Western Sussex Hospitals
NHS Foundation Trust

Meeting of the Board of Directors

10.00 to 12.45 on Thursday 06 August 2020

Virtual Meeting via MS Teams

AGENDA – MEETING IN PUBLIC

1.	10.00	**Welcome and Apologies for Absence** To note	Verbal	Chair
2.	10.00	**Declarations of Interests** To note	Verbal	All
3.	10.00	**Minutes of Board Meeting held on 30 January 2020** FOR INFORMATION	Enclosure	Chair
4.	10.00	**Matters Arising from the Minutes** NONE	Enclosure	Chair
5.	10.05	**Report from Chief Executive** To receive and note overview of the Trust's activities **INTEGRATED PERFORMANCE REPORT including REFRESH, RESTORE, RECOVERY UPDATE**	Presentation	Marianne Griffiths
6.	10.20	**Introduction from Chief Executive** To receive and note overview of the Trust's activities	Enclosure	Marianne Griffiths
7.	10.25	**Quality Improvement** To receive and agree any necessary actions *After this section the Chair of Quality Assurance Committee will be invited to provide their report included at item 11* To receive assurance from Committee and recommendations from the Committee	Enclosure	Tim Taylor Maggie Davies
8.	10.45	**Systems and Partnerships** To receive and agree any necessary actions	Enclosure	Fiona Ashworth
9.	11.00	**Sustainability** To receive and agree any necessary actions *After these two sections the Chair of Finance and Performance Committee will be invited to provide their report included at item 12* To receive assurance from Committee and recommendations from the Committee	Enclosure	Marianne Griffiths
10.	11.15	**Our People** To receive and agree any necessary actions *At this point the Chairs of the Committees will be invited to provide any additional assurance from the work of their*	Enclosure	Jennie Shore

committees.

ASSURANCE REPORTS FROM COMMITTEES

11.	-	**Report from Quality Assurance Committee** - **from the meetings on the 25 June & 30 July 2020*:*** To receive assurance from Committee and recommendations from the Committee **Reports recommended for information only:** - ***Annual Patient Experience Report***** - ***Annual Serious Incidents Report***** - ***Learning from Deaths report*****	Enclosure	Joanna Crane
12.	-	**Report from Finance and Performance Chair** - **from the meetings on the 25 June & 30 July 2020** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
13.	11.30	**Report from Audit Chair *including the Annual Audit Committee report to Board*** - **from the meeting on the 09 July 2020** To receive assurance from Committee and recommendations from the Committee	Enclosure	Jon Furmston
14.	11.40	**Board Assurance Framework** To approve	Enclosure	Glen Palethorpe

OUR PEOPLE

15.	11.50	**Annual WRES and WDES Surveys**** To approve for publication on Trust website	Enclosure	Jennie Shore

WELL LED & COMPLIANCE

16.	12.10	**Annual Medical Appraisal and Revalidation Report 2019/20** To approve	Enclosure	Tim Taylor
17.	12.20	**Company Secretary Report** To note	Enclosure	Glen Palethorpe

OTHER

18.	12.30	**Any Other Business** To receive and action	Verbal	Chair
19.	12.35	**Questions from the public** To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting.	Verbal	Chair
20.	12.45	**Date and time of next meeting:** The next meeting in public of the Board of Directors is scheduled to take place at **10:30** on **01 October 2020**.	Verbal	Chair

To resolve to move to into private session

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

** Hard copies of these reports are available on request via email to t.humphrys@nhs.net

Trust Board of Directors Quoracy

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

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

Minutes

Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 30 January 2020, Bateman Room, Chichester Medical Education Centre, St Richard's Hospital, Chichester.

Present:	Alan McCarthy	Chairman
	Patrick Boyle	Non-Executive Director
	Mike Rymer	Non-Executive Director
	Joanna Crane	Non-Executive Director
	Kirstin Baker	Non-Executive Director Advisor
	Dame Marianne Griffiths	Chief Executive
	George Findlay	Chief Medical Officer & Deputy Chief Executive
	Pete Landstrom	Chief Strategy and Delivery Officer
	Karen Geoghegan	Chief Financial Officer
	Fiona Ashworth	Chief Operating Officer
In Attendance:	Jo Fanning	Assistant HR Director
	Alison Ingoe	Finance Director
	Tim Taylor	Medical Director
	Glen Palethorpe	Group Company Secretary
	Jan Simmons	Corporate Governance Officer
		For item 16:
	Ian Arbuthnot	Director of IM&T
	Grant Harris	Head of IT Operations & Medical Records
	Andy Banks	Head of IT Applications Management
	Susan Harman	Head of Programmes & Projects

TB/01/20/01 Welcome and Apologies

1.1 The Chair welcomed all those present to the meeting.

1.2 Apologies were received from Lizzie Peers and Jon Furmston; the meeting was confirmed as quorate.

TB/01/20/02 Declarations of Interests

2.1 There were no declarations of interest.

TB/01/20/03 Minutes of Board Meeting held on 28 November 2019

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

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

TB/01/20/04 Matters arising from Minutes

4.1 The Matters Arising from previous meetings were received and agreed that all the Matters Arising related either to items on the agenda or were on a forward agenda plan and therefore could be closed.

TB/01/20/05 Chief Executive's Report

5.1 Dame Marianne Griffiths introduced the Chief Executive's report and presented the headlines for the previous two months:

5.2 **Triple Win for Western**
Marianne was pleased to report a triple win in the Finance Team. Both Chief Financial Officer, Karen Geoghegan and Chief Nurse, Maggie Davies and the Trust had all won top awards. Karen had been named Finance Director of the Year and Maggie won Clinician of the Year at the National Healthcare Finance Awards in London. Meanwhile the Trust had also won the NHS Finance Award at the Health Business Awards on the same day.

5.3 With staff making extraordinary efforts to maintain the highest standards of care during an exceptionally busy Christmas, New Year and January, Marianne formally expressed her thanks and admiration to all the staff and volunteers and said how their skill, ingenuity and dedication enabled the Trust to provide outstanding care to patients when they needed it most.

5.4 Marianne reported that the Trust had now achieved 74.2% of all frontline staff having now received their flu vaccination; this was the highest percentage ever achieved. Regular vaccination sessions would continue until the end of February.

5.5 An issue taken extremely seriously by the Trust was that an unacceptable proportion of staff experienced abuse and even physical harm while at work. Increased support and guidance for staff had been put in place of the past year and this month the Trust had hosted a Respecting Our People week to enable staff to provide feedback as well as learn about initiatives put in place to protect and care for them at work.

5.6 Marianne continued by congratulating the nursing and midwifery students from Surrey, Brighton, the Open and Overseas universities who celebrated their graduation at a join ceremony at Worthing Hospital in November. Many of those who trained in the Trust went on to start their first jobs with the organisation.

5.7 The Trust also marked World Prematurity Day with purple floodlighting at St Richard's Hospital, organised by the Neonatal Unit. The aim was to help raise awareness of the challenges premature babies and their families faced.

5.8 Marianne went on to say that the Trust were welcoming VIP visitors today to celebrate the opening of the new patient catering kitchen in St Richard's Hospital. There had been a big investment to increase the menu options for patients and to provide food cooked as freshly as possible and regenerated on the wards. Patients could now choose from 50 main meal options at lunch and supper every day.

5.9 Hundreds of staff had now signed up to be a Rainbow Warrior at Western Sussex, reinforcing the Trust's commitment to diversity and inclusion. Anyone wearing the rainbow badge was someone who pledged to be non-judgmental and supportive when it came to issues of sexuality and gender identity. The Rainbow pin badge and lanyard signaled to LGBT+ people that they were in an inclusive environment. One of the Trust's Governors was also supporting this initiative and is part of those who provide training to our staff.

5.10 Marianne was pleased to report that Employee of the Month awards had been received by the Laundry team at St Richard's Hospital, James Walker, Emergency Floor Manager and Neil Hopwood, Pharmacy Technician.

5.11 Marianne was proud to highlight the new Green Steering Group which she chaired. The group would look at procurement, waste, energy and utilities,

as well as green travel and the Trust's sustainable development management plan. Through the Green Travel Plan new cycle storage had been introduced as well as modernized and improved changing facilities for staff, a scheme to give staff public transport concessions and provided a cross-site minibus service. As a result, the equivalent of 2,000 car journeys have been taken off the road, saving 60 tons of CO2 every year.

5.12 In Estates and Facilities, colleagues had benefitted from the Trust's Patient First methodology and had introduced improvement boards with 25 members of the team having been trained as facilitators by the Kaizen team. Already in one year the team had implemented 132 changes, from introducing knee pads to reduce MSK injuries and reducing food waste through improvements to patient meal service provision on the delivery suite.

5.13 Marianne was also pleased to announce that David McLaughlin and Sue Fisher had also been appointed as Director and Deputy Director of Estates and Facilities.

5.14 The Patient Safety team had hosted a learning from deaths special event in December where Campaigner, Paula Gowan, supported the Trust in the improvement journey.

5.15 Marianne drew the Board's attention to the diary highlights for the previous month noting amongst others an NHSI/E site visit, Acute Network meetings, the Volunteer's Christmas Thank You event and meetings with partner organisation.

5.16 In the coming months the Trust would be expecting the findings of the Staff Survey to be published and that today there was a visit by The Secretary of State for Health and Social Care, Matt Hancock MP to congratulate staff on their second 'Outstanding' CQC report and he would also attend the official opening of the brand new kitchen at St Richard's Hospital by the Government's new hospital food tsar and celebrity chef, Pru Leith.

5.17 Finally, Marianne added that work continued on the development of the new group structure, following the decision to further develop the relationship between BSUH and WSHT. The Trusts and their assets would remain separate, operating as equal partners and the benefits of the current relationship would be maintained and extended. Work to determine the best group structure was ongoing and further details would be provided in due course as decisions were made.

5.18 **The Board NOTED the Chief Executive's Report**

TB/01/20/06 Integrated Performance Report

6.1 Dame Marianne Griffiths introduced the Integrated Performance Report explaining that Patient First was the Trust's methodology encapsulating the Trust's vision, values and goals.

TB/01/20/07 Quality Improvement

7.1 Tim Taylor updated the Board on the key messages from the Quality section of the report, with particular focus on mortality.

7.2 The Board was advised that the Trust's crude mortality had been stable over the last three years and showed modest improvement last year. The latest Trust HSMR, including data for the 12 months up to and including

September 2019, had risen to 104.9 driven by the rising HSMR at St Richard's Hospital.

7.3 However, the 12 month rolling crude mortality rate for the Trust was 2.78% for December 2019 (down from 2.88% in Dec 2018) while the Summary Hospital Mortality Indicator (SHMI) had risen slightly to 0.99 for the 12 month up to and including June 2019.

7.4 The Trust's investigation with Dr Foster into the rising HSMR showed causes included a reduction in sepsis coding with less co-morbidities and palliative care activity captured on the Chichester site alongside an increase in HSMR for patients admitted at weekends.

7.5 The HSMR and coding working group, chaired by the Medical Director, had introduced an HSMR dashboard monitoring key parameters, including up to date levels of sepsis and palliative care coding. This monitored changes in key factors promptly, well before they were reflected in the HSMR.

7.6 Monthly sepsis coding reconciliation meetings were now held with the Medicine Division, an HSMR/coding workshop for clinical leaders had taken place and the top 10 tips for coding were displayed in the workplace. Sepsis coding guidance had been reissued. Palliative care coding was now cross referenced with the Somerset registry and measures were underway to address issues with multi-consultant non-elective admissions that could reduce the capture of co-morbidities.

7.7 Tim then drew the Board's attention to the Stroke service performance where the latest SSNAP performance published in December 2019 had seen Worthing Hospital achieve a grade A with a score of 88, which was the highest score the unit had achieved to date, improving from a B in the previous reporting period. St Richard's Hospital achieved a grade C with a score of 62 which was a deterioration from a grade B in the last reporting period but improvements were being made which would see the service return to a grade B. St Richard's was a stable grade B for the calendar year.

7.8 The specific areas of performance that deteriorated at St Richard's related to the front-door phase of the stroke pathway, including a deterioration of time to CT scan, time to Stroke Unit and thrombolysis within 60 minutes. A robust improvement plan was in place with St Richard's expected to recover in the first quarter 2020/21.

7.9 Maggie Davies reported that there was a incidence of flu on Castle Ward, Worthing Hospital, which had been reported on 5 December 2019 and was dealt with and resolved within eight days, which was an incredibly short period of time to deal with such an incident. A number of actions had been taken and on-site flu testing had enabled the quick isolation of the affected patients. Maggie added that 94% of staff on Castle Ward had received their flu vaccinations by 5 December 2019 and it had been a credit to the staff and housekeeping teams that the incidence of flu had been contained so quickly.

7.10 With regard to safer staffing, Maggie advised the Board that a census of nursing staff was conducted twice daily and had been included in the report to provide reassurance over the process and its outcome.

7.11 The Board noted that the proportion of patients who suffered no new harm during their inpatient stay at WSHFT was 98.6% against the Trust target of 99%. This compared to a national performance of 97.7%.

7.12 Overall, cases of Hospital Associated VTE had decreased with 13 cases in December compared to the peak in October of 30 and one case remaining under review. Lots of quality improvement work was under way in the fracture clinic pathway for patients with lower limb immobilization as well as nationally.

7.13 The Board was informed that there had been 136 falls during the month which was above the monthly goal following a very successful month in November which had seen the lowest number of falls in 2 years.

7.14 Maggie went on to advise the Board that December had been a challenging month with regard to patients responding to the Friends and Family Test although the Trust had delivered 96% against 94% last year and all recommended goals had been met. The A&E Department in Worthing Hospital had seen a 95% recommendation rate despite high activity and A&E improvement work at St Richard's Hospital had also seen very positive impact on patient feedback.

7.15 The Trust's breakthrough objective of improving satisfaction with noise at night had achieved 63% satisfaction in December which represented an improvement, compared to the downward trend of previous months. 10 driver wards were developing improvement plans using data gathered from staff and patient surveys.

7.16 Joanna Crane and Alan McCarthy both commented that they had been assured in respect of the Trust's SHMI and crude mortality performance noting that the issue had been primarily a source of coding.

7.17 In relation to HSMR, Mike Rymer enquired with regard to palliative care, if having 10 consultants on the Worthing site made a difference to their coding. Tim Taylor replied that palliative care coding was now cross referenced with the Somerset registry and measures were under way to address the issues with multi-consultant non-elective admissions that could reduce the capture of co-morbidities.

7.18 Mike Rymer asked if there had been an improvement in the TIA target, to which Marianne replied that a plan was being developed that would have a material impact and its outcome would be reported to Board in due course. Marianne also suggested that it might be useful for Simona Caronia to give a presentation to the Board on the work being undertaken in this respect.

TB/01/20/08 Systems & Partnership

8.1 Alan McCarthy introduced Fiona Ashworth who had recently joined the Trust as Chief Operating Officer.

8.2 Fiona presented the report and drew out the following key areas:

8.3 The Trust had experienced continued high levels of emergency patients attending both A&E Departments, with +7% in December 2019 compared to December 2018, with a 14% increase in patients aged over 65 years. The year to date activity was +8.4% compared to the same period in 18/19, with a +13.9% increase in over 65s. Currently the Trust was the 15th best performing Trust in the country against a picture of challenge nationally with increase attendances and complex admissions. There had also been an increase in the number of mental health patients who had needed inpatient care.

8.4 Overall, bed occupancy at the Trust had increased to 95.0% in December 2019 which was a marginal increase from the prior month. The Trust had 22 more 7-day length of stay patients in hospital on average each day in December 2019 compared with December 2018.

8.5 A&E 4-hour performance for December was 86.24%, compared to the national performance of 79.8% with zero 12 hour breaches.

8.6 RTT compliance in December was 83.26% and zero patients waited longer than 52 weeks for treatment. The Trust was refocussing efforts to increase activity with support from alternative providers, increased productivity and additional internal WLIs and locum support. The overall waiting list size increased by 1289 compared to the prior month, with 13% more clock starting events Dec-19 than Dec-18.

8.7 Cancer performance for December was compliant against 2 of 7 reportable cancer targets with provisional 62-day performance of 73.1%. National average performance was 77.4% (November-19). Cancer referrals in December were 11% higher than Dec-18.

8.8 Diagnostic performance was compliant at 0.94%. National performance (November-19) was 2.9%.

8.9 The Chairman invited the Chair of the Finance and Performance Committee, Patrick Boyle, to update the Board on their recent meeting and the assurances received in relation to Systems and Partnerships.

8.10 Patrick Boyle explained that the role of the Finance and Performance Committee was to provide greater scrutiny of the plans. He added that it was important to recognise the increase in demand and the challenging period it had been for the Trust. Although the Trust was clearly behind their targets for A&E, Cancer and RTT performance the Committee had been pleased to see a return to compliance in month for diagnostics. Patrick reassured the Board that the Committee had discussed improvement actions and the oversight of these being provided by the Chief Operating Officer and Chief Executive Officer and the Committee receive reports on the delivery of these actions.

TB/01/20/09 Sustainability

9.1 Karen Geoghegan advised the Board that at the end of Quarter 3 the Trust was reporting a surplus of £1.96m and had delivered the quarterly control total which was important in order to earn £2.5m of provider sustainability (PSF) income, bringing the total PSF earned in 2019/20 to £5.4m.

9.2 The year-end control total was a surplus of £2.46m. A further £2.9m of PSF was available to the Trust if it delivered its control total in full.

9.3 The Trust was currently forecasting delivery of the year-end control total however, delivery would be extremely challenging.

9.4 During Quarter 3, the Trust bed base remained above planned levels due to increased occupancy from patients with a long length of stay and delayed transfers of care. This would be further challenged during the winter period and would need close operational management alongside engagement and support from community and social care partners.

9.5 Medical workforce expenditure had reduced slightly during Quarter 3, as actions to realise the benefits from earlier investment in new workforce

models began to deliver. However, the full benefits were yet to be fully realized and there were emerging pressures in a number of specialties that would require action during Quarter 4.

9.6 At the end of December, the finance risk rating was '1'.

9.7 The Efficiency programme had delivered £8.5m of efficiencies at the end of December, resulting in a shortfall of £0.6m against plan. The year-end forecast remained on plan with the Trust expecting to deliver just under £12m of efficiencies; schemes for next year were already being planned.

9.8 Capital expenditure remained above plan due to earlier purchase of replacement medical equipment and the completion of schemes deferred from the previous year. The year-end forecast was on plan.

9.9 The Board noted that at the end of December cash was below plan by £7.7m. As agreed, as part of the Cash Strategy, creditor days had been reduced to 30 days for approved supplier invoices.

9.10 The Board was asked to note that the delivery of the year-end control total would be challenging and would require close management. The Finance and Operational teams would be working closely together over the next few months to achieve this.

9.11 The Chairman invited the Chair of the Finance and Performance Committee, Patrick Boyle, to update the Board on their recent meeting and the assurances received in relation to Sustainability.

9.12 Patrick advised the Board that the Committee had received the financial performance reports for Month 9 and was assured in respect of the Trust's performance against the plan for Month 9 with the Trust recording £1.95m surplus excluding PSF and MRET which was in line with the Trust's approved plan. The Committee was informed of the risks to meeting the year end control total and the plans developed to meet the Trust's annual plan. The Committee recognised that the BAF risks, which increased in Quarter 3, had not yet been mitigated sufficiently to reduce these back to either Quarter 2 levels or their target score. The Committee was confident that improvement actions were being taken to deal with the increased risks as recorded within the BAF.

TB/01/20/10 Our People

10.1 Jo Fanning highlighted the key areas from the Staff Engagement section of the report.

10.2 In December the Trust spent £26.4m on workforce which was £498k above budget. The majority of overspend continued to be in medical staffing, although the variance had improved significantly from £636k above budget in Month 8 to just £356k in Month 9.

10.3 Jo reported that turnover had decreased again in December to 7% and remained at its lowest rate since September 2014. Core Division had seen a significant reduction in turnover and had now reached the ceiling level of 8.5% a reduction from 12.3% in December 2018. There would be a focus on a review of staff survey data to focus on preventative action that could be taken to retain staff.

10.4 The monthly sickness absence rates had increased in November and December in line with the usual seasonal trend. However, as the rates

remained lower than the same period in 2018, the 12-month sickness absence rate continued to fall. The 12-month sickness rate was now at its lowest level since 2011 and was demonstrated across most areas in the Trust.

10.5 The Board was advised that staff appraisal compliance had increased by 1% to 88%. However, the focus was being maintained with Divisions to continue to increase appraisal compliance rates.

10.6 Statutory and mandatory training had shown a gradual improvement with 8 out of 9 modules remaining above the Trust target of 90%.

10.7 Jo went on to advise the Board that the staff engagement score remained just above the target of 7.6 at 7.62 and 71% of staff able to make improvements happen in their area of work, which continued to be significantly higher than the Trust target of 63%.

10.8 In respect of Staff Health and Wellbeing, a mental health wellbeing training pilot was underway with three courses having taken place in November and December 2019 with further courses planned for February.

10.9 The flu campaign was progressing well with 72% uptake for frontline staff.

10.10 The Staff survey closed with a 55% response rate, compare to 64% response rate in 2018. Initial results had been received, with detailed results available at the end of January enabling further analysis. The National results would be available in February, at which point the Trust results could also be shared.

10.11 The Board was informed that the final session for the pilot Level 3 Leadership programme, delivered by NHS Elect, had been held in January. An evaluation of the programme would be undertaken by KSS. The Leadership development opportunities, in collaboration with the Sussex Leadership and Talent STP, continued to progress. Seven staff from WSHFT had attended a two-day Coaching Foundation Skills course and an additional six courses would be advertised shortly. A number of additional programmes were in development and would be launched in early 2020.

TB/01/20/11 Report from Quality Assurance Committee
From the meeting on 5 December 2019

11.1 The Board **NOTED** the Report from the Quality Assurance Committee Chair, highlights of which had been received as part of the Integrated Performance Report.

TB/01/20/12 Report from Finance and Performance Chair
From the meeting on 27 January 2020

12.1 The Board **NOTED** the verbal update from the Finance and Performance Committee Chair, highlights of which had been received as part of the Integrated Performance Report.

TB/01/20/13 Report from Charitable Funds Chair
From the meeting on 10 January 2020

13.1 Joanna Crane presented the report from the Charitable Funds Committee advising that a request by Cancer Services had been approved.

13.2 The Committee had also received the Strategic and Operational Report for September to November 2019 which detailed the events hosted by the Charity during the three-month period, and was assured as to their value, in particular the success of the First Fifty Club hosted by Rolls Royce, which had already seen a significant donation to Love Your Hospital.

13.3 Joanna advised the Board of the departure of Love Your Hospital Charity Manager, Amanda Tucker and thanked her for her hard work, vision and the progression of the Charity under her leadership.

13.4 **The Board NOTED the report from the Charitable Funds Committee Chair.**

TB/01/20/14 Report from Audit Chair
From the meeting on 10 January 2020

14.1 Joanna Crane presented the report from the Audit Committee, highlighting that the Committee had received the final reports from the Internal Auditors in relation to four recently completed audits: Falls Pathway, Medicines Management and Key Financial Systems. It had received positive assurance in relation to these reports and the progress made against recommendations from both these and previous audits.

14.2 Joanna congratulated and praised the Finance Team for achieving a double substantial assurance from the Auditors in respect of the Trust's key financial systems.

14.3 The Committee had also received the Annual Audit Plan from the External Auditors and had been assured that work and planning was underway to ensure a seamless year-end. Joanna added that the Committee would be pleased to see a similar approach being adopted now that both WSHFT and BSUH now had the same audit manager.

14.4 The Committee had also received the Declaration of Interest update and had been assured by the high number of returns received to date.

14.5 Joanna advised the Board that Dr Patrick Carr would be standing down as the Trust's Guardian of Safe Working and took the opportunity to formally express the thanks of the Board for all his work during his time in this role.

14.6 The Committee had not referred any matters to the Executive for review following its review of the Board Assurance Framework.

14.7 **The Board NOTED the report from the Audit Chair**

TB/01/20/15 Board Assurance Framework

15.1 Glen Palethorpe drew the Board's attention to the summary of the key strategic risks within the Board Assurance Framework (BAF) and noted that the information received through the integrated performance report and assurance reports from Committee Chairs link to the details in the BAF.

15.2 The Board was assured that the information it had received from the Integrated Performance Report and Committee Chairs supported the current position that no risks required to be elevated. However, at the end of Quarter 2 the Finance and Performance Committee recognised the reports from the Executive showed increased risk in relation to the financial position of the Trust and the increase in demand as a pressure on risk 5.3 in relation to the delivery of the Trust's operational targets.

15.3 At the start of Quarter 3 the Finance and Performance Committee agreed and recommended to the Board that the BAF risks 2.1 and 2.2 be increased to a current score of 16 for each risk. Countermeasure reports in the form of the Trust's road map to deliver the Trust's control total had been presented to Finance and Performance Committee which included information on planned mitigations and the delivery of which would be tracked within the routine reports to Finance and Performance Committee.

15.4 The Board agreed that the Trust continued to recognise the pressure within the wider system which could increase the risk in relation to strategic risk 5.1.

15.5 **The Board NOTED and APPROVED the Board Assurance Framework.**

TB/01/20/16 Information Management and Technology Service Presentation

16.1 The Board welcomed Ian Arbuthnot. Grant Harris, Susan Harman and Andy Banks to deliver the Clinically Led IT presentation.

16.2 Ian gave an overview of the developing strategy which had seen the active engagement of clinical, operational, and support staff. Key stakeholders had been engaged to ensure the strategy met the demands of staff and patients and was now being assessed against the new NHS Long Term Plan.

16.3 Ian informed the Board that, under the Group Director role, the IT function effectively was one across both WSHFT and BSUH; this had enabled the Trusts to standardise systems and opened up more opportunities to move further together in 2021.

16.4 Grant Harris then informed the Board that numerous different Cyber Security solutions had been put in place and the Trust had engaged fully with NHS Digital's CareCERT with all client devices enrolled in the Microsoft Advanced Threat Protection system. The Trust had currently migrated 59% of staff to Windows 10 and over three quarters of the fax machines had been removed, leaving less than 50. In addition, Trust-wide WiFi coverage had been increased for both patients and staff.

16.5 The Board noted that the IT Helpdesk had been an outsourced service until November 2016 when it was brought back in house where calls were automatically assigned to the right IT specialist to enable a faster service and an automated workflow implemented for repeat tasks such as requesting application accounts. During 2019 the IT Helpdesk had answered 37,032 calls and Technical Operations teams had resolved 19,393 tickets.

16.6 Grant went on to report that, in conjunction with Canon, a new Green Initiative was introduced where all the Trust's Canon printer consumables and toners were recycled rather than being sent to landfill. Currently 10 large bags of printer consumables a month were being recycled. Also, by using the Canon printers and enforcing duplex printing, the Trust had saved the equivalent of 798k trees and 1.6m litres of water. The IT team also worked with a company that repurposed old waste PCs and server equipment, ensuring that these were recycled and reused where appropriate.

16.7 Susan Harman then presented the section on the Electronic Prescribing and Administration System (EPMA) explaining that 90% of medicines

prescribing was completed on EPMA, with the aim for all prescribing to be completed electronically by the end of 2020, well ahead of NHS Digital's target of being paperless by 2024. 30,000 In-patient, discharge and Outpatient prescriptions were completed every month.

16.8 Susan went on to advise the Board of the benefits of Order Comms, the Electronic requesting of Pathology and Radiology Tests that included faster outpatient radiology referrals, clinicians having access to results in the right place at the right time and elimination of 1m+ handwritten forms and all integrated with the Trust's clinical portal.

16.9 Andy Banks updated the Board with regard to eObs (Patientrack) the electronic observation system used by the Trust and Evolve, the document management system that stored scanned paper notes. 350,000 sets of notes had been digitized and were immediately available on the system, resulting in over 200 clinics that no longer sent any paper.

16.10 Andy went on to advise the Board of the Patient Portal that provided patients with instant access to their information and the ability to share and manage that information with friends/family and health professionals.

16.11 Ian added that work was taking place to pilot virtual clinics in Gastro IBD and it was hoped to soon go live with these.

16.12 The Board also noted that a number of other initiatives had been or were being introduced including self-service check in for Outpatients, a clinical messaging service to replace outdated bleeps/pagers to be deployed at both WSHFT and BSUH, and a clinical portal that would allow clinicians to see all relevant information on one screen.

16.13 Karen Geoghegan asked if the patient portal would be accessible to all the organisations across the STP. Ian replied that currently the system, led by WSHFT, would also be available to BSUH and ESHT and work was under way to enable its use with GP systems.

16.14 Responding to a question from Joanna Crane, Ian assured the Board that training was in place to ensure that new members of staff were trained to use the various systems.

16.15 Alan McCarthy was encouraged to see that both WSHFT and BSUH were learning from each other and that virtual clinics were being piloted which was a good example of technology supporting a better patient experience.

16.16 The Board expressed their thanks to Ian and his team for their excellent work and achievements.

16.17 **The Board RECEIVED the presentation of the Information Management & Technology Service.**

TB/01/20/17 Annual Equality Report

17.1 Jo Fanning introduced the Annual Equality Report for 2019. The report helped to demonstrate how the Trust was progressing in delivering fair, equitable and inclusive services, as both a healthcare provider and an employer. Data gathered from 1 April 2018 to 31 March 2019 had been analysed with actions to be taken as a result.

17.2 A number of equality objectives were considered that included building on group working and pooling knowledge, equality monitoring status, variation

of staff experience in the workplace, recruitment selection and better engagement with patients.

17.3 Jo went on to highlight that the Trust undertook a wide range of work and projects to support the equality agenda to benefit both patients and staff and to ensure that as many people as possible had a voice into the way services were delivered. Some of the key initiatives that occurred during 2018/19 included the Staff Conference where the theme was 'Inclusion', the Rainbow Warrior initiative, Changing Places facility at Southlands Hospital, purchase of the 'Recite Me' system to improve accessibility of the Trust's website, StaffNet and Outpatient booking service and participation in Worthing Pride.

17.4 The Board was pleased to see the number of projects in support of the Trust's stated above and below the line behaviors that gave a good platform for action plans to be to progressed and the enthusiasm of managers to support and publicise throughout the organisation.

17.5 Joanna asked if there was any evidence of reverse discrimination by choosing not to declare their status. As there was no data available for this currently, Jo would follow this up, although it was thought the difference might be as a result of people not declaring their status in the first instance and subsequently not taking the time to complete it.

17.6 **The Board APPROVED the Annual Report for publication.**

17.7 The Board noted that, as Marianne Griffiths and Alan McCarthy had to leave the meeting, Mike Rymer and George Findlay would assume the roles of Chair and Deputy Chief Executive respectively. Mike confirmed that the Board remained quorate.

TB/01/20/18 Annual Gender Pay Gap Report

18.1 Jo Fanning presented the Annual Gender Pay Gap Report advising that it summarised the Trust's Gender Pay Gap (GPG) as at the 31 March 2019 snapshot, demonstrating the difference in average hourly pay and bonus payments between men and women. The Trust was mandated to report and publish six calculations on the Government website with a written statement confirming the calculations were accurate. The information was then published on the Trust's website.

18.2 The Gender Pay Gap (GPG) reporting showed the difference in average hourly pay and bonus payments between men and women and the Trust were required to analyse the information to identify any underlying root causes for GPG and to put in place remedial actions to address and mitigate this. The benefits of reporting GPG included building a reputation for being known as a fair and progressive employer, attracting a wider pool of recruits, enhancing productivity and creating a culture committed to tackling inequality.

18.3 The Board noted a 20% difference in favour of male employees when using the mean hourly rate; this was a decrease of 1.16% on the 2018 figures and was seen as a positive step in direction.

18.4 Responding to a question from Joanna Crane if it was felt that there was an issue to address Jo replied that there was a gender pay gap nationally and the Trust was in line with other Trusts; however notwithstanding the national picture a piece of work was already in hand to review what more the Trust could do to reduce this gap going forward.

18.5 George Findlay added that the Trust recognised that one of the key factors in driving this reported gap was the level of male Medical and Dental employees who received a Clinical Excellence Award (CEA). There was a general reduction in the gap in both the mean and median, which was a positive decrease but it was known that fewer female doctors applied for these awards.

The Board APPROVED the report for publication.

18.6

TB/01/20/19 Emergency Preparedness and Resilience and Response Assurance (EPRR) Report

19.1 Fiona Ashworth presented the report highlighting that the NHS England core Standards for Emergency Preparedness, Resilience and Response (EPRR) were the minimum standards which NHS organisations and providers of NHS funded care must meet to ensure they were able to respond to a wide range of incident and emergencies that could affect health or patient care.

19.2 The report summarised the Trust's assessment against the EPRR Core Standards for the 2019 Assurance and cited the current rating as 'FULLY Compliant'.

19.3 Fiona added that in addition to the 64 core standards cited the Trust had undertaken two extra pieces of work focusing on 'Severe Weather' and Hazardous Substances, neither of which were part of the core standard assessment.

19.4 **The Board NOTED the report, APPROVED the findings and AGREED the overall compliance rating.**

TB/01/20/20 Annual Emergency Planning and Business Continuity Report

20.1 Fiona Ashworth introduced the Annual Emergency Planning and Business Continuity Report for 2019 advising that it summarised the Trust's assessment against the EPRR Core Standards for the 2019 Assurance, which cited the Trust's current rating as 'FULLY Compliant'.

20.2 The past year had seen continued development in the Trust's Emergency Planning and Business Continuity arrangements and resilience, however more work was required at some service level areas to achieve full resilience and the necessary work streams had been identified in the work programme for 2020.

20.3 Fiona Ashworth provided a brief update to the Board and commended the preparation work that had been undertaken by the Trust during the past 18 months. Fiona informed the Board that, although some structural arrangements were required to remain in place until further instructions were received, the Trust was no longer required to provide any further EU Exit planning updates as the UK would now be exiting with a deal.

20.4 Joanna was surprised not to see IT continuity included in the specific emergency planning and business continuity risks for the Trust listed on Datix and asked if this was covered elsewhere. Fiona responded saying that there were multiple risks on the Trust's Risk Register relating to IT

issues and cyber-attacks and these were tracked elsewhere and did inform the EPPR compliance rating.

20.5 **The Board NOTED the contents of, and endorsed the Emergency Planning and Business Continuity annual report.**

TB/01/20/21 Company Secretary Report

21.1 Glen Palethorpe presented the Company Secretary report explaining that the report provided the Board with an update, including matters for which the Trust had complied with NHS I or other regulatory requirements.

21.2 **Schedule of meetings for 2020/21**
The Trust had continued to have Public Board and Public Council of Governors meetings taking place across both the Trust's two principal sites in Chichester and Worthing.

21.3 The Board meetings remained bi-monthly on a Thursday but with them moving to be a week behind the supporting Committee meetings, meaning that they would now fall in the first few days of the next month.

21.4 The Council meetings had moved to three times a year. This was based on feedback from Governors who, through the revised integrated performance report presented to Board, felt they could reduce slightly the frequency of meetings to three from the previous four.

21.5 **Annual General Members Meeting**
The Trust was provisionally targeting the Thursday 30 July 202 for its AGM, with its being held in Worthing this year.

21.6 **Committee Quoracy Update**
The Trust had looked at the Quoracy of its Board Sub Committees and the Committees had made the changes noted in the report, to ensure that they continued to function effectively. The Board members had agreed these changes in between the Board meeting in November and the current meeting.

21.7 **The Board NOTED the report and CONFIRMED the changes the Board had approved in December.**

TB/01/20/16 Other Business

16.1 There was no other business to discuss.

TB/01/20/17 The Chair formally closed the meeting

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

18.1 The Board noted that no formal questions had been received.

18.2 Following a question from a member of the public on the Annual Equality Report, George Findlay confirmed that the Board paid great attention to equality and diversity within the Trust and a number of improvements had been identified including the development of a 3-year action plan to address issues of inequality.

18.3 Stuart Fleming drew the Board's attention to page 66 of the Annual Equality Report and asked it to be noted that all Governors were required to be

members of the Trust. George Findlay noted the discrepancy and would have the figure amended accordingly. **GF/JF**

18.4 Having been impressed by the apprenticeship schemes, John Bull asked how these were progressing. Jo Fanning replied that the schemes were a key part of the work around operational planning and hard to fill roles and the Trust were working very closely with the Divisions to determine where apprentices could be best placed.

18.5 Andrew Ratcliffe questioned if a process was in place for the reporting of high levels of litigation faced by the NHS generally. George Findlay answered that the Annual Report that was presented to the Board contained a report of claims; it was recognised as a growing trend within the NHS and increasingly so in a number of key specialties. George added that the Trust subscribed to the Clinical Negligence Scheme for Trusts (CNST) scheme that covered the risk of litigation; the Trust had seen a significant reduction in payment to the scheme signifying the level of safety in the organisation.

TB/01/20/19 Resolution into Board Committee

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

TB/01/20/20 Date of Next Meeting

20.1 It was noted that the next Board Meeting would take place at 10.30 on **Thursday 26 March 2020** in the **Bateman Room, CMEC, St Richard's Hospital, Spitalfield Lane, Chichester.**

Jan Simmons
Corporate Governance Officer
January 2020

Signed as a correct record of the meeting

Chair…….

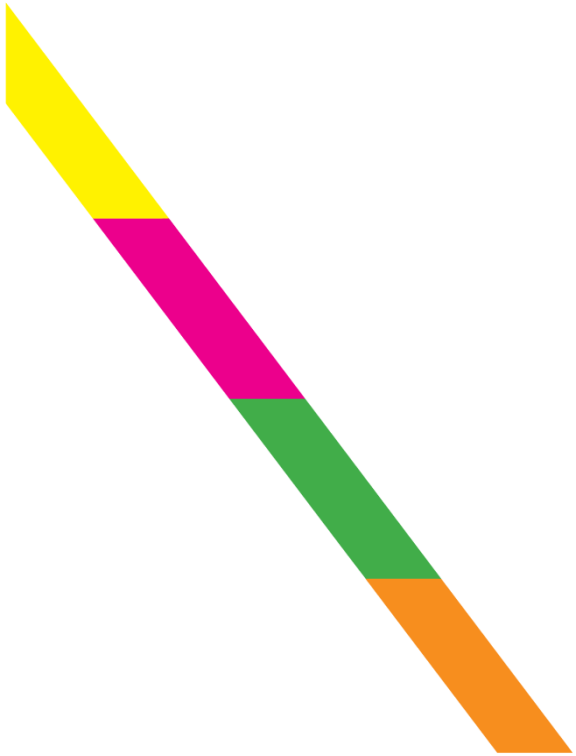
Date…….

NHS
Western Sussex Hospitals
NHS Foundation Trust

Chief executive's report

Dame Marianne Griffiths

6 AUGUST 2020



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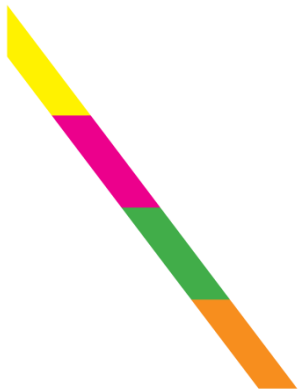


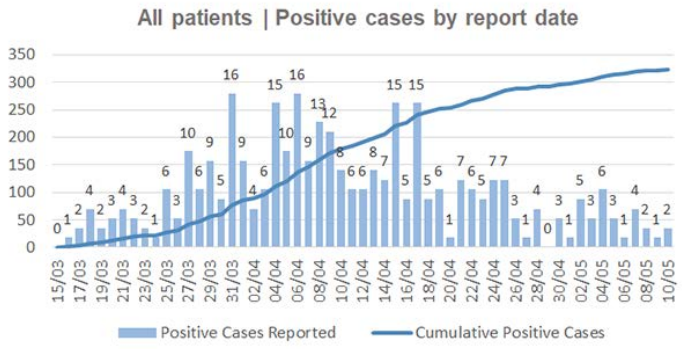
Headlines: Covid-19

NHS
Western Sussex Hospitals
NHS Foundation Trust

Seven months on unprecedented impact

10 January	Western Sussex emergency preparedness planning starts
31 January	First UK Covid-19 patient confirmed
7 February	Worthing A&E doctor tests positive after Italy trip: 50 A&E staff self-isolate
11 February	First Covid-19 case in Western Sussex Hospitals
5 March	First UK patient dies with COVID-19
11 March	Global pandemic declared by WHO
11 March	Western Sussex incident room opens
23 March	UK lockdown starts

Covid-19 patient cases peak in mid-April but continue May to June



Headlines: Covid-19

Western Sussex Hospitals NHS Foundation Trust

Extensive measures taken to protect patients and staff

- Discharge To Assess
- Virtual appointments
- 24/7 mental health provision
- Increased critical care capacity
- Red and Green / Covid and non-Covid areas
- Redeployed staff
- Workforce hub
- Shielding and self-isolating staff >5%

National guidance changed almost daily and staff adapted and overcame the many challenges with incredibly agility, ingenuity and commitment to our patients, each other and the health service.

Headlines: Covid-19

Western Sussex Hospitals NHS Foundation Trust

Applauding recovery and comforting loss

Staff lined the corridors to clap and cheer Covid-19 patients on their way home after being critically unwell with the new disease. In some instances, these emotional and hugely uplifting scenes were shared on BBC and ITV news. This included Donna Morgan (pictured right) who, at 92 days, was the trust's longest staying Covid inpatient.

Tragically, many other families have had to grieve the loss of their loved one during the pandemic. More than 100 patients have died in our hospitals from Covid 19. Our staff have done all they can to comfort them. Childhood sweethearts Pat and Ron Wood were enabled to hold hands until the end before they both died from Covid after more than 70 years of marriage and love.

Headlines: Covid-19

NHS
Western Sussex Hospitals
NHS Foundation Trust

Wonderful support for our staff

The support shown to our staff during the pandemic has been extraordinary and we wish to thank everyone who has taken the time to think of our hospital teams since Covid began.

- Public support – rainbow pictures and gifts flooded in
- Business support – fresh food, supplies and services
- Volunteers – so many people gave up their time to help
- Charity – Love Your Hospital donations and gifts

Sadly, there are too many to mention here without doing some an injustice, but everyone's kindness, generosity and goodwill has been incredible and has meant so for our staff working in such difficult circumstances. Thank you.

Headlines: Covid-19

NHS
Western Sussex Hospitals
NHS Foundation Trust

#PortraitsforNHSheroes

A national project to immortalise in pictures many of the NHS professionals working through the Covid-19 pandemic has seen dozens of Western Sussex colleagues painted for posterity. Our thanks to all the artists who volunteered their time and skill to paint such evocative images. They are all wonderful!

Headlines: Covid-19

Western Sussex Hospitals NHS Foundation Trust

Proud to support Covid-19 research

More than 500 patients from Western Sussex Hospitals have been enrolled into Covid-19 clinical trials to help improve care for people with the new disease. The Research & Innovation team have been working seven days a week alongside their clinical colleagues to recruit patients into public health priority research trials.

Headlines: Merger

NHS
Western Sussex Hospitals
NHS Foundation Trust

WSHT and BSUH merger - better for everyone

Western Sussex Hospitals (WSHT) and Brighton and Sussex University Hospitals (BSUH) have announced plans to pursue a merger between the two trusts. The Trust Boards believe a new, single organisation will create exciting opportunities for the hospitals to grow and develop services and continue to deliver outstanding care to communities across Sussex. BSUH and WSHT have worked closely together and shared an executive team since April 2017. The next steps are the development of a full business case with staff, partners, governors, members and local communities involved in creating the new organisation.

> *"To achieve together what we cannot achieve alone*

Headlines

International Year of the Nurse and Midwife

Marking the 200th anniversary of Florence Nightingale's birth, we treated all staff to a much-deserved cream tea on 12 May to thank everyone for their service during the pandemic. Our thanks to sponsors Love Your Hospital.

Headlines: Employee of the Month

Western Sussex Hospitals NHS Foundation Trust

Award ‘cherry on top’ for patient catering team

The catering team won the *Employee of the Month* award for February but did not receive their certificate until May due to Covid-19. The recognition is a ‘cherry on top’ for the team who earlier this year also received the highest of praise from both celebrity chef Pru Leith and health secretary Matt Hancock. On a visit to St Richard’s, Pru Leith said: “The truth is, this is the best institutional food I have ever eaten! I think it is amazing. I walked round and I couldn’t think of a single thing to complain about - which is not like me!”

Headlines: Employee of the Month

NHS
Western Sussex Hospitals
NHS Foundation Trust

"Western at its best"

The A&E teams at St Richard's and Worthing won the *Employee of the Month* for March following a compelling nomination by lead governor Lyn Camps. Unfortunately, the presentation was delayed until June due to the pandemic.

In March, what lay ahead was uncertain but the trust's A&E departments had already experienced the impact of coronavirus in February when one doctor with the virus led to nearly 50 colleagues needing to self-isolate for 14 days.

Lyn said: "The approach to this incident by all of the staff was fantastic and very much a 'can do' attitude which allowed the trust to keep A&Es open and without any sense of panic." The governors described this as "Western at its best".

Headlines: Trainee doctor awards

NHS
Western Sussex Hospitals
NHS Foundation Trust

Recognising excellence

The Postgraduate Medical Education department held their annual Trainee Doctor Excellence Awards on 3 July to recognise the achievements of junior doctors and those who support them.

It was a great privilege to present many of the prizes. The climax was the presentation of the Sophie Spooner Legacy Cup.


Aneka Popat - Core & GP Peer Award


Laura Bannon - Core & GP Peer Award


Lucy Gumbiti-Zimuto - Foundation Peer Award


Lisa Neville - Dir. of Medical Education Award


Edwyn Lim - Peer Award - Higher & SAS Award


Caroline Bailey - MDT Clinical Winner


Julie Ide - MDT Non-Clinical Winner


Phoebe Jane - Peer Award Winner


Jane Boxall - MDT Non-Clinical Award


Sam Rawlins - Foundation Peer Award


Chris Chandler - Trainer of the Year Winner


Joseph Ayathamattam - Undergraduate Winner

This year's winner, Dr Tess Pepper (pictured right) received 27 nominations. Colleagues said: "Dr Tess Pepper has continually been supportive, available to help, great at teaching, friendly and knowledgeable"

Headlines:

Western Sussex Hospitals NHS Foundation Trust

New £3m respiratory ward

A new 20-bed specialist ward is being developed in Worthing Hospital to provide modern purpose-designed facilities to improve care for patients with respiratory illnesses. A £3 million investment will see the new respiratory ward open early next year following refurbishment of 774m^2 of administrative space on the first floor of the East Wing into a new clinical area.

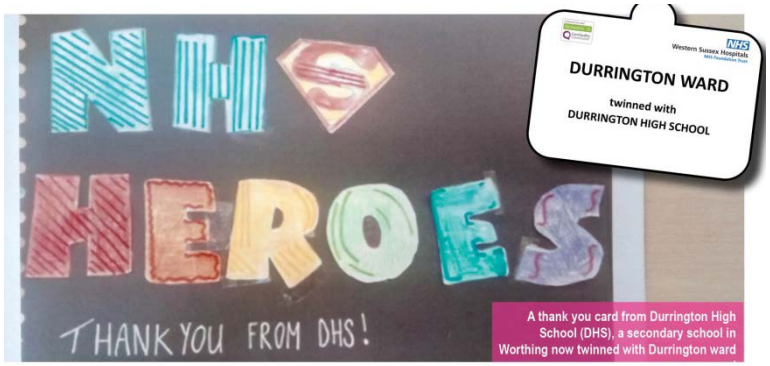
“We’re feeling buoyed by the investment in the department,” said lead respiratory consultant, Dr Katrine Steele. “We have of course been very involved in the delivery of Covid care and so this is welcome good news at a time when we’re all feeling tired.”

Headlines

Western Sussex Hospitals NHS Foundation Trust

Congratulations – it's twins!

A new twinning initiative launched in May, pairing our wards and departments with schools and communities in West Sussex to create a legacy of lasting support for our hospitals, long after the pandemic ends. In many cases, wards are being twinned with those who share their name.



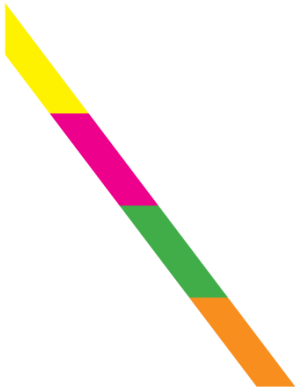
A thank you card from Durrington High School (DHS), a secondary school in Worthing now twinned with Durrington ward

For instance, Durrington High School in Worthing is proudly twinning with Durrington ward. Headteacher, Chris Woodcock, said: "Kindness is one of our core values at Durrington High School. Our students will love the opportunity to get creative and share messages to patients and staff on Durrington ward."

Headlines

Western Sussex Hospitals NHS Foundation Trust

- Protecting BAME Communities in Sussex
- COVID-19 briefing calls with MPs
- QVH Boards
- Sussex Acute Collaborative Network
- Staff briefings at St Richard's and Worthing
- Sussex Integrated Care development
- Green Steering Group



Looking ahead

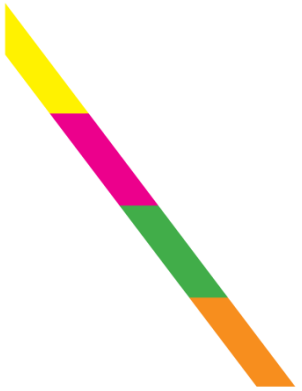
NHS
Western Sussex Hospitals
NHS Foundation Trust

Restoring our services

Work is underway to restore all services, with priority areas already seeing and treating patients. Covid-19 has created an inevitable backlog but those patients most in need will be prioritised as services resume. The virtual appointment capability put in place during the pandemic will also continue and is being expanded across more services to ensure we can provide care to more patients. We are also working to reassure patients that it is safe to attend our hospitals and that if they are invited to attend, it's important they do so.

Planning for the future

We announced earlier this month that the two Trusts would be merging. Work is underway on the development of the new structure to ensure we can do what is best for our patients and people. The aim is to have the new merged Trust in place by April 2021.



Thank you – any questions?

Western Sussex Hospitals
NHS Foundation Trust

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	6-10	**Meeting:**	Trust Board	**Meeting Date:**	06 Aug 2020
Report Title:	**Integrated Performance Report**				
Sponsoring Executive Director:	Marianne Griffiths, Tim Taylor, Maggie Davies, Fiona Ashworth, Karen Geoghegan				
Author(s):	Marianne Griffiths, Tim Taylor, Maggie Davies, Fiona Ashworth, Karen Geoghegan and Jennie Shore				
Report previously considered by and date:	Individual elements considered by relevant Board Committee				
Purpose of the report:					
Information		☐	Assurance		✓
Review and Discussion		✓	Approval / Agreement		☐
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability		✓
Our People		✓	Quality		✓
Systems and Partnerships		✓			
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe		✓	Effective		✓
Caring		✓	Responsive		✓
Well-led		✓	Use of Resources		✓
Communication and Consultation:					
Executive Summary:					
Attached is the Trust's integrated performance report.					
Key Recommendation(s):					
To note the content and following receipt of the Committee assurance reports, consider if there are areas for referral back to the Committees where enhanced assurance is required.					

