12 month rolling number of observed deaths at WSHT has been steadily reducing. The 1703 deaths in the 12 months up to and including March 2019 represents an 8.6% reduction in observed deaths when compared to the year before. However this coincided with a larger 13.6% reduction in the numbers of expected deaths predicted by Dr Foster. The larger reduction in expected deaths compared to observed deaths has resulted in a rising HMSR.

The cause of the larger reduction in expected deaths is primarily due to changing levels of coded activity for sepsis. There were national changes to the way sepsis is coded in April 2017 increasing coded activity followed by further changes in April 2018 reducing it. This has prompted a larger variation in coded sepsis at WSHT when compared with other Trusts and a bigger reduction is sepsis coding that seen elsewhere.

Work is ongoing to understand the changing HSMR and is also focussing on levels of palliative care coding and the capture of co-morbidities in patients who have died.

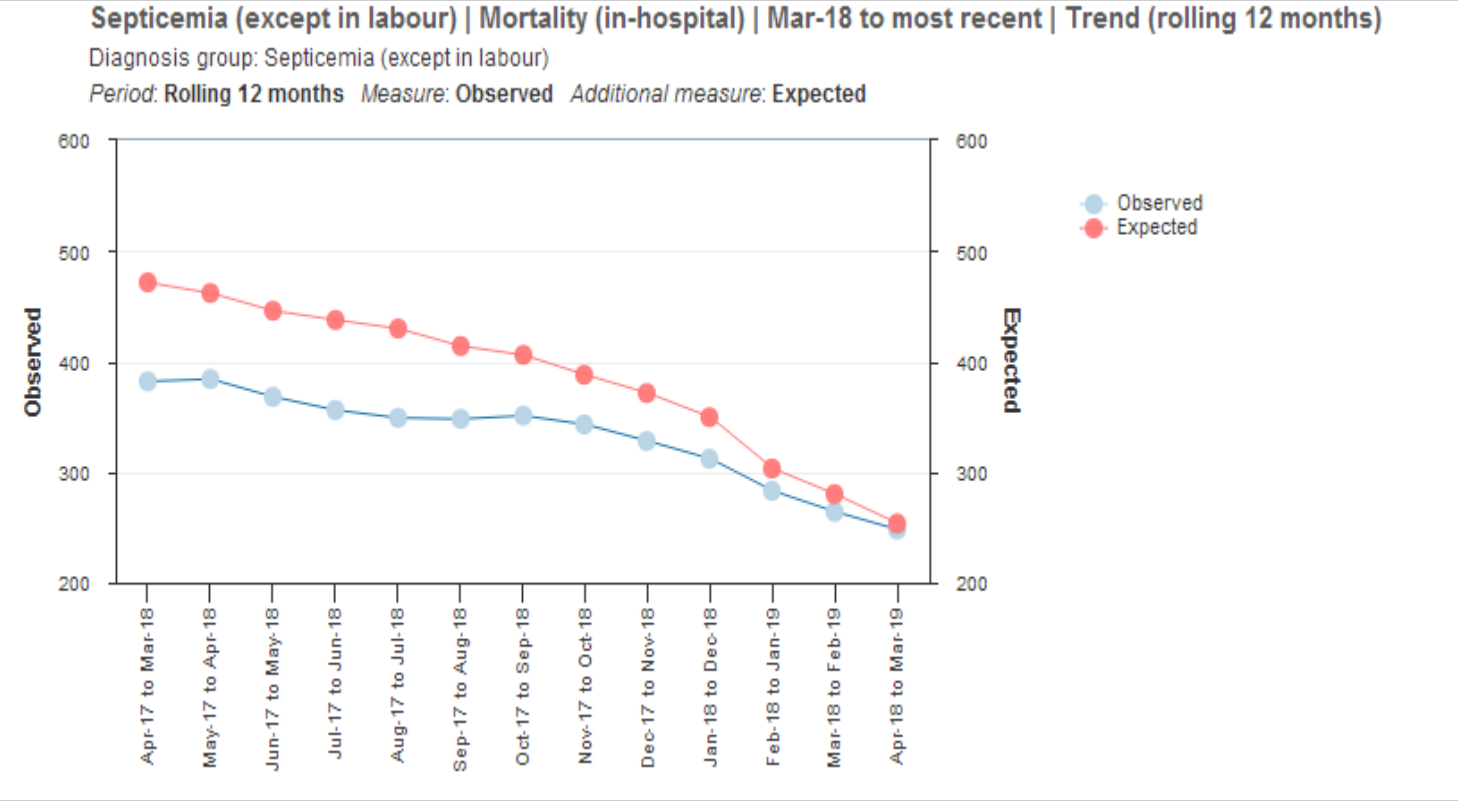
# Quality Performance - Effectiveness

Observed and Expected Deaths



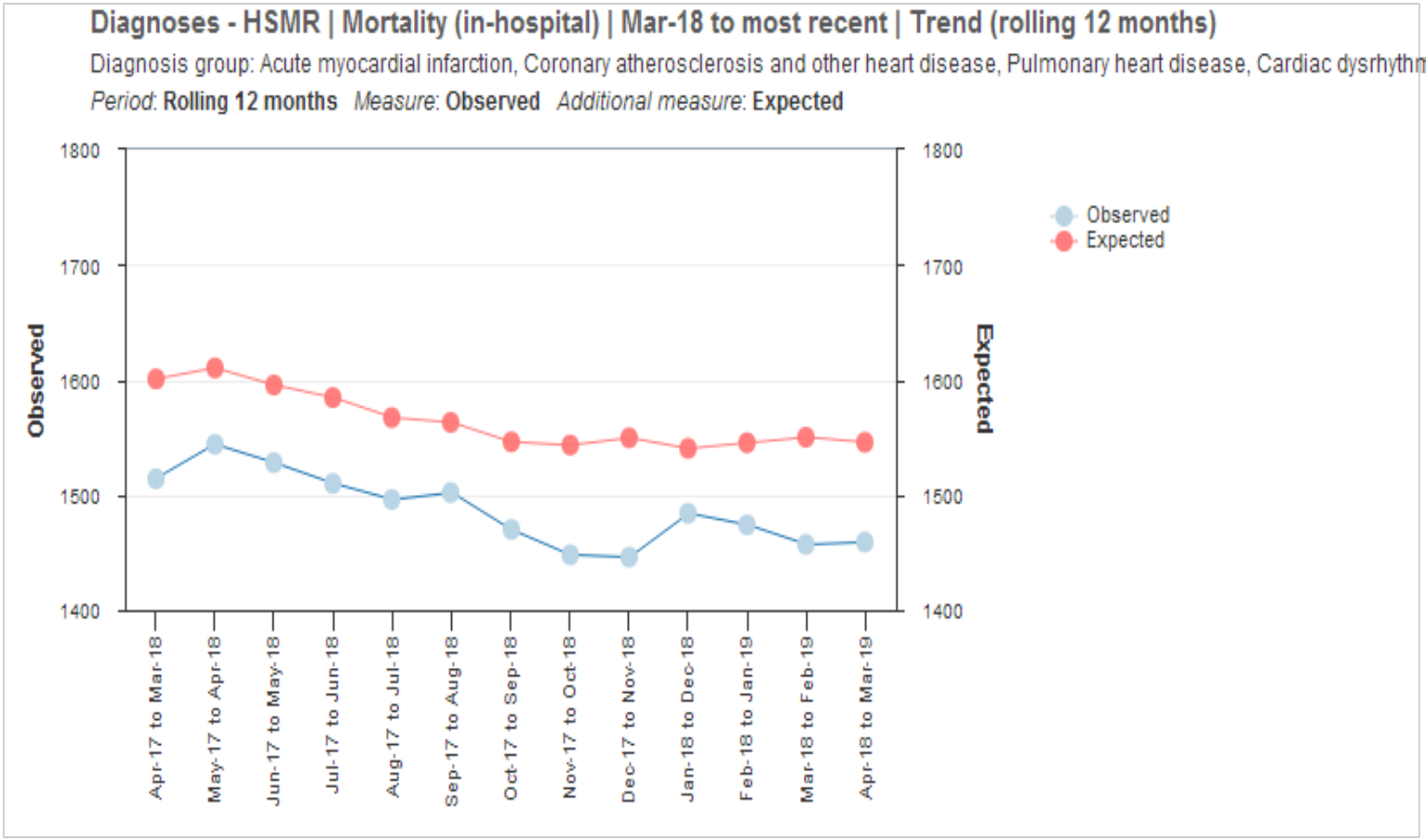
# Quality Performance - Effectiveness

Sepsis Deaths – Observed and Expected



# Quality Performance - Effectiveness

Observed & Expected Deaths excluding Sepsis



# Quality Performance - Safety

| Quality |
| --- |
| **Preventable Mortality** |
| **Target: HSMR Top 20% in the Country** |
| **Avoidable Harm** |
| **Target: Patient Safety Thermometer 99% Harm Free Care** |

The patient safety thermometer tool looks at point prevalence of four key harms –

- Falls
- Pressure ulcers
- Urinary tract infections
- Deep vein thrombosis (DVT) and pulmonary embolism (PE)

The actual number of patients who suffered no new harm during their inpatient stay at WSHFT was 98.7%.

# Quality Performance - Experience

The Trust works closely with patients and families across our services to ensure their views and experiences inform our improvement work. It is therefore very pleasing to note that our staff have:

- Embraced the duty of candour process so successfully
- Reformed how we respond when people raise concerns
- Our ward sisters and matrons pick up the phone as soon as a complaint is raised and in so doing are often able to solve problems directly
- Use of patient stories in our education programmes, sharing at huddles(via the safety newsletter) and at key trust meetings

# Systems & Partnerships – Summary

**Systems & Partnerships**

**Non Elective Care**

**Target: A&E 95% <4hrs**

**Elective Care**

**Target: RTT 92% <18wks**

- In line with the National picture the Trust saw significant increases in numbers of emergency patients attending both A&Es. Increase of 7.3% at Worthing and 4.3% at St Richards.

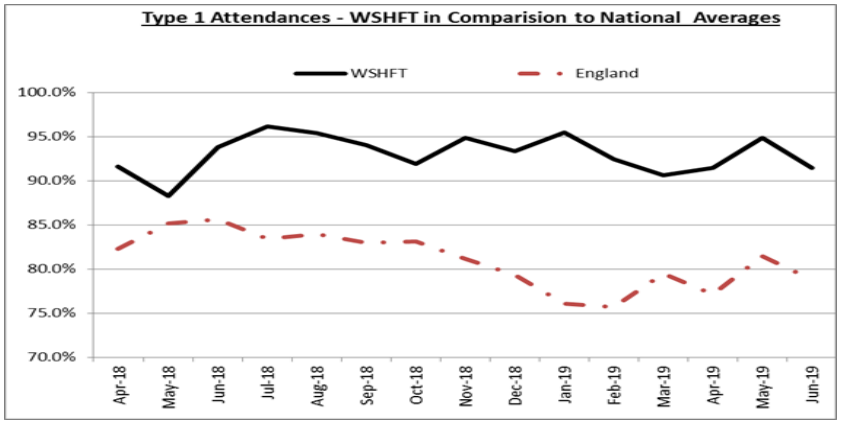
- A&E 4hr performance for June 19 was 92.4%, compared to 86.4% National performance. There were no 12 hr breaches. WSHFT sites were the 9th highest performing Type 1 A&Es nationally.

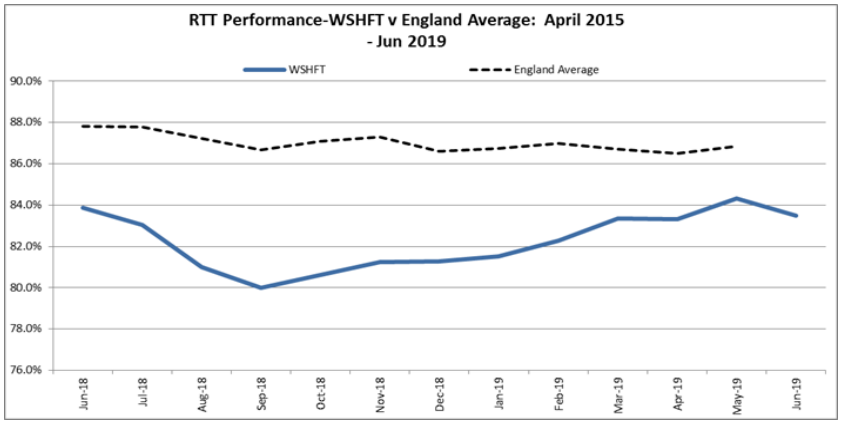
- RTT compliance in June 19 was 83.5% with no patients waiting over 52 weeks. The lower number of working days in June and lower activity impacted but the Trust remains on track to deliver the 92% target by the end of the year. The compliance against the RTT target for patients on an outpatient pathway improved to 90%.

- Cancer performance for June-19 is compliant against all of the targets, with 85.1% of patients treated within 62 days. This is well ahead of the Trust's recovery plan and in the context of continued significant increased demand. National average performance (May-19) deteriorated further to 77.5%.

- Diagnostic performance was non-compliant for the first time in June at 3%. This was directly linked to the loss of 150 scopes due to the loss of WLIs. Action taken and Trust is currently compliant again in July. National performance (May-19) was 4.5%.

# Systems & Partnerships – True North Metrics




- June 19 A&E performance was 92.4%
- June 19 saw a 3.8% increase in ambulance conveyances, a 6.0% increase in A&E attendances and a resulting 2.4% increase in subsequent emergency admissions compared to June 18
- There has been a 13.4% increase in the time in the dept for Mental Health patients as a proportion of all patient time in the department

**Actions Underway:**

- Kaizen led early morning discharge programme.
- Super Stranded improvement programme (LHE wide)
- Additional medical staff deployed within A&E
- Partnership programme of care for Mental Health with successfully commissioning of CORE24 Mental Health services agreed
- GP Extended Hubs commencing 1st August
- New Medical staffing model commences 1st August

- Jun-19 RTT performance was 83.5% for all specialties
- There were no patients waiting 52 weeks at end June 19
- The overall size of the waiting list reduced by 87 from May to June
- Outpatient compliance improved to 90% in June 19
- Key areas of pressure remain Orthopaedics, Ophthalmology, OMFS services and Gastroenterology – plans in place for all specialties

**Actions Underway:**

- Continued improvement theatre and outpatient efficiency programmes
- Additional capacity both internally and from external partners to mitigate loss of activity through WLI and pension concerns
- Substantive recruitment plans to fill vacancies in context of national shortages in some areas
- Enhanced weekly speciality PTL reviews in place
-

# Systems & Partnerships – Key Metrics

## Cancer Metrics

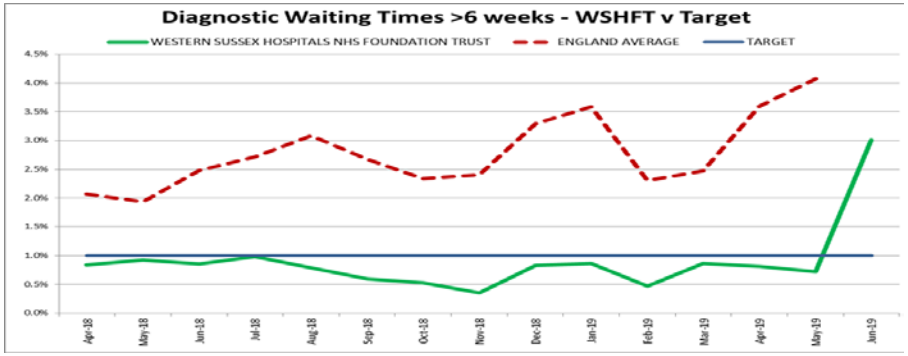
| Monthly and YTD | Target | 2019/20 YTD | Jun-19 |
|---|---|---|---|
| 2wk GP to 1st OP | 93.0% | 93.9% | 93.1% |
| 2wk GP to 1st OP (Breast) | 93.0% | 94.8% | 95.6% |
| 31day subsequent treatment (surgery) | 94.0% | 98.1% | 94.1% |
| 31day subsequent treatment (drug) | 98.0% | 100.0% | 100.0% |
| 31day subsequent treatment (all) | 96.0% | 98.1% | 97.6% |
| 62day referral to treatment (screening) | 90.0% | 90.4% | 91.5% |
| 62day referral to treatment (all Cancers) | 85.0% | 84.2% | 85.1% |

- The Trust was compliant against 7 of 7 reportable cancer metrics in June-19.
- 85.1% of patients were treated within the 62 day target in June 19, above the target and well above the National position of 77.5%
- Significant continued growth in cancer referrals - up a further 9.4% in 19/20, above the increased 18.2 % in 18/19

**Actions Underway:**

- Implementation of Optimal Pathway project (for colorectal patients) plus equivalent streamlined processes for prostate cancers
- Additional specialist nursing for prostate cancers
- Additional diagnostic capacity (imaging and histopathology).
- Enhanced daily tracking for over 62 day waiters with clear escalation rules , to expedite next steps for each patient.
- Review of MDT processes to ensure timely decision making.
- Focus on reduction to 7 day for first outpatient appointment.

## Diagnostic 6 Weeks




- Diagnostic performance was non-compliant with the national target in June 19 at 3% (compared to National of 4.5%)
- Short term capacity constraints in endoscopy have directly affected the performance in June – all other diagnostic modalities compliant
- The overall diagnostic waiting list reduced by 271 compared to May-18

**Actions Underway:**

- Additional locums have been engaged in July to clear the backlog
- Trust Nurse Endoscopists have backfilled additional sessions in July to clear the backlog
- Endoscopy forecast for July to have 0 patients waiting over 6 weeks and return to compliance with the target
- Medium term innovations in pathways adopting FIT testing proposed to support increases in recurrent capacity

# Sustainability - Summary

**Sustainability**

**Financial Management**

**Target: Break Even**

- The Trust is reporting a surplus £1.0m, excluding PSF and MRET, at the end of quarter 1.

- Achievement of the plan has enabled the Trust to be eligible to receive PSF income of £1.25m. The Trust will also receive payment of £0.8m of MRET income.

- The Trust remains on trajectory to deliver an underlying surplus of £2.5m at the end of the financial year. Delivery of this surplus will enable receipt of an additional £11.6m of PSF and MRET income, achieving the year-end control total of £14.1m

- At the end of Q2, the Trust must deliver a cumulative surplus of £2.28m to be eligible for a further £1.67m of PSF income. Delivery will require improved performance, primarily within elective activity and tight control of the cost base, particularly in relation to medical pay, which is a break-through objective for 2019/20.

# Sustainability - Key Metrics

## SOF Finance Rating — G

| | Plan | Actual/ Forecast |
|---|---|---|
| Year to Date | 1 | 1 |
| Year End Forecast | 1 | 1 |

At the end of June the aggregate finance rating is a '1'.

## Control Total (exc PSF) Surplus £k — G

| | Plan | Actual / Forecast |
|---|---|---|
| Year to Date (exc PSF*) £k | 976 | 992 |
| Year End Forecast (exc PSF) £k | 2,459 | 2,459 |
| Year to Date (inc PSF) £k | 3,043 | 3,829 |
| Year End Forecast (inc PSF) £k | 14,062 | 14,832 |

The Trust is reporting a surplus of £0.99m, excluding PSF and MRET funding at the end of June, delivering the plan for the quarter.

## Efficiency & Transformation Programme £k — G

| | Plan | Actual/ Forecast |
|---|---|---|
| Year to Date £k | 3,138 | 3,138 |
| Year End Forecast £k | 11,728 | 11,728 |

Savings of £3.1m have been achieved, delivering in full against the plan for the quarter. Back office, procurement and commercial efficiencies are delivering ahead of plan to mitigate timing delays in some of the operational schemes.

## Capital £k — G

| | Plan | Actual/ Forecast |
|---|---|---|
| Year to Date £k | 1,188 | 1,607 |
| Year End Forecast £k | 20,304 | 20,304 |

Year to date Capital Expenditure totals £1.6m. The forecast is being reviewed and scrutinised by CIG to ensure the full year programme value is not exceeded.

*PSF includes two funding streams - provider sustainability funds and MRET funding.

# Sustainability - Key Metrics

## Income £k — G

| | Plan | Actual/ Forecast |
|---|---|---|
| Year to Date £k | 114,581,131 | 116,483,863 |
| Year End Forecast | 463,679 | 462,843 |

At the end of June, income is £ 1.9m ahead of plan due to high levels of non-elective spells and A&E activity. Daycase and elective income continues to be behind plan. Outpatient income is also behind plan in June but is favourable in the year to date.

## Operating Costs £k — A

| | Plan | Actual/ Forecast |
|---|---|---|
| Year to Date £k | (107,625) | (109,492) |
| Year End Forecast £k | (437,011) | (436,232) |

At the end of June operating costs are £1.87m adverse to plan. Pay is £1.0m above plan predominantly driven by Medical expenditure. Non pay expenditure is £0.85m above plan. High cost drugs and devices are £0.1m below plan which is matched by income.

## Agency Ceiling £k — G

| | Plan | Actual/ Forecast |
|---|---|---|
| Year to Date £k | 3,603 | 2,757 |
| Year End Forecast £k | 14,969 | 2,757 |

Agency expenditure is £0.85m below the agency ceiling Medical agency expenditure has increased in month. Implementation of medical workforce models are intended to reduce these costs in future months.

## Cash £k — G

| | Plan | Actual/ Forecast |
|---|---|---|
| Year to Date £k | 16,540 | 11,520 |
| Year End Forecast £k | 28,620 | 28,620 |

At the end of June cash is behind plan by £5m as cash reserves have been utilised in both May and June to maintain our Creditor Days position (at < 40 days) for operating expenses.

# Sustainability - Action & Recommendations

There are no actions required of the Board.

The Board is asked to note the following:

- There has been a further distribution of Provider Sustainability Funding (PSF) from 2018/19. The Trust will receive a further £0.77m of PSF. As this adjustment was notified after the accounts were approved it will be reported in the 2019/20 position but will not contribute towards delivery of the 2019/20 control total.

- Emergency activity pressures have impacted on full implementation of the new models of care programme. Utilising the AIC, the Trust will be working with system partners to manage the issues that are impacting on demand and occupancy.

- The Trust is forecasting delivery in full of the £14.1m control total surplus including PSF and MRET for 2019/20.

# Our People – Summary

| People |
| --- |
| **Staff Engagement** |
| **Target: Engagement Score Top in the Country** |

## 1.0 INTRODUCTION

- Pay – overall £42k favourable position , but medical pay £252k adverse. YTD £1.12m adverse
- KPI's – overall performance favourable with exception of appraisal rates and statutory and mandatory training for medics
- Engagement score – at 8.05 highest engagement score to date with improvement across all divisions
- Breakthrough objective – 69.47% staff able to make improvements happen in their area of work

# Operational Performance – Capacity and Capability

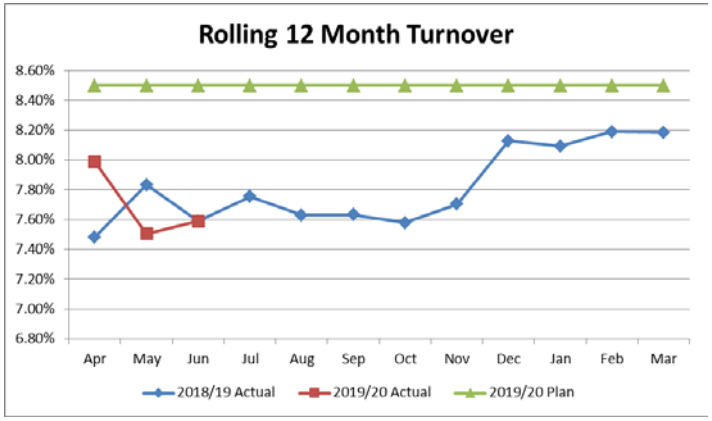
| | Annual Budget £000s | In Month Budget £000s | In Month Actual £000s | In Month Variance £000s | Year to Date Budget £000s | Year to Date Actual £000s | Year to Date Variance £000s |
|---|---|---|---|---|---|---|---|
| **PAY** | | | | | | | |
| Medical Staff | (83,760) | (7,192) | (7,444) | (252) | (21,191) | (22,677) | (1,486) |
| Nursing Staff | (115,735) | (9,558) | (9,467) | 91 | (29,293) | (29,538) | (245) |
| Professional Staff | (41,994) | (3,513) | (3,371) | 142 | (10,654) | (10,389) | 264 |
| Admin & Management Staff | (44,784) | (3,716) | (3,657) | 59 | (11,333) | (11,016) | 317 |
| Estates Staff | (16,663) | (1,378) | (1,376) | 2 | (4,224) | (4,196) | 28 |
| Total | (302,936) | (25,356) | (25,314) | 42 | (76,694) | (77,815) | (1,121) |

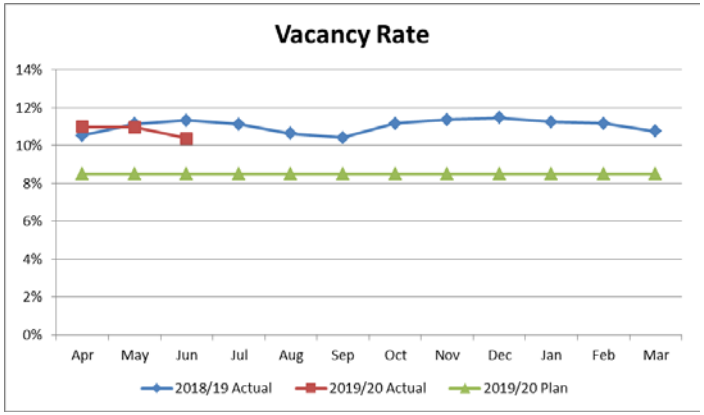
In June the Trust spent £25.3m on these workforce groups - £0.3m lower than the previous month and now within in-month budget. The most significant variance remains in Medical staffing where despite an overspend of £720k in M1 this is slowing to £252k in M3. This also follows a £200k budget uplift. Overspends in medical staff are largely driving the staff group being £1.5m above budget. All other staff groups spent within their pay budget in Month 3

Despite a reduced budget requirement, contracted staff have increased to the highest WTE volume in the past 12 months. This has also enabled a higher % worked to budget, with a further 47 WTE worked in M3 than M2. Temporary workforce has increased by 0.3% WTE, however the overall cost of temporary staff has lowered.

| | | Last Month | This Month | Variance |
|---|---|---|---|---|
| Budgeted Establishment | wte | 6785.4 | 6764 | ↓ |
| % Worked to Budget (wte) | % | 97.1% | 98.1% | ↑ |
| Temporary Workforce (WTE) | % | 9.9% | 10.2% | ↑ |
| Agency | % | 1.4% | 1.6% | ↑ |
| Bank | % | 8.0% | 8.1% | ↑ |

# Operational Performance – Key Metrics




- Turnover increased slightly in June to 7.6% but remains significantly below the Trust ceiling of 8.5%
- Core and Corporate turnover remain above the Trust ceiling rate
- Core Division have completed an A3 on turnover and identified a number of actions to improve retention. The Division are ensuring that stay interviews are being carried out to minimise the number of leavers within the first 2 years. They are also engaging in joint working with local Trusts on workforce issues.

**Improvement Focus:**

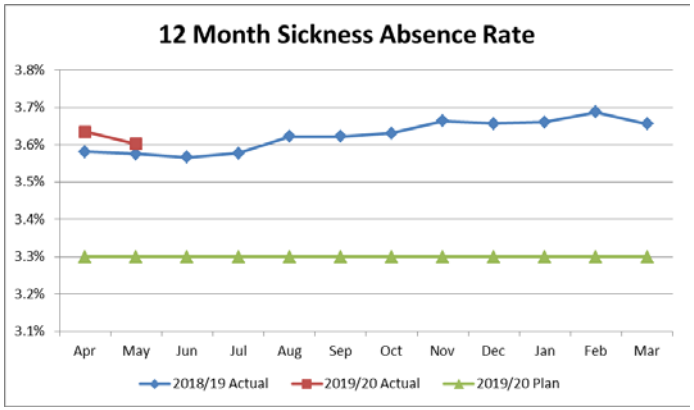
- Core Division to progress their work on retention focusing on hot spot areas
- Trustwide review of flexible working and retirement to be taken forward, utilising information from exit interviews

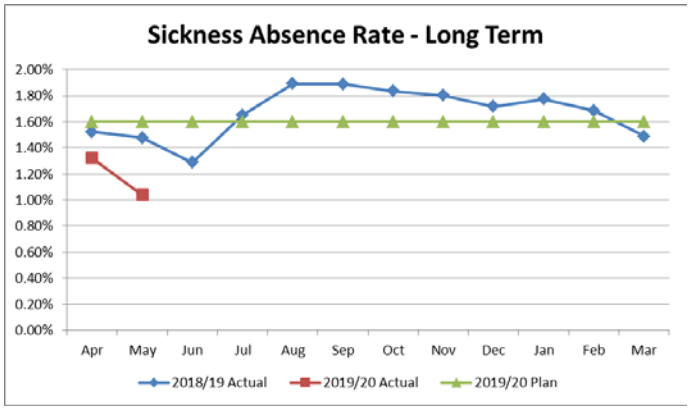
- Vacancy rate has decreased again in June down to 10.4%
- Vacancy rates in Medicine and Estates and Facilities remain high
- Vacancies in Medicine mainly in nursing and medical staff
- Actions underway to improve medical staff recruitment in Medicine including refreshed adverts, improved recruitment packs, and increase in Clinical Fellow posts
- Nursing recruitment day being held on 20 July
- Refer a friend scheme for Band 5 nurses to be piloted from August

**Improvement Focus:**

- To continue with focused initiatives to improve recruitment

# Operational Performance – Key Metrics



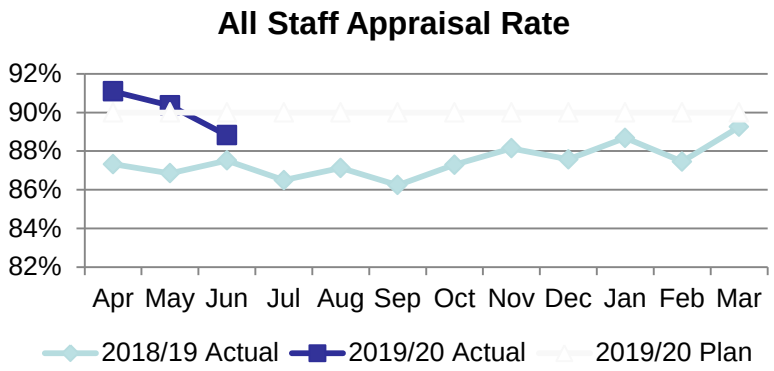

- Monthly sickness absence rates during April and May have been significantly lower than in April and May the previous year (0.3% and 0.4% lower respectively)
- All Divisions (other than Corporate) saw a decrease in absence levels in May and were below their ceiling percentage
- This low level of sickness in the first 2 months of the year is impacting on the 12 month rate which has reduced to slightly above the rate at the same time last year
- Long term absence fell quite significantly during April and May and this makes up the majority of the reduction in the overall absence level.

- The Divisions are taking forward actions to reduce sickness absence including:
  - Medicine Division have held away days including health and wellbeing focus.
  - Women and Children are taking forward work to understand their levels of mental health absence
  - Surgery are looking at junior doctor sickness absence to address causes and issues
  - Estates and Facilities have completed an A3 which will be reported on through SDR

**Improvement Focus:**

- To continue Divisionally led projects to improve sickness absence rates

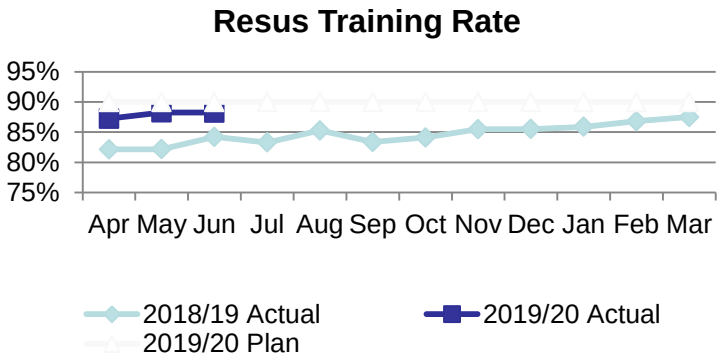
# Operational Performance – Key Metrics




- Appraisal compliance reduced to 88.3% in June
- Medical appraisal remains compliant at 92%
- Deterioration in Medicine division to 82.6% following 111 staff out of date in last month
- 33% of appraisals out of date less than 1 month
- 90%+ compliance in all divisions except Medicine and Surgery

**Improvement Focus:**

- Prioritising appraisals within A&E's and Emergency Floors and staff out of date by more than 3 months




- 8 out of 9 STAM modules remain above the Trust target of 90%
- With exception of Core division, overall medical staff compliance is below 90%
- Resus training is slightly below the Trust target at 88.2% but is continuing to show an improvement against last year
- Whilst the overall rate for Safeguarding Adults is 92.3%, the compliance for level 2 (clinical staff) is 61.7%.

**Improvement Focus:**

- Continue to work with the Medical Director and medical leaders to improve the attendance rates for medical staff
- Prioritise medical staff who are out of date by 1 training module to improve overall compliance
- Continue to work with divisions to improve clinical staff's attendance on Safeguarding Adults training through e-learning or standalone sessions

# Improving Staff Engagement

**Staff Engagement Score** (Pulse Survey)

- 8.05 in June with 100 participants
- Reflects staff conferences, STAR nominations, Patient First briefings, divisional engagement programmes and visits, PFIS refresh
- 93% recommendation as place to work
- 97% recommendation as place to be treated

**Breakthrough Objective** (Pulse Survey)

- 69.5% of staff were able to make improvements happen in their area of work
- Compares to 61.01% in June 2018
- Reflects PFIS refresh and change of content and emphasis on Western Sussex Way module delivered on Health and Safety days

**Health and Wellbeing**

- Health and wellbeing plans presented to Trust Executive Committee including pilot programmes of mental health champion training, burnout prevention groups and work with Sussex Partnership Foundation Trust on suicide prevention
- Flu campaign preparation and planning underway to achieve 80% target

**Equalities and Inclusion**

- WRES and WDES reports and improvement plans scheduled for Diversity Matters Group (22 July)
- Participation in Worthing Pride 13 July
- Rainbow Warriors launched with pledges from over 250 staff to sign up
- Engagement plan for works to multi-faith prayer room at Southlands
- Programme to improve quality of monitoring data commenced

**Staff Conference**

- The second Staff Conference was held at the Hilton Avisford Park on 13 June
- 191 staff attended on the day from across all professions in the Trust
- There were 32 DNAs on the day
- Feedback on both Staff Conferences very positive.  The overall rating achieved a score of 4.6 (out of 5.0)

# Improving Staff Engagement

**Recruitment and Retention**

- Fill-rate for medical training posts from August to October 2019 confirmed and local recruitment under way to fill outstanding vacancies including the Clinical Fellows in Medicine and Emergency Medicine. Improved fill in most specialties
- Working days from offer to completion of recruitment checks has been within the agreed KPI for last 4 months for external recruitment (<33 days) and last 2 months for internal recruitment (<20 days)
- Overall time to hire is 81 days against a target of 72 days – this is impacted by long notice periods and aligning start dates with training for some groups of staff. Work will be undertaken to identify ways to reduce this
- Nursing recruitment day taking place on 20 July at St Richards Hospital

**Widening Participation**

- The Trust Apprentice Levy digital account balance at end June 2019 was £2.4m
- Apprentice awards ceremonies for 20 staff who completed an apprenticeship programme during 2018/19 held
- 13 work experience placements in June within physiotherapy, inpatient wards and medical imaging

**Workforce Systems**

- Programme of work to improve compliance and embed functionality of Safecare commenced
- Roll-out of e-rostering for junior doctors completed in medicine at SRH. Lessons learned, including improving engagement with doctors built into August rotation with roll out to junior doctors at Wg

**Other**

- Outcome of Junior Doctor contract review completed and BMA members voted in agreement of proposed deal. Awaiting implementation timeline to review actions required locally and impact to rota patterns and exception reporting process
- Pension tax seminars in place during July and August. To date 80 staff registered to attend

# Communications & Engagement

**Patient First STAR Awards**

- More than 800 nominations received for annual staff and volunteer recognition awards
- Significant year-on-year increase in nominations (476% over 5 years)
- 110 nominations from members of the public (400% increase)
- More than 80% of nominations endorsed by appropriate manager
- All nominated staff and volunteers will be receiving a personalised certificate of congratulations
- Judging panel convenes 1 August to determine shortlist
- Shortlisted nominees incited to Patient First STAR Awards dinner and prize ceremony at Worthing Assembly Hall on 26 September

**Staff briefing / Q&A sessions with executive team**

The communications team organises staff briefings and Q&A sessions with the executive team in each of the trust's hospitals.

- Since 25 March, approximately 700 members of staff have attended 15 meetings
- A further 12 meetings are arranged and taking place in the coming weeks

**Social Media**

The communications team uses social media to communicate directly with thousands of people living locally, as well as our staff and interested parties further afield. The number of *followers* our main social media channels attract continues to grow:

- Facebook (@westernsussexhospitals) – 4,856 followers (+9.3% since April)
- Twitter (@westernsussex) – 3,935 followers (+7.6% since April)
- Instagram (@westernsussexhospitals) – 1,664 followers (+15% since April)
- Social media reach for popular trust stories ranges from 50,000 to 100,000+

The communications team also provides support and guidance to other teams, specialties and departments to use social media to improve staff engagement, as well as communication with patients, partners and stakeholders.

- The communications team regularly sets up new trust accounts
- Currently, the trust has more than 30 Twitter, Facebook and Instagram accounts
- Staff and public are encouraged to use the hashtag #WSHT to help people track the organisation on social media

# Communications & Engagement

**External website & StaffNet**

The communications team manages the trust's external and internal websites, regularly publishing new information.

- www.westernsussexhospitals.nhs.uk = 41,000 users + 153,000 unique page views / month (+10% year-on year)
- StaffNet (trust intranet) = 418,000 page views / month (+20% year-on-year)

**Media / press releases**

The Communications team manages a number of media enquiries every week, issuing statements as appropriate.
The team also drafts news releases which are published on the trust website, promoted via social media and issued to news organisations.
Recent news releases picked up by the media include:

- Hospital apprentices win Health Education awards
- 1200 more patients discharged in the morning
- Happy 10th Birthday #wesTENsussex
- Could you be a Western Sussex Hospitals governor?
- Western Sussex clinicians in world first for marathon research
- Multi-million pound investment in Radiology services
- Top 10 A&E performance secures multi-million pound investment
- Public invited to Trust Board meeting
- Mums invited to join exciting new partnership
- Expert advice on allergies available
- Invite to Council of Governors
- Western Sussex named Top Hospital winner 2019
- Trainee Doctor Excellence Awards
- *ReciteMe* - new software makes our websites more accessible
- Invitation to Annual General Meeting

Western Sussex Hospitals
NHS Foundation Trust

| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 11 | **Meeting:** | Trust Board | **Meeting Date:** | 25 July 19 |
| **Report Title:** | Finance and Performance Committee Report to Board | | | | |
| **Sponsoring Executive Director:** | Lizzie Peers, Non-Executive Director | | | | |
| **Author(s):** | Lizzie Peers, Non-Executive Director | | | | |
| **Report previously considered by and date:** | N/A direct report to Board | | | | |
| **Purpose of the report:** | | | | | |
| Information | ✓ | | Assurance | ✓ | |
| Review and Discussion | ✓ | | Approval / Agreement | ☐ | |
| **Reason for submission to Trust Board in Private only (where relevant):** | | | | | |
| Commercial confidentiality | ☐ | | Staff confidentiality | ☐ | |
| Patient confidentiality | ☐ | | Other exceptional circumstances | ☐ | |
| **Link to Trust Strategic Themes:** | | | | | |
| Patient Care | ✓ | | Sustainability | ✓ | |
| Our People | ✓ | | Quality | ✓ | |
| Systems and Partnerships | ✓ | | | | |
| **Any implications for:** | | | | | |
| Quality | | | | | |
| Financial | | | | | |
| Workforce | | | | | |
| **Link to CQC Domains:** | | | | | |
| Safe | ☐ | | Effective | ☐ | |
| Caring | ☐ | | Responsive | ☐ | |
| Well-led | ☐ | | Use of Resources | ☐ | |
| **Communication and Consultation:** | | | | | |

**Executive Summary:**

The Finance and Performance Committee met on 4 July 2019 and was quorate as it was attended by five Non-Executive Directors and the Chief Executive, Chief Delivery and Strategy Officer, Chief Medical Officer. Attending the meeting were also the Finance Director, Managing Director, Director of Human Resources and Director of Efficiency & Delivery.

The Committee received its planned items and debated these reports in accordance with its cycle of business.

**Key Recommendation(s):**

The Board is asked to **NOTE:**

The Trust has been notified of a further £770k of Provider Sustainability Funding (PSF) from NHSI in respect of 2018/19, taking the total amount received to £28.033m

The Committee gained assurance from the reports received and its review of the BAF. The Committee did not refer any matters to the Executive for review.

The Committee reviewed and were assured over the two business cases for the Medicine Division relating to the Implementation of New Models of Care and Medical Junior Doctors which are enablers to the delivery of the Trust's efficiency programme.

Western Sussex Hospitals NHS Foundation Trust

To: Trust Board

Date: 25 July 2019

From: Finance and Performance Committee

Agenda Item: 11

**COMMITTEE HIGHLIGHTS REPORT TO BOARD**

| Meeting | Meeting Date | Chair | Quorate | |
|---|---|---|---|---|
| | | | yes | no |
| **Finance and Performance Committee** | **4 July 2019** | **Lizzie Peers** | ✓ | ☐ |

## Declarations of Interest Made

There were no interests declared in relation to the business of the Committee.

## Assurance received at the Committee meeting

- The Committee **RECEIVED** the suite of financial performance reports. The Committee was assured in respect of the Trust's performance against the plan for Month 2, noting the higher than planned contract activity linked to high attendances in A&E, although it was noted that these were not as high as they had been in Month 1, an increase in non-elective spells and increased numbers of outpatient attendances.
- The Committee **RECEIVED** an update on workforce performance and was assured over the Trust's performance across the range of key areas for Month 2 including; appraisal compliance, statutory and mandatory training compliance, sickness rates and staff turnover noting a pleasing reduction in staff turnover.
- The Committee **RECEIVED** the Efficiency Programme update, noting that in Month 2 financial savings of £1.01m had been achieved, and was assured over the plans for delivery of both in-month planned savings and year-end forecasts.
- The suite of operational performance reports was **RECEIVED** by the Committee with additional information in relation to the Trust's performance trajectories for 2019/20. The Committee noted that the Trust was not compliant against the constitutional target for A&E; the Trust was compliant against 6 of the 7 Cancer metrics. Referral to Treatment compliance improved in May, and Diagnostic performance remained compliant despite increased demand pressures. The Committee noted the increased risk to these targets of the demand pressures.
- The Committee **RECEIVED** the presentations used as part of the Use of Resources assessment on 27 June 2019 and were advised that the information provided an uplifting showcase of the Trust at its very best.
- The Committee **RECEIVED** and were assured over the two business cases for the Medicine Division relating to the Implementation of New Models of Care which will provide a more ambulatory service to those patients not requiring 24/7 nursing care and Medical Junior Doctors which looks to rebuild junior doctor rotas to be delivered through substantive employment of Physician Associates and Clinical Fellows. Both of these initiatives are enablers to the delivery of the Trust's efficiency programme.
- The Committee **RECIEVED** the Board Assurance Framework and was assured through the reports at the Committee meeting that there were no risks that were under-scored that needed referring back to the Executive.

## Actions taken by the Committee within its Terms of Reference

There were no specific actions that required a Committee decision at this meeting.

| Items to come back to Committee (Items the Committee keeping an eye on) | |
|---|---|
| ▪ The Committee requested that an action plan in relation to performance against Time to Triage and Time to Treatment be shared with Committee at a future meeting.<br><br>▪ The Committee requested that the Management Development Training Programme includes practical training on key business processes and this links with the Leadership Programme in development at present.<br><br>▪ The Committee requested that the process for reporting the implementation of the New Models of Care business case to Board, be brought to the Committee for approval. | |
| **Items referred to the Board or another Committee for decision or action** | |
| **Item** | **Referred to** |
| The Committee did not have any items to refer to the Board or other Sub-Committees of the Board. | |

Western Sussex Hospitals
NHS Foundation Trust

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|---|---|---|---|---|---|
| **Agenda Item:** | 12 | **Meeting:** | Trust Board | **Meeting Date:** | 25 July 19 |
| **Report Title:** | Audit Committee Report to Board | | | | |
| **Sponsoring Executive Director:** | Jon Furmston, Non-Executive Director | | | | |
| **Author(s):** | Jon Furmston, Non-Executive Director | | | | |
| **Report previously considered by and date:** | N/A direct report to Board | | | | |
| **Purpose of the report:** | | | | | |
| Information | ☐ | | Assurance | ✓ | |
| Review and Discussion | ☐ | | Approval / Agreement | ☐ | |
| **Reason for submission to Trust Board in Private only (where relevant):** | | | | | |
| Commercial confidentiality | ☐ | | Staff confidentiality | ☐ | |
| Patient confidentiality | ☐ | | Other exceptional circumstances | ☐ | |
| **Link to Trust Strategic Themes:** | | | | | |
| Patient Care | ✓ | | Sustainability | ✓ | |
| Our People | ✓ | | Quality | ✓ | |
| Systems and Partnerships | ✓ | | | | |
| **Any implications for:** | | | | | |
| Quality | | | | | |
| Financial | | | | | |
| Workforce | | | | | |
| **Link to CQC Domains:** | | | | | |
| Safe | ☐ | | Effective | ☐ | |
| Caring | ☐ | | Responsive | ☐ | |
| Well-led | ✓ | | Use of Resources | ☐ | |
| **Communication and Consultation:** | | | | | |
| | | | | | |

**Executive Summary:**

The Audit Committee met on the 08 July 2019 and was quorate as it was attended by two Non-Executive Directors. Attending the meeting were also the Trust's External and Internal Auditors, the Trust's Local Counter Fraud Specialist, the Director of Finance and the Group Company Secretary.

The Committee received its planned items and debated these reports in accordance with its cycle of business.

The Committee reviewed its effectiveness over the previous year and that of its key assurance providers, external audit, internal audit and the local counter fraud specialist. This was encapsulated in an annual report, which is included as an appendix to this report, and culminated in agreement that there were no issues identified that required a change to the Committee's terms of reference.

**Key Recommendation(s):**

The Board is asked to **NOTE:**

The Committee gained assurance from the reports received and its review of the BAF. The Committee did not refer any matters to the Executive for review.

The Committee reviewed its activity over the last year (2018/19) and did not identify any issues that would require a change to its terms of reference.

Date: 25 July 2019

To: Trust Board

From: Audit Committee Agenda Item: 12

**COMMITTEE HIGHLIGHTS REPORT TO BOARD**

| Meeting | Meeting Date | Chair | Quorate | |
|---|---|---|---|---|
| **Audit Committee** | **08 July 2019** | **Jon Furmston** | **yes** | **no** |
| | | | ✓ | ☐ |

**Declarations of Interest Made**

No interests were declared.

**Assurance received at the Committee meeting**

- The Committee **RECEIVED** the BAF and information on the supporting high scoring risks and agreed that the BAF encapsulated the key strategic risks, that the assigned oversight committees for each risk were appropriate and that the expected assurances were reasonable.
- The Committee **RECEIVED** assurance from the Internal Audit Strategic and Operational Plan for 2019/20, that it was aligned with the Trust's key risk areas.
- The Committee **RECEIVED** assurance from Internal Audit in relation to the Trust's Medical Rostering process notably that the Trust was making ongoing and continued progress in this area.
- The Committee **RECEIVED** assurance from the Local Counter Fraud Specialist that fraud risks were being managed and that additional training within the Procurement Department was being provided.
- The Committee reviewed its effectiveness over the previous year and that of its key assurance providers, external audit, internal audit and the local counter fraud specialist. This was encapsulated in an annual report, which is included as an appendix to this report, and culminated in agreement that there were no issues identified that required a change to the Committee's terms of reference.

**Actions taken by the Committee within its Terms of Reference**

- The Committee **APPROVED** the Internal Audit Strategic and Operational Plan for 2019/20.

**Items to come back to Committee / Group (Items Committee / Group keeping an eye on)**

- The Committee agreed that it would receive Deep Dives on a regular basis, on the risks within the BAF that are not specifically reported to any of the other Committees of the Board so that it could assure itself that the level of risk is appropriate and being managed suitably.

**Items referred to the Board or another Committee for decision or action**

| Item | Referred to |
|---|---|
| The Committee did not have any actions to escalate to the Board or refer to any other sub-committee of the Board. | |

To: Audit Committee Date: July 2019

From: Chair of the Audit Committee Agenda Item: 12

**FOR ENDORSEMENT**

**DRAFT - ANNUAL REPORT FROM THE AUDIT COMMITTEE TO THE BOARD 2018-19**

## 1.00 INTRODUCTION

1.01 The purpose of this report is to formally report to the Board on the work of the Audit Committee during the period 1 April 2018 to 31March 2019 and to set out how the Committee has met its terms of reference and key priorities.

1.02 The Audit Committee's Terms of Reference require it to report annually to the Board outlining the work it has undertaken during the year and where necessary, highlighting any areas of concern.

## 2.00 EXECUTIVE SUMMARY

2.01 The Audit Committee has the delegated authority to act on behalf of the Board in accordance with the Constitution, Standing Orders, Standing Financial Instructions and Scheme of Delegation. It follows best practice guidance as set out in the NHS Audit Committee Handbook providing a form of independent check upon the management of the Trust.

2.02 The Committee is responsible for providing assurance to the Board that appropriate systems of internal control and risk management are in place covering all corporate and clinical areas of the Trust. In carrying out this work the Audit Committee obtains assurance from the work of the Internal Audit, External Audit and Counter Fraud Services.

2.03 The Committee independently reviews, monitors and reports to the Board on the attainment of effective control systems and financial reporting processes.

2.04 The Committee reviews the financial year-end Annual Report, Annual Accounts and Annual Governance Statement with the External Auditor prior to Board approval and sign off.

## 3.00 COMMITTEE MEMBERSHIP AND MEETINGS

3.01 The Committee comprises solely of independent Non-Executive Directors in line with the Code of Governance for Foundation Trusts. There are three Non-Executive Directors who are allocated to the Committee although all Non-Executive Directors, except the Chair, can attend the meeting. Following the implementation of the management contract with Brighton and Sussex University Hospitals NHS Trust in 2017/18 two Non-Executive Director advisers also regularly attend the Audit Committee, which strengthens the oversight that the Committee is able to provide.

3.02 The Chief Financial Officer, Chief Workforce and Organisational Development Officer, Finance Director, Company Secretary, Local Counter Fraud Services, Internal and External Auditors are regular attendees at meetings of the Committee. Other senior Trust officers also attend Committee meetings for specific items at the Committee's request.

3.03 The table below details the membership and attendance of Committee members in respect of the period 1 April 2018 to 31March 2019.

| Name | Apr | May | Jul* | Oct | Jan | Total |
|---|---|---|---|---|---|---|
| Jon Furmston (Non-Executive Director and Committee Chair) | ✓ | ✓ | ✓ | ✓ | ✓ | 5 of 5 |
| Lizzie Peers (Non-Executive Director) | ✓ | ✓ | × | ✓ | ✓ | 4 of 5 |
| Joanna Crane ^^ (Non-Executive Director) | ✓ | × | × | × | ✓ | 2 of 5 |
| Martin Sinclair (Associate non voting Non-Executive Director) | ✓ | ✓ | ✓ | ✓ | ✓ | 5 of 5 |
| Kirstin Baker (Associate non voting Non-Executive Director) | ✓ | ✓ | ✓ | ✓ | × | 4 of 5 |

* The July Committee was not quorate – items requiring agreement were circulated post meeting for approval and ratified at next meeting.
^^ Joanna Crane joined the Committee after the start of the year and it was acknowledged that Joanna had other commitments which would impact on her ability to attend some of the meetings during the year.

3.05 In order to share learning and to ensure linkages are made across Trust Committees the membership of the Audit Committee includes the Chair of the Quality and Risk Committee (Joanna Crane) renamed for 2019/20 as the Quality Assurance Committee and a member of the Finance and Investment Committee (Lizzie Peers) now the Chair of the renamed Finance and Performance Committee.

## 4.00 CYCLE OF BUSINESS

4.01 The Audit Committee agenda is based upon an agreed forward work plan which is reviewed and approved at the start of the financial year.

4.02 Audits are agreed jointly by both the Executive and the Non-Executive Committee members at the start of the year and are focused on areas of perceived highest risk. The Audit Committee receives the reports of those audits and tracks the implementation of recommendations at each of its meetings.

4.03 In order to maintain independent channels of communication, the members of the Audit Committee hold a private meeting collectively with External Audit, Internal Audit and Counter Fraud ahead of each Audit Committee. This provides all parties the opportunity to raise any issues without the presence of management.

4.04 The Committee followed its agreed annual work plan throughout the year and received a series of post project reviews and executive presentations around internal audit, external audit and Local Counter Fraud Services.

## 5.00 INTERNAL AUDIT

5.01 Internal audit provide an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives.

5.02 The Trust's Internal Auditor is BDO LLP.

5.03 The Internal Audit plan for 2017/18 was approved by the Audit Committee in April 2018. The plan was based upon discussions held with management and the Audit Committee and was constructed in such a way as to gain a level of assurance on the main financial and management systems reviewed.

5.04 The Head of Internal Audit presents a progress report to each of the Committee's meetings. The report sets out progress against the agreed audit plan, and the principal outcomes from audits completed in the period since the previous meeting. The Committee also receives a summary of all reports together with the full report of any audit with a Limited Assurance rating.

5.05 During the year the Audit Committee received 10 Internal Audit reports, with 4 reviews carried forward to 2019/20. Internal Audit Reports receive two Assurance ratings; one relates to the Design of the system being reviewed while the other relates to the Effectiveness of the system being reviewed. Internal Audit can provide Assurance Levels of: 'substantial', 'moderate', 'limited' or 'no' assurance. Of the audits relevant to this period all received assurance levels of either moderate or limited and action plans are in place, and monitored, to ensure recommendations are addressed. None of the audits received Limited Assurance for both 'design' and 'Effectiveness' of the system.

5.06 Based on work undertaken during the period of this report the Head of Internal Audit has stated in his Head of Internal Audit Opinion that "Overall, we are able to provide moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently". This level of opinion is the same as provided for the previous year, 2017/18.

5.07 In forming their opinion they took into account that, the Trust had delivered its control total, that the majority of audits provided moderate assurance including the key audits of key financial systems, divisional governance and data quality. Internal Audit provided only one part limited assurance opinion in the year and this was over the effectiveness of the well-designed controls. For this area specifically, as well as in respect of all recommendations made, actions to address their findings were confirmed by Internal Audit to be underway.

