Western Sussex Hospitals
NHS Foundation Trust

Meeting of the Board of Directors

10:30 to 13:15 on Thursday 30 May 2019

John Bull Conference Room, Worthing Hospital Education Centre, Worthing Hospital, Lyndhurst Road, BN11 2DH

AGENDA – MEETING IN PUBLIC

1.	10:30	**Welcome and Apologies for Absence** To note	Verbal	Chair
2.	10:30	**Declarations of Interests** To note	Verbal	All
3.	10:30	**Minutes of Board Meeting held on 28 March 2019** To approve	Enclosure	Chair
4.	10:35	**Matters Arising from the Minutes** To note	Enclosure	Chair
5.	10.40	**Report from Chief Executive** To receive and note overview of the Trust's activities	Enclosure	Marianne Griffiths
6.	10.50	**2019/20 Operational Plan** To receive	Enclosure	Oliver Phillips
		INTEGRATED PERFORMANCE REPORT		
7.	11:00	**Introduction from Chief Executive** To receive and note overview of the Trust's activities	Enclosure	Marianne Griffiths
8.	11:05	**Quality Performance** To receive and agree any necessary actions	Enclosure	George Findlay Maggie Davies
9.	11:15	**Organisational Development and Workforce Performance** To receive and agree any necessary actions	Enclosure	Denise Farmer
10.	11:25	**Financial Performance** To receive and agree any necessary actions	Enclosure	Karen Geoghegan
11.	11:35	**Operational Performance** To receive and agree any necessary actions	Enclosure	Amanda Fadero
		ASSURANCE REPORTS FROM COMMITTEES		
12.	11:45	**Report from Finance and Performance Chair** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
13.	11:50	**Receive report from Audit Committee Chair** To receive assurance from Committee and recommendations from the Committee	Enclosure	Jon Furmston

		SERVICE PRESENTATION		
14.	11:55	**Women and Children's Service Presentation** To receive assurance over application of patient first processes	Presentation	Division
		OUR PEOPLE		
15.	12.10	**Equality and Inclusion paper** To endorse planned actions	Enclosure	Denise Farmer
		QUALITY		
16.	12.20	**Quarter 4 Learning from Deaths Update** To receive and agree any necessary actions	Enclosure	George Findlay
17.	12:30	**Annual Patient Experience Report** To receive activity information for 2018/19	Enclosure	Maggie Davies
		WELL LED & COMPLIANCE		
18.	12:45	**Annual Provider License Self Certifications** To approve for publication on the web site	Enclosure	Glen Palethorpe
		OTHER		
19.	12:50	**Any Other Business** To receive and action	Verbal	Chair
20.	13:00	**Questions from the public** To receive and respond to questions submitted by the public	Verbal	Chair
21.	13:15	**Date and time of next meeting:** The next meeting in private of the Board of Directors is scheduled to take place at **9:30** on **25th July 2019** in the Bateman Room, CMEC, St Richard's Hospital, Chichester.	Verbal	Chair
22.	13:15	**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*		

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 11.30am on Thursday 28 March 2019, Mickerson Hall, Chichester Medical Education Centre, St Richard's Hospital, Spitalfield Lane, Chichester, PO19 6SE

Present:	Alan McCarthy	Chairman
	Patrick Boyle	Non-Executive Director
	Mike Rymer	Non-Executive Director
	Joanna Crane	Non-Executive Director
	Martin Sinclair	Non-Executive Director Adviser
	Kirstin Baker	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
	Nicola Ranger	Chief Nurse & Patient Safety Officer
	Pete Landstrom	Chief Delivery & Strategy Officer
	Jayne Black	Chief Operating Officer
In Attendance:	Glen Palethorpe	Group Company Secretary
	Tanya Humphrys	Board Administrator

TB/03/19/01 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/03/19/02 Declarations of Interests

2.1 There were no declarations of interest.

TB/03/19/03 Minutes of Board Meeting held on 31 January 2019

3.1 The Board received the minutes of the meeting held on 31 January 2019.

3.2 The Chairman advised the Board that in the minutes of the January meeting comments from John Thompson had not been captured. The Chairman apologised to John who was in attendance, and advised that going forward all comments would be captured correctly.

3.3 **The Board resolved that the minutes of the Board meeting held on 31 January 2019, would be approved as a correct record of the meeting and signed by the Chairman.**

TB/03/19/04 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/03/19/05 Chief Executive's Report

5.1 Before Dame Marianne Griffiths presented her report, the Chairman took the opportunity to congratulate her on being named CEO of the year by the Health Service Journal for the second year in a row. Marianne thanked

the Chairman for his kind words, commenting that it is an award that should go to the team.

5.2 Marianne went on to present her Chief Executives Report and begun by highlighting the Trusts initiative for the 'Perfect Month' in March to end the financial and performance year with a special focus on Referral to Treatment Time (RTT), cancer waits and patient flow during the month. Marianne explained that staff had made a concerted effort over the last 10 days with the Trust averaging almost 98% for A&E targets, and that all the extra effort will enable us to end the year in the best position possible.
The Board was advised that the latest Staff Survey keeps Western Sussex Hospitals in the top 20% of Trusts, with our highest ever staff engagement score. Marianne commented that it was really encouraging that so many staff take the time to complete the annual staff survey.

5.3 Marianne highlighted to the Board the recent opening of the Maternity Bereavement Suite at Worthing Hospital, the Board heard that the new suite will offer a home from home environment with a private entrance away from the main delivery suite. Marianne commented that it epitomised empathy and care and thanked the charity and all those involved for their efforts.

5.4 Marianne congratulated the Trusts Research nurses who recently won an award for being the 'Top Recruiter' of participants into a national study and the the Research & Development team has won two awards at the Partner Research Awards, organised by the National Institute for Health Research (Kent, Surrey & Sussex). Head of research, Dr Cate Bell, was a joint winner of the Improvement & Innovation Award, while clinical trials nurses Linda Folkes and Carla Lewis won the Involving Patients in Research Award.

5.5 The Trust recently invited the CQC back to the Trust for an engagement event with the Women and Children's division, the division received very good feedback following the visit.

5.6 Marianne took the opportunity to thank Nicola Ranger for all her hard work in the two years she has been with the Trust noting that she will be leaving in the Summer. The Board was advised that the chance to review the management structure was taken with news of Nicolas departure, as a result the Trust along with Brighton and Sussex Univerity Hospitals NHS Trust will be moving to a Chief Nurse on each site. Marianne explained that the recruitment process for WSHFT had just concluded and that she was delighted to share that Dr Maggie Davies had been appointed as the Trusts new Chief Nurse.

TB/03/19/06 Quality Report – Month 11

6.1 George Findlay introduced the Quality Report and highlighted the following key points.

6.2 The Board was advised that crude non-elective mortality reduced from 3.28% reported in January to 2.81% reported in February, also remaining lower than the equivalent month in 2018. The year to date mortality rate is 2.64% and the rolling 12 month mortality rate is 2.96%.

6.3 In relation to HSMR the remains a gap in respect of being within the top performing Trusts, but this is slightly smaller than previously for the twelve months to October 2018 (benchmark period July 2018), performance places the Trust on the 22nd centile (29 out of 133 Trusts).

6.4 George noted that the number of patients being screened for dementia that are staying over 72 hours had seen a drop in performance, but assured the Board that the Trust was expecting to see an improvement in the next few months

6.5 The Board was advised that there was ongoing work between the Chief Operating Officer and the Divisions to ensure that there are always Stroke beds available as the Trust continues to improve its SNNAP performance data.

6.6 Nicola Ranger updated the Board on areas of patient safety noting that to date the Trust has had 31 cases of Clostridium Difficile which was still within the annual maximum target of 38.

6.7 It was noted that there had been a lot of work taking place on the wards in relation to pressure care particularly on the Ortho-geriatric wards, Nicola explained that there was joint learning with the Community Trust due to the number of patients being admitted with existing pressure ulcers.

6.8 Nicola explained to the Board that there had been a decrease in the number of mixed sex breaches across the Trust for February and although the Trust was striving to improve the trajectory, Nicola stressed that making the best clinical decision for the patient was the primary concern.

6.9 Mike Rymer commented that it was good to see an improvement against the TIA target but highlighted the increase in cancelled clinics within 6 weeks. George commented that the processes and policies remained the same but that there was ongoing work to look into this further in order to rectify the issue.

6.10 Patrick Boyle commented on the deterioration in the response times to formal complaints highlighting that this was an area the Trust was previously doing well in. Nicola acknowledged that the decline was a concern and noted that there had been some capacity issues in the Pals and Complaints team, in addition that extra support was being arranged for the Surgery Division due to this being where the greatest deterioration was.

6.11 Marianne Griffiths highlighted that the Trusts Family and Friends Test results have improved considerably when compared to not only the previous year but also when compared regionally and nationally. Marianne commented that the Board needs to recognise that the drop in figures is a sign of a busy winter and that the teams should all be commended.

6.12 The Board **NOTED** the Performance Report for Month 11.

TB/03/19/6a Quality and Risk Committee Report to Board

6a.1 Joanna Crane presented the report from the Quality and Risk Committee (QRC) held on 08 March 2019.

6a.2 The following items were discussed at the Committee meeting:

- The Quarter 3 Patient Experience Report for 2018/19 was discussed, which is now going to be a standing item on the QRC agenda. The maternity inpatient Survey was a highlight with very positive results.
- Following a recent Audit Committee action the QRC was notified of 55 clinical areas that now had secure lock boxes for patients to keep their property securely.

- The Committee received the Annual Clinical Audit Plan for 2019/20, which links closely to a number of CQC Key Lines of Enquiry (KLOE). In addition it was noted that lessons learned as a result of SIRIs will be more closely linked to future Clinical Audit activity.
- Joanna advised the Board that there had been an improvement in the compliance with NICE Guidance, but noted there was still more to do.

6a.3 Mike Rymer highlighted to the Board that the QRC had also received a very assuring update from Dr Colin Spring, Chief of Surgery Division, on the progress the Trust has made against the actions from the British Orthopaedic Association visit one year ago.

6a.4 The Board thanked Joanna for the report and **NOTED** its content.

TB/03/19/07 Performance Report – Month 11

7.1 Jayne Black introduced the Performance Report.

7.2 The Board was advised that for Month 11 the Trust had seen over 900 additional attendances in A&E which is an increase of 9.11% on the previous year, Jayne commended the teams on their hard work and resilience during this busy period.

7.3 It was noted that nationally A&E did relatively well and at the time of the meeting, for March, the Trust had achieved 94.86% against the National Constitutional target in A&E, making it 94.17% year to date and for the week 98.45%.

7.4 Jayne explained to the Board that in relation to ambulance handovers and conveyances the Trust had seen an increase equating to approximately 10 additional ambulances a day.

7.5 Jayne highlighted that a great deal of work had taken place in “Perfect March”, particularly around stranded patients and the ongoing work within the system to improve Delayed Transfers of Care (DTOCs), it was noted that there had been a slight reduction in DTOCs in March.

7.6 The Board was advised that the Trust had maintained its target of keeping Referral to Treatment waiting times below the level in 2018, Jayne explained that the Trusts target was 85.2% and that the departments we were working tirelessly to try and achieve this.

7.7 George Findlay commented that theatre productivity had also improved with a nearly 80% increase in improvement, which will help enable the RTT recovery plan for 2019/20. Jayne explained that the Surgery Division had moved a large proportion of theatre lists over to Southlands; this helped the Trust achieve 95% utilisation.

7.8 The Chairman commented that in the context of reginal and national performance the Trusts performance was fantastic.

7.9 The Board **NOTED** the Performance Report for February.

TB/03/19/08 Organisational Development and Workforce Transformation Report – Month 11

8.1 Denise Farmer presented the Workforce Report for Month 11.

8.2 The Board was advised that Workforce capacity increased to 97% of the

budgeted establishments in February. Denise explained that in Month 11, overall workforce spend was £24.96m. This is slightly higher than Month 10 and £56k above budget. Year to date, the paybill remains £2.7m adverse to the budget. Medical workforce spend continues to drive the adverse position and whilst agency spend overall was at its lowest during 2018/19, medical agency spend had deteriorated in month.

8.3 Denise explained that there was currently work underway to complete a self-assessment against the NHSI Job Planning Attainment Levels.

8.4 It was noted that from the 01 April the Electronic Staff Record would be available for all staff providing more accurate and accessible information, in addition that the Trust would be moving to electronic pay slips from this date.

8.5 There is ongoing work within the Trust to improve appraisal rates, it was noted that the current policy has been reviewed to ensure that it continues to align to patient first and the new pay progression framework.

8.6 Denise highlighted that the Trust had once again performed well in the National Staff Survey and is once again in the top 20 Trusts nationally. It was highlighted that Estates and Facilities had made considerable progress in engagement and that violence and aggression was going to be a corporate project for 2019/20.

8.7 Denise drew the Boards attention to Appendix 1, Gender Pay Gap Report, noting that there had been some movement from the previous year, however that the majority of Trust staff were on Agenda for Change (AfC) pay contracts.

8.8 Denise explained that the Trust is supporting the development of female staff on Agenda for Change contracts in addition to supporting medical and dental staff around this year's Clinical Excellence Awards with the completion of applications by female staff.

8.9 The Chairman asked Denise if she had concerns regarding the reported gender pay gap. In response she explained that yes because there was a gap, however noted that it was due to the NHS having a national payscale and the way the national clinical excellence awards work

8.10 The Board **NOTED** the Workforce Report for Month 11.

TB/03/19/09 Financial Performance – Month 11

9.1 Karen Geoghegan presented the Financial Performance Report.

9.2 In February the Trust reported a deficit of £0.59m excluding Provider Sustainability Fund income (PSF) for the month.

9.3 The year-end control total is a surplus of £1.185m and achievement of the control means that the Trust will be eligible for £5.7m of PSF income.

9.4 The Trust is forecasting achievement of the control, however, this will be challenging and will require close management of a number of operational and contractual risks

9.5 Karen explained that pay remains the greatest challenge at £1.7m above plan, it was noted that the Trust has seen some improvement with agency spend at its lowest level all year at £3.9m below the ceiling limit.

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9.6 Karen highlighted to the Board that over the previous three years the Trust had reduced agency spend by 52%, which is a significant achievement,

9.7 The Board was advised that Capital spend has been consistently behind plan; however there has been a lot of spend in the last few weeks which will see this achieve its plan.

9.8 The Trust is reporting a Financial Suitability Risk Rating of '1', the best a Trust can we awarded.

9.9 The Board thanked Karen for the Financial Performance Report for month 11 and **NOTED** the report.

TB/03/19/10 CNST ATAIN Action Plan

10.1 Nicola Ranger introduced the CNST ATAIN Action Plan, explaining to the Board that in 2018/19 maternity did very well with the action plan, as a result gained nearly £1m.

10.2 The Board was advised that the Trust was striving to do this for a second year, with the aim to improve maternity and neo-natal safety.

10.3 As part of the action plan the Board is required to have oversight of the Trusts safety initiative, Nicola explained that the initiative is to decrease the number of full term babies that go to the neo-natal unit for care.

10.4 It was noted that NHSI have advised following a review of patient safety reports nationally, neonatal hospital admission data and litigation claims data, the areas of focus for avoiding term admissions are:

- Respiratory conditions
- Hypoglycaemia
- Jaundice
- Asphyxia

10.5 Mike Rymer commented that it was good to see the progress and suggested that oversight of the action plan be through the Quality Assurance Committee. The Board agreed this would be the correct governance process for oversight to be provided.

10.6 **ACTION:** Quality Assurance Committee to take lead oversight of the CNST ATAIN Action Plan and report up to Board. **JC/TH**

10.7 The Board **NOTED** the CNST ATAIN Action Plan.

TB/03/19/11 Use of Trust Seal

11.1 Glen Palethorpe presented to the Board the Use of the Trust Seal for the period of April 2018 to March 2019.

11.2 The Board was advised that it is a requirement of the Trust Standing Orders that a register of sealing is maintained, its use is affixed in the presence of two senior employees duly authorised by the Chief Executive and that the use of the Common Seal is reported to the Trust Board.

11.3 It was noted that the seal had been used three times in the period stated and had been used in accordance with the Trusts Standing Orders.

11.4 The Board **NOTED** the report detailing the Use of the Trust Seal.

TB/03/19/12 Board Assurance Framework

12.1 Glen Palethorpe presented the Board Assurance Framework (BAF) for Quarter 4.

12.2 Glen explained that the report shows the movement from Quarter 3 to its current position at Quarter 4 and was received by the Trust Executive Committee (TEC) in March.

12.3 It was noted that there would be further movement reflective of assurances received today specifically in respect of the financial risks and these would be reflected in the year end information used to support the Trust's Annual Governance Statement.

12.4 In summary the Trust has been assured that it has managed seven of its BAF risks to their stated target risk scores. There remain four risks that are above their target score.

12.5 For the two with significant current risk scores there are actions being undertaken across the month of March which are planned to reduce these risks and assurance will flow through the Finance and Performance Committee to their April meeting.

12.6 This updated information will be fed through to the Annual Governance Statement which will be brought to the Board in May.

12.7 Marianne Griffiths referred to risk 1.1, commenting that the Trusts Friends and Family Test is performing well against the national targets, in addition patient safety is very good. Therefore, although there has been a slight deterioration Marianne felt strongly that this risk should be deescalated as it was significantly higher than it needed to be.

12.8 Glen advised that the risk reflected the current point in time but assured the Board he would pick up the comments and reflect those in the final risk score reflected in the Annual Governance Statement . **GP**

12.9 **ACTION:** Risk 1.1 to be deescalated to reflect the comments made by the Board.

12.9 The Board **NOTED** the Quarter 4 Board Assurance Framework.

TB/03/19/13 STP Population Health Check

13.1 Dame Marianne Griffiths introduced the Sustainability Transformation Partnership – Population Health Check.

13.2 Marianne explained to the Board that the STP had requested that the paper be shared to all Boards in a transparent way. The Population Health Check represents a diagnostic for our system and highlights the priority areas that need focus to allow health and care services to better meet the needs of our populations. It builds on local plans and intelligence and aims to provide a unified picture of the key areas for change across the health and care system.

13.3 There are five priority areas highlighted in the Health Check:

- Workforce and capacity strategy
- Shared decision-making and patient activation
- Re-framing our cultural norms to make the right lifestyle choices easy

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to make.
- Addressing unwarranted clinical variation.
- Mental and physical health services and social services closer to home with good communication and co-ordination.

13.4 Marianne advised the Board that at this stage the paper was for information but that going forward it would inform the acute strategy in our area.

13.5 The Chairman commented that it was a very good read and was a clinically led diagnosis of what needs to change within the Health system.

13.6 The Board **NOTED** and **RECEIVED** the STP Population Health Check Report.

TB/03/19/14 Terms of Reference

14.1 Glen Palethorpe introduced the Terms of Reference.

14.2 Glen explained that the Terms of Reference (ToR) for the Quality and Assurance Committee and Finance and Performance Committee were being brought to the Board for final ratification.

14.3 It was noted that both sets of ToR had been received, reviewed and approved by the respective Committee members. They were presented alongside ToR for Audit Committee, Charitable Funds Committee and Appointment and Remuneration Committee ToR to allow the Board to see the full suite and the interlinkage between Committees.

14.4 George Findlay commented that the QAC terms of reference would need to reflect the change in position to Chief Nurse, once Dr Maggie Davies is in post.

14.5 **ACTION:** QAC Terms of Reference to be amended to reflect Chief Nurse, at the end of June when the change takes effect. **GP**

14.6 The Board **APPROVED** the revised Terms of Reference for the Quality Assurance and Finance and performance Committees.

TB/03/19/15 Other Business

15.1 There was no other business to discuss.

TB/03/19/16 The Chair formally closed the meeting

TB/03/19/17 Questions from Members of the Public

17.1 Lead Governor, Roger Hammond expressed his thanks to Nicola Ranger for all the work that she has done for the Trust in the time that she has been with WSHT.

17.2 Roger went on to advise the Board that he had recently heard of the death of a friend at Worthing Hospital, the family had expressed how delighted they had been with the compassionate care that had been provided by staff at all stages.

17.3 Member of the public, Roger Keyworth advised the Board of the superb treatment he had recently received when visiting the hospital as a patient, commenting that the visit had been “first rate”.

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TB/03/19/18 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/03/19/19 Date of Next Meeting

19.1 It was noted that the next Board Meeting would take place on **Thursday 30 May 2019** in the **John Bull Conference Room, Worthing Health Education Centre, Worthing Hospital, Lyndhurst Road, BN11 2DH**

Tanya Humphrys
Board Administrator
March 2019

Signed as an accurate record of the meeting

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Chair

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Date

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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	July 2019	On the forward agenda plan for July.
28 March 2019	**TB/03/19/12.9**	**BAF:** Risk 1.1 to be deescalated to reflect the comments made by the Board.	Glen Palethorpe	**Completed**	Risk deescalated and reported to the Audit Committee in April.
28 March 2019	**TB/03/19/14.5**	**Terms of Reference:** QAC Terms of Reference to be amended to reflect Chief Nurse, at the end of June when the change takes effect.	Glen Palethorpe	**Completed**	Changes to the TOR for the Quality Assurance Committee made.

Chief Executive's Report

Dame Marianne Griffiths
May 2019

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Contents

- Celebrations: April and May
- Diary highlights
- Looking ahead

Celebrations

10 years of Western Sussex

We celebrated a decade of achievements and improvements on our 10th birthday in April, 10 years after our trust was formed on 1 April 2009. Within four years, Western Sussex Hospitals won Foundation Trust status and in April 2016 we became the first multi-site hospital trust to be rated “Outstanding” by the Care Quality Commission.

Launching Patient First STAR Awards

Nominations opened in April for our annual staff and volunteer recognition awards, which is always one of the most uplifting occasions in the hospitals’ year. Our support for each other is one of our key strengths at Western Sussex and we look forward to receiving suggestions for those doing so many inspirational things for the benefit of our patients. Last year we received more than 600 entries, for the event supported by our charity Love Your Hospital. The nominations deadline is midnight on Friday 31 May.

Top 10 A&E performance & multi-million pound bonus

In 2018/19, Western Sussex Hospitals had the ninth best Type 1 A&E performance in England, helping us to secure millions of pounds to spend on new equipment for patients. We finished the year in March with 95% of patients in A&E at Worthing Hospital or St Richard’s Hospital in Chichester seen, treated, admitted or discharged within four hours. We also delivered a £1.194 million surplus, which combined with our A&E performance, earned the trust a further £27 million of capital investment.

Celebrations

Multi-million radiology investment

A new CT scanner at Worthing Hospital was officially opened on Thursday 25 April by former Olympic, World, European and Commonwealth track and field champion Sally Gunnell OBE DL. The new Canon Aquillion Prime SP CT scanner provides enhanced imaging to improve diagnostic results for A&E patients, ward patients and the early detection of cancers.

£8.5 million endoscopy investment

An £8.5 million programme is underway to improve endoscopy equipment that helps diagnose and treat more than 30,000 patients a year at St Richard's and Worthing.

Improving patient catering

A new menu providing greater choice and better availability of food and drink for inpatients is part of a £2.5m improvement programme to redesign the trust's Patient Catering Service.

Leadership development

Agreed Matron and Band 7 leadership development programme.

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

Looking ahead

Preparing for our Care Quality Commission (CQC) Inspection

The CQC wrote to confirm that it plans to inspect our trust this summer. Inspections are now formed of three parts: a core inspection, a Well-led assessment and a review of our Use of Resources conducted by NHS Improvement. Inspections usually take place within 12 weeks of the date given which means we can expect to welcome inspectors at some point before the end of July. The core inspection is unannounced and could take place at any time, on any site and involve any team or department.

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.

E&D conference: Day Two of our annual events

The second of our annual staff conferences takes 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.

Judging our Patient First STAR Awards nominations

With nominations closing at the end of May, our attention will soon turn to the judging panel to agree the shortlist for the awards on 1 August. The shortlist will be shared with the organisations as part of preparations for the event on 26 September.

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	6	**Meeting:**	Trust Board	**Meeting Date:**	30 May 19
Report Title:	2019/20 Operational Plan				
Sponsoring Executive Director:	Pete Landstrom, Chief Delivery and Strategy Officer				
Author(s):	Oliver Phillips, Director of Strategy and Planning				
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	Sets out the Trust's ambitions for Quality for 2019/20				
Financial	Provides a summary of the Trust's financial expectations for 2019/20				
Workforce	Provides the key Workforce improvements for 2019/20				
Link to CQC Domains:					
Safe	✓		Effective	✓	
Caring	✓		Responsive	✓	
Well-led	✓		Use of Resources	✓	

Communication and Consultation:

The full Operational Plan was approved by the Trust Board in March and submitted to NHS Improvement in April 2019

Executive Summary:

The Trust's Operational Plan is a key document which, on an annual basis, summarises the Trust's approach to delivery of Access, Workforce, Quality and Financial targets and standards. It also summarises the Trust's Strategic Direction, outlining the Trust's True North, Breakthrough Objectives, Strategic Initiatives and Corporate Projects.

