Western Sussex Hospitals
NHS Foundation Trust

Meeting of the Board of Directors

10.00am to 12.20 on Thursday 26th July 2018

Boardroom, Washington Suite, Worthing Hospital, Lyndhurst Road, Worthing
BN11 2DH

AGENDA – MEETING IN PUBLIC

1	10.00	**Welcome and Apologies for Absence**		Chair
2	10.00	**Declarations of Interests**		All
3	10.00	**Minutes of Board Meeting held on 26 April 2018** To approve	Enclosure	Chair
4	10.05	**Matters Arising from the Minutes** To note	Enclosure	Chair
5	10.10	**Chief Executive's Report** To receive and agree any necessary actions	Enclosure	MG
		PATIENT SAFETY/EXPERIENCE ITEMS		
6	10.20	**6.1 Quality Report** **6.2 Performance Report** **6.3 Organisational Development and Workforce** **6.4 Financial Performance** To receive and agree any necessary actions	Enclosure Enclosure Enclosure Enclosure	GF/NR JB DF KG
7	11.00	**Learning from Deaths** To receive and agree any necessary action	Enclosure	GF/TT
8	11.15	**Annual Patient Experience Report** To receive and agree any necessary actions	Enclosure	NR
9	11.30	**Adult Safeguarding Annual Report** To receive and agree any necessary actions	Enclosure	NR/AB
		STRATEGIC ITEMS		
10	11.45	**Annual Report for Appraisal and Revalidation** To receive and agree any necessary action	Enclosure	GF/CS
		OTHER ITEMS		
11	12.00	**Other Business**		

12	12.10	**Resolution into Board Committee** To pass the following resolution: "That the Board now meets in private due to the confidential nature of the business to be transacted."	Verbal	Chair
13	12.10	**Date of Next Meeting** The next meeting in public of the Board of Directors is scheduled to take place at 10.00am on 25th October 2018 in the Bateman Room, Chichester Medical Education Centre, St Richard's Hospital, Spitalfield Lane, Chichester, PO19 6SE.		Chair
14	12.10	**Close of Meeting**		Chair
15	12.10 – 12.20	**Questions from the Public** Following the close of the meeting there will be an opportunity for members of the public to ask questions about the business considered by the Board.		Chair

Company Secretary
Tel: 01903 285288

Western Sussex Hospitals
NHS Foundation Trust

Minutes

Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 26 April 2018, Boardroom, Washington Suite, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH.

Present:	Mike Viggers	Non-Executive Director (Chairman)
	Joanna Crane	Non-Executive Director
	Mike Rymer	Non-Executive Director
	Patrick Boyle	Non-Executive Director
	Lizzie Peers	Non-Executive Director
	Marianne Griffiths	Chief Executive
	Karen Geoghegan	Chief Financial Officer
	Denise Farmer	Chief Workforce and OD Officer
	Nicola Ranger	Chief Nurse & Patient Safety Officer
	Jane Farrell	Interim Chief Operating Officer
	Jayne Black	Chief Operating Officer
In Attendance:	Kirstin Baker	Non-Executive Director Adviser
	Martin Sinclair	Non-Executive Director Adviser
	Ryck Albertyn	Trust Clinical Lead Organ Donation (For Item 11)
	Angela Fisher	Non-Clinical Lead Organ Donation (For Item 11)
	Brian Courtney	Interim Director of Corporate Governance
	Tanya Humphrys	Board Administrator

TB/04/18/01 Welcome and Apologies

1.1 The Chair welcomed all those present to the meeting. In particular Jayne Black the Trusts new Chief Operating Officer and thanked Jane Farrell who has been the Trusts interim Chief Operating Officer.

1.2 Apologies were received from Pete Landstrom, George Findlay and Jon Furmston.

TB/04/18/02 Declarations of Interests

2.1 There were no declarations of interest.

TB/04/18/03 Minutes of Board Meeting held on 01 February 2018

3.1 The Board received the minutes of the meeting held on 01 February 2018.

3.2 **The Board resolved that the minutes of the Board meeting held on 01 February 2018, would be approved as an accurate record of the meeting and signed by the Chairman.**

TB/04/18/04 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/04/18/05 Chief Executive's Report

5.1 Marianne Griffiths presented her Chief Executives Report and begun by thanking the Staff for their hard work and dedication through the last quarter of 2017/18 which had been particularly challenging, characterised

by unprecedented demand for urgent care and exceptionally cold weather, compounded by high incidence of flu and seasonal infections. Marianne commended Staff for doing an outstanding job of trying to keep our patients safe.

5.2 Marianne acknowledged the results of the NHS Staff Survey, noting that almost 60% of staff at Western Sussex Hospitals had completed the survey. WSHT was ranked in the top five Trusts in England where employees are most likely to recommend their hospital as a place to work or be treated.

5.3 The Board was advised that the old Ophthalmology Unit at Worthing has been reopened as a new Ward. The newly refurbished 20-bed ward is bright and spacious and importantly provides better facilities for our patients, such as more side rooms all with en-suite shower room facilities.

5.4 On Thursday 1 February, the Secretary of State for Health Jeremy Hunt MP paid his third visit to the trust and reiterated his support for our Patient First approach, while speaking to staff about the Department of Health's ambition to make the NHS the safest health service in the world.

5.5 Marianne congratulated the Trusts Employees of the Month for the Quarter:

- Nicole Jones – Staff nurse Nicole Jones on Fishbourne ward at St Richard's was nominated by ward manager Sophie Wright for being a fantastic new addition to their team and always being enthusiastic, caring and flexible to help others.
- Julie Emery – Head and neck clinical nurse specialist Julie Emery was nominated by Macmillan dietitian Carolyn Stapely who commended Julie's compassion and empathy for patients and their loved ones. This was particularly demonstrated in the support she gave to a family whose relative had passed away unexpectedly following their operation.
- Lisa Simmons – Housekeeper Lisa Simmons was nominated by housekeeping manager Gill Sorrell for her excellent commitment to patient care, and going above and beyond for mums-to-be and their families in the maternity department in Worthing Hospital.

5.6 Marianne concluded her Chief Executives Report by explaining that this would be the last Public Board for Trust Chairman, Mike Viggers. Marianne acknowledged what a difficult decision it had been for the Chairman to step down and took the opportunity to thank him for his support and fantastic leadership over the last eight years. Concluding that he would be greatly missed by everyone.

5.7 Mike thanked Marianne for her kind words, commenting that he had felt privileged to see firsthand the kindness and care provided by WSHT staff.

TB/04/18/06 Quality Report – Month 12

Nicola Ranger introduced the Quality Report and highlighted the key points.

6.1 The Board was advised that crude non-elective mortality decreased from 3.86% in February to 3.52% in March, this is marginally higher than the equivalent month in 2017 (3.46%).

6.2 The Trusts HSMR for the twelve months to December 2017 was 88.1. The twelve month HSMR to December 2017, split by site continued to be lower

for St Richard's 84.2 in comparison to Worthing and Southlands 91.5.

6.3 The difference was marginally lower than the previous month and remains well within acceptable variation limits, with both sites remaining below 100.

6.4 It was noted that the Trusts Caesarean Section rate from January to February remained static at 31.3% (28.5% YTD) against a target of 26.5%.

6.5 Nicola advised the Board that in March, 59 patients with a diagnosis of dementia were moved at night (between 23:00-07:00hrs), this was a rise from January when a total of 44 patients were moved at night. The Boards attention was drawn to the detailed report in Appendix 3.

6.6 Nicola explained that there is ongoing work with the Kiazen team to try and discharge patients earlier, before midday, so that ward to ward moves can be made earlier to help reduce nighttime moves.

6.7 It was noted that an overview of the Trusts work in relation to NICE guidance was included in the Quality Report.

6.8 The Board was advised that the incidence of pressure ulcers, category 2 and above including those developing within 72 hours after admission per 1000 bed days, in March was 1.25, against a national rate of 0.9.

6.9 It was noted that there is ongoing work with the Kaizen team that is being implemented; ensuring that patients who no longer require pressure redistribution mattress are identified within the safety huddles and the de-escalation process is discussed. Embedding this in the safety huddles, will ensure that pressure redistribution systems no longer required will be returned to the equipment library and utilised for other patients requiring pressure redistribution surfaces in a timely manner.

6.10 Nicola advised that there would be a new Tissue Viability annual report introduced at the appropriate juncture and brought back to the Board for review at a future meeting. **NR**

6.11 Marianne Griffiths raised concerns about the level of Community pressure damage that the Trust was seeing. Nicola concurred and advised that she would raise it at the CCG Quality meeting.

6.12 Patrick Boyle welcomed the data around night moves and asked the reasons behind them. Marianne explained that it was primarily to do with flow and bed pressure, but noted the continued improvement work with the Kiazen team.

6.13 Mike Viggers thanked Nicola for the report and requested that further information in relation to the reason behind night moves be included in the next report. **NR**

TB/01/18/07 Performance Report – Month 12

The Performance Report was introduced by Jane Farrell.

7.1 Jane advised the Board that Operationally March saw an increased level of A&E demand, and an increase in emergency admissions relative to the same period in 2017.

7.2 It was noted that there was a 4% increase in non-elective activity overall.

With an increase of 10.3% in Emergency admissions in comparison to last year. .

7.3 Over 65 emergency admissions increased in March 2018 with a 12.8% increase compared to March 2017. For patients 85 and over, the increase was 19.2%.

7.4 Worthing saw an average of 490 beds occupied in March, and an average occupancy of 97.0%, with the highest occupancy of 99.8% on 7th March. Emergency medical length of stay at Worthing increased marginally to 7.2 days in March from 7.1 days February. SRH saw an average of 387 beds occupied in March. Occupancy at SRH averaged 94.1% in March 2018, reaching 99.3% also on 7th March. For SRH, emergency medical length of stay increased marginally from 5.6 days on average in February to 5.7 days March.

7.5 Jane highlighted that current performance has improved considerably in April with a level of performance that has not been achieved since October 2017, noting that it is a promising start to Quarter 1.

7.6 It was noted that Referral to Treatment elective plans were impacted by winter pressures, however there were no 52 week breaches.

7.7 The Trust was compliant against all Cancer metrics in month.

7.8 Jane commented that March was a tough month and it is a testament to our staff that the Trust, when compared against national figures, apart from RTT is amongst the higher achieving Trusts.

7.9 Mike Rymer asked whether some of the pressures in A&E could be attributed to General Practice closing for four working days over the Easter period.

7.10 Mike Viggers requested that when the Board receives the Winter Review that the impact of Primary Care closures on A&E is included. **JB**

7.11 The Chairman praised the Trusts staff on their hard work and dedication, highlighting that the performance in Cancer is incredible in comparison to the national picture.

TB/01/18/08 Organisational Development and Workforce Transformation Report – Month 12

Denise Farmer presented the Workforce Report for Month 9.

8.1 The Board was advised that operational pressures continued during March with additional capacity open across both bed-holding hospitals. This resulted in workforce capacity exceeding the budgeted establishment.

8.2 It was noted that total spend on agency staff in 2017/18 was £12.86m, compared to £18.90m in 2016/17 Medical agency accounted for 54% of total use with nursing agency accounting for 33%.

8.3 Denise explained that there had been really positive improvements in Estates and Facilities with the ongoing work to strengthen management structures within the department.

8.4 The Boards attention was drawn to the update on the proposed changes

to NHS Terms and Conditions – Contract Refresh 2018.

8.5 Patrick Boyle enquired whether the changes to the Terms and Conditions for staff could result in dispute. In response Denise advised that the majority of unions were recommending the refresh, or putting it to members with no recommendation.

TB/01/18/09 Financial Performance – Month 12

Karen Geoghegan presented the Financial Performance Report.

9.1 The Trust reported a deficit of £2.3m at the end of March, excluding STF.

9.2 This included a £0.6m surplus on 2017/18 operational activities, in line with the revised forecast agreed with the Finance and Investment Committee in January, and a £2.9m adverse movement following completion of expert determination for the outstanding dispute of £8.6m in relation to 2016/17.

9.3 The Trust has earned £6.5m STF for performance in Quarter 1 to Quarter 3 and an incentive distribution at year end of a further £3.4m bringing the total to £9.9m for 2017/18.

9.4 The out-turn position; including STF is a surplus of £7.7m.

9.5 The Trust is reporting an FSRR rating of '2'.

9.6 Mike Viggers commended the Trust on the £7.7m surplus achieved. In addition Mike commented on the positive work between Finance and Human Resources on reducing agency spend.

TB/01/18/10 Nursing Staffing Capacity Report

Nicola Ranger presented the Nursing Staffing Capacity Report.

10.1 The Board was advised that currently the Trust has a registered Nurse vacancy of 217 whole time equivalent (WTE) and 17 WTE HCAs under establishment.

10.2 It was noted that there remains focussed activity on nursing recruitment, retention, sickness management and in increasing the Trusts bank pool while aiming to reduce the use of agency staff. The Trust are currently using a variety of recruitment methods including return to practice, flexible working and rotation programmes to our recruitment adverts.

10.3 Nicola explained that the Trust has not sacrificed safe staffing in the bid to reduce agency, highlighting that staffing is reviewed up to four times daily.

10.4 It was noted that the intention is to try and increase the number of bank shifts that the Trusts substantive staff do.

10.5 Nicola explained that the number of bank shifts by WSHT substantive staff had increased to between 70 and 100 per week, which has significantly improved the care of the patients.

10.6 It was noted that retention rates have also improved with WSHT currently better than the national average.

10.7 The Board was advised that there had been significant work to look at the

ratios in Maternity following concerns raised by staff. Nicola explained that following a review of the rosters there were a number of factors, one of the key issues was a consistently high level of maternity leave.

10.8 It was noted that representatives of maternity at Worthing met with the Chief Nurse to discuss concerns and an action was been taken to resolve most of the issues.

10.9 Staffing levels have since improved and are being closely monitored by the matrons and escalated where there are identified shortfalls. There is only a small level of vacancy in maternity and active recruitment is an ongoing priority.

10.10 Mike Viggers thanked Nicola for the report and requested that a further review of Maternity be included in the next Nursing Staffing Capacity Report in October. **NR**

TB/01/18/11 Annual Report on Organ Donation

The Board received a detailed presentation alongside the annual organ donation report

11.1 Ryck Albertyn presented the report and began by thanking and acknowledging all the families and patients that donate to help those that need it.

11.2 Ryck explained that nationally 457 patients died while on the active list waiting for their transplant, a further 875 were removed from the transplant list.

11.3 It was highlighted that there had been a slight decrease in the figures in comparison to the previous year, but noted that the numbers are so small that a change of 1 would impact significantly on the percentages.

11.4 The Board was advised that the Organ Donation Committee had been able to fund a number of different areas that it is hoped will have a positive impact on the comfort of patients and their families in ITU.

11.5 Finally Ryck advised the Board that both himself and Angela Fisher, Non-clinical Lead for Organ Donation, would be stepping down, commenting that they would ensure that there is a transition period.

11.6 Mike Viggers thanked both Ryck and Angela for their continued dedication.

11.7 Marianne Griffiths commented that the team had been inspirational and achieved so much and thanked them for all their hard work.

TB/01/18/12 Annual Quality Report 2017/18

12.1 Nicola Ranger advised the Board that they were receiving the third draft of the Trusts Annual Quality Report for 2017/18 for information.

12.2 Nicola requested that should the Board have any additional comments that they be provided by 01st May 2018.

12.3 The Board **NOTED** the Quality Report 2017/18

TB/01/18/13 Provider Self-Certification

13.1 Brian Courtney presented the Provider Self-Certification which is required by NHS Improvement under the NHS Provider License, Risk Assessment Framework and the Health and Social Care Act 2012.

13.2 The Board of Directors **APPROVED** the Self-Certifications and that they would signed by the Chairman and Chief Executive.

TB/01/18/14 Use of Trust Seal

14.1 Brian Courtney presented the Notification of Sealed Documents Report.

14.2 The Board **NOTED** that one item had been signed under Seal during the period of 01st January 2018 to 30th March 2018.

TB/01/18/15 Proposed Amendments to the Trust Constitution

15.1 Mike Viggers advised the Board that further proposed amendments had been made to the Trust Constitution.

15.2 It was noted that the amended Constitution detailed changes in the number of appointed Governors in certain constituencies, all of which were approved by the Council of Governors at their meeting on 15th June 2018.

15.3 A final version of the amended Trust Constitution would be presented at the Council of Governors meeting in June.

15.4 The Board **APPROVED** the proposed amendments to the Trust Constitution.

TB/01/18/16 Other Business

14.1 There was no other business to discuss.

TB/01/18/17 Resolution into Board Committee

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

TB/01/18/18 Date of Next Meeting

16.1 It was noted that the next Board Meeting would take place on **Thursday 26th July** in the **Boardroom, Washington Suite, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH.**

TB/01/18/19 The Chair formally closed the meeting

TB/01/18/20 Questions from Members of the Public

20.1 John Thompson thanked Mike Viggers, Chairman, for his ongoing support with the Council of Governors, commenting that he would be greatly missed and wishing him a happy retirement.

20.2 John went on to comment on a recent Peer Review he had been involved in and what a positive experience it had been. John noted that they went to Southsea Ward which was busy but had a fantastic atmosphere, feedback from staff and patients was very positive.

20.3 Jane Ramage commented how positive it was to see the improvements and developments taking place with the Trust, in line with ongoing work. Jane advised the Board that the 'Friends' were hoping to fund a piece of equipment that assists with the diagnosis of neutropenic sepsis.

20.4 Ian Strand asked about mandatory training and commented that the Trust no longer provides an overall indication of how the organisation is performing. Denise Farmer explained that the Trust looks at each department in detail, where there are no concerns being raised this is not reported into Board.

20.5 Sue Cook praised the Trusts A&E departments for their tremendous work in the new year under unprecedented pressure.

Tanya Humphrys
Board Administrator
April 2018

Signed as an accurate record of the meeting

……
Chair
……
Date

MATTERS ARISING
Board in Public

Agenda Item: 4

Meeting	Minute Ref	Action	Responsible Person	Deadline	Status
01st February 2018	**TB/01/18/10.10**	**Learning from Deaths** - report to have oversight on how it links in to governance structures and other areas of learning within the Organisation.	GF/TT	26th July 2018	On the forward agenda plan for July Public Board.
01st February 2018	**TB/01/18/10.11**	**Learning from Deaths** - report to include some detail on training and support for the in-depth reviewers.	GF/TT	26th July 2018	On the forward agenda plan for July Public Board.
26th April 2018	**TB/04/18/6.10**	**Quality Report** - annual report on category 3 and 4 pressure ulcers to be introduced.	NR	TBA	
26th April 2018	**TB/04/18/6.13**	**Quality Report** - More detailed information on the reasons for the night moves and bed space, and the work linked to early discharge.	GF/NR	Completed	**Completed** – Included as part of the Quality Report on 31st May 2018.
26th April 2018	**TB/04/18/7.10**	**Performance Report** – Incorporate into the winter review an overview of Primary Care and the impact of not running a seven day service on the Trust.	JB	Completed	**Completed** – Received at Board on 31st May 2018.
28th June 2018	**PB/06/18/5.2**	**Quality Report** - Site specific Mortality figures and more detail to be included in the report in Month 3	GF	26th July 2018	Included as part of the Quality Report.
28th June 2018	**PB/06/18/5.3**	**Quality Report** - Further information on discharges before midday to be included in the next report	GF	26th July 2018	Included as part of the Quality Report.
28th June 2018	**PB/06/18/5.4**	**Quality Report -** Update on the progress of the 24/7 Stroke Thrombolysis.	GF	26th July 2018	Included as part of the Quality Report.
28th June 2018	**PB/06/18/5.6**	**Quality Report** - Some additional narrative in relation to Antimicrobial Consumption	GF/NR	26th July 2018	Included as part of the Quality Report.

Western Sussex Hospitals
NHS Foundation Trust

To: Trust Board **Date:** 26th July 2018

From: Marianne Griffiths, Chief Executive Agenda Item: **5**

FOR INFORMATION

CHIEF EXECUTIVE'S BOARD PAPER

1. **Highlights and headlines**

NHS 70

On Thursday 5 July, we joined NHS colleagues nationwide in the celebrations to mark the 70th anniversary of the National Health Service. Special "Thank you" hampers, funded by charitable means and containing supplies of tea, coffee, biscuits and healthy snacks, were delivered to all teams and departments by trust leaders, ambassadors and governors. The trust also used a social media campaign to highlight advancements in local healthcare over the decades, as well as key members of staff who have done amazing things to go above and beyond, while caring for local people. A group of six colleagues attended a ceremony at Westminster Abbey along with 4,000 other NHS employees and medical secretary Tanya Sell represented the trust at a reception hosted by the Prime Minister at No. 10 Downing Street. I wish to thank everyone involved with our NHS70 celebrations. It was a fantastic opportunity to recognise all our staff for their continued hard work, dedication and commitment to our patients.

Top Hospital 2018 award

In May, the trust won a prestigious award made only to the best-performing hospitals in the country. The CHKS Top Hospital Awards are data driven and determined by healthcare improvement specialists CHKS. We are very proud to be ranked among the very best hospitals in the country by CHKS in recognition of the quality of services and care we provide to our patients. This Top Hospital award recognises our strong record of delivering on health outcomes and patient safety, which entirely due to the hard work of our staff and their ambition to always do the best for patients.

Education & Training Award

We are delighted to follow on from winning Best Organisation last year by this month winning the Education & Training award at the 2018 Patient Safety Awards in Manchester. The award was in recognition of our continuous improvement staff training programme designed to create an army of problem solvers, led by our Kaizen team. More than 440 staff have received training so far and some of the 2017 graduates have used their new skills to reduce delayed discharges from the intensive care unit which enabled Western Sussex Hospitals to be the only trust in England to meet a new national quality target last year. Our award is dedicated to all colleagues who have been trained to both yellow and green belt standard and who now look to make improvements as part of daily business. Our congratulations go to the Kaizen team and indeed everyone who has taken part in what the judges described as an excellent training programme.

HRH Countess of Wessex opens Western Sussex Eye Care | Southlands

Her Royal Highness the Countess of Wessex, GCVO officially opened our new £7.5 million eye service in Shoreham on 8 May. Amongst those in attendance was Mrs Edith Bain, an 82-year-old patient from Southbourne, who was blind in one eye for 70 years before her vision was repaired by the eye care team. It was uplifting to hear Mrs Bain's story and especially how wonderful the staff were including Mr Masoud Teimory, who was the consultant responsible for repairing Mrs Bain's vision.

Fond farewell to chairman Mike Viggers and welcome to Alan McCarthy

In May we bade a fond farewell to chairman Mike Viggers after eight years of loyal service and leadership of Western Sussex Hospitals. Mike was an outstanding chair and has played an invaluable role in so many of our achievements - from launching Patient First to being rated Outstanding, Mike has led us to success. On behalf of us all at Western Sussex, I wish to publicly thank Mike for everything he has done for us and wish him the happiest retirement in the world – he deserves it.

I am pleased to confirm the appointment of Alan McCarthy as joint-chairman of Western Sussex Hospitals and Brighton University and Sussex Hospitals. Alan joins us from Sussex and Surrey Healthcare NHS Trust where as chairman for the past eight years he has made a fantastic contribution to the successful transformation of the trust. His appointment is an exciting development for us and we are confident his extensive experience and energy will help us continue to achieve great things in the years to come.

Finally, thank you to Patrick Boyle for standing in as interim chairman while the recruitment of a new chair takes place. Patrick will return to his duties as a non-

executive director on the board once Alan begins his tenure at the end of the summer.

CQC “very impressed” by surgery division

The Care Quality Commission formally visited the trust in May for the first time since our full inspection in December 2015 which resulted in our overall *Outstanding* CQC rating. Focusing on our Surgery division only, the inspectors fed back that they were very impressed with what they saw and importantly they had no significant concerns to raise with us. I wish to congratulate colleagues on their excellent preparation and positive engagement with the inspection process.

Outstanding researchers win awards at conference

Clinical colleagues making an outstanding contribution to research were recognised at the trust’s second annual research conference, which this year for the first time hosted a new awards programme. Congratulations to the winners and runners up in each of the three categories:

The team award for outstanding contribution to supporting NHS Research was won by **maternity services** at St Richard’s and Worthing, in recognition of the consistent expansion of their research portfolio in recent years and their investment in research by developing roles for a registrar/research fellow and midwife/clinical doctoral fellow.

Critical care consultant, **Dr Luke Hodgson** was the winner of the individual award for outstanding contribution to supporting NHS Research, in recognition of his internationally recognised work and mentorship of other trust staff in understanding the basic principles and importance of the NHS.

And finally the new researcher of the year accolade went to practice development midwife **Anita Clarke**. Anita’s research on pressure damage in maternity care has translated into changes in clinical practice that improve care for women in labour and prevent avoidable skin damage.

Thank you to our Volunteers

During National Volunteers Week (1-7 June), we said thank you to all our volunteers. Nearly 900 people give their time freely to assist teams in our hospitals and I am delighted that more than 200 volunteers were able to attend our volunteer celebration events at St Richard’s Hospital and The Dome in Worthing, where

awards for long service were also made to those passing significant milestones of voluntary service.

Royal Wedding

To celebrate the union of Prince Harry and Meghan Markle on Saturday 19 May, we provided a special Royal Wedding dinner service to all our inpatients. Thank you to all staff that helped make this possible as well as those who arranged royal parties to enable their patients to enjoy the big day.

Apprentice awards

Congratulations to trust apprentices **Niamh Mulhall** and **Kam Hull** who both won awards at the Health and Education England (Kent, Surrey and Sussex) annual apprentice awards. Niamh, who works with the medical staffing team, won the level three non-clinical award, while healthcare assistant Kam won the level two clinical award. The trust also came runner-up in apprentice employer of the year category, which we won last year. Congratulations to everyone involved.

2. Events and Visits

Thank You Lunches

To recognise the continued hard work of all our staff, we will be laying on special ‘thank you’ lunches again for staff and volunteers on Monday 20 August at St Richard’s, Thursday 30 August at Worthing and Friday 31 August at Southlands.

Staff Conference

Our annual ‘Where Better Never Stops’ staff conference takes place on the 11 and 18 October at Fontwell Park with the theme of patient experience this year. We are thrilled to welcome former rugby player Matt King OBE as our keynote speaker and look forward to a packed programme of innovations and reflections on improving patient experience.

Patient First STAR Awards

Our annual staff recognition awards takes place again this year on Wednesday 3 October following the submission of a record number of nominations in May. More than 630 members of staff, volunteers and teams were put forward for special recognition by their colleagues, patients and the public. Thank you to everyone who

took the time to nominate. The first round of judging takes place soon, after which this year's shortlist will be announced.

Diary dates

The next Council of Governors meetings take place on 20 September (The Dome, 21-22 Marine Parade, Worthing BN11 3PT - from 9.30am) and 10 December (Mickerson Hall - Chichester Medical Education Centre, St Richard's Hospital - from 9.30am).

The next public Trust Board meetings take place on 25 October (10am-12.30pm Boardroom, Washington Suite, Worthing Hospital) and 31 January 2019 (10am-12.30pm, Bateman Room, Chichester Medical Education Centre, St Richard's Hospital).

I would urge anyone wishing to keep in touch with trust news and dates of future events to become a member of the Foundation Trust. Please follow the link on our website. Members automatically receive our monthly e-newsletter called @WesternSussex.

3. **Our People**

Employees of the Month

Employees of the Month can be nominated by patients, visitors or staff. Winners receive £50, a letter of commendation on their HR file and an invitation to the trust's annual staff recognition awards.

- **Broadwater and Buckingham wards** – Congratulations to Broadwater and Buckingham wards teams who were nominated by matron Sue Shepherd for their joint work to improve patient safety and quality of care amid unprecedented winter pressures earlier this year. Both wards have been extremely receptive to new guidelines that they themselves helped to develop.

- **Sharon Reed** – Congratulations to lead infection control and prevention nurse, Sharon Reed who was nominated by Dr Susie Jerwood. Although relatively new to her post, Sharon has gone above and beyond by putting in extra hours without being asked and gave up planned holiday to ensure infection control advice was delivered in a timely manner amid a flu outbreak.
- **Ann Maloney** – Congratulations to acute oncology nurse lead Ann Maloney who was nominated by improvement practitioner Jamie Cochrane for

developing new pathways to improve care for patients with suspected neutropenic sepsis.

Welcome to new colleagues

Dr Ildiko Telegdy, Consultant Rheumatologist (St Richard's) – start date October 2018 (TBC)

Dr Victoria Sharp, Consultant Paediatrician (St Richard's) – start date 12 April 2018

Dr Dorothy Hawes, Consultant Paediatrician (St Richard's) – start date 1 August 2018

Dr Pelvender Gill, Fixed Term Consultant Histopathologist (St Richard's) – start date 1 May 2018

Mr Mohammed Mobasheri, Consultant in General Surgery (St Richard's) – start date October 2018 (TBC)

Mr James Grant, Consultant in Orthodontics (St Richard's) – start date TBC

Mr Farzad Borumandi, Consultant in Oral and Maxillofacial Surgery (St Richard's) – start date TBC

Mr Partha Chakraborty, Consultant Ophthalmologist (Southlands) – start date 10 September 2018

Dr Maxworth Hu, Fixed Term Consultant in Gastroenterology (Worthing) – start date 17 September 2018 for 6 months

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Executive Board/Quality Board
Date of Meeting: 26th July 2018 Agenda Item: 6.1

Title
Month 03 (June), 2018/19 Monthly Quality Report
Responsible Executive Director
Dr George Findlay (Chief Medical Officer) and Nicola Ranger (Chief Nurse)
Prepared by
Jo Habben (Head of Clinical Governance and Patient Safety)
Status
Disclosable
Summary of Proposal
Not applicable
Implications for Quality of Care
Describes performance against quality outcome KPIs, including safety, infection control, experience, effectiveness and mortality.
Link to Strategic Objectives/Board Assurance Framework
This report pulls together key national, regional and local quality indicators relating to quality and safety providing assurance for the Board and (if necessary) highlighting issues.
Financial Implications
Describes KPIs that have potential financial impact (e.g. CQUIN.)
Human Resource Implications
Describes KPIs linked to workforce.
Recommendation
The Board is asked to: Note the contents of this report.
Communication and Consultation
Not applicable
Appendices
Appendix 1: Quality Scorecard Appendix 2: Ward Staffing Scorecard Appendix 3: Early Discharges (before midday) Update Appendix 4: Site Specific Mortality Summary

1 INTRODUCTION

1.1 This report brings together key national, regional and local indicators relating to quality, performance and safety. The purpose of the report is to bring to the attention of the Trust Board quality performance within Western Sussex Hospitals Foundation Trust (WSHFT).

1.2 The paper describes performance on an exceptional basis determined by RAG (red/amber/green) ratings based on national, regional or local targets.

2 2018/19 REFRESH

2.1 There has been a refresh of the Monthly Quality Report for 2018/19 to reflect the key quality objectives for the next year aligned to Patient First and our True North objective[1]. The report follows the same format as previously using the same suite of metrics, with revised targets using similar logic in the interim to that applied for 2017/18:-

- If 2017/18 performance exceeded target, then 2017/18 actuals used as 2018/19 target
- If 2017/18 performance did not meet target then 2017/18 target remains the same for 2018/19
- If there is a national or set target then that will continue as the measure
- Any metrics with no target set continue as before

2.1.2 The Quality Scorecard for 2018/19 incorporates the following changes:

- Site view

  New indicators:

a) E45- % of Part 2 inpatient deaths reviewed
b) E54- Reduced A&E visits for a cohort of frequent attenders who would benefit from MH interventions
c) E59-Rate of discharges by Midday under section 'Increase discharge effectiveness'
d) E55-Normal delivery rate under section 'To improve maternity care by encouraging natural childbirth'
e) E58-Induction of labour
f) S48-Focus on anticoagulants: Average no. patients per day on VTE missing report (EPMA)

- Removal of some indicators as advised
- Some minor re-arranging of metrics and changes to metric definitions

[1] *Patient First is our long term approach to transforming services. 'True North' is the one constant towards which the four strategic themes for the organisation – sustainability, people, quality improvement and Systems & partnerships – should lead.*

3 KEY QUALITY OBJECTIVES

3.1 Scorecard Definitions

3.1.1 The full Clinical Quality Scorecard is presented as Appendix 1. Figures are in-month figures (e.g. the number of falls reported in June) unless otherwise stated. The scorecard shows 13 months to allow trends to be identified, although some data items are reported retrospectively. Year to date actuals/targets are based on financial years unless otherwise stated (standardised mortality ratios are recorded as 12 month positions for example). A subset of the key measures from the report is presented at 3.3. These currently remain the same sub-set as last year and will be refreshed when the new scorecard is established.

3.1.2 Exception reports are included under the relevant section of this report (Effectiveness, Safety and Patient Experience).

3.1.3 Although the scorecard reflects 13 months of data, only the current financial year and year to date values are RAG rated - with the exception of those metrics reported in arrears where the most recent data-point of last year is RAG rated.

3.2 Domain scores

3.2.1 The score is an overall indication of the performance in relation to each of the domains - Effectiveness, Safety and Patient Experience. The score is calculated as follows: Each RAG rated indicator for a month is scored: red scores 1, amber scores 2, green scores 3. These scores are then totalled and divided by the total number of indicators with RAG ratings to give a score for the domain as a whole between 1 and 3. This final score can then itself be RAG rated with >2.5 giving an overall green, 1.5 to 2.5 amber and <1.5 an overall red score for the domain as a whole. For example if a domain had two greens and a red the calculation would be as follows:

3 (green) + 3 (green) + 1 (red) = 7
7 / 3 (i.e. the total number of metrics) = 2.33 i.e. amber overall.

3.2.2 Domain scores are calculated based on the year to date RAG ratings for each metric. Previous months are retrospectively updated to take account of any measures reported in arrears, and should additional metrics be added within the domain. As with any aggregate indicator, it remains essential that the Board retains sight of the individual elements as well as the domain score as a whole.

3.3 Overview of Key Quality Objectives

3.3.1 The following table shows performance against key quality objectives.

Indicator	April 2018	May 2018	June 2018	2018/19 to date	2018/19 Target / limit
Effectiveness Domain Score	1.86	2.14	1.95	2.15	
Safety Domain Score	2.23	2.27	2.13	2.30	
Experience Domain Score	2.48	2.43	2.61	2.52	
E01 Trust crude mortality rate (non-elective)	3.10%	2.21%	2.05%	2.45%	3.10%
E03 Hospital Standardised Mortality Ratio for top 56 diagnoses (Dr Foster, based on rolling 12 months)				89.8	100
S06 Number of Serious Incidents Requiring Investigation (number reported in month)	8	4	7	19	53
S14 Numbers of hospital attributable MRSA	0	0	0	0	0
S28 Numbers of hospital C. diff where a lapse in the quality of care was noted	0	2	0	2	16
X38 The Friends and Family Test: Percentage Recommending Inpatients	97.2%	96.7%	97.2%	97.0%	97%
X39 The Friends and Family Test: Percentage Recommending A&E	91.7%	93.8%	95.6%	94.3%	93%
X13 Mixed Sex Accommodation breaches (number of breaches)	0	0	0	0	0
X18 Number of complaints	26	42	25	93	456

4 EFFECTIVENESS

4. 1 Crude Trust Mortality

4.1.1 Due to the low level of mortality experienced in elective care, the Trust measures mortality in relation to non-elective activity using the previous year as a benchmark.

4.1.2 Crude non-elective mortality decreased from 2.21% in May to 2.05% in June, this is lower than the equivalent month in 2018 (2.56%).

4.1.3 The number of non-elective patients (Crude) who died in June was 124 (2.05%) from 6040 discharges. Worthing and Southlands reported 67 deaths of 3172 discharges (2.11%) and St Richards Hospital reported 57 deaths of 2868 discharges (1.99%). The year to date mortality rate is 2.45% and the rolling 12 month mortality rate is 3.08%.

4.2 Hospital Standardised Mortality Ratio (HSMR)

4.2.1 There is a delay in data being available in Dr Foster tools to allow for coding and processing by the Health and Social Care Information Centre and Dr Foster. The most recent data available is March 2018.

4.2.2 The Trust's HSMR for the twelve months to March 2018 is 89.8 (1865 deaths against expected 2077) 100 is the level predicted by the Dr Foster model using the December 2017 benchmark.

4.2.3 The twelve month HSMR to February 2018 split by site continues to be lower for St Richard's 83.3 (834 deaths against expected 1002) than for Worthing and Southlands 95.9 (1031 deaths against expected 1075). The difference is marginally higher on the Worthing site than the previous month and remains well within acceptable variation limits, with both sites remaining below 100.

4.2.4 E10. 30 day mortality rate following hip fracture – remains relatively static and in March 2018 was reported at 7.5% against target of 5.70% (YTD actual 7.5%).

4.2.6 A further report is available to clinical leaders in the Trust showing the clinical diagnostic areas with high actual versus expected mortality and any mortality CuSum alerts.

4.2.7 The Trust has set the goal of achieving a position within the top 20% of Trusts as measured by HSMR. For the twelve months to March 2018 performance using this measure continues to place us just within the top 20% of Trusts on the 18th centile.

4.3 Summary Hospital-Level Mortality Indicator (SHMI)

4.3.1 The latest data made available by the Health and Social Care Information Centre is for the period to August 2017. The Trust value remains at 0.95 (where 1.00 is the national average), with the Trust banded as "*as expected".*

4.4 Exception Reports Relating to Effectiveness

4.4.1 E13. C-Section rate- the Trust Caesarean Section rate from May to June shows a marginal increase to 29.8% against a target of 27.8%. Each case where a woman has a caesarean delivery undergoes a review process to look for learning opportunities. No systemic causes or trends have been identified and practice is very much in line with national recommendations for safe practice and NICE guidance. Increasing normal birth continues to be an area of focus for the division and rates are closely monitored via monthly divisional performance reviews.

4.4.2 E47. % patients with sepsis receiving antibiotic therapy within one hour (new indicator). Mays's data has increased from April to 76.53% in May against the YTD target of 90%. A summary report will be provided with M4 Quality Report due to additional information required/due (denominator) from Public Health England (PHE).

4.4.3 E58. Induction of labour (new indicator). June's data reports 35.8% against a target of 29.4%. A summary report will be provided with M4 Quality Report.

4.4.4 E59. Rate of discharges by midday (new indicator). June's data reports a steady increase to 15.6% against a target of 45%. A summary report is included in Appendix 4.

4.4.5 E42. Night time moves in patients with a diagnosis of dementia. In June, 35 patients with a diagnosis of dementia were moved at night (between 23:00-07:00hrs), this is a slight increase from May when a total of 26 patients were moved at night, but remains well below the Trust target. Initial thoughts are this continued improvement may be in relation to the introduction of the new Patient Flow Team, ensuring timely transfer from 16:00hrs- 22:00hrs.

4.4.6 E45. % of part 2 inpatient death reviewed. In relation to the Trust mortality review (MR) process in June; 48.8% of part 2 MR was completed against a Trust target of 100%. The mortality review process/team are currently awaiting business case approval in line with the recommendations of the newly published guidance for Trusts on 'Learning from Deaths.'

4.5 Stroke Care (Reported May)- Overall not site specific.

4.5.1 E27. Stroke thrombolysis within 60 minutes of arrival demonstrates a 75% return against a target of 95%.

4.4.5 E30. The percentage of patients at high risk Transient Ischemic Attack (TIA) seen within 24 hours records a return of 16.7% against an annual target of 60%.

4.4.6 E26. % CT scans undertaken within 12 hours has increased from 93.5% in April to 100% in May, against an annual target of 95%.

4.4.7 E28. % Swallow screen for stroke patients within 4 hours of admission has increased from 75.0% in April to 82.4% in May, against an annual target of 95%.

4.4.8 Stroke performance is benchmarked against the Sentinel Stroke Audit (SSNAP), with sites being graded from A-D based on 10 domains (44 metrics). Data and grading is published in 4-monthly periods Dec-Mar, Apr-Jul and Aug-Nov.

4.4.9 The most recently published SSNAP data is for the period Dec-Mar 2018. Worthing achieved an overall B (79) grade, against a grade A (83) in the last reporting period. St Richard's saw a reduction by one point of the overall score but maintained a grade C (68).

4.4.10 A Kaizen improvement project is established to identify opportunities to improve the efficiency of the stroke pathway and uplift performance on both sites to a grade A. Analysis of historical SSNAP data showed that St Richard's had the opportunity to increase its overall score from C to B by focussing on key three areas.

4.4.11 At the start of May 2018, a 24/7 thrombolysis service started at St Richard's hospital. Nursing on the stroke ward and in A&E has been enhanced to support this new service. The consultant on-call rota is delivered jointly by the Worthing and St Richard's stroke teams.

4.4.12 Stratification of SSNAP data had shown a disparity in out of hours (OOH) and in-hours performance against the percentage of patients admitted to the unit within four hours. The implementation of a 24/7 thrombolysis is beginning to demonstrate an upward improvement trend and will be evaluated three months post implementation.

5 SAFETY

5.1 Central Alert System (CAS) Safety Alerts

5.1.1 There are no outstanding alerts for the Trust up to June 2018.

5.2 Serious Incidents Requiring Investigation (SIRIs)

5.2.1 There were 7 reported incidents categorised as a Serious Incident (SI) requiring investigation in June.

5.2.2 There were 3 maternity incidents reported since April that have met the 'Each Baby Counts' criteria and are currently being investigated by the Health Safety Investigation Branch (HSIB). In June, on the Worthing site, one baby (neonate) required transfer to NICU for cooling and one twin (neonate) required transfer to NICU for cooling. In April, on the SRH site, one baby was sadly stillborn. These are independent investigations and all three reports will be finalised and published in December 2018.

5.2.3 Regarding serious incident's investigated internally at WSHFT; one patient fell and sustained a fractured neck of femur requiring further surgery, there was one incident reported regarding the unexpected death of a patient following insertion of a pacemaker (post discharge), a patient who developed a hospital acquired thrombosis (HAT) requiring transfer to tertiary care ICU, and a 'Never Event' where a patient received air (via air flow meter) instead of oxygen therapy as prescribed.

5.2.4 A detailed serious incident report is provided to the committee section of the Trust board. The board should note there can be slight variation in the month-by-month numbers between the SI report and the number of significant incidents – this is because incidents are attributed to the month in which they occur whereas the SI data is based on the month in which the SI was reported externally.

5.2.5 Any incidents that are reported as causing significant harm (moderate, severe or resulting in the death of a patient) are notified immediately to the senior team in the Trust including the chief nurse and the chief medical officer with at least weekly updates on progress. In June 23 incidents were reported, against a yearly target of 153.

5.2.6 On a monthly basis there is triangulation of information arising out of complaints, claims, incidents, Freedom to Speak Up themes, safeguarding (Serious Case Review) and inquests to identify any areas of learning or for focus. The Triangulation Committee continues to focus on how we share learning across the organisation, with a detailed 'Deep Dive' focus on an incident(s) (where the learning for the organisation is significant) being discussed at each meeting.

5.3 Infection control

5.3.1 There were 0 cases of Clostridium Difficile reported in June where there was a noted lapse in care attributable to the Trust. The Trust remains within the C.diff trajectory and the Trusts C.diff action plan has been refreshed for 2018/2019 following a workshop. This action plan is discussed at every Infection control operational group meeting (ICOG) and every Trust Infection Control Committee (TICC) meeting and is a live working document.

5.3.2 The allocated Trust target limit for 2018/19 (C/Diff) is set at 38 [2]. Incidence in June was 0 cases per 100,000 bed days against the national average for 2016/17 of 13.2 cases per 100,000 bed days[3].

5.3.1 S16a. Number of hospital attributable MSSA bacteremia cases in June has been reported as a total of 0.

5.3.2 S17a. Number of hospital attributable E.coli cases in June has been reported as a total of 5. All 5 E.coli bacteremia cases had a thorough RCA completed with a triangulation of Matron/Sister and IPC team input. Frequently, despite a thorough RCA, no specific root cause is found however learning opportunities are always taken forwards. These include; the Infection Prevention & Control Team have communicated the importance of hydration and catheter care and have raised at sister meetings, ward away days and face to face training. All 5 cases were raised at ICOG to ensure shared learning and dissemination. IP&C, with support from CCG, are formulating a Trust trajectory and ambition plan to follow the set Quality Premium of reducing E.coli bacteremia's by 10%. This will be shared and discussed at July TICC (Trust Infection Control Committee).

5.3.3 S44. Antimicrobial stewardship and consumption: 2% reduction in overall antibiotic consumption. April's data continues to demonstrate a steady rise to 15% against a target of -0.4%. A summary report will be provided with M4 Quality Report.

5.4 Falls

5.4.1 In June, inpatient falls decreased from a total of 131 reported in May, to 124 reported in June (remaining well within the Trust target), and of these 31 resulted in harm. From overall monthly total of 124, 56 falls were noted at Worthing Hospital and 58 were recorded at St Richards Hospital.

5.4.2 There were 5 falls resulting in a moderate degree of harm to patients. One of these incidents resulted in a patient injury of a neck of femur fracture, and has been reported as a Serious Incident as outlined in 5.2.3.

[2] *NHSI (2017) Clostridium difficile infection objectives for NHS organisations in 2017/18 and guidance on sanction implementation. Page 5*
[3] *https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data.*

5.4.3 The number of falls in June equates to 4.84 per 1,000 bed days against a national figure of 6.63.[4] Of the falls reported as resulting in harm in June, those causing significant harm (severe harm/death) equate to 0 per 1000 bed days against the national figure of 0.19.

5.4.4 Due to existing co-morbidities and frailty the deconditioning of our patients remains a risk and confusion in patients remains a dominant theme when a patient falls.

5.4.5 Wellbeing volunteer work continues and physios are also piloting the 'mobility volunteer' on Barrow Ward.

5.5 Tissue Viability

5.5.1 During June the Trust reported at total of 26 incidents of pressure damage both equal to and greater than European Pressure Ulcer Advisory Group (EPUAP) category 2- a slight increase in reporting from Mays's data of 23. Of these reported cases- there were 22 category 2 hospital acquired pressure ulcers, 1 category 3 pressure ulcer, 1 suspected deep tissue injuries (SDTI), and 1 unstageable injury. Of the overall total of 26, 13 of these incidents occurred at the Worthing Site and 13 occurred at the St Richards hospital site

5.5.2 The incidence of pressure ulcers, category 2 and above including those developing within 72 hours after admission per 1000 bed days in June was 1.0, against a national rate of 0.85 (as per the Safety Thermometer data).

5.5.3 There were 180 patients admitted to the Trust from the community with existing pressure damage, the majority being from the patient's own home (137).

5.5.4 Moisture related skin damage remains a significant concern and forms a key pillar of the trust A3. Vigilance in skin checks is another key theme this month highlighted by the number of device related ulcers (TEDs, tubingx2 and a bedpan). Numbers of patients admitted with pre-existing skin damage remains high. Patients discharged with suspected deep tissue injury(SDTI) have not received expected visits by community teams

5.5.5 The tissue viability team has commenced a weekly stand up (team safety huddle) to review emerging concerns and ensure proactive support of ward improvement work. The tissue viability clinical nurse specialists are contacting their community counterparts to ensure effective communication about patients discharged with SDTI. An audit of discharge referrals is planned for August.

[4] *Royal College of Physicians. National Audit of Inpatient Falls: audit report 2015. London: RCP, 2015.*

5.6 NHS Patient Safety Thermometer

5.6.1 The NHS Patient Safety Thermometer is used across all relevant acute wards. This tool looks at point prevalence of four key harms - falls, pressure ulcers, urinary tract infections and deep vein thrombosis (DVT) and pulmonary embolism (PE) in all patients on a specific day in the month. A dashboard is available to each ward showing Trust-wide and ward-level data for each individual harm as well as the harm-free care score. These numbers are also shared via the new ward screens.

5.6.2 S02. The harm-free care score for the Trust in June was 94.5%- against the annual target of 95.7%.

5.6.3 The Safety Thermometer includes harms suffered by the patient in healthcare settings prior to admission. The actual number of patients who suffered no new harm during their inpatient stay at WSHFT (indicator S03) in June was 97.7% against a national average of 97.8%. The internal target of 99% is set by the organisation (YTD 98.4%).

5.6.4 S11. Compliance with VTE assessment of patients was 94.2% against a target of 95.3% (YTD 93.9%).

5.6.5 National data relating to the NHS safety thermometer is available here:
http://www.safetythermometer.nhs

5.6.6 S48-Focus on anticoagulants: Average no. patients per day on VTE missing report Electronic Prescribing Medication Administration (EPMA). June's data reports 60.7 against a Trust target of 50.

5.6.7 Anti-coagulants are widely used within the organisation for both prophylaxis and for treatment of venous thromboembolism (VTE). The use of the medication carries risks of error and omission – both within this organisation and nationally. Within the organisation over the last year a number of key areas were identified for focus of which the following areas have made significant progress:

- Prescribing of new oral anticoagulant drugs with varied or insufficient consultation and counselling – including the issue of a 'preventable future death' notice from the coroner in relation to a recent episode
- Lack of clear information about anti-coagulated patients being transferred with patients at discharge

5.6.8 However there are still a couple of areas that require further focus to reduce risk:

- Lack of VTE prophylactic prescribing despite completion of VTE risk assessment – approximately 20 patient per year experience a VTE episode due to lack of prophylactic prescribing.

- Differences in process and guidelines for bridging patients on anti-coagulants and ensuring alignment to the revised Trust-wide bridging guidelines. Up to 70 surgical procedures per year cancelled due to anticoagulant issues.

5.6.9 To improve outcomes for patients, and reduce risk, there is an aligned review of patients appearing on the EPMA miss-match report jointly across core and medical divisions, including an assessment of the revised EPMA report within the ward rounds.

6 PATIENT EXPERIENCE

6.1.1 PALS and Complaints

6.1.2 During June the Trust received 26 complaints, the top five themes (in order) being noted as clinical treatment, date for appointment, communication (oral), staff attitude, date of admission.

6.1.3 The top five themes for PALS concerns trust wide during June 2018 (in order) are noted as date for appointment, clinical treatment, staff attitude/behaviour, admission/transfer/discharge, communication (oral).

6.1.4 X21. Complaints about nursing were reported as 5 against an annual target of 39. YTD actual is recorded as 10.

6.1.5 Divisions continue to embed a more proactive response to new complaints to try to facilitate resolution quickly for patients and families. The Executive team set a target of working towards achieving 60% of complaints to be closed within 25 days each month. 79% of formal complaints were resolved within 25 working days in June (previously 11.8% in at the end of June 2017).

6.1.6 The Quarterly Complaints Report provides an in-depth analysis of trends and lessons learned. This is reviewed by the Patient Experience and Feedback Committee and is presented to the Trust Board.

6.2 Friends and Family Test (FFT)

6.2.1 Patients who access hospital services are asked whether they would recommend WSHFT to their friends or family if they needed similar treatment. Patients who access inpatient, outpatient, day-case, A&E and maternity are all offered the opportunity to respond to the question.

6.2.2 Immediate feedback is provided to wards and departments on a continuous basis to ensure staff can address problems or get positive feedback as quickly as possible. In addition to this, a dashboard is available giving wards access to their individual scores and a poster printed with ward performance to display to the public. Ward ‘recommend’ rates are shown on the screens installed on wards.

6.3 Friends and Family Test Response Rates:

6.3.1 Work continues to improve response rates (inpatient) towards a target this year of 40% (with an interim target for A&E of 23% YTD actual 19.3%). The average response rate in 2017/18 for NHS acute trusts was 12.7%. Currently, response rates for maternity- delivery care for June are below the Trust target.

6.3.2 While acknowledging work still to be done in achieving better response rates particularly in A&E, which continues to improve, the proportion of patients who would have recommended our services to friends and family in June compares favourably with national median benchmark and also against our internal target as per the table below:

6.3.3

	Percentage recommending WSHFT in June (plus YTD)	**Target**
Inpatient care	97.2% (97.0%)	97%
A&E	95.6% (94.3%)	93%
Maternity: Delivery care	97.2% (97.6%)	97%
Outpatient care	96.3% (96.6%)	97%
Maternity: Antenatal care	100% (98.6%)	97%
Maternity: Postnatal ward	97.2% (97.6%)	97%
Maternity: Postnatal community care	100% (100%)	97%

6.3.4 X39. Of note, A&E continues exceeded 93% *likely to recommend*; reflecting improved waiting times in June.

6.3.5 X08. Percentage of re-booked outpatient appointments was recorded in June as 11.3% against an annual target of 7.8%. This correlates with the increase in PALS contacts (X11) relating to appointment problems- 0.15% against an annual target of 0.08%.

