NHS
Western Sussex Hospitals
NHS Foundation Trust

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Annual Report and Accounts 2016 / 17

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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 2016-17

1. Performance Report

1.1 Welcome from the Chairman and Chief Executive

This was the first year we were operating as an officially, externally recognised "outstanding" Trust. Following the publication of the Care Quality Commission's report in early April 2016, everyone who works for Western Sussex Hospitals had the recognition they so rightly deserved.

We've all been working hard to maintain those standards witnessed and praised by the CQC. We have continued striving to be even better. Our workforce has risen to every challenge and the patients are the ones benefitting.

In 2016/17, we continued with the roll out of our Patient First Improvement System (PFIS). It is transforming wards, empowering staff and driving lasting improvements. Even those members of staff who might have been sceptical at first are realising the benefits and finding they have more time to care for patients now that their processes work more efficiently.

Perhaps the most important of the CQC inspectors' findings was the extent to which colleagues at all levels and across all areas recognised the value of Patient First and were enthused by the possibilities of innovation in service delivery and care.

Patient First recognises that it is the people involved in providing a service who are best placed to identify and drive the improvements that need to be made there, and that 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.

A new challenge that came our way in 2016/17, was the request from NHS Improvement that we support our neighbours in Brighton and Sussex University Hospitals to find their way out of the safety and financial special measures that they are under.

We spent a long time considering how we could best offer our support, while continuing to improve standards across Western Sussex Hospitals. Through a detailed impact analysis, we were able to design a new management structure that will enable us to help our neighbours for the benefit of patients and continue to drive improvements here.

The coming year is going to be challenging, but if there's one thing we know, a challenge is just something Western Sussex Hospitals rises to.

…… 25 May 2017

Marianne Griffiths, Chief Executive

Western Sussex Hospitals NHS Foundation Trust

…… 25 May 2017

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 7,067 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 2016/17, we held 594,337 outpatient appointments (2015/16: 585,846), treated 141,824 inpatient and day cases (2015/16: 135,792) and saw 138,196 patients in A&E (2015/16: 136,804)

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 14,000 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 2016/17 was £435 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 key access targets and outcomes objectives set out in the Single Oversight Framework* drawn up by NHS Improvement, the new overseer of health care organisations.

These are:

- A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge
- Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate − patients on an incomplete pathway
- All cancers – maximum 62-day wait for first treatment from:
  - urgent GP referral for suspected cancer
  - NHS cancer screening service referral
- Maximum 6-week wait for diagnostic procedures

*NHS Improvement published the new Single Oversight Framework for providers in September 2016. The framework replaced the Monitor Risk Assessment Framework and was introduced from 1st October 2016.

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 possible patient experience.

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 key access targets and outcomes objectives used to assess operational performance under the Single Oversight 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 as well as monthly surveys of nine key questions relating to staff engagement

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 59% of WSHFT staff took part in the 2016 survey, an increase of five percentage points from 54% in 2015, 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 NHS Improvement Single Oversight Framework in 2016/17 and shows consistent compliance and/or improvement. Detailed narrative of each element follows the table.

NHS Improvement Single Oversight Framework			MARCH 2017													
		Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date	Trend
OP1	A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	96.56%	95.99%	95.97%	93.85%	94.24%	95.86%	93.50%	94.38%	91.01%	91.08%	93.75%	95.81%	94.37%	
OP2	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	86.95%	88.15%	88.35%	88.41%	88.67%	89.20%	90.12%	91.76%	92.04%	92.01%	91.80%	92.01%	89.90%	
OP3A	All cancers : 62-day wait for first treatment following urgent GP Referral	85%	86.09%	86.45%	85.91%	86.96%	85.83%	89.92%	88.85%	88.69%	86.23%	86.29%	87.13%	90.66%	87.47%	
OP3B	All cancers : 62-day wait for first treatment following consultant screening service referral	90%	93.62%	96.08%	95.31%	100.00%	100.00%	93.94%	100.00%	100.00%	96.61%	97.37%	88.37%	100.00%	96.47%	
OP4	Maximum 6-week wait for diagnostic procedures	94%	2.41%	1.50%	1.28%	0.27%	0.49%	0.88%	0.97%	0.85%	0.95%	2.33%	1.51%	0.84%	1.21%	

A&E waiting times

The Trust achieved an average 94.4% compliance rate against A&E four hour wait targets. This has been set against a backdrop of a sustained increase in demand, with a 3.9% increase in emergency admissions. Western Sussex Hospitals was in the top 10 performing Trusts in the country for A&E delivery as reported by NHS England.

Referral to Treatment (RTT)

The Trust delivered against RTT targets for the first time in a number of years in 2016/17, meaning that over 28,000 patients who would have had to have previously waited longer than 18 weeks were treated in time. We increased the overall numbers of patients treated by 6.4% compared to the previous year while at the same time the number of referrals increase by nearly 12,000 (4.8%) over the year.

Cancer

The Trust completed the year with fully compliant with the target waiting times to see, diagnose and treat patients with suspected cancer. This was set against a context the context of a 10.6% increase in cancer referral demand in 2016/17, which follows an 18.8% increase in cancer referrals in 2015/16. Despite these unprecedented increases in demand, patients are benefitting from the best and most consistent cancer work in the history of the Trust.

Diagnostics

The Trust delivered diagnostic investigations within the 6 week target for patients in 2016/17, representing one of the best years for delivery of the target in the Trust's history.

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

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 2016/17 to 3.05%.

In 2016/17, the Trust maintained its position within 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 27th today.

We have focused specifically over recent years on improving mortality rates among hip fracture patients. In 2016/17, these stood at 68.63, having already fallen to 77.2 in 2015/16 on the Dr Foster HSMR measure, against an expected average of 100.0.

We have focused on reduction in crude non-elective mortality associated with sepsis through our Deteriorating Patient Improvement Programme. We have seen a reduction in crude non-elective mortality associated with sepsis over the past two years from 115.10% in 2015 90.63% in 2016/17 as of November 2016

Safe care

In 2016/17 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 has been a 19% reduction in inpatient falls over the last two years, with just under 10% reduction over 2016/17. This equates to 474 less falls. However, it remains a major area of concern for the Trust as we aim to reduce in hospital harms.

The Trust has met the targets and requirements for the following medicines related CQUINs for 16/17

- Medicines Safety Thermometer (including the use of the Summary Care record)
- Antimicrobial prescribing review and volume used
- Chemotherapy dose banding

We have also seen a marked decrease in the number of incidents involving drug/ prescribing errors, which have fallen from 1,247 in 2013/14 to 826 in 2016/17.

Another strong indicator of safe care is the number of pressure sores patients develop while in our care. Unfortunately, and despite efforts to reduce the number of pressure ulcers, we have seen a significant rise in hospital acquired pressure damage. In part, this is due to the changed our approach to reporting or order to gather more data.

We had aimed to deliver a target of 10% reduction in grade 2+ pressure damage from the 2015/16 baseline. We achieved a 6% reduction. We have put in place essential foundations on which to see improvements in the coming 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 41% of trusts for recommendation, against a target of top 30%
- In maternity, our recommendation rate increased to 96.7%, putting us back above the national average and into the top 40% of trusts. Our response rate almost doubled from 11.7% in 2015/16 to 22.8% in 2016/17.
- For inpatient recommendation, we scored above the national average for both Worthing and St Richard's Hospitals for the first time ever with a score of 95.84%
- Among outpatients, we also scored above the national average of 92.5% with a score of 95.1%. This has increased from 92.4%.

We are taking steps to improve our performance in the areas outlined above.

Staff Experience

In 2016/17, we incorporated our reliable care goal into our other improvement goals and split our "improving patient and staff experience" goal into two distinct workstreams.

During 2016/17, the Trust's engagement score improved from 3.78 to 3.88, above the national average of 3.81.

For the sixth year, the Trust rolled out the NHS staff survey to all permanent staff and achieved its highest response rate of 59%, an increase of 5% on last year (see Staff Report section for a detailed breakdown).

1.3.4 Financial performance

The key highlights for the Trust's financial performance during the period from 1st April 2016 – 31st March 2017 were:

- Against a challenging financial environment the Trust incurred a retained surplus of £8.8m. The Trust delivered a financial risk rating of 2 at year end, out of a possible top rating of 1.
- Cost improvement programme savings of £18.2m (4% of turnover)
- *Expenditure on capital schemes of £17m, including Southlands Ophthalmology, Endoscopy equipment and medical imaging equipment*

replacement. The capital programme was supported by the Love Your Hospital team who donated over £250,000

As the year progressed the Trust experienced:

- Significantly higher than planned increases in urgent care, 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.

The Trust saved £18.2m 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.

As at the end of March 2017, the Trust is reporting a surplus of £8.8m after adjustment for impairments and donated assets as summarised in the table below.

Financial Performance for 2016/17	**£m**
Net Surplus	£ 0.83
Add back:	
Impairment of Fixed Assets	£ 8.01
Retained Surplus	£ 8.84

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 £8.01m 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 2017/18, including its financial plans. The Trust forecasts reaching a Use of Resource Rating of 2 and delivering a control total surplus, as defined by NHS Improvement, of £14.9m, 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 from Oct 2016 was covered under the Use of Resource Rating which is driven by assessments on liquidity, capital service cover, income and expenditure margin, variance to plan and agency expenditure. The highest rating that can be achieved is a score of 1. A score of 2 indicates no significant financial concerns and a score of 3 requires an increased level of monitoring. The Trust scored a 1 in quarter three and a 2 in quarter 4. In the first six months under the previous governance ratings where 4 was the highest and 1 was the lowest, the Trust scored a 3 in quarter one and a 4 in quarter 2.

There were no formal interventions by the regulator during the year 2016/17.

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 £690k on external consultancy services in 2016/17, primarily to support the patient first initiative.

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.

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 commitments:

- Decarbonise our facilities in line with NHS national targets. We will identify an Energy Partner to support us in reducing energy emissions and costs.
- CO2 reduction, in our buildings energy consumption to meet NHS National targets under the Climate Change Act 2008 (we will have a 34% reduction against our baseline).

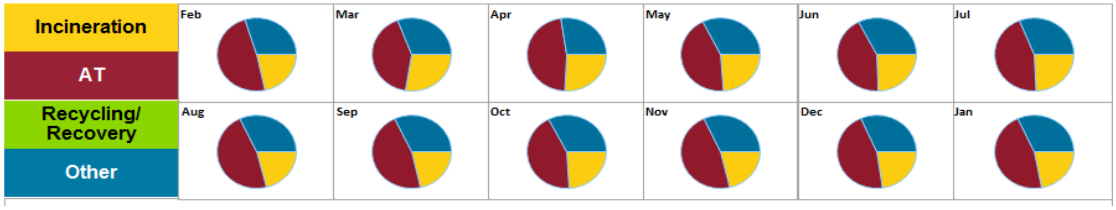
- Decarbonise our travel and transport operations minimise the Environmental and Health impacts associated with the movement of staff, patients and goods.
- Support staff and patients switch to more active and sustainable ways of travelling, Shifting away from car, dependency, solo car occupancy. Support health and wellbeing, cut costs, reduce carbon emissions.
- Green Travel Plan, with a focusing engaging and supporting staff, patients and visitors to change their mode of travel in a practical way, reducing single car occupancy and engaging in active travel.
- Demonstrate commitment to sustainable procurement in line with the Social Value Act integrating environmental and social principles into our core procurement practices alongside economic considerations.
- Ensure staff across the Trust better understand the impact of our procurement practices, through measurement and engagement.
- Inform, empower and support our workforce to take action to deliver high quality care today in a way that does not compromise our ability to deliver care in the future.
- Embed sustainability into HR policies and practices and ensure that staff development processes support a shift to more sustainable and resilient healthcare delivery with clear senior leadership.
- Engage with other local trusts and business sharing local sustainability issues.
- On the 23rd March 2017 we held a National Sustainability day at Worthing and SRH this will be strongly supported by local authorities and contractors we will engage with our patients and local community on sustainable lifestyles, supporting them in actions that benefit their health and wellbeing, supporting preventative care.
- Create infrastructure, supply chain and logistics operations that are resilient to changes in climate and extreme weather events through our resilience and business continuity programmes.
- Work with clinical services to ensure we are prepared for the projected impacts of climate change impact on the Trust, including changing health needs of our patients and disruption to delivery of our services.
- Embed sustainability into our governance structures, ensuring effective, targeted action is possible at all levels of the Trust and in both clinical and non-clinical areas.
- Monitor and measure our progress against the Sustainable Development Management Plan and adopt transparent public reporting as a fundamental principle for improvement and good governance.
- We are currently completing the Institute of Environment Management and Assessment to measure of our sustainability improvements. This will support environmental compliance ensuring we have the correct licences and consents in place all.
- Report energy, water and waste performance to Trust staff: Develop a Sustainability page on the intranet to achieve this.
- Maintain a clean, healthy and safe environment. We will minimise waste, increase recycling and reduce the environmental impact of landfill.

Key operational indicators during 2016/17 demonstrate and reflect that the Trust deployed significant and additional winter escalation capacity. Average Inpatient Bed Occupancy increased to 95.5% in December. This additional activity showed an increased patient and visitor's footfall to our hospitals. We have performed well with Waste management alongside increased activity across our sites.

The chart below demonstrates clinical waste activity in 2016/17. Blue represents non-infectious waste known as offensive waste. Burgundy refers to Alternative Treatment (AT) waste; which is waste that is autoclaved and treated.

We have reduced infectious waste through a drive to improve waste segregation which has meant the amount sent for incineration (Yellow) remains stable and is not increasing.

Further reducing the amount of waste which requires autoclave processing or incineration will help us achieve our aim of reducing carbon emissions as a result of waste disposal.



1.3.6 Influences on performance 2016-17

Staff commitment

The commitment and dedication of our 7,067 staff continues to feature strongly in our performance. In the last 12 months, our staff have cared for more people than ever before, achieved better outcomes and standards than ever before, and have continued to do so with compassion, kindness and respect. Despite the unprecedented pressures on services, particularly during the autumn and winter, our staff survey results for 2016, across all staff groups and divisions, were the best we have ever seen.

Following on from our CQC inspection in December 2015 and subsequent publishing of results in March 2016, we have had a string of external visits and invitations to share our good practice. This included the first of a series of events for other NHS trusts to come to our hospitals and see the Patient First programme for themselves. Hosted by chief executive Marianne Griffiths, and working with partners KPMG, the day included tours of our wards and emergency floor as well as presentations from medical director and colleagues leading improvements projects across the trust.

In the autumn, building on our philosophy of continuous improvement we held two staff conferences, supported by the Trust's charity Love Your Hospital, where our teams were able to showcase their improvement, innovation and learning through a series of workshops and short vignettes. Keynote speakers provided stimulation,

inspiration and challenge to more than 500 staff who described feeling proud of their colleagues and passionate about the difference they make to the local community.

During last year we coped well with the impact of a series of prolonged periods of industrial action by junior doctors in protest of new terms and conditions of service, with minimal disruption to patient services. Multi-disciplinary working at all levels facilitated this and good engagement with our junior doctors and their representatives was maintained.

We held our first outstanding visits event with representatives from other trusts to share our learning from our Patient First Programme. Feedback included “Lots of tips and practice examples, tempered with realism”.

Every week, stories of outstanding care and commitment are shared and whilst we know we have more to do, we truly believe that our staff are really very special.

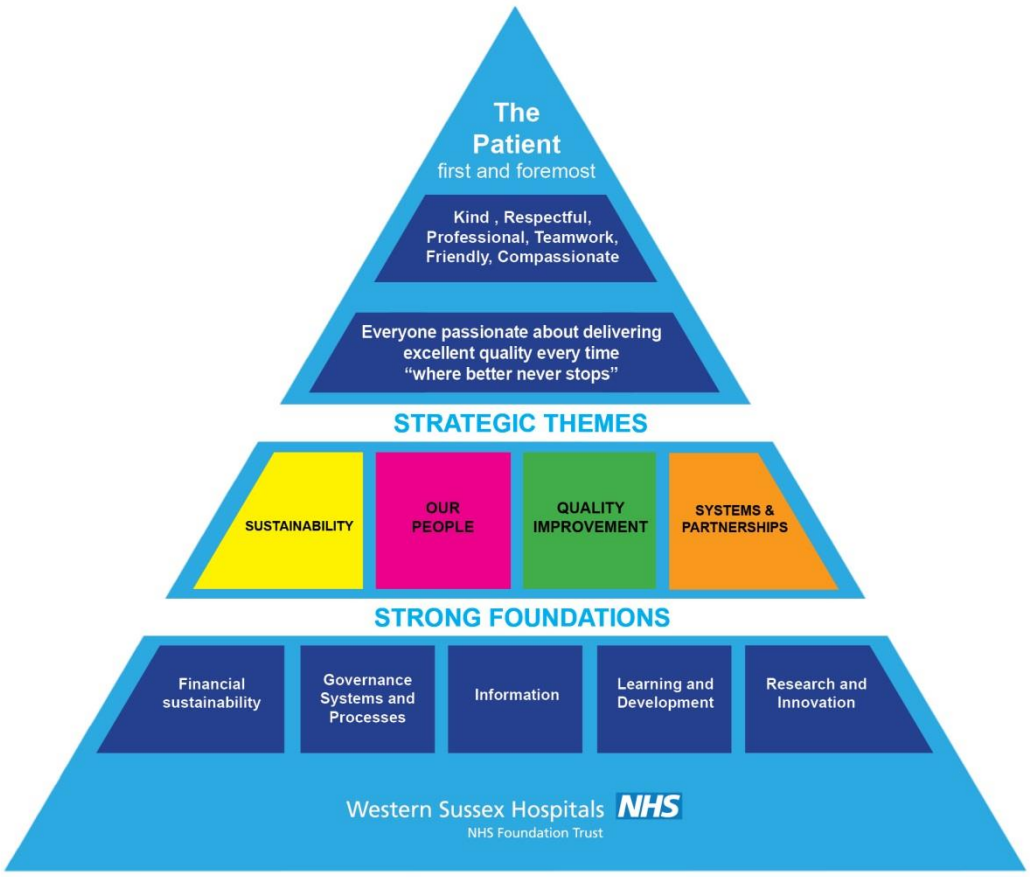
Patient First

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 – our leading, 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

How it is delivered

Patient First is supported by 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.

Patient First in 2016/17

This has been the year that Patient First really embedded within the organisation, started making sense to the vast majority of staff and really showed strong benefits.

We rolled out the Patient First Improvement System (PFIS) with the first wave in May. The areas that have been through the PFIS process have been completely transformed. It is resulting in better leaders and better care.

While some staff were sceptical at first about a management system that might interrupt their patient care, those same staff members have embraced Patient First, owning and replicating the processes to keep realising benefits. One member of staff commented that now they have a fast-track solution to solving problems, they have more time to care for patients.

For example, on some of our PFIS wards we've seen a reduction in falls of over 50%. It has completely changed ways of working and strengthened our leadership.

Progress against our True North and Breakthrough objectives is described in detail in section two of the Quality Report section of this Annual Report.

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.

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 five acute 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. Since then, significant work has been carried out to improve the timeliness

of discharges from our Intensive Treatment Units and specifically preventing discharges at night.

The improvement meant that Western Sussex is the only trust in the country to meet a new national quality target, set by NHS England. It asked trusts to reduce by 30% the number of critical care bed days lost due to delayed discharges, specifically for ward fit patients waiting more than 24 hours.

Between January and March 2017 there were just nine discharges delayed by more than 24 hours from ICU at St Richard's and 42 in Worthing. Together, the total of 51 is a 35% reduction on the previous three month period.

The full CQC report is published here – www.cqc.org.uk/provider/RYR

Discharge from hospital

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 2016/17 there were typically more than 100 people on our wards who no longer needed to be there.

We continue to work with our partners and Coastal West Sussex Clinical Commissioning Group in order to address the issue.

Recruitment

During 2016-17, we also recruited more staff than ever and there was a net increase in our workforce of 307.5 full time equivalent. Our overall vacancy rate fell from 12% to 10% but this still remains a challenge for us both financially, through the cost of covering shifts with agency staff, and in terms of continuity of care we are able to provide as we have to move staff away from their designated areas to help cover elsewhere.

In the autumn, we held two trust-wide recruitment fayres and over 450 people attended the hospitals and registered their interest in a job or career. We will repeat this in 2017-18 and continue with our dedicated one-stop recruitment events for registered nurses, healthcare assistants and scientists and allied health professionals.

Staff recruited from the Philippines in late 2015 have now joined the Trust and international recruitment will feature in our strategy over the next three years. This will supplement the numbers recruited from the UK including current year one, two and three students until the outturn of the first nurse bursaries students in 2019. The

impact of Brexit on our EU staff supply is monitored through our retention work stream. To date this has had little effect and it is not anticipated to materially affect the Trust.

In the last 12 months we have been successful in recruiting qualified staff from both domestic and international recruitment. Our staff retention has also improved, with staff turnover decreasing by 1.3% to 7.9%. We have introduced stay interviews to ensure we know what we are doing well and what we need to improve upon for our new starters. This supplements what our staff tell us through an exit questionnaire when they leave the organisation.

During 2016/17, and as part of the Sustainability breakthrough objective, a lot of work has been spent reducing the reliance on agency staff. Whilst there has been a shift towards capped compliance, the majority of suppliers remain above capped rates. This will continue to remain a top priority in 2017/18.

Key achievements 2016/17

- Reduced agency staff used from 5.5% to 3.3%
- Increased the number of staff contracted by 307.5 FTE
- Improved rolling 12 month turnover of staff from 9.2% to 7.9%

Working with Brighton and Sussex University Hospitals

Early in 2016/17, as a result of our successful performance, we were asked to help Brighton and Sussex University Hospitals (BSUH) improve performance. Our neighbouring Trust is in special measures for safety and finances, which, inevitably, has a knock-on effect for patients in Western Sussex.

While keen to support our neighbours and improve care for patients across the whole of Sussex, we conducted a full impact assessment to be sure that services within Western Sussex Hospitals would not be negatively impacted.

We will appoint a new managing director to take responsibility for the day-to-day operation of the hospitals, while new directors will also be appointed to work below Board level in a move that will enable the executive team to take a more strategic role across the two trusts while retaining direct lines of accountability into each.

25 May 2017

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 2016/17 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

The Outstanding rating we received from the CQC 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:

- We started the financial year with the news that Western Sussex Hospitals was ranked fourth best in the country for A&E waiting times. Over the previous 12 months, more than 96 per cent of people who attended A&E in West Sussex were seen, treated, admitted or discharged in under four hours.

- This ranking was swiftly followed by the CQC's report, which rated Western Sussex Hospitals as outstanding.
- The new Emergency Floor model of care at Worthing Hospital and St Richard's in Chichester was been shortlisted for an Acute Medicine Innovation award by the Health Service Journal (HSJ). The HSJ Awards have recognised, celebrated and promoted the finest achievements in the NHS for 35 years, and showcased them to the service's most influential leaders.
- Western Sussex Hospitals' CEO, Marianne Griffiths, won the prestigious Chief Executive of the Year accolade also at the HSJ awards. Marianne was nominated by the Trust's Chairman, Mike Viggers, who praised her inspirational leadership which helped Western Sussex Hospitals become one of only five acute hospital trusts in the country to be awarded the Care Quality Commission's highest rating of Outstanding earlier this year.

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.

Education opportunities for nurses and midwives

Clinical Academic Pathways give nurses, midwives and allied health professionals the opportunity to combine a clinical and an academic career while investing in clinical research that could benefit our patients. As part of this new model, staff spend two days per week on their clinical practice and the remainder of their working time conducting research. Working in the clinical setting gives them the opportunity to put their research findings to use.

Health Education Kent, Surrey and Sussex has contributed a £250,000 investment to help fund the programme.

Trust's biggest ever recruitment day

In the autumn, the Trust embarked on its biggest ever recruitment drive, holding two workshop days and inviting potential employees from across the region to apply for a wide variety of roles on the day. The recruitment days offered jobseekers the opportunity to learn more about the Trust, attend tours and meet our teams. Over the two events, 300 attendees applied for a variety of roles, including apprenticeships, nursing and midwifery roles, admin roles and volunteering.

Partnering with the police for the welfare of patients

A&E teams at Worthing hospital have co-designed a new Trust-wide process with Sussex Police missing persons team, to provide a responsive Police service to vulnerable patients who leave the A&E department. This includes provision of a timely welfare check to patients if required. This is an innovation to improve patient safety particularly patients with mental health needs, and is a fabulous example of the Acute Trust collaborative approach with Sussex Police as our partners in this innovation.

Efficiency

Over the financial year, we made efficiency savings worth £18million through better use of our resources. These savings required the involvement of every team across the Trust. We have all had to learn to pay more attention to the small things, to notice where our money is being spent and to come up with innovative ways to spend less, while continuing to improve patient care.

Staff

One of our biggest problems has been the use of expensive agency staff. In 2016/17, we committed to tackling this issue. We worked with our agencies, exiting very high cost suppliers and securing lower rates with all remaining agencies.

Alongside that work we also invested in recruitment. In part, this involved revising job plans to make jobs with Western Sussex more attractive.

Moving from a reliance on agency staff to in bigger in-house workforce makes it easier for us to invest in our people through training and development, which results in better quality services for patients. Our nurses in particular have worked extremely hard to drive down reliance on agency staff and recruit more permanent people.

Reducing our reliance on agency staff was the biggest of around 40 different schemes in making our staffing more efficient, which also included reducing sickness and improving staff retention.

Looking ahead to the coming year, we will focus on addressing junior doctor vacancies and strengthening that workforce.

Procurement

Throughout 2016/17, we have made great strides in reducing the cost we pay for the products we use. We have standardised our supplies across clinical teams for better consistency. Not only does this mean that patients are being treated with the same equipment wherever they are in the hospitals, but it enables us to take advantage of preferential rates by buying in volume.

We will continue to drive down costs in this way year on year.

Retail catering

Our estates team have carried out a whole range of projects to make our buildings work better for the Trust. One initiative was the outsourcing of our retail catering services across the Trust. We awarded a contract to Compass Group to run our shops, restaurants and cafes. The move will see a £1.1m investment in upgrading the main entrances of our hospitals and generate an additional £450k a year to invest in patient services, the first instalment of which will be allocated for new radiology and ultrasound equipment at Worthing and St Richard’s hospitals.

Strategic developments

Ophthalmology at Southlands

In our biggest capital project ever as a Trust, our £7.5 million investment in creating a dedicated eye care centre at Southlands Hospital is on time and on budget. The site was handed back to the Trust from the developers in April 2017.

This investment should give a clear guide to local people that we are committed to Southlands hospital.

In preparation for moving our ophthalmology services to Southlands and in order to make the best use of our new facilities, we have had to review all our processes, reduce the backlog and waiting lists and improve services. As a result, waiting times are shorter and complaints are down, and we haven't even moved in yet.

The new centre will 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.

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 14,461 patients, relatives, visitors, carers and other service users during the year.
- In 35% of cases, we helped put things right via our PALS service within one working day.
- 61% of enquiries were on-the-spot general advice and information requests.
- 4% of all enquiries required a formal investigation under the NHS Complaints Procedure.

There was a significant reduction in the number of formal complaints referred to the Parliamentary Health Service Ombudsman (PHSO) for independent review by the complainant *(these may relate to complaints made to the trust in earlier years even though received in the reporting financial year).* 14 requests were received compared to 28 the previous year. Of these 14, 50% have not been upheld, 29% are still under review and 21% 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 preventable mortality and improving outcomes
- Avoiding harm
- Improving patient experience
- Improving staff engagement

Within the period covered by the Quality Strategy, the Trust sets out annual priorities under each of the four key areas of focus. Progress against the 2016/17 objectives is described in the Performance Analysis section of this report. As we enter the final year of this Quality Report, we continue working towards our 2018 goals. Again, more details are available in the Quality Report section.

Reducing preventable 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

Avoiding harm

- 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
- 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 patients

- 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
- Reduce complaints and improve the timeliness of complaint responses

Improving staff engagement

- 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

The Trust has a robust Quality Governance Structure which is overseen at Board level by the Quality and Risk Committee and at Executive Level through the Quality Board Chaired by the Executive Medical Director. The Trust's Annual Quality Improvement objectives are set out in the Quality Report. As part of its Patient First Improvement Programme the Trust has agreed key Quality Improvement (True North) objectives and these relate to; improving the Friends and Family Scores, Improving Hospital Standardised Mortality ratio, improving Patient Thermometer scores, improving Referral to Treatment and A&E Waiting times. Progress against these key metrics is presented to Trust Board monthly.

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.

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. Subjects covered this year include quality priorities and better births, an introduction to cancer services and cancer patient voices and information about the Bachelor of Nursing Adult programme at the University of Portsmouth.

Stakeholders were also given the opportunity to feed into our new wayfinding strategy, designed to make it easier for patients and visitors to find their way around our hospitals. All attendees receive a dementia update at each stakeholder session.

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.

2.1.2.2 Membership engagement

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

Our e-newsletter, @WesternSussex, remains a popular channel for communicating with members. It contains news, event information, feedback methods and articles such as "You said, we did".

We hold regular "Medicine for Members" events, where members can learn more about how the Trust runs and gain insight into specific clinical areas. Topics in the last year included presentations about dementia and ophthalmology and a clinical skills tour. Member feedback following the clinical skills tour included this quote: *"Very informative. Julie displayed her passion and pride in her work on simulation*

and is a credit to the Trust. Well done." Julie Turner, who presented the session received our Employee of the Month accolade after being nominated by a member of the audience.

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 2016 to 31 March 2017.

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).

Our Board of Directors 01 April 2016 to 31 March 2017

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

Patrick Boyle (Term of Office to 19-01-2021)

Non-Executive Director Designate

EXECUTIVE DIRECTORS

Marianne Griffiths, Chief Executive

Pete Landstrom, Chief Operating Officer (From 18th April 2016)

Denise Farmer, Director of Organisational Development and Leadership

Dr George Findlay, Medical Director

Karen Geoghegan, Director of Finance

Amanda Parker, Director of Nursing and Patient Safety (until 31st March 2017)

The Chair and Non-Executive Director 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.

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 NHS Improvement's 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), NHS Improvement 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. The Trust now receives a newly developed Patient First metric report that reflects the Trust's True North priorities, breakthrough objectives, strategic initiatives and corporate projects.

During the period of this report the Board held 10 Board meetings, 2 review days and 7 Seminars. The Board Review day is where the future strategic aims and objectives of the organisation are considered. In addition there was a joint review day between the Board and the Council of Governors.

Board seminars covered a range of topics including; Risk Management, Outpatient Improvement Programme, Local Health Economy Strategic changes – ACO and Patient Experience Strategy Development.

Attendance at Board meetings 1 April 2016 to 31 March 2017

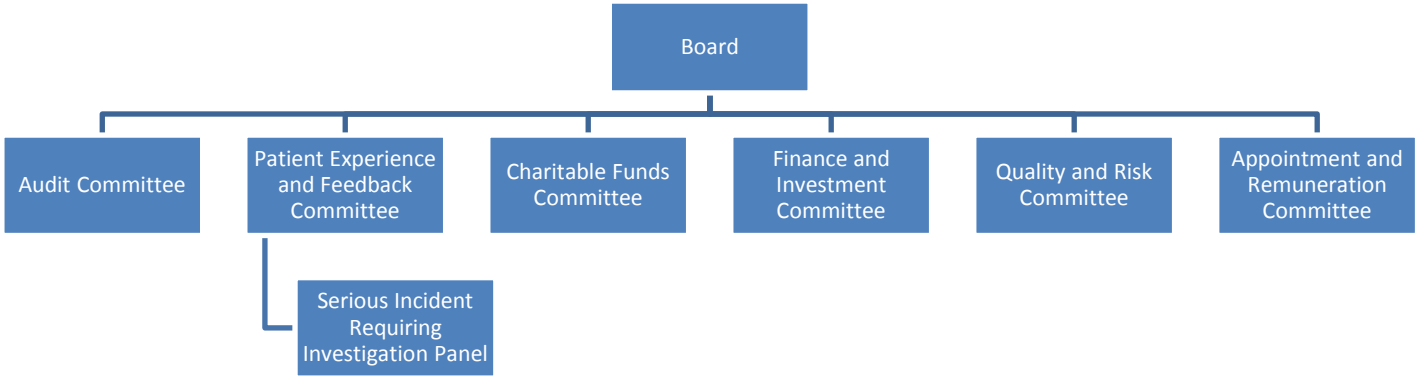
Name	Total Meetings Eligible	Apr	May	Jun	Jul	Sep	Oct	Nov	Jan	Feb	Mar	Total Meetings Attended [1]
Mike Viggers	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
Bill Brown	10	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	9
Joanna Crane	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
Jon Furmston	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
Lizzie Peers	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
Mike Rymer	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
Marianne Griffiths	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
Pete Landstrom	10	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	9
George Findlay	10	✓	✗	✓	✓	✗	✓	✓	✗	✓	✓	7
Karen Geoghegan	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
Amanda Parker	10	✓	✓	✓	✓	✓	✓	✗	✗	✗	✗	6
Denise Farmer	10	✓	✓	✗	✓	✗	✓	✓	✓	✓	✗	7

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] Notes:
Please note there were no Board meetings in either August or December 2016. A Board Pack was issued to the Board on both occasions reporting on standing items of the Board agenda.



1. 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 2016 to 31 March 2017 is set out in the table below:

Register of Members attendance at Audit Committee meeting for the period 01 April 2016 to 31 March 2017						
	April	May	July	October	January	Total
Jon Furmston	✓	✓	✓	✓	✓	5
Bill Brown	✓	✓	✓	✓	✓	5
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.

2. **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) *Maggie Davies as Interim Director of Nursing and Patient Safety from 1 January 2017.*

3. **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.

4. **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) *Maggie Davies as Interim Director of Nursing and Patient Safety from 1 January 2017.*

5. **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) *Maggie Davies as Interim Director of Nursing and Patient Safety from 1 January 2017.*

6. **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)

7. **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 27th**	**June 29th**	**Oct 26th**	**Nov 30th**	**Dec 21st**	**Jan 19th**	**Jan 25th**	**Mar 29th**	**Total**
Mike Viggers	✓	✓	✓	✓	✓	✓	✓	✓	8
Bill Brown	✓	×	✓	✓	✓	✓	✓	✓	7
Joanna Crane	✓	✓	✓	✓	✓	✓	✓	✓	8
Jon Furmston	✓	✓	✓	✓	✓	✓	✓	✓	8
Lizzie Peers	✓	✓	✓	✓	✓	×	✓	✓	7
Mike Rymer	✓	✓	✓	✓	×	×	✓	✓	6

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 14 July 2016.

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.

The Governors undertook a recruitment exercise that was established and overseen by their Nomination and Remuneration Committee. Patrick Boyle was appointed by the Council of Governors as a Non-Executive designate at their meeting of 20 January 2017.

Statement of Compliance with the NHS Foundation Trust Code of Governance 2016-17

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.

Single Oversight Framework

The Trust is subject to the NHS Improvement's Single Oversight Framework which provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

For the period from Quarter 3 of 2016/17 the Trust has been rated as follows:

Q3	Segment 1

Q4	Segment 2

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures form 1 to 4, where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Financial sustainability	Capital service capacity	1	1	1	1	1	1
	Liquidity	2	2	2	1	2	3
Financial Efficiency	I& E margin	1	1	1	1	1	1
Financial Controls	Distance from financial plan	2	2	2	2	3	3
	Agency spend	1	1	1	2	2	2
Overall scoring		**1**	**1**	**1**	**1**	**2**	**2**

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 in include attendance from a Non-Executive Director. The reviews are also 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	**2016/17 Number**	**2016/17 £0**
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	123,243	205,940
Total Non-NHS Trade Invoices Paid Within Target	27,390	100,737
Percentage of Non NHS Trade Invoices Paid Within Target	22.22%	48.92%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	2,660	20,782
Total NHS Trade Invoices Paid Within Target	284	10,993
Percentage of NHS Trade Invoices Paid Within Target	10.68%	52.90%

2.2 Governors' Report

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. Governors also participate in other activities in support of the Trust's work.

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 Trusts auditor
- Receive the Trusts 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
- 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 elected 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	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 seven new Governors were appointed and two Governors were reappointed for a second three year term.

During the year 1 April 2016 to 31 March 2017 attendance at Council of Governor meetings was as follows;

Constituency	Full Name	End of Term of Office	Number of COG meetings attended[2]
Elected Governors			
Public - Adur	Barbara Porter	30 June 2019	2 of 4
Public - Adur	John Todd	30 September 2018	3 of 4
Public - Arun	Margaret Bamford	30 June 2016	0 of 1
Public - Arun	Neil Chisman	30 June 2019	2 of 3
Public - Arun	Brian Hughes	30 June 2016	0 of 1
Public - Arun	Jill Long	30 September 2018	4 of 4
Public - Arun	Anita Mackenzie	30 June 2019	3 of 3
Public - Arun	John Thompson	30 September 2018	4 of 4
Public - Chichester	Vicki King	30 June 2016	3 of 3
Public - Chichester	Abigail Rowe	30 June 2016	0 of 1
Public - Chichester	Margaret Burgess	30 September 2018	4 of 4

[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, reflecting new members to the Council in year.

Public – Chichester	Jim Jennings	30 June 2019	3 of 3
Public - Horsham	Vacant	30 June 2016	N/A
Public - Horsham	Penny Richardson	30 June 2019	3 of 3
Public - Worthing	Roger Hammond	30 June 2019	3 of 3
Public - Worthing	Shirley Hawkridge	30 June 2016	0 of 1
Public - Worthing	Beda Oliver	30 June 2016	1 of 1
Public - Worthing	John Bull	30 September 2018	4 of 4
Patient	Paul Benson	30 June 2016	0 of 1
Patient	Jennifer Edgell	30 June 2016	0 of 1
Patient	Richard Farmer	30 September 2018	3 of 4
Patient	Stuart Fleming	30 June 2019	1 of 3
Staff Governors			
Additional Clinical Services	Greg Dalilling	30 June 2016	0 of 1
Estates & Ancillary	Natalie Matthews	30 June 2019	3 of 3
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	4 of 4
Medical & Dental	Richard Venn	30 June 2019	3 of 4
Appointed Governors			
West Sussex County Council	Councillor Nigel Peters	30 June 2016	0 of 1
West Sussex County Council	Councillor Ashvin Patel	30 September 2019	0 of 2
Brighton & Sussex Medical School	Peter Pimblett-Dennis	30 June 2016	1 of 1
Brighton &Sussex Medical	Snežana Lević	30 June 2016	

School			
Friends of WSHT Hospitals	Jane Ramage	27 July 2016	2 of 3
Worthing Borough Council	Councillor Val Turner	30 June 2017	3 of 4
Chichester District Council	Councillor Gillian Keegan	30 June 2018	3 of 4
University of Brighton School of Nursing & Midwifery	Andrew Lloyd	30 September 2018	2 of 4

Governor Expenses

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

	1 April 2016 to 31 March 2017	1 April 2015 to 31 March 2016
Total number of governors in office (as at 31st March 2017)	23	26
Number of governors receiving expenses	11	11
Aggregate sum of expenses paid to governors	£7319.34	£6,204

Lead Governor

NHS Improvement (NHSI) 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 NHSI if circumstance required direct communication between the COG and the Regulator. Until 31st October 2016 the Lead Governor was Vicki King, Public Elected Governor for the Chichester Constituency with Richard Farmer, Patient Governor acting as Deputy Lead Governor. From 1st November 2016 the role has been undertaken by John Thompson, Public Governor for Arun Constituency with Jill Long, Public Governor for Arun, acting as Deputy Lead Governor. Both were elected by the full Council.

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 their work and that of any Committees on which they serve.

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 six 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 assurance and risk, harm-free care, research and innovation, seven day working, ward accreditation, trust finances and Kaizen 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.

NHS Improvement 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, Ward Accreditations and 'Sit and See' observations. The Governors also supported and assisted with preparation for the Trust-wide Care Quality Commission Inspection by participating in "mock inspections".

Governors Annual Programme

This is reviewed at each CoG and the objectives of this programme are;

- To implement the Council of Governors Annual Programme for 2016-17 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.

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 NHS Improvement 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 Appointments

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 2016 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 Chair and other Non-Executive Directors Appraisals for 2016
- 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
- Outcomes of Exit Interviews with retiring Governors

It is the responsibility of the Governor Nomination and Remuneration Committee, with the Chair of Western Sussex Hospitals NHS Foundation Trust, to consider appropriate Non-Executive Director (NED) succession planning. Following detailed discussion by the Committee in early 2016 and as reported to Council at its meeting on 14 July 2016 it was agreed to begin the recruitment process to appoint a new NED for Western Sussex Hospitals NHS Foundation Trust. The recruitment and selection process was overseen by the Committee. As a result the Committee made a unanimous recommendation to the Council of Governors at their meeting in January 2017 regarding the appointment of a new NED. The recommendation was approved by the Council of Governors at its meeting held on the 19 January 2017.

Membership

Membership Strategy

The Trust currently has a Membership Strategy for the period 2015-2018, which is updated annually 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 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 patients, carers and staff. 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. This was followed by further consultation in 2017, supported by the Trust's Membership Committee

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 2016 which includes information on the Trusts Membership and in particular the age profiles and ethnicity. The 2016 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 continue to distribute @WesternSussex, a monthly 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 have also successfully recruited new members with visits to outpatients departments at St Richard's, Worthing and Southlands hospitals.

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.

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

Currently the Trust had 7,811 public and patient members on March 31, 2017. All Staff are automatically enrolled as members on starting employment with the Trust.

The Membership Strategy for the Trust gives an aim of increasing the number of public members by 1% year each year whilst maintaining staff and patient member numbers.

Constituency	Membership as at 31 March 2016	Membership as at 31 March 2017
Adur	1,179	1,188
Arun	2,432	2,479
Chichester	2,081	2,116
Horsham	399	468
Worthing	1,222	1,296
Patient	234	264

Appointment of External Auditors

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

NHS Improvement 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 continued to reports on its work to each Council of Governors meeting in 2016.

In accordance with the timeline agreed at the Council of Governors meetings the tender competition was run on Crown Commercial Service's ConsultancyONE Framework Agreement RM1502 Lot 5.4 External Audit & Advice. Invitations to Tender were issued to all the suppliers on this framework agreement.

The written bids were evaluated by the working Group against the criteria set out in the invitation document. As a result of the scoring all firms who had tendered for the contract were invited to a presentation day. The presentations, clarification questions, and a question and answer section within the presentations were included as part of the weighted scoring.

From the presentation day a preferred firm was agreed upon and subsequently approved by full Council of Governors at its meeting held on the 14 July 2016.

Members of the Council of Governors: as at 31 March 2017

Constituency name	Full Name	End of current term of office
Elected Governors		
Public - Adur	Barbara Porter	30 June 2019
Public - Adur	John Todd	30 September 2018
Public - Arun	Neil Chisman	30 June 2019
Public - Arun	Anita Mackenzie	30 June 2019
Public - Arun	Jill Long	30 September 2018
Public - Arun	John Thompson	30 September 2018
Public – Chichester	Maggie Burgess	30 September 2018
Public - Chichester	Jim Jennings	30 June 2019
Public – Horsham	Penny Richardson	30 June 2019
Public - Worthing	John Bull	30 September 2018

Public – Worthing	Roger Hammond	30 June 2019
Patient	Richard Farmer	30 September 2018
Patient	Stuart Fleming	30 June 2019
Staff Governors		
Medical & Dental	Richard Venn	30 June 2019
Nursing & Midwifery	David Walsh	30 September 2018
Scientific, Technical & Professional	Helen Dobbin	30 September 2018
Estates & Ancillary	Natalie Matthews	30 June 2019
Administrative & Clerical	Andrew Harvey	30 September 2018
Appointed Governors		
West Sussex County Council	Councillor Ashvin Patel	30 June 2019
Brighton & Sussex Medical School	Snežana Lević	30 June 2019
University of Brighton School of Nursing & Midwifery	Andrew Lloyd	30 June 2018
Worthing Borough Council	Councillor Val Turner	30 June 2017
Chichester District Council	Councillor Gillian Keegan	30 June 2018

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 2016/17 year.

2.3 Staff Report

Western Sussex Hospitals NHS Foundation Trust is the proud employer of 7,000 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	2016/17 Total Number	2015/16 Total Number
Medical and dental	719	-	**719**	699
Ambulance staff	-	-	**-**	-
Administration and estates	1,250	-	**1,250**	1,194
Healthcare assistants and other support staff	1,599	-	**1,599**	1,498
Nursing, midwifery and health visiting staff	1,644	-	**1,644**	1,615
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	641	-	**641**	587
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Agency and contract staff	-	238	**238**	275
Bank staff	-	458	**458**	448
Other	6	56	**62**	6
Total average numbers	**5,859**	**752**	**6,611**	**6,322**
Of which:				
Number of employees (WTE) engaged on capital projects	6	-	**6**	16

The Trust's sickness absence rate is 3.8% for the year 206/17.

2.3.1 Equality and Diversity

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.

We employ a diverse workforce, proportionately greater than the population and communities that we serve. We are proud of the unique contribution our staff make and the value this adds delivering and supporting high patient care.

Support is available for staff through a number of forums:

- Celebrating Cultures Network (incorporates Black, Minority, Ethnic (BME) and religion and belief)*
- Lesbian, Gay, Bisexual and Transgender (LGBT) Network
- Carers Forum*
- Disability Forum*

*includes patient and community representatives

During 2016 we have seen many great examples of celebrating diversity and we publicise these on the Trust's StaffNet, through the Trust's weekly 'Headlines' staff publication and by using notice boards and newsletters. We have continued to raise the profile of Equality and Diversity (E&D) by taking part in NHS Employers Equality, Diversity and Human Rights week during May 2016 as well as holding E&D awareness stands at two annual staff conferences, during which a group of staff delivered workshops sharing the culture of the Philippines.

This year the Trust was selected to become a partner on the NHS Employers Diversity and Inclusion Partners Programme for the first time. As a partner, we will work with NHS Employers, NHS England, NHS Improvement and Health Education England to support system-wide efforts to improve the measurement of E&D across the NHS. It also provides the opportunity to network and bring fresh ideas and practices into the organisation.

Staff mandatory E&D training has been refreshed and updated and now includes a section covering awareness of unconscious bias which explains 'how bias play out in our world'.

The Trust Equality Delivery System 2 submission was finalised and published on the E&D pages of the Trusts website, this process was used to agree our new Equality objectives, and these were published in April 2016.

We completed and published our second NHS Workforce Race Equality Standard (WRES) return on the 1 July 2016. The Trust's position against last year's return is shown, as well as our results compared to other Trusts in our geographical area and a specific WRES action plan has been proposed.

The Trust's established "Celebrating Cultures" network gained a new chair and continues to grow in membership.

At the end of the financial year, the makeup of the Trust by gender was:

	Female	**Male**
Non-executive directors	2 (40%)	3 (60%)
Executive directors	4 (67%	2 (33%)
Other senior managers	27 (56.3%)	21 (43.7%)
Other staff	5,418 (77.3%)	1,588 (22.7%)

Full details of our equality and diversity monitoring data and plans can be found on our website.

2.3.2 Staff survey

Over the last 12 months, staff engagement has improved across the Trust. Every year, we encourage all substantive staff to participate in the National NHS Staff

Survey. The survey results provide the Trust with a picture of staff experience across nine domains which in turn informs targeted local improvement for staff experience and well-being.

In 2016, 4,000 staff (59 per cent) completed the survey which is an increase of 500 staff (54 per cent) in the previous year. Overall the staff survey results display a positive picture for overall staff engagement placing the Trust 'above and better than average' for the key indicators when compared to other acute trusts. The national average response rates and mean average for overall staff engagement in acute trusts is 44 per cent.

We have improved our staff engagement score year on year for the past three years, reflecting the significant amount of work undertaken in the roll out of the Patient First Programme.

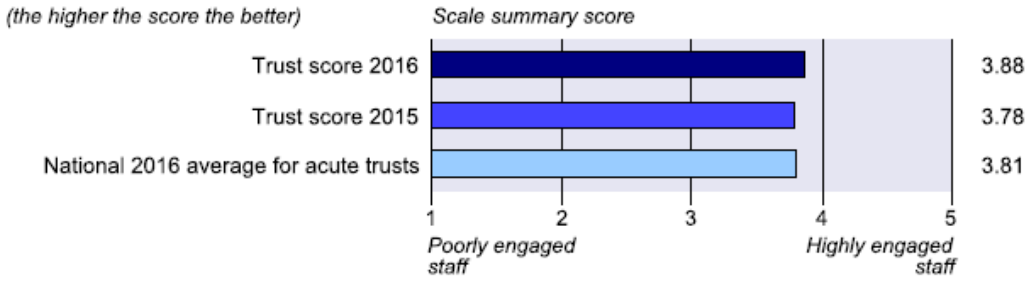
Our overall engagement score, ranked on a scale of 1 to 5 (low to high), improved from 3.78 in 2015 to 3.88 in 2016. We are particularly proud that in the advocacy domain (known as the Staff Family and Friends Tests) our staffs' recommendation as a place to work and receive treatment placed us in the top 20 per cent of NHS acute trusts.

The survey was open between October and December 2016, and all staff were encouraged to participate. Free tea, coffee and a slice of cake was provided at dedicated survey events to boost participation. The survey featured in various internal communications across the Trust, including the staff newsletter, Headlines, and on posters in staff areas adopting the Patient First strategic theme of 'Our People'.

The advocacy domain comprises five questions, and shows a marked improvement in the last 12 months:

		Your Trust in 2016	Average (median) for acute trusts	Your Trust in 2015
Q21a	"Care of patients / service users is my organisation's top priority"	82%	76%	77%
Q21b	"My organisation acts on concerns raised by patients / service users"	76%	74%	73%
Q21c	"I would recommend my organisation as a place to work"	72%	62%	65%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	79%	70%	73%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.98	3.77	3.82

OVERALL STAFF ENGAGEMENT



Source: 2016 Staff Survey

Our five highest scoring staff survey results relative to other acute trusts in England include:

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	Trust score 91% Acute average 87%
Staff recommendation as a place to work or receive treatment	Trust score 3.98 Acute average 3.76
Percentage of staff satisfied with the opportunities for flexible working patterns	Trust score 54% Acute score 51%
Organisation and management in health and well-being	Trust score 3.72 Acute score 3.61
Support from immediate managers	Trust score 3.78 Acute score 3.73

We achieved our best results in the advocacy domain ('Friends and Family' question) and on themes on staff health and well-being and equal opportunities. Continued improvement in these areas remains encouraging and demonstrates sustained development, which supports our commitment to develop our workforce.

To ensure continued development of staff engagement throughout the year, from July 2016 the Trust introduced its own pulse survey during the monthly health and safety updates. Staff are asked nine questions that make up the composite staff engagement score. This score is shared with each division and provides the Trust with engagement trends across the year.

Areas comparing least favourably with other acute trusts in England and where targeted improvements will be implemented in the year ahead include:

Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12	Trust score 18%

months	Acute average 15%
Percentage of staff experiencing physical violence from staff in the last 12 months	Trust score 3% Acute average 2%
Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleague or themselves	Trust score 62% Acute score 56%
Quality of non-mandatory training, learning or development	Trust score 4.01 Acute score 4.05
Percentage of staff agreeing that their role makes a difference to patients or service users	Trust score 89% Acute score 90%

Despite the investment in upskilling staff in conflict resolution and safer handling and strengthening trust policy towards inappropriate behaviour, our largest concern remains violence, aggression and harassment and bullying, particularly on the grounds of ethnicity. The outcomes of the recent internal audit on Violence and Aggression will be implemented. This includes a series of 'pop up roadshows' to better understand and develop further supporting solutions for staff who experience violence.

Areas where the Trust demonstrates the largest local changes and where staff experience has improved since the 2015 survey are set out below. These results are encouraging and demonstrate the commitment supporting the principles of 'Patient First' is becoming embedded into the organisational culture. All key findings in this area have improved and 'support from immediate managers' has seen continued improvement for a second year.

Quality of non-mandatory training learning or development	2016 Trust score 4.01 2015 Trust score 3.96
Recognition and value of staff by managers and the organisation	2016 Trust score 3.53 2015 Trust score 3.43
Support from immediate managers	2016 Trust score 3.78 2015 Trust score 3.69
Staff satisfaction with the quality and care they are able to deliver	2016 Trust score 3.93 2015 Trust score 3.83

To support active involvement and support improvements in overall staff engagement within the Trust, the results of the annual and monthly staff survey results are disseminated to each of the divisions. The Organisational Development function has prepared and circulated Divisional staff engagement reports, 'at a glance' divisional posters detailing scores contributing to the staff engagement score and divisional top and bottom five staff survey results. These resources will be used along with regular feedback obtained at mandatory training pulse checks and will inform discussion with Divisional Management Teams to improve overall engagement.

Future priorities and looking ahead to 2017/18

The 2016 survey indicates a positive increase in staff engagement and it is believed that engagement amongst the workforce will continue to improve as we focus on the delivery of continuous improvement through our Patient First Programme.

We want our staff experience to be strengthened further because we know that by doing so, our patient experience will also improve. To achieve that we will focus on:

- Implementing the recommendations from the internal violence and aggression audit and work with stakeholders to communicate regularly on key learnings, staff experience story, support networks and a refresher on the Trust's polices and processes.
- Continuing to support improvements in staff health and well-being.
- Supporting staff in feeling confident to raise concerns about unsafe clinical practice by learning from incidents through the 'Speaking Out Guardians' and associated networks.
- Promoting equality and diversity throughout the Trust through the Celebrating Cultures Forum to reduce discrimination of staff from ethnic backgrounds.
- Improving opportunities for staff to contribute ideas towards making improvements at work and lead positive change.
- Promoting and raising the profile of the 'Improvement' question and 'breakthrough objective' throughout the Trust and at improvement huddles.
- Continuing to evaluate pulse checks at regular intervals throughout the year on how engaged staff are feeling.

Continuing active divisional engagement through best practice sharing and projects taking place as part of the rebranded Staff Survey Steering Group renamed 'Staff Care and Engagement Group'.

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 1,606 courses were delivered by the Trust's Learning and Development Unit. In addition, 536 staff attended external workshops and conferences.

Attendance on statutory and mandatory training was consistently high throughout 2016-17 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 fifth Staff Conference, titled Where Better Never Stops, ran twice in 2016. A total of 570 staff (almost 10% of Trust staff) attended the Conference this year, an increase of 80 delegates from 2015. Demand for places was high and the Conference was fully booked before the programmes were announced. This year over 60% of delegates had not attended the Staff Conference before. Attendees heard from a number of teams leading improvement projects in their areas of work. All of the speakers were selected to ensure that they fitted with the theme of innovation and quality improvement. We were also able to secure some excellent Keynote speakers ; Chris Hobson, CEO NHS Providers, Tommy Whitelaw, Dementia Carers Voices and Marcus Powell, Kings Fund. The overall feedback from both Conferences was extremely positive and comments included; "inspiring", "brilliant", "very proud to hear about the fantastic work being undertaken in the Trust".

Apprenticeships

In 2016/2017, a total of 66 new Apprentices were recruited into different departments around the Trust. In addition, a total of 34 existing staff enrolled onto Apprenticeship qualifications.

Over the past year, we have introduced a new apprentice role called the 'General Assistant'. The aim of this role is to support nursing staff on the wards. This has been proved to be very successful and since been reviewed, the outcome being that a significant amount of nursing time had been reduced, so that they could focus on personal care.

In March 2017, the Trust won 'Apprentice Employer of the Year' for Kent Surrey and Sussex at the HEE KSS Apprentice Awards. Along with this, the Trust had 2 other winners and 3 runners-up from the individual categories. In addition one of the trust's Apprentices won 'Apprentice of the Year' for KSS in the National NHS Apprentice Awards 2017.

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 2016/17 were 93.2%, up from 92.7% in 2015/16.

The Trust continues to invest in staff health and wellbeing, recognising that it is a key component of staff engagement. Our health and wellbeing plans over the last year have focused on two key factors in sickness absence within our Trust and the NHS as whole: mental health and musculoskeletal problems. These key themes will continue to form the basis of our plans for 2017/18.

<u>Key achievements 2016/17</u>

- Expanding our existing Staff Physiotherapy service
- Increasing our Counselling provision,
- Running a variety of courses for staff and managers to support emotional wellbeing, including Emotional Resilience, Supporting Psychological Wellbeing in the workplace and Mindfulness groups
- Continued to run Schwartz Rounds on a regular basis
- Introduced pilot supervision groups for staff
- Increased our flu vaccination rates from 36.8% to 60.7% of frontline staff,
- We delivered a range of wellbeing events for staff – exercise tasters, Boot Camp for
- Beginners, Workplace Challenge, Stress awareness events, try-a-bike sessions, access to Physiotherapy gym, massage sessions for staff, walking challenges.

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 2016/17	**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	-	4	**4**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**4**	**4**
Total resource cost (£)	£0	£119,000	**£119,000**

	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**

Exit packages: other (non-compulsory) departure payments

	2016/17		**2015/16**	
	Payments agreed	**Total value of agreements**	**Payments agreed**	**va agreer**
	Number	**£000**	**Number**	
Voluntary redundancies including early retirement contractual costs	4	119	-	
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	**4**	**119**	**-**	
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	

2.3.7 Off-payroll engagements

The Trust did not make any off-payroll engagements in the financial year.

…… 25 May 2017

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 'Managing the Trust' 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.

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
Mr Peter Landstrom	Chief Operating Officer	18/04/2016	6 months	3 months
Mrs Geoghegan	Director of Finance	01/02/2014	6 months	3 months
Mrs Amanda Parker	Director of Nursing and Patient Safety	02/02/2015	Left 31/03/2017	
Mrs Denise Farmer	Director of Organisational Development and Leadership	01/04/2009	6 months	3 months
Dr George Findlay	Medical Director and Deputy	27/01/2014	6 months	3 months

	Chief Executive			

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.