The attached slides provide a high level summary of the Operational Plan, which was required to be submitted to NHSI at the beginning of April 2019. The summary will be posted on the Trust's website.

Key Recommendation(s):

The Board is asked to REVIEW the summary Operational Plan prior to the plan being posted on the Trust's website.

Western Sussex Hospitals NHS Foundation Trust

Operational Plan
Trust Board
28th March 2019

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Introduction – WSHT Operational Plan 19/20

Western Sussex Hospitals NHS Foundation Trust

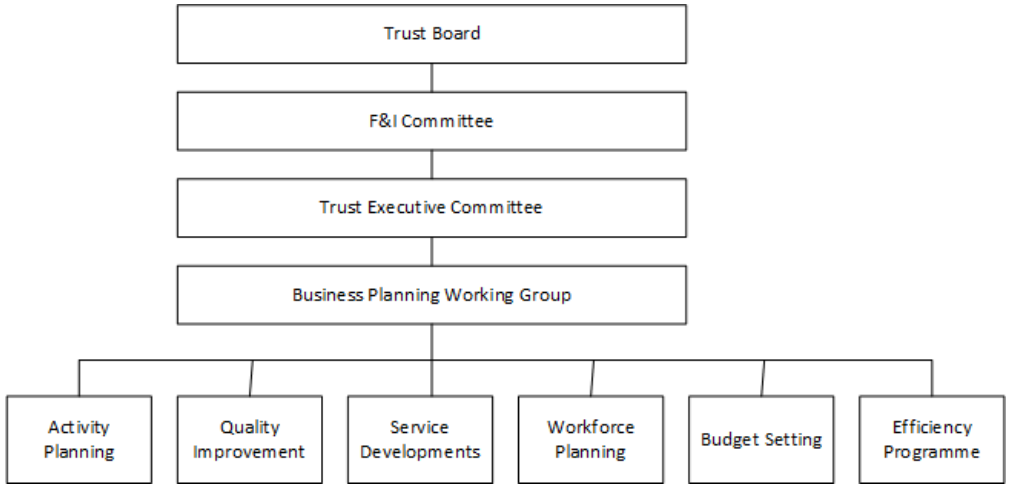
- Our Operational Plan for 19/20 demonstrates how we plan to sustain our outstanding CQC rating and continue our improvement journey;
- Our revised Strategic Initiatives will ensure long term improvement in the face of a range of complex demands across performance, productivity, finance, quality and system development;
- Our Corporate Projects have been refreshed for 19/20 – and include Western 'Outstanding', Clinical Strategy Delivery, Delivery of Seven Day Services, Reducing Abusive Behaviours, and our Facilities and Estates Response to the '6 Facet' Survey;
- The Operational Plan sets out how during 19/20 we will achieve our ambitions and was submitted to NHS Improvement in April 2020.

Business planning governance and process

Western Sussex Hospitals NHS Foundation Trust

Governance

Business planning has been led by a multifunctional team across the Trust with control provided by directors and regular reporting to Trust Executive



High level process

The integrated process has brought together top-down strategic planning with divisional prioritisation

October

Business planning approach agreed at Trust Executive Committee

November to March

Strategic initiatives, corporate projects and breakthrough objectives

Integrated operational planning across quality, performance, activity, workforce and finance

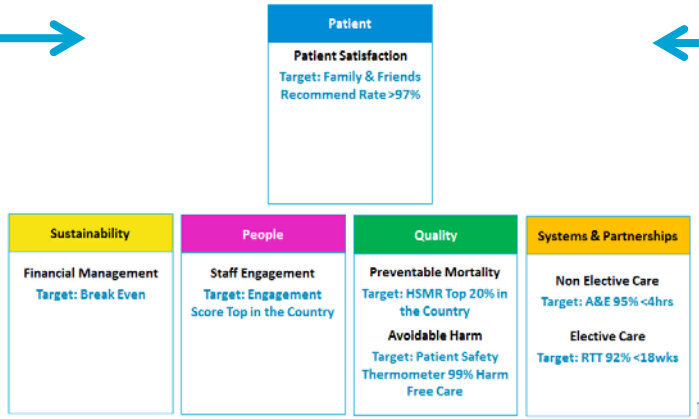
April

Cascade through Catchball process

Strategy Deployment Framework

NHS
Western Sussex Hospitals
NHS Foundation Trust

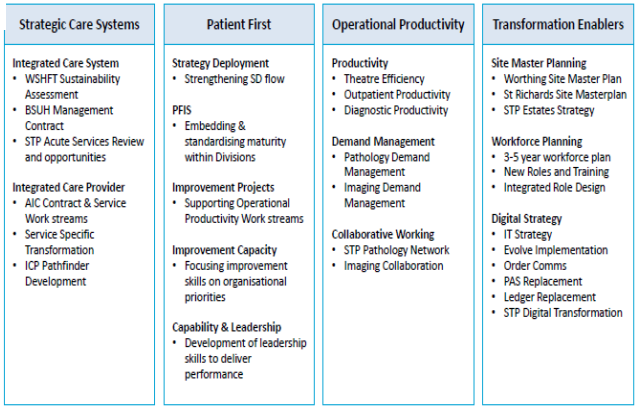
True North



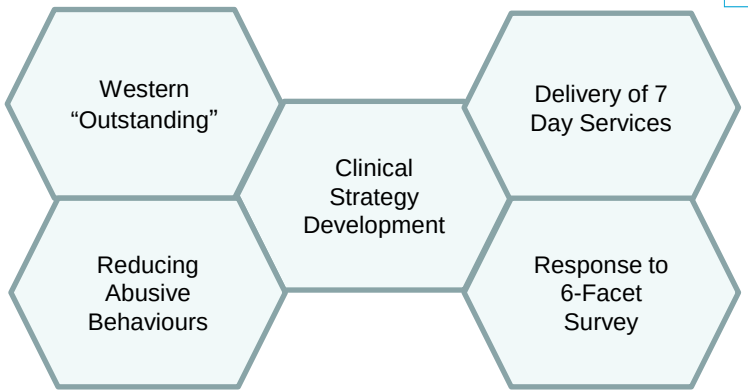
Breakthrough Objectives

True North Domain	2019/20 Confirmed
Patient	Change – Reduction in noise at night
Sustainability	Continue - Reduction in Medical Workforce Pay
People	Continue - Staff feel able to make Improvements
Quality	Change – reduction in hospital associated VTE
Systems & Partnerships	Continue - Increase the numbers of discharges before 12 noon

Strategic Initiatives



Corporate Projects



True North Metrics

Western Sussex Hospitals
NHS Foundation Trust

Patient

Patient Satisfaction

Target: Family & Friends Recommend Rate >97%

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

Breakthrough objectives

Western Sussex Hospitals NHS Foundation Trust

True North Domain	2019/20 Confirmed
Patient	Change – Reduction in noise at night
Sustainability	Continue - Reduction in Medical Workforce Pay
People	Continue - Staff feel able to make Improvements
Quality	Change – reduction in hospital associated VTE
Systems & Partnerships	Continue - Increase the numbers of discharges before 12 noon

Strategic Initiatives

Western Sussex Hospitals
NHS Foundation Trust

Strategic Care Systems

Integrated Care System
- WSHFT Sustainability Assessment
- BSUH Management Contract
- STP Acute Services Review and opportunities

Integrated Care Provider
- AIC Contract & Service Work streams
- Service Specific Transformation
- ICP Pathfinder Development

Patient First

Strategy Deployment
- Strengthening SD flow

PFIS
- Embedding & standardising maturity within Divisions

Improvement Projects
- Supporting Operational Productivity Work streams

Improvement Capacity
- Focusing improvement skills on organisational priorities

Capability & Leadership
- Development of leadership skills to deliver performance

Operational Productivity

Productivity
- Theatre Efficiency
- Outpatient Productivity
- Diagnostic Productivity

Demand Management
- Pathology Demand Management
- Imaging Demand Management

Collaborative Working
- STP Pathology Network
- Imaging Collaboration

Transformation Enablers

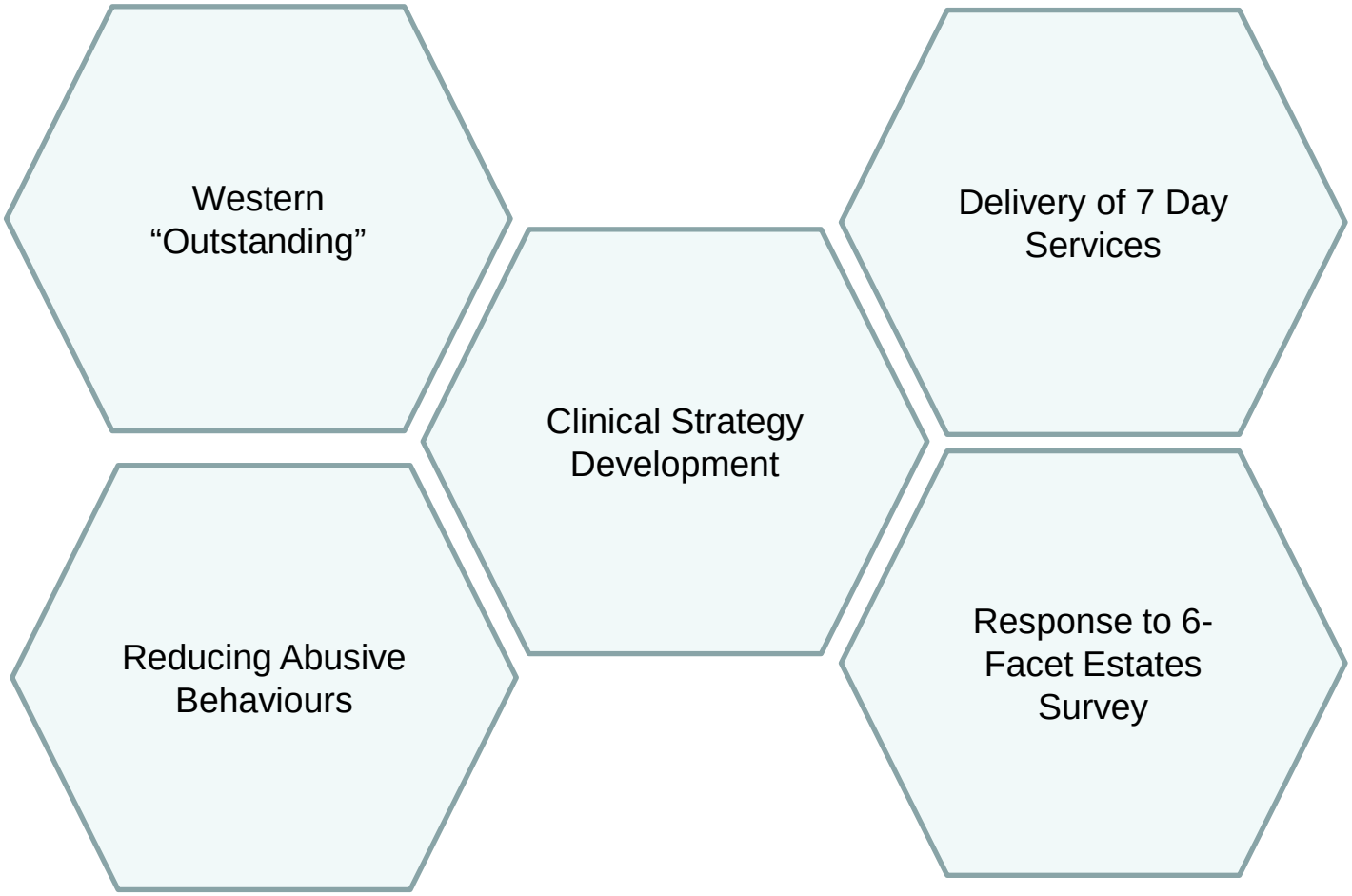
Site Master Planning
- Worthing Site Master Plan
- St Richard's Site Masterplan
- STP Estates Strategy

Workforce Planning
- 3-5 year workforce plan
- New Roles and Training
- Integrated Role Design

Digital Strategy
- IT Strategy
- Evolve Implementation
- Order Comms
- PAS Replacement
- Ledger Replacement
- STP Digital Transformation

Corporate Projects

Western Sussex Hospitals NHS Foundation Trust

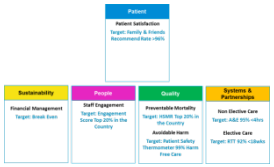


Constitutional Standards

Western Sussex Hospitals
NHS Foundation Trust

Start point

- A&E less than 4 hour waits - average performance across 18/19 – 94.1% - top 15% in the country;
- Referral to Treatment Time (RTT) - performance at March 19 – 83.4%;
- RTT 52 week waits – total of 10 breaches during18/19;
- Diagnostics more than 6 weeks – performance at March 19 – 0.86%;
- Cancer - First treatment following GP referral less than 62 days – average performance across 18/19 – 80%



Organisational goals

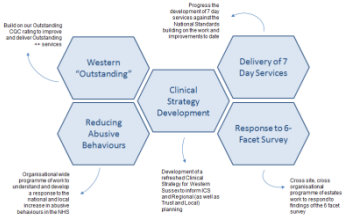
Target by April 2020:

- 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%

Progress to date

Performance to date:

- A&E less than 4 hour waits – improving from 18/19;
- RTT – Improving from October 18;
- RTT 52 week waits – March 19 – zero breaches;
- Diagnostics 6 weeks – consistently achieving this target;
- Cancer - First treatment – managing significant increases in referrals for Breast, Urology, Colorectal referrals with performance variable across 18/19.



Priorities for 19/20

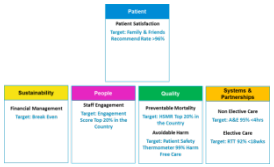
- The Trust has a range of projects to improve flow for elective and non-elective care

Quality

Western Sussex Hospitals NHS Foundation Trust

Start point

- Trust achieved CQC rating of ‘Outstanding’ in December 2015;
- St Richard’s Hospital and Worthing Hospital received individual inspection rating of ‘Outstanding’ and Southlands Hospital of ‘Good’.

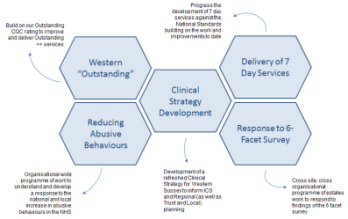


Organisational goals

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

Progress to date

- Preventable Mortality - mortality (HSMR) figure in November 2018 was 89.43, placing us just inside the top 20% of best-performing trusts nationally;
- Harm Free Care – year to date at February 98.55%;
- Patient Satisfaction: 95% patient recommend rate;



Priorities for 19/20

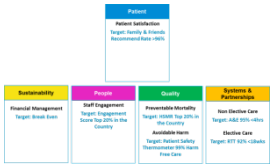
- Deliver Quality Priorities;
- Develop and implement Clinical Strategy;
- Improvements in delivering 7 day services;
- Further develop Quality and Improvement capacity through PFIS;
- Maintain CQC rating of Outstanding.

Workforce

Western Sussex Hospitals NHS Foundation Trust

Start point

- Challenges in workforce supply;
- Shortages in a range of nursing groups, medical grades, specialities and Allied Health Professionals (AHPs);
- Increased vacancy rate and turn over;
- Ageing workforce.

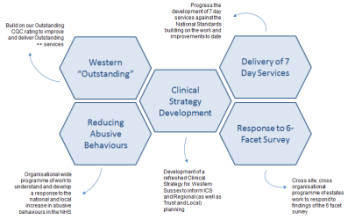


Organisational goals

- Staff engagement – True North Target - Engagement score top in the country;
- Staff able to make improvements – Breakthrough objective – to reach 63%;
- Reducing abusive behaviours – Corporate Project to address safety.

Progress to date

- Staff engagement – better than national average - 7.2/10 – best 7.6;
- Staff able to make improvements – above national average - 59% as compared national average of 56%;
- Safety culture – below national average – 9.3 as compared to a 9.4.



Priorities for 19/20

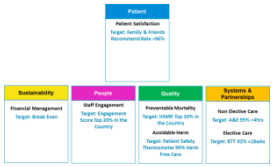
- Develop new roles and ways of working to support workforce supply challenges;
- Workforce plans and Clinical Strategy aligned;
- Delivery of improvements in staff engagement, ability of staff to make improvements, reduction in abusive behaviours and Patient First Improvement System (PFIS) including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

Finance and Activity

Western Sussex Hospitals NHS Foundation Trust

Start point

- Delivered surplus position for each of last three years (2016/17 - 2018/19);
- Reference cost index of 92 and historically below 100;
- Delivered efficiency programme in excess of 4% of cost base for each of the last three years;
- Developed Aligned Incentives Contract with Coastal West Sussex CCG and defined key programmes of work.



Organisational goals

- Deliver financial control total;
- Reduce premium pay costs (break-through objective for 2016/17 and 2017/18);
- Return medical workforce spend to budget (current break through objective).

Progress to date

- Delivered control total in 2018/19;
- Agency expenditure reduced from £23.3m in 2015/16 to £10.7 m in 2018/19 - a reduction of 54%;
- Reduction in underlying medical pay run rate of 10%;
- Aligned Incentive Contract in place for two years, delivering savings in excess of £10m to health economy.

Priorities for 19/20

- Deliver a control total (including Provider Sustainability Fund and Marginal Rate Emergency Tariff) of £14.062m surplus for 2019/20 and efficiency requirement of £11.7m;
- Theatre and Outpatient Productivity;
- Diagnostic demand management (incl. primary care);
- New Models of Care;
- Medical workforce redesign;
- ICP Pathfinder Development.

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	7-11	**Meeting:**	Board	**Meeting Date:**	30 May 2019
Report Title:	**Integrated Performance Report**				
Sponsoring Executive Director:	Marianne Griffiths, George Findlay, Maggie Davies, Amanda Fadero, Karen Geoghegan and Denise Farmer				
Author(s):	Marianne Griffiths, George Findlay, Maggie Davies, Amanda Fadero, Karen Geoghegan and Denise Farmer				
Report previously considered by and date:	Individual elements considered by relevant Board 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:					
Attached is the Trust's integrated performance report.					
Key Recommendation(s):					
To note the content and following receipt of the Committee assurance reports, consider if there are areas for referral back to the Committees where enhanced assurance is required.					

Integrated Performance Report

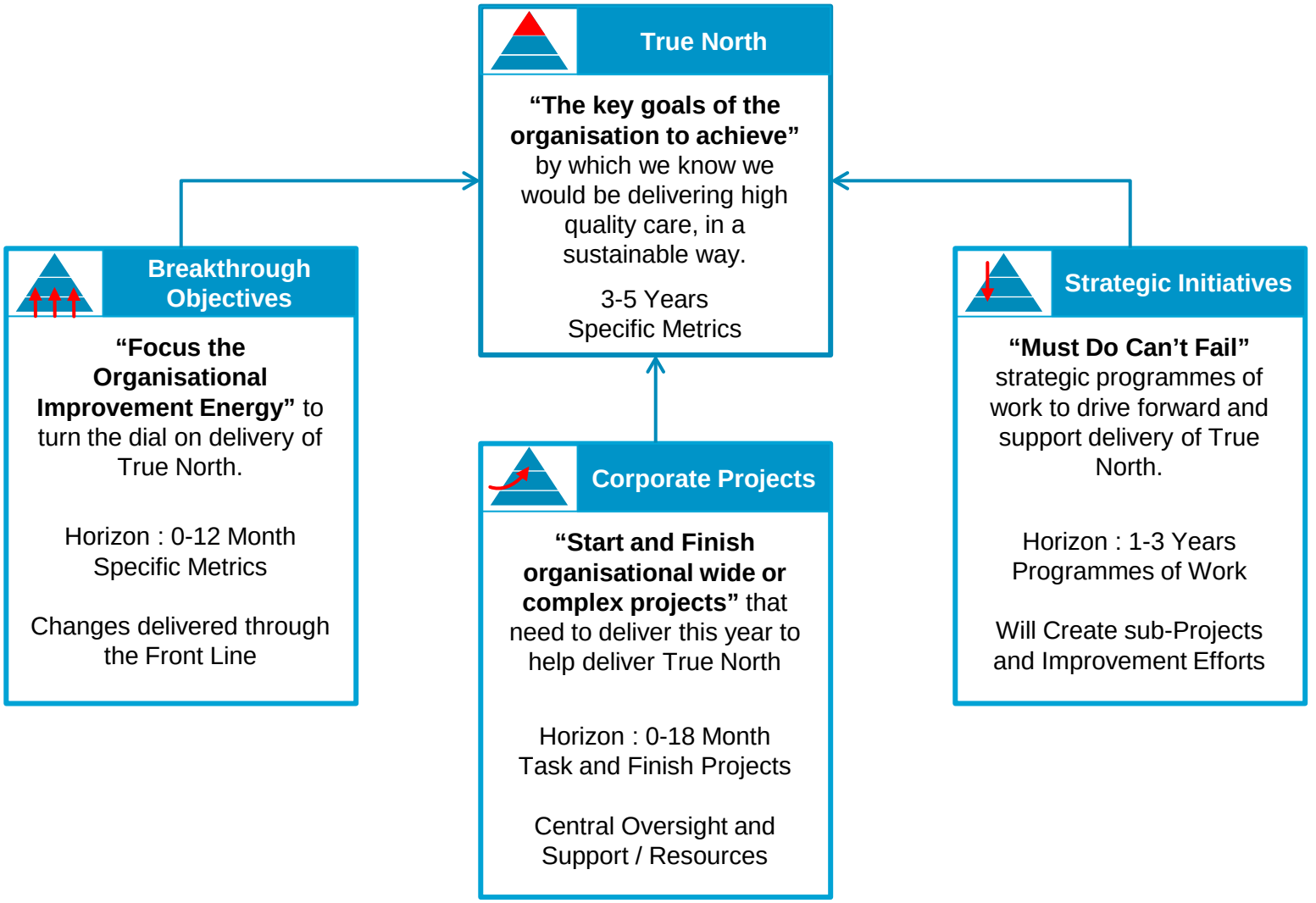
May 2018

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 January 2019 and has risen to 92.5. There has been an accompanying deterioration to the 31st Percentile when compared nationally. The Trust remains statistically significantly low in terms of both the HSMR and SMR with a marginal increasing trend in the point value of the HSMR itself.

The causes for the rising HMSR have been investigated and quarterly report provided by Dr Foster.

The Trust remains statistically significantly low in terms of both HSMR and SMR with a marginal increasing trend in the point value of the HSMR itself. This trend is apparent at SRH and the HMSR at Worthing is stable.

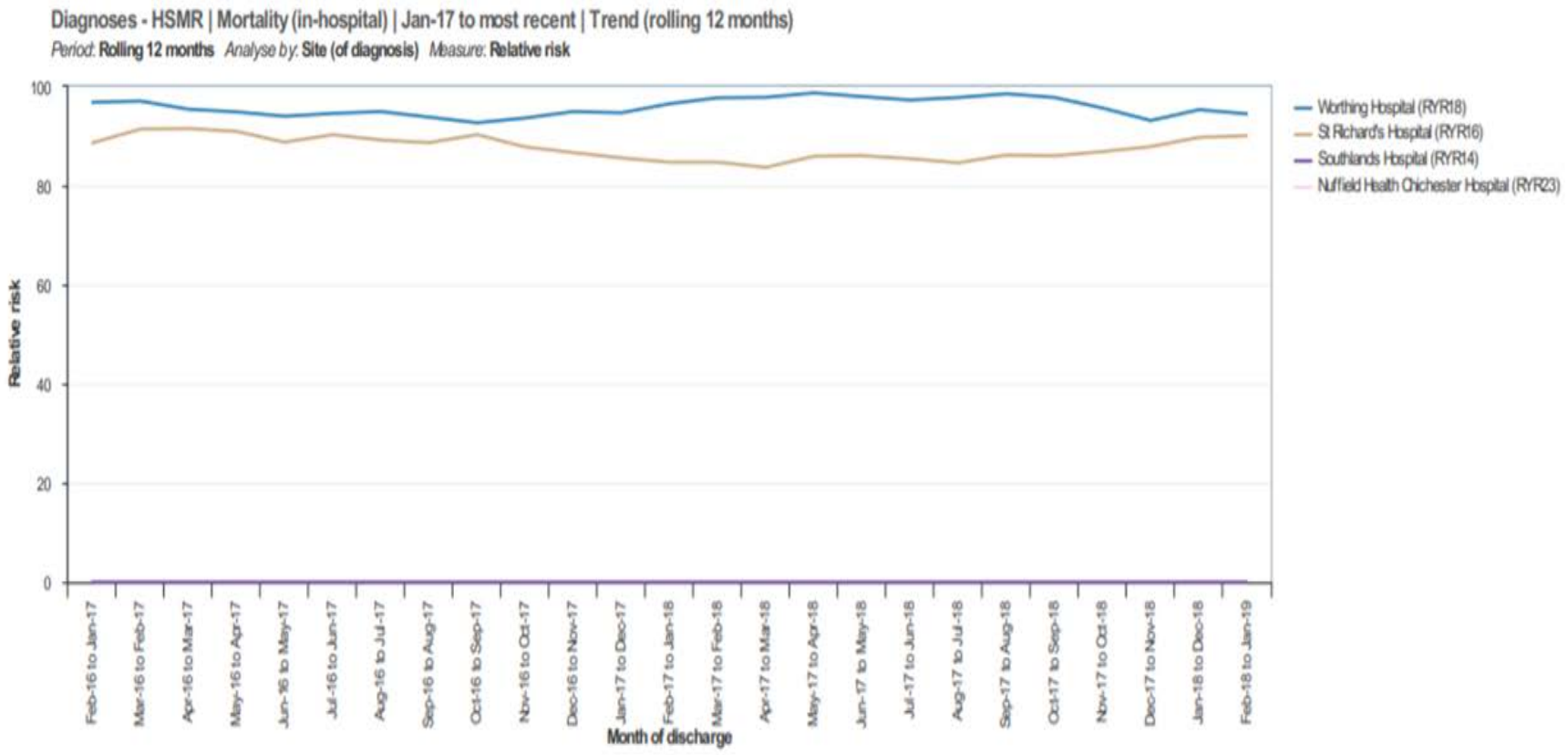
Observed mortality is falling but at a greater rate at Worthing despite the higher levels of comorbidity coded activity there. A concurrent rise in activity is mainly due to 0 day admissions on both sites.