6.3.6 X09. Clinics cancelled with less than 6 weeks' notice for annual/study leave has decreased in June to 19 from May's data data of 35.

7 RECOMMENDATION

7.1 The Board is asked to note the contents of this report.

Jo Habben
Head of Clinical Governance and Patient Safety
17th June 2018.

Keith Ashall, Senior Health Intelligence Analyst
t: 01903 205111 (ext 84478)

QUALITY SCORECARD - WSHFT

JUNE 2018

		JUL	AUG	SEP	OCT	NOV	DSEC	JAN	FEB	MAR	APR	MAY	Jun	YTD Actual	YTD Target	Target	Trend
EFFECTIVENESS																	
	Effectiveness domain score	2.52	2.52	2.48	2.46	2.36	2.29	2.22	2.30	2.47	1.86	2.14	1.95	2.15			
	Trust-wide mortality																
E01	Trust crude mortality rate (non-elective)	2.64%	2.60%	2.65%	3.15%	3.06%	3.26%	4.25%	3.86%	3.52%	3.10%	2.21%	2.05%	2.45%	3.10%	3.10%	
E02	Crude mortality rate (non-elective): 12 month rolling	3.09%	3.09%	3.09%	3.07%	3.06%	3.05%	3.07%	3.10%	3.11%	3.13%	3.08%	3.03%	3.08%	3.11%	3.11%	
E03	Trust Hospital Standardised Mortality Ratio (HSMR) (rollin 12M)	88.8	88.4	88.7	88.2	88.5	88.1	89.0	90.2	89.8				89.8	100	100	
E04	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)		0.95											0.95	1	1	
E45	% of Part 2 inpatient deaths reviewed	86.8%	88.2%	91.4%	89.6%	91.6%	85.9%	83.5%	76.2%	67.3%	72.4%	72.6%	48.8%	65.8%	100%	100%	
	Improve mortality in specific conditions																
E47	% patients with sepsis receiving antibiotic therapy within one hour *NEW*	78.6%	85.5%	87.1%	84.0%	81.8%	80.4%	74.4%	77.6%	77.8%	74.55%	76.53%		75.66%	90%	90%	
	Reduce mortality following hip fracture																
E09	SMR for hip fracture (all diagnoses/procedures) (rolling 12M)	101.3	95.7	92.2	89.4	93.8	88.5	95.0	97.3	101.5				101.5	100	100	
E10	30 day mortality rate following hip fracture (rolling 12M)	7.2%	7.3%	7.1%	7.8%	7.7%	6.8%	7.4%	7.6%	7.5%				7.5%	5.70%	5.70%	
	Increase discharge effectiveness																
E59	Rate of discharges by Midday	14.1%	13.1%	13.1%	13.0%	14.2%	13.9%	14.8%	13.7%	14.5%	12.8%	13.9%	15.6%	14.2%	45%	45%	
	Reduce the rate of readmission following discharge from the Trust																
E11	Emergency readmissions within 30 days %	14.7%	13.4%	13.8%	14.4%	14.0%	13.6%	13.2%	14.4%	13.8%	14.13%	14.44%	14.42%	14.33%	13%	13%	
	To improve maternity care by encouraging natural childbirth																
E13	C-Section Rate	22.8%	27.0%	29.4%	27.1%	28.8%	33.0%	29.4%	32.1%	31.3%	26.40%	28.20%	29.80%	28.13%	27.80%	27.8%	
E15	% Deliveries complicated by post-partum haemorrhage	0.2%	0.2%	0.2%	0.7%	0.2%	0.3%	0.5%	1.1%	0.2%	0.20%	1.00%	0.20%	0.47%	1%	1%	
E17	Admission of term babies to neonatal care	3.4%	3.7%	2.5%	3.5%	2.6%	3.8%	2.1%	3.8%	3.1%	4.30%	4.10%	4.40%	4.27%	10%	10%	
E58	Induction of labour	35.9%	34.3%	28.9%	36.5%	34.5%	41.8%	36.7%	34.1%	38.8%	37.90%	39.80%	35.80%	37.83%	29.4%	29.4%	
E60	Normal delivery rate	37.8%	33.9%	37.4%	36.5%	35.5%	30.5%	30.8%	31.0%	28.5%	34.0%	27.5%	29.8%	30.4%	NA	NA	
	Caring for the elderly patient																
E18	% Emergency admissions staying over 72h screened for dementia	90.6%	91.8%	82.9%	94.2%	96.9%	87.3%	93.8%	93.0%	88.9%	91.32%	91.01%	93.10%	91.79%	90%	90%	
E39	Ward moves for patients flagged with dementia	203	180	110	174	163	217	236	193	182	207	186	203	596	564	2257	
E42	Night-time ward moves for patients flagged with dementia : Total	38	22	23	44	44	66	42	44	59	45	26	35	106	125	500	
E42	Night-time ward moves for patients flagged with dementia : % Total excluding Emergency Floor	18.8%	9.5%	25.0%	30.8%	25.0%	20.0%	26.0%	42.7%	23.7%	15.6%	15.4%	22.9%	18.0%	NA	NA	
	Stroke care																
E26	% CT scans undertaken within 12 hours	95.9%	96.9%	95.1%	90.2%	97.6%	93.6%	91.9%	97.9%	95.9%	93.5%	100.0%		96.7%	95%	95%	
E27	% Stroke thrombolysis within 60 minutes of hospital arrival	69.2%	100.0%	71.4%	81.8%	77.8%	88.9%	66.7%	40.0%	50.0%	0.0%	75.0%		75.0%	95%	95%	
E28	% Swallow screen for stroke patients within 4 hours of admission	71.1%	84.4%	87.9%	83.3%	87.8%	71.8%	66.2%	85.4%	94.0%	75.0%	82.4%		78.7%	95%	95%	
E29	% of stroke patients admitted to stroke unit within 4 hours of admission	70.1%	70.3%	76.8%	74.4%	75.0%	72.3%	50.0%	79.2%	74.0%	71.7%	81.6%		76.7%	90%	90%	
E30	% high risk TIA patients seen within 24 hours	33.3%	5.0%	8.3%	15.4%	7.7%	0.0%	14.3%	0.0%	16.7%	15.4%	16.7%		16.0%	60%	60%	
	Ensure active engagement with research																
E23	Patients recruited with CRN portfolio										147	119	298	564	700	2800	
	Data Quality																
E37	% inpatients with electronic discharge summaries produced	94.6%	93.2%	92.7%	93.4%	92.6%	91.5%	92.2%	92.7%	92.0%	92.8%	92.2%	92.8%	92.6%	94.2%	94.2%	

Keith Ashall, Senior Health Intelligence Analyst
t: 01903 205111 (ext 84478)

QUALITY SCORECARD - WSHFT

JUNE 2018

		JUL	AUG	SEP	OCT	NOV	DSEC	JAN	FEB	MAR	APR	MAY	Jun	YTD Actual	YTD Target	Target	Trend
	Mental Health Care *NEW*																
E54	Reduced A&E vists for a cohort of frequent attenders who would benefit from MH interventions	27	36	34	26	31	18	17	22	28	27	34	33	94	122	488	
SAFETY																	
	Safety domain score	2.39	2.06	2.19	2.06	2.22	2.14	2.19	2.31	2.07	2.23	2.27	2.13	2.30			
	Safer staffing																
S36	Safer Staffing: Average fill rate - registered nurses/ midwives (day shifts)	96.2%	94.2%	94.0%	91.7%	94.3%	94.1%	95.6%	92.2%	93.0%	92.0%	94.1%	93.4%	93.2%	95%	95%	
S37	Safer Staffing: Average fill rate - registered nurses/ midwives (night shifts)	97.0%	94.0%	94.9%	91.2%	95.1%	93.7%	97.1%	90.6%	90.1%	90.6%	94.8%	95.5%	93.6%	95%	95%	
S38	Safer Staffing: Average fill rate - care staff (day shifts)	94.8%	93.4%	94.3%	90.5%	92.7%	93.6%	93.8%	90.3%	90.5%	92.4%	94.0%	93.8%	93.4%	95%	95%	
S39	Safer Staffing: Average fill rate - care staff (night shifts)	96.4%	92.4%	93.8%	91.2%	95.2%	93.3%	95.8%	92.4%	92.7%	94.7%	94.9%	96.6%	95.4%	95%	95%	
S41	Care Hours Per Patient Day (CHPPD)	6.8	6.9	7.1	6.4	6.5	6.4	6.4	6.3	6.6	6.5	6.8	7.1	6.8	NA	NA	
	NHS safety thermometer																
S02	Safety Thermometer: % of patients harm-free	96.9%	95.3%	95.5%	94.4%	92.8%	92.8%	94.4%	95.3%	93.5%	96.0%	95.0%	94.5%	95.1%	95.70%	95.70%	
S03	Safety Thermometer: % of patients with no new harms	98.9%	98.8%	98.8%	98.4%	97.2%	97.5%	97.9%	98.7%	97.9%	98.5%	99.0%	97.7%	98.4%	99%	99%	
	Monitoring of clinical incidents																
S19	NEVER events	0	0	1	0	0	0	0	0	0	1	0	1	2	0	0	
S04	Total incidents	723	740	686	802	773	765	849	715	763	739	775	770	2284	2288	9150	
S05	Total moderate, severe or death incidents	10	18	14	15	21	14	11	16	12	18	14	23	55	38	153	
S06	Total serious incidents (SIRIs)	1	5	6	2	4	10	6	3	2	8	4	7	19	13	53	
S07	Number of outstanding CAS alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Improve safety of prescribing																
S08	Total incidents involving drug/prescribing errors	85	88	73	93	85	82	100	75	79	86	81	87	254	254	1016	
S09	Moderate/severe incidents involving drug/prescribing errors	1	3	0	0	0	0	0	0	0	1	0	2	3	1	5	
	Reduce incidence of healthcare acquired infections																
S14	Number of hospital attributable MRSA cases	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	
S15	Number of hospital C.diff cases	4	4	1	2	3	1	6	3	5	2	4	1	7	9	38	
S28	Number of C. diff cases where a lapse in the quality of care was noted	1	4	1	0	2	1	4	2	2	0	2	0	2	4	16	
S16	Number of reportable MSSA bacteraemia cases	5	12	9	9	9	8	6	7	7	10	7	7	24	23	94	
S16a	Number of hosptial attributable MSSA bacteraemia cases	1	3	2	3	2	2	1	3	1	0	3	0	3	5	22	
S17	Number of reportable E.coli cases	39	49	31	38	36	25	35	29	33	32	32	30	94	188	751	
S17a	Number of hospital attributable E.coli cases	5	7	3	6	6	6	8	7	3	4	6	5	15	15	60	
	Improve theatre safety for patients																
S18	Full compliance with WHO Surgical Safety Checklist	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.00%	100%	
S30	SSIs: Total hip replacement (YTD is rolling 12 months)		2.5%			1.6%			3.0%					-	1.1%	1.1%	
S33	SSIs: Total knee replacement (YTD is rolling 12 months)		4.1%			2.2%			0.0%					-	1.5%	1.5%	
S34	SSIs: Large bowel surgery (YTD is rolling 12 months)		15.0%			9.9%			5.4%					-	12%	12%	
S35	SSIs: Breast surgery (YTD is rolling 12 months)		5.2%			5.5%			3.3%					-	3.8%	3.8%	
	Reduce number of falls in hospital																
S50	All falls	136	129	105	133	134	160	0	298	160	128	131	124	383	363	1452	

Keith Ashall, Senior Health Intelligence Analyst
t: 01903 205111 (ext 84478)

QUALITY SCORECARD - WSHFT

JUNE 2018

		JUL	AUG	SEP	OCT	NOV	DSEC	JAN	FEB	MAR	APR	MAY	Jun	YTD Actual	YTD Target	Target	Trend
S21	Falls resulting in harm	36	39	31	43	38	46	47	38	40	39	25	31	95	115	459	
S22	Falls resulting in severe harm or death	0	0	1	0	0	0	0	1	0	0	0	0	0	0	1	
	Pressure ulcers																
S49	Grade 2+ pressure ulcers	16	17	25	33	52	46	43	19	37	27	23	26	76	60	240	
	Other safety metrics																
S11	VTE Assessment Compliance	94.2%	94.9%	94.1%	94.9%	93.8%	93.0%	93.9%	94.1%	93.2%	94.1%	93.4%	94.2%	93.9%	95.3%	95.3%	
	Medicines Optimisation *NEW*																
S44	Antimicrobial stewardship and consumption: 2% Reduction in overall antibiotic consumption	9.8%	3.3%	3.5%	8.4%	0.5%	7.6%	6.0%	4.7%	15.8%	15%			15%	-4.0%	-4.0%	
S45	Antimicrobial stewardship and consumption: 1% reduction in the use of carbapenems	20.0%	34.0%	2.0%	8.0%	-24.0%	2.0%	-1.0%	13.5%	-5.7%	-40%	-31%		-36%	-2.0%	-2.0%	
S47	Focus on anticoagulants: Patients on Direct Oral Anticoagulants (NOACs) receiving counselling	52.0%	50.0%	49.0%	56.0%	52.0%	46.0%	50.0%	46.0%	36.0%	62%	75%		68.5%	50.0%	50.0%	
S48	Focus on anticoagulants: Average no. patients per day on VTE prophylaxis missing report *NEW*												60.7	60.7	50	50	
EXPERIENCE																	
	Experience domain score	2.13	2.26	2.48	2.39	2.52	2.52	2.52	2.48	2.32	2.48	2.43	2.61	2.52			
	Friends and Family Test																
X38	Trust Friends and Family Recommend %: Inpatient	96.7%	96.9%	96.7%	96.7%	97.0%	95.7%	97.0%	97.0%	96.3%	97.2%	96.7%	97.2%	97.0%	97%	97%	
X39	Trust Friends and Family Recommend %: A&E	84.8%	84.8%	84.0%	85.5%	88.1%	84.5%	88.0%	88.5%	87.4%	91.7%	93.8%	95.6%	94.3%	93%	93%	
X40	Maternity Friends and Family Recommend %: Antenatal care (36 weeks)	95.5%	100.0%	100.0%	96.6%	100.0%	89.5%	100.0%	100.0%	100.0%	97.4%	100.0%	100.0%	98.8%	97%	97%	
X41	Maternity Friends and Family Recommend %: Delivery care	97.9%	97.2%	96.1%	97.5%	98.5%	97.9%	98.9%	98.4%	98.0%	97.5%	97.9%	97.2%	97.6%	97%	97%	
X42	Maternity Friends and Family Recommend %: Postnatal ward	97.9%	97.2%	96.1%	97.5%	98.5%	97.9%	98.9%	98.4%	98.0%	97.5%	97.9%	97.2%	97.6%	97%	97%	
X43	Maternity Friends and Family Recommend %: Postnatal community care	97.3%	96.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97%	97%	
X44	Trust Friends and Family Recommend %: Outpatient	96.4%	96.8%	97.4%	97.1%	97.2%	97.2%	97.7%	96.5%	97.1%	96.7%	96.7%	96.3%	96.6%	97%	97%	
	Friends and Family Test response rates																
X24	Trust Friends and Family Response Rate: Inpatient	32.0%	41.9%	35.4%	42.2%	41.8%	35.2%	34.5%	39.0%	33.1%	37.6%	42.6%	43.7%	41.4%	40%	40%	
X25	Trust Friends and Family Response Rate: A&E	9.9%	11.3%	8.1%	11.6%	13.6%	11.0%	9.1%	8.0%	10.1%	10.4%	19.6%	27.5%	19.3%	23%	23%	
X33	Maternity Friends and Family Response Rate: Delivery care	33.6%	33.9%	58.5%	80.5%	65.2%	39.9%	87.9%	51.2%	48.1%	47.5%	47.0%	36.1%	43.6%	40%	40%	
	Reduction in patients suffering a bad experience dealing with the Trust																
X08	Percentage of re-booked outpatient appointments	13.0%	12.1%	12.4%	12.6%	11.9%	13.0%	12.4%	13.6%	14.1%	13.2%	11.8%	11.3%	12.1%	7.80%	7.8%	
X09	Clinics cancelled with less than 6 weeks notice for annual/study leave	71	70	40	26	23	20	44	41	18	22	35	19	76	71	285	
X11	PALS contacts relating to appointment problems (% of total appts)	0.09%	0.08%	0.09%	0.09%	0.09%	0.10%	0.10%	0.12%	0.13%	0.14%	0.15%	0.18%	0.15%	0.08%	0.08%	
X12	Reduce patients cancelled on the day of surgery for non-clinical reasons	23	35	9	56	41	19	29	30	42	26	12	13	51	84	336	
X13	Breaches of mixed sex accommodation arrangements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Nutritional Assessment																
X14	Compliance with MUST tool after 24 hours	86.8%	87.0%	88.3%	88.3%	87.4%	83.4%	83.0%	85.6%	78.4%	87.7%	88.7%	91.6%	89.4%	80%	80%	
X15	Compliance with MUST tool after 7 days	99.0%	99.5%	99.4%	99.2%	99.3%	98.8%	98.1%	98.7%	100.0%	99.3%	98.9%	99.1%	99.1%	95%	95%	
	Cleanliness / PLACE Survey																
X16	Internal PLACE compliance	93%	98%	95%	97%	95%	96%	97%	97%	97%	98%	98%	97%	98%	95%	95%	
	Improve our customer service and become a more caring organisation																
X18	Number of complaints	44	40	38	32	42	30	34	28	38	26	42	25	93	114	456	

Keith Ashall, Senior Health Intelligence Analyst
t: 01903 205111 (ext 84478)

QUALITY SCORECARD - WSHFT

JUNE 2018

		JUL	AUG	SEP	OCT	NOV	DŞEC	JAN	FEB	MAR	APR	MAY	Jun	YTD Actual	YTD Target	Target	Trend
X19	Complaints where staff attitude or behaviour is an issue	5	2	4	6	2	3	1	0	3	1	2	2	5	11	43	
X20	Complaints where staff communication is an issue	6	7	1	1	2	0	2	2	0	0	2	3	5	10	39	
X21	Complaints about nursing	4	5	0	5	9	2	2	2	5	5	6	5	16	10	39	
	Staff engagement (indicators/targets not yet agreed) *NEW*																
X47	Local staff engagement score: I am able to make improvements happen in my area of work	59.3%	65.1%	64.5%	60.8%	57.6%	66.1%	60.3%	56.5%	59.6%	67.6%	64.2%	61.0%	64.3%	68%	68%	

Keith Ashall, Senior Health Intelligence Analyst
t: 01903 205111 (ext 84478)

QUALITY SCORECARD - Worthing

JUNE 2018

		JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	YTD Actual	YTD Target	Target	Trend
EFFECTIVENESS																	
	Effectiveness domain score	2.52	2.52	2.48	2.46	2.36	2.29	2.22	2.30	2.47	2.14	1.95	1.81	2.00			
	Trust-wide mortality																
E01	Trust crude mortality rate (non-elective)	2.50%	2.81%	2.55%	4.05%	3.96%	3.47%	4.51%	4.04%	3.85%	2.96%	2.60%	2.11%	2.55%	3.10%	3.10%	
E02	Crude mortality rate (non-elective): 12 month rolling	3.34%	3.32%	3.27%	3.29%	3.33%	3.34%	3.68%	3.40%	3.42%	3.40%	3.33%	3.29%	3.34%	3.11%	3.11%	
E03	Trust Hospital Standardised Mortality Ratio (HSMR) (rollin 12M)	91.2	90.6	89.7	90.6	91.8	91.5	94.1	95.6	95.9				95.6	100	100	
E04	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)		n/a											n/a			
E45	% of Part 2 inpatient deaths reviewed	85.5%	90.1%	95.9%	88.8%	97.5%	94.3%	86.5%	76.1%	69.4%	80.4%	65.1%	42.6%	64.6%	100%	100%	
	Improve mortality in specific conditions																
E47	% patients with sepsis receiving antibiotic therapy within one hour *NEW*	78.2%	90.2%	89.5%	85.0%	79.0%	79.0%	74.5%	77.8%	76.5%	72.26%	73.65%		72.98%	90%	90%	
	Reduce mortality following hip fracture																
E09	SMR for hip fracture (all diagnoses/procedures) (rolling 12M)	112.9	104.1	101.5	100.1	109.5	96.1	106.2	114.2	112.4				112.4	100	100	
E10	30 day mortality rate following hip fracture (rolling 12M)	7.7%	7.5%	7.4%	7.6%	7.4%	7.4%	8.4%	9.0%	8.5%				8.55%	5.70%	5.70%	
	Increase discharge effectiveness																
E59	Rate of discharges by Midday	12.9%	12.4%	12.3%	12.1%	14.3%	13.6%	13.4%	13.5%	13.7%	11.9%	14.1%	15.1%	13.8%	45%	45%	
	Reduce the rate of readmission following discharge from the Trust																
E11	Emergency readmissions within 30 days %	15.1%	13.3%	14.0%	14.7%	13.5%	13.8%	12.8%	15.1%	13.1%	14.81%	14.27%	14.78%	14.63%	13%	13%	
	To improve maternity care by encouraging natural childbirth																
E13	C-Section Rate	19.7%	28.3%	35.1%	27.7%	30.8%	36.6%	26.9%	30.2%	29.9%	26.10%	28.30%	31.50%	28.63%	27.80%	27.8%	
E15	% Deliveries complicated by post-partum haemorrhage	0.0%	0.0%	0.5%	1.0%	0.0%	0.6%	0.5%	1.6%	0.5%	0.00%	2.00%	0.50%	0.83%	1%	1%	
E17	Admission of term babies to neonatal care	3.6%	1.8%	1.5%	3.9%	1.9%	2.2%	1.5%	3.2%	3.1%	3.40%	1.50%	1.90%	2.27%	10%	10%	
E58	Induction of labour	34.5%	31.6%	29.8%	39.1%	30.8%	38.3%	35.8%	32.4%	34.5%	33.50%	41.80%	32.50%	35.93%	29.4%	29.4%	
E60	Normal delivery rate	37.7%	32.5%	35.6%	33.2%	35.1%	29.1%	34.3%	34.6%	30.9%	37.4%	27.9%	31.5%	32.3%	NA	NA	
	Caring for the elderly patient																
E18	% Emergency admissions staying over 72h screened for dementia	90.0%	92.0%	86.5%	93.8%	95.8%	87.0%	94.9%	94.2%	91.8%	92.49%	94.41%	94.82%	93.94%	90%	90%	
E39	Ward moves for patients flagged with dementia	91	55	38	97	76	99	122	92	70	90	74	99	263	254	1014	
E42	Night-time ward moves for patients flagged with dementia : Total	22	11	11	23	26	37	25	25	26	19	13	18	50	62	247	
E42	Night-time ward moves for patients flagged with dementia : % Total excluding Emergency Floor	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
	Stroke care																
E26	% CT scans undertaken within 12 hours	98.0%	96.8%	92.9%	89.5%	97.8%	100.0%	90.9%	100.0%	97.7%	87.5%	100.0%	0.0%	93.8%	95%	95%	
E27	% Stroke thrombolysis within 60 minutes of hospital arrival	75.0%	100.0%	75.0%	66.7%	50.0%	83.3%	40.0%	0.0%	40.0%	0.0%	50.0%	0.0%	50.0%	95%	95%	
E28	% Swallow screen for stroke patients within 4 hours of admission	78.0%	90.3%	100.0%	91.2%	100.0%	100.0%	88.2%	100.0%	97.4%	100.0%	100.0%	0.0%	100.0%	95%	95%	
E29	% of stroke patients admitted to stroke unit within 4 hours of admission	68.0%	71.0%	69.0%	76.3%	71.7%	82.4%	122.7%	100.0%	72.7%	100.0%	71.4%	0.0%	85.7%	90%	90%	
E30	% high risk TIA patients seen within 24 hours	0.0%	0.0%	0.0%	14.3%	0.0%	0.0%	0.0%	0.0%	25.0%	28.6%	14.3%	0.0%	21.4%	60%	60%	
	Ensure active engagement with research																
E23	Patients recruited with CRN portfolio										78	80	75	233	350	1400	
	Data Quality																
E37	% inpatients with electronic discharge summaries produced	94.4%	92.0%	91.4%	92.8%	92.8%	90.2%	91.7%	92.2%	92.2%	92.1%	92.2%	92.5%	92.3%	94.2%	94.2%	
	Mental Health Care *NEW*																
E54	Reduced A&E vists for a cohort of frequent attenders who would benefit from MH interventions	9	24	16	3	12	7	7	2	12	6	5	5	16	55	218	

Keith Ashall, Senior Health Intelligence Analyst
t: 01903 205111 (ext 84478)

SAFETY

	Safety domain score	2.39	2.06	2.19	2.06	2.22	2.14	2.19	2.31	2.07	2.30	2.33	2.48	2.19		
	Safer staffing															
S36	Safer Staffing: Average fill rate - registered nurses/ midwives (day shifts)	95.2%	94.0%	94.2%	92.4%	93.2%	95.1%	93.4%	92.9%	92.8%	91.9%	93.9%	93.0%	93.0%	95%	95%
S37	Safer Staffing: Average fill rate - registered nurses/ midwives (night shifts)	97.2%	96.4%	97.2%	93.4%	96.3%	95.5%	97.1%	93.5%	90.5%	91.5%	96.2%	96.2%	94.6%	95%	95%
S38	Safer Staffing: Average fill rate - care staff (day shifts)	93.7%	93.3%	94.6%	90.2%	90.9%	94.4%	90.9%	89.3%	89.9%	92.7%	94.7%	94.9%	94.1%	95%	95%
S39	Safer Staffing: Average fill rate - care staff (night shifts)	96.6%	95.4%	96.8%	96.0%	98.3%	96.3%	95.5%	97.1%	95.8%	97.7%	96.9%	98.9%	97.8%	95%	95%
S41	Care Hours Per Patient Day (CHPPD)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	NHS safety thermometer															
S02	Safety Thermometer: % of patients harm-free	96.0%	94.6%	95.1%	93.5%	92.3%	94.1%	93.8%	95.1%	93.0%	95.6%	93.7%	94.0%	94.5%	95.70%	95.70%
S03	Safety Thermometer: % of patients with no new harms	99.0%	98.3%	99.2%	98.1%	96.5%	97.6%	97.9%	98.7%	97.7%	98.7%	98.8%	97.1%	98.2%	99%	99%
	Monitoring of clinical incidents															
S19	NEVER events	0	0	1	0	0	0	0	0	0	1	0	0	1	0	0
S04	Total incidents	385	409	372	439	422	387	454	384	409	375	392	384	1151	1235	4942
S05	Total moderate, severe or death incidents	3	8	10	9	14	7	8	11	7	7	8	13	28	20	82
S06	Total serious incidents (SIRIs)	1	3	4	0	2	4	2	3	1	3	3	4	10	7	27
S07	Number of outstanding CAS alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Improve safety of prescribing															
S08	Total incidents involving drug/prescribing errors	49	51	45	51	50	44	52	49	44	57	46	46	149	143	574
S09	Moderate/severe incidents involving drug/prescribing errors	0	1	0	0	0	0	0	0	0	0	0	1	1	1	3
	Reduce incidence of healthcare acquired infections															
S14	Number of hospital attributable MRSA cases	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0
S15	Number of hospital C.diff cases	2	1	1	1	3	0	4	2	3	1	1	1	3	5	19
S28	Number of C. diff cases where a lapse in the quality of care was noted	0	1	1	0	2	0	2	1	2	0	0	0	0	2	8
S16	Number of reportable MSSA bacteraemia cases	4	6	6	6	5	6	6	5	4	8	5	4	17	12	47
S16a	Number of hosptial attributable MSSA bacteraemia cases	1	1	1	2	2	2	1	3	0	0	3	0	3	3	11
S17	Number of reportable E.coli cases	23	32	14	18	23	15	18	13	16	21	19	15	55	108	432
S17a	Number of hospital attributable E.coli cases	4	5	2	3	5	5	4	4	0	3	4	2	9	8	30
	Improve theatre safety for patients															
S18	Full compliance with WHO Surgical Safety Checklist	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.00%	100%
S30	SSIs: Total hip replacement (YTD is rolling 12 months)		n/a			n/a			n/a						n/a	n/a
S33	SSIs: Total knee replacement (YTD is rolling 12 months)		n/a			n/a			n/a						n/a	n/a
S34	SSIs: Large bowel surgery (YTD is rolling 12 months)		20.4%			12.0%			4.4%					-	12%	12%
S35	SSIs: Breast surgery (YTD is rolling 12 months)		45.8%			4.6%			3.6%					-	3.8%	3.8%
	Reduce number of falls in hospital															
S50	All falls	63	70	53	77	57	78	99	60	77	55	64	56	175	182	726
S21	Falls resulting in harm	15	27	21	27	14	25	32	22	24	18	13	15	46	64	254
S22	Falls resulting in severe harm or death	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
S40	Repeat falls	6	8	3	7	6	3	6	5	9	4	3	1	8	15	62
S23	Falls assessment within 24hrs of admission (Surgery only)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Pressure ulcers															
S49	Grade 2+ pressure ulcers	11	13	15	23	41	32	26	13	22	19	19	13	51	30	120

Keith Ashall, Senior Health Intelligence Analyst
t: 01903 205111 (ext 84478)

	Other safety metrics															
S11	VTE Assessment Compliance	95.3%	95.4%	93.8%	94.8%	93.8%	93.9%	94.7%	95.1%	93.3%	93.8%	93.8%	94.7%	94.1%	95.3%	95.3%
	Medicines Optimisation *NEW*															
S44	Antimicrobial stewardship and consumption: 2% Reduction in overall antibiotic consumption *NEW*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
S45	Antimicrobial stewardship and consumption: 1% reduction in the use of carbapenems *NEW*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
S46	Antimicrobial stewardship and consumption: 1% reduction in the use of Tazocin *NEW*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
S47	Focus on anticoagulants: Patients on Direct Oral Anticoagulants (NOACs) receiving counselling *NEW*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
S48	Focus on anticoagulants: Average no. patients per day on VTE prophylaxis missing report *NEW*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
EXPERIENCE																
	Experience domain score	2.13	2.26	2.48	2.39	2.52	2.52	2.52	2.48	2.32	2.25	2.60	2.55	2.55		
	Friends and Family Test															
X38	Trust Friends and Family Recommend %: Inpatient	96.8%	96.2%	96.8%	95.9%	96.7%	94.6%	97.3%	96.8%	95.6%	97.1%	97.0%	96.8%	96.9%	97%	97%
X39	Trust Friends and Family Recommend %: A&E	85.5%	88.1%	86.0%	84.6%	85.8%	82.6%	87.6%	88.6%	89.5%	91.5%	95.5%	96.7%	95.6%	93%	93%
X40	Maternity Friends and Family Recommend %: Antenatal care (36 weeks)	50.0%	100.0%	100.0%	94.6%	100.0%	100.0%	100.0%	100.0%	100.0%	95.8%	100.0%	100.0%	98.0%	97%	97%
X41	Maternity Friends and Family Recommend %: Delivery care	97.6%	95.3%	95.2%	96.8%	99.1%	100.0%	98.8%	97.7%	97.1%	96.7%	95.5%	95.8%	96.0%	97%	97%
X42	Maternity Friends and Family Recommend %: Postnatal ward	97.6%	95.3%	95.2%	96.8%	99.1%	100.0%	98.8%	97.7%	97.1%	96.7%	95.5%	95.8%	96.0%	97%	97%
X43	Maternity Friends and Family Recommend %: Postnatal community care	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
X44	Trust Friends and Family Recommend %: Outpatient	96.2%	96.8%	96.6%	96.6%	0.0%	97.4%	97.9%	96.3%	97.4%	96.3%	97.1%	95.9%	96.5%	97%	97%
	Friends and Family Test response rates															
X24	Trust Friends and Family Response Rate: Inpatient	29.3%	40.0%	34.4%	38.5%	37.0%	30.0%	30.2%	37.9%	37.7%	36.9%	45.2%	43.4%	42.0%	40%	40%
X25	Trust Friends and Family Response Rate: A&E	11.1%	12.7%	8.1%	9.9%	12.4%	9.4%	8.2%	8.2%	12.3%	11.1%	26.7%	42.8%	27.0%	23%	23%
X33	Maternity Friends and Family Response Rate: Delivery care	37.7%	40.1%	44.0%	61.9%	56.3%	28.0%	80.6%	48.4%	35.6%	44.3%	43.8%	35.0%	41.0%	40%	40%
	Reduction in patients suffering a bad experience dealing with the Trust															
X08	Percentage of re-booked outpatient appointments	13.4%	12.2%	12.5%	12.9%	12.6%	13.9%	13.2%	14.1%	14.9%	13.7%	12.5%	11.7%	12.6%	7.80%	7.8%
X09	Clinics cancelled with less than 6 weeks notice for annual/study leave	55	50	15	16	8	9	34	24	13	15	19	7	41	39	156
X11	PALS contacts relating to appointment problems (% of total appts)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
X12	Reduce patients cancelled on the day of surgery for non-clinical reasons	10	17	5	43	25	12	7	5	16	16	5	5	26	42	168
X13	Breaches of mixed sex accommodation arrangements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Nutritional Assessment															
X14	Compliance with MUST tool after 24 hours	86.2%	83.4%	87.4%	85.4%	82.8%	81.6%	79.7%	87.0%	75.0%	89.6%	90.3%	91.7%	90.5%	80%	80%
X15	Compliance with MUST tool after 7 days	99.0%	99.5%	99.7%	99.1%	99.1%	98.8%	99.2%	99.2%	100.0%	99.8%	99.3%	99.2%	99.4%	95%	95%
	Cleanliness / PLACE Survey															
X16	Internal PLACE compliance	96%	97%	96%	95%	94%	96%	98%	98%	98%	98%	98%	98%	98%	95%	95%
	Improve our customer service and become a more caring organisation															
X18	Number of complaints	27	21	29	17	26	16	23	13	18	11	19	12	42	57	228
X19	Complaints where staff attitude or behaviour is an issue	3	1	4	3	0	2	0	0	1	0	1	1	2	5	22
X20	Complaints where staff communication is an issue	5	4	0	1	2	0	1	2	0	0	1	1	2	5	20
X21	Complaints about nursing	1	2	0	1	8	0	1	1	3	4	2	2	8	5	20
	Staff engagement (indicators/targets not yet agreed) *NEW*															
X47	Local staff engagement score: I am able to make improvements happen in my area of work	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Keith Ashall, Senior Health Intelligence Analyst
t: 01903 205111 (ext 84478)

QUALITY SCORECARD - St Richards

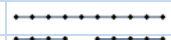
JUNE 2018

		JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	YTD Actual	YTD Target	Target	Trend
EFFECTIVENESS																	
	Effectiveness domain score	2.52	2.52	2.48	2.46	2.36	2.29	2.22	2.30	2.47	1.94	2.06	2.13	2.21			
	Trust-wide mortality																
E01	Trust crude mortality rate (non-elective)	2.80%	2.36%	2.77%	2.26%	2.10%	3.03%	3.98%	3.66%	3.17%	3.24%	1.78%	1.99%	2.33%	3.10%	3.10%	
E02	Crude mortality rate (non-elective): 12 month rolling	2.82%	2.84%	2.90%	2.83%	2.76%	2.74%	2.75%	2.78%	2.77%	2.84%	2.80%	2.76%	2.80%	3.11%	3.11%	
E03	Trust Hospital Standardised Mortality Ratio (HSMR) (rollin 12M)	89.1	85.9	87.6	85.6	84.9	84.2	83.4	84.5	83.3				83.3	100	100	
E04	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)		n/a											n/a			
E45	% of Part 2 inpatient deaths reviewed	88.2%	85.7%	87.0%	91.0%	79.7%	75.3%	80.0%	76.3%	64.6%	64.5%	84.6%	56.1%	67.3%	100%	100%	
	Improve mortality in specific conditions																
E47	% patients with sepsis receiving antibiotic therapy within one hour *NEW*	79.2%	82.6%	83.6%	81.6%	90.9%	90.9%	74.2%	77.3%	80.7%	85.71%	83.08%		83.87%	90%	90%	
	Reduce mortality following hip fracture																
E09	SMR for hip fracture (all diagnoses/procedures) (rolling 12M)	89.1	87.4	83.3	79.1	78.7	80.4	82.2	77.8	88.3				88.3	100	100	
E10	30 day mortality rate following hip fracture (rolling 12M)	6.6%	7.0%	6.9%	8.1%	8.1%	6.3%	6.3%	5.9%	6.3%				6.33%	5.70%	5.70%	
	Increase discharge effectiveness																
E59	Rate of discharges by Midday	15.3%	13.8%	13.9%	13.9%	14.0%	14.2%	16.1%	13.9%	15.3%	13.8%	13.8%	16.2%	14.6%	45%	45%	
	Reduce the rate of readmission following discharge from the Trust																
E11	Emergency readmissions within 30 days %	14.2%	13.5%	13.6%	14.1%	14.5%	13.3%	13.5%	13.7%	14.5%	13.42%	14.61%	14.07%	14.03%	13%	13%	
	To improve maternity care by encouraging natural childbirth																
E13	C-Section Rate	26.1%	25.8%	24.1%	26.6%	26.8%	29.6%	31.7%	34.1%	32.6%	26.60%	28.10%	28.10%	27.60%	27.80%	27.8%	
E15	% Deliveries complicated by post-partum haemorrhage	0.5%	0.5%	0.0%	0.4%	0.5%	0.0%	0.4%	0.6%	0.0%	0.50%	0.00%	0.00%	0.17%	1%	1%	
E17	Admission of term babies to neonatal care	3.3%	5.5%	3.3%	3.2%	3.3%	5.3%	2.7%	4.4%	3.1%	5.10%	6.80%	7.00%	6.30%	10%	10%	
E58	Induction of labour	37.4%	37.1%	28.0%	34.4%	38.3%	45.2%	37.5%	35.7%	42.4%	42.10%	37.90%	39.20%	39.73%	29.4%	29.4%	
E60	Normal delivery rate	37.9%	35.2%	39.1%	39.3%	35.9%	31.7%	27.6%	27.4%	26.3%	30.8%	27.1%	28.1%	28.7%	NA	NA	
	Caring for the elderly patient																
E18	% Emergency admissions staying over 72h screened for dementia	91.4%	91.5%	79.0%	94.7%	98.1%	87.5%	92.4%	90.5%	85.0%	89.77%	87.92%	90.96%	89.46%	90%	90%	
E39	Ward moves for patients flagged with dementia	112	125	72	77	87	118	114	101	102	117	112	104	333	308	1233	
E42	Night-time ward moves for patients flagged with dementia : Total	16	11	12	21	18	29	17	19	33	26	13	17	56	63	252	
E42	Night-time ward moves for patients flagged with dementia : % Total excluding Emergency Floor	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	NA	NA	
	Stroke care																
E26	% CT scans undertaken within 12 hours	95.6%	96.8%	97.3%	90.9%	97.4%	89.7%	92.2%	96.4%	93.1%	94.7%	100.0%		97.4%	95%	95%	
E27	% Stroke thrombolysis within 60 minutes of hospital arrival	60.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	66.7%	66.7%	0.0%	83.3%		83.3%	95%	95%	
E28	% Swallow screen for stroke patients within 4 hours of admission	62.2%	80.6%	74.2%	76.3%	74.3%	57.7%	59.6%	80.0%	89.3%	70.6%	77.8%		74.2%	95%	95%	
E29	% of stroke patients admitted to stroke unit within 4 hours of admission	73.3%	71.0%	83.8%	72.7%	78.9%	65.5%	19.6%	67.9%	75.9%	65.8%	83.9%		74.8%	90%	90%	
E30	% high risk TIA patients seen within 24 hours	50.0%	9.1%	12.5%	16.7%	9.1%	0.0%	14.3%	0.0%	0.0%	0.0%	20.0%		10.0%	60%	60%	
	Ensure active engagement with research																
E23	Patients recruited with CRN portfolio										68	32	217	317	350	1400	
	Data Quality																

Keith Ashall, Senior Health Intelligence Analyst
t: 01903 205111 (ext 84478)

E37	% inpatients with electronic discharge summaries produced	94.8%	94.2%	93.9%	93.9%	93.9%	92.6%	92.6%	93.2%	92.0%	93.4%	92.2%	93.1%	92.9%	94.2%	94.2%	
	Mental Health Care *NEW*																
E54	Reduced A&E vists for a cohort of frequent attenders who would benefit from MH interventions	18	12	18	23	19	11	10	20	16	21	29	28	78	55	218	
SAFETY																	
	Safety domain score	2.39	2.06	2.19	2.06	2.22	2.14	2.19	2.31	2.07	2.37	2.56	2.11	2.30			
	Safer staffing																
S36	Safer Staffing: Average fill rate - registered nurses/ midwives (day shifts)	97.4%	94.4%	93.8%	90.9%	95.6%	92.9%	98.3%	91.4%	93.1%	92.1%	94.3%	93.8%	93.4%	95%	95%	
S37	Safer Staffing: Average fill rate - registered nurses/ midwives (night shifts)	96.8%	90.8%	92.0%	88.2%	93.6%	91.4%	97.2%	87.0%	89.6%	89.4%	93.0%	94.6%	92.3%	95%	95%	
S38	Safer Staffing: Average fill rate - care staff (day shifts)	96.4%	93.7%	93.8%	90.8%	95.2%	92.5%	97.9%	91.6%	91.2%	91.9%	93.0%	92.2%	92.4%	95%	95%	
S39	Safer Staffing: Average fill rate - care staff (night shifts)	96.0%	88.1%	89.5%	84.6%	90.8%	89.1%	96.2%	85.8%	88.3%	90.6%	92.2%	93.4%	92.0%	95%	95%	
S41	Care Hours Per Patient Day (CHPPD)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
	NHS safety thermometer																
S02	Safety Thermometer: % of patients harm-free	97.8%	96.0%	96.4%	95.2%	93.5%	91.1%	94.9%	95.3%	93.8%	96.4%	95.7%	95.1%	95.8%	95.70%	95.70%	
S03	Safety Thermometer: % of patients with no new harms	98.8%	99.5%	98.2%	98.7%	98.1%	97.4%	97.8%	98.6%	98.0%	98.2%	94.1%	98.3%	96.9%	99%	99%	
	Monitoring of clinical incidents																
S19	NEVER events	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	
S04	Total incidents	338	331	314	363	351	378	395	331	354	364	383	386	1133	1052	4208	
S05	Total moderate, severe or death incidents	7	10	4	6	7	7	3	5	5	11	6	10	27	18	74	
S06	Total serious incidents (SIRIs)	0	2	2	2	2	6	4	0	1	5	1	3	9	7	28	
S07	Number of outstanding CAS alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Improve safety of prescribing																
S08	Total incidents involving drug/prescribing errors	36	37	28	42	35	38	48	26	35	29	35	41	105	110	442	
S09	Moderate/severe incidents involving drug/prescribing errors	1	2	0	0	0	0	0	0	0	1	0	1	2	1	3	
	Reduce incidence of healthcare acquired infections																
S14	Number of hospital attributable MRSA cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
S15	Number of hospital C.diff cases	2	3	0	1	0	1	2	1	2	1	3	0	4	5	19	
S28	Number of C. diff cases where a lapse in the quality of care was noted	1	3	0	0	0	1	2	1	0	0	2	0	2	2	8	
S16	Number of reportable MSSA bacteraemia cases	1	6	3	3	4	2	0	2	3	2	2	3	7	12	47	
S16a	Number of hosptial attributable MSSA bacteraemia cases	0	2	1	1	0	0	0	0	1	0	0	0	0	3	11	
S17	Number of reportable E.coli cases	16	17	17	20	13	10	17	16	17	11	13	15	39	80	319	
S17a	Number of hospital attributable E.coli cases	1	2	1	3	1	1	4	3	3	1	2	3	6	8	30	
	Improve theatre safety for patients																
S18	Full compliance with WHO Surgical Safety Checklist	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.00%	100%	
S30	SSIs: Total hip replacement (YTD is rolling 12 months)		2.5%			1.6%			3.0%					-	1.1%	1.1%	
S33	SSIs: Total knee replacement (YTD is rolling 12 months)		4.1%			10.6%			0.0%					-	1.5%	1.5%	
S34	SSIs: Large bowel surgery (YTD is rolling 12 months)		10.6%			8.5%			6.1%					-	12%	12%	
S35	SSIs: Breast surgery (YTD is rolling 12 months)		65.8%			0.0%			2.9%					-	3.8%	3.8%	
	Reduce number of falls in hospital																
S50	All falls	73	59	52	56	77	82	80	59	83	73	67	68	208	182	726	

Keith Ashall, Senior Health Intelligence Analyst
t: 01903 205111 (ext 84478)

S21	Falls resulting in harm	21	12	10	16	24	21	15	16	16	21	12	16	49	51	205	
S22	Falls resulting in severe harm or death	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	
S40	Repeat falls	1	4	0	5	4	4	3	3	4	3	2	6	11	9	36	
S23	Falls assessment within 24hrs of admission (Surgery only)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
	Pressure ulcers																
S49	Grade 2+ pressure ulcers	5	4	10	10	11	14	17	6	15	8	4	13	25	30	120	
	Other safety metrics																
S11	VTE Assessment Compliance	93.0%	94.3%	94.3%	95.0%	93.7%	92.0%	92.9%	92.9%	93.2%	94.5%	93.0%	93.5%	93.6%	95.3%	95.3%	
	Medicines Optimisation *NEW*																
S44	Antimicrobial stewardship and consumption: 2% Reduction in overall antibiotic consumption	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
S45	Antimicrobial stewardship and consumption: 1% reduction in the use of carbapenems	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
S46	Antimicrobial stewardship and consumption: 1% reduction in the use of Tazocin	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
S47	Focus on anticoagulants: Patients on Direct Oral Anticoagulants (NOACs) receiving counselling	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
S48	Focus on anticoagulants: Average no. patients per day on VTE prophylaxis missing report *NEW*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
EXPERIENCE																	
	Experience domain score	2.13	2.26	2.48	2.39	2.52	2.52	2.52	2.48	2.32	2.65	2.30	2.40	2.55			
	Friends and Family Test																
X38	Trust Friends and Family Recommend %: Inpatient	96.5%	97.6%	96.6%	97.4%	97.3%	96.5%	96.8%	97.2%	97.3%	97.4%	96.3%	97.7%	97.1%	97%	97%	
X39	Trust Friends and Family Recommend %: A&E	83.6%	79.6%	81.5%	86.3%	90.5%	86.3%	88.4%	88.3%	82.9%	91.9%	88.2%	87.5%	89.2%	93%	93%	
X40	Maternity Friends and Family Recommend %: Antenatal care (36 weeks)	100.0%	100.0%	100.0%	100.0%	100.0%	77.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97%	97%	
X41	Maternity Friends and Family Recommend %: Delivery care	98.4%	100.0%	96.6%	97.9%	98.1%	96.8%	99.0%	99.0%	98.5%	98.1%	100.0%	98.6%	98.9%	97%	97%	
X42	Maternity Friends and Family Recommend %: Postnatal ward	98.4%	100.0%	96.6%	97.9%	98.1%	96.8%	99.0%	99.0%	98.5%	98.1%	100.0%	98.6%	98.9%	97%	97%	
X43	Maternity Friends and Family Recommend %: Postnatal community care	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
X44	Trust Friends and Family Recommend %: Outpatient	95.7%	96.9%	98.1%	98.4%	0.0%	96.6%	97.5%	97.3%	96.8%	97.0%	96.2%	96.7%	96.6%	97%	97%	
	Friends and Family Test response rates																
X24	Trust Friends and Family Response Rate: Inpatient	34.8%	44.0%	36.4%	45.6%	46.6%	40.4%	38.8%	40.3%	28.2%	38.4%	39.8%	44.1%	40.8%	40%	40%	
X25	Trust Friends and Family Response Rate: A&E	8.5%	9.7%	8.0%	13.7%	15.2%	13.1%	10.2%	7.7%	7.4%	9.6%	10.4%	8.0%	9.3%	23%	23%	
X33	Maternity Friends and Family Response Rate: Delivery care	29.4%	27.7%	72.0%	95.9%	74.2%	51.1%	94.6%	54.2%	58.9%	50.5%	50.2%	37.2%	46.1%	40%	40%	
	Reduction in patients suffering a bad experience dealing with the Trust																
X08	Percentage of re-booked outpatient appointments	12.4%	11.9%	12.3%	12.1%	10.9%	11.6%	11.1%	12.8%	13.0%	12.4%	10.8%	10.7%	11.3%	7.80%	7.8%	
X09	Clinics cancelled with less than 6 weeks notice for annual/study leave	16	20	25	10	15	11	10	17	3	7	16	12	35	32	129	
X11	PALS contacts relating to appointment problems (% of total appts)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
X12	Reduce patients cancelled on the day of surgery for non-clinical reasons	13	18	4	13	16	7	22	25	26	9	7	8	24	42	168	
X13	Breaches of mixed sex accommodation arrangements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Nutritional Assessment																
X14	Compliance with MUST tool after 24 hours	87.4%	90.3%	89.1%	90.8%	91.3%	85.0%	85.7%	84.5%	81.7%	86.2%	87.3%	91.6%	88.3%	80%	80%	
X15	Compliance with MUST tool after 7 days	99.0%	99.5%	99.1%	99.2%	99.6%	98.7%	96.7%	98.2%	100.0%	98.9%	98.4%	99.0%	98.8%	95%	95%	
	Cleanliness / PLACE Survey																
X16	Internal PLACE compliance	90%	98%	94%	98%	95%	95%	96%	96%	96%	97%	97%	96%	97%	95%	95%	
	Improve our customer service and become a more caring organisation																

Keith Ashall, Senior Health Intelligence Analyst
t: 01903 205111 (ext 84478)

X18	Number of complaints	17	19	9	15	16	14	11	15	20	15	23	13	51	57	228	
X19	Complaints where staff attitude or behaviour is an issue	2	1	0	3	2	1	1	0	2	1	1	1	3	5	22	
X20	Complaints where staff communication is an issue	1	3	1	0	0	0	1	0	0	0	1	2	3	5	20	
X21	Complaints about nursing	3	3	0	4	1	2	1	1	2	1	4	3	8	5	20	
	Staff engagement (indicators/targets not yet agreed) *NEW*																
X47	Local staff engagement score: I am able to make improvements happen in my area of work	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	

