Western Sussex Hospitals NHS
NHS Foundation Trust

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Annual Report and Accounts 2015 / 16

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Presented to Parliament pursuant to Schedule 7, paragraph 25(4) (a) of the National Health Service Act 2006

Western Sussex Hospitals NHS Foundation Trust Annual Report 2015-16

1. Performance Report

1.1 Welcome From the Chairman and Chief Executive

For Western Sussex Hospitals NHS Foundation Trust, 2015/16 was a year like no other.

Not because we cared for more people than ever before, although we did indeed experience another record year in demand. Not because we operated under ever-tighter resource constraints either, although that was the case too. And not because we performed ever-more efficiently and innovatively to meet these challenges also.

What made 2015/16 so different and potentially transformational for us was the fact that this was the year in which the way we work, the vision we have set for ourselves and the culture that underpins everything we do were subjected to the most intense external scrutiny.

In December, we underwent our Care Quality Commission inspection, the toughest examination any healthcare organisation can experience. When the results were published soon after our regulatory year end, we became only the third acute trust in the country to be awarded the highest possible rating: Outstanding.

As its name suggests, the Commission prioritises quality of care above all else, not just in terms of access, systems and outcomes but also in the human definition of the term: looking at the compassion and empathy we extend to our patients and each other. There really is no higher accolade our staff could receive. We are beyond proud of them, and the communities we serve can take great confidence in the hospitals that are here for them.

But the inspectors did not just examine what we do and how we do it, they also explored the structures that underpin our practice and create the platforms from which we are able to deliver outstanding care. The most important thing they found there was that, from board to ward, we all understand the unique challenges our hospitals face and we all buy in to the approach we have developed to respond to them.

The inspectors learned, for example, that we have one of the most elderly populations in the country – if you walk round our wards, you are likely to find a patient aged over 100 on nearly every one – and they saw that we put the implications of that fact right at the heart of all our planning and strategies.

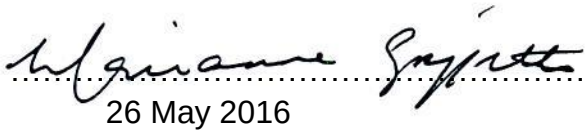
At one end of the scale, they have steered the development of an award-winning partnership scheme to reduce avoidable admissions and the creation of our ground-breaking Emergency Floors that give patients rapid access to diagnostics and multi-disciplinary care in a single setting; at the other, they are behind our ‘Welcome Home Packs’ initiative, which provides vulnerable older patients with fridge and food cupboard essentials as they are discharged from hospital.

We describe this focus as ‘Patient First’, which will enable us to build on the Outstanding CQC rating and continue to improve services over the long-term. This

approach is based on standardisation and system redesign, supported by a philosophy of continuous improvement, led by front-line staff empowered to identify, initiate and lead positive change.

Looking ahead, perhaps the most important of the CQC inspectors' findings was the extent to which colleagues at all levels and across all areas felt able to make the positive change Patient First describes and were enthused by the possibilities of innovation in service delivery and care.

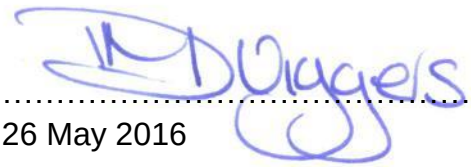
Patient First recognises that it is the people at the sharp end of hospital services who are best placed to identify and drive the improvements that need to be made there, but it requires inventive and dedicated people to make the most of that opportunity. At Western Sussex, we are extremely fortunate to have these exceptional people throughout our hospitals. They are the reason we have achieved so much in the seven years since the Trust was established, and the source of our confidence in the improvements that are still to come.



26 May 2016

Marianne Griffiths, Chief Executive

Western Sussex Hospitals NHS Foundation Trust



26 May 2016

Mike Viggers, Chairman

Western Sussex Hospitals NHS Foundation Trust

1.2 About the Trust

Western Sussex Hospitals NHS Foundation Trust serves a population of around 450,000 people across a catchment area covering most of West Sussex.

The Trust runs three hospitals:

- St.Richard's Hospital in Chichester,
- Southlands Hospital in Shoreham-by-Sea, and
- Worthing Hospital in the centre of Worthing.

St Richard's and Worthing hospitals provide 24-hour A&E, acute medical care, maternity and children's services, while Southlands specialises in day-case procedures and diagnostic and outpatient appointments.

In addition to our three hospitals, we provide a range of services in other community settings, including

- Bognor War Memorial Hospital,
- Crawley Hospital,
- health centres,
- GP surgeries, and
- sexual health clinics.

The organisation was created in 2009 by a merger of the Royal West Sussex and Worthing and Southlands Hospitals NHS Trusts, and has been an NHS Foundation Trust since 2013.

Our services are delivered through four clinical divisions – Medicine, Surgery, Women & Children and Core Services – and two enabling ones: Corporate, and Facilities & Estates.

We employ 6,881 people across all our sites, including nursing and midwifery staff, medical and dental staff, technicians and scientists, and are always looking for more skilled and caring people to join our teams.

In 2015/16, we held 585,846 outpatient appointments, treated 135,792 inpatient and day cases and saw 136,804 patients in A&E.

Throughout the year, our staff were supported by the activities of around 1,000 volunteers, who help in everything from serving meals and meeting and greeting patients to performing clerical duties, offering emotional support, befriending and listening.

As an NHS Foundation Trust, we also benefit from a membership of more than 7,000 staff, patients and members of our community, who are able to help guide our future plans and priorities through a range of channels including our Council of Governors.

As well as representing the views of local people, our governors act as a "critical friend" to the Trust, holding the organisation to account and monitoring our performance.

Our income for 2015/16 was £402 million, and our principal service commissioner was Coastal West Sussex Clinical Commissioning Group. We work closely with commissioners and other healthcare providers to use our budget to provide high-quality, integrated care for local people.

We were inspected by the Care Quality Commission, the independent regulator of health and social care in England, during December 2015, and awarded the highest possible rating, Outstanding.

Our ambition now is to build further on this achievement and continue to improve the quality of care we can offer our community. The principal risks that could affect the achievement of these objectives are related to rising levels of local demand and the national issue of recruitment, both of which are discussed more fully in the Performance Analysis section of this report. The directors have considered that on best estimates of future activity and cash flow the Trust is able to prepare its accounts on a going concern basis.

The headquarters of the Foundation Trust are:

Chief Executive's Office

Worthing Hospital

Lyndhurst Road

Worthing

West Sussex

BN11 2DH

1.3 Performance Analysis

1.3.1 Key performance indicators

Regulatory standards

The operational performance of Western Sussex Hospitals NHS Foundation Trust is measured against the 13 key access targets and outcomes objectives set out in the Risk Assessment Framework drawn up by Monitor (now part of NHS Improvement, the new overseer of health care organisations).

These are:

- Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted
- Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted
- Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway
- A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge
- All cancers: 62-day maximum wait for first treatment following urgent GP referral
- All cancers: 62-day maximum wait for first treatment following consultant screening service referral
- All cancers: 31-day maximum wait for second or subsequent treatment – surgery treatments
- All cancers: 31-day maximum wait for second or subsequent treatment – drug treatments
- All cancers: 31-day maximum wait from diagnosis to first treatment
- Cancer: Two-week maximum wait from referral to date seen – all patients
- Cancer: Two-week maximum wait from referral to date seen – symptomatic breast patients
- Clostridium Difficile: Meeting the C.Diff objective
- Certification against compliance with requirements re access to healthcare for people with a learning disability

Internal priorities

Alongside the performance standards we are required to meet by our regulators and external assessors, the Trust also sets itself a number of specific internal objectives that provide an additional means of measuring

progress towards our strategic goals, which in turn contribute to delivering our long-term ambition of providing 'the best care every time'.

Our four key strategic goals and associated performance targets are as follows:

Strategic goal	**Performance goal**
Reducing mortality and improving outcomes	To be in the top 20% of NHS organisations with lowest risk-adjusted mortality
Safe care	100% of patients receiving safe, harm-free care as measured by the following six harms: • Hospital acquired pressure ulcers • Catheter associated urinary tract infection • Avoidable venous thromboembolism (VTE) • Harm from falls • Hospital acquired infection • Medication errors
Reliable care	To achieve 95% reliability in compliance with the following care bundles: • Stroke or high risk transient ischaemic attack (TIA) care bundle • Sepsis care bundle • Acute Kidney Injury care bundle • Achieve 100% reliability in the recording of patient observations (at frequency determined for specific patients), and appropriate escalation to promote early recognition of deteriorating patients
Improved patient and staff experience	To be in the top 20% of NHS Trusts in country for patient and staff experience survey results

You can read more about the Trust's strategic goals in the Quality Report section of this Annual Report.

1.3.2 Monitoring performance

Regulatory standards

Western Sussex Hospitals NHS Foundation Trust utilises an extensive Performance Framework to ensure sustained delivery of key measures based on the principles of the Balanced Scorecard. This framework ensures scrutiny, assurance, and where necessary, remedial actions and follow through to compliance recovery. The layering of this framework ensures oversight occurs through

- Care Group review of departmental/ward delivery,
- Divisional Management Board review of associated Care Groups,
- Divisional Performance Reviews undertaken by the Trust Executive, and finally,
- monthly performance review by Trust Board.

Each layer of review and action considers both the 13 key access targets and outcomes objectives used to assess operational performance under the Monitor/NHS Improvement Risk Assessment Framework, and a wider set of balanced scorecard indicators that have been selected to provide a more complete view of operational risks and interdependencies. The review process is underpinned by an extensive suite of business intelligence tools designed to show outcomes, but also the drivers of potential compliance risks such as changing demand profiles.

Internal priorities

Progress towards the performance objectives that support our four key strategic goals is also monitored on an ongoing basis using a similar range of quantitative and qualitative measures.

These are described in detail in the Quality Report section of this Annual Report but can be summarised as follows:

Reducing mortality and improving outcomes

At WSHFT we use two measures of risk-adjusted mortality rates to monitor our performance and progress:

- The Hospital Standardised Mortality Ratio (HSMR) produced by Dr Foster Intelligence, and
- The Summary Hospital Mortality Indicator (SHMI) produced by the Health and Social Care Information Centre.

We place a stronger emphasis on the HSMR figures, as these are produced monthly rather than on the quarterly basis of SHMI, and also use crude non-elective mortality rates (the number of deaths in hospital as a percentage of the total number of patients discharged) as a more immediate indicator again.

Safe care

We monitor incidence of harm through three primary means:

- An electronic clinical incident reporting system,
- The NHS Patient Safety Thermometer, and
- Health Care Acquired Infection (HCAI) surveillance programmes.

Our electronic reporting system enables us to track patterns of clinical incidents, falls, medication errors and pressure ulcers to ensure lessons are learned on both a case-by-case and thematic basis.

The Safety Thermometer is a monthly audit examining whether any patient on an inpatient ward has suffered a fall, pressure ulcer or venous thromboembolism (VTE) event, or contracted a urinary tract infection (UTI) if they have a catheter.

The national HCAI surveillance programmes in which we participate require us to count and report all cases of Meticillin-resistant Staphylococcus Aureus (MRSA) found in blood sampling and Clostridium difficile (C.difficile) detected in stool samples. We also monitor bowel, breast, hip and knee surgery patients for surgical site infection (SSI) following their operation.

Reliable care

Care bundle compliance for stroke patients is monitored through the Sentinel Stroke National Audit Programme (SSNAP), supplemented by additional internal data that feeds into a local performance dashboard.

There are currently no national arrangements in place to capture data on sepsis and Acute Kidney Injury, meaning we use a sticker system to track bundle elements in patient notes. However, we plan to move to automated monitoring in future, beginning with the AKI bundle at Worthing.

Improved patient and staff experience

We monitor the quality of patient and staff experiences within the trust through a range of reporting mechanisms:

- The NHS Friends and Family Test
- Inpatient surveys
- Complaints and Patient Advice and Liaison Service (PALS) enquiries
- The annual NHS Staff Survey

The NHS Friends and Family Test requires hospitals to ask all adult inpatients, outpatients, day surgery patients, maternity service users and A&E attenders how likely they are to recommend the ward or department in which they were treated to friends and relatives if they needed similar treatment or care.

We supplement the data we receive from the Friends and family Test with our own, more detailed inpatient surveys completed by patients using hand-held tablets shortly before their discharge.

Other means of monitoring experience include feedback from complaints and PALs enquiries and comments placed on social media and the NHS choices website, feedback via Healthwatch West Sussex.

Staff experience is assessed through the annual Staff Survey, which asks a number of questions linked to the NHS Constitution and ranks levels of staff engagement on a scale of one to five. Some 54% of WSHFT staff took part in the 2015 survey, placing us within the top 20% of trusts for participation.

1.3.3 Clinical performance

Regulatory standards

The following table identifies in-year delivery and trending of the specific objectives of the Monitor/NHS Improvement Risk Assessment Framework in 2015/16 and shows consistent compliance and/or improvement. Detailed narrative of each element follows the table.

Monitor Risk Assessment Framework: Operational Indicators 2015/16

		Threshold	Q4 2014/15	Weighted Score	Q1	Weighted Score	Q2	Weighted Score	Q3	Weighted Score	Q4	Weighted Score (Forecast)	Trend
ACCESS													
M1	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90%	85.30%	2.0	83.84%	2.0							
M2	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95%	84.50%		85.28%								
M3	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete	92%	87.71%		87.66%		84.99%	1.0	86.61%	1.0	86.35%	1.0	
M5	A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	95.90%	0.0	97.46%	0.0	96.63%	0.0	95.10%	0.0	95.31%	0.0	
M6a	All cancers : 62-day wait for first treatment following urgent GP Referral	85%	87.13%	0.0	86.96%	0.0	87.53%	0.0	86.01%	0.0	85.85%	0.0	
M6b	All cancers : 62-day wait for first treatment following consultant screening service referral	90%	91.43%		94.12%		97.09%		95.43%		98.99%		
M7a	All cancers : 31-day wait for second or subsequent treatment - surgery treatments	94%	98.75%	0.0	100.00%	0.0	100.00%	0.0	100.00%	0.0	100.00%	0.0	
M7b	All cancers : 31-day wait for second or subsequent treatment - drug treatments	98%	100.00%		100.00%		100.00%		100.00%		100.00%		
M8	All cancers : 31-day wait from diagnosis to first treatment	96%	98.32%	0.0	99.21%	0.0	99.73%	0.0	99.34%	0.0	99.24%	0.0	
M9a	Cancer : two week wait from referral to date first seen - All patients	93%	92.01%	1.0	90.47%	1.0	93.64%	1.0	97.91%	0.0	97.28%	0.0	
M9b	Cancer : two week wait from referral to date first seen - Symptomatic breast patients	93%	91.37%		84.08%		91.13%		97.59%		97.27%		
OUTCOMES													
M17	Clostridium Difficile – meeting the Clostridium Difficile objective	39	6	0.0	7	0.0	11	0.0	12	0.0	6	0.0	
M27	Certification against compliance with requirements re access to healthcare for people with a learning	YES		0.0	YES	0.0	YES	0.0	YES	0.0	YES	0.0	
Monitor Compliance Framework Score				3.0		3.0		2.0		1.0		1.0	

Green : 0	Amber/Green : 1	Amber : 2	Amber/Red : 3	Red : 4 or more

Notes

i From 1 October 2013 MRSA was removed from the Monitor Risk Assessment Framework

ii Targets for admitted and non-admitted completed RTT pathways have been removed from Monitor's risk assessment framework with effect from 24 June 2015.

Referral to Treatment (RTT)

Sustained historic demand above planned levels has compromised RTT delivery, and enforced the need for a formal recovery programme in 2015/16. The Trust delivered 3,332 (2.5%) more completed pathways in 2015/16 than planned under the Joint RTT Recovery Programme submitted to NHSE/Monitor by WSHFT and Coastal West Sussex CCG, however, in year demand exceeded planned levels and compromised the effectiveness of recovery actions. Cumulatively, referrals were 8,145 cases (4.5%) higher than plan for full year 2015/16.

As part of in year actions to address excess referrals, the Trust took the lead for the co-ordinating NHS commissioned independent sector capacity, and in combination with the additional volumes at the Trust this action supported significant improvement from August 2015.

WSHFT and Coastal West Sussex CCG continue to work closely with NHSE/Monitor to deliver recovery to plans but regrettably, actions implemented in 2015/16 have not proved sufficient to offset on-going above plan referrals. In turn, this has enforced extension of existing recovery trajectories and pushed forecast incomplete compliance back to the later quarter of 2016/17.

The one area of sustained non-compliance at WSHFT relates to the continued 'managed fail' in Referral to Treatment (RTT) as part of an agreed recovery programme.

A&E waiting times

The Trust was one of the few nationally that has consistently delivered 95% compliance within four hours for patients arriving at A&E to admission, transfer, or discharge. This has been set against a backdrop of significant and sustained increases in demand, with a 1.6% increase in A&E attendances in 2015/16 versus 2014/15 and a 5.7% increase in non-elective admissions.

Formally reportable delayed transfers of care (DTOC) have also placed significant pressures on the Trust's ability to maintain flow with a range of 2.5% to 4.5% observed in the year. This excludes patients who are medically fit for discharge (MFFD) but have not yet been classified as delayed transfers under national guidance, as a multi-disciplinary case review had not taken place. In real terms, this reflects an impact in 'lost' beds that fluctuated for DTOCs between 22 and 44 beds, while MFFD equated to the loss of between 80-150 beds.

Based on cumulative compliance for the full year 2015/16 national data shows WSHFT to have had the highest cumulative compliance in the South of England and the 4th highest compliance level nationally.

Cancer

The Trust completed the year with full compliance across all cancer metrics, set against a context the context of an 18.8% increase in cancer referral demand in 2015/16 compared to 2014/15, and an 18.3% increase in cancer treatment activity.

Unprecedented demand above plan in 2014/15 enforced an extensive recovery programmes through the first half of 2015/16 restoring compliance in 2 week rule by the end of Quarter 2. These actions delivered full compliance in both July and August, however, Symptomatic Breast compliance for Quarter 2 was compromised as a result of short notice and unavoidable absence of a single consultant and the loss of 10 sessions in September. Cross cover arrangements were rapidly put in place, however, this event, coupled with unplanned additional demand levels, generated unavoidable breaches in this low volume metric from which recovery was impossible. This atypical event was resolved swiftly, but noted to demonstrate that the Q2 compliance failure related to a two week period of non-compliance in a single metric.

Contextually, nationally published data shows WSHFT to mirror compliance for initial attendance following a cancer referral, and to be in 36% of trusts nationally that are delivering definitive treatment within 62 days.

Internal priorities

Performance against our key internal goals for the year, as set out by our Quality Strategy, is summarised as follows, with full detail available in the Quality Report section of this Annual Report.

Reducing mortality and improving outcomes

In 2015/16, the Trust achieved its goal of being in the 20% of NHS organisations with the lowest risk-adjusted mortality rates. In ranking terms, we have moved from being 112th out of 141 organisations in 2011/12 to standing 23rd today.

We have also focused over recent years on improving mortality rates among hip fracture patients. In 2015/16, these stood at 77.2 on the Dr Foster HSMR measure, against an expected average of 100.0.

Our SHMI and crude mortality rates rose slightly during the year, albeit with the former doing so inside the expected range and the latter increasing below the national trend.

Safe care

In 2015/16 we made significant progress towards our goal of 100% of patients receiving safe care that exposed them to none of the six key harms identified as part of our strategic objectives.

There were no cases of hospital-acquired MRSA during the year and we again achieved a reduced incidence of C.difficile, meeting both our national and internal stretch targets.

On average each month, 4-6% of patients experience either a fall, pressure ulcer, VTE event or a catheter-associated urinary tract infection, although only 2% do so after admission.

Reliable care

Major strides to improve systems and processes so that patients are seen, assessed and begin treatment earlier and more comprehensively led to Worthing Hospital being rated the seventh best in the country for stroke care, and St Richard's 35th, in the Sentinel Stroke National Audit Programme assessment results published in August 2015. Both sites were outside the top 100 just a few years ago.

Our focus on Acute Kidney Injury (AKI) through our Deteriorating Patient programme also enabled us to reduce crude non-elective mortality associated with AKI during the year.

Improved patient and staff experience

Our performance against internal goals for the NHS Family and Friends Test was as follows:

- In A&E, we were among the top 40% of trusts for recommendation, against a target of top 30%
- In maternity, our response and recommendation rates both reduced against 2014/15 levels to slip just below the national average.
- For inpatient recommendation, we did not achieve our in-year objective of being in line with the national average
- Among outpatients, we achieved one goal in improving our recommendation rating but not sufficiently to reach the national average

We are taking steps to improve our performance in the areas outlined above, in order that we meet all four internal goals.

Our NHS Staff Survey results showed an increase in the proportion of staff feeling positive about the overall quality of services and care offered by the trust, but again we were slightly below the national average on this measure.

1.3.4 Financial performance

The key highlights for the Trust's financial performance during the period from 1st April 2015 – 31st March 2016 were:

- Against a challenging financial environment the Trust incurred a retained deficit of £4.8m. The Trust delivered a financial risk rating of 2 at year end, out of a possible top rating of 4.
- Cost improvement programme savings of £16.3m
- Expenditure on capital schemes of £17m, including upgrading Endoscopy facilities and a new Interventional Radiology Room.

As the year progressed the Trust experienced:

- Pressure on staffing rotas which led to an increase in the use of agency staff, particularly for nurses and doctors.
- Significantly higher than planned increases in Non-elective activity, A&E attendances and outpatient procedures.
- A rise in the proportion of admissions from the over 85 years age group, who have a longer average stay and an increase in acuity levels.
- A significant increase in referrals for urgent and elective treatment in certain specialties.

The Trust saved £16.3m by streamlining processes, improving productivity smarter procurement and reducing waste.

Over the next financial year we aim to deliver a further £19m of savings. Like all NHS organisations, the income we earn for the procedures we carry out, known as the tariff, has risen more slowly than the inflationary costs of running our services, including pension changes. So, over time, we are paid less than the increase in the costs of the services we deliver while, at the same time, also serving a growing demand.

We also need to recover the deficit incurred in 2015/16 and provide funding for some new investments.

As at the end of March 2016, the Trust is reporting a deficit of £4.8m after adjustment for impairments and donated assets as summarised in the table below.

Financial Performance for 2015/16	**£m**
Net Deficit	(£8.55)
Add back:	
Impairment of Fixed Assets	£3.73
Retained Deficit	(£4.82)

The Trust undertakes an annual revaluation of its estate on a Modern Equivalent Asset basis for land and buildings. Any movements in the value of the estate are reflected in either the revaluation reserve or the income and expenditure account depending on the nature of the change and any previous changes in respect of that asset. The impairments of £3.73m relate to net changes in asset value following the annual revaluation.

Long-term Liabilities

The affordability of long-term loans is considered by the Trust Board prior to approval. Further information on the Trust's long-term borrowings is available within Note 29 to the accounts.

Financial Outlook

The Trust has published its operational plan for 2016/17, including its financial plans. The Trust forecasts reaching a Financial Sustainability Risk Rating of 4 and delivering a control total surplus, as defined by NHS Improvement, of £16.4m, which includes funding from the Sustainability and Transformation Fund. The Cost Improvement Programme for the next financial year amounts to £19m.

Going Concern

After making enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts.

Governance Ratings

The Trust is assessed under NHS Improvement's Risk Assessment Framework. Financial risk is covered under the Financial Sustainability Risk Rating which is driven by assessments on liquidity, capital service cover, income and expenditure margin and variance to plan. The highest rating that can be achieved is a score of 4. A score of 3 indicates no significant financial concerns and a score of 2 requires an increased level of monitoring. The Trust scored a 3 in quarters one and two and a 2 for the remaining two quarters.

There were no formal interventions by the regulator during the year 2015/16.

Other Financial Information

Accounting policies for pensions and other retirement benefits are set out in Note 1.3 to the accounts.

Details of senior employees' remuneration can be found within the remuneration report.

There are no post balance sheet events.

The Trust spent £758k on external consultancy services in 2015/16, primarily to support the patient first initiative, the efficiency scheme and the development of business cases.

In the period there were no individuals who retired early on ill-health grounds.

Note 37 to the accounts sets out, in relation to the financial instruments, an indication of the financial risk management objectives and policies of the Trust and the exposure of the entity to price risk, credit risk, liquidity risk and cash flow risk, where material for the assessment of the assets, liabilities, financial position and results of the Trust.

Income Disclosure

The income from the provision of goods and services for the purposes of the health service in England is greater than the income from the provision of goods and services for any other purposes. Income from goods and services not for the purposes of the health service in England is required to at a

minimum cover the full cost of delivery of the goods and services. Any surplus from these activities is reinvested and supports the provision of goods and services for the purposes of the health service in England.

In the period there were no individuals who retired early on ill-health grounds.

Note 37 to the accounts sets out, in relation to the financial instruments, an indication of the financial risk management objectives and policies of the Trust and the exposure of the entity to price risk, credit risk, liquidity risk and cash flow risk, where material for the assessment of the assets, liabilities, financial position and results of the Trust.

Director's Statement

The directors are required under the NHS Health Service Act 2006 to prepare accounts for each financial year.

The directors consider the Annual Report and Accounts, taken as a whole, to be fair, balanced and understandable and provide the information necessary for patients, regulators, and stakeholders to assess the Trust's performance, business model and strategy.

Each director of the Trust Board, at the time of approval of the Annual Report and Financial Statements, declares that:

- So far as they are aware, there is no relevant audit information of which the Trust's auditor is unaware; and
- The director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

1.3.5 Environmental impacts

The Estates, Facilities and Capital team has embraced the concept of sustainability and provides leadership to enable the Trust to operate in a way that ensures a high regard for energy efficiency, carbon reduction, waste management and the most appropriate use of materials and other resources. We will also give due consideration to the use of sustainable travel.

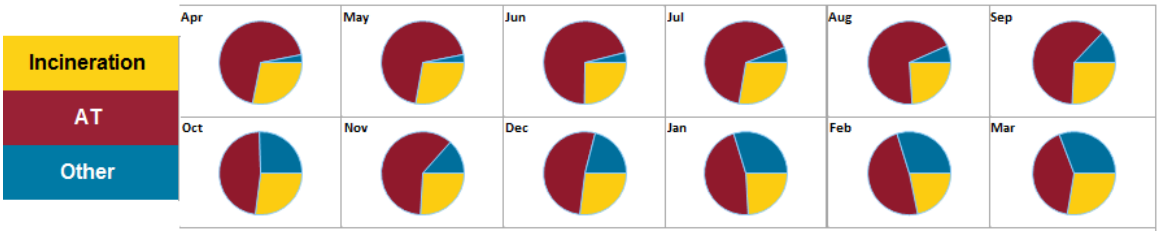
We are taking a *'one step at a time'* approach for the different messages and campaigns.

Our sustainability objectives for 2015/16 were to provide a dedicated resource to drive sustainability across Western Sussex Hospitals. We have:

- Reduced our waste output by 20 tonnes, thus reducing our carbon emissions from waste disposal as a result
- Appointed a new post of Sustainability Manager
- Set up a Green Travel Group
- Worked with a local school to start a green garden project
- Engaged with other local trusts on sustainability issues

The following chart refers only to clinical waste and shows that in 2015/16 we have reduced infectious waste through a drive to increase non-infectious waste, which is less harmful to the environment as it is not required to receive autoclave processing and so reduces carbon emissions from our waste disposal process. There is also a financial saving to the Trust.

(The blue section of the chart shows the planned increase in non-infectious waste. AT refers to Alternative Treatment rather than waste sent for incineration.)



Sustainability Objectives 2016/17

- Green Travel Plan: We have established a Green Travel Plan Group to address transport issues and concerns and promote healthy living while giving a range of travel options to all staff groups. The group includes staff from across the Trust and will add external members from local travel providers, councils and other interested transport groups. A staff and visitor questionnaire will be sent out to gain feedback from all to analyse current travel arrangements across the Trust.
- Environmental Strategy: This will be completed by May 2016
- Good Corporate Citizenship Assessment Model: Participation will improve audit ratings from (Getting Started) to (Getting There) in 2016/17 We will then aim for the last stage of the scheme to excellent in 2017/18. The scheme gives us a measure of our sustainability improvements and is recommended by NHS Sustainable Development.
- Report energy, water and waste performance to Trust staff: We will develop a Sustainability page on the intranet to achieve this
- Reduce carbon consumption: Our energy use will continue to be measured and managed to reduce our carbon consumption based on gross internal floor space

1.3.6 Influences on performance 2015-16

Staff commitment

The most important influence on the Trust's performance during 2015/16 was the commitment and dedication of our 6,881 staff, who cared for more people than ever before, achieved better outcomes and standards than ever before, and still found time to treat their patients with compassion, kindness and dignity.

Their tireless willingness to go the extra mile was reflected in another record number of nominations for our staff recognition awards (400+), a string of external health award wins and nominations, and a CQC inspection that received an unprecedented number of submissions from patients and carers offering feedback that was "overwhelmingly and almost exclusively positive".

The CQC's Chief inspector of Hospitals, Professor Sir Mike Richards, commended the positive attitude of staff and the Trust's innovative approach to continually improving the care you provide.

He said: "Staff we spoke with were exceptionally compassionate when talking about patients and we observed kindness not only towards patients but towards each other whilst on site.

"We were flooded with requests from staff wanting to tell us about specific pieces of work they were doing, how much they liked working for the trust and how supportive the trust executive team were of innovative ideas and further learning as a tool for improvements in patient care.

"Multidisciplinary working was a very strong feature across the hospitals that resulted in better patient care and outcomes.

"There was clear professional respect between all levels and disciplines of staff. We saw real warmth amongst teams and an open and trusting culture."

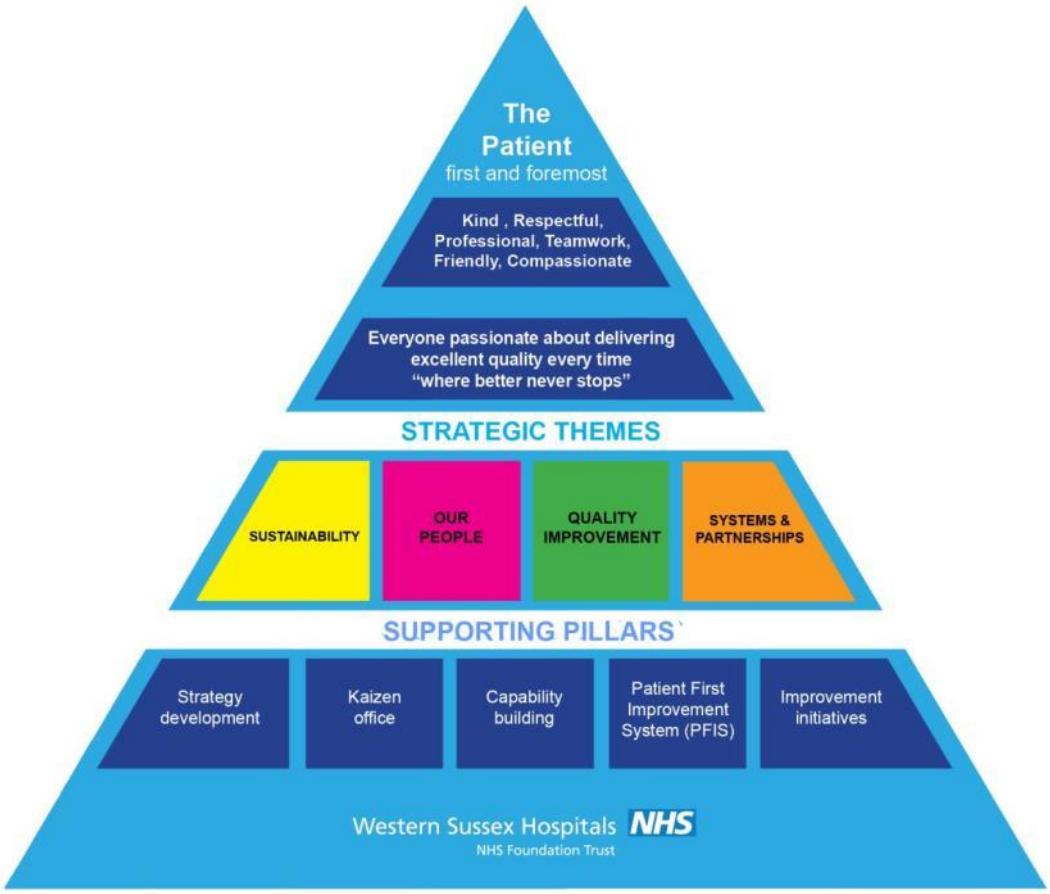
Patient First

The Trust Board recognises that much of the strength of our hospitals lies in the skill, enthusiasm and innovation of our staff and has actively sought to build an organisational culture that empowers these teams and individuals to make lasting changes that benefit our patients and community.

To do this, we have developed Patient First – a new, long-term approach to transforming the way we deliver our services for the better.

Patient First is a programme based on standardisation, system redesign and ongoing development of care pathways, built on a philosophy of incremental and continuous improvement led by front-line staff empowered to initiate and lead positive change.

We describe the structure and focus of Patient First visually in the form of a triangle.



The Patient, first and foremost, is at the apex of the triangle, to make explicit the commitment that everything we do, no matter how large or small, should always contribute to improving outcomes and experiences for the people we care for in our hospitals.

This is the 'True North' of our organisation – the one constant towards which we must always set our direction of travel in order to achieve our vision.

The middle tier of the triangle identifies the four strategic themes on which we need to focus to create the organisation our patients want us to become:

- Sustainability
- People

- Quality improvement
- Systems and partnerships

Finally, the base of the triangle is comprised of the five pillars that will support the strategic themes and help us achieve the targets we have set under each:

- Strategy deployment
- Kaizen Office
- Capability building
- Patient First Improvement System (PFIS)
- Improvement Initiatives

The Patient First Improvement Programme uses the methodologies of the Lean and Six Sigma improvement framework, which has been proven throughout the world as a highly-successful system for enabling sustained progress towards strategic goals.

This approach has enabled us to identify a True North metric and associated objective for each of the strategic themes – essentially a point of focus and measurement that will make the strongest direct contribution towards moving us forward towards our Patient First goal:

- Theme: Sustainability

  Metric: Budget management

  Objective: Break even

- Theme: People

  Metric: Staff engagement score

  Objective: Top 20% in the country

- Theme: Quality improvement

  Metrics: Preventable mortality

  Avoiding harm

  Objectives: HSMR among best 20% in the country

  99% harm-free care on Patient Safety Thermometer

- Theme: Systems and partnerships

  Metric: Patient flow

  Objectives: Referral-to-treatment time less than 18 weeks for 92% of patients

A&E waits of under four hours for 95% of attenders

The cultural change needed to achieve service transformation on this scale requires a significant degree of support, which is what the triangle's five underlying pillars have been created to provide – all working collectively but each with a specific focus of its own.

Strategy Deployment identifies and reviews the True North objectives for each strategic theme and is responsible for cascading these throughout the trust to enable all improvement initiatives to support these common goals.

The **Kaizen Office** is the Trust's centre of excellence for the Lean techniques underpinning Patient First, home to a dedicated team tasked with enabling a consistent and sustainable Trust-wide approach to improvement over the long term.

Capability building is about equipping our staff with the skills to deliver continuous improvement, with training available for every staff member, beginning at induction and going all the way through to Lean practitioner level.

The **Patient First Improvement System** (PFIS) is a Trust-wide Lean Management system which will empower front-line staff at all levels to make changes aligned to the True North goals and give back 'time to care' by removing wasteful activities and improving processes.

Improvement initiatives are specific, larger projects aligned to True North metrics and breakthrough goals, managed by Lean-trained staff and supported by the Kaizen Office.

Demand

Our hospitals continue to get busier and busier every year as demand for services continues to increase, putting ever-greater pressure on our staff and requiring us to work ever more efficiently and think in more innovative ways to meet the changing needs of our population.

Since the Trust was formed in 2009, the number of outpatient appointments we hold every year has increased by 67% to more than 585,000; the number of day case operations we perform has grown 63% to almost 63,000; and A&E attendances are up 15% to nearly 137,000.

Discharge

Being able to discharge patients in a safe and timely manner has a major impact on the functioning of the entire hospital system, as we cannot admit

new patients if the beds we need to accommodate them are still occupied by patients who are well enough to leave.

Delayed discharges are a major issue across the health care system; at Western Sussex Hospitals, at any point during 2015/16 there were typically more than 100 people on our wards who no longer needed to be there.

We continue to work with our community partners to improve the discharge process and constantly review our internal systems. In February 2016, for example, we imposed a three-week 'managed business continuity' period to co-ordinate and prioritise action across the Trust to standardise best practice such as 'daily board rounds' (which we have seen reduce average length of stay on some wards from 15 days to 11) and enable us to discharge safely as many people as possible, reducing our need for escalation beds and enabling clinical staff to remain in their designated areas rather than be moved around to meet increased capacity needs.

Recruitment

The national shortage of nurses facing the NHS is well documented – the total runs to 20,000 across the country in all. At Western Sussex Hospitals our nurse vacancy rate peaked at 309 in December 2015, a shortfall that creates significant challenges for us both financially – through the cost of covering shifts with agency staff – and in terms of the continuity of care we are able to provide as we have to move nurses away from their designated areas to help cover elsewhere.

We have, however, begun to reduce our vacancy rate through a range of recruitment and retention initiatives during 2015/16:

- We introduced innovative 'one-stop' nurse recruitment events, which alternate between Worthing and St Richard's Hospitals and give applicants the opportunity to meet senior nurses, discover more about the Trust and be tested and interviewed all within a few hours, with those successful offered a job on the spot. Over the year, we recruited 100 new nurses in this way and the events were featured on the BBC1 regional current affairs programme *Inside Out*.

- In the summer of 2015, we sent a team to the Philippines to recruit another 149 nurses, having previously attracted a further 26 from a similar visit to Portugal and Spain.

- We have also focused on developing staff retention initiatives, including a health and wellbeing programme, 'stay' interviews to find solutions to problems before people resign, electronic beds that enable one nurse

to move a patient rather than three, new support roles to get more nurses on wards, and higher rates of pay for bank staff.

- Our programme of recruiting and supporting apprentices continues with A total of 43 new apprentices recruited during 2015/16 (an increase of 15 from 2014-2015). This means the Trust has recruited more than 100 apprentices. In addition, the Trust achieved recognition for our achievements in recruiting and developing apprentices at the KSS Apprentice Awards, where Western Sussex was overall winner of the Level 2 Clinical Award and runner-up in another five categories.

In 2016/17 we will continue to develop our recruitment strategy by adding new initiatives to those we already have in place, including attending regional and national events and running campaigns across digital and social media.

We also need to recruit more staff across a range of other professions and roles, including middle-grade doctors, health care assistants and radiologists, and hope that our Patient First approach and position as one of only three trusts in the country rated as Outstanding by the CQC will help us attract more of the high-calibre people we seek.

1.3.7 Post-year events

CQC Inspection Results

On 20 April 2016, the Care Quality Commission (CQC) published the results of the inspection visits it made to Western Sussex Hospitals during December 2015.

Our CQC rating is ‘Outstanding’, making us one of only three trusts in the country to be awarded the highest possible grade.

The inspectors rated the overall standard of care the Trust provides as Outstanding and gave the same grade to our accident and emergency department, medical care, end-of-life care, maternity, gynaecology and children’s services.

On the five key measures the CQC measures performance against, Western Sussex was awarded an Outstanding grade for being effective, caring and well-led, and was marked Good for safety also. Referral-to-treatment (RTT) times meant we were considered as Requires Improvement on the responsiveness measure, although the inspectors recognised that we had a clear understanding of the issues we faced and robust plans in place to address them.

We did not receive a single Enforcement Action identifying specific areas in which improvement needs to be made, just two Requirement Notices (around availability of pressure-relieving equipment and fridge storage of medicines) and 16 ‘should’ actions.

Hospital Ratings

St Richard’s and Worthing Hospitals were both rated Outstanding. Southlands was rated as Good, but was only inspected in two areas – surgery and outpatients – and achieved exactly the same standards as St Richard’s and Worthing in these.

Service Ratings

The services inspected by the CQC were:

- Urgent and Emergency Care
- Medical Care (including Older People)
- End-of-Life Care
- Surgery
- Critical Care
- Outpatients and Diagnostics
- Maternity and Gynaecology
- Children and Young People’s Services

Urgent and Emergency Care, Medical Care, Maternity & Gynaecology, Children & Young People’s Services and End-of-Life Care were all rated Outstanding at both St Richard’s and Worthing. Surgery and Outpatients & Diagnostics were rated Good at all three hospitals sites.

Critical Care was given a Requires Improvement grading at both St Richard’s and Worthing.

The full report is published on the CQC website – www.cqc.org.uk/provider/RYR

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26 May 2016

Marianne Griffiths, Chief Executive

Western Sussex Hospitals NHS Foundation Trust

2. Accountability Report

2.1 Directors' Report

Our Board of Directors is responsible for the management and performance of the Trust, and for setting its future strategy.

This section of the Annual Report provides an overview of 2015/16 from an operational and strategic standpoint, outlines the in-year development of the Trust's relationships and partnerships with stakeholders, and details its governance and management arrangements from a Board perspective.

2.1.1 Patient Care

Care Quality Commission Inspection

For patient care, the most significant event of 2015/16 was the announced and unannounced inspection visits staged by the Care Quality Commission at all three of our hospitals during December. When the results of the visit were reported in April 2016 (see Post-Year Events), the Outstanding rating we received provided tremendous reassurance for our patients that we provide some of the very best care in the country.

The CQC's Chief Inspector of Hospitals, Professor Sir Mike Richards, commended the positive attitude of staff and their innovative solutions to continually enhancing the care they provide. He said: "We were flooded with requests from staff wanting to tell us about specific pieces of work they were doing, how much they liked working for the trust and how supportive the trust executive team were of innovative ideas and further learning as a tool for improvements in patient care.

"Multidisciplinary working was a very strong feature across the hospital that resulted in better patient care and outcomes. There was clear professional respect between all levels and disciplines of staff. We saw real warmth amongst teams and an open and trusting culture."

The Outstanding rating was also a significant endorsement of the thinking behind our Patient First Improvement Programme (see Influences on Performance).

Like all NHS trusts, we face some very challenging issues, but what impressed the inspectors was that we acknowledge our weaknesses and have in place a strong vision of how we will overcome them. We know that frontline staff have the best understanding of what needs to be done to make

services better for patients and through our Patient First programme we are giving them the skills and support to make that change happen.

Awards

Once again, many of our staff, services and innovations were recognised with awards from colleagues, the public and the wider NHS. This year's successes included:

- The prestigious NHS England and NHS Employers Kate Granger Award for Compassionate Care was won by our pathology team working with colleagues in paediatrics for their Harvey's Gang initiative, which enables young patients to spend time in the labs learning about their bloods and the testing procedure.
- Our midwives won an All-Party Parliamentary Award for their weight management in pregnancy programme, their efforts to support partners to stay overnight on post-natal wards, and the work of their specialist case loading team to help young and vulnerable women.

  They also won the Patient, Carer and Public Engagement category in the Kent Surrey Sussex Academic Health Science Network Awards, where the trust was also short-listed for improvements made to the fractured neck of femur pathway.

- The Trust won two important prizes at the NHS Kent, Sussex & Surrey Leadership Recognition Awards, where our Trust Board was named Governing Body of the Year and the WSHFT-led One Call One Team initiative that enables more patients to receive care in their homes came top in the Outstanding Collaborative Leadership category.
- Three of our apprentices won prizes at the Health Education Kent Surrey and Sussex NHS Apprenticeship Awards, including apprentice of the year, while the Trust itself was named runner-up as the region's apprentice employer of the year.
- The Fernhurst Centre at St Richard's Hospital received a five-star Quality Environment Award from Macmillan.
- The almost one million meals served by our restaurants and inpatient kitchens were given a gold-standard Eat Out Eat Well award by Environmental Health inspectors for their ingredients, preparation, healthy options and promotion of good nutritional choices.
- And among our individual award winners, Helen Lee was named Audiologist of the Year by the British Academy of Audiology for her compassionate care of a young patient with tinnitus, while home enteral feeding dietitian Catherine Foster received an Extra Mile Award from the Motor Neurone Disease Association for her outstanding professional care.

You can read more about our award winners and their impact on patient care in the Quality Report section of this Annual report.

Innovations

Not every innovation we come up with goes in for an award, but our clinicians and support staff are constantly finding new ways to improve standards of safety, care and patient experience all the same. In 2015/16 alone, they developed new systems to identify patients at risk of potentially fatal complications, made sure our elderly patients never go home to an empty cupboard or fridge, and literally went the extra mile to find the staff we need to get more nurses onto our wards.

Early warning system protects patients at risk

In July 2015, the Trust introduced a new alerting system to improve the identification of patients suffering or at risk of potentially fatal acute kidney injury (AKI).

Western Sussex clinicians developed the new system with monitoring technology provider Patientrack to enable staff to record observations electronically at the bedside and be alerted to any early warning scores it calculates.

The next stage for 2016 is to speed up the early warning process further still by automatically emailing alerts to mobile phones carried by ward sisters.

A warmer Welcome Home for the elderly

Since September 2015, older people returning home after a stay in our hospitals have been benefitting from a new ‘Welcome Home’ scheme set up by staff and supported by our volunteers and local supermarkets.

The initiative helps frail and isolated patients feel more comfortable on their first night back home by making sure they have essentials like milk, bread, cheese and fruit ready and waiting.

Sepsis campaign saves lives

The same month, the Trust launched a new awareness campaign aimed at helping clinicians to recognise and treat the potentially life-threatening condition sepsis more quickly.

Our two Accident & Emergency departments introduced a new sepsis screening tool to help doctors check for signs of the condition and then get

patients affected the antibiotics and treatment they need inside an hour of diagnosis.

The Trust also now runs on-the-spot training sessions for clinical staff to help them recognise the early signs of sepsis. Using a hi-tech simulation dummy placed in A&E, staff are exposed to the recorded data from a real patient who was admitted with sepsis so they can train in a near-live situation.

Going the extra miles to recruit more nurses

Throughout 2015/16, we ran a major campaign to recruit more nurses across our hospitals and help the Trust address a national shortfall of some 20,000.

We have been holding regular recruitment and selection days at both St Richard's and Worthing Hospitals to enable candidates to be interviewed, assessed and offered jobs all on the same day, and have appointed 149 nurses from the Philippines plus 28 from Spain and Portugal.

Safer prescribing through real-time reports

The new electronic prescribing and medicine administration system introduced to all adult wards across 2015 has enabled us to develop new data extraction methods that enable pharmacists and consultants to monitor patients taking antibiotics in real-time.

This new live tracking ability, which allows them to access drug information by patient, type, ward and prescriber, enables them to identify patients most in need of their attention and target their input without having to wait for referral.

Keeping patients and visitors in the picture

During 2015/16 we installed real-time information screens in 38 wards across the Trust to give patients and visitors an insight into the work of the people treating them and the standards of care being achieved.

The automated screens display performance statistics ranging from Friends and Family Test results and the number of falls and pressure ulcers experienced during the past month to ward staffing levels and infection rates, as well as useful information such as visiting times and a staff uniform guide.

Strategic developments

Major strategic developments that either completed or progressed during 2015/16 were the Coastal West Sussex MSK Redesign Programme, Western Sussex Eye Care | Southlands, outpatient service improvements and the Emergency Floors at Worthing and St Richard's.

Coastal West Sussex MSK Redesign Programme

Western Sussex Hospitals NHS Foundation Trust was appointed lead provider of musculoskeletal (MSK) services in the Coastal West Sussex area in June 2015 and has been working with our partners Sussex Community NHS Trust and Independent Lives to develop a radical new approach to delivering outpatient and elective surgical care for patients with these types of conditions.

This redesign programme will bring together the best approaches from a range of providers to make care pathways smoother and more efficient, with shorter waits and fewer cancellations. We hope the new service will be in place during the summer of 2016.

Western Sussex Eye Care I Southlands

In October, we unveiled our plans for a new £7.5 million eye care centre at Southlands Hospital, a patient-focused, state-of-the-art facility designed to enable more people to receive all tests, results and diagnosis in one visit, with many treatments also available on the same day.

The ophthalmology unit, to be called Western Sussex Eye Care | Southlands, will open in 2017 and see more than 3,000 patients a month to meet a rising trend in demand that has seen referrals from GPs and opticians growing 15% a year.

It complements the multi-million pound investment already made at St Richard's Hospital, Chichester, and completes a new service – Western Sussex Eye Care – being introduced by our dedicated team of ophthalmology specialists across the Trust.

Outpatient improvements

During 2015/16 we completed an important diagnostic exercise to identify opportunities to improve processes and patient experience in the Trust's outpatient services. A range of recommendations around referral and grading, appointment booking, attendance and follow-up based on staff-patient feedback and data analysis will now be prioritised for implementation over the next year.

Emergency Floor development: St Richard's and Worthing

Following the success of the new Emergency Floor opened at Worthing Hospital in December 2014, we extended the model to St Richard's during 2015/16.

The Emergency Floor concept brings together the existing Acute Medicine, Medicine for the Elderly and Surgical Assessment Units in a single operation

that removes traditional boundaries between hospital, community and primary care, and improves outcomes by ensuring patients have rapid access to diagnostics and multi-disciplinary expertise in a single setting.

The Worthing pilot was one of only four sites in the country selected to be part of the Royal College of Physicians' (RCP) Future Hospital Programme, which aims to foster system-wide improvement in the care of medical patients nationwide.

Results from Worthing show the new system has made a significant contribution to reducing A&E waiting times, overall lengths of hospital stay, ward moves, readmissions and mortality rates, and improved the quality of care patients receive.

Complaints

Our Patient Advice and Liaison Service (PALS) is usually the first port of call for anyone who has a problem they need to trust to look into or resolve. PALS officers are able to offer advice on how and where to complain, investigate concerns and help bring resolution when things have gone wrong. Our complaints team investigates more complex and serious concerns that require a formal investigation about past events.

Full details of PALS and complaints activity are included in the Quality Report section of this Annual Report, but some key figures are as follows:

- The Customer Relations team dealt with 12,595 patients, relatives, visitors, carers and other service users during the year.
- In 36% of cases, we helped put things right via our PALS service within one working day.
- 59% of enquiries were on-the-spot general advice and information requests.
- 5% of all enquiries required a formal investigation under the NHS Complaints Procedure.

None of the formal complaints received in 2015/16 have yet been referred to the Parliamentary Health Service Ombudsman (PHSO) for independent review by the complainant. However there were 28 cases referred to the PHSO relating to complaints made in previous years. Of these 25% have not been upheld, 46% are still under review and 29% were upheld.

Quality Improvement

Our continuing focus on quality improvement was a major factor in the Care Quality Commission's assessment of the Trust as an Outstanding healthcare organisation.

Continuous improvement is a key strand of the philosophy behind our Patient First programme and is guided by the Quality Strategy we published in 2015 to cover the period to 2018.

The Quality Strategy sets out the four broad areas in which our improvement efforts can have the strongest positive effect on outcomes and experiences for patients. These are:

- Reducing mortality and improving outcomes
- Delivering safe, harm-free care
- Delivering reliable care
- Improving the experience of patients and staff

Within the period covered by the Quality Strategy, the Trust sets out annual priorities under each of the four key areas of focus. Achievement against the 2015/16 objectives is described in the Performance Analysis section of this report, while those we have established for 2016/17 are as follows. Again, more details are available in the Quality Report section.

Reducing mortality and improving outcomes

- 95% achievement of the implementation of care bundles to improve the recognition and care of physiologically deteriorating patients, including sepsis, acute kidney injury and preventing cardiac arrest
- Reduction in the number of still births and implementation of recommendations from National Maternity Review
- Implementation of the End of Life Care Strategy

Delivering safe, harm-free care

- Reduction of in-hospital falls by 30%
- Implementation of a Medicines Optimisation Strategy
- Reduction of in-hospital acquired pressure ulcers by 10%
- Improvements in culture and environment to promote harm-free care, including continued roll-out of ward accreditation, and enabling staff to raise concerns

Delivering reliable care

- Continued improvement of the stroke care pathway (SSNAP)
- Continued improvement of the frail elderly dementia pathway

- Roll-out of the Enhanced Quality Emergency Laparotomy Programme with the AHSN Collaborative

Improving the experience of patient and staff

Patient experience:

- Improvement in patient experience of discharge
- Reduction in delays in discharge
- Improved mealtime support/nutrition
- Improvement in privacy/provision of private areas
- Improved communication with a particular focus on access and outpatients
- Improved experience for young people receiving care across the Trust through the Children's Board recommendations

Staff experience:

- Build the capability and capacity for improvement through Patient First and increase the number of staff reporting that they can make change happen in their work area
- Close the workforce capacity gap with sustainable solutions through the Workforce Transformation Programme
- Further integration of education and research, plus development of a Clinical Academic Pathway
- Health and Wellbeing programmes

2.1.2 Stakeholder Relations

Collaborative working is key to achieving the ambitions of our Patient First programme's Systems and Partnerships strategic theme, which puts a strong focus on the way we work with our external partners as well as on a multi-disciplinary basis within the Trust. Our approach is, and always has been, based on openness, honesty and a genuine desire to listen to and act on feedback to improve our services and our patients' experience.

Our partners in our local 'health economy' include GPs, community healthcare providers, the Coastal West Sussex Clinical Commissioning Group, social care providers, charities, the ambulance service and mental health trust.

The multi-agency, WSHFT-led One Call One Team initiative, which won the NHS Kent Surrey and Sussex Outstanding Collaborative Leadership Award in 2016, is a prime example of the standards we aim for in our partnership working and of the quality of care we can offer patients by innovating in this way.

Our current major piece of partnership work is the redesign of musculoskeletal services, on which we have been working with Sussex Community NHS Trust and the Independent Lives charity to create a quicker, smoother and more efficient patient pathway by bringing together the best approaches from a range of providers.

Collaborative working also extends beyond our local area as we seek to partner with other healthcare organisations across the country and abroad to improve the standards of care we offer. Our Patient First programme, for example, is based on the methods adopted by Virginia Mason Hospital in Seattle, USA, which were in turn adapted from the Lean Management techniques of the Toyota corporation in Japan.

Two of the most important national collaborations we were part of during 2015/16 are NHS QUEST and the Acute Frailty Network.

NHS QUEST

NHS QUEST is the first member-convened network for foundation trusts who wish to focus relentlessly on improving quality and safety by working together, sharing challenges and designing innovative solutions to provide the best care possible for patients.

In 2015/16, WSHFT was part of collaborative groups working on breakthrough developments for deteriorating patients (focused on sepsis, Acute Kidney Injury (AKI) and cardiac arrests), as well as looking at falls prevention and medications safety.

As well as continuing with these programmes in 2016/17, the Trust is also working with QUEST to develop a strategic patient safety dashboard and a 'ward to board' reporting tool.

Acute Frailty Network

The Acute Frailty Network is an NHS England-backed national programme to support healthcare organisations in the rapid development and expansion of emergency services for frail older people.

At Western Sussex we have used this support to establish an Acute Frailty Network Programme Board in partnership with colleagues from primary care, Sussex Community NHS Trust and our CCG to provide a responsive forum for clinicians and senior managers in planning and delivering this type of care.

During 2016/17 the Programme Board will define the scope of our hospitals' acute frailty services and then standardise the delivery of care in this field.

2.1.2.1 Stakeholder events

The two main regular events the Trust runs for members, patients, carers and interested members of the public are our quarterly Stakeholder Forum and our topical Medicine for Members series.

Stakeholder Forum

Our quarterly Stakeholder Forum, hosted by our Director of Nursing and Patient Safety, attracts an enthusiastic group of attendees and provides an opportunity for them to discuss proposed initiatives, share experiences and provide invaluable information which directly influences our plans and services. Examples of areas in which this feedback has made a particularly helpful contribution include our work around values and staff behaviour, wayfinding within our hospitals and information provided pre-operatively and at discharge.

During 2015/16, our members were encouraged to give feedback on our Quality Objectives, resuscitation and planning future care patient information and our Research and Innovation Strategy following presentations at the Stakeholder Forum.

Medicine for Members

Staged at St Richard's and Worthing Hospitals, these events provide an opportunity for Trust members to attend a presentation by a clinician on an area of their specialist expertise and then ask questions on the subject afterwards.

Events during 2015/16 covered topics such as Sepsis and offered a tour of our Clinical Skills and Simulation Suite. Trust staff have also attended a local meeting of the Chichester Macular Society, organised sessions on Ulcerative Colitis and Crohn's Disease and spoken at Cancerwise, a charity for patients with cancer in Chichester.

2.1.2.2 Membership engagement

This year, we surveyed our members to ask: "Are we reaching you?" And pleasingly, the answer was a resounding "yes":

- 90% of responders thought the information they received was "about right"
- 55% agreed that as a member they could help shape services
- 70% knew how to provide feedback about services

- 85% would recommend becoming a member to family or friends.

We have also continued to refine and improve the way we communicate with members and enable them to share their views.

An e-newsletter called @WesternSussex has been developed and is emailed regularly to our members. It contains news, event information, feedback methods and articles such as “You said, we did”.

Governor-led engagement includes community-based recruitment specifically targeting men, the under-60s and Minority Ethnic groups. Governors have held ‘pop-up’ recruitment events at Pulborough Medical Centre, supermarkets within our catchment area, Mother and Baby clinics and on-site within our hospitals.

The re-design of Musculoskeletal (MSK) services during 2015/16 provided us with an opportunity to rethink our approach to public and patient engagement. The re-design programme itself has a Public Engagement work stream led by the Chief Executive of a third-sector partner, Independent Lives, which is a user-led charity working for adults living with disability in West Sussex.

We have undertaken broad public engagement work to inform and test the re-design at several stages and as a result of the positive impact of this work we plan to create a Patient Voice Lead within the Senior Management Structure for MSK services to ensure that the voice of patients continues to be heard not just during the ongoing redesign and but also once delivery of the new service commences across our catchment.

We already have two successful Patient Voice groups working with our Cancer Services teams. Ex-patients and carers meet alternate months to review current cancer activities, raise any concerns and also support new developments.

In 2015/16 we re-launched the St Richard’s Hospital Cancer Patient Voice with the support of the Macmillan involvement co-ordinator, while our Worthing Cancer Patient Voice has been actively involved in the continued development of our website.

We ran three successful health and wellbeing events for cancer patients and were grateful to the patient volunteers who helped guide patients to specific talks and through the information market place. Our Prostate Cancer Hormone Nurse Specialist has set up a new nurse-led service following a review of the hormone cancer pathway and is receiving feedback from patients about their experiences.

2.1.3 Managing the Trust

The Trust's Constitution sets out the way in which the Council of Governors and the Board of Directors will operate and work together including their key areas of responsibilities.

The Trust's Scheme of Delegation sets out the responsibilities of the Trust's Board and key Committees.

In the event of dispute between the Council and the Board then the dispute resolution procedure set out in the Constitution shall be followed in order to resolve the matters concerned. This has not been required during the period 1 April 2015 to 31 March 2016.

The Board is responsible for the management of the Trust and for ensuring proper standards of corporate governance are maintained. The Board accounts for the performance of the Trust and consults on its future strategy with its members through the Council of Governors (CoG).

Board of Directors

The Chair and Non-Executive Directors are appointed by the Council of Governors.

The Directors of the Trust for the period of this report are shown in the table below together with their attendance at Board meetings for the same period. All of the Non-Executive Directors are considered to be independent.

The Chair of the Board is also the Chair of the Council of Governors.

Our Board of Directors: 1 April 2015 to 31 March 2016

Non-executive Directors

Mike Viggers, Chairman (Term of Office to 10-01-2019)

Chair of the Finance and Investment Committee

Jon Furmston (Term of Office to 01-04-2017)

Chair of the Audit Committee

Bill Brown, Deputy Chair (Term of Office to 01-03-2018)

Chair of the Patient Experience and Feedback Committee

Chair of the Serious Incident Review Panel

Joanna Crane, Senior Independent Director (Term of Office to 01-04-2017)

Chair of the Quality and Risk Committee

Lizzie Peers (Term of Office to 14-04-2017)

Chair of Charitable Funds Committee

Mike Rymer (Term of Office to 22-01-2018)

Non-Executive Director

Martin Phillips (Term of Office ended 31-07-2015)

Non-Executive Director

Executive Directors

Marianne Griffiths, Chief Executive

Jane Farrell, Deputy Chief Executive and Chief Operating Officer (Left 31st March 2016)

Denise Farmer, Director of Organisational Development and Leadership

Dr George Findlay, Medical Director

Karen Geoghegan, Finance Director

Amanda Parker, Director of Nursing and Patient Safety

Deputy Chair

Good practice suggests that the Trust should have a Deputy Chair to stand in during any period of absence of the Chair. The Trust Constitution makes provision for the appointment of a Deputy Chair and Monitors guidance states that this should be a Council of Governors appointment although it would be expected that the Chair would make a recommendation to Governors.

Bill Brown, Non-Executive Director, is the Deputy Chair.

Senior Independent Director

The Senior Independent Director is a Non-Executive Director appointed by the Board as a whole in consultation with the Council of Governors. The Senior Independent Director has a key role in supporting the Chair in leading the Board and acting as a sounding board and source of advice for the Chair.

Joanna Crane, Non-Executive Director, is the Senior Independent Director.

Operation of the Board

The Board has agreed a scheme of reservation and delegation which sets out those decisions which must be taken by the Board and those which may be delegated to the Executive or to Board sub-committees.

The Board sets the Trust's strategic aims and provides active leadership of the Trust. It is collectively responsible for the exercise of its powers and the performance of the Trust, for ensuring compliance with the Trust's Provider Licence, relevant statutory requirements and contractual obligations, and for ensuring the quality and safety of services. It does this through the approval of key policies and procedures, the annual plan and budget for the year, and schemes for investment or disinvestment above the level of delegation.

The Non-Executive Directors play a key role in taking a broad, strategic view, ensuring constructive challenge is made and supporting and scrutinising the performance of the Executive Directors whilst helping to develop proposals on strategy.

Board meetings are held in Public and there is the opportunity for members of the public to ask questions of the Board.

Board meetings follow a formal agenda which includes Patient Safety and Experience and a range of Strategic and Operational items including; clinical governance, financial and non-financial performance, together with performance against quality indicators set by the Care Quality Commission (CQC), Monitor and by the Executive. These include measures for infection control targets, patient access to the Trust, waiting times, length of stay, complaints data and the results of the Friends and Family Test.

During the period of this report the Board held 10 Board meetings, one review day and 10 Seminars. The Board Review day is where the future strategic aims and objectives of the organisation are considered. In addition, the Board of Directors and Council of Governors hold an annual joint Review Day to consider the strategic issues facing the Trust.

Board seminars covered a range of topics including; Workforce Transformation, Bed Reconfiguration, Impact and Learning from implementing a new Emergency Floor model, Quest Falls Collaborative and Infection Control.

Attendance at Board meetings 1 April 2015 to 31 March 2016

Name	Total Meetings Eligible	Apr	May	Jun	Jul	Sep	Oct	Nov	Jan	Feb	Mar	Total Meetings Attended
Mike Viggers	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
Bill Brown	10	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	9
Joanna Crane	10	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	9
Jon Furmston	10	✓	✓	✗	✓	✓	✗	✓	✓	✓	✓	8
Lizzie Peers	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
Martin Phillips[1]	3	✓	✓	✓								
Mike Rymer[2]	10	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	9
Marianne Griffiths	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
Jane Farrell[3]	10	✓	✓	✗	✓	✓	✗	✓	✓	✓	✗	7
George Findlay	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
Karen Geoghegan	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
Amanda Parker	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
Denise Farmer	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10

Board Committees

The Board has established a number of formal sub-committee's that support the discharging of the Board's responsibilities. Each Committee is chaired by a Non-Executive Director.

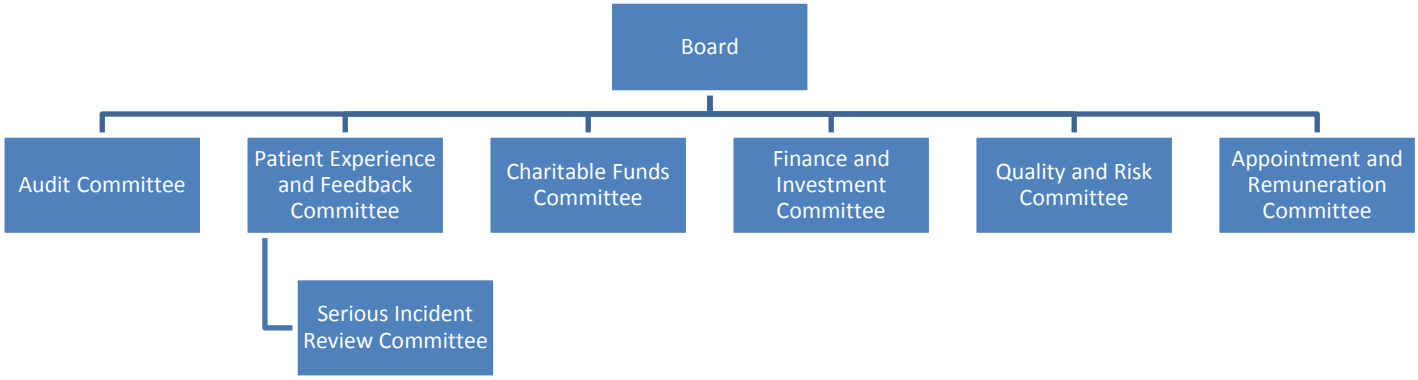
These committee's do not operate independently of each but where appropriate operate together (and indeed report to one another) to ensure full coverage and clarity on all areas of Trust activity.

[1] Martin Phillips retired as Non-Executive Director on 8 July 2015

[2] Mike Rymer was a Non-Executive Director (Designate) until 8 July 2015 when he took up his substantive post as a Non-Executive Director following the retirement of Martin Phillips. Mike Rymer attended the April and May Board in a non-voting capacity.

[3] Jane Farrell was Chief Operating Officer and Deputy Chief Executive until 31 March 2016

Notes:
Please note there were no board meetings in either August or December 2015. A Board Pack was issued to the Board on both occasions reporting on standing items of the Board agenda.



i. Audit Committee

The existence of an independent Audit Committee is the central means by which the Trust Board ensures effective control arrangements are in place. The Committee comprises of three Non-Executive Directors in line with the Code of Governance for Foundation Trusts.

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

The Audit Committee receives and considers reports from Internal Audit, External Audit and Local Counter Fraud Services.

The Audit Committee membership and attendance in respect of the period 01 April 2015 to 31 March 2016 is set out in the table below:

Register of Members attendance at Audit Committee meeting for the period 01 April 2015 to 31 March 2016						
	April	May	July	October	January	Total
Jon Furmston	✓	✓	✓	✓	✓	5
Bill Brown	✓	✓	×	✓	✓	4
Lizzie Peers	✓	✓	✓	✓	✓	5

The Director of Finance, Director of Organisational Development and Leadership, Local Counter Fraud Services, Internal and External Auditors are regular attendees at meetings of the Committee. The Committee requests other senior Trust officers to attend for specific items. The Committee is supported by the Company Secretary.

During the year the Council of Governors approved the reappointment of the Trust's External Auditors, Ernst and Young.

The Trust does not have its own Internal Audit or Counter Fraud functions. The Trust's Internal Auditor is BDO LLP. The Trust's Local Counter Fraud Service is provided by RSM UK.

The Audit Committee Agenda is based upon an agreed annual work-plan. 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.

The Audit Committee is responsible to the Board for reviewing the adequacy of the governance, risk management and internal control processes within 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.