For this 12 month period, observed exceeded expected deaths in two key diagnostic groups. Intestinal obstruction without hernia (Chichester) and epilepsy (Worthing). The numbers are small and under review using the mortality review process.

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 0 day non-elective admissions with a potential impact on the expected mortality rate, particularly at St Richard's.

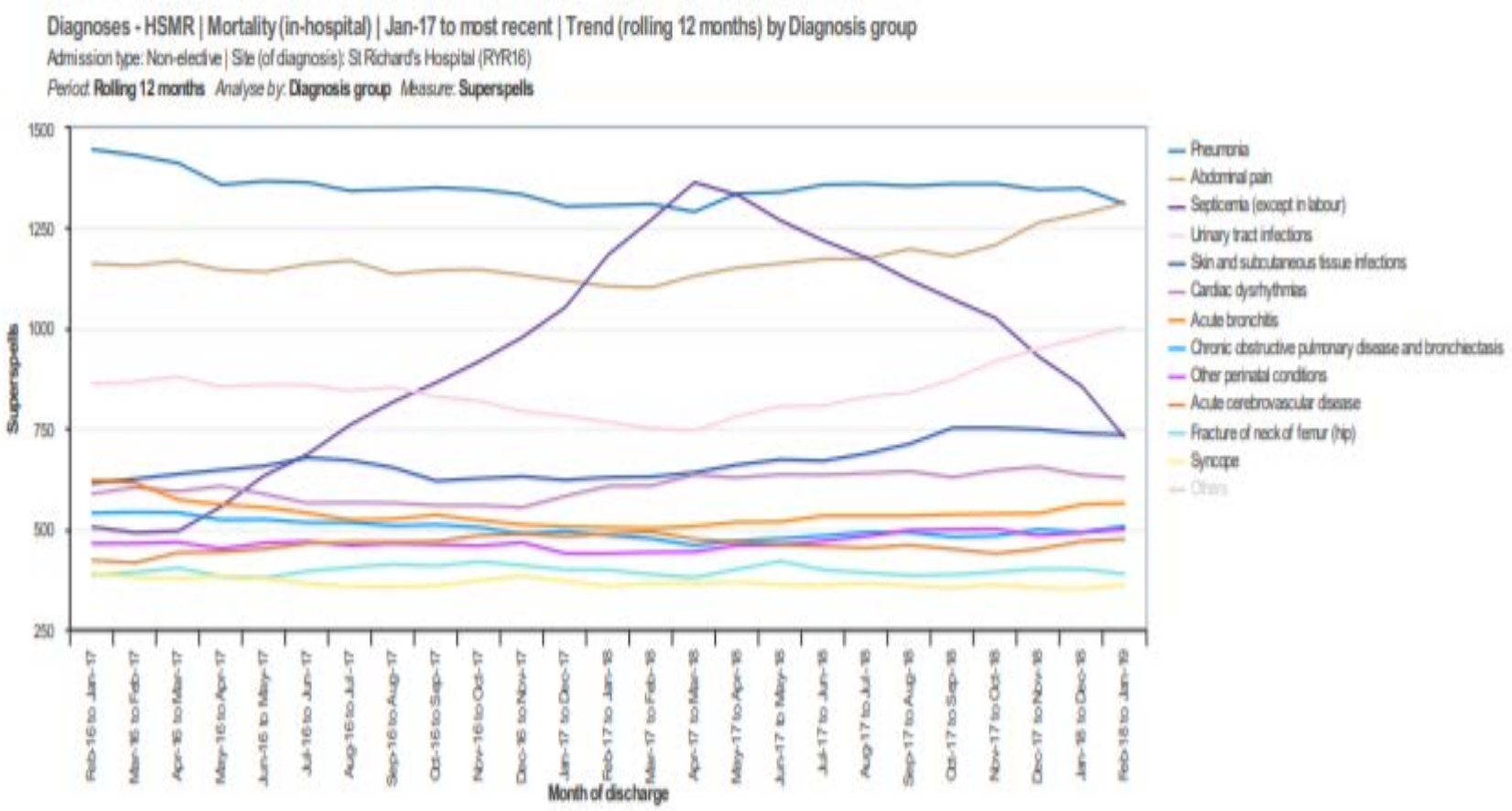
Quality Performance - Effectiveness

Monthly HMSR at Site Level



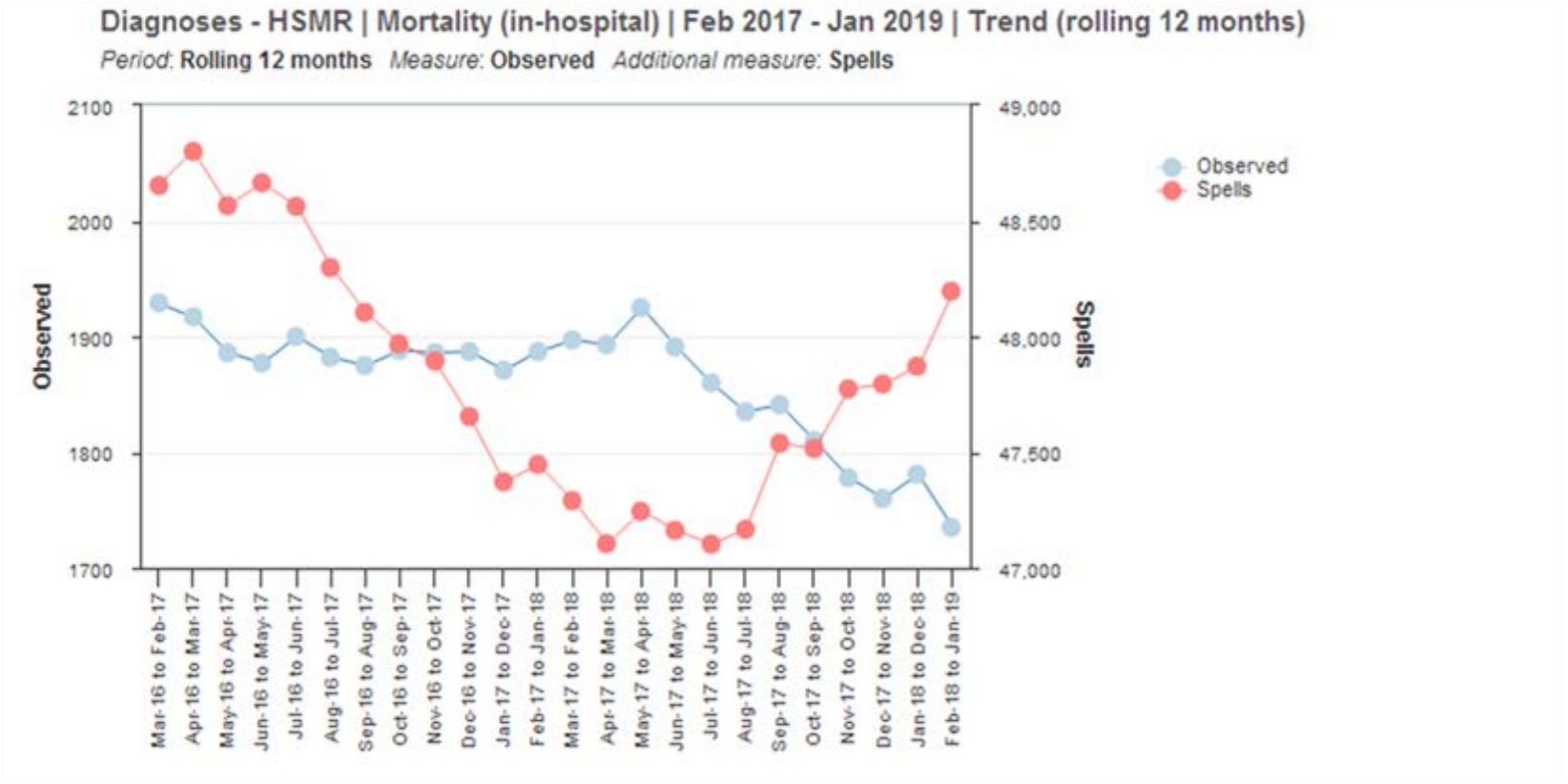
Quality Performance - Effectiveness

Coding variation - SRH



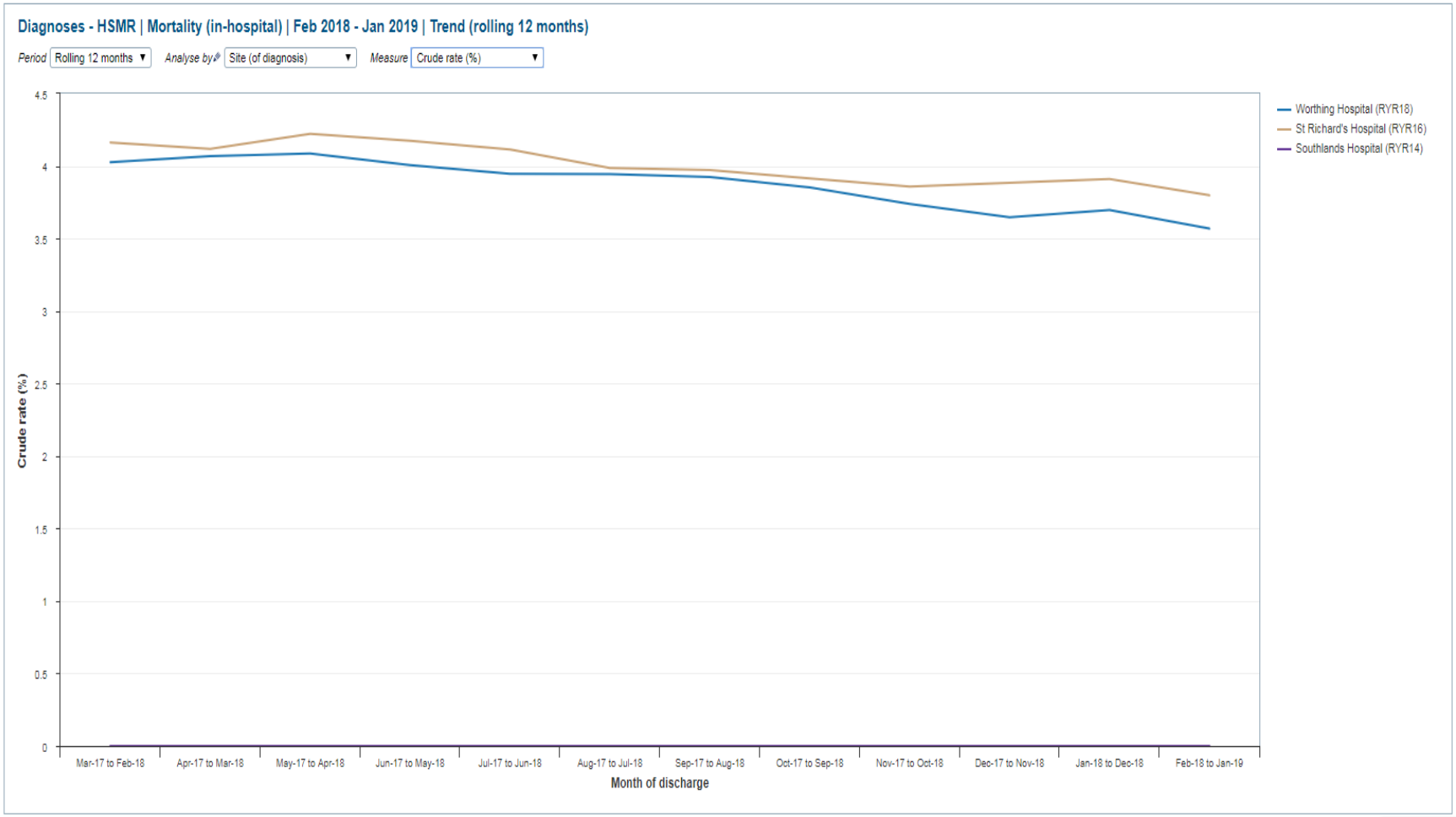
Quality Performance - Effectiveness

Observed Deaths



Quality Performance - Effectiveness

Crude Mortality Rate



Quality Performance - Safety

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

Key messages for Board

Safety: Norovirus outbreak: An increase in diarrhoea and vomiting symptoms was promptly identified the week beginning 15th April at SRH. This swiftly became a confirmed Norovirus outbreak on Friday 26th April.

An outbreak control team was initiated and daily outbreak calls were executed and formally minuted. Risk measures were immediately deployed; including environmental precautions, enhanced cleaning, raising hand washing profile amongst all staff groups and senior nursing and IP&C teams constantly advising with the affected clinical areas. The outbreaks last known transmission was 12.5.19 and on 15.5.19 SRH Norovirus outbreak was declared over.

Worthing overlapped SRH outbreak and the Trust observed an increased incident of vomiting and on 9.5.19 a D&V outbreak was promptly declared. All additional risk mitigations are in place and extra support for the clinical areas, including weekend working by the IP&C team.

Quality Performance - Experience

Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 99% Harm Free Care

Key messages for Board

Experience: Friends and Family: the proportion of patients who would have recommended our services to friends and family in April compares favourably with the national median benchmark and also against our internal target.

	Percentage recommending WSHFT in December (plus YTD)	Target
Inpatient care	97.8% (97.8%)	97%
A&E	94.3% (94.3%)	93%
Maternity: Delivery care	98.0% (98.0%)	97%
Outpatient care	97.5% (97.5%)	97%
Maternity: Antenatal care	100% (100%)	97%
Maternity: Postnatal ward	98.0% (98.0%)	97%
Maternity: Postnatal community care	100% (100%)	97%

* *Safer staffing data available on the Trust website via the Trust Quality Report.*

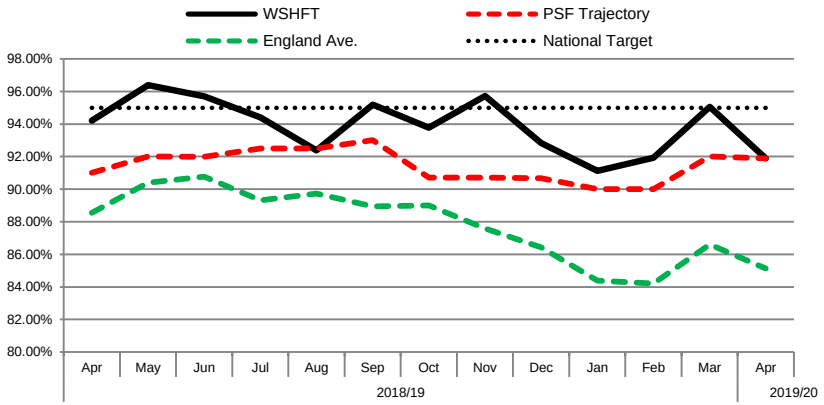
Operational Performance – Summary

Systems & Partnerships
Non Elective Care
Target: A&E 95% <4hrs
Elective Care
Target: RTT 92% <18wks

- A&E 4hr target performance April-19 was 91.9%, compared to 85.1% National Average performance.
- RTT 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 in the context of continued significant increased demand, compared to 79.75 National Average(March).
- Diagnostic performance was compliant (0.81%) for the 16th consecutive month despite demand pressures, compared to National Average (March) of 2.5%

Operational Performance – True North Metrics

A&E 4 Hour Performance

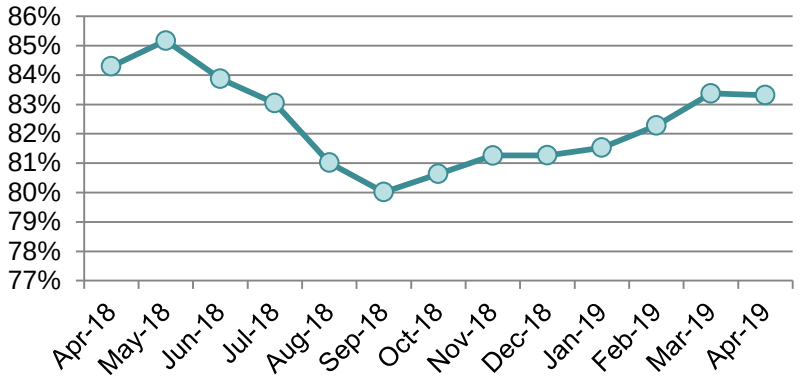


- The Trust achieved 91.89% in April-19 non-compliant against Constitutional Target.
- This was 3.2% lower than the same period last year.
- April-19 saw a 10.8% increase in ambulance conveyances, a 7.3% increase in A&E attendances and a resulting 6.6% increase in subsequent emergency admissions compared to April-18.
- Bed availability at SRH was also affected by the closure of over 30 beds due to a D&V outbreak at the hospital.

Improvement Actions:

- Kaizen led early morning discharge programme.
- Super Stranded improvement programme (LHE wide).
- Additional Bed capacity SRH.
- Additional medical staff deployed within A&E.
- Partnership programme of care for Mental Health.

RTT 18 Week Performance



- Apr-19 RTT performance was 83.3% for all specialties, a deterioration of -0.06% since Mar-19.
- There were zero 52 week waiters at end Mar-19.
- The overall size of the waiting list grew from March to April, slightly below plan.
- Improvement Plan aim to recover performance to compliant position by end of 19/20.

Improvement Actions:

- Continued improvement theatre and outpatient efficiency programmes.
- Additional capacity both internally and from external partners.
- Substantive recruitment plans to fill vacancies in context of national shortages in some areas.

Operational Performance – Key Metrics

Cancer Metrics

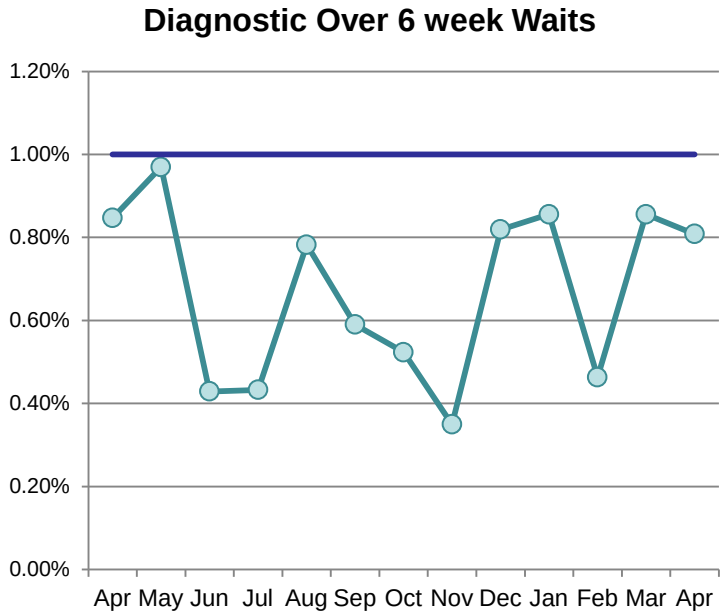
Monthly and YTD	Target	2019/20 YTD	Apr-19
2wk GP to 1st OP	93.0%	94.0%	94.0%
2wk GP to 1st OP (Breast)	93.0%	91.5%	91.5%
31day subsequent treatment (surgery)	94.0%	89.5%	89.5%
31day subsequent treatment (drug)	94.0%	100.0%	100.0%
31day subsequent treatment (all)	98.0%	96.9%	96.9%
62day referral to treatment (screening)	90.0%	90.0%	90.0%
62day referral to treatment (upgrade)	85.0%	79.5%	79.5%
62day referral to treatment (all Cancers)	85.0%	82.1%	82.1%

- The Trust was compliant against 4 of 8 cancer metrics in April-19.
- The Trust was non-compliant against 2 week GP referral to outpatient for breast symptomatic patients with 91.5% April-19.
- The Trust was also non-compliant against the 62 day urgent referral to treatment target of 85%, with 82.1% of patients commencing treatment within 62 days.

Improvement Actions

- Implementation of Optimum 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.

Diagnostic 6 week Performance



- Diagnostic performance was compliant with the national target for the full 12 months of 18/19 and continues to be compliant in April-19.
- This is despite demand increases, which have been matched through increased activity and productivity.

Financial Performance - Summary

Sustainability

Financial Management

Target: Break Even

- At the end of April, the Trust is reporting a deficit of £0.1m excluding PSF income.
- Performance at the end of April is in line with plan and the Trust is on trajectory to deliver an underlying surplus of £2.5m which will release an additional £11.6m. This will achieve the year-end control total of £14.1m
- At the end of Q1, the Trust needs to deliver a surplus of £1.0m in order to earn £1.25m of PSF income. In 2019/20 there are no performance or access targets associated with the payment of PSF income. MRET income of £0.8m will be paid for Q1 as the Trust has accepted its control total.
- Delivery of the control total will require close management of elective and non-elective capacity and control of the cost base, particularly in relation to medical pay, which is a break-through objective for 2019/20.

Financial Performance – Key Metrics

SOF Finance Rating — G

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

At the end of April the aggregate finance rating is a '1'. All individual metrics are in line plan and are also reporting a '1'.

Control Total Surplus £k — G

	Plan	Actual / Forecast
Year to Date (exc PSF*) £k	(131)	(126)
Year End Forecast (exc PSF) £k	2,459	2,459
Year to Date (inc PSF) £k	558	563
Year End Forecast (inc PSF) £k	14,062	14,062

At the end of April, the Trust is reporting a deficit of £0.1m, excluding PSF and MRET funding. Emergency activity was above plan in month but the increased activity levels led to additional capacity being opened.

Efficiency Programme £k — G

	Plan	Actual/ Forecast
Year to Date £k	1,078	1,078
Year End Forecast £k	11,728	11,728

Savings of £1.1m have been achieved against a plan of £1.1m (100%).

Capital £k — G

	Plan	Actual/ Forecast
Year to Date £k	283	224
Year End Forecast £k	20,304	20,304

Capital expenditure in the month of April totalled £224k. Medical equipment priorities have been agreed and orders are being placed. Other schemes are progressing through Capital Investment Group.

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

Financial Performance – Key Metrics

Income £k — **G**

	Plan	Actual/ Forecast
Year to Date £k	37,991	39,036
Year End Forecast	463,765	463,765

At the end of April, income is £ 1.0m ahead of plan due to high levels of non-elective and A&E activity. Daycase and elective income is behind plan but has been offset by higher levels of outpatient income.

Operating Costs £k — **A**

	Plan	Actual/ Forecast
Year to Date £k	(36,130)	(37,119)
Year End Forecast £k	(437,158)	(437,158)

At the end April, operating costs are £1.0m above to plan. Pay was £0.m above budget, predominantly within Medical and Nursing expenditure. Non pay expenditure was £0.43m above plan, of which £0.15m related high cost drugs and devices.

Agency Ceiling £k — **G**

	Plan	Actual/ Forecast
Year to Date £k	1,192	924
Year End Forecast £k	14,969	10,846

Agency expenditure is £0.3m below the agency ceiling in April. The underlying run rate is higher than March due to increased medical agency expenditure in month. The Trust is forecasting to be below its agency ceiling at year-end due to the introduction of new workforce and care models.

Cash £k — **G**

	Plan	Actual/ Forecast
Year to Date £k	14,187	14,142
Year End Forecast £k	28,620	28,620

At the end of April the cash position is in line with plan, reflecting that the income and expenditure and capital positions are also in line with plan.

Financial Performance - Action & Recommendations

There are no actions required of the Board.