SAFER STAFFING SCORECARD - Registered Nurses

June 2018

	Shift	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Actual	Trend
WSHFT	**Day**	**97.6%**	**96.2%**	**94.2%**	**94.0%**	**91.7%**	**94.3%**	**94.1%**	**95.6%**	**92.2%**	**93.0%**	**92.0%**	**94.1%**	**93.4%**	**93.2%**	
	Night	**98.4%**	**97.0%**	**94.0%**	**94.9%**	**91.2%**	**95.1%**	**93.7%**	**97.1%**	**90.6%**	**90.1%**	**90.6%**	**94.8%**	**95.5%**	**93.6%**	
Acute Cardiac Unit	Day	100.0%	98.7%	97.4%	95.3%	95.2%	95.7%	91.3%	98.7%	94.3%	94.5%	92.3%	92.9%	96.0%	93.7%	
	Night	100.0%	100.0%	97.6%	97.5%	96.0%	95.0%	92.7%	98.4%	93.8%	91.9%	91.7%	95.2%	100.0%	95.6%	
Ashling	Day	97.0%	97.8%	91.8%	95.2%	86.7%	95.2%	95.3%	96.8%	90.9%	93.9%	89.3%	90.0%	84.8%	88.0%	
	Night	95.0%	91.9%	82.3%	91.7%	75.8%	91.7%	91.9%	91.9%	80.4%	80.6%	81.7%	79.0%	80.0%	80.2%	
Balcombe	Day	-	-	-	-	-	-	-	-	-	-	81.3%	77.6%	90.2%	83.0%	
	Night	-	-	-	-	-	-	-	-	-	-	90.0%	91.9%	96.7%	92.9%	
Barrow	Day	98.6%	97.3%	93.8%	96.1%	95.2%	90.8%	96.8%	93.5%	92.9%	96.0%	93.6%	95.2%	93.6%	94.1%	
	Night	99.2%	99.2%	97.6%	98.3%	97.6%	98.3%	95.2%	96.8%	92.0%	92.7%	93.3%	99.2%	97.5%	96.7%	
Becket	Day	95.3%	95.2%	94.5%	96.0%	93.2%	97.3%	100.0%	98.1%	97.9%	97.4%	93.0%	96.5%	96.0%	95.2%	
	Night	100.0%	100.0%	98.4%	100.0%	96.8%	98.3%	100.0%	100.0%	100.0%	90.3%	83.3%	96.8%	98.3%	92.9%	
Beeding	Day	88.0%	87.7%	100.0%	97.4%	100.0%	97.3%	93.3%	94.9%	97.1%	90.4%	100.0%	97.4%	95.9%	97.7%	
	Night	89.9%	86.8%	100.0%	95.8%	100.0%	94.7%	93.8%	97.3%	94.2%	89.3%	100.0%	89.0%	98.6%	95.8%	
Bluefin	Day	91.4%	96.6%	97.2%	99.0%	100.0%	98.4%	100.0%	100.0%	97.4%	100.0%	93.2%	95.1%	94.3%	94.1%	
	Night	99.0%	99.1%	100.0%	100.0%	96.7%	95.9%	98.4%	97.6%	97.3%	98.3%	96.6%	96.3%	94.8%	96.0%	
Bosham	Day	98.8%	97.6%	97.2%	95.8%	91.1%	99.6%	97.6%	98.4%	96.9%	92.7%	99.6%	98.8%	98.3%	98.9%	
	Night	96.7%	95.2%	95.2%	91.7%	83.9%	100.0%	96.8%	96.8%	96.4%	87.1%	95.0%	96.8%	98.3%	96.7%	
Botolphs	Day	93.5%	94.1%	93.4%	95.4%	93.0%	96.6%	94.8%	95.2%	89.8%	91.1%	87.7%	93.0%	92.7%	91.2%	
	Night	95.6%	95.7%	94.6%	100.0%	92.5%	96.7%	92.5%	94.6%	89.3%	91.4%	91.1%	100.0%	100.0%	97.1%	
Boxgrove	Day	99.6%	97.6%	95.2%	96.7%	87.9%	91.3%	89.9%	98.0%	88.8%	90.7%	88.3%	87.5%	90.4%	88.7%	
	Night	100.0%	95.2%	90.3%	95.0%	83.9%	80.0%	80.6%	95.2%	78.6%	80.6%	81.7%	79.0%	90.0%	83.5%	
Buckingham	Day	98.5%	95.7%	98.1%	98.5%	82.7%	90.6%	87.0%	80.4%	83.0%	81.7%	84.1%	96.7%	95.5%	92.1%	
	Night	100.0%	96.8%	100.0%	100.0%	100.0%	100.0%	98.4%	96.8%	94.6%	85.5%	81.7%	100.0%	100.0%	94.0%	
Burlington	Day	99.4%	98.2%	89.4%	95.1%	86.7%	87.2%	94.0%	91.2%	94.1%	88.8%	-			-	
	Night	100.0%	98.4%	96.8%	100.0%	96.8%	93.3%	98.4%	100.0%	98.2%	90.3%	-			-	

SAFER STAFFING SCORECARD - Registered Nurses

June 2018

	Shift	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Actual	Trend
WSHFT	**Day**	**97.6%**	**96.2%**	**94.2%**	**94.0%**	**91.7%**	**94.3%**	**94.1%**	**95.6%**	**92.2%**	**93.0%**	**92.0%**	**94.1%**	**93.4%**	**93.2%**	
	Night	**98.4%**	**97.0%**	**94.0%**	**94.9%**	**91.2%**	**95.1%**	**93.7%**	**97.1%**	**90.6%**	**90.1%**	**90.6%**	**94.8%**	**95.5%**	**93.6%**	
Castle	Day	100.0%	93.5%	96.1%	96.7%	97.1%	96.3%	96.8%	94.3%	92.9%	94.3%	95.6%	98.2%	95.9%	96.6%	
	Night	98.9%	98.9%	91.4%	93.3%	86.0%	92.2%	95.7%	93.5%	84.5%	80.6%	93.3%	96.8%	97.8%	96.0%	
Chichester Emergency Floor	Day	97.1%	94.7%	90.8%	87.5%	86.2%	93.0%	91.0%	98.1%	90.7%	94.2%	92.4%	95.1%	90.8%	92.8%	
	Night	96.4%	95.6%	87.3%	85.9%	84.6%	93.2%	92.5%	97.8%	86.9%	92.1%	93.2%	93.4%	93.2%	93.3%	
Chilgrove	Day	98.5%	98.1%	96.7%	96.1%	94.8%	99.0%	98.1%	100.0%	93.8%	87.8%	91.7%	97.7%	97.1%	95.5%	
	Night	96.7%	96.8%	88.7%	90.0%	87.1%	98.3%	98.4%	100.0%	87.5%	77.4%	86.7%	98.4%	96.7%	94.0%	
Chiltington	Day	97.9%	94.0%	91.1%	94.2%	91.1%	93.3%	93.1%	95.2%	95.1%	94.4%	93.8%	95.2%	95.0%	94.6%	
	Night	98.3%	96.8%	98.4%	98.3%	95.2%	98.3%	96.8%	98.4%	98.2%	91.9%	88.3%	98.4%	100.0%	95.6%	
Clapham	Day	97.5%	92.3%	92.7%	91.7%	88.7%	95.8%	95.6%	93.5%	99.6%	98.4%	97.1%	96.4%	98.8%	97.4%	
	Night	96.7%	96.8%	93.5%	96.7%	87.1%	93.3%	95.2%	98.4%	96.4%	93.5%	93.3%	100.0%	98.3%	97.3%	
Coombes	Day	95.4%	91.1%	90.7%	90.8%	93.5%	93.3%	96.0%	89.5%	93.3%	94.4%	91.3%	93.5%	99.2%	94.6%	
	Night	100.0%	91.9%	91.9%	95.0%	96.8%	98.3%	96.8%	96.8%	96.4%	82.3%	78.3%	96.8%	98.3%	91.2%	
Courtlands	Day	97.3%	94.5%	92.6%	92.7%	92.6%	95.0%	95.2%	95.2%	92.9%	94.8%	94.3%	94.8%	94.7%	94.6%	
	Night	100.0%	98.1%	96.1%	94.7%	92.9%	96.0%	94.2%	95.5%	94.3%	92.9%	94.7%	94.8%	99.3%	96.3%	
Ditchling	Day	98.1%	98.6%	94.9%	91.9%	91.7%	90.5%	94.5%	92.2%	88.8%	88.5%	94.8%	96.8%	91.4%	94.3%	
	Night	100.0%	98.4%	100.0%	98.3%	95.2%	98.3%	100.0%	100.0%	96.4%	93.5%	91.7%	98.4%	98.3%	96.2%	
Durrington	Day	97.1%	96.8%	93.5%	95.7%	91.7%	94.3%	96.8%	93.5%	96.9%	98.6%	94.8%	99.1%	94.3%	96.1%	
	Night	100.0%	100.0%	98.4%	98.3%	98.4%	95.0%	98.4%	100.0%	100.0%	98.4%	91.7%	100.0%	98.3%	96.7%	
Eartham	Day	98.8%	96.8%	96.0%	93.8%	91.5%	92.1%	94.8%	96.8%	93.8%	91.1%	91.7%	96.4%	95.4%	94.5%	
	Night	100.0%	98.9%	98.9%	100.0%	97.8%	96.7%	98.9%	100.0%	95.2%	93.5%	95.6%	97.8%	100.0%	97.8%	
Eastbrook	Day	100.0%	97.4%	97.0%	93.7%	91.7%	89.7%	91.2%	92.2%	95.2%	91.3%	87.8%	90.1%	86.5%	88.2%	
	Night	100.0%	98.4%	96.8%	100.0%	96.8%	100.0%	98.4%	98.4%	96.4%	95.2%	90.0%	100.0%	100.0%	96.7%	
Emergency Floor Worthing	Day	96.1%	95.7%	92.7%	91.0%	90.9%	89.9%	93.4%	91.1%	87.6%	87.0%	88.1%	88.3%	85.3%	87.2%	
	Night	99.7%	96.8%	93.5%	94.7%	86.6%	95.0%	91.1%	95.2%	89.3%	86.0%	90.0%	92.2%	87.8%	90.0%	

SAFER STAFFING SCORECARD - Registered Nurses

June 2018

	Shift	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Actual	Trend
WSHFT	**Day**	**97.6%**	**96.2%**	**94.2%**	**94.0%**	**91.7%**	**94.3%**	**94.1%**	**95.6%**	**92.2%**	**93.0%**	**92.0%**	**94.1%**	**93.4%**	**93.2%**	
	Night	**98.4%**	**97.0%**	**94.0%**	**94.9%**	**91.2%**	**95.1%**	**93.7%**	**97.1%**	**90.6%**	**90.1%**	**90.6%**	**94.8%**	**95.5%**	**93.6%**	
Enhanced Surgical Care Unit	Day	99.2%	100.0%	100.0%	99.2%	100.0%	100.0%	99.2%	100.0%	100.0%	99.2%	100.0%	100.0%	100.0%	100.0%	
	Night	100.0%	96.8%	100.0%	93.3%	96.8%	100.0%	96.8%	100.0%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	
Erringham	Day	96.2%	91.7%	94.0%	94.3%	94.5%	94.8%	97.7%	95.4%	95.4%	97.7%	97.1%	95.9%	91.9%	95.0%	
	Night	100.0%	96.8%	100.0%	100.0%	93.5%	98.3%	98.4%	100.0%	91.1%	91.9%	90.0%	98.4%	98.3%	95.6%	
Fishbourne	Day	97.5%	99.6%	98.8%	93.3%	97.2%	96.7%	88.7%	98.8%	87.9%	92.7%	88.3%	96.0%	95.0%	93.1%	
	Night	100.0%	100.0%	100.0%	86.7%	100.0%	93.3%	79.0%	100.0%	75.0%	80.6%	76.7%	87.1%	96.7%	86.8%	
Ford	Day	99.3%	98.1%	95.2%	95.0%	92.9%	97.7%	95.5%	99.4%	95.0%	97.1%	93.0%	94.5%	92.0%	93.2%	
	Night	98.9%	96.8%	91.4%	92.2%	88.2%	94.4%	92.5%	97.8%	92.9%	92.5%	87.8%	93.5%	90.0%	90.5%	
Howard Children's Unit	Day	97.4%	100.0%	99.0%	99.0%	100.0%	97.5%	99.2%	100.0%	94.6%	98.3%	100.0%	100.0%	100.0%	100.0%	
	Night	93.4%	99.0%	96.9%	98.9%	99.2%	100.0%	99.2%	100.0%	95.5%	100.0%	99.0%	100.0%	100.0%	99.6%	
Lavant	Day	98.5%	97.1%	92.5%	93.7%	90.0%	95.9%	90.3%	96.1%	85.7%	90.7%	87.4%	90.7%	95.2%	91.1%	
	Night	96.7%	96.8%	83.9%	88.3%	83.9%	90.0%	82.3%	88.7%	66.1%	85.5%	75.0%	91.9%	93.3%	86.8%	
Middleton	Day	98.8%	96.0%	88.3%	92.5%	84.3%	92.5%	87.5%	97.6%	84.4%	86.7%	88.3%	87.9%	90.4%	88.9%	
	Night	100.0%	95.2%	64.5%	85.0%	66.1%	86.7%	77.4%	93.5%	60.7%	71.0%	75.0%	79.0%	86.7%	80.2%	
Neonatal Unit	Day	95.2%	100.0%	98.9%	98.6%	100.0%	100.0%	100.0%	97.6%	98.6%	98.8%	98.2%	96.5%	98.8%	97.8%	
	Night	100.0%	98.8%	98.9%	100.0%	100.0%	94.7%	100.0%	97.6%	98.6%	100.0%	100.0%	100.0%	93.8%	97.8%	
Petworth	Day	100.0%	96.8%	91.4%	90.0%	90.3%	92.2%	94.1%	99.5%	92.3%	95.7%	90.6%	96.2%	97.8%	94.9%	
	Night	100.0%	96.8%	91.9%	88.3%	90.3%	90.0%	96.8%	98.4%	94.6%	95.2%	91.7%	100.0%	98.3%	96.7%	
Selsey	Day	99.6%	97.9%	95.4%	93.1%	85.4%	95.7%	90.8%	99.2%	93.5%	93.3%	97.0%	98.3%	95.7%	97.0%	
	Night	100.0%	97.8%	93.5%	92.2%	81.7%	94.4%	89.2%	97.8%	92.9%	93.5%	95.6%	94.6%	97.8%	96.0%	
Wittering	Day	98.8%	96.8%	96.4%	95.0%	94.8%	96.3%	97.6%	98.8%	90.2%	90.7%	93.3%	97.2%	98.3%	96.3%	
	Night	96.7%	93.5%	93.5%	96.7%	91.9%	93.3%	95.2%	98.4%	83.9%	88.7%	90.0%	96.8%	98.3%	95.1%	

SAFER STAFFING SCORECARD - Care Staff

June 2018

	Shift	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Actual	Trend
WSHFT	**Day**	**95.3%**	**94.8%**	**93.4%**	**94.3%**	**90.5%**	**92.7%**	**93.6%**	**93.8%**	**90.3%**	**90.5%**	**92.4%**	**94.0%**	**93.8%**	**93.4%**	
	Night	**95.2%**	**96.4%**	**92.4%**	**93.8%**	**91.2%**	**95.2%**	**93.3%**	**95.8%**	**92.4%**	**92.7%**	**94.7%**	**94.9%**	**96.6%**	**95.4%**	
Acute Cardiac Unit	Day	96.7%	93.5%	91.0%	94.0%	88.4%	94.7%	91.0%	95.5%	88.6%	95.5%	86.7%	89.7%	90.7%	89.0%	
	Night	90.0%	90.3%	74.2%	86.7%	67.7%	76.7%	90.3%	83.9%	67.9%	90.3%	73.3%	83.9%	76.7%	78.0%	
Ashling	Day	97.1%	96.8%	91.7%	97.6%	93.5%	95.7%	92.2%	98.6%	94.4%	93.5%	93.8%	93.5%	95.2%	94.2%	
	Night	95.0%	96.8%	85.5%	95.0%	88.7%	91.7%	85.5%	98.4%	83.9%	85.5%	98.3%	90.3%	91.7%	93.4%	
Balcombe	Day	-	-	-	-	-	-	-	-	-	-	84.4%	94.4%	94.9%	91.3%	
	Night	-	-	-	-	-	-	-	-	-	-	93.3%	100.0%	100.0%	97.8%	
Barrow	Day	93.3%	92.2%	95.2%	91.4%	88.2%	89.7%	94.1%	90.1%	87.8%	86.0%	94.4%	93.5%	94.4%	94.1%	
	Night	97.5%	96.8%	97.6%	95.8%	94.4%	99.2%	98.4%	98.4%	99.1%	92.7%	99.2%	98.4%	99.2%	98.9%	
Becket	Day	93.7%	93.8%	87.8%	97.2%	83.6%	90.8%	97.2%	92.5%	87.9%	88.4%	92.9%	96.6%	96.5%	95.3%	
	Night	95.0%	96.8%	93.5%	98.3%	96.8%	100.0%	96.8%	95.2%	100.0%	93.5%	100.0%	100.0%	100.0%	100.0%	
Beeding	Day	97.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Night	100.0%	100.0%	100.0%	100.0%	100.0%	93.9%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Bluefin	Day	100.0%	90.5%	94.3%	100.0%	100.0%	83.1%	100.0%	100.0%	97.6%	74.2%	88.3%	96.7%	94.1%	91.9%	
	Night	90.3%	96.8%	87.1%	92.9%	100.0%	90.3%	96.8%	93.3%	92.6%	87.1%	100.0%	71.0%	77.4%	82.4%	
Bosham	Day	99.3%	92.3%	92.9%	91.3%	93.5%	96.7%	94.8%	97.4%	93.6%	84.5%	91.3%	96.8%	98.7%	95.6%	
	Night	98.3%	93.5%	90.3%	88.3%	95.2%	98.3%	96.8%	96.8%	92.9%	88.7%	91.7%	96.8%	98.3%	95.6%	
Botolphs	Day	93.9%	95.5%	93.0%	97.7%	90.0%	93.5%	91.8%	89.3%	93.9%	90.0%	91.6%	92.3%	92.0%	91.9%	
	Night	96.7%	90.3%	91.9%	96.7%	96.8%	98.3%	93.5%	91.9%	91.1%	98.4%	93.3%	95.2%	100.0%	96.2%	
Boxgrove	Day	99.5%	96.3%	95.4%	94.3%	93.5%	95.7%	93.1%	95.9%	95.4%	92.6%	87.6%	92.2%	85.2%	88.4%	
	Night	100.0%	95.2%	90.3%	86.7%	93.5%	91.7%	82.3%	91.9%	89.3%	90.3%	81.7%	93.5%	85.0%	86.8%	
Buckingham	Day	95.6%	95.2%	93.9%	96.2%	82.9%	86.7%	88.5%	82.2%	77.0%	82.3%	89.3%	98.2%	93.7%	93.8%	
	Night	95.0%	98.4%	96.8%	100.0%	95.2%	98.3%	95.2%	95.2%	92.9%	96.8%	93.3%	95.2%	100.0%	96.2%	
Burlington	Day	90.6%	88.6%	91.6%	86.2%	91.4%	87.7%	97.1%	96.5%	93.0%	93.0%	-	-	-	-	
	Night	100.0%	100.0%	93.5%	100.0%	90.3%	96.7%	96.8%	100.0%	100.0%	93.5%	-	-	-	-	

SAFER STAFFING SCORECARD - Care Staff

June 2018

	Shift	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Actual	Trend
WSHFT	**Day**	**95.3%**	**94.8%**	**93.4%**	**94.3%**	**90.5%**	**92.7%**	**93.6%**	**93.8%**	**90.3%**	**90.5%**	**92.4%**	**94.0%**	**93.8%**	**93.4%**	
	Night	**95.2%**	**96.4%**	**92.4%**	**93.8%**	**91.2%**	**95.2%**	**93.3%**	**95.8%**	**92.4%**	**92.7%**	**94.7%**	**94.9%**	**96.6%**	**95.4%**	
Castle	Day	96.2%	94.5%	94.0%	95.2%	94.0%	91.4%	97.2%	95.9%	94.9%	82.9%	95.7%	95.4%	95.2%	95.4%	
	Night	100.0%	96.8%	95.2%	98.3%	98.4%	100.0%	91.9%	91.9%	92.9%	88.7%	93.3%	100.0%	100.0%	97.8%	
Chichester Emergency Floor	Day	97.5%	97.3%	96.0%	93.1%	89.0%	93.9%	89.3%	98.4%	92.6%	92.8%	90.9%	90.1%	91.7%	90.9%	
	Night	94.4%	94.5%	89.1%	87.2%	75.3%	80.3%	73.8%	94.6%	86.4%	84.9%	74.5%	79.6%	92.9%	82.3%	
Chilgrove	Day	99.2%	96.0%	90.3%	92.5%	83.1%	90.8%	96.0%	100.0%	84.8%	77.4%	91.7%	96.8%	97.5%	95.3%	
	Night	100.0%	96.8%	90.3%	91.7%	75.8%	91.7%	95.2%	100.0%	89.3%	83.9%	98.3%	98.4%	98.3%	98.4%	
Chiltington	Day	90.0%	91.4%	93.0%	96.1%	95.2%	90.0%	95.7%	95.7%	94.0%	93.5%	95.0%	94.1%	98.9%	96.0%	
	Night	91.7%	95.2%	88.7%	95.0%	95.2%	96.7%	95.2%	93.5%	98.2%	98.4%	96.7%	96.8%	100.0%	97.8%	
Clapham	Day	94.8%	91.2%	94.9%	97.1%	91.2%	89.0%	92.6%	83.9%	88.3%	91.7%	91.0%	97.2%	96.2%	94.8%	
	Night	95.0%	93.5%	91.9%	95.0%	93.5%	93.3%	90.3%	95.2%	98.2%	93.5%	98.3%	100.0%	98.3%	98.9%	
Coombes	Day	75.6%	91.9%	91.9%	95.6%	89.8%	91.7%	93.0%	96.2%	91.1%	84.9%	90.0%	92.5%	95.6%	92.7%	
	Night	85.0%	96.8%	93.5%	95.0%	96.8%	98.3%	98.4%	90.3%	98.2%	96.8%	96.7%	95.2%	100.0%	97.3%	
Courtlands	Day	96.0%	96.1%	96.8%	98.0%	92.3%	92.0%	94.2%	86.5%	92.9%	92.9%	88.7%	95.5%	95.3%	93.2%	
	Night	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Ditchling	Day	91.7%	90.3%	88.2%	88.3%	80.6%	90.6%	93.0%	93.0%	85.7%	93.0%	90.0%	97.8%	94.4%	94.1%	
	Night	91.7%	95.2%	96.8%	98.3%	98.4%	98.3%	95.2%	96.8%	96.4%	95.2%	98.3%	93.5%	98.3%	96.7%	
Durrington	Day	99.2%	97.6%	95.6%	94.2%	90.7%	93.8%	94.0%	93.1%	89.3%	94.8%	97.1%	95.6%	94.2%	95.6%	
	Night	91.7%	98.4%	96.8%	96.7%	93.5%	100.0%	93.5%	100.0%	100.0%	98.4%	100.0%	100.0%	98.3%	99.5%	
Eartham	Day	89.3%	95.5%	86.5%	89.3%	85.8%	91.3%	93.5%	80.6%	76.4%	81.9%	92.0%	95.5%	90.7%	92.7%	
	Night	96.7%	90.3%	87.1%	90.0%	90.3%	93.3%	100.0%	90.3%	89.3%	100.0%	96.7%	93.5%	96.7%	95.6%	
Eastbrook	Day	100.0%	97.4%	94.2%	97.3%	92.3%	90.7%	96.1%	90.3%	85.0%	88.4%	92.0%	94.2%	92.7%	93.0%	
	Night	95.0%	93.5%	96.8%	93.3%	98.4%	100.0%	96.8%	95.2%	94.6%	95.2%	100.0%	98.4%	96.7%	98.4%	
Emergency Floor Worthing	Day	93.8%	93.1%	96.6%	96.5%	94.0%	93.7%	96.5%	94.2%	90.0%	92.4%	93.2%	93.9%	96.0%	94.3%	
	Night	95.7%	98.7%	98.7%	97.3%	95.2%	99.3%	98.7%	97.4%	98.9%	97.4%	98.3%	97.7%	100.0%	98.7%	

SAFER STAFFING SCORECARD - Care Staff

June 2018

	Shift	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Actual	Trend
WSHFT	**Day**	**95.3%**	**94.8%**	**93.4%**	**94.3%**	**90.5%**	**92.7%**	**93.6%**	**93.8%**	**90.3%**	**90.5%**	**92.4%**	**94.0%**	**93.8%**	**93.4%**	
	Night	**95.2%**	**96.4%**	**92.4%**	**93.8%**	**91.2%**	**95.2%**	**93.3%**	**95.8%**	**92.4%**	**92.7%**	**94.7%**	**94.9%**	**96.6%**	**95.4%**	
Enhanced Surgical Care Unit	Day	95.0%	99.2%	100.0%	100.0%	99.2%	99.2%	100.0%	98.4%	97.3%	98.4%	100.0%	100.0%	99.2%	99.7%	
	Night	90.0%	100.0%	96.8%	96.7%	100.0%	100.0%	96.8%	93.5%	92.9%	96.8%	100.0%	96.8%	100.0%	98.9%	
Erringham	Day	100.0%	91.0%	78.1%	85.3%	80.6%	76.0%	85.2%	74.8%	85.7%	97.4%	95.3%	86.5%	92.7%	91.4%	
	Night	100.0%	95.2%	91.9%	98.3%	100.0%	100.0%	93.5%	90.3%	98.2%	96.8%	98.3%	95.2%	100.0%	97.8%	
Fishbourne	Day	93.3%	96.8%	89.2%	93.3%	90.3%	95.0%	87.1%	98.9%	92.3%	95.2%	86.7%	86.0%	93.9%	88.8%	
	Night	86.7%	98.4%	82.3%	90.0%	85.5%	91.7%	79.0%	98.4%	83.9%	93.5%	86.7%	87.1%	93.3%	89.0%	
Ford	Day	96.0%	94.8%	93.5%	94.7%	91.6%	92.7%	92.9%	98.1%	92.1%	90.3%	92.7%	93.5%	78.7%	88.4%	
	Night	93.3%	95.2%	91.9%	93.3%	91.9%	88.3%	93.5%	96.8%	87.5%	88.7%	95.0%	96.8%	91.7%	94.5%	
Howard Children's Unit	Day	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.5%	85.2%	85.7%	96.8%	93.3%	80.6%	100.0%	91.2%	
	Night	66.7%	100.0%	84.0%	73.3%	64.5%	93.3%	96.2%	92.0%	53.8%	74.2%	93.3%	71.0%	86.7%	83.5%	
Lavant	Day	97.5%	97.6%	93.5%	92.1%	92.7%	96.3%	89.9%	97.6%	91.5%	90.3%	96.3%	92.7%	90.8%	93.3%	
	Night	95.0%	95.2%	79.0%	80.0%	83.9%	90.0%	77.4%	95.2%	82.1%	82.3%	93.3%	90.3%	86.7%	90.1%	
Middleton	Day	99.3%	92.3%	92.9%	93.3%	80.0%	94.7%	91.0%	97.4%	88.6%	92.9%	90.0%	91.0%	96.0%	92.3%	
	Night	100.0%	95.2%	88.7%	95.0%	67.7%	90.0%	91.9%	98.4%	87.5%	90.3%	93.3%	91.9%	96.7%	94.0%	
Neonatal Unit	Day	82.6%	93.3%	100.0%	91.7%	100.0%	75.0%	92.3%	96.6%	95.7%	96.2%	92.3%	95.2%	84.0%	90.3%	
	Night	88.0%	100.0%	89.7%	87.5%	90.0%	89.5%	95.8%	93.5%	92.0%	100.0%	96.6%	96.3%	100.0%	97.5%	
Petworth	Day	98.0%	96.8%	98.1%	95.3%	96.8%	96.0%	97.4%	98.7%	95.7%	96.1%	97.3%	93.5%	90.7%	93.8%	
	Night	96.7%	93.5%	95.2%	95.0%	95.2%	91.7%	96.8%	98.4%	94.6%	98.4%	96.7%	90.3%	95.0%	94.0%	
Selsey	Day	98.4%	97.9%	93.2%	97.8%	93.2%	96.7%	99.0%	100.0%	94.2%	92.7%	96.2%	99.5%	97.8%	97.9%	
	Night	96.7%	96.8%	87.1%	96.7%	93.5%	93.3%	96.8%	100.0%	91.1%	88.7%	96.7%	100.0%	100.0%	98.9%	
Wittering	Day	99.3%	100.0%	93.5%	88.0%	80.6%	94.7%	91.6%	99.4%	82.9%	80.6%	92.7%	99.4%	96.7%	96.3%	
	Night	98.3%	100.0%	91.9%	85.0%	75.8%	95.0%	93.5%	100.0%	82.1%	83.9%	93.3%	100.0%	100.0%	97.8%	

SAFER STAFFING SCORECARD - CHPPD

June 2018

	Care Hours Per Patient Day (CHPPD)	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Average	Trend
WSHFT	**Nurse**	**4.0**	**4.0**	**4.0**	**4.1**	**3.8**	**3.8**	**3.7**	**3.8**	**3.7**	**3.7**	**3.7**	**4.1**	**4.1**	**4.0**	
	Care	**2.8**	**2.8**	**2.9**	**3.0**	**2.7**	**2.7**	**2.7**	**2.7**	**2.6**	**2.6**	**2.7**	**3.0**	**3.0**	**2.9**	
	Overall	**6.8**	**6.8**	**6.9**	**7.1**	**6.4**	**6.5**	**6.4**	**6.4**	**6.3**	**6.3**	**6.5**	**7.1**	**7.1**	**6.9**	
Acute Cardiac Unit	Nurse	4.6	4.9	4.5	4.5	4.7	5.0	4.5	4.4	4.3	4.4	4.4	4.8	4.7	4.6	
	Care	1.9	2.0	1.7	1.9	1.8	2.0	1.9	1.8	1.7	1.9	1.7	1.9	1.8	1.8	
	Overall	6.5	6.9	6.2	6.4	6.4	7.0	6.5	6.3	6.0	6.3	6.1	6.7	6.6	6.5	
Ashling	Nurse	3.5	4.2	5.3	6.0	3.1	3.4	3.3	3.6	3.2	3.3	3.1	3.4	4.0	3.4	
	Care	2.8	3.5	4.4	5.0	2.7	2.8	2.6	3.0	2.7	2.7	2.8	2.9	3.6	3.1	
	Overall	6.3	7.7	9.7	11.0	5.8	6.2	5.9	6.5	5.9	5.9	5.9	6.3	7.6	6.5	
Balcombe	Nurse	-	-	-	-	-	-	-	-	-	-	2.7	3.1	3.0	2.9	
	Care	-	-	-	-	-	-	-	-	-	-	2.1	2.7	2.3	2.3	
	Overall	-	-	-	-	-	-	-	-	-	-	4.8	5.7	5.3	5.2	
Barrow	Nurse	3.8	3.5	3.3	3.4	3.4	3.3	3.4	3.3	3.3	3.6	3.9	4.0	3.5	3.8	
	Care	3.6	3.3	3.4	3.2	3.2	3.2	3.4	3.2	3.3	3.3	4.0	3.9	3.5	3.8	
	Overall	7.4	6.8	6.7	6.6	6.5	6.5	6.8	6.6	6.6	6.9	7.9	7.9	7.0	7.6	
Becket	Nurse	4.5	4.5	4.4	4.4	4.2	4.4	4.6	4.3	4.6	4.4	4.4	4.8	4.4	4.5	
	Care	2.5	2.5	2.3	2.5	2.2	2.4	2.5	2.3	2.4	2.3	2.5	2.7	2.5	2.6	
	Overall	7.0	7.0	6.7	6.8	6.5	6.8	7.1	6.6	7.1	6.7	6.9	7.5	7.0	7.1	
Beeding	Nurse	4.3	4.8	5.3	4.8	7.4	5.1	5.8	8.1	6.0	7.4	7.1	6.1	6.8	6.6	
	Care	1.8	2.2	2.3	2.2	3.4	2.2	2.3	3.3	2.5	3.0	3.2	2.7	2.9	2.9	
	Overall	6.0	7.0	7.6	7.0	10.8	7.3	8.1	11.4	8.5	10.4	10.3	8.8	9.7	9.5	
Bluefin	Nurse	4.2	4.8	5.9	5.5	5.6	4.6	6.6	5.3	5.3	4.6	5.1	5.0	5.1	5.1	
	Care	1.4	1.5	2.3	1.8	1.4	1.5	1.9	1.3	1.6	1.4	1.5	1.2	1.5	1.4	
	Overall	5.6	6.3	8.2	7.2	7.0	6.1	8.5	6.5	6.9	5.9	6.6	6.2	6.6	6.5	
Bosham	Nurse	3.6	3.3	3.5	3.6	3.3	3.6	3.5	3.4	3.4	3.3	3.5	3.8	4.1	3.8	
	Care	2.5	2.2	2.3	2.4	2.4	2.5	2.4	2.4	2.3	2.2	2.3	2.6	2.9	2.6	
	Overall	6.1	5.6	5.9	6.0	5.7	6.1	5.9	5.8	5.7	5.4	5.7	6.4	6.9	6.3	

SAFER STAFFING SCORECARD - CHPPD

June 2018

	Care Hours Per Patient Day (CHPPD)	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Average	Trend
WSHFT	**Nurse**	**4.0**	**4.0**	**4.0**	**4.1**	**3.8**	**3.8**	**3.7**	**3.8**	**3.7**	**3.7**	**3.7**	**4.1**	**4.1**	**4.0**	
	Care	**2.8**	**2.8**	**2.9**	**3.0**	**2.7**	**2.7**	**2.7**	**2.7**	**2.6**	**2.6**	**2.7**	**3.0**	**3.0**	**2.9**	
	Overall	**6.8**	**6.8**	**6.9**	**7.1**	**6.4**	**6.5**	**6.4**	**6.4**	**6.3**	**6.3**	**6.5**	**7.1**	**7.1**	**6.9**	
Botolphs	Nurse	4.2	3.5	3.8	3.8	3.5	3.7	3.6	3.6	3.5	3.5	3.6	4.4	4.1	4.0	
	Care	3.8	3.2	3.4	3.5	3.2	3.3	3.2	3.1	3.3	3.2	3.4	3.9	3.7	3.7	
	Overall	8.0	6.8	7.3	7.4	6.7	7.0	6.9	6.7	6.8	6.7	7.1	8.3	7.9	7.7	
Boxgrove	Nurse	3.1	3.0	3.7	3.0	2.7	2.8	2.7	3.0	2.8	2.8	2.8	2.8	2.9	2.8	
	Care	2.8	2.7	3.3	2.6	2.6	2.6	2.5	2.7	2.7	2.6	2.5	2.8	2.5	2.6	
	Overall	5.9	5.7	7.0	5.6	5.3	5.4	5.3	5.7	5.5	5.3	5.3	5.6	5.4	5.4	
Buckingham	Nurse	3.1	2.7	3.3	3.3	2.2	2.1	2.1	2.0	2.0	1.9	2.1	3.3	3.2	2.8	
	Care	2.5	2.3	2.6	2.7	1.8	1.7	1.8	1.7	1.6	1.7	1.9	2.8	2.7	2.4	
	Overall	5.6	5.1	5.9	6.0	4.0	3.8	3.9	3.6	3.6	3.6	3.9	6.1	5.9	5.2	
Burlington	Nurse	3.7	3.5	3.3	3.4	3.1	3.1	3.3	3.4	3.5	3.2	-	-	-	-	
	Care	2.5	2.4	2.5	2.4	2.4	2.3	2.5	2.6	2.6	2.5	-	-	-	-	
	Overall	6.2	5.8	5.8	5.8	5.5	5.5	5.9	6.0	6.0	5.8	-	-	-	-	
Castle	Nurse	3.9	3.8	3.7	3.8	3.6	3.7	3.7	3.7	3.5	3.5	3.7	4.1	3.8	3.9	
	Care	2.9	2.9	2.8	2.9	2.7	2.7	2.8	2.8	2.7	2.4	2.8	3.0	2.9	2.9	
	Overall	6.8	6.7	6.5	6.7	6.4	6.4	6.5	6.5	6.2	6.0	6.5	7.1	6.7	6.8	
Chichester Emergency Floor	Nurse	4.4	4.6	4.7	4.5	4.4	4.8	4.1	4.5	3.9	3.9	4.2	5.0	5.0	4.7	
	Care	2.4	2.6	2.8	2.7	2.5	2.7	2.2	2.5	2.2	2.1	2.2	2.6	2.8	2.5	
	Overall	6.8	7.2	7.5	7.2	6.9	7.5	6.3	7.0	6.1	6.1	6.4	7.6	7.8	7.2	
Chilgrove	Nurse	4.2	5.3	5.0	4.3	4.5	4.3	5.2	5.1	5.2	4.9	4.5	5.2	5.3	5.0	
	Care	2.9	3.5	3.2	2.8	2.7	2.7	3.5	3.4	3.3	3.1	3.2	3.5	3.6	3.4	
	Overall	7.1	8.8	8.2	7.2	7.2	7.0	8.7	8.5	8.5	8.0	7.8	8.7	8.9	8.4	
Chiltington	Nurse	4.2	3.9	3.9	4.1	3.8	4.1	4.0	4.0	4.1	4.2	4.1	4.7	4.4	4.4	
	Care	3.1	3.1	3.1	3.3	3.2	3.2	3.3	3.2	3.2	3.4	3.4	3.8	3.7	3.6	
	Overall	7.4	7.0	7.0	7.4	7.0	7.4	7.3	7.1	7.3	7.6	7.4	8.5	8.1	8.0	
Clapham	Nurse	3.3	3.0	3.0	2.9	2.8	3.1	3.1	3.0	3.2	3.2	3.2	3.5	3.3	3.3	
	Care	2.9	2.7	2.7	2.8	2.6	2.6	2.7	2.4	2.6	2.8	2.8	3.1	2.9	3.0	
	Overall	6.2	5.7	5.7	5.7	5.4	5.8	5.8	5.4	5.8	6.0	6.0	6.6	6.3	6.3	

SAFER STAFFING SCORECARD - CHPPD

June 2018

	Care Hours Per Patient Day (CHPPD)	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Average	Trend
WSHFT	**Nurse**	**4.0**	**4.0**	**4.0**	**4.1**	**3.8**	**3.8**	**3.7**	**3.8**	**3.7**	**3.7**	**3.7**	**4.1**	**4.1**	**4.0**	
	Care	**2.8**	**2.8**	**2.9**	**3.0**	**2.7**	**2.7**	**2.7**	**2.7**	**2.6**	**2.6**	**2.7**	**3.0**	**3.0**	**2.9**	
	Overall	**6.8**	**6.8**	**6.9**	**7.1**	**6.4**	**6.5**	**6.4**	**6.4**	**6.3**	**6.3**	**6.5**	**7.1**	**7.1**	**6.9**	
Coombes	Nurse	3.1	2.9	2.8	3.0	2.9	3.0	3.0	2.9	3.0	3.1	3.1	3.2	3.4	3.3	
	Care	2.0	2.3	2.3	2.5	2.3	2.4	2.4	2.4	2.4	2.4	2.6	2.5	2.7	2.6	
	Overall	5.2	5.2	5.2	5.4	5.2	5.4	5.3	5.3	5.4	5.6	5.7	5.7	6.1	5.8	
Courtlands	Nurse	8.3	7.9	8.3	8.9	7.9	7.7	7.6	7.5	8.1	7.9	8.6	8.0	8.6	8.4	
	Care	2.7	2.6	2.9	3.1	2.6	2.5	2.5	2.3	2.7	2.6	2.7	2.7	2.8	2.7	
	Overall	11.0	10.6	11.2	12.0	10.5	10.2	10.1	9.7	10.8	10.5	11.3	10.7	11.5	11.1	
Ditchling	Nurse	3.1	3.1	3.0	2.9	2.9	2.9	3.1	3.0	2.9	2.9	3.0	3.2	3.2	3.1	
	Care	2.6	2.5	2.5	2.5	2.4	2.6	2.7	2.6	2.5	2.6	2.6	2.8	2.9	2.8	
	Overall	5.7	5.6	5.6	5.4	5.2	5.4	5.8	5.6	5.4	5.5	5.6	6.0	6.0	5.9	
Durrington	Nurse	3.2	3.2	3.1	3.1	3.0	3.1	3.2	3.1	3.2	3.3	3.1	3.4	3.2	3.3	
	Care	3.6	3.6	3.5	3.4	3.3	3.5	3.4	3.4	3.3	3.5	3.6	3.7	3.5	3.6	
	Overall	6.8	6.8	6.7	6.6	6.3	6.6	6.6	6.5	6.6	6.8	6.7	7.2	6.7	6.9	
Eartham	Nurse	4.5	4.3	4.3	4.5	4.3	4.2	4.2	4.4	4.2	4.1	4.3	4.7	4.7	4.6	
	Care	2.2	2.3	2.1	2.3	2.2	2.3	2.3	2.0	1.9	2.0	2.4	2.5	2.4	2.4	
	Overall	6.7	6.7	6.5	6.8	6.5	6.5	6.5	6.4	6.1	6.1	6.7	7.2	7.2	7.0	
Eastbrook	Nurse	3.6	3.3	3.4	6.0	4.4	3.2	3.2	3.4	3.3	3.3	3.1	3.6	3.2	3.3	
	Care	2.6	2.5	2.5	4.5	3.3	2.4	2.5	2.4	2.3	2.4	2.4	2.7	2.5	2.6	
	Overall	6.2	5.8	5.9	10.4	7.6	5.6	5.7	5.8	5.6	5.7	5.5	6.3	5.7	5.8	
Emergency Floor	Nurse	5.4	4.9	5.0	5.0	4.3	4.5	4.4	4.2	4.5	4.2	4.9	5.7	4.8	5.1	
	Care	4.4	4.0	4.3	4.4	3.8	3.9	3.8	3.6	3.9	3.8	4.4	5.0	4.5	4.6	
	Overall	9.7	8.9	9.3	9.3	8.1	8.4	8.2	7.8	8.4	8.0	9.4	10.7	9.3	9.8	
Enhanced Surgical Care Unit	Nurse	9.1	9.5	8.9	9.3	8.8	8.5	8.9	9.3	8.7	9.9	9.5	10.3	9.7	9.8	
	Care	8.6	9.5	8.9	9.5	8.8	8.5	8.9	9.0	8.4	9.7	9.5	10.3	9.6	9.8	
	Overall	17.7	19.0	17.8	18.8	17.6	17.0	17.8	18.3	17.1	19.6	19.0	20.6	19.3	19.6	
Erringham	Nurse	3.4	3.2	3.3	3.3	3.3	3.3	3.3	3.2	3.2	3.3	3.4	3.6	3.3	3.4	
	Care	2.8	2.5	2.2	2.4	2.3	2.2	2.3	2.0	2.4	2.6	2.7	2.6	2.6	2.6	
	Overall	6.2	5.7	5.6	5.7	5.6	5.5	5.7	5.2	5.6	5.9	6.1	6.1	5.8	6.0	

SAFER STAFFING SCORECARD - CHPPD

June 2018

	Care Hours Per Patient Day (CHPPD)	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Average	Trend
WSHFT	**Nurse**	**4.0**	**4.0**	**4.0**	**4.1**	**3.8**	**3.8**	**3.7**	**3.8**	**3.7**	**3.7**	**3.7**	**4.1**	**4.1**	**4.0**	
	Care	**2.8**	**2.8**	**2.9**	**3.0**	**2.7**	**2.7**	**2.7**	**2.7**	**2.6**	**2.6**	**2.7**	**3.0**	**3.0**	**2.9**	
	Overall	**6.8**	**6.8**	**6.9**	**7.1**	**6.4**	**6.5**	**6.4**	**6.4**	**6.3**	**6.3**	**6.5**	**7.1**	**7.1**	**6.9**	
Fishbourne	Nurse	3.2	3.9	3.3	3.2	3.2	3.3	2.9	3.2	2.8	3.0	2.8	3.2	4.6	3.4	
	Care	2.4	3.1	2.4	2.6	2.4	2.6	2.2	2.6	2.4	2.5	2.3	2.4	3.7	2.7	
	Overall	5.5	7.0	5.7	5.8	5.6	5.9	5.1	5.8	5.2	5.5	5.1	5.6	8.3	6.1	
Ford	Nurse	4.3	5.4	4.0	4.1	3.8	4.2	4.0	4.3	4.1	4.1	3.9	4.2	4.0	4.1	
	Care	2.2	2.8	2.1	2.2	2.1	2.1	2.1	2.3	2.1	2.1	2.1	2.3	2.0	2.1	
	Overall	6.5	8.1	6.1	6.2	5.9	6.3	6.1	6.6	6.3	6.2	6.1	6.5	6.0	6.2	
Howard Children's Unit	Nurse	7.5	7.0	7.0	6.9	8.4	5.4	6.6	5.8	6.1	5.2	5.2	5.7	4.6	5.1	
	Care	0.5	1.7	1.9	1.9	1.7	1.3	1.4	1.0	1.1	1.2	1.5	1.4	1.4	1.4	
	Overall	8.0	8.7	8.9	8.9	10.2	6.7	8.0	6.9	7.2	6.3	6.6	7.1	6.1	6.6	
Lavant	Nurse	3.5	4.5	3.5	3.7	3.3	3.7	3.3	3.3	2.8	3.1	3.0	3.5	3.6	3.4	
	Care	3.1	4.1	3.1	3.2	3.1	3.4	2.9	3.0	2.8	2.8	3.1	3.2	3.1	3.1	
	Overall	6.6	8.6	6.6	6.9	6.4	7.0	6.2	6.3	5.6	6.0	6.1	6.7	6.7	6.5	
Middleton	Nurse	3.1	3.1	3.6	3.1	2.7	3.0	2.8	3.1	2.6	2.7	2.7	3.0	3.1	2.9	
	Care	2.2	2.1	2.8	2.2	1.8	2.1	2.1	2.2	2.0	2.1	2.0	2.2	2.4	2.2	
	Overall	5.3	5.2	6.3	5.4	4.5	5.1	4.8	5.2	4.6	4.7	4.8	5.2	5.5	5.1	
Neonatal Unit	Nurse	5.1	6.4	5.8	8.3	8.0	6.4	6.3	6.0	5.5	6.4	7.3	9.1	7.3	7.8	
	Care	1.3	2.3	1.8	2.0	3.0	1.3	1.8	2.1	1.7	2.0	2.4	2.7	2.1	2.4	
	Overall	6.4	8.7	7.6	10.3	11.0	7.7	8.1	8.1	7.2	8.5	9.7	11.9	9.4	10.2	
Petworth	Nurse	3.3	3.5	3.1	11.2	3.1	3.1	3.2	3.3	3.1	3.2	3.1	3.4	4.6	3.6	
	Care	2.8	3.1	2.9	10.5	2.9	2.8	2.9	2.9	2.8	2.8	2.9	2.8	3.8	3.1	
	Overall	6.2	6.6	6.0	21.7	5.9	6.0	6.0	6.2	5.9	6.0	5.9	6.2	8.4	6.7	
Selsey	Nurse	3.9	3.6	3.8	3.7	3.3	3.7	3.5	3.7	3.6	3.8	3.6	4.0	3.8	3.8	
	Care	2.9	2.7	2.8	3.0	2.8	2.8	2.9	2.9	2.7	2.8	2.8	3.1	3.0	2.9	
	Overall	6.8	6.3	6.6	6.6	6.1	6.5	6.3	6.6	6.4	6.6	6.4	7.1	6.8	6.8	
Wittering	Nurse	3.3	3.2	3.6	3.4	3.4	3.6	3.2	3.4	3.1	3.0	3.1	3.4	3.8	3.4	
	Care	2.3	2.3	2.4	2.2	2.0	2.5	2.2	2.4	2.0	1.9	2.2	2.4	2.6	2.4	
	Overall	5.7	5.5	6.0	5.6	5.5	6.0	5.4	5.8	5.2	4.9	5.3	5.8	6.4	5.8	

Morning Discharges Update for Quality Board

The Emergency Floor and medical wards, represent c.70% of total discharges. There is an opportunity to release beds and generate a significant impact if we are able to influence factors that are preventing patients from being discharged before midday.

The impact of not reaching the desired level of discharges before midday includes: Total Discharge target for the Trust (+7%), CQUIN target for over 65's (50% 3-7 days LOS), Ward bed availability, and Emergency Floor flow. There is also a significant impact on patient experience. Benefits to earlier discharge would include: Sending patients home in daylight, having full use of community services once discharged, better utilisation of discharge lounge, ability to move patients through A and E and the EF earlier in the day, more staff during the day shift to enable transfers, full MDT available when patients get to base wards.

Projects were undertaken on Castle, Boxgrove and Emergency Floor Worthing as part of PFIS and Yellow Belt Training. Effective countermeasures were found to support discharging patients before midday and a number of PDSA cycles are underway including: Preparing of TTO's the day before, potential dischargeable patients being seen first in ward round and TTO's being written with a pharmacist. 10 further wards have been selected to expand the pilot and are undergoing their problem solving for their individual top contributors.

Common top contributors identified by the pilot wards include:

1. Transport Service (Booking, delay to book as TTO not written)
2. Transport Service (delay in arrival, not utilising next day booking)
3. Package of Care (Care hours starting late in the day)
4. Prioritisation of decision to discharge and communication to MDT (Late decision to discharge, subsequent needs to improve communication to MDT)
5. Awaiting specialist input and/or investigations
6. TTO Process (Timeliness of completing TTO, processing of TTO, TTO right first time)

Current actions for the pilot wards:

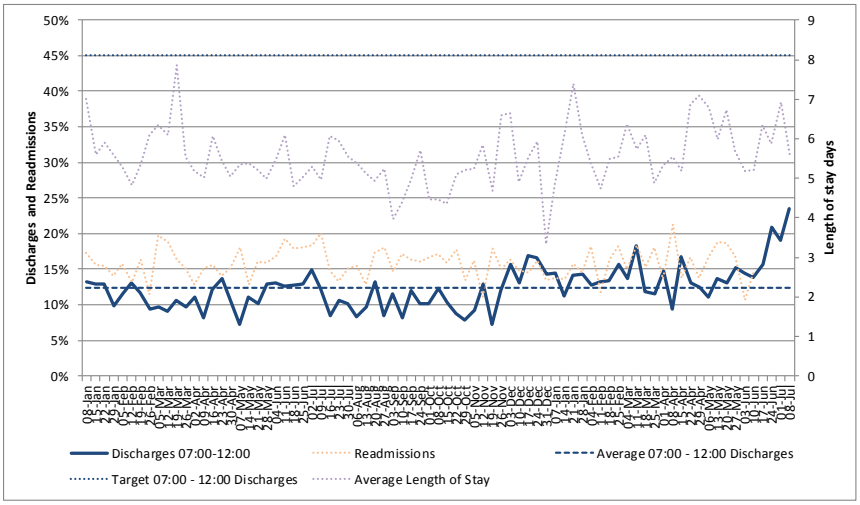
- Divisional Coaches (CGM's) assigned to wards
- Jeannie Bauman to lead Coaches
- Weekly Executive huddle established (Kaizen, Pharmacy, Divisional Coaches, Gethin Hughes, Jayne Black and George Findlay)
- Dashboard created with weekly data
- All pilot wards are now working through their own A3, supported by Divisional Coach and Kaizen Team
- Currently on wards – Root Cause Analysis undertaken, local data being collected, huddles and project teams being established
- Actions for wards - Continue to work through A3 process (Complete RCA, Analyse local data, Countermeasures, start a PDSA cycle)

Progress to date:

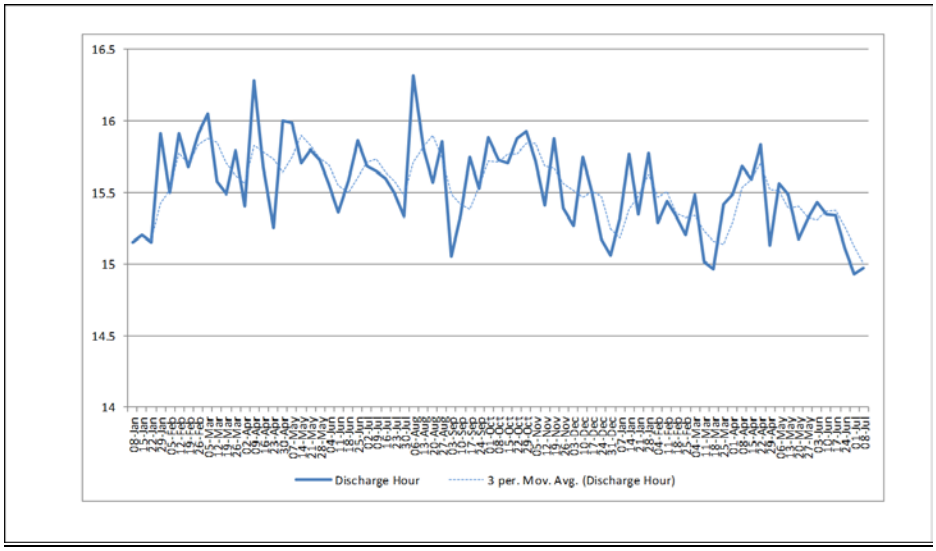
From the start of Q1 (Week ending 08/04/18), before midday discharges were at 8% across the pilot wards. Week ending 08/07/18 before midday discharges have increased to 23% across the pilot wards.