5.08 Internal Audit also reflected that the Trust has a good record in implementing internal audit recommendations and through their testing they had confirmed closure of nearly all prior year recommendations (94% having been confirmed as closed, with all high grade recommendations confirmed as closed). Internal Audit confirmed that for the 3 remaining recommendations action was in progress and these did not pose any unaddressed significant risk.

5.09 At the end of 2018/19 the Audit Committee oversaw the tender process for the appointment of the Trust's Internal Auditors and as part of this process the Committee endorsed the approach to seek the ability through this procurement process to have a consistent Internal Audit supplier across both Western Sussex Hospitals NHS Foundation Trust and Brighton and Sussex Universities Hospital NHS Trusts.

## 6.00 LOCAL COUNTER FRAUD SERVICE (LCFS)

6.01 The Counter Fraud service is provided by RSM and reports quarterly to the Committee. There is a dedicated team responsible for day to day awareness and activities. The reports describe proactive work to prevent or deter fraud and also set out the results of reactive work undertaken in response to referrals about suspected fraud.

6.02 A work plan for 2018/19 was agreed with the Finance Director and approved at the Audit Committee in April 2018. The work plan outlined the core Local Counter Fraud Specialist (LCFS) activities to be undertaken during the financial year within the agreed resources. Key activities undertaken during the financial year include areas of strategic governance, inform and involve, prevent and deter and hold to account.

6.03 In addition the update report from LCFS included an organisational risk profile, updated each meeting, which helps to provide a 'tracker' of where the Trust sits in relation to key fraud risks.

6.04 During the year the LCFS participated in a number of proactive projects to prevent or detect fraud. The LCFS also advised on improvements to policies and procedures, to reduce the risk of fraud.

6.05 The Local Counter Fraud Specialist reports annually on behalf of the Trust to the Counter Fraud Authority in relation to compliance against the Standard for Providers. The Trust has again achieved an overall status of GREEN for the year 2018/19 as shown below:

| **Area of Activity** | **SRT Rating** |
|---|---|
| Strategic governance | Green |
| Inform and involve | Green |
| Prevent and deter | Green |
| Hold to account | Green |
| **Overall rating** | Green |

6.06 During the year the Audit Committee oversaw the tender process for the appointment of the Trust's LCFS. This process saw RSM successfully reappointed.

## 7.00 YEAR END REPORTING

7.01 The Committee reviewed and approved the Annual Report (including the Quality Account) and Accounts and the Annual Governance Statement allowing the Audit Committee members to be appropriately engaged in the preparation of the Annual Report and Accounts.

7.02 The Committee also received the assurance report to External Audit from the Chief Financial Officer and Audit Committee chair and endorsed its content that there were no matters that had not been disclosed to the Auditors.

7.03 The Committee received a report on the Trust's processes for registering declarations of interest, the receipt of gifts, hospitality and sponsorship along with the compliance with the fit and proper person's regime. The Committee was informed of the high return rate across the Trust.

## 8.00 EXTERNAL AUDIT

8.01 External Audit report to the Trust on the findings from their audit work, in particular their review of the financial statements and the Trust's economy, efficiency and effectiveness in its use of resources.

8.02 The Trust's external auditors are Ernst and Young.

8.03 Ernst Young reported quarterly to the Committee. These reports included approval of the approach to the audit of the financial statements. The table below summarises the key elements of external audit work undertaken during the year:

| **Area of Work** | **Conclusion** |
|---|---|
| **Opinion on the Trust's:** | |
| Financial statements | Unqualified 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. |
| Parts of the remuneration and staff report to be audited | There were no matters to report. |
| Consistency of the information in the performance report and accountability report with the financial statements | Financial information in the performance report and accountability report and published with the financial statements was consistent with the Annual Accounts. |
| **Reports by exception:** | |
| Consistency of Annual Governance Statement | The Governance Statement was consistent with External Audit's understanding of the Trust. |
| Consistency of the Annual Report within knowledge we have acquired during the course of our audit | There were no matters to report. |
| Referrals to NHS Improvement (formerly Monitor) | There were no matters to report. |
| Public interest report | There were no matters to report in the public interest. |
| Value for money conclusion | There were no matters to report |
| Examining the contents of the Trust's Quality Report and testing of two mandated performance indicators and one indicator selected by the Council of Governors | External audit issued an unqualified limited assurance report. |
| Reporting to NHS Improvement (formerly Monitor) on the Trust's consolidation schedules | External audit concluded that the Trust's consolidation schedules agreed to the Trust's audited financial statements. |
| Reporting to the National Audit Office (NAO) in line with group instructions | There were no matters to report. |

## 9.00 Reporting to the Trust Board

9.01 The Committee reported to the Trust Board after each meeting. A summary of the key points of discussion at each meeting, for example highlights of the internal audit reports or any formal recommendations were provided to the Board.

## 10.00 Engagement with the Council of Governors

10.01 The Chair of the Audit Committee continued to ensure the Governors were kept informed of the work of the Committee and how the Committee discharged its responsibilities.

10.02 On 20 September 2018, the Chair reported to the Council of Governors on the work of the Audit Committee. The update also provided the Council of Governors with a report on the performance of the External Auditor, Ernst & Young across the year 2018/19.

## 11.00 COMMITTEE SELF ASSESSMENT QUESTIONNAIRE

11.01 Committee members and regular Trust attendees completed a short committee assessment questionnaire based on the questionnaire within HFMA NHS Audit Committee handbook. The responders were able to provide comments to support their answers where they felt they would be useful.

11.02 For each question the responder was asked to state if they would strongly agree, agree, degree, strongly disagree or neither agree or disagree with the statement made. For each question the responder was able to indicate that they didn't know, as for some questions not every responder would be expected to know). The questionnaire was split over four areas, the operation of the committee in general, external audit, internal audit and counter fraud delivery.

**Summary of results**

<u>Audit Committee in general</u>

11.03 Of the 11 questions, excluding "don't know" responses, there was only one question which had a response which was not "agreed" or "strongly agreed". This one question / statement was in relation to the assessment of plans. The Board has direct oversight of the Trust's operational and financial plans and in respect of plans for improvement then these are reviewed at QAC and F&P which most responders appeared to reflect worked well. Other comments supplied show the Committee's drive for improvement through the use of the Trust's BAF to shape the work of the Committee.

<u>External Audit</u>

11.04 All of the 10 questions had at least one response which was not a positive agreement responses. For two of these, many of the responders reflected on the specific remit that External Audit have and how this shapes their work, but they would still wish to see more sharing of knowledge from their wider client base to help shape the debate and work of the Audit Committee. The main areas flagged for improvement across the remaining 8 questions related to communication and engagement with the Trust, reporting of findings to get beyond the technical reporting and the investment needed to maintain credibility with the turnover of more junior team members. Whilst many of

the matters referred to will be for the management and auditors to work through, the Committee will seek, through its receipt of information across the year, to see an improvement in the working relationships between the audit team and the Trust and where possible the language used within the reports is made less technical.

Internal Audit

11.05 There were 10 questions in this section and excluding "don't know" responses only one question did not receive positive responses from all responders. This related to a desire for the HoIA to share wider experiences in respect of adding value from their wider client base in their wider reporting to the Committee and engagement with the Trust.

Local Counter Fraud

11.06 There were 10 questions in this section and excluding "don't know" responses, three of the questions did not receive positive responses from all responders. The main theme identified across these questions was a desire to see a clearer articulation of the impact of recommended improvements.

## 12.00 Conclusion

12.01 The Audit Committee of Western Sussex Hospitals NHS Foundation Trust is of the view that it has taken appropriate steps to perform its duties as delegated by the Board and it has no cause to raise any issues of significant concern with the Board arising from its work during 2018/19.

12.02 In making this statement, the Committee members acknowledge the support given to it by management, in particular the Chief Financial Officer, Trust Director of Finance, Chief Workforce and Organisational Development Officer and the Company Secretary, and that given by the internal and external auditors along with the local counter fraud specialist.

12.03 During 2018-19, the Committee will keep under review its working arrangements and ensure it continues to develop its own practice to improve its own effectiveness.

## 13.00 Recommendations

13.01 The Committee is asked to:

- **Endorse** that this Annual Report be provided to the Board

**Jon Furmston**
**Chair of the Audit Committee**
**July 2019**

Western Sussex Hospitals
NHS Foundation Trust

| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 13 | **Meeting:** | Trust Board | **Meeting Date:** | 25 July 19 |
| **Report Title:** | Quality Assurance Committee Report to Board | | | | |
| **Sponsoring Executive Director:** | Joanna Crane, Non-Executive Director | | | | |
| **Author(s):** | Joanna Crane, Non-Executive Director | | | | |
| **Report previously considered by and date:** | N/A direct report to Board | | | | |
| **Purpose of the report:** | | | | | |
| Information | ✓ | | Assurance | ✓ | |
| Review and Discussion | ✓ | | Approval / Agreement | ☐ | |
| **Reason for submission to Trust Board in Private only (where relevant):** | | | | | |
| Commercial confidentiality | ☐ | | Staff confidentiality | ☐ | |
| Patient confidentiality | ☐ | | Other exceptional circumstances | ☐ | |
| **Link to Trust Strategic Themes:** | | | | | |
| Patient Care | ✓ | | Sustainability | ✓ | |
| Our People | ✓ | | Quality | ✓ | |
| Systems and Partnerships | ☐ | | | | |
| **Any implications for:** | | | | | |
| Quality | | | | | |
| Financial | | | | | |
| Workforce | | | | | |
| **Link to CQC Domains:** | | | | | |
| Safe | ✓ | | Effective | ✓ | |
| Caring | ✓ | | Responsive | ✓ | |
| Well-led | ✓ | | Use of Resources | ☐ | |
| **Communication and Consultation:** | | | | | |
| | | | | | |

**Executive Summary:**

The Quality Assurance Committee met on the 6 June 2019 and was quorate as it was attended by four Non-Executive Directors including the Chairman and the Chief Nurse, Chief Workforce & Organisational Development Officer, Chief Medical Officer, the Trust Medical Director along with the Chiefs of both Surgery and Medicine Division.

The Committee received its planned items and debated these reports in accordance with its cycle of business.

**Key Recommendation(s):**

The Board is asked to **NOTE:**

The assurances received through the reports received and that the Committee through its review of the BAF did not refer any matters to the executive for review

The Committee referred two maters to the Audit Committee for follow up as they referred to Internal Audit report findings

The Committee received as expected the Annual Serious Incident Report whose revised format enabled learning to be better highlighted and shared.

Western Sussex Hospitals NHS Foundation Trust

To: Trust Board

Date: 25 July 2019

From: Quality Assurance Committee

Agenda Item: 13

**COMMITTEE HIGHLIGHTS REPORT TO BOARD**

| Meeting | Meeting Date | Chair | Quorate | |
|---|---|---|---|---|
| | | | yes | no |
| **Quality Assurance Committee** | **Thursday 6 June 2019** | **Joanna Crane** | ✓ | ☐ |

## Declarations of Interest Made

None

## Assurance received at the Committee meeting

- The Committee **RECEIVED** the Freedom to Speak Up Annual Report, presented by one of the Freedom to Speak up Guardians and were assured from their work over the Trust's culture of openness and learning.
- The Committee **RECEIVED** a presentation on a Deep Dive into End of Life Care, which highlighted the successes notably that training is being rolled out for all staff to provide support on an annual basis.
- The Committee **RECEIVED** an update on the 7 Day Services Board Assurance Framework and were assured over the Trust's reported position. The Committee were assured the area of compliance against the 7 Day Service framework was a corporate project for 2019/20 then executive attention to this area would be given across the year.
- The Committee **RECEIVED** a comprehensive update on Employee Relations, noting this complemented the assurance provided to the Finance and Performance Committee through the Workforce and Capacity reporting to the Finance and Performance Committee.
- The Committee **RECEIVED** its six monthly Information Governance report, noting that the Trust had submitted the required Data Security Toolkit for 2018/19 at the end of March 2019, The Committee was assured over the submission through the receipt of the detailed self-assessment made by the IG Team.
- The Committee **RECEIVED** an update on External Visits to the Trust in particular the Maternity Screening visit in early June which recorded exemplary findings and a Fire Visit at St Richard's which had also been extremely positive.
- The Committee **RECEIVED** the Board Assurance Framework and was assured through the reports at the Committee meeting that there were no risks that were under-scored that needing referring back to the Executive. The Committee did recommend that the assurance provided by the Annual Serious Incident Report to be added to the Board Assurance Framework as source of assurance.

## Actions taken by the Committee within its Terms of Reference

There were no specific actions that required a Committee decision at this meeting.

## Items to come back to Committee (Items Committee / Group keeping an eye on)

- The Committee requested a Deep Dive into Mental Health be presented at its next Committee meeting in September.

| Items referred to the Board or another Committee for decision or action | |
|---|---|
| **Item** | **Referred to** |
| Assurance provided by Annual SI Report to be shared with the Audit Committee in respect of the additional source of assurance this provides. | Audit Committee – for information. |
| Assurance that training workshops have been provided to the Divisions in relation to Risk Management apart from one for which a date has been set. | Audit Committee – to close down outstanding Internal Audit action |

Western Sussex Hospitals
NHS Foundation Trust

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|---|---|---|---|---|---|
| **Agenda Item:** | 14 | **Meeting:** | Board | **Meeting Date:** | 25 July 2019 |
| **Report Title:** | **Q1 Board Assurance Framework – 2019/20** | | | | |
| **Sponsoring Executive Director:** | Glen Palethorpe, Group Company Secretary | | | | |
| **Author(s):** | Glen Palethorpe, Group Company Secretary | | | | |
| **Report previously considered by and date:** | QAC – 6 June 2019<br>F&P – 4 July 2019<br>Audit Committee – 8 July 2019 | | | | |

| **Purpose of the report:** | | | |
|---|---|---|---|
| Information | ☐ | Assurance | ✓ |
| Review and Discussion | ☐ | Approval / Agreement | ✓ |
| **Reason for submission to Trust Board in Private only (where relevant):** | | | |
| Commercial confidentiality | ✓ | Staff confidentiality | ☐ |
| Patient confidentiality | ☐ | Other exceptional circumstances | ☐ |
| **Link to Trust Strategic Themes:** | | | |
| Patient Care | ✓ | Sustainability | ✓ |
| Our People | ✓ | Quality | ✓ |
| Systems and Partnerships | ✓ | | |

| **Any implications for:** | |
|---|---|
| Quality | Quality related strategic risks |
| Financial | Finance related strategic risks |
| Workforce | Workforce related strategic risks |

| **Link to CQC Domains:** | | | |
|---|---|---|---|
| Safe | ✓ | Effective | ✓ |
| Caring | ✓ | Responsive | ✓ |
| Well-led | ✓ | Use of Resources | ✓ |

**Communication and Consultation:**

The Board Assurance Framework has been prepared in conjunction with each of the five Chief Officers, focussing on respective strategic objectives and determining their associated strategic risks.

**Executive Summary:**

**Introduction**

The Board approved the initial BAF in May and the BAF was then considered by the Quality Assurance Committee in June, the Finance and Performance Committee and Audit Committee in July.

The review by the Board considered the target risk score against the Trust's risk appetite which is embedded within the Trust's Risk Management Strategy which was approved in April 2019. Noting that there may be more than one component to be considered when determining the individual target risk score. For ease of reference the Trust's agreed risk appetite is included as at Appendix A to this paper.

**BAF Summary**

The table overleaf shows by risk the Q1 score and the target risk score, noting that some of the risks are at their target score and thus the BAF process for those risks will be about securing assurance that this acceptable (target) level of risk is maintained

| BAF: Strategic Objectives and Strategic Risks<br>(Key: I = Impact L = Likelihood T = Total) | Risk Scores | | | | | |
|---|---|---|---|---|---|---|
| | Opening risk | | | Target | | |
| | I | L | T | I | L | T |
| **1. Patient**<br>***Quality Assurance Committee*** | | | | | | |
| 1.1 we are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact and loss of market share | 2 | 3 | **6** | 2 | 2 | **4** |
| **2. Sustainability**<br>***Finance and Performance Committee*** | | | | | | |
| 2.1 We are unable to align or invest in our workforce, finance, estate and IM&T infrastructure effectively to support operational resilience, deliver our strategic and operational plans and improve care for patients | 3 | 4 | **12** | 3 | 3 | **9** |
| 2.2 We cannot continue to deliver ongoing efficiencies and flex our resources in an agile way resulting in the Trust not being able to live within its resources given the rising demands on our services | 3 | 4 | **12** | 3 | 3 | **9** |
| 2.3 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties | 3 | 3 | **9** | 3 | 3 | **9** |
| **3. People**<br>***Quality Assurance Committee*** | | | | | | |
| 3.1 We are unable to appropriately develop cultural change and involve and engage staff in a way that leads to continuous improvements in patient experience, patient outcomes, and staff morale and wellbeing | 3 | 3 | **9** | 3 | 2 | **6** |
| 3,2 We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of staff adversely impacting on patient experience and the safety, quality and sustainability of our services | 3 | 3 | **9** | 3 | 3 | **9** |
| **4. Quality Improvement**<br>***Quality Assurance Committee*** | | | | | | |
| 4.1 We are unable to deliver and demonstrate compliance with regulatory requirements or clinical standards adversely impacting on patient safety and our registration and accreditation by regulatory and supervisory bodies | 2 | 3 | **6** | 2 | 2 | **4** |
| 4.2 We are unable to deliver service improvements and improve safety, care quality and outcomes for our patients or demonstrate that our services are clinically effective | 2 | 3 | **6** | 2 | 2 | **4** |
| **5. Systems and Partnerships**<br>***Finance and Performance Committee*** | | | | | | |
| 5.1 We are unable to develop and maintain collaborative relationships with partner organisations based on shared aims, objectives, and timescales leading to an adverse impact on our ability to operate efficiently and effectively within our health economy in line with the NHS Long Term Plan | 3 | 3 | **9** | 3 | 2 | **6** |
| 5.2 We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability. | 4 | 3 | **12** | 4 | 2 | **8** |
| 5.3 We are unable to deliver and demonstrate consistent compliance with operational and NHS constitutional standards resulting in an adverse impact on patient care and the reputation of the Trust | 4 | 3 | **12** | 4 | 2 | **8** |

**Committee review**

Each BAF risk has an allocated lead oversight Committee, however, it is recognised that for some risks other Committees will also receive assurance against elements of control with respect to that risk.

Quality Assurance Committee

The Committee's review of the risks to which they have allocated oversight and their receipt of assurance at the meeting in June did not identify any negative assurance that required any risk to be

referred back to the Executive for review for being under stated. The Committee received an annual report on serious incidents which it felt should be referred to as a source of assurance within the BAF for risk 1.1although that assurance in itself the committee did not feel would generate a reduction in the current risk from that of 6 but did provide assurance that the risk would not need to be scored higher.

Finance and Performance Committee

The Committee's review of the risks to which they have allocated oversight and their receipt of assurance at the meeting at the beginning of July did not identify any negative assurance that required any risk to be referred back to the Executive for review for being under stated. The Committee however, did recognise the increase in demand as a pressure on risk 5.3 in relation to the delivery of the the Trust operational targets. The Committee agreed that pressure did not warrant a change in the score at that time and that their receipt of their expected reports and assurance would enable them to recognise or endorse in the current score made the Executive over the next few months if the service demands continue to exceed the Trust and wider health economy assumptions.

Audit Committee

The Audit Committee considered the BAF along with the key highly scoring risks that underpin the BAF and felt its revised structure regarding having a direct mapping of the sources of assurance to the key control was an improvement. The Committee agreed to consider which of the BAF risks it intended to review in more detail over the year to complement the reviews undertaken by the Quality Assurance and Finance and Performance Committees.

**Key Recommendation(s):**

The Board is recommended to consider the level of current risk recorded within the BAF against reported assurances via the various Committees and assurances provided direct to the Board over the first quarter of the year and agree that this represents a balanced view of assurance and its impact on the key risks to the achievement of the Trust's stated objectives.

## Appendix A

### Risk Appetite Statement

The Boards of NHS Trusts are accountable for ensuring the quality, safety and sustainability of the services they provide to patients. Brighton and Sussex University Hospitals NHS Trust sets clear expectations for the Trust through strategic objectives.

The Trust operates in a high risk environment and the day to day management of risk is an expected and integral part of the business of any healthcare provider. Overall, the Board has a **moderate** appetite for risk in relation to the achievement of its objectives and takes active and ongoing actions as part of our daily operational management and strategic planning to reinforce our risk controls in order to minimise risk to a tolerable level.

Our Board Assurance Framework and risk registers will continue to reflect material risks that may prevent the Trust from fulfilling its role in delivering clinical services which meet regulatory and NHS Constitutional standards and the expectations of our stakeholders and patients. We have defined our appetite for risk in relation to our strategic objectives as follows:

**Patient Care**: We make delivering an excellent care experience for our patients our highest priority. However, we will accept **moderate** risks to patient experience if this is required to achieve patient safety and quality improvements.

> We have a **low** risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality, safety and sustainability, may affect the reputation of the Trust or of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Board.

**Safety**: We will deliver safe, high quality clinical services and demonstrate they achieve optimal clinical outcomes and deliver best practice for our patients whilst ensuring we meet regulatory standards. Overall, our risk appetite for safety is **low**. Specifically:

> We have a **low** appetite for risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.

> We have a **low** appetite for risks that may jeopardise patient safety.

> We recognise that it can be in the best interests of patients to have a **moderate** appetite for some individual patient care and treatment risks in order to achieve the best outcomes. Therefore we support our staff to work in collaboration with the people who use our services to develop appropriate and safe care and treatment plans based on assessment of need and clinical risk.

> We will apply strict safety protocols for all of clinical and non-clinical activity, when and wherever possible. We will report, record and investigate our incidents and ensure that we continue to learn lessons to improve the safety and quality of our services.

**Sustainability**: We strive to use our resources efficiently and effectively for the benefit of our patients and their care and ensure our services are clinically, operationally, and financially sustainable. We will always aim to achieve this objective; however, overall we have a **moderate** appetite for risk in this area. Specifically:

We have a **moderate** appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.

We are committed to providing patient care in a therapeutic environment and providing staff with an environment and supporting infrastructure in which to perform their duties. However, we have a **moderate** appetite for some risks related to our infrastructure and estate except where these adversely impact on patient safety, care quality and regulatory compliance

We will increase our appetite for financial risk to **significant** in some instances and consider all potential delivery options to ensure the delivery of our objectives. Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards. A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require sign off by the Board.

We are prepared to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level. Value and benefits will be considered and resources allocated in order to capitalise on opportunities.

**People:** We value and respect all our staff equitably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles. We will rarely accept risks that would limit our ability to achieve this objective and the Trust's overall risk appetite for workforce related risks is **low**. Specifically:

We have a **low** appetite for risks related to the recruitment, retention and training of staff to deliver safe, high quality services and good patient experience.

We have **no** appetite for risks associated with unprofessional conduct, bullying, or an individual's competence to perform roles or tasks safely nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our values.

We have a **moderate** appetite for risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing, and staff development models where these enhance or improve patient safety, care quality, service delivery or financial sustainability.

We have **no** appetite for any risk that could result in staff being non-compliant with legislation, or any frameworks provided by professional bodies.

We have **no** appetite for any risk that could result in us being in breach of our contractual or statutory responsibilities in relation to our staff or in a breach of our staff's employment rights.

**Systems and Partnerships**: We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards. Overall we have a **moderate** appetite for risks to the achievement of this objective. Specifically:

We have a **moderate** appetite for risk where this results in improvements in the design or delivery of healthcare services for our patients or the population we serve. Our appetite for risk in this area recognises that the Trust operates in a complex environment and is subject to very challenging economic conditions and changing demographics with intense scrutiny. We consider the risks associated with innovation, creativity and clinical research to be an essential part of the Trust's risk profile. We increase our appetite for risk in this area to **significant** in order to maximise the opportunities to improve patient outcomes and the Trust's sustainability. . A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require support of the Board.

We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards.

Western Sussex Hospitals
NHS Foundation Trust

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|---|---|---|---|---|---|
| **Agenda Item:** | 16 | **Meeting:** | Trust Board | **Meeting Date:** | 25/7/2019 |
| **Report Title:** | Organ Donation Annual Report 2018/19 | | | | |
| **Sponsoring Executive Director:** | George Findlay, Chief Medical Officer | | | | |
| **Author(s):** | Dr Andrew Hetreed, Clinical Lead for Organ Donation | | | | |
| **Report previously considered by and date:** | | | | | |
| **Purpose of the report:** | | | | | |
| Information | ✓ | | Assurance | ☐ | |
| Review and Discussion | ☐ | | Approval / Agreement | ☐ | |
| **Reason for submission to Trust Board in Private only (where relevant):** | | | | | |
| Commercial confidentiality | ☐ | | Staff confidentiality | ☐ | |
| Patient confidentiality | ☐ | | Other exceptional circumstances | ☐ | |
| **Link to Trust Strategic Themes:** | | | | | |
| Patient Care | ✓ | | Sustainability | ☐ | |
| Our People | ☐ | | Quality | ✓ | |
| Systems and Partnerships | ✓ | | | | |
| **Any implications for:** | | | | | |
| Quality | | | | | |
| Financial | Donor activity is associated with financial recompense to the trust | | | | |
| Workforce | | | | | |
| **Link to CQC Domains:** | | | | | |
| Safe | ☐ | | Effective | ✓ | |
| Caring | ✓ | | Responsive | ✓ | |
| Well-led | ✓ | | Use of Resources | ☐ | |
| **Communication and Consultation:** | | | | | |
| | | | | | |

**Executive Summary:**

The Annual Organ Donation report details the performance of Western Sussex Hospitals NHS Foundation Trust for 2018/19.

**Key Recommendation(s):**

The Board is asked to NOTE this report.

Western Sussex Hospitals NHS
NHS Foundation Trust

NHS
Blood and Transplant

# Organ Donation Activity 2018/19

Dr Andrew Hetreed

Clinical Lead for Organ Donation

WSHT

NHS
Blood and Transplant

# What We Do

- Over 3,500 lives are saved or improved annually by organ donation
- Around 6,500 patients remain on the waiting list
- Nearly 10 patients a week will die whilst waiting for a transplant

Western Sussex Hospitals NHS
NHS Foundation Trust

NHS Blood and Transplant

# 1st April 2018 – 31st March 2019

- 12 deceased solid organ donors
- 29 patients received a transplant as a result

**Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2018 - 31 March 2019 (1 April 2017 - 31 March 2018 for comparison)**

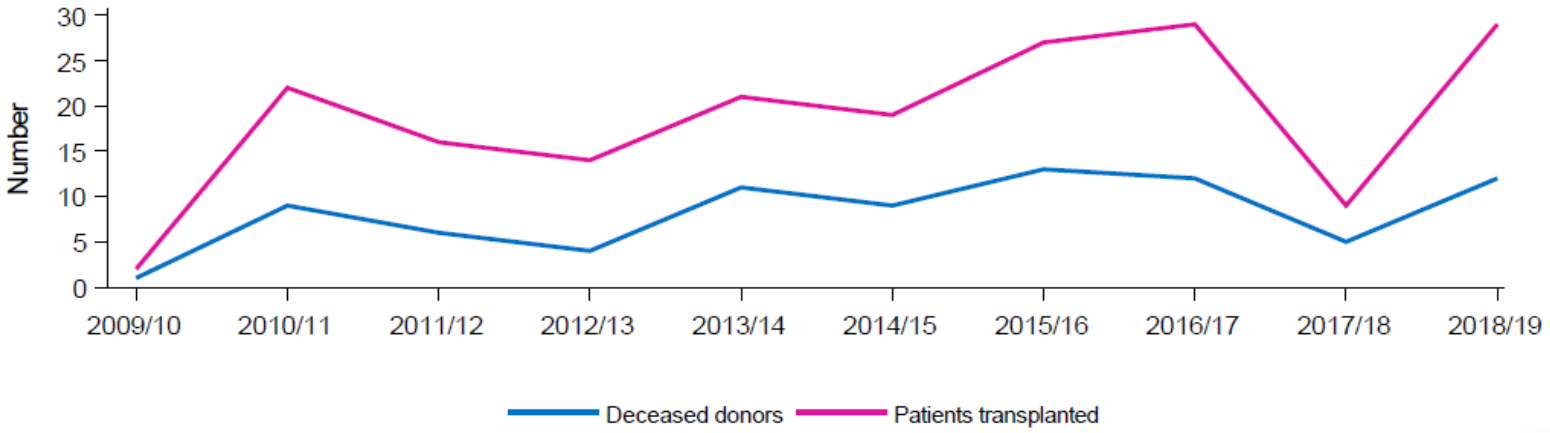
| Donor type | Number of donors | | Number of patients transplanted | | Average number of organs donated per donor Trust | | UK | |
|---|---|---|---|---|---|---|---|---|
| DBD | 6 | (3) | 16 | (7) | 3.3 | (4.3) | 3.5 | (3.7) |
| DCD | 6 | (2) | 13 | (2) | 2.8 | (2.0) | 2.7 | (2.7) |
| DBD and DCD | 12 | (5) | 29 | (9) | 3.1 | (3.4) | 3.2 | (3.3) |

Western Sussex Hospitals NHS
NHS Foundation Trust

NHS
Blood and Transplant

# The Last 10 years

**Figure 1.1 Number of donors and patients transplanted, 1 April 2009 - 31 March 2019**




Western Sussex Hospitals NHS
NHS Foundation Trust

NHS Blood and Transplant

# National Potential Donor Audit

- Audit of potential donation activity in UK hospitals
- Allows the performance of WSHT in key areas to be compared to national performance and targets

Western Sussex Hospitals NHS
NHS Foundation Trust

Goal: The agreed 2018/19 national targets for DBD and DCD consent rates are 78% and 72%, respectively.

NHS Blood and Transplant

**Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2018 - 31 March 2019**

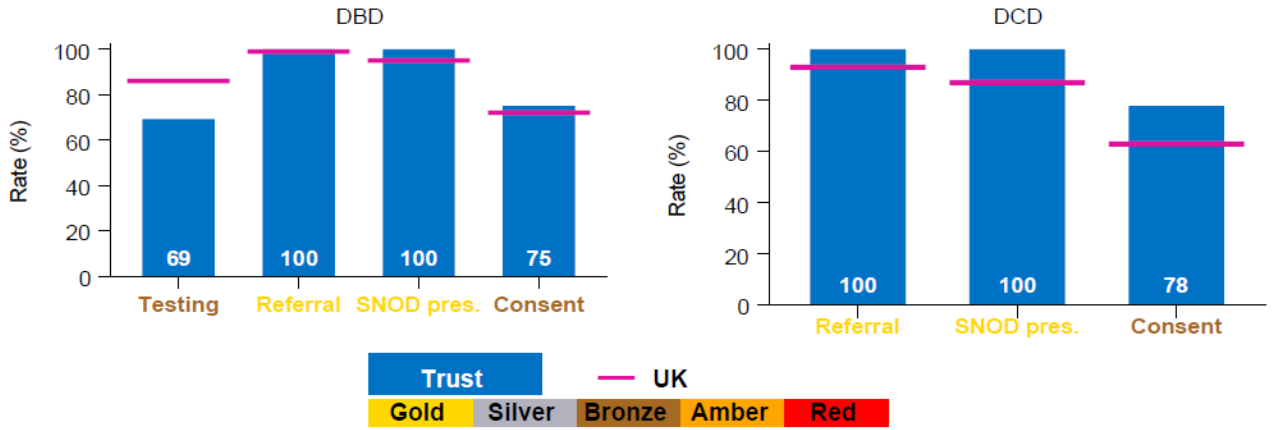
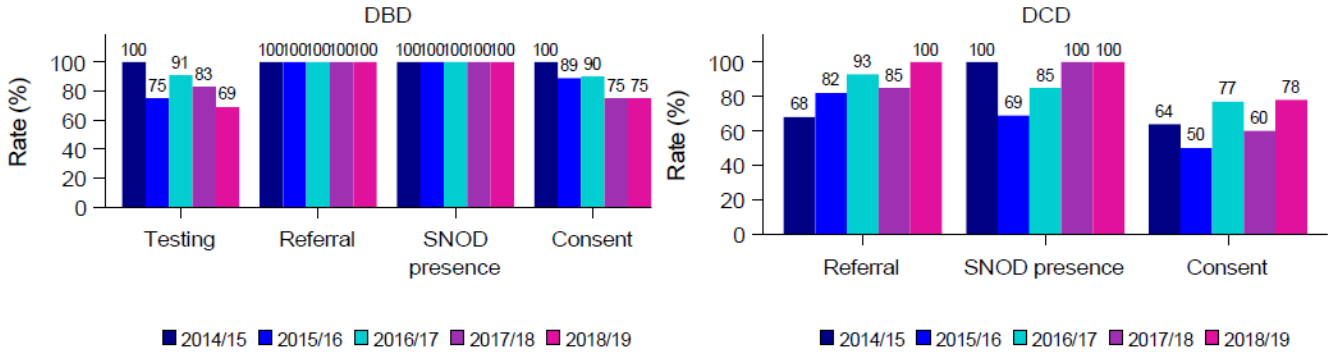



**Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2014 - 31 March 2019**




Western Sussex Hospitals NHS
NHS Foundation Trust

NHS Blood and Transplant

## Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2018 - 31 March 2019

| | DBD | | DCD | | Deceased donors | |
|---|---|---|---|---|---|---|
| | Trust | UK | Trust | UK | Trust | UK |
| Patients meeting organ donation referral criteria[1] | 13 | 2004 | 30 | 5974 | 41 | 7728 |
| Referred to Organ Donation Service | 13 | 1982 | 30 | 5539 | 41 | 7287 |
| *Referral rate %* | G *100%* | *99%* | G *100%* | *93%* | G *100%* | *94%* |
| Neurological death tested | 9 | 1715 | | | | |
| *Testing rate %* | B *69%* | *86%* | | | | |
| Eligible donors[2] | 8 | 1635 | 26 | 4180 | 34 | 5815 |
| Family approached | 8 | 1493 | 9 | 1752 | 17 | 3245 |
| Family approached and SNOD present | 8 | 1423 | 9 | 1527 | 17 | 2950 |
| *% of approaches where SNOD present* | G *100%* | *95%* | G *100%* | *87%* | G *100%* | *91%* |
| Consent ascertained | 6 | 1082 | 7 | 1099 | 13 | 2181 |
| *Consent rate %* | B *75%* | *72%* | B *78%* | *63%* | B *76%* | *67%* |
| Actual donors (PDA data) | 6 | 970 | 6 | 612 | 12 | 1582 |
| *% of consented donors that became actual donors* | *100%* | *90%* | *86%* | *56%* | *92%* | *73%* |

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

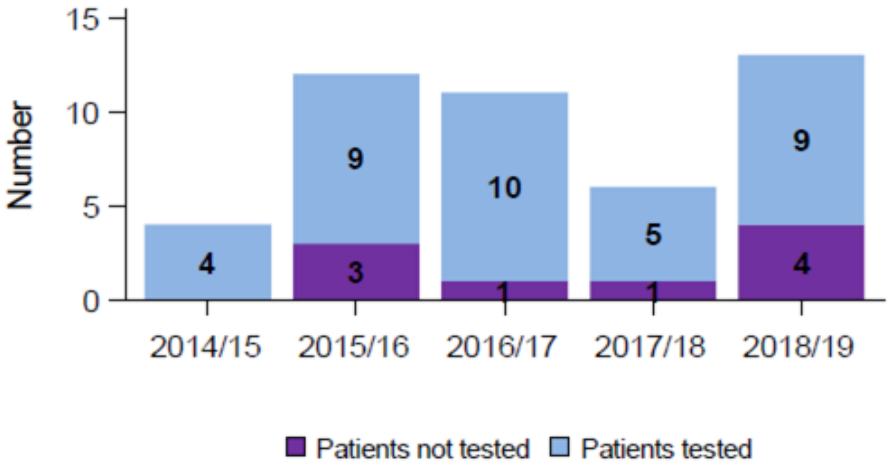
Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

Western Sussex Hospitals NHS
NHS Foundation Trust

Goal: neurological death tests are performed wherever possible.

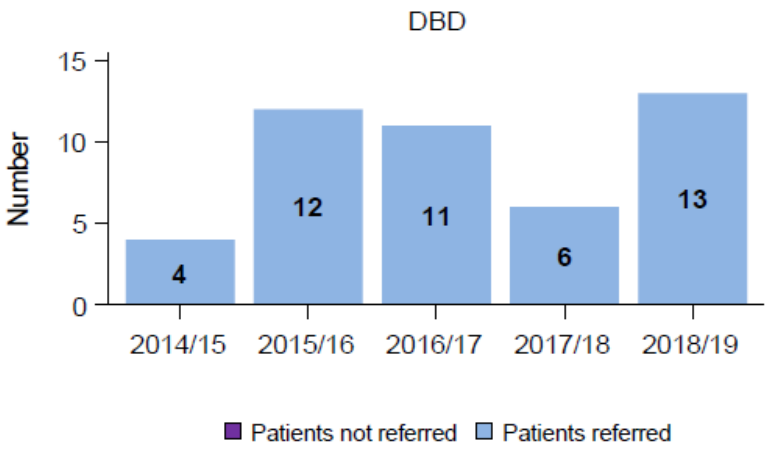
**Figure 3.1 Number of patients with suspected neurological death, 1 April 2014 - 31 March 2019**

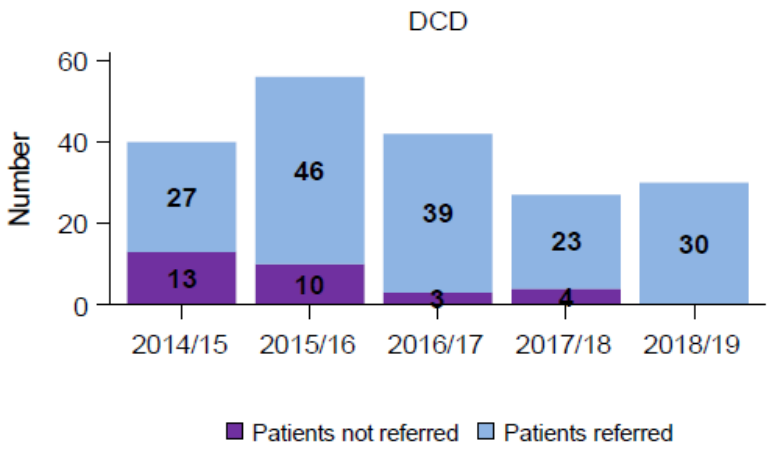


**Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].**

**Aim: There should be no purple on the following charts.**

**Figure 3.2 Number of patients meeting referral criteria, 1 April 2014 - 31 March 2019**

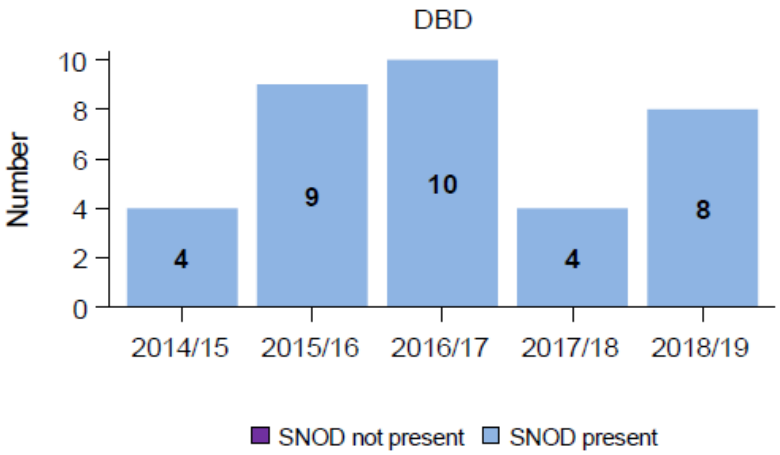


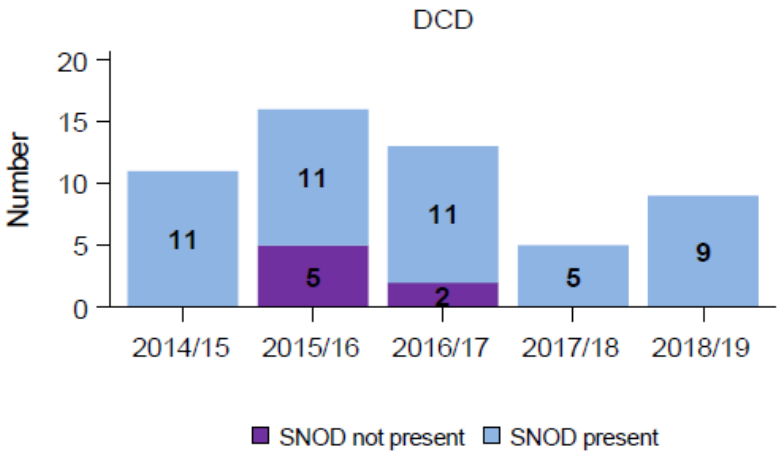



**Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]**

**Aim: There should be no purple on the following charts.**

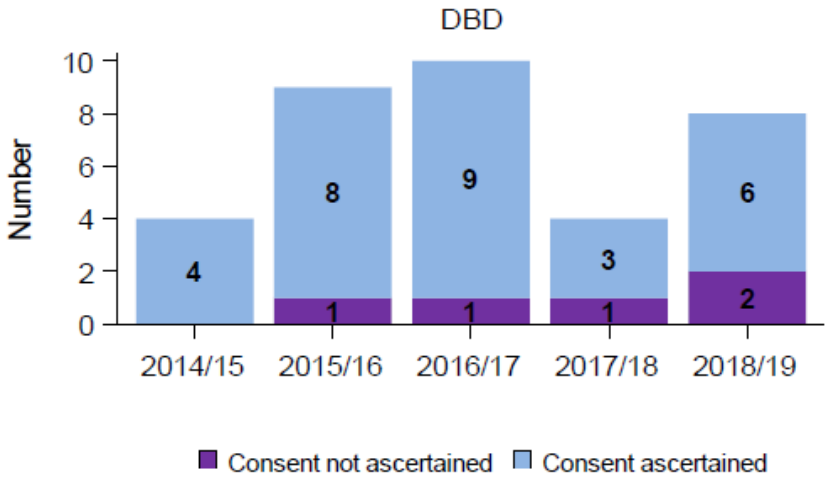
**Figure 3.3 Number of families approached by SNOD presence, 1 April 2014 - 31 March 2019**

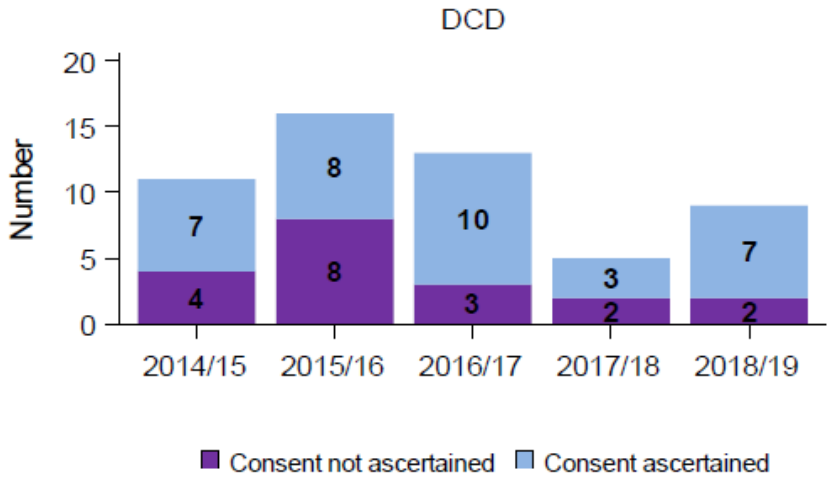


**Goal: The agreed 2018/19 national targets for DBD and DCD consent/authorisation rates are 78% and 72%, respectively.**

**Figure 3.4 Number of families approached, 1 April 2014 - 31 March 2019**



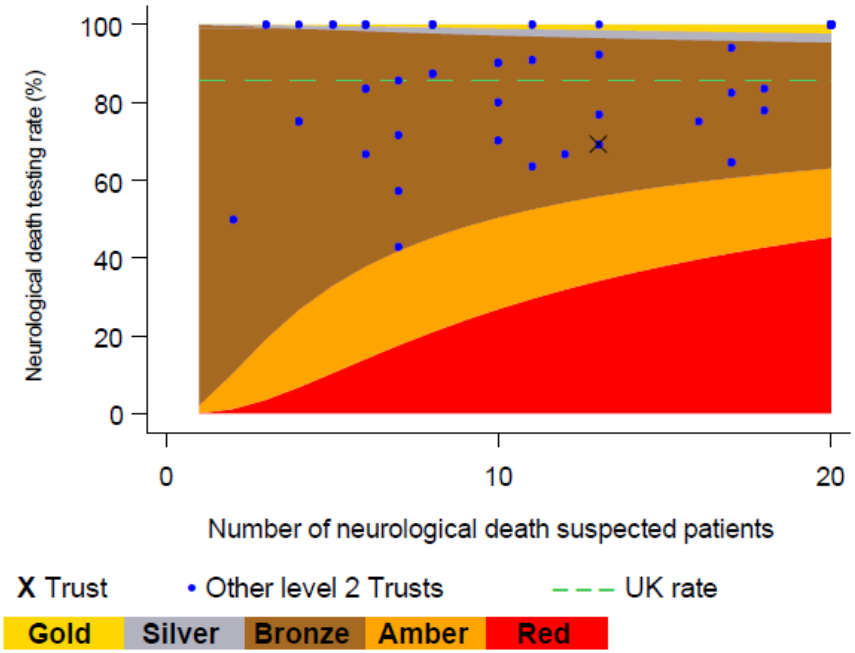



NHS Blood and Transplant

# Comparative Data

Goal: neurological death tests are performed wherever possible.

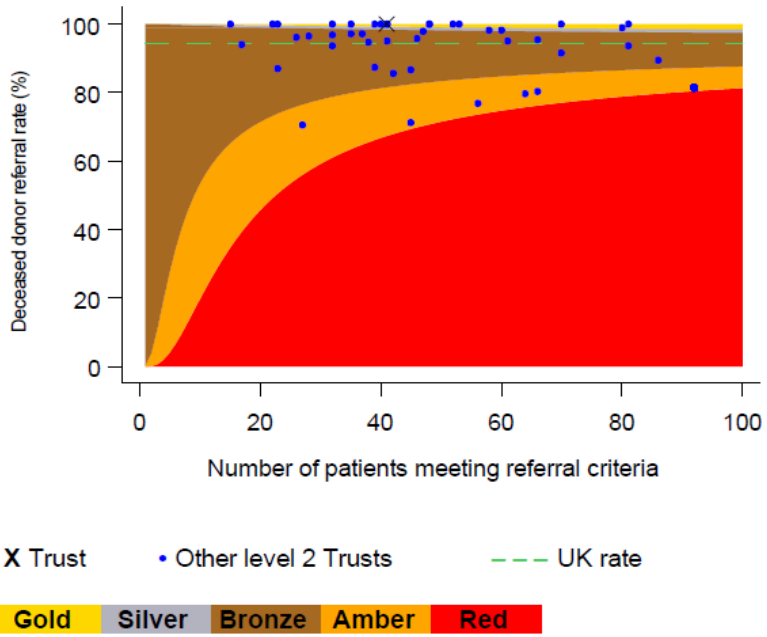
**Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2018 - 31 March 2019**



NHS
Blood and Transplant

**Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].**

**Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2018 - 31 March 2019**



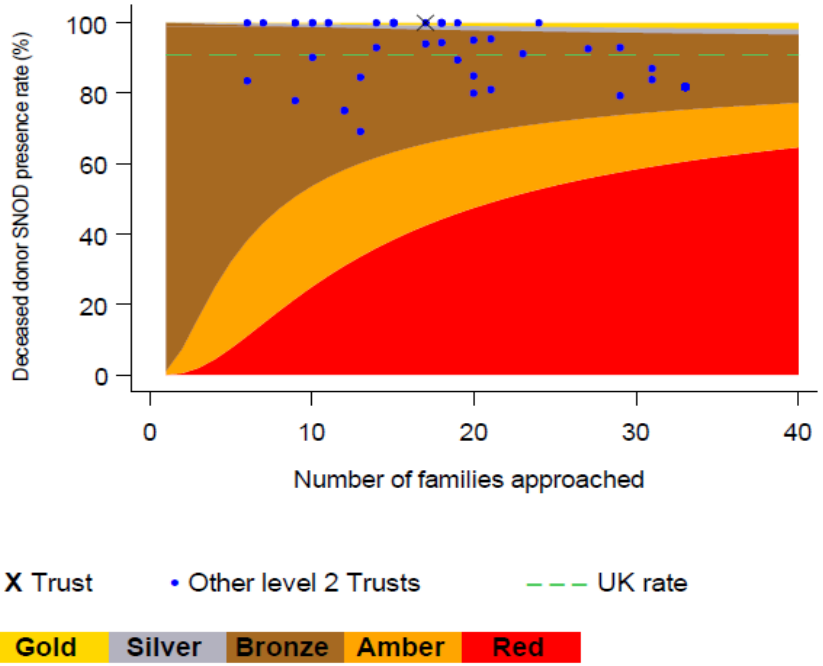

When compared with UK performance Western Sussex Hospitals NHS Foundation Trust was exceptional (gold) for referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service.

Western Sussex Hospitals NHS
NHS Foundation Trust

**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.[3]**

NHS Blood and Transplant

**Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2018 - 31 March 2019**



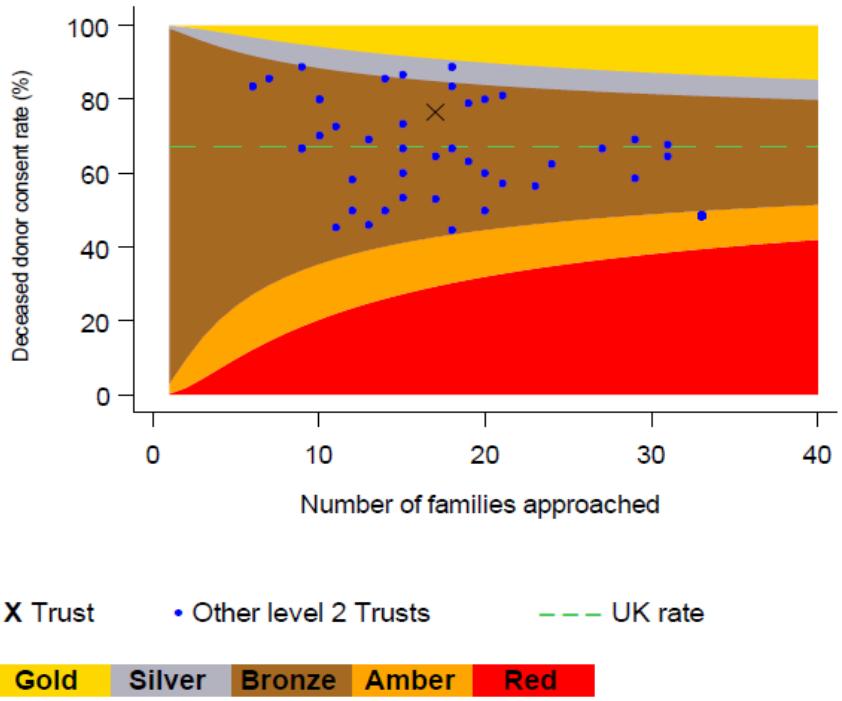

When compared with UK performance Western Sussex Hospitals NHS Foundation Trust was exceptional (gold) for Specialist Nurse presence when approaching families to discuss organ donation.

Western Sussex Hospitals NHS Foundation Trust

**Goal: The agreed 2018/19 national targets for DBD and DCD consent/authorisation rates are 78% and 72%, respectively.**

NHS Blood and Transplant

**Figure 4.4 Funnel plot of consent rate, 1 April 2018 - 31 March 2019**




When compared with UK performance the consent rate in Western Sussex Hospitals NHS Foundation Trust was average (bronze).

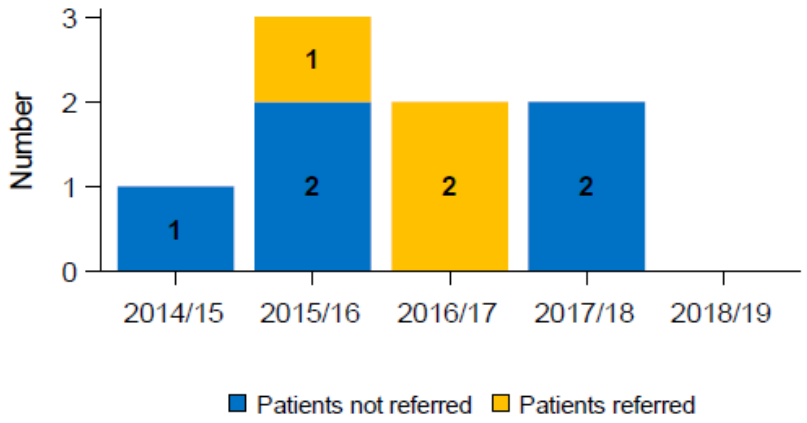
Western Sussex Hospitals NHS Foundation Trust

NHS Blood and Transplant

# Emergency Department Data

**Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.**
**Aim: There should be no blue on the following chart.**

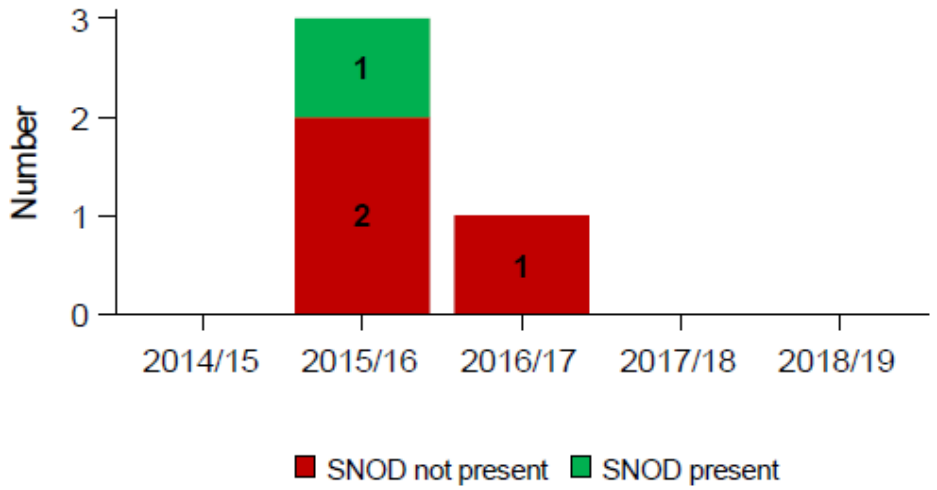
**Figure 6.1 Number of patients meeting referral criteria that died in the ED, 1 April 2014 - 31 March 2019**




Western Sussex Hospitals NHS
NHS Foundation Trust

**Goal: No family is approached in ED regarding organ donation without a SNOD present.**
**Aim: There should be no red on the following chart.**

**Figure 6.2 Number of families approached in ED by SNOD presence, 1 April 2014 - 31 March 2019**



NHS Blood and Transplant

# Summary

- Our performance during 2018/19 has been excellent in several key metrics
- Achieving 100% referral across both sites reflects the efforts put in at all levels of the team
- Neurological death testing rates are a regional issue, and are the next target in our sights
- Keep up the good work!
- A special mention to our volunteers

Western Sussex Hospitals NHS
NHS Foundation Trust

NHS
Blood and Transplant

# Useful Links

- www.odt.nhs.uk
- www.nhsbt.nhs.uk
- www.organdonation.nhs.uk

Western Sussex Hospitals NHS
NHS Foundation Trust

# Actual and Potential Deceased Organ Donation 1 April 2018 - 31 March 2019

NHS Blood and Transplant

# Western Sussex Hospitals NHS Foundation Trust

## Taking Organ Transplantation to 2020

In 2018/19, from 13 consented donors the Trust facilitated 12 actual solid organ donors resulting in 29 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

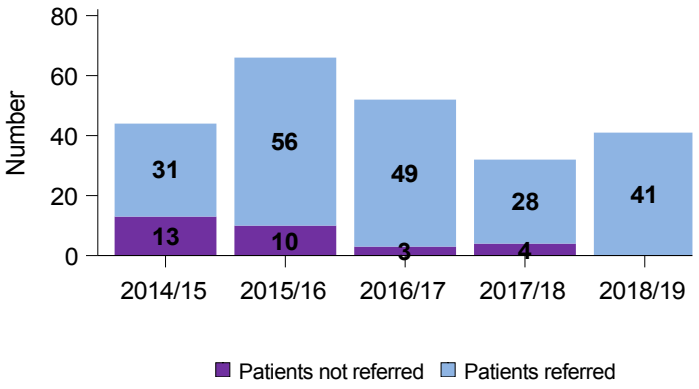
In addition to the 12 proceeding donors there was one consented donor that did not proceed.