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

The Audit Committee agrees the schedule of Internal Audit reviews at the start of the year and receives the reports of those audits and tracks the implementation of recommendations at each of its meetings.

ii. Quality and Risk Committee

The Quality and Risk Committee supports the Board in ensuring that the Trust's management of clinical and non-clinical processes and controls are effective in setting and monitoring good standards and continuously improving the quality of services provided by the Trust.

Quality and Risk Committee Membership
Joanna Crane (Non-Executive Director and Chair)
Lizzie Peers (Non-Executive Director)
Mike Rymer (Non-Executive Director)
George Findlay (Medical Director)
Amanda Parker (Director of Nursing and Patient Safety)

iii. Finance and Investment Committee

The Finance and Investments Committee supports the Board to ensure that all appropriate action is taken to achieve the financial objectives of the Trust through regular review of financial strategies and performance, investments, and capital and estates plans and performance.

The Committee is chaired by the Chair of the Trust and all Non-Executive and Executive Directors are invited to attend.

iv. Patient Experience and Feedback Committee

The Patient Experience and Feedback Committee provides assurance to the Quality and Risk Committee and the Board that the Trust manages comments, compliments, concerns and complaints from patients and the public in a sensitive and effective manner and that a process of organisational learning is in place to ensure that identified improvements are embedded within the organisational framework.

Patient Experience and Feedback Committee Membership
Bill Brown (Non-Executive Director and Chair)
Joanna Crane (Non-Executive Director)
Mike Rymer (Non-Executive Director)
George Findlay (Medical Director)
Amanda Parker (Director of Nursing and Patient Safety)

v. Serious Incidents Requiring Investigation (SIRI) Review Panel

The purpose of the SIRI Panel is to provide assurance to the Board that all SIRIs are investigated robustly and that opportunities for improvement are identified and acted upon.

SIRI Review Panel Membership
Bill Brown (Non-Executive Director and Chair)
Joanna Crane (Non-Executive Director)
Mike Rymer (Non-Executive Director)
George Findlay (Medical Director)
Amanda Parker (Director of Nursing and Patient Safety)

vi. Charitable Funds Committee

The purpose of the Charitable Funds Committee is to monitor progress and performance against the strategic direction of the Charitable Trust's fundraising activity as determined by the Board as corporate Trustee; to approve and monitor expenditure of charitable funds in line with specified priority requirements; and to monitor the management of the Trust's investment portfolio ensuring that the Trust at all times adheres to Charity Law and to best practice in governance and fundraising.

Charitable Funds Committee Membership
Lizzie Peers (Non-Executive Director and Chair)
Joanna Crane (Non-Executive Director)
Denise Farmer (Director of Organisational Development and Leadership)
Karen Geoghegan (Director of Finance and Estates)

vii. Appointment and Remuneration Committee

The Committee sets the terms and conditions of the Executive Directors. This committee's membership is Non-Executive Directors only.

Appointment and Remuneration Committee Membership
Mike Viggers (Chair of Trust)
Bill Brown (Non-Executive Director)
Joanna Crane (Non-Executive Director)
Jon Furmston (Non-Executive Director)
Lizzie Peers (Non-Executive Director)
Mike Rymer (Non-Executive Director)

Meeting attendance for the period was:

Non-Executive Director	**Apr 29th**	**July 1st**	**July 29th**	**Aug 26th**	**Oct 28th**	**Jan 7th**	**Mar 2nd**	**Mar 22nd**	**Total**
Mike Viggers	✓	✓	✓	✓	✓	✓	✓	✓	8/8
Bill Brown	✓	×	✓	✓	×	✓	✓	✓	6/8
Joanna Crane	×	✓	×	✓	✓	×	✓	✓	5/8
Jon Furmston	×	×	✓	×	✓	✓	✓	✓	5/8
Martin Phillips	✓	✓	✓						3/3
Lizzie Peers	✓	✓	✓	✓	✓	✓	✓	✓	8/8
Mike Rymer	✓	×	✓	✓	✓	✓	✓	✓	7/8

In attendance at meetings are the Chief Executive, Director of Organisational Development and Leadership and the Company Secretary.

During the period the Committee did not procure any external advice relating to pay and the Trust does not operate performance related pay.

Appointments and appraisal

The Chief Executive undertakes an appraisal on the performance of the Executive Directors, which are formally reported to the Appointment and Remuneration Committee.

The Chair conducts the Chief Executive's appraisal which is reported in the same way.

The Chair undertakes the appraisal of the Non-Executive Directors, having sought feedback from other Directors. The Senior Independent Director conducted the appraisal of the Chair which included feedback from Directors and Governors.

The Chair and Non-Executive Directors appraisals were formally reported to the Council of Governors in private on 16 July 2015.

The Chairman, other Non-Executive Directors, and the Chief Executive are responsible for deciding the appointment of Executive Directors.

Non-Executive Directors are appointed by the Council of Governors with the process being led by the Governors Nomination and Remuneration Committee. Non-Executive Directors are appointed for a three-year term in office. A Non-Executive can be re-elected for a second three-year term in office on an uncontested basis, subject to the recommendation of the Chairman and approval by the Council of Governors.

Statement of Compliance with the NHS Foundation Trust Code of Governance 2015-16
Western Sussex NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Statement of compliance with the NHS Constitution

The Board of Directors takes account of the NHS Constitution in its decisions and actions, as they relate to patients, the public and staff. The Board of Directors is compliant with the principles, rights and pledges set out in the Constitution.

Statement on Directors Disclosures
The Annual Report is required to include a statement that for each individual, who is a director at the time the report is approved, as follows:

- So far as each director is aware, there is no relevant audit information of the which the (external) auditor is unaware; and
- the director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

All Directors have confirmed the above statement.

Declarations of Interest

The Chair has not declared any significant commitments that require disclosure.

The Trust holds a register of company directorships and other significant interests, held by both directors and governors, which may conflict with their management responsibilities. The Trust Board receives an Annual Report on Board Declarations in the public part of its meeting. The Council of Governors receives an Annual report on Governors Declarations in the public part of its meeting.

Details of declarations are held on a Trust Register and are available from the Company Secretary upon request.

2.1.4 Governing Service Quality

The Trust carries out quarterly governance reviews to provide assurance that appropriate governance arrangements are embedded into the work of the divisions and that high standards of quality and safety are being maintained.

The quarterly review meetings are chaired by the Medical Director or the Director of Nursing and are supported by monthly divisional governance meetings focusing on the frameworks and issues raised within each operational division.

2.1.5 Disclosures to Auditors

The directors are required under the NHS Health Service Act 2006 to prepare accounts for each financial year.

The directors consider the annual report and accounts, taken as a whole, is fair, balances and understandable and provides the information necessary for patients, regulators, and stakeholders to assess the Trust's performance, business model and strategy.
Each director of the Trust Board, at the time of approval of the Annual Report and Financial Statements, declares that:

- So far as they are aware, there is no relevant audit information of which the Trust's auditor is unaware; and

- The director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information

2.1.6 Income Disclosures

The income from the provision of goods and services for the purposes of the health service in England is greater than the income from the provision of goods and services for any other purposes. Income from goods and services not for the purposes of the health service in England is required to at a minimum cover the full cost of delivery of the goods and services. Any surplus from these activities is reinvested and supports the provision of goods and services for the purposes of the health service in England.

2.1.7 Better Payments Practice Code

The Trust's measure of performance in paying suppliers is the Better Payment Practice Code (BPPC). The Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

Measure of Compliance	**2015/16 Number**	**2015/16 £000**
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	113,156	145,606
Total Non-NHS Trade Invoices Paid Within Target	35,937	55,608
Percentage of Non NHS Trade Invoices Paid Within Target	31.8%	38.2%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	3,467	22,071
Total NHS Trade Invoices Paid Within Target	854	12,558
Percentage of NHS Trade Invoices Paid Within Target	24.6%	56.9%

2.2 Governors' Report

2.2.1 Council of Governors

As a Foundation Trust Western Sussex NHS Hospitals has a Council of Governors (CoG). The Board of the Trust is directly responsible for the performance and success of the Trust and satisfying the CoG that the Board is achieving its aims and fulfilling its statutory obligations. Governors act as a vital link to the local community and report matters of concern raised with them, to the Board, via Governor Patient Experience and Engagement Committee.

Members of the Council of Governors: as at 31 March 2016

Constituency name	Full Name	End of current term of office
Elected Governors		
Public - Adur	Barbara Porter	30 June 2016
Public - Adur	John Todd	30 September 2018
Public - Arun	Margaret Bamford	30 June 2016
Public –Arun	Brian Hughes	30 June 2016
Public - Arun	Jill Long	30 September 2018
Public - Arun	John Thompson	30 September 2018
Public – Chichester	Maggie Burgess	30 September 2018
Public – Chichester	Vicki King	30 June 2016
Public – Chichester	Abigail Rowe	30 June 2016
Public – Horsham	Vacant	30 June 2016
Public – Worthing	Shirley Hawkridge	30 June 2016
Public - Worthing	John Bull	30 September 2018
Public - Worthing	Beda Oliver	30 June 2016
Patient	Paul Benson	30 June 2016
Patient	Jennifer Edgell	30 June 2016
Patient	Richard Farmer	30 September 2018
Staff Governors		
Medical & Dental	Richard Venn	30 June 2019

Nursing & Midwifery	David Walsh	30 September 2018
Scientific, Technical & Professional	Helen Dobbin	30 September 2018
Additional Clinical Services	Greg Dalilling	30 June 2016
Estates & Ancillary	Vacant	30 June 2016
Administrative & Clerical	Andrew Harvey	30 September 2018
Appointed Governors		
West Sussex County Council	Nigel Peters	30 June 2016
Brighton & Sussex Medical School	Peter Pimblett-Dennis	30 June 2016
Friends of WSHT Hospitals and WRVS	Jane Ramage	30 June 2016
University of Brighton School of Nursing & Midwifery	Andrew Lloyd	30 June 2018
Worthing Borough Council	Councillor Val Turner	30 June 2017
Chichester District Council	Gillian Keegan	30 June 2018

Role of Governors

The CoG has a number of statutory roles and responsibilities as follows;

- Appoint and, if appropriate, remove the Chair
- Appoint and, if appropriate, remove the other Non-Executive Directors
- Decide the remuneration and allowances and other terms and conditions of office of the chair and other Non-Executive Directors
- Approve (or not) and new appointment of a Chief Executive
- Approve and, if appropriate, remove the Trust's auditor
- Receive the Trust's Annual Accounts and Annual report at a general meeting of the CoG
- Hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors
- Represent the interests of the members of the Trust, and public
- Approve Significant Transactions as defined by Monitor guidance
- Approve an application by the Trust to enter into a merger or acquisition
- Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose; and
- Approve amendments to the Trust's Constitution

Composition of the CoG

The CoG comprises the following Constituencies;

Elected Public and Patient Governors

The CoG has sixteen Governors elected from its membership that represent the public and patients (thirteen) and three Governors who represent patients who live out of the catchment area of the Trust.. Public Governors are elected from within Local Authority areas. The number of Governors for each constituency is in proportion to the population within the area using WSHFT services.

Area	Number
Adur	2
Arun	4
Chichester	3
Horsham	1
Worthing	3
Patient	3
Total Elected Public and Patient Governors	**16**

Staff Governors

There are six staff Governors drawn from different areas of the workforce and elected by staff members from those particular professional areas.

Professional Area	Number
Medical and Dental	1
Nursing and Midwifery	1
Scientific, Technical and Professional	1
Additional Clinical Services	1
Estates and Ancillary	1
Administrative and Clerical	1
Total Elected Staff Governors	**6**

Stakeholder Governors

The Trust has a further six Governors who are appointed by partnership or stakeholder organisations.

Partner/Stakeholder Organisation	Number
West Sussex County Council	1
Brighton and Sussex Medical School	1
Friends of WSHT Hospitals and WRVS	1
University of Brighton School of Nursing and Midwifery	1
Worthing Borough Council	1
Chichester District Council	1
Total Partner/Stakeholder Governors	**6**

Governor Elections were held during the year as several had come to the end of their first term of office. As a result of the elections six new Governors were appointed and two Governors were reappointed for a second three year term.

During the year 1 April 2015 to 31 March 2016 attendance at Council of Governor meetings was as follows:

Constituency	Full Name	End of Term of Office	Number of CoG meetings attended[4]
Elected Governors			
Public - Adur	Barbara Porter	30 June 2016	1 of 4
Public - Adur	John Todd	30 September 2018	4 of 4
Public - Arun	Margaret Boulton	30 September 2015	1 of 2

[4] Shows the Number of Council of Governor meetings attended by the individual Governor as a proportion of the number of meetings they were eligible to attend, reflecting new members to the Council in year.

Public - Arun	Alison Langley	30 September 2015	1 of 2
Public - Arun	Margaret Bamford	30 June 2016	4 of 4
Public - Arun	Brian Hughes	30 June 2016	2 of 4
Public - Arun	Jill Long	30 September 2018	2 of 2
Public - Arun	John Thompson	30 September 2018	2 of 2
Public - Chichester	Stuart Fleming	30 September 2015	0 of 2
Public - Chichester	Vicki King	30 June 2016	4 of 4
Public - Chichester	Abigail Rowe	30 June 2016	2 of 4
Public - Chichester	Margaret Burgess	30 September 2018	2 of 2
Public - Horsham	Vacant	30 June 2016	N/A
Public - Worthing	David Langley	30 September 2015	1 of 2
Public - Worthing	Shirley Hawkridge	30 June 2016	2 of 4
Public - Worthing	Beda Oliver	30 June 2016	4 of 4
Public - Worthing	John Bull	30 September 2018	2 of 2
Patient	Paul Benson	30 June 2016	2 of 4
Patient	Jennifer Edgell	30 June 2016	4 of 4
Patient	Richard Farmer	30 September 2018	3 of 4
Staff Governors			
Administrative & Clerical	Jenny Garvey	30 September 2015	0 of 2
Additional Clinical Services	Greg Daliling	30 June 2016	4 of 4
Estates & Ancillary	Vacant	30 June 2016	N/A
Nursing & Midwifery	David Walsh	30 September 2018	3 of 4
Scientific, Technical & Professional	Helen Dobbin	30 September 2018	4 of 4
Administrative & Clerical	Andrew Harvey	30 September 2018	2 of 2
Medical & Dental	Richard Venn	30 June 2019	1 of 1
Appointed Governors			
University of Brighton School of Nursing & Midwifery	Shirley Bach	30 June 2015	1 of 1
Chichester District Council	Robert Hayes	30 June 2016	0 of 1

West Sussex County Council	Nigel Peters	30 June 2016	0 of 4
Brighton & Sussex Medical School	Peter Pimblett-Dennis	30 June 2016	2 of 4
Friends of WSHT Hospitals and WRVS	Jane Ramage	30 June 2016	2 of 4
Worthing Borough Council	Councillor Val Turner	30 June 2017	4 of 4
Chichester District Council	Gillian Keegan	30 June 2018	2 of 3
University of Brighton School of Nursing & Midwifery	Andrew Lloyd	30 September 2018	2 of 2

***shows the Number of Council of Governor meetings attended by the individual Governor as a proportion of the number of meetings they were eligible to attend, this reflects leavers and new members during the year.*

2.2.2 Governor Expenses

The Trust is required to disclose the value of expenses claimed by the CoG during the financial year.

	1 April 2015 to 31 March 2016	1 April 2014 to 31 March 2015
Total number of governors in office (as at 31st March 2016)	26	25
Number of governors receiving expenses	11	11
Aggregate sum of expenses paid to governors	£ 6,204	£6,500

2.2.3 Lead Governor

Monitor requires that a CoG elects a Lead Governor to be the primary link with the Foundation Trust. A Lead Governor is elected by the full Council and would also be the formal link to Monitor if circumstance required direct communication between the CoG and the Regulator. Until 31st October 2015 the Lead Governor was Margaret Bamford, Public Elected Governor for the Arun Constituency. From 1st November 2015 the role has been undertaken by Vicki King, Public Governor for the Chichester Constituency, having been elected by the full Council

2.2.4 Governor Engagement

There are four Council of Governors meetings held in public each year. The CoG meetings are attended by members of the Trust Board. The agenda at each meeting includes reports from Governors, the Chief Executive and one of the Non-Executive Directors provides a presentation on the work of a particular Board Sub-Committee

In addition, the Board and Council meet together once a year to discuss key issues and developments. This meeting is augmented by two assurance meetings per year held in private between the Governors and Non-Executive Directors only. In addition the Chair and Chief Executive have held seven drop in/briefing sessions for Governors during this financial year.

To support Governors in their role the Trust runs several information Seminars per year on areas of interest. This year these included, Private Patients Activity, End of Life Care, NHS Litigation, NHS and Trust Finances, the Trust wide Bed Reconfiguration Project and the Quest Programme (falls prevention work).

The CoG has an active and vibrant Membership Committee, which has close links with the Patient Experience and Engagement Committee, and a Nomination and Remuneration Committee.

Monitor requires foundation trusts to provide forward planning for each financial year, prepared by the Board of Directors. Governors are consulted on the development of these forward plans and are able to input views from the public and members they represent via Strategy workshops .

Governors are involved in many aspects of the Trust including improvement programme workgroups, Trust conferences, Stakeholder meetings, undertaking PLACE visits and 'Sit and See' observations. The Governors also supported and assisted with preparation for the Trust wide Care Quality Commission Inspection by undertaking "mock inspections".

Governors Annual Programme

The objectives of this programme, which is reviewed at every CoG, are:

- To implement the Council of Governors Annual Programme for 2016 – 2017 which contains the forward schedule of Council business;
- To review the current arrangements for the Chair and Non Executives' appraisals and revise where appropriate;
- To market - test remuneration levels of the WSHFT Chair and the Non-Executive Directors ;
- To represent to the Trust the interests of the Members of the WSHFT and the public;
- To agree and introduce a process whereby Governors contribute to the development of the WSHFT Strategy;
- To review the WSHFT Membership strategy, revise where appropriate and implement in accordance with the Membership Targets.

The programme sets out how these objectives will be achieved under the headings of, Listening and representing, Holding to account and Governance.

2.2.5 Holding the Non-Executive Directors to account for the performance of the Trust Board

Principles

Governors have an important role in making an NHS foundation trust publicly accountable for the services it provides. They bring valuable perspectives and contributions to its activities. Importantly, Governors are expected to hold Non-Executive Directors to account for the performance of the Trust Board of Directors and the following sets out the principles of how Governors discharge this responsibility.

- To ensure that the process of holding to account is transparent and fulfils the statutory duties of the CoG
- To make the most effective and efficient use of time and resources, and to avoid duplication
- To reflect the Monitor guidance that Governors should via the NEDs seek assurance that there are effective strategies, policies and processes in place to ensure good governance of the Trust.
- To be proportionate, recognising that Governors are volunteers and that Non Executives are contracted for two and a half days per month only.

Appraisal and Appointment

It is the responsibility of the Council of Governors to appoint the Chair and other Non-Executive Directors and to oversee the appraisal process of the Chair and Non-Executive Directors.

The Governors Nomination and Remuneration Committee (GNaRC) oversee these processes on behalf of the Council. The Chair and other Non-Executive appraisals for 2015 have been undertaken and reported to the full CoG sitting in private.

At no time during the period has the Council of Governors exercised its formal power to require a Non-Executive Director to attend a Council meeting and account for the performance of the Trust.

Some of the key items discussed by the GNaRC during the year were:

- The recommendation to the Council of Governors that the Chairman of the Trust be reappointed for a second three year period with effect from 10th January 2016.
- The Chair and other Non-Executive Directors Appraisals for 2015
- A review of the Committee's effectiveness and Terms of Reference
- A review of the Non-Executive Director (NED) appraisal process
- Review of number and skill mix of Non-Executive Directors

It is the responsibility of the Council of Governors to appoint the Chair and other Non-Executive Directors. These processes are overseen by the GNaRC on behalf of the Council of Governors to whom it makes recommendations. In January 2015 the GNaRC started consideration with regards to the Chair, noting that his term of office

ended in January 2016. The Committee noted that the CoG, if it wishes, is empowered to re-appoint the Chair for a further term of 3-years.

The Committee met with the Deputy Chair in March 2015 to discuss its options and agreed a process which included seeking the views of Governors and both the Non-Executive and Executive Teams. A further Committee was held to review the Chairs achievements against key criteria.

Following this process the Committee presented a case to the April 2016 CoG meeting recommending that the Chair should be re-appointed for a further 3-year period. This was unanimously agreed by the CoG at its meeting on 14th April 2016.

2.2.5 Membership

Membership Strategy

The Trust currently has a Membership Strategy for the period 2015-2018, which is updated with the help of the Governor's Membership Committee. This strategy acknowledges that it is a responsibility of a Foundation Trust to recruit communicate and engage with members and the broader public as a way of ensuring service provision meets the needs of service users. The Trust's strategy aims to recruit a representative membership base that is actively engaged in working for the good of the Trust. It also considers and monitors engagement levels through annual surveys and by tracking responses rates to in year activity. For the period 2015-2016 a major consultation was carried out with members on the development of the Trust's Quality Strategy. Other work includes targeting specific groups of members to ensure that the Trust membership is representative of the population it serves.

The Trust's Membership Strategy is supported by a full action plan which outlines how the strategic aims will be implemented and the objectives of the strategy achieved.

The Trust Board received the Annual Equality & Diversity Performance Report 2015 which includes information on the Trust's Membership and in particular the age profiles and ethnicity. The 2015 reported recognised that the current membership is not entirely representative of the community it serves and this is an area of focus for the Membership Committee.

Keeping in touch with members

In preparation for the implementation of the Trust's new Membership Strategy, which aims to engage more strategically with existing members, we launched @WesternSussex, a biweekly html email newsletter. The newsletter includes news from across the Trust that we think will be of interest to our members as well as event dates and links to Trust news covered by our local media.

To add value for our members we offer a suite of member events. These include Stakeholder Forum meetings, where a range of stakeholders are invited to listen to presentations and debate the hot topics of the day, and Medicine for Members events, where presenters focus on a specific health issue with the aim of informing the audience.

Governors perform a key role in recruiting new members. They hold regular recruitment events at GP surgeries, health centres and Children and Family centres across the area. Venues visited have reflected areas where the current membership is under represented and recruitment of younger members via visits to Children and Family centres has been particularly successful.

Governors spend time at these events describing the role of a Trust member and gathering feedback on services across the Trust and its future plans. All feedback is then shared with our Patient Engagement and Experience committee to help us continue to improve services.
All Governors can be contacted via a Trust generic email address which is advertised on the Trust website and through other communications sent to members. Governor "Who is who" posters have also been developed and contain information on how to contact your local Governor. These have been designed so that they can be displayed in Doctors Surgeries , Libraries and Community Centres. Communication with Directors is encouraged and undertaken via the Trust's Communication Team.

An individual must be at least 16 years old to become a member of the trust.

Currently the Trust has 7,547 public members . All Staff are automatically enrolled as members on starting employment with the Trust.

Constituency	**Membership as at 31 March 2016**
Adur	1,179
Arun	2,432
Chichester	2,081
Horsham	399
Worthing	1,222
Patient	234

2.2.6 Appointment of External Auditors

It is the responsibility of the Governors to appoint and/or re-appoint the external auditor of the Trust.

The Audit Committee reported to the Council of Governors, at its meeting in July 2015, on the external auditor after the completion of that year's audit. This report assessed the work of the auditor with regard to the quality of the work undertaken and the fees charged. The Council of Governors approved the appointment of the current auditors the coming year's audit.

Monitor recommends that the appointment of the Trust's external auditor should be subject to an open tender process every three to five years. In 2015 a working group of the Council of Governors was established to oversee the appointment process of an external auditor of the Trust from 2016/17 Accounts. The sub-group reports on its work to each Council of Governors meeting.

2.2.7 Disclosures and Declarations of Interests

The Chair of the Council of Governors has not declared any other significant commitments that require disclosure. The Chair submits an Annual Declaration of Interest Statement and Fit and Proper Person Declaration which are reported in public at Trust Board.

Governors are required to complete a Declaration of Interest which are held on a Trust Register and available from the Company Secretary upon request.

Resolution of Disputes

The Trust Constitution sets out at Section 12 the process for dealing with any dispute between the Council of Governors and trust Board. The Council of Governors and trust Board have a positive working relationship and the process has not been used during the 2015/16 year.

2.3 Staff Report

Western Sussex Hospitals NHS Foundation Trust is the proud employer of 6,881 people. We rely on each and every one of those people to enable us to continue providing high quality care to the people of West Sussex.

Whether nurses, doctors, midwives, consultants, porters, healthcare assistants, radiographers, technicians, researchers, support service providers or the people who run our catering, everyone within the Trust has their role to play.

Our workforce is the single biggest reason that we have become the high performing, high quality organisation we are today. Our people are a credit to the Trust, to the people they serve and to the area as a whole.

In return for their dedication to the Trust, we promise the people who work here the same level of dedication from their employer.

We encourage staff to be involved in the Trust's decision making processes, through a series of surveys and consultations and through a number of groups that seek to involve staff in making decisions about the way the Trust is run, how it is doing in terms of performance targets, finance and quality, and how it will develop. For example, the Trust's Employee Partnership, made up of local and regional union representatives, staff, governors and managers is chaired by the Director of Organisational Development and meets monthly to form the basis of a constructive and co-operative approach towards achieving our goals.

Average number of employees (WTE basis)

	Permanent Number	Other Number	2015/16 Total Number	2014/15 Total Number
Medical and dental	699	-	**699**	692
Ambulance staff	-	-	**-**	-
Administration and estates	1,194	-	**1,194**	1,154
Healthcare assistants and other support staff	1,498	-	**1,498**	1,461
Nursing, midwifery and health visiting staff	1,615	-	**1,615**	1,682
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	587	-	**587**	580
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Agency and contract staff	-	275	**275**	170
Bank staff	-	448	**448**	471
Other	6	-	**6**	6
Total average numbers	**5,599**	**723**	**6,322**	**6,216**
Of which:				
Number of employees (WTE) engaged on capital projects	15	1	**16**	6

2.3.1 Equality and Diversity

At the end of the financial year, the breakdown of male and female staff was as follows:

	Female	Male
Non-Executive Directors	2 (40%)	3 (60%)
Directors	4 (67%)	2 (33%)
Other senior managers	157 (69%)	72 (31%)
Employees	5,144 (78%)	1,465 (22%)

Our Equality and Diversity Policy is wide-ranging and aims to protect employees from discrimination while promoting equal opportunity and the value of diverse cultures and backgrounds within the workforce.

We recognise that in serving diverse communities, we need to recruit and retain the right people with the right skills to deliver high-quality care. This can best be achieved through a workforce that reflects the community that it serves.

Staff and patient diversity is viewed positively and, in recognising that everyone is different, the Trust values equally the unique contribution that individuals from different backgrounds can make. Support is available for staff through the Trust's Celebrating Cultures Network (which incorporates BME and Religion and Belief) and more widely through the SEC (South East Coast) BME network. Additionally, the Trust hosts a Lesbian, Gay, Bisexual and Transgender (LGBT) Network and a Disability Forum internally for staff and patients.

The Trust is committed to equal opportunities for all. Our aim is to ensure that no patient, carer or visitor to the Trust, job applicant or member of staff, is discriminated against on the grounds of the following protected characteristics:

- gender
- marital status
- pregnancy, maternity or paternity
- race, colour, nationality, national or ethnic origin
- disability
- religion or belief
- sexual orientation
- age

- gender reassignment

Selection for employment, training and promotion will be based solely on objective and job-related criteria.

If staff have a disability or develop a disability during their time working with the Trust, reasonable adjustments will be made to prevent them from being placed at a substantial disadvantage in all aspects of employment including recruitment and selection, training, transfer, career development and retention. The Trust adheres to the five commitments of the 'Two Ticks' symbol to encourage job applications from disabled people.

Our recruitment policy adds:

> *The Trust is committed to the fair treatment of its staff and its potential staff regardless of race, gender or gender reassignment, religion or belief, sexual orientation, age, disability, marital status, pregnancy and maternity status, social and employment status, HIV status, political affiliation, trade union membership or responsibility for dependents and offending background.*

All posts will be advertised (including fixed-term appointments and secondments which are intended to last longer than three months).

If the recruiting manager wishes to limit application numbers we have the option not to specify a closing date on the NHS Jobs website, which also states that we reserve the right to close the vacancy once we have received sufficient applications. We therefore advise submitting an application as early as possible to avoid disappointment. It is the recruiting manager's responsibility to monitor the number of applications received and inform the relevant HR recruitment administrator when sufficient numbers have been reached and the advert needs to be closed.

All external adverts, either printed or placed online must comply with the Trust's corporate image and must be processed through the Human Resources Recruitment Team.

All recruitment will be subject to equal opportunities monitoring on an annual basis.

Short-listing and selection will be based solely on the extent to which candidates fulfil the criteria for the post as stated in the person specification, which describes the essential and desirable skill and experience levels for candidates to meet. All short-listed applicants for positions will have a panel interview as part of the selection process, and all interviews will be conducted face to face, except under exceptional circumstances.

All interview panels will consist of at least two members, one of whom should be the recruiting manager. Records of interview panels held are maintained for one year by the HR Recruitment Team. The successful candidate's interview paperwork will be kept on their personal file.

At least one of the panel members must have had appropriate training in recruitment and equality and diversity training. Equality training must be completed every three years.

The Trust will comply with the requirements of NHS Employment Standards and ensure that all necessary checks and clearances are carried out prior to employing an individual.

2.3.2 Staff survey

Every year, we encourage staff to participate in the national staff survey. The survey results give each health trust a picture of how its staff think it's preforming as an employer and as a heath trust.

In 2015, 54 per cent of our people completed the survey (a decrease from 56 per cent in the previous year). Despite the Trust's overall response rate reducing from 2014 we remain above average for the key indicators putting us in the top 20 per cent of acute trusts in England.

The survey was open from September to December 2015, and all staff were encouraged to participate. Free tea, coffee and a slice of cake was provided at dedicated survey events to boost participation and the survey featured in various internal communications across the Trust, including the staff newsletter, Headlines and on posters in staff areas adopting the strategic theme of 'Our People' as part of the Patient First Programme.

Given the challenging work pressures and staffing levels overall the 2015 survey highlights positive achievements even though some responses not changing to a level that is statically significant.

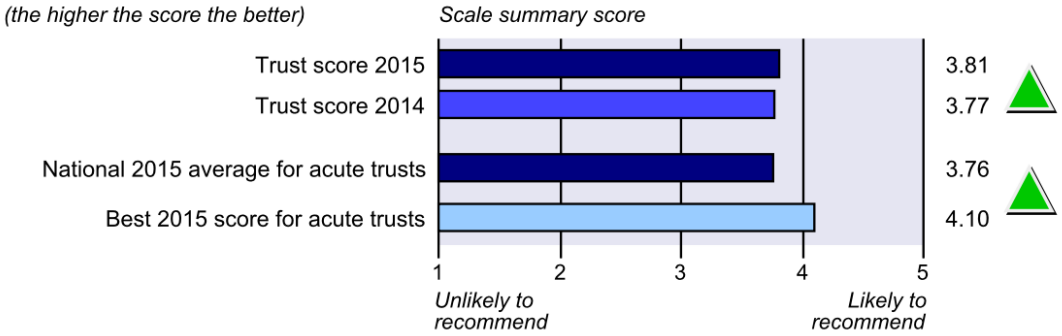
The "Friends and Family question" asks staff whether they would recommend the Trust as a place to work or receive treatment. The score is out of five. Our staff currently give our Trust a score of 3.82, which is an increase from 3.77 in 2014 and above the National average score of 3.76.

This is reflective of staff stating that the care of patients is the Trust's top priority and we believe is a positive reflection of the roll out of the Patient Fist Programme

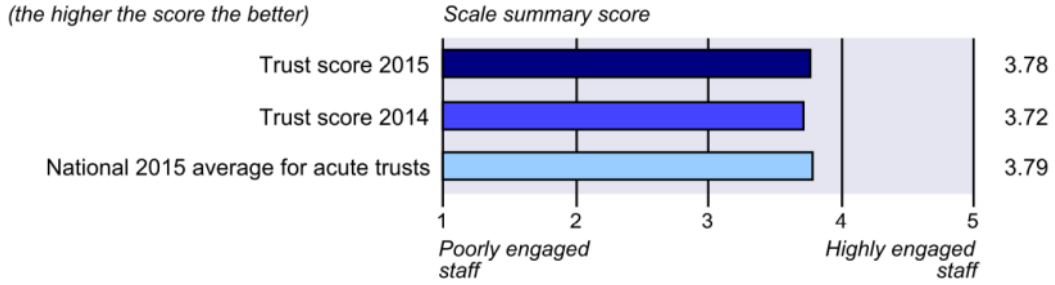
The survey has also seen an increase in staff engagement. As a True North metric we will be focusing on transforming our systems and processes in order to improve the patient and staff experience.

		Your Trust in 2015	Average (median) for acute trusts	Your Trust in 2014
Q21a	"Care of patients / service users is my organisation's top priority"	77%	75%	73%
Q21b	"My organisation acts on concerns raised by patients / service users"	73%	73%	72%
Q21c	"I would recommend my organisation as a place to work"	65%	61%	63%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	73%	70%	71%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.82	3.76	3.77

KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment



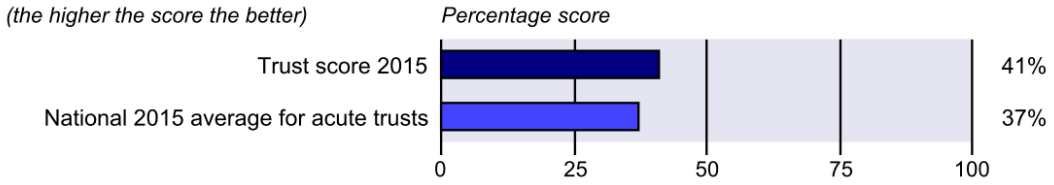
OVERALL STAFF ENGAGEMENT



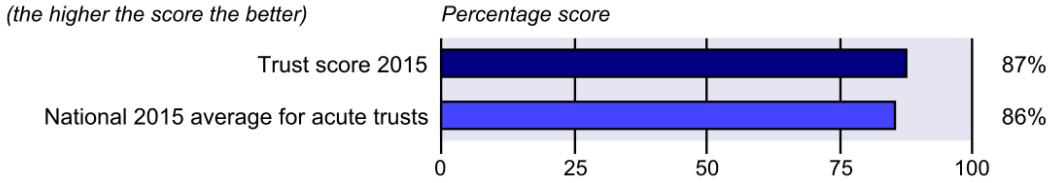
Source: 2015 Staff Survey

We achieved our best results on the friends and family question and on several questions around our staff health and wellbeing and appraisals, which is in line with our commitment to develop our people.

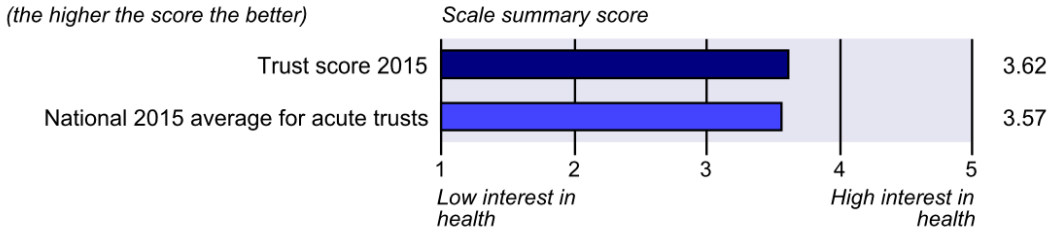
✓KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse



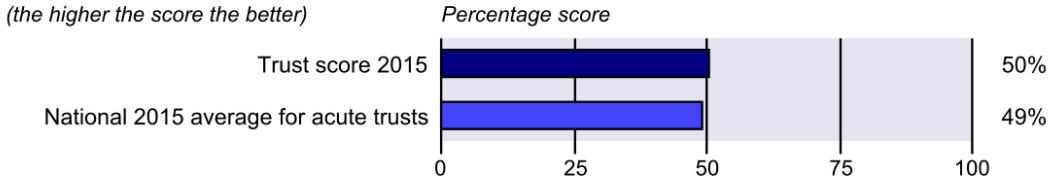
✓KF11. Percentage of staff appraised in last 12 months



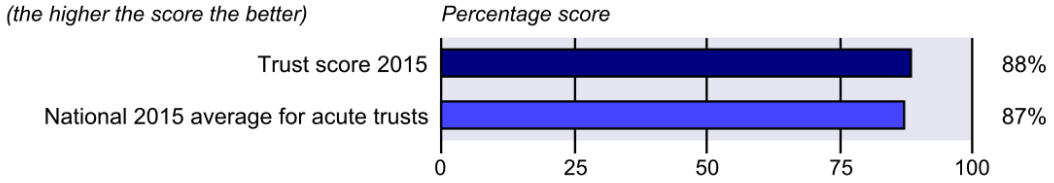
✓KF19. Organisation and management interest in and action on health and wellbeing



✓KF15. Percentage of staff satisfied with the opportunities for flexible working patterns



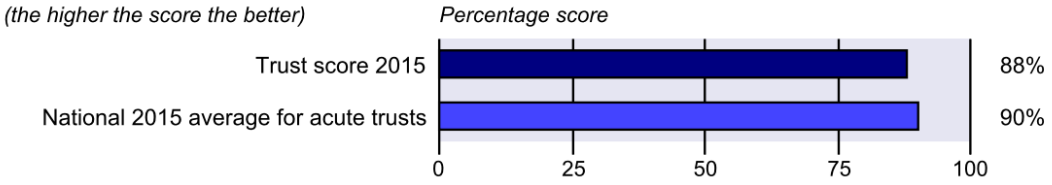
✓KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



Despite the investment in upskilling staff in conflict resolution and safer handling and strengthening trust policy towards inappropriate behaviour. Further work is to be undertaken throughout 2016 in a series of open forums to better understand and develop solutions to staff experience to violence.

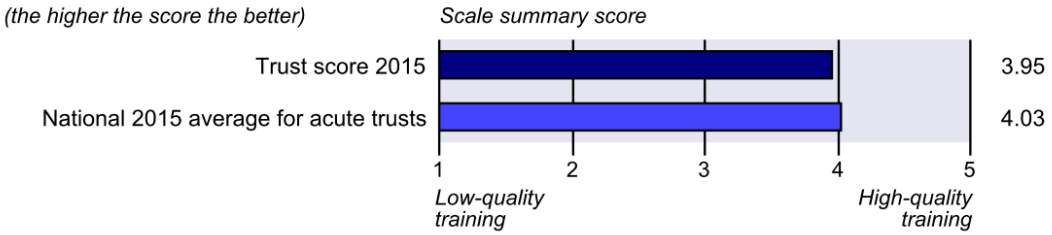
! KF3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



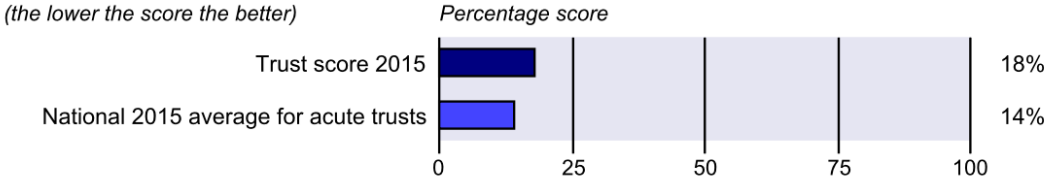
! KF13. Quality of non-mandatory training, learning or development

(the higher the score the better)



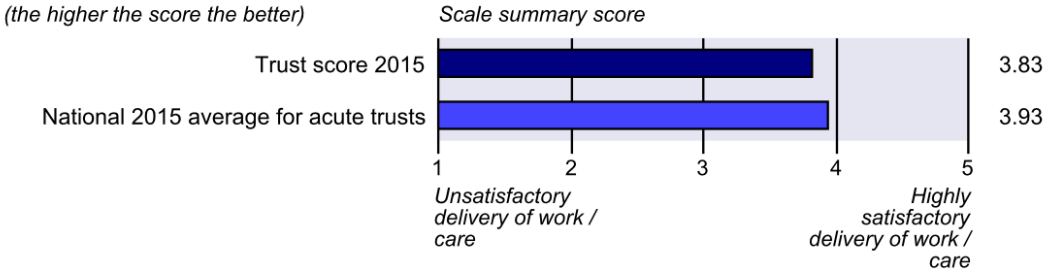
! KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



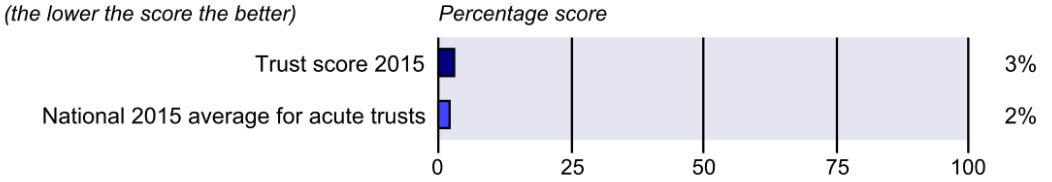
! KF2. Staff satisfaction with the quality of work and patient care they are able to deliver

(the higher the score the better)



! KF23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)

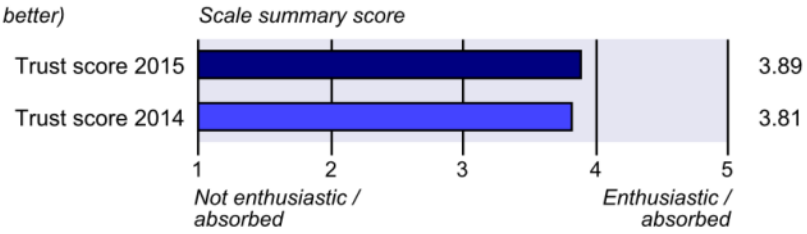


Below are the details of the largest local changes where staff experience has improved since the 2014 survey. These results are particularly encouraging and demonstrate that the principles of Patient First are becoming embedded into the organisation.

WHERE STAFF EXPERIENCE HAS IMPROVED

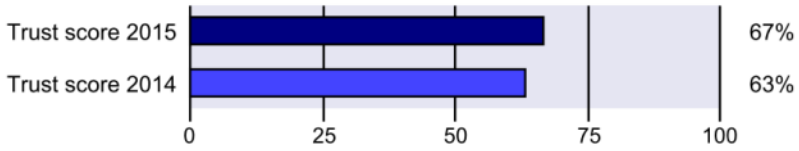
✓KF4. Staff motivation at work

(the higher the score the better)



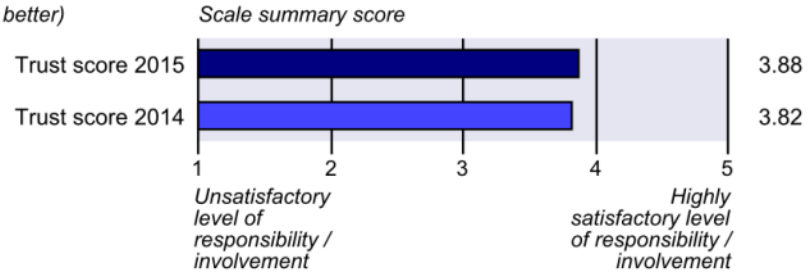
✓KF7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)



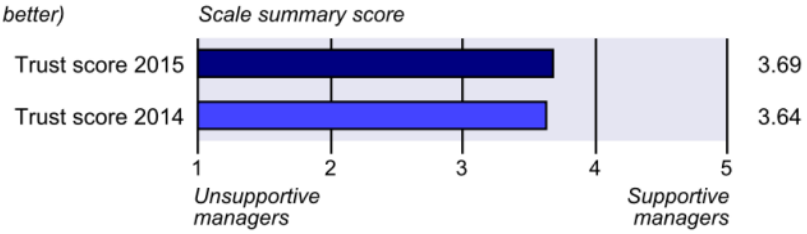
✓KF8. Staff satisfaction with level of responsibility and involvement

(the higher the score the better)



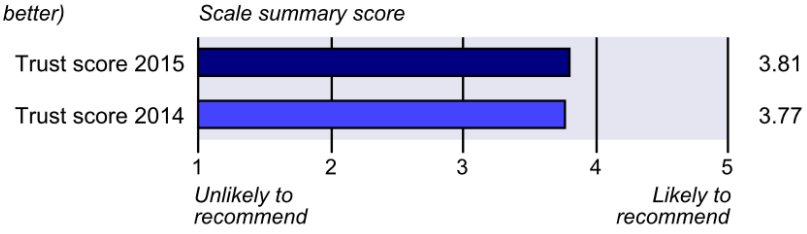
✓KF10. Support from immediate managers

(the higher the score the better)



✓KF1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



Looking ahead to 2016/2017

We want our Staff Survey results to be more positive. To achieve that we will focus on:

- Understanding areas of concern regarding violence, abuse and harassment and supporting staff in feeling safe
- Continuing to support improvements in staff health and wellbeing including staff working extra hours by recruiting into areas with staffing vacancies
- Supporting staff in feeling confident to raise concerns about unsafe clinical practice by learning from incidents
- Improving opportunities for staff to contribute ideas towards making improvements at work and lead positive change

Over the coming year we have committed to support active engagement as a Trust by analysing findings and develop divisional action plans to improve staff engagement. In doing so a Staff Survey Steering Group, named 'Wisdom of our Workforce', (WOW) is set up to provide leadership and strategic direction.

2.3.3 Learning and development

At Western Sussex Hospitals NHS Foundation Trust we aim to foster an inclusive culture of education, training and development for all staff.

We are proud of the career progression pathways we offer – from apprenticeships to leading and transforming organisations – and have a team of staff dedicated to supporting colleagues' development including NMC-qualified nurse teachers and researchers.

We have established partnerships with a number of educational organisations, including the Universities of Surrey and Brighton, which provide learning and development opportunities for nurses, midwives and other healthcare professionals who wish to develop their professional practice and academic careers.

Our speciality programmes aim to produce high-quality clinicians with a broad range of skills that will enable them to practice as consultants across the United Kingdom. Some of this training is funded through the Kent Surrey Sussex Deanery. Over the course of the last year, a total of 1,308 courses were delivered by the Trust's Learning and Development Unit. In addition, 525 staff attended external workshops and conferences.

Attendance on statutory and mandatory training was consistently high throughout 2015-16 and remains just above the Trust target of 90%. The Trust continues to have one of the highest attendance rates for statutory and mandatory training across the UK.

Staff conference

Our fourth Staff Conference, titled *Where Better Never Stops*, ran twice in 2015. A total of 490 staff attended the conference, an increase of 265 delegates from 2014. The focus of this year's conference programme included an update on the Patient First Programme, sharing examples of Patient First in action across the Trust, and launching the Patient First Improvement Programme.

All speakers were selected to ensure that they fitted in closely with the theme of quality improvement and we had two different key note speakers for each conference. In September, Jenny Moloney, from the Hospital for Sick Children, Toronto, provided an invaluable insight into how to implement continuous improvement in a hospital setting. In November, Professor David Oliver, President of the British Geriatrics Society, gave an entertaining presentation on the need to make acute care fit for an ageing population. Overall, the feedback on all presentations was very positive, with delegates finding the inclusion of the patient voice in some presentations very moving and powerful.

Apprenticeships

A total of 43 new apprentices were recruited during 2015/16 (an increase of 15 from 2014-2015).

In recognition of National Apprentice week, the Trust ran a number of events. These included stalls to promote the wide range of apprenticeship schemes available, and an in-house award ceremony at which Chief Executive Marianne Griffiths presented certificates to Trust staff who had completed their apprenticeship during the last 12 months.

We have also celebrated the appointment of the 100th new apprentice to start in the Trust, in the Patient Access team. In addition, the Trust achieved recognition for our achievements in recruiting and developing apprentices at the KSS Apprentice Awards, where Western Sussex was overall winner of the Level 2 Clinical Award and runner-up in another five categories.

Pre-employment programmes

A pre -employment programme for students who are interested in a career in the NHS, including medicine, nursing and midwifery, was launched in the Trust during 2015/16. This was run in partnership with Health Education Kent, Surrey and Sussex and the Sussex Education Business partnership. Twelve students spent a week in class covering subjects such as infection control, manual handling and safeguarding before undertaking two-week placements across our hospital sites including clinical and non-clinical areas. The final week provided an Employability Skills certificate.

Consultant development

A new development programme for 22 consultants and SASG doctors in their second third years in post was launched at WSHFT in September 2015. The aim of this initiative was to deliver a programme to new consultants which

embeds the Trust's values and behaviours, embraces the strategic themes of Patient First, and facilitates and supports their involvement with Trust issues from an early stage in their consultant career.

2.3.4 Health and safety

Health and safety compliance at Western Sussex Hospitals NHS Foundation Trust is managed by the Risk (Non-Clinical) Team and monitored at Board level by the Health and Safety Committee on a quarterly basis. A Health and Safety Report is also published annually and made available to staff via the Trust extranet, along with the Policy for the Management of Health, Safety and Risk.

The Health and Safety Committee reviews reports, policies and accident data on issues relating to the following areas of health and safety: fire, manual handling, security, training, estates and facilities, occupational health, staff incidents, stress, radiation protection and non-clinical risk management.

Health and safety incidents are logged on the Trust's Datix incident reporting system, while risk assessments around issues such as dangerous substances, display screen equipment, fire and manual handling tasks are carried out using the Safety, Health and Environment (SHE) software package.

Health and safety training is mandatory for all staff on induction and then on a triennial cycle. Attendance rates for 2015/16 were 92.7%.

2.3.5 Fraud, bribery and corruption statement

Western Sussex Hospitals NHS Foundation Trust is committed to eliminating fraud and corruption within the NHS, freeing up public resources for better patient care. To this end, the Trust employs a specialist counter-fraud service to provide a comprehensive programme against fraud and corruption which is overseen by the Trust's Audit Committee.

All anti-fraud and corruption legislation is complied with, and a recent development, the Bribery Act 2010, has added to the Trust's duties in this respect. It is a criminal offence to give, promise or offer a bribe, and to request, agree to receive, or accept a bribe. A bribe may take the form of any financial or other advantage to another person in order to induce a person to perform improperly.

Although the Bribery Act permits hospitality, all staff are required to consider on an individual basis whether accepting any hospitality offered is appropriate

and should they then elect to take it, to record it within the Trust's Hospitality register (in line with the Receipt of Hospitality, Gifts and Inducements Policy) so that it has been fully disclosed.

It is also important that all of our contractors and agents comply with our policies and procedures.

When entering into contracts with organisations the Trust follows the NHS standard terms and conditions of contract for the purchase of goods and supplies.

We ask all who have dealings with the Trust, as employees, agents, trading partners, stakeholders and patients, to help us in our fight against fraud and corruption and to contact the counter-fraud service in confidence if they have any concerns or suspicions.

2.3.6 Exit packages

This disclosure reports the number and value of exit packages agreed during the year.

Reporting of compensation schemes - exit packages 2015/16
These payments were due to restructuring

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	**-**
£10,001 - £25,000	-	-	**-**
£25,001 - 50,000	1	-	**1**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	1	-	**1**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**2**	**-**	**2**
Total resource cost (£)	£157,000	£0	**£157,000**

Reporting of compensation schemes - exit packages 2014/15
These payments were due to restructuring

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			

<£10,000	8	-	**8**
£10,001 - £25,000	2	-	**2**
£25,001 - 50,000	1	-	**1**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**12**	**-**	**12**
Total resource cost (£)	£202,000	£0	**£202,000**

Exit packages: other (non-compulsory) departure payments

	2015/16		**2014/15**	
	Payments agreed	**Total value of agreements**	**Payments agreed**	**Total value of agreements**
	Number	**£000**	**Number**	**£000**
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**-**	**-**	**-**	**-**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

.....

26 May 2016

Marianne Griffiths, Chief Executive

Western Sussex Hospitals NHS Foundation Trust

2.4 Remuneration Report

2.4.1 Annual Statement on Remuneration

It is the responsibility of the Appointment and Remuneration Committee of Non-Executive Directors to oversee the pay arrangements of Executive Directors, details of the committee can be found within the 'How the Trust is Run' section of this report. During the period of this report there have been no substantial changes to the base salary of Senior Managers.

2.4.2 Senior Managers Remuneration Policy

All Directors performance is subject to an annual appraisal the outcome of which is reported to the Appointment and Remuneration Committee by the Chief Executive. This is prior to any decision being made on Executive remuneration.

For the Chief Executive Officer, their appraisal is undertaken by the Chair of the Trust with a report then submitted to the Committee.

The annual appraisal method is chosen as it is an effective way to assess performance against a range of performance targets and leadership responsibilities and includes feedback from Non-Executive Directors and peers as part of a 360 degree feedback process.

In coming to any decision on remuneration, the Committee takes account of the circumstances of the Trust, the size and complexity of the role, any changes in the Directors portfolio, the performance of the individual and any appropriate national guidance. Senior managers are remunerated based on these decisions. Any performance related pay award by the Committee is within the context of the NHS Very Senior Managers Pay Framework.

In considering Senior Managers Pay the Committee took note of national benchmark data provided by NHS Providers and the requirement to consider any pay above a threshold of £142,500.

2.4.3 Future Policy Table

Please see in the following table details of the components of the remuneration package for senior managers. This is made up of;

Components of Senior Managers remuneration:
Base Salary
Performance related pay (where appropriate).

Base salaries are set in line with market information and are designed to ensure retention, or recruitment, of the calibre and experience required to deliver the aims of the Trust. Salaries are revised annually and uplifted only if:

- There is demonstrable evidence that an uplift is required to keep in line with the market
- A change in portfolio necessitates an uplift

The performance related pay scheme is based on the NHS Pay framework for Very Senior Managers. The Appointment and Remuneration Committee would, annually, consider whether the overall performance of the Trust warrants consideration of a performance related element being paid and if so the parameters of such an award.

2.4.4 Service Contracts, Obligations and Policy on Payment for Loss of Office

HM Treasury has issued specific guidance on severance payments within 'Managing Public Money' and special severance payments when staff leave requires Treasury approval.

All contracts are permanent with no fixed end date. There are no contractual provisions for payments on termination of contract.

The table below shows the date of contracts and notice periods.

Name	Title	Date of Contract	Notice period from the Trust	Notice period to the Trust
Mrs Marianne Griffiths	Chief Executive	01/04/2009	6 months	3 months
Mrs Jane Farrell	Chief Operating Officer and deputy Chief Executive	01/04/2009	Left 31/03/2016	
Mrs Karen Geoghegan	Director of Finance and Estates	01/02/2014	6 months	3 months
Mrs Amanda Parker	Director of Nursing and Patient Safety	02/02/2015	6 months	3 months
Mrs Denise Farmer	Director of Organisational	01/04/2009	6 months	3 months

	Development and Leadership			
Dr George Findlay	Medical Director	27/01/2014	6 months	3 months

2.4.5 Statement of Consideration of Employment Conditions Elsewhere in the Foundation Trust

In considering any decision on remuneration the Committee takes note of both the organisational and national context.

2.4.6 Salary and pension entitlements of senior managers

The following information is subject to audit.

A) Remuneration 2015/16

Name and Title	Salary (Bands of £5000)	Expenses and Benefits in Kind (nearest £100)	Annual Performance Related Bonus (Bands of £5000)	Long Term Related Bonus (Bands of £5000)	Pension Related Benefit (Bands of £2500)	Total (Bands of £5000)
	£000	£00	£000	£000	£000	£000
Ms M Griffiths Chief Executive	200 - 205	177	15 – 20	0	15 -17.5	250 – 255
Ms J Farrell Chief Operating Officer	145 – 150	28	5 - 10	0	0	150 - 155
Mrs K Geoghegan Director of Finance	140 – 145	0	5 - 10	0	0	145 - 150
Dr G Findlay Medical Director	160 - 165	186	0	55 - 60	0	230 – 235
Mrs A Parker Director of Nursing and Patient Safety	115 - 120	26	0	0	195 - 197.5	315 – 320
Mrs D Farmer Director of Organisational Development & Leadership	120 - 125	17	0 - 5	0	0	125 - 130
Mr M Viggers Chairman	40 - 45	55	0	0	0	40 - 45
Mrs J Crane Non-Executive Director	10 - 15	20	0	0	0	10 - 15

Mr J Furmston Non-Executive Director	10 - 15	0	0	0	0	10 - 15
Mr M Phillips Non-Executive Director Left 8th July 2015	0 - 5	5	0	0	0	0 - 5
Mr W Brown Non-Executive Director	10 - 15	7	0	0	0	10 - 15
Mr M Rymer Non-Executive Director	10 - 15	0	0	0	0	10 - 15
Ms L Peers Non-Executive Director	10 - 15	15	0	0	0	10 - 15

B) Pension Entitlements at 31st March 2016

	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2016 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2016 (nearest £1,000)	Cash Equivalent Transfer Value at 31 March 2015 (nearest £1,000)	Real increase in Cash Equivalent Transfer Value (nearest £1,000)	Employer's contribution to Stakeholder Pension
	£000	£000	£000	£000	£000	£000	£000	£000
Ms M Griffiths	0 - 2.5	5 - 7.5	30 - 35	90 - 95	625	563	55	Nil
Ms J Farrell	0 - 2.5	2.5 - 5	55 - 60	165 - 170	1,172	1,123	36	Nil
Mrs K Geoghegan	0	0	35 - 40	115 - 120	658	628	23	Nil
Dr G Findlay	0 - 2.5	2.5 - 5	40 - 45	120 - 125	714	647	60	Nil
Mrs A Parker	7.5 - 10	27.5 - 30	40 - 45	120 - 125	807	601	199	Nil
Mrs D Farmer	0 - 2.5	2.5 - 5	50 - 55	150 - 155	1,146	1,093	40	Nil

C) Remuneration 1st April 2014 to 31st March 2015

	2014/15					
Name and Title	**Salary (Bands of £5000)**	**Expenses and Benefits in Kind (nearest £100)**	**Annual Performance Related Bonus (Bands of £5000)**	**Long Term Performance Related Bonus (Bands of £5000)**	**Pension Related Benefit (Bands of £2,500)**	**Total (Bands of £5000)**
	£000	£00	£000	£000	£000	£000
Ms M Griffiths Chief Executive	195 - 200	95	15 - 20	0	0	210 - 215
Ms J Farrell Chief Operating Officer	140 - 145	61	5 - 10	0	0	85 - 90
Mrs K Geoghegan Director of Finance	135 - 140	53	0 - 5	0	35 – 37.5	180 – 185
Dr G Findlay Medical Director	155 - 162	261	-	40 - 45	62.5 - 65	290-295
Mrs C Stone Director of Nursing and Patient Safety Left 31.12.14	70 - 75	80	0 - 5	0	0	15 - 20
Mrs A Parker Director of Nursing and Patient Safety Commenced 02.02.15	15 - 20	0	0	0	0	0 - 5
Mrs D Farmer Director of Organisational	115 - 120	84	0 - 5	0	0	60-55

Development & Leadership						
Mr M Viggers Chairman	40 - 45	76	0	0	0	50 – 55
Mr A Clark Vice Chairman Left 27.05.14	0 - 5	0	0	0	0	0 – 5
Mrs J Crane Non-Executive Director	10 - 15	1	0	0	0	10 – 15
Mr J Furmston Non-Executive Director	10 - 15	4	0	0	0	10 – 15
Mr M Phillips Non-Executive Director	10 - 15	6	0	0	0	10 – 15
Mr W Brown Non-Executive Director	10 - 15	8	0	0	0	10 – 15
Mr M Rymer Commenced 01.02.15	0 - 5	0	0	0	0	0 - 5
Ms L Peers Commenced 12.05.14	10 - 15	11	0	0	0	10 - 15

D) Pension Entitlements 1st April 2014 to 31st March 2015

	Real increase in pension at age 60 (bands of £2,500)	**Real increase in pension lump sum at aged 60** (bands of £2,500)	**Total accrued pension at age 60 at 31 March 2015** (bands of £5,000)	**Lump sum at age 60 related to accrued pension at 31 March 2015**	**Cash Equivalent Transfer Value at 31 March 2015** (nearest £1,000)	**Cash Equivalent Transfer Value at 31 March 2014** (nearest £1,000)	**Real increase in Cash Equivalent Transfer Value** (nearest £1,000)	**Employer's contribution to Stakeholder Pension**
	£000	£000	£000	£000	£000	£000	£000	£000
Ms M Griffiths	0 - 2.5	0 - 2.5	25 - 30	80 – 85	563	521	28	Nil
Ms J Farrell	-2.5 - 0	-5 to -7.5	50 – 55	160 - 165	1123	1100	-7	Nil
Mrs K Geoghegan	0 - 2.5	5 – 7.5	35 - 40	115 - 120	628	558	55	Nil
Dr George Findlay	2.5 - 5	10 – 12.5	35 - 40	115 - 120	647	550	82	Nil
Mrs C Stone	-2.5 – 0	-5 to - 7.5	45 - 50	135 - 140	902	895	-18	Nil
Mrs A Parker Commenced 02.02.15	-2.5 - 0	-2.5 - 0	30 - 35	90 - 95	601	600	-15	Nil
Mrs D Farmer	-2.5 - 0	-5 to -7.5	45 - 50	145 - 150	1093	1080	-17	Nil

Notes:

1. The long term performance bonus for George Findlay relates to a national Clinical Excellence Award.
2. Where the pension benefits calculations for Executive Directors in 2015-16 resulted in negative values, these have been expressed as zero in accordance with guidance in the Foundation Trust Annual Reporting Manual. However these negative values have been taken into in account in calculating the total remuneration.
3. As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

4. Information on accrued pension benefits is provided by the NHS Pensions Agency

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Total Pension Entitlement

Normal retirement age for the NHS Pension Scheme is either 60 (for members in the 1995 scheme) or 65 (for members in the 2008 scheme). On retirement members receive their accrued pension and members in the 1995 scheme receive a lump sum equal to three times their annual pension. Members may choose to retire from work before their normal pension age and draw their benefits although these will be reduced because they will be paid earlier than expected. Further information about scheme rules and entitlements is available from http://www.nhsbsa.nhs.uk/pensions

Median Pay

The median remuneration was £27k. The ratio between this and the mid-point of the banded remuneration of the highest paid director was 1:8

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions or pension benefits.

26 May 2016

Marianne Griffiths, Chief Executive

Western Sussex Hospitals NHS Foundation Trust

2.5 Regulatory Ratings

The Trust is assessed under NHS Improvement's (formerly Monitor) Risk Assessment Framework. Financial risk is covered under the Financial Sustainability Risk Rating which is driven by a range of financial metrics. The highest rating that can be achieved is 4. A score of 3 indicates no significant financial concerns. The trust had a rating of 2 for quarters three and four which reflects the challenging financial environment in which it is operating.

NHS Improvement (formerly Monitor) Risk Ratings				
Rating	Q1	Q2	Q3	Q4
Financial Sustainability Risk Rating	3	3	2	2
Governance Rating	Under Review – requesting further information *	Under Review – requesting further information *	Under Review – requesting further information *	Under Review – requesting further information *

- Note that the 'Under Review'* rating relates to non-achievement of Referral to Treatment targets. The Trust is actively working with NHS Improvement and other partners to address the underperformance in this area.

2.6 Statement of Accounting Officer's Responsibilities

Statement of Chief Executive's responsibilities as the Accounting Officer of Western Sussex Hospitals NHS Foundation Trust for the period 1 April 2015 to 31 March 2016

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by Monitor.

Under the NHS Act 2006, Monitor has directed Western Sussex Hospitals NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Western Sussex Hospitals NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed …  ….. Chief Executive: 26 May 2016

2.7 Annual Governance Statement

2.7.1 Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The Trust's Standing Orders and Scheme of Delegated Authority outline the accountability arrangements and scope of responsibility of the Board of Directors ('the Board'), Executive Directors and trust officers.

The Board receives regular minutes and reports from each of the nominated committees that report into it. The terms of reference of the committees of the Board are regularly reviewed to ensure that governance arrangements continue to be fit for purpose.

2.7.2 The Purpose of the System of Internal Control

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

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Western Sussex Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Western Sussex Hospitals NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

2.7.3 Capacity to handle risk

Trust Board

The Trust has a Risk Management Strategy and Policy, endorsed by the Board of Directors and reviewed and monitored through the Trust Quality and Risk Committee to the Board.

In part the Quality and Risk Committee monitors and obtains assurance as to the effectiveness of the processes, systems and structures for good clinical governance at the Trust, and to seek their continuous improvement. The Board of Directors recognise that risk management is an integral part of good management practice and to be most effective should be embedded in the Trust's culture. The Board is therefore committed to ensuring that risk management is embedded as part of the Trust's philosophy, practice and planning and is not viewed or practiced as a separate programme and that responsibility for implementation is accepted at all levels of the organisation.

Non-executive Directors

The Audit Committee is chaired by a nominated Non-Executive Director. All Non-Executive Directors have a responsibility to challenge robustly the effective management of risk and to seek reasonable assurance of adequate control.

Executive Director of Nursing and Patient Safety

The Executive Director of Nursing and Patient Safety is accountable for the strategic development and implementation of organisational risk management, including Local Security Management and ensuring there is a robust system in place for monitoring compliance with standards and the Care Quality Commission (CQC) Registration legal requirements.

The Director of Nursing and Patient Safety is also responsible for managing patient and non-patient safety, complaints, patient information and medical legal matters.

Executive Director of Finance and Estates

The Executive Director of Finance and Estates oversees the adoption and operation of the Trust's Standing Financial Instructions including the rules relating to budgetary control, procurement, banking, losses and controls over income and expenditure transactions, and is the lead for counter fraud.

The Executive Director of Finance and Estates attends the Trust's Audit Committee but is not a member, and liaises with internal audit, external audit and counter fraud services, who undertake programmes of audit with a risk based approach.

Our Approach to Risk

Risk management training forms part of the essential training package that all staff are required to complete. All new members of staff attend a mandatory induction covering key elements of risk management, supplemented by local induction. The organisation provides mandatory and statutory training that all staff must attend.

During the year additional one-to-one training was provided to all Ward Sisters to ensure that risk awareness is embedded at this level.

The Trust seeks to learn from incidents and complaints as well as good practice through a range of mechanisms including benchmarking, clinical supervision and reflective practice, individual and peer reviews, performance management,

continuing professional development programmes, clinical audit, the application of evidence-based practice and reviewing compliance with risk management standards. There are formal mechanisms in place to ensure that external changes to best practice, such as those issued by the National Institute for Health and Clinical Excellence, are incorporated into Trust policies and procedures.

The Trust also proactively seeks to reduce risk to patients and staff and participates in initiatives such as NHS QUEST (the first member convened network for foundation trusts who wish to focus on improving quality and safety) and collaborative's developed through the Academic Health Science Network (eg such as the Falls collaborative).

2.7.4 The Risk and Control Framework

The Trust's Risk Management Strategy and Policy provide a framework for achieving the integration of risk management in the Trust's strategic aims and objectives. The strategy and policy encompass the Trust's risk management process and set out how staff are supported and trained to enable them to identify, evaluate and manage risk.

As part of its ongoing development of Risk Management, the Board developed a Risk Appetite Statement during 2014/15. The purpose of a Risk Appetite Statement is to provide a broad framework of the Board's willingness (to allow management) to take risks in pursuit of strategic objectives. Utilising this statement the Board set a 'target' risk score to be achieved for each of the Strategic Objectives captured within the Board Assurance Framework and to report achievement against these on an on-going basis.

During June of this year the Trust's Internal Auditor undertook a Risk Maturity Assessment. The purpose of this is to support an embedded risk management culture across the Trust. As an advisory piece of work the assessment did not generate an audit opinion but rather highlighted areas of good practice and opportunities for improvement.