Integrated Performance Report

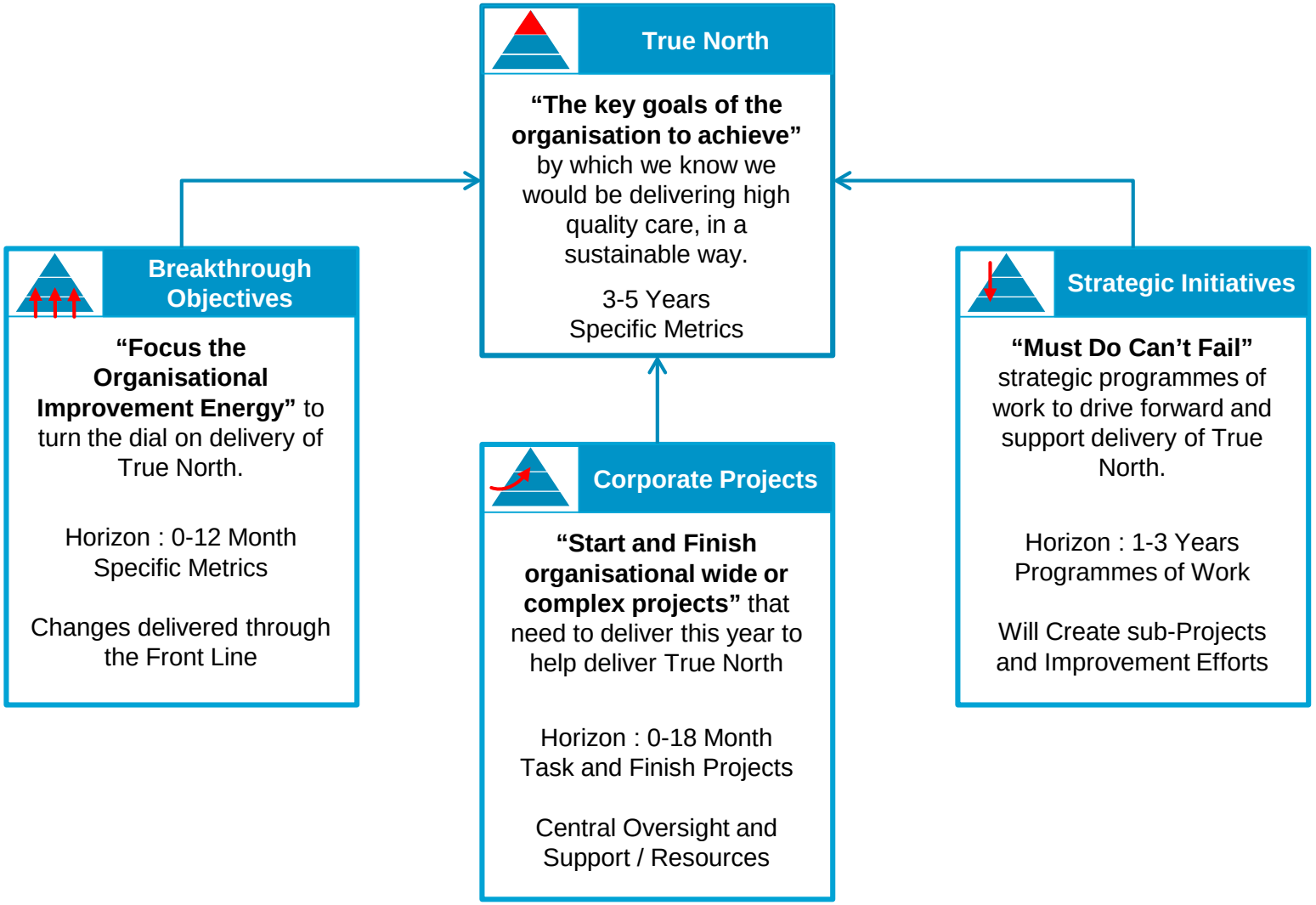
August 2020

NHS
Western Sussex Hospitals
NHS Foundation Trust

Contents

Structure of the report

Patient First Strategy Deployment Framework



Patient First True North

Key Goals for the Organisation to achieve sustainably

Patient

Patient Satisfaction

Target: Family & Friends Recommend Rate >96%

Sustainability

Financial Management

Target: Break Even

People

Staff Engagement

Target: Engagement Score Top in the Country

Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 99% Harm Free Care

Systems & Partnerships

Non Elective Care

Target: A&E 95% <4hrs

Elective Care

Target: RTT 92% <18wks

Quality Performance - Effectiveness

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

Mortality

The HSMR up to and including March 2020 has reduced to 102.3 (56th percentile) and the in month HSMR for March has also reduced to 89.9 (28th percentile). The 12 month rolling site specific HSMR for St.Richard's Hospital (100.4) and is now lower than Worthing (103.8).

The crude mortality (non-elective) in June was 2.41% and the 12 month rolling crude (non-elective) mortality rate including June 2020 is 2.98% against a target of 3.11%.

The latest SHMI for the 12 months up to and including February 2020 is 101.28. This falls within the statistically 'as expected range' although represents a slight increase in value from the previous 100.61.

Quality Performance - Effectiveness

Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 99% Harm Free Care

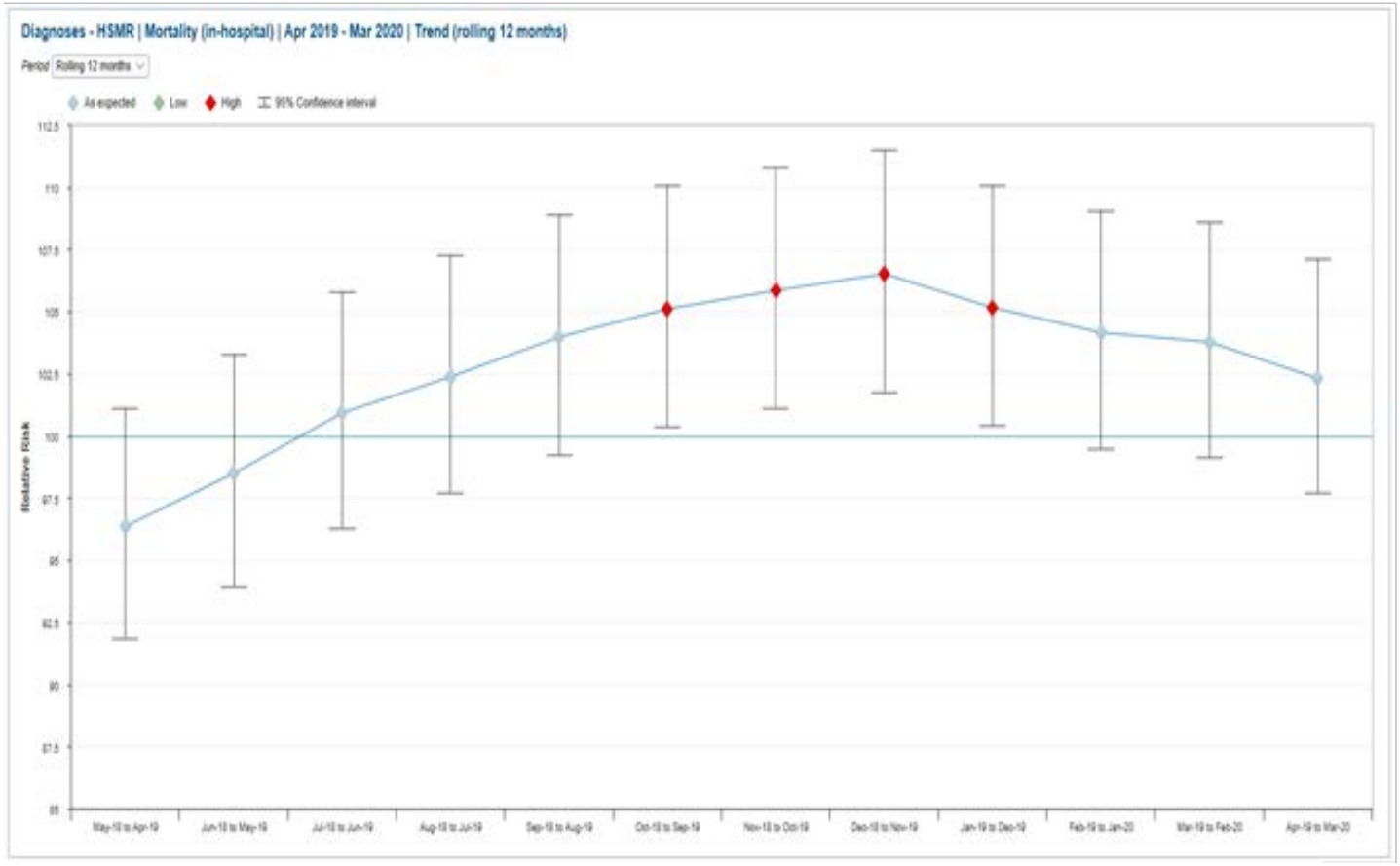
COVID-19 Mortality

In May, 27 inpatients died with a current COVID-19 positive test result. This was inaccurately reported as 34 in the last report due to a data filtering error.

Five inpatients died with a current COVID-19 positive test result in June (4 at SRH and 1 at Worthing).

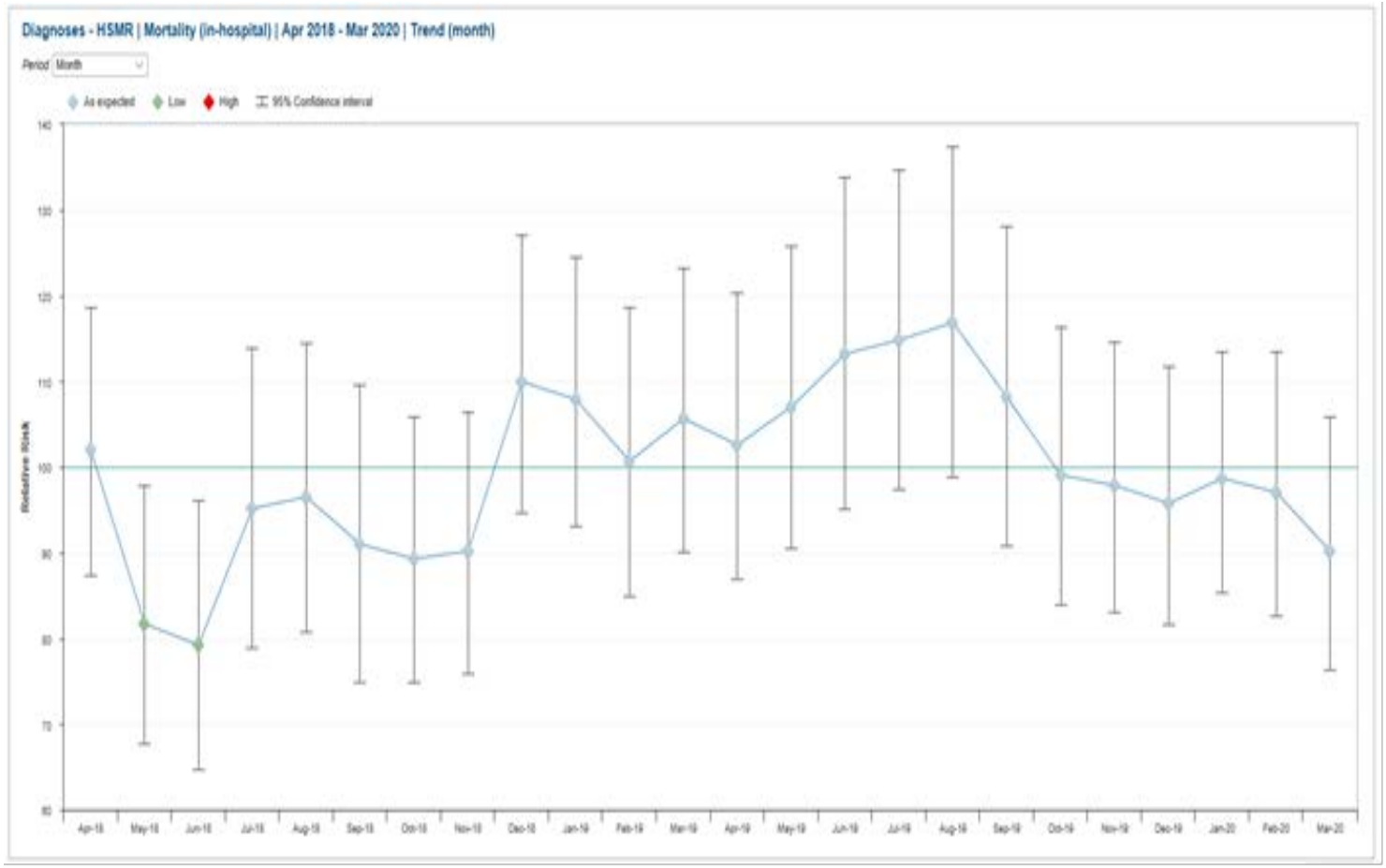
Quality Performance - Effectiveness

WSHT - 12 month rolling HSMR



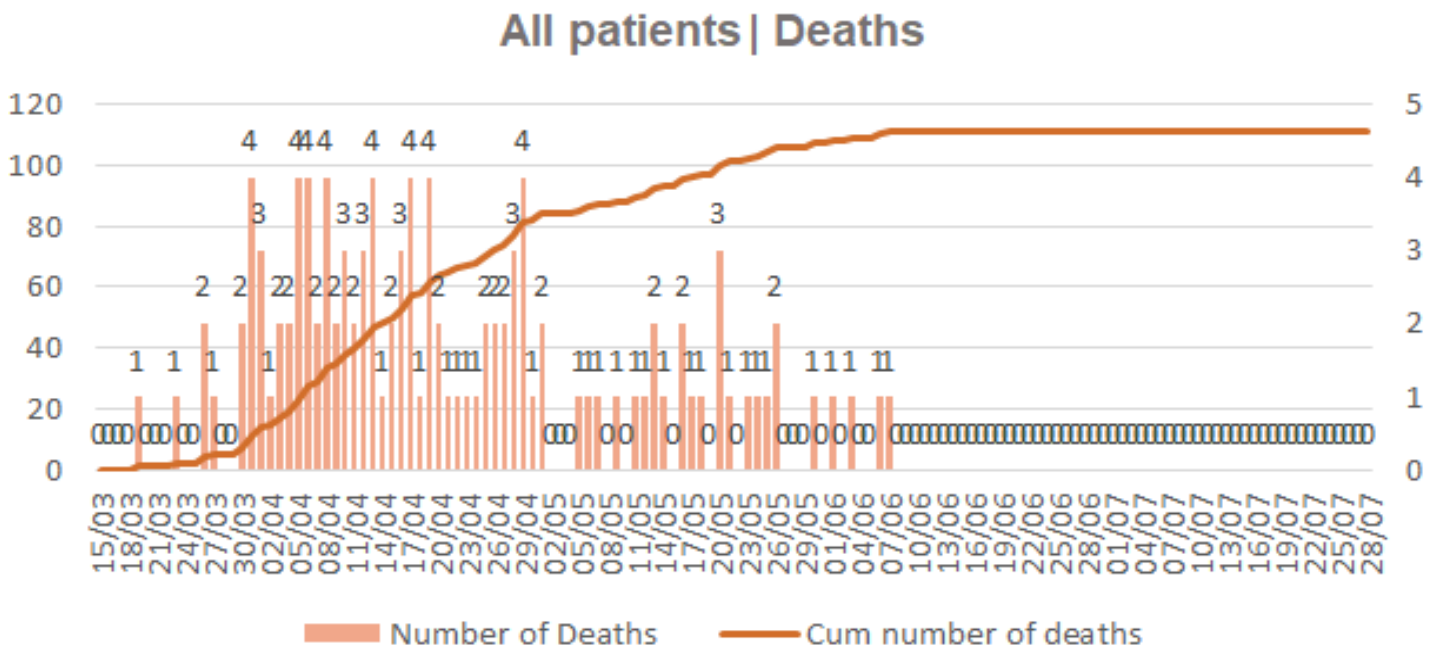
Quality Performance - Effectiveness

WSHT – In Month HSMR



Quality Performance - Effectiveness

Deaths due to COVID-19



Quality Performance - Effectiveness

Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 99% Harm Free Care

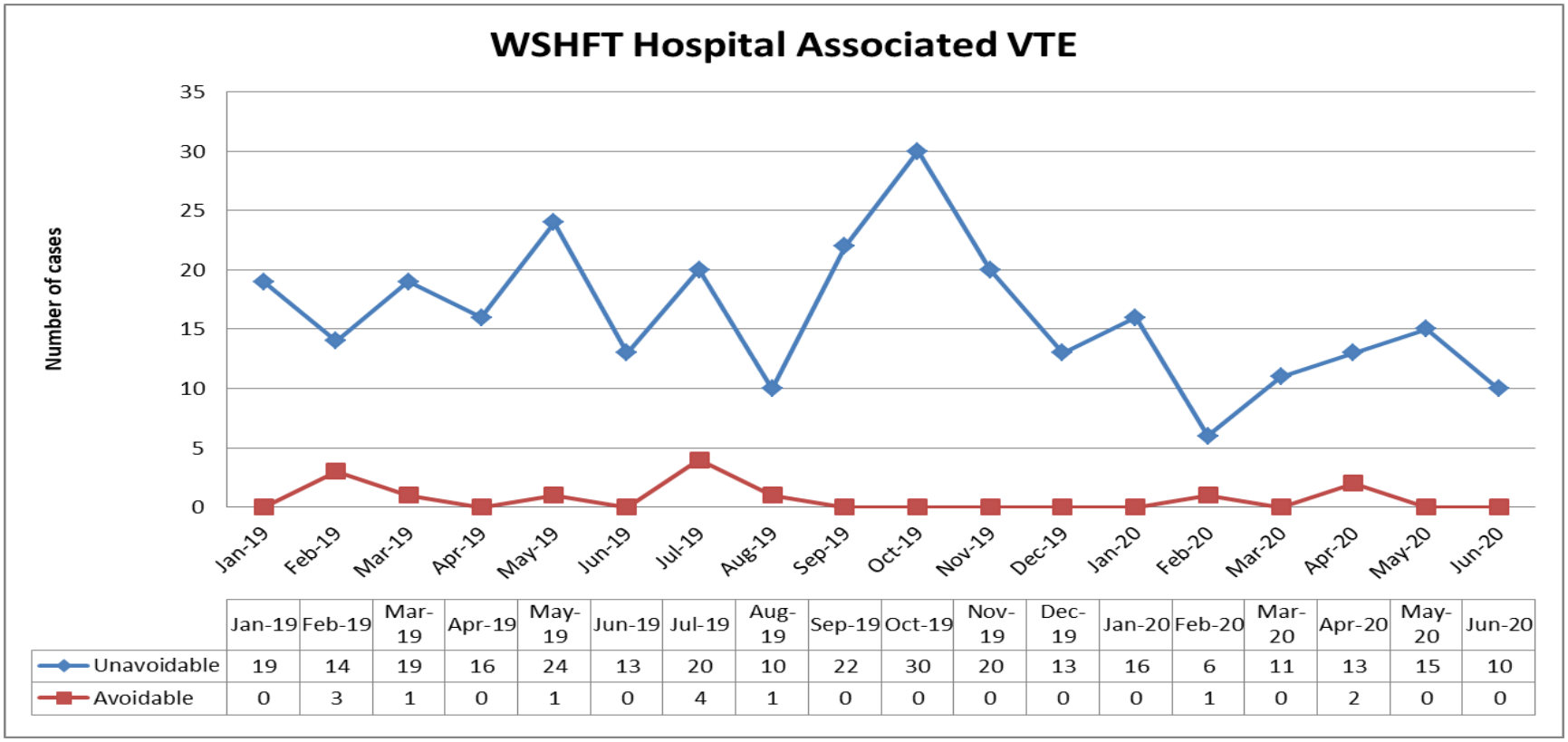
Stroke services

The latest published quarterly SSNAP performance (January to March 2020 & published in June 2020) demonstrates that St Richard's achieved a grade B with an attainment score of 74, maintaining the score and grade achieved in the previous quarter. Worthing maintained a grade A with an attainment score of 84, maintaining the grade achieved in the previous quarter.

From March submissions to the SSNAP database were no longer mandatory due to covid . WSHT continued to submit data throughout this period that comes to an end on August 15th. Mandatory reporting then resumes.

Avoidable Harm– Breakthrough Objective

Reducing Hospital Associated VTE: goal to reduce avoidable VTE by 50% by end March 2020 and maintain this improvement through 2020/21



	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Unavoidable	19	14	19	16	24	13	20	10	22	30	20	13	16	6	11	13	15	10
Avoidable	0	3	1	0	1	0	4	1	0	0	0	0	0	1	0	2	0	0

Quality Performance - Safety

Infection Prevention and Control COVID-19: BAF

- NHSE have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Each of the 10 criteria (KloE) has a subset of headings requiring evidence and assurance. This forms the structure for the CQC Emergency Support Framework (COVID-19).

- July update: CQC confirm full assurance with ESF

Quality Performance - Safety

Infection Prevention and Control: Key Lines of Enquiry (KLoE)

1. **Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users ✓ COMPLIANT**

2. **Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections ✓ COMPLIANT**

3. **Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance ✓ COMPLIANT**

4. **Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion ✓ COMPLIANT**

5. **Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people ✓ COMPLIANT**

6. **Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection ✓ COMPLIANT**

7. **Provide or secure adequate isolation facilities ✓ COMPLIANT**

8. **Secure adequate access to laboratory support as appropriate ✓ COMPLIANT**

9. **Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections ✓ COMPLIANT**

10. **Have a system in place to manage the occupational health needs and obligations of staff in relation to infection ✓COMPLIANT**

Introduction of PPE Safety Officers

1. Deliver ward based training to clinical and non-clinical health care workers on the correct and safe use of PPE for non-aerosol generating procedures, aerosol generating procedures and high risk areas.

2. Deliver training to staff to be able to undertake FFP3 respirator FIT testing/checking.

3. Deliver training to staff on how and when to effectively perform hand hygiene with alcohol hand rub and with soap and water.

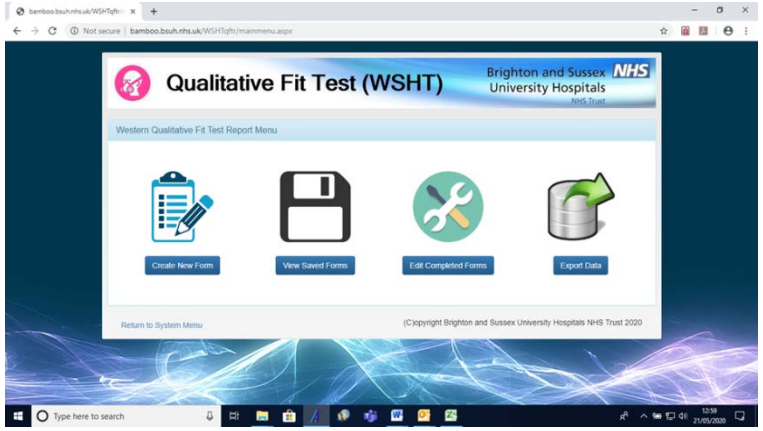
4. Provide access to PPE donning and doffing posters and staff resources to COVID-19 work areas.

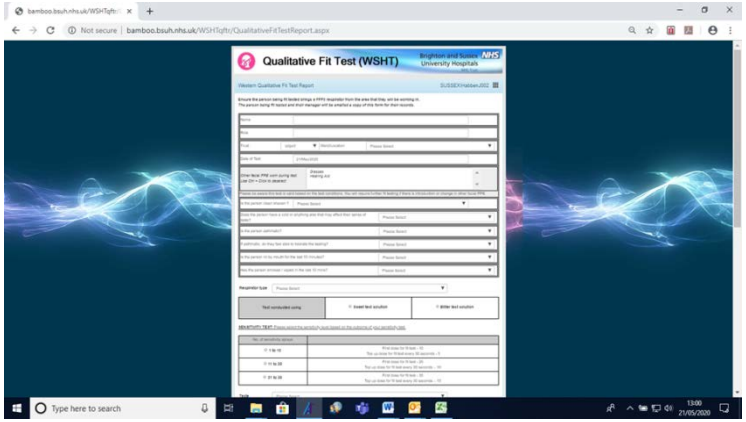
5. Liaise with materials management to ensure all necessary PPE is located close to the point of use.

PPE: FFP3 Staff FIT testing database

The electronic e-portal is the revised system for collating all the correct information required to assure staff that they have been FIT tested for PPE safely and correctly. A support team are adding the retrospective *paper* records of all staff who have been previously FIT tested to the new system.

The database will record both the FIT test procedure as well as the specific FFP3 mask type the staff member has been tested with and pass/failed on. The staff member and line manager both receive a copy of the FIT test certificate.





Quality Performance - Safety

Infection Prevention and Control

Covid-19: during June 2020 there remained a continued focus and vigilance for all teams across the Trust. June observed particular efforts on the restoration and recovery of all services within the Trust that were ceased due to the pandemic.

June 2020 observed similar numbers of COVID-19 tests for patients, across both St Richards & Worthing sites. The following table highlights the tests completed for June 2020 and the numbers of COVID-19 positive results received.

Patient testing:

June 2020	No. tested (admission only)	Positives
SRH	1690 (May 1608)	4
Worthing	1625 (May 1689)	8

Staff Testing:

June 2020	No. staff tested	Positives
SRH	32 (May 71)	0
Worthing	47 (May 210)	0
Tested Elsewhere	58	1

Quality Performance - Avoidable Harm

Key messages for Board

True North Metrics: Patient Safety Thermometer:

- We delivered 98.5% harm free care(in-hospital harms) during 2019/20 as described by the NHS Patient Safety Thermometer
- NHS England announced in March that the collection of this data would discontinue from April 2020
- Plans are underway for nationally-produced replacement data to support improvement drawn from routinely collected sources.
- At WSHFT we continue to monitor and report our falls, pressure ulcers and VTE very closely using our datix incident reporting system.

Quality

Preventable Mortality

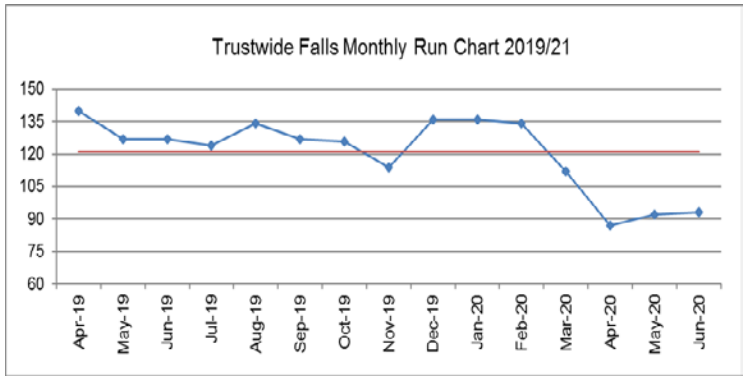
Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 99% Harm Free Care – replacement metric under review

Avoidable Harm– Key Metrics

Falls

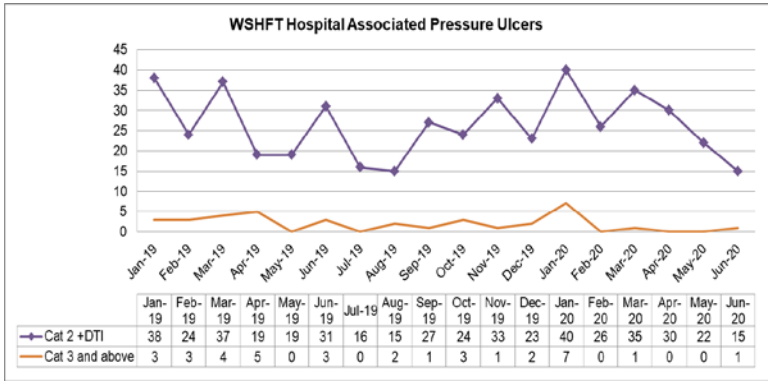


Trust Goal: no more than 120 falls each month

Current Performance and Actions:

- The number of falls in Q1 has been well below the Trust goal
- There is a caution however in that the falls rate is higher than the average rate for 2019/20 – due to the number of unoccupied beds.
- The rate for June has shown an improvement with 93 falls in month reflecting a rate of 5.01, compared to 5.16 in May and 5.72 in April (2019 falls rate average = 4.58)
- Two key themes have emerged:
  - PPE and adjusted safe working practicies has proved a challenge to maintaining proactive Baywatching
  - Delirium is recognised as a key challenge in patients with Covid, particularly those with dementia.

Pressure Ulcers



	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Cat 2 +DTI	38	24	37	19	19	31	16	15	27	24	33	23	40	26	35	30	22	15
Cat 3 and above	3	3	4	5	0	3	0	2	1	3	1	2	7	0	1	0	0	1

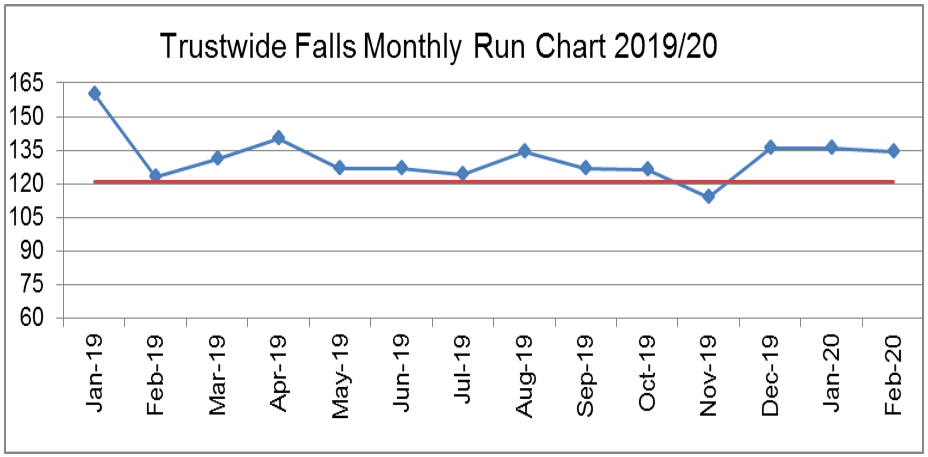
Trust goal: 30% reduction i.e. no more than 2 patients develop category 3 and above ulcer in hospital

Current Performance and Actions:

- We delivered the planned 10% reduction in cat 3 ulcers during 2019/20 and have set a further ambitious goal of 30% reduction during 2020/21
- Currently on target with 1 patient with cat 3 and above ulcer in Q1
- There was a rise in cat 2 ulcers during March and April in surgery due to patients with COVID in ITU Prompt response by the teams ensured that these wounds did not deteriorate. All patients were closely monitored through to discharge by the tissue viability team.

Avoidable Harm– Key Metrics

Falls

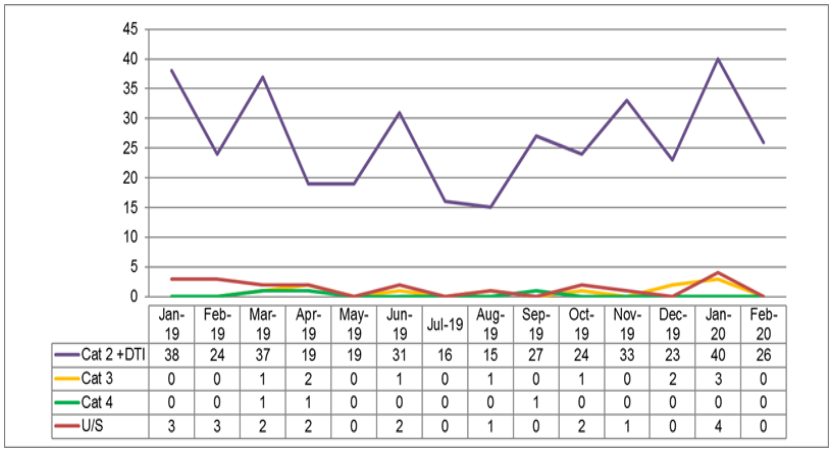


Trust Goal: no more than 120 falls each month

Current Performance and Actions

- 134 falls in month, reflecting the higher activity of winter months with Worthing Emergency Floor experiencing particular challenge
- Whilst above goal for the past 3 months the performance compared over winter compared to previous years is much improved
- Work continues for the national falls CQUIN which focusses on compliance with recording of lying and standing blood pressure, provision of mobility aids and avoidance of psychotropic medication.
- Observational audits for Q4 to date showing positive performance in all metrics.

Pressure Ulcers



	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Cat 2 +DTI	38	24	37	19	19	31	16	15	27	24	33	23	40	26
Cat 3	0	0	1	2	0	1	0	1	0	1	0	2	3	0
Cat 4	0	0	1	1	0	0	0	0	1	0	0	0	0	0
U/S	3	3	2	2	0	2	0	1	0	2	1	0	4	0

Trust goal: 10% reduction i.e. no more than 2 patients develop category 3 and above ulcer in hospital

Current Performance and Actions:

- There were no patients who developed a cat 3 or above ulcer in February, much improved from January when 6 patients (7 ulcers) developed cat 3 and above.
- We are on track to deliver the 10% reduction despite the January challenge
- The overall number of less serious(cat 2) ulcers remains higher than desired.
- The TV team are working closely with key wards to support their improvement efforts, with early assessment and effective targeted repositioning being key areas of work.

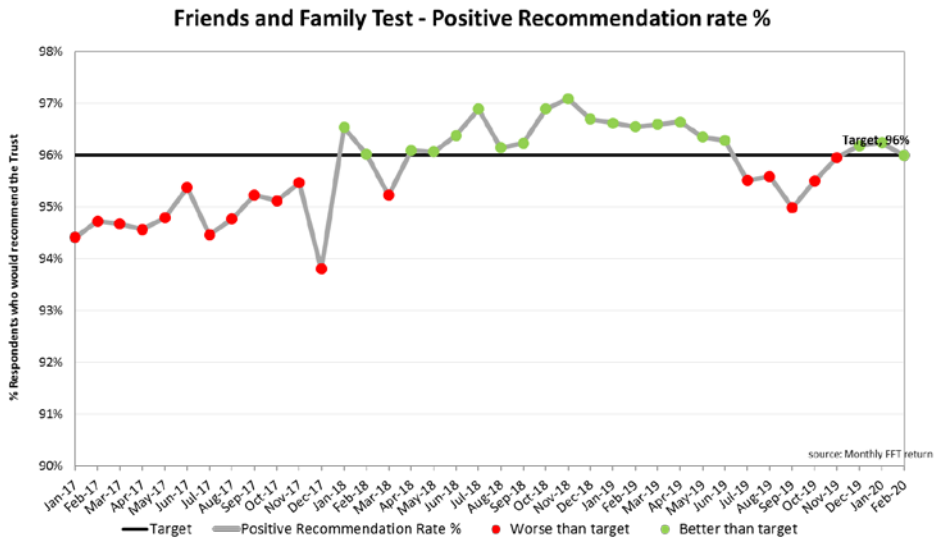
Quality Performance – Experience

Key Messages for the Board

True North Metric: to be a top 20% of NHS Trusts in the country for recommendation by patients responding to the Friends and Family Test.

Family & Friends Recommend Rate: 96%

- Trust goal delivered for the last 3 months with overall 96% satisfaction
- Inpatient, Outpatient and Maternity have all met the recommendation goals
- Inpatient response rate still requires improvement; driver wards are working on approaches to provide consistent and sustainable rates of feedback
- A/E Worthing saw 92.3% recommendation rate in February, slightly below target despite high activity and impact of COVID-19



Current Performance:

Inpatients: 97.% recommendation (goal = 97%)
Response rate: 29.3% (goal = 40%)

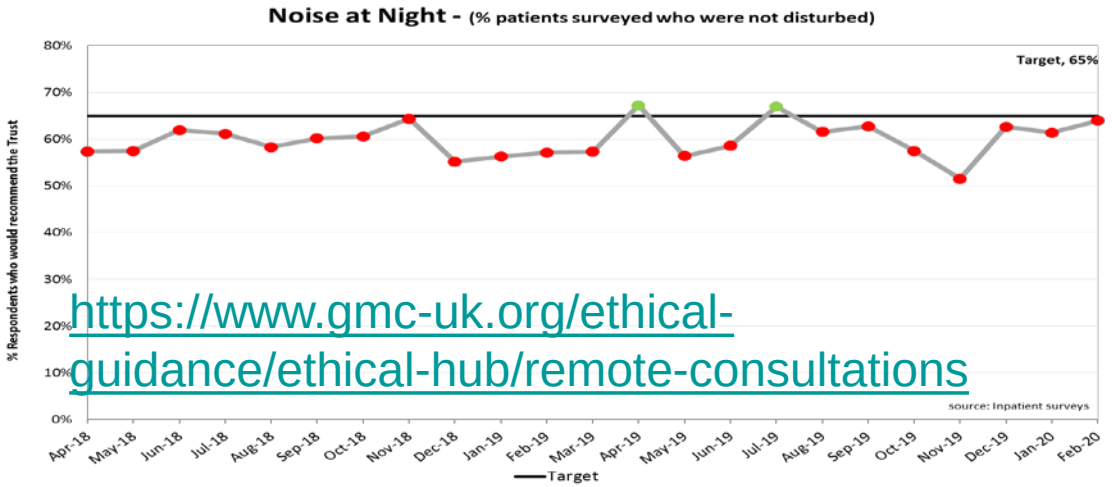
A/E : 92.3% recommendation (goal = 93%)
Response rate: 26.5% (goal = 20%)

Outpatients: 97.7% recommendation(goal = 97%)
Response Rate: N/A

Maternity: 98.% recommendation(goal = 97%)
Response rate: 55.1% (goal = 40%)

Quality Performance – Experience – Breakthrough Objective

Improving Satisfaction With Noise at Night: Goal = 65% satisfaction by end March 2020



https://www.gmc-uk.org/ethical-guidance/ethical-hub/remote-consultations

Current Performance :

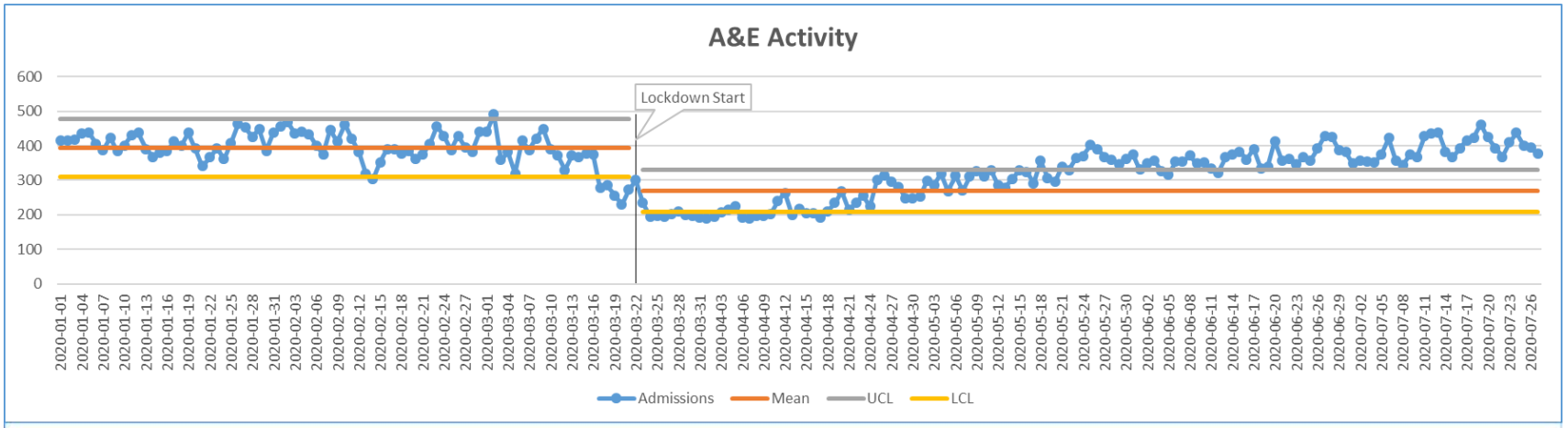
- 64% satisfaction in February represents a further improvement , only slightly below target.
- 10 driver wards continue work on their improvement plans using data gathered from staff and patient surveys
- Weekly huddles in place attended by divisional leads to monitor and direct improvement work in real- time

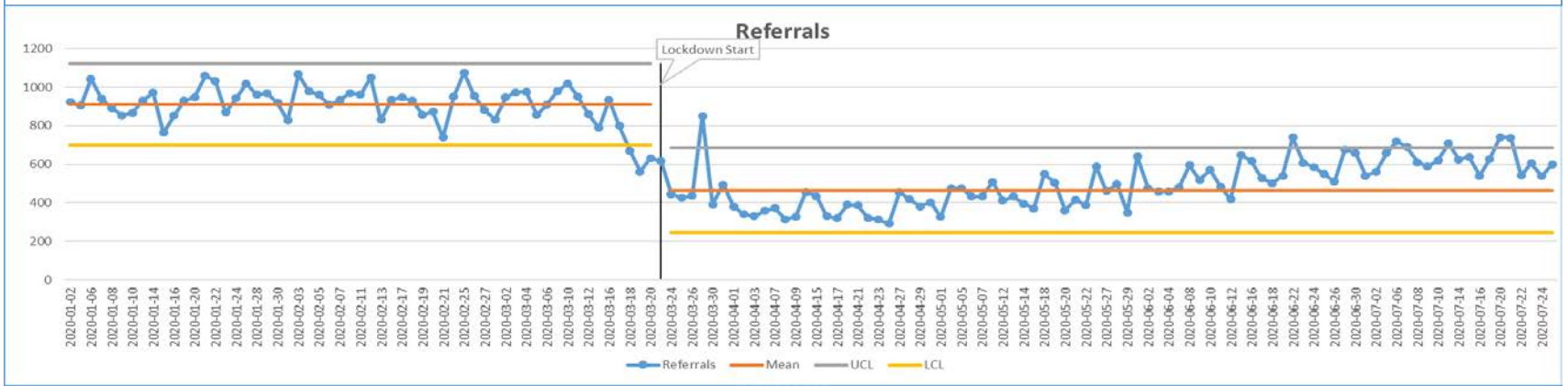
Current Improvement work includes:

- Reducing number and impact of night time arrivals
- Supporting patients with confusion to reduce their distress, including early recognition of delirium
- Reviewing appropriateness of night time observations
- Standardising use of ward welcome packs which contain ear plugs and eye masks
- Communication campaign with staff and patient leaflets to support awareness work with teams and patients

Performance Summary – Demand

- Coronavirus has materially impacted on demand, activity and associated performance against Constitutional Standards this financial year.
- The Trust has commenced safe restoration of elective services by clinical priority as lockdown has eased.
- A&E Demand fell to 229 average attendances per day April (58% of pre covid level), but restored to 82.4% restored compared to June-19.
- Elective Referral Demand fell to 43% of pre covid level during lockdown (23rd March to end June), this is returning at a slower pace than emergency care, 69% of pre covid level week ending 26th July





Performance Summary

- A&E 4 Hour attendance performance June 96.65%, Worthing 96.7%, SRH 96.1%, compared to 92.8% National Average.

- Jun-20 RTT performance was 49% for all specialties. 374 patients were waiting >52 weeks end June-20. The overall waiting list size increased by 316 compared to the prior month to 36127 (+0.9%), whilst the backlog (routine patients) increased by 4297 patients to 14,126 (+30%)

- The Trust was compliant against 4 of 7 reportable cancer metrics in Jun-19, with Provisional 62 day performance of 77.1%. The trust was compliant for 2 week waits (97.6% against 93% target). 62 day screening was 0%, due to time lag associated with the screening programme over the last three months and very low numbers of patients provisionally commencing treatment.

- The Trust was significantly non-compliant in Jun 2020 at 62.7% for 6 week diagnostics. This has fallen marginally due to a rise in the waiting list size at a greater rate than the increase in over 6 week waits, mainly as a result of capacity constraints for Non-obstetric Ultrasound.

Systems & Partnerships

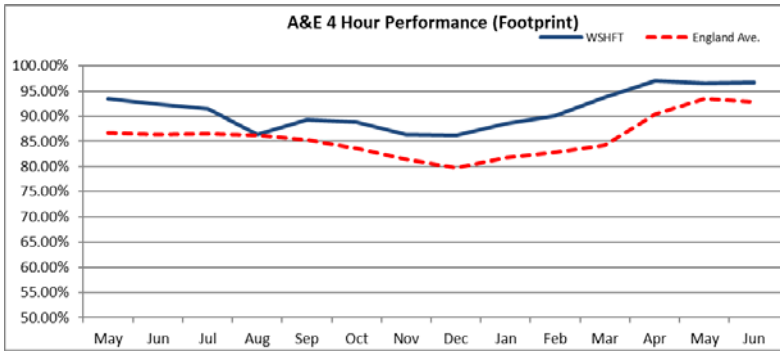
Non Elective Care

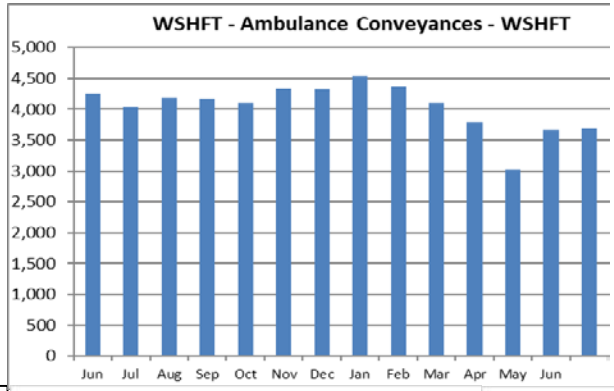
Target: A&E 95% <4hrs

Elective Care

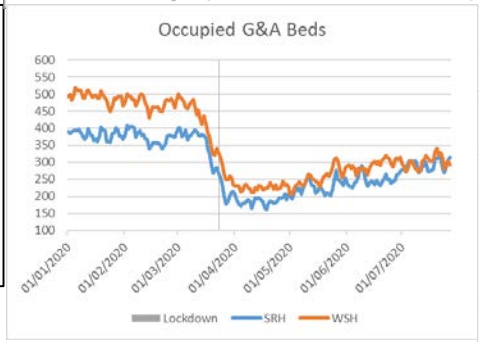
Target: RTT 92% <18wks

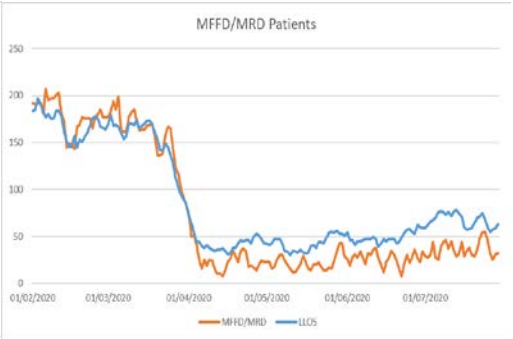
Systems & Partnerships – A&E





- A&E 4 Hour Attendance Performance June 96.65%, Worthing 96.7%, SRH 96.1%, compared to 92.8% National Average.
- A&E Attendances June-20 82.4% restored relative to June-19.
- Emergency Admissions -16.1% Jun-20 compared to Jun-19
- Ambulance conveyances 8.5% lower than June-19.
- LLOS (over 21 day stay) fell from 178 2nd March to 24 average April-20, increased to 49 average in Jun-20.
- MFFD averaged 157, but fell from a peak of 199 5th March, to 25 April-20, which increased to 26 Jun.

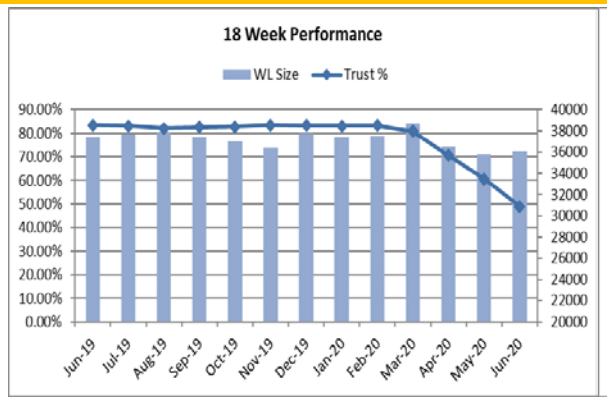


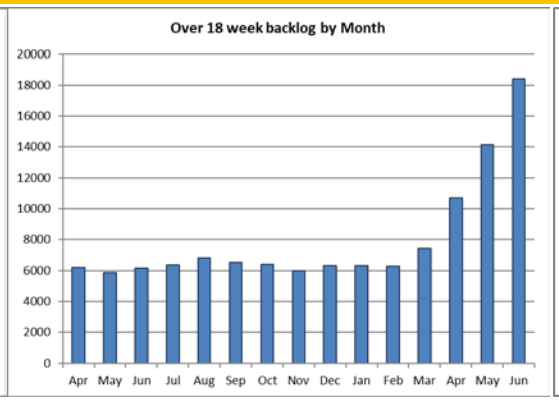


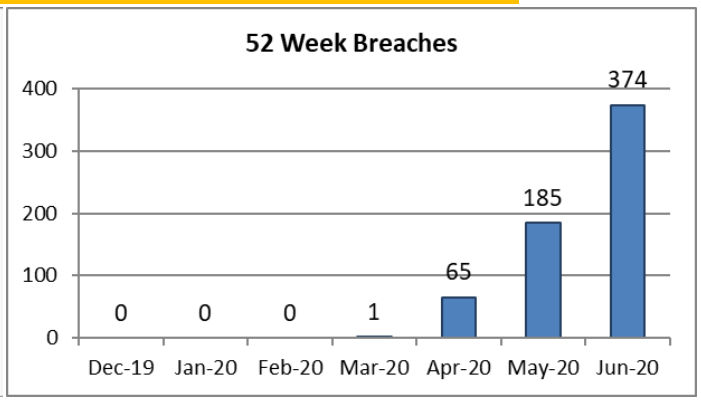
Emergency Flow Improvement Actions

- Reinvigorate focus on Early Morning discharge programme to increase volumes of discharge before 12 noon to assist A&E decompression
- Mental Health joint programme with WSHFT and SPFT, but also system wide programme to improve pathways of care.
- Partnership programme for new models of care, across #NOF pathway, enhanced GP streaming, Same Day Emergency Care/Ambulatory Care including FRACA, Cardiology
- Appointment of new clinical directors in A&E and emergency floors
- A&E configuration review to support flow.
- Work with SCFT to manage flow and mitigate MRD/LLOS patients including system wide community bed review

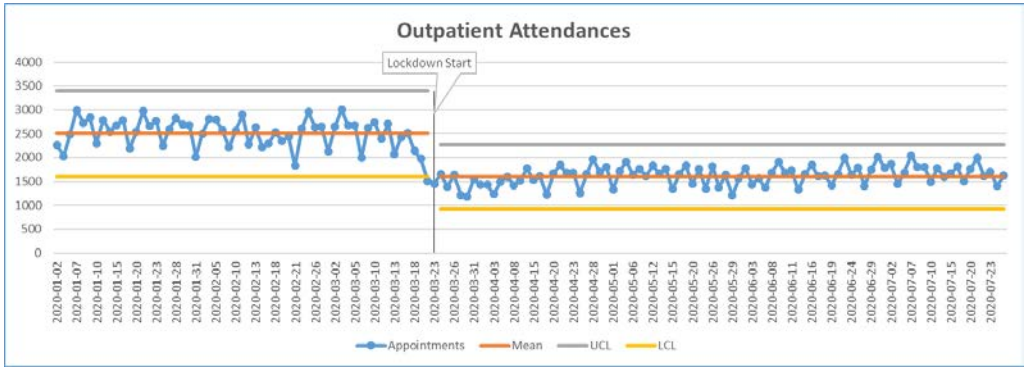
Systems & Partnerships – RTT

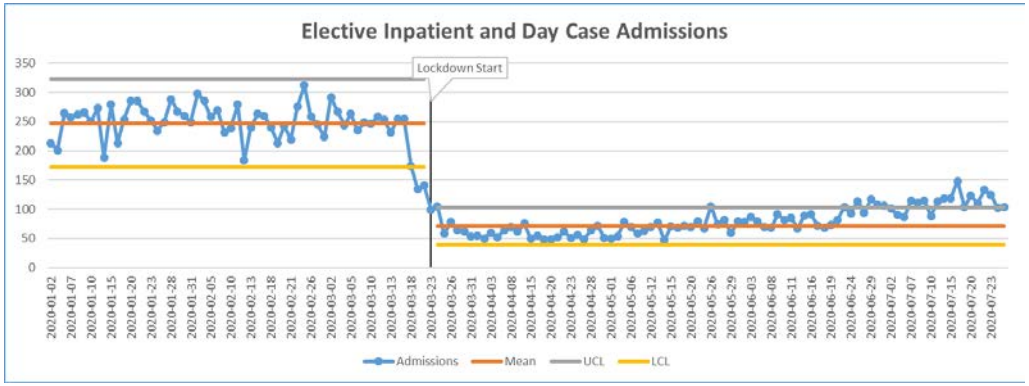






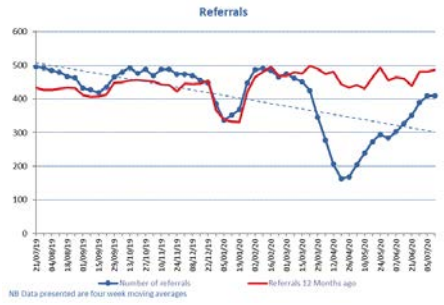
- Jun-20 RTT performance was 49% for all specialties
- 374 patients were waiting >52 weeks end June-20
- The overall waiting list size increased by 316 compared to the prior month to 36,127 (+0.9%), whilst the backlog (routine patients) increased by 4,297 patients to 14,126 (+30%)
- Outpatient Activity is 68% restored week ending 26th July.
- Inpatient and Day Case Activity is 48% week ending 26th July.
- Key Actions:
    - Theatre and Outpatient Restoration Programmes commenced with planned substantial increases August-20 supported by newly appointed operational programme manager.
    - IS support across hotspot areas - orthopaedics, ophthalmology, endoscopy, clinical physiology, urology, with 1,413 additional activities undertaken year to date.
    - “Locking” in virtual appointments @5,000 per week since lockdown
    - Cross group working to address capacity constraints and solutions collaboratively.
    - 20:20 demand and capacity modelling completed end July-20 to support planning

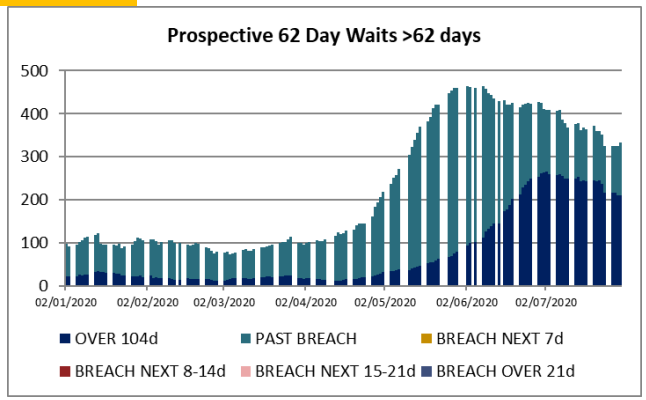




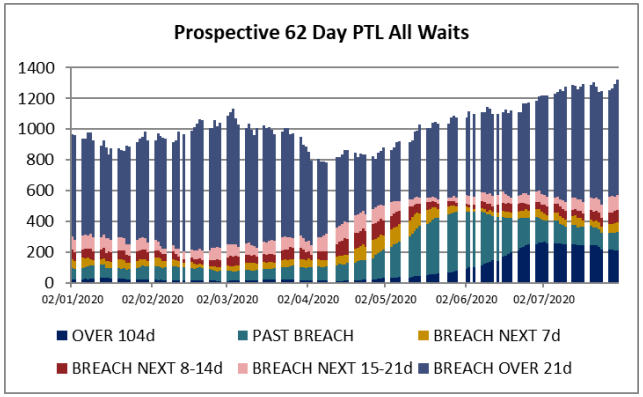
Systems & Partnerships – Cancer

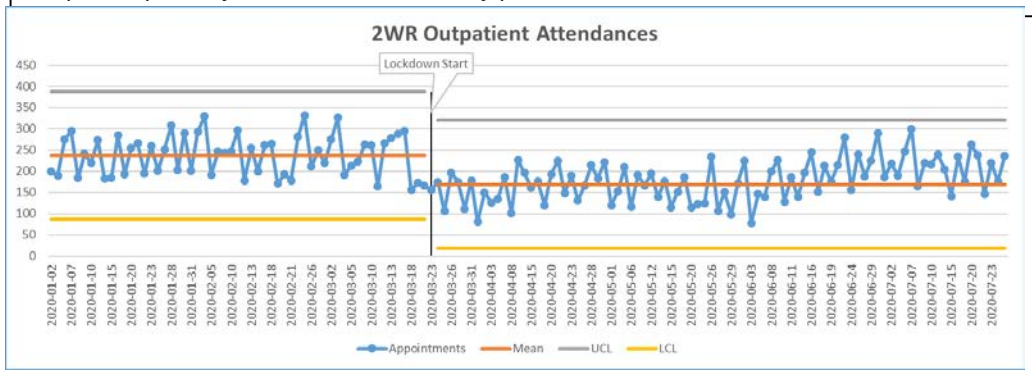
	2020/21			
	May-20	Jun-20	YTD	Target
2 week GP ref to 1st OP	98.0%	97.6%	96.2%	93.0%
2 week GP ref to 1st OP - breast symptoms	96.2%	99.1%	94.5%	93.0%
31 day 2nd or subs trtmnt - surgery	91.7%	94.4%	94.9%	94.0%
31 day 2nd or subs trtmnt - drug	100.0%	100.0%	100.0%	98.0%
31 day diag to trtmnt all cancers	84.1%	93.1%	91.0%	96.0%
62 day ref to trtmnt: screening	50.0%	0.0%	69.8%	90.0%
62 day ref to trtmnt : upgrade	68.8%	86.7%	83.1%	85.0%
62 days urgent GP ref to trtmnt : all cancers	67.9%	77.1%	73.9%	85.0%

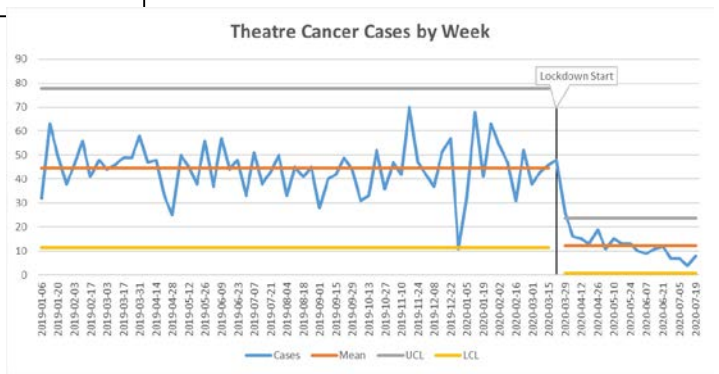




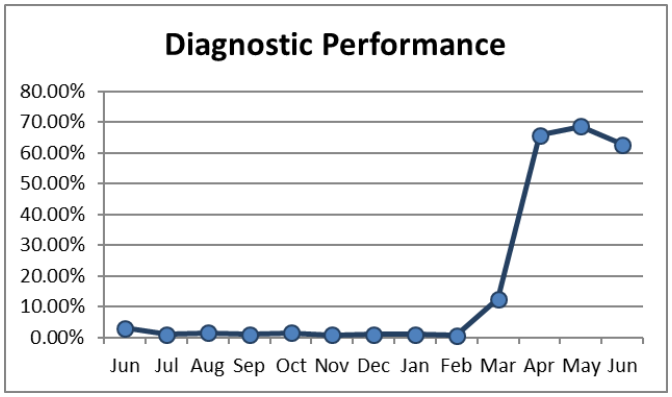
- The Trust was compliant against 4 of 7 reportable cancer metrics in Jun-19, with Provisional 62 day performance of 77.1%
- The trust was compliant for 2 week waits (97.6% against 93% target). 62 day screening was 0%, due to time lag associated with the screening programme over the last three months and very low numbers of patients (5) provisionally commencing treatment.
- June-20 demand has increased following an exceptionally low demand April during lockdown following the Covid-19 outbreak. Demand is now only marginally lower than would be expected with 90.2% restored relative to Jun-19.
- The overall waiting list reduced in April, but as capacity was constrained particularly for endoscopic investigations (colorectal and upper GI anatomical sites), the wait time grew prospectively to a peak of 464 June 2nd but has fallen to 326 patients 29th July following the impact of increased activity, diagnostics, and surgery, whilst demand was lower than pre-covid levels 62 days ago.
- The Trust is carefully restoring and recovering services with support from the independent sector and internal ring-fencing of surgical and investigative capacity further to revised National and Royal College guidance.
- FIT testing for colorectal patients has also commenced June-20 which will impact positively for colorectal patient pathways and associated 62 day performance.