## Best quality of care in organ donation

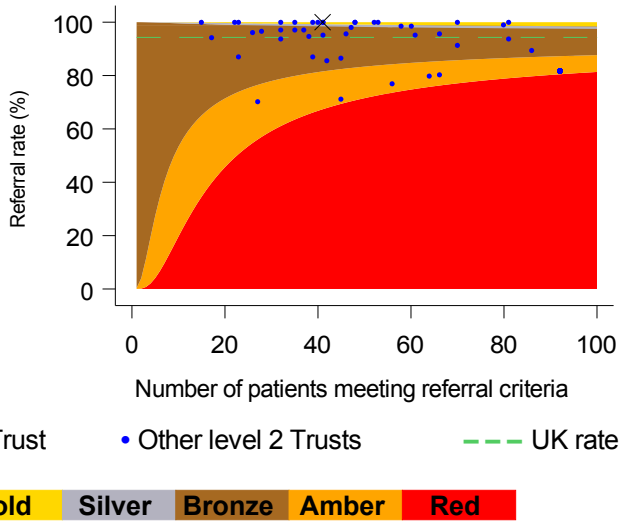
### Referral of potential deceased organ donors

**Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service**

**Aim: There should be no purple on the chart**




**Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold**



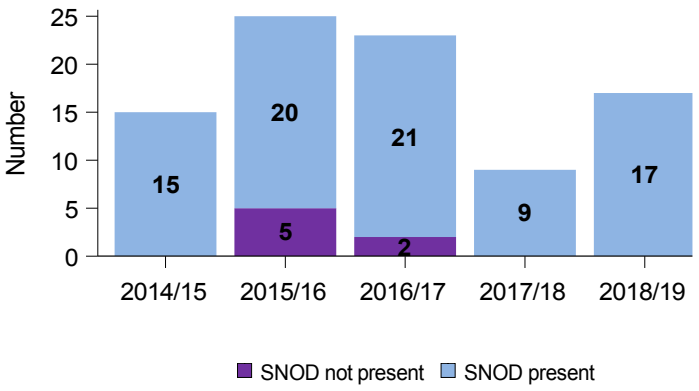

The Trust referred 41 potential organ donors during 2018/19. There were no occasions where potential organ donors were not referred.

When compared with UK performance, the Trust was exceptional (gold) for referral of potential organ donors to NHS Blood and Transplant.

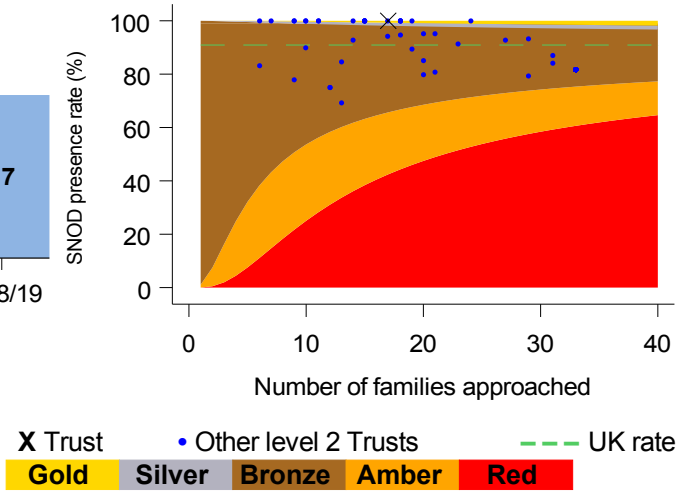
# Presence of Specialist Nurse for Organ Donation

**Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families**

**Aim: There should be no purple on the chart**




**Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold**




A SNOD was present for 17 organ donation discussions with families during 2018/19. There were no occasions where a SNOD was not present.

When compared with UK performance, the Trust was exceptional (gold) for SNOD presence when approaching families to discuss organ donation.

## Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

**Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data**

| | South East Coast* | UK |
|---|---|---|
| **1 April 2018 - 31 March 2019** | | |
| Deceased donors | 91 | 1,600 |
| Transplants from deceased donors | 236 | 3,943 |
| Deaths on the transplant list | 19 | 403 |
| **As at 31 March 2019** | | |
| Active transplant list | 267 | 6,083 |
| Number of NHS ODR opt-in registrations (% registered)** | 2,096,289 (45%) | 26,496,220 (41%) |

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 4.63 million, based on ONS 2011 census data

## Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Trust are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

**Key numbers, rates and comparison with UK data, 1 April 2018 - 31 March 2019**

| | DBD | | DCD | | Deceased donors | |
|---|---|---|---|---|---|---|
| | Trust | UK | Trust | UK | Trust | UK |
| Patients meeting organ donation referral criteria[1] | 13 | 2004 | 30 | 5974 | 41 | 7728 |
| Referred to Organ Donation Service | 13 | 1982 | 30 | 5539 | 41 | 7287 |
| *Referral rate %* | G *100%* | *99%* | G *100%* | *93%* | G *100%* | *94%* |
| Neurological death tested | 9 | 1715 | | | | |
| *Testing rate %* | B *69%* | *86%* | | | | |
| Eligible donors[2] | 8 | 1635 | 26 | 4180 | 34 | 5815 |
| Family approached | 8 | 1493 | 9 | 1752 | 17 | 3245 |
| Family approached and SNOD present | 8 | 1423 | 9 | 1527 | 17 | 2950 |
| *% of approaches where SNOD present* | G *100%* | *95%* | G *100%* | *87%* | G *100%* | *91%* |
| Consent ascertained | 6 | 1082 | 7 | 1099 | 13 | 2181 |
| *Consent rate %* | B *75%* | *72%* | B *78%* | *63%* | B *76%* | *67%* |
| Actual donors (PDA data) | 6 | 970 | 6 | 612 | 12 | 1582 |
| *% of consented donors that became actual donors* | *100%* | *90%* | *86%* | *56%* | *92%* | *73%* |

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

For further information, including definitions, see the latest Potential Donor Audit report at www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/

Western Sussex Hospitals NHS Foundation Trust

# Workforce Race Equality Scheme (WRES)

# Workforce Disability Standard (WDES)

Board overview – July 2019

Denise Farmer
Chief Workforce and OD Officer

NHS
Western Sussex Hospitals
NHS Foundation Trust

# Workforce Race Equality Scheme

- Introduced in the NHS to address the inequalities of black and minority ethnic (BME) staff compared to their white colleagues
- Requires NHS organisations to close the gap between BME and white staff experience across nine key indicators
- Mandated through the NHS Standard Contract in 2015/16
- Published on the Trust website
- Improvement against the WRES action plan is monitored through the Diversity Matters Group

# WRES indicators

| Indicator 1 | Indicator 2 | Indicator 3 | Indicator 4 |
|---|---|---|---|
| •Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM compared with the percentage of staff in the overall workforce | •Relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts | •Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process | •Relative likelihood of BME staff accessing non mandatory training and CPD as compared to white staff |

| Indicator 5 | Indicator 6 | Indicator 7 | Indicator 8 | Indicator 9 |
|---|---|---|---|---|
| •Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months | •Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months | •Percentage believing that trust provides equal opportunities for career progression or promotion | •In the last 12 months have you personally experienced discrimination at work? | •Percentage difference between the organisations' Board membership and its overall workforce |

| WRES Indicator | Metric Description | | 2016 Score | 2017 Score | 2018 Score | 2019 Score | Direction | Peer Median* |
|---|---|---|---|---|---|---|---|---|
| 2 | Relative likelihood of White applicants being appointed from shortlisting compared to that of BME applicants | | 1.35 | 1.15 | 1.22 | 3.40 | ▲ | 1.24 |
| 3 | Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process | | 1.56 | 2.09 | 1.74 | 0.07 | ▼ | 1.74 |
| 4 | Relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff | | 0.89 | 1.03 | 0.91 | 0.90 | ▼ | 0.93 |
| 5 | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | BME<br>White | 35.0%<br>29.5% | 32.2%<br>29.0% | 32.3%<br>29.4% | 36.1%<br>29.2% | ▲ | 34.4% |
| 6 | Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months | BME<br>White | 23.5%<br>24.6% | 23.3%<br>23.7% | 25.5%<br>23.2% | 24.9%<br>22.9% | ▼ | 26.7% |
| 7 | Percentage believing that the Trust provides equal opportunities for career progression or promotion | BME<br>White | 85.8%<br>89.4% | 84.3%<br>92.0% | 83.6%<br>90.3% | 82.7%<br>89.8% | ▼ | 81.1% |
| 8 | In the last 12 months have you personally experienced discrimination at work? | BME<br>White | 13.4%<br>7.05% | 11.5%<br>6.3% | 11.4%<br>5.9% | 14.3%<br>6.3% | ▲ | 14.3% |
| 9 | Percentage of BME Board membership | | 0.0% | 0.0% | 6.7% | 6.7% | ▲ | 7.4% |

**Indicators 2-4** (source: trust data)
BME staff were relatively:

- less likely to be appointed from shortlisting
- less likely to enter the formal disciplinary process
- more likely to access non mandatory training and CPD

***across STP** - Indicators 2-4 (source: 2018 WRES submission)
Indicators 5-8 (source: Staff Survey 2018)

**Indicators 5-8** (source: Staff Survey)
BME staff reported a worse experience than white staff for all four NHS staff survey questions

**Indicator 9** (source: ESR)
BME representation on the board is lower than the 15.3% BME representation in the organisation

# Workforce Disability Equality Scheme

- Introduced to improve both the number of disabled people in employment and their experience in the workplace compared to non disabled people
- Includes people with a hidden disability
- Requires us to close the gap between disabled and non disabled staff experience across ten metrics
- Mandated through the NHS Standard Contract from 1 April 2019
- Restricted for the first 2 years to NHS and Foundation Trusts
- Published on the Trust website
- Improvement against the WDES action plan will be monitored through the Diversity Matters Group

# WDES metrics

**Metric 1**

- Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM compared with the percentage of staff in the overall workforce

**Metric 2**

- Relative likelihood of disabled staff being appointed from shortlisting compared to that of non disabled staff being appointed from shortlisting across all posts

**Metric 3**

- Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

**Metric 4a**

- Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from – patients, service users, their relatives or other members of the public, managers and colleagues

**Metric 4b**

- Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

**Metric 5**

- Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion

**Metric 6**

- Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

**Metric 7**

- Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

**Metric 8**

- Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

**Metric 9a**

- The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation

**Metric 9b**

- Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

**Metric 10**

Percentage difference between the organisation's board voting membership and its organisation's overall workforce

| WDES Metric | Metric Description | | 2019 Score | Average Acute | Direction compared to peers |
|---|---|---|---|---|---|
| 1 | Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM compared with the percentage of staff in the overall workforce | | 2.5% | Not yet available | ▼ |
| 2 | Relative likelihood of disabled staff being appointed from shortlisting compared to that of non disabled staff being appointed from shortlisting across all posts | | 0.92 | Not yet available | ▲ |
| 3 | Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure | | No cases | Not yet available | ▲ |

**Monitoring data** – 30% of staff have not declared their disability status

**Metrics 1 – 3** (source: trust data)

Disabled staff were relatively:

- more likely to be appointed from shortlisting
- Unlikely to enter a capability process process

| WDES Metric | Metric Description | | 2019 Score | Average Acute | Direction compared to peers |
|---|---|---|---|---|---|
| 4a | Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from – patients, service users, their relatives or other members of the public | Disabled<br>Non disabled | 36.2%<br>29.0% | 33.8%<br>27.3% | ▲ |
| 4a | Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from – managers | Disabled<br>Non disabled | 19.0%<br>9.6% | 20.8%<br>12.4% | ▼ |
| 4a | Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from – colleagues | Disabled<br>Non disabled | 29.3%<br>15.7% | 28.5%<br>19.0% | ▲ |
| 4b | Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it | Disabled<br>Non disabled | 49.4%<br>48.5% | 44.5%<br>44.4% | ▲ |
| 5 | Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion | Disabled<br>Non disabled | 83.5%<br>89.6% | 77.4%<br>84.4% | ▲ |
| 6 | Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties | Disabled<br>Non disabled | 33.3%<br>24.1% | 34.1%<br>23.6% | ▼ |
| 7 | Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work | Disabled<br>Non disabled | 37.5%<br>52.2% | 46.8%<br>57.4% | ▲ |
| 8 | Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work | | 75.5% | 72.1% | ▲ |
| 9a | The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation | Disabled<br>Non disabled | 6.9%<br>7.3% | 6.6%<br>7.1% | ▲ |
| 9b | Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? | | | | |
| 10 | Percentage difference between the organisation's board voting membership and its organisation's overall workforce | Disabled<br>Non disabled | -2.5% | Not yet available | ▼ |

**Metrics 4-9a** (source: Staff Survey)
Whilst the Trust is better than average for acute trusts across 6 areas, disabled staff reported a worse experience than non-disabled staff across all relevant NHS staff survey questions

**Metric 10** (source: ESR)

Western Sussex Hospitals
NHS Foundation Trust

| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 17 | **Meeting:** | Trust Board | **Meeting Date:** | 25 July 19 |
| **Report Title:** | Workforce Race Equality Standard (WRES) 2018-19 | | | | |
| **Sponsoring Executive Director:** | Denise Farmer, Chief Workforce and Organisational Development Director | | | | |
| **Author(s):** | Simon Anjoyeb, Deputy Head of Inclusion (BSUH/WSHFT)<br>Nikki Kriel, Organisational Development Manager | | | | |
| **Report previously considered by and date:** | Diversity Matters Group (DMG) 29/04/19 and 22/07/19 | | | | |

| **Purpose of the report:** | | | |
|---|---|---|---|
| Information | ☐ | Assurance | X |
| Review and Discussion | ☐ | Approval / Agreement | X |

| **Reason for submission to Trust Board in Private only (where relevant):** | | | |
|---|---|---|---|
| Commercial confidentiality | ☐ | Staff confidentiality | ☐ |
| Patient confidentiality | ☐ | Other exceptional circumstances | ☐ |

| **Link to Trust Strategic Themes:** | | | |
|---|---|---|---|
| Patient Care | X | Sustainability | ☐ |
| Our People | X | Quality | X |
| Systems and Partnerships | ☐ | | |

| **Any implications for:** | |
|---|---|
| Quality | Excellent care is far more likely to meet the needs of all patients when the workforce is drawn from diverse communities which is reflective of the population served, and when all our staff are themselves free from discrimination |
| Financial | Increase in staff engagement and satisfaction, therefore less time and finance spent on employee relations issues and turnover |
| Workforce | As described above |

| **Link to CQC Domains:** | | | |
|---|---|---|---|
| Safe | ☐ | Effective | ☐ |
| Caring | ☐ | Responsive | X |
| Well-led | X | Use of Resources | X |

**Communication and Consultation:**

Recognising equality and celebrating diversity is an integral part of the Trusts core business, Patient First improvement programme and 'We Care' vision. Data from the findings in this report feed into the Trust's Equality objectives and annual equality report. The submission of the WRES report is mandatory in the 2015/16 Standard NHS Contract. The regulators, the Care Quality Commission (CQC) and NHS Improvement, will use the report to help assess whether NHS organisations are well-led. The Trust is required to publish annual WRES data on NHS Digital Strategic Data Collection (SDCS) by 31/07/19 and revised WRES action plan published on the Trusts website by 27/09/19

**Executive Summary:**

This report seeks to update the Trust Board on the annual WRES report (data is taken from ESR for the period 01/04/18-31/03/19 and 2018 Staff Survey results) and actions to be taken as a result of this analysis. The WRES aims to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The WRES compares the experience of BME and white staff with the objective of closing the gaps highlighted by nine indicators.

**Key Recommendation(s):**

**The Board is asked to APPROVE the report and make recommendations to the WRES action plan**

Western Sussex Hospitals
NHS Foundation Trust

# Western Sussex Hospitals NHS Foundation Trust

## Workforce Race Equality Standard 2018-19

# Introduction

Recent research on race equality in the NHS workforce makes challenging reading for boards in provider organisations. Evidence shows that if you are from a black and minority ethnic background (BME) you are less likely to be appointed once shortlisted, less likely to be selected for training and development programmes, more likely to experience harassment, bullying and abuse, and more likely to be disciplined and dismissed.

Black and minority ethic staff are significantly underrepresented in senior management positions and at board level. In 2012, just 1 per cent of NHS Chief Executives came from a BME background, compared to 16 per cent BME representation in the NHS workforce. Most worryingly, despite a multitude of race equality initiatives and examples of provider good practice since the 2004 Race Equality Action Plan, many of the key indicators are either static or actually getting worse.

**Leading by example: The race equality opportunity for NHS provider boards, 2014 – NHS Providers**

This challenge is one that **all** NHS organisations need to meet because:

- It suggests talent is being wasted through unfairness in the appointment, treatment and development of a large section of the NHS workforce
- It suggests precious resources are wasted through the impact of such treatment on the morale, discretionary effort, and other consequences of such treatment
- Research shows convincingly that such treatment adversely affects the care and treatment of all patients
- Research shows that diverse teams and leaderships are more likely to show the innovation and increase the organisational effectiveness  the NHS needs
- Organisations whose leadership composition bears little relationship to that of the communities served will be less likely to deliver the patient focussed care that is needed

The NHS has responded by the introduction of the Workforce Race Equality Standard, which requires all NHS providers to start to address these issues.

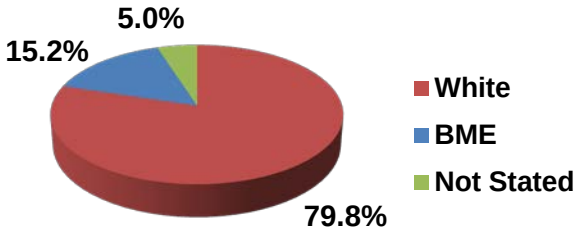
# Background Information

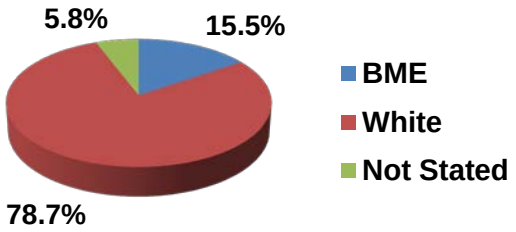
**1) Total number of staff:**

| 2017-18 | 2018-19 |
|---|---|
| 7053 headcount | 7104 headcount |

Proportion of BME staff employed within this organisation at the date of this report:

| | 2017-18 | | 2018-19 | |
|---|---|---|---|---|
| | Headcount | % of Staff | Headcount | % of Staff |
| **White** | 5627 | 79.8% | 5588 | 78.7% |
| **BME** | 1075 | 15.2% | 1100 | 15.5% |
| **Not Stated** | 351 | 5.0% | 416 | 5.8% |
| **Total** | 7053 | 100.0% | 7104 | 100.0% |




2017-18 2018-19

**2) Self-reporting**

**a) The proportion of total staff who have self-reported their ethnicity:**

| | 2017-18 | | 2018-19 | |
|---|---|---|---|---|
| | Headcount | % of Staff | Headcount | % of Staff |
| **Ethnicity Declared** | 6702 | 95.0% | 6688 | 94.1% |
| **Ethnicity Not Declared** | 351 | 5.0% | 416 | 5.9% |
| **Total** | 7053 | 100.0% | 7104 | 100.0% |

**b) Has any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity?**

**c)** We collect information relating to staff ethnicity as part of the recruitment process. Electronic Staff Records self-service has also been rolled out to all staff in April 2019, which provides staff with the opportunity to update their ethnicity confidentially.

**d) Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity?**
A full review of the monitoring information documents took place. We collect information relating to staff ethnicity as part of the recruitment process.

**3) Workforce Data**

**a) What period does the organisation's workforce data refer to?**
April 2018 to March 2019.

**4) Definition of BME under to WRES**
In line with the categories taken from the 2001 Census:

| BME | Unknown | White |
|---|---|---|
| D - Mixed white and black Caribbean | Z - not stated | A - White - British |
| E - Mixed white and black African | NULL | B - White - Irish |
| F - Mixed white and Asian | Unknown | C - Any other white background |
| G - Any other mixed background | | |
| H - Asian or Asian British - Indian | | |
| J - Asian or Asian British - Pakistani | | |
| K - Asian or Asian British - Bangladeshi | | |
| L - Any other Asian background | | |
| M - Black or black British - Caribbean | | |
| N - Black or black British - African | | |
| P - Any other black background | | |
| R - Chinese | | |
| S - Any other ethnic group | | |

**5) Population Demographic 2011 Census (Southeast England)**

| | Census 2011 |
|---|---|
| BME | 9% |
| White | 91% |
| Unknown | 0% |

# Workforce Race Equality Indicators

***For each of the indicators, the standard compares the metrics for white and BME staff.***

**Indicator 1 - Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce**

**Note: Organisations should undertake this calculation separately for non-clinical and for clinical staff.**

| | Non-Clinical | | | | | |
|---|---|---|---|---|---|---|
| | White | BME | Unknown | Total | White % | BME% |
| **Band 1** | 235 | 49 | 3 | 287 | 81.88% | 17.07% |
| **Band 2** | 471 | 30 | 19 | 520 | 90.58% | 5.77% |
| **Band 3** | 355 | 15 | 10 | 380 | 93.42% | 3.95% |
| **Band 4** | 269 | 14 | 7 | 290 | 92.76% | 4.83% |
| **Band 5** | 117 | 6 | 5 | 128 | 91.41% | 4.69% |
| **Band 6** | 100 | 2 | 5 | 107 | 93.46% | 1.87% |
| **Band 7** | 52 | 4 | 3 | 59 | 88.14% | 6.78% |
| **Band 8a** | 46 | 3 | 3 | 52 | 88.46% | 5.77% |
| **Band 8b** | 33 | 2 | | 35 | 94.29% | 5.71% |
| **Band 8c** | 20 | | | 20 | 100.00% | 0.00% |
| **Band 8d** | 5 | | 2 | 7 | 71.43% | 0.00% |
| **Band 9** | 4 | | | 4 | 100.00% | 0.00% |
| **VSM** | 11 | 1 | 1 | 13 | 84.62% | 7.69% |
| **Other** | 10 | | 7 | 17 | 58.82% | 0.00% |
| **Total** | **1728** | **126** | **65** | **1919** | **90.05%** | **6.57%** |

**What the data tells us:**

- The overall population of non-clinical BME staff in the majority of bands is under represented compared to the overall population demographic statistics in the 2011 Census (9%). Though there has been a marginal increase of non-clinical BME staff of 0.11% when comparing to 2017-18.
- There appears to be a higher representation at 17.07% of BME staff in the lowest paid roles at Band 1. In line with Agenda for Change Refresh, Band 1 positions will be phased out by March 2021.

- All other bands except VSM (very senior managers) appear to be underrepresented by BME staff.

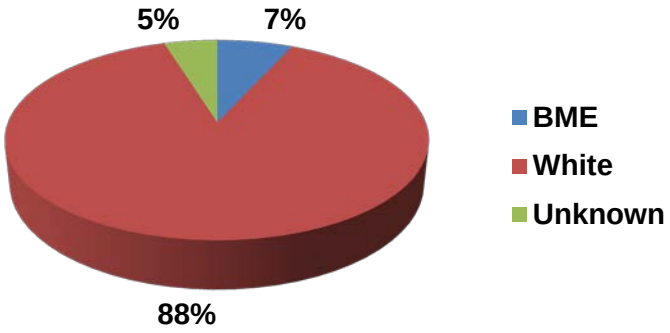
| | Clinical | | | | | |
|---|---|---|---|---|---|---|
| | **White** | **BME** | **Unknown** | **Total** | **White %** | **BME%** |
| **Band 1** | 30 | 2 | | 32 | 93.8% | 6.3% |
| **Band 2** | 841 | 188 | 78 | 1107 | 76.0% | 17.0% |
| **Band 3** | 201 | 40 | 17 | 258 | 77.9% | 15.5% |
| **Band 4** | 136 | 13 | 9 | 158 | 86.1% | 8.2% |
| **Band 5** | 743 | 331 | 96 | 1170 | 63.5% | 28.3% |
| **Band 6** | 774 | 126 | 42 | 942 | 82.2% | 13.4% |
| **Band 7** | 487 | 34 | 26 | 547 | 89.0% | 6.2% |
| **Band 8a** | 92 | 9 | 6 | 107 | 86.0% | 8.4% |
| **Band 8b** | 27 | | | 27 | 100.0% | 0.0% |
| **Band 8c** | 10 | | | 10 | 100.0% | 0.0% |
| **Band 8d** | 3 | | | 3 | 100.0% | 0.0% |
| **Band 9** | 2 | | | 2 | 100.0% | 0.0% |
| **VSM** | 8 | | 2 | 10 | 80.0% | 0.0% |
| **Consultants** | 257 | 88 | 16 | 361 | 71.2% | 24.4% |
| **Non-consultant career grade** | 42 | 34 | 8 | 84 | 50.0% | 40.5% |
| **Trainee** | 207 | 109 | 50 | 366 | 56.6% | 29.8% |
| **Other** | | | 1 | 1 | 0.0% | 0.0% |
| **Total** | **3860** | **974** | **351** | **5185** | **74.4%** | **18.8%** |

**What the data tells us:**

- The overall population of clinical BME staff is more than the overall population statistics in the 2011 Census (9%). Though there has been an overall decrease of the percentage (0.87%) of non-clinical BME staff when comparing to 2017-18.
- There appears to be a higher representation of BME staff in clinical roles, which can be attributed to the diverse nationalities employed and also follows the national trend. The highest representation is at non-consultant career grade at 40.5%.
- There appears to be a higher representation for non-medical clinical roles for BME staff at Bands 5 (Staff Nurse) and Bands 2/3 (Healthcare Assistants). This would suggest the need to investigate if there is a blockage to progression.
- All other bands including VSM (very senior managers) is underrepresented by BME staff.

## Indicator 2 - Relative likelihood of staff being appointed from shortlisting across all posts

| | Shortlisted | Appointed | Relative Likelihood of being appointed |
|---|---|---|---|
| **White** | 4313 | 446 | 0.1034083 |
| **BME** | 1253 | 38 | 0.0303272 |
| **Not Stated** | 156 | 24 | 0.1538461 |
| **Total** | 5722 | 511 | |




The likelihood of white candidates being appointed from shortlisting:
446 / 4313 = 0.1034083

The likelihood of BME candidates being appointed from shortlisting:
38 / 1253 = 0.0303272

The relative likelihood of white staff being appointed from shortlisting compared to BME staff is: 0.1034083 (white candidates) / 0.0303272 (BME candidates) = **3.4 times.**

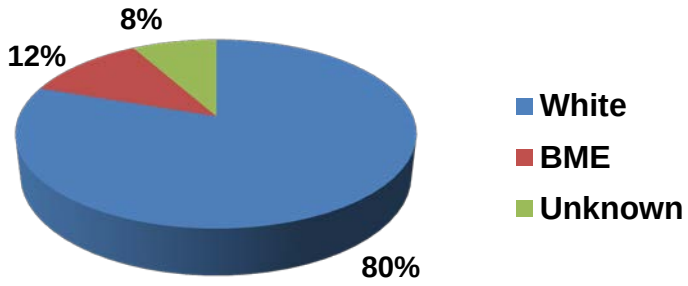

*In this instance the data suggests BME candidates are less likely than white candidates to be appointed from shortlisting.*

In 2017-18 the relative likelihood was 1.2 (in favour of white candidates), compared to this year this has now doubled.

## Indicator 3 - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

**Note: This indicator will be based on data from a two year rolling average of the current year and the previous year**

| | Disciplinary Procedures 2017/18 | Disciplinary Procedures 2018/19 | Total number of procedures | Number in Workforce | Relative Likelihood of entering procedure |
|---|---|---|---|---|---|
| **White** | 12 | 57 | **69** | 5588 | 0.0123478 |
| **BME** | 4 | 6 | **10** | 1100 | 0.0090909 |
| **Unknown** | 3 | 4 | **7** | 416 | 0.0168269 |




The likelihood of white staff entering the formal disciplinary process:
69 / 5588 = 0.0123478

The likelihood of BME staff entering the formal disciplinary process:
10 / 1100 = 0.0090909

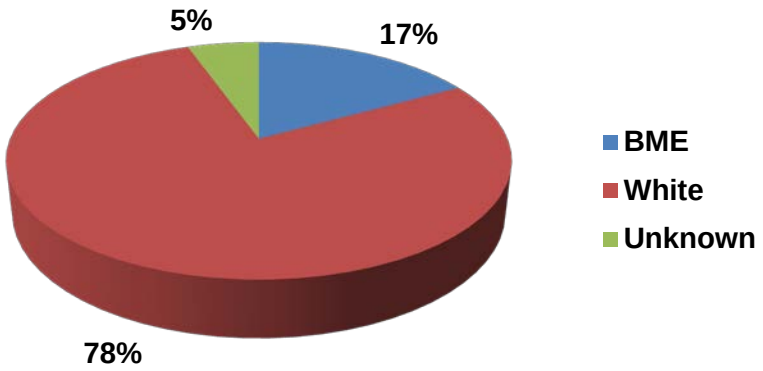
The relative likelihood of BME staff entering the formal disciplinary process compared to white staff is: 0.0090909 (BME Staff) / 0.0123478 (White Staff) = **0.07 times.**


*In this instance the data suggests that BME staff members are less likely than white staff to enter into a formal disciplinary process***.**

The 2017/18 WRES report stated there was a likelihood of 1.75 of BME staff entering into a formal disciplinary process over white staff. In this report we can see there has been a significant decrease in likelihood of BME staff entering the formal disciplinary process.

## Indicator 4 - Relative likelihood of staff accessing non-mandatory training and CPD.

| | Number in workforce | No. of staff accessing non-mandatory/CPD training | Relative likelihood of accessing non-mandatory/CPD training |
|---|---|---|---|
| **BME** | 1100 | 853 | 0.6993557 |
| **White** | 5588 | 3908 | 0.7754545 |
| **Unknown** | 416 | 274 | 0.6586538 |
| **Total** | 7104 | 5035 | |




The data supplied for 2018-19 related to applications for education funding submitted by allied health professionals and nursing and midwifery staff.

Likelihood of white staff accessing non-mandatory/CPD training:
3908 / 5588 = 0.6993557

Likelihood of BME staff accessing non-mandatory/CPD training:
853 / 1100 = 0.7754545

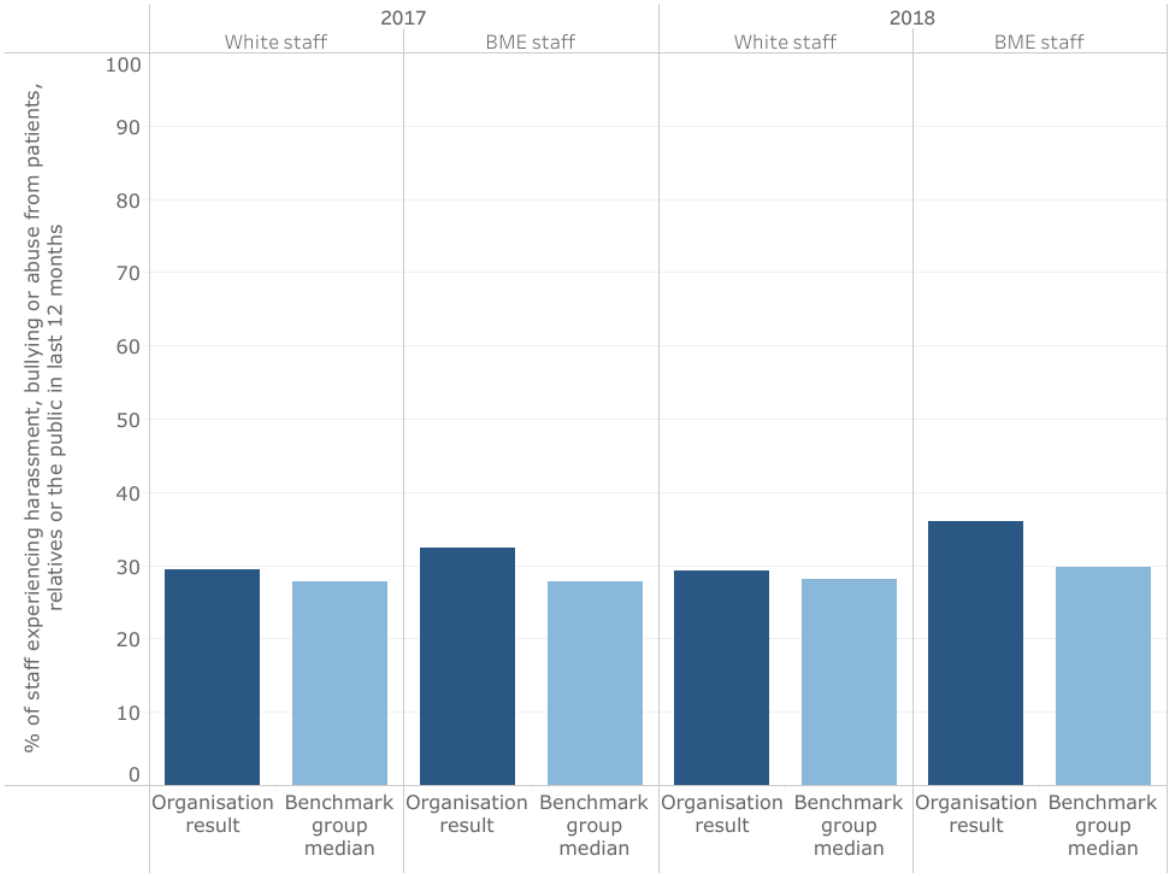
Relative likelihood of white staff accessing non-mandatory/CPD training compared to BME staff: 0.6993557 (White Staff) / 0.7754545 (BME Staff) = **0.90 times.**


*In this instance the data suggests white staff are less likely to have non-mandatory / CPD training than BME staff.*

In the 2017-18 report the relative likelihood was 0.91 (in favour of BME staff), compared to this year the likelihood has remained about the same.

## Indicator 5 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months – previously known as KF25 from NHS Staff Survey

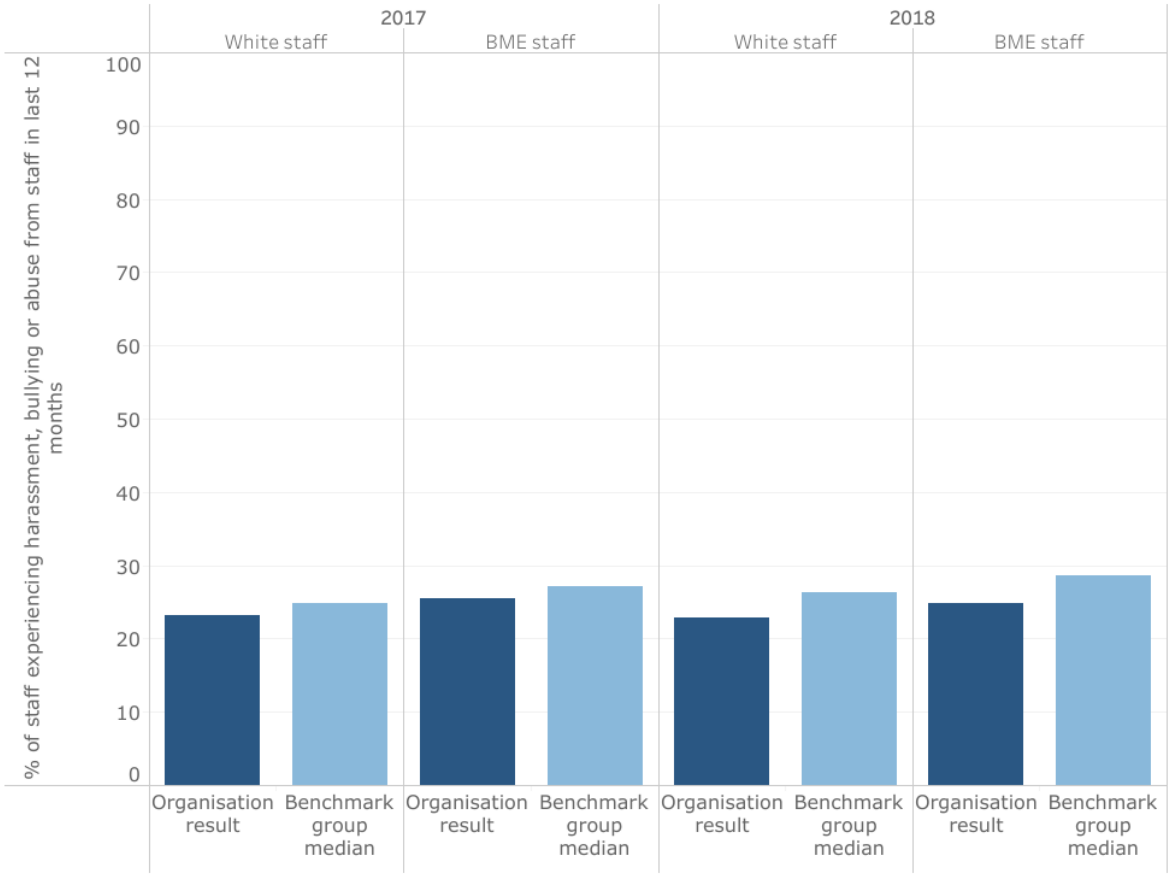
| Staff Survey | White Staff | | BME Staff | |
|---|---|---|---|---|
| | WSHFT staff | Acute Average | WSHFT staff | Acute Average |
| 2017 | 29.4% | 27.8% | 32.3% | 27.8% |
| 2018 | 29.2% | 28.2% | 36.1% | 29.8% |




Both white and BME staff experience harassment, bullying or abuse from patients, relatives or the public above the national average. It would appear from 2017-18 to 2018-19 the percentage of BME people experiencing harassment, bullying or abuse from patients, relatives or the public has increased.

## Indicator 6 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months – previously known as KF26 from NHS Staff Survey

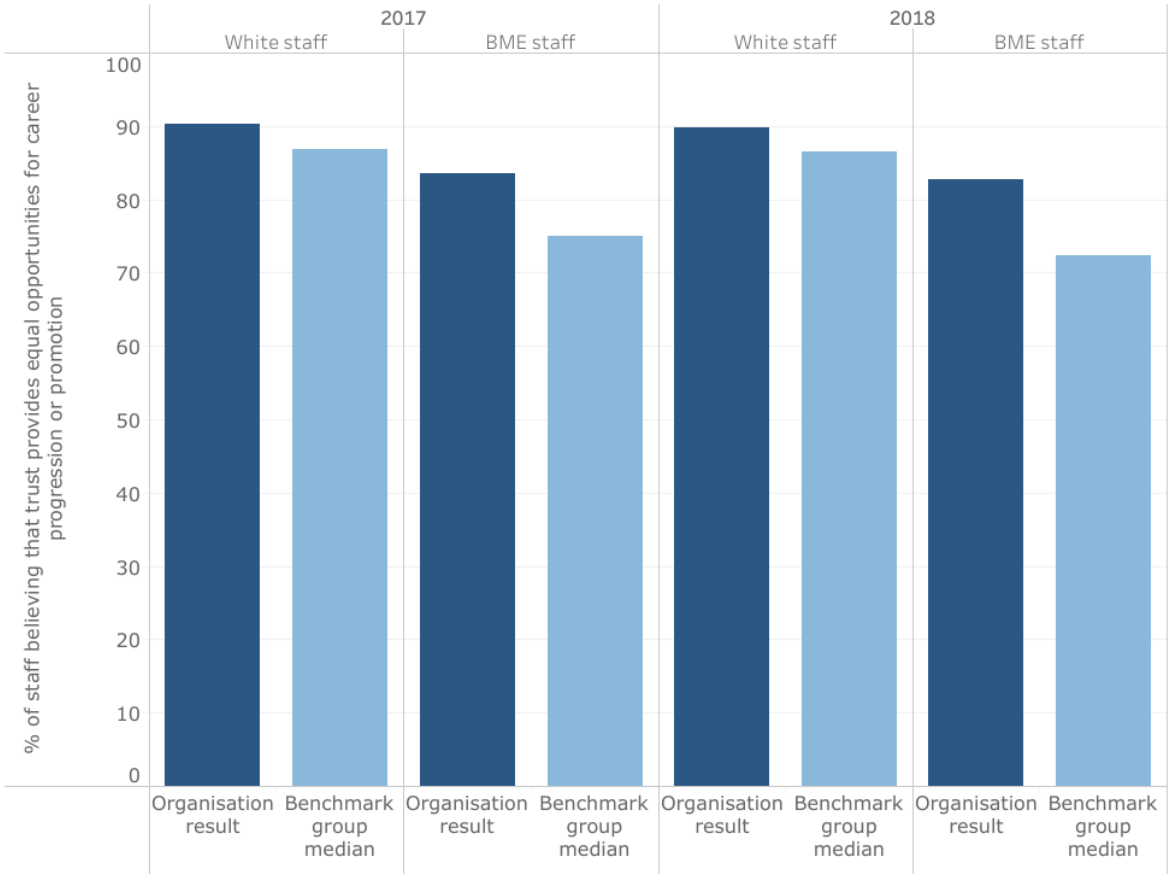
| Staff Survey | White Staff | | BME Staff | |
|---|---|---|---|---|
| | WSHFT staff | Acute Average | WSHFT staff | Acute Average |
| 2017 | 23.2% | 24.8% | 25.5% | 27.2% |
| 2018 | 22.9% | 26.4% | 24.9% | 28.6% |




Over the last two financial years, the percentage of BME staff experiencing harassment bullying or abuse from staff has been below the national average for acute trusts.

## Indicator 7 - Percentage believing that trust provides equal opportunities for career progression or promotion – previously known as KF21 from NHS Staff Survey

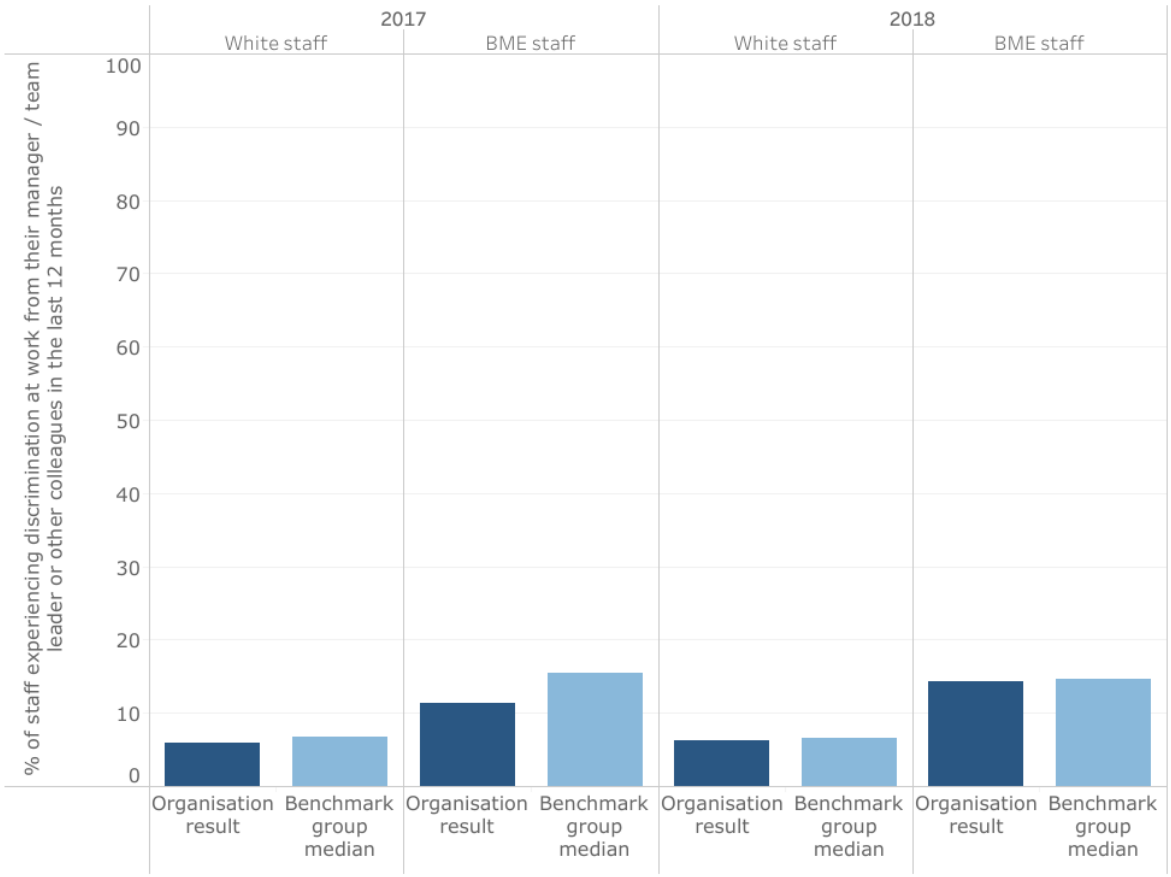
| Staff Survey | White Staff | | BME Staff | |
|---|---|---|---|---|
| | WSHFT staff | Acute Average | WSHFT staff | Acute Average |
| 2017 | 90.3% | 86.6% | 83.6% | 75.0% |
| 2018 | 89.8% | 86.5% | 82.7% | 72.3% |




Whilst the percentage of BME staff believing that the trust provides equality opportunities is consistently higher than the national average, it should be noted that there has been a small decrease from 2017 to 2018.

## Indicator 8 - In the last 12 months have you personally experienced discrimination at work? Q15(a&b) from the Staff Survey

| Staff Survey | White Staff | | BME Staff | |
|---|---|---|---|---|
| | WSHFT staff | Acute Average | WSHFT staff | Acute Average |
| 2017 | 5.9% | 6.7% | 11.4% | 15.5% |
| 2018 | 6.3% | 6.6% | 14.3% | 14.6% |




Whilst the percentage of BME staff experiencing discrimination at work from your Manager/team leader or other colleagues is below the average for acute trusts, there has been a circa 3% increase from 2017 to 2018.

Driving improvements in indicator 8 the Trust has commissioned a corporate project to 'Reduce Abusive Behaviours' throughout the workforce where the impact of WRES will be addressed.

**Indicator 9 - compare the difference for white and BME staff: Percentage difference between:**

The organisation's Board executive voting membership and its overall workforce

| | Overall Workforce | | Executive Board Voting Membership | | |
|---|---|---|---|---|---|
| | **Number in workforce** | **% in workforce** | **Number on board** | **% of board** | **% Difference** |
| **BME Staff** | 1100 | 15.5% | 1 | 6.7% | **-8.8%** |
| **White Staff** | 5588 | 78.7% | 12 | 80.0% | **1.3%** |
| **Unknown** | 416 | 5.8% | 2 | 13.3% | **7.5%** |
| **Total** | 7104 | 100.0% | 15 | 100.0% | |

**6. Are there any other factors or data which should be taken into consideration in assessing progress?**

In 2018 the national NHS Staff Survey was open to all WSHFT Trust staff to participate in which a potential sample of circa 6,500 were permitted. A total of 4,363 responses were received from staff.

The Trust's Annual Equality Report is also produced and the workforce data is analysed for trends across recruitment, employee relations, training and development and demographics. The report is scrutinised and approved by the Trust's Senior Management Team, and the actions feed into the Trust's Equality Objectives.

**a. Any issues of completeness of data**

This report is based on information presented to the Trust's Management Board in July 2019.

**b. Any matters relating to the reliability of comparisons with previous years**

None.

