Western Sussex Hospitals
NHS Foundation Trust

Meeting of the Board of Directors

10:30 to 13:00 on Thursday 26 September 2019

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

AGENDA – MEETING IN PUBLIC

1.	10.30	**Welcome and Apologies for Absence** To note	Verbal	Chair
2.	10.30	**Declarations of Interests** To note	Verbal	All
3.	10.30	**Minutes of Board Meeting held on 25 July 2019** To approve	Enclosure	Chair
4.	10.30	**Matters Arising from the Minutes** NONE	None	Chair
5.	10.35	**Report from Chief Executive** To receive and note overview of the Trust's activities	Enclosure	Marianne Griffiths
		INTEGRATED PERFORMANCE REPORT		
6.	10.45	**Introduction from Chief Executive** To receive and note overview of the Trust's activities	Enclosure	Marianne Griffiths
7.	10.55	**Quality Improvement** To receive and agree any necessary actions *After this section the Chair of Quality Assurance Committee will be invited to provide their report included at item 12* To receive assurance from Committee and recommendations from the Committee	Enclosure	George Findlay Maggie Davies
8.	11.10	**Systems and Partnerships** To receive and agree any necessary actions	Enclosure	Amanda Fadero
9.	11.20	**Sustainability** To receive and agree any necessary actions *After these two sections the Chair of Finance and Performance Committee will be invited to provide their report included at item 11* To receive assurance from Committee and recommendations from the Committee	Enclosure	Karen Geoghegan
10.	11.30	**Our People** To receive and agree any necessary actions *At this point the Chairs of the Committee will be invited to provide any additional assurance from the work of their*	Enclosure	Denise Farmer

committees.

ASSURANCE REPORTS FROM COMMITTEES

11.	-	**Report from Quality Assurance Chair *including Quality Strategy 2019-21*** To receive assurance from Committee and recommendations from the Committee	To follow	Mike Rymer
12.	-	**Report from Finance and Performance Chair** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
13.	11.45	**Board Assurance Framework** To approve for publication on the web site	Enclosure	Glen Palethorpe

SERVICE PRESENTATION

14.	11.50	**Critical Care Service Presentation** To receive assurance over application of patient first processes	Presentation	Surgery Division

OUR PEOPLE

15.	12.05	**Nurse Staffing Capacity Report** To receive and agree any necessary actions	Enclosure	Maggie Davies

QUALITY

16.	12.15	**Annual Infection Control Report** To receive activity information for 2018/19	Presentation	Maggie Davies/ Sharon Reed

WELL LED & COMPLIANCE

17.	12.30	**Winter Plan** To receive and agree any necessary actions	Presentation	Amanda Fadero
18.	12.40	**Company Secretary Report** To note	Enclosure	Glen Palethorpe

OTHER

19.	12.45	**Any Other Business** To receive and action	Verbal	Chair
20.	12.50	**Questions from the public** To receive and respond to questions submitted by the public	Verbal	Chair
21.	13.00	**Date and time of next meeting:** The next meeting in public of the Board of Directors is scheduled to take place at **09:30** on **28th November 2019** in the Bateman Room, CMEC, St Richard's Hospital.	Verbal	Chair

To resolve to move to into private session

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

Trust Board of Directors Quoracy

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

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

Minutes

Minutes of the Board of Directors meeting held in Public at 09.30am on Thursday 25 July 2019, Mickerson Hall, Chichester Medical Education Centre, St Richard's Hospital, Spitalfield Lane, Chichester, PO19 6SE.

Present:	Alan McCarthy	Chairman
	Patrick Boyle	Non-Executive Director
	Mike Rymer	Non-Executive Director
	Joanna Crane	Non-Executive Director
	Lizzie Peers	Non-Executive Director
	Kirstin Baker	Non-Executive Director Adviser
	Dame Marianne Griffiths	Chief Executive
	George Findlay	Chief Medical Officer & Deputy Chief Executive
	Denise Farmer	Chief Workforce and OD Officer
	Maggie Davies	Chief Nurse
	Amanda Fadero	Managing Director
In Attendance:	Alison Ingoe	Finance Director
	Amanda Wellesley	Chief of Service – Medicine (For Item 15)
	Julie Thomas	Head of Nursing – Medicine (For Item 15)
	Andrew Hetreed	Clinical Lead for Organ Donation (For Item 16)
	Cathy Coppard	Named Nurse Safeguarding – Children (For Item 19)
	Annie Blackwell	Named Nurse Safeguarding – Adults (For Item 19)
	Glen Palethorpe	Group Company Secretary
	Tanya Humphrys	Board Administrator

TB/07/19/01 Welcome and Apologies

1.1 The Chair welcomed all those present to the meeting.

1.2 Apologies were received from Karen Geoghegan, Pete Landstrom and Jon Furmston.

TB/07/19/02 Declarations of Interests

2.1 There were no declarations of interest.

TB/07/19/03 Minutes of Board Meeting held on 30 May 2019

3.1 The Board received the minutes of the meeting held on 30 May 2019.

3.2 **The Board resolved that the minutes of the Board meeting held on 30 May 2019, would be approved as a correct record of the meeting and signed by the Chairman.**

TB/07/19/04 Matters arising from Minutes

4.1 The Matters Arising from previous meetings were received.

4.2 All Matters Arising related to items on the agenda or were on a forward agenda plan and the Board agreed to close all items.

TB/07/19/05 Chief Executive's Report

5.1 Dame Marianne Griffiths introducted the Chief Executives report and highlighted the following key areas.

5.2 **Worthing Pride** – The Board was advised that the first week of July saw Worthing hold its second Pride, with colleagues from Sussex Partnership, Sussex Community NHS trusts and Unite joining Western Sussex colleagues at Worthing Pride to celebrate the diversity of our organisations and the people we serve.

5.3 **Equality and Diversity Staff Conference** – Marriane noted that the Trust held the second of its staff conferences on 13 June. The conference theme this year is *Diverse, Inclusive and Together* and is part of a wider strategy of celebrating diversity at WSHT as the Trust continue to improve the services it provides.

5.4 **Fraility Intervention Teams** – The Board was advised that new Fraility Intervention Teams (FIT) had been established to provide more specialist support for older and more frail patients in the trust's emergency departments.

5.5 **Junior Doctors Excellence Awards** – Marianne highlighted that the Trust had recently held its inaugural Trainee Doctor Excellence Awards in Arundel on 21 June, which saw 170 nominations and was a truly uplifting event.

5.6 Marianne went on to advise the Board about a number of other achievements that had taken place within the Trust in the previous months, including formally recognising the Trust Volunteers and in particular the Friends of Chichester Hospitals as they celebrated receiving the highest honour a voluntary group can be given.

5.7 Marianne went on to draw the Board's attention to the following diary highlights and explained breifly the value the Trust had received from attendance at these events:

- Meetings with partner organisations
- Sustainability and Transformation Partnership
- Acute Network
- Healthcare Women Leaders Network
- NHS Providers Quality Conference
- NHS Confederation Annual Conference
- Medical Education Conference
- Volunteers Summer tea party
- Council of Governors meeting
- Band 7 leadership programme

5.8 Looking ahead Marianne advised the Board that the CQC inspection regime was progressing , the Trust had the Use of Resources assessment in June and an unannounced service inspection earlier in the week [23 and 24 July] which focused on Critical Care. Marianne paid tribute to all the staff who engaged with the inspectors with pride and enthusiasm, commenting that she couldn't be more proud.

5.9 Finally Marianne noted that the Trust had received 820 nominations as part of this years STAR Awards event, with judging taking place soon. Marianne highlighted that 120 of the nominations came from patients with some incredible stories particularly in relation to care and compassion.

5.10 The Board **NOTED** the Chief Executive's Report.

TB/07/19/06 Integrated Performance Report

6.1 Dame Marianne Griffiths introduced the Integrated Performance Report explaining that Patient First is the Trust's methodology encapsulating the Trust's vison, values and goals and how it aligns its processes and governance, highlighting that there are three key streams of work that feed into the Trust's Patient First True North; Breakthrough Objectives, Corporate Projects and Strategic Initiatives.

6.2 **Quality**
George Findlay updated the Board on the key messages from the Quality section of the report noting that in relation to Mortality the Trust aspiration was to be in the top 20 hospitals and over the previous months HSMR has been trending upwards, putting WSHT in the 38 percentile.

6.3 George explained that following analysis of the data for the observed number of deaths compared to the expected number of deaths, there had been a reduction in the actual number of deaths but there had been a greater decrease in the number of expected deaths. The Board was advised that it was felt this is largely down to coding, it was noted that there had been national changes to the way sepsis is coded. George explained that WSHT had implemented these changes and the result being the change in expected death figures. George assured the Board that the Trust has a process correctly and accurately coding sepsis and has no concerns regarding the data.

6.4 Maggie Davies advised the Board that the Trust continues to deliver its planned improvement work within falls and that the actual number of patients who suffered no new harm during their inpatient stay at WSHT during June was at 98.7%, just below the stretching target of 99%.

6.5 The Board was updated regarding patient experience performance, Maggie explained that the Trust works closely with patients and families across its services to ensure their views and experiences inform our improvement work. It was noted that in recent months WSHFT staff had:

- Continued to embrace the duty of candour process successfully
- Reformed how we respond when people raise concerns to centre our responses to the person, seeing ward sisters and matrons pick up the phone as soon as a complaint is raised and in so doing are often able to solve problems directly
- Used patient stories in our education programmes, sharing at huddles (via the safety newsletter) and at key trust meetings.

6.6 The Chairman invited the Chair of the Quality Assurance Committee, Joanna Crane, to update the Board on their recent meeting and the assurances received in relation to Quality.

6.7 Joanna explained that the Committee had received a number of one off updates which were detailed within the report to Board, it was noted that the Committee had been provided with very good assurance in respect of the incident report and application of the duty of candour where it is clear that the Trust has a very strong reporting culture.

6.8 It was noted that the Committee had received reports that provided assurance in relation to mortality reviews and the Gosport independent panel report assured the Committee that the Trust has robust processes and checks in place to prevent similar incidents happening within WSHFT due to the strong reporting culture.

6.9 The Committee also received a Deep Dive into End of Life Care (EOLC) which focused on the support provided by the Trust to patients and

families dealing with EOLC which gave assurance over the Trust's processes.

6.10 Alan McCarthy asked, in relation to HSMR, whether other Trusts were experiencing the same changes with their data. George explained that comparison is difficult as there is a technical coding issue at present and there is ongoing work to resolve the issue, working in conjunction with clinicians and coders to ensure that the information provided in patient notes is complete and therefore is coded correctly especially in relation to Sepsis.

6.11 **Systems & Partnerships**

Amanda Fadero drew out the following key points in respect of the Trust's operational performance in June 2019:

- A&E 4hr performance for June 19 was 92.4%, compared to 86.4% National performance. There were no 12 hr breaches. WSHFT sites were the 9th highest performing Type 1 A&Es nationally.
- RTT compliance in June 19 was 83.5% with no patients waiting over 52 weeks. The lower number of working days in June and lower activity impacted on the Trust in month performance but the Trust remains on track to deliver the 92% target by the end of the year. The compliance against the RTT target for patients on an outpatient pathway improved to 90%.
- Cancer performance for June-19 was compliant against all of the targets, with 85.1% of patients treated within 62 days. This is well ahead of the Trust's recovery plan and in the context of continued significant increased demand.
- Diagnostic performance was non-compliant for the first time in June at 3%. This was directly linked to the loss of 150 procedures due to the loss of WLIs. Action was taken and Trust is currently compliant again in July.

6.12 **Sustainability**

Alison Ingoe noted that the Trust was reporting a surplus £1.0m, excluding Provider Sustainability Fund (PSF) and Marginal Rate Emergency Tariff (MRET), at the end of quarter 1.

6.13 The Board was advised that achievement of the plan had enabled the Trust to be eligible to receive PSF income of £1.25m. The Trust will also receive payment of £0.8m of MRET income. The Trust remains on trajectory to deliver an underlying surplus of £2.5m at the end of the financial year. Delivery of this surplus will enable receipt of an additional £11.6m of PSF and MRET income, achieving the year-end control total of £14.1m

6.14 It was noted that at the end of Quarter 2, the Trust must deliver a cumulative surplus of £2.28m to be eligible for a further £1.67m of PSF income. Delivery will require improved performance, primarily within elective activity and tight control of the cost base, particularly in relation to medical pay, which is a break-through objective for 2019/20.

6.15 Alison explained that due to high levels of A&E attendances the Trust had not been able to flex down beds as had been hoped, despite high levels of demand the Trust continued to perform well against the agency ceiling.

6.16 The Chairman invited the Chair of the Finance and Performance Committee, Lizzie Peers, to update the Board on their recent meeting and the assurances received in relation to Systems & Partnerships and Sustainability.

6.17 Lizzie advised the Board that the Finance and Performance Committee had noted the delivery of the Quarter 1 control total and thanked the Trust's staff for continuing to deliver despite the increased operational demand. The Committee had noted that it felt there was still more opportunity to improve its productivity, however Lizzie highlighted that there had been sustained Theatre improvements.

6.18 The Board was advised that the Committee had received the presentations used as part of the recent Use of Resources assessment which provided the Committee with an uplifting showcase of the Trust at its very best.

6.19 Lizzie noted that the Committee had received assurance in relation to the Efficiency Programme and the achievement of financial savings both in-month and the programmes overall planned savings.

6.20 Mike Rymer advised the Board that the Committee had also had discussions in relation to strengthening the links between the Finance and Performance Committee and Quality Assurance Committee regarding looking at quality aspects of performance BAF risks.

6.21 Patrick Boyle noted that the Trust had been in receipt of some additional funds following the redistribution of PSF monies at the end of the year and asked how this would be spent. Marianne explained that the funds could only be used on Capital and due to the central hold on excess spending this year it would carry forward to 2020/21, Marianne assured the Board the funds would not be lost.

6.22 **Our People**
Denise Farmer noted the key notes from the staff engagement section of the report and drew the Boards attention to the following key areas noting that in June Staff Engagement score had measured its highest to date at 8.05 with improvements across all Divisions.

6.23 The Board was advised that the Trust was very actively recruiting and was piloting a 'refer a friend' scheme with Band 5 nurses. Denise noted that appraisal rates had decreased in June but assured the Board that there was an improvement trajectory plan in place.

6.24 It was noted that there was proactive work taking place with refreshing of Patient First Improvement System (PFIS) wards in addition to the further rollout of PFIS in wards that are yet to 'go live'.

6.25 Kirstin Baker congratulated the Trust on the engagement score and asked how the Trust intended to use the Apprentice Levy. Denise explained that the Trust had very active plans to use it and was proactively pursuing viable options.

6.26 The Board **NOTED** the Integrated Performance Report.

TB/07/19/07 Report from the Finance and Performance Committee Chair

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

TB/07/19/08 Report from the Quality Assurance Committee Chair

8.1 In addition to the highlights provided by Joanna Crane under the Quality section of the Integrated Performance Report, the following areas were brought to the Boards attention.

8.2 Joanna noted that the Quality and Assurance Committee had received the Employee Relations report which had been particularly assuring, the Committee had noted the increase in the number of reported concerns many in relation to more complex issues that previously would not have been raised which supported the engagement score improvement that staff feel they can raise concerns. In addition the Committee had received the Annual Freedom to Speak Up Report, none of the issues taken to the freedom to speak up guardians had related to patient safety and all were very closely linked with HR.

8.3 The Board **NOTED** the report from the Quality Assurance Chair.

TB/07/19/09 Report from the Audit Committee Chair including Annual Report to the Board

9.1 Joanna Crane presented the Chairs report from the Audit Committee on behalf of Jon Furmston who was absent from the Board meeting, highlighting that the last Committee meeting had received information and reports relating to 2018/19 and looking forward to 2019/20. The Committee received the Strategic and Operational Plan from Internal Auditors BDO which was aligned with the Trust's key risk areas.

9.2 The Board was advised that the Committee had received the final report on the Trust's Medical Rostering process, Joanna commented that there was still a lot of work to be done but noted that the Audit highlighted that the Trust's focus is in all the right areas which gave assurance over the Trust's improvement actions.

9.3 Joanna drew the Board's attention to the Committee's Annual Report to the Board, highlighting that the Trust had received 10 Internal Audit reports in 2018/19 that had resulted in action points and all of these had all been dealt with in a timely manner which was noted an impressive achievement.

9.4 Finally the Board was advised that the Committee would be receiving reports on the following areas in the coming months, Bed Management, Sickness Management and a particular focus on the areas within the Board Assurance Framework that were not covered by other Board Committees.

9.5 The Board **NOTED** the Report from the Audit Committee Chair.

TB/07/19/10 Board Assurance Framework

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

10.2 Glen advised that the Committees have recommended to the Board that currently they are not minded to make any changes to the current risk scores. However it was noted that the Committees are conscious that the BAF represents the current challenges particularly in relation to constitutional targets, which continue to be monitored by the Finance and Performance Committee on a monthly basis.

10.3 The Board **NOTED** the Board Assurance Framework.

TB/07/19/11 Annual Workforce Race Equality Survey Results & Annual Workforce Disability Equality Survey Results

11.1 Denise Farmer introduced the Annual Workforce Race Equality Survey Results (WRES) and the Annual Workforce Disability Equality Survey Results (WDES) presentation. Denise explained that there was ongoing work within the Trust against the action plans at included with both reports to support improvement in making recruitment fair within WSHFT.

11.2 The Board was advised that in relation to the WRES the Trust has introduced proactive training for interviews following some shared learning with Brighton and Sussex University Hospitals Trust (BSUH). In addition Denise highlighted that the Trust had focused its Staff Conference on Equality and Inclusion this year and would be looking at Board membership in the future in relation to Non-Executive Directors.

11.3 Denise explained that the WDES had been introduced this year and its introduction is to improve both the number of disabled people in employment and their experience in the workplace compared to non-disabled people, this includes people with a hidden disability. The Board was advised that improvement against both the WRES and WDES action plans would be monitored through the Diversity Matters Group which is chaired by Dame Marianne Griffiths.

11.4 Patrick Boyle asked in relation to the WDES and the Trust's commitment to tackling the issues what support is available for staff. Denise explained that it is about the Trust being able support staff to make adjustments and there are a number of ways that can happen, in the future sharing some of those stories and examples with the Board it is hoped will evidence the improvements the Trust is making.

11.5 Alan McCarthy asked whether WHSFT was an outlier in relation to the WDES results. Denise explained that 2019/20 was a first year baseline, it was noted that across the STP Trusts would be sharing their data to see how they compare locally.

11.6 The Board **APPROVED** the publication of the Annual Workforce Race Equality Survey Results and the Annual Workforce Disability Equality Survey Results data.

TB/07/19/12 Medicine Service Presentation

12.1 Amanda Wellesley and Julie Thomas introduced the Urgent and Emergency Care Service Presentation and drew the Board's attention to the following key areas.

12.2 Amanda set the scene by explaining the areas at both Worthing and St Richard's that the Urgent and Emergency Care Services are responsible for:

- 2 elderly day hospitals
- 2 oncology/ chemotherapy day units
- 3 cardiac catheter labs
- 2 Endoscopy units
- 2 A&E departments
- 2 Emergency floors
- 1 neurological disabled specialist unit

Southlands

- Mainly speciality outpatients provided

12.3 Julie went on to highlight to the Board the areas that make the team proud, explaining that they have a team that is full of compassion and always go the extra mile so much so that every year the Division has members of staff that are nominated for Employee of the Month and STAR Awards.

12.4 The Board was advised that the team has a very multidisciplinary way of working and staff work together with the patient at the center of all that they do. Julie drew the Boards attention to a particular occasion when they had a husband and wife admitted and the team went out of their way to keep them together.

12.5 Julie explained to the Board that in relation to Friends and Family Test results the A&E departments at WSHFT are in the top 10 Trusts with 95% satisfaction from patients compared to an average of 87% nationally. It was noted that negative comments tend to be in relation to comfort and waiting in A&E. Amanda explained that these areas are addressed through the safety huddles which the teams respond to really positively.

12.6 It was noted that the department, as part of the early discharge project, is working on discharging or moving patients as early in the day as possible to help improve the flow of patients through the hospitals, in addition it helps with the decrease in moving elderly and dementia patients at night.

12.7 Amanda and Julie went on to highlight to the Board other areas that the team are proud of including, care of mental health patients, pressure damage improvement, pathway changes for 24/7 Stroke Thrombolysis, increased use of ambulatory care pathways and performance which is above the national average making WSHFT emergency departments one of the top performing Trusts nationally.

12.8 Amanda noted that the biggest challenge that the department faces is in relation to staffing, with staff all working incredibly hard. Amanda went on to explain that there were options being explored for different recruitment roles including nurse associate roles.

12.9 Mike Rymer commented that the teams should be congratulated on the FFT results and added that it was positive to see all the good work taking place around mental health.

12.10 Alan McCarthy thanked Amanda and Julie and added that it was fantastic what had been achieved given the high demand for services.

12.11 The Board **NOTED** the Medicine Service Presentation.

TB/07/19/13 Annual Organ Donation Report 2018/19

13.1 Dr Andrew Hetreed introduced the presentation for the Annual Organ Donation Report 2018/19 and highlighted the following key points.

13.2 Andrew explained that between 01 April 2018 and 31 March 2019 the Trust had received 12 deceased solid organ donors and as a result 29 patients received a transplant, it was noted that for a Trust the size of WSHT this number of donors is quite substantial.

13.3 The Board was advised that the Specialist Nurse for Organ Donation

(SNOD) presence is largely the reason that the Trust is performing so well and exceeding expectations in some areas. Andrew explained that Tracey Thomas is the Trusts embedded nurse for Organ Donation which means the Trust is able to maintain a positive presence rate.

13.4 Andrew summarised that the Trust's performance during 2018/19 had been excellent in several key metrics, achieving 100% referral across both sites reflects the effort put in at all levels of the team, neurological death testing rates are a regional issue, and are the next target in the teams sights and finally Andrew gave special mention to the organ donation volunteers.

13.5 Joanna Crane asked whether the Trust collects feedback from families that have provided donors. Andrew explained that the data is collected nationally; NHS Blood and Transplant have a process to audit this centrally. With regard to specific data on family satisfaction Andrew explained that there is a lot of follow up and support provided to families, if there were any concerns the Trust would be alerted. In addition the Trust has a follow up clinic with patients through the intensive care unit (ICU).

13.6 The Board **NOTED** the 2018/19 Organ Donation Annual Report.

TB/07/19/14 Annual Adults & Children's Safeguarding Report

14.1 Cathy Coppard and Annie Blackwell introduced the 2018/19 Annual Adults Safeguarding and Children's Safeguarding Reports and drew the Boards attention to the following key points in their supporting presentation.

14.2 **Children's Safeguarding**
Cathy highlighted the activity undertaken by the team for the previous year:

- 28,303 children's A&E attendances reviewed
- 1010 social care referrals
- 2315 safeguarding concerns
- 6 MHA detainments
- 71% increase in safeguarding activity
- Total staff training 96%

14.3 It was noted that social care referrals had increased by 24% compared to the previous year. Cathy went on to advise the Board that in the previous year there had been a lot of information sharing with other agencies which had been helped greatly by the roll out of Evolve. Cathy explained that as part of the ongoing integrated working West Sussex County Council was looking to pilot a project with a focus on Mental Health and self-harm in young people.

14.4 The Board was advised that there had been an increase in activity of 71% and that the team were currently involved with two serious case reviews. It was noted that improvement work continues and the priorities for 2019/20 were also highlighted:

- ICON- coping with 'crying babies'; preventing abusive head trauma
- Quality of information sharing
- Domestic abuse support in hospitals
- Safeguarding Children training > 95% for all staff and levels

14.5 **Adults Safeguarding**
Annie drew the Board's attention the Safeguarding Adults team activity for 2018/19:

- 441 Safeguarding Concerns raised

- 18 Requests for Information (under Care Act)
- 425 Deprivation of Liberty Safeguards (DoLS) authorisation requests
- 71 Detentions under the Mental Health Act

14.6 Annie highlighted to the Board that Adults and Children's safeguarding was very different, notably the number of Safeguarding concerns that are raised. The team had 71 detentions under the mental health act in 2018/19, Annie explained that the Trust had seen a 210% increase in MHA detentions in the first quarter of 2019/20.

14.7 Annie highlighted the teams achievements from the previous year, the second multi-agency conference which had been very well received, the team are looking at new ways of learning from Safeguarding Adults Reviews and the introduction of a new Intercollegiate document for safeguarding training levels.

14.8 Looking ahead to 2019/20 the following priorities for Safeguarding Adults was shared with the Board:

- Development of a Safeguarding Adults Strategy
- Development of a safeguarding dashboard
- Audit quality of safeguarding referrals
- Re-audit Section 5(2) paperwork

14.9 Alan McCarthy asked whether the arrangements currently in place with West Sussex County Council were working well. Cathy explained that nationally there is more emphasis around partnership working and noted that WSCC were currently in a challenged position following a recent Ofsted inspection rating them inadequate. Cathy added that unlike Adults, Children's safeguarding doesn't have onsite social workers.

14.10 The Board thanked Cathy and Annie for their presentation and **APPROVED** both Safeguarding Annual Reports for publication on the website.

TB/07/19/15 CNST Maternity Standards

15.1 Maggie Davies presented the CNST Maternity Standards Report and advised the Board that the report provided assurance that the Trust had sufficient evidence to meet the Safer Standards for Maternity Care as, reviewed and approved by the Head of Midwifery and Chief Nurse. It was noted that the Board of Directors was being asked to self-certify the Trust was compliant to the ten standards based on the Safer Standards for Maternity Care in order to achieve the 10% discount on maternity insurance premiums.

15.2 Maggie assured the Board that the evidence had been fully reviewed by herself and Lynn Woolley, Head of Midwifery, and that the evidence was retained to support the submission.

15.3 The Board **APPROVED** the submission of evidence and that the declaration form would be signed by the Chief Executive.

TB/07/19/16 Annual Medical Appraisal & Revalidation Report 2018/19

16.1 George Findlay introduced the Annual Medical Appraisal and Revalidation Report 2018/19 and drew the Board's attention to the following key areas.

16.2 The Board was advised that the Trust has a prescribed connection with just under 500 doctors, of the 497 medical staff with a prescribed

connection with WSHT 451 had a completed appraisal which is 90.7% meaning that the Trust is above the 90% threshold.

16.3 George went on to explain that the continued improvement over the last three years represented progress in appraisal engagement, particularly by permanent staff whose appraisal return rate is 96% (91% in 2017/18). It was noted that locally employed doctors, these doctors are short term, temporary or bank doctors, prove more of a challenge to get into the appraisal process.

16.4 The Board was advised that a high proportion of WSHT doctors were in their second revalidation cycle, 104 revalidation submissions were made to the GMC in the reporting year 2018/19, compared to 35 in the previous year, with very few deferral and no non-engagements.

16.5 George asked the Board to approve that the Trust had met the required level of appraisal and revalidation compliance and for approval of the Statement of Compliance to be signed by the Trusts Responsible Officer.

16.6 The Board **APPROVED** the Annual Medical and Revalidation Report and for the signing of the Statement of Compliance by George Findlay as the Responsible Officer for the Trust.

TB/07/19/17 Company Secretary Report

17.1 Glen Palethorpe presented the Company Secretary Report and explained that the report provided the Board with an update on matters for which the Trust has complied with NHSi or other regularly requirements.

17.2 **Annual report, quality account and financial statement**
The Trust was required to submit its audited annual report, quality account and financial statements to NHSi by noon on the 29 May 2019. A further submission was required by the Trust to submit these as one combined file to NHSi by the 19 July 2019. It was noted that the Trust had achieved these requirements.

17.3 The Board was advised that the Trust had published its annual report and accounts on its website at: https://www.westernsussexhospitals.nhs.uk/your-trust/about/annual-report/. It was noted that the annual report would be presented to the public, members and governors at the Council of Governors meeting which would be part of the Trust's Annual General Meeting on the 25 July.

17.4 **Quality Account**
The Trust was required to submit its audited quality account to NHS Choices by the 30 June 2019 and place this on the Trust's website. The Trust complied with this requirement and the quality account can be found on the website at: https://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=1715.

17.5 **Learning from deaths report and annual report**
Finally Glen drew the Boards attention to the Learning from Deaths Quarter 4 Report and Annual Report highlighting that the Trust is required to receive reports on learning from deaths. The Board was reminded that the detail of this report had been scrutinised by the Quality Assurance Committee especially in respect of the Trust's processes for learning from the review of deaths. Glen explained that the outcome of this learning manifests itself in the Trust's mortality indices; these are tracked within the routine report to the Board as part of the Integrated Performance Report.

17.6 The Board **NOTED** the Submission of the Annual Report, Quality Account and Financial Statement.

17.7 The Board **NOTED** the Learning from Deaths Quarter 4 Report and Annual Report.

TB/07/19/18 Other Business

18.1 There was no other business to discuss.

TB/07/19/19 The Chair formally closed the meeting

TB/07/19/20 Questions from Members of the Public

20.1 John Thompson acknowledged that both the Adults and Children's Safeguarding Teams are hugely respected by other agencies and thanked them for their Annual Reports.

20.2 John went on to comment that the level of control over the risks in the Board Assurance Framework were very assuring.

20.3 Finally John paid tribute to the Trust Senior Leadership team following the recent CQC unannounced service visit.

20.4 John Bull commented that he had recently attended the Trainee Doctor Excellence Awards and suggested that some of the lovely phrases from the nominations should be put into a word cloud and shared with the Board. John went on to ask whether Medical agency bills had been a concern. George Findlay explained that the Trust spend on Medical agency is slightly higher than the national average but that the Trust is not an outlier. George explained that most of the excess spend was in A&E but that there was ongoing work to try and reduce the spend on Medical workforce.

20.5 Andrew Radcliffe thanked the Board for the improvements made to the Board meeting and went on to ask if the Trust was looking at alternative options including non-pensionable pay for staff given the recently reported national pensions issue. George Findlay explained that Waiting List Initiatives (WLIs) are not pensionable, noting that this was a national issue that is being looked at nationally. Dame Marianne Griffiths explained that it is a national pay contract therefore it is not possible to vary staff pay and the only flexibility the Trust has is in relation to WLIs.

TB/07/19/21 Resolution into Board Committee

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

TB/07/19/22 Date of Next Meeting

22.1 It was noted that the next Board Meeting would take place on **Thursday 26 September 2019** in **John Bull Conference Room, Worthing Health Education Centre, Worthing Hospital, Lyndhurst Road, Worthing.**

Tanya Humphrys
Board Administrator

July 2019

Signed as a correct record of the meeting

Chair……

Date……

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	5	**Meeting:**	Trust Board	**Meeting Date:**	26 Sept 19
Report Title:	Chief Executive Report				
Sponsoring Executive Director:	Dame Marianne Griffiths, Chief Executive				
Author(s):	Jonathan Keeble, Director of Communications & Engagement				
Report previously considered by and date:	N/A				
Purpose of the report:					
Information	✓		Assurance	☐	
Review and Discussion	☐		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	✓	
Our People	✓		Quality	✓	
Systems and Partnerships	☐				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	☐		Effective	☐	
Caring	✓		Responsive	☐	
Well-led	✓		Use of Resources	☐	
Communication and Consultation:					

Executive Summary:

This report provides an overview for the Trust's activities for the months of August and September.