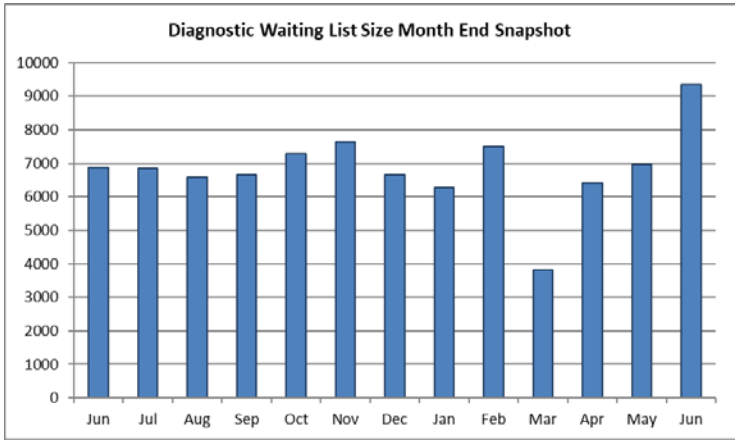


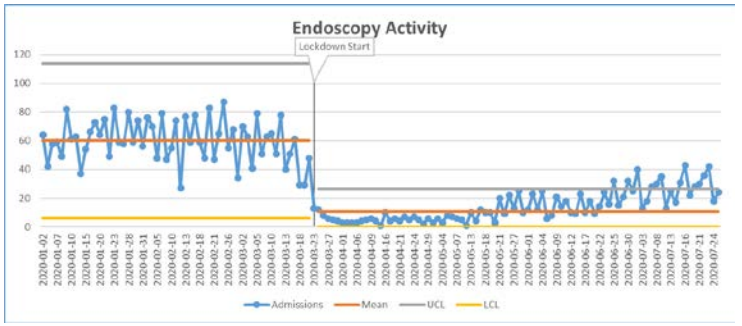


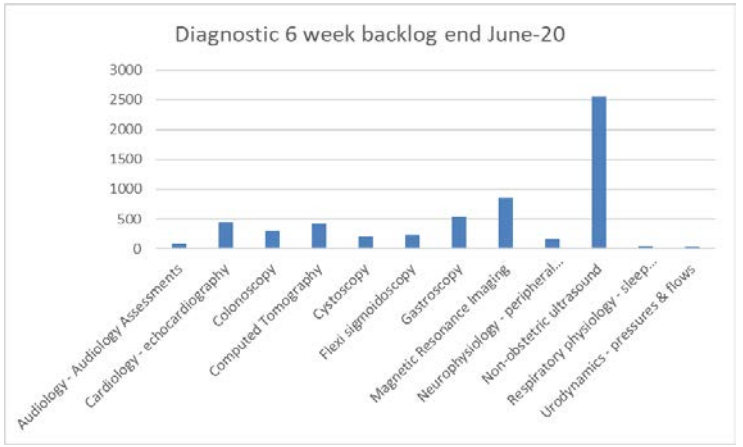
Systems & Partnerships – Diagnostics



- The Trust was significantly non-compliant in Jun 2020 at 62.7%. This has fallen marginally due to a rise in the waiting list size at a greater rate than the increase in over 6 week waits.
- Due to Covid-19 and associated constraints to capacity following National Clinical Guidelines, particularly with regard to aerosol generating procedures, the wait times for diagnostic tests have increased significantly at the end of Jun-20. The Trust is following revised guidance to gradually restore and recover care as much as is possible within safe capacity constraints.
- New governance arrangements have been established at the Trust to manage this recovery, and further additional IS support is being sought for additional capacity where possible. This is a long term programme given the scale of restoration and recovery required and the available capacity during covid pandemic being lower than pre-covid-19 levels (at this stage)
- Largest challenge Non Obstetric Ultrasound (NOUS) where demand has grown whilst capacity is constrained. Work with primary care for additional alternatives and pathway redesign are in train alongside IS support and cross group collaboration to mitigate this risk.
- Endoscopic modalities have increased internal lists both plaintime and at weekends, supplemented by IS capacity and FIT testing pathway design







Sustainability - Summary

Sustainability

Financial Management

Target: Break Even

- On 17th March 2020, it was announced that operational planning for 2020/21 would be suspended and that interim financial arrangements would be put in place for April 2020 - July 2020.

- The purpose of the interim financial framework is to remove routine burdens and allow NHS organisations to devote maximum operational effort to COVID readiness and response. This has been achieved through simplifying contracting for the duration of the crisis and ensuring that sufficient funding is available to respond.

- All Trusts are being provided with a guaranteed minimum level of income, to underpin a breakeven position; received in the form of block payments.

- Providers can also claim for additional costs where the block payments do not equal actual costs to reflect genuine and reasonable additional marginal costs due to COVID-19.

- The Trust is reporting a breakeven position at the end of June, in line with the financial framework guidance issued from NHSE/I. Additional income of £6.1m has been included within the position to reflect the genuine and reasonable additional marginal costs incurred as a result of COVID-19 and to recompense for any associated reduction in other income streams.

Sustainability - Key Metrics

Control Total Surplus £k — G

	Plan	Actual/Forecast
Year to Date	0	0
Year End Forecast	0	0

In line with the financial framework guidance issued from NHSE/I, the Trust is reporting a breakeven position at the end of quarter 1. The position includes £6.1m of income from NHSE/I as part of the monthly true-up process to ensure that all organisations report a break-even position. Further analysis of the position is shown in the COVID-19 summary.

COVID-19 £k — G

	Full Cost	Marginal
COVID-19 Response	(4,298)	(3,088)
Shortfall Other Income		(3,023)

True-up income of £3m has been included in the year to date position to reflect the difference between the block and top-up values anticipated by NHSE/I and commercial and non-contract income received in quarter 1. A further £3.1m of income has also been included to reflect marginal costs incurred in relation to COVID-19.

Capital £k — G

	Plan	Actual/Forecast
Year to Date	2,331	2,564
Year End Forecast	24,410	26,372

The forecast is £1.9m above plan, which is the expenditure on capital equipment to support the COVID-19 surge and resilience plans, £0.9m of which was delivered in Q1. The plan and forecast for IT expenditure includes £3.1m, relating to Year 2 of the Digital Aspirant programme.

Cash £k — G

	Plan	Actual/Forecast
Year to Date	22,417	71,306
Year End Forecast	12,244	12,245

Cash is £48.9m ahead of plan at the end of M3. Under the interim financial framework, block and top-up payments for July amounting to £36.5m were received in M3 which has accounted for the significant movement in the cash balance.

Sustainability - Reforms to NHS Cash and Capital Regime (20/21)

With effect from 01/04/20, the following changes have been confirmed:

- New Public Dividend Capital (PDC) was issued to repay over £13 billion of the NHS' historic debt, in effect writing it off.
- A move away from interest-bearing loans for future interim capital and revenue support, which instead will be provided as PDC.
- Provision of a capital spending envelope for the year to each local area, within which each STP/ICS will be expected to work together to manage their spending.

Sustainability - Action & Recommendations

There are no actions required of the Board.

The Board is asked to note the following:

- The financial framework is still evolving in relation to the financial arrangements for September 2020 and beyond. NHSE/I have held a series of webinars and regional meetings to brief on progress and developments.

- Any changes to the financial framework, and the impact thereof, will be shared with the Finance and Performance Committee; who will continue to provide oversight on behalf of the Board.

- Plans to restore and recover elective activity have been developed and are reviewed by the Group Executive at both the Refresh, Restore and Recovery Delivery Board and at individual Divisional meetings.

OUR PEOPLE

People

Staff Engagement

Target: Engagement Score Top in the Country

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Health and Wellbeing	3
Equality and Diversity	4
Risk Assessments	5
Operational Performance	6-9
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Workforce Performance – Summary

People

Staff Engagement

Target: Engagement Score Top in the Country

- Planned and routine workforce activities including staff engagement were suspended in mid-March 2020 in response to Covid-19 and the impact on the key deliverables of the Interim People Plan and associated workforce KPIs is reflected in Q1 performance

- A programme was established to provide quick and reactive structures to respond to workforce issues caused by the pandemic, across the following workstreams:

    - Policy and Guidance
    - Workforce Capacity and Deployment
    - Skills development
    - Health and Wellbeing
    - Reporting and Monitoring

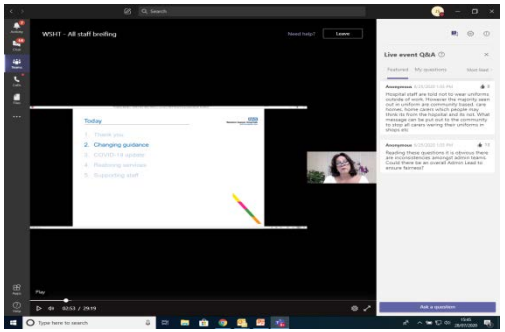
- Focus during Q1 changed from capacity and deployment, managed through the workforce hub, to health and wellbeing including equality, diversity and inclusion

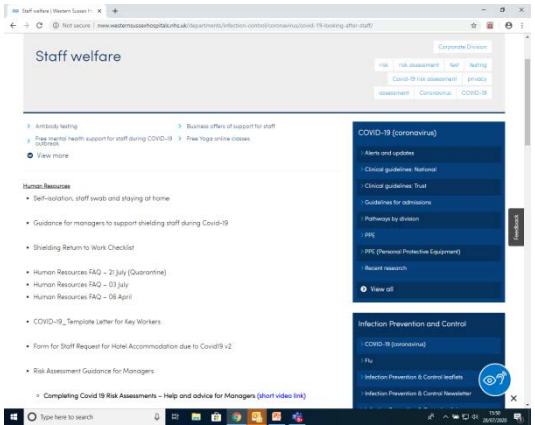
- Pay spend was £2.2M adverse in Q1 with £2.5m spend on agency

- A programme for the refresh, restore and recovery of workforce priorities in response to the impact of Covid-19 has been developed and is being finalised for Q2

Health and Wellbeing

- The health, safety and wellbeing of our workforce remains a prime focus and engagement with staff features highly. Activities have included:
  - Regular Executive-led staff briefings live through MS Teams that has facilitated significant uptake in attendance (upwards of 500 staff per briefing)
  - Individual risk assessments prioritised for staff and volunteers from a BAME background, have an underlying health condition, are high risk or are vulnerable to ensure that actions to mitigate risks are identified and taken (100% compliance by 31 July)
  - Workplace risk assessments completed with measures taken to be Covid-19 safe
  - First Class Lounges and quiet spaces in place across Worthing and St Richards Hospitals, supported by Project Wingman (in excess of 500 staff per week utilising)
  - On-site staff (and household) testing facilities including track and trace in place with follow up welfare calls (940 staff tested with 81% negative results)
  - Wellbeing Wednesdays continuing including health MOT's
  - Employee Assistance Programme in place and strengthened counselling and psychological support available
  - Staff wellbeing survey that will inform our bid for charitable funds





Health and Wellbeing: Equality, Diversity and Inclusion

- Equality, Diversity and Inclusion has also featured prominently in the health and wellbeing of our staff. The risk factors for staff that are emerging from those identifying with a protected characteristic have been incorporated into our risk assessments (eg. race, disability, gender and pregnancy)

- Regular Chief Executive led engagement with our local networks to better understand the issues faced by our BAME staff in particular

- Seminar held in June to engage with the Board and provide assurance against the NHSE/I checklist on how our BAME workforce is being supported

- We have strengthened our EDI function with a short term secondment to work specifically with our BAME staff and communities, to encourage colleagues to speak up and to improve engagement with local networks

- The reporting requirements for the Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) for 2019/20 were suspended at the outset of the Covid 19 pandemic. However given the disparity in health outcomes now known, reporting has been reintroduced.

- Actions to address the disparities identified from our WRES and WDES reports will be integral to our Workforce 3R's programme

Risk Assessments

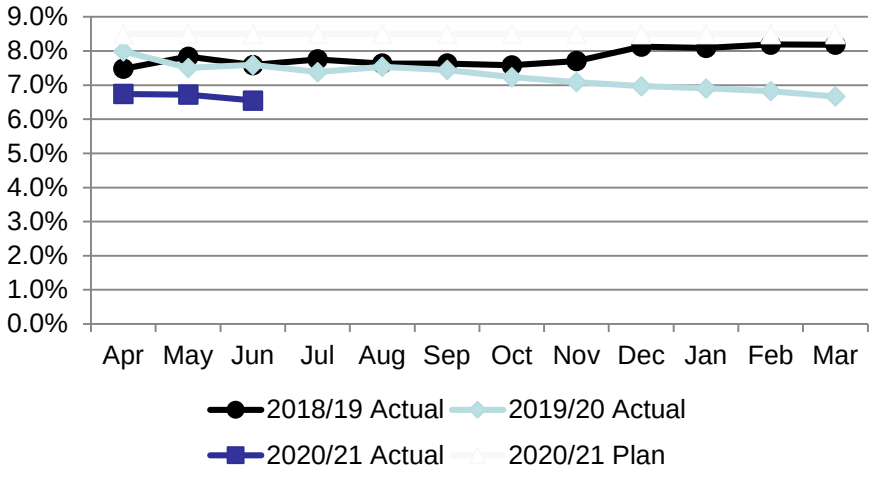
During Q1 completion of individual staff risk assessments has commenced. These are being prioritised for those groups who have been found to be at increased risk associated with COVID-19 ('at-risk') and extends to bank staff, volunteers and agency workers.

In line with the national ambition, the Trust expects to be 100% compliant for all BAME staff and those with a known underlying health condition. Where the Trust is the lead employer for doctors in training currently on rotation in GP practices and psychiatry, confirmation of completion is being urgently sought.

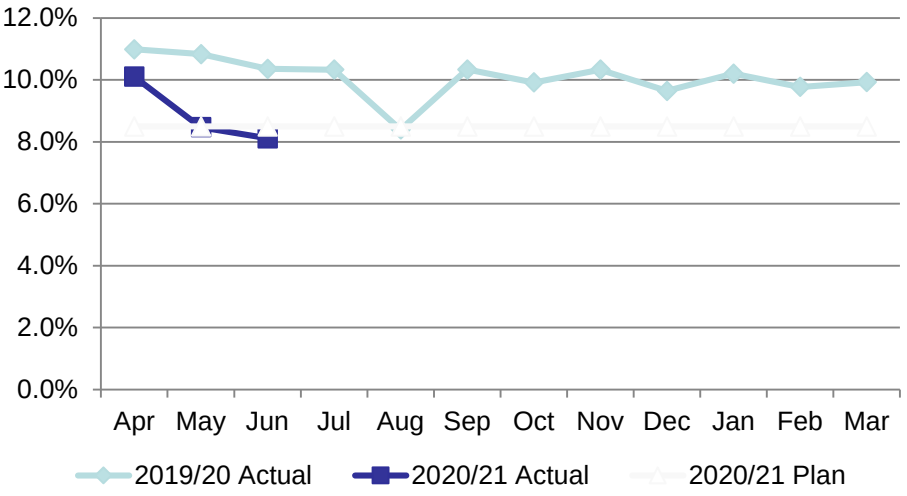
Priority group	Total required	Number completed	Percentage
Black and Asian Minority Ethnic (BAME)	1252	1202	96%
Underlying health condition (non-BAME)	400	391	98%
Shielding (non-BAME)	184	171	93%
Pregnancy (non-BAME)	75	73	97%
Age 70 or over (non-BAME)	72	63	88%

Operational Performance – Turnover and Vacancies

Rolling 12 Month Turnover



Vacancy Rate

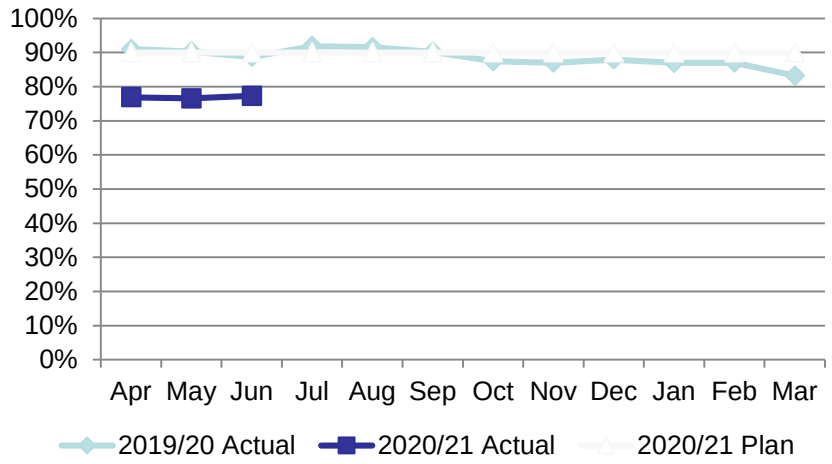


- Turnover has continued to fall throughout Q1 and is not an unexpected outcome of the pandemic
- At 6.5% this represents the lowest number of leavers within the organisation
- Will continue to be a watch metric against the Trust ceiling of 8.5%
- Retention of staff (ie. the number of staff who remain in post for 12 months or more) remains high at 87.5% . This compares to 86.3% in June 2019.

- The number of vacancies continues to reduce and is now at 8.1% compared to 10.4% in June 2019
- The workforce has grown by 255.4 wte in the last 12 months with significant increases in the number of registered nurses and HCA's employed

Operational Performance – Appraisals and Statutory and Mandatory Training

All Staff Appraisal Rate



- With the exception of the Estates and Facilities division, appraisal compliance has dropped significantly below the target of 90%
- Whilst improvement has been made in month 2, it is not anticipated that full recovery will be made until Q3
- A refresh of the appraisal process, paused during Covid, is being re-started and is expected to support the improvement required

Statutory and Mandatory Training

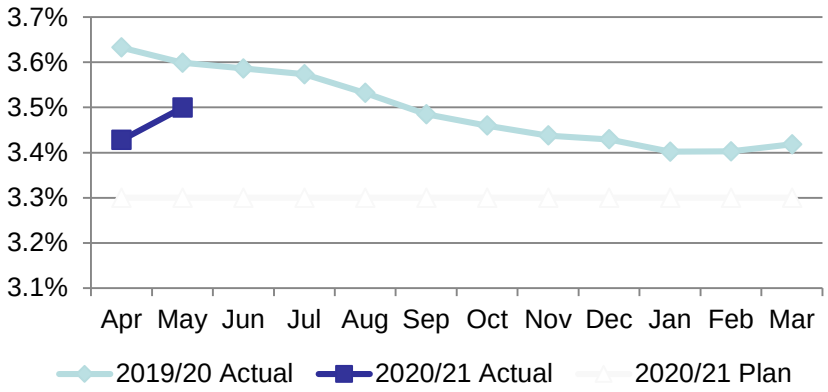
With the exception of manual handling and resuscitation training, all other modules have continued to be available via e-learning. Overall compliance is 85%

A new learning platform has launched that offers staff an alternative to e-learning

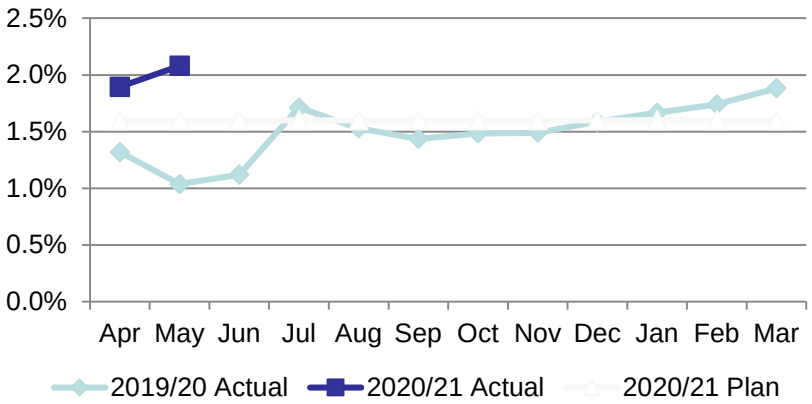
Face to face training has now been restored for manual handling and resuscitation and compliance is expected by January 2021

Operational Performance – Sickness Absence

12 Month Sickness Absence Rate

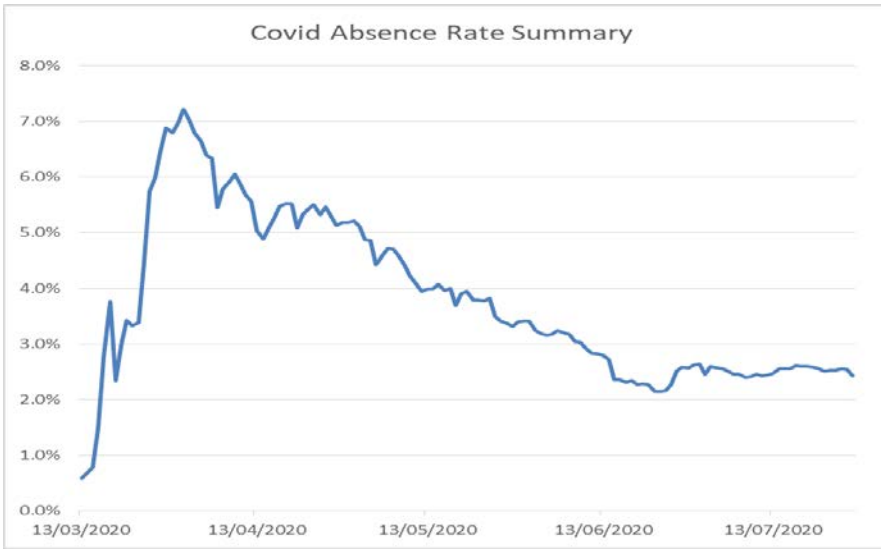


Sickness Absence Rate - Long Term



- Monthly sickness absence rates for non COVID absence increased in month from 3.3% to 3.6%
- This has resulted in the 12 month sickness absence rate increasing marginally to 3.5%
- Whilst the level of short term sickness remains unchanged from last month, the number of staff on long term absence represents 58% of our total sickness absence compared to 36% last year
- There has been a further increase in both the prevalence (0.8% to 1.4%) and proportion (26% to 38%) of mental health absence in the Trust compared to May 2019
- Supporting improvement in staff mental health is a key objective of our health and wellbeing plans

Operational Performance - COVID related absence



- Covid related absence has fallen consistently since the end of March. This is largely due to the significant fall in self and household isolation as a result of staff testing and fall in prevalence of Covid
- Absence due to shielding staff now makes up the majority of covid related absence and this will begin to reduce in August as a number of our shielding staff are able to return to work. Risk assessments for this group of staff have been completed to support their return and/or alternative arrangement.
- It is important to note that many of the shielders are only absent from the workplace but are in fact carrying out work from home

Workforce 3R's Programme

- Programme for the refresh, restore and recovery of workforce priorities in response to the impact of Covid-19 developed and being finalised

- Patient First methodology used to define problem, understand root causes, develop countermeasures and priorities for delivery over the next 6-9 months

- Five key workstreams underpinned by guiding principles

  Health, Safety and Wellbeing
  Capacity Capability and Deployment
  Support and Development
  Leadership and Culture
  Integration

- Delivery will be monitored through the 3R's Programme Board

- Oversight of delivery through Board Committees at Finance and Performance and Quality Assurance from M5

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	11	**Meeting:**	Trust Board	**Meeting Date:**	06 August 2020
Report Title:	Quality Assurance Committee Report to Board				
Sponsoring Executive Director:	Joanna Crane, Non-Executive Director				
Author(s):	Joanna Crane, Non-Executive Director				
Report previously considered by and date:	N/A direct report to Board				

Purpose of the report:			
Information	✓	Assurance	✓
Review and Discussion	☐	Approval / Agreement	☐

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

Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	☐
Our People	✓	Quality	✓
Systems and Partnerships	☐		

Any implications for:	
Quality	
Financial	
Workforce	

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

Communication and Consultation:

Executive Summary:

The Quality Assurance Committee met on the 25 June 2020 and was quorate as it was attended by four Non-Executive Directors and the Chief Nurse, Chief Operational Officer and the Trust Medical Director, along with the Chief of Women and Children Division.

The Committee meeting, under the revised Committee governance arrangements, focused on key quality matters, including Mortality, Serious Incidents, Patient Experience and Infection Prevention and Control.

The Quality Assurance Committee met on 30 July 2020 was quorate and was attended by five Non-Executive Directors including the Trust Chair and the Chief Nurse, Chief Operating Officer and the Trust Medical Director and Trust HR Director along with the Chief Pharmacist.

The Committee meeting, working towards its normal cycle of business, received reports covering quality performance, learning from deaths, junior doctors, and an update on medicines management. The Committee also received the Annual Workforce Race Equality Standard report and the Annual Workforce Disability Equality Standard report.

Key Recommendation(s):

The Board is asked**:**

- **NOTE** that the Committee recommends to the Board for their information
    - the Annual Patient Experience Report for 2019/20,

- the Annual Serious Incident Report for 2019.20
- the Learning from Deaths report for Quarter 4 of 2019/20 and quarter 1 of 2020/21,
- the 2019/20 Annual Workforce Race Equality Standard report and
- the 2019/20 Annual Workforce Disability Equality Standard Report.

Western Sussex Hospitals NHS Foundation Trust

To: Trust Board

Date: 06 August 2020

From: Quality Assurance Committee

Agenda Item: 11

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Quality Assurance Committee	**25 June 2020**	**Joanna Crane**	✓	☐
	30 July 2020	**Joanna Crane**	✓	

Declarations of Interest Made

No interests were declared.

Assurance received at the Committee meeting

From the meeting held on 25 June 2020:

- The Committee **RECEIVED** a presentation in respect of Looked After Children Services and was **ASSURED** in relation to the ongoing improvements within the service.
- The Committee **RECEIVED** the Trust's 2019/20 Patient Experience Annual report and was informed over the actions being taken by the Trust to enhance its processes to further enhance the patent's experience of Trust services. As a result of the Committee **RECOMMENDED** this report for receipt at the Board.
- The Committee **RECEIVED** the Trust's 2019/20 Annual Serious Incident report and was informed over the processes for disseminating this learning across the Trust. The Committee **APPROVED** this report.
- The Committee **RECEIVED** the quarterly Incident Report including Duty of Candour Audit noting that the Trust had maintained 100% within the duty of candour audit for the last year, with the Medicine Division managing candour particularly well leaving the Committee **ASSURED** that Candour is well embedded at the Trust.
- The Committee **RECEIVED** a quarterly update from Patient Experience and was **ASSURED** that the core values of the Friends and Family Test were continuing to be met and that the Trust had scored above the national average.
- The Committee **RECEIVED** information on the Infection Prevention and Control Board Assurance Tool and was **ASSURED** that there were no significant gaps in control with this also being reported to Board.

From the meeting held on 30 July 2020:

- The Committee **RECEIVED** presentation in respect of Medicines Management and was **ASSURED** over the Trust's processes including the work being undertaken in respect of medicine optimisation and the improvements linked to a 2019/20 Internal Audit review into this area.
- The Committee **RECEIVED** the report on the Trust's quality metrics, covering the domains of Clinical Effectiveness, Safety, and Patient Experience. The Medical Director took the Committee through the elements of effectiveness including Mortality covering the Crude mortality rate, HMSR and SHMI and was **ASSURED** over the actions taken supporting mortality improved performance. The Medical Director also reported the outcome of the latest Sentinel Stroke National Audit Programme which provided **ASSURANCE** over the quality of these services at both Worthing and St Richards Hospitals.

The Chief Nurse took the Committee through the elements of Patient Safety and Experience and was **ASSURED** over the actions being taken from the learning identified across these areas.

- The Committee **RECEIVED** the exception report form the Quality Board and **NOTED** there were no matters referred to the Committee for support or action.

- The Committee **RECEIVED** the learning from deaths report and was **ASSURED** over the processes applied to support learning during this period. The Committee **NOTED** the action plan developed from the learning identified recognising the outcome of these actions will be reflected in subsequent reports.

- The Committee **RECEIVED** the Guardian of Safe working report for Quarter 1 of 2020/21 and was **ASSURED** over the processes to support Junior Doctors and the proactive support the Guardian provides to staff.

- The Committee **RECEIVED** the Trust's 2019/20 Annual Workforce Race Equality Standard report and the Committee was updated on the actions being taken across each area to improve the Trust's positon in relation to each indicator. Following discussion of the report the Committee **RECOMMENDED** this for receipt at the Board.

- The Committee **RECEIVED** the Trust's 2019/20 Annual Workforce Disability Equality Standard report and the Committee was updated on the actions being taken across each area to improve the Trust's positon in relation to each metric. Following discussion of the report the Committee **RECOMMENDED** this for receipt at the Board.

- The Committee **RECEIVED** the BAF within the pack and information in respect to a number of risks was presented within the papers taken at the meeting.

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

From the meeting held on 25 June 2020:

- The Committee requested that it receive the National Annual Fractured Neck of Femur Report at a future meeting.
- The Committee requested that Avoidable readmissions were added to the monthly quality Scorecard.

From the meeting held on 30 July 2020:

- The Committee requested that the outcome of the Maternity Peer review with BSUH be shared at the future meeting for then updating Board.
- The Committee requested further information on the Stroke TIA performance differences between St Richards and Worthing.
- The Committee requested a review of the sustainability of the action taken following the BOA report to provide assurance against the current reported SSI levels within T&O.

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

Item	Referred to
There were no specific matters which were referred to the Finance & Performance Committee.	No matters required referral to the Finance and Performance Committee
The Committee recommended to the Board for their information the Trust's • 2019/20 Annual Patient Experience Report • 2019/20 Annual Workforce Race Equality Standard Report	Board for information

• 2019/20 Annual Workforce Disability Equality Standard Report • Learning from Deaths report	

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	11.1	**Meeting:**	Trust Board	**Meeting Date:**	06 Aug 20
Report Title:	Patient Experience Annual Report 2019/20				
Sponsoring Executive Director:	Maggie Davies, Chief Nurse				
Author(s):	Head of Patient Experience and Patient Experience Team Lead				
Report previously considered by and date:					

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

Any implications for:	
Quality	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 fiscal year 2019/2020.
Financial	
Workforce	

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

Communication and Consultation:

Executive Summary:

- FFT response and recommendation rates have exceeded national average throughout 2019/20. FFT data for March 2020 has not been included due to the suspension of FFT and patient surveys by NHS England and NHS Improvement during the Covid-19 pandemic
- An action plan is in place to reflect the Internal audit report received from BDO in Sept 2019 which found that there was room for improvement within the correspondence surrounding complaints including: acknowledging complaints within three working days, responding to complaints within 25 working days and providing updates to complainants where there are delays.
- Overall Performance during 2019/20; Acknowledgement within three working days continues to require improvement because there are delays with the respective managers making contact with the complainant by phone and confirming the approach with the complaints team. 57% of formal complaints were resolved within 25 working days against an internal target of 65%. The rate of re-opened complaints remains unchanged at 15%.
- The top 3 themes indicating low rates of patient experience and satisfaction relate to clinical treatment, (delays with appointments and co-ordination of care), issues with communication and events linked to admission, transfer or discharge of patients.

Key Recommendation(s):

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

Patient Experience Annual Report

2019 – 2020

Compiled by:

Katrina O'Shea – Head of Patient Experience
Janet Campbell – Patient Experience & Insight Officer
Tracey Nevell- Patient Experience Team Lead

Contents

Introduction

Patient experience matters. 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]. Overall, excellent patient experience is indicative of excellent patient care.

The Trust's strategy and Patient First Programme is the commitment where patients are at the heart of everything we do and that a patient centred way of working is embedded across the Trust. Improving patient experience is our long term approach to transforming our services for the better, by giving staff the skills to deliver continuous improvement and to put our patients first.

During 2019/20 feedback was received from a wide range of sources, including Friends and Family Test (FFT) feedback, national and real time patient surveys and Patient Advice Liaison Service (PALS) concerns and complaints[2].

The purpose of this report is to provide a review of the feedback data collected through these methods during the fiscal year 2019/20. It must be noted that the data presented is inclusive from April 2019 to the end of February 2020. FFT Data for March 2020 has not been included due to the suspension of FFT and patient surveys from NHS England during the Covid-19 pandemic.

How we Share and Act on Feedback

The Chief Nurse is the Executive Lead for patient experience and provides regular reports to the Trust Board, providing an oversight of patient experience. Quarterly reports are shared at public Trust Board meetings.

Non Executive Directors' review the patient experience feedback and associated quality improvement activities at the Quality Assurance Committee (QAC). Another review routinely occurs on a quarterly basis at the Patient Experience Engagement Committee (PEEC). Membership of PEEC includes representation from: Director of Estates and Facilities, Director of Research, Innovation and Clinical Effectiveness, Head of Nursing for Outpatients and Access, Trust Company Secretary, Coastal West Sussex Clinical Commissioning Group, Trust Governors, and Healthwatch. Their role is to review the programme and be assured that action on improving and responding to patient experience concerns are addressed.

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.

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

[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

patients but also towards each other and go above and beyond the expected level of care.

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

Local Improvements Implemented during 2019/20, benefitting Patient Experience

Noise at Night Breakthrough Objective

Sleep is important for healing and sleep deprivation is recognised as a major concern for patients in hospitals. The National Inpatient Survey 2017 results were published in June 2018 and confirmed that the area that had most deteriorated for inpatients at WSHFT was noise at night. The response to the question that was placed in the bottom 20% of Trusts nationally was in relation to patients' experience of noise at night from other patients.

National trends are similar with the CQC commenting that there are a large proportion of patients (40%), affected by noise from other patients, and over time this is mostly unchanging. Noise is a modifiable cause of some sleep disruptions in hospitals, and when reduced can lead to more sleep.

The Trust breakthrough objective for 2019/20 was for our inpatient real time patient experience survey (RTPE) satisfaction rates to increase from a Trust wide monthly average of 54% to 65%, by the end of March 2020.

Methodology & Voice of the Customer

Analysis of inpatients comments from real time patient experience (RTPE) surveys in 2018/19 were used as a baseline and revealed that the noise disturbance comes from a myriad of sources. Examples of these are confused patients, staff conversations, activity of clinical area, and routine alarms from a variety of equipment, (staff bleeps, ward phones, infusion pumps, cardiac monitors etc.).

The clinical areas that were most challenged by noise at night, with satisfaction rates of less than 30% satisfaction during the year 2018/19 were identified as driver wards. These wards are Emergency Floor, Selsey ward, Bosham ward, ACU, Petworth ward, Middleton ward and Birdham ward at St Richard's. At Worthing, these wards are Emergency Floor, Buckingham ward, Courtlands ward, Durrington ward and Eartham ward.

Actions

- Divisions developed A3 plans during Q2 to identify driver wards to test out improvement ideas based on local data.
- Patient and staff noise at night surveys were designed to enable deeper questioning of people's experiences. The governors and volunteers visited wards and discharge

lounges to talk to patients in September and October 2019, to gather more detailed feedback.

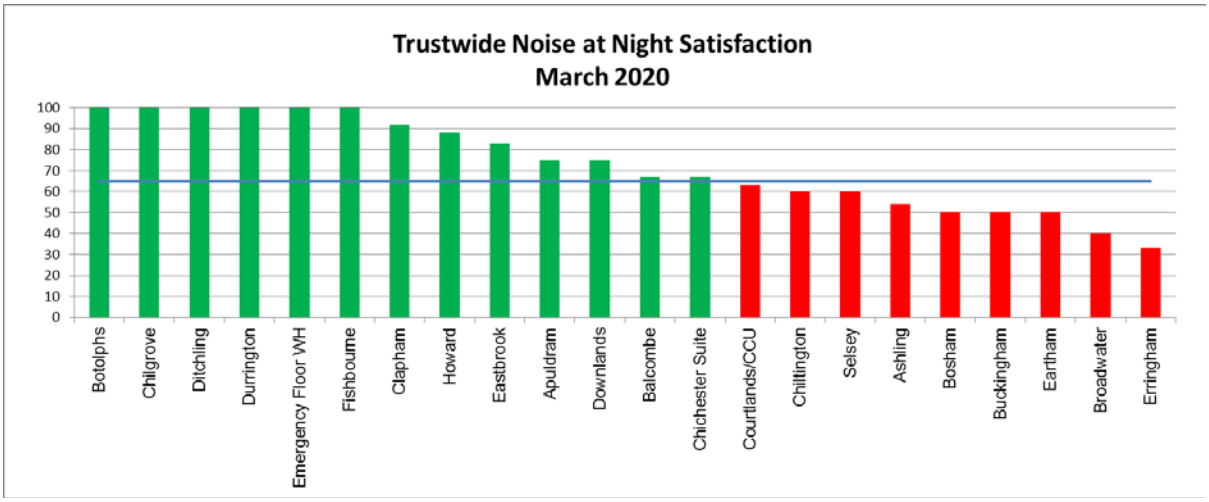
- Estates and Facilities team worked with the driver wards to look at ways in which they could make improvements; for example, where equipment, bin lids, call bell volume, alarms and doors were causing issues.
- A weekly stand up huddle with Kaizen support was implemented, and attended by Heads of Nursing, Estates and facilities leads. The huddle reviewed patient comments and measured the impact of the actions that had been introduced in an attempt to improve the situation.
- The Patient Experience Team Lead attended improvement huddles on the driver wards to help support improvement work.
- PALS Team Manager worked closely with patient experience volunteers to support the gathering of sufficient survey data in order to inform the direction of improvement work.
- An awareness campaign for staff and patients was launched in February 2020, supported by Communications team, providing advice and information for staff on Staffnet.
- Guidance leaflets have been drafted and will be available to download from Staffnet, with top tips to help reduce noise and to help our patients to get a good night's sleep. These will be launched to coincide with a theme of the week in the near future so that all staff hear about them.
- The leaflet for staff outlines how to reduce noise at night.
- The leaflet for patients offers information about the types of noise to expect and how they can play a role in reducing noise at night.
- Patient sleep kits, including ear plugs and an eye mask are available for staff to offer to all patients. This is a stock item from Materials Management.
- Through the Trust's weekly communication and huddle headlines during March 2020 awareness has been raised and celebration of positive steps taken by wards has been shared.
- Staff have been asked to look at how they can further improve this theme by asking them to:
  - Discuss their own ward survey results
  - Ensure all staff know where the sleep kits are kept on their ward.
  - Review whether there is a set routine for ensuring these are offered to patients.
  - Review what wards are doing to try to reduce activity such as night time transfers.
  - Review what can be done to support patients who may become distressed at night.
  - Consider other improvements that can be made to ensure our patients are well rested after a night in our care.
- The Catering Department are rolling out a programme to ensure there is a supply of decaf drinks available to all wards as an option for helping settle patients at night.

Outcomes

Patient satisfaction rates with noise at night for the year is shown in the table overleaf. Unfortunately, the results displayed do not show a shift or improving trend as yet, and data collection has been inconsistent across the months:

Percentage Satisfaction	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Trustwide	57%	56%	55%	66%	61%	58%	57%	50%	63%	61%	64%	68%
Worthing	55%	60%	71%	64%	59%	59%	61%	58%	66%	62%	68%	75%
St Richard's	58%	52%	40%	68%	66%	55%	52%	41%	55%	58%	58%	44%

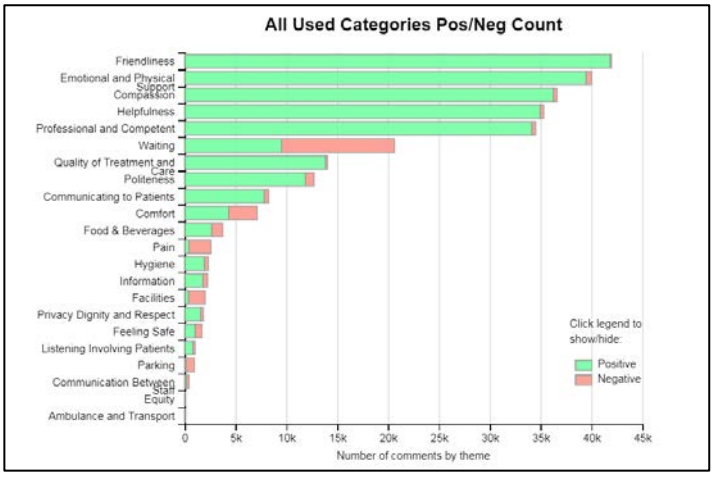
Performance breakdowns by Trust and site are shown below for the month of March 2020 in areas where volunteers were undertaking surveys during the month.



Friends and Family Test

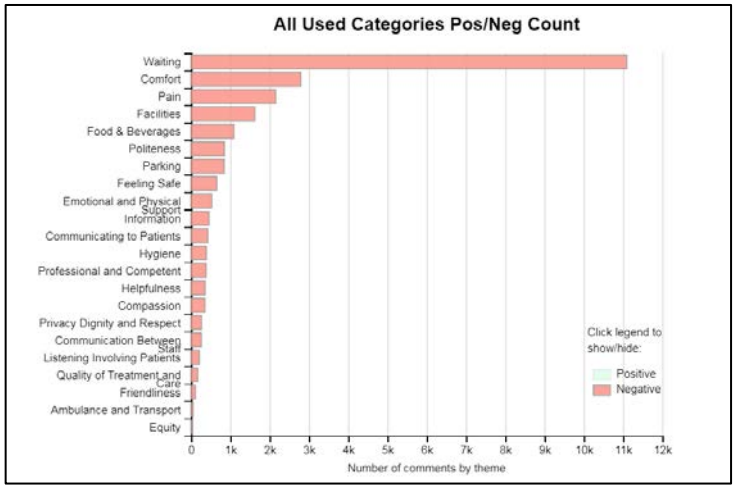
The Friends and Family Test (FFT) is a national survey designed to give patients a quick way to express their satisfaction with the care and service they have received. Our Trust utilises returned tests through a multitude of facets. Initially, FFT results help raise any issues patients may have with any of our services, 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.

Our software Pansensic thematic analysis tool collates the most commonly raised themes identified by patients into positive and neutral feedback. The tables below show an overview and focus on the positive and negative themes for the year, allowing a clear analysis of areas to celebrate and those that require further exploration.



Friendliness, emotional and physical support, compassion, helpfulness and professional and competent staff consistently features highly in the positive feedback received.

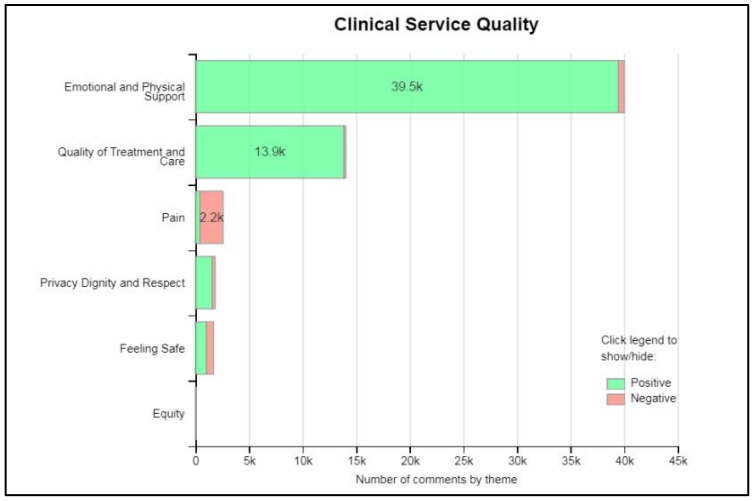
These categories were consistently identified throughout the year, as being the most valued by our patients.



The areas of most concern from patients relate to waiting, predominantly for outpatient appointment dates and also whilst attending clinic.
This has been identified across all three operational sites.

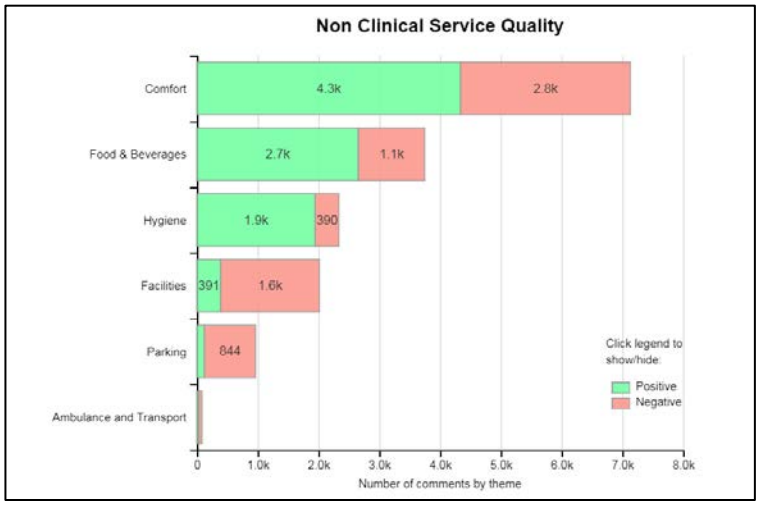
Comfort comments related to the temperature of the environment and noise at night.

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



Patient comments relating to pain identify having to wait for pain relief whilst attending A&E, or delays in medication being administered on the wards.

This is experienced by patients across both Worthing and St. Richard's sites.



Comfort comments include being too hot or too cold in outpatient areas and wards, and waiting areas being uncomfortable.

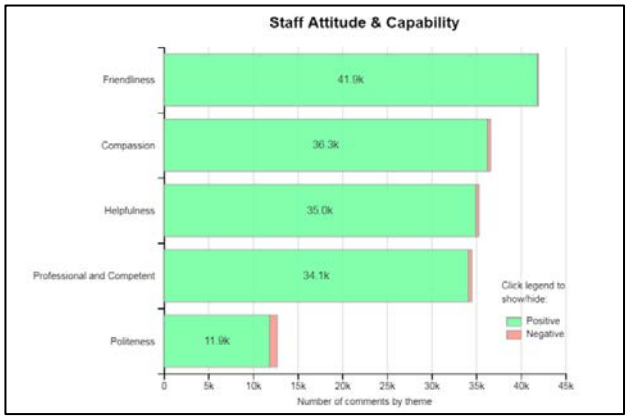
Food comments identify taste and temperature as the main areas of dissatisfaction.

Facilities concern lack of TV's and problems with Trust wifi.

Parking feedbak relates to lack of spaces and increasing/high cost.

A particular positive area of note, is how our staff are perceived by patients and how their actions make them feel.

The majority of patients comment upon how friendly, approachable and welcoming our teams are, across all sites and specialties:



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.

How Do We Monitor It?