Western Sussex Hospitals NHS Foundation Trust

**WRES ACTION PLAN - Priorities**

**Agreed by Diversity Matters Group October 2018 – updated July 2019**

**2018 – 2021**

| 1. | Issue | BME applicants appear to be less successful through our recruitment processes than White applicants | | | | | |
|---|---|---|---|---|---|---|---|
| | **What is already in place?** | **Recruitment & Selection Policy, Shortlisting through TRAC requires scoring and recording for shortlisting, Interview assessment sheets require scoring, At least 2 people required to interview** | | | | | |
| | **Actions required** | **Outcome** | **WRES Indicator(s)** | **Theme(s)** | **Lead** | **Timescale** | **Progress Update** |
| 1.1 | Promote the benefits and outcomes of employing a diverse workforce through Recruitment & Selection training | To achieve a fair and equitable recruitment process | 1, 2, 7 | Recruitment<br>Selection<br>Training | Sarah Read | Complete | Recruitment & Selection training includes:<br>Unconscious bias discussed in R&S training. Pre-employment checks in place to eliminate individuals progressing due to immigration status. |
| 1.2 | Monitor, review and publish recruitment monitoring data | To achieve a fair and equitable recruitment process and ensure no blockages in any | 2, 7 | Recruitment<br>Training | Nikki Kriel<br><br>Abbi Eastland / | July 19<br><br>January 20 | Published annually since 2015 via the Workforce Race Equality Standard.<br><br>Medical HR and Recruitment provide annual detailed reports to inform the Trusts annual equality report. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | area | | | Mel Clay<br><br>Babs Harris / Nikki Kriel | On-going | Annual data is reviewed to understand differences in the WRES data and develop future actions to improve BME experience |
| 1.3 | Offer BME staff career development support and interview skills training | To develop training opportunities for BME staff to aid career development | 4, 7 | Education<br>Training | Val Fish | August 19<br><br>August 19 | BME Leadership offered to all. Opportunity shared with Practice Development / Matrons to encourage applications. Available programmes<br>- Stepping Up for band 5-7. Applications from 9 July and will close when full. Commence Oct 2019 through to March 2020<br>- Ready Now Programme for Band 8a above. Residential hosted in Leeds. Applications open late 2020.<br>Babs Harris attended WRES Expert programme in 2018 and learning being shared<br>Generic interview skills training currently offered trust wide. Consider options for specific session for BME staff to attend |
| 1.4 | Recruitment images and internal headlines articles to be representative of population | To actively encourage a greater diversity of applicants | 2, 7 | Recruitment<br>Communication | Jonathan Keeble / Abbi Eastland / Mel Clay | Complete | Trust Communication Lead for corporate images is Theo Cronin. In all promotional and team engagements events, we aim to ensure a greater diversity of our workforce are represented |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1.5 | Increase the declaration rate of BME staff within the organisation | To ensure we understand the ethnic make-up of our organisation | All indicators | Recruitment<br>Communication<br>Training<br>Education<br>Appraisal<br>Selection | Nikki Kriel | | Develop information booklet 'Monitoring data' - Tell us about You. To raise awareness within the organisation and for all new starters |

| **2.** | **Issue** | **Staff from BME groups appear more likely to be subject to formal processes than White staff, Disciplinary Policy, Grievance & Fair treatment Policy** | | | | | |
|---|---|---|---|---|---|---|---|
| | **What is already in place?** | **Employee Relations Tracker records all informal and formal processes** | | | | | |
| | **Actions required** | **Outcome** | **WRES Indicator(s)** | **Theme(s)** | **Lead** | **Timescale** | **Progress Update** |
| 2.1 | Ensure Trust policies are equally applied to all staff | Fairness in the application of all policies regardless of race / ethnicity | 3, 8 | Communication<br>Training | Babs Harris | April 19<br><br>August 19 | Met with Company Secretary in April 2019 to discuss formal process and quality assurance review to take place on a 6 monthly basis.<br><br>Guidance on how to complete an Equality Impact Assessment being developed to support those undertaking an assessment |
| 2.2 | Ensure staff in leadership roles throughout the organisation are equipped to | Greater understanding and knowledge of the impact of race discrimination | 3, 6, 8 | Communications<br>Appraisal<br>Education | Babs Harris | September 19 | Diversity awareness sessions to be rolled out to senior leaders to understand the impact and importance to equality in the workplace |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | understand the complexities of race equality | Reduction in numbers of BME staff progressing to formal cases | | | | | |

| **3.** | **Issue** | **Through the staff survey BME staff report higher levels of bullying; harassment or abuse from colleagues/managers than White staff** | | | | | |
|---|---|---|---|---|---|---|---|
| | **What is already in place?** | **Dignity at Work Policy (Bullying & Harassment, Freedom to Speak Up Guardian, Raising Concerns/Freedom to Speak Up Policy, Staff Counselling, Pop Up Schwartz Rounds, Celebrating Cultures Network** | | | | | |
| | **Actions required** | **Outcome** | **WRES Indicator(s)** | **Theme(s)** | **Lead** | **Timescale** | **Progress Update** |
| 3.1 | Deliver a session in the 'Western Sussex Way' training. Initiate conversations to include equalities discrimination, bullying concerns, impact of poor values & behaviours. Set expected standard and how to challenge/de-escalate. Promote Freedom To Speak Up | Internal material to be developed for staff to better understand the role of Freedom to Speak Up Guardian<br>Monthly pulse check captured to Division and staffgroup level to evidence monthly feelings towards V&A. Questions to be added to the staff engagement questionnaire | 5, 6, 8 | Communication<br>Education<br>Training | David Clayton-Evans | Complete | Freedom to Speak Up Guardian has a slot on Induction and Health & safety training and continues to be at many Trust events.<br><br>Equality & Diversity training promotes discrimination against any of the protected characteristics will not be tolerated. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Guardian | from Jan 2019 | | | | | |
| 3.2 | Highlight what our Zero Tolerance approach is | Educate through the Reducing Abusive Behaviours' Trust-wide project | 5 | Training<br>Education<br>Communication | Nikki Kriel | August 2019 | Violence & Aggression Policy merged with the Security Policy to form a combined policy known as the Security Policy.<br>The Reducing Abusive Behaviours Steering group meets monthly and is currently developing a set of tools and co-ordinating a mandatory roll out of Conflict Resolution Training (CRT) to A&E and the Emergency Floor. |

| **4.** | **Issue** | **A higher percentage of BME staff report experiencing discrimination at work in the last 12 months** | | | | | |
|---|---|---|---|---|---|---|---|
| | **What is already in place** | **Equality & Diversity Policy; Equality and Diversity session at corporate Trust Induction and mandatory Health & Safety training programme. Equality Impact Assessment within workforce policies, Freedom To Speak Up Guardian, Raising Concerns/Freedom to Speak Up Policy, Celebrating Cultures Network** | | | | | |
| | **Actions required** | **Outcome** | **WRES Indicator(s)** | **Theme(s)** | **Lead** | **Timescale** | **Progress Update** |
| 4.1 | Examples of hate crime behaviours communicated at mandatory health & safety training programme | An organisational understanding of the impact discrimination can have on individuals | 8 | Education<br>Training | Nikki Kriel | Complete | Hate crime included in the Equality, Diversity & Inclusion Policy and included at Equality & Diversity sessions.<br>PC Allen attended Inclusion staff conference and shared hate crime process to 380 attendees. Future plans underway to incorporate hate crime message to new practice |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | development cohorts and team away days |
| 4.2 | Review and update the Violence and Aggression Policy | Current policy will be updated to ensure relevant to current issues. | 5, 6 | Training<br>Communication | David McLaughlin | Complete | Policy updated and approved by TEC. Policy now known as the Security Policy. All signposting on StaffNet for V&A policy directs to Security Policy. Policy live for 1 year in line with future Security arrangements and CRT training |
| 4.3 | Drive improvements through the commissioned 'Reducing Abusive Behaviours' Trust-wide project | To be in the top 20% of acute trusts for all domains linked with violence, aggression, harassment and discrimination in the 2019 national staff survey results. Results due in February 2020. | 5, 6, 8 | Education<br>Training<br>Communication | Nikki Kriel | February 2020 | New reporting themes introduced in 2018 survey.<br>Indicator 8 - 14.3% BME / 6.3% White. Discrimination - 51.1% of all staff personally experienced discrimination at work on the grounds of Ethnicity.<br>Reduce BME staff survey scores by 2.9% (target 11.4%)<br>Reduce Ethnic Background staff survey scores by 8.7% (target 42.4%) |

| **5.** | **Issue** | **Percentage of organisations BME executive voting membership** | | | | | |
|---|---|---|---|---|---|---|---|
| | **What is already in place** | **Equality & Diversity Policy, Equality Impact Assessment within workforce policies, Diversity Matters Group, Celebrating Cultures Network** | | | | | |
| | **Actions required** | **Outcome** | **WRES Indicator(s)** | **Theme(s)** | **Lead** | **Timescale** | **Progress Update** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 5.1 | Reach out and engage with local communities to encourage applications from BME citizens to become a non-executive director when vacancies arise | Improved BME representation of executive membership | 9 | Education<br><br>Culture | Jonathan Keeble / Babs Harris | December 2019 | Prior to non-executive director vacancies becoming available engage collaboratively with local community groups to encourage ethic minority applications |

Reference:

Indicator 1 Percentage of staff in each of the Agenda for Change Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

Indicator 2 Relative likelihood of staff being appointed from shortlisting across all posts

Indicator 3 Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Indicator 4 Relative likelihood of staff accessing non-mandatory training and CPD

Indicator 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months - KF25 from NHS Staff Survey

Indicator 6 Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months - KF26 from NHS Staff Survey

Indicator 7 Percentage believing that trust provides equal opportunities for career progression or promotion - KF21 from NHS Staff Survey

Indicator 8 In the last 12 months have you personally experienced discrimination at work from your Manager/team leader or other colleagues? Q17(b) from the Staff Survey

Indicator 9 Compare the difference for white and BME staff: Percentage difference between:

- The organisation’s Board voting membership and its overall workforce
- The organisation’s Board executive membership and its overall workforce

Western Sussex Hospitals
NHS Foundation Trust

| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 18 | **Meeting:** | Trust Board | **Meeting Date:** | 22 July 2019 |
| **Report Title:** | Workforce Disability Equality Standard (WDES) 2018-19 | | | | |
| **Sponsoring Executive Director:** | Denise Farmer, Chief Workforce and Organisational Development Director | | | | |
| **Author(s):** | Simon Anjoyeb, Deputy Head of Inclusion (BSUH/WSHFT)<br>Nikki Kriel, Organisational Development Manager | | | | |
| **Report previously considered by and date:** | Diversity Matters Group (DMG) - virtually with membership 08/07/19 and DMG agenda 22/07/19 | | | | |

| **Purpose of the report:** | | | |
|---|---|---|---|
| Information | ☐ | Assurance | X |
| Review and Discussion | ☐ | Approval / Agreement | X |
| **Reason for submission to Trust Board in Private only (where relevant):** | | | |
| Commercial confidentiality | ☐ | Staff confidentiality | ☐ |
| Patient confidentiality | ☐ | Other exceptional circumstances | ☐ |
| **Link to Trust Strategic Themes:** | | | |
| Patient Care | X | Sustainability | ☐ |
| Our People | X | Quality | X |
| Systems and Partnerships | ☐ | | |

| **Any implications for:** | |
|---|---|
| Quality | Excellent care is far more likely to meet the needs of all patients when the workforce is drawn from diverse communities which is reflective of the population served, and when all our staff are themselves free from discrimination |
| Financial | Increase in staff engagement and satisfaction, therefore less time and finance spent on employee relations issues and turnover |
| Workforce | As described above |

| **Link to CQC Domains:** | | | |
|---|---|---|---|
| Safe | ☐ | Effective | ☐ |
| Caring | ☐ | Responsive | X |
| Well-led | X | Use of Resources | X |

**Communication and Consultation:**

Recognising equality and celebrating diversity is an integral part of the Trusts core business, Patient First improvement programme and 'We Care' vision. Data from the findings in this report feed into the Trust's Equality objectives and annual equality report. The first submission of the WDES report is mandatory in the 2018/19 Standard NHS Contract. The regulators, the Care Quality Commission (CQC) and NHS Improvement, will use the report to help assess whether NHS organisations are well-led. The Trust is required to publish annual WDES data on NHS Digital Strategic Data Collection Service (SDCS) by 01/08/19 and WDES action plan developed and published on the Trusts website by 30/09/19. The WDES action plan has been developed by the disability forum and is subject to ratification at the Diversity Matters Group (DMG) on 22/07/19.

**Executive Summary:**

This report seeks to update the Trust Board on the annual WDES report (data is taken from ESR for the period 01/04/18-31/03/19 and 2018 Staff Survey results) and actions to be taken as a result of this analysis. The purpose of WDES is to improve the experience of Disabled staff working in, and seeking employment in the NHS and aims to increase understanding of Disabled patients' needs and patient outcomes. The WDES compares the experience of disabled and non-disabled staff with the objective of closing the gaps highlighted by ten metrics.

**Key Recommendation(s):**

**The Board is asked to APPROVE the report and make recommendations to the WDES action plan which is in development following the introduction of the new standard**

Western Sussex Hospitals
NHS Foundation Trust

# Western Sussex Hospitals NHS Foundation Trust

## Workforce Disability Equality Standard 2018-19

# Introduction

There has been legal protection for workers with disabilities for many years, making it unlawful to treat a worker with a disability less equally than workers without a disability. The most recent legislation that offers this protection is the Equality Act 2010.

The act goes further than just banning unfair behaviour to workers with disabilities, it also places public sector organisations under duty to seek opportunities to proactively address areas of equality of opportunity and promoting good relations between workers with disabilities and those without.

Whilst there have been improvements with societal attitudes towards people with disabilities, they have not necessarily moved as quickly as the act (and its predecessors) had intended. This being the case, there are still many inequalities surrounding the employment of workers with disabilities. The employment rate of people with disabilities is 51.3%, versus those without 81.4%, this means a difference of 30.1%. This difference is often referred to as the disability employment gap. Given that 22% of adults of working age have a disability, more needs to be done to close this gap. [1]

Breaking down disability further the picture for people with mental ill health and learning disabilities is far worse. 1 in 4 adults and 1 in 10 children experience mental health illnesses in their lifetime [2] however; the stigma around mental health is still rife within the UK. In the 2016 green paper Improving Lives: The Work, Health and Disability Green Paper, states only 32% of people with mental illness were in work. There are approximately 1.5 million people in the UK with some form of Learning Disability, of which 17% of people of working age are in paid employment. It is estimated that 28% of adults of working age with mild or moderate learning disabilities, 10% of adults of working age with severe learning disabilities and 0% of adults of working adults with profound learning disabilities are in employment. [3]

The inequalities can be vast, and may include inflexible recruitment practices that do not take the needs of the candidate's disability, providing adequate reasonable adjustments in the workplace, progression into more senior roles, overrepresentation in employee relations procedures, poor attitudes to those with a disability and poor

1 Briefing Paper 7540, People with Disabilities in Employment, 30 November 2018, Andrew Powell: House of Commons Library).

2 (Improving Lives: The work, Health and Disability Green Paper, NHS England)

3 (Emerson and Hatton, 2008)

access to development opportunities. These inequalities help to build a picture of poor employment / retention rates and experiences of employment.

The Workforce Disability Equality Standard (WDES) was introduced in April 2019 by NHS England; it was developed to demonstrate compliance with:

- UK Government's pledge to increase the number of disabled people in employment - this was made in November 2017
- The NHS Constitution - relating to the rights of staff
- The 'social model of disability' - recognising the societal barriers that people with disabilities face which is the disabling factor, not an individual's medical condition or impairment
- The Equality Act 2010 - specific requirements not to discriminate against workers with a disability, advancing equality and fostering good relations
- 'Nothing about us without us' - a phrase used by the disability movement to denote a central principle of inclusion: that actions and decisions that affect or are about people with disabilities should be taken with disabled peoplvce.

The standard allows NHS organisations to review the experiences and outcomes of both staff with and without disabilities. The standard provides a framework for NHS organisations to review their key employment cycle policies, practices and processes to identify if inequalities (listed above) exist, and gives them an opportunity to engage with disabled workers to put actions in place to address areas of inequality.

There are some specific issues that impact workers with disabilities and NHS organisations, these include:

- Significant under reporting of the numbers of staff who declare themselves as having a disability
- 15% difference between Electronic Staff Records (ESR) and Staff Survey declaration rates. ESR is the integrated Human Resources and Payroll system.
- Lack of representation of disabled staff at senior levels
- Disabled staff consistently report:
    - higher levels of bullying and harassment
    - less satisfaction with appraisals and career
    - lack of development opportunities

Through this programme and with annual reporting it is hoped NHS Organisations will see many benefits including, continuous improvement for workers with a disability, better understanding of the needs of workers with a disability, improved data (declaration rates), improvements to the culture, improved employment and retention.

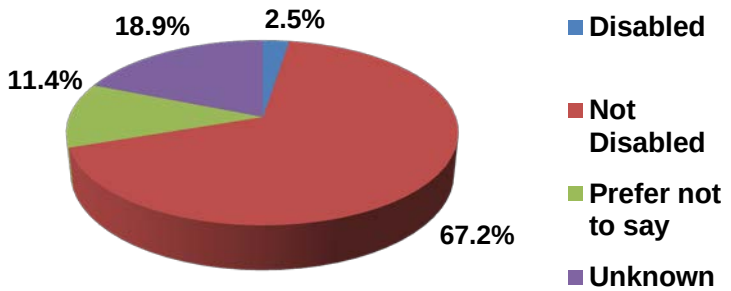
# Background Information

**1) Total number of staff:**

| 2019 |
|---|
| 7073 |

Proportion of staff with a disability employed within this organisation at the date of this report:

| | 2019 | |
|---|---|---|
| | Headcount | % of Staff |
| **Disabled** | 180 | 2.5% |
| **Not Disabled** | 4754 | 67.2% |
| **Prefer not to say** | 803 | 11.4% |
| **Unknown** | 1336 | 18.9% |
| **Total** | 7073 | 100.0% |




2019

**2) Self-reporting**

**a) The proportion of total staff who have self-reported their disability status:**

| | 2019 | |
|---|---|---|
| | Headcount | % of Staff |
| **Disability Status Declared** | 4934 | 69.8% |
| **Disability Status Not Declared** | 2139 | 30.2% |
| **Total** | 7073 | 100.0% |

**b) Have any steps been taken in the last reporting period to improve the level of self-reporting by disability?**

We collect information relating to disability as part of the recruitment process. The Trust has launched the Electronic Staff Records self-service facility which allows staff to update their disability status confidentially.

**c) Are any steps planned during the current reporting period to improve the level of self-reporting by disability?**

The Trust is planning to undertake an exercise to improve the workforce declaration of diversity monitoring data across all protected characteristics.

**3) Workforce Data**

**a) What period does the organisation's workforce data refer to?**

1 April 2018 to 31 March 2019.

**4) How is disability defined under the standard?**

The standard uses the definition of disability found in the Equality Act 2010. Under the act a person is considered as having a disability if they have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities.

**5) Population Demographic 2011 Census (Southeast England)**

| | Census 2011 |
|---|---|
| Activity limited a lot | 6.9% |
| Activity limited a little* | 8.8% |

* Within this section there will be some (not all) people who would meet the test under the Equality Act 2010 as being disabled, but it is impossible to say what proportion.

# Workforce Disability Equality Metrics

***For each of the indicators, the standard compares the metrics for staff with a disability and staff without a disability.***

**Metric 1 - Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce.**

Cluster 1: AfC Band 1, 2, 3 and 4
Cluster 2: AfC Band 5, 6 and 7
Cluster 3: AfC Band 8a and 8b
Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)
Cluster 5: Medical and Dental staff, Consultants
Cluster 6: Medical and Dental staff, Non consultant career grade
Cluster 7: Medical and Dental staff, Medical and dental trainee grades

**Note: Organisations should undertake this calculation separately for non-clinical and for clinical staff.**

| | Non-Clinical | | | | | |
|---|---|---|---|---|---|---|
| | **Disabled** | **Not Disabled** | **Not Known** | **Total** | **Disabled %** | **Not Disabled %** |
| **Cluster 1** | 48 | 1000 | 422 | 1470 | **3.2%** | **68.0%** |
| **Cluster 2** | 4 | 207 | 84 | 295 | **1.4%** | **70.1%** |
| **Cluster 3** | 3 | 68 | 15 | 86 | **3.5%** | **79.1%** |
| **Cluster 4** | 0 | 38 | 12 | 50 | **0.0%** | **76.0%** |
| **Total** | **55** | **1313** | **533** | **1901** | **2.9%** | **69.1%** |

In the table above in the column labelled ‘Disabled %’ the green cells demonstrate representation is either equal or more than the general representation of disabled staff in the workforce (2.5%). The red cell details an underrepresentation when compared to the general representation of disabled staff in the workforce.

**What the data tells us:**

- There is a higher than expected representation of staff with declared disabilities in cluster 1 (bands 1-4) and cluster 3 (bands 8a and 8b).
- There is a lower than expected representation of staff with declared disabilities in cluster 2 (bands 5-7) and cluster 4 (bands 8c-9 and VSM).

| | Clinical | | | | | |
|---|---|---|---|---|---|---|
| | **Disabled** | **Not Disabled** | **Not Known** | **Total** | **Disabled %** | **Not Disabled %** |
| **Cluster 1** | 43 | 1078 | 422 | 1543 | **2.8%** | **69.9%** |
| **Cluster 2** | 65 | 1769 | 829 | 2663 | **2.4%** | **66.4%** |
| **Cluster 3** | 4 | 95 | 36 | 135 | **3.0%** | **70.4%** |
| **Cluster 4** | 0 | 14 | 11 | 25 | **0.0%** | **56.0%** |
| **Cluster 5** | 7 | 189 | 119 | 315 | **2.2%** | **60.0%** |
| **Cluster 6** | 4 | 241 | 121 | 366 | **1.1%** | **65.8%** |
| **Cluster 7** | 2 | 55 | 68 | 125 | **1.6%** | **44.0%** |
| **Total** | **125** | **3441** | **1606** | **5172** | **2.4%** | **66.5%** |

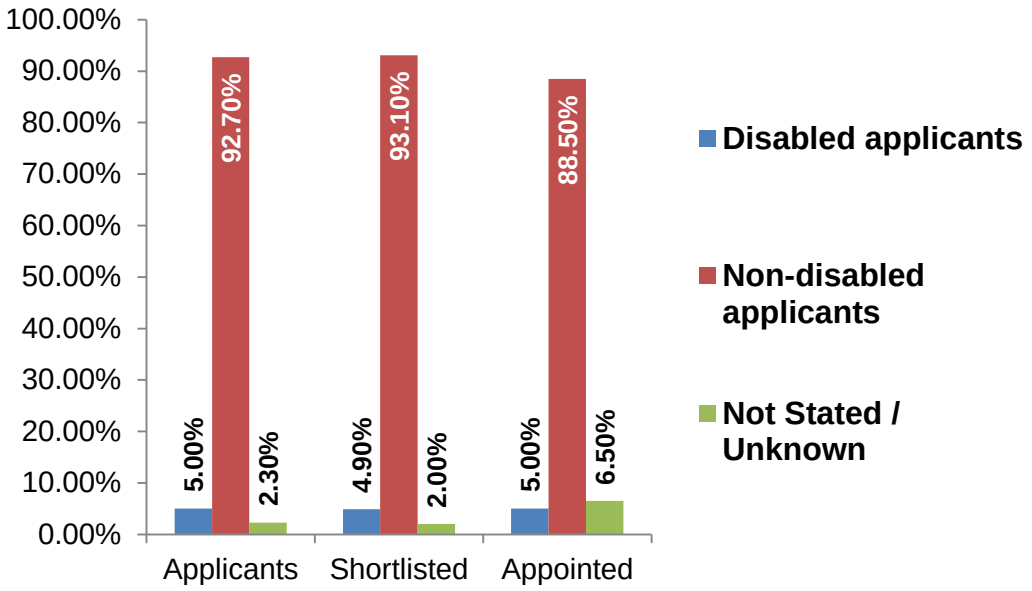
In the table above in the column labelled 'Disabled %' the green cells demonstrate representation is either equal or more than the general representation of disabled staff in the workforce (2.5%). The red cell details an underrepresentation when compared to the general representation of disabled staff in the workforce.

**What the data tells us:**

- There is a higher than expected representation of staff with declared disabilities in cluster 1 (bands 1-4) and cluster 3 (bands 8a and 8b).
- For all other grades there is a lower than expected representation of staff with a declared disability.
- Staff with a declared disability are underrepresented in medical and dental grades (clusters 5-7).

**Metric 2 - Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts. This refers to both external and internal posts.**

| | Applicants | | Shortlisted | | Appointed | | Relative Likelihood of being appointed |
|---|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % | |
| Disabled applicants | 859 | 5.0% | 525 | 4.9% | 27 | 5.0% | 0.0514285 |
| Non-disabled applicants | 15988 | 92.7% | 9972 | 93.1% | 474 | 88.5 % | 0.047533 |
| Not Stated / Unknown | 405 | 2.3% | 211 | 2.0% | 35 | 6.5% | 0.1658767 |
| **Total** | **17252** | **100%** | **10708** | **100%** | **536** | **100%** | |




The likelihood of non-disabled candidates being appointed from shortlisting:
474 / 9972 = 0.047533

The likelihood of disabled candidates being appointed from shortlisting:
27 / 525 = 0.0514285

The relative likelihood of non-disabled candidates being appointed from shortlisting compared to disabled staff is: 0.047533 (non-disabled candidates) / 0.0514285 (disabled candidates) = **0.92 times.**

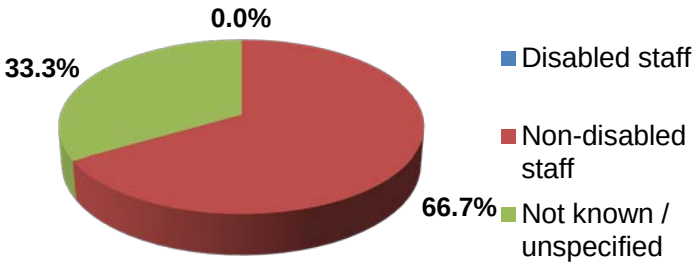
| | |
|---|---|
| Disabled applicants | 1.00 |
| Non-disabled applicants | 0.92 |

*In this instance the data suggests disabled candidates are slightly more likely than non-disabled candidates to be appointed from shortlisting.*

**Metric 3 - Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.**

**Note: This indicator will be based on data from a two year rolling average of the current year and the previous year**

| | Number of Capability Procedures | Number in Workforce | Relative Likelihood of entering procedure |
|---|---|---|---|
| **Disabled staff** | 0 | 180 | 0.000000 |
| **Non-disabled staff** | 6 | 4754 | 0.001262 |
| **Not known / unspecified** | 3 | 2139 | 0.001403 |




The likelihood of non-disabled staff entering the formal disciplinary process:
6 / 4754 = 0.001262

The likelihood of disabled staff entering the formal disciplinary process:
0 / 180 = 0.000000

The relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff is: 0.000000 (Disabled Staff) / 0.001262 (non-disabled Staff) = **0.0 times.**

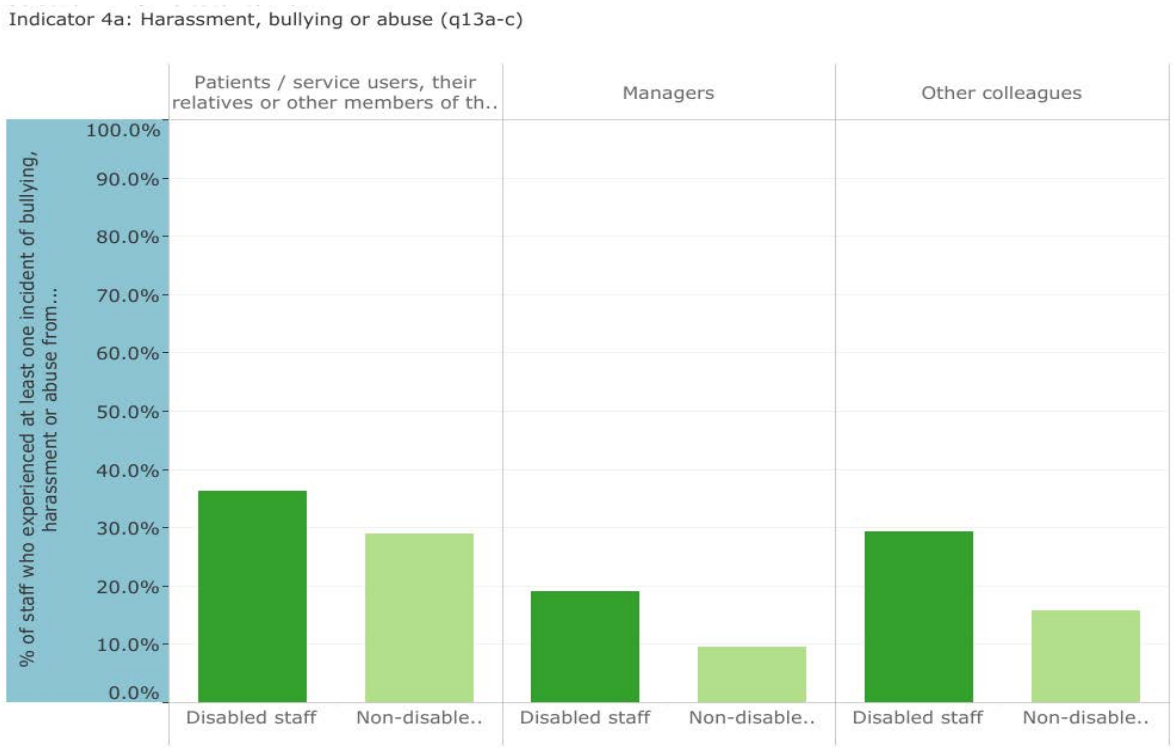
| | | |
|---|---|---|
| **Disabled Staff** | | 0.0 |
| **Non-disabled Staff** | | 1.0 |

*In this instance the data suggests that non-disabled staff members are more likely than disabled staff to enter into a formal capability process*.

**Metric 4a - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:**

- **Patients / service users, their relatives or other members of the public**
- **Managers**
- **Other colleagues**

| | Patients/service users, their relatives or other members of the public | Managers | Other colleagues |
|---|---|---|---|
| **Disabled staff** | 36.2% | 19.0% | 29.3% |
| **Non-disabled staff** | 29.0% | 9.6% | 15.7% |

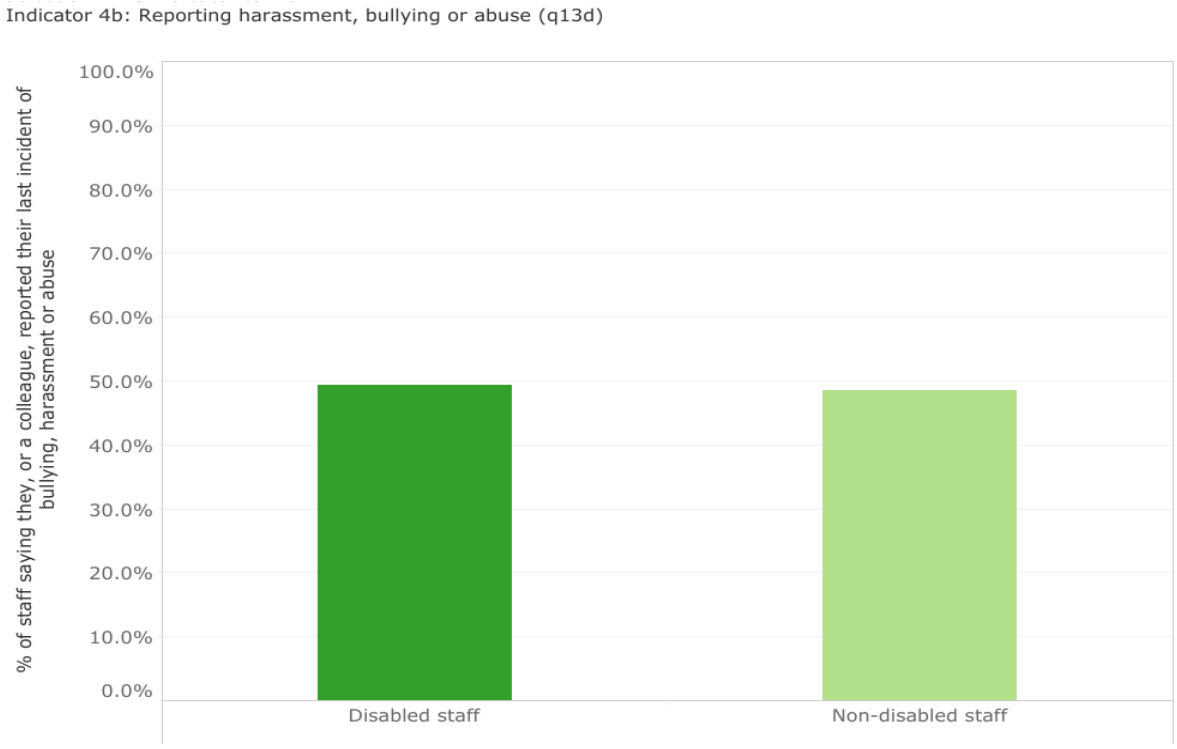



**What the data tells us:**

- Displayed as a likelihood:
  - Disabled staff are 1.25 times more likely to experience harassment, bullying or abuse from patients/service users, their relatives or other members of the public than non-disabled staff.
  - Disabled staff are 1.98 times more likely to experience harassment, bullying or abuse from managers than non-disabled staff.
  - Disabled staff are 1.87 times more likely to experience harassment, bullying or abuse from other colleagues than non-disabled staff.

## Metric 4b - Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

| | |
|---|---|
| **Disabled staff** | **49.4%** |
| **Non-disabled staff** | 48.5% |

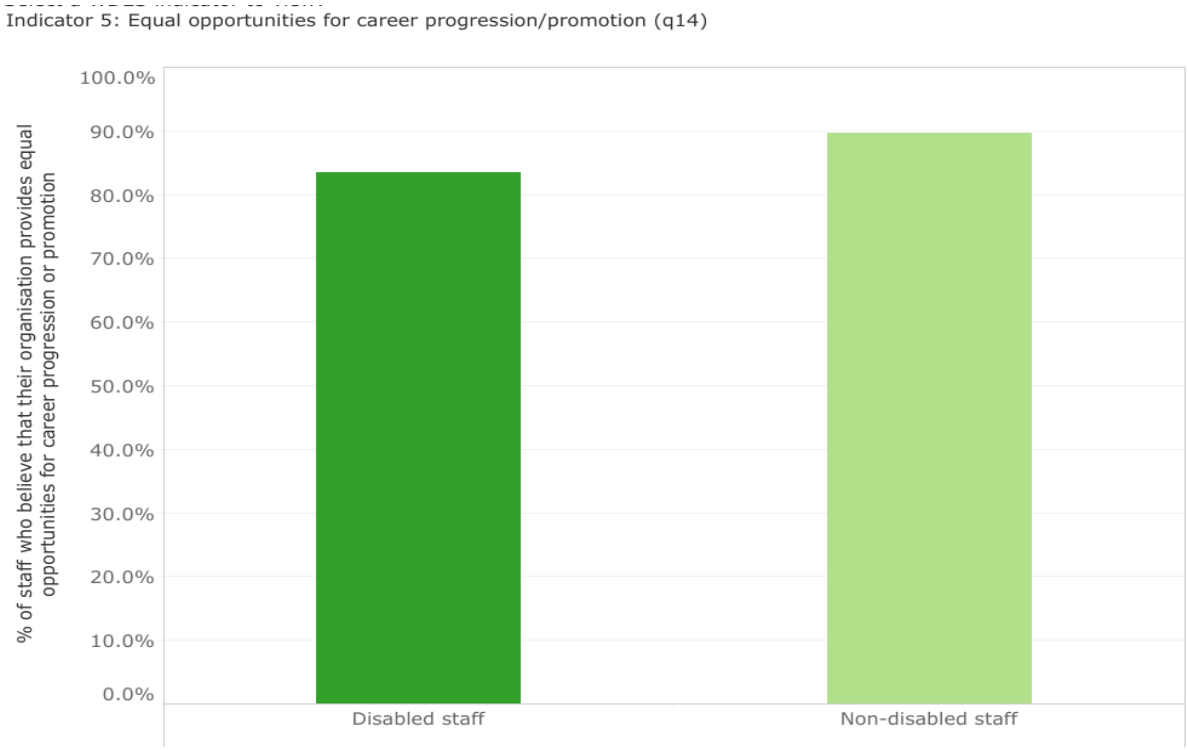



## What the data tells us:

- Displayed as a likelihood:
  - Disabled staff are 1.02 times more likely to report incidents of harassment, bullying or abuse at work than non-disabled staff.

## Metric 5 - Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

| | |
|---|---|
| **Disabled staff** | **83.5%** |
| **Non-disabled staff** | 89.6% |

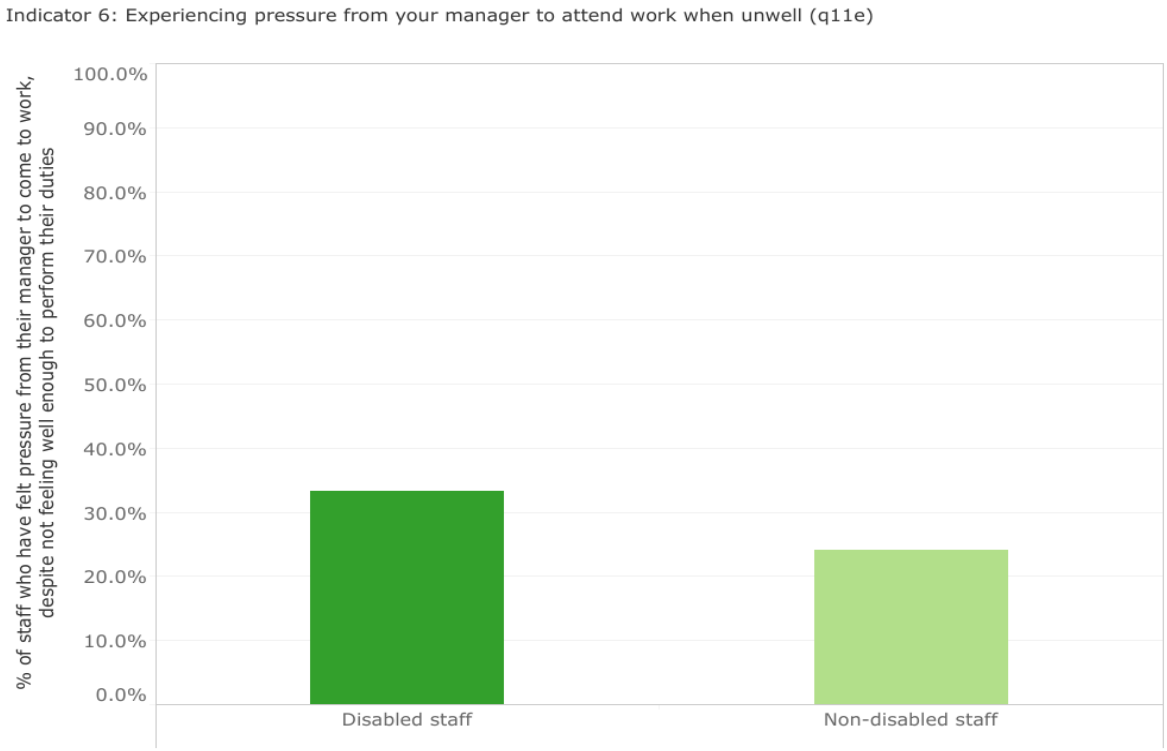



### What the data tells us:

- Fewer disabled staff feel the Trust provides equal opportunities for career progression or promotion than non-disabled staff.

## Metric 6 - Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

| | |
|---|---|
| **Disabled staff** | **33.3%** |
| **Non-disabled staff** | 24.1% |

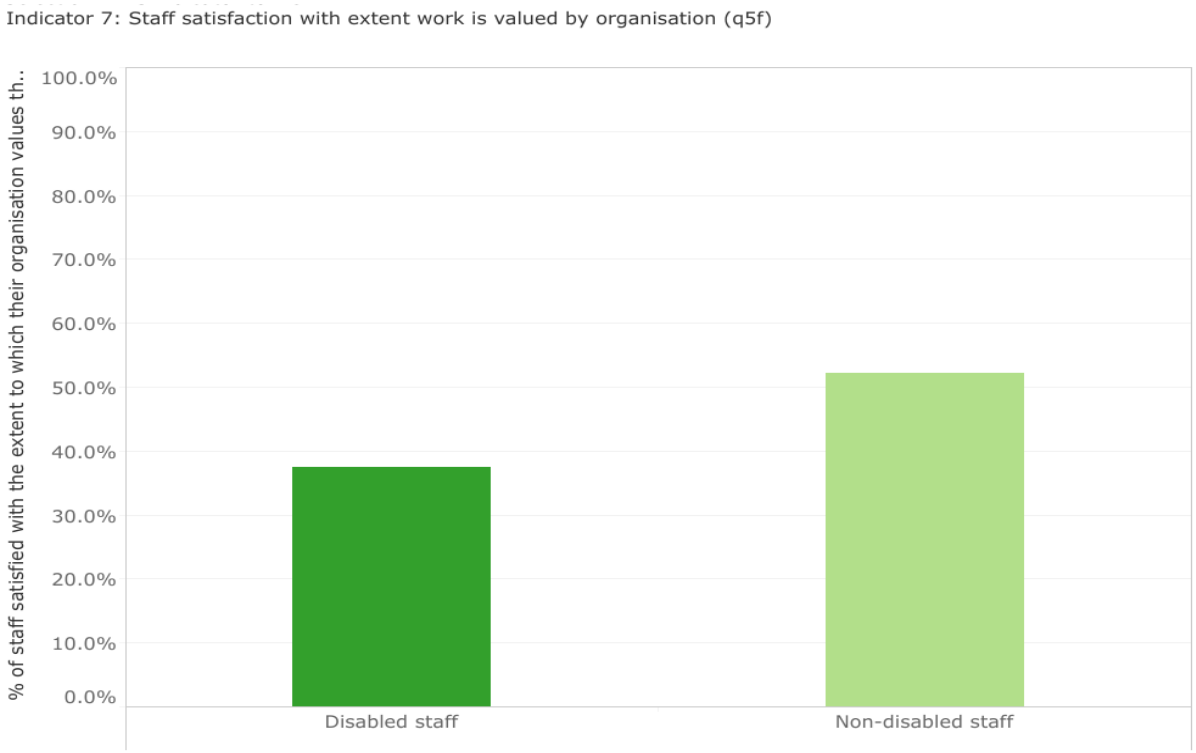



### What the data tells us:

- Displayed as a likelihood:
  - Disabled staff are 1.38 times more likely to have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties than non-disabled staff.

## Metric 7 - Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

| | |
|---|---|
| **Disabled staff** | **37.5%** |
| **Non-disabled staff** | 52.2% |

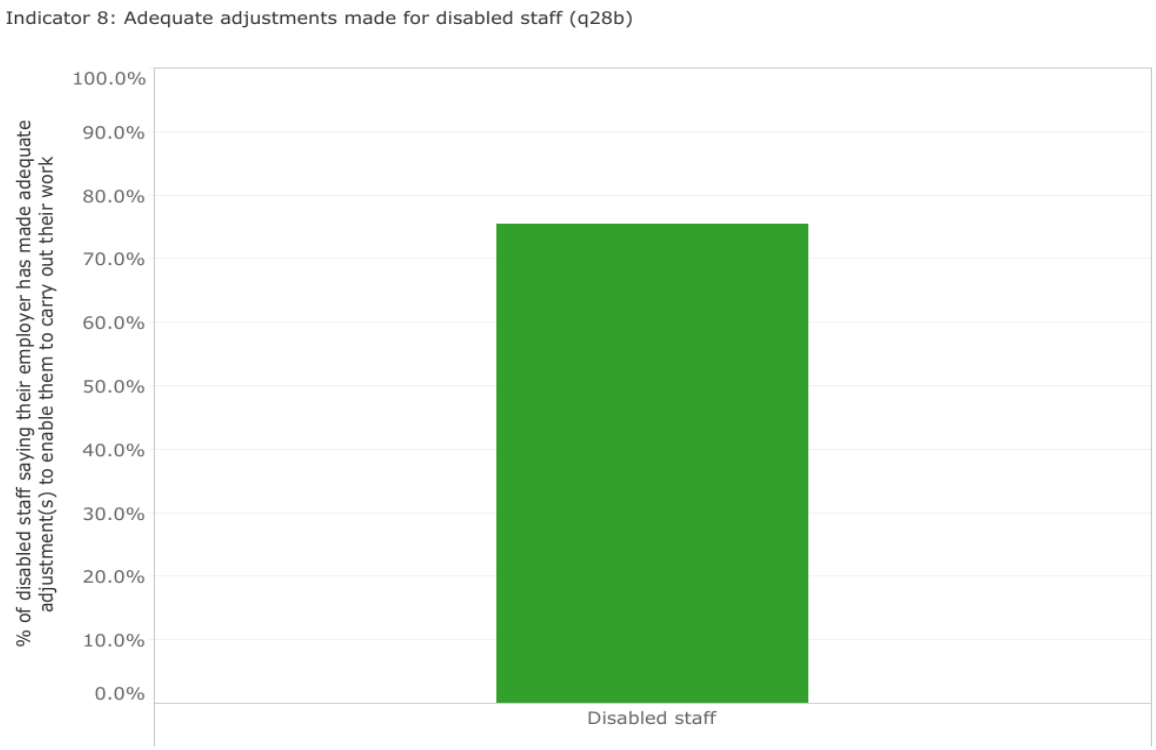



### What the data tells us:

- Fewer disabled staff feel they are satisfied with the extent to which their organisation values their work than non-disabled staff. However, the overall scores for disabled staff is quite low.

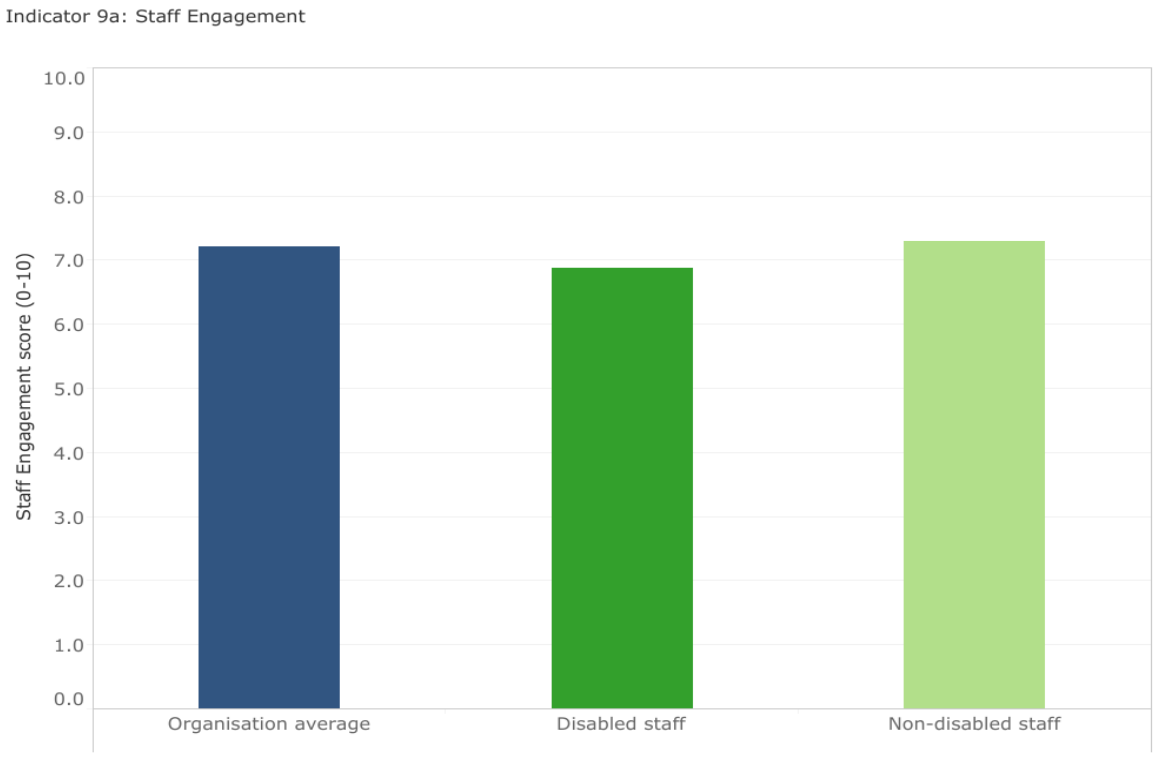
## Metric 8 - Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

| | |
|---|---|
| **Disabled staff** | **75.5%** |



## Metric 9a - The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

| Disabled staff | 6.9 |
|---|---|
| **Non-disabled staff** | 7.3 |
| **WSHFT average** | 7.2 |




## Metric 9b - Has your trust taken action to facilitate the voices of disabled staff in your organisation to be heard?

**Yes** - The Trust has a disability staff network. The aim of the network is to provide an avenue for staff to discuss disability related issues, the WDES outcomes and action plan was discussed with the network. The network reports to the Diversity Matters Steering Group, which is chaired by the Chief Executive and the Chief Workforce and Organisational Development Officer.

## Metric 10 - Percentage difference between the organisation's board voting membership and its organisation's overall workforce, disaggregated:

### (i) The organisation's Board voting membership and its overall workforce

| | Overall Workforce | | Voting Board Membership | | |
|---|---|---|---|---|---|
| | **Number in workforce** | **% in workforce** | **Number on board** | **% of board** | **% Difference** |
| **Disabled** | 180 | 2.5% | 0 | 0.0% | **-2.5%** |
| **Non-disabled** | 4754 | 67.2% | 7 | 46.7% | **-20.5%** |
| **Not known** | 2139 | 30.3% | 8 | 53.3% | **23.0%** |
| **Total** | 7073 | 100.0% | 15 | 100.0% | |

### (ii) The organisation's Board executive membership and its overall workforce

| | Overall Workforce | | Executive Board Membership | | |
|---|---|---|---|---|---|
| | **Number in workforce** | **% in workforce** | **Number on board** | **% of board** | **% Difference** |
| **Disabled** | 180 | 2.5% | 0 | 0.0% | **-2.5%** |
| **Non-disabled** | 4754 | 67.2% | 7 | 46.7% | **-20.5%** |
| **Not known** | 2139 | 30.3% | 8 | 53.3% | **23.0%** |
| **Total** | 7073 | 100.0% | 15 | 100.0% | |

**Are there any other factors or data which should be taken into consideration in assessing progress?**

In 2018 the NHS Staff Survey was open to all Western Sussex Hospitals NHS Foundation Trust staff to participate in which a potential sample of circa 6,500 were permitted to participate. A total of 4,363 responses were received from staff.

The Trust's Annual Equality Report is also produced and the workforce data is analysed for trends across recruitment, employee relations, training and development and demographics. The report is scrutinised and approved by the Trust's Senior Management Team, and the actions feed into the Trust's Equality Objectives.

The system used to provide recruitment data, picks up all recruitment activity across a user specified period, in this instance 1 April 2018 to 31 March 2019. The system does not differentiate recruitment campaigns that start and finish within this period.

**Any issues of completeness of data**

a. **Any matters relating to the reliability of comparisons with previous years**
   Not applicable - this is the launch report for the Workforce Disability Equality Standard.

b. **Any issues of completeness of data**
   This report is based on information presented to the Trust's Management Board in July 2019.

**WDES ACTION PLAN - Priorities**
**To Be Agreed by Diversity Matters Group - July 2019**
**2019 – 2021**

Western Sussex Hospitals NHS Foundation Trust

| # | Actions required | Outcome | WDES Metric(s) | Theme(s) | Lead | Timescale | Progress Update |
|---|---|---|---|---|---|---|---|
| 1.1 | Increase the declaration rate of the disability status of the workforce | This will enable the Trust to have a clearer and more accurate picture of the workforce and how policies and procedures impact disabled staff | 1, 2, | Process | Nikki Kriel | Sep-19 | Develop information booklet 'Monitoring data 'what's is got to do with you' to raise awareness within organisation / new starters. |
| | | | | | Gemma Leach | Aug-19 | Develop Quick Reference Guides (QRC) to promote ESR self-service facility so individuals can update personal information directly online |
| | | | | | Abbi Eastland | Aug-19 | Review information provided to new starters to encourage declaration during employment application process |
| | | | | | Shereen Robinson / Jo Fanning | Aug-19 | Review scope to expand HR / OH process to periodically ask employee if they want to update disability status when appropriate? |
| | | | | | David Clayton-Evans | September | Host visual engagement stands for disability forum / HR to share information / raise awareness and promote disabilities. Demonstrate how to update personal information via ESR self-service facility |
| 1.2 | Identify and profile visible disability champions | Raise awareness of disability throughout the organisation to help improve confidence among staff to declare their | 1 | Culture Education | David Clayton-Evans | Aug-19 | Approach Disability forum for case studies and arrange promotional storyline through communications / headlines |
| 1.3 | Continue with the Disability Confident Scheme | Provide a structure for addressing HR / Recruitment issues around providing appropriate support to disabled staff and candidates | 1,2 | Culture | Abbi Eastland | Sep-19 | Review information available on recruitment pages to ensure candidates are informed where to go if further support is needed during the employement application process |
| | | | | Education | | | Increase knowledge with recruiting managers that if a candidate declares a disability, they meet the minimum criteria an interview is guaranteed |
| 1.4 | Review OH process | Promote declaration of health conditions and improve accessibility to OH services aswell as support and training for managers to manage and support individuals | 1, 6 | Culture Education | Jo Fanning | Sep-19 | Review OH documentation for new starters. Review guidance for managers supporting employees through management of bardford scores |
| 1.5 | Review Recruitment & Selection training | What is not acceptable to ask a disabled person at interview | 1 | Process | Sarah Read | Sep-19 | Review content of training materials to ensure appropriate content of disabilty considered |
| | | | | | Nikki Kriel Abbi Eastland | Sep-19 | Promote Access to Work guidance with line managers and ER Team. Promote and increase undertsanding of reasonable adjustments made to support individual attending interviews with line managers |
| 1.6 | Promote structures that provide support for disabled staff | Raise awareness of disability and how support should and could be offered | 1,5,6 | Culture Education | David Clayton-Evans | Oct-19 | Promote disability forum and host awareness stands |
| 1.7 | Review hate crime process | Ensure process enables reporting of disablity hate crime | 4a, 4b | Process | Nikki Kriel Delia Read | Sep-19 | Link in with Reducing Abusive Behaviuors project. Review data and yearly trends of numbers of staff reporting. Ensure Freedom to Speak up Guardian is promoted and signposted |
| 1.8 | Promote disabled people in the organisations commuincations / advertisment | Support and boost recruitment and retention of disabled staff | 1, 4a, 7 | Culture Education | Jonathan Keeble | Sep-19 | Trust Communication Lead for corporate images is Theo Cronin. In all promotional and team engagements events, we aim to ensure a greater diversity of our workforce are represented. Approach Disability forum for case studies and arrange promotional storyline through communications / headlines |

**Reference:**

Metric 1 centage of staff in AfC pay bands or medical and dental subgroups and very senior managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce.

Metric 2 Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts. This refers to both external and internal posts.

Metric 3 Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Metric 4a Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

- Patients / service users, their relatives or other members of the public
- Managers
- Other colleagues

Metric 4b Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

Metric 5 Percentage of Disabled staff compared to non-disabled staff belieiving that the Trust provides equal opportunities for career progression or promotion

Metric 6 Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Metric 7 Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Metric 8 Percentage of Disabled staff saying that tjier employer has made adequate adjustment(s) to enable them to carry out thier work

Metric a The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

Metric 9b Has your trust taken action to facilitate the voices of disabled staff in your organisation to be heard?

Metric 10 Percentage difference between the organisation's board votingh membership and its organisation's overall workforce, disaggregated:
(i) The organisation's Board voting membership and its overall workforce
(ii) The organisation's Board executive membership and its overall workforce

Western Sussex Hospitals
NHS Foundation Trust

| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 19 | **Meeting:** | Trust Board | **Meeting Date:** | 25/7/19 |
| **Report Title:** | Safeguarding Adults & Safeguarding Children's Annual Report Presentation | | | | |
| **Sponsoring Executive Director:** | Dr Maggie Davies, Chief Nurse | | | | |
| **Author(s):** | Annie Blackwell, Trust Senior Lead for Safeguarding Adults<br>Cathy Coppard, Trust Senior Lead for Safeguarding Children | | | | |
| **Report previously considered by and date:** | Safeguarding Strategy Committee | | | | |
| **Purpose of the report:** | | | | | |
| Information | | ✓ | Assurance | | ☐ |
| Review and Discussion | | ☐ | Approval / Agreement | | ✓ |
| **Reason for submission to Trust Board in Private only (where relevant):** | | | | | |
| Commercial confidentiality | | ☐ | Staff confidentiality | | ☐ |
| Patient confidentiality | | ☐ | Other exceptional circumstances | | ☐ |
| **Link to Trust Strategic Themes:** | | | | | |
| Patient Care | | ✓ | Sustainability | | ☐ |
| Our People | | ☐ | Quality | | ✓ |
| Systems and Partnerships | | ☐ | | | |
| **Any implications for:** | | | | | |
| Quality | | | | | |
| Financial | | | | | |
| Workforce | | | | | |
| **Link to CQC Domains:** | | | | | |
| Safe | | ☐ | Effective | | ☐ |
| Caring | | ☐ | Responsive | | ☐ |
| Well-led | | ✓ | Use of Resources | | ☐ |
| **Communication and Consultation:** | | | | | |
| | | | | | |

**Executive Summary:**

This presentation provides an overview of the Trusts activity within the Adults and Children's Safeguarding Teams, detailing the previous year's activity, key priorities, challenges and achievements.

**Key Recommendation(s):**

The Board are asked to **APPROVE** this report.