The report found that "the Trust's overall approach to risk is sound with many areas of good practice identified". Some areas of improvement were also identified; these have been responded to and reported via the Trust Audit Committee.

Principal risks, during the period, to compliance with the governance conditions of the Foundation Trust Licence centred on; achieving the forecast financial outturn within what was a challenging operational environment together with non-achievement of Referral to Treatment (RTT) targets. Issues relating to recruiting the required workforce play a significant part in these issues, as has increased referral demand.

Significant mitigating action has taken place and the trust has achieved an efficiency programme of circa £18m. To help address workforce issues additional local, European and international recruitment has taken place.

Throughout 2015-16 the Trust has had Monitor governance rating of 'Under Review' relating to the non-achievement of RTT targets. The Trust has worked closely with

Commissioners and other agencies including Monitor (our regulator) to jointly agree a robust action plan to implement corrective action to address the Referral to Treatment issue.

During the year the Trust has re-forecast its financial out-turn position and at Quarter 4 achieved a Financial Sustainability Risk Rating of 2.

The Board approves the quarterly self-assessment submission to Monitor stating the anticipated Governance Risk Rating and Financial Sustainability Risk Rating to be achieved by the Trust.

The Board and its sub-committee's receive monthly performance reports for scrutiny with the Monitor quarterly report being presented to Trust Board in public.

Responsibilities of Directors and Board sub-committees are set out in the Annual Report.

Divisional risk registers are reviewed at each quarters Divisional Governance meeting, new operational risks identified and assessed, and issues and learning from all areas considered. They also carry out detailed reviews, action planning and assurance checks in response to the Care Quality Commission's (CQC) Standards.

Specific committees that consider potential risks faced by the Trust and /or reviewing the action and implementation of actions to mitigate them are: the Board, Quality and Risk Committee, Audit Committee, the Trust Executive Committee, Quality Board, Information Governance Steering Group and the Health and Safety Committee.

Risks are identified in many different ways within the organisation, including regular reviews of the risk registers (for example; by the trust Audit Committee and Quality and Risk Committee) are undertaken to ensure that the register accurately and clearly reflects the known risks within the organisation enabling focus at both operational and strategic levels to resolve them.

The risk register is used to inform the Trust's Assurance Framework, this is reviewed by the Board of Directors in full three times a year. The Assurance Framework identifies the Trust's appetite for risk, sets out the principal risks to the achievement of the Trust's organisational objectives, and the mitigation strategies required.

Opportunities to identify risks and concerns are also available through independent visits, to trust inpatient, community and corporate facilities, these are regularly undertaken by Executive and Non-Executive Directors and others, including the Trust Clinical Governance Team who identify concerns or issues while undertaking mock CQC inspections.

Incident reporting is actively encouraged within the Trust, and a comprehensive programme of investigation and follow up of all incidents is in place.

During the period of this report the Trust regrettably had two Never Events. Serious Incidents are subject to a thorough internal review to identify Root Causes and learning, action plans are developed and monitored. All Serious Incidents including Never Events were reported as required to the Clinical Commissioning Group,

Monitor and to NHS England. A full investigation has been undertaken and outcome and recommendations were reported to the Trust Board.

The Trust uses software on tablet devices as a way of capturing feedback from patients and the information from these is shared within clinical services. Patient experience is a regular item on the agenda of both the Trust Board and the Council of Governors who take a keen interest in this area and who routinely seek assurance that the Trust is acting on patient feedback.

During the year the Trust's Internal Auditors undertook a review of the arrangements in place to meet the new Fit and Proper Person requirements (FPPR) for Directors that came into force for all NHS bodies from November 2014. Overall the Auditor assessed that there was moderate assurance there are appropriate controls in place to ensure the Trust is meeting the requirement of the new standard, and substantial assurance the controls in place were operating effectively.

Major risks during this period included the on-going implications of a challenging workforce recruitment environment, significant external change in the local and national health economy together with the significance of the cost improvement programme for the year, these will remain a significant risk for 2016/17.

In support of mitigating these risks the Trust has launched its new Patient First programme to ensure continued focus on improving quality and the patient experience.

In addition the Trust has a Programme Management Office to ensure robust focus and governance in supporting the delivery of the Cost Improvement Scheme.

2.7.4.1 Compliance with CQC

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust has received a Rating of Outstanding following the CQC Hospital Inspection in December 2015.

2.7.4.2 Compliance with Equality, Diversity and Human Rights Legislation

The Equality and Diversity agenda is overseen by a cross organisational steering group chaired by the Chief Executive with Non-Executive Director attendance.

The Trust has a clear focus on safety and quality and our patient-centred values are applied by staff while at work every day, regardless of who they are and where they come from. More than 70 nations are represented among our 6,500 staff, all of whom by working for Western Sussex Hospitals NHS Foundation Trust have chosen to dedicate their professional lives to caring for people.

Together we are determined to put our patients at the heart of everything we do and turn our very good organisation into a great one. Ensuring high quality, safe services are available to all sections of the community and provided by a workforce that reflects the diversity of our population is an essential part of this journey. Each year

the Trust produces an annual report on our performance for equality and diversity in relation to staff and patients. This report provides us with an opportunity to celebrate the progress we have made so far, provide key information in relation to equality and diversity and express our commitment to removing inequalities, through a robust action plan and accountability structure, while promoting equality and diversity at the Trust.

In addition to our annual report we have live equality and diversity objectives that are developed in consultation with our internal and external stakeholders and regularly run equality and diversity events in the Trust and the local community. Control measures are in place to ensure that all the Trust's obligations under equality legislation are complied with and all Policies and Consultation documents together with major Business Cases are subject to an equality impact assessment to ensure no group is unintentionally disadvantaged.

2.7.4.3 Compliance with NHS Pension Scheme Regulations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

2.7.4.4 Compliance with Climate Change Adaptation Reporting to Meet the Requirements Under the Climate Change Act 2008

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

2.7.5 Review of economy, efficiency and effectiveness of the use of resources

The Board of Directors developed its business objectives for the period of this report through a dynamic process which involved staff throughout the organisation and the Council of Governors. All objectives are quantifiable and measurable and performance is reviewed through the Audit Committee, Quality and Risk Committee and the Board.

The Trust works closely with its Internal Audit providers to gain additional assurance on Trust processes. Areas of concern are highlighted and reviewed, following which action plans are developed and monitored through to implementation.

Performance against the business objectives, key actions required to improve performance, and other key messages are communicated to staff monthly through an embedded team briefing process.

Over the last two years the Trust has made considerable savings against its Efficiency and Transformation Programme demonstrating sustainability and improvements in economy and efficiency. The Finance and Investment Committee receives monthly reports on the delivery of the Efficiency and Transformation Programme and plans are reviewed by the Quality and Risk Committee to ensure there is no negative impact upon the quality of service provision.

The following policies and processes are in place to ensure that resources are used economically, efficiently and effectively:

- Scheme of Delegation and Reservation of Powers to the Board.
- A robust pay and non-pay budgetary control system
- A suite of effective and consistently applied financial controls
- Effective tendering procedures
- Robust establishment controls
- Continuous service and cost improvement and modernisation

Over the past year the Trust has further developed its Programme Management Office to support the delivery of Cost Improvement Programme and this is now and embedded way of working.

In addition the Trust has established a new Kaizen Office ('the practice of continuous improvement') which will help our patients benefit from the continuous improvement of all our services.

The Kaizen team, led by a newly appointed Director of Improvement, will help teams embed Lean-thinking into their everyday activities. They will train staff in proven techniques to increase their problem-solving capability and help them eliminate waste and error at every level of the organisation.

The Kaizen team will also identify best practices and learning from outside of the Trust and help apply them to best effect at Western Sussex to make sure all our patients receive excellent care every time they need us.

2.7.6 Information Governance

The Trust has an Information Governance Lead whose role is predominantly focused on achieving NHS information governance standards, including those set out in the Information Governance (IG) Toolkit (IGT). In this, he is supported by an IG Team and IG Steering Group (IGSG), the latter of which is Chaired by the Caldicott Guardian (who reports on activity bi-annually to the Quality and Risk Committee). The IGSG reviews and agrees key information policies within the Trust.

Through the Medical Director who, pending the appointment of a new Director of Information Management and Technology, is the interim Senior Information Risk

Owner (SIRO), and the IGSG, the Trust is proactively embedding robust IG practices throughout the organisation.

Risks to data security are identified in the risk register. The Trust's IGSG role is to ensure compliance with information governance standards to raise the profile of data security risks and to develop mitigation, especially through staff training and awareness. The Trust has achieved Level 2 of the IGT.

The Trust is disappointed to report that there have been two serious IG incidents during 2015-16 that required reporting to the Information Commissioner Officer (ICO). A serious IG incident is defined by the Health and Social Care Information Centre as any IG, information security or cyber security incident that is graded at Level 2 or above using its Checklist Guidance.

The first incident concerned a small number of letters and other documents containing personal confidential data (PCD) being sent in error via courier to the Trust's external payroll provider over a period of approximately three months. The incident was investigated by the ICO whom were satisfied with the action the Trust had taken to rectify the situation and taken action to prevent the incident recurring, no further action is to be taken by the ICO.

The second incident concerns an audit data set, including a limited amount of PCD, being mistakenly sent to a private individual's email address. The ICO's investigation with regard to this incident is ongoing.

2.7.7 Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Annual Quality Report 2015-16 has been developed in line with relevant national guidance.

The report sets out the priorities for the coming year and includes patient safety, patient experience and clinical effectiveness indicators. To assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data, the Board has:

Appointed the Medical Director to lead and advise us on all matters relating to the preparation of the Trust's annual Quality Report.

Put in place a system to receive and act upon feedback on the accounts from the following local stakeholders; Governors, Coastal West Sussex Clinical Commissioning Group, Healthwatch West Sussex and West Sussex County Council Health and Adult Social Care Committee.

Developed standards of data quality for those involved in the collection and reporting of metrics, and has developed training for staff.

Put in place appropriate systems to collect the data, and to review and report the quality metrics to the Board of Directors through the Quality and Risk Committee and the regular performance and quality reports to the board.

The Trust Executive Committee and the Board of Directors review performance against CQUIN and other quality indicators on a monthly basis through the Quality Report which is the joint responsibility of the Medical Director and Director of Nursing and Patient Safety.

All policies are ratified by the Trust's Executive Committee and include an Equality Impact Assessment which identifies any risk of individuals or groups being disadvantaged by that policy together with actions being taken to mitigate that risk.

All major plans are discussed and agreed at Trust Board with a focus on the impact on service quality. All Cost Improvement Plans have a Quality Impact Assessment undertaken which is reviewed by the Quality and Risk Committee prior to notification at a Public Board meeting.

Compliance with CQC standards is monitored by the Trust Executive Committee and the Boards Quality and Risk Committee.

The Trust is required to state how it assures the quality and accuracy of elective waiting time data, and the risks to the quality and accuracy of this data; Recording and reporting accuracy is subject to external audit as part of the Trust's audit programme, and statutory elective waiting time submissions are subject to consistency checks by NHS England and Monitor.

2.7.7.1 Patient First

Patient First is our trust-wide approach to improving the quality of care we offer patients.

It asks us to look at the pathways our patients take and think about how we could redesign our systems to take out waste and reduce the possibility of error, to make those pathways better.

It's also about standardising our practices so that every patient gets a great service each and every time we see them.

The philosophy behind Patient First is centred on:

- The patient being at the heart of every element of change
- The need for cultural change across the organisation
- Continuous improvement of our services through small steps of change
- Constantly testing the patient pathway to see how we can develop
- Encouraging frontline staff to lead the redesign processes
- Equal voices for all

2.7.7.2 Sign up to Safety

Sign up to Safety is a patient safety initiative announced in March 2014 by the Secretary of State. The Trust signed up with a commitment to its safety pledges in September 2014 to ensure the delivery of high quality care. Progress against the pledges is tracked via the Executive Quality Board and reported to the Quality and Risk Committee that receives regular updates on progress made on meeting those pledges.

2.7.8 Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control.

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

The Board and its sub-committees form an important aspect of control and I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee and the Quality and Risk Committee.

The Finance and Investment Committee is chaired by the Chair and plays a key role in assuring me on delivery of the Trust financial position.

The Quarterly review of the Board Assurance Framework and progress against Corporate Objectives provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by:

- The Trust's compliance against CQC registration and the fundamental standards
- The findings from the full CQC inspection undertaken in December under the new hospital inspection regime
- Annual Staff Survey
- National Patient Surveys
- Programme of work undertaken by internal and external auditors and Counter Fraud
- Responses from Monitor to the quarterly Board declaration process

- The output of the extensive 'deep dive' undertaken as part of our self-assessment and reflection preparation for our CQC inspection using the established inspection frameworks.
- The attainment of the IQIPS (Improving Quality in Physiological Services) programme run by the Royal College of Physicians.

As part of work to ensure continuous improvement, the format, structure and content of both the corporate risk register and board assurance framework have been subject to revision and amendment during the year in response to feedback from directors and recommendations regarding best practice from auditors.

2.7.8.1 Board of Directors

The Trust's governance structure comprises the Board and the following Committees: Quality & Risk, Patient Experience and Feedback, Serious Incident Review Panel, Finance & Investment, Audit, Charitable Funds and Appointments & Remuneration), and an executive management structure. There is good Non-executive and Executive attendance at Board which is detailed in the Trust's Annual Report.

I provide an update on any significant events or matters that affect the Trust at each meeting of the Board of Directors. The Board also receives regular reports on the significant risks identified in the Board Assurance Framework and actions to mitigate these, and summary reports from board committees including the Audit Committee and Quality and Risk Committee following each committee meeting.

2.7.8.2 Clinical Audit

The Board lead for Clinical Audit is the Medical Director who, through the Clinical Audit Manager, ensures sustained focus and attention to detail of clinical audit activity. Reporting is regularly provided to the Quality and Risk Committee.

2.7.8.3 Internal Audit

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 and the Audit Committee works with the Internal Auditors to develop an agreed annual work plan. The work plan is kept under review during the year and amended if required to respond to a new or emerging issue.

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 is in the context of a 'scale' used by Internal audit of : Full Assurance, Moderate Assurance, Limited Assurance, No Assurance.

During the period 1 April 2015 to 31 March 2016 the Committee received fourteen Internal Audit reports at its four meetings. 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'. Of the audits relevant to this period all received assurance levels of either substantial or moderate.

At its meeting in April 2016 the Audit Committee received five additional completed audit reports. Of these, two audits received Moderate Assurance and four received Limited Assurance.

2.7.8.4 External Audit

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.

In addition, the External Auditor reports to the Council of Governors on its findings of their audit of the Financial Statements and the Quality Report.

2.7.8.5 Audit Committee

The Audit Committee is a sub-committee of the Board of Directors and reports directly to it. Its membership comprises of Non-Executive Directors.

The Audit Committee is responsible to the Board of Directors for reviewing the adequacy of the governance, risk management and internal control processes within the Trust. In carrying out this work, the Audit Committee primarily utilises the work of internal and external audit. The Audit Committee also obtains assurance from the views of other external agencies about the Trust's procedures, such as from the Care Quality Commission.

More specifically, the Audit Committee:

- reviews and discusses the Annual Report and Accounts with the external auditor before the Board of Directors approves and signs off the financial statements;
- ensures there is an effective internal audit function established by management that meets the mandatory NHS internal audit standards, produced by the Department of Health, and reviews the work and findings of the internal auditor;
- agrees the schedule of internal audit reviews, receives the relevant reports and follows up on issues raised. The Audit Committee also follows up on any issues relating to process identified at the Clinical Governance Committee and/or Quality Committees;
- receives and monitors policies and procedures associated with countering fraud and corruption.
- receives reports from the independent local counter fraud service provided by RSM Tenon who present a counter fraud progress report to each meeting; and

- reviews arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters.

The Audit Committee is also responsible for reviewing evidence of the overall effectiveness of the system of internal control, governance and risk management.

The Internal Audit programme is risk based and focussed on high risk areas identified on the Trust's Assurance Framework. The programme includes matters of interest or concern identified by management and the Audit Committee during the planning phase, however, the plan is left flexible to allow the Committee to respond effectively if urgent issues arise.

Many of the key internal control processes and data quality were tested through the year by Internal Audit. No significant gaps in control or assurance were identified. The Audit Committee reviews all action plans arising from Internal Audits to ensure compliance.

The Audit Committee operates alongside the Quality and Risk Committee to maintain oversight of material risks affecting the Trust and the means by which risk is monitored and controlled. In support of this one member Non-Executive Director sits on both the Audit committee and Quality and Risk Committee.

The Audit Committee reviews the Annual Accounts before approval.

The Audit Committee provides a report to the Trust Board on its activities following each Committee meeting, together with an Annual Report.

2.7.8.6 Quality and Risk Committee

The purpose of the Quality and Risk Committee is to support the Board in ensuring that the Trust's management and clinical and non-clinical processes and controls are effective in setting and monitoring good standards and continuously improving the quality of services provided by the Trust in line with the principles and values of the Patient First programme.

The Quality Committee also takes responsibility for overseeing the progress of the Trust in compliance with external standards by regularly reviewing and monitoring the following:

- Risk Register and Assurance Framework
- Clinical Audit Plan
- Health and Safety Executive inspections and any associated action plans
- Learning from Root Cause Analysis and Serious Incidents
- The ongoing development of the Quality Report and the standards set out within it
- CQC registration issues
- Claims and Litigation information is routinely reported to the Trust Board

In addition the Committee reviews the quality impact of all efficiency and transformation programmes.

The Clinical Governance frameworks were reviewed during the year of this report and new reporting requirements agreed. The framework includes quarterly Divisional Governance Reviews of the clinical divisions together with IT and Facilities/Estates, which are monitored by the Quality and Risk Committee on behalf of the Trust Board, each of these are attended by a Non-Executive Director and chaired by either the Medical Director or Director of Nursing. A summary of Divisional Governance meetings is presented to the Quality and Risk Committee at each meeting.

2.7.8.7 Risk Triangulation Committee

The trust has established a Risk Triangulation Committee to provide a forum to review high and severe complaints, PALs and legal claims, clinical incidents, significant incidents related to Health and Safety and Human Resources to ensure that trends and themes are identified and reported to the Board and Divisions in a timely manner.

2.9 Conclusion

Over the period 1 April 2015 to 31 March 2016 I have overseen actions to ensure that we continue to improve the systems of control we operate. No significant gaps in control or assurance were identified in the period covered by this report. Where opportunities for improvement have been identified robust action plans have been put in place.

Although not a direct control issue the trust, in line with the national picture, has struggled to keep pace with rising demand and to achieve Referral to Treatment (RTT) targets and this has impacted on our Monitor Governance rating.

The Trust has constructed detailed recovery plans to restore RTT compliance and RTT completed pathways exceed the planned volumes in recovery plans, however referral demand has compromised recovery. In response, in September 2015 the Trust implemented a Programme Management Office to use all NHS funded capacity (both independent and NHS) through the provision of a single point of waiting list co-ordination and management.

The Trust continues to work closely with Monitor, NHSE Surrey and Sussex Local Area Team, Coastal West Sussex CCG and the IMAS 18 week Intensive Support Team.

In addition our Financial Sustainability rating has deteriorated in year from a Rating of 3 to a 2 as at 31 March 2016. To support the Trust financial sustainability it has developed three key elements aimed at improving efficiency while assuring quality, these are: a robust efficiency and transformation programme manged through a Programme Management Office, an Executive led Workforce Transformation Programme, and a Kaizan (Continuous Improvement) Office.

Feedback from internal and external sources has been generally very positive, and where weaknesses or areas for improvement have been identified, action plans have been put in place to ensure delivery.

I am particularly pleased that the Care Quality Commission issued an overall rating of Outstanding which reflects well on our governance processes. Details of the inspection findings can be found under the CQC section of the Annual Report.

Marianne Griffiths

Chief Executive

26 May 2016

Quality Report 2015/16

Western Sussex Hospitals NHS
NHS Foundation Trust

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Appendix 2: Actions resulting from reviews of national clinical audits

Appendix 3: Actions resulting from reviews of local clinical audits

Annex 1: Statements from our commissioners, local Healthwatch organisation and Overview and Scrutiny Committee

Annex 2: Statement of directors' responsibility for the Quality Report

Limited Assurance Report on Quality

PART ONE: STATEMENT FROM OUR CHIEF EXECUTIVE

Welcome to our Quality Report 2015/16, which details our priorities for improvement over the year ahead and highlights some of our key achievements in the past year.

As chief executive, I am extremely proud of the care our patients receive and I am confident the safety and quality of all our services will continue to improve.

Indeed, our approach to improvement, what we call our Patient First programme, received significant endorsement from the Care Quality Commission in their Quality Report, published in April. The report described Western Sussex Hospitals as one which aspires to be one of the best patient-centred services in the NHS, with a trust-wide mantra of patient first, adding that "the trust focuses first on improving quality and safety" and that inspectors observed a "clear focus on quality improvement, innovation and safety, starting even before patients are admitted."

'Patient First' is a programme based on standardisation, system redesign and ongoing development of care pathways, built on a philosophy of incremental and continuous improvement led by front-line staff empowered to initiate and lead positive change.

Progress includes the appointment of a new Director of Continuous Improvement to lead a large continuous improvement training programme aimed at ensuring our staff are both empowered and have the tools they need to make improvements in the care we provide. We have also established our Kaizen Office, and welcomed a team of Improvement Practitioners working with staff to make improvements across our wards and departments.

We have started to roll out our Patient First Improvement System, in a series of waves across the Trust's wards and services. Teams take part in formal training and team-days, and are also coached in the use of continuous improvement tools at the frontline to ensure the tools become embedded in day to day practice. This is an exciting programme which teams are embracing with passion and enthusiasm.

I am incredibly proud of the Trust's 6,500 staff members who against a back-drop of ever increasing demand for our services and significant winter pressures in 2015/16 continued to deliver against the goals we set for quality improvement last year.

More than 96 per cent of people who attended Accident & Emergency in West Sussex over
the past 12 months were seen, treated, admitted or discharged in under four hours. I am delighted to report that the most recent national data available ranks Western Sussex Hospitals fourth in the country in terms of A&E performance. While the 4-hour target relates to waiting times in A&E, it is a genuine reflection of how the whole hospital system is working, with staff proactively managing patient flow from admission to discharge.

Our staff have worked incredibly hard to achieve this hugely impressive result, this year helping more patients than ever before.

Over the last two years we have opened new Emergency Floors at both St Richard's and Worthing Hospitals. The Emergency Floors are a single point of access for all emergency and urgent medical and surgical admissions, whether referred by A&E or GPs; they provide standardised acute care in a modern environment supported by highly skilled staff.

The newly opened emergency floor at St Richards will build on the significant benefits for patients already demonstrated on our Worthing site where, for example, the average length of stay of stay for surgical patients has reduced by 22% since the opening of the Emergency Floor last year.

This year we have also significantly improved our position for risk adjusted mortality. Our risk adjusted position reaching levels aligned to the best performing 20% of NHS trusts in England. Over the next year we will seek to continue to reduce levels of avoidable mortality particular focus on the management of deteriorating patients and the identification and management of sepsis.

Stroke services at both St Richard's and Worthing Hospitals have now achieved B ratings for the Sentinel Stroke National Audit Programme (SSNAP). Nationally trusts are measured at site level for compliance against six domains (acute care; specialist

roles; interdisciplinary services; transient ischaemic attack / neurovascular clinic; quality improvement, training and research; and planning and access to specialist support). Each trust site is given an overall score: a letter from A to E (with A being the highest).

In the last published national data (October to December 2015) stroke services at both sites were graded B (an improvement from C in the case of both Worthing and St Richard's Hospitals from the same period in 2014). For context, of the 215 Trust sites in England and Wales, 82 (38%) were graded B or above, 12% were graded A. This is a huge achievement, our Stroke Team's improvement efforts were recognised at this year's Trust Patient First Star Awards.

We have made great strides in infection control in recent years, with over a 50% reduction hospital acquired in *C.difficile* infections over the last four years. There were only 36 cases of *C.difficile* during 2015/16 which means the Trust finished the year well within the target maximum of 39. There were no cases of avoidable MRSA (Methicillin-resistant *Staphylococcus aureus)* last year and the Trust's target remains zero cases for the coming year. I would like to commended staff for their diligence and hard work which ensured patients benefitted from these impressive results despite ever-increasing demand for services.

However, we recognise there is more we can do, which is why we continue to pursue improvements to achieve our key quality goals:

- Reducing mortality and improving outcomes
- Safe care
- Reliable care
- Improved patient and staff experience

Following a month long engagement exercise with our staff, patients, members, partners and stakeholders we have agreed the improvement priorities for each area for 2016/17. We have set ourselves ambitious targets for measurable improvement against each goal which will improve the quality thousands of our patients experience over the next 12 months.

The Patient First Programme provides the philosophy, new organisational structure and methodologies to relentlessly pursue continuous improvement against each of these goals.

We hope that this Quality Report provides you with a clear picture of what we have achieved over the past year and how we will continually build upon these foundations and deliver against our 2016/17 quality improvement priorities.

We have written the report in plain English wherever possible to ensure it is widely accessible for all interested parties, and will continue to refine all our literature to meet this ambition.

The information contained within the Quality Report is, to the best of my knowledge, accurate.

Marianne Griffiths
Chief Executive

Inspected and rated
Outstanding
CareQuality Commission

1.1 Key Achievements 2015/16

We aim to provide **'the best care every time'**. We will focus our attention on programmes of work that will ensure that we continuously improve the safety and reliability of the care that we give to patients, but also improve their experience of that care.

Key goals

- **Reducing mortality and improving outcomes**
- **Safe care**
- **Reliable care**
- **Improved patient and staff experience**

We will build on the strong foundations we have in place in delivering high quality care. The delivery of our ambition to provide the best care every time is underpinned by significant investment in our 'Patient First Programme'.

Last year Western Sussex Hospitals NHS Foundation Trust committed to a number of key quality improvement priorities, our achievements in relation to these priorities, and other areas of achievement in improving the quality of the care we provide, are highlighted herein. A more detailed review of quality performance over 2015/16 is set out in part two and three of this report.

Western Sussex Hospitals NHS
NHS Foundation Trust

Key Achievements 2015/16

- Inspected and rated **'Outstanding'** by the Care Quality Commission — Patient First
- in the best **20%** nationally — we have improved our position for risk adjusted **mortality** — Reducing mortality
- **4th** best nationally — our **A&E departments** are ranked 4th best in the country — Reducing mortality
- **50%** reduction in hospital acquired ***Clostridium difficile*** infections in the last four years — Safe care
- **11%** reduction in **falls** since 2014/15, 8.4% over the last three years — Safe care
- **Ward Accreditation** programme rolled out: based on the CQC's fundamental standards of care — Safe care
- **Electronic prescribing and Medicines Administration** system rolled out across Trust adult — Safe care
- in the best **38%** nationally — we have improved our **stroke care** services across the Trust — Reliable care
- new **Emergency Floors** have reduced patient length of stay, mortality, readmission rates and waiting times — Reliable care
- **96%** of our inpatients feel **confident and safe in our care** — Patient experience
- over **90%** of patients admitted as emergencies **screened** and **assessed** for **dementia** — Patient experience
- 10 **Schwartz Rounds** have run, providing a safe place in which staff can share their experiences — Staff experience
- **Patient First Improvement System** has launched: empowering and equipping staff to improve care — Staff experience

1.2 Awards 2015/16

Overview of awards during the year

- In September 2015 the pathology team, working with paediatric colleagues won NHS England and NHS Employers' Kate Granger Team award for Compassionate Care, for their Harvey's Gang initiative. The initiative enables young patients to spend time in the pathology labs learning about their bloods and testing processes.
- In June 2015, the Fernhurst Centre at St Richard's Hospital secured a five star Quality Environment Award from Macmillan.
- Nine of our apprentices were shortlisted for regional Health Education England NHS Apprenticeship Awards in March 2016, one winning the Level 2 Apprentice of the Year Award (Clinical) and another being placed as runner up. Our apprentices also secured runner up places for Level 3 Apprentice of the Year (Non-clinical) and Apprentice Champion of the Year 2016. The Trust was also nominated for the prestigious Apprentice Employer of the Year award.
- The Trust won a Health Education England funding award for Learning Zone and Mobile Learning Zone – a new initiative to provide easily accessible and mobile clinical simulation training for multi-disciplinary teams within acute and primary care environments (2015).
- Three of our catering outlets at Worthing Hospital won 'Eat Out, Eat Well' Awards in August 2015 for promoting health eating. The award scheme has been developed to reward good practice and highlights businesses that are making it easier for their customers to make healthier choices when eating out.
- The Trust's Chief Audiologist was crowned Audiologist of the Year by the British Academy of Audiology (BAA) in November 2015.
- In December 2015 the St Richard's Accident & Emergency nurses won the Special Recognition Award at the Chichester Observer's Community Awards as voted for by the local public.
- Our Home Enteral Feeding Dietician was awarded the Motor Neurone Disease Association (West Sussex South Branch) Extra Mile Award for persistent and professional care of a motor neurone disease patient in April 2015.
- Western Sussex Hospitals NHS Foundation Trust was awarded UKAS (United Kingdom Accreditation Service) Accreditation for their adult hearing services at Worthing and Southlands Hospitals in September 2015, recognising the high standards of care and recent quality improvement work. The inspectors' feedback was overwhelmingly positive, with the department

commended in a number of areas including clinical practice, the caring and professional manner of staff and for being generally well run.

Part Two: A review of quality improvement 2015/16 - priorities for improvement in 2016/17

2.1. Our progress and plans

2.1.1 Introduction

Western Sussex Hospitals NHS Foundation Trust (WSHFT) developed a new Quality Strategy last year that sets out a programme of work over the next three years (2015-2018) to support continuous improvement in the quality of care we provide.

We aim to provide **'the best care every time'**. We will focus our attention on programmes of work that will ensure that we continuously improve the safety and reliability of the care that we give to patients, but also improve their experience of that care.

Key goals

- **Reducing mortality and improving outcomes**
- **Safe care**
- **Reliable care**
- **Improved patient and staff experience**

We will build on the strong foundations we have in place in delivering high quality care. The delivery of our ambition to provide the best care every time will be underpinned by significant investment in our **Patient First Improvement Programme.**

The top quality priorities relate to the Trust's 'True North' quality and safety metrics. These are the core metrics that establish a measure of our organisational health and provide a system-wide focus for improvement – the link between the organisation's most important goals from the clinical areas and the Executive Board. These are called **'True North' metrics.**

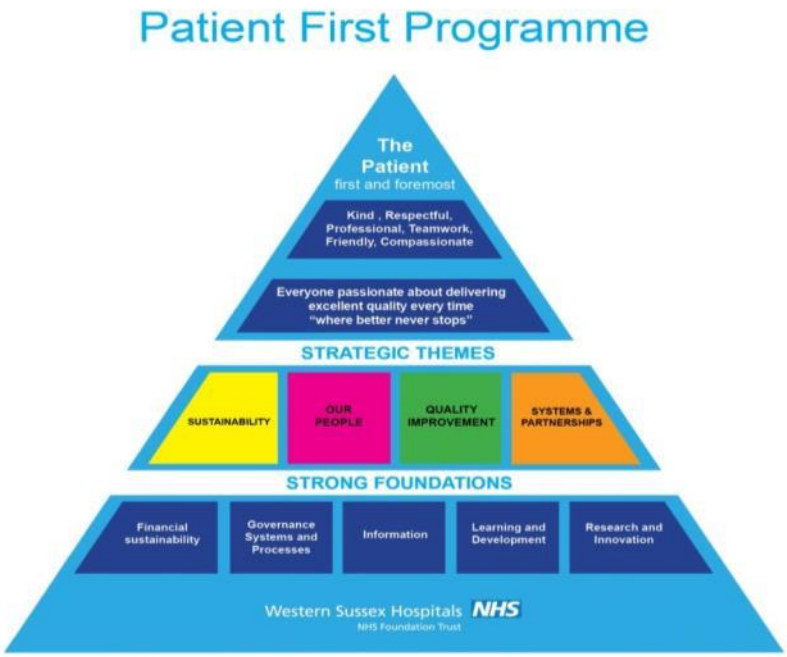
For quality and patient experience, the True North metrics have been agreed as:

- **Preventable Mortality – Target HSMR top 20% in the country;**
- **Avoid Harm – Patient Safety Thermometer 99% Harm free care;**
- **Patient Satisfaction – Friend and Family Test overall score 96%**

Patient First Improvement Programme

The Patient First Programme was established in November 2014 and provides oversight and direction for the Trust's continuous improvement activity. The Patient First Programme is the Trust's approach to transforming the way we deliver services. It is based on standardisation, system redesign and the improvement of patient pathways, built on a philosophy of incremental and continuous improvement. It is led by front-line staff empowered to initiate and lead positive change. The methodology has been translated from a system designed at ThedaCare, a Canadian Hospital Group, who successfully used Lean improvement techniques to transform their organisation. Significant investment at Western Sussex is enabling the ThedaCare System to be adapted and deployed across the Trust.

The Patient First Improvement Programme is the Trust's plan to give staff the skills to deliver continuous improvement and to put our Patients First. The structure and approach of the programme is represented by the triangle below.



In simple terms, the main aim of our Patient First Improvement Programme is to empower and enable everyone to be passionate about delivering excellent care every time.

In 2015/16, the Programme focused in four main areas:

- **Patient First Improvement Programme / system**
- **Non Elective Flow**
- **Elective Flow**
- **Workforce**

The **Patient First Improvement Programme** is a programme developed and delivered in partnership with KPMG and aims to support the Trust's development toward becoming a Lean organisation. There are five areas of development described as pillars each of which have specific and aligned deliverables:

Strategy Deployment	Patient First Kaizen Office	Capability Building	Patient First Improvement System	Improvement Projects
➢ True North metrics ➢ Breakthrough Objectives ➢ Strategic Initiatives	➢ Director of Continuous Improvement ➢ Team of improvement practitioners	➢ 19 Green Belts ➢ 250 Yellow Belts ➢ Six level training plan	➢ 12 Lean management units	➢ Six Lean improvement projects

There has been good progress in 2015/16 to establish the programme and undertake the planning work for all five pillars, whilst building internal capacity to allow work to focus in 2016/17 on delivering improvement. 2016/17 objectives will include review of Trust business processes to focus attention on the agreed True North metrics, delivery of Lean management units and Lean improvement projects all of which are in the early stages of implementation The programme will be continue to be supported by an extensive communications plan.

There are two aligned programmes of work that aim to improve patient flow through our hospitals: **Non-Elective Flow** and **Elective Flow**. The focus of both programmes in 2015/16 is improved alignment of demand and capacity: correct configuration of beds for different clinical specialties to better manage non-elective and elective demand, and theatre scheduling to deliver the Trust's elective plan. Each programme is supported by a number of improvement work streams:

	Non–elective flow improvement workstream	Elective flow improvement workstream

Enabling improvement	➢ Ambulatory Care Pathways ➢ Senior Daily Review ➢ Reducing the number of people who are Medically Fit for Discharge (MFFD) who have delays in discharge or transfer of care	➢ New model of one stop pre-assessment ➢ Theatre utilisation: o Booking standards o Theatre readiness o Southlands Hospital optimisation

This work will continue in 2016/17 but will also be refreshed to address the significant workforce constraints that have impacted full delivery in 2015/16. For non-elective flow there will be a greater emphasis on standardising best practice flow processes across Worthing and St. Richard's Hospitals. For elective flow, this will mean targeting our improvement work in the high volume, high value surgical specialties. Both areas are also benefiting from alignment with the Patient First Improvement Programme, including: improvement projects in both areas plus Patient First Improvement System (PFIS) in more wards, Worthing operating theatres and Worthing outpatients.

The Trust's attention also focused in 2015/16 on increasing our **workforce** and reducing reliance on temporary staffing to ensure access to safe services for patients: this will remain a top priority in 2016/17 and beyond. The Trust made significant progress in improving recruitment to address key gaps in the Medical Workforce including in Anaesthetics, Ophthalmology, Radiology and the Nursing Workforce. This work will continue in 2016/17 and will include a response to the heightened control environment in place to drive a reduction in agency expenditure.

We are building continuous improvement **capacity** throughout our workforce with our Patient First Improvement Programme. Over 1000 staff will receive Lean[5] methodology training, with 'Green Belt' and 'Yellow Belt' Lean improvement training already underway.

[5] Lean is an improvement approach to improve flow and eliminate waste that was developed by Toyota.
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/lean.html

The **Patient First Improvement System** (PFIS) is our Lean management system, developing our staff to solve problems and improve performance. PFIS is rolled out in a series of waves each taking approximately five months to deliver. As well as formal training and team-days, each team is also coached in the use of the tools at the frontline to ensure they become embedded in day to day practice. Key elements include status sheet exchanges (structured daily discussions to learn about the business of the unit, proactively plan and provide coaching opportunities); establishment of Unit Leadership Teams who have ownership for the performance of their unit; daily improvement huddles where staff identify improvements in their own area that they are able to make themselves; and implementation of process and leader standard work to ensure improvements can be sustained. Wave One, consisting of four wards (Botolphs, Clapham, Fishbourne and Wittering), complete the programme in April 2016. Wave Two (commencing March 2016) includes two further wards (Lavant and Selsey wards) as well as two non-ward areas (Worthing Theatres and Worthing and Southlands Outpatients). Wave Three will commence in July 2016.

Strategic programmes

Other strategic programmes aimed at improving the quality of our services include:

- **Coastal West Sussex MSK[6] Redesign Programme**

The Coastal West Sussex MSK Redesign Programme arose from the Clinical Commissioning Group's commissioning and re-procurement of MSK services in recent years. We have been working alongside our partners, Sussex Community NHS Foundation Trust and Independent Lives, to develop a radically different approach to delivering outpatient and elective surgical care for patients with musculoskeletal problems; this includes adults with rheumatological, chronic pain and orthopaedic needs as well as adults who are currently accessing outpatient physiotherapy services.

Across the whole local health economy around £47-50m a year is spent MSK services both with WSHFT, Sussex Community NHS Foundation Trust and other NHS and independent sector providers. The intention of the MSK Redesign Programme is to bring together the very best approaches to delivering pathways of care, with WSHFT leading provision of these services alongside a range of other providers.

[6] MSK, musculoskeletal

The redesigned pathways of MSK care will ensure that more consistent and more efficient patient journeys are delivered, resulting in fewer negative issues such as cancellations and long waits for diagnosis or treatment.

We expect in the next few months to formally sign off these new pathways with the Coastal West Sussex Clinical Commissioning Group (CCG)[7] and to commence delivering these changed services from July 2016. The contract will run for five years and we expect ongoing service redesign and change to be a component of the service throughout that time.

- **Western Sussex Eye Care I Southlands**

The Trust is investing £7.5 million in a state of the art new eye care facility to improve eye care for our patients. Ophthalmology specialists from the Trust have been working with patients, architects and developers to create new and more patient-centred facilities at Southlands Hospital. The service will be called 'Western Sussex Eye Care | Southlands and is designed to enable patients to receive all tests, results and diagnoses in one visit, with many treatments also available on the same day. The project complements the multi-million pound investment already made at St Richard's Hospital, Chichester, and cements a new service – Western Sussex Eye Care – being introduced by our dedicated team of eye care specialists across the Trust.

- **Outpatient improvements**

An outpatient improvement diagnostic has been completed this year to focus on improvement opportunities in the Trust's outpatient services. The diagnostic phase has involved significant staff and patient engagement along with data analysis. Recommendations have been made for improvements in referral and grading, booking of appointments and attendance and follow up. Improvements will be prioritised and implemented over the next year to improve processes and patient experience of these services.

- **Development of the Emergency Floors at both Worthing and St Richard's Hospitals**

[7] Clinical Commissioning Group (CCG): CCGs are groups of general practices, working as a statutory NHS body, with responsibility for the planning and commissioning of the best health care services for their patients and population. There are currently 209 CCGs in England. Coastal West Sussex CCG is the CCG responsible for commissioning health care services from WSHFT.

On both of the Trust's acute sites, our Emergency Floors combine the Acute Medicine, Medicine for the Elderly and Surgical Assessment Units into one operational unit; this removes traditional boundaries between hospital, community and primary care. The co-location of acute admissions and multi-disciplinary support ensures rapid access to diagnostic and treatment interventions which improve outcomes and safe transfers of care. The Emergency Floors focus care around the patient, enabling treatment from a multi-disciplinary team, led by one consultant, in a single setting.

Patients benefit from the expertise of physicians, surgeons and elderly care specialists working together. Admission pathways are standardised and enhanced - from both primary care and A&E, resulting in reductions in overall length of stay, a reduced number of ward moves, an overall improvement in mortality, and an improvement in the quality of the care experienced by patients. In addition, the increased use of ambulatory care pathways reduces the need for hospitalisation without an increase in readmissions.

Six-month data from the Worthing Emergency Floor (which opened first) shows a reduction in length of stay in Medicine (by 3%) and Surgery (by 22%); an improvement in zero and one day length of stay of 7% for elderly care patients[8]; a 4% reduction in mortality and 5% in readmission rates. A reduction in patients waiting in A&E for longer than 4-hours (by up to 11%) has been accompanied by sustained positive feedback from patients.

2.1.2 Reducing mortality and improving outcomes

GOAL: To be in the 20% of NHS organisations with lowest risk adjusted mortality

We aim to reduce avoidable mortality and improve the clinical outcomes of patients receiving care at our hospitals. We will benchmark ourselves against other NHS organisations with a goal to be one of the NHS organisations with the lowest risk adjusted mortality rates.

[8] This means more of our elderly care patients are staying for shorter periods (zero and one day stays) than previously.

Why is this important?

About half of all deaths in the UK take place in hospital. The overwhelming majority of these deaths are unavoidable. The person dying has received the best possible treatment to try to save his or her life, or it has been agreed that further attempts at cure would not be in the patient's best interest and the person receives palliative treatment.

We know, however, that in all healthcare systems things can and do go wrong. Healthcare is very complex and sometimes things that could be done for a patient are omitted or else errors are made which cause patients harm. Sometimes this means that patients die who might not have, had we done things differently. This is what we mean by 'avoidable mortality'. More often, if things go wrong with care, patients fail to achieve the optimal level of recovery or improvement. By concentrating on this area we will end up with safer hospitals, save lives, and ensure the best possible clinical outcomes for patients.

How do we monitor it?

Hospital mortality refers to the number of patients who die while in hospital. The simplest way of measuring this is to look at the crude rate; that is the number of deaths in hospital as a percentage of the total number of patients discharged. Given the very low mortality for elective care (care that is scheduled in advance because it does not involve a medical emergency); this is usually done for non-elective patients only.

In order to compare mortality rates between different NHS Trusts it is necessary to consider the mix of patients treated. For example a trust with a very elderly, complex patient group might have a higher crude mortality rate than one that had younger or less acutely ill patients. To adjust for this it is necessary to standardise the mortality rate for trusts, thereby taking into account the patient mix. This is usually done by calculating an 'expected' mortality rate based on the age, diagnosis and procedures carried out on the actual patients treated by each trust. A mortality ratio is then calculated by dividing the actual number of deaths at a trust by the expected number and multiplying by 100. A rate greater than 100 suggests a higher than average standardised mortality rate and a rate less than 100 a better than average mortality rate.

There are two main tools available to the NHS to risk adjust mortality in this way: 1. The Hospital Standardised Mortality Ratio (HSMR) produced by Dr Foster Intelligence and 2. The Summary Hospital Mortality Indicator (SHMI) produced by the Health and Social Care Information Centre. These two tools both work in similar ways but the HSMR includes only the 56 diagnosis groups (medical conditions) with the highest mortality, whereas the SHMI includes all diagnosis groups. The SHMI also includes deaths occurring in the 30 days following hospital discharge whereas the HSMR includes only in-hospital deaths. The SHMI calculation also does not include the final stage of multiplying by 100 (a trust with exactly as many deaths as predicted by each of the respective models would have an HSMR of 100, but a SHMI of 1.00).

At WSHFT both these tools are used to measure mortality, however a greater focus is placed on the HSMR as this is available monthly (approximately three to four months after discharge) whereas the SHMI is only produced quarterly (approximately six to nine months after discharge). The crude non-elective mortality rate is also used as a more immediate indicator of progress or to identify areas of concern and to sense check that improvements are real and not the result of changes in coding or recording.

How do we report on it?[9]

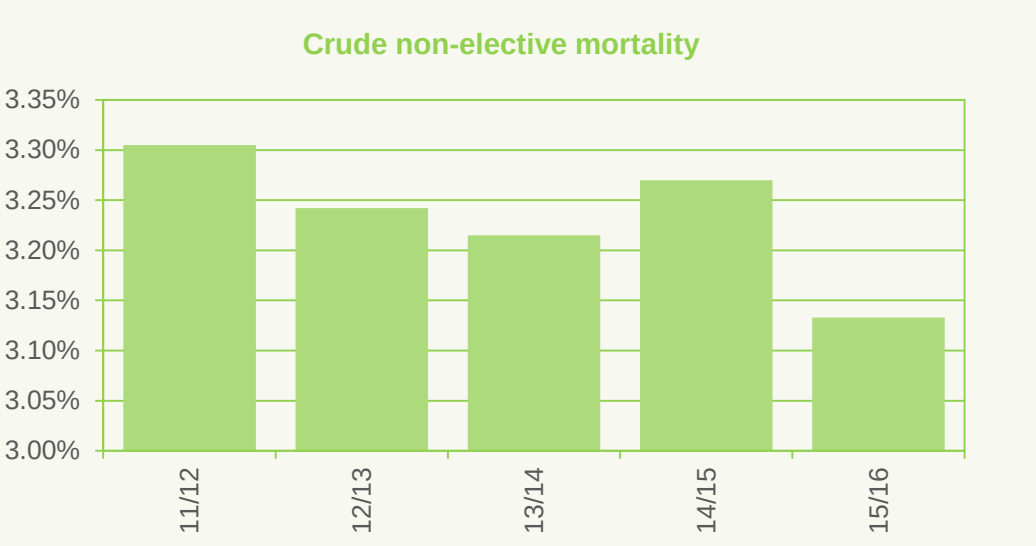
The Dr Foster HSMR, SHMI, and crude mortality figures are reported to the Trust Board every month as part of a regular Quality Report. Senior clinical leaders also review the crude mortality numbers monthly. The Mortality Steering Group review all mortality data across the Trust.

Where are we now?

Over the last few years crude non-elective mortality at WSHFT has fallen year on year from 3.60% in 2010/11 to 3.22% in 2013/14. 2014/15 saw a marginal increase to 3.27% but crude non-elective mortality has continued to fall in 2015/16 to 3.13%. Five years' crude non-elective mortality data combined for all WSHFT hospitals is shown in Figure 1.

Figure 1. Crude non-elective mortality

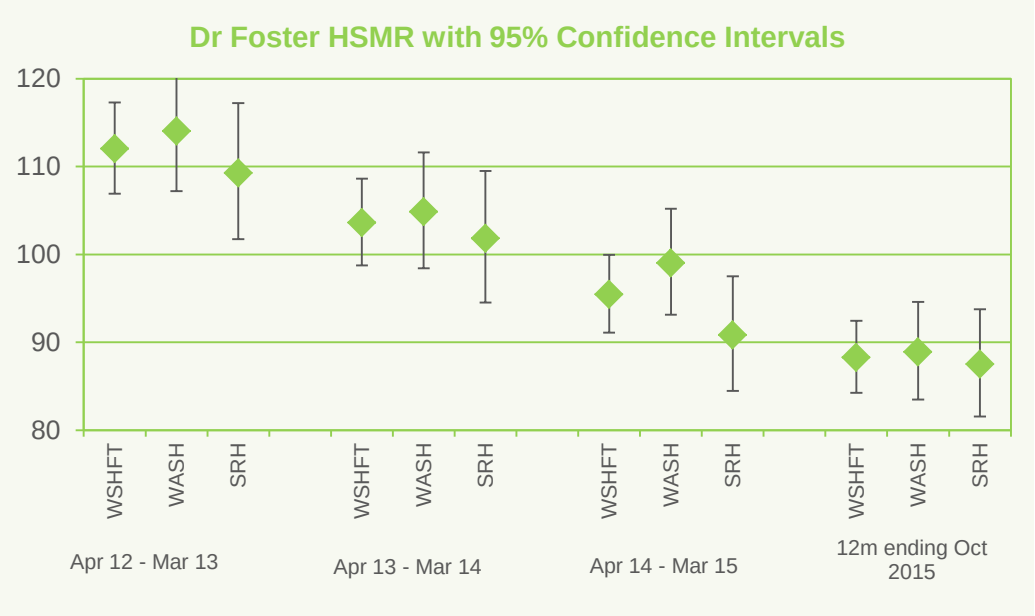
[9] Please be advised that for all data presented in this report figures are reported in full financial years (1st April to 31st March) unless otherwise stated.



Over the same period the Trust's risk adjusted mortality rate has also fallen. Each year Dr Foster re-base their figures to account for reducing mortality in the country as a whole (effectively resetting the benchmark to the most recent year). As such showing improvement is difficult. Nonetheless the Trust's Dr Foster HSMR improved from 107.48 in 2011/12 to 95.44 in 2014/15 (the last full financial years' worth of data). Due to the delay for Dr Foster data (to allow for coding and processing), Figure 2. below shows the 12 months to Oct 2015 as the most recent data point, where a further improvement to 89.48 can be seen.

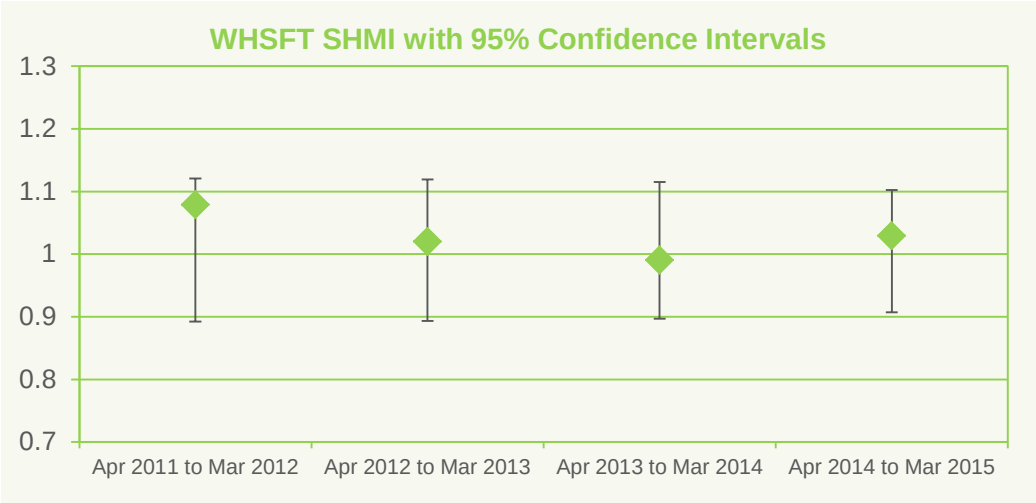
Figure 2. Dr Foster Hospital Standardised Mortality Ratio[10]

[10] WSHFT, Trust level data. WASH, Worthing & Southlands Hospitals. SRH, St Richard's Hospital.



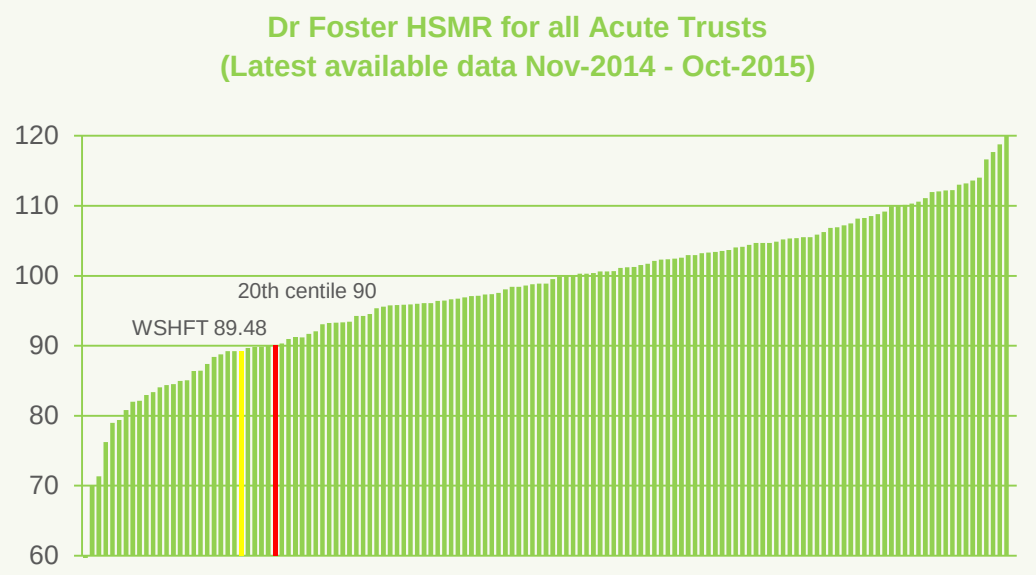
The SHMI score shows a marginal increase to 1.03 in 2014/15, which remains in expected range (the HSCIC do not publish SHMI data broken down by site so the results shown are for the whole Trust) shown in Figure 3.

Figure 3. Summary Hospital Mortality Indicator



The improvement in the Trust's mortality rate can be seen in the position of its HSMR score in relation to other acute trusts. In 2011/12 the Trust's HSMR of 107.5 was ranked 112 of 141 acute trusts (the 79th centile), whereas for the latest data (12 months to October 2015) the Trust's HSMR of 89.48 is now ranked 23rd of 141 (the 17th centile), see Figure 4. As described in our Quality Strategy over the next three years we would like to continue to improve and remain in the top 20% of trusts with the lowest HSMR. We will focus specifically on our 'True North' goal of zero avoidable deaths.

Figure 4. Dr Foster Hospital Standardised Mortality Ratio for all Acute Trusts



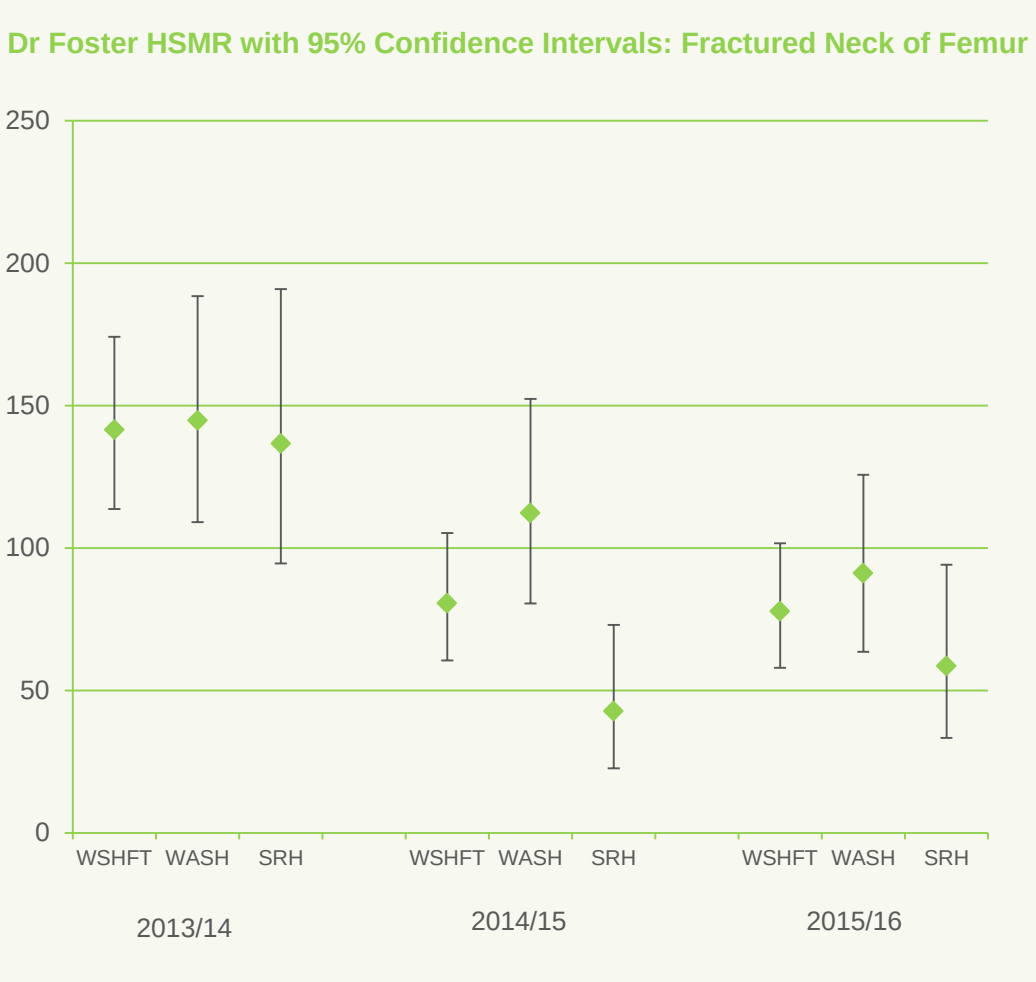
Over the next year and the course of the 2015/18 Quality Strategy we propose to continue to focus on key areas such as fractured neck of femur and acute kidney injury where we have previously delivered improvement, however have not yet seen the scale of reduction in mortality we would like.

Reduction in mortality following hip fracture

We have continued our emphasis on best practice for our patients who have suffered hip fracture; using a care bundle[11] approach and ensuring that patients who are medically fit for operations receive surgery within 36 hours. As a result our standardised mortality rate following hip fracture has fallen to below the level expected for our patient group: WSHFT = 77.2 where 100 is the expected (Dr Foster data for the 12 months to October 2015).

Figure 5. Dr Foster HSMR Fractured Neck of Femur

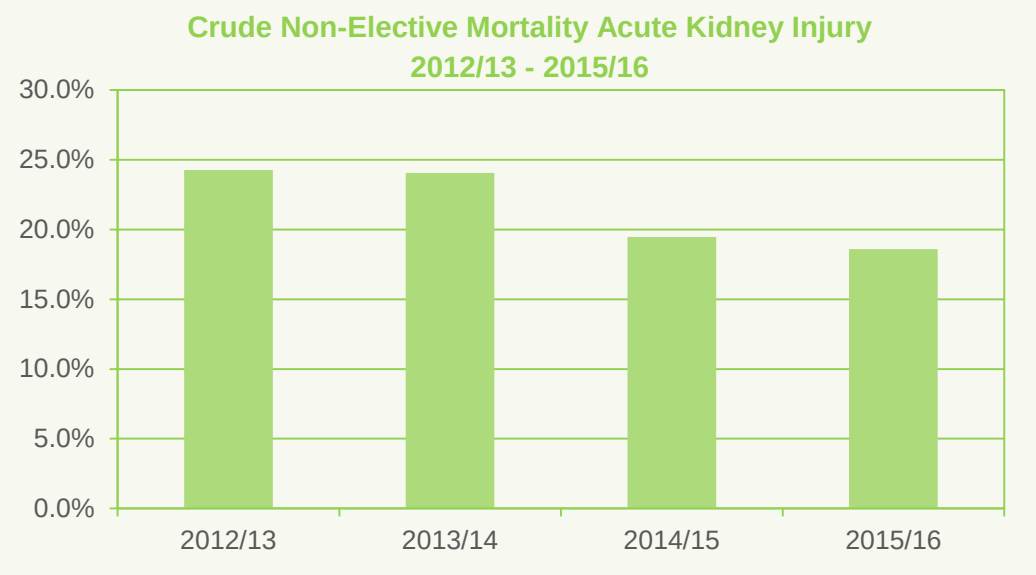
[11] Care bundles are small sets of evidence-based interventions which, when used together consistently by a single healthcare team, have been shown to significantly improve patient outcomes.



Reduction in crude non-elective mortality Acute Kidney Injury (AKI)

We have focused on reduction in crude non-elective mortality associated with AKI through our Deteriorating Patient Improvement Programme. We have seen a reduction in crude non-elective mortality associated with AKI over the last year.

Figure 6. Crude Non-Elective Mortality Acute Kidney Injury (as a percentage of deaths for non-elective patients with AKI divided by number of patients discharged with this condition each year)



Reduction mortality in other specific disease groups

In addition to this we continue to focus on reducing mortality in the following disease groups.

- Fluid and electrolyte disorders
- Gastro intestinal bleeding[12]

For both these areas the Trust has seen raised levels of risk adjusted mortality in the past. Detailed reviews have been undertaken, and although no significant failings of care were noted, these were felt to be important areas for the Trust to continue to monitor.

[12] Please note gastro-intestinal bleed was incorrectly referred to as genito-urinary bleed in last year's Quality Report.

Figure 7. Fluid and Electrolyte Disorders – HSMR (Relative Risk) – January 2013 – November 2015

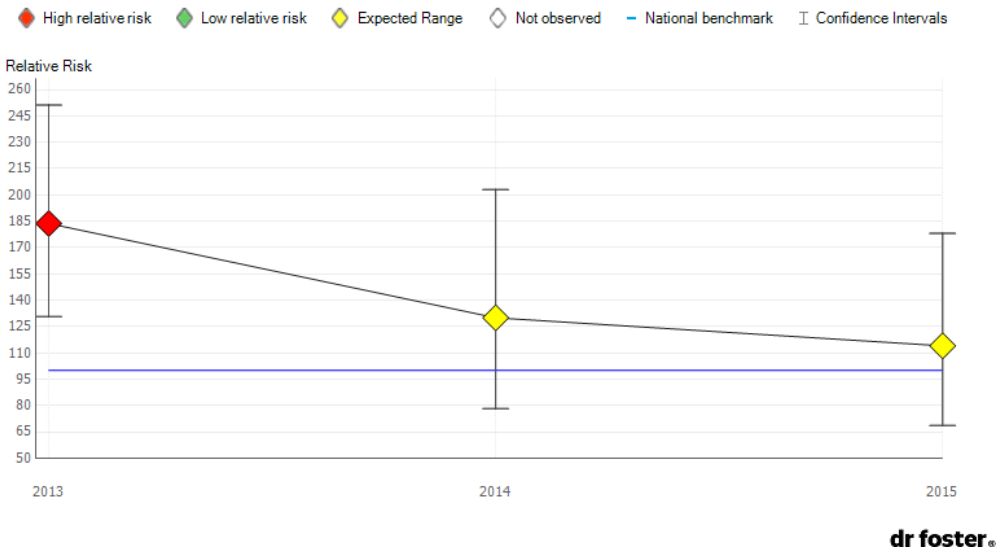
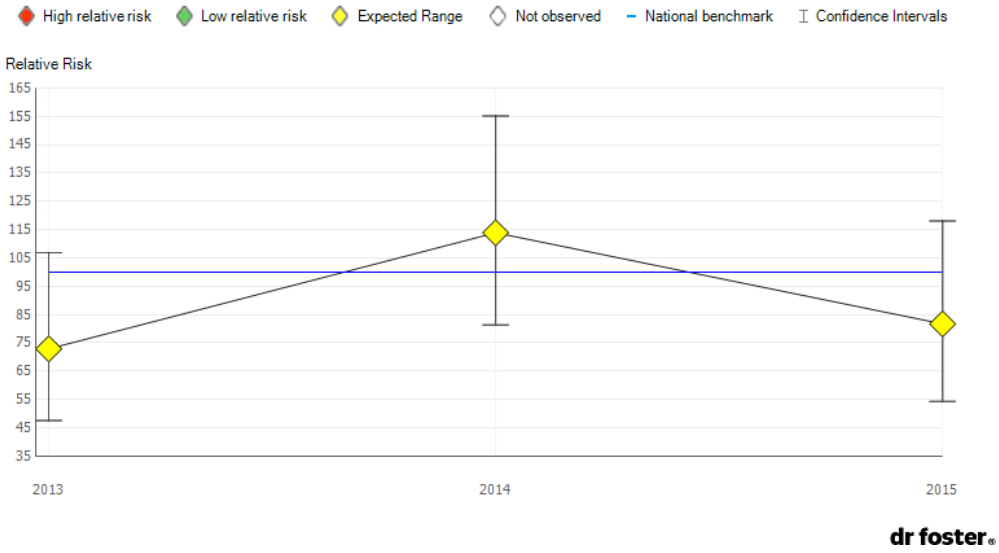


Figure 8. Gastro-intestinal Haemorrhage – HSMR (Relative Risk) – January 2013 – November 2015



Key Quality Improvement Priorities for 2015-16

Last year we committed to delivering further reduction in avoidable mortality rates across the organisation through a number of focused quality improvement programmes including:

- **Implementation of care bundles to improve the recognition and care of physiologically deteriorating patients including sepsis, acute kidney injury and preventing cardiac arrest.**
- **Further development of a programme of structured review of every death occurring in the hospital to ensure learning.**
- **Implementation of the 'Better Births' programme**
- **Delivery of the End of Life Care Strategy.**

Improvement programmes for 2015/16

- **Implementation of care bundles to improve the recognition and care of physiologically deteriorating patients including sepsis, acute kidney injury and preventing cardiac arrest.**
- **Target - 95% compliance with sepsis and acute kidney injury care bundles by 2018**

We have introduced 'care bundle' systems of care for patients with these conditions. Care bundles are small sets of evidence-based interventions which, when used together consistently by a single healthcare team, have been shown to significantly improve patient outcomes.

We have also continued to use 'Patientrack software', an advanced observation and assessment system that gives our nurses and doctors early warning if a sick patient's condition is deteriorating; this helps early and effective intervention to get things back on course. Patientrack increases patient safety and we expect it to help in reducing avoidable mortality. Our Patientrack system has been further enhanced to include specific electronic assessment packs for AKI and sepsis.

- **Implementation of sepsis care bundle**

Severe sepsis is the most common and least recognised complication of infective illness that causes at least 37,000 deaths and 100,000 hospital admissions in the UK per year. We know that early recognition and treatment has a significant impact on the outcome for patients with severe sepsis.

We collect information on both the screening for and recognition of severe sepsis for emergency admissions to the Trust. We then record if key care bundle elements (Sepsis 6 BUFALO care bundle) have been delivered to patients in line with national guidance; we monitor overall deployment of all elements of the 'Sepsis 6' care bundle and additionally the key measure of administration of antibiotics within one hour of a patient being flagged / identified as having severe sepsis (red-flag). Evidence indicates that for every hour administration of antibiotics is delayed there is an 8% increase in mortality.

Our goals in 2015/16

- To raise awareness of severe sepsis across all health care professionals in the Trust through a programme of education and training
- To develop and implement an electronic screening and treatment support tool using our bedside monitoring system (Patientrack)
- To establish a baseline for improving compliance with early recognition and treatment guidelines
- To improve compliance with early recognition guidelines and treatment guidelines

Key achievements 2015/16

- Development and implementation of an electronic screening and treatment support tool for sepsis
- A wide range of education events and awareness raising campaigns were run across the Trust
- Established a clear baseline and commenced a formal improvement programme to increase compliance with sepsis guidelines
- Made a significant contribution to the Kent, Surrey and Sussex patient safety programme on sepsis.

Progress in delivering the improvement in compliance with sepsis guidelines has not been as rapid as hoped.

It should be noted that data capture has significantly improved as the project has progressed therefore sampling at the start of the project was not as complete as during later months.