2.4.5 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 2016/17

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	240 - 245	23	20-25	0	75 – 77.5	340 – 345
Mr P Landstrom Chief Operating Officer	125-130	28	0	0	67.5-70	195-200
Mrs K Geoghegan Director of Finance	145 – 150	17	5-10	0	0	150 - 155

Dr G Findlay Medical Director	150 – 155	34	0	60 – 65	0	210 -215
Mrs A Parker Director of Nursing and Patient Safety	125 – 130	15	5-10	0	0	130 -135
Mrs D Farmer Director of Organisational Development & Leadership	120 - 125	24	5-10	0	0	130 - 135
Mr M Viggers Chairman	40 - 45	62	0	0	0	50 - 55
Mrs J Crane Non-Executive Director	10 - 15	10	0	0	0	10 - 15
Mr J Furmston Non-Executive Director	10 - 15	3	0	0	0	10 - 15
Mr W Brown Non-Executive Director	10 – 15	10	0	0	0	10 - 15
Mr M Rymer Non-Executive Director	10 - 15	7	0	0	0	10 - 15
Ms L Peers Non-Executive Director	10 - 15	10	0	0	0	10 - 15

B) Pension Entitlements at 31st March 2017

	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 2017 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2016 (nearest £1,000)	Cash Equivalent Transfer Value at 31 March 2016 (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	2.5 – 5.0	10 – 15	35 – 40	105 – 110	775	625	134	Nil
Mr P Landstrom	2.5-5.0	10-15	15-20	50-55	226	177	80	Nil
Mrs K Geoghegan	0	0	35 - 40	115 - 120	653	633	57	Nil
Dr G Findlay	0	0	40 - 45	120 - 125	719	675	111	Nil
Mrs A Parker	0 -2.5	0 -2.5	40 - 45	125 – 130	860	807	33	Nil
Mrs D Farmer	0	0	50 - 55	150 - 155	0	1,145	0	Nil

C) Remuneration 1st April 2015 to 31st March 2016

	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 Performance Related Bonus (Bands of £5000)	Pension Related Benefit (Bands of £2,500)	Total (Bands of £5000)
	£000	£00	£000	£000	£000	£000
Mrs 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	-	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 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

D) Pension Entitlements 1st April 2015 to 31st March 2016

	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension	Cash Equivalent Transfer Value at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2014	Real increase in Cash Equivalent Transfer Value	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	1172	1123	36	Nil
Mrs K Geoghegan	0	0	35 - 40	115 - 120	658	628	23	Nil
Dr George 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	1146	1093	40	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 2016-17 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.

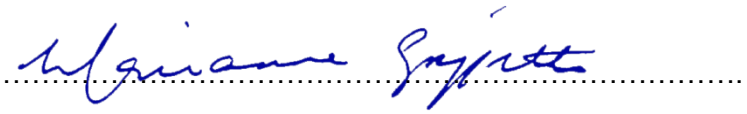
Total Pension Entitlement

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.



25 May 2017

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 2016 to 31 March 2017

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 *NHS Improvement*.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Western Sussex Hospitals NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis *required by those Directions*. 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 *Department of Health Group Accounting Manual* and in particular to:

- observe the Accounts Direction issued by *NHS Improvement*, 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* (*and the Department of Health Group Accounting 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 the NHS Foundation Trust Accounting Officer memorandum.

Signed  .....

Chief Executive: 25 May 2017

2.7 Annual Governance Statement for the period 1 April 2016 to 31 March 2017

2.7.1 Scope of Responsibility

1.1 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*.

1.2 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.

1.3 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

2.1 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 Hospital 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 2017 and up to the date of approval of the annual report and accounts..

2.7.3 Capacity to handle risk

3.1 Trust Board

3.2 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. 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.

3.3 Non-executive Directors

3.4 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.

3.5 Executive Director of Nursing and Patient Safety

3.6 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.

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

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3.8 Executive Director of Finance and Estates

3.9 The Executive Director of Finance 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.

3.10 The Executive Director of Finance 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.

3.11 Our Approach to Risk

3.12 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.

3.13 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 collaboratives developed through the Academic Health Science Network (eg such as the Falls collaborative).

2.7.4 The Risk and Control Framework

4.1 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. During 2015/16 the Board approved an organisational risk appetite statement which forms the basis of its approach to risk.

4.2 In April of this year the Trust Board received a Risk seminar presentation undertaken by the Trust Internal Auditors senior team.

4.3 During the year both the Quality and Risk Committee and Audit Committee reviewed and approved a revised risk reporting framework and presented this to the Trust Board in October. The new Patient First report is now presented monthly at Trust Board and each month the risk rating is reviewed, against a 'target' risk score, by the responsible Executive. The report integrates the strategic deployment and reporting of True North and associated metrics along with the previous Board Assurance Framework.

4.4 The report presents True North Metrics alongside Breakthrough Objectives, Strategic Initiatives and Corporate Projects and provides an integrated approach to reviewing risk against these areas.

4.5 The new reporting has been well received, not only by Trust Board, but also members of public in attendance.

4.6 Principle risks, during the period, to compliance with the governance conditions of the Foundation Trust Licence centred on; (a) achieving the forecast financial outturn and (b) non-achievement of Referral to Treatment (RTT) targets although in January 2017 the Trust was compliant (92.01%) with the RTT National Constitutional Target.

4.7 During the year the NHS Improvement Risk Assessment Framework was replaced with the single oversight framework aimed at providing an integrated approach for both NHS Foundation Trusts and Trusts, across regulation and performance management.

4.8 Under the proposals, all Trusts are placed in one of four segments depending on their performance. Since its introduction the Trust has been in Segment 1, the best performing segment allocated.

4.9 For the first half of the year the Board approved the quarterly self-assessment submission to NHS Improvement (formerly Monitor) stating the anticipated Governance Risk Rating and Financial Sustainability Risk Rating to be achieved by the Trust. This self-assessment ceased from October following the introduction of the Single Oversight Framework.

4.10 Divisional risk registers are regularly reviewed by all Divisions and new operational risks identified and assessed. 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.

4.11 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.

4.12 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.

4.13 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.

4.14 Incident reporting is actively encouraged within the Trust, and a comprehensive programme of investigation and follow up of all incidents is in place. Indeed this was commended within the CQC Inspection Report where they stated that "*The Trust wide learning from incidents and complaints was well embedded. In all areas of the hospital, staff could give us example of where improvements had been made as a result of complaints, comments or incidents".*

4.15 During the period of this report the Trust regrettably had three Never Events. Serious Incidents are subject to a thorough internal review to identify Root Causes and learning. All Serious Incidents including Never Events were reported as required to the Clinical Commissioning Group, NHS Improvement and to NHS England. A full investigation is undertaken and the outcome and recommendations reported to the Trust Board.

4.16 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.

4.17 Major risks during this period included the on-going implications of significant external change in the local and national health economy. Alongside this the financial challenge remains high and the Trust has set itself a significant cost improvement programme for the year; this will remain a priority for 2017/18. An overarching risk has been with regards to recruiting and retaining a sustainable workforce and this remains a local and national challenge.

4.18 In support of mitigating these risks the Trust has its Patient First programme, which is now well embedded and helps to ensure continued focus on improving quality and the patient experience.

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

4.20 The issue of IT system and data security has been a focus of the Audit Committee during 2016/17 and this is highlighted through the corporate risk register which is reviewed by the Quality and Risk Committee and Trust executive Committee.

2.7.5 Compliance with CQC

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

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

2.7.6 Compliance with Equality, Diversity and Human Rights Legislation

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

6.2 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.

6.3 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 and promoting equality and diversity at the Trust.

6.4 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 are subject to an equality impact assessment to ensure no group is unintentionally disadvantaged.

2.7.7 Compliance with NHS Pension Scheme Regulations

7.1 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.

2.7.8 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.

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

The Board of Directors developed its objectives for the period of this report using the principles embedded within its Patient First Programme and has identified True North objectives for the Trust. All objectives are quantifiable and measurable and performance is reviewed through the Audit Committee, Quality and Risk Committee and the Board.

9.2 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.

9.3 Performance against objectives, key actions required to improve performance, and other key messages are communicated to staff monthly through a team briefing process which begins with a face to face briefing with senior managers.

9.4 Over the last three years the Trust has made considerable savings through its Efficiency Programme, demonstrating sustainability and improvements in economy and efficiency. The Finance and Investment Committee pays particular attention to the delivery of the Efficiency Programme. The Trust has used the findings and recommendations of the report by Lord Carter "Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations" to inform the development of the Efficiency Programme. Individual efficiency schemes are reviewed by the Quality and Risk Committee to ensure there is no negative impact upon service provision with further scrutiny being provided by the Quality Committee.

9.5 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

2.8 Annual Quality Report

8.1 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 period. NHS Improvement (in exercise of the powers conferred on 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.

8.2 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.
- The Medical director has established a Quality Board to provide focus on continuously improving clinical practice.
- Put in place a system to receive and act upon feedback on the accounts from the following local stakeholders; Coastal West Sussex Clinical Commissioning Group, Healthwatch West Sussex and West Sussex County Council Health and Adult Social Care Committee.
- The Council of Governors have been engaged and selected a quality standard for audit.
- 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.

8.3 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.

8.4 Compliance with CQC standards is monitored by the Quality and Risk Committee and performance against CQUIN and other quality targets is monitored by the Board of Directors.

8.5 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 constancy checks by NHS England and Monitor. As part of a national programme, Trust waiting list validation processes were scrutinised in Feb 2015 by the NHSE South RTT Subject Matter Lead and full assurance given. In addition, elective waiting list is a Quality Account measure and subject to further regular patient level audit.

3. Review of Effectiveness

3.1 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 who 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. 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 Quality and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

3.2 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.

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

3.4 The previous reviews of the Board Assurance Framework and now the new Patient First Metric Report provide me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

3.5 My review is also informed by:

- The outcome of the CQC Hospital Inspection reported in April 2016 – rated Outstanding
- The Trust's assurance process for monitoring levels of compliance against CQC registration
- Annual Staff Survey
- Programme of work undertaken by internal and external auditors and Counter Fraud
- Clinical Pathology Accreditation (CPA)

3.6 The effectiveness of the Board Governance processes are, in part, reviewed through a self – assessment process undertaken every two years by each Board sub-committee. This ensures the Committees remain aligned to the requirement of the Board in discharging its responsibility.

3.7 The effectiveness of governance processes was externally validated through the CQC Hospital inspection which rated the Trust as Outstanding within the Well-Led domain which incorporates governance as a key theme.

3.7 While the Board discharges its responsibility through the sub-committees the Chair of each sub-committee reports key items to the Board following each sub-committee meeting.

3.8 The Annual Corporate governance statement is approved by the Board prior to its submission and performance against the nationally mandated targets is reported monthly in public thereby demonstrating the Trusts progress as the requirement of its provider licence.

3.1 Board of Directors

3.1.1 The Trust's governance structure comprises the Board, a number of Committees (Quality & Risk, 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.

3.1.2 It is worthy of note that as part of its overall CQC rating of Outstanding the Trust received an Outstanding rating for the 'Well-Led' domain which reviews "the leadership, management and governance of the organisation to make sure it is providing high quality care that is based on individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture"

3.1.3 I provide an update on any significant events or matters that affect the Trust at each meeting of the Board of Directors.

3.1.4 I am very proud of the establishment of our Patient First Programme and how it is now part of the fabric of the Trust. Patient First is our Trust-wide approach to improving the quality of the care we offer patients. It is based on looking at the pathways our patients take and thinking, how could we redesign our systems to take out any waste and reduce any possibility for errors to make that pathway even better. It is also about standardising our practices so that a Patient gets a great service each and every time we see them.

3.1.5 The philosophy behind the programme is centered 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

3.2 Clinical Audit

3.2.1 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.

3.3 Internal Audit

3.3.1 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.

3.3.2 Management work with the Internal Auditors to develop an agreed annual work plan.

3.3.3 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."

3.3.4 During the period 1 April 2016 to 31 March 2017 the Audit Committee met four times and received fourteen Internal Audit reports. 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 moderate or limited. Only one audit received Limited Assurance for both 'design' and 'Effectiveness' of the system; this related to Cyber Security and Disaster Recovery and a robust action plan is in place to improve this position.

3.3.5 At its meeting in April 2017 the Audit Committee completed an audit report, which was issued with moderate assurance relating to design and moderate assurance regarding effectiveness. The Committee noted that four other audits are in progress and will be finalised shortly – these will not impact the annual Head of Internal Audit Opinion.

- Key Financial Systems – Draft report stage (Moderate Assurance)
- Clinical Coding – Advisory in nature
- Projects Assurance (Benefits Realisation)
- Pre-employment checks – Late addition to audit plan

3.4 External Audit

3.4.1 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.

3.5 Audit Committee

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

3.5.2 The Audit Committee is responsible for overseeing the activities of Internal Audit, External Audit and Counter Fraud. For each of these it:

- approved the annual (and strategic) work plans at the beginning of the financial year and updates to these throughout the year
- has received reports on the work undertaken to date and the findings
- has reviewed the management response to reports, in particular the implementation of recommendations to date via tracker reports

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

3.5.4 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 Non-Executive members of the Audit Committee during the planning phase, however, the plan is left flexible to allow the Committee to respond effectively if urgent issues arise.

3.5.5 This year has seen the introduction of a Non-Executive sponsor for each audit to strengthen the accountability of agreed audits.

3.5.6 Many of the key internal control processes 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.

3.5.7 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 Non-Executive Director member sits on both the Audit committee and Quality and Risk Committee.

3.5.8 The Audit Committee reviews the Annual Accounts before approval and provides a report to the Trust Board on its activities following each Committee meeting.

3.5.9 The Non-Executives of the Audit Committee meet prior to each Committee in private with Internal Audit, External Audit and Local Counter Fraud Services to assure themselves of the Trust's approach to audit and risk issues.

3.6 Quality and Risk Committee

3.6.1 The Quality and Risk 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
- 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
- CQC registration issues
- Claims and Litigation information is routinely reported to the Trust Board.
- Information Governance

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

3.6.3 The revised Clinical Governance frameworks have continued since merger and the establishment of the Clinical Divisional structures in October 2009. This process included the development of a programme of quarterly Divisional Governance Reviews of the clinical divisions plus IT and Facilities/Estates, each of these is attended by a Non-Executive Director and is chaired by either the Director of Nursing or the Medical Director.

3.7 Information Governance

3.7.1 The Trust is pleased to report that there have been no serious information governance incidents including data loss or confidentiality breaches that require reporting. A serious incident is defined by the Information Commissioner as any incident classified as a Level 2 Information Governance incident.

3.7.2 The Trust has a Head of Information Governance whose role is predominantly focused on achieving the standards set out in the Information Governance Toolkit. In this, he is supported by the Information Governance Assurance and Strategy Group (IGASG) which reviews and agrees key information policies within the Trust.

3.7.3 Through the Director of Information Technology, who is the Senior Information Risk Officer (SIRO), and the IGASG the Trust works to ensure that Information Governance has a high profile in the Trust.

3.7.4 Risks to data security are identified in the risk register. The role of it 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.

3.8 Conclusion

3.8.1 During the period 1 April 2016 to 31 March 2017 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.

3.8.2 The outcome of our CQC Hospital Inspection in December 2015 was published on the 19 April 2016 and I am delighted that the Trust received an Outstanding rating.

3.8.3 CQC stated: "We saw evidence of a consistent approach to compassionate care, an empathy and understanding towards patients and a supportive environment."

3.8.4 They added also that a "supportive, caring, compassionate approach to patients spread across all core services" and that this "ethos of compassionate care extended beyond clinical staff".

3.8.5 The CQC inspectors made particular mention of the Trust's impressive achievements in improving quality of care and outcomes for patients, with reductions in mortality rates now putting us among the country's 20 best trusts on that measure.

3.8.6 It is worthy of note in relation to the Annual Governance Statement that the Trust was rated as Outstanding against the Well Led Domain. With CQC noting that "The very strong governance systems allowed the trust to focus on safety and improved patient outcomes at all levels. Local managers could see how the wards and departments in their control were performing. The board involvement allowed proper assurance through involvement in governance meetings".

In March of this year the Board approved the Trust entering into a 3-year management contract to run Brighton and Sussex University Hospital Trust (BSUH).

The purpose of this support arrangement is to help stabilise BSUH, a trust that has many positive attributes but has seen significant senior management change over recent years.

Before approving the leadership support for BSUH, the Trust Board sought assurance that performance at WSHFT would not be compromised by the additional responsibilities. The trust carried out a full impact and delivery assessment of the new relationship, which included a series of in-depth briefings and interviews with senior clinical and corporate staff at BSUH and an external due diligence process conducted by KPMG. The board were satisfied the arrangement would benefit patients served by both organisations.

I would like to thank all of our staff for their effort and commitment to providing safe, high quality care.

Signed (by order of the Board of Directors)

Marianne Griffiths

Chief Executive

25 May 2017

Western Sussex Hospitals
NHS Foundation Trust

Quality Report 2016/17

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Limited Assurance Report on Quality

Part One: Statement on Quality from the Chief Executive

2016/17 has been another successful year for Western Sussex Hospitals NHS Foundation Trust. We received an outstanding rating from the CQC following our inspection in December 2015, making us one of only five NHS non-specialist acute Trusts to receive this overall rating.

Our staff have consistently delivered more and more high-quality care despite seemingly ever-increasing demand for our services. Our overall Outstanding rating is also superb news for our patients, who will have the reassurance that 63 independent regulators have conducted a thorough investigation of our organisation and determined that we provide and support some of the very best care in the country.

Our top rating is also a fantastic endorsement of the thinking behind our Patient First Improvement Programme. 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 Improvement Programme we are giving our staff the skills and support to make that change happen.

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.

Our staff provide exemplary standards of care, day in, day out, and to be rated Outstanding by the CQC is acknowledgement of the exceptional service they provide to the people of West Sussex.

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 saying:

"We saw real warmth amongst teams and an open and trusting culture."

"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."

A team of CQC inspectors and specialists, including doctors, nurses, managers and experts by experience, spent four days during December 2015 inspecting the Trust's hospitals, followed by an unannounced visit just before Christmas 2015. The inspectors said the care we provide is Outstanding, the effectiveness of the trust is Outstanding and we also earned an Outstanding grade for being well-led. Urgent & Emergency Care, Medical Care (including Older People), Maternity & Gynaecology, Children & Young People's Services and End-of-Life Care were also all rated Outstanding by the CQC.

Inspectors also rated the overall standards of care patients receive as Outstanding, saying: ***"We saw evidence of a consistent approach to compassionate care, an empathy and understanding towards patients and a supportive environment."***

They added that the ***"supportive, caring, compassionate approach to patients spread across all core services"*** and that this ***"ethos of compassionate care extended beyond clinical staff"***.

On virtually every measure our staff are delivering more and more, while at the same time driving up standards. The CQC inspectors made particular mention of the Trust's impressive achievements in improving quality of care and outcomes for patients, with reductions in mortality rates now putting us among the country's 20% best trusts.

Trust Chairman Mike Viggers joined me in thanking staff for their stalwart commitment to delivering exceptional standards of patient care, despite unprecedented demand for services. He said:

"On virtually every measure our staff are delivering more and more, while at the same time driving up standards and the quality of care experienced by our patients."

"Being rated as Outstanding by the CQC is no less than they deserve and we welcome the watchdog's findings in support of the approach we have taken to make sure we always improve quality for the population we serve."

"We are committed to continually improving everything we do for our patients, and this latest milestone is yet another strong foundation upon which to build an even greater service for patients."

Our 'Patient First Improvement Programme' is 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 continue to roll out our Patient First Improvement System at pace, 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 2016/17 continued to deliver against the goals we set for quality improvement last year.

I am delighted to report that the most recent national data available ranks Western Sussex Hospitals as one of the top ten performing trusts nationally for A&E performance. While the four hour target to see, treat and then admit or discharge patients 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. We achieved all seven cancer waiting time and treatment targets in 2016/17, and furthermore, we also met the national elective surgery waiting time target for referral to treatment within 18 weeks in December and January, for the first time in over two years.

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

The 2016 NHS Staff Survey was released in early March 2017 and I am delighted to report that there were some really positive findings for us here at Western Sussex Hospitals. We improved our results in all 32 of the survey's 'key findings' and we're in the top 20% of acute trusts on four important measures including willingness to recommend our hospitals as places to work or be treated.

Alongside that, some of the analysis we've carried out on responses at divisional level suggests that our Patient First Improvement Programme is having a really positive effect on how people feel about their work and their ability to bring about positive change.

I was encouraged by the sheer number of our staff who took the time to share their views: 3,959 members of staff, or 59% of our entire workforce. That's an increase of almost 10% on 2015 and way ahead of this year's national response rate of 44%. The response rate is important because the more people's views we are able to canvass, the more information we have to base our decisions on. That in turn means we can be more confident in identifying the good things we want to do more of and the negative issues we need to address.

If you were a clinician thinking of changing a patient's treatment regime, I'm pretty sure you'd want to have as full a view of their medical records as possible before making your decision. The same is true for the Trust as an organisation: the more we know about people's experiences and how they feel about their work, the more we can do to improve them.

Taking measurements is a key part of the improvement methodologies behind Patient First – if you don't have any data, you don't know how big a problem is the issue you want to resolve and you'll have no idea whether the solution you come up with has had any effect.

That's why we survey our patients and staff on a regular basis – we carry out real-time patient experience surveys on wards and departments every day, and when staff attend their annual mandatory training session they are asked some simple but important questions around measures such as willingness to recommend the trust as a place to be treated or work, how motivated and engaged they feel at work, and how they see their ability to contribute to improvements in their team or department. These are great snapshots that allow us to track changes in experience and opinion month by month, and respond quickly to any trends or issues we see emerging.

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.

However, we recognise there is more we can do, which is why we continue to pursue improvements to achieve our key quality goals as set out in our Quality Strategy:

- Reducing preventable mortality and improving outcomes
- Avoiding harm
- Improving patient experience
- Improving staff engagement

Following a month long engagement exercise with our staff, volunteers, patients, members, partners and stakeholders we have agreed the improvement priorities for each area for 2017/18. 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 Improvement Programme provides the philosophy, organisational structure and methodologies to relentlessly pursue continuous improvement against each of these goals.

I am pleased to confirm that the Trust Board has reviewed the 2016/17 Quality Report and confirm that it is a true and fair reflection of our performance. 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 2017/18 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.

Finally, I'd like to extend a special thank you to all the staff and volunteers who work so tirelessly at Western Sussex Hospitals to make every day better for the lives of patients and the communities we serve. It is their contribution which makes us who we are.

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

Marianne Griffiths
Chief Executive

Key Achievements 2016/17[3]

Sepsis: reduction in mortality
Our non-elective rolling annual relative risk mortality for sepsis has improved from 115 to 91 between January 2015 and November 2016

Inpatient Falls: promising reduction programme results
Two wards have reduced falls by more than 50% with a further three reducing falls by 40-50%

Mortality: sustained reduction in mortality
We are in top 20% of Trusts for non-elective mortality

Critical care: improvements in delayed discharge
30% reduction in the delayed discharge of 'ward fit' patients from ITU to our wards.

Child Protection - Information Sharing: national early adopter
New information sharing system to improve child protection

Western Sussex Eye Care | Southlands: new multi-million facility built
Relocation of outpatient and day surgery ophthalmology care

Workforce transformation: reduction in agency spend
19% reduction in agency spend since 2015/16 saving £4.4million

Clinical Academic Pathway: developed
Funding support from Health Education KSS and collaboration with local HEIs

Maternity services: 'Team of the Year'
Public Health Midwives won RCM award for 'Always stepping it up': improving services for women with additional needs

[3] KSS: Kent, Surrey & Sussex, HEI: Higher Education Institution, RCM: Royal College of Midwives, PFIS: Patient First Improvement System

Western Sussex is an ''Outstanding'' Trust

Last year England's Chief Inspector of Hospitals named Western Sussex Hospitals NHS Foundation Trust (WSHFT) as one of only five non-specialist acute trusts to be awarded a rating of *Outstanding* after its inspection by the Care Quality Commission.

Factors that contributed to the *Outstanding* rating included:

- a clear and consistent focus on safety
- demonstrably delivering care that is based on the needs of patients
- trust-wide learning from incidents and complaints, and
- exceptional leadership.

The Chief Inspector of Hospitals, Professor Sir Mike Richards, said:

"Western Sussex Hospitals NHS Foundation Trust aspires to be one of the best patient-centred services in the National Health Service, with a trust-wide mantra of patients first. We found that this ambition was understood and embedded in the practice of staff across all professions and at all levels.''

''The Trust focuses first on improving quality and safety. Staff and patients who we met during this inspection spoke positively about the patient journey and the striving for continual improvement. We found a clear focus on quality improvement, innovation and safety, starting even before patients are admitted. Services are clearly designed to meet the needs of individuals, with services providing continuity of care from the hospital into the community."

''I congratulate the Trust and all its staff on this Outstanding rating."

This achievement is a testament to our **'Outstanding staff'** delivering outstanding care throughout our services. Our services providing Urgent and Emergency Care, Medical Care, Maternity & Gynaecology, Children and Young People's Services and End-of-Life Care were all rated *Outstanding* by the CQC.

Professor Sir Mike Richards reflected on our staff:

"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."

Our overall *Outstanding* rating is also superb news for our patients who will have the reassurance that 63 independent regulators have conducted a thorough investigation of our organisation and determined that we provide and support some of the very best care in the country.

Our top rating is also a fantastic endorsement of the thinking behind our Patient First Programme. 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 our staff the skills and support to make that change happen.

Marianne Griffiths, Our Chief Executive reflects on building on our achievements:

''The CQC's Outstanding rating marks a new beginning for us and a major milestone on our seven-year journey from merger, through Foundation Trust status and now onto confirmation as one of the very best acute trusts in the country. The CQC has renewed our conviction that we are on the right track. We now continue to excel, lead by example and keep improving all that we do for our patients. We are Western Sussex – where better never stops!''

Our Patient First Programme continues help us shape our quality improvement priorities and equip and empower staff throughout our hospitals to continuously improve the services and care we provide.

Part Two: Priorities for improvement and statements of assurance from the Board

2.1. Our progress and plans

2.1.1 Our Trust approach to Quality Improvement

Every three years we produce a Quality Strategy, which sets out our focus to improve our hospitals' services for patients, visitors, staff and partners. We aim to provide 'the best care every time'. We focus on programmes that will ensure we continuously improve the safety and reliability of care, and improve patients' experience of this.

Key goals[4] of our Quality Strategy include:

- **Reducing mortality and improving outcomes[5]**
- **Safe care[6]**
- **Improving patient experience**
- **Improving staff engagement[7]**

Each year we engage staff, patients, the wider public and our local health economy / Sustainability and Transformation Plan (STP)[8] partners regarding our quality priorities, and actively act on feedback.

Our Quality Strategy and priorities are consistent with the STPs.

The Quality Strategy is monitored by the Quality Board and the Trust Board. The Quality Board is established to enable ongoing monitoring through the Quality

[4] We have incorporated our 'providing more reliable care' goal in to our other improvement goals and split our 'improving patient and staff experience' goal in to individual workstreams.

[5] Previously we referred to this goal as 'saving more lives and improving outcomes'.

[6] Previously we referred to this goal as 'providing safer care'.

[7] Previously we referred to this goal as 'improving staff experience'.

[8] Sustainability and transformation plans (STPs) have been developed by NHS and local government leaders in 44 parts of England. The plans offer a chance for health and social care leaders to work together to improve care and manage limited resources. Source: Kings Fund.

Scorecard, to review patients' outcomes and initiate actions to drive quality improvement.

Western Sussex Patient First Programme

We recognise that the strength of our hospitals lies in our staff, and have built an organisational culture that empowers teams and individuals to make lasting changes that benefit our patients and community. To do this, we have developed Patient First – the Trust's bespoke approach to sustaining a culture of continuous improvement.

Patient First is our long-term approach to transforming hospital services for the better by giving staff the skills to deliver continuous improvement and to put our Patients First. We empower our front-line staff through training and support them with a suite of tools, the freedom to work out where opportunities are, and the skills and support to make change happen and to make it sustainable.

Patient First is based on proven improvement methodologies, most notably the principles of 'kaizen' (or 'continuous improvement') and the Lean[9] approach to management developed by the Toyota Motor Company and adapted successfully for use in healthcare by organisations such as the Virginia Mason Medical Center.

We have evolved these further for the specific needs of our hospitals and community to create our own Patient First Improvement System as a framework for service development through:

- Redesigning systems to take out waste and reduce the possibility of error, and
- Standardising practices to make sure every patient experiences a high quality service each and every time we see them.

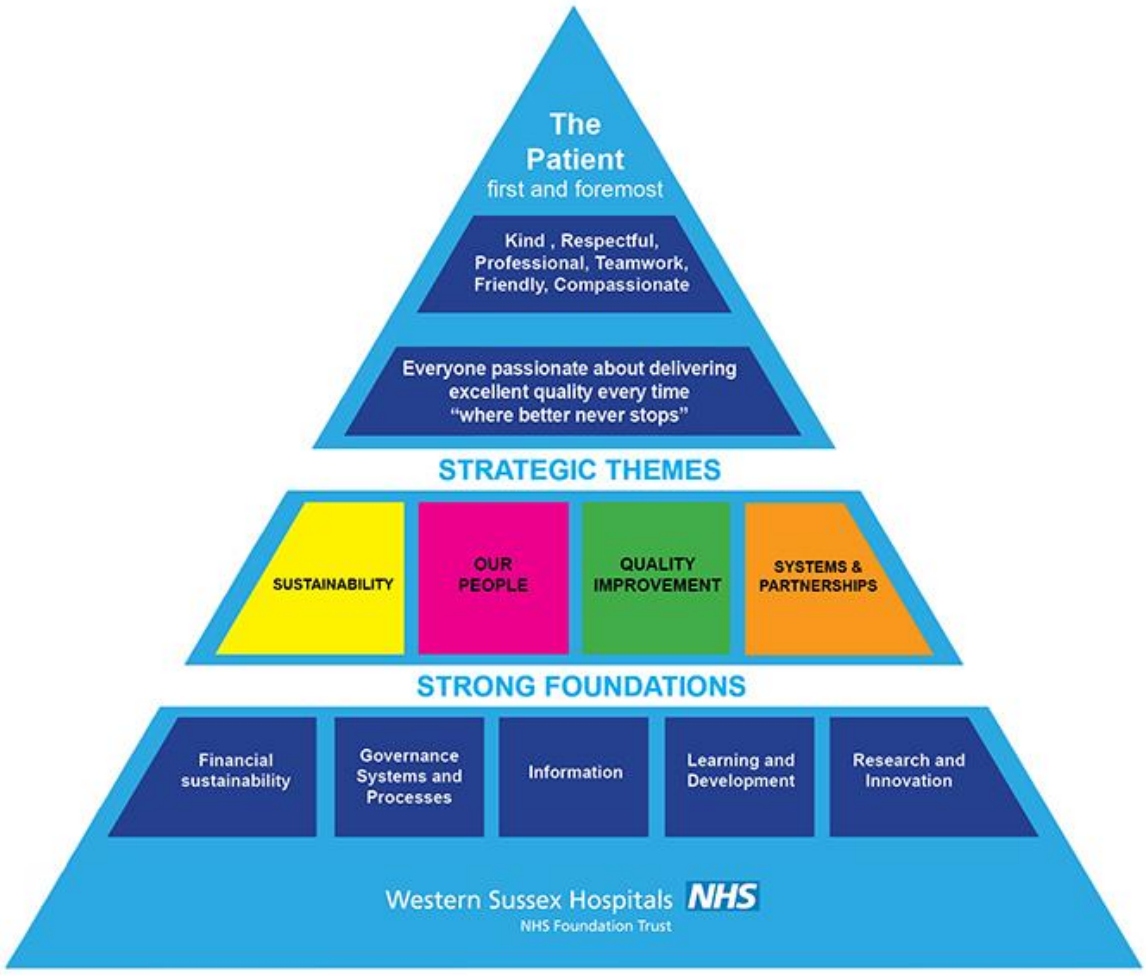
This new Western Sussex approach is driven by six key principles:

- The patient at the heart of every element of change
- Cultural change across the organisation
- Continuous improvement of our services through small steps of incremental change
- Constant testing of the patient pathway to find new opportunities to develop

[9] 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

- Encouraging front-line staff to lead the redesign processes
- Equal voices for all

We describe the structure and focus of Patient First in the form of a triangle, illustrated below:



The Patient is at the apex, to make explicit the commitment that everything we do should contribute to improving outcomes and experiences for the people we care for. This is the 'True North' of our organisation.

Below the apex, 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** Patient First will not succeed without robust programme management arrangements to ensure its efficiency, transformation and quality improvement programmes are delivered successfully.

• **Our people** Patient First requires a re-evaluation of our organisation's culture and a genuine change in the way we operate – major shifts that require all our people to understand, embrace and lead the processes involved.

• **Quality improvement** Continuous improvement is at the heart of Patient First – making small changes on a frequent basis to keep raising standards and quality.

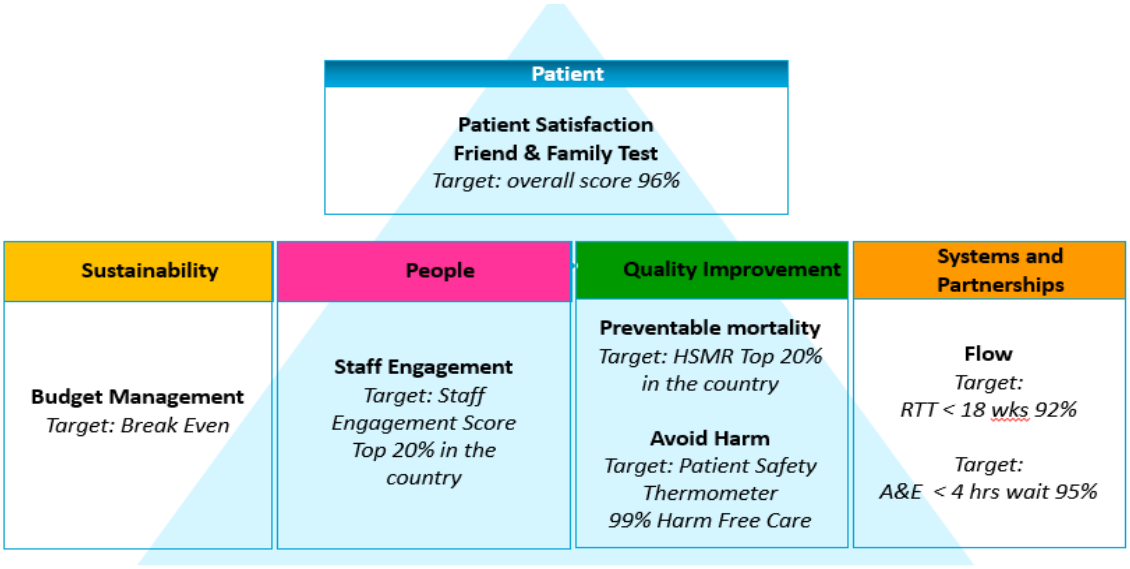
• **Systems and partnerships** The Trust does not exist in a vacuum – to provide genuinely patient-centred care, Patient First must reach out beyond our hospitals to continuously improve our system-wide processes and pathways, and influence others to make sure that all decisions affecting our work are made in the best interest of patients.

Finally, the Patient First triangle has to be supported by strong foundations. Our ambitions to deliver consistently excellent and constantly improving care will be underpinned by financial sustainability, good governance systems and processes, accurate information, a commitment to learning and development, and valuing research and innovation.

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. Further information about Patient First can be found on the Trust website: www.westernsussexhospitals.nhs.uk/your-trust/performance/patient-first/

True North

Our top priorities relate to the Trust's 'True North' quality and safety improvement metrics. These establish a measure of our organisational health and provide a system-wide improvement focus. True North is the compass that keeps our hospitals heading in the right direction – a fixed point we should always refer to when identifying which improvements and projects to prioritise.



Note: HSMR is Hospital Standardised Mortality Ratio. RTT is Referral To Treatment waiting times. A&E is Accident and Emergency.

For Quality Improvement our True North Metrics are the reduction in preventable mortality, and provision of harm free care. Over the last year we have focused relentlessly on our Breakthrough Objectives, those that will take us furthest and fastest towards our overall True North, as the key objectives to deliver this.

True North	Breakthroughs Objective	Measure	Baseline	Target
Systems and Partnerships	'Medically fit for discharge' patients	Reasons for delay on 'Medically fit for discharge' patients	7-10 day Length of Stay	Reduction 5-6 days
Quality and Safety	We will reduce the number of falls in our hospitals – focus on top 10 wards first	Number of falls	514	30% reduction per year across whole trust
People	Staff state they are able to make improvements in their place of work	Staff survey questions on a monthly basis	51% of staff	To be agreed - new data being collated at staff Health & Safety days
Sustainability	We will reduce our agency spend	Reduction in usage and cost of agency staffing expenditure	£23m 2015/16	£17m 2016/17

Our breakthrough objectives will be regularly reviewed to ensure that we focus on the key improvements that will deliver our True North Metrics.

Western Sussex Patient First Improvement System

The **Patient First Improvement System** (PFIS) is our Lean management system, developing our staff to solve problems and improve performance. PFIS is rolled out

to new wards or departments 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 improvement tools 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 issues in their own area that they are able to improve themselves; and implementation of process and leader standard work to ensure improvements can be sustained.

Building an 'army of problem solvers'

We are building continuous improvement **capacity** throughout our workforce with our Patient First Improvement Programme.

The programme is developing a 'Trust-wide' network of Lean professionals and teams empowered to solve problems, improve processes and pathways using Lean tools. It enables 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.

The programme encompasses a 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 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 includes a session on the Patient First Improvement Programme and staff are introduced to some key concepts and practices in Lean healthcare as well as reinforcing Trust values and overarching objectives ('True North').

The programme also includes 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 and staff attending the training are expected to deliver small projects aligned to Trust objectives. Trust staff leading larger

improvement projects undertake ‘Green Belt’ training to ensure the benefit of Lean methodology is applied rigorously to support all our continuous improvement programmes.

2.1.2 How we learn

We have robust systems in place for reviewing incidents, complaints and claims within our clinical divisions[10]. Each clinical division has a governance lead to coordinate this activity and help the Divisions to track and complete the actions arising out of each of these areas. Divisions also use safety huddles[11], newsletters and staff meetings to help communicate changes made in response to learning.

When things go wrong for patients, talking to the person affected or their family provides crucial context to any investigation. We continue to develop and encourage an open and honest approach to supporting patients who have been harmed, or their families, as candour and transparency are core values for Western Sussex Hospitals.

Sharing learning across the organisation is a challenge and this is done in a number of ways:

- Each month a short Patient Story is cascaded across the Trust. Patient stories are an anonymised version of something adverse that may have happened either locally or nationally. Personalising the story is an effective way of helping staff to appreciate the impact on the individual and therefore to better capture what went wrong. Patient stories include three or four key points for staff to consider in their practice.

- Every week we have a 'Theme of the Week' to identify an area for concentrated focus. The theme of the week will be discussed at every daily safety huddle for that week to try to capture all staff on duty. The theme is also often featured as part of the monthly Safety Newsletter to reinforce the messages.

- Clinical Divisions have protected time each month for learning in the form of a 'Clinical Governance Half Day' and Divisions can use this time flexibly to explore themes and share learning at service or specialty level.

[10] Our Trust is organised into divisions – these group together clinical and also non-clinical specialties in to small business units. Our clinical divisions are: Medicine, Surgery, Women & Children and Core.

[11] Safety huddles, a multi-disciplinary approach to flagging concerns at the beginning of the day. Further information about safety huddles and how they work can be found in our short film: www.youtube.com/watch?v=2DUgg8yRpvc

- Each Clinical Division maintains an up-to-date risk register where significant risks to quality and safety of care are recorded and monitored. The risk register is a key component of the organisation's approach to safety and improvement as our improvement focus is aligned to resolving or controlling risks to safety and quality of services and care provided.

Learning from Deaths

During 2016/17 the Trust embarked on a programme to develop a process for the screening and review of all deaths in our hospitals. In response to the Care Quality Commission's publication 'Learning, candour and accountability'[12] the Secretary of State made a range of commitments to improve how the NHS learns from reviewing the care provided to patients who die. The Trust is fully committed to implementing these recommendations and throughout 2016/17 we have developed and piloted a local screening tool for all deaths, convened a mortality 'Community of Practice'[13] in collaboration with the KSS AHSN[14], and become an early adopter of the national programme and tool for full mortality review including reviewer training.

This work will continue to progress through 2017/18 in line with NHS Improvement recommendations.

[12] www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

[13] Communities of practice offer an ideal opportunity to connect people working across WSHFT and support development of best practice. This can help implement new ideas and support the shaping of existing knowledge into new practices that can help people to do their jobs more effectively. This places value on understanding the context of practice and how new knowledge can be integrated within this to enhance individualised approaches to achieving quality patient care. These communities of practice can function in real-time face-to-face settings or as e-communities of practice.

[14] Kent, Surrey, Sussex Academic Health Science Network www.kssahsn.net

2.1.3 GOAL 1 - Reducing preventable mortality and improving outcomes

GOAL: To be in the 20% of NHS organisations for the Hospital Standardised Mortality Ratio

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.

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 (HSCIC). 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.

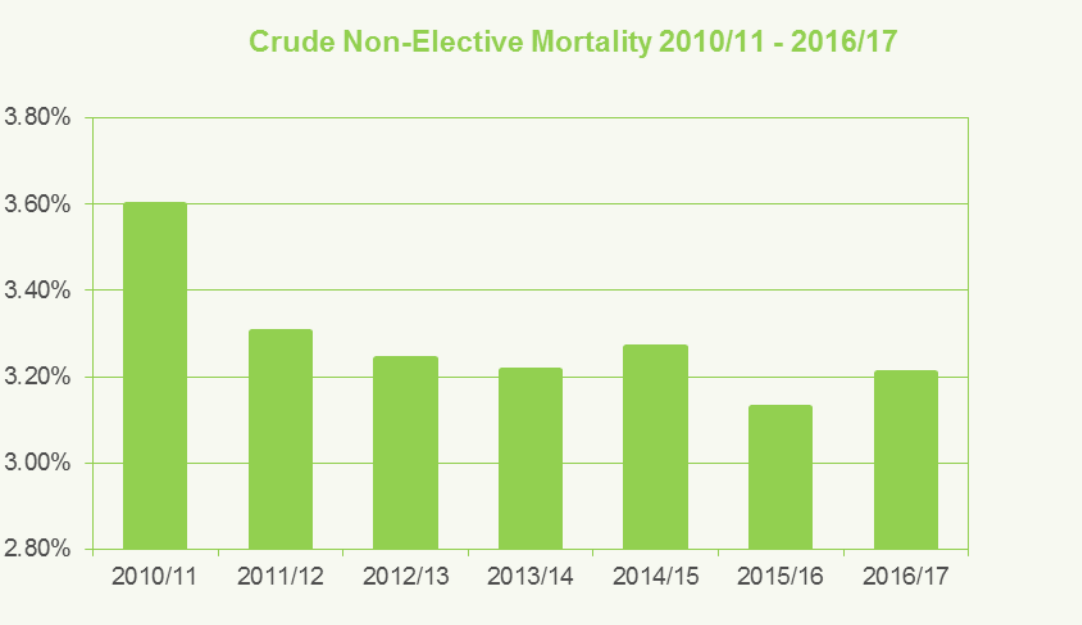
How do we report on it?[15]

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 reporting to the Trust Quality Board.

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 2016/17 to 3.21%. Six full years' crude non-elective mortality data and provisional figures for 2016/17 combined for all WSHFT hospitals is shown in Figure 1.

Figure 1. Crude non-elective mortality

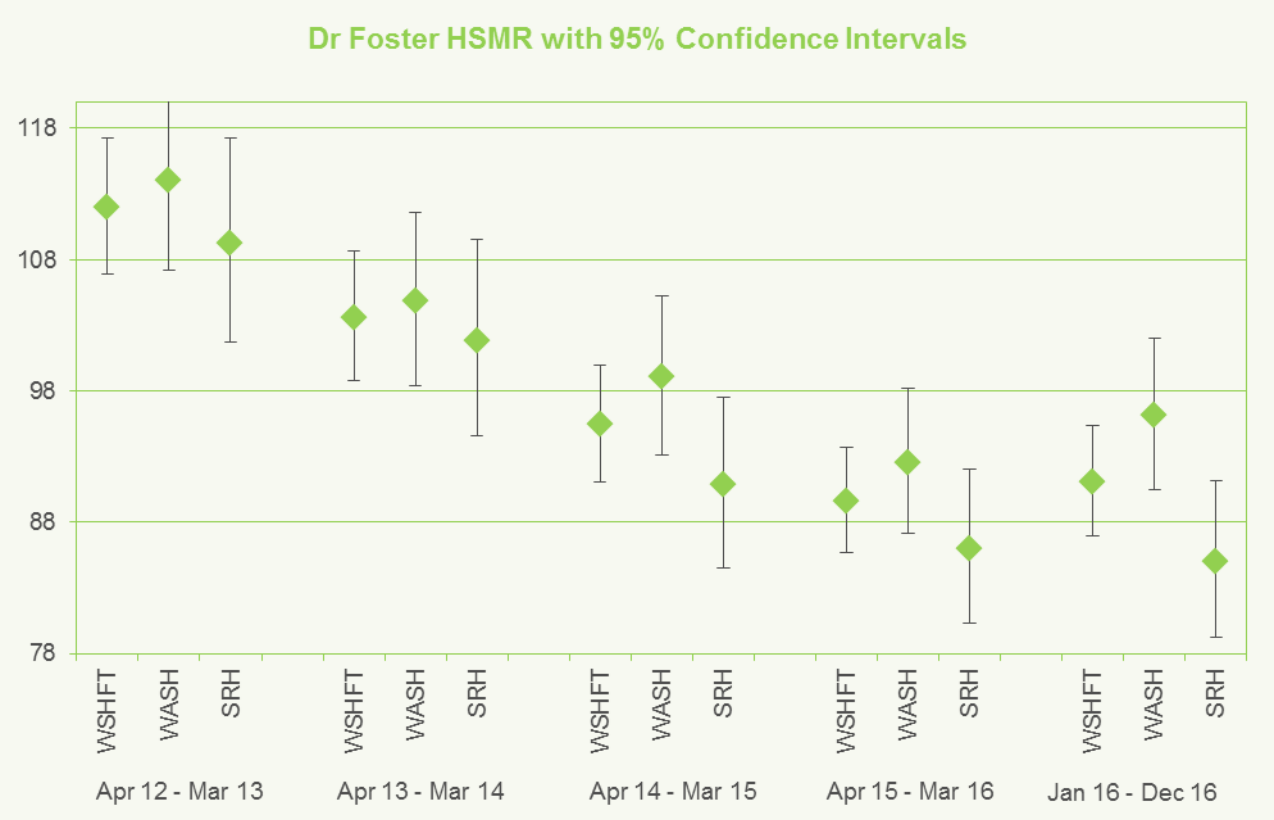


Over the same period the Trust's risk adjusted mortality rate has also fallen. Each year Dr Foster re-base their figures to account for reducing mortality in the country as a whole (effectively resetting the benchmark to the most recent year). As such showing improvement is difficult. The Trust's Dr Foster HSMR improved from 107.48 in 2011/12 to 89.62 in 2015/16 (the last full financial years' worth of data). Due to the

[15] 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.

delay for Dr Foster data (to allow for coding and processing), Figure 2 below shows the 12 months to December 2016 as the most recent data point with performance at 91.09.

Figure 2. Dr Foster Hospital Standardised Mortality Ratio[16]



The SHMI score shows a marginal decrease to 0.97 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.

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). However, for the latest data

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

available, (12 months to December 2016), the Trust's HSMR of 91.26 is now ranked 24th of 136 trusts (20th centile) see Figure 4. As described in our Quality Strategy 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 3. Summary Hospital Mortality Indicator

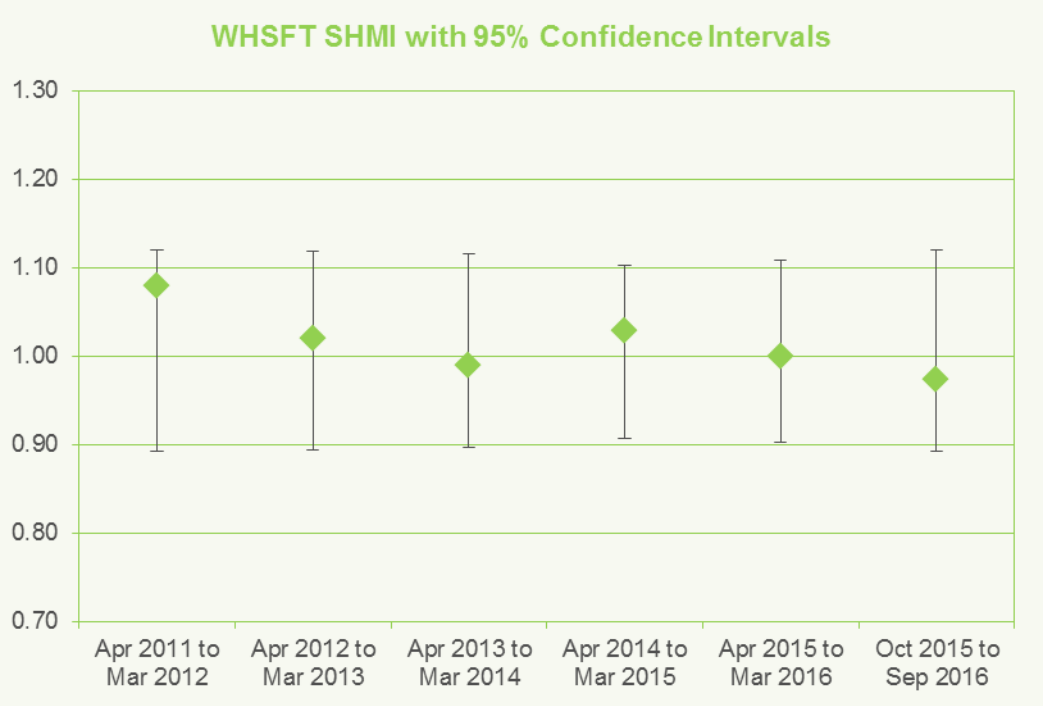
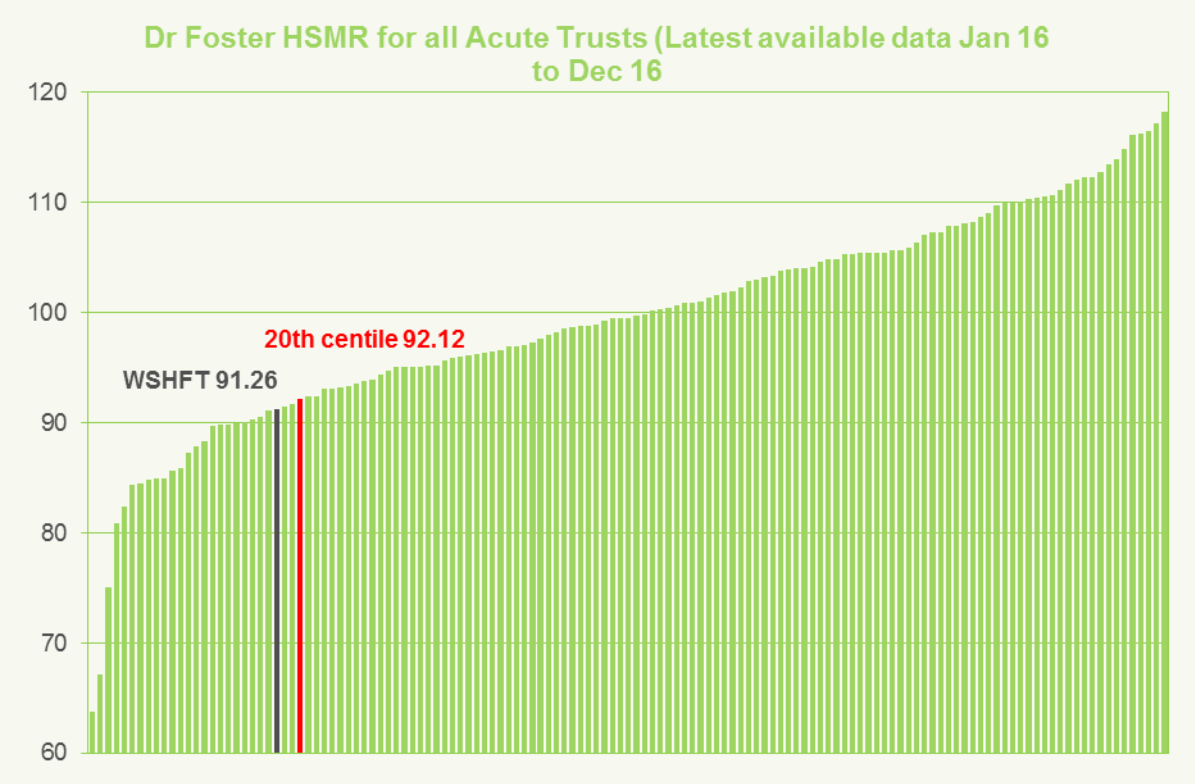


Figure 4. Dr Foster Hospital Standardised Mortality Ratio for all Acute Trusts



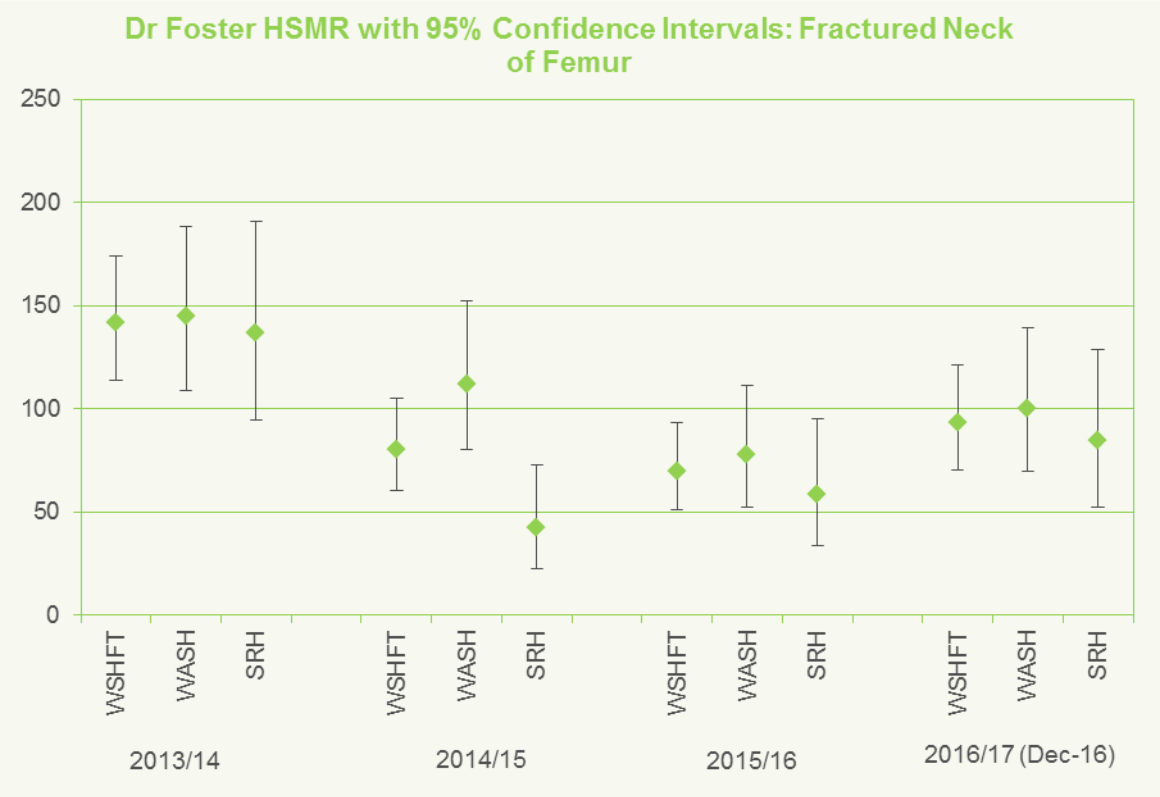
Over the next year and the course of the 2015/18 Quality Strategy we propose to continue to focus on key areas such as fractured neck of femur, acute kidney injury and sepsis where we have previously delivered improvement, but have however not yet seen the scale of reduction in mortality we would like.

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[17] 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 = 93.56 where 100 is the expected (Dr Foster data for the 12 months to December 2016).

