Western Sussex Hospitals
NHS Foundation Trust

Meeting of the Board of Directors

13.15 to 15.55 on Thursday 1st March 2018

John Bull Room, WHEC, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH

AGENDA – MEETING IN COMMITTEE

1.	13.15	**Welcome and Apologies for Absence**		Chair
2.	13.15	**Declarations of Interests**		All
3.	13.15	**Minutes of Board Meeting held on 1 February 2018** To approve	Enclosure	Chair
4.	13.20	**Matters Arising from the Minutes** To note	Enclosure	Chair
		PATIENT SAFETY/EXPERIENCE ITEMS		
5.	13.25	**Patient First Metrics** To note	Enclosure	All
		5.1 Quality Report	Enclosure	GF/NR
		5.2 Performance Report	Enclosure	JF
		5.3 Organisational Development and Workforce	Enclosure	DF
		5.4 Financial Performance To receive and agree any necessary actions	Enclosure	KG
6.	14.05	**Serious Incidents Requiring Investigation Report** To receive and agree any necessary actions	Enclosure	NR
7.	14.15	**British Orthopaedic Association Visit Feedback** To receive and agree any necessary actions	Enclosure	GF
		OPERATIONAL ITEMS		
8.	14.25	**Gender Pay Gap Review** To receive and agree any necessary actions	Enclosure	DF
9.	14.35	**Domestic Services Review** To receive and agree any necessary actions	Enclosure	KG/DJ
10.	14.45	**Public and Visitor Car Parking Review** To receive and agree any necessary actions	Enclosure	KG/DJ
		OTHER ITEMS		
11.	14.55	**Board Self-Assessment** To receive and agree any necessary actions	Enclosure	MV

12.	15.05	**Reports from Other Meetings:** ▪ **Charitable Funds Committee – 05th February 2018** ▪ **Patient Experience & Feedback Committee – 09th February 2018** To note	Verbal Verbal	LP JF
13.	15.15	**Other Business**		Chair
14.	15.20	**Date of Next Meeting** The next meeting in public of the Board of Directors is scheduled to take place at 14.00 on 28th March 2018 in the Boardroom, St Mary's Hall, Royal Sussex County Hospital, Eastern Road, Brighton, BN2 5BE		Chair

MEETING OF THE BOARD OF TRUSTEES OF THE LOVE YOUR HOSPITAL CHARITY

1.	15.20	**Investments and Reserves Policy** To approve	Enclosure	LP
2.	15.30	**Annual Budget (Including Management Charge) 2018/19** To approve	Enclosure	LP
3.	15.40	**Non Love Your Hospital and Trust Charities having access to the hospital to raise funds and profile** To approve	Verbal	LP
4.	15.50	**Other Business**		Chair
5.	15.55	**Close of Business**		Chair

Andy Gray
Director Corporate Governance
Tel: 01903 285288 / Mobile: 07785332416

Western Sussex Hospitals
NHS Foundation Trust

Minutes

Minutes of the Board of Directors meeting held in Private