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

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

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

There is also a requirement to support the gathering of feedback from groups who may have problems with providing feedback through traditional methods, e.g. patients with learning disabilities, dementia, visual and hearing impairment.
Cards are used to capture the majority of our FFT feedback including: all outpatient and day case areas although SMS[3] feedback is utilised for patients that have been discharged from our A&E departments.

How Do We Report It?

Patient feedback, both from FFT comments and recommendation rates and RTPE surveys are routinely provided directly to ward and department managers on a monthly basis. Key metrics are included in the Quality Scorecard provided to the Trust Board. This performance is also displayed on ward screens for that ward for staff, visitors and patients to see.

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

FFT - Specific Goals for 2019/20

Our True North goal is 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:

- Our internal Trust target is to achieve a recommendation rate (of equal or greater than) 92% and a response rate of (equal or greater than) 20%. Achieving these internal targets would place the Trust in the top 20% NHS Trusts for FFT response and the top 30% position for recommendation rates.

Maternity:

- To improve our current very positive position aiming for a top 30% ranking for both FFT response 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. The Trust has set Maternity's response target at 40% and the recommendation target at 97%.

Inpatient:

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

Outpatient:

- To improve FFT response rates and achieve recommendation rates in line with other touchpoints, of 97%.

FFT Performance 2019/20 Trustwide:

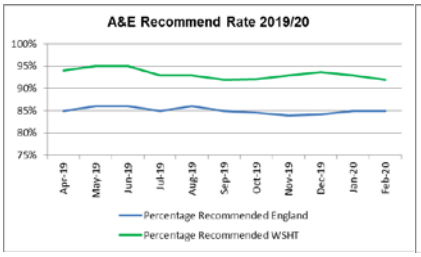
	Recommend			Response		
	Rank	Trusts	Centile	Rank	Trusts	Centile
A&E	16	137	12	4	137	3
Inpatient	52	148	35	34	148	23
Maternity (Births)	32	126	25	2	126	2
Outpatient	19	149	13	48	149	32

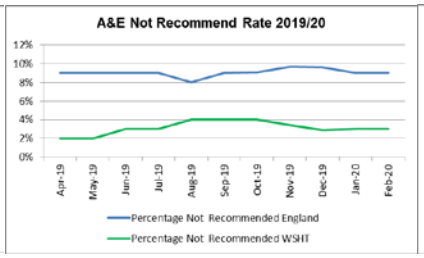
Data presented is inclusive from April 2019 to the end of February 2020. FFT Data for March 2020 has not been included due to the suspension of FFT and patient surveys from NHS England during the Covid-19 pandemic.

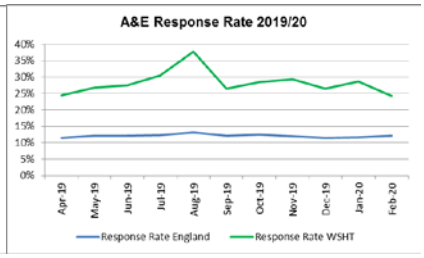
FFT Recommend Rates								
	2019/20 Data to Jan 2020	National Average Data to Dec 2019	Best performing Trust Data to Dec 2019	Worst performing Trust Data to Dec 2019	2018/19	2017/18	2016/17	2015/16
Overall Trustwide	95.77%	92.48%	99.34%	79.64%	96.65%	95.06%	94.20%	93.03%
A&E	93.2%	85.06%	98.42%	63.81%	95.2%	85.8%	89.01%	91.39%
Maternity/ Birth	97.9%	96.68%	100.00 %	81.04%	97.3%	97.8%	97.64%	96.20%
Inpatient & Day Case	97.2%	95.65%	99.75%	77.70%	97.3%	96.8%	96.06%	95.20%
Outpatient	97.3%	93.48%	99.32%	80.93%	96.8%	97.0%	95.43%	92.40%

FFT Performance 2019/20 A&E:

A&E FFT recommendation rate is 93.3% compared to a national average of 85.0%.
The Trusts A&E FFT response rate is 27.0% compared to national average of 12.0% during 2019/20.







FFT A&E Recommend Rate:

	2015/ 16	2016/ 17	2017/ 18	2018/ 19	2019/ 20	National average 2019/20	National position 2019/20
Trustwide	91.4%	89.0%	85.8%	95.3%	93.3%	85.0%	10 out of 137 (7th centile)

FFT A&E Response Rate:

	2015/ 16	2016/ 17	2017/ 18	2018/ 19	2019/ 20	National average 2019/20	National position 2019/20
Trustwide	17.8%	12.5%	9.9%	23.8%	27.0%	12.0%	7 out of 137 (5th centile)

FFT Performance 2019/20 Inpatients

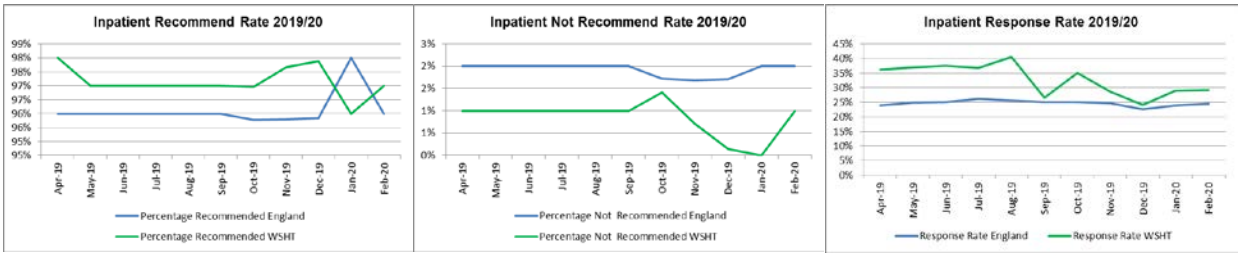
Our Inpatients FFT recommend rate of 97.3% against the national average of 95.9%. This improvement over last year saw our national position increase to 34th of 148 (23rd centile).

Our inpatient FFT response rate reached 33.1% compared to a national average of 24.6%, resulting in our position improving to 12th of 148 (8th centile).

Response rates reduced significantly over Q2, due to data not being submitted within the required timescale to be included in the national return. Reminder emails are sent each month to all areas and we are working with Civica Engagement Solutions (previously MES) to establish if this can be an automated action on the software system.

Although reduced in Q3 and 4, response rates were just above national rates of 24.0% and 24.4%. There are a small number of areas which have consistently low rates of responses; these wards have chosen FFT response rates as driver metric for the coming months to try to address their challenge. The PALS team and a group of volunteers working with the patient experience team now visit these wards at the end of each month to support completion and collection of surveys to improve return rates. The Patient Experience team are also working with the matrons and ward leads to help identify and support bottlenecks that are contributing to a lower response rate. It is expected to see the improvement plans deliver more consistent feedback moving forward.

Recommend rates met the required target at 98.0% and 97.0% for January and February 2020; against national rates of 96.0% for both months. Not recommend rates ranged between 0.0% and 1.0%, with national rates being 2.0% for both months.



FFT Inpatient Recommend Rate:

	2015/16	2016/17	2017/18	2018/19	2019/20	National average 2019/20	National position 2019/20
Trustwide	95.2%	96.1%	96.8%	97.3%	97.3%	95.9%	34 out of 148 (23rd centile)

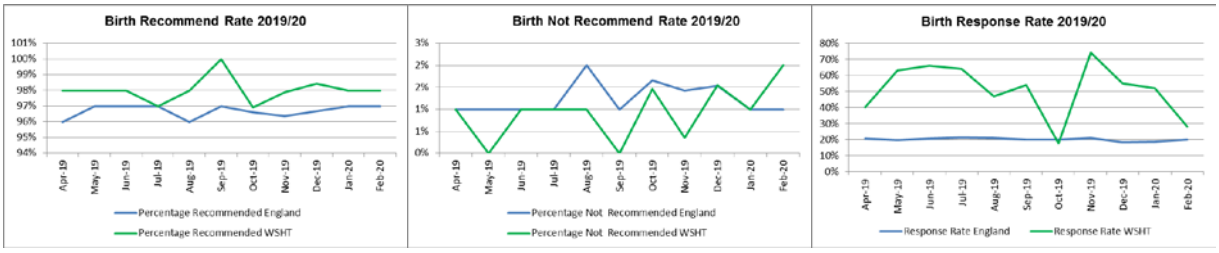
FFT Inpatient Response Rate:

	2015/16	2016/17	2017/18	2018/19	2019/20	National average 2019/20	National position 2019/20
Trustwide	25.8%	34.7%	37.8%	42.5%	33.1%	24.6%	12 out of 148 (8th centile)

FFT Performance 2019/20 Maternity

Our FFT birth response rate is 36.4% compared to the national average of 20.0%, which helped increased our national position from 6th of 130 NHS trusts (5th centile).

Maternity recommendation rates are at 97.7% compared to a national average of 96.7% puts the trust 47 out of 130 NHS trusts (36th centile).



FFT Maternity Delivery Response Rate:

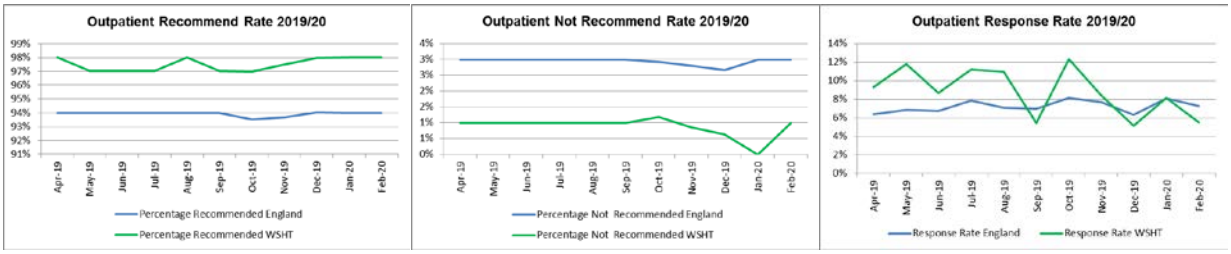
	2015/16	2016/17	2017/18	2018/19	2019/20	National average 2019/20	National position 2019/20
Trustwide	11.7%	29.1%	50.7%	50.8%	36.4%	20.0%	6 out of 130 (5th centile)

FFT Maternity Delivery Recommend Rate:

	2015/16	2016/17	2017/18	2018/19	2019/20	National average 2019/20	National position 2019/20
Trustwide	96.2%	97.6%	97.8%	97.0%	97.7%	96.7%	47 out of 130 (36th centile)

FFT Performance 2019/20 Outpatients

It is very encouraging to see that our overall recommendation rate has been maintained Trustwide at 97.3%, against a national average of 93.8%.



National Surveys

During 2019 we have participated in or received results for five key national surveys conducted on behalf of the Care Quality Commission (CQC):

- National Inpatient Survey 2018.
- National Childrens & Young Persons Survey 2018.
- National Urgent & Emergency Care Survey 2108.
- National Cancer Patient Survey.
- National Maternity Care Pathway Survey 2018.

Summaries of our performance are listed in the sections below.

National Inpatient Survey 2018

The Care Quality Commission National Inpatient Survey 2018 was published on 20th June 2019.

The National Inpatient Survey was undertaken on a random sample or patients aged 16 years or older, who had at least one overnight stay in July 2018. Patients whose treatment related to maternity or, patients admitted for day case patients were excluded.

Overall, 627 patients completed the questionnaire, with a response rate of 51.8% compared to a national response rate of 45%.

The 2018 National Inpatient Survey included two new questions:

- Was the care and support you expected available when you needed it? (section 9 "Leaving hospital")
- During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?

Overall the majority of question scores have stayed relatively unchanged with no significant difference between last year's and this year's scores for 59 questions.

The trust's results were banded as 'about the same' as most trusts for 62 questions and better than most trusts for 1 question.

The question 'Were you given enough privacy when being examined or treated? scored better than most Trusts at 9.7.

There were no questions where the trust was banded as worse than most trusts.

Our top scoring questions scoring 9.0 or above (out of a possible score of 10) are as follows:

- In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you? (9.3).
- While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex? (9.2).
- In your opinion, how clean was the hospital room or ward that you were in? (9.3).
- During your time in hospital, did you get enough to drink? (9.4).
- Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)? (9.3).
- Did you have confidence and trust in the nurses treating you? (9.1).
- Did nurses talk in front of you as if you weren't there? (9.2).
- How much information about your condition or treatment was given to you? (9.0).
- Were you given enough privacy when being examined or treated? (9.7).
- Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand? (9.1).

- Overall, did you feel you were treated with respect and dignity while you were in the hospital? (9.2).

Only two scores showing any significant reduction from last year (although remaining in line with most other trusts).

- Did you get enough help from staff to wash or keep yourself clean?, (8.2 down from 8.7).
- Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?, (2.2 down from 2.9).

The priority area identified as of most concern in the 2017 inpatient national survey was noise at night. It is positive that both questions relating to this area have shown some improvement although this area remains a key objective over the coming year:

- Were you ever bothered by noise at night from other patients? Score 5.9 compared to 5.5 in 2017(national range 4.6 to 8.5).
- Were you ever bothered by noise at night from hospital staff? Score 8.4 compared to 8.1 in 2017(national range 6.9 to 9.3).

Review of the comments provided alongside the question scores provides a rich source of data to help direct future improvement efforts.

There were 339 comments about staff, 262 about care and treatment, 223 about the pathway of care and 142 about the hospital environment and facilities. More than half of the comments made were positive.

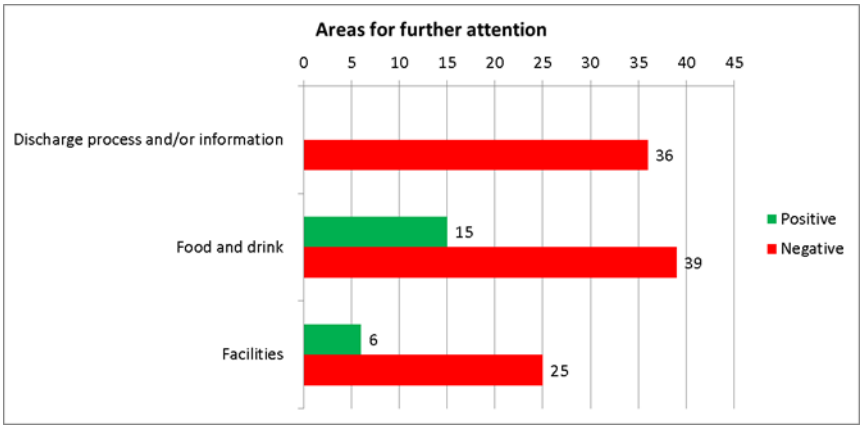
Over three quarters of the comments about staff were positive. 93% of comments about nurses and all comments about therapists were positive. Half of the negative comments about staff were about staff shortages although the overall score relating to staffing levels has not seen a reduction compared to the 2017 survey. The provision of safe staffing continues to be a Trust priority reinforced by the reduction in the score for the question relating to assistance with washing, (score 8.2).

Over half the comments about the pathway of care were positive. Comments about the hospital stay itself were largely positive. The discharge process/information received most of the negative comments in this area, although improving slightly from last year. Areas identified are waiting for medication and discharge summaries and delays from the time patients are told they are going home, to when they actually leave the ward or discharge lounge.

Over half the comments about care and treatment were positive. A quarter of the negative comments in this area related to communication, including different staff saying different things about their care, having difficulty finding out what was going on, staff not communicating with each other and the length of time it can take before the patient speaks to a doctor about their treatment and stay.

Almost three quarters of comments about the hospital environment and facilities were negative.

Particular areas for further attention highlighted in the analysis of the comments were:



The discharge process and information, food and drink and facilities.

National Childrens & Young Persons Survey 2018

The National Children and Young People's Patient Survey is part of the NHS patient survey programme, and was last completed in 2016.

Overall, 372 patients completed the questionnaire, with a response rate of 30.22% compared to a national response rate of 25%.

Patients were eligible to participate in the survey if there were admitted to hospital as an inpatient, planned day case or an emergency patient who did not require an overnight stay and were aged between 15 days and 15 years old, when discharged between 01 November and 31 December 2018.

Exclusions were babies whose mother was the primary patient or babies who were only admitted to a Special Care Baby Unit or Neonatal/Intensive Care Unit.

The survey used three different surveys, and two approaches at gaining feedback:

- Survey 0 to 7, for patients between 15 days and 7 years old at the time of discharge. This survey was completed entirely by the parent or carer.
- Survey 8 to 11, for those between 8 and 11 years old at the time of discharge.
- Survey 12 to 15, for patients between 12 and 15 years old at the time of discharge.
- Both surveys 8 to 11 and 12 to 15 had a short section for the child or young person to complete, followed by a separate section for their parent or carer to complete.

The report for the Trust was received into the organisation in November 2019.

- Trust results were better than most Trusts for 8 questions.
- Trust results were worse than most Trusts for 0 questions.
- Trust results were about the same as other Trusts for 56 questions.

The following questions scored better, when compared to 2016:

- (X36) During any operations or procedures, did staff play with your child to distract them?
- (X66) Did a member of staff tell you who to talk to if you were worried about anything when you got home?

There were no results significantly lower, when compared to 2016.

For the remaining 55 questions, there were no statistically significant differences between 2016 and 2018 results.

Areas where the Trust scored above the statistical expected range. This is based on the statistic which determines where the Trust score could fall without differing significantly from average.

Areas where performance was above national average, (case mix adjusted):

The Hospital Ward		Respondents	2018 Score	2018 Band	2016 Score
Aged 8-15	(X51) If you used the hospital wi-fi, was it good enough to do what you wanted?	76	7.8	Better	n/a
Aged 0-7	(X9) Were there enough things for your child to do in the hospital?	244	8.6	Better	8.9
Aged 0-7	(X10) Did staff play with your child at all while they were in hospital?	135	8.2	Better	7.7
The Hospital Staff					
Aged 0-7	(x14) Did the members of staff treating your child communicate with them in a way that your child could understand?	253	8.3	Better	7.9
Aged 0-15	(X22) Were the different members of staff caring for and treating your child aware of their medical history?	327	8.0	Better	7.5
Facilities					
Aged 0-15	(X31) How would you rate the facilities for parents or carers staying overnight?	164	8.0	Better	n/a
Operations and Procedures					
Aged 0-15	(X36) During any operations or procedures, did staff play with your child or do anything to distract them?	107	8.6	Better	7.1
Aged 0-15	(X37) Afterwards, did staff explain to you how the operations or procedures had gone?	140	9.2	Better	8.7

Urgent & Emergency Care Survey 2018

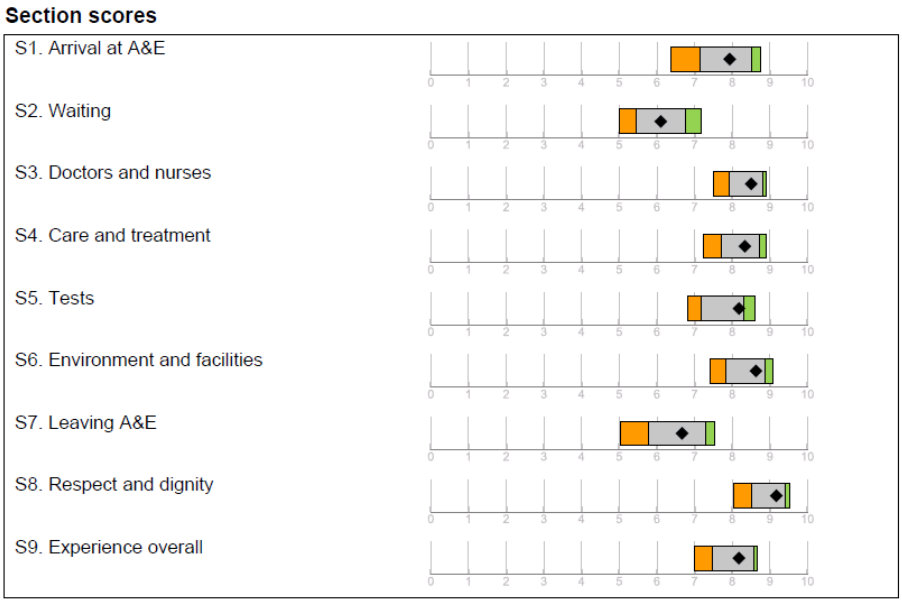
The Urgent & Emergency Care (UEC) Survey is part of the NHS patient survey programme, and was last completed in 2016. Patients were eligible to participate in the survey if they were aged 16 years or older and had attended UEC services during September 2018.

The data has been standardised by the age and gender of the respondent, to ensure that no Trust will appear worse or better than another because of its respondents' profile. This enables more accurate comparison of results from different Trusts with different population profiles.

The graphs show the score for the Trust (identified as a black diamond), compared to the range of scores achieved by all Trusts taking part in the survey:

- If the score lies in the grey section, the result is “about the same” as most other Trusts.
- If the score lies in the orange section, the result is “worse”, compared to most other Trusts.
- If the score is in the green section, the result is “better” than most other Trusts.

Overall section graphs are shown below, with the Trust being in the “about the same” score:



Areas where performance was better than other Trusts:

Area where performance was lower when compared to 2016:

Urgent & Emergency Care (UEC) Survey 2018
Western Sussex Hospitals NHS Foundation Trust

	Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
Care and treatment						
Q24 Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?	8.9	8.0	9.4	412	9.3	↓

The divisions have reviewed the results for both surveys and will devise plans for any identified improvement actions; reporting and monitoring via divisional governance meetings.

National Cancer Patient Survey 2018

In Western Sussex Hospitals NHS Foundation Trust, the survey was undertaken on all adult patients (aged 16 years or older), with a confirmed primary diagnosis of cancer who had been admitted as inpatients for cancer related treatment, or who were seen as day case patients for cancer related treatment and were discharged between 01 April 2018 and 30 June 2018.

The patients included in the sample had cancer ICD10 codes (C00-99, excluding C44, C84 and D05) in the first diagnostic field of their patient records and were alive at the commencement of the data collection in October 2018. Deceased checks were undertaken on three occasions, to ensure surveys were not sent to patients who had died since their treatment.

Overall, 929 patients completed the questionnaire, with a response rate of 69% compared to a national response rate of 64%. The report for the Trust was received into the organisation in September 2019.

The following questions are included in the cancer dashboard developed by Public Health England and NHS England, and were selected in discussion with the national Cancer Patient Experience Advisory Group to reflect the key patient experience domains, (provision of information, involvement in decision, care transition, interpersonal relations and respect and dignity). The results below are all case mix adjusted:

- 8.8 The average rating given by respondents when asked to rate their care on a scale of zero (very poor) to 10 (very good);
- 77% of respondents said they were definitely involved as much as they wanted to be in decisions about their care and treatment;
- 90% of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through treatment;
- 85% of respondents said that it had been “quite easy” or “very easy” to contact their Clinical Nurse Specialist;
- 91% of respondents said that overall they were always treated with dignity and respect while they were in hospital;
- 96% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left the hospital;
- 60% of respondents said that they thought the GP’s and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment;

The top scoring questions, scoring 90% or above are shown below:

- (Q5) Before your diagnostic tests, did you have all the information you needed about your test? (97%);
- (Q17) Were you given the name of a clinical nurse specialist who would support you through your treatment? (90%);

- (Q25) Before your operation, did you have all the information you needed about your operation? (96%);
- (Q34) As an inpatient, were you given enough privacy when discussing your condition or treatment? (90%);
- (Q37) As an inpatient, do you think you were treated with respect and dignity while you were in the hospital? (91%);
- (Q39) As an inpatient, did the staff tell you who to contact if you were worried about your condition or treatment after you left hospital (96%);
- (Q42) The last time you had an outpatients appointment with a cancer doctor, did they have the right documents, such as medical notes, x-rays and test results? (96%);
- (Q52) As far as you know, was your GP given enough information about your condition and the treatment you had at the hospital? (95%);

Areas where performance was above national average, (case mix adjusted):

Question		Trust Result	National Average
5	Before your diagnostic tests, did you have all the information you needed about your test?	97%	94%
7	Were the results of your diagnostic tests explained in a way you could understand?	84%	79%
26	After your operation, did a member of staff explain how it had gone in a way you could understand?	84%	79%
31	As an inpatient, did you have confidence and trust in the ward nurses treating you?	81%	75%
32	In your opinion, were there enough nurses on duty to care for you in hospital?	77%	67%
33	While you were in hospital did the doctors and nurses ask you what name you prefer to be called by?	82%	69%
34	As an inpatient, were you given enough privacy when discussing your condition or treatment?	90%	86%

There were no areas where performance was significantly below the results obtained in the prior year, 2017 (unadjusted scores). Areas where performance was below the national average, (case mix adjusted):

Question		Trust Result	National Average
1	Patient saw GP once/twice before being told they had to go to hospital	76%	77%
13	Were the possible side effects of treatment(s) explained in a way you could understand?	72%	73%
15	Before you started treatment(s), were you also told about any side effects of the treatment that could affect you in the future rather than straight away?	54%	56%
16	Before you started your treatment(s), were you involved as much as you wanted to be in decisions about your care and treatment?	77%	79%
17	Were you given the name of a clinical nurse specialist who	90%	91%

	would support you through your treatment?		
29	As an inpatient, did you have confidence and trust in the doctors treating you?	83%	85%
36	As an inpatient, do you think the hospital staff did everything they could to help control your pain?	81%	84%
41	While being treated as an outpatient or day case, did you find someone on the hospital staff to talk to about your worries or fears?	70%	71%
44	Beforehand, did you have all the information you needed about your radiotherapy treatment?	85%	86%
45	Once you started treatment, were you given enough information about whether your radiotherapy was working in a way you could understand?	59%	60%
50	During your cancer treatment, were you given enough care and support from health or social services (e.g.: district nurse, home help, physiotherapist)?	50%	53%
55	As far as you know, was your GP given enough information about your condition and the treatment you had at the hospital?	34%	35%
58	Since your diagnosis, has anyone discussed with you whether you would like to take part in cancer research?	22%	31%

National Maternity Care Pathway Survey 2018

The National Maternity Care Pathway Survey is part of the NHS patient survey programme, and was last completed in 2018. The 2019 survey of women's experiences of maternity care had a national response rate of 36.5%. The Trust response rate was 43%.

Women were eligible if they had a live birth during February 2019, were aged 16 years or older and gave birth under the care of the NHS. Responses from women who were identified as receiving their antenatal and postnatal care from the same Trust at which they gave birth, were used to calculate scores and benchmark results. Three reports for antenatal, labour and birth and postnatal care were received into the organisation at the end of January 2020.

- Trust results were better than most Trusts for 10 questions.
- Trust results were worse than most Trusts for 0 questions.
- Trust results were about the same as other Trusts for 42 questions.

One question had a statistically significant difference from 2018.

For all other questions, there were no statistically significant differences (whether lower or higher), between 2018 and 2019 results.

Areas where the Trust scored above the statistical expected range. This is based on the statistic which determines where the Trust score could fall without differing significantly from average, as overleaf:

Antenatal Care		Respondents	2019 Score	2019 Band	2018 Score
B9	During your antenatal check ups were you given enough time to ask questions or discuss your pregnancy.	140	9.2	Better	9.1
B14	During your pregnancy, did you have a telephone number for a member of the midwifery team that you could contact?	138	10.0	Better	9.8
Labour and Birth					
C18	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	149	9.7	Better	9.6
Postnatal Care					
E3	Did you feel that midwives and other health professionals took your personal circumstances into account when giving advice about feeding your baby?	134	8.7	Better	N/A
F2	When you were home after the birth, did you have a telephone number for a midwifery or health visiting team that you could contact?	138	10.0	Better	N/A
F9	Did the midwife or midwifery team that you saw take your personal circumstances into account when giving advice?	132	9.2	Better	N/A
F12	Did a midwife or health visitor ask you about your mental health?	139	9.9	Better	N/A
F13	Were you given information about any changes you might experience to your mental health after having your baby?	136	8.2	Better	N/A
F14	Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	120	9.0	Better	N/A
F16	In the six weeks after the birth of your baby, did you receive help and advice from a midwife or health visitor about feeding your baby?	124	8.5	Better	8.5

There was one area where performance was significantly below the results obtained in the prior survey year, 2018.

Postnatal Care		Respondents	2019 Score	Change from 2018	2018 Score
F6	How often would you have liked to have seen a midwife?	139	7.3	↓	8.4

Real Time inpatient Experience Surveys (RTPE)

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

Overall from April 2019 to March 2020, 6,889 surveys have been completed by patients in many different areas including inpatient wards, outpatients, paediatrics and a number of specialist services an increase of 2.3% on the previous year.

The data below references satisfaction by the use of the FFT question, by survey where the sample size is greater than 20 surveys:

Name of Survey	Satisfaction	Surveys completed
Adult Inpatient	92%	3,465
Gynaecology Outpatient Clinic	91%	1,104
Haematology Services	89%	342
PHIN (private patients FFT)	94%	329
Children's Inpatient	98%	279
Virtual Fracture Clinic	83%	279
Endoscopy Unit	94%	266
Urology Patient Pathway	84%	233
Cardiac Rehabilitation	78%	204
Neonatal Unit	97%	189
Emergency Floor	95%	95
Adult Outpatient - Fernhurst Clinic	91%	33
Diabetic Eye Screening	95%	22

Satisfaction rates are noted to be lower than the average shown in the table above for virtual fracture clinic, urology patient pathway and cardiac rehabilitation.

In addition, there were 3,464 responses to the adult inpatient RTPE survey during this period, an 8.5% reduction on the previous year. Some of this reduction can be attributed to the suspension of RTPE surveys in March 2020 due to Covid-19 pandemic. However, a reduction in RTPE survey activity was reported in monthly reports for December 2019 and January 2020, with the areas having the greatest challenge being Barrow, Birdham, Boxgrove, Coombes, Ditchling, Durrington and Ford wards. Further engagement will occur with the clinical teams to explore ways in which volunteers can support the collection of feedback from patients cared for within these wards.

An overview is shown below, which identifies a trend of discharge planning, food and noise at night as the areas of most concern for patients:

Questions	2019									2020			Target
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
FFT Recommend	95	95	96	93	95	94	93	94	98	94	95	97	75
Welcome & Kindness	96	96	96	95	95	96	94	96	96	96	95	97	75
Cleanliness	91	91	91	92	92	91	90	92	91	94	93	93	75
Food	75	74	70	72	72	72	68	70	75	73	75	74	75
Assistance with Meals	89	90	94	88	89	92	90	90	84	93	94	94	75
Noise at Night	67	56	58	66	60	61	57	50	62	61	65	76	65
Call Button Response	84	85	87	85	84	88	83	82	87	83	86	91	75
Medication Explanation	88	88	88	88	87	88	88	87	93	89	89	92	75
Pain Control	93	87	92	89	89	94	91	90	90	89	92	95	75
Care Decisions	84	84	84	83	83	85	80	82	83	83	85	91	75
Discharge Planning	55	54	50	49	51	56	45	48	54	50	58	73	75
Communication	90	92	91	90	89	91	89	87	91	90	87	88	75
Privacy	85	82	85	86	85	84	82	84	86	85	85	89	75
Safe & Confident	97	98	96	97	98	97	96	97	98	97	96	98	75
Respect & Dignity	97	98	98	97	97	98	97	96	97	97	96	99	75
Trust Overall Satisfaction	83	82	82	82	81	82	80	79	83	82	82	86	75
Number Of Responses	397	328	297	342	352	251	303	267	160	211	346	210	3,464

This data is broken down further by question and division overleaf:

FFT Recommend													
Division	Responses	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan - 20	Feb - 20	Mar - 20
Medicine	1514	92	92	94	90	91	95	90	92	97	91	89	96
Surgery	1950	98	97	96	96	97	94	97	97	99	95	99	98
	Overall	95	95	95	93	95	94	93	94	98	94	95	97
	Total	397	328	297	342	352	251	303	267	160	211	346	210

Welcome & Kindness													
Division	Responses	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan - 20	Feb - 20	Mar - 20
Medicine	1514	95	94	94	94	93	95	93	95	94	95	92	95
Surgery	1950	97	97	97	96	97	97	96	97	97	97	97	98
	Overall	96	96	96	95	95	96	94	96	96	96	95	97
	Total	397	328	297	342	352	251	303	267	160	211	346	210

Cleanliness													
Division	Responses	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan - 20	Feb - 20	Mar - 20
Medicine	1514	89	89	91	91	90	89	88	92	91	93	90	95
Surgery	1950	93	92	91	93	94	92	92	91	92	94	95	93
	Overall	91	91	91	92	92	91	90	92	91	94	93	93
	Total	397	328	297	342	352	251	303	267	160	211	346	210

Care Decisions													
Division	Responses	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan - 20	Feb - 20	Mar - 20
Medicine	1514	79	81	74	79	78	84	80	82	82	76	79	86
Surgery	1950	88	86	90	87	86	86	80	82	83	87	90	93
	Overall	84	84	85	83	83	85	80	82	83	83	85	91
	Total	397	328	297	342	352	251	303	267	160	211	346	210

Assistance with Meals													
Division	Responses	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan - 20	Feb - 20	Mar - 20
Medicine	1514	90	89	89	83	81	89	85	84	82	79	86	92
Surgery	1950	88	90	97	90	94	93	96	96	87	98	98	95
	Overall	89	90	94	87	89	92	90	90	84	92	95	94
	Total	397	328	297	342	352	251	303	267	160	211	346	210

Communication													
Division	Responses	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan - 20	Feb - 20	Mar - 20
Medicine	1514	87	90	89	89	89	90	87	87	93	88	85	92
Surgery	1950	93	93	92	91	89	92	90	88	89	90	88	86
	Overall	91	92	91	90	89	91	89	87	91	89	87	88
	Total	397	328	297	342	352	251	303	267	160	211	346	210

Call Button Response													
Division	Responses	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan - 20	Feb - 20	Mar - 20
Medicine	1514	78	83	83	82	82	85	82	82	86	81	80	90
Surgery	1950	89	86	90	88	84	90	84	82	88	84	89	93
	Overall	84	85	87	85	83	88	83	82	87	83	86	91
	Total	397	328	297	342	352	251	303	267	160	211	346	210

Medication Explanation													
Division	Responses	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan - 20	Feb - 20	Mar - 20
Medicine	1514	83	88	87	88	83	86	83	87	91	84	80	87
Surgery	1950	93	89	88	88	89	90	93	87	96	93	95	94
	Overall	88	88	88	88	87	88	88	87	93	89	89	92
	Total	397	328	297	342	352	251	303	267	160	211	346	210

Pain Control													
Division	Responses	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan - 20	Feb - 20	Mar - 20
Medicine	1514	88	78	87	83	80	93	88	87	88	79	85	94
Surgery	1950	96	92	95	94	93	94	96	92	92	94	95	95
	Overall	93	87	92	89	88	94	92	90	90	89	92	95
	Total	397	328	297	342	352	251	303	267	160	211	346	210

Privacy													
Division	Responses	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan - 20	Feb - 20	Mar - 20
Medicine	1514	84	80	84	86	83	83	81	86	86	84	80	86
Surgery	1950	87	84	85	86	87	85	84	83	86	85	89	90
	Overall	86	82	85	86	85	84	82	84	86	85	85	89
	Total	397	328	297	342	352	251	303	267	160	211	346	210

Safe & Confident													
Division	Responses	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan - 20	Feb - 20	Mar - 20
Medicine	1514	96	99	95	96	97	96	94	97	98	96	94	97
Surgery	1950	99	97	97	97	98	98	98	97	98	98	97	98
	Overall	97	98	96	97	98	97	96	97	98	97	96	98
	Total	397	328	297	342	352	251	303	267	160	211	346	210

Respect & Dignity													
Division	Responses	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan - 20	Feb - 20	Mar - 20
Medicine	1514	94	96	99	96	95	97	96	96	96	97	92	98
Surgery	1950	98	98	97	98	99	98	98	97	99	98	99	99
	Overall	97	98	98	97	97	98	97	96	97	97	96	99
	Total	397	328	297	342	352	251	303	267	160	211	346	210

Food													
Division	Responses	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan - 20	Feb - 20	Mar - 20
Medicine	1514	74	74	70	73	70	73	67	69	75	72	73	75
Surgery	1950	76	73	70	71	73	72	69	70	76	74	77	73
	Overall	75	74	70	72	72	72	68	70	75	73	75	74
	Total	397	328	297	342	352	251	303	267	160	211	346	210

Discharge Planning													
Division	Responses	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan - 20	Feb - 20	Mar - 20
Medicine	1514	47	47	44	45	46	54	37	39	47	38	36	61
Surgery	1950	60	59	53	52	54	57	52	59	61	58	72	79
	Overall	54	54	50	49	51	56	45	48	54	50	58	73
	Total	397	328	297	342	352	251	303	267	160	211	346	210

Noise at Night													
Division	Responses	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan - 20	Feb - 20	Mar - 20
Medicine	1514	61	54	55	61	55	50	58	48	66	51	47	64
Surgery	1950	73	58	59	71	65	69	55	54	58	67	79	83
	Overall	68	56	58	66	61	61	57	51	62	61	65	76
	Total	397	328	297	342	352	251	303	267	160	211	346	210

Other Forms of Feedback – Healthwatch Reports
Enter and View Visits 2019

Visits were undertaken during March and April 2019 at Worthing and St. Richard's hospitals, the final report was published in August 2019. The final reports are published on the Healthwatch West Sussex website and are shared with the Trust, regulators, the local authority, and NHS commissioners and quality assurers, the public, and Healthwatch England.

A team of five Authorised Representatives visited Worthing Hospital on Friday 29 March and St Richard's Hospital on Friday 26 April 2019. The visits were unannounced although the Trust was aware that there would be visits during this time period.

The visits were conducted during the morning to the following areas:

- Accident and Emergency
- X-ray and Radiology
- Main Outpatients
- Discharge lounges
- Endoscopy
- Maternity Unit – Bramber Ward (Worthing Hospital)
- Coombes Ward (Worthing Hospital)
- Neo-natal Unit (St. Richards Hospital)
- Children's Unit (St. Richards Hospital)

The teams focused on observing how people experienced the service through watching and listening, speaking to people using the service and their family and friend carers, to find out more about their experiences and views and observing the nature and quality of services and speaking to staff.

The team produced a detailed report providing their overall reflections about the two hospital sites and also detailed feedback for each department visited. The full report can be viewed via the following link:
https://www.healthwatchwestsussex.co.uk/report/2019-08-27/hospital-visting-programme-st-richards-and-worthing-hospitals

The findings are summarised as follows:

- Patients at both hospitals spoke in the main very highly of individual staff members and teams who demonstrated high standards of care, although there were some who had not had such good experience. This feedback has helped inform the report's recommendations.
- Healthwatch highlighted a number of areas where they found examples of good practice and positive patient engagement and care – particularly in the Endoscopy Unit at Worthing and the Neo-natal Unit at St Richard's.
- The main reception areas at both sites were open, clean and airy; however there were access issues on both sites relating to the lowered desk sections which should be clear in order to support wheelchair users.
- The reviewers also commented on the differences between the hospital sites particularly in reference to how the discharge lounges were used.

- There were a range of comments across the areas visited relating to facilities and estates and cleaning standards.
- The recent updating of the signage as part of our wayfinding programme was praised. The reviewers recommended that this programme be extended to all areas to provide consistency and ease of access.

The report provided detailed recommendations for improvement for each department, with the following highlighted as a priority:

- The Trust should review the process and practices linked to the discharge of patients, at both hospitals, to create consistency and efficiency in the use of discharge lounges, to support patients to leave the hospital promptly when well enough to do so. We would suggest any review should include discharge staff; pharmacy teams, patients and any other stakeholders that can bring knowledge to a review.
- The Trust should audit and work with the housekeeping services across the hospitals, to support staff to deliver a consistently high standard of cleanliness.
- The report made a number of recommendations relating to estates and facilities with particular reference to Coombes Ward layout and facilities support.
- St Richards Hospital's Accident and Emergency Department should ensure there are portable screens, or review the use of space, to make sure patients coming in by ambulance are transferred in a private and dignified way.
- Recognising that signage across the Trust is generally good, we would recommend there needs to be a methodology for regularly updating signage and temporary notices, to enable visitors to easily get to the right location.

The feedback provided by Healthwatch following the Enter and View visits has provided invaluable information to allow the trust to celebrate areas of positive practice and also to understand the opportunities for improvement. The report findings were shared with the teams that were visited and the Trust has provided a full response which has been included within the final report published on Healthwatch website.

A detailed action plan has also been produced to ensure that all practical elements, particularly those relating to the facilities and estates observations are addressed. The Trust will continue to ensure that Healthwatch are kept appraised through our regular engagement meetings of our improvement work particularly in reference to the discharge process improvement programme.

Eye Clinic Observations 2019

A study was commissioned and conducted in partnership between 4Sight Vision Support, Healthwatch West Sussex and the University of Chichester. The aim of the study was to identify patient experience and service knowledge of people who accessed the eye clinics at Southlands and St. Richard's hospitals and to learn how aware patients were of the SCA service provided by 4Sight Vision Support. The ambition for this study was to evaluate the future sustainability and benefit of an investment in this type of service.

The study also aimed to assess whether WSHFT is successfully implementing the Adult UK Sight Loss Pathway stages:

- Referral.
- Diagnosis.
- Early Intervention – advice, information, emotional support.

Observations were carried out within the eye clinics of both St. Richard's and Southlands hospitals. The study used a specific questionnaire to capture views and comments. Those who consented to be involved in the study were interviewed, whenever possible in a quiet, private room away from the clinic waiting area. The study included 22 questions about the patients' eye condition, their experience at the Eye Clinic and living with an eye condition, the support they received initially and after diagnosis provided by the two eye clinics, and about the support (if any) that patients had received from other community organisations such as: 4Sight Vision Support, Macular Society, and the RNIB.

A total of 85 people voluntarily participated in the study, with interviews taking place over a 13 day period between 12 July and 17 August 2018.

The full report has been published on the Healthwatch website and can be found via the following link:
https://www.healthwatchwestsussex.co.uk/report/2019-07-10/eye-clinic-observations

The study has shown an overall positive patient experience at both Eye Clinics, with helpful patient feedback concerning:

- The appointments process and length of waiting times whilst in clinics
- Communication between healthcare professionals and patients - particularly in relation to information about their eye condition
- Concerns around procedures
- Travelling time and cost for patients when travelling to and from the hospitals.

The study also highlighted a low level of patient and their family/friend carers' awareness of 4Sight Vision Support and of its Sight Care Advisor service (SCA), and of other sight loss sector organisation. It was noted that there is not a prompt or mechanism for clinical staff working in these eye clinics to refer patients to non-medical support organisations.

The report made 10 recommendations for improvement as follows:

1. WSHFT review waiting times at each of the clinics with a view to minimising the wait for patients and to ensure patients and their family/friend carers are adequately prepared for their clinical experience. For example, amending the appointment letter waiting time indication from 2 to 3 hours.
2. Consider installing a dedicated telephone service for ophthalmic patients; as many have regular appointments, to reduce anxiety experienced when people do not receive their appointments. Currently, people report it is difficult to navigate the system to chase up appointments, made worse by patients' deteriorating sight.

3. Review all written communication/templates to ensure these meet the needs of people accessing the clinics, for example having a minimum of Arial 14 font and then the ability to enlarge the font for individual patients, to ensure the Trust is compliant with the Accessible Information Standard.
4. WSHFT to look at how its staff can be supported to improve clinical communication, so patients gain a better understanding of their eye condition and to reduce their stress and anxiety.
5. In line with best practice nationally, (including emerging integrated care models and systems), WSHFT reviews the terms and provision of any future SCA service at the Eye Clinics to ensure that patients benefit from access to community support as quickly as possible after diagnosis.
6. WSHFT examines its referral process from consultants, and other hospital staff, to the Sight Care Advisors (SCA) to create a more robust and proactive referral pathway within the Eye Clinics. A simple way of providing information to patients would be to include 4Sight Vision Support & Sight Care Advisors details on all appointment letters and patient correspondence.
7. If 4Sight continues to offer support at the clinics the service works with WSHFT to create a dedicated phone line for the SCA service to support the referral pathway.
8. If 4Sight plans to continue to provide the SCA support, the two organisations identify how to improvement the integration of the services into the daily work of the Eye Clinics and where appropriate, these staff can confidently contribute to and participate in staff meetings, training sessions and any other opportunities that can help to strengthen the pathway and ensure better outcomes for patients.
9. WSHFT and 4Sight to review the information on non-medical provision, to make sure appropriate and relevant services are promoted and accessible to sight loss patients within the Eye Clinic settings. It should be noted that this is already part of the NICE pathway for eye conditions (2018). The creation and maintenance of an information stand, with appropriate booklets of the main eye conditions could support patients in their understanding and self-management of their current and future eye conditions.
10. WSHFT to review and align car park charges bands to coincide with the expected length of time patients are likely to spend in the clinic.

The observations and recommendations for improvement provided by Healthwatch in this detailed study are welcomed by the ophthalmology service leads. The report findings have been incorporated into the full ophthalmology action plan. The team plan to work closely with 4Sight in order to implement the recommendations.

The action plan has been shared with Healthwatch and the Trust will continue to provide regular updates about the progress of delivery of the plan to the Patient Experience and Engagement Committee.

Other Forms of Feedback – NHS Choices

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. Our NHS choices cover 4 pages: a WSHT specific page, and separate pages for Southlands, St Richard's, and Worthing hospitals. Our current scores are overall 5 stars. Patient comments throughout the year include:

- “I was sent by my doctor in Littlehampton to have an xray at Worthing. I was worried that when I arrived, the queues for xrays would be phenomenal and I would be there hours. I drove to Worthing, parked, walked to the department was checked in, waited for around 5 mins in the general waiting area, then was taken to the xray area where I changed and waited another few minutes before entering the xray room and having the xray taken. What terrific service and what a speedy efficient turnaround in this department. Everyone was friendly and helpful and it was amazing. That's what I call wonderful! Thank you xray department staff for being a shining example of our brilliant NHS service.”
- “The Endoscopy Unit at Worthing should be very proud of themselves for their excellently run department. From the moment I entered the department right through my treatment and to discharge I was treated with so much compassion by all the staff, something that sadly has been missing from a lot of departments in the hospital recently due to workload pressures. At every step my procedure was thoroughly explained and I was given a choice of options. I was treated on time so minimising stress due to waiting and the atmosphere in the treatment room was kind and relaxed. Thank you to all the staff involved for making an unpleasant procedure one that I would not worry about having done again providing it was at Worthing.”
- “I went to A&E yesterday on the advice of minor injuries unit. The staff at St Richards were friendly, professional and very focused. I was never ignored and was fully informed of my condition and proposed treatment. On a very busy day I was treated with dignity and respect. A great big thank you for looking after me and getting me better, keep up the good work, you are all a shining example of your profession.”
- “I self-referred as requested by my GP, and from the time my physio phoned me and all through my visits for help with the arthritis in my knee, I was completely 100% satisfied with all that was done for me. My physio was very knowledgeable and professional, she talked through everything that she was going to do and gave me exercises that I could do at home. She has now referred me on to MSK and sent me a copy of the referral letter.”

PALS and Complaints Service

The Patient Experience Team gather and analyse patient feedback and provide advice on how and where to complain, investigate matters of concern and help facilitate a resolution when things have gone wrong. The Patient Advice and Liaison Service (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.

Complaints & Patient Activity

The tables below show both inpatient and outpatient complaints as compared to patient activity, by site:

Inpatients	Complaints	Total Inpatients & Day Cases	Rate per 1,000
Worthing	37	88,478	0.42
St. Richard's	27	49,262	0.55
Other	3	0	0
Total	67	137,740	0.49*

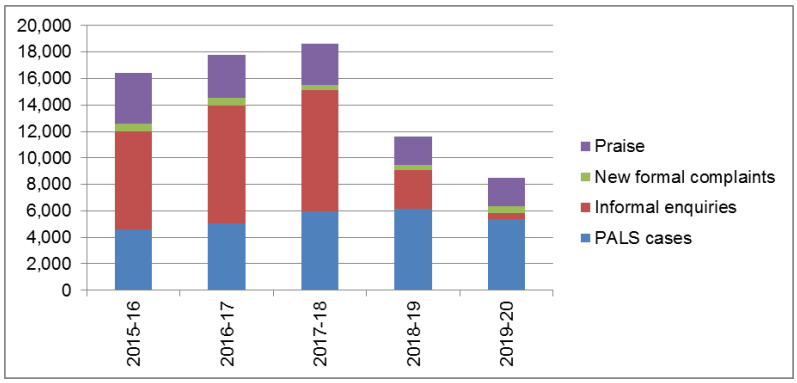
Outpatients	Complaints	Total Attendances	Rate per 10,000
Worthing	21	360,981	0.58
St. Richard's	15	262,920	0.53
Other	3	0	0
Total	38	623,901	0.61*

*These figures achieved in 2019/20 are lower than those reported in 2018/19; which were Inpatients rate per 1,000 = 0.53 and outpatients rate =0.69

Type of Cases

	2015-16	2016-17	2017-18	2018-19	2019/20
PALS cases	4,582	5,061	5,990	6,152	5,368
Informal enquiries	7,426	8,914	9,106	2,897	463*
New formal complaints	587	576	431	416	535
Praise	3,823	3,246	3,084	2,123	2,149
Total	**16,418**	**17,797**	**18,611**	**11,588**	**8,515**

* Informal enquiries are no longer recorded to focus effort on the themes emerging from concerns.



Formal Complaints Performance

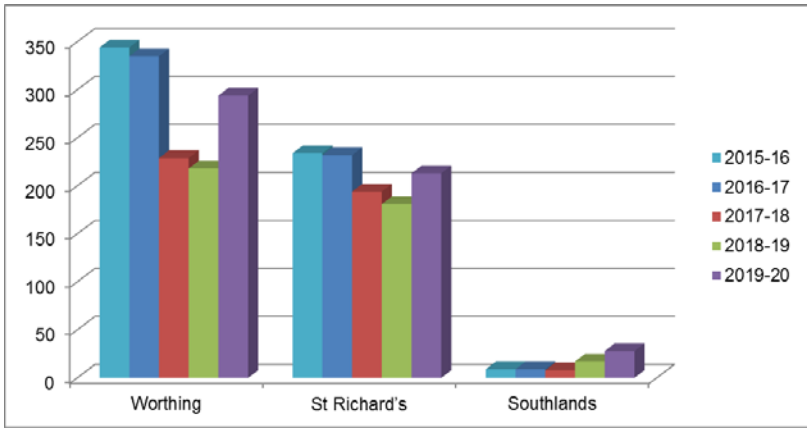
Performance Metrics	Q1	Q2	Q3	Q4	Total
Number of new complaints:	116	128	151	140	535
Number of closed cases:	114	120	161	125	520
Number closed in 25 days (%)	54%	65%	59%	50%	57%
Re-opened cases	29	20	17	11	77
Re-opened cases (%)	25%	11%	18%	9%	15%

The number of new complaints increased throughout from 416 the previous year to 535 during 2019/20 Our Trust objective during 2019/20 was to consistently maintain

a 25 working day response rate of 65% for formal complaints. This target was partially achieved during 2019/20 and our response rate deteriorated during Q3 and Q4 as the number of complaints received increased.

Formal Complaints Received by Site

	2015-16	2016-17	2017-18	2018-19	2019/20
Worthing	344	335	229	218	294
St Richard's	234	232	194	181	213
Southlands	9	9	8	17	28
Total	**587**	**576**	**431**	**416**	**535**



The increase in complaints in Q3 continued in Q4 and the chart above shows how this compares to the previous 5 years.

Formal Complaint Response Times

The Trust has an internal target to respond to formal complaints within 25 working days at least 65% of the time. Unfortunately this was only achieved Trust wide during Q2 of last year. The breakdown of response rates during 2019/20 across all divisions is shown below:

	% in 25 days			
	Q1	Q2	Q3	Q4
Trust wide	(116) **54%**	(128) **65%**	(151) **59%**	(140) **50%**
Women & Child Health	(11) 65%	(14) 67%	(18) 88%	(15) 64%
Medicine	(53) 62%	(64) 72%	(69) 65%	(75) 55%
Surgery	(38) 27%	(37) 58%	(48) 37%	(42) 33%

(no) = no of new complaints received

The Divisional scorecards capture this performance and the Executive Team review this with each division at regular strategic (SDR) meetings throughout the financial year.

During 2019/20 our Trust wide performance within 25 working days was 57%.

Formal Complaint Re-Open Rates

The number of formal complaints that have reopened has improved during the year:

	Re-open rate
Q1	25%
Q2	18%
Q3	11%
Q4	9%

The complaints team met with the Heads of Nursing regularly to review all open cases and those that re-open. There has been a focused effort in ensuring that telephone contact and face to face meetings took place during local resolution to understand the issues and how to resolve them. A meeting was offered in all re-opened cases to help diffuse anxiety, worry and misunderstandings. These measures have helped to reduce the number of cases that progress beyond local resolution.

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 2019/20.