Figure 9. Percentage of flagged sepsis patients receiving antibiotics within one hour

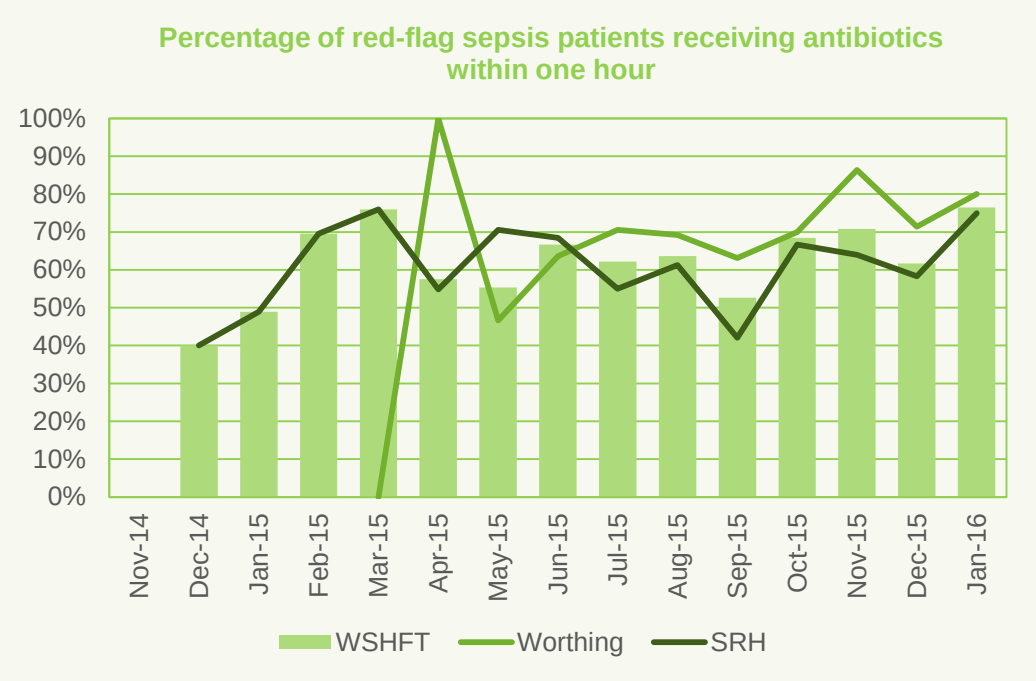
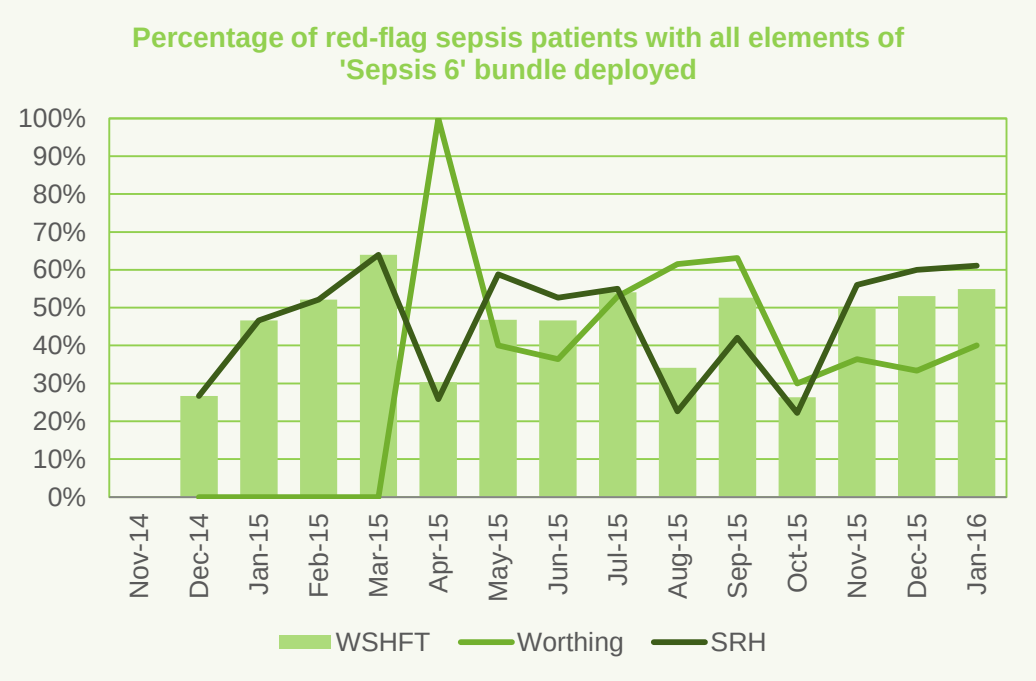


Figure 10. Percentage of flagged sepsis patients with all elements of the 'Sepsis 6' care bundle deployed



Improvement plans for 2016/17

The Trust has committed to a continuous improvement programme for 2016/17 supported by the Kaizen Office[13], to maximise the impact of the programme across the Trust in terms of compliance with sepsis care bundles and reduction in mortality.

Paul Murphy and Adrian Richardson look at Patientrack data on the emergency floor of Worthing General Hospital, while Richard Venn and Luke Hodgson discuss the latest developments.

BUFALO Sepsis campaign

Patientrack has been used to support a big campaign on sepsis. Medical staff are encouraged to consider whether patients could be at risk of sepsis, and if they are Patientrack prompts them to undertake certain interventions.

Collectively, these have the acronym BUFALO: blood cultures, urine output, fluids, antibiotics, lactate and oxygen. The BUFALO campaign (originating from Bradford Teaching Hospitals NHS Foundation Trust) includes bright red BUFALO posters on hospital walls and Sepsis Champions - staff wearing BUFALO badges on their uniforms to promote the campaign.

[13] **Kaizen** is the Japanese term given to this practice of continuous improvement, and the Kaizen Office is the Trust's leadership facility for continuous improvement.

❖ **Implementation of Acute Kidney Injury (AKI) care bundle**

Sudden damage to the kidney (Acute Kidney Injury, AKI) is a serious problem affecting as many as one in five emergency admissions. Hospital patients developing AKI have increased risk of morbidity and mortality, and longer lengths of stay. AKI costs the NHS £620m per year; more than breast cancer or skin and lung cancer combined.

AKI is commonly due to intercurrent illness[14], infection, or the side effects of drugs. One third of cases occur in hospital where the elderly are at especially high risk.

Our goals in 2015/16

- To raise awareness of AKI across all health care professionals in the Trust through a programme of education and training
- To develop and implement an electronic screening and treatment support tool using our bedside monitoring system (Patientrack)
- To establish a clear baseline and commence a formal improvement programme
- To improve compliance with early recognition guidelines and treatment guidelines
- To reduce the number of patients in the 'at risk' category who develop AKI whilst in hospital
- To reduce the number of patients admitted with AKI who have a worsening kidney function whilst an inpatient

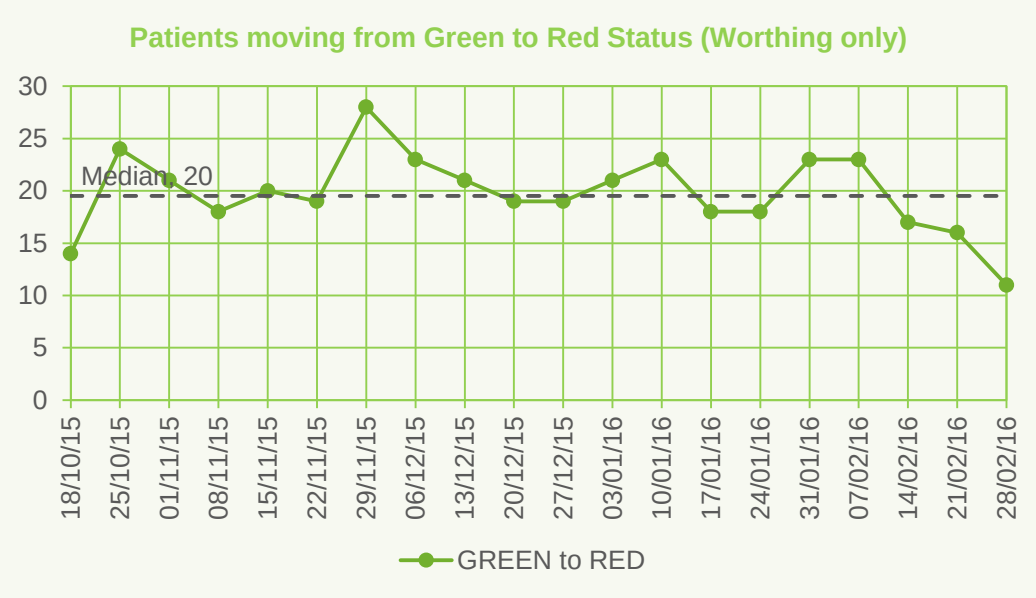
Key achievements 2015/16

- Development and implementation of an electronic screening and treatment support tool for AKI (currently only on one site, due to unavoidable delays in the implementation of the electronic alert and care bundle - monitoring has been slow to be established)
- A wide range of education events and awareness raising campaigns were run across the Trust
- Established a clear baseline and commenced a formal improvement programme

[14] An intercurrent illness is an illness that occurs during the course of another illness (with which it has no connection).

- Led work across KSS related to AKI discharge information
- Early signs that the programme is positively affecting the outcome for patients with AKI or at risk of AKI though this is not statistically significant at this stage

Figure 11. Patients moving from green to red AKI status (Worthing Hospital site)



Improvement plans for 2016/17

The Trust has committed to a continuous improvement programme for 2016/17 to maximise the impact of improvement interventions aimed at increasing compliance with the AKI care bundle.

❖ **Preventing cardiac arrest**

Cardiac arrest can unfortunately be the outcome for a patient if clinical deterioration has not been recognised and acted upon. When someone is nearing the natural end of their life, intervention with active resuscitation is not always appropriate; the Trust is working on ensuring that the wishes of these patients to have a peaceful and dignified death are ensured through good documentation and communication.

Comprehensive data is routinely collected on all cardiac arrests occurring in our hospitals. The focus for quality improvement work in 2015/16 has been on reducing the number of cardiac arrests and reducing cardiac arrest interventions in patients where a 'Do Not Attempt Resuscitation Order (DNACPR)'[15] may have been more appropriate.

Our goals for 2015/16

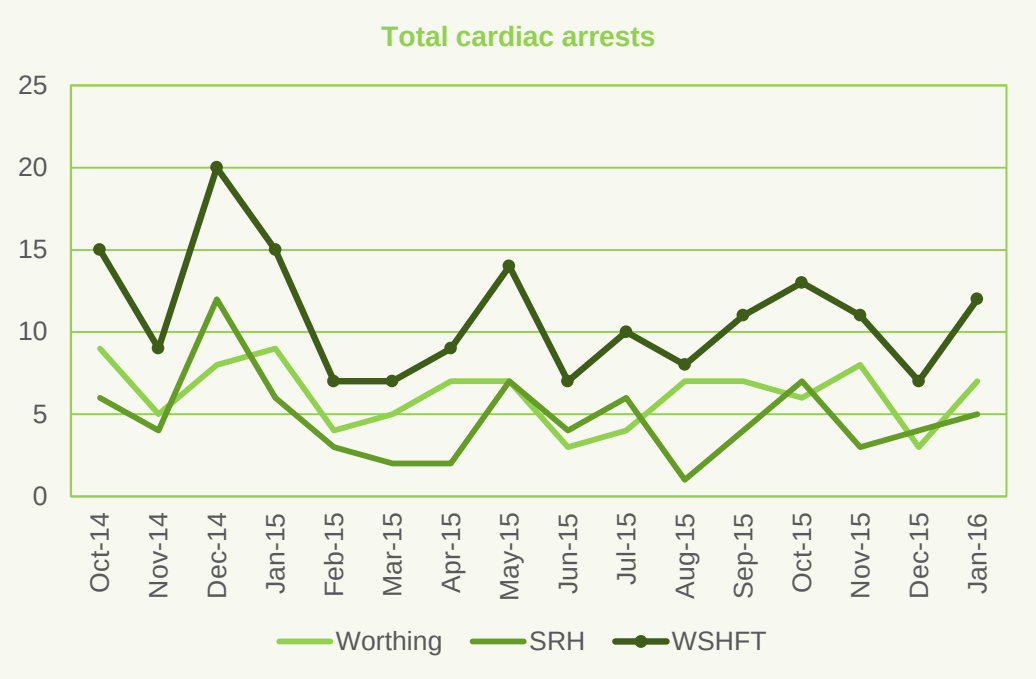
[15] Do Not Attempt Resuscitation Order (DNACPR – Do Not Attempt Cardiopulmonary Resuscitation) is a clear and fully documented decision not to resuscitate a patient. For further information please visit www.westernsussexhospitals.nhs.uk/services/palliative-care/

- Reduce number of inappropriate cardiac arrest calls
- Maintain reduction in cardiac arrests
- Pilot nurse initiated future care planning including discussions about patient wishes regarding resuscitation

Key achievements 2015/16

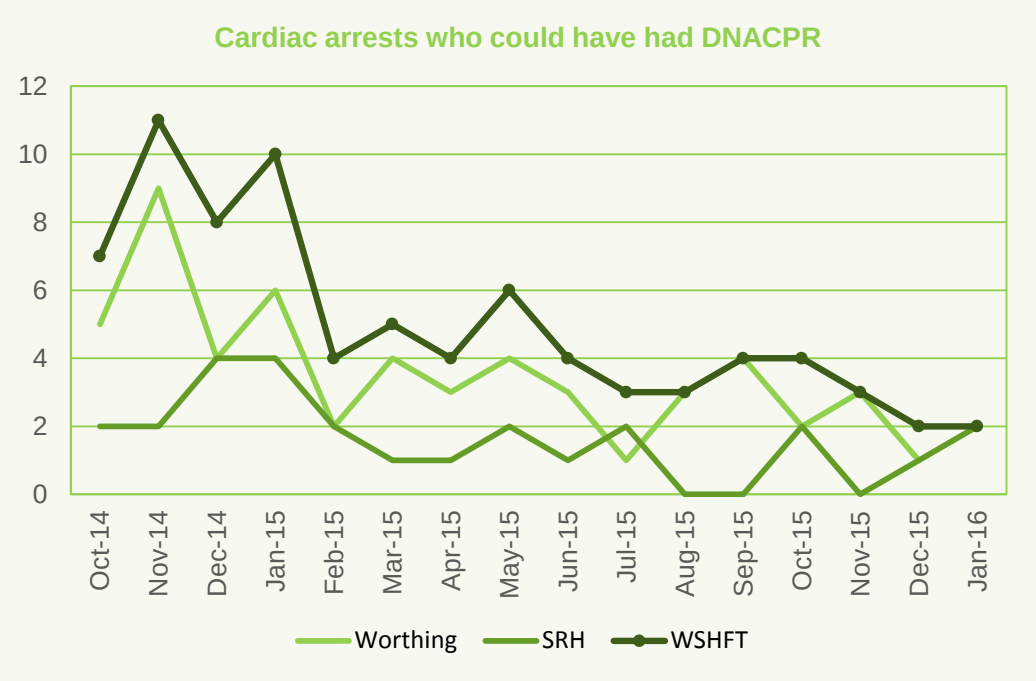
- Successfully piloted nurse initiated planning of future care
- Workshops with palliative care, specialist nurses, Outreach[16], ward nurses
- Patient 'frailty' DNACPR information sheet
- Maintained a reduction in cardiac arrests
- Maintained a reduction in unnecessary cardiac arrest calls

Figure 12. Total cardiac arrests



[16] The Trust has an Outreach Team working on reducing avoidable mortality and improving clinical outcomes through our Deteriorating Patient Programme. The Outreach Team provide specialist support across the Trust for sepsis, acute kidney injury and cardiac arrest.

Figure 13. Total cardiac arrests where patient could have had DNA CPR



Improvement plans for 2016/17

The Trust will continue to focus on the reduction of cardiac arrests and increasing nurse initiated planning of future care (including patient and carer's wishes regarding resuscitation as part of the deteriorating patient programme and advanced care planning work streams).

- **Further development of a programme of structured review of every death occurring in the hospital to ensure learning.**
- **Target - review of all deaths occurring in hospital by 2016/17 to highlight learning, eliminate avoidable deaths**

The Trust recognises the importance of monitoring mortality and acting on any trends identified. Over the last year we have focused on our internal review processes to ensure that every death occurring in the hospital is reviewed. This is important so we do not miss opportunities to learn, and we can continue to reduce avoidable deaths in our hospitals. The Trust has established a new Mortality Steering Group, reporting to the Quality Board, to lead and co-ordinate the implementation of a process that ensures all deaths are reviewed. The group will also oversee the wider strategy for mortality reduction.

The Trust's work in relation to avoidable mortality is in line NHS England future plans for national guidance on mortality review. This is a continuation of the work NHS England commissioned from NCEPOD[17] in 2015 in which the Trust actively participated.

No formal mortality alerts were received by the Trust in 2015/16. As part of the on-going monitoring of key areas, the Trust undertook further reviews of deaths associated with Unspecified Renal Failure and Cardiac Arrest. These reviews did not identify any serious deficits in care but re-emphasised the importance of the end of life programme of work in collaboration with health economy partners.

- **Implementation of Better Births programme**
- **Target – improved patient engagement (increase in Maternity Friends and Family Test recommend rate), reduction in still birth rate by 2018.**

Our goals for 2015/16

The Better Birth programme has been developed with the engagement of staff and patients and focuses on:

- **Person centred care** focused on continuity of care in all care settings and how this might be improved,
- **Engagement and Involvement** focused on improving staff, patient and carer involvement in service improvement,
- **Always Events** focused on the things we should always aim to do,
- **Quality and effectiveness** focused on the development of a midwifery led unit at Worthing Hospital, increasing electronic/web based support for women, and learning from best practice in other units with multi-disciplinary working groups.
- **Access and Support** focused on improving information for self-referral and booking, and ways to enhance the transfer home process and avoid delays.

[17] NCEPOD, National Confidential Enquiry into Patient Outcome and Death: http://www.ncepod.org.uk/

Maternity Services
Patient & Staff Engagement Event

Western Sussex Hospitals NHS Foundation Trust

Western Sussex Hospitals NHS
NHS Foundation Trust

Pictures from the event evening

5 key topic areas with facilitated activity to support collaborative discussion and generation of ideas

Key achievements 2015/16

Maternity services at the Trust were rated Outstanding in our recent CQC inspection with inspectors reporting[18]:

- "The arrangements in maternity were particularly impressive with planned pathways and support for vulnerable women, female genital mutilation, first time mothers, teenagers and drug and alcohol dependency all in place. Staff also had access to safeguarding supervision."
- "Consultant cover in maternity was better than the national guidelines."
- "The staff knowledge of vulnerable adult and safeguarding children and how they should proceed if concerns arose was a significant strength. There was very good joint and interagency working. The transfer of responsibility for the management of 'at risk' babies from maternity (during the antenatal period) to paediatrics (following delivery) was seamless."

Development of maternity care pathways with focus on meeting individual's care needs

- Community midwifery teams have been reorganised to improve antenatal and postnatal continuity. New care pathways have been developed for young parents with a focus on meeting individual care needs.
- The maternity service website has been further developed to include new online referral forms.

Enhancing engagement and involvement of patients and staff to improve maternity services

- Facebook and Twitter are now in use with good engagement – patient support groups are hosted from Trust Facebook pages facilitated by specialist leads, these include a weight management in pregnancy group, a young parents group, diabetes in pregnancy group and a maternity expert group.
- Staff master classes have been held on using social media in healthcare and a staff Facebook page 'Maternity Staffchat' in now in use with over 200 members currently. Staff chat is proving very helpful in inter-unit communication particularly for engaging staff in educational events cross site.

Focus on Always Events – core standards of care for maternity services

[18] https://www.cqc.org.uk/sites/default/files/new_reports/AAAE8369.pdf

- The 'My name is' campaign rolled out in early December 2015 promoting best practice in staff introductions to patients.
- Supervisors of midwives are developing a midwifery philosophy for WSHFT maternity services.

Reducing mortality and morbidity and improving outcomes and experience

- Funding has been obtained and training and computer roll out of GROW customised growth charts[19] due for completion March 2016.
- Funding has been obtained for community midwifery connectivity via laptop – currently service being rolled out across WHSFT maternity.
- The Induction of labour care pathway review and redevelopment is in progress. Initial benchmarking has been completed via audit of practice and patient engagement.

Enhance access to & support for service users within maternity services

- A triage service is now in place and has been well evaluated – we have seen an extremely positive response in access to services in the CQC National Maternity Patient Survey 2015.
- Work is in advanced stages with the local Public Health and Children's Services Team on a development project for an electronic network to support access and ongoing support for parents across acute and primary care services.

Table 1a. Caesarean section rates

	2013/14	2014/15	2015/16
C-Section Rate (national rate)	26.1% (26.2%)	26.9% (26.5%)	27.3% Not available until Nov 2016

Table 1b. Still birth rates

	2013	2014	2015	2016 (to 31/03/16)

[19] GROW (Gestation Related Optimal Weight) customised growth charts are personalised growth charts created individually for each expectant mother and used to monitor the growth of babies during pregnancy.

Still births (Worthing/SRH)	20 (11 / 9)	14 (7 / 7)	16 (13 / 3)	9 (4 / 5)

The most recent comparative data for stillbirth (2013) shows the UK still has one of the highest rates of stillbirth in Europe at 4.7 per 1,000 total births in 2013. France (10.4 per 1000) and Bulgaria (8 per 1000) had the highest stillbirth rates in Europe, whereas Spain and Slovenia (2.3 per 1000) and Finland (1.9 per 1000) had the lowest. The expected comparative rate of stillbirth at WSHFT would be 24 per year (Total births 2015 = 5307) however, over the previous three years WSHFT has maintained rates well below the expected national average. Our figures also include all cases of stillbirth and medical terminations for severe fetal abnormality at all gestations from 24 weeks of pregnancy to term.

In 2015/16 WSHFT have been working in collaboration with the KSS Maternity Strategic Clinical Network and Department of Health to fully implement a best practice care bundle for reducing stillbirth and are also taking part in a national clinical research trial focusing on reducing stillbirth –AFFIRM[20].

Reducing caesarean section rates remains a challenge; we will continue to focus on this area.

Improvement plans for 2016/17

- We will continue to focus on reduction in caesarean section rate. An enhanced recovery programme for elective caesarean section is being developed.

- Following successful implementation of the reducing stillbirth care bundle 'Saving Babies Lives' (https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf) which is now fully embedded in practice, we will roll out implementation of a new NHS England Patient Safety care bundle for reducing unexpected term admission to the neonatal unit – this has been agreed as a collaborative project between

[20] The AFFIRM study is a national research study which will test to see if rates of stillbirth may be reduced by introducing an interventional package of care based around reporting and management of decreased fetal movements. Further information can be found at www.crh.ed.ac.uk/affirm

maternity and neonatal services – further information detail can be found at https://www.england.nhs.uk/patientsafety/re-act/red-term-ad/.

- We will develop a post natal readmissions and sepsis improvement work stream in 2016/17.

- **Delivery of End of Life Care Strategy**
- **Target – full implementation of End of Life Strategy by 2018**

End of Life care is one of the core services of WSHFT. There are approximately 2000 deaths per year across the hospital sites, and whilst there are concerted efforts taking place to reduce the number of deaths in hospital, approximately half of all expected and unavoidable deaths occur in acute care settings. It is therefore essential that we do everything we can to ensure and enable excellent quality of care for patients and their families at the end of life.

Priorities for Care of the Dying Person

1. The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the persons needs and wishes and these are regularly reviewed.
2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
4. The needs of families and others identified as important to the dying person are explored, respected and met as far as possible.
5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

Our goals in 2015/16

The Trust is implementing an End of Life Care Strategy aimed at improving the quality of care for patients and their families at the end of life focused on these key priorities.

Key achievements 2015/16

End of Life Care services at the Trust were rated Outstanding in our recent CQC inspection with inspectors reporting:

- “Outcomes for patients on end of life pathways considerably exceeded benchmarked standards.”

- "End of Life Care was of a particular high standard in terms of compliance with evidence based care, with excellent national audit results and the development of personalised plans for patients on an end of life pathway."
- "The access indicators for patients on an end of life pathway were outstanding. 95% of referred patients were seen within 48 hours, 98% had a clear documented discussion recognising the end of life pathway and 70% received a chaplaincy review. This in addition to the 79% of patients dying at their preferred place of death produces a remarkable level of performance."

The new End of Life Care Strategy was published in September 2015 and communicated in the months up to Christmas. This reflected the National AMBITIONs[21] document released by the National Palliative and End of Life Care Partnership 2015. End of Life Care Folders were set up for each ward in November 2015; a copy of the strategy can be found in every folder.

The Trust has implemented a two year improvement programme, also reflected in a local CQUIN ('Commissioning for Quality and Innovation' payment framework)[22]. The programme focuses on:

- Ensuring 'Individualised Care Plans' are in place for patients recognised as dying
- Offering support with Advance Care planning for patients recognised as possibly dying within the next year
- The roll out of Sage and Thyme[23] communication training across all staff groups
- Ward level education to support the implementation of area wide End of Life Guidance as agreed by the area wide group which includes Coastal West Sussex CCG End of Life Lead and representatives from all local providers.

[21] http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf

[22] Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at: http://www.westernsussexhospitals.nhs.uk/your-trust/performance/

[23] The Sage & Thyme communication skills workshops are designed to give various levels of staff the tools to carry out various levels of support, advanced care guidance and end of life conversations with distressed patients and relatives.

Following the independent review and recommendations from the More Care Less Pathway Report (July 2013)[24] the Liverpool Care Pathway (LCP) it was withdrawn from use across the Trust.

Implementing the guidance from the Leadership Alliance for Care of Dying People 'One Chance to get it right' (June 2014)[25] an Individualised Plan of Care for the Last Days of Life has been developed paying particularly attention to the five priorities of care. This care plan has been introduced into all ward areas and supports the nursing care of patients recognised to be in the last few days of life, with a particular focus on communication.

Advance care plans for those recognised as possibly dying within the next year are offered by the Palliative Care Team where appropriate. We have seen a gradual increase in the number of advanced care plans offered. This work requires input from across all care settings.

Table 2. Number of patients with an Advance Care Plan in place

Month	2014		2015		2016	
January	13	16%	19	24%	63	49%
February	3	4%	28	35%	65	42%
March	3	4%	40	50%	71	44%
April	5	6%	25	31%		
May	9	11%	15	19%		
June	7	9%	19	24%		
July	7	9%	28	35%		
August	9	11%	14	18%		

[24] Department of Health (2013) More care, less pathway: a review of the Liverpool Care Pathway https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf

[25] Leadership Alliance for the Care of Dying People (2014) Once chance to get it right https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf

September	10	13%	23	29%		
October	10	9%	24	13%		
November	14	11%	27	12%		
December	5	4%	30	15%		
TOTAL	**95**	**8%**	**292**	**14%**		

Education to ensure all those patients recognised as dying have an advanced care plan remains ongoing. Increasing numbers of staff have been trained at ward level since May 2015 when training commenced. Training is often undertaken at ward meetings, but also at group and 1:1 sessions. End of Life training is also given to Health Care Assistants during their clinical preparation training. The team has provided education on End of Life Care to 611 members of Trust staff since formal recording commenced in May 2015.

There has been good take-up of Sage and Thyme Communication training places by staff across the Trust. Staff groups who have attended include trained nursing and allied health professional staff, as well as untrained nursing staff and administrators. Sage & Thyme level 1 and 2 are both being actively promoted to ensure take-up remains high.

The Trust Palliative Care Team has been expanded to include an extra Clinical Nurse Specialist post at both our Chichester and Worthing sites. These posts have both been funded by our local hospices. We have also increased our Band 6 nursing capacity in the team.

Following the expansion of the team in September 2014 the volume of referrals has proportionally increased (table 3).

Table 3. Number of referrals to Palliative Care Team

Month	2014	2015	2016
January	80	166	168
February	71	157	192
March	89	154	199

April	105	142	
May	79	137	
June	121	158	
July	105	171	
August	94	169	
September	120	198	
October	107	191	
November	122	234	
December	122	203	
TOTAL	**1,215**	**2,080**	

Improvement plans for 2016/17

We will continue to implement the End of Life Care Strategy programmes; we will also focus on two key areas:

- We will implement the Point of Care Foundation project – 'Living Well to the Very End' programme[26]. Focusing on improving patient experience, this project relates to the successful use of the End of Life Hub within the acute setting alongside other providers. The aim is to improve coordination of care, focusing on developing the dissemination of patients' wishes and care issues on admission to and discharge from acute care. The ultimate aim will be that we reduce the number of inappropriate readmissions to acute care and that more people achieve their preferred place of care and death.
- We will focus on improving privacy and dignity as a theme alongside the role out of the End of Life Strategy, including improving private spaces for giving bad news.

Key Quality Improvement Priorities for 2016-17

[26] A patient-centred quality improvement collaborative supported by The Health Foundation and run in partnership between The Point of Care Foundation and NHS England (South). The programme will focus on improving care at the end of life across care settings, with the initial teams participating in the project going forward to mentor others across the NHS.

Saving more lives and improving outcomes:

- **Deteriorating Patients: continued improvement in the implementation of care bundles to improve the recognition and care of physiologically deteriorating patients including sepsis, acute kidney injury and preventing cardiac arrest – 95% compliance**
- **Continued Better Births Programme: reduction in the number of still births and implementation of recommendations from National Maternity Review**
- **Continued Implementation of the End of Life Care Strategy**

2.1.3 Safe Care

GOAL: 100% of patients receiving safe, harm-free care as measured by the following six harms:

- **Hospital acquired pressure ulcers**
- **Catheter associated urinary tract infection (CAUTI)**
- **Avoidable venous thromboembolism (VTE)**
- **Harm from falls**
- **Hospital acquired infection**
- **Medication errors**

WSHFT is committed to providing safe, high quality services. We aim to provide safe, harm -free care for all patients. Whilst we recognise that this is a challenging goal, we are committed to reviewing all harms to ensure that we learn and continuously improve care.

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What is harm?

Hospital acquired infections, pressure sores and other complications are examples of harm which are sadly commonplace across hospitals in the UK. Despite the extraordinary hard work of healthcare professionals patients are harmed in hospitals every day. Most harm experienced by patients is minor or very minor, but in some cases it can be life-changing for the patient and their family, or can even tragically result in death.

Harm is defined in many ways but a common belief in healthcare terms is that harm is 'unintended physical or emotional injury resulting from, or contributed to by clinical care (including the absence of indicated treatment or best practice) that requires additional monitoring, treatment or extended stay in hospital'. Simply put, harm is suboptimal care which reaches the patient either because of something that should not have happened or as a result of something that should have happened but did not.

How do we monitor harm?

The Trust has an electronic reporting system for recording clinical incidents and identifying patterns to help ensure that lessons are learned from both individual

incidents and general themes. The Trust uses this system to report to the Trust Board the levels of incidents, medication errors, falls and pressure ulcers. In addition to this, one day every month there is a Trust-wide audit of every patient currently on an inpatient ward to identify whether they have suffered one or more of four potential harms: pressure ulcers, falls, VTEs such as deep vein thrombosis or pulmonary embolism, and urinary tract infections (UTI) for patients with catheters. This tool – the NHS Patient Safety Thermometer – is used nationally. It distinguishes between harms that have occurred prior to admission such as falls in care homes and those that have occurred since admission, known as 'new harms'

Health Care Acquired Infections such as Methicillin-resistant *Staphylococcus aureus (MRSA)* and *Clostridium difficile* (*C.difficile*) are not currently included on the NHS Safety Thermometer but are nonetheless closely monitored.

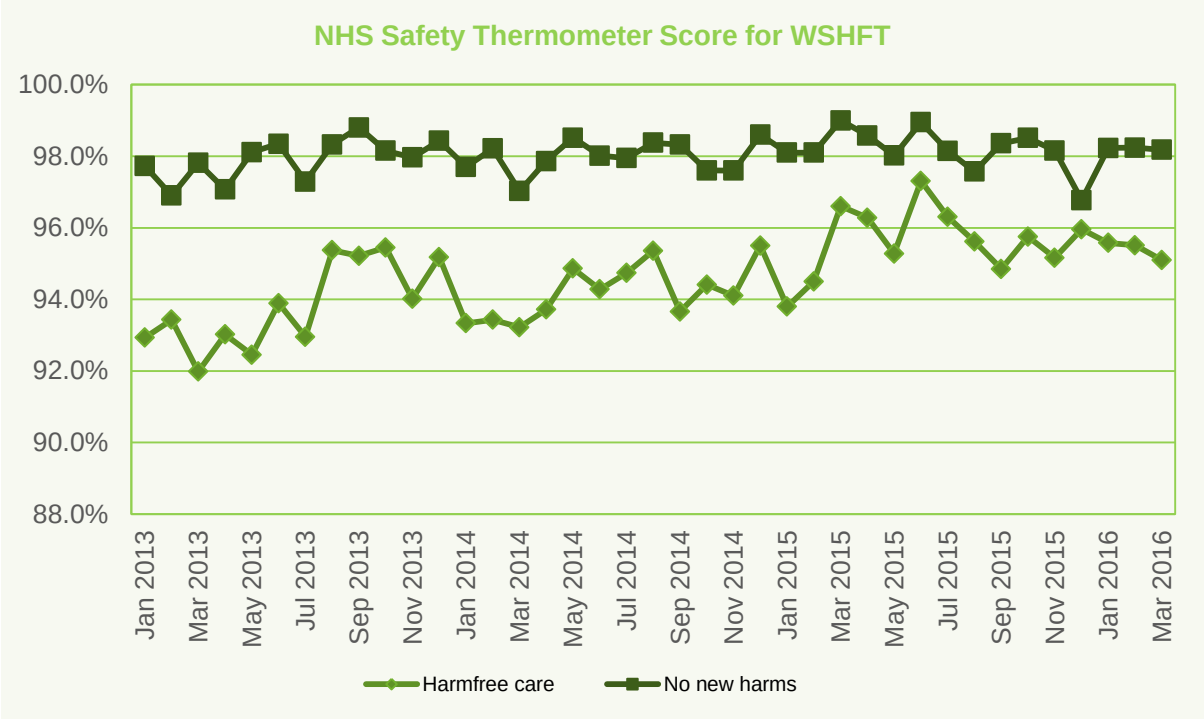
Errors in prescription and administration of drugs, although a significant cause of serious incidents nationally, is also not currently included in the NHS Patient Safety Thermometer; the Trust however participates in the use of the national Medication Safety Thermometer to support the data captured by the main Safety Thermometer.

How do we report on it?

In-hospital harms are reported to the Trust Board each month.

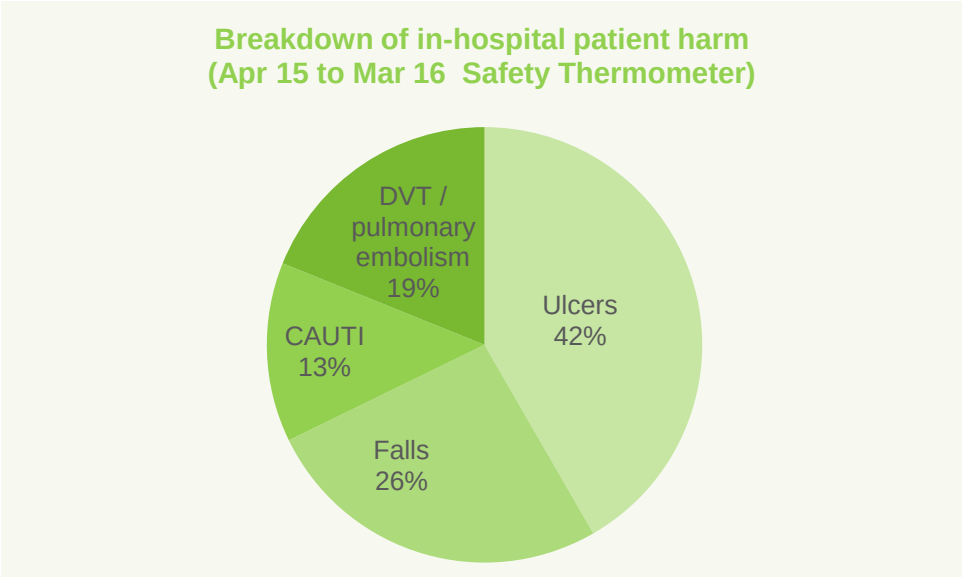
Where we are now?

Figure 14. NHS Safety Thermometer Score



Each month between 4% and 6% of patients experience a harmful event (a fall, pressure ulcer, VTE event CAUTI). Of these, 2% occur after admission to WSHFT. Of the four types of harm currently measured by the patient safety thermometer, all four occurred at WSHFT during 2015/16. Future work streams will continue to focus on all four of these areas as well as other aspects of ward safety.

Figure 15. Breakdown of in-hospital patient harm



The Trust has set a ‘True North’ goal of 100% harm free care. This will be the focus of our quality improvement work for 2016/17.

Future work streams will continue to focus on all four of these areas as well as other aspects of ward safety. On the day we undertake the Trust-wide data collection for the safety thermometer audit we review our patients who have experienced harms to ensure we have the correct actions in place to meet their needs, and also to assess whether their harm is avoidable or unavoidable; sharing learning from this review at our Heads of Nursing meeting. During the past year we have set up a new Trust ‘New Harm Free Care Group’ comprising multidisciplinary team representatives to support the falls and pressure ulcer improvement programmes.

Key Quality Improvement Priorities for 2015-16

Last year we committed to delivering further continuous improvement in the safety of care provided across the organisation through a number of focused quality improvement programmes aimed at:

- **Reducing the incidence of hospital acquired infection through:**
  - Root cause analysis of every post 72 hours case of hospital acquired infection to ascertain whether there was a lapse of care,
  - Programme of maintaining infection control standards including hospital hygiene, hand hygiene, isolation practice and antimicrobial stewardship,
  - On-going surveillance of surgical procedures through Surgical Site Infection Committee.

- **Reducing the number of falls within hospitals through:**
  - Review of every fall in hospital against best practice in falls prevention,
  - Participation in NHS QUEST[27] Collaborative Falls Programme. This programme has the overarching aim of delivering a 50% reduction in falls.

- **Implementation of a Medicines Optimisation Strategy, including the introduction of electronic prescribing**

- **Further development the safety culture of the organisation through:**
  - Roll out of 'safety huddles'[28],
  - Roll out of a programme of ward accreditation,
  - Improving the feedback to staff on actions taken following incident investigations,
  - Audit of the organisations approach to risk and incident reporting,

[27] A network of Foundation Trusts who wish to focus relentlessly on improving quality and safety.
[28] Safety huddles, a multi-disciplinary approach to flagging concerns at the beginning of the day.

- Actions taken in line with our 'Sign up to Safety Pledges'

Improvement programmes for 2015/16

- **Reducing the incidence of hospital acquired infection**
- **Target – reduction in hospital acquired infection (see bacterium specific targets)**

Why is this important?

Serious infections acquired by patients while they are in hospital have become an increasingly recognised problem in the last 20 years or more. Increased use of antibiotics around the world has led to the development of bacteria that are resistant to antibiotics; the best known of these is MRSA (Meticillin-resistant *Staphylococcus aureus).* This organism is found not only in hospitals, but also in the community as a whole. In most people it causes no harm, but if normal defences are weakened by other illness or injuries then the bacterium can get into their bodies and cause blood stream and other infections that are very serious and difficult to treat. In recent years, serious infections with MRSA have become less frequent through multiple different interventions. We screen all patients entering hospital for MRSA in their nose (the commonest place to find it) and for those who have it we prescribe decolonisation treatment. Good cleaning and good hand hygiene and other infection control practice on the part of staff, patients and visitors also help to reduce rates of infection.

Simply relying on new antibiotics to cure infections like MRSA and other drug resistant organisms is not enough, partly because soon the bacteria become resistant to the new antibiotics too, but also because new antibiotics are not being developed. The emergence of multi-resistance in many different organisms is an increasing concern.

Another problem that has emerged and is associated with the widespread use of antibiotics is *C.difficile* associated diarrhoea. *C.difficile* is a bacterium that lives in the

gut of a few healthy people alongside many other bacteria, and causes no problems at all. When antibiotics are prescribed, this may upset the relative proportions of bacteria in favour of *C.difficile*, enabling it to multiply. *C.difficile* produces a toxin that can cause diarrhoea which is occasionally severe. The organism, or its spores (a dormant form of the bug which is extremely resistant to disinfection), may spread from person to person. That in itself may not immediately cause the next patient harm, but if that person then receives a course of antibiotics in the future, it may then precipitate *C. difficile* diarrhoea.

There are two main actions we use to prevent *C.difficile* diarrhoea. First, we have strict antibiotic prescribing policies to reduce the chances of it developing. Secondly, in order to prevent spread from one patient to another, we isolate patients who develop diarrhoea, and adopt particularly scrupulous hygiene measures when caring for these patients. All areas that have had patients with *C.difficile* diarrhoea are deep cleaned after the patient recovers.

From 2011/12, the Chief Executive has chaired the Root Cause Analysis meetings of hospital acquired *C.difficile* and MRSA bacteraemia cases.

Another area of increasingly recognised concern is post-operative infection at the site of a surgical wound. This is known as Surgical Site Infection (SSI) and is an important cause of slow recovery or poor outcome. Whilst this is a concern in all types of surgery, over the last year we have been monitoring infections in large bowel surgery, hip and knee replacement surgery and breast surgery.

How do we monitor it?

We participate in several mandatory and non-mandatory national surveillance programmes. We count and report all cases of MRSA bacteraemia (where MRSA is found on blood sampling). Only those cases that develop the infection after 48 hours of admission are considered to be hospital acquired.

We also count and report all cases where *C.difficile* toxin is detected in stool samples. Those patients who are positive 72 hours after admission are considered to be hospital acquired cases.

Surgical patients who are operated on in the categories for which we are undertaking SSI surveillance are all monitored for signs of infection both during their initial admission, up to 30 days for bowel and breast surgery, and one year for hip and knee surgery. These data are collated quarterly through the national programme.

How do we report it?

The numbers are reported each month to our public Board meeting. In addition, a full investigation is made into all hospital acquired MRSA bacteraemia and *C.difficile* cases and the results of the investigation reviewed at a meeting with the Chief Executive, Director of Nursing and Medical Director. These investigations and meetings enable swift corrective action and ensure learning from each event is shared Trust-wide.

Our goals in 2015/16

Healthcare associated infections are associated with considerable morbidity and mortality. In 2015/16, we committed to maintaining our continuous programme of measures to control and reduce hospital acquired infection, and investigate any cases using root cause analysis. The limits we were set for the past year for hospital acquired infection were zero avoidable cases of MRSA bacteraemia and 39 hospital acquired cases of *C. difficile*. NHS England guidance for 2014/15[29] required all cases of *C. difficile* to be subject to a full local health economy root cause analysis. If the review of a case does not highlight any lapse of care the case will not form part of the trajectory. However, an internal 'stretch' target with a limit of 18 potentially avoidable cases (i.e. cases where we identify lapses in care) was agreed in order to further reduce cases.

SSIs are receiving increasing media focus and in 2015/16 the Trust aimed to improve current infection rates. Our programme is based on published NICE (National Institute for Health and Care Excellence) quality standards and requires a whole Trust multi-disciplinary team approach.

Key achievements 2015/16

~ Healthcare Associated Infections (HCAIs)

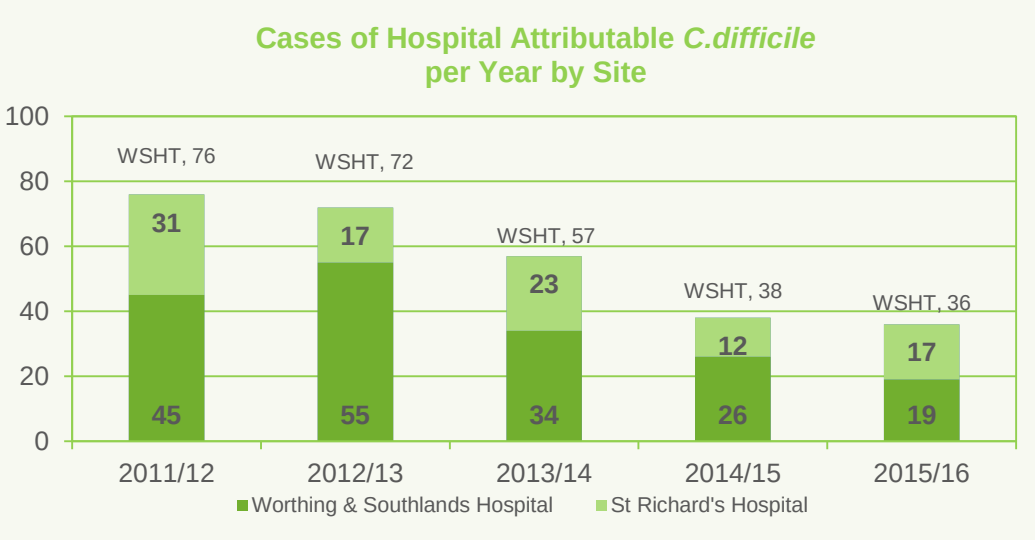
Table 4. Numbers of hospital acquired infections 2011-2016

	MRSA	Total hospital *C. difficile*	*C. difficile* with a lapse in care
2011/12	0	76	Not reported
2012/13	1	72	Not reported
2013/14	4	57	Not reported
2014/15	1	38	20
2015/16	0	36	20

[29] http://www.england.nhs.uk/ourwork/patientsafety/associated-infections/clostridium-difficile/

We have had zero acquired cases of MRSA bacteraemia in 2015/16 *C.difficile*. Both Worthing Hospital and St Richard's Hospital have had lower levels of *C.difficile* in 2015/16 than previous years. We achieved our national target and our internal stretch target for levels of *C.difficile* infection in 2015/16.

Figure 16. Cases of hospital attributable *C.difficile* per year by site



The work to reduce MRSA/MSSA[30] bacteraemias and *C.difficile* infections is on-going; fundamental preventative measures are part of day to day healthcare at WSHFT. There many elements involved in HCAI prevention including screening for MRSA in pre-operative and emergency patients, a focus on invasive devices including regular and on-going audit by clinical staff, and ward and classroom based education on the important and often basic aspects of infection prevention and control. A programme of maintaining infection control standards including hospital hygiene, hand hygiene, isolation practice and antimicrobial stewardship is monitored by the Infection Prevention and Control Team.

An emerging threat is of more multidrug resistant bacteria including Carbapenemase Producing Enterobacteriaciae (CPE). Such bacteria are of global concern, but whilst numbers in the UK are relatively low, they are increasing. For some of these bacteria there are no available antibiotics to treat what can be severe and rapidly life-threatening infections. We actively look for patients at risk of carrying CPEs, including patients from abroad and other healthcare facilities. Patients are screened and our isolation policy put in place if we detect a positive patient. We have not detected any CPEs to date.

[30] MSSA, meticillin susceptible *Staphylococcus aureus*

We are planning on reviewing the MRSA screening policy following the issuing of national guidance. We will use the NICE Infection Prevention and Control Quality Standard as a basis for planning work in the next year.

~ Catheter Associated UTI's (CAUTIs)

The monitoring of CAUTI is part of the NHS Patient Safety Thermometer. As there is no guidance towards national rates we monitor all reported CAUTIs on the Safety Thermometer monthly audit day to ensure that patients with catheters are receiving care with best practice. From doing this work we have managed to introduce an updated catheter care plan and also a West Sussex wide Catheter Passport[31].

~ Surgical Site Infections (SSIs)

SSIs are monitored on a regular basis. We take part in Public Health England national infection monitoring schemes for total hip replacements, total knee replacements, breast surgery and bowel surgery.

Surgical patients who are operated on in the categories for which we are undertaking SSI surveillance are monitored for signs of infection both during their initial admission and up to 30 days afterwards for bowel and breast surgery, and up to one year post surgery for hip and knee surgery. These data sets are collated quarterly through the national surveillance programme.

Table 5. Surgical Site Infections (SSIs) – Inpatient and readmission rates

	WSHFT baseline – Oct 13 - Sept 14	WSHFT rate Oct 14-Sept 15	National rate / All Hospitals total (rolling 5 year)
Total hip replacement	0.6%	1.6%	0.6%
Total knee replacement	0.7%	0.9%	0.5%
Large bowel surgery	13.6% (SRH 15.7% Worthing 11.5%)	13.1% (SRH 13.7 % Worthing 12.4 %)	9.9%

[31] A booklet for patients across West Sussex called 'Looking after your Urinary Catheter (Catheter Passport)', designed to provide advice on looking after urinary catheters.

Breast surgery	1.8% (SRH 2% Worthing 1.6%)	1% (SRH 0.8% Worthing 1.2%)	0.9%

Improvement plans for 2016/17

Our work to reduce hospital acquired infections is on-going, and the fundamental preventative measures are part of day to day healthcare at WSHFT. In 2016/17 we will also deliver the following programmes of work:

- We will review the MRSA screening policy following the issue of national guidance. We will use the NICE Infection Prevention and Control Quality standards as a basis for planning work.
- Following the success of the West Sussex-wide Catheter Passport initiative we plan to continue with the current programme. We will also look at ways of embedding the work in the wider community by working with our community colleagues to ensure that the catheter passports are available in all care and residential homes.
- Our programme of work to reduce SSIs is based on published NICE Quality Standards and will focus on a whole Trust multi-disciplinary team approach co-ordinated through the Trust surgical Infection Committee.

- **Reducing the number of falls within hospitals**
- **Target 30% reduction in in hospital falls by 2017/18**

Why is this important?

Falls are one of the most challenging harms to address with a complexity of factors contributing to an individual's risk of falling. It is nationally recognised that interventions to reduce falls in one area are often difficult to replicate in others.

How do we monitor it?

The Trust monitors its falls incidence closely every month and reports through the Quality Report and Trust Board. The Trust has aimed to have no more than 42 harmful falls each month and has achieved this trajectory. Expressed as a rate of 1.4 falls per 1000 occupied bed days, this is well below the national benchmark of 2.5 falls per 1000 occupied bed days (Royal College of Physicians Report of the 2011 Inpatient Falls Pilot Audit). The national safety thermometer is also used to monitor

where WSHFT stand against the national picture. The safety thermometer shows WSHFT as being in line with the national and regional levels for the total number of falls reported, but better than average for the number of falls resulting in harm.

Our goals in 2015/16

It is recognised that approximately one third of patients who sustain harm from falling have already fallen in our care. From 2014 we have monitored this through the Quality Report to Trust Board each month; we aimed to achieve a 10% reduction from baseline in 2014/15. From October 2014 the Trust has used the Safety Thermometer to review our delivery of best practice in falls prevention. Every patient who has fallen is reviewed against strict criteria (falls assessment, intentional rounding[32], wards moves, staffing) and falls classified as preventable and non-preventable. A proposed target of no greater than 2014/15 falls was set for 2015/16.

As part of the Trust's membership of NHS QUEST (a network of Foundation Trusts who wish to focus relentlessly on improving quality and safety), the Trust is engaged in the Breakthrough Series Collaborative: Falls Programme. This programme had the overarching aim for 2015/16 of delivering a 50% reduction in falls in pilot wards.

Key achievements 2015/16

We have achieved an 8.4% reduction in falls resulting in harm over the last three years, with an 11.3% reduction over 2015/16, however it remains a major area of concern for the Trust as we aim to reduce in hospital harms.

Table 6. Falls data for WSHFT 2013-16

	2013/14	2014/15	2015/16
Falls resulting in harm	498	514	456
Falls resulting in severe harm or death	5	1	2
Falls assessment within 24hrs of admission	92.7%	90.9%	86.7%

Our Trust joined the Breakthrough Series Collaborative: Falls Programme in September 2014 with two pilot wards (Boxgrove and Broadwater) working towards their ambitious goal for the first year from December 2014. The Harm Free Care group met every six weeks to support the work and the sharing of successful interventions to other areas. The focus of the programme has been to work with teams to help them to understand why their patients fall, reviewing the times of day,

[32] 'Intentional rounding' is the term used to describe carrying out regular checks of the patient to ensure that all their essential care needs are met and that they are safe and comfortable.

location of the fall and the activity the patient was undertaking at the time. As can be seen from the two ward graphs there has been a positive and sustained reduction in falls on both wards. Two core interventions have been shown to have a positive impact: SWARM, an immediate multidisciplinary review of the patient and 'Baywatch', a requirement to keep bays where patients are known to be at risk of falling manned at all times. The Baywatch team can include any member of the ward team including volunteers and ward clerks. Other key interventions involved with this success include reviewing our ward environments to promote safety e.g. accessible call bells, non-shiny, non-slip flooring and ensuring we have the correct staffing levels in place.

Figure 17. Falls data for Broadwater ward

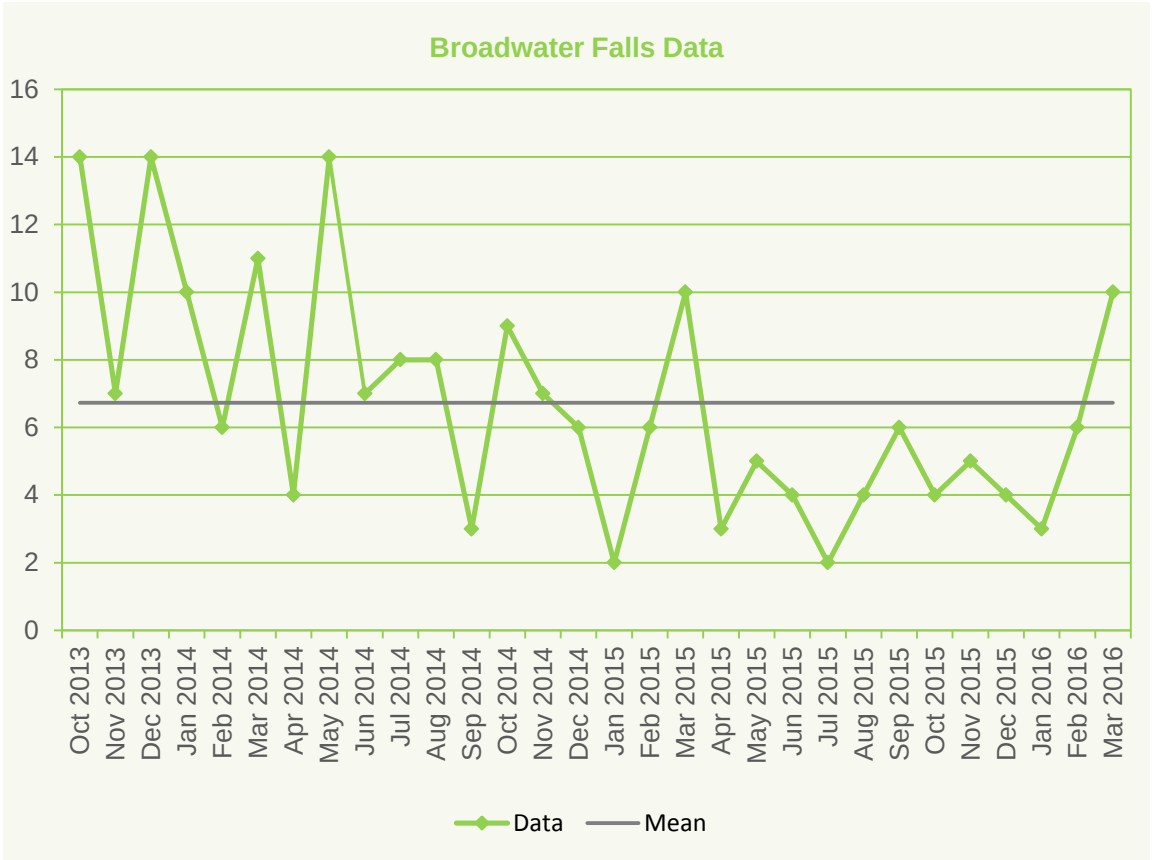
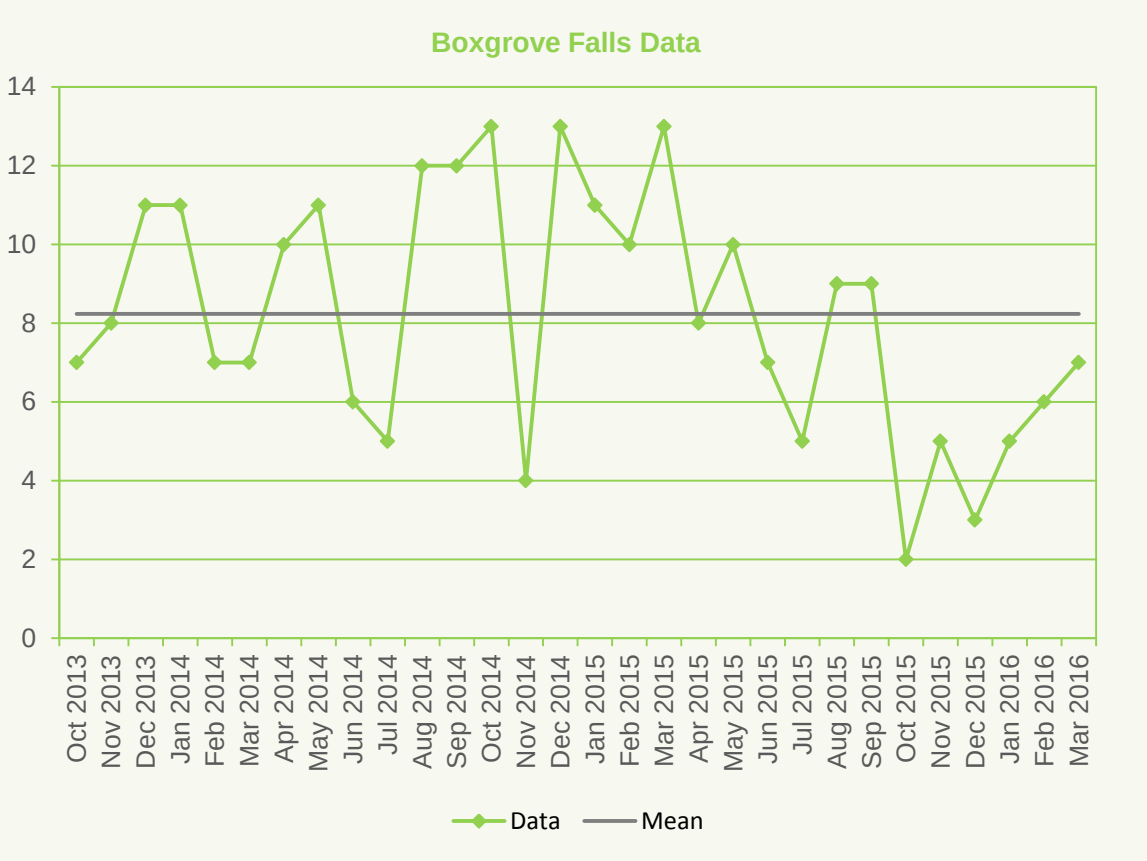


Figure 18. Falls data for Boxgrove ward



Improvement plans for 2016/17

A reduction in in-hospital falls is a major improvement area for the Trust in 2016/17 and represents a breakthrough objective with a target of 30% reduction in in-hospitals falls over the next year. This work will be supported by the Patient First Improvement System. The falls improvement programme for 2016/17 will build on the success of year one of the QUEST Falls Collaborative work, expanding the pilot ward improvement work to ten further wards.

Other areas of harm prevention

- **Skin damage / pressure ulcer reduction**

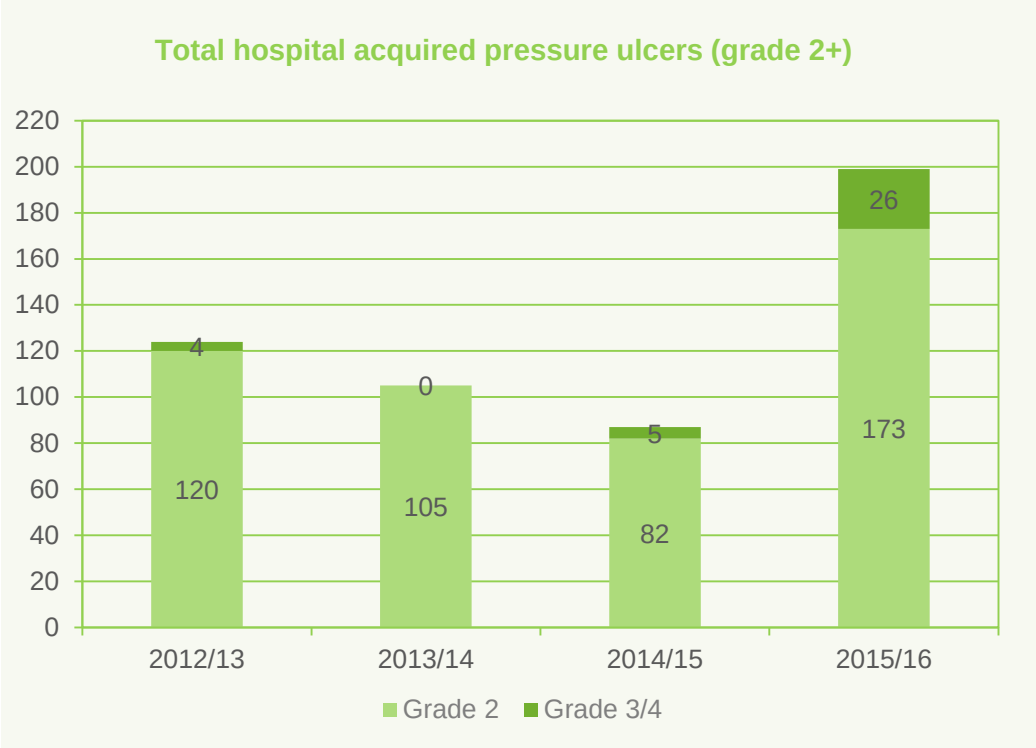
Falls and pressure ulcers account for the majority of harms experienced by our patients.

Whilst a high proportion of patients with pressure ulcers are admitted to hospital with existing skin damage, we have seen a significant rise in hospital acquired pressure

damage in 2015/16. We changed our approach to the way we report skin damage in May 2015 which has led to this increase. We now report all skin damage caused by medical devices such as orthopaedic collars; we report all ulcers that deteriorate in our care; we report all ulcers that develop within 72 hours of admission as being hospital acquired damage.

The following data is taken from our ongoing monitoring of all pressure ulcers.

Figure 19. Total hospital acquired pressure ulcers (grade 2+)



We take every incidence of skin damage very seriously and so alongside the change in reporting we have put in place a number of new measures including:

- Full root cause analysis led by Tissue Viability Nurse for all hospital acquired damage (grade 2 and above)
- Pressure ulcer panel, chaired by the Medical Director / Director of Nursing to review every case of grade 3 and above damage to ensure learning is understood and appropriate actions are put in place
- New photography protocol to improve the assessment and communication across areas
- Pressure ulcer collaborative with our Sussex Community NHS Foundation Trust partners to work closely together on our shared challenges
- Pilot of new pressure ulcer risk assessment tool called ‘Purpose T’ which will be rolled out Trust wide during the coming year

- Introduction of new patient information leaflet
- Pilot of a new pressure ulcer passport
- A change in the Tissue Viability Team structure to provide increased support for wards.

Improvement plans for 2016/17

New measures to reduce harm from skin damage will continue over 2016/17 with a focused programme rolling out a new pressure ulcer risk assessment tool called 'Purpose T' during the coming year.

We will deliver a target of 10% reduction in grade 2+ avoidable pressure damage from the baseline of 2015/16.

❖ **Implementation of a Medicines Optimisation Strategy, including the introduction of electronic prescribing**

❖ **Target – implementation of Medicines Optimisation Strategy, reduction in prescribing errors**

Our goals in 2015/16

In 2014/15, using the Trust Development Authority's (TDA) Medicines Optimisation (MO) framework, a self-assessment was conducted and an action plan for key areas of improvement in 2015/16 was developed. The underpinning mechanism for oversight and monitoring of progress with the plan and its key components is through the Medicines Optimisation Committee (MOC) which was established and embedded throughout 2015. The MOC manages all medicines related processes including reviewing medication incidents, reviewing staff MO training, managed entry of new drugs, patient experience in relation to medicines and policies and guidelines involving medicines.

Key achievements 2015/16

Figure 20. TDA MO Framework 2014/15

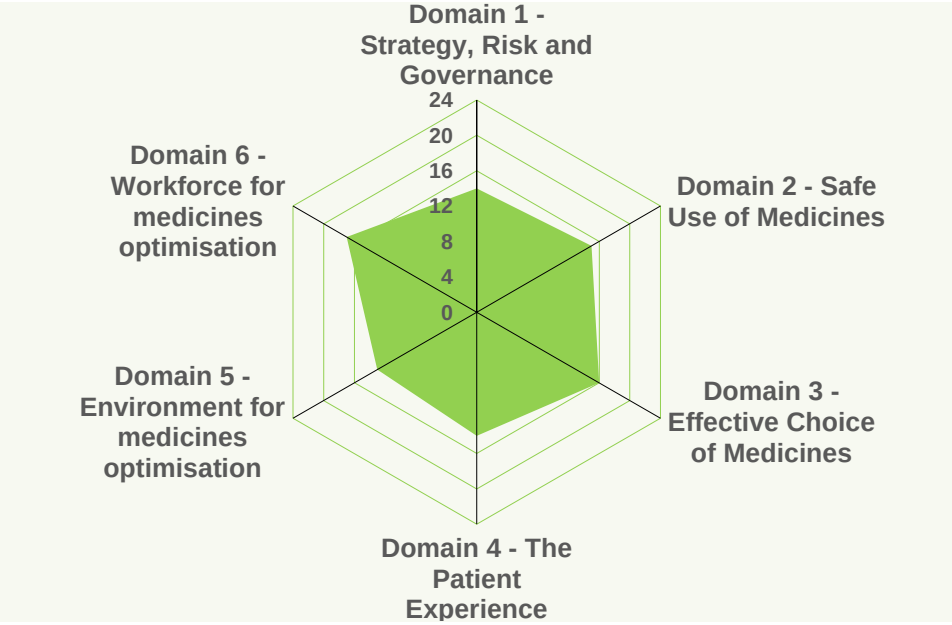
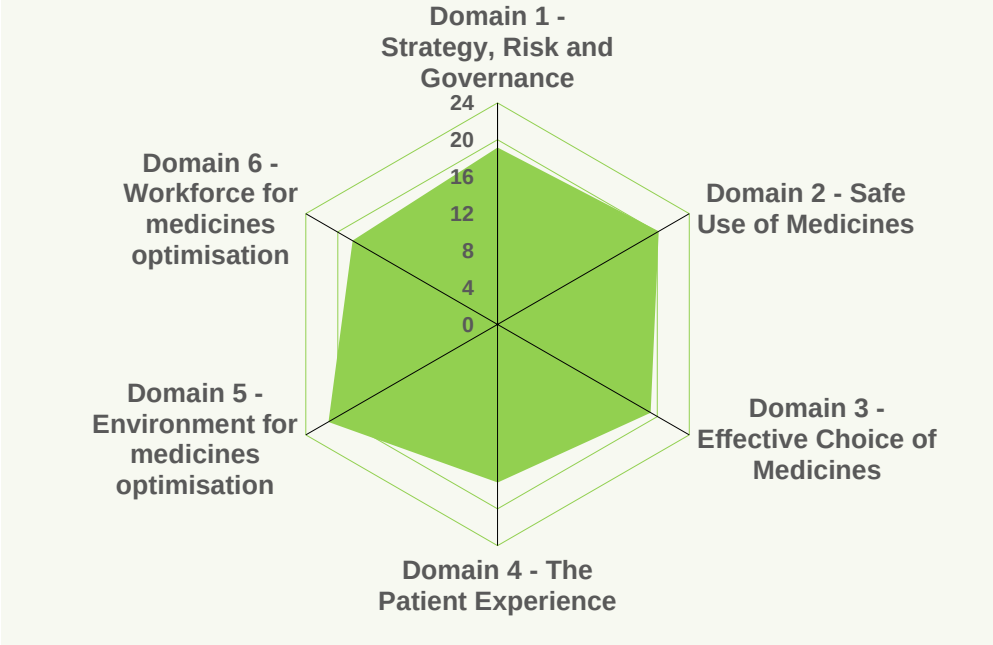


Figure 21. TDA MO Framework 2015/16



The computerised system for Electronic Prescribing and Medicines Administration (EPMA) has been introduced to all adult in-patients areas, except Maternity and ITU, throughout 2015. The rollout has required significant training and new ways of working for prescribers, nurses administering medicines and pharmacy staff reviewing prescriptions and providing supplies.