Data

% of Discharges 07.00-12.00 on Pilot Wards



Average time of Discharge on Pilot Wards



Appendix 4: Site Specific Mortality Summary

An analysis has been undertaken to ascertain why the rolling 12 month HMSR risk metric has been diverging since September 2017 when the scores for both sites were very close. This followed a 12 month period of convergence (figure 1). Of note, crude mortality rates that have historically been marginally higher at Chichester (figure 2).

Figure 1.

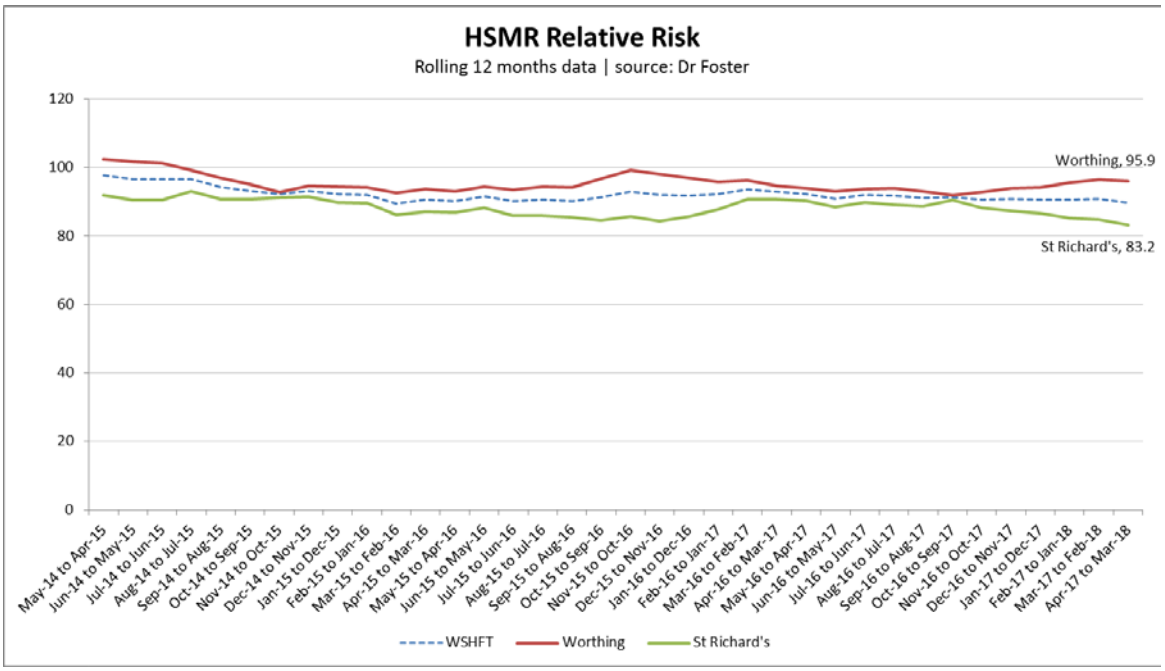
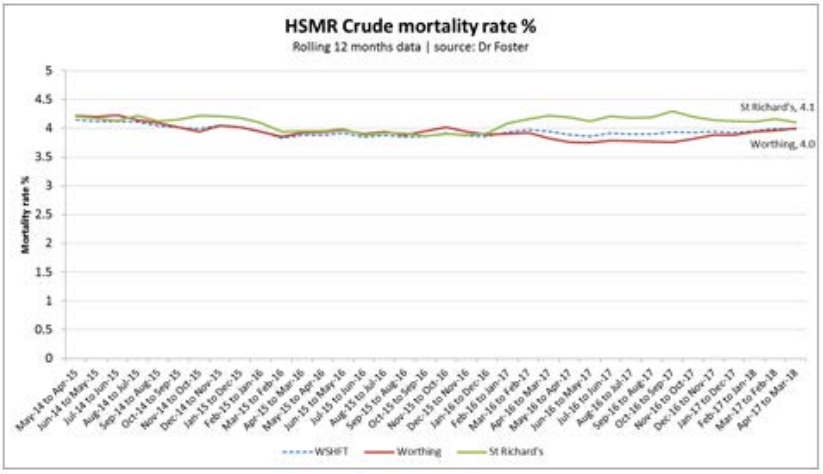
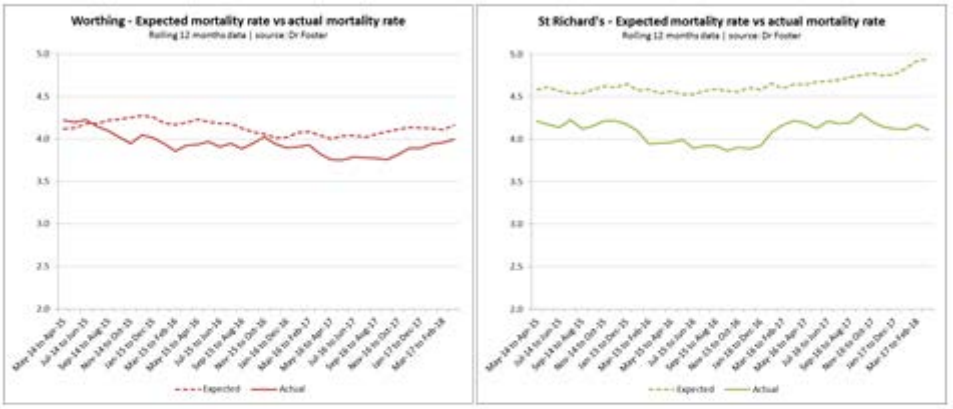


Figure 2.



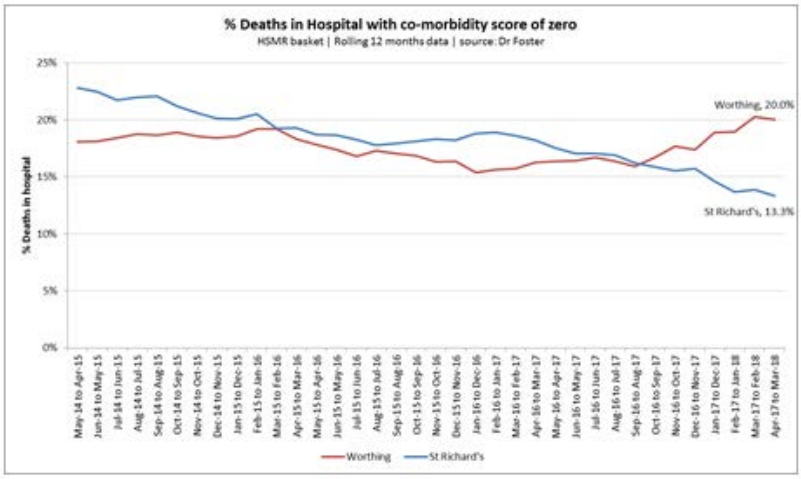
Over the recent period of divergence there has been a rise in the expected mortality rate at Chichester while the rate has remained stable at Worthing. Possible explanations for the rise include increasing acuity or coding changes (Figure 3).

Figure 3.



This period has seen a widening gap in the proportion fo deaths with a with a comorbidity score of zero. In the 12 months to March 2018, 20% of deaths at Worthing had a co-morbidity score of zero compared to 13.3% at Chichester. If Chichester rates prevailed at Worthing then approximately 70 fewer deaths would have had zero comorbidity scores (7% of all HMSR deaths). This may be significant (figure 4).

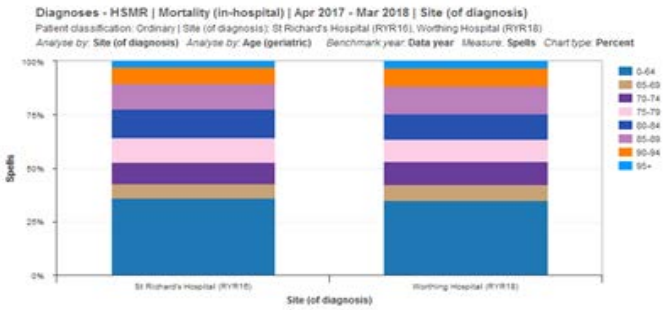
Figure 4.



Over the last 2 years palliative care coding rates have been increasing for both hospitals but are similar on both sites. This is unlikely to contribute to inter-site differences.

Worthing has slightly higher proportion of patients over 95 years (2.9 vs 2.6%). This equates to approximately 80 more patients in total. The case mix adjustment differentiates in bands of 5 years up to the age of 90 but not beyond so numbers in the very elderly age group can impact HMSR. However this difference has remained constant over the last 3 years and is unlikely to contribute to account for the divergence (figure 5)

Figure 5.



In summary, differences in co-morbidity coding are the only characteristics that appear to account for the divergence. A further analysis by specific diagnosis is awaited.

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board

Date of Meeting: 26th July

Agenda Item: 6.2

Title
Month 3, 2018-19 Performance Report
Responsible Executive Director
Jayne Black, Chief Operating Officer
Prepared by
Giles Frost, Interim Director – Performance & Information
Status
Disclosable
Summary of Proposal
The paper sets out organisational compliance against national and local key performance metrics. The report summarises both in year and projected year end performance for Western Sussex Hospitals NHS Foundation Trust, as detailed in dedicated performance scorecards relating to Quality Board indicators aligned to the Quality Strategy, the NHSI Single Oversight Framework and, when relevant, other indicators. This paper describes performance on an exceptional basis determined by RAG rating, key national/regulatory significance, or in year trend analysis.
Implications for Quality of Care
Describes Quality Outcome KPIs
Link to Strategic Objectives/Board Assurance Framework
Trust Strategic Theme B - Provide the highest possible quality of care to our patients. This we will do through focusing on a range of measures to improve clinical effectiveness. *Trust Strategic Theme G* - Ensure the sustainability of our organisation by exceeding our national targets and financial performance and investing in appropriate infrastructure and capacity. *Trust Strategic Theme* F - Improve our performance against a range of quality, access and productivity measures through the introduction and spread of best practice throughout the organisation.
Financial Implications
Describes KPIs linked to financial performance
Human Resource Implications
Describes KPIs linked to workforce
Recommendation
The Board is asked to: NOTE the Trust position against the NHS Single Oversight Framework and STF Performance Monitoring targets.
Communication and Consultation
Not applicable
Appendices
Appendix 1: Key Performance Deliverables, Operational Performance Scorecard, Single Oversight Framework Scorecard, STF Performance Monitoring.

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board Date: 26 July 2018

From: Jayne Black, Chief Operating Officer Agenda Item: 6.2

FOR INFORMATION

WSHFT PERFORMANCE REPORT: MONTH 3, 2018/19

1. INTRODUCTION

1.1 This report summarises both current in year and projected performance for Western Sussex Hospitals NHS Foundation Trust, with further detail provided in the appendices relating to:

- The NHSI Single Oversight Framework
- Key Performance Deliverables Report
- Operational Performance Scorecard
- Sustainability and Transformation Fund Performance Monitoring

1.2 This paper provides the Board with an update on performance on a specific basis determined by RAG rating, national significance, or in year trend analysis.

1.3 Introduced as a condition of the National Sustainability and Transformation Programme and Funding, all Trusts have again submitted joint performance trajectories on the key areas of A&E, RTT, and Cancer. The detailed tracking of the Trust's performance against this trajectory is included in an Appendix of this report, and performance against the requirements is summarised for each relevant performance area. The trajectory has changed for 2018/19 based on specific criteria for all indicators. The Sustainability and Transformation Fund payments in 2018/19 are indicatively based on A&E performance against trajectory as per NHS Improvement guidance.

2. SUMMARY PERFORMANCE

2.1 Under the Single Oversight Framework, the Trust was non-compliant for Cancer 62 day performance. RTT 18 week compliance was below the national constitutional target and STF performance trajectory for June. A&E performance remained significantly ahead of both STF trajectory and National constitutional target of 95%. Diagnostics was compliant against national target in June.

2.2 Operationally June saw an increased level of A&E demand, and an increase in emergency admissions relative to the same period in 2017. However, emergency patient flow has improved compared to preceding months.

- 12,278 A&E attendances compared to 11,985 in June 2017 (representing a 2.4% increase on this time last year). For patients aged 65 and over there was an increase in attendances of 5.5%. For patients aged 85 and over, there was actually a decrease of 2.7%.
- 5,079 emergency admissions in June 2018 comparison to 4,669 in June 2017, an increase of 8.8%.
- Over 65 emergency admissions increased in June 2018 with a 5.5% increase compared to June 2017. For patients 85 and over, there was a decrease of 3.2%.
- Formally reportable Delayed Transfers of Care totalled 3.45% for June 2018. This is an increase from the May figure of 2.66%.
- Average Inpatient Bed Occupancy reached 91.24% in June, a slight increase on May occupancy of 0.5%. The highest occupancy the trust reached during the month was 95.33% and the lowest was 86.85%. On average, 4 escalation beds per day were open across the trust during June, ranging from between 0 to 13 beds. This is a decrease of 2.5 beds on average from the May position. The Trust flexes the number of open beds to respond to fluctuations in demand.

3. KEY AREAS OF PERFORMANCE

3.1 A&E Compliance

3.1.1 The Trust was compliant against the National target in June, with 96.08% of patients waiting less than four hours from arrival at A&E to admission, transfer, or discharge, a decrease of 0.5% against May performance. This includes attendances from Bognor Minor Injuries Unit, and the emergency floor activity from both sites as part of the Trust STP footprint.

3.1.2 June performance of 96.08% was above the delivery requirements of the in-month Sustainability and Transformation Fund trajectory for quarter 1 of 92%.

3.1.3 By site, St Richard's Hospital (SRH) performance in June was 95.17%, with Worthing (WSH) achieving 96.18%. Emergency admissions at SRH decreased by 3.0% from June 2017. Worthing saw a small increase in emergency admissions of 0.9% over the same period. For the 85+ age group, SRH saw an increase of 4.9%, an additional 18 admissions from this time last year, compared to Worthing with an increase of 3.3% and an additional 16 admissions.

3.1.4 Worthing saw an average of 445 beds occupied in June, which is an increase of 6 beds from 439 in May. Worthing had an average occupancy of 92.61% in May, with the highest occupancy of

97.37% on 4th June. Emergency medical length of stay at Worthing decreased to 5.8 days in June from 6.2 days May. SRH saw an average of 346 beds occupied in June, a decrease of 15 from 361 in May 2018. Occupancy at SRH averaged 89.53% in June 2018, reaching 95.44% on 10th June. For SRH, emergency medical length of stay remained reduced to 5.1 days on average in June from 5.5 days in May.

3.1.5 In May, delayed transfers of care (DTOC) increased to 3.45% compared to 2.66% in May. June DTOCs peaked at 3.8% week ending 3rd June. In real terms, this reflects an impact in 'lost' beds that fluctuated between a minimum of c26 beds and a high of c30 beds during the month.

3.1.6 Patients who were medically fit for discharge (MFFD) increased by 9 to 131 patients on average per day in June. The number of patients medically fit for discharge fluctuated from 109 patients on the 1st June and 156 on 14th June.

3.1.7 The number of adult patients (medical and surgical patients) with a LOS greater than 7 days at the trust was 45 patients less on average per day compared to June 2017. This is 14 fewer patients on average than observed May 2018.

3.1.8 Nationally and regionally A&E delivery has improved since the start of April and the picture is improved from June in the previous year. National performance increased to 90.7% in June 2018 from 90.4% in May 2018 for all attendances. Board members should note these figures also include type 3 A&E attendances (such as minor injuries units) for non-acute providers. Regionally, compliance for the South of England reduced to 90.9% from 92.0% in May, with NHS England South Surrey & Sussex Trusts (excluding WSHFT) generating aggregate compliance of 90.6%.

3.1.9 The publication of national data confirms that WSHFT with 96.6% was the 18th highest performing trust nationally in June 2018 (14th year to date), and the 2nd best performing trust in NHS South. Note that these figures include type 3 attendances for other non-acute providers in the Coastal West Sussex Acute Trust Footprint.

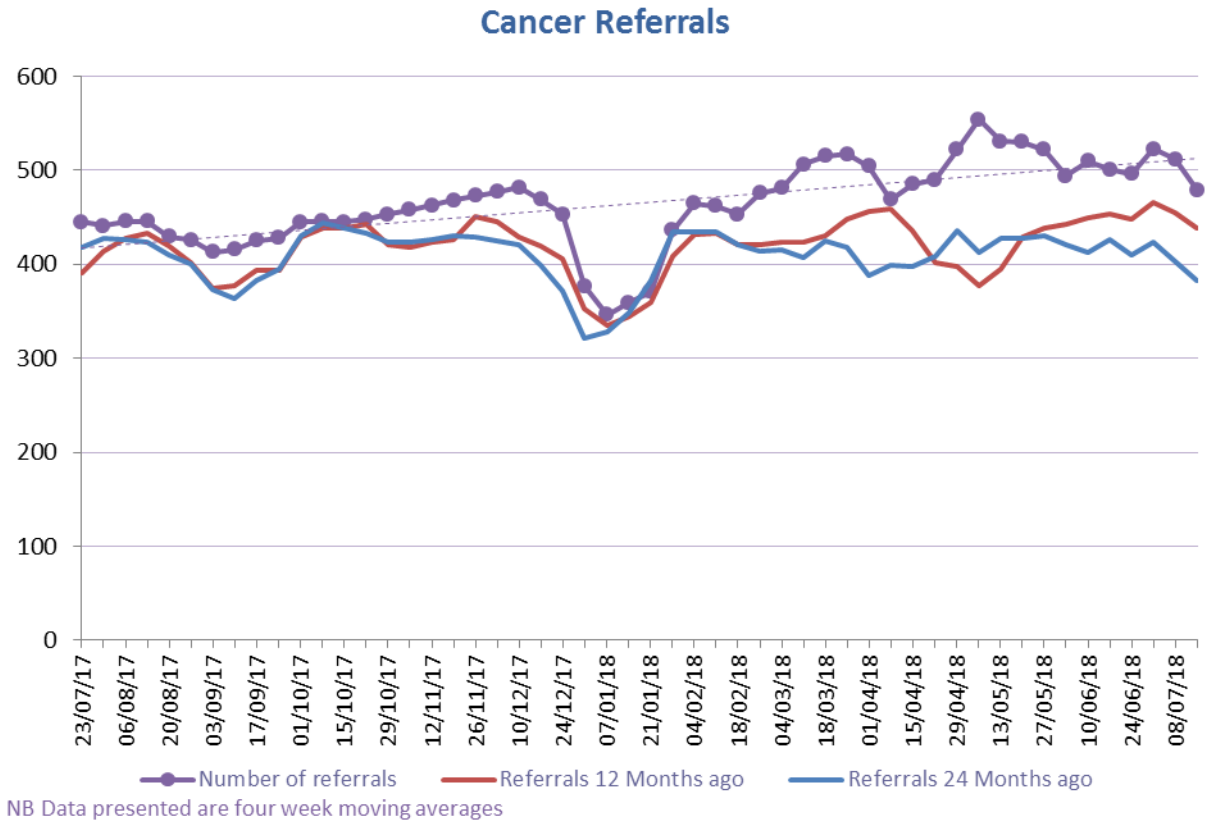
3.1.10 For type 1 attendances only (major A&E Unit activity, including the Trust's Emergency Floor activity), the Trust's performance for June 2018 was 95.4% and was ranked 20th best performing trust and 9th best year to date.

3.1.11 Performance has remained compliant into July, with A&E performance of 95.6% up to the 15th of the month.

3.2 Cancer

3.2.1 For the Single Oversight Framework for June, the Trust was not compliant against the 62 day 2 week rule (76.31%) and screening metrics (84.62%). Of the 7 wider cancer metrics, (including metrics outside of the Single Oversight Framework) the Trust was compliant against the three 31 day decision to treatment metrics. The other cancer metrics the Trust did not meet was the 2 week breast symptomatic target with 65.13% against the target of 93%, and the 2 week rule target which provisionally was 90.54%.

3.2.2 Further to significant referral pressure described in the last performance paper, cancer referrals received in June 2018 were 12.2% higher than in June 2017 and 23.5% higher than June 2016. There has been significant variation by anatomical site, with 28.9% increase in breast cancer referrals, a 34.4% increase in colorectal cancer referrals, and a 24.5% increase in urological cancers. There was also a 19% increase in referrals for skin cancers, relative to the same period the previous year.



3.2.3 As noted in last month's performance paper, the Cancer team with support from clinical divisions has looked to mitigate where possible the impact of this spike in demand, by undertaking additional outpatients, diagnostics and treatments including TRUS, template biopsy and MDT support for urology. Additional clinics, service redesign to free up capacity and additional mammographers are being recruited to support the increase in demand for breast cancer

patients. The Trust is also exploring further options to outsource diagnostics to boost short term capacity further.

3.2.4 Given the scale of demand increase (in April and May in particular), the additional capacity from the actions above did not match the spike in demand. However, the Trust is anticipating an improved position from July 2018 for 2 week performance, and from August for 62 day performance as the treatments associated with the spike in urology demand (April and May) will have commenced treatment.

3.2.5 For context, latest comparative nationally published data relating to May 2018 shows national aggregate compliance for cancer attendance fell to:

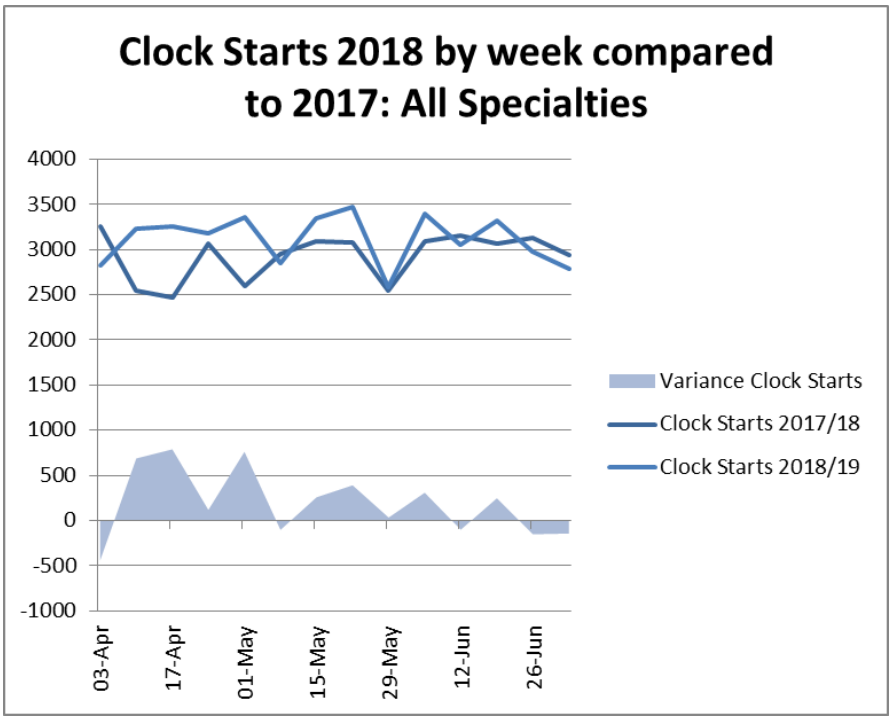
- 81.1% for treatment within 62 days from GP referral (target 85.0%) compared to WSHFT performance of 77.8%. In May 2018, 55% of Trusts receiving GP referrals in England were non-compliant against this standard.

3.3 Referral to Treatment (RTT/18 Weeks)

3.3.1 The Trust was non-compliant against the National Constitutional Target of 92% in May with 83.9% of pathways waiting less than 18 weeks. This is 1.3% deterioration in performance since May (85.2%). Numbers of patients waiting over 18 weeks increased by 457 patients between months.

3.3.2 There were zero patients waiting over 52 weeks at the end June 2018.

3.3.3 The Trust has observed a 7.3% rise in referrals starting RTT clocks in Quarter 1 of 2018 compared to the equivalent time frame in 2017. This equates to an increase of 2775 additional pathways relative to the same time last year. At the same time, the Trust has stopped 5% fewer RTT clocks in quarter 1 2018 compared to Q1 2017. The compound effect of which has meant an increase in the RTT waiting list size (of approximately 3000 since March 2017). The Trust met with Coastal CCG colleagues to discuss steps that can be collectively taken to redress this balance on the 17th July, with particular focus on orthopaedics, urology and cardiology activity. The weekly trend in RTT clock starts 2018 and 2017 is shown below:



3.3.4 As noted last month, the Trust is undertaking recovery actions against the main non-compliant areas. This is in particular for ophthalmology, orthopaedics, cardiology and neurology. The Chief Operating Officer is leading weekly meetings with all divisions to reinvigorate pathway management, booking processes, and clinic and theatre productivity.

3.3.5 The Trust completed 11,004 RTT patient pathways in June 2018.

3.3.6 Latest published national data relates to May 2018 and shows national compliance has slightly increased to 87.7% from 87.5%. Over half (51%) of Trusts were non-compliant in May.

3.3.7 As noted at the May board, the Trust is undertaking a focussed project reviewing patients who are overdue follow up attendances according to the Trust PAS system, to ensure these are reviewed via clinical or electronic triage to validate, prioritise, treat and/or discharge accordingly to improve patient experience. Since March the cohort of 16120 patients Trust wide has reduced by 44% to 9027 13th July and work is ongoing to continue to reduce this cohort.

3.4 Diagnostic Test Waiting Times

3.4.1 The Trust compliance for June was 0.43% over 6 week waiters across all diagnostic modes, which is compliant against the 1% national target. This represents 22 over 6 week waiters of a total list of 5,085 patients.

3.4.2 WSHFT performance compared favourably against regional peers in May (the latest comparable national data); with South of England Region aggregate compliance of 4.6% and National

compliance at 2.7%, compared to WSHFT May performance of 0.98%. Just under half of all Acute Trusts (48.5%) were non-compliant in May 2018.

4 RECOMMENDATION

4.1 The Board is asked to receive the Month 3 position.

4.2 The Board is also asked to note the year to date compliance against the delivery requirements of the Sustainability and Transformation Fund (STF) for A&E, and in month provisional non-compliant position for cancer 62 day performance and RTT.

Jayne Black, Chief Operating Officer

18th July 2018

Mark Dennis, Head of Information Services
t: 01903 285273 (ext 85273)

OPERATIONAL PERFORMANCE SCORECARD

JUNE 2018

		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	2018/19 YTD	2018/19 Target	Trend
NATIONAL AND OPERATIONAL PERFORMANCE TARGETS																	
O01	A&E : Four-hour maximum wait from arrival to admission, transfer or discharge	94.1%	94.2%	95.1%	95.4%	94.1%	92.7%	85.4%	89.5%	92.8%	90.0%	94.6%	96.66%	96.08%	95.81%	95%	
O02	Cancer: 2 week GP referral to 1st outpatient	95.65%	95.92%	96.91%	95.75%	96.71%	96.71%	96.97%	95.94%	96.84%	97.12%	96.49%	96.08%	90.6%	94.45%	93%	
O03	Cancer: 2 week GP referral to 1st outpatient - breast symptoms	98.26%	92.67%	98.73%	99.19%	97.24%	94.87%	96.89%	91.58%	99.32%	95.53%	93.53%	88.04%	65.13%	83.00%	93%	
O04	Cancer: 31 day second or subsequent treatment - surgery	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	100.0%	98.46%	94%	
O05	Cancer: 31 day second or subsequent treatment - drug	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98%	
O06	Cancer: 31 day diagnosis to treatment for all cancers	99.64%	99.65%	100.00%	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	99.6%	100.0%	100.0%	100.0%	100.0%	96%	
O07	Cancer: 62 day referral to treatment from screening	90.91%	98.08%	94.20%	98.15%	94.23%	94.20%	96.00%	85.19%	96.55%	97.62%	90.70%	98.15%	84.62%	91.9%	90%	
O08	Cancer: 62 day referral to treatment from hospital specialist	94.44%	84.62%	68.75%	67.86%	96.15%	92.86%	89.66%	84.00%	96.77%	82.76%	90.91%	89.74%	73.17%	84.1%	N/A	
O09	Cancer: 62 days urgent GP referral to treatment of all cancers	89.33%	86.22%	86.55%	87.74%	88.92%	91.91%	86.29%	88.06%	86.03%	90.56%	88.07%	77.78%	76.22%	80.5%	85%	
O14	RTT - Incomplete - 92% in 18 weeks	90.58%	89.41%	88.95%	88.72%	88.42%	89.02%	87.07%	86.64%	86.36%	85.10%	84.34%	85.17%	83.87%	84.46%	92%	
O15	RTT delivery in all specialties (Incomplete pathways)	8	9	11	10	11	11	12	13	11	12	11	12	13	13	0	
O16	Diagnostic Test Waiting Times	0.92%	1.00%	1.28%	0.99%	0.61%	0.69%	1.31%	0.83%	0.68%	0.97%	0.85%	0.98%	0.43%	0.75%	<1%	
O17	Cancelled operations not re-booked within 28 days	0	1	1	0	1	2	0	3	2	3	8	3	1	12	-	
O18	Urgent operations cancelled for the second time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	
O19	Clinics cancelled with less than 6 weeks notice for annual/study leave	15	71	71	40	26	23	20	44	41	21	22	35	19	379	-	
O20	Mixed Sex Accommodation breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
O33	Delayed transfers of care	3.15%	3.34%	4.32%	4.15%	3.34%	3.47%	2.73%	3.07%	3.14%	2.99%	2.52%	2.66%	3.46%	2.9%	3.0%	
IMPROVING CLINICAL PROCESSES																	
O23	% hip fracture repair within 36 hours	95.3%	89.3%	84.2%	88.2%	88.0%	90.5%	83.3%	96.2%	83.3%	88.1%	70.1%	84.5%	71.4%	75.6%	90%	
O24	Patients that have spent more than 90% of their stay in hospital on a stroke unit[+]	90.9%		92.7%				90.9%	84.3%	84.0%	88.5%	98.0%	81.0%		90.6%	80%	

Mark Dennis, Head of Information Services
t: 01903 285273 (ext 85273)

OPERATIONAL PERFORMANCE SCORECARD

JUNE 2018

		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	2018/19 YTD	2018/19 Target	Trend
OPERATIONAL EFFICIENCY																	
O36	Average length of stay - Elective	3.04	3.07	3.09	2.99	3.35	3.22	3.63	2.95	3.13	3.41	2.97	3.10	2.74	2.94	3.72	
O37	Average length of stay - Non-elective Surgery	5.87	5.34	5.76	5.66	5.29	5.93	5.38	5.80	5.89	5.51	5.91	5.70	5.01	5.54	6.07	
O38	Average length of stay - Non-elective Medicine	7.68	7.88	7.61	7.31	7.82	7.79	7.37	8.03	7.88	7.94	7.73	7.39	7.16	7.42	7.80	
O39	Day case rate (CQC day case basket of procedures) source: Dr Foster (reported 2-3 months in arrears)	88.38%	86.03%	90.80%	89.70%	90.10%	90.00%	91.85%	93.86%	93.40%	91.35%				90.44%	75.0%	
O40	Elective day of surgery rate (DOSR)	98.5%	98.1%	98.2%	98.4%	98.5%	99.1%	98.2%	98.9%	98.9%	96.5%	98.3%	98.5%	98.0%	98.3%	90.0%	
O41	Did not attend rate (outpatients)	6.80%	6.36%	6.36%	6.09%	5.80%	5.72%	6.38%	6.11%	6.32%	6.26%	5.92%	6.16%	6.46%	6.09%	7.65%	
SUSTAINABILITY																	
O43	Bank staff - % of all staff pay	6.92%	7.07%	8.40%	8.99%	7.85%	8.29%	8.12%	7.49%	8.62%	8.46%	8.90%	8.36%	8.69%	8.65%	7%	
O44	Agency staff - % of all staff pay	5.58%	5.03%	4.30%	4.51%	3.84%	5.06%	4.28%	4.30%	3.67%	3.96%	3.79%	4.40%	3.98%	4.06%	2%	
O45	Nurse : occupied bed ratio	1.793	1.785	1.850	1.861	1.805	1.774	1.741	1.690	1.760	1.729	1.768	1.888	1.910	1.855	-	
O46	% nurses who are registered	67.99%	67.78%	67.71%	67.67%	68.40%	68.30%	68.34%	68.49%	68.58%	68.35%	68.25%	68.46%	68.33%	68.35%	-	
O47	% Staff appraised	89.50%	86.80%	89.11%	88.05%	88.37%	88.20%	87.60%	87.70%	87.00%	86.20%	87.32%	86.80%	87.50%	87.50%	90%	
O48	Sickness Absence: % Sickness (reported one month in arrears)	3.27%	3.31%	3.20%	3.77%	3.80%	3.60%	3.80%	4.30%	3.58%	3.68%	3.50%	3.10%		3.30%	3.3%	
O49	Staff Turnover: Turnover rate (YTD position)	8.30%	8.10%	8.14%	8.00%	8.24%	8.20%	7.80%	7.70%	7.40%	7.50%	7.48%	7.80%	7.60%	7.60%	11%	
ACTIVITY																	
A01	Day Cases	4,990	4,707	4,784	4,767	4,900	5,359	4,248	5,056	4,471	4,613	4,602	4,866	4,841	4,602	65,791	
A02	Elective Inpatients	660	633	580	614	548	589	456	362	484	410	405	545	534	405	7,950	
A03	Non-elective inpatients	5,779	5,765	5,544	5,622	5,814	5,827	5,842	6,076	5,387	6,229	5,947	6,110	6,037	5,947	74,930	
A04	Outpatient First attendances	13,731	12,832	12,817	12,859	13,808	13,992	10,732	13,444	11,509	12,483	12,024	13,326	13,112	12,024	181,895	
A05	Outpatient Follow-up attendances	21,719	19,668	20,904	20,796	22,271	23,697	18,067	23,174	19,733	20,969	21,272	23,492	22,859	21,272	277,837	
A06	Outpatients with procedure	6,111	5,333	6,217	6,521	7,287	7,131	5,196	6,612	6,407	5,948	6,098	6,799	6,274	6,098	79,490	
A07	A&E Attendances	11,985	12,531	11,960	11,598	11,734	11,566	11,865	10,648	10,127	11,805	11,770	12,537	12,277	11,770	155,438	

Notes

1 National reporting for these performance measures is on a quarterly basis. Data are subject to change up to the final submission deadline due to ongoing data validation and verification.

2 Data are provisional best estimates and will be amended to reflect the position signed-off in the relevant statutory returns in due course.

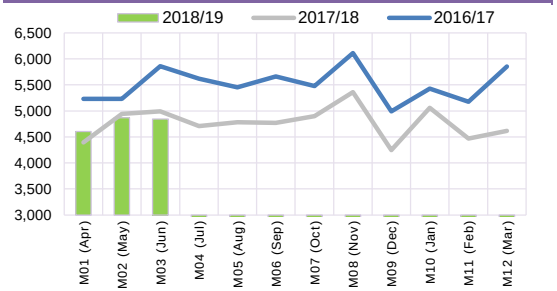
3 Staff sickness is reported one month in arrears.

4 A&E counting kept consistent with 2017/18 LHE reporting January 2018, following NHSE revised guidance to remove non co-terminous MIU activity and EF type 3 attendances from monthly Trust reporting from January (which is then subsequently reallocated back to the LHE)

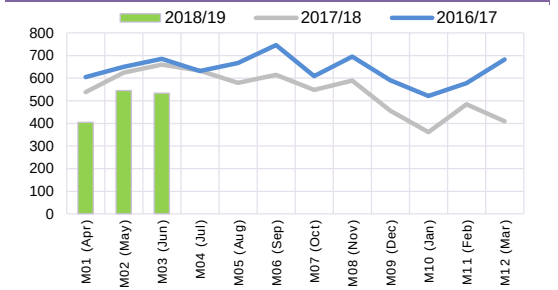
Mark Dennis, Head of Information Services
t: 01903 285273 (ext 85273)

Activity Trends

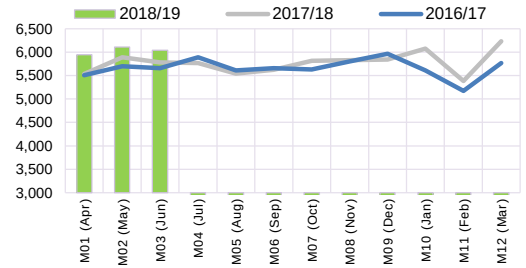
Day Cases



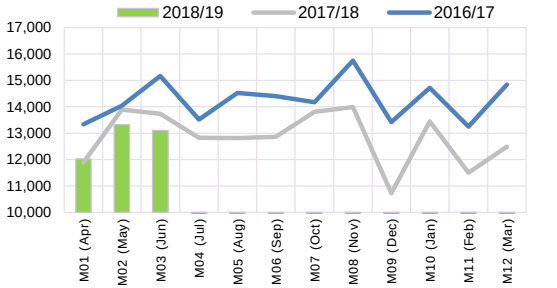
Elective Inpatients



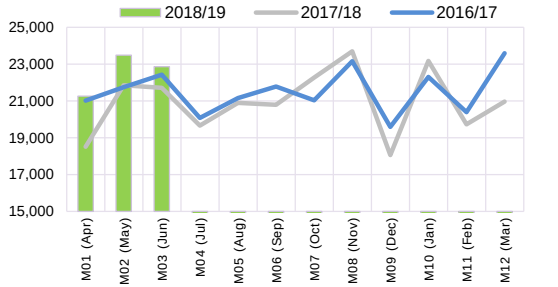
Non-elective Inpatients



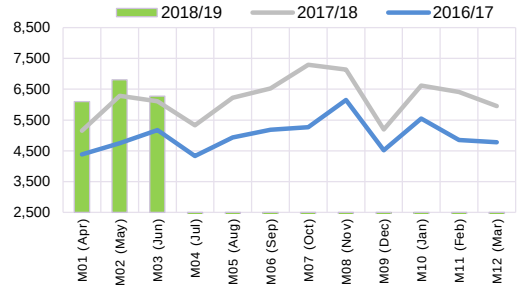
First Outpatients



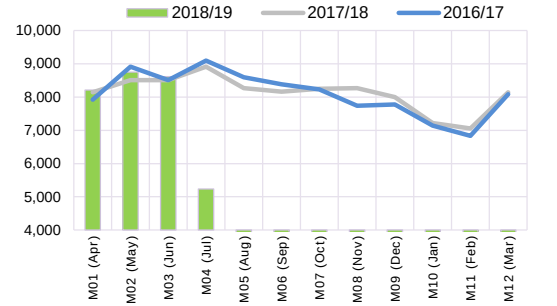
Follow-up Outpatients



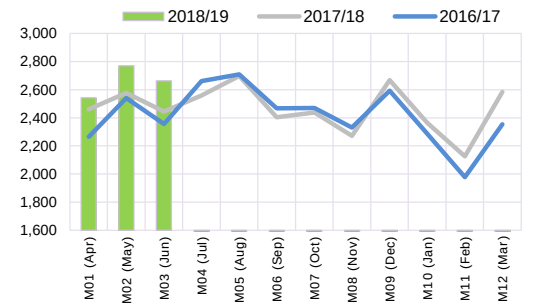
Outpatients with Procedure



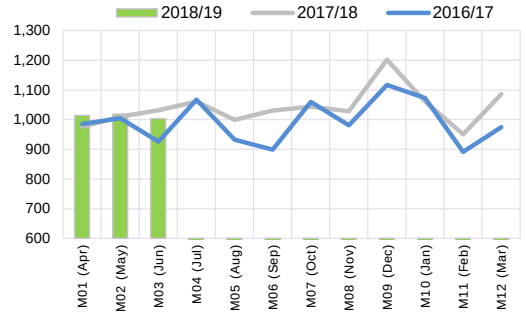
A&E Attendances (age 0-64)



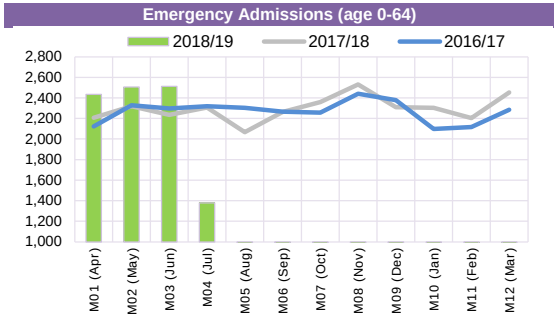
A&E Attendances (age 65-84)



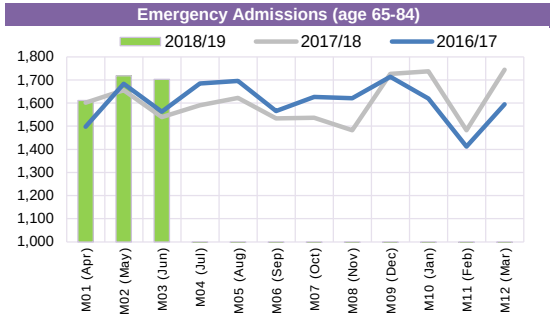
A&E Attendances (age >85)



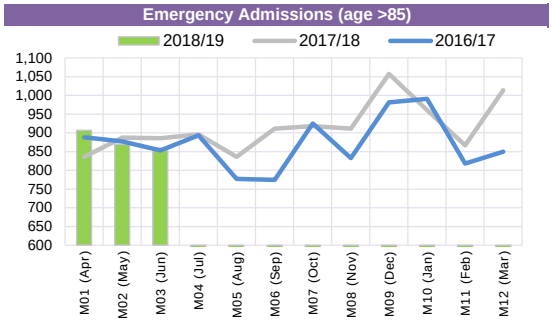
Emergency Admissions (age 0-64)



Emergency Admissions (age 65-84)



Emergency Admissions (age >85)



Mark Dennis, Head of Information Services
t: 01903 285273 (ext 5273)

NHS Improvement Single Oversight Framework

JUN 2018

		Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date	Trend
Operational Performance Metrics																
OP1	A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	94.6%	96.7%	96.1%										95.8%	
OP2	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	84.3%	85.2%	83.9%										88.5%	
OP3A	All cancers : 62-day wait for first treatment following urgent GP Referral	85%	88.1%	77.8%	76.2%										80.5%	
OP3B	All cancers : 62-day wait for first treatment following consultant screening service referral	90%	90.7%	98.2%	84.6%										91.9%	
OP4	Maximum 6-week wait for diagnostic procedures	1%	0.9%	1.0%	0.4%										0.7%	

Notes

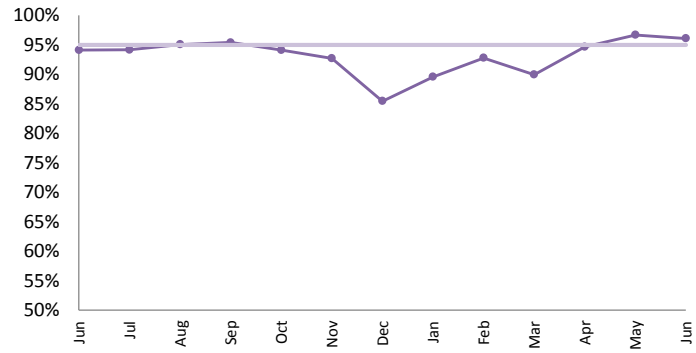
Mark Dennis, Head of Information Services
t: 01903 285273 (ext 85273)

Key Performance Deliverables Report

JUNE 2018

A&E 4-hour waiting time target

Target	Month	YTD	Projected O/T
95%	96.08%	95.68%	>95%



Description / Comments / Actions

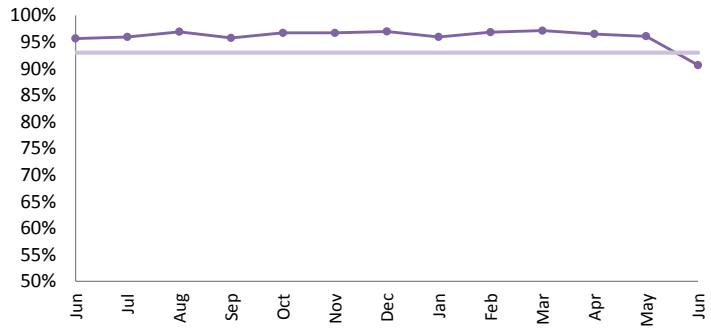
Patients can expect to be admitted, transferred or discharged in 4 hours from arrival in A&E

Sustained increases in underlying demand and acuity. Increased demand challenging ability to maintain hospital/system flow essential to delivery of A&E waiting time.

Actions:
1. Enhanced discharge planning arrangements
2. Augmented patient flow arrangements in conjunction with external partners
3. Dedicated operational delivery review cycle under the leadership of the Chief Operating Officer

Cancer - Two weeks from urgent GP referral to first appointment

Target	Month	YTD	Projected O/T
93.0%	90.62%	95.38%	>93%



Description / Comments / Actions

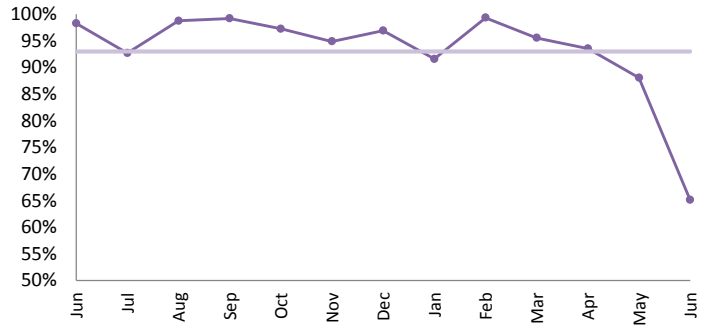
Patients can expect to be seen within 2 weeks following an urgent GP referral for suspected cancer.

Significant and sustained increases in demand level.

Actions:
1. Management/tracking oversight through DDO led Cancer Delivery Group
2. Dedicated weekly review led by Chief Operating Officer

Cancer - Two weeks from urgent GP referral to first appt - Breast symptoms

Target	Month	YTD	Projected O/T
93%	65.13%	90.73%	>93%



Description / Comments / Actions

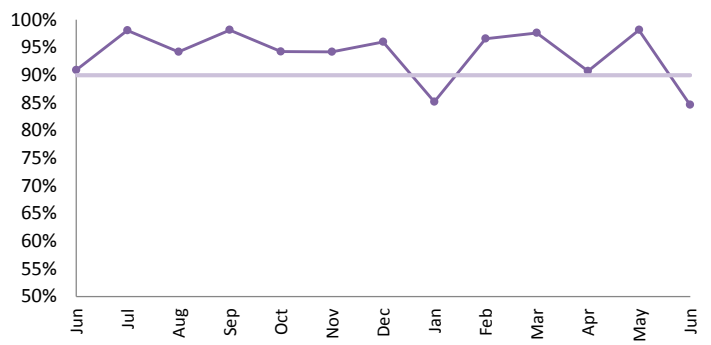
Patients with breast symptoms can expect to be seen within 2 weeks following an urgent GP referral.

Significant and sustained increases in demand level.

Actions:
1. Management/tracking oversight through DDO led Cancer Delivery Group
2. Dedicated weekly review led by Chief Operating Officer

Cancer - 62 days from referral to treatment following screening contact

Target	Month	YTD	Projected O/T
90%	84.62%	94.85%	>90%



Description / Comments / Actions

Patients with cancer can expect to commence treatment within 62 days following referral after a positive screening test.

Delays in receipt of onward referral from screening which reduces the time to secure capacity to treat patients.

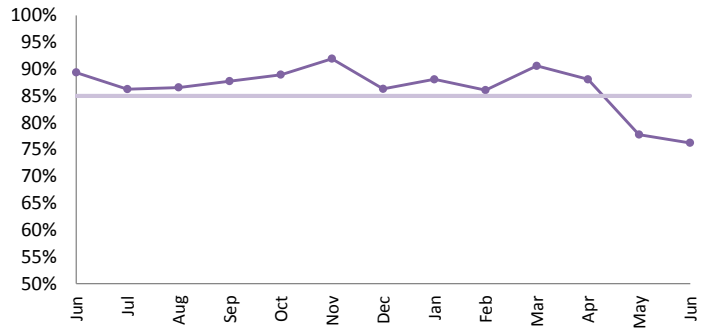
Actions:
1. Management/tracking oversight through DDO led Cancer Delivery Group
2. Dedicated weekly review led by Chief Operating Officer

Key Performance Deliverables Report

JUNE 2018

Cancer - 62 days from referral to treatment following urgent referral by a GP.

Target	Month	YTD	Projected O/T
85%	76.22%	82.17%	>85%



Description / Comments / Actions

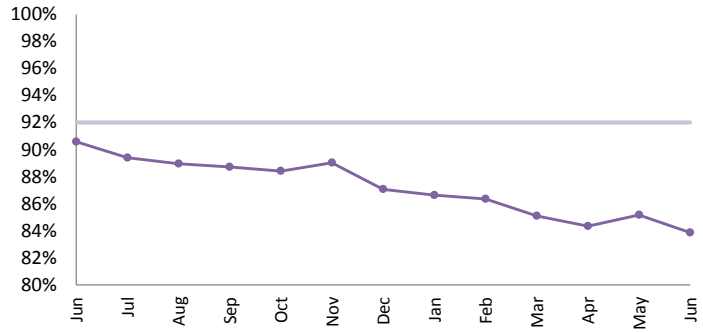
Patients with cancer can expect to commence treatment within 62 days following urgent referral by a GP.

Demand pressure exposing pathway efficiencies. Reduces the time to secure capacity to treat patients.

Actions:
1. Management/tracking oversight through DDO led Cancer Delivery Group
2. Dedicated weekly review led by Chief Operating Officer

Referral to treatment - Incomplete Pathways

Target	Month	YTD	Projected O/T
92.0%	83.87%	84.76%	>90%



Description / Comments / Actions

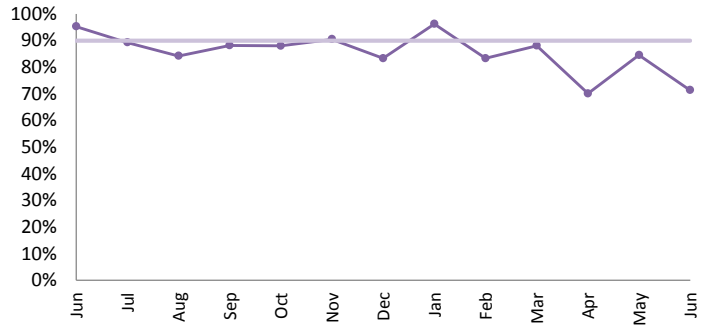
All patients can expect to commence treatment within 18 weeks of a referral to consultant.

Non-compliance an expected outcome of planned RTT recovery programme.

Actions:
1. Increase in internal capacity as per Monitor/NHSE agreed Joint Recovery Plan developed with support from IMAS
2. CCWSCCG commitment to reduced demand levels as supporting component of Joint Recovery Plan.
3. Dedicated weekly Divisional review meeting, with overarching assurance review by Chief Operating Officer (also weekly)
4. System Summit meetings with Monitor/NHSE to ensure partner deliver of agree Joint Recovery Plan actions.

% Medically fit hip fracture patients going to theatre within 36 hours

Target	Month	YTD	Projected O/T
90%	71.40%	77.42%	>90%



Description / Comments / Actions

To ensure the best possible outcomes, hip fracture patients who are medically fit should be operated on within 36 hours of admission. This standard is part of the 'Best Practice Tariff' payment process under PbR.

Increased volume of demand and variation of demand have impacted sustained compliance.

Actions:
1. Improved tracking and escalation processes in place to manage fluctuations in demand on a daily basis
2. Revised protocol introduced based on four key demand based triggers to ensure early escalation/intervention in periods of abnormal demand.

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Board

Date of Meeting: 26 July 2018 Agenda Item: 6.3

Title:
Report on Organisational Development and Workforce performance
Responsible Executive Director
Denise Farmer, Director of OD and Leadership
Prepared by:
Jennie Shore, Human Resources Director
Status:
Disclosable
Summary of Proposal:
This report details the Trust's performance in relation to the supply, development and engagement of its workforce and the organisations culture.
Implications for Quality of Care:
Provision of high quality, engaged staff has a direct impact on the quality of care.
Financial Implications:
Supports good financial performance
Human Resource Implications:
As described
Recommendation
The Board is asked to NOTE the report
Consultation:
n/a
Appendices:
None

This report can be made available in other formats and in other languages. To discuss your requirements please contact the Company Secretary, on 01903 285288.