The Board is asked to note the following:

- Updated workforce models for Paediatrics and Emergency Medicine which will reduce agency spend were approved by Trust Executive ;
- Details of the new models of care programme, which will build upon successful pilots during Winter 2018/19, are currently being finalised in order for implementation to begin in Q1.
- Elective capacity plans are being reviewed and ratified at Executive level to ensure alignment with performance trajectories submitted to NHSI;
- Contract signature is outstanding with both the Sussex and East Surrey CCG Alliance and NHS England. A contract position has been agreed with the CCG Alliance but signature is delayed by issues outside of Coastal West Sussex. Progress has been made with NHS England, contract values are aligned and contract documentation is being reviewed by both parties.
- The Trust is forecasting delivery of the control total £14.1m surplus including securing PSF in full.

Improving Staff Engagement

People

Staff Engagement
Target: Engagement Score Top in the Country

Staff Briefings led by Executives and Trust Directors across the Trust during April and May have been well attended. Divisional management teams have also been actively engaged with ward/department huddles.

Equality, Diversity and Inclusion strategy has been agreed and an improvement plan developed. The plan focuses on addressing the issues specifically arising from our WRES and WDES and more broadly by improving the experience of staff who identify with a protected characteristic. The Diversity Matters Steering Group will monitor progress of agreed improvements.

Worthing Pride will take place on Saturday 13 July and the Trust has a stand at Beach House grounds and will be participating in the seafront parade.

Staff conferences planned for 24 May and 13 June are fully booked. Themed around equality, diversity and inclusion, the 200-delegate events will raise awareness through key note speakers, workshop activities and inclusion cafes. This will also provide an opportunity to engage staff in the development of a behaviour compact that supports reducing abusive behaviour in the workplace.

Widening Participation 60 people attended Apprentice Fair in Worthing in April, 11 Year 10 students participated in the Introduction to the NHS programme and 17 apprentices started work.

Agenda for Change Contract Refresh as part of the new terms and conditions, a proposal to move from a manager-led to an employee-led appraisal process has been agreed. This was developed in conjunction with Staff Side colleagues and is aimed at improving engagement and the quality of the appraisal whilst linked to the new pay progression framework. A detailed project plan is being outlined. It is anticipated that by the end of June all 300 staff currently in a Band 1 role will have had a 1-1 meeting to offer transition into a Band 2 role. Whilst this has been a resource-intensive piece of work, it has engaged staff to agree their development into enhanced roles, with 87% uptake.

Patient First Awards nominations for this year's Star Awards close on 31 May and staff, volunteers and patients are being encouraged to nominate. Last year over 630 nominations were received and this year it is hoped this will be even higher.

Workforce Performance – Summary

Workforce capacity: 97% (Substantive 87%, Bank 8.4%, Agency 1.4%)

Workforce spend: £27m (£878k adverse, 83% medical)

Actions to address workforce spend include recruitment into alternate roles to increase workforce capacity, thus moving activity from premium into plain time. Overall workforce spend will be reviewed alongside specific actions, to ensure triangulation between removal of agency premium and total workforce spend, thus ensuring spend is not moved from one workforce group to another.

A&E business case approved that will see the substantive recruitment of clinical fellows, ENP's and ENA's. Recruitment commenced. £1m savings anticipated to be delivered over 2 years with £478k in 2019/20. Other enablers within Medicine division include new models of care and pathway changes that will impact positively on medical and nursing workforce, junior doctor rota improvements and use of alternative roles including physician associates.

Paediatrics business case approved for an additional 7 Resident On-Call Consultants (ROC's) that will lead to the removal of agency and provide a more sustainable workforce.

Continuing to collaborate in STP agency market management workstream and agency rate negotiations.

ESR employee self service: 87% of staff accessed payslips on-line since go live 1 April. This compares to 45-50% uptake in other NHS trusts.

Operational Performance – Key Metrics

KPI	Target	Current position	Comments
Staff engagement score (out of 10)	7.6	7.7	Collected at H&S days. Refreshed target based on 2018 annual staff survey.
Staff able to make improvement happen (Q4d)	68.0%	68.7%	Compares to 58.8% in 2018 staff survey.
Appraisal compliance	90.0%	91.3%	5 of our 6 Divisions are compliant with an improving position in the Medicine Division.
Statutory and mandatory training compliance	90.0%	93.5%	Compliant in 8 out of 9 modules. Improving position for resuscitation training (87.2%). Improvement plan in place for medical staff.
Sickness rate Rolling 12 month In month	3.3%	3.7% 3.9%	Short term sickness dropped in month with the exception of Estates and Facilities division.
Staff Turnover	8.5%	8.0%	Core division remains exception at 11.5% although improved in month. Turnover for RN 6.2% and HCA 8.4%.

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	12	**Meeting:**	Trust Board	**Meeting Date:**	30 May 2019
Report Title:	Finance and Performance Committee Report to Board				
Sponsoring Director:		Lizzie Peers, Non-Executive Director			
Author(s):		Lizzie Peers, Non-Executive Director			
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:

The Finance and Performance Committee met on 29 April 2019. It was quorate with four NEDs and was attended by the Chief Executive, Chief Finance Officer, Trust Finance Director, Chief Delivery and Strategy Officer, Chief Workforce and Organisational Development Director, Chief Operating Officer and Director of Efficiency & Delivery.

The Committee recognised that this was the first meeting under its revised terms of reference and incorporating detailed performance information. During the meeting the Committee reflected on the level of information needed to effectively fulfil its terms of reference. It was agreed that the usual business rules as applied across the Trust would be applied to the information presented to the Committee and that counter measure reports would also be provided to set out the actions being taken, if a deteriorating trend is identified. It was also noted that the Committee would be subject to more in-depth review as part of the May Board Improvement Huddle.

The Committee through its receipt of the finance and performance information was assured over the processes applied in respect of the delivery of the Trust's control total for 2018/19, and the delivery of the 2018/19 efficiency programme. It was recognised that delivery represented an outstanding result, given the huge demand, workforce and financial challenges faced.

The Committee were also pleased to note work on the 2019/20 efficiency programme which had resulted in some 70% of the programme having already been assessed as assured and risk adjusted, recognising there are some highly complex schemes.

Reports were also received and discussed on workforce, procurement and Evolve, with a verbal update on use of resources.

The Committee approved the Trust's travel, lease car and subsistence policy following the outcome of a routine review.

Key Recommendation(s):

The Board is asked to **NOTE:**

That the Trust delivered its agreed control total and delivered a £28m surplus, earning £11m more PSF than plan because the Trust delivered both its financial control total and the required A&E performance. The whole Trust is to be thanked for achieving this outstanding result.

The level of assurance that flowed through to this Committee especially in respect of the 2019/20 efficiency programme development and its well advanced maturity was high, although recognising a range of risks.

The matters the Committee is seeking to scrutinise in particular over the forthcoming months include the Evolve Project against it set milestones and benefits realised, the further development of workforce reporting and the counter measures in respect of performance where these are needed and for the Medicine Division with its highly complex key efficiency schemes.

The Committee will continue to review the depth and scope of information it receives over the first quarter of 2019/20 seeking to apply the Trust's business rules for escalated information where deterioration has occurred or there is an increased risk of a deteriorating position occurring.

To: Trust Board Date: 30 May 2019

From: Lizzie Peers, Finance and Performance Committee Chair. Agenda Item: 12

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Finance and Performance Committee	**29 April 2019**	**Lizzie Peers**	**yes**	**no**
			✓	☐

Declarations of Interest Made

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

Actions taken by the Committee

The Committee received the suite of Financial Performance reports. The Committee was assured over the processes applied in respect of the delivery of the Trust's control total for 2018/19, capital programme and the management of its cash balances. The Committee recognised the excellent work undertaken to deliver the £28m surplus, earning £11m more PSF than plan because the Trust delivered both its financial control total and the required A&E performance. The application and use of the additional money was discussed. It was noted that a Strategic Cash Reserve proposal would come to F&P in Q2.

The Committee received the developing Workforce performance report and was assured over the actions described by the Executive to address the Trust's continued improvements across a range of workforce metrics. Retention hot spots and a range of work to address workforce challenges were also discussed.

The Committee was very pleased to receive the report on the full delivery of the 2018/19 efficiency programme. Estates and Facilities were highlighted for their all-round strong performance, including mitigations where there was slippage. The Committee was assured over the 2019/20 processes, having received information from the Director of Efficiency and Delivery that some 70% of the 2019/20 efficiency programme had already been assessed as assured and risk adjusted. It was recognised that there were some highly complex schemes and some more challenged areas. The Committee was assured that these would be subject to appropriate robust governance and oversight to support delivery whilst still delivering business as usual activity. It was agreed that the Committee would receive and seek more detailed information and assurance on the risks areas, as needed.

The Committee received the suite of Operational Performance reports. In recognition of this being the first meeting with its enhanced focus on performance the Committee reflected on the level of information it needed to effectively fulfil its Terms of Reference. The Committee felt that whilst seeing the depth of information it had received at this meeting was useful, it should not need this level routinely, but would rather utilise the business rules applied across the Trust to require information, supported by counter measure reports if a deteriorating trend is identified. Triangulation for example of efficiency programmes and the impact LOS would need to be considered. From discussion of the performance dashboards, the Committee was assured that actions were being taken to sustain the Trust's good performance across A&E and Diagnostics and that actions had been developed to improve performance in respect of the sustainability of Cancer performance improvement. The Committee also discussed the improvement plans and performance in respect of the Trust's 18wk performance and some of the pressures within the waiting list and extent of referral demand.

The Committee was assured over the Trust's procurement activity, recognising there is a lag in this improvement flowing to the national model hospital metrics and that significant work was underway to understand variances and identify real opportunities and capture these. The Committee also recognised that the Trust's size in respect of procurement opportunities impacted on its benchmarked position.

A presentation was given on Evolve setting out the positive impact this project had and the roll out timeframes. The Committee was given assurances that it was working to budget and time and that more detail on this, benefits realisation and the position of Evolve in the wider IT development programme would be given at a future F&P.

A verbal update on the use of resources assessment was given. Performance across the KLOEs was discussed and the Committee were assured that this workstream was well underway.

Actions to come back to Committee (Items Committee keeping an eye on)

The Committee asked that in the next scheduled update on IT the delivery of the evolve business case milestones and benefits realised be reported.

The Committee asked that business rules be applied and they receive information on the counter measure performance as Medicine delivers their key efficiency schemes across 2019/20 and on any other key areas of performance where these measures are needed.

The Committee agreed they will continue to review the depth of information it receives over the first quarter of the year seeking to apply the Trust's business rules for escalated information where deterioration has occurred or there is an increased risk of a deteriorating position occurring.

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

Item	Referred to
There were no items that required Board/other Committee action or decision	

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	13	**Meeting:**	Trust Board	**Meeting Date:**	30 May 2019
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:	Not applicable 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 12 April 2019, it was attended by the Trust Finance Director and Group Company Secretary along with the Trust's External Auditors, Internal Auditors and Local Counter Fraud Specialist.

The meeting was quorate and was able to discharge its planned items through the receipt and debate of the reports in accordance with its cycle of business.

Key Recommendation(s):

The Board is asked to **NOTE:**

The Audit Committee received and discussed the Internal Audit Report endorsing the steps being taken by the Trust to reduce Medical Expenditure within the Medical Division.

The Audit Committee received a positive Head of Internal Audit Opinion.

The Audit Committee endorsed the draft Annual Governance Statement as a balanced view of the Trust's governance, risk management and internal control processes and that this be included in the draft Annual Report for submission to the External Auditors.

The Trust is on track to submit its financial statements to the External Auditors and that the feedback from the external auditors interim work had been positive.

Western Sussex Hospitals NHS Foundation Trust

To: Trust Board

Date: 30 May 2019

From: Jon Furmston, Audit Committee Chair

Agenda Item: 13

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	**12 April 2019**	**Jon Furmston**	yes	no
			✓	☐

Declarations of Interest Made

None

Actions taken by the Committee

- The Committee **RECEIVED** positive moderate assurance in respect of both design and effectiveness from Internal Audit regarding the IT Asset Management Audit.
- The Committee **RECEIVED** an advisory report on the Medical Expenditure within the Medical Division, which confirmed that the Trust was dealing with the correct issues in order to tackle the overspend which had occurred within the Division.
- The Committee **RECEIVED** the draft of the Head of Internal Audit Opinion; which provided the Committee with an overall Moderate Opinion around the Trusts system of internal controls, based on the Trust's delivery of its financial position, the positive nature of the majority of the internal audit reviews and a strong history of delivering actions where recommendations for improvement have been made
- The Committee **APPROVED** the Local Counter Fraud Specialist Annual Report, following the successfully re-tendering of RSM.
- The Committee **APPROVED** the Going Concern Assessment Report and therein the preparation of the accounts on this basis.
- The Committee **RECEIVED** an updated version of the BAF reflecting the enhanced assurances received since the report presented to Trust Board on 28 March 2019, specifically reflecting the expected reductions in risks 2.1 and 2.2 in relation to budgetary control and the Trust's efficiency plan delivery.
- The Committee **RECEIVED** the first draft of the Annual Governance Statement and agreed it represented a balanced view of the Trust's governance, risk management and internal control frameworks and should be included in the draft Annual Report.
- The Committee **NOTED** and **ENDORSED** the Annual Management and Audit Committee assurance letters that have been submitted to the Trusts External Auditors.
- The Committee **RECEIVED** the post project evaluation on the DocMan Referral System, which provide assurance on the benefits to reducing clinical risk and speeding up the referral process. The Committee agreed this should be presented to TEC to facilitate learning across the Trust.

Actions to come back to Committee (Items Committee keeping an eye on)

- The Committee will ensure the LCFS devotes sufficient focus on cyber fraud within their programme of work for the coming year.
- The Committee sought information on any individuals that have not submitted a declaration of interest on more than one occasion and actions being taken to reinforce their accountability for submission.
- The Committee asked that the Medial Expenditure Advisory Report learning be shared with the other Divisions and the resulting action plan from Medical Workforce Action Group to come back to the Committee for oversight of progress.

Items referred to the Board or another Committee / Group for decision or action

Item	Referred to
Medial Expenditure Advisory Report learning and outcomes to be shared across all divisions.	Medical Workforce Action Group to action.

DocMan Post Project Evaluation learning to be shared across the Trust to aid learning for future business cases.	TEC to receive this report to disseminate the learning across the Trust
Board to have sight of the Trust's actions in respect of the new CQC publication - "Opening the Door to Change", learning from Never Events.	To be considered by the CQC oversight Group who will identify a lead to update the Board.

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	15	**Meeting:**	Trust Board	**Meeting Date:**	30 May 19
Report Title:	Equality, Diversity and Inclusion				
Sponsoring Executive Director:	Denise Farmer, Chief Workforce and OD Officer				
Author(s):	Jennie Shore, HR Director				
Report previously considered by and date:	TEC 16 May 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					
Financial					
Workforce	Applies to all staff and volunteers				
Link to CQC Domains:					
Safe		☐	Effective		☐
Caring		✓	Responsive		✓
Well-led		✓	Use of Resources		☐
Communication and Consultation:					

Executive Summary:

This paper sets out our strategy for improving equality, diversity and inclusion together with an improvement plan that sets out measurable objectives that meet our legal and social responsibilities and continues to shift our culture to one that embraces difference.

Actions directly focused to WRES and WDES are included.

Key Recommendation(s):

The Board is asked to **ENDORSE** the planned actions detailed in the paper.

To: **Trust Board** Date: 30 May 2019

From: Denise Farmer, Chief Workforce & OD Officer Agenda Item: 15

FOR INFORMATION

EQUALITY, DIVERSITY AND INCLUSION

1.0 INTRODUCTION

The Equality, Diversity and Inclusion agenda is a very broad one as it covers Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) as well as our duties under the Public Sector Equality Duty (PSED). It also encompasses our ambitions to be an employer that reflects the societal expectations of the 21st century, which include us being truly reflective of the communities we currently serve, and ensuring that we are able to attract and retain staff from those communities.

This strategy is accompanied by an improvement plan that sets out measurable objectives aimed at delivering our legal responsibilities, whilst continuing with our shift in culture to one that fully embraces all types of equality and diversity. These objectives encompass the ongoing actions from our Diversity Matters Group, as well as setting out some new actions directly focused to WRES and WDES.

The CQC 'Equally Outstanding Guide' for the NHS clearly sets out the link between staff feeling valued and respected with equal opportunities and outstanding quality care. As an organisation that really values our CQC 'Outstanding' rating this is integral to our business.

2.0 BACKGROUND

The workforce issues faced by the NHS as a whole are not dissimilar to those experienced within Western Sussex Hospitals NHS Foundation Trust. Progress has been made in some areas but there are still significant differences in the way that some staff with additional protected characteristics experience the workplace.

In 2015 NHS England launched the Workforce Race Equality Standard. This standard is now in its fourth year and requires NHS organisations to provide data to NHS England on their performance on the following nine metrics: (WRES indicators compare the data for White and BME staff)

1. Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive Board members) compared to the percentage of staff in the overall workforce disaggregated by non-clinical staff; clinical staff (non-medical & medical and dental)
2. Relative likelihood of staff being appointed from shortlisting across all posts
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
4. Relative likelihood of staff accessing non-mandatory training and CPD
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
6. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

7. Percentage believing that the trust provides equal opportunities for career progression/promotion
8. In the last 12 months the number of staff who have personally experienced discrimination at work from their manager/team leader/other colleagues
9. Percentage difference between the organisations' Board membership and its overall workforce disaggregated: by coting membership of the Board; by executive membership of the Board

The Workforce Disability Equality Standard is now mandated in the NHS Standard Contract and applies to all NHS Trusts from April 2019. It is a data standard that uses metrics in a similar way to WRES to determine and assess the experiences of disabled staff within the NHS (WDES indicators compared the data for disabled and non-disabled staff) as follows:

1. Percentage of staff in AfC or medical and dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce
2. Relative likelihood of staff being appointed across all posts
3. Relative likelihood of staff entering the formal capability process, as measured by entry into a formal capability procedure
4. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, the public, managers or colleagues in the last 12 months and Percentage saying the last time they experienced the above they reported it.
5. Percentage of staff who believe the Trust provides equal opportunities for career progression or promotion
6. Percentage of staff saying they felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
7. Percentage of disabled staff saying that they are satisfied with the extent to which their organisation values their work
8. Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work
9. The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation. Whether the trust has taken action to facilitate the voices of disabled staff to be heard within the organisation
10. Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.

Gender Pay Gap, monitoring data and ensuring our LGBTQ+ staff are able to benefit from the shared work being undertaken by our colleagues at BSUH are the other main equality drivers during 2019/20.

3.0 CURRENT POSITION

3.1 Our progress against the Workforce Race Equality Standard (WRES) 2018/19 shows that:

- There is a higher representation 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 202.1
- Overall BME staff are under-represented in non-clinical roles compared to the overall population.
- Although for clinical staff there is an over-representation of BME staff compared to overall population, this decreases in non-medical clinical roles.
- Like many other NHS organisations there is under-representation of BME staff at VSM level.
- Data is suggesting that individuals are less likely to be shortlisted for a position if they are a BME candidate
- Regrettably many members of staff have felt bullied or abused by patients or their relatives; however the percentage of BME staff experiencing this has increased.
- The percentage of BME staff who feel they have been discriminated against by their Manager/team leader has increased during the last year.

3.2 Workforce Disability Equality Standard (WDES)

This will be our first year of completing this Standard. Our WDES report is currently being produced by our colleagues at BSUH and will be available by the end of May. Our focus will be to ensure that we concentrate on the areas requiring the most improvement.

3.3 Annual Equality Report

This report which is produced annually has set out some clearly defined objectives, which are aligned to items highlighted within the improvement plan:

- Declaration rates for the various protected characteristics throughout the organisation vary from 100% for Gender and Age, 65.7% for Disability, 72.2% for Religion or Belief and 76.7% for Sexual Orientation
- Better engagement with patients to encourage greater trust with patient monitoring exercises
- Analyse and review recruitment and selection processes and provide training to improve fairness and equity of outcome across protected characteristic groups
- The 'Reducing Abusive Behaviours' corporate project via a campaign is being undertaken as part of WRES and WDES.

3.4 The current capacity to drive improvement in equality, diversity and inclusion has on the whole been led from within the OD and Leadership directorate with a small resource and limited expertise. In order to support the delivery of the improvement plan and make the cultural shift required, Barbara Harris, Head of Inclusion with other colleagues from BSUH has started to work collaboratively with the trust. This is very welcomed and will provide the expertise and span of knowledge required, help to identify a future resource plan and build on continuous improvement and shared learning.

4.0 IMPROVEMENT PLAN

Key improvements that we intend to focus on over the next 2 years include:

- 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 completing 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 this 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.

5.0 COMMUNICATION AND ENGAGEMENT

Key messages must be outlined on a regular basis and shared with staff, patients, service users and the wider community. This is to ensure that the message does not get lost that we are an inclusive organisation.

- We need to highlight and promote why this is important to us
- Why our senior leadership team is fully behind this and driving the culture of change forward
- The benefit that this has not just to our staff, but also in the way we deliver care
- How progress is being measured and monitored
- What has been undertaken so far

6.0 MONITORING AND REVIEW

Progress will be reported via Diversity Matters Group.

7.0 CONCLUSION

The CQC 'Equally Outstanding Guide' for the NHS sets out the clear link between staff feeling valued and respected with equal opportunities and outstanding quality care. At Western Sussex Hospitals NHS Foundation Trust we wish to continue to be recognised as an organisation that delivers Outstanding care and provides Outstanding services and by adopting the recommendations highlighted above, we will continue to demonstrate that:

- We have a leadership that is fully committed to equality and inclusion
- Are continuing to develop a strong culture of inclusivity, where our staff are equally fully engaged in the improvements that are required
- Are listening to the people using our services
- Are not afraid to tackle difficult issues

8.0 RECOMMENDATIONS

The Committee is asked to:

a) Review and comment on the attached new Strategy and Improvement Plan and the governance monitoring and reporting arrangements set out

b) Approve both documents and the programme of work set out, making any further recommendations as appropriate

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	16	**Meeting:**	Trust Board	**Meeting Date:**	30/5/2019
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:	Jan 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	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 and discuss the progress toward implementation of the 'Learning from Deaths' policy and the learning identified from structured mortality reviews.					

1. Screening of Deaths

1.1 The Trust currently screens deaths at consultant level using a set of prompts designed to cover board areas where problems in care may occur and referral for Structured Judgement Review may occur through this process.

1.2 In Quarter 3 73% of deaths were screened through this process.

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 limited and can lead to delays in identifying cases for full review. The Trust continues to aspire to move toward a daily review process and will be piloting this during Q1 2019-20.

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 Reviewed by LeDeR process	Avoidable LD Deaths*	Total % of deaths reviewed
Oct 18	166	30	1	0	0	0	0	18.1%
Nov 18	160	24	0	3	3	0	0	16.9%
Dec 18	204	25	0	0	0	0	0	12.2%
Total (Q3 18/19)	530	79	1	0	3	0	0	15.5%

*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 Q3 that was considered more likely than not due to problems in the care of the patient.

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 3 referred for SJR have been reviewed.

2.2 The table above shows the Q3 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 for deaths occurring in Q3.

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 3.