Western Sussex Hospitals NHS Foundation Trust

# Trust Board Annual Safeguarding Children & Adults Reports

Cathy Coppard, Named Nurse for Safeguarding Children

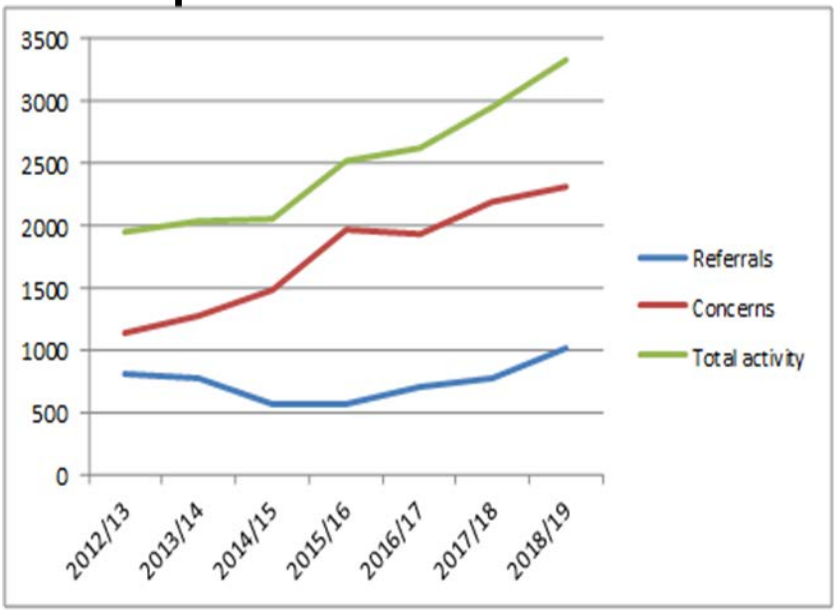
Annie Blackwell, Trust Senior Lead for Safeguarding Adults

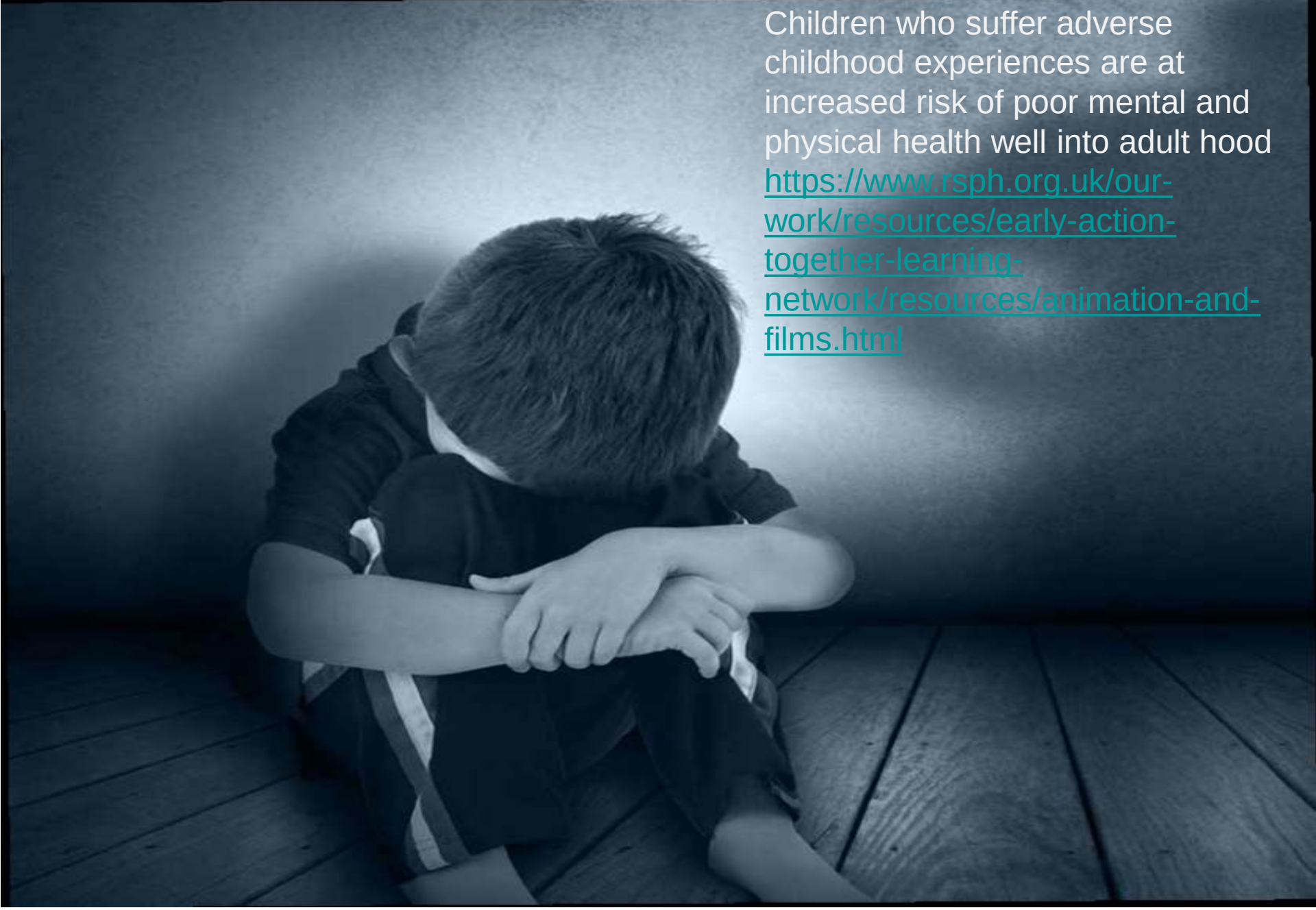
NHS
Western Sussex Hospitals
NHS Foundation Trust

# Children's Safeguarding Activity

- 28,303 children's A&E attendances reviewed
- 1010 social care referrals
- 2315 safeguarding concerns
- 6 MHA detainments
- 71% increase in safeguarding activity
- Total staff training 96%

- Partnership working
- Information sharing
- Serious case reviews
- Improvement work






# Adverse Childhood Experiences

# Children's safeguarding priorities

- Neglect
- ICON- coping with 'crying babies'; preventing abusive head trauma
- Quality of information sharing
- Domestic abuse support in hospitals
- Safeguarding Children training > 95% for all staff and levels

# The Safeguarding Adults Team

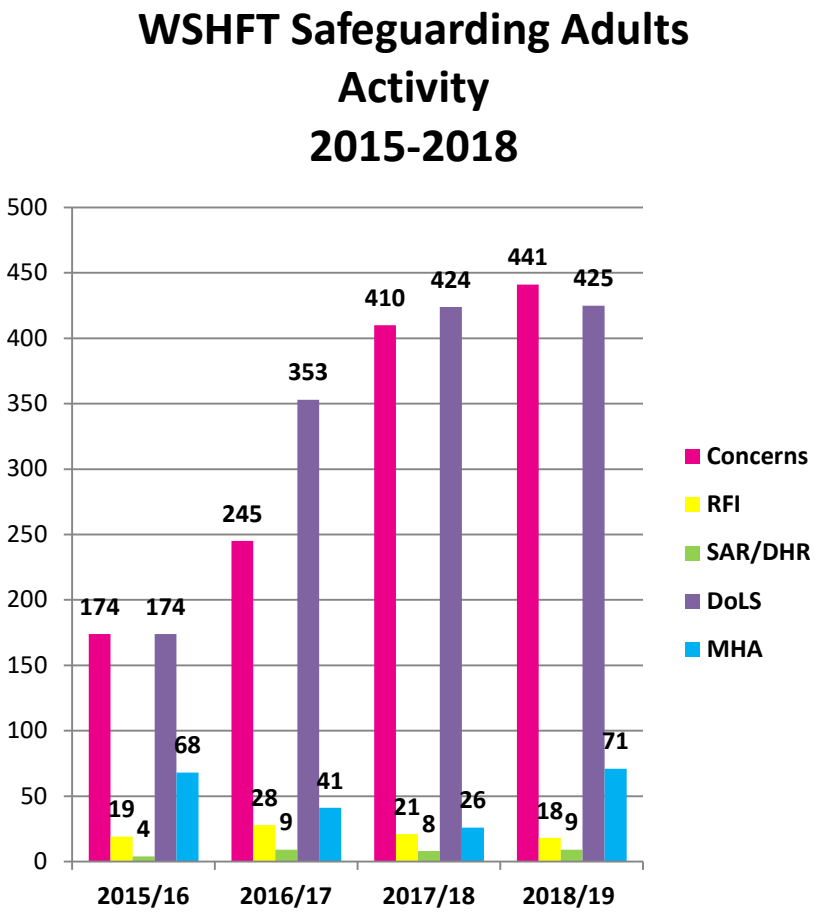
Annie Blackwell
Trust Senior Lead for Safeguarding Adults

Monique Devlin
Safeguarding Nurse Specialist

Marianna Wilmott,
Team Administrator

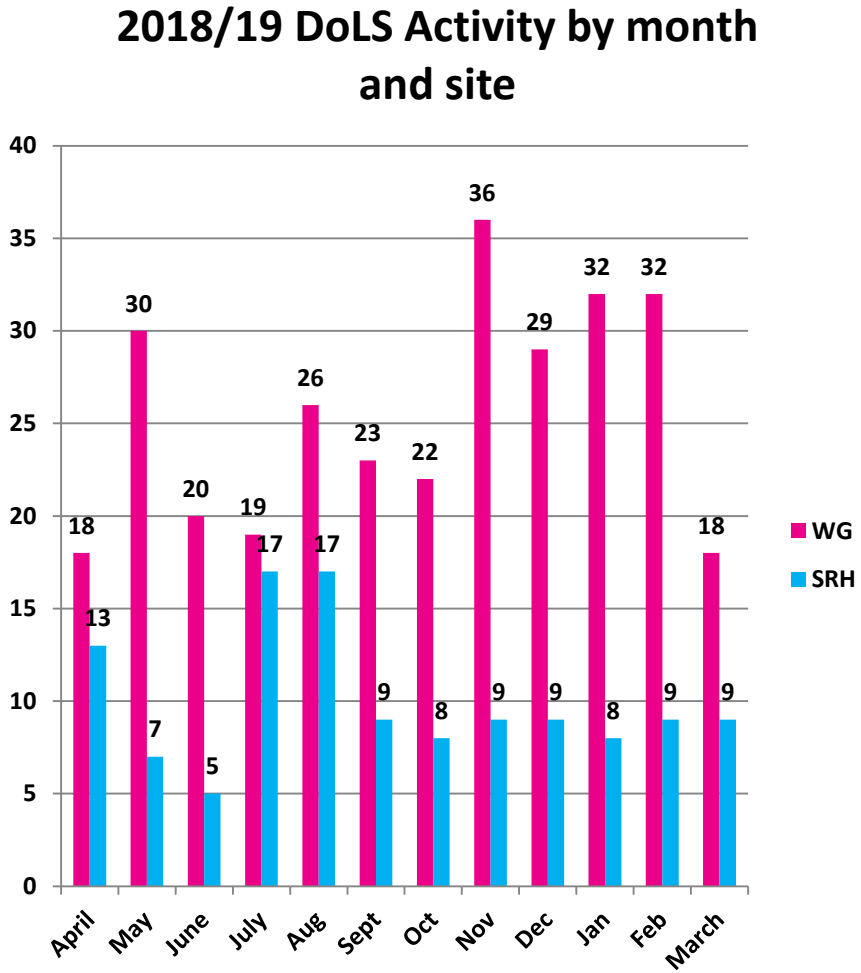
# Safeguarding Adults Activity

- **In 2018/19**
  - 441 Safeguarding Concerns raised
  - 18 Requests for Information (under Care Act)
  - 425 DoLS authorisation requests
  - 71 Detentions under the MHA



# Deprivation of Liberty Safeguards (DoLS) Activity

- **In 2018/19**
  - 425 requests compared with 424 for 2017/18
  - 5 patients (1%) were assessed by the DoLS Team from the local authority



# Challenges

- Small specialist team
- Rising demand and increasing activity
- Increasingly complex cases

# Achievements


- 2nd Multi-Agency Conference
- New ways of sharing learning from Safeguarding Adults Reviews
- Intercollegiate Document introduced new safeguarding training levels

# Priorities for 2019-20

- Development of a Safeguarding Adults Strategy
- Development of a safeguarding dashboard
- Audit quality of safeguarding referrals
- Re-audit Section 5(2) paperwork

# Thank You

Western Sussex Hospitals
NHS Foundation Trust

| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 19 | **Meeting:** | Trust Board | **Meeting Date:** | 25/7/19 |
| **Report Title:** | Safeguarding Adults Annual Report | | | | |
| **Sponsoring Executive Director:** | | | Dr Maggie Davies | | |
| **Author(s):** | | | Annie Blackwell | | |
| **Report previously considered by and date:** | | | Safeguarding Strategy Committee | | |
| **Purpose of the report:** | | | | | |
| Information | | | ✓ | Assurance | ☐ |
| Review and Discussion | | | ☐ | Approval / Agreement | ✓ |
| **Reason for submission to Trust Board in Private only (where relevant):** | | | | | |
| Commercial confidentiality | | | ☐ | Staff confidentiality | ☐ |
| Patient confidentiality | | | ☐ | Other exceptional circumstances | ☐ |
| **Link to Trust Strategic Themes:** | | | | | |
| Patient Care | | | ✓ | Sustainability | ☐ |
| Our People | | | ☐ | Quality | ✓ |
| Systems and Partnerships | | | ☐ | | |
| **Any implications for:** | | | | | |
| Quality | | | | | |
| Financial | | | | | |
| Workforce | | | | | |
| **Link to CQC Domains:** | | | | | |
| Safe | | | ☐ | Effective | ☐ |
| Caring | | | ☐ | Responsive | ☐ |
| Well-led | | | ✓ | Use of Resources | ☐ |
| **Communication and Consultation:** | | | | | |

**Executive Summary:**

Safeguarding adults is fundamental to the care delivered within the Trust, and continues to be "everyone's business".

The annual safeguarding adults report provides an update on safeguarding adults' activity within Western Sussex Hospitals Foundation Trust from 1st April 2018 - 31st March 2019 and compares this with the available activity data from the local authority.

This report defines the structures and processes of the safeguarding adults services within the Trust and how these relate to wider safeguarding arrangements.

The report will also include an update on training provision and on activity in relation to the Mental Capacity Act (Deprivation of Liberty Safeguards requests) and Mental Health Act detentions.

The report demonstrates an increase across all aspects of safeguarding, Deprivation of Liberty Safeguards and Mental health Act activity.

**Key Recommendation(s):**

The Board are asked to approve this report.

Western Sussex Hospitals
NHS Foundation Trust

# - Annual Report -
# Safeguarding Adults
# April 2019


Prepared By:

Annie Blackwell

Trust Senior Lead for Safeguarding Adults

# Table of Contents

# 1. Introduction and Executive Summary

Safeguarding adults is fundamental to the care delivered within the Trust, and continues to be "everyone's business".

The annual safeguarding adults report provides an update on safeguarding adults' activity within Western Sussex Hospitals Foundation Trust from 1st April 2018 - 31st March 2019 and compares this with the available activity data from the local authority.

This report defines the structures and processes of the safeguarding adults services within the Trust and how these relate to wider safeguarding arrangements.

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The Care Act 2014 delivered the legislation which governs safeguarding activity. Safeguarding duties apply to an adult aged 18 or over who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

# 2. Governance and Accountability Arrangements

### 2.1 The Safeguarding Adults Team at WSHFT

The safeguarding adults team consists of an executive lead and a small team.

| | |
|---|---|
| Maggie Davies | Executive Lead, Chief Nurse |
| Annie Blackwell | Trust Senior Lead for Safeguarding Adults (1.0 WTE) |
| Monique Devlin | Safeguarding Nurse Specialist (0.8 WTE) |
| Recruited | Mental Capacity Act Lead (0.9 WTE) |
| Marianna Wilmott | Team Administrator (0.44 WTE) |

From 1st April 2018, the Trust Senior Lead for Safeguarding Adults assumed line management responsibility for the Dementia Matron.

This year the safeguarding adults team have faced a number of staffing changes and challenges. The MCA Lead was on long term sick leave which left only one full-time member of staff in the team. In April an experienced member of the team retired and a new colleague joined, just as the MCA Lead returned from sick leave. In January the team were left shocked and stunned with the sudden death of Nikki Mardell the MCA Lead. Despite these difficulties, the team have risen to the challenges and have continued to meet the core needs of the service. However, the loss of a full time member of staff combined with increasing levels of activity has adversely affected the team's ability to deliver the level quality service we strive for.

### 2.2 Role & Responsibility of the West Sussex Safeguarding Adults Board (WSSAB)

The main objective of a Safeguarding Adults Board is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria set out in the Act.

The Care Act states that a Safeguarding Adults Board has three core duties:

- It must publish a strategic plan for each financial year that sets out how it will meet its main objective and what the members will do to achieve this. The plan must be developed with local community involvement, and the SAB must consult the local Healthwatch organisation. The plan should be evidence based and make use of all available evidence and intelligence from partners to form and develop its plan.

- It must publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any Safeguarding Adults Reviews and subsequent action.

- It must conduct any Safeguarding Adults Review in accordance with Section 44 of the Act.

In addition to the statutory requirements, the WSSAB has the following aims:

- The Board strives to make sure that the voices of adults with care and support needs, their families and their carers are heard
- The Board sets the strategic direction for safeguarding
- To have effective processes in place to prevent and respond to abuse and neglect
- To raise awareness of the importance of safeguarding through publicity campaigns

The WSSAB has a number of sub-groups. The safeguarding adults team attend the Learning and Development (formerly called the Training) sub-group and the Quality and Performance sub group.
The West Sussex Safeguarding Adults Board (WSSAB) receives assurance of each organisations performance through an assurance document.
Western Sussex Hospitals Foundation Trust is represented on this Board by Nursing Director, Dr Maggie Davies and Annie Blackwell, Trust Senior Lead for Safeguarding Adults.

### 2.3 NHS Professionals Forum

This forum has been in operation since 2007 in a variety of formats. Currently this is a meeting open to all safeguarding adults professionals within the NHS across Sussex.

Meetings are quarterly and are informal in nature, enabling safeguarding professionals to recommend practice changes or improvements to the Safeguarding Adults Boards, discuss cases, issues and share knowledge and experience.

Western Sussex Hospitals Foundation Trust is represented at these meetings by the Trust Senior Lead for Safeguarding Adults, Annie Blackwell.

### 2.4 The Adult Safeguarding Operational Group (WSHFT)

The Adult Safeguarding Operational Group meets quarterly.

The purpose of the group is as follows:

- To ensure that safeguarding adults procedures are in place across the Trust and they are adhered to.
- To act as a link between WSHFT and the West Sussex Safeguarding Adults Board and its sub-groups, and to disseminate information between these groups.
- To recommend to the Quality Board those policy changes that are required as the result of local or national developments.
- To recommend to the Quality Board those policy & practice changes that are required as a result of learning from safeguarding enquiries.
- To monitor the implementation of the Care Act 2014 within WSHFT.

Attendance at this meeting has been low; and so the format has been reviewed with the aim to focus more on learning from safeguarding cases.

### 2.5 Adults & Children's Safeguarding Strategy Committee

The Safeguarding Strategy Committee meets quarterly.

The purpose of the Committee is as follows:

- Ensure there are mechanisms in place to alert staff to safeguarding policies and procedures.
- Ensure relevant staff have appropriate training in relation to national safeguarding requirements for both adults and children (i.e. Intercollegiate Guidance 2014) and the clinical divisions are able to demonstrate compliance.
- Scrutiny of the training strategy in line with local and national learning opportunities available.
- To consider progression of annual report development.
- Ensure dissemination of information from local Safeguarding Children's Board and Safeguarding Adults Board.
- Review any new guidance and set the direction for safeguarding strategy.
- Identify, monitor and ratify guidelines and procedures, making recommendations on changes aligned to national best practice. These will then be deemed ready for ratification at the Quality and Risk Committee, and onward cascade into the organisation.
- To consider audit recommendations, taking forward any action points through relevant fora e.g. Patient Safety.

The Executive Lead is the Nursing Director Dr Maggie Davies and the Non-Executive Director was Joanna Crane. Both have attended the meetings, which are also attended by the Safeguarding Leads for Adults and Children and by the Adults and Children's safeguarding doctors. From March 2019, non-executive director representation at these meetings will end. The safeguarding leads have been advised that sufficient assurance has been received regarding the governance of the committee and the escalation of any outstanding concerns.

## 3. Review of the Year

### 3.1 Safeguarding Adults Board Developments (2017-18)

The Safeguarding Adults Board has recently published their annual report for the period 2017-18. This included the following local developments:

- The launch of safeguarding training standards in the private, voluntary and independent sectors
- Challenge events held across agencies to improve practice

- Benchmarking the West Sussex Safeguarding Adults Board against Safeguarding Adults Boards from other localities
- The development of a customer feedback form, development of new information leaflets and events to enhance engagement and share learning
- Review of referral routes for safeguarding concerns to ensure quality issues are separated from genuine safeguarding concerns, to enable timely responses across the partnership
- Increased raising of awareness of safeguarding issues via the media, training and roadshows throughout West Sussex.

### 3.2 CQC Regulation 13-Safeguarding Service Users from Abuse and Improper Treatment

The CQC regulations introduced the "Fundamental Standards of Care". As part of the Fundamental Standards the CQC introduced Regulation 13-Safeguarding Service Users from Abuse and Improper Treatment. The regulation sets out the clear requirements for providers to ensure the safety of their service users by ensuring adherence to the following:

- Systems and processes must be established and operated effectively to prevent abuse of service users.
- Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of any allegation or evidence of such abuse.
- Care or treatment of the service users is provided in the way set out in the regulation.
- A service user is not deprived of their liberty for the purpose of receiving care or treatment without lawful authority.
- Restraint of the service user is only undertaken in accordance with the requirements of the regulations.

The safeguarding adults team have continued to provide evidence to the Compliance Team on a regular basis to demonstrate our compliance with these regulations. The data supplied includes policies, as well as data on safeguarding cases, the number of DoLs authorisation requests and numbers approved and the number of people detained under the Mental Health Act.

### 3.3 West Sussex Safeguarding Adults Policy and Procedures

A review of the Sussex Safeguarding Adults Policy and Procedures was finally completed and the new, electronic policy and procedures were published in June 2018. For the first time, this is only available electronically, to facilitate regular updates. The Trust's safeguarding policy has been updated to reflect the changes to the Sussex Safeguarding Adults Policy and Procedures.

### 3.4 West Sussex County Council Safeguarding Activity

West Sussex County Council is the lead agency for safeguarding and has a duty to record all safeguarding activity on behalf of the multi-agency partnership and the West Sussex Safeguarding Adults Board. Concerns from agencies are usually raised using the online form and are screened by West Sussex Adult's Care Point and decisions are made regarding action required. The local authority extracts data from the West Sussex

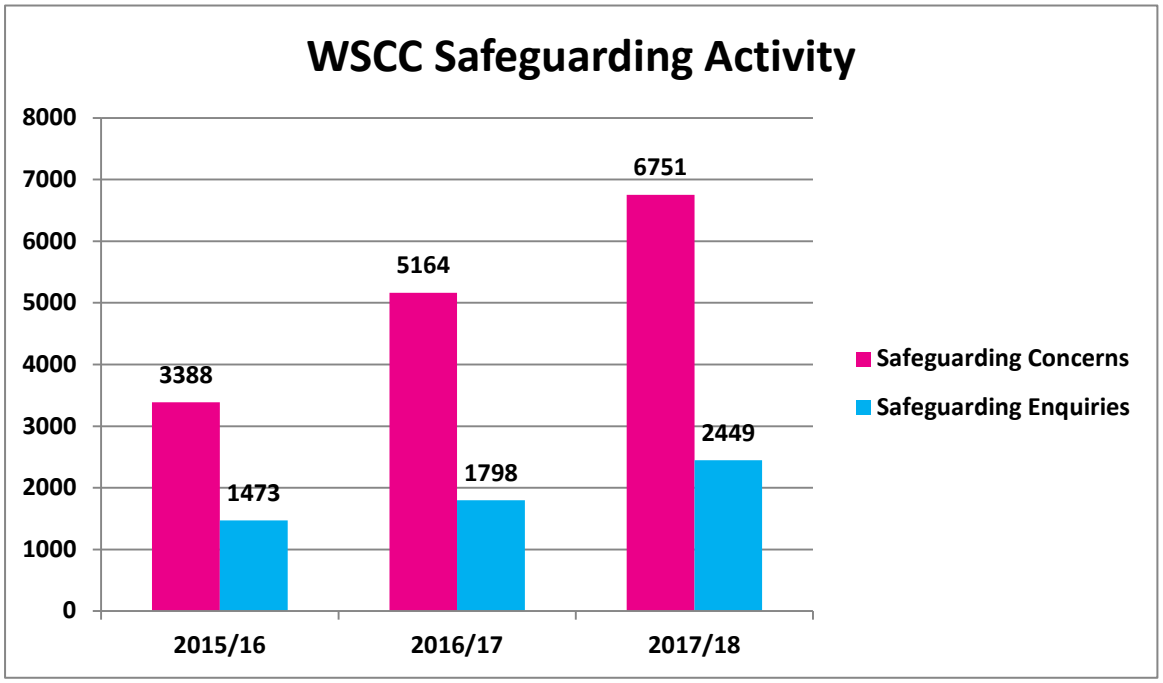
County Council's 'Mosaic' system and this is included in the Department of Health returns.

Previous years have seen the Department of Health making amendments to the way data is recorded and reported in West Sussex. This change, together with the additional categories of abuse introduced by the Care Act (self-neglect, modern slavery and domestic abuse) has meant that it has been difficult to make direct year on year comparisons.

The data given below is taken from the West Sussex Safeguarding Adults Board's Annual Report 2017-18, which is the most recent data available currently.
The Safeguarding Adult's Board annual report contains data on both the total number of safeguarding concerns and the number of concerns which become safeguarding enquiries (also known as Section 42 enquiries).

Table 1 illustrates the total number of safeguarding concerns received by West Sussex County Council, and the number of concerns which became safeguarding enquiries in the last three years.

**Table 1: Safeguarding activity within WSCC**




The WSSAB has also commissioned a number of Safeguarding Adults Reviews; details of these can be found in section 4.4 of this report.

## 4. Trust Safeguarding Adults Activity

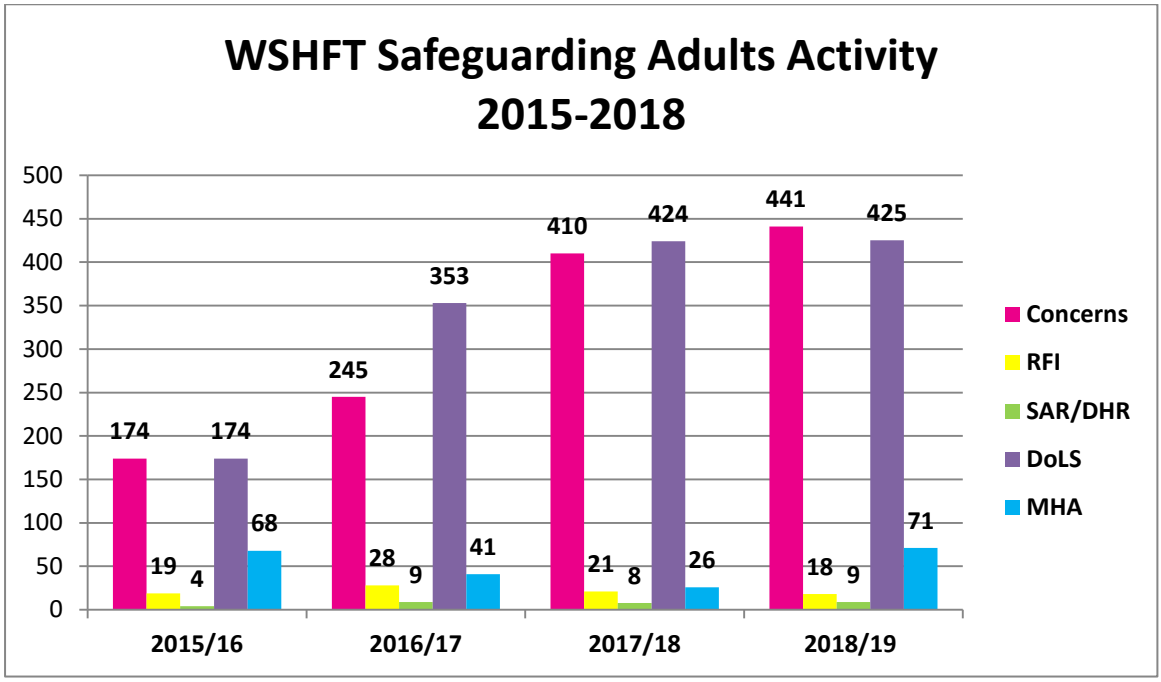
### 4.1 Trust Safeguarding Adults Team Activity

The Safeguarding Adults Team's activities include safeguarding casework, Safeguarding Adults Reviews (SARs), monitoring and logging all Deprivation of Liberty Safeguards (DoLs) and informing the Care Quality Commission (CQC) of the outcomes, as well as the recording of those patients detained to WSHFT under the Mental Health Act.

The current position in terms of reporting safeguarding concerns for women with children remains through Child Access Point, in the interest of "Think Family". However, should there be an adult concern, without a child interface, which could be the case in gynaecology or sexual health then it is likely that the referral would be made to adult social care via the usual referral process.

Table 2 details the WSHFT Safeguarding Adults Team's main areas of activity over the last four years. This includes data on all safeguarding concerns: external (community-based) concerns raised by Trust staff; concerns raised about Trust care, Safeguarding Adults Reviews (SARs) and "Requests for Information" (RFI) to inform external safeguarding enquiries. Under the Care Act, the Trust is required to respond to such requests for information to inform safeguarding enquiries. Data on the non-safeguarding aspects of the team's work (the number of Deprivation of Liberty Safeguards (DoLS) authorisation requests and data on Mental Health Act detentions to WSHFT) is also included.

**Table 2: Comparison of all Safeguarding activity within WSHFT 2015-2018.**




This table clearly demonstrates that year on year, activity has continued to increase.

Last year, the total activity across all aspects of safeguarding work has increased by 7%. This is on a background of lengthy staff shortages for most of the year. Activity will be continually reviewed to determine what activity is essential and what aspects are no longer able to be supported within current staffing levels.

### 4.2 Trust Safeguarding S42 Enquiries

In 2017/18, the total number of concerns raised during the year was 410; of these, only 72 (18%) were related to Trust care and of these, 66 (16% of total concerns) became Section 42 enquiries. In last year's annual report, it was predicted that the number of Section 42 enquiries relating to Trust care would increase. Despite the total number of safeguarding concerns raised during the year increasing, the total number of

safeguarding concerns that progressed to a full safeguarding enquiry actually remained the same.

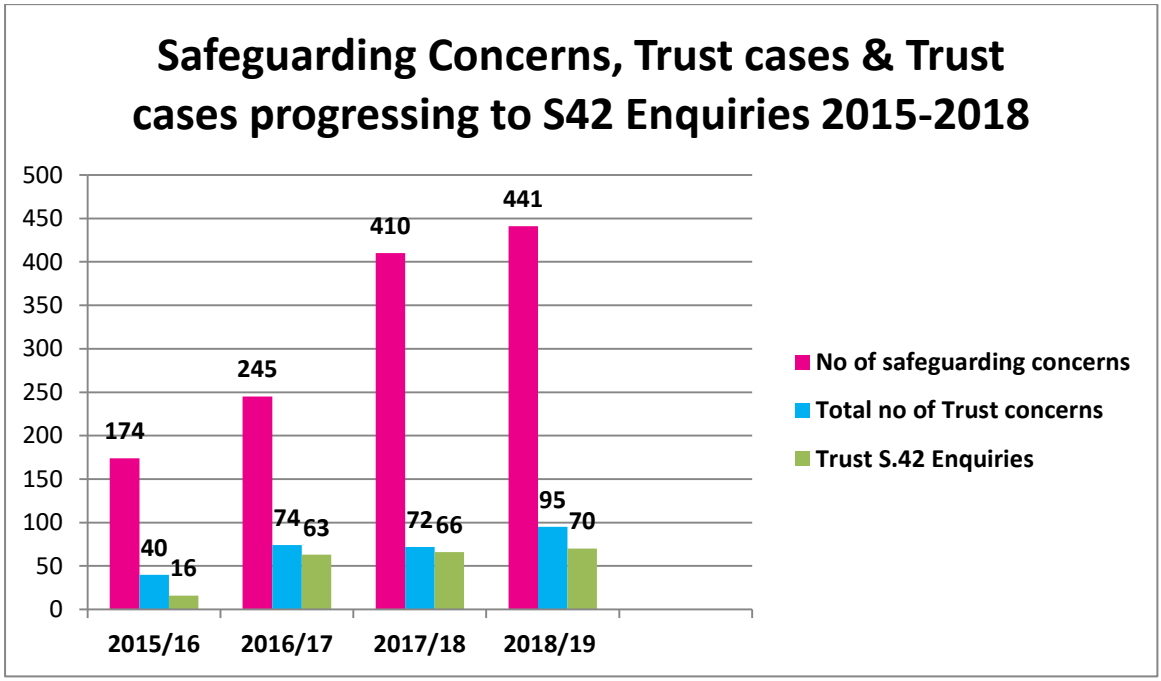
This year, the total number of concerns raised was 441. Of these, 95 were related to Trust care and 71 (16% of total concerns) became Section 42 enquiries. This figure is very similar to the data from the previous year. The remaining cases were either deemed for information gathering only and did not progress to full enquiries or were logged as quality.

During previous years, the safeguarding adults team had challenged some of the Section 42 enquiries, stating that they were not safeguarding issues, but issues related to quality, and so should be managed outside of the safeguarding process.

It is worth noting that the local authority has now reviewed the process by which the safeguarding concerns are managed, and those cases which relate to quality, are now removed from the safeguarding process.

Table 3 shows the data for the last 4 years on the number of safeguarding concerns received by WSHFT and includes both concerns about issues related to care in the community (external cases) and Trust care.

**Table 3: Trust safeguarding concerns progressing to S42 enquiries**

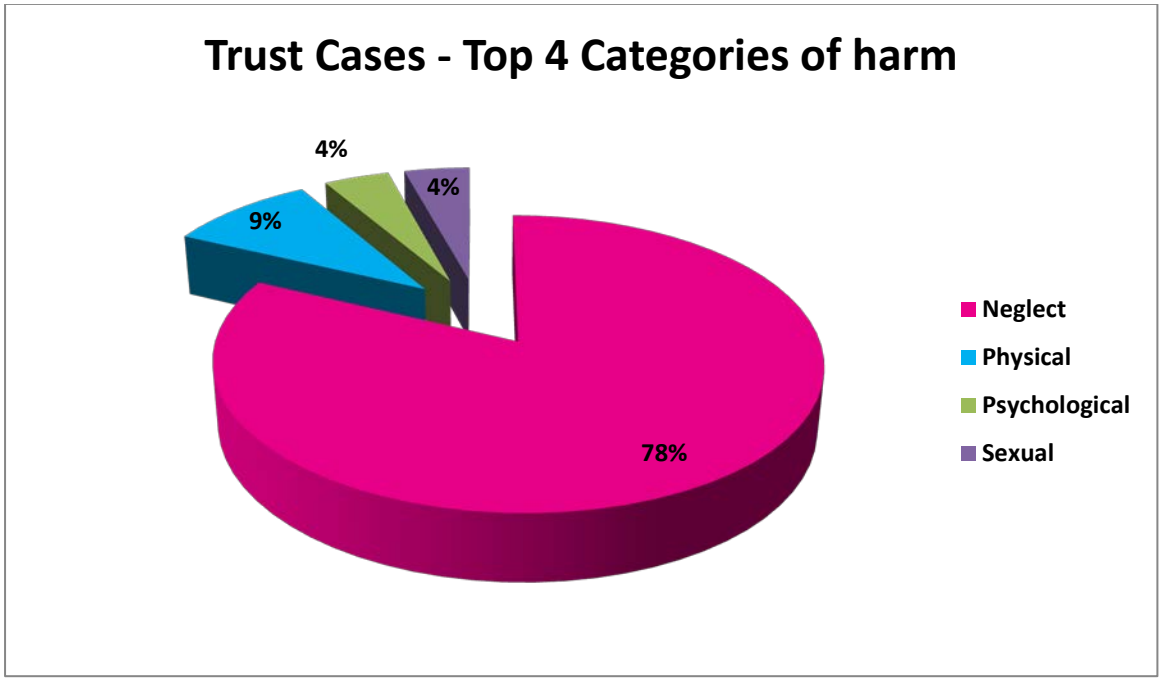



### 4.3 Types of harm in Trust cases

The Care Act cites 10 categories of abuse or harm, and trust concerns are logged as being one of these categories. Analysis of the detail for Trust safeguarding concerns indicates that the top two concerns were the same as last year: Neglect was the largest category, with Physical the second largest. Psychological harm and sexual abuse were in joint third place.

Chart 1 illustrates the Trust concerns by category type.

**Chart 1: Trust concerns by category of abuse:**




The "neglect" category covers a wide range of concerns, from pressure damage to poor discharges and issues with medication.

The physical cases include bruising noted after the patients were discharged, and two patient on patient assaults.

The psychological cases included staff interactions where staff were believed to have been speaking inappropriately to patients.

The sexual abuse cases included the actions of a patient's partner whilst visiting and the actions of a staff member whilst undertaking personal care which were reported as possibly inappropriate. The Police were informed but have taken no action.

### 4.4 Safeguarding Adults Reviews

The Safeguarding Adults Team received 9 requests in relation to Safeguarding Adults Reviews (SARs) and Domestic Homicide reviews. Of the six "Summary of Information" requests received, none became a full SAR; one became a learning review.

Two SARs from 2017-18, which the safeguarding adults team contributed to, were published this year.

Learning from future SARs will be shared with the Heads of Nursing via the monthly updates and then shared within the divisions.

### 4.5 Domestic Violence Referrals

The change in the delivery of domestic violence support within West Sussex continues to be a challenge, and there continues to be no domestic violence advisor on site.

Work has continued to develop a business case for a Harm Reduction Worker, who would work with those experiencing domestic abuse, but also frequent users of A&E services and the homeless, for example. However, to date, this case has not been successful. The

concerns in relation to a lack of access to specialist support on site have been added to the Risk Register this year.

The safeguarding adults team are unable to attend the MARAC (Multi-Agency Risk Assessment Conference) meetings, and have previously supported the work of MARAC by supplying related health information on specific individuals to the meetings in each area. However, with the loss of a team member in January, there has been no capacity to be able to continue with this.

### 4.6 Prevent Agenda

Prevent is the government's anti-radicalisation strategy, and Prevent continues to sit within safeguarding. Although WSHFT is deemed to be a low risk area, in the last year we have been required to submit data on Prevent referrals and training to NHS England.

There remains a requirement for Prevent Level 3 training (previously referred to as WRAP -Workshop Raising Awareness of Prevent) to be completed by specific staff groups, with the data being reported to NHS England on a quarterly basis.

This year, the Level 3 training has been available online as e-learning, and this has been encouraged as WSHFT does not have an accredited WRAP trainer. There have been no Prevent referrals this year.

## 5. Safeguarding Adults Training

This year has seen a significant change in safeguarding adults training requirements. In August the intercollegiate document on Adult Safeguarding: Roles and Competencies for Health Care Staff was published. This sets out 5 levels of safeguarding training; the required level is determined by the job role.

All WSHFT job roles and safeguarding adults training requirements have been reviewed and the new levels identified. Work continues to ensure that the workforce reports accurately reflect the training level required for each staff member. The intercollegiate document confirms that the expectation is that all staff will have met their required training level by 2021. The last year has seen the E-learning for Health safeguarding adults modules available to staff via ESR for the first time.

The staffing issues in the safeguarding adults team has meant that delivering face to face training more than twice a week has not been possible and this is reflected in the training figures, which are down on last year's figures. However, a booklet has been developed for Level 1, safeguarding training e-learning is now available for levels 1 and 2, and staff have been encouraged to make use of this resource. Following the appointment of a part-time Bank staff member, face to face training was re-launched in March 2019. The expectation is that the training figures will increase as more staff complete the e-learning.

The challenge around the safeguarding team having the capacity to deliver an increased number of training sessions continues. In the coming year, the safeguarding leads for adults and children will be preparing a business case for a safeguarding trainer/practitioner to assist with meeting the training delivery requirements.

## 6. Mental Capacity Act Activity

As was seen in Table 2, there has been a steady increase in the number of Deprivation of Liberty Safeguards (DoLs) authorisation requests being made over the last 4 years. The number of referrals made this year was the same as last year.

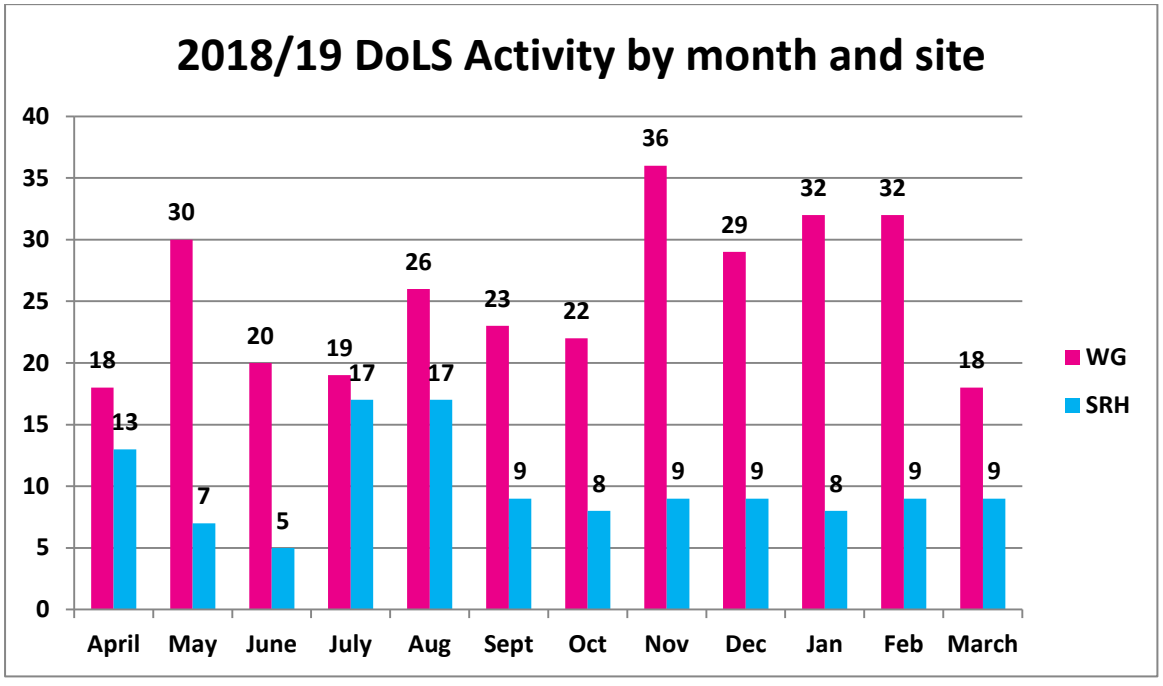
The actual number of patients being assessed by the DoLS team to determine whether the detention is lawful and the least restrictive remains low. Of the 425 authorisation requests, only 5 patients (1%) were seen and assessed by the WSCC team and 3 standard authorisations were granted. This is due to the large number of DoLS authorisation requests being received by the DoLs team from across the county. The DoLS team have reviewed their processes but acute hospitals are not seen as a priority area.

The low rate of assessments by the DoLS Team has been raised at the NHS Safeguarding Professionals meeting as an area of risk and is also on the Trust's Risk Register.

In order to mitigate the risk of patients being detained unlawfully, the MCA Lead has developed a "Weekly DoLS Review" sticker. This is a coloured sticker which documents whether the patient still lacks capacity to consent to care and treatment, whether the patient is still being treated in their best interests and in the least restrictive way and whether the DoLS team have been updated. The stickers are used as evidence that the need for a DoLS has been reviewed, even though the DoLS team have not been out to assess.

Table 4 illustrates the DoLS referrals by month and site.

**Table 4: WSHFT DoLS Referrals**




Prior to the death of the MCA lead, work had continued to deliver training on undertaking capacity assessments to enable staff to feel more confident in doing so.

The MCA Lead also completed two audits in August 2018; one was a Mental Capacity Audit of DoLS requests and the other examined the number of IMCA (Independent Mental Capacity Advocate) referrals.

The MCA audit examined Patients flagged on Sema with a diagnosis of dementia, delirium or a learning disability. It would be expected that in this cohort of patients the consideration and documentation of issues of mental capacity, including appropriate assessments and referrals, would be recorded in the patient notes.

Capacity to consent to be in hospital for care and treatment was documented for none of the patients admitted to Worthing Hospital or St Richard's Hospital.
Nineteen patients with a low MMSE (or similar) were identified in the audit, none had a capacity assessment undertaken. This audit clearly demonstrates that further work is required to ensure accurate assessment and documentation of capacity in relation to consent to care and treatment.
Further capacity audits continue and are being undertaken by the medical staff.

The second audit examined how many patients with a diagnosis of dementia or delirium were unbefriended. This means that if they were then deemed to lack capacity and a decision was needed regarding their treatment, there was nobody with whom it was appropriate to consult. In such cases, if the treatment is deemed "serious medical treatment" then a referral to an IMCA is required.
The results from the IMCA audit indicated that of the patients admitted to St Richard's Hospital 46 (98%) had documented involvement of family or friends, in comparison this was 47 (90%) for those patients admitted to Worthing Hospital.

### 6.1 The future of DoLS

The Law Commission has reviewed the Deprivation of Liberty Safeguards and in March 2017, it produced their proposal on a replacement for the Deprivation of Liberty Safeguards (DoLS), and suggested amendments to the Mental Capacity Act itself. The changes to the act are to incorporate the new scheme, called the Liberty Protection Safeguards (LiPS), and to strengthen people's rights in areas such as best interest decisions.
The proposed scheme would result in "the responsible body" (i.e. WSHFT) would conduct a capacity assessment, a medical assessment and an assessment of whether the planned care arrangements are "necessary and proportionate".

If implemented, this change would have a significant impact on processes, frontline staff and the safeguarding team. Currently there is a concern that the Trust would not have sufficient suitably trained staff that would be able to undertake the relevant assessments.

A final decision in relation to the future of DoLs is still awaited.

## 7. Mental Health Activity

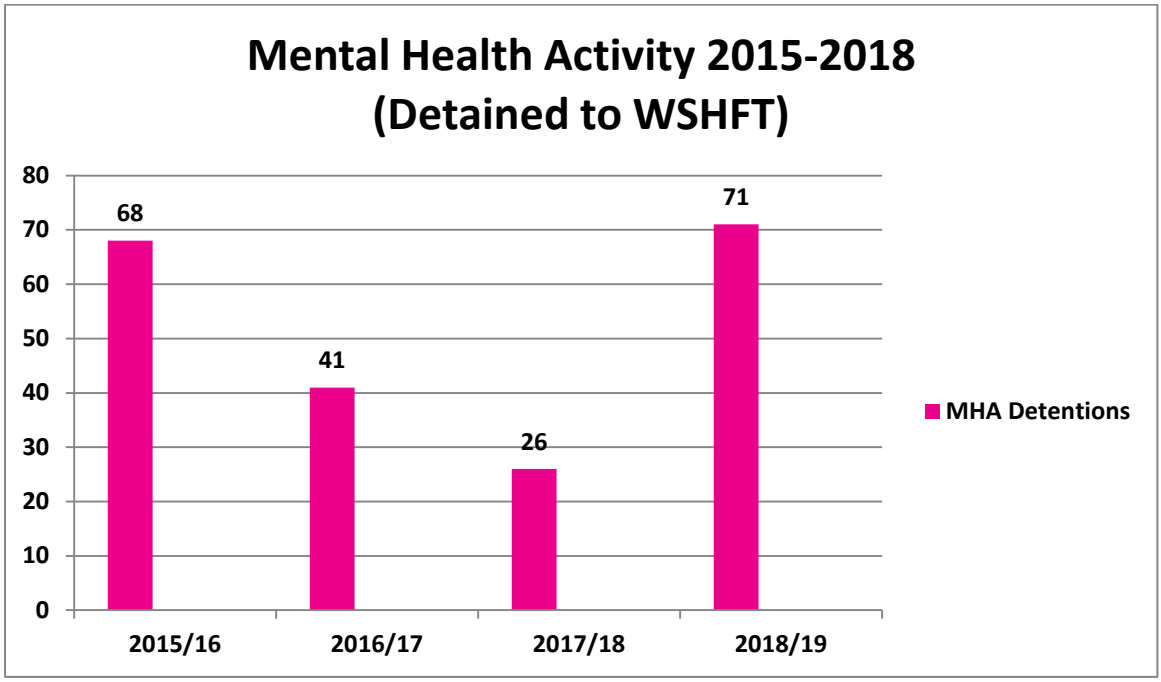
WSHFT has a contract with Sussex Partnership Foundation Trust for the administration of the Mental Health Act (MHA) process. This includes the management of the legal papers associated with those patients detained to the Trust under the MHA, as well as admin support when patients appeal to a Tribunal against their detention. In addition, the contract includes the delivery of training to staff on the mental health act.

Work has continued this year to improve the process by which detentions are reported and to facilitate the correct completion of the section papers. The guidance and flowcharts on the MHA process has been updated and the Mental Health Act folders, which are held in certain wards/departments been reviewed and updated, with new

reference files being produced for the children's wards, due to the continued increase in under 18's being detained to the Trust under a section.

Table 5 shows the increase in the number of patients detained to WSHFT under the MHA between 2015-2018.

**Table 5: MHA Activity**




### 7.1 MHA Section 5(2) Audit

In the autumn of 2018, an audit of compliance with the Section 5(2) policy was undertaken by three Foundation Year 1 doctors employed by SPFT.

The results of this audit showed that, for the most part, the section 5(2) forms were completed correctly for each patient. With regards to documentation in the notes, it was clear with all patients the reason for the section 5(2) ending. There were some gaps in relation to documentation and awareness of roles and responsibilities and this highlights the potential need for more training required.

## 8. Learning Disability Activity

The Learning Disability Peer Reviews took place in November 2018. This was the sixth year that the Peer Review had been undertaken.

The feedback from the reviewers was in the main very positive. The review report recognised that each year Trust staff have worked hard to achieve the goals set in the action plans from the previous years. The review identified that there have been improvements in the support that people with learning disabilities are receiving and staff generally want to provide a good service.

The findings are summarised below:

Positive Findings:

- A wide range of tools are available to support patients with a learning disability (e.g. This is Me: My Care Passport, hospital communication book, pictorial menus)
- Awareness of the LD Nurse and those that had used the LD nurse had found the service useful
- Quiet spaces available in some areas for families/carers to use
- Improved signage at Worthing Hospital
- Awareness of the Mental Capacity Act, but some staff still reported lacking confidence in undertaking assessments of capacity
- Good admission and discharge processes
- Patients with a learning disability were found to be being treated with dignity and respect

Areas for improvement:

- Although many resources have been provided over the years, the use of these resources and access to these resources remains a challenge
- Some resources could not be located, and may have been borrowed and not returned.
- Some wards/departments were unable to locate the poster advertising the details of the LD Nurse service
- An adult changing area is still not available on any of the Trust sites
- Lack of knowledge around the use of LD magnets
- Many staff were unaware of the LD Action Plan-it was felt that this was something which more senior staff would be aware of
- Obtaining patient feedback using the “Kinda Magic” tool could be improved

The report recognised the large workforce, with many staff working shifts, and an increasing workload made the challenge of ensuring the information on LD resources was appropriately cascaded. The report recommended that the Trust look at ways of ensuring the resources the Trust does have to support patients with learning disabilities are used effectively.

### 8.1 Learning Disability Meetings

The Learning Disability Improvement Standards have been reviewed by the Matron for Safer Care, and this work will guide developments over the coming year.

The purpose and function of Learning Disability Steering Group meetings has been reviewed. It is proposed that from April 2019, a new LD Strategy Group be created, to deliver the LD Strategy as follows:

- To monitor the implementation of the Learning Disability Improvement Standards from NHSI.
- To monitor the action plan developed following the Learning Disability Peer Reviews.
- To receive updates and recommendations from the Learning Disability reviews undertaken as part of the LeDeR programme.
- To recommend areas for service development to the Safeguarding Strategy Committee by exception reporting.
- To plan and monitor actions to deliver LD relevant areas of the NICE guidelines for mental capacity (NG108).

A separate meeting involving the service users and professionals will also continue to be held. This will be more operational in nature.

### 8.2 Learning Disability Reviews (LeDeR)

The Trust is actively supporting the nation-wide LeDeR review programme. Although WSHFT does not have any LeDeR reviewers, trust staff have provided assistance to external reviewers in their review of cases. Under this programme, the death of anyone with a learning disability is referred for a possible review. The reviews can be very time consuming and there is a challenge for staff to find the time to assist with the reviews, in addition to their usual job role. Although a number of notifications to the LeDeR programme have been made, to date the Trust has not received a completed final report on any cases. This concern has been escalated with the CCG.

## 9. Review of this year's priorities

The priorities set for this year were as follows:

**PRIORITY 1:** To hold the second multi-agency safeguarding conference in May 2018

**Outcome:**

- This event was held in May 2018 and was attended by over 100 staff from across the health economy
- The topics included the role of the Coroner's Office in safeguarding issues, a barrister on capacity issues, the role of the Fire & Rescue Service in safeguarding work and an Independent Mental Capacity Advocate and the role IMCAs play in supporting people who lack capacity.
- The event also included an opportunity to visit the "Gift Box" and learn more about modern slavery

**PRIORITY 2:** To review and improve the mechanism of monitoring the learning from Safeguarding Adults Reviews

**Outcome:**

- There were no full Safeguarding Adults Reviews undertaken in 2018, which involved the safeguarding adults team
- In the future, briefing on learning from SARs will be included in the monthly safeguarding update sent to the Heads of Nursing
- The use of the Safety and Learning newsletter to share this learning is also being explored

**PRIORITY 3:** To launch the new Level 3 safeguarding adults training

**Outcome:**

- Level 3 training was developed and was due to be rolled out during safeguarding month in November
- The planned training was to include guest speakers including the Police and IMCA, however, due to very low numbers, the training was cancelled
- Further dates are planned from April-May 2019

**PRIORITY 4:** To continue to work with the medical teams to increase awareness of the mental capacity act

**Outcome:**

- Work with medical colleagues remains ongoing
- NICE guidance on capacity has been reviewed and an assessment of the Trust's compliance with the recommendations has been made

## 10. Conclusions and priorities for 2019-20

### Conclusions

The past year has been a challenging one for the Safeguarding Adults Team, due to staff numbers being significantly reduced for a period of months.

The year has seen an increase in reporting, both of safeguarding concerns and requests for DoLS authorisations, which is evidence of increased awareness of the issues. This is despite a reduction in training numbers.

The focus in the coming year will be on the quality of the safeguarding concern referrals and the DoLS requests. Although improvements have been noted, a formal audit on the quality of these documents will guide the development of future training programmes.

The ability to respond to the increase in safeguarding activity has been a challenge this year to the staffing issues previously stated. Recruitment for a replacement Mental Capacity Lead is underway. Once the team is up to full establishment, it is anticipated that planned projects can begin.

Throughout the very difficult past few months, the Safeguarding Adults Team has continued to meet any new challenges as they are presented, and strive to actively embed safeguarding practice throughout the whole Trust.