Figure 5. Dr Foster HSMR Fractured Neck of Femur

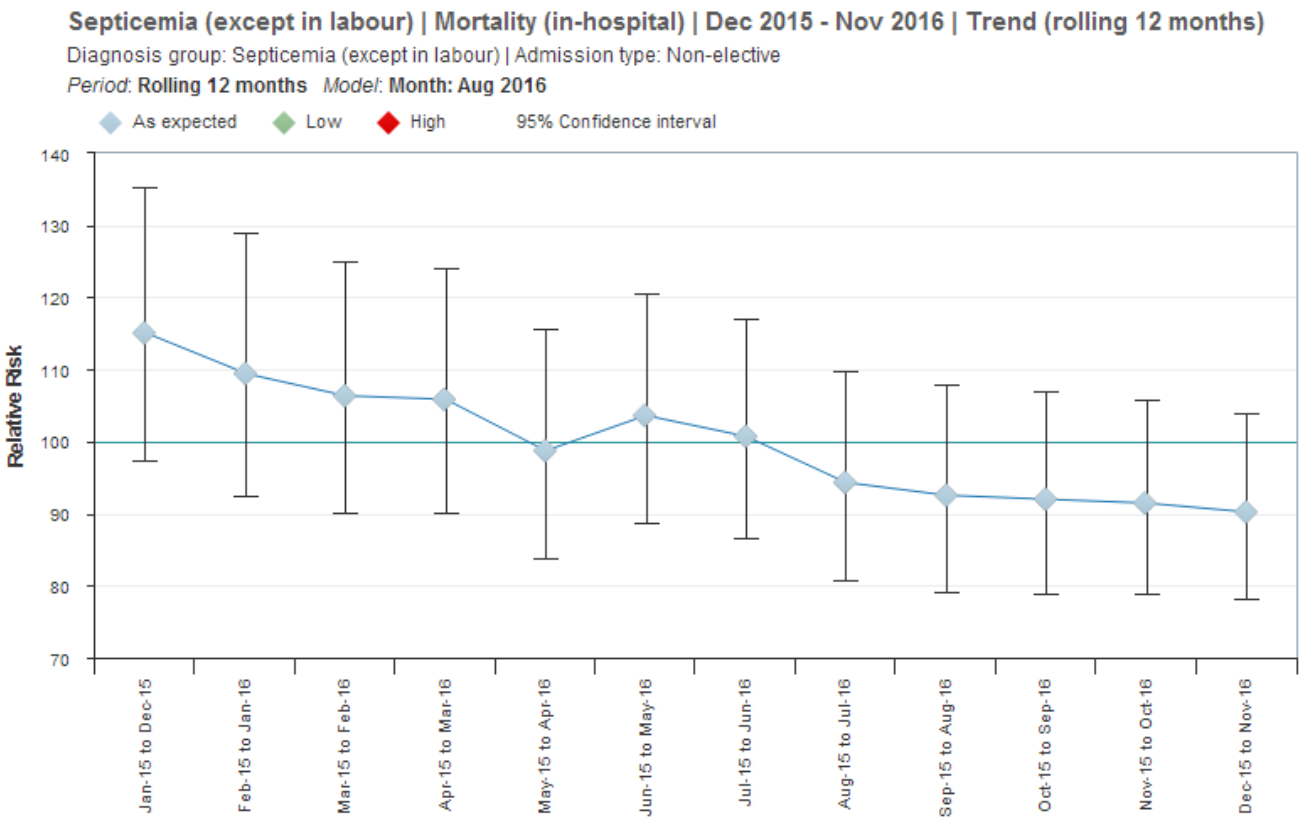
[17] Care bundles are small sets of evidence-based interventions which, when used together consistently by a single healthcare team, have been shown to significantly improve patient outcomes.



Reduction in crude non-elective mortality sepsis

We have focused on reduction in crude non-elective mortality associated with sepsis through our Deteriorating Patient Improvement Programme. We have seen a reduction in crude non-elective mortality associated with sepsis over the past two years from 115.10% in 2015 90.63% in 2016/17 as of November 2016.

Figure 6. Non-Elective rolling annual relative risk mortality for sepsis



Source: Dr Foster

Reduction mortality in other specific disease groups

The Trust reviews mortality outlier reports on a monthly basis from Dr. Foster, with comprehensive analysis of whether the Trust mortality rate is above, below or as expected for particular care groups and across our hospital sites given the demographic and comorbidities for patients within these groups. Where the Trust becomes an outlier, this information is retrospectively reviewed by lead clinicians. There have been no centrally triggered outlier reports in 2016-17.

Our Quality Improvement Programmes for 2016-17

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

Reducing Mortality and Improving Outcomes Programmes 2016/17	Target Achieved/ On Plan	Close to Target	Behind Plan
Deteriorating Patient Programme			▲
Better Births Programme	▲		
End of Life Care Programme	▲		
Stroke care pathway (SSNAP)		▲	
Frail elderly dementia pathway	▲		
Enhanced Quality Emergency Laparotomy Programme with AHSN Collaborative	▲		

Deteriorating Patient Programme

Aim: **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.**

Target: **95% compliance with sepsis and acute kidney injury care bundles**

By when: **March 2018**

Progress: **Behind plan**

We have introduced 'care bundle' systems of care for patients with sepsis and acute kidney injury. 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, 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, a mnemonic Trust staff use to remember the six tasks associated with identification and treatment of sepsis: blood cultures, urine

output, fluids, antibiotics, lactate and oxygen) have been delivered to patients in line with national guidance; we monitor overall deployment of all elements of the 'Sepsis 6' care bundle and with a focus on the key measure of administration of antibiotics within one hour of a patient being flagged / identified as having severe sepsis (red-flag). Evidence[18] indicates that for every hour administration of antibiotics is delayed there is an 8% increase in mortality. We have focused on achieving this target as part of the 2016/17 national Commissioning for Quality and Innovation (CQUIN) national goals.

Our goals in 2016/17

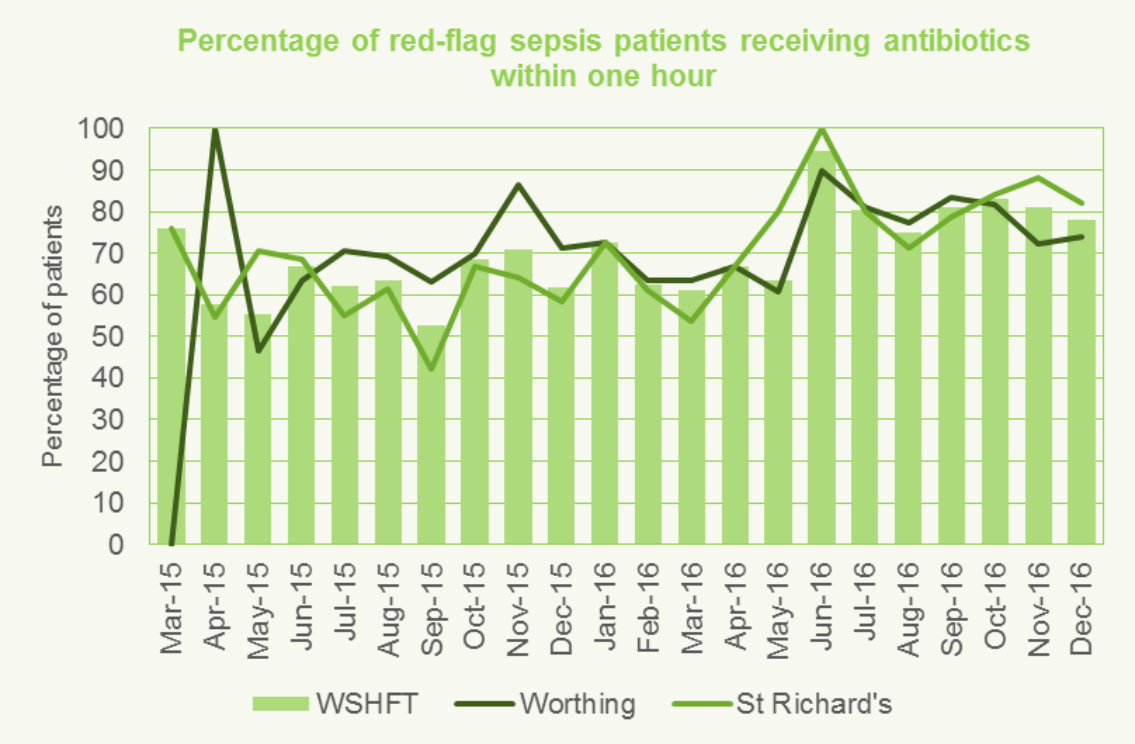
Our goals for this programme in 2016/17 have continued to focus on raising awareness of severe sepsis across all health care professionals in the Trust through a programme of education and training. The ongoing development and implementation of an electronic screening and treatment support tool using our bedside monitoring system (Patientrack), and the routine monitoring of care bundle compliance through prospective and retrospective data collection.

Improvements achieved 2016/17

- Further development of the electronic screening and treatment support tool for sepsis based on clinician feedback.
- A wide range of education events and awareness raising campaigns run across the Trust.
- The establishment of formal improvement programmes in Accident and Emergency departments and Emergency Floors.
- Continued to make a significant contribution to the Kent, Surrey and Sussex Patient Safety Collaborative programme on sepsis.
- Contributed to sepsis education in primary care by providing a sepsis workshop as part of the GP education programme.
- Working with the ambulance service to ensure a good process of communication and feedback.

[18] Kumar A, Roberts D, Wood KE et al. Duration of hypotension prior to initiation of effective antimicrobial therapy is the critical determinant of survival in human septic shock. Critical Care Medicine 2006; 34: 1589–96.

Figure 7. Percentage of flagged sepsis patients receiving antibiotics within one hour



N.B. Jan to March 2016 period did not include the 72 hour antibiotic review which was added to the NHS England CQUIN definition from April 2016.

Further improvements identified

The Trust has committed to a continuous improvement programme for 2017/18 supported by the Kaizen Office[19], to maximise the impact of the programme across the Trust in terms of compliance with sepsis care bundles and reduction in mortality. Project plans have been developed in the emergency admitting areas in the Trust with clear project leads from within the clinical teams.

Lean tools drive improvement – News from the Kaizen Office

September 2016 saw two major quality improvement events, the first looking at how we improve the pathway for patients admitted with sepsis.

[19] **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.

We currently recognise sepsis in a large percentage of patients admitted, however we still have a way to go. The event held at Worthing bought together medical and nursing staff from A&E as well as pharmacy, outreach, clinical nurse specialists and the data collection department. Together this multi-disciplinary team mapped out the patient journey from A&E admission through to receipt of the 'Bufalo' care bundle (a group of tests and treatment designed to combat sepsis), and then on to admission to a ward.

Kaizen sepsis event

The workshop highlighted over 30 areas where we can make improvements. Our Kaizen Improvement Practitioners will now work with the A&E and Emergency Floor teams to see how these opportunities could be used to try and standardise the care our patients receive.

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 between £434m and £620m per year; more than breast cancer or skin and lung cancer combined[20].

[20] NICE Clinical guideline [CG169], Acute kidney injury: prevention, detection and management, August 2013.

AKI is commonly due to intercurrent illness[21], 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 2016/17

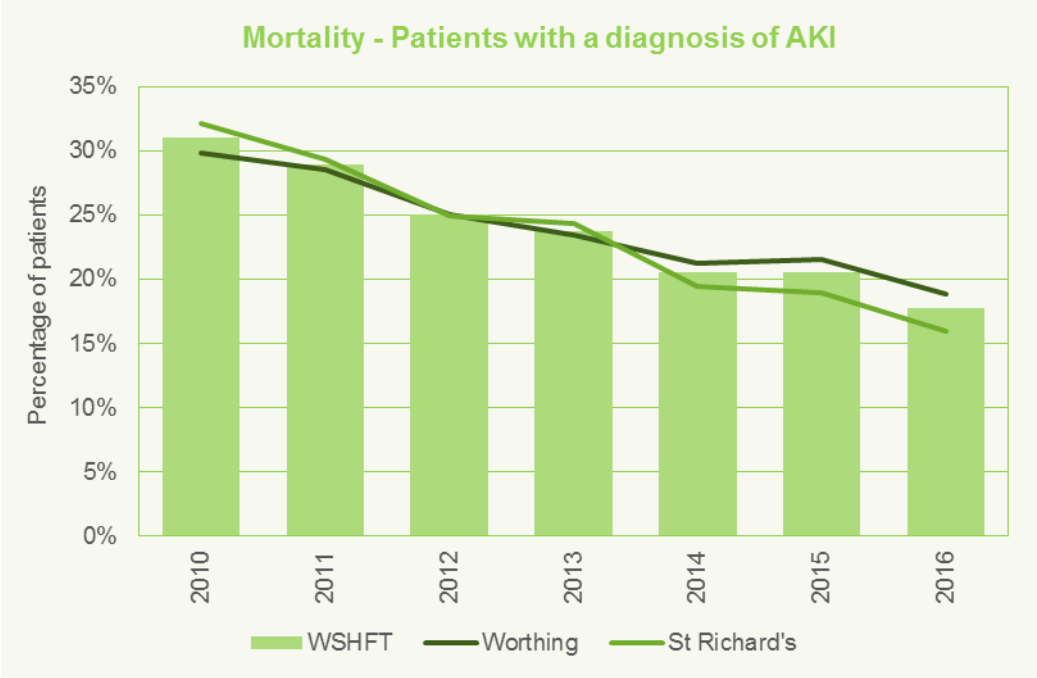
- To continue to raise awareness of AKI across all health care professionals in the Trust through a programme of education and training.
- To further embed the electronic screening and treatment support tool using our bedside monitoring system (Patientrack).
- To improve compliance with early recognition 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 whose kidney function then worsens further during their stay in hospital.

Improvements achieved 2016/17

- Electronic screening and treatment support tool for AKI has been rolled out to both acute sites: Worthing and St Richard's Hospitals.
- A continued programme of education, in particular simulation training in the clinical setting, has continued.
- Continued to make significant contributions to the AHSN Patient Safety Collaborative programme.
- Established some joint working with primary care.
- Early signs that the programme is positively affecting the outcome for patients with AKI or at risk of AKI (although this is not statistically significant at this stage).

Figure 8. Mortality figure for patients with a diagnosis of AKI

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



Further improvements identified

The Trust has committed to a continuous improvement programme for 2017/18 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.

Our goals in 2016/17

Comprehensive data is routinely collected on all cardiac arrests occurring in our hospitals. The focus for quality improvement work in 2016/17 has continued to be on reducing the number of cardiac arrests and reducing cardiac arrest interventions in

patients where a 'Do Not Attempt Resuscitation Order' (DNACPR)[22] may have been more appropriate.

Improvements achieved 2016/17

Despite the on-going work as part of the wider Deteriorating Patient Programme the Trust has not seen the improvements hoped for in 2016-17. There has been an increase in the number of cardiac arrests to pre-workstream levels. Root cause analysis of cardiac arrests has not identified any worsening issues around escalation of the deteriorating patient but have identified a continuing concern regarding cardiac arrest interventions in patients where a DNACPR may have been more appropriate. In recognition of this the training related to the initiation of DNACPR discussions and decision making has been incorporated into the mandated resuscitation training programme from October 2016.

Figure 9. Total cardiac arrests

[22] 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/

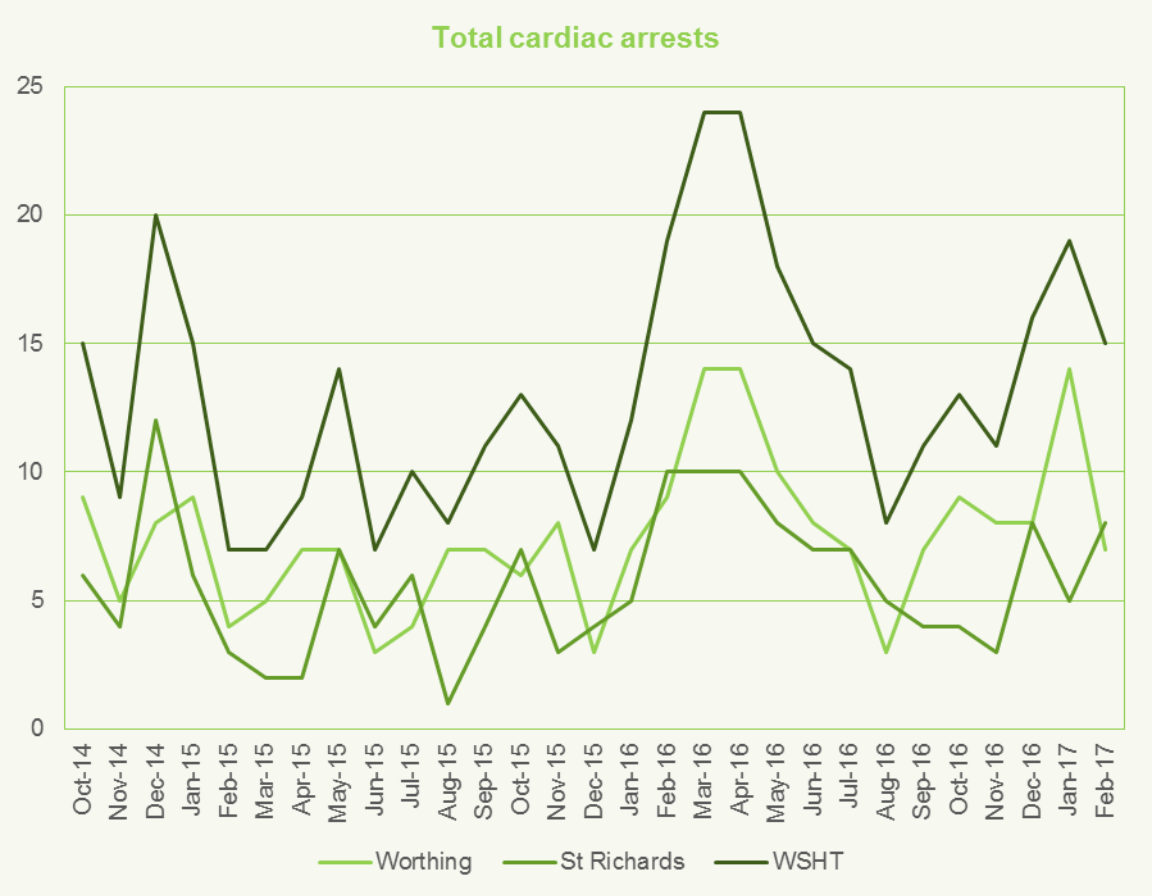
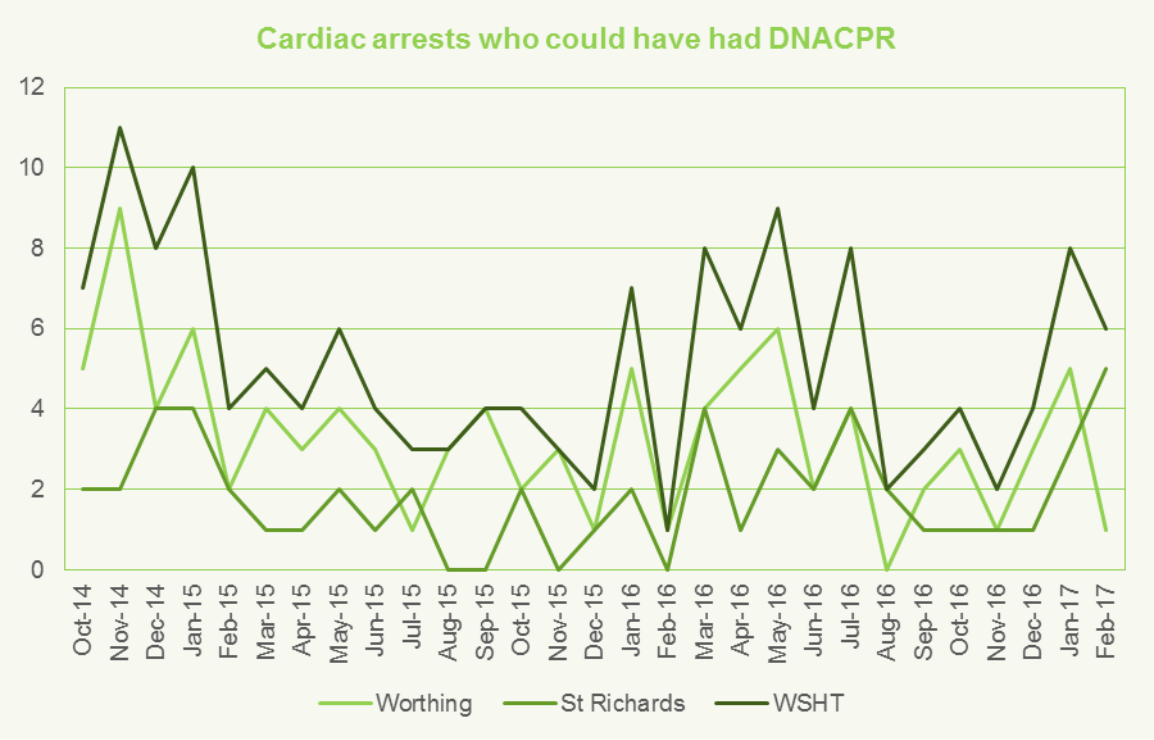


Figure 10. Total cardiac arrests where patient could have had DNA CPR



Further improvements identified

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 advanced care planning work streams and on-going development of the resuscitation training programme).

Better Births Programme

Aim: Continued Better Births Programme: reduction in the number of still births and implementation of recommendations from National Maternity Review

Target: Improved patient engagement (increase in Maternity Friends and Family Test recommend rate), reduction in still birth rate.

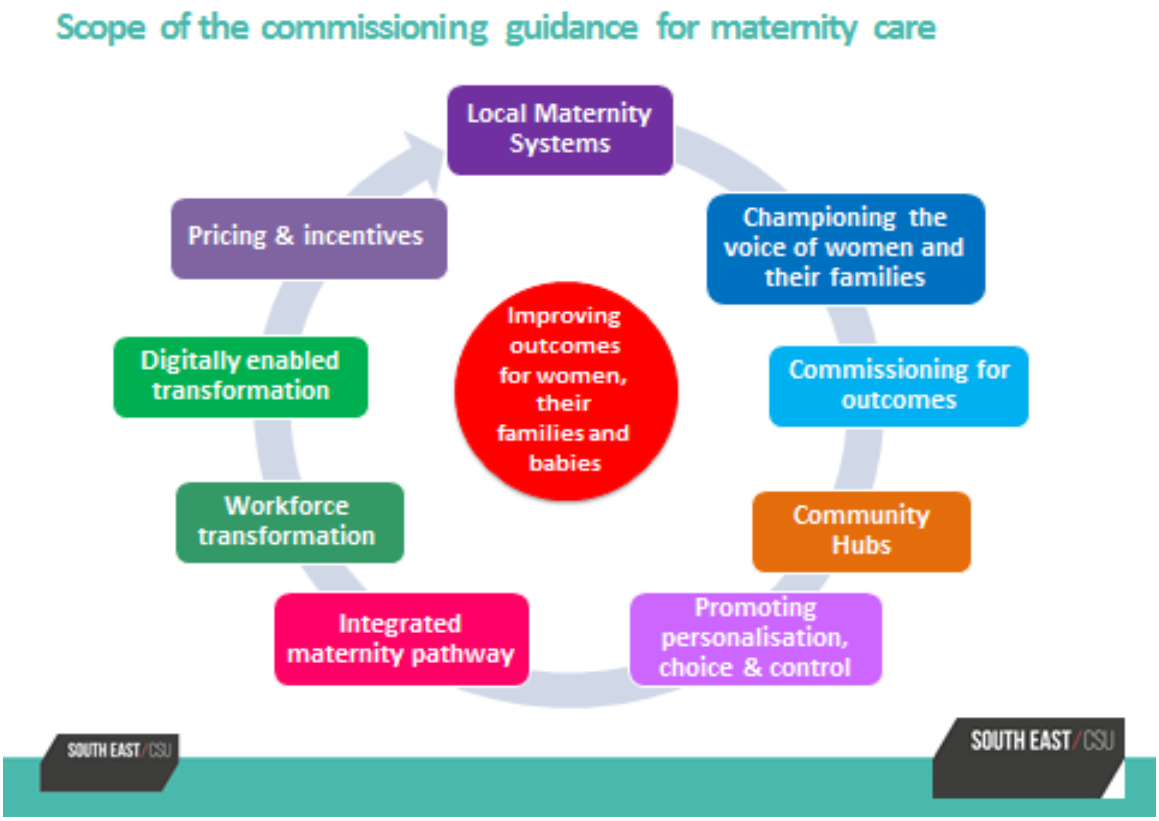
By when: March 2018

Progress: On plan

Our goals in 2016/17

- **Better Births Programme**

This has been the main focus for improvement for maternity services. National Commissioning Guidance for Maternity Care is used to monitor our progress. The diagram below identifies key areas for improvement planning:



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

- Personalised care, centred on the woman, her baby and her family: based on their needs and their decisions, where they have a genuine choice informed by unbiased information. Continuity of carer: to ensure safe care based on relationships of mutual trust and respect, in line with the woman's decisions.
- Safer care, with professionals working together across boundaries to ensure rapid referral and access to the right care in the right place; leadership focussed on a culture of safety across organisations and investigation leading to honest and open discussions and learning when things go wrong.
- Better postnatal care and perinatal mental healthcare: Reduction in mother and baby postnatal re-admissions. Implementation of the National Perinatal Mental Health plan[23].
- A culture of multi-professional working and training: breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.

Better Births engagement event

The Better Births engagement event was held at the White Swan in Arundel on the evening of the 1st March 2017 and a wide range of staff from the women & children's division and service user representatives were invited to attend to contribute their thoughts and ideas for developing local services.

More than 70 people attended on the night, with a good mix of experience and perspectives.

It was an opportunity to learn about service developments, space to share ideas and to listen to inspirational speakers. Key to the evening was the sharing of valuable national information regarding changes in maternity and neonatal services against the national Better Births - National Maternity Transformation Programme. The event was well received and evaluated by all.

[23] https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

Better Births engagement event

- **Saving Babies Lives'**[24]

This is a national care bundle for reducing stillbirth. The national programme aims to halve the rates of stillbirths by 2030, with a 20% reduction by 2020. The care bundle provides an evidence-based framework for maternity services. Over the last year we aimed to fully embed this care bundle into practice.

- **Normalising Birth Programme**

This is a locally led programme that seeks to profile normal and supported birth. We aimed to:

- Better facilitate the use of clinical environment in the hospital to support birth,
- Increase the number of women risked assessed to birth on the St Richard's Hospital Birth Centre,
- Improve the use of low risk rooms on the Worthing Hospital site and increase our homebirth rate.

Hypnobirthing[25] classes are available to couples both sites. These classes offer an enhanced service to attract women to our units as they promote women's confidence in supportive birth.

- **Reducing the incident of skin damage injury in maternity services**

We aimed to implement the Purpose T, a pressure ulcer risk assessment tool, in line with the wider Trust roll out of improvements in skin assessment.

[24] https://www.england.nhs.uk/mat-transformation/saving-babies/

[25] Hypnobirthing is an established and well recognised antenatal birth preparation programme that uses the power of positive language to combine easy-to-learn methods of deep relaxation, breathing techniques, visualisation and affirmative positive thinking which reduces anxiety, stress, fatigue, fear and pain to help achieve a calm and gentle birth.

Improvements achieved 2016/17

➢ **Maternity services at the Trust were rated Outstanding in our recent CQC inspection with inspectors reporting[26]:**

- "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."
- "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."

➢ **We have developed 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. The website has been upgraded with new media presentations to enable women to view the excellent services offered by maternity services.
- The use of laptops for all community midwives has been implemented, providing staff with access to hospital-held maternity patient information whilst out visiting mothers in the community. The use of the hospital Patientrack system by community midwives is in development.

➢ **We have implemented the Neonatal and Infant Physical Examination (NIPE)[27]:**

Implementation of the electronic NIPE SMART system in February 2016 - development of fail-safes to enhance safety, quality of care and communication between multidisciplinary teams.

[26] https://www.cqc.org.uk/sites/default/files/new_reports/AAAE8369.pdf
[27] https://www.gov.uk/guidance/newborn-and-infant-physical-examination-screening-programme-overview

➢ **We have introduced the Newborn Hearing Programme (NHSP)[28]:**

Introduction of the new programme in early 2016; Maternity Support Workers have been trained to provide newborn hearing screening assessments and have achieved the highest regional result (99.6%) of babies being screened within four weeks of birth result.

➢ **We have introduced a specialist Twin Clinic on the St Richard's Hospital Site:**

This mirrors the successful service already offered at Worthing Hospital.

➢ **We have expanded our range of multidisciplinary training:**

This is now mandatory within our service in-line with the Government recommendations within the National Maternity Report[29] and covers both routine and emergency situations.

➢ **We have enhanced engagement and involvement of patients and staff to improve maternity services:**

- Our Facebook page and Twitter account 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.
- Supervisors of Midwives developed a midwifery philosophy for WSHFT maternity services. This is in light of the ending of Statutory Midwifery Supervision in March 2017[30].

➢ **We have focused on reducing mortality and morbidity whilst improving outcomes and experience:**

- GROW[31] customised growth charts are now running in all antenatal care areas. Community Midwives throughout the trust now have access to laptops (in order to access patient information whilst working in the community) and improvement

[28] https://www.gov.uk/guidance/newborn-hearing-screening-programme-overview

[29] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

[30] https://www.gov.uk/government/publications/changes-to-midwife-supervision-in-the-uk

[31] 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.

in communication via Medway (our maternity information system) is a focus for 2017.

- The Induction of labour care pathway has been reviewed and redevelopment is in progress. The AFFIRM[32] trial has been completed and we continue to practise with the AFFIRM pathway until the report is published, and our Induction of Labour Pathway can be developed.
- The diabetic care pathway has been updated in line with the national reducing stillbirth initiative[33].

➢ **We have enhanced access to, and support for service users within maternity services:**

- A triage service run by a small group of experienced midwives is now in place. The service provides mothers to be and new mothers with access to support in all aspects of maternity care, antenatal, labour and postnatal. The triage service has been well evaluated – we have seen an extremely positive response in access to services in the CQC National Maternity Patient Survey 2015. It continues to evolve with the recent addition of a Results Pathway, enabling women to be contacted with slow-time results therefore allowing greater efficiency with in-patient turnover.
- Work is in advanced stages with local Public Health and Children's Services teams on a development project for an electronic network to support access and on-going support for parents across acute and primary care services (Family Assist).

Maternity services Friends and Family Test feedback

We measure success using the Friends and Family Test (FFT) feedback – maternity services recommend rate. The FFT aims to provide a simple headline metric which, when combined with follow-up questions, can be used across the maternity pathway to drive a culture change of continuous recognition of good practice and potential improvements in the quality of the care received by NHS patients and service users.

[32] 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

[33] https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf

Women are asked for brief feedback at three points during the time that we care for them:

- At around 36 weeks of pregnancy (during the antenatal care period)
- After the birth of their baby and stay on the postnatal ward (during the birth and postnatal care period)
- At discharge from community care.

FFT continues to be a priority in Maternity to help establish feedback for our services; FFT is a crucial part of our 'True North' objectives.

Table 1. Friends and Family Test Maternity Delivery recommend rate

	2013/14 (from October 2013)	2014/15	2015/16	2016/17 (Apr to Feb 2017)	National average 2016/17 (Apr to Feb 2017)	National position 2016/17 (Apr to Feb 2017)
WSHFT	96.60%	97.00%	96.20%	97.30%	96.50%	41st of 134 (31st centile)
Worthing	94.80%	94.70%	96.30%	95.70%	96.50%	N/A
St Richard's	97.60%	98.50%	96.20%	98.20%	96.50%	N/A

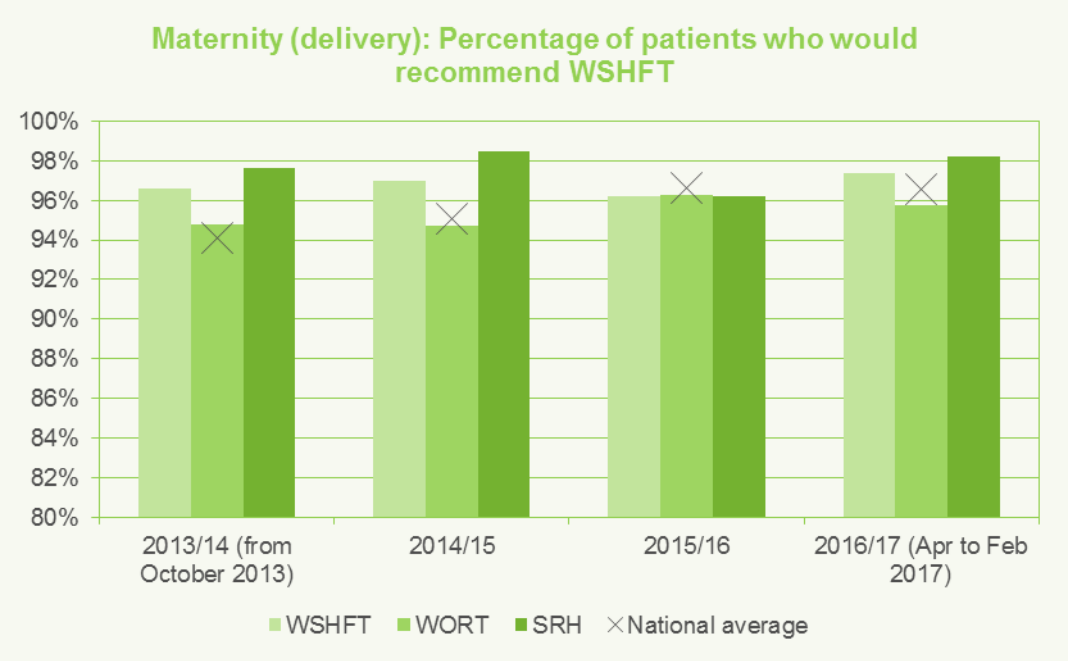
N.B. 2016/17 figures presented are Apr to Feb 2017 only. 2015/16 data in this table provides full year information; 2015/16 data in the Quality Report 2015/16 provided available data from Apr to Feb 2016 only.

Table 2. Friends and Family Test Maternity Delivery survey response rate

	2013/14 (from October 2013)	2014/15	2015/16	2016/17 (Apr to Feb 2017)	National average 2016/17 (Apr to Feb 2017)	National position 2016/17 (Apr to Feb 2017)
WSHFT	17.00%	29.10%	11.70%	26.60%	23.10%	45th of 134 (33rd centile)
Worthing	13.60%	25.40%	11.10%	19.80%	23.10%	N/A
St Richard's	20.40%	32.30%	12.30%	32.60%	23.10%	N/A

N.B. 2016/17 figures presented are Apr to Feb 2017 only. 2015/16 data in this table provides full year information; 2015/16 data in the Quality Report 2015/16 provided available data from Apr to Feb 2016 only.

Figure 11. Friends and Family Test – Maternity Delivery percentage of patients who would recommend WSHFT



Caesarean section and still birth rates

Table 3a. Caesarean section rates

	2013/14	2014/15	2015/16	2016/17
C-Section Rate (national rate)	26.1% (26.2%)	26.9% (26.5%)	27.3% (27.1%)*	28.60% Not available until Nov 2017

** NHS Hospital Maternity Activity from NHS Digital.*

Table 3b. Still birth rates

	2013	2014	2015	2015/16*	2016/17
Still births (Worthing/SRH)	20 (11 / 9)	14 (7 / 7)	16 (13 / 3)	24 (16 / 8)	16 (7 / 9)

** This data was reported by calendar year in last year's Quality Report but it now presented as financial year data which is the standard time frame for NHS data.*

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. In 2014, the stillbirth rate remained at 4.7 per 1,000 total births.

In 2016/17 the rate of stillbirth at WSHFT currently stands at 16 (3.2 per 1000 births). Our figures also include all cases of stillbirth and medical terminations for severe foetal abnormality at all gestations from 24 weeks of pregnancy to term.

In collaboration with the KSS Maternity Strategic Clinical Network and Department of Health WSHFT has been working to fully implement a best practice care bundle for reducing stillbirth and have taken part in a national clinical research trial focusing on reducing stillbirth – AFFIRM. Despite the trial being completed we have decided to continue to work within the trial guidelines, as best practise, until the results are published.

Reducing caesarean section rates remains a challenge; with the national rate increasing in line with the WSHFT rate; the focus will continue in this area. The enhanced recovery programme is now embedded in care for routine elective caesarean sections.

Further improvements identified

Following successful implementation of the reducing stillbirth care bundle 'Saving Babies Lives'[34] 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[35] – this has been agreed as a collaborative project between maternity and neonatal services.

[34] www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf

[35] www.england.nhs.uk/patientsafety/re-act/red-term-ad/

The National Sands (Stillbirth and neonatal death charity) recommended Bereavement Care Pathway[36] is expected to be launched in spring 2017 and will be implemented at WSHFT.

This continues to be a quality improvement programme for 2017/18.

Public health midwives win national "Team of the Year"

The Trust's Public Health Maternity Team won the prestigious Team of the Year prize at the Royal College of Midwives Annual Midwifery Awards in London during March 2017. Midwives Kelly Pierce and Claire Parr accepted the award on behalf of the Maternity Team for their public health project entitled 'Always stepping it up'. The project was devised to help to improve services particularly for women with additional needs or vulnerabilities. Judges said they were very impressed with the passion and enthusiasm of the whole team, which includes midwives and maternity support workers (MSW). Head of Midwifery, Tracey Mudd, said: "I am delighted and proud of this worthy acknowledgement and achievement - the innovative hard work, training and education undertaken by the whole public health maternity team influences and impacts on the whole of maternity services that enables excellence in care for all women, babies and their families."

The RCM commended the team for developing services that help support all women and their families as well as an enhanced service for those with additional needs.

These include a weight management programme for women with a body mass index greater than 30, Birth Afterthoughts service, newborn hearing screening by MSWs delivering public health messages, alongside nicotine replacement therapy on the ward, a flu and pertussis immunisations programme, and anomaly scanning. Chief Executive of the RCM, Cathy Warwick, said; "I congratulate all the hardworking midwives and MSWs who have worked tirelessly to get this public health project off the ground and in doing so they have undoubtedly personalised and improved the care that women and their babies are now receiving at Western Sussex Hospitals NHS Foundation Trust." "To win an award is a real achievement and I would like to thank them and their colleagues for their

[36] https://www.sands.org.uk/professionals/projects-improve-bereavement-care/national-bereavement-care-pathway

dedication, skill and commitment to women, babies and their families."

Our award winning Public Health Maternity Team

End of Life Care Programme

Aim: **Continued Implementation of the End of Life Care Strategy**

Target: **Full implementation of the End of Life Care Strategy**

By when: **March 2018**

Progress: **On plan**

End of Life care is one of the core services of WSHFT. There are approximately 2,400 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.

As an organisation we strive to provide patients, especially those at the end of life, with high quality care that includes the provision of as much privacy and dignity as possible within the constraints of our accommodation and patient safety.

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. Patients that might die within the next year due to their deteriorating condition are recognised and that appropriate conversations take place to ensure that they receive the right care in the right place in accordance with their wishes.
3. Sensitive communication takes place between staff and the dying person, and those identified as important to them.
4. 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.
5. The needs of families and others identified as important to the dying person are explored, respected and met as far as possible.
6. 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.
7. Where it is agreed that resuscitation would be inappropriate this will be clearly documented and communicated to all relevant people to ensure that the individuals wishes are adhered to.
8. After death a patient will be cared for in a caring and respectful manner making every effort to ensure that their privacy, dignity and wishes are respected.

Our goals in 2016/17

- The Trust is in the second year of implementing an “End of Life Care” Strategy aimed at improving the quality of care for patients and their families at the end of life.
- The implementation of the End of Life Care HUB, known as ECHO is important for better, earlier co-ordination of care for patients moving toward end of life. As an organisation we want to see this implemented across the organisation sharing information to and from our partners in a seamless manner, ensuring quality care is consistent and in line with patient wishes.

- Education of staff in elements of quality end of life care will be ongoing in order to equip the ever changing workforce with up to date skills and knowledge to deliver quality care in hospital.
- To further develop the team to provider greater Specialist Consultant Medical input across the Hospital and to enable a seven day working nursing team.

~ Improved privacy / provision of private areas:

- To ensure that there is ongoing training through both informal and informal routes of staff at all levels in respect of privacy and dignity. This relates to all levels of care both physical and emotional.
- Ensure that all staff respect the privacy of patients when talking about or to them in open areas. Wherever possible ensure privacy away from others who do not need to know the information or be aware of the sensitivity involved in the information being communicated.
- To monitor and reinforce systems in place to make the best use of the accommodation we have, i.e. in respect of securing bed curtains during the breaking of bad news or delivery of personal care, moving patients to side rooms when they are dying and have family who want to be remain by the bedside and if not possible then positioning them in the ward where privacy can be facilitated both for the patient and the others in the ward.
- Further explore the identification and adaptation of an area on each ward or area that can be used to discuss sensitive matters with patients, relative or staff.

Front cover image from the End of Life Care Strategy

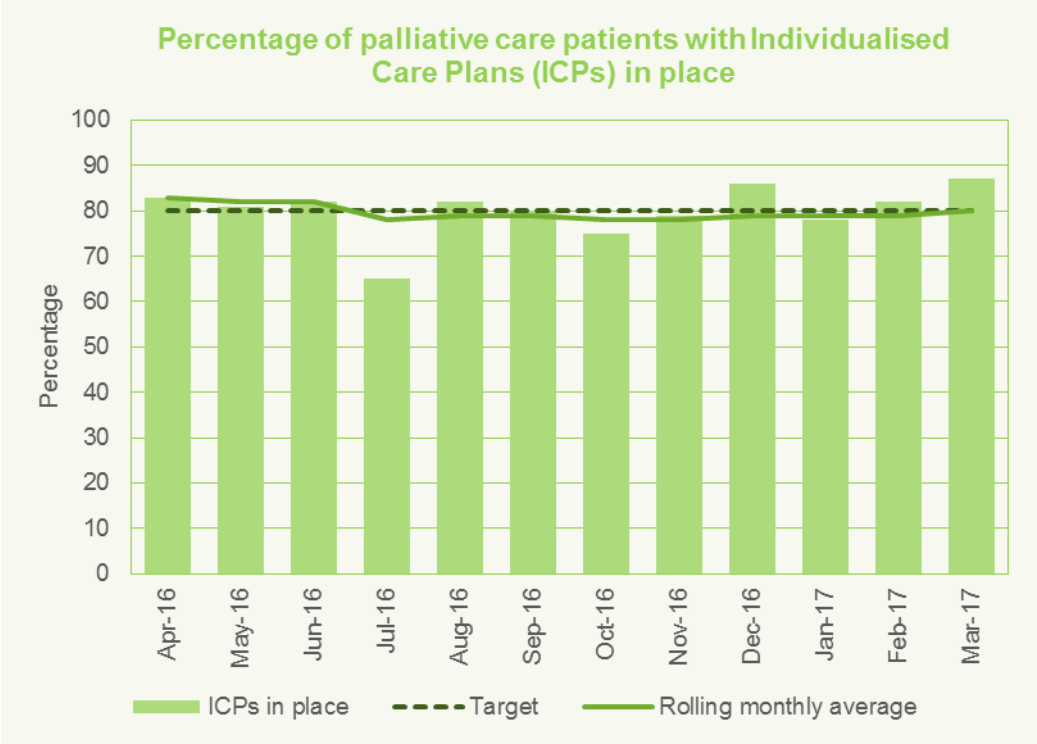
Improvements achieved 2016/17

1. The Trust has implemented a two year improvement programme, also reflected in a local CQUIN ('Commissioning for Quality and Innovation' payment framework)[37]. The programme focuses on:
   - Ensuring 'Individualised Care Plans' are in place for patients recognised as dying (target 80% of patients)
   - The roll out of Sage and Thyme[38] 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.

Figure 12. Palliative Care Individualised Care Plans CQUIN 2016/17

[37] 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/

[38] 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.



2. The Trust has implemented the area wide End of Life guidance across the organisation.
3. The End of Life Care HUB, known as ECHO, continues to be implemented across the Trust. Progress to date has been very good, and the project has been well received. The Point of Care Foundation project, supporting this work, is coming to an end but the implementation of the ECHO Hub will remain as a service improvement project over the next year.
4. There has been good take-up of Sage & 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.

Figure 13. CQUIN – Sage & Thyme Communications Training Level One

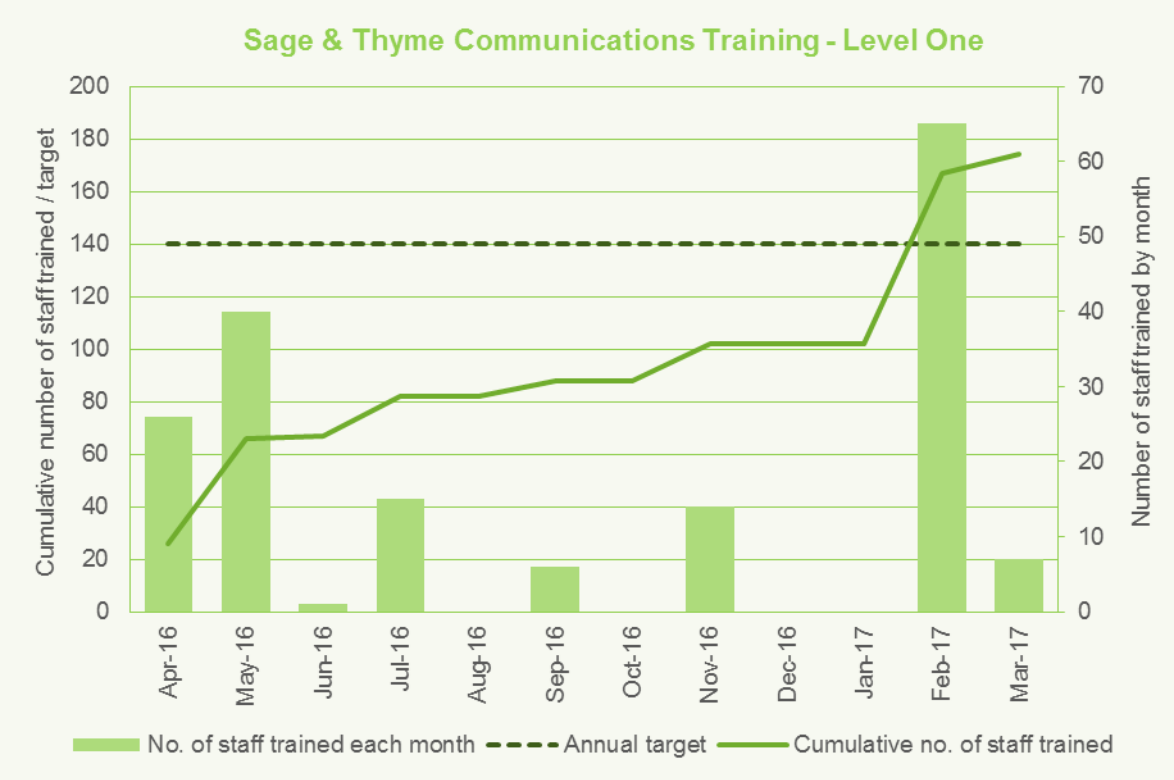
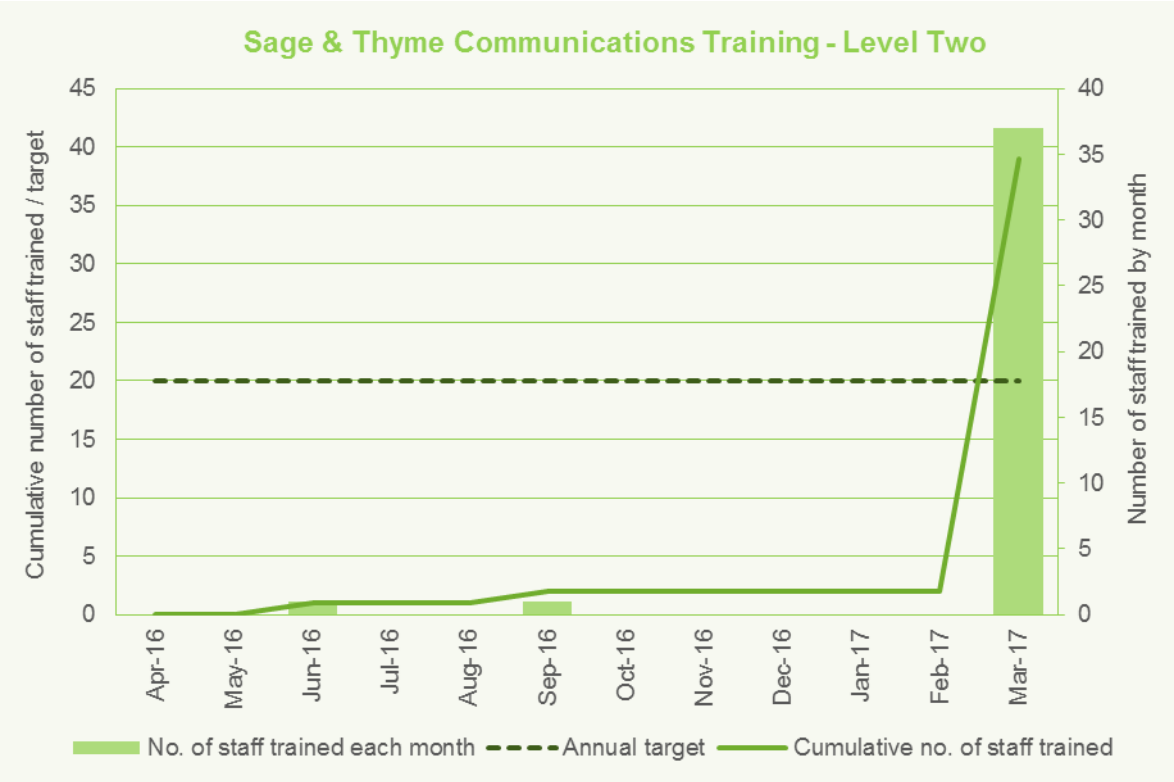


Figure 14. CQUIN – Sage & Thyme Communications Training Level Two



5. The Trust's Palliative Care Team has been expanded to include an extra Clinical Nurse Specialist post at both our Chichester and Worthing sites. These posts had both been funded by our local hospices, but due to the proven

benefits of increasing the team they are now supported by the Trust. We have also increased our Band 6 nursing capacity in the team.

6. The team have seen an ongoing increase in the number of referrals to the team both with malignant disease and non- malignant.

Table 4. Number of referrals to Palliative Care Team

Month	2014	2015	2016	2017
January	80	166	166*	221
February	71	157	189*	154
March	89	154	194*	202
April	105	142	193	
May	79	137	173	
June	121	158	185	
July	105	171	197	
August	94	169	198	
September	120	198	169	
October	107	191	198	
November	122	234	204	
December	122	203	180	
TOTAL	**1,215**	**2,080**	**2,246**	

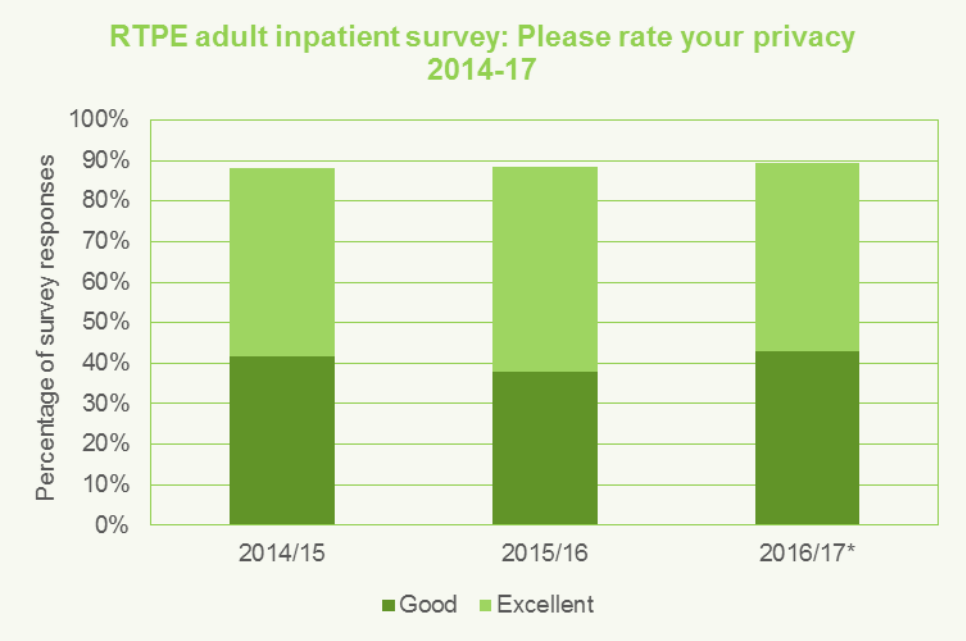
**These figures were reported in our 2015/16 Quality Report according to our local clerical database (January: 168, February: 192, March: 199). They have been recalculated for 2016/17 from the Somerset Cancer Register, from which all other reported datapoints in this table are taken from.*

~ Improved privacy / provision of private areas:

- Modernisation of the viewing room on the St Richards site makes the room accessible to all groups of patients.
- Real-time patient experience surveys have demonstrated an increase in patient satisfaction rates with regard to privacy in 2016-17 (data to end of February 2017) to 89.26% from 88.51% in 2015-16. During 2014-15 the same satisfaction rate was measured at 88.26%; there has been a small but steady improvement in this aspect of care. Interestingly treating patients with dignity and respect is usually in the top three responses for overall satisfaction trust wide.

- Patient-Led Assessments of the Care Environment (PLACE)[39] external assessments which examine the extent to which the environment supports the delivery of care with regards to our patient's privacy, dignity and wellbeing have demonstrated a very positive improvement for Worthing Hospital from 81.40% in the 2015 survey to 87.53% in 2016. St Richard's Hospital has also demonstrated improvement from 87.48% to 87.90% over the same time period. In the 2016 patient led-assessments we scored above average for privacy, dignity and wellbeing. 2017 PLACE assessments are due to complete in June 2017.

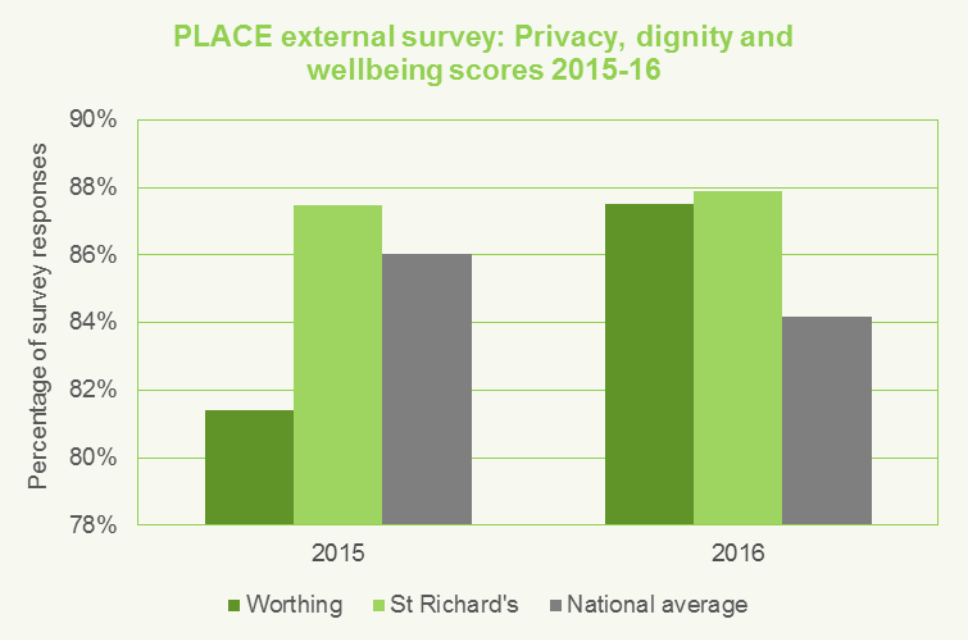
Figure 15. Real-time patient experience (RTPE) survey: Please rate your privacy



** N.B. 2016/17 data is from April 2016 to February 2017 only.*

Figure 16. PLACE privacy, dignity and wellbeing scores (the extent to which the environment supports the delivery of care with regards to the patient's privacy, dignity and wellbeing)

[39] http://content.digital.nhs.uk/PLACE



Further improvements identified

1. We will continue to implement the End of Life Care Strategy across the Trust.
2. We will continue to implement the ECHO Hub expanding beyond the areas we have piloted over the last year and increasing the number of patients added to the register.
3. End of Life education will continue to be delivered over the next year by the Palliative Care Team in both a formal and informal setting.
4. The seven day working of the nursing team will be implemented to support rapid discharge home to die pathways[40] and to enhance continuity of plans and advice.
5. The Trust has signed up to a national two year CQUIN addressing both discussion of patients who die within 30 days of having chemotherapy and the MDT approach to how we agree a patients treatment plan when chemotherapy is no longer of benefit.
6. Having successfully implemented the personalised care plan across the Trust this will be reviewed to ensure it remains fit for purpose.

[40] The rapid discharge home to die pathway is used to facilitate the seamless discharge from hospital to home / care home of patients who have a prognosis of days to short weeks to live. The pathway is used to ensure that patients receive the care and support needed to achieve their preferred place of care and death and to prevent inappropriate readmissions.

~ Improved privacy / provision of private areas:

7. Review with Learning Development and Practice Development how and where training around privacy and dignity takes place and how this is monitored in both Clinical and non- clinical roles.
8. Include privacy, respect and dignity within the PLACE audits that take place on a regular basis.
9. Refresh the work stream within the End of Life Board around the identification of key areas for breaking bad news in each clinical area and the adaptation required to make those fit for purpose.
10. Identify and procure a stock of recliner chairs or folding beds to make it possible for relatives to remain the bedside of a patient who is severely ill and will benefit from having a relative or friend stay with them.

Stroke care pathway

Aim: Continued improvement in stroke care pathway

Target: Improvement in SSNAP

By when: March 2017

Progress: Close to target

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.

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:

- 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.

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 in 2016/17

We set ourselves a number of specific goals for 2016/17. 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.