Number of Cases	Q1	Q2	Q3	Q4	**Totals**
Outstanding previous quarter	7	8	6	6	N/A
New Referrals	4	1	1	1	**7**
Closed	3	3	1	4	**11**
Upheld	-	1	-	-	**1**
Partly Upheld	1	-	-	2	**3**
Not Upheld	2	2	1	2	**7**
Total Open	**8**	**6**	**6**	**6**	**N/A**

The number of formal complaints referred to the Parliamentary Health Service Ombudsman (PHSO) for independent review by the complainant (these may relate to complaints made to the Trust in earlier years even though received in the reporting financial year), was seven and this a reduction of 2* compared to the previous year. Of these seven, two have been partially upheld, four remain under review and one a decision about whether to investigate or not is awaited.

The actual number differs to the table re: PHSO outcome as one case concluded during 2019/20 which had opened during 2018/19.

ID	PHSO Year Opened	PSHO Year Closed	Outcome
27114	2016	Action plan outstanding	Upheld
37673	2018	2019	Upheld
41326	2018	2019	Partially upheld.
50569	2019	2020	Partially upheld.
55781	2018		Partially upheld.

37097	2018	2019	Not upheld.
57099	2019	2019	Not upheld.
43135	2019	2019	Not upheld.
63036	2019	n/a	Outcome awaited.
53112	2018	n/a	Outcome awaited.
43992	2020	n/a	Awaiting decision to investigate.
48686	2019	n/a	Awaiting decision to investigate.
45982	2019	2019	Confirmed not investigating.
46409	2019	2020	Confirmed not investigating.
56933	2018	2020	Confirmed not investigating.
57327	2019	2020	Confirmed not investigating.
56933	2018	2020	Confirmed not investigating.
57327	2019	2020	Confirmed not investigating.

Actions required following PHSO findings 2019/20:

ID	Outcome	Issues & Findings/Learning
50569	Partially upheld	Missed opportunity to discuss patient's end of life plans and preferred place to die and make arrangements for them to go home. Involvement of the palliative care team and fast track discharge should have been done sooner. The Trust has completed some joint work between the discharge team and palliative care team to ensure patients are fast tracked home. End of life discussions and decisions about treatment have also been raised at the medicine governance meetings to discuss EoL care planning and importance of early decision making. A national audit has also taken place for EoL patients. Additionally, the palliative care team have expanded their availability on wards to include weekends.
55781	Partially upheld	Failure to request an older persons mental health team referral within an appropriate timeframe, and not raising a safeguarding issue with West Sussex County Council. Action still outstanding.
27114	Upheld	Failure to provide adequate treatment for sepsis in relation to delayed and inconsistent use of antibiotics when sepsis was initially suspected. There was a lost opportunity to achieve a better clinical outcome for the patient. An ongoing programme of education and promotion of sepsis awareness including training for foundation programme doctors is in place including use of simulation from critical care outreach nurses. The Trust now follow the BUFALO protocol when sepsis is suspected and sepsis champions have been introduced in all our clinical areas. Electronic prescribing is also now in place within A&E.
37673	Partially upheld	Failure to provide adequate record keeping in respect of drug administration and a lack of pain-scoring. Poor complaint handling. An audit of consent forms has taken place and the importance of team brief whilst prioritising CEPOD cases has been reinforced. Learning has been presented in departmental mortality and morbidity meetings. The process of documenting complaints meetings has been reviewed.

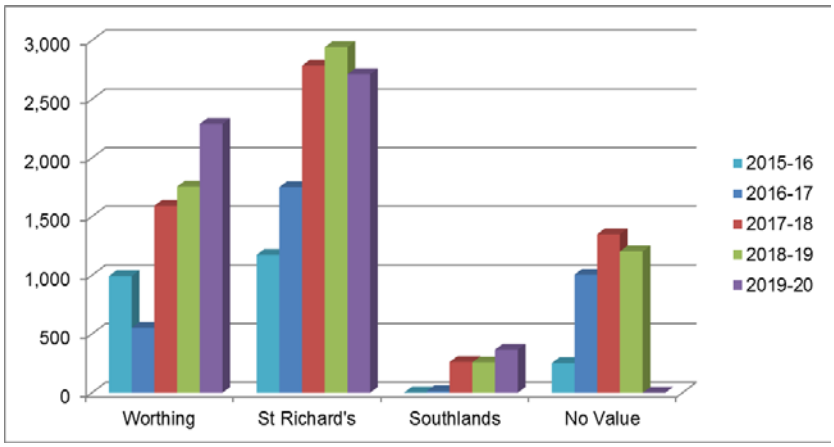
41326	Upheld	Failure to explain the full details of the patient's knee operation and the impact of this on a patient with Osteogenesis Imperfecta (OI). Teaching and education update sessions about OI have taken place and wider access to information about this condition is now available.

Lessons Learnt

The top 3 themes indicating low rates of patient experience and satisfaction relate to clinical treatment, (delays with appointments and co-ordination of care), issues with communication and events linked to admission, transfer or discharge of patients. The out-patients team have worked on an improvement project which has resulted in changes to how patients are reminded of their appointments and how outpatient referrals are triaged and managed. It is anticipated that these improvements will be demonstrated through future patient experience reports.
The QAC meets on behalf of the Trust Board regularly to review the PALS concerns and formal complaints received, reviewing any patterns and themes emerging.

PALS Concerns Received by Site

	2015-16	2016-17	2017-18	2018-19	2019/20
Worthing	994	552	1,592	1,755	2,290
St Richard's	1,174	1,750	2,785	2,943	2,712
Southlands	2	15	261	258	366
Location not recorded	252	1,006	1,350	1,204	0
Total	**2,422**	**3,323**	**5,988**	**6,160**	**5,368**



The PALS team are no longer logging all enquiries due to the number of general queries passing through this service and to ensure that our efforts and priority are focused on the concerns received.

Concerns about date for appointment remains the highest cause of dissatisfaction and concern for patients. It is hoped that this trend continues to reduce as new ways of working are put in place following an improvement project undertaken by the outpatients team.

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 been consistently higher than in previous quarters during Q3 and Q4 of 2019/20. Date for appointment, clinical treatment and staff attitude/behaviour are the most common reasons for members of the public to seek assistance from the PALS team or make a formal complaint. Urgent care areas have been linked to feedback relating to staff behaviours and attitude which has been addressed earlier on in this report.

	Concern	Formal Complaint	Total
Apr 2019	595	34	629
May 2019	515	48	563
Jun 2019	453	34	487
Jul 2019	482	42	524
Aug 2019	455	41	496
Sep 2019	389	45	434
Oct 2019	514	58	572
Nov 2019	401	55	456
Dec 2019	307	38	345
Jan 2020	549	45	594
Feb 2020	392	53	445
Mar 2020	316	42	358
Total	**5,368**	**535**	**5,903**

The number of complaints received in A&E at St Richards increased during the first half of the year. The Patient Experience team met with the multidisciplinary team to help identify and support areas for improvement as attitude of staff featured in the FFT surveys as well. The team put together an action plan to help address and support the problem areas identified and specifically looked at pain management, reinforcing the correct pathway for staff to follow during the triage process. Activity on both sites was high but the overall % of complaints compared to this was only 0.06%. There is a strong emphasis on reviewing PALS concerns where a consultant and matron contact patients and their families routinely. This practice helps reduce formal complaints and is successfully supporting patients and resolving issues at the time.

Co-ordination of medical treatment continues to feature most highly in clinical treatment complaints. This describes patients with often complex pathways who have concerns about their treatment and what will happen next. To help understand these issues in more depth, the Patient Experience team have introduced additional sub subjects to support the reason why clinical treatment has been raised. These include test results being unclear, post-operative recovery and follow up care and

support, to ensure that patients worries about financial, practical and emotional support following surgery or treatment are understood.

Internal Audit Report – Patient Experience

As part of the delivery of the Trust's 2019/20 audit plan, a report has been presented to the Trust's Audit Committee on Patient Experience and has provided moderate assurance over the design effectiveness and moderate assurance over the operational effectiveness for the systems in place.

Overall, they found that the systems are largely in place to enable appropriate handling of complaints and the ability to share learning within the divisions. They concluded that the Trust has processes in place to manage the complaints processes but improvements could be made to enhance the ability to report on the reasons behind delays in complaints or what lessons have been learned.

Monitoring and more detailed reporting will be continued to ensure compliance with the 25 day response time and 3 day acknowledgement requirement and work is being undertaken to enhance the data collated within the lessons learned section on datix. The agreed action plan is shared at the end of this document, (page 37).

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

Ref	Finding & Recommendation	Management Response	Responsible Officer	Implementation date	Q3 Update
1	Complaints Response and Acknowledgement Times In accordance with the Complaints Policy, complaints should be acknowledged within three working days of receipt and responded to within 25 working days. When complaints responses are delayed and likely to exceed the 25 working day limit, patients should be updated as soon as possible and evidence retained to support this.	We welcome the findings highlighting compliance with response to complainants within 25 days at 70%, which is in line with our current monitored performance and above our in-year improvement goal of 60%. Our divisional heads of nursing will continue to work closely with the complaints team to build on this performance and the Trust will monitor and report compliance monthly to Quality Board. We will also work to ensure that we always acknowledge complaints within 3 days and when a complaint response is taking longer than expected that we contact the complainant to apologise and explain the progress to date. We will audit our documentation with respect to this quarterly	Patient Experience Manager	31 Dec 2019	25 days response times monitored and reported to quality board each month; Q3 performance 59%. Q4 25 day performance:50% During Q3, acknowledgement of formal complaints within 3 working days were achieved in 90.1% of cases (136 out of 151). Q4 Acknowledgement times:98%

Ref	Finding & Recommendation	Management Response	Responsible Officer	Implementation date	Q3 Update
2	Datix recording Work should be undertaken to enhance the data collated within the lessons learned tab on Datix. This should ensure that the coding available is practical and fit for purpose. This should be completed by staff and then subsequently reported on at applicable committees to share best practice on a quarterly basis.	The Trust currently reviews and reports the themes from complaints at the monthly triangulation meeting, and at the quarterly PEFC and QAC meetings. We welcome the finding that there is opportunity to improve our use of the datix system in order to make thematic review of root causes more straightforward. We will explore the use of the lessons learned tab with the divisional leads and report our findings be the end of quarter 3 2019.	Patient Experience Manager	31 Dec 2019	Team Away Day in December 2019; further workshop planned with divisional nursing leads in 2020 where this will form part of the discussions.
3	Evidence of reviews of learning Quarterly reviews of learning from other divisions should be completed and placed in agendas as a standard quarterly item as agreed during the monthly minutes dated 25.6.18.	We welcome the findings that the majority of divisional governance processes for review of complaints have been recognised as robust. The Core division has put in place the recommendation described above regarding standard agenda item. We will audit agendas to ensure that this is the case every quarter.	Patient Experience Manager	31 Dec 2019	In place, action complete. In Q1 2020/21 the lessons learnt tab on datix is now routinely being completed to provide the divisions with lessons learnt information.

Western Sussex Hospitals NHS
NHS Foundation Trust

Agenda Item:	11.2	**Meeting:**	Trust Board	**Meeting Date:**	06 Aug 20
Report Title:	**ANNUAL SERIOUS INCIDENT REPORT (2019-2020)**				
Sponsoring Executive Director:	Dr George Findlay (Chief Medical Officer) and Maggie Davies (Chief Nurse)				
Author(s):	Jo Habben Head of Clinical Governance and Patient Safety				
Report previously considered by and date:	N/A				
Purpose of the report:					
Information	✓		Assurance	✓	
Review and Discussion	✓		Approval / Agreement	✓	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality			Staff confidentiality		
Patient confidentiality			Other exceptional circumstances		
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	✓	
Our People	✓		Quality	✓	
Systems and Partnerships	✓				
Any implications for:					
Quality	✓				
Financial	✓				
Workforce	✓				
Link to CQC Domains:					
Safe	✓		Effective	✓	
Caring	✓		Responsive	✓	
Well-led	✓		Use of Resources	✓	
Communication and Consultation:					

Executive Summary:

The purpose of this report is to provide an annual overview of key themes, risks and outcomes arising from the Serious Incidents (SI) reported and investigated (using Root Cause Analysis RCA methodology) at Western Sussex Hospitals NHS Foundation Trust (the Trust) from the period of time beginning 01/04/19 until 31/03/20 (Q1-Q4).

The report also provides assurance that appropriate clinical governance arrangements are embedded into the work of the divisions and that high standards of quality and safety are being maintained to avoid harm.

Key Recommendation(s):

The Quality Assurance Committee is asked to note and approve the contents of this report.

Contents

ANNUAL SERIOUS INCIDENT REPORT 2019-20

1.0 INTRODUCTION

1.1 *"Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.*

1.2 *Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.*

1.3 *The needs of those affected should be the primary concern of those involved in the response to and the investigation of serious incidents. Patients and their families/carers and victims' families must be involved and supported throughout the investigation process.*

1.4 *There is no definitive list of events/incidents that constitute a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents. Where lists are created there is a tendency to not appropriately investigate things that are not on the list even when they should be investigated, and equally a tendency to undertake full investigations of incidents where that may not be warranted simply because they seem to fit a description of an incident on a list"* NHSE Serious Incident Framework 2015[1].

1.5 When a serious incident does occur it can have a devastating and far reaching effect. The effect may impact not only on those people directly involved, be they patients, relatives, staff or visitors, but also on the reputation of the health care organisation, the service or the profession within which the incident occurred, and also on the wider National Health Service (NHS).

1.6 Western Sussex Hospitals NHS Foundation Trust (the Trust) is required to demonstrate accountability for effective governance and learning following a serious incident. The organisation is accountable to the clinical commissioning groups (CCG) in relation to the investigation of serious incidents. The Trust is committed to making patient safety a priority and to doing the utmost to prevent injury, ill-health and harm to patients, staff and visitors, and to prevent loss and damage to NHS assets, the Trust's reputation and to prevent breaches of patient confidentiality.

[1] *NHSE Serious Incident Framework 2015 consultation 2018-19: new guidance published in March 2020 as part of the Patient Safety Incident Response Framework 2019-20*

1.7 The Trust has a responsibility to ensure that when a serious incident does happen, there are systematic measures in place for:

- Safeguarding people, property, the resources and reputation of the Trust
- Understanding why the event occurred
- Ensuring that steps are taken to reduce the chance of a similar incident happening again
- Reporting to other external bodies where necessary, and
- Sharing the learning both within organisations and with other NHS organisations and providers of NHS-funded care

1.7.1 The Trust promotes and encourages an open and fair '*no blame'* culture across the organisation in line with the Trust vision and aims.

1.8 The purpose of this report is to provide an annual overview of key themes, risks and outcomes arising from the Serious Incidents (SI) reported and investigated (using Root Cause Analysis RCA methodology) at Western Sussex Hospitals NHS Foundation Trust (the Trust) from the period of time beginning 01/04/19 until 31/03/20 (Q1-Q4).

1.9 In 2018-19 the quality and governance process in relation to SI investigation, including management of the Duty of Candour (DoC) was reviewed. New policies were written, the methodology of investigation refreshed and improved, and a comprehensive accredited training programme implemented.

1.10 This report provides a summary of the progress; providing assurance that appropriate clinical governance arrangements regarding shared learning from SI are embedded into the work of the divisions and that a high standard of quality and safety are being maintained.

2.0 GENERAL PRINCIPLES

2.1 The principle aim of any investigation or enquiry is to learn from an incident and where possible, to prevent reoccurrence. In all instances, the priority is to ensure the immediate safety and the needs of individuals affected by the incident are attended to, including any urgent clinical care which may reduce the harmful impact and a Duty of Candour process being initiated. In addition a safe environment should be re-established, all equipment or medication retained and isolated, and all relevant documentation copied and secured.

2.2 The organisation should give early consideration to the provision of information and support to patients, relatives and carers and staff involved in the incident. The organisation must follow guidance provided in the Trust 'Duty of Candour' policy which is available on the intranet.

2.3 The needs and involvement of staff involved in the incident should also be considered. The NHS Improvement (NHSI) '*A just culture guide'*, should be referred to promote fair and consistent staff treatment within and between healthcare organisations and aims to help the NHS move away from attributing blame and instead find the cause when things go wrong.

3.0 SHARED LEARNING

3.1 Learning following an incident is defined as safety, practice and process issues which have contributed to the incident but from which others can learn. Examples of learning are given below:

a. Solutions to address incident root causes which may be relevant to other teams, services and provider organisations
b. Good practice which reduced the potential impact of the incident
c. Early detection or intervention which reduced the potential impact of the incident
d. Lessons from conducting the investigation which may improve the management of investigations in future
e. Sharing the lessons learned across the organisation/region
f. Evidence of assurance via clinical audit programme, peer review and triangulation

4.0 THE PATIENT SAFETY LANDSCAPE (NATIONAL)

4.1 Health Safety Investigation Branch (HSIB)

4.1.1 The Healthcare Safety Investigation Branch (HSIB) was established by an expert advisory group following recommendations from a government inquiry into clinical incident investigations. HSIB became operational on 1 April 2017. The purpose being to conduct effective investigations, and by sharing the learning, improve patient safety, raise standards, and support learning across the healthcare system in England.

4.1.2 In November 2017, the Secretary of State for Health, Jeremy Hunt, announced a new maternity safety strategy. The strategy called on HSIB to undertake approximately 1000 independent maternity investigations. From April 2018, HSIB now undertake maternity investigations identified as Serious Incidents (SI) which meet the following criteria;

4.1.3 Eligible babies include all term babies (at least 37+0 completed weeks of gestation) born following labour who have one of the following outcomes;

1. **Intrapartum stillbirth**: where the baby was thought to be alive at the start of labour but was born with no signs of life.

2. **Early neonatal death**: when the baby died within the first week of life (0-6) days of any cause.

3. **Severe brain injury** diagnosed in the first 7 days of life, when the baby:
    - Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE); or
    - Was therapeutically cooled (active cooling only); or
    - Had decreased central tone and was comatose and had seizures of any kind.

4. **Maternal Deaths:** Direct or indirect maternal deaths in the perinatal period (during or within 42 days of the end of pregnancy). Coincidental maternal deaths will not be investigated.

4.1.4 From April 2020 HSIB will no longer routinely investigate maternity events involving cooled babies where there is no apparent neurological injury confirmed following therapy.

4.2 NHS Improvement (NHSI) 'A Just Culture'

4.2.1 The '*A Just Culture'* guide was published by NHSI in 2018. The guide supports conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. The guide asks a series of questions that help clarify whether there truly is something specific about an individual that needs support or management versus whether the issue is wider, in which case singling out the individual is often unfair and counter-productive. The guide reduces the role of unconscious bias when making decisions and will ensure all individuals are consistently treated equally and fairly no matter what their staff group, profession or background.

4.2.2 The '*A Just Culture'* guide has been added to the newly published 'Management and Investigation of Serious Incident' Trust policy.

4.3 Patient Safety Incident Response Framework 2020: (*An introductory framework for implementation by nationally appointed early adopters*) March 2020

4.3.1 The new introductory Patient Safety Incident Response Framework (PSIRF) responds to calls for a new approach to incident management, one which facilitates inquisitive examination of a wider range of patient safety incidents "*in the spirit of reflection and learning"* rather than as part of a "*framework of accountability*". Informed by feedback and drawing on good practice from healthcare and other sectors, it supports a systematic, compassionate and proficient response to patient safety incidents; anchored in the principles of openness, fair accountability, learning and continuous improvement.

4.3.2 The Patient Safety Incident Response Framework (PSIRF) provides the NHS with guidance on how to respond to patient safety incidents, with no distinction between incidents and 'serious incidents' – for the purpose of learning. As such it is relevant to all bodies involved in providing; commissioning, supporting, overseeing and

regulating NHS-funded care. This includes services operating as part of a primary care network and other independent, non-NHS providers of NHS-funded care/services.

4.3.3 Several early adopter systems[2] are now working to implement this framework and by learning from their experiences, supportive resources will be developed and further refine the framework ahead of its wider implementation across the NHS from 2021.

5. THE PATIENT SAFETY LANDSCAPE (LOCAL)

5.1 The Clinical Commissioning Groups

5.1.2 Under the original NHSE SI Framework 2015, the clinical commissioning group (quality teams) hold the responsibility and accountability for the review, monitoring and closure of all healthcare providers Serious Incident's reported on StEIS[3]. When completed and authorised for closure by the medical director/chief nurse; all investigation reports are submitted to the CCG. These investigation reports are finally closed following review/discussion by the Sussex NHS Commissioners CCG Serious Incident Review Group (SIRG). Ongoing improvement plans are monitored by the local CCG via the Trust Performance and Quality Review Meetings (PQRM).

5.1.2 Under the PSIRF, the 'StEIS' reporting platform will change from a system enabling commissioners to monitor the process and progress relating to individual patient safety investigations, to a reporting and monitoring system for providers.

5.1.3 In line with the recommendation in the PSIRF, where STPs[4] and/or ICSs/ICPs[5] within STPs are assuming both provider and commissioning roles, effective governance and accountability systems must be established to fulfil the relevant responsibilities of provider and commissioning organisations in responding to patient safety incidents. Specific structures and procedures will be developed locally to fit with local arrangements and service architecture.

5.1.4 Multiple commissioners often contract services from the same provider; this can lead to confusion for the provider if each commissioner establishes separate reporting routes and sets different expectations. Commissioning organisations have a responsibility to work together to develop governance structures which support a co-ordinated approach to the oversight of patient safety incident management in all the services they commission.

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[2] *Other than the early adopters, organisations are not expected to start implementing the requirements in this framework until early 2021. All NHS-funded organisations will likely be required to fully deliver the framework by late 2021*

[3] *Strategic Executive Information System- the national database for reporting Serious Incident.*

[4] *Sustainability and Transformation Partnership*

[5] *Integrated Care Provider*

5.1.5 Related to this, in line with the recommendation from the PSIF, Regional Independent Investigation Teams (RIITs) will help identify those incidents highlighting system-based, cross-system issues that may require a centrally co-ordinated and independent PSII, such as a mental health-related homicide.

5.2 WSHFT Triangulation Committee

5.2.1 There are multiple opportunities through the incident management process to extract and share information, and this information can be used in different ways to support safety improvement. Information can be used at a team, department, organisation or system level to identify the most commonly reported incident types and insight about the nature of these incidents; triangulation with information from other sources (e.g. complaints, claims and coroner inquests) can provide further insight into the level of risk and potential opportunity for improvement.

5.2.1 The terms of reference for the Trust Triangulation Committee were refreshed and reviewed in 2019. The overarching aim of the committee being to provide a transparent and open multi-disciplinary forum in order to both triangulate and share the learning from; Serious Incident, complaints, inquests, clinical incidents, and safeguarding reviews. The overall objective and purpose of the monthly committee is to both focus on, and ensure that all trends, themes and human factors are identified and actioned, with a primary focus on the organisational sharing of the lessons learned.

5.2.2 Each meeting focuses on a 'deep dive presentation of a Serious Incident that may also triangulate with an inquest, high grade complaint or a mortality review. The shared learning from the presentation informs the publication of the monthly newsletter '*The Patient Story*', and informs the content for the Trust publication '*Theme of the Week'*. In addition the divisions are invited to the next meeting to demonstrate and present how they have shared the learning or improvement recommendations.

5.2.3 Patient Stories presented at Triangulation the Committee (April 2019-March 2020)

Date distributed	Patient Story
April 2019	SI - Traumatic injury sustained from stairwell fall
May 2019	SI - Near miss: SCBU wrist identification
	SI - Never Event: Retained swab (maternity)
June 2019	SI - Near miss: Missing screw following knee surgery
July 2019	SI - Misplaced naso-gastric tube (not Never Event)
	SI - Neonatal death
October 2019	SI - IG breach
November 2019	SI – Maternity: Eclampsia/seizure
January 2020	SI - Never Event: Wrong site block
February 2020	SI – Patient death due to ischaemic bowel
	SI – Patient Death due to clostridium wound infection
March 2020	SI – Renal stent/lost to follow up

5.2.3 National learning is also shared via HSIB publications of investigation reports.

5.2.4 HSIB investigation report publications and recommendations discussed at the Triangulation Committee meeting between 01/04/19 and 31/03/20:

24/04/19	1) Wrong route administration of oral medicine into a vein *(HSIB Published April 2019)*
24/07/19	2) Undetected button and coin battery ingestion *(HSIB Published June 2019)*
23/10/19	3) Wrong patient details on blood sample *(HSIB Published Sept 2019)*
	4) Management of chronic conditions in prisons *(HSIB Published Oct 2019)*
27/11/19	5) Electronic prescribing and medicines administration systems/safe discharge *(HSIB Published Oct 2019)*
29/01/20	6) Detection of retained vaginal swabs and tampons following childbirth *(HSIB Published Dec 2019)*
	7) Lack of timely monitoring of patients with glaucoma *(HSIB Published Jan 2020)*
	8) Delayed recognition of acute aortic dissection *(HSIB Published Jan 2020)*
26/02/20	9) Potential under-recognised risk of harm from the use of propranolol *(HSIB Published Feb 2019)*

5.3 Falls and Serious Incident reporting

5.3.1 Since 2013, on the direction/request of the Sussex clinical commissioning group's heads of quality, all patients who fell and sustained a fracture to their neck of femur requiring surgery were reported as a Serious Incident and investigated as such. All providers of healthcare in the Kent Surrey and Sussex region followed this directive.

The current investigation methodology takes the form of an 'After Action Review' (AAR) that was first developed at Brighton and Sussex University Hospitals (BSUH) as part of the falls reduction improvement programme.

5.3.2 In more recent years, as quality improvement (QI) methodology has developed, organisations have developed multiple work streams and programmes dedicated to QI; this is supported by the regional Kent Surrey and Sussex Quality and Patient Safety Collaborative (KSSQPSC).

5.3.3 Falls reduction was previously a key breakthrough objective of the 'Patient First' programme. Now in its 4th year, the programme has seen more than a 30% reduction in all falls which has been matched by a reduction in falls leading to serious harm. The approach involves intensive focus with the wards where most falls take place, using QI methodology to try to understand root causes and then working through PDSA (plan/do/study/act) cycles to implement interventions. The Kaizen and safer care team provide weekly input to the wards to ensure real-time review of progress and learning.

5.3.4 In Jan 2018, a review was completed at WSHFT regarding the value, shared learning, and action planning regarding the reporting and investigating of every patient who falls and fractures their neck of femur (requiring surgery) as a SI. The findings evidenced that as an organisation, the vast majority of AARs followed an identical format and learning- in addition a number of AAR's evidenced no root cause and no identified learning (visitors had fallen accidently in public areas).

5.3.5 Of note this does not include falls that cause severe harm/death from head injury, complex multifactorial falls causing harm, or themes or clusters identified in one or more clinical areas which would still follow the NHSE SI guidance as being reported and investigated as a Serious Incident.

5.3.6 As an organisation, the Trust is able to fully assure our commissioners and regulators that our learning is shared and the ongoing quality improvement work continues. Quality leads from the clinical commissioning groups have been invited to join the monthly '*Peer Review'* process, in particular focusing on visiting any areas of concern that may also be highlighted from the CQC Insight Data, (such as incidents of pressure damage or falls). In addition, the CCG quality leads are also invited to attend the Trust Triangulation Committee, which focuses on how as a Trust we share learning from complaints, inquests, serious incident, safeguarding reviews, mortality and feedback from the Trust freedom to speak up guardian.

5.3.7 The corporate '*Patient First'* Kaizen project focusing on the falls improvement work, is shared within the ward improvement and safety huddles. Projects such as 'Baywatch' have seen a significant improvement (decline) in the number of falls across the organisation.

5.3.8 In July 2018, following submission of the assurance evidence to the Sussex CCG's it was agreed that WSHFT were no longer required to report every fall that resulted in a fractured neck of femur as an SI. WSHFT are currently the only organisational

regionally to have been authorised to change the reporting framework. This is due a final review with a view to standardisation across the county by the Sussex Clinical Commissioning Groups in 2020.

5.4 Monthly Peer Review

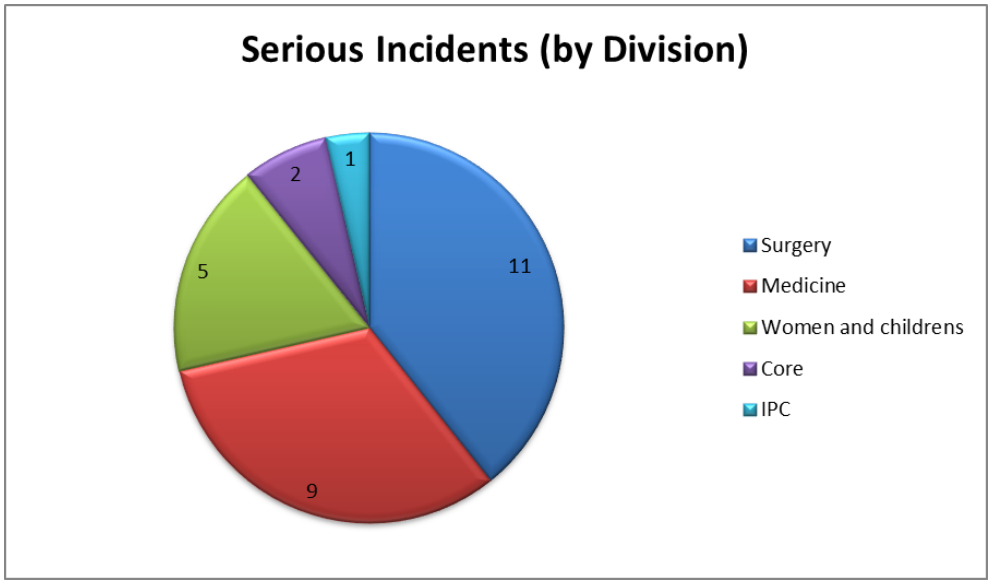
5.4.1 The monthly peer review process brings together members of staff from all divisions and disciplines to review the quality and safety of a service using a CQC framework derived from both the CQC *'Fundamental Standards of Care'*, and the '*Key Lines of Enquiry*' KLoEs. Soft intelligence is taken from themes identified in reported Serious Incidents to decide which areas to support with a peer review visit. Shared learning and improvement plans are owned by the matrons and managers.

5.4.2 The peer review process also provides assurance that the lessons learned and 'Patient Story' shared within the Triangulation Committee, are reaching the clinical areas and discussed within the safety huddles.

6. WSHFT REPORTED SERIOUS INCIDENTS 2019-20.

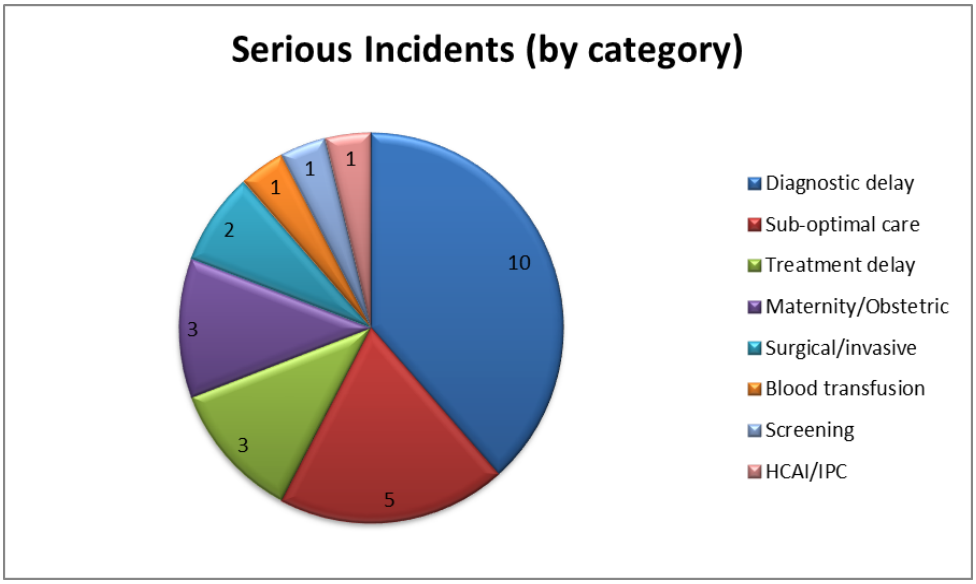
6.1 A total of 29 Serious Incidents were reported from 01/04/19 until 31/03/20, one incident related to consent was downgraded. (Figure 1 demonstrates reported SI's by division). This is a reduction of 17 from the previous year.

6.1.2 Figure 1:



6.1.3 Figure 2 demonstrates Serious Incident by category.

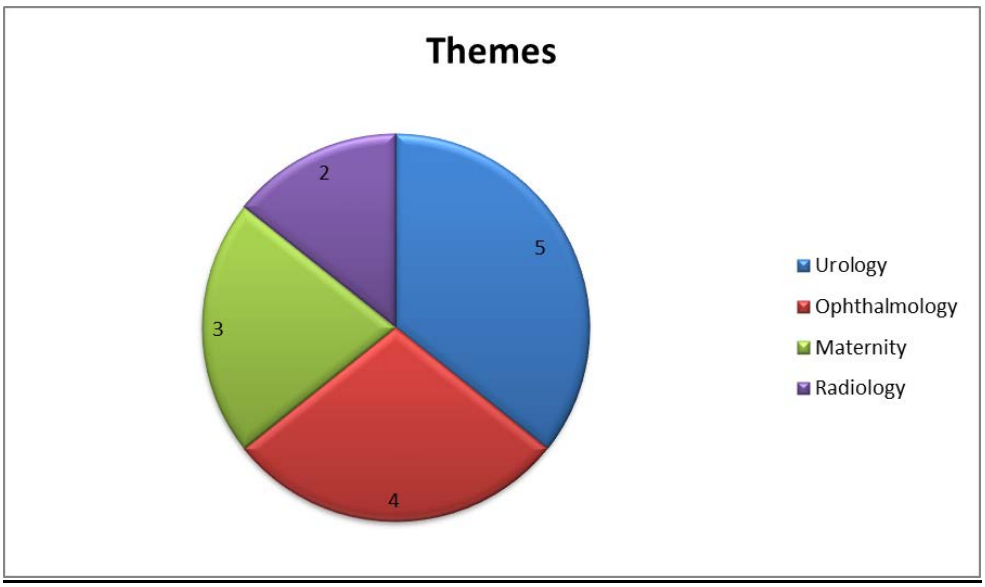
6.1.4 Figure 2:



6.2 Themes

6.2.1 Figure 3 demonstrates the top 4 themes for the organisation in relation to Serious Incident by speciality. Urology and radiology reported Serious Incidents in relation missed diagnosis with patients '*lost to follow up'*. Ophthalmology reported 4 Serious Incidents in relation to delayed follow up and treatment resulting in patient's loss of vision. Maternity reported 3 Serious Incidents, 2 of which are currently under investigation by the Health Safety Investigation Branch (HSIB).

6.2.2 Figure 3:



6.3 Unexpected Death

6.3.1 A quarterly detailed report submitted to the Care Quality Commission (CQC) providing all the Trust investigation reports (in full) in relation to unexpected deaths as apart the 'Learning from Deaths' programme. All unexpected deaths are screened via the mortality review process

6.4 Mortality Review and Inquest

6.4.1 All Serious Incident investigation reports are provided on request to the Coroner as part of the requirement to submit the documentation for inquest evidence. In relation to the Trust mortality reviews, the Learning from Deaths Manager is now in post and is working alongside the patient safety team to ensure that the Structured Judgement Review (SJR) process aligns fully with the requirement to report a Serious Incident when *poor care* and shared learning is identified. From 01/04/19-31/03/20: a total of 5 SI's have been raised following the SJR process under the category: "*Suboptimal care of the deteriorating patient*".

6.5 Figure 7 details all reported Serious Incidents (in chronological order) at WSHFT from 01/04/19-31/03/20.

6.5.1 **Figure 7 (WSHFT total reported SI 2019/20):**

STEIS No	Date of Incident:	Date Identified:	Clinical Area:	Type of Incident	Description of what happened:
2019/8693	28-Nov-18	17-Apr-19	WH Surgery	Diagnostic incident including delay meeting SI criteria	Urology patient with a history of renal cancer presented with paralysis from spinal metastases
2019/8928	14-Nov-18	15-Apr-19	SRH Radiology	Diagnostic incident including delay meeting SI criteria	Missed diagnosis of lung cancer
2019/9103	20-Mar-19	27-Mar-19	Sexual health	Confidential information leak/information governance breach	A breach of confidential personal information (Sexual Health)
2019/9462	30-Apr-19	30-Apr-19	SRH Medicine; Surgery	HCAI/Infection control incident meeting SI criteria	Outbreak of Norovirus on 6 inpatient wards at St Richards Hospital
2019/10312	08-May-19	10-May-19	WH Medicine	Diagnostic incident including delay meeting SI criteria	Missed diagnosis of cancer (gastrenterology)
2019/10844	16-Nov-18	05-May-19	WH Medicine	Diagnostic incident including delay meeting SI criteria	Missed diagnosis of lung cancer
2019/11043	28-Mar-19	25-Mar-19	WH Ophthalmology	Screening issues meeting SI criteria	Baby has significant vision loss following a retinal detachment
2019/11563	03-May-19	24-May-19	SRH Surgery	Diagnostic incident including delay meeting SI criteria	Urology missed diagnosis of ovarian cancer
2019/12736	23-Feb-19	05-Jun-19	SRH Surgery	Sub-optimal care of the deteriorating patient meeting SI criteria	SI Following Structured Judgement Review (SJR) mortality review
2019/12737	08-Feb-19	05-Jun-19	WH Medicine	Sub-optimal care of the deteriorating patient meeting SI criteria	SI Following Structured Judgement Review (SJR) mortality review
2019/12851	04-Jun-19	10-Jun-19	WH Obstetric	Maternity/Obstetric incident meeting SI criteria: mother only	A patient with eclampsia resulting in ITU admission
2019/14210	18-Jun-19	26-Jun-19	WH Medicine	Confidential information leak/information governance breach	A breach of confidential personal informaton (Sexual Health)
2019/15182	24-May-19	10-Jul-19	WH Theatre	Sub-optimal care of the deteriorating patient meeting SI criteria	SI Following Structured Judgement Review (SJR) mortality review
2019/16930	12-Feb-19	31-Jul-19	WH Medicine	Sub-optimal care of the deteriorating patient meeting SI criteria	SI Following Structured Judgement Review (SJR) mortality review
2019/16945	17-Mar-19	31-Jul-19	WH Medicine	Sub-optimal care of the deteriorating patient meeting SI criteria	SI Following Structured Judgement Review (SJR) mortality review
2019/22070	07-Oct-19	09-Oct-19	SRH Obstetric (HSIB)	Maternity/Obstetric incident meeting SI criteria: mother only	Postpartum haemorrhage: ITU admission maternal death
2019/22406	15-Mar-19	11-Oct-19	WH A&E	Diagnostic incident including delay meeting SI criteria	Missed diagnosis pulmomary embolism (patient died)
2019/22476	21-May-15	14-Oct-19	SRH Surgery	Treatment delay meeting SI criteria	Urology patient lost to follow up resulting in nephrectomy
2019/22729	16-Oct-19	16-Oct-19	SRH Theatre	Surgical/invasive procedure incident meeting SI criteria	Never Event: wrong site block
2019/23868	30-Oct-19	31-Oct-19	WH Surgery	Diagnostic incident including delay meeting SI criteria	Missed diagnosis renal cancer
2019/25868	28-Nov-19	28-Nov-19	SRH Obstetric (HSIB)	Maternity/Obstetric incident meeting SI criteria: baby only	Intrapartum stillbirth
2019/26630	30-Nov-19	09-Dec-19	SRH Neonatal	Blood product/ transfusion incident meeting SI criteria	Cryoprecipitate given instead of fresh frozen plasma to newborn
2019/27516	27-Sep-19	19-Dec-19	SRH Ophthalmology	Treatment delay meeting SI criteria	Patient lost to follow up resulting in permanent loss of vision
2020/2303	02-Dec-19	22-Jan-20	WH Radiology	Diagnostic incident including delay meeting SI criteria	Missed diagnosis pulmonary embolism (patient died)
2020/3790	14-Jul-19	22-Feb-20	SRH A&E	Diagnostic incident including delay meeting SI criteria	Missed diagnosis gynae cancer
2020/3796	14-Feb-20	21-Feb-20	WH A&E	Diagnostic incident including delay meeting SI criteria	Missed diagnosis mycardial infarction (MI) resulting in cardiac arrest (patient died)
2020/4558	19-Feb-20	04-Mar-20	SRH Surgery	Treatment delay meeting SI criteria	Urology patient Lost to follow up prostate cancer
2020/4908	14-Dec-19	04-Mar-20	SRH Ophthalmology	Surgical/invasive procedure incident meeting SI criteria	Cataract surgery resulting in permanent vision loss

7. NEVER EVENTS

7.1 Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

7.1.2 In December 2018 CQC published a report *"Opening the door to change- NHS safety culture and the need for transformation"*. The report focused on the following questions:
1) How is the guidance to prevent Never Events, including patient safety alerts, regarded by trusts?
2) How effectively do trusts implement the safety guidance?
3) How do other system partners support trusts with the implementation of safety guidance? What can we learn from other industries?

7.1.3 At WSHFT all measures are in place to fully reduce the risk of a NE. The organisation has robust guidance and measures in place both in the Trust policy 'Management of Serious Incident' and the CAS (Central alerting System) policy. A recent audit (March 2020) demonstrates 100% compliance with CAS alert.

7.1.4 National investigation reports by HSIB are shared within the organisation via the Triangulation Committee and the patient safety team. In 2020, three national investigations have been published and shared in relation to NE; wrong prosthesis (knee), insertion of incorrect intraocular lens and the unintentional connection of a patient requiring oxygen to an air flowmeter.

7.1.6 In 2016 WSHFT a number of senior staff attended the 'Global Air' Human Factors Training in Healthcare 5 day course. The 8 members of staff consisted of 2 patient safety team, 1 ED consultant, 1 HR representative, 1 practice development representative, 1 learning and development representative (clinical simulation) 1 health and safety manager and 1 quality improvement lead (Kaizen). The training focused on both the lessons learned and the identified human factors that contribute to human error within the airline industry.

7.1.8 Following the training, the learning and development team incorporated human factors training into the clinical update day, Acute Illness Management (AIMs) training, clinical simulation training and scenario and into the Schwartz round programme.

7.1.7 Human factors training is also incorporated into the Trust 'Management of Serious Incident and Duty of Candour' training and this session is delivered by a national investigator from HSIB. The training incorporates the most recent models and tools that originate from the process and analysis methodology used within non-healthcare related industries.

7.2 Never Events reported 2019-2020

7.2.1 There was 1 Never Event reported in 2019-20:

1. Surgery- Worthing theatres: Wrong site nerve block (anaesthetic) resulting in low harm.

7.2.2 Following the investigation, robust improvement plans have been initiated. Regarding the surgical NE of wrong site block, education, a refresh of the WHO Surgical Checklist process, '*Stop the Block'* safety initiative and implementation of a Local Safety Standard for Invasive Procedures (LocSSIP) have been completed. In addition, human factors' training (in particular situational awareness) is covered in the SI/DoC Trust training. The matrons for theatres, head of nursing for surgery, anaesthetists, clinical directors and chiefs of service have all attended the training.

7.2.3 The clinical audit team completed a gap analysis audit in relation to clinical areas that complete invasive procedures to ensure LocSSIP's are implemented and in routine use. The WHO Surgical Safety Checklist is audited monthly and the compliance reported in the monthly Trust quality report (100%). The revised 'Theatre Professional Standards' policy including the guidance on the WHO safety standards has recently been published and ratified by the Nursing and Midwifery Board (NMB).

7.2.4 On 01/04/19, LocSSIP compliance was recorded at 31% providing limited assurance only. In March 2020, the compliance was recorded at 95% with only one LocSSIP review outstanding.

7.2.4 The learning from a recent HSIB report into a similar incident (NE) has been shared with the divisions via the Triangulation Committee. The learning has also been shared via the monthly Patient Safety Newsletter and the Trust publication '*Theme of the Week'.*

7.2.5 Nationally, NE data was extracted on 11 March 2020, 435 Serious Incidents on the StEIS system met the criteria of a Never Event and had a reported incident date between 1 April 2019 and 29 February 2020.

7.2.6 Of the 435 reported Never Events, *Wrong Site Surgery* was the highest category with 218 reported incidents, and of these, wrong site nerve block demonstrated the highest number of nationally reported NE in this category with a total of 53 reported incidents.

8.0 THEMATIC REVIEW

8.1 Ophthalmology

8.1.1 In 2018-19**,** serious incidents reported and investigated in relation to ophthalmology highlighted the divisional risk regarding the follow up backlog for ophthalmology patient in regard to patients with glaucoma. This was confirmed as a national issue following the publication of the HSIB investigation report: "*Lack of timely monitoring of patients with glaucoma*" in January 2020. A number of national system recommendations were made including:

1. *The Royal College of Ophthalmologists, working with relevant stakeholders, develops models and review workforce required for the optimal delivery of glaucoma care. The models should be tested and evaluated. The Royal College of Ophthalmologists agrees criteria for the risk stratification of patients with glaucoma so that practice can be standardised across NHS hospital eye services[6].*
2. *NHS England/Improvement require commissioners to agree, under their service contracts, the action that providers will take to ensure compliance with the Portfolio of Indicators for Eye Health and Care follow-up performance standard.*
3. *NHS Digital includes provision for identifying, prioritising and monitoring patients at risk of developing sight loss within the next version of the national Commissioning Data Set. Provision should include the ability to record a risk rating and the recommended follow-up date for each patient, meaning these are mandated data items for collection by hospital eye services. This should be carried out in consultation with key stakeholders such as the Royal College of Ophthalmologists and patient administration system suppliers.*
4. *International Glaucoma Association facilitates the funding of research into the development and evaluation of an automated, predictive risk stratification tool.*

8.1.2 There remains a sustained focus and constant monitoring and initiatives such as the recruitment of Failsafe Officers overseeing and quality checking the ophthalmology follow-up appointment process. A Trust wide quality improvement action plan implemented in 2019 has seen a significant reduction in the numbers of patients awaiting follow-up; (although this is expected to rise during the course of the Covid-19 pandemic). In addition, a number of successful quality initiatives have been introduced within ophthalmology regarding staff skill mix and workforce reducing the risk of further avoidable harms. An ophthalmology *Quality Summit* was held in January 2020 to appraise the HSIB recommendations and review the Trust wide action plan.

[6] *RCO- Covid-10 Risk Ratification Tool introduced March 2020*

8.2 Urology and radiology

8.2.1 Serious Incidents reported and investigated in relation to urology highlighted the divisional risk regarding the lack of a robust central recording system for patients who require ongoing monitoring such as PSA (prostate specific antigen) but do not need a follow up appointment, unless they require recall following the test.

8.2.2 The functionality required to support this electronically is within the '*order-comms'* system. This will flag when results are back and is currently being implemented with radiology as part of the core services 2019-20 policy and diagnostic priority work programme.

8.2.3 On a more national level, missed diagnosis in the diagnostic pathway (in particular radiology 'unexpected and significant findings'), and delayed follow-up for treatment have been investigated by HSIB. In July 2019 the HSIB published the investigation report: *"Failures in communication or follow-up of unexpected significant radiological findings*". A number of national system recommendations were made including:

- *NHSX[7] develop a method of digitally notifying patients of results. This should be used to inform patients of unexpected significant radiological findings after an agreed timeframe. It should be developed in conjunction with the Royal College of Radiologists. The notification system should be tested and evaluated.*

8.4 Monitoring

8.4.1 All incidents reported on RLDatix® (electronic risk and incident reporting system) are screened by the central patient safety team. A summary report is produced on a weekly basis detailing all incidents recording 'moderate' harm and above (serious harm/death) and this is reviewed at a weekly Serious Incident Review Meeting (SIRM). Any incident that may meet SI criteria is also discussed and the decision made to raise the incident formally on the StEIS database.

8.5 Moderate harm

8.5.1 All patients who sustain moderate/severe harm/death that do not meet SI criteria with still undergo robust investigation and Duty of Candour. In 2018 2 new templates were developed:

1) Concise RCA template
2) Known complication investigation template

[7] *NHSX is a United Kingdom Government unit with responsibility for setting national policy and developing best practice for National Health Service technology, digital and data, including data sharing and transparency.*

8.5.2 These templates are used for the RCA[8] investigation and presented within the divisions via the clinical governance meetings and signed off for closure by either the divisional director or chief of service. The investigation reports and Duty of Candour documentation is then uploaded to RLDatix. If during the investigation further information is obtained that highlights a concern regarding the provision of patient care, a Serious Incident will be raised on StEIS and a comprehensive investigation completed.

8.5.3 The new style reports have been well received by the Coroner, in particular the 'known complication' investigation template.

8.5.4 All patient safety incidents (anonymised) are reported via Datix to the National Reporting and Learning System (NRLS). The NRLS provide a 6 monthly report on the organisational reporting statistics.

8.5.5 NRLS Data: although 2019 demonstrates an improvement in reporting data, WSHFT are still considered an outlier for potential *under-reporting, (*however the data set is subjective and has been under review in line with the introduction of the PSIRF). A business case for a system upgrade for the RLDatix electronic reporting system to ensure improved and streamlined incident reporting was approved in February 2020. A quality improvement project plan will commence in 2020-21 for the implementation of Datix IQ.

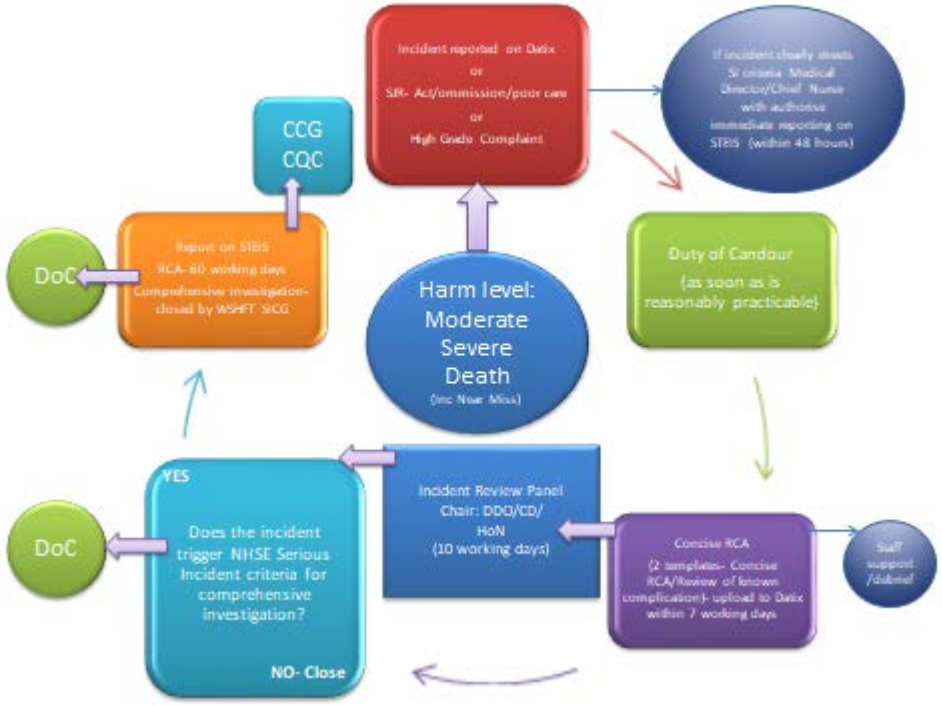
8.5.6 As part of the recommendations from the 'NHS Patient Safety Strategy 2019': NRLS is due to be replaced by the new 'Patient Safety Incident Management System' (PSIMS).

8.5.7 Figure 9 outlines the process for monitoring and investigating incidents (moderate harm and above).

8.5.8 Figure 10 outlines the process for sharing learning within the organisation.

[8] *PSIRF Recommends: Terminology: 'systems-based PSII' replaces the term root cause analysis (RCA).*

8.5.9 Figure 9. Process for monitoring and investigating incidents:



8.5.10 Figure 10. Process for shared learning:

9.0 DUTY OF CANDOUR

9.1 The Trust has demonstrated a consistently improved performance with 100% compliance reported with Duty of Candour in Q1-4. A quarterly audit report is produced and presented at both executive and divisional governance meetings.

9.2 The 'Patient Story'

9.2.1 Following the presentation of a Serious Incident investigation at the monthly Triangulation Committee, a '*Patient Story'* newsletter is published in order to share the lessons learned from the investigation. The newsletter is aimed for use within the safety huddles, clinical simulation and Schwartz rounds. The cascade of shared learning will be assured and audited via the Trust monthly peer review process.

9.3 Theme of the Week

9.3.1 The Trust '*Theme of the Week'* publication circulated Trustwide within the '*Huddle Headlines'* is an aide memoire to assist the teams to cascade quality and safety information across the organisation. Each week the patient safety team choose a subject that correlates with the lessons learned from the presentations and shared learning or risks identified at the monthly Triangulation Committee. This theme is also matched to the CQC Fundamental Standards of Care framework.