### Priorities for 2019-20

The priorities for the Safeguarding Adults team for the coming year are:

**PRIORITY 1:** To develop a safeguarding adults strategy, in line with the Safeguarding Adults Board Strategy

**PRIORITY 2:** To develop a safeguarding dashboard in line with the dashboards produced by the Safeguarding Adults Board

**PRIORITY 3:** To undertake an audit of quality of the safeguarding adults concern forms and the DoLS authorisation request forms

**PRIORITY 4:** To repeat the audit of the Section 5(2) documentation and detention process

**PRIORITY 5:** To undertake an audit of the completion of Section 132 reading of rights documentation

## 11. Appendix A-Link to West Sussex Safeguarding Board Annual Report 2017-18

**http://www.westsussexsab.org.uk/wp-content/uploads/2019/02/SAB-Annual-Report-2017-18.pdf**

Western Sussex Hospitals
NHS Foundation Trust

| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 19 | **Meeting:** | WSHFT Board Agenda Public | **Meeting Date:** | 25.07.2019 |
| **Report Title:** | Children's Annual; Safeguarding Report | | | | |
| **Sponsoring Executive Director:** | Maggie Davies | | | | |
| **Author(s):** | Catherine Coppard | | | | |
| **Report previously considered by and date:** | Safeguarding Strategy Committee 25.06.2019 | | | | |
| **Purpose of the report:** | | | | | |
| Information | ✓ | | Assurance | ✓ | |
| Review and Discussion | ☐ | | Approval / Agreement | ☐ | |
| **Reason for submission to Trust Board in Private only (where relevant):** | | | | | |
| Commercial confidentiality | ☐ | | Staff confidentiality | ☐ | |
| Patient confidentiality | ☐ | | Other exceptional circumstances | ☐ | |
| **Link to Trust Strategic Themes:** | | | | | |
| Patient Care | ✓ | | Sustainability | ✓ | |
| Our People | ✓ | | Quality | ✓ | |
| Systems and Partnerships | ✓ | | | | |
| **Any implications for:** | | | | | |
| Quality | 1. Negative Patient experience.<br>2. Loss of public confidence in the Trust.<br>3. In compliance with **The Children Act 2004 (section 11)** WSHFT has statutory responsibilities to co-ordinate and ensure the effectiveness of what is done for the purposes of safeguarding and promoting the welfare of children. It remains the responsibility of organisations to develop and maintain quality standards and assurance, to ensure appropriate systems and processes are in place and to embed a safeguarding culture within the organisation. | | | | |
| Financial | 1. Subsequent patient litigation claims may occur<br>2. Loss of Commissioner Confidence may result in loss of Trust business | | | | |
| Workforce | 1. Professional performance management issues for individuals<br>2. Learning and development requirements<br>3. Organisational behavioural and cultural issues | | | | |
| **Link to CQC Domains:** | | | | | |
| Safe | ✓ | | Effective | ✓ | |
| Caring | ✓ | | Responsive | ✓ | |
| Well-led | ✓ | | Use of Resources | ✓ | |
| **Communication and Consultation:** | | | | | |
| Shared with the WSHFT Safeguarding Strategy Committee and with the will be shared with the CCG and WSSCP | | | | | |

**Executive Summary:**

- The Trust bi-annual Section 11 (Children Act 2004) audit, completed in 2018 demonstrates a safe service whilst acknowledging and addressing the challenges relating to safeguarding children. The subsequent improvement plan has also been completed. (Appendix 1)

- Activity for this year is almost 50% higher on the Worthing site compared to the St Richards site and referrals to children's social care have increased by 24%. Overall, since 2012 there has been a 71% increase in overall safeguarding activity.

- There are significant local and national challenges which need to be considered for safeguarding children.

- Serious case review (SCR) activity has increased; WSHFT are currently involved with two

serious care reviews; SCR V and SCR W. There are however a number of historical serious case reviews in West Sussex which WSHFT have ongoing involvement with Table

- There is a significant volume of information sharing involved when safeguarding children. The safeguarding team continue to focus on improving the process and quality of information sharing and supporting and encouraging practitioners to use their professional curiosity.

- The child protection policy was updated in June 2019 to include changes in legislation.

- The overall training figures remain above the WSHFT target of 95% however there are pockets and for those particular groups who fall under the target, in particular medical staff; they are being directed to the e-learning for health training modules and an improved recording process is being developed with the support of Learning and development.

- Adverse Childhood Experiences (ACE's) and caring for 'crying babies' have been the key training themes delivered, during the year.

- Arrangements for Liberty Protection Safeguards being introduced from 2020 will need to be considered for children aged 16 years

- Children presenting to hospital with self-harm and suicidal ideation and detainments under the Mental Health Act children have all increased.

- Safeguarding arrangements for the unborn baby have been strengthened. Maternity safeguarding team at Worthing have increased their establishment (0.4 wte). West Sussex Children's Social Care, have introduced two new; pre-assessment social worker posts.

- This report also identifies improvement work and the wider challenges faced within the system.

**Key Recommendation(s):**

The child safeguarding priorities for Western Sussex Hospitals NHS Foundation Trust for the following year are shown as follows;

1. Neglect- recognition and response
2. Implementing the abusive head trauma prevention programme; ICON- caring for 'crying babies'.
3. Safeguarding children training compliance for all staff to be greater than 95%
4. Improving the quality and processes for Information sharing across the system;

4.1 Safeguarding notifications on the patient administrative system (Sema helix) need to include MARAC (multi agency risk assessment conference) domestic abuse alerts. .

4.2 An Integrated solution for linking the patient administrative system (Sema helix) with CP-IS at WSHFT.

4.3 Processes for information sharing with healthy child programme

4.4 Quality of referrals

5. Implement, once agreed, the newly commissioned child death and child protection medical arrangements.
6. Improving the quality of medical photography
7. Domestic abuse support within WSHFT
8. Audit

Western Sussex Hospitals NHS
NHS Foundation Trust

# Annual Report
# Safeguarding Children
# June 2019


Prepared by:

Catherine Coppard

Named Nurse for Safeguarding Children

## Table of Contents

# 1. INTRODUCTION AND EXECUTIVE SUMMARY

*The welfare of children is paramount'* as defined by The Children Act 1989 and 2004 and guided by the following principles, safeguarding children should be;

- a child centred approach
- a coordinated approach; safeguarding children is everyone's responsibility;
- early help is beneficial and it is better to offer early help to children and families as early as possible, before issues escalate and become more damaging
- effective information sharing between practitioners and local organisations and agencies enables the safeguarding of children

(Working Together 2018)

This report defines the structures and processes for safeguarding children and how these relate to wider safeguarding children arrangements within the Trust. The report also reviews WSHFT children's safeguarding activity and improvement plans and outlines relevant safeguarding children guidance and policy.

As required by Section 11 of The Children Act 2004, WSHFT addresses the statutory duty to promote a culture where safeguarding is everyone's business and poor practice is identified and tackled by having effective safeguarding arrangements in place to safeguard vulnerable children. These arrangements include:

- Senior management commitment to safeguarding children
- Identification of a Named Doctor, Named Nurse & Named midwife for Safeguarding Children.
- Sound governance & accountability
- Safe recruitment,
- Effective training for staff & learning from serious case reviews and research,
- Supervision arrangements,
- Listening to the '*voice of the children'* when considering developments
- Working in partnership with other agencies

The Department for Education (DfE) is responsible for child protection and sets out policy, legislation and statutory guidance on how the children's safeguarding system should work.

It is also important to be aware of the role of external regulators such as CQC and JTAI (Joint Targeted area inspections) in monitoring safeguarding systems within organisations. WSHFT safeguarding team, continue to lead and support the trust in the continuous improvement of children's safeguarding. Quarterly reports are provided to the safeguarding strategic committee, W&C Division, CCG and West Sussex Safeguarding Children Board Partnership (WSSCP), formerly known as West Sussex Safeguarding Children's Board (WSSCB).

### Key messages for the Board:

This report demonstrates that:

- The Trust bi-annual Section 11 (Children Act 2004) audit, completed in 2018

demonstrates a safe service whilst acknowledging and addressing the challenges relating to safeguarding children. The subsequent improvement plan has also been completed. (Appendix 1)

- Activity for this year is almost 50% higher on the Worthing site compared to the St Richards site. Referrals to children's social care have increased by 24%. Overall, since 2012 there has been an increase of 71%.

- There are significant local and national challenges which need to be considered for safeguarding children.

- Serious case review (SCR) activity has increased; WSHFT are currently involved with two serious care reviews; SCR V and SCR W. There are however a number of historical serious case reviews in West Sussex which WSHFT have ongoing involvement with Table

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- The child protection policy was updated in June 2019 to include changes in legislation.

- The overall training figures remain above the WSHFT target of 95% however there are pockets and for those particular groups who fall under the target, in particular medical staff; they are being directed to the e-learning for health training modules and an improved recording process is being developed with the support of Learning and development.

- Adverse Childhood Experiences (ACE's) and caring for 'crying babies' have been the key training themes delivered, during the year.

- Arrangements for Liberty Protection Safeguards being introduced from 2020 will need to be considered for children aged 16 years

- Children presenting to hospital with self harm and suicidal ideation and detainments under the Mental Health Act children have all increased.

- Safeguarding arrangements for the unborn baby have been strengthened. Maternity safeguarding team at Worthing have increased their establishment (0.4 wte). West Sussex Children's Social Care, have introduced two new; pre-assessment social worker posts.

- This report also identifies improvement work and the wider challenges faced within the system.

# 2. GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

In compliance with The Children Act 2004 (section 11) WSHFT has statutory responsibilities to co-ordinate and ensure the effectiveness of what is done for the purposes of safeguarding and promoting the welfare of children. It remains the responsibility of organisations to develop and maintain quality standards and assurance, to ensure appropriate systems and processes are in place and to embed a safeguarding culture within the organisation through mechanisms such as safe recruitment processes including use of vetting and barring, staff induction, effective training and education, patient experience and feedback, critical incident analysis, risk assessments and risk registers, cyclical and other reviews and audits, annual staff appraisal and revalidation of professional staff. It is also important to be aware of the role of external regulators such as CQC in monitoring safeguarding systems within organisations. WSHFT safeguarding team continue to lead and support the trust in the continuous improvement of children's safeguarding processes; training, guidelines, information sharing, auditing and performance. Quarterly reports are provided to the safeguarding strategic committee, W&C Division, CCG and WSSCB. The updated section 11 audit which outlines WSHFT compliance to our statutory obligations is included in appendix 1.

## 2.1 **WSHFT Safeguarding Children Team**

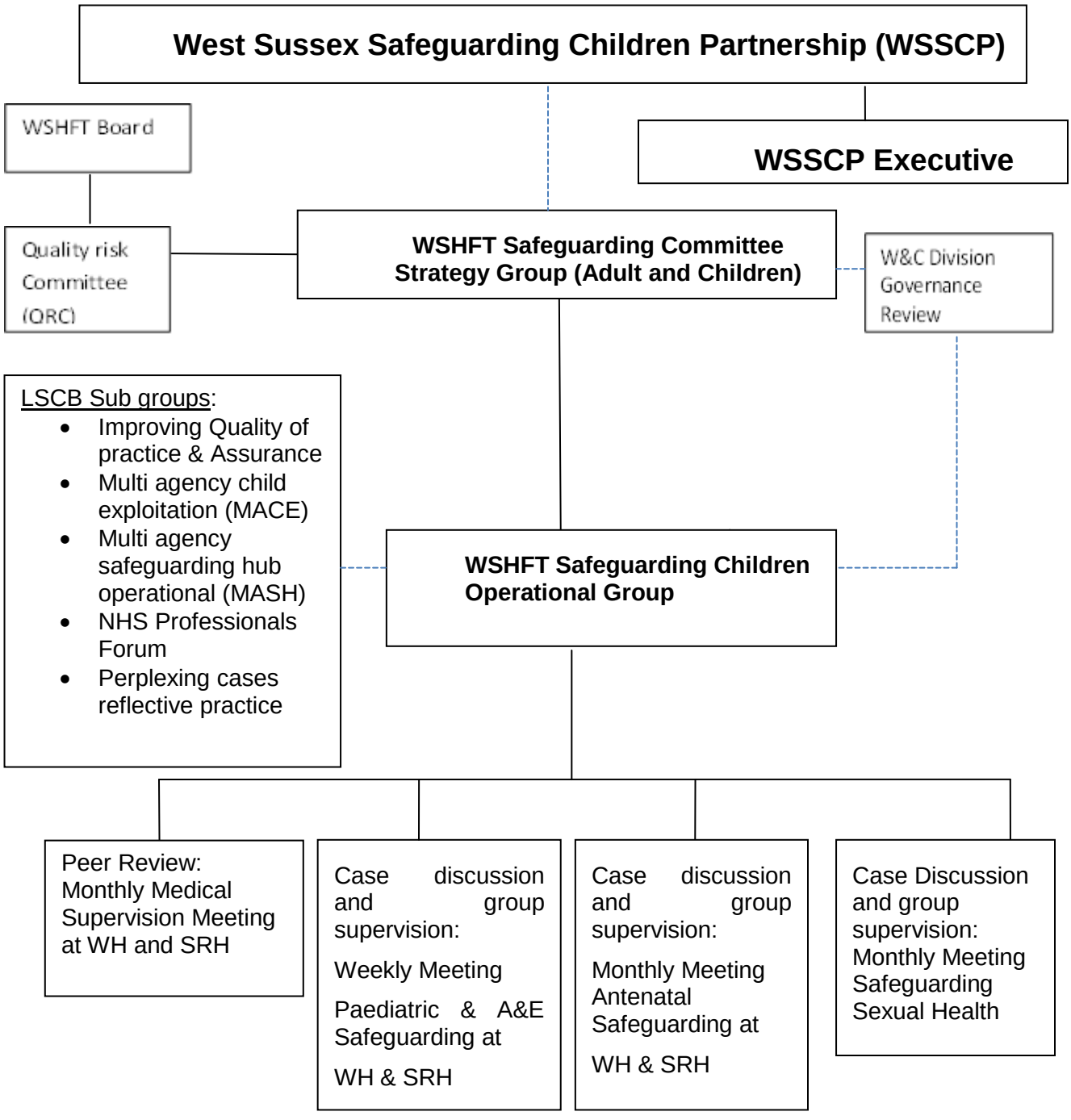
The Children's Act 2004 placed 'a requirement on each acute trust to appoint named professionals to take the professional lead for safeguarding children within the Trust and to advise all staff employed by the Trust on awareness and processes related to child protection and safeguarding children.'

| | |
|---|---|
| Nicola Ranger/Maggie Davies | Chief Nurse & Executive Lead and (*Prevent Lead*) |
| Catherine Coppard | Lead Nurse & Named nurse Safeguarding Children |
| Rowena Remorino (SRH) & Pauline Shute (WH): | Named Doctors |
| Gail Addison | Named Midwife and (*FGM lead*) |
| Joan Davidson | Safeguarding Nurse |
| Clare Hosking & Sarah Barwick | Safeguarding Midwives |
| Kathy Walker, Susannah Hutchby & Julie-Ann Harper | Safeguarding and liaison nurses |
| Helen McCutchan | Sexual Health Matron & (*CSE Lead*) |
| Rachel Lee | Sexual Health Lead Safeguarding Doctor |
| Helen Milne | ED Consultant (WH) |
| Katie Manning | ED Consultant (SRH) |

**Designated Doctor and Nurse**

| | |
|---|---|
| NHS West Sussex Designated Nurse: | vacant since April 2019 |
| NHS Sussex Designated Doctor: | Dr Jamie Carter |

## 2.2 **WSHFT Safeguarding Children Structure**


West Sussex Safeguarding Children Partnership (WSSCP)
WSHFT Board
WSSCP Executive
Quality risk Committee (QRC)
WSHFT Safeguarding Committee Strategy Group (Adult and Children)
W&C Division Governance Review
LSCB Sub groups:
Improving Quality of practice & Assurance
Multi agency child exploitation (MACE)
Multi agency safeguarding hub operational (MASH)
NHS Professionals Forum
Perplexing cases reflective practice
WSHFT Safeguarding Children Operational Group
Peer Review: Monthly Medical Supervision Meeting at WH and SRH
Case discussion and group supervision:
Weekly Meeting
Paediatric & A&E Safeguarding at
WH & SRH
Case discussion and group supervision:
Monthly Meeting Antenatal Safeguarding at
WH & SRH
Case Discussion and group supervision: Monthly Meeting Safeguarding Sexual Health

## 2.3 Role and Responsibility of the West Sussex Safeguarding Children's Partnership (WSSCP)

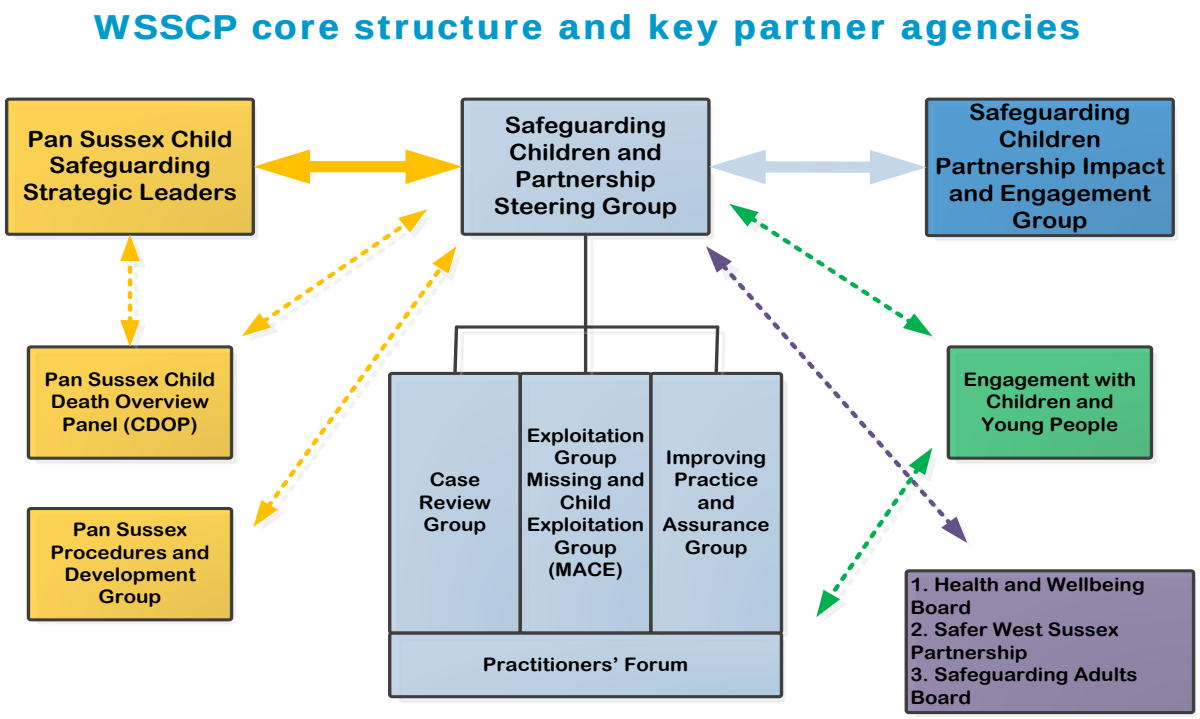
In June 2019 West Sussex Safeguarding Children Board (WSSCB) was replaced with the West Sussex Safeguarding Children Partnership (WSSCP). WSSCP is a partnership of all the different organisations working together to safeguard and promote the welfare of children and young people across the county. The Children Act 2004, as amended by the Children and Social Work Act 2017, strengthens this relationship by placing new duties on key local agencies; Police, CCG and the local authority. (Working Together to Safeguard Children, 2018)

West Sussex are using this opportunity to reshape multi-agency safeguarding arrangements to improve services to children, young people and their families. It is clear from recent local developments that a strong and purposeful multi-agency approach to child protection is essential to drive swift and sustainable improvements to practice in key areas of child abuse, such as neglect.

WSSCP Business Plan Priorities for 2018/19 focused on four priorities:

- Prevention and protection of children at risk of or experiencing Neglect
- Prevention and protection of children from exploitation and abuse
- Children's emotional wellbeing and mental health
- Provision of Early Help to children, including scrutiny of MASH functions

Fig 1



In addition to the work of the sub groups, outlined in this report, the WSSCP also continues to monitor, contribute and learn from national and regional serious case reviews and other Local Safeguarding Children's Partnership strategic priorities. The named professionals are active members of the WSSCP.

## 2.4 **WSSCP Sub groups**

The following subgroups are attended by WSHFT safeguarding team;

### 2.4.1 **Improving Quality of Practice and Assurance**

The Improving Quality of Practice and Assurance Group;

- Monitor and evaluate selected key data and information to measure the effectiveness of how partners (referred to as Safeguarding Partners) are fulfilling their responsibilities to safeguard, promote and improve outcomes for the welfare of children and young people in the county.
- Report to West Sussex Safeguarding Partners Board areas of risk or performance emerging trends, which may in turn require action by the Board or one of its' sub-groups.
- Hold strategic oversight of the multi-agency training programme ensuring national and local improvements are included within practice.
- Identify responses and action required to practice improvement needs in order to improve outcomes for children.

### 2.4.2 **NHS Professionals Forum**

This quarterly forum is open to all safeguarding children professionals working within the NHS in West Sussex. Meetings are informal in nature enabling safeguarding professionals to discuss cases, issues and share experience. Its key terms of references are:

- To coordinate child protection and safeguarding developments for NHS staff within West Sussex.
- To provide professional advice and support to the WSSCP.
- To develop a safeguarding clinical network across West Sussex that supports senior practitioners in undertaking their role.
- To consider and review the findings and recommendations from Serious Case Reviews in respect to practice and training implications.
- To share learning and promote and support audit.

### 2.4.3 **Multi agency Child Exploitation (MACE)**

Safeguarding children's team and sexual health, contribute relevant information. The sexual health matron attends on behalf of WSHFT.

### 2.4.4 **Multi agency safeguarding hub (MASH) Operational Groups**

The MASH is a single point of contact for all safeguarding concerns regarding children and young people in West Sussex and includes Early Help and brings together expert professionals, from services that have contact with children, young people and families, and makes the best

possible use of their combined knowledge and resources to keep children safe from harm and promote these and their families wellbeing.

The children's safeguarding team feed into this group through the health contacts in MASH.

### 2.4.5 **Perplexing cases reflective practice group**

The aim of this group is to facilitate a multi-agency consultation forum to discuss perplexing cases of abnormal illness behaviour which may not strictly meet the definition of FII but which is nevertheless a cause of professional concern. Consultation with peers named or designated Professionals and colleagues in other agencies form an important part of the process of making sense of the underlying reasons for the signs of abnormal illness behaviour.

The Terms of reference of this group are currently under review.

## 2.5 **WSHFT Safeguarding Children Meetings**

### 2.5.1 **Safeguarding children case discussion meetings;**

- Weekly Meeting Paediatric & A&E Safeguarding at WH & SRH
- Monthly maternity meeting
- Monthly sexual health meeting

These well attended weekly multi-disciplinary meetings provide an invaluable forum for case discussion, information sharing, decision making, resolution, group supervision and learning. Furthermore, partnership working and relationships are positively developed through the attendance of CAMHS A&E liaison and for the antenatal meetings; perinatal mental health practitioners, health visitors, are also invited. In order to strengthen safeguarding arrangements pre- birth it is planned for the newly appointed pre-birth assessment social workers within West Sussex, to also be invited.

### 2.5.2 **Peer Review: Monthly Medical Supervision Meeting at WH &SRH**

Chaired by the named doctor on each site, these are well attended by consultant pediatricians and named nurse. The purpose of these meetings, are to;

- Promote a culture of learning and professional support, drawing on the existing evidence base relevant to child abuse.
- Provide assurance that practitioners meet a measure of standard and are therefore more reliable in their practice.
- To reduce professional isolation and improve sharing of best practice with discussion of complex patients in a challenging but supportive way.
- To provide a regular documented review of practice as expected by the judiciary, GMC and RCPCH; evidence of involvement should be provided for consultant appraisal and revalidation.

### 2.5.3 **Safeguarding Children's Operational Group**

The Group meet quarterly and are responsible for the effective operational implementation and performance of the safeguarding children framework within the Trust. More specifically the group;

- Ensure there are mechanisms in place to alert staff to safeguarding policies and procedures.
- Ensure there is sufficient safeguarding training to enable staff to carry out their duties to safeguard children.
- Communicate and disseminate WSSCP and sub group information and guidance, including relevant serious case reviews through existing divisional structures.
- Ensure dissemination of relevant national information and guidance
- Monitor and identify when guidelines require updating, making recommendations on changes aligned to national best practice. These will then be deemed ready for divisional ratification at the divisional governance meeting and onward cascade through divisions and the WSHFT safeguarding strategic group
- To consider the annual audit plan and recommendations, taking forward any actions through relevant forums.
- Track progress on any serious case reviews or action plans.
- Monitor additional actions and learning needs identifying learning events as required.

### 2.5.4 **Safeguarding Committee (Strategic Group)**

This integrated adults and children's safeguarding group meet quarterly and is responsible for assuring the effective implementation and performance monitoring of the safeguarding framework within the Trust, adhering to statutory requirements; Section 11 of the Children Act 2004 and 2010 and The Care Act 2014 and national frameworks; Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (NHS England, July 2015)**.**

More specifically the purpose is to;

- Report mechanisms are in place and to provide assurance to the CCG through the annual assurance and quarterly exception reports.
- Ensure there are mechanisms in place to alert staff to Safeguarding policies and local procedures.
- Monitor training compliance, ensuring relevant staff have appropriate training in accordance with the Intercollegiate guidance (RCN 2019)
- Monitor the quality of training and safeguarding practice
- Scrutiny of safeguarding processes; including training and information sharing
- Oversee the provision and development of the annual safeguarding report.
- Monitor the dissemination of information from the WSSCB and subgroups, including relevant serious case reviews.
- Review any new guidance and set the direction for the safeguarding strategy.
- Identify, monitor and ratify safeguarding policy, making recommendations on changes aligned to national best practice. These will then be deemed ready for ratification at the Quality and Risk Committee, and onward cascade into the organisation.
- To consider audit recommendations, taking forward any actions through relevant forum e.g. Patient Safety.
- Review of safeguarding team structures and ability to discharge statutory responsibilities

# 3 REVIEW OF THE YEAR:

## 3.1 **Quality improvements and evaluation of progress against priorities set in the annual report 2018;**

### 3.1.1 Safeguarding notifications on the patient administrative system (Sema helix) need to include MARAC (multi agency risk assessment conference) domestic abuse alerts. .

There has been minimal change with this improvement work; therefore the following will be carried forward into 2019/20.

Not all relevant domestic abuse information, received from MARAC, is shared within the trust. Currently, only high risk alerts are shared with A&E for domestic abuse and children known to have been discussed at MARAC are inputted into the safeguarding folder onto a child's electronic patient records (EVOLVE). Administrative funding support is required to input and manage the information shared from MARAC onto the trust patient administrative system (Sema helix).

### 3.1.2 A solution for integrating the patient administration system Sema helix with the Child protection Information sharing (CP-IS) system is required at WSHFT.

There has been no change with this improvement work. WSHFT has not introduced the integrated IT solution to link CP-IS and Sema helix (patient administrative system) therefore this issue remains on the trust risk register **(ID 1255).** Currently CP-IS access remains a manual process and is open to human error. This remains an ongoing challenge for emergency departments and a potential risk to children. This risk is being actively managed between A&E and the safeguarding children team and funding for the IT solution at WSHFT is still awaited.

### 3.1.3 The quality of safeguarding and Information sharing processes, within WSHFT and with partner agencies.

This remains a focus of ongoing improvement work. Information sharing is a key element of safeguarding and continues to remain a central focus for improvement. Within WSHFT, improvements have been made with the establishment of electronic patient records (EVOLVE) and a secure safeguarding folder which allows practitioners.to access relevant information. The internal safeguarding information sharing form has also been updated. Safeguarding professionals in WSHFT now have access to relevant safeguarding information held by the local authority and we have gone live with the national FGM-IS.

Challenges do however remain with securing an efficient and sustainable solution for information sharing external to WSHFT. These challenges have been raised at the NHS professional's forum and with partner agencies and are being shared with the WSSCP improving practice and quality assurance group.

### 3.1.4 Section 11 audit improvement plan actioned & updated (Appendix 1)

The improvement plan has been completed and shared with WSSCP.

### 3.1.5 Safeguarding children training compliance for all staff groups to be greater than 95%

Improvements have been made with training compliance in W&C division. However, compliance remains low and below target for medical staff within medicine who require level 2 or 3 training, depending where they work and with surgery level 2 training.

The safeguarding team are actively seeking a solution with the WSHFT learning and development team and medical education teams. The safeguarding training strategy was updated December 2018 and a business case is being submitted for additional funding to support the delivery of safeguarding training.

Currently due to the limited capacity for the safeguarding teams to deliver the level 2 training programmes, staff are being directed to e-learning via NLMS and some additional face to face level 2 sessions have been offered, however there has been poor uptake.

It is envisaged, with additional resourcing for the purposes of delivering safeguarding training, the safeguarding teams could deliver the following training session (table 1) alongside adult safeguarding.

Table 1. Proposed; Level 2 safeguarding training programme for 2020

| Time | Duration | Subject | Speaker |
|---|---|---|---|
| 09-10:00 | 60 mins | Review of MCA, capacity assessments & DoLS | *MCA Lead* |
| 10-11:00 | 60 mins | Safeguarding adults process & Prevent | *Adults* |
| 11-11.20 | 20 mins | Coffee Break | |
| 11.20-12:20 | 60 mins | Safeguarding Children | *Children's* |
| 12:20-13:00 | 40 mins | Learning Disabilities | *L&D* |

Training guidance has also been shared with the medical education for the purposes of sharing with new trainees at induction, so that they are clear which training they are required to undertake.

### 3.1.5 Serious case reviews; Improvement plans completed and learning from serious case shared.

For 2018/19 Learning has been shared for SCR U, T and V through learning events and training events. The following table outlines outstanding actions following recent serious case reviews.

Table 2 SCR – outstanding actions from improvement programme

| Outcome | Action | Lead | Progress Update |
|---|---|---|---|
| **Preventative advice and guidance for coping with 'Crying babies' to be provided to all staff and new parents** | Include in safeguarding training for staff<br><br>Share with new parents<br><br>Information to be made available via Staffnet and Family assist<br><br>A&E and CAU/CYPDU to share with new parents during attendance of 'crying baby' | GA/CC | **June 2019;**<br><br>Included at all level 3 training sessions and advice available on staff Net<br><br>Included in the antenatal and postnatal period and on the NNU's<br><br>Funding for ICON (led by WSSCP) to be agreed for roll out within West Sussex |
| **Timely and Relevant Information to be shared with community health partner organisations** | Electronic Discharge Summaries sent to the GP also to be sent electronically to the Healthy Child Programme **(**HCP) and community services in SCFT who are working with the child. | All | **June 2019**<br><br>Meeting to be arranged with IT applications |
| **Domestic abuse support for hospitals** | Hospitals to have an independent domestic abuse support advisor (IDVA) | MD/ AB/CC | **June 2019**<br><br>STP to review domestic abuse support within health.<br><br>Pilot agreed for an IDVA to be based initially at Worthing, managed by WSCC and funded by the police crime commissioners (PCC). Start date to be agreed |

### 3.1.6 A review of the safeguarding arrangements for the unborn baby

Safeguarding arrangements for the unborn baby have been strengthened through an increase of 0.4wte within the maternity safeguarding team establishment at Worthing and the introduction of two pre-assessment social workers employed by West Sussex County Council.

3.1.7 New and updated WSHFT Safeguarding Children Policy and guidance

- Safeguarding children's training Strategy
- Safeguarding Children Policy
- Female Genital Mutilation (FGM) Guideline
- Abusive Head Trauma (AHT) pathway
- Unexpected Child death/ Joint agency response (JAR) pathway

## 3.1 National and Local including; context; guidance, reviews and policy change.

### 3.2.1 National Context

Local safeguarding needs to be seen in the context of national reports, serious case reviews and the political arena. The danger of online sexual abuse needs to be recognised and understood as social media and the internet are an everyday factor in the lives of children and young people. Furthermore, the complexity of safeguarding; FGM, modern slavery and Exploitation; including Child sexual exploitation and county lines drugs networks which are increasingly recruiting children in provincial towns to sell drugs rather than trafficking children and young people from London and other major cities.

**Online abuse:** How safe are our children? (NSPCC 2019) report from an overview of the last five years of data on child abuse online;

- year on year increases in the numbers and rates of police-recorded online child sexual offences
- increases in police-recorded offences of obscene publications or indecent photos in all four UK nations over the last five years
- increases in the number of URLs confirmed by the Internet Watch Foundation (IWF) as containing child sexual abuse imagery since 2015
- less than half of children aged 12 to 15 say they know how to change their settings to control who can view their social media
- the majority of parents, carers and members of the public agree that social networks should have a legal responsibility to keep children safe on their platforms.

(NSPCC 2019)

**Child Poverty:** is reported to be rising;

- 4.1 million children are living in poverty, a rise of 500,000 in the last five years;
- Four million workers are living in poverty –a rise of more than half a million over five years; and
- In-work poverty has been rising even faster than employment, driven almost entirely by increasing poverty among working parents. (Joseph Rowntree Foundation 2018)

**Childhood Vulnerability:**
It is reported that 2.4 million children are growing up with a vulnerable background and 829,000 are 'invisible to children's services (Children's commissioner for England 2019)

Fig 2 .


(Children's Commissioner for England 2019)

**Adverse childhood experiences (ACE's);** healthy attachment and preventing or mitigating the impact of stressful or traumatic experiences in childhood depends on involving the whole family. Exposure to stresses or adversity in the first 1000 days of a child's life has an adverse effect on a child's development. The House of Commons Health and Social Care Committee (HC 2019)report ' First 1000 days of life'; calls for a national long term plan to be considered for England that seeks to reduce adverse childhood experiences by focussing on issues such as child poverty, improving school readiness and reducing infant mortality rates.

### 3.2.2 **Local Context**

In 2017 there were 190,400 children in West Sussex. Although West Sussex remains one of the least deprived areas in the country, there are areas of deprivation in Arun, which rank in the poorest 10% of neighbourhoods in England.

Fig 3

**The Children in Need (CiN)**[29] **rate (per 10,000) increased in 2017 to 279.6,** this is lower than England but broadly in line with comparable authorities. As at March 2017 there were 4,802 children in need, although DfE note that data supplied by West Sussex is likely to have contained some duplicate cases.

**The rate (per 10,000) of referrals to social services has increased year on year from 2014**. In 2017 the rate was 508 per 10,000. This is higher than comparable local authorities, lower than England.

**Section 47 enquires** [30] **(started within year) increased in 2017, to 126.3 per 10,000.** This is similar to comparable authorities, lower than England.

**Children subject to a Child Protection Plan (CPP) increased in 2017**, a rate per 10,000 of 32, lower than England and comparable authorities.

**The percentage of children who became subject to a CPP for a second time held steady at approximately 22.7%.** This is in line with comparable authorities but higher than England (18.7%).

**As at 31 March there were 665 children looked after, the rate has increased slightly to 39 per 10,000 in 2017 from 37 per 10,000 in 2016**. The rate in West Sussex remains lower than comparable authorities and England. There was an increase in the number of unaccompanied asylum seeking children, 75 (as at March 2017), compared with 65 in 2016.

**First time entrants to criminal justice system declined in the county, down to 168 per 1,000 10–17 year olds in 2017,** this is now amongst the lowest of CIPFA comparable local authorities.

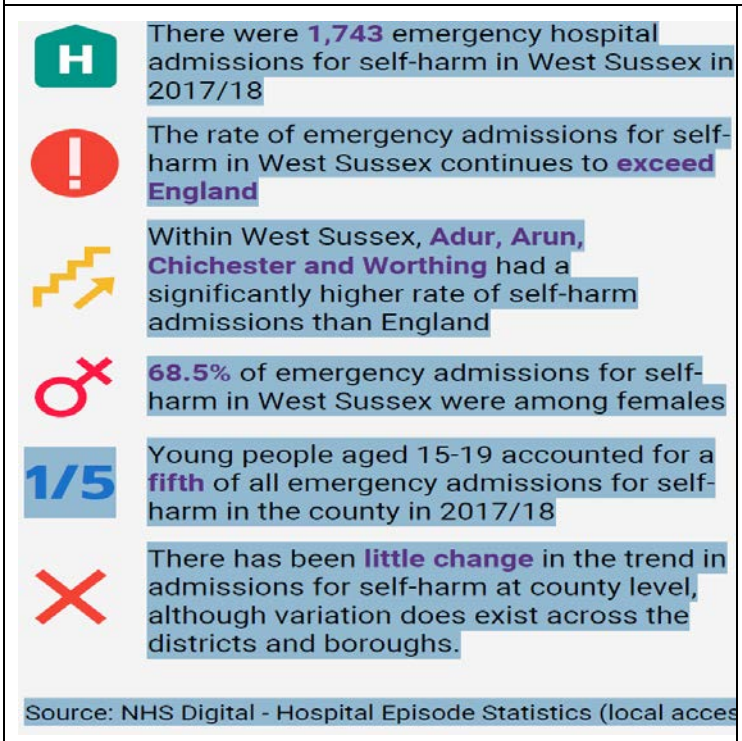
West Sussex Joint Strategic Needs Assessment: Summary 2018

West Sussex Children's services were inspected by Ofsted and the report published 8th May 2019 found services to be 'inadequate'. This provides a number of serious challenges. In particular the Ofsted report (2019) highlights there are; 'Critical weaknesses in how agencies identify and respond to neglect are evident across the service'/. The report also highlights; 'Accumulating concerns about the neglect children have experienced are not always recognised or understood, resulting in a lack of assertive action and to some children experiencing profound and potentially long-term consequences'.

WSHFT are actively engaging with children's social care and relevant partners with a Neglect improvement programme.

**Table 3. Hospital attendances with Self Harm**

**Self-harm** is a public health priority in West Sussex. There are many complex factors that contribute to self-harm however the possibility that self-harm, including serious eating disorder, has been caused or triggered by any form of abuse or chronic neglect cannot be overlooked.




The rate of emergency admissions for self harm in West Sussex is far higher than the national rate 220.3 per 100,000 (1743 admissions) in 2016/17 (England 185.3). Although this relates to all ages, self-harming is high amongst young women aged 15-24 years. Provisional data 2017/18 suggests no change locally.

The rate of emergency admissions for intentional self-harm for 10-24 year olds was 499.9 per 100,000 (637 admissions). This was significantly higher than the national rate.

In total, children and young people aged 10-24 account for 39% of all admissions for self-harm in West Sussex.

West Sussex Joint Strategic Needs Assessment: Summary 2018

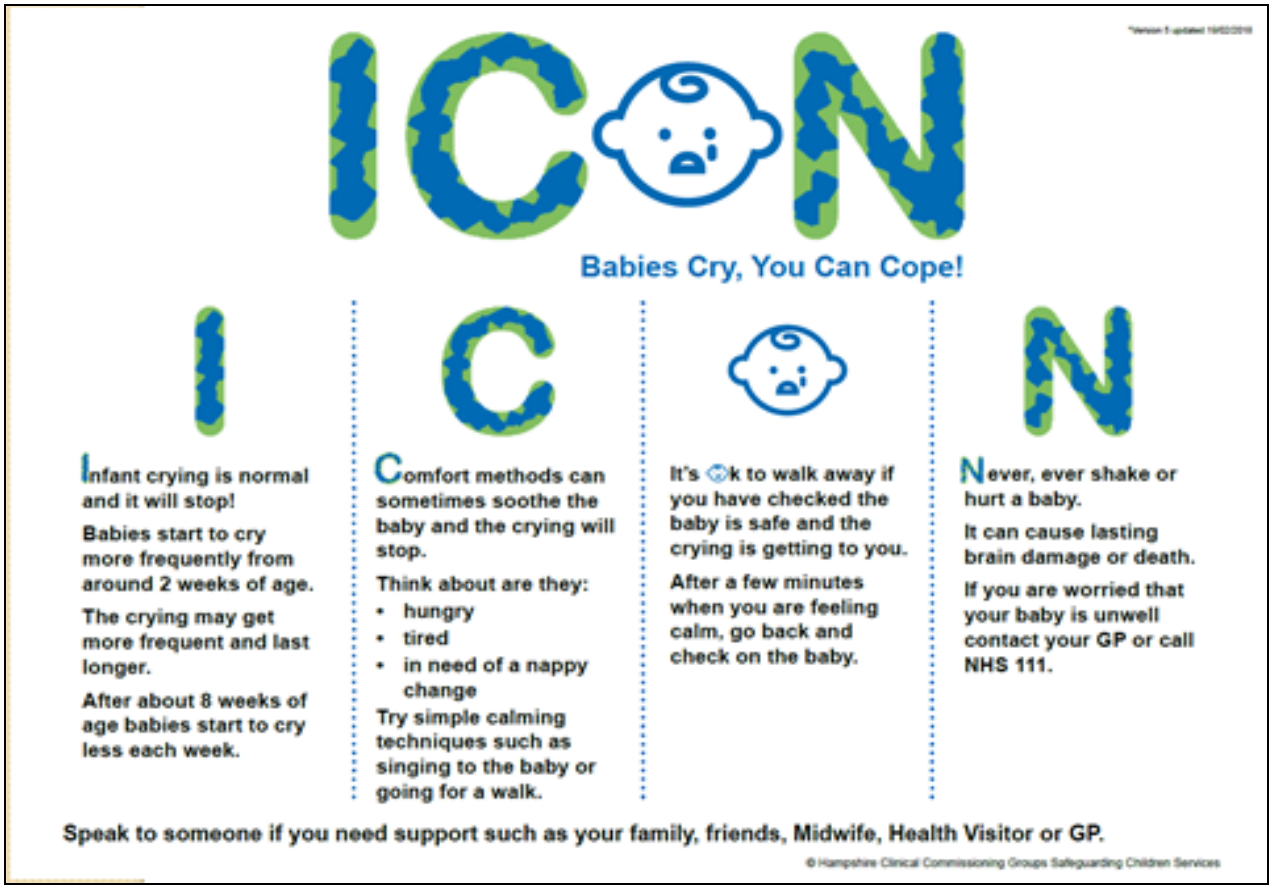
**Preventing Abusive Head Trauma and coping with 'Crying babies'**

There has been a rise in the number of infants with significant head injuries and West Sussex has a higher number of incidents than East Sussex or Brighton and Hove. Most incidents are a result of a momentary loss of control and better preventative advice and guidance is needed.

Research from www.iconcope.org suggests that persistent crying in babies is a potential trigger for some parents/care givers to lose control and shake a baby. It also shows that around 70% of babies are shaken by men. A prevention programme therefore should include male caregivers and take the best opportunities to reach them, as well as support all parents/caregivers, with information about crying and how to cope with a crying baby. In particular, the hospital based intervention has been shown in previous studies to be crucial in engaging with male caregivers.

It has been agreed by WSSCP for ICON, an evidence based preventative programme consisting of a series of brief interventions that reinforce a simple message, is rolled out across West Sussex, once funding for this programme has been agreed.

Fig 3 Prevention Programme against abusive head trauma (AHT)




Suzanne Smith (2016) [www.iconcope.org](http://www.iconcope.org)

### 3.2.3 National New Guidance:

- **Working Together to Safeguard Children: a guide to interagency working to safeguard and promote the welfare of children ( HM Government 2018)**

  Key changes to this guidance are as follows;

  - Early Help; practitioners should be alert to the potential need for early help
  - New partnership arrangements replacing the local safeguarding children's boards. Multi-agency safeguarding arrangements; under new legislation three safeguarding partners (local authorities, police and the clinical commissioning groups) must make new partnership arrangements to work together with relevant agencies to safeguard and protect children in their local area
  - A new process for national and local Child safeguarding Practice Reviews, which will replace serious case reviews

- New arrangements for Child death reviews

- **Child death Review Statutory and Operational Guidance (England) (HM Government October 2018)**

  This guidance sets out key features of what a good child death process looks like and combines best practice and statutory requirements. A child death review must be carried out for all children regardless of the cause of death. This includes the death of any live-born baby. The purpose of the guidance is to;

  - improve the experience of bereaved families and professionals after the death of a child, and;
  - ensure that information from the child death review process is systematically captured to enable local learning through the national child mortality database, to identify learning at the national level, and inform changes in policy and practice.

**Liberty Protection Safeguards (LPS)**

As from 1st October 2020 LPS will replace the current deprivation of liberty standards (dols) and will apply to children from the age of 16 years. This will have implications for hospitals.

**Safeguarding Children and Young People: Roles and Competencies for Healthcare staff: intercollegiate document (4th edition) (RCN 2019)** updated guidance includes changes to legislation and statutory guidance in England and education and learning logs to enable individuals to record their learning and form a 'passport' for those who move on to new jobs or other organisations.

### 3.2.4 Local Serious Case Reviews

When a child dies or is seriously harmed, including death by suspected suicide, and abuse or neglect is known or suspected to be a factor in the death, the LSCB is required to conduct a Serious Case Review into the involvement of organisations and professionals in the lives of the child and the family. The purpose of a Serious Case Review is to establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard children, identify what needs to be changed and, as a consequence, improve multi-agency working to better safeguard and promote the welfare of children.

Table 4 Local Serious Case reviews (SCR)

| Recent SCR Themes; abusive head trauma, 'crying babies', neglect, concealed pregnancy, fabricated induced illness, information sharing, parental mental health, domestic abuse and parental prescribed drug misuse. www.westsussexscb.org.uk/reviews/west-sussex/ | | | |
|---|---|---|---|
| Child | Date TOR agreed | Review Type | Status |
| SCR W | 26.06.19 | TBC | New |
| SCR V | 07.03.18 | SILP (serious incident learning review) | WSHFT Involvement and contribution Publication awaited |
| SCR U | 20.04.18 | SILP | WSHFT Involvement and contribution Publication awaited |
| SCR T | 17.10.17 | Learning review type SCR | WSHFT Involvement and contribution Publication awaited |
| SCR N | 07.09.16 | SILP | WSHFT Involvement and contribution Publication awaited |

The volume of SCR work has had a significant impact on the safeguarding team and the individual practitioners who were involved. Key themes from the serious case reviews include; Neglect, Concealed pregnancies, 'Crying babies', Abusive head trauma and fabricated illness (FII). Actions are being monitored by WSSCP and WSHFT Safeguarding committee. There has been a significant increase in the number of serious case reviews and associated activity over the last there years which WSHFT have contributed and participated in as outlined in Table 5. The publication of some of these reviews is delayed due to court proceedings; however improvement plans and shared learning, related to these serious case reviews, are in progress or have been completed.

### 3.2.5 Joint targeted area inspections (JTAI):

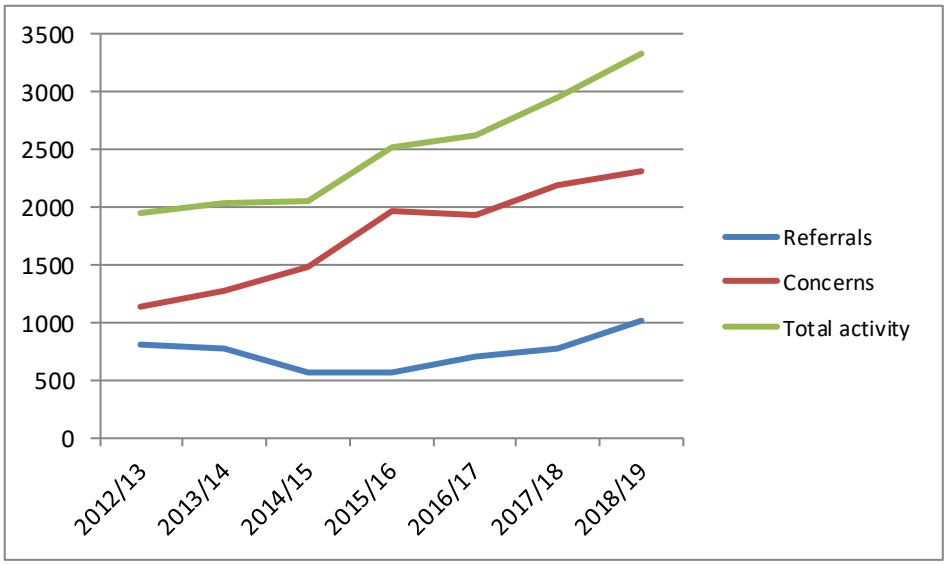
JTAIs are an evaluation of the multi-agency 'front door' for child protection, when children at risk of harm first become known to local services. They also include a 'deep dive' investigation and evaluation of the experiences of children and young people at risk of a specific type (or types) of harm, or the support and care of children looked after and/or care leavers. The theme of a JTAI will periodically change and over the past few years WSHFT have participated in preparing for an inspection for the following JTAI's; children living with neglect, exploitation, domestic abuse, child sexual abuse.

## 3.3 **Safeguarding Children Activity:**

There continues to be an annual rise in safeguarding & liaison activity;

- 28,303 A&E attendance s were reviewed by the safeguarding & liaison team
- 1010 referrals were made to children's social care
- 2315 safeguarding concerns raised
- Activity is significantly higher on the Worthing Hospital site.

**Fig 4 Summary of WSHFT Safeguarding Yearly Activity 2012-2019**




Attendance to hospital with mental health issues and self-harm remain a concerns and continue to increase on an annual basis. Referrals to social care increased by 24%. Mental Health Act detainments increased to 6. Staff are reminded to follow the Sussex child protection procedures for these attendances and share information, including with social care.

Children's safeguarding team work in partnership with both the children's and adult mental health liaison teams for individual cases and continue to develop partnership working arrangements. .During the year there were concerns raised regarding the capacity of the CAMHS A&E liaison service in meeting the volume of need. These issues were escalated and are being managed with additional resources within the team.

Children who present in crisis to hospital with challenging behaviour also remain a concern. These attendances, are reviewed on an individual basis and learning shared at WSHFT and with partner agencies.

There has also been is an increase in the numbers of complex safeguarding cases and perplexing cases this can be particularly challenging and resource intensive.

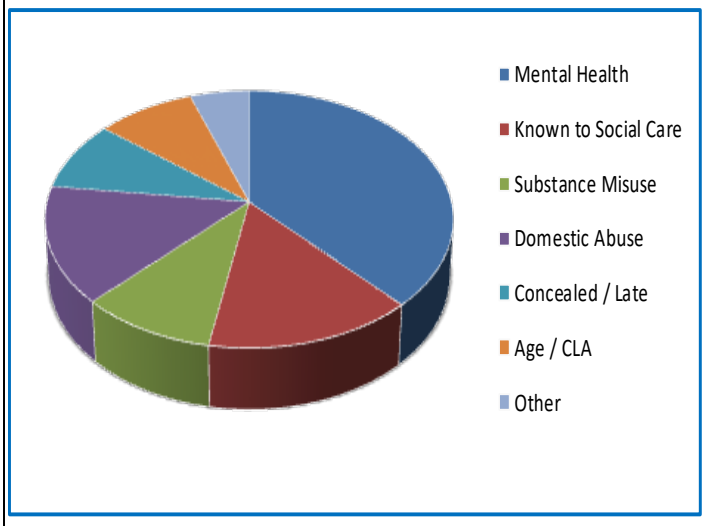
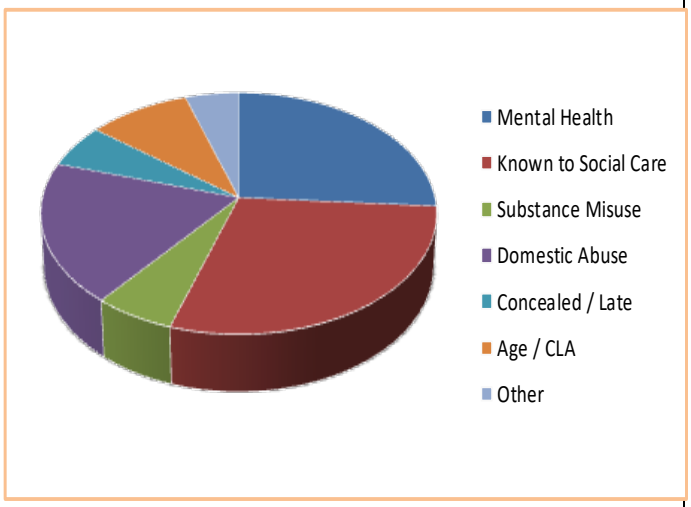
Safeguarding concerns due to household dysfunction including domestic abuse, remains high.

Child protection medical work, due to resource issues, is currently on the WSHFT trust risk register and currently being reviewed by the commissioners. Child protection medical photography is also is an area of work for quality improvement. It is envisaged that an adequately resourced service on both sites for Child Protection work will provide an improved experience for children and the family and practitioners involved.

**Table 5 Summary of WSHFT Safeguarding Activity by Principle Concern (Apr18 to Mar19)**
( NB: this does not include maternity safeguarding data)

| Principal Concern | SRH | WH | Crawley (sexual health) |
|---|---|---|---|
| **THINK FAMILY -Household Dysfunction & Adult Issues:** drug/alcohol misuse/ domestic/poverty /mental health/ Housing/ | 174 | 358 | <5 |
| **Child mental health & emotional health**; anxiety, challenging behaviour, anger management, bullying, self-harm, mental health, eating disorders | 261 | 533 | <5 |
| **Child physical**: including perplexing cases, FII | 117 | 218 | |
| **Child sexual abuse**; CSA, CSE, FGM | 10 | 23 | <5 |
| **Risky behaviour**: Drug/alcohol problems, vulnerable, exploitation | 118 | 341 | 59 |
| **Neglect concerns;** parenting concerns/ DNA /attachment/supervision/preventable accident/NEET | 207 | 362 | |
| **Child death** | 1 | 1 | |
| **Child Protection medical** | 24 | 86 | |

**Fig 5 Maternity: Summary of Safeguarding Activity by Principle concern (2018)**

| Worthing | St Richards Hospital |
|---|---|
|  |  |
| Mental health- 164<br>Known to social care- 79<br>Domestic Abuse- 63<br>Concealed and late booking- 32<br>Age/CLA - 38<br>Substance misuse- 41<br>Other- 23<br>85 babies were placed onto Child Protection or Child & Family Plan | Mental health - 58<br>Known to social care - 64<br>Domestic Abuse- 42<br>Concealed and late booking- 13<br>Age/CLA - 21<br>Substance misuse- 13<br>Other- 11<br>64 babies were placed onto Child Protection or Child & Family Plan |

## 3.4 **Unexpected Child Death 18/19**

There were sadly 2 unexpected child deaths during this time. The unexpected child death process was followed and both deaths are being reviewed by the West Sussex Child death overview panel (CDOP).

The child death review process arrangements are currently being reviewed in accordance with national guidance. New arrangements will need to be in place from September 2019.