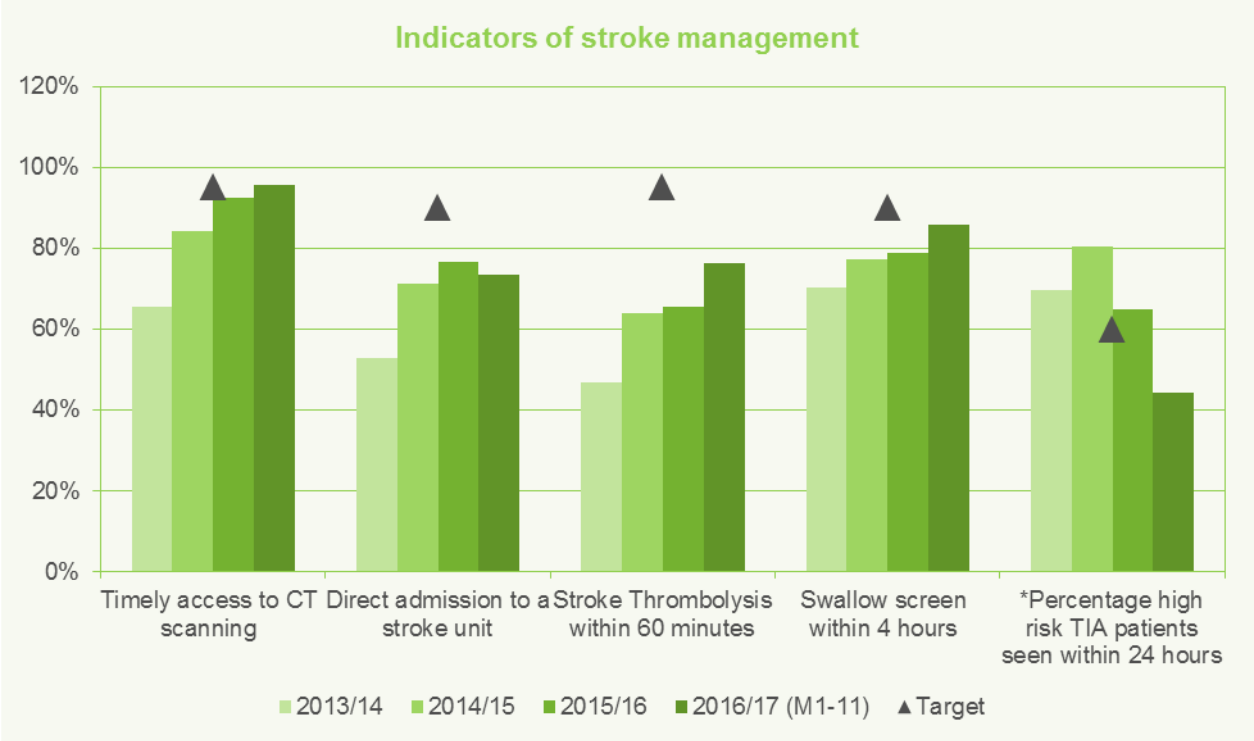
Improvements achieved 2016/17

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 (April to November 2016) Worthing Hospital was graded B and St Richard's Hospital was graded B. For context, of the 149 Trust sites submitting data, 60 (26%) were graded B, 18% were graded A.

The goals outlined above 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 17. Indicators of stroke management 2013/14 to 2016/17



N.B. 2016/17 data is from April 2016 to February 2017 only.

Further improvements identified

The Trust has made progress in the timely access to CT scans, percentage of patients receiving thrombolysis within 60 minutes and percentage of patients receiving swallow screening within four hours. We remain, however, short of our stretch targets, these targets reflect a gold-standard service that few providers currently achieve, they remain our ultimate aim and therefore stroke care improvement remains a priority for 2017/18, with the Trust seeking to make further progress towards attaining these levels. Over 2017/18 we will particularly focus on achieving scanning within one hour for all suspected stroke in line with new Royal College of Practitioner's guidance[41].

[41] Royal College of Physician's National Clinical Guideline for Stroke 2016. https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx

Frail elderly dementia pathway

Aim: Continued improvement in the frail elderly dementia 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

By when: March 2017

Progress: On plan

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 provision of excellent care for all our patients with a dementia and their carers within our geographical boundaries. We were rated 'Outstanding' for dementia care during the CQC inspection in December 2015. On admission all patients are assessed for potential early diagnosis of a dementia. If the initial assessment leads to concern, this is then followed up on discharge with general practice. We also ensure that all of our patients with a known diagnosis of dementia are identified and supported throughout their hospital stay by a specialist dementia team. The team will liaise with external agencies and our partnership trusts to ensure that appropriate communication regarding the care needs of both patients and carer is undertaken. The dementia specialist team support follows a person-centred care model approach looking at all psychology, physical and emotional wellbeing needs of the patient.

Our goals in 2016/17

- 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 2016/17.

- To meet the key target of at least 75% of patients with a known diagnosis of dementia having a completed 'Knowing Me' document within 72 hours of admission.
- Completion of the environmental gap analysis with completion of the upgrade of two wards to dementia-friendly environments.
- Staff training for tier one (all staff) and tier two (where applicable) levels in dementia care to continue with an increased update from 2015/16 baseline.
- Review of carer support services and 'John's Campaign'[42].
- Roll out of 'My Dementia Improvement Network'[43] communication and interactive games IT system.
- Develop collaborative working and peer support across the West Sussex region throughout all key objectives.

Improvements achieved 2016/17

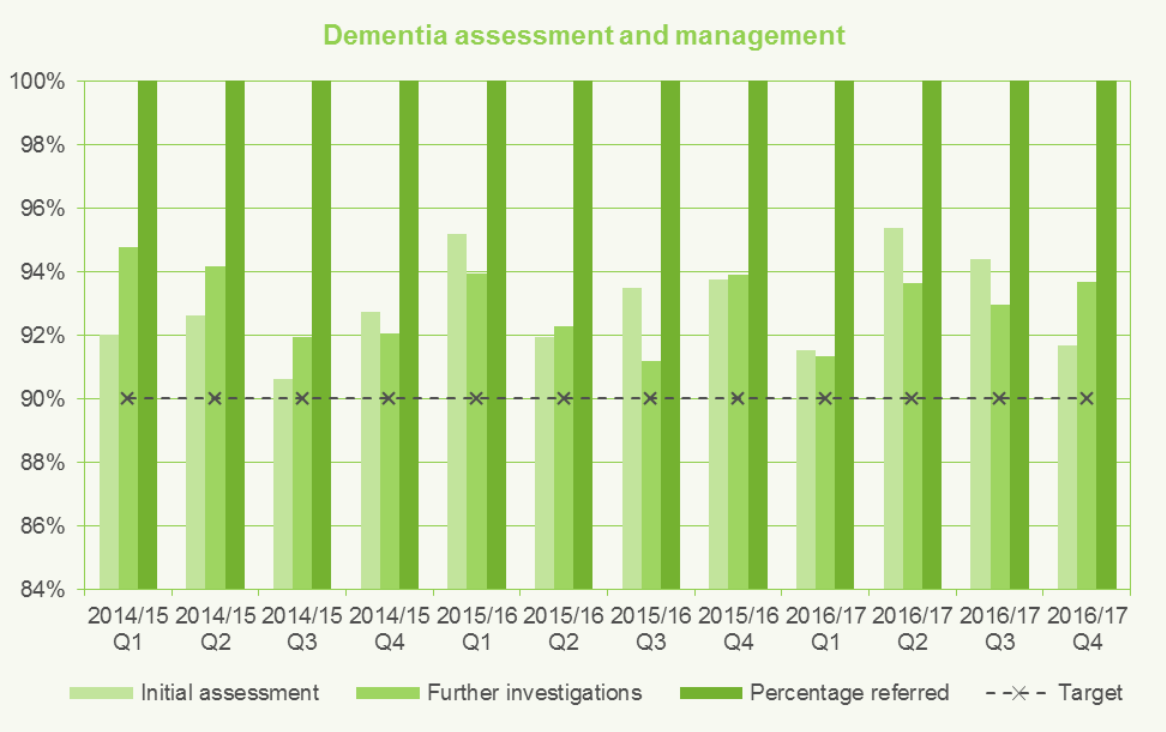
~ Dementia screening

We have continued to exceed 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 exceeded 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 (Patientrack) we ensure the GP is always informed of screening results in a timely fashion with any possible need for onward referral being addressed.

Figure 18. Indicators for dementia assessment and management 2014-2017

[42] John's campaign is a national appeal from carers for the right to stay with people with dementia in hospital: http://johnscampaign.org.uk

[43] A network to provide dementia support to organisations, including information, learning and support across the patient pathway: www.mydementiaimprovementnetwork.co.uk



~ Knowing Me[44] Documentation

We have maintained a comprehensive weekly audit programme over 2016/17 to ensure compliance with this key aspect of the Trust's Dementia Strategy as part of enabling our patients with a dementia to receive personalised care.

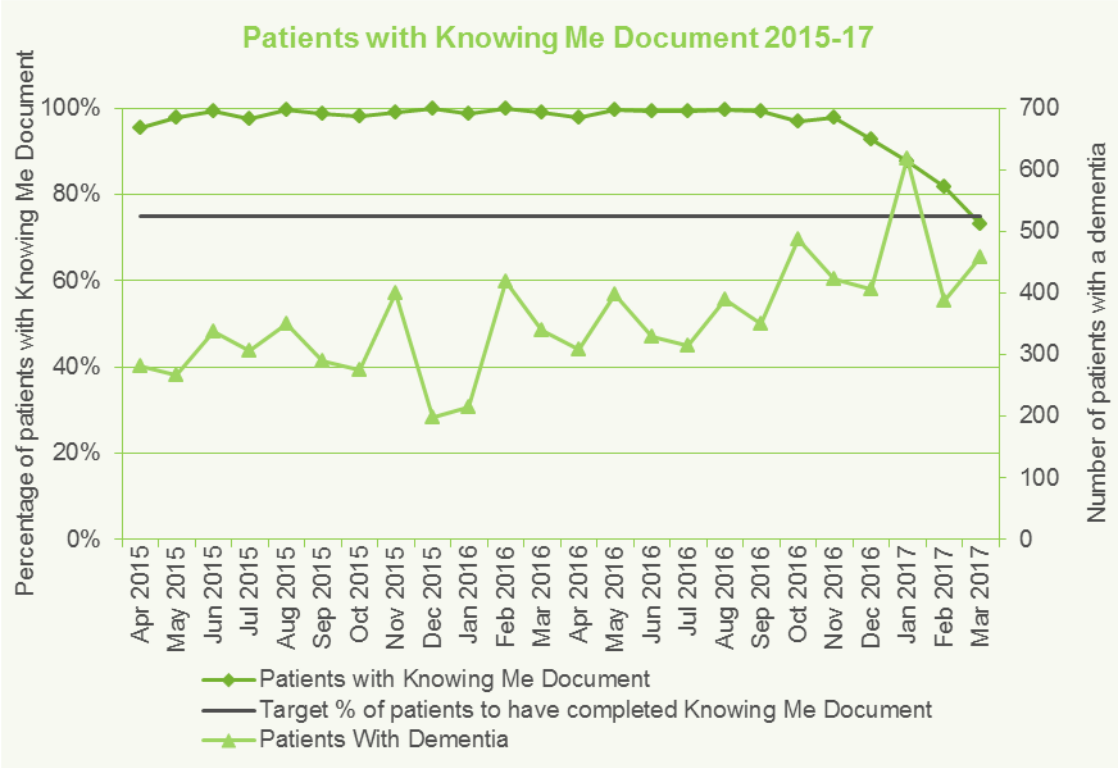
The Knowing Me document is based on the 'This is Me'[45] document produced by the Alzheimer's Society to enable staff to fully understand the needs of the patient at times when effective communication may be compromised. The document contains relevant personal information that may be completed by family or carers as a communication aid. These documents have proved invaluable in providing person-centred care, particularly with our temporary staffing workforce.

Monthly reviews of overall compliance of use have been above the 75% target for the majority of months (eleven out of twelve) since March 2016.

Figure 19. Percentage of patients with completed 'Knowing Me' document in place

[44] '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.

[45] https://www.alzheimers.org.uk/download/downloads/id/3423/this_is_me.pdf



~ Dementia friendly environments

A King's Fund environmental audit tool[46] was used to undertake a gap analysis regarding dementia friendly environments across two wards in 2015/16 and a further two during 2016/17. On completion of the analysis a paper was presented to the Trust Executive Committee with specific regard to suitable furnishings, equipment, signage and colour that would be used for all future refurbishments within the Trust. The Executive Committee overwhelmingly agreed these standards, so that all future refurbishment will meet dementia friendly guidance. During 2016/17 the original two wards completed their refurbishment and two further wards have also been renovated.

Close liaison between the dementia team and the estates department has also led to discussions commencing regarding an arts project both inside and outside of the hospitals. The dementia friendly wards have 'faux windows' in place showing garden and beach vistas to calm and soothe. The four wards also have multi-function rooms where therapeutic activities are undertaken with patients with a dementia in a homely setting.

[46] http://www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-design-dementia

For patients undergoing one to one observation approval from the divisions was given that, if safe to do so, they may be taken off the ward to the hospital restaurants for a hot drink and cake with the ward then being charged. This helps to reduce boredom and agitation that some patients with a dementia experience whilst in hospital.

The role of the dementia assistant has been reviewed and they now participate in activities on a one to one basis with patients on the ward to assist in the care of those patients. A pilot in Worthing using the Wishing Well Musicians is due to commence in March 2017, which will again provide therapeutic intervention on a group activity basis.

The 'Knowing Me' volunteers continue to contribute in a most valuable way by spending time talking, undertaking activities and assisting with nutritional support for our patients with a dementia.

The local community across both sites have actively supported the provision of twiddle muffs and twiddle mats for our patients. The generosity has been incredible with groups such as Women's Institute, local Scouting and Guiding groups, as well as individuals maintaining a constant supply.

~ Staff training

A programme of dementia training continued to be delivered throughout the year with agreement being reached that this would be a mandatory component for all staff on an annual basis. The mandatory training constitutes dementia awareness training for all staff, whereas a more specialised two day dementia course has been run for staff caring for patients in the ward setting; this has included members of the nursing and therapies teams. A further need for role-specific training was identified throughout the year and the first of these sessions were delivered to members of the security and portering teams in February.

Discussion is underway between the Trust, Sussex Community NHS Foundation Trust and Sussex Partnership NHS Foundation Trust for the provision of one to one observation training and development of a programme for relevant training across the three organisations.

To support with the accuracy of the dementia assessments and to enhance the overall knowledge base, the Clinical Nurse Specialist for Dementia now provides a training session on the Junior Doctor induction programmes.

~ Review of carer support services and 'John's Campaign'

The roles of the carer support nurses continue to be vital in the provision of supporting families and carers whilst their loved ones were in hospital, including signposting to our external agencies as required. Developments occurred throughout the year leading to both sites now having specialised West Sussex Carer support teams within the acute hospitals. This has enabled the role of the carer support nurse to be reviewed and updated to that of a dementia nurse, thus increasing the provision of specialised dementia nursing care for our patients. The dementia team continue to have very close links with carer support to ensure that carers still receive the support they require.

The John's Campaign highlights the importance of recognising the needs of carers and the important role carers play in supporting patients with a dementia. The Trust has previously not had a formal carers policy with wards reacting on an ad-hoc basis as the need arose. A draft policy has now been written to underpin the best practice when supporting carers based on the principles of the John's Campaign. Highlights of this new policy include open visiting for carers, free car-parking for carers, meal provision for carers and recliner chairs to enable a carer to rest by the bedside. Within the draft policy the 'carers passport' is present which is given to the carer so staff are aware that they have the above entitlements. There is also a carers charter which would be displayed on all wards stating how staff will support the carer and also the carers commitment to Trust's values and principles.

~ 'My Dementia Improvement Network'

The trial of devices provided by 'My Dementia Improvement Network' which provides a standalone communication and interactive games IT system with a software package that includes a range of therapeutic tools and memory related activities proved to be highly successful. As a result in this past year, the Friends of the Hospital agreed to fund five devices across the Trust to be used by any patient who would benefit. The 'Knowing Me' volunteers will be receiving training on these devices in March 2017 to support the wards in being able to provide this activity.

Further improvements identified

Improvement plans for 2017/18 include:

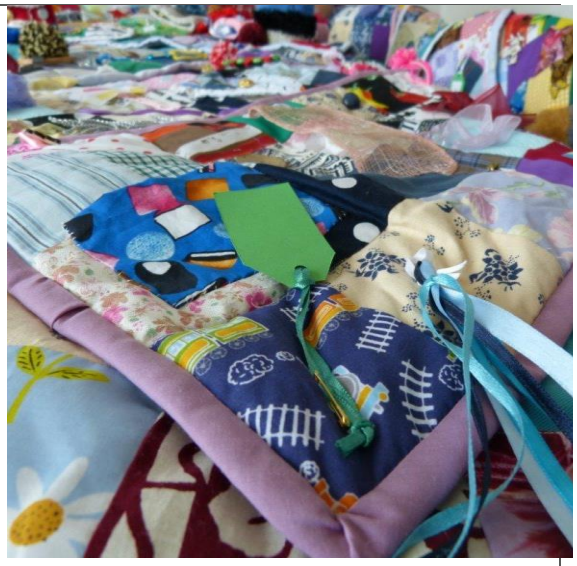
- Further developments supporting dementia friendly hospitals, to include provision of 'bus-stops'[47], increased artwork and development of dementia friendly garden areas.
- Ratification, implementation and embedding of the Carer's Policy.
- Membership to John's Campaign and provision of banners with other appropriate signage and awareness for our main hospital areas.
- Further progress collaborative training with our local partners for a unified approach to training and resource provision.
- Reinvigorate and promote the Trust website resources for dementia highlighting the care provision available in our Trust.

A community of knitters

A collection of donated Twiddlemuffs and Twiddlemats received by our specialist dementia team: Many individuals and local groups knit these colourful aids for our patients. The interesting bits and bobs attached to the inside and outside of the muffs and mats provide patients with some simple stimulation which many of those with a dementia find reassuring and comforting.

[47] 'Bus-stops' will be benches and seating areas along main hospital corridors to provide an area for patients and their carers to have a rest and enjoy a different outlook on our hospitals.

Twiddlemuffs



Twiddlemats

Enhanced Quality Emergency Laparotomy Programme

Aim: Roll-out of Enhanced Quality Emergency Laparotomy Programme with Academic Health Science Network (AHSN)[48] Collaborative

Target: 95% data completeness on national database, Improvement in the consistent delivery of the agreed care bundle for emergency laparotomy patients

By when: March 2017

Progress: On plan

High-risk patients undergoing surgery account for 12.5% of all in-patient surgical procedures but 80% of deaths nationally. The national audit for emergency laparotomy has been running since 2012-13 and aims to improve the quality of care for patients undergoing emergency laparotomy through the provision of high quality comparative data from all providers.

Our goals in 2016/17

- To improve data quality and completeness of submissions to the National Emergency Laparotomy Database.
- Clinical teams responsible for delivering emergency laparotomy services actively participate in AHSN led improvement events.
- To improve compliance with key care bundle elements highlighted as part of the national improvement programme.

Improvements achieved 2016/17

- 100% of cases 'locked' on national database.
- Senior clinician attendance at all AHSN improvement programme events.
- Significant improvements in senior grade surgical and anaesthetic staff present during surgery.

[48] http://www.ahsnnetwork.com/

Figure 20. Emergency laparotomy care bundle performance – Worthing Hospital

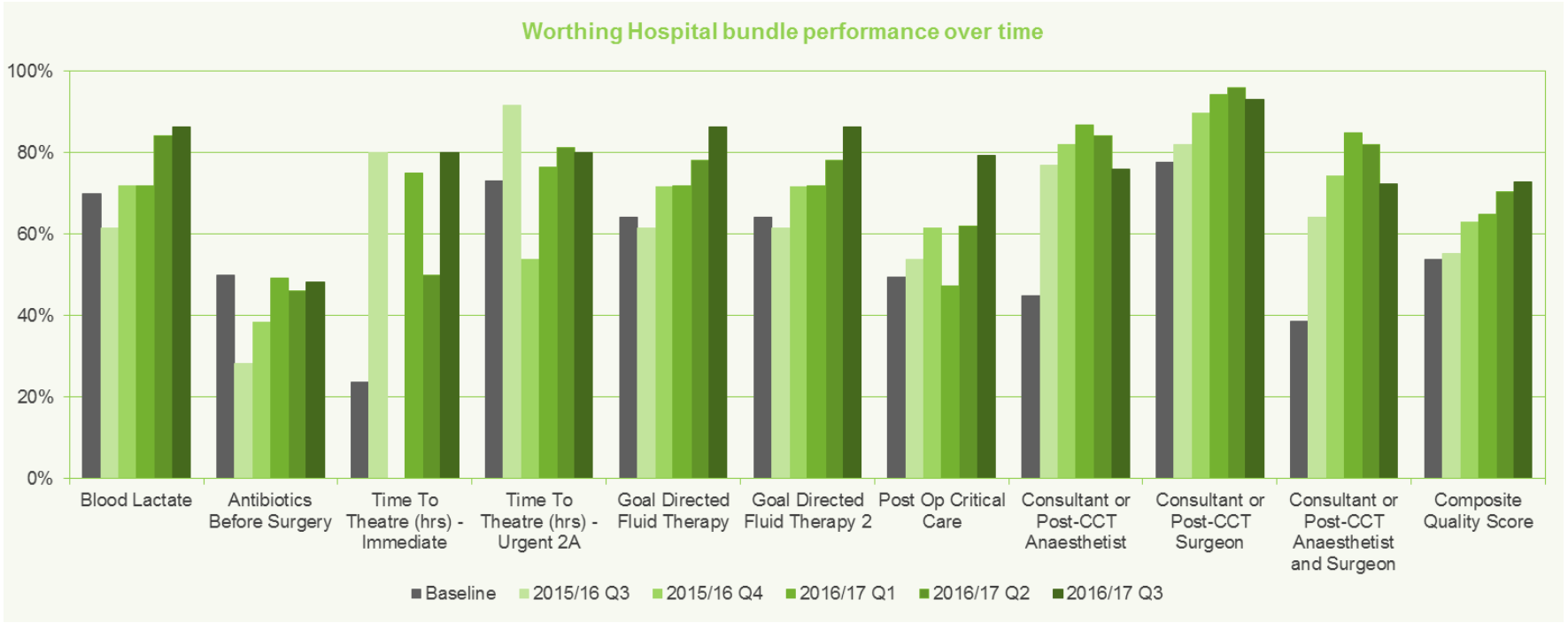
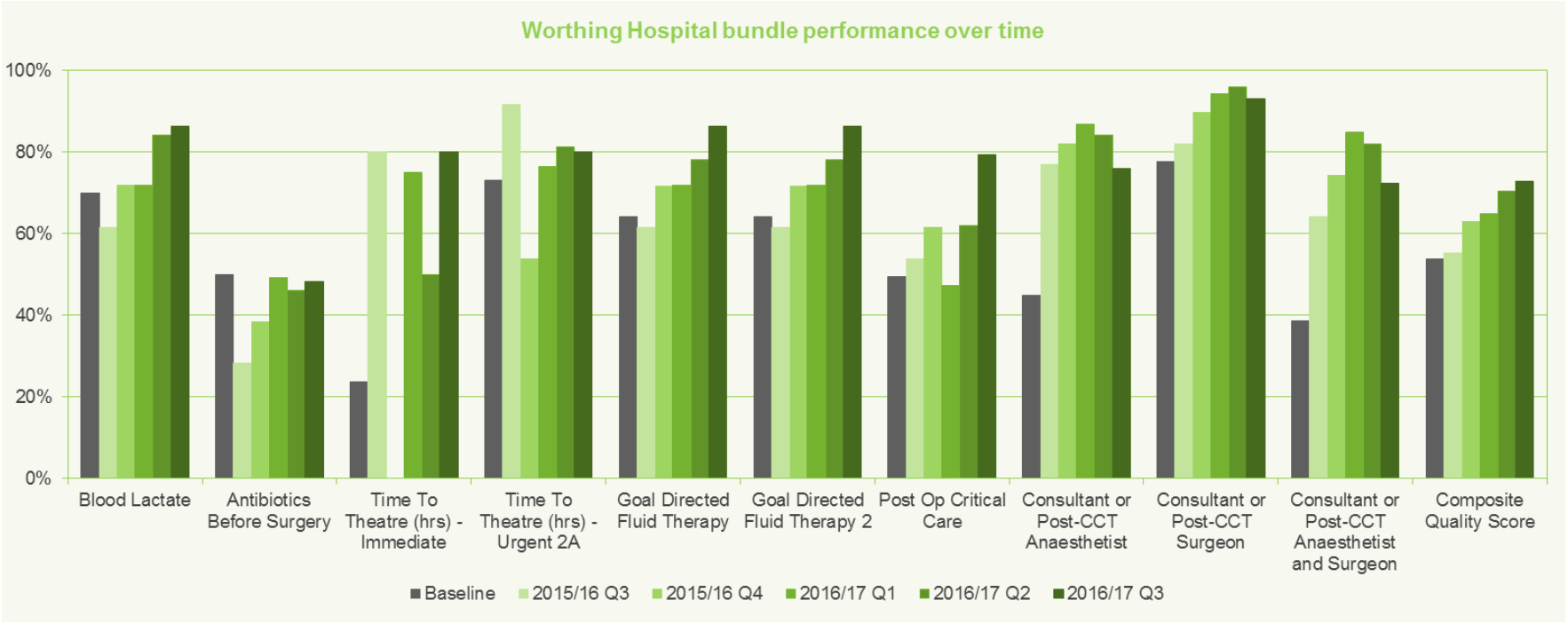


Figure 21. Emergency laparotomy care bundle performance – St Richard's Hospital



Further improvements identified

As the AHSN supported programme comes to a close in 2017 the Trust will continue to monitor progress against the key care bundle elements and supports necessary improvements with a focus on:

- Post-operative access to critical care
- Pre-operative lactate and antibiotics
- Intra-operative goal directed therapy

GOAL 1: Reducing preventable mortality and improving outcomes: Improvement Programmes for 2017-18

Sepsis

Deteriorating patient programme

Continued improvement in the implementation of the sepsis care bundle.

Target: 80% compliance with Sepsis 6 care bundle in 2017-18, 95% in 2018-19

Target (CQUIN): 90% of patients to receive antibiotic therapy within one hour in 2017-18, 95% in 2018-19

Preventable mortality

Better Births

Better Births programme

Continue to focus on normalising birth and reducing caesarean section rates.

Target: reduction in caesarean section rates to 26.5%

Preventable mortality

Frailty

Care for Older People with frailty programme

Improvement in frailty pathway - implementation of new frailty assessment tool.

Target: reduction in admissions of frail older patients by 10% over the next two years *(to be confirmed)*

Preventable mortality

Mortality

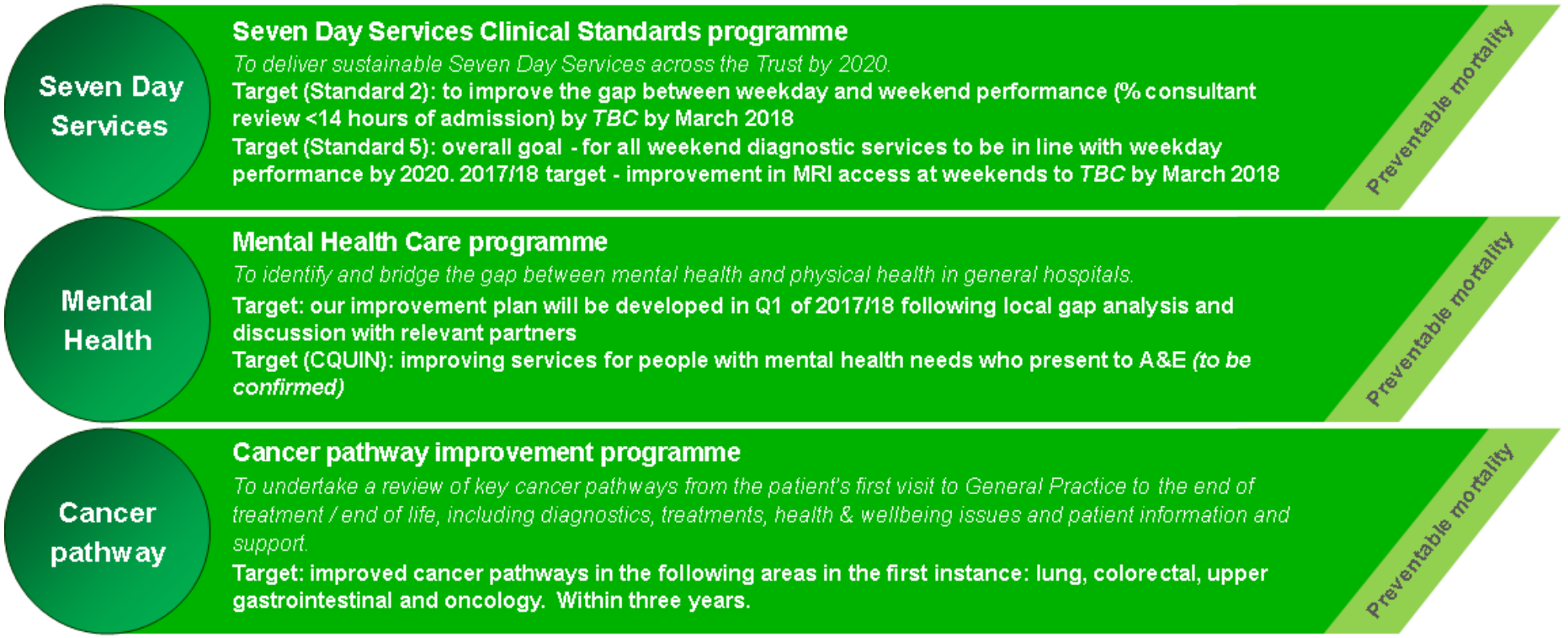
Mortality review and learning programme

Roll out of new inpatient death review process and systems to identify and learn from any identified problems in care / avoidable mortality.

Target: 100% of in-patient deaths are reviewed

Preventable mortality

Western Sussex Hospitals
NHS Foundation Trust



GOAL 1: Reducing preventable mortality and improving outcomes - Improvement Programmes for 2017-18

Our **Deteriorating Patient** and **Better Births** Quality Improvement Programmes continue into 2017/18.

We have developed new Quality Improvement Programmes in the areas of:

- **Care for Older People with Frailty,**
- **Mortality Review and Learning,**
- **Seven Day Services Clinical Standards.**

In addition we will be starting to identify and develop our improvements plan to address the **Quality of Mental Health Care** offered in the Trust with our local health economy partners within the STP footprint.

We will also be undertaking a **Cancer Pathway Improvement Programme** with a review of key cancer patient pathways in key cancer specialties; by working with our CCG and with funding support from Macmillan Cancer Support we hope to make our service fit for purpose in the future.

❖ Care for Older People with Frailty

The Trust took part in a 12-month national improvement programme run by the Acute Frailty Network (AFN) in 2016. This professional network supports participating sites to rapidly adopt and expand their emergency services for frail older people.

The Acute Frailty Network Programme Board provided a forum for senior managers and clinicians to plan and manage the development and delivery of services to improve acute care for frail older people. The Board's membership included partner agencies Coastal West Sussex CCG and Primary Care.

The Board adopted the Trust Kaizen methodology to define the scope of acute frailty services in the Trust. Working with a Kaizen Improvement Practitioner the team reviewed the

difference between the delivery of acute frailty services on the two acute sites by undertaking a multidisciplinary two site Value Stream Mapping exercise. The information from this and data gathered by the informatics team were used to identify the opportunities for pathway improvement and this has helped in shaping the strategy for designing front door services for older people with frailty. As part of the network the St Richard's Hospital site was visited by Professor Simon Conroy and a team from the AFN who gave feedback on the current service.

The next phase which is informed by data gathered on activity is to recruit two Band 7 Frailty Practitioners (one for each acute site) to triage older people with frailty presenting with frailty syndromes e.g. Falls, delirium etc., with a view to commencing Comprehensive Geriatric Assessment which has been proven to improve outcomes including reduction of readmission rate, institutionalisation and mortality.

This will be an iterative process of service design using data to inform pathway design and assess value to patients, staff and the Trust. In addition there is an on-going piece of work looking at the best service design for frailty on the emergency floor at SRH.

As part of the process we also gathered patient feedback about the first 72hrs of their admission and we produced an "emotional map" from this data.

As part of the work an exciting new system has been introduced to triage and score people over 65 presenting to hospital which will assess their level of frailty (Clinical Frailty Scale) and ensure they get the right treatment faster and by the right team. This has the potential to assist in other in reach services in the future e.g. surgical liaison and will allow us to compare our own data year on year.

With ever increasing numbers of non-elective attendances and admissions of older people with frailty and or multiple long term conditions we expect this development will assist in ensuring high quality safe effective and efficient patient care and will help keep flow moving through the acute trust.

Target: To improve the identification of patients with frailty syndrome and develop a pathway with which to provide robust care for this patient group.

Ambitious plans for care of the elderly patients start

Experts from the National Acute Frailty Network were welcomed to St Richard's in April 2016 as part of a 12-month programme designed to support the development of services for frail, elderly patients.

Set up in 2014 by Dr Simon Conroy, the network aims to gather and share good practice from around the country as well as provide specific improvement support.

Western Sussex Hospitals is one of only 12 trusts across the country that has secured a place on the prestigious programme, which includes site visits, national events and access to a dedicated service improvement coach.

The Trust has also set up an Acute Frailty Programme board with broad representation including geriatricians, therapists, information, nursing and operational teams as well as commissioners, community and other partner organisations.

Dr David Hunt, the Trust's clinical director for elderly care, said: "I am really proud of the care our teams provide for our frail elderly patients and I know there is real commitment to become outstanding. We've seen significant improvements in the care we provide for patients suffering a stroke and those with fractured hips. We want to apply the same focus for our elderly patients and the support from the network will help us do exactly that."

As part of the visit, the Acute Frailty Network team spent time in A&E to understand how and where older patients access urgent care. They also received a presentation from Dr Hunt who explained the way urgent care services are configured at both St Richard's and Worthing. One of the key differences is the fact that Worthing's Emergency Floor has a specific zone for frail elderly patients, whereas St Richard's does not.

Dr Conroy said: "The Acute Frailty Network team were delighted to visit sunny Chichester and the

buoyant and progressive team involved in caring for older people with frailty at the hospital. We are excited to be part of their improvement journey, which is already off to a flying start!"

Trust staff will be attending a national conference at the end of May 2016, with other key next steps including the recruitment of a patient leader. Members of the board are also attending workshops during the year which will identify other good practice around the country which could contribute to the ongoing discussions.

❖ Mortality Review and Learning

The Trust recognises the importance of monitoring mortality and acting on any trends identified. During 2016/17 the Trust embarked on a programme to develop a process for the screening and review of all deaths in hospital. Subsequently, in response to the Care Quality Commissions publication 'Learning, candour and accountability' the Secretary of State made a range of commitments to improve how the NHS learns from reviewing the care provided to patients who die. The Trust is fully committed to implementing these recommendations and throughout 2016/17 we have developed and piloted a local screening tool for all deaths, convened a mortality 'Community of Practice' in collaboration with the KSS AHSN, and become an early adoption of the national programme and tool for full mortality review including reviewer training.

This work will continue to progress through 2017/18 in line with NHS Improvement recommendations overseen by our Medical Director and Mortality Steering Group, reporting to the Trust Quality Board and Executive Board.

Target 100% of in-patient deaths are reviewed by March 2018 and systems are in place to identify and learn from any identified problems in care / avoidable mortality. Data relating to learning from case record review of in-patient deaths / avoidable mortality will be published quarterly through 2017/18 in line with NHS Improvement / CQC recommendations.

❖ Seven Day Services Clinical Standards

Our overall True North objective is to deliver sustainable Seven Day Services across the Trust by 2020 which will:

- Improve access for patients
- Improve patient outcomes by expediting management decisions, improving patient flow and reducing weekend and out of hours mortality

- Enable better demand capacity management

Seven Day Services are a nationally mandated requirement for all Trusts with four clinically validated standards:[49]

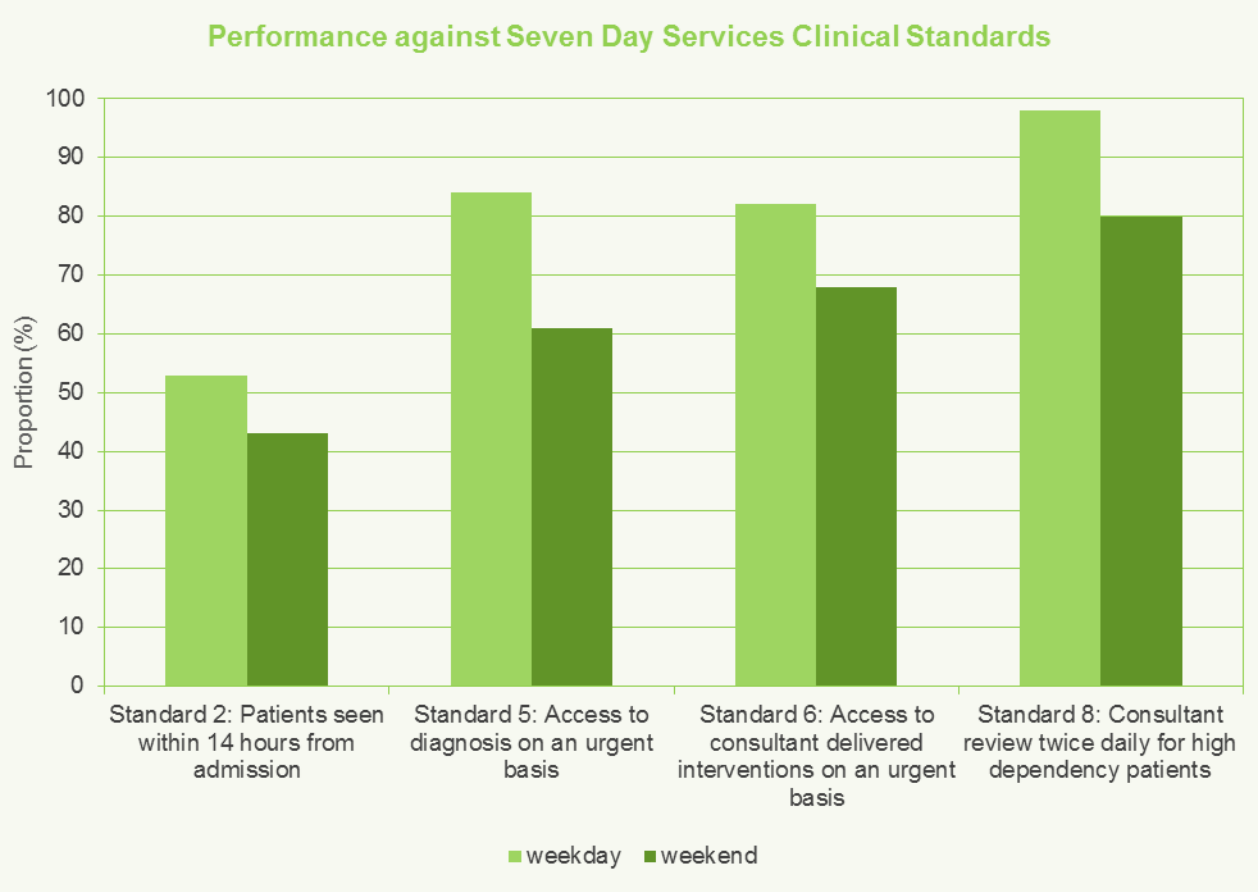
- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others.

The Trust takes part in the NHS England Seven Day Service audit, which involves a detailed retrospective review of >200 sets of case notes from the full range of admitting specialties for a week at regular intervals – our baseline audit was carried out in July 2016.

Figure 22. Performance against 7DS standards (July 2016 Audit data)

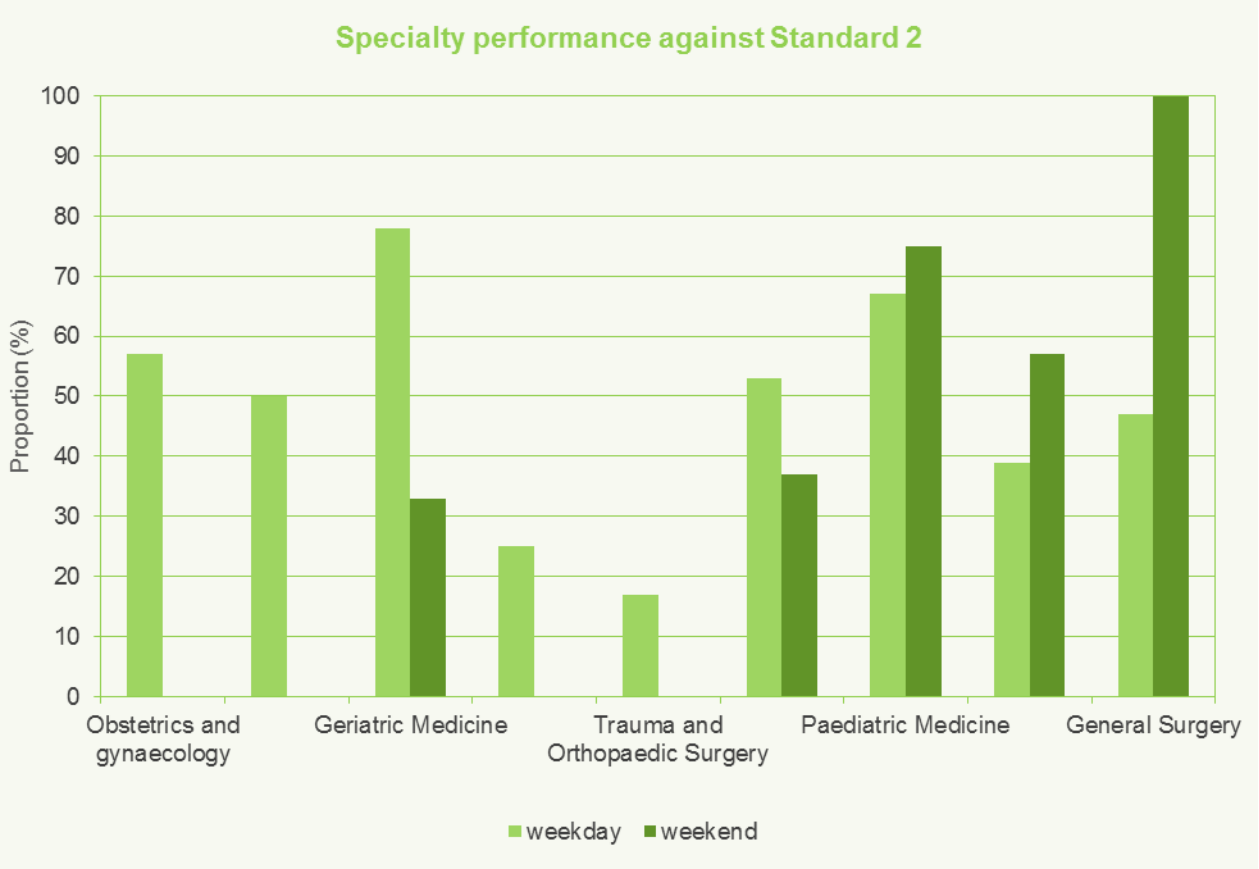
[49] https://improvement.nhs.uk/uploads/documents/7DS_clarification_of_priority_standards.pdf

Seven-day Services in Hospitals: Clarification of Priority Clinical Standards. December 2016. NHS Improvement NHS England.



Initial analysis suggest that there is room for improvement across all four standards over week days, with clear trends showing deteriorating performance over the weekend.

Figure 23. Specialty performance against Standard 2 (July 2016 Audit data)



Focused problem solving is underway with Clinical Divisions, developing improvement plans to deliver improvements focusing specifically on Standard 2 'Patients reviewed by consultant within 14 hours of admission;' and Standard 8 'Twice daily consultant reviews' over 2017/18.

Standard 2 target – To improve the gap between weekday and weekend performance (percentage consultant review within 14 hours of admission) by 23 percentage points on a weekday (target 76%) and 32 percentage points on a weekend day (target 75%) by March 2018.
Baseline 2016 – weekday performance 53% weekend 43%.

Standard 8 target – To improve the proportion of twice daily consultant reviews of patients with high dependency needs to 100% by March 2018.
Baseline 2016 – weekday performance 98% weekend 80%.

❖ Mental Health Care improvements

This year we will be identifying the improvements we need to make to address the Quality of Mental Health Care offered in the Trust, working with local health economy partners across the STP footprint. Patients with mental health needs appear to be increasing within the acute

care setting and the management of such patients can be very challenging for multidisciplinary teams in the acute assessment areas – A&E and emergency floors and on the wards. Many of these patients require frequent mental health reviews to ensure appropriate treatment / management and enhanced nursing care (specialling 1:1 provision) to ensure theirs and other patients' safety in the acute environment.

There is a need to have some improvement and standardisation of pathways and guidelines for patients in all age groups and settings to ensure effective care and safe management and this will require teams in the acute, mental health and community trusts to be working in partnership to ensure these are developed.

The Trust has established a multi-professional Mental Health Board to enable improvements and standardisation of care of complex older people, adult, maternal and child patients with mental health issues, irrespective of setting.

The Mental Health Board oversees any recommendations from local or national reviews in this area.

Our initial improvement plans for 2017/18 will reflect gaps /actions identified in response to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 'Treat as One' study[50] aimed at bridging the gap between mental health and physical health in general hospitals. Our improvement plan will be developed in Q1 of 2017/18 following local gap analysis in the light of 'Treat as One' national recommendation and discussion with relevant partners. This report has wide ranging recommendations and is likely to be a significant improvement programme delivered over a number of years.

We will continue to work on:

- Shared protocols for training and education of staff in MH Capacity assessments
- Shared protocols for the care of Older People with MH & dementia issues
- A&E have a number of ongoing workstreams including working procedures with the MH liaison teams, the police and WS Social Care services
- Shared protocols with CAMHs in both A&E and paediatric wards
- A new network is being established for Maternal MH care

[50] Treat as One – Bridging the gap between mental and physical healthcare in general hospitals. A report published by the National Confidential Enquiry into Patient Outcome and Death (2017) http://www.ncepod.org.uk/2017report1/downloads/TreatAsOne_FullReport.pdf

The Trust also participates in NCEPOD's Young People's Mental Health study with the Children's Board overseeing action plans to address any recommendations made.

❖ Cancer pathway improvement programme

Working in partnership with the CCG and the Kaizen Team we will be undertaking a review of key cancer pathways from the patient's first visit to General Practice to end of Treatment / end of life. Whilst the exact changes to the patient pathways will be determined following detailed mapping, it is anticipated that at least the following will be addressed:

- Patient information pathway
- Key worker pathway and handover as patient moves through their pathway
- Treatment summary that facilitates improved cancer care reviews
- Health and wellbeing clinics
- Physical activity
- Diagnostic booking processes
- Improved waiting times

We will bring together national guidance, clinical need and patient experience issues to develop 'timed' clinical pathways that can be owned by the individual patient and audited on an annual basis.

Macmillan Cancer Support has awarded us a grant to support the facilitation of the programme for three years and we plan to support one of our Clinical Nurse Specialists to write up the project as part of her postgraduate dissertation.

The programme will focus on the following areas in the first instance: colorectal, lung, upper gastro-intestinal, urology, breast and haematology.

By undertaking this work in key cancer specialties we hope to make our service fit for purpose in the future and provide patients with more control by making care pathways clearer and expectations of care more explicit and transparent from the moment a patient visits their GP with symptoms or receives their diagnosis.

Target: Improved cancer pathways in the following areas in the first instance: colorectal, lung, upper gastro-intestinal, urology, breast and haematology. Within three years.

2.1.4 GOAL 2 – Avoiding Harm

GOAL: 99% of patients receiving safe, harm-free care as measured by the national Patient Safety Thermometer.

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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Why is this important?

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 harm of the incidents reported. 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.

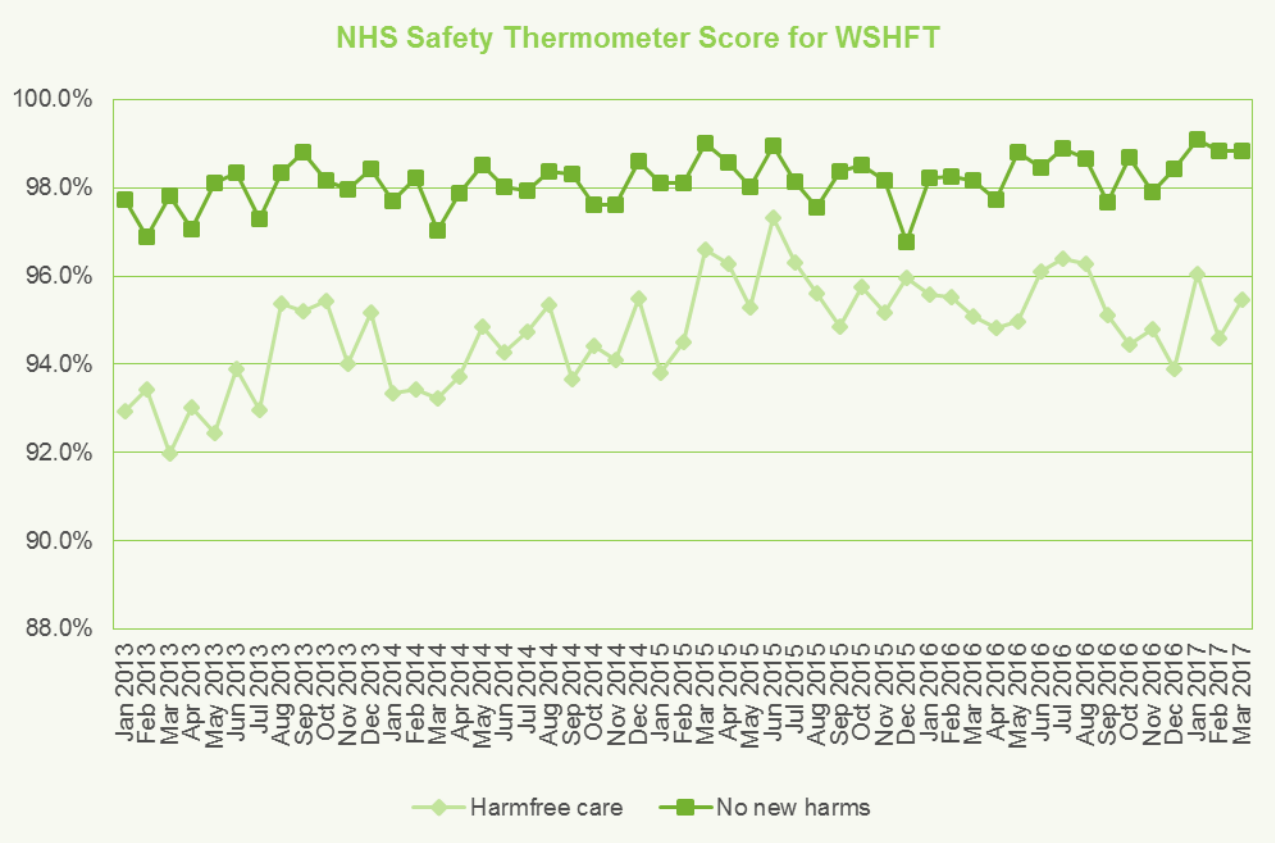
Errors in prescription and administration of drugs, although a significant cause of serious incidents nationally, is also not currently included in the NHS Patient Safety Thermometer; the Trust however participates in the use of the national Medication Safety Thermometer to support the data captured by the main Safety Thermometer.

How do we report on it?

In-hospital harms are reported to the Trust Board each month.

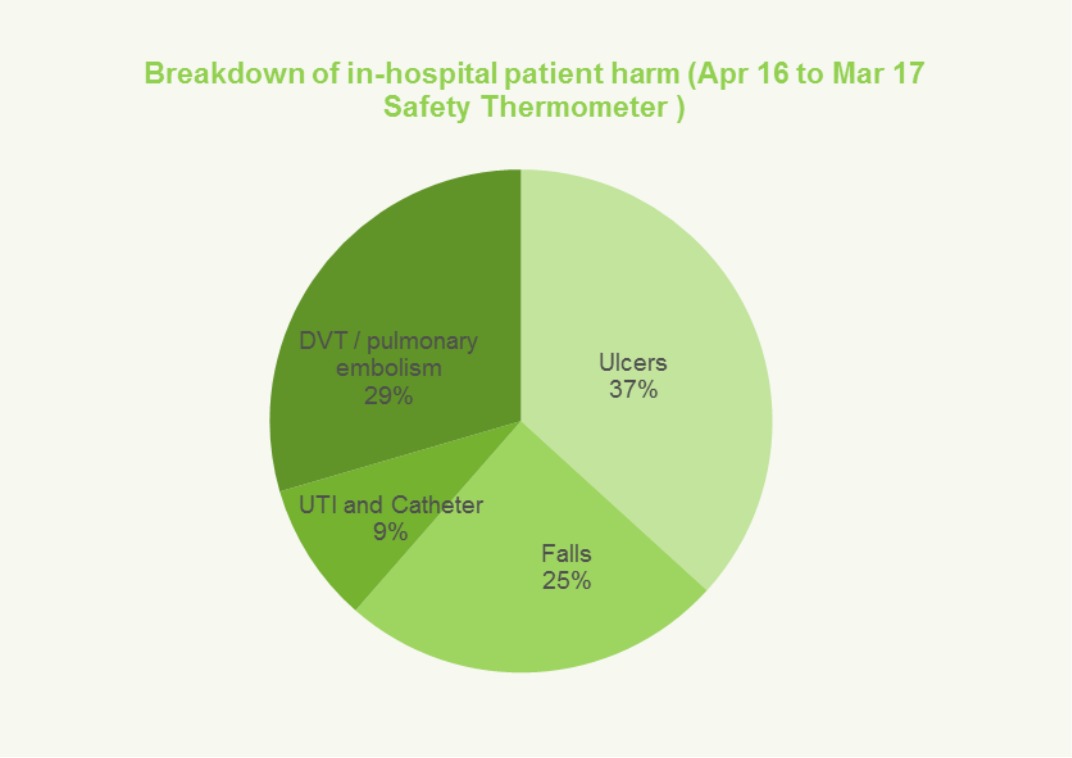
Where we are now?

Figure 24. 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 2016/17. Future work streams will continue to focus on all four of these areas as well as other aspects of ward safety.

Figure 25. 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 2017/18.

Our Quality Improvement Programmes for 2016-17

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.

Avoiding Harm Programmes 2016/17	Target Achieved/ On Plan	Close to Target	Behind Plan
Falls Reduction Programme			▲
Medicines Optimisation Programme	▲		
Skin Damage Reduction Programme			▲
Improvements in culture and environment to promote harm free care	▲		

Falls Reduction Programme

Aim: Reducing the number of within hospital falls

Target: 30% reduction in in hospital falls

By when: March 2017

Progress: Behind plan

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.

The Trust monitors its falls incidence closely every month and reports through the Quality Report and Trust Board. The Trust maintained the performance of the previous year achieving an average of 37 harmful falls per month. Expressed as a rate of 6.79 falls per 1000 occupied bed days (7.14 in 2015), this is well below the national benchmark of 5.6 falls per 1000 occupied bed days (Royal College of Physicians National Audit of Inpatient Falls 2015 average for acute trusts). 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 2016/17

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 maintain the performance for 2016/17. 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[51], wards moves, staffing) and falls classified as preventable and non-preventable. A proposed target of no greater than 2015/16 falls was set for 2016/17.

[51] '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.

As part of the Trust's True North Objective for Quality aiming to deliver 99% harm Free Care, the Trust has set an ambitious breakthrough objective aiming to reduce falls by 30%. This programme involves 10 key wards (where most falls take place) conducting intensive quality improvement work with the aim for 2016/17 of delivering a 50% reduction in falls.

Improvements achieved 2016/17

We have achieved a 19% reduction in inpatient falls over the last three years (2512 falls in 2014/15, 2038 in 2016/17), with a 9.4% reduction over 2016/17. This equates to nearly 500 fewer inpatient falls in 2016/17 compared to 2014/15. However it remains a major area of concern for the Trust as we aim to reduce in hospital harms.

Table 5. Falls data for WSHFT 2013-17

	2013/14	2014/15	2015/16	2016/17
Number of falls reported in an inpatient location	*Not available*	2512	2249	2038
Falls resulting in harm	498	514	456	451
Falls resulting in severe harm or death	5	1	2	2
Falls assessment within 24hrs of admission	92.7%	90.9%	86.7%	86.82%

Following on from the success and learning of our work with the NHS Quest Breakthrough Series Collaborative in 2015 we commenced an ambitious Patient First falls reduction programme in May 2016 involving the ten wards where patient falls take place most frequently. The programme used a structured methodology for wards to review their own data using a 'Why? Why? Why? Approach' to try to understand the root cause for their falls themes (e.g. time of day of falls, where the falls take place, activity at the time of the fall). Wards then worked through improvement cycles to try to address the underlying reasons for patient falls. This methodology ensures a bespoke approach to the challenge as solutions will vary depending on the particular patient group and ward environment. The project has been led by the Safer Care Team, supported by the Kaizen Team with close executive involvement, supported by weekly review meetings to ensure that issues are addressed as quickly as possible. Alongside this focussed approach to problem solving the Trust has continued to embed the two core interventions that 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.

The results from this project have been very positive: two wards have seen a greater than 50% reduction in falls since the project started and a further three wards have seen more than 40% reduction in falls. In October, four wards moved to a watch phase (as their performance was so positive) and four additional wards joined the programme.

Whilst the overall goal to reduce inpatient falls across the Trust by 30% has not been reached it is positive, that despite increasing activity and bed occupancy, that the previous year's improvement has been maintained and built on with an overall 19% reduction since 2014/15.