2.4 The SJRs also categorises problems into broad themes where issues identified. Table 3 shows these for deaths in quarter 3

Table 2: Data labels show the number of responses for the criteria

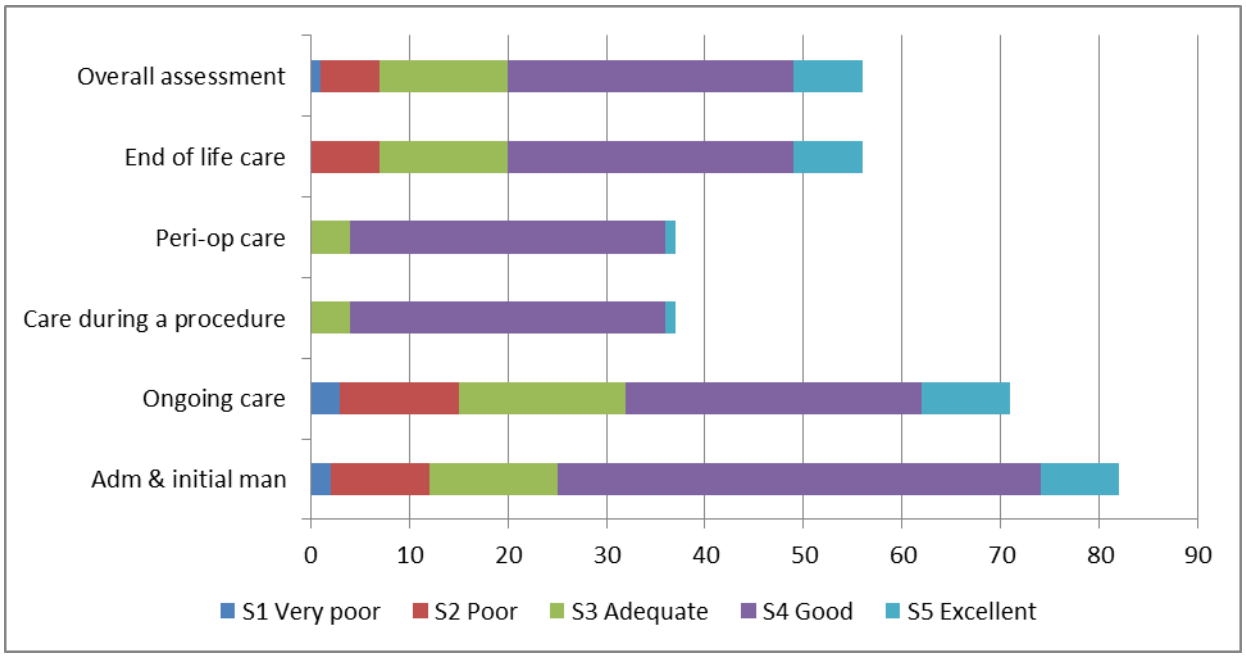
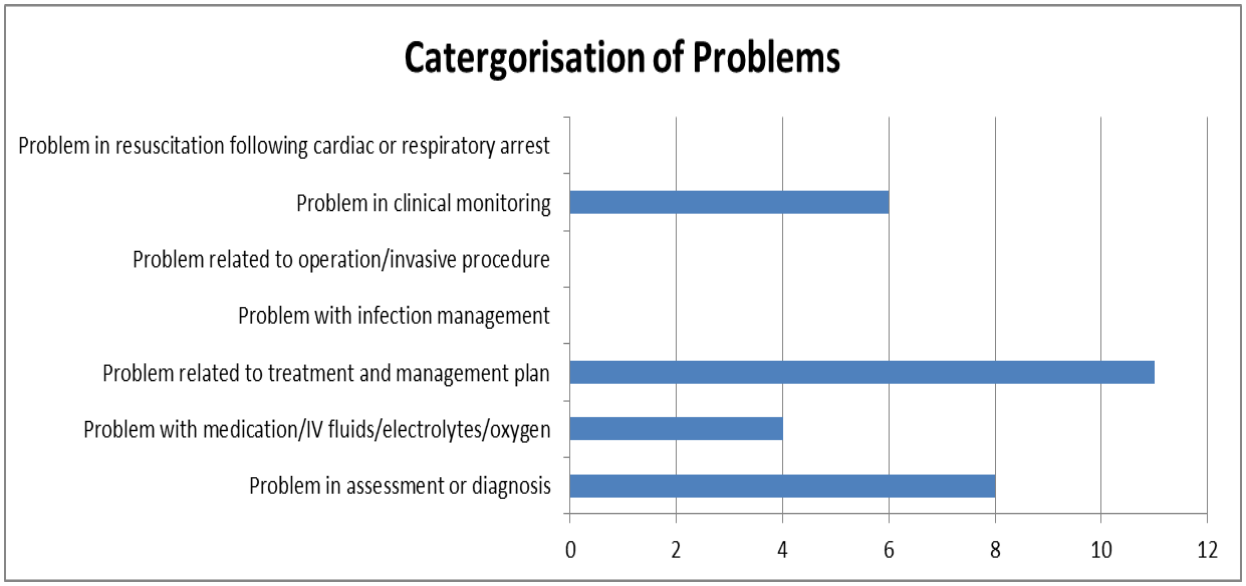


Table 3: Data labels show the number of responses for the criteria



Structured Judgement Reviews Q2 - Learning

Overall Care Score	**Learning Themes**	**Actions**
Excellent Care	Multiple examples of excellent end of life decision making and well documented discussions with patients/families and carers One example of excellent multi-organisational teamwork to fulfil an elderly frail patients wish to die at home	Feedback to relevant clinical teams. Use as examples in training

Good Care	Examples of prompt identification and rapid management of both inpatient and emergency presentations with sepsis Multiple examples of good, well documented timely end of life decision making and family discussions	Feedback to relevant clinical teams
Adequate Care	Lack of capacity assessment with regard to end of life decision making and difficulties obtaining psychiatric review Over intervention and unclear ceilings of treatment related to end of life. Examples of failed discharges due to an insufficient package of care	New appointment to adult safeguarding in post providing support for the capacity assessment process End of life issues arising from the review process have been discussed at an end of life summit and are forming part of a broader strategic EOL action plan Further work to investigate 30 day readmission rate.
Poor Care	Late consideration of ceilings of treatment in very frail elderly patients Communication/continuity of care issues related to medical outliers.	See actions under 'adequate
Very Poor Care	Missed pulmonary embolism	Case presented at clinical governance meeting on February 27th 2019. Feedback to A&E teams at departmental case / mortality meetings – March 2019. Case presented at Triangulation committee, and included in monthly patient safety briefing for use at daily huddles. Present at mortality and deteriorating patients group.

3.

Capacity and Risk

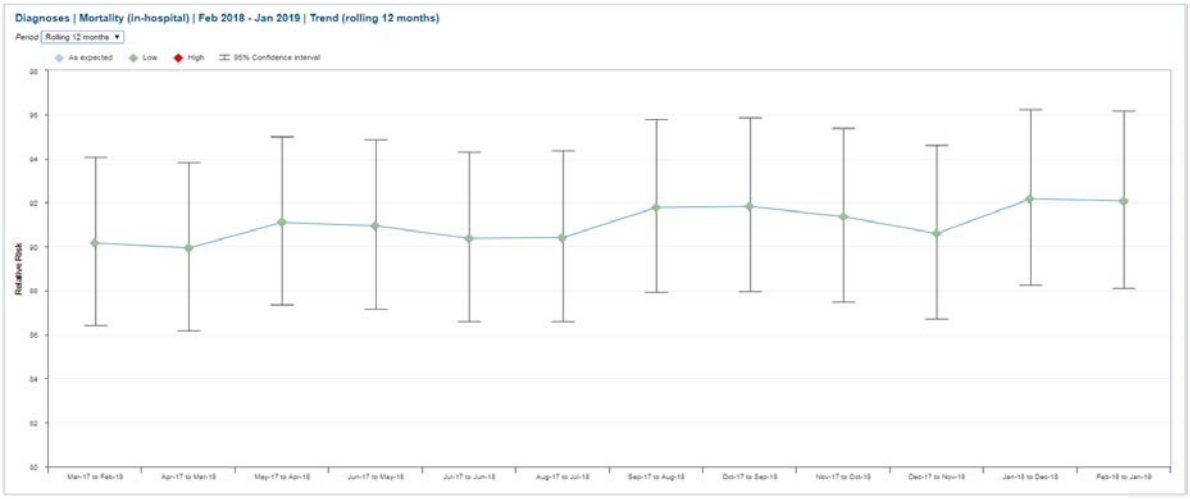
3.1 For reviews of deaths occurring in Q3 capacity has remained an issue. All reviewer posts are however now filled and a new process of allocation has now commenced

3.2 A learning from deaths manager has now been appointed who is currently leading the review of current screening and structured review processes.

4. Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)

4.1 For the 12 months to January 2019 performance using HSMR is 92.45 (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.

4.2



Progress and Next Steps

4.3 The Trust has now recruited to all it's reviewer posts and a new method of allocation established

4.4 A Learning from Deaths Manager has been appointed who is co-ordinating review activity and leading on improving screening/review processes and ensuring learning is shared across the organisation

4.5 A change in the current screening process to a 'daily' review process will be tested early in July 2019 with view to rolling out across the organisation

4.6 Learning from review activity continues to be presented in a number of internal and external forums.

4.7 An end of life summit was held in May in collaboration with local hospices, commissioners and primary care representatives to bring together related work streams and refine and prioritise a programme of work.

4.8 The mortality steering group is amalgamating with the end of life board to ensure a co-ordinated strategic plan is delivered and broaden the membership of both groups

4.9 A Darzi project has commenced part of which will look at how we can better involve bereaved relatives and carers in the learning from deaths process.

5. CQC Learning from Deaths – Driving Improvement Report (Appendix 1)

5.1 The CQC carried out qualitative analysis of interviews and focus groups with inspection staff and advisors. They were all involved in well-led inspections between September 2017 and June 2018. They also carried out a case study analysis of three trusts that were rated outstanding for well-led between September 2017 and June 2018.

5.2 The CQC found significant variation in how trusts are implementing the learning from deaths guidance. While awareness of the guidance is high, some trusts were finding it more difficult than others to make the changes they need.

5.3 The findings suggested the factors that help trusts to put the guidance into practice are:

- values and behaviours that encourage engagement with families and carers
- clear and consistent leadership
- a positive, open and learning culture
- staff with resources, training and support
- positive working relationships with other organisations

5.4 The full CQC report is included in addition to a brief summary of the work we are doing locally to address the main themes (appendix 2)

6. Recommendation

6.1 The Board is asked to receive and discuss this report and the learning identified from the structured judgement review process.

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Care Quality Commission

Corporate member of
Plain English Campaign
Committed to clearer
communication
459

Western Sussex Hospitals
NHS Foundation Trust

Briefing on the CQC Review of learning from Deaths

Background

In December 2016, the CQC 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. Guidance issued by the National Quality Board in March 2017, the specific guidance for NHS trusts on working with families and carers, published in July 2018, and the announcement of the new arrangements for introducing medical examiners are some of the developments the Trust has been working on over the last 10 months. This report, through examples and case studies, identifies some good practice examples and on-going concerns based on a CQC review of progress.

The Report

The report highlight five themes that were found to support or inhibit a trusts ability to improve from the process. The following factors were identified as key to trusts implements the 'Learning from Deaths' guidance well

- values and behaviours that encourage engagement with families and carers and support for staff
- clear and consistent leadership and governance by a specific person who is at a reasonably high level in a trust's hierarchy
- a positive, open and learning culture that encourages staff to speak up about safety issues and has a focus on improving the care of patients
- staff with the resources, training and support to carry out reviews and investigations
- positive working relationships with other organisations also providing care for the person who has died, to enable the sharing of information and learning from any investigation.

A number of examples of good practice are highlighted in the report

What are we doing?

Values and behaviours that encourage engagement with families and carers and support for staff

1. We have updated our SI policy/process and training to reflect the core principles set out in the 2018 national guidance
2. We are in the process of updating the relative/carer information pack to reflect the national recommendations
3. We have a Darzi project which has just commenced which will focus on both how we care for relatives/carers at the time of bereavement and how we involve them more directly in the learning from deaths process

Clear and consistent leadership and governance by a specific person who is at a reasonably high level in a trust's hierarchy

1. Our process is currently lead by the medical director supported by the clinical effectiveness and newly appointed learning from deaths manager
2. Currently governance is through reporting to quality board with additional reporting to the Triangulation committee and the joint Performance and Quality group with our commissioners. Additionally a quarterly report is presented at the end of life board
3. We need to consider how this is reflected in divisional governance agendas
4. We are currently reviewing the learning from deaths process which will include descision making around individual cases, better links with the complaints and SI process and communication and feedback with individuals, speciality teams mortality and morbidity process and divisional governance processes.

A positive, open and learning culture that encourages staff to speak up about safety issues and has a focus on improving the care of patients

1. This is reflected across our Trust policies but with particular reference to the SI policy and the Raising Concerns (whilstleblowing) policy

Staff with the resources, training and support to carry out reviews and investigations

1. The trust has invested in 6 reviewers and provided training to a number of other staff groups to support the SJR process. We have not taken a view that all staff need to be trained in the SJR process but focused on developing expertise among key staff. As the process develops we will need to review this. There is also training provided for carrying out RCA's as part of the wider training programme around managing serious incidents

Positive working relationships with other organisations also providing care for the person who has died, to enable the sharing of information and learning from any investigation.

1. We have opened membership of the trusts mortality steering group and panel to include external partners with varying success. We have had good attendance by our local hospice palliative care consultants but primary care have been unable to provide anyone to attend to date. The amalgamation of the mortality steering group and end of life board will broaden membership of the steering group but this will need further attention in 2019

2. We have developed good working relationships with LeDeR process both supporting reviewers and attending the wider strategic LeDeR meetings. The capacity problems with LeDeR and the slowness of reporting have however meant there has not been the opportunity to fully realise the benefits of this process. This will need to be progressed going forward

3. We have presented thematic learning at GP forums in an effort to share some of our learning and prepare the way for the rolling out of review to primary care in the future

4. Priorities for 2019 must include how we can have closer liaison with both primary care, community and mental health both in the individual review process and sharing the learning from the learning from deaths work.

The report contains a number of useful case studies that we can use as we refine and further develop our own processes

Simon Higgs
Clinical Effectiveness Manager

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Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	17	**Meeting:**	Trust Board	**Meeting Date:**	30 May 19
Report Title:	Annual Patient Experience Report 2018/19				
Sponsoring Executive Director:	Maggie Davies, Chief Nurse				
Author(s):	Lisa Ekinsmyth, Matron for Quality Katrina O'Shea, Patient Experience Matron				
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:

The purpose of this report is to provide 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 within Western Sussex Hospitals NHS Trust for 2018/19.

Key Recommendation(s):

The Board is asked to **RECEIVE** this report.

Western Sussex Hospitals
NHS Foundation Trust

Patient Experience Annual Report

2018 – 2019

Compiled by:

Katrina O'Shea – Head of Patient Experience

Contents

Introduction

Patient experience matters. Systematic reviews have shown 'consistent positive associations between patient experience, patient safety and clinical effectiveness for a wide range of disease areas, settings, outcome measures and study designs'[1]. In short, excellent patient experience is indicative of excellent care.

At the heart of the Trust's strategy is the commitment to create a culture where patients really are at the heart of everything we do and that a patient centred way of working is embedded across the Trust.

During 2018/19 we received feedback from patients, from a wide range of sources including Friends and Family Test feedback, national and real-time patient surveys, Patient Advice Liaison Service (PALS) enquiries and complaints[2].

This feedback provides us with a rich picture of patient experience while also offering insight into what matters to patients. We want to be an organisation that truly listens, learns, changes and improves whilst being open and transparent, sharing the learning widely.

Improving patient experience is at the heart of the Trust's vision and values, and our Patient First Programme. Patient First is our long-term approach to transforming hospital services for the better by giving staff the skills to deliver continuous improvement and to put our patients first.

The purpose of this report is to provide 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 within Western Sussex Hospitals NHS Trust during 2018.

Patient experience monthly reports are provided to operational teams and patient comments are automatically shared with our staff. Leaders of our clinical services use the feedback we receive from patients to shape quality improvement activities at ward level and see whether the improvements we are making improve patient experience over time.

The Trust Board has oversight of patient experience through quarterly reports at public Trust Board meetings. The Chief Nurse is the Executive Lead for patient experience. Non-Executive Directors chair the Patient Experience and Feedback Committee that oversee the Patient experience feedback activities and patient experience improvement programmes within the Trust. Their role is to be assured that action on improving and responding to patient experience concerns are addressed.

Membership of the Patient Experience and Engagement Committee includes representation from; Trust staff, Coastal West Sussex Clinical Commissioning Group, Trust Governors, and Health watch. This group routinely reviews patient experience improvement programme actions and progress, to ensure areas of poor patient experience are addressed.

We know from existing feedback there are many examples of excellent care and experience being delivered by our staff and the overwhelming majority of patient's comments are very positive. Staff are frequently described of as kind not only towards patients but also towards each other and go above and beyond the expected level of care.

[1] Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open 2013;3:e001570. doi:10.1136/bmjopen-2012- 001570

[2] Friends and Family Test is a national survey used to measure patient experience

However there are occasions where we know we do not get things right for every patient every time. Our Patient Experience Strategy has been developed during 2018 using feedback from our patients to help drive improvements. It sets out how we will improve, sustain and develop essential aspects of care and how we will measure progress. Full details of the seven ambitions within the strategy are included at the end of this report.

Local Improvements Implemented during 2018, benefitting Patient Experience

Progress of Always Events Improvement Project

In March 2018, Ford Ward commenced a coaching programme with NHS England called Always Events®, the objective of this is to identify improvements based on the patient's perspective and experience. The team created a vision statement during their team away days: 'My family and I will be communicated with when there are changes in my condition'. The aim of the quality improvement work is to achieve 90% of patients/families will state they have been kept up to date about their condition and treatment.

The team on Ford Ward have recently introduced a communication aid which gives a general update of individual patient's care. The team is also reviewing the contents of a folder of information that is provided for patients and family with patients to see if the content is up to date and considered useful by the intended audience. These two changes will continue through PDSA cycles to understand what is preferred from the patient's and family's perspective.

The team on Ford Ward discussed at an away day what good communication feels like across the team and with families and have drafted a staff commitment regarding how they will always communicate with each other, patients and their relatives/carers:

- Treat everyone with warmth, understanding and compassion.
- Respect others and try to understand their perspective, always be non-judgemental and tolerant.
- Always be kind, helpful, caring and friendly with everyone.
- Always be honest, informative and seek advice from others if unsure, (i.e colleagues, patients and families).

This engagement opportunity was well received by the nursing team and there has been a reduction in negative feedback received on this ward following Ford Ward's team day. The ethos of Always Events will continue to be shared across the Trust in the future.

Changes Introduced to improve Security of Patient's Property

A charitable donation of nearly £4,000 during Q3 from Pizazz (the staff Choir at St Richards Hospital) has been used to purchase secure property boxes for 55 clinical areas across the Trust. It is anticipated that a designated safe place will reduce the number of items that cannot be located after they have been taken for safe keeping.

Following the launch of the revised property policy in 2018 a new document for listing patient's valuables has also been trialled and implemented. This change to our documentation standard is hoped will increase compliance but it will also mean that patients can opt to have cash returned to them rather than a cheque which used to be the standard method for the returning money to all patients.

Accessible Information Standard

The Accessible Information Standard aims to make sure that disabled people who are our patients, service users and their carers and parents have access to information that they can

understand and any communication support they need. This includes making sure people get information in different formats if they need it, such as large print, Braille, embossed, easy read, via email and visual/British Sign Language (BSL).

The Trust has an Accessible Information Policy to ensure that there is a clear process for staff to identify, record, flag, share and provide communication support to patients, carer and parents who may have a disability, impairment or sensory loss. A wider communication cascade is required to raise the use of the EIDO leaflets so that patients reliably receive high quality, written information in a range of languages. A film is currently being edited that will illustrate the negative impact it has on patients when their communication needs are not recorded reliably on Sema, or managed by staff.

Training is being arranged for targeted staff that routinely book or welcome patients into clinics to increase the likelihood of a person's communication needs being routinely recorded when they have contact with the Trust. Broad training has also commenced via the Health and Safety mandatory training session to encourage staff to support patients if they recognise that they have communication needs.

The outcome of the business case for a software application called 'recite me' is awaited. This software will enable people to adapt the written information that is available on the Trust website, to 103 different languages and convert text to speech.

Another IT application called SNOMED will also prompt staff to record patient's communication needs on an annual basis when SEMA is upgraded with this functionality.

Extended Visiting Hours

The visiting times across the Trust for all adult patients has increased to 10:00-22:00 throughout 2018. The decision, which applies to all adult inpatient areas, was informed by feedback from pilots on six wards where open visiting 24 hours a day was trialled for three months.

Benefits from extended hours include more opportunities for consultants and therapists to talk in person with relatives, who in turn will hopefully feel less rushed when trying to speak to the nurse in charge. Previously staff often received a sudden influx of enquiries at 3pm, just as visiting hours began.

The change enhances patient experience by the simple truth that patients enjoy visits and some will also benefit by their visitors assisting at mealtimes.

It is hoped car parking will also prove easier for visitors if demand is spread more throughout the day.

There has not been an increase in concerns or complaints from patients or their families since this increased access has been introduced.

PAT Dogs

Pets and animals enhance the quality of life for many people, they can provide valuable companionship, stimulation and comfort. Following a trial last year a draft Animals and Pets in Hospital Policy has been written in order to address infection control concerns about the potential health risks of implementing therapeutic visits by PAT dogs. The policy also includes allowing patients' pet dogs and other suitable species of pet to be brought into the hospital environment for certain circumstances and was ratified in October 2018.

The process of recruiting PAT Dogs and their owners is being implemented by the Voluntary Services Managers. The scheme will result in PAT dogs and their owners being linked with a ward so that they can form a weekly visiting routine and develop therapeutic relationships with

the patients and clinical teams. Initial feedback is that the PAT Dogs are very popular and requests for visits are greater than can be provided during the early phases of implementation.

Achievements in relation to the two Key Patient Experience Improvement Goals for 2018/19

- To align to our Patient First, true north metric for patient experience which will use our FFT scores and return rate. For 2018/19 we aim to achieve >97% satisfaction <0.7% not recommend rate and a return rate >40%. There has been significant progress and a marked improvement in performance. A&E had an internal target of >93% satisfaction <0.7% not recommend rate and a 20% return rate. All areas are engaging well in activities that will work towards achieving this objective.

The goal for 2018 was that by the end of 2018/19 we would have no more than 60 complaints open and 60% of formal complaints would be responded to within 25 working days.

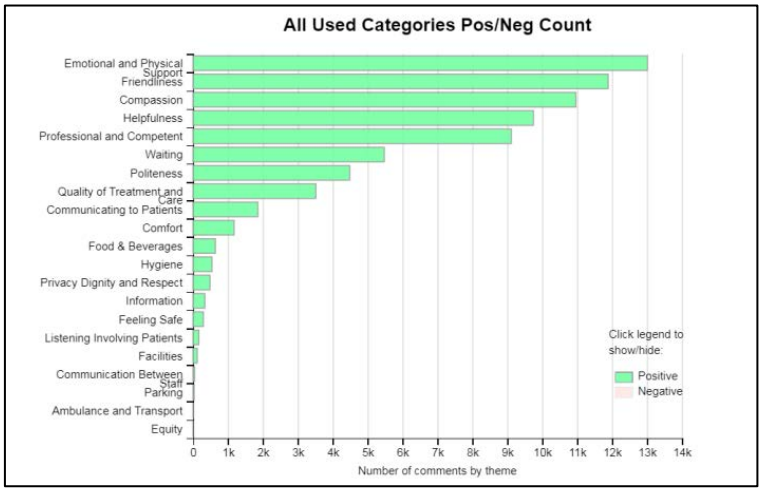
- At the time of reporting we have 80 complaints open.

- 61% of formal complaints are resolved within 25 working days at the end of March 2019 (previously 11.8% in at the end of June 2017).

Friends and Family Test

The Friends and Family Test (FFT) is a national survey designed to give the public an easy way to express their feedback. Our trust utilises returned tests through a multitude of facets. Initially, FFT results help raise any issues patients may have with our service, often illuminating latent issues which are not raised through the formal complaints process. Negative feedback is swiftly analysed and provides us with an initial step for improvement.

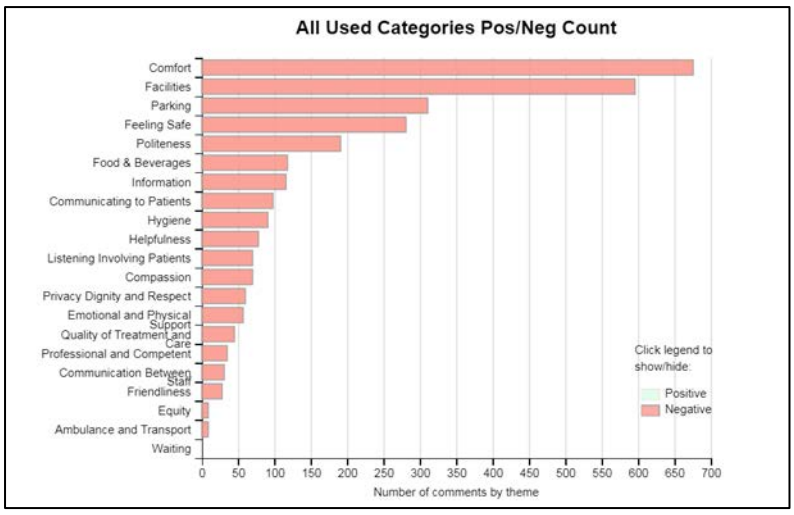
Positive and neutral feedback provides a further prospect of quality improvement. Our software Pansensic's thematic analysis tool provides a rich source of the most commonly raised themes brought up by patients. The tables below separate the positive and negative themes for the year, allowing a clear analysis of areas to celebrate and those that require further exploration.