Key Recommendation(s):

The Board is asked to NOTE this report.

Chief Executive's Report

September 2019

Western Sussex Hospitals
NHS Foundation Trust

Contents

- Headlines: July and August
- Looking outwards
- Looking ahead

Headlines

Support for mental health patients

Improvements are being jointly implemented by the trust and Sussex Partnership NHS Foundation Trust for patients with mental health needs. These include a range of developments - expansion of the Community Crisis response team to 24/7, a crisis lounge in Worthing town centre, psychiatric assessment lounges will be rolled out across Sussex. We have confirmed funding to expand the mental health liaison teams in both A&E departments; and a new clinical director post for mental health to support the implementation of these changes and ensure we get the maximum benefit locally for our patients.

Refer a friend scheme launched

The trust has launched a Refer a Friend scheme as part of its wider recruitment efforts. Existing staff can be rewarded with up to £750 if they successfully refer a staff nurse, operating department practitioner or midwife to come and work with us. The new member of the team will also receive an additional £250, once they have completed their first year. For more information, please visit westernsussexhospitals.nhs.uk/you-trust/careers

£5m investment in IM&T innovations and devices

New IT innovations and improvements for both staff and patients are coming thanks to a £4.9 million investment in the trust's information management and technology (IM&T) this year. This includes £450,000 on new computers and other staff devices; £417,000 on Radiology and Pathology order communications; and £450,000 on a new secure clinical messaging service. A new online portal for patients will also enable them to view appointment letters and results on their phone, tablet or PC.

Headlines

Discharge project showcased at AGM

The success of the “putting patients first through earlier discharges” improvement project was showcased at the trust’s AGM in July. Over 12 months, 3,600 more patients left hospital before 3pm on their day of discharge, thanks to teams working together in new ways on 16 pilot wards. Attendees also heard a review of the year (18/19) and accounts, which are available on our website.

Clinical scholars improve patient care

Our staff development programme has celebrated the graduation of its second set of Clinical Improvement Scholars. Eight members of staff dedicated two days a week for a year to developing research, leadership and quality improvement skills they can use to support better outcomes and care. The programme, which is the first of its kind in the country, saw nurses, midwives and allied healthcare professionals work to improve patient or staff experience through projects ranging from hydration and reducing mortality to improving outcomes.

Nurses receive high praise in survey

The high standards set by Western Sussex in last year’s national NHS Inpatient Survey have been maintained in the latest results. Patients were particularly complimentary about the people caring for them, with 93% of comments about nurses being positive, and 73% for staff overall.

Diary highlights

- Meetings with partner organisations
- Sustainability and Transformation Partnership
- Acute Network
- MPs
- West Sussex County Council
- Graduation, University of Brighton
- CQC Well-led and Core Inspection
- All staff briefings – St Richard's, Worthing, Southlands
- Consultant engagement briefing
- Council of Governors meeting
- Thank you events

Looking ahead

Care Quality Commission inspection

The inspection of our trust began in June with a review of our Use of Resources, carried out by NHS Improvement. Inspections are now formed of three parts and our well-led assessment and unannounced core services inspection are also now complete. We are expecting their report and rating to be published at some point in the next few months.

We were last inspected in December 2015, which resulted in the publication of our “Outstanding” CQC report in April 2016. Our improvement programme called Patient First was just beginning then and our staff were proud to demonstrate the many ways this has led to significant improvements across the organisation in the last three years.

Patient First STAR Awards

Final preparations are underway for this year’s Patient First STAR awards, which take place this evening (26 September). The list of all those shortlisted has been shared with the organisation – thanks again to all those who made nominations, both staff and public. Winners will be revealed at the awards ceremony and published on our Facebook and Twitter accounts.

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	6-10	**Meeting:**	Trust Board	**Meeting Date:**	26 Sept 2019
Report Title:	**Integrated Performance Report**				
Sponsoring Executive Director:	Marianne Griffiths, George Findlay, Maggie Davies, Amanda Fadero, Alison Ingoe and Denise Farmer				
Author(s):	Marianne Griffiths, George Findlay, Maggie Davies, Amanda Fadero, Karen Geoghegan and Denise Farmer				
Report previously considered by and date:	Individual elements considered by relevant Board Committee				
Purpose of the report:					
Information	☐		Assurance	✓	
Review and Discussion	✓		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	✓	
Our People	✓		Quality	✓	
Systems and Partnerships	✓				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	✓		Effective	✓	
Caring	✓		Responsive	✓	
Well-led	✓		Use of Resources	✓	
Communication and Consultation:					
Executive Summary:					
Attached is the Trust's integrated performance report.					
Key Recommendation(s):					
To note the content and following receipt of the Committee assurance reports, consider if there are areas for referral back to the Committees where enhanced assurance is required.					

Integrated Performance Report

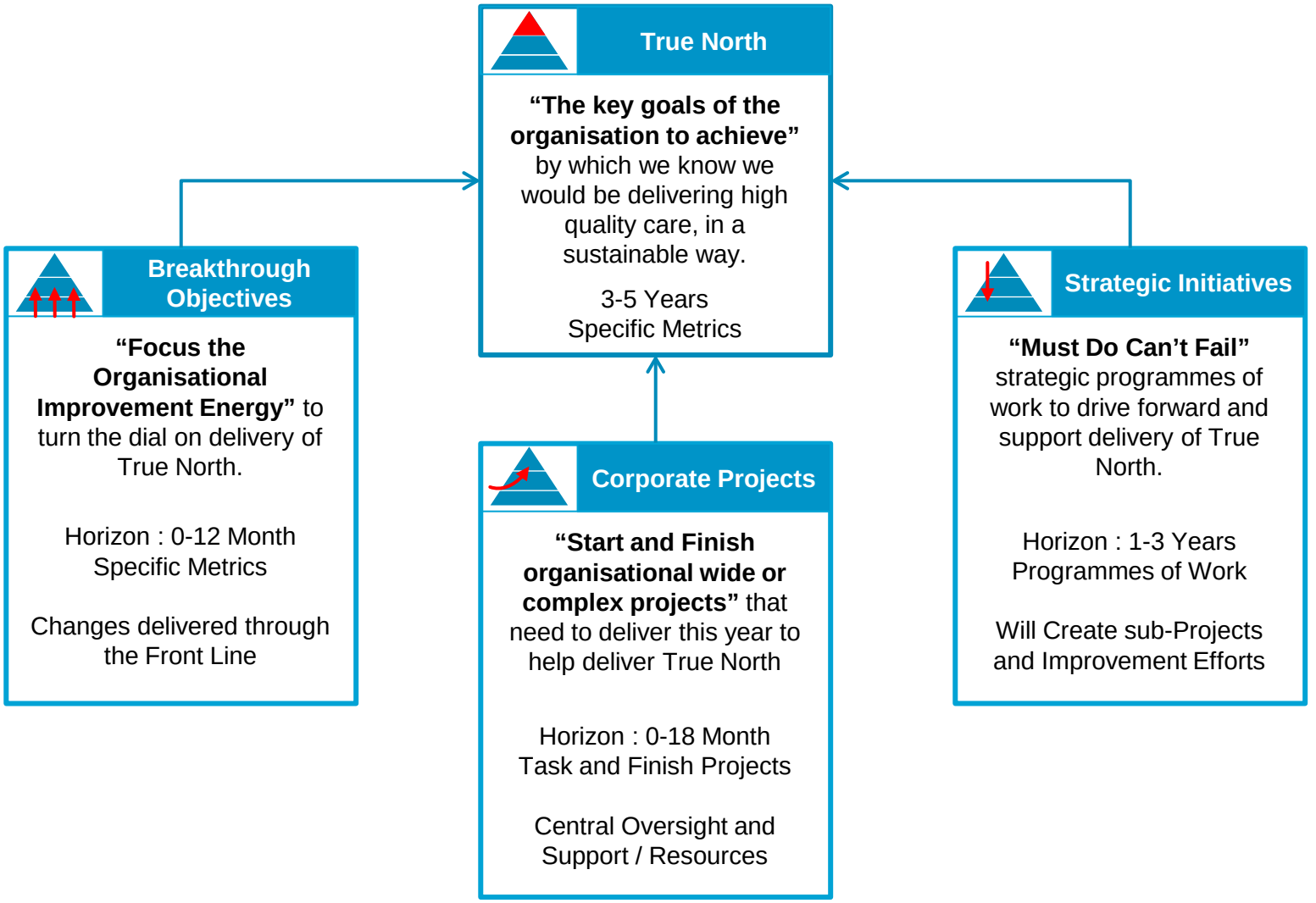
September 2019

Western Sussex Hospitals
NHS Foundation Trust

Contents

Structure of the report

Patient First Strategy Deployment Framework



Patient First True North

Key Goals for the Organisation to achieve sustainably

Patient

Patient Satisfaction

Target: Family & Friends Recommend Rate >96%

Sustainability

Financial Management

Target: Break Even

People

Staff Engagement

Target: Engagement Score Top in the Country

Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 99% Harm Free Care

Systems & Partnerships

Non Elective Care

Target: A&E 95% <4hrs

Elective Care

Target: RTT 92% <18wks

Quality Performance - Effectiveness

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

Key messages for Board

Effectiveness:.

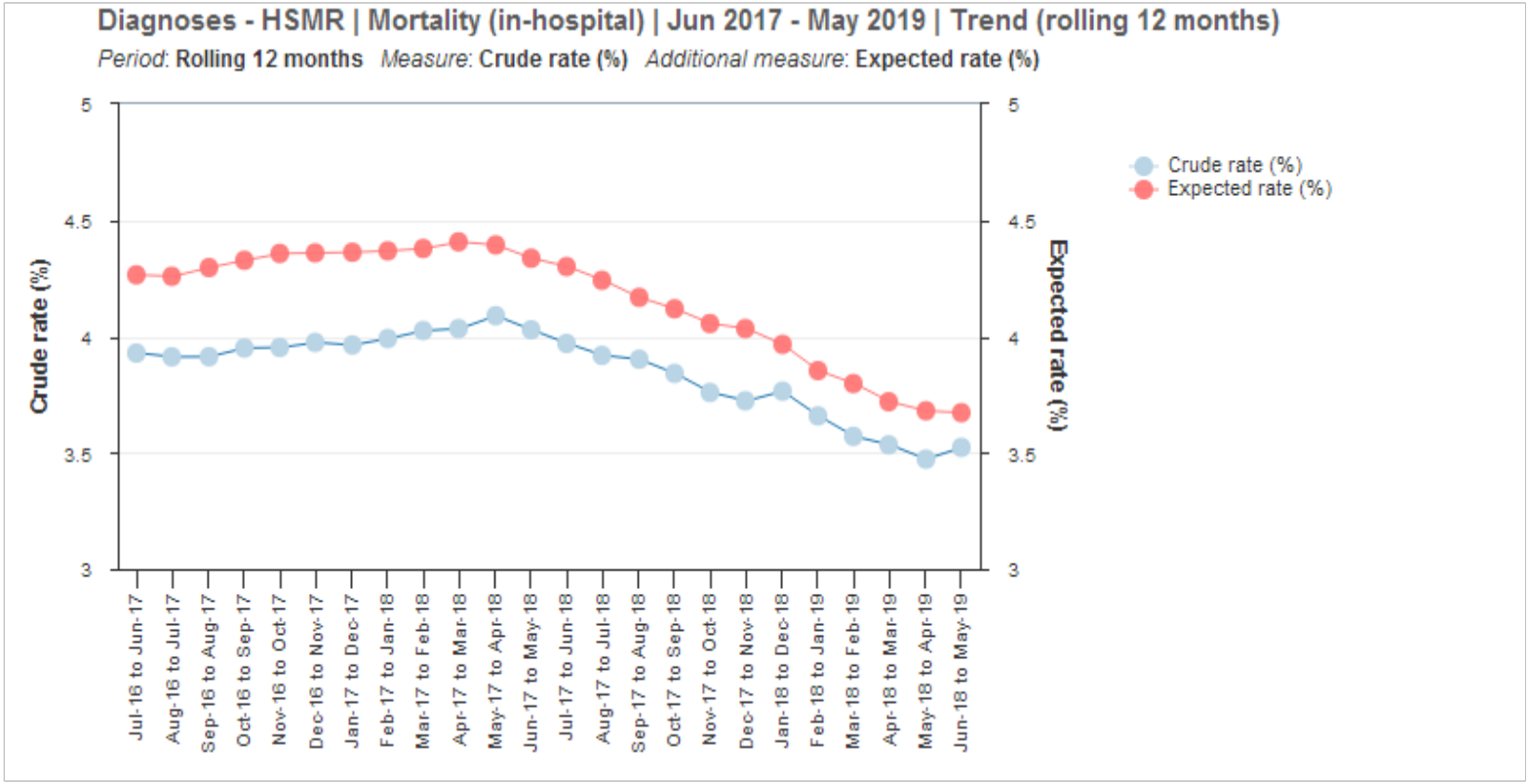
The Trust HSMR has risen to 95.9 (48th percentile) continuing a rising trend that began several months ago although the actual numbers of deaths at the Trust are reducing. Our investigations show changes in sepsis coding on the Chichester site have contributed to a rising HSMR there, while the HSMR at Worthing remains static.

At Chichester sepsis coding has reduced. This reduces the number of expected deaths and overall risk of mortality at WSHT and despite the decrease in observed deaths has caused the rising HSMR.

The sepsis group including clinicians, coding, the information team and chaired by the medical director is in place and oversees a monthly review of sepsis coding to ensure accurate recognition and consistency. However there is a considerable time lag before these actions can potentially impact the WSHT HSMR.

The successful pilot for the new daily mortality review process has taken place and plans are underway to implement this fully in the near future. Initial feedback has been excellent and the change speeds up and streamlines the review process and provides an important opportunity for trainees.

Quality Performance - Effectiveness



Quality Performance - Safety

Quality

Safety Thermometer Pressure damage Cat 2 or above (As a percentage of inpatients on day of audit) in August 0.2% of patients compared to national rate of 0.8% (for acute providers)

During August the Trust reported at total of 17 incidents of pressure damage both equal to and greater than European Pressure Ulcer Advisory Group (EPUAP) category 2, a considerable decrease in reporting from June's number of 34 (and lower than the equivalent month last year of 21).

This is the second consecutive month with all divisions achieving improvement goals. Weekly safer care improvement huddles are now embedded on both sites.

Quality Performance - Safety

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

The patient safety thermometer tool looks at point prevalence of four key harms –

- Falls
- Pressure ulcers
- Urinary tract infections
- Deep vein thrombosis (DVT) and pulmonary embolism (PE)

The actual number of patients who suffered no new harm during their inpatient stay at WSHFT was 98.9% against the Trust target of 99%. This is the highest recorded result for 2 years.

Quality Performance - Experience

During August the Trust received 41 complaints, the top four themes (in order) were recorded as clinical treatment (22), communication (6), date for appointment (4) and staff behaviour (4).

Divisions continue to embed a more proactive response to new complaints to try to facilitate resolution quickly for patients and families. In August, 66% of complaints collectively were closed within 25 working days, delivering the Trust improvement goal (65%).

The overall number of open complaints is in line with July with 82 open cases at time of reporting, although further progress is required to achieve the goal of 60.

Quality Performance - Experience

Friends and Family Test Response Rates:

Work continues to improve response rates (inpatient) towards a target this year of 40% (with an interim target for A&E of 23% (YTD actual 30.9%).

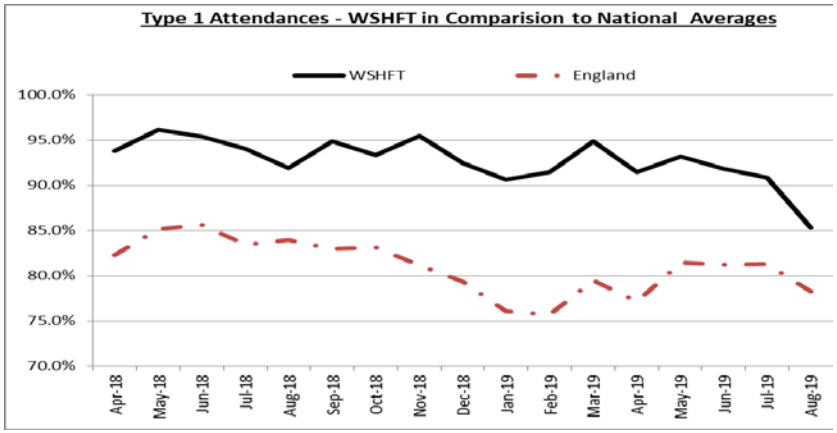
August's data has met the Trust target and reports 40.5% compliance (YTD 38.2%).

Systems & Partnerships – Summary

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

- The Trust saw continued significant increases in numbers of emergency patients attending both A&Es, with +9.2% August-19 compared to August-18, with 15.2% increase in over 85s.
- Greater acuity of patient impacted on length of stay which increased Aug-19 by 0.27 days compared to Jul-19 whilst the Trust had 14 more 7 day LOS patients in hospital on average each day Aug-19 compared with Aug-18 which constrained flow, particularly at SRH site.
- A&E 4hr performance for August-19 was 86.3%, compared to 86.28% National performance. There were no 12 hr breaches.
- RTT compliance in June 19 was 82.0% with no patients waiting over 52 weeks. Lower activity impacted, alongside higher demand than planned. The Trust is refocussing efforts to increase activity with support from alternative providers, increased productivity and additional internal WLIs and locum support.
- Cancer performance for August-19 is compliant against 6 of 8 cancer targets with provisional 78.1% for patients treated within 62 days. National average performance was 77.6% (July-19).
- Diagnostic performance was marginally non-compliant at 1.5%. This was mainly due to continued capacity pressure for endoscopic modalities. Additional locum support has been secured in September and Trust is projecting recovery September. National performance (July-19) was 3.5%.

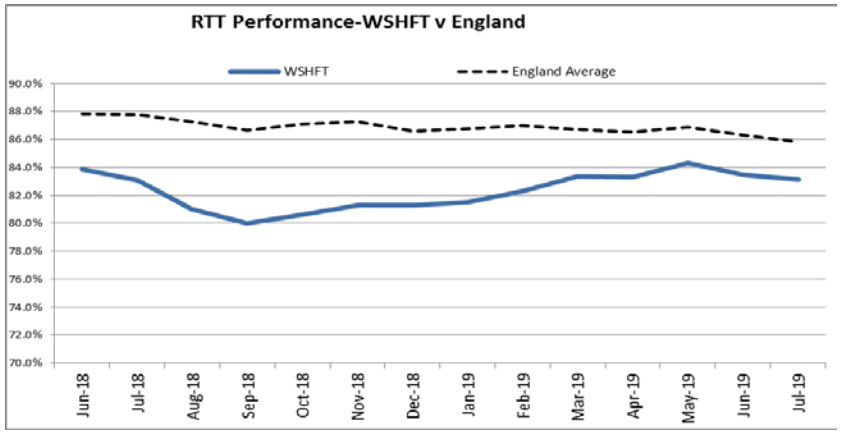
Systems & Partnerships – True North Metrics



- August 19 A&E performance was 86.33%
- August 19 saw an 8.6% increase in ambulance conveyances, a 9.2% increase in A&E attendances and a 0.4% increase in subsequent emergency admissions compared to August 18
- Over 85 admissions up 8.5% compared to Aug-18
- There has been a 1.2% increase in the time in the dept for Mental Health patients as a proportion of all patient time in the department August-19 compared to August-18

Actions Underway:

- Kaizen led early morning discharge programme.
- Super Stranded improvement programme (LHE wide)
- Additional medical staff deployed within A&E
- Additional bed capacity opened at SRH
- Partnership programme of care for Mental Health with successful commissioning of CORE24 Mental Health services agreed
- GP Extended Hubs commencing 1st August
- New Medical staffing model commences 1st August



- Aug-19 RTT performance was 82% for all specialties
- There were no patients waiting 52 weeks at end August 19
- The overall size of the waiting list increased by 265 waiters from July to August.
- Key areas of pressure remain Orthopaedics, Ophthalmology, OMFS services and Gastroenterology – plans in place for all specialties

Actions Underway:

- Continued improvement theatre and outpatient efficiency programmes
- Additional capacity both internally and from external partners to mitigate loss of activity through WLI and pension concerns
- Substantive recruitment plans to fill vacancies in context of national shortages in some areas
- Enhanced weekly speciality PTL reviews in place and daily task and finish group ophthalmology.

Systems & Partnerships – Key Metrics

Cancer Metrics

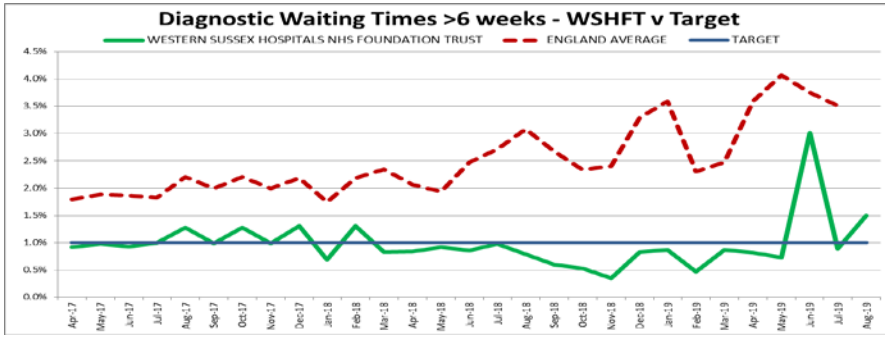
Monthly and YTD	Target	2019/20 YTD	Jul-18
2wk GP to 1st OP	93.0%	94.2%	93.1%
2wk GP to 1st OP (Breast)	93.0%	95.6%	95.5%
31day subsequent treatment (surgery)	94.0%	97.3%	100.0%
31day subsequent treatment (drug)	98.0%	100.0%	100.0%
31day subsequent treatment (all)	96.0%	97.8%	99.2%
62day referral to treatment (screening)	90.0%	91.9%	91.2%
62day referral to treatment (upgrade)	85.0%	77.2%	75.0%
62day referral to treatment (all Cancers)	85.0%	81.7%	78.1%

- The Trust was compliant against 6 of 7 reportable cancer metrics in August-19.
- 78.1% of patients were treated within the 62 day target in Aug 19 provisionally.
- Significant continued growth in cancer referrals - up a further 12% in 19/20, above the increased 18.2% in 18/19

Actions Underway:

- Implementation of Optimal Pathway project (for colorectal patients) plus equivalent streamlined processes for prostate cancers
- Additional specialist nursing for prostate cancers
- Additional diagnostic capacity (imaging and histopathology).
- Enhanced daily tracking for over 62 day waiters with clear escalation rules , to expedite next steps for each patient.
- Review of MDT processes to ensure timely decision making.
- Focus on reduction to 7 day for first outpatient appointment.

Diagnostic 6 Weeks



- Diagnostic performance was non-compliant with the national target in August 19 at 1.5% (compared to National of 3.5%)
- Short term capacity constraints in endoscopy continue to impact
- The overall diagnostic waiting list reduced by 263 compared to Jul-19
- Anticipated recovery Sept-19

Actions Underway:

- Additional locums have been engaged in September to clear the backlog
- Trust Nurse Endoscopists have backfilled additional sessions in July to clear the backlog
- Washers at SRH are back in service Mid-September
- Medium term innovations in pathways adopting FIT testing proposed to support increases in recurrent capacity

Sustainability - Summary

Sustainability

Financial Management

Target: Break Even

- At the end of August the Trust reported a deficit of £0.53m. This brings the cumulative position, excluding PSF and MRET, to £1.56m which is in line with the planned position.

- At the end of Q2, the Trust must deliver a cumulative surplus of £2.28m to be eligible for a further £1.67m of PSF income. The Trust is forecasting delivering of the Q2 control total. To date technical opportunities have supported delivery of the position and have offset operational financial pressures, but will not be available to the same extent in future months.

- The Trust is forecasting delivery of the year-end £14.1m control total surplus, including PSF and MRET. Delivery will be challenging and will require tight control of the cost base with a targeted focus on reducing medical pay and bringing clinical supplies and services expenditure in line with plan. Increased elective activity throughput to improve RTT performance will need to be delivered from within existing capacity with a focus on productivity improvements.

Sustainability - Key Metrics

SOF Finance Rating — G

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

At the end of August the aggregate finance rating is a '1'. The all individual metric ratings are in line with plan.

Control Total (exc PSF) Surplus £k — G

	Plan	Actual / Forecast
Year to Date (exc PSF*) £k	1,529	1,561
Year End Forecast (exc PSF) £k	2,459	2,459
Year to Date (inc PSF) £k	5,252	6,054
Year End Forecast (inc PSF) £k	14,062	14,832

At the end of August the Trust is reporting a surplus of £1.56m excluding PSF and MRET funding, in line with the year to date plan. The year end forecast includes the £0.77m bonus PSF relating to 2018/19's performance.

Efficiency & Transformation Programme £k — G

	Plan	Actual/ Forecast
Year to Date £k	5,378	5,378
Year End Forecast £k	11,728	11,728

The efficiency programme has delivered £5.4m and remains on trajectory to deliver the £11.73m plan. Timing delays in some of the operational schemes are being mitigated by Back office and procurement efficiencies.

Capital — G

	Plan	Actual/ Forecast
Year to Date £k	2,672	4,341
Year End Forecast £k	20,304	20,304

Capital expenditure remains above plan due to earlier purchase of replacement medical equipment and the completion of schemes deferred from the previous year. The forecast is being reviewed by CIG to ensure the full year programme value is not exceeded.

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

Sustainability - Key Metrics

Income £k — G

	Plan	Actual/ Forecast
Year to Date £k	191,190	195,177
Year End Forecast	464,021	465,556

Income is £ 4.0m ahead of plan. The income for non-elective spell activity and accident and emergency attendances are above plan again in August and are the key contributors to the positive cumulative position.

Operating Costs £k — R

	Plan	Actual/ Forecast
Year to Date £k	(179,695)	(183,714)
Year End Forecast £k	(437,354)	(437,452)

Operating costs are £4.02m adverse to plan at the end of August. The key contributor to the £2.27m adverse pay position remains Medical expenditure. Clinical supplies remain the key driver of non pay expenditure within the operational divisions.

Agency Ceiling £k — G

	Plan	Actual/ Forecast
Year to Date £k	5,973	4,903
Year End Forecast £k	14,969	10,470

Medical agency expenditure increased to £1.2m in August, with medical agency usage the key driver of this increase. The Trust remains below the agency ceiling for the year to date and is forecasting that this will be maintained at year-end.

Cash £k — G

	Plan	Actual/ Forecast
Year to Date £k	34,293	28,326
Year End Forecast £k	28,620	28,620

At the end of August cash is behind plan by £6m. Cash reserves have been utilised to maintain our Creditor Days position (at < 40 days) thereby reducing the value of outstanding creditors.

Sustainability - Action & Recommendations

There are no actions required of the Board.

The Board is asked to note the following:

- Despite delivering length of stay improvements in ambulatory and short-stay non-elective activity, the beds occupied by long length-of-stay patients has been increasing which has prevented full realisation of benefits. Additional actions with partners in Q3 will target this cohort of patients and a refreshed bed plan is being produced.

- Medical staff expenditure is an area of increased focus following significant increases in premium expenditure following the junior doctor rotation as result of vacancies and requirements for some staff to be supernumerary. Reduced spend following the implementation of new workforce models is expected to occur from M6.

- The Trust is forecasting delivery of the year-end control total of £14.1m including PSF and MRET.

Workforce Performance – Summary

People

Staff Engagement

Target: Engagement Score Top in the Country

1.0 INTRODUCTION

- Pay – overall £882 adverse position , medical pay £851k adverse. YTD £2.24m adverse
- KPI's – overall performance favourable with exception of statutory and mandatory training for medical staff
- Engagement score – at 7.87 and therefore above target of 7.2
- Breakthrough objective – 72.22% staff able to make improvements happen in their area of work against a target of 63%

Operational Performance – Capacity and Capability

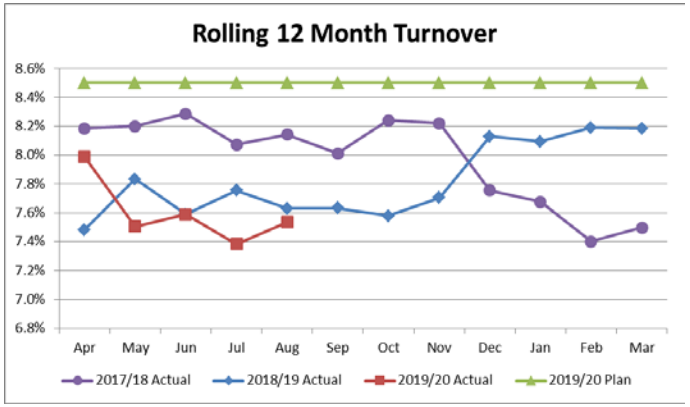
	Annual Budget £000s	In Month			Year to Date		
		Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s
PAY							
Medical Staff	(83,844)	(7,231)	(8,083)	(851)	(35,557)	(38,146)	(2,589)
Nursing Staff	(115,938)	(9,600)	(9,738)	(138)	(48,431)	(49,046)	(615)
Professional Staff	(42,147)	(3,517)	(3,413)	104	(17,618)	(17,114)	504
Admin & Management Staff	(44,782)	(3,733)	(3,651)	82	(18,811)	(18,280)	531
Estates Staff	(16,711)	(1,383)	(1,462)	(79)	(7,001)	(7,068)	(67)
Total	(303,421)	(25,465)	(26,347)	(882)	(127,417)	(129,654)	(2,236)

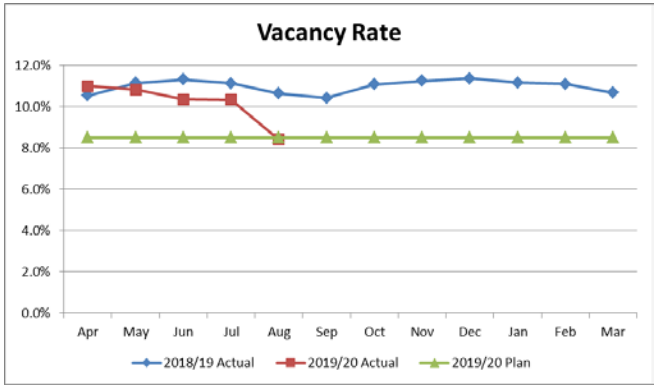
In M5 19/20 the Trust spent £26.4m – an increase of £800k over M4. Year-to-date variance has increased from £1.4m in M4 to £2.24m over budget in M5. Most significant area of overspend is Medical, where there is both an increase in A&E demand and a higher than usual number of junior doctors who are supernumerary resulting in high levels of temporary workforce. Nursing workforce spend reduced slightly in M5, although remains over-spent both in-month and year-to-date.

With junior doctor workforce rotation taking place in August, dashboards indicate high contracted WTEs – however this is due to both original and new staff members being shown in-month and will be corrected once residual workforce is confirmed. All other staff groups – including registered and HCA nursing – have maintained similar levels of contracted workforce, with worked-to-budget ratio slightly increased through higher % usage of bank temporary workforce (particularly medical).