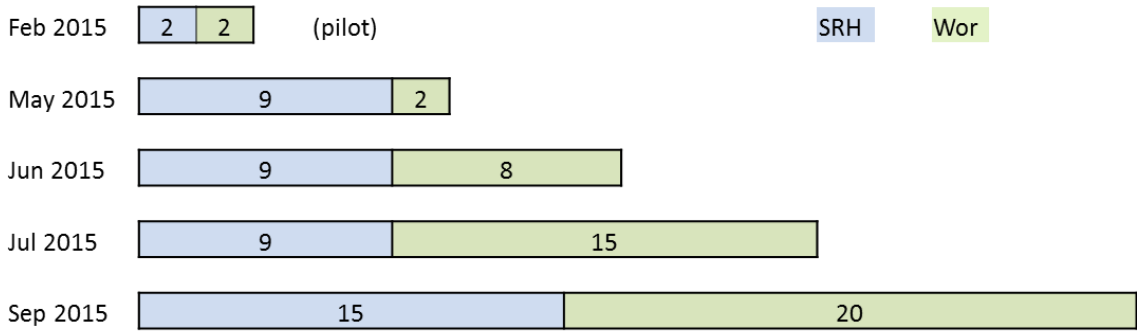
There have been improvements in: the quality of data in relation to prescribing and administration (for example recording reasons for omitted doses); the alerting of particular medicines for patients with allergies (and adherence to this alert data with

prescriptions changed accordingly); the use of real-time prescribing data to review care (for example the use of daily antibiotic prescription reports); standardised prescribing of sets of drugs within protocols and/or drugs within the catalogue.

Pharmacists and technicians are using a daily report which combines EPMA data with SEMA[33] and Patientrack data to provide a patient overview to allow them to target patients with greatest need for review and input. Use of an e-system in a complex area such as prescribing and administration means that there new issues and challenges to overcome as well as opportunities for development - this will form part of the work programme for the coming year.

[33] Sema Helix is our computerised patient information system.

Table 7. EPMA Cumulative Rollout – no. of medical and surgical wards including AMUs



~ Medicines Optimisation Strategy

The Trust Medicines Optimisation strategy 2016-2018 has been drafted and is currently out for consultation with key clinical staff throughout the organisation. The strategy sets out the vision and goals for development and quality improvement in all aspects of medicines use.

~ Medicines storage

Following a successful bid to the 'Love Your Hospital' charitable fund, new individual, digitally lockable lockers have been fitted to all adult in-patient bed spaces in order to provide safe and secure storage of patients' own drugs. The lockers also help with ensuring that medicines are safely ready for transfer with patients when they are moved between wards. The lockers are a first step towards developing self-administration processes within the Trust.

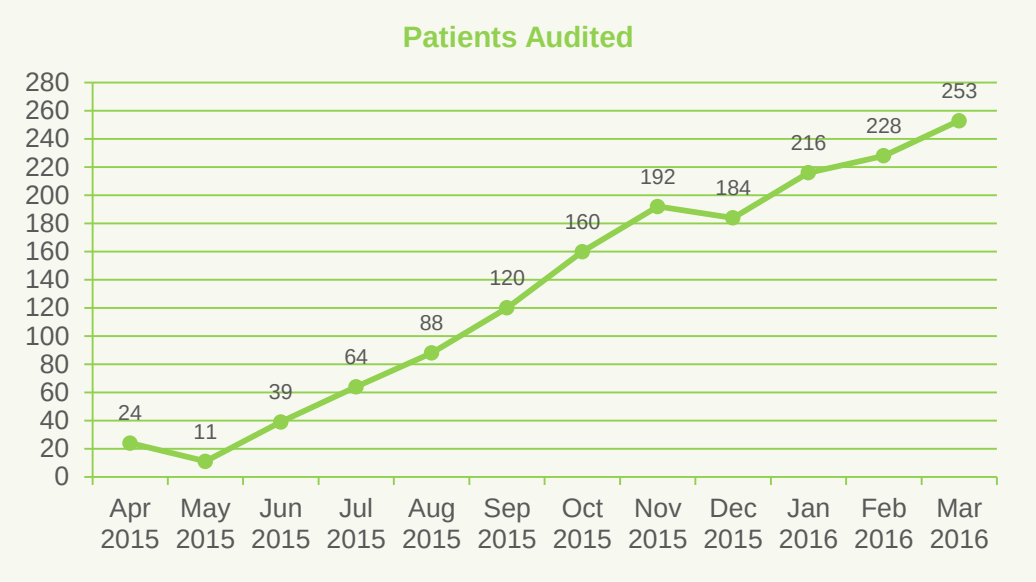
As well as improving storage for patients' own drugs, ward drug storage areas have also been improved with new locks on treatment doors, replacement fridges in some areas and a standardised improved fridge temperature monitoring process. All are key improvements to ensure our medicines are stored appropriately and safely at a ward level.

~ Medicines Safety Thermometer

As a member of NHS QUEST we are part of a newly forming medications safety community coming together for cross-organisational work on the Medicines Safety Thermometer. This thermometer is based on the principles of the original Safety Thermometer, with medicines-use elements targeted at areas known to provide greatest risk. The use of the thermometer has been rolled out by pharmacy and

nursing staff to all adult in-patient wards and data has been submitted as part of the national benchmarking exercise. The data allows comparison of allergy recording rates, omitted doses of medication and prescribing of high risk medication. The benchmark data and comparisons will be used to determine areas for improvement in 2016/17.

Figure 22. Medicines Safety Thermometer audit



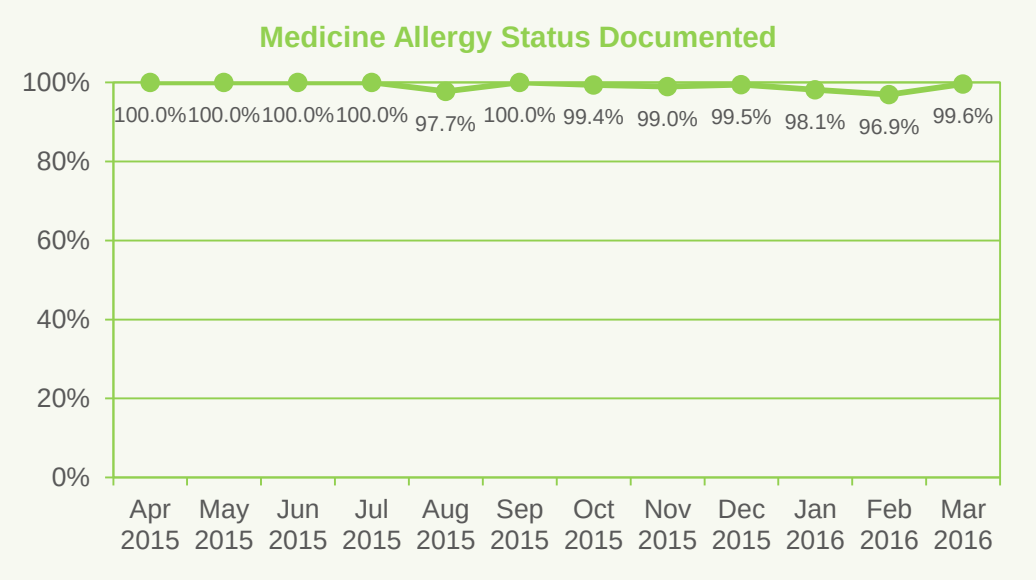


Table 8. Total incidents involving drug/prescribing errors

	2013/14	2014/15	2015/16
Total Incidents involving	1247	1239	1100

drug/prescribing errors			
Moderate/severe incidents involving drug/prescribing errors	5	5	6

Improvement plans for 2016/17

The benchmarked data from the Medicines Safety Thermometer will be used to identify opportunity for improvement, i.e. where our performance or activity is below the national benchmarked average. This may include targeted improvement within the completion of a pharmacy led Medicines Reconciliation (a formal documented check on prescribing on admission).

The JAC system for EPMA will continue to be rolled out to the remaining areas of the Trust during 2016/17 and a clinical decision making group will be established to assist in reviewing how the system is used, prescribing choices and opportunities for using the system to improve clinical care and safety.

We will work to improve the quality of information provided at discharge in relation to medicines, for patients, carers, GPs and where applicable residential, nursing or community care providers. This transfer of information should meet the standards set by the Royal Pharmaceutical Society with particular emphasis on high risk or complex mediations.

We will develop pilot sites for self-administration of medicines processes, with new systems now in place to allow this. Such systems will ensure appropriate patients remain engaged in managing their medicines whilst in-patients and have the time to become familiar with new treatments during their episode of care.

Work will be undertaken this year to improve the efficiency of the discharge process in relation to medicines, seeking opportunities to streamline prescribing and supply as well as improving the information given to patients.

❖ **Safety culture**

The Trust is proud of its achievements in continuing to improve our quality improvement and safety culture. National recommendations and commitments in the wake of a number of national reports highlighted how a poor safety culture impacts

on patients. These recommendations have supported us in being able to identify how we can continue to take a proactive approach in improving safe care for patients.

During the year we have rolled out safety huddles; a multidisciplinary approach to flagging concerns at the beginning of the day. We have also rolled out ward accreditation - a performance framework that is based upon the Care Quality Commission's fundamental standards of care, it provides an objective assessment tool to review the safety and quality of care delivered on wards across WSHFT.
We have been using patient stories to feedback to staff in our monthly Trust Brief, an update for staff on how incidents have impacted on an individual patient and the steps we have taken to prevent any reoccurrence. Feedback to staff following incidents is important and during 2015/16 we have upgraded our incident reporting system so that we can easily provide feedback to staff who have reported incidents. We have also reviewed our approach to providing broader organisational feedback and learning following patient safety incidents.

WSHFT are members of the Kent Surrey Sussex Academic Health Sciences Network Patient Safety Collaborative (KSS AHSN[34] PSC) and look for opportunities for regional shared learning and quality improvement to improve patient safety.

Improvement plans for 2016/17

During 2016/17 we will continue to focus on the safety culture of the Trust with a particular focus on enabling staff to raise safety concerns - 'Freedom to Speak up'[35]

- **Ward Accreditation**
- **Target - implement ward accreditation across inpatient wards in the Trust in 2015/16**

Ward accreditation is a performance framework that is based upon the Care Quality Commission's fundamental standards of care. It provides an objective assessment tool to review the safety and quality of care delivered on wards across the Trust.

[34] www.england.nhs.uk/ourwork/part-rel/ahsn/

[35] Sir Robert Francis QC (2015) Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS: http://webarchive.nationalarchives.gov.uk/20150218150343/https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

The aim of the ward accreditation programme is to support ward managers in identifying what is working well and where further improvements are required. This process promotes the development of a strong culture of continuous improvement within the Trust and enables teams to develop from delivering good care, to excellent care.

Ward accreditation status is measured through observational assessments, documentation audits, patient and staff interviews and a review of ward level performance metrics.

The Ward Accreditation Framework is designed around 14 standards with each one being subdivided into three elements: Environment, Care and Leadership.
The 14 standards are:

1. Organisation and Management of the Clinical Area
2. Safeguarding Patients
3. Pain Management
4. Patient Safety
5. Environmental Safety
6. Nutrition and Hydration
7. End of Life Care
8. Medicines Management
9. Person Centred Care
10. Pressure Ulcers
11. Elimination
12. Communication
13. Infection Control
14. Staff Safety

Objectives of Ward Accreditation Programme at WSHFT

- To standardise information to ensure that ward managers are able to review their team's performance easily on a monthly basis
- To support continuous improvement through the creation of action plans to improve the quality and safety of care and thus achieve higher accreditation status
- To increase visibility of ward performance

Our goals in 2015/16

Our goal for 2015/16 was to implement ward accreditation across all inpatient wards in the Trust.

Key achievements 2015/16

The criteria below have been developed during 2015/16 to determine how wards qualify as bronze, silver or gold accreditation status.

Table 9. Ward accreditation scoring criteria

	Bronze	Silver >75% core and 5 metrics	Gold >90% core and 8 metrics
Award	Ward accreditation score >75% + less than 4 Core Metrics	Ward Accreditation score >75% Core + 5 Other Metrics achieved	Ward Accreditation. score >90% Core + 8 Other Metrics achieved

The introduction of the Ward Accreditation Dashboard has provided senior nurse managers with feedback on a monthly basis of key performance metrics at ward level. Ward Managers and Matrons were initially cautious of the introduction of a third party, other than their immediate line manager, assessing their performance. However confidence has increased as staff have realised that the process is supportive and provides a mechanism to share best practice across the Trust.

Thirty-eight wards were assessed as achieving bronze status during 2015/16. Results of the initial assessments range between 59% and 89%. All medical and surgical wards have action plans in place. The maternity wards are excluded from the programme because the assessment tool does not include measures of care that are specifically relevant to maternity care/new born babies.

The second wave of ward assessments has recently commenced and there are early signs of improvement.

Improvement plans for 2016/17

Over the next year we will continue to embed the Ward Accreditation Programme to support consistency in the delivery of safe and high quality care for patients at across the trust.

The Trust has set a goal of at least eight wards achieving silver accreditation status by the end of 2016/17.

We have identified two standards for targeted support in 2016/17:

<u>Organisation and Management of the Clinical Area</u>

- To ensure that ward teams reliably undertake daily safety checks of equipment.
- To ensure temporary staff receive a local induction to the clinical environment.

Nutrition and Hydration

- Improve the percentage of nutritional assessments completed within 24 hours of admission, and the timely completion of weekly nutritional reviews.
- Targeted ward teams will receive ward based training and support to improve patient assistance with meals and rates of patient satisfaction at mealtimes.

- **Safety Huddles**
- **Target - implement safety huddles across clinical areas of the Trust in 2015/16**

The key aim of a 'Safety Huddle' is to identify the potential risks and challenges for the day ahead and what can be done to minimize these risks / challenges. In a safety huddle all members of staff from Consultants to Housekeepers are encouraged to gather at the same time each day for 5–7 minutes to work through a set of five fixed questions.

The safety huddles provide a safe forum for staff to share their concerns and issues, and often results in staff feeling empowered to take immediate steps to improve the situation.

Safety huddles have been introduced to empower staff to develop skills to overcome patient safety issues specific to their environment.

Safety huddles have the potential to:

- Reduce the number of clinical incidents
- Increase the number of morning discharges
- Reduce staff isolation
- Reduce out-of-hours activity

Safety huddles offer staff the opportunity to:

- Look back – to review safety, quality and flow issues during the past 24 hours
- Look ahead – to anticipate, predict and plan for safety, quality and flow in the next 24 hours
- Follow up – to report on unexpected or significant events and plan how to resolve them

Our goals in 2015/16

Our goal for 2015/16 was to implement safety huddles across clinical areas of the Trust.

Key achievements 2015/16

Safety huddles are happening at the same time in Divisions across the Trust. They are expected to foster greater team working and achieve a shared goal of improved patient safety.

Identified issues are written up on whiteboards during the huddle and remain on display until they are resolved. This openness provides assurance to all that teams are aware of issues and are actively engaging in ways to improve the situation. Actions to improve aspects of patient safety are now being taken on a daily basis and are followed up on until they are resolved. Actions taken should result in the reduction of clinical incidents, delays, improved communication and team working. It is hoped that over time there will be a reduction in clinical incidents, patient complaints and work associated stress.

Improvement plans for 2016/17

The introduction of Improvement Huddles as part of the Patient First Improvement System may result in further development of our safety huddle programme. This will become clearer as more teams are introduced to the Patient First Improvement System during 2016/17.

Safeguarding

The Trust is proud of the safeguarding support provided across the Trust. Some current initiatives include:

- The safeguarding team has developed a credit card sized quick-reference guide for staff to carry which contains key points to remember when caring for vulnerable patients including information on the new Care Act 2014 and what you should do when you have a safeguarding concern.
- A quick-reference card outlining Mental Capacity Act (MCA) principles to help guide staff.
- There is expert support for the MCA and DOLS[36] in the form of a dedicated MCA lead.
- The Trust has formed key working relationships with the police and ambulance service to which provides valuable learning and improvement.
- A tool has been developed to assist with prioritisation and management of patients with mental illness.
- The MCA lead has been involved in developing the "Deciding right" app - for use by clinicians and others when dealing with patients and in particular those at the end of life. Some of the categories the app deals with are:

A- Starting point

B- Shared decision making with Individual who has capacity

C- Best interests process for a child or young person lacking capacity

D- Best interests process for an adult lacking capacity

E- Checking advance decisions

F- Framework for CPR decisions

G- DOLS

H- Withdrawing life-sustaining devices

[36] DOLs, The Deprivation of Liberty Safeguards are part of the Mental Capacity Act 2005 and aim to ensure people are looked after in a way that does not inappropriately restrict their freedom.

Key Quality Improvement Priorities for 2016-17

Delivering 100% harm free care:

- **Reducing the number of within hospital falls - 30%**
- **Medicines Optimisation Strategy implementation focusing on medicines safety**
- **Reduction of in-hospital acquired pressure ulcers – 10%**
- **Improvements in culture and environment to promote harm free care, including continued roll out of ward accreditation, and enabling staff to raise concerns - 'Freedom to speak up'**

2.1.4 Reliable care

GOAL: Achieve 95% reliability in compliance with the following care bundles:

- **Stroke or high risk transient ischaemic attack (TIA) care bundle**
- **Sepsis care bundle**
- **Acute Kidney Injury (AKI) care bundle**
- **Achieve 100% reliability in the recording of patient observations (at frequency determined for specific patients), and appropriate escalation to promote early recognition of deteriorating patients**

Why is it important?

Studies have shown that there is inconsistency in the delivery of high quality care and that patients often only receive a fraction of the care that is recommended. 'Reliability science' can help health care providers redesign systems to make sure that more patients receive all the elements of care they need.

Traditionally healthcare has monitored care given to patients by looking at individual aspects of that care. An example of this might be the number of patients who have had a stroke who are given aspirin within 24 hours of the event. Often hospitals would report their performance against these aspects of care individually. We know however, that best practice tells us there are a series of interventions that should be given within 24 hours of a stroke, and unless the patient receives all of them then their chance of the best possible outcome is reduced. These series of interventions are known as bundles. The Institute for Healthcare Improvement developed the concept of "bundles" to help health care providers to reliably deliver the best possible care for patients undergoing particular treatments with inherent improvements in outcome if the bundle is delivered reliably.

Over the next three years we will use the principles of care 'bundles' to improve care in the following areas: stroke or high risk TIA, sepsis, and acute kidney injury.

How do we monitor it?

Stroke data is captured as part of the Sentinel Stroke National Audit Programme (SSNAP). We utilise the reports published by SSNAP, but to ensure our clinical teams have sufficiently timely data in order to make improvements we supplement this with unpublished data in a local stroke performance dashboard.

Unlike stroke, where national arrangements are in place for data capture, for sepsis and AKI local processes are required for data capture. In both cases there is currently a sticker for recording all elements of the bundle in patient notes, however the plan to launch the AKI bundle electronically at Worthing will allow for more automated data collection in the future.

How do we report it?

The Trust Quality Board has responsibility for delivery of improvement in these priority areas; however key metrics will continue to be reported to the Trust Board.

Where are we now?

Progress in implementing key care bundles/pathways is described below.

Key Quality Improvement Priorities for 2015-16

Last year we committed to delivering further continuous improvement in the reliability of care provided across the organisation through a number of focused quality improvement programmes including:

- **Implementation of stroke or high risk TIA care bundle**
- **Implementation of sepsis care bundle**
  (Please note progress for this care bundle is reported under the reducing mortality section)
- **Implementation of acute kidney injury care bundle**
  (Please note progress for this care bundle is reported under the reducing mortality section)
- **Improvement in referral and discharge information**
- **Implementation of new enhanced recovery programme for atrial fibrillation**
  (Please note that this improvement programme was not pursued for 2015/16 as the KSS AHSN Collaborative improvement programme was chosen with a community rather than acute care focus)
- **Implementation of first stage of seven day services programme**
  Specific improvement projects for 2015/16 including:
    - Real time patient satisfaction monitoring, incorporating both ‘in’ and ‘out of hours’ periods,

- The development and piloting of an electronic tool to improve handover between day time and night time care teams. This will be available to all clinical areas by October 2015,
- Conducting a gap analysis against Keogh standard two[37] 'Time to first consultant review'. Development of strategic options for managing increased workforce requirements with a view to compliance in quarter 4 (Jan – March 2016),
- The development and piloting of a multi-disciplinary board round framework.

- **Implementation of first stage of care pathway for frail elderly patients – including building on dementia care pathway**
  - Implementation of Dementia Strategy,
  - Participation and collaborative learning from regional Frailty Network membership.

Improvement programmes for 2015/16

- **Implementation of stroke or high risk TIA care bundle**
- **Target – improvement in SNNAP outcome measures**

Why is this important?

Stroke represents a substantial burden both upon NHS services and society as a whole. There is clear evidence that taking appropriate measures to minimise the risk of stroke in patients at high risk, for example patients suffering transient ischaemic attack, and ensuring best practice for patients admitted suffering to hospital with a completed stroke significantly improves outcomes. This requires the careful co-ordination of medical, and sometimes surgical, treatment pathways.

How do we monitor and measure progress?

The Trust engages in the Sentinel Stroke National Audit Programme (SSNAP) run by the Royal College of Physicians. This programme monitors and benchmarks clinical performance and outcomes against a range of key targets including:

[37] NHS Improvement (2012) Equity for All: Delivering safe care – seven days a week. http://www.nhsiq.nhs.uk/resource-search/publications/nhs-imp-seven-days.aspx

- Timely access to computerised tomography (CT) scanning in patients admitted to hospital with suspected stroke,
- Direct admission (within 4hrs) to a stroke unit, following arrival at hospital,
- Incidence of thrombolysis for appropriate stroke cases,
- Key pathway metrics including timely assessment by Consultants, Physiotherapists and Occupational Therapists and access to Speech and Language Therapy Services.

How do we report progress in achieving this priority?

SSNAP reports more than 40 outcome and performance measures – which are grouped into 'domains'; Trusts are assigned scores for each domain. SSNAP reports are issued quarterly, illustrating benchmarked performance for the service, and identifying areas for improvement.

Our goals for 2015/16

We set ourselves a number of specific goals for 2015/16. These were that:

- All CT scans for patients admitted to hospital with a likely diagnosis of acute stroke will be undertaken within 12 hours of admission and all patients that may benefit from stroke thrombolytic treatment will be scanned immediately and treated within 60 minutes of hospital arrival.
- All stroke patients will have a swallow screen within 4 hours of admission.
- At least 90% of stroke patients will be admitted to the stroke unit within 4 hours of arrival at hospital.

Key achievements 2015/16

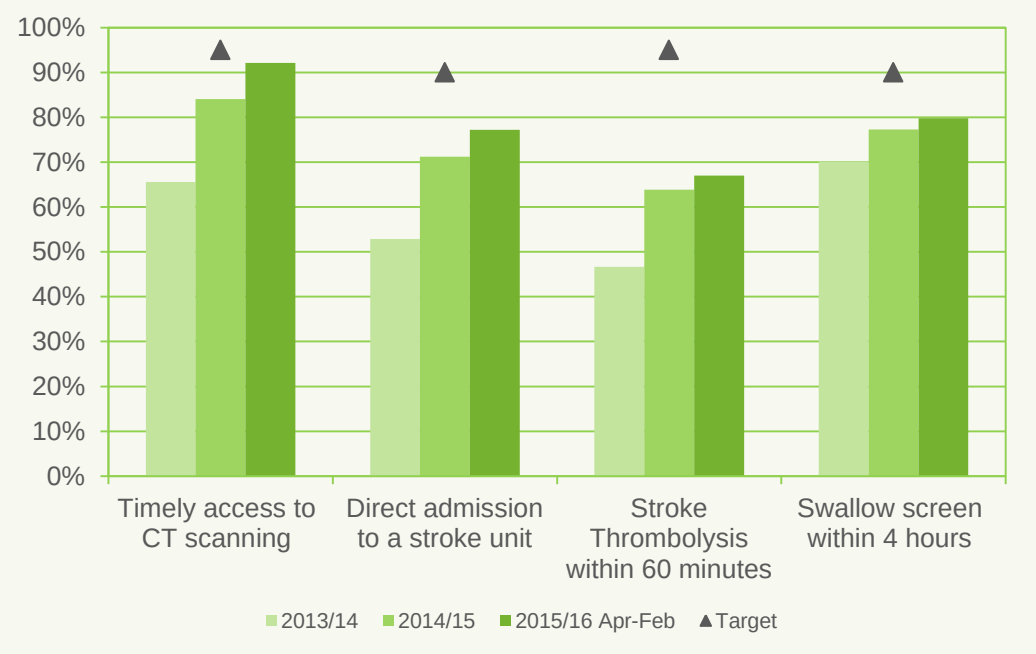
Nationally stroke care is measured by the Sentinel Stroke National Audit Programme. Trusts are measured at site level for compliance against six domains (acute care; specialist roles; interdisciplinary services; TIA / neurovascular clinic; quality improvement, training and research; and planning and access to specialist support). Each trust site is given an overall score: a letter from A to E (with A being the highest).

In the last published national data (October to December 2015) both Trust sites were graded B (an improvement from C in the case of both Worthing and St Richard's Hospitals from the same period in 2014). For context, of the 215 Trust sites in England and Wales, 82 (38%) were graded B or above, 12% were graded A.

The Stroke Team were recipients of our Patient First Award for their improvement work in 2015/16.

The measures outlined as priorities in the last Trust Quality Report are a subset of the measures collected by SSNAP and use the same data (although supplemented by unpublished data for the most recent months). Performance for each of the priorities is shown below.

Figure 23. Indicators of stroke management 2013/14 to 2015/16



Improvement plans for 2016/17

As can be seen from the graph, the Trust has made considerable progress against each of these metrics over the past year. We remain, however, short of the targets proposed last year. While these targets are stretch targets that reflect a gold-standard service that few providers currently achieve, they remain our ultimate aim and therefore stroke care remains a key priority for 2016/17, with the Trust seeking to make further progress towards attaining these levels

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❖ **Improvement in referral and discharge information**

~ Electronic Discharge Summaries

Over recent years the Trust has implemented the use of Electronic Discharge Summaries (EDS) for inpatients being discharged. The implementation of EDS offers opportunity to improve both the quality and reliability of communication between Trust clinicians and primary care partners.

Our goals in 2015/16

- Increasing the reliability and timeliness of published electronic discharge summaries to primary care.
- Working with primary care partners to agree and plan implementation of any improvements to the EDS template that will improve the quality of the information communicated
- Establishing a multi stakeholder Steering Group to oversee action plans in relation to 1 and 2 and consider the opportunities and further roll out plan for EDS e.g. outpatient discharge.

Key achievements 2015/16

- Establishment of a Trust Electronic Discharge Summaries Operational Group
- Established a baseline for the dispatch and timeliness of electronic discharge summaries to primary care, and reviewed practice regarding EDS publication at ward level.

Figure 24. Number of EDS sent compared against total number of discharges per month

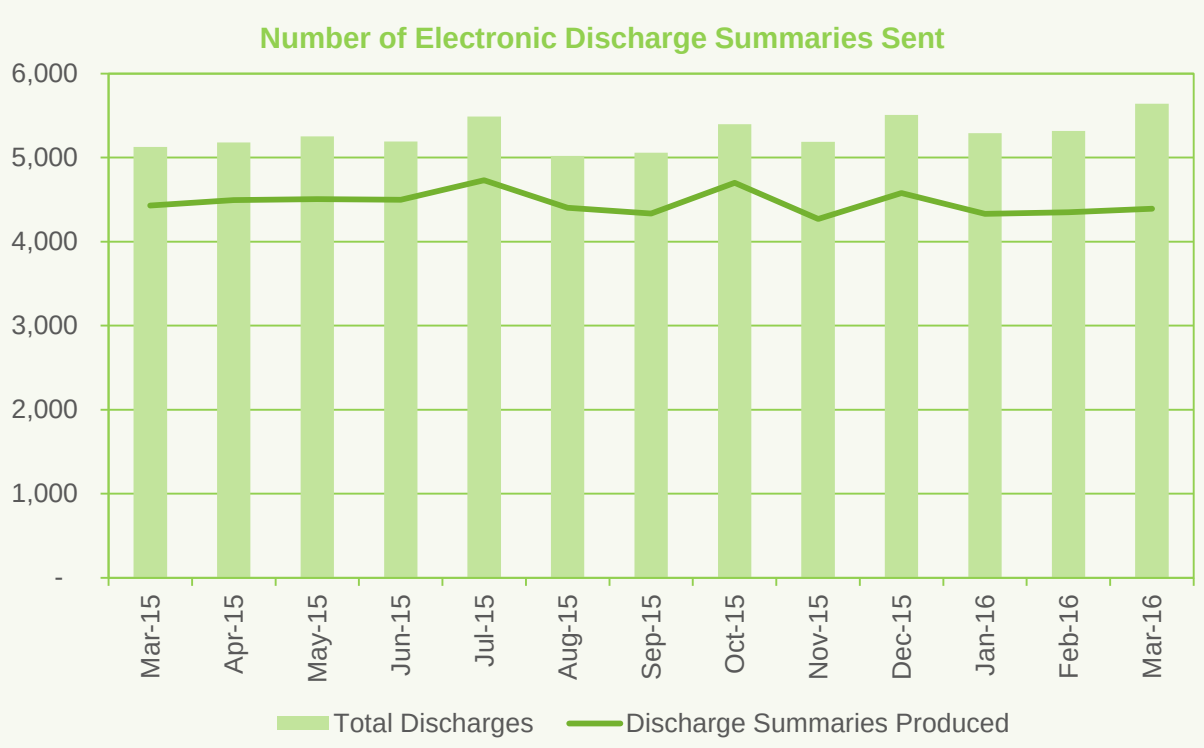
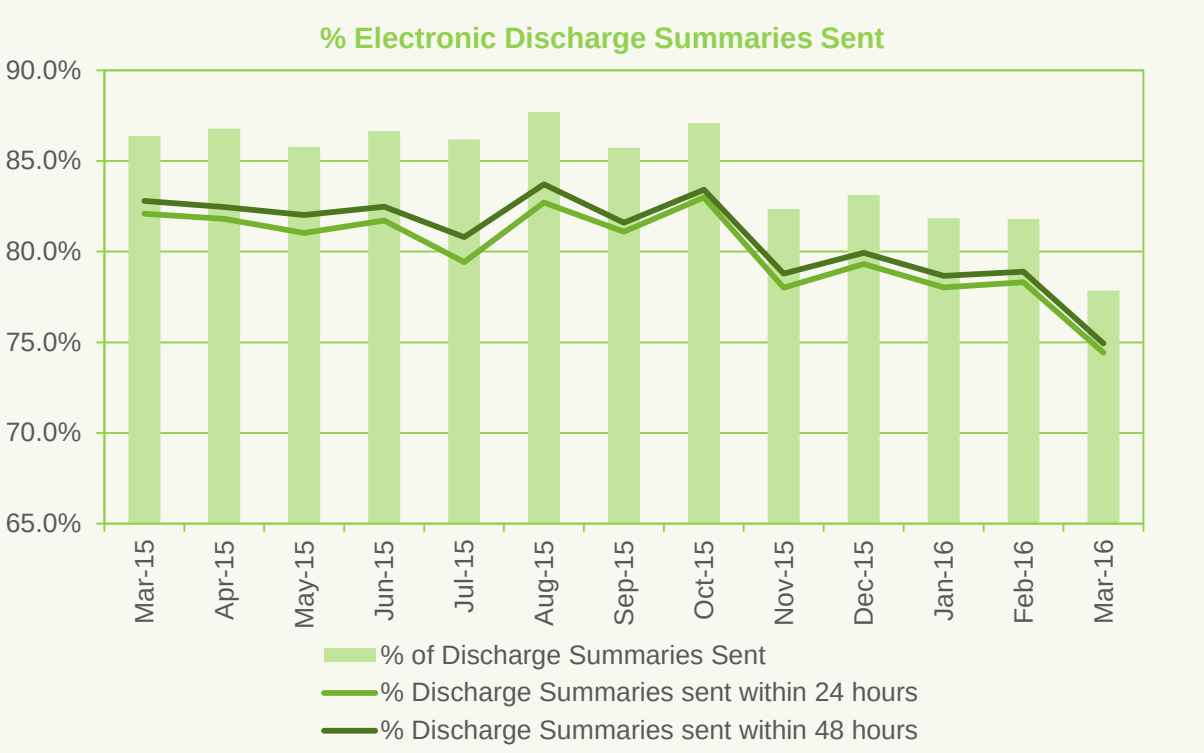


Figure 25. Percentage of EDS sent showing those sent within 24 and 48 hours



Improvement plans for 2016/17

The Trust will continue to focus on increasing the reliability and timeliness of published electronic discharge summaries to primary care in 2016/17 using 'Plan-Do-Study-Act' (PDSA) cycles and standard work.

The Trust has been unable to establish a multi-stakeholder steering group this year due other health economy priorities taking precedence. This will be a key part of year two of the programme in 2016/17

~ Improving patient experience of discharge

Our goals in 2015/16

The National In-Patient Survey 2014/15 highlighted that the discharge process across WSHFT requires improvement. Patients stated that:

- They have not been given enough notice of discharge
- They have experienced long waits for their discharge medication
- They do not receive enough information about the purpose and side effects of their medications.

A team of six staff were selected to undertake an improvement project.

Aim: For 90% of patient responses on Lavant Ward to be positive when asked about their discharge by May 2016.

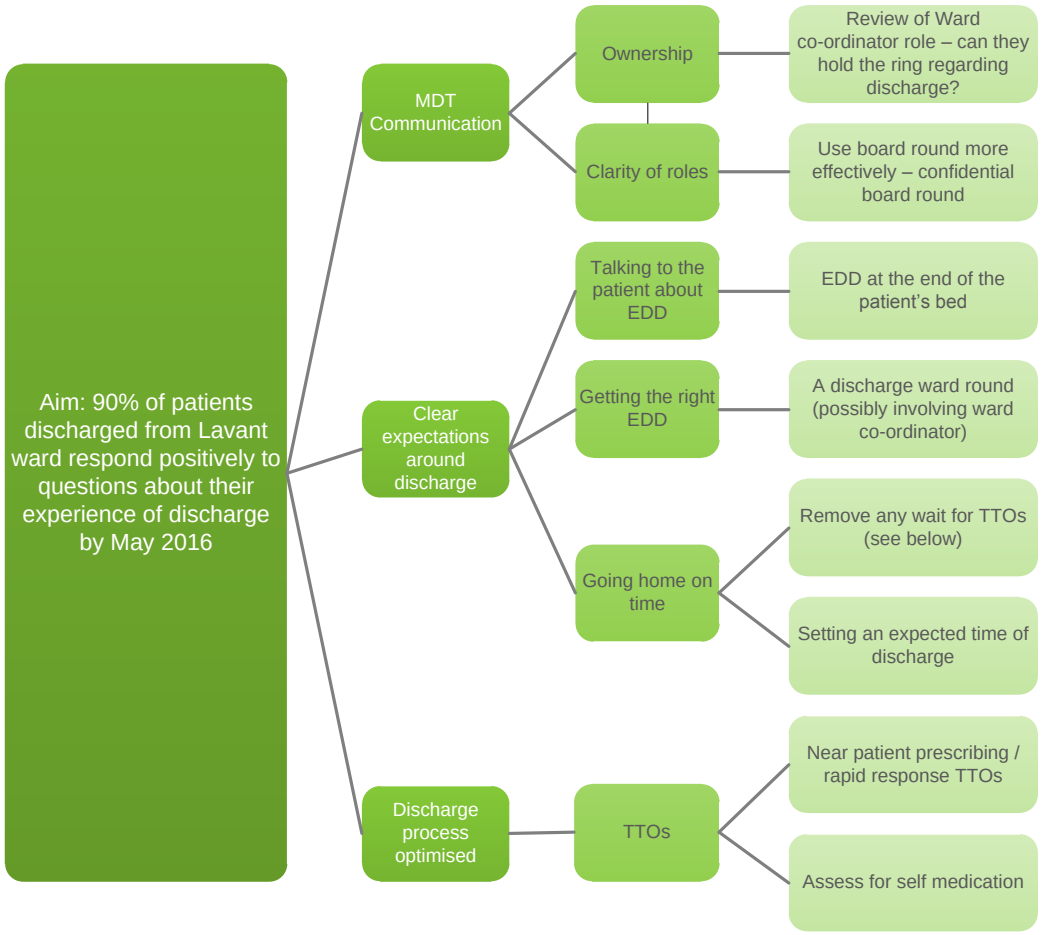
This ward was chosen because the Real time Patient Experience (RTPE) surveys reveal that only 43% of patients are satisfied with their discharge experience from Lavant Ward.

Key achievements 2015/16

Patient satisfaction with discharge has reached 82% when asked about discharge from Lavant Ward in January 2016.

The 'Lavant Leapers' project has been led by all members of the multidisciplinary team on Lavant ward. Using quality improvement science and the views of patients related to their experience of the discharge process the team identified a number of key areas for focused improvement.

Figure 26. Lavant Leapers PDSA interventions



The team tried and tested various interventions whilst continuing to monitor the patient experience, keeping those that impacted positively. As a result the patient experience has improved over the course of the year. The multidisciplinary team have found the experience very positive and empowering and are continuing use these methodologies.

Figure 27a. Impact of Lavant Leapers interventions on patient experience on Lavant Ward

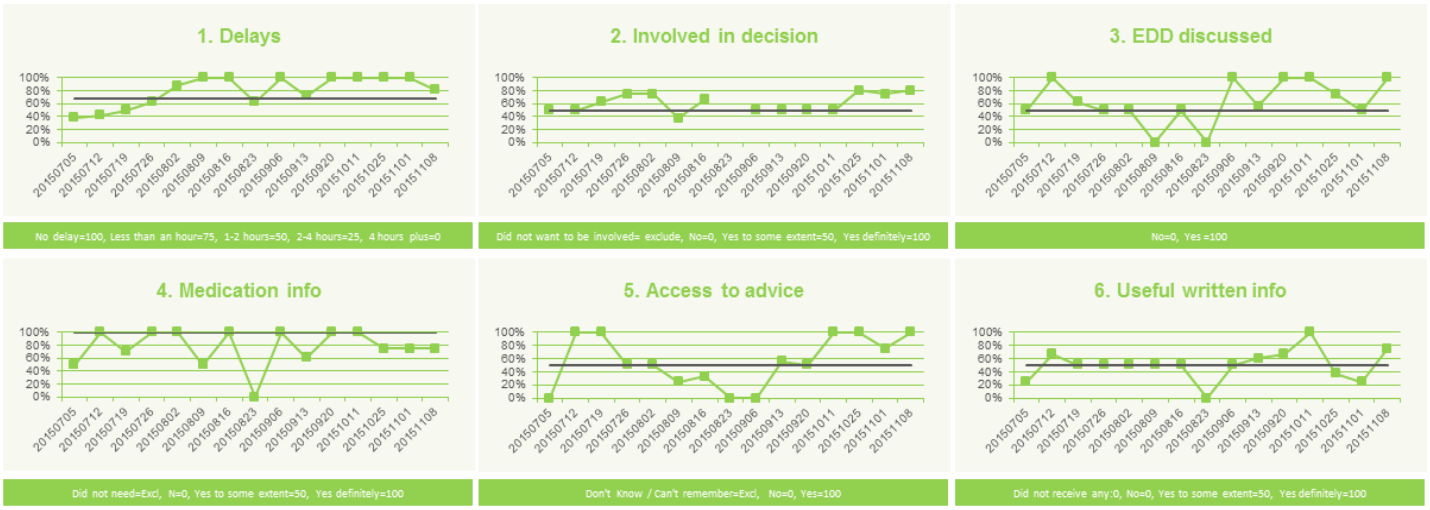
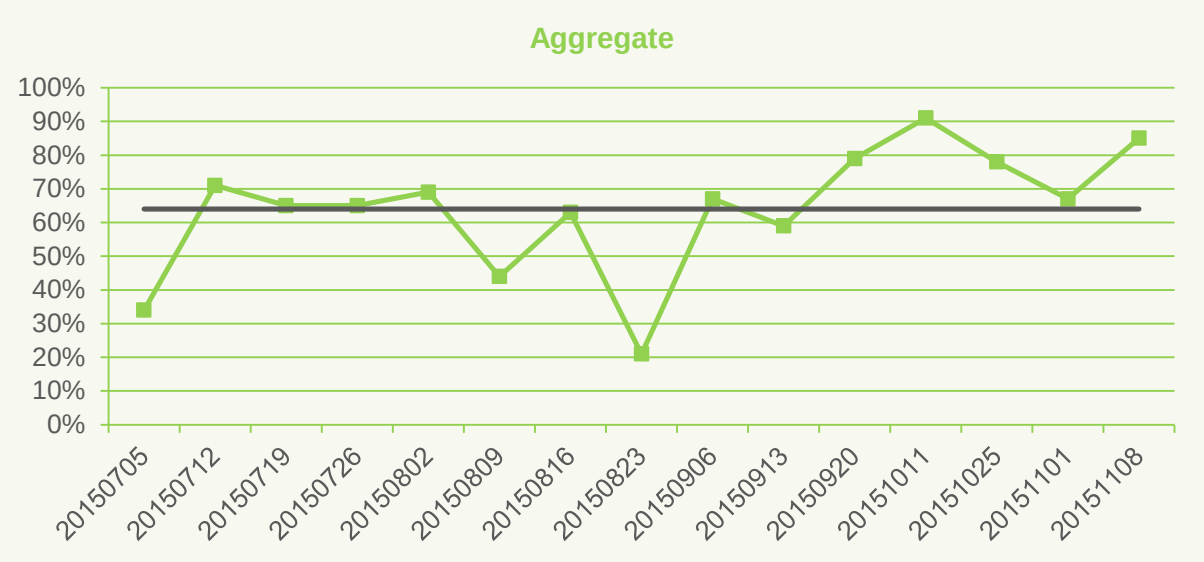


Figure 27b. Impact of Lavant Leapers interventions on patient experience on Lavant Ward



The team have met on a monthly basis and attended three theoretical workshops in Manchester. Actions to date have included:

- A telephone survey undertaken weekly with patients that have recently been discharged from Lavant Ward to gather feedback on their overall satisfaction of discharge. The responses have been collated on the Meridian software that the Trust uses for patient feedback
- Staff attending the board round (Mon-Fri) now includes the discharge co-ordinator and a member of the pharmacy team
- A member of staff is selected at the board round to speak to the patient and their carer about the expected date of discharge
- The expected date of discharge is written and displayed at the patient's bedside
- The board round standard operating procedure for WSHFT has been updated to reflect these steps
- Therapists have introduced progress planning meetings with families to help manage expectations and these have been very well received.
- A new style of written information describing staff roles and hospital stroke pathway has been created and is displayed on Lavant Ward
- A patient and visitor information leaflet has been created for Lavant Ward detailing the usual routines on the ward
- A cupboard on the ward has been allocated for the introduction of ward based dispensing of discharge prescriptions (TTOs[38]). An independent label printer and a

[38] TTO, To Take Out – these are medicines given to a patient on discharge from hospital for them to use at home.

pharmacy computer was installed and this has reduced the turnaround time for TTO's from 90 minutes to 15 minutes.

Improvement plans for 2016/17

A project has just begun to adjust the pharmacy clinical service to enable a more ward based service provision, including local TTO preparation, on 15 wards across the Trust.

The patient and visitor information leaflet and information describing staff roles will be introduced to all adult ward areas across the Trust.

A project implementation plan is being drafted by a member of the Project Management Office to support sharing of the lessons learned across the Trust in improving patient experience of discharge.

- **Implementation of first stage of seven day services programme**
- **Target – All new patients have a consultant review within 14 hours of hospital admission by 2018.**

The delivery of seven day services is a priority for WSHFT. We are developing a significant programme of work aimed at ensuring equity in care for patients regardless of the day of the week in line with national developments (Keogh - NHS Improvement 2012)[39]. This is a challenging, yet key area of work as there is now compelling case for appropriate healthcare services to be accessible seven days a week, to avoid compromising patient care, safety, and patient experience. There will be a number of key goals associated with this programme; we have chosen access to timely consultant review as an overarching indicator of progress in this area.

We are undertaking a number of audits to identify how far we have to go to achieve this target and to establish a baseline for improvement. Ultimately, however, we would like to establish systems whereby performance against these targets can be monitored routinely, without resorting to the additional work that audit entails.

Currently we have an internal seven day working programme steering group that monitor progress against all the seven day recommendations. To achieve all the recommendations within the Keogh report requires a whole system approach across the health economy, and

[39] NHS Improvement (2012) Equity for All: Delivering safe care – seven days a week. http://www.nhsiq.nhs.uk/resource-search/publications/nhs-imp-seven-days.aspx

we are therefore working with commissioners and partner organisations to ensure this approach is adopted.

Our goals in 2015/16

- Real time patient satisfaction monitoring, incorporating both 'in' and 'out of hours' periods,
- The development and piloting of an electronic tool to improve handover between day time and night time care teams. This will be available to all clinical areas by October 2015,
- Conducting a gap analysis against Keogh standard two 'Time to first consultant review'. Development of strategic options for managing increased workforce requirements with a view to compliance in quarter 4 (Jan –March 2016),
- The development and piloting of a multi-disciplinary board round framework.

Key achievements 2015/16

- The difference in care across the days of the week is something that is often highlighted in the national press. In 2015 we put in place an adjustment to the Patient Experience survey that allows us to review patient experience dependent on the day and time of admission.
- Implementation of an electronic tool to improve handover between day time and night time care teams. The E-handover tool defines which patients need review, providing a consistent and standardised handover on both sites.
- Currently piloting acute physician presence on the Emergency Floor at Worthing Hospital at weekends. This enables patients to be seen within 14 hours meeting the criteria of the Keogh standards. Pilot to be continued for a six month period followed by a full review.
- Pharmacy service provision on Saturdays and Sundays on both sites focusses on the Emergency Floors.
- Multi-disciplinary board round framework rolled out.

Improvement plans for 2016/17

- Continuation of pilot of acute physician presence on the Emergency Floor at Worthing Hospital at weekends
- Programme plan for full seven day diagnostic services

- **Implementation of first stage of care pathway for frail elderly patients – including building on dementia care pathway**
- **Target - screening at least 90% of patients aged 75 and over admitted as emergencies for symptoms and signs of dementia, and communicating the need for additional follow up to their GPs**

The prevalence of dementia is steadily increasing throughout the UK and the impact of this is greatest in areas with a very high elderly population - such as West Sussex. Although dementia is generally an inexorably progressive disorder, early identification and carefully targeted therapeutic intervention can slow the rate of progression and enhance the quality of life of patients.

As an acute trust provider, we play an important role in managing the increasing burden of dementia care in West Sussex. We screen for the early symptoms or signs of dementia in all of the elderly patients admitted with other another illness to our acute sites. We also ensure that all of our patients in whom dementia has been previously diagnosed, and who require hospital treatment because of other illnesses, are carefully and holistically managed, providing safe and dignified care at all times. This includes specific measures to best manage any cognitive and behavioural needs, in addition to treatment of the physical condition causing their admission. Dementia patients in hospital are likely to be disorientated and frightened and may only display their anxiety through their behaviour. For patients with dementia, dealing effectively and kindly with behavioural disturbance is of paramount importance to us – reducing the risk of both complications and prolonged hospital stay.

Our goals 2015/16

- To meet the key target of screening at least 90% of patients aged 75 and over admitted as emergencies for symptoms and signs of dementia, and communicating the need for additional follow up to their GPs throughout the entire year 2015/16.
- To embed the use of the 'Knowing Me' documentation throughout the whole Trust as assessed by repeated clinical audit measures, and to receive regular audit feedback from the carers and relatives of patients with dementia, to ensure that they feel supported and satisfied with the care provided.
- To evaluate the impact on care of dementia cohort areas within elderly care wards, reviewing their effectiveness in relation to length of stay, complications, and ward moves. Depending on the results of this review, we will consider whether this model,

which has proved to be very successful in other trusts, needs to be continued and/or extended.

- To develop a dementia pathway that promotes a smooth transition from the acute setting to the community, and reduces discharge delays.
- To introduce a Sema Helix flag for dementia patients to reduce ward moves.

Key achievements 2015/16

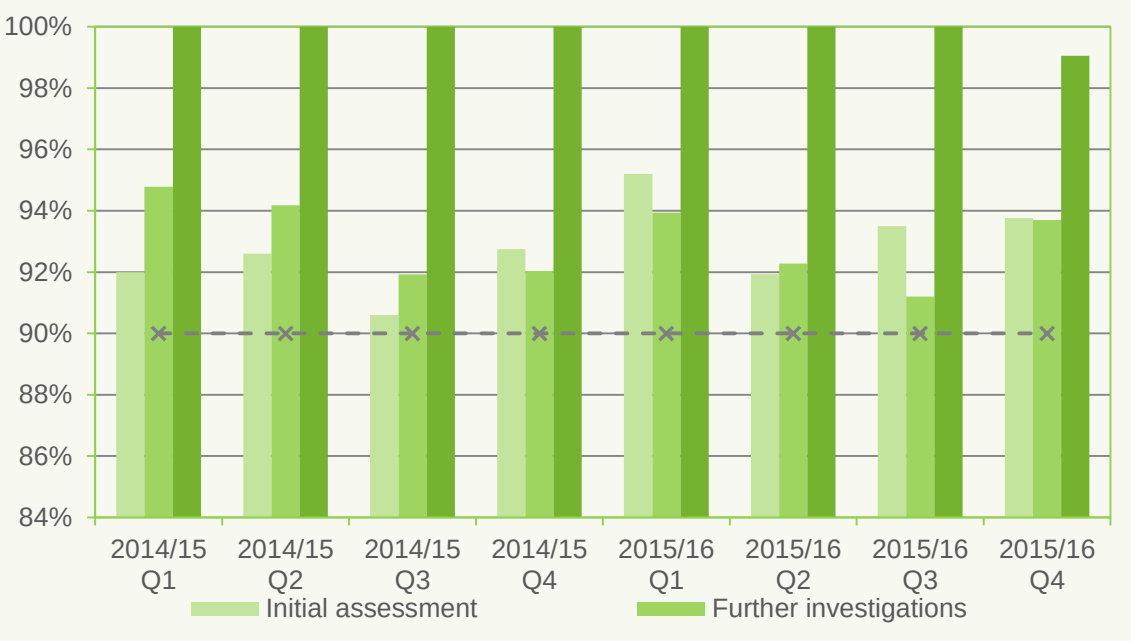
~ Dementia Strategy

The Trust is committed to improving the care and experience of our patients suffering with dementia and our Dementia Strategy clearly defines our vision, values and objectives for caring for people with dementia.

~ Dementia screening

We have continued to meet the National Target of assessing 90% of patients (aged 75 years or over) admitted as emergencies for symptoms and signs of dementia over the year. We have also met the target of 90% for conducting further investigations where the initial assessment suggests dementia or is inconclusive and informing the GP of the need to refer patients with suspected dementia on to tertiary services. By using an electronic assessment (on our Patientrack system) we ensure the GP is always informed of the results of the screen in a timely way and any possible need for onward referral, without requiring clinicians to take time to write a letter.

Figure 28. Indicators for dementia assessment and management 2014-2016



~ Knowing Me[40] Documentation and Carers Survey

We have undertaken a comprehensive audit programme over 2015/16 to ensure compliance with these key aspects of the Trust's Dementia Strategy.

The Knowing Me document is used for patients that may not always be able to tell staff themselves what they like and dislike. The details within the document ensure that we can provide reassurance and support to vulnerable patients whilst reflecting their preferences in how care is delivered. Every person is an individual and whether it is knowing how many sugars someone likes in their tea, or what music they like it all helps to improve their experience in an acute hospital setting.

Monthly reviews of overall compliance of use has been consistently at 98-100% since March 2015.

The carers' survey has been given out by the wards over 2015/16 this gives valuable feedback ensuring both the quality of care offered to this vulnerable patient group and that sufficient support is offered to their carers. We have had good feedback with carer satisfaction being at 80%. Results of both the documentation audits and carers survey are fed back routinely to the wards as part of an integrated dementia dashboard. Carer support nurses have been in place on both sites over 2015/16 and this role has proved immensely value for the carers and ward staff in providing a link for carers to identify any concerns and to ensure they receive signposting to other services to support them following discharge.

~ Dementia cohort areas within elderly care wards

Two ward areas since 2014 have been used as pilot areas to group patients primarily with dementia. To make these areas dementia friendly bays were painted in different colours, toilet doors are now a bright yellow with picture symbols used for toilet doors and on single rooms. All of these allow patients to orientate themselves within the ward area more easily. Additional seating has also been provided so that patients' seating is not only provided at the bedside. The ability to secure the main ward doors has also been useful to stop wandering patients leaving the ward. The use of the ward areas has continued to help impact the number of ward moves these patients undergo.

In view of the success of the above there has been further work in 2015/16 reviewing two other ward areas identified for refurbishment into dementia friendly areas. There has been

[40] 'Knowing Me' documentation is used for patients that may not always be able to tell staff themselves what they like and dislike. The details within the document ensure that we can provide reassurance and support to vulnerable patients whilst reflecting their preferences in how care is delivered.

some progress in changing some aspects of the environment, such as changing areas into multifunctional rooms for patients and relatives, toilet areas, clocks and some minor furnishings. We have been unable to complete full refurbishment such as painting bays and doors as above as this requires decant of the wards – this is planned for quarter one of 2016/17

~ Dementia friendly environments across the hospital sites

During 2015/16 work has also begun to undertake a gap analysis of the hospital environment generally. This has been undertaken by the occupational therapist dementia specialist and nurse specialist, using the King's Fund environmental audit tool[41]. Guidance is in the process of being produced which will ensure that future fixtures and furnishings will be in line with best guidance for our dementia patients. This piece of work will be continued in 2016/17.

~ Training and education

Our Dementia Specialist Nurses have worked closely with the ward staff to ensure they have had additional training to support the care delivered to patients with dementia, the inclusion of training around delirium also being introduced in 2016/17. Dementia champions have been introduced in the wards, clinical and therapy areas. These individuals have extra training and act as a link role in supporting other staff and patients/relatives.

~ Nutritional support

Following pilot of the use of finger food (helping patients to more ably feed themselves, and supporting small amounts of food often which many older patients find more manageable) the menus have now been rolled out across all the Trust's wards. To further support nutrition the specialist nurses continue to work with our dementia volunteers to enhance the quality of our patients' experiences and dining companions have been re-launched in 2015. The Trust has continued the 'Let's do lunch' initiative where other WSHFT staff also help with socialisation and eating at lunchtime. This is now being extended with support from local students who are joining patients for dinner.

Volunteers continue to come and socialise with patients, looking at reading material and talking with them. Wards all have activity boxes which help to keep patients with dementia stimulated and more settled. On one of the wards the physiotherapist has commenced a short joint exercise period prior to lunch in one of the bays.

[41] http://www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-design-dementia

~ Dementia pathway

A pathway document has been written that highlights best practice for patients with dementia. This went live during 2015 and is shared on our intranet. There are also plans to share the pathway document with local GPs, it is hoped that this will support the admission and discharge of patients with dementia.

~ Sema Helix flag

This flag for patients with confirmed diagnoses of dementia has continued to be used over 2015/16. The flag is placed on the information system by the specialist nurses when patients are admitted. It has proved helpful in avoiding unnecessary ward moves and in particular night-time moves for patients with dementia. The flag has also supported collaboration with the Community Proactive Care Team who are provided with updates relating to admissions for patients flagged as having dementia.

~ Night and ward moves

We continue to monitor the number of moves deemed unnecessary (i.e. not for clinical need) or moves overnight for patients with dementia on a monthly basis. Wards identify patients who should not move and use board magnets to highlight these in order to try to assist decision making when bed allocation needed with the site team. The number of moves is improving on both sites and there are plans to re-instigate the use of a sticker in the patient's notes to clearly indicate the reason for out of hours moves to aid with audit of reasons.

~ Western Sussex Hospitals NHS Foundation Trust's Annual General Meeting (AGM)

The Trust's AGM was focused on dementia which coincided with the CQC themed inspection of the Trust for dementia. Two CQC Inspectors undertook a thorough evaluation of our dementia care practices and their initial feedback was very positive. They said good compassionate care was clearly demonstrated on the two wards they visited, Ashling and Selsey, and in some areas they witnessed outstanding care. They also remarked about the kindness of staff, for example, the housekeeper on Ashling Ward gave patients plenty of time to decide what meal they wanted for lunch. Such a simple decision can be very demanding if you have a dementia. The CQC felt staff showed both skill and compassion when dealing with patients, and said they were sensitive to patients' needs as well as their dignity. The Inspectors also praised the Trust's Dementia Strategy, which was presented to the Board that month, and were impressed by the dementia volunteers and the activities they help to facilitate.

Improvement plans for 2016/17

Improvement plans for 2016/17 include:

- Ongoing audit of dementia assessment targets, sema flag, ward moves, use of Knowing Me documentation, and carer survey results.
- Dementia Matron commences role in Quarter One 2016/17 – key work streams initially will be to review and complete the environmental gap analysis, ensuring guidelines are produced for the Trust and to develop links with community services and dementia crisis team.
- Complete the upgrade to two wards with regards to dementia friendly environment[42].
- Training for staff to include management of delirium and development of simulation training, and training of chaplaincy visitors.
- Review of carer support services and 'John's Campaign'[43].
- Further review of the 'Knowing Me' document to encourage its use and make it easier for relatives to complete.
- Working with the Acute Frailty Network[44] to support improvement and redesign of acute frailty services within first 72 hours post emergency admission.
- Working with Sussex Partnership NHS Foundation Trust to develop a business case for shared care wards on both sites.

[42] In line with the King's Fund programme to improve the care environment for people with dementia in hospital: www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-design-dementia

[43] John's campaign is a national appeal from carers for the right to stay with people with dementia in hospital: http://johnscampaign.org.uk

[44] A national collaborative improvement model looking to optimise acute care of frail older people in England: www.acutefrailtynetwork.org.uk

- Trial of devices provided by 'My Dementia Improvement Network'[45] which provide a standalone communication and interactive games IT system with a software package that includes a range of therapeutic tools and memory related activities. These have been supported in part for a trial by the Friends of the Hospital. If successful a full bid would be put forward for devices on both sites.

❖ **Acute Frailty Network**

The Trust has secured a place on The Acute Frailty Network as one of 12 participating organisations. This is a 12 month improvement programme designed as a professional network to support participating sites to rapidly adopt and expand their emergency services for frail older people. The National programme is delivered by an experienced team of clinicians, operational managers and improvement leaders and is made up of national collaborative events workshops, site visits, webinars and on-site individual support for participating teams. 12 sites are participating in the second wave of the programme which is fully supported by NHS England, Monitor and the NHS Trust Development Authority (both part of NHS Improvement[46]) working with partners from The Association of Directors of Adult Social Services in England, The Society for Acute Medicine, Age UK, The British Geriatrics Society, The Royal College of Nursing and The Royal College of Physicians.

The Trust has established an Acute Frailty Network Programme Board in order to provide a forum for senior managers and clinicians to plan and manage the development and delivery of services to improve emergency care for frail older people. The Board's membership includes partner agencies Sussex Community NHS Foundation Trust, Coastal West Sussex CCG and Primary Care.

The priorities and objectives of the Board are to define the scope of acute frailty services in the Trust and review the current service model with an intention to standardise the delivery of care taking into consideration the best available evidence base. The Board will consider the following over the next year:

- Review the difference between the delivery of acute frailty services on the two acute sites
- In conjunction with the Kaizen Office process map the pathways from arrival at the hospital to transfer back into the community or to a substantive ward

[45] A network to provide dementia support to organisations, including information, learning and support across the patient pathway: www.mydementiaimprovementnetwork.co.uk
[46] https://improvement.nhs.uk/

Other areas of progress in increasing reliability and standardisation this year

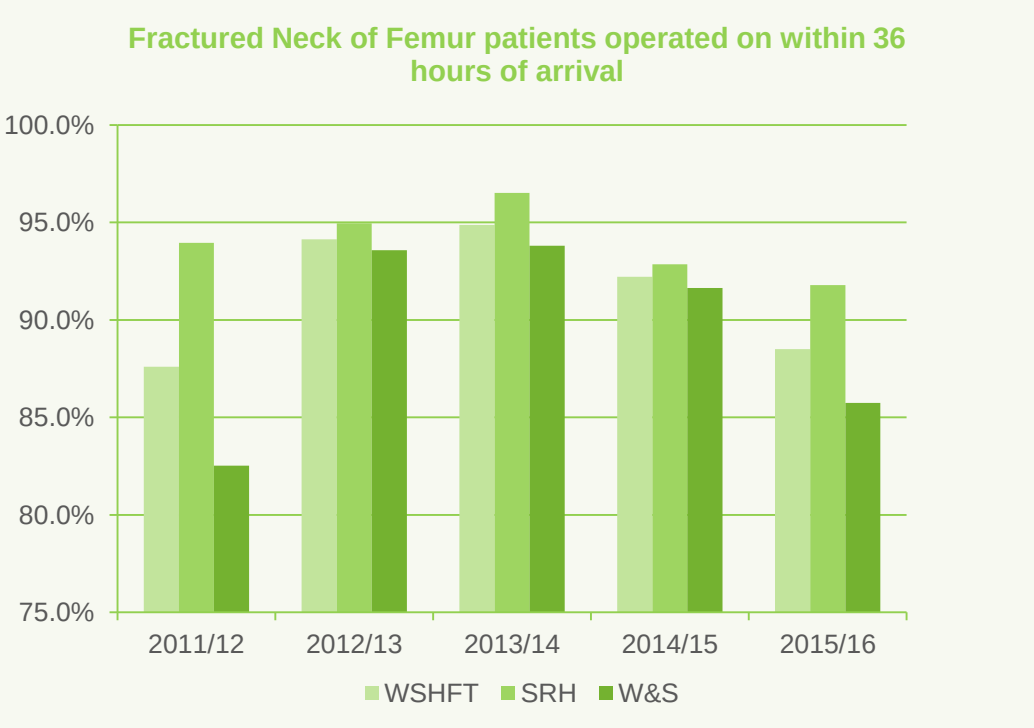
Over the last few years the Trust has introduced 'care bundle' systems of care for patients with a number of conditions including pneumonia, chronic obstructive pulmonary disease, acute kidney injury and chronic heart failure.

Over the last year we have also led significant developments in the pathways for patients with hip fracture.

Improvements in our ortho-geriatric[47] pathway

An important area of focus over the last year has been the pathway for patients admitted with hip fracture. One of the key elements of the ortho-geriatric pathway is ensuring timely surgery for patients admitted with hip fracture. Performance is monitored very closely with updates on the proportion of appropriate patients operated on within the allocated timeframe reported to the Chief Executive on a regular basis and to the Trust Board every month. Performance deteriorated marginally in 2015/16, particularly over the latter part of the year at Worthing Hospital due to trauma demand pressures.

Fig.29 Patients with hip fracture operated on within 36 hours



[47] Orthogeriatrics is the specialism which cares for elderly orthopaedic inpatients, most often following a fractured hip.

The Enhancing Quality and Recovery Programme

Now in its fifth year, the Enhancing Quality and Recovery (EQR) Programme is delivering sustainable transformational change. The programme continues to support quality improvement for existing pathways and the development of new work streams. The programme's overarching aim is to support clinical teams to *get it right for every patient every time*.

The programme continues to be part of the service improvement work being overseen by the local Academic Health Science Network (AHSN), linking to key strategic priorities for development and improvement in Kent, Surrey and Sussex (KSS).

The Trust has continued to actively participate in both the strategic development of the programmes and the work streams, with clinicians from Western Sussex Hospitals providing strategic clinical leadership across KSS for the Enhanced Recovery programmes. The Trust's Chief Executive also chairs the KSS AHSN Improvement Board.

~ **Enhancing Quality - Community Acquired Pneumonia**

In 2015 the pneumonia programme continued to undergo some changes as part of the work to align itself with the British Thoracic Society/NICE guidance[48]. The Trust has continued to collect and submit data on all patients admitted with pneumonia. Although the Trust has continued to perform well in giving patients with pneumonia antibiotics within 6 hours from arrival it recognises work still needs to done in 2016/17 on formal oxygen prescription and CURB scoring[49].

EQ Heart Failure

The Trust has continued to work hard to maintain the standard it achieved in 2014-15. The heart failure teams have continued to make a significant contribution to the programme development and there has now been full transition to using the National Heart Failure Database[50].

[48] The British Thoracic Society and the National Institute for Health and Care Excellence guidance on pneumonia make specific recommendations regarding the timing of X-rays and the assessment and prescription of oxygen. These have been added to the EQ care bundle in order to align the programme with these national recommendations.

[49] An assessment of the severity of pneumonia.

[50] An audit database of patients with an unscheduled admission to hospital in England and Wales who are discharged with a primary diagnosis of heart failure: www.ucl.ac.uk/nicor/audits/heartfailure

Acute Kidney Injury (AKI)

The Trust has continued to collect and submit data to the KSS AHSN AKI programme which has moved to the patient safety arm of the KSS AHSN. The Trust has also played a very active role in programme development and continues to be represented on the national AKI programme work groups. This part of the programme is now fully aligned with the wider programme of AKI work related to the 'deteriorating patient' highlighted elsewhere in the Quality Report.

Enhanced Recovery Programmes

The Trust has continued to maintain and monitor enhanced recovery programmes in three clinical pathways. Work in 2016/17 will include:

- Continuation of the existing pathways with some on-going changes in methodology,
- Continuing the work that has already commenced on chronic obstructive pulmonary disease (COPD) and bone health,
- Full implementation on the work that has already commenced on Enhanced Recovery in Emergency Laparotomy,
- The caesarean section pathway programme was removed from the KSS AHSN work programme at the suggestion of NHS England. The Trust is however keen to develop a local programme for Caesarean section in 2016/17.

Key Quality Improvement Priorities for 2016-17

Standardisation of care:

- **Continued improvement in stroke care pathway (SSNAP)**
- **Continued improvement in the frail elderly dementia pathway**
- **Roll-out of Enhanced Quality Emergency Laparotomy Programme with AHSN Collaborative**

2.1.5 Improved patient and staff experience

GOAL: Achieve top 20% of NHS Trusts in country for patient and staff experience surveys

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2.1.5.1 Improving patient experience

GOAL: Achieve top 20% of NHS Trusts in country for patient experience surveys (Friends and Family Test)

Why is it important?

Improving the patient experience is at the heart of the Trust's vision and values, and is a central aspect of our Patient First Programme.