10.0 TRAINING

10.1 In 2018 a 2 day[9] accredited (Royal College of Physicians) training module 'Management of Serious Incident and Duty of Candour Training' was introduced.

10.1.2 The trainers Jo Habben- Head of Clinical Governance and Patient Safety WSHFT and Mel Ottewill National Investigator Health Safety Investigation Branch (HSIB) designed an agenda that fulfilled all the elements of the recommended training, but also incorporated a solid human factors and patient centred focus, openly sharing their varied experiences of investigations and meetings with patients who may have been harmed, or families/carers that are bereaved. The training also analyses human error and introduces the NHSI '*A Just Culture Guide'* also incorporated in the new WSHFT SI policy published in 2018.

10.1.3 In addition the trainers designed the course so that both days were thoughtfully facilitated, interactive, safe spaces to test, share, and openly discuss practice. The aim being to spark and generate active conversations with and between the delegates, rather than them being the passive recipients of the presentations. The trainers also aimed to promote confidence within the group to share their own experiences and provide a space in which all began to work together to develop a solution focus

[9] *Patient safety incident investigators: the PSIRF recommends: patient safety incident investigators must have been trained over a minimum of two days in systems-based PSII.*

10.1.4 Day 2 of the training centres on patient, family and carer experience, with guest presenters presenting patient stories from WSHFT and learning from national patient safety reviews (James Titcombe Morecambe Bay/Kirkup Report).

10.1.5 Professional actors are utilised on day 2 to assist with the scenarios regarding Duty of Candour training, and in order to fully share the learning- these example scenarios are taken from Serious Incidents that had been reported and investigated at WSHFT. Whilst the trainers both acknowledge this is the most challenging session for the delegates, it also consistently scores the highest scores on the evaluation.

10.1.6 In total from 2018-2020 over 350 delegates have been trained across the Kent Surrey and Sussex region (11 cohorts). At WSHFT since 2018- over 200 consultants, junior doctors, AHP's, pharmacists, senior nurses, students, Darzi fellows, NHS Graduates and service/care group managers have attended the training. The training is championed by both the medical director and chief nurse.

10.1.7 In December 2019 a regional "*Sharing the learning from Deaths/SI"* conference was hosted by WSHFT. Sussex providers from acute, community, mental health Trusts and adult social care along with the clinical commissioning groups were invited. A particular focus was centred on The Learning Disabilities Mortality Review (LeDeR) Programme with a presentation from international speaker Paula McGowan. The event was attended by 200 delegates.

11.0 POLICY AND GUIDANCE

11.1 The 'Management and Investigation of Serious Incident' and the 'Duty of Candour' Trust policies were both reviewed and re-written in 2018. The policies were ratified at the Nursing and Midwifery Board (NMB) and promoted and circulated in the Trust Patient Safety Newsletter. Both policies offer practical guidance and templates for both investigation, and example letters to assist the Duty of Candour process.

11.1.2 Both the policies and templates have been well received by staff and have notably improved the quality and standard of the investigation process and documentation.

11.1.3 The NHSE SI Framework 2015 has undergone recent consultation resulting in the recommendation to replace the previous framework with "*The Patient Safety Incident Response Framework*". The PSIRF will support the NHS to operate systems, underpinned by behaviours, decisions and actions that assist learning. The PSIRF outlines a broader scope: describing principles, systems, processes, skills and behaviours for incident management as part of a broader system approach, providing and signposting guidance and support for preparing for and responding to patient safety incidents in a range of ways, moving away from a focus on current thresholds for 'Serious Incident'.

11.1.3 The PSIRF moves away from reactive and hard-to-define thresholds for 'Serious Incident' investigation and towards a proactive approach to learning from incidents. It promotes a range of proportionate safety management responses.

11.1.4 Investigation approach: safety investigation is now tightly defined. Quality of investigation is the priority with the selection of incidents for safety investigation based on opportunity for learning and need to cover the range of incident outcomes.

11.1.5 Experience for those affected: expectations are clearly set for informing, engaging and supporting patients, families, carers and staff involved in patient safety incidents and investigations. In accordance with a just culture, staff involved in incidents are treated with equity and fairness.

11.1.4 WSHFT policies will be reviewed and aligned with the new guidance (in line with the early adopters) when the final PSIRF framework was published in March 2020.

12.0 QUALITY ASSURANCE

12.1 The NHSE SI Framework 2015 maintains that all SI investigation reports require submission the CCG's for closure within 60 working days[10] (unless an extension is authorised).

12.1.2 In 2019-20 86% of WSHFT investigation reports were submitted to the CCG within the 60 day timeframe (24/28), in relation to the 4 late submissions; all were submitted within 16 days of the deadline. The patient/family and CQC also receive a copy of the final investigation report.

12.1.3 Following submission to the CCG, all RCA investigations reports are quality controlled via a "*first line triage*" process and are returned to the provider if they do not meet the required standard. In 2019-20, 95% of investigation reports were closed on first submission to the CCG Serious Incident Review Group with no further action required (an improvement from 67.5% reported the previous year).

12.1.4 In 2018 the WSHFT Patient Safety Team introduced a '*SI Closure Checklist'* and from April 2019, a WSHFT Serious Incident Closure Group (SICG) has been convened. Chaired by the medical director/chief nurse the purpose of the panel will be to review and quality control all finalised reports prior to submission to the Sussex CCG's and to orchestrate as a Trust how we share the lessons learned.

12.1.5 Feedback from the CCG's is as follows (April 2020):

"The CCG Serious Incident Scrutiny Group has observed that WSHT is often seen as an exemplar organisation in terms of the quality of the investigation reports submitted to the CCG. The reports when first submitted rarely require any 'first line triage' and are forwarded straight to the panel. The panel has observed that reports provide a high level of assurance in terms of providing a clear background and context, root cause, lessons learned/recommendations and detailed action plans. Duty of candour is also evidenced to a high standard and reports are generally considered to be written in a transparent way that keeps the patient and/or family in mind when reading them".

[10] *PSIRF recommends: Investigation timeframe: timeframes are more flexible and set in consultation with the patient and/or family. They should average three months and never exceed six.*

12.2 CQC Inspection 2019: Safety- Outstanding

12.2.1 In the summer of 2019: WSHFT was inspected by the Care Quality Commission. Previously whilst the overall inspection rating for the Trust was '*Outstanding*' (2015 inspection) the domain of '*Safety*' had been rated as '*Good*'. During the 2019 inspection the team of experts thoroughly reviewed the safety systems, policies and reports, with a particular focus on SI reporting and investigation. The findings are documented in the inspection report as follows:

12.2.3 "*The trust was committed to improving services by learning from when things go wrong. Training on root cause analysis (RCA) and investigations was provided for all those involved in investigating and managing serious incidents. Divisional teams were focussed on monitoring lessons learned and the implementation of action plans. We reviewed six serious incident reports and found they were of a very good standard. There were clear terms of reference for the investigation which was proportionate to the incident and level of risk. We noted there was a focus on leaning and opportunities for improvement rather than blame. We saw that any immediate actions to prevent recurrence were noted. The RCAs were made explicit and there were clear conclusions and recommendations for further action.*

12.2.4 Patients and their families were included in the review, where appropriate, and offered the opportunity to share their stories with the board.

12.2.5 All incidents had senior clinical oversight and consideration of safeguarding issues raised. The trust took actions to implement and embed learning from RCAs. During our ongoing monitoring of the trust, we found the trust to be proactive, open and transparent in relation to incidents and actions taken. We were informed promptly of areas of concern, updated with the progress of investigations and supplied with RCA's and associated action and monitoring plans.

12.2.6 The trust showed a consistent and robust approach to the reporting and investigating of serious incidents. Actions set specific, measurable, ambitious, realistic targets (SMART) and learning was embedded across the organisation. Duty of candour requirements were followed consistently and there was evidence in every investigation of patient / family involvement.

12.2.7 The trust looked at themes and trends and focussed heavily on quality improvement of these, for example the recent falls project that had seen a reduction in falls and reduction in harm from falls. Duty of candour for moderate and severe incidents had sustained 100% across quarter three and quarter four in 2018/2019".

12.3.8 In 2019, the CQC domain of '*Safe*' was rated as '*Outstanding'* making WSHFT the only NHS non-specialist acute trust to receive this rating across all 5 domains (safe, effective, caring, and well-led).

13.0 CONCLUSION

13.1 During 2018-19 a complete review and refresh of the processes for the reporting and investigation of Serious Incident within the organisation was implemented. This review focused on the patient family/carer being fully informed and involved in the investigation from inception, and the training and development of skilled and experienced investigators. The introduction of new policies, procedures and templates underpinned this process. Now in its second year of implementation; the results of this review have demonstrated continued improvement in both the quality and assurance in relation to the management of Serious Incident.

13.2 It is encouraging to note that whilst WSHFT have not been selected as an 'early adopter' of the PSIRF; all the policies, guidance and methodology from the 2018-19 review, mirror the new proposals.

13.3 Feedback from staff and the Sussex CCG's remain favourable and patients and families have benefited from an open and honest culture of involvement. Duty of Candour has been embedded, and the Trust continues to be 100% compliant with the regulation.

13.4 The introduction of the *'A Just Culture'* process has enabled staff to feel more confident when raising and reporting Serious Incident, and the lessons learned are more widely shared via the division, with the improvement plans being owned by the teams.

13.5 On a national level, the same themes and trends identified at WSHFT are also being investigated by HSIB.

13.6 Implementation of the RLDatix IQ upgrade will improved efficiency and effectiveness of quality and risk management processes resulting in safer patient care with improved accuracy and timeliness of reporting and provision of assurances.

13.7 In 2019, the CQC domain of 'Safe' was rated as 'Outstanding' making WSHFT the only NHS non-specialist acute trust to receive this rating across all 5 domains (safe, effective, caring, and well-led).

14.0 RECOMMENDATION

14.1 The Quality Assurance Committee is asked to NOTE and APPROVE the contents of this report.

Jo Habben
Head of Clinical Governance and Patient Safety

April 2020

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	11.3	**Meeting:**	Trust Board	**Meeting Date:**	06 Aug 20
Report Title:	Learning from Deaths Q4 19/20 and Q1 20/21				
Sponsoring Executive Director:	George Finlay Chief Medical Officer				
Author(s):	Tim Taylor Medical Director, Alison Young Head of Quality Improvement, Mary Evans Learning from Deaths Manager				
Report previously considered by and date:	Trust Board 22/07/2020				

Purpose of the report:			
Information	☐	Assurance	✓
Review and Discussion	✓	Approval / Agreement	☐

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

Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	☐
Our People	☐	Quality	✓
Systems and Partnerships	☐		

Any implications for:	
Quality	Learning and quality improvement from the review of deaths
Financial	Nil
Workforce	Training requirements and time for individuals to undertake and respond to learning

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

Communication and Consultation:

A plan for communication is being developed

Executive Summary:

The purpose of the briefing is to update the Board of progress in the implementation of the structured approach for reviewing the deaths of patients to provide assurance on care and identify areas where it could have been improved.

Key Recommendation(s):

The Committee is asked to: Receive and discuss the progress toward implementation of the 'Learning from Deaths' policy and the learning identified from structured mortality reviews.

Learning from Deaths Mortality Report Quarter 4 19/20 and Quarter 1 20/21

1. Background:

Prior to the 2019/20 quarter four reporting period, consultant level mortality screening informing Trust wide structure judgment review process continued. This was in line with the expected process and previous outcome reports to the Quality Board.

However, from mid-quarter four there was significant process disruptions associated with the implementation of business continuity plans in response to the Corona virus pandemic. This was compounded by technical issues within the Trust wide electronic consultant screening system and has limited the availability of complete and validated outcome data to report for quarter four.

2. Screening of deaths from Mid quarter four to end of quarter one reporting period:

It was agreed that an independent consultant screening process established during March would continue until the end of May 2020. This was due to the continued limitations in the electronic consultant review system as well as the proportion of consultants available during the business continuity period.

2.1 From April 1st 2020 until 31st May 2020, additional screening was undertaken by the Learning from Deaths Manager as well as the recently retired Head of Clinical Effectiveness re-employed via bank duties, as an expert in the mortality review process. Additional input was utilised according to the availability of consultant mortality reviewers and other clinicians. Screening outcomes and referral to structure judgement reviews was overseen by the Trusts Medical Director during newly established weekly mortality panels.

2.2 In addition to the above, all inpatient deaths occurring in the previous month relating to patients with a positive COVID 19 result were reviewed. The process for referral on to full Structured Judgement Review (SJR) or patient safety incident investigation remained the focus of the adapted screening process.

2.3 The weekly mortality panel is now well established and continues to be chaired by the Trust's Medical Director; it aims to review screened inpatient deaths and associated SJR outcomes.

3. Activity and Outcomes from Screening during quarter one:

Table 1: Details the total number of deaths during April and May 2020 against the number screened according to each site. A total of 327 deaths of which 315 (96%) have been screened to date.

Table 1: Total Deaths	**St Richards**			**Worthing**		
	Number	**Screened**	**% Screened**	**Number**	**Screened**	**% Screened**
April	88	85	96%	106	106	100%
May	64	55	86%	69	69	100%
Total	**152**	**140**	**93%**	**175**	**175**	**100%**

Table 2: Details the number of deaths during April and May 2020 relating to inpatients with a COVID 19 positive swab result. A total of 97 patients of which 95 (98%) have been screened to date.

Table 2: COVID19 positive deaths	**St Richards**			**Worthing**		
	Number	**Screened**	**% Screened**	**Number**	**Screened**	**% Screened**
April	27	27	100%	43	43	100%
May	10	8	80%	17	17	100%
Total	**37**	**35**	**95%**	**60**	**60**	**100%**

4. Structured judgement reviews (SJR) during April and May 2020:

Table 3: Details the number of screened deaths escalated to SJR process with number and percent completed. A total of 58 (18%) of the 315 completed screenings were escalated to an SJR. A total of 52 (90%) of these SRJs have been completed to date.

Table 3:SJRs	St Richards			Worthing		
	Number escalated	Completed	% Completed	Number escalated	Completed	% Completed
Non-COVID 19						
April	8	8	100%	10	8	80%
May	7	6	86%	10	8	80%
Total	**15**	**14**	**93%**	**20**	**16**	**80%**
With COVID 19 positive result						
April	7	7	100%	13	13	100%
May	1	1	100%	2	1	50%
Total	**8**	**8**	**100%**	**15**	**14**	**93%**
Totals per site						
	23	**22**	**96%**	**35**	**30**	**86%**
Total -Trust wide						
	58	**52**	**90%**			

Table 4: Details the final overall outcome scores of SJR that were completed from the April and May 2020 screening:

Overall outcome score	St Richards (*n*=21)	Worthing (*n*=26)
Non COVID 19 deaths:	**N=13**	**N=13**
1 – Very poor	1	1
2 – Poor	5	1
3 – Satisfactory	3	7
4 – Good	4	3
5 – Very good	0	1
Patient deaths with COVID 19 positive result	**N=8**	**N=13**
1 – Very poor	0	0
2 – Poor	1	1
3 – Satisfactory	3	8
4 – Good	3	4
5 – Very good	1	0

4.1 To note: A total of 5 cases currently excluded for the following reasons:

- Pending panel review (one case)
- Awaiting further information from clinicians (three cases)
- Awaiting 2nd SJR (one case)

4.2 Zero deaths during this period have been identified as more likely than not caused by deficits in care.

4.3 Currently 39 % of patient deaths during June 2020 have been screened via the electronic screening process. Competed data and review outcomes of these deaths will be included within next reporting period.

Table 5: Details the Number of Trust deaths that were escalated for Structured judgement reviews during Q1 20/21

Table 5 SJRs	**Total Deaths**	**Total Deaths SJ Reviewed**	**Avoidable Deaths**	**Total % of deaths SJ reviewed**
April 20	194	36	0	19%
May 20	133	16	0	12%
June 20	124	12	0	10%
Total (Q1 20/21)	**451**	**64**	**0**	**14%**

5. **Table 6**: Details the number of Learning disabilities (LD) mortality reviews during quarter 1.

Table 6 LD reviews	**St Richards**			**Worthing**		
	Screened	**SJR completed**	**% Completed**	**Screened**	**SJR completed**	**% completed**
April	2	2	100%	0	0	100%
May	0	0	100%	1	1	100%
June	0	0	100%	2	2	100%
Total	**2**	**2**	**100%**	**3**	**3**	**100%**

5.1 In total, five LD patients were identified, screened and completed the SJR process. None of these deaths have been identified as more likely than not to be caused by deficits in care.

5.2 The two LD patient deaths at St. Richard's hospital were associated with COVID 19 positive results.

5.3 Learning disabilities mortality review (LeDeR) programme introduced a rapid review form in the event of COVID 19. Completion of these is to help identify any learning or practise that will

improve: local support, escalating of concerns or prevent further deaths. Information from WSHFT has been submitted via the Sussex LeDeR programme lead, to aid these reviews.

5.4 To date no formal feedback has been received. These reviews are not part of the NHS England/Improvement Learning Disability Mortality Review (LeDeR) programme; Full LeDeR reviews will take place in due course.

6. Learning from deaths themes:

6.1 The increased use of palliative care teams, with seven day a week support has significantly improved end of life care for inpatients, with earlier recognition of end of life care needs.

6.2 The use of new documentation within patient records: i.e. record of contact with family, and treatment escalation plans have proven to be beneficial to patient care.

6.3 There have been a number of potentially nosocomial cases of COVID 19 where patients have died. To date the Broadwater ward outbreak at Worthing Hospital has been investigated as a patient safety serious incident - other cases remain under patient safety investigation in collaboration with the Infection Prevention and Control team.

6.4 The criteria for swabbing patients admitted and with clinical signs of suspected COVID 19 in the frail and elderly have changed as a result of lessons learned.

6.5 Several patients with advanced care plans with preferred place of death in community settings have died very soon after admission to hospital.

6.6 In the cases where elements of care were judged to be poor this was associated with patient pathway reviews at the weekends.

6.7 The pathways of care for patients with regard to non-invasive ventilation (NIV) and continuous positive airway pressure (CPAP) differed across Trust sites and would benefit from standardisation.

6.8 Elderly, frail trauma patients would benefit from enhanced medical team input via ortho-geriatricians service - this has been a theme in a number of cases judged as poor care.

7. Current capacity and future sustainability of robust mortality review processes:

7.1 The Trust wide mortality process has reverted back to the electronic consultant screening system from the beginning of June.

7.2 Seven Medical Examiners have been appointed within the Trust in line with the recently launched Medical Examiners system mandated for all Trusts within England and Wales.

7.3 It is anticipated that phased Medical Examiner activity will commence from the beginning of August 2020. Electronic consultant screening will continue to operate until the Medical Examiner's office has been fully implemented across the Trust.

8. Recommendations

- All mortality screening to be undertaken by Medical Examiner's office in place of the existing electronic screening from 1st October 2020.

- Joint working between MEO, Learning from Deaths Manager and Bereavement to develop the RL Datix IQ Mortality Module.

Table 7: Details Planned action in reponse to learning themes

THEME	ACTION	LEAD	Target due date
Increased use of palliative care teams, with seven day a week support has significantly improved end of life care for inpatients, with earlier recognition of end of life care needs	Share learning themes and support a business case for palliative care resources	ME/TT	August 2020
The use of record of contact with family, and treatment escalation plans	Share learning	ME	August 2020
Nosocomial cases of COVID 19	Share learning themes from investigations and change processes and procedures according to findings	ME/TT	August 2020
Patients with advanced care plans being admitted to hospital and dying soon after admission	Advanced care plans to be raised at Mortality and End of Life Care Board	ME	Next meeting
Poor care associated with patient pathway reviews and weekends	Communicate issues to the HSMR group.	TT	Next meeting
Non standardisation of pathways for use of NIV and CPAP across sites	Review of NIV and CPAP pathways at the clinical advisory group	TT	Next meeting
Medical input for frail, elderly who have been admitted under trauma and orthopaedics.	To be raised with Medical and Surgical Division	TT/ME	July 2020

Mary Evans – Learning from Deaths Manager

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	12	**Meeting:**	Trust Board	**Meeting Date:**	06 August 2020
Report Title:	Finance and Performance Committee Report to Board				
Sponsoring Executive Director:	Lizzie Peers, Non-Executive Director				
Author(s):	Lizzie Peers, Non-Executive Director				
Report previously considered by and date:	N/A direct report to Board				
Purpose of the report:					
Information	✓		Assurance	✓	
Review and Discussion	✓		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	✓	
Our People	✓		Quality	✓	
Systems and Partnerships	✓				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	☐		Effective	✓	
Caring	☐		Responsive	☐	
Well-led	✓		Use of Resources	✓	
Communication and Consultation:					

Executive Summary:

The Finance and Performance Committee met on 25 June 2020 and was quorate as it was attended by five Non-Executive Directors, the Chair and the Chief Financial Officer, Chief Operational Officer and Chief Nurse. The Trust Director of Finance was also in attendance.

The Finance and Performance Committee met on the 30 July 2020 and was quorate as it was attended by five Non-Executive Directors including the Trust Chair, and the Chief Executive, the Chief Financial Officer, the Chief Operational Officer and the Chief Nurse. The Trust Director of Finance and Trust HR Director were also in attendance.

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

Key Recommendation(s):

The Board is asked to**:**

NOTE the assurance provided in respect of the Trust's performance plans and the established Covid-19 improvement plans.

NOTE the assurance provided in relation to the delivery against the revised financial framework between April – June 2020.

NOTE the view of the Committee in respect of the BAF risks it has oversight for in that the current scores are a fair reflection of these risks.

Western Sussex Hospitals NHS Foundation Trust

To: Trust Board

Date: 06 August 2020

From: Finance and Performance Committee

Agenda Item: 12

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Finance and Performance Committee	**25 June 2020**	**Lizzie Peers**	✓	☐
	30 July 2020	**Lizzie Peers**	✓	

Declarations of Interest Made

No interests were declared.

Assurance received at the Committee meeting

- The Committee **RECEIVED** a report from the Chief Operating Officer on the Trust's performance and the impact of Covid-19 on the established improvement plans at both the June and July meetings. The Committee was updated on the work being undertaken in respect of the development of the performance plans, within the national refresh, restore and recover framework and the Committee noted the challenges and constraints the Trust was seeking to work through within the developing plan. The Committee had a detailed discussion on these plans and the challenges facing the Trust and those within the wider system and was **ASSURED** over the level of detail being applied to the performance planning. The Committee discussed the development of the Trust's winter plan recognising this is being developed across the system to bring more resilience into this year's plan. The Committee recognised these challenges are reflected within the Trust BAF risk 5.3.

- The Committee **RECEIVED** a report on the Trust's financial performance and noted the position for month two at the June and month three at the July meeting under the revised national financial regime. The Committee was **ASSURED** over the processes applied in support of the claim for incremental Covid-19 cost top up income, recognising the returns from April and May 2020 had been approved by NHSE/I, with June's claim with NHSE/I to allow them to undertake their scheduled review. The Committee was informed that the Covid-19 capital request approval process is protracted by the central review of all requests. The Committee discussed the financial regime and the risks that many occur in the second half of the year should the regime change. The Committee recognised that whilst the Trust has achieved its financial duties to break even the future risks do mean that risks 2.1 and 2.2 were fairly reflected.

- The Committee **RECEIVED** a report on the delivery of 2019/20 efficiency programme and the lessons from the review of that programme's successful delivery that are to be applied to the developing 2020/21 programme.

- The Committee **RECEIVED** a report on the workforce performance indicators, noting that the workforce has grown overall. The Committee was updated on the risk assessment processes applied supporting our staffs wellbeing. The Committee was **ASSURED** over the plans being developed to improve performance across support for staff with sickness and those to undertake training through various training platforms. The Committee **RECEIVED**
- an overview of the work being undertaken to support and develop staff during the delivery of the refresh, restore and recovery plan.

- The Committee **AGREED** at its July meeting that the Trust should pursue further options in relation to the use of renewables and wider technological solutions in relation to the pursuit of carbon reduction and associated benefits through the Trust's Green Sustainability Group.

- The Committee reviewed the BAF risks for which it has oversight for and **AGREED** these were fairly represented.

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

- The Committee requested that it maintain informed regarding patient choice and the number of patients declining to attend hospital.
- The Committee requested to have continued updates of the remodelling and restoration of services as part of the Refresh, Recover and Restore programme.
- The Committee will receive an update on the 2020/21 developing efficiency programme opportunities at its next meeting linked to the PLICS developments

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

Item	Referred to
The Committee recommended to the Board that the risks within the BAF for which it has oversight are fairly represented.	Board as part its approval of the BAF
No specific matters were referred to Quality Assurance Committee recognising that QAC will continue to review the quality impact of the continued performance demands on the Trust.	

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	13	**Meeting:**	Trust Board	**Meeting Date:**	06 August 2020
Report Title:	Audit Committee Report to Board				
Sponsoring Executive Director:	Jon Furmston, Non-Executive Director				
Author(s):	Jon Furmston, Non-Executive Director				
Report previously considered by and date:	N/A direct report to Board				
Purpose of the report:					
Information	☐		Assurance	✓	
Review and Discussion	☐		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	✓	
Our People	✓		Quality	✓	
Systems and Partnerships	✓				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	☐		Effective	☐	
Caring	☐		Responsive	☐	
Well-led	✓		Use of Resources	☐	
Communication and Consultation:					

Executive Summary:

The Audit Committee met on the 09 July 2020 and was quorate as it was attended by three Non-Executive Directors. Attending the meeting were also the Trust's External and Internal Auditors, the Trust's Local Counter Fraud Specialist, the Chief Operating Officer, Director of Finance and the Group Company Secretary.

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

Key Recommendation(s):

The Board is asked to **NOTE:**

- The assurances secured through the reports reviewed and that the Committee did not refer any matters to the Board for review.
- The Committee **NOTED** the revised plan from Internal Audit and noted that it would incorporate a link to the Refresh, Restore, Recover processes and this revised plan would come back to the Committee in October 2020.

- The Committee **NOTED** the External Audit Letter and there were no changes to the opinions presented to the Board when approving the annual report and accounts. The Committee **NOTED** that the scheduled review of the external audit for 2019/20 would be reported to the next meeting.
- To **NOTE** the Audit Committee Annual Report (appendix a) which summarised the work of the Audit Committee over the last year.

To: Trust Board Date: 06 August 2020

From: Audit Committee Agenda Item: 13

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	**09 July 2020**	**Jon Furmston**	**yes**	**no**
			✓	☐

Declarations of Interest Made

No interests were declared.

Assurance received at the Committee meeting

- The Committee **RECEIVED** the Internal Audit progress report incorporating the management action plans for the Charitable Funds Audit. It received positive **ASSURANCE** in relation to this report and the progress made against recommendations from both this and previous audits despite the delays due to Covid-19.
- The Committee **RECEIVED** the Internal Audit Updated Annual Plan for 2020/21 and was **ASSURED** that it was aligned with the Trust's strategic objectives and risks.
- The Committee received **ASSURANCE** from the Local Counter Fraud Specialist update, in particular that RSM had completed a review of the control changes implemented during the Covid-19 response.
- The Committee **RECEIVED** the External Audit Letter and noted there were no changes to the opinions presented to the Board when approving the annual report and accounts.
- The Committee **NOTED** that the scheduled review of the external audit for 2019/20 would be reported to the next meeting.
- The Committee **RECEIVED** the Annual Audit Committee Report and **RECOMMENDED** it to Trust Board for noting as it provides the Board with an understanding of the Committee's work over the last year.
- The Committee **RECEIVED** information over the processes applied over use of waivers and reflected that their use was reasonable.
- The Committee **RECEIVED** a Post Project Evaluation on Pathology LIMS. The Committee was **ASSURED** that as a result of the project the Trust now has a modern integrated LIMS system which will facilitate further local modernisation of process.

Actions taken by the Committee within its Terms of Reference

- The Committee **ENDORSED** the Annual Audit Committee Report to be presented to Trust Board for noting.

Items to come back to Committee / Group (Items Committee / Group keeping an eye on)	
▪ The Committee agreed that the IM&T cyber security action plan should be presented at the October Committee meeting. ▪ The revised plan from Internal Audit should show the linkages to the Trust's Refresh, Restore, Recover processes and be presented back to the Committee in October 2020. ▪ The outcome of the Trust annual accounts debrief meeting with the External Auditors will be presented at the October Committee meeting.	
Items referred to the Board or another Committee for decision or action	
Item	**Referred to**
▪ There were no matters the Committee needed to refer to the Board for action. However, the Committee asked the Board take particular note of the Committee's annual report which provides a useful summary of their work over the previous year.	

Western Sussex Hospitals NHS Foundation Trust

To: Trust Board Date: August 2020

From: Chair of the Audit Committee Agenda Item: 13.1

FOR ENDORSEMENT

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

1.00 INTRODUCTION

1.01 The purpose of this report is to formally report to the Board on the work of the Audit Committee during the period 1 April 2019 to 31 March 2020 and to set out how the Committee has met its terms of reference and key priorities.

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

2.00 EXECUTIVE SUMMARY

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

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

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

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

2.05 The Committee was pleased to see the use of the Trust's Board Assurance Framework within each Board Committee meeting shaping their assurance reporting to the Board. The Audit Committee undertook a focused review of the people risks and was able to report positively to the Board on the processes for their oversight.

3.00 COMMITTEE MEMBERSHIP AND MEETINGS

- 3.01 The Committee comprises solely of independent Non-Executive Directors in line with the Code of Governance for Foundation Trusts. There are three Non-Executive Directors who are allocated to the Committee although all Non-Executive Directors, except the Chair, can attend the meeting. Following the implementation of the management contract with BSUH in 2017/18, the Non-Executive Directors on the BSUH Audit Committee also sit as advisers on the WSHT Audit Committee. This strengthens the oversight that the Committee is able to provide and ensures consistency of approach and shared learning.

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

3.03 The table below details the membership and attendance of Committee members in respect of the period 1 April 2019 to 31 March 2020.

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

3.04 In order to share learning and to ensure linkages are made across Trust Committees the membership of the Audit Committee includes the Chair of the Quality and Risk Committee (Joanna Crane) and the Chair of the Finance and Performance Committee (Lizzie Peers).

4.00 CYCLE OF BUSINESS

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

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

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

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

5.00 INTERNAL AUDIT

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

5.02 The Trust's Internal Auditor is BDO LLP who were reappointed following a successful tender process.

5.03 The Internal Audit plan for 2019/20 was approved by the Audit Committee in April 2019. Performance against the approved plan is attached as **Appendix A**. The plan was based upon discussions held with management and the Audit Committee and was constructed in such a way as to gain a level of assurance on the main financial and management systems reviewed.

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

5.05 During the year the Audit Committee received 10 finalised Internal Audit reports, with those in draft and in progress being carried forward to 2019/20. Internal Audit Reports receive two Assurance ratings; one relates to the Design of the system being reviewed while the other relates to the Effectiveness of the system being reviewed. Internal Audit can provide Assurance Levels of: 'substantial', 'moderate', 'limited' or 'no' assurance. Of the audits relevant to this period two received substantial assurance for both design and effectiveness. There was one limited assurance opinion and the remainder received moderate assurance. For this area specifically, actions to address their findings were confirmed by Internal Audit to be underway. None of the audits received Limited Assurance for both 'design' and 'Effectiveness' of the system.

5.06 Based on work undertaken during the period of this report the Head of Internal Audit has stated in his Head of Internal Audit Opinion that "Overall, we are able to provide moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently". This level of opinion is the same as provided for the previous year, 2018/19.

5.07 In forming their opinion they took into account that, the Trust had delivered its control total, that the majority of audits provided moderate assurance including the key audits of key financial systems & Ledger Implementation and data security & protection toolkit. In respect of all recommendations made, actions to address their findings were confirmed by Internal Audit to be underway.

5.08 Internal Audit also reflected that the Trust has a good record in implementing internal audit recommendations and through their testing they had confirmed closure of nearly all prior year recommendations. There is currently 1 remaining audit at draft report stage; the outcome has been taken into consideration for the overall audit opinion. This have not yet been finalised due to the operational impact of Covid-19 on the Trust.

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

6.00 LOCAL COUNTER FRAUD SERVICE (LCFS)

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

6.02 A work plan for 2019/20 was agreed with the Finance Director and approved at the Audit Committee in April 2019. The work plan outlined the core Local Counter Fraud Specialist

(LCFS) activities to be undertaken during the financial year within the agreed resources. Key activities undertaken include areas of strategic governance, inform and involve, prevent and deter and hold to account.

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

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

6.05 The Local Counter Fraud Specialist reports annually on behalf of the Trust to the Counter Fraud Authority in relation to compliance against the Standard for Providers. The Trust has again achieved an overall status of GREEN for the year 2019/20 as shown below:

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

7.00 YEAR END REPORTING

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

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

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

7.04 The submission of the 2019/20 Accounts and Annual Report took place on the 24 June 2020. Although this was in line with the national timetable it was sometime later than originally anticipated.

8.00 EXTERNAL AUDIT

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

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

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

Area of Work	Conclusion
Opinion on the Trust's:	
Financial statements	Unqualified opinion – the financial statements give a true and fair view of the state Trust's affairs as at 31 March 2020 and of its income and expenditure for the year then ended.
Parts of the remuneration and staff report to be audited	There were no matters to report.
Consistency of the information in the performance report and accountability report with the financial statements	Financial information in the performance report and accountability report and published with the financial statements was consistent with the Annual Accounts.
Reports by exception:	
Consistency of Annual Governance Statement	The Governance Statement was consistent with External Audit's understanding of the Trust.
Consistency of the Annual Report within knowledge we have acquired during the course of our audit	There were no matters to report.
Referrals to NHS Improvement (formerly Monitor)	There were no matters to report.
Public interest report	There were no matters to report in the public interest.
Value for money conclusion	There were no matters to report
Reporting to NHS Improvement (formerly Monitor) on the Trust's consolidation schedules	External audit concluded that the Trust's consolidation schedules agreed to the Trust's audited financial statements.
Reporting to the National Audit Office (NAO) in line with group instructions	There were no matters to report.

8.04 It is normal practice for there to be a full debrief to the Audit Committee following the submission of the year-end accounts. The Audit Committee have identified a number of areas for reflection that they will expect to see addressed in this years' debrief.

9.00 Reporting to the Trust Board

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

10.00 Engagement with the Council of Governors

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

10.02 On 03 October 2019, the Chair reported to the Council of Governors on the work of the Audit Committee. The update also provided the Council of Governors with a report on the performance of the External Auditor, Ernst & Young across the year 2018/19.

11.00 Conclusion

11.01 The Audit Committee of Western Sussex Hospitals NHS Foundation Trust is of the view that it has taken appropriate steps to perform its duties as delegated by the Board and it has no cause to raise any issues of significant concern with the Board arising from its work during 2019/20.

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

11.03 The Audit Committee supported the work undertaken by the Board as it recognised the challenges facing the Trust in managing the Covid-19 issues and the decision of the Board to proactively adjust its Board and Committee Governance processes, to ensure they were appropriately focused. This was supported by an increased frequency of Quality Assurance Committee meetings to maintain a focus on quality in line with the Board's risk appetite. The Audit Committee like the Board and other Committees embraced the use of technology to enable it to function effectively and continue to meet and deliver against its terms of reference.

11.04 During 2020/21, the Committee will keep under review its working arrangements and ensure it continues to develop its own practice to improve its own effectiveness.

12.00 Recommendations

12.01 The Board is asked to:

- **Note** this Annual Report.

Jon Furmston
Chair of the Audit Committee
July 2020

APPENDIX A: INTERNAL AUDIT OPERATIONAL PLAN 2019/20

Audit	Exec Lead	Due Date	Planning	Field work	Reporting	Date received by the Audit Committee
Medical Rostering	Medical Director	Q1	✔	✔	✔	04 July 2019
Bed Management	Chief Operating Officer	Q1	✔	✔	✔	03 October 2019
Patient Experience	Director of Nursing	Q1	✔	✔	✔	03 October 2019
Sickness Absence Management	Director of HR	Q1	✔	✔	✔	03 October 2019
Medical Device Management	Chief Nurse	Q2	✔	✔	✔	03 October 2019
Medicines Management	Chief Nurse	Oct	✔	✔	✔	10 January 2020
Key Financial Systems	Director of Finance	Nov	✔	✔	✔	10 January 2020
Falls Pathway	Chief Nurse	Nov	✔	✔	✔	10 January 2020
Cyber Security **	Information Management & Technology Director	Jan	✔	✔	✔	20 April 2020
Data Security & Protection Toolkit **	Information Management & Technology Director	Feb	✔	✔	✔	20 April 2020
Charitable Funds	Director of Finance	Feb	✔	✔	✔	Draft 20 April 2020 Final 09 July 2020

** Audits were undertaken jointly with Brighton & Sussex University Hospitals NHS Trust

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	14	**Meeting:**	Trust Board	**Meeting Date:**	6 Aug 2020
Report Title:	**Board Assurance Framework – 2020/21**				
Sponsoring Executive Director:	Glen Palethorpe, Group Company Secretary				
Author(s):	Glen Palethorpe, Group Company Secretary				
Report previously considered by and date:	The relevant risks have been considered by Quality Assurance Committee 30 July 2020 Finance and Performance Committee 30 July 2020				
Purpose of the report:					
Information		☐	Assurance		✓
Review and Discussion		☐	Approval / Agreement		✓
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability		✓
Our People		✓	Quality		✓
Systems and Partnerships		✓			
Any implications for:					
Quality	Quality related strategic risks				
Financial	Finance related strategic risks				
Workforce	Workforce related strategic risks				
Link to CQC Domains:					
Safe		✓	Effective		✓
Caring		✓	Responsive		✓
Well-led		✓	Use of Resources		✓
Communication and Consultation:					
The Board Assurance Framework has been prepared in conjunction with each of the five Chief Officers, focussing on respective strategic objectives and determining their associated strategic risks.					
Executive Summary:					

Introduction

The Trust has identified 13 strategic risks which have been assessed against the Trust's risk appetite when setting their target score. The Trust's risk appetite statements are under review and in setting the target risk scores reflect the Board's view in respect of patient treatment times being aligned to their clinical priority and need rather than solely being driven by the duration of the wait.

The scoring of the strategic risks for Quarter 1 (the opening score for 2020/21) has taken into account the changing environment the Trust is operating within post Covid. There have been two risks added to the BAF for 2020/21, both are these are within the people section of the BAF. The first 3.2 relates to the cultural risk that may occur through the merger, but this risk score is being mitigated to its target score and the second 3.4 relates to the risk to staff wellbeing resulting from increased demands brought about by the pandemic and whilst many actions have been taken further work is being undertaken through the Trust's Refresh, Restoration and Recovery plans.

The highest current risk score is risk 5.3 which is in relation to the Trust's consistent delivery of the NHS Constitutional targets, which like all NHS providers; have been impacted following implementation of the national requirements to cease certain activities during the pandemic. As

with a number of the BAF risks, the plans to mitigate this risk will be delivered through Trust's Refresh, Recovery and Restoration plans.

BAF SUMMARY

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Opening risk			Risk Scores											
				Q2			Q3			Q4			Target		
	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
1. Patient ***Quality Assurance Committee***															
1.1 We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact, and loss of market share in the period of recovery and restoration post the covid-19 pandemic.	3	3	**9**										3	2	**6**
2. Sustainability ***Finance and Performance Committee***															
2.1 We are unable to align or invest in our workforce, finance, estate and IM&T infrastructure effectively to support operational resilience, deliver our strategic and operational plans and improve care for patients	4	3	**12**										4	2	**8**
2.2 We cannot deliver ongoing efficiencies and flex our resources in an agile way resulting in an increasing or unmanaged deficit and inefficient, unaffordable and unsustainable services	4	3	**12**										4	2	**8**
2.3 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties	4	2	**8**										4	2	**8**
3. People ***Quality Assurance Committee and Board***															
3.1 We are unable to develop and sustain the leadership and organisational capability and capacity to lead on-	4	3	**12**										4	2	**8**

going performance improvement and build a high performing organisation.															
3.2 We are unable to effect cultural change and involve and engage staff in a way that leads to continuous improvements in patient experience, patient outcomes, and staff morale and wellbeing	4	2	**8**									**4**	2		**8**
3.3 We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of staff adversely impacting on patient experience and the safety, quality and sustainability of our services	3	3	**9**										3	2	**6**
3.4 We are unable to consistently meet the health, safety and wellbeing needs of our staff as we recover and restore services in line with CV-19 restrictions	4	3	**12**										4	2	**8**
4. Quality Improvement ***Quality Assurance Committee***															
4.1 We are unable to deliver and demonstrate compliance with regulatory requirements or clinical standards adversely impacting on patient safety and our registration and accreditation by regulatory and supervisory bodies	3	3	**9**										3	2	**6**
4.2 We are unable to deliver service improvements and improve safety, care quality and outcomes for our patients or demonstrate that our services are clinically effective	3	3	**9**										3	2	**6**
5. Systems and Partnerships ***Finance and Performance Committee***															

5.1 We are unable to develop and maintain collaborative relationships with partner organisations based on shared aims, objectives, and timescales leading to an adverse impact on our ability to operate efficiently and effectively within our health economy	4	3	**12**										4	2	**8**
5.2 We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability.	4	3	**12**										4	2	**8**
5.3 We are unable to deliver and demonstrate consistent compliance with operational and NHS constitutional standards resulting in an adverse impact on patient care and financial penalties	4	5	**20**										4	2	**8**

Key Recommendation(s):

The Board is asked to consider the current risk scores in light of the assurances provided by the respective oversight committees and the assurances received directly at the Board and agree the current scores are fairly represented.

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	15	**Meeting:**	Trust Board	**Meeting Date:**	06 Aug 20
Report Title:	Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) 2019-2020 Overview				
Sponsoring Executive Director:	Jennie Shore, Human Resources Director				
Author(s):	Jennie Shore, Human Resources Director				
Report previously considered by and date:					
Purpose of the report:					
Information	☐		Assurance		X
Review and Discussion	☐		Approval / Agreement		X
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality		☐
Patient confidentiality	☐		Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care	X		Sustainability		☐
Our People	X		Quality		X
Systems and Partnerships	☐				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	☐		Effective		X
Caring	☐		Responsive		X
Well-led	X		Use of Resources		X

Communication and Consultation:

Executive Summary:

This Report provides an overview of the annual Workforce Race Equality Standard (WRES) and annual Workforce Disability Standard (WDES).
The full reports are included as appendices to the presentation.

Appendix 1: Workforce Race Equality Standard Report 2019/20
Appendix 2: Workforce Disability Standard Report 2019/20

Key Recommendation(s):

The Board is asked to **APPROVE** the annual WRES report and make recommendations to be incorporated into the current WRES action plan 2018-2021

The Board is asked to **APPROVE** the annual WDES report and make recommendations to be incorporated into the current WRES action plan 2019-2021

Western Sussex Hospitals NHS Foundation Trust

Workforce Race Equality Scheme (WRES)

Workforce Disability Standard (WDES)

Board overview – July 2020

Jennie Shore
HR Director

NHS
Western Sussex Hospitals
NHS Foundation Trust

Workforce Race Equality Scheme

- Introduced in the NHS to address the inequalities of black and minority ethnic (BME) staff compared to their white colleagues
- Requires NHS organisations to close the gap between BME and white staff experience across nine key indicators
- Mandated through the NHS Standard Contract in 2015/16
- Published on the Trust website
- Improvement against the WRES action plan is integral to the Workforce 3R's Programme and monitored through the Diversity Matters Group

WRES indicators

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

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

WRES Indicator	Metric Description		2016 Score	2017 Score	2018 Score	2019 Score	2020 Score	Direction
2	Relative likelihood of White applicants being appointed from shortlisting compared to that of BME applicants		1.35	1.15	1.22	1.22	1.32	Deteriorated
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process		1.56	2.09	1.74	0.07	0.96	No detriment
4	Relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff		0.89	1.03	0.91	0.90	1.00	No change
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	BME White	35.0% 29.5%	32.2% 29.0%	32.3% 29.4%	36.1% 29.2%	37.8% 27.6%	Deteriorated Improved
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME White	23.5% 24.6%	23.3% 23.7%	25.5% 23.2%	24.9% 22.9%	24.9% 24.0%	No change Deteriorated
7	Percentage believing that the Trust provides equal opportunities for career progression or promotion	BME White	85.8% 89.4%	84.3% 92.0%	83.6% 90.3%	82.7% 89.8%	81.0% 88.5%	Deteriorated Deteriorated
8	In the last 12 months have you personally experienced discrimination at work?	BME White	13.4% 7.05%	11.5% 6.3%	11.4% 5.9%	14.3% 6.3%	13.1% 6.3%	Improved No change
9	Percentage of BME Board membership		0.0%	0.0%	6.7%	6.7%	0.0%	Deteriorated

Indicators 2-4 (source: trust data)

BME staff were relatively:

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

Indicators 5-8 (source: Staff Survey)

BME staff reported a worse experience than white staff for two of the NHS staff survey questions. There has been improvement in indicator 8 and indicator 6 remains unchanged

Indicator 9 (source: ESR)

BME representation on the board is not representative of the 16.7% BME workforce.

Workforce Disability Equality Scheme

- Introduced to improve both the number of disabled people in employment and their experience in the workplace compared to non disabled people
- Includes people with a hidden disability
- Requires us to close the gap between disabled and non disabled staff experience across ten metrics
- Mandated through the NHS Standard Contract from 1 April 2019
- Restricted for the first 2 years to NHS and Foundation Trusts
- Published on the Trust website
- Improvement against the WDES action plan is integral to the Workforce 3R's Programme will be monitored through the Diversity Matters Group

WDES metrics

Metric 1

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

Metric 2

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

Metric 3

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

Metric 4a

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

Metric 4b

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

Metric 5

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

Metric 6

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

Metric 7

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

Metric 8

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

Metric 9a

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

Metric 9b

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

Metric 10

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

WDES Metric	Metric Description		2019 Score	2020 Score	Direction
1	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM compared with the percentage of staff in the overall workforce		2.5%	2.9%	Improved
2	Relative likelihood of disabled staff being appointed from shortlisting compared to that of non disabled staff being appointed from shortlisting across all posts		0.92	1.85	Deteriorated
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure		No cases	No cases	No detriment

Monitoring data – 27.8% of staff have not declared their disability status compared to 30.2% in 2019. This is an improved position and follows the introduction of ESR Self Service where individuals can update their status.

Metrics 1 – 3 (source: trust data)
Disabled staff were relatively:

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

WDES Metric	Metric Description		2019 Score	2020 Score	Direction
4a	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from – patients, service users, their relatives or other members of the public	Disabled Non disabled	36.2% 29.0%	36.7% 27.6%	Deteriorated
4a	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from – managers	Disabled Non disabled	19.0% 9.6%	18.3% 9.8%	Improved
4a	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from – colleagues	Disabled Non disabled	29.3% 15.7%	29.5% 16.5%	Deteriorated
4b	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Disabled Non disabled	49.4% 48.5%	44.2% 44.9%	Improved
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion	Disabled Non disabled	83.5% 89.6%	80.4% 88.6%	Deteriorated
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Disabled Non disabled	33.3% 24.1%	35.5% 23.5%	Deteriorated
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	Disabled Non disabled	37.5% 52.2%	40.1% 55.8%	Improved
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work		75.5%	73.1%	Deteriorated
9a	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation	Disabled Non disabled	6.9% 7.3%	6.9% 7.4%	No change
9b	Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?		Yes	Yes	
10	Percentage difference between the organisation's board voting membership and its organisation's overall workforce	Disabled Non disabled	-2.5%	-2.5%	No change

Metrics 4-9a (source: Staff Survey)
Whilst there has been improvement in three metrics, disabled staff reported a worse experience than non-disabled staff across all relevant NHS staff survey questions

Metric 10 (source: ESR)

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	15.2	**Meeting:**	Trust Board	**Meeting Date:**	06 Aug 20
Report Title:	Appendix 1: Workforce Race Equality Standard (WRES) 2019-2020				
Sponsoring Executive Director:	Jennie Shore, Human Resources Director				
Author(s):	Nikki Kriel, Organisational Development Manager David Clayton-Evans, Interim Head of Charity				
Report previously considered by and date:	Diversity Matters Group (DMG) 21/07/20 Celebrating Cultures Network 06/07/20				
Purpose of the report:					
Information		☐	Assurance		X
Review and Discussion		☐	Approval / Agreement		X
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		X	Sustainability		☐
Our People		X	Quality		X
Systems and Partnerships		☐			
Any implications for:					
Quality	Excellent care is far more likely to meet the needs of all patients when the workforce is drawn from diverse communities which is reflective of the population served, and when all our staff are themselves free from discrimination				
Financial	Increase in staff engagement and satisfaction, therefore less time and finance spent on employee relations issues and turnover				
Workforce	As described above				
Link to CQC Domains:					
Safe		☐	Effective		X
Caring		☐	Responsive		X
Well-led		X	Use of Resources		X

Communication and Consultation:

Recognising equality and celebrating diversity is an integral part of the Trusts core business, Patient First improvement programme and 'We Care' vision. Data from the findings in this report feed into the Trust's Equality objectives and annual equality report. The submission of the WRES report is mandatory in the 2015/16 Standard NHS Contract. The regulators, the Care Quality Commission (CQC) and NHS Improvement, will use the report to help assess whether NHS organisations are well-led. The Trust is required to publish annual WRES data on the Trust's website and NHS Digital Strategic Data Collection (SDCS) by 31/08/20. The revised WRES action plan is to be published on the Trusts website by 31/10/20. The National 2020 WRES Data Analysis report aims to be published in December 2020.

Executive Summary:

This report seeks to update the Trust Board on the annual WRES report (data is taken from ESR for the period 01/04/19-31/03/20 and 2019 Staff Survey results) and actions to be taken as a result of this analysis. The WRES aims to ensure employees from Black, Asian and Minority Ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The WRES compares the experience of BAME and white staff with the objective of closing the gaps highlighted by nine indicators.

Key Recommendation(s):

The Board is asked to APPROVE the annual report and make recommendations to be incorporated into the current WRES action plan 2018-2021

Western Sussex Hospitals
NHS Foundation Trust

Western Sussex Hospitals NHS Foundation Trust

Workforce Race Equality Standard 2019-20

Introduction

“It can’t be right that ten years after the launch of the NHS race-equality plan, while 41% of NHS staff in London are from Black and ethnic minority backgrounds, similar in proportion to the Londoners they serve, only 8% of trust board directors are, with two-fifths of London trust boards having no BME directors at all.

Similar patterns apply elsewhere, and have actually been going backwards”.

Simon Stevens, Chief Executive - NHS England. May 2014

The NHS has a workforce of 1.4 million people, of which 21% are from a BAME background. Whilst there is good representation of BAME people in GP, hospital doctor and nursing and midwifery roles - this does not always translate to career progression. This can be seen by the levels of BAME staff in senior management roles in the NHS in England, there are:

- 8 BAME CEOs (236 Trusts) as of March 2019
- 9 BAME Chairs as of March 2018
- 11 BAME Executive Directors of Nursing as of March 2019
- 37 BAME Medical Directors as of March 2018
- Less than 6% of very senior managers are from BAME backgrounds

The Workforce Race Equality Standard (WRES) helps to shine a light where NHS organisations are doing well and where there is need for improvement. The WRES uses statistical data to demonstrate the experience and outcomes of BAME staff compared to white staff through many stages of the employment journey. A requirement of the standard is to develop action plans to address any areas of inequity that has been highlighted by the data.

The WRES is an annual process, and helps NHS organisation demonstrate that they are making progress year-on-year by improving working conditions for BAME staff in the NHS.