Figure 26. Falls data for the project wards

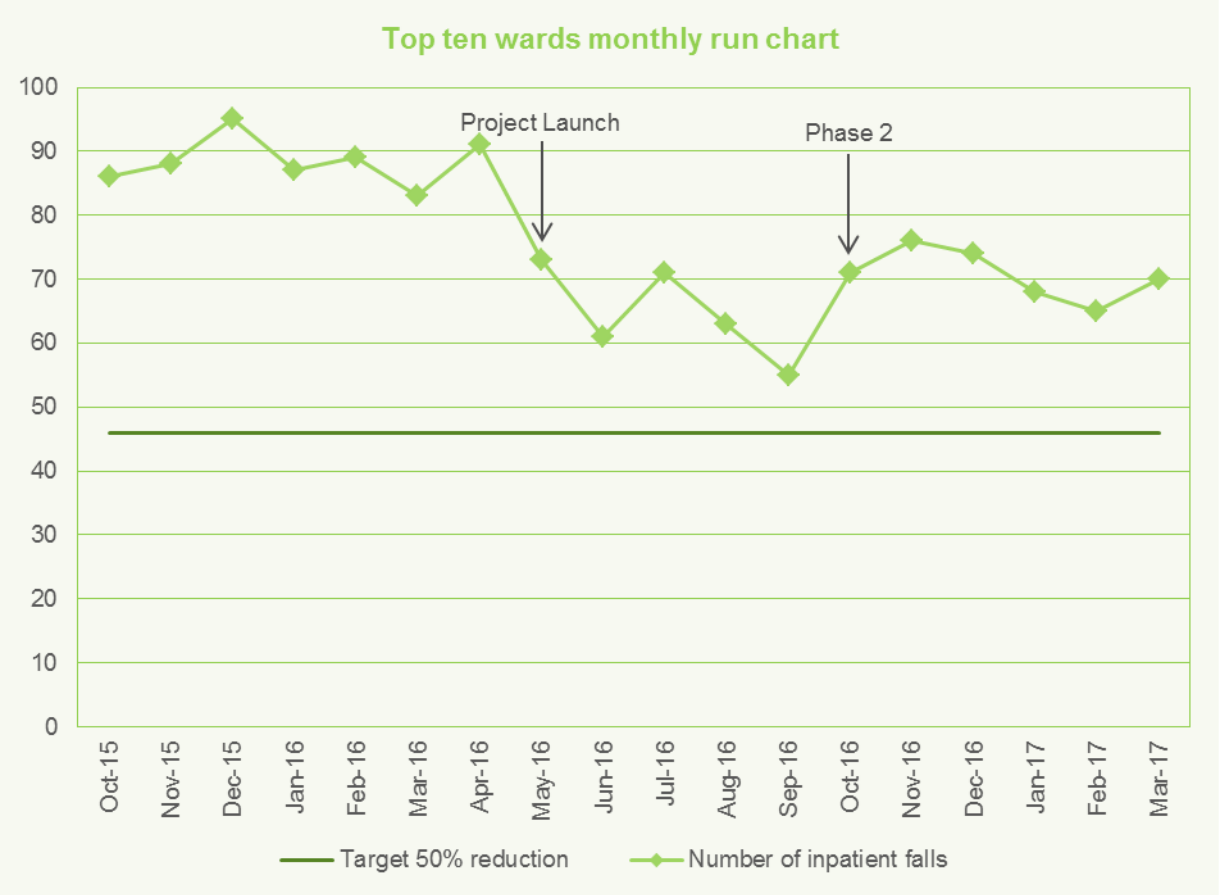
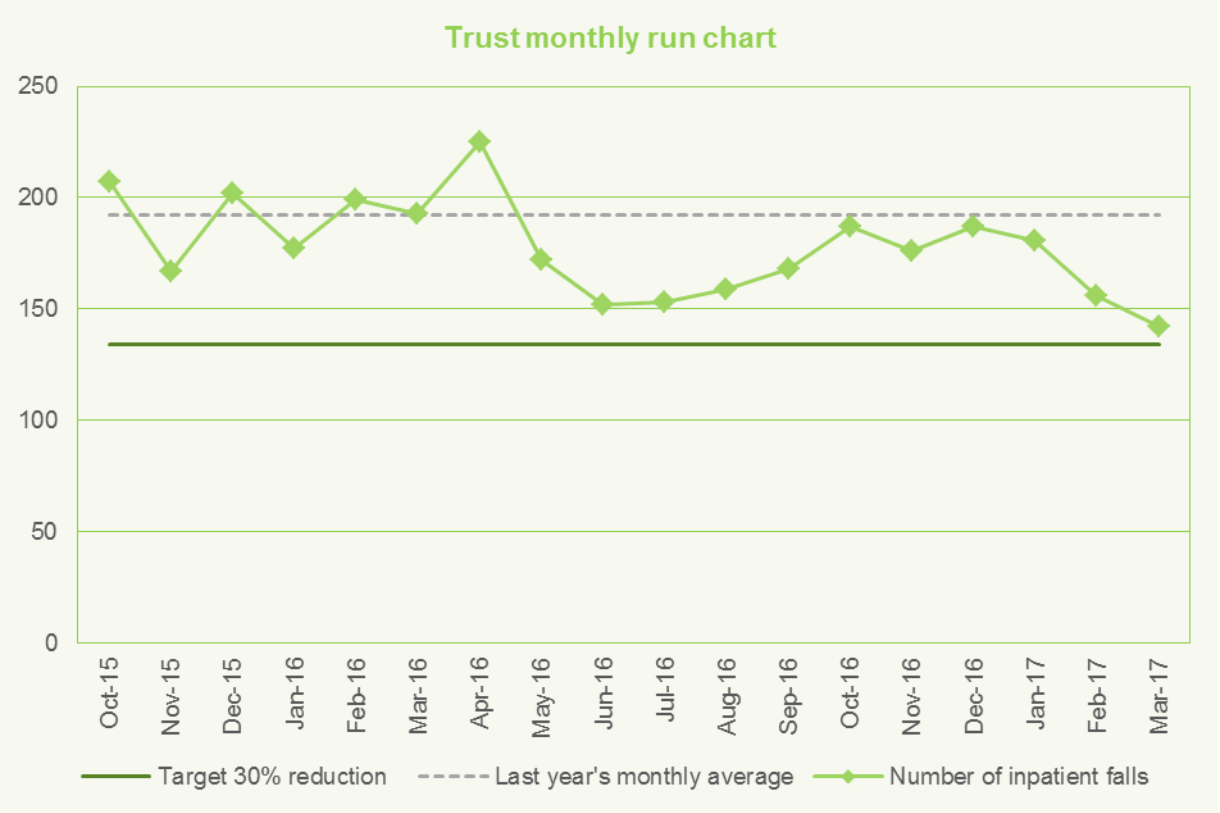


Figure 27. In-patient falls across the Trust



Further improvements identified

A reduction in in-hospital falls continues to be a major improvement area for the Trust in 2017/18 and represents a breakthrough objective with a target to embed improvements to maintain the current performance and build on this to deliver of 30% reduction in in-hospitals falls over the next year. This work will continue to be supported by the Patient First Improvement System and led by the divisional teams.

Patient First falls event

Medicines Optimisation Programme

Aim: Medicines Optimisation Strategy implementation focusing on medicines safety

Target: Implementation of Medicines Optimisation Strategy, reduction in prescribing errors

By when: March 2018

Progress: On plan

Our goals in 2016/17

- To complete the rollout of the JAC system for Electronic Prescribing and Medicines Administration and establish a clinical decision making group assist in reviewing how the system is used, prescribing choices and opportunities for using the system to improve clinical care and safety.

- To use the Medicines Safety Thermometer data to identify opportunity for improvement, i.e. where our performance or activity is below the national benchmarked average.

- 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.

- Planned work 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.

- To 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. (It was agreed by the Heads of Nursing part way through 2016/17 that this was no longer a priority safety and quality initiative compared to other medicines optimisation initiatives; this opportunity was not explored during 2016/17.)

Improvements achieved 2016/17

~ Electronic Prescribing and Medicines Administration (EPMA)

The computerised system for Electronic Prescribing and Medicines Administration has been extended to cover prescribing within day surgery, maternity and out-patient areas. There has been significant work during the year to develop the reporting functionality of the system to cover real-time prescribing information (such as antimicrobial prescribing or high dose insulin prescribing) or trend and performance monitoring such as omitted doses or medicines reconciliation performance. A clinical decision group was established and this group, with multi-disciplinary representation, has worked through a variety of key issues such as warfarin prescribing, oxygen prescribing and other areas for improved use of the system.

~ Discharge processes

Changes have been made to the transfer of information from EPMA to the Electronic Discharge System and these have improved some problems experienced in providing medication summaries at discharge. An audit and improvement project is underway focussed on patients transferred to community hospitals to ensure that accurate information about medication history and current prescription is provided.

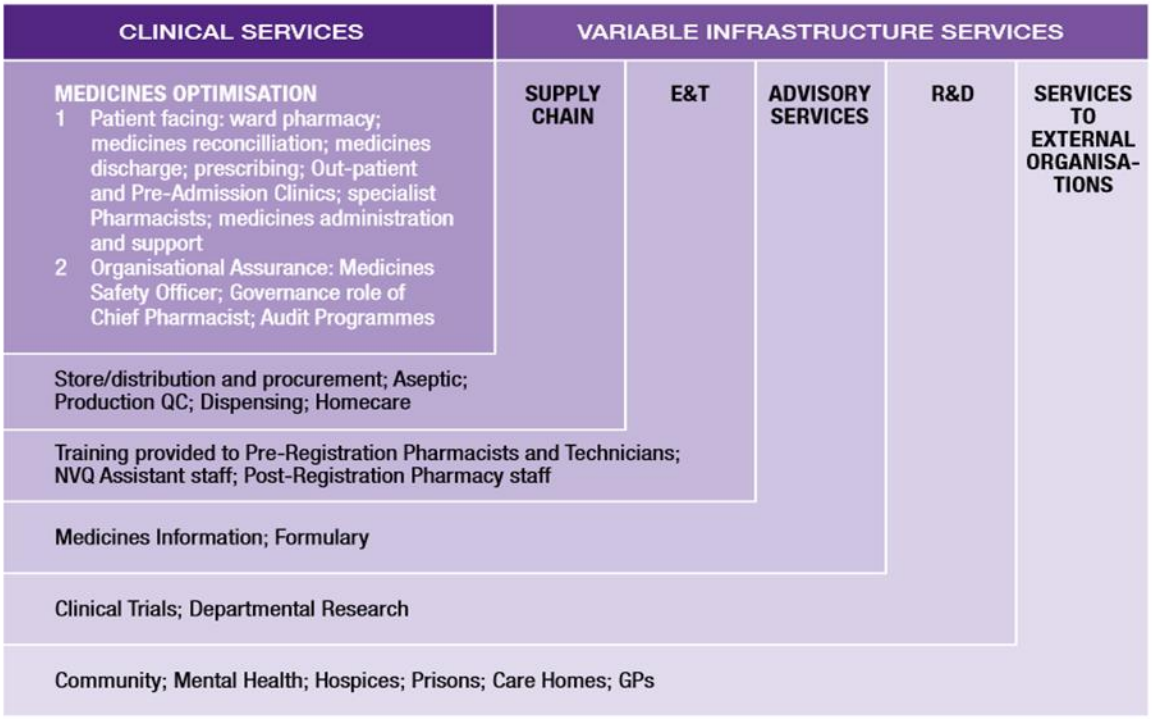
Changes have been implemented within pharmacy teams to focus on providing dispensing services at a ward level in order to improve the efficiency of supply at discharge. An improvement project is also underway which involves the pharmacist accompanying the junior doctor during the discharge prescribing process – early indications are that this will reduced delays, identify discrepancies and inaccuracies sooner and improve the quality of information included on the discharge prescription.

~ Medicines Optimisation and Pharmacy Transformation Plan

The Carter Model Hospital report[52] defined areas of development required for hospital pharmacy and transformation plans alongside the development of a benchmarking dashboard. The report defines key infrastructure services for acute hospitals which are required in order to ensure a quality and safe medicines service and a range of variable services which could be delivered in an alternate way.

[52] https://www.gov.uk/government/news/review-shows-how-nhs-hospitals-can-save-money-and-improve-care

Figure 28. Hospital pharmacy services



From: Operational productivity and performance in English NHS acute hospitals: Unwarranted variations, An independent report for the Department of Health by Lord Carter of Coles, February 2016[53]

Key elements of the Medicines Optimisation dashboard relate to quality and safety. A draft transformation plan has been developed, submitted and accepted and this outlines area of current good practice and areas for further development.

~ Medicines storage

The annual medicines storage audit was undertaken in May 2016; the results show a high level of compliance. Areas with non-compliance have been re-audited and action plans are in place for resolving outstanding issues. A programme of work is well underway for formalised recording and mapping of the temperature storage for ward drug storage areas; this is to provide assurance against the requirement for ambient temperature storage of 25°C. The pharmacy departments at Worthing and St Richard's Hospitals have both benefited from the installation of air conditioning which has rectified the excessive drug storage temperatures in both locations.

~ Medicines Safety Thermometer

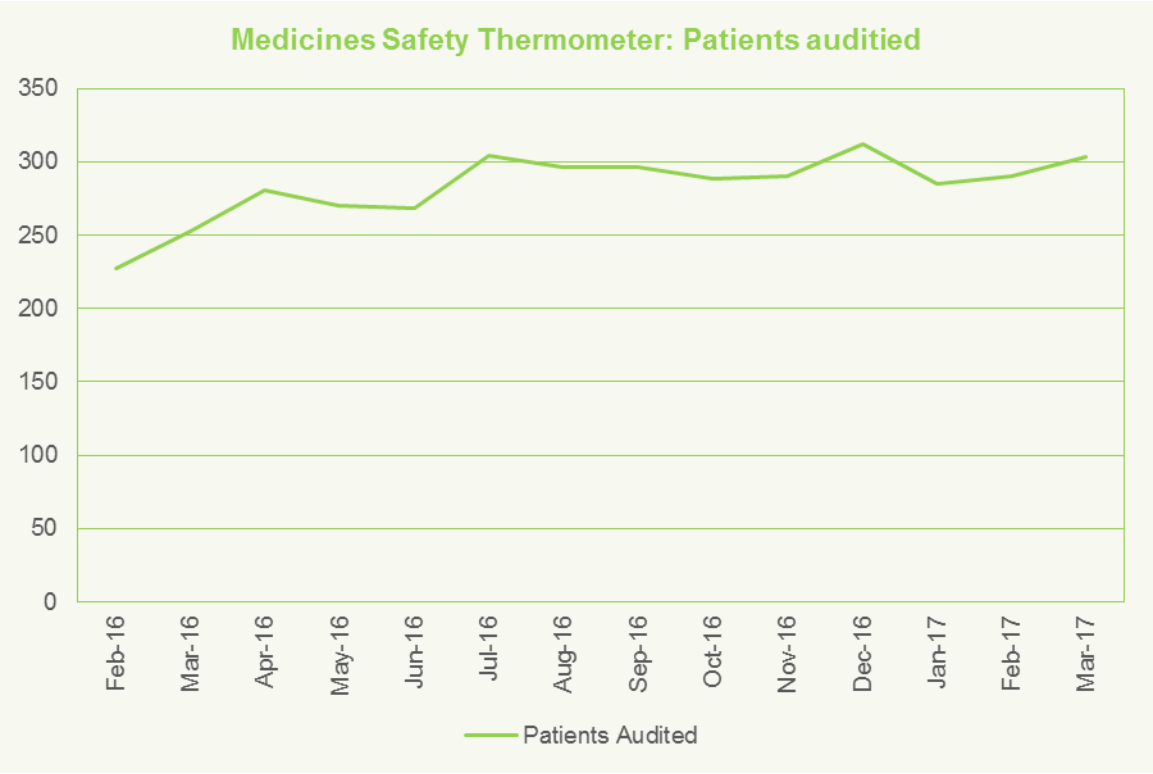
We have continued to progress work on the Medicines Safety Thermometer within the acute adult in-patient areas. The tool has been used consistently through the year. This

[53] www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

thermometer is based on the principles of the original Safety Thermometer, with medicines-use elements targeted at areas known to provide greatest risk. The data allows comparison of allergy recording rates, omitted doses of medication and prescribing of high risk medication. From the 2015/16 data collection and comparisons we identified four key priorities:

1) Targeting the completion of Medicines Reconciliation (MR)
2) Review of the thermometer outputs within the local clinical team
3) A focus on omitted doses
4) A focus on anti-coagulant prescribing

Figure 29. Medicines Safety Thermometer audit



Progress with medicines reconciliation has seen a steady improvement over the year; this improvement has also been linked to a CQUIN delivery and will form part of the Model Hospital Medicines Optimisation dashboard.

Table 6. Medicines Reconciliation rates against target for 2016/17

	Q1 16/17 baseline	%	CQUIN target Q2	Actual Q2	CQUIN target Q3	Actual Q3	CQUIN target Q4	Actual Q4
1a. MR completed for patients admitted for >24hrs	4773	77%	79%	**83%**	81%	**87%**	83%	**88%**
1b. MR completed for patients admitted for >4d	3486	90%	91%	**94%**	93%	**96%**	95%	**97%**
1c. MR completed up to 48hrs	2942	48%	53%	**59%**	58%	**66%**	63%	**63%**

The use of the Medicines Safety Thermometer has resulted in a focus on anticoagulant prescribing, supply and administration during 2016/17. Five areas were identified for assessment and improvement: VTE assessment to prescribing; patient information; dosing and decision making; bridging guidelines, and planning for discharge. Work is underway in all five areas to evaluate our current position and trial improvements in order to reduce risk and incidents and optimise treatment. It is anticipated that this work will continue into 2017/18.

CQUINs

The Trust has met the targets and requirements for the following medicines related CQUINs for 2016/17

- Medicines Safety Thermometer (including the use of the Summary Care record)
- Antimicrobial prescribing review and volume used
- Chemotherapy dose banding

Table 7. Total incidents involving drug/prescribing errors

	2013/14	2014/15	2015/16	2016/17
Total Incidents involving drug/prescribing errors	1247	1239	1100	1088
Moderate/severe incidents involving drug/prescribing errors	5	5	6	8

Further improvements identified

Work will continue to improve the following key safety improvements:

- Maintain or improve the Medicines Reconciliation completion rates achieved in Q4 of 2016/17
- Focus on anticoagulants: target 50% patients on New Oral Anticoagulants (NOACs) with documented counselling, 100% patients with correct prophylaxis prescribed, reduce surgery cancelled due to anticoagulant issues
- Antimicrobial stewardship and consumption - Target (CQUIN): 2% Reduction in overall antibiotic consumption per 1,000 admission, 1% reduction in the use of carbopenems and Tazocin
- Improve the quality of information relating to medication at discharge to GPs, community hospitals and community pharmacists
- Omitted doses, with particular focus on high risk medicines, linked if possible to the work of the AHSN

We are exploring options to introduce an updated version of JAC EPMA during 2017/18 and also to pilot the use of electronic drug storage cabinets for improved accuracy, stock recording, audit trails and security.

Skin Damage Reduction Programme

Aim: Reducing the number of in-hospital acquired pressure damage

Target: 10% reduction in grade 2+ pressure damage from the baseline of 2015/16

By when: March 2017

Progress: Behind plan

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 continue in 2016/17. We changed significantly 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.

Our goals in 2016/17

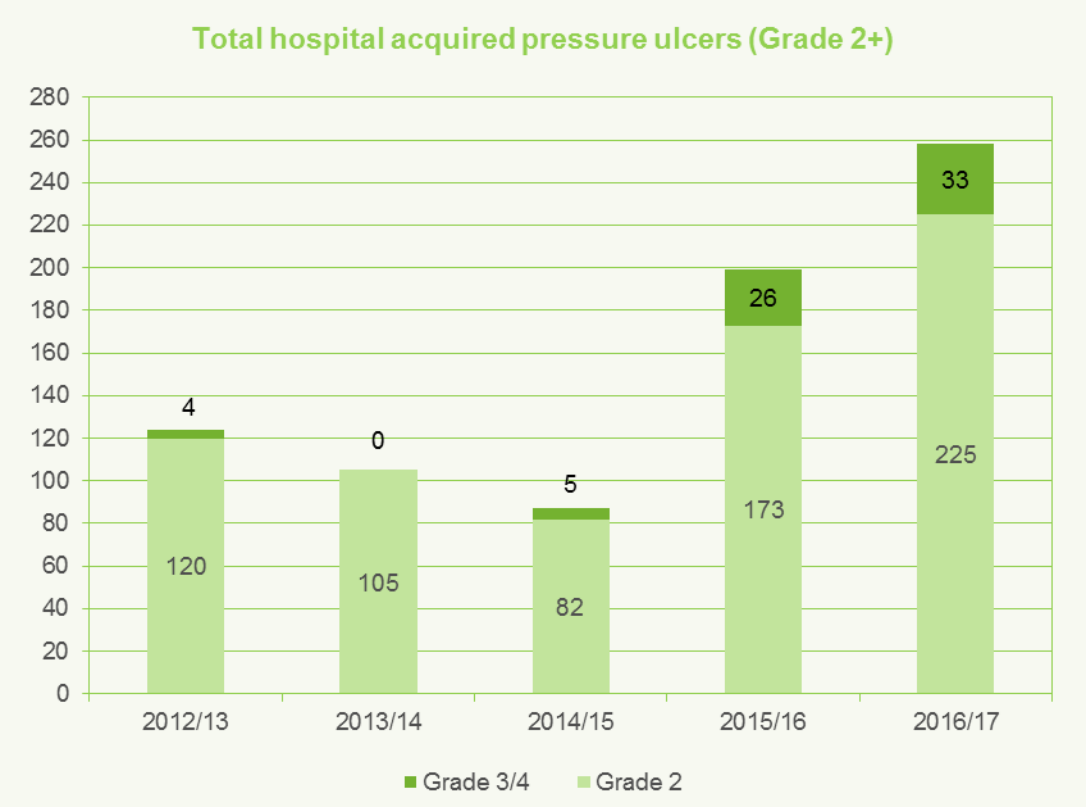
New measures to reduce harm from skin damage continued through 2016/17 with a focused programme rolling out a new pressure ulcer risk assessment tool called ‘Purpose T’.

Whilst we had aimed to deliver a target of 10% reduction in grade 2+ avoidable pressure damage from the baseline of 2015/16, this was not met. We have however put in place essential foundations on which to see improvements in the coming year.

Improvements achieved 2016/17

The following data is taken from our ongoing monitoring of all pressure ulcers.

Figure 30. 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:

- In addition to the Pressure Ulcer Panel, chaired by the Medical Director / Director of Nursing to review every case of grade 3 we now have weekly pressure ulcer panels for all category 2 pressure ulcers chaired by the Matron for Safer Care to ensure learning is shared and appropriate actions are put in place.
- Cameras purchased for all wards to support timely and accurate assessment and communication across areas.
- Full implementation of the new Purpose-T risk assessment tool following the successful pilot during 2015/16.
- Addition of harm free care education (including falls and pressure ulcer prevention) on mandatory training for all clinical staff.
- We continue to work with our Sussex Community NHS Foundation Trust partners through the Harm Free Care Collaborative working closely together on our shared challenges. We have co-designed a pressure ulcer prevention module which will launch in 2017; this aims to build tissue viability expertise across our clinical areas.
- A change in the Tissue Viability Team structure to provide increased support for wards led by a new matron role focusing specifically on Harm Free Care.

- ‘React to Red’ awareness campaign to improve the recognition by all staff of the earliest signs of skin damage.
- Pilot of the SWARM approach (already successfully used in the falls project) to ensure all appropriate actions are in place when a category 1 pressure ulcer is identified to try to prevent deterioration. (Category 1 skin damage is a reversible harm).

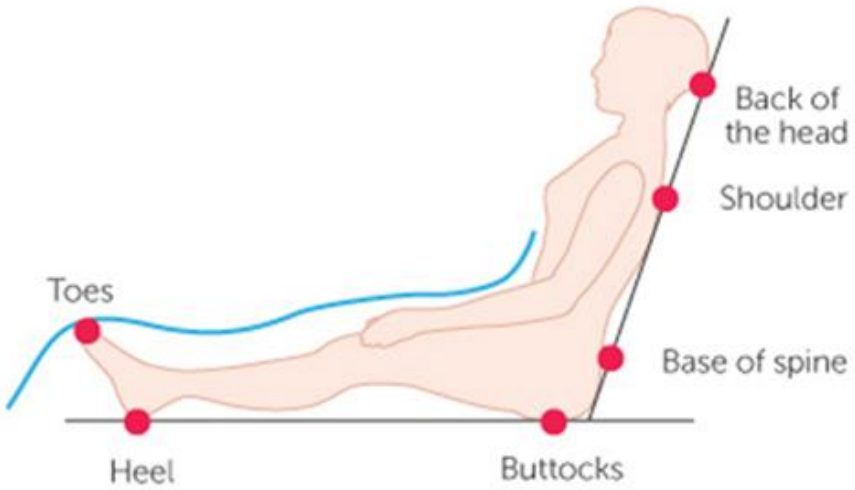
Further improvements identified

The measures to reduce harm from skin damage will continue over 2017/18 with a focused programme using Patient First improvement methodology, working with teams to understand and address the causes of pressure damage in their patient group.

We will deliver a target of 10% reduction in grade 2+ pressure damage from the baseline of January - December 2016.

Are you Purpose T ready?

The Trust launched a new assessment tool to at the end of October 2016 to reduce harm caused from skin damage. The new tool called ‘Purpose T’ (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) will help deliver a target 10% reduction in avoidable pressure damage from the baseline of 2016/17.



Purpose T skin assessment tool

Purpose T uses a simple colour system rather than a score to describe risk. This makes a

clear distinction between patients with an existing pressure ulcer(s) (or scarring from previous ulcers) = RED and those without current damage but who are at risk and require primary prevention = AMBER.

The focus of Purpose T is continual assessment of skin status and ongoing review of whether current interventions are keeping the patient safe from deterioration. All patients are assessed for the risk of pressure ulcers on admission and then either weekly or when their condition changes.

The Purpose T tool was developed following an extensive research study at Leeds university hospital and has since been adopted by many Trusts across the country after recent research showed previous assessment tools contained flaws.

Improvements in culture and environment to promote harm free care

Aim: **Improvements in culture and environment to promote harm free care**

By when: **Ongoing**

Progress: **On plan**

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.

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 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.
When things go wrong for patients, talking to the person affected or their family provides crucial context to any investigation. The organisation continues to develop and encourage an open and honest approach to dealing with patients who have been harmed or their families as candour and transparency are core values for Western Sussex Hospitals.

The roll out of our Patient First Improvement Systems across clinical areas has really helped increase staff confidence and capability in identifying areas in which we can improve the quality and safety of the care we provide, with teams flagging and acting on 'improvement tickets'.

We have seen a significant improvement in staff engagement scores over the last year as measured by the NHS Staff Survey which is an important indicator of a positive culture and environment.

WSHFT are members of the Kent Surrey Sussex Academic Health Sciences Network Patient Safety Collaborative (KSS AHSN[54] PSC) and look for opportunities for regional shared learning and quality improvement to improve patient safety.

❖ Continued roll out of ward accreditation

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.

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.

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

Ward accreditation status is measured through observational assessments, documentation audits, patient and staff interviews and a review of ward level performance metrics. The criteria below determine how wards qualify as bronze, silver or gold accreditation status.

[54] www.england.nhs.uk/ourwork/part-rel/ahsn/

Table 8. 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

Since 2015/16 the Ward Accreditation Programme has provided assurance as well as contributed to an improvement in ward performance at Western Sussex Hospitals NHS Foundation Trust, (WSHFT).

Since its inception there have been some changes to the Ward Accreditation Programme and the way supporting information is captured, in particular as the Patient First programme has accelerated.

The ward quality metrics that underpin the progression from bronze to silver status were changed in April 2016 to align to the Patient First True North Strategy for improvement and align to measure harm free objectives. Each metric has a three month or six month duration for success. This is to ensure that the wards can demonstrate their performance is consistently being delivered, before they are awarded a higher accreditation status. The ethos behind this was to provide stretch targets in order to achieve improvements. This comprehensive data set is circulated monthly to all senior nursing leaders, matrons and ward managers. The change in measurement emphasises the priorities for improving patient experience and outcomes.

Our goals in 2016/17

Eight Wards to achieve Silver Ward Accreditation status by the end of March 2017. The two standards identified for targeted support in 2016/17 were:

1. **Organisation and Management of the Clinical Area**

Aim:

- To ensure that ward teams reliably undertake daily safety checks of equipment.

- To ensure temporary staff receive a local induction to the clinical environment.

2. Nutrition and Hydration

Aim:

- 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 and rates of patient satisfaction at mealtimes

Improvements achieved 2016/17

We achieved our goal of eight wards achieving silver ward accreditation status: Botolphs, Beeding, Burlington, Courtlands, Downlands, Neonatal Unit, Lavant and Castle Ward.
During 2016/17 Thirty wards were assessed as achieving bronze status Results of the assessments range between 71% and 92%. All wards have seen an improvement in their assessment scores attained following their first assessment.

Daily safety checklists have been created for staff in charge of each ward to ensure that every ward team reliably undertakes daily safety checks. These records are visible at ward reception areas they are used by staff to evidence essential cleaning and replenishments of vital equipment such as bedside suction, calibration of blood sugar machines has occurred. These daily checklists have become part of the daily routine for senior nurses in charge of the wards and continue to be completed routinely.

Orientation checklists were re-launched during 2015 to record that temporary staff are given standard patient safety information when they commence a shift within the Trust. Audits show that this is used 60% of the time. Ward managers have agreed to keep the forms in the ward rota folders so that ward staff can find them easily and this requirement has been highlighted at ward safety huddles in a bid to improve this further. Nursing staff have explained that the majority of temporary staff that are employed live locally and are familiar with the Trusts systems and processes so it is not required often and this has meant it has been more challenging to embed this reliably.

The percentage of nutritional assessments completed within 24 hours of admission has improved 55.70% to 83.80% over 2016/17.

Further improvements identified

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.

1. Our goal for 2016/17 is to assess the ward accreditation audit tool and its current place in the wider context of Patient First to reduce duplication of auditing by a variety of staff and to streamline processes.
2. Link the results to PFIS so that ward managers can align their improvement opportunities and prevent duplication
3. Increase the number of nursing staff that can complete a ward accreditation assessment to provide resilience to the programme. This will also ensure that more nurses understand ward accreditation and contribute continuous improvement ideas.

❖ Freedom to speak up

The recommendations of "Freedom to Speak Up"[55], the review commissioned by the Secretary of State and chaired by Sir Robert Francis QC, were published in February 2015. The purpose of the review was to provide independent advice and recommendations on creating a more open and honest reporting culture in the NHS. The review followed on from the Public Inquiry, also chaired by Sir Robert, into the Mid Staffordshire NHS Foundation Trust which exposed unacceptable levels of patient care and a staff culture that deterred staff from raising concerns.

One of the recommendations from the review was that every Trust should have a Freedom to Speak Up Guardian. This person is someone who is approachable, confidential and available if staff want to share a concern which may be worrying them in relation to the organisation or their work. A Non-executive Director has been appointed to support the work of the local Guardians. The local Guardians are supported by a national office (The Office of the National Guardian) and a new National Guardian leads the initiative.

Our goals in 2016/17

Continued focus on the safety culture of the Trust with a particular focus on enabling staff to raise safety concerns - 'Freedom to Speak up'.

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[55] 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

Improvements achieved 2016/17

We have appointed two staff as our Freedom to Speak Up Guardians, both of whom are passionate about patient safety and about our commitment to the Patient First Programme in our Trust. Our Guardians' appointment reinforces our desire to build upon our open and listening culture where patient and staff views contribute to the running of our Trust. Acting in an independent capacity, our Guardians will help support us to do this by listening to staff and supporting them to raise concerns so that our Trust is an open, transparent place to work.

The Freedom to Speak Up Guardians work has been advertised in Headlines and by way of a poster campaign. The two local Guardians will visit all wards and departments on all three sites.

Our new Freedom to Speak Up Guardians

In February 2017 we were pleased to announce the appointment of our new Freedom to Speak Up Guardians Shelton Bates and Delia Reed.

Shelton Bates and Delia Reed

National Guardian
Freedom to Speak Up

DRAW THE LINE
RAISING CONCERNS
TOGETHER WE CAN MAKE A DIFFERENCE

Further improvements identified

We understand that staff may be worried about raising a concern; however we know that by listening to staff we can keep improving our services for our patients and the working environment for all staff. We therefore need to continue to develop our open and honest culture where all staff feel comfortable about raising concerns no matter how big or small they may be. The Freedom to Speak Up Guardians work confidentially and no details of the person raising the concerns will be shared without that person's permission. The Guardians will meet regularly at Director level and will be reporting both locally and nationally on the nature of the concerns raised.

We are also committed to listening to our patients and visitors and we receive feedback in many different ways which will enable us to do this.

The Child Protection – Information Sharing (CP-IS) project

The CP-IS project is an NHS England sponsored work programme dedicated to developing an information sharing solution that will deliver a higher level of protection to children who visit NHS unscheduled care settings (for example Accident & Emergency departments). It proposes to do so by connecting local authorities' child protection social care IT systems with those used by staff in NHS unscheduled care settings therefore when implemented, it will help to deliver the Department of Health policy "Making sure health and social care services work together".[56]

Evidence suggests that children living in abusive and neglectful home environments are more likely to move across different authority boundaries, meaning that access to locally held child protection information is sometimes not possible. CP-IS will address this problem and provide a national system for healthcare staff to access with nationwide information regarding children under a Child Protection Plan, those classed as 'looked after' or unborn children with a pre-birth protection plan. Healthcare staff will be more easily able to identify children at risk – this will aid clinicians in their decision making process and promote communication with the relevant social care body responsible.

Following partnership working with our local authority and NHS digital we were pleased to

[56] NHS England, Guidance for Designated Professionals Safeguarding Children and Child Protection-Information Sharing, published 22/12/16.

launch this new system in our A&E departments at Western Sussex in May 2016 as an early adopter. We will be rolling the system out to our maternity departments in due course so that they can be aware of an unborn baby subject to a pre-birth child protection plan. We are currently initiating the system across our paediatric wards and children's assessment units so that they have access to information if a child has a Child Protection Plan or is a 'looked after' child.

As part of continuous improvement we are in contact with our local authority regarding data quality issues. This contact has benefited developing relationships and partnership working.

As an early adopter and high user of the system, the Trust has benefited from early adoption, specifically:

• The project has helped improve data quality inputting for A&E clerks through enabling access to the Summary Care Record[57]

• Partnership working with local authority

• Knowledge about those children who are 'looked after' children as well as children on a child protection plan.

• Social workers are alerted electronically about a child's attendance to an urgent care facility.

• A&E staff can see if a child has presented to other urgent care facilities (frequent attendances for these vulnerable children is a red flag).

It is envisaged that all local authorities and NHS urgent care facilities will be using this system across England and Wales in the next few years. This will facilitate information sharing for vulnerable children across boundaries and above all support improvement in outcomes. The more services that join this system, the greater the benefits for all.

[57] A Summary Care Record is a short summary of your GP medical record available electronically to NHS clinicians nationally.

GOAL 2: Avoiding harm: Improvement Programmes for 2017-18

Falls

Falls reduction programme

The programme will continue to expand this year with a target of 30% reduction in in-hospitals falls (from baseline of 2015/16) over the next year.

Target: 30% reduction in in-hospital falls *(to be confirmed)*

Avoiding harm

Skin damage

Skin damage reduction programme

Continued reduction in in-hospital acquired pressure damage.

Target: 10% reduction in grade 2+ avoidable pressure damage *(to be confirmed)*

Avoiding harm

Medicines optimisation

Medicines Optimisation Programme

Continued roll out our Medicines Optimisation Strategy.

Target 1: ≥ Q4 2016/17 Medicines Reconciliation, 2. anticoagulants: 50% patients on New Oral Anticoagulants with documented counselling, 100% correct prophylaxis prescribed, reduce surgery cancelled due to anticoagulant issues, 3. improve quality of medicines information at discharge, 4. omitted doses - focus on high risk medicines, 5. CQUIN target: 2% reduction in overall antibiotic consumption per 1,000 admission, 1% reduction in the use of carbopenems and Tazocin

Avoiding harm

Diagnostics

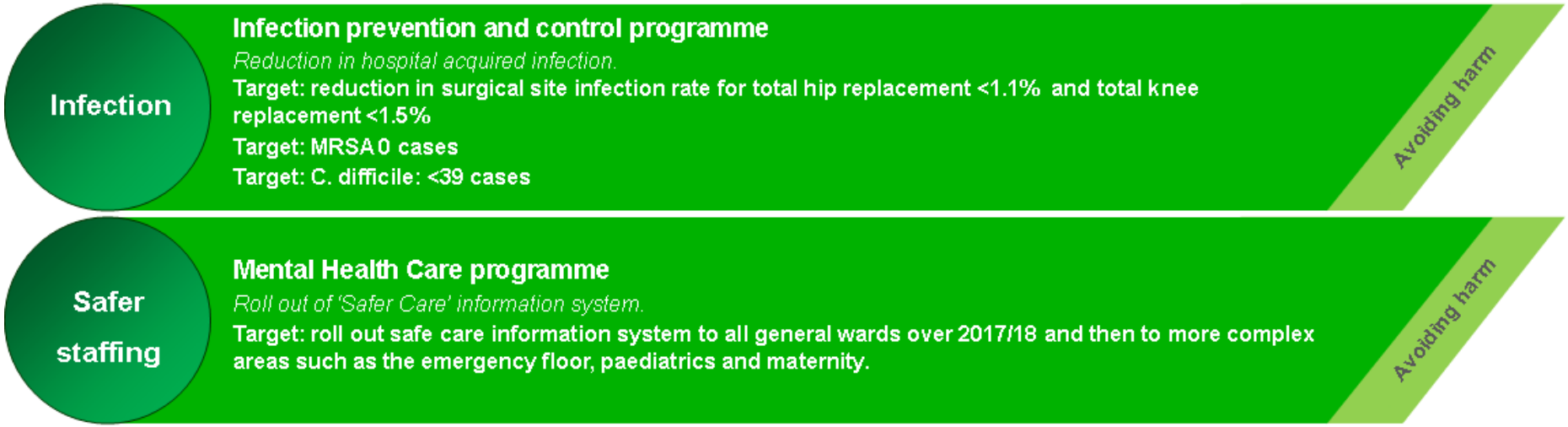
Diagnostic resulting programme

To ensure all ordered diagnostic tests are undertaken, reviewed, acted upon, escalated appropriately and finally communicated to the patient/GP within the timeframe required.

Target: Further progress with specification, procurement and implementation of a new diagnostic resulting programme over the next 3-5 years.

Avoiding harm

NHS
Western Sussex Hospitals
NHS Foundation Trust



GOAL 2: Avoiding Harm – Improvement Programmes for 2017-18

Our Avoiding Harm Improvement Programmes for **Falls Reduction, Skin Damage Reduction** and **Medicines Optimisation** are set to continue in to 2017/18.

We have developed additional Quality Improvement Programmes in the areas of:

- **Diagnostic resulting**
- **Safer staffing**

We are also refreshing our Quality Improvement Programme for:

- **Continued improvement in infection prevention and control**

❖ Diagnostic Resulting Programme

This programme aims to ensure we have a robust and consistent Trust wide programme in place to ensure that all ordered tests are undertaken, reviewed, acted upon, escalated appropriately and finally communicated to the patient/GP within the timeframe required. This will help to prevent delayed diagnosis and treatment and reduce the number of repeat diagnostics undertaken.

Target: Further progress with specification, procurement and implementation of a new diagnostic resulting programme over the next 3-5 years.

❖ Supporting safer staffing: roll out of 'Safer Care' information system

A review of staffing requirements to deliver safe care is undertaken twice a year; that this is sufficient is assured through biannual reports to the Board of Directors on staff and patient acuity levels along with preventable harms and patient experience information. Throughout the year our ward staffing requirement compliance statistics have published at ward level for all to see. This data, along with ward specific information, supports each wards achievement within our ward accreditation framework. During 2016/17 we commenced roll out of the 'Safer Care' information system that supports trust wide information on ward staffing and patient acuity and aids in decision making around delivering safer care for our patients. For 2017/18 our goal is to roll out our safe care information system to all our general wards and then to add in roll out to more complex areas such as the emergency floor, paediatrics and maternity.

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)[58] 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)[59]
- Cavendish Review (2013)[60], 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)[61]
- '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)[62]
- 'Hard truths' The journey to putting patients first' (DH, 2013)[63]

As a result of the recommendations 'Safe staffing for Nursing in adult inpatient wards in acute hospitals' (NICE 2014)[64] 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

[58] The King's Fund. Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. House of Commons.

[59] Keogh, B. (2013). Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. NHS England.

[60] Cavendish, C. (2013). An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings. Department of Health.

[61] Berwick, D. (2013). A promise to learn – a commitment to act: improving the safety of patients in England. Department of Health.

[62] 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.

[63] Hunt, J. (2013). Hard Truths: the journey to putting patients first. Department of Health.

[64] Safe Staffing Advisory Committee (2014). Safe staffing for nursing in adult inpatient wards in acute hospitals. National Institute for Health and Care Excellence.

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 31. Safer staffing reporting – registered nurses average fill rate

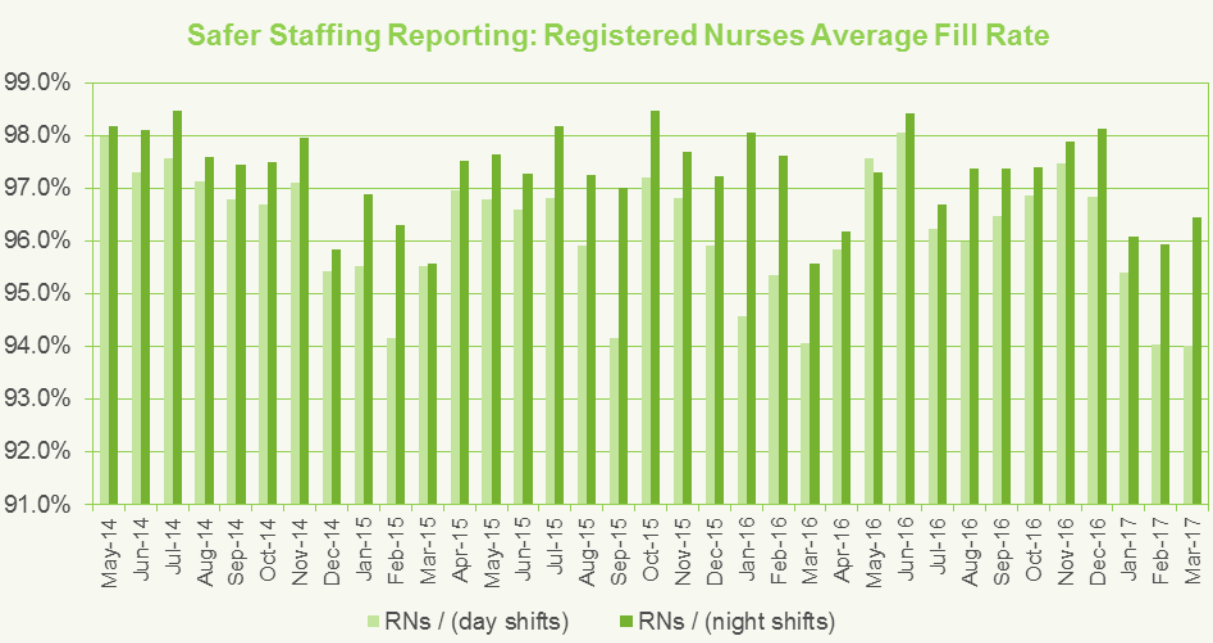
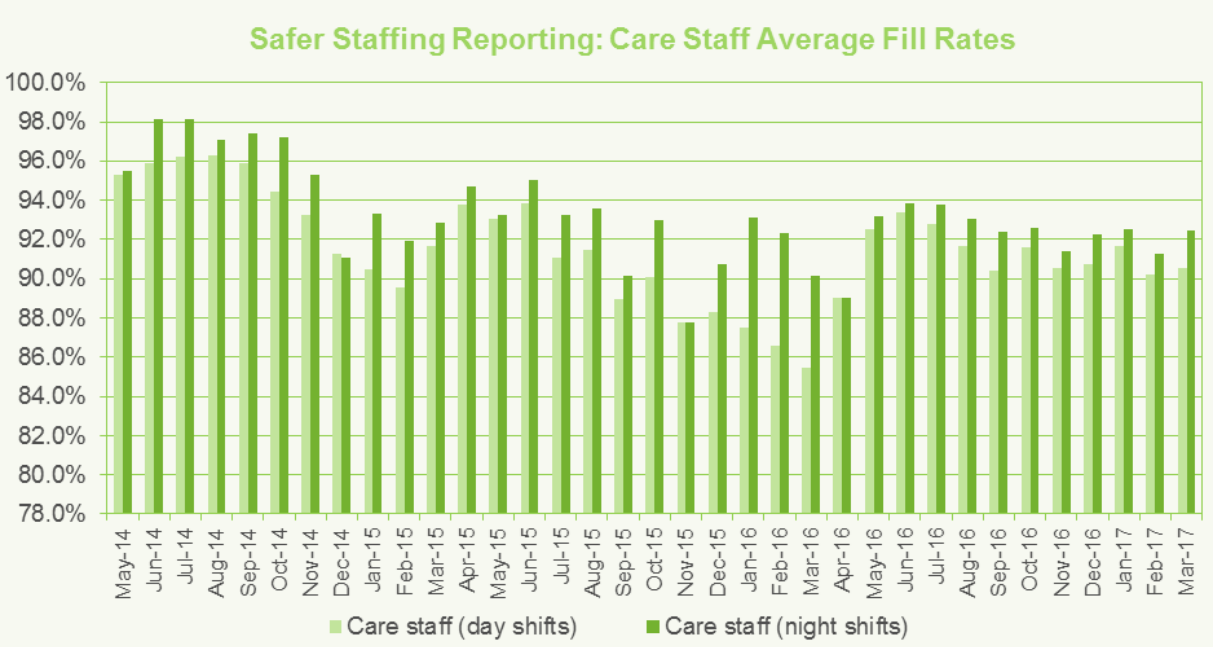


Figure 32. Staffer staffing reporting – care staff average fill rate



Target: in 2017/18 we will aim to roll out our safe care information system to all our general wards followed by roll out to more complex areas such as the emergency floor, paediatrics and maternity.

❖ Continued improvement in infection prevention and control

Healthcare associated infections (HCAI) are infections resulting from clinical care or treatment in hospital, as an inpatient or outpatient, nursing homes or even the patient's own home. Previously known as 'hospital acquired infection' or 'nosocomial infection', the current term reflects the fact that a great deal of healthcare is now undertaken outside the hospital setting. HCAI's are well recognised as a cause of increased morbidity and mortality and whilst some are not preventable our objective is to prevent them where possible by good basic Infection Prevention and Control practices such as hand hygiene, cleanliness and antimicrobial stewardship. The work to reduce the rates of HCAI's involves the local Healthcare economy with close working with the CCG, Sussex Community Trust and Sussex Partnership towards the common goal.

The term HCAI covers a wide range of infections. The most well-known include those caused by meticillin-resistant *Staphylococcus aureus* (MRSA), meticillin-sensitive *Staphylococcus aureus* (MSSA), *Clostridium difficile* (*C. difficile*) and *Escherichia coli* (*E. coli*). Although anyone can get an HCAI some people are more susceptible to acquiring an infection.

Clostridium difficile associated diarrhoea is an example of an infection that is commonly healthcare associated and rarely occurs in the absence of any healthcare interactions. *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 three main actions we use to prevent *C.difficile* diarrhoea. First, we have strict antibiotic prescribing policies to reduce the chances of it developing. Our policies are updated yearly and one of the main drivers for change is to reduce the likelihood of *C difficile* associated diarrhoea. Secondly, in order to prevent spread from one patient to another, we aim to isolate patients who develop diarrhoea, and thirdly we adopt particularly scrupulous hygiene measures when caring for these patients, for example we advise the use of soap and water for hand hygiene rather than alcohol hand gel that might be used in other areas.

All areas that have had patients with *C.difficile* diarrhoea are deep cleaned with vaporised hydrogen peroxide after the patient recovers or is transferred.

MRSA continues to be a concern in the healthcare setting as well as in the wider community. 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.

From 2011/12, there has been executive representation in the Root Cause Analysis meetings of hospital acquired *C.difficile* and MRSA bacteraemia cases. This ensures that if there are any issues requiring executive decisions they are dealt with in a timely manner.

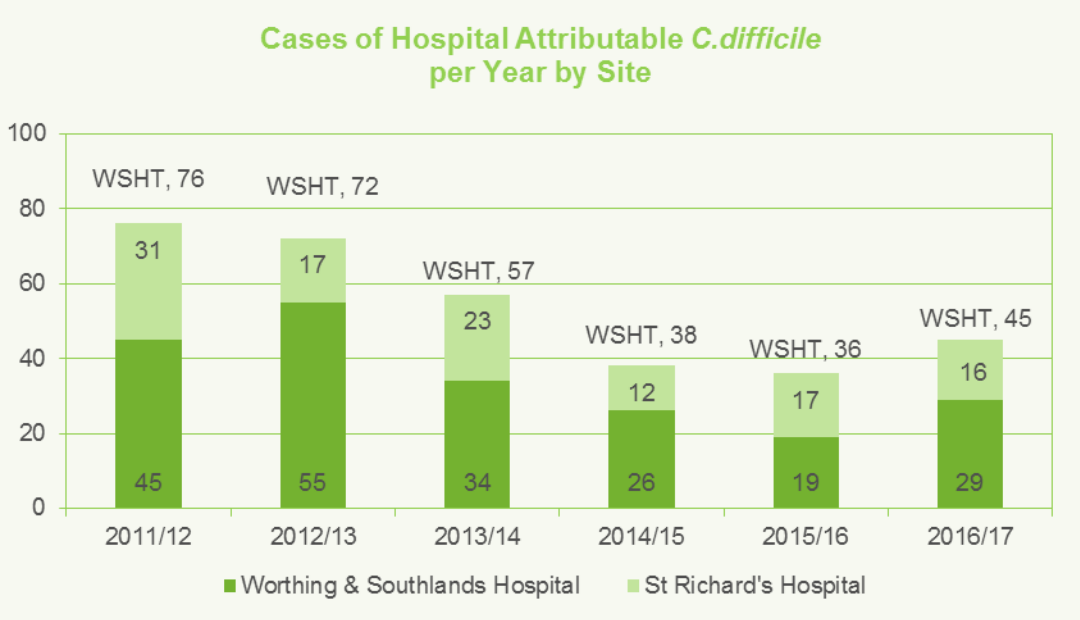
~ Healthcare Associated Infections (HCAIs)

Table 9. 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
2016/17	1	45	24

We have had one acquired case of MRSA bacteraemia in 2016/17 and 45 of *C.difficile*. C.difficile levels have slightly increased in 2016/17 and the target of 36 has been exceeded.

Figure 33. Cases of hospital attributable *C.difficile* per year by site



E. coli is the most frequent cause of blood stream infection locally and nationally. All cases are reported to the Public Health England mandatory database each month which provides an opportunity for comparison with other trusts. The majority of cases are linked to urinary tract infections, bile duct sepsis and other gastrointestinal sources. The majority of cases of *E. coli* bacteraemia are present at the time of admission to hospital and, therefore, in most cases represent community-acquired infection.

Antibiotic resistance is another concern in the healthcare setting. Bacteria can acquire defences against antibiotics which is more likely to happen if they are exposed to antibiotics. As bacteria and other organisms become more resistant the number of useful antibiotics becomes less and can create problems for treatment. Very few novel antibiotics have become available in recent years.

World-wide there are increasing numbers of 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 had two patients with CPEs found on screening. Both had come from other healthcare facilities, one with a known infection,

one was not known to us. Neither required treatment for their CPE whilst admitted i.e. they were colonised rather than infected.

As well as the on-going daily work aimed at reducing HCAI's the hospital environment is closely monitored to ensure it is safe for patient care. This involves the fabric of the clinical areas, water hygiene, air ventilation, and monitoring of medical devices. The standards are monitored closely through water and air sampling and as part of the Infection Prevention & Control (IP&C) and Estates audit programme.

The IP&C team are involved in monitoring Infection rates from elective total knee and hip replacements, breast surgery and large bowel surgery. A post-operative wound care clinic has been open since June 2016 which has been effective in providing wound advice to patients and facilitated some early intervention.

~ 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[65].

~ 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.

[65] A booklet for patients across West Sussex called 'Looking after your Urinary Catheter (Catheter Passport)', designed to provide advice on looking after urinary catheters.

Table 10. Surgical Site Infections (SSIs) – Inpatient and readmission rates

	WSHFT baseline Oct 13 - Sep 14	WSHFT rate Oct 14 - Sep 15	WSHFT rate Apr 15 - Mar 16	WSHFT rate Apr 16 - Mar 17	National rate / All Hospitals total (rolling 5 year)*
Total hip replacement	0.6%	1.6%	2.0%	3.0%	0.6%
Total knee replacement	0.7%	0.9%	1.6%	3.2%	0.6%
Large bowel surgery	13.6% (SRH 15.7% Worthing 11.5%)	13.1% (SRH 13.7 % Worthing 12.4 %)	*Not available*	11.6%	9.8%
Breast surgery	1.8% (SRH 2% Worthing 1.6%)	1.0% (SRH 0.8% Worthing 1.2%)	*Not available*	5.4%	0.8%

** Cumulative SSI incidence (%) by Surgical Category, NHS hospitals in England, April 2011 to March 2016*

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 2017/18 we will also deliver the following programmes of work:

- **Surveillance**: continued surveillance of HCAIs, SSI prevention and reduction, establish use of wound care protocol on surgical wards and a number of surveillance audits.
- **Reducing the infection risk from the use of medical devices:** focusing on peripheral cannula care and standard audits.
- **The environment – reducing reservoirs of infection:** through environmental and other audits, ward refurbishments, improving isolation facilities and a review of systems and procedures.
- **Hygiene in clinical practice:** focusing on training in personal protective equipment, junior doctor training and commode cleanliness audits.
- **Antimicrobial prescribing:** review of current prescribing guidelines, support and delivery of CQUINS and compliance with the recommendations in the NICE guidance on Antimicrobial Stewardship.

- **Management and organisation:** thorough update of IP&C policies and continued infection control training.
- **Research and development:** Review Rapid Review Panel[66] recommendations and identify items to be discussed at team meetings.

[66] Department of Health panel which considers infection control products and provides recommendations as to their effectiveness.

2.1.5 GOAL 3 – Improved Patient Experience

GOAL: Achieve top 20% of NHS Trusts in country for patient experience surveys (Friends and Family Test)

We have set a 'True North' long term goal to achieve 96% recommendation for Friends and Family Test feedback, and reduce 'not recommend' rates. Departments within the Trust have different aspects to focus on depending on their patient experience themes.

Improvement huddles are being implemented as part of the Patient First Improvement Programme across the Trust to empower staff to resolve recurring issues that lead to a poor patient or staff experience.

Our forward improvement focus addresses reduction in complaints and improving the timeliness of complaint responses. We are also focused on improvement projects where we see trends in poor patient experience. We will also be developing our ability to correlate staff experience with patient experience to enable a greater understanding of where improvements can be made.

Our aim for 2016/17 was to achieve an inpatient return rate of 40% 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.

Why is this 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.

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?

The FFT guidance for inpatients, A&E and maternity was updated by NHS England in April 2015. All organisations providing acute NHS services have been required to implement the Friends and Family Test (FFT) day case scores contribute to the overall inpatient results. The survey has also been expanded to include children.

Any patient who wants to provide their feedback should do so via FFT, but they do not need to be asked to do so after every appointment or course of treatment. The Trust makes sure that the patients have the opportunity, and are aware of that opportunity. Each patient must be surveyed at discharge or within 48 hours of discharge and the standardised question format must be as follows:

"How likely are you to recommend our ward (or department) to friends and family if they needed similar care or treatment?"

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

Satisfaction is described as a 'percentage of patients who would recommend' the service to their friends and family.

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 in-patients. 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[67], feedback via Healthwatch[68] West Sussex.

How do we report on 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?

~ 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?

[67] http://www.nhs.uk/

[68] Healthwatch, the national consumer champion in health and care: www.healthwatch.co.uk

- 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?
- 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

A&E: The tables and graphs show that A&E performs above the national average for both response rates and satisfaction. Although the response rate for the Trust at 12.90% is above the national average, there has been a significant decrease over the period from 2014/15. It is likely that this is due to the increased volumes of patients attending A&E. Our teams will try and address this decrease in response rates by introducing iPads to our reception areas to enable patients to complete these surveys independently from staff and also by using text message reminders. Worthing has decreased from a response rate of 21.5% in 2015/16 to 14% in 2016/17, St Richard's saw a similar decrease between 2014/15 and 2015/16 and in 2016/17 the rate is at 11.6% which is just below the national average. The recommend rate

has also decreased on both sites by around 2% from 2015/16 figures. However, both sites remain above the national average of 86.2%.

Table 11. Friends and Family Test A&E recommend rate

	2013/14	2014/15	2015/16	2016/17 (Apr to Feb 2017)	National average 2016/17 (Apr to Feb 2017)	National position 2016/17 (Apr to Feb 2017)
WSHFT	91.00%	90.60%	91.39%	89.15%	86.20%	60th of 142 (42nd centile)
Worthing	90.00%	90.90%	92.77%	90.70%	86.20%	N/A
St Richard's	91.30%	90.30%	88.68%	86.90%	86.20%	N/A

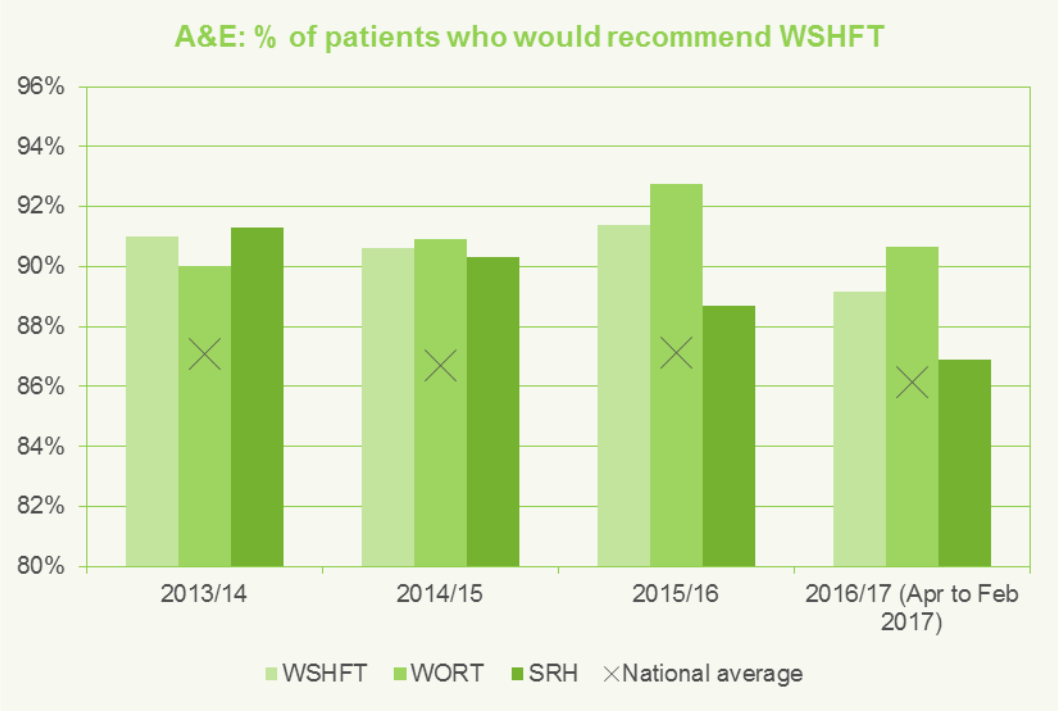
N.B. 2016/17 figures presented are Apr to Feb 2017 only. 2015/16 data in this table provides full year information; 2015/16 data in the Quality Report 2015/16 provided available data from Apr to Feb 2016 only.