		Last Month M4	This Month M5	Variance
Budgeted Establishment	wte	6789.8	6824.1	↑
Worked to Budget (wte)	%	98.2%	98.3%	↑
Temporary Workforce (wte)	%	10.7%	11.1%	↑
Agency	%	1.7%	1.7%	→
Bank	%	8.6%	8.9%	↑

Operational Performance – Key Metrics





- Staff turnover remains better than plan at 7.5%
- This ranges from 6.1% in the Surgery division to 9.7% in the Core division

Improvement Focus:

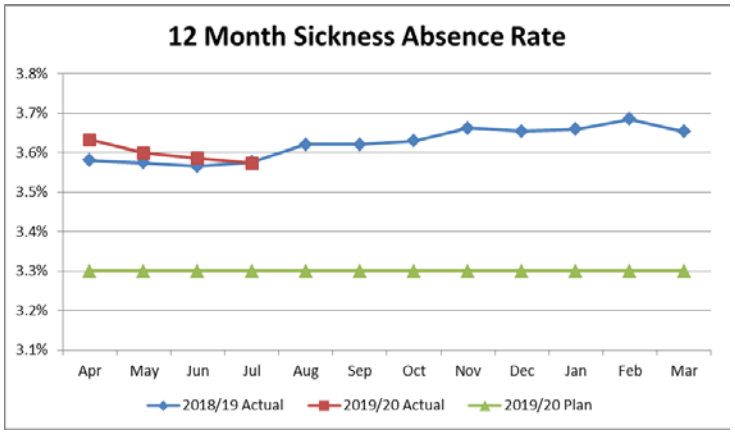
- Core Division continuing to progress their work on retention
- On-line exit questionnaires and reporting functionality being developed to enable staff to complete and submit directly through Membership Engagement Services software

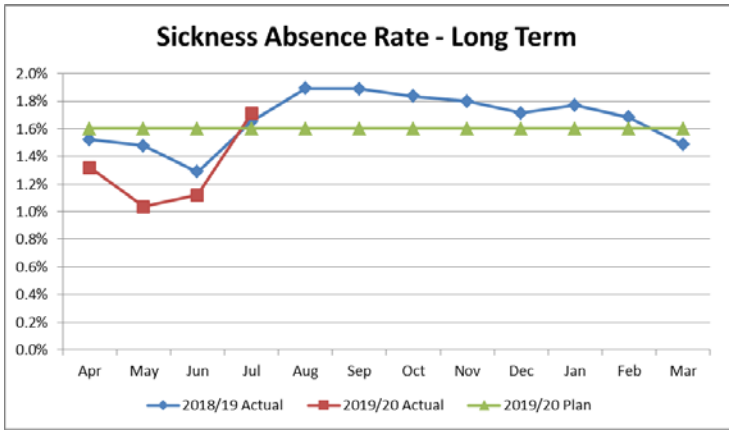
- Vacancy rate has decreased again in August to 8.5%
- Vacancy rates in Medicine and Estates and Facilities divisions remain higher than average but are improving
- Vacancies in Medicine mainly in nursing and medical staff
- Successful recruitment to A&E and Paediatrics business cases
- Business cases for 24 trainee Nursing Associates (12 in Sept 2019 and a further 12 in Feb 2020) and enhanced RN ratios on acute medical wards agreed
- Refer a friend scheme for Band 5 nurses launched on 1 August but poor uptake to date

Improvement Focus:

- 5 year workforce plans for nursing being developed to include refreshed strategies for domestic and international recruitment, retention, apprentices and new roles.

Operational Performance – Key Metrics





- Monthly sickness absence rates are broadly similar to the same time last year with a rolling 12 month rate of 3.6%
- Estates and Facilities division continues to experience higher absence than the rest of the organisation
- Long term absence has increased over the last 3 months
- Whilst short term absence peaked in June to 1.9% of absence it returned to usual levels of 1.6% in July

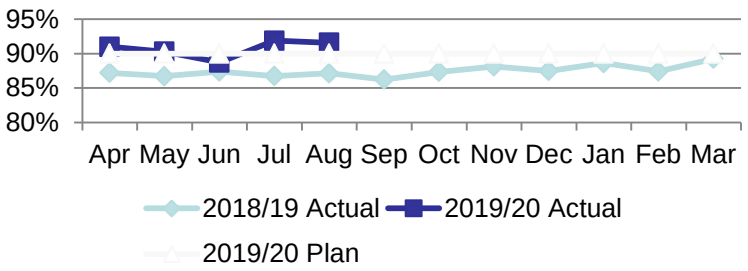
- There has been an increase in the number of staff experiencing stress related and MSK related absence and this is contributing to the increase in long term absence
- Pilots of mental health training for managers taking place in September, November and February
- 2 programmes to be piloted – one day mental health champion training and the two day mental health first aider training
- Interest in training has been high for all programmes with cross Divisional representation in pilot

Improvement Focus:

- To continue Divisionally led projects to improve sickness absence rates

Operational Performance – Key Metrics

All Staff Appraisal Rate

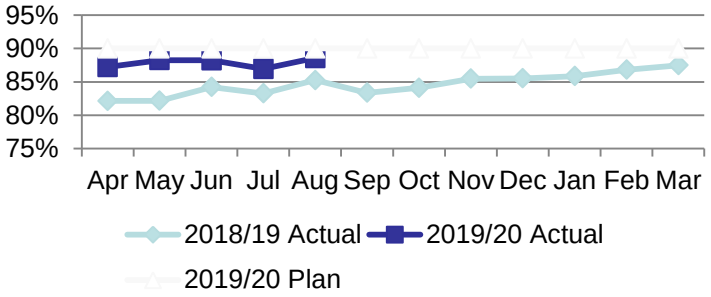


- 90% appraisal compliance during July and August
- Significant improvement since 2018/19

Improvement Focus:

- Maintain improvement through Q3 and Q4

Resus Training Rate



- 8 out of 9 STAM modules continue to remain above the Trust target of 90%
- Overall medical staff compliance is below 90%
- Resus training is slightly below the Trust target at 88.6% but continues to show a slow but improving position

Improvement Focus:

- Moving to national learning management system (NLMS) platform for all e-learning from 1 October. This will expected to improve access and will align to national content
- Medical staff compliance through Chiefs and Medical Director

Improving Staff Engagement

Staff Engagement Score (Pulse Survey)

- 7.87 with 131 participants. This is against a target of 7.6 and has been above plan since February 2019.
- Estates and Facilities highest engagement score to date at 7.84
- August was another very active engagement month with Thank You events, STAR nominations, Patient First briefings, divisional engagement programmes and visits, PFIS refresh
- Staff advocacy is a key component of the engagement score and in month 96.1% of staff recommended the organisation as place to work. This is the highest score to date. 84.6% of staff recommended the trust as place to be treated. This is a deterioration from usual recommendation levels reflecting significant operational and staffing pressures during August. Noting that this is a one-off decrease, divisional teams have been asked to explore further

Breakthrough Objective (Pulse Survey)

- 72.5% of staff were able to make improvements happen in their area of work – highest percentage to date
- Compares to 59.2% in August 2018
- Reflects roll out of PFIS refresh and change of content and emphasis on Western Sussex Way module delivered on Health and Safety days

Best Place to Work

- An online platform to engage staff on ideas for the Best Place to Work launched on 10 September for a 2 week period
- All staff have been invited to participate in a conversation about what is important to them and what it would take to be the best place to work
- At the end of week 1, 960 participants (15%) had registered with over 7,500 contributions including ideas, comments and votes
- A detailed analysis of the top ideas will be available in early October and this will inform our improvement plan

Staff Survey

- 2019 Staff Survey will be open from 3 October until 29 November
- A mixture of electronic and paper questionnaires will be sent, and incorporate learning from last year

Health and Wellbeing

- The work to improve staff mental health is noted under Operational Performance - Long term absence narrative above
- Doctors in Mind app launched in August
- Feedback to be collated before decision taken regarding benefits of wider roll out across other staff groups
- Flu Campaign underway and anticipated to commence in early October (approx. 1 week later than previous years)

Improving Staff Engagement

Equalities and Inclusion

- WRES and WDES action plans are due in October

Recruitment and Retention

- Recruitment to the Chief Operating Officer vacancy commenced with final selection due on 11 October
- With the exception of August, the number of working days from offer to completion of recruitment checks has been within the agreed KPI's of external recruitment (<33 days) and internal recruitment (<20 days)
- Non-medical recruitment during August high with a 43% increase in the number of offers made. These are anticipated to convert to starts during October and November
- Overall time to hire increased to 82.5 days against a target of 72 days. More candidates are now awaiting the outcome of their employment checks prior to issuing their notice

Workforce Systems

- Programme of work to improve compliance and embed functionality of Safecare commenced. Compliance improved to 81.3%
- Roll-out of e-rostering for junior doctors in general medicine across both sites completed for August rotation
- Benefits include zero breaches to safe working hours and EWTD
- Go live in DoME at Worthing due on 4 December, following the next rotation

Thank You Events

- During August a series of thank you events for staff were held across the hospital sites
- These were extremely very well attended and over 7,500 re-usable mugs and cakes were given out to staff and volunteers

Long Service Awards

- Over 50 staff attended a 30 year long service award lunch during August
- 40 year awards will be held during October at the Harbour Hotel, Chichester and Palm Court Pavillion, Worthing

Other

- Consultation on new proposals for the NHS Pension Scheme for senior medical staff has commenced and closes on 1 November.
- The Department of Health and Social Care (DHSC) are preparing a draft proposal for a workplace ISA which would be a flexibility within the reward offer for new starters to the NHS. The proposal considers employees who are in the first five years of service within the NHS and the opportunity to flex pension contributions into an employer based savings

Improving Staff Engagement and Communications

Patient First STAR Awards

- Nearly 400 members of staff and guests are attending this year's Patient First STAR Awards on 26 September a Worthing Assembly Hall
- The annual staff recognition awards are organised by the communications team and kindly funded by the Love Your Hospital charity
- A record 800 nominees will be receiving a personalised certificate of congratulations in the coming weeks
- Significant year-on-year increase in nominations (476% over 5 years)
- 110 nominations from members of the public (400% increase)

Staff briefing / Q&A sessions with executive team

The communications team organises staff briefings and Q&A sessions with the executive team in each of the trust's hospitals.

- Since 25 March, approximately 850 members of staff have attended 18 meetings
- Further meetings are arranged each month for Autumn / Winter

Social Media

The communications team uses social media to communicate directly with thousands of people living locally, as well as our staff and interested parties further afield. The number of *followers* our main social media channels attract continues to grow:

• Facebook (@westernsussexhospitals)	4,982 followers	(+2.6% since July)
• Twitter (@westernsussex)	4,071 followers	(+3.5% since July)
• Instagram (@westernsussexhospitals)	1,751 followers	(+5.2% since July)
• Social media reach for popular stories	50,000 to 100,000+	

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	11	**Meeting:**	Trust Board	**Meeting Date:**	26 Sep 19
Report Title:	WSHFT Quality Strategy 2019-21				
Sponsoring Executive Director:	George Findlay, Chief Medical Officer				
Author(s):	Viv Colleran, Director of Clinical Effectiveness, Research and Innovation				
Report previously considered by and date:	TEC 20 June 2019 Quality Board 11 June 2019				

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

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

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

Any implications for:	
Quality	Introduces the Trust's quality improvement goals for the next three years and the means by which we will achieve these improvements.
Financial	
Workforce	

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

Communication and Consultation:

Goals developed through divisional input and discussion Quality Board Nov 18, linked to trusts' annual planning, consulted on at staff conference Autumn 2018, linked to patient experience strategy
Review by GF, MD, TT and communications.
Review by TEC (20/06/19), Quality Board (11/06/19), PEEC (25/06/19), Healthwatch and the CCG (via email), and themes reviewed by staff at 2018 Staff Conference.

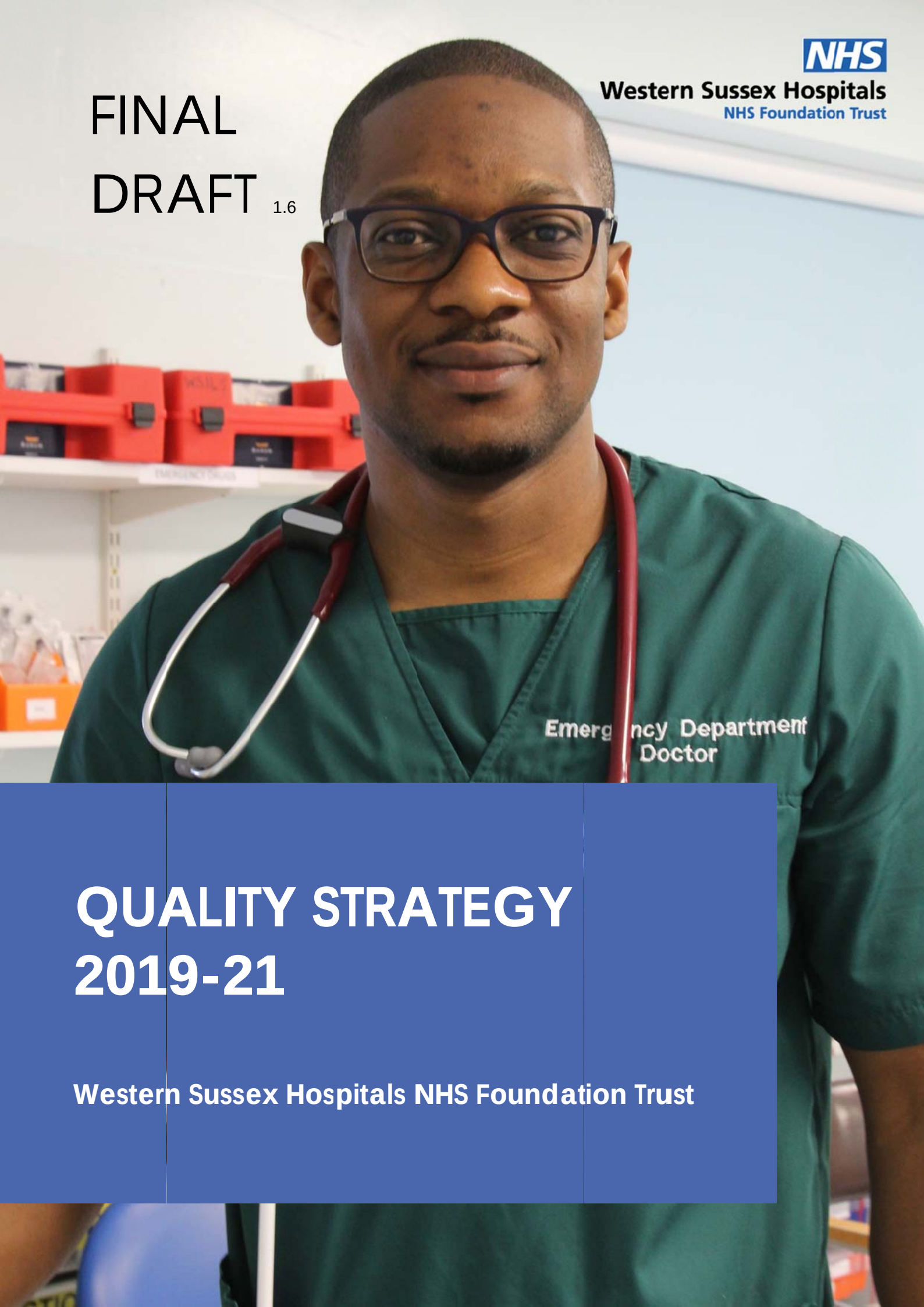
QAC review and approval: 23/09/19
Trust Board review and approval: 26/09/19

Executive Summary:

Our Quality Strategy introduces the Trust's quality improvement goals for the next three years and the means by which we will achieve these improvements. The Strategy also provides an overview of the Patient First programme, the way in which we support and enable continuous improvement and the way in which we prioritise our improvement goals.

Key Recommendation(s):

WSHFT Quality Strategy 2019-21: **for approval**



NHS
Western Sussex Hospitals
NHS Foundation Trust

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QUALITY STRATEGY 2019-21

Western Sussex Hospitals NHS Foundation Trust

Introduction

Welcome to Western Sussex Hospitals NHS Foundation Trust's Quality Strategy 2019-21. Our Quality Strategy introduces the Trust's quality improvement goals for the next three years and the means by which we will achieve these improvements.

As you read the strategy, you will see that our Patient First Improvement Programme drives each of its elements. Patient First is the Trust's long-term approach to transforming the way we deliver our services. It is a programme based on standardisation, system redesign and the improvement of patient pathways, built on a philosophy of incremental and continuous improvement that is led by front-line staff empowered to initiate and lead positive change.

Striving to continually improve all that we do has been part of our DNA since the trust was created in 2009. Patient First provides a formal focus for that mind-set which will push up standards of safety and quality further still.

Our priorities are shaped by the need to respond to the rapidly changing healthcare needs of the communities we support, and do so in a climate of rising demand for our services and ever-increasing pressure on the resources available to provide them.

This Quality Strategy refreshes and builds on improvements achieved through the Trust's previous Quality Strategy 2015-18. Our quality goals 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.

I am delighted with the quality improvements we have seen over the last few years. Under our goal to reduce preventable mortality, we have seen our HSMR score improved from 107.48 in 2011/12 (ranked 112 of 141 acute trusts; 79th centile) to 89.43 in 2017/18. Data for the 12 months to March 2019 shows performance at 94.9 just outside the 20th centile. This is an amazing achievement.

Under our avoiding harm goal, we have sustained a 30% reduction in in hospital falls from a baseline of 2015/16. Over 2018/19 we have achieved a 20% reduction in numbers of pressure ulcers overall. We have achieved a 28% reduction in category 3 and above pressure ulcers contributing to our Trust ambition to

eliminate category three and above pressure ulcers. These achievements make our hospitals safer and are so important for our patient and carers.

Under our improving patient experience goal, our Friends and Family Test feedback is above the national average. We have initiated exciting projects to improve patient experience including extended visiting hours, a new carers' policy, and enhanced environments for patients with dementia.

Under our staff engagement goal, the results of the NHS Staff Survey demonstrate that, despite the ever-growing pressure under which we work, staff commitment to patients and each other remains at record levels.

Staff engagement is the key measure of the annual survey, as it is a proven fact that engaged staff provide better care for patients and are better able to help their organisation improve. Engaged staff understand what an organisation is trying to achieve, know how they can play their part and feel valued for the contribution they make and the commitment they give. That is right at the core of Patient First's 'Our People' theme and it is really heartening that the standards we set in earning our "Outstanding" rating from the CQC in 2016 have become our new normal rather than a high-water mark for the trust.

This refreshed Quality Strategy now sets out some clear targets for Patient First to deliver on. We are confident it will do exactly that and are hugely excited by the transformative impact this will have on quality of care for all our patients.

I have the privilege to work with so many extraordinary and caring colleagues at Western Sussex committed to always improving the care and services we provide. I look forward to our continued focus on quality improvement during the years ahead.

Dame Marianne Griffiths
Chief Executive

What we do

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. The Trust became a Foundation Trust on 1st July 2013.

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, diagnostics 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 Estates & Facilities.

Purpose of the Quality Strategy 2019-21

Western Sussex Hospitals NHS Foundation Trust Quality Strategy 2019-2021 refreshes and builds on our previous Quality Strategy. This strategy sets out our Patient First approach to sustaining a culture of continuous improvement. It outlines the Trust's quality improvement goals for the next three years aligned under our True North metrics and current improvement programmes supporting the delivery of these goals.

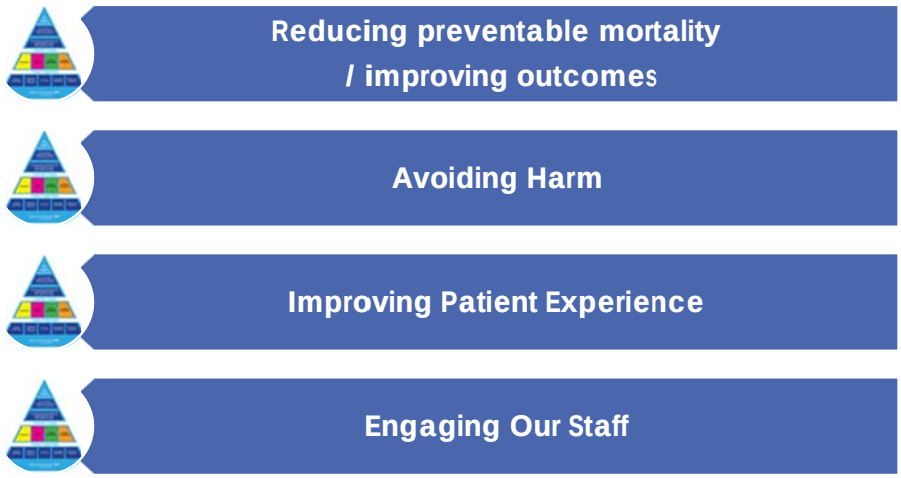
The strategy also outlines how we develop our quality priorities and the operational and assurance processes that support the delivery of our quality improvement plan.

Progress against our quality improvement goals is summarised and made publically available each year in our Annual Quality Report: www.westernsussexhospitals.nhs.uk/your-trust/performance

Our approach to quality improvement

We aim to consistently provide high quality care. Over the next three years, we will focus our attention on programmes of work that will ensure that we continuously improve the safety and clinical effectiveness of the care that we give to patients, ensuring we also improve the experience of care for our patients.

Key goals

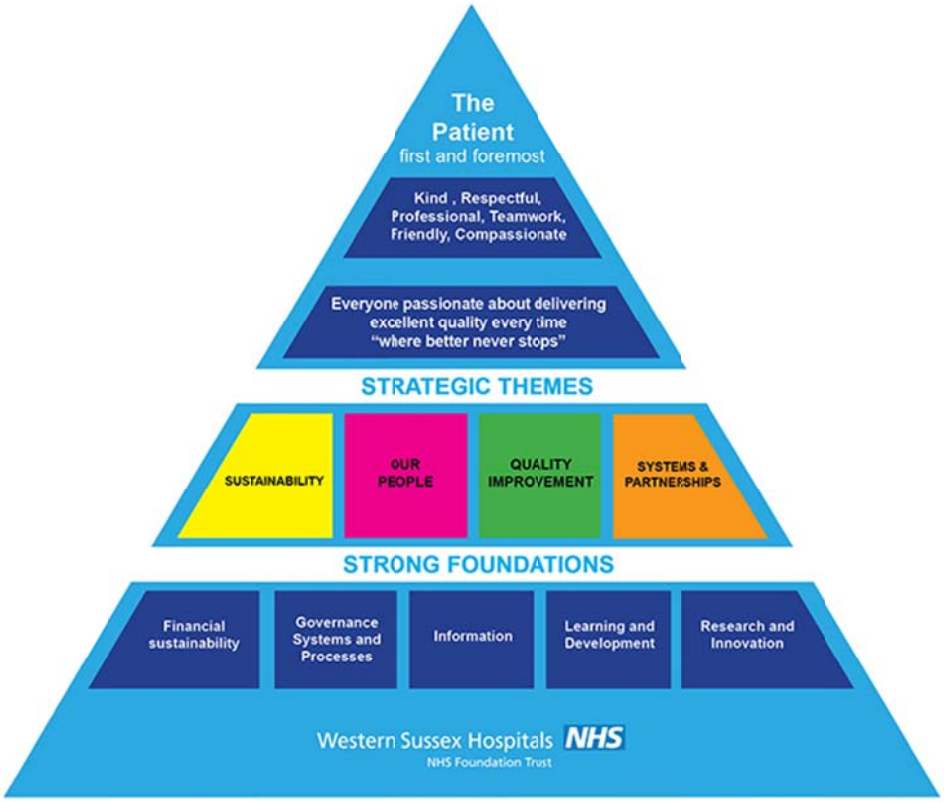


Patient First Programme

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.

The Patient First Programme drives quality improvement at Western Sussex Hospitals. It comprises four strategic themes: sustainability; our people; quality improvement; and systems and partnerships; to enable excellent care for patients.

In simple terms, the main aim of our Patient First 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.

Patient	Sustainability	People	Quality	Systems & Partnerships
Patient Satisfaction Target: Family & Friends Recommend Rate >97%	Financial Management Target: Break Even	Staff Engagement Target: Engagement Score Top in the Country	Preventable Mortality Target: HSMR Top 20% in the Country Avoidable Harm Target: Patient Safety Thermometer 99% Harm Free Care	Non Elective Care Target: A&E 95% <4hrs Elective Care Target: RTT 92% <18wks

Breakthrough objectives

For each Strategic Theme we set a 'breakthrough objective'. Breakthrough objectives are those that will take us furthest and fastest towards our overall True North. For Quality Improvement our current True North Metrics are the **reduction in preventable mortality**, and provision of **harm free care**. Our breakthrough objectives are regularly reviewed to ensure that we focus on the key improvements that will deliver our True North metrics.

Our True North objectives are cascaded throughout the Trust and from Board to ward using a process referred to as 'catch ball'. This occurs with each Division and the Executive ensuring:

- Divisions understand how to contribute to achieving the organisational priorities;
- Agreement of what additional local priorities each division needs to achieve;
- Mutual agreement of these objectives, as well as the resources required to achieve them.

Strategic Initiatives[1]

In order to ensure long-term improvement, the Trust has identified four strategic initiatives, which are listed below. These are 1-3 year work programmes, aimed at strengthening the Trust's capability, capacity and governance, to make the improvements it aspires to.

Strategic Care Systems	Patient First	Operational Productivity	Transformation Enablers
Integrated Care System • WSHFT Sustainability Assessment • BSUH Management Contract • STP Acute Services Review and opportunities **Integrated Care Provider** • AIC Contract & Service Work streams • Service Specific Transformation • ICP Pathfinder Development	**Strategy Deployment** • Strengthening SD flow **PFIS** • Embedding & standardising maturity within Divisions **Improvement Projects** • Supporting Operational Productivity Work streams **Improvement Capacity** • Focusing improvement skills on organisational priorities **Capability & Leadership** • Development of leadership skills to deliver performance	**Productivity** • Theatre Efficiency • Outpatient Productivity • Diagnostic Productivity **Demand Management** • Pathology Demand Management • Imaging Demand Management **Collaborative Working** • STP Pathology Network • Imaging Collaboration	**Site Master Planning** • Worthing Site Master Plan • St Richard's Site Masterplan • STP Estates Strategy **Workforce Planning** • 3-5 year workforce plan • New Roles and Training • Integrated Role Design **Digital Strategy** • IT Strategy • Evolve Implementation • Order Comms • PAS Replacement • Ledger Replacement • STP Digital Transformation

[1] BSUH – Brighton and Sussex University Hospitals NHS Trust, STP - Sustainability and Transformation Partnership - New partnerships between NHS and local councils across England which will develop proposals to improve health and care, AIC – Aligned Incentive Contact - contract with commissioners, ICP – Integrated Care Provider – an organisation providing care as part of an alliance of NHS, local councils and other organisations.

Corporate Projects

The Trust has identified five corporate projects (shorter term 'start and finish' projects) with a 12-18 month time frame, which are of sufficiently complex nature or are cross organisational, and therefore require specific corporate leadership and oversight. For 2019/20, these include:

- Western 'Outstanding' - Build on our Outstanding CQC rating to improve and deliver outstanding services;
- Clinical Strategy Delivery - Development of a refreshed Clinical Strategy for Western Sussex to inform the Integrated Care System (ICS) and regional (as well as Trust and local) planning;
- Delivery of 7-Day Services - Progress the development of seven day services against the national standards building on the work and improvements to date;
- Reducing Abusive Behaviours – Organisational-wide programme of work to understand and develop a response to the national and local increase in abusive behaviours in the NHS;
- Response to 6-Facet Survey[2] – Cross-site, cross-organisational programme of estates work to respond to findings of the six-facet survey.

Trust annual operational plans enable the Trust to progress against the overall tests set by the government to:

- Improve productivity and efficiency;
- Eliminate provider deficits;
- Reduce unwarranted variation in quality of care;
- Incentivise systems to work together to redesign patient care;
- Improve how we manage demand effectively;
- Make better use of capital investment.

Clinical Strategy

During 2019/20, the Trust will refresh its Clinical Strategy for the next five years. The strategy provides an opportunity to plan for a greater level of service reconfiguration that will support workforce planning, clinical sustainability and quality in the context of escalating patient need and complexity. The strategy will be developed collaboratively with system partners to ensure alignment with wider clinical strategy at both Coastal Care area and STP level. It will also provide the context to deliver the requirements of the NHS Long Term Plan.

[2] Six Facet Survey (NHS): land and property appraisal assessing physical condition; functional suitability; space utilisation; quality; statutory compliance; environmental management.

Setting and delivering our priorities for quality improvement

Our annual quality priorities form part of our broader ambition to deliver our True North metrics and the goals set out in this Quality Strategy: Reducing preventable mortality and improving outcomes, avoiding harm, improving patient experience, and engaging our staff. In order to develop our annual quality priorities we analyse quality indicators and benchmarking data, and engage widely.

The quality planning cycle forms part of the Trust's annual business planning cycle. Each year Divisions plan their improvement activity in line with our True North metrics. Divisional quality improvement priorities are presented to the Quality Board in autumn each year and discussed alongside Trust quality data, benchmarking and review outcomes, patient experience feedback, staff survey feedback and other strategic developments. Through the Quality Board the Divisions agree a set of quality improvements for the following year which are then included in divisional and trust level annual plans and scorecards.

Each year our annual quality priorities are set out in the Annual Quality Report for formal approval. The following groups are invited to review our quality improvement priorities on an annual basis: The Trust's Council of Governors, Coastal West Sussex CCG, Healthwatch West Sussex and the County Council's Health and Adult Social Care Select Committee.