Western Sussex Hospitals
NHS Foundation Trust

To: Trust Board Date: July 2018

From: Denise Farmer, Chief Workforce and OD Officer Agenda Item: 6.3

FOR INFORMATION

WORKFORCE AND ORGANISATIONAL DEVELOPMENT REPORT

1.00 Introduction

1.01 This sets out the key headlines relating to the Trust's workforce at 30 June 2018.

2.00 Workforce Capacity

2.01 Workforce capacity used fell to 97% of budgeted establishments during June, representing a decrease of 50.6 wte from last month. This includes a net reduction of 31 wte substantive staff in post. There was an adjustment to the establishment to reflect the planned closure of Apuldram Ward at St Richard's Hospital in month. As a result of these changes, the vacancy rate has marginally increased to 11.3%.

2.02 The amount of bank staff used overall remained at similar levels to May and the use of agency staff reduced.

2.03 For the first time in 8 months, overall pay spend in month 3 was £881k favourable. Medical pay remains a particular concern and whilst the level of overspend slowed during June, at the end of Q1 the position was £1m adverse. The use of medical agency has averaged at 46 wte per week in 2018/19 at a cost of £13,200 per month per wte. Vacancies, short term sickness and maternity leave cover continue to drive agency spend, particularly within DoME, general medicine, radiology and paediatrics.

2.04 The Medical Workforce Action Group, led by the Medical Director and Chief Operating Officer, has a number of workstreams in place to address these issues. This includes developing alternative roles, improved recruitment, job planning and e-rostering and digital platforms that support greater bank uptake.

2.05 Again whilst there was a significant reduction in the spend in nursing, pay was £18.9k adverse during June, bringing the position at the end of Q1 to £313k adverse. During June the amount of bank usage increased by 12 wte without a commensurate reduction in agency usage. This resulted in additional expenditure of £51k in month. The majority of this additional cost follows the increasing number of mental health patients being seen in our hospitals because of a lack of specialist beds locally within mental health.

2.06 Plans to manage the changeover of junior doctors, scheduled to take place on 1 August is well advanced. Medical HR and Postgraduate Medical Education teams are working closely to

complete the external recruitment to unfilled vacancies, delivering the induction and ensuring onboarding processes are finalised.

3.00 Workforce Efficiency

3.01 Sickness absence reduced during again in May to 3.1% with the rolling 12 month position remaining at 3.6%. The number of sickness episodes reduced in month and this is reflected in the decrease in short term absence.

3.02 The sickness rates vary across the divisions from 2.2% in the Core division to 4.7% in Estates and Facilities. The focused attention on addressing musculoskeletal (MSK) issues within Estates and Facilities has seen the number of days lost decrease significantly from 354 in October 2017 to 173 in May 2018. This work will continue and the division will now seek to improve stress, anxiety and depression disorders which have seen a rise over the last few months.

3.03 Health and wellbeing continues to be a priority and a business case to extend the current activities together with project management support is being developed.

3.04 Staff turnover reduced to 7.6% in month. .All divisions experienced a decrease in the number of staff leaving the Trust and ranged from 4.7% in the Women and Children Division to 11.8% in the Core Division.

4.00 NHS Terms and Conditions of Service: Contract Refresh 2018

4.01 The NHS Staff Council ratified the new 3 year pay deal in early July and the pay advisory notices have now been issued.

4.02 The 2018/19 pay award will now be applied and staff are scheduled to receive a minimum of 3% cost of living rise in their July pay. Weekly paid staff received the uplift from 13 July. Subject to final confirmation by the ESR provider (IBM), arrears are expected to be paid in August. Any leavers from the Trust between 1 April and 30 June will receive back pay in September.

4.03 The new system of pay progression, linked to performance, will commence from 1 April 2019. Pay progression will no longer be automatic and will be subject to a satisfactory appraisal outcome and up to date statutory and mandatory training compliance.

4.04 The next phase of implementation is the redesign and delivery of appraisal training for managers and staff.

4.05 This 12-18 month project, with implementation overseen by a representative steering group, has been recommended to be a corporate project for 2018/19.

4.06 It is estimated that the cost of the pay deal, which, with the exception of vacancies at 31 March 2018, will be fully funded in 2018/19, will be circa £6m.

5.00 Appraisals

5.01 At the end of June, 87.5% of staff have had an appraisal within the last 12 months. I am pleased to report that for the first time, four out of the six divisions met or exceeded the Trust target of 90%, with one division close at 89.9%. The Medicine Division has seen an improved position in month and still has more work to do.

6.00 Equality and Diversity

6.01 On 14 July, Worthing hosted its first Pride event. The Trust was well represented, with Stuart Fleming, Governor and Chair of the LGBT network, leading the local team. The event, including a seafront procession saw a good turnout and those taking part reported feeling very welcomed by the local community.

The Trust's stand, sponsored by Love Your Hospital charity, received positive attention from participants and attracted a lot of interest in our volunteers' service.

During July, Pride flags have flown at St Richards and Worthing Hospitals to celebrate this year's events.

6.02 The Workforce Race Equality Scheme (WRES) data is due for publication on 31 July. A report, using the same format as BSUH, is being prepared in readiness for approval at the Diversity Matters Group on 30 July. This will be circulated to the Board and will also be uploaded on the Government website.

7.00 Staff Survey

7.01 Preparations for the 2018 National Staff Survey are beginning. It is anticipated that the survey will commence on 1 October and run for 8 weeks, closing in early December.

7.02 We have been advised that some questions will be re-phrased and two new themes will be included. There will be new questions about staff stress at work and staff intention to leave, including destination on leaving.

8.00 Reducing Abusive Behaviours

8.01 An area of concern arising from previous staff survey results has been the number of staff who have experienced violence and aggression and/or harassment and bullying.

8.02 Using the A3 problem solving methodologies, a corporate project to reduce the abusive behaviours experienced by staff has been developed. This has used to engage with a wide range of stakeholders and contributions have been made by chiefs of service, clinical directors, matrons, ward managers, admin and clerical staff, dementia nurses, security and estates staff, manual handling trainers, BME network, practice development and midwives. The level 1 A3 has identified that this problem is multi-faceted and complex.

8.03 The action to address this problem will be the introduction of a Trust-wide campaign. Four focuses of the corporate campaign bannered "It's Not OK" are:

- Promote and market
- Educate and upskill
- Support and care
- Monitor and review

8.04 A steering group to oversee implementation is currently being established with a series of task and finish groups to lead on key workstreams. It is expected that the task and finish groups will develop level 2 A3's.

8.05 Regular updates on the outcomes of the project will be provided to the Board.

9.00 Staff Engagement

9.01 A range of staff engagement events have been undertaken or are being finalised. More details are set out in section 13.01. This includes:

- Hampers to wards and departments to celebrate the NHS 70th birthday
- Thank You lunches planned for the end of August across the three main hospital sites
- Staff conferences during October for over 500 staff
- STARS on 3 October.

9.02 Staff engagement scores collected at the Your Health and Safety days remain high. During June, the overall engagement score was 3.93. It was over 4.00 in the Medicine and Women and Children's divisions. Whilst low within the Estates and Facilities division, it is noted that there is a lot of organisational change within housekeeping and patient catering with a review being undertaken about options for the laundry, which is causing uncertainty for staff. This is reflected in their recommendation as a place to work of 74.2%, compared to the Trust average of 87.5%.

10.00 GMC Survey

10.01 The results of the annual GMC survey have now been published. The survey assesses the training experience and satisfaction of junior doctors across a number of domains including rota design, workload, education and teaching and quality of support.

10.02 There have been real improvements this year, against a national picture which has seen a significant increase in the number of domains flagged red.

10.03 Experience was rated particularly high in anaesthetics at Worthing (rated green in 10 domains) and obstetrics and gynaecology (rated green in 9 domains). Within trauma and orthopaedics at Chichester, experience was less satisfactory (rated red in 3 domains).

10.04 An in depth analysis of each indicator will be undertaken post-changeover next month.

11.00 Statutory and Mandatory Training

11.01 Attendance on eight out of nine of the modules remains above the Trust's target of 90%. Attendance on resuscitation is currently below the Trust's target at 84.2%, but attendance rates are improving and there was an increase of 2% since the previous month. This is mainly due to lower attendance rates for Medical staff and certain patient facing staff in Facilities and Estates (e.g. porters). The Learning and Development team is working with the Medical Director and Director of Estates to develop an action plan to redress this.

11.02 The higher rates of DNAs and late withdrawals on training during the first few months of the year, continues to impact on our overall capacity and led to an increase in demand for training places for Patient Handling training. An additional 30 courses providing 420 additional places

have been organised. This has placed a cost pressure on resources and attendance reinforced with divisions.

11.03 The number of staff who have never completed any training is 15, an increase of 5 since last month. Five of those on the list are medical staff who have joined the Trust in the last 6 months and have not completed their mandatory on-line Induction training. The remaining 10 on the list have now been working in the Trust for at least seven months and have still not completed any mandatory training This has been escalated to Chiefs/ DDOs and we will continue to work with Divisions to ensure that these individuals completed their training as soon as possible.

12.00 Widening Participation

12.01 Apprentice Levy

The Trust's Apprentice Levy contribution for June 2018 was £98k, with the additional 10% government contribution the total amount entering the Apprentice Service (TAS) Account in June was £103.6k.

Payments for apprenticeship qualifications are deducted monthly from the Apprentice Account.

The total spends out of the Levy account for June 2018 was £15.3k with a digital account balance of £1.3m.

Monthly expenditure will increase over the coming months as more staff start their apprentice programmes. It is anticipated that in September up to 6 staff will start on degree apprenticeship programmes and 10 staff will enroll onto the nurse associate apprenticeship.

The Education and Skills Funding Agency are still in the process of developing a forecasting tool; this will enable organisations to accurately predict how they can allocate apprentice Levy funds in the future. It is anticipated that in May/June 2019 unspent Levy funds will be returned to central government. There is still no guidance on how this will be implemented.

A report has been submitted to NHS Improvement outlining the Trust's contributions to the apprentice levy, the amount that has been spent and the issues that are causing delays in allocating/spending the Levy.

The purpose of gathering this information is to:

- Understand the net cost of the apprenticeship levy, to support identification of areas of best practice and provide support to those who are not benefiting as fully as they could.
- Understand anything that is delaying or stopping disposals in the trust or STP so that NHS I can form a definitive list, and use experts and contacts to see how they can support this to be unlocked.

12.02 Apprentice starts

In the last month five new apprentices have started in the Trust, one healthcare support worker and, four business and administration apprentices.

We have eight apprentices who are waiting for start dates and six posts that are in advert/waiting for interview.

12.03 Procurement

The cardiac physiology degree and the healthcare support worker (level 2 and 3) apprenticeships have now been signed off internally and the contracts are in the process of being awarded.

The surgical care practitioner tender closes on the 23 July.

12.04 Work Experience

During July the Widening Participation (WP) team visited Tangmere Primary School for a careers event. This is the first primary school event that the team has attended. The purpose is to raise awareness of the variety of careers in the NHS and to help dispel myths surrounding gender stereotypical roles in the NHS.

The team also took part in the Apprentice Fair at Northbrook Metropolitan College, organised by West Sussex County Council and the National Careers Service. They were accompanied by an Apprentice from the medical imaging department. This event generated a lot of interest regarding apprenticeship and work experience in WSHFT.

Due to an increase in requests for work experience for students less than 16 years of age a decision has been made to revise the age we offer work experience. The Trust will now offer non-clinical work experience to students aged 14 and over. Risk assessments will be updated and the work experience guidelines are in the process of being revised and updated, this includes reviewing the age at which work experience can be completed across all departments in the trust.

This is in line with HEE guidelines for work experience and departments across the Trust have indicated that they are happy to support this.

There have also been 18 adhoc work experience placements over the past month. This includes students on the wards, ICT, medical imaging and the physiotherapy department.

13.0 Strategic Integrated Education & Research

13.01 Developments

Two Nurse Education Fellows in post from 8 May 2018. Funded by HEKSS. Joint PGME/PD appointment. One year posts to look at GMC red flags and drive change where required.

Trust study leave policies (non-medical) to be reviewed following task and finish group report to ensure transparency and consistency. In draft format. Ongoing and to be completed July 2018.

Trust has a career path for nursing which currently gives the opportunities for staff without any academic qualification to progress through academic levels 2,3 and the level 5 Nurse Associate. Further opportunities are being investigated to introduce the registered nurse degree apprenticeship and a business case is currently being presented to TEC to support a further two cohorts of Nurse Associates over the next 12 months.

Trust Leadership Strategy scoping exercise completed. Proposal document presented to DF and JS. Funding (for staff) required to progress further.

Clinical Academic Pathway Programme offering Clinical Improvement Scholar Programme and Senior Clinical Improvement Scholar Programme. Also a PhD in midwifery working with Southampton Uni.

Two posts advertised for combined GP/Trust posts with academic element funded by HEKSS. CCG and Trust collaboration - opportunities for GP trainees at the end of their training scheme who want a portfolio career.

13.02 Challenges

NHS Employers have set up an Employees Reference Group to look at the impact of the changes to the 69 medical specialty curricula and the 32 medical sub specialty curricula. All will change by 2020. GMC to approve all new curricula. Employers responsible for the delivery of curricula.

HEKSS CPD cash and CPD University Funding – confirmed June 2018. 19.7% reduction in CPD cash for 2018/19. Continuing review of CPD allocations to individuals versus funding based on departmental head count.

14.00 Communications, Engagement and Fundraising

14.01 Strategic communications

The communications team has continued to work with colleagues from across the trust to provide support for a number of strategic campaigns and initiatives.

Our People – building staff engagement

- NHS70 “Thank You” hampers – the communications team, with assistance from customer care and ambassador colleagues, arranged for every department to receive “Thank you” hampers containing supplies of tea and coffee, as well as biscuits and healthy eating snacks, funded by charitable means and community support. Trust leaders, ambassadors and governors spent the day hand-delivering many hundreds of cardboard boxes full of goodies, to all clinical and non-clinical teams.

- NHS70 team pictures – hundreds of colleagues turned out for large group photographs taken by the communications team at St Richard’s, Worthing and Southlands hospitals on 5 July to mark the historic occasion of the 70th anniversary of the NHS. The pictures attracted more than 35,000 views + more than 2,000 reactions, comments or shares on Facebook; and more than 6,200 Twitter impressions with nearly 460 engagements.

- NHS70 #WSHT social media campaign – the group pictures were used to crown a #NHS70 social media campaign run by the communications team to celebrate trust staff and highlight service developments over the decades. Our #WSHT “Thank you - you’re amazing” and “Then & Now” social media posts achieved nearly 100,000 views on Facebook and more than 36,500 impressions on Twitter.

- Patient First STAR Awards – following a successful publicity campaign that achieved a record number of nominations this year, the communications team has been

processing more than 600 entries by category for members of the judging panel to deliberate later this month. Preparations are also underway for the celebratory dinner and ceremony taking place on Wednesday 3 October.

- Wellbeing Wednesdays – the regular promotion of Wellbeing Wednesdays continues to improve awareness of the wider staff health & wellbeing programme across the trust. New activities for the first Wednesday of the month include softball in the park and basketball hoop skills.

- Our people "Thank you" lunches – the communications team is playing an active role in the organisation of this year's staff and volunteer free "Thank you" lunches which take place at St Richard's (20 August); Worthing (30 August); and Southlands (31 August). The events are the trust's largest staff engagement event with nearly 4,500 colleagues attending in 2017 when **Wellbeing Wednesdays** were launched and the trust's "Thank you" post cards introduced to the organisation. This year's staff engagement theme will highlight how colleagues feel able to make improvements at Western Sussex Hospitals as part of their daily business.

- Staff conference – the communications team is playing an active role in the staff conference planning group to ensure this year's theme of Patient Experience improves staff engagement and both celebrates successes and prompts colleagues to improve patient experience in line with the trust's new Patient Experience Strategy.

- Social media monitoring – the communications team routinely monitors social media, as well as traditional media, and shares all comments with teams mentioned for them to be shared at team huddles and meetings. The feedback is overwhelmingly positive and gives our hardworking teams a genuine boost when they see how patients or visitors have taken the time to say thank you online or in the media.

- Social media monitoring – more and more teams, specialties and departments are using social media to improve staff engagement, as well as communication with patients, partners and stakeholders. The communications team regularly sets up new accounts and provides advice to colleagues managing trust social media channels. Following new additions this month, the trust has 15 Twitter accounts, 12 Facebook accounts and two Instagram accounts.

14.02 <u>Fundraising</u>

Love Your Hospital, the trust's dedicated charity, continues to raise funds and develop richer ties with the communities we serve in support Western Sussex Hospitals.

Corporate and Community

- A number of local businesses held NHS70 Big7Tea parties in aid of the charity, following a successful campaign.
- Nature's Way supported the Love Your Hospital goody bags handed out to inpatients on the 70th birthday of the NHS.

- A year's sponsorship has been secured for the continuation of *Welcome Home Packs* (containing food items and milk) to help isolated patients settle back home better. *Kardinal Healthcare* is supporting Worthing Hospital and *In Home Care* is supporting St Richard's Hospital.

Marketing

- The charity received a fantastic response throughout the week celebrating the 70th birthday of the NHS, especially following visits from local MPs Gillian Keegan (Chichester) and Tim Loughton (East Worthing and Shoreham), who both helped the charity gift a piece of cake to every inpatient at St Richard's and Worthing on Thursday 5 July. External coverage was secured in the Worthing Herald, Chichester Observer, Chichester Post, along with an interview with the Head of Charity on Spirit FM.

- There is now confirmation that Love Your Hospital will have a 'Staff Fundraiser of the Year Award' category at the Patient First STAR Awards 2018 to recognise staff and volunteers whose fundraising goes above and beyond. This will be a great help in raising awareness of the charity internally.

- As main sponsor, the charity has also confirmed it will be hosting a 'How Charitable Funds Puts the Patient First' workshop at this year's " Where better never stops" Staff Conferences on 11 and 18 October.

Lottery

- Online lottery sign-ups have now reached 122. Onsite recruitment will launch from August. We will continue to monitor sales during 2018/19 to enable benchmarking of the lottery strategy moving forward.

15.00 Recommendation

The Board is asked to NOTE the report.

WSHFT WORKFORCE SCORECARD

June 2018

Key performance Indicators		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	2018/19 YTD	Target/ Ceiling	Amber Limit	Trend
1) WORKFORCE CAPACITY	*NB*																	
Budgeted FTE		6591.3	6609.3	6610.5	6614.8	6619.1	6619.1	6634.6	6634.6	6634.6	6638.1	6741.1	6757.0	6735.4	**6744.5**	N/A	N/A	
Total FTE Used		6632.5	6564.5	6596.5	6560.6	6602.6	6666.4	6597.7	6570.7	6652.4	6669.1	6668.1	6579.4	6528.8	**6592.1**	N/A	N/A	
Total FTE Used Variance from Budget		41.2	-44.8	-14.0	-54.2	-16.5	47.3	-36.9	-63.9	17.8	31.0	-73.0	-177.6	-206.6	**N/A**	N/A	N/A	
Total FTE Used Vacancy Factor		-0.6%	0.7%	0.2%	0.8%	0.2%	-0.7%	0.6%	1.0%	-0.3%	-0.5%	1.1%	2.6%	3.1%	**2.3%**	N/A	N/A	
Substantive Contracted FTE		6029.2	6011.6	6188.9	6046.9	6062.1	6036.5	6040.4	6037.2	6034.8	6049.1	6031.2	6003.9	5972.9	**6002.7**	N/A	N/A	
Substantive FTE Worked		5883.5	5868.5	5888.7	5877.4	5917.9	5922.9	5932.9	5923.9	5939.3	5971.5	5936.8	5900.8	5878.5	**5905.4**	N/A	N/A	
Substantive FTE Used Vacancy Factor		8.5%	9.0%	6.4%	8.6%	8.4%	8.8%	9.0%	9.0%	9.0%	8.9%	10.5%	11.1%	11.3%	**11.0%**	N/A	N/A	
Bank Usage As % Of Total FTE Used		8.6%	8.1%	8.6%	8.4%	8.5%	8.9%	8.4%	7.9%	9.1%	8.8%	9.3%	8.4%	8.4%	**8.7%**	N/A	N/A	
Agency Usage As % Of Total FTE Used		2.7%	2.5%	2.1%	2.1%	1.9%	2.3%	1.7%	1.9%	1.6%	1.7%	1.7%	1.9%	1.6%	**1.7%**	N/A	N/A	
2) WORKFORCE EFFICIENCY	*NB*																	
Rolling 12 Month Sickness Absence	1	3.6%	3.6%	3.5%	3.6%	3.6%	3.5%	3.5%	3.5%	3.5%	3.6%	3.6%	3.6%		**N/A**	3.3%	3.3%	
In Month Sickness Absence %		3.3%	3.3%	3.2%	3.8%	3.8%	3.6%	3.8%	4.3%	3.6%	3.7%	3.5%	3.1%		**3.3%**	3.3%	3.3%	
In Month Maternity Leave %		2.3%	2.4%	2.3%	2.3%	2.4%	2.4%	2.4%	2.4%	2.3%	2.4%	2.4%	2.5%		**2.4%**	N/A	N/A	
In Month Other Absence %		1.7%	1.5%	1.2%	1.8%	1.9%	2.2%	1.5%	1.4%	1.8%	1.7%	1.6%	1.7%		**1.7%**	N/A	N/A	
In Month Total Absence %		7.2%	7.2%	6.7%	7.9%	8.1%	8.2%	7.7%	8.1%	7.8%	7.8%	7.5%	7.3%		**7.4%**	N/A	N/A	
Sickness Episodes		1128	1157	1145	1317	1435	1535	1753	1887	1381	1473	1321	1165		**N/A**			
Maternity Heads		187	199	195	188	196	194	199	198	190	187	195	194		**N/A**	N/A	N/A	
In Month Long Term Sickness Absence % (28 Days Or More)		1.5%	1.5%	1.6%	1.7%	1.7%	1.5%	1.4%	1.3%	1.3%	1.5%	1.5%	1.5%		**1.5%**	N/A	N/A	
In Month Short Term Sickness Absence % (<28 days)		1.8%	1.8%	1.6%	2.1%	2.0%	2.2%	2.5%	3.0%	2.3%	2.2%	2.0%	1.6%		**1.8%**	N/A	N/A	
In Month Stress Related Sickness Absence %		0.7%	0.6%	0.6%	0.8%	0.8%	0.7%	0.7%	0.6%	0.7%	0.6%	0.7%	0.6%		**0.7%**	N/A	N/A	
In Month Musculo Skeletal Sickness Absence %		0.7%	0.7%	0.7%	0.7%	0.7%	0.6%	0.7%	0.7%	0.7%	0.8%	0.7%	0.7%		**0.7%**	N/A	N/A	
Number of Staff breaching Management Triggers for sickness absence		1037	1020	998	995	1009	1016	1026	1047	1028	1029	1032	1030		**N/A**			
% of Staff (headcount)		14.7%	14.5%	14.2%	14.1%	14.3%	14.4%	14.5%	14.8%	14.6%	14.6%	14.7%	14.7%		**N/A**			
Rolling 12 Month Turnover		8.3%	8.1%	8.1%	8.0%	8.2%	8.2%	7.8%	7.7%	7.4%	7.5%	7.5%	7.8%	7.6%	**N/A**	8.5%	8.5%	
3) TRAINING & PERSONAL DEVELOPMENT	*NB*																	
% Appraisals Up To Date		89.5%	86.8%	89.1%	88.1%	88.4%	88.2%	87.6%	87.7%	87.0%	86.2%	87.3%	86.8%	87.5%	**N/A**	90.0%	80.0%	
% In Date - Fire		92.6%	89.9%	92.2%	92.2%	92.4%	93.0%	92.3%	93.0%	93.4%	93.7%	94.6%	94.4%	94.0%	**N/A**	90.0%	80.0%	
% In Date - Infection Control (Role Specific)		90.6%	88.2%	90.9%	90.8%	90.8%	91.9%	91.4%	92.2%	92.3%	92.0%	93.1%	92.8%	92.8%	**N/A**	90.0%	80.0%	
% In Date - Back Training (Role Specific)		93.1%	91.6%	92.3%	92.0%	92.4%	93.8%	93.7%	94.1%	94.1%	94.2%	94.4%	94.1%	94.0%	**N/A**	90.0%	80.0%	
% In Date - Child Protection (Role Specific)		97.4%	96.0%	96.5%	96.7%	96.9%	97.7%	97.7%	98.0%	98.0%	98.2%	98.1%	97.8%	97.6%	**N/A**	90.0%	80.0%	
% In Date - Information Governance		90.6%	89.0%	91.1%	91.3%	91.1%	91.9%	91.2%	92.2%	92.1%	91.8%	93.0%	92.8%	92.3%	**N/A**	90.0%	80.0%	
% In Date - Adult Protection		96.5%	94.7%	95.3%	95.3%	95.4%	96.9%	96.9%	96.7%	96.4%	96.1%	95.7%	95.0%	93.8%	**N/A**	90.0%	80.0%	
% in Date - Equality & Diversity		84.5%	88.2%	89.5%	90.1%	90.7%	92.3%	92.9%	94.7%	95.0%	95.5%	96.4%	96.7%	96.8%	**N/A**	90.0%	80.0%	
% in Date - Health & Safety		94.8%	90.2%	90.8%	90.4%	90.4%	91.2%	91.0%	91.0%	91.2%	91.2%	91.3%	91.2%	91.2%	**N/A**	90.0%	80.0%	
% in Date - Resus		81.3%	78.5%	80.9%	80.3%	80.6%	81.4%	82.6%	81.3%	81.4%	81.4%	82.1%	82.2%	84.2%	**N/A**	90.0%	80.0%	
Number of Staff with no mandatory training		6	8	5	4	5	5	3	3	3	11	8	10	15	**N/A**			
Number of Staff > 12 months since any mandatory training		0	0	0	0	0	0	0	0	0	0	0	0	0	**N/A**			
4) REAL-TIME STAFF FEEDBACK	*NB*																	
Total Respondents To Survey		386	258	212	300	257	276	239	170	204	288	309	269	330	**908**	N/A	N/A	
% Respondents who would recommend this trust as a place to work		84.9%	83.1%	82.5%	84.3%	86.4%	89.8%	85.3%	84.0%	87.7%	85.9%	87.4%	87.3%	87.5%	**87.4%**	N/A	N/A	
% Respondents happy with standard of care if a friend/relative needed treatment		91.5%	91.6%	92.7%	91.2%	90.8%	94.7%	91.5%	91.1%	93.1%	95.4%	93.9%	92.5%	92.2%	**92.9%**	N/A	N/A	
Overall Staff Engagement Composite Score	3	3.98	3.89	3.93	3.88	3.94	3.91	3.91	3.87	3.85	3.93	3.93	4.00	3.93	**N/A**	4.02	3.78	

Notes:

1 Absence data is available one month in arrears.

3 Overall indicator for staff engagement is a composite score using 3 key finding questions, friend and family recommendation, motivation and making improvements.

3 WSHT Total Respondents To Survey is greater than the sum of the divisional Total Respondents To Survey as some staff did not select a division when completing the survey.

3 Baseline Data from 2016 Staff Survey, Overall Staff Engagement Score - 3.88

Western Sussex Hospitals
NHS Foundation Trust

To: Trust Board

Date of Meeting: 26th July 2018 Agenda Item: 6.4

Title
Financial Performance - June 2018
Presented by
Karen Geoghegan, Chief Financial Officer
Prepared by
Alison Ingoe, Finance Director; Karen Seabridge, Assistant Director of Finance
Status
Confidential
Summary of Proposal
The Trust reported a deficit of £0.82m, excluding PSF income; against a planned deficit of £0.88m, thereby achieving the Q1 control total. Delivery of the financial control total alongside the A&E waiting time trajectory means the Trust is eligible to receive £2.4m of income from the Provider Sustainability Fund for Q1. The Trust is reporting an FSRR rating of '1'. The Financial Performance paper provides further detail on the Trust's financial position.
Implications for Quality of Care
Financial planning principles have been established to ensure that expenditure budgets reflect anticipated activity levels and that agreed staffing levels are maintained.
Support for/integration with Corporate Objectives and Strategies
G1. Maintain an acceptable financial risk rating
Financial Implications
These are noted within the Financial Performance Report
Human Resource Implications
N/A
Recommendation
The Board is asked to NOTE the Financial Performance Report for June 2018.
Consultation
N/A
Appendices
Financial Performance Report

Finance Report M3 2018/19

Western Sussex Hospitals NHS Foundation Trust

Summary

The Trust reported a deficit of £0.82m, excluding PSF income; against a planned deficit of £0.88m, thereby achieving the Q1 control total. Delivery of the financial control total alongside the A&E waiting time trajectory means the Trust is eligible to receive £2.4m of income from the Provider Sustainability Fund for Q1. The Trust is reporting an FSRR rating of '1'.

SOF Finance Rating — G

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

The Trust is reporting an FSRR rating of '1', in line with the planned position for Q1.

Control Total (exc PSF) Surplus £k — G

	Plan	Actual / Forecast
Year to Date £k	(884)	(822)
Year End Forecast £k	1,185	1,185

At the end of June the Trust achieved its Q1 control total and will be eligible to receive £2.4m PSF funding. Elective activity has decreased in comparison to May, however, there were also reductions in the underlying pay and non pay positions.

Premium Pay Spend £k — G

	Plan	Actual
Agency Ceiling (YTD) £k	4,210	2,906
WLI Payments (YTD) £k	443	497
Total Premium Pay (YTD) £k	4,653	3,403

Premium pay expenditure has continued at a similar run rate in month and is £1.25m below the target. Waiting List payments reduced marginally in comparison to May but remain above target. Agency expenditure reduced in Nursing and AHP staff but this was offset by increases in Medical staff.

Income £k — G

	Plan	Actual / Forecast
Year to Date £k	107,854	108,721
Year End Forecast	434,417	434,417

Cumulatively income is £0.9m ahead of plan. Non-elective admissions and A&E attendances have increased again in June. Elective activity and outpatient services have decreased and continue to be behind plan. Private patient income has increased in June, but remains behind plan year to date.

Operating Costs £k — R

	Plan	Actual / Forecast
Year to Date £k	(102,831)	(103,734)
Year End Forecast £k	(409,601)	(409,601)

Medical and Nursing staffing remain above plan cumulatively, but in comparison to May the underlying pay position reduced by £0.6m in aggregate accross the staff groups. This is as a consequence of reducing bed capacity in line with seasonal expectation. Non Pay remains above plan with clinical supplies and services costs remaining the key pressure.

Agency Ceiling £k — G

	Plan	Actual/Forecast
Year to Date £k	4,210	2,906
Year End Forecast £k	14,969	18,234

In aggregate agency expenditure reduced compared to May and cumulative expenditure is £1.3m below the ceiling target. For a subsequent month medical agency usage has increased which has been offset by a reduction in nursing and AHP agency expenditure.

Cash £k — A

	Plan	Actual
Year to Date £k	1,276	5,002
Year End Forecast £k	16,974	16,974

At the end of June the cash position is ahead of plan by £3.7m. This is primarily due to timimg of capital expenditure and a favourable movement in working capital driven by settlement of aged debt.

Capital £k — A

	Plan	Actual / Forecast
Year to Date £k	2,311	1,752
Year End Forecast £k	17,145	17,145

At the end of May, capital expenditure totalled £1.7m. Expenditure is £0.6m lower than plan due to later starts on some projects. Total expenditure in year is forecast to be on plan.

Efficiency and Transformation Programme £k — A

	Plan	Actual / Forecast
Year to Date £k	3,831	3,873
Year End Forecast £k	18,235	18,066

Year-to-date savings of £3.87m have been achieved against a plan of £3.83m. The FOT is £0.2m adverse to plan, reflecting expected shortfalls in Car Parking income and Pharmacy schemes.

Key Risks:

1. The Trust has agreed 2018/19 activity and income on an aligned incentives (AIC) basis with its main commissioner, Coastal West Sussex CCG. Although the AIC approach has improved joint working between the Trust and CWS CCG, this is still in its early stages and governance arrangements are not yet fully embedded. The ability to progress and resolve issues remains a risk.
2. Reducing premium staffing costs remains a significant challenge. Although the Trust has seen some successes in reducing agency expenditure within nursing, in other areas costs have increased, predominantly within medical staff. A medical workforce action group with Director leadership has been established to provide oversight and focus in this area.
3. The financial plan for 2018/19 and reported performance are based on an assumed 1% pay uplift. A national pay award, which proposes increases in excess of this, is currently being consulted upon. Any increased pay award is expected to fully funded centrally and therefore should not impact on the Trust's financial performance. The Trust has established a working group to oversee the implementation of contract changes and to monitor and manage any financial impact.
4. Alignment of capacity to non-elective and elective activity levels and responsiveness to changes in levels of demand. Close management of capacity and flow will be required.

Finance Report M3 2018/19 — SOF Finance Rating — G

At the end of June, the finance rating is a '1'. The Capital Service Capacity, I&E Maring and Distance from Financial Plan metrics went from '3' in May to '1' in June which has resulted in the overall rating having risen from a '2' to a '1'.

YTD	Plan Metric	Plan Rating	Actual Metric	Actual Rating
Capital Service Capacity	2.6	1	2.7	1
Liquidity	(2.5)	2	(3.6)	2
I&E Margin	2.1%	1	2.2%	1
Distance from Financial Plan	0.0%	1	0.1%	1
Agency Spend	(28.2)%	1	(30.6)%	1
2018/19 Finance Rating		**1**		**1**

Area	Metric	Construction	Rating 1 (best)	2	3	4 (worst)	Weighting
Financial Sustainability	Capital Service Capacity	Revenue available for capital service / Annual debt service	2.5x	1.75x	1.25x	<1.25x	20%
	Liquidity Days	Working capital balance x 360 / Annual operating expenses	0.0	(7.0)	(14.0)	<(14.0)	20%
Financial Efficiency	I&E Margin	I&E Surplus or deficit / Total Operating and Non Op Income	1%	0%	(1)%	≤(1)%	20%
Financial Controls	Distance from Financial Plan	YTD Actual I&E Surplus/Deficit - YTD Planned I&E Surplus/Deficit / YTD Planned I&E Surplus/Deficit	0%	(1)%	(2)%	≤(2)%	20%
	Agency Ceiling	YTD Actual Agency Ceiling - YTD Planned Agency Ceiling / YTD Planned Agency Ceiling	0%	25%	50%	≥50%	20%

Finance Report M3 2018/19 — Surplus — G

The Trust achieved the Q1 control total, reporting a deficit of £0.82m, excluding PSF income; against a planned deficit of £0.88m. Delivery of the financial control total alongside the A&E waiting time trajectory means the Trust is eligible to receive £2.4m of income from the Provider Sustainability Fund.

	Year To Date		
	Plan	Actual	Variance
	£k	£k	£k
Underlying Surplus (Deficit) excluding PSF	**(884)**	**(822)**	**62**
add Provider Sustainability Fund	2,438	2,438	-
Performance against Control Total including PSF	**1,553**	**1,615**	**62**

	Year Forecast		
	Plan	Forecast	Variance
	£k	£k	£k
Underlying Surplus (Deficit) excluding PSF	**1,185**	**1,185**	**0**
add Provider Sustainability Fund	**16,252**	**16,252**	-
Performance against Control Total including PSF	**17,437**	**17,437**	**0**

Income is £1.7m above plan in aggregate. A&E attendances and admissions increased in June but elective activity continued at a similar level to May and remains behind plan.

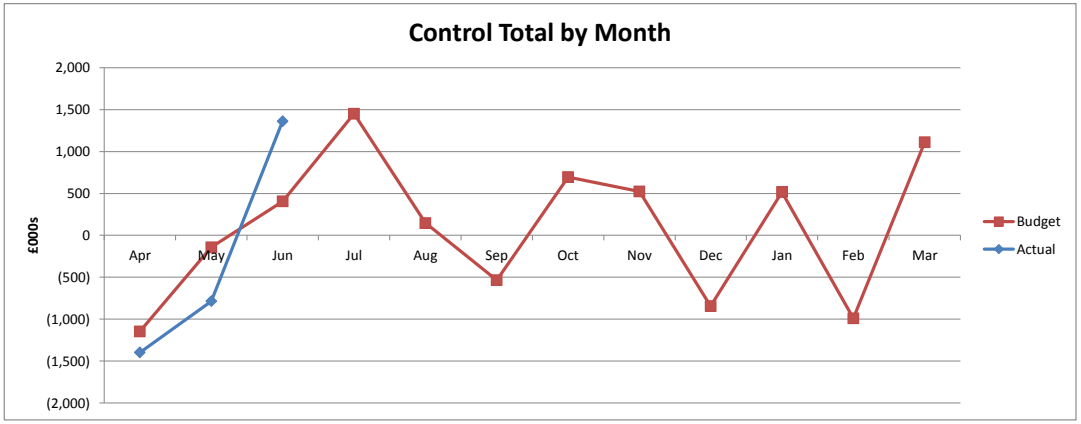
The underlying pay expenditure decreased in June by £0.6m but Medical and Nursing expenditure continues to be above plan cumulatively. Substantive and Locum medical expenditure both decreased but this reduction was partially mitigated by increased agency expenditure. Nursing expenditure decreased by £0.3m in month with all both substantive and temporary costs reducing. All other staff remain close to plan levels with vacancies continuing to be held where possible in non clinical areas which partially mitigates the pressure in clinical areas.

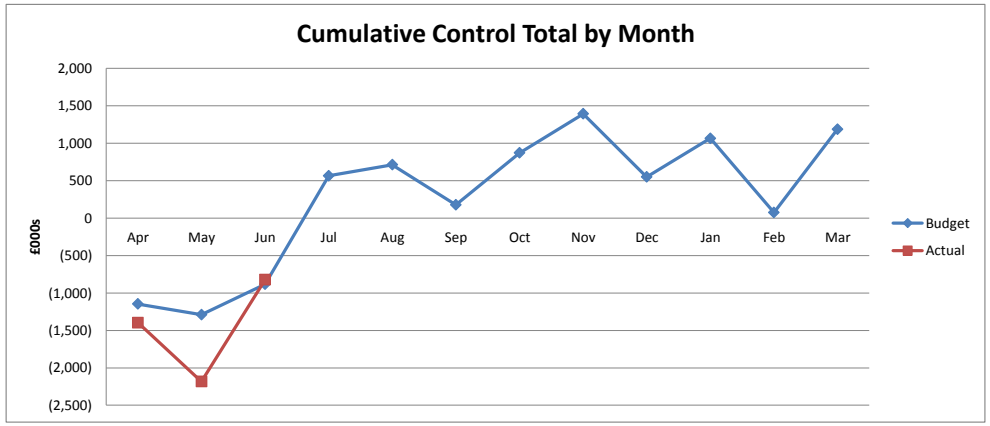
Non pay expenditure decreased by £0.5m in comparison to May with clinical supplies and services showing the largest reduction. PbR exclusions increased by £0.08m, the costs of which are matched with income. The clinical supplies and services expenditure reductions were predominantly linked to activity with a decrease being seen in pathology consumables and prosthetics costs following Trauma and Orthopaedic activity reducing in comparison to the levels delivered in May.

	Year to Date			
	Prev Yr Actual	Plan	Actual	Variance
	£k	£k	£k	£k
Income	*106,696*	107,854	108,721	867
Pay	*(70,720)*	(72,074)	(71,814)	260
Non-Pay (tariff)	(22,259)	(23,081)	(23,754)	(673)
Non-Pay (PbR exc)	(7,667)	(7,676)	(8,166)	(490)
EBITDA *	***6,050***	**5,023**	**4,987**	**(37)**
Profit / Loss on Disposal of Fixed Assets	*(0)*	-	0	0
Interest Payable	*(226)*	(146)	(136)	10
Interest Receivable	*5*	6	13	7
Depreciation	*(3,123)*	(3,658)	(3,658)	0
Impairments	-	-	-	-
Public Dividend Capital Dividend	*(1,947)*	(2,106)	(2,110)	(3)
Net Surplus / (Deficit)	***759***	**(881)**	**(904)**	**(23)**
less: Impairment	-	-	-	-
Retained Surplus/(Deficit)	**759**	**(881)**	**(904)**	**(23)**
Donated Assets	*(249)*	(234)	(116)	118
Donated Asset Depreciation and Amortisation	*230*	231	198	(32)
less Profit/Loss on Disposal of Fixed Assets	*0*	-	(0)	(0)
Control Total excluding PSF	**741**	**(884)**	**(822)**	62
add Provider Sustainability Fund	1,734	2,438	2,438	-
Control Total including PSF	**2,475**	**1,553**	**1,615**	**62**

* EBITDA Earnings before Interest Taxation Depreciation and Amortisation

	Full Year		
	Plan	Actual	Variance
	£k	£k	£k
Income	434,417	434,417	(0)
Pay	(287,602)	(288,160)	(557)
Non-Pay (tariff)	(91,148)	(90,326)	823
Non-Pay (PbR exc)	(30,851)	(31,116)	(265)
EBITDA *	**24,816**	**24,816**	**0**
Profit / Loss on Disposal of Fixed Assets	-	0	0
Interest Payable	(586)	(586)	-
Interest Receivable	24	24	-
Depreciation	(14,630)	(14,630)	-
Impairments	-	-	-
Public Dividend Capital Dividend	(8,425)	(8,425)	-
Net Surplus / (Deficit)	**1,199**	**1,199**	**0**
less: Impairment	-	-	-
Retained Surplus/(Deficit)	**1,199**	**1,199**	**0**
Donated Assets	(937)	(937)	-
Donated Asset Depreciation and Amortisation	923	923	-
less Profit/Loss on Disposal of Fixed Assets	-	(0)	(0)
Control Total excluding PSF	**1,185**	**1,185**	0
add Provider Sustainability Fund	16,252	16,252	-
Control Total including PSF	**17,437**	**17,437**	**0**





Finance Report M3 2018/19 — Provider Sustainability Fund — G

At the end of Q1, the Trust met its quarterly financial control trajectory.

Cumulative performance against the the A&E waiting time target at the end of Q1 has been met and is above both the constitutional target and the cumulative PSF trajectory.

			Actual YTD Apr-17	Actual YTD May-17	Actual YTD Jun-17	Q1	Q2	Q3	Q4	2017/18
	Plan	£000s	(1,147)	(1,290)	(884)	**(884)**	**177**	**549**	**1,185**	1,185
Financial Control Total (exc PSF)	Actual	£000s	(1,398)	(2,172)	(822)	**(822)**	**0**	**0**	**0**	0
Eligible for PSF Funding										
PSF Income Available		£000s	813	1,626	2,438	**2,438**	**5,688**	**10,564**	**16,252**	16,252
Delivery of Financial Control Total	Achieved?		No	No	Yes					
	Income	70.0%	0	0	1,707	**1,707**	**3,982**	**7,395**	**11,376**	11,376
A&E Waiting Times	Achieved?		Yes	Yes	Yes					
	Income	30.0%	244	488	731	**731**	1,706	3,169	4,876	4,876
RTT	Achieved?		No	No	No					
	Income	0.0%				**0**				0
Cancer	Achieved?		Yes	No	No					
	Income	0.0%				**0**				0
Total PSF Income Achieved (£000s)			**0**	**0**	**2,438**	**2,438**	**0**	**0**	**0**	**0**

Finance Report M3 2018/19 — Income — G

Income is £0.9m ahead of plan year to date. Overperformance in income from activities is counter-balanced by underperformance in the services grouped within the other operating income, particularly private patient services.

Year To Date

	Prev Yr. Actual £k	Plan £k	Actual £k	Variance £k
Total Income	**106,696**	**107,854**	**108,721**	**867**

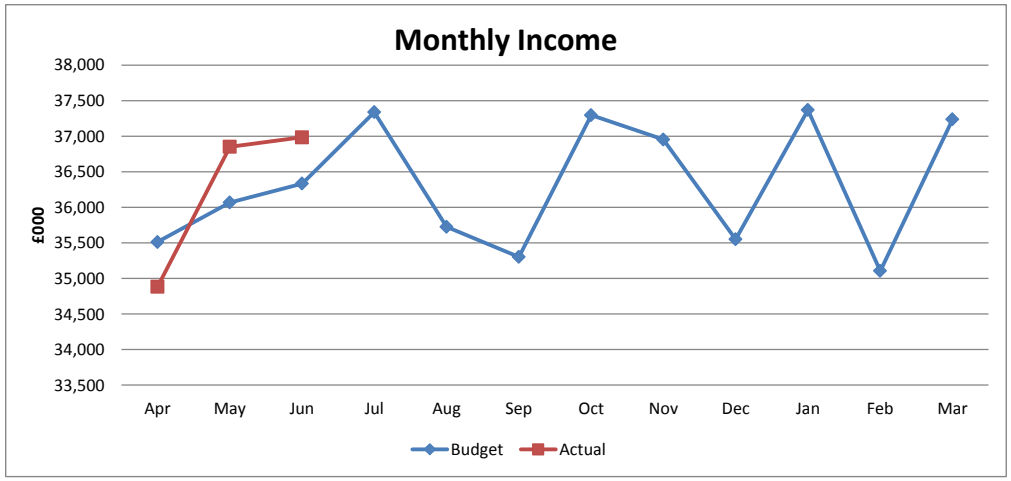
Year End Forecast

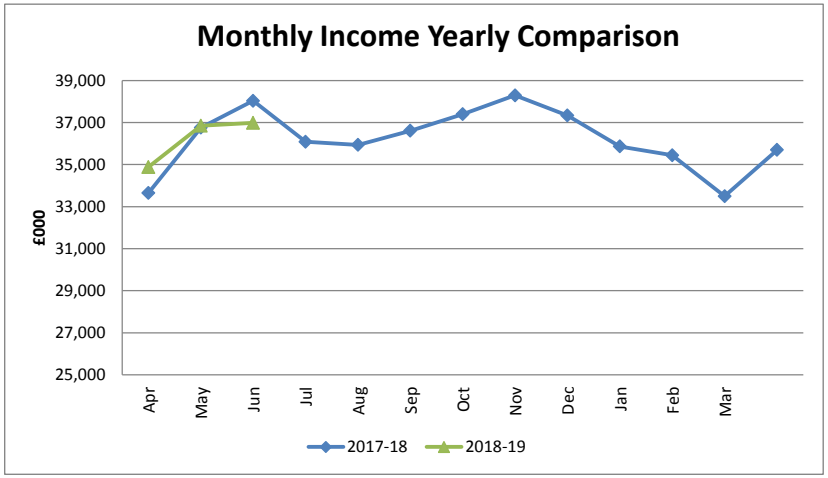
	Plan £k	Actual £k	Variance £k
Total Income	**434,417**	**434,417**	**0**

At the end of June, income from activites is overperforming by £1.6m year to date. Non-elective activity and income levels per calender day have increased again in June as have the number of patients coming to the Trust's A&E departments on both sites. Elective activity has decreased in June and activity levels remain behind plan.

Private patient income has increased in June although continues to be behind plan year to date. Donated asset income also remains behind plan, however this is excluded from the calculation of the control total.

	Year to Date				Full Year		
Income	***Prev Yr Actual £k***	**Plan £k**	**Actual £k**	**Variance £k**	**Plan £k**	**Actual £k**	**Variance £k**
Coastal West Sussex	*76,231*	78,453	79,145	692	315,981	315,981	0
Other Clinical Commissioning Groups	*4,808*	4,823	4,976	153	20,337	20,337	0
Specialist LAT	*11,383*	11,762	12,173	411	47,048	47,048	0
WSCC - Sexual Health	*1,322*	1,340	1,273	(67)	5,420	5,420	0
NCA	*1,300*	593	1,360	768	3,774	3,774	0
Other Trust Income	*1,011*	(12)	(286)	(274)	(54)	(54)	0
Income From Activities	***96,055***	***96,958***	***98,641***	***1,683***	**392,506**	**392,506**	**0**
Private Patients	*1,634*	2,166	1,665	(501)	7,082	7,082	0
Education, Training and Research	*2,409*	3,688	3,552	(136)	14,752	14,752	0
Donated Asset / Grant Income	*125*	234	116	(118)	937	937	0
Other Income (exc PSF)	*6,473*	4,808	4,746	(61)	19,140	19,140	0
Other Operating Income	***10,641***	***10,896***	***10,080***	***(816)***	**41,911**	**41,911**	**0**
Total Income	**106,696**	**107,854**	**108,721**	**867**	**434,417**	**434,417**	**0**
Sustainability and Transformation Funding (PSF)	*1,734*	2,438	2,438	0	16,252	16,252	0
Total Income including PSF	**108,430**	**110,292**	**111,158**	**867**	***450,669***	**450,669**	**0**
of which : PbR Drugs/Devices	*7,667*	*7,676*	*8,166*	*490*			





Finance Report M3 2018/19 — Contract Performance — G

The Trust reports income based on the contract monitoring position for prior months and an estimate of income for the current month based on priced and coded activity in the month as available. An estimate is made for the value of uncoded spells and missing days and included within the reported income position.

1) Context

The Trust signed two-year contracts with all of its major commissioners in 2017/18. The Trust has agreed contract envelopes for 2018/19 with its major commissioners that are in line with the anticipated values in the financial plan.

2) YTD Report

Trust internal monitoring information shows underperformance against the Trust's main CCG contract.
It is important to note that the performance indicated is compared to the Trust's plan and does not necessarily reflect the over-performance against commissioner contracts.

Table 1. Total Financial Values by Contract

	Estimated Values YTD (inc CQUIN) £'000			
	FYE Plan	YTD Plan	YTD Actual	YTD Var
Coastal West Sussex	315,981	78,453	79,145	692
Other CCG Acute contracts	20,337	4,823	4,976	153
NHS England	47,048	11,762	12,173	411
Integrated Sexual Health Services	5,420	1,340	1,273	(67)
Non Contract Activity	3,774	593	1,360	768
Total	**392,560**	**96,971**	**98,927**	**1,956**

NB: Variances are reported against Western Sussex Hospitals Planned Income Levels

Table 2. Activity and Income by Point of Delivery

	Activity Volumes			£'000		
Point of Delivery	YTD Plan	YTD Actual	YTD Var	YTD Plan	YTD Actual	YTD Var
Daycases	14,721	14,305	(416)	9,283	9,137	(145)
Elective Spells	1,813	1,484	(329)	6,119	5,193	(927)
Elective Excess Bed days	242	128	(114)	61	32	(30)
Non Elective Spells	14,017	14,365	348	31,095	32,510	1,415
Non Elective short-stay	3,254	3,725	471	2,439	2,871	432
Non Elective Excess Bed days	3,836	3,481	(355)	959	924	(35)
Outpatients	153,969	150,700	(3,269)	16,085	15,646	(439)
A&E	35,813	36,584	771	4,647	4,940	293
PbR exclusions				7,676	8,166	490
Critical Care				3,315	3,195	(120)
Maternity Pathway				2,618	2,632	14
OP Diagnostic Imaging				1,906	1,955	49
Sexual Health				1,307	1,273	(34)
Direct Access Pathology				2,507	2,597	90
Other Direct Access (Imaging and Dietetics)				552	585	33
Other				4,604	5,488	884
CQUIN				1,797	1,783	(14)
Total				96,971	98,927	1,955

Table 3. - Reconciliation to Income Reporting

	£000s		
	FYE Plan	YTD Plan	YTD Actual
Contract Monitoring Performance	385,719	95,174	97,144
CQUIN 2.0%	6,841	1,797	1,783
Total Contracted Income	**392,560**	**96,971**	**98,927**
Income Recharged non-contract			
Maternity pathway payment	(197)	(49)	(51)
Cystic Fibrosis	146	37	49
Other invoicing	0	0	2
Work-in-progress adjustment	0	0	(286)
Total Income from Activities	**392,509**	**96,958**	**98,641**
Strategic Transformation Fund	16,252	2,438	2,438
Total Income from Activities plus PSF	**408,761**	**99,396**	**101,078**

Table 4. Contract Income by CCG and NHS England

SUSSEX CCGs and NHS ENGLAND	£'000		
	YTD Plan	YTD Actual	YTD Var
NHS COASTAL WEST SUSSEX CCG	78,453	79,145	692
NHS HORSHAM AND MID SUSSEX CCG	1,395	1,256	(139)
NHS BRIGHTON AND HOVE CCG	1,317	1,456	139
NHS HIGH WEALD LEWES HAVENS CCG	144	92	(52)
NHS CRAWLEY CCG	110	83	(27)
NHS EASTBOURNE, HAILSHAM AND SEAFORD CCG	126	120	(6)
NHS HASTINGS AND ROTHER CCG	57	65	8
NHS SOUTH EASTERN HAMPSHIRE CCG	1,598	1,482	(116)
NHS PORTSMOUTH CCG	152	183	31
NHS FAREHAM AND GOSPORT CCG	73	80	7
NHS GUILDFORD AND WAVERLEY CCG	174	159	(15)
Subtotal CCG Acute Contracts	**83,599**	**84,121**	**522**
NHS England	11,967	12,173	206
Total	**95,566**	**96,294**	**728**

This table represents the Trusts assessment of the performance against commissioners only with whom a Contract SLA has been agreed.