Table 12. Friends and Family Test A&E survey response rate

	2013/14	2014/15	2015/16	2016/17 (Apr to Feb 2017)	National average 2016/17 (Apr to Feb 2017)	National position 2016/17 (Apr to Feb 2017)
WSHFT	18.90%	26.70%	17.80%	12.90%	12.70%	73rd of 142 (51st centile)
Worthing	16.20%	27.50%	21.50%	14.00%	12.70%	N/A
St Richard's	22.10%	25.90%	13.30%	11.60%	12.70%	N/A

N.B. 2016/17 figures presented are Apr to Feb 2017 only. 2015/16 data in this table provides full year information; 2015/16 data in the Quality Report 2015/16 provided available data from Apr to Feb 2016 only.

Figure 34. Friends and Family Test - A&E % of patients who would recommend WSHFT



N.B. 2016/17 figures presented are Apr to Feb 2017 only. 2015/16 updated from last year's report where only Apr to Feb figures were available.

Maternity

The maternity recommend results for the Trust as a whole have increased by 1.1% from 96.2% in 2015/16 to 97.3% in 2016/17 which is above the national average of 96.5%. However, performance in Worthing hospital has declined from last year by 0.6% and is now below the national average. The response rate has increased for the Trust overall from 11.7% in 2015/16 to 26.6% and is now above the national average of 23.1%. St Richard's Hospital response rate has returned to 2014/15 levels and is over the national average, however lower response levels at Worthing remain a concern and a focus for 2017/18.

Table 13. Friends and Family Test Maternity Delivery recommend rate

	2013/14 (from October 2013)	2014/15	2015/16	2016/17 (Apr to Feb 2017)	National average 2016/17 (Apr to Feb 2017)	National position 2016/17 (Apr to Feb 2017)
WSHFT	96.60%	97.00%	96.20%	97.30%	96.50%	41st of 134 (31st centile)
Worthing	94.80%	94.70%	96.30%	95.70%	96.50%	N/A
St Richard's	97.60%	98.50%	96.20%	98.20%	96.50%	N/A

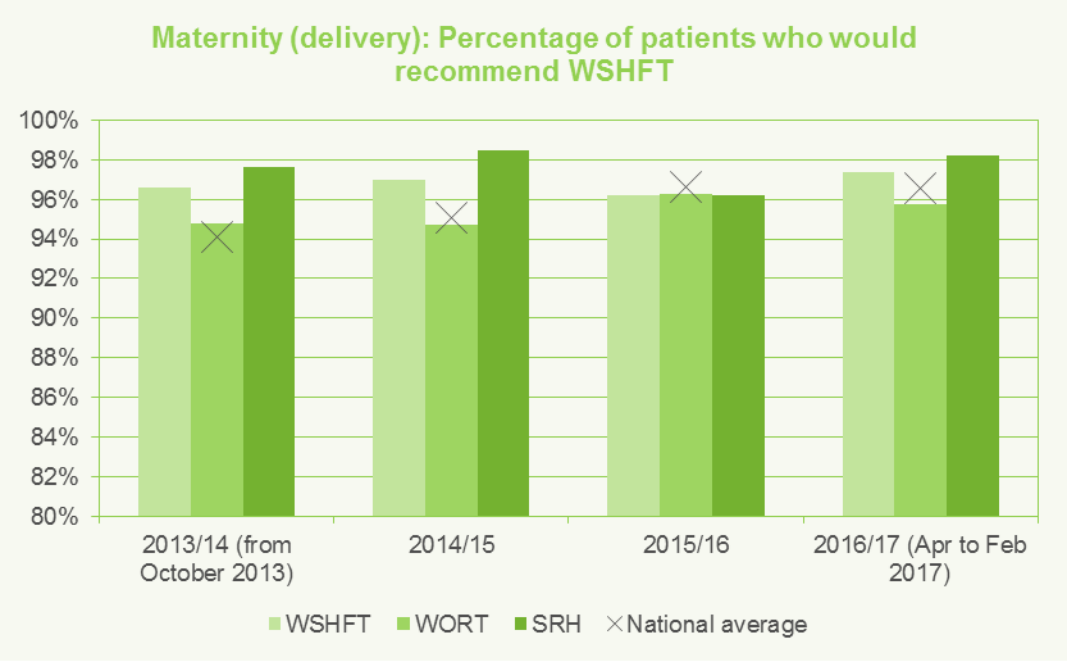
N.B. 2016/17 figures presented are Apr to Feb 2017 only. 2015/16 data in this table provides full year information; 2015/16 data in the Quality Report 2015/16 provided available data from Apr to Feb 2016 only.

Table 14. Friends and Family Test Maternity Delivery survey response rate

	2013/14 (from October 2013)	2014/15	2015/16	2016/17 (Apr to Feb 2017)	National average 2016/17 (Apr to Feb 2017)	National position 2016/17 (Apr to Feb 2017)
WSHFT	17.00%	29.10%	11.70%	26.60%	23.10%	45th of 134 (33rd centile)
Worthing	13.60%	25.40%	11.10%	19.80%	23.10%	N/A
St Richard's	20.40%	32.30%	12.30%	32.60%	23.10%	N/A

N.B. 2016/17 figures presented are Apr to Feb 2017 only. 2015/16 data in this table provides full year information; 2015/16 data in the Quality Report 2015/16 provided available data from Apr to Feb 2016 only.

Figure 35. Friends and Family Test – Maternity Delivery percentage of patients who would recommend WSHFT



Inpatients

The Trust as a whole has improved its recommend position from last year at 95.2% to 95.99% in 2016/17. For the first time since data has been collected, the position for both Worthing and St Richard's Hospitals is above the national average of 95.4%. The Trust's position in the rankings has also increased from 121st out of 178 trusts in 2015/16 to a current position of 95th out of 175 trusts (54th centile). Our recommendation score has increased significantly over the past year from 25.8% in 2015/16 to 35.0% in 2016/17. Worthing Hospital has seen a response increase of 12.6% over the year, which is around

20% above the national average. St Richard's response has increased but not at the same level. The Trust as a whole is now ranked at 41st out of 175 trusts (23rd centile).

Table 15. Friends and Family Test Inpatient recommend rate

	2013/14	2014/15	2015/16	2016/17 (Apr to Feb 2017)	National average 2016/17 (Apr to Feb 2017)	National position 2016/17 (Apr to Feb 2017)
WSHFT	92.20%	92.40%	95.20%	95.99%	95.40%	95th of 175 (54th centile)
Worthing	91.50%	92.10%	94.50%	96.10%	95.40%	N/A
St Richard's	92.90%	92.70%	95.50%	95.80%	95.40%	N/A

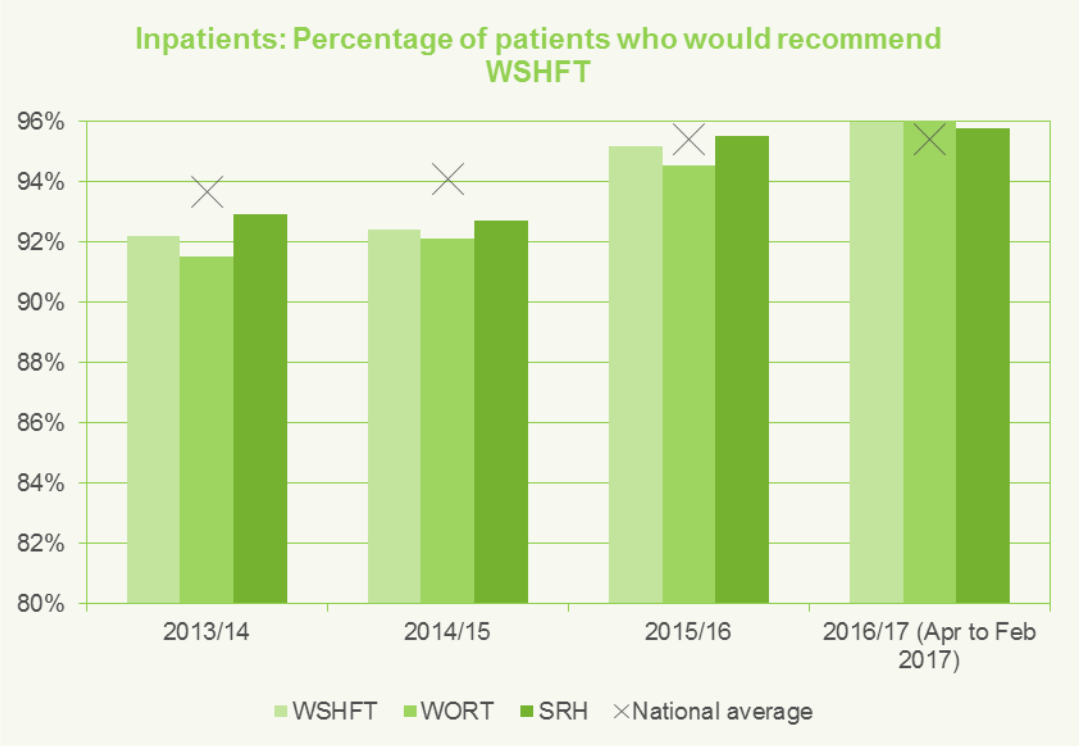
N.B. 2016/17 figures presented are Apr to Feb 2017 only. 2015/16 data in this table provides full year information; 2015/16 data in the Quality Report 2015/16 provided available data from Apr to Feb 2016 only.

Table 16. Friends and Family Test Inpatient survey response rate

	2013/14	2014/15	2015/16	2016/17 (Apr to Feb 2017)	National average 2016/17 (Apr to Feb 2017)	National position 2016/17 (Apr to Feb 2017)
WSHFT	21.40%	30.70%	25.80%	35.00%	24.20%	41st of 175 (23rd centile)
Worthing	20.90%	30.80%	29.50%	42.10%	24.20%	N/A
St Richard's	21.90%	30.60%	25.20%	27.60%	24.20%	N/A

N.B. 2016/17 figures presented are Apr to Feb 2017 only. 2015/16 data in this table provides full year information; 2015/16 data in the Quality Report 2015/16 provided available data from Apr to Feb 2016 only.

Figure 36. Friends and Family Test – Inpatients % of patients who would recommend WSHFT

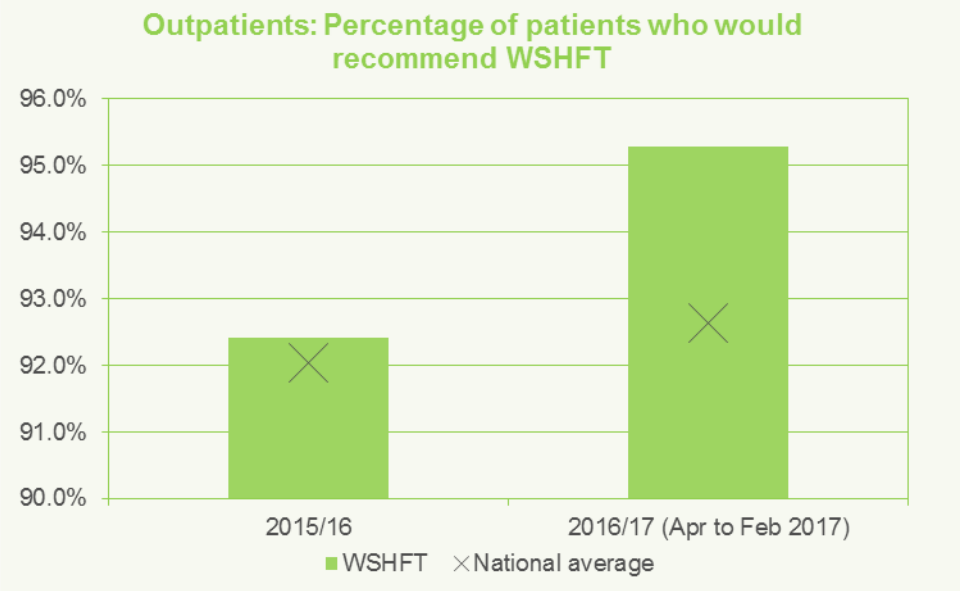


Out Patients

The number of surveys completed for outpatients has continued to grow since their introduction in 2014/15.

In 2016/17, 17,709 surveys were been completed compared to 10,699 in 2015/16. The recommend rate has increased from 92.4% to 95.3% in 2016/17 (as of February 2017) which is above the national average for the same period (92.6%).

Figure 37. Friends and Family Test – Outpatients percentage of patients who would recommend WSHFT



N.B. 2016/17 figures presented are Apr to Feb 2017 only. 2015/16 updated from last year's report where only Apr to Feb figures were available.

~ Streamlining our Feedback Mechanisms

We have put 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 real-time patient experience survey system (RTPE) to capture the majority of our FFT feedback including: SMS[69] feedback for our A&E departments, all outpatient and day case areas. We still have a dual approach for our inpatient wards; however since April 2016 all feedback has been captured through one survey system. This will allow us to amalgamate results in key areas across a range of surveys.

During 2016/17 we completed a total of 3728 real-time inpatient surveys and achieved an overall inpatient satisfaction of 80.82% against a target of 84%. The common reasons for in-patient dis-satisfaction are noise at night, patient's rating of food and lack of information relating to their discharge from hospital. Ward and departmental leads receive detailed feedback each month, including every patient comment and question score which enables them to set local improvement goals for areas identified as being a concern.

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

We will continue to undertake real-time surveys and track our progress against these challenges. Our goal will be to achieve the objective of 97% inpatient FFT recommendation rates in 2017/18.

Table 17. RTPE inpatient satisfaction

	2014/15	2015/16	2016/17	2016/17 target
'Overall inpatient satisfaction'	81.72%	81.03%*	80.82%	84%

** This figure was reported in error in our 2015/16 Quality Report as 84%.*

~ 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 34 ward / department visits since April 2016.

We conducted an external learning disability review in September 2016 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.

Focus on Patient First: Hospital in-patient birthday celebrations

The Trust's ethos of 'Patient First' really has spread through the organisation across clinical and non-clinical areas. Tim Short, a Senior Developer with the Trust's Informatics Team, suggested alerting wards with details of any in-patients who had a birthday coming up. He thought the idea would at least allow staff to say 'Happy Birthday' to their patients if not do something more special, like in the case of patients staying on our children's wards.

Our amazing group of Trust Ambassadors took the idea one step further and Katrina O'Shea, Matron for Patient Experience, and colleagues developed a process by which patients staying in hospital over their birthday receive a personalised birthday card and birthday muffin as a surprise on their lunch time meal tray.

Birthday muffin

The new initiative was piloted in March this year on Becket and Coombes wards and was swiftly followed by a Trust-wide launch for which the service has run seamlessly ever since. Tim said "Just a thought which might make a patients stay slightly brighter".

Our Quality Improvement Programmes for 2016-17

Last year we committed to delivering further continuous improvement in patient experience through a number of focused quality improvement programmes including:

Improved Patient Experience Programmes 2016/17	Target Achieved/ On Plan	Close to Target	Behind Plan
Discharge improvement programme	Improvements in discharge are included in the strategic programme addressing **Non-Elective Flow** which can be found on page 178.		
Improving mealtime support / nutrition		▲	
Improving privacy / provision of private areas	Improving privacy and provision of private areas are included in the **End of Life Care Programme** which can be found on page 48.		
Improving communication with a particular focus on access and outpatients	▲		
Improving experience of young people receiving care across the Trust	▲		

Improving Mealtime Support / Nutrition

Aim: To Improve Mealtime Support / Nutrition

Target: For all elderly care wards to introduce a standard nutritional board that highlights any patients that are at risk of malnutrition and require assistance at mealtimes. Recruitment of additional dining companions to support wards in providing mealtime assistance.

By when: March 2018

Progress: Close to target

The aim of the improvement work on nutrition is for staff and patients to experience a clear well–led process every mealtime.

Poor nutrition increases morbidity and mortality, prolongs length of stay in healthcare environments and increases costs of care. It has been estimated that 40% of adults admitted to acute hospitals and care homes are at risk of malnutrition and 66% of patients lose weight while in hospital. Patients in hospital often have increased nutritional requirements caused by their medical condition, as well as more barriers to achieving those requirements such as reduced appetite, pain or impaired physical status.

We run a 'Dining Companions' scheme to support wards in providing mealtime assistance with the help of non-clinical staff volunteers. The Dining Companion role is very valuable in supporting patients to feel better; alongside delivering meals, volunteers sit with and talk to patients who benefit greatly from the engagement and social interaction this provides. All Dining companions who assist patients with eating and drinking receive training from the Dieticians and Speech and Language teams and also go out with a buddy for their first visits to ensure they feel comfortable taking on the role.

The facilitation of a timely meal service will potentially reduce complaints, length of stay and help ensure good outcomes for patients. Visible leadership during mealtime service will result in staff encouraging patients to eat and supporting them during meal times.

Our goals in 2016/17

The matrons engage ward staff to follow the mealtime standard in order to improve the support of patients at mealtimes. The impact was measured through improved patient satisfaction rates with hospital food. To contribute to improving patient satisfaction rates, we aimed to assess 90% of all adult patients using MUST (Malnutrition Universal Screening Tool), a nutritional screening tool to identify adults who are malnourished or at risk of malnutrition, within 24 hours of admission.

We aimed to scope, design and introduce a standard nutritional board to all elderly care wards to provide a visual reference for staff to cross check that they are serving the correct food and providing an appropriate level of assistance to the patients.

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 lunchtime. Further identification of wards and departments where mealtime support is required by Dining Companions with further recruitment and training of additional staff volunteers. We will link more closely with real time data coming from Inpatient feedback to provide support where required.

Improvements achieved 2016/17

We have monitored our performance with our real time surveys throughout the year but have not been able to maintain a satisfaction rate of 90% for assistance at mealtimes throughout 2016/17. Observing care in action has shown that there is a variable process at mealtimes across the trust which is dependent on the staff that are on duty each day. A mealtime standard has been created by matrons and the ward managers for Trust wide use to clarify how mealtimes should be managed.

MUST assessments are being completed in a more timely way now that they are recorded on Patientrack; we have improved our assessment rate within 24 hours of admission from 55.70% to 83.80% over the year to date. The introduction of a weekly report has provided additional opportunities for senior staff to help the ward teams to focus on how they can ensure that the MUST assessments are completed within 24 hours of admission.

Figure 38. Patient satisfaction with mealtime assistance

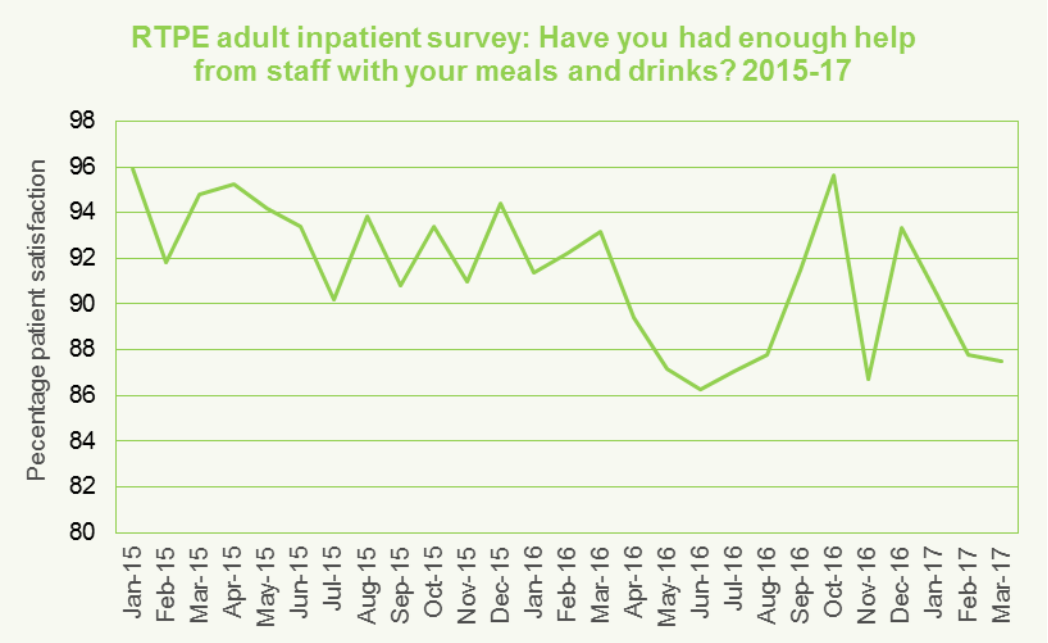
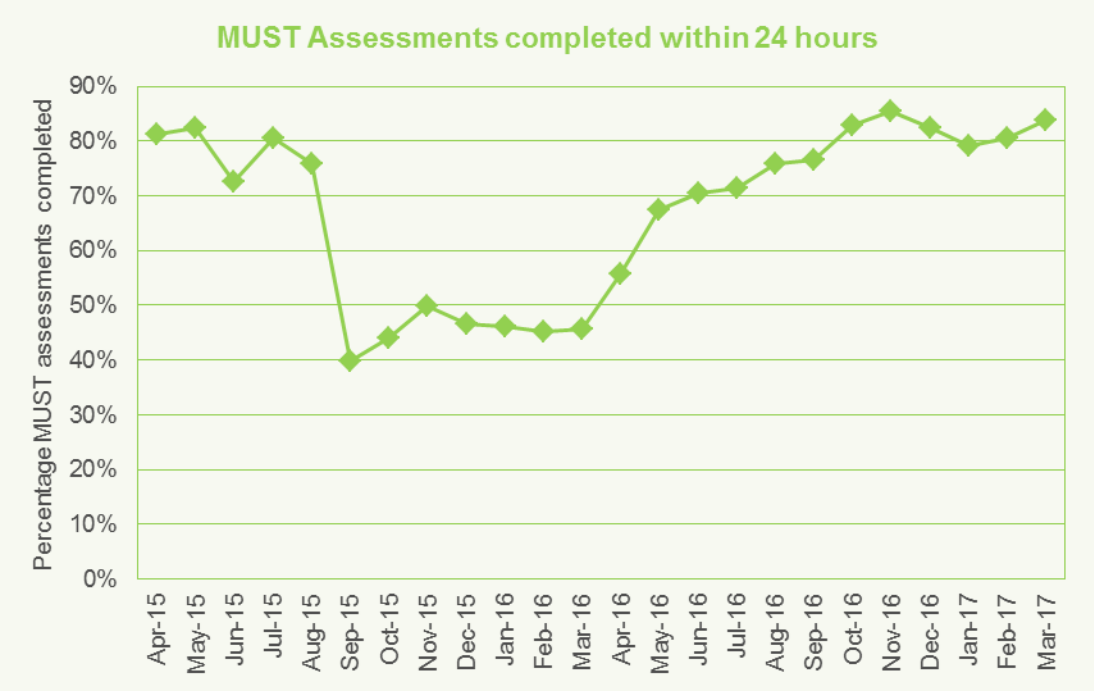


Figure 39. Percentage of completed MUST Assessments within 24 hours in 2015-17



Ideas have been gathered from teams of staff in relation to the design of a standard nutritional board for the elderly care wards. The proposal is for the nutritional boards to be displayed in the location that the food is served from on each ward and it is intended that they will be used as a visual reference for staff to cross check that they are serving the correct food and providing an appropriate level of assistance to the patients. The boards will

identify patients who are:

- losing weight in hospital,
- have an outstanding MUST assessment,
- in need of assistance with their meal.

Displaying this information will ensure senior nurses can quickly identify whether additional staff are required to maintain a good standard of assistance to help patients to eat. High MUST scores are an indicator of our patient's frailty and nursing dependency and this is an objective way of sensing the overall care needs of the patients on any given ward. The approach will also reinforce the link between the result of the patient's nutritional assessment and actions thereafter.

Dining companions continue to support wards in providing mealtime assistance. Whilst the number of mealtime dining companions has remained steady with a mixture of both public volunteers who give their time freely and staff companions who have found time where possible to provide help, unfortunately many of the recruited Staff Dining companions have often been limited or often unable to be a companions due to the challenges and constraints experienced within their own working roles. However during times of recent Business Continuity many staff dining companions have again come forward to support patients and colleagues in the busiest of circumstances. Training for Dining Companions is now included on the Volunteer Induction days and these sessions are able to be accessed by Staff Volunteers also.

Further improvements identified

We will continue to work on developing our standard nutritional boards and aim to implement them across all elderly care wards in 2017/18.

A review of the Volunteer service is currently underway with hope that this may allow for the recruitment of more public volunteers who can support this initiative. It is hoped to increase the recruitment of Volunteers both Public and Staff to further support the Dining Companion scheme. The volunteer team will continue to work with both Wards and the Patient Experience team to identify where more volunteers are needed and then look to recruit to these roles.

Improving Communication with a particular focus on Access and Outpatients

Aim: Improved communication with a particular focus on Access and Outpatients

Target: Increased responsiveness to telephone calls regarding appointments

By when: March 2017

Progress: On plan

Real-time surveys and comments from our Friends and Family Test results show communication and information continues to be a challenge.

The most common area of concern for outpatients relates to communication regarding patient waiting times when booking appointments via the call centre, missed appointments and waiting time to be seen in our Outpatient Departments.

The most common areas of concern for inpatients relates to communication about discharge planning and medication.

Our goals in 2016/17

Access and Outpatients

- Increased responsiveness to telephone calls regarding appointments
- Improved communication about waiting time in outpatient clinics: goal 100% display of waiting times on white boards.

Inpatients

- Discharge planning: involving patients (and where appropriate their relatives and carers) in discussions about their discharge: goal 70% patient satisfaction as monitored by our real time survey system.
- Information about medications, in particular explanations regarding side effects of medications and what dangers to watch out for: goal 90% patient satisfaction as monitored by our real time survey system.

Improvements achieved 2016/17

Access and Outpatients

- Voice Message reminders in all areas for appointments
- Improved response times for telephone inquiries
- Standardisation of white board in each area which includes information on running time of clinic
- Verbal communication on arrival when checking in as to whether the clinic is running late
- Nursing staff updating patients every 15 minutes verbally if there were any changes
- Improving response rates for completion of Family and Friends Test
- Displaying patient results from the surveys

We have seen an encouraging improvement in voice reminders for appointments and the response times in answering calls in the call centre. Monitoring for communications of waiting times in OPD is completed via audit and responses through the patient survey and have shown that we have yet to achieve 100% display of waiting times on white boards. We acknowledge that there are still elements that can be improved and continue to monitor and use feedback to inform changes.

Figure 40. Average time to answer Two Week Rule

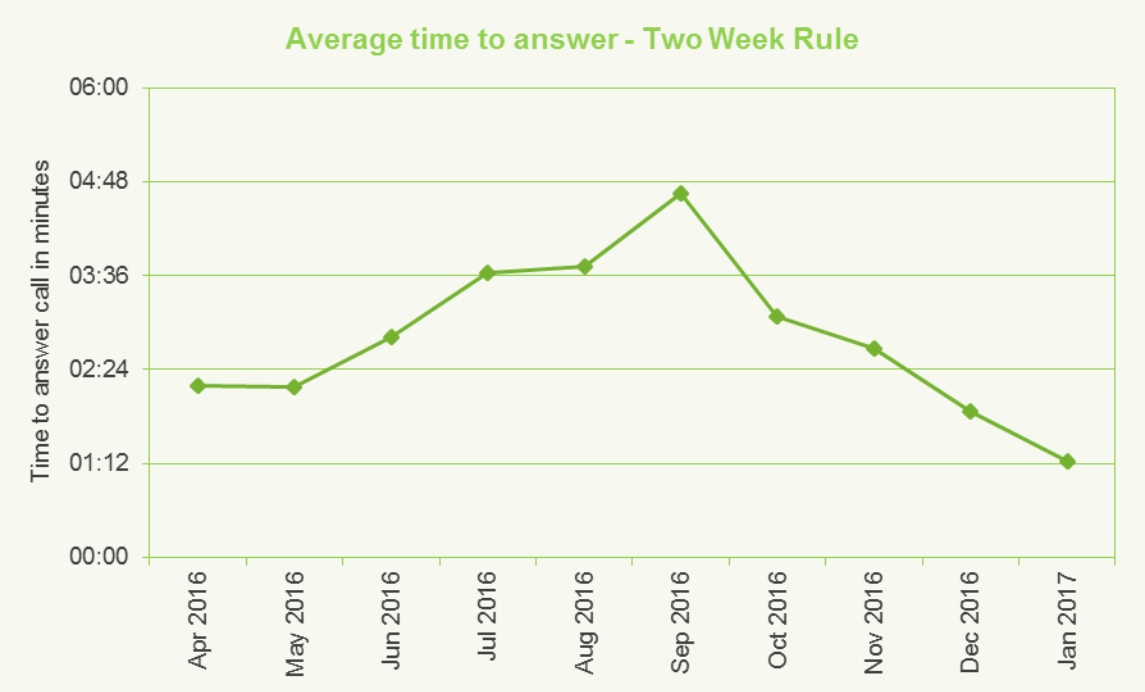
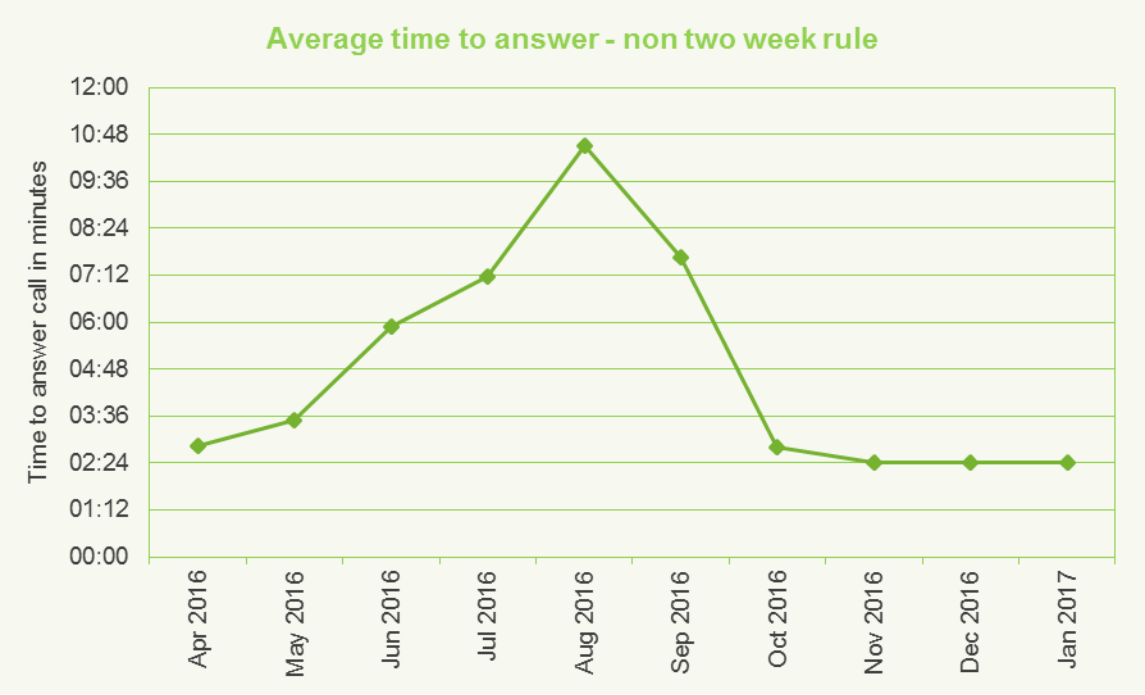


Figure 41. Average time to answer non-Two Week Rule



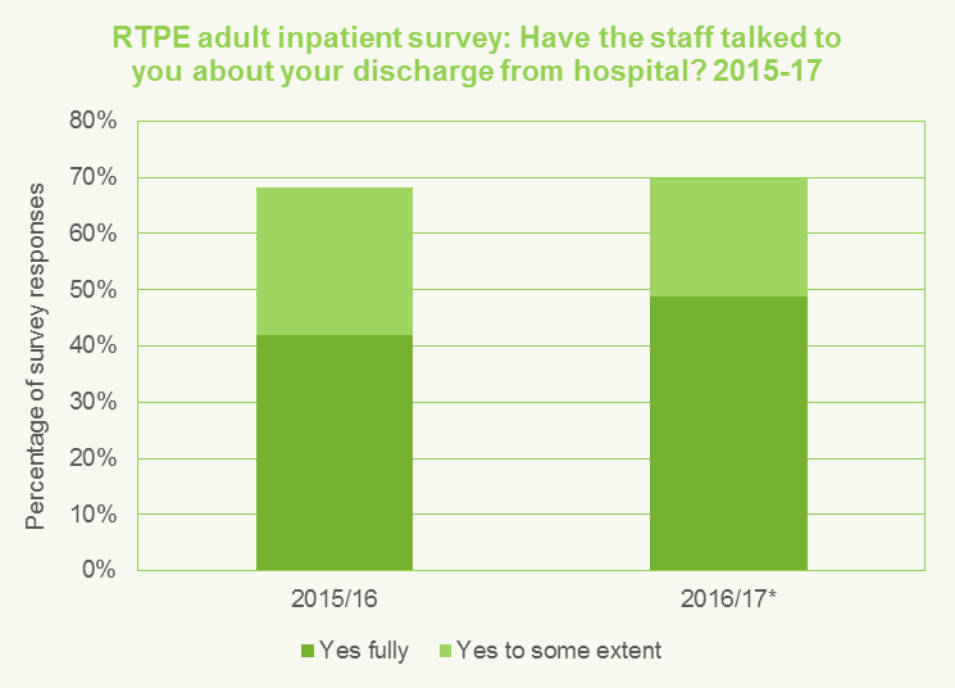
The Trust has initiated a large **Outpatient Improvement** strategic programme making improvements across outpatient referral and booking processes – page 173.

Inpatients

We used the real time survey system to monitor our performance through the year with challenging targets for improvement in the responses to questions relating to discharge planning and medicines information. We did not meet the ambitious targets we set, but nevertheless delivered satisfaction scores as follows:

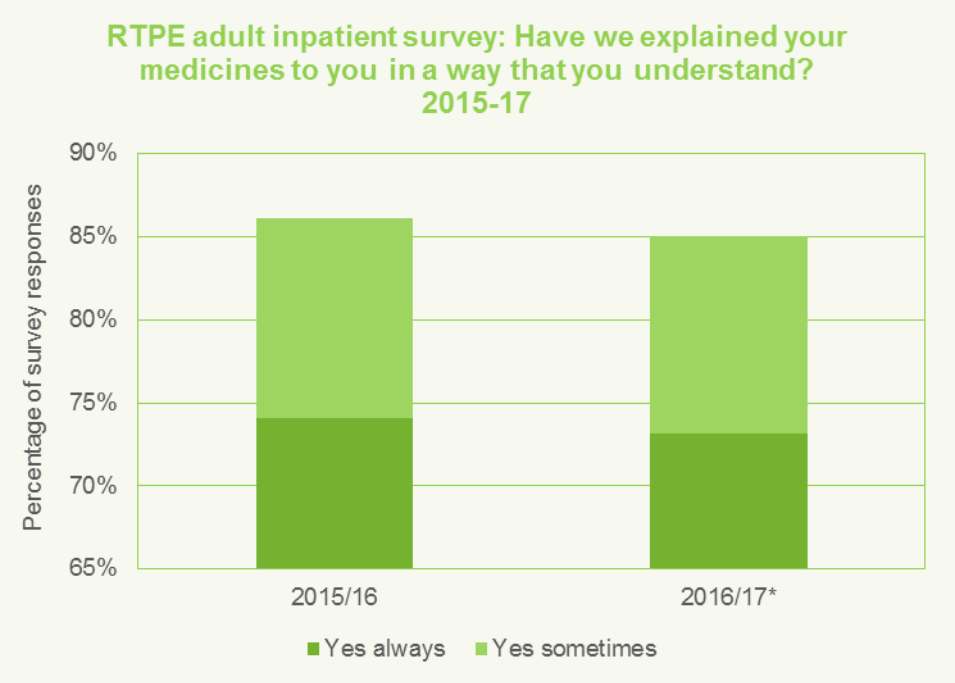
- Involvement in discussion about discharge (goal 70%): patient satisfaction score in 2016/17 (to February 2017) 69.82%
- Explanations about medications (goal 90%): patient satisfaction score in 2016/17 (to February 2017) 85.02%

Figure 42. Patient satisfaction regarding involvement in discussion about discharge



** N.B. 2016/17 data is from April 2016 to February 2017 only.*

Figure 43. Patient satisfaction regarding explanations about medications



** N.B. 2016/17 data is from April 2016 to February 2017 only.*

Between April 2016 and February 2017, 4274 patients were asked: Have we explained your medicines to you in a way that you understand? The patients gave this a satisfaction rating

of 85.02%. A total of 224 comments were recorded: of these 34 (15%) relate to confusion/lack of clarity on medication and 28 (13%) note poor communication as a problem.

More generally the patient medication helpline continues to receive 15-20 calls per month from patients with queries after discharge. Plans are being explored over the coming year to develop post-discharge communication and referral to community pharmacy for targeted patients; this will prompt the medicine usage review service provided by community pharmacists.

Further improvements identified

The most common reason that patients cite formal complaints is due to co-ordination of medical treatment and this is the causal factor in Surgery, Medicine and Women and Children's Division's. The specialties that receive the most complaints have been identified within the divisions so that focussed improvement work can be undertaken. In Surgery this is trauma and orthopaedics, in Medicine this is A&E and acute medicine (Emergency Floors), in Women and Children's this is split equally between obstetrics and gynaecology services.

An increased risk to patient safety has been identified, through incident reporting, when patients are initiated on New Oral Anti-Coagulants under the care of WSHFT. These medicines carry similar risk to warfarin but do not have the formal pathways of long term monitoring and review and are less well understood and recognised by patients. In order to improve patient understanding and reduce the likelihood of significant risk, work is underway to develop a more comprehensive pack of information and a counselling checklist for patients taking these medicines. Guidelines will clarify roles of medical, pharmacy and nursing staff in educating patients and clear documentation of counselling will be used to ensure that all patients receive the necessary information.

Discharge Lounge offers new service

The Discharge Lounge teams at Worthing and St Richard's relaunched the service they provide in January 2017 so more patients can benefit from their facilities at the end of their stay in hospital. Increasing the use of the discharge lounges will also improve patient flow and the quality of care the Trust provides.

Rien Moore, care group manager for Medicine, said: "The teams have been working exceptionally hard to bring their services into line with each other and we are very excited to be relaunching the Discharge Lounge service. We know that if more patients are discharged earlier in the day to the lounges, we will be much better able to meet the demand for ward beds from our emergency and assessment units. However, in the past, there has sometimes been a mismatch between what the patients and ward teams require and what the lounges have been able to offer – but we are confident the new service addresses most of these issues."

The Discharge Lounge can now take patients that can transfer with two people, as well as patients on oxygen or with a dementia, subject to an assessment by the lounge team. They will also phone through district nurse referrals, talk to One Call (our partner service facilitating access to urgent care services in the community), arrange transport and give medication or injections.

Discharge Lounge poster

Katrina O'Shea, Matron for Patient Experience, is clear that refreshed discharge service is better for our patients. Katrina said "patients using the Discharge Lounge service will have dedicated staff looking after their discharge from hospital. This means that patients using the service can expect to be discharged earlier in the day, allowing them more time to settle in back at home. There is also free car parking for those coming to Worthing to collect patients discharged via the lounges, benefiting both patients and carers. In addition, every patient that uses the Discharge Lounge is helping another patient. Using the facilities at the discharge lounge releases beds on wards for new patients so that we can care for all of our patient's as safely as possible."

A recent survey revealed that 98% of patients are "extremely satisfied" with their discharge

lounge experience, which includes hot meals and drinks.

Medical Director Dr George Findlay said: "Every day we have patients in A&E and on the Emergency Floors who need the specialist care our ward teams provide, but often those same patients have to wait for beds to be released because others are waiting to be discharged. By referring these patients earlier in the day to the lounges, our specialist ward teams will be freed up to admit and provide more timely, quality care to those most in need."

The improvements introduced to the discharge lounge service contribute to a series of Patient First initiatives within the Systems & Partnerships strategic theme, all aimed at improving patient flow from admission to discharge.

Improving Experience of Young People Receiving Care across the Trust

Aim: Improved Experience of Young People Receiving Care across the Trust

Target: To ensure children and Young people have the same outstanding experience where ever they are seen in the Trust

By when: March 2017

Progress: On plan

The Children's Board was formed during 2016/17 to support and enable the development and delivery of the Trust's strategic objectives for child health services across the Trust:

- To create a networked approach to general and subspecialist surgical services for children and young people, ensuring the WSHT is able to meet best practice standards, such as those seen in 'Are we there yet'[70].
- To establish joint working partnerships with primary and community care providers, to enable safe care for children and young people along the urgent care pathway.
- To create a sustainable solution for A & E services for children and young people, ensuring best practice standards are fully met.
- To develop robust transition arrangements for all young people into adult services, and supportive mechanisms for young adults.
- To ensure children and young people's outpatient services are provided in designated child appropriate areas, and the facilities and staffing centre around their needs.

Our goals in 2016/17

Work streams actively monitored through the Children's Board in 2016/17 were:

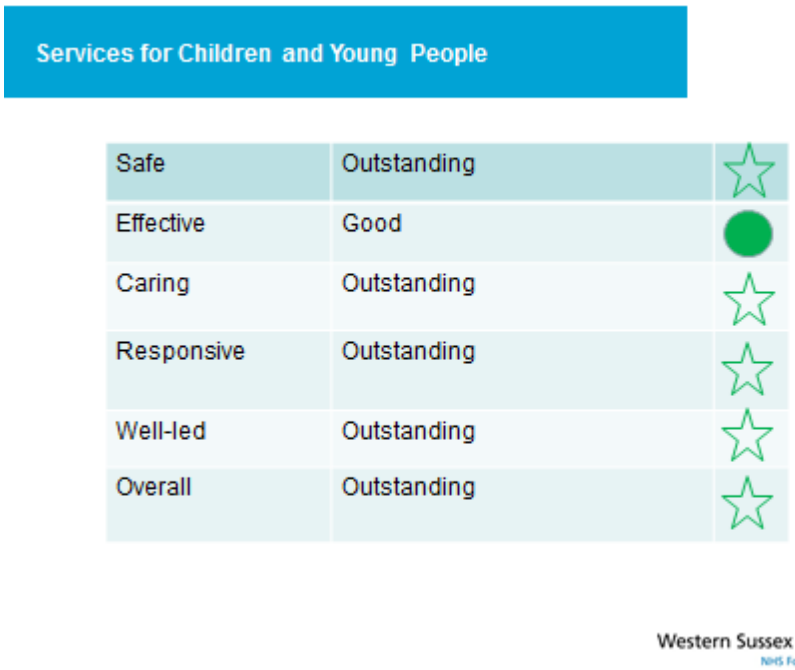
- A & E and urgent care
- Child and Adolescent Mental Health Services and transition into adult care
- Children with disabilities
- Neonates
- Surgical specialities
- Outpatients
- Harvey's Gang

[70] http://www.ncepod.org.uk/2011report1/downloads/SIC_fullreport.pdf

Improvements achieved 2016/17

The Care Quality commission rated Children's Services as Outstanding, as identified below.

Figure 44. 2015 WSHFT CQC rating for Children and Young People



Following our Outstanding rating we continued to focus on this area through quality improvement. Our achievements in 2016/17 included:

- Surgical representation at Children's Board.
- A networked approach to surgical care has developed with both Brighton and Southampton surgeons linking with paediatric day surgery at St Richards' Hospital.
- An audit into surgical care was been undertaken and will shortly be presented at the next joint surgical/paediatric clinical governance half day.
- The lead consultant for mental health is now attending the Trust's Mental Health Board to help to progress the difficulties in assessing and treating young people with extreme mental health needs.
- We have rolled out the principles of 'Ready ,Steady, Go'[71], a preparation programme designed to prepare young people with ongoing needs for adult health services, and to gain independence.
- A Clinical Governance half day was jointly provided between Medicine and paediatrics to support the provision for the care over young adults cared for in Adult wards

[71] http://ep.bmj.com/content/edpract/100/6/313.full.pdf

- Harvey's Gang continues to develop its work both within the Trust and nationally.
- A Kaizen-supported project looking at efficiency in outpatients has been launched to consider referral pathways, so that children are seen by the right person at outset, which we hope will negate the need for follow up

Further improvements identified

The Children's Board acts as the decision making forum for adding to or completing the work streams, and the next meeting will define the 2017/18 work streams, but those identified in 2016/17 will continue until all actions complete. It is likely that Neonatology will feature as a dominant field next year.

Driving to theatre in style! World's Smallest Rolls-Royce donated to St Richard's Hospital.

Welcoming the Rolls Royce SRH

Children at St Richard's are now arriving for surgery in style – driving the world's smallest Rolls-Royce to the operating theatre. The appropriately-named Rolls Royce SRH was delivered to the hospital last Wednesday by the luxury car manufacturer, who built the handmade vehicle especially for patients in the paediatric day surgery unit.

Preparing for an operation can be daunting for younger patients so staff do all they can to make it a fun experience. At St Richard's, children have enjoyed the distraction of driving a toy car to surgery for years, so when the jeep they had been using began to tire the Trust's Love Your Hospital charity approached Chichester-based Rolls-Royce to provide a replacement. Amanda Tucker, head of charity at Love Your Hospital, said: "We asked Rolls-Royce Motor Cars at Goodwood if they could help us replace an old scale car in the children's unit but we never expected to receive such an incredible gift." "The company's employees volunteered hundreds of hours of their own time to hand-build this remarkable electric vehicle which will delight boys and girls coming to hospital for treatment."

The Rolls-Royce SRH will allow children awaiting surgery to drive themselves to the operating theatre through the paediatric unit corridors, which are lined with 'traffic signs'.

GOAL 3: Improved Patient Experience - Improvement Programmes for 2017-18

Improving patient experience is a central objective for all our improvement work. We have set a True North Trust-wide long term goal to achieve 96% recommendation for Friends and Family Test feedback, and reduce 'not recommend' rates. Departments within the Trust have different aspects to focus on depending on their patient experience themes.

- Improvement huddles are being implemented as part of the Patient First Improvement Programme across the Trust to empower staff to resolve recurring issues that lead to a poor patient or staff experience. We will also be developing our ability to correlate staff experience with patient experience to enable a greater understanding of where improvements can be made. Our priority area for next year will be to focus on improving communication.
- Our forward improvement focus addresses reduction in complaints and improving the timeliness of complaint responses. We are also focused on improvement projects where we see trends in poor patient experience. Projects include improving discharge experience and improving outpatient appointment booking experience.
- Improving experience of young people receiving care across the Trust through the Children's Board recommendations with a particular focus on improvements in children's outpatient care.

We have developed a new Quality Improvement Programme to focus on reducing complaints and improving the timeliness of complaint responses. We will continue to develop our approach to empowering staff to resolve recurring issues that lead to a poor patient or staff experience through the Patient First Improvement Programme.

❖ Improving communication

A majority of the complaints received are due to poor communication. Although there has been training workshops in the past they still haven't tackled the recurring problem of communication complaints. The top five reasons patients complain about oral communication are:

1. Lack of clear explanation patient's state they were uninformed of what to expect.

2. The manner in which the message is conveyed.
3. Poor co-ordination of medical treatment.
4. Patients not being verbally told things (e.g. risks, options and timeframes of treatment).
5. Treatment didn't have expected outcome.

Additional staff training is needed to address these negative themes around communication and deliver continuous improvement. The specific audience for additional training should be the middle grade managers and Consultants. This is because our managers need to role model the best communication habits in order to support and develop junior members of staff. Workshops will be delivered in a dynamic and thought-provoking way that will challenge participants to look at their own communication style, reflect on the effectiveness of their interactions and plan for changes that can be implemented back in the workplace. This approach is intended to raise staff's self-awareness of their communication style and improve the impact and effectiveness of their communication.

Patients also frequently comment upon the lack or real time updates of

1. Appointment delays
2. Discharge dates
3. A&E waiting times

Actions are required to provide information about waiting times, delays and discharge dates so that this much required information is provided consistently to patients and their families.

❖ Reducing complaints and improving the timeliness of complaint responses

A new complaints process was trialled in Surgery division in April 2016 to address why previously only 15% of complaints were responded to within 25 working days. A Care Group Manager or a Matron now calls the complainant within 48 hours of receiving the complaint. This new way of working has led to 40% of complaints being responded to within 25 days. This process was implemented within the medicine division in Oct 2016 with a view to this becoming standard work across the Trust. The impact is shown below:

- Quicker resolution and satisfaction of issues that historically took months to close down
- Improved speed of response in reply to formal complaints
- Significant reduction in formal complaints
- Improved working relationships between division and complaints team

- Streamlined process as a result of all complaints now going to two people in division (CGM and Matron) instead of all staff involved, potentially up to 10 staff with no knowledge in complaints team of ability to respond and/or in a timely way. CMG and Matron now able to direct to right people and have authority to ensure timely responses.

A Trust breakthrough objective for improving patient experience is due to be considered for 2017/18 as part of deploying our Patient First Improvement Strategy. We have proposed that divisions work toward achieving a target 30% - 40% reduction in the number of formal complaints (this is subject to ratification by Trust Board).

Complaints performance

Table 18. Formal complaints referred to the Parliamentary Health Service Ombudsman

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Number of new cases referred in year**	15	16	17	17	28	14
Declined/not upheld*	13	12	13	13	14	7
Further local resolution taken by the Trust*	1	4	2	-	-	1
Upheld/recommendations (partially or in full)*	1	-	2	4	14	2
Decision awaited*	-	-	-	-	-	4

**Figures reported relate to complaint outcomes within the given year; due to the time taken for cases to be referred and reviewed by the Parliamentary Health Service Ombudsman the majority of these complaints will not have been referred within the year they are reported.*

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

2.1.6 GOAL 4 – Improving Staff Engagement

GOAL: To be in the top 20% performing acute NHS trusts in the country – NHS Staff Survey engagement score

'Our People' is a strategic theme in our Patient First Programme; we cannot deliver Patient First without engaging really well with our staff.

We have set an ambitious target to be in the top 20% of acute trusts for NHS Staff Survey engagement scores.

We have identified that the key elements that make up our staff engagement score are:

- Staff recommendation of the trust as a place to work or receive treatment
- Staff motivation at work
- Staff ability to contribute towards improvements at work

Last year our breakthrough objective (i.e. an objective that can be translated across all staff groups) was to increase the number of staff who feel they can make improvements in their area of work.

In 2017/18 we will continue to focus on the breakthrough objective with those departments where the percentage of staff who feel unable to make improvements happen in their workplace is lowest. We will also strengthen the development programme for our clinical leaders and operational managers to equip them with the tools needed to facilitate great staff engagement. This will include coaching, Lean improvement methodology, change management, effective rostering and good human resource management.

Why is this important?

Staff determine the experience of their workplace and organisation by the many interactions, or not, with their line manager. Effective team working, led and managed by great leaders, delivers better outcomes for patients and increases staff productivity and satisfaction.

How do we monitor it?

The national NHS staff survey assesses the quality of staff experience through a number of questions linked to the NHS Constitution. Scores range from 1 to 5, indicating low to high engagement.

Through our monthly annual health and safety updates for staff, we ask staff to complete a questionnaire that replicates the nine questions that determine the engagement score. This is monitored by division and by key staff group.

How do we report on it?

NHS Staff Survey data is reviewed by the Trust Board and the Trust Quality Board. The monthly composite engagement scores are reported through Clinical Divisional Boards. During 2017/18, the results against each of nine questions will also be available to inform the development of a focused action plan and appropriate intervention.

Where are we now?

During 2016/17, the Trust's engagement score improved from 3.78 to 3.88, above the national average of 3.81.

For the sixth year, the Trust rolled out the NHS staff survey to all permanent staff and achieved its highest response rate of 59%, an increase of 5% on last year.

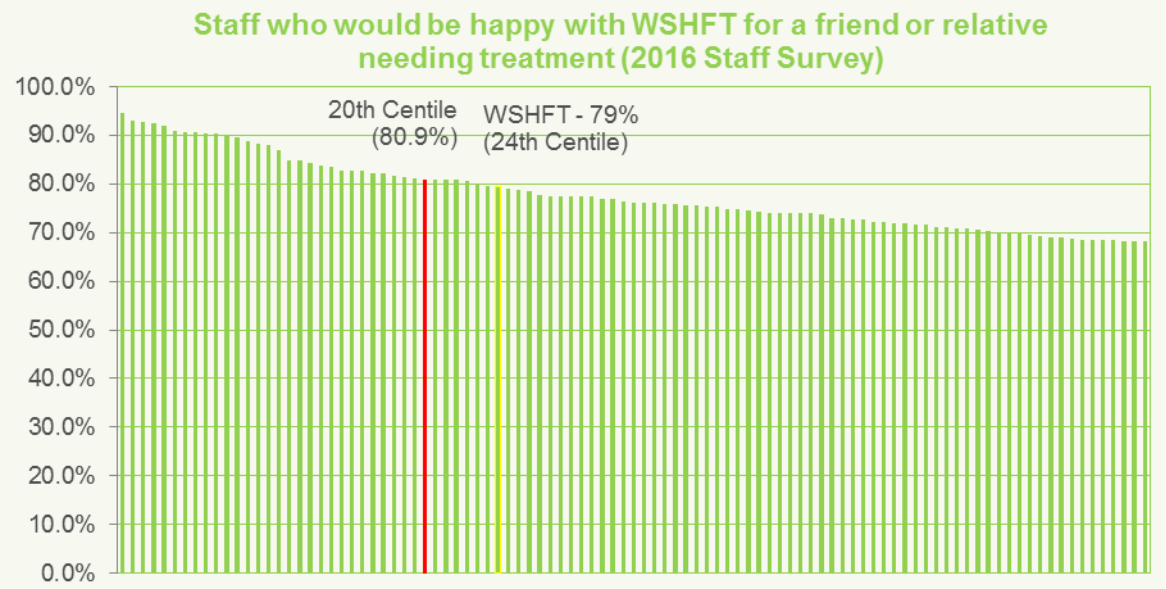
Table 19. 2016 NHS Staff Survey results WSHFT

		Your Trust in 2016	Average (median) for acute trusts	Your Trust in 2015
Q21a	"Care of patients / service users is my organisation's top priority"	**82%**	76%	**77%**
Q21b	"My organisation acts on concerns raised by patients / service users"	**76%**	74%	**73%**
Q21c	"I would recommend my organisation as a place to work"	**72%**	62%	**65%**
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	**79%**	70%	**73%***
KF1	Staff recommendation of the trust as a place to work or receive treatment (Q21a, 21c-d)	**3.98**	3.77	**3.82**

Source: 2016 NHS Staff Survey

** This figure was reported in error in our 2015/16 Quality Report as 71%.*

Figure 45. 2016 Staff Survey – percentage of staff who would be happy with WSHFT for a friend or relative needing treatment



Staff Survey highlights impact of Patient First

The Right Honourable Lord Prior, Minister for NHS Productivity, *attending a Patient First improvement huddle.*

This year's NHS Staff Survey results have given another important vote of confidence to the Patient First programme at the heart of our efforts to continue improving patient care. The headlines from the survey are that results at Western Sussex improved year on year across all 32 of the 'key finding' measures assessed, and put us in the top 20% of acute trusts on four of these:

- Recommendation of the organisation as a place to work or receive treatment
- Organisation and management interest in, and action on, health and wellbeing
- Satisfaction with opportunities for flexible working arrangements
- Belief that the organisation provides equal opportunities for career progression and promotion.

Just as importantly, analysis of some of the important individual questions contributing to these key findings, and a breakdown of responses across our six divisions, gives a clearer picture of the positive impact Patient First is having. The trust has identified nine key Staff Survey indicators of engagement that are most important in creating the working environment needed for positive, patient-centred change to take place. These include agreement with statements around opportunities to show initiative, ability to make improvement suggestions and, most important of all, ability "to make improvements happen in my area of work". Overall, our results on most of these measures are around the national average, but in the Medicine and Surgery divisions, on which Patient First has focused so far, we have seen some major increases in positive sentiment between 2015 and 2016.

For example, in Surgery, the proportion of respondents agreeing that they have frequent opportunities to show initiative in their role increased by 10 percentage points to 76%. Ability to make suggestions to improve my team/department's work saw an eight-point improvement to 75%, while the key 'ability to make improvements happen' measure was also up eight points, to 53%. And recommendation of the trust as a place to work jumped 13 points to 72%.

In Medicine, starting from a higher baseline in 2015, recommendation as a place to work was up eight points to 75%, ability to make improvement suggestions increased by three (to 77%) and ability to make improvements happen was up by four (55%).