Development and oversight of the Quality Strategy

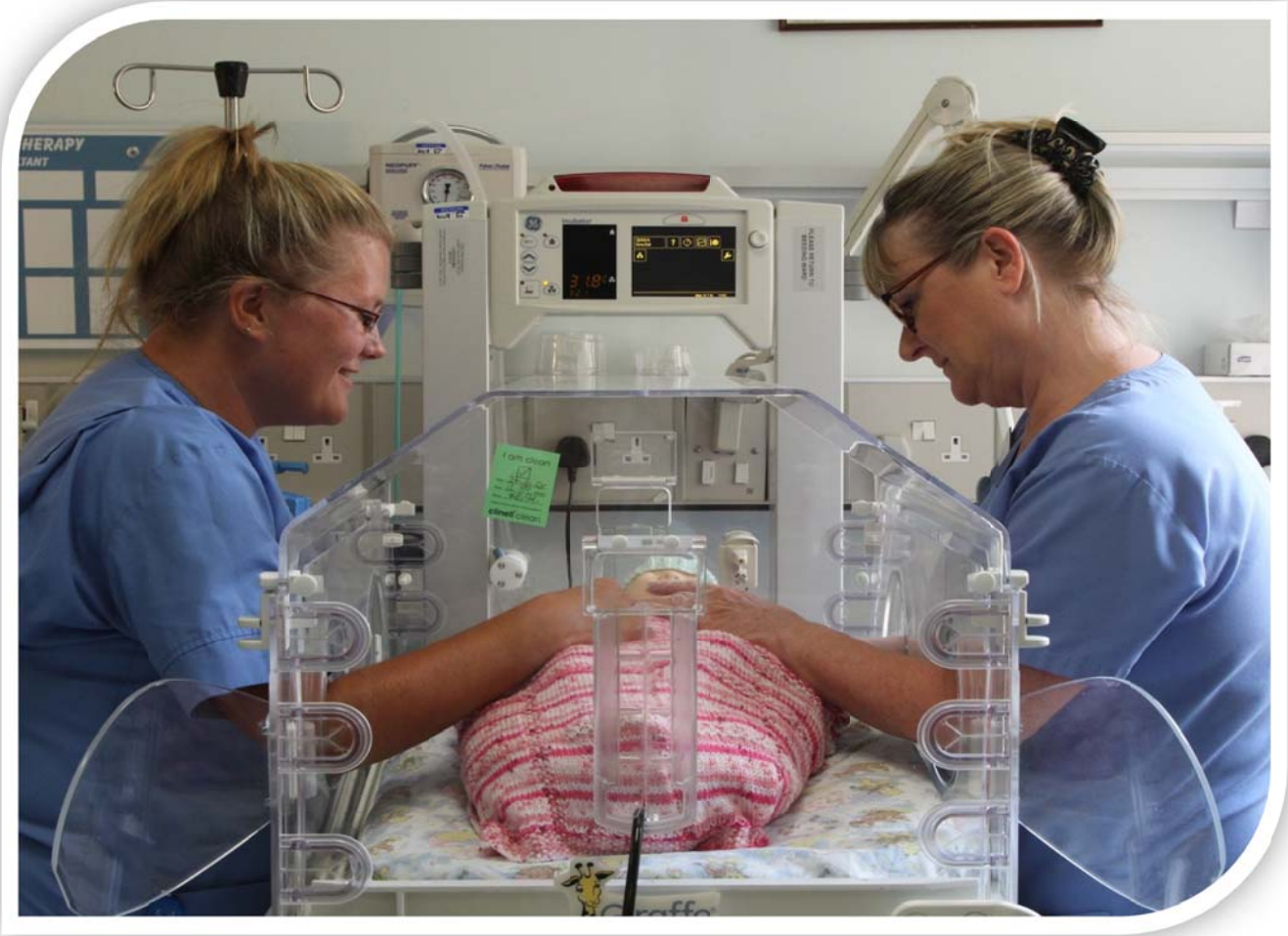
The Trust's Quality Board has the responsibility to develop and oversee the implementation of the Quality Strategy. The Quality Board will ensure that the Trust has in place robust arrangements to effectively identify and monitor programmes for improvement based on internal, regional and national quality priorities together with information from across the Divisions relating to safety and quality.

Divisional accountability for elements of our quality improvement programme is achieved through early engagement work relating to setting meaningful local improvement priorities and the cascade of accountabilities through our strategy deployment processes.

Quality Assurance

The Trust's Quality Assurance Committee provides an assurance function in relation to the Trust's Quality Strategy, its targets and outcomes, including:

- To review and recommend to the Board the Quality Strategy of the Trust, and to monitor progress against the strategy and other improvement plans such as improvement programmes within Patient First that may impact on clinical quality;
- To ensure there are robust systems for monitoring clinical quality performance indicators within Divisions and to receive reports on clinical quality performance measures;
- To review and monitor Quality Impact Assessments (QIA) relating to Efficiency and Transformation programmes to gain assurance that there will be no unforeseen detrimental impact on quality of care for patients;
- And in response to requests from the Board, or where appropriate as decided by the Committee, monitor the implementation of action / improvement plans in respect of quality of care, particularly in relation to incidents, survey outcomes (including Staff Survey) and similar issues.



Enabling quality improvement

Patient First Improvement System (PFIS)

Using the Patient First approach, the Trust has developed a bespoke approach to sustaining a culture of continuous improvement. Our programme is based on Lean thinking, standardisation, system redesign, ongoing development of care pathways, and is built on a philosophy of incremental, continuous improvement by front-line staff empowered to initiate and lead positive change. PFIS helps our wards and departments to support and sustain large-scale improvement projects. The PFIS system involves four months of training for each ward or department team through attendance at a series of modules and team days. Staff learn to implement PFIS in their areas and adopt new Lean management techniques including 'A3 problem solving', 'Plan Do Study Act' (PDSA) approaches, standard work, process observation, as well as implementing improvement huddles.

Evidence-based practice

We aim to ensure that care is delivered in line with best available clinical evidence, including NICE[3] standards, Royal College guidelines and recommendation arising from national confidential enquiries. We use clinical audit findings and outcome data to benchmark our care and focus improvement. By understanding our current position in relation to national guidance and comparative outcome data we can work towards minimising any variations in practice.

As part of our research and innovation strategy goals we focus on building evidence-based practice and research skills. The Trust offers a Clinical Academic Scholarship Programme and accredited evidenced-based practice modules. Staff are supported to use best evidence in their clinical decision-making and quality improvements by a team of clinical librarians.

[3] National Institute for Health and Care Excellence

Our Quality Goals

Supporting wellbeing

Supporting wellbeing is a key focus for all healthcare providers and an important part of the NHS Long Term Plan. We work in partnership to help people stay healthy and prevent ill health. Our maternity transformation programme helps to make sure that everyone gets the best start in life. Our health advice programme aims to support people to reduce risky behaviours, such as drinking excess alcohol and smoking that cause ill health. Through our frailty programme we focus on providing ambulatory care to keep people out of hospital, prevent deconditioning and help our frail elderly patients to stay active whilst being cared for in our hospitals. Our mental health programme helps to improve the pathways of care for patients experiencing mental health problems and support those regularly attending our emergency services.

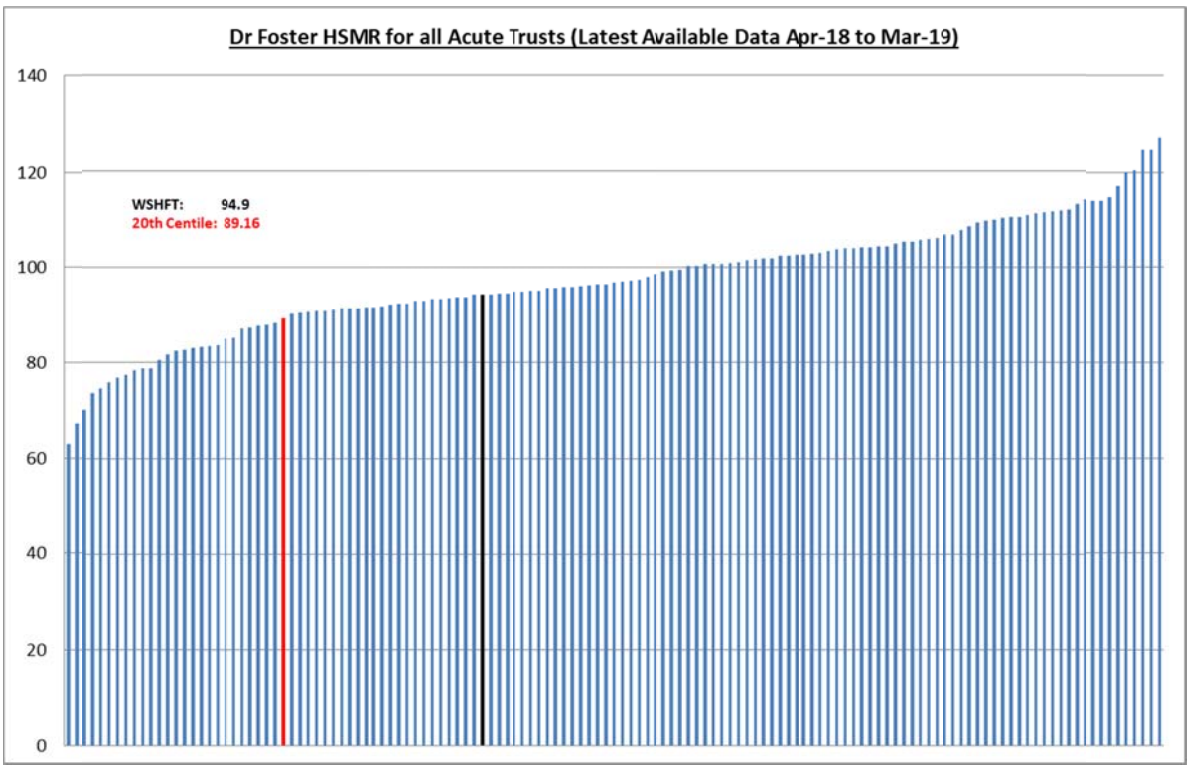
Reducing preventable mortality and improving outcomes

True North goal: To be in the top 20% of NHS organisations for the Hospital Standardised Mortality Ratio (HSMR)

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 curative treatment would not be in the patient's best interest and the person receives palliative treatment.

We know 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.

The primary indicator for our 'reducing preventable mortality and improving outcomes' goal is hospital mortality. The Trust uses Dr Foster's HSMR risk adjusted mortality tool to monitor this.



Our HSMR score improved from 107.48 in 2011/12 (ranked 112 of 141 acute trusts; 79th centile) to 89.43 in 2017/18. Due to the delay for Dr Foster data (to allow for coding and processing) the graph above shows the 12 months to March 2019 as the most recent data point with performance at 94.9 just outside the 20th centile.

We will continue to improve and ensure we are in the top 20% of trusts with the lowest HSMR. We will focus specifically on our 'True North' goal of zero avoidable deaths.

We will also focus on improving the care and experience of those facing the end of their life through the End-of-Life Care Strategy overseen by our End-of-Life Board.

Programmes supporting this goal:

Improving delivery of the 'Sepsis 6' care bundle

Aim: Reduce delays in recognising and treating sepsis, reduce patients' risk of adverse outcomes.

Further improvement against Seven Day Services (7DS) standards

Aim: Focus on Clinical Standard 2 - all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours of admission to hospital.

Maternity Transformation Programme

Aims include: Increasing the number of Smoke-Free Pregnancies to reduce the incidence of stillbirth and other complications of pregnancy; Reducing perinatal mortality & morbidity through fulll compliance with the Saving Babies Lives care bundle; Continuity of Carer for 'most' women by 2020/21.

Improvement to the Mental Health Pathway

Aim: To review current service levels in order to plan and develop new service provision to meet the needs of our patients; working with partners and commissioners to seek new pathways to support the growing patient cohort.

Frailty Improvement Programme

Aim: To enhance our provision for frail patients by establishing an integrated ambulatory frailty unit and frailty intervention team model.

Getting It Right First Time (GIRFT)

Aim: Reduce unwarranted variation in clinical practice and improve the quality, efficiency and performance of our services and clinical outcomes for our patients.

Avoiding Harm

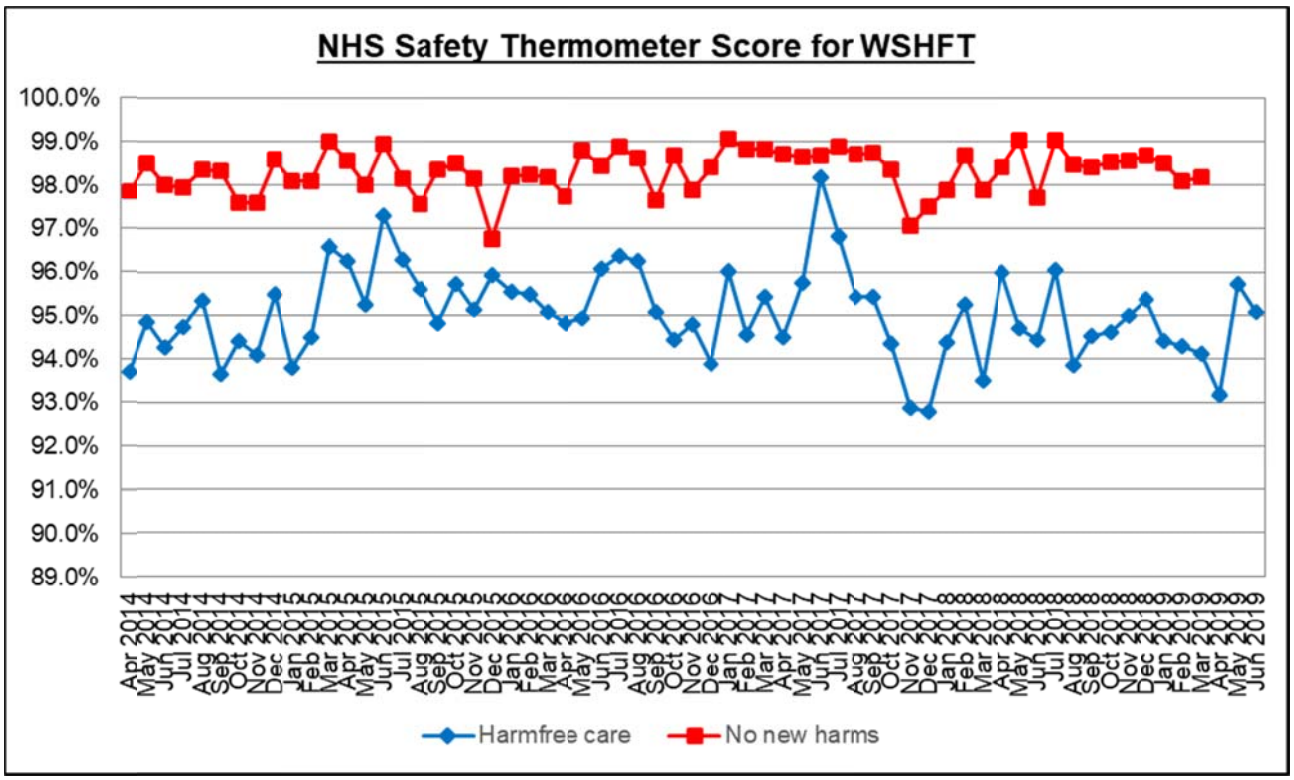
True North goal: 99% of patients receiving safe, harm free care as measured by the NHS Patient Safety Thermometer

Western Sussex 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.

Hospital acquired infections, pressure sores and other complications are examples of harm, which are sadly commonplace in 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.

The Trust uses the national NHS Patient Safety Thermometer to monitor overall harm-free care. This tool looks at point prevalence of four key harms in all patients on a specific day in the month: falls, pressure ulcers, urinary tract infections, plus the venous thromboembolisms (VTE) deep vein thrombosis and pulmonary embolism. 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'.

The NHS Safety Thermometer includes harms suffered by the patient in healthcare settings prior to admission. The percentage of patients who suffered no new harm during their inpatient stay at WSHFT in 2018/19 was 98.48% and close to achieving the challenging internal target of 99% set by the Trust. This positive position sets us up well in aiming to achieve our 99% target.



Programmes supporting this goal:

Falls prevention

Aim: To maintain the Trust-wide 30% reduction in inpatient falls against our 2016/17baseline.

Reduction in hospital-associated venous thromboembolism (VTE)

Aim: The reduction of hospital associated VTE is a key quality breakthrough objective for 2019/20, with a goal to reduce avoidable VTE by 50% from our 2018/19 baseline.

Medicine optimisation programme

Aims include: Delivery of Top Ten medicines savings identified by the national Medicines Value Programme; Reduction in the use of antimicrobial conusmption; Delivery of the Medicines Optimisation CQUIN (Commissioning for Quality and Innovation) goal.

Elimination of severe pressure damage

Aim: to build on the improvement of 2018/19 aiming to deliver a further 10% reduction in hospital-acquired category 3 and above ulcers.

Improving patient experience

True North goal: 97% recommendation for Friends and Family Test feedback

Western Sussex Hospitals NHS Foundation Trust is committed to the delivery of patient-centred care for all patients. Patients can expect to receive exceptional care that meets both their physical and emotional needs. Improving patient experience is at the heart of the Trust's vision and values, and is a central aspect of our Patient First Programme.

The experience that a person has of their care, treatment and support is one of the three parts of high-quality care, alongside clinical effectiveness and safety. A person's experience starts from their very first contact with the health and care system, right through to their last, which may be years after their first treatment, and can include end-of-life care.

The Friends and Family Test (FFT) is a national survey designed to give the public an easy way to express their feedback. FFT returns also allows a comparison to be made at a national level. A high FFT return and recommend rate is indicative of a good service. In 2018/19, our FFT response rates were higher than the national average across A&E, inpatient and maternity services.

Our FFT patient feedback consistently ranks higher than the national average. We now seek to build on our achievements and reach the top 20% of NHS Trusts for FFT recommendation scores. To do this we have set a 'True North' long term goal to achieve 97% recommendation for FFT feedback, and reduce 'not recommend' rates.

Hearing the voice of the patient through the Friends and Family Test gives staff the opportunity to listen to patients' experiences and to make improvements. We respond to feedback on a regular basis with immediate and longer-term actions being taken to improve experience for all patients. Individual wards and departments use the information to respond within their areas using the 'you said…we did' principle.

Friends and Family Test recommend rates								
	Latest available data to May 2019	National average Latest available data to May 2019	Best performing Trust Latest available data to May 2019	Worst performing Trust Latest available data to May 2019	2018/19	2017/18	2016/17	2015/16
A&E	95.30%	85.58%	100%	54.55%	95.23%	85.8%	89.01%	91.39%
Maternity delivery	97.62%	97.09%	100%	86.54%	97.33%	97.8%	97.64%	96.20%
Inpatients	97.03%	95.66%	100%	75.44%	97.33%	96.8%	96.06%	95.20%
Outpatients	96.53%	93.41%	100%	75.00%	96.84%	97.0%	95.43%	92.4%
Data source: NHS England								

Programmes supporting this goal:

Patient Experience Strategy

Aim: All patients will feel safe, comfortable and listened to whilst in our care.

Reducing noise at night

Aim: To increase inpatient (Real Time Patient Experience) satisfaction rates from a Trust wide monthly average of 54% to 65% by end of March 2020.

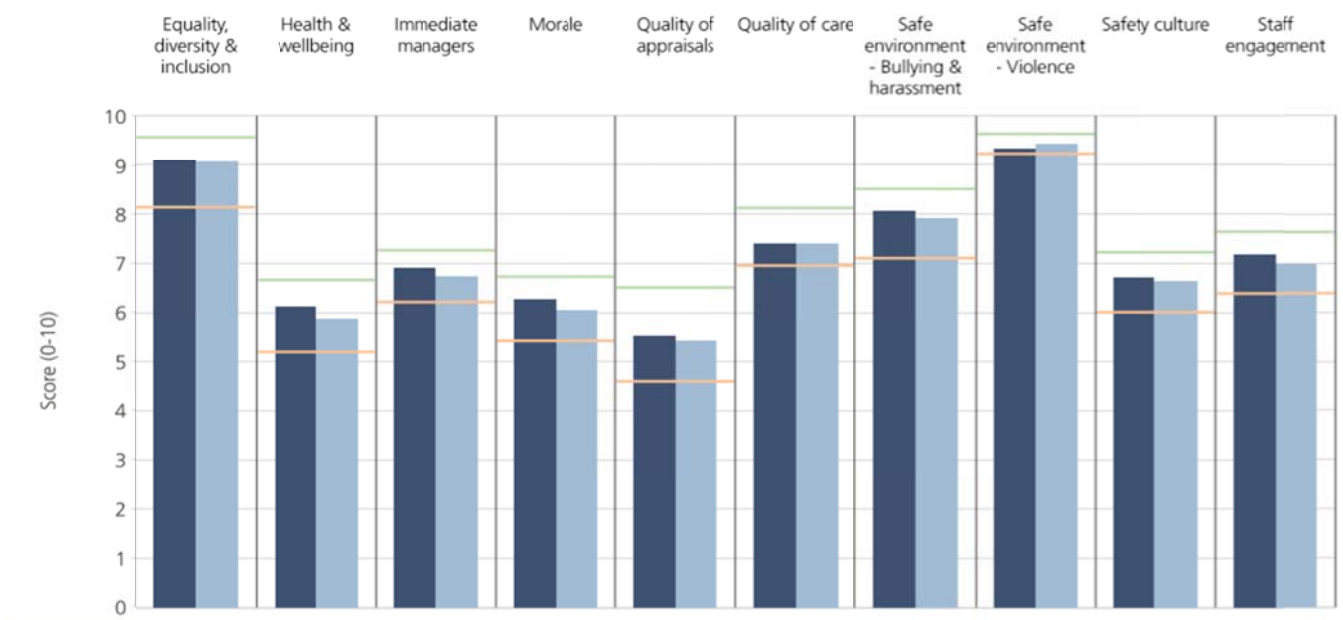
Engaging our staff

True North goal: To become the top performing Acute Trust in the country for staff engagement by 2020

'Our People' determine the experience of their workplace. When individuals are highly engaged in their work they think and behave positively, are emotionally resourceful and have better health. Ultimately, high staff engagement leads to delivering better outcomes for patients, increases staff productivity, satisfaction and compliments.

The national NHS Staff Survey is a way of assessing the quality of staff experience through a number of questions linked to the NHS Constitution. For the 2018 national staff survey NHS England revised and restructured the scoring system to measure trusts on a scale of 0-10, rather than the 0-5 scale used previously. Improvements were also made to the survey analysis outcomes based on ten key themes.

2018 Staff Survey Theme Results Overview:



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	9.1	6.1	6.9	6.3	5.5	7.4	8.1	9.3	6.7	7.2
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4
Responses	4,305	4,335	4,332	4,286	3,852	3,835	4,301	4,299	4,306	4,350

On the new scale, Western Sussex Hospitals scored 7.2 for overall staff engagement in 2018, unchanged from the 2016 and 2017 results when recalculated according to the new scale. These results rank the Trust in the top 20 acute trusts in England and Wales.

Our aim is to support the Trust's journey to become a NHS model employer; the 'Our People' True North goal is to become the top performing acute trust in the country by 2020. Based on the new methodology scoring system, a Trust-wide target has been set to achieve a staff engagement score of 7.6.

To realise the 'Our People' objective and become the top performing acute trust for staff engagement by 2020 will require the Trust to demonstrate to staff that Western Sussex Hospitals NHS Foundation Trust is the best place to work. Whilst our performance is continuing to improve and our organisational culture reflects our values, the Trust is taking part in an innovative culture transformational project, 'Best Place to Work', to support our journey.

In addition to the 'Best Place to Work' initiative, improvements are being made to reduce the poor behaviours staff experience which were reported in the staff survey. During 2019/20, a Trust-wide corporate project approach was introduced to reduce the abusive behaviours staff experience and improve how incidents are dealt with. The project will support the Trust's Workforce Race Equality Standard (WRES) action plan to improve the experience of our Black Minority Ethnic (BME) workforce and also links to the Trust Equality agenda.

Progressing our work on equality, diversity and inclusion is important and will be the focus of our 2019/20 staff conference. The aim is to further integrate and increase awareness of diversity throughout the workforce. Working collaboratively and understanding the different needs of patients and staff, Western Sussex will improve patient services and establish stronger links in the local community.

It is anticipated that staff engagement will improve as we continue to roll out our Patient First Improvement System. In addition, we will also focus on:

- Implementing the Reducing Abusive Behaviour corporate project to obtain a statistically significant change in the 2019 staff survey results.
- Promoting equality, diversity and inclusion throughout the Trust through the annual staff conference and our diversity groups (Celebrating Cultures, LGBT network and Disabilities forum) to reduce discrimination of staff.
- Continuing to deliver the Trust's 'Wellbeing Wednesdays' programme, increase health & wellbeing champion membership and promote staff health & wellbeing programme to new starters and existing members of staff.

- Identifying key initiatives that will improve the mental health and wellbeing of staff.
- Using an online platform as part of the Best Place to Work initiative to engage staff and co-design strategies to improve engagement.
- Supporting staff in feeling confident to raise concerns about unsafe clinical practice by learning from incidents through the Freedom to Speak Up Guardians and associated networks.
- Continuing to grow the Staff Survey Champion membership within all Divisions.
- Developing a corporate engagement strategy for the national staff survey.

How we learn

We have robust systems in place for reviewing incidents, complaints and claims within our clinical divisions. 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, 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 NHS Foundation Trust.

Learning from incidents

The Trust's Patient Safety Team is currently undertaking an improvement project regarding the Datix incident reporting system. We aim to understand and improve shared feedback and learning.

We host a Serious Incident Investigator training programme accredited by the Royal College of Physicians and sponsored by the Kent Surrey and Sussex Quality and Patient Safety Collaborative (KSS AHSN). The programme is facilitated by staff from the Trust and Healthcare Safety Investigation Branch and provides training on how to investigate serious incidents using a Human Factors approach, the Duty of Candour and involving the patient, their family and carers. A further training programme is planned for 2019/20 with an annual training programme under development.

Trends and themes from incidents, complaints, inquests and deaths (mortality) are shared at the monthly Trust Triangulation Committee, with the learning translated into the Patient Safety and Learning Newsletter, for use by the teams in safety and improvement huddles. The Trust is using the new NHS Patient Safety Strategy (2019) as a driver for further improvements to patient safety culture and safety systems.

Learning from deaths

In accordance with national mortality guidance the Trust runs a screening and structured judgement review process to identify and learn from deaths. The thematic learning from this activity is linking to other key work streams and groups such as the End of Life & Mortality Board, the Deteriorating Patient Group and the Triangulation Committee to ensure the learning informs strategic planning and development in those key areas. This work will continue to progress with an improvement programme piloting processes for daily review panels. We have also been successful in attracting a KSS HEE[4] Darzi Fellow who will work with us in 2019/20 leading a co-produced project exploring how we best work with families as we learn from deaths.

[4] Kent Surrey Sussex Heath Education England

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Western Sussex Hospitals

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	12	**Meeting:**	Trust Board	**Meeting Date:**	26 Sept 19
Report Title:	Finance and Performance Committee Report to Board				
Sponsoring Executive Director:	Lizzie Peers, Non-Executive Director				
Author(s):	Lizzie Peers, Non-Executive Director				
Report previously considered by and date:	N/A direct report to Board				
Purpose of the report:					
Information	✓		Assurance	✓	
Review and Discussion	✓		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	✓	
Our People	✓		Quality	✓	
Systems and Partnerships	✓				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	☐		Effective	☐	
Caring	☐		Responsive	☐	
Well-led	☐		Use of Resources	☐	
Communication and Consultation:					

Executive Summary:

The Finance and Performance Committee met on 29 August 2019 and was quorate as it was attended by three Non-Executive Directors and the Chief Finance Officer, Chief Workforce and Organisational Development Officer, Chief Medical Office and Chief Nurse. Attending the meeting were also the Finance Director, Managing Director, Director of Human Resources and Director of Performance.

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

Key Recommendation(s):

The Board is asked to **NOTE** the assurances received at the meeting and that based on these the Committee did not refer any matter to any other Committee and did not refer any strategic risk to the Executives for review.

Western Sussex Hospitals NHS Foundation Trust

To: Trust Board

Date: 26 September 2019

From: Finance and Performance Committee

Agenda Item: 12

COMMITTEE HIGHLIGHTS REPORT TO BOARD

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

Declarations of Interest Made

There were no declarations of interest

Assurance received at the Committee meeting

- The Committee **RECEIVED** the financial performance reports for Month 4. The Committee was **ASSURED** in respect of the Trust's performance against the plan for Month 4 with the Trust recording a £1.1m surplus excluding PSF and MRET which is in line with the Trust's approved plan. The Committee agreed to continue to monitor the work being delivered to mitigate the increase in activity levels. The Committee was **ASSURED** over the plans supporting the delivery of the control total.

- The Committee **RECEIVED** the Efficiency Programme update, noting that in Month 4 the programme was on track to meet with year to date delivery of £4.3m against a plan of £4.3m with forecast outturn for full delivery of the plan. The Committee noted the increased risk in the plan but was **ASSURED** by the mitigations in place and that the BAF correctly records the current level of risk.

- The suite of operational performance reports was **RECEIVED** by the Committee, which noted the Trust's position against constitutional standards and discussed the trajectories in place to improve the Trust's performance. The Committee noted that the Trust was behind its planned trajectories for A&E, two of the Cancer Metrics and RTT but had returned to a compliant position for diagnostics. The Committee recognised the demand and activity delivery risks and was **ASSURED** that the BAF correctly records this level of risk.

- The Committee **RECEIVED** the National Cost Collection Publication – 2018/19 Submission and was **ASSURED** by the compliant submission of data ahead of the deadline and noted the rich data collated and its use in supporting the Trust's Use of Resources programme.

Actions taken by the Committee within its Terms of Reference

The Committee chose not to refer any of the risks it has oversight for back to the Executives for review as the Committee was assured over the risks current scores based on the business of Committee.

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

- The Committee agreed to receive a deep dive in respect of the Trust's RTT performance plans at its next meeting.

- The Committee requested further information in relation to the impact of demand on the Trust's Bed Plan efficiency scheme versus actions the Trust can take to reduce the current effect.

Items referred to the Board or another Committee for decision or action	
Item	**Referred to**
▪ The Committee referred no matters to other Board Committees and referred no matter to the Public Board.	

NHS
Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	13	**Meeting:**	Board	**Meeting Date:**	26 Sept 2019
Report Title:	**Q2 Board Assurance Framework – 2019/20**				
Sponsoring Executive Director:	Glen Palethorpe, Group Company Secretary				
Author(s):	Glen Palethorpe, Group Company Secretary				
Report previously considered by and date:	TEC – 19 Sept 2019 QAC – 23 Sept 2019 F&P – 23 Sept 2019				
Purpose of the report:					
Information		☐	Assurance		✓
Review and Discussion		☐	Approval / Agreement		✓
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		✓	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability		✓
Our People		✓	Quality		✓
Systems and Partnerships		✓			
Any implications for:					
Quality	Quality related strategic risks				
Financial	Finance related strategic risks				
Workforce	Workforce related strategic risks				
Link to CQC Domains:					
Safe		✓	Effective		✓
Caring		✓	Responsive		✓
Well-led		✓	Use of Resources		✓

Communication and Consultation:

The Board Assurance Framework has been prepared in conjunction with each of the five Chief Officers, focussing on respective strategic objectives and determining their associated strategic risks.

Executive Summary:

Introduction

The Trust has identified 11 strategic risks to the delivery of its objectives. The oversight of the management of these strategic risks is documented within the Board Assurance Framework. Each risk has an assigned oversight committee who review the detail of the listed assurances and their impact on the current score along with the delivery of the actions to reduce to or maintain the risk at its target score.

For quarter 2 at 13 September there have been no changes from the Q1 assessed score.

BAF Summary

The table overleaf shows by risk, their current score and their target risk score. Noting that for one risk (3.2) this is scored at its target score and thus the BAF process for this risk is about securing assurance that this acceptable (target) level of risk is maintained.