There are some differences between the Trust's income plan and the agreed contract values due to QIPP assumptions

Finance Report M3 2018/19 | **Operating Costs** | **R**

The underlying pay position remains adverse to plan in both Medical and Nursing staffing cumulatively, but expenditure reduced by £0.6m in comparison to May. Bed capacity reduced in line with seasonal expectation and orientation periods ended resulting in substantive pay reductions. A benefit arising from the quarterly review of the annual leave accrual was recognised in the June position, however, the underlying pay position was on plan in M3. Non Pay remains above plan with clinical supplies and services costs remaining the key pressure.

	Year To Date			
	Prev Yr Actual	Plan	Actual	Variance
		£k	£k	£k
Pay	*(70,720)*	(72,074)	(71,814)	260
Non Pay	*(29,926)*	(30,757)	(31,920)	(1,163)
Operational Costs	*(100,646)*	(102,831)	(103,734)	(903)

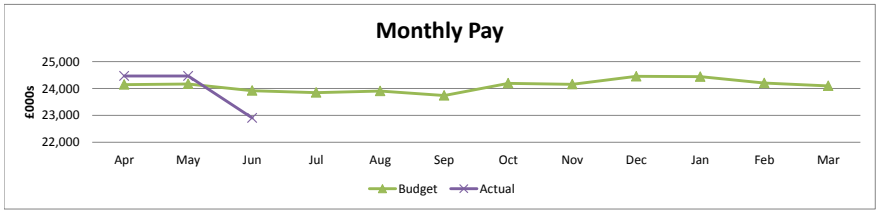
	Year Forecast		
	Plan	Actual	Variance
	£k	£k	£k
Pay	(287,602)	(288,160)	(557)
Non Pay	(121,999)	(121,442)	558
Operational Costs	(409,601)	(409,601)	0

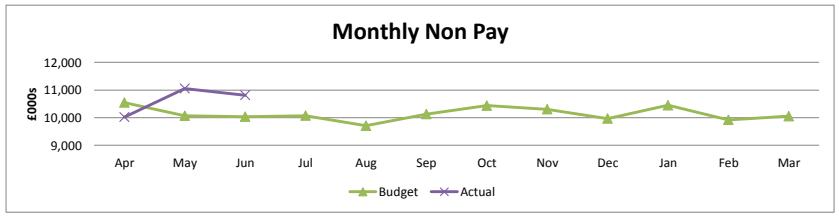
Pay: in comparison to May medical pay decreased by £0.1m with both substantive and locum expenditure decreasing partially mitigated by agency expenditure increasing. In aggregate pay remains above plan with premium rate cover continuing to be incurred to cover vacancies. Additional internal locum cover is also be utilised to maintain rota cover where out of hours shifts are unable to be worked as a result of sickness or maternity. Nursing expenditure by £0.3m in totality across substantive, bank and agency staff; following expected seasonal bed closures and completion of orientation periods for overseas staff. All other staff types are currently within plan with vacancies in management and admin staff continue to mitigate some of the pressure in clinical areas.

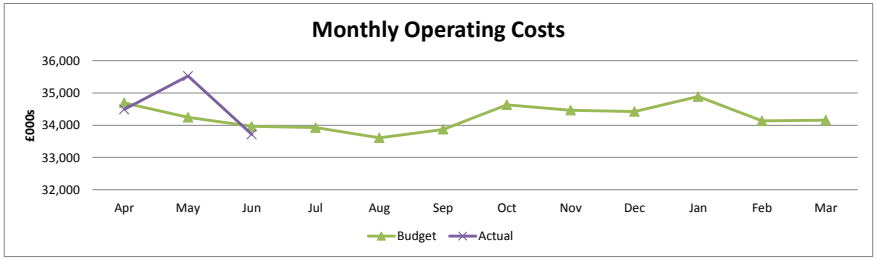
Non Pay: For a subsequent month high cost drug and device usage increased and is currently £0.5m above plan. Although this increase is offset within income, the growing expenditure trajectory is concerning . The sharp activity increases seen in May for Trauma and Orthopaedics and Ophthalmology did not continue and as a result clinical supplies and services expenditure decreased by £0.3m. Cumulatively this area remains the key driver of the non pay adverse position to plan.

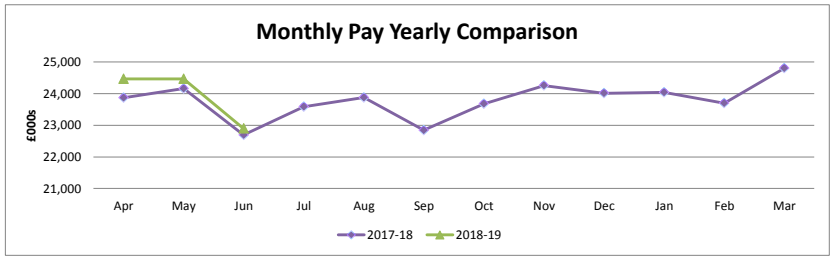
	Year to Date			
	Prep Yr. Actual	Plan	Actual	Variance
	£k	£k	£k	£k
Pay				
Management & Admin	(9,982)	(10,393)	(10,089)	304
Medical and Dental Staff	(20,337)	(20,750)	(21,447)	(697)
Nursing & Midwifery	(27,590)	(26,755)	(27,005)	(249)
Other Healthcare	(9,931)	(10,003)	(9,922)	82
Estates	(3,810)	(3,863)	(3,805)	58
Other Staff	931	(309)	453	762
Total Pay	**(70,720)**	**(72,074)**	**(71,814)**	**260**
Non-Pay				
Services from Other NHS Bodies	(643)	(638)	(544)	93
Purchase of Healthcare from Non NHS Bodies	-	-	-	-
Drugs & Medical Gases - tariff	(2,968)	(3,212)	(3,381)	(169)
Drugs & Medical Gases - PbR excluded	(6,384)	(6,463)	(6,523)	(60)
Drugs & Medical Gases - Cancer Drug Fund	(491)	(364)	(609)	(245)
Supplies and Services - Clinical	(8,572)	(8,584)	(9,005)	(422)
Supplies and Services - Clinical PbR Excluded	(792)	(849)	(1,034)	(185)
Supplies and Services - General	(984)	(874)	(887)	(13)
Establishment Expenses	(1,520)	(1,358)	(1,365)	(7)
Premises	(3,946)	(4,014)	(4,009)	6
Education and Training	(218)	(300)	(224)	76
Clinical Negligence Premium	(2,523)	(3,442)	(3,440)	2
Other Non-Pay	(886)	(659)	(898)	(239)
Total Non-Pay	**(29,926)**	**(30,757)**	**(31,920)**	**(1,163)**
Total Expenditure	**(100,646)**	**(102,831)**	**(103,734)**	**(903)**

	Full Year		
	Plan	Actual	Variance
	£k	£k	£k
Pay			
Management & Admin	(42,045)	(41,700)	345
Medical and Dental Staff	(79,848)	(81,498)	(1,650)
Nursing & Midwifery	(108,116)	(108,869)	(753)
Other Healthcare	(39,055)	(38,894)	162
Estates	(15,474)	(15,218)	256
Other Staff	(3,064)	(1,981)	1,084
Total Pay	**(287,602)**	**(288,160)**	**(557)**
Non-Pay			
Services from Other NHS Bodies	(2,660)	(2,178)	482
Purchase of Healthcare from Non NHS Bodies	-	-	-
Drugs & Medical Gases	(12,941)	(13,244)	(303)
Drugs & Medical Gases - PbR excluded	(22,370)	(23,013)	(644)
Drugs & Medical Gases - Cancer Drug Fund	(4,863)	(4,435)	428
Supplies and Services - Clinical	(34,146)	(34,620)	(474)
Supplies and Services - Clinical PbR Excluded	(3,619)	(3,668)	(49)
Supplies and Services - General	(3,524)	(3,547)	(23)
Establishment Expenses	(5,388)	(5,133)	254
Premises	(16,299)	(15,715)	584
Education and Training	(1,200)	(897)	302
Clinical Negligence Premium	(13,351)	(13,351)	-
Other Non-Pay	(1,640)	(1,640)	-
Total Non-Pay	**(121,999)**	**(121,442)**	**558**
Total Expenditure	**(409,601)**	**(409,601)**	**0**







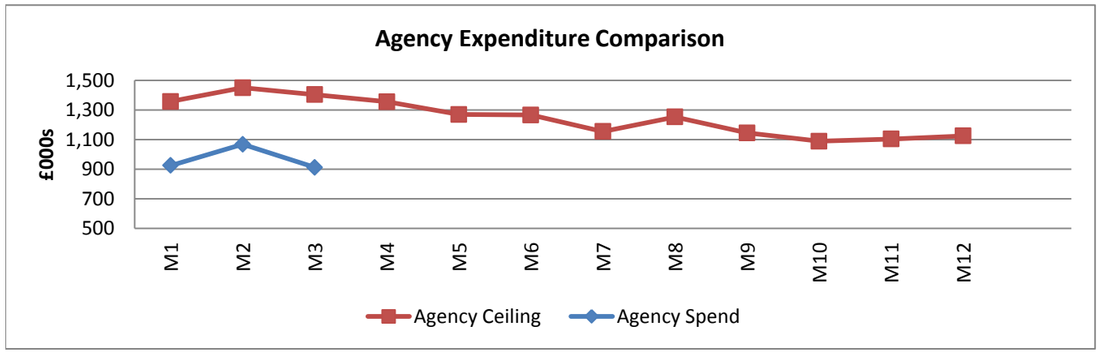


Finance Report M3 2018/19 — Payroll & Premium Pay Costs — G

Agency	Year To Date				
	2016/17	*2017/18*	Ceiling	Actual	Variance
	£k	*£k*	£k	£k	£k
Medical and Dental Staff	*(871)*	*(1,193)*	(2,180)	(1,842)	338
Nursing & Midwifery	*(1,894)*	*(1,100)*	(1,698)	(648)	1,049
Other Healthcare	*(491)*	*(208)*	(332)	(320)	12
Management & Admin	*(103)*	-	-	(63)	(63)
Ancillary Staff	*(90)*	*(2)*	-	(33)	(33)
	-				
	(3,449)	***(2,503)***	***(4,210)***	**(2,906)**	**1,304**

Waiting List Initiative Payments

	Year to Date		
	Budget	Actual	Variance
Division			
Surgery	(260)	(190)	70
Medicine	-	(87)	(87)
Core	(178)	(192)	(14)
Women & Children	(3)	(25)	(22)
Corporate	*(3)*	*(3)*	(0)
	(443)	***(497)***	**(54)**



Medical Locum

	Year to Date		
	Budget	Actual	Variance
Division			
Surgery	(34)	(335)	(301)
Medicine	(162)	(1,535)	(1,373)
Core	(127)	(113)	14
Women & Children	(33)	(199)	(166)
Corporate	*(5)*	*(9)*	(4)
	(361)	***(2,191)***	**(1,830)**

Payroll	Year To Date			
	Prev Yr Actual	Plan	Actual	Variance
	£k	£k	£k	£k
Medical and Dental Staff	*(17,974)*	*(18,818)*	*(16,972)*	1,846
Nursing & Midwifery	*(25,792)*	*(26,508)*	*(26,302)*	206
Other Healthcare	*(9,529)*	*(9,883)*	*(9,602)*	281
Management & Admin	*(9,968)*	*(10,359)*	*(10,026)*	333
Estates	*(3,803)*	*(3,856)*	*(3,772)*	84
Other Staff	*931*	*(309)*	*453*	762
	(66,135)	**(69,733)**	**(66,220)**	**3,513**

Staff in post incl Bank	Year To Date			
	Prev Yr Actual	Plan	Actual	Variance
	WTE	WTE	WTE	WTE
Medical and Dental Staff	*711*	831	814	17
Nursing & Midwifery	*2,706*	2,854	2,744	109
Other Healthcare	*1,002*	1,062	993	69
Management & Admin	*1,294*	1,336	1,275	61
Estates	*613*	653	600	53
Other Staff	-	0	-	0
	6,326	**6,735**	**6,426**	**309**

Finance Report M3 2018/19 — Divisional Performance — R

Surgery: Activity continued at a similar level in comparison with May resulting in a marginal income increase in June's position. Although in aggregate activity was higher than planned levels, the division has not been able to recover the year to date shortfall. Expenditure incurred in delivery of the activity continues to exceed plan predominantly within non pay. Pay was favourable to plan due to medical staffing vacancies across the division, particularly with Ophthalmology. The adverse performance within non pay continues to be driven by increased clinical supplies and services.

	Year To Date				
	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Contract Income	25,331	26,186	25,659	(527)	R
Other Income	573	598	666	68	G
Total Income	**25,904**	**26,784**	**26,325**	**(459)**	R
Pay	(15,803)	(15,909)	(15,890)	18	G
Non Pay	(5,641)	(5,180)	(5,516)	(336)	R
Total Expenditure	**(21,444)**	**(21,089)**	**(21,406)**	**(318)**	R
EBITDA Surplus/(Deficit)	**4,461**	**5,695**	**4,918**	**(777)**	R

Medicine: A&E attendances increased in June resulting in income in aggregate exceeding plan in June. This did, however, impact on non pay expenditure with a resulting increase in drugs and clinical supplies and services expenditure which remain key drivers of the non pay position. There continues to be pressure on Medical Pay costs due to agency and locum premium particularly within junior doctors. This is being driven by short term and short notice staffing issues. These issues are being addressed and the overall run rate for medical staff has reduced in comparison to May as enhanced controls begin to take effect. The ongoing difficulties with regard to nurse recruitment continues to drive expenditure above plan spend did decrease in comparison to May.

	Year To Date				
	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Contract Income	41,138	42,364	43,249	885	G
Other Income	836	717	682	(35)	R
Total Income	**41,974**	**43,081**	**43,932**	**851**	G
Pay	(23,186)	(22,168)	(23,061)	(893)	R
Non Pay	(8,598)	(8,414)	(9,083)	(670)	R
Total Expenditure	**(31,784)**	**(30,582)**	**(32,144)**	**(1,562)**	R
EBITDA Surplus/(Deficit)	**10,190**	**12,499**	**11,787**	**(712)**	R

Core: Income continues to be delivered above plan due to high cost drug activity volumes. This is matched by expenditure within non pay. Pathology income remains above plan, mitigating pressures in Medical Imaging activity which continues to deliver below plan resulting in contract income remaining on plan in aggregate. Non pay expenditure has reduced in month with lower expenditure being incurred for consumables and drug costs, although cumulatively these areas remain the key drivers of non pay. Pay decreased in comparison to May due to a combination of continuing vacancies and the TUPE of pharmacy staff who previously provided the clinical element of the mental health pharmacy contract.

	Year To Date				
	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Contract Income	10,975	10,980	11,245	265	G
Other Income	2,813	3,013	2,964	(50)	R
Total Income	**13,788**	**13,993**	**14,209**	**216**	G
Pay	(14,068)	(13,985)	(14,044)	(59)	R
Non Pay	(5,972)	(5,960)	(6,485)	(524)	R
Total Expenditure	**(20,040)**	**(19,945)**	**(20,529)**	**(583)**	R
EBITDA Surplus/(Deficit)	**(6,252)**	**(5,952)**	**(6,320)**	**(367)**	R

Women & Children: Non elective activity within Paediatrics continues at high levels driving the positive variance to plan in contract income. This over performance mitigates reductions in neonatology activity. Pay expenditure reduced in June following reductions of agency and bank relating to mental health nursing. Medical pay also reduced as internal locum solutions were negotiated to cover vacancies. Locum spend required to cover medical staff sickness and maternity leave, in addition to paying the substantive member of staff are expected to continue into Q2 contributing to an overall adverse pay position.

	Year To Date				
	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Contract Income	15,698	15,600	15,857	258	G
Other Income	213	211	242	31	G
Total Income	**15,911**	**15,810**	**16,099**	**289**	G
Pay	(7,860)	(7,863)	(8,064)	(201)	R
Non Pay	(2,929)	(3,387)	(3,423)	(36)	R
Total Expenditure	**(10,789)**	**(11,250)**	**(11,487)**	**(237)**	R
EBITDA Surplus/(Deficit)	**5,122**	**4,560**	**4,612**	**52**	G

Facilities & Estates: The division continues to deliver under plan cumulatively with reduced pay expenditure offsetting the adverse variance in income. A reduction in long-stay parking continues to impact car parking income, following an increase in tariff at St Richards. Pay is below plan with vacancies in estates, catering and compliance staff. Non pay expenditure has reduced following non recurrent expenditure in May.

	Year To Date				
	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Contract Income	-	-	-	-	
Other Income	1,057	1,182	1,113	(69)	R
Total Income	**1,057**	**1,182**	**1,113**	**(69)**	R
Pay	(3,787)	(3,885)	(3,780)	105	G
Non Pay	(3,562)	(3,703)	(3,702)	0	G
Total Expenditure	**(7,349)**	**(7,588)**	**(7,483)**	**105**	G
EBITDA Surplus/(Deficit)	**(6,292)**	**(6,406)**	**(6,370)**	**37**	G

Corporate: An increased number of patients treated, coupled with a richer casemix of activity has resulted in private patient income increasing in June by £0.1m in comparison to May. This is an improving trajectory but income remains £0.5m behind plan cumulatively. Management and admin expenditure in corporate areas remain favourable to plan helping to mitigate some of the pressure in clinical areas through tight vacancy management.

	Year To Date				
	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Contract Income	-	1,828	2,631	802	G
Other Income	4,150	5,175	4,412	(762)	R
Total Income	**4,150**	**7,003**	**7,043**	**40**	G
Pay	(6,795)	(8,263)	(6,974)	1,289	G
Non Pay	(3,497)	(4,113)	(3,711)	402	G
Total Expenditure	**(10,292)**	**(12,376)**	**(10,684)**	**1,692**	G
EBITDA Surplus/(Deficit)	**(6,142)**	**(5,373)**	**(3,641)**	**1,732**	G

Finance Report M3 2018/19 — Statement of Financial Position

The Trust Balance Sheet is produced on a monthly basis, and reflects changes in the asset values, as well as movement in liabilities.

	Year to Date				Full Year Forecast			
	Plan	Actual	Variance	Notes	Plan	Actual	Variance	Notes
	£k	£k	£k		£k	£k	£k	
Property, Plant and Equipment	270,940	268,442	(2,498)	1	269,850	269,850	-	
Intangible Assets	6,616	7,124	508		6,616	6,616	-	
Other Assets	-	-	-		-	-	-	
Non Current Assets	**277,556**	**275,567**	**(1,989)**		**276,466**	**276,466**	**-**	
Inventories	6,395	7,103	708		6,450	6,450	-	
Trade, Other Receivables, Other Current Assets	44,542	32,828	(11,714)	2	47,569	47,569	-	
Cash and Cash Equivalents	1,276	5,002	3,726		16,974	16,974	-	
Non Current Assets Held for Sale	-	-	-		-	-	-	
Current Assets	**52,213**	**44,933**	**(7,280)**		**70,993**	**70,993**	**-**	
Trade and Other Payables	(26,128)	(23,935)	2,193	3	(28,030)	(28,030)	-	
Borrowings	(1,698)	(1,656)	42		(2,198)	(2,198)	-	
Other Financial Liabilities	(19,603)	(17,898)	1,705		(17,196)	(17,196)	-	
Provisions	(311)	(366)	(55)		(559)	(559)	-	
Other Liabilities	(2,314)	(40)	2,274		(2,795)	(2,795)	-	
Current Liabilities	**(50,054)**	**(43,895)**	**6,159**		**(50,778)**	**(50,778)**	**-**	
Borrowings	(20,536)	(20,536)	0		(18,378)	(18,378)	-	
Trade and Other Payables	-	-	-		-	-	-	
Provisions	(2,876)	(2,773)	103		(2,627)	(2,627)	-	
TOTAL ASSETS EMPLOYED	**256,303**	**253,295**	**(3,008)**		**275,676**	**275,676**	**-**	
Financed by:								
Public Dividend Capital	240,844	240,844	0		240,844	240,844	-	
Retained Earnings	(33,259)	(38,480)	(5,221)		(9,886)	(9,886)	-	
Surplus/(Deficit) for Year	-	-	-		-	-	-	
Revaluation Reserve	48,718	50,931	2,213		44,718	44,718	-	
TOTAL TAXPAYERS EQUITY	**256,303**	**253,295**	**(3,008)**		**275,676**	**275,676**	**-**	

1. The non current asset position includes the impact of the District Valuer's valuation and slippage on the year to date capital programme, however more schemes have been approved and are now in progress.
2. Trade receivables are lower than plan due to receipt of cash payment which were not anticipated until later in the year, including Coastal West Sussex CCG £4.6m, £3.7m Q4 Sustainability and Transformation Funding (STF) & NHS England £1.3m.
3. Trade and Other Payables is lower than plan due to slippage on the capital programme at month 3. There is a reduction in the Trade Payables as a result of the STF cash becoming available.

Finance Report M3 2018/19 — Cash — A

At the end of June the cash position is ahead of plan by £3.7m. This is primarily due to timimg of capital expenditure and a favourable movement in working capital driven by settlement of aged debt.

	Year To Date		
	Plan	Actual	Variance
	£k	£k	£k
Cash Balance	**1,276**	**5,002**	**3,726**

	Full Year Forecast		
	Plan	Actual	Variance
	£k	£k	£k
	16,974	**16,974**	**-**

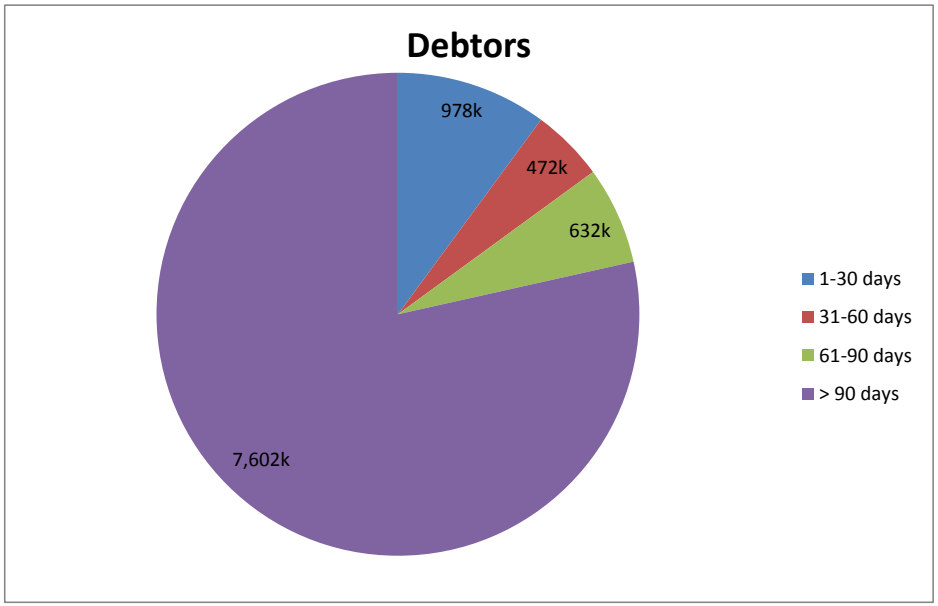
	Year to Date		
	Plan	Actual	Variance
	£k	£k	£k
EBITDA	7,256	7,309	53
Movement in Working Capital	(8,587)	(6,274)	2,313
Provisions	-	(59)	(59)
Cashflow from Operations	**(1,331)**	**975**	**2,306**
Capital Expenditure	(3,259)	(1,752)	1,507
Cash receipt from asset sales	-	-	-
Cashflow before financing	**(4,590)**	**(776)**	**3,814**
PDC Received	-	0	0
PDC Repaid	-	-	-
Dividends Paid	-	1	1
Interest on Loans and leases	(172)	(53)	119
Interest received	-	13	13
Donations received in cash	-	116	116
Drawdown on debt	-	-	-
Repayment of debt	(500)	(500)	-
Cashflow from financing	**(672)**	**(424)**	**248**
Net Cash Inflow / (Outflow)	**(5,262)**	**(1,200)**	**4,062**
Opening Cash Balance	6,538	6,202	(336)
Closing Cash Balance	**1,276**	**5,002**	**3,726**

	Full Year		
	Plan	Actual	Variance
	£k	£k	£k
EBITDA	40,257	40,257	-
Movement in Working Capital	(1,403)	(1,519)	(116)
Provisions	-	-	-
Cashflow from Operations	**38,854**	**38,738**	**(116)**
Capital Expenditure	(17,145)	(17,145)	-
Cash receipt from asset sales	-	-	-
Cashflow before financing	**21,709**	**21,593**	**(116)**
PDC Received	-	0	0
PDC Repaid	(8,425)	(8,425)	-
Dividends Paid		-	-
Interest on Loans and leases	(690)	(690)	-
Interest received	-	-	-
Donations received in cash	-	116	116
Drawdown on debt	-	-	-
Repayment of debt	(2,158)	(2,158)	-
Cashflow from financing	**(11,273)**	**(11,157)**	**116**
Net Cash Inflow / (Outflow)	**10,436**	**10,436**	0
Opening Cash Balance	6,538	6,538	-
Closing Cash Balance	**16,974**	**16,974**	**0**

Finance Report M3 2018/19 — Aged Debtors

The Trust debtors are a mixture of invoiced debtors, accrued income and prepayments as set out in the table below. The Trust has outstanding debtors of 31 days or more of £8.7m, which is a reduction of £2.2m since May. The most significant debtors greater than 90 days relate to outstanding balances with five hospital trusts for provider to provider agreements and specialist drugs/services.

	Within Terms	Overdue				Total
		1-30 days	31-60 days	61-90 days	> 90 days	
	£k	£k	£k	£k	£k	£k
CCG's	51	175	72	241	626	1,164
NHS England (in Health Education England)	516	27	7	34	209	793
NHS Trusts	852	201	263	209	3,038	4,563
Foundation Trusts	900	448	41	75	2,243	3,707
Other NHS	-	15	2	14	130	161
Non-NHS	175	112	87	59	1,356	1,789
Total	**2,493**	**978**	**472**	**632**	**7,602**	**12,178**
	20%	**8%**	**4%**	**5%**	**62%**	
Provision for Bad Debts (including RTA Provision)					(785)	
Accrued Income (including Work in Progress)					13,954	
Prepayments					2,266	
Other Debtors					5,216	
Total Trade & Other Receivables					**32,827**	



Other debtors includes £2.4m of RTA debtors, £1.6m of Private Patients, £0.6m relates to Charity funding (of which £0.06m relates to the League of Friends and £0.58m relates to LYH) and £0.6m relating to VAT and other debtors.
Accrued income includes £3.5m STF income for 2017/18 and £2.4m relating to STF Q1 18/19 income, £1.1m of provider to provider income, work-in-progress £3.0m and £4.0m of other accrued income including commisioner and training income.

Finance Report M3 2018/19 — Capital — A

At the end of June, capital expenditure totalled £1.7m. The largest areas of expenditure include £0.26m on Client Devices, £0.21m GP Internet Access, £0.18m Water Safety Assessments, £0.18m Bed re-configuration. Expenditure is £0.6m lower than plan due to later starts on some projects than planned. Total expenditure in year is forecast to be on plan.

Year To Date	Plan £k	Actual £k	Variance £k
Total Capital	**2,311**	**1,752**	**(559)**

Year End Forecast	Plan £k	Actual £k	Variance £k
Total Capital	**17,145**	**17,145**	**-**

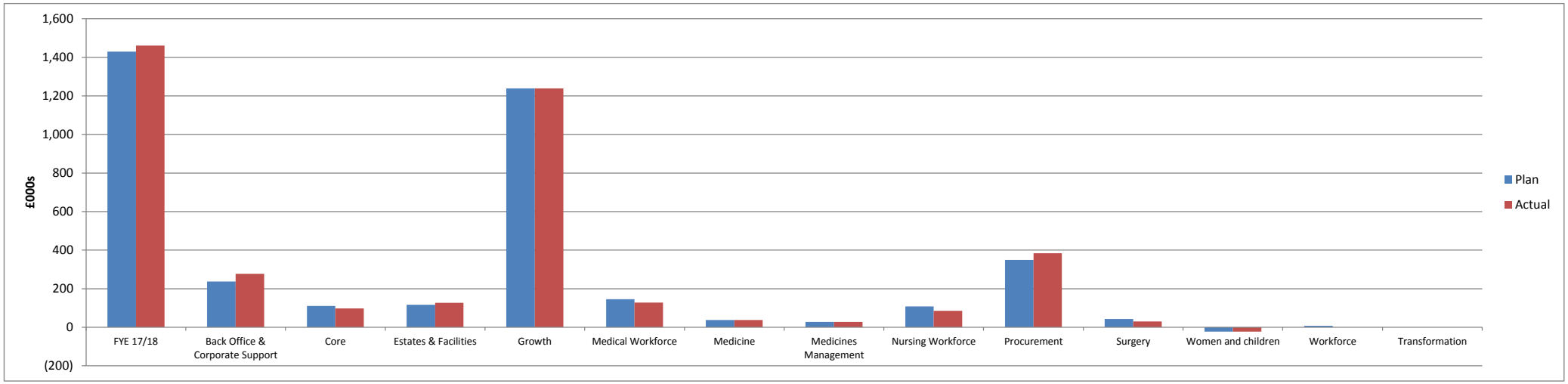
Capital	Year to Date			Full Year		
	Budget	Actual	Variance	Plan	Actual	Variance
Source of Funds	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Depreciation (net of IFRIC 12)	3,427	3,460	33	14,630	14,630	-
Loan Repayments	(173)	(136)	37	(1,163)	(1,163)	-
Charitable Funds	-	-	-		-	-
Donation/Grants	234	116	(118)	937	937	-
NHS England (Evolve)	41	41	-	180	180	-
Cash Reserves/Other			-	2,561	2,561	-
	3,530	**3,481**	**(49)**	**17,145**	**17,145**	**-**
Application of Funds						
Other Service Developments	2,317	584	(1,733)	11,885	11,885	-
Medical Equipment	143	45	(98)	2,514	2,514	-
Facilities & Estates	0	185	184	2,018	2,018	-
Information Technology	232	543	311	4,237	4,237	-
Misc	-	27	27	-	-	-
Deferred Scheme	407	369	(38)	2,086	2,086	-
Charitable Funds	25	-	(25)	437	437	-
GP Streaming	-	-	-	-	-	-
Overprogramming	(813)	-	813	(6,032)	(6,032)	-
Total Expenditure	**2,311**	**1,752**	**(559)**	**17,145**	**17,145**	**-**

Finance Report M3 2018/19 | **Efficiency and Transformation Programme** | **A**

Year-to-date savings of £3.87m have been achieved against a plan of £3.83m. A delay in the agreement of an uplift to a service level agreement and lower than planned car parking income have been mitigated by increased procurement savings and overseas visitor income. The FOT is £0.2m adverse to plan, reflecting expected shortfalls in Car Parking income and Pharmacy schemes.

	Year-to-Date			Full Year		
Workstream	**Plan**	**Actual**	**Variance**	**Plan**	**Forecast**	**Variance**
	£k	**£k**	**£k**	**£k**	**£k**	**£k**
FYE 17/18	1,430	1,461	32	2,716	2,716	-
Back Office & Corporate Support	238	277	39	1,118	1,118	0
Core	111	98	(13)	2,700	2,468	(233)
Estates & Facilities	116	127	10	831	811	(20)
Growth	1,239	1,239	-	1,723	1,723	-
Medical Workforce	146	128	(18)	2,350	2,358	8
Medicine	38	38	(0)	930	930	(0)
Medicines Management	28	28	-	302	337	34
Nursing Workforce	108	85	(23)	725	758	34
Procurement	349	384	35	1,997	1,997	-
Surgery	43	30	(13)	1,476	1,453	(22)
Women and children	(22)	(22)	-	1,102	1,139	38
Workforce	7	-	(7)	160	153	(7)
Transformation	-	-	-	107	107	-
Efficiency Plan Total	**3,831**	**3,873**	**43**	**18,235**	**18,066**	**(169)**

Month 3 Plan vs Actual



Western Sussex Hospitals
NHS Foundation Trust

To: Trust Board

Date of Meeting: 26th July 2018 Agenda Item: 7

Title
Learning from Deaths
Responsible Executive Directors
George Findlay Chief Medical Officer
Prepared by
Tim Taylor Medical Director, Simon Higgs Clinical Effectiveness Manager
Status
Disclosable
Summary of Proposal
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.
Implications for Quality of Care
Opportunity to gain assurance on care or identify areas for focused improvement
Link to Strategic Objectives/Board Assurance Framework
A1, A2, B1, B2 and C1.
Financial Implications
Reviewers and co-ordination of activity
Human Resource Implications
There are training requirements and allocated protected time for individuals to undertake the full review element of this process.
Recommendation
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.
Communication and Consultation
A plan for communication is being developed
Appendices

Learning from Deaths

1. Purpose

1.1. There are approximately 2200 deaths occurring in WSHFT every year. This paper updates on the implementation of the WSHFT Learning from Deaths Policy. The key learning identified from mortality screening and structured mortality reviews completed for quarters one to four 2017/18 thus far is highlighted. Crude and risk adjusted mortality for the Trust is also provided.

2. Background

2.1. In March 2017 the National Quality Board published guidance based on the recommendations from the Care Quality Commission (CQC) report *'Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England'*.
In accordance with the new national guidance screening reviews of all deaths commenced in April 2017. This entails a consultant review of each case against a template of commonly identified potential problems. A Learning from Deaths Policy was published in October 2017 and structured judgement mortality review (SJR) was introduced from quarter two 2017/18. SJR provides in depth reviews for triggered cases.

2.2. **Criteria for Structured Judgement Case note Review:** The mortality review process includes a programme of SJR based on the Royal College of Physicians (RCP) methodology.

2.3. As per guidance the structured review methodology will not apply to child deaths. The national mortality review process for children is due to be published at a later date. Until revised guidance is released child deaths will follow current Trust policy which is in line with existing national guidance.

2.4. A new national process for perinatal deaths has now been commenced and local processes changed to reflect the new central reporting process. An update will be provided to a future Trust Board as part of this report.

2.5. Maternal deaths will also follow an existing mandated process until further central guidance is received.

3. Implementation of the Trust Policy on Learning from Deaths

Governance

3.1. The Chief Medical Officer is the Board level lead with a lead non-executive director with responsibility for oversight of process.

3.2. The operational process is led by the Clinical Effectiveness Manager through the Mortality Steering Group which reports to the Trust Quality Board

Screening Review

3.3. All deaths are reviewed at consultant level using a set of prompts designed to cover broad areas where problems in care may occur. Examples of prompts include:

- Family/carer concerns
- Recognition of deterioration and escalation
- Fluid and medication management
- End of life care

Consultants are also asked if they would like an independent review of the case. The output from this screening is also used to prioritise cases for SJR and all screening is reviewed to identify learning independent of the SJR process

Reviewers

3.4. Four reviewers, led by the medical director have been recruited from the consultant body to undertake independent reviews and contribute to mortality panel meetings to triangulate learning. Further recruitment pending.

Training:

3.5. The Clinical Effectiveness Manager and one of the Care of the Elderly Consultants have received tier one training in Structured Judgement Review with the Royal College of Physicians. Completion of this training enables participants to train others in the SJR methodology.
The 4 reviewers have reached a level of practice where they are undertaking reviews independently and discuss cases with peers as necessary. The number of SJR's has therefore increased but is not yet at a level as stated in the Learning from Deaths policy.

3.6. Training has also been undertaken for relevant groups of nursing staff e.g. outreach teams in order for them to participate in the review process.

Involving Families and Carers

3.7. Central guidance was published in July 2018 and an action plan will be developed in response and reported with this paper to a subsequent Trust Board

3.8. Work continues with the hospital chaplain and bereavement teams staff to encourage relatives and carers to feedback any issues or concerns at an early stage.

4. Number of Deaths Quarters 1-4

4.1 Table 1 shows the number of deaths across all specialities during 2017-18

Deaths in 2017/18					
	Deaths Apr-Jun 2017	Deaths Jul-Sep 2017	Deaths Oct-Dec 2017	Deaths Jan-Mar 2018	Total deaths by category 2017/18
Adults (inpatient)	486	453	562	696	2197
Adults (A&E)	19	14	22	20	75
Adults (maternal)	0	0	0	1	1
Paediatrics (inpatient)	0	0	1	0	1
Paediatrics (A&E)	0	0	1	3	4
Total deaths by quarter 2017/18	505	467	586	720	2278

Other deaths in 2017/18					
	Deaths Apr-Jun 2017	Deaths Jul-Sep 2017	Deaths Oct-Dec 2017	Deaths Jan-Mar 2018	Total deaths 2017/18
Neonatal	0	3	0	3	6
Stillbirths	5	6	6	2	19

5. Screening and Structured Judgement Reviews

5.1. Screening has been in place since April 2017 and structured judgement review process implemented in quarter two. It should be noted however that the recruitment of formal reviewers was only finalised at the end of quarter three

Table 2 provides the number of inpatient deaths, number of deaths screened and number of SJR's completed for quarters one to four.

Table 2: Screening and SJR reviews 2017-18

	Quarter 1 2017	Quarter 2 2017	Quarter 3 2017	Quarter 4 2017
Total number of deaths (adult inpatients only)	486	453	562	696*
Total number of deaths screened	429 (88.2%)	397 (87.6%)	492 (87.5%)	525 (75.4%)
Learning disabilities deaths	0	4	3	7**
SJR's Referred NB: Referred by screening consultant or automatically if high risk category ticked on screening form	103 (21.2%)	88 (19.4%)	118 (20.9%)	105 (15.1%)
Total number of structured reviews	11 (2.2%)	23(5.1%)	41(7.2%)	53 (7.6%)
Total number of second reviews	0	4	6	5
Number of deaths where the quality of care was judged more likely than not to have led to harm	0	0	1	***2

***The higher number of deaths and lower screening compliance is a likely result of the unprecedented winter pressures during Q4

****Only one of these cases has been subject to external LeDeR review at the time of this report. This is due to capacity issues within the external LeDeR programme. Of the 7 deaths reported in Q4, 5 have had SJR's completed with 2 pending.

*****Deaths in this category are referred to the Serious Incident (SI)process for investigation. The

NHSE states in the SI 'frequently asked questions: *'The fact that a death was due to a number of omissions and delays for example, rather than a single catastrophic error does not mean it does not count as a 'Serious Incident'. Deaths that were probably avoidable on the basis of retrospective case record review almost certainly meet Serious Incident criteria. It is acknowledged that typically, deaths of this kind will be reported at the point the avoidable death was identified rather than at the point where individual incident contributing to the death occurred'*

Table 3: Screening and SJR reviews Q1 2018-19*

	Quarter 1 2018	Quarter 2 2018	Quarter 3 2018	Quarter 4 2018
Total number of deaths (adults)	454			
Total number of deaths screened	293 (64.5%)			
Learning disabilities deaths	2			
SJR's Referred NB: Referred by screening consultant or automatically if high risk category ticked on screening form	50 (11.0%)			
Total number of structured reviews	11 (2.2%)			
Total number of second reviews	1			
Number of deaths where the quality of care was judged more likely than not to have led to harm	1 ***			

***These figures are subject to significant change due to the timing of this report and will be updated in future reports

5.2 Structured Judgement Review – Q4

Overall Care Score		**Learning Themes**	**Actions**
Excellent Care	20	Prompt review and decision making by senior staff Excellent end of life discussion and decision making at an early stage	Feedback to relevant clinical teams
Good Care	17	Prompt recognition and subsequent response to deterioration Regular senior review with examples of patient centered escalation plans Very good end of life care including clear documentation of sensitive patient/family discussions and excellent symptom control	Feedback to relevant clinical teams
Adequate Care	9	Late decision making for end of life care with no ceiling of treatment discussed. Lack of regular senior review Slightly delayed diagnosis due to delayed review of CT scan Inappropriate primary care referral via A/E rather than to on call medical team Hospital acquired influenza	Feedback of specific issues to End of Life Care Board Feedback to relevant clinical teams Discussion with primary care
Poor Care	5	Significant delay in end of life care decision making, agreeing subsequent palliation and	Feedback to End of Life Care Board

		undertaking unnecessary tests. Unclear targets set for oxygen saturation Poor management of AKI	 Feedback to relevant clinical team Discuss with respiratory teams re methods of improving target setting and recording of oxygen saturations *See action below
Very Poor Care	2	Lack of recognition of severity of metabolic disturbances Delayed recognition of deterioration and response overnight. Inadequate investigation based on pre-admission history	Referral of cases through serious incident process. *Refresh of educational programme related to deteriorating patients with a focus on AKI and other metabolic indicators Feed back to Deteriorating Patient Group. Improvement A3 to be developed to identify key issues and develop strategies to mitigate future risks. Individual feedback to relevant clinical staff

It was judged by reviewers that the quality of care was judged more likely than not to have led to harm.

5.3 Capacity and Risk

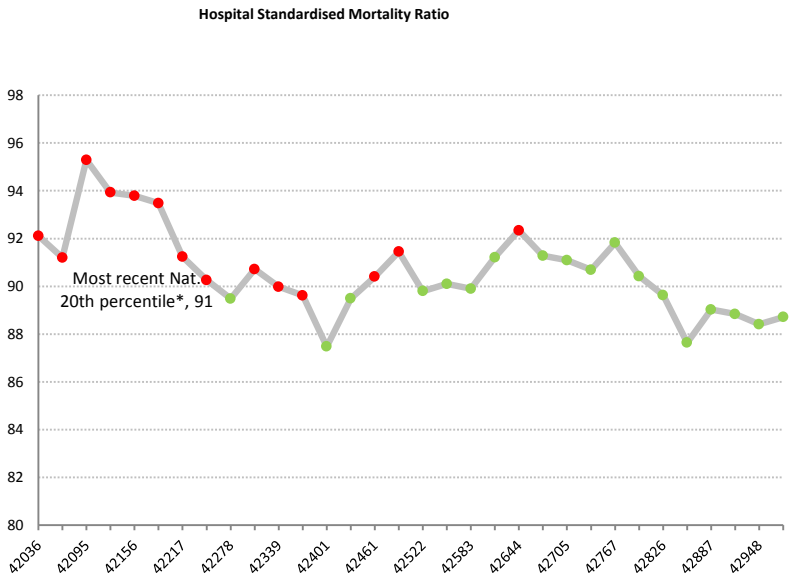
Current capacity to undertake SJR is not sufficient to meet targets described in policy. For Q4 a significant number of SJR's are outstanding at the time of this report. In the majority of cases it is not possible to assess the level of risk this may represent until the reviews are completed. This also results in delayed referral to the 'Serious Incident' process complicating investigation and more importantly impacting on families and carers if candour is triggered some time after death.

Increasing capacity is therefore seen as a priority and both the process/methodology and resource are being examined. In order to address the backlog for Q4 an event has been organised to complete the outstanding SJR's. This taking place on 27th July 2018

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

6.1 The latest SHMI data made available by the Health and Social Care Information Centre is for the period to Dec 2017. The Trust value is 0.96% (where 1.00 is the national average), with the Trust banded as 'as expected'.

6.2 For the twelve months to March 2018 performance using HSMR is 89.8 (with 100 being the expected) continues to place us within the top 20% of Trusts on the 18th centile. There have been no mortality outliers reported for WSHFT from the CQC or the Dr Foster Unit at Imperial College



source: Dr Foster

7.0 Summary

In accordance with the new national mortality guidance, the Trust has developed a 'Learning from Deaths' policy, screening and a structured judgement review process. This paper describes progress toward the implementation of the policy and summarises the learning identified to date.

7.1 Next Steps

7.1.1 Increasing capacity to undertake SJR's and improve the timeliness of reviews. This will include reviewing methodology and resources.

7.1.2 Implement a structured communication programme for sharing learning more effectively across the organisation.

7.1.3 Respond to national guidance on working with bereaved families and carers which was published in mid July 2018

7.1.4 Further develop the mortality panel process and membership

7.1.5 Implement the electronic recording of SJR activity using 'Datix' and ensure goods links with the complaints and serious incident processes

7.1.6 Continue to work with the End of Life Board to support strategy development and implementation in collaboration with health economy partners

8.0 RECOMMENDATION

The Board is asked to receive and discuss the implementation of the 'Learning from Deaths' policy and the learning identified from screening and structured judgement reviews.

Western Sussex Hospitals
NHS Foundation Trust

To: Trust Board

Date of Meeting: 26th July 2018 Agenda Item: 8

Title
Annual Patient Experience Report 2017/18
Responsible Executive Director
Nicola Ranger, Chief Nurse
Prepared by
Katrina O'Shea, Matron – Patient Experience Tracey Nevell, Customer Relations Manager
Status
Disclosable
Summary of Proposal
The purpose of this report is to provide a review of the data collected in financial year 2017-18 through the Friends and Family Test, the Real–time survey system and Sit and See programme and to bring to the attention of the Patient Experience and Feedback Committee and Trust Board information relating to PALS enquiries and formal complaints received within Western Sussex Hospitals NHS Foundation Trust.
Implications for Quality of Care
The implementation of the Patient Experience Strategy will ensure the Trust is addressing areas of concern in a timely manner for the purposes of improving the patient experience of users receiving care from the Trusts services.
Financial Implications
1. Loss of Commissioner confidence may result in loss of Trust business.
Human Resource Implications
1. Professional performance management issues for individuals. 2. Learning and development requirements. 3. Organisational, behavioural and cultural issues.
Recommendation
The Committee is asked to NOTE the report.
Communication and Consultation
Patient Experience and Feedback Committee, Divisions and Customer Relations Team.
Appendices
Nil

Patient Experience Annual Report

2017 – 2018

Compiled by:

Katrina O'Shea – Matron 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 2017/18 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 2017.

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.

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[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 2017 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 2017, benefitting Patient Experience

Carers Policy

The Dementia Matron has implemented a Carers policy in June 2017 in line with John's Campaign, which comes from a vision to ensure that any carer who is visiting their loved ones is welcomed and feels valued in our Trust. Implementing this policy on welcoming active carers of people with high level care needs will aid recovery, improve the patient experience and assist in provision of care according to patient's needs and not restricted by regimented visiting hours.

The benefits of the carers policy are:

- Ward staff can phone the kitchen up to 15 minutes before a meal is served and request a free meal is provided to a carer so that they can dine with their loved one on the ward.
- If the visitor shows their carers passport at to the main reception at Chichester or the car parking warden hut at Worthing they will be given free car parking as they exit.
- Open visiting is also available and the palliative team are currently auditing how many recliner chairs and single put up beds are available to ensure that the carer's comfort can be reliably provided.

Extended Visiting Hours

A pilot of open visiting for all relatives took place in October, November and Dec 2016 and mixed feedback was received. This was discussed at various committees and a decision was reached to change the visiting times across the Trust for all adult patients to 10:00-22:00 from 01 December 2017. A communication cascade including posters and banners promoting this change was arranged to support the launch.

Pilot PAT Dogs

A pilot introducing PAT dogs commenced at St Richards Hospital on Howard Ward and Donald Wilson House in December 2017 and is planned to be extended to include elderly care wards. A space is being identified where the dogs can be located on site, to allow for patients to be escorted away from ward areas in order to meet the dogs. The Trust Infection Control Committee will continue to monitor this trial and it is anticipated that the service will be extended to include Worthing Hospital.

Achievements in relation to the three Key Patient Experience Improvement Goals for 2017/18

1. To align to our Patient First, true north metric for patient experience which will use our FFT scores and return rate. For 2017/18 we aim to achieve >97% satisfaction <0.7% and a return rate >40%. There has been significant progress and a marked improvement in performance . Maternity birth touchpoint has achieved true north during March 2018. All areas are engaging well in activities that will work towards achieving this objective.

2. The goal for 2017 was that by the end of 2017/18 we would have no more than 60 complaints open and this has been achieved. On average we currently receive 35-40 complaints per month and have approximately 60 open formal complaints.

    - 63% of formal complaints are resolved within 25 working days at the end of March 2018 (previously 11.8% in at the end of June 2017).
    - Closure of formal complaints in a shorter timeframe; 89% in 60 days for January to March 2018 (latest data available) (compared to 30% in April to June 2017).

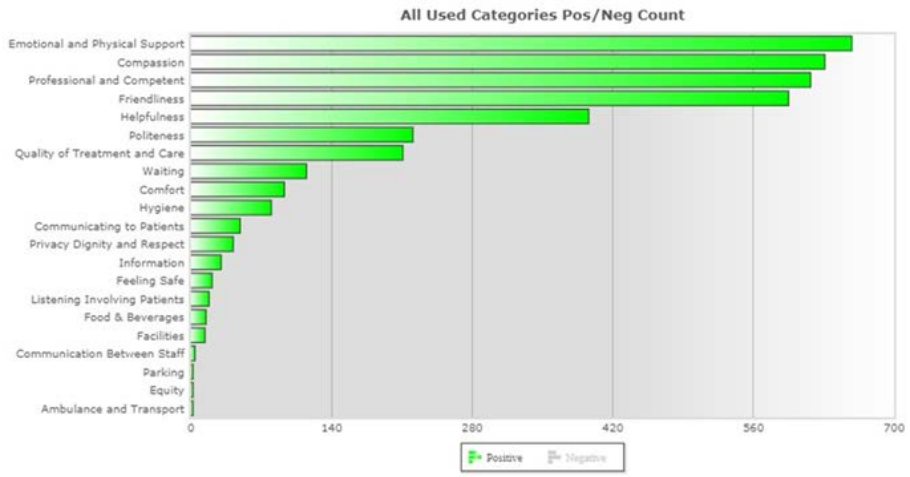
3. An operational group is meeting monthly to ensure that there is a clear process for staff to identify, record, flag, share and provide communication support to patients, carer and parents who may have a disability, impairment or sensory loss. An action plan has been created to measure our progress of implementation of the Accessible Information Standard across the Trust. This will be 75% achieved in June 2018 when an IT application called SNOMED is introduced, as this will prompt staff to record patient's communication needs so that they can be met.

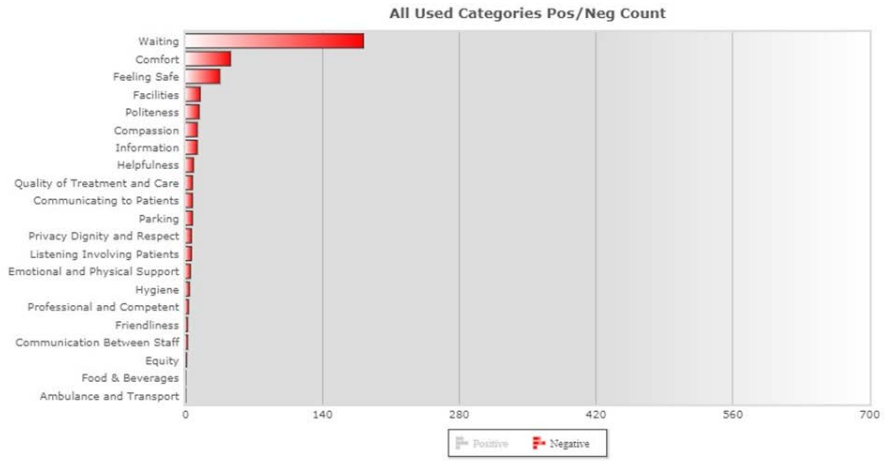
Friends and Family Test

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 access to Pansensic, following our contract with MES, allows staff to easily observe themes brought up in FFT returns. 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 allowing a clear analysis of areas to celebrate and those that require further exploration.