These two divisions have so far seen 17 wards, theatres at St Richard's and Worthing, and outpatients across all three sites enter the Patient First Improvement System (PFIS), a whole-department training programme that uses Lean management techniques to develop people's ability to problem solve, eliminate waste and improve services on a continual basis. They have also benefited from targeted improvement projects designed to address specific issues where potential for significant service improvements or patient experience gains has been identified.

Chief executive Marianne Griffiths said: "We know that levels of staff engagement are key to an organisation's ability to improve: if people feel positive about their work, that they have a voice in what happens in their team, and are empowered to drive through change themselves, then improvement happens quickly and often. If they don't feel this way, then it doesn't." "So what the results across Medicine and Surgery are telling us is that as Patient First becomes more embedded, then staff engagement improves significantly and we have a launch pad for further improvement again."

Women & Children is the next clinical division due to join PFIS, which will then expand into areas providing direct frontline clinical support such as pharmacy, estates, pathology and housekeeping. Areas such as HR, safety and IT will then follow.

Areas identified for improvement were principally related to experience of physical violence, staff feeling pressure from managers, colleagues or themselves to come in to work despite feeling unwell, and quality of non-mandatory training.

Our Quality Improvement Programmes for 2016-17

Last year we committed to delivering further continuous improvement in staff engagement through a number of focused quality improvement programmes including:

Improved Staff Engagement Programmes 2016/17	Target Achieved/ On Plan	Close to Target	Behind Plan
Patient First Quality Improvement Programme	▲		
Workforce Transformation Programme		▲	
Development of Clinical Academic Pathway	▲		
Health and Wellbeing Programmes	▲		

Patient First Improvement Programme

Aim: To roll out the Patient First Improvement Programme across all clinical areas of the Trust

By when: March 2018

Progress: On plan

The overall aim of the Patient First Improvement Programme is to develop a 'Trust-wide' network of Lean professionals and teams empowered to solve problems, improve processes and pathways using Lean tools, which is sustainable and shows tangible benefits for Patient care, service and experience.

As part of this, the capability pillar aims 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 enables 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 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 includes a session on the Patient First Improvement Programme and staff are introduced to some key concepts and practices in Lean healthcare as well as reinforcing Trust values and overarching objectives ('True North').

There is also 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 and staff attending the training are expected to deliver small projects aligned to Trust objectives. Those undertaking larger projects are 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 is the development of a community of Lean Practitioners within the Trust who participate in continuous professional development within the Lean Improvement arena, creating a sustainable internal resource to support the Patient First Improvement Programme.

This training sits alongside and supports the rollout of the Patient First Improvement System (PFIS), the Trust's Lean Management System. Over the course of 3 months wards and departments supported in implementing Lean improvement tools such Status Sheet Exchanges, Standard Work and Daily Improvement Huddles to ensure the benefits achieved by larger improvement projects are supported and sustained by daily continuous improvement and standard work.

Our goals in 2016/17

Implementation of Patient First Improvement Programme in line with overarching plan.

Improvements achieved 2016/17

- Rollout of Patient First Improvement System to 14 wards and departments (seven further with training underway).
- Delivery of twice weekly Lean Awareness / Patient First Introduction sessions as part of Trust annual mandatory training update (over 4000 staff trained in the year to April 2017), and training of over 200 staff to Yellow-belt level and 18 staff to Green-belt.
- Delivery of six 'Green-belt projects' and supporting a number of additional projects aligned to key Trust objectives (e.g. delayed discharges from ITU, falls reduction, sepsis).

Further improvements identified

- Increased alignment of Yellow-belt training to project delivery: 100% of yellow belt graduates will be involved in the delivery of a project aligned to Trust priorities.
- Training of second cohort of Trust staff to Green-belt level with delivery of appropriately scaled and aligned projects.
- Development of Trust Lean Practitioners (Patient First Kaizen Office) towards Black-belt status.
- Rollout of Patient First Improvement System to 18 further wards and departments.

Workforce Transformation Programme

Aim: To reduce the volume and cost of agency staff by 10%
To achieve agency cap compliance and expenditure
To reduce the number of unfilled vacancies across the Trust (to be agreed by staff group) by recruiting to them substantively or filling in a different way

Target: To reduce the volume and cost of agency staff by 10%

By when: March 2017

Progress: Close to target

During 2016/17, and as part of the Sustainability breakthrough objective, a lot of work has been spent reducing the reliance on agency staff. Whilst there has been a shift towards capped compliance, the majority of suppliers remain above capped rates. This will continue to remain a top priority in 2017/18.

In the last 12 months we have been successful in recruiting qualified staff from both domestic and international recruitment. Our staff retention has also improved, with staff turnover decreasing by 1.3% to 7.9%. We have introduced stay interviews to ensure we know what we are doing well and what we need to improve upon for our new starters. This supplements what our staff tell us through an exit questionnaire when they leave the organisation.

During 2017/18 we will structure our thinking through an A3 methodology, to identify how we address on-going shortages in registered nurses, healthcare scientists, radiologists and junior doctors through different roles and ways of working.

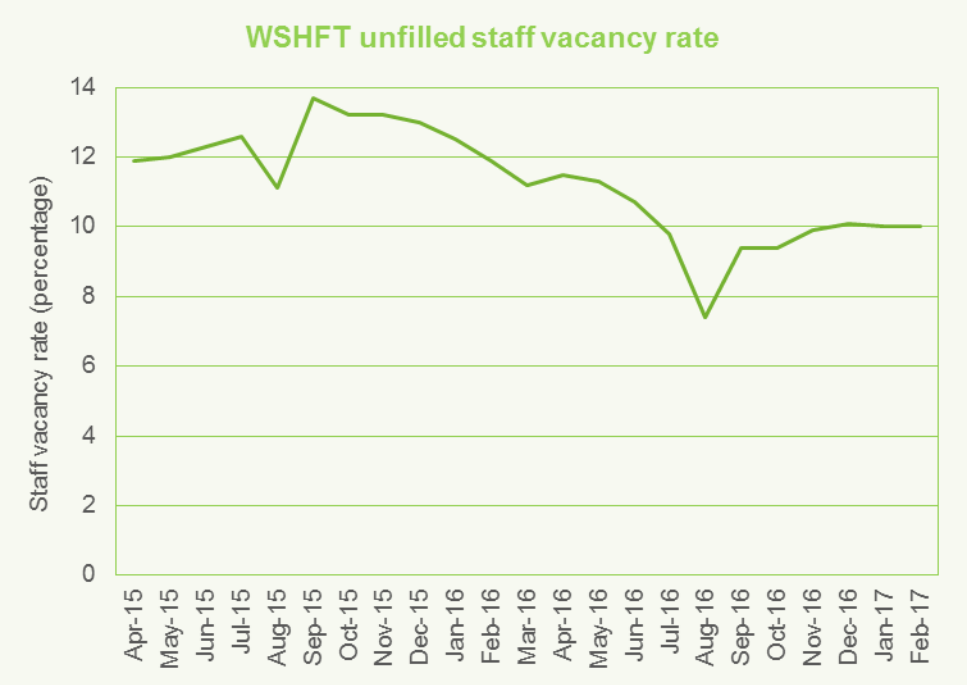
Our goals in 2016/17

- To reduce the volume and cost of agency staff by 10%
- To achieve agency cap compliance and expenditure
- To reduce the number of unfilled vacancies across the Trust (to be agreed by staff group) by recruiting to them substantively or filling in a different way

Improvements achieved 2016/17

- Reduced the amount of agency used from £23.3m in 2015/16 to £18.9m in 2016/17: this represents a 19% reduction in agency spend
- Reduced use of agency staff, although we have not yet achieved our target cap rates
- Increased the number of substantive staff contracted by 200.90 whole time equivalents
- Improved rolling 12 month turnover of staff from 9.1% to 8.0%
- Reduced the number of unfilled vacancies across the Trust (see figure below)

Figure 46. Staff vacancy rate



Further improvements identified

- Strengthen our apprenticeship strategy including pay and reward
- Extend the number and range of apprentices available to include trail blazers in therapies and healthcare sciences
- To develop and implement a skills escalator for therapists and healthcare scientists
- To enrich the strategy for nursing

Our biggest recruitment drive ever

On home shores, the Trust's 'one stop' nursing recruitment events continue fortnightly in Worthing and Chichester. Newly qualified, experienced, or return to nursing candidates are welcome to attend. The Trust is confident all nurses interested in a new role can find a rewarding position with the organisation. Interested applicants can apply online to attend and then on the day meet the senior nursing team, discuss available opportunities, have an interview and assessments, and hopefully leave with a job offer and a start date. Those new to nursing will benefit from a highly-regarded year-long education/preceptorship programme and have the option to work across many specialties on the Trust's rotational programme.

Nurse recruitment poster

Two special recruitment days held on Saturdays at St Richard's and Worthing in October 2016 proved successful with more than 300 people attending to talk about working for Western Sussex. Staff were encouraged to bring along potential new colleagues with a prize-draw to win £50 for any member of staff supporting the trust's biggest ever recruitment drive. 160 people who attended were interested in healthcare roles and more than 50 signed up for the trust's flexible part-time admin positions. The interest in our apprenticeships was also superb.

Development of a Clinical Academic Pathway (CAP) for Nursing, Midwifery and Allied Health Professionals

Aim: Development of the CAP programme

Target: Roll out Autumn 2017

By when: March 2018

Progress: On plan

As part of or new Research and Innovation Strategy we have progressed well in developing a Clinical Academic Pathway for nursing, midwifery and allied health 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 last year we have now developed a clinical academic pathway model with funding from Health Education Kent, Surrey and Sussex to roll the programme out at WSHFT over the next three years. We are also working as a pilot site member with the Association of UK University Hospitals project group on their national strategy for embedding Clinical Academic Roles within NHS practice.

Our goals in 2016/17

Our aim was to develop a Clinical Academic Pathway programme supporting clinical nurses, midwives and allied health professionals to bring research and the latest evidence based practice to everyday NHS care, supporting continuous improvement, improved outcomes, better use of resources and developing a research aware, skilled and confident workforce.

Improvements achieved 2016/17

- Completion of the development phase of the WSHFT Clinical Academic Pathway – a programme designed to support staff within an NHS framework from pre-degree to post-doctoral levels. The programme has been presented and agreed by the WSHFT Trust board for roll out across the organisation in 2017/19
- Achievement of £250,000 funding support from Health Education Kent, Surrey and Sussex to support roll out of the programme over the next three years.

- Development of collaborative relationships with local Higher Education Institutes and Wessex Doctoral programme to support WSHFT CAP programme.

Further improvements identified

The WSHFT CAP programme will start with first cohort of programme interns and doctoral studentships in September 2017. Key priority areas for the first year of the programme are linked to the WSHFT Quality Strategy and will focus on harm free care.

Figure 47. CAP Programme objectives mapped to Patient First

Extending Health and Wellbeing Programmes

Aim: **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

By when: **March 2017**

Progress: **On plan**

The Trust continues to invest in staff health and wellbeing, recognising that it is a key component of staff engagement. Our health and wellbeing plans over the last year have focused on two key factors in sickness absence within our Trust and the NHS as whole: mental health and musculoskeletal problems. These key themes will continue to form the basis of our plans for 2017/18.

Our goals in 2016/17

- 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

Improvements achieved 2016/17

During 2016/17 we have successfully implemented a number of programmes including:

- Expanding our existing Staff Physiotherapy service,
- Increasing our Counselling provision,
- Running a variety of courses for staff and managers to support emotional wellbeing, including Emotional Resilience, Supporting Psychological Wellbeing in the workplace and Mindfulness groups,
- Continued to run Schwartz Rounds on a regular basis,
- Introduced pilot supervision groups for staff,
- Increased our flu vaccination rates from 36.8% to 60.7% of frontline staff,

- We delivered a range of wellbeing events for staff – exercise tasters, Boot Camp for Beginners, Workplace Challenge, Stress awareness events, try-a-bike sessions, access to Physiotherapy gym, massage sessions for staff, walking challenges.

Further improvements identified

During 2017/18 we will be looking to make further developments on the support for emotional wellbeing for staff and musculoskeletal problems. We will be reviewing how we can focus our initiatives on improving the prevention of health problems in addition to continuing with the existing support available for staff.

Staff attending a 'Bootcamp for Beginners' class.

GOAL 4: Improved Staff Engagement - Improvement Programmes for 2017-18

For 2017/18 quality and governance priorities have been set by clinical divisions and a **resilient and affordable workforce** continues to feature strongly. **Delivering 7 day services** is integral to the development of workforce plans, together with the impact on other national imperatives including legislative changes, the Carter review and Brexit.

Initiatives focus on workforce development including:

- **Recruitment and retention strategies**
- **Skill mix reviews**
- **Development of new sustainable roles**
- **Development of integrated and collaborative ways of working**

We will continue to roll out our **Patient First Quality Improvement Programme** as a major tool for developing staff to be empowered and equipped to improve care.

We are implementing a **Clinical Academic Pathway** to support staff in delivering high quality evidence based care.

We continue to develop our successful **staff wellbeing programmes**.

❖ Workforce development including recruitment and retention strategies, skill mix reviews, development of new sustainable roles and development of integrated and collaborative ways of working

Recruitment and retention strategies that include the arrival of further cohorts of nurses from the Philippines throughout the year; one-stop recruitment days for registered nurses, HCA's, radiographers and scientists; careers and recruitment events; sponsorship through access courses; the development of training pathways and a junior doctor rotation programme. A business plan to secure the continuing supply of registered nurses from the Philippines for the next 3 years is being developed. This will supplement the numbers recruited from the UK including current year 1, 2 and 3 students until the outturn of the first nurse bursaries students in 2019. The impact of Brexit on our EU staff supply is monitored through our

retention work stream. To date this has had little effect and it is not anticipated to materially affect the Trust.

Skill mix reviews – where recruitment is challenging, the use of different skills is being adopted. This includes the use of ENP's, increasing the number of HCA's and extended scope practitioners. Redesign of the remaining pathology specialties, outpatient and sexual health services are now planned with opportunities for skill mix review.

The Trust is continuing to develop new roles to support service delivery and 7 day working. It is anticipated that the introduction of the Apprenticeship Levy from April 2017 will provide other opportunities to develop new roles including an Associate Nurse Practitioner and Associate Allied Health Professionals.

Redesigning MSK pathways for elective and outpatient care to shorten waiting times and control health economy costs is being progressed. The Trust is leading on delivering an integrated service collaboratively with Sussex Community NHS Foundation Trust and third parties. The use of GP consultants within Medicine is currently being explored.

The Women and Children's Division is working collaboratively with the Coastal West Sussex CCG on children's' outpatient care.

❖ Patient First Quality Improvement Programme

During 2016/17 we identified three non-clinical departments where staff engagement was a concern and who were in a cohort for roll out of the Patient First Improvement System (PFIS). Focused attention has been given to these areas and using a Plan, Do, Study and Act (PDSA) cycle, engagement is improving. The learning from these pilot areas is being used for other areas and will inform the 2017/18 programme of work when the results by cost centre are available from the NHS Staff Survey 2016. There is also evidence that staff engagement has improved across the three waves of PFIS roll out.

Whilst engagement is measured across three domains by a series of nine questions to give an overall engagement score (noted in 2.1.6), the full set of results from the NHS Staff Survey 2016 demonstrate quality improvement has been made across a number of areas.
An extract of the key areas of improvement where staff are satisfied or very satisfied are shown in the following table.

Table 20. NHS Staff Survey 2016 results

Question	2015	2016	Improvement
Q5f. The extent to which my organisation values my work	41%	43%	2%
Q6c. I am able to deliver the care I aspire to	65%	69%	4%
Q8b. Communication between senior management and staff is effective	37%	43%	6%
Q8c. Senior managers here try to involve staff in important decisions	31%	36%	5%
Q13b. I would feel secure raising concerns about unsafe clinical practice	63%	67%	4%
Q13c. I am confident that my organisation would address my concern	51%	57%	6%
Q21a. Care of patients/service users is my organisation's top priority	78%	81%	3%
Q21b. My organisation acts on concerns raised by patients/ service users	73%	76%	3%
Q21c. I would recommend my organisation as a place to work	65%	72%	7%
Q21d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	73%	80%	7%

During 2017/18, we anticipate that the continuing roll-out of the PFIS will see further rises in staff engagement and therefore the number of staff who are satisfied or very satisfied with their experience at work.

Through the strategy deployment of the lean management system, divisional teams will be cascading the True North objectives and redesigning their performance meetings so that they are aligned to improving staff engagement at all levels of the Trust.

Through the Trust's annual health and safety update, staff are also being educated about the Patient First programme and by the end of 2018 it is expected that all staff will be familiar with the concepts of lean improvement tools and their application in a health setting. Yellow belt training will continue to be rolled out and master classes delivered by an ever increasing capacity of workplace practitioners

In the meantime, focused attention will be given to engage with our ethnic minority staff who told us that the level of discrimination that they had experienced on the grounds of their ethnic origin increased from 40% to 46%. Through our Celebrating Cultures Group and our recently established Safe Care and Engagement Group, we will seek to better understand this serious issue and co-design interventions to improve staff experience.

2.1.7 Overview of Improvement Programmes for Next Year

Improvement programmes 2017/18	*Goal*	Target
Goal 1: Reducing preventable mortality and improving outcomes		
Deteriorating patient programme	*Continued improvement in the implementation of the sepsis care bundle*	*80% compliance with Sepsis 6 care bundle in 2017-18, 95% in 2018-19* *Target (CQUIN):* • *90% of patients to receive antibiotic therapy within one hour in 2017-18, 95% in 2018-19* • *Timely identification of Sepsis in ED and inpatient settings (to be confirmed)* • *72hr antibiotic review for sepsis (to be confirmed)*
Better Births programme	*Continue to focus on normalising birth and reducing caesarean section rates*	*Reduction in caesarean section < 26.5%*
Care for Older People with Frailty programme	*Improvement in frailty pathway – implementation of new frailty assessment tool*	*Improvement in the identification of patients with frailty syndrome* *Development of a pathway with which to provide robust care for this patient group.*
Mortality Review and Learning programme	*Roll out of new inpatient death review process and systems to identify and learn from any identified problems in care / avoidable mortality*	*100% of in-patient deaths are reviewed*
Seven Day Services Clinical Standards programme	*To deliver sustainable Seven Day Services across the Trust by 2020*	*Standard 2 target – To improve the gap between weekday and weekend performance (percentage consultant review within 14 hours of admission) by 23 percentage points on a weekday (target 76%) and 32 percentage points on a weekend day (target 75%) by March 2018.*

Improvement programmes 2017/18	*Goal*	Target
		Standard 8 target – To improve the proportion of twice daily consultant reviews of patients with high dependency needs to 100% by March 2018.
Mental Health Care programme	*Our initial improvement plans for 2017/18 will reflect gaps /actions identified in response to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 'Treat as One' study aimed at bridging the gap between mental health and physical health in general hospitals.*	*Our improvement plan will be developed in Q1 of 2017/18 following local gap analysis in the light of 'Treat as One' national recommendation and discussion with relevant partners.* *Target (CQUIN): Improving services for people with mental health needs who present to A&E (to be confirmed)*
Cancer pathway improvement programme	*We will undertake a review of key cancer pathways from the patient's first visit to General Practice to end of treatment / end of life including:* *• Patient information pathway* *• Key worker pathway and handover as patient moves through their pathway* *• Treatment summary that facilitates improved cancer care reviews* *• Health and wellbeing clinics* *• Physical activity* *• Diagnostic booking processes* *• Improved waiting times*	*Improved cancer pathways in the following areas in the first instance: colorectal, lung, upper gastro-intestinal, urology, breast and haematology. Within three years.*
Goal 2: Avoiding Harm		
Falls reduction programme	*Reduction in in-hospital falls*	*30% reduction in-hospital falls (to be confirmed).*
Skin damage reduction programme	*Reduction in-hospital acquired pressure damage*	*10% reduction in grade 2+ avoidable pressure damage (baseline: Jan-Dec 2016).*
Medicines Optimisation programme	*The year we will continue to roll out our Medicines Optimisation Strategy that sets out the vision and goals for development and quality improvement in all aspects of medicines use.*	*Maintain or improve the Medicines Reconciliation completion rates achieved in Q4 of 2016/17* *Focus on anticoagulants: target 50% patients on New Oral Anticoagulants (NOACs) with documented counselling,*

Improvement programmes 2017/18	*Goal*	Target
		100% patients with correct prophylaxis prescribed, reduce surgery cancelled due to anticoagulant issues *Antimicrobial stewardship and consumption - Target (CQUIN): 2% Reduction in overall antibiotic consumption per 1,000 admission, 1% reduction in the use of carbopenems and Tazocin* *Improve the quality of information relating to medication at discharge to GPs, community hospitals and community pharmacists* *Omitted doses, with particular focus on high risk medicines, linked if possible to the work of the AHSN*
Diagnostic resulting programme	*We have convened a programme board to scope and implement a robust and consistent Trust-wide programme to ensure that all ordered diagnostic tests are undertaken, reviewed, acted upon, escalated appropriately and finally communicated to the patient/GP within the timeframe required. This will help to prevent delayed diagnosis and treatment and reduce the number of repeat diagnostics undertaken.*	*Further progress with specification, procurement and implementation of a new diagnostic resulting programme over the next 3-5 years.*
Infection prevention and control programme	*Reduction in hospital acquired infection*	*Reduction in surgical site infection rate:* • *Total hip replacement <1.1%* • *Total knee replacement <1.5%* *MRSA: 0 cases* *C. difficile: <39 cases*
Safer staffing programme	*Roll out of 'Safer Care' information system*	*For 2017/18 our goal is to roll out our safe care information system to all our general wards and then to add in roll out to more complex areas such as the emergency floor, paediatrics and maternity.*

Improvement programmes 2017/18	*Goal*	Target
Goal 3: Improved Patient Experience		
Improving communication programme	*Focus on improved communication regarding waiting times, delays and discharge dates*	*FFT aim to achieve >97% satisfaction and a return rate of >40%.*
Reducing complaints and improving the timeliness of complaint responses	*Reducing complaints and improving the timeliness of complaint responses*	*<60 open complaints per month by the end of 2017/18.*
Goal 4: Improved Staff Engagement		
Developing a resilient and affordable workforce	*Recruitment and retention strategies* *Skill mix reviews* *Development of new sustainable roles* *Development of integrated and collaborative ways of working*	*Implementation of programmes to support the development of a resilient and affordable workforce.*
Patient First Quality Improvement Programme	*Continued roll out across all clinical areas*	*Increased alignment of Yellow-belt training to project delivery: 100% of yellow belt graduates will be involved in the delivery of a project aligned to Trust priorities.* *Training of second cohort of Trust staff to Green-belt level with delivery of appropriately scaled and aligned projects.* *Development of Trust Lean Practitioners (Patient First Kaizen Office) towards Black-belt status.* *Rollout of Patient First Improvement System to 18 further wards and departments.*
Clinical Academic Pathway	*Establishing a clinical academic pathway for nurses, midwives and AHPs*	*To develop a community of practice supporting staff engagement and providing opportunities to champion improvements in practice through the use of research and evidence based practice.* *To develop a clinical academic pathway providing support for novice researchers*

Improvement programmes 2017/18	*Goal*	Target
		at all levels enabling them to grow a research career whilst maintaining close links to clinical practice and collaborative working with higher education institutions. *To further develop innovative improvements in care in areas identified as our quality priorities through partnership working and collaborative research*
Staff well-being programme	*Further developments on the support for emotional wellbeing for staff and musculoskeletal problems.*	*Target: Implementation of programmes to support emotional wellbeing and musculoskeletal problems.* *Target (CQUIN):* • *Improving staff health & wellbeing (to be confirmed)* • *Improving the uptake of flu vaccinations for frontline clinical staff (to be confirmed)*

2.1.8 Other Strategic Initiatives

Outpatient improvements

A significant improvement project was undertaken this year looking at improvements for the Outpatients bookings process across the Trust. The booking team participated in a workshop aiming to understand the Outpatients bookings process pathway and process steps, its capabilities and performance levels to help surface issues, challenges and bottlenecks, in order to identify areas for improvement using Kaizen / Lean tools.

Booking team Kaizen workshop.

Any delays within the end-to-end process have the potential to increase the waiting times for referred patients. The impact of which leads to poor patient experience and the inherent risks associated to treatment delays for these patients. The top three problems were identified as: referrals being lost in the system, clinics being cancelled and delays in processing emails to the GP inbox. Improvement work has focused on these areas and delivered reductions in referral processing times. This programme continues into 2017/18.

ITU Delayed Discharge Project

The Critical Care Units at both Worthing and St Richard's Hospitals had ongoing issues with patient discharges to the wards being significantly delayed, sometimes for days at a time. As

well as being a very poor experience for our patients, this situation created a number of further problems, including:

- a high number of night time discharges, which are linked to increased mortality and less favourable outcomes for patients
- a significant number of 'lost bed days' owing to beds being occupied by 'ward fit' patients who could have been discharged from ITU
- delayed admissions to the unit and decisions to avoid admissions where patients might have benefitted from a very short stay on the unit

These problems are seen nationally, and for 2016/17 NHS England introduced a CQUIN target across country to reduce delayed discharges by 30%.

The ITU Delayed Discharge Project launched in September 2016 with a workshop facilitated by the Kaizen team. Key stakeholders from across the patient pathway attended, including nursing and medical staff from critical care, site management teams, therapies and operational managers. At the workshop, the group mapped the patient journey and identified key problem areas, then prioritised these to create three 'A3 projects' to drive improvements.

The complexities of ITU Delayed Discharge process mapping.

The teams from each of the three projects have worked together to make a number of big changes to how we manage the patient pathway through critical care:

Project 1: ITU beds not considered part of the emergency bed capacity

The team set an initial target for site management teams to prioritise 2 discharges from critical care per day. Communication channels were reviewed and dedicated patient

management boards for critical care were developed and installed in the site management offices, with both site and critical care teams responsible for keeping them up to date. Roles and responsibilities for all participants were defined to reduce duplication of work and make sure all essential actions are covered.

Project 2: Ward round standardisation

The ward round process was mapped in detail, and the team felt that poor flow of information was a major problem. A 'ward fit' time of 11am was identified for critical care teams to notify the site team about patient moves required following the daily ward round, ensuring that both teams were prepared to discuss plans for the day at that time.

Project 3: Infection control

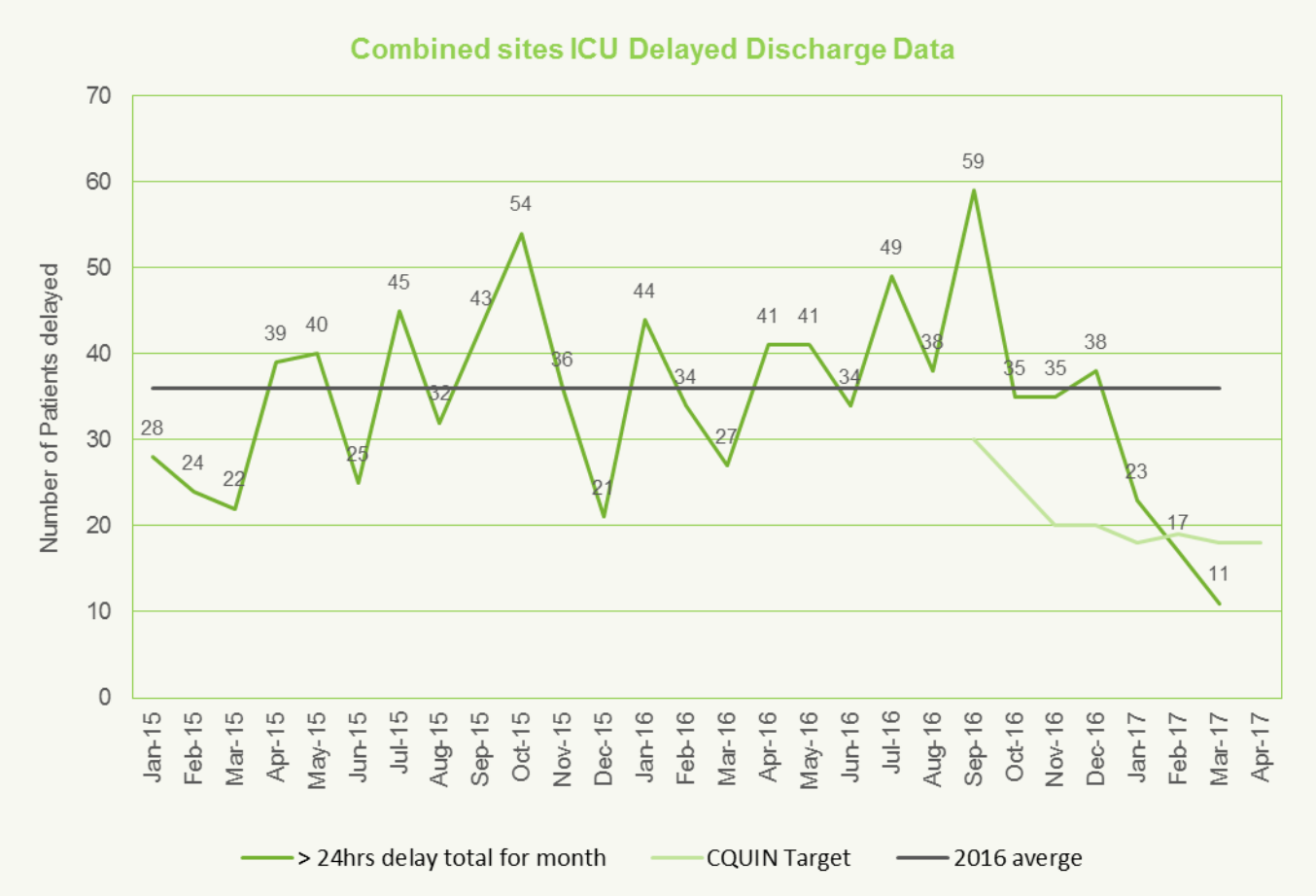
Clinical teams worked together to change the way we manage patients who are or might be infectious. They created an addendum to the Trust infection control policy with explicit directions for the management of these patients in critical care.

The ITU Delayed Discharge Project has been very successful, and as a result of the actions taken both sites have reported an improved ability to manage the flow of patients into and out of critical care. Teams across the patient pathway have reported feeling more in control of and confident about their part in the processes.

Delayed discharges have seen a significant reduction. The CQUIN target for Quarter 4 is for no more than 51 patients to have their discharge delayed by greater than 24 hours, and we are on track to meet this target, representing a 30% improvement on our performance last year. We have also been able to reduce night time discharges at both sites as we are now focusing on moving our patients during core hours.

The graph below shows the number of patients whose discharge was delayed for more than 24 hours for the past two years, and the sustained reduction in delays since the project began in September 2016.

Figure 48. Delayed discharge data



Despite achieving more timely patient discharges we have not seen a drop in occupancy rates on either unit. This suggests that more patients who can benefit from intensive care are able to access the service even for a very short time and are not delayed in receiving that care.

Western Sussex Eye Care | Southlands

Western Sussex Eye Care | Southlands is a multi-million pound project to relocate outpatients care and day surgery ophthalmology to a brand new, purpose-designed and more spacious facility.

Consultant ophthalmologist, Dr Masoud Teimory, says the state-of-the-art specialist unit under construction will enable the Trust to become a centre of excellence for eye care. Ophthalmology Matron, Emma Plummer, is enthusiastic about the opportunities for

nursing staff to lead more clinics, become nurse specialists and provide a leading service that will attract patients from miles around.

Demand for eye care has increased dramatically in recent years as new techniques have developed for previously untreatable conditions. For example, patients with age-related macular degeneration who used to be registered blind now become life-long patients, attending clinics five times a year for special injections. With this ever-increasing demand the service has simply outgrown its base at Worthing and needs a renewed modern layout to enable better ways of working that enhance patient experience.

The aim is to develop 'one stop' patient pathways for a number of common eye conditions so patients will only have to attend a clinic once to receive tests, diagnosis and treatment, and in the future, potentially surgery on the same day.

An artist's impression of the entrance to the new building.

The new unit has been purpose designed so care revolves around the patient in multi-purpose treatment rooms, similar to the redeveloped Ophthalmology department at St Richard's, which will continue to operate as normal when Western Sussex Eye Care | Southlands opens in June 2017. The bespoke design reduces the need for elderly patients to get up and down as they visit different members of staff in different cubicles, as currently occurs in the Worthing department. To staff the new centre, which will initially open from 7.30am to 8pm, nursing numbers will be increased to compliment the ten consultant ophthalmologists who now work for the trust.

Interior layout of the new ophthalmology building.

Non-Elective Flow Improvements

The Trust has initiated a strategic improvement programme addressing non-elective flow under our 'Systems and Partnerships' True North focus. Improvement projects have started in the following areas and will continue throughout 2017/18. These projects have a key impact on the smooth flow of patients attending the hospital from emergency admission to discharge and the experience of patients within the hospital.

Projects include:

- Medicines TTO (To Take Out) process improvement project
- Discharge Lounge utilisation project
- Specialty bed availability project
- Bed turn project
- Integrated discharge improvement project

Our Medicines TTO process improvement project aims to address the level of TTOs Not right First Time (NRFT) in the TTO turnaround process. With a baseline of 50% of TTOs Not Right First Time we have a level of efficiency that is not fit to meet bed turn demand. This project is in the implementation phase and aims to deliver 100% TTOs Right First Time, with a target of 75% RFT by the end of March 2018. This can be achieved through changes in TTO process including piloting dedicated slots each day where Drs and Pharmacists write TTOs together.

Our Discharge Lounge utilisation project aims to increase in-patient ward usage of the Discharge Lounges. We have identified communication as a key reason for site variation in the % patients discharged via the lounge. New initiatives focus on communication, aligning

Discharge Lounge patient criteria across sites, and aligning Discharge Lounge opening times across sites.

Early benefits include:

- Increased numbers of patients using the Worthing Hospital Discharge Lounge
- Improved support to wards, with the Discharge Lounges able to take more patients than before
- Revised metric of median time of discharge from base in-patient wards providing a clearer indication of where good habits exist and where wards require further support

Our Specialty bed availability project is in an early base line data collection phase, this project will look at improving specialty bed availability over the next year.

Our Bed Turn project has been underway this year focused on improving the process that delay the time between a hospital bed being empty once a patient has been discharged and the bed being in use again with a new patient. Improvement initiatives have included:

- Managing the cleaning of the bed space using a Standard work document to ensure consistent quality, safety and timely outcome every time
- Reducing delays in transfer time and improving patient experience by the target ward going to collect their patients
- Improving communication from ward to Emergency Floor by issuing a mobile phone to the Emergency Floor co-ordinator and communicating via flow chart

Early benefits have included:

- Greater control back in the hands of the wards – Empowerment and team working throughout the pathway
- Improved communication
- Earlier average transfer times across the trust – bring the average time of ward admission forward in the day
- Fewer night transfers to wards (after 22:00) across the trust

Our Integrated discharge improvement project aims to improve processes being followed by the Integrated Discharge Team to increase efficiency and reduce the Length of Stay (LOS) of patients who are Medically Fit For Discharge (MFFD) from a baseline medium of 7 days to 3.5 days.

This project is in its early stages with pilot improvement initiatives including:

- Improving MFFD decision process

- Agreeing collateral information form for use
- Agreeing process checklists, referral forms & geographical areas

Anticipated benefits include:

- Improved Process for MFFD assessment
- Integrated team working
- Roles and Responsibility clearly defined
- Reduction in Not Medically Fit (NMF)%

Record improvements for ICU discharges

The number of delayed discharges from the Trust's intensive care units (ICU) has fallen to a record low due to successful improvement project, led by the critical care and site teams.

In the week from 16 to 22 of January, there were only three patients who stayed on the ICUs for more than 24 hours, once they were deemed ward fit for discharge. This compares to 13 patients a week, on average, before the teams participated in a Kaizen Workshop last September, to tackle the problem of delayed ICU discharges.

Dr Shaun Anderson, clinical lead for critical care in Worthing, said: "I have long been frustrated by the inability to put the right patients in the right beds, at the right time, because of problems with delayed discharges." "This in turn leads to delayed admissions and increased night time discharges, which are not in the best interests of our patients."

The issue is one faced by many hospitals and was highlighted by the Care Quality Commission following their inspection. The Trust immediately prioritised it and the Patient First Kaizen approach was used to bring teams together in order to identify issues within their control to improve, using problem-solving methodology. The teams set to work and immediately began to see significant gains in quality. For example, in October, >24hr delayed discharges were reduced from 54 in 2015 to 35 last year. Problematic night time discharges also fell by a third from nine to six, while desired under 4-hour discharges increased from 14 to 21 year on year.

Dr Anderson said: "Having never been involved in one of these Kaizen processes I was a bit sceptical but, at the first meeting, it was clear they had a process and they had brought all the right people together – the ICU team, nursing staff, site managers, and management." "People wanted to make it better and the Lean improvement methodology helps you drive that. Immediately, I was delighted to start seeing a change in both attitude and results."

On 20th January 2017, the teams showcased their results at a *Lunch and Learn* event in the Kaizen Space at Worthing, attended by Chief Executive Marianne Griffiths, Chief Operating Officer Pete Landstrom and Finance Director Karen Geoghegan.

ICU discharge 'Lunch and Learn' event

Pete said: "This project has always been about increasing quality for patients and what has been achieved in so short a period, while we have been extraordinarily busy, is hugely impressive." "Not only have delayed discharges plummeted, but we have also seen huge reductions in night time transfers, which is significant in terms of patient quality. Interestingly, we have also observed a reduction in the overall average length of stay for patients." "I would like to congratulate everyone who has participated in this improvement project – it is a superb example of what is possible for our patients when teams commit to our new improvement processes."

Patient First Improvement Practitioner, Nick Chambers, reflects on the project: "We have discussed with NHS England and we believe we are the only Trust in the country to have made a real difference to our patients when it comes to improving timely discharges from ICU. This project is proof that a Kaizen approach to problem solving does work - bringing teams together who are involved in the same pathway to find solutions to shared problems and managing the improvement using a data driven, scientific approach. For ICU and the site teams it has paid dividends – it allowed us to ask 'what in our process has caused this to happen' rather than concentrate on individuals or teams. I have learnt there are no shortcuts to successful improvement initiatives – jumping to solutions is not the answer – it takes a team effort, using data, and having permission, time and support to make it work."

2.1.9 Requested Local Improvement Plans

2.1.9.1 How we are implementing the Duty of Candour[72]

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 patients harm. The locally developed policy we work to is '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

[72] 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.

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 policy describes 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. A Patient Information Leaflet[73] is available clearly outlining our commitment to patients and families when things go wrong.

2.1.9.2 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'[74] 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.

[73] http://www.westernsussexhospitals.nhs.uk/wp-content/uploads/2016/04/Duty-of-Candour-leaflet.pdf
[74] https://www.england.nhs.uk/signuptosafety/

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.

- **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.

Western Sussex Hospitals NHS Foundation Trust

Our 'Sign up to Safety' Improvement Plan is shown below:

SIGN UP TO SAFETY PROGRESS REPORT UPDATED 15th February 2017

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
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. **UPDATE: management of candour will now pass to the Divisions and compliance will be monitored via the Triangulation Committee** An Internal Audit has been undertaken with moderate assurance and the action plan is being worked through.	Head of Clinical Governance	Ongoing	Complete

Date Opened	Safety Commitment	Action / Progress	Responsible Person/Group	Deadline	Rag Status
		In preparation for handing over the candour process to the divisions, Datix has been updated with a drop down box requiring confirmation of candour. This will make audit of the process easier.			
		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. The organisation has committed to an internal Freedom to Speak Up Guardian and recruitment is underway.	Freedom to Speak up Steering Group	Ongoing	Complete
		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
		To implement an overarching Mortality and Morbidity Steering Group which is currently piloting a tool to review all deaths.	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 **UPDATE: The Patient Safety page of the intranet is now almost complete and will give a central place for staff to find information and resources.**	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	Complete

Date Opened	Safety Commitment	Action / Progress	Responsible Person/Group	Deadline	Rag Status
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
		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	Care Groups/Departments	Ongoing	Complete
		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	Complete
		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
		The be a proactive member of the National Falls Collaborative and ensure learning is reported at the	Deputy Director of Nursing	Ongoing	Complete

Date Opened	Safety Commitment	Action / Progress	Responsible Person/Group	Deadline	Rag Status
		Heads of Nursing meeting			
		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
		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**

Date Opened	Safety Commitment	Action / Progress	Responsible Person/Group	Deadline	Rag Status
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	Complete
		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	Complete
		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	Complete
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	Complete
16th September 2014	Listen to our staff, demonstrating that we are open to new ideas and encouraging forward-thinking, personal development and	To implement training for staff in improvement methodology via the Patient First Programme.	Patient First Programme management Board	Ongoing	Complete

Date Opened	Safety Commitment	Action / Progress	Responsible Person/Group	Deadline	Rag Status
	education by:				
	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

2.1.9.3 Staff Survey Result for indicators KF26/KF21

Below are our NHS Staff Survey results for indicators KF26 - Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months, and KF21 – Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion, for the Workforce Race Equality Standard[75].

~ KF26 - Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

The indicator in the NHS Staff Survey 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?

Table 21. 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)

2016 Definition	2015	2016	National average 2016: 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%%	14.80%	16.0% (10% to 24.1%)

[75] www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard

~ KF21 – Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion.

Table 22/23. 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	2016	National average 2016: Acute Trusts (range)
Percentage believing that Trust provides equal opportunities for career progression or promotion	91.90%	90.90%	89.40%	91.99%	No national average (Range 70.8% to 95.2%)

Data taken from the NHS Staff Survey Workforce Race Equality Standard section.

Black and minority ethnic groups (4-16):	2013	2014	2015	2016	National average 2016: Acute Trusts (range)
Percentage believing that the Trust provides equal opportunities for career progression or promotion	79.90%	76.70%	85.80%	84.32%	No national average (Range 44.7% to 100%)

Data taken from the NHS Staff Survey Workforce Race Equality Standard section. National average not available.

2.1.9.4 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 five non-specialist 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

NHS
Western Sussex Hospitals
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

Western Sussex Hospitals NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Outpatients & Diagnostic Imaging	Good	N/A	Good	Requires Improvement	Good	Good

NHS
Western Sussex Hospitals
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	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Children & Young People	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
End of Life Care	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

Western Sussex Hospitals NHS Foundation Trust

	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 produced a robust action plan to address the issues highlighted which is being monitored internally and by the CQC until completion.

2.1.10 Developing our Quality Strategy and Quality Priorities 2017/18

Engaging staff, patients, public and stakeholders

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 experience programme.

Our Quality Priorities for 2017/18 form part of our broader ambition set out in our Quality Strategy for 2015-18, and our True North metrics. In order to develop our annual quality priorities and quality improvement breakthrough objectives we analyse quality indicators and benchmarking data and engage widely. In the autumn of 2016 our divisions engaged with their staff about the priorities for the forthcoming year under the Quality Strategy goals: Reducing avoidable mortality and improving outcomes, delivering harm free care, improving patient experience and improving staff engagement. Divisional improvement priorities were presented to the Quality Board in November 2016 and discussed alongside the Trust Quality scorecard data, quality improvement programme progress through 2016/17 and other strategic developments. The Quality Board and Trust Executive Committee agreed a draft set of quality priorities for 2017/18 to go out for wider engagement. A web based engagement exercise was conducted throughout February 2017 aimed at staff, volunteers, patients, public and our key stakeholders with approximately 500 responses received. Meetings with Stakeholders representatives[76] 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 2017 and a discussion was held at the Stakeholder's Forum event in February 2017.

[76] CCG, HASC Select Committee, and Healthwatch West Sussex.

In response to the consultation exercise we have added a programme on improving cancer pathways. We will also be providing patients and the public with more information regarding our current improvement activities, focused on areas such as outpatient experience.

The Quality Board have agreed the final Quality Priorities for 2017/18 taking into account feedback received.

Quality Priorities will continue to 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 programmes set out in the Trust Quality Strategy and annual plans. Divisional accountability for elements of our quality improvement programme is achieved through early engagement work relating to setting meaningful annual improvement priorities and local objectives and the cascade of accountabilities through our strategy deployment processes.

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 2016/17 the Western Sussex Hospitals NHS Foundation Trust provided and/or sub-contracted 135 relevant health services.

The Western Sussex Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 135 of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by The Western Sussex Hospitals NHS Foundation Trust for 2016/17.

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 2016/17, 39 national clinical audits and six 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 2016/17 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 2016/17, 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 25 national clinical audits were reviewed by the provider in 2016/17 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 82 local clinical audits were reviewed by the provider in 2016/17 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 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 1349.

In 2016/17 we have developed 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 2017-20:

- Increase opportunities for patients to participate in high quality clinical research that aims to improve patient care.
- Implement innovative improvements in patient care at pace through standardisation, robust improvement science, partnership and shared learning.
- Implement the Patient First Improvement System empowering all staff to lead change and improvements in care for patients.
- 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 2016/17 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 2016/17 and for the following 12 month period are available electronically at:

http://www.westernsussexhospitals.nhs.uk/wp-content/uploads/2014/08/Commissioning-for-Quality-and-Innovation-CQUIN-Programme-for-2016-17.pdf

The income dependent on achieving Commissioning for Quality and Innovation and associated payments are shown below:

Table 24. CQUIN total income 2016/17

	2015/16	2016/17
Total income dependent on CQUIN	£7,770,369	£7,727,384
Associated payment	£7,770,369	7,727,384

The above 2016/17 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 2017/18 contracts with Coastal West Sussex CCG, NHS England and Public Health England are still under negotiation, once agreed, details of our 1718 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 2016/17.

Western Sussex Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

2.2.6 Data Quality

Western Sussex Hospitals NHS Foundation Trust submitted records during 2016/17[77] 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
98.1% 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 Assessment Report overall score for 2016/17 was 79% and was graded green (satisfactory). This equates to a very robust Level 2 result (to achieve this a minimum score of Level 2 on each of the 45 requirements must be met, along with an overall score of at least 66%).

[77] Period covers April 2016 to February 2017.

Western Sussex Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period 2016/17 by the Audit Commission[78].

Western Sussex Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

1. Internal training and audit program: Clinical Coding have created a program of training and audit. In three year cycles we will provide training and auditing on each of the major specialties we code in the Trust.
2. Information Governance (IG) audit: An annual audit of 200 episodes is provided by an NHS Digital approved Auditor for IG purposes. Coding errors are turned into learning and shared with the coding team.
3. National Standards NHS Digital approved training: Every new member of staff attends a 25 day NHS Digital National Standards course provided by an approved experienced Classification Service Certified Trainer. Every experienced coder attends a four day NHS Digital National Standards Refresher course provided by an approved experienced Classification Service Certified Trainer. We also encourage staff to further their understanding by studying for a professional qualification and we provide a four day NHS Digital National Standards Revision course by an approved experienced Classification Service Certified trainer to help staff achieve 'Accredited Clinical Coder' Status.

2.2.7 Core Quality Indicators for Quality Accounts 2016/17

The following core quality indicators are relevant to Western Sussex Hospitals NHS Foundation Trust. They relate to the NHS Outcomes Framework. For each indicator[79], data for 2016/17 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

[78] Please note the Audit Commission closed 31st March 2015, however this is a mandated statement. **NHS Improvement comment:** References to the Audit Commission are now out of date because it has closed. From 2014 responsibility for coding and costing assurance transferred to Monitor and then NHS Improvement. From 2016/17 this programme has applied a new methodology and there is no longer a standalone 'costing audit' with errors rates as envisaged by this line in the regulations.

[79] 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.

around the national average, and within the expected range. The mortality rate has been reducing steadily since 2011/12. This reduced from 1.03 in 2014/15 to 1.00 in 2015/16 which is the national average. Provisional 2016/17 data shows that the mortality rate is continuing to remain within the expected range.

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 25. Summary Hospital-level Mortality Indicator (SHMI)

	2011/12*	2012/13*	2013/14*	2014/15	2015/16	2016/17	National Average (range)**
SHMI	1.08	1.02	0.99	1.03	1.00	0.97	1.00 (0.69 to 1.17)
Percentage of patient deaths palliative care coded at either diagnosis of specialty level	13.7%	16.9%	19.5%	26.6%	33.5%	33.6%	29.7% (0.4% to 56.3%)

**2011/12 to 2013/14 figures revised and NHS Digital Nationally published figures used.*

***National average is based on 2015/16: Apr 15 to Mar 16.*

N.B. All years reported are financial year 1st April to 31st March with the exception of: 2015/16 (reporting year Apr15-Mar16) and 2016/17 (figures Oct15-Sep16).

Patient Reported Outcome Measures[80]

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[81], show that our treatments are effective in improving the health of our patients.

[80] 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.

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 26. 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 (finalised)	Apr 2015 to Mar 2016 (provisional)*	National Average (2015/16)	Apr 2016 to Sep 2016 (provisional)*	National average (2016/17 Apr to Sep)
Groin hernia surgery: EQ 5D Index (casemix adjusted health gain)	0.099	0.075	0.072	0.079	0.053	0.088	0.092	0.087 (range 0.005 to 0.162)
Hip replacement (primary): EQ 5D Index (casemix adjusted health gain)	0.387	0.435	0.419	0.422	0.404	0.438	0.330	0.449 (range 0.330 to 0.537)
Knee replacement (primary): EQ 5D Index (casemix adjusted health gain)	0.292	0.320	0.305	0.283	0.312	0.320	0.310	0.337 (range 0.259 to 0.430)

Data source: http://www.hscic.gov.uk/proms

* Provisional data relates to the February 2017 publications by the HSCIC which is the most recent data available.

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

[81] 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.

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 27. 28 day readmissions

28 day readmissions	2010/11	2011/12[82]	National average for large acute hospital (range)*	2014/15**	2015/16**	2016/17**
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%)	13.43%	13.09%	13.97%
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%)	12.66%	13.28%	12.56%

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: No national data has been published since.
** Performance from 2014 onwards is based on local data. Given the risk adjustment applied by the HSCIC, these numbers cannot be compared directly to those from 2010/11 or 2011/12.

30 day readmissions

Table 28. 30 day readmissions

30 day readmissions	2013/14	2014/15	2015/16	2016/17	*National average for large acute hospital (range)**
Emergency readmissions	12.40%	13.20%	13.70%	14.24%	*National data has not*

[82] 2011/12 data is the most recent available nationally from the Health and Social Care Information Centre (HSCIC).

within 30 days %					*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 29. Responsiveness to patient needs

Responsiveness to patient needs	2011	2012	2013	2014	2015	2016	National average (range)*
Responsiveness to the personal needs of patients	64.4	65.7	69.4	67.0	69.1	*Not available until Aug 2017*	69.6 (58.9 to 86.2)

* National average based on 2015.

2016 data on Responsiveness to Patient Needs and patient experience to be published in the 2016 survey results due in August 2017.

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 30. Percentage of staff who would recommend the Trust as a provider of care to their friends or family

	2012	2013	2014	2015	2016	National average 2016: 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%	79%	69.8% (48% to 95%)

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 31. Percentage of patients admitted to hospital who were risk assessed for venous thromboembolism

	2012/13	2013/14	2014/15	2015/16	2016/17*
Percentage of patients admitted to hospital who were risk assessed for venous thromboembolism	93.40%	96.00%	95.90%	94.90%**	95.70%
National Average	N/A	N/A	N/A	95.67%***	95.60%

* 2016/17 data represents published data from April to December 2016. Jan-Mar 2017 data is not released until June 2017.

** The 2015/16 figure has been updated to reflect published National VTE data. The 2015/16 Quality Report quoted unvalidated local data.

*** National Average 2015/16 has been updated from 2015/16 Q2 (April – September 2015) figure provided in last year's Quality Report.

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 32. Number of *C.difficile* cases

	2011/12	2012/13	2013/14	2014/15	2015/16*	2016/17	National average (range)**
Number of C *difficile* cases (patients aged 2 or over)	76	72	57	38	36*	45	N/A
Rate of C *difficile* per 100,000 bed days (patients aged 2 or over)	24.4	23.7	18.9	12.6	11.1*	13.5	14.9 (0 to 66)

* The 2015/16 data for WSHFT presented in last year's Quality Report has been updated with published data from Public Health England.

** National average based on 2015/16. The next national rates will not be published until August 2017.

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 33. 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	Apr 2016 to Sep 2016	Oct 2016 to Mar 2017
Number of patient safety incidents	5345	4781	4880	4628	4771	5070	4954	4984
Rate of patient safety incidents per 1,000 bed days	N/A	N/A	N/A	28.2	29.74	25.61	25.2	25.2
Number of patient safety incidents resulting in moderate, severe harm or death	78	66	73	74	74	82	79	83
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%	1.59%	1.67%
Total Serious Incidents	17	17	31	30	43	36	48	26

Source: Datix System

The Patient Safety Incident data presented is that collected locally through our Datix system. This is to enable recent data to be shown against a comparable dataset rather than use nationally collected HSCIC data which is reported in arrears. 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 prior to 2015/16. 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 34. Patient safety indicators

Indicator	2012/13	2013/14	2014/15	2015/16	2016/17	Target 2016/17
Safer Staffing: Average fill rate - registered nurses/ midwives (day shifts)			96.5%	95.93%	96.2%	95%
Safer Staffing: Average fill rate - registered nurses/ midwives (night shifts)			97.3%	97.46%	97.1%	95%
Safer Staffing: Average fill rate - care staff (day shifts)			93.7%	89.82%	91.3%	95%
Safer Staffing: Average fill rate - care staff (night shifts)			95.3%	92.26%	92.3%	95%
Care Hours Per Patient Day (CHPPD)	n/a	n/a	n/a	n/a	6.50	tbc
Safety Thermometer: % of patients harm-free	94.4%	94.0%	94.6%	95.70%	95.3%	95.70%
Safety Thermometer: % of patients with no new harms		98.0%	98.2%	98.30%	98.5%	99%
% of patients with catheters and UTIs where best practice protocol was not followed.			0.2%	0.10%	0.06%	0.1%
Total incidents[£]	8,091	9,354	9,508	9,841	9,938	8,122 - 10,988
Total moderate, severe or death incidents[£]	93	144	147	156	162	153
Total serious incidents (SIRIs)[£]	26	34	61	79	74	60
Number of outstanding CAS alerts		0	0	0	0	0
Total incidents involving drug/prescribing errors	1,101	1,077	1,242	1,100	1,088	1,056 - 1,428
Moderate/severe incidents involving drug/prescribing errors	6	6	5	6	8	5
Number of hospital attributable MRSA cases	1	4	1	0	1	0
Number of hospital C.diff cases	72	57	38	36	45	39
Number of C. diff cases where a lapse in the quality of care was noted			21	20	24	16
Number of reportable MSSA bacteraemia cases	72	68	75	85	113	tbc

Indicator	2012/13	2013/14	2014/15	2015/16	2016/17	Target 2016/17
Number of reportable E.coli cases	274	286	313	312	417	tbc
Full compliance with WHO Surgical Safety Checklist	100%	100%	100%	100%	100%	100%
NEVER events	3	1	0	2	3	0
~SSIs: Total hip replacement (YTD is rolling 12 months)**			1.1%		3.0%	1.1%
~SSIs: Total knee replacement (YTD is rolling 12 months)**			0.8%		3.2%	1.5%
~SSIs: Large bowel surgery (YTD is rolling 12 months)**			14.9%		11.6%	12%
~SSIs: Breast surgery (YTD is rolling 12 months)**			4.2%		5.4%	3.8%
Falls resulting in harm£	481	461	510	456	451	456
Falls resulting in severe harm or death£	2	5	1	2	2	1
Repeat falls					97	113
Falls assessment within 24hrs of admission	90.9%	92.7%	90.9%	86.7%	86.8%	80%
Avoidable falls identified on the Safety Thermometer		0.62%	0.98%	0.83%	0.65%	0.76%
Grade 2 pressure ulcers	120	105	82	173	225	156
Grade 3 & 4 pressure ulcers	4	0	5	26	33	23
VTE Assessment Compliance	93.4%	96.0%	95.9%	*94.903%	95.3%	95%

~SSI data for 2015/16 is not all 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.

* Full 2015/16 year data presented compared to part year data presented in the 2015/16 Quality Report - 2015/16 updated with validated nationally published NHS figure (NHS Digital).

** Year to date data is to September 2016.

Clinical Effectiveness

Table 35. Clinical Effectiveness Indicators

Indicator	2012/13	2013/14	2014/15	2015/16	2016/17	Target 2016/17
Trust crude mortality rate (non-elective)	3.24%	3.22%	3.27%	3.13%	3.21%	3.13%
Crude mortality rate (non-elective): 12 month rolling	3.24%	3.22%	3.27%	3.13%	3.21%	3.13%
$Trust Hospital Standardised Mortality Ratio (HSMR)	112.03	103.6	95.4	**89.6	91.1	92.0
+Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	1.02	0.99	1.03	**1.00	0.97	1.00
Crude non-elective mortality for Renal failure	24.3%	24.1%	19.5%	**14.5%	15.5%	18.6%
$SMR for hip fracture (all diagnoses/procedures)	144.2	141.5	80.6	**70.1	93.6	100
$Worthing SMR for hip fracture (all diagnoses/procedures)	132.0	144.8	112.3	**78.1	100.1	100
$St Richard's SMR for hip fracture (all diagnoses/procedures)	163.1	136.6	42.7	**58.8	84.4	100
$30 day mortality rate following hip fracture	11.10%	8.3%	8.7%	**5.2%	6.4%	5.70%
Emergency readmissions within 30 days %		12.4%	13.2%	13.7%	14.2%	13%
C-Section Rate	24.7%	26.1%	26.9%	27.3%	28.6%	26%
% Mothers requiring forceps for delivery	11.30%	11.9%	11.9%	11.5%	11.8%	<15%
% Deliveries complicated by post-partum haemorrhage	0.7%	0.8%	0.6%	0.5%	0.5%	1%
Maternal deaths		0	0	0	0	0
% Admission of term babies to neonatal care		3.2%	2.4%	3.0%	3.3%	< 10%
% Emergency admissions staying over 72h screened for dementia		62.6%	92.4%	93.7%	93.2%	90%
% Patients identified as at risk of dementia for whom further investigations are carried out		82.1%	92.4%	91.9%	92.2%	90%
% Patients with identified dementia referred to specialist services		94.5%	98.9%	99.4%	100.0%	90%
Number of admissions for patients with dementia flag			1,832	2,442	2,921	NA
Ward moves for patients flagged with dementia			1,102	1,744	2,638	1,800

Indicator	2012/13	2013/14	2014/15	2015/16	2016/17	Target 2016/17
Night-time ward moves for patients flagged with dementia			492	470	555	120
Documentation Audit: % patients with dementia with Knowing Me document			75.4%	98.7%	92.5%	75%
*% CT scans undertaken within 12 hours			82.2%	**92.4%	95.5%	95%
*% Stroke thrombolysis within 60 minutes of hospital arrival			60.4%	**65.4%	76.2%	95%
*% Swallow screen for stroke patients within 4 hours of admission			77.0%	**78.9%	85.8%	95%
*% of stroke patients admitted to stroke unit within 4 hours of admission			69.8%	**76.4%	73.5%	90%
*% high risk TIA patients seen within 24 hours			77.3%	**64.8%	44.1%	60%
Patients recruited to interventional studies within CRN portfolio	540	282	179	201	258	tbc
Patients recruited to observational studies within CRN portfolio	417	285	1,093	405	980	tbc
Local Clinical Research Network (LCRN) Score	3,120	1,695	1,983	1,410	2,271	1,410
**NHS IC Data validity summary (YTD)	97.5%	98.7%	99.9%	**99.9%	99.9	96.6
% inpatients with electronic discharge summaries produced			84.2%	**84.2%	94.2%	tbc

*2015/16 figures for Stroke Indicators and NHS IC data validity are reported a month in arrears (Apr 15 to Feb 17)

+ Reported in arrears: 2016/17 Q2 is the latest available data.