The opportunity to hear the voice of the patient through the Friends and Family test gives staff the opportunity to listen to patients' experiences and to make improvements. Feedback is responded to on a regular basis and immediate and longer term actions taken to improve the experience for patients. Wards use the information to feedback within their area using the 'you said…we did' principle. Examples of immediate action taken from Friends and Family Test feedback during 2015/16 include; making newspapers available in Accident and Emergency Departments (A&E), providing clocks in areas so people are aware of the time, additional information leaflets in A&E, refreshments in areas where people were waiting i.e. A&E and Outpatients Department. Other examples include; increasing our volunteers, asking our estates team to address noisy doors and temperature concerns, changes to our night time settling routine and ensuring that there is food available on the wards outside of normal mealtimes for patients.

The Trust has invested heavily in staff training to improve the experience of patients through its customer care programme. This has included:

- Induction and recruitment have been radically redesigned to ensure all staff are fully focused on delivering great care, this extends to the Induction Day and implementation of Welcome Day,
- Successful pilot for delivery of Western Sussex Way training programme, aimed at groups of staff to improve customer care,
- Over 96 staff have become 'ambassadors', to act as exemplars of best practice and guides to others,

- Employee of the month - this is awarded to staff or teams who are nominated by either other staff or patients who recognise that someone has gone over and above in providing care or in delivering their role.

How do we monitor it?

From 1 April 2013, all organisations providing acute NHS services have been required to implement the Friends and Family Test (FFT) across adult inpatients (who have stayed at least one night in hospital) and adult patients who have attended A&E and left without being admitted.

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 implemented the Friends and Family Question in October 2013, asking this question of mothers at four key points of their maternity journey: antenatal care (at 36 weeks pregnancy), delivery, postnatal ward and community care.

A new scoring system for satisfaction was adopted by NHS England in September 2014 replacing the net promoter score with the much clearer system of the 'percentage patients who would recommend' the service to their friends and family.

From April 2015 all outpatient and day case areas have also been mandated to offer patients the opportunity to complete the FFT feedback with the day case scores contributing to the overall inpatient results. The survey has also been expanded to include children. 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.

Our aim for 2015/16 was to increase the return rate and to be above the national average scores across all areas. It should be noted that the national results for maternity only allow for comparison of the question asked at delivery.

While the Friends and Family test is important, it is not the only means through which the Trust can assess the experience of its patients and carers. The Trust supplements the information from Friends and Family with a more detailed inpatient survey carried out by patients shortly before discharge on hand-held tablets. This survey includes a number of questions directed specifically for carers of patients and assesses experience of patients admitted both in working hours and at night-times and weekends. There are also a number of more specific surveys looking at experience of patients in particular services and departments.

Other means of monitoring experience include feedback from complaints and PALS (Patient Advice and Liaison Service) enquiries and comments placed on social media, the NHS Choices website[51], feedback via Healthwatch[52] West Sussex.

How do we report it?

Feedback, both from the Friends and Family Test and other patient experience measures, is routinely provided directly to wards and departments, both at aggregate level and individual comments where appropriate. Aggregate measures are reviewed at ward, site, and divisional level and key metrics included in the Quality Scorecard provided to the Trust Board. Each ward is encouraged to publically display the Friends and Family Test score for that ward for patients to see.

Where are we now?

Friends and Family Test and local patient experience feedback

~ National Inpatient Survey

The National Inpatient Survey conducted on behalf of the care quality commission (CQC) provides a detailed picture of how patients view us across a number of dimensions. It includes measures that relate strongly to the care and compassion shown by individual staff and the organisation as a whole. This survey is a snap shot at one point in time conducted in one month, August, with the results being reviewed by the Trust Quality Board to support the planning of our improvement goals. The results for 2015/16 show that we are performing within the expected range for the majority of areas. We have scored highly in the following areas:

- Cleanliness of wards, including toilets and bathrooms
- Nursing staff answering questions in a clear and understandable way
- Treating patients with respect and dignity
- Patients feeling well looked after by staff
- Discussion of need for adaptations/equipment for discharge.

We have also shown significant improvement of five points or more in the following areas:

- Do you think staff did all they could to help control your pain?
- From the time you arrived, did you feel it was a long wait to get a bed on a ward?
- Were you given clear written/printed information on medicines?

[51] http://www.nhs.uk/

[52] Healthwatch, the national consumer champion in health and care: www.healthwatch.co.uk

- Were the side-effects of medicines to watch for when home explained?

Where we need to do better:
It is particularly pleasing that we have shown significant improvement in the two questions relating to medication as these were identified as key areas for improvement following the previous year's survey. We know that we still have much to do in this area and the question 'Was the purpose of medicines to take home explained understandably?' was low scoring compared to other organisations. Other areas identified in this survey for improvement include:

- Were hand-wash gels available for patients and visitors to use?
- Prior to your operation, did the anaesthetist explain understandably how they would control any pain?
- Before leaving, were you given written or printed discharge information?
- Was the purpose of medicines to take home explained understandably?
- Did doctors/nurses give family/friend all information needed to help care for you?

The only area where we have shown a significant drop (five points or more) in score is the question relating to explanation by an anaesthetist about how pain would be managed: we saw a nine point drop in satisfaction.

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

~ The Friends and Family Test

Our goals in 2015/16

A&E: to maintain our current excellent position in the top 20 in terms of the response rates. To achieve top 30 position for recommendation.

Maternity: to improve our current very positive position aiming for excellent with top 30 ranking for both return rates and satisfaction on both sites. It should be noted that the national results for maternity only allow for comparison of the question asked at delivery.

Inpatient: to improve return rates and achieve a recommendation score in line with the national average.

Outpatient: To improve response numbers and achieve satisfaction rates in line with national average.

Key achievements 2015/16

A&E: The tables and graphs show that A&E performs above the national average for both response rates and satisfaction. We did not meet our own objective of maintaining the top 20 position for return rate, and whilst we did see an improvement we did not achieve the top 30 position for recommendation. It is of note that St Richard's A&E department, whilst remaining above the national average, has seen a drop on both response and return rate compared to last year – this has been compensated by Worthing's significant gains.

Table 10. Friends and Family Test A&E recommend rate

	2013/14	2014/15	2015/16	National average (2015/16)	National position (2015/16)
WSHFT	91.00%	90.60%	91.40%	87.42%	54th of 145 (37th centile)
Worthing	90.00%	90.90%	92.77%	87.42%	N/A
St Richard's	91.30%	90.30%	88.68%	87.42%	N/A

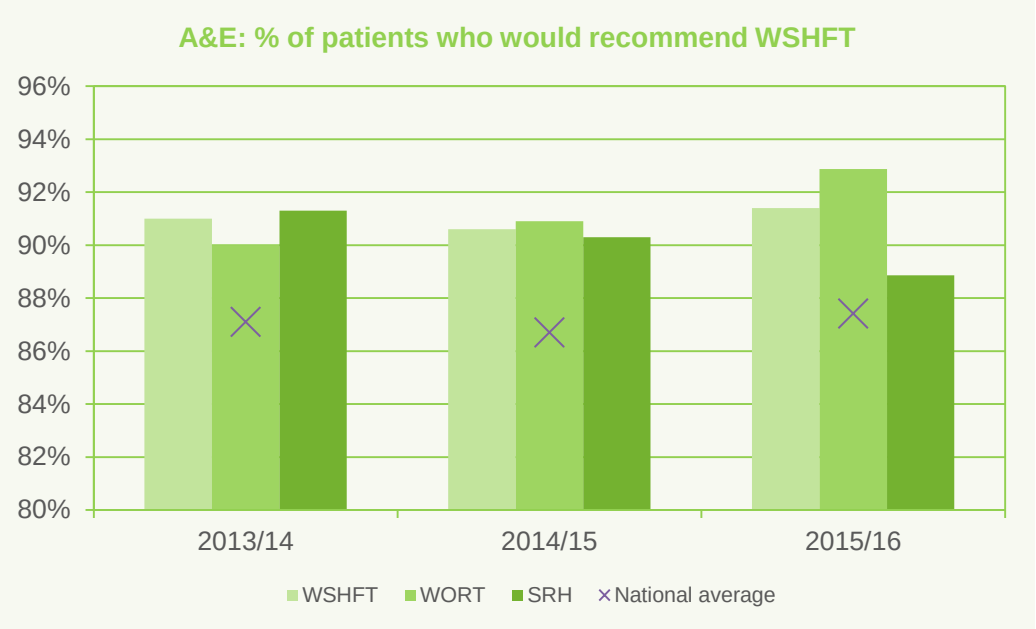
N.B. 2015/16 National figures presented are Apr to Feb 2016 only.

Table 11. Friends and Family Test A&E survey response rate

	2013/14	2014/15	2015/16	National average (2015/16)	National position (2015/16)
WSHFT	18.90%	26.70%	17.80%	13.92%	48th of 145 (33rd centile)
Worthing	16.20%	27.50%	21.52%	13.92%	N/A
St Richard's	22.10%	25.90%	13.30%	13.92%	N/A

N.B. 2015/16 National figures presented are Apr to Feb 2016 only.

Figure 30. Friends and Family Test - A&E % of patients who would recommend WSHFT



N.B. 2015/16 National figures presented are Apr to Feb 2016 only.

Maternity

The maternity results for both sites have reduced compared to 2014/15, and for satisfaction are now just below the national figures for 2015/16. It is of concern that the response rate is extremely low compared to the national picture; this will be a focus for 2016/17.

Table 12. Friends and Family Test Maternity Delivery recommend rate

	2013/14 (from October 2013)	2014/15	2015/16	National average (2015/16)	National position (2015/16)
WSHFT	96.60%	97.00%	95.70%	96.66%	44th of 138 (32nd centile)
Worthing	94.80%	94.70%	96.60%	96.66%	N/A
St Richard's	97.60%	98.50%	94.80%	96.66%	N/A

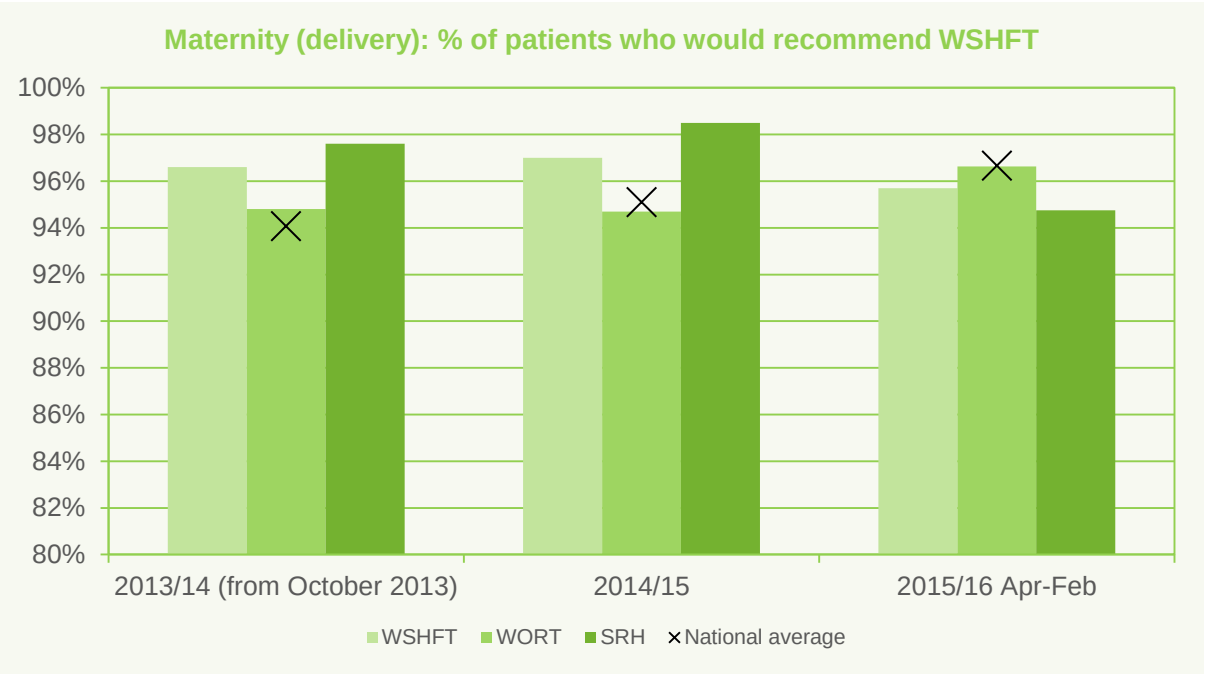
N.B. 2015/16 National figures presented are Apr to Feb 2016 only.

Table 13. Friends and Family Test Maternity Delivery survey response rate

	2013/14 (from October 2013)	2014/15	2015/16	National average (2015/16)	National position (2015/16)
WSHFT	17.00%	29.10%	11.42%	22.85%	117th of 138 (85th centile)
Worthing	13.60%	25.40%	11.35%	22.85%	N/A
St Richard's	20.40%	32.30%	11.49%	22.85%	N/A

N.B. 2015/16 National figures presented are Apr to Feb 2016 only.

Figure 31. Friends and Family Test – Maternity Delivery percentage of patients who would recommend WSHFT



Inpatients

While the Trust is currently exceeding the minimum response rate requirement for inpatients further work is required if we are to achieve our ambition for excellence. We had delivered a significant increase in response rates in 2014/15 but this reduced in 2015/16 (along with the national picture). We have however improved our position from 123rd of 157 (78th centile) organisations to 94th of 176 (53rd centile) organisations. A factor which contributed to this level of performance is that from May this year the results from day cases were included in the inpatient scores. Although this led to a significant drop in response rates it has improved as the year has progressed; we still have some way to go to deliver our target of being in line with national average for all our Trust sites (in particular for St. Richard's Hospital), although we have achieved this for the second part of the year. Our recommendation score, whilst improved compared to our performance nationally last year, still remains below the national average. It must be acknowledged that the national figures compare us to a number of specialist centres, however there are district general hospitals who achieve well above the national average. We want to be an excellent Trust and therefore we must set a clear plan to improve our current below average position.

Table 14. Friends and Family Test Inpatient recommend rate

	2013/14	2014/15	2015/16	National average (2015/16)	National position (2015/16)
WSHFT	92.20%	92.40%	95.22%	95.68%	121st of 178 (68th centile)
Worthing	91.50%	92.10%	94.81%	95.68%	N/A
St Richard's	92.90%	92.70%	95.63%	95.68%	N/A

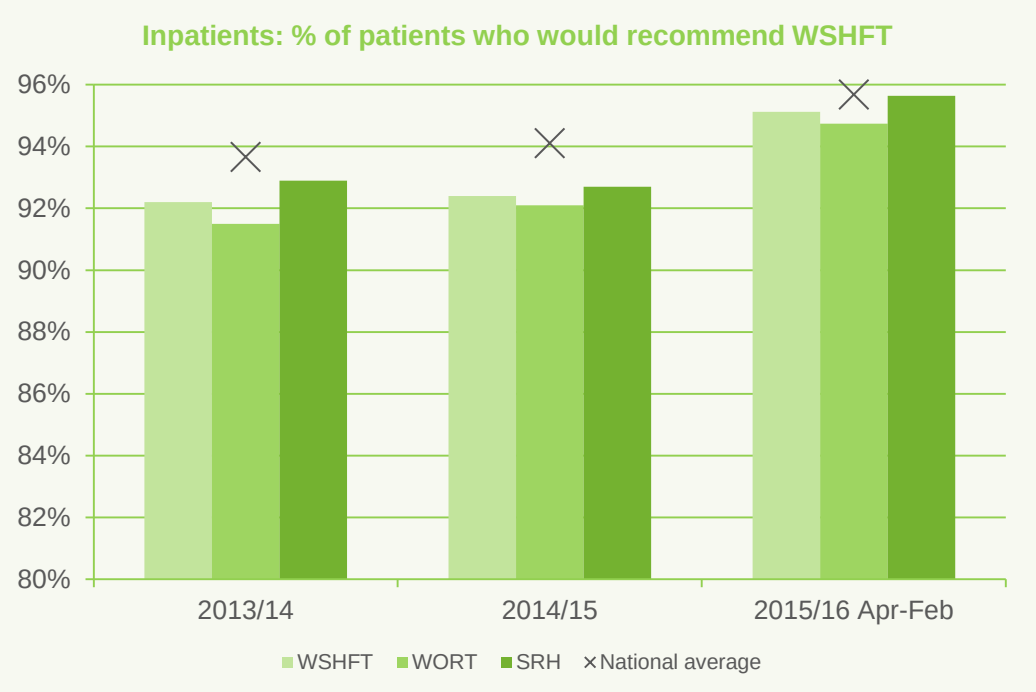
N.B. 2015/16 National figures presented are Apr to Feb 2016 only.

Table 15. Friends and Family Test Inpatient survey response rate

	2013/14	2014/15	2015/16	National average (2015/16)	National position (2015/16)
WSHFT	21.40%	30.70%	26.14%	25.54%	94th of 178 (53rd centile)
Worthing	20.90%	30.80%	29.74%	25.54%	N/A
St Richard's	21.90%	30.60%	25.18%	25.54%	N/A

N.B. 2015/16 National figures presented are Apr to Feb 2016 only.

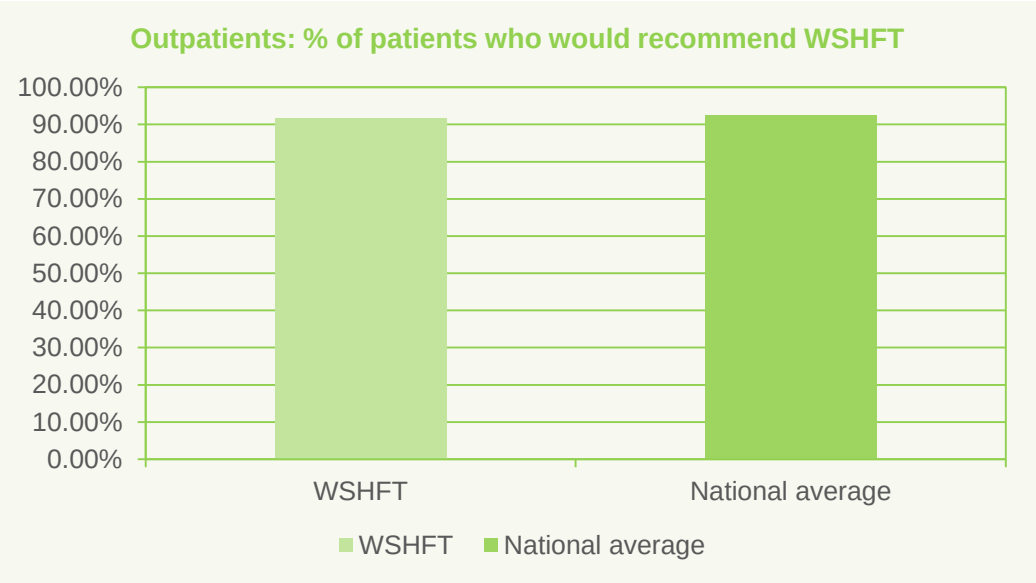
Figure 32. Friends and Family Test – Inpatients % of patients who would recommend WSHFT



Out Patients

The number of surveys completed for outpatients in 2014/15 was not as high as we would have liked with only 785 returns – this was therefore a key priority for improvement during 2015/16. It is pleasing that between April 2015 and March 2016, 10,699 Friends and Family surveys were completed across outpatient clinics, with overall recommendation of 91.6%. Whilst it is very encouraging to see such an increase in engagement in outpatient areas we still have some work to do to deliver our aim of excellence. Our recommendation rate is currently slightly below the national average of 92.3% (data to February 2016).

Figure 33. Friends and Family Test – Outpatients percentage of patients who would recommend WSHFT



N.B. 2015/16 National figures presented are Apr to Feb 2016 only.

Key Quality Improvement Priorities for 2015-16

Last year we committed to delivering further continuous improvement in patient experience through a number of focused quality improvement programmes including:

- **Patient experience improvement programme focusing on: meal-time support, privacy, night time care, information and communication.**

❖ **Streamlining our Feedback Mechanisms**

We have fulfilled our commitment to putting in place a programme to streamline our survey and reporting approaches, ensuring that the Friends and Family Test is embedded in all appropriate feedback collection mechanisms.

We now use the meridian real-time patient experience survey system (RTPE) to capture the majority of our FFT feedback including: SMS[53] feedback for our A&E departments, dementia team post discharge phone calls, all outpatient and day case areas. We still have a dual approach for our inpatient wards; however by April 2016 all feedback will be captured through one survey system. This will allow us to amalgamate results in key areas across a range of surveys.

The difference in care across the days of the week is something that is often highlighted in the national press. There are national standards about this issue (the Keogh standards) one of which is to ensure that patient experience is reviewed dependant on the day and time of admission. In 2015 we put in place an adjustment to the survey that allows us to do this.

We have also put in place TV screens in every ward during the past year which display results for our patient satisfaction, both in hours and out of hours. Ward and departmental leads receive detailed feedback each month, including every patient comment and question score, which enables them to celebrate excellence with their teams and to set local improvement goals for areas identified as being of concern. The ward accreditation scheme which commenced this year requires all areas to show that they are using the patient feedback to make positive changes to improve patient experience.

From April 2015 to March 2016, 22,692 surveys have been completed by patients in many different areas including inpatient wards, outpatients, children's and a number of specialist services. There were some 3,914 responses to the adult inpatient real-time survey during this period.

Our aim for 2015/16

To achieve 84% satisfaction for the following measures regardless of day or time of admission: 'Overall inpatient satisfaction' and 'Do you feel confident and safe in our care?'

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

Key achievements 2015/16

Our aim was to achieve 84% satisfaction for the following measures regardless of day or time of admission, this has been achieved.

Table 16. Key achievements 2015/16

	Mon to Fri	Weekends	Night	Achieved?
'Overall inpatient satisfaction'	84%	84%	84%	√
"Do you feel confident and safe in our care?"	96.5%	97%	96%	√

This is an excellent performance considering current national concerns.

~ Other Sources of Feedback

We have also continued to expand our Care and Compassion programme (called 'sit and see'). This involves staff and volunteers, who have received training in use of an assessment tool, visiting ward areas and observing patient - visitor and staff interactions and scoring every interaction as positive, passive or poor. We have conducted 59 ward / department visits and trained 21 members of staff and governors since April 2015, taking the Trust total observers to 76.

We conducted an external learning disability review in September 2015 following on from the previous year's successful review. This involved members of Sussex Community NHS Foundation Trust together with service users with learning disabilities visiting wards and departments on both sites and reviewing our compliance against key standards. Themes from the previous visit including understanding of mental capacity, lack of picture menus, challenges with signage and way finding were a central focus of this year's review. We received praise from the team who recognised the progress made with improving our staff's knowledge of the Mental Capacity Act. They were impressed with our new toilet signs and the dedication of staff to making adjustments for patients with learning disability. The new

picture menus, although evident, were noted as not being well used; a lack of easy read patient information was also noted. Whilst there have been improvements to our signage there were concerns that there is still much to do. The Learning Disability Steering Group have used this feedback to formulate a full action plan for the coming year.

~ Meal- time Support

Despite the introduction of Dining Companion's Scheme in 2013 we have unfortunately seen a downward trend in the satisfaction for mealtime support in the 2014/15 national survey to 71. This was also reflected in the carer's survey scores and 'sit and see' observations that were conducted at mealtimes. During the past year we have made considerable efforts to try to increase the number of volunteers assisting our patients at mealtimes. This includes the 'Let's Do Lunch' campaign where non-clinical staff -volunteer at lunch time. We also made a successful bid for funding through Nesta[54] with the Department of Health to try to increase the numbers of young people volunteering in our Trust. Since the project commenced in May 2015, we have recruited an additional 163 young people, the majority of whom provide mealtime assistance.

We have monitored our performance with our real time surveys throughout the year and are pleased that we have sustained a satisfaction score of above 90% both in our inpatient survey and the carers' survey. This has not been reflected in our score for the national survey where we only achieved a score of 69. Mealtimes remain a key focus for us for the coming year.

~ **Privacy**

Our aim for 2015/16 was to be a top performing Trust for privacy. We launched our 'Do Not Disturb' curtain pegs in April 2015 and have used the ward accreditation scheme to require wards to identify a private area for breaking bad news. We commenced a programme to replace our curtain stock with disposable curtains in November 2015 and have used the 'sit and see' programme to continue to monitor and challenge privacy across our wards and departments.

We monitored our performance for privacy through the year using our real-time survey system and achieved a satisfaction score of 85% which was our goal (although we did not achieve this consistently each month dropping to 81% at times). The National Patient Survey

[54] http://www.nesta.org.uk/

scores have shown further improvement with 96 scored for privacy during examination and 87 scored for privacy during discussions.

~ Night time care

Whilst we had seen an improved satisfaction in 2014/15 for noise at night caused by patients, scoring 58, we aimed to go further in 2015/16 with a number of actions. During the past year we have used the ward accreditation scheme to monitor the implementation of the Trust welcome pack which contains eye mask and ear plugs. We have also introduced soft closure bins to areas which did not have this in place. We have conducted a set of night time ward visits using the 'sit and see' tool to provide direct feedback to staff. The Director of Nursing has reviewed night time staffing levels and increased staffing establishments where it was found that the staffing model was not correct for the dependency of the patients. We also conducted a detailed review with patients to try to get a better understanding of the causes of night time noise. Overwhelmingly we have been told that it is other patients who are the source of the majority of disturbance with 89% patients stating that they felt that staff were doing everything they could to help reduce noise. The dementia team has put in place training for staff to help them practice the skills they need to care for patients with delirium. The night-time moves of any patients with dementia have also been closely monitored and challenged by the dementia team as part of the dementia CQUIN.

Our aim for the year was to improve satisfaction score as measured using the real-time patient experience survey to 70% (baseline = 36.7% of patients reporting they are disturbed at night) and to reduce night-time ward moves for patients with dementia as monitored by the dementia CQUIN[2]. We have achieved 63% satisfaction for the year which is slightly higher than the national patient survey score of 56%. This work will continue to be a key workstream in the coming year.

~ Information and communication

The national patient survey, real-time surveys and comments from our Friends and Family Test results show communication and information continues to be a challenge. The most common areas of concern for inpatients relate to pre-operative information, involvement in decisions about their care, discharge planning and medication.

[2] Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2014/15 and for the following 12 month period are available electronically at: http://www.westernsussexhospitals.nhs.uk/wp-content/uploads/2014/08/CQUIN-Goals-2014-15.pdf

During 2015/16 we put in place a number of actions to try to improve our performance. Initiatives include:

- a full action plan led by pharmacy to try to improve information about medication,
- standardisation of ward boards and handover
- end of bed information folders
- purchase of the easy read package that allows quick access to a wide range of patient information leaflets
- Review of pre-op information with the Stakeholder Forum[55]
- Pre-op services review by surgery
- Introduction of comprehensive patient discharge booklet
- Dementia team using post discharge phone calls to ensure carers have the expected access to support
- 'Lavant Leapers' improvement project to improve multidisciplinary approach to proactive discharge planning
- Patient information a core element of the ward accreditation programme

In the 2015/16 national inpatient survey we have seen some improvement in scores in key areas; scoring 76 (72 in 2014/15) for involvement in decisions about care and 71 for patients being involved in discharge decisions (68 for 2014/15). It must be noted that the results discussed in this report are based on the report produced by the survey company that conducted the survey on our behalf. The full CQC report is not yet available and so we are not able to conduct a full comparison with other Trusts across the NHS. As discussed earlier we have seen an encouraging improvement in some elements of information about medication although there is still much to be done in this area. We used the real time survey system to monitor our performance through the year with challenging targets for improvement in the three questions relating to information. We delivered satisfaction scores as follows:

- Involvement in decision making: above 85% (goal 85%)
- Involvement in discussion about discharge: above 60% (goal 70%)
- Explanations about medications: above 88% (goal 90%)

We also aimed to improve our satisfaction for pre-operative information in the 2015/16 national survey. There are a number of questions relating to pre-operative information, the

[55] http://www.westernsussexhospitals.nhs.uk/your-trust/members/getting-involved/stakeholder-forum/

question concerning explanation of risks and benefits scored 87 which is slightly under our 90% goal. The question about explanation of how pain will be managed has shown a significant drop of nine points scoring 83 compared to 92 last year. Understanding why this scored so poorly and putting in actions to improve our performance in this area will be a key goal for the coming year.

~ **Out-patient Experience**

We delivered our main aim for 2015/16 which was to gather more feedback in outpatients to help us to understand our challenges. We have worked with our stakeholders to identify opportunities for improvement including conducting regular 'sit and see' visits across our clinics. The customer care service lead has worked with teams to support them to improve their communication and to demonstrate a caring and compassionate approach. Our aim was to improve the welcome by reception staff, improve the information given to patients about what will happen in the department and to improve information about waiting times. Due to only a small number of patients (606) completing the more detailed questionnaire we have not had a sufficient cohort in order to monitor the specific goals effectively using this approach. However our care group managers and outpatient nursing leads have received monthly reports detailing every comment in addition to the Friends and Family score. This has enabled teams to celebrate their successes and respond to the issues highlighted by patients at a local level. We know that our most common areas for concern are access, patients tell us that they often struggle to find the right person to talk to when there are issues with their appointments; waiting times and information about waiting times when in the department.

Our improvement priorities for 2016/17

Our priorities for 2016/17 reflect the workstreams that we have commenced in 2015/16, building on improvements and doing further work to understand why we have not delivered on improvement targets in some areas. A key element of the work will be to understand and address local variations in experience, with wards and departments learning from each other's successes. This work will be delivered through the Patient First Programme using quality improvement methodology to ensure staff delivering frontline care are fully involved in developing improvement initiatives.

Our broad workstreams are as follows:

- Improving patient experience of discharge
- Reduction in delays in discharge
- Improving mealtime support / nutrition

- Improving privacy / provision of private areas
- Improving communication with a particular focus on access and outpatients. This will include preoperative assessment.

Our performance will be monitored using the Friends and Family Question with the requirement for all wards and departments to show that they are reviewing and acting on their individual themes.

We have set a True North Trust-wide long term goal to achieve 98% recommendation for Friends and Family Test feedback and a 0% 'unlikely to recommend' feedback with a response rate of greater than 50%. Departments will have different aspects to focus on depending on their patient experience concerns.

PALS and Complaints Service

The Customer Relations team (Patient Advice and Liaison Service (PALS) and complaints team) provide advice on how and where to complain, investigate matters of concern and help facilitate a resolution when things have gone wrong. PALS carry out signposting, provide information, advice or reassurance and manage issues that can be resolved quickly, assisting patients / relatives who need time to discuss concerns. They also 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.

- The Customer Relations team has dealt with 12,595 patients, relatives, visitors, carers and other service users during the year to date.
- In 36% of cases, we helped put things right via our PALS service within one working day.
- 59% of enquiries were on the spot general advice and information requests.
- 5% of all enquiries required a formal investigation under the NHS Complaints Procedure.
- None of the formal complaints received in 2015/16 have yet been referred to the Parliamentary Health Service Ombudsman (PHSO) for independent review by the complainant. However there were 28 cases referred to the PHSO relating to complaints made in previous years. Of these 25% have not been upheld, 46% are still under review and 29% were upheld.

~ Positive outcomes / lessons learnt

We are aware that the number of issues around appointments has risen over the recent years, some of this is related to a significant increase in specialties such as ophthalmology where the criteria for referral has changed and our capacity to see patients has not grown at the same rate. The stream of work within our transformation project in ophthalmology, which began in 2014/15, includes outpatient appointments and has seen the number of complaints and concerns gradually decrease during 2015/16.

In addition, the Trust is implementing a number of further improvements as a result of PALS enquiries and formal complaints throughout the year:

We have recently introduced a 'Do Not Move Policy' which will ensure that the sickest patients and those nearing the final stages of their life are only moved once all other options have been carefully considered.

The antenatal clinic has changed the clinic letter template to include an address and explanation as to why treatment is required. In addition, the letters will now be sent electronically to GPs to improve the new process.

We are preparing junior doctors for difficult conversations such as delivering significant news and discussion regarding DNACPR and introducing structured teaching in the form of medical simulation for exactly these circumstances.

A more robust system has been put in place for patients discharged on new anticoagulation medication to indicate that a formal referral to the anticoagulation service needs to be made.

Following a complaint made about confusion over the plans for a patient's follow up in cardiology, changes have been made to the format of the appointment letter with the nurse led cardiac clinic.

~ Further detail

Table 17. New and closed cases

	2012-13	2013-14	2014-15	2015-16
PALS cases	2,807	3,149	3,627	4582

Informal enquiries	4,089	5,110	8,939	7426
New formal complaints	565	522	574	587
Praise	5,010	4,574	4,385	3,823

Table 18. Formal complaints received by site

	2012-13	2013-14	2014-15	2015-16
Worthing	336	337	349	344
Southlands	19	7	11	9
St Richard's	210	178	214	234
Total	565	522	574	587

Table 19. PALS Enquiries received by site

	2012-13	2013-14	2014-15	2015-16
Worthing	1,100	1,443	1,597	2219
Southlands	63	36	67	18
St Richard's	1,643	1,674	1,963	2345
Not site related	2	-	-	-
Total	2,808	3,153	3,627	4,582

Table 20. Top five enquiries (PALS & complaints) received by category

	2012-13	2013-14	2014-15	2015-16
Communication	789	834	993	1568
Appointments	605	882	1092	1088
Clinical Treatment	791	832	769	965

Attitude of Staff	183	222	269	327
Date of Admission	285	174	245	303

Table 21. Formal complaints referred to the Parliamentary Health Service Ombudsman

	2011-12	2012-13	2013-14	2014-15	2015-16
Declined/not upheld	13	12	13	5	7
Further local resolution taken by the Trust	1	4	2	-	-
Upheld/recommendations (partially or in full)	1	-	2	2	8
Decision awaited	-	-	-	10	13
Total	15	16	17	17	28

Key Quality Improvement Priorities for 2016-17

Improving patient experience:

- **Improving patient experience of discharge**
- **Reduction in delays in discharge**
- **Improving mealtime support / nutrition**
- **Improving privacy / provision of private areas**
- **Improving communication with a particular focus on access and outpatients**
- **Improving experience of young people receiving care across the Trust through the Children's Board recommendations**

2.1.5.2 Patient First in action

A touching tribute paid by staff at Worthing Hospital to a young boy who died from leukaemia is proving inspirational for healthcare providers across the NHS and around the world.

Harvey's Gang

Harvey Buster Baldwin, who passed away on October 6, 2014, has been honoured by giving his name to a new blood grouping machine at the hospital. That simple act has precipitated a remarkable chain of events that will see life-saving equipment now named after the patients it helps all across Europe, the Middle East, and Africa.

Harvey first became ill with acute myeloid leukaemia aged six and, over the next 20 months, his battle with cancer saw him spend many weeks in hospital. Much of his care at Worthing Hospital concerned the delivery of life-saving blood products for which he and his family would have to wait while they were processed safely. Harvey was curious about what happened to his blood once it vanished into the vacuum tube which shoots samples straight to Pathology, so the children's ward arranged for him to visit the haematology laboratories. "He really enjoyed his tour," said his mum, Claire Baldwin. "He brought in his own blood and processed it from start to finish, wearing a little lab coat with a trainee biomedical scientist badge, which he loved." His dad, Richard, added: "To give him that insight was absolutely marvellous and it made him, as well as us, understand why it takes so long to process blood."

A year later the department heard that Harvey had lost his battle with leukaemia following four months of remission thanks to a bone marrow transplant from his brother. In honour of Harvey they resolved to name their newest machine after him and, on 6 November, 2014, Claire and Richard Baldwin were invited to unveil at Worthing Hospital the world's first ORTHO Vision Analyser blood grouping machine.

The couple were humbled to hear a pledge from the machine's manufacturers to name the first 100 new machines sold in Europe, Middle East and Africa after patients. Collectively the patients, their stories and the machines would be known as Harvey's Gang.

Claire said: “We are so honoured and proud that not only will Harvey’s memory be kept alive at Worthing Hospital, but now he is leaving an international legacy.” Richard added: “To know that some good has come from all this is just brilliant – Harvey’s legacy is leaving positive things behind to enlighten other children and staff.”

More critically ill youngsters are now enjoying trainee scientist tours with their families at Worthing Hospital, wearing special mini lab coats with personalised badges made by hospital staff that explain they are part of ‘Harvey’s Gang’.

The tours also have a dramatic impact on the scientists at work, refocusing their drive and reminding them that every vial of blood they process represents a child or a patient in need of their help. Similarly, the decision to name a machine after a patient and having a photograph of someone like Harvey proudly displayed also puts the patient right in the heart of essential support services which take place behind the front line.

Welcome Home Packs

Welcome Home Packs have been introduced to provide frail and isolated patients with enough food and drink to ensure they do not have to worry about their first 24 hours back at home.

The contents are being provided by Morrison’s, Sainsbury’s, Tesco and Waitrose supermarkets in Worthing. The packs, containing essentials like milk, bread, cheese and fruit, ensure that patients in need of extra support have a few supplies for their first night back home.

Discharge can be stressful and worrying for some patients and the Welcome Home Packs address a very basic need, making sure they will have food nearby.

Welcome Home Packs are being piloted at Worthing Hospital from September 2015 before the scheme is rolled out to St Richard’s in Chichester.

Cardiac buddy service

The WSHFT Cardiac Rehab Team work in partnership with a local Charitable Trust to provide our patients with a cardiac buddy service. We currently have around 24 buddies registered as hospital volunteers; all have been diagnosed with a heart condition and have completed the Cardiac Rehab Programme. We also have some carer buddies who can share experiences of what it is like to care for a person with a heart condition.

Buddies attend our regular information sessions provide valuable reassurance and support to patients. The cardiac rehab staff provide education about managing their long term condition, and between the talks, patients can discuss their concerns over a cup of tea (provided by the charity). All this takes place in a non-clinical setting – a community leisure centre - where there is also access to the cardiac rehab staff if there are any concerns the buddies are unable to deal with. We have developed these sessions over a number of years, in response to patient feedback which is always very positive and highlights the difference this service makes to their recovery.

We also have buddies working alongside us on the wards and at all our exercise classes. The charity also funds a helpline for patients to call if they are unable to get to our sessions.

Rehabilitation in critical care

Respiratory Physiotherapists from Western Sussex Hospitals initiated a regional peer group of physiotherapists, expanding to include other allied health professionals (AHPs) within critical care. The group initially reviewed rehabilitation in critical care across the network and went on to develop the Sussex Rehabilitation Pathway in response to NICE guidelines and to ensure a consistent approach across the region.

Benchmarking practice through action research led to:

- Robust inpatient pathways
- Follow-up clinics and patient support groups
- Individual trusts developing documentation to ensure compliance with NICE guidelines
- Initiation of multi-disciplinary team meetings – for joint goal setting and co-ordinated rehabilitation plans
- Reviewing outcome measures and audit tools

The introduction of an in-patient pathway for critically ill patients, alongside a specialist member of staff facilitating the process, has ensured that all intensive care unit (ITU) patients receive the same high quality care after transfer to the ward setting including goal setting, action plans and full involvement of the MDT. Transfer from ITU to the ward environment can often be the most difficult part of a patient's journey due to the complex, and at times, distressing nature of their hospital stay. Having a consistent point of contact and an advocate for their complex needs helps them to feel supported and understood during the transition phase.

The introduction of formalised multi-disciplinary meetings has created an opportunity for the MDT to establish co-ordinated rehabilitation goals and action plans to ensure that this is on every staff member's agenda. This creates a focus for everyone to work together in the aim of facilitating the most rapid and most optimal recovery.

The patient is contacted once discharged home and is offered further physiotherapy and follow up to enable them to return to as much of their previous life as is possible. This means that the quality and extent of a patient's physical and mental recovery is enhanced, going beyond basic survival and discharge from hospital.

The formation of this network has also enabled us to cultivate links with specialist AHPs throughout the region, enabling learning and information sharing to help continually develop practice and improve patient care. Through this process we have been able to promote the role and importance of rehabilitation to the wider critical care network.

Urology outpatient service with investigation clinic

The urology service has a high degree of outpatient demand. Before the introduction of this model (October 2014 at St. Richard's Hospital and October 2015 at Southlands Hospital) patients would have to attend multiple appointments before receiving a diagnosis and possible treatment options. The urological pathway is such that patients may require a flow rate, a flexible cystoscopy, plus ultra sound of their bladder and or kidneys. These diagnostic tests used to occur on separate visits for patients, as well the need for them to attend a new and follow-up appointment with a Consultant or Registrar.

The team explored creative solutions to reduce demand on the service and improve the patient experience. Following review of best practice and visiting other Trusts, a new model was designed – called the Outpatient with Investigation Model (OPI).

The OPI clinic brings together a multi-disciplinary team enabling the patient to have their initial consultation, required diagnostics and diagnosis with a discussion regarding treatment options, all within an outpatient environment.

Over the past year, over 1,100 patients have experienced the OPI clinic at St. Richard's Hospital. Of these, 25% have been discharged at that appointment and 15% have been placed on the waiting list for surgery. The overwhelming majority would have had at least one diagnostic test, reducing unnecessary visits for patients by at least half, and increasing capacity in the team to see more patients. We have also implemented 'live typing' whereby clinics letters are typed in real time so there is no delay in informing the GP about their patient's management.

The service at Southlands Hospital (covering the population of Worthing and Southlands) started in October 2015. Over 120 patients have used the service, with 30% either being discharged or added to the waiting list.

There are patients who require a CT, MRI or other diagnostics that unfortunately cannot be provided on the day. We have recently been piloting a virtual results clinic for this group. Traditionally, these patients would be automatically booked into a follow-up slot after their diagnostic. Two consultants at St. Richard's Hospital are trialling reviewing the image, patient record and clinic letters virtually. This pilot is still in its early stages, but the indication is that 80% of patients are able to be reviewed and next steps agreed by this method, saving them both time and a reducing their wait. The key to success is clearly explaining the process to patients at their initial consultation and to date, we have received no negative comments from patients about the service. We hope to implement this method across the Trust in the near future.

Increasing opportunity for patients to participate in high quality clinical research

During the last year reconstructive surgeons at the Trust have led pioneering research for patients suffering from stoma care problems by implementing a commonly used breast surgery technique. Consultant Breast Surgeon, Mr Riccardo Bonomi, led the research with the aims of improving quality of life for patients and avoiding major surgery. The procedure, called lipomodelling or 'fat transfer', uses a minimally invasive technique to reduce stoma leakages caused by peri-stomal skin contour abnormalities.

"It has completely changed my life"

Some patients suffering from serious bowel or bladder problems, such as cancer, inflammatory bowel disease, diverticulosis or faecal incontinence, may require surgical treatment followed by formation of a stoma to manage their condition. It's estimated that over 100,000 people in the UK alone have a stoma.

"Every aspect of my life has been improved" "Much happier more accepting of my stoma"

Stomas divert either faeces or urine through their opening in the abdominal wall to an external pouch on the outside of a patient's body. The effectiveness of these pouches is largely dependent on how well they seal: uneven skin surface around a stoma can result in management problems like leakage of stool, skin trauma, soiling of clothing, poor quality of life and frequent change of stoma appliances. Stoma management costs also increase due to additional stoma nurse care and use of additional stoma appliances. Stomas can be re-sited to try and improve symptomatic problems, but this may require major surgery which is likely to be difficult and potentially bowel-damaging due to scar tissue from initial operations.

Mr Bonomi and his team have performed lipomodelling on six patients suffering with leakage problems related to a permanent stoma. The research provides early evidence that lipomodelling is feasible, safe and beneficial in patients with stoma problems. There is evidence to suggest that quality of life can be improved by reducing the leakage from the stoma bag leading to less soiling of clothes and less frequent stoma bag change.

"Definitely recommend other patients get involved in research projects"

The research team are now in the process of applying for external research funding to expand the study to a gold standard randomised controlled trial.

research changed my life

2.1.5.3 Improving staff experience

Goal: Achieve top 20% of NHS trusts in country – NHS Staff Survey engagement score

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Why is it important?

It is well recognised that engagement of staff is a factor in job performance. Borrill, West, Shapiro and Rees (2000)[56]; Harter, Schmidt and Hayes (2002)[57]; Boorman (2009)[58]; West and Dawson (2012)[59] demonstrate that good engagement leads to improved quality, mortality and safety measures including improved infection rates, productivity, staff absence and turnover, patient and staff satisfaction.

How do we measure it?

The national NHS Staff Survey assesses the quality of staff experience through a number of questions linked to the NHS Constitution. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their Trust) and 5 indicating that staff are highly engaged.

How do we report it?

NHS Staff Survey data is reviewed by the Trust Board and Trust Quality Board, a breakdown of data is provided by survey question to Clinical Divisions for celebration or improvement action.

Where are we now?

For 2015/16, the Trust's staff engagement score was similar to the national average of 3.79, at 3.78. This is a composite score that includes how motivated staff feel, how confident they are in the services we provide, how they feel about working here and the extent to which they can affect and implement improvements.

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[56] Borrill, C.S., West, M.A., Shapiro, D. and Rees, A. (2000). Team Working and Effectiveness in Health Care.British Journal of Health Care Management. Vol 6, No 8.

[57] Harter J.K.,Schmidt F.L., Hayes T.L (2002) Business-unit level relationship between Employee satisfaction, employee engagement and business outcomes – a meta-analysis (2002) Journal of Applied Psychologgy Text. Vol 87 No 2.

[58] Boorman, S. (August 2009) NHS Health and Wellbeing Review, Interim Report. Department of Health

[59] http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf (accessed: 31 October 2014)

The Trust Board has agreed that staff engagement is the 'True North' objective for how we deliver the 'Our People' element of the Trust's vision. We have set a target to be in the top 20% of acute trusts next year; our aim is to be the top performing acute trust.

We have deconstructed the elements of our staff engagement scores in order to understand how, in which areas, and with which staff groups, we most need to focus on improving engagement.

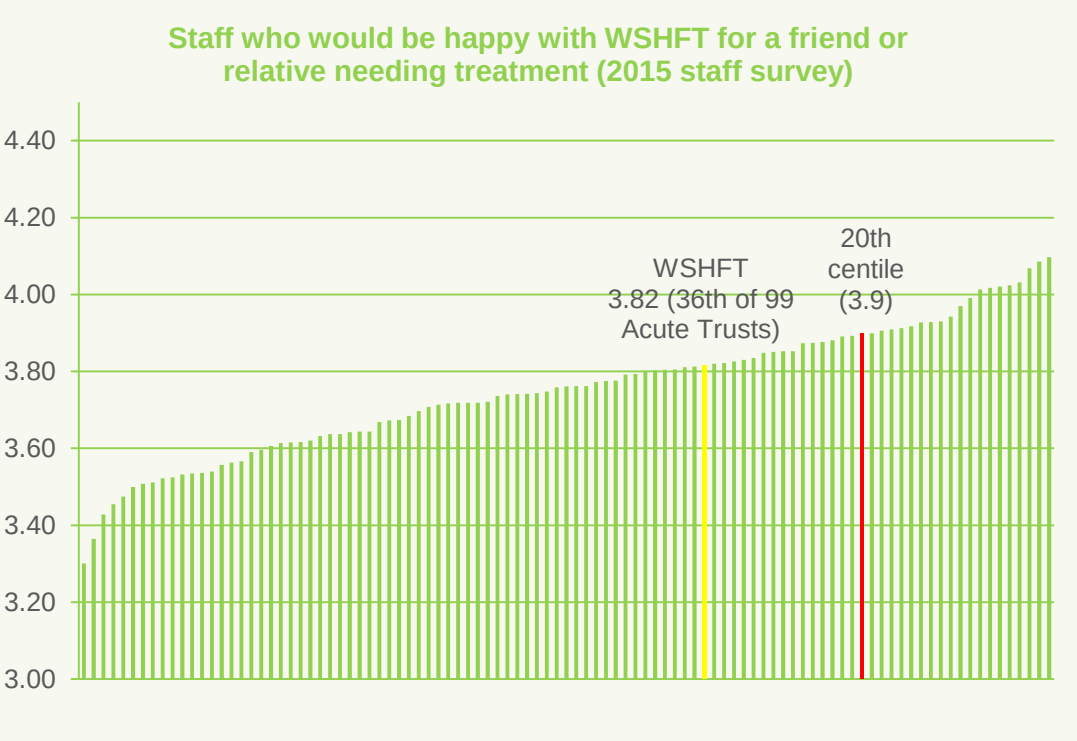
Whilst we will develop these priorities with staff focus groups, we have identified as a breakthrough objective (i.e. an objective that can be translated across all staff groups) that we will increase the number of staff who feel they can make improvements in their area of work. We are currently developing the action plans to support this and the methodology for monitoring success.

Table 22. 2015 NHS Staff Survey results WSHFT

		Your Trust in 2015	Average (median) for acute trusts	Your Trust in 2014
Q21a	"Care of patients / service users is my organisation's top priority"	**77**	75	73
Q21b	"My organisation acts on concerns raised by patients / service users"	**73**	73	72
Q21c	"I would recommend my organisation as a place to work"	**65**	61	63
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	**71**	65	73
KF1	Staff recommendation of the trust as a place to work or receive treatment (Q21a, 21c-d)	**3.82**	3.76	3.77

Source: 2015 NHS Staff Survey

Figure 34. 2015 Staff Survey – Staff who would be happy with WSHFT for a friend or relative needing treatment



Key Quality Improvement Priorities for 2015-16

Last year we committed to delivering further continuous improvement in staff experience through a number of focused quality improvement programmes including:

- **Staff engagement events**
- **Extending staff health and wellbeing programmes throughout 2015/16**
- **Roll out of Schwartz Rounds**

Improvement programmes for 2015/16

❖ Improving staff engagement

Our goals in 2015/16

In 2015/16 we committed to a number of staff engagement events to increase staff engagement.

Key achievements 2015/16

Over the last year the Trust has held a range of engagement events including Patient First open sessions with the Chief Executive Officer (CEO), Quality Time open sessions with the Director of Nursing and large staff recognition events such as our annual thank you lunch where staff enjoyed a complimentary lunch and were encouraged to talk about areas where the Trust could do better. We were delighted with the engagement of staff at our recent CQC visit where extra feedback sessions were held as so many staff wanted to talk to inspectors about the work of their teams in improving patient care.

The Surgical Division continue to work hard at improving medical engagement across their staff. This has been strengthened by the appointment of five new Clinical Directors in the Division who have worked hard at improving integration and flow of communication across the Divisional Care Groups. A key area of focus for the Division going in to 2016/17 will be how the Division can feedback more effectively the governance agenda to their consultants. Examples include learning from incidents in specialties which may be a different discipline for a consultant, complaints, work on-going to improve performance and the management of risk across the Division. Early indicators are that improvements have been made in many areas.

Particular focus has been on the engagement of estates and facilities staff. Forums for staff have been set up and engagement approaches are currently being reviewed.

Achieving the highest levels of medical engagement is a priority for the Trust and a Medical Engagement Strategy and Action plan are in place following concerns raised by the Medical Engagement Scale (MES) survey in 2014. The priorities in the action plan have been linked to those identified by medical staff in the MES and a subsequent extensive listening exercise undertaken by the CEO and Medical Director.

The priorities are:

- Improve communication and visibility of clinical leaders
- Improve transparency of strategic decision making
- Support doctors to improve services.

Good progress has been made with the action plan and in 2015 monthly evening off site meetings were established for consultants to foster good communication and discuss Trust strategy. These have been well attended and a very successful joint meeting held with the GPs. Additional lunch-time meetings have been held with the CEO and Medical Director for the individual divisions.

Improvement plans for 2016/17

The Divisions have developed their own medical engagement action plans and in 2016/17 the MES will be repeated to ascertain whether levels of engagement have improved.

❖ **Extending health and wellbeing programmes**

Our goals in 2015/16

It is recognised that caring about staff health and wellbeing is a fundamental component of staff engagement, with mental health and stress related absence a major contributor to sickness absence in the NHS. We understand that for staff to deliver high-quality care they must be healthy and emotionally resilient themselves and they must be supported to cope with the demands of their work. Our health and wellbeing strategy includes the development of annual improvement plans.

In 2015/16 we aimed to extend our Health and Wellbeing Programmes for staff.

Key achievements 2015/16

During 2015/16 we have successfully implemented a number of programmes including:

- We continued to run a staff physiotherapy service to reduce musculoskeletal injury,
- We designed and implemented Mindfulness and stress management training for staff and managers to improve emotional resilience,
- We ran an annual flu vaccination programme,
- We introduced a weight management programme,

- We delivered a range of wellbeing events for staff – exercise tasters – yoga, Pilates and 'Zumba', try-a-bike sessions, healthy eating and lifestyle roadshows, sing-a-long stress busters and massage to name a few.

Improvement plans for 2016/17

In 2016/17 we will focus on:

- Introducing and promoting physical activity schemes for staff
- Improving support for emotional wellbeing
- Continuing to offer a staff physiotherapy service
- Working to improve uptake of flu vaccination for frontline staff

We will continue to support the management of sickness absence through professionally recognised best practice. This will include early identification and intervention by managers when there are changes in behaviour, return to work interviews for every episode of sickness absence and formal action when an absence trigger is reached.
We continue to focus on reducing sickness absence, which was 3.84% in 2015/16.

❖ **Roll out of Schwartz Rounds**

Our goals in 2015/16

Last year we committed to rolling out Schwartz Rounds. The purpose of a Schwartz Round is to allow all staff clinical and non-clinical a safe place in which to share the impact of, plus challenges and experiences of delivering services in a hospital setting. The rounds are open to all staff - there is no need to book and they are completely confidential. Lunch is also provided so that no one misses out by attending the round.

Supported by facilitators many of each audience gather and then share how a lead story makes them feel. Staff are able to share some of their own experiences as well as empathising with the colleagues who have shared their stories.

Schwartz Rounds take place on alternate months at St Richard's and Worthing Hospitals sites. Schwartz Rounds are part of an ongoing provision that will become part of hospital life.

Key achievements 2015/16

Ten Schwartz Rounds have been delivered with five themes being repeated on each site:

- 'You see a lot in this Job'
- 'I've only got one pair of hands'
- 'When the system fails'
- 'A day I'll never forget'
- 'When care meets conflict'

Feedback from our Schwartz Rounds has been extremely positive:

- "A powerful experience which should continue"
- "I thought that the panel were very brave to discuss their experiences – not sure I could have done it myself"
- "Really Powerful"
- "Very moving and enlightening. Gave a powerful insight into issues affecting colleagues in all walks of NHS life"
- "Very inspiring – important work for the Trust to do to improve the culture of care and compassion for patients and staff"
- "Good to share and see the human factors"
- "Speaking up makes a difference"
- "Very good to listen to people's experiences good and bad!"
- "Thank you it is really useful to hear others experiences and how they have stayed with them – I am not alone"
- "Very open (rewarding), courageous work by all concerned & fantastic, thank you all"
- "Very emotional and thought provoking"
- "Really gave me an insight into how the hospital works outside the non-clinical areas"

The rounds have also been observed by an individual mentor from the Point of Care Foundation who described the rounds as:

- "It was apparent that efforts had been made to maximise attendance through posters, leafleting and visiting wards and departments. The round was held at 4.30pm, an unusual time for a Round, but to try and capture attendance by clinical staff. It showed that the steering group are doing everything they can to try and promote Schwartz Rounds"
- "The introduction was professional, managing to expertly cover all aspects. Textbook"

- "The round up after the presentations was excellent. Although Rounds have not been held at this and their sister site for long the facilitators gave a master class in how to conduct a round, effortlessly sharing the responsibilities for guiding the discussion"
- "The steering group are thinking a great deal and trying hard to maximise attendance across two sites and to capture all staff groups"
- "On this occasion the panel were pre-prepared, but only met as a panel just before the round"
- "A discussion on the nature of dealing with complaints and the pressure of incessant emails was relevant to the discussion"
- "It is clear that the administrator and facilitators and undoubtedly other members of the steering group who I did not meet are working hard to promote Schwartz Rounds"
- "The 'talking heads' video that went across the Trust involving members of staff and the leaflet 'What is a Schwartz Round?' are excellent"
- "The facilitators are very professional and with the administrator show great commitment to Schwartz Rounds. A force for good"

We have now trained an additional Clinical Lead / Facilitator to support the continued deployment of Schwartz Rounds. The Schwartz Round Steering Group will come under the stewardship of the Health and Wellbeing Group who represent a wide group of Trust colleagues, departments and services.

Improvement plans for 2016/17

Over 2016/17 we will develop the range of Schwartz Round themes and increase attendance from hard to reach groups not strongly represented, including colleagues from facilities, estates and capital as well as clinical colleagues on ward and department environments. We will also increase the number of available speakers from which to draw Schwartz Round panels.

❖ **Western Sussex Ambassadors**

Ambassadors are employees of the Trust from across all directorates, departments and at all levels who have demonstrated a commitment and enthusiasm towards creating positive experiences for the people that they meet whether it's patients, visitors, members of the public or colleagues.

Ambassadors stand out among their colleagues in their positive attitude and behaviour, being proactive in their offers to help others and facilitate. An Ambassador is a person who demonstrates a problem solving approach in their work, not waiting for someone to come and ask for help but instead being forward in offering assistance to others.

Ambassadors come from a wide range of backgrounds and job roles. We currently have Ambassadors from facilities and estates, nursing and medicine, human resources and learning and development, access and service change, midwifery and children's services, core services, patient experience, communication, patient liaison and many others.

As well as being outstanding role models and helping people in their everyday work, Ambassadors have been extremely active in supporting the Trust to raise the profile of creating a culture of positive experiences. Ambassadors have been represented both at the Trust Patient First STAR Awards[60], where they shared information with colleagues about the Trust's commitment to customer care, and at the staff conference where they facilitated group activities and discussions promoting engagement and involvement around key learning activities for the Trust.

Ambassadors have also been actively involved in supporting initiatives around improving patient experiences including volunteering for the 'Meet and Greet' host roles and volunteering for the 'Let's do Lunch' Dining Companion project. Ambassadors have also helped in the design and delivery of the Western Sussex Way Training programme which has met with huge success and interest across the organisation. Ambassadors have actively been involved both with the design of resources and also with facilitating parts of the training itself.

Key achievements 2015/16

[60] Our Patient First STAR Awards are an annual opportunity to say a special thank you to a member of staff, team or service you feel deserves to be singled out for particular praise.

2015/16 has been a very busy year for the Ambassadors with involvement in the following key areas:

- Facilitation and support at two staff conferences (September and November 2015)
- Support at Patient First STAR Awards
- Support and engagement for the CQC visit including mock assessments and engaging with inspectors
- Attendance and promotion of Health and Wellbeing events
- Involvement in way finding for users of hospital services
- Involvement in 'Sit and See' patient experience visits
- Supporting staff recognition events including the annual staff thank you lunches
- Attendance at Patient First roadshows and conferences
- Buddying with new overseas colleagues
- Supporting specific customer care initiatives
- Co-facilitating on Welcome Day induction programme for new staff
- Supporting delivery of Western Sussex Way customer care programme

There are now 96 Ambassadors from across the organisation.

Improvement plans for 2016/17

Over the next year we will:

- Continue the growth of Ambassador representation
- Increase public and internal recognition and understanding of the Ambassador role
- Enhance and develop the potential areas of Ambassador involvement.

Key Quality Improvement Priorities for 2016-17

Workforce Transformation Programme

The Trust's attention in 2015/16 also focused on increasing our workforce and reducing reliance on temporary staffing, ensuring access to safe services for patients. This will remain a top priority in 2016/17 and beyond.

We have had some success in recruiting staff through both domestic and international recruitment campaigns in 2015/16. We have also done some detailed analysis of turnover, leading us to focus on recruits in their first year / few years and increasing the support

available to this group of staff through 'stay interviews'. We will build on this work over the coming year.

The Trust has made significant progress in improving recruitment to address key gaps in the Medical Workforce including in Anaesthetics, Ophthalmology, Radiology and the Nursing Workforce. This work needs to continue in 2016/17 and the Trust also needs to respond to the heightened control environment that will be in place to drive a reduction in agency expenditure.

Safer Staffing

It is recognised that to deliver safe and effective care to patients there is a balance of staffing numbers and skill mix that is required. Currently we supplement unfilled shifts due to vacancies with agency and bank staff. We are however undertaking a recruitment programme that aims to ensure we have a substantive workforce that is sufficient to meet patient demand and patients' needs.

A report is presented to the Board twice a year on a review of ward establishments as directed by the National Quality Board (NQB). This report covers all nurses on adult and children's wards and midwifery requirements. The NQB has stipulated that; 'Boards must take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability'. This requirement came following a number of national reports.

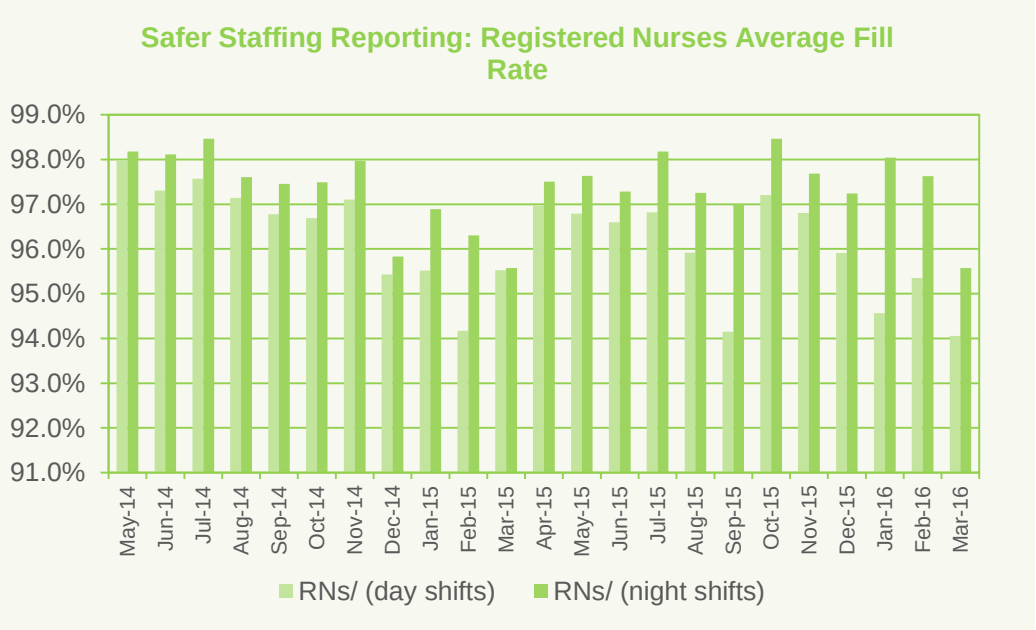
- The Francis Report on Mid Staffordshire (2013)[61] resulted in the publication of a number of documents focussing on the importance of safe nurse staffing levels
- Keogh review into the quality of care and treatment provided in 14 hospital trusts in England (2013)[62]
- Cavendish Review (2013)[63], an independent enquiry into healthcare assistants and support workers in the NHS and social care setting
- Berwick Report on improving the safety of patients in England (2013)[64]

[61] The King's Fund. Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. House of Commons.
[62] Keogh, B. (2013). Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. NHS England.
[63] Cavendish, C. (2013). An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings. Department of Health.
[64] Berwick, D. (2013). A promise to learn – a commitment to act: improving the safety of patients in England. Department of Health.

- 'How to ensure the right people, with the right skills, are in the place at the right time. A guide to nursing, midwifery and care staffing capacity and capability' (National Quality Board 2013)[65]
- 'Hard truths' The journey to putting patients first' (DH, 2013)[66]

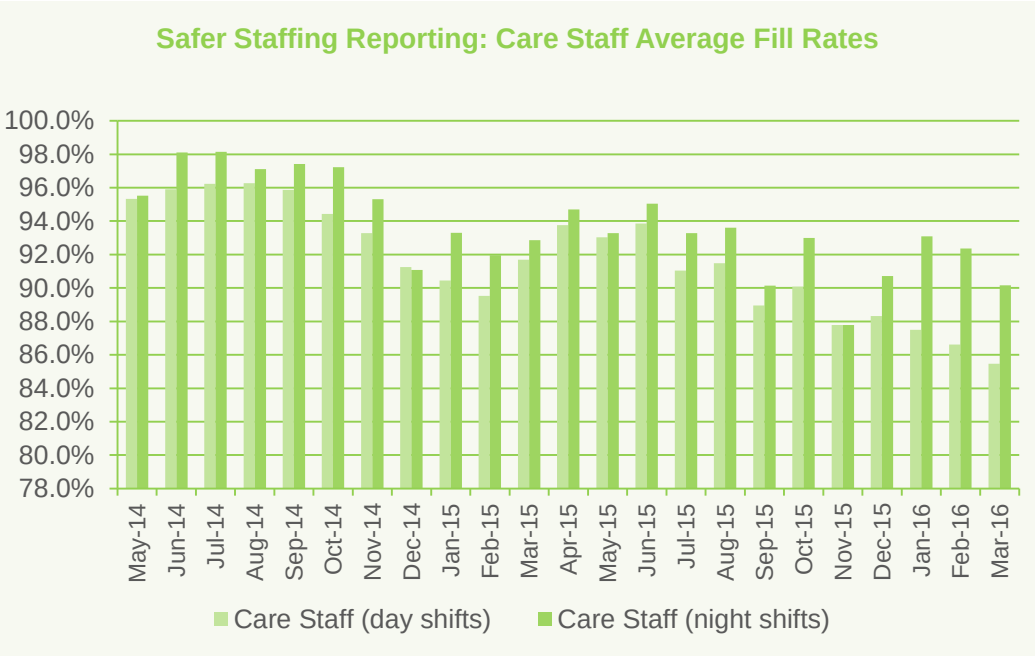
As a result of the recommendations 'Safe staffing for Nursing in adult inpatient wards in acute hospitals' (NICE 2014)[67] was developed, this provides detail on the methodology for undertaking a staffing review and, processes requirements for escalation, including the introduction of 'red flags' which were a series of incidents that NICE identified should be reported by ward staff. Red flags are reported through our incident reporting system and reviewed each month. The Board also receives monthly information on the percentage of staff shifts filled. Ward staff display publicly daily information, shift by shift, the staff available versus those that were planned for the shift.

Figure 35. Safer staffing reporting – registered nurses average fill rate



[65] Cummings, J. (2013). How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability. NHS England.
[66] Hunt, J. (2013). Hard Truths: the journey to putting patients first. Department of Health.
[67] Safe Staffing Advisory Committee (2014). Safe staffing for nursing in adult inpatient wards in acute hospitals. National Institute for Health and Care Excellence.

Figure 36. Staffer staffing reporting – care staff average fill rate



Patient First Improvement System – Building improvement capacity

The Patient First Improvement Programme Education Plan is being fully developed based on a proposed direction of travel considered and endorsed by the Patient First Programme Board on 15th March 2016.

The overall aim of the Education Plan is to create a framework for learning and development for all staff to ensure they develop the skills and receive the support necessary to respond to the Trust-wide implementation of the Patient First Improvement Programme. The plan will enable all staff to progress in their awareness, understanding and knowledge of the Patient First Improvement Programme and of Lean systems and practices in healthcare and their application in the Trust.

Based on tiers of progression designed to achieve the aims set out above, the plan encompasses the most basic introduction through Trust induction, setting the context of Lean improvement within the aspirations of the Trust to put the Patient First in all that it does. New staff will gain an overview of the importance of a culture of continuous improvement and of the behaviours and attitudes encouraged to achieve this. Annual mandatory training updates will include a session on the Patient First Improvement Programme and staff will be introduced to some key concepts and practices in Lean healthcare. The plan includes regular skills development and updating sessions (Lean Awareness) and there will be a rolling programme of Yellow Belt training, delivered by the

Patient First Kaizen Office. Yellow Belt training is intended for those directly involved in improvement activity. Those leading projects will be expected to undertake Green Belt training to ensure the benefit of Lean methodology is applied to improvement activity. The plan incorporates the development of a programme of standalone sessions in Lean Improvement tools from introductory sessions to master classes delivered by Trust experts. Underpinning the plan will be the development of a community of Lean Practitioners within the Trust who will participate in continuous professional development within the Lean Improvement arena, creating a sustainable internal resource to support the Patient First Improvement Programme.