Physical and emotional support provided by friendly, helpful, compassionate and professional staffs are most valued by patients, the total comments received for each listed below:

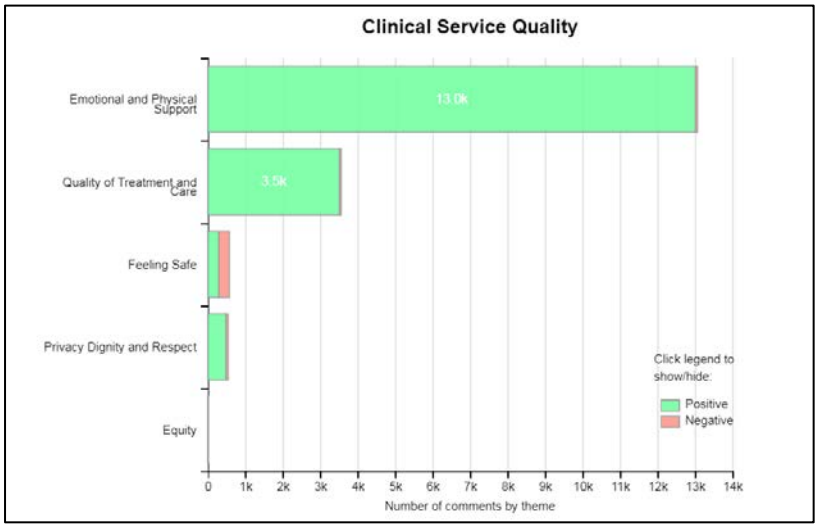
Emotional/Physical Support 13,016
Friendliness 11,891
Compassion 10,965
Helpfulness 9,751
Professional/competent 9,117

Comfort, facilities, parking and feeling safe are the areas of most concern for our patients, the numbers of comments received for each listed overleaf:



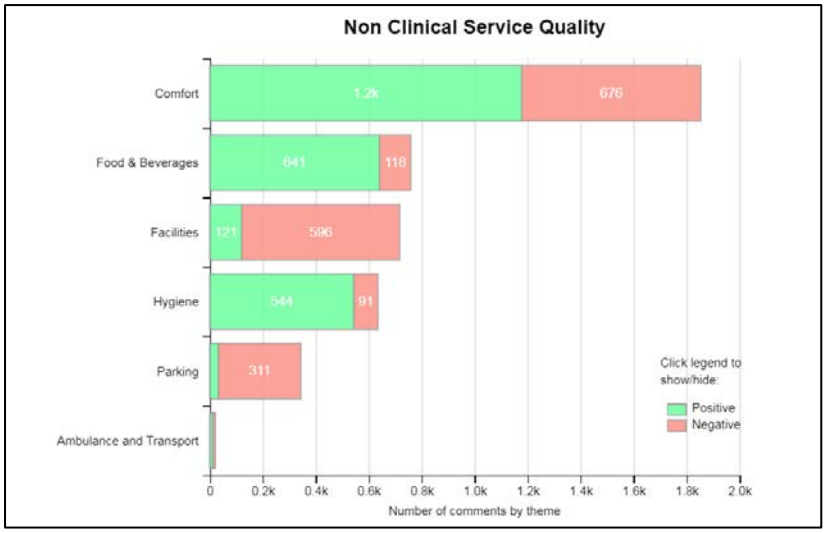
Comfort 676
Facilities 596
Parking 311
Feeling safe 281

This can be further analysed by clinical and non-clinical themes, as below:



Patient negative comments on feeling safe describe:

Upsetting verbal abuse from patients towards staff and other patients.
Rude, abusive and intimidating visitors
Feeling isolated or left alone.



Patient comments relating to comfort and facilities describe:

Being too hot or too cold in both outpatient and inpatient areas.
Crowded and cramped waiting areas.
Noise on the wards at night from other patients, monitors and staff.
Uncomfortable seating in maternity, outpatients clinics.

Parking comments relate to difficulty parking, lack of spaces and cost of parking.

FFT returns also allow for a comparison to be made with our Trust on a national scale. A high return and recommendation rate of FFT scores is indicative of a good service. Moreover, it allows members of the public to easily see how well their local hospital performs. Improving our FFT return and recommendation rate thus allows us to instil greater confidence in our Trust by our local community. We therefore attempt to become one of the top 20% of NHS Trusts in country for recommendation by patients responding to the Friends and Family Test.

How Do We Monitor It?

From 1 April 2013, (for inpatients and A&E attendees), 1 October 2013 (for maternity) and April 2015 (for children, outpatient and day case areas) organisations providing acute NHS services have been required to implement FFT.

Each patient must be surveyed at discharge or within 48 hours of discharge and the standardised question format must be as follows: "How likely are you to recommend our ward (or department) to friends and family if they needed similar care or treatment?"

The maternity areas ask this question of mothers at four key points of their maternity journey: antenatal care (at 36 weeks pregnancy), delivery, postnatal ward and community care.

There is also a requirement to support the gathering of feedback from groups who may have problems with providing feedback through traditional methods, e.g. patients with learning disabilities, dementia, visual and hearing impairment.

Cards are used to capture the majority of our FFT feedback including: all outpatient and day case areas although SMS[3] feedback is utilised for patients that have been discharged from our A&E departments.

How Do We Report It?

Patient feedback, both from FFT and real time patient experience (RTPE) surveys are routinely provided directly to ward and department managers on a monthly basis which include individual comments. Key metrics are included in the Quality Scorecard provided to the Trust Board. Each ward displays the FFT score for that ward for patients and staff to see.

FFT - Specific Goals for 2018/19

Our overall goal for 2018/19 was to increase FFT scores to a level that places us in the top 20% of NHS Trusts in the country for recommendation rates.

A&E:

- To achieve an increase in response rates which places the Trust in the top 20% NHS Trusts in terms of the FFT response rates. To achieve a top 30% position for recommendation.

Maternity:

- To improve our current very positive position aiming for a top 30% ranking for both FFT return rates and recommendation rates on both sites. It should be noted that the national FFT results for maternity only allow for comparison of the question asked at delivery.

Inpatient:

- To achieve 40% FFT response rate for in-patients, 97% recommendation rate, and not to exceed 0.7% not recommend rate.

Outpatient:

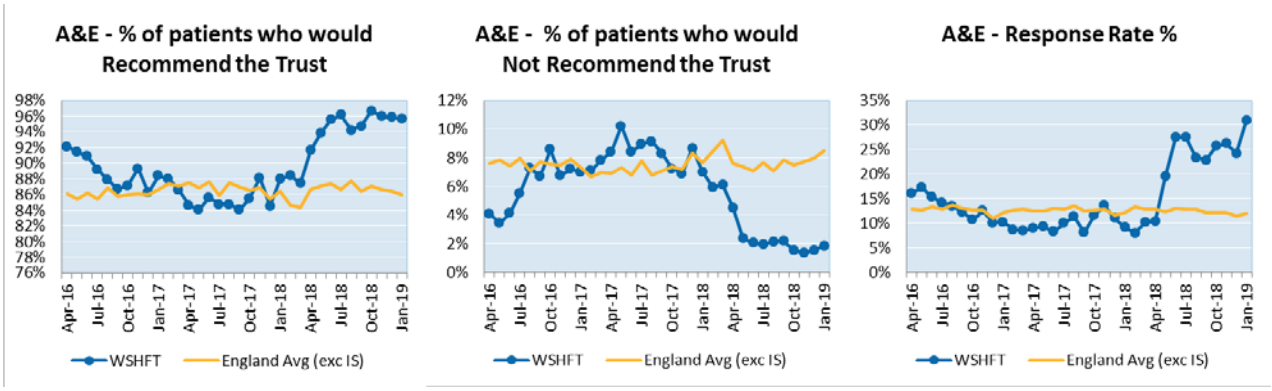
- To improve FFT response rate and achieve recommendation rates in line with national average of 92%.

[3] SMS, short message service, i.e. a 'text message'

FFT Performance 2018/19 A&E:

A&E FFT recommendation rate is 95% compared to a national average of 87%. This performance is just outside the top 10% of for 2018/19 year to date. The trust is currently ranked 10th out of 137 trusts (7th centile). We have achieved our goal of returning to the top 20% nationally for A&E FFT recommendation during 2018/19.

The Trusts A&E FFT response rate is 24% compared to national average of 12% during 2018/19.



N.B. 2018/19 National figures presented are Apr 18 to Jan 19 only.

FFT A&E Recommend Rate:

	2014/15	2015/16	2016/17	2017/18	2018/19	National average 2018/19 *	National position 2018/19
WSHFT	90.60%	91.39%	89.01%	85.8%	95.3%	86.8%	10 out of 137 (7th centile)
Worthing	90.90%	92.77%	90.5%	86.2%	96.2%	N/A	N/A
St Richards	90.30%	88.68%	86.7%	85.2%	91.3%	N/A	N/A

N.B. 2018/19 National average figures presented are Apr 18 to Jan 19 only.

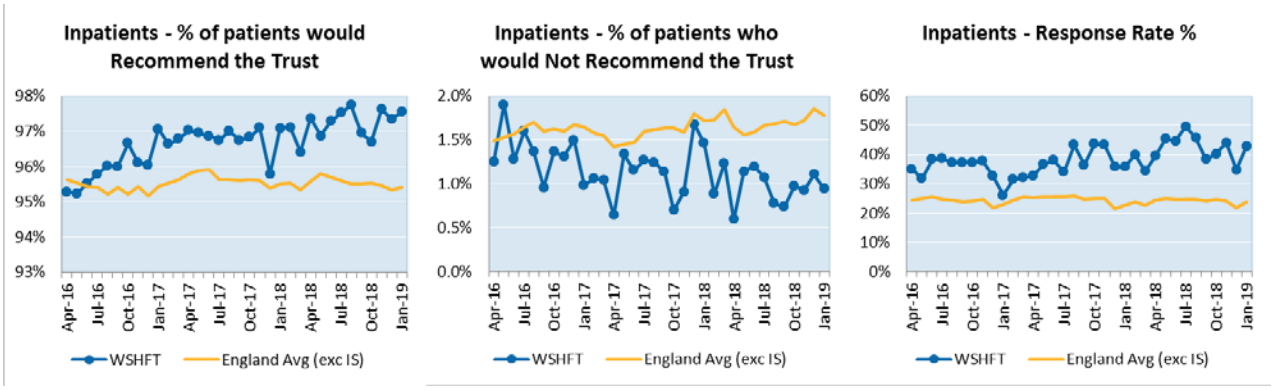
FFT A&E Response Rate:

	2014/15	2015/16	2016/17	2017/18	2018/19	National average 2018/19 *	National position 2018/19
WSHFT	26.70%	17.8%	12.5%	9.9%	23.8%	12.4%	7 out of 137 (5th centile)
Worthing	27.50%	21.5%	13.6%	10.1%	34.4%	N/A	N/A
St Richards	25.90%	13.3%	11.2%	9.7%	9.8%	N/A	N/A

N.B. 2018/19 National average figures presented are Apr 18 to Jan 19 only.

FFT Performance 2018/19 Inpatients

Our Inpatients FFT recommend rate of 97% is ranked in the top 25% of trusts nationally and exceeds the national average of 95.5%. This improvement over last year saw our national position increase to 34th of 148 (23rd centile). Our inpatient FFT response rate reached 42.5% compared to a national average of 24%, resulting in our position improving to 12th of 148 (8th centile) and FFT Inpatients attaining a 40% response rate across the Trust which is an improvement on last year's performance.



FFT Inpatient Recommend Rate:

	2014/15	2015/16	2016/17	2017/18	2018/19	National average 2018/19 *	National position 2018/19
WSHFT	92.40%	95.2%	96.1%	96.8%	97.3%	95.5%	34 out of 148 (23rd centile)
Worthing	92.10%	94.5%	96.1%	97.0%	98.3%	NA	NA
St Richard's	92.70%	95.5%	95.9%	96.4%	96.5%	NA	NA

N.B. 2018/19 National figures presented are Apr 18 to Jan 19 only.

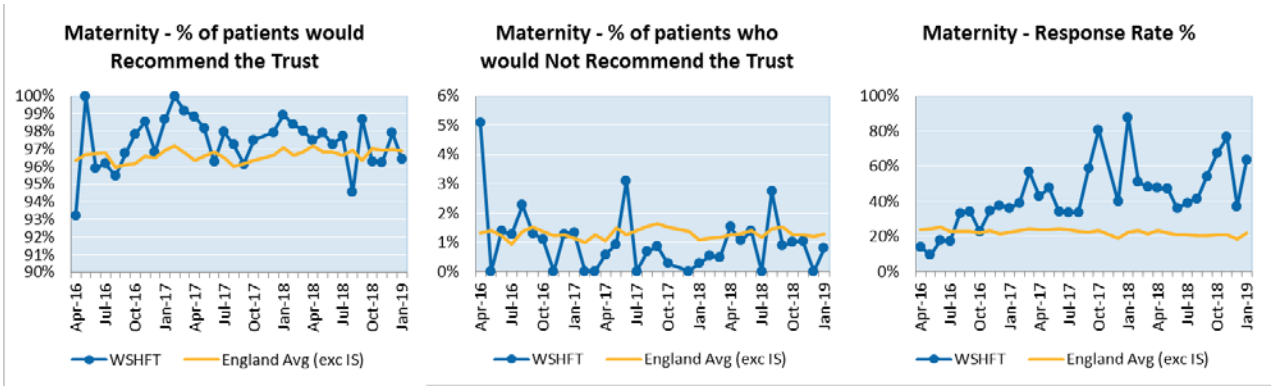
FFT Inpatient Response Rate:

	2014/15	2015/16	2016/17	2017/18	2018/19	National average 2018/19 *	National position 2018/19
WSHFT	30.70%	25.8%	34.7%	37.8%	42.5%	24.2%	12 out of 148 (8th centile)
Worthing	30.80%	29.5%	42.3%	36.5%	48.8%	NA	NA
St Richard's	30.60%	25.2%	26.9%	39.3%	38.5%	NA	NA

N.B. 2018/19 National figures presented are Apr 18 to Jan 19 only.

FFT Performance 2018/19 Maternity

Our FFT birth response rate surpasses improvements seen in our inpatient scores. Maternity response rate has been maintained at 51% compared to the national average of 20.9 which helped increased our national position from 6th of 130 NHS trusts (5th centile).
Maternity recommendation rates are at 97% compared to a national average of 96.9% puts the trust 47 out of 130 NHS trusts (36th centile).



FFT Maternity Delivery Response Rate:

	2014/15	2015/16	2016/17	2017/18	2018/19	National average 2018/19 *	National position 2018/19
WSHFT	29.10%	11.7%	29.1%	50.7%	50.8%	20.9%	6 out of 130 (5th centile)
Worthing	25.40%	11.1%	24.4%	48.6%	48.9%	NA	NA
St Richard's	32.30%	12.3%	33.3%	52.7%	52.5%	NA	NA

N.B. 2018/19 National figures presented are Apr 18 to Jan 19 only.

FFT Maternity Delivery Recommend Rate:

	2014/15	2015/16	2016/17	2017/18	2018/19	National average 2018/19 *	National position 2018/19
WSHFT	97.00%	96.2%	97.6%	97.8%	97.0%	96.9%	47 out of 130 (36th centile)
Worthing	94.70%	96.3%	96.5%	97.2%	96.4%	NA	NA
St Richard's	98.50%	96.2%	98.4%	98.3%	97.4%	NA	NA

N.B. 2018/19 National figures presented are Apr 18 to Jan 19 only.

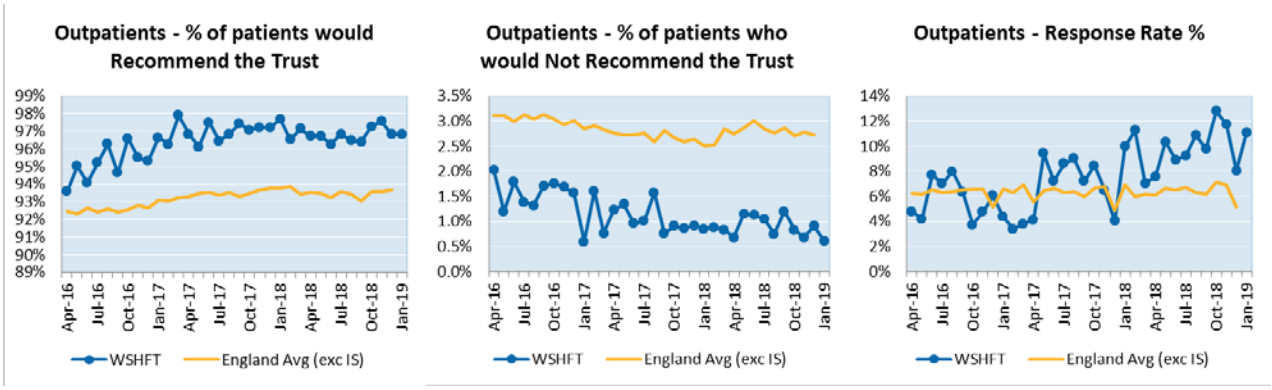
FFT Performance 2018/19 Outpatients

It is very encouraging to see that our overall recommendation rate has been maintained Trustwide at 96.8%, just below the target of 97%. This is a significant achievement as the National Outpatient recommend rate is 93.5% for 2018/19.

An overview of positive and negative themes reveals patients disatisfaction relates to:

- Parking dissatisfaction continues to be due to the lack of general spaces at Worthing and St Richard's.
- Comfort issues raised were due high temperatures on Bosham Ward, the noise of the MRI scanner and the waiting area in Breast Symptomatic at St Richard's being dark.
- Facilities comments included not enough seating in Eye Care at Southlands and no one to welcome you to Rheumatology Clinic at Southlands.

There is an opportunity to improve the consistent use of parking concessions overall across the Trust. This will be progressed with Estates & Facilities in the coming months. It is hoped that the implementation of the Trust Green Travel Plan will also alleviate some of the parking challenges faced during the daytime for patients and their families.



We also use the information we gather from a range of other methods to inform us of patient experience, this helps us understand where we can make improvements and does allow us to monitor the progress towards our goals.

National Surveys

During 2018 we have participated in three key national surveys conducted on behalf of the Care Quality Commission (CQC); the Cancer Inpatient Survey, the National Maternity Survey and the National Inpatient Survey. The full In Patient Survey report will be published later in 2019 and the highlights of these results are provided below.

National Inpatient Survey 2018

The National Inpatient Survey results have been delayed by the Survey Co-ordination Centre because there appears to have been changes to the results this year compared to the previous year.

At the time of reporting the trust has received headline information which reveals that:
Whilst comments about staff, care and treatment and the pathway of care were more positive than negative, comments about aspects of the hospital environment and facilities were largely negative.

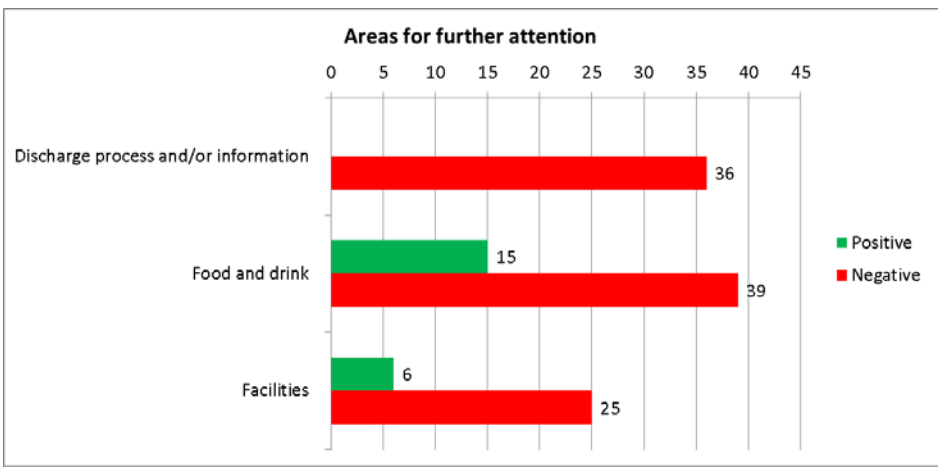
Over half the comments about the pathway of care were positive. Comments about the hospital stay itself were largely positive. The discharge process/information received most of the negative comments in this area.

Over half the comments about care and treatment were positive. A quarter of the negative comments in this area related to communication.

Over three quarters of the comments about staff were positive. 20% of comments about doctors were negative. 93% of comments about nurses and all comments about therapists were positive. It is worth noting that half of the negative comments about staff were about staff shortages.

Almost three quarters of comments about the hospital environment and facilities were negative. 72% of comments about food and drink were negative. 81% of general comments about facilities were negative.
Particular areas for further attention highlighted in the analysis of the comments were:

- The discharge process and information
- Food and drink
- Facilities



National Cancer Patient Experience Survey 2017 Results

The patients included in the sample were all aged over 16 and had relevant cancer ICD 10 codes in the first diagnosis field of their patient records. Deceased checks were undertaken up to three times during sampling. The questions were unchanged compared to the 2016 survey. The survey was commissioned and managed by NHS England during 2017 and the Trust achieved a 70% response rate, (621 patients) which is more than the national average of 63%.

The age and gender distribution of the respondents for the Trust was as follows:

	16-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Total
Male	2	0	2	13	30	103	88	17	**254**
Female	0	2	6	52	79	133	75	20	**367**
Total	**2**	**2**	**8**	**65**	**109**	**235**	**163**	**37**	**621**

Questions which scored better than expected were:

- 88% Groups of doctors or nurses did not talk in front of patient as if they were not there.
- 86% Staff explained how operation had gone in an understandable way.

Every other question was scored within the expected range for our Trust.

Comparisons by tumour type is provided for the Trust, and an action plan will be created to deliver opportunities for improvement. The numbers of patients responding from each tumour group is shown below:

Tumour Group	Number of Respondents
Brain/CNS	0
Breast	161
Gynaecological	39
Colorectal	97
Lung	25
Skin	4
Haematological	151
Upper Gastroenterological	26
Other	44
Urological	30
Prostate	31
Sarcoma	2
Head & Neck	11

The average rating given by respondents when asked to rate their cancer care provided at WSHFT on a scale of 0, (very poor) to 10, (very good) was 8.8.

- 94% said that the hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital.
- 91% said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment.
- 87% said that overall, they were always treated with dignity and respect while they were in hospital.
- 86% said that it had been ‘quite easy’ or ‘very easy’ to contact their Clinical Nurse Specialist.
- 79% said that they were definitely involved as much as they wanted to be in decisions about their care or treatment.

- 59% said that they thought the GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment.

National Maternity Patient Experience Survey 2018 Results

During the summer of 2018, a questionnaire was sent to all women aged 16 years or older who gave birth in February 2018. Exclusions to this survey included women whose baby had died during or since delivery, women who had a stillbirth, women who were in hospital or whose baby was in hospital at the time the sample was drawn, women who had a concealed pregnancy, women whose baby was taken into care (foster care or adopted)..

The Trusts rating overall was graded as 'About the same' which indicates that the trust is performing about the same as most other trusts that took part in the survey.

Overall scores for Labour and Birth = 9.3 out of 10
High scores were given for questions relating to skin to skin contact with the baby shortly after birth; 9.6 out of 10 and partners being involved as much as they wanted to be 9.8 out of 10.

Staff = 9 out of 10
A high score, 9.6 out of 10 was reached for being **spoken to** during labour and birth, in a way they could understand.

The Head of Midwifery has commenced improvement work to increase women's opportunity to move around and choose the most comfortable position during labour. This was rated as about the same and scored 8.5 out of 10.

Care in Hospital After Birth = 7.9 out of 10
The highest scoring question in this section was in relation to the cleanliness of the hospital which was scored at 9.4 out of 10.

The lowest scoring question was about discharge from hospital being **delayed and** this was scored as 4.5 out of 10 which was about the same when compared to other Trusts

Questions which scored better than other Trusts were:

- Staff introducing themselves before treatment or examination
- Being treated with kindness and understanding by staff after the birth.

Key findings from the Maternity Survey 2018 for England
There had been small improvements across most questions from 2013 to 2017, very few questions showed this trend continuing between 2017 and 2018, with some questions showing a decline.

This includes women's experiences of:
- Being given enough information about emotional changes which may be experienced after giving birth
- Being given enough information about their physical recovery after giving birth
- Being visited by a midwife at home after giving birth
- Seeing a midwife often enough at home after giving birth
- Staff awareness of the mother and baby's medical history

The next National Maternity Survey sample will be drawn in March 2019

Real Time Surveys

The Trust supplements the information received from the Friends and Family Test with a more detailed inpatient survey carried out by patients on hand-held tablets. Ward and departmental leads receive patient comments and question scores for all their surveys, which enables them to celebrate excellence with their teams and to set local improvement goals where areas are identified as being of concern.

Overall from April 2018 to March 2019, 6,734 surveys have been completed by patients in many different areas including inpatient wards, outpatients, paediatrics and a number of specialist services an increase of 6.8% on the previous year.