The table also shows pictorially the movement in risk between the current score for Q2 and that recorded for Q1. (⟷ No change, ↑ an increase in risk and ↓ a decrease in risk

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores								
	Opening risk			Q2			Target		
	I	L	T	I	L	T	I	L	T
1. Patient ***Quality Assurance Committee***									
1.1 we are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact and loss of market share	2	3	**6**	2	3	**6** ↔	2	2	**4**
2. Sustainability ***Finance and Performance Committee***									
2.1 We are unable to align or invest in our workforce, finance, estate and IM&T infrastructure effectively to support operational resilience, deliver our strategic and operational plans and improve care for patients	3	4	**12**	3	4	**12** ↔	3	3	**9**
2.2 We cannot continue to deliver ongoing efficiencies and flex our resources in an agile way resulting in the Trust not being able to live within its resources given the rising demands on our services	3	4	**12**	3	4	**12** ↔	3	3	**9**
2.3 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties	3	3	**9**	3	3	**9** ↔	3	3	**9**
3. People ***Quality Assurance Committee***									
3.1 We are unable to appropriately develop cultural change and involve and engage staff in a way that leads to continuous improvements in patient experience, patient outcomes, and staff morale and wellbeing	3	3	**9**	3	3	**9** ↔	3	2	**6**
3,2 We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of staff adversely impacting on patient experience and the safety, quality and sustainability of our services	3	3	**9**	3	3	**9** ↔	3	3	**9**
4. Quality Improvement ***Quality Assurance Committee***									
4.1 We are unable to deliver and demonstrate compliance with regulatory requirements or clinical standards adversely impacting on patient safety and our registration and accreditation by regulatory and supervisory bodies	2	3	**6**	2	3	**6** ↔	2	2	**4**
4.2 We are unable to deliver service improvements and improve safety, care quality and outcomes for our patients or demonstrate that our services are clinically effective	2	3	**6**	2	3	**6** ↔	2	2	**4**
5. Systems and Partnerships ***Finance and Performance Committee***									
5.1 We are unable to develop and maintain collaborative relationships with partner organisations based on shared aims, objectives, and timescales leading to an adverse impact on our ability to operate efficiently and effectively within our health economy in line with the NHS Long Term Plan	3	3	**9**	3	3	**9** ↔	3	2	**6**
5.2 We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability.	4	3	**12**	4	3	**12** ↔	4	2	**8**
5.3 We are unable to deliver and demonstrate consistent compliance with operational and NHS constitutional standards resulting in an adverse impact on patient care and the reputation of the Trust	4	3	**12**	4	3	**12** ↔	4	2	**8**

Committee review

Each BAF risk has an allocated lead oversight Committee, however, it is recognised that for some risks other Committees will also receive assurance against elements of control with respect to that risk.

Quality Assurance Committee

The Committee's review of the risks to which they have allocated oversight and their receipt of assurance at their meetings across Quarter 1 and the start of Quarter 2 did not identify any negative assurance that required any risk to be referred back to the Executive for review for being under stated.

Finance and Performance Committee

The Committee's review of the risks to which they have allocated oversight and their receipt of assurance at their meetings across Quarter 1 and the start of Quarter 2 did not identify any negative assurance that required any risk to be referred back to the Executive for review for being under stated.

The Committee however, did recognise the increase in demand as a pressure on risk 5.3 in relation to the delivery of the Trust's operational targets. The Committee agreed that the receipt of their expected reports and assurance would enable them to recognise or endorse if a change in the current score is needed over the next few months if the service demands continue to exceed the Trust and wider health economy assumptions.

The Committee at its meeting in August also asked for the BAF to reflect the General Ledger update planned for 2019/20 within risk 2.3, recognising this did not alter the current risk score.

Audit Committee

The Audit Committee considered the BAF along with the key highly scoring risks that underpin the BAF and felt there was no need to refer any risk to the Executive for review for being under stated. The Committee did decide that it would undertake a more detail review at its October Committee meeting of risks 3.1 and 3.2 to complement the reviews undertaken by the Quality Assurance and Finance and Performance Committees as the assurances supporting these risks span both Committees.

Trust Executive Committee

The Trust Executive Committee consider the BAF alongside the highly scored divisional / corporate risks. The Committee has not identified any increasing risks that have required a reassessment of the scored strategic risks.

Key Recommendation(s):

The Board is recommended to consider the level of current risk recorded within the BAF against reported assurances via the various Committees and assurances provided direct to the Board over the period covered by this report and agree that this represents a balanced view of assurance and its impact on the key risks to the achievement of the Trust's stated objectives.

Appendix A

Risk Appetite Statement

The Boards of NHS Trusts are accountable for ensuring the quality, safety and sustainability of the services they provide to patients. Western Sussex Hospitals NHS Foundation Trust sets clear expectations for the Trust through strategic objectives.

The Trust operates in a high risk environment and the day to day management of risk is an expected and integral part of the business of any healthcare provider. Overall, the Board has a **moderate** appetite for risk in relation to the achievement of its objectives and takes active and ongoing actions as part of our daily operational management and strategic planning to reinforce our risk controls in order to minimise risk to a tolerable level.

Our Board Assurance Framework and risk registers will continue to reflect material risks that may prevent the Trust from fulfilling its role in delivering clinical services which meet regulatory and NHS Constitutional standards and the expectations of our stakeholders and patients. We have defined our appetite for risk in relation to our strategic objectives as follows:

Patient Care: We make delivering an excellent care experience for our patients our highest priority. However, we will accept **moderate** risks to patient experience if this is required to achieve patient safety and quality improvements.

> We have a **low** risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality, safety and sustainability, may affect the reputation of the Trust or of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Board.

Safety: We will deliver safe, high quality clinical services and demonstrate they achieve optimal clinical outcomes and deliver best practice for our patients whilst ensuring we meet regulatory standards. Overall, our risk appetite for safety is **low**. Specifically:

> We have a **low** appetite for risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.

> We have a **low** appetite for risks that may jeopardise patient safety.

> We recognise that it can be in the best interests of patients to have a **moderate** appetite for some individual patient care and treatment risks in order to achieve the best outcomes. Therefore we support our staff to work in collaboration with the people who use our services to develop appropriate and safe care and treatment plans based on assessment of need and clinical risk.

> We will apply strict safety protocols for all of clinical and non-clinical activity, when and wherever possible. We will report, record and investigate our incidents and ensure that we continue to learn lessons to improve the safety and quality of our services.

Sustainability: We strive to use our resources efficiently and effectively for the benefit of our patients and their care and ensure our services are clinically, operationally, and financially sustainable. We will always aim to achieve this objective; however, overall we have a **moderate** appetite for risk in this area. Specifically:

We have a **moderate** appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.

We are committed to providing patient care in a therapeutic environment and providing staff with an environment and supporting infrastructure in which to perform their duties. However, we have a **moderate** appetite for some risks related to our infrastructure and estate except where these adversely impact on patient safety, care quality and regulatory compliance

We will increase our appetite for financial risk to **significant** in some instances and consider all potential delivery options to ensure the delivery of our objectives. Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards. A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require sign off by the Board.

We are prepared to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level. Value and benefits will be considered and resources allocated in order to capitalise on opportunities.

People: We value and respect all our staff equitably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles. We will rarely accept risks that would limit our ability to achieve this objective and the Trust's overall risk appetite for workforce related risks is **low**. Specifically:

We have a **low** appetite for risks related to the recruitment, retention and training of staff to deliver safe, high quality services and good patient experience.

We have **no** appetite for risks associated with unprofessional conduct, bullying, or an individual's competence to perform roles or tasks safely nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our values.

We have a **moderate** appetite for risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing, and staff development models where these enhance or improve patient safety, care quality, service delivery or financial sustainability.

We have **no** appetite for any risk that could result in staff being non-compliant with legislation, or any frameworks provided by professional bodies.

We have **no** appetite for any risk that could result in us being in breach of our contractual or statutory responsibilities in relation to our staff or in a breach of our staff's employment rights.

Systems and Partnerships: We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards. Overall we have a **moderate** appetite for risks to the achievement of this objective. Specifically:

We have a **moderate** appetite for risk where this results in improvements in the design or delivery of healthcare services for our patients or the population we serve. Our appetite for risk in this area recognises that the Trust operates in a complex environment and is subject to very challenging economic conditions and changing demographics with intense scrutiny. We consider the risks associated with innovation, creativity and clinical research to be an essential part of the Trust's risk profile. We increase our appetite for risk in this area to **significant** in order to maximise the opportunities to improve patient outcomes and the Trust's sustainability. . A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require support of the Board.

We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards.

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	15	**Meeting:**	Trust Board	**Meeting Date:**	26 Sept 19
Report Title:	**Nursing Staffing Capacity Report**				
Sponsoring Executive Director:	Maggie Davies Chief Nurse				
Author(s):	Maggie Davies Chief Nurse Jo Habben Head of Clinical Governance and Patient Safety				
Report previously considered by and date:					

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

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

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

Any implications for:	
Quality	Safe staffing level for nursing are evidenced as having an impact on quality and safety of patient care
Financial	Achieving workforce KPIs will support the financial plan
Workforce	Recruitment and retention of suitably qualified staff is an essential for sustaining high quality care

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

Communication and Consultation:

Executive Summary:

This report incorporates key national, regional and local staffing indicators providing assurance for the Board and highlighting issues of concern.

Key Recommendation(s):

The Board is asked to NOTE the report.

Western Sussex Hospitals
NHS Foundation Trust

Report to the Board of Directors

Nurse Staffing and Capacity Levels Report for Adult Inpatient wards,

Midwifery and Children's Wards across Western Sussex Hospitals Foundation Trust

Q3-4 2018-19

1 Introduction

1.1 The purpose of this report is to present to the board a review of ward nurse staffing level as directed by the National Quality Board (NQB). 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'. Within their recommendations it states that every six months as required by the NHS England *Hard Truths* report that the board of directors should receive and discuss at a public board meeting a report on staffing capacity and capability. This requirement came following a number of national reports.

- The Francis report in Mid Staffordshire (2013) 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).
- Cavendish review (2013), 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).
- '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).
- 'Hard truths. The journey to putting patients first' (DH, 2013).
- Developing workforce safeguards: supporting providers to deliver high quality care through safe and effective staffing. (NHSi October 2018).

1.2 As a result of the recommendations 'Safe staffing for Nursing in adult inpatient wards in acute hospitals' (NICE 2014) was developed, this provides detail on the methodology for undertaking a staffing review and, processes requirements for escalation including the introduction of 'red flags' which were a series of incidents that NICE identified should be reported by ward staff. (Appendix 1). These are reported through Datix and reviewed each month at the triangulation committee.

1.3 In October 2018 NHSI published *Developing Workforce Safeguards; supporting provider to deliver high quality care through safe and effective staffing.* *https://improvement.nhs.uk/documents/3320/Developing_workforce_safeguards.pdf.*

This is in recognition that there are significant recruitment and retention challenges in most professional groups in the health service and that health systems and boards are having to make tough decisions to ensure that services deliver the best outcomes in financially challenged times. The document has a number of recommendations on workforce safeguards, from April 2019 every provider's compliance with these will be assessed by NHSI through the Annual Governance Statement and the Single Oversight Framework.

The recommendations are relevant to all staff groups and include;

- Consistency in approach to safer staffing
- Good practice guidance for effective workforce planning
- Deployment of staff, governance and redesign of tools to assess staffing
- How to respond to unplanned workforce changes

All Trusts must ensure NQBs 2016 guidance is formally embedded in their safe staffing guidance, which states:

- That the workforce consists of sufficient, sustainably qualified, competent and experienced staff to meet care and treatment needs safely and effectively.
- That there is a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service to keep them safe at all times.
- In deciding on staffing Trusts must use an approach that reflects current legislation and guidance where it is available.

The board currently receives monthly information on the percentage of staff shifts filled (RN & HCA) and since May 2016 on the number of care hours per patient per day by ward as a part of the board quality report. Currently wards display publicly, daily information shift by shift of the staff available versus those that were planned for the shift.

The Nurse Director, Nurse Director for Workforce and Education and Director of HR are establishing a task and finish group to address the recommendations and from April 2019 the Safer Staffing Board reports will remain six monthly and include all other clinical professions.

2. Vacancies

2.1 The board is reminded that registered nurse workforce capacity across the local region and nationally remains a challenge to all health providers. There are an estimated 41,772 RN vacancies in England in September 2018, a rise of 6,000 from April 2018. Whilst there is a continued effort for both national and international recruitment, much of the activity in the Trust focusses on retention and *'grow your own',* this recognises that the supply of registered nurses is challenged.

Key factors influencing this are; the removal of the NHS bursary for student nurses (500 fewer university places being filled in September 2018) and Brexit which may be impacting on the profession's ability to attract nurses from Europe.

WSHT has a recruitment campaign that is focussed on national and international recruitment to reduce the current RN nurse shortfall. Bank and agency staff are utilised to maintain safe staffing of wards where ever possible. Currently the trust has a registered nurse vacancy of 274 WTE and 79 WTE HCAs under establishment (at 31.07.19). There remains focussed activity on nursing recruitment, retention, sickness management and in increasing our bank pool while aiming to reduce our use of agency staff. The Trust are currently using a variety of recruitment methods including return to practice, flexible working and rotation programmes to our recruitment adverts. We have a rolling programme of recruitment dates on both sites.

3. Adult Inpatient wards

This report will now summarise the position on the adult inpatient wards at WSHT, children's wards and maternity department staffing, including Registered Nurse ratios to patient by ward and by site.

3.1 Calculating staffing requirements is not straight forward and is dependent upon a number of factors. These include; the dependency (acuity) of patients on nursing care and factors such as skill mix of staff available and others including the culture and leadership of the team. The last acuity staffing review was undertaken in October 2018 using the Shelford Model and whilst the review is complete further work is being undertaken to compare findings with previous audits.

3.2 A review of all adult ward templates led by the chief nurse and senior nurses looking at ward establishments and the higher nurse to patient ratios at night. The review, undertaken in January 2019 highlighted the requirement for further investment based on the acuity and dependency (level1-2) of the patients on the most acute medical and surgical spinal wards at Worthing. The wards highlighted were Botolphs, Erringham, Eastbrook and Coombes[1].

[1] *The business case will improve number of care hours spent with each patient per day (CHPPD) and bring WSHT from the lowest quartile nearer to the national mean. This will enhance the RN patient ratio and bring this in line with RCN and NICE guidelines on Level 1 & 2 acute medical wards 24/7.*

3.3 The staffing ratios on adult wards within the Trust are presented in Table 1. The table details by ward, the RN staffing established and planned ratios over a 24 hour period during -the day and night shifts on all adult wards in the trust. This data excludes the ward coordinator from the ratios in the day time but the nurse in charge is included at night. On the day shifts, the variance on the wards is between 1:5 to1:10.0 (excluding the ward coordinator). On the night shifts across the wards on both sites the ratios vary between 1:5 and 1:13. There is currently no evidence that the higher patient to nurse ratio at night is affecting safety but where there are only 2 trained nurses at night it can have an impact on RNs due to work demand and resilience at night.

On the emergency floor, the establishment is adjusted for RN staffing ratios are 1:5.6 at Worthing and 1:6.9 at St Richards. If the acuity and dependency requirements on any particular shift on any ward necessitates additional RN, RMN or HCA support, there is a well-established system of requesting additional support via temporary or bank staffing, authorised by the Head of Nursing. There is also significant work being undertaken to improve early morning discharge of patients to decrease the demands on the night staff. This data is presented in Table 1.

3.4 Currently the Trust produces an acute site operation plan for each hospital, and which is reported 4 times daily to the site team. This is cascaded to the Chief Executive, Chief Operating Officer, Chief Nurse and Executive Director on call together with key operational staff across the Trust. Within the body of the report staffing levels and shortfalls are reported and mitigation plans are updated. In line with previous winters, during the winter months the trust has opened additional bed capacity on both Worthing and St Richards sites to meet the demand of high numbers of admissions particularly in our over 85 year old population. Safer care has also been implemented across the Trust to record the daily actual vs planned staffing on the adult wards. The next stage of implementation will be to operationalise this data during the operational site meetings where staff deployment is revised based on acuity and dependency.

Safe Staffing Data – (CHPPD Oct 2018)

Table 1

Ward	No. of beds	RN to Patient ratio – Day	RN to patient ratio - Night	CHPPD (Trust Wide)		
				RN	HCA	Overall
Acute Cardiac Unit	27	1 :6.8	1 :6.8	4.2	2.0	6.2
Aldwick	10	1:5	1:5	6.8	4.8	11.6
Ashling	26	1 :8.7	1 :8.7	2.8	3.3	6.1
Birdham	19	1 :9.5	1 :9.5	2.8	3.3	6.1
Bosham	26	1 :8.7	1:8.7 until 01:30 1:13	3.2	3.0	6.2
Boxgrove	27	1:9	1:13	2.7	3.6	6.3
Chichester Suite	16	1:5.3	1:8	5.0	3.7	8.7
Chilgrove	22	1:7	1:11	4.2	3.7	8.0
Donald Wilson House	12	1:6	1:6	5.1	5.1	10.1
Emergency Floor – SRH	55	1 :6.9	1 :6.9	5.0	3.5	8.5
Fishbourne	26	1 :8.7	1 :8.7	3.3	3.0	6.3
Ford	26	1 :6.5	1 :8.6	3.3	2.9	6.1
Lavant	26	1 :6.7	1:13	3.1	3.2	6.3
Middleton	27	1 :6.8	1:9	3.0	3.1	6.1
Petworth Ward	20	1:10	1:10	3.0	3.0	6.0
Selsey	26	1 :8.7	1:8.7 until 01:30 1:13	3.5	3.7	7.2
Wittering	26	1 :8.7	1:13	3.2	3.3	6.5
Balcombe	24	1:8	1:8	24.5	21.5	46.1
Barrow	20	1:10	1:10	2.8	3.5	6.3
Becket	22	1 :7.5	1:11	2.8	3.5	6.3
Botollphs	28	1:7	1:11	4.0	3.5	7.5
Broadwater	22	1 :7.3	1:11	2.9	3.1	6.0
Buckingham	22	1 :7.3	1:11	3.0	3.8	6.7
Castle	26	1 :6.5	1 :8.6	3.2	2.8	6.0
Chiltington	21	1:7	1 :10.5	3.6	3.4	7.0
Clapham	27	1 :9	1:9 until 01:30 1 :13.5	3.1	3.2	6.4
Coombes	27	1 :9	1:13	3.4	3.5	6.9
Courtlands	17	1 :5.7	1:4	5.7	1.8	7.5
Ditchling	24	1:8	1:12	3.3	3.1	6.3
Downlands Suite	11	1:5.5	1:5.5	7.7	2.2	9.9
Durrington	23	1 :7.6	1 :11.5	2.8	3.5	6.3
Eartham	21	1:7	1:10.5	2.8	3.1	5.9
Eastbrook	23	1 :7.6	1 :11.5	3.3	2.6	5.9
Emergency Floor - W	67	1 :5.6	1 :5.6	4.9	3.6	8.5
Erringham	22	1 :7.3	1:11	4.1	3.1	7.2
ESCU	5	1:2.5	1:2.5	11.0	3.9	14.9

3.5 Care Hours per Patient Day (CHPPD)

3.5.1 'Model Hospital' provides details on the average number of actual nurse care hours spend with each patient per day. In May 2019, the data indictes that WSHT is in the lower quartile of RN distribution CHPPD. *CHPPD is calculated by the total care hours (sum of actual hours worked) by nursing and midwifery staff, divided by total patient bed days (daily patient count snapshot by ward at 23.59). Day care, CDU, clinical assessment areas, additional capacity wards and A&E are excluded.*

3.5.2 In May 2019 the CHPPD data by national median was **8.1** vs WSHT **7.4** overall. RN national median **4.8** Vs **3.9** WSHT. HCA national median **3.2** Vs Trust **3.5** note that WSHT is now higher than the national median for HCA's. Table 2/3 and 4 present where WSHT are placed nationally with CHPPD for both RN and HCA.

Table 2 – Total (RN/Midwives/HCA) distribution of CHPPD (the bold line to the left represents the WSFT position nationally)

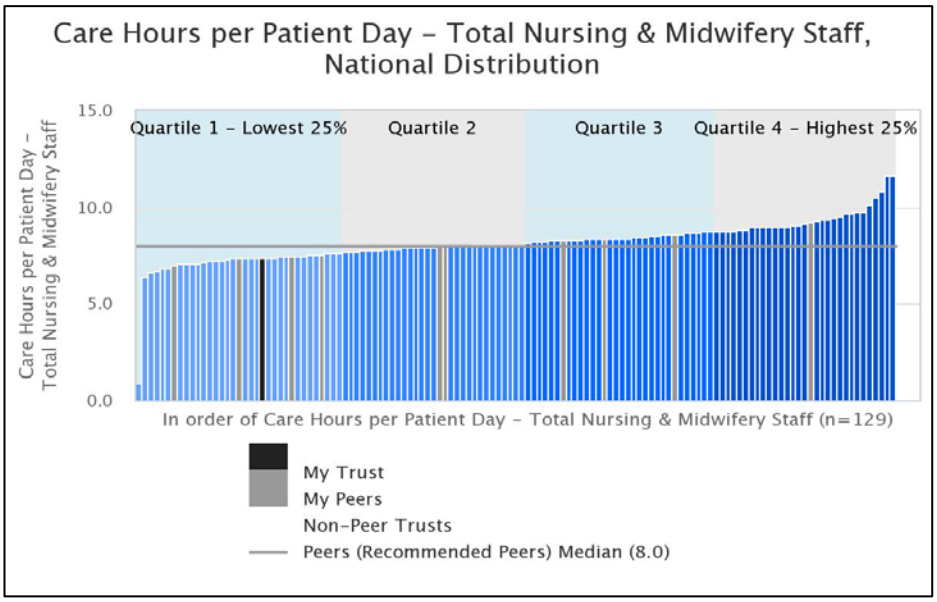


Table 3 – RN distribution of CHPPD (the bold line to the left represents the WSFT position nationally)

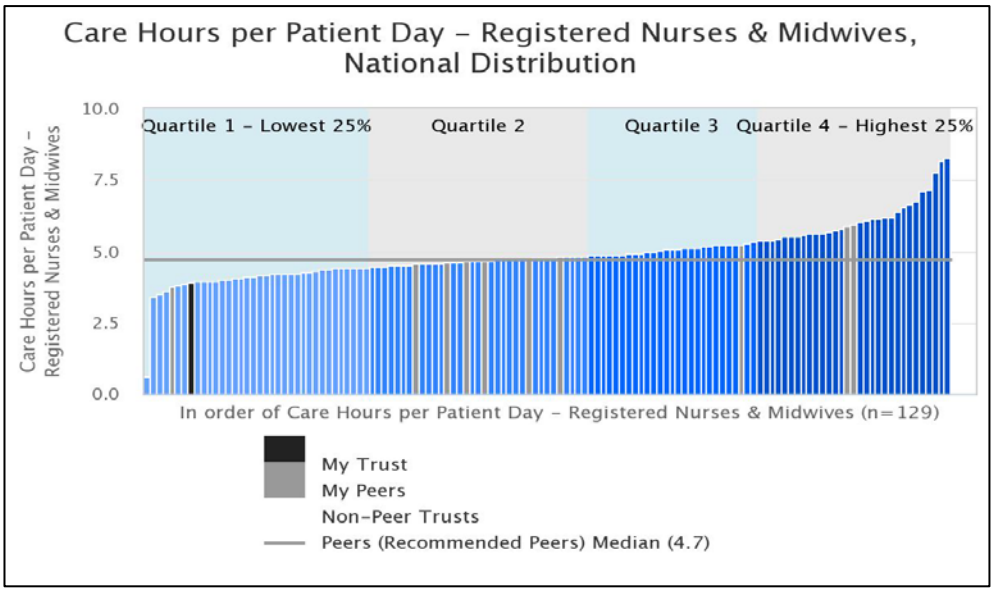
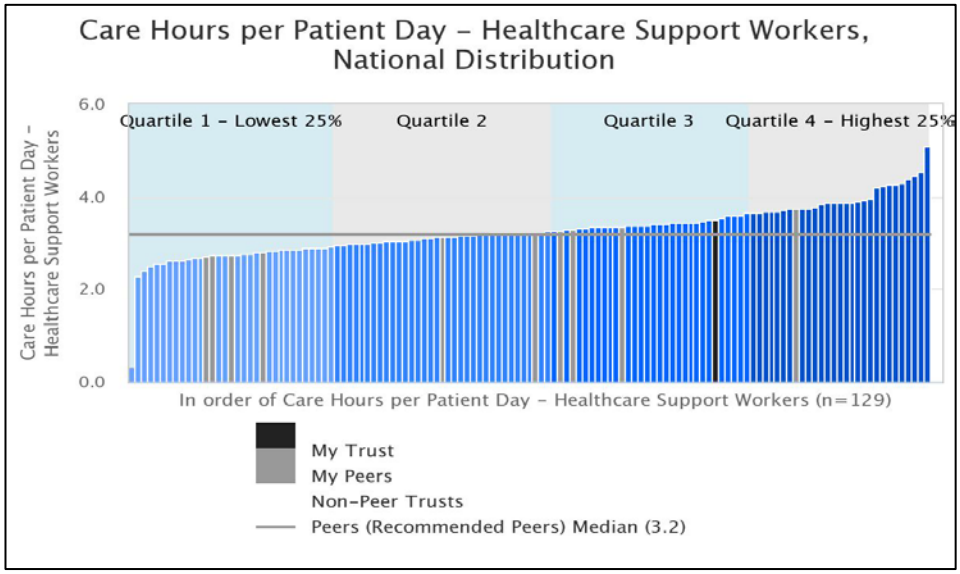


Table 4 – HCA distribution of CHPPD



3.6 Vacancy Rates and Recruitment

3.6.1 The vacancy factor for all areas is managed by the use of bank and agency staff and the board receive a monthly dashboard summarising the percentage of filled shifts by ward and role (registered / non registered staff) every month within the quality report. The monthly quality report also includes safety metrics including falls and pressure ulcers. Registered nursing staff continue to be recruited through monthly domestic campaign's led by the Lead Nurse for Workforce.

3.7 Overseas recruitment

3.7.1 The Overseas campaign remains successful, 15 nurses arrived between January and December 2018 with a current 100% OSCE pass rate. A further 9 arrived in QTR4. A further trip to the Philippines was undertaken in October 2018 with a recruitment offer given to 110 candidates.

3.8 Red Flags

3.8.1 Each wards publicly displays the daily nurse staffing information (RNs & HCAs) per shift. This information is the actual vs planned staffing on each ward. An escalation process (see above) is available for staff to follow when staffing does not meet the planned numbers and a process for recording red flag incidents is in place. Boxgrove is reporting more red flags than other wards, this does not triangulate with the fill rate on the ward and will be discussed with the Matron for the area

3.8.2 The data for the red flags incidents can be found in Appendix A.

4 Maternity

4.1 WSHT midwifery staffing extends across the acute and community settings. The professionally endorsed model for assessing whether midwifery staffing is at a safe level is based on the crude numbers of women who give birth together with the acuity of the cohort. The previous assessment of the midwifery workforce numbers using the Birthrate Plus tool was in 2012 when a ratio of 1:29 was recommended. Having completed a further assessment in Q3 2018, the assessment report concluded that based on the acuity of our women, the Trust should have a ratio of 1:27 on each site. Current budgeted establishment maps well to this probably due to a small reduction in birth numbers with 1:27 on the Worthing site and 1:28 on the SRH site.

4.2 Currently the template for staffing maternity for each shift is: a midwifery coordinator to oversee the shift[1], 8 midwives and 4 maternity assistants allocated to days and nights (on nights one of the 8 midwives is twilight only). The coordinator allocates and moves staff throughout the shift depending on the needs and acuity of the women. The maternity wards on each site have 27 beds where midwives are caring for women in the antenatal period together with new mothers and babies. The labour wards on each site have 8 birthing rooms with an additional two birthing rooms on the Birth Centre at SRH. Following the development of the Maple Suite at Worthing, both sites have dedicated bereavement facilities for parents.

4.3 Maternity is an 'ebb and flow' service that requires flexible use of midwives and support staff across the labour ward and maternity ward settings. Although a small amount of elective work is undertaken (elective caesarean and induction for example), childbirth is unpredictable both in terms of demand and the potentially rapid change in the acuity profile. At times there is need for escalation. Labour wards are prioritised and midwives will move from the maternity ward to labour ward when this is required for safety. This can at times impact on the numbers of midwives on the maternity ward who are available to support women. For example, if there are 6 women on labour ward requiring one-to-one care (either because they are in established labour, having an elective caesarean or are high risk), only 2 midwives will be left to care for the women on the maternity ward. The service has recently reviewed the escalation procedure and there is a dedicated Midwifery Manager on call 24/7 to support staffing and decision making at times of increased activity. As a last resort the community midwives on call can be called in to support, there was a likelihood that they were then unavailable for homebirths and may in fact have worked much of the previous day prior to the on-call with a risk to their wellbeing. A strict limit has now been placed on their requirement to support and they will be called in for a maximum of four hours and only following discussion with Manager-On-Call.

[1] This midwife is based on labour ward and should be supernumerary as the role extends to coordinating the whole of the inpatient setting and to community out of hours.

4.4 Despite having the required budgeted establishment and proactive recruitment leading to a low vacancy factor, there are still workforce challenges:

- Due to the specialist nature of midwifery and the national requirements for fitness to practice, mandatory training requirements are over and above the Trust allocation for other nursing groups
- High headcount due to an almost 70% part time workforce compounds this issue by having to release more staff for training
- Consistently high level of maternity leave
- Short and long term sickness absence
- Staff with specific rostering requirements due to ill health and supported by the Occupational Health Service

A number of initiatives have been undertaken since the last report. There was a refreshed training needs analysis reducing the number of training days for midwives and review of where midwives with limited flexibility or the inability to work nights to more 9-5 roles to enable recruitment of midwives able to work across the shift system.

4.5 **Continuity of midwife:** A significant development in terms of the models of care and likely staffing needs for the future is the move to a case-loading model of care. The maternity component of the Five Year Forward View is called 'Better Births'[2] and requires services to develop models to provid safer care with increased personalisation and choice for women and their families.

4.6 A key part of the programme is the requirement to move to a case-loading model for 'most' women by 2021. The interim target of 20% of women being booked to this model of care by March 2019 was achieved within the currently funded establishment making WSHT compliant with the NHS Planning Guidance. By March 2020 there is an expectation of achieving 35% of women booked to the model and the Head of Midwifery is working through staff engagement to develop models that meet the requirements without imposing burnout on the workforce given the significant on-call component to the roles. This is a significant challenge.

The cost of expanding continuity models is a currently unknown. The maternity transformation programme overseen by the STP is undertaking an independent workforce assessment across the four acute trusts to establish what the workforce needs are and therefore the gaps and potential costs of expanding continuity.

[2] National Maternity Review - Better Births: Improving outcomes of maternity services in England. A five Year Forward View for maternity care. (February 2016) www.england,nhs.uk/ourwork/futurenhs/mat-review

5 Paediatrics & Neonatal Nursing

5.1 The Head of Nursing for Paediatrics is currently leading a review of nursing establishments across both Paediatrics and neonates to establish the safety and sustainability of the current nursing models. The current nursing model has a seasonal variation: as an attempt to recognise the changes in both activity and acuity with the current "Summer/Winter" model and sees a variation in WTE during the different model templates. The "summer" model is active from 1st April – 30th September and the "winter" model is active from 1st October to the 31st March.

5.2 There is evidence to support that although activity may reduce in the "summer" period, the acuity of the children on the children's ward may not reduce and these need to be reflected in the workforce establishment.

5.3 The introduction of the Paedatric Nursery Nurse (PNN) is now complete and provides a trained member of staff who can take a pre-determined caseload of patients. The PNN provides 24/7 and have a positive impact on providing safe staffing levels for the Paediatric unit.

5.4 The Head of Nursing undertook a workforce review for both Paediatrics and Neonates during the month of August/September. For Paediatrics the RCN (2013) guidance: Defining safe staffing levels for children and young people's services tool was used. This involved data collection three times a day collecting both age and dependency data. For the Neonatal areas the audits have been benchmarked against the standards aligned to the neonatal nursing workforce and WSHT provides compliance data through the validated tool: Badgernet.