## 3.5 **Staff Training**

### 3.5.1 Training Compliance

Table 6. Safeguarding Children Training by Division (02.05.2019)

| Division | ALL WSHT STAFF (Excluding Bank) | | | MEDICS ONLY | | | NON MEDICS | | |
|---|---|---|---|---|---|---|---|---|---|
| | Heads | Total Up To Date | % Up To Date | Heads | Total Up To Date | % Up To Date | Heads | Total Up To Date | % Up To Date |
| Core Services | 1527 | 1478 | 96.8% | 64 | 46 | 71.9% | 1463 | 1432 | 97.9% |
| Corporate | 800 | 773 | 96.6% | 68 | 53 | 77.9% | 732 | 720 | 98.4% |
| Facilities & Estates | 552 | 543 | 98.4% | 0 | 0 | - | 552 | 543 | 98.4% |
| Medicine | 2014 | 1905 | 94.6% | 284 | 206 | 72.5% | 1730 | 1699 | 98.2% |
| Surgery | 1370 | 1293 | 94.4% | 268 | 208 | 77.6% | 1102 | 1085 | 98.5% |
| Women & Children | 801 | 786 | 98.1% | 120 | 114 | 95.0% | 681 | 672 | 98.7% |
| **Total** | 7064 | 6778 | 96.0% | 804 | 627 | 78.0% | 6260 | 6151 | 98.3% |

Table 7 Safeguarding Children Training by Level Required (02.05.2019)

| Level Required | ALL WSHT STAFF (Excluding Bank) | | | MEDICS ONLY | | | NON MEDICS | | |
|---|---|---|---|---|---|---|---|---|---|
| | Heads | Total Up To Date | % Up To Date | Heads | Total Up To Date | % Up To Date | Heads | Total Up To Date | % Up To Date |
| Level 1 | 2046 | 2002 | 97.8% | 0 | 0 | - | 2046 | 2002 | 97.8% |
| Level 2 | 4098 | 3884 | 94.8% | 619 | 465 | 75.1% | 3479 | 3419 | 98.3% |
| Level 3 | 920 | 892 | 97.0% | 185 | 162 | 87.6% | 735 | 730 | 99.3% |
| **Total** | 7064 | 6778 | 96.0% | 804 | 627 | 78.0% | 6260 | 6151 | 98.3% |

RAG Rating
95%+
90%-94%
<90%

Safeguarding training is defined in accordance with the Intercollegiate Guidance (RCN 2019). A summary of the notable changes outlined in this guidance is as follows;

- Annual appraisal is crucial in determining an individual's attainment and maintenance of required knowledge, skills and competence. (Currently compliance assurance is provided by training figures through L&D)

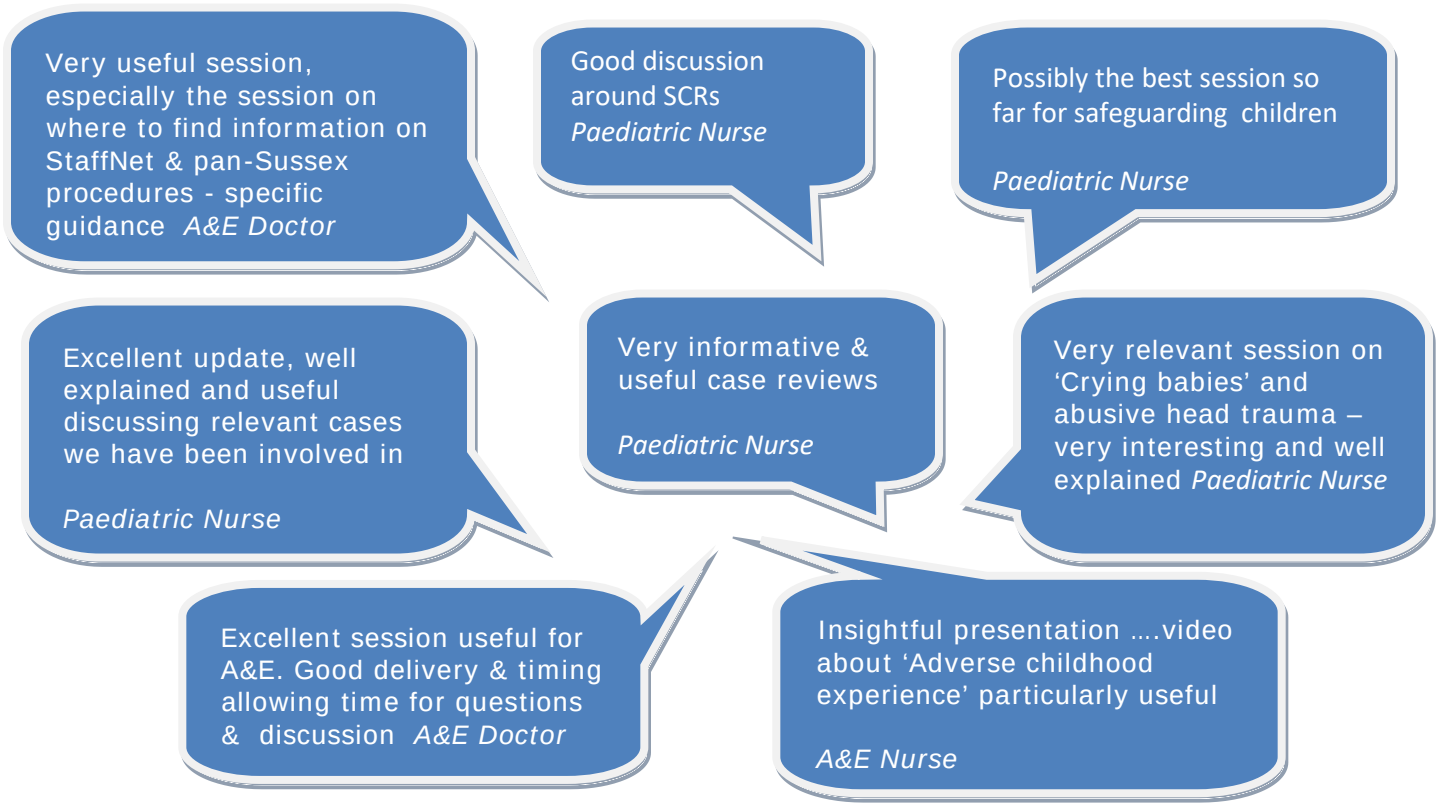
- Employers need to be assured that appraisers have the necessary knowledge, skills and competence to undertake appraisals and for medical and nursing staff to oversee revalidation. (RCN 2019)
- The guidance emphasises a blended approach to learning which maximises learning opportunities and includes multiagency training for staff requiring level 3 training
- All levels have explicit learning outcomes and a recommended length of time
- Safeguarding specialist staff, excluding named professionals who, require a more detailed specialist level 3 training programme.
- Named professionals require level 4 training and are currently compliant against standards.

The Performance for safeguarding training compliance for medical staff remains below the WSHFT target of 95% and is significantly below target for medical staff and for some staff groups who require level 2. Discussions have been held with learning and development (L&D) and medical education. The training strategy was revised December 2018 and staff, who do not attend face to face training sessions, are advised to undertake the e-learning training.

A business case is being submitted to resource the delivery of safeguarding training across the trust. The Foundation Trainees (F1s and F2s) have access to a range of safeguarding NLMS modules through their Horus e-portfolios which is monitored through post graduate medical education. All other training is monitored through WSHFT Learning and development.

### 3.5.2 **Evaluation and Audit of training**

**Recent staff feedback from Level 3 safeguarding children training:**



Improvements have been made to integrate adult and children's safeguarding at level 1 trust induction and for the volunteers training. Work is currently underway with L&D to review level 2 training delivery in order to ensure it meets service need and is continues to remain compliant with the intercollegiate national standards. (RCN 2019)

Overall evaluation of the level 3 training is reported as good - excellent and well regarded by our internal and external stakeholders and staff report that they have a good understanding of their role and responsibilities. Audit of feedback of level 3 training delivered at WSHFT, outlined in appendix 2, is being further explored and forms part of our continuous improvement plan.

## 3.6 **Supervision**

Supervision is provided in accordance with the framework outlined in the Safeguarding policy. Group supervision is available for practitioners at the safeguarding case discussion meetings or peer review. Supervision is also available on a 1:1 basis. Named professionals receive supervision quarterly by designated safeguarding professionals. Supervision is now also offered at the WSHFT specialist children's nurses' forum.

## 3.7 **Information Sharing and Communication**

The **Child Protection Information Sharing** (CP-IS) Project sponsored by NHS Digital supports the sharing of information between health and social care for children that are subject to Child Protection Plan (CPP) and for Looked after Children (LAC). It makes available, to health professionals working in unscheduled healthcare, CPP/ LAC information, held in social care systems in order to support child protection decision making and support more collaborative working.

WSHFT went live in both A&E departments in May 2016 as phase 1 using a manual process via the Summary Care Record Application (SCRa). Unfortunately the manual process has generated problems as it is open to user error and is subject to risk when not used for every child's attendance. It was planned when CP-IS was introduced for an integrated IT solution (phase 2) between CP-IS and SemaHelix to be implemented by IT within WSHFT, however there has been no progress with this as yet. This problem currently sits on the WSFHT risk register.

Some progress has been made with information sharing; maternity. Following learning from **SCR U**, now have access to Read only care information (ROCI) for access to relevant health information from GP records, for their clients. FGM-IS went live in WSHFT in January 2019. Safeguarding information is now available via the electronic patient records (EVOLVE) safeguarding folder. This came as a recommendation from **SCR V** ensuring relevant information is made available to support health professionals' decision making.
It is noted however that a workable solution is still required to ensure relevant email correspondence and information from other sources is easily electronically transferred into the child's safeguarding folder on EVOLVE.

The following are also an area for improvement; information sharing process between WSHFT and the healthy child programme (HCP) and the quality of discharge summaries to the GP.

A Monthly newsletter developed and issued by the safeguarding children's team, includes partnership news, guidance, learning from serious case reviews and training opportunities and is shared with safeguarding leads, Heads of Nursing, A&E, sexual health, paediatric staff, and also available on StaffNet.

### 3.8 **Audit**

The quality of referrals and record keeping and completed safeguarding flow charts in A&E are continuously monitored and audited across site. All are included in our quality improvement plan. The safeguarding children's team have also participated in WSSCB multi-agency safeguarding audits which have included the following; child sexual abuse, attendance at strategy meetings and child exploitation.

Audit Plan for the forthcoming year will include an audit of the safeguarding standards for children in emergency care, Children's Safeguarding Policy and also the recognition and response to neglect.

## 4. CONCLUSIONS AND PRIORITIES FOR THE FORTHCOMING YEAR

Safeguarding practice at WSHFT continues to be challenged due to the increasing safeguarding activity, each year and the effects of the local and national context we are working within. The resourcing of this activity, particularly in relation to the delivery of safeguarding training, child protection medicals needs to be closely monitored and reviewed.

Other areas of challenge and concern highlighted in the report include; meeting the needs of the increasing numbers of children and young people frequently attending hospital seeking help and support, in particular for those who attend with mental health issues and self-harm. Also, maintaining effective communication and information sharing across the safeguarding system when there are multiple agencies and IT systems involved, in an environment which is complex and dynamic, remains challenging. Effective partnership working with children, families and partner agencies in addition to prevention and early help support are essential and continue to be the focus of improvement.

Overall, improving processes, effective partnership working and a supportive culture, with staff clear of their safeguarding responsibilities, supports the safeguarding of children. Progress continues in the development of training, communication and information sharing processes within WSHFT and between partner agencies. Furthermore, the safeguarding team continue to share learning and endeavour to embed effective safeguarding practice throughout the whole Trust. The team also actively contributes and participates to the collaborative work of the WSSCP in order to find new ways of working and continually improve the quality of the safeguarding service.

## 4.1 **Priorities**

The child safeguarding priorities for Western Sussex Hospitals NHS Foundation Trust for the following year are shown as follows;

1. Neglect
2. Implementing; ICON- caring for ‘crying babies’
3. Safeguarding children training compliance for all staff to be greater than 95%
4. Improving the quality and processes for Information sharing across the system;

4.1 Safeguarding notifications on the patient administrative system (Sema helix) need to include MARAC (multi agency risk assessment conference) domestic abuse alerts. .

4.2 An Integrated solution for linking the patient administrative system (Sema helix) with CP-IS at WSHFT.

4.3 Processes for information sharing with healthy child programme

4.4 Quality of referrals

5. Implementing, once agreed, the newly commissioned child death and child protection medical arrangements.
6. Improving the quality of medical photography
7. Domestic abuse support within WSHFT
8. Audit

## 5. GLOSSARY OF TERMS

| | |
|---|---|
| CCG | Clinical Commissioning Group |
| CP-IS | Child Protection information sharing system |
| CQC | Care Quality Commission |
| CSE | Child Sexual Exploitation |
| DFE | Department for Education |
| EPR (EVOLVE) | Electronic Patient Records |
| FGM | Female Genital Mutilation |
| FGM-IS | Female Genital Information Sharing System |
| HCP | Healthy Child Programme (health visitors & school nurses) |
| JTAI | Joint targeted area inspection |
| LSCB | Local Safeguarding Children's Board |
| MACSE | Multi agency Child sexual exploitation |
| MARAC | Multi-agency risk assessment conference |
| NAHI | Non-accidental head injury |
| NICE | National institute of clinical effectiveness |
| ROCI | Read only care information |
| SCR | Serious case review |
| STP | Sustainable transformation plan |
| WSHFT | Western Sussex Hospitals NHS Foundation Trust |
| WSSCB | West Sussex Safeguarding Children Board |
| WSSCP | West Sussex Safeguarding Children Partnership |

**Appendix 1**

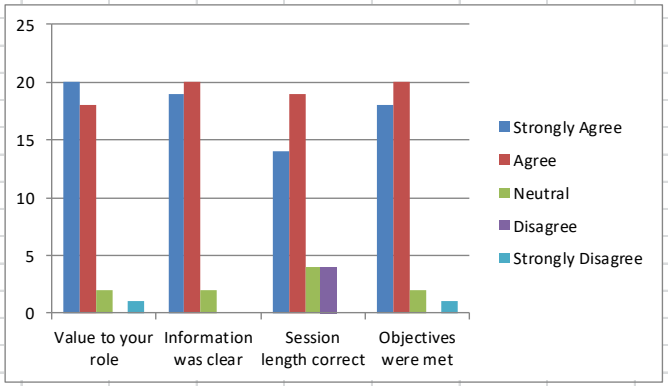
| Section 11 Audit: Improvement Plan | | | | | |
|---|---|---|---|---|---|
| **Name of agency** | | **Western Sussex Hospital NHS Foundation Trust** | | | |
| **Reference No** | **Standard Number** | **RAG rating** | **Action needed** | **Timescale** | **Lead officer** |
| 1 | 1.3 | Green | Arrangements for safeguarding in maternity need to be strengthened. Named midwife role requires a job description and supervision arrangements with the designated nurse to be organised.<br>Action taken; supervision arrangements in place with deputy designated nurses. JD being presented to WSHFT job evaluation | July 18 | LM/GA |
| 2 | 6.2 | Green | Process for ensuring compliance with recruitment policy- ensuring one member of the panel has undertaken the safer recruitment training. Audit conducted July 2018- the compliance rate was lower than expected.<br>Actions taken- Recruitment &Selection Policy updated to the following statement; 'every panel must comprise at least two assessors and the Trust expects that as a minimum, one panel member on each interview will have attended the Trust's in-house recruitment training."<br>This will be communicated within the trust through normal communication channels. | May 19 | JF/SR |
| 3 | 8.8 | Green | Patient related information needs to be kept in one central location; this includes emails related to patient care.<br>Action taken: Safeguarding information now stored in the safeguarding folder on electronic patient records (Evolve) and is trust policy | Dec 18 | VT/CC |

**Appendix 2**

**CHILD PROTECTION TRAINING LEVEL 3 TRAINING SEPTEMBER 2018 - FEBRUARY 2019**

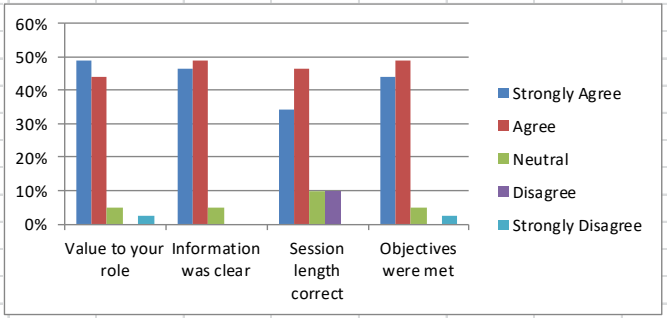
**41 FORMS COMPLETED**

| | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | |
|---|---|---|---|---|---|---|
| Value to your role | 20 | 18 | 2 | 0 | 1 | 41 |
| Information was clear | 19 | 20 | 2 | 0 | 0 | 41 |
| Session length correct | 14 | 19 | 4 | 4 | 0 | 41 |
| Objectives were met | 18 | 20 | 2 | 0 | 1 | 41 |
| **TOTAL** | 71 | 77 | 10 | 4 | 2 | 164 |
| | 43.29% | 46.95% | 6.10% | 2.44% | 1.22% | 100.00% |



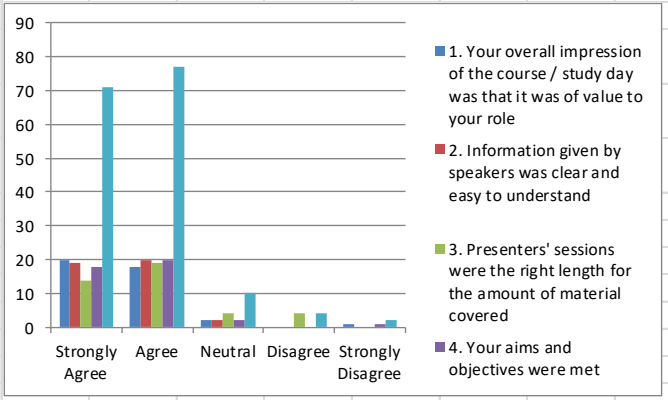

**41 FORMS COMPLETED**

| | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| Value to your role | 48.8% | 43.9% | 4.9% | 0.0% | 2.4% |
| Information was clear | 46.3% | 48.8% | 4.9% | 0.0% | 0.0% |
| Session length correct | 34.1% | 46.3% | 9.8% | 9.8% | 0.0% |
| Objectives were met | 43.9% | 48.8% | 4.9% | 0.0% | 2.4% |
| **TOTAL** | 43.3% | 47.0% | 6.1% | 2.4% | 1.2% |




**41 FORMS COMPLETED**

| | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | |
|---|---|---|---|---|---|---|
| 1. Your overall impression of the course / study day was that it was of value to your role | 20 | 18 | 2 | 0 | 1 | 41 |
| 2. Information given by speakers was clear and easy to understand | 19 | 20 | 2 | 0 | 0 | 41 |
| 3. Presenters' sessions were the right length for the amount of material covered | 14 | 19 | 4 | 4 | 0 | 41 |
| 4. Your aims and objectives were met | 18 | 20 | 2 | 0 | 1 | 41 |
| **TOTAL** | 71 | 77 | 10 | 4 | 2 | 164 |
| | 43.29% | 46.95% | 6.10% | 2.44% | 1.22% | 100.00% |



## Appendix 3 Safeguarding Children Activity 2018-2019

The following data details safeguarding activity per area within WSHFT and is based on the number of safeguarding concerns raised and referrals to children's social care.

| St Richards Hospital (SRH) Children's Social Care Referral: 2018/19 | | | | | | |
|---|---|---|---|---|---|---|
| **Department** | **Total Referrals 2017/18** | **Q1 Apr - Jun** | **Q2 Jul - Sept** | **Q3 Oct - Dec** | **Q4 Jan - Mar** | **Total Referrals 2018/19** |
| Maternity | 129 | 34 | 44 | 40 | 43 | 161 |
| Paediatrics | 36 | 17 | 9 | 12 | 17 | 55 |
| A & E | 79 | 43 | 25 | 49 | 80 | 197 |
| Sexual Health | 12 | 1 | 3 | 1 | 2 | 7 |
| Other | 14 | 5 | 4 | 1 | 5 | 15 |
| | **270** | | | | **TOTAL Referrals** | **435** |

| St Richards Hospital (SRH) Safeguarding Concern: 2018/19 | | | | | | |
|---|---|---|---|---|---|---|
| **Department** | **Total Concerns 2017/18** | **Q1Apr - Jun** | **Q2 Jul - Sept** | **Q3 Oct - Dec** | **Q4 Jan - Mar** | **Total Concerns 2018/19** |
| Maternity | 66 | 15 | 15 | 16 | 30 | 76 |
| Paediatrics | 149 | 35 | 40 | 23 | 43 | 141 |
| A & E | 411 | 122 | 107 | 101 | 107 | 437 |
| Sexual Health | 6 | 0 | 4 | 0 | 2 | 6 |
| Other | 30 | 9 | 4 | 5 | 9 | 27 |
| | **662** | | | | **TOTAL Concerns** | **687** |

**SRH Total Safeguarding Activity: 1,122**

| Worthing Hospital (WH) Social Services Referral: 2018/19 | | | | | | |
|---|---|---|---|---|---|---|
| **Department** | **Total Referrals 2017/18** | **Q1Apr - Jun** | **Q2 Jul - Sept** | **Q3 Oct - Dec** | **Q4 Jan - Mar** | **Total Referrals 2018/19** |
| Maternity | 152 | 45 | 40 | 44 | 56 | 185 |
| Paediatrics | 60 | 23 | 29 | 32 | 16 | 100 |
| A & E | 207 | 63 | 55 | 48 | 32 | 198 |
| Sexual Health | 38 | 12 | 16 | 13 | 17 | 58 |
| Other | 36 | 10 | 3 | 7 | 5 | 25 |
| | **493** | | | | **TOTAL Referrals** | **566** |

| Worthing Hospital (WH) Safeguarding Concern: 2018/19 | | | | | | |
|---|---|---|---|---|---|---|
| **Department** | **Total Concern 2017/18** | **Q1 Apr - Jun** | **Q2 Jul - Sept** | **Q3 Oct - Dec** | **Q4 Jan - Mar** | **Total Concerns 2018/19** |
| Maternity | 280 | 66 | 73 | 58 | 81 | 278 |
| Paediatrics | 468 | 120 | 142 | 144 | 69 | 475 |
| A & E | 571 | 132 | 152 | 160 | 228 | 672 |
| Sexual Health | 110 | 23 | 16 | 13 | 25 | 77 |
| Other | 66 | 7 | 21 | 25 | 20 | 73 |
| | **1,495** | | | | **TOTAL Concerns** | **1,575** |
| **Worthing Total Safeguarding Activity: 2,141** | | | | | | |

| Crawley Safeguarding Forms Completed: 2018/19 | | | | | | |
|---|---|---|---|---|---|---|
| **Dept. Crawley Sexual Health** | **Total 2017/18** | **Q1Apr - Jun** | **Q2 Jul - Sept** | **Q3 Oct - Dec** | **Q4 Jan - Mar** | **Total 2018/19** |
| Referrals | 5 | 3 | 0 | 4 | 2 | 9 |
| Concerns | 26 | 14 | 8 | 16 | 15 | 53 |
| **Crawley Total safeguarding activity: 62** | | | | | | |

Western Sussex Hospitals
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| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 20 | **Meeting:** | Trust Board | **Meeting Date:** | 25 July 19 |
| **Report Title:** | CNST Self Certification Declaration | | | | |
| **Sponsoring Executive Director:** | Maggie Davies, Chief Nurse | | | | |
| **Author(s):** | Lynn Woolley, Head of Midwifery | | | | |
| **Report previously considered by and date:** | The Head of Midwifery has liaised with the Clinical Director for Obs & Gynae, Chief Nurse, Head of Nursing, Midwifery Teams across sites, Maternity Information Analyst/Clerical Manager, Consultant Anesthetist and Legal Services Manager when reviewing the evidence required to demonstrate compliance against the ten standards.<br>Updates on progress have also taken place with Executive Directors at Efficiency Steering Group Meetings and as part of the fortnightly W&C PMO Assurance meetings. | | | | |
| **Purpose of the report:** | | | | | |
| Information | ☐ | | Assurance | ☐ | |
| Review and Discussion | ☐ | | Approval / Agreement | ✓ | |
| **Reason for submission to Trust Board in Private only (where relevant):** | | | | | |
| Commercial confidentiality | ☐ | | Staff confidentiality | ☐ | |
| Patient confidentiality | ☐ | | Other exceptional circumstances | ☐ | |
| **Link to Trust Strategic Themes:** | | | | | |
| Patient Care | ✓ | | Sustainability | ☐ | |
| Our People | ☐ | | Quality | ✓ | |
| Systems and Partnerships | ☐ | | | | |
| **Any implications for:** | | | | | |
| Quality | The aim is to incentivise the implementation of good practice across all maternity units. By meeting the 10 criteria, Trusts are likely to deliver safer maternity services and may be expected to have fewer cases of injuries leading to negligence claims. | | | | |
| Financial | The DoH is incentivising the delivery of best practice to improve safety in maternity services by providing a discount on Clinical Negligence Scheme for Trusts (CNST) maternity premia. 10% discount on the Maternity incentive contribution for WSHT equates to £625k. | | | | |
| Workforce | | | | | |
| **Link to CQC Domains:** | | | | | |
| Safe | ☐ | | Effective | ☐ | |
| Caring | ☐ | | Responsive | ☐ | |
| Well-led | ☐ | | Use of Resources | ☐ | |
| **Communication and Consultation:** | | | | | |
| | | | | | |
| **Executive Summary:** | | | | | |
| This report provides assurance that the Trust has sufficient evidence to meet the Safer Standards for Maternity Care as, reviewed and approved by the Head of Midwifery and Chief Nurse. The Board of Directors is asked to self-certify the Trust is compliant to the ten standards based on the Safer Standards for Maternity Care in order to achieve the 10% discount on maternity insurance premiums. | | | | | |
| **Key Recommendation(s):** | | | | | |
| The Board/Committee is asked to **APPROVE** the paper and evidence to meet the Safer Standards for Maternity Care as put forward, reviewed and approved by the Head of Midwifery, Clinical Director and Chief Nurse. The Board of Directors is asked to self-certify the Trust is compliant to the ten standards based on the Safer Standards for Maternity Care. | | | | | |

## Maternity incentive scheme - Guidance

| | |
|---|---|
| Trust Name | **Western Sussex Hospitals NHS Trust** |
| Trust Code | **T673** |

This document **must** be used to complete your trust self certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. Your trust name will populate each tab. **If the trust name box is coloured pink please update it.**

**Guidance Tab** - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.** There are three additional tabs within this document:

**Tab A - Safety actions entry sheet** - Please select 'Yes' or 'No' to demonstrate compliance with each maternity incentive scheme safety action. Note, entering 'Yes' denotes full compliance with the safety action as detailed within the condition of the scheme. The information which has been populated in this tab, will automatically populate onto tab C which is the board declaration form

**Tab B - Action plan entry sheet** - This must be completed for each maternity incentive scheme safety action which has **not** been met. If you are not requesting any funding to support implementation of your action plan - Please enter 0. **If cells are coloured pink then please update them.**

**Tab C - Board declaration form** - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (Column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution. Once the submission has been discussed and approved at trust board, please add an electronic signature into the document. If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **MIS@resolution.nhs.uk**

Technical guidance and frequently asked questions can be accessed here :
https://resolution.nhs.uk/resources/maternity-incentive-scheme-year-two

Submissions for the maternity incentive scheme must be received no later than **12 noon on Thursday 15 August 2019** to **MIS@resolution.nhs.uk**

You are required to submit this document (and a signed copy of the board declaration form, if there is no electronic signature added). Please do not send evidence to NHS Resolution.

NHS Resolution

# Section A : Maternity safety actions - Western Sussex Hospitals NHS Trust

| Action No. | Maternity safety action | Action met? (Y/N) |
|---|---|---|
| 1 | Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard? | Yes |
| 2 | Are you submitting data to the Maternity Services Data Set to the required standard? | Yes |
| 3 | Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme? | Yes |
| 4 | Can you demonstrate an effective system of medical workforce planning to the required standard? | Yes |
| 5 | Can you demonstrate an effective system of midwifery workforce planning to the required standard? | Yes |
| 6 | Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle? | Yes |
| 7 | Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback? | Yes |
| 8 | Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year? | Yes |
| 9 | Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues? | Yes |
| 10 | Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme? | Yes |

# Section B : Action plan details for Western Sussex Hospitals NHS Trust

**An action plan should be completed for each safety action that has not been met**

## Action plan 1

| | | | |
|---|---|---|---|
| **Safety action** | Q8 In-house training | **To be met by** | Q1 2020/21 |

**Work to meet action**

*Although we were able to meet the standard, we would aim to expand current provision of MDT PROMPT training. This is high fidelity simulation that maximises the opportunities for learning - from a clinical perspective but also in relation to identifying Human Factors that may increase the level of risk when dealing with obstetric emergencies. PROMPT is gold standard training and increasing access to the training would contribute to recruitment and retention as well as safety. This will require a robust business case for the resource to implement and there is support from the Chief Nurse as Board level Maternity Safety Champion to begin exploring this for 2020/21.*

*We currently run only 3 PROMPT sessions in total across both sites. This is insufficient to get all of our team through this type of training each year so the remainder of the team undertake more traditional low fidelity MDT training. We would propose increasing the PROMPT provision to 10-12 sessions per year to ensure that the majority of the MDT undertake this annually.*

| | | | |
|---|---|---|---|
| **Does this action plan have executive level sign off** | Yes | **Action plan agreed by head of midwifery/clinical director?** | Yes |
| **Action plan owner** | *Lynn Woolley Head of Midwifery* | | |
| **Lead executive director** | *Maggie Davies* | | |
| **Amount requested from the incentive fund, if required** | | | - |
| **Reason for not meeting action** | *Action met. This is an additional and enhanced approach to training and will ensure that the theatre staff that are now scrubbing for caesarean at SRH are included in the training for next year.* | | |
| **Rationale** | *This training will ensure that all of our MDT's are able to traing together with high fidelity simulation, enhancing and embedding learning. This is crucial given the increasing risk factors that women present with.* | | |

| | |
|---|---|
| **Benefits** | *Real time simulation to help develop the systems and process for emergencies by identifying the system and Human Factors elements that when they occur in real emergencies can have a direct effect on the outcome form women and babies.*<br><br>*This type of training develops the leadership and team skills of the MDT who work regularly in high risk obstetrics.*<br><br>*We have an in-house group of enthusiastic and skilled clinicians (anaesthetists, obstetricians, midwives) who are willing to participate as faculty in running the training regularly.* |
| **Risk assessment** | *The low fidelity training session is acceptable in terms of meeting the CNST standard but there is enormous added value for safety in encouraging teams to undertake the accredited, high quality PROMPT training.* |

## Maternity incentive scheme - Board declaration Form

| | |
|---|---|
| **Trust name** | **Western Sussex Hospitals NHS Trust** |
| **Trust code** | **T673** |

An electronic signature must also be uploaded. Documents which have not been signed will not be accepted.

| | Safety actions | Action plan | Funds requested | Validations |
|---|---|---|---|---|
| Q1 NPMRT | Yes | | - | |
| Q2 MSDS | Yes | | - | |
| Q3 Transitional care | Yes | | - | |
| Q4 Medical workforce planning | Yes | | - | |
| Q5 Midwifery workforce planning | Yes | | - | |
| Q6 SBL care bundle | Yes | | - | |
| Q7 Patient feedback | Yes | | - | |
| Q8 In-house training | Yes | Yes | - | You have met the action as well as submitting an action plan, please check |
| Q9 Safety Champions | Yes | | - | |
| Q10 EN scheme | Yes | | - | |
| **Total safety actions** | **10** | **1** | | **You have a validation on 1 safety action. Please recheck tab A (Safety actions) and/or B (Action plan entry) before discussing with your board and commissioners before submitting this form to NHS Resolution.** |
| **Total sum requested** | | | **-** | |

**Sign-off process:**

**Electronic signature**

**For and on behalf of the board of** Western Sussex Hospitals NHS Trust

**Confirming that:**

The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

The content of this form has been discussed with the commissioner(s) of the trust's maternity services

If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)

We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

| | |
|---|---|
| **Name:** | |
| **Position:** | |
| **Date:** | |

Western Sussex Hospitals
NHS Foundation Trust

| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 21 | **Meeting:** | Meeting of the Board of Directors | **Meeting Date:** | 25th July 2019 |
| **Report Title:** | Annual Board Report for Appraisal and Revalidation | | | | |
| **Sponsoring Executive Director:** | George Findlay – Chief Medical Officer/Responsible Office (RO) | | | | |
| **Author(s):** | Christopher Smith – Assistant Medical Director for Appraisal and Revalidation (AMD) | | | | |
| **Report previously considered by and date:** | | | | | |
| **Purpose of the report:** | | | | | |
| Information | ✓ | | Assurance | ✓ | |
| Review and Discussion | ✓ | | Approval / Agreement | ✓ | |
| **Reason for submission to Trust Board in Private only (where relevant):** | | | | | |
| Commercial confidentiality | ☐ | | Staff confidentiality | ☐ | |
| Patient confidentiality | ☐ | | Other exceptional circumstances | ☐ | |
| **Link to Trust Strategic Themes:** | | | | | |
| Patient Care | ✓ | | Sustainability | ✓ | |
| Our People | ✓ | | Quality | ✓ | |
| Systems and Partnerships | ✓ | | | | |
| **Any implications for:** | | | | | |
| Quality | Revalidation is the process for determining whether doctors are fit to practice. It drives quality improvement and patient safety through medical appraisal. | | | | |
| Financial | The Trust has a statutory obligation to provide the resources required to support the successful implementation of revalidation.<br><br>Additional licence requirements | | | | |
| Workforce | The duties of the Responsible Officer have considerable overlap with HR processes. Areas where HR need to support the RO include, systems and processes, advice on employee relations and employment law, resources for case management and case investigation and training and induction. | | | | |
| **Link to CQC Domains:** | | | | | |
| Safe | ✓ | | Effective | ✓ | |
| Caring | ✓ | | Responsive | ✓ | |
| Well-led | ✓ | | Use of Resources | ✓ | |
| **Communication and Consultation:** | | | | | |
| | | | | | |

**Executive Summary:**

This report is to update the Trust Board on revalidation and medical appraisal. The report provides the necessary assurance to allow a positive Statement of Compliance to be made to the higher-level Responsible Officer.

**Key Recommendation(s):**

(a) The Board is asked to accept this report as evidence of progress implementing revalidation and medical appraisal. The annual report is to be shared with the higher-level responsible officer

(b) The Board is asked to approve the 'Statement of Compliance' confirming that the organisation, as a designated body, is in compliance with the regulations

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board

Date: 25th July 2019

From: Christopher Smith
Assistant Medical Director for Appraisal and Revalidation

Agenda Item: 20

**FOR DECISION & INFORMATION**

# ANNUAL BOARD REPORT FOR APPRAISAL AND REVALIDATION

## 1.0 INTRODUCTION

1.01 Medical Appraisal and Revalidation is well established in the Trust. The second cycle of GMC revalidation is underway. An Independent Verification visit from NHSE took place in 2015 and found good evidence of high standards throughout and we are due a follow up review later this year. The electronic platform, Healthmedics by Allocate Software introduced in October 2016, has bedded in and is used by all doctors during Trust appraisal. All appraisal activity is supported and reviewed by the Revalidation Team and the Medical Workforce and Appraisal Governance group.

The purpose of this paper is to update the Trust Board on revalidation and medical appraisal and to give the necessary assurance to allow a positive Statement of Compliance to be made to the Higher Level Responsible Officer.

## 2.00 SUMMARY OF PROPOSAL

2.01 This paper updates the Trust Board on revalidation and medical appraisal for the 2018/19 reporting year, 1st April 2018 to 31st March 2019. It provides the supporting information to enable completion of the Statement of Compliance required for the Higher Level Responsible Officer.

Reviewing the Trust's revalidation and appraisal performance from April 1st 2018 to March 31st 2019 shows that on the 31st March 2019, the Trust had a prescribed connection with 497 doctors (466 in 2018 and 431 in 2017). This includes permanent and fixed term consultants, staff and associate specialist grade (SASG), medical bank and medical training initiative (MTI) doctors.

Trainee doctors have a connection with Health Education England, eg HEKSS, rather than the Trust.

Regarding the 497 medical staff with a prescribed connection to WSHFT:

451 had a completed appraisal which is 90.7% for 2019
399 completed in 2018 which was 85.6%
347 completed in 2017 which was 80.5%

This represents a continued improvement in appraisal engagement, particularly by permanent staff whose appraisal return rate is 96% (91% in 2017/18).

Within the 497 medical staff, there are 155 Locally Employed Doctors, (LEDs). These doctors are short term, temporary or bank doctors and they represent a further increase on the 128 LEDs linked last year.

123 (79.4%) LEDs had an appraisal during the 2018/19 reporting year, at WSHFT or before starting at the Trust, an increase on the 74% appraised last year.

31 LEDs were not due to have an appraisal in the reporting period, being new to the NHS or having started at WSHT late in the year. LEDs present the most challenging to support and engage with appraisal and revalidation, due to the temporary nature of their work.

A high proportion of WSHT doctors are in their second revalidation cycle, 104 revalidation submissions were made to the GMC in the reporting year 2018/19, compared to 35 in the previous year. 6 were deferred due to insufficient information 2 of which were subsequently revalidated within the reporting year. No doctors were declared 'non-engaged', although one REV 6 submission was made. A REV6 is a request to the GMC to send a 'non-engagement concern' letter to a doctor.

2.02 The Trust has a statutory duty to support the Responsible Officer in discharging their duties under the Medical Professional (Responsible Officer) Regulations[1] and it is expected that provider boards will continue to oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors
- Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed

## 3.00 RECOMMENDATIONS

(a) The Board is asked to accept this report as evidence of progress implementing revalidation and medical appraisal. The annual report is to be shared with the higher-level responsible officer

(b) The Board is asked to approve the 'Statement of Compliance' confirming that the organisation, as a designated body, is in compliance with the regulations

## 4.00 GOVERNANCE ARRANGEMENTS

4.01 Responsible Officer (RO)

Dr George Findlay

Assistant Medical Director for Revalidation and Appraisal (AMD)

Dr Christopher Smith

Senior Appraisers (SA)

| | |
|---|---|
| Core: | Dr Sean McHale |
| Medicine: | Dr Mike Chard (retired March 2019) |
| Surgery: | Mr David Beattie |
| Women and Children: | Dr Emma Rutland |

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practice and Revalidation) Regulations Order of Council 2012'

| | |
|---|---|
| Radiology: | Dr Nick Ashford (retired March 2019) |
| Hospices | Dr Emma Rutland (since April 2019) |

Following the retirement of Nick Ashford at the end of March, Sean McHale has taken on the role of SA for Radiology. Two new senior appraisers have been appointed to replace Mike Chard

Nick Pegge - will take responsibility for doctors working in Emergency Medicine, Acute Medicine and Care of the Elderly
Khurrum Baig - will take responsibility for the remaining doctors within the Medicine Division.
Emma Rutland has expanded her role to include doctors working at St Barnabas and St Wilfrid's Hospices for whom Chris Smith acts as Responsible Officer.

Medical HR Lead

Mrs Mandi Atkinson

Revalidation Manager

Ms Lynn Helyer

Revalidation Administrator

Ms Rebecca Downer

The Medical Workforce Governance and Appraisal Group

This group is chaired by the RO and is held quarterly. It is attended by the MD, AMD, revalidation manager and representation from Employee Relations Team/HR. The group oversees GMC concerns, local concerns, and any appraisal or revalidation issues, policy and procedures.

The Medical Appraisal and Revalidation Group (MARG)

This Group oversees the implementation of revalidation and appraisal and is chaired by the AMD and attended by the Senior Appraisers, SASG lead, the revalidation team, Hospice Leads and Lay Representative, (Roger Hammond, retired March 2019 - the new Lay Representative is Jonathan Todd, Governor, WSHFT). The committee meet quarterly and work to terms of reference defined within the appraisal policy.

Maintaining the list of doctors with a prescribed connection to WSHFT

The Revalidation Manager updates the list of doctors with a prescribed connection to WSHFT as their designated body, by adding or removing them from GMC Connect. The GMC Connect list of doctors is validated against Electronic Staff Record (ESR) data on a monthly basis.

Internal Assurance

Internal assurance follows the recommendations of the NHS England Framework for Quality Assurance for Responsible Officers and Revalidation (2014).

4.02 Policy and Guidance

The NHSE Medical Appraisal Policy (NHS England 2015)

In accordance with the NHSE Medical Appraisal Policy, the doctors' appraiser is allocated by the Revalidation Team. The allocations are based on the appraisees' previous appraiser history, appraiser availability, specialty and location. Obvious conflicts of interest are avoided and where possible, doctors will keep the same appraiser for three consecutive years. These recommendations are facilitated by the introduction of the Allocate appraisal software in October 2016.

There are additional ROANs (Responsible Officer Appraisal Network) information sheets relating to proportionate submission of evidence at appraisal and tracking scope of work for trainees.

The Trust Appraisal and Revalidation policy was revised and updated in March 2019 to reflect the use of the new Allocate e-appraisal software, the NHSE policy, to align with BSUH and clarify "due by" dates.

Improving the Inputs to Medical Appraisal (NHS England 2016)

This document provides guidance on the necessary supporting information for doctors undertaking their appraisal and includes templates and checklists and recommendations for those having annual reviews outside their designated body. Further guidance is provided on supporting information in the context of those undertaking low volumes of work and obtaining patient feedback in non-standard situations.

Information Flows to Support Medical Governance and Responsible Officer Statutory Function (NHS England 2016)

This guidance sets out the main channels along which information about a doctor's medical practice may need to flow, in support of good medical governance and the statutory duties of the responsible officer and in support of patient safety and quality of care. This guidance includes a pre-employment checklist with which WSHFT complies.

## 5.0 MEDICAL APPRAISAL

5.01 The Trust's medical appraisal rate for doctors with a prescribed connection to WSHT, as reported in the AOA (Annual Organisational Audit) to NHS England, has continued to improve and in the 2018/19 reporting period was 90.7%. This represents a rise of 10% in two years against a backdrop of an additional 66 doctors in the same period.

| | 2016/17 | 2017/18 | **2018/19** |
|---|---|---|---|
| Number of doctors | 431 | 466 | **497** |
| Number of completed appraisals | 347 (80.5%) | 399 (85.6%) | **451 (90.7%)** |
| Approved incomplete or missed appraisals | 57 (13.2%) | 45 (9.7%) | **41 (8.2%)** |
| Unapproved incomplete or missed appraisals | 27 (6.3%) | 22 (4.7%) | **5 (1.1%)** |

Missed and incomplete appraisals

There were 41 approved incomplete appraisals, 31 were LEDS (Locally Employed Doctors) whose appraisals have not been completed as they were not due or they had been in the Trust less than 3 months. The remaining 10 have acceptable reasons for missing an appraisal, such as long tern sickness, maternity or paternity leave.

This year, 5 doctors failed to complete an appraisal in the reporting year. One was issued a REV 6, one retrospectively informed the Revalidation Team of complex family issues, one was catching up from previous delayed appraisals, due to long term appraiser sickness, the remaining two were delayed without explanation. All have since had their appraisal.

As in previous years, time, work and life pressures affecting appraisees and appraisers were a

contributory factor to appraisals being missed or incomplete. Examples include reasons mentioned above, retirement and recent return to work of appraisees or recent appointment to post. Variations in speeds of uptake, familiarity and understanding of the Allocate system for doctors new to the Trust continue to generate delays, but this is improving.

The recent BDO audit highlighted the appraisal "due date" was open to significant variation in interpretation, which in some cases lead to delays in appraisal completion and sign off. This has been addressed in the Trust Policy.

5.02 Appraiser Numbers

There are currently 67 active appraisers, including the Medical Director, AMD, 5 Senior Appraisers, 8 Clinical Directors and all 4 Chiefs of Service. Since April 2018 seven doctors have attended new appraiser training and have been initiated into the role. A further 7 attended new appraiser training on 1st April 2019. Each appraiser is awarded 0.5 SPA towards their job plan. To maintain and develop their skills, appraisers are expected to undertake between 8 and 10 appraisals a year.

The Trust continues to provide appraisals for the two local hospices under a Service Level Agreement.

The revalidation team complies with the NHSE Medical Appraisal Policy (NHS England 2015) in that appraisers are allocated to appraisees. This helps even out the workload for appraisers.

5.03 Quality Assurance

The number of completed appraisals for 2018/2019 has increased from 399 in 2017/18 to 451. The number of linked doctors has risen from 466 to 497. The percentage appraised has increase to 90.7% from 85.6%.

Consultant and SASG doctor numbers are similar to last year and the return rate for appraisals in this group is 95%.

The temporary/short term contract holder numbers continues to increase from 92 in 2016/17, 128 in March 2018 to 155 in March 2019, of these 79% had an appraisal in the reporting period.

The Trust's quality assurance follows the NHS England Quality Assurance Framework.

<u>Quarterly Reporting</u>

Data on the appraisal rate is reported quarterly to NHS England by the Revalidation Manager.

<u>Annual Organisational Audit</u>

The 2018/19 Annual Organisational Audit (AOA) was submitted in May 2019 to NHS England. It enables benchmarking against other comparable organisations. The full report is not out yet for comparison purposes. Trend data to 2017 is available below, with a different format of trend data presented by NHSE up to 2018

# Annual Organisational Audit 2016/17

## South data

| | 2014/15 | 2015/16 | 2016/17 | Trend |
|---|---|---|---|---|
| Responses | 155 (100%) | 157 (100%) | 167 (100%) | ↑ |
| Connected doctors | 31,722 | 33,308 | 34,081 | ↑ |
| Appraisal rate | 88.5% | 87.5% | 91.6% | ↑ |



# AOA 2016/17: Appraisal rates (South)

**Previous year comparison**

| | 2015/16 | | 2016/17 | |
|---|---|---|---|---|
| | **Doctors** | **%** | **Doctors** | **%** |
| Complete | 29,128 | 87.5% | 31,210 | 91.6% ↑ |
| Incomplete or missing (approved) | 2,915 | 8.8% | 2,031 | 6% ↓ |
| Incomplete or missing (unapproved) | 1,263 | 3.8% | 840 | 2.5% ↓ |
| **Totals** | **33,306** | **100%** | **34,081** | **100%** |

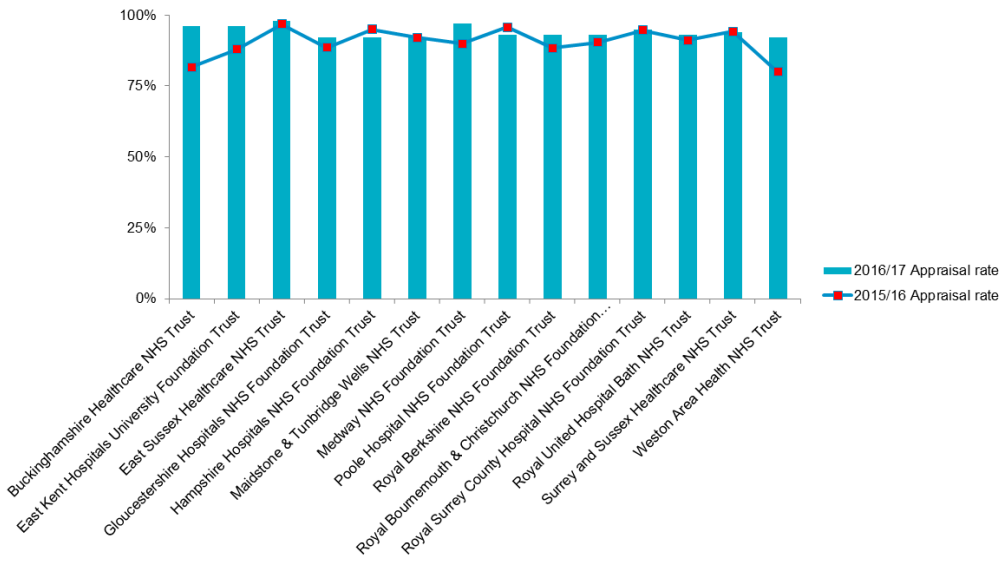
# AOA 2016/17: Appraisal rates

**South performance against national rates**

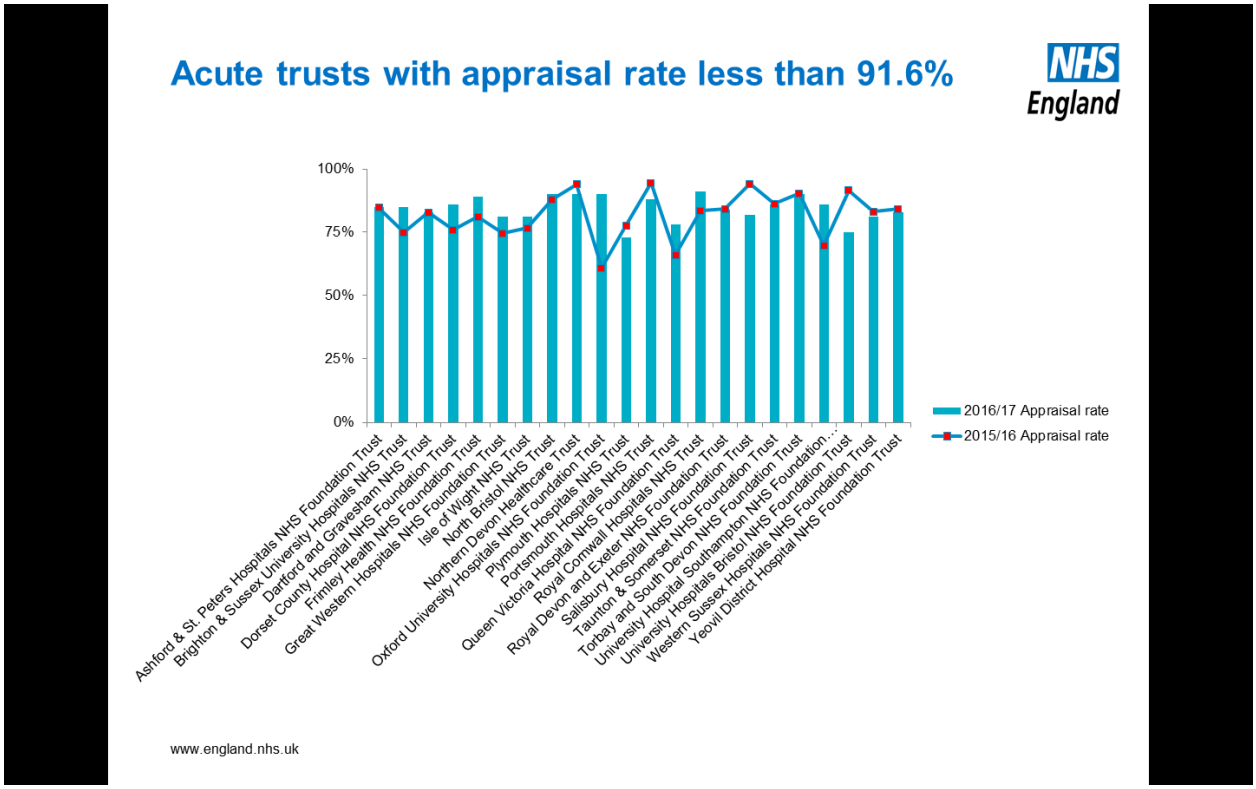
| Connected doctors | 2016/17 | |
|---|---|---|
| | National | South |
| Consultants | 91.7% | 91.6% |
| SAS | 87.0% | 89.6% |
| Performers List | 95.2% | 96.2% |
| Practising Privileges | 87.4% | 100% |
| Temporary/short term | 78.8% | 79.2% |
| Other | 91.2% | 93% |
| **Totals** | **90.7%** | **91.6%** |

www.england.nhs.uk

# Acute trusts with appraisal rate greater than 91.6%

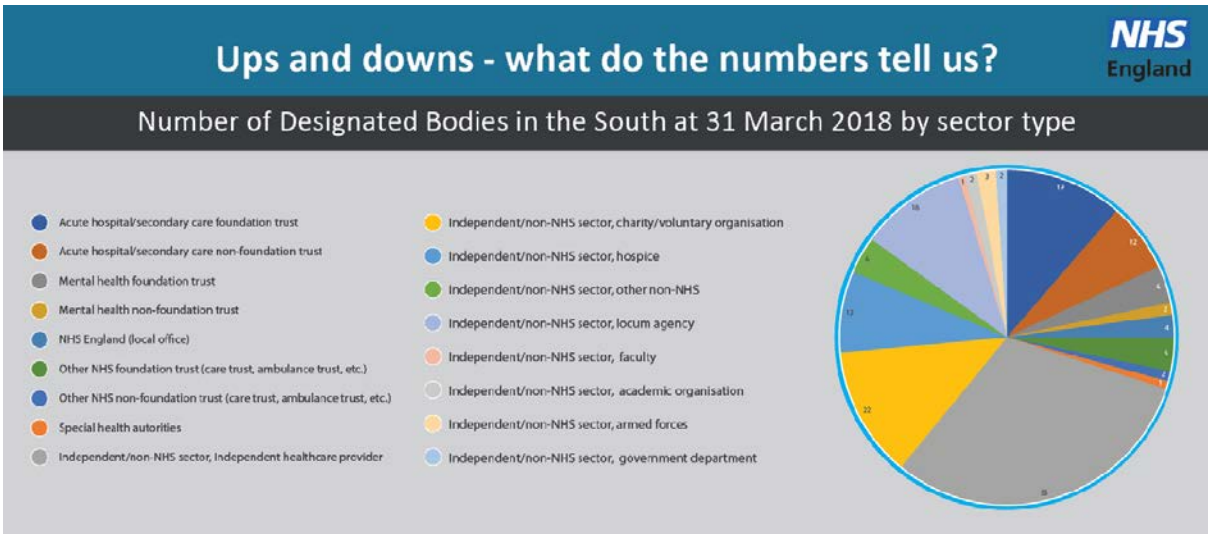



www.england.nhs.uk



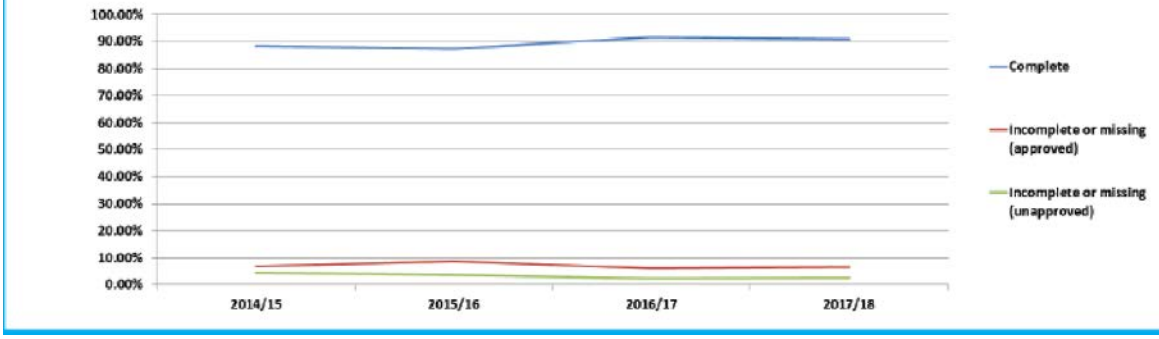

Last year (2017/18) WHSFT was below the national and regional average when compared to 2017. The 2017 graphs outline acute Trusts performance, with 14 being above the national average and 22 (including WSHFT) falling below. The organisations missing from the data set are smaller organisations such as hospices and smaller care groups, whose appraisal return is often 100%, tending to slightly skew results to larger Trusts disadvantage.

The 2018 AOA trend data is reported below.