As detailed below, compassionate, physical and emotional support provided by friendly, helpful and professional staff is most valued by patients.





As can be seen waiting time is the greatest cause of negative experience. Further analysis shows that this includes waiting for appointments, waiting in the discharge lounge for transport and waiting for medication to go home. Patients have fed back that they find it hard waiting for their day surgery to occur after booking in at 07:15 as they become more anxious as well as waiting to see a doctor when they attend as an emergency. Response to call bells on inpatient wards has also been described at times as long as 10-15 minutes or more when staff are busy and this is a concern for those patients that are calling to request assistance to access a toilet.

The comfort category incorporates the delay some of our patients experience when they require emergency access to a bed. At busy times patients can wait for some hours on a chair or trolley, unfortunately at times of peak demand we receive feedback that the supply of pillows and blankets can be problematic out of core hours. A few of our patients on wards have commented that they have found our beds to be uncomfortable. Several references have been made indicating that the waiting room chairs in both A&E departments and Pagham Suite are uncomfortable if sat on for several hours.

Further analysis of comments collected under the category 'feeling safe' describe patients feeling worried about other confused patients behaviour, particularly at night and a few comments have referenced concerns that there seems to be a shortage of night staff. Patients have felt particularly worried if they are unable to reach their call bell and have expressed there have been occasions when they have waited a long time to receive a response.

Of the few comments made in the politeness category these relate to patients describing staff as discourteous or abrupt. Patients have also expressed concern because other patients have been rude to staff.

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.

Since January 2017 the Trust has benefitted from software that is able to provide an analysis of patient's comments and categorise these into patient emotions so that reports are more detailed and result in staff understanding which issues can be addressed to deliver an improvement in patient experience.

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 2017/18

Our overall goal for 2017/18 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 maintain our current excellent position 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.

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

Outpatient:

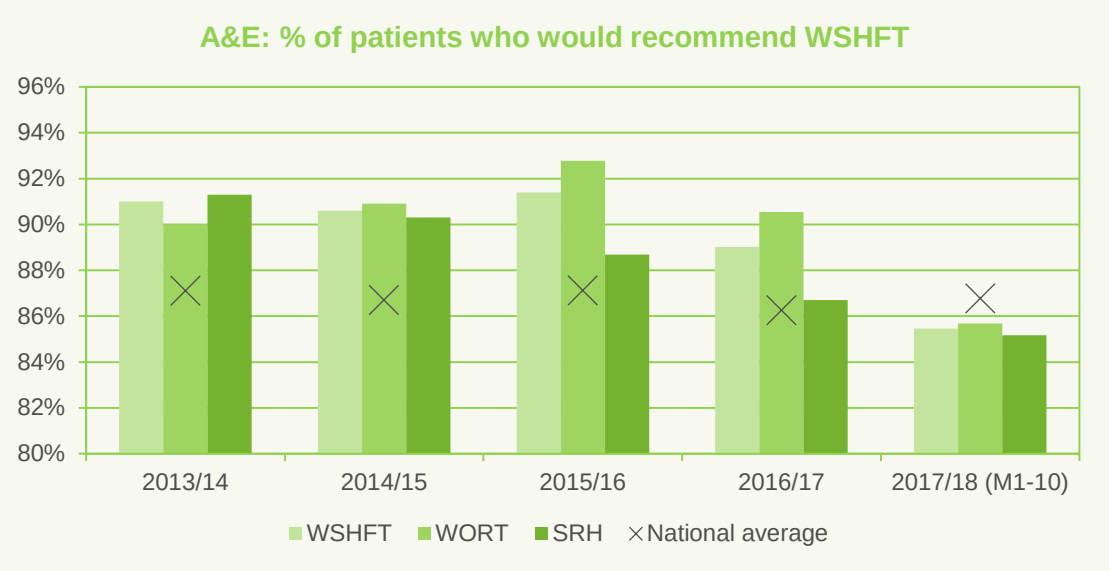
- To improve FFT response rate and achieve recommendation rates in line with national average of 92%.

FFT Performance 2017/18 A&E:

In 2017/18, for the first time, the A&E FFT performance has fallen below the national average. The trust is currently ranked 76th out of 139 trusts. In 2015/16, the trust was 49th.

Performance for this indicator has been falling since 2015/16. Nationally, performance since 2013/14 has remained fairly static. However, WSHFT has seen a 6% decrease over the same period.

We did not meet our goal of returning to the top 20% nationally for FFT recommendation.



FFT A&E Recommend Rate:

	2013/14	2014/15	2015/16	2016/17	2017/18 (Apr-17 to Jan-18)	National average 2017/18 (	National position 2017/18
WSHFT	91.00%	90.60%	91.39%	89.01%	85.45%	86.8%	84 of 137 (62nd centile)
Worthing	90.00%	90.90%	92.77%	90.5%	85.7%	86.8%	NA
St Richards	91.30%	90.30%	88.68%	86.7%	85.2%	86.8%	NA

N.B. 2017/18 National average figures presented are Apr 17 to Jan 18 only.

FFT A&E Response Rate:

	2013/14	2014/15	2015/16	2016/17	2017/18 (Apr-17 to Jan-18)	National average 2017/18	National position 2017/18
WSHFT	18.90%	26.70%	17.8%	12.5%	10.1%	12.6%	79th of 137 (58th centile)
Worthing	16.20%	27.50%	21.5%	13.6%	10.1%	12.6%	NA
St Richards	22.10%	25.90%	13.3%	11.2%	10.1%	12.6%	NA

N.B. 2017/18 National average figures presented are Apr 17 to Jan 18 only.

FFT Performance 2017/18 Inpatients

Our inpatients FFT recommendation score did not rank in the top 20% of NHS trusts nationally, nevertheless there are numerous improvements which have taken place. Our recommendation rates have recorded their highest ever scores to now exceed the national average. This improvement over last year saw our national position increase to 60th of 150 (40th centile). Our inpatient FFT response rate saw even larger gains over last year, with our position improving from 36th of 175 (21st centile) to 20th of 150 (14th centile).

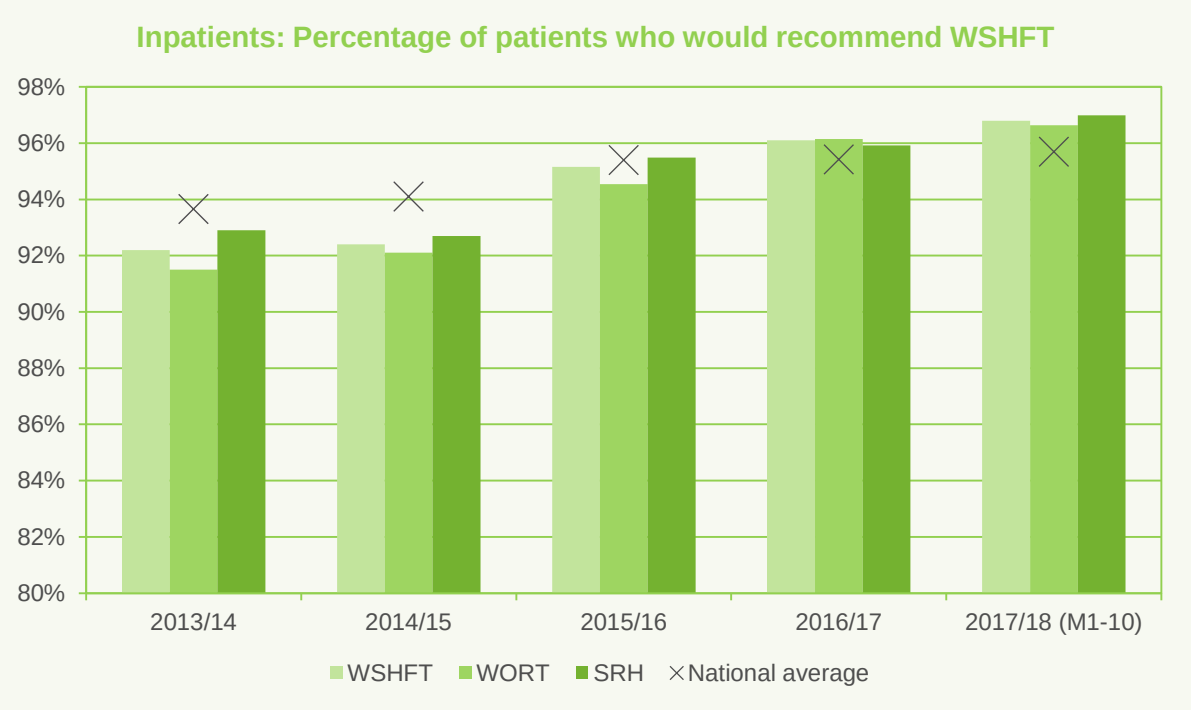
With a response rate averaging at 39% we have not achieved our objective to attain a 40% response rate across the Trust, nevertheless this represents a more modest improvement on last year.

FFT Inpatient Recommend Rate:

	2013/14	2014/15	2015/16	2016/17	2017/18 (Apr-17 to Jan-18)	National average 2017/18	National position 2017/18
WSHFT	92.20%	92.40%	95.2%	96.10%	96.80%	95.70%	60th of 150 (40th centile)
Worthing	91.50%	92.10%	94.5%	96.1%	96.6%	95.70%	NA
St Richard's	92.90%	92.70%	95.5%	95.9%	97.0%	95.70%	NA

N.B. 2017/18 National figures presented are Apr 17 to Jan 2018 only.

FFT Inpatients - Percentage of Patients who Would Recommend WSHFT



FFT Inpatient Response Rate:

	2013/14	2014/15	2015/16	2016/17	2017/18 (Apr-17 to Jan-18)	National average 2017/18 (	National position 2017/18
WSHFT	21.40%	30.70%	25.8%	34.7%	39.2%	24.65%	20th of 150 (14th centile)
Worthing	20.90%	30.80%	29.5%	42.3%	38.6%	24.65%	NA
St Richard's	21.90%	30.60%	25.2%	26.9%	39.7%	24.65%	NA

N.B. 2017/18 National figures presented are Apr 17 to Jan 2018 only.

FFT Performance 2018/18 Maternity

Our FFT birth response rate surpasses improvements seen in our inpatient scores. Maternity response rate improved from 29% to 51% during 17/18, which helped increased our national position from 62nd of 135 NHS trusts (46th centile) to 5th of 130 (4th centile). The increase means that our Trust achieves satisfaction rates 1% above the national average.

FFT Maternity Delivery Response Rate:

	2013/14 (from Oct 2013)	2014/15	2015/16	2016/17	2017/18 (Apr-17 to Jan-18)	National average 2017/18	National position 2017/18
WSHFT	17.00%	29.10%	11.7%	29.1%	51.0%	22.9%	5th of 130 (4th centile)
Worthing	13.60%	25.40%	11.1%	24.4%	50.1%	22.9%	NA
St Richard's	20.40%	32.30%	12.3%	33.3%	52.0%	22.9%	NA

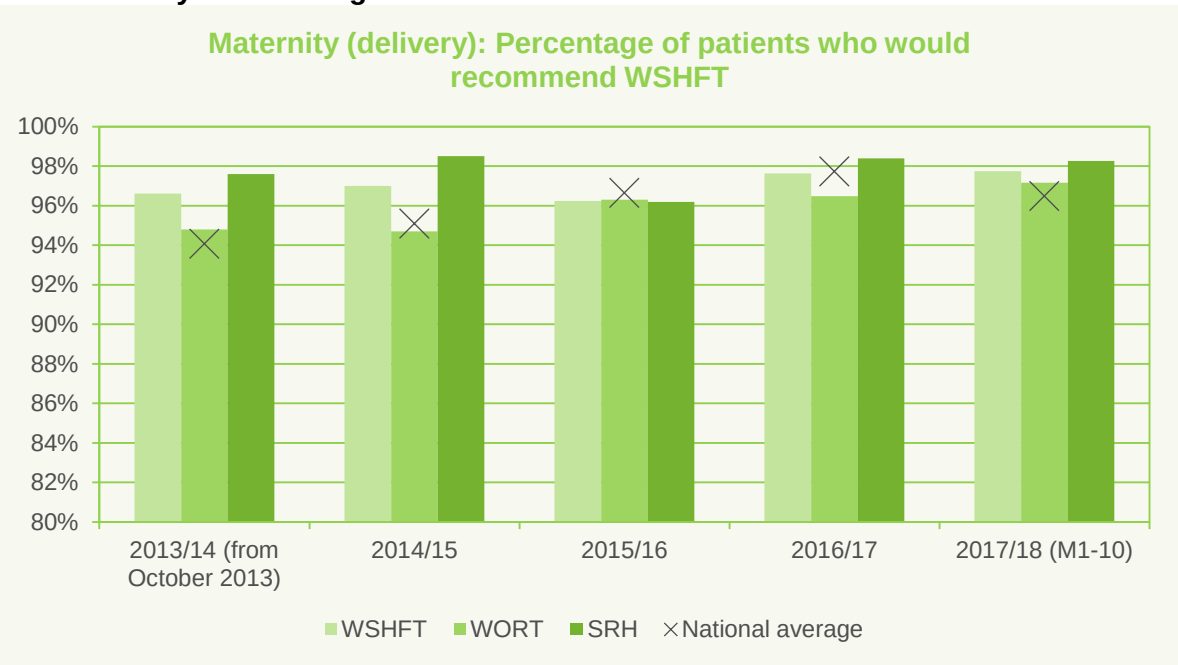
N.B. 2017/18 National figures presented are Apr 17 to Jan 2018 only.

FFT Maternity Delivery Recommend Rate:

	2013/14 (from Oct 2013)	2014/15	2015/16	2016/17	2017/18 (Apr-17 to Jan-18)	National average 2017/18	National position 2017/18
WSHFT	96.60%	97.00%	96.2%	97.6%	97.7%	96.5%	33rd of 130 (25th centile)
Worthing	94.80%	94.70%	96.3%	96.5%	97.2%	96.5%	NA
St Richard's	97.60%	98.50%	96.2%	98.4%	98.3%	96.5%	NA

N.B. 2017/18 National figures presented are Apr 17 to Jan 2018 only.

FFT Maternity – Percentage of Patients who Would Recommend WSHFT

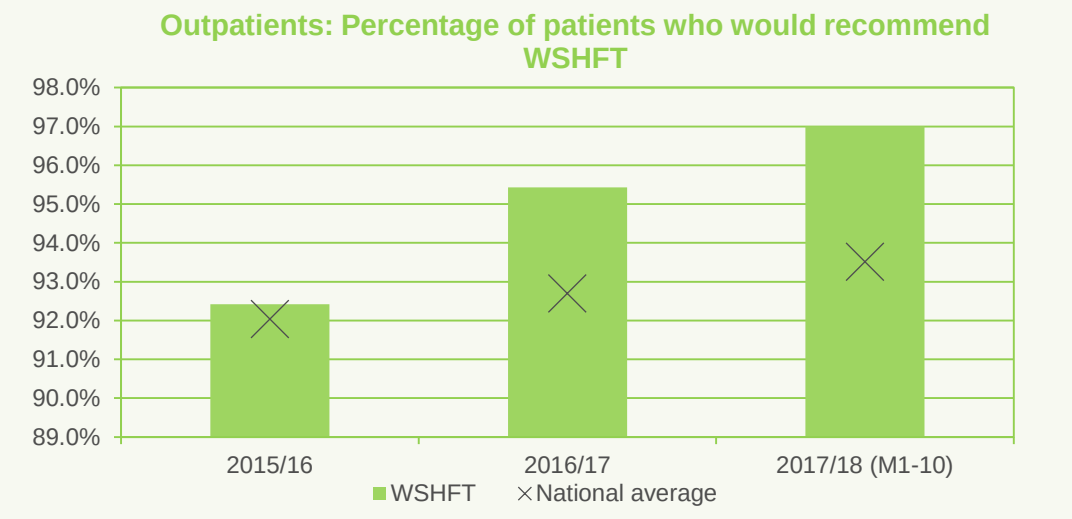


N.B. 2017/18 National figures presented are Apr 17 to Jan 2018 only.

FFT Performance 2017/18 Outpatients

It is very encouraging to see that our overall recommendation rate has increased to 97% which exceeds the national average (93.5%). Our outpatients departments recommend rate was recognised and celebrated by the Secretary of State during 2017/18.

FFT Outpatients - Percentage of Patients who Would Recommend WSHFT



N.B. 2017/18 National figures presented are Apr 17 to Jan 2018 only.

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 2017 we have participated in four key national surveys conducted on behalf of the Care Quality Commission (CQC); the National Inpatient Survey, the Emergency Department Survey, the National Maternity Survey, and Children and Young People's Inpatients and Day Case Survey. The full In Patient Survey report will be published in June 2018 and the highlights of these results are provided below.

National Inpatient Survey

The National Inpatient Survey conducted on behalf of the CQC provides a detailed picture of how patients view us across a number of dimensions. It includes measures that relate strongly to the care and compassion shown by individual staff and the organisation as a whole. This survey is a snap shot at one point in time conducted in one month, August, with the results being reviewed by the Trust Quality Board to support the planning of our improvement goals. The Trust response rate in report summarises the results of the National Inpatient Survey of patients seen in July 2017.

- With 581 surveys returned completed, the Trust had a response rate of 49.4%.
- The Trust scored an average score of 77% which is higher than in 2016.
- The Trust scored in the top 20% of Trusts on 15 questions and the bottom 20% of Trusts on 1 question.
- Compared with the 2016 survey, the Trust showed a 5% or greater improvement on 13 question scores.

The full report for 2017/18 will not be released until June 2018 and it is not currently possible to fully review our performance in comparison with the national picture.

Review of the results at a purely Trust level (in comparison with last year) for 2017/18 show that we are performing within the expected range for the majority of areas. We have scored highly in the following areas:

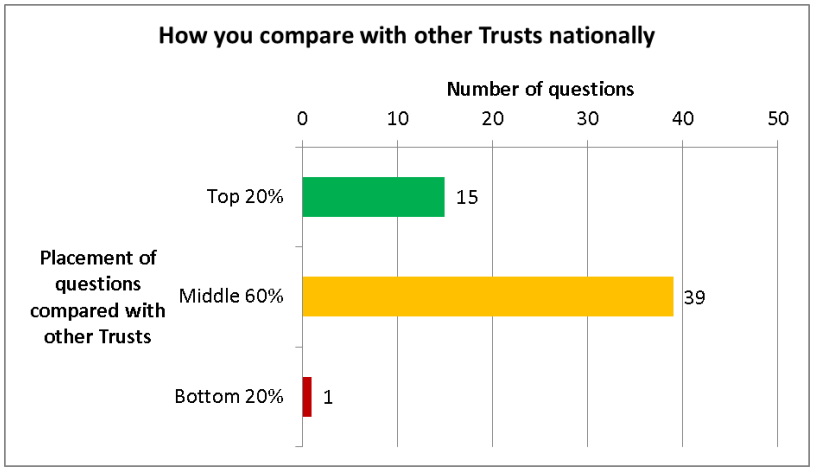
- Provision of information in A&E
- Waiting for a bed
- Room/ward cleanliness and privacy
- Practical and emotional support from staff
- Hospital food quality
- Confidence in nurses and teamworking
- Staff communications/information giving

The one area statistically identified in this survey that requires improvement is managing noise at night from other patients.

This data is collected from the CQC Inpatient Survey which is conducted every year. Respondents are asked the question: "Were you involved as much as you wanted to be in decisions about your care and treatment?" The option responses are "Yes, definitely", "Yes, to some extent" or "No". Results are then calculated by converting each respondent's answer to a question into a score (from 0 to 10), then averaging these to arrive at a single score for the trust, for each question. The higher the score, the better a trust is performing.

The trust's position/score is 8.9 in 2017 and this has remained between 8.9 and 9 over last 5 years. Nationally in top 3rd of table, although no national comparison is given. A very crude estimated national average is around the 8.85 mark. The full report for 2017/18 will not be released until June 2018 and it is not currently possible to fully review our performance in comparison with the national picture. However, benchmark comparision puts

the trust at 49th out of 149 Trusts in 2016. The minimum score being 8.15, and the maximum being 9.52.



National Children's and Young People's Inpatients and Day Case Survey

There are 4 questions where WSHT have received lower scores compared with most other Trusts in the survey:

- Offering a choice of admission dates where possible to 0-7 year olds 2.8 compared to a range of 1.6 to 6.
- Allowing access to parents and carers to be able to prepare food themselves if they wanted to. Scored 5.8 compared to a range 2.1 - 8.0.
- Staff playing or completing activities with the child/young person aged between 8 -11 years of age scored 3.5 compared to a range of 2.5 - 6.6.
- Involving children aged 8-15 years of age in decisions about their care and treatment scored 5.8 compared to a range of 5.4 - 7.9.

There are 4 questions where WSHT result is better compared with most other Trusts in the survey:

- Did the hospital change your child's admission date at all aged 0-7 years of age
- Having enough things to do in hospital for children aged 0-15 years of age
- Staff introducing themselves to children aged between 0-7 years of age
- Staff explaining procedures and operations beforehand to children aged between 8-15 years of age

Emergency Department Survey

The National Emergency Department Survey results are due to be published in July 2017. The response rate for 2016 has been measured as 25.6% this is a reduction from the previous response rate of 40.5% in 2015. There was one question that our score dropped by a statistically significant amount:

- Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?

Waiting times are a continuous area for improvement for hospitals globally. Nevertheless it is disappointing that our Trust has fallen back on the previous improvements we have made. FFT comments reveal that staff attitude is an influencing factor in the patients overall experience when they have suffered a long wait. They show that many patients who suffer a

long wait are still willing to give us positive feedback if we have displayed positive staff attitude. However many patients who complained about waiting times were upset that they did not receive any communication as to how long the wait would be or why they were waiting. Poor communication exasperates long waiting times. Improving our communication about the expected waiting time, and inform our patients that there is a triage system in place would help to provide a more positive patient experience.

Creating a pleasant environment makes the difference for patients. Patients regularly comment on the cleanliness, chairs, drink and snack machines, and the overall feeling of welcome a good environment can bring. Many patients struggle with anxiety, claustrophobia and other mental health concerns. For them to wait several hours in an unpleasant environment can be very difficult and traumatising. It would be beneficial to look for ways in which we can improve our environment as many comments received from patients waiting in A&E in December stated that the reception area was cold and the seating was uncomfortable.

National Maternity Survey

The Trust took part in the National Maternity Survey of Women that have had a birth experience during February 2017. The results were published in January 2018 and statistically relevant improvements were achieved in 5 questions across the maternity pathway (antenatal, birth and post natal care). Generally the other questions were categorised as 'about the same' and it is reassuring to know that patient satisfaction has not deteriorated since the previous National Maternity Survey was collected by the CQC in 2015.
Improved Questions:

Ante Natal

- During your antenatal check-ups, did the midwives listen to you?

Post Natal

Results had significantly improved against the following questions:

- Were your decisions about how you wanted to feed your baby respected by midwives?
- Were you given enough information about any emotional changes you might experience after the birth?
- Were you told who you could contact if you needed advice about any emotional changes you might experience after the birth?
- Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP?

One opportunity for improvement was identified as increasing facilities within the environment so that women during labour are able to move around and choose a position that increases their comfort.

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 score, which enables them to celebrate excellence with their teams and to set local improvement goals for areas identified as being of concern.

A heat map displaying the responses given to our monthly inpatient survey reveals that our lowest performing areas are noise at night, discussions about discharge, and experience of food. These 3 themes are consistent and also triangulate with the opportunities for improvement identified via the National Inpatient Survey 2017. Action plans are being developed with teams to improve these areas of low satisfaction. Contributing factors

leading to the creation of noise at night are described as confused patients calling out, other patients snoring or talking, bleeping equipment, squeaky trolley wheels, air pumps as well as staff talking.

Overall from April 2017 to March 2018, 6,066 surveys have been completed by patients in many different areas including inpatient wards, outpatients, children's and a number of specialist services. There were some 3,912 responses to the adult inpatient RTPE survey during this period.

Triangulating our RTPE survey results with PALs concerns and complaints has shown that our non-elective areas, (both A&E and Emergency Floor's) and wards with patients experiencing a longer length of stay due to orthopaedic or elderly rehabilitation incur more frequent occurrences of patient dissatisfaction.

Breakdown of the Number of Local Surveys Undertaken:

	2016-17		2017-18	
Name of Survey	% Satisfaction	Numbers of Surveys completed	% Satisfaction	Numbers of Surveys completed
Adult Inpatient	80%	3,746	93%	3,912
PHIN	N/A	N/A	98%	237
Outpatient	72%	20	-	-
Children's Inpatient	92%	469	99%	608
Neonatal Unit	95%	243	98%	249
Paediatric Oncology	100%	4	100%	6
Paediatric Neurology Outpatients	N/A	N/A	84%	45
Endoscopy Unit	92%	282	93%	276
Emergency Floor	83%	202	95%	77
End of Life Care	71%	70	91%	88
Acute Oncology	N/A	N/A	67%	3
Antenatal	95%	271	100%	41
Birth and Postnatal Inpatient Survey	97%	1,131	96%	55
Postnatal Community	99%	276	100%	5
Carers Questionnaire	91%	84	-	-
Carers Discharge	86%	56	100%	2
Adult Outpatient - Fernhurst Clinic	92%	72	88%	17
Outpatient Fernhurst Centre	83%	28	100%	1
Gynaecology Outpatient Clinic	N/A	N/A	89%	347
Therapies Outpatient	98%	1,495	99%	97
Therapies Inpatient	90%	426	-	-

Other Forms of Feedback

A change in methodology for capturing care in action will be implemented in April 2018 called peer review; this process will address the frequency in which staff, volunteers and Governors are asked to undertake internal audit across the Trust.

NHS Choices and Patient Opinion

Patients have the opportunity to provide feedback through public forums such as NHS Choices and Patient Opinion, the communications team respond to most of this feedback. NHS Choices has the Trust at a current rating of 4 stars. An example of a positive comment that was left in Dec 2017 is below:

- The whole of my experience with the various consultants and physiotherapists liaising closely took away any worries and fears. I would like to thank all of you from the bottom of my heart from the bookings clerk to the consultants.

A change in process has been implemented during 2017 so that we can provide assurance that any comment posted onto NHS choices website will be responded to within 48 hours.

Learning Disability Peer Review

The last external learning disability review took place in September 2016 and it is due to be repeated as part of the Peer Review process during September 2018.

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 2017 a full review of the volunteering service has been undertaken with the aim to widen the scope of volunteering in the Trust whilst ensuring that we have the infrastructure to support our ambitions.

Patient Information

We aim to consistently meet the new Assessable Information Standard introduced by the CQC. Meeting this standard will improve the access to our services, how people experience our services, and the outcome which patients receive. WSHFT is for all members of the public and our improvements to information services will eradicate any latent issues to those with communication difficulties.

PALS and Complaints Service

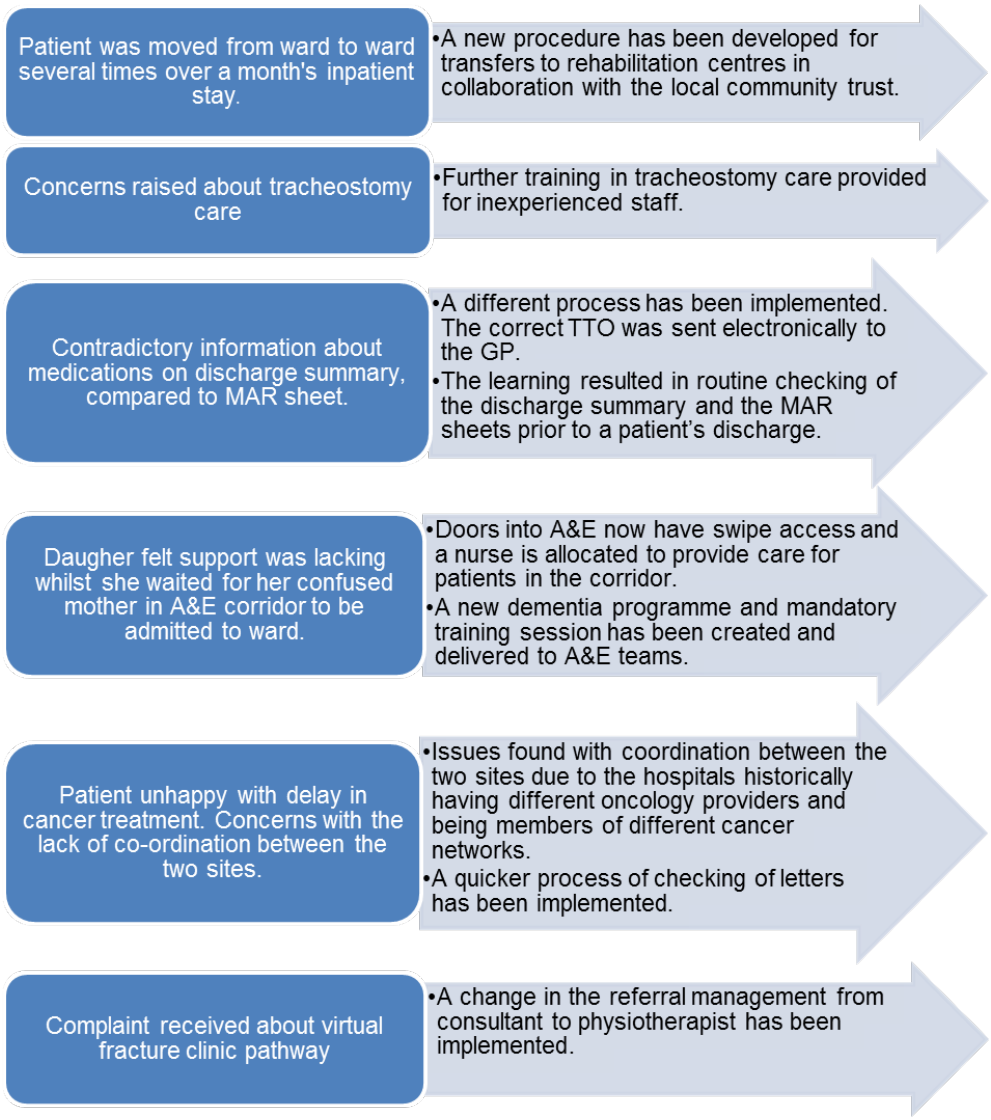
The Customer Relations Team (Patient Advice and Liaison Service and complaints team) provide advice on how and where to complain, investigate matters of concern and help facilitate a resolution when things have gone wrong. PALS carry out signposting, provide information, advice or reassurance and manage 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:	114	118	103	96	431
No acknowledged within 3 working days (%)	-	-	-	-	98%
No of closed cases:	153	139	115	103	510
No closed in 25 days (%)	12%	28%	57%	52%	37%
No closed in 26-60 days (%)	30%	56%	33%	36%	39%
Re-opened cases	17	19	23	16	75

Lessons Learnt

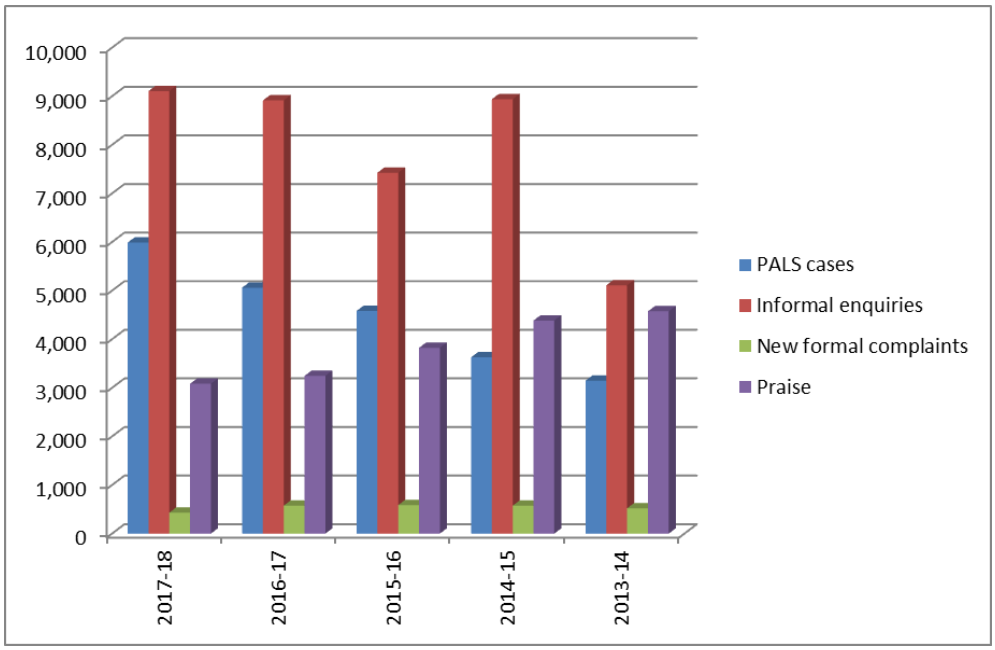
We are aware that the number of issues around appointments has risen over the recent years, some of this is related to a significant increase in specialties such as ophthalmology where the criteria for referral has changed and our capacity to see patients has not grown at the same rate. The patient experience strategy was launched in 2018 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:



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. The committee audited a selection of formal complaints received in 2017-18 to ensure that the complaints process is managed fairly and effectively and in accordance with policy and procedure.

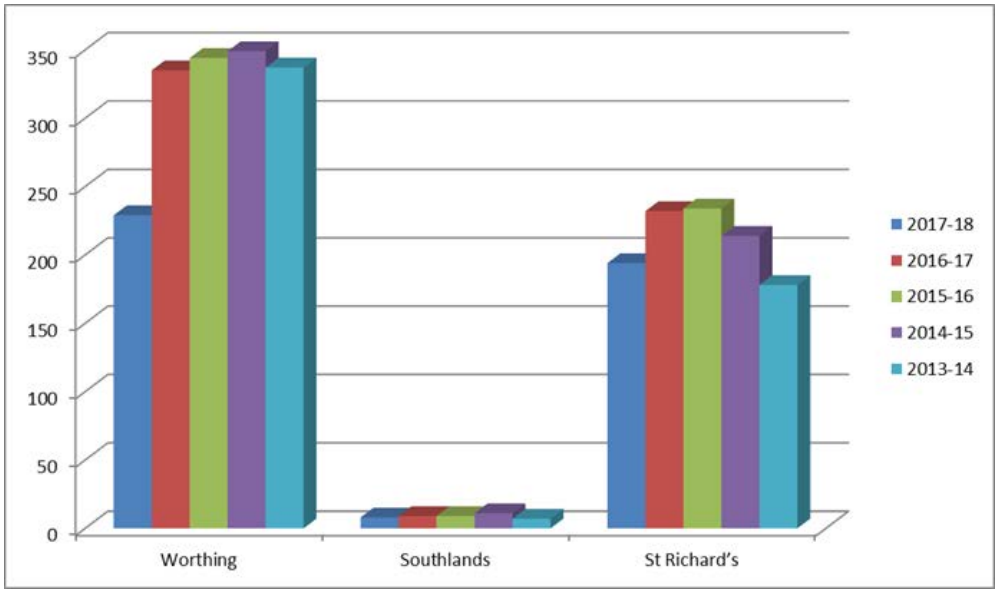
Type of Cases

	2017-18	2016-17	2015-16	2014-15	2013-14
PALS cases	5,990	5,061	4,582	3,627	3,149
Informal enquiries	9,106	8,914	7,426	8,939	5,110
New formal complaints	431	576	587	574	522
Praise	3,084	3,246	3,823	4,385	4,574



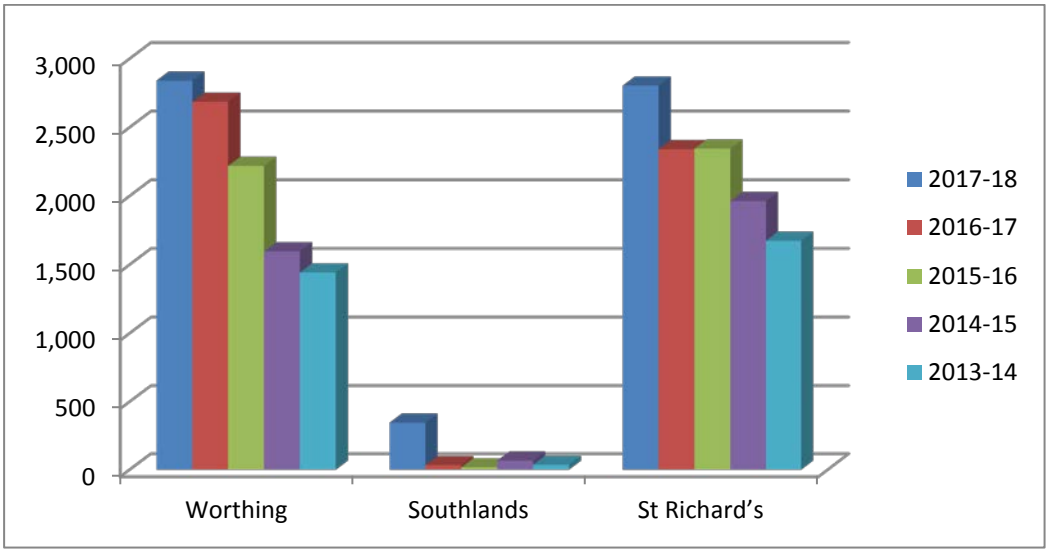
Formal Complaints Received by Site

	2017-18	2016-17	2015-16	2014-15	2013-14
Worthing	229	335	344	349	337
Southlands	8	9	9	11	7
St Richard's	194	232	234	214	178
Total	**431**	**576**	**587**	**574**	**522**



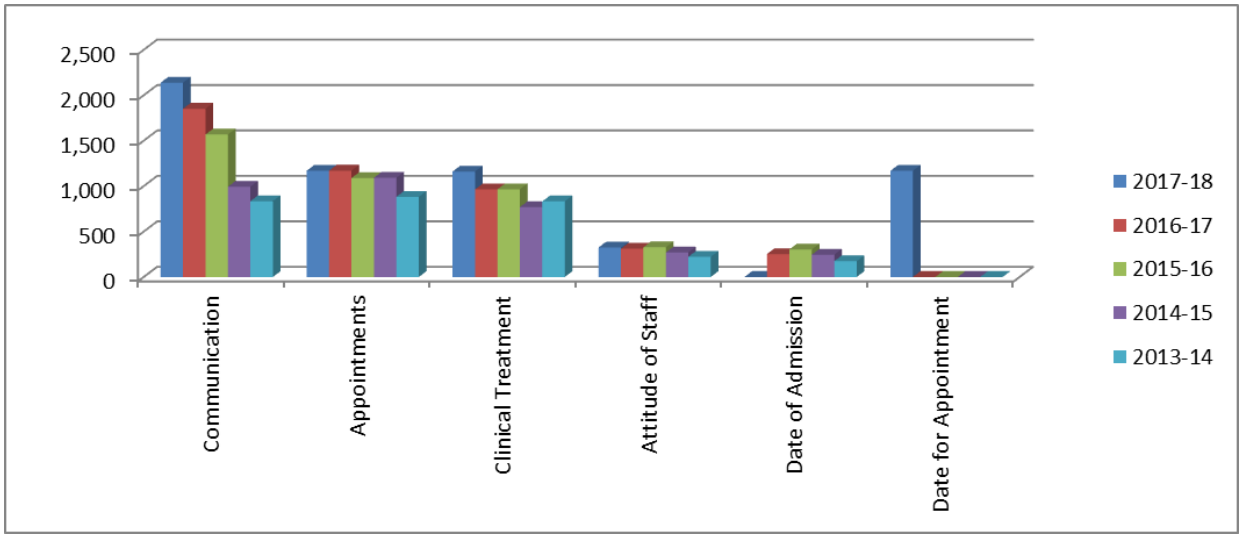
PALS Enquiries Received by Site

	2017-18	2016-17	2015-16	2014-15	2013-14
Worthing	2,840	2,686	2,219	1,597	1,443
Southlands	346	34	18	67	36
St Richard's	2,804	2,341	2,345	1,963	1,674
Total	**5,990**	**5,061**	**4,582**	**3,627**	**3,153**



Top 5 Enquiries (PALS & Complaints) Received by Category

	2017-18	2016-17	2015-16	2014-15	2013-14
Communication	2,138	1,851	1,568	993	834
Appointments	1,168	1,170	1,088	1,092	882
Clinical Treatment	1,160	963	965	769	832
Attitude of Staff	324	312	327	269	222
Date of Admission	0	252	303	245	174
Date for Appointment	1,168	0	0	0	0



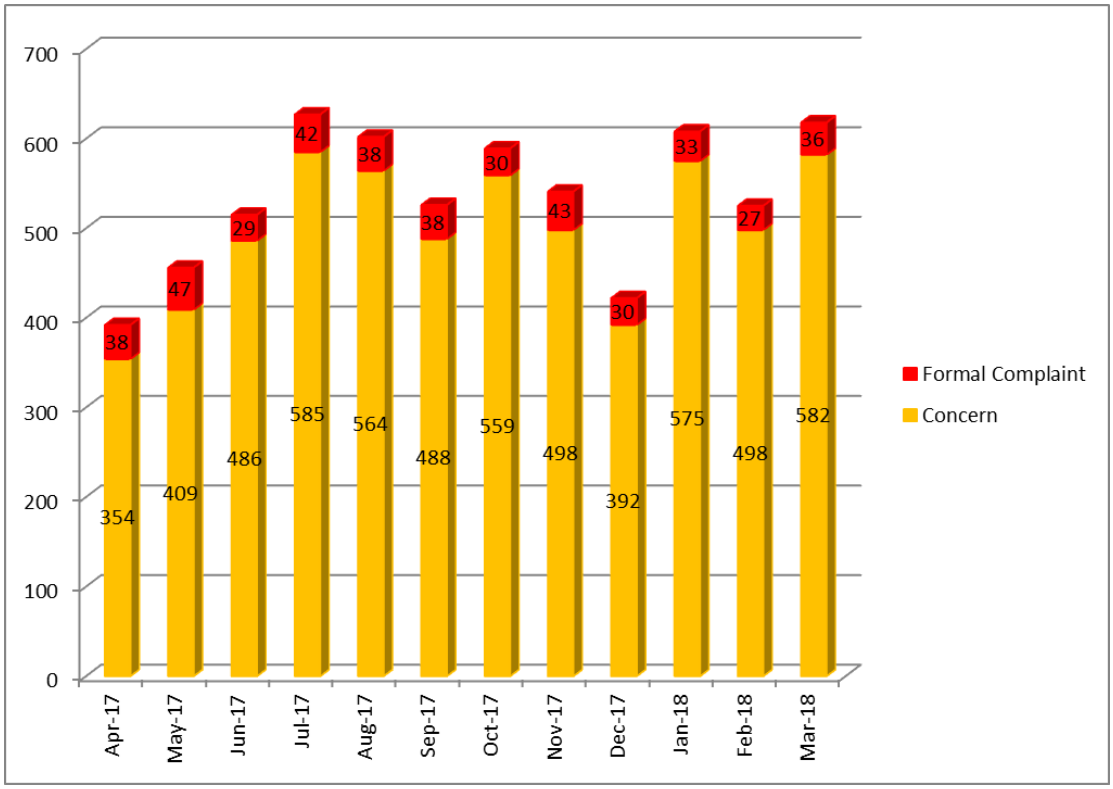
Formal Complaints Compared with Hospital Activity

	2017-18	2016-17	2015-16	2014-15	2013-14
Complaints relating to inpatient care	195	263	247	243	233
Rate per 1000 bed days	0.57	**0.76**	**0.75**	**0.75**	**0.74**
Complaints relating to outpatient appointments	142	221	261	226	197
Rate per 10,000 new appointments	4.92	**9.29**	**11.40**	**10.50**	**10.06**
Complaints relating to A&E	84	94	79	105	92
Rate per 1,000 A&E attendances	0.60	**0.68**	**0.58**	**0.78**	**0.69**

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 39 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 2017	354	38	**392**
May 2017	409	47	**456**
Jun 2017	486	29	**515**
Jul 2017	585	42	**627**
Aug 2017	564	38	**602**
Sep 2017	488	38	**526**
Oct 2017	559	30	**589**
Nov 2017	498	43	**541**
Dec 2017	392	30	**422**
Jan 2018	575	33	**608**
Feb 2018	498	27	**525**
Mar 2018	582	36	**618**
Total	**5990**	**431**	**6421**

A majority of the complaints received are due to poor communication. Although there has been training in the past this has not tackled the recurring problem of communication complaints.

During 2017, additional staff training has been provided through the Health and Safety mandatory training as well as the opportunity to attend a study day in March 2018 involving actors who will demonstrate that how staff communicate directly impacts upon how patients feel about their care overall. Well recognised scenarios will be recreated to challenge perceptions, improve understanding and create recognition and empathy in a 'safe', positive learning environment.

Reducing Complaints and Improving the Timeliness of Complaint Responses

There has been a significant improvement in the formal complaint responses within 25 working days and in Q2 over half (57%) of the complaints closed, met this target compared to 28% in the previous quarter. It is also of note that the number closed within 60 days reached 90%.

The responsiveness to complaint responses during 2017 across the three largest divisions is shown below:

Division	% in 25 days			% in 26-60 days		
	Q2 17-18	Q3 17-18	Q4 17-18	Q2 17-18	Q3 17-18	Q4 17-18
Women & Children	14%	63%	62%	60%	28%	25%
Medicine	20%	50%	52%	55%	33%	41%
Surgery	34%	70%	38%	61%	25%	46%
Core	86%	50%	100%	14%	57%	0%

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 were working towards achieving 60% of complaints closed within 25 days by the end of December 2017 and the trust reached 57%. This improvement in performance has been achieved by introducing a whiteboard meeting on each site that provides an opportunity for the complaints team to discuss progress with each divisional representative and prioritise actions to deliver a response within 25 working days. The Strategy Deployment Review (SDR) process has also significantly raised the importance of reducing delays to formal complaints with senior divisional managers.

The number of formal complaints that have reopened has increased compared to previous performance measured in 2016-17. 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 increase in the number of cases that have re-opened since the response rate has increased.

	Re-open rate %
Q1 17-18	10%
Q2 17-18	15%
Q3 17-18	20%
Q4 17-18	16%

The number of PALS enquiries and general information requests has also increased significantly year on year.

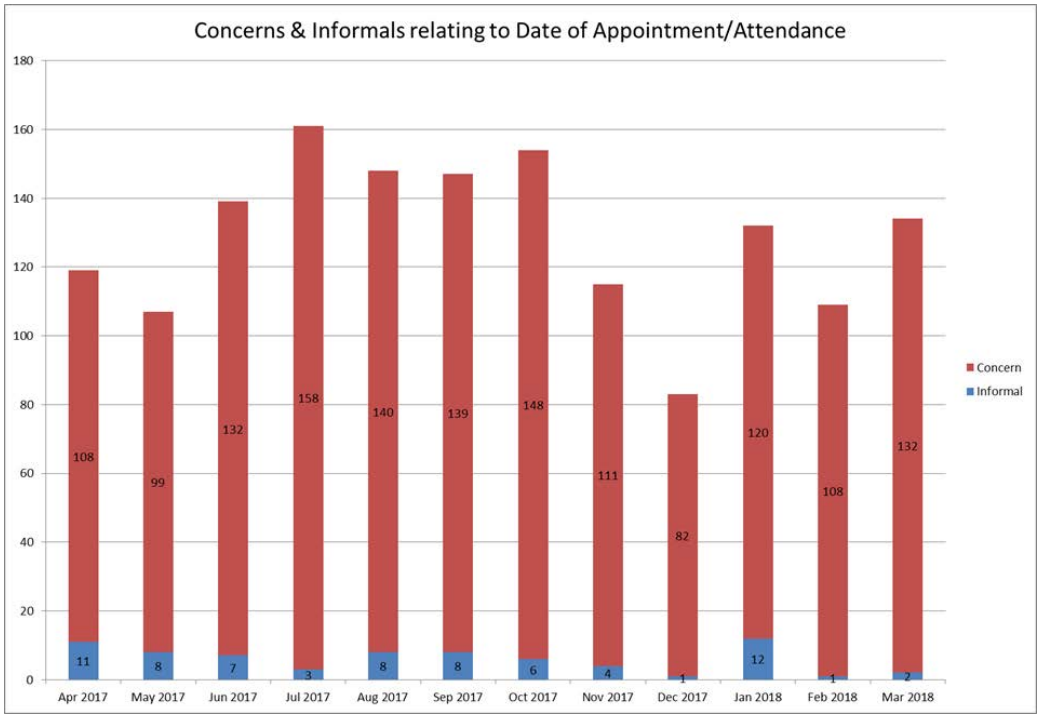
The number of appointment related complaints and PALS enquiries has similarly increased and the Trust is currently working to reduce the level of dissatisfaction and improve processes. Clinical treatment remains the most common reason for a making a formal

complaint, when this subject is looked at in more detail it relates to the co-ordination of medical treatment.

Oral communication remains the most common reason for patients and their families raising a concern or an informal enquiry with our PAL's service. In March 2018 the trust commissioned two half day drama-based training sessions for any staff to explore how to deal with difficult subjects, sensitively and sensibly, to enable positive change in the workplace. Feedback was extremely positive as can be seen below and it is hoped that this style of communication can be repeated again in the future.

- "The whole session was fabulous – far exceeded my expectations and very thought provoking."
- "The fact that the content was based on the real experiences within our Trust was the thing which gave it the most powerful impact – this is not somewhere else, we are great but we do still get it wrong at times so it is very humbling to be made to face this reality and take some time to really explore how we as individuals really can influence the experience of our colleagues and patients /families using our service. We can all do our little bit. The content was nothing new but the way it was presented ensured that no one could realistically ignore the message."

The graph below shows that there has been an increase in the number of contacts made to PALS in relation to outpatient services. 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 below shows how the PALS concerns linked to Southlands has increased significantly since June 2017. Further review of the records reveals that 70% are linked to the Ophthalmology Eye Care Unit now based at Southlands Hospital.

	Worthing	St Richard's	Southlands	Total
Apr 2017	150	198	6	**354**
May 2017	194	206	9	**409**
Jun 2017	238	240	8	**486**
Jul 2017	238	294	53	**585**
Aug 2017	260	269	35	**564**
Sep 2017	223	223	42	**488**
Oct 2017	283	237	39	**559**
Nov 2017	270	200	28	**498**
Dec 2017	187	186	19	**392**
Jan 2018	305	240	30	**575**
Feb 2018	229	231	38	**498**
Mar 2018	263	280	39	**582**
Total	**2840**	**2804**	**346**	**5990**

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 2017/18. During this time, almost three quarters of all cases closed (73%) were not upheld and a decision is awaited on a further 5 cases. In the two cases upheld, a total of £2,000 was awarded as compensation to address service failures. There has been a significant reduction in the number of cases referred to the Ombudsman. There are now only five cases open.

Number of Cases	Q1 2017-18	Q2 2017-18	Q3 2017-18	**Q4 2017-18**	**Totals**
Outstanding previous Quarter	7	4	8	4	**-**
New Referrals	2	5	-	2	**9**
Closed	5	1	4	1	**11**
Upheld	-	-	1	-	**1**
Partly Upheld	2	-	-	-	**2**
Not Upheld	3	1	3	1	**8**
Total Open	**4**	**8**	**4**	**5**	**5**

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

*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.

Upheld Cases

First received	Description	Ombudsman outcome narrative	Division (primary)
04/08/15	Various concerns regarding difficult diagnostic pathway and delay in appointments when requested by consultant. Complainant says that decision to administer Chemo a wrong one and has some issues around nursing care.	The family were awarded £1,500 to recognise the serious impact/emotional distress and an action plan put in place to learn lessons. The Ombudsman found failings in relation to administrative errors, lack of informed consent for chemo, nutritional support, oral hygiene, psychological needs and complaints handling process.	Core
18/04/16	Patient suffered with infection after having metal pin inserted to their leg after break. Feels that follow up treatment to infection was lacking and had to go to QVH and BSUH for further treatment.	Trust challenged elements of the report. However the Ombudsman's decision remained partially upheld. They found failings in relation to weight bearing advice given at discharge as the most recent x-ray had shown no evidence of bone healing. The Trust has apologised and provided an action plan to address these failings.	Surgery
07/09/15	Between July 2014 and May 2015, Worthing Hospital failed to diagnose and treat patient's heart problem. Subsequent diagnosis took place at Southampton General hospital. The cardiology team failed to diagnose bradycardia between July 2014 and May 2015 despite the patient having attended (A&E) a few times with acute symptoms.	£500 compensation awarded to reflect the impact of this delay on the patient's wellbeing and action plan put in place to learn lessons. The Ombudsman partially upheld the complaint because the Trust failed to offer a pacemaker from November 2014 onwards resulting in a reduced quality of life for approximately six months.	Medicine

Our Goals for 2018/19

To Implement 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.