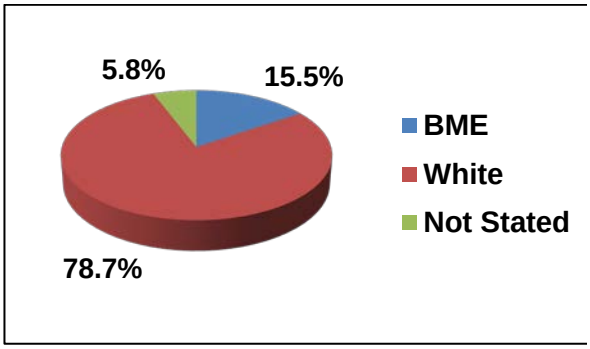
Background Information

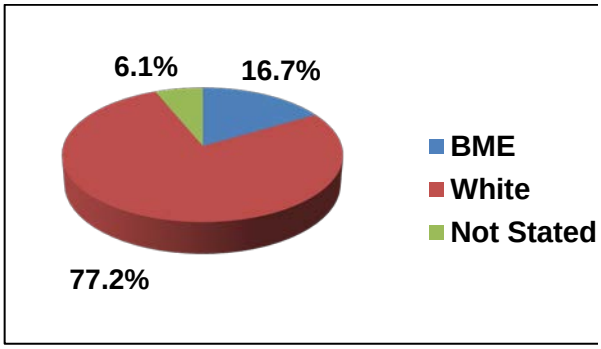
1) Total number of staff:

2018-19	2019-20
7104 headcount	7317 headcount

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

	2018-19		2019-20	
	Headcount	% of Staff	Headcount	% of Staff
White	5588	78.7%	5650	77.2%
BAME	1100	15.5%	1219	16.7%
Not Stated	416	5.8%	448	6.1%
Total	7104	100.0%	7317	100.0%





2018-19 2019-20

2) Self-reporting

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

	2018-19		2019-20	
	Headcount	% of Staff	Headcount	% of Staff
Ethnicity Declared	6688	94.2%	6869	93.9%
Ethnicity Not Declared	416	5.8%	448	6.1%
Total	7104	100.0%	7317	100.0%

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

We collect information relating to staff ethnicity as part of the recruitment process. An Electronic Staff Records (ESR) self-service process has been established to update ethnicity confidentially. Throughout 2019/2020 we ran an internal campaign encouraging staff to declare their diversity monitoring data.

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

We recognise there are ways to improve staff reporting their ethnicity. We will continue to collect information relating to staff ethnicity as part of the recruitment process. In addition, we are developing a planned approach to contact staff when their ethnicity is unknown and encourage them to declare their information confidentially.

Alignment of ESR records with the completion of staff risk assessments for our BAME staff has also provided an opportunity for staff to update their ethnicity where it was not declared.

3) Workforce Data

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

1st April 2019 to 31st March 2020.

4) Definition of BAME under WRES

In line with the categories taken from the 2001 Census:

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

5) Population Demographic 2011 Census (Southeast England)

	Census 2011
BME	9%
White	91%
Unknown	0%

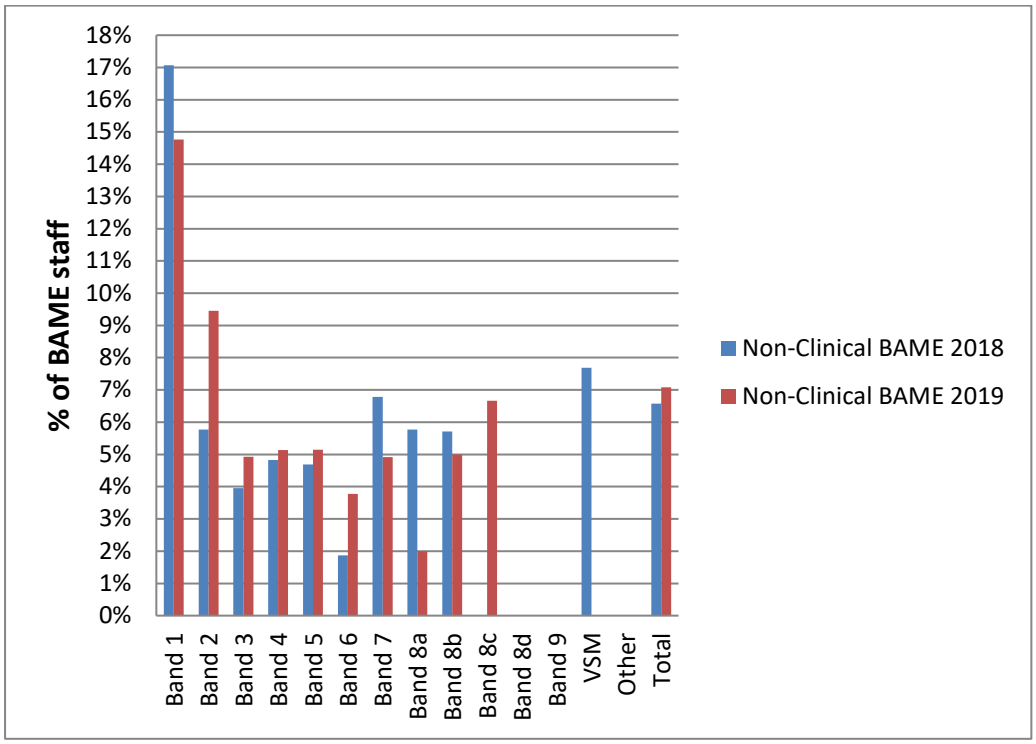
Workforce Race Equality Indicators

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

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

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

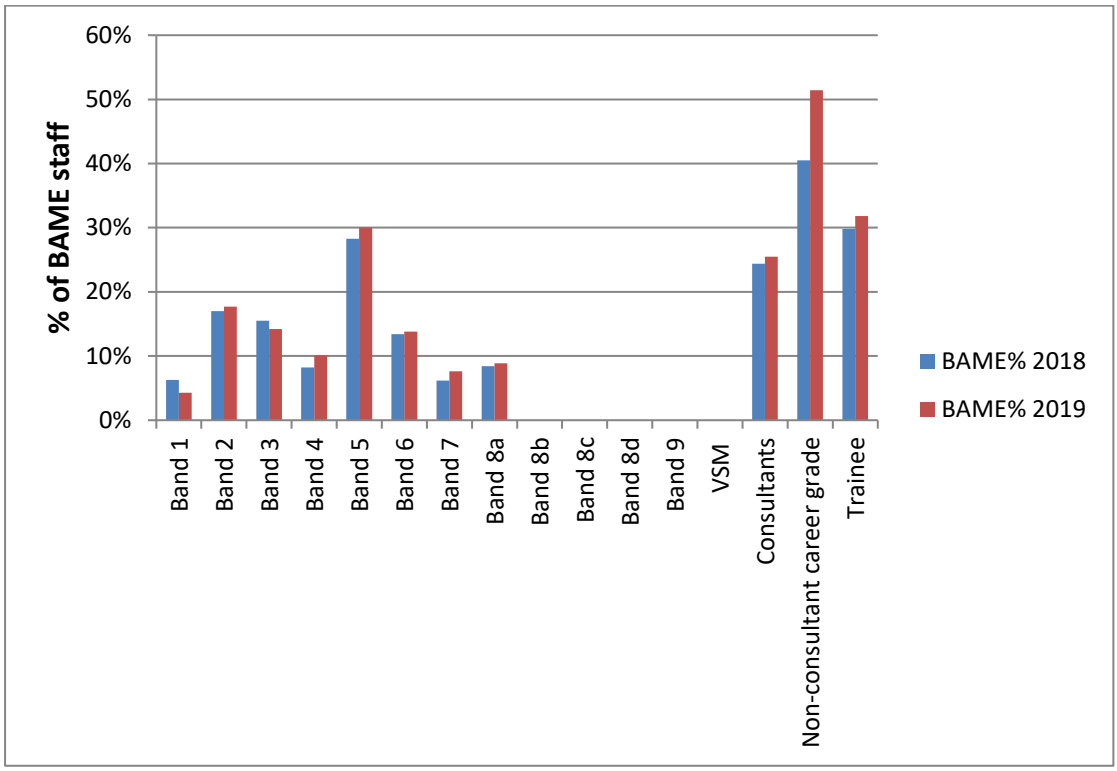
	Non-Clinical					
	White	BME	Unknown	Total	White %	BME%
Band 1	124	22	3	149	83.2%	14.8%
Band 2	586	64	27	677	86.6%	9.5%
Band 3	372	20	14	406	91.6%	4.9%
Band 4	272	15	5	292	93.2%	5.1%
Band 5	124	7	5	136	91.2%	5.1%
Band 6	99	4	3	106	93.4%	3.8%
Band 7	56	3	2	61	91.8%	4.9%
Band 8a	46	1	3	50	92.0%	2.0%
Band 8b	38	2	0	40	95.0%	5.0%
Band 8c	14	1	0	15	93.3%	6.7%
Band 8d	5	0	1	6	83.3%	0.0%
Band 9	7	0	0	7	100.0%	0.0%
VSM	11	0	2	13	84.6%	0.0%
Other	0	0	0	0	0.0%	0.0%
Total	**1754**	**139**	**65**	**1958**	**89.6%**	**7.1%**



What the data tells us:

- Apart from Band 1 and Band 2, the overall population of non-clinical BAME staff in the majority of bands is under represented compared to the overall population demographic statistics in the 2011 Census (9%).
- There is a higher representation of BAME staff in the lowest paid roles at Band 1 (14.8 %) and Band 2 (9.5%). This has decreased for Band 1 roles in line with Agenda for Change Refresh, as Band 1 positions are being phased out by March 2021.
- All other bands are underrepresented by BAME staff.
- Due to the low numbers of overall colleagues In the VSM category, one member of staff leaving the Trust between 2018/19 to 2019/20, has created the percentage change from 7% down to 0%.

	Clinical					
	White	**BAME**	**Unknown**	**Total**	**White %**	**BAME%**
Band 1	19	1	3	23	82.6%	4.3%
Band 2	825	195	82	1102	74.9%	17.7%
Band 3	216	38	14	268	80.6%	14.2%
Band 4	136	16	7	159	85.5%	10.1%
Band 5	717	362	126	1205	59.5%	30.0%
Band 6	817	138	43	998	81.9%	13.8%
Band 7	505	44	32	581	86.9%	7.6%
Band 8a	97	10	6	113	85.8%	8.8%
Band 8b	28	0	1	29	96.6%	0.0%
Band 8c	9	0	0	9	100.0%	0.0%
Band 8d	2	0	0	2	100.0%	0.0%
Band 9	2	0	0	2	100.0%	0.0%
VSM	3	0	0	3	100.0%	0.0%
Consultants	265	97	19	381	69.6%	25.5%
Non-consultant career grade	57	71	10	138	41.3%	51.4%
Trainee	193	108	39	340	56.8%	31.8%
Other	5	0	2	7	71.4%	0.0%
Total	**3896**	**1080**	**384**	**5360**	**72.7%**	**20.1%**



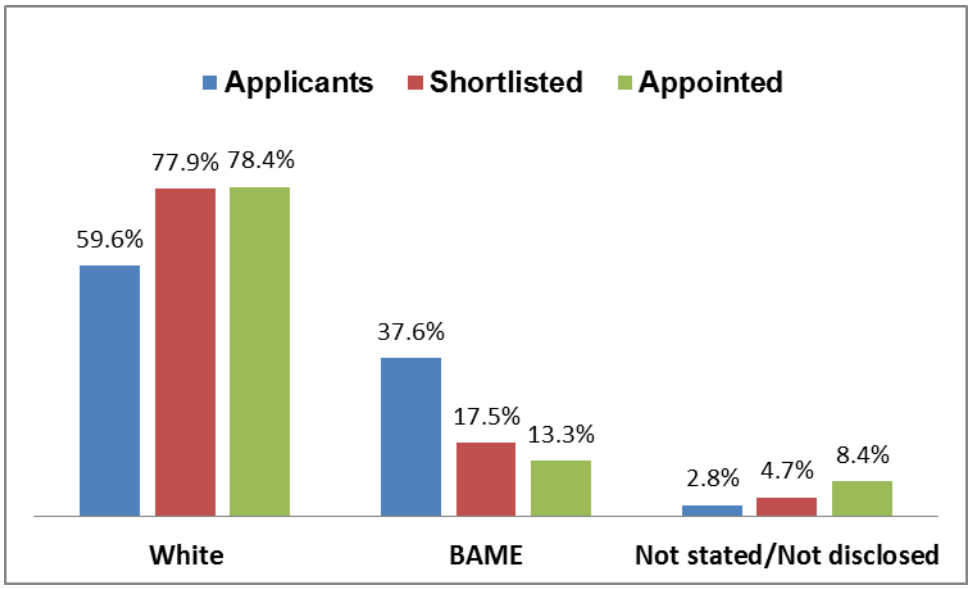
What the data tells us:

- The overall population of clinical BAME staff is more than the overall population statistics in the 2011 Census (9%). There has been an overall increase in the percentage (1.4%) of non-clinical BAME staff when comparing to 2018-19.
- There is a higher representation of BAME staff in clinical roles, which can be attributed to the diverse nationalities employed, our overseas recruitment campaigns in recent years and also follows the national trend. The highest representation is at non-consultant career grade at 51.4%.
- There continues to be a higher representation for clinical roles for BAME staff at Bands 5 (i.e. Staff Nurse) and Bands 2/3 (i.e. Healthcare Assistants). This represents the starting point for these roles with many staff not progressing beyond this. This requires targeted action to improve career progression.

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

Data for indicator 2 has been produced using twelve months for non-medical staff and ten months data for medical staff. This is due to the period when the original data was extracted from the Trac system in March 2020 not being accurate and when the data was re extracted in June 2020 the system only provided a data set for a 10 month period.

	Applicants		Shortlisted		Appointed		Relative Likelihood of being appointed
	Number	%	Number	%	Number	%	
White	6762	59.6%	2381	77.9%	597	78.4%	**0.250735**
BAME	4266	37.6%	534	17.5%	101	13.3%	**0.189139**
Not stated/ Not disclosed	321	2.8%	142	4.7%	64	8.4%	**0.450704**
Total	**11349**	**100%**	**3057**	**100%**	**762**	**100%**	



The likelihood of white candidates being appointed from shortlisting:
597 / 2381 = 0.250735

The likelihood of BAME candidates being appointed from shortlisting:
101 / 534 = 0.189139

The relative likelihood of white candidates being appointed from shortlisting compared to BAME staff is 0.250735 (white candidates) / 0.189139 (BAME candidates) = 1.32 times.

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

What the data tells us:

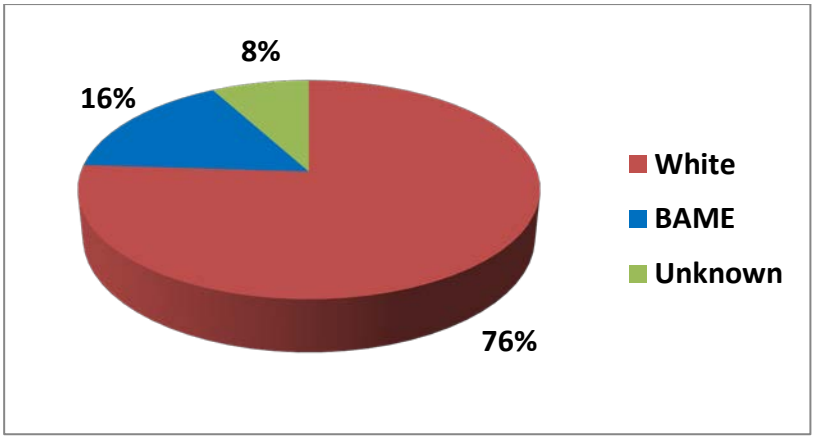
In 2018-19 the relative likelihood was 1.22 (in favour of white candidates) and this has increased to 1.32 in 2019- 2020.

When reviewing the data of those applicants who are successfully shortlisted from the application stage the data shows those from a BAME background are less likely to reach the shortlisting stage. This is an area further investigation is required to understand why improvement is not being seen.

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

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

	Disciplinary Procedures 2018/19	Disciplinary Procedures 2019/20	Total number of procedures	Number in Workforce	Relative Likelihood of entering procedure
White	27	41	68 (76%)	5650	0.012035
BAME	3	11	14 (16%)	1219	0.011485
Unknown	4	3	7 (8%)	448	0.015625



The likelihood of white staff entering the formal disciplinary process:
68 / 5650 = 0.012035

The likelihood of BAME staff entering the formal disciplinary process:
14 / 1219 = 0.011485

The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff is: 0.011485 (BAME Staff) / 0.012035 (White Staff) = **0.96 times.**

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

What the data tells us:

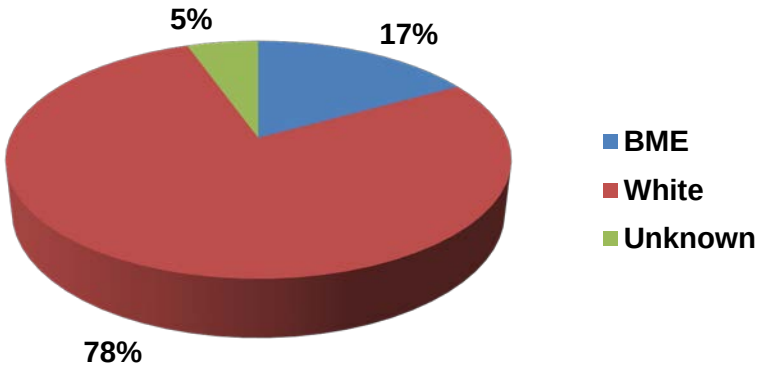
The 2018/19 WRES report included informal and formal disciplinary cases. This has been amended in the 2019/20 report to only record formal disciplinary cases over a 2 year rolling period and is in line with national guidance. In this report we can see there has been a significant increase in both BAME and White staff entering the formal disciplinary process.

In 2019/20 we saw significant increases for disciplinary action related to the following three areas: staff Absent With Out Leave (AWOL), staff behaviour and information governance breaches. In two of these three increasing areas of activity no BAME staff entered the disciplinary process at all in 2019/20. It is believed the increase in behaviour related cases reflects the work the Trust has done on reducing abusive behaviours and the launch of its above/below the line approach during the year which has helped focus attention in this area and given managers greater confidence to have discussions with staff and progress actions.

Furthermore, where disciplinary action is required, panels are constituted to include representation from BAME representatives to ensure there is no unconscious bias.

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

	Number in workforce	No. of staff accessing non-mandatory/CPD training	Relative likelihood of accessing non-mandatory/CPD training
White	5650	4955 (78%)	0.876991
BME	1219	1064 (17%)	0.872847
Unknown	448	370 (5%)	0.825892
Total	7317	6389	



What the data tells us:

The data supplied for 2019-20 related to applications for education funding submitted by allied health professionals and nursing and midwifery staff.

Likelihood of white staff accessing non-mandatory/CPD training:
4955 / 5659 = 0.876991

Likelihood of BAME staff accessing non-mandatory/CPD training:
1064 / 1219 = 0.872847

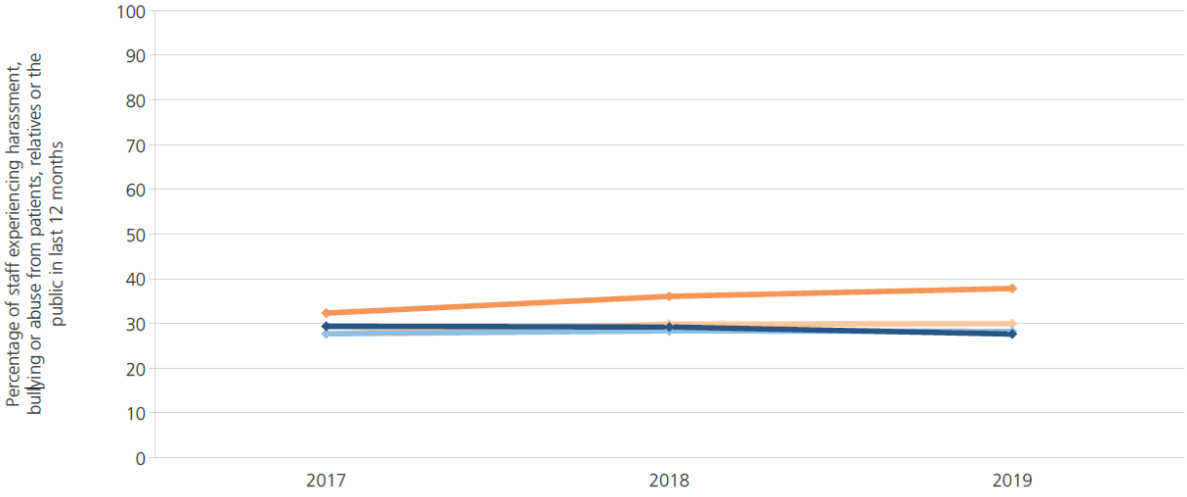
Relative likelihood of white staff accessing non-mandatory/CPD training compared to BAME staff: 0.876991 (White Staff) / 0.872847 (BAME Staff) = **1.00 times.**

In this instance the data suggests white and BAME are just as likely to have access to non-mandatory / CPD training.

In the 2018-19 report the relative likelihood was 0.90 (in favour of BAME staff), and is now equal for both white and BAME staff.

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

Staff Survey	White Staff		BAME Staff	
	WSHFT staff	Acute Average	WSHFT staff	Acute Average
2017	29.4%	27.7%	32.3%	27.7%
2018	29.2%	28.4%	36.1%	29.8%
2019	27.6%	28.2%	37.8%	29.9%



	2017	2018	2019
White: Your org	29.4%	29.2%	27.6%
BME: Your org	32.3%	36.1%	37.8%
White: Average	27.7%	28.4%	28.2%
BME: Average	27.7%	29.8%	29.9%
White: Responses	3,763	3,583	3,137
BME: Responses	597	624	571

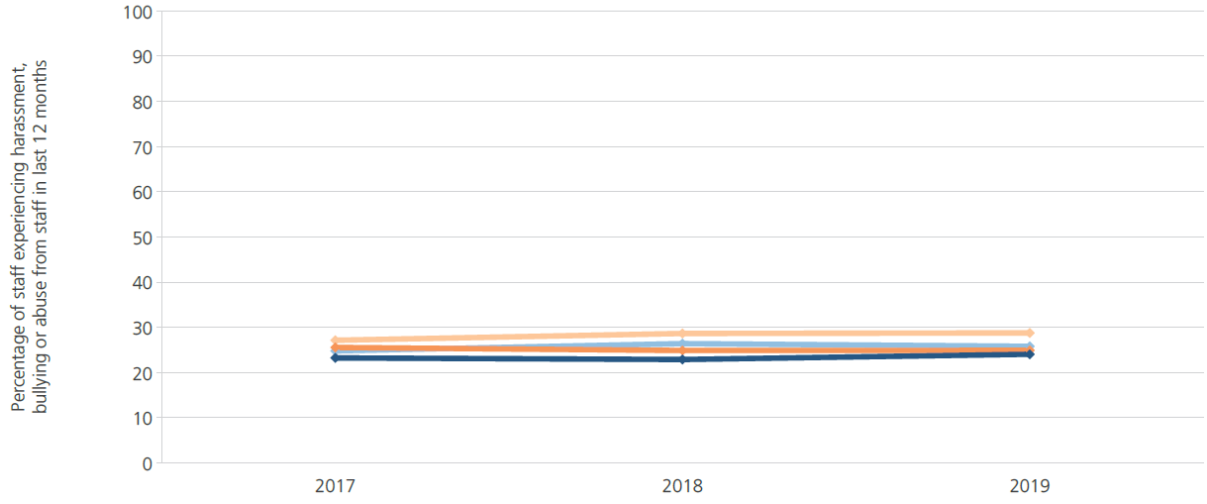
Average calculated as the median for the benchmark group

What the data tells us:

Both white and BAME staff experience harassment, bullying or abuse from patients, relatives or the public above the national average. It would appear year on year, from 2017 to 2019, the percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public has increased, whilst there has been a slight decrease for white staff. The number of our BAME staff experiencing harassment, bullying or abuse from patients is significantly higher than the national average.

Indicator 6 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Staff Survey	White Staff		BAME Staff	
	WSHFT staff	Acute Average	WSHFT staff	Acute Average
2017	23.2%	24.8%	25.5%	27.1%
2018	22.9%	26.4%	24.9%	28.6%
2019	24.0%	25.8%	24.9%	28.8%



	2017	2018	2019
White: Your org	23.2%	22.9%	24.0%
BME: Your org	25.5%	24.9%	24.9%
White: Average	24.8%	26.4%	25.8%
BME: Average	27.1%	28.6%	28.8%
White: Responses	3,775	3,588	3,144
BME: Responses	599	627	570

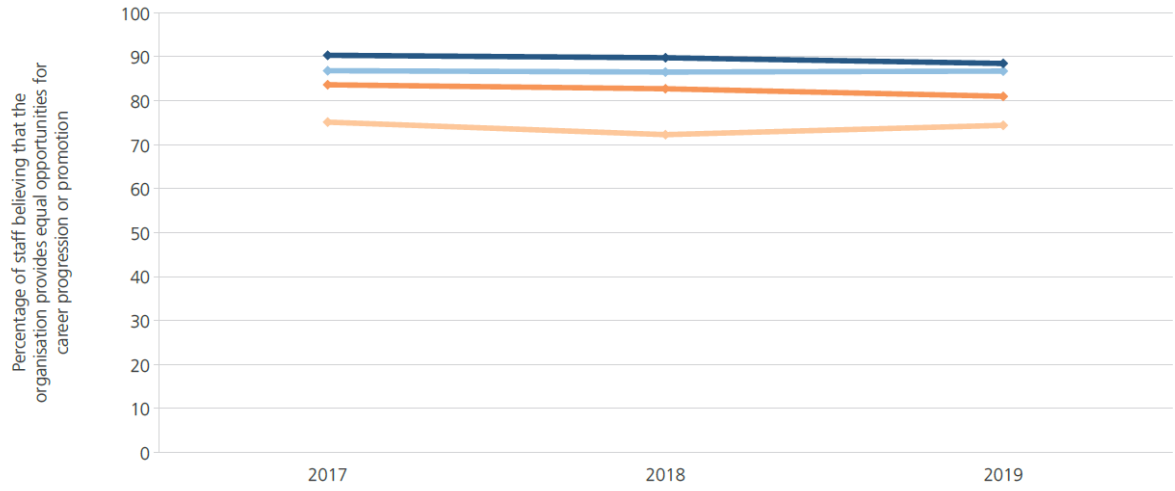
Average calculated as the median for the benchmark group

What the data tells us:

From 2018 to 2019, the percentage of BAME staff experiencing harassment bullying or abuse from staff has remained the same for the Trust. This is below the national average for acute trusts. However, for white staff there has been an increase from 2018 to 2019 and whilst this is also below the national average, it remains a worrying trend.

Indicator 7 - Percentage believing that trust provides equal opportunities for career progression or promotion

Staff Survey	White Staff		BAME Staff	
	WSHFT staff	Acute Average	WSHFT staff	Acute Average
2017	90.3%	86.8%	83.6%	75.1%
2018	89.8%	86.5%	82.7%	72.3%
2019	88.5%	86.7%	81.0%	74.4%



	2017	2018	2019
White: Your org	90.3%	89.8%	88.5%
BME: Your org	83.6%	82.7%	81.0%
White: Average	86.8%	86.5%	86.7%
BME: Average	75.1%	72.3%	74.4%
White: Responses	2,695	2,558	2,227
BME: Responses	427	422	405

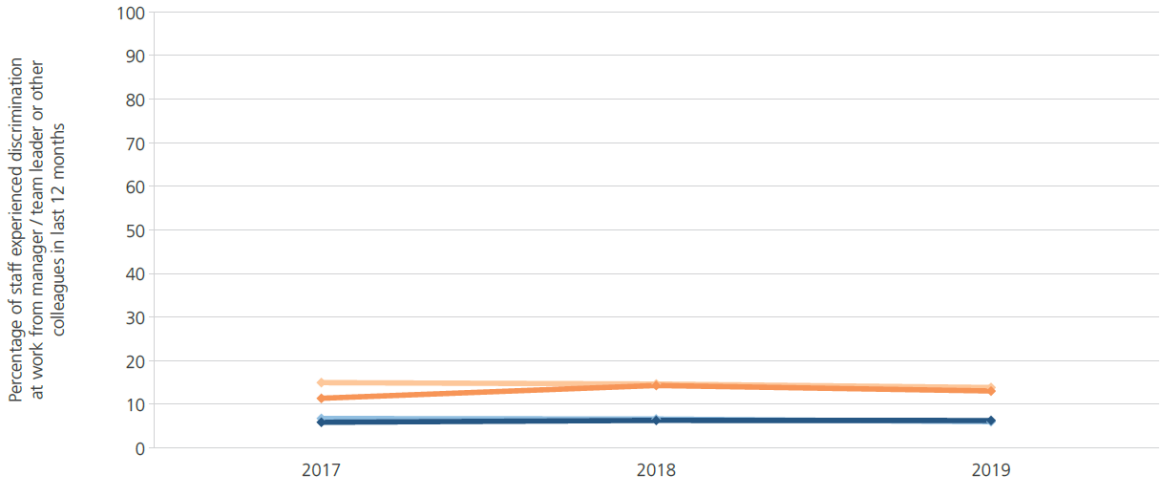
Average calculated as the median for the benchmark group

What the data tells us:

Whilst the percentage of BAME staff believing that the trust provides equal opportunities is consistently higher than the national average, it should be noted that there has been a decrease from 2018 to 2019 by -1.7%.

Indicator 8 - In the last 12 months have you personally experienced discrimination at work?

Staff Survey	White Staff		BAME Staff	
	WSHFT staff	Acute Average	WSHFT staff	Acute Average
2017	5.9%	6.7%	11.4%	15.0%
2018	6.3%	6.6%	14.3%	14.6%
2019	6.3%	6.0%	13.1%	13.8%



	2017	2018	2019
White: Your org	5.9%	6.3%	6.3%
BME: Your org	11.4%	14.3%	13.1%
White: Average	6.7%	6.6%	6.0%
BME: Average	15.0%	14.6%	13.8%
White: Responses	3,759	3,566	3,124
BME: Responses	580	622	567

Average calculated as the median for the benchmark group

What the data tells us:

The percentage of BAME staff experiencing discrimination at work from their manager/team leader or other colleagues, is slightly below the average for acute trusts, and has decreased from 2018 to 2019.

In order to drive improvements in indicator 8 the trust commissioned a corporate project to 'Reduce Abusive Behaviours' across all staff groups. During Covid-19 this project has been paused and a refresh is being undertaken.

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

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

	Overall Workforce		Executive Board Voting Membership		
	Number in workforce	**% in workforce**	**Number on board**	**% of board**	**% Difference**
BAME Staff	1219	16.7%	0	0.0%	**-16.7%**
White Staff	5650	77.2%	12	85.7%	**8.5%**
Unknown	448	6.1%	2	14.3%	**8.2%**
Total	7317	100.0%	14	100.0%	

What the data tells us:

There is no BAME representation at Executive Board level.

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

In 2019 the national NHS Staff Survey was open to all Western Sussex Hospitals substantive staff to participate in which a potential sample of circa 6,500 staff were encouraged to undertake the survey. A total of 3,864 responses were received from staff.

The Trust's Annual Equality Report is also produced and the workforce data is analysed for trends across recruitment, employee relations, training and development and demographics. The report is scrutinised and approved by the Trust's Diversity Matters Group and Quality Assurance Committee. Resulting actions feed into the Trust's Equality Objectives and the Quality Strategy.

a. Any issues of completeness of data

This report is based on information presented to the Trust's Quality Assurance Committee in July 2020.

Data for indicator 2 has been produced using twelve months for non-medical staff and ten months data for medical staff. This is due to the period when the original data was extracted from the Trac system in March 2020 not being accurate and when the data was re extracted in June 2020 the system only provided a data set for a 10 month period.

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

The 2018/19 WRES report included informal and formal disciplinary cases. This has been amended in the 2019/20 report to only record formal disciplinary cases over a 2 year rolling period and is in line with national guidance.

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	15	**Meeting:**	Trust Board	**Meeting Date:**	06 Aug 20
Report Title:	Appendix 2: Workforce Disability Equality Standard (WDES) 2019-2020				
Sponsoring Executive Director:	Jennie Shore, Human Resources Director				
Author(s):	Nikki Kriel, Organisational Development Manager David Clayton-Evans, Interim Head of Charity				
Report previously considered by and date:	Diversity Matters Group (DMG) 21/07/20 Disability Forum 14/07/20				
Purpose of the report:					
Information		☐	Assurance		X
Review and Discussion		☐	Approval / Agreement		X
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		X	Sustainability		☐
Our People		X	Quality		X
Systems and Partnerships		☐			
Any implications for:					
Quality	Excellent care is far more likely to meet the needs of all patients when the workforce is drawn from diverse communities which is reflective of the population served, and when all our staff are themselves free from discrimination				
Financial	Increase in staff engagement and satisfaction, therefore less time and finance spent on employee relations issues and turnover				
Workforce	As described above				
Link to CQC Domains:					
Safe		☐	Effective		X
Caring		☐	Responsive		X
Well-led		X	Use of Resources		X

Communication and Consultation:

Recognising equality and celebrating diversity is an integral part of the Trusts core business, Patient First improvement programme and 'We Care' vision. Data from the findings in this report feed into the Trust's Equality objectives and annual equality report. The submission of the WDES report is mandatory in the 2018/19 Standard NHS Contract. The regulators, the Care Quality Commission (CQC) and NHS Improvement, will use the report to help assess whether NHS organisations are well-led. The Trust is required to publish annual WDES data on the Trust's website and NHS Digital Strategic Data Collection (SDCS) by 31/08/20. The revised WDES action plan is to be published on the Trusts website by 31/10/20. The National 2020 WDES Data Analysis report aims to be published in December 2020.

Executive Summary:

This report seeks to update the Trust Board on the annual WDES report (data is taken from ESR for the period 01/04/19-31/03/20 and 2019 Staff Survey results) and actions to be taken as a result of this analysis. The WDES aims to ensure employees who have a disability have equal access to career opportunities and receive fair treatment in the workplace. The WDES compares the experience of Disabled and Non-Disabled staff with the objective of closing the gaps highlighted by ten indicators.

Key Recommendation(s):

The Board is asked to APPROVE the annual report and make recommendations to be incorporated into the current WDES action plan 2019-2021

Western Sussex Hospitals
NHS Foundation Trust

Western Sussex Hospitals NHS Foundation Trust

Workforce Disability Equality Standard 2019-20

Introduction

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

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

Whilst there have been improvements with societal attitudes towards people with disabilities, they have not necessarily moved as quickly as the act (and its predecessors) had intended. This being the case, there are still many inequalities surrounding the employment of workers with disabilities. The employment rate of people with disabilities is 51.3%, versus those without 81.4%, this means a difference of 30.1%. This difference is often referred to as the disability employment gap. Given that 22% of adults of working age have a disability, more needs to be done to close this gap. (Briefing Paper 7540, People with Disabilities in Employment, 30 November 2018, Andrew Powell: House of Commons Library).

Breaking down disability further the picture for people with mental ill health and learning disabilities is far worse. 1 in 4 adults and 1 in 10 children experience mental health illnesses in their lifetime (NHS England) however, the stigma around mental health is still rife within the UK. In the 2016 green paper Improving Lives: The Work, Health and Disability Green Paper, states that only 32% of people with mental illness were in work. There are approximately 1.5 million people in the UK with some form of Learning Disability, of which 17% of people of working age are in paid employment. It is estimated that 28% of adults of working age with mild or moderate learning disabilities, 10% of adults of working age with severe learning disabilities and 0% of adults of working adults with profound learning disabilities are in employment (Emerson and Hatton, 2008).

The inequalities can be vast, and may include inflexible recruitment practices that do not take the needs of the candidate's disability, providing adequate reasonable adjustments in the workplace, progression into more senior roles, overrepresentation in employee relations procedures, poor attitudes to those with a disability and poor access to development opportunities. These inequalities help to build a picture of poor employment/retention rates and experiences of employment.

The Workforce Disability Standard was introduced in April 2019 by NHS England, it was developed to demonstrate compliance with:

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

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

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

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

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

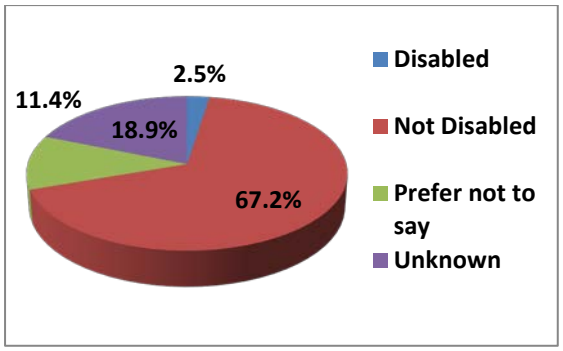
Background Information

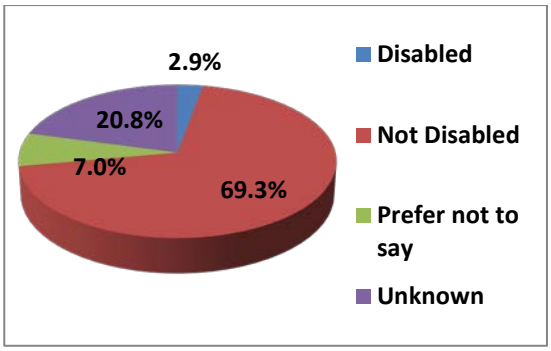
1) Total number of staff:

2019	2020
7073	7317

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

	2018-2019		2019-2020	
	Headcount	% of Staff	Headcount	% of Staff
Disabled	180	2.5%	212	2.9%
Not Disabled	4754	67.2%	5068	69.3%
Prefer not to say	803	11.4%	514	7.0%
Unknown	1336	18.9%	1523	20.8%
Total	7073	100.0%	7317	100%





2018-2019	2019-2020

2) Self-reporting

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

	2018-2019		2019-2020	
	Headcount	% of Staff	Headcount	% of Staff
Disability Status Declared	4934	69.8%	5280	72.2%
Disability Status Not Declared	2139	30.2%	2037	27.8%
Total	7073	100.0%	7317	100.0%

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

We collect information relating to disability as part of the recruitment process. The Trust has launched the Electronic Staff Records self-service facility which allows staff to update their disability status confidentially. Throughout 2019/2020 we ran an internal campaign encouraging staff to declare their diversity monitoring data.

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

We recognise there are ways to improve staff reporting their disability status. We will continue to collect information relating to staff disability as part of the recruitment process. In addition, we are developing a planned approach to contact staff when their disability is unknown and encourage them to declare their information confidentially.

3) Workforce Data

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

1 April 2019 to 31 March 2020.

4) How is disability defined under the standard?

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

5) Population Demographic 2011 Census (Southeast England)

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

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

Workforce Disability Equality Metrics

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

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

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

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

	Non-Clinical 2019-2020					
	Disabled	**Not Disabled**	**Not Known**	**Total**	**Disabled %**	**Not Disabled %**
Cluster 1	58	1068	398	1524	**3.8%**	**70.1%**
Cluster 2	5	223	75	303	**1.7%**	**73.6%**
Cluster 3	2	74	14	90	**2.2%**	**82.2%**
Cluster 4	0	33	8	41	**0.0%**	**80.5%**
Total	**65**	**1398**	**495**	**1958**	**3.3%**	**71.3%**

In the table above in the column labelled 'Disabled %' the green cells demonstrate representation is either equal or more than the general representation of disabled staff in the workforce (2.9%). The red cell details an underrepresentation when compared to the general representation of disabled staff in the workforce.

What the data tells us:

- In 2019 – 2020, there is a higher than expected representation of staff with declared disabilities in cluster 1 but this has reduced in cluster 3 (bands 8a and 8b) from the previous report (2018- 2019).

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

	Clinical 2019-2020					
	Disabled	Not Disabled	Not Known	Total	Disabled %	Not Disabled %
Cluster 1	50	1114	388	1552	3.2%	71.8%
Cluster 2	68	1923	793	2784	2.4%	69.1%
Cluster 3	5	102	35	142	3.5%	71.8%
Cluster 4	0	7	6	13	0.0%	53.8%
Cluster 5	7	254	122	383	1.8%	66.3%
Cluster 6	3	78	57	138	2.2%	56.5%
Cluster 7	14	190	136	340	4.1%	55.9%
Other	0	2	5	7	0.0%	28.6%
Total	147	3670	1542	5359	2.7%	68.5%

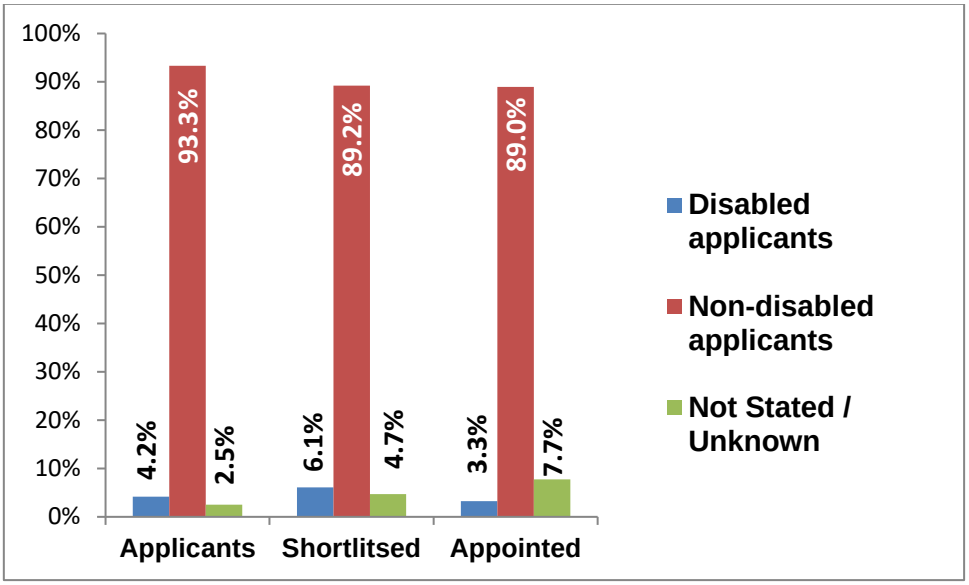
In the table above in the column labelled 'Disabled %' the green cells demonstrate representation is either equal or more than the general representation of disabled staff in the workforce (2.9%). The red cell details an underrepresentation when compared to the general representation of disabled staff in the workforce.

What the data tells us:

- There is a higher than expected representation of staff with declared disabilities in cluster 1 (bands 1-4), cluster 3 (bands 8a and 8b) and cluster 7 (Medical and Dental staff, Medical and dental trainee grades).
- For all other grades there is a lower than expected representation of staff with a declared disability.

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

	Applicants		Shortlisted		Appointed		Relative Likelihood of being appointed
	Number	%	Number	%	Number	%	
Disabled applicants	477	4.2%	186	6.1%	25	3.3%	0.134409
Non-disabled applicants	10588	93.3%	2727	89.2%	678	89.0%	0.248625
Not Stated / Unknown	284	2.5%	144	4.7%	59	7.7%	0.409722
Total	11349	100%	3057	100%	762	100%	



The likelihood of non-disabled candidates being appointed from shortlisting:
678 / 2727 = 0.248625

The likelihood of disabled candidates being appointed from shortlisting:
25 / 186 = 0.134409

The relative likelihood of non-disabled candidates being appointed from shortlisting compared to disabled staff is: 0.248625 (non-disabled candidates) / 0.134409 (disabled candidates) = **1.85 times.**

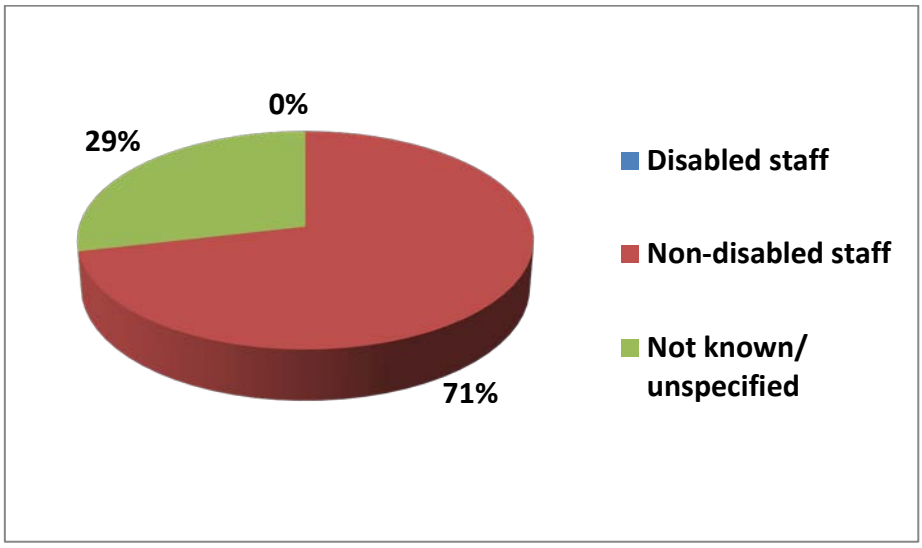
Disabled staff	1.00
Non-disabled staff	1.85

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

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

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

	Number of Capability Procedures 2018/2019	Number of Capability Procedures 2019/2020	Total number of procedures	Number in Workforce	Relative Likelihood of entering procedure
Disabled staff	0	0	0 (0%)	212	0
Non-disabled staff	1	4	5 (71%)	5068	0.000987
Not known/ unspecified	2	0	2 (29%)	2037	0.000973



The likelihood of non-disabled staff entering the formal disciplinary process:
5 / 5068 = 0.000987

The likelihood of disabled staff entering the formal disciplinary process:
0 / 212 = 0

The relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff is: 0.000000 (Disabled Staff) / 0.000987 (non-disabled Staff) = **0.0 times.**

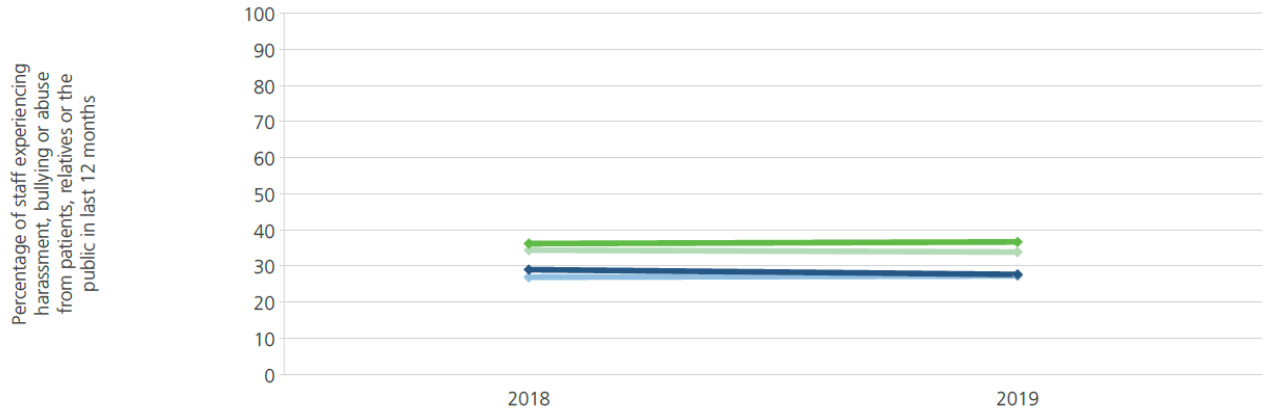
Disabled Staff		0.0
Non-disabled Staff		1.0

*In this instance no disabled staff members have entered into a capability process during the period. Therefore we are unable to reach any conclusions***.**

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

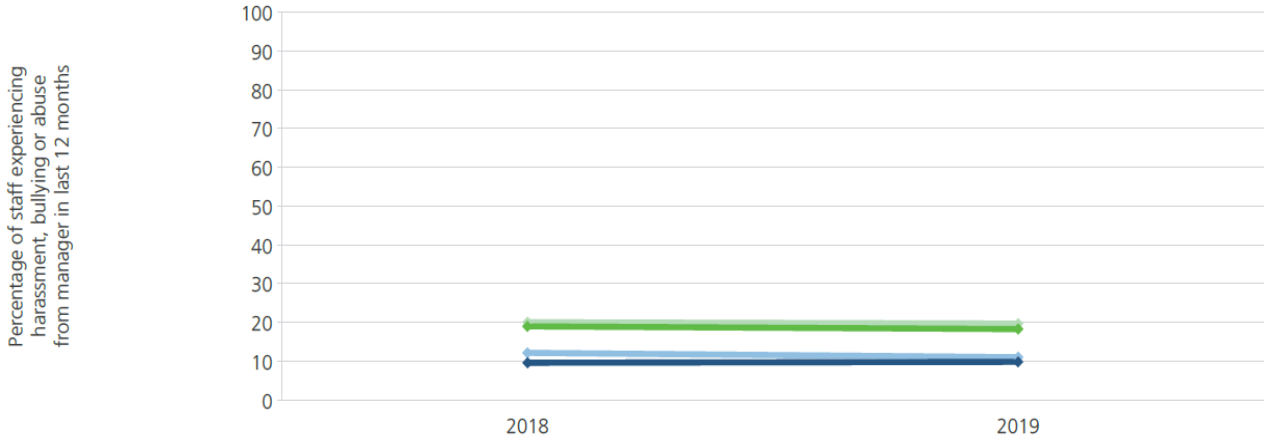
- **Patients / service users, their relatives or other members of the public**
- **Managers**
- **Other colleagues**

	Patients/service users, their relatives or other members of the public 2018-2019	Patients/service users, their relatives or other members of the public 2019-2020	Managers 2018-2019	Managers 2019-2020	Other colleagues 2018-2019	Other colleagues 2019-2020
Disabled staff	36.2%	36.7%	19.0%	18.3%	29.3%	29.5%
Non-disabled staff	29.0%	27.6%	9.6%	9.8%	15.7%	16.5%
Acute Average (Disabled)	34.4%	33.9%	20.0%	19.7%	28.3%	28.1%
Acute Average (Non-Disabled)	26.9%	27.3%	12.1%	11.0%	18.9%	18.4%



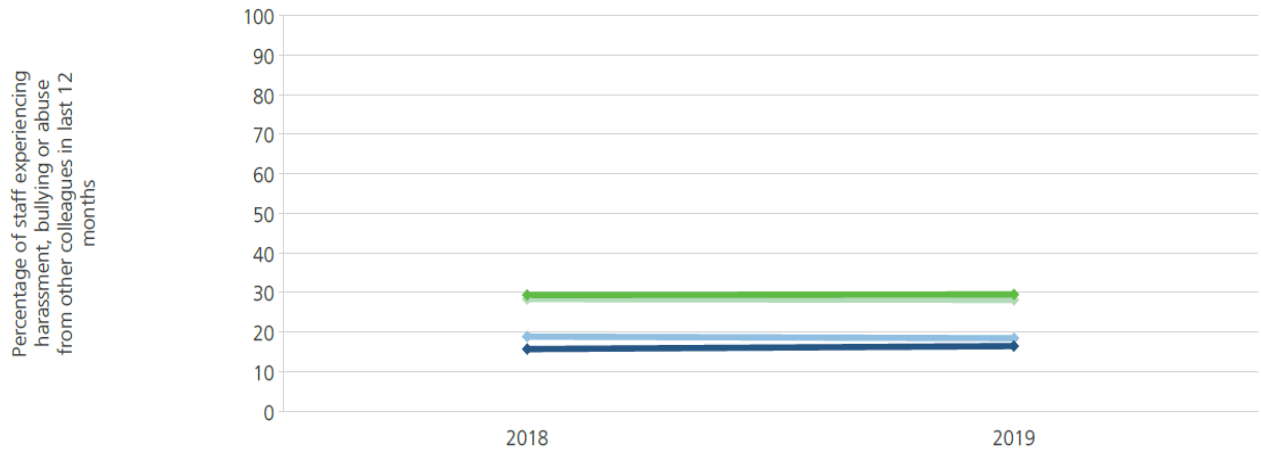
Disabled staff: Your org	36.2%	36.7%
Non-disabled staff: Your org	29.0%	27.6%
Disabled staff: Average	34.4%	33.9%
Non-disabled staff: Average	26.9%	27.3%
Disabled staff: Responses	765	731
Non-disabled staff: Responses	3,498	3,002

Average calculated as the median for the benchmark group



Disabled staff: Your org	19.0%	18.3%
Non-disabled staff: Your org	9.6%	9.8%
Disabled staff: Average	20.0%	19.7%
Non-disabled staff: Average	12.1%	11.0%
Disabled staff: Responses	764	728
Non-disabled staff: Responses	3,482	2,982

Average calculated as the median for the benchmark group



	2018	2019
Disabled staff: Your org	29.3%	29.5%
Non-disabled staff: Your org	15.7%	16.5%
Disabled staff: Average	28.3%	28.1%
Non-disabled staff: Average	18.9%	18.4%
Disabled staff: Responses	753	725
Non-disabled staff: Responses	3,460	2,966

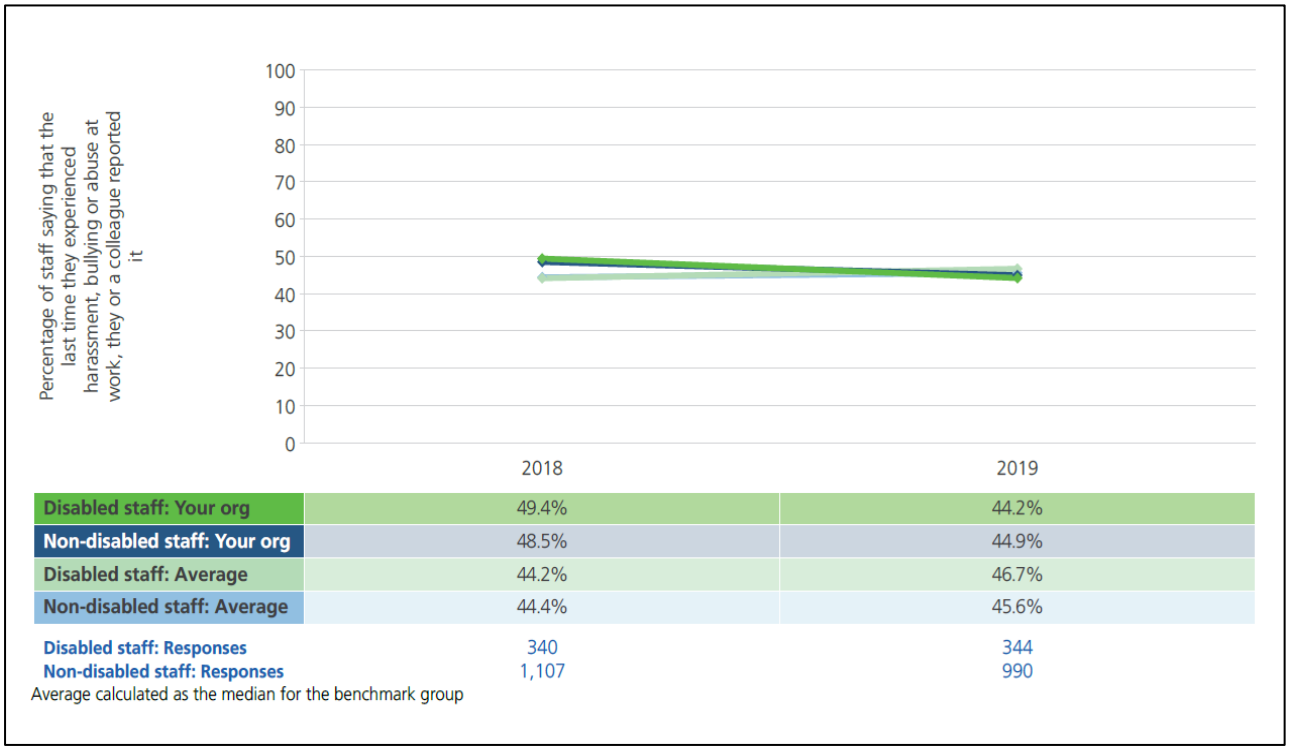
Average calculated as the median for the benchmark group

What the data tells us:

- Since 2018-2019, there has been an increase (+0.5%) in the number of disabled staff experiencing harassment, bullying and abuse from patients, service users, etc. This is above the national average for acute trusts (33.9%). Disabled staff are 1.3 times more likely than non-disabled staff to experience this type of behaviour from this group.
- Since 2018-2019, there has been a small decrease (-0.7 %) in the number of disabled staff experiencing from harassment, bullying and abuse from their manager. This is below the national average for acute trusts (19.7%). Disabled staff are 1.9 times more likely than non-disabled staff to experience this type of behaviour from this group.
- Since 2018-2019, there has been an increase (+0.2%) in the number of disabled staff experiencing from harassment, bullying and abuse from other colleagues. This is above the national average for acute trusts (28.1%). Disabled staff are 1.8 times more likely than non-disabled staff to experience this type of behaviour from this group.
- In all cases, disabled staff experienced more harassment, bullying and abuse from all groups than non-disabled staff.