Breakdown of the Number of Local Surveys Undertaken:

	2017-18		2018-19	
Name of Survey	Satisfaction	Surveys completed	Satisfaction	Surveys completed
Adult Inpatient	93%	3,912	94%	3,797
PHIN (private patients inc. FFT)	98%	237	90%	122
Children's Inpatient	99%	608	98%	519
Neonatal Unit	98%	249	99%	203
Endoscopy Unit	93%	276	95%	228
Emergency Floor	95%	77	93%	86
End of Life Care	91%	88	94%	34
Antenatal	100%	41	96%	49
Birth and Postnatal Inpatient	96%	55	93%	30
Postnatal Community	100%	5	100%	3
Adult Outpatient - Fernhurst Clinic	88%	17	100%	1
Outpatient Fernhurst Centre	100%	1	94%	33
Gynaecology Outpatient Clinic	89%	347	81%	1,210
Therapies Outpatient	99%	97	100%	49
Diabetic Eye Screening	95%	260	98%	176
Cardiac Rehabilitation	N/A	N/A	99%	189
Neonatal Outpatients	N/A	N/A	100%	5
Total Surveys		6,270		6,734

In addition, there were 3,786 responses to the adult inpatient RTPE survey during this period, a 3.2% reduction on the previous year.

The heat map overleaf displaying the responses given to our monthly RTPE inpatient survey reveals that our lowest performing areas are noise at night, discussions about discharge, and experience of food. These 3 themes are consistent with the previous year and also triangulate with the opportunities for improvement identified via the National Inpatient Survey 2018.

Noise at night has been identified as a breakthrough objective for 2019/20. More detailed analysis of the patients comments reveal that the noise disturbance comes from a myriad of sources: confused patients, staff conversations/activity of clinical area, routine alarms from a variety of equipment including staff bleeps, ward phones, infusion pumps, cardiac monitors etc. An improvement project will commence identifying areas for focus in the coming year.

FFT Recommend

Division	Number of Responses	Apr - 18	May - 18	Jun - 18	Jul - 18	Aug - 18	Sept - 18	Oct - 18	Nov - 18	Dec - 18	Jan - 19	Feb - 19	Mar - 19
Corporate	219	100	100	100	89	100	94	86	100	97	100	100	100
Medicine	1877	94	92	93	95	95	94	93	94	96	96	96	93
Surgery	1690	95	96	97	96	95	96	95	96	97	96	98	95
Overall		95	94	95	95	95	95	94	95	96	96	97	94
Number of Responses		337	292	281	338	332	332	375	368	254	228	296	340

Welcome & Kindness

Division	Number of Responses	Apr - 18	May - 18	Jun - 18	Jul - 18	Aug - 18	Sept - 18	Oct - 18	Nov - 18	Dec - 18	Jan - 19	Feb - 19	Mar - 19
Corporate	219	97	100	98	99	100	90	95	98	96	94	96	100
Medicine	1877	93	95	95	94	95	93	94	94	96	95	95	95
Surgery	1690	94	97	98	96	95	96	95	96	96	94	94	94
Overall		94	96	96	95	95	95	94	95	96	95	95	95
Number of Responses		336	293	282	337	331	333	374	368	256	228	297	341

Cleanliness

Division	Number of Responses	Apr - 18	May - 18	Jun - 18	Jul - 18	Aug - 18	Sept - 18	Oct - 18	Nov - 18	Dec - 18	Jan - 19	Feb - 19	Mar - 19
Corporate	219	97	93	96	93	93	89	95	96	93	88	89	93
Medicine	1877	91	91	91	90	90	93	92	90	88	92	89	92
Surgery	1690	91	92	93	91	88	88	89	92	91	91	90	89
Overall		91	92	92	91	89	90	91	91	90	91	89	91
Number of Responses		337	292	282	335	332	334	373	368	255	228	297	341

Food

Division	Number of Responses	Apr - 18	May - 18	Jun - 18	Jul - 18	Aug - 18	Sept - 18	Oct - 18	Nov - 18	Dec - 18	Jan - 19	Feb - 19	Mar - 19
Corporate	219	75	75	80	71	79	74	72	81	74	69	69	73
Medicine	1877	72	73	74	73	74	75	78	73	71	75	71	75
Surgery	1690	74	76	79	75	70	68	74	73	72	72	74	75
Overall		72	74	76	74	73	71	75	73	72	73	72	75
Number of Responses		337	290	279	333	330	332	371	365	252	226	296	339

Assistance with Meals

Division	Number of Responses	Apr - 18	May - 18	Jun - 18	Jul - 18	Aug - 18	Sept - 18	Oct - 18	Nov - 18	Dec - 18	Jan - 19	Feb - 19	Mar - 19
Corporate	219	100	92	94	100	100	91	89	100	90	100	97	83
Medicine	1877	83	91	91	86	93	77	88	82	91	92	88	94
Surgery	1690	90	90	93	92	86	89	90	90	91	85	89	91
Overall		86	91	92	89	91	84	89	87	91	88	90	91
Number of Responses		334	292	282	334	331	333	375	368	254	228	297	340

Noise at Night

Division	Number of Responses	Apr - 18	May - 18	Jun - 18	Jul - 18	Aug - 18	Sept - 18	Oct - 18	Nov - 18	Dec - 18	Jan - 19	Feb - 19	Mar - 19
Corporate	219	64	50	79	88	64	59	64	58	70	75	88	79
Medicine	1877	56	53	58	61	57	55	55	64	47	59	55	58
Surgery	1690	58	64	65	59	59	64	64	65	59	53	56	54
Overall		57	58	62	61	59	60	61	64	55	56	57	57
Number of Responses		328	289	279	331	328	332	373	365	256	228	296	337

Call Button Response

Division	Number of Responses	Apr - 18	May - 18	Jun - 18	Jul - 18	Aug - 18	Sept - 18	Oct - 18	Nov - 18	Dec - 18	Jan - 19	Feb - 19	Mar - 19
Corporate	219	91	100	100	95	88	77	80	94	90	75	95	85
Medicine	1877	79	88	87	80	84	86	84	82	83	77	85	84
Surgery	1690	83	81	92	86	91	89	88	86	87	84	87	85
Overall		80	86	90	83	87	87	86	84	85	81	86	85
Number of Responses		330	290	282	333	331	329	371	363	256	227	294	336

Medication Explanation

Division	Number of Responses	Apr - 18	May - 18	Jun - 18	Jul - 18	Aug - 18	Sept - 18	Oct - 18	Nov - 18	Dec - 18	Jan - 19	Feb - 19	Mar - 19
Corporate	219	93	100	92	100	95	88	89	95	91	88	88	100
Medicine	1877	83	83	86	82	86	81	79	85	82	85	88	84
Surgery	1690	95	90	93	92	86	94	89	93	91	90	91	90
Overall		87	86	89	87	86	88	85	89	87	88	89	88
Number of Responses		334	289	278	329	330	331	372	364	255	228	294	338

Pain Control

Division	Number of Responses	Apr - 18	May - 18	Jun - 18	Jul - 18	Aug - 18	Sept - 18	Oct - 18	Nov - 18	Dec - 18	Jan - 19	Feb - 19	Mar - 19
Corporate	219	94	100	93	100	92	92	90	100	92	75	91	93
Medicine	1877	92	85	86	85	90	90	88	85	87	91	88	80
Surgery	1690	93	92	98	91	91	95	91	96	91	94	91	93
Overall		92	88	91	89	91	93	90	91	89	92	90	87
Number of Responses		333	292	280	333	330	331	375	364	254	228	296	340

Care Decisions

Division	Number of Responses	Apr - 18	May - 18	Jun - 18	Jul - 18	Aug - 18	Sept - 18	Oct - 18	Nov - 18	Dec - 18	Jan - 19	Feb - 19	Mar - 19
Corporate	219	87	94	86	87	95	82	88	91	88	75	88	93
Medicine	1877	77	80	79	76	80	80	80	80	78	78	83	82
Surgery	1690	83	86	91	82	78	88	86	87	88	83	81	81
Overall		79	82	84	79	80	85	84	83	84	81	82	82
Number of Responses		336	291	282	335	331	330	373	365	255	227	296	339

Discharge Planning

Division	Number of Responses	Apr - 18	May - 18	Jun - 18	Jul - 18	Aug - 18	Sept - 18	Oct - 18	Nov - 18	Dec - 18	Jan - 19	Feb - 19	Mar - 19
Corporate	219	80	81	96	82	75	82	69	77	82	63	71	80
Medicine	1877	50	44	42	45	44	43	46	40	46	38	41	45
Surgery	1690	53	52	63	56	53	53	50	56	52	50	57	49
Overall		53	48	53	52	50	50	51	49	54	45	50	49
Number of Responses		336	290	282	333	330	329	374	365	256	227	295	338

Communication

Division	Number of Responses	Apr - 18	May - 18	Jun - 18	Jul - 18	Aug - 18	Sept - 18	Oct - 18	Nov - 18	Dec - 18	Jan - 19	Feb - 19	Mar - 19
Corporate	219	-	-	96	94	89	83	89	100	92	63	89	97
Medicine	1877	-	86	87	87	87	90	91	90	90	85	92	91
Surgery	1690	-	88	95	89	89	91	90	89	91	88	89	91
Overall		-	87	91	88	88	90	90	90	91	86	91	91
Number of Responses		0	56	271	326	320	326	367	356	253	221	293	338

Privacy

Division	Number of Responses	Apr - 18	May - 18	Jun - 18	Jul - 18	Aug - 18	Sept - 18	Oct - 18	Nov - 18	Dec - 18	Jan - 19	Feb - 19	Mar - 19
Corporate	219	89	88	96	96	88	86	86	96	86	75	88	90
Medicine	1877	82	81	85	84	84	84	83	84	84	88	85	84
Surgery	1690	85	88	88	84	80	83	82	85	84	83	86	84
Overall		83	84	87	84	83	83	83	85	84	85	85	85
Number of Responses		334	290	279	334	330	332	372	365	254	226	295	339

Safe & Confident

Division	Number of Responses	Apr - 18	May - 18	Jun - 18	Jul - 18	Aug - 18	Sept - 18	Oct - 18	Nov - 18	Dec - 18	Jan - 19	Feb - 19	Mar - 19
Corporate	219	100	100	83	97	98	92	92	100	94	75	92	93
Medicine	1877	95	96	94	94	96	97	96	97	93	97	99	95
Surgery	1690	96	99	99	97	95	97	96	97	97	96	95	94
Overall		96	97	96	95	96	97	96	97	95	96	97	94
Number of Responses		335	289	278	335	329	332	374	363	254	228	296	337

Respect & Dignity

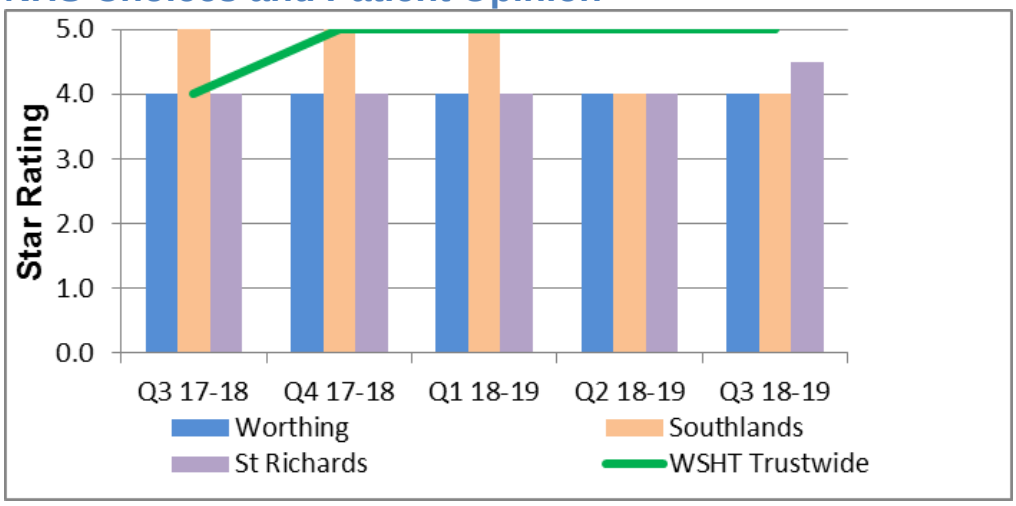
Division	Number of Responses	Apr - 18	May - 18	Jun - 18	Jul - 18	Aug - 18	Sept - 18	Oct - 18	Nov - 18	Dec - 18	Jan - 19	Feb - 19	Mar - 19
Corporate	219	97	100	100	100	98	92	92	100	97	100	92	97
Medicine	1877	94	96	95	96	97	97	96	98	98	96	98	98
Surgery	1690	96	97	99	97	97	99	96	98	98	98	99	97
Overall		95	97	97	97	97	97	95	98	98	97	98	97
Number of Responses		333	287	281	337	328	330	373	365	253	227	296	340

Other Forms of Feedback: Peer Review

A change in methodology for capturing care in action was implemented in April 2018 called peer review; this process has engaged staff, volunteers and Governors to undertake internal audit across the Trust on a monthly basis. Staff use a template to assess the services accurately and consistently. Feedback is discussed regarding the specific services based on the documentation and evidence provided, and the observations and interviews/discussions experienced on the day of the visit.

Adopting this approach will ensure that the principles and practice employed by the CQC when inspecting is embedded directly into service delivery and clinical practice. The focus to this approach is one which uses the CQC Fundamental Standards that support and populate the 5 key questions and key lines of enquiry (Safe, Effective, Caring, Responsive and Well-led) to provide the assurance that the fundamental regulations are embedded.

NHS Choices and Patient Opinion



Patients have the opportunity to provide feedback through public forums such as NHS Choices and Patient Opinion, the PALs team respond to most of this feedback within 48 hours. NHS Choices has the Trust at a current rating of 4 stars. The graph above displays the data for the last year, including the previous Q3 2017/18. All sites have received a 4 star rating consistently throughout the period.

An example of a positive comment that was left December 2018 is included below:

“Had Day Surgery operation today, the staff were brilliant from beginning to end felt relaxed throughout. No wonder it is outstanding this is due to its outstanding staff thank you to you all from the surgeon down to the receptionist you are a credit to the NHS”

Volunteers

Many people choose to become involved with the work of the Trust as volunteers and contribute many hours each year adding value and improving patient experience.

There are a variety of volunteering opportunities within most departments broadly divided as clinical and non-clinical. We also have some very specific volunteer activities of which we are very proud, working with specialist teams such as the therapeutic volunteers(providing massage and hand care),cardiac rehabilitation buddies, Knowing Me volunteers (supporting dementia therapeutic activities), chaplaincy, and hospital radio. We work with the League of Friends who provides a hospital café, shop and trolley services, and have recently joined forces with the Samaritans to provide regular support in our A&E waiting rooms.

In 2018 a volunteering strategy has been launched with the aim to widen the scope of volunteering in the Trust whilst ensuring that we have the infrastructure to support our ambitions. The induction process is going to be much quicker and simpler for members of our community who approach the trust and want to volunteer.

PALS and Complaints Service

The Customer Relations Team (Patient Advice and Liaison Service and complaints team) provide advice on how and where to complain, investigate matters of concern and help facilitate a resolution when things have gone wrong. PALS carry out signposting, provide information, advice or reassurance and manage issues that can be resolved quickly, assisting patients/relatives who need time to discuss concerns and operate a triage service for telephone and face to face enquiries. The complaints team investigate more complex and serious concerns that require a formal investigation about past events.

Formal Complaints Performance

Performance Metrics	Q1	Q2	Q3	Q4	Total
No of new complaints:	95	112	108	101	416
No of closed cases:	105	112	95	121	433
No closed in 25 days (%)	57%	84%	51%	51%	61%
No closed in 26-60 days (%)	34%	14%	47%	53%	37%
Re-opened cases	12	20	24	16	72

Lessons Learnt

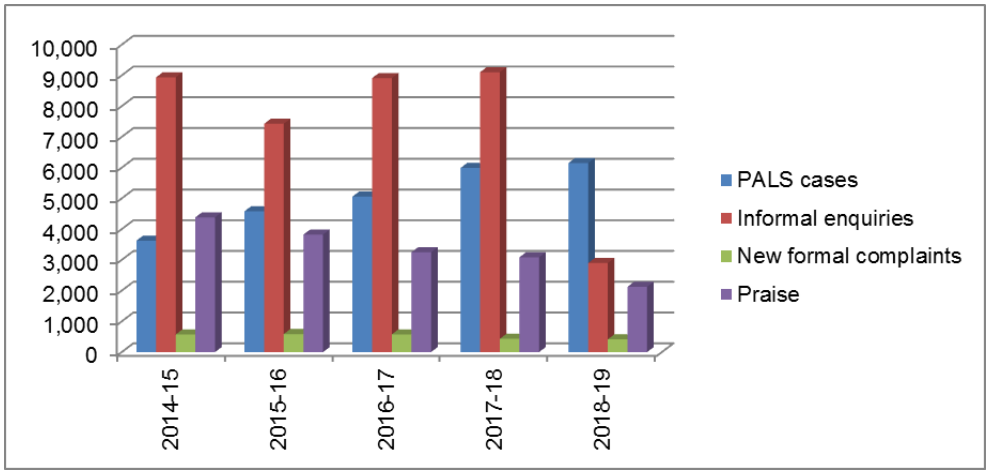
We are aware that the number of issues around appointments has risen over the recent years, some of this is related to a significant increase in specialties such as ophthalmology where the criteria for referral has changed and our capacity to see patients has not grown at the same rate. The Kaizen team are facilitating an outpatient improvement project which will drive improvements in patient experience themes. In addition the Trust has implemented a number of further improvements as a result of PALS enquiries and formal complaints throughout the year:

Daughter raised concerns that her Father's Do not attempt resuscitation order had not been discussed with her	•DNAR process discussed at daily safety huddles, training held on 14 November for junior doctors and audit to be undertaken.
Patient was told 20-24 week waiting time for urgent spinal triage cases	•Extra funding was provided to create an additional clinic
Immunotherapy not prescribed for 5 days following emergency admission	•A training session within the rolling programme at junior doctors induction.
Issues relate to prescription of eye drops,	•Actions including recognition of eye conditions and the importance of giving eye drops, particularly for glaucoma at nursing training days. The ward is looking to start a relative clinic to ensure better communication.
There was a delay in surgical review of patient as the on call team were with a trauma case.	•Apologies given for delay in giving pain relief while patient was in A&E. It is hoped that the extension of EPMA into A&E will resolve this situation as the doctors will be able to prescribe remotely. A multidisciplinary group are focussing on improving patients experience in relation to pain management across the Trust

The Patient Experience and Feedback Committee meets on behalf of the Trust Board four times a year to discuss the PALS enquiries and formal complaints received in detail, reviewing any patterns and themes emerging.

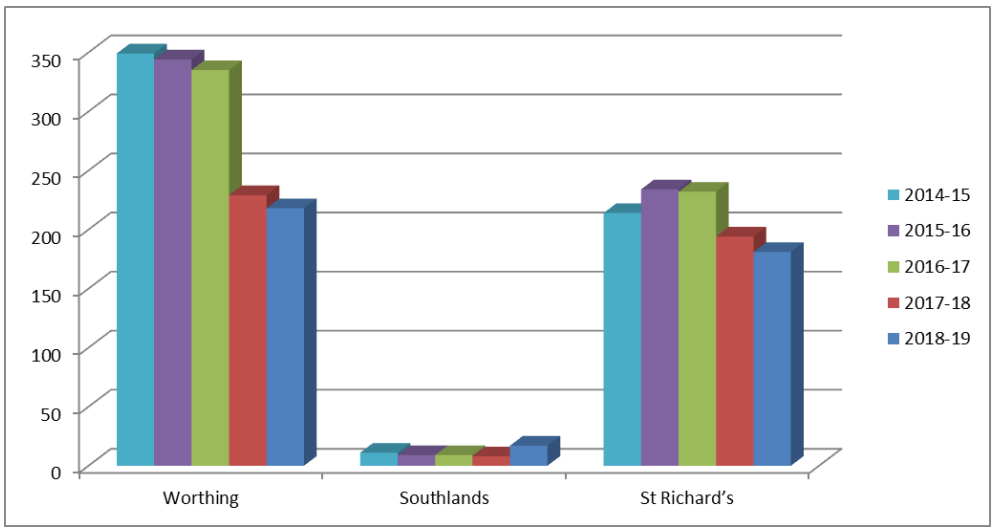
Type of Cases

	2014-15	2015-16	2016-17	2017-18	2018-19
PALS cases	3,627	4,582	5,061	5,990	6,152
Informal enquiries	8,939	7,426	8,914	9,106	2,897
New formal complaints	574	587	576	431	416
Praise	4,385	3,823	3,246	3,084	2,123
Total	**17,525**	**16,418**	**17,797**	**18,611**	**11,588**



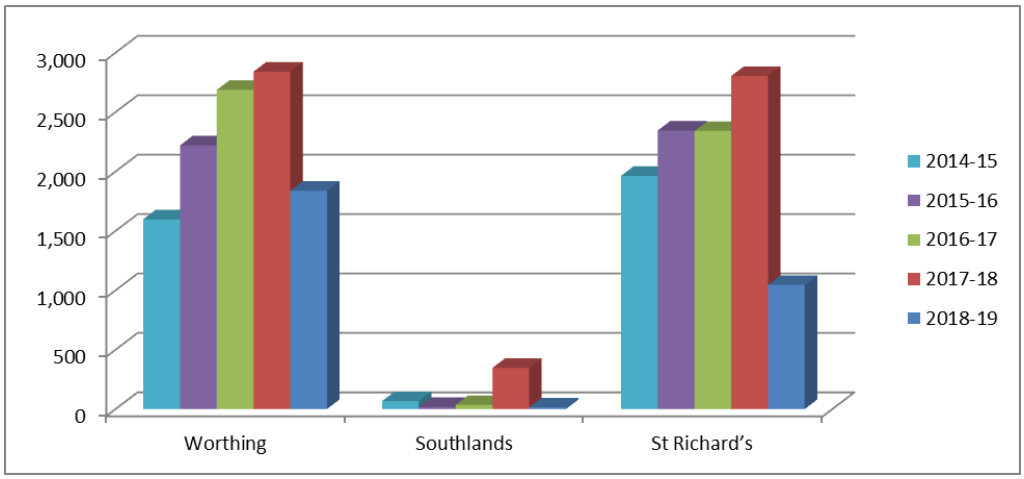
Formal Complaints Received by Site

	2014-15	2015-16	2016-17	2017-18	2018-19
Worthing	349	344	335	229	218
Southlands	11	9	9	8	17
St Richard's	214	234	232	194	181
Total	**574**	**587**	**576**	**431**	**416**



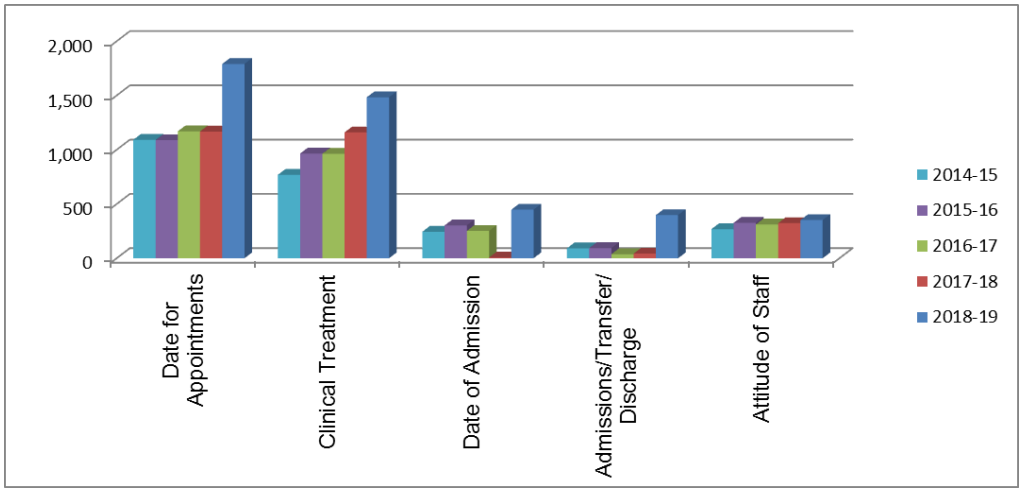
PALS Enquiries Received by Site

	2014-15	2015-16	2016-17	2017-18	2018-19
Worthing	1,597	2,219	2,686	2,840	1,838
Southlands	67	18	34	346	14
St Richard's	1,963	2,345	2,341	2,804	1,045
Total	**3,627**	**4,582**	**5,061**	**5,990**	**2,897**



Top 5 PALS Enquiries Received by Category

	2014-15	2016-17	2015-16	2017-18	2018-19
Date for appointment	1,092	1,170	1,088	1,168	1,791
Clinical treatment	769	963	965	1,160	1,484
Attitude of staff	269	312	327	324	352
Date of admission	245	252	303	7	448
Admission/transfer/discharge	92	38	94	43	398



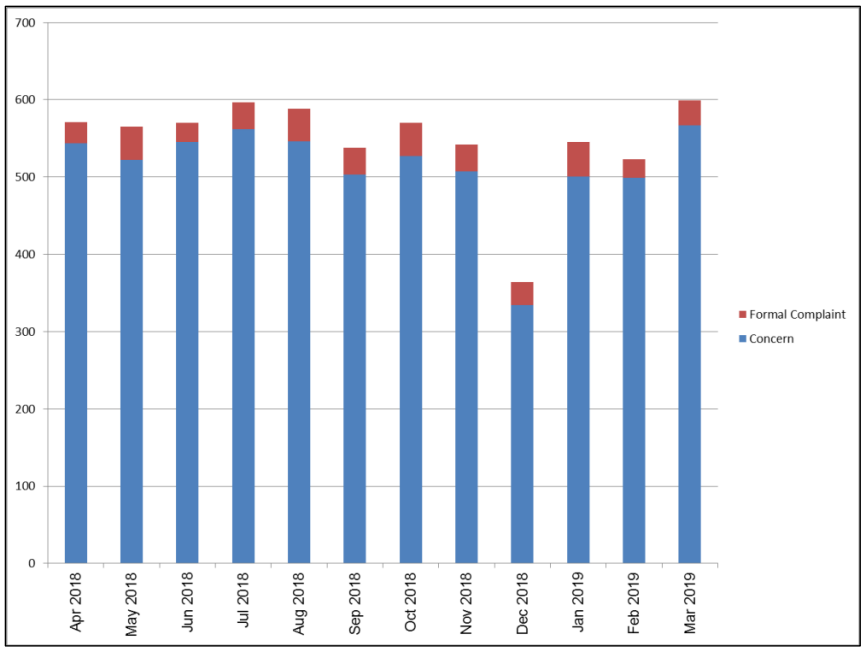
Formal Complaints Compared with Hospital Activity

	2014-15	2015-16	2016-17	2017-18	2018-19
Relating to inpatient care	243	247	263	195	177
Rate per 1000 bed days	0.75	0.75	0.76	0.57	0.53
Relating to outpatient appointments	226	261	221	142	153
Rate per 10,000 new appointments	10.50	11.40	9.29	4.92	6.94
Relating to A&E	105	79	94	84	73
Rate per 1,000 A&E attendances	0.78	0.58	0.68	0.60	0.50

Complaints and PALS Improvement

There is an increasing focus on listening to, acting upon and learning from feedback from service users because of the importance placed on our values of prioritising the patient voice. This includes ensuring that feedback from the Friends and Family Test, from audits and surveys, and from complaints feeds into learning and quality assurance and improvement processes.