Development of a Clinical Academic Pathway for Nursing, Midwifery and Allied Health Professionals

As part of or new Research and Innovation Strategy we have started to develop a Clinical Academic Pathway for nursing, midwifery and AHP professionals. We aim to build our research capacity around our clinical quality priorities and support the diffusion and spread of best practice and innovation across the Trust.

Following a successful engagement and consultation exercise with staff this year we are now working on the pathway model with support from the Association of UK University Hospitals 'Embedding Clinical Academic Roles' Task and Finish Group.

Key Quality Improvement Priorities for 2016-17

Improving staff experience:

- **Patient First Quality Improvement Programme – building the capability and capacity for improvement and increasing the number of staff reporting that they can make improvements in their work area**
- **Workforce Transformation Programme – closing the workforce capacity gap with sustainable solutions**
- **Further integration of education and research – development of Clinical Academic Pathway**
- **Health and Wellbeing programmes**

2.1.6 Requested Local Improvement Plans

2.1.6.1 How we are Implementing the Duty of Candour[68]

Keeping patients safe is our most important responsibility and we want to do everything we can to ensure that we cause no harm.

Sometimes though, patients do suffer harm while in our care. This can be due to a complication of a procedure that couldn't be avoided or sometimes due to a mistake or error. For the vast majority of patients, any harm caused can be put right or is only minor in nature. A very small number of patients may suffer more serious or permanent harm.

We have a strong philosophy of openness because we recognise that this is the way to show respect to our patients, deliver safe care and learn from any incidents that cause our

[68] http://www.cqc.org.uk/content/regulation-20-duty-candour

The Statutory Duty of Candour was introduced in November 2014. The duty sets standards of openness and transparency with patients that NHS organisations must comply with.

patients harm. This year we implemented a new policy 'Being Open and the Duty of Candour'.

Being open with patients about all aspects of their care is an ethical, legal, professional and contractual duty on individuals and on healthcare organisations. Honesty, when things go wrong in health care in particular, is crucial to ensuring that the reasons for what happened are understood. It also aids the identification of what steps can be taken to prevent recurrence; this is particularly important where a patient has suffered harm as the result of an adverse incident.

The purpose of the new policy is to describe the organisational and individual responsibilities of those working for Western Sussex Hospitals NHS Foundation Trust. For individuals this includes professional responsibility to both this organisation and to the relevant professional regulator for the area of practice.

All of our staff are trained to report any incidents - from very minor errors to more serious incidents. An investigation is then undertaken to look into what happened. Investigations will look at the details surrounding an incident step-by-step, including for example what is written in the medical notes and what staff may remember. Each investigation report will also consider whether there were any staffing or equipment problems or training issues. The person investigating should be able to pinpoint what caused the incident and to decide if anything could have prevented it. Actions can then be taken to try and stop it from happening again.

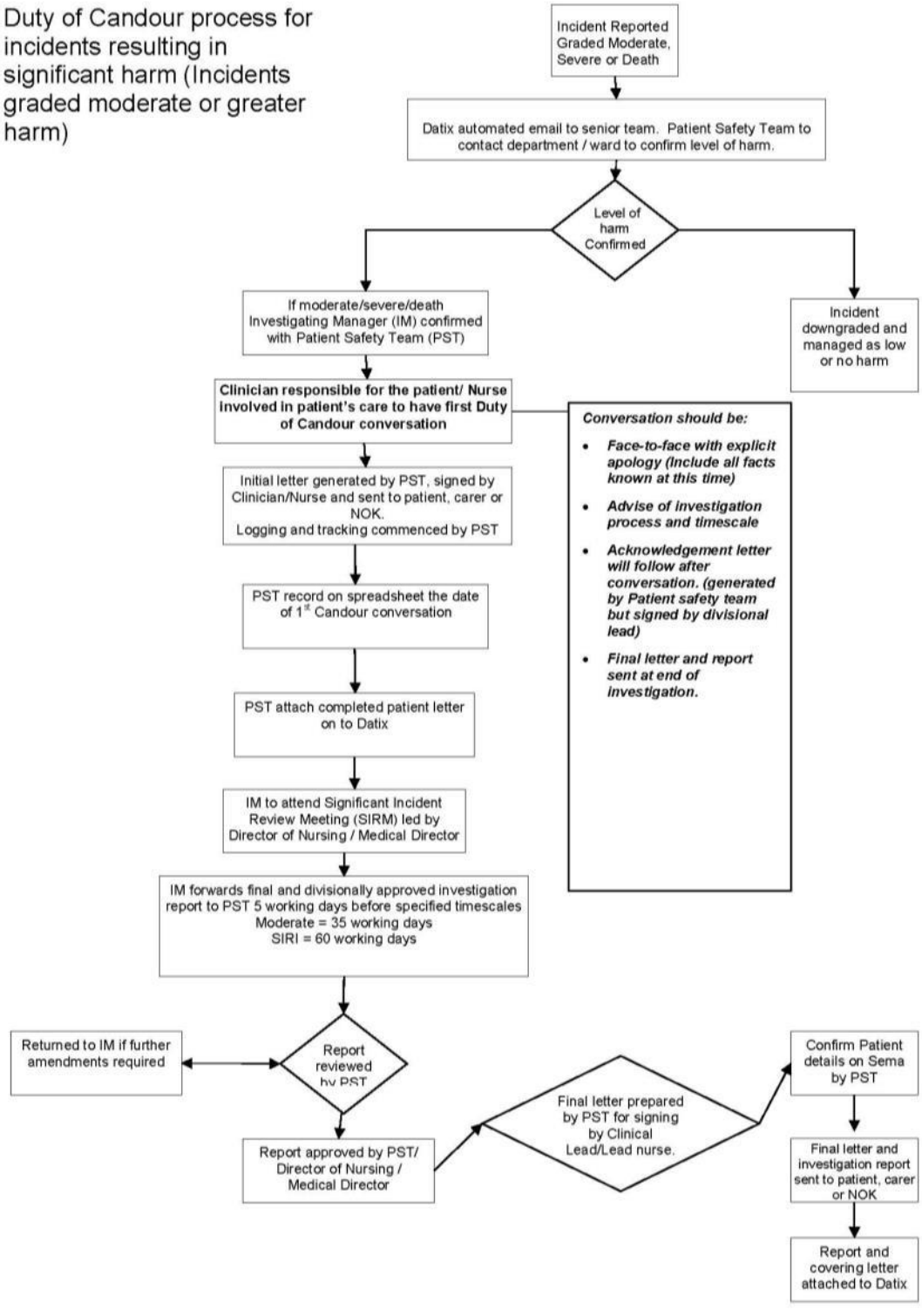
For the organisation as a whole, there is a statutory duty of candour under the Health and Social Care Act (2012) as well as a contractual duty based on the NHS Standard Contract. The NHS Litigation Authority will also monitor candour in relation to incidents leading to claim.

The policy aims to ensure that staff feel empowered and supported to 'do the right thing' and be honest with patients at all stages of their care, especially if they have been harmed as a result of either an unexpected or unintended incident.

The Trust has implemented the following Duty of Candour flowchart which is shown overleaf and also a new Patient Information Leaflet[69]:

[69] http://www.westernsussexhospitals.nhs.uk/wp-content/uploads/2016/04/Duty-of-Candour-leaflet.pdf

Duty of Candour process for incidents resulting in significant harm (Incidents graded moderate or greater harm)



2.1.6.2 Patient Safety Improvement Plan - Sign up to Safety

The Trust's commitments to delivering safe, harm free care are reflected in our 'Sign up to Safety' pledges. 'Sign Up to Safety - Listen, Learn, Act'[70] is an NHS England campaign to encourage NHS organisations to listen to patients, carers and staff, learn from what they say when things go wrong, and take actions to improve patients' safety. Our Sign up to Safety commitment forms a core part of the Trust's new Quality Strategy; the delivery of these pledges is overseen by the Trust Quality Board.

These are our pledges:

- **Putting Safety First - we will:**
  - Publicise and promote our ambition to be identified locally and nationally as a leader in high quality health care,
  - Embed within the organisation the expectation that the safety of patients is a central pillar of our core business and that we report, learn and respond when there are unexpected or unintended poor outcomes for patients,
  - Commit to improving the recognition of patients at risk of acute kidney injury and provide early intervention to prevent deterioration,
  - Develop an educational programme to improve the timely recognition and treatment of sepsis and use our electronic early warning system score to support this,
  - Develop a medicines improvement strategy focusing on high risk medicines and electronic-prescribing.

- **Continually Learning – we will:**
  - Publish our quality data monthly and use this to inform our quality improvement work streams,
  - Share the stories of individual patients with all staff via the monthly Trust Brief,
  - Follow through to completion any actions required as a result of investigations or audit,
  - Share learning across our organisation and with collaborative partners regionally and nationally,
  - Have visible Trust leadership in the clinical areas talking to patients, their families and staff to hear their concerns.

[70] https://www.england.nhs.uk/signuptosafety/

- **Honesty – we will:**
  - Foster an open and honest culture and clearly demonstrate this through visibility and openness with patients and staff,
  - Improve the skills of senior nurses and clinicians in communicating with patients and their families when something goes wrong and create a culture where clinicians feel supported and unafraid to do the right thing,
  - Develop a structural process for staff to feedback candidly their concerns regarding patient safety with particular focus on the observations made by junior doctors and nurses in training,
  - Fully implement the Duty of Candour and work with staff to build skills to disclose.

- **Collaboration – we will:**
  - Be an active participant in the establishment of the regional Patient Safety Collaborative,
  - Actively engage with local and national partners to collaboratively improve care including NHS QUEST, AHSN Patient Safety Collaborative,
  - Improve communication between hospital and primary care recognising that transition between services can present high levels of risk to patients,
  - Work in partnership with patients in preventing harm by introducing a new patient safety briefing for patients to encourage their engagement and involvement,
  - Engage and share with nursing and care homes regarding evidence based practice on improving patient safety.

- **Support – we will:**
  - Commit to supporting our staff in striving for continuous quality improvement,
  - Provide support for trainees to learn about safety and improvement,
  - Support our staff during the significant change process that may be required to make our organisation safer,
  - Listen to our staff, demonstrating that we are open to new ideas and encouraging forward thinking, personal development and education by offering a variety of courses to build improvement skills, developing a pool of improvement coaches, implementing Schwartz Rounds, and using collaborative technologies to engage and share.

Our ‘Sign up to Safety’ Improvement Plan is shown below:

RAG Status Key: Red: Not on target - risk of failure to deliver Amber: Deviation from plan but anticipate recovery Green: On target for completion Blue: Action complete

Date Opened	Safety Commitment	Action / Progress	Responsible Person/Group	Deadline	Rag Status
16th September 2014	Publicise and promote our ambition to be identified locally and nationally as a leader in high quality healthcare	The Quality Strategy was developed following a wide staff and public engagement exercise	Director of Research and Innovation	01/07/2015	Complete
		The Trust's Quality Strategy is due to be approved by the Trust Board (to be published on the public facing website)	Director of Research and Innovation	01/07/2015	Complete

Date Opened	Safety Commitment	Action / Progress	Responsible Person/Group	Deadline	Rag Status
16th September 2014	Embed within the organisation the expectation that safety of patients is a central pillar of our core business and that we report, learn and respond when there are unexpected or unintended poor outcomes for patients.	The Trust's Duty of Candour policy was approved and the process is being facilitated by the Patient Safety team until such time that it is embedded within the organisation. Update: the Patient safety team are still providing the facilitation of the process An Internal Audit has been undertaken with moderate assurance and the action plan is being worked through. In preparation for handing over the candour process to the divisions, datix has been updated with a drop down box requiring confirmation of candour.	Head of Patient Safety	Ongoing	Green
		The Trust has reviewed and updated the Serious Incident Review Policy in line with the new SIRI framework and rolled out to all staff involved in undertaking investigations	Head of Patient Safety	June 2015	Complete
		The Trust has reviewed the "Freedom to Speak Up Review" and developed appropriate actions	Freedom to Speak up Steering Group	Ongoing	Green
		To ensure each division holds a monthly and quarterly governance meetings where incidents are reviewed for learning and action taken to ensure improved patient outcomes	Divisional Governance Reviews	Ongoing	Complete

Date Opened	Safety Commitment	Action / Progress	Responsible Person/Group	Deadline	Rag Status
		To implement an overarching Mortality and Morbidity Steering Group which is currently piloting a tool to review all deaths prior to roll out by Q3.	Medical Director	In place	Complete
		To hold a Hospital Acquired Thrombosis (HAT) review to consider all HATs for learning and action	Thrombosis Committee	Ongoing	Complete
		To implement a monthly Patient Safety Newsletter	Head of Patient Safety	September 2015 and Ongoing	Complete
16th September 2014	Commit to improving the recognition of patients at risk of Acute Kidney Injury and provide early intervention to prevent deterioration	To ensure Improvement actions are being managed through NHS Quest Programme.	NHS Quest Programme Board	Ongoing	Green
16th September 2014	Develop an educational programme to improve timely recognition and treatment of Sepsis and use our electronic Early Warning System score to support this.	To ensure Improvement actions are being managed through NHS Quest Programme.	NHS Quest Programme Board	Ongoing	Complete
16th September 2014	Develop a medicines improvement strategy focussing on high risk medicines and e-prescribing	To ensure Improvement actions are being managed through Medicines Optimisation Committee	Medicines Optimisation Committee	Ongoing	Complete
16th September 2014	Publish our data monthly and use this to inform improvement work streams	To report the Quality Scorecard to the Trust Board on a monthly basis	Trust Board	Ongoing	Complete

Date Opened	Safety Commitment	Action / Progress	Responsible Person/Group	Deadline	Rag Status
		Update: Quality metrics to be developed for the improvement workstreams which will be tracked through the Quality Board and reported to the Trust Board. Quality metrics supporting the oversight of the Quality Strategy have been agreed.	Quality Board	Ongoing	Complete
		To ensure that each specialty holds a clinical governance half day which is attended by medical staff. Update: Clinical Governance half days are occurring throughout the Trust - some areas still to get on board	Care Groups/Departments	Ongoing	Green
		To share patient stories in the monthly trust brief	Head of Patient Safety	Ongoing	Complete
16th September 2014	Follow through to completion any actions required as a result of investigations or audit	A standard action tracker to be rolled out for use within the divisional governance process where all divisional actions (as a result of RCAs, Audits, complaints, claims etc.) are logged and monitored until completion.	Head of Clinical Governance	Ongoing	Green
		A new Clinical Audit and Effectiveness Committee to be established to monitor learning from audits.	Director of Research and Innovation	Ongoing	Complete
16th September 2014	Share learning across divisions within the organisation and with collaborative partners regionally and nationally	The be a proactive member of the Pressure Damage Prevention Coastal Collaborative and ensure learning is reported at the Heads of Nursing meeting	Deputy Director of Nursing	Ongoing	Complete

Date Opened	Safety Commitment	Action / Progress	Responsible Person/Group	Deadline	Rag Status
		The be a proactive member of the National Falls Collaborative and ensure learning is reported at the Heads of Nursing meeting	Deputy Director of Nursing	Ongoing	Complete
		To ensure all Serious Patient Safety incidents are shared with the Trust's commissioners	Head of Patient Safety	Ongoing	Complete
		To ensure learning is shared from NHS England's Central Alerting System for all Patient Safety Alerts. Update: CAS Alerts are shared via the datix system and disseminated throughout divisions by appointed leads. Performance monitored via TEC	Head of Patient Safety	Ongoing	Complete
16th September 2014	Have visible Trust leadership in the clinical areas talking to patients, their families and staff to hear concerns and foster an open and honest culture.	To roll out daily Safety huddles within wards and departments	All Managers	Ongoing	Complete
		The Director of Nursing to implement regular Quality time sessions for all staff	Director of Nursing	Ongoing	Complete
		Chief Executive to undertake regular walkabouts at all 3 hospital sites	Chief Executive	Ongoing	Complete
		To hold regular Patient First Conferences for all staff	Patient First Programme management Board	Ongoing	Complete
		Senior nursing staff to undertake regular safety and compliance walkabouts	Heads of Nursing	Ongoing	Green

Date Opened	Safety Commitment	Action / Progress	Responsible Person/Group	Deadline	Rag Status
		To ensure patients are represented at various meetings i.e. Cancer peer reviews	All Managers	Ongoing	Amber
		To undertake monthly consultant engagement meetings	Medical Director	Ongoing	Complete
		The Director of Nursing to take over as chair of the Patient Experience and Feedback Committee	Director of Nursing	Ongoing	Complete
16th September 2014	Improve the skills of senior nurses and clinicians in communicating with patients and their families when something goes wrong and create a culture where clinicians feel supported and unafraid to do the right thing	Education on the legal Duty of Candour to be rolled out throughout the Trust	Head of Clinical Governance	Apr-15	Complete
		The Trust has reviewed the "Freedom to Speak Up Review" and implemented appropriate actions	Freedom to Speak up Steering Group	Ongoing	**Green**
16th September 2014	Develop a structured process for staff to feedback candidly their concerns regarding patient safety with a particular focus on the observations made by junior doctors and nurses in training	The Director of Nursing to implement regular Quality time sessions for all staff	Director of Nursing	Ongoing	Complete
		To engage the new cohort of Junior Doctors in an Educational Supervision programme which is overseen by the Medical Education Centres	Medical Education Centres	September 2015 and Ongoing	Complete
		To encourage Junior Doctors to take part in the GMC survey	Medical Education Centres	September 2015 and Ongoing	Green

Date Opened	Safety Commitment	Action / Progress	Responsible Person/Group	Deadline	Rag Status
		To engage with local hospices, primary care, CCG and community Trust to improve end of life care for patients through shared care plans and joint guidance	End of Life Care Board	Ongoing	Green
16th September 2014	Improve communication between the hospital and primary care recognising the transition between the services can present a high level risk to patients	To review patient pathways through the Patient First Programme Board	Patient First Programme Management Board	Ongoing	Green
		To introduce Electronic Discharge summaries through improved IT solutions	Quality Board	Ongoing	**Green**
		The Trust is producing a video to encourage patient involvement - update: uploaded to Trust intranet	Katrina O'Shea/Lisa Ekinsmyth	Ongoing	Complete
16th September 2014	Work in partnership with patients in preventing harm by introducing a new patient safety briefing for patients to encourage their engagement and involvement	Improving Tissue viability within the community is a key part of the Pressure Damage Prevention Coastal Collaborative ongoing work	Deputy Director of Nursing	Ongoing	Green
16th September 2014	Engage and share with Nursing & Care homes regarding evidence based practice on improving patient safety	Continuous quality improvement to be driven through the Patient First Workstream	Patient First Programme management Board	Ongoing	Green
16th September 2014	Commit to supporting our staff in striving for continuous quality improvement	Training for staff in improvement methodology to be rolled out as part of the Patient First Programme	Patient First Programme management Board	Ongoing	Green

Date Opened	Safety Commitment	Action / Progress	Responsible Person/Group	Deadline	Rag Status
16th September 2014	Listen to our staff, demonstrating that we are open to new ideas and encouraging forward-thinking, personal development and education by:	to implement training for staff in improvement methodology via the Patient First Programme	Patient First Programme management Board	Ongoing	Green
	Offering a variety of courses to build improvement skills				
	Develop a pool of improvement coaches				
	Use collaborative technologies to engage and share	To ensure Schwartz rounds take place on a monthly basis	Schwartz Steering Group	ongoing	Complete

2.1.6.3 Staff Survey Result for indicators KF19/KF27

Below are our NHS Staff Survey results for indicators KF19 - Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months, and KF27 – Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion.

~ KF19 - Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

The indicator in the NHS Staff Survey now reads:

"Question 14: In the last 12 months how many times have you personally experienced physical violence at work from...

a) Patients / service users, their relatives or other members of the public

b) Managers

c) Other colleagues

Options: Never, 1-2, 3-5, 6-10, more than 10

d) The last time you experienced physical violence at work, did you or a colleague report it?

The indicator has changed definition between 2014 and 2015 and results are therefore not comparable between years. Previously the indicator read "In the last 12 months how many times have you personally experienced physical violence at work from... b) Managers / team leader or other colleagues" The phrase "Physical Violence" has been replaced with "harassment, bullying or abuse" which is a broader definition hence the higher rate.

Table 23. "In the last 12 months how many times have you personally experienced physical violence at work from... b) Managers / team leader or other colleagues"

Pre-2015 Definition	2012	2013	2014	National average 2014
In the last 12 months how many times have you personally experienced physical violence at work from... b) Managers / team leader or other colleagues *(1 or more incidents counted as experiencing violence)*	3.45%	2.12%	2.84%	2.58%

Table 24. In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...(b) managers (c) colleagues (more than 1 incident counted as experiencing harassment, bullying or abuse)

2015 Definition	2015	National average 2015: Acute Trusts (range)
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...(b) managers (c) colleagues *(1 or more incidents counted as experiencing harassment, bullying or abuse)*	15.5%%	16.5% (0% to 34.5%)

~ KF27 – Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion.

Table 25/26. Percentage of staff believing that Trust provides equal opportunities for career progression or promotion

Using NHS Staff Survey question "Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?" Responses grouped into 2 sections – White ethnic groups (1 to 3) and Black and minority ethnic groups (4-16):

White (groups 1-3):	2013	2014	2015	*National average 2015: Acute Trusts (range)
Percentage believing that Trust provides equal opportunities for career progression or promotion	91.9%	90.9%	89.4%	No national average (Range 62.9% to 100%)

Data taken from the NHS Staff Survey Workforce Race Equality Standard section.

**National average not available by ethnic groups, but overall figure is 87% for Acute Trusts.*

Black and minority ethnic groups (4-16):	2013	2014	2015	*National average 2015: Acute Trusts (range)
Percentage believing that the Trust provides equal opportunities for career progression or promotion	79.9%	76.7%	85.8%	No national average (Range 38.5% to 100%)

Data taken from the NHS Staff Survey Workforce Race Equality Standard section. National average not available.

**National average not available by ethnic groups, but overall figure is 87% for Acute Trusts.*

2.1.6.4 CQC Ratings Grid

Western Sussex Hospitals NHS Foundation Trust participated in a comprehensive inspection of all Trust Services by the CQC between the 8th and 11th December 2015. This was part of the CQC's comprehensive programme of inspection of all NHS Acute Trusts.

The CQC published the Trust's inspection findings on Wednesday 20th April 2016. The Trust received an overall inspection rating of "Outstanding" with St Richard's Hospital and Worthing Hospital receiving an individual inspection rating of "Outstanding" overall and Southlands Hospital receiving an individual inspection rating of Good". This CQC rating has now placed the Trust as one of the top three Acute Trusts in the country.

The detailed ratings are as follows:

Western Sussex Hospitals Overall Provider Rating

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Overall Trust	Good	☆ Outstanding	☆ Outstanding	Requires Improvement	☆ Outstanding	☆ Outstanding

Western Sussex Hospitals NHS
NHS Foundation Trust

St Richard's Hospital

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Overall Hospital Rating	Good	☆ Outstanding	☆ Outstanding	Requires Improvement	☆ Outstanding	☆ Outstanding
Urgent & Emergency Services	Good	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Medical Care	Good	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Surgery	Good	Good	☆ Outstanding	Requires Improvement	Good	Good
Critical Care	Requires Improvement	Good	☆ Outstanding	Requires Improvement	Good	Requires Improvement
Maternity & Gynaecology	☆ Outstanding	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Children & Young People	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
End of Life Care	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Outpatients & Diagnostic Imaging	Good	N/A	Good	Requires Improvement	Good	Good

Western Sussex Hospitals NHS
NHS Foundation Trust

Worthing Hospital

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Overall Hospital Rating	Good	☆ Outstanding	☆ Outstanding	Requires Improvement	☆ Outstanding	☆ Outstanding
Urgent & Emergency Services	Good	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Medical Care	Good	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Surgery	Good	Good	☆ Outstanding	Requires Improvement	Good	Good
Critical Care	Requires Improvement	Good	☆ Outstanding	Requires Improvement	Good	Requires Improvement
Maternity & Gynaecology		☆ Outstanding	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Children & Young People	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
End of Life Care	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Outpatients & Diagnostic Imaging	Good	N/A	Good	Requires Improvement	Good	Good

Southlands Hospital

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Overall Hospital Rating	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients & Diagnostic Imaging	Good	☆ Outstanding	Good	Requires Improvement	Good	Good

The Trust has been given two requirements notices regarding the inspection, these are as follows:

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (2) (f)

The hospital must ensure that there are sufficient quantities of pressure relieving equipment to ensure the safety of service users and to meet their needs.

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (2) (g)

The hospital must ensure the proper and safe management of medicines by ensuring medicine fridge records are up to date and daily checks on emergency medicines.

The Trust was also given 16 “Should do” actions. These are areas that the CQC have found that the Trust should make improvements on.

The Trust is currently producing a robust action plan to address the issues highlighted which will be monitored internally and by the CQC until completion.

2.1.7 Developing our Quality Strategy 2015-18 and Quality Priorities 2016/17

Western Sussex Hospitals NHS Foundation Trust has a proud history of involving patients, the public, its Foundation Trust Members and staff in the development of the services we provide. This includes the planning, designing, delivering and improvement of services to ensure they are of high quality and responsive to the needs of the diverse community that we serve.

This has been achieved through our well established Stakeholder Forum, a range of patient participation groups, our Patient Advice and Liaison team as well as our patient feedback programme.

Quality Strategy 2015-18 development

Last year we built on this work in the development of the Trust's Quality Strategy. Our aim was to ensure that through our Quality Strategy 2015-2018, we continually improve the quality of the service we provide, in line with the standards laid out for us both nationally and, importantly by our patients.

The Trust has been keen to involve as broad an audience as possible in the development of the strategy including the following key groups:

- Patients
- Patients' families and visitors
- Patient groups
- Staff
- Members
- Wider public (potential patients/ visitors)
- Healthwatch and other public health groups
- League of Friends charities and other supporters groups
- Local partners and interested parties, including local authorities, MPs and community associations

Initial draft overarching quality improvement goals and supporting programmes of work were worked up through engagement with Clinical Divisions, and review of progress against current quality priorities and strategic goals by the Trust Quality Board. In February 2015 stakeholders were invited to comment on the Trust's draft strategy document. The document included information about how the Trust is currently performing along with four "goals" for the next three years, stories about how care has improved in recent years and plans to go

on improving, as well as a survey for participants to give their feedback and highlight their concerns and priorities. The document was made available in hard copy and on the Trust's website. The Trust was keen to make the consultation a genuine opportunity for stakeholder engagement and input in to the strategy. The primary way in which people gave their views was to complete an online survey and this was promoted in a number of ways to encourage as many people as possible to participate. The results were then fed back to the Trust Quality Board and used to inform the next stage of the Quality Strategy's development. The results were also shared with stakeholders and staff and public.

Development of 2016/17 Quality Priorities

Our Quality Priorities for 2016/17 form part of our broader ambition set out in the Quality Strategy for 2015-18. In order to develop these priorities we ran a further engagement exercise: In the autumn of 2015 divisions engaged with their staff about the priorities for the forthcoming year under the Quality Strategy's four goals: Reducing mortality and improving outcomes, Safe care, Reliable care, Improved patient and staff experience. Divisional priorities were presented to the Quality Board in November 2015 and discussed alongside the Trust Quality scorecard and other strategic developments. The Quality and Risk Committee and Patient Engagement and Experience Committee were also invited to propose their priorities in terms of quality. The Quality Board and Trust Executive Committee agreed a draft set of quality priorities for 2016/17 to go out for wider engagement. A web based engagement exercise was conducted throughout February 2016 aimed at staff, patients, public and our key stakeholders. Meetings with Stakeholders representatives[71] were also held to discuss potential quality priorities and to signpost the Quality Priority engagement exercise. Draft Quality Priorities were presented at the Council of Governor's meeting in January 2016 and a discussion was held at the Stakeholder's Forum event in March 2016.

The Quality Board have agreed the final Quality Priorities for 2016/17 taking into account feedback received. Quality Priorities will be reviewed to ensure they support the Trust's 'True North' strategic goals and have clear improvement plans.

Ensuring delivery of our Quality Priorities

The delivery of key Quality Priorities will be monitored by the Trust Executive Board through the regular Quality Report and scorecard. The Trust Quality Board will monitor the delivery of detailed quality improvement work programmes set out in the Trust Quality Strategy.

[71] CCG, HASC Select Committee, and Healthwatch West Sussex.

2.2 Statements of Assurance Regarding Clinical Quality

The following statements of assurance are made from the Trust Executive Board.

2.2.1 Relevant Health Services and Income

During 2015/16 Western Sussex Hospitals NHS Foundation Trust provided and/or sub-contracted 136 contracts to provide health services.

The Western Sussex Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 136 of these contracts.

The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of relevant health services by The Western Sussex Hospitals NHS Foundation Trust for 2015/16.

2.2.2 Participation in National Clinical Audits and National Confidential Enquiries

Clinical audit is the process by which clinical staff measures how well we perform certain tests and treatments against agreed standards and then develop plans for improvement. It is a key part of continuous quality improvement. Western Sussex Hospitals NHS Foundation Trust, like other NHS organisations, participates in national audits - where care across the country is assessed (and sometimes organisations are compared with each other) - as well as locally organised audits. The National Confidential Enquiries are similar but use in depth reviews of what occurred in order to develop new recommendations for better care of patients.

During 2015/16, 39 national clinical audits and three national confidential enquiries covered relevant health services that Western Sussex Hospitals NHS Foundation Trust provides.

The above national clinical audits and confidential enquiries are those listed by the National Clinical Audit Advisory Group and made available at the Department of Health website. They are shown in Appendix 1.

During that period Western Sussex Hospitals NHS Foundation Trust participated in 95% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Western Sussex Hospitals NHS Foundation Trust was eligible to participate in during 2015/16 are shown in Appendix 1.

The national clinical audits and national confidential enquiries that Western Sussex Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2015/16, are listed below in Appendix 1 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 26 national clinical audits were reviewed by the provider in 2015/16 and Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Reports of national clinical audits are disseminated to the Trust's Clinical Divisions for their actions. Main points of action for national clinical audits listed by the National Clinical Audit Advisory Group are shown in appendix 2.

The reports of 112 local clinical audits were reviewed by the provider in 2015/16 and Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Reports of local clinical audits are disseminated to the Trust's Clinical Divisions for their actions. Main points of action for a sample of local clinical audits are shown in appendix 3.

2.2.3 Research as a driver for improving the quality of care and patient experience

The number of patients receiving relevant health services provided or sub-contracted by Western Sussex Hospitals NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 646.

In 2015/16 we began to draft a new Research and Innovation Strategy to set out the Trust's ambition for the development of research and innovation over the next three years. The Trust undertakes research and promotes innovation because high quality clinical research and innovation improve clinical outcomes for patients. Our ambition is to deliver high quality patient care through innovation and continuous quality improvement, education and research.

Clinical research is now carried out as a core part of NHS services. The Health and Social Care Act (2012) places a statutory duty on the NHS to promote research. The NHS Constitution includes a commitment to promote, conduct and use research to improve the current and future health and care of the population. Research and innovation within the

Trust supports the aims of our Patient First Programme - to empower and enable everyone to be passionate about delivering excellent care every time.

Our research and innovation goals for 2015-18:

- To implement innovative improvements in patient care at pace through standardisation, robust improvement science, partnership and shared learning.
- To increase opportunities for patients to participate in high quality clinical research that aims to improve patient care.
- To deliver a Clinical Academic Nursing, Midwifery and Allied Health Professional Strategy that promotes a professional, well-trained and up to date healthcare workforce leading best practice and innovation.

2.2.4 Incentives for Improved Quality

A proportion of Western Sussex Hospitals NHS Foundation Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between Western Sussex Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at:

http://www.westernsussexhospitals.nhs.uk/wp-content/uploads/2016/02/Commissioning-for-Quality-and-Innovation-CQUIN-schemes-for-2015-2016.pdf

The income dependent on achieving Commissioning for Quality and Innovation and associated payments are shown below:

Table 27. CQUIN total income 2015/16

	2014/15	2015/16
Total income dependent on CQUIN	£8,513,422	£7,770,369
Associated payment	£8,513,422	£7,770,369

The above 2015/16 value is based on the reconciled position for months 1-9 with estimates for the full year. The final value may differ from this. The reduction in CQUIN value for 2015/16 compared to 2014/15 is due to revisions in the methodology for calculating CQUIN values.

The 2016/17 contracts with Coastal West Sussex CCG, NHS England and Public Health England are still under negotiation, once agreed, details of our 1617 CQUIN programme will be published on the Trust web site.

2.2.5 External Regulation

Western Sussex Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is “registered without conditions”. The Care Quality Commission has not taken enforcement action against Western Sussex Hospitals NHS Foundation Trust during 2015/16.

Western Sussex Hospitals NHS Foundation Trust has participated in a comprehensive inspection of all Trust Services by the CQC during 8th-11th December 2016. This is part of the CQC’s comprehensive programme of inspection of all NHS Acute Trusts. The ratings provided by the CQC are listed in detail in section 2.1.6.4. Our registration status remains compliant with the CQC.

2.2.6 Data Quality

Western Sussex Hospitals NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS number was:

99.6% for admitted patient care;

99.9% for out-patient care; and

97.4% for accident and emergency care

- which included the patient's valid General Medical Practice Code was:

100% for admitted patient care;

100% for outpatient care; and

100% for accident and emergency care

Western Sussex Hospitals NHS Foundation Trust's Information Governance Toolkit Assessment for 2015/16 was submitted at Level 2, which is graded as satisfactory by the Health and Social Care Information Centre. The minimum score for a Level 2 is 66%; the Trust submitted a return of 84%.

Western Sussex Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period 2015/16 by the Audit Commission[72].

Western Sussex Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

1. Continue with an internal program of audit provided by a Health & Social Care Information Centre (HSCIC) Approved Experienced Clinical Coding Auditor.
2. The Trust is introducing an Electronic Patient Record, rolling out to one specialty at a time. We will use this as a platform to engage with the services to ensure that the data capture is complete and accurate and fit for coding and Payment by Results.
3. Bi-monthly internal training sessions take place for the teams on both sites and will continue to do so, with weekly email reminders on national standards.
4. All new staff attend a national standards course delivered by an HSCIC approved experienced trainer and all other staff attend a refresher course delivered by an HSCIC approved experienced trainer.

[72] Please note the Audit Commission closed 31st March 2015, however this is a mandated statement.

2.2.7 Core Quality Indicators for Quality Accounts 2015/16

The following core quality indicators are relevant to Western Sussex Hospitals NHS Foundation Trust. They relate to the NHS Outcomes Framework. For each indicator[73], data for 2015/16 and previous years, and data to allow comparison with national averages, are provided in the tables.

Summary Hospital-level Mortality Indicator (SHMI)

The Western Sussex Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: Mortality rates over the past 12 months have been around the national average, and within the expected range. The mortality rate has steadily reduced for the preceding two reported years. There is a marginal increase to 1.03 in the most recent reporting period (April 2014 – March 2015)

The Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve this number, and so the quality of its services, by: (a) maintaining monthly reporting of mortality statistics to Divisions and the Board; (b) continuing to focus on the implementation of care pathways in key mortality areas; and (c) strengthening arrangements for identifying and treating patients who deteriorate suddenly.

Table 28. Summary Hospital-level Mortality Indicator (SHMI)

	2011/12	2012/13	2013/14	2014/15	National Average (range)*
SHMI	1.08	1.02	0.99	1.03	1.00 (0.76 to 1.16)
Percentage of patient deaths palliative care coded at either diagnosis of specialty level	14.0%	17.8%	21.1%	26.63%	25.7% (10.08% to 50.85%)

*National average is based on 2014/15.

[73] Definitions for each of the core quality indicators are available on the Health and Social Care Information Centre website, see: https://indicators.ic.nhs.uk/webview/. This describes the data source to be used. In some cases data for the most recent period is not available.

N.B. All years reported are financial year 1st April to 31st March.

Patient Reported Outcome Measures[74]

The Western Sussex Hospitals NHS Foundation Trust considers that the outcome scores are as described for the following reasons: These data, which are based on quality of life measures[75], show that our treatments are effective in improving the health of our patients.

The Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve these outcome scores, and so the quality of its services, by: (a) ensuring regular feedback of PROMs data to clinical teams; and (b) working with commissioners to ensure that treatments are offered to those groups of patients most likely to benefit from the particular treatment.

Table 29. PROMS data

Patient Reported Outcome Measures	Apr 2011 to Mar 2012 (finalised)	Apr 2012 to Mar 2013 (finalised)	Apr 2013 to Mar 2014 (finalised)	Apr 2014 to Mar 2015 (provisional)*	Apr-15 – Sep-15 (provisional)*	National average (range)**
Groin hernia surgery: EQ 5D Index (casemix adjusted health gain)	0.099	0.075	0.071	0.079	0.043	0.088 (0.00 to 0.149)
Hip replacement (primary): EQ 5D Index (casemix adjusted health gain)	0.387	0.435	0.419	0.422	0.423	0.454 (0.359 to 0.546)
Knee replacement (primary): EQ 5D Index (casemix adjusted health gain)	0.292	0.32	0.304	0.283	0.27	0.33 (0.207 to 0.460)

Data source: http://www.hscic.gov.uk/proms

[74] Patient Reported Outcome Measures (PROMs) collect information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. The data adds to the wealth of information available on the care delivered to NHS-funded patients to complement existing information on the quality of services. Since 1 April 2009, hospitals providing four key elective surgeries for the English NHS have been inviting patients to complete questionnaires before and after their surgery The PROMs programme covers four common elective surgical procedures: groin hernia operations, hip replacements, knee replacements and varicose vein operations.

[75] All NHS patients having certain types of surgery are invited to fill in questionnaires about their health and quality of life before and after their operation.

* Provisional data relates to the February 2016 publications by the HSCIC which is the most recent data available.

**National average based on April 2015 to Sep 2015 (provisional data).
WSHFT does not carry out sufficient numbers of varicose vein procedures to be included in PROMS data.

28 day readmissions

The Western Sussex Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: While the Trust works hard to plan discharges appropriately, in some instances readmissions still occur. The rate of readmissions is in line with peers.

The Western Sussex Hospitals NHS Foundation Trust intends to take/has taken the following actions to improve this rate, and so the quality of its services: by continuing to work closely with commissioners and other health organisations to identify patients at risk of readmission and putting in place services to prevent them requiring further immediate hospital care. In particular we will identify those cases where readmissions could have been prevented by organising care differently and make the appropriate changes to reduce the level of readmissions.

Table 30. 28 day readmissions

28 day readmissions	2010/11	2011/12[76]	National average for large acute hospital (range)*
Patients 0 to 15 readmitted to a hospital which forms part of the trust within 28 days of being discharged	10.76% (as expected)	11.72% (higher than expected)	10.02% (6.40% to 14.94%)
Patients 16 and over readmitted to a hospital which forms part of the trust within 28 days of being discharged	10.45% (lower than expected)	11.36% (as expected)	11.44% (9.34% to 13.80%)

These figures are based on the indirectly age, sex, method of admission, diagnosis and procedure standardised percentages produced by the Health and Social Care Information Centre.
*National average based on 2011/12 data.

[76] 2011/12 data is the most recent available nationally from the Health and Social Care Information Centre (HSCIC).

The latest performance (for 2014/15) based on local data is 11.86% for patients 0 to 15 and 11.79% for patients aged 16 or over. However, given the risk adjustment applied by the HSCIC, these numbers cannot be compared directly to those in the table above.

30 day readmissions

Table 31. 30 day readmissions

30 day readmissions	2013/14	2014/15	*2015/16*	*National average for large acute hospital (range)**
Emergency readmissions within 30 days %	12.4%	13.2%	13.7%	*National data has not been published at Trust level since 2011/12*

Percentage of emergency admissions occurring within 30 days of the last, previous discharge after admission, indirectly standardised rate (excludes cancer and obstetrics). This data is collected locally and reported monthly in the WSHFT Quality Scorecard.

Responsiveness to patient needs

The Western Sussex Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the Trust's involvement in Care and Compassion Reviews has ensured responsiveness to the personal needs of patients in line with its peers.

The Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve this data, and so the quality of its services, by: (a) using results from real time patient experience tracking to constantly identify areas for improvement; and (b) identifying areas for further improvement from the care and compassion peer review programme.

Table 32. Responsiveness to patient needs

Responsiveness to patient needs	2011	2012	2013	2014 (based on local data)	2015	National average (range)*
Responsiveness to the personal needs of	64.4	65.7	69.4	67.0	Not yet available	68.7 (57.4 to 84.2)

patients						

* National average based on 2013.

2015 data on Responsiveness to Patient Needs and patient experience to be published in the 2015 survey results due in May 2016.

Proportion of staff who would recommend the Trust to Friends and Family

The Western Sussex Hospitals NHS Foundation Trust considers that this percentage is as described for the following reasons: an increasing proportion of staff is positive about the overall quality of the services and care offered by the Trust.

The Western Sussex Hospitals NHS Foundation Trust intends to take/has taken the following actions to improve this percentage, and so the quality of its services, by: using regular feedback opportunities to capture staff views about how we can improve. We have also reviewed staffing ratios, particularly in ward areas and have improved our staff engagement (including communications) such that staff feel more able to contribute to, and be aware of, service improvements.

Table 33. Percentage of staff who would recommend the Trust as a provider of care to their friends or family

	2012	2013	2014	2015	National average 2015: Acute Trusts (range)
Percentage of staff who would recommend the Trust as a provider of care to their friends or family	64%	73%	71%	73%	75% (17.7% to 100%)

*National average relates to 2015.

Venous Thromboembolism (VTE) Risk Assessments

The Western Sussex Hospitals NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trust has focused on this area and made good progress on embedding it into normal practice with a sustained increase in the proportion of patients screened.

The Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by: (a) a continued focus in this

area; and (b) an increased emphasis on improving outcomes such as reducing rates of harm from VTE.

Table 34. Percentage of patients admitted to hospital who were risk assessed for venous thromboembolism

	2012/13	2013/14	2014/15	2015/16	National average*
Percentage of patients admitted to hospital who were risk assessed for venous thromboembolism	93.4%	96.0%	95.9%	92.5%	96.0%*

* National average based on Q2 2015/16.

C.difficile

The Western Sussex Hospitals NHS Foundation Trust Considers that this rate is as described for the following reasons: A relentless and constant focus is required to minimise the level of *C.difficile* infection. Particular challenges include the need for antibiotic usage in a frail and ill patient population and balancing this with the risk of causing *C.difficile* disease.

The Western Sussex Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by: (a) enhancements to our antibiotic prescribing policies; (b) heightened environmental cleaning; and (c) targeted review of the patient pathway for these patients.

Table 35. Number of C. *difficile* cases

	2011/12	2012/13	2013/14	2014/15	2015/16	National average (range)*
Number of C *difficile* cases (patients aged 2 or over)	76	72	57	38	36	N/A
Rate of C *difficile* per 100,000 bed days (patients aged 2 or over)	24.4	23.7	18.9	12.6	11.4	14.7 (0 to 37.1)

*National average based on 2013/14.

Patient Safety Incidents

The Western Sussex Hospitals NHS Foundation Trust considers that this number and/or rate is as described for the following reasons: The Trust is a high reporter of patient safety incidents in the South East Coast Region for large acute Trusts, signifying a positive reporting culture for learning and improving from when things have gone wrong, with effective systems in place to minimise the risks of significant harm to patients.

The Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve this number and/or rate, and so the quality of its services, by: The Trust will continue to promote the reporting of patient safety incidents across the organisation in order to learn and improve. Themes, trends and learning from incidents will continue to be discussed and analysed through a variety of forums including the divisional clinical governance sessions, Triangulation Group, the Trust Brief newsletter and Divisional Governance Reviews.

Table 36. Patient safety incidents

	Apr 2013 to Sep 2013	Oct 2013 to Mar 2014	Apr 2014 to Sep 2014	Oct-2014 to Mar 2015	Apr 2015 to Sep 2015	Oct-2015 to Mar 2016
Number of patient safety incidents	5345	4781	4880	4628	4771	5070
Rate of patient safety incidents per 1,000 bed days	N/A	N/A	N/A	28.2	29.74	25.61
Number of patient safety incidents resulting in moderate, severe harm or death	78	66	73	74	74	82
Moderate, Severe harm or death incidents as a percentage of the total incidents	1.46%	1.86%	1.49%	1.60%	1.55%	1.62%
Total Serious Incidents	17	17	31	30	43	36

Source: Datix System

In the previous edition of this report (2014/15), historical Patient Safety Incident data for the Quality Accounts was reported from nationally collected data by HSCIC but submitted by the Trust. The most recently available data here was 2014/15. To enable recent data to be shown against a comparable

dataset, we have used locally reported data. The figures from the table above are reported and submitted to the Quality and Risk Committee. The incident numbers were retrospectively updated against previously reported figures in 2013/14 and 2014/15. Previously only the most recent month was updated, whereas now to allow accurate audit and increase transparency, previous months will be updated to reflect any changes in categorisation that may have occurred following investigation. As a result the level of harm caused could be either increased or decreased per month on what was previously reported. To allow this to occur it has been necessary to assign incidents to the month in which they occurred rather than the month in which they were reported. The impact of this has been on the following indicators: total incidents, moderate and above incidents and Serious Incidents Requiring Investigation (SIRI). We consider this data to be a more accurate reflection of Patient Safety Incident reporting in the Trust.

Part Three: Other Information

Please note our progress against improvement priorities in last year's Quality Report are provided in section 2.

3.1 Local Quality Indicators – clinical effectiveness; patient safety; and patient experience

The following indicators are drawn from the Trust Quality Scorecard which is reviewed by the Trust Board each month. They relate to the three domains of quality: patient safety, clinical effectiveness, and patient experience. Quality indicators reported to the Board are selected to provide a comprehensive picture of clinical quality in areas identified through our clinical quality strategy and the priorities for quality improvement set out in our quality reports. We consult with external stakeholders and patient representatives, as well as our own staff, about quality, ensuring that a broad range of interests are reflected in the planning of quality developments and reporting of quality indicators.

Where available, in the following tables, we provide historical and national performance data to demonstrate our progress over time and our performance compared to other healthcare providers.

Every year, the Trust reviews the set of key metrics that it provides to the Trust Board to ensure that they remain appropriate to providing assurance about the high quality and safety of patient care. New metrics, such as the Patient Safety Thermometer (rolled out in 2012/13) and the Friends and Family Test (also implemented in 2012/13 for inpatients and A&E and expanded to include Maternity during 2013/14, and outpatients in 2015/16), offer additional scope for benchmarking and comparison with other trusts. As such this year's list of local quality indicators is slightly different from that contained in our previous Quality Reports. Metrics that are no longer reported formally to the Trust Board may continue to be measured, reported and reviewed by other groups within the Trust.

Patient Safety

Table 37. Patient safety indicators

Indicator	2012/13	2013/14	2014/15	2015/16	Target 2015/16
Safer Staffing: Average fill rate - registered nurses (day shifts)			96.5%	95.93%	tbc
Safer Staffing: Average fill rate - registered nurses (night shifts)			97.3%	97.46%	tbc
Safer Staffing: Average fill rate - care staff (day shifts)			93.7%	89.82%	tbc
Safer Staffing: Average fill rate - care staff (night shifts)			95.3%	92.26%	tbc
Safety Thermometer: % of patients harm-free	94.4%	94.0%	94.6%	95.70%	93.8%
Safety Thermometer: % of patients with no new harms		98.0%	98.2%	98.30%	99.0%
% of patients with catheters and UTIs where best practice protocol was not followed.			0.2%	0.10%	0.2%
Total incidents£	8,091	9,354	9,508	9,841	8,122 - 10,988
Total moderate, severe or death incidents£	93	144	147	156	153
Total serious incidents (SIRIs)£	26	34	61	79	60
Number of outstanding Central Alerting System alerts		0	0	0	0
Total incidents involving drug/prescribing errors	1,101	1,077	1,242	1,100	1,056 - 1,428
Moderate/severe incidents involving drug/prescribing errors	6	6	5	6	5
Number of hospital attributable MRSA cases	1	4	1	0	0
Number of hospital *C.diff* cases	72	57	38	36	39
Number of *C. diff* cases where a lapse in the quality of care was noted			21	20	18
Number of reportable MSSA bacteraemia cases	72	68	75	85	n/a
Number of reportable *E.coli* cases	274	286	313	312	n/a
Full compliance with WHO Surgical Safety Checklist	100%	100%	100%	100%	100%

Indicator	2012/13	2013/14	2014/15	2015/16	Target 2015/16
NEVER events[77]	3	1	0	2	0
~SSIs: Total hip replacement (Year to Date (YTD) is rolling 12 months)			1.1%		tbc
~SSIs: Total knee replacement (YTD is rolling 12 months)			0.8%		tbc
~SSIs: Large bowel surgery (YTD is rolling 12 months)			14.9%		tbc
~SSIs: Breast surgery (YTD is rolling 12 months)			4.2%		tbc
Falls resulting in harm£	481	461	510	456	513
Falls resulting in severe harm or death£	2	5	1	2	1
Falls assessment within 24hrs of admission	90.9%	92.7%	90.9%	86.7%	80.0%
Avoidable falls identified on the Safety Thermometer		0.62%	0.98%	0.83%	0.76%
Grade 2 pressure ulcers	120	105	82	173	tbc
Grade 3 & 4 pressure ulcers	4	0	5	26	tbc
VTE Assessment Compliance	93.4%	96.0%	95.9%	92.5%	95.0%

~SSI data for 2015/16 is not yet available

£ Incidents and falls reporting from Datix: The way this is reported changed between 2013/14 and 2014/15 – Monthly reports retrospectively updated throughout year to reflect any changes in categorisation that may have occurred following investigation where the level of harm caused could be either increased or decreased. To allow this to occur incidents are assigned to the month in which they occurred rather than the month in which they were reported.

[77] Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Clinical Effectiveness

Table 38. Clinical Effectiveness Indicators

Indicator	2012/13	2013/14	2014/15	2015/16	Target 2015/16
Trust crude mortality rate (non-elective)	3.24%	3.22%	3.27%	3.13%	3.27%
Crude mortality rate (non-elective): 12 month rolling	3.24%	3.22%	3.27%	3.13%	3.27%
$Trust Hospital Standardised Mortality Ratio (HSMR)	112.03	103.6	95.4	90.0	92.0
+Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	1.02	0.99	1.03	1.00	1.00
Crude non-elective mortality for Renal failure	24.28%	24.1%	19.5%	18.6%	19.9%
$SMR for hip fracture (all diagnoses/procedures)	144.2	141.5	80.6	77.8	100.0
$Worthing SMR for hip fracture (all diagnoses/procedures)	132.0	144.8	112.3	91.1	100.0
$St Richard's SMR for hip fracture (all diagnoses/procedures)	163.1	136.6	42.7	58.6	100.0
$30 day mortality rate following hip fracture	11.10%	8.3%	8.7%	5.7%	8.2%
Emergency readmissions within 30 days %		12.4%	13.2%	13.7%	13.0%
Caesarean-Section Rate	24.7%	26.1%	26.9%	27.3%	26.0%
% Mothers requiring forceps for delivery	11.30%	11.9%	11.9%	11.5%	<15.0%
% Deliveries complicated by post-partum haemorrhage	0.7%	0.8%	0.6%	0.5%	1.0%
Maternal deaths		0	0	0	0
% Admission of term babies to neonatal care		3.2%	2.4%	3.0%	<10.0%
% Emergency admissions staying over 72h screened for dementia		62.6%	92.4%	93.7%	90.0%
% Patients identified as at risk of dementia for whom further investigations are carried out		82.1%	92.4%	91.9%	90.0%
% Patients with identified dementia referred to specialist services		94.5%	98.9%	99.4%	90.0%
Number of admissions for patients with dementia flag			1,832	2442	tbc
Ward moves for patients flagged with dementia			1,102	1744	tbc
Night-time ward moves for patients flagged with dementia			492	470	tbc

Indicator	2012/13	2013/14	2014/15	2015/16	Target 2015/16
Documentation Audit: % patients with dementia with Knowing Me document			75.4%	98.7%	75.0%
*% CT scans undertaken within 12 hours			82.2%	92.2%	95.0%
*% Stroke thrombolysis within 60 minutes of hospital arrival			60.4%	67.0%	95.0%
*% Swallow screen for stroke patients within 4 hours of admission			77.0%	79.8%	95.0%
*% of stroke patients admitted to stroke unit within 4 hours of admission			69.8%	77.2%	90.0%
*% high risk TIA patients seen within 24 hours			77.3%	63.9%	60.0%
Patients recruited to interventional studies within Clinical Research Network portfolio	540	282	179	201	n/a
Patients recruited to observational studies within Clinical Research Network portfolio	417	285	1,093	405	n/a
Local Clinical Research Network (LCRN) Score	3,120	1,695	1,983	1,410	1,305
*NHS IC Data validity summary (YTD)	97.5%	98.7%	99.9%	99.9%	96.1%
% in-patients with electronic discharge summaries produced			84.2%	84.2%	tbc

*2015/16 figures for Stroke Indicators and NHS IC data validity are reported a month in arrears (Apr 15 to Feb 16)

+ Reported in arrears: 2015/16 Q2 is the latest available data.

$ Latest available data is 2015/16 Q3. The Standardised Mortality Ratio (SMR) is the Dr Foster measure described under Priority 3 above but measured at lower than Hospital level, in this case for only patients with a hip fracture diagnosis(i.e. SMR = HSMR without the H). Data is shown by financial years plus the most recent 12 months available (even though this overlaps with the previous period) (this is a slight change from previous years). Dr Foster rebase their data to take account of improvements in mortality levels nationally. The figures in the table above are based on the 2014/15 rebasing and therefore the 2013/14 value here will not match previously reported values.

Patient Experience

Table 39. Patient Experience Indicators

Indicator	2012/13	2013/14	2014/15	2015/16	Target 2015/16
Trust Friends and Family Recommend %: Inpatient			92.7%	95.2%	tbc
Trust Friends and Family Recommend %: A&E			90.9%	91.4%	tbc
Maternity Friends and Family Recommend %: Antenatal care (36 weeks)			96.1%	96.2%	tbc
Maternity Friends and Family Recommend %: Delivery care			97.1%	95.7%	tbc
Maternity Friends and Family Recommend %: Postnatal ward			94.5%	95.7%	tbc
Maternity Friends and Family Recommend %: Postnatal community care			89.5%	98.1%	tbc
Trust Friends and Family Recommend %: Outpatient				91.6%	tbc
Trust Friends and Family Response Rate: Inpatient		21.1%	34.5%	26.1%	30%
Trust Friends and Family Response Rate: A&E		19.7%	27.0%	17.8%	25%
Maternity Friends and Family Response Rate: Delivery care			29.1%	11.4%	tbc
Percentage of re-booked outpatient appointments	9.8%	8.6%	8.7%	7.8%	8.6%
Clinics cancelled with less than 6 weeks' notice for annual/study leave	376	266	340	281	340
PALS contacts relating to appointment problems (% of total appts)	0.12%	0.13%	0.09%	0.08%	0.09%
Reduce patients cancelled on the day of surgery for non-clinical reasons	455	319	399	337	399
Breaches of mixed sex accommodation arrangements		0	0	1	0
Compliance with MUST[78] tool after 24 hours	85.6%	86.2%	81.8%	60.9%	80.0%
Compliance with MUST tool after 7 days	95.4%	97.2%	94.9%	91.2%	95.0%
Internal Patient-led assessments of the care environment (PLACE) compliance : St Richard's Hospital	95.0%	97.2%	97.8%	93.3%	85.0%

[78] MUST, Malnutrition Universal Screening Tool - this is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under-nutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

Indicator	2012/13	2013/14	2014/15	2015/16	Target 2015/16
Internal PLACE compliance : Worthing Hospital	95.0%	95.2%	95.1%	95.8%	85.0%
Number of complaints	565	522	574	587	570
Complaints where staff attitude or behaviour is an issue	56	46	67	54	67
Complaints where staff communication is an issue	75	49	49	66	49
Complaints about nursing	41	29	46	39	46

Note: Complaints section relates to formal complaints only, does not include complaints received through PALS.

3.2 Access and Outcome Indicators relevant to our Trust (as described by Monitor's Risk Assessment Framework)

Monitor is the sector regulator for health services in England and works closely with the Care Quality Commission, the quality and safety regulator. As a Foundation Trust, we report to Monitor our performance against a limited set of national measures of access and outcome. Monitor uses performance against these indicators as a trigger to detect potential governance issues in foundation hospitals.

Table 40 shows performance against the relevant indicators in Monitor's Risk Assessment Framework[79]. These are key national targets. The Trust is given an overall weighted score based on the number of indicators that it has not met. An overall score of 0 is coded green; 1 amber/green; 2 amber; 3 amber/red; and 4 or more red. Compliance is judged on a quarterly basis, but based upon monthly submissions. A trust is judged non-compliant for a particular metric for any quarter in which it submits a non-compliant position. Monitor suggests the inclusion in this report of an aggregate position for the year based on arithmetic averages for each month.

Western Sussex Hospitals scored 1 point in quarter 4 2015/16 of the Monitor Risk Assessment Framework. This was due to non-compliance for the Referral to Treatment Waiting Target. The Trust with Coastal West Sussex CCG have been undertaking a joint recovery programme, supported by Monitor and NHS England, which requires an increase in definitive treatments by the Trust, and mitigation of referral demand through a range of primary care demand management schemes. Should both elements of the recovery programme occur as anticipated, the Trust will achieve a compliant position by December 2016.

79 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/455893/RAF_revised_25_August.pdf

Performance Against the Monitor Risk Assessment Framework 2015/16

Table 40. Performance against the Monitor Risk Assessment Framework

	Target	Q1	Q2	Q3	Q4 (tbc)	Aggregate position
ACCESS						
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	×	×	×	×	86.88%
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	✓	✓	✓	✓	96.13%
All cancers : 62-day wait for first treatment following urgent GP Referral*	85%	✓	✓	✓	✓	86.59%
All cancers : 62-day wait for first treatment following consultant screening service referral*	90%					96.2%
All cancers : 31-day wait for second or subsequent treatment - surgery treatments*	94%	✓	✓	✓	✓	100%
All cancers : 31-day wait for second or subsequent treatment - drug treatments*	98%					100%
All cancers : 31-day wait from diagnosis to first treatment*	96%	✓	✓	✓	✓	99.4%
Cancer : two week wait from referral to date first seen - All patients*	93%	×	✓	✓	✓	94.91%
Cancer : two week wait from referral to date first seen - Symptomatic breast patients*	93%		×			92.56%
OUTCOMES						

Clostridium difficile – meeting the *Clostridium difficile* objective	56	✓	✓	✓	✓	36
Certification against compliance with requirements re access to healthcare for people with a learning disability	✓	✓	✓	✓	✓	✓
Overall monitor compliance framework score		**2.0**	**2.0**	**1.0**	**1.0**	**2**

*Validation for Quarter 4 cancer targets is not due to be completed until June 2015. As such the table above uses the validated position for quarter 1, 2 and 3 plus the provision position for quarter 4.

Appendices and Annex

Appendix 1: National Clinical Audits including Patient Outcomes Programme (listed by the National Clinical Audit Advisory Group)

Appendix 2: Actions resulting from reviews of national clinical audits

Appendix 3: Actions resulting from reviews of local clinical audits

Annex 1: Statements from our commissioners, local Healthwatch organisation and Overview and Scrutiny Committee

Annex 2: Statement of directors' responsibility for the quality report

Limited Assurance Report on Quality

Appendix 1 - National Clinical Audits listed by the National Clinical Audit Advisory Group, and National Confidential Enquiries listed 2015/16

Audit Title	National Clinical Audit and patient Outcomes (NCAPOP)	Was the Trust eligible to take part	Did the Trust take part	Percentage of data completed
Acute coronary syndrome or Acute myocardial infarction – MINAP National Institute for Cardiovascular Outcomes Research	Y	Y	Y	Ongoing
Bowel Cancer (NBOCAP) Royal College of Surgeons of England	Y	Y	Y	Ongoing
Cardiac Rhythm Management (CRM) National Institute for Cardiovascular Outcomes Research	Y	Y	Y	Ongoing
Case Mix Programme (CMP) Intensive Care National Audit & Research Centre (ICNARC)	N	Y	Y	Ongoing
Coronary angioplasty National Institute for Cardiovascular Outcomes Research	Y	Y	Y	Ongoing
Diabetes (Adult) - Foot care Audit Health and Social Care Information Centre	Y	Y	Y	Ongoing
Diabetes (Adult) - National pregnancy in diabetes Health and Social Care Information Centre	Y	Y	Y	Ongoing

Audit Title	National Clinical Audit and patient Outcomes (NCAPOP)	Was the Trust eligible to take part	Did the Trust take part	Percentage of data completed
Diabetes (Adult) – National diabetes inpatient audit (NADIA) Health and Social Care Information Centre	Y	Y	Y	Ongoing
Diabetes (Adult) - National diabetes Health and Social Care Information Centre	Y	Y	N	N/A
Diabetes (Paediatric) NPDA Royal College of Paediatrics and Child Health	Y	Y	Y	Ongoing
Elective surgery (National PROMs Programme) Health and Social Care Information Centre	N	Y	Y	Ongoing
Emergency Use of Oxygen British Thoracic Society	N	Y	Y	100%
End of Life Care Royal College of Physicians (London)	Y	Y	Y	100%
Falls and Fragility Fractures Audit Programme (FFFAP) – National Falls audit Royal College of Physicians (London)	Y	Y	Y	Ongoing

Audit Title	National Clinical Audit and patient Outcomes (NCAPOP)	Was the Trust eligible to take part	Did the Trust take part	Percentage of data completed
Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip Fracture Database Royal College of Physicians (London)	Y	Y	Y	Ongoing
Inflammatory Bowel Disease (IBD) programme Royal College of Physicians (London)	Y	Y	Y	Ongoing
Lung cancer – NLCA Royal College of Physicians	Y	Y	Y	Ongoing
Major trauma: Trauma Audit & Research Network The Trauma Audit & Research Network	N	Y	Y	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review MBRRACE-UK, National Perinatal Epidemiology Unit	Y	Y	Y	Ongoing
Medical and surgical : clinical outcome review programme: National confidential enquiry into patient outcome and death NCEPOD	Y	Y	Y	Please see table below
National Cardiac Arrest Audit Intensive Care National Audit & Research Centre (ICNARC)	N	Y	Y	Ongoing

Audit Title	National Clinical Audit and patient Outcomes (NCAPOP)	Was the Trust eligible to take part	Did the Trust take part	Percentage of data completed
National Comparative Audit of Blood Transfusion programme - Patient Blood Management in Scheduled Surgery NHS Blood and Transplant	N	Y	Y	100%
National Comparative Audit of Blood Transfusion programme - Use of blood in Lower GI bleeding NHS Blood and Transplant	N	Y	Y	100%
National Complicated Diverticulitis Audit (CAD) Yorkshire Surgical Research Collaborative	N	Y	Y	Ongoing
National Emergency Laparotomy Audit (NELA) Royal College of Anaesthetists	Y	Y	Y	Ongoing
National Heart failure National Institute for Cardiovascular Outcomes Research	Y	Y	Y	Ongoing
National Joint Registry (NJR) Healthcare Quality Improvement Partnership	Y	Y	Y	Ongoing
National Ophthalmology Audit Royal College of Ophthalmologists	Y	Y	N	N/A

Audit Title	National Clinical Audit and patient Outcomes (NCAPOP)	Was the Trust eligible to take part	Did the Trust take part	Percentage of data completed
National Prostate Cancer Audit Clinical Effectiveness Unit, The Royal College of Surgeons of England	Y	Y	Y	Ongoing
Neonatal Intensive and Special Care (NNAP) The Royal College of Paediatrics and Child Health	Y	Y	Y	Ongoing
Oesophago-gastric cancer (NAOGC) Royal College of Surgeons of England	Y	Y	Y	Ongoing
Paediatric Asthma British Thoracic Society	N	Y	Y	100%
Procedural Sedation in Adults (care in emergency departments) Royal College of Emergency Medicine	N	Y	Y	100%
Rheumatoid and Early Inflammatory Arthritis British Society of Rheumatology	Y	Y	Y	Ongoing
Sentinel Stroke National Audit Programme (SSNAP) Royal College of Physicians (London)	Y	Y	Y	Ongoing
UK Cystic Fibrosis Registry	N	Y	Y	Ongoing

Audit Title	National Clinical Audit and patient Outcomes (NCAPOP)	Was the Trust eligible to take part	Did the Trust take part	Percentage of data completed
Cystic Fibrosis Trust				
UK Parkinson's Audit (previously known as National Parkinson's Audit) Parkinson's UK	N	Y	Y – SRH only*	100%
Vital signs in Children (care in emergency departments) Royal College of Emergency Medicine	N	Y	Y	100%
VTE risk in lower limb immobilisation (care in emergency departments) Royal College of Emergency Medicine	N	Y	Y	100%

* Worthing site undertook a local audit focusing on medication being given at the right time.

Western Sussex Hospitals NHS
NHS Foundation Trust

National Confidential Enquiries listed 2015/16

National Confidential Enquiries	Was the Trust eligible to take part	Did the Trust take part	Percentage case notes submitted
Sepsis	Yes	Yes	100%
Gastro-intestinal Haemorrhage	Yes	Yes	100%
Acute Pancreatitis	Yes	Yes	80%

Appendix 2 - Actions resulting from reviews of National Clinical Audits 2015/16

Audit title	Main points of action
Chronic Obstructive Pulmonary Disease National [RCP/ BTS]	Western Sussex Hospitals NHS Foundation Trust was found to be compliant in the majority of the standards set. An area identified where improvement could be made was the administration of smoking cessation advice. A recommendation was to introduce a robust smoking cessation programme in the Trust and to have a dedicated smoking cessation practitioner. Post in place.
National Hip Fracture Database – 6th report [NHFD]	From the previous year's report a local recommendation was made to investigate the validity of the data submitted, as it was as it was felt that the results do not reflect our practice in those patients with sub-trochanteric fractures undergoing nailing. Following this investigation there were two areas identified for improvement. To improve the accuracy of coding and documentation a sticker was designed and introduced for usage in theatre for all emergency hip fractures. Trust wide monthly ortho-geriatric meetings have commenced these include clinical governance feedback.
Initial Management of the Fitting Child Clinical [RCEM]	The audit identified that the Emergency Department staff should develop a simple proforma for recording information about a fit. There is now a proforma in place for treating children fitting on arrival. Compliance was good regarding the training on European Advanced Paediatric Life Support.
Hip Fracture Database Anaesthesia Sprint Audit of Practice [FFFAP]	The Department of Anaesthesia have raised awareness of Bone Cement Implantation Syndrome by continuous risk assessments pre-operatively as part of multidisciplinary trauma meeting. Regarding regional nerve blocks staff have attended workshop on setting up regional block service Patients are fast tracked from A & E pre-operatively. A teaching programme has been introduced for junior doctors to perform blocks on ward.
Inpatient Care for Adults with Ulcerative Colitis [RCP]	Western Sussex Hospitals NHS Foundation Trust was found to be compliant in the majority of the standards set. An area identified where improvement could be made was the implementation of a treatment pathway. The Department agreed to make the pathway readily available to aid timely treatment decision making. A business case has been put forward to promote the need for further irritable bowel disease nurse support for inpatients.