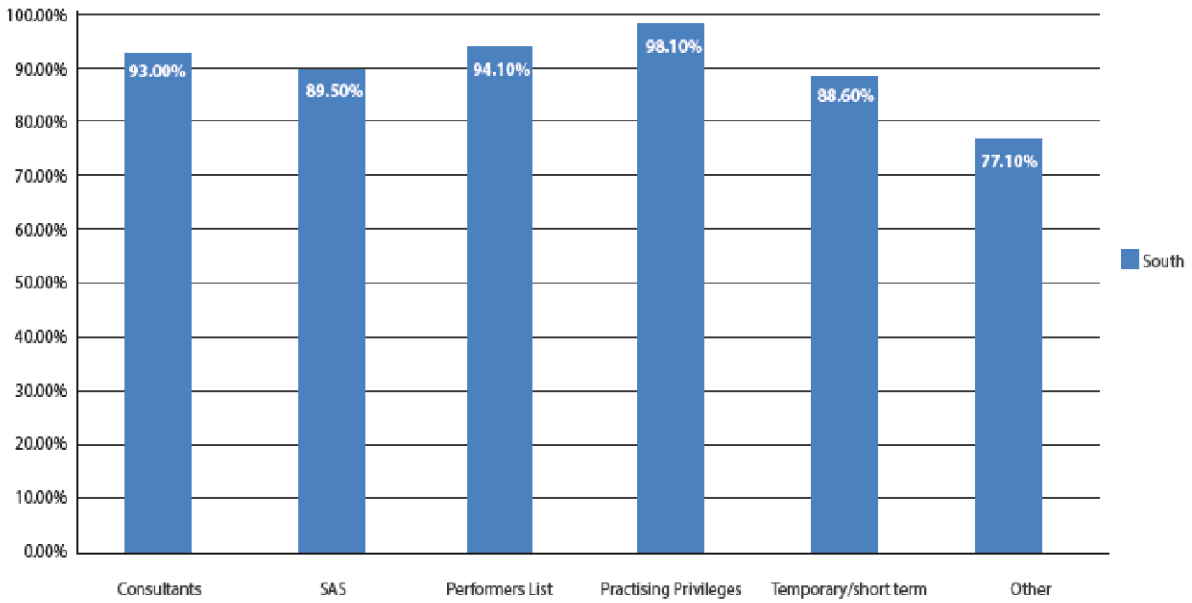


| | 2014/15 | | 2015/16 | | 2016/17 | | 2017/18 | |
|---|---|---|---|---|---|---|---|---|
| | Doctors | % | Doctors | % | Doctors | % | Doctors | % |
| Complete | 27,187 | 88.50% | 29,128 | 87.50% | 31,210 | 91.60% | 32,453 | 90.90% |
| Incomplete or missing (approved) | 2136 | 7% | 2,915 | 8.80% | 2,031 | 6% | 2,317 | 6.50% |
| Incomplete or missing (unapproved) | 1399 | 4.60% | 1,263 | 3.80% | 840 | 2.50% | 913 | 2.60% |
| Totals | 30,722 | 100% | 33,306 | 100% | 34,081 | 100% | 35,683 | 100% |

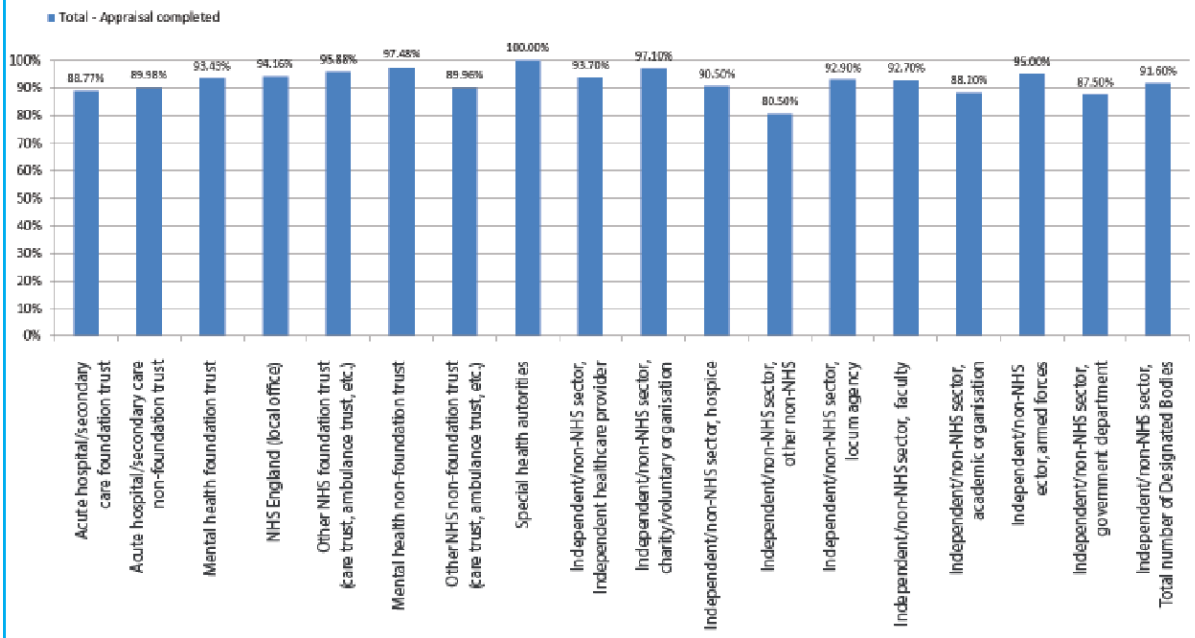
## Appraisal rates in the South region



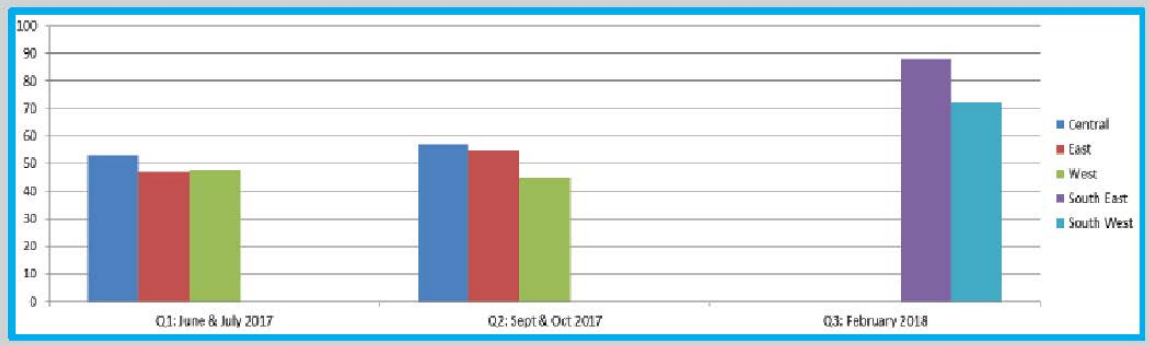

## Appraisal rates by doctor type



## South Region Appraisal rates by organisation type 2017/18




## Responsible Officer and Appraisal Leads network attendance 2017/18




The table top discussions with colleagues about the appraisal issues, hearing their experience and ideas for what is working for them. I thought the presentation about GP revalidation was really informative and helpful.

I liked the three wise "people" at the beginning. Well done, short and snappy and good handovers and subject matters.

I particularly liked, and will take away information, on doctors drifting into difficulty. This is a hugely important subject and was very well delivered.

Great opportunity to meet people and listen to how things are managed elsewhere and in different organisations. Helps bench mark where we are. I found the discussion about Performance assessment and how that can feed into appraisal useful and am considering a template for my organisation.

Most useful: Presentations by ROs on managing difficult cases and developing an appraisal system.

Take home message: Always cross reference your RO decisions

The advice for the 360 degree reflection for physicians who do not see patients and the GMC developments.

The pace and variety of the meeting is useful. Much of the interesting work occurs during the case discussions, either in plenary or small groups.

## Higher Level Responsible Officer Quality Reviews (HLROQRs)

The Higher Level Responsible Officer Quality Reviews ensure compliance and understanding of the RO regulations and are an excellent forum for sharing good practice, identifying challenges and discussing areas for improvement. Feedback is sought from the organisations, review teams and lay representatives - some of which is reflected below:

**HLROQRs started in 2015 (originally as Independent Verification Visits).**
**To date 151 Designated Bodies have had a review.**


**Of that number 44 organisations joined one of 11 'Small Designated Bodies' HLROQRs for those who had a small number of prescribed connections.**


In the 2018/19 reporting year, the WSHFT appraisal rate has improved to 90.7% with 96% for all permanent staff. There is further room for improvement, but this is mainly the short term and temporary LEDs. Our data compares favourably with appraisal rates for other acute hospitals in the region.

In two years, the number of completed appraisals has increased from 347 in 2016/17 to 451 in 2018/19

Future efforts will attempt to address temporary doctors' appraisal needs as part of improving the appraisal processes in general (see below)

<u>Quality assurance of appraisals</u>

The BDO audit of WSHFT appraisal processes in April 2018 highlighted that processes and quality of appraisal and appraisal processes were good in some areas with some recommendations for improvement. The full audit report is part of last year's AAR.

The WSHFT revalidation team introduced the concept of a "due by date" to encourage more timely completion of appraisal meetings, with some evidence of success. Improvements to the adequate completion of appraisal summaries, with improved PDP and reflection has been highlighted in appraisal update meetings, bulletins and supported by Senior Appraiser feedback using the ASPAT scoring tool where appropriate. This will be reviewed in a higher Level Responsible Officer Quality Review due in the autumn 2019

Complaints and Serious Incidents

There have been no complaints or serious incidents arising from appraisal or revalidation.

Quality assurance of Appraisers

Quality assurance is embedded during the recruitment and training processes for appraisers and senior appraisers. There are appraiser development updates, feedback to appraisers from appraisees and seniors appraisers as part of appraisers' scope of practice and at final sign off.

Recruitment

Appraisers are recruited using a job description and person specification. New appraisers discuss the role with the divisional senior appraiser and are required to attend an approved training course. New appraisers have an experienced appraiser sitting in for their first one or two appraisals, offering feedback and support in line with NHSE recommendations.

Appraiser development

There are two development workshops for appraisers each year. These include updates and information sharing from national appraisal updates and RO network meetings, presented by the AMD, senior appraisers or invited outside speakers.

Appraisal for Appraisers

The appraiser role is considered during appraiser's annual appraisal and forms part of these doctors' scope of practice. This includes a review of their appraisees' feedback.

Quality Assurance of appraisals

The senior appraisers review all appraisals for completeness and quality. They provide support and feedback to appraisers as part of the final sign off process (see below). This area of feedback was surveyed this year and appraisers and appraisees reported that senior appraisal advice to be helpful.

Final sign off

Final sign off continues to be a key role for senior appraisers who review each appraisal to ensure appropriate supporting information has been included and that appraisals reach the standards required for revalidation. The need for feedback is at the discretion of the senior appraiser, guided by the ASPAT tool and always given if the appraisal is returned for any reason or needs further work, which is a feature in built into the allocate system.

Following a successful appraisal completion or second/final sign off, it is possible to provide qualitative feedback via individual e-mail, but currently this has to be uploaded by hand into allocate. This limitation on the positive feedback loop element is something the revalidation team continues to discuss with Allocate Software. QA reference tools, provided by NHSE, help standardise and support this process.

Doctor's feedback on the quality of their appraisals

Appraisees are obliged to provide feedback about the organisation of the appraisal, the appraisal process and their appraiser. The Revalidation Team review the feedback and share /action as appropriate. Responses indicate continued high levels of satisfaction of the appraisal process by those being appraised.

5.04 Access, security and confidentiality

Information is held securely in the Allocate web-based appraisal folders and only accessible to appraisers, the relevant senior appraiser, AMD for revalidation and appraisal, responsible officer and revalidation administrators.

5.05 Clinical Governance

The Trust provides data for doctors undergoing their appraisal as a consultant data pack from the IT department. Other information available includes mandatory training status, declaration of interest and datix summary. Triangulation of employment HR details, Chief of Service and Line manager review, outstanding investigations and GMC notices occur via the RO checklist prior to a revalidation recommendation.

## 6.0 REVALIDATION RECOMMENDATIONS

6.01

| | 2017/18 | 2018/19 |
|---|---|---|
| Number of recommendations made | 35 | 104 |
| Recommendations completed on time | 34 | 103 |
| Positive recommendations | 21 | 98 |
| Deferral requests | 14 | 6 |
| Non-engagement notifications | 0 | 0 |
| Late recommendations | 1 | 1 |
| REV 6 submissions | 0 | 1 |
| Number of formal investigations carried out under MHPS | 4 | ? |

In 2017/18 3 deferrals were subsequently revalidated and in 2018/19, 2 deferrals were subsequently revalidated.

## 7.0 RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

7.01 The TRAC system provides a robust and auditable process for all recruitment including Medical Bank, fixed term and substantive posts (excluding Agency locums) for pre-employment and ID checks including Revalidation and RO references. As per guidance, transfer of RO to RO information is not requested until the new incumbent starts at the Trust.

7.02 Locum doctors

Locum doctors arranged through the Temporary Staffing team are sourced via NHS CPP National Clinical Staffing Framework and Crown Commercial Solutions (CCS) Framework Agencies, which are NHSi compliant and have responsibility for ensuring Locums comply with pre-employment requirements/checks.

If it is not possible to source a locum through either Framework Agency, the Division authorises the use of a non-framework agency, the Temporary Staffing Team will ask the Agency to complete a RO type reference and checklist to confirm that all the necessary checks have been fulfilled.

## 8.0 MONITORING PERFORMANCE

8.01 Doctor's performance is monitored at Clinical Lead, Divisional and Executive levels.

At divisional level, performance of individuals, teams and specialities are monitored through the monthly divisional operational and governance meetings and at the quarterly divisional governance reviews. These meetings incorporate service line management, complaints and litigation, risk reporting and mortality and morbidity data.

At executive level the medical director monitors Clinical Outcome Benchmarking data from Dr Foster including relevant alerts and handles any concerns that arise according to the Raising Concerns Policy.

Performance concerns can also be raised through the appraisal process and the process for this is defined in the Remediation and Re-skilling Policy. No serious concerns arose about performance at appraisal in the 2018/19 appraisal year.

## 9.0 RESPONDING TO CONCERNS AND REMEDIATION

9.01 *For the period April 2018 to March 2019 there were 2 formal investigations carried out under Maintaining High Professional Standards (MHPS). One of these led to no formal action and one is still in progress.*

*No members of medical staff were excluded from work or had formal restrictions on their practice imposed.*

*The Employee Relations team continue to support the informal management of concerns wherever appropriate, ensuring that advice is also sought from NHS Resolution and our GMC Liaison.*

## 10.0 RISKS AND ISSUES

10.1 Medical Appraisal Rates

The overall medical appraisal rate remains below the National target of 95%. The rate is better than previous years at 90.7% (up from 80% and 85.6%) and compares favourably with acute trust hospitals in the region.

The impact of increasing numbers of temporary/short term doctor numbers and not being able to discount doctors whose appraisal does not fall due, reduces the documented overall appraisal completion rate. The completion rate for permanent doctors is 96%, which may be hard to improve upon.

WSHFT overall completion rate has picked up following further clarification of the “due by date”. Moving “due by dates” away from the end of the reporting year has helped reduce late appraisals becoming missed appraisals and this process continues to be modified.

Using escalation processes, for delays in completion has, to date, been a rare intervention. For repeat offenders, it may become a necessary tool to use under the direction of the Medical Workforce Governance and Appraisal Group. In 2018/19, WSHFT sanctioned one REV6 (notice to the GMC of non engagement with appraisal). The issue is being resolved, does not involve patient safety concerns and is under review.

Since April 2017, monthly Strategy Deployment Review (SDR) meetings have taken place within each division. Appraisal is a key metric in the SDR scorecard, raising the profile of appraisal engagement with Clinical Leads. Counter measures are put place if the metric is red flagged. This process is helpful, but it does not directly correlate with the AOA metric requested by NHSE for completed and fully signed off appraisals related to due date.

## 11.0 EXECUTIVE TEAM REFLECTIONS (draft suggestions)

11.1 The number of doctors linked to WSHFT and the number of medical appraisals undertaken at the Trust has increased. It is noted on the Allocate software system; there is an increase in total number of linked doctors to WSHFT with a disproportionate increase in temporary/short term doctors including a higher proportion of overseas doctors working in the UK for the first time. Many of these doctors are encountering the GMC's enhanced appraisal process for the first time. Howard Lewis, from the GMC and Dr Adrian Richardson (SASG lead) have been looking at further support for this group of doctors.

This year's improved appraisal rate is anticipated to continue in the next reporting year by concentrating efforts to supporting the Locally Employed (short term and temporary) Doctors (LEDs)

Year on year increases 6.5% (18/19) 8.1% (17/18) and 3.5% (16/17) of doctors with a prescribed connection to the Trust, as the Designated Body, has been observed.

The overall Trust appraisal rate will be compared to the 2018/19 national average when the report becomes available, but at 90.7%% it is not far from desired target level of 95% and last year's national level of 90.9%.

Work will continue to raise the appraisal rate towards the desired level of 95%. We will continue to identify reasons for late appraisals and develop support for those doctors who need it.

The new Allocate system sends out reminders and facilitates identifying, chasing and supporting those falling behind. Timely reminders from the revalidation team follow. Subsequent escalation will be through the Medical Workforce Governance and Appraisal Group, set up in March 2018.

Over the last year appraisers have continued to meet the increase in demand and while significant progress has been made with doctors on temporary and short-term contracts there is more to do. Identifying a doctors appraisal needs after time away, working irregular hours on the bank, dipping in and out of training posts or returning from abroad continue to present a variety of challenges.

11.2 Corrective Actions, Improvement Plan and Next Steps

<u>Actions for the Trust in 2019/20 are shown below:</u>

- Provide Designated Body Statement of Compliance to NHS England
- Continue to liaise with Allocate Software team regarding system developments to improve and streamline the e-appraisal system.
- Prepare for up coming HLROQR visit (Autumn 2019)
- Continue work to raise the appraisal rate towards 95%, particularly focusing on Locally Employed Doctors (LEDs) and maintain the 96% appraisal rate achieved by permanent staff
- Ratify the Trust Appraisal Policy, updated March 2019
- Continue to develop the role of the Medical Workforce Governance and Appraisal Group

- Continue to develop and support the role of Senior Appraisers
- Continue the appraiser updates and bulletins
- Continue to disseminate RO network advice, updates

**Appendix 1**

**Designated Body Statement of Compliance**

The board of Western Sussex Hospitals NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   | Requirement satisfied |
   |---|

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   | Requirement satisfied |
   |---|

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   | Requirement satisfied |
   |---|

4. Medical appraisers participate in on-going performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   | Requirement satisfied |
   |---|

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   | Requirement satisfied |
   |---|

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   | Requirement satisfied |
   |---|

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   | Requirement satisfied |
   |---|

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

| Requirement satisfied |
|---|

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[3] have qualifications and experience appropriate to the work performed; and

| Requirement satisfied |
|---|

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

| Requirement satisfied |
|---|

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

[Chief Executive or Chairman a board member (or Executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _

[3] Doctors with a prescribed connection to the designated body on the date of reporting.

Western Sussex Hospitals
NHS Foundation Trust

| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 22 | **Meeting:** | Board | **Meeting Date:** | 25 July 2019 |
| **Report Title:** | **Company Secretary Report** | | | | |
| **Sponsoring Executive Director:** | | | Glen Palethorpe, Group Company Secretary | | |
| **Author(s):** | | | Glen Palethorpe, Group Company Secretary | | |
| **Report previously considered by and date:** | | | | | |
| **Purpose of the report:** | | | | | |
| Information | | ☐ | Assurance | | ✓ |
| Review and Discussion | | ☐ | Approval / Agreement | | ✓ |
| **Reason for submission to Trust Board in Private only (where relevant):** | | | | | |
| Commercial confidentiality | | ☐ | Staff confidentiality | | ☐ |
| Patient confidentiality | | ☐ | Other exceptional circumstances | | ☐ |
| **Link to Trust Strategic Themes:** | | | | | |
| Patient Care | | ✓ | Sustainability | | ✓ |
| Our People | | ✓ | Quality | | ✓ |
| Systems and Partnerships | | ✓ | | | |
| **Any implications for:** | | | | | |
| Quality | | | | | |
| Financial | | | | | |
| Workforce | | | | | |
| **Link to CQC Domains:** | | | | | |
| Safe | | ✓ | Effective | | ✓ |
| Caring | | ✓ | Responsive | | ✓ |
| Well-led | | ✓ | Use of Resources | | ✓ |
| **Communication and Consultation:** | | | | | |
| | | | | | |

**Executive Summary:**

This report provides the Board with a report on matters for which the Trust has complied with a NHS I or other regularly requirement. This report does not seek to duplicate matters that are subject to separate agenda items at today's board meeting.

**Annual report, quality account and financial statement**

The Trust was required to submit its audited annual report, quality account and financial statements to NHS I by noon on the 29 May. A further submission is required by the Trust to submit these as one combined file to NHS I by the 19 July. The Trust achieved these requirements.

The Trust has published its annual report and accounts on its web site at (https://www.westernsussexhospitals.nhs.uk/your-trust/about/annual-report/). The annual report will be presented to the public, members and governors at the Council of Governors meeting which is part of the Trust's Annual General Meeting on the 25 July.

**Quality Account**

The Trust was required to submit its audited quality account to NHS Choices by the 30 June and place this on the Trust's website. The Trust complied with this requirement and the quality account can be found on the their web site at https://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=1715).

**Learning from deaths report and annual report** (both are attached as an appendix to this report)

The Trust is required to receive reports on learning from deaths. The Board is reminded that the detail of this report has been scrutinised by the Quality Assurance Committee especially in respect of the Trust's processes for learning from the review of deaths. The focus for learning is to improve the Trust's processes. The outcome of this learning manifests itself in the Trust's mortality indices; these are tracked within the routine report to the Board as part of the Integrated Performance Report.

**Key Recommendation(s):**

The Board is recommended to

**NOTE** the Trust has complied with the requirements to submit the Trust's annual report and accounts to NHS I and has published these documents on its website.

**NOTE** the Trust has complied with the requirement to submit the Trust's Quality Account and published this on the NHS Choices web site and as part of the Trust's annual report it has been published on the Trust's website.

**NOTE** the Trust's learning from deaths report and note the learning identified from the structured judgement review process.

Western Sussex Hospitals
NHS Foundation Trust

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|---|---|---|---|---|---|
| **Agenda Item:** | 22 | **Meeting:** | Trust Board | **Meeting Date:** | 25 July 2019 |
| **Report Title:** | Learning from Deaths | | | | |
| **Sponsoring Executive Director:** | George Finlay Chief Medical Officer | | | | |
| **Author(s):** | Tim Taylor Medical Director, Simon Higgs Clinical Effectiveness | | | | |
| **Report previously considered by and date:** | | | | | |
| **Purpose of the report:** | | | | | |
| Information | ☐ | | Assurance | ✓ | |
| Review and Discussion | ✓ | | Approval / Agreement | ☐ | |
| **Reason for submission to Trust Board in Private only (where relevant):** | | | | | |
| Commercial confidentiality | ☐ | | Staff confidentiality | ☐ | |
| Patient confidentiality | ☐ | | Other exceptional circumstances | ☐ | |
| **Link to Trust Strategic Themes:** | | | | | |
| Patient Care | ✓ | | Sustainability | ☐ | |
| Our People | ☐ | | Quality | ✓ | |
| Systems and Partnerships | ☐ | | | | |
| **Any implications for:** | | | | | |
| Quality | Learning and quality improvement from the review of deaths | | | | |
| Financial | Nil | | | | |
| Workforce | Training requirements and time for individuals to undertake and respond to learning | | | | |
| **Link to CQC Domains:** | | | | | |
| Safe | ✓ | | Effective | ✓ | |
| Caring | ✓ | | Responsive | ✓ | |
| Well-led | ☐ | | Use of Resources | ☐ | |
| **Communication and Consultation:** | | | | | |
| A plan for communication is being developed | | | | | |

**Executive Summary:**

The purpose of the briefing is to update the Board of progress in the implementation of the structured approach for reviewing the deaths of patients to provide assurance on care and identify areas where it could have been improved

**Key Recommendation(s):**

The Board is asked to receive this report and note the learning identified from the structured judgement review process.

# Learning from Deaths

## 1. Screening of Deaths

1.1 The Trust currently screens deaths at consultant level using a set of prompts designed to cover broad areas where problems in care may occur with referral for Structured Judgement Review where appropriate.

1.2 In Quarter 475.5% of deaths were screened through this process at the time of this report.

1.3 In addition deaths occurring in categories as defined in the 'Learning from Deaths Policy' are automatically identified for SJR

1.4 It is recognised that the current process for screening is can lead to delays in identifying cases for full review. The Trust continues to aspire to move toward a daily review process. This has been delayed due to operational pressures and will take place in Quarter 2

## 2. Outcomes from Structured Judgement Reviews

Table 1 (LD refers to patients with learning difficulties)

| | Total Deaths (not LD) | Total Deaths Reviewed (not LD) | Avoidable Deaths* (not LD) | LD Deaths | LD Deaths Reviewed internally | LD Deaths Completed Reviews by LeDeR process | Avoidable LD Deaths* | Total % of deaths reviewed |
|---|---|---|---|---|---|---|---|---|
| **Jan 2019** | 210 | 14 | 0 | 2 | 2 | 0 | 0 | 6.6% |
| **Feb 19** | 161 | 28 | 0 | 0 | 0 | 0 | 0 | 17.4% |
| **March 19** | 191 | 20 | *1 | 2 | 2 | 0 | 0 | 10.5% |
| **Total (Q4 18/19)** | 562 | 64 | 0 | 4 | 4 | 0 | 0 | 9.7% |

*Death more likely than not due to problems in the care of the patients

*There has been one death identified in the SJR process in Q4 that was considered more likely than not due to problems in the care of the patient. *It should be noted that this case continues to be under investigation. It should also be noted that at the time of publication of this report there are still a number of other Q4 cases where preliminary review raised concerns about the quality of care undergoing further investigation and these will be included in future reporting.*

2.1 The Department of Health provides a dashboard for Trusts to use to publish data on the number of deaths that have been reviewed in their organisations. See Table 1. All deaths occurring in Quarter 4 referred for SJR have been reviewed.

2.2 The table above shows the Q4 18/19 data for WSHFT. LD refers to deaths in patients with learning disabilities. Note that 'LD deaths reviewed' refers to the external LeDeR process. All LD deaths have been reviewed internally. There are no completed LeDeR reviews for deaths occurring in Q4.

2.3 The SJRs review 6 discreet areas of care. Table 2 shows the level of care that the patients have been recorded as receiving across the reviews of deaths in quarter 4.

2.4 The SJRs also categorises problems into broad themes where issues identified. Table 3 shows these for deaths in quarter 4

Table 2: Data labels show the number of responses for the criteria

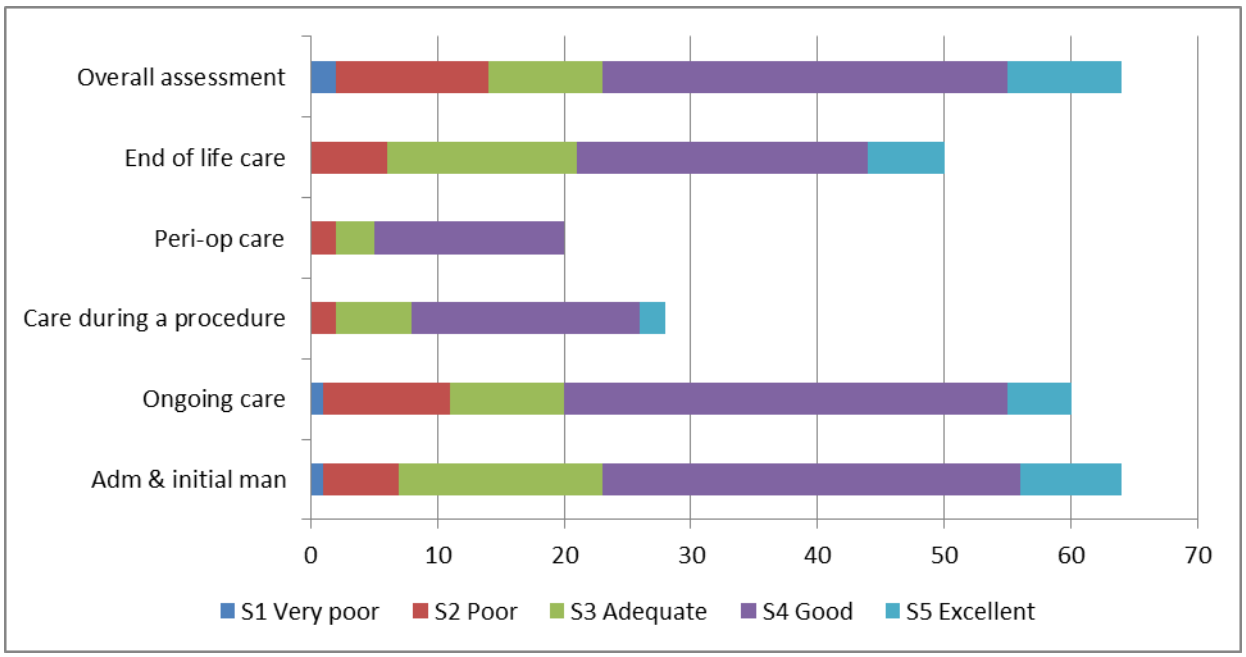
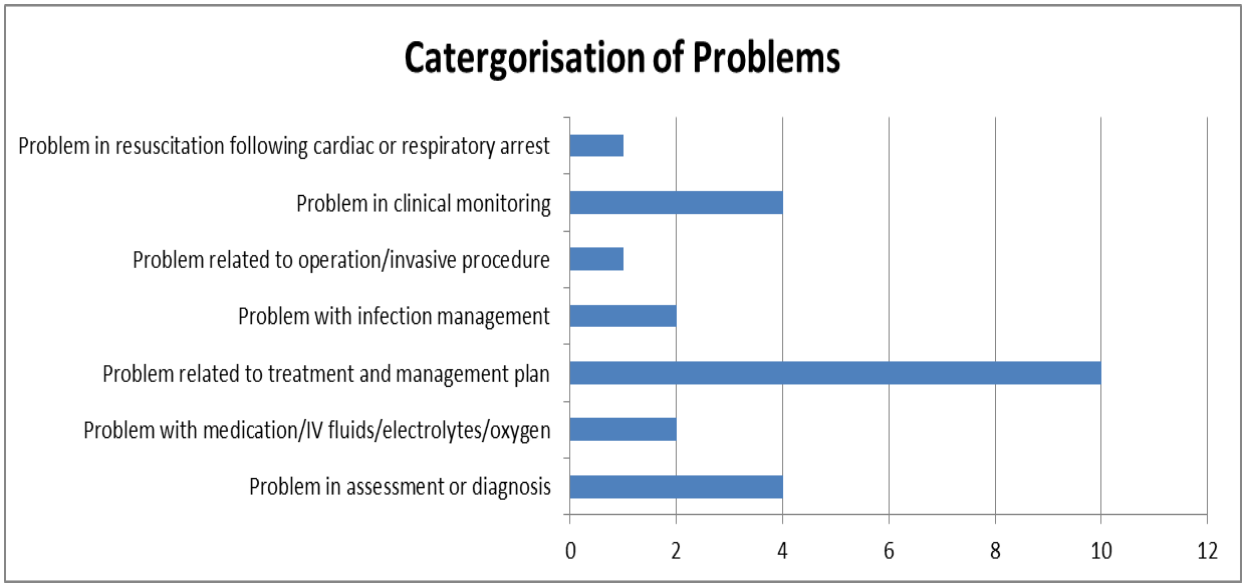



Table 3: Data labels show the number of responses for the criteria




**Structured Judgement Reviews Q4 - Learning**

| **Overall Care Score** | **Learning Themes** | **Actions** |
|---|---|---|
| Excellent Care | Examples of excellent best interest discussions, multidisciplinary teamwork and family/carer involvement in planning developing and implementing end of life plans. | Feedback to relevant clinical teams. Use as examples in training and to triangulation committee |

| Overall Care Score | Learning Themes | Actions |
|---|---|---|
| | Examples of the timely recognition of deterioration and treatment of sepsis | |
| Good Care | Examples of very well managed fractured neck of femur pathways in the very complex frail elderly patient<br><br>Examples of very good multidisciplinary working and communication<br><br>Example of good management of delirium and identification of cause in a very complex patient<br><br>Good example of best interest and end of life discussion related to learning disability<br><br>Examples of very clear escalation plans | Feedback to relevant clinical teams |
| Adequate Care | Late best interest discussions related to learning disability patients at end of life<br><br>Over intervention and unclear ceilings of treatment related to end of life.<br><br>Examples of delays in medical review post deterioration | Ongoing feedback to and liaison with the Learning Disability Strategy Group as part of the broader work Feeding into the End of Life strategy development. Mortality Steering Group has now merged with End of Life Board.<br><br>Use to inform work programme of the deteriorating patient group |
| Poor Care | Examples of late recognition and escalation in the deteriorating patient with particular emphasis on changing blood picture<br><br>Lack of monitoring of patients medically fit for discharge. Limited consultant review post fractured neck of femur and lack of documented pre-operative risk assessment<br><br>Lack of consultant review in the frail elderly surgical patient | Use to inform work programme of the deteriorating patient group Feedback to clinical teams. Raise issue through triangulation/ learning forums<br><br>Feed back to fractured neck of femur clinical groups. Progress standard reporting to groups from SJR process<br><br>Feedback to clinical teams. Raise issue through triangulation/ |

| Overall Care Score | Learning Themes | Actions |
|---|---|---|
| | | learning forums |
| Very Poor Care | Delay in recognition and treatment of deteriorating patient.<br><br>Problems with inter-departmental communication<br><br>Management of post procedural complication | This refers to a single case that is currently undergoing further review as a root cause analysis and will be presented at triangulation group and other learning forums once complete |

## 3. Capacity and Risk

3.1 For reviews of deaths occurring in Q4 capacity has remained an issue as a slightly revised way of working is established and new reviewers gain experience.

3.2 The newly appointed learning from deaths manager has been reviewing processes and the Trust will be piloting a daily review process Quarter 2 2019

## 4. Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)

4.1 For the 12 months to March 2019 performance using HSMR is 94.9 (with 100 being the expected). There have been no mortality outliers reported for WSHFT from the CQC or the Dr Foster Unit at Imperial College.


## 5. Progress and Next Steps

5.1 The newly appointed Learning from Deaths Manager has reviewed and mapped the current processes which is informing both changes to the review process and operational management.

5.2 Learning from Death case presentations are now a standing item on the Triangulation Committee agenda

5.3 A change in the current screening process to a 'daily' review process will be tested early in Quarter 2 2019 with view to rolling out across the organisation

5.4 Learning from review activity continues to be presented in a number of internal and external forums.

5.5 The newly amalgamated End of Life Board/Mortality Steering Group has met and has is establishing new terms of reference

**6. Recommendation**

6.1 The Board is asked to receive this report and note the learning identified from the structured judgement review process.

Western Sussex Hospitals
NHS Foundation Trust

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| **Agenda Item:** | 22 | **Meeting:** | Trust Board | **Meeting Date:** | 25 July 2019 |
| **Report Title:** | **ANNUAL LEARNING FROM DEATHS REPORT (2018-2019)** | | | | |
| **Sponsoring Executive Director:** | Dr George Findlay (Chief Medical Officer) and Dr Tim Taylor (Medical Director) | | | | |
| **Author(s):** | Simon Higgs, Head of Clinical Effectiveness | | | | |
| **Report previously considered by and date:** | N/A | | | | |
| **Purpose of the report:** | | | | | |
| Information | | | Assurance | ✓ | |
| Review and Discussion | | | Approval / Agreement | | |
| **Reason for submission to Trust Board in Private only (where relevant):** | | | | | |
| Commercial confidentiality | | | Staff confidentiality | | |
| Patient confidentiality | | | Other exceptional circumstances | | |
| **Link to Trust Strategic Themes:** | | | | | |
| Patient Care | ✓ | | Sustainability | ✓ | |
| Our People | ✓ | | Quality | ✓ | |
| Systems and Partnerships | ✓ | | | | |
| **Any implications for:** | | | | | |
| Quality | ✓ | | | | |
| Financial | ✓ | | | | |
| Workforce | ✓ | | | | |
| **Link to CQC Domains:** | | | | | |
| Safe | ✓ | | Effective | ✓ | |
| Caring | ✓ | | Responsive | ✓ | |
| Well-led | ✓ | | Use of Resources | ✓ | |
| **Communication and Consultation:** | | | | | |
| | | | | | |
| **Executive Summary:** | | | | | |
| The purpose of this report is to provide an annual overview of key themes, and outcomes arising from the Learning from Deaths process at Western Sussex Hospitals NHS Foundation Trust (the Trust) from the period of time beginning 01/04/18 until 31/03/19 (Q1-Q4). | | | | | |
| **Key Recommendation(s):** | | | | | |
| **The Board is asked to note the contents of this report** | | | | | |

Western Sussex Hospitals
NHS Foundation Trust

# ANNUAL LEARNING FROM DEATHS REPORT (2018-2019)

## Contents

# ANNUAL LEARNING FROM DEATHS SUMMARY REPORT 2018-19

## 1.0 INTRODUCTION

1.1 *In December 2016, the Care Quality Commission report Learning, candour and accountability* detailed concerns about the way NHS trusts investigate and learn from the deaths of people in their care, and the extent to which families and carers are involved in the investigations process.*

1.2 Following the publication of the report, the Department of Health and Social Care established the Learning from Deaths Programme Board, overseen by the National Quality Board, to implement the report's recommendations. In March 2017, the National Quality Board issued national guidance for NHS trusts on learning from deaths**. The purpose of the national guidance was to initiate a standardised approach on learning from deaths in NHS trusts providing acute, mental health and community health services. It included:

- The need to ensure governance arrangements and processes facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care
- The appointment of an executive director and non-executive director to take responsibility for oversight of progress
- Having a clear policy in place for engaging with bereaved families and carers

1.3 When death is the outcome of illness it brings great challenge for families and carers. Expected or not; the effect of losing a loved one and their experience of the care provided leading up to death will have a lasting effect. We therefore have a duty to families and carers to be advocates of their loved one who is no longer able to speak by being open, transparent and willing to learn the lessons that emerge from their clinical journey.

1.4 Western Sussex Hospitals NHS Foundation Trust (the Trust) is required to demonstrate accountability for effective governance and learning from deaths of patients not only whilst in their care but, in collaboration with other healthcare providers where actions or omissions may have contributed to death. The Trust is committed to making Learning from Deaths central to learning culture and governance processes

1.5 The learning from deaths work is clearly closely linked with the process of learning, candour and accountability related to the serious incident process. This report should therefore be considered with both the trusts patient safety strategy and the annual serious incident report 2018-19

1.6 The purpose of this report is to provide an annual overview of the activity, key themes and outcomes arising from the learning from deaths process from the period of time beginning 01/04/18 until 31/03/19 (Q1-Q4).

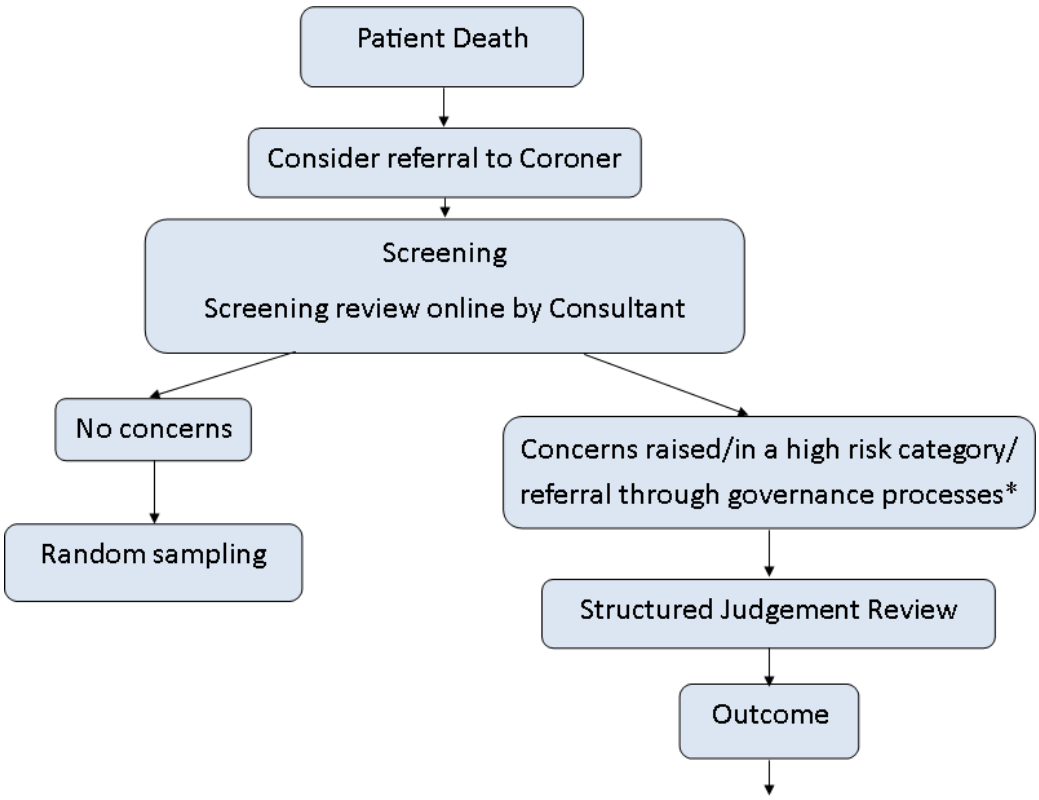
1.7 In 2018-19 the quality and governance process in relation to SI investigation, including management of the Duty of Candour (DoC) was reviewed. New policies were written, the methodology of investigation refreshed and improved, and a comprehensive accredited training programme implemented.

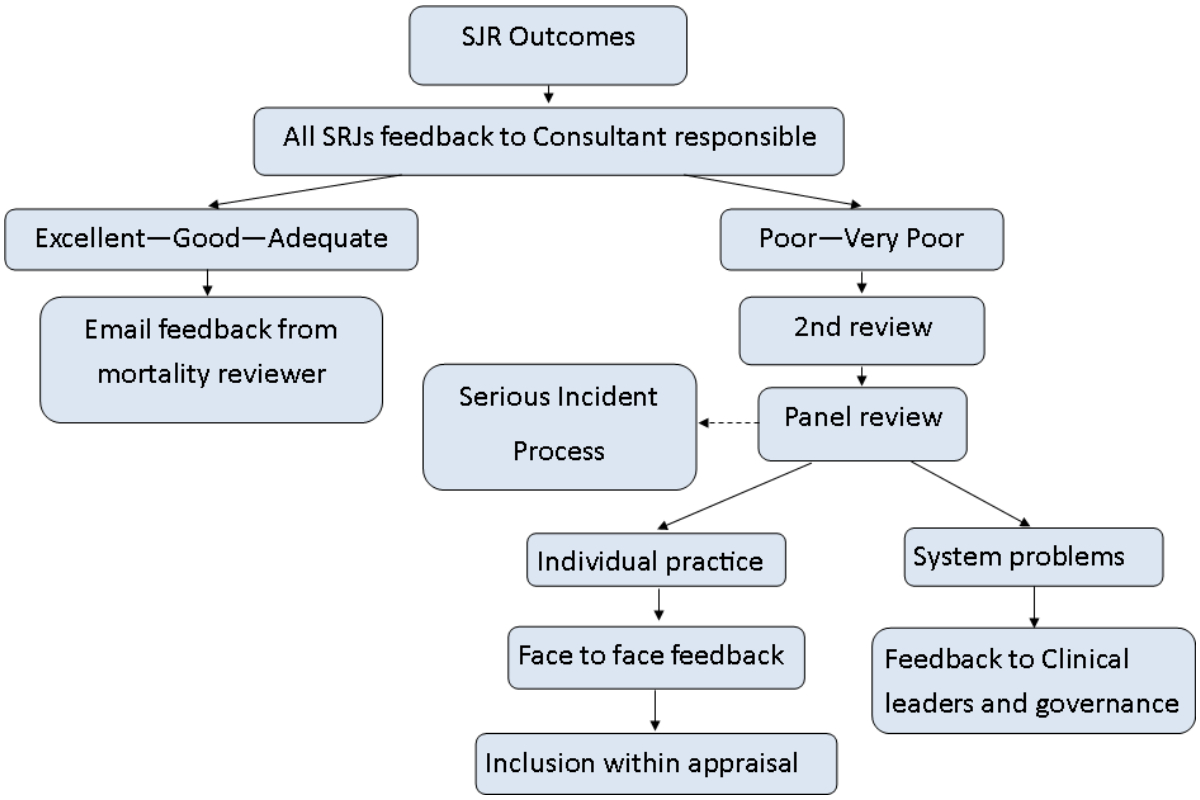
1.8 This report provides a summary of progress; providing assurance that appropriate clinical governance arrangements are in place and acknowledging that improvements are required in order to maximise the benefits of this learning process and imbed it as central to our learning and quality improvement processes

**Learning, Candour and Accountability- A review of the way NHS trusts review and investigate the deaths of patients in England, December 2016*

***National Guidance on Learning from Deaths – National Quality Board March 2017*

## 2.0 LEARNING FROM DEATHS METHODOLOGY






| Patient group | Inclusion/Methodology |
|---|---|
| Adult inpatient | Structured Judgement Review is undertaken for<br>• Any death where independent review has been requested as a result of screening<br>• All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision that has not been addressed<br>• All deaths of those with significant mental illness or learning disability<br>NB a modified SJR is being developed nationally for severe mental illness deaths which the Trust will adopt for appropriate cases once available<br>• All deaths in a speciality, particular diagnosis or treatment group where an 'alarm' has been raised either internally or via Dr Foster, CQC or any other external source<br>• Any death within 24 hours of surgery<br>• Any death where death would be unexpected eg following elective surgery or in low risk diagnostic groups<br>• Any death where any member of staff has raised a concern about care |
| Child (under 18) | Reviews of these deaths are mandatory and will be undertaken in accordance with *Working together to safeguard children* [1] (2015) and the current child death overview panel processes which is reflected in local policy for the management of |

| Patient group | Inclusion/Methodology |
|---|---|
| | sudden unexpected death in an infant or child http://nww.westernsussexhospitals.nhs.uk/assets/Unexpected-Child-Death-JAR-Pathway-2019.pdf |
| Learning disability | All deaths related to individuals with learning disabilities will be subject to a Structured Judgement Review. Additionally the Trust will also support the external LeDeR [2] reviews and actively participate as members of the Sussex LeDeR Steering Group. |
| Perinatal and maternity | All perinatal[4] deaths will be reviewed, using the new national perinatal mortality review tool . All maternal and perinatal deaths are will meet the definition of a Serious Incident and will be investigated accordingly in line with the local guideline on maternal death http://nww.westernsussexhospitals.nhs.uk/assets/cg1190-maternal-death-guideline-v4.pdf |

## 3.0 SCREENING OF DEATHS

3.1 The Trust currently screens deaths at consultant level using a set of prompts designed to cover broad areas where problems in care may occur and referral for Structured Judgement Review may occur through this process.

3.2 Between April 2018 and March 2019 a total of 885 of the 1113 (79.5%) adult inpatient deaths were screened by consultants using the electronic screening system.

3.3 The delays inherent in the current screening methodology are acknowledged and the Trust is planning to implement a daily review process with a view to rolling this out across the Trust in 2019-20. This will ensure that all deaths are screened in a timely way.

## 4.0 STRUCTURED JUDGEMENT REVIEW ACTIVITY AND OUTCOMES

4.1 The Department of Health provides a dashboard for Trusts to use to publish data on the number of deaths that have been reviewed in their organisations. **See Table 1**.

4.2 The table shows the Q4 18/19 data for WSHFT. LD refers to deaths in patients with learning disabilities. Note that 'LD deaths reviewed' refers to the external LeDeR process. All LD deaths have been reviewed internally. There are no completed LeDeR reviews for deaths occurring in Q4.

4.3 The SJRs review 6 discreet areas of care. Table 2 shows the level of care that the patients have been recorded as receiving across the reviews of deaths in 2018-19.

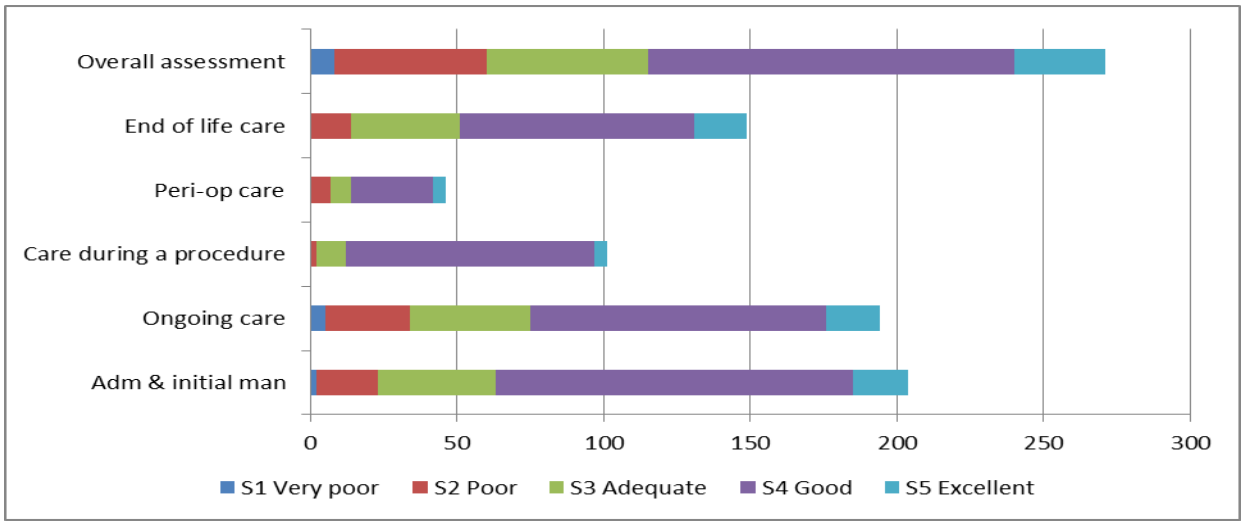
4.5 It should also be noted that at the time of publication of this report there are still a number of Q4 cases where preliminary review raised concerns about the quality of care undergoing further investigation and these will be included in future reporting.

4.6 **Table 1:** (LD refers to patients with learning difficulties)

| | Total Deaths (not LD) | Total Deaths Reviewed (not LD) | Avoidable Deaths* (not LD) | LD Deaths | LD Deaths Reviewed internally | LD Deaths Completed Reviews by LeDeR process | Avoidable LD Deaths* | Total % of deaths reviewed |
|---|---|---|---|---|---|---|---|---|
| **Quarter 1 2018-19** | 453 | 63 | 1 | 2 | 2 | 0 | 0 | 14.3% |
| **Quarter 2 2018-19** | 427 | 71 | 0 | 1 | 1 | 0 | 0 | 16.8% |
| **Quarter 3 2018-19** | 530 | 79 | 1 | 3 | 3 | 0 | 0 | 15.5% |
| **Quarter 4 2018-19** | 562 | 62 | *1 | 2 | 2 | 0 | 0 | 11.4% |
| **Total 2018/19** | 1972 | 275 | 3 | 8 | 8 | 0 | 0 | 14.0% |

- *There has been one death identified in the SJR process in Q4 that was considered more likely than not due to problems in the care of the patient. *It should be noted that this case continues to be under investigation. It should also be noted that at the time of publication of this report there are still a number of other Q4 cases where preliminary review raised concerns about the quality of care undergoing further investigation and these will be included in future reporting.*

4.7 **Table 2:** Data labels show the scores for each phase of care



## 5.0 LEARNING THEMES

5.1 Whilst the thematic learning highlighted in this report is focused on cases where poor care has been identified it is important to note that the review process also demonstrates that good and excellent care is also identified as part of this process. It is important that this good and excellent care is also acknowledged and the Trust is in the process of developing better ways of communicating this to staff and patients as part of the learning from deaths process

5.2 Below are the main learning themes from review activity together with the broad areas of action. These will be explored further in the full annual report

### 5.3 End of Life Care

- Late recognition of end of life
- Over intervention, lack of consideration of ceilings of treatment and unclear ceilings of treatment plans at end of life

Actions:

- Merging of the mortality steering group and end of life board to support the end of life strategy
- The Trust organised a collaborative end of life summit which agreed health economy wide priorities for improvement. These include the implementation of the national RESPECT tool
- Working with commissioners, primary care and academic partners to establish a research programme focused on over intervention at the end of life

### 5.4 Deteriorating Patients

- Late recognition of deterioration and delayed escalation
- Recognition and treatment of acute kidney injury and sepsis

Actions:

- Escalation prompts built into the Trusts track and trigger system (Patientrack) from next upgrade in Q2 2019
- Alerting using mobile technology has been successfully piloted and will be rolled out in Q2
- Programme of education has continued, led by the Trusts outreach teams which has included study days, themed weeks, simulation and the use of sepsis and AKI champions (AKI angels)
- Refresh of sepsis programme with a focus on emergency floors.

### 5.5 Senior Review

- Issues related to a lack of senior review

Actions:

- Part of a broader action plan as part of the work on 7 day services strategy

5.6 **Learning Disabilities**

The Trust has proactively supported the LeDeR review process both through regular attendance at the steering group hosted by Brighton and Hove CCG and supporting reviewers should information be required related to our contact with the individual.

- Delayed best interest and end of life discussions
- Communication
- Family/carer involvement in care

Actions:

- Establishment of a learning disability strategy group and lead
- Learning from reviews is informing the development of strategy

## 6.0 SHARING LEARNING

6.1 There is close liaison between the clinical effectiveness team who manage the learning from deaths process and the patient safety team. With the exception of the individual feedback given post reviews, the broader sharing of learning follows the process outlined in the serious incident annual report highlighted in figure 1 below.

6.2 It is recognised that there have been some limitations in sharing the learning from mortality review and the further development of this through standard speciality reporting closer liaison with speciality mortality and morbidity processes is a priority area for development in 2019-20

**Figure 1:** Process for shared learning:

6.3 The Trust has proactively shared learning from both the process and reviews across a wider number of forums including:

- Commissioners as part of routine performance monitoring forum
- Primary care through GP education forum
- Kent, Surrey and Sussex AHSN through various networking events

## 7.0 PRIORITIES FOR THE LEARNING FROM DEATHS PROCESS 2019-20

- Pilot and staged implementation of a daily mortality review process in order to:
    - o Reduce time between death and identification of problems in care
    - o Better targeting of structured judgement review activity
    - o Provide greater support for junior doctors
    - o Support the bereavement team process
- Continue to develop better ways of sharing learning with staff at all levels

## 8.0 RECOMMENDATION

The Trust Board is asked to NOTE the contents of this report.

Simon Higgs
Head of Clinical Effectiveness

July 2019