The number of formal complaints has continued to reduce from an average of 50 per month to 35 over the last 12 months. This sustained reduction is thought to be as a direct result of senior managers telephoning the complainant and demonstrating an open approach to providing a quick resolution.



	Concern	Formal Complaint	Total
Apr 2018	544	27	571
May 2018	522	43	565
Jun 2018	545	25	570
Jul 2018	562	35	597
Aug 2018	546	42	588
Sep 2018	503	35	538
Oct 2018	527	43	570

	Concern	Formal Complaint	Total
Nov 2018	507	35	542
Dec 2018	334	30	364
Jan 2019	501	44	545
Feb 2019	499	24	523
Mar 2019	567	32	599
Total	**6,157**	**415**	**6,572**

A majority of the complaints received are due to poor coordination of clinical treatment. This can be broken down by more helpful sub-subjects to describe the issues patients are complaining about. Generally patients complain about the co-ordination of treatment which is most commonly affected by the number of times that appointments are re-scheduled and this features most frequently within PALS concerns. Formal complaints cite this as a cause of negative experience too, but often these describe frustration caused by the number of steps experienced within our pathways before they can receive a diagnosis that addresses their symptoms.

Nursing shortages and wrong diagnosis also features within this category and is a contributory factor found within this category which is shared with specialty managers to ensure learning from complaints.

Reducing Complaints and Improving the Timeliness of Complaint Responses

The responsiveness to complaint responses during 2018 across the three largest divisions is shown below:

Division	% in 25 days			
	Q1 18-19	Q2 18-19	Q3 18-19	Q4 18-19
Women & Children	64%	80%	96%	100%
Medicine	65%	83%	68%	47%
Surgery	36%	83%	50%	60%

The Divisional scorecards now capture the percentage of complaints that are responded to within 25 days. The Executive Team have also set a breakthrough objective to reduce the number of complaints received due to clinical treatment. Performance against this objective will be managed via strategy deployment throughout the financial year.

We have seen a reduction of the percentage of complaints closed within 25 working days during Q3 and Q4 of 2018/19 to 51%. This deterioration in performance has occurred due to the challenges faced when trying to gather responses from clinical staff and this is compounded further if a complaint concerns cross-divisional care. The Strategy Deployment Review (SDR) process has significantly raised the importance of reducing delays to formal complaints with senior divisional managers and it is felt that engagement of more clinical leaders would be beneficial to reduce delays further.

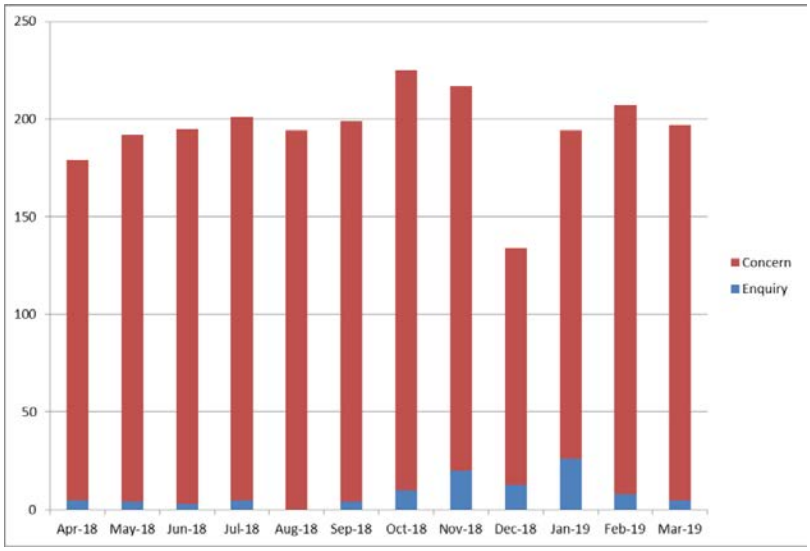
The number of formal complaints that have reopened has increased compared to previous performance measured in 2017-18. This rate will continue to be monitored as a measure of how successful local resolution has been, especially with a focus on responding quicker to complaints with a first response, looking at the reasons for re-open. This trend may reflect that we could improve our understanding of what the complainant is seeking to resolve from the complaint process before we offer the option of a local resolution meeting or a written

response. The table below shows the number of cases that have re-opened since the response rate target has been in effect.

	Re-open rate
Q1 18-19	17%
Q2 18-19	19%
Q3 18-19	24%
Q4 18-19	16%

The number of PALS enquiries and general information requests has increased significantly year on year. The PALS team will not log the enquiries in 2019 unless the enquiry highlights an opportunity for the Trust to implement an improvement. This change in recording activity is being introduced to save the team time and ensure they are able to respond to contacts within the 1 working day timeframe.
The number of appointment related complaints and PALS concerns have similarly increased and the Trust is currently working to reduce the level of dissatisfaction and improve processes.

Appointments is the most common reason for patients and their families raising a concern or an informal enquiry with our PAL's service. Further analysis of outpatient data reveals that the primary cause for concern is linked to the patient's perception that there is an unacceptable wait for an appointment; this data suggests that patients are not aware of the estimated waiting time they are likely to encounter when referred for hospital outpatient appointment.



Cancellation of appointments is the second most common reason for seeking assistance from PALs in relation to the appointment process whilst repetitive re-booking of appointments is logged as the 3rd most common cause of dissatisfaction. This is due to approximately 1,000 patients' appointments being moved each month which leads to short notice cancellations and subsequent clinic additions.

The services which are linked most often to PALs concerns related to waiting for and cancellation of appointments, are ophthalmology and trauma and orthopaedics. The number of PALs concerns raised about appointments is monitored via the Trust scorecard. It is anticipated that this figure could reduce as text reminders have been introduced and capacity planning is ongoing for ophthalmology as follow up appointments continue to be a challenge within this specialty.

The table overleaf shows how the PALS concerns linked to Southlands Hospital has remained relatively constant since the Ophthalmology Eye Care Unit opened there.

	Worthing	St Richard's	Southlands	Total
Apr 2018	266	258	20	544
May 2018	261	240	21	522
Jun 2018	275	242	28	545
Jul 2018	283	255	24	562
Aug 2018	276	255	15	546
Sep 2018	241	246	16	503
Oct 2018	234	263	30	527
Nov 2018	223	256	28	507
Dec 2018	152	159	23	334
Jan 2019	224	260	17	501
Feb 2019	242	234	23	499
Mar 2019	281	273	13	567
Total	**2,958**	**2,941**	**258**	**6,157**

Parliamentary Health Service Ombudsman (PHSO)

The table below shows the number of formal complaints that were referred by the complainant to the Parliamentary Health Service Ombudsman (PHSO) during 2018/19.

Number of Cases	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19	**Totals**
Outstanding previous Quarter	5	5	8	7	**25**
New Referrals	1	3	1	4	**9**
Closed	1	-	2	4	**7**
Upheld	-	-	-	1	**1**
Partly Upheld	-	-	-	2	**2**
Not Upheld	4	-	2	2	**8**
Total Open	**5**	**8**	**7**	**3**	**23**

A total of eight complaints investigated by the PHSO have not been upheld during 2018/19.

One case was upheld. The changes that have been implemented in relation to this case are that when a patient has a complex pathway post-operatively the operating surgeon should lead on their care and any discussions related to complex management plans should be discussed in a benign gynaecology MDT meeting. The Gynaecology lead will create a patient information leaflet which compares different types of hysterectomies and describes the risks and benefits as well as alternatives for patients. Junior doctors are to escalate any readmissions following a surgical procedure to the consultant on call for review and also inform the operating consultant of their patient's attendance and the management plan.
Two cases were partly upheld:

1) The PHSO report stated that the Trust should have informed the patient of the changes to the procedure on their knee as soon as they recovered from the anaesthetic or on the ward round. The Trust are ensuring doctors give patients the opportunity to view their own X-Rays post procedure so that patients are reliably informed if surgery has changed during a procedure. The Trust is creating an action plan to improve the communication issues that occurred in this case.

2) The PHSO found failings in record keeping, lack of consent discussion, delaying the surgery and in its complaint handling. The Trust has apologised for the distress caused to the complainant and compensation of £2,750 has been offered. A full action plan will be shared by June 2019.

	2014-15	2015-16	2016-17	2017-18	2018-19
New cases referred in year*	17	28	14	9	9
Declined/not upheld	13	14	7	8	8
Further local resolution taken by the Trust	-	-	1	-	-
Upheld/recommendations (partially or in full)	4	14	2	3	3
Decision awaited	-	-	4	5	6

*The number of new complaints referred to us by the Parliamentary Health Service Ombudsman within the given year. Due to the time taken for cases to be referred and reviewed by the Parliamentary Health Service Ombudsman these cases may relate to complaints made to the Trust in an earlier year and not always have a resolution within the same year.

Our Goals for 2019/20

To Embed the Patient Experience Strategy (Contains Seven Ambitions)

1. Make Feedback 'business as usual'
In order to improve patient experience we need to ensure that we gather feedback from sufficient people to know that this is reliable. We also need to ensure our systems support prompt review of comments such that they can inform our improvement work. Develop staff that embrace feedback as a way of improving care.

2. **Improve Timely response to concerns and complaints**
Our first aim is to try to ensure that patients/carers concerns are dealt with in the moment, so that they can be resolved. However, if people have had a poor experience it is essential that they are supported to raise their concerns and that these concerns are responded to in a timely manner. Currently this is not the case; we have undertaken a full review our complaints system to put in place processes that will address the backlog of complaints and ensure smooth and efficient future system. We have also put in place a robust system to respond to concerns raised via social media.

3. **We want patients to receive a coordinated approach to their care across the Trust.**
The most common reason for complaints are concerns about clinical treatment. Additional analysis shows that this is due, in the main, to coordination of care. Further work is underway to understand the range of contributing factors more clearly to support direction of improvement work. It is important that we measure whether patients know the name of their Consultant and who is co-ordinating their care and can talk to staff about their treatment before they are discharged.

4. **Improve overall experience of the discharge process from our care.**
Our national inpatient survey and real-time patient feedback survey indicate that we have much to do to improve how we work with patients and their families to ensure safe and positive discharge experience. We realise that some of our patient discharge processes can be complex and recognise that we need to improve the discharge home experience for all of our patients.

5. **Improve communication so that all patients have access to the information they need.**

Communication is a key theme, generating significant number of concerns via PALS system and also a prime contributing factor across a range of areas of poor experience. Our data also tells us that when we get this right this has a considerable positive impact on people's confidence and overall experience of care. This work will incorporate how we enable people with additional communication needs to be informed and supported throughout their journey.

6. **Safe Staff & Workforce Culture.**

Review of our FFT comments shows that when patients experience friendly, compassionate and professional care this has overwhelmingly positive effect on their experience. Through our customer care work programme we will promote the importance of these values, help staff recognise the contribution they make to patient experience and develop leaders who are confident to challenge poor behaviour. We also continue to grow our volunteer workforce who we recognise have a powerful positive impact on patient experience.

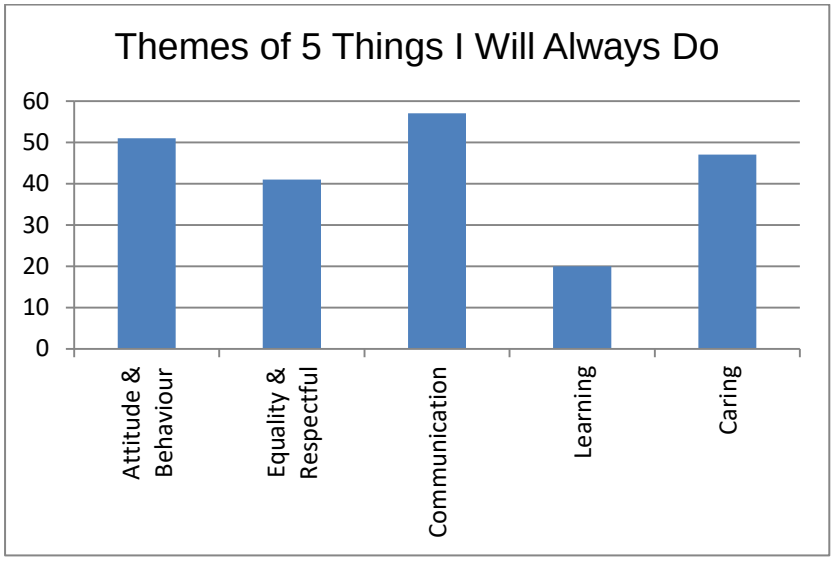
7. **Actively listen to ensure we learn from patient feedback and make improvements where necessary.**

We recognise that whilst we have a number of feedback sources, there are currently limited opportunities for more detailed engagement. We plan to put in place a programme of 'listening' events to help us explore with patients and families areas of concern. This ambition also includes work that we are doing to ensure that we deliver the best possible level of fundamental care. Our current feedback tells us that we need to make improvements in how we care for patients at night, delivering timely and effective management of pain; timely response to call bells, assistance to those that need it at mealtimes and involvement of patients in decisions about their care and discharge from our care.

Delivering the Ambitions

Senior nursing and clinical staff are working with the patient experience team in focussed working groups to develop the ambitions and actions required to deliver goals. Baseline measures have been identified for each ambition so that impact can be identified.

The annual staff conference held in October 2018 focussed on Patient Experience and over 600 staff from a cross section of roles attended. Pledges were made by those that attended about the actions they will take to ensure that patients have the best experience of our care Which have been ranked as the top 5 subjects below:



It is hoped that a staff charter will be produced to remind everyone of the importance of really listening to what matters most to patients and remaining empathic to the situations that occur.

Monitoring Progress

Progress toward goals will be monitored by the Nursing and Midwifery Board and the Patient Experience and Engagement Committee with overall scrutiny at Patient Experience and Feedback Committee.

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	18	**Meeting:**	Trust Board	**Meeting Date:**	30 May 2019
Report Title:	Provider Licence Conditions – Annual Self Certifications				
Sponsoring 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:

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 web site.

NHS improvement provide a template for these declaration where explanations are required if the Trust can not provide a complaint declaration. Only for condition FT4 does the template allow for a rationale to be included for the Trust's ability to signify compliance to be included therefore as well as the required template a short explanatory paper has been prepared to allow the Board to understand the supporting rationale for the complaint declaration being recommended.

Key Recommendation(s):

The Board is asked to **APPROVE :**

That the Trust is complaint for each element within the required annual declarations.

That the template declarations be placed on the Trust's website in accordance with NHS I's requirements.

Introduction

The Board is required to make a number of declarations at the year end. Trusts are required to publish their declaration on their web site.

Certifications

There are three sets of declarations required, these are attached using the provided NHS I templates.

Declaration 1 – this relates to NHS Provider License General Condition 6 - Systems for compliance with license conditions (FTs and NHS trusts) and for FTs that are providers of designation Commissioner Requested Services are required to make an extra declaration on their Continuity of Services condition 7 - Availability of Resources.

Declaration 2 - this relates to NHS Provider License General Condition FT4 – Corporate Governance and for FTs only there is a separate Declaration 3 relating to the Training for Governors.

Trust Position

Declaration 1 (appendix 1)

General Condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

The Board is required to confirm it is compliant with the following certification, or explain why it can't certify itself as complaint.

Following a review for the purpose of paragraph 2(b) of license condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the license, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

It is recommended the Board a positive "confirmed" declaration is made. This is supported by the view of NHS Improvement within their regular meetings and that the Trust is segmented in segment 2 where only segments 3 & 4 indicate a risk or actual breech of the License.

Continuity of Service condition 7 – Availability of Resources

The Trust does not have any Commissioner Requested Services; therefore this declaration is not required.

Declaration 2 (appendix 2)

Condition FT4 - Corporate Governance Statement

The Board is required to indicate it is complaint with the following statements or if not state why it is non complaint.

1) The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

It is recommended the Board signify its compliance as the Board is assured from the work of the Audit Committee, its Internal and External Auditors and their opinions received during the year. The Board's view as to its governance processes is reflected within the Trust's Annual Governance Statement.

2) The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.

It is recommended the Board signify its compliance as the Chief Financial Officer and Trust Board Secretary has made the Board, Audit Committee and Executives aware of monitor guidance and any impact / improvements to be made within Trust systems as a result.

3) The Board is satisfied that the Trust implements:

(a) Effective board and committee structures;
(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
(c) Clear reporting lines and accountabilities throughout its organisation.

It is recommended the Board signify its compliance as these processes were referred to and their effectiveness was considered by the Accountable Officer when drafting the Trust's Annual Governance Statement with this description then considered by the Audit Committee as it endorsed the AGS for submission to the Auditors. Respective Committee reporting to the Board is operating effectively as evidenced by the regular reports to the Board from each Committee Chair.

4) The Board is satisfied that the Trust effectively implements systems and/or processes:

(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) To ensure compliance with health care standards binding on the Licensee

including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements.

It is recommended the Board signify its compliance as the Board both directly and through its Committee structure has been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year. Where issues have arisen during the year, for example in respect of operational performance, timely actions have been implement to improve these areas, albeit that the areas of delivery of the Cancer performance standard and the national referral to treatment target performance standard have not been consistently achieved for this year.

The Trust has delivered its control total and efficiency programme and the Audit Committee has recommended based on the information it has received that the Trust can prepare its financial statements on a going concern basis,

Assurance is obtained as to the quality of the data supporting the Trust's performance reporting through the annual internal audit work programme. The Board has received regular assurance over the delivery of the Trust's control total and efficiency plan.

Key risks and associated assurance have been reported to the Audit Committee and Board during the year through receipt and review of the Trust's Board Assurance Framework.

5) The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) That the Board receives and takes into account accurate,

comprehensive, timely and up to date information on quality of care;
(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

It is recommended the Board signify its compliance as there is clear leadership and accountability for the delivery of high quality and safe services within the Trust. This is detailed with the Trust's Quality Account and the statements contained therein. The Board both directly and through its Committee structures ensures that a focus is maintained on the delivery of quality services. The Trust's quality priorities continue to be set in consultation with the Governors and other stakeholders with regular reporting of the delivery against these priorities provided to the Board and the Council of Governors and our Commissioners. The effectiveness of these processes was again considered by the Accountable Officer in drafting the Annual Governance Statement which in turn was subject to consideration by the Audit Committee prior to its submission to the Auditors and inclusion within the Annual Report.

6) The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

It is recommended the Board signify its compliance as the Trust has established a process that ensures that all Board Members are "fit and proper" persons. This process has been applied to Board appointments made in the year. An annual review of all Board Members continuation as fit and proper persons has been undertaken and reported to the Audit Committee at the end of the year. The Board through its receipt of Workforce, Leadership and Organisational Development reports has been assured over the actions being taken to mitigate the workforce risks in relation to recruitment and retention. Regular reporting is provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce. All transformation schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services. The Trust has a number of established Executive and Senior Management development programmes these activities are designed to support and strengthen the personnel on the Board, those reporting to the Board and those within the rest of the Trust.

Declaration 3 (appendix 2)

Training of Governors

The Board is required to indicate it is complaint with the following statement or if not state why it is non complaint.

The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

It is recommended the Board signify its compliance as the Trust has established a programme of training for the Governors, which includes new governors taking part in the Trust's new staff induction programme, complemented by tailored governor induction training supplemented by information workshops where new information on developments are discussed. Also at Council of Governors meeting a presentation is made by a Non Executive on the role and work of their Committee thus allowing Governors to knowledge to be enhanced.

The Chair and Chief Executive regularly meet with the Governors and no issues over their training have been raised during this year.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Western Sussex Hospitals NHS Foundation Trust *Insert name of organisation*

NHS Improvement

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates | **2018/19** | Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		Please Respond

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Alan McCarthy	**Name**	Marainne Griffiths
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	30 May 2019	**Date**	30 May 2019

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Western Sussex Hospitals NHS Foundation Trust

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | **2018/19** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board is assured from the work of the Audit Committee, its Internal and External Auditors and their opinions received during the year. The Board's view as to its governance processes is reflected within the Trust's Annual Governance Statement.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Chief Financial Officer and Trust Board Secretary has made the Board, Audit Committee and Executives aware of monitor guidance and any impact / improvements to be made within Trust systems as a result.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	These processes were referred to and their effectiveness was considered by the Accountable Officer when drafting the Trust's Annual Governance Statement with this description then considered by the Audit Committee as it endorsed the AGS for submission to the Auditors. Respective Committee reporting to the Board is operating effectively as evidenced by the regular reports to the Board from each Committee Chair.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Board both directly and through its Committee structure has been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year. Where issues have arisen during the year, for example in respect of operational performance, timely actions have been implement to improve these areas, albeit that the areas of delivery of the Cancer performance standard and the national referral to treatment target performance standard have not been consistently achieved for this year. The Trust has delivered its control total and efficiency programme and the Audit Committee has recommended based on the information it has received that the Trust can prepare its financial statements on a going concern basis. Assurance is obtained as to the quality of the data supporting the Trust's performance reporting through the annual internal audit work programme. The Board has received regular assurance over the delivery of the Trust's control total and efficiency plan. Key risks and associated assurance have been reported to the Audit Committee and Board during the year through receipt and review of the Trust's Board Assurance Framework.	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	There is clear leadership and accountability for the delivery of high quality and safe services within the Trust. This is detailed with the Trust's Quality Account and the statements contained therein. The Board both directly and through its Committee structures ensures that a focus is maintained on the delivery of quality services. The Trust's quality priorities continue to be set in consultation with the Governors and other stakeholders with regular reporting of the delivery against these priorities provided to the Board and the Council of Governors and our Commissioners. The effectiveness of these processes was again considered by the Accountable Officer in drafting the Annual Governance Statement which in turn was subject to consideration by the Audit Committee prior to its submission to the Auditors and inclusion within the Annual Report.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Trust has established a process that ensures that all Board Members are "fit and proper" persons. This process has been applied to Board appointments made in the year. An annual review of all Board Members continuation as fit and proper persons has been undertaken and reported to the Audit Committee at the end of the year. The Board through its receipt of Workforce, Leadership and Organisational Development reports has been assured over the actions being taken to mitigate the workforce risks in relation to recruitment and retention. Regular reporting is provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce. All transformation schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services. The Trust has a number of established Executive and Senior Management development programmes these activities are designed to support and strengthen the personnel on the Board, those reporting to the Board and those within the rest of the Trust.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name Alan McCarthy **Name** Marianne Griffiths

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Worksheet "Training of governors"

Financial Year to which self-certification relates | **2018/19** | Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Alan McCarthy	**Name**	Marianne Griffiths
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	30 May 2019	**Date**	30 May 2019

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A