$ Latest available data is 2016/17 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 2013/14 rebasing and therefore the 2013/14 value here will not match previously reported values."

** Full 2015/16 year data presented compared to part year data presented in the 2015/16 Quality Report

Patient Experience

Table 36. Patient Experience Indicators

Indicator	2012/13	2013/14	2014/15	2015/16	2016/17	Target 2016/17
Trust Friends and Family Recommend %: Inpatient			92.7%	95.2%	96.0%	97%
Trust Friends and Family Recommend %: A&E			90.9%	91.4%	89.0%	93%
Maternity Friends and Family Recommend %: Antenatal care (36 weeks)			96.1%	96.2%	96.7%	97%
Maternity Friends and Family Recommend %: Delivery care			97.1%	*96.2%	97.6%	97%
Maternity Friends and Family Recommend %: Postnatal ward			94.5%	95.7%	97.6%	97%
Maternity Friends and Family Recommend %: Postnatal community care			89.5%	98.1%	98.8%	97%
Trust Friends and Family Recommend %: Outpatient				*92.4%	95.4%	97%
Trust Friends and Family Response Rate: Inpatient		21.1%	34.5%	*25.8%	34.3%	40%
Trust Friends and Family Response Rate: A&E		19.7%	27.0%	*17.8%	12.5%	23%
Maternity Friends and Family Response Rate: Delivery care			29.1%	*11.7%	29.1%	40%
Percentage of re-booked outpatient appointments	9.8%	8.6%	8.7%	7.8%	8.9%	7.80%
Clinics cancelled with less than 6 week's notice for annual/study leave	376	266	340	281	278	281
PALS contacts relating to appointment problems (% of total appts)	0.12%	0.13%	0.09%	0.08%	0.08%	0.08%
Reduce patients cancelled on the day of surgery for non-clinical reasons	455	319	399	337	361	337
Breaches of mixed sex accommodation arrangements		0	0	1	6	0
Compliance with MUST[83] tool after 24 hours	85.6%	86.2%	81.8%	60.9%	76.0%	80%
Compliance with MUST tool after 7 days	95.4%	97.2%	94.9%	91.2%	97.8%	95%

[83] 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	2016/17	Target 2016/17
Internal PLACE compliance : St Richard's Hospital	95.0%	97.2%	97.8%	93.3%	94%	95%
Internal PLACE compliance : Worthing Hospital	95.0%	95.2%	95.1%	95.8%	95%	95%
Number of complaints	565	522	574	587	585	570
Complaints where staff attitude or behaviour is an issue	56	46	67	54	59	54
Complaints where staff communication is an issue	75	49	49	66	54	49
Complaints about nursing	41	29	46	39	59	39

Note 1: Complaints section relates to formal complaints only, does not include complaints received through PALS.

Note 2: Friends and Family Indicators - We report year end unvalidated figures in the Quality Scorecard. The FFT results published in the main body of this report are the validated figures published a month in arrears by NHS England.

* Full 2015/16 year data presented compared to part year data presented in the 2015/16 Quality Report

3.2 Access and Outcome Indicators relevant to our Trust (as described by Monitor's Risk Assessment Framework)

On the 1st April, Monitor was combined with the NHS Trust Development Authority, Patient Safety department, Advancing Change Team and Intensive Support Teams, into a new body called NHS Improvement (NHSI). They are responsible for overseeing foundation trusts and NHS Trusts, as well as independent providers, offering support to these providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. Western Sussex Hospitals report performance to NHSI against a limited set of national measures of access and outcome. NHSI uses performance against these indicators as a trigger to detect potential governance issues in hospitals.

Introduced in 2016/17 as a condition of the National Sustainability and Transformation Programme and funding, all Trusts have submitted joint performance plans on the key areas of A&E, RTT, Cancer, and Diagnostics. The detailed tracking of the Trust's performance against this trajectory is included in an Appendix of this report, and performance against the requirements is summarised for each relevant performance area.

NHS Improvement published the new Single Oversight Framework[84] for providers in September 2016. The framework replaces the Monitor Risk Assessment Framework and was introduced from 1st October 2016.

Table 37 shows performance against the relevant indicators in Monitor's Risk Assessment Framework[85] for Quarter 1 and 2 of 2016/17. 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. Western Sussex Hospitals scored 1 point in quarter 1 2016/17 of the Monitor Risk Assessment Framework and 2 points in quarter 2. This was due to non-compliance for the Referral to Treatment Waiting Target in quarters 1 and 2, and non-compliance against A&E 4 hour target in Quarter 2. The Trust with Coastal West Sussex CCG have been undertaking a joint recovery programme, supported by Monitor and NHS

[84] https://improvement.nhs.uk/uploads/documents/Single_Oversight_Framework_published_30_September_2016.pdf

[85] www.gov.uk/government/uploads/system/uploads/attachment_data/file/455893/RAF_revised_25_August.pdf

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.

The Trust Performance Quarter 3 against the Single Oversight framework shows compliant RTT position for December 2016 as planned as part of the Trust recovery trajectory. A&E performance for Quarter 3 was non-compliant. It was however compliant against the Trust's Strategic Transformation Fund (STF) trajectory (>94.5% Year to Date April – December 2016).

Trust performance Quarter 4 showed A&E performance below 95% in aggregate, due to non-compliant months January (91.08%) and February 93.75%. March 2017 however was compliant at 95.81%. RTT performance was compliant January and March (92% respectively). Cancer 62 day performance was compliant in aggregate quarter 4. Diagnostic performance was below the 1% target in January and February, but was compliant at the end of March (0.84%).

Performance Against the Monitor Risk Assessment Framework and NHS Improvement Single Oversight Framework 2016/17

Table 37. Performance against the NHS Improvement Single Oversight Framework

	Threshold	Weighting	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	1.0	96.56%	95.99%	95.97%	93.85%	94.24%	95.86%	93.50%	94.38%	91.01%	91.08%	93.75%	95.81%	94.37%
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	1.0	86.95%	88.15%	88.35%	88.41%	88.67%	89.20%	90.12%	91.76%	92.04%	92.01%	91.80%	92.01%	89.90%
All cancers : 62-day wait for first treatment following urgent GP Referral	85%	1.0	86.09%	86.45%	85.91%	86.96%	85.83%	89.92%	88.85%	88.69%	86.23%	86.29%	87.13%	90.66%	87.47%
All cancers : 62-day wait for first treatment following consultant screening service referral	90%		93.62%	96.08%	95.31%	100.00%	100.00%	93.94%	100.00%	100.00%	96.61%	97.37%	88.37%	100.00%	96.47%
Maximum 6-week wait for diagnostic procedures	94%	1.0	2.41%	1.50%	1.28%	0.27%	0.49%	0.88%	0.97%	0.85%	0.95%	2.33%	1.51%	0.84%	1.21%

Additional Indicators (Not included in Single Oversight Framework, but part of Monitor Risk Assessment Framework):

	Target 2016/17	Actual 2016/17
C. Diff - Number of hospital *C.diff* cases	39	46
C. Diff - Number of *C.diff* cases where a lapse in the quality of care was noted	16	21*

** Data to end of February 2017.*

Table 38. Strategic Transformation Fund Performance Trajectory Monitoring

			Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
RTT	Trajectory	52 Week Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
		Total Patients Waiting	36,390	36,792	36,247	37,107	36,645	35,535	37,802	37,802	37,802	36,884	37,533	37,660
		Patients waiting >18 weeks	5,216	4,916	4,616	4,316	4,166	3,866	3,566	3,241	3,041	2,951	3,003	3,013
		Compliance	85.67%	86.64%	87.26%	88.37%	88.63%	89.12%	90.57%	91.43%	91.96%	92.00%	92.00%	92.00%
	Actual	52 Week Trajectory	0	0	0	0	0	0	0	0	0	1	1	0
		Total Patients Waiting	35,584	35,148	34,317	34,682	35,096	35,078	34,658	33,101	32,349	32,294	33.022	33,823
		Patients waiting >18 weeks	4,645	4,164	3,999	4,021	3,978	3,789	3,425	2,728	2,574	2,579	2,709	2,703
		Cumulatively Ahead (behind trajectory)	571	1,323	1,939	2,234	2,422	2,499	2,624	3,137	3,620	3,991	4,284	4,594
		Compliance	86.95%	88.15%	88.35%	88.41%	88.67%	89.20%	90.12%	91.76%	92.04%	92.01%	91.80%	92.01%
A&E	Trajectory	Trust Patients Seen	11,194	11,748	11,632	12,125	12,080	11,280	11,309	10,571	10,710	10,454	9,790	11,693
		>4 Hours	559	587	581	606	604	564	565	528	535	522	489	584
		Performance	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
	Actual	Trust Patients Seen	12,138	13,465	12,811	13,848	13,299	12,718	12,747	12,048	12,472	11,565	10,696	12,382
		>4 Hours	417	540	516	851	766	526	828	677	1,121	1,032	668	519
		Performance	96.56%	95.99%	95.97%	93.85%	94.24%	95.86%	93.50%	94.38%	91.01%	91.08%	93.75%	95.81%
		Cumulative Performance	96.56%	96.26%	96.17%	95.55%	95.29%	95.38%	95.12%	95.03%	94.6%	94.3%	94.2%	94.4%
Cancer	Trajectory	Trust Patients Seen	165.0	140.0	174.5	172.0	161.0	170.5	172.5	176.5	170.0	169.0	151.0	170.0
		>62 days wait	24.5	21.0	26.0	25.5	24.0	25.5	25.5	26.0	25.5	25.0	22.5	25.5
		Performance	85.15%	85.00%	85.10%	85.17%	85.09%	85.04%	85.22%	85.27%	85.00%	85.21%	85.10%	85.00%
	Actual	Trust Patients Seen	160.5	156	174.5	141	149	140.5	169	188	153	179.5	*188.5*	164.5
		>62 days wait	21	19	23.5	16.5	18	13.5	17	22	18	22.5	*24*	13.5
		Performance	86.92%	87.82%	86.53%	88.30%	87.92%	90.39%	89.94%	88.30%	88.24%	87.47%	*87.27%*	*91.79%*
Diagnostics	Trajectory	Trust Patients Waiting	6,237	6,387	6,446	6,481	6,610	6,619	6,604	6,563	6,762	6,762	6,762	6,762
		>6 weeks wait	261	311	270	205	234	143	66	66	68	68	68	68
		Performance	4.2%	4.9%	4.2%	3.2%	3.5%	2.2%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
	Actual	Trust Patients Waiting	5,928	6,131	5,702	5,216	5,103	5,114	4,937	5,396	5,063	5,245	5,350	5,473

			Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
		>6 weeks wait	143	92	73	14	25	45	48	46	48	122	81	46
		Performance	2.41%	1.50%	1.28%	0.27%	0.49%	0.88%	0.97%	0.85%	0.95%	2.33%	1.51%	0.84%
		Cumulative Ahead (behind trajectory)	118	337	534	725	934	1032	1050	1070	1089	1035	1022	1043

Note: For STF cancer metric, cancer 62 day for first treatment following urgent referral, and following consultant screening service referral are combined into an aggregate metric with an 85% target, so cancer performance table 37 and 38 are not directly comparable.

	Performance meets Constitutional Standard and STF Trajectory
	Performance meets STF Trajectory but not Constitutional Standard
	Performance doesn't meet STF Trajectory

Western Sussex Hospitals
NHS Foundation Trust

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 2016/17

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
Adult Asthma British Thoracic Society	N	Y	Y	100%
Adult Cardiac Surgery National Institute for Cardiovascular Outcomes Research (NICOR)	Y	N	N/A	N/A
Asthma (paediatric and adult) care in emergency departments Royal College of Emergency Medicine	Y	Y	Y	100%
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
Chronic Kidney Disease in primary care Informatica Systems Ltd	N	N	N/A	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
Congenital Heart Disease (CHD) National Institute for Cardiovascular Outcomes Research (NICOR)	N	N	N/A	N/A
Coronary angioplasty National Institute for Cardiovascular Outcomes Research	Y	Y	Y	Ongoing
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
Endocrine and Thyroid National Audit British Association of Endocrine and Thyroid Surgeons	Y	SRH only	Y	Ongoing
Falls and Fragility Fractures Audit Programme (FFFAP) – National Falls audit Royal College of Physicians (London)	Y	Y	Y	Ongoing
Head and Neck Cancer Saving Faces - The Facial Surgery Research Foundation	Y	Y	Y	Ongoing
Inflammatory Bowel Disease (IBD) programme Royal College of Physicians (London)	Y	Y	Y	Ongoing
Learning Disability Mortality Review Programme (LeDeR Programme) University of Bristol	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
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 , Surgical, Mental Health and Child Health : clinical outcome review programme: National confidential enquiry into patient outcome and death NCEPOD	Y	Y	Y	Please see table below
National Audit of Dementia Royal College of Psychiatrists	Y	Y	Y	100%
National Audit of Pulmonary Hypertension Health & Social Care Information Centre (HSCIC)	N	N	N/A	N/A
National Cardiac Arrest Audit Intensive Care National Audit & Research Centre (ICNARC)	N	Y	Y	Ongoing
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme Royal College of Physicians	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
National Comparative Audit of Blood Transfusion programme -Patient Blood Management in Scheduled Surgery NHS Blood and Transplant	N	Y	Y	100%
National Diabetes Audit – Adults Health & Social Care Information Centre (HSCIC)	Y	Y	N	Lack of IT support Primary / Secondary Care
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 Lung Cancer Audit (NLCA) Royal College of Physicians	Y	Y	Y	Ongoing
National Neurosurgery Audit Programme Society of British Neurological Surgeons	N	N	N/A	N/A
National Ophthalmology Audit Royal College of Ophthalmologists	Y	Y	N	Lack of IT support

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
National Vascular Registry Royal College of Surgeons of England	N	N	N/A	N/A
Neonatal Intensive and Special Care (NNAP) The Royal College of Paediatrics and Child Health	Y	Y	Y	Ongoing
Nephrectomy audit British Association of Urological Surgeons	Y	Y	Y	Ongoing
Oesophago-gastric cancer (NAOGC) Royal College of Surgeons of England	Y	Y	Y	Ongoing
Paediatric Intensive Care (PICANet) University of Leeds	N	N	N/A	N/A
Paediatric Pneumonia British Thoracic Society	Y	Y	Y	100%
Percutaneous Nephrolithotomy (PCNL) British Association of Urological Surgeons	Y	Y	Y	Ongoing
Prescribing Observatory for Mental Health (POMH-UK) Royal College of Psychiatrists	N	N	N/A	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
Radical Prostatectomy Audit British Association of Urological Surgeons	Y	Y	Y	Ongoing
Renal Replacement Therapy (Renal Registry) UK Renal Registry	N	N	N/A	N/A
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
Severe Sepsis and Septic Shock – care in emergency departments Royal College of Emergency Medicine	Y	Y	Y	100%
Specialist rehabilitation for patients with complex needs London North West Healthcare NHS Trust	N	N	N/A	N/A
Stress Urinary Incontinence Audit British Association of Urological Surgeons	Y	Y	Y	Ongoing
UK Cystic Fibrosis Registry Cystic Fibrosis Trust	N	Y	Y	Ongoing

Western Sussex Hospitals NHS Foundation Trust

National Confidential Enquiries listed 2016/17

National Confidential Enquiries	Was the Trust eligible to take part	Did the Trust take part	Percentage case notes submitted
Mental Health	✓	✓	100%
Acute Pancreatitis	✓	✓	100%
Acute Non Invasive Ventilation	✓	✓	100%
Chronic Neurodisability	✓	✓	Study still open
Young Peoples Mental Health	✓	✓	Study still open
Cancer in Children, Teens and Young Adults	✓	✓	100%

Appendix 2 - Actions resulting from reviews of National Clinical Audits 2016/17

Audit title	Main points of action
National Hip Fracture Database [NHFD]	Worthing Hospital was an early adopter of the NHFD and it found the annual reports particularly useful to benchmark outcomes compared with other trusts nationally. These data provided a stimulus to reduce 30-day mortality for patients with hip fracture. In 2010–11 mortality was 17.9%, triggering a mortality alert. With support from the trust board and by collaborative working across geriatrics, orthopaedics, anaesthetics and the whole MDT, a new pathway was implemented. This incorporated best practice as identified by the database and it resulted in a reduction in mortality to 9.8% in 2012–13. When the 2014 NHFD annual report was published, it was clear that, although much improved, mortality was still above the national average at 10.8% for the previous 3 years (compared with 8.4% nationally). Since then, adherence to our pathway has been monitored and fed back to individuals and teams where adherence has wavered. Root cause analyses are run (by consultants from geriatrics, orthopaedics and anaesthetics) for all hip fracture deaths and learning points are circulated to all members of the MDT. Unadjusted 30-day mortality has now reduced to 6.4% for patients admitted in 2015 and 5.5% for the first 4 months of 2016. The pathway has been subsequently improved by incorporating knowledge gained over the last 5 years along with aspects of the NICE guidelines on falls and bone health assessments.
National Paediatric Diabetes report [NPDA]	The results of the audit showed improvements regarding the HbA1c results with an increased number of patients with a lower rate of <58 mmol [increase rate of 12% for WG and 9% for

Audit title	Main points of action
	SRH from last year] HbA1C and a decreased number of patients with a higher rate of 80+ mmol [decrease rate of 15.5% for WG and 2% for SRH from last year] which highlights a continuous focus of care.
End of life – EoL [RCP]	The documents regarding the needs of the person(s) important to the patient were promoted by the introduction of individualised End of Life care plans/ pathways. The documented frequency of the team's awareness of an individual care plan for the dying patient was low and needs to be increased.
National pregnancy in diabetes [Health & Social Care Information Centre]	WSHT updated their guidelines and care pathway for the management of women with diabetes in pregnancy incorporating changes recommended in the new NICE guideline as well as additional local changes which include a lower threshold (BM>7) for commencing sliding scale in labour in order to minimise percentage of infants admitted to NNU with rebound hypoglycaemia, an updated insulin sliding scale introduced, links to the Trust DKA guideline, uniform across the Trust – a change to universal screening of gestational diabetes at 28 weeks' gestation with early (at booking) screening of any woman with risk factors for gestational diabetes
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis [Northgate	WSHT developed referral criteria and management pathways for Early Inflammatory Arthritis (made available on CCG website); Large group teaching sessions were undertaken for GPs e.g. at GP Forum in Worthing and lunch clubs in Chichester.
Case Mix Programme (CMP) [INARC]	An audit of delayed admissions - Formal Audit with automated ICIP dashboard metric generation. Address patient flow and out of hours discharges, through a Kaizen event with work streams.

Appendix 3 - Actions resulting from reviews of local clinical audits 2016/17

Actions resulting from reviews of local clinical audits 2016-17

Title of audit	Recommendations/Actions
Smoking Cessation audit	A previous audit on advice for patients regarding smoking cessation was undertaken. The results were poor. Mandatory training on smoking cessation for all new staff in the trust was then undertaken. All patients in the re-audit, who were admitted as an emergency admission, were given advice on smoking cessation. There is now an electronic learning module for new doctors at induction.
Intraoperative Laryngeal Mask Airway (LMA) Cuff pressures and postoperative sore throat	A re-audit of LMA cuff pressures and the incidence of sore throat in the recovery room following the introduction of a syringe technique to lower cuff air volumes and therefore pressures was undertaken. The incidence of sore throat in the re-audit was half that of the original audit. Almost five times as many LMAs had cuff pressures within manufacturer recommendations following implementation of the plan. The audit intervention appears to have been successful at reducing LMA cuff pressures.
Audit of dietetic input with adult patients admitted to WSHT with Crohn's disease as a primary diagnosis	The Royal College of Physicians produced a report in February 2012 called the 'Report of the results for the national clinical audit of adult inflammatory bowel disease inpatient care in the UK'. This report recommends that all patients admitted with Crohn's disease should be seen by a dietitian. Following this report we completed an audit of dietetic input of adult patients admitted to WSHT with Crohn's disease as a primary diagnosis in 2013. The 2013 audit found 23% of patients were seen by a dietitian during their admission for Crohn's disease when looking at the Trust as a whole. We have now as a trust improved to 55%. We still need to improve, in particular with targeting the admissions wards to initiate a referral at the earliest opportunity.
Metastatic Spinal	MSCC is estimated to occur in approximately 5 to 10% of all

Title of audit	Recommendations/Actions
Cord Compression [MSCC]	cancer patients affecting not only quality of life but also prognosis. The strongest predictor of response to treatment is the functional status of the patient at the time of diagnosis. Therefore in order to prevent paralysis, the patient becoming immobile, it is vital to ensure the best possible outcome and quality of life by early diagnosis. Before 2012 there was no Acute Oncology Nurse led Team. A team was developed with a remit to coordinate the MSCC service during working hours. Now in 2016 we have a named coordinator for the service along with the implementation of the non-urgent seven day pathway has proved successful. The data clearly demonstrates that more patients are now being referred to the non-urgent pathway for imaging with a significant number having interventional treatment.
Retrospective audit of PEG tube placement	The original audit was undertaken in 2014 and re-audited in 2016. In 2016 the mortality rate was reduced by 10%, and the complication rate was reduced. Documentation of the MDT discussion increased to 93% . Consistency in dietitian involvement increased to 93%, and documentation of discussion with patient or family increased to 97%. Consent or Capacity assessment increased to 90%
Standards for intravenous fluid therapy - audit of maintenance fluids in surgical inpatients	WSHFT compared the department's practices of prescribing maintenance IV fluids to adult surgical inpatients with recommendations made by NICE CG174 and the GIFTASUP both before and after a teaching programme designed to re-familiarise doctors with the same guidelines.

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

Statement from Coastal West Sussex Clinical Commissioning Group

21st April 2017

NHS
Coastal West Sussex
Clinical Commissioning Group

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Marianne Griffiths
Chief Executive
Western Sussex Hospitals NHS Foundation Trust
St Richards Hospital
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Sent electronically to: Vivienne.Colleran@wsht.nhs.uk

21 April 2017

Dear Marianne,

Thank you for sending the draft Quality Report to Coastal West Sussex CCG.

The Quality Report has been reviewed and Coastal West Sussex CCG confirms that the account demonstrates progress against the priorities identified for 2016/17. 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 2016/17, 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 continued achievement and success of the Patient First programme with its focus on patients and the continued improvement of quality and safety; the Harm-Free Care work is commendable. The CCG wishes to acknowledge formally your ongoing contribution to the reduction of falls. We note the 10% reduction in 2016-2017 is a reflection of the work undertaken by ward teams and a focal point for the Board through True North metrics.

We note the success of the Maternity Services 'Team of the Year' RCM award for the improvement of services for women with additional needs and the considerable number of staff who have won either individual or team national awards.

The Quality Report 2016/17 outlines priorities for improvement in 2017/18 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.

Healthcare Associated Infections (HCAI) remains an area of concern as the *C.difficile* target of 39 has been exceeded. CWS CCG acknowledges the whole health economy approach taken by the Trust in this challenging area and executive oversight of the Root Cause Analysis meetings for *C.difficile* and MRSA bacteraemia cases. We will continue to work with the organisation to deliver the outcomes required for the year ahead with a focus on where the majority of these infections occur.

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

M. Dodd

Marie Dodd
Chief Operating Officer

NHS
Western Sussex Hospitals
NHS Foundation Trust

Statement from Healthwatch West Sussex

25th April 2017

Together we speak louder

healthwatch West Sussex

Healthwatch West Sussex response to Western Sussex Hospitals NHS Foundation Trust's Quality Accounts

As the independent voice for patients, Healthwatch West Sussex is committed to ensuring local people are involved in the improvement and development of health and social care services.

For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts, which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers). In West Sussex this translates to seven Quality Accounts from NHS Trusts. Each document is usually over 50 pages long and contains lengthy detailed accounts of how the Trust feels it has listened and engaged with patients to improve services.

Each year, we spend many hours of valuable time reading the draft accounts and giving clear guidance on how they could be improved to make them meaningful for the public. Each year we also state that each and every Trust could, and should, be doing more to proactively engage and listen to all the communities it serves.

Whilst we appreciate that the process of Quality Accounts is imposed on Trusts, we do not believe it is a process that benefits patients or family and friend carers, in its current format. This format has remained the same despite Healthwatch working strategically on this for over two years. We have reducing resources and we want to focus our effort where it has the most effect on patient care and we do not believe quality accounts have this impact.

This year we have been more proactive in our own engagement with local people in their communities, more direct in our influencing work and more critical of how commissioners and providers are communicating with local people. These activities have been a positive process and we feel a better use of our resource.

We remain committed to providing feedback to the Trust through a variety of channels to improve the quality, experience and safety of its patients.

Western Sussex Hospitals
NHS Foundation Trust

Healthwatch West Sussex 2017

Registered office: Healthwatch West Sussex C.I.C. 896 Christchurch Road, Pokesdown, BH7 6DL
Healthwatch West Sussex is a Community Interest Company limited by guarantee (No. 08557470)

Statement from Health & Adult Social Care Select Committee, West Sussex County Council

7th March 2017

From: Helena Cox [mailto:helena.cox@westsussex.gov.uk]
Sent: 07 March 2017 16:21
To: Colleran Vivienne (Western Sussex Hospitals); James Walsh
Cc: Bryan Turner; Francis Melissa (Western Sussex Hospitals); Findlay George (Western Sussex Hospitals)
Subject: RE: WSHFT Quality Improvement priorities for 2017/18 and Quality Report 2016/17 preparation

Dear Viv,

Just so you are aware HASC agreed last year that formal responses from the committee to Quality Accounts (QA), from last year onwards, would only be forwarded to NHS providers where HASC had undertaken formal scrutiny within the previous financial year. Therefore, we would not expect to formally respond to your draft QA this year. However, of course the Chairman and Vice Chairman can receive it for their information.

Any queries please let me know.

Kind regards,

Helena

west sussex county council

Helena Cox | Senior Advisor | Democratic Services **West Sussex County Council** | Location: Room 102, County Hall, Chichester, West Sussex. PO19 1RQ |Internal: 22533 | External: 0330 22 22533 | E-mail: **helena.cox@westsussex.gov.uk**
www.westsussex.gov.uk

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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.
NHS Improvement 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 2016/17 and supporting guidance

 the content of the Quality Report is not inconsistent with internal and external sources of information including:

- o board minutes and papers for the period April 2016 to [the date of this statement]
- o papers relating to quality reported to the board over the period April 2016 to [the date of this statement]
- o feedback from commissioners dated 21/04/2017
- o feedback from governors dated 03/03//2017
- o feedback from local Healthwatch organisations dated 25/04/2017
- o feedback from Overview and Scrutiny Committee dated 07/03/2017
- o the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 12/04/2017
- o the [latest] national patient survey 02/03/2017
- o the [latest] national staff survey 23/03/2017
- o the Head of Internal Audit's annual opinion of the trust's control environment dated 29/03/2017

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o CQC inspection report dated 20/04/2016

 the Quality Report presents a balanced picture of the NHS foundation 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 NHS Improvement'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

25th May 2017.....Date.....Chairman

25th May 2017.....Date.....Chief Executive

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Western Sussex Hospitals
NHS Foundation Trust

Limited Assurance Report on Quality

Western Sussex Hospitals
NHS Foundation Trust

Western Sussex Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2017

Western Sussex Hospitals
NHS Foundation Trust

Foreword to the accounts

Western Sussex Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2017, 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 **25th May 2017**

Statement of Comprehensive Income

	Note	2016/17 £000	2015/16 £000
Operating income from patient care activities	3	389,822	368,254
Other operating income	4	44,805	34,211
Total operating income from continuing operations		**434,627**	**402,465**
Operating expenses	5, 7	(425,329)	(402,612)
Operating surplus/(deficit) from continuing operations		**9,298**	**(147)**
Finance income	10	25	40
Finance expenses	11	(896)	(888)
PDC dividends payable		(7,604)	(7,551)
Net finance costs		**(8,475)**	**(8,399)**
Gains/(losses) of disposal of non-current assets	12	5	(5)
Surplus/(deficit) for the year		**828**	**(8,551)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(6,418)	(7,086)
Revaluations	18	723	17,837
Other reserve movements		4	-
Total comprehensive income/(expense) for the period		**(4,863)**	**2,200**

Statement of Financial Position

	Note	31 March 2017 £000	31 March 2016 £000
Non-current assets			
Intangible assets	15	3,972	2,364
Property, plant and equipment	16	268,574	280,615
Total non-current assets		**272,546**	**282,979**
Current assets			
Inventories	23	6,719	6,234
Trade and other receivables	24	30,432	22,762
Cash and cash equivalents	28	6,040	6,986
Total current assets		**43,191**	**35,982**
Current liabilities			
Trade and other payables	29	(41,697)	(38,219)
Other liabilities	31	(2,077)	(1,777)
Borrowings	32	(2,196)	(2,224)
Other financial liabilities	30	-	-
Provisions	34	(389)	(372)
Total current liabilities		**(46,359)**	**(42,592)**
Total assets less current liabilities		**269,378**	**276,369**
Non-current liabilities			
Trade and other payables	29	-	-
Other liabilities	31	-	-
Borrowings	32	(22,734)	(24,978)
Other financial liabilities	30	-	-
Provisions	34	(2,959)	(2,862)
Total non-current liabilities		**(25,693)**	**(27,840)**
Total assets employed		**243,685**	**248,529**
Financed by			
Public dividend capital		239,210	239,191
Revaluation reserve		47,821	53,516
Income and expenditure reserve		(43,346)	(44,178)
Total taxpayers' equity		**243,685**	**248,529**

The notes on pages 1 to 47 form part of these accounts.

Signed .....

Name **Marianne Griffiths**

Job title **Chief Executive**

Date **25th May 2017**

Statement of Changes in Equity for the year ended 31st march 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**239,191**	**53,516**	**(44,178)**	**248,529**
At start of period for new FTs	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	828	**828**
Transfers by absorption: transfers between reserves	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	**-**
Other transfers between reserves	-	-	-	**-**
Impairments	-	(6,418)	-	**(6,418)**
Revaluations	-	723	-	**723**
Transfer to retained earnings on disposal of assets	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	**-**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	**-**
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	**-**
Other recognised gains and losses	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	**-**
Public dividend capital received	19	-	-	**19**
Public dividend capital repaid	-	-	-	**-**
Public dividend capital written off	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	**-**
Other reserve movements	-	-	4	**4**
Taxpayers' and others' equity at 31 March 2017	**239,210**	**47,821**	**(43,346)**	**243,685**

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**
Prior period adjustment	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2015 - restated	**239,091**	**42,765**	**(35,627)**	**246,229**
At start of period for new FTs	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	(8,551)	**(8,551)**
Transfers by absorption: transfers between reserves	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	**-**
Other transfers between reserves	-	-	-	**-**
Impairments	-	(7,086)	-	**(7,086)**
Revaluations	-	17,837	-	**17,837**
Transfer to retained earnings on disposal of assets	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	**-**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	**-**
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	**-**
Other recognised gains and losses	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	**-**
Public dividend capital received	101	-	-	**101**
Public dividend capital repaid	-	-	-	**-**
Public dividend capital written off	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	**-**
Other reserve movements	(0)	-	-	**(0)**
Taxpayers' and others' equity at 31 March 2016	**239,191**	**53,516**	**(44,178)**	**248,529**

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	2016/17 £000	2015/16 £000
Cash flows from operating activities			
Operating surplus/(deficit)		9,298	(147)
Non-cash income and expense:			
Depreciation and amortisation	5.1	13,644	13,669
Net impairments	6	8,013	3,731
Income recognised in respect of capital donations	4	(1,847)	(1,519)
(Increase)/decrease in receivables and other assets		(7,995)	(1,691)
(Increase)/decrease in inventories		(485)	(182)
Increase/(decrease) in payables and other liabilities		4,125	(4,566)
Increase/(decrease) in provisions		107	(326)
Net cash generated from/(used in) operating activities		**24,859**	**8,969**
Cash flows from investing activities			
Interest received		25	40
Purchase of intangible assets		(1,763)	(2,139)
Purchase of property, plant, equipment and investment property		(15,546)	(13,346)
Sales of property, plant, equipment and investment property		5	-
Receipt of cash donations to purchase capital assets		1,847	1,519
Net cash generated from/(used in) investing activities		**(15,432)**	**(13,926)**
Cash flows from financing activities			
Public dividend capital received		19	101
Public dividend capital repaid		-	-
Movement on loans from the Department of Health		(2,157)	(2,157)
Capital element of finance lease rental payments		(115)	(103)
Interest paid on finance lease liabilities		(167)	(173)
Other interest paid		(718)	(669)
PDC dividend paid		(7,235)	(8,203)
Net cash generated from/(used in) financing activities		**(10,373)**	**(11,205)**
Increase/(decrease) in cash and cash equivalents		**(946)**	**(16,162)**
Cash and cash equivalents at 1 April		**6,986**	**23,148**
Cash and cash equivalents at 31 March	28.1	**6,040**	**6,986**

Notes to the Accounts

Note 1 Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. 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.

Going concern

The HM Treasury FReM 2016-17 has interpreted and adapted this for the public sector as "the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."

After making enquiries, the directors have a reasonable expectation that the 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.

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 IAS 27 Consolidated and Separate 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 has the power to exercise a significant influence. 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 assets, and obligations for the liabilities relating to 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.

At the end of the financial year, there were four unresolved data validation and reconciliation differences between the Trust and its principal commissioner, NHS Coastal West Sussex CCG. These amounted to a difference of £8.6m between the parties. These differences issues have not been resolved through the escalated negotiation process set out in the NHS Standard Contract and therefore the Trust and the CCG have agreed to progress to formal mediation. This mediation will not take place until June 2017.

In the absence of an outcome from the mediation process, the Trust has made an assessment of the risk, informed by legal advice and has included a provision within the income value in the accounts based on this assessment. The remaining income value has been reported in accordance with the accounting policy on recognition of income set out in Note 1.2

This therefore creates an uncertainty within the accounts, which would be material were the outcome of the mediation to go predominantly against the Trust.

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 DH GAM, impairments that arise from a clear consumption of economic benefits or of 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. :

- management are committed to a plan to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as "held for sale"; and
- 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.

Useful Economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min Life Years	Max Life Years
Land	1	35
Buildings, excluding dwellings	1	89
Dwellings	17	83
Plant & Machinery	5	35
Transport Equipment	0	0
Information Technology	1	7
Furniture & Fittings	1	15

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the FT expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

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.

Useful economic life of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min Life Years	Max Life Years
Intangible assets - internally generated		
Information technology	1	7
Development expenditure	1	7
Other	1	7
Intangible assets - purchased		
Software	1	7
Licences & trademarks	1	7
Patents	1	7
Other	1	7
Goodwill	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 account. 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 38.2 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 39 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 39, 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	Financial Year for which change applies
IFRS 9 Financial Instruments	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 14 Regulatory Deferral Accounts	Not yet EU-endorsed as is unlikely to be adopted by many EU countries. Applies to first time adopters of IFRS after 1 Jan 2016. Therefore not applicable to DH group bodies.
IFRS 15 Revenue from Contracts with Customers	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 16 Leases	Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

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)

	2016/17 £000	2015/16 £000
Acute services		
Elective income	67,315	64,547
Non elective income	124,761	113,470
Outpatient income	65,196	59,926
A & E income	16,112	15,162
Other NHS clinical income	108,155	107,711
All services		
Private patient income	6,556	6,147
Other clinical income	1,728	1,291
Total income from activities	**389,822**	**368,254**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2016/17 £000**	**2015/16 £000**
CCGs and NHS England	376,175	353,866
Local authorities	4,895	6,585
Department of Health	-	-
Other NHS foundation trusts	377	365
NHS trusts	-	-
NHS other	79	43
Non-NHS: private patients	6,556	6,147
Non-NHS: overseas patients (chargeable to patient)	269	180
NHS injury scheme (was RTA)	1,212	907
Non NHS: other	259	161
Additional income for delivery of healthcare services	-	-
Total income from activities	**389,822**	**368,254**
Of which:		
Related to continuing operations	389,822	368,254

Income from Patient Activities includes £373,725k (15/16: £347,234k) in respect of Commissioner Requested Services and £22,378k (15/16: £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 22.94% (15/16: 21.99%) 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)

	2016/17	2015/16
	£000	£000
Income recognised this year	269	180
Cash payments received in-year	146	84

Note 4 Other operating income

	2016/17	2015/16
	£000	£000
Research and development	1,248	192
Education and training	13,399	10,752
Receipt of capital grants and donations	1,847	1,519
Charitable and other contributions to expenditure	-	-
Non-patient care services to other bodies	13,445	16,258
Support from the Department of Health for mergers	-	-
Sustainability and Transformation Fund income	9,901	-
Other income	4,965	5,490
Total other operating income	**44,805**	**34,211**
Of which:		
Related to continuing operations	44,805	34,211
Related to discontinued operations	-	-

Note 5.1 Operating expenses

	2016/17	2015/16
	£000	£000
Services from NHS foundation trusts	542	518
Services from NHS trusts	2,329	2,138
Services from CCGs and NHS England	608	1,035
Employee expenses - executive directors	1,108	1,098
Remuneration of non-executive directors	121	122
Employee expenses - staff	281,581	267,465
Supplies and services - clinical	37,655	37,558
Supplies and services - general	4,502	4,229
Establishment	3,236	3,440
Transport	1,289	1,332
Premises	15,209	14,146
Increase/(decrease) in provision for impairment of receivables	24	18
Change in provisions discount rate(s)	228	(20)
Drug costs	40,447	38,276
Rentals under operating leases	11	49
Depreciation on property, plant and equipment	13,488	13,504
Amortisation on intangible assets	156	165
Net impairments	8,013	3,731
Audit fees payable to the external auditor		
audit services- statutory audit	83	80
other auditor remuneration (external auditor only)	-	73
Clinical negligence	7,261	5,187
Legal fees	677	596
Consultancy costs	690	758
Training, courses and conferences	1,009	1,055
Patient travel	112	107
Car parking & security	464	389
Redundancy	-	143
Early retirements	92	-
Hospitality	3	5
Insurance	625	577
Other services, eg external payroll	696	680
Losses, ex gratia & special payments	91	(75)
Other	2,979	4,233
Total	**425,329**	**402,612**
Of which:		
Related to continuing operations	425,329	402,612

Operating expenses includes expenditure accrued for which no invoice had been received by 31st March 2017. 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

Operating expenses includes expenditure accrued for which no invoice had been received by 31st March 2017. 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

	2016/17 £000	2015/16 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	73
Total	**-**	**73**

Note 5.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £2m (2015/16: £2m).

Note 6 Impairment of assets

	2016/17 £000	2015/16 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	8,013	3,731
Total net impairments charged to operating surplus / deficit	**8,013**	**3,731**
Impairments charged to the revaluation reserve	6,418	7,086
Total net impairments	**14,431**	**10,817**

Note 5.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £2m (2015/16: £2m).

Note 6 Impairment of assets

	2016/17 £000	2015/16 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	8,013	3,731
Total net impairments charged to operating surplus / deficit	**8,013**	**3,731**
Impairments charged to the revaluation reserve	6,418	7,086
Total net impairments	**14,431**	**10,817**

Note 7 Employee benefits

	2016/17 Total £000	2015/16 Total £000
Salaries and wages	**218,586**	206,425
Social security costs	**20,388**	15,564
Employer's contributions to NHS pensions	**25,440**	24,063
Pension cost - other	**-**	-
Other post employment benefits	**-**	-
Other employment benefits	**-**	-
Termination benefits	**-**	143
Temporary staff (including agency)	**18,887**	23,263
Total gross staff costs	**283,301**	**269,458**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**283,301**	**269,458**
Of which		
Costs capitalised as part of assets	612	752

Note 7.1 Retirements due to ill-health

During 2016/17 there were 4 early retirements from the trust agreed on the grounds of ill-health (6 in 2015/16). The estimated additional pension liabilities of these ill-health retirements is £282k (£345k in 2015/16).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that 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 scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) 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 scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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. These accounts can be viewed on the NHS Pensions website and are published annually. 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 schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed 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.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 9 Operating leases

	2016/17 £000	2015/16 £000
Operating lease expense		
Minimum lease payments	11	49
Total	**11**	**49**

	31 March 2017 £000	31 March 2016 £000
Future minimum lease payments due:		
- not later than one year;	11	49
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total	**11**	**49**
Future minimum sublease payments to be received	-	-

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2016/17	2015/16
	£000	£000
Interest on bank accounts	25	40
Total	**25**	**40**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2016/17	2015/16
	£000	£000
Interest expense:		
Loans from the Department of Health	710	670
Finance leases	171	174
Interest on late payment of commercial debt	8	-
Total interest expense	**889**	**844**
Other finance costs (unwinding of discounts)	7	44
Total	**896**	**888**

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2016/17	2015/16
	£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 Gains/losses on disposal/derecognition of non-current assets

	2016/17	2015/16
	£000	£000
Profit on disposal of non-current assets	5	-
Loss on disposal of non-current assets	-	(5)
Net profit/(loss) on disposal of non-current assets	**5**	**(5)**

Note 13 Corporation tax

The Trust did not pay any Corporation Tax in 2016/17

Note 14 Discontinued operations

There were no discontinued operations in 2016/17

Note 15.1 Intangible assets - 2016/17

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**5,461**	**1,863**	**7,324**
Valuation/gross cost at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	-
Additions	4	1,759	**1,763**
Impairments	-	-	-
Reversals of impairments	-	-	-
Reclassifications	299	(299)	-
Revaluations	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Gross cost at 31 March 2017	**5,764**	**3,323**	**9,087**
Amortisation at 1 April 2016 - brought forward	**4,960**	**-**	**4,960**
Amortisation at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	-
Provided during the year	156	-	**156**
Impairments	-	-	-
Reversals of impairments	-	-	-
Reclassifications	-	-	-
Revaluations	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Amortisation at 31 March 2017	**5,116**	**-**	**5,116**
Net book value at 31 March 2017	**649**	**3,323**	**3,972**
Net book value at 1 April 2016	**501**	**1,863**	**2,364**

Note 15.2 Intangible assets - 2015/16

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2015 - as previously stated	**5,185**	**-**	**5,185**
Prior period adjustments	-	-	-
Gross cost at 1 April 2015 - restated	**5,185**	**-**	**5,185**
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	-	-	-
Valuation/gross cost at 31 March 2016	**5,461**	**1,863**	**7,324**
Amortisation at 1 April 2015 - as previously stated	**4,795**	**-**	**4,795**
Prior period adjustments	-	-	-
Amortisation at 1 April 2015 - restated	**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 16.1 Property, plant and equipment - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2016 - brought forward	**36,963**	**329,459**	**11,504**	**2,754**	**62,670**	**264**	**19,206**	**2,504**	**465,324**
Valuation/gross cost at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	290	3,328	-	6,969	3,865	-	681	22	**15,155**
Impairments	(154)	(5,830)	(434)	-	-	-	-	-	**(6,418)**
Reversals of impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	1,129	-	(1,129)	-	-	-	-	-
Revaluations	319	340	64	-	-	-	-	-	**723**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(457)	-	-	-	**(457)**
Valuation/gross cost at 31 March 2017	**37,418**	**328,426**	**11,134**	**8,594**	**66,078**	**264**	**19,887**	**2,526**	**474,327**
Accumulated depreciation at 1 April 2016 - brought forward	**18,216**	**107,281**	**3,700**	**-**	**40,916**	**264**	**12,325**	**2,007**	**184,709**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	8,656	166	-	3,239	-	1,353	74	**13,488**
Impairments	696	6,974	412	-	-	-	-	-	**8,082**
Reversals of impairments	(10)	(50)	(9)	-	-	-	-	-	**(69)**
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-	-
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals/ derecognition	-	-	-	-	(457)	-	-	-	**(457)**
Accumulated depreciation at 31 March 2017	**18,902**	**122,861**	**4,269**	**-**	**43,698**	**264**	**13,678**	**2,081**	**205,753**
Net book value at 31 March 2017	**18,516**	**205,565**	**6,865**	**8,594**	**22,380**	**-**	**6,209**	**445**	**268,574**
Net book value at 1 April 2016	**18,747**	**222,178**	**7,804**	**2,754**	**21,754**	**-**	**6,881**	**497**	**280,615**

The additions balance above is reduced by £775k due to VAT reclaims received during the year in relation to prior year additions.

Note 16.2 Property, plant and equipment - 2015/16

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2015 - as previously stated	**42,780**	**306,091**	**11,335**	**1,226**	**62,505**	**264**	**16,782**	**2,241**	**443,224**
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation/gross cost at 1 April 2015 - restated	**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	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	-	-	-
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**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
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 - as previously stated	**2,027**	**111,566**	**3,450**	**-**	**41,125**	**264**	**10,762**	**1,863**	**171,057**
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2015 - restated	**2,027**	**111,566**	**3,450**	**-**	**41,125**	**264**	**10,762**	**1,863**	**171,057**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	-	-	-
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)**
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-	-
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
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 16.3 Property, plant and equipment financing - 2016/17

	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 2017									
Owned	18,108	193,969	4,708	8,594	18,543	-	6,103	251	**250,276**
Finance leased	-	-	2,157	-	290	-	-	-	**2,447**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	**-**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Government granted	-	-	-	-	-	-	-	-	**-**
Donated	408	11,596	-	-	3,547	-	106	194	**15,851**
NBV total at 31 March 2017	**18,516**	**205,565**	**6,865**	**8,594**	**22,380**	**-**	**6,209**	**445**	**268,574**

Note 16.4 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**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	**-**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Government granted	-	-	-	-	-	-	-	-	**-**
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 17 Donations of property, plant and equipment

There is no difference between the cash provided and the fair value of the assets acquired.

Note 18 Revaluations of property, plant and equipment

The date of the valuation was the 22nd March 2017 and was carried out by the District Valuer. It was a desktop exercise using the latest BCIS indices and local market conditions to value Buildings, Dwellings & Land on an alternative site basis, with site optimisation applied.

Note 19.1 Investment Property

The Trust had no investments in 2016/17

Note 19.2 Investment property income and expenses

The Trust had no investment property income and expenses in 2016/17

Note 20 Investments in associates (and joint ventures)

The Trust has no investments in unconsolidated subsidiaries, joint ventures, associates or unconsolidated entities.

Note 21 Other investments

The Trust has no other investments in 2016/17.

Note 22 Disclosure of interests in other entities

The Trust has no interests in unconsolidated subsidiaries, joint ventures, associates or unconsolidated entities.

Note 22 Disclosure of interests in other entities

The Trust has no interests in unconsolidated subsidiaries, joint ventures, associates or unconsolidated entities.

Note 23 Inventories

	31 March 2017 £000	31 March 2016 £000
Drugs	2,685	2,724
Work In progress	-	-
Consumables	3,859	3,365
Energy	95	59
Inventories carried at fair value less costs to sell	-	-
Other	80	86
Total inventories	**6,719**	**6,234**

Inventories recognised in expenses for the year were £48,698k (2015/16: £39,209k). Write-down of inventories recognised as expenses for the year were £0k (2015/16: £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 24.1 Trade receivables and other receivables

	31 March 2017 £000	31 March 2016 £000
Current		
Trade receivables due from NHS bodies	13,610	8,146
Receivables due from NHS charities	329	585
Provision for impaired receivables	(741)	(882)
Prepayments (non-PFI)	1,436	2,405
Accrued income	10,036	6,867
PDC dividend receivable	-	325
VAT receivable	-	106
Other receivables	5,762	5,210
Total current trade and other receivables	**30,432**	**22,762**
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 2017 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 24.2 Provision for impairment of receivables

	2016/17	2015/16
	£000	£000
At 1 April as previously stated	**882**	**958**
Increase in provision	24	18
Amounts utilised	(165)	(94)
Unused amounts reversed	-	-
At 31 March	**741**	**882**

The provision for impairment of receivables is in line with IFRS and are based on incurred losses and not general losses.

Note 24.3 Analysis of financial assets

	31 March 2017		31 March 2016	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	42	-	16	-
30-60 Days	125	-	22	-
60-90 days	182	-	19	-
90- 180 days	139	-	58	-
Over 180 days	253	-	767	-
Total	**741**	**-**	**882**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	360	-	843	-
30-60 Days	158	-	490	-
60-90 days	109	-	251	-
90- 180 days	248	-	423	-
Over 180 days	1,410	-	1,813	-
Total	**2,285**	**-**	**3,819**	**-**

Note 24.4 Finance Lease receivables

The Foundation Trust was not a lessor during the reporting period.

Note 25 Other assets

The Trust has no other assets.

Note 26 Other financial assets

The Trust has no other financial assets.

Note 27.1 Non-current assets for sale and assets in disposal groups

The Board has not declared any assets being surplus to requirements in 2016/17

Note 27.2 Liabilities in disposal groups

The Trust has no liabilities in disposal groups.

Note 28.1 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.

	2016/17	2015/16
	£000	£000
At 1 April	**6,986**	**23,148**
Net change in year	(946)	(16,162)
At 31 March	**6,040**	**6,986**
Broken down into:		
Cash at commercial banks and in hand	(97)	(25)
Cash with the Government Banking Service	6,137	7,011
Total cash and cash equivalents as in SoFP	**6,040**	**6,986**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**6,040**	**6,986**

Note 28.2 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 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 2017	31 March 2016
	£000	£000
Bank balances	1	1
Total third party assets	**1**	**1**

Note 29.1 Trade and other payables

	31 March 2017 £000	31 March 2016 £000
Current		
NHS trade payables	2,013	1,032
Other trade payables	12,271	11,601
Capital payables	3,532	3,923
Social security costs	3,064	2,462
VAT payable	56	-
Other taxes payable	2,730	2,583
Other payables	3,530	3,659
Accruals	14,457	12,959
PDC dividend payable	44	-
Total current trade and other payables	**41,697**	**38,219**
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 29.2 Early retirements in NHS payables above

The trust has no early retirements in NHS payables above.

Note 30 Other financial liabilities

The trust has no other financial liabilities.

Note 31 Other liabilities

	31 March 2017 £000	31 March 2016 £000
Current		
Deferred grants income	315	105
Deferred goods and services income	1,762	1,672
Total other current liabilities	**2,077**	**1,777**
Total other non-current liabilities	**-**	**-**

Note 32 Borrowings

	31 March 2017 £000	31 March 2016 £000
Current		
Loans from the Department of Health	2,158	2,158
Obligations under finance leases	38	66
Total current borrowings	**2,196**	**2,224**
Non-current		
Loans from the Department of Health	20,455	22,612
Obligations under finance leases	2,279	2,366
Total non-current borrowings	**22,734**	**24,978**

Note 33 Finance leases

Note 33.1 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 33.2 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 2017 £000	31 March 2016 £000
Gross lease liabilities	**12,101**	**12,389**
of which liabilities are due:		
- not later than one year;	207	221
- later than one year and not later than five years;	830	879
- later than five years.	11,064	11,289
Finance charges allocated to future periods	(9,785)	(9,957)
Net lease liabilities	**2,317**	**2,432**
of which payable:		
- not later than one year;	38	66
- later than one year and not later than five years;	176	201
- later than five years.	2,103	2,165
	2,317	**2,432**
Contingent rent recognised as an expense in the period	116	114

Note 34.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Other legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2016	**1,392**	**141**	**1,701**	**3,234**
Change in the discount rate	87	-	141	**228**
Arising during the year	27	65	96	**188**
Utilised during the year	(131)	-	(99)	**(230)**
Reversed unused	(32)	(47)	-	**(79)**
Unwinding of discount	3	-	4	**7**
At 31 March 2017	**1,346**	**159**	**1,843**	**3,348**
Expected timing of cash flows:				
- not later than one year;	131	159	99	**389**
- later than one year and not later than five years;	508	-	393	**901**
- later than five years.	707	-	1,351	**2,058**
Total	**1,346**	**159**	**1,843**	**3,348**

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.

Other provisions relate to injury benefits that are administered by the NHS Business Services Authority.

Any variation in outcome compared to the provisions are accounted for in the next financial year.

Note 34.2 Clinical negligence liabilities

At 31 March 2017, £141,133k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Western Sussex Hospitals NHS Foundation Trust (31 March 2016: £111,942k).

Note 35 Contingent assets and liabilities

	31 March 2017 £000	31 March 2016 £000
Value of contingent liabilities		
NHS Litigation Authority legal claims	(48)	(53)
Gross value of contingent liabilities	**(48)**	**(53)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(48)**	**(53)**
Net value of contingent assets	**-**	**-**

The Foundation Trust has no contingent liabilities other than those advised by the NHSLA as at 31st March 2017 shown above.

The Foundation Trust has no contingent assets.

Note 36 Contractual capital commitments

	31 March 2017 £000	31 March 2016 £000
Property, plant and equipment	3,219	8,974
Intangible assets	-	809
Total	**3,219**	**9,783**

Note 37 Financial instruments

Note 37.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Commissioners and the way those Commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has some powers to borrow or invest surplus funds. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

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 2017 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 NHS Improvement's Continuity of Services Risk Rating. The Trust is not, therefore, exposed to significant liquidity risks.

Note 37.2 Financial assets

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total £000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	26,740	-	-	-	**26,740**
Cash and cash equivalents at bank and in hand	6,040	-	-	-	**6,040**
Total at 31 March 2017	**32,780**	**-**	**-**	**-**	**32,780**

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total £000
Assets as per SoFP as at 31 March 2016					
Embedded derivatives	20,639	-	-	-	**20,639**
Cash and cash equivalents at bank and in hand	6,986	-	-	-	**6,986**
Total at 31 March 2016	**27,625**	**-**	**-**	**-**	**27,625**

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 2017			
Borrowings excluding finance lease and PFI liabilities	22,613	-	**22,613**
Obligations under finance leases	2,317	-	**2,317**
Trade and other payables excluding non financial liabilities	32,272	-	**32,272**
Total at 31 March 2017	**57,202**	**-**	**57,202**

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2016			
Borrowings excluding finance lease and PFI liabilities	24,770	-	**24,770**
Obligations under finance leases	2,432	-	**2,432**
Trade and other payables excluding non financial liabilities	29,352	-	**29,352**
Total at 31 March 2016	**56,554**	**-**	**56,554**

Note 37.4 Maturity of financial liabilities

	31 March 2017	31 March 2016
	£000	£000
In one year or less	32,272	31,576
In more than one year but not more than two years	2,196	2,194
In more than two years but not more than five years	7,518	5,865
In more than five years	15,216	16,919
Total	**57,202**	**56,554**

Note 37.5 Fair values of financial assets at 31 March 2017

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 2017

	Book value	Fair value
	£000	£000
Loans	20,455	20,455
Other	2,279	2,279
Total	**22,734**	**22,734**

Note 37.7 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

	2016/17		2015/16	
	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	60	68	51	61
Total special payments	**60**	**68**	**51**	**61**
Total losses and special payments	**60**	**68**	**51**	**61**

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

Early in 2016/17, as a result of our successful performance, we were asked to help Brighton and Sussex University Hospitals (BSUH) improve performance. Our neighbouring Trust is in special measures for safety and finances, which, inevitably, has a knock-on effect for patients in Western Sussex.

In March of this year the Board approved the Trust entering into a 3-year management contract to run Brighton and Sussex University Hospital Trust (BSUH). The purpose of this support arrangement is to help stabilise BSUH, a trust that has many positive attributes but has seen significant senior management change over recent years.

Note 42 Related parties

	Receivables		Payables	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
NHS Coastal West Sussex	11,074	3,170	1,472	1,472
NHS England	5,284	3,547	344	302
Sussex Community Trust	1,437	1,137	142	262
Sussex Partnership Foundation Trust	1,406	1,464	59	213
Western Sussex Hospitals Charities and Other Related Charities	793	1,007		-
Total	**19,993**	**10,325**	**2,018**	**2,249**

Details of related party transactions with individuals are as follows:

	Income		Expenditure	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
BT (related to Jon Furmston, Non-Executive Director)			84	89

	Income		Expenditure	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
NHS Coastal West Sussex	302,507	284,231	-	94
NHS England	67,034	53,731	608	1,080
Sussex Community Trust	3,162	3,610	423	649
Sussex Partnership Foundation Trust	3,576	3,533	189	467
South Eastern Hampshire CCG	6,017	5,756	-	-
Health Education England	12,864	13,216	-	3
Charities	560	1,519		
Total	**395,721**	**365,596**	**1,220**	**2,293**

NHS
Western Sussex Hospitals
NHS Foundation Trust