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

To: Trust Board

Date of Meeting: 26th July 2018 Agenda Item: 9

2017 Annual Adults Safeguarding Report
The purpose of this report is to provide the Trust Board with an update on developments and activity in relation to safeguarding adults work
Responsible Executive Director
Nicola Ranger
Prepared by
Annie Blackwell, Trust Lead for Safeguarding Adults
Status
Disclosable
Summary of Proposal
The purpose of this report is to provide the Board with an overview of annual Adult Safeguarding within Western Sussex Hospital NHS Foundation Trust.
Implications for Quality of Care
1. Negative Patient experience. 2. Loss of public confidence in the Trust. 3. Failure of compliance with Care Quality Commission standards and Health & Social Care Act 2008.
Link to Strategic Objectives/Board Assurance Framework
Patient Safety agenda – improving the patient experience/learning lessons.
Financial Implications
1. Subsequent patient litigation claims may occur 2. Loss of Commissioner Confidence may result in loss of Trust business.
Human Resource Implications
1. Professional performance management issues for individuals 2. Learning and development requirements 3. Organisational behavioural and cultural issues
Recommendation
The Board is asked to note the contents of this report
Communication and Consultation
Not applicable
Appendices

Western Sussex Hospitals NHS

NHS Foundation Trust

Annual Report: Safeguarding Adults

June 2018

Prepared By:

Annie Blackwell

Trust Senior Lead for Safeguarding Adults

Table of Contents

1. Introduction and Executive Summary

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

The annual safeguarding adults report provides an update on safeguarding adults activity within Western Sussex Hospitals Foundation Trust from 1st April 2017- 31st March 2018 and compares this with the available activity data from the local authority.

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

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

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

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

2. Governance and Accountability Arrangements

2.1 The Safeguarding Adults Team at WSHFT

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

Chief Nurse	Executive Lead
Annie Blackwell	Trust Senior Lead for Safeguarding Adults
Pam Mariner	Safeguarding Nurse Specialist (retires end April 2018)
Nikki Mardell	Mental Capacity Act Lead
Marianna Wilmott	Team Administrator

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

The expansion of the safeguarding team improved the service as there was a greater capacity to visit and support the wards and deliver ad hoc training. However the impact of this has been increased activity which is now adversely impacting on the team's ability to support the wards as effectively as we would like.

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

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

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

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

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

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

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

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

The WSSAB has a number of sub-groups (Training, Quality and Assurance and Communications and Promotions). The safeguarding adults team attend the training and quality and assurance group meetings.

The West Sussex Safeguarding Adults Board (WSSAB) receives assurance of each organisations performance through an assurance document.
Western Sussex Hospitals Foundation Trust is represented on this Board by Nursing Director, Dr Maggie Davies.

2.3 NHS Professionals Forum

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

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

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

2.4 The Adult Safeguarding Operational Group (WSHFT)

The Adult Safeguarding Operational Group meets quarterly.

The purpose of the group is as follows:

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

- To recommend to the Quality Board those policy & practice changes that are required as a result of learning from safeguarding enquiries.
- To monitor the implementation of the Care Act 2014 within WSHFT.

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

2.5 Adults & Children's Safeguarding Strategy Committee

The Safeguarding Strategy Committee meets 3 times a year.

The purpose of the Committee is as follows:

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

The Executive Lead is the Nursing Director Dr Maggie Davies and the Non-Executive Director is Joanna Crane; both attend these meetings, which are also attended by the Safeguarding Leads for Adults and Children and by the Adults and Children's safeguarding doctors.

3. Review of the Year

3.1 National and Local Assessments and Policy Changes Care Act 2014

The Care Act (2014) resulted in significant changes to the safeguarding adults' process, and it took some time for the changes to become embedded within the local authority safeguarding processes. Under the Act, the local authority has the statutory duty for undertaking enquiries or for causing enquiries to be made where there are concerns about an adult who meets the criteria for safeguarding duties identified in section 1 on page 3.

Any safeguarding concern which relates to an adult who meets the 3 key tests should be managed via a Section 42 enquiry (section 42 refers to that part (section) of the Act).

The 3 key tests are as follows:

- Is experiencing or is at risk of abuse and neglect
- Has care and support needs
- As a result of these care and support needs is unable to protect themselves from harm or abuse

The Care Act also introduced new categories of abuse: domestic violence or abuse, modern slavery, and self-neglect, in addition to categories already identified: sexual, physical, psychological, financial, neglect, organisational abuse and discrimination. These new categories have resulted in an increase in the numbers of safeguarding concerns being raised.

Nationally, there has continued to be reports of safeguarding cases which have continued to raise public awareness of the issue of adult abuse. There have been a number of Safeguarding Adults Reviews in West Sussex, and organisations have been required to submit action plans.

Within the Trust, increased awareness of safeguarding issues is evident by the increased number of safeguarding concerns reported by trust staff. This year has seen a 67% increase in the number of concerns reported to the safeguarding adults team.

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

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

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

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

3.3 West Sussex Safeguarding Adults Policy and Procedures

A review of the pan Sussex Safeguarding Adults Policy and Procedures is currently being undertaken; the original completion date was June-July 2017, but publication is now expected in June/July 2018. Once these have been published, the Trust policy will be updated to reflect the changes in the safeguarding procedures.

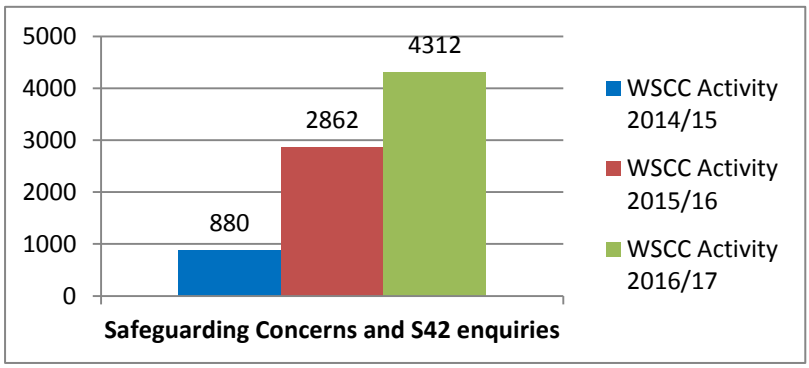
3.4 West Sussex County Council Safeguarding Activity

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

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

The data given below is taken from the West Sussex Adult Safeguarding Board's Annual Report 2016-17, which was the most recent data available at the time of writing this report. Table 1 illustrates the number of safeguarding concerns, and safeguarding enquiries actioned by the local authority in the last three years.

Table 1: Safeguarding activity within WSCC



The WSSAB has also commissioned a number of Safeguarding Adults Reviews; WSHFT has been involved in two recent SARs, and the reports are due to be published shortly.

4. Trust Safeguarding Adults Activity

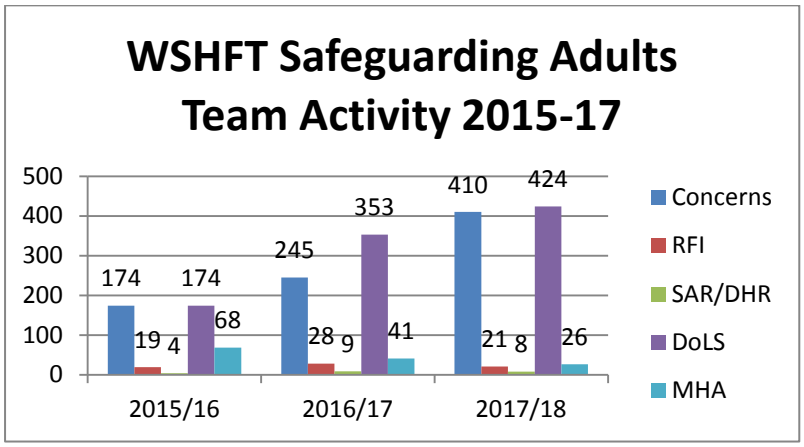
4.1 Trust Safeguarding Adults Team Activity

The Safeguarding Adults Team's work includes safeguarding casework, Safeguarding Adults Reviews (SARs) and logging all Deprivation of Liberty Safeguards (DoLs) as well as the recording of those patients detained to WSHFT under the Mental Health Act.

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

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

Table 2: Comparison of all Safeguarding activity within WSHFT 2015-2017.



This table clearly demonstrates that year on year, the number of both safeguarding concerns and DoLS authorisation requests has continued to increase.

In the last year, the number of safeguarding concerns being raised has increased by 67% and DoLS authorisation requests have increased by 20%. This increase in activity is not matched with an increase in staff and workload will be continually reviewed to determine what is essential and what aspects are no longer able to be supported.

4.2 Trust Safeguarding S42 Enquiries

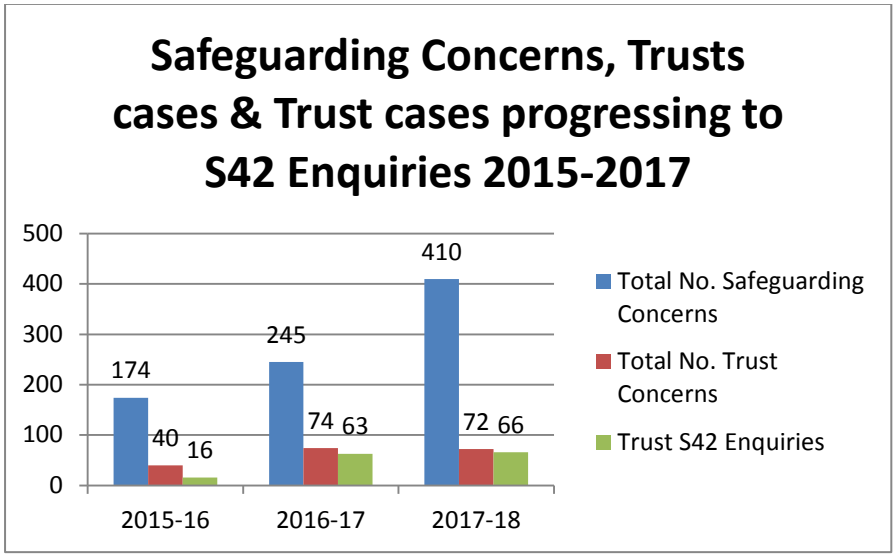
In last year's annual report, it was predicted that the number of Section 42 enquiries relating to Trust care would increase. Despite the total number of safeguarding concerns raised during the year increasing, the total number of safeguarding concerns raised about Trust care actually decreased. In 2016/17, 25% of the 245 concerns related to Trust care and resulted in a S42 enquiry.

In 2017/18, the total number of concerns raised during the year was 410; of these, only 72 (18%) were related to Trust care and of these, 66 (16%) became Section 42 enquiries.

The reason for this decrease is unclear; data from future years will need to be analysed to determine if this trend is sustained.

Table 3 illustrates data for the last 3 years on the total number of safeguarding concerns received by WSHFT and includes both concerns about external care provision and Trust care provision. Further detail is given on the number of trust cases which progressed to Section 42 (S42) enquiries.

Table 3: Trust safeguarding concerns progressing to S42 enquiries



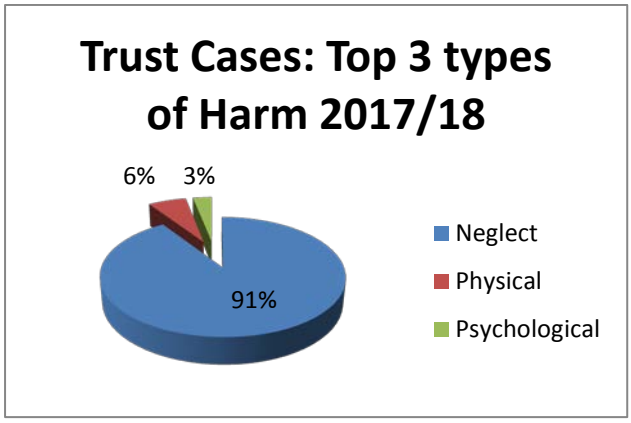
The safeguarding adults team have challenged some of the Section 42 enquiries, believing that they are not safeguarding issues, but issues related to quality, and so should be managed outside of the safeguarding process. It is expected that the revised Sussex Safeguarding Adults Policy and Procedures will recognise such incidents and advise on a more appropriate method for managing them.

4.3 Types of harm in Trust cases

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

Chart 1 illustrates the Trust concerns by category type.

Chart 1: Trust concerns by category of abuse:



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

The physical cases include a patient who reported alleged rough handling by an agency nurse; bruising, which was found to be the result of medication and not an assault, and two “patient on patient” incidents.

The two psychological cases were incidents which related to staff attitude which allegedly caused the two patients some distress.

4.4 Safeguarding Adults Reviews

The Safeguarding Adults Team received 8 “Summary of Information” requests during the year. None of these became full Safeguarding Adults Reviews. However, the Trust continued to be involved in two SARs from the previous year, both of which are due to be published imminently.

Learning from these SARs which the Trust had no direct involvement will be included in an overarching Action Plan.

4.5 Domestic Violence Referrals

Changes in the way in which domestic violence support is delivered in West Sussex has meant that WORTH services are no longer based on site, with the effect that the close working relationship that WSHFT had with WORTH has diminished and data on referrals to WORTH is no longer collected as WORTH does not exist in its previous format.

Work has been ongoing throughout the year to develop a business case for a Harm Reduction Worker, who would work with those experiencing domestic abuse, but also frequent users of A&E services and the homeless, for example. The safeguarding teams have approached various organisations for funding but so far, to no avail.

Although the safeguarding adults team are unable to attend MARAC (Multi-Agency Risk Assessment Conference) meetings, we continue to support the work of MARAC by supplying related health information on specific individuals to the meetings in each area.

4.6 Prevent Agenda

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

The last year has seen the requirement for Prevent WRAP (Workshop Raising Awareness of Prevent) training to be delivered to specific staff groups, with the data being reported to NHS England on a quarterly basis. The training of those staff who require WRAP training continues, but this is slow as WSHFT does not yet have an accredited WRAP trainer.

5.0 Safeguarding Adults Training

The delivery of safeguarding training was a challenge initially due to resource issues, but since the appointment of the Safeguarding Nurse Specialist and Mental Capacity Act Lead, the capacity to deliver training has improved greatly. This is evident in the training figures which have increased from 76.1% in May 2013 to 96.3% as at March 2018.

The first Safeguarding Adults Intercollegiate document for roles and competencies for health care staff was published in February 2016 and is currently being amended. This sets out the required levels of training required for staff depending upon their role. Most clinical staff will require training to Level 2; those staff undertaking S42 enquiries will

require training to Level 3. In addition, more detailed training on modern slavery and PREVENT will also be required in the coming years.

In the last year, safeguarding adults and mental capacity act training has been included in the Annual Clinical Update. This has enabled more targeted training for clinical staff (as recommended in the intercollegiate document) and was based around case examples.

The provision of e-learning for Safeguarding Adults and Children will be changed to the E-learning for Health platform as soon as Internet Explorer 11 has been implemented. These modules are externally verified and updated and are the e-learning modules supported and recommended by the Trust Safeguarding Leads.

As stated in section 4.6, Prevent WRAP training has been delivered this year. The focus has been on A&E and the sexual health teams. The training content is very specific and can only be delivered by a Prevent trainer certified by the Home Office. As WSHFT do not have any certified trainers, these training sessions are being delivered by the Prevent Lead at the CCG. The expectation is that the CCG Prevent Lead will train staff here in WSHFT who can then become accredited WRAP trainers to take the training forward.

6. Mental Capacity Act Activity

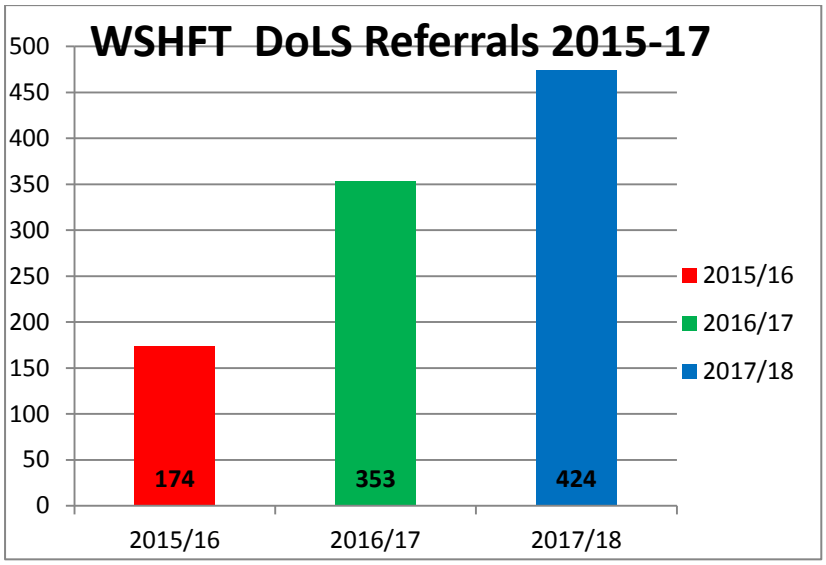
As stated in Section 4.1 of this report, the last year has seen an increase in the number of Deprivation of Liberty Safeguards (DoLs) authorisation requests being made. The number of referrals being made has steadily increased over the last 3 years.

Despite this increase in referrals, the actual number of patients being assessed by the DoLS team to determine whether the detention is lawful and the least restrictive remains low. Of the 424 authorisation requests, only 36 patients (8.5%) were seen and assessed by the WSCC team. This is due to the large number of DoLS authorisation requests being received by the DoLs team from across the county, and lack of staff capacity to respond.

The low rate of assessments by the DoLS Team has been raised at the NHS Safeguarding Professionals meeting as an area of risk.

Table 4 illustrates the increased in the number of DoLS referrals made by WSHFT over the last 3 years.

Table 4: WSHFT DoLS Referrals



Work has continued to deliver training on undertaking capacity assessments to enable staff to feel more confident in doing so; a session on assessment of capacity to consent to care and treatment was included in the Annual Clinical Update this year.

The increase in activity in both safeguarding and DoLS should be viewed positively, as improved recognition of both safeguarding concerns and when a Deprivation of Liberty may be occurring.

It is anticipated that, as awareness of mental capacity and DoLS issues continues to increase, activity will also continue to increase.

The reason for this is believed to be a greater awareness by nursing staff of MCA issues and DoLS requirements, and the work that the MCA Lead has been doing around this subject. In addition, the MCA Lead has being doing work around recognising and promoting the wards who make the most DoLS referrals and those areas with the highest quality of referrals, with prizes awarded for the ward teams.

6.1 The future of DoLS

The Law Commission has reviewed the Deprivation of Liberty Safeguards and in March 2017, it produced their proposal on a replacement for the Deprivation of Liberty Safeguards (DoLS), and suggested amendments to the Mental Capacity Act itself. The changes to the act are to incorporate the new scheme, called the Liberty Protection Safeguards (LiPS), and to strengthen people's rights in areas such as best interest decisions.

The proposed scheme would result in "the responsible body" (i.e. WSHFT) would conduct a capacity assessment, a medical assessment and an assessment of whether the planned care arrangements are "necessary and proportionate".

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

7. Mental Health Activity

WSHFT has a contract with Sussex Partnership Foundation Trust for the administration of the legal papers associated with those patients detained to the Trust under the Mental Health Act, as well as for the delivery of training on the mental health act.

Work has continued this year to improve the process by which detentions are reported and to facilitate the correct completion of the section papers. Guidance for the completion of the Section 5(2) papers has been produced and site-specific section papers have been produced to reduce the risk of incomplete addresses, which is a common reason why section papers are invalidated.

The Mental Health Act folders, which are held in certain wards/departments are being reviewed and updated by SPFT. Once the new template has been agreed, the contents in the folders will be updated.

New MHA folders will be developed for the children's wards, due to the increase in detentions of under 18 year olds within the Trust.

8. Learning Disability Activity

The Learning Disability Liaison Nurses have worked with WSHFT colleagues to develop an admission checklist to try and ensure a patient with learning disabilities and complex

needs receives appropriate care. This was presented at the Nursing and Midwifery Board meeting in April and is currently being trialled.

8.1 Learning Disability Reviews (LeDeR)

The Trust is actively participating in the nation-wide LeDeR review programme. Although WSHFT does not have any LeDeR reviewers, we are assisting external reviewers in their review of cases. Under this programme, the death of anyone with a learning disability is referred for a possible review. The reviews can be very time consuming and there is a challenge for staff to find the time to assist with the reviews, in addition to their usual job role.

9. Review of this year's priorities

The priorities set for this year were as follows:

PRIORITY 1: To re-launch the Safeguarding Adults team following a "re-branding exercise" with the aim of making the team more visible.

Outcome:

- The team now wear a "team uniform" for easier identification
- Updated team posters have been distributed, in team colours
- Safeguarding web page has been updated
- The safeguarding adults team held two safeguarding champions events this year
- The team also held events for Safeguarding Week in November, and has had items in Headlines
- The safeguarding team also has also joined Twitter to tweet news updates and events
-

PRIORITY 2: For the CCG to undertake an audit of the delivery of safeguarding/MCA training

Outcome:

- The CCG were unable to complete this.

PRIORITY 3: To review the safeguarding adults training following the audit and ensure that it meets the requirements of the intercollegiate document

1. To continue to deliver specific in-house training for Enquiry Officers (Level 3 training)

2. To introduce a new e-learning training package for safeguarding and mental capacity act training (E-Learning for Health)

3. To monitor the action plan and implement the recommendations from the external safeguarding adults audit

4. To monitor the action plan and implement the recommendations from the external DoLS audit.

5. To utilise the "Action" module within Datix to monitor safeguarding action plans

Outcome:

- Level 3 training is being developed to include sessions from external speakers
- E –learning for health safeguarding module is now available
- Action plans for the safeguarding adults reviews have been developed and monitored via the ASOG meetings
- The use of the Datix module has been problematic due to technical issues but these have now been resolved

10. Conclusions and priorities for 2018-19

Conclusions

The ability to respond to the increase in safeguarding activity has been strengthened by the additional team members. This year has seen an increase in reporting, both of safeguarding concerns and requests for DoLS authorisations, which is evidence of increased awareness of the issues. The Safeguarding Team continue to meet any new challenges as they are presented, and strive to actively embed safeguarding practice throughout the whole Trust.

The effectiveness of the safeguarding team was acknowledged in the CQC report.

The changes related to the Care Act continue to become embedded in practice, with local solutions being agreed between health and social care to improve the safeguarding enquiry process. It will take time for the new process to fully embed throughout the organisation and the amendments to the Care Act guidance has not assisted this process, but excellent interagency working between the trust and adult social care means that the challenges are being met and overcome together.

Priorities for 2018-19

The priorities for the Safeguarding Adults team for the coming year are:

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

PRIORITY 2: To launch the new Level 3 safeguarding adults training

PRIORITY 3: To review and improve the mechanism of monitoring the learning from Safeguarding Adults Reviews

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

Western Sussex Hospitals
NHS Foundation Trust

To: Trust Board

Date of Meeting: 26th July 2018 Agenda Item: 11

Annual Board Report for Appraisal & Revalidation 2018
This report is to update the Trust Board on revalidation and medical appraisal. The report provides the necessary assurance to allow a positive Statement of Compliance to be made to the higher-level responsible officer
Responsible Executive Director
George Findlay – Medical Director/Responsible Officer (RO)
Prepared by
Christopher Smith – Assistant Medical Director for Appraisal & Revalidation (AMD)
Status
Disclosable
Summary of Proposal
This report represents the Trust's revalidation and appraisal performance for 2017/18. It outlines the number of medical appraisals undertaken, revalidation recommendations made and next steps for the forthcoming year
Implications for Quality of Care
Revalidation is the process for determining whether doctors are fit to practice. This further drives quality improvement and patient safety through medical appraisal as highlighted in the Pearson review; "Taking Revalidation Forward" Sir Keith Pearson's review of medical revalidation January 2017 Improving the process of relicensing for doctors (http://www.gmc-uk.org/doctors/revalidation/9610.asp)
Link to Strategic Objectives/Board Assurance Framework
Links to Corporate Objectives on Quality Improvement, Leadership & Safety, Staff Engagement
Financial Implications
The Trust has a statutory obligation to provide the resources required to support the successful implementation of revalidation
Human Resource Implications
The duties of the Responsible Officer have considerable overlap with HR processes. Areas where HR need to support the RO include, systems and processes, advice on employee relations and employment law, resources for case management and case investigation and training and induction
Recommendation
The Board is asked to note the contents of the Annual Report for Appraisal & Revalidation and approve submission of the Statement of Compliance
Communication and Consultation
This report will be shared with the Trust's medical appraisers
Appendices
Appendix 1 - Statement of Compliance (to be signed by CEO/Chairman)

Western Sussex Hospitals
NHS Foundation Trust

To: Trust Board

Date: 26th July 2018

From: Christopher Smith
Assistant Medical Director for Appraisal and Revalidation

Agenda Item: 11

FOR DECISION & INFORMATION

ANNUAL BOARD REPORT FOR APPRAISAL AND REVALIDATION

1.0 INTRODUCTION

1.01 Medical Appraisal and Revalidation is now well established at the Trust. The second cycle of GMC revalidation is underway. An Independent Verification visit from NHSE took place in 2015 and found good evidence of high standards throughout. The electronic platform for documenting appraisal was changed from CRMS to Healthmedics by Allocate Software in October 2016. In April 2018 BDO were commissioned to conduct an audit of Trust appraisal processes highlighting good areas and some areas for improvement.

The purpose of this paper is to update the Trust Board on revalidation and medical appraisal and to give the necessary assurance to allow a positive Statement of Compliance to be made to the Higher Level Responsible Officer.

2.00 SUMMARY OF PROPOSAL

2.01 This paper updates the Trust Board on revalidation and medical appraisal for the 2017/18 appraisal reporting year, 1st April 2017 to 31st March 2018. It provides the supporting information to enable completion of the Statement of Compliance required for the Higher Level Responsible Officer.

The Trust has a statutory responsibility to ensure that doctors keep up to date and are fit to practice. Revalidation plays a strong part in driving improvements in professional practice and is a critical tool for patient safety.

Reviewing the Trust's revalidation and appraisal performance from April 1st 2017 to March 31st 2018 shows that on the 31st March 2018 the Trust had a prescribed connection with 466 doctors (431 in 2017). This includes permanent and fixed term consultants, staff and associate specialist grade (SASG), medical bank and medical training initiative (MTI) doctors. Trainee doctors have a connection with Health Education England, eg HEKSS, rather than the Trust.

Regarding the 466 medical staff with a prescribed connection to WSHFT, 399 (347 in 2017) had a completed appraisal which equates to 85.6% for this appraisal year (80.5% in the 2016/17). This represents an improvement in appraisal engagement, particularly by permanent staff whose appraisal return rate is 91%. There was a larger number of temporary doctors (128), whose appraisal was not due within the reporting period, who for reporting purposes, were regarded as incomplete. This resulted in 95 of the 128 short term contract doctors (74%) completing their appraisal.

In total 35 revalidation submissions were made to the GMC: 21 positive recommendations to revalidate and 14 deferrals (3 of which were subsequently revalidated within the reporting

year). No doctors were declared 'non-engaged' and all deferrals were due to insufficient evidence at the time the submission was due.

2.02 The Trust has a statutory duty to support the Responsible Officer in discharging their duties under the Medical Professional (Responsible Officer) Regulations[1] and it is expected that provider boards will continue to oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors
- Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed

3.00 RECOMMENDATIONS

(a) The Board is asked to accept this report as evidence of progress implementing revalidation and medical appraisal. The annual report is to be shared with the higher-level responsible officer

(b) The Board is asked to approve the 'Statement of Compliance' confirming that the organisation, as a designated body, is in compliance with the regulations

4.00 GOVERNANCE ARRANGEMENTS

4.01 Responsible Officer (RO)

Dr George Findlay

Assistant Medical Director for Revalidation and Appraisal (AMD)

Dr Christopher Smith

Senior Appraisers (SA)

Core:	Dr Sean McHale (appointed November 2017)
Medicine:	Dr Mike Chard
Surgery:	Mr David Beattie
Women and Children:	Dr Emma Rutland (appointed July 2017)
Radiology:	Dr Nick Ashford

Medical HR Lead

Ms Mandi Atkinson

Revalidation Manager

Ms Lynn Helyer

Revalidation Administrator

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practice and Revalidation) Regulations Order of Council 2012'

The Medical Workforce Governance and Appraisal Group

This group is chaired by the RO and is held quarterly. It is attended by the MD, AMD, revalidation manager and representation from Employee Relations Team/HR. The group oversees GMC concerns, local concerns, appraisal updates, revalidation recommendations, policy and procedures.

The Medical Appraisal and Revalidation Group (MARG)

This Group oversees the implementation of revalidation and appraisal and is chaired by the AMD and attended by the Senior Appraisers, SASG lead, the revalidation team, Hospice Leads and Roger Hammond (Lay Representative). The committee meet quarterly and work to terms of reference defined within the appraisal policy.

Maintaining the list of doctors with a prescribed connection to WSHFT

The Revalidation Manager updates the list of doctors with a prescribed connection to WSHFT as their designated body, by adding or removing them from GMC Connect. The GMC Connect list of doctors is validated against Electronic Staff Record (ESR) data on a monthly basis.

Internal Assurance

Internal assurance follows the recommendations of the NHS England Framework for Quality Assurance for Responsible Officers and Revalidation (2014).

4.02 Policy and Guidance

The NHSE Medical Appraisal Policy (NHS England 2015)

In 2015, some small but important revisions were made to the NHSE Medical Appraisal Policy. Notable revisions include the stipulation that allocation of a doctor's appraiser is the preferred system rather than "appraisee choice". It is an expectation that doctors will keep the same appraiser for three years in a row. These recommendations are in place with the introduction of the Allocate appraisal software in October 2016.

Other notable changes include the provision of advice when a doctor returns to practice following a break and a new set of appraiser assurance tools.

The Trust Appraisal and Revalidation policy was revised in 2017 to reflect the use of the new Allocate software for appraisal. The policy is due for review this year and will include the following NHSE Appraisal and Revalidation guidance updates:

Improving the Inputs to Medical Appraisal (NHS England 2016)

This document provides guidance on the necessary supporting information for doctors undertaking their appraisal and includes templates and checklists and recommendations for those having annual reviews outside their designated body. Further guidance is provided on supporting information in the context of those undertaking low volumes of work and obtaining patient feedback in non-standard situations.

Information Flows to Support Medical Governance and Responsible Officer Statutory Function (NHS England 2016)

This guidance sets out the main channels along which information about a doctor's medical practice may need to flow, in support of good medical governance and the statutory duties of the responsible officer and in support of patient safety and quality of care. This guidance includes a pre-employment checklist with which WSHFT complies.

5.0 MEDICAL APPRAISAL

5.01 Last year's Appraisal Performance Data 2016/17 (for reference)

The Trust medical appraisal rate for doctors with a prescribed connection for 2016/17 was 80.5% as reported in the AOA (Annual Organisational Audit) to NHS England

- Number of doctors – 431
- Number of completed appraisals – 347 (80.5%)
- Approved incomplete or missed appraisals – 57 (13.2%)
- Unapproved incomplete or missed appraisals – 27 (6.3%)

Appraisal Performance Data 2017/18

The Trust medical appraisal rate for doctors with a prescribed connection for 2017/18 is 85.6% as reported in the AOA (Annual Organisational Audit) to NHS England

- Number of doctors – 466
- Number of completed appraisals – 399 (85.6%)
- Approved incomplete or missed appraisals – 45 (9.7%)
- Unapproved incomplete or missed appraisals – 22 (4.7%)

Missed and incomplete appraisals

Following the disconnection from CRMS, at the end of October 2016, a high proportion of appraisal meetings were deferred until the new software was installed. The impact of this resulted in a backlog of appraisals in the last quarter of 2016 and the first quarter of 2017.

This year the pressure has been felt around the end of the appraisal year (January to March) as appraisal due dates carried forward from the previous year were brought forward to avoid missing the March 31st deadline.

As in previous years, time, work and life pressures affecting appraisees and appraisers were a contributory factor to appraisals being missed or incomplete. Other specific examples include, long term sick leave, maternity leave, retirement and return to work of appraisees or appraisers and recent appointment to post. Variations in speeds of uptake, familiarity and understanding of the Allocate system continue to be an issue, but this is improving.

The recent BDO audit highlighted the appraisal "due date" was open to significant variation in interpretation, which in some cases lead to delays in appraisal completion and sign off.

5.02 Appraiser Numbers

There are currently 61 active appraisers, including the AMD, 5 senior appraisers, 13 Clinical Directors with 4 pending training. Since April 2017 eight consultants have attended new appraiser training and are being initiated into the role. Each appraiser is awarded 0.5 SPA towards their job plan. To maintain and develop their skills, appraisers are expected to undertake approximately 8 appraisals, although 13 appraisers did more than 10.

The Trust continues to provide appraisals for the two local hospices under a Service Level Agreement.

The revalidation team complies with the NHSE Medical Appraisal Policy (NHS England 2015) in that appraisers are allocated to appraisees. This helps even out the workload for appraisers who should undertake approximately 8 appraisals each year.

5.03 Quality Assurance

The Trust's quality assurance follows the NHS England Quality Assurance Framework.

Quarterly Reporting

Data on the appraisal rate is reported quarterly to NHS England by the Revalidation Manager.

Annual Organisational Audit

The 2017/18 Annual Organisational Audit (AOA) was submitted in May 2018 to NHS England. It enables benchmarking against other comparable organisations. The full report is not out yet for comparison purposes. Trend data to 2017 is available below

NHS England

Annual Organisational Audit 2016/17

South data

	2014/15	2015/16	2016/17	Trend
Responses	155 (100%)	157 (100%)	167 (100%)	↑
Connected doctors	31,722	33,308	34,081	↑
Appraisal rate	88.5%	87.5%	91.6%	↑

www.england.nhs.uk

AOA 2016/17: Appraisal rates (South)

Previous year comparison

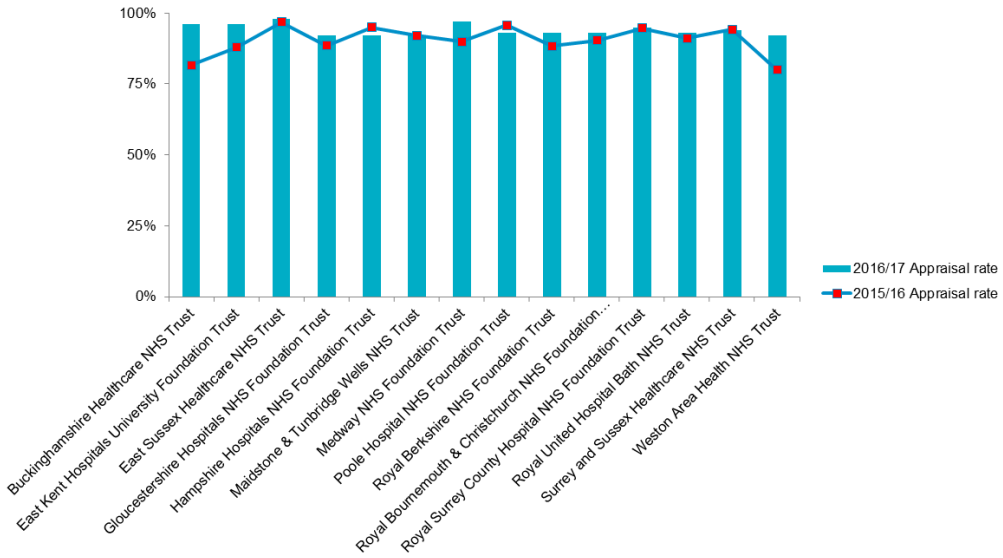
	2015/16		2016/17	
	Doctors	**%**	**Doctors**	**%**
Complete	29,128	87.5%	31,210	91.6% ↑
Incomplete or missing (approved)	2,915	8.8%	2,031	6% ↓
Incomplete or missing (unapproved)	1,263	3.8%	840	2.5% ↓
Totals	**33,306**	**100%**	**34,081**	**100%**

AOA 2016/17: Appraisal rates

South performance against national rates

Connected doctors	2016/17	
	National	**South**
Consultants	91.7%	91.6% ✓
SAS	87.0%	89.6% ↑
Performers List	95.2%	96.2% ↑
Practising Privileges	87.4%	100% ↑
Temporary/short term	78.8%	79.2% ↑
Other	91.2%	93% ↑
Totals	**90.7%**	**91.6%** ↑

Acute trusts with appraisal rate greater than 91.6%



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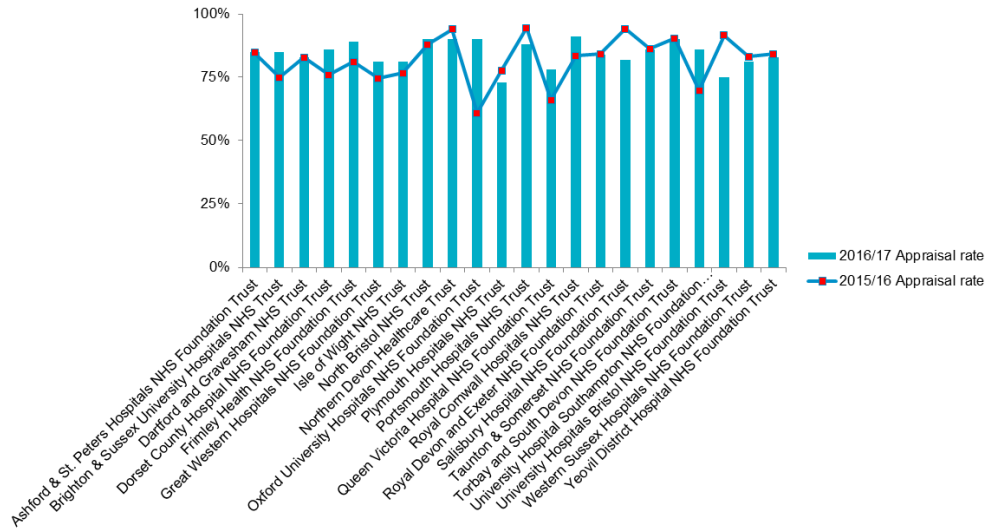
Acute trusts with appraisal rate less than 91.6%



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WHSFT is below the national and regional average when compared to 2017. The 2017 graphs outline acute Trusts performance, with 14 being above the national average and 22 (including WSHFT) falling below. The organisations missing from the data set are smaller organisations such as hospices and smaller care groups, whose appraisal return is often 100%, tending to slightly skew results to larger Trusts disadvantage. The 2018 AOA data will be reported and published later in the year. While WSHFT has improved, there is further room for improvement.

The number of completed appraisals for 2017/18 has increased from 347 in 2016/17 to 399. The number of linked doctors has risen from 431 to 466. The percentage increase is up to 85% from 80%..

Consultant and SGASS doctor numbers are similar to last year and return rate for appraisals in this group is 91% (close to last year's national average)

The temporary/short term contract holder numbers continue to increase from 92 in 2016/17 to 128 in March 2018. As in the previous year, the return rate for completed appraisals is lower at 74% (lower than the 2017 average of 79%)

Future efforts will attempt to address temporary doctors appraisal needs as part of improving the appraisal processes in general (see below)

Quality assurance of appraisals

BDO were commissioned to conduct an audit of WSHFT appraisal processes in April 2018. It highlighted that processes and quality of appraisal and appraisal processes were good in some areas with some recommendations for improvement. The full report is attached as an appendix. A summary is given (in italics below)

Areas of good practice identified were:

There is a requirement for all appraisals to be reviewed and signed off by a Senior Appraiser, providing a second level of independent review and quality assurance.

Senior Appraisers work with the Revalidation Manager in matching appraisers with appraisees to ensure that the process is fair and appropriate and that doctors do not have the same appraiser for more than three consecutive years, as per the requirements of the NHS Medical Appraisal Policy

The Revalidation Team reviews and validates medical bank doctors through regular meetings with Medical HR the rota co-ordinators, in order to ensure the accuracy of the number of medical bank doctors with whom the Trust has a prescribed connection as a designated body

There is ongoing training throughout the year for both appraisers and appraisees, including full day training sessions for appraisers and regular revalidation updates from the AMD for Revalidation & Appraisal. Medical Director of Revalidation

Whilst we have noted significant delays in the completion of 2017/18 appraisals, we also found that 56 appraisals have been completed ahead of their recorded due date

Our assessment of the appraisal form and PDP for the doctors in our sample indicated consistently high scores in some areas, including the number of PDP items, the completion of the previous year's PDP and the description of the doctor's scope of work.

However, we identified the following areas of improvement:

For 21 of the 25 appraisals tested, we found significant delays between the appraisal due date and the actual appraisal meeting date, ranging from one day to 153 days, and the reasons for the delays have not been consistently recorded (not an issue for SBH)

Whilst doctors are provided with sufficient guidance with regards to their appraisal, we found that appraisals are often returned due to the lack of supporting documentation, inappropriate completion of the appraisal form or the inclusion of patient identifiable information, resulting to in further delays in the appraisal process

Our assessment of the appraisal form and PDP for the doctors in our sample indicated consistently low scores in some areas, including setting inadequate or inappropriate objectives in the PDP, the lack of appraisee reflection and the absence of documented statements from the appraiser's summary that enhance the quality of the appraisal

Conclusion

Based on our review we have raised three medium level recommendations and three observations. Overall, the Trust has a sound system of internal controls, however there are weaknesses identified relating to the completion of the appraisals, both in terms of time and quality, that could undermine the Responsible Officer's ability to provide appropriate recommendations to the GMC. Consequently, we conclude moderate assurance over both the design of the controls and their operational effectiveness.

WSHFT revalidation team will review the audit findings. Actions to improve timely completion, adequate completion of appraisals with improved PDP and reflection will be agreed and implemented.

Complaints and Serious Incidents

There have been no complaints or serious incidents arising from appraisal or revalidation.

Quality assurance of Appraisers

Quality assurance is embedded during the recruitment processes for appraisers and senior appraisers. There are appraiser development updates, feedback to appraisers from appraisees and seniors appraisers as part of appraisers' scope of practice and at final sign off

Recruitment

Appraisers are recruited using a job description and person specification. New appraisers discuss the role with the divisional senior appraiser and are required to attend an approved training course. New appraisers have an experienced appraiser sitting in for their first one or two appraisals, offering feedback and support in line with NHSE recommendations.

Appraiser development

There are development days for appraisers. These include demonstrations of Allocate software updates, coaching, updates and information sharing from national appraisal updates and RO network meetings, presented by the AMD, senior appraisers and with invited outside speakers.

Appraisal for Appraisers

The appraiser role is considered during appraiser's annual appraisal and forms part of these doctors' scope of practice. This includes a review of their appraisees' feedback.

Quality Assurance of appraisals

The senior appraisers review all appraisals for completeness and quality. They provide support and feedback to appraisers as part of the final sign off process (see below). This area of feedback was surveyed this year and appraisers and appraisees reported that senior appraisal advice to be helpful.

Final sign off

Final sign off continues to be a key role for senior appraisers who review each appraisal to ensure appropriate supporting information has been included and that appraisals reach the standards required for revalidation. The Allocate appraisal software does not support this process as conveniently as CRMS. The need for feedback is now at the discretion of the senior appraiser and always given if the appraisal is returned for any reason or needs further work, which is a feature in built into the allocate system.

Following a successful appraisal completion or second/final sign off, it is possible to provide qualitative feedback via individual e mail, but currently this has to be uploaded by hand into allocate. This limitation on the positive feedback loop element is something the revalidation team has discussed with Allocate Software and should become available with a system update in July. QA reference tools, provided by NHSE, help standardise and support this process.

Doctor's feedback on the quality of their appraisals

Appraisees are obliged to provide feedback about the organisation of the appraisal, the appraisal process and their appraiser. Responses indicate continued high levels of satisfaction of the appraisal process by those being appraised.

5.04 Access, security and confidentiality

Information is held securely in the Allocate web-based appraisal folders and only accessible to appraisers, the relevant senior appraiser, AMD for revalidation and appraisal, responsible officer and revalidation administrators.

5.05 Clinical Governance

The Trust provides data for doctors undergoing their appraisal as a data pack from the IT department. This includes information on attendance at mandatory training.

6.0 REVALIDATION RECOMMENDATIONS

6.01 Number of recommendations for the 17/18 appraisal year – 35

Recommendations completed on time – 34

Positive recommendations – 21 (including 3 previously deferred)

Deferral requests – 14 (including 3 subsequently revalidated)

Non-engagement notifications – 0

Late recommendations - 1

Number of formal investigations carried out under MHPS - 4

7.0 RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

7.01 The TRAC system provides a robust and auditable process for all recruitment including Medical Bank, fixed term and substantive posts (excluding Agency locums) for pre-employment and ID checks including Revalidation and RO references. As per guidance, transfer of RO to RO information is not requested until the new incumbent starts at the Trust.

7.02 Locum doctors

Locum doctors arranged through the Temporary Staffing team are sourced via Crown Commercial Solutions (CCS) Framework Agencies and CPP Framework, which is Monitor compliant and have responsibility for ensuring Locums comply with pre-employment requirements/checks.

If it is not possible to source a locum through either Framework Agency, the Division authorises the use of a non-framework agency, the Temporary Staffing Team will ask the Agency to complete a RO type reference and checklist to confirm that all the necessary checks have been fulfilled.

8.0 MONITORING PERFORMANCE

8.01 Doctor's performance is monitored at Clinical Lead, Divisional and Executive levels.

At divisional level, performance of individuals, teams and specialities are monitored through the monthly divisional operational and governance meetings and at the quarterly divisional governance reviews. These meetings incorporate service line management, complaints and litigation, risk reporting and mortality and morbidity data.

At executive level the medical director monitors Clinical Outcome Benchmarking data from Dr Foster including relevant alerts and handles any concerns that arise according to the Raising Concerns Policy.

Performance concerns can also be raised through the appraisal process and the process for this is defined in the Remediation and Re-skilling Policy. No serious concerns arose about performance at appraisal in the 2017/18 appraisal year.

9.0 RESPONDING TO CONCERNS AND REMEDIATION

9.01 For the period April 2017 to March 2018 there were 4 formal investigations carried out under Maintaining High Professional Standards (MHPS). Three of these led to no formal action and one is progressing through a formal conduct process.

Three members of medical staff were excluded from work or had formal restrictions on their practice imposed.

One of these cases was for a trainee and involved joint working with Health Education Kent, Surrey and Sussex. This has led to considerable learning for all parties in relation to how capability and conduct concerns for trainees should be managed. Learning events are planned to consider how to ensure this learning is shared and results in improvements in processes moving forward.

The Trust continues to improve the processes and support available for those managing concerns for doctors in training. The Employee Relations team work closely with the Director of Medical Education, Post Graduate Medical Education department, Medical Director and Chiefs of Service to address concerns in the most appropriate way. As part of this sessions have been held at the Clinical Directors meetings and Local Academic Board. Further sessions are planned for Educational and Clinical Supervisors throughout the rest of the year.

The Employee Relations team continue to support the informal management of concerns wherever appropriate, ensuring that advice is also sought from the National Clinical Assessment Service and our GMC Liaison.

10.0 RISKS AND ISSUES

10.1 Medical Appraisal Rates

The medical appraisal rate remains below the National target of 95%. The rate is better in comparison to the previous year, from 80% to 85.6%. This may still reflect the impact of introducing a new appraisal system together with higher temporary/short term doctor numbers and unclear understanding of "due date" versus "due by date".

Moving forward, the completion rate should pick up following further clarification of the "due by date". Moving due by dates away from the end of the reporting year will help and this process has been started. Using escalation processes for delays in completion has to date been a rare intervention but for repeat offenders may become a necessary tool to use under the direction of the (relatively newly formed) Medical Workforce Governance and Appraisal Group.

Since April 2017, monthly Strategy Deployment Review (SDR) meetings have taken place within each division. Appraisal is a key metric in the SDR scorecard, raising the profile of appraisal engagement with Clinical Leads. Counter measures are put place if the metric is red flagged. This process is helpful, but it does not directly correlate with the AOA metric requested by NHSE for completed and fully signed off appraisals related to due date.

11.0 EXECUTIVE TEAM REFLECTIONS

11.1 The number of medical appraisals undertaken at the Trust has increased. It is noted on the Allocate software system, there is an increase in total number of linked doctors to WSHFT with a disproportionate increase in temporary/short term doctors including a higher proportion of overseas doctors working in the UK for the first time. Many of these doctors are encountering the GMC's enhanced appraisal process for the first time

This year's improved appraisal rate is anticipated to continue in the next reporting year. The recommendation from the BDO audit is that "due by" dates (an ambiguous phrase) is changed to "completion date". This will help to provide a defined finish date for appraisers and appraisee to understand they are to have had an appraisal meeting and subsequent sign offs completed by the "completion date". This will provide clear cut delineation between completed and late appraisals and facilitate implementation of support and escalation processes

An 8.1% (3.5% in 2016/17) increase in doctors with a prescribed connection to the Trust as their Designated Body has been observed. The overall Trust appraisal rate will be compared to the national average when the report becomes available, but at 85% it remains below a desired target level of 95% and last year's national level of 90.6%.

Work will continue to raise the appraisal rate towards the desired level of 95%. We will continue try to and identify reasons for late appraisals but BDO may have identified the key area and we will encourage appraisers to arrange meeting dates early, rather than postponing or delaying meetings.

The new Allocate system sends out reminders and facilitates identifying, chasing and supporting those falling behind. Timely reminders from the revalidation team follow. Subsequent escalation will be through the Medical Workforce Governance and Appraisal Group which was set up in March 2018.

Over the last year appraisers have continued to meet the increase in demand and while significant progress has been made with doctors on temporary and short term contracts there is more to do. Identifying a doctors appraisal needs after time away, working irregular hours on

the bank, dipping in and out of training posts or returning from abroad present a variety of challenges.

It would help if the NHSE had a different way to categorise overseas/temporary doctors, who are new to the organisation but not due an appraisal before the end of the reporting year. These doctors are currently reported as 'missed.' The change in reporting category would help our figures slightly and remove an artificial need to try to appraise these doctors too early. This has been reported back to NHSE in the invited comments in their annual AOA report. This suggestion will be followed up at Regional Network meetings.

We commissioned an external audit of WSHFT appraisal processes, by BDO in April 2018, similar to the audit carried out in 2014. This highlighted good practices and suggested areas for improvement.

11.2 Corrective Actions, Improvement Plan and Next Steps

Actions for the Trust in 2018/19 are shown below:

- Provide Designated Body Statement of Compliance to NHS England
- Liaise with Allocate Software team regarding system developments to improve and streamline the e-appraisal system.
- Respond to BDO audit findings
- Continue work to raise the appraisal rate towards 95% using clearer completion dates and escalation through the Medical Workforce Governance and Appraisal Group
- Update the Trust Appraisal Policy, due 2018
- Develop the role the Medical Workforce Governance and Appraisal Group
- Continue to develop the role of Senior Appraisers
- Continue the appraiser updates
- Continue to disseminate RO network advice, updates

Appendix 1

Designated Body Statement of Compliance

The board of Western Sussex Hospitals NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Requirement satisfied

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Requirement satisfied

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Requirement satisfied

4. Medical appraisers participate in on-going performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

Requirement satisfied

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Requirement satisfied

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

Requirement satisfied

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Requirement satisfied

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Requirement satisfied

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[3] have qualifications and experience appropriate to the work performed; and

Requirement satisfied

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Requirement satisfied

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

[Chief Executive or Chairman a board member (or Executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _

[3] Doctors with a prescribed connection to the designated body on the date of reporting.