5.5 The workforce review highlighted deterioration in the compliance to professional standards but the implementation of the PNN has contributed to this supporting and maintaining safe staffing levels. Following this the Head of Nursing will be introducing the Shelford safer nursing tool in February 2019 to collate further data analysis to support the safe and sustainability of nursing staffing levels. The findings of the February audit will be presented to the Chief Nurse.

6 Summary

This report provides information on all adult inpatient wards at WSHT, maternity and children's wards. Following the acuity and dependency review conducted in quarter 4, I am pleased to report that in September 2019, further trust investment has been made to enhance the ratios on Coombes, Eastbrook, Erringham and Botolphs ward (late shifts where required and night shifts). The details will be included in the next report to the board. In addition, further investment into the nurse associate programme at the Trust has also been committed. Recruitment of nursing and midwifery staff is essential and will need to continue at pace, locally, nationally and internationally. However, the supply of nurses and midwives is limited and focussed activity in the Trust will be on retaining staff, increasing our student numbers and how we develop our own people to become skilled registered

practitioners. These measures are particularly important as universities are reporting up to a 32% reduction of applicants following the removal of the bursary for student nurses / midwives.

APPENDIX A

Nursing Red Flags
Nursing Red Flag Events – October 18-March 19 (Quarter 3 and 4 2018/19)

	Unplanned omission in providing patient needs	Delay of more than 30 minutes in providing pain relief	Vital signs not assessed/ recorded as per care plan	Delay or omission of intentional rounding	Shortfall of registered nurse establishment (>8hrs or 25%)	Less than 2 registered nurses on the ward	Delayed or cancelled time cancelled critical activity	Missed or delayed care (i.e. delay of 60 mins or more in washing & suturing	Missed medication during an admission to hospital or midwifery-led unit	Delay of 30 mins or more between presentation & triage	Delay of 2 hours or more between admission for induction and beginning of process	Delayed recognition of & action on abnormal vital signs	**Total**
Accident & Emergency (SRH)	3	0	0	0	6	0	0	1	1	2	0	1	**14**
Accident & Emergency (WH)	0	0	1	0	0	0	0	0	1	0	0	0	**2**
Acute Cardiac Unit	0	0	0	0	0	0	0	0	1	0	0	0	**1**
Aldwick Ward	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Any other Location in Hospital	0	0	0	0	1	1	0	0	0	0	0	0	**2**
Ashling Ward	1	1	1	0	2	0	0	0	0	0	0	0	**5**
Balcombe Ward	1	1	0	0	0	0	0	1	0	0	0	0	**3**
Barrow Ward	10	4	2	6	17	2	4	3	0	0	0	2	**50**
Beacon Ward	1	0	0	1	0	2	0	0	0	0	0	0	**4**
Becket Ward	0	0	0	0	1	0	0	0	0	0	0	0	**1**
Botolphs Ward	1	1	0	0	3	0	0	1	0	0	0	0	**6**
Boxgrove Ward	8	0	1	0	4	1	0	1	0	0	0	0	**15**
Bramber Ward	0	0	0	0	0	1	0	0	0	0	1	0	**2**
BroadwaterWard	1	2	1	1	3	0	0	1	0	0	0	0	**9**
Buckingham Ward	4	3	4	2	6	1	0	1	0	0	0	0	**21**
Burlington Ward	0	0	0	1	1	1	0	0	0	0	0	0	**3**
Castle Ward	0	1	0	1	1	1	0	0	0	0	0	0	**4**
CCU/Courtlands	0	0	0	0	1	0	0	0	0	0	0	0	**1**
Clapham	0	0	0	0	1	0	0	0	0	0	0	0	**1**
Coombes ward	0	0	0	0	1	0	0	0	0	0	0	0	**1**
Delivery Suite	1	0	0	0	0	0	1	0	0	0	0	1	**3**

Ditchling Ward	1	0	0	0	0	0	0	0	0	0	0	0	**1**
Downlands Suite	0	0	0	0	0	2	0	0	0	0	0	0	**2**
Durrington Ward	0	0	0	0	0	0	0	0	0	0	0	1	**1**
Eartham Ward	2	1	1	1	3	1	0	0	0	0	0	0	**9**
Eastbrook Ward	1	1	1	1	1	0	0	0	0	0	0	0	**5**
Emergency Floor (WH)	1	0	2	0	1	0	1	0	0	0	0	0	**5**
Ford Ward	1	0	0	0	1	0	0	0	0	0	0	0	**2**
Lavant Ward	1	0	1	0	3	0	0	0	0	0	0	0	**5**
Middleton Ward	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Pharmacy	1	0	0	0	0	0	0	0	0	0	0	0	**1**
Selsey Ward	0	0	0	0	0	0	0	0	0	0	0	2	**2**
Theatres	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Total	**39**	**15**	**15**	**14**	**57**	**14**	**8**	**9**	**3**	**2**	**1**	**7**	**184**

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	16	**Meeting:**	WSHT Public Board Meeting	**Meeting Date:**	26.09.2019
Report Title:	Infection Prevention & Control Annual Report 2018/19				
Sponsoring Executive Director:	Maggie Davies				
Author(s):	Dr S Jerwood & Sharon Reed				
Report previously considered by and date:	Trust Infection Control Committee 16.09.2019				
Purpose of the report:					
Information	✓		Assurance	✓	
Review and Discussion	☐		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	✓	
Our People	✓		Quality	✓	
Systems and Partnerships	✓				
Any implications for:					
Quality	1) In compliance with Health & Social Care Act (2008) 'good infection prevention (including cleanliness) is essential to ensure that people who use health and social care services receive safe and effective care'. 2) Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone. 3) Negative impact on patient, relatives, staff and Trust if quality assurance and standards are not upheld.				
Financial	1) Financial impact of on-call service/seven day provision. 2) Patient litigation claims can occur. 3) Loss of Commissioner confidence may result in loss of Trust business.				
Workforce	1) Learning and development requirements for all staff employed by the Trust, to include students and volunteers. 2) Organisational behaviour and cultural issues. 3) Workforce of small Infection Prevention Team and requirements of the service.				
Link to CQC Domains:					
Safe	✓		Effective	✓	
Caring	✓		Responsive	☐	
Well-led	✓		Use of Resources	☐	
Communication and Consultation:					
Shared with the Trust Infection Control Committee whom include PHE representative, CCG quality lead and Westerns community partners.					
Executive Summary:					

- The Trust *Clostridioides difficile* attributed infections for 2018/19 came in under trajectory. Multi-disciplinary review of each case, with all learning opportunities identified and actioned.
- There were 0 cases of post-48 hours MRSA bacteraemia. A Trust action plan continues with an ambition to reduce contaminated blood culture rates.
- With the exception of two, all clinical wards and departments have had an environmental audit performed at least once during 2018/2019 by the infection prevention and control team nurses.
- The overall training figures are 92% (average) and the infection prevention and control team deem training as one of the top priorities of the service delivery.

- The infection prevention team are a small and dynamic team that have provided an on-call service for 3 months of the year. A challenging task that needed precise management to achieve support for the Trust during periods of increased incidence or outbreak.

- All clinical areas have had an infection prevention 15 minute rapid review. This is completed with facilities team and the Matron of the area. This review allows assurance of not only environmental cleanliness but observations of correct hand hygiene and use of personal protective equipment.

Key Recommendation(s):

1) Continue efforts and trails to reduce blood culture contamination rates.

2) Emphasise outbreak or increased incidence infection control measures to all clinical and non-clinical staff.

3) Support anti-microbial stewardship group to achieve CQUIN for 2019/20.

4) Increase staff influenza vaccination rates for 2019/20 season to achieve 80% CQUIN target.

5) Devise, with support from clinicians, successful patient influenza vaccination for Trust inpatients.

6) Review of a seven day service for future planning.

The Board is asked to APPROVE this report for publication

Western Sussex Hospitals
NHS Foundation Trust

- Annual Report - Infection Prevention & Control 2018-2019

Prepared By:

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Western Sussex Hospitals NHS Foundation Trust

Infection Prevention and Control Annual report 2018/2019

1 Executive Summary

1.1.1 This is the report of the Western Sussex Hospitals NHS Foundation Trust Infection Prevention and Control Team for 1 April 2018-31st March 2019

1.1.2 There were 32 cases of post-72 hours *Clostridioides difficile* in WSHFT against a maximum objective of 38. Of these 15 were deemed to have lapses in care by the executive-led RCA panel. The main issues were the environment (19), isolation (4) and incorrect sampling (6).

1.1.3 *C. difficile* Trust action plan was formulated following a multi-disciplinary workshop in April 2018. These actions were applied throughout 2018/19.

1.1.4 There were 0 cases of post-48 hours MRSA bacteraemia.

1.1.5 There were 25 cases of post-48 hours MSSA bacteraemia.

1.1.6 Contaminated blood cultures are continuing to be monitored as we are seeing high rates, in particular from the Emergency Departments.

1.1.7 Gram-negative organisms including Carbapenemase-producing *Enterobacteriaceae* (CPE) are not increasing dramatically in this area but there is increased concern and vigilance due to outbreaks in other areas.

1.1.8 With the exception of two, all clinical wards and departments have had an environmental audit performed at least once during 2018/2019 by the infection prevention and control team nurses. The audit report, written by the auditor, includes recommendations for changing practice and suggestions for ward/clinical improvements.

1.1.9 The Water Safety Group has been very active this year with monthly meetings discussing testing and maintenance of water. There are a number of outlets being managed for Legionella and/or *Pseudomonas aeruginosa.* These outlets, that have tested positive, have had a point of use water filter applied immediately and estates remedial action planned to identify and rectify the root cause.

1.1.10 Antimicrobial Stewardship is monitored by the antimicrobial pharmacists and consultant microbiologists. We achieved 3 of the 4 CQUINS despite the targets being very difficult due to our previously tight control making it more difficult to decrease use further.

2 Introduction

2.1.1 The purpose of this report is to reassure the patients, public, staff, the Trust Board of Directors, Governors and Coastal West Sussex Clinical Commissioning Group (CCG) that the system of Health Care Associated Infection (HCAI) management meets its obligations with regard to patient safety and clinical governance. It is also to reassure that best practice is followed as identified in the Hygiene Code and Care Quality Commission underpinning national and local guidance and provide assurance that the Trust remains compliant with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health, 2015).

2.1.2 Investment in infection prevention and control remains both necessary and cost effective. It will be made clear during this report how we believe we are performing, where we do well and where we would like to do better.

2.2 IPCT

2.2.1 The Director of Infection Prevention and Control (DIPC) is the Executive Chief Nurse.

2.2.2 The WSHFT IPCT comprises:

- 1 WTE Band 8b
- 1.8 WTE Band 7
- 2.2 WTE Band 6
- 0.8 WTE Band 4 Secretarial support

Please see **Appendix 1** for further details on structure.

2.2.3 There is approximately 1.6PA of Infection Control Doctor (ICD) time but this has been reduced further since a Microbiology consultant resigned and recruitment has been unsuccessful. Previously (before 2015) there was 4PA of ICD time but this was reduced when the post-holder resigned and the post was withdrawn.

2.2.4 The IPCT covers 8.30am – 5pm daily with out-of-hours advice being given by the microbiology on-call service. IPCT have an on-call rota during the winter months (Jan – March) which was used during the Outbreaks.

2.3 Infection Prevention and Control Governance Structure

2.3.1 The Trust Infection Control Committee (TICC) meets quarterly and is chaired by the DIPC.

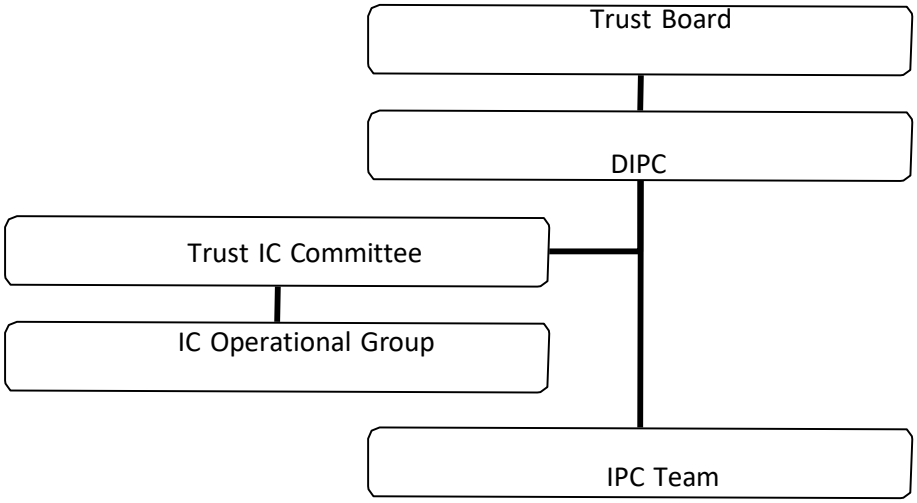
2.3.2 TICC reports to the Trust Board as per Figure 1.

2.3.3 TICC terms of reference are to be found in **Appendix 2**. The main purpose of TICC is to provide strategic direction to the Trust's management of infection prevention and control activity.

2.3.4 TICC provides assurance that the system of Health Care Associated Infection (HCAI) management is via a detailed framework to ensure the Board meets its obligations with regard to patient safety and clinical governance. It is also to ensure that best practice is followed as identified in the Hygiene Code and Care Quality Commission underpinning national and local guidance.

2.3.5 At TICC there is representation from each division (Medicine, Surgery, Women & Children, Corporate, Facilities & Estates, Consultant in Communicable Disease Control; Public Health England and Community partners).

Figure 1 IPCT reporting lines



2.3.6 The Infection Control Operational Group (ICOG) meets monthly and is chaired by the Lead IP&C Nurse.

2.3.7 ICOG reports to TICC as per figure 1 above.

2.3.8 ICOG terms of reference are to be found on the intranet within Infection Prevention and Control Management Arrangements Policy Version 4.

2.3.9 The main purpose of ICOG is to provide a high level management forum to ensure senior managers keep abreast of pertinent issues relating to IP&C and participate in effecting necessary change throughout the organization in a timely manner.

2.3.10 Over 2018/2019 both TICC and ICOG have been well attended and have been quorate at every meeting.

2.3.11 Information from both ICOG and TICC meetings are fed back via divisional leads. In addition the IP&C team feedback relevant information every month to the Sister meetings/team huddles.

3 Summary of performance 2018/19

3.1 *Clostridioides difficile* Infection(CDI)

3.1.1 There were 32 cases of CDI against a maximum allowed of 38 with 35 cases in 2017/2018 and 46 cases in 2016/17. All post-72 hours cases are reviewed by an executive-led (or their representative) RCA panel to establish whether there was any potential lapse in care which could either have led to the case, or increase the risk of further cases (for example by delayed isolation of the patient). 15 cases were deemed not to reach the standard we expect for a range of reasons but most commonly an unsatisfactory environment. The environment is further divided into nursing or facility elements to identify emerging trends.

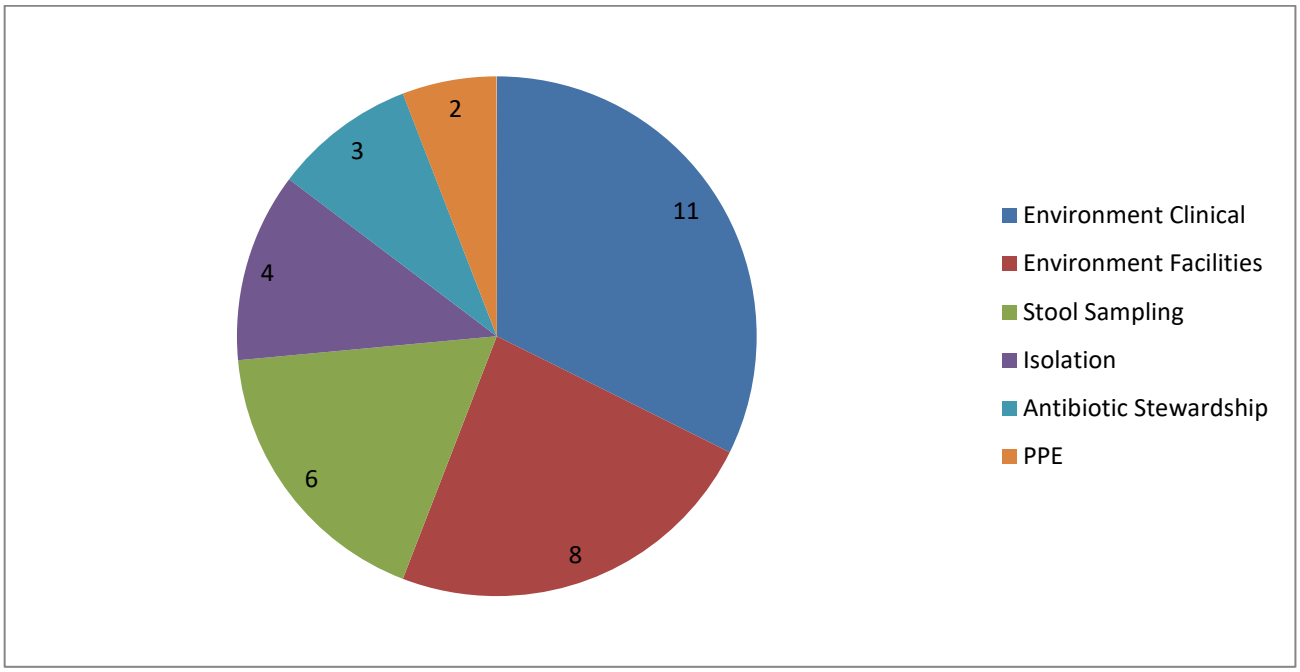


Figure 2 A Pie chart to show the distribution of lapses of CDI.

Frequently more than one cause of lapse was found.

3.1.2 A CDI action plan from 2018/19 was enacted during the year. This focused on previous years' lapses in care, with a multi-disciplinary workshop exploring trends and potential learning opportunities to minimise risk of CDI. Please see **Appendix 3**.

3.2 Methicillin-resistant *Staphylococcus aureus* (MRSA)

3.2.1 There were 3 pre-48 hours MRSA bacteraemias and no trust-acquired MRSA bacteraemias. Due to the low incidence within the locality a full PIR was not required. WSHFT IPCT supported the PIR initiation of all 3 community acquired MRSA bacteraemias.

3.2.2 Whilst 0 post-48 hour MSRA bacteraemias WSHFT continue to be proactive by continuing methods to reduce blood culture contamination rate, specifically within A&Es

3.3 Methicillin-susceptible *Staphylococcus aureus* (MSSA)

3.3.1 Due to the increased work load with Gram-negative bacteraemias post-48 hour MSSA bacteraemias were only investigated with a brief RCA.

3.3.2 There were 25 cases of post-48 hours MSSA bacteraemia, compared to 24 in 2017/18.

3.3.3 Of these 23 had Route Causes Analysis carried out. 6 of these were deemed to be avoidable, 5 of which were line related and one was felt to represent contamination only. In 9 cases it was not possible to assess whether it was avoidable or not.

3.3.4 During this time period there were 75 non-Trust cases (pre-48 hours). The Trust IPCT no longer carries out RCAs on these cases.

3.3.5 The actions in the MRSA action plan are also relevant for MSSA bacteraemias in particular the decolonisation of patients, sterile blood culture packs and antimicrobial stewardship.

3.3.6 The implementation of sterile blood culture packs was delayed due to staff shortages and winter pressures but a trial is due to take place in Summer 2019.

3.4 Contaminated blood cultures

3.4.1 There has been a high rate of contaminated blood cultures for many years. The average contamination rate in the Accident and Emergency departments was 42% (range 28 – 53) of positive cultures in Worthing and 62% (range 50-82) in St Richard's.

3.4.2 The improvement measures are on-going. The biggest improvement was seen when weekly results were sent directly to the Worthing A&E department but staff shortages have meant this could not be continued.

3.5 Gram-negative bacteraemias

3.5.1 There has been growing scrutiny over Gram-negative bacteraemias over the past few years. During the 17/18 year mandatory reporting of *Klebsiella spp.* and *Pseudomonas aeruginosa* came into effect, as well as the previously reported *E. coli* bacteraemia data.

3.5.2 The government launched an initiative in April 2017, to reduce Gram-negative infections by 50% by 2021. There was a 5% reduction from 16/17 to 17/18 (418vs398).

3.5.3 In 18/19 the total count was 343 representing a reduction of 13.8% since 17/18 and 17.9% since the initiative begun. This is a significant achievement especially when results are compared with neighbouring Trusts.

3.5.4 The planned collaboration with the GP practices to look at matched controls in GP practice to see if there are any differences at presentation which will allow earlier intervention was not achieved due to staff shortages.

3.5.5 Other interventions have been developed in conjunction with the CCG as the majority of *E. coli* bacteraemia cases are admitted directly from the community.

3.5.6 Since April 2017 *Klebsiella spp.* and *Pseudomonas aeruginosa* bacteraemias are also reportable. Unlike *E. coli* bacteraemias these are more likely to be health-care associated infections.

3.5.7 The number of hospital-acquired *Klebsiella spp.* bacteraemias fell from 24 in 2017/18 to 13 in 2018/19. Given the small number of these bacteraemias this apparently large change may be due to chance rather than a sustained change. During the same period the community onset cases went from 54 to 62.

3.5.8 The number of hospital-acquired *Pseudomonas aeruginosa* bacteraemias went from 12 in 2017/18 to 16 in 2018/19. During the same period the community onset cases went from 29 to 45.

3.5.9 Multi-resistant Gram-negative organisms are also becoming an increasing problem. To date we have seen no bacteraemias caused by Carbapenemase-Producing Enterobacteriaceae (CPE) but have seen a few on clinical or screening specimens for example Gram-negative screen or urine samples.

3.5.10 All patients who have received in-patient care abroad or outside of our immediate region are required to be isolated on admission until they have a negative Gram-negative screen.

3.6 Surveillance, Auditing and Teaching

3.6.1 **Main IPC Audits**

- Similar to previous years, IPCT have strived to undertake at least one main audit in every clinical/operational area across all 3 sites. This has been exceptionally challenging during 2018/19 due to 2 staff members retiring, delayed new starters and prolonged winter pressures.

- In total 126 main audits were performed during 2018/19. Each audit takes approximately one hour to observe practice and review the environment. This does not include the Infection prevention team's time to collate findings, write the audit report, send and review the action plan. In total, each audit takes a minimum of 2 hours.

- The team have worked extremely hard and whilst there were 2 areas (1 SRH & 1 Worthing) that did not receive a main IPC audit within the year, the number of audits completed, although down in numbers from 2017/18, have shown the perseverance and dedication from the team. The SRH area not audited is an escalation ward area and Worthing area is the Day Hospital. These will be priority audits early 2019/20.

- The return rate, for departments to send back completed action plans, has been poor throughout 2018/19 and IPCT escalate this to ICOG to improve compliance. The audit cycle includes closing the audit loop and IPCT must be sent the completed action plans to provide evidence of noting the recommendations and resolving the non-compliances.

3.6.2 **Main audit trends**

- Laundry room floors contaminated (some cluttered with equipment).
- Contaminated bladed fans.
- Sharps temporary closure not in use, protruding sharps.
- Over full used laundry bags.
- Incorrect waste segregation.
- Sunset foams/Hibiscrub not utilised as single use products
- Ward kitchens not fit for purpose
- Cluttered bays/bedsides
- Condition of floors (bays/corridors). Floors need repair or replacement and in particular corridor and bay floors need scrubbing.

3.6.3 **Spot check audits**

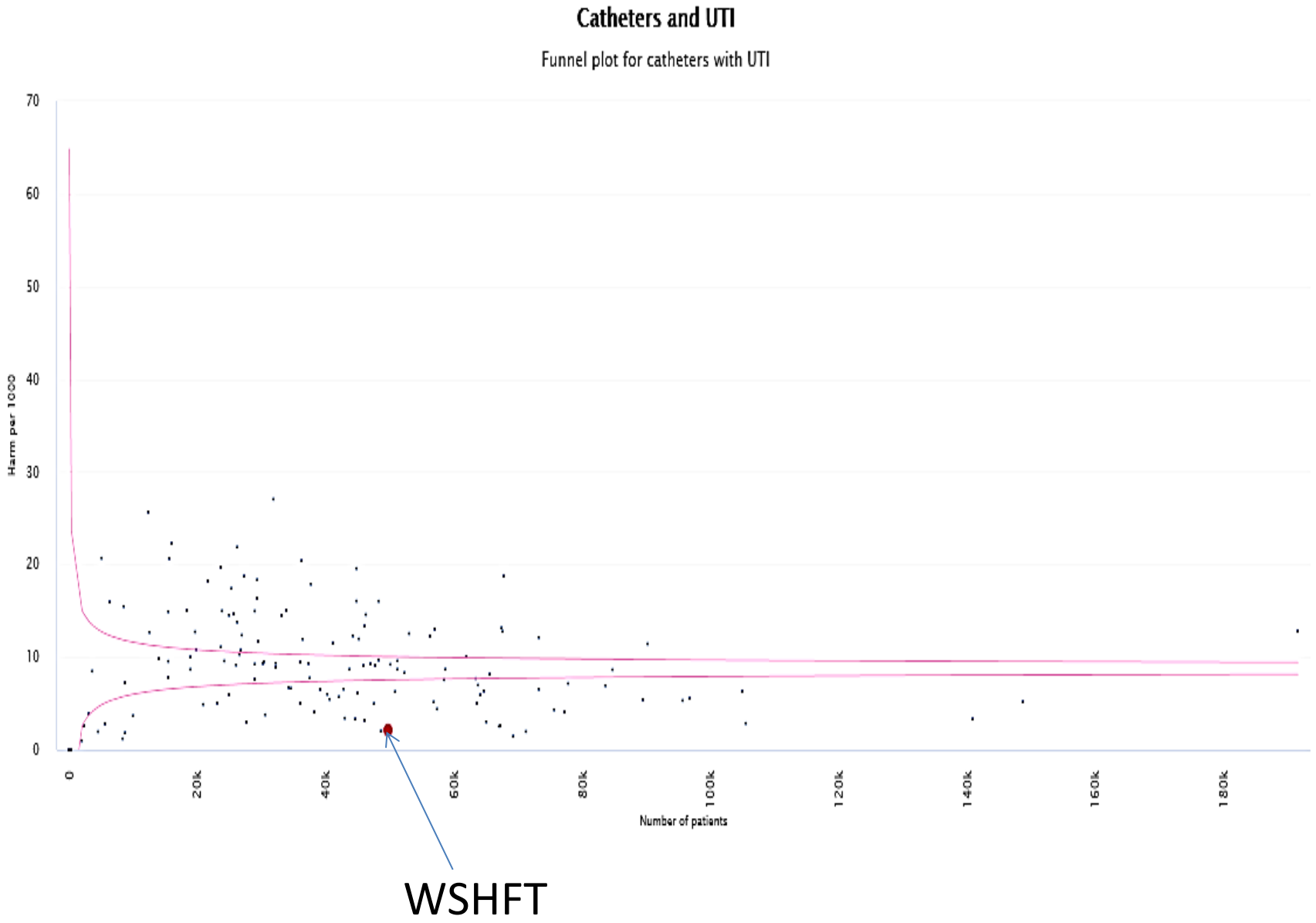
Spot check audits are a quick 15 minute review of a clinical area that can help support or change practice within the clinical environment. These have been utilised to investigate any highlighted concerns and are a useful tool to re-audit an area after a poor audit outcome or observation. They are implemented as a multi-disciplinary team approach, with matrons and facilities team members, to ensure all aspects of clinical areas are reviewed. This year there has been a robust programme to ensure all clinical areas had a monthly spot check completed and allowed for comparison and trend analysis. The pass benchmark has remained at 85% however if any bodily fluids were found then it was an instant fail, regardless of the score.

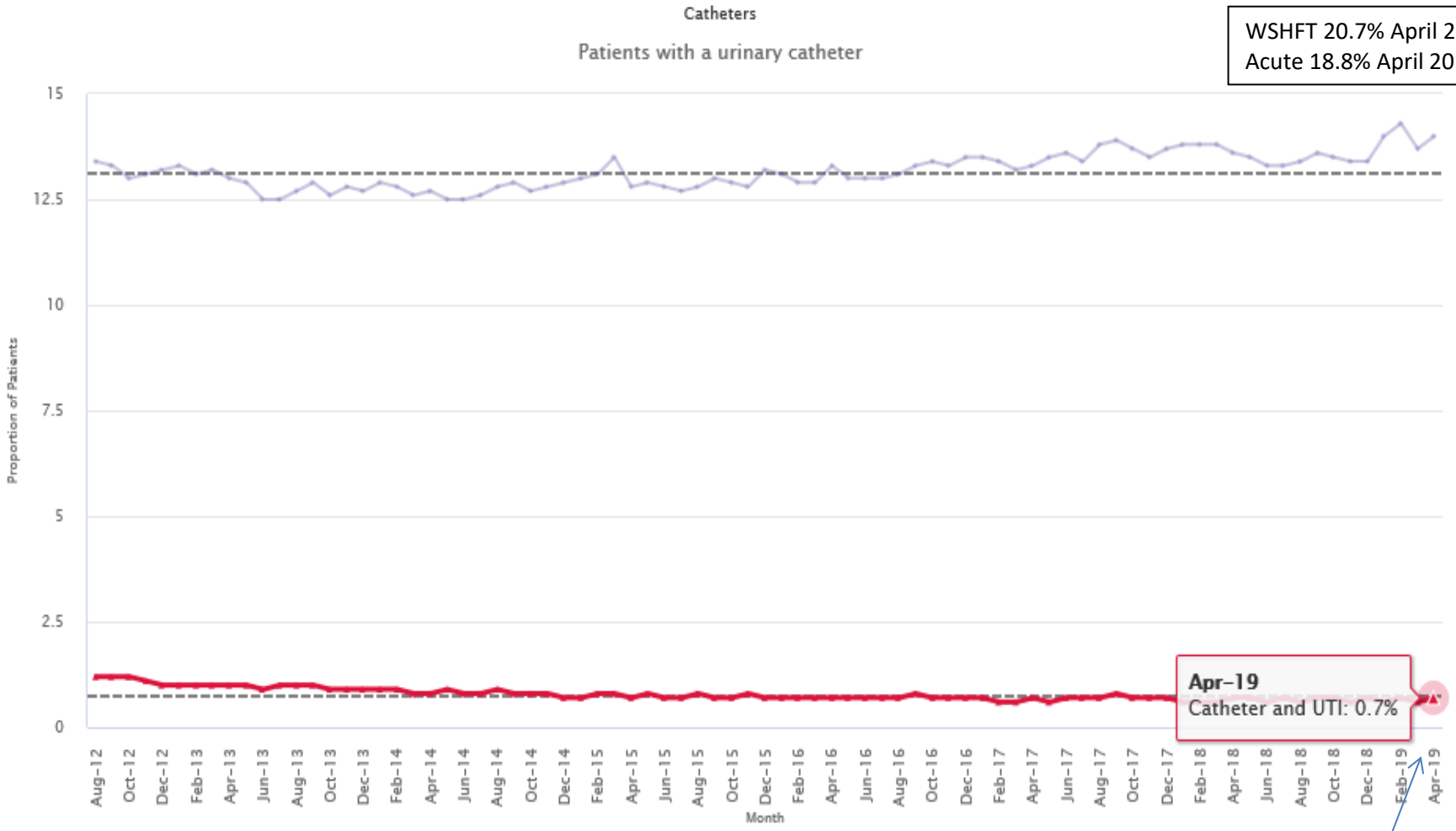
In 2018/19 423 spot checks were completed across the Trust, this was a marginal decrease from the previous year (458). The number of failures was disappointing with 228 (273 2017/18) spot checks failing to achieve 85% or above. This gave a Trust spot check pass rate of 46% compared to 40% in 2017/18. Whilst this overall percentage is low, all non-compliances were communicated to the wards/facilities/estates for immediate action. Non compliances to best practice were discussed at monthly ICOG meetings by the division representatives.