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

2018-2019		2019-2020	
Disabled staff	49.4%	Disabled staff	44.2%
Non-disabled staff	48.5%	Non-disabled staff	44.9%
Acute Average (Disabled)	44.2%	Acute Average (Disabled)	46.7%
Acute Average (Non-Disabled)	44.4%	Acute Average (Non-Disabled)	45.6%



	2018	2019
Disabled staff: Your org	49.4%	44.2%
Non-disabled staff: Your org	48.5%	44.9%
Disabled staff: Average	44.2%	46.7%
Non-disabled staff: Average	44.4%	45.6%
Disabled staff: Responses	340	344
Non-disabled staff: Responses	1,107	990

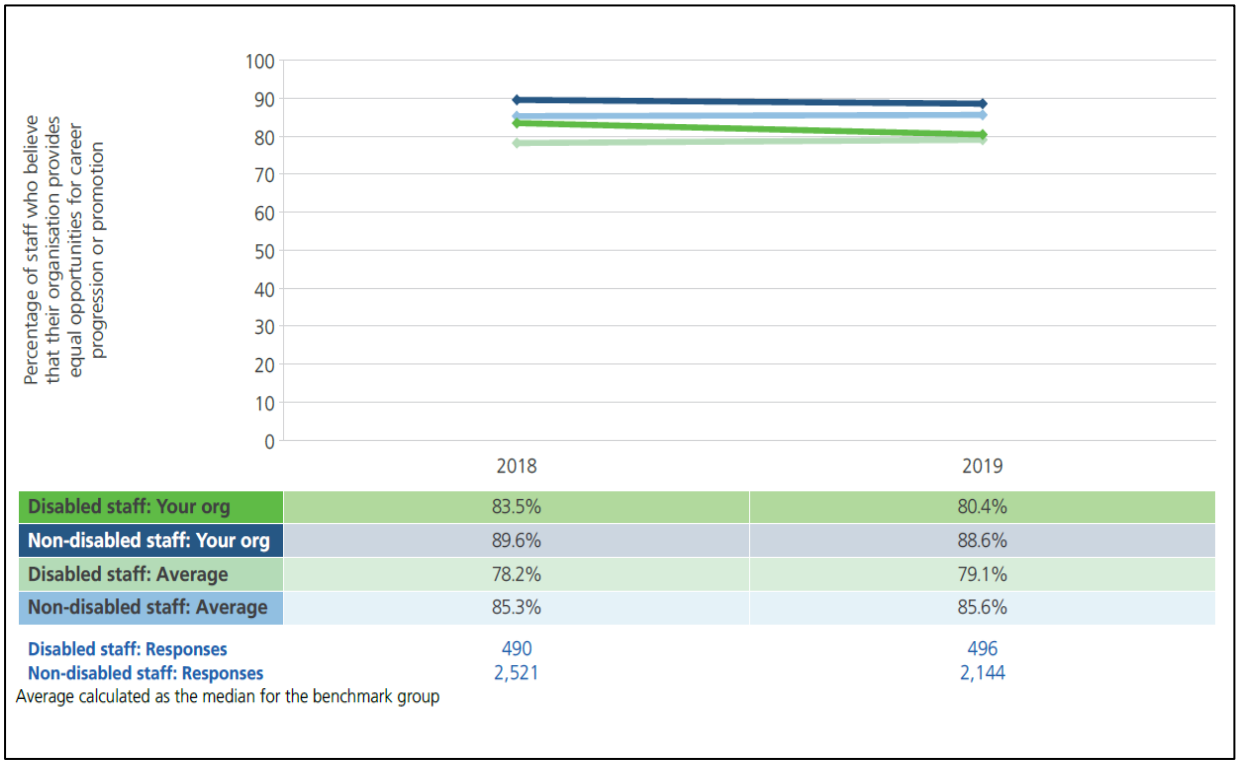
Average calculated as the median for the benchmark group

What the data tells us:

- In 2019, a small difference shows that disabled staff are 0.7% less likely to report incidents of harassment, bullying or abuse at work, than non-disabled staff.
- Fewer disabled staff (-5.2%) stated that they would report incidents compared to the previous year. The percentage of disabled staff (44.2%) is lower than the national average (46.7%).
- Statistically, the difference between disabled and non-disabled staff is not significant – they have a likelihood of 0.98 when comparing both groups in the recent staff survey.

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

2018-2019		2019-2020	
Disabled staff	83.5%	Disabled staff	80.4%
Non-disabled staff	89.6%	Non-disabled staff	88.6%
Acute Average (Disabled)	78.2%	Acute Average (Disabled)	79.1%
Acute Average (Non-Disabled)	85.3%	Acute Average (Non-Disabled)	85.6%



Disabled staff: Your org	83.5%	80.4%
Non-disabled staff: Your org	89.6%	88.6%
Disabled staff: Average	78.2%	79.1%
Non-disabled staff: Average	85.3%	85.6%
Disabled staff: Responses	490	496
Non-disabled staff: Responses	2,521	2,144

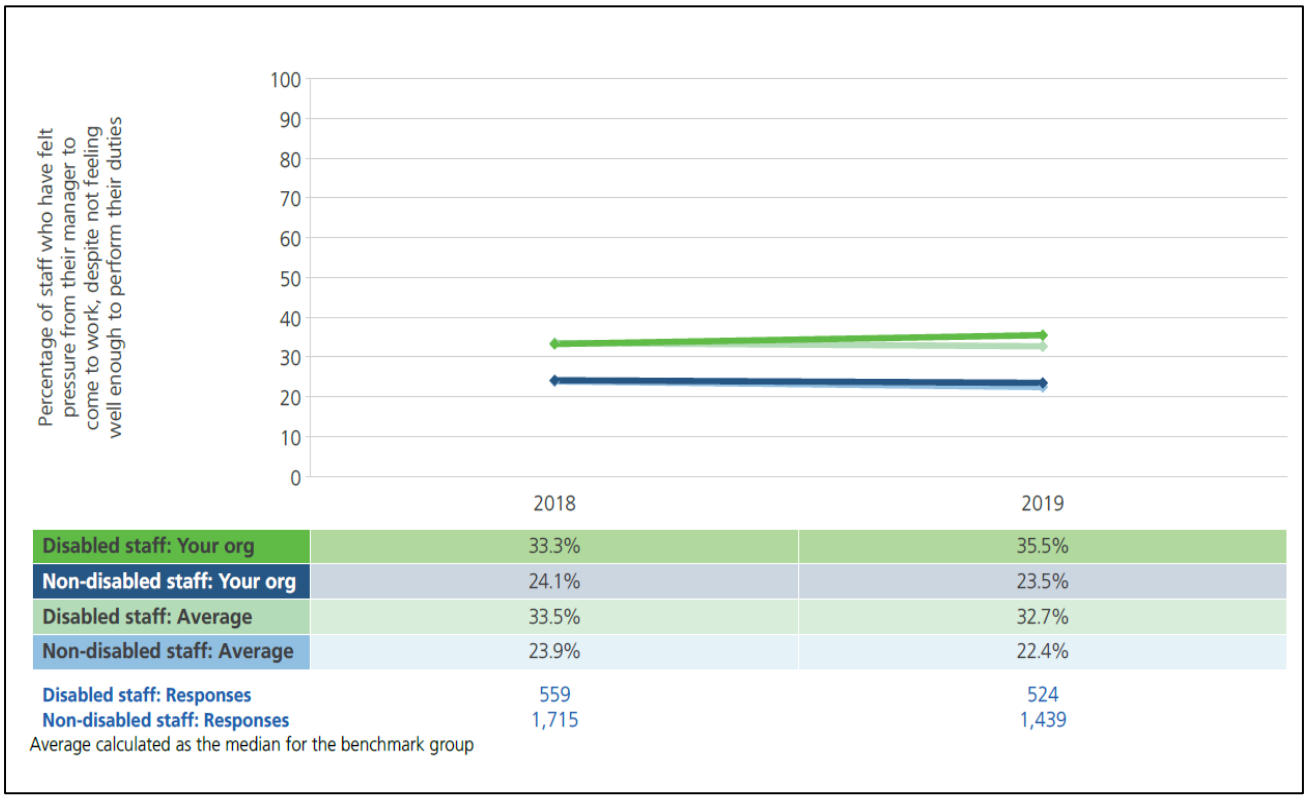
Average calculated as the median for the benchmark group

What the data tells us:

- Fewer disabled staff feel the Trust provides equal opportunities for career progression or promotion than non-disabled staff.
- Compared to last year there was a decrease (-3.1%) in the number of disabled staff (80.4%) that felt the Trust provides equal opportunities for career progression or promotion, this is slightly higher than the national average for acute trusts (79.1%).
- As a likelihood, disabled staff are 0.91 times as likely as non-disabled staff to feel that the Trust provides equal opportunities for career progression or promotion.

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

2018-2019		2019-2020	
Disabled staff	33.3%	Disabled staff	35.5%
Non-disabled staff	24.1%	Non-disabled staff	23.5%
Acute Average (Disabled)	33.5%	Acute Average (Disabled)	32.7%
Acute Average (Non-Disabled)	23.9%	Acute Average (Non-Disabled)	22.4%



	2018	2019
Disabled staff: Your org	33.3%	35.5%
Non-disabled staff: Your org	24.1%	23.5%
Disabled staff: Average	33.5%	32.7%
Non-disabled staff: Average	23.9%	22.4%
Disabled staff: Responses	559	524
Non-disabled staff: Responses	1,715	1,439

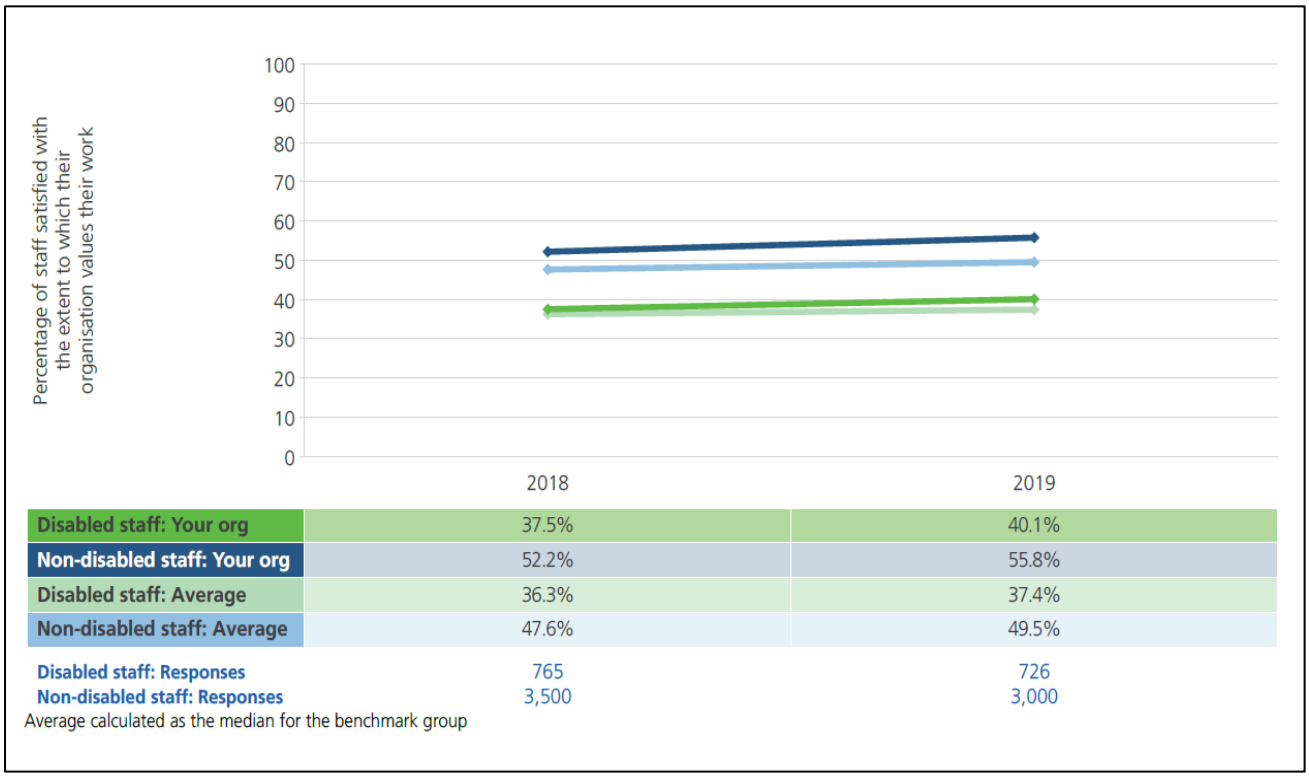
Average calculated as the median for the benchmark group

What the data tells us:

- More disabled staff generally have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties, when compared to non-disabled staff.
- Compared to last year there has been an increase (+2.2%) of disabled staff (35.5%) that have felt pressure to attend work when not well enough. This is above the national average for acute trusts (32.7%).
- As a likelihood, disabled staff are 1.5 times more likely to feel pressure to attend work when not well enough, when compared to non-disabled staff.

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

2018-2019		2019-2020	
Disabled staff	37.5%	Disabled staff	40.1%
Non-disabled staff	52.2%	Non-disabled staff	55.8%
Acute Average (Disabled)	36.3%	Acute Average (Disabled)	37.4%
Acute Average (Non-Disabled)	47.6%	Acute Average (Non-Disabled)	49.5%



Disabled staff: Your org	37.5%	40.1%
Non-disabled staff: Your org	52.2%	55.8%
Disabled staff: Average	36.3%	37.4%
Non-disabled staff: Average	47.6%	49.5%
Disabled staff: Responses	765	726
Non-disabled staff: Responses	3,500	3,000

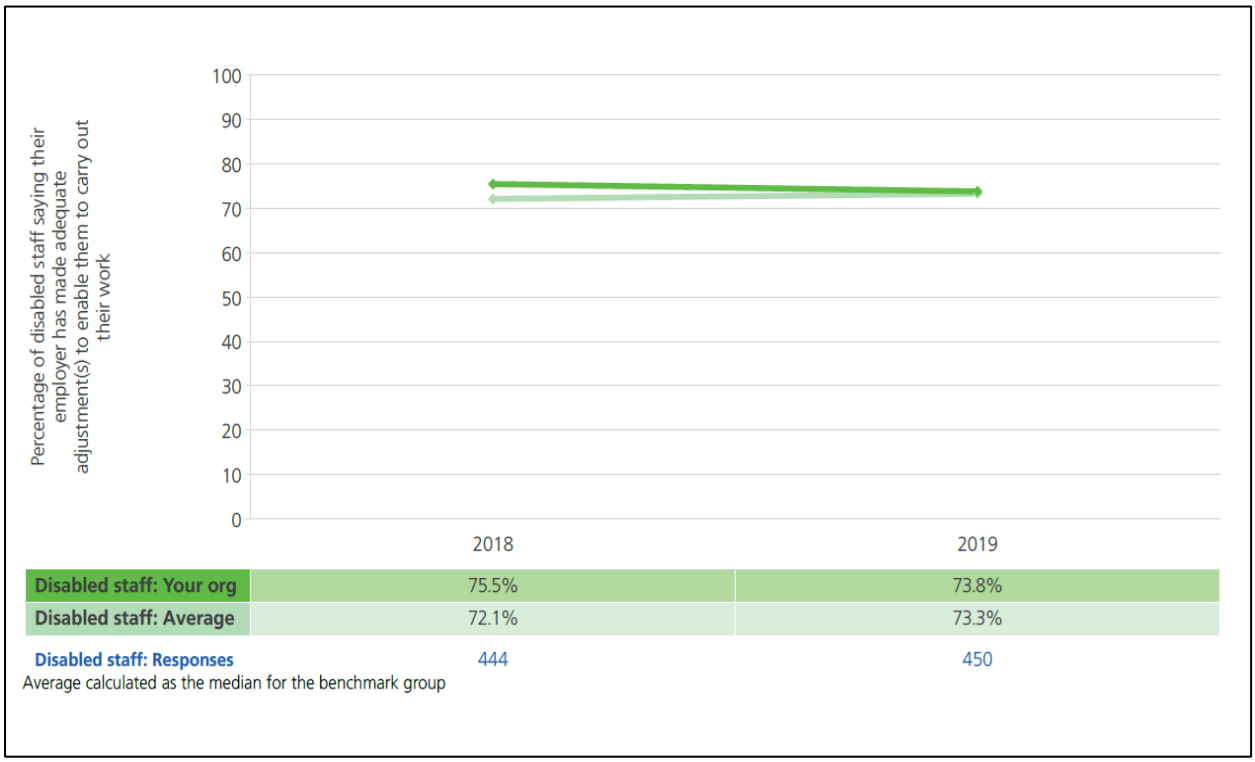
Average calculated as the median for the benchmark group

What the data tells us:

- Fewer disabled staff feel they are satisfied with the extent to which their organisation values their work than non-disabled staff.
- Compared to last year there has been a increase (+2.6%) of disabled staff (40.1%) that have felt satisfied with the extent to which their organisation values their work. This is above the national average for acute trusts (37.4%).
- As a ratio, disabled staff are 0.7 times as likely to have felt satisfied with the extent to which their organisation values their work, when compared to non-disabled staff.

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

2018-2019		2019-2020	
Disabled staff	75.5%	Disabled staff	73.8%
Disabled staff – average	72.1%	Disabled staff - average	73.3%

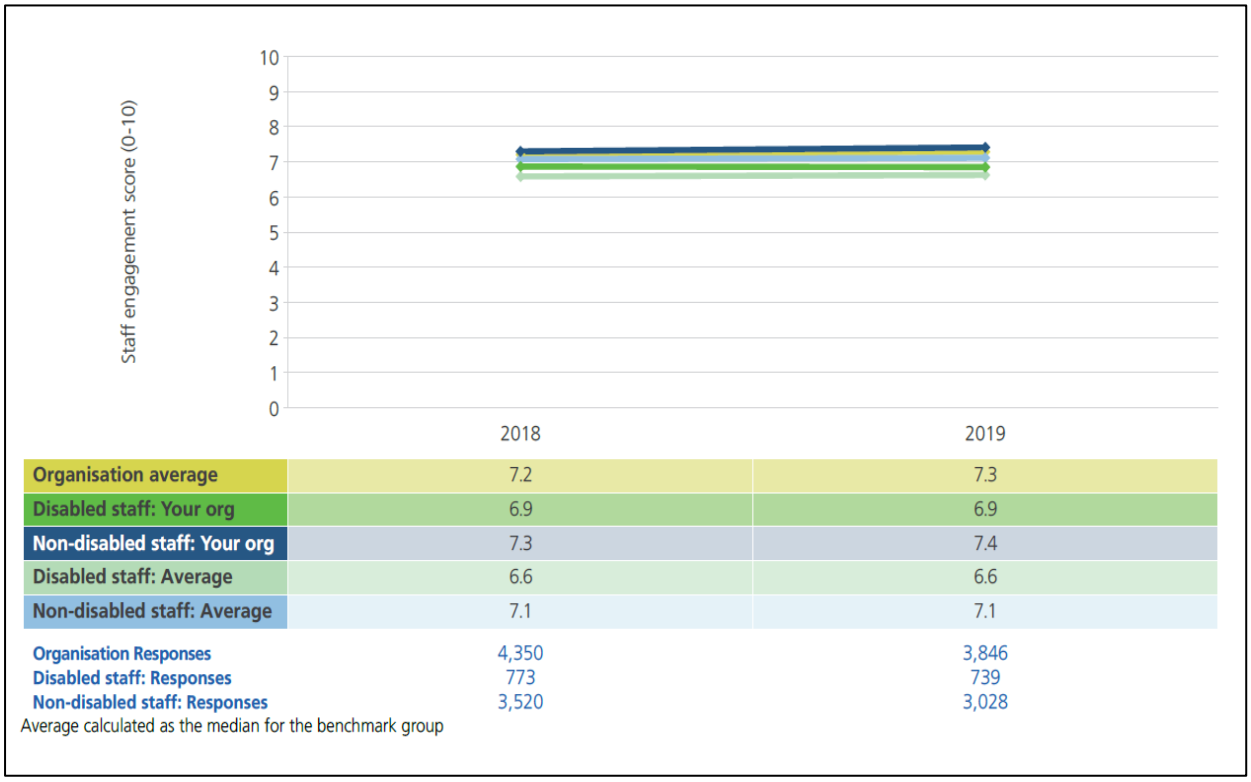


What does the data tell us:

- There has been a decrease in staff (-1.7%) from last year that feel they have been provided with adequate reasonable adjustments
- The Trust score is marginally above (+0.5%) the national average (73.3%) for acute Trusts.

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

2018-2019		2019-2020	
Disabled staff	6.9	Disabled staff	6.9
Non-disabled staff	7.3	Non-disabled staff	7.4
Acute Average (Disabled)	6.6	Acute Average (Disabled)	6.6
Acute Average (Non-Disabled)	7.1	Acute Average (Non-Disabled)	7.1



	2018	2019
Organisation average	7.2	7.3
Disabled staff: Your org	6.9	6.9
Non-disabled staff: Your org	7.3	7.4
Disabled staff: Average	6.6	6.6
Non-disabled staff: Average	7.1	7.1
Organisation Responses	4,350	3,846
Disabled staff: Responses	773	739
Non-disabled staff: Responses	3,520	3,028

Average calculated as the median for the benchmark group

What does the data tell us:

- There has been no change in the Staff Engagement score for disabled staff in the Trust
- The Staff Engagement score for disabled staff in the Trust is (6.9%) and is marginally above (+0.3%) the national average (6.6) for acute Trusts.

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

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

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

(i) The organisation's Board voting membership and its overall workforce 2019-2020

	Overall Workforce		Voting Board Membership		
	Number in workforce	**% in workforce**	**Number on board**	**% of board**	**% Difference**
Disabled	212	2.9%	0	0.0%	**-2.9%**
Non-disabled	5068	69.3%	9	64.3%	**-5.0%**
Not known	2037	27.8%	5	35.7%	**7.9%**
Total	7317	100.0%	14	100.0%	

(ii) The organisation's Board executive membership and its overall workforce 2019-2020

	Overall Workforce		Executive Board Membership		
	Number in workforce	**% in workforce**	**Number on board**	**% of board**	**% Difference**
Disabled	212	2.9%	0	0.0%	**-2.9%**
Non-disabled	5068	69.3%	9	64.3%	**-5.0%**
Not known	2037	27.8%	5	35.7%	**7.9%**
Total	7317	100.0%	14	100.0%	

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

In 2019 the NHS Staff Survey was open to all Western Sussex Hospitals NHS Foundation Trust staff to participate in which a potential sample of circa 6,500 were permitted to participate. A total of 3,864 responses were received from staff.

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

The system used to provide recruitment data, picks up all recruitment activity across a user specified period, in this instance 1 April 2019 to 31 March 2020. The system does not differentiate recruitment campaigns that start and finish within this period.

a. Any issues of completeness of data
None

b. Any matters relating to the reliability of comparisons with previous years
None

Agenda Item:	16	**Meeting:**	Trust Board	**Meeting Date:**	6.8.20
Report Title:	Annual Report/Update for Appraisal & Revalidation				
Sponsoring Executive Director:	George Findlay – Chief Medical Officer/Responsible Officer (RO)				
Author(s):	Christopher Smith – Assistant Medical Director for Appraisal and Revalidation (AMD)				
Report previously considered by and date:					
Purpose of the report:					
Information	✓		Assurance	✓	
Review and Discussion	✓		Approval / Agreement	✓	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	✓	
Our People	✓		Quality	✓	
Systems and Partnerships	✓				
Any implications for:					
Quality	Revalidation is the process for determining whether doctors are fit to practice. It drives quality and patient safety through medical appraisal				
Financial	The Trust has a statutory obligation to provide the resources required to support revalidation Additional licence requirements				
Workforce	The duties of the Responsible Officer have considerable overlap with HR processes. Areas where HR need to support the RO include, systems and processes, advice on employee relations and employment law, resources for case management and case investigations and training and induction				
Link to CQC Domains:					
Safe	✓		Effective	✓	
Caring	✓		Responsive	✓	
Well-led	✓		Use of Resources	✓	
Communication and Consultation:					

Executive Summary:

The report is to update the Trust Board on medical appraisal and revalidation. The report provides the necessary assurance to allow a positive Statement of Compliance to be submitted to the Higher Level Responsible Officer.

The report references the GMC, and subsequent Trust, response to the Covid 19 pandemic and the impact this had on Appraisal and Revalidation within WSHT.

Key Recommendation(s):

a) The Board are asked to accept this report as evidence of revalidation and medical appraisal. The Annual Report is to be shared with the Higher Level Responsible Officer.

b) The Board is asked to approve the 'Statement of Compliance' confirming that the organisation, as a Designated Body, is in compliance with the regulations

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board

Date: 6th August 2020

From: Christopher Smith
Assistant Medical Director for Appraisal and Revalidation

Agenda Item: 16

FOR DECISION & INFORMATION

ANNUAL BOARD REPORT FOR MEDICAL APPRAISAL AND REVALIDATION

1.0 INTRODUCTION

1.01 Medical Appraisal and Revalidation is well established in the Trust. Appraisal activity is supported and reviewed by the Revalidation Team (RT), quality assured by the Medical Appraisal Revalidation Group (MARG) and governance overseen the Medical Workforce and Appraisal Governance Group (MWAG).

The Covid 19 pandemic (C19) resulted in the GMC suggesting cessation of appraisals and deferral of revalidation dates and the RT responded to these challenges.

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 2019/20 reporting year, 1st April 2019 to 31st March 2020. It provides the supporting information to enable completion of the 'Statement of Compliance' required for the Higher Level Responsible Officer.

Reviewing the Trust's revalidation and appraisal performance from April 1st 2019 to March 31st 2020 indicates that on the 31st March 2020, the Trust had a prescribed connection with 525 doctors which represents a continued increase (497 in 2019, 466 in 2018 and 431 in 2017). This includes permanent and fixed term consultants, staff and associate specialist grade (SASG), medical bank and medical training initiative (MTI) doctors.

Trainee doctors have a connection with Health Education England, eg HEKSS, rather than the Trust.

Regarding the 525 medical staff with a prescribed connection to WSHFT:

508 were appraisal compliant in 2020 which is 96.7%

This represents a continued year on year improvement in appraisal engagement:

2018/19 – 90.7%
2017/18 – 85.6%
2016/17 – 80.5%

A high proportion of WSHT doctors are in their second revalidation cycle. 140 revalidation submissions were made to the GMC in the reporting year 2019/20 – 14 were deferred due to

insufficient information, 6 of which were subsequently revalidated within the reporting year. No doctors were declared non engaged although one doctor's revalidation is on hold due to an ongoing investigation.

Due to the Covid 19 Pandemic, no recommendations were made after 21st March 2020 when the GMC halted all revalidation activity.

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

Medical Director (MD)

Dr Timothy Taylor

Assistant Medical Director for Revalidation and Appraisal (AMD)

Dr Christopher Smith

Senior Appraisers (SA)

Core:	Dr Sean McHale
Medicine:	Dr Nick Pegge
	Mr Khurrum Baig
Surgery:	Mr David Beattie
Women and Children:	Dr Emma Rutland
Hospices:	Dr Emma Rutland

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practice and Revalidation) Regulations Order of Council 2012'

Dr Christopher Smith has retired and is stepping down from the AMD role pending the appointment of a replacement. Dr Sean McHale has retired from his Senior Appraiser role and a replacement is required.

Dr Nick Pegge takes responsibility for doctors working in Emergency Medicine, Acute Medicine and Care of the Elderly
Mr Khurrum Baig takes responsibility for the remaining doctors within the Medicine Division.
Emma Rutland has continued her role to include doctors working at St Barnabas and St Wilfrid's Hospices for whom Chris Smith acts as Responsible Officer.

Medical HR Lead

Mrs Karin Boulden (Interim)

Revalidation Manager

Ms Lynn Helyer

Revalidation Administrator

Ms Rebecca Downer

The Medical Workforce Governance and Appraisal Group (MWAG)

This group is chaired by the RO and is held quarterly. It is attended by the MD, AMD, revalidation manager and representation from Employee Relations Team/HR. The group oversees GMC concerns, local concerns, and any appraisal or revalidation issues, policy and procedures.

The Medical Appraisal and Revalidation Group (MARG)

This Group oversees the implementation of revalidation and appraisal and is chaired by the AMD and attended by the Senior Appraisers, SASG lead, the revalidation team, Hospice Leads and Lay Representative. 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 as advised by Medical HR. The GMC Connect list of doctors is validated against Electronic Staff Record (ESR) data on a monthly basis.

Internal Assurance

Internal assurance follows the recommendations of the NHS England Framework for Quality Assurance for Responsible Officers and Revalidation (2014).

4.02 Policy and Guidance

The NHSE Medical Appraisal Policy (NHS England 2015)

In accordance with the NHSE Medical Appraisal Policy, the doctors' appraiser is allocated by the Revalidation Team. The allocations are based on the appraisees' previous appraiser history, appraiser availability, specialty and location. Obvious conflicts of interest are avoided and where possible, doctors will keep the same appraiser for three consecutive years. Appraisals have been recorded on Allocate e-appraisal software since October 2016.

The Trust Appraisal and Revalidation policy was revised and updated in March 2019 to reflect the use of the new Allocate e-appraisal software, the NHSE policy, to align with BSUH and clarify "due by" dates.

Improving the Inputs to Medical Appraisal (NHS England 2016)

This document provides guidance on the necessary supporting information for doctors undertaking their appraisal and includes templates and checklists and recommendations for those having annual reviews outside their designated body. Further guidance is provided on supporting information in the context of those undertaking low volumes of work and obtaining patient feedback in non-standard situations.

Information Flows to Support Medical Governance and Responsible Officer Statutory Function (NHS England 2016)

This guidance sets out the main channels along which information about a doctor's medical practice may need to flow, in support of good medical governance and the statutory duties of the responsible officer and in support of patient safety and quality of care. This guidance includes a pre-employment checklist with which WSHFT complies.

5.0 MEDICAL APPRAISAL

5.01 The Trust's medical appraisal rate for doctors with a prescribed connection to WSHT, has continued to improve and in the 2019/20 was 96.7% (2018/19 reporting period was 90.7%). This represents a rise of 10% in two years against a backdrop of an additional 59 doctors in the same period.

	2016/17	2017/18	2018/19	**2019/20**
Number of doctors	431	466	497	**525**
Number of completed appraisals	347 (80.5%)	399 (85.6%)	451 (90.7%)	**508 (96.7%)**

Missed Appraisals

There were 17 doctors who failed to have an appraisal in the reporting year. This represents an increase of 12 since last year. 14 have since completed their appraisals, Two have been deferred due to Covid 19 work and one is on a phased return following long term absence.

5.02 Appraiser Numbers

There are currently 66 active appraisers, including the Medical Director, AMD, 5 Senior Appraisers, 7 Clinical Directors and all 4 Chiefs of Service.

The appraisal role should be recognized by 0.5 SPA in the doctor's job plan to enable them to do between 8 and 10 appraisals a year. Some appraisers have only been able to negotiate 0.25 SPA for which they will do 4 – 5 appraisals a year and for others, there is no time allowance recognized in their job plan or it is subsumed within other SPA activities. The lack of specific SPA allocation in job plans, continues to be an issue.

The Trust continues to provide appraisals for the two local hospices under a Service Level Agreement.

The revalidation team complies with the NHSE Medical Appraisal Policy (NHS England 2015) in that appraisers are allocated to appraisees. This helps even out the workload for appraisers.

5.03 Quality Assurance

The 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

A 2019/20 Annual Organisational Audit (AOA) was not requested due to Covid 19. It is not possible to benchmark WSHFT against other comparable organisations this year. Trend data up to 2018 is available in last years report.

Activity has increased since last year.

Impact of Covid 19

On 19th March, the GMC advised that doctors who are due to revalidate before the end of September 2020 would have their revalidation date deferred for one year. The last WSHT recommendation for the 2019/20 reporting period was submitted on 21.3.20. Of note, on 4th June 2020, this was extended to 31st March 2021, with all doctors put under notice to revalidate (this is normally a 3 month window). This will create a compression in the RV cycle, with increase numbers of recommendations due.

The planned Higher Lever Responsible Officer Quality Review for WSHFT did not take place in September 2019. It has not been rescheduled yet. This review, when rearranged, provides useful feedback on our current systems, shares good practice and offers feedback. It will generate an action log which can feed into future reports.

Appraisers Spring 2020 Update not held (last update November 2019 received good feedback from those attending)

AOA/quarterly report for Q3 not required.

New Appraiser Training postponed to October 2020

RO Network Meetings currently on hold (last held in February 2020)

Reduced Revalidation Team resources to counteract childcare issues.

Appraisals due April to June 2020 deferred 1 year although reinstated for:

Doctors leaving the Trust, impending long term absence, new post
Doctors missing March 31st 2020 deadline to complete the previous year's appraisal
Doctor's where concerns are raised

Short term doctors taking up posts in August 2020 have been supported with an end of placement Clinical Review, developed locally by the RT as a portfolio tool, to provide supporting information in subsequent appraisals. This group are usually doctors returning to full time training posts. This arrangement is with the agreement of the appropriate Health Education England (HEE) Responsible Officer

To reduce issues related to social distancing concerns, use of larger rooms, masks and use of Microsoft team meetings platforms (or similar) have been encouraged.

Latest notices from GMC and Higher RO for NHS England – See Appendices

Complaints and Serious Incidents

There have been no complaints or serious incidents arising from appraisal or revalidation.

Quality assurance of Appraisers

Quality assurance is embedded during the recruitment and training processes for appraisers and senior appraisers and is further supported by appraiser development updates, feedback given to appraisers from appraisees and seniors appraisers as part of appraisers' scope of practice and at final appraisal 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 a Senior Appraiser / an experienced appraiser sitting in for their first one or two appraisals, offering feedback and support in line with NHSE recommendations.

Recruitment is dependent on time being available in the doctors job plan.

Appraiser development

There are normally two development workshops for appraisers each year, due to C19 only one was possible. These include updates and information sharing from national appraisal updates and RO network meetings, presented by the AMD, senior appraisers or invited outside speakers.

Appraisal for Appraisers

The appraiser role is considered during appraiser's annual appraisal and forms part of these doctors' scope of practice. This includes a review of their appraisees' feedback.

Quality Assurance of appraisals

The senior appraisers review all appraisals for completeness and quality. They provide support and feedback to appraisers as part of the final sign off process (see below). This area of feedback was last surveyed in 2018 when appraisers and appraisees reported that senior appraisal advice was helpful.

Final sign off

Final sign off continues to be a key role for senior appraisers who review each appraisal to ensure appropriate supporting information has been included and that appraisals reach the standards required for revalidation. The need for feedback is at the discretion of the senior appraiser, guided by the ASPAT tool and always given if the appraisal is returned for any reason or needs further work, which is a feature in built into the allocate system.

Increasingly appraisees and appraisers are encouraged to adopt a "what, so what, what next" approach in reflecting and appraising the value of activity. In other words to view the impact on patient care, safety, efficiency, efficacy and empathy.

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 continues to be an issue with Allocate Software.

Quality assurance reference tools, provided by NHSE, help standardise and support this process.

Doctor's feedback on the quality of their appraisals

Appraisees are obliged to provide feedback about the organisation of the appraisal, the appraisal process and their appraiser. The Revalidation Team review the feedback and share /action as appropriate. Responses indicate continued high levels of satisfaction with the appraisal process by those being appraised.

5.04 Access, security and confidentiality

Information is held securely in the Allocate web-based appraisal folders and only accessible to appraisers, the relevant senior appraiser, AMD for revalidation and appraisal, responsible officer and revalidation administrators.

5.05 Clinical Governance

The Trust provides data for doctors undergoing their appraisal as a consultant data pack from the IT department. Other information available includes mandatory training status, declaration of interest and Datix summary. Triangulation of employment HR details, Chief of Service and Line manager review, outstanding investigations and GMC notices occur via the RO checklist prior to a revalidation recommendation.

6.0 REVALIDATION RECOMMENDATIONS

6.01

	2017/18	2018/19	2019/20
Number of recommendations made	35	104	141
Recommendations completed on time	34	103	140
Positive recommendations	21	98	127
Deferral requests	14	6	14
Non-engagement notifications	0	0	0
Late recommendations	1	1	1
REV 6 submissions	0	1	0
Number of formal investigations carried out under MHPS	4	2	1

In 2019/2020 6 deferrals were subsequently revalidated. The late recommendation was a GMC admin issue as the doctor had been referred to them for investigation and should have been put on hold.

7.0 RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

7.01 The TRAC system provides a robust and auditable process for all recruitment including Medical Bank, fixed term and substantive posts (excluding Agency locums) for pre-employment and ID checks including Revalidation and RO references. As per guidance, transfer of RO to RO information is not requested until the new incumbent starts at the Trust.

7.02 Locum doctors

Locum doctors arranged through the Temporary Staffing team are sourced via NHS CPP National Clinical Staffing Framework and Crown Commercial Solutions (CCS) Framework Agencies, which are NHSi compliant and have responsibility for ensuring Locums comply with pre-employment requirements/checks.

If it is not possible to source a locum through either Framework Agency, the Division authorises the use of a non-framework agency, the Temporary Staffing Team will ask the Agency to complete a RO type reference and checklist to confirm that all the necessary checks have been fulfilled.

8.0 MONITORING PERFORMANCE

8.01 Doctor's performance is monitored at Clinical Lead, Divisional and Executive levels.

At divisional level, performance of individuals, teams and specialities are monitored through the monthly divisional operational and governance meetings and at the quarterly divisional governance reviews. These meetings incorporate service line management, complaints and litigation, risk reporting and mortality and morbidity data.

At executive level the medical director monitors Clinical Outcome Benchmarking data from Dr Foster, GIRFT, national databases such a fracture neck of femur and NELA (National Emergency Laparotomy Audit). WSHFT has internal mechanisms using Medical Examiners to review outcomes, including relevant alerts. Any concerns that arise are managed 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 2019/20 appraisal year.

9.0 RESPONDING TO CONCERNS AND REMEDIATION

9.01 For the period April 2019 to March 2020 there was 1 formal investigation carried out under Maintaining High Professional Standards (MHPS). This led to formal action. There was also formal action taken from an investigation commenced in the previous reporting year for a trainee doctor.

One member of medical staff was excluded from work.

The Employee Relations team continue to support the informal management of concerns wherever appropriate, ensuring that advice is also sought from NHS Resolutions and GMC Employee Liaison.

10.0 RISKS AND ISSUES

10.1 Medical Appraisal Rates

For the first time, WSHT have exceeded the National target of 95%. The rate of 96.7% includes doctors who are new to the NHS and not due an appraisal within the reporting year or had an in-date appraisal when joining the Trust. Improved processes have enabled the Revalidation Team to capture this information more robustly and new incumbents are not allocated an appraisal due date in Q3 of the reporting year.

11.0 EXECUTIVE TEAM REFLECTIONS (draft suggestions)

11.1 The number of doctors linked to WSHFT and the number of medical appraisals continues to increase. There remains 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. Continued support for the GMC "Welcome to the UK" programme is desirable

Appointment of a new SASG lead is required.

The retirement of the AMD and one of the SA's require replacement appointments.

Returning to pre-C19 activity will benefit from accelerated training and support for new appraisers. There is a high risk of a shortage in appraisers; new appraisers have not been able to attend training, older appraisers are retiring and other appraisers stepping down as service pressures encroach and the number of doctors who require appraisal continues to increase.

The financing of appraisal activity would benefit from review. Many appraisers are fully recognised for their contribution, but this is not universal throughout the Trust. Job planning negotiations can be time consuming and holding a budget to reimburse appraisers would be helpful. Specified time needs to be identified in job plans for all doctors with an appraiser role.

Transparent financing of appraisal activity is desirable. Clarity surrounding appraiser time, Senior Appraiser and AMD posts, training costs, allocate licences and system administration should all be included and incorporated into the AAR in future.

Streamlining Appraisal activity between WSHFT and BSUH (Brighton) may be a sensible long term prospect. This might include cross site quality assurance and governance processes, adopting one system (such as allocate or L2P) and potential cost improvements.

11.2 Corrective Actions, Improvement Plan and Next Steps

<u>Actions for the Trust in 2019/20 are shown below:</u>

- Provide Designated Body Statement of Compliance to NHS England
- Continue to liaise with Allocate Software team regarding system developments to improve and streamline the e-appraisal system.
- Await update regarding HLROQR visit
- Continue work to raise the overall WSHFT appraisal rate
- Improve finance arrangements in delivery of appraisal
- Appoint AMD, SA and SASG lead (and RO for the two local Hospices)
- Succession plan for the Revalidation Manager
- Continue to develop the role of the Medical Workforce Governance and Appraisal Group
- Continue to develop and support the role of Senior Appraisers
- Continue the appraiser updates and bulletins
- Continue to disseminate RO network advice, updates

Appendix 1

Designated Body Statement of Compliance

The board of Western Sussex Hospitals NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Requirement satisfied

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Requirement satisfied

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Requirement satisfied

4. Medical appraisers participate in on-going performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

Requirement satisfied

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Requirement satisfied

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

Requirement satisfied

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Requirement satisfied

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Requirement satisfied

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

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

Appendix 2 NHS and GMC Covid 19 Notifications

To: All Responsible Officers and Medical Directors in England

Professor Stephen Powis
National Medical Director
Skipton House
80 London Road
SE1 6LH

19 March 2020

Dear Colleague

Covid-19 and professional standards activities (including appraisal and revalidation)

I am writing about changes to professional standards activities in light of the latest Government advice on managing the Covid-19 outbreak. Professional standards activities safeguard patient safety and quality of care, support professional development and ensure that action is taken when concerns arise. However, in the current situation it is entirely appropriate to free up capacity to maintain essential care and minimise spread.

Medical Appraisal

As National Responsible Officer for NHS England and Improvement and the person who delegates the Senior Responsible Owner function for The Medical Profession (Responsible Officers) Regulations 2010 (amended 2013) in England I strongly recommend that appraisals are suspended from the date of this letter until further notice, unless there are exceptional circumstances agreed by both the appraisee and appraiser. This should immediately increase capacity in our workforce by allowing appraisers to return to clinical practice.

Until reinstated, Responsible Officers (ROs) should classify appraisals which are affected as 'approved missed' appraisals. For clarity, affected appraisals will be regarded as cancelled, not postponed.

Revalidation decisions

The GMC has now issued guidance that doctors who are due to revalidate before the end of September 2020 will have their revalidation date deferred for one year. This will be kept under review the GMC will make further deferrals as necessary.

This decision has been made to give doctors more time to reschedule and complete appraisals, and to avoid the need for ROs to make revalidation recommendations during this time.

The GMC has started making changes to its systems so that notifications about

NHS Resolution

MHPS: Guidance during the COVID-19 outbreak

This guidance has been produced in consultation with NHS Employers to provide some general interim guidance to NHS organisations regarding the managing of concerns in accordance with *Maintaining High Professional Standards in the NHS* (MHPS) during the COVID-19 outbreak. We are aware of the intense pressure that frontline and management staff will be under during this time and the significant constraints on their time.

In this context we are advising NHS organisations to consider how best they can manage concerns about practitioners during this difficult time. Our advice, which is set out below, is consistent with the advice issued on 19 March 2020 by Professor Stephen Powis, National Medical Director of NHS England. Specifically, it is crucial for NHS organisations to continue to have oversight of professional concerns, but as the situation evolves the priority will be those concerns assessed as high risk. Our advice is that NHS organisations will have to carefully consider what, if any, action on managing concerns can be undertaken during these difficult times and how ongoing investigations should be handled, always considering patient safety and public protection first. Robust and tailored support is essential for practitioners at this time, especially if restrictions or exclusion are in place or processes are prolonged.

We recommend adopting a pragmatic approach to the management of concerns under MHPS during this time and documenting in writing any steps taken (including the decision not to do anything). Practitioner Performance Advice remains available to support you at any stage with the resolution of concerns.

1. **Urgent concerns**
   If a potentially serious urgent concern arises, including relating to any newly redeployed/returning practitioner, then it is likely to require immediate action. The organisation should consider what form of interim action is required to address the immediate problem. We recommend that serious consideration should be given at this time as to whether alternatives to exclusion or substantial restrictions on clinical practice can be considered, so that the practitioner is not removed from the workplace at a time when there is such immense pressure on clinical staff. However, patient safety remains the priority. Remember that there should be, in so far as possible, a preliminary analysis, which usually includes a discussion with the practitioner. This should also take account of the pressures of the current exceptional circumstances and the impact this will have on clinical decision making and practitioners in general to ensure there is a fair, proportionate and reasonable approach to any concerns. However, if the working circumstances of the practitioner are considered to be underlying factors for the concerning behaviour/actions, there should be serious consideration of deploying the practitioner to a less pressured environment.

   Concerns regarding trainees that are sufficiently serious to extend beyond dealing with as a training matter should involve the relevant educational supervisor and postgraduate dean.

2. **Investigation nearing completion**
   Where an investigation is almost completed, then we would recommend that, if possible, it is concluded as quickly as possible, so that clinical staff can continue to provide frontline services, if the findings of the investigation indicate this to be appropriate. An 'agreed sanction' or 'agreed outcome' process with a behavioural agreement can enable speedier resolution. This is usually practicable where the practitioner essentially accepts the findings of the investigation

General Medical Council

ROs and SPs

Dear,

Coronavirus (COVID-19) - our plans for revalidation

I hope you're keeping well. I'm writing with an update on our plans for revalidation for the rest of 2020 and into 2021.

We wrote to you in March and explained we had changed revalidation dates for doctors who were due to revalidate between 17 March and the end of September 2020.

Since then, we've been talking to Responsible Officers (ROs) across the UK to understand how we can best support doctors to revalidate in the coming months. In response to the feedback we've received, we've decided to move the dates of a further group of doctors.

Doctors with revalidation dates between 1 October 2020 and 16 March 2021 will have their dates moved back by one year.

We will write to these doctors next week, making it clear that they don't need to contact you, and that you'll be in touch if you need any information from them.

Recommendations to revalidate

ROs have also told us that they'd like more flexibility to make recommendations to revalidate doctors where they're ready to do so. Therefore, we'll also put all doctors whose dates have been moved as part of our response to the pandemic, under notice.

This means you can make a recommendation to revalidate any doctor whose date has been changed, from the date we inform them, up until their new revalidation date. They'll appear on the 'Under notice doctors' section on GMC Connect. This will include those who were in the first cohort of doctors, with an original revalidation submission date between 17 March and 30 September 2020. We'll continue to set new revalidation submission dates five years from the current submission date when we revalidate a doctor.

Deferral and non-engagement recommendations

If you need to make a deferral recommendation, please don't do this until the doctor is within four months of their revalidation date. You must inform us if a doctor isn't

participating in the local processes that underpin revalidation. You can do this by sending us a REV6 - Request to send a non-engagement concern letter to a doctor form. We'll then write to the doctor to remind them that they must participate to maintain their licence to practise. Please also discuss this as usual with your Employer Liaison Adviser (ELA).

Appraisals

We expect doctors to continue to engage in clinical governance activity as normal. The exception to this is if you have stopped providing appraisals as part of your local response to the pandemic. We've already explained that we support the suspension of appraisal during the pandemic, and that a missed appraisal shouldn't affect a recommendation for a doctor who is otherwise ready to revalidate. You can make a recommendation to revalidate a doctor with less than five appraisals so long as all the supporting information has been collected and discussed at other appraisals earlier in this revalidation cycle.

If you have any questions, please contact your ELA. Alternatively please contact our revalidation team on 0161 923 6602 (+44 161 923 6602) or by email at revalidation-support@gmc-uk.org

Thank you again for everything that you're doing to deliver patient care and support doctors during these challenging times.

Best wishes,

Blake Dobson
Assistant Director – Revalidation, Licensing and Specialist Applications

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	17	**Meeting:**	Board of Directors	**Meeting Date:**	6 August 2020
Report Title:	**Company Secretary Report**				
Sponsoring Executive Director:			Glen Palethorpe, Group Company Secretary		
Author(s):			Glen Palethorpe, Group Company Secretary		
Report previously considered by and date:					
Purpose of the report:					
Information		✓	Assurance		✓
Review and Discussion		☐	Approval / Agreement		☐
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability		✓
Our People		✓	Quality		✓
Systems and Partnerships		✓			
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe		☐	Effective		☐
Caring		☐	Responsive		☐
Well-led		✓	Use of Resources		✓
Communication and Consultation:					
Executive Summary:					

2019/20 year end NHS I Licence self-declarations

The Board approved its required NHS I Licence self declarations and these have been published on the Trust's website at https://www.westernsussexhospitals.nhs.uk/your-trust/about/annual-report/

2019/20 Annual Report and Accounts

Following the Board's approval of the Trust Annual Report and Accounts these were presented to Parliament. Following these being accepted by Parliament these have been placed on the Trust's website at https://www.westernsussexhospitals.nhs.uk/your-trust/about/annual-report/

2019/20 Quality Account

The Trust's Quality Account has been completed and post its approval by the Board has been placed on the Trust's website at https://www.westernsussexhospitals.nhs.uk/your-trust/performance/

Annual General Meeting

Given the change in the Annual Reporting timescales the date for the Annual General Meeting has now been set for the 30 September. The plan is that this meeting is to take place via MS Teams and

details of how the public can join that meeting will be placed on our website nearer the time. This meeting will incorporate the presentation of the Trust's annual report and accounts to the Council of Governors.

Key Recommendation(s):

The Board is asked to **NOTE** that the Trust's Annual Report and Accounts and the Quality Account have been placed on our website.

The Board is asked to **NOTE** that the Annual General Meeting has been set for the 30 September 2020.