Audit title	Main points of action
Myocardial Ischaemia National Audit Project [MINAP]	Regarding timeliness of angiography following nSTEMI[80]. This Quality Standard is already achieved in a high proportion of patients at Western Sussex Hospitals NHS Foundation Trust, however, barriers to achievement include the failure to ring fence cardiology beds for cardiac patients; the use of the catheter lab recovery bay as an escalation ward. This continues to be work in progress.
National heart failure audit [NICOR]	NICOR recommend that when incorrect coding of heart failure is identified, efforts should be made to change the coding diagnosis by working with the Trust's coding department. Western Sussex Hospitals NHS Foundation Trust now holds bi-monthly meetings within the coding department to address these issues.
Pleural Procedures [BTS]	The results of the audit recommended that a pro forma for pleural procedures should be used. A profoma has been designed at Western Sussex Hospitals NHS Foundation Trust and the proforma rolled out to the Emergency Floor.
National Paediatric Diabetes Audit [NaDIA]	NaDIA made a national recommendation to improve the timing and suitability of meals in relation to medications. Western Sussex Hospitals NHS Foundation Trust now educates staff to ensure medications are given at the appropriate time according to the delivery of the meals. The dieticians are reviewing the hospitals menus.
National Audit of Inpatient Falls [RCP]	Whilst the Western Sussex Hospitals NHS Foundation Trust performance in the national audit was well above national average there were areas for identified for improvement. Current plans for falls assessment to be included on Patientrack; this will allow real-time alerts/monitoring. Educational tools already available and will be redistributed to all areas. Falls Link practitioner scheme to be re-launched to support ward based education. Education about correct technique for lying and standing blood pressure monitoring to be included as part of mandatory education/competency assessment for all nursing staff. Regarding medication review - in particular medications that are likely to increase risks of falling. Western Sussex Hospitals NHS Foundation Trust to add the falls risk trigger to the electronic prescribing tool. Falls risk assessment when on Patientrack will include requirement to consider and alert re: risk medication. The Royal College of Physicians tool is now available on the Trust intranet (StaffNet). Medication Review to be included as part of mandatory competency for trained staff.

[80] nSTEMI, non-ST segment elevation myocardial infarction – a type of heart attack

Appendix 3 - Actions resulting from reviews of local clinical audits 2015/16

Actions resulting from reviews of local clinical audits 2015-16

Title of audit	Recommendations/Actions
Quality of the Operation Notes in Trauma and Elective Orthopaedic Patients	An improved proforma is now capturing the relevant data is available in theatres. All trauma theatre leads and operating surgeons have been made aware of proforma availability. The use of the proforma has increased form 52% to 98%.
Gentamicin Audit	The results of the audit have been presented to the Morbidity and Mortality Meeting and doctors have been instructed about how important is to prescribe gentamicin correctly. The guidelines were clarified. There has been an improvement of 16.5% in the correct prescribing of gentamicin since the original audit in early 2015.
Safeguarding - Advice given to Children and young people presenting to A&E with a history of drug and/or alcohol use	The aim of the audit was to identify the support offered by WSHFT for young people with drug and alcohol problems, and to identify any trends and information sharing that were in place. A standard process for offering advice, sign posting for early help or referring to external local government support services is now embedded in A&E and rolled out throughout the Trust.
Opportunities to test for HIV in patients presenting with late disease an audit against national HIV testing guidelines	Continue to promote targeted testing in primary and secondary care as per guidelines i.e. indicator conditions and persons with risk factors. WSHFT HIV testing guideline written. HIV testing pathway developed in collaboration with Microbiology. To be published with HIV testing guideline on the intranet and the GP/WSHFT website along with referral proforma for new diagnoses.
Post colposcopy nurse run smear clinic patient satisfaction survey	Following the treatment for abnormal cells of the cervix in colposcopy often women are required to have a follow-up smears. These are usually every 6 months and are done in a nurse led cytology clinic. The nurse led cytology (cervical smear) clinic at St Richard's Hospital is a newly established clinic; set up in 2013, whilst at Worthing this was set-up in 1999. The results of the audit show continued delivery of a high quality nurse led service.
Audit of Stroke - Occupational Therapy	In the 'referral and assessment' audit questions the 'agreed timeframe' has changed since the 2013 audit from 'within 48 hours of referral' to 'within 72 hours of a stroke'. This is in line with the Royal College of Physicians (2012) stroke guidelines. In future audits determine use of 'standardised cognitive assessments' will be audited rather than simply 'assessment of cognition'.
Clinical use and relevance of urine pneumococcus antigen testing	Agreement from the Clinical Microbiology Management Meeting was that the urine pneumococcus antigen test should not be routinely offered in the Trust.

Title of audit	Recommendations/Actions
Neutropenic Sepsis	Education has been given Trust wide regarding neutropenic sepsis audit stickers. The stickers have been rolled out to help collect data. The neutropenic pathway has been streamlined for "out of hours" care. Performance against the neutropenic sepsis pathway is now on the risk register. An Induction programme has been established for all new staff in A&E/AMU.
Asthma Audit – Are Patients Getting Recommended Follow-up After A&E Discharge?	The audit identified the need to record information giving (e.g. seek GP appointment within 48 hours, giving of information leaflet) in the GP letter. To also increase direct respiratory follow-up by having a weekly clinic patients could be booked into directly via a book kept in the department or an online web form, similar to that used by oncology / palliative care.
Women's views of being given benign breast biopsy results either by telephone or in person	100% of the women were relieved, delighted and happy to receive their benign results earlier than their scheduled clinic appointment by phone. The audit reassured WSHFT to continue to give benign results by telephone (with the option of still attending results clinic) using the algorithm in the NHS Breast Screening Programme Guidelines. To consider sending a more detailed and individualised letter to each woman rather than a standardised letter.
Re-audit Local Diabetic Pregnancy Audit - part of a rolling programme	Adapt local guidelines for intrapartum targets as per NICE (plasma glucose level of 4-7 mmol before meals at other times of the day apart from waking). Improve 1:1 dietary sessions – intention is to recruit dietician to fill vacancy. Improve documentation of hypo pathway forms – to peer review to check improvement. To be re-audited December 2016.
Antibiotic prophylaxis after primary joint replacement	Results of the audit were discussed at departmental level and a global email to the orthopaedic team highlighting guidelines for antibiotic usage [prophylaxis] .Information to be added to the Enhanced Recovery Programme. Information to be added to the junior doctor's induction.
Vulval Clinic Patient Satisfaction Survey	Still need to improve the waiting time at the clinic, however, 100% of patients were happy with care of the medical and nursing staff, 100% of patients felt that their privacy and dignity were respected and 98% of women were happy to recommend the clinic to the friends & family.
Skin lesions in Ophthalmology - are we meeting our targets for time to treatment?	The audit identified that there was a need to increase staffing levels in order to reduce the wait for non-malignant lesions to be treated. This post has already been advertised and filled.
Safeguarding - Advice given to Children and young people presenting to A&E with a history of drug and/or	The audit identified that the referral process in the Emergency Department should be simplified and then communicated to staff. The referral process has now been cascaded to staff including the paediatric wards. A recommendation from the audit results was to ensure information sharing 'in the best interests of the child' is clear to all children and young people and families who use Trust

Title of audit	Recommendations/Actions
alcohol use	services. As a result of this information posters are visible in Emergency Department areas and on the children's wards. Information is also available on the Trust intranet (StaffNet) and included in training.

Annex 1: Statements from our commissioners, local Healthwatch organisation and Overview and Scrutiny Committee

Statement from Coastal West Sussex Clinical Commissioning Group

16th May 2016

Western Sussex Hospitals NHS
NHS Foundation Trust

NHS
Coastal West Sussex
Clinical Commissioning Group

Coastal West Sussex Clinical Commissioning Group
1 The Causeway
Goring-By-Sea
Worthing
West Sussex, BN12 6BT

Tel: 01903 708604
Julia.carr@nhs.net
Website: www.westsussex.nhs.uk

Marianne Griffiths
Chief Executive
Western Sussex Hospitals NHS Foundation Trust
St Richards Hospital
Chichester
West Sussex
PO19 6SE

16th May 2016

Dear Marianne

Thank you for sending Coastal West Sussex CCG the draft Quality Report for 2015/16.

The Quality Report has been reviewed and Coastal West Sussex CCG confirms that the account demonstrates progress against the priorities identified for 2015/16. It provides information across the three areas of quality: patient safety; patient experience, and clinical effectiveness and demonstrates an on-going commitment to improving quality of care.

Western Sussex Hospitals NHS Foundation Trust has achieved many successes in 2015/16, most notably being rated by the Care Quality Commission as 'Outstanding' in April 2016. This is a considerable achievement and clear recognition of the hard work and determination of all those working in the organisation to deliver high quality care.

There a number of initiatives of particular note: the Patient First programme with its focus on patients and the continued improvement of quality and safety; the prevention and improvement work linked with Health Care Associated Infection is commendable. The CCG wishes to acknowledge formally your ongoing contribution to the health economy wide programme aimed at the reduction of Clostridium *difficile* infections; we note the considerable number of staff who have won either individual or team national awards and hope that this talent and enthusiasm will be used to spread innovation and improvement across all teams.

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The Quality Report 2015/16 outlines priorities for improvement in 2016/17 as well as how success will be measured in future and we support these priorities and the detailed work that underpins them. We will continue to seek assurance regarding progress of implementation throughout the year via our established assurance processes.

Whilst we acknowledge the improvement in ratings for the Sentinel Stroke National Audit Programme for stroke services at both St Richards and Worthing hospital sites, we will continue to work with the organisation and the Clinical Senate in order to secure further improvement. Achievement of compliance with the referral time to treatment as outlined in the NHS Constitution

has been challenging in 2015/16 and we will continue to work with the organisation to deliver the improvement plan, as well as develop ways in which demand can be proactively managed.

Coastal West Sussex CCG looks forward to working collaboratively with Western Sussex Hospitals NHS Foundation Trust in the continued improvement of quality services for today's patients and development of sustainable models of care for the future.

Yours Sincerely

Julia Carr

Head of Quality & Nursing, CWS CCG

Statement from Healthwatch West Sussex

11th May 2016

Working to make sure the consumer's voice is always heard and helps shape the provision of health and social care services in West Sussex

healthwatch West Sussex

Western Sussex Hospitals Foundation Trust Quality Accounts 2016

1. Introduction

This year's report again represents the considerable efforts and achievements of the Trust in improving the quality of healthcare. It also illustrates the challenges of compiling a complex account for multiple purposes to tight deadlines. Annual quality accounts would be simpler for readers if they were focused on the three main dimensions - of clinical effectiveness, safety of care and patient and staff experience.

A first step in part two could be to incorporate "reliable care", which requires compliance with evidence-based guidelines, care bundles and pathways (clinical process), with mortality and results (clinical outcome). These could combined as a section on "clinical effectiveness" and include relevant information which is currently provided in part three and in appendices, such as on local and national clinical audits and patient reported outcome measures.

Although mentioned early in the CEO statement on page 4, details of the remarkable achievements in assessment in December 2015 by the Care Quality Commission are buried on page 145. The commission rated both St Richard's and Worthing hospitals as "outstanding" overall, higher than the Trust's self-assessment, awarding outstanding and good ratings equally to both on the dimensions of safety, effectiveness, caring and leadership. The dimension of "responsiveness" was assessed as needing improvement in surgery, critical care, outpatients and imaging, based on waiting times, delay in patient flow and discharge, and a high rate of outpatient appointment cancellations by the hospitals. However, the CQC reported "*Overall, we found that Western Sussex Hospitals NHS Foundation Trust was providing outstanding care and treatment to the community it served. We saw many examples of very good practice across all areas of the hospital. Where we identified shortcomings, the trust was aware of them and was already addressing the issues.*" Only 2% of 169 hospitals were rated outstanding by CQC in 2014/15.

2. Clinical effectiveness

Overall in-hospital mortality rates have reduced across the trust. In 2011/12 the trust HSMR ranked 112 (out of 141 acute trusts in England) but has now improved to rank 23. Rates for Fractured Neck of Femur, which had previously been above national average, show commendable improvement in both sites. The significant difference between the two hospitals may reflect difference in case mix but deserves further explanation. These improved results are associated with earlier surgical intervention. Mortality from fluid and electrolyte disorders, ranked as high risk 2013, has also reduced and is now within the national expected range.

On both of the Trust's acute sites, emergency floors now combine acute medicine, medicine for the elderly and surgical assessment into one operational unit in order to focus care around the patient, who receives treatment from a multidisciplinary team, led by one consultant.

Six-month data reported from the Worthing Emergency Floor (which opened first) *"show a reduction in length of stay in Medicine and Surgery; an improvement in 0 and 1-day length of stay of 7% for elderly care patients; a 4% reduction in mortality and 5% in readmission rates. A reduction in patients waiting in A&E for longer than 4-hours by up to 11% has been accompanied by sustained positive feedback from patients."* Further detail from both sites would be welcomed to show the benefits to patients as well as to the Trust.

The Coastal West Sussex musculoskeletal (MSK) programme aims to redesign patient care pathways of care and more consistent and more efficient patient journeys from 2016. Patients and Healthwatch attended the engagement workshops to input into the redesign process. The benefits, such as reductions in cancellations or long waits for diagnosis or treatment may be reported in next year's quality accounts.

The management of stroke has improved progressively against four indicators of the national audit programme (figure 23, p.72). Stroke services at both St. Richard's and Worthing Hospitals have been rated by the Sentinel Stroke National Audit Programme as in the top third of 215 sites across the country.

3. Safe care

The Trust has set a goal that 100% of patients receive safe, care free from six "harms" - hospital acquired pressure ulcers, catheter associated urinary tract infection, avoidable venous thromboembolism (VTE), falls, hospital acquired infection and medication errors. No timescale is set for achieving the targets and the current incidence is not clearly defined.

Falls and pressure ulcers account for the majority of harms experienced by patients. Patient falls have reduced across the trust generally, and a pilot scheme of care planning and close supervision has reduced falls in two wards and will be extended to 10 more. Currently, the rate of falls per 1000 occupied bed days *"is well below the national benchmark of 2.5"*. Pressure ulcers had been reduced over the previous three years (fig 19); an increase in the current reporting year may be attributed to adopting a broader definition which will be used for future comparison.

Over the past five years, infections with MRSA have reduced to zero, and infections with C difficile have more than halved. These are key measures of hospital acquired infection across the NHS and their reduction is a credit to infection control within the Trust. Surgical Site Infection rates, reported in Table 5 for joint replacement, large bowel surgery and breast surgery, suggest that infections in large bowel surgery remain above the national average, if the data are correct. Similar discrepancies were noted in versions of the 2015 quality accounts and deserve comment from the Trust.

4. Patient and staff experience

The National In-Patient Survey, Friends and Family Test and local "real time patient experience" surveys previously identified concerns especially over discharge arrangements, waiting times and communication.

Healthwatch West Sussex also found concerns around discharge arrangements when we spoke to patient and their carer's last summer, which we reported on in October 2015. Through our follow-up discussions with the Trust it is clear much as changed and this is reflected in account. The multi-disciplinary team in one ward, where only 43% patients had reported being satisfied with their discharge experience, developed an improvement programme over one year which resulted in a satisfaction rate of 82%.

Satisfaction with the A&E department (T 10 p 96) has risen in Worthing but fallen slightly at St Richard's, yet remains above the national average for England. Satisfaction with information about A&E waiting time has been low (score 29%).

Satisfaction with maternity services is in line with national rates, except for a reduction at St Richard's during 2015/16. Satisfaction with inpatient services is improving across the Trust and is consistent with the national rates.

The activities of the Patient Advice and Liaison Service (PALS) and complaints team (presented in tables 17-20 p.107) indicate an increasing uptake of these services. Four years ago, the top five issues of concern were clinical treatment, communication, date of admission, and attitude of staff. Clinical treatment and communication each accounted for 30% of the top five in 2012/13; but accounted for 23% and 36% respectively by 2015/16. Patient perceptions of clinical care had improved but communications had not.

PLACE compliance scores (T43 p 169) continue to be 10% above the 85% target at St Richard's and Worthing Hospitals.

The "Duty of Candour" (section 2.1.6.1 p.129) was introduced in November 2014, setting standards of openness and transparency with patients with which NHS organisations (rather than individuals) must comply. This re-enforces several elements of the national 'Sign Up to Safety" campaign (reported in Quality Account 2015) to encourage NHS organisations to listen to patients, carers and staff, learn from what they say when things go wrong and take actions to improve patients' safety.

5. Conclusions

The Trust and staff are to be commended on the volume of quality initiatives reported and on recognition from numerous regional and national awards, especially the ratings by the Care Quality Commission. The format prescribed for annual quality accounts inhibits clear description and linkage of how standards, goals and targets are defined, how achievement is measured and what improvements result. These elements of the quality cycle are fragmented within and between annual reports, making for hard reading and limiting the transparency and value of quality accounts as public information.

Western Sussex Hospitals NHS
NHS Foundation Trust

Statement from Health & Adult Social Care Select Committee, West Sussex County Council

21st April 2016

21 April 2016 11:37

Dear WSHFT,

We will be providing feedback on this basis, which means that we have nothing to comment on as we haven't scrutinised any WSHFT services in the past year.

Rob.

Rob Castle | Assistant Democratic Services Officer, West Sussex County Council |
Location: Room 21, County Hall, Chichester, PO19 1RQ
Internal: **22546** | External: **033022 22546** | E-mail: rob.castle@westsussex.gov.uk

6 April 2016

To All Chief Executives, NHS Provider Trusts

SENT VIA E-MAIL

Dear Chief Executive,

Recommendations from Health and Adult Social Care Select Committee
10 March

At its meeting on 10 March, HASC considered the process for its contribution to NHS providers Quality Accounts from 2016.

As the committee's contribution is on a voluntary basis, based on the knowledge it has of the provider and should be returned to the provider within 30 days of receipt it was agreed that responses from the committee, from 2016 onwards, will only be forwarded to NHS providers where HASC has undertaken formal scrutiny of within the previous financial year.

Yours sincerely,

Margaret Evans

Mrs Margaret Evans

Chairman, Health and Adult Social Care Select Committee

Annex 2: Statement of directors' responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

  - board minutes and papers for the period April 2015 to 26th May 2016
  - papers relating to Quality reported to the board over the period April 2015 to 26th May 2016
  - feedback from commissioners dated 16/05/2016
  - feedback from governors dated 14/03/2016
  - feedback from local Healthwatch organisations dated 11/05/2016
  - feedback from Overview and Scrutiny Committee dated 21/04/2016
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 08/05/2016
  - the latest national patient survey February 2016[81]
  - the latest national staff survey 2015
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 14/04/2016
  - CQC Intelligent Monitoring Report dated May 2015[82]

- the Quality Report presents a balanced picture of the NHS Foundation

[81] Awaiting final version of survey data. The Care Quality Commission has confirmed that the publication date for the 2015 Inpatient Survey will be 8th June 2016.

[82] The last intelligent monitoring report for WSHFT published by CQC.

Trust's performance over the period covered

- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with Monitor's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report. The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report. By order of the board

NB: sign and date in any colour ink except black

26 May 2016.....Date.....  .....Chairman

26 May 2016.....Date.....  .....Chief Executive

Statement of the chief executive's responsibilities as the accounting officer of Western Sussex Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by Monitor.

Under the NHS Act 2006, Monitor has directed Western Sussex Hospitals NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Western Sussex Hospitals NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum.*

Signed.....
Chief Executive Date: 26th May 2016

Independent auditor's report to the Council of Governors of Western Sussex Hospitals NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of Western Sussex Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Western Sussex Hospitals NHS Foundation Trust's quality report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the national priority indicators as mandated by Monitor.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance
- the quality report is not consistent in all material respects with the sources specified in Detailed Guidance for External Assurance on Quality Reports 2015/16; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance and the six dimensions of data quality set out in the 'Detailed Guidance for External Assurance on Quality Reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual', and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2015 to 26 May 2016;
- papers relating to quality reported to the Board over the period April 2015 to 26 May 2016;
- feedback from Commissioners, dated 16/05/2016
- feedback from Governors, dated 14/03/2016
- feedback from local Healthwatch organisations, dated 11/05/2016
- feedback from Overview and Scrutiny Committee dated 21/04/2016

- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 08/05/2016
- the latest national patient survey, dated February 2016
- the latest national staff survey, dated 2015
- Care Quality Commission Intelligent Monitoring Report, dated May 2015
- the 2015/16 Head of Internal Audit's annual opinion over the Trust's control environment; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Western Sussex Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Western Sussex Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Western Sussex Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation ;
- comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual' to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'. The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Western Sussex Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance
- the Quality Report is not consistent in all material respects with the sources specified in Detailed Guidance for External Assurance on Quality Reports 2015/16; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance.

Ernst & Young LLP

Ernst & Young LLP
Reading
26 May 2016

Western Sussex Hospitals NHS
NHS Foundation Trust

Western Sussex Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2016

Western Sussex Hospitals NHS
NHS Foundation Trust

Foreword to the accounts

Western Sussex Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2016, have been prepared by Western Sussex Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed .....

Name Marianne Griffiths

Job title Chief Executive

Date 26 May 2016

Statement of Comprehensive Income

	Note	2015/16 £000	2014/15 £000
Operating income from patient care activities	3	368,254	357,145
Other operating income	4	49,100	46,080
Total operating income from continuing operations		**417,354**	**403,225**
Operating expenses	5, 7	(417,506)	(385,240)
Operating surplus/(deficit) from continuing operations		**(152)**	**17,985**
Finance income	10	40	32
Finance expenses	11	(888)	(1,033)
PDC dividends payable		(7,551)	(7,318)
Net finance costs		**(8,399)**	**(8,319)**
Surplus/(deficit) for the year		**(8,551)**	**9,666**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(7,086)	-
Revaluations	17	17,837	10,179
Total comprehensive income/(expense) for the period		**2,200**	**19,845**

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Total comprehensive income/(expense) for the period		**2,200**	**19,845**

Statement of Financial Position

	Note	31 March 2016 £000	31 March 2015 £000
Non-current assets			
Intangible assets	14	2,364	390
Property, plant and equipment	15	280,615	272,167
Total non-current assets		**282,979**	**272,557**
Current assets			
Inventories	20	6,234	6,052
Trade and other receivables	21	22,762	20,746
Cash and cash equivalents	25	6,986	23,148
Total current assets		**35,982**	**49,946**
Current liabilities			
Trade and other payables	26	(38,219)	(41,440)
Other liabilities	28	(1,777)	(1,990)
Borrowings	29	(2,224)	(2,190)
Provisions	31	(372)	(508)
Total current liabilities		**(42,592)**	**(46,128)**
Total assets less current liabilities		**276,369**	**276,375**
Non-current liabilities			
Borrowings	29	(24,978)	(27,138)
Provisions	31	(2,862)	(3,008)
Total non-current liabilities		**(27,840)**	**(30,146)**
Total assets employed		**248,529**	**246,229**
Financed by			
Public dividend capital		239,191	239,091
Revaluation reserve		53,516	42,765
Income and expenditure reserve		(44,178)	(35,627)
Total taxpayers' equity		**248,529**	**246,229**

The notes on pages 8 to 51 form part of these accounts.

The financial statements on pages 1 to 51 were approved by the board on 26 May 2016 and signed on its behalf by :

Signed : .....

Marianne Griffiths

Title : Chief Executive

Date 26 May 2016

Statement of Changes in Equity for the year ended 31 March 2016

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**239,091**	**42,765**	**(35,627)**	**246,229**
At start of period for new FTs	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	(8,551)	**(8,551)**
Impairments	-	(7,086)	-	**(7,086)**
Revaluations	-	17,837	-	**17,837**
Public dividend capital received	100	-	-	**100**
Taxpayers' and others' equity at 31 March 2016	**239,191**	**53,516**	**(44,178)**	**248,529**

Statement of Changes in Equity for the year ended 31 March 2015

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2014 - brought forward	**238,701**	**34,095**	**(46,802)**	**225,994**
Prior period adjustment	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2014 - restated	**238,701**	**34,095**	**(46,802)**	**225,994**
At start of period for new FTs	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	9,666	**9,666**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(1,509)	1,509	**-**
Revaluations	-	10,179	-	**10,179**
Public dividend capital received	390	-	-	**390**
Taxpayers' and others' equity at 31 March 2015	**239,091**	**42,765**	**(35,627)**	**246,229**

Information on reserves

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

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

Available-for-sale investment reserve
This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows

	Note	2015/16 £000	2014/15 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(152)	17,985
Non-cash income and expense:			
Depreciation and amortisation	5.1	13,669	14,281
Impairments and reversals of impairments	6	3,731	(8,880)
(Gain)/loss on disposal of non-current assets	5.1	5	(1,964)
Income recognised in respect of capital donations	4	(1,519)	(1,384)
(Increase)/decrease in receivables and other assets		(1,691)	(1,559)
(Increase)/decrease in inventories		(182)	(112)
Increase/(decrease) in payables and other liabilities		(4,566)	9,586
Increase/(decrease) in provisions		(326)	15
Net cash generated from/(used in) operating activities		**8,969**	**27,968**
Cash flows from investing activities			
Interest received		40	32
Purchase of intangible assets		(2,139)	-
Purchase of property, plant, equipment and investment property		(13,346)	(14,970)
Sales of property, plant, equipment and investment property		-	6,688
Receipt of cash donations to purchase capital assets		1,519	1,384
Net cash generated from/(used in) investing activities		**(13,926)**	**(6,866)**
Cash flows from financing activities			
Public dividend capital received		100	390
Movement on loans from the Department of Health		(2,157)	(4,572)
Capital element of finance lease rental payments		(103)	(326)
Interest paid on finance lease liabilities		(173)	(185)
Other interest paid		(669)	(808)
PDC dividend paid		(8,203)	(7,038)
Net cash generated from/(used in) financing activities		**(11,205)**	**(12,539)**
Increase/(decrease) in cash and cash equivalents		**(16,162)**	**8,563**
Cash and cash equivalents at 1 April		**23,148**	**14,585**
Cash and cash equivalents at start of period for new FTs		**-**	**-**
Cash and cash equivalents transferred under absorption accounting	39	-	-
Cash and cash equivalents at 31 March	25.1	**6,986**	**23,148**

Note 1 Accounting policies and other information

Monitor is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2015/16 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

1.1 Consolidation

The NHS foundation trust is the corporate trustee to the NHS charitable fund Western Sussex Hospitals Charity and Related Charities, which operates as Love Your Hospital Charity (Registered charity No. 1049201).

Under the provisions of IFRS10 Consolidated Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' returns, where those funds are determined to be material. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Trust has reviewed its NHS charitable funds and concluded that they are not material and so are not consolidated within these accounts.

Subsidiaries

Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The Trust has no subsidiaries.

Associates

Associate entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The Trust has no associates.

Joint ventures

Joint ventures are arrangements in which the trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. The Trust has no joint ventures.

Joint operations

Joint operations are arrangements in which the trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. The trust does not have joint operations.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

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

No employees are members of the Local Government Superannuation Scheme.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of “other comprehensive income”.

1.4 Expenditure on other goods and services

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

1.5 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

it is held for use in delivering services or for administrative purposes;

it is probable that future economic benefits will flow to, or service potential be provided to, the trust;

it is expected to be used for more than one financial year; and

the cost of the item can be measured reliably.

NHS bodies adopt a capitalisation threshold of £5,000. This figure includes VAT where it is not recoverable.

“Grouped assets” are a collection of assets which individually may be valued at less than £5,000 but which form a single collective asset because the items fulfil all the following criteria:

the items are functionally interdependent; and

the items are acquired at about the same date and are planned for disposal at about the same date; and

the items are under single managerial control; and

each individual asset thus grouped has a value of over £250

IT hardware is considered inter-dependent when attached to a network, the fact that it may be capable of stand-alone use notwithstanding. The effect of this is that all IT equipment purchases, where the final three criteria listed above apply, are capitalised.

Assets, which are capital in nature, but which are individually valued at less than £5,000 but more than £250, are capitalised as collective or “grouped” assets where they are acquired as part of the initial setting up of a new building. The enhancement or refurbishment of a ward or unit should be treated in the same way as “new build,” provided that work would be considered as “subsequent expenditure” in IAS16 terms.

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

Measurement

Valuation

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

All assets are measured subsequently at valuation. Land and buildings used for the trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value or current value in existing use at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values or current value in existing use are determined as follows:

● Land and non-specialised buildings – market value for existing use

● Specialised buildings – depreciated replacement cost

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

The carrying value of fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value. Assets not of sufficiently low value and/or not having sufficiently short lives for depreciated replacement cost to be materially the same as fair value, are indexed.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will

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

Depreciation

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

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

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

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

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

Impairments

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

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

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

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

the sale must be highly probable i.e. :

o management are committed to a plan to sell the asset;

o an active programme has begun to find a buyer and complete the sale;

o the asset is being actively marketed at a reasonable price;

o the sale is expected to be completed within 12 months of the date of classification as "Held for Sale"; and

o the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their "fair value less costs to sell". Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as "Held for Sale" and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as "on-Statement of Financial Position" by the trust.

The Trust has not entered into any PFI transactions.

1.6 Intangible assets

Recognition

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

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:

the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;

the trust intends to complete the asset and sell or use it;

the trust has the ability to sell or use the asset;

how the intangible asset will generate probable future economic or service delivery benefits, e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;

adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset; and

the trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

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

1.7 Revenue government and other grants

Government grants are grants from Government bodies other than income from commissioners or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

1.9 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure", loans and receivables or "available-for-sale financial assets".

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trade unless they are designated as hedges.

Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure accounts. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "Finance Costs" in the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices, independent appraisals and discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of

impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

1.10 Leases

Finance leases

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

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

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

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

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

1.11 Provisions

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

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 31.2 but is not recognised in the NHS foundation trust's accounts.

Non-clinical risk pooling

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

1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 32 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 32, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

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

1.13 Public Dividend Capital

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

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

donated assets (including lottery funded assets),

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

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

1.14 Value Added Tax

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

1.15 Corporation tax

The trust has determined that it is has no corporation tax liability as it does not operate any commercial activities that are not part of core health care delivery.

1.16 Foreign exchange

The functional and presentational currencies of the trust are sterling. The trust has not entered into any material foreign exchange transactions and has no assets or liabilities held in foreign currencies.

1.17 Third party assets

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

1.18 Losses and special payments

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

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

1.19 Transfers of functions to / from other NHS or local government bodies

No functions have been transferred to the trust from another NHS or local government body.

1.20 Accounting Standards that have been issued but have not been adopted

Change Published

Published by the IASB

Financial Year for which change applies

IFRS 11 (amendment) – acquisition of an interest in a joint operation May 2014. Not yet EU adopted. Expected to be effective from 2016/17.

IAS 16 (amendment) and IAS 38 (amendment) – depreciation and amortisation May 2014. Not yet EU adopted. Expected to be effective from 2016/17.

IAS 16 (amendment) and IAS 41 (amendment) – bearer plants June 2014. Not yet EU adopted. Expected to be effective from 2016/17.

IAS 27 (amendment) – equity method in separate financial statements August 2014. Not yet EU adopted. Expected to be effective from 2016/17.

IFRS 10 (amendment) and IAS 28 (amendment) – sale or contribution of assets September 2014. Not yet EU adopted. Expected to be effective from 2016/17.

IFRS 10 (amendment) and IAS 28 (amendment) – investment entities applying the consolidation exception December 2014. Not yet EU adopted. Expected to be effective from 2016/17.

IAS 1 (amendment) – disclosure initiative December 2014. Not yet EU adopted. Expected to be effective from 2016/17.

IFRS 15 Revenue from contracts with customers May 2014. Not yet EU adopted. Expected to be effective from 2017/18.

Annual improvements to IFRS: 2012-15 cycle September 2014. Not yet EU adopted. Expected to be effective from 2017/18.

IFRS 9 Financial Instruments July 2014. Not yet EU adopted. Expected to be effective from 2018/19.

Note 2 Operating Segments

Consistent with previous years, the Trust takes the view that there is a single operating segment - the provision of healthcare.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2015/16	2014/15
	£000	£000
Acute services		
Elective income	64,547	65,594
Non elective income	113,470	109,937
Outpatient income	59,926	54,565
A & E income	15,162	13,586
Other NHS clinical income	107,711	106,082
Private patient income	6,147	6,441
Other clinical income	1,291	940
Total income from activities	**368,254**	**357,145**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2015/16	2014/15
	£000	£000
CCGs and NHS England	353,866	341,478
Local authorities	6,585	7,971
Department of Health	-	-
Other NHS foundation trusts	365	263
NHS trusts	-	-
NHS other	43	52
Non-NHS: private patients	6,147	6,441
Non-NHS: overseas patients (chargeable to patient)	180	84
NHS injury scheme (was RTA)	907	718
Non NHS: other	161	138
Additional income for delivery of healthcare services	-	-
Total income from activities	**368,254**	**357,145**
Of which:		
Related to continuing operations	368,254	357,145

Income from Patient Activities includes £347,234k in respect of Commissioner Requested Services and £21,020k in respect of services that were not Commissioner requested.

Injury cost recovery income is subject to a provision for impairment of receivables of 21.99% (14/15: 18.9%) to reflect expected rates of collection.

Revenue from patient care services includes income accrued for activity where commissioning data had not been completed. Wherever possible reference is made back to patient level activity data and contract but estimates and assumptions are applied in order to ensure the completeness of income reported.

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2015/16	2014/15
	£000	£000
Income recognised this year	180	84
Cash payments received in-year	84	33
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	-	-

Note 4 Other operating income

	2015/16	2014/15
	£000	£000
Research and development	192	184
Education and training	10,752	10,615
Receipt of capital grants and donations from NHS Charities	875	1,385
Receipt of capital grants and donations from Other Bodies	644	-
Non-patient care services to other bodies	16,258	17,115
Support from the Department of Health for mergers	-	-
Profit on disposal of non-current assets	-	1,964
Reversal of impairments	14,889	9,738
Rental revenue from operating leases	-	-
Rental revenue from finance leases	-	-
Amortisation of PFI deferred credits	-	-
Income in respect of staff costs where accounted on gross basis	-	-
Other income	5,490	5,079
Total other operating income	**49,100**	**46,080**
Of which:		
Related to continuing operations	49,100	46,080
Related to discontinued operations	-	-

Note 5.1 Operating expenses

	2015/16	2014/15
	£000	£000
Services from NHS foundation trusts	518	400
Services from NHS trusts	2,138	2,261
Services from CCGs and NHS England	1,035	1,043
Services from other NHS bodies	-	-
Purchase of healthcare from non NHS bodies	-	-
Purchase of social care	-	-
Employee expenses - executive directors	1,098	1,061
Remuneration of non-executive directors	122	122
Employee expenses - staff	267,465	257,107
Supplies and services - clinical	37,558	35,729
Supplies and services - general	4,229	4,427
Establishment	3,440	3,185
Research and development	-	109
Transport	1,332	1,507
Premises	14,146	14,166
Increase/(decrease) in provision for impairment of receivables	18	57
Increase/(decrease) in other provisions	-	-
Change in provisions discount rate(s)	(20)	160
Inventories written down	-	-
Drug costs	269	315
Inventories consumed	38,007	33,835
Rentals under operating leases	49	38
Depreciation on property, plant and equipment	13,504	13,770
Amortisation on intangible assets	165	511
Impairments	18,620	858
Audit fees payable to the external auditor		
audit services- statutory audit	80	72
other auditor remuneration (external auditor only)	73	-
Clinical negligence	5,187	5,347
Loss on disposal of non-current assets	5	-
Legal fees	596	602
Consultancy costs	758	1,789
Internal audit costs	-	-
Training, courses and conferences	1,055	1,102
Patient travel	107	84
Car parking & security	389	458
Redundancy	143	176
Early retirements	-	-
Hospitality	5	23
Publishing	-	-
Insurance	577	530
Other services, eg external payroll	680	990
Grossing up consortium arrangements	-	-

Losses, ex gratia & special payments	(75)	188
Other	4,233	3,218
Total	**417,506**	**385,240**
Of which:		
Related to continuing operations	417,506	385,240

Operating expenses includes expenditure accrued for which no invoice had been received by 31st March 2016. In some cases it is necessary to use estimates based on knowledge of goods and services received. Wherever possible reference is made back to the value of orders but estimates and assumptions are applied in order to ensure the completeness of expenditure reported. Due to the volume of transactions adjustments are not made to prior periods unless the difference between the estimate and the actual value is material.

For expenditure accruals, any variation in outcome compared to the estimates used are accounted for in the next period. These estimates and assumptions are consistent with the previous year.

Directors remuneration is set out above and includes employer contributions to the NHS Pension Scheme.

Note 5.2 Other auditor remuneration

	2015/16	2014/15
	£000	£000
Other auditor remuneration paid to the external auditor:		
Other non-audit services	73	-
Total	**73**	**-**

Note 5.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £2m (2014/15: £2m).

Note 6 Impairment of assets

	2015/16	2014/15
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	858
Changes in market price	3,731	(9,738)
Other	-	-
Total net impairments charged to operating surplus / deficit	**3,731**	**(8,880)**
Impairments charged to the revaluation reserve	7,086	-
Total net impairments	**10,817**	**(8,880)**

Note 7 Employee benefits

	Permanent	Other	2015/16 Total	2014/15 Total
	£000	£000	£000	£000
Salaries and wages	195,577	10,848	**206,425**	202,844
Social security costs	12,492	3,072	**15,564**	16,680
Employer's contributions to NHS pensions	20,600	3,463	**24,063**	23,598
Termination benefits	143	-	**143**	176
Agency/contract staff	-	23,263	**23,263**	15,368
Total gross staff costs	**228,812**	**40,646**	**269,458**	**258,666**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**228,812**	**40,646**	**269,458**	**258,666**
Of which				
Costs capitalised as part of assets	752	-	**752**	322

Note 7.1 Retirements due to ill-health

During 2015/16 there were no early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2015). The estimated additional pension liabilities of these ill-health retirements is £0k (£328k in 2014/15).

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

Note 7.2 Directors' remuneration

The aggregate amounts payable to directors were:

	2015/16	2014/15
	£000	£000
Salary	995	967
Taxable benefits	53	72
Performance related bonuses	96	82
Employer's pension contributions	135	130
Total	**1,279**	**1,251**

Further details of directors' remuneration can be found in the remuneration report.

Note 8 Pension costs

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

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

a)Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation.

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained.

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Note 8 Pensions contd

c) Scheme provisions

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Those employees who are not eligible to join the NHS Pension scheme are enrolled into the National Employees Savings Trust (NEST) scheme. This is to comply with the Government's auto enrolment requirements. NEST is a defined contribution scheme with a phased employer contribution rate.

Note 9 Operating leases

	2015/16 £000	2014/15 £000
Operating lease expense		
Minimum lease payments	49	38
Total	**49**	**38**

	31 March 2016 £000	31 March 2015 £000
Future minimum lease payments due:		
- not later than one year;	49	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total	**49**	**-**
Future minimum sublease payments to be received	-	-

Note 10 Finance income

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

	2015/16	2014/15
	£000	£000
Interest on bank accounts	40	32
Total	**40**	**32**

Note 11.1 Finance expenditure

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

	2015/16	2014/15
	£000	£000
Interest expense:		
Loans from the Department of Health	670	809
Finance leases	174	175
Other	-	10
Total interest expense	**844**	**994**
Other finance costs	-	-
Total	**844**	**994**
Unwinding of discount on provisions	44	39
Total Finance Expenditure	**888**	**1,033**

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2015/16	2014/15
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 12 Corporation tax

The Trust did not pay any Corporation Tax in 2015/16

Note 13 Discontinued operations

There were no discontinued operations in 2015/16

Note 14.1 Intangible assets - 2015/16

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**5,185**	**-**	**5,185**
Valuation/gross cost at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	-
Additions	276	1,863	**2,139**
Impairments	-	-	-
Reversals of impairments	-	-	-
Reclassifications	-	-	-
Revaluations	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Gross cost at 31 March 2016	**5,461**	**1,863**	**7,324**
Amortisation at 1 April 2015 - brought forward	**4,795**	**-**	**4,795**
Amortisation at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	-
Provided during the year	165	-	**165**
Impairments	-	-	-
Reversals of impairments	-	-	-
Reclassifications	-	-	-
Revaluations	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Amortisation at 31 March 2016	**4,960**	**-**	**4,960**
Net book value at 31 March 2016	**501**	**1,863**	**2,364**
Net book value at 1 April 2015	**390**	**-**	**390**

Note 14.2 Intangible assets - 2014/15

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2014 - as previously stated	**5,185**	**-**	**5,185**
Prior period adjustments	-	-	-
Gross cost at 1 April 2014 - restated	**5,185**	**-**	**5,185**
Gross cost at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	-
Additions	-	-	-
Impairments	-	-	-
Reversals of impairments	-	-	-
Reclassifications	-	-	-

Revaluations	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Valuation/gross cost at 31 March 2015	**5,185**	**-**	**5,185**
Amortisation at 1 April 2014 - as previously stated	**4,284**	**-**	**4,284**
Prior period adjustments	-	-	-
Amortisation at 1 April 2014 - restated	**4,284**	**-**	**4,284**
Amortisation at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	-
Provided during the year	511	-	**511**
Impairments	-	-	-
Reversals of impairments	-	-	-
Reclassifications	-	-	-
Revaluations	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Amortisation at 31 March 2015	**4,795**	**-**	**4,795**
Net book value at 31 March 2015	**390**	**-**	**390**
Net book value at 1 April 2014	**901**	**-**	**901**

Note 15.1 Property, plant and equipment - 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**42,780**	**306,091**	**11,335**	**1,226**	**62,505**	**264**	**16,782**	**2,241**	**443,224**
Valuation/gross cost at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	-	4,166	-	5,038	3,369	-	2,110	254	**14,937**
Impairments	(6,239)	(549)	(298)	-	-	-	-	-	**(7,086)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	2,803	-	(3,510)	384	-	314	9	**-**
Revaluations	422	16,948	467	-	-	-	-	-	**17,837**
Disposals / derecognition	-	-	-	-	(3,588)	-	-	-	**(3,588)**
Valuation/gross cost at 31 March 2016	**36,963**	**329,459**	**11,504**	**2,754**	**62,670**	**264**	**19,206**	**2,504**	**465,324**
Accumulated depreciation at 1 April 2015 - brought forward	**2,027**	**111,566**	**3,450**	**-**	**41,125**	**264**	**10,762**	**1,863**	**171,057**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	-	8,260	163	-	3,374	-	1,563	144	**13,504**
Impairments	16,189	2,334	97	-	-	-	-	-	**18,620**
Reversals of impairments	-	(14,879)	(10)	-	-	-	-	-	**(14,889)**
Disposals/ derecognition	-	-	-	-	(3,583)	-	-	-	**(3,583)**
Accumulated depreciation at 31 March 2016	**18,216**	**107,281**	**3,700**	**-**	**40,916**	**264**	**12,325**	**2,007**	**184,709**
Net book value at 31 March 2016	**18,747**	**222,178**	**7,804**	**2,754**	**21,754**	**-**	**6,881**	**497**	**280,615**
Net book value at 1 April 2015	**40,753**	**194,525**	**7,885**	**1,226**	**21,380**	**-**	**6,020**	**378**	**272,167**

£3,425k included within the £3,588k disposals balance relate to finance leases which expired and were all fully depreciated prior to the start of the 2015/16 financial year.

Note 15.2 Property, plant and equipment - 2014/15

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2014 - as previously stated	**40,123**	**289,984**	**11,300**	**756**	**60,242**	**264**	**14,909**	**2,438**	**420,016**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 1 April 2014 - restated	**40,123**	**289,984**	**11,300**	**756**	**60,242**	**264**	**14,909**	**2,438**	**420,016**
Valuation/gross cost at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions - purchased/ leased/ grants/ donations	240	2,685	80	7,352	3,566	-	1,873	16	**15,812**
Reclassifications	-	8,385	(764)	(6,882)	(526)	-	-	(213)	**-**
Revaluations	3,368	6,092	719	-	-	-	-	-	**10,179**
Transfers to/ from assets held for sale	(951)	(1,055)	-	-	-	-	-	-	**(2,006)**
Disposals / derecognition	-	-	-	-	(777)	-	-	-	**(777)**
Valuation/gross cost at 31 March 2015	**42,780**	**306,091**	**11,335**	**1,226**	**62,505**	**264**	**16,782**	**2,241**	**443,224**
Accumulated depreciation at 1 April 2014 - as previously stated	**2,429**	**111,930**	**3,363**	**-**	**38,297**	**246**	**8,907**	**1,653**	**166,825**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2014 - restated	**2,429**	**111,930**	**3,363**	**-**	**38,297**	**246**	**8,907**	**1,653**	**166,825**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	-	7,944	167	-	3,576	18	1,855	210	**13,770**
Impairments	362	463	-	-	33	-	-	-	**858**
Reversals of impairments	(764)	(8,894)	(80)	-	-	-	-	-	**(9,738)**
Reclassifications	-	123	-	-	(123)	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(658)	-	-	-	**(658)**
Accumulated depreciation at 31 March 2015	**2,027**	**111,566**	**3,450**	**-**	**41,125**	**264**	**10,762**	**1,863**	**171,057**
Net book value at 31 March 2015	**40,753**	**194,525**	**7,885**	**1,226**	**21,380**	**-**	**6,020**	**378**	**272,167**
Net book value at 1 April 2014	**37,694**	**178,054**	**7,937**	**756**	**21,945**	**18**	**6,002**	**785**	**253,191**

Note 15.3 Property, plant and equipment financing - 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016									
Owned	18,692	211,578	5,459	2,754	17,209	-	6,749	260	**262,701**
Finance leased	-	-	2,345	-	400	-	-	-	**2,745**
Donated	55	10,600	-	-	4,145	-	132	237	**15,169**
NBV total at 31 March 2016	**18,747**	**222,178**	**7,804**	**2,754**	**21,754**	**-**	**6,881**	**497**	**280,615**

Note 15.4 Property, plant and equipment financing - 2014/15

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2015									
Owned	40,700	183,780	5,646	1,226	17,379	-	6,020	317	**255,068**
Finance leased	-	-	2,239	-	414	-	-	-	**2,653**
Donated	53	10,745	-	-	3,587	-	-	61	**14,446**
NBV total at 31 March 2015	**40,753**	**194,525**	**7,885**	**1,226**	**21,380**	**-**	**6,020**	**378**	**272,167**

Note 16 Donations of property, plant and equipment

There is no difference between the cash provided and the fair value of the assets acquired

Note 17 Revaluations of property, plant and equipment

The date of the valuation was the 29th February 2016 and was carried out by the District Valuer and was a desktop exercise using the latest BCIS indices and local market conditions

Note 18.1 Investments - 2015/16

The Trust had no investments in 2015/16

Note 18.2 Investments - 2014/15

The Trust had no investments in 2014/15

Note 19 Disclosure of interests in other entities

The Trust has no interests in unconsolidated subsidiaries, joint ventures, associates or unconsolidated entities

Note 20 Inventories

	31 March 2016	31 March 2015
	£000	£000
Drugs	2,724	2,563
Consumables	3,365	3,304
Energy	59	96
Other	86	89
Total inventories	**6,234**	**6,052**

Inventories recognised in expenses for the year were £39,209k (2014/15: £34,866k). Write-down of inventories recognised as expenses for the year were £0k (2014/15: £0k).

As stated in Note 1.8, the use of the first-in first-out cost formula to value inventories is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 21.1 Trade receivables and other receivables

	31 March 2016	31 March 2015
	£000	£000
Current		
Trade receivables due from NHS bodies	8,146	5,689
Receivables due from NHS charities	585	937
Provision for impaired receivables	(882)	(958)
Prepayments (non-PFI)	2,405	2,344
Accrued income	6,867	7,200
PDC dividend receivable	325	-
VAT receivable	106	251
Other receivables	5,210	5,283
Total current trade and other receivables	**22,762**	**20,746**
Total non-current trade and other receivables	**-**	**-**

As stated in Note 3.2, some accrued income is based on estimates in order to ensure the completeness of income reported. This occurred at the end of March 2016 so the level of trade and other receivables will reflect the same value. Any variation in outcome compared to the estimates used are accounted for in the next financial period. This approach is consistent with the previous year.

Note 21.2 Provision for impairment of receivables

	2015/16	2014/15
	£000	£000
At 1 April as previously stated	**958**	**914**
Prior period adjustments	-	-
At 1 April - restated	**958**	**914**
At start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
Increase in provision	18	57
Amounts utilised	(94)	(13)
Unused amounts reversed	-	-
At 31 March	**882**	**958**

The provision for impairment of receivables is in line with IFRS and are based on incurred losses and not general losses.

Note 21.3 Analysis of impaired receivables

	31 March 2016		31 March 2015	
	Trade receivables	Other receivables	Trade receivables	Other receivables
Ageing of impaired receivables	**£000**	**£000**	**£000**	**£000**
0 - 30 days	-	16	-	18
30-60 Days	4	18	-	13
60-90 days	8	11	1	25
90- 180 days	-	58	57	38
Over 180 days	462	305	542	264
Total	**474**	**408**	**600**	**358**
Ageing of non-impaired receivables past their due date				
0 - 30 days	785	57	1,270	75
30-60 Days	426	64	449	58
60-90 days	211	40	89	109
90- 180 days	216	207	167	166
Over 180 days	735	1,078	361	1,131
Total	**2,373**	**1,446**	**2,336**	**1,539**

Note 21 Finance Lease receivables

The Foundation Trust was not a lessor during the reporting period.

Note 22 Other assets

The Trust has no other assets

Note 23 Other financial assets

The Trust has no other financial assets

Note 24.1 Non-current assets for sale and assets in disposal groups

The Board has not declared any assets being surplus to requirements in 2015/16

Note 24.2 Liabilities in disposal groups

The Trust has no liabilities in disposal groups

Note 25.1 Cash and cash equivalents movements

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

	2015/16	2014/15
	£000	£000
At 1 April	**23,148**	**14,585**
Prior period adjustments	-	-
At 1 April (restated)	**23,148**	**14,585**
At start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
Net change in year	(16,162)	8,563
At 31 March	**6,986**	**23,148**
Broken down into:		
Cash at commercial banks and in hand	(25)	240
Cash with the Government Banking Service	7,011	22,908
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**6,986**	**23,148**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**6,986**	**23,148**

Note 25.2 Third party assets held by the NHS foundation trust

Western Sussex Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2016	31 March 2015
	£000	£000
Bank balances	1	19
Monies on deposit	-	-
Total third party assets	**1**	**19**

Note 26.1 Trade and other payables

	31 March 2016 £000	31 March 2015 £000
Current		
Receipts in advance	-	2,549
NHS trade payables	1,032	1,176
Amounts due to other related parties	-	-
Other trade payables	11,601	11,554
Capital payables	3,923	2,464
Social security costs	2,462	2,379
VAT payable	-	-
Other taxes payable	2,583	2,557
Other payables	3,659	3,659
Accruals	12,959	14,775
PDC dividend payable	-	327
Total current trade and other payables	**38,219**	**41,440**
Total non-current trade and other payables	**-**	**-**

Any estimation method used is selected based on the nature of the expense. The primary estimation methods are the use of contracted sums for outstanding invoices or estimation based on average payments in prior periods.

Any variation in outcome of expenditure accruals compared to the estimates used are accounted for in the next period. These estimates and assumptions are consistent with the previous year.

Note 26.2 Early retirements in NHS payables above

The trust has no early retirements in NHS payables above

Note 27 Other financial liabilities

The trust has no other financial liabilities

Note 28 Other liabilities

	31 March 2016 £000	31 March 2015 £000
Current		
Deferred grants income	105	-
Deferred goods and services income	1,672	1,990
Total other current liabilities	**1,777**	**1,990**
Total other non-current liabilities	**-**	**-**

Note 29 Borrowings

	31 March 2016 £000	31 March 2015 £000
Current		
Loans from the Department of Health	2,158	2,158
Obligations under finance leases	66	32
Total current borrowings	**2,224**	**2,190**
Non-current		
Loans from the Department of Health	22,612	24,769
Obligations under finance leases	2,366	2,369
Total non-current borrowings	**24,978**	**27,138**

Note 30 Finance leases

Note 30.1 Western Sussex Hospitals NHS Foundation Trust as a lessor

There are no future lease receipts due under finance lease agreements where Western Sussex Hospitals NHS Foundation Trust is the lessor.

Note 30.2 Western Sussex Hospitals NHS Foundation Trust as a lessee

Obligations under finance leases where Western Sussex Hospitals NHS Foundation Trust is the lessee.

	31 March 2016 £000	31 March 2015 £000
Gross lease liabilities	**12,389**	**12,530**
of which liabilities are due:		
- not later than one year;	221	207
- later than one year and not later than five years;	879	828
- later than five years.	11,289	11,495
Finance charges allocated to future periods	(9,957)	(10,129)
Net lease liabilities	**2,432**	**2,401**
of which payable:		
- not later than one year;	66	32
- later than one year and not later than five years;	201	157
- later than five years.	2,165	2,212
Total of future minimum sublease payments to be received at the reporting date	**-**	**-**
Contingent rent recognised as an expense in the period	114	117

Note 31.1 Provisions for liabilities and charges analysis

	Pensions - former directors	Pensions - other staff	Other legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2015	**99**	**1,381**	**266**	**15**	**1,755**	**3,516**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	**-**
Change in the discount rate	-	(5)	-	-	(15)	**(20)**
Arising during the year	2	27	60	158	36	**283**
Utilised during the year	(7)	(125)	(38)	(158)	(99)	**(427)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	**-**
Reversed unused	-	-	(147)	(15)	-	**(162)**
Unwinding of discount	1	19	-	-	24	**44**
At 31 March 2016	**95**	**1,297**	**141**	**-**	**1,701**	**3,234**
Expected timing of cash flows:						
- not later than one year;	7	125	141	-	99	**372**
- later than one year and not later than five years;	29	465	-	-	381	**875**
- later than five years.	59	707	-	-	1,221	**1,987**
Total	**95**	**1,297**	**141**	**-**	**1,701**	**3,234**

Pension costs are based upon known amounts that will have to be paid to the NHS Pensions Agency in respect of staff who have retired early. By their very nature, provisions are estimates, though informed. For the calculation of pension and injury benefit liabilities, government actuary figures for expected mortality have been used and for legal claims, data is provided by the NHS Litigation Authority.

Provisions related to injury benefits is administered by the NHS Business Services Authority.

Any variation in outcome compared to the provisions are accounted for in the next financial year.

Note 31.2 Clinical negligence liabilities

At 31 March 2016, £111,942k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Western Sussex Hospitals NHS Foundation Trust (31 March 2015: £27,826k).

The provision for legal claims is based on the report from the NHS Litigation Authority (NHSLA) for the period ending 31st March 2016.

Note 32 Contingent assets and liabilities

	31 March 2016 £000	31 March 2015 £000
Value of contingent liabilities		
NHS Litigation Authority legal claims	(53)	(106)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**(53)**	**(106)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(53)**	**(106)**
Net value of contingent assets	**-**	**-**

The Foundation Trust has no contingent liabilities other than those advised by the NHSLA as at 31st March 2016 shown above.

The Foundation Trust has no contingent assets.

Note 33 Contractual capital commitments

	31 March 2016 £000	31 March 2015 £000
Property, plant and equipment	8,974	3,265
Intangible assets	809	346
Total	**9,783**	**3,611**

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2016 are in receivables from customers, as disclosed in the trade and other receivables note to the accounts.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups (CCGs), which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from a combination of its own self-generated funds and capital investment loans with reference to Monitor's Continuity of Services Risk Rating. The Trust is not, therefore, exposed to significant liquidity risks.

Note 37.2 Financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2016					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non-financial assets	20,639	-	-	-	**20,639**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	6,986	-	-	-	**6,986**
Total at 31 March 2016	**27,625**	**-**	**-**	**-**	**27,625**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2015					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non-financial assets	16,253	-	-	-	**16,253**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	23,148	-	-	-	**23,148**
Total at 31 March 2015	**39,401**	**-**	**-**	**-**	**39,401**

Note 37.3 Financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2016			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	24,770	-	**24,770**
Obligations under finance leases	2,432	-	**2,432**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non-financial liabilities	29,352	-	**29,352**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2016	**56,554**	**-**	**56,554**

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2015			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	26,927	-	**26,927**
Obligations under finance leases	2,401	-	**2,401**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non-financial liabilities	30,376	-	**30,376**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2015	**59,704**	**-**	**59,704**

Note 37.4 Maturity of financial liabilities

	31 March 2016	31 March 2015
	£000	£000
In one year or less	31,576	32,566
In more than one year but not more than two years	2,194	2,193
In more than two years but not more than five years	5,865	6,207
In more than five years	16,919	18,738
Total	**56,554**	**59,704**

Note 37.5 Fair values of financial assets at 31 March 2016

There are no financial assets held at book value or fair value by the Trust.

Note 37.6 Fair values of financial liabilities at 31 March 2016

	Book value	Fair value
	£000	£000
Non-current trade and other payables excluding non-financial liabilities	-	-
Provisions under contract	-	-
Loans	22,612	22,612
Other	2,367	2,367
Total	**24,979**	**24,979**

Note 37 Changes in the benefit obligation and fair value of plan assets during the year

There are no changes in the benefit obligation and fair value of plan assets during the year for the amounts recognised in the Statement of Financial Position

Note 38 Losses and special payments

	2015/16		2014/15	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Total losses	-	-	-	-
Special payments				
Ex-gratia payments	51	61	56	114
Total special payments	**51**	**61**	**56**	**114**
Total losses and special payments	**51**	**61**	**56**	**114**
Compensation payments received		-		-

Note 39 Transfers by absorption
There were no transfers by absorption in the reporting period.

Note 40 Prior period adjustments
There are no prior period adjustments

Note 41 Events after the reporting date
There are no events after the reporting period

Note 42 Related parties

	Receivables		Payables	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
NHS Coastal West Sussex	3,170	3,772	1,472	1,566
NHS England	3,547	2,122	302	317
Sussex Community Trust	1,137	1,222	262	91
Sussex Partnership Foundation Trust	1,464	847	213	-
Western Sussex Hospitals Charities and Other Related Charities	1,007	937	-	-
Total	**10,325**	**8,900**	**2,249**	**1,974**

Details of related party transactions with individuals are as follows:

	Income		Expenditure	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
BT (related to Jon Furmston, Non-Executive Director)	-	-	89	131

	Income		Expenditure	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
NHS Coastal West Sussex	284,231	273,644	94	-
NHS England	53,731	48,802	1,080	1,225
Sussex Community Trust	3,610	3,793	649	582
Sussex Partnership Foundation Trust	3,533	3,612	467	294
South Eastern Hampshire CCG	5,756	5,582	-	-
Health Education England	13,216	9,894	3	7
Western Sussex Hospitals Charities and Other Related Charities	1,519	1,601		-
Total	**365,596**	**346,928**	**2,293**	**2,108**

INDEPENDENT AUDITOR'S STATEMENT TO THE DIRECTORS OF WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST ON THE NHS FOUNDATION TRUST CONSOLIDATION SCHEDULES

We have examined the consolidation schedules designated FTC1 to FTC38 excluding FTC0, FTC8a and FTC8b of Western Sussex Hospitals NHS Foundation Trust for the year ended 31 March 2016, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This statement is made solely to the Board of Directors of Western Sussex Hospitals NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 (the Act) and paragraph 4.2 of the Code of Audit Practice and for no other purpose.

For the purpose of this statement, reviewing the consistency of figures between the audited financial statements and the consolidation schedules extends only to those figures within the audited financial statements which are also published in the consolidation schedules.

Auditors are required to report on any differences over £250,000 between the audited financial statements and the consolidation schedules.

Unqualified audit opinion on the audited financial statements; no differences identified:

The figures reported in the consolidation schedules are consistent with the audited financial statements, on which we have issued an unqualified opinion.

Paul King
for and on behalf of Ernst & Young LLP
Reading
26 May 2016

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST

Certificate

We certify that we have completed the audit of the financial statements of Western Sussex Hospitals NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office on behalf of the Comptroller and Auditor General (C&AG).

Our opinion on the financial statements

In our opinion, the financial statements:

- give a true and fair view of the state of Western Sussex Hospitals NHS Foundation Trust's affairs as at 31 March 2016 and of its income and expenditure and cash flows for the year then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16 and the directions under paragraph 25 of Schedule 7 of the National Health Service Act 2006;

What we have audited

Western Sussex Hospitals NHS Foundation Trust's financial statements comprise:

- the Trust's Statement of Comprehensive Income;
- the Trust's Statement of Financial Position;
- the Trust's Statement of Changes in Taxpayers' Equity;
- the Trust's Statement of Cash Flows; and
- the related notes 1 to 42.

The financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16 issued by Monitor. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRS), as adopted by the European Union and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts.

Overview of our audit approach

Risks of material misstatement	• Risk of Fraud in revenue Recognition; and • Risk of Management Override.
Audit scope	• We have performed a full audit on the Trust's financial statements,
Materiality	• Overall Trust materiality of £4.175 million which represents 1% of estimated gross operating expenses from continuing operations.

Our assessment of risk of material misstatement

Risk	Our response to the risk	What we concluded to the Audit Committee
Risk of Fraud in revenue Recognition Our audit planning highlighted the financial pressures the NHS as a whole is experiencing. Specifically we identified the pressure on Western Sussex Hospitals NHS Foundation Trust to achieve its financial forecast, or to present an improved position. The financial pressures on the Trust mean that there is a risk of manipulation of the reported financial position to achieve the forecast outturn.	For both income and expenditure we undertook controls testing on the accounts receivable and accounts payable systems respectively. The significant elements of our substantive testing included: ► reviewing and testing revenue and expenditure recognition policies; ► reviewing with management any accounting estimates on revenue or expenditure recognition for evidence of bias; ► evaluating the outcomes of the Department of Health's agreement of balances exercise, focusing our work on the significant mismatches between the Trust and its counterparties and seeking sufficient and appropriate audit evidence to understand the basis of the Trust's disclosed balances in both income and expenditure, and the associated receivables and payables balances; and ► developing a testing strategy to test material revenue and expenditure streams; ► for income, seeking to agree or reconcile recognised income through to annual source evidence, and to understand the nature of	We concluded that there was sufficient and appropriate evidence in all of the audit procedures performed.

	any significant variations or agreements made on or around the end of the period; and ► for expenditure, testing of the Trust's accruals process at year end, and its cut-off arrangements.	
Risk of Management Override As identified in ISA (UK and Ireland) 240, management is in a unique position to perpetrate fraud because of its ability to manipulate accounting records directly or indirectly and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. We identify and respond to this fraud risk on every audit engagement. Specifically we identified the pressure on Western Sussex Hospitals NHS Foundation Trust to achieve its financial forecast, or to present an improved position may increase this risk.	Our substantive testing included: ► testing the appropriateness of journal entries recorded in the general ledger and other adjustments made in the preparation of the financial statements; ► reviewing accounting estimates for evidence of management bias; and ► evaluating the business rationale for significant unusual transactions.	We concluded that there was sufficient and appropriate evidence in all of the audit procedures performed.

In the prior year, our auditor's report included a risk of material misstatement in relation to:

- the Trust's financial position; and
- the disposal of Southlands Hospital.

In the current year, the Trust's financial position is considered as part of our risk of fraud in revenue recognition, whilst the disposal of Southlands Hospital was completed in 2014/15.

The scope of our audit

Our assessment of audit risk, our evaluation of materiality and our allocation of performance materiality determine our audit strategy and scope. In assessing the risk of material misstatement to the financial statements, we focus audit effort towards higher risk areas, such as management judgements and estimates and balances that are considered significant based on value and complexity. We ensure that our audit provides adequate assurance of these significant accounts identified.

The audit team follows a programme of work to ensure we have obtained an understanding of; the entity-level controls of the Trust and the Trust's system, including documentation and walking through key financial systems which assisted us in identifying and assessing risks of material misstatement due to fraud and error, as well as assisting us in determining the most appropriate audit strategy.

We were provided with sufficient access to the Trust to ensure appropriate audit procedures could be completed.

Our application of materiality

We apply the concept of materiality in planning and performing the audit, in evaluating the effect of identified misstatements on the audit and in forming our audit opinion.

Materiality
The magnitude of an omission or misstatement that, individually or in the aggregate, could reasonably be expected to influence the economic decisions of the users of the financial statements. Materiality provides a basis for determining the nature and extent of our audit procedures.

We determined materiality for the Trust to be £4.175 million (2014/15: £3.9 million), which is 1% (2014/15: 1%) of estimated gross operating expenses from continuing operations. We believe that gross operating expenses provide us with a basis for determining the nature, timing and extent of risk assessment procedures to identify our assessment of the risks of material misstatement.

Performance materiality
The application of materiality at the individual account or balance level. It is set at an amount to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality.

On the basis of our risk assessments, together with our assessment of the Trust's overall control environment, our judgement was that performance materiality was 75% (2014/15: 75%) of our planning materiality, namely £3.131 million (2014/15: £2.925 million). We have set performance materiality at this percentage to ensure that the total uncorrected and undetected audit differences do not exceed our materiality for the financial statements as a whole.

Reporting threshold
An amount below which identified misstatements are considered as being clearly trivial.

We agreed with the Audit Committee that we would report to them all uncorrected audit differences in excess of £0.208m (2014/15: £0.195m), which is set at 5% of materiality, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds.

We evaluate any uncorrected misstatements against both the quantitative measures of materiality discussed above and in light of other relevant qualitative considerations in forming our opinion.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the accounting officer; and the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Respective responsibilities of accounting officer and auditors

As explained more fully in the Statement of Accounting Officer's Responsibilities, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the NHS Act 2006, the Code of Audit Practice issued by the National Audit Office (NAO) on behalf of the Comptroller and Auditor General, and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Opinion on other matters prescribe by the Code of Audit Practice issued by the NAO

In our opinion:

- the information given in the performance report and accountability report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the parts of the Remuneration and Staff report identified as subject to audit has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16.

Matters on which we report by exception

The Code of Audit Practice requires us to report to you if

We issue a report in the public interest under schedule 10(3) of the National Health Service Act 2006.	We have no exceptions to report.

We refer the matter to Monitor under schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.	We have no exceptions to report.
We are not satisfied that the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources as required by schedule 10(1)(d) of the National Health Service Act 2006.	We have no exceptions to report.

Other matters on which we report by exception

NHS Foundation Trust Annual Reporting Manual 2015/16 and ISAs (UK and Ireland) reporting	We are required to report to you if, in our opinion, information in the Annual Report is: • materially inconsistent with the information in the audited financial statements; or • apparently materially incorrect based on, or materially inconsistent with, our knowledge of the NHS Foundation Trust acquired in the course of performing our audit; or • otherwise misleading. In particular, we consider if: • we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable; or • whether the annual report appropriately discloses those matters that were communicated to the Audit Committee which we consider should have been disclosed.	We have no exceptions to report.
Code of Audit Practice issued by the NAO	We are required to report to you if we have been unable to satisfy ourselves that: • the Annual Governance Statement, and other information published with the financial statements meets the disclosure requirements set out in the NHS Foundation Trust Annual	We have no exceptions to report.

	Reporting Manual 2015/16 and is not misleading or inconsistent with other information forthcoming from the audit; and • proper practices have been observed in the compilation of the financial statements.	

Who we are reporting to

This report is made solely to the Council of Governors of Western Sussex Hospitals NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors, for our audit work, for this report, or for the opinions we have formed.

Paul King
for and on behalf of Ernst & Young LLP
Reading
26 May 2016

Western Sussex Hospitals NHS

NHS Foundation Trust