(Previous year in brackets)	**SRH**	**Worthing & Southlands**
Main Audit Total	54 (64)	72 (65)
Action Plan completed by dept/area & returned to IPC	29 returned (53% return rate)	35 returned (48% return rate)
Spot check Total	218 (181)	205 (277)
Pass	78 passed	117 passed
Fail	140 failed	88 failed

3.6.4 **Safety Thermometer Audit**

The main urinary catheter audits were undertaken as part of the monthly Safety Thermometer data collection and provide reassurance regarding documentation and standards of catheter care. Whilst this is no longer part of a CQUIN, IPCT validated the clinical CA-UTI data and feedback every month to WSHFT Harm free care team. Below are National CA-UTI results and a funnel graph comparing WSHFT to other NHS acute Trusts.


Catheters and UTI
Funnel plot for catheters with UTI
Harm per 1000
70
60
50
40
30
20
10
0
0
20k
40k
60k
80k
100k
120k
140k
160k
180k
Number of patients
WSHFT



Catheter Associated –Urinary Tract Infection
WSHFT 0.7% April 2019.
Acute 0.9% April 2019

3.6.5 Vascular Access Device Audit

Whilst the IPCT have previously performed bi-monthly vascular access device audits, during 2018/19 the frequency of these point prevalent audits ceased. This was discussed during team meetings, and was a consequence of 2 staff members retiring, delayed new starters and prolonged winter pressures. Whilst this was disappointing the plan for 2019/20, when the team is at full staffing compliment, will be to reinstate the vascular access audits and report directly to ICOG for learning opportunities to take forwards.

The IPCT were aware a drop in observing and auditing peripheral and long lines could have the potential to increase device related infections. Therefore the lead IPC nurse discussed the gap analysis at ICOG. Historically every clinical area completed several high impact intervention audits every month and reported these findings into ICOG. The results were exceptionally pleasing to read however the lead IPC nurse suggested a drop in the number of monthly high impact audits to allow a changing monthly audit theme. This change in process allowed clinical focus on a particular intervention and, whilst it reduced auditing for clinical staff, it had a desired refreshed feel and encouraged meaningful data that highlighted true learning opportunities to change practice. Bi-monthly, both peripheral and long lines were reviewed and concerns were rectified at the time of the observation and the results were fed back to ICOG.

3.6.6 **Commode Audit**

Each month a commode audit was undertaken by IPCT. This has expanded to include the assessment of all bedpans, shower chairs and raised toilets seats, as these were often found contaminated during spot check audits. These results are included in the IPC monthly report for ICOG and discussed at Sister Meetings. The commode audits were also reviewed at each *Clostridioides difficile* root cause analysis meeting throughout 2018/19.

Table 1 Monthly cleanliness audit of commodes, raised toilet seats, shower chairs and bed pans.

Clean √	**SRH**				**Worthing**			
Dirty X	**Commodes**	**RTS**	**S.Chairs**	**Bedpans**	**Commodes**	**RTS**	**S.Chairs**	**Bedpans**
April 18	76 √ 4 X	45 √ 3 X	37 √ 0 X	95 √ 1 X	73 √ 4 X	12 √ 0 X	42 √ 0 X	74 √ 0 X
May	57 √ 11 X	28 √ 3 X	27 √ 0 X	96 √ 1 X	84 √ 4 X	25 √ 0 X	47 √ 2 X	85 √ 0 X
June	70 √ 1 X	38 √ 2 X	42 √ 0 X	87 √ 0 X	78 √ 3 X	10 √ 1 X	41 √ 2 X	72 √ 5 X
July	74 √ 2 X	45 √ 6 X	34 √ 3 X	90 √ 0 X	71 √ 2 X	17 √ 0 X	31 √ 0 X	81 √ 1 X
August	69 √ 0 X	40 √ 0 X	39 √ 0 X	77 √ 0 X	95 √ 4 X	12 √ 0 X	23 √ 1 X	83 √ 0 X
September	71 √ 0 X	26 √ 0 X	43 √ 0 X	83 √ 0 X	80 √ 2 X	6 √ 0 X	23 √ 3 X	78 √ 1 X
October	75 √ 1 X	39 √ 0 X	40 √ 0 X	87 √ 0 X	67 √ 2 X	12 √ 0 X	24 √ 1 X	72 √ 0 X
November	63 √ 5 X	15 √ 3 X	20 √ 0 X	80 √ 0 X	66 √ 5 X	14 √ 2 X	23 √ 0 X	57 √ 0 X
December	70 √ 2 X	20 √ 0 X	31 √ 0 X	85 √ 0 X	63 √ 6 X	4 √ 0 X	25 √ 2 X	67 √ 0 X
January 19	63 √ 1 X	18 √ 0 X	19 √ 0 X	89 √ 1 X	25 √ 2 X	3 √ 1 X	8 √ 1 X	29 √ 1 X
February	34 √ 3 X	2 √ 0 X	nil	65 √ 2 X	35 √ 3 X	4 √ 1 X	10 √ 0 X	23 √ 0 X
March	62 √ 3 X	20 √ 4 X	21 √ 0 X	78 √ 0 X	62 √ 3 X	1 √ 1 X	14 √ 0 X	54 √ 0 X

Table 2 Monthly cleanliness annual scores 2018/19

SRH 2018/19	Clean	Dirty	
Commodes	784	33	95%
Raised toilet seats	330	21	94%
Shower chairs	350	3	99%
Bedpans	1018	5	99%
WG 2018/19			
Commodes	782	40	95%
Raised toilet seats	120	7	94%
Shower chairs	311	12	96%
Bedpans	777	8	98%

3.6.7 **Technical Cleaning Audits**

In addition to the routine cleaning schedule, ward side rooms and bays were deep "infectious cleaned". This was implemented when a patient who poses an Infectious risk has been moved from a bed space or discharged and prior to another patient being allocated that bed space. Infectious cleans are supplemented with vaporised hydrogen peroxide (VHP) (*Bioquell®*) for additional environmental disinfection as directed by IPCT. The annual deep clean programme was completed across both sites and this too involves the use of Bioquell VHP. Further Bioquell machines were purchased to support the deep clean programme delivery.

3.6.8 displays the technical audit overall scores from the weekly inspections made by facilities. Often these were completed as separate audits however on occasion they were in conjunction with the IPCT and performed alongside a planned spot check.

3.6.9 **Patient Led Assessment of the Care Environment (PLACE**)

Weekly PLACE assessments were undertaken across Worthing and SRH sites and monthly in Southlands. IPCT attended the PLACE visits in conjunction with Patient-representatives, Governors, Matrons and facilities team members. The PLACE team reviewed the clinical areas from a patient's viewpoint and assessed cleanliness within the general environment, privacy and dignity and food. A bi-monthly PLACE strategy meeting enabled the PLACE results, actions and recommendations to be reviewed. The strategy meeting was a structured meeting that discussed each concern raised at PLACE and what actions were implemented to rectify and resolve the problem.

3.6.10 **Appendix 5** displays monthly PLACE scores. Southlands has had some lower scores during the year and this is because the infrastructure and overall décor of the hospital. Throughout the year there have been several capital projects underway to modernise Southlands hospital and this should be reflected in the 2019/20 PLACE monthly score sheet.

The external annual PLACE inspection, that all health care providers adhere to, was held at Western Sussex on 8th, 9th, 10th and 11th May 2018. The results, whilst having a positive overall outcome, highlighted several concerns including condition of furniture in particular condition of chairs, lack of storage within clinical areas and the condition of some older floors. These were raised at the PLACE strategy meeting and recommendations put in place to overcome some of the concerns.

3.6.11 **Teaching**

The IPCT undertook several training sessions every week throughout the year. These included scheduled teaching (Health & Safety update, Paediatric, Midwifery, overseas), face to face opportunistic teaching, local department training (ward away days) and joining in staff huddles to discuss relevant IPC topics. On occasion the IPCT have had to cancel training sessions but this was only if there were no other options. This only occurred approximately 5 times and candidates were offered IPC e-learning module, information booklets and the opportunity to rebook to ensure they had up to date IPC refreshers.

The table below shows the Infection control training figures for 2018/19 taken from the monthly board report. Achieving above 91% for 12 consecutive months is down to the IPCT's dedication, commitment to imparting accurate and safe education and in true support of Getting It Right First Time. Learning and development have commended the training percentages and sent a message of thanks 'thank you and your team for all their hard work and effort in delivering all the training and achieving a really good percentage of staff trained over the last 12 months, another great job!'

Table 3 IPC teaching figures 2018/19

Apr-18	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-19	Feb	Mar	Apr-19
93.1%	92.8%	92.8%	91.2%	91.2%	90.8%	91.8%	91.9%	91.6%	92.5%	92.6%	92.4%	93.2%

3.7 SSI

Table 4 Surgical Site Infection (SSI) Rates for 18/19

Surgery	Total year 18/19 IP/Readm rate	National Benchmark	Total year 18/19 (incl.Superficial	National Benchmark
THR	**1.3%** (8/635)	0.4%	1.7% (11/635)	0.9 %
TKR	**0.4 %** (2/564)	0.4%	1.6 % (9/564)	1.3 %
Large Bowel SRH	**8.8%** (24/273)	8.6 %	9.2% (25/273)	11.1%
Large Bowel Worthing	**10.9 %** (24/220)	8.6 %	11.4 % (25/220)	11.1%
Breast SRH	**1.7%** (4/232)	0.7%	3% (7/232)	3.1%
Breast Worthing	**1.5 %** (8/545)	0.7%	2.6% (14/545)	3.1%

3.7.1

- The Surgical Site Infection Surveillance Team comprises:-
  0.4 WTE Band 8a
  1.0 WTE Band 7
  0.6 WTE Band 5

- Actions to reduce SSI rates are monitored through the Trust Infection Control Operational Group and Committee. The SSI Committee met twice in the year chaired by the Chief of Surgery
- In-patient and readmission rates are reported in line with the PHE.
- Post discharge surveillance is routinely undertaken by the SSISS nurses to ensure an accurate rate of infection
- All infections are discussed with the surgical teams involved and agreed before submitting the data to PHE
- Outlier letters have been received and responses sent with on-going actions detailed.

- All Operating theatres are re-validated annually to include microbiological air sampling. An annual IP&C audit is undertaken and spot-checks are completed monthly.
- The management of theatre scrub uniforms remains a challenge and is yet to be resolved.

3.7.2 **Orthopaedics**

- The OneTogether project was monitored through workshop meetings. The Standards agreed have been incorporated into the Chichester & Worthing Enhanced Recovery Pathway (CWERP) document.
- The standards are based on NICE Quality standard [QS49] October 2013 and include aspects of the patients pathway pre, peri and post-operatively including basic aspects of skin preparation , prophylactic antibiotic management, normothermia, asepsis, surgical environment and wound management
- The purchase of a continuous core temperature monitoring system has not been approved. All arthroplasty patients are actively warmed but temperatures are not consistently recorded peri-operatively.
- As inpatient/readmission post-operative infections are identified a SWARM process is initiated to ensure a full RCA is completed and that the MDT is involved. The SWARM meeting has often involved the patient.
- The RCA's have been presented to an executive led panel , but going forward they will be discussed at the Trauma & Orthopaedic Clinical Governance meetings for more appropriate peer review.
- Chilgrove ward remains as the ring-fenced ward for elective arthroplasty cases. During winter pressure months these beds were protected by transferring them to the Chichester Suite.
- OneTogether 'Small Changes' Award presented at the SSI Workshop in recognition of the actions taken to reduce SSI's
- Wound Clinic for arthroplasty cases is run by the Senior SSI Nurse. Post-operative patients who have wound concerns can contact the Nurse and if necessary be seen within the day. This has meant patients have been treated promptly and been able to access expert wound care. Patient feedback has been excellent.

3.7.3 **Colorectal**

- The use of pre-operative bowel preparation and oral neomycin for hemicolectomy cases is now standard across the Trust.

3.7.4 **Breast**

- This is a low participation category
- Review of each case at clinical governance meetings – learning focused on patient selection.
- Infection Prevention & Control Doctor and SSI Matron attended clinical governance to discuss use of prophylactic antibiotics and operating procedures
- Used the check list published in the EJSO to discuss at Clinical Governance – all recommendations are in place within Western Sussex
- Observations of practice in theatres.

3.8 Water Safety Group

3.8.1 The water safety group met monthly with a joint quarterly operational meeting with the appointed external Authorised Engineer attending. It is a multi-disciplinary, productive group which monitor, measure and action water within the Trust. All positive water sample results are discussed at the monthly meeting and estates discuss immediate actions and planned remedial work.
In addition the water safety group includes Worthing's Hydrotherapy pool and in 2017 a separate Hydrotherapy pool sub water safety group was initiated. This sub group generated a hydrotherapy pool policy and a separate pool procedure manual.

Both water safety group and hydrotherapy pool meetings are minuted with the addition of a comprehensive action plan that is revisited every month. For further WSHFT water information please see Facilities and Estates annual report.

3.8.2 The estates department, across 3 sites annually take;

1,154 water samples for Pseudomonas.

920 water samples for Legionella.

Pseudomonas testing is on pre-flushed water to comply with the mandatory and statutory HTM04-01 requirements. The standard requires all identified outlets to be tested every six months.

The Legionella water samples are pre and post-flush samples to comply with the mandatory and statutory HTM04 01 requirements. The standard requires all identified outlets to be tested every quarter following a trend of weekly / monthly testing. In this category only high risk areas are required to be tested.

This stated total number of water samples (2074) was not the entire total tested at WSHFT as this does not include samples that are repeated due to a positive count.

3.8.3 April 2019 Incident in Hydrotherapy pool - The hydrotherapy pool was found to have high levels of pseudomonas following regular pool sampling and reporting from the reference laboratory. The hydrotherapy pool was immediately closed to patients and staff whilst an investigation was carried out. A Datix was submitted (number 116474) and a root cause analysis performed by Deputy Director of Facilities and Estates. The investigation found the likely cause of the high pseudomonas readings were due to incorrect sampling as the water sample was taken from the plant room. Changes to sampling point (now the pool water directly in the pool) and backwash timings have been changed as a result. Following this the pool was reopened once water samples confirmed zero waterborne pathogens.
All patients, that had exposure to the high colony count, had their medical notes reviewed. This was to identify any high risk patients that may have used the hydrotherapy pool facility during or prior to the incident. None were identified as at high risk. The two outside groups who use the pool were notified.

3.9 Specialist Ventilation Group

3.9.1 The specialist ventilation group met monthly throughout 2018/19. It is a multi-disciplinary, productive group which monitor, measure and action air quality within the Trust. A theatre shut down plan, for all 3 sites, has ensured all theatre suites have been validated and returned to use with minimal disruption to hospital service. For further WSHFT specialist ventilation information please see Facilities and Estates annual report.

3.9.2 Estates service and re validate 26 operating theatres, 2 endoscopy suites, 2 Aseptic suites, 3 Cath Labs and 8 isolation rooms every year.

3.9.3 IPCT air test each theatre for microbiological air sampling post deep clean and have, due to the size of the IPCT, had to train a small number of theatre staff to complete the air testing. This ensures the theatre shutdown is not prolonged and service can resume as per plan. An air testing policy inclusive of a pictorial guide and competency assessments has supported the theatre staff with performing this activity. Two days post air testing the IPCT calculated the microbiological data and this was always over a weekend. The IPCT always complete this weekend work to ensure there is sufficient time for a further deep clean to be performed and retest if the air test fails. This process minimises disruption to surgical capacity.

3.9.4 A permit to work, attached to the theatre door upon shut down, was designed to ensure each department involved within the theatre shut down completed their role and responsibilities, prior to signing the document and handing it over to the next department. This process enabled a leaner, efficient way of working that reduced complications and delays with theatre air testing. However during 2018/19 the permit to work has not been completed succinctly and there have been several shut downs that have not followed a streamline process. This has been discussed at the ventilation operational group and the team are working together to try to ensure a smooth theatre shutdown process for 2019/20.

3.10 Antimicrobial Stewardship

3.10.1 Point prevalence survey data was taken in March 2018 to be compared to South Central England Area Network. Key findings:

- Lower % of patients on antibiotics vs other hospitals (28% vs 33%)
- Higher % of IV use vs oral use (58% vs 54%)
- Lower % missing stop/review date (14% vs 29%) (75% on drug chart vs 56%)
- Indication documented on the chart 68% vs 53%
- 94% considered to comply with AM formulary vs 88%
- Only 6.3% (vs 11%) not considered to have a 72 hour review. Decision;
    - Continue: 64% vs 73%
    - Change to oral: 22% vs 14.6%
    - Switch based on clinical picture: 7.3% vs 8%
    - Stop antibiotics: 6.7% vs 3.9%
- Higher % use of narrower spectrum use antibiotics (amoxicillin, gentamicin, metronidazole; around 3-4% higher each)

- Higher % use of co-amoxiclav (16.4% vs 13%), teicoplanin (7.2% vs 3%) & levofloxacin (3.8% vs 1%) although lower use of meropenem (0.8% vs 2.2%) and Tazocin (2.3% vs 7%)

3.10.2 Guideline updates – Antifungal treatment and prophylaxis guidelines developed and implemented within Microguide throughout 2018-19. Audits undertaken as per antifungal CQUIN and demonstrated good compliance to national and local guidelines.

Obstetric and paediatric guidance to be approved in Oct 2019 with plans to undertake Sexual Health update and prophylaxis update next – earlier than 2020/21 as planned.

3.10.3 CQUIN

Figure 3 2018/19 CQUIN results

Indicator		**Achievement**
Reduction in total antimicrobial consumption by 2% compared to 2016 data		End of year target not met: +8.7%
Maintenance of carbapenem compared to 2017/18 data (i.e. no increase)		End of year target met: -28%
Antibiotics from access group of WHO AWaRe categories – **Access** group > 55% of total antibiotics used (narrow-spectrum)		End of year target met: 60%
Ensure patients being treated for sepsis have a senior review of their antimicrobials between 24-72 hrs of therapy initiation.	Q1 – 25%	57%
	Q2 – 50%	95%
	Q3 – 75%	90%
	Q4 – 90%	92%

Figure 4 Plans for 19/20

Objective	**Progress**
Progression of OPAT	Tazocin polyfusors in successful trial at Worthing – 1 year review and audit completed to be presented at conference. To be shared cross-site. OPAT PMS database being trialled over 6 months by antimicrobial pharmacist and Antimicrobial Stewardship Lead Consultant.
Guideline updates	Update planned including paediatrics and obstetrics guidance. In contact with sexual health and obstetrics and to be presented to October 2019 MOC.
Audit programme	To be rolled out in August with the new intake of doctors. Created audit pack and working with clinicians to find best areas to audit.
Antifungal stewardship programme	Antifungal treatment and prophylaxis guidelines developed and implemented within Microguide, national consensus reached on prophylaxis patient groups so to implement this into our guidance.

3.10.4 Antibiotic consumption - Consumption indicators as above will be removed from the CQUIN and simplified. The total antibiotic indicator will feature in the NHS Standard Contract with a new baseline of 2018 calendar year. The target is a 1% reduction. This will remain a significant challenge for us as an organisation as antimicrobial use continues to increase year on year. This is tracked monthly to review progress.

3.11 Outbreaks/Incidents

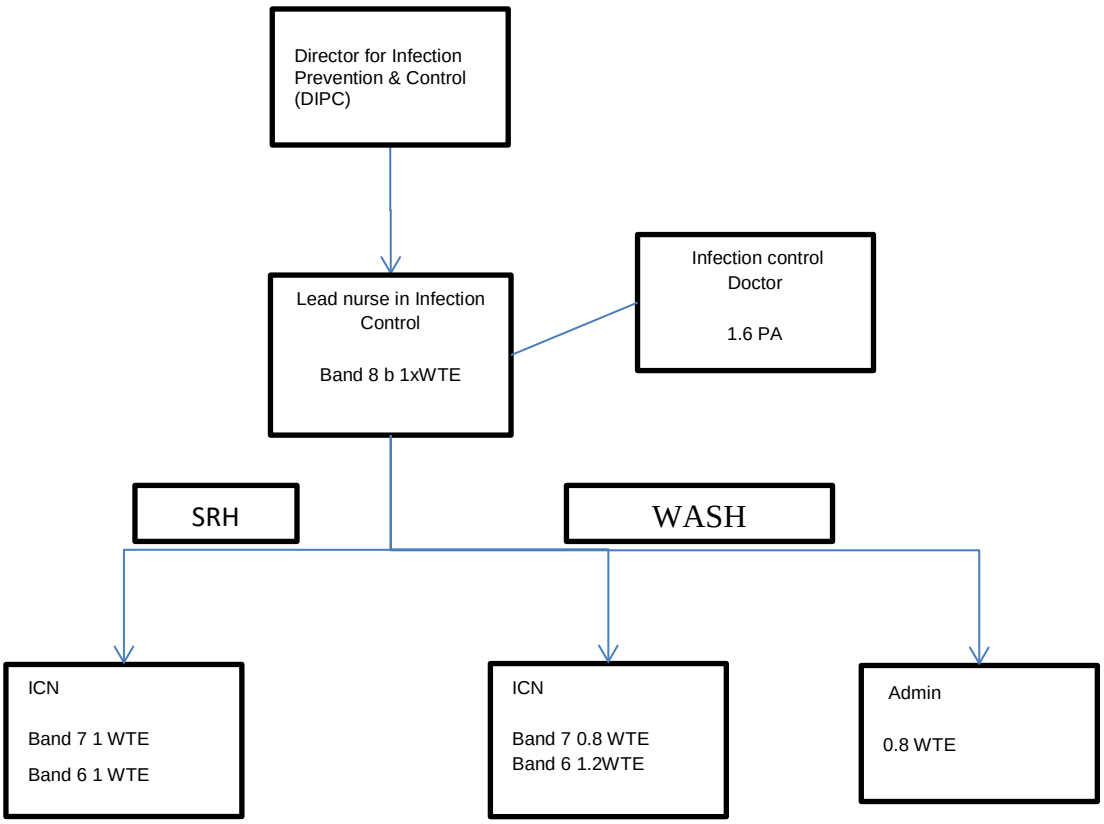
3.11.1 In May 2018 local community measles outbreak impacted the hospitals when undiagnosed patients came into contact with staff and other patients. All three patients with unsuspected Measles had been previously vaccinated and presented atypically. All three were >35 years old. Ninety-seven tracing letters were sent to potential contacts from which there was no confirmed onward transmission.

3.11.2 October/November 2018. Fishbourne ward, SRH closed for 12 days with confirmed Norovirus (15 staff members were also symptomatic). All infection prevention precautions were immediately implemented and transmission was controlled.

3.11.3 January 2019 - Two cases of Group A streptococcus in the same hospital in the same month. The first was a case of invasive Group A streptococcus with no known source in a patient with multiple co-morbidities who was also a member of staff. The second patient was admitted to the ward where the staff member usually worked but had not been working for the previous 19 days. The isolates were both sent for typing and came back as emm 89, which represents about 13% of the strains locally. Since there was no contact between the staff member and the patient and no other cases identified this was not declared an outbreak. Public Health England were involved in the investigation.

3.11.4 February 2019 – Following advice from Public Health England a look back exercise was undertaken following diagnosis of smear-negative TB in a patient with minimal cough. 26 patients and a number of staff were followed-up by the TB team and Team Prevent . The patient was deemed very low infectious risk due to be smear-negative and having minimal cough and no positive contacts were identified.

Appendix 1 The IPCT structure



Appendix 2 TERMS OF REFERENCE TRUST INFECTION CONTROL COMMITTEE (TICC)

Membership

Director of Nursing / DIPC (Chair)
Medical Director
Infection Control Doctor / Consultant Microbiologist
Lead Nurse Infection Control
Infection Control Team
Antimicrobial Pharmacist
Decontamination Lead
Heads of Nursing - Medicine
Heads of Nursing - Surgery
Head of Women & Children
Consultant in Communicable Disease Control
Occupational Health Manager
CCG Infection Control Lead Nurse
SCT Nurse Representative
Associate Director of Facilities
Associate Director of Estates
Medical representation from each Division
Core Services Lead
Nominated Non-Executive Director

The group will be chaired by the Director of Infection Prevention and Control. Other members of staff may be invited if appropriate.

2. In attendance

2.1 Other members of Trust staff, including other Executive Directors, may be invited to attend to present and/or discuss particular items on the Agenda. The Trust Chair (if not the nominated Chair or member of the Committee) and Chief Executive have the right to attend any meeting of the Committee as desired.

3. Purpose

3.1 To provide strategic direction to the Trust's management of infection prevention and control activity.

3.2 To ensure that the system of Health Care Associated Infection (HCAI) management is via a detailed framework to ensure the Board meets its obligations with regard to patient safety and clinical governance. It is also to ensure that best practice is followed as identified in the Hygiene Code and Care Quality Commission underpinning national and local guidance.

4. Duties

To ensure the purpose is met, the group is responsible for the following:

4.1. To agree the annual Infection Control programme, review the progress of the programme and assist in its effective implementation. Regular reports will be received on:

- Outbreaks of infection in any part of the Trust's premises
- Surgical wound site surveillance modules
- Audit results as part of national or local surveillance
- Relevant external and national reports

4.2 To advise on the most effective use of resources available for implementation of the programme.

4.3 To implement, audit and review policies on all aspects of infection prevention and control.

4.4 To monitor compliance with action plans and infection control standards as specified by the Department of Health and/or external bodies.

4.5 To draw the attention of the Chief Executive and Director of Infection Prevention and Control (DIPC) to any serious problems or potential hazards relating to infection control and patient safety.

4.6 To provide support, guidance and advice to the Infection Prevention and Control Team (IPCT).

4.7 To inform itself on HCAI trends, improvements and areas of concern.

4.8 To provide a core of personnel to form an Outbreak Control Team (OCT) when directed by the Infection Control Doctor, (ICD) or DIPC.

4.9 To ensure effective implementation of a plan for the management of outbreaks in the hospital and monitor its implementation.

4.10 To exchange minutes and information from the PHE and the CCG, ensuring that appropriate action is undertaken.

4.11 To ensure that risk assessments are undertaken with regard to the infection control team.

4.12 To promote and facilitate the education of all Trust staff in infection control practice and procedures.

4.13 To receive and agree an annual report and infection prevention and control programme, including plans for surveillance. This should be submitted for acknowledgement to the Trust Board.

4.14 To encourage communication among the different disciplines involved to share difficulties, successes and ideas in the management of infection prevention and control.

4.15 To receive and act upon reports from the Antimicrobial Stewardship Group

5. Quorum

5.1 The Quorum will consist of 10 members, of whom at least 4 must be the following (or their nominated representatives):

Director of Infection Prevention and Control
Infection Control Doctor
Senior Nurse, Infection Control
Representative of each Division (Medicine, Surgery, Women & Children, Corporate)
Facilities & Estates

A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

6. Frequency of meetings

6.1 The group will meet quarterly. The formal meetings will meet the above objectives.

7. Minutes and Reporting

7.1 Agendas and briefing papers should be prepared and circulated in sufficient time for Committee Members to give them due consideration.

Distribution of minutes: Clinical Governance Committee, Trust Board, Integrated Governance Committee, Drugs & Therapeutics Committee, Patient Safety Committee.

7.2 Minutes of Committee meetings should be formally recorded and distributed to Committee Members within 1 month of the meetings. Subject to the approval of the Chair, the Minutes will be submitted to the Trust Board at its next meeting and may be presented by the Committee Chair.

7.3 An annual report from the Committee to the Trust Board will be produced to demonstrate the Committee's discharge of its duties. This report will be presented to the Trust Board within the first quarter of the financial year.

7.4 The Committee will report directly to the Trust Board.

8. Conduct of Business

8.1 The conduct of business will conform to guidance set out in the Trust Board Standing Orders, unless alternative arrangements are defined in these Terms of Reference.

Author: DIPC

Date approved …… Signed ……..…….
Director of Infection Prevention & Control

Date for review ……..

Appendix 3 *Clostridioides difficile* Trust action plan

Version 5 - 31.03.19					
				KEY	
Reducing Trust Rates of *C. difficile*. Trust Limit for 2018/19 is 38			**Closed**	Task Closed	
			Complete	Task Complete, and evidence received	
Meeting 26.04.18- attendees Dr Susie Jerwood, Sharon Reed, Anna Cottle, Gill Sorrell, Julie Thomas, Pauline Cheeseman.			**GREEN**	Task on Track to achieve Target Finish Date	
			AMBER	Task slipping, measures in place to achieve Forecast Finish Date	
			RED	Task not on track	
Issue	**Action**	**Lead**	**RAG status**	**Summary/Update on Progress**	**Target due date**
2017/18 *Clostridioides difficile* rates came in under Trajectory with 35 Trust cases against a limit of 39. 20 of these cases were judged to be a lapse in care when reviewed against the *C.difficile* High Impact Interventions	*C. difficile* 'Workshop' to review cases and lapses.	Sharon Reed	Complete	Workshop held 26.04.18. Attendees above Focus on *C.*diff RCA review outcomes and lapses for 2017/18. 35 cases against a trajectory of 39 . 21 cases in Worthing and 14 in SRH 20 Lapses in Total for 2017/18	Complete
Dirty Commodes (3 lapses Worthing, 1 lapse SRH)					
Ensuring commodes are checked for cleanliness	3x day spot checks to continue Include raised toilet seats	Matrons	**RED**	17.04.18 Trust audit undertaken by ICN's. 3 surgical wards not completing/1 ward completing but not documenting at SRH. 4 medical wards, 1 surgical and 1 maternity ward not completing at Worthing. 31.03.19 3 times a day checking is sporadic and documentation of safety checks have slipped.	Ongoing

	Daily allocation of Commode & raised toilet seat 'auditor'	Ward Sisters	**AMBER**	24.05.18 To be discussed at Sister meetings, huddles	Ongoing
Training	Training of temporary and agency staff Producing a book with general Trust information to include IP&C and Commode cleaning	IPC Lead to discuss with Ashlee Metcalf	**AMBER**	02.07.18 Ashlee Metcalfe setting up an information/competency booklet working party - awaiting date.	01/07/18
	Commode cleaning Posters- ensure in all sluice rooms	IPCT, matrons	Complete		Complete
	New staff - ensure all are signed off re commode cleaning competency	Matrons and Ward Sisters	Complete		Ongoing
	Revisit commode video	ICT , Practice developm ent	Complete	24.05.18 Commode video to stay on intranet for easy access to all.	Complete
Sample Sending/Diarrhoea Management					
Documentation	Ensure that Patient track documentation of previous samples can be seen . To assist with 3 type 5's in 24 hours	Sharon Reed , Caroline Gilfrin, Patient track team	**AMBER**	27.09.18 Patient track reprioritised their work load and this has been pushed back. No update available	01.08.18

	Sema C.D.I. alert to transfer across to Patient track to create a CDI Flag on the ward page.	Sharon Reed , Caroline Gilfrin, Patient track team	**RED**	02.07.18 Awaiting final P/T test	01.08.19
	Amend CDI RCA tool to include specimen sending and add in changes to allocation of lapse/amend HII.	Sharon Reed	Complete	01.06.18 RCA tool amended. To be trialled at RCA workshop 07.06.18. 02.07.18 RCA tool worked well, will use going forwards.	Complete
	Nurse in charge of patient to countersign diarrhoea samples prior to sending to lab	Matrons/ IPCT/Sister	**RED**	27.09.18 To discuss again at Sister meetings to encourage counter signature	01.09.18
Training	Investigate ways of informing medical staff to seek advice before requesting repeat faecal samples for previous CDI & previous *C.difficile* equivocal patients i.e. a medical newsletter on Infection control/micro information.	Medical Director Tim Taylor/Susie Jerwood	**AMBER**	27.09.18 Susie and Sharon to attend Chiefs meeting October to discuss management of *C.*diff/specimen sending	13.10.18

Laxative guidelines	Review Trust laxative guidelines	Fikile Moyo/Dr Yeo/Sharon Reed	Complete	04.06.18 Guidelines presented at medicines optimisations committee in May 2018 - await response. 27.09.18 Asked for an update on guidelines. 01.11.18 Updated and on intranet.	Complete
Delay in isolation (5 lapses Worthing, 4 lapses SRH)					
Patients with diarrhoea should be isolated within 4 hours, however patients should ideally stay within the specialist wards	Wards to escalate cases of diarrhoea to IPCT and Site team	Matrons	Complete	Generally happening but to be reinforced	Ongoing
	Datix all cases of diarrhoea where isolation cannot be achieved within 4 hours. Investigating manager Matron/Sister	Wards, Matrons	**AMBER**	24.05.18 Balcombe ward complete Datix however no other wards complete this yet. 31.03.19 Castle & Balcombe now completing Datix forms for delay in isolation.	01.09.18
Training	Add scenario's regarding management of diarrhoea into training sessions	IPCT	Complete	04.06.18 IPCT meeting to discuss teaching presentations. 24.05.18 Caroline/Anna work in progress. 02.07.18 Diarrhoea scenarios discussed at teaching sessions.	Complete

Site team representation required at *C.difficile* RCA Review meeting. During 2017/2018 site team attended 36% of CDI washups at SRH and 24% at Worthing.	Site team invited to CDI RCA review meetings	Rien Moore	Complete	02.07.18 RCA meeting at Worthing changed to 16.15 and site team have been able to accommodate this on some occasions. Better attendance from site team across site.	Ongoing
	CDI RCA review times to be changed to Monday 09.00 at SRH and Thursday 16.15 at Worthing to allow site team to attend.	Sharon Reed/IPC Team	Complete		Compete
Environment (8 lapses Worthing, 8 lapses SRH)					
Ward environment generally clean with high % technical audits. IC environmental audits and spot checks throughout 17/18 have been variable. Deep cleaning programme (including bioquell) achieved for Worthing and SRH with the exception of ITU on both sites.	Monthly spotcheck audits to include Matron/IPC/Facilities. A robust timetable is required to ensure all clinical areas are inspected every month.	Facilities / Anne Sillence	**AMBER**		01.08.18
	Deep clean programme to include Bioquell for all wards	Matrons, Facilities, IPCT	**Complete**	24.05.18 Deep clean programme sent out for SRH but this needs minor alterations and resending. 02.07.18 Deep clean & Bioquell programme running well on both sites. Weekly meetings with estates/facilities/Matrons and IPC. 27.09.18 Deep clean programme well underway on both sites.	Complete

	Facility capacity/workforce support required to sustain cleaning standards for 7 day working week	Susanne Fisher, Dave Harbutt, Gill Sorrell	**AMBER**		Ongoing
Antimicrobial prescribing (4 lapses Worthing , 5 lapse SRH)					
Medical representation required at *C.difficile* meetings. During 2017/2018 medical representation at CDI washup meetings consisted of 43% of CDI washups at SRH and 29% at Worthing.	Medical team invited to attend RCA review meetings	Medical Director/Tim Taylor	**RED**	02.07.18 Invite SHO or Reg if Consultant unable to attend. 27.09.18 Remains poor attendance by medical staff.	01.09.18
Daily review of antibiotics	Add antimicrobial prescribing section to the daily ward round sheet	Jo Munns/David Hilbert	**RED**	To be explored	01.09.18
Indication & duration not recorded on prescription	Encourage nurses to discuss antibiotic prescriptions with medical teams Include in medicine Safety Days for Nurses Update EPMA system so that Indication and duration field is mandatory.	Matrons, Ward Sisters, David Hilbert & Jo Munns	**Complete**	17.05.18 Jo/David both highlight on the medicine safety days to the nurses, to encourage challenging antibiotic prescriptions and encourage the drs to document so indication and stop dates are clear for all staff. 27.09.18 Staff ask if IV antibiotics are required prior to IV device change/insertion.	Ongoing

Co-amoxiclav prescribed in 21/35 *C.*diff cases (7 off these were lapses)	Update antimicrobial formulary	Jo Munns, David Hilbert/AMS group	**Complete**	July 2018 - updated	Complete
PPE / Hand Hygiene (1 lapse Worthing, 3 Lapses SRH)					
Focus on basic Infection Control	Theme of the week to raise IC policy on Bare below the elbow, Jewellery, Lanyards, Hair (tying up) Mobile phone use and bags.	Sharon Reed	**Complete**	02.07.18 Theme of the Week booked for 14.08.18	Complete
	Support with challenging Medical staff who do not comply with Uniform policy and Infection Control Policies	Medical Director/Tim Taylor	**Complete**	27.09.18 Susie and Sharon to attend Chiefs meeting October to discuss management of *C.*diff/specimen sending	Complete
Unnecessary glove wearing	Combine Hand Hygiene audits with Glove wearing audit	Sharon Reed	**Complete**	24.05.18 Glove audit tool available, ICOG changing way of monthly audits. 02.07.18 Multi-disciplinary meeting set for 17.07.18 to discuss incorporating glove wearing and HII audits. 17.07.18 Matron/IPC meeting. Gloves and Hand hygiene audit to be completed every month. Rotation of IV lines, Catheter care, MRSA decol audits (1 per month). 01.10.18 Launch of new PPE/Hand hygiene audit tools.	Complete
Preparedness for CDI changes in 2019-20.					

NHSI National guidance will be reducing the number of days to identify hospital onset healthcare associated cases from ≥3 to ≥2 days following admission from 2019/20 reporting.	Identify from 2018/19 CDI data how this future change will effect WSHFT CDI numbers	Sharon Reed	**Complete**	24.05.18 Data collecting and reporting into ICOG monthly	Complete
	Begin to inform and roll out this information at medical and surgical Sister meetings to allow for the information to be embedded prior to execution.	IPCT	**Complete**		Complete
Medical/Nursing/Facilities/IPCT learning opportunities					
Medical staff need to use the CDI RCA learning to ensure antibiotic, PPI and sampling actions are embedded to prevent reoccurrence	Feedback learning opportunities to medical/surgical clinical governance meetings	Medical Director Tim Taylor	**Complete**	27.09.18 Susie and Sharon to attend Chiefs meeting October to discuss management of *C.*diff/specimen sending	Complete
CDI washup - identification of Chairperson for each Trust acquired CDI.	IPC Secretary to liaise with Exec team PA's to ensure a Chair is available at every CDI washup meeting	Sharon Reed/IPC Team Secretary	**Complete**	31.05.18 Sharon has discussed this with IPC secretary and the PA's will be emailed to ask whom can chair the meeting. 02.07.18 Remains challenging to identify the chair at CDI RCA meetings. 20.07.18 Exec PA's send email of Chair availability.	Ongoing

CDI washup meeting organisation needs a streamline process across both sites.	IPC secretary will be the link for the washup meetings on both sites. She will send out meeting invitations and send RCA templates to the appropriate ward/dept.	Sharon Reed/IPC Team Secretary	**Complete**	31.05.18 Sharon has discussed this with IPC secretary the Washup meeting organisation and communication will be completed by IPC secretary going forwards.	Complete

Appendix 4 Technical cleaning scores for all three Western Sussex hospital sites

St Richards Technical Cleaning Scores - Year 2018-19											
Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
94%	0%	92%	92%	0%	90%	94%	0%	0%	0%	0%	0%
0%	87%	96%	87%	0%	86%	90%	0%	0%	0%	0%	75%

Worthing Technical Cleaning Scores - Year 2018-19												
Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-18
98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
97%	98%	96%	97%	96%	96%	97%	92%	95%	96%	96%	96%	97%
93%	95%	90%	91%	0%	93%	85%	85%	89%	86%	93%	87%	93%
92%	96%	0%	85%	75%	0%	0%	75%	86%	0%	75%	85%	92%

Southlands Technical Cleaning Scores - Year 2018-19											
Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
98%	98%	99%	98%	98%	98%	98%	98%	98%	98%	98%	97%
98%	99%	98%	98%	98%	100%	98%	100%	98%	99%	98%	99%
0%	94%	0%	0%	0%	93%	0%	0%	93%	0%	0%	95%
83%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Appendix 5 PLACE audit compliance for all three Western Sussex hospital sites

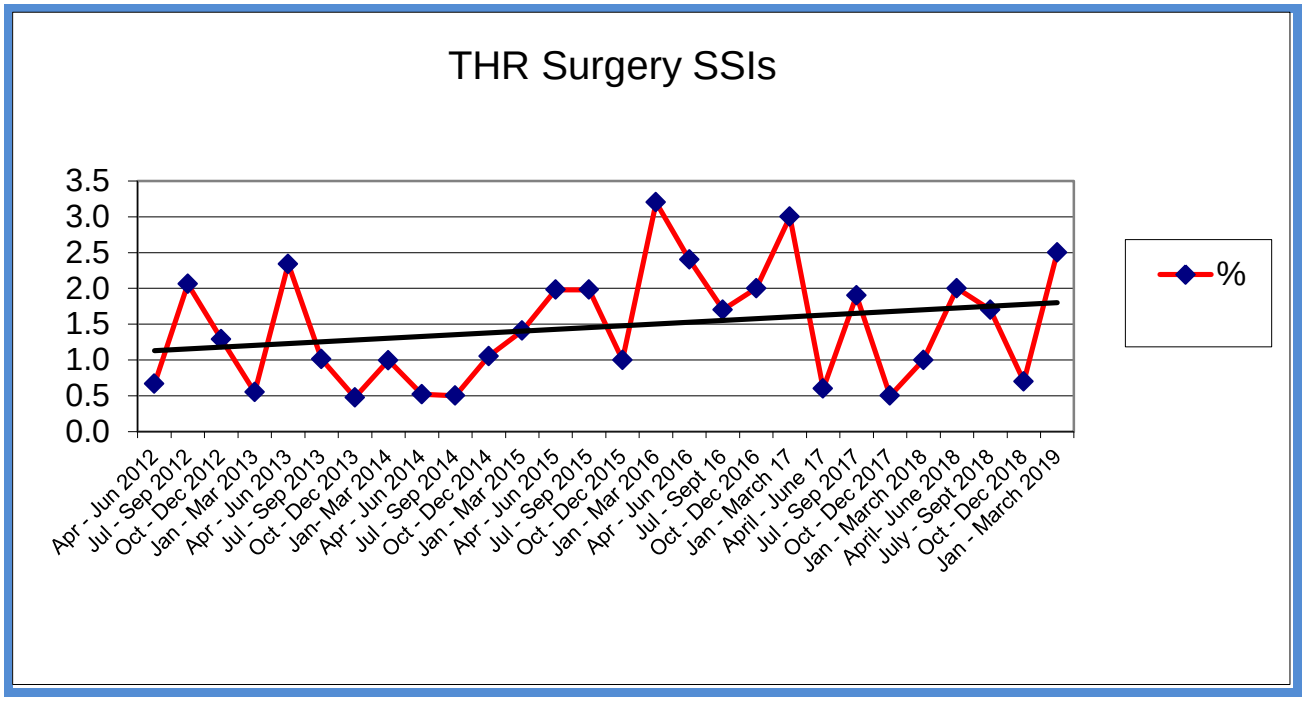
St. Richards Internal PLACE Audit Compliance -Year 2018-19											
Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
97%	97%	96%	96%	97%	95%	97%	95%	89%	96%	94%	97%

Worthing Internal PLACE Audit Compliance - Year 2018-19											
Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
98%	98%	98%	97%	97%	95%	96%	97%	99%	97%	91%	99%

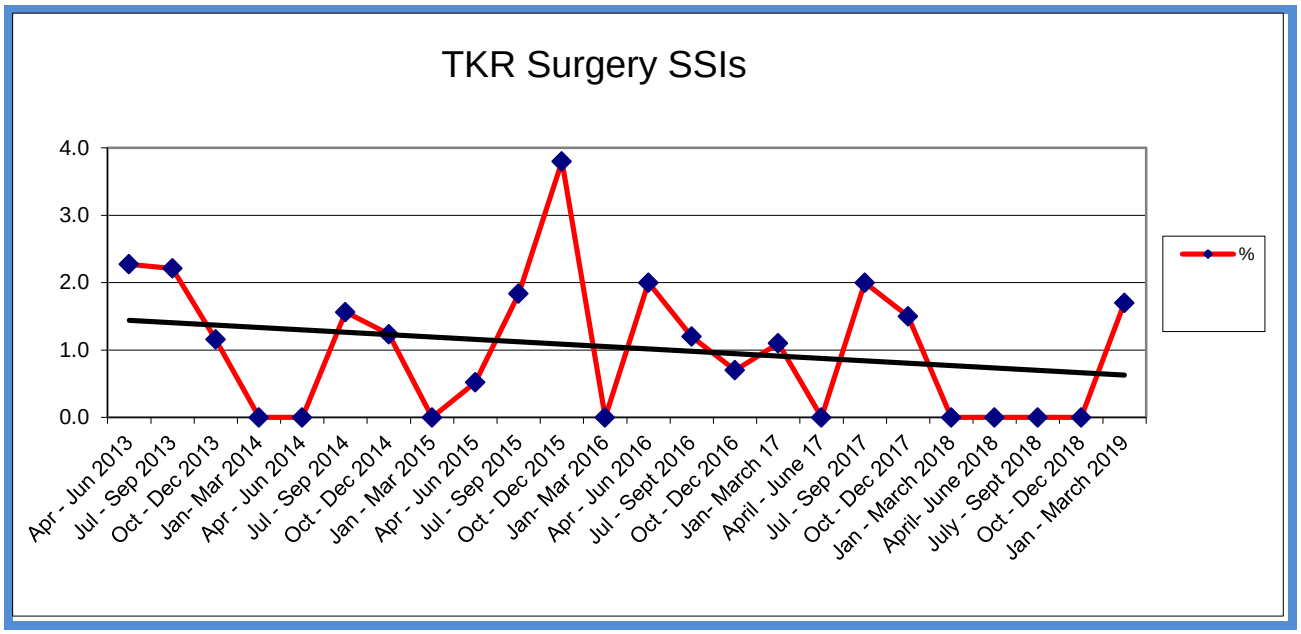
Southlands Internal PLACE Audit Compliance - Year 2018-19											
Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
96%	99%	50%	98%	92%	Rescheduled	94%	91%	91%	89%	79%	97%

Appendix 6 Surgical Site Infection Graphs.

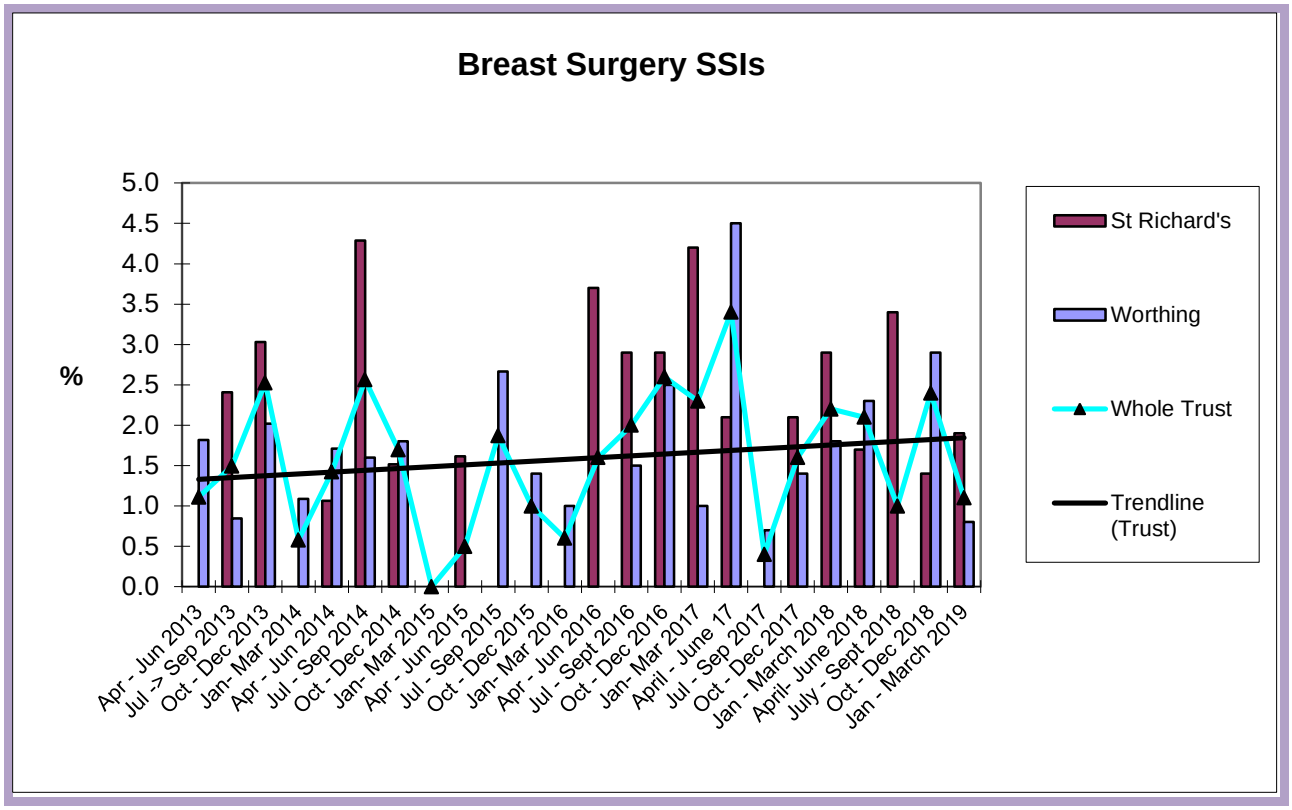
Total Hip Surgery



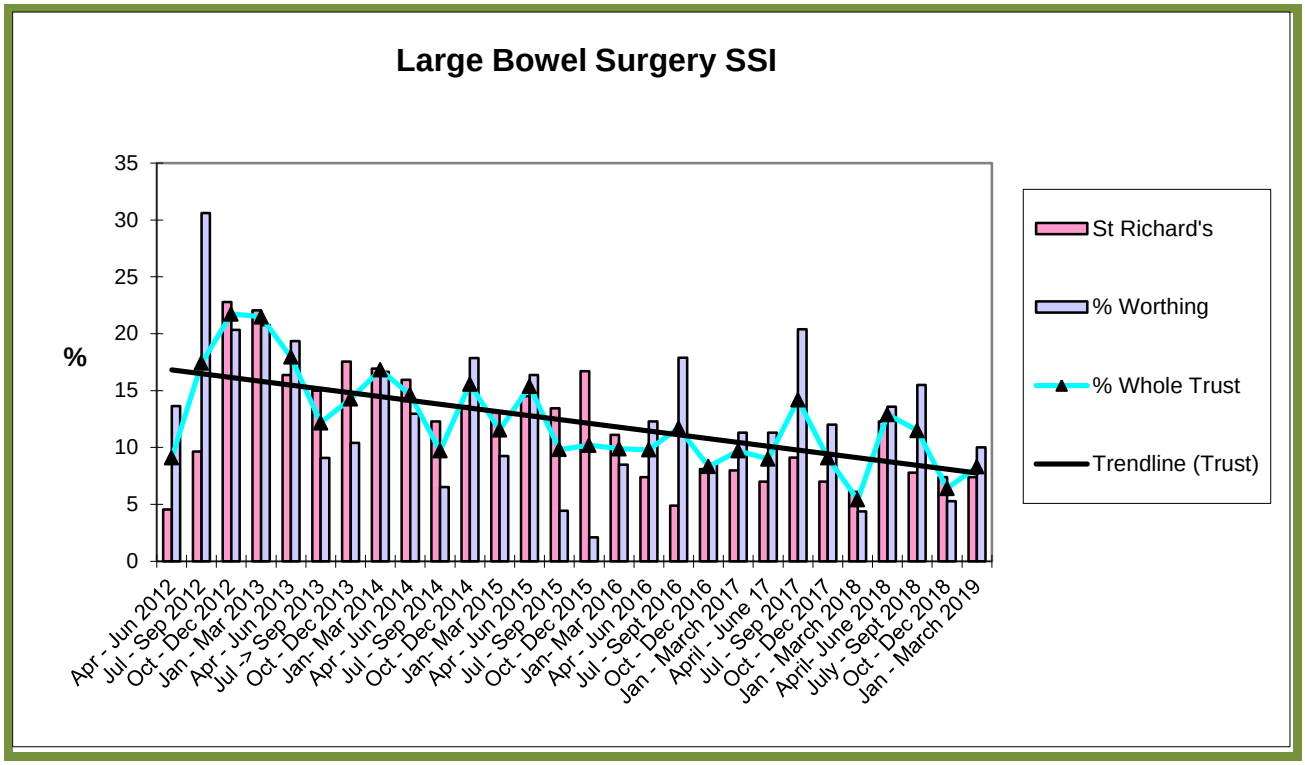
Total Knee Surgery



Breast Surgery



Large Bowel Surgery



Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	18	**Meeting:**	Board	**Meeting Date:**	26 Sept 2019
Report Title:	**Company Secretary Report**				
Sponsoring Executive Director:			Glen Palethorpe, Group Company Secretary		
Author(s):			Glen Palethorpe, Group Company Secretary		
Report previously considered by and date:			Health and Safety Committee		
Purpose of the report:					
Information		☐	Assurance		✓
Review and Discussion		☐	Approval / Agreement		☐
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability		✓
Our People		✓	Quality		✓
Systems and Partnerships		✓			
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe		✓	Effective		✓
Caring		✓	Responsive		✓
Well-led		✓	Use of Resources		✓
Communication and Consultation:					

Executive Summary:

This report provides the Board with a report on matters for which the Trust has complied with a NHS I or other regularly requirements. This report does not seek to duplicate matters that are subject to separate agenda items at today's board meeting.

2018/19 Health and Safety Annual report (attached at appendix 1)

The Trust produces an Annual report on the Trust's compliance with its Health and Safety requirements. The detailed oversight of this work is delivered via the Health and Safety Committee.

The overall conclusion for 2018/19 as supported by the Health and Safety Committee is

> *The Trust has been compliant with its H&S requirements, there were no HSE reactive or planned inspections and the Trust has had no HSE performance actions taken against it.*

Key Recommendation(s):

The Board is recommended to

NOTE the Trust's Health and Safety annual report.

Western Sussex Hospitals
NHS Foundation Trust

Health and Safety Annual Summary Report 2018-19

1. Introduction

1.1 The Health Safety and Risk Annual Report summarises the position and progress made against the Trust Health Safety and Risk Policy, Statement of Intent and the implementation of the Health Safety and Risk Policies and Procedures used by the Trust to minimise the risk and keep Patients, Staff and Visitors safe.

1.2 The Health & Safety Policy Statement and Board Approved Statement of Intent require those responsible for Health and Safety within the Trust premises and for Trust activities to:

- Comply with Health and Safety legislation;
- Implement Health and Safety arrangements through a risk-managed approach;
- Comply with monitoring and reporting mechanisms appropriate to internal and external key stakeholders and statutory bodies; and
- Develop partnership working and consultation throughout the Trust to ensure Health and Safety arrangements are maintained within the Trust environment for staff, contractors, visitors and patients.

1.3 The Trust monitors risk, Health and Safety arrangements via the Trust Health and Safety Committee which meet Quarterly, and via the Quality and Risk Committee, from the 1 April 2018 renamed the Quality Assurance Committee, and the Trust Executive Committee (TEC).

1.4 The Health and Safety Committee also receives reports from several other Committees, Steering Groups and/or key pieces of work in relation to Health and Safety, or that cover a main concern, which requires a specific task to enable it to be managed safely.

In 2018/19 these where:

- Radiation Committee
- Security
- Fire Safety;
- Estates and Facilities
- Occupational Health
- Staff Welfare
- Manual handling (Back care Advisor)
- Staff Side Union
- Risk Manager

- Learning & Development (Training)

2. Conclusions

2.1 The Trust has been compliant with its H&S requirements, there were no HSE reactive or planned inspections and the Trust has had no HSE performance actions taken against it.

2.2 The risk team has supported the Trust to remain compliant over the year. The team has built an electronic risk environment around the Safety Health & Environment software system (SHE) that allows the bundling of assessments, inspections and audits to provide a rich source of data to tackle emerging issues before they become a significant compliance risk.

2.3 The SHE system presents each Manager or Director with a one page snapshot of their areas assessments. All managers have complete access to all Trust assessments but can set the dashboard for their individual areas. They are informed automatically when any assessment is due for review, action or approval. Senior Managers/Directors are informed automatically when an assessment scoring 12 plus is placed or altered on the system.

3 Summary

3.1 Below is a summary of the delivery of H&S activity for 2018/19

Area	Position at Q4 2019
Risk assessment in place and monitored	The risk assessments for Health & Safety are in place and monitored by the SHE system. Improvements can be made by managers to ensure the assessments are reviewed in a timely manner. Just 4.6% of assessments exceeded their reviews dates.
Action to reduce risk across the Trust	The Health & Safety Committee have reduced the number of risks running at 12 from 21 to 12 in the last year. 19/20 should see a further reduction into single figures.
Risk Management and trend reaction	Datix the Trust's risk management system is updated with information derived from the SHE health and safety assessments and actions taken to reduce risks.
Staff Training	Currently achieving the target of 95%
Policy	The current policy has been reviewed, updated as appropriate. The review of the policy took longer than anticipated and was concluded in August 2019, a few months after the planed review period.
Compliance	The objectives indicate a high level of compliance with only 4.6% of reviews exceeded their review date. A business case has been developed to secure extra support to enhance this rate further.
Alert Response	The risk team complete all relevant alert actions in a

Area	Position at Q4 2019
	timely manner and report this to the Patient Safety Team who monitor Trust compliance (the Trust has been compliant with alerts)
Good practice	The risk team promote good safety practice and have updated the Health Safety and Risk Handbook this year to cater for staff and management as well as contributing to Huddle Headlines.
External Assessment	The Trust has not had any HSE inspections in 2018/19.

3.2 The table below provides an update against the 9 specific objectives set for the H&S Committee.

Objectives	Position 18/19
No 1. The Trust identifies and assesses Health and Safety risks across the organisation using standard processes to ensure compliance with the Trust's legal and statutory responsibilities.	All managers and staff are trained in risk and are expected to Identify and assess hazards in their area. All H&S risk are recorded on the SHE software package and made available to all staff via the SHE Portal, staff-net and QR codes. Currently data held on SHE identifies all areas of the Trust and tracks the completion of assessments. Some areas do not require assessments and an audit will be completed to assure this judgement is valid.
No 2. The Trust takes action to improve Health and Safety through the managing of risks and incidents in accordance with Trust policy in order to produce demonstrable improvements in Health and Safety compliance and a reduction in Health and Safety related incidents.	The Trust manages H&S risk via the SHE system in which constant efforts are made to review assessments in order to find safer ways of completing the task in a safer fashion. Limiting or mechanising manual handling as new techniques or equipment become available. Reducing the risk posed by agents by using safer options or reducing the number of agents to the lowest level. Injuries from dirty sharps were the most frequent injury in 18/19. Action was taken to raise awareness through the internal Huddle Headlines publication and through safety huddles of the different types of sharps injury and how to manage the risk with a view to reducing the 19/20 numbers, numbers have reduced following the awareness of

Objectives	Position 18/19
	safer sharps practices. The Trust's analysis of RIDDOR reports highlighted an area of increased incidents within maternity relating to the operation of the new Birthing bed. The Trust's Manual Handling team and the suppliers developed a user training package with training delivered to all maternity staff and all new midwifes. Following this training there have been no further accidents following these actions.
No 3. The Trust maintains an accurate record/register of Health and Safety risks and incidents in order to enable the effective management of Health and Safety risks and the identification of trends	Datix the Trust's risk management system is updated with information derived from the SHE health and safety assessments and actions taken to reduce risks. Risks Scoring 12 plus are transferred onto the Datix system for inclusion in the risk register.
No 4. The Trust trains all staff to operate in accordance with the Trust's Health and Safety policy and procedures to allow staff to maintain their own Health and Safety, as well as that of fellow staff, patients, visitors and others using Trust services or entering/working on Trust premises	Training has been delivered across the year through the following events • Induction • Health & Safety Update (STAM training) • e-learning • Volunteers training • Student nurses training days • Maternity Safety Training For the year H&S training performance met the Trust's target of 95.0%
No 5. The Trust ensures its Health and Safety policies and procedures are up to date in order to support the Trust to	The H&S Policy has been reviewed and reflects changes overseen by the H&S Committee. The Policy was approved at TEC in August 2019.Individual polices attached to the main policy will be reviewed on a quarterly cycle. Q1 19/20 saw

Objectives	Position 18/19
comply with its legal and statutory duties in relation to Health and Safety	the Policy for the Management of Safety Audit reviewed by the Health & Safety Committee.
No 6. The Trust is able to monitor and report on its Health and Safety compliance in order to support the identification of risks and issues and provide internal and external assurance	The H&S Committee received updates during the year and received a detailed report at its meeting in July which supports the 2018/19 Annual Report presented to Board.
No 7. The Trust is able to respond to alerts issued through the Central Alerting System in a timely and appropriate way in order to ensure learning and risks identified across the NHS and more widely inform the Trust's Health and Safety practice and actions	The risk team complete all relevant alert actions in a timely manner and report this to the Patient Safety Team who monitor Trust compliance (the Trust has been compliant with alerts)
No 8. The Trust actively promotes good Health and Safety practice and awareness to all staff, patients, contractors and others using Trust services or entering/working on Trust premises in order to maintain and improve compliance with Health and Safety Standards.	The Trust utilises Staff-net and the SHE Portal to facilitate staff access to assessments surveys and audits. Contractors and supplied with a safety handbook. The safety team have produced a staff safety handbook and are working on an improved Manager guide to risk.
No 9. The Trust is able to manage and respond	The Trust has no scheduled or reactive inspections from the Health & Safety Executive in 2018/19

Objectives	Position 18/19
to the requirements of external assessments and regulatory/compliance inspections in order to ensure an accurate and comprehensive picture of Trust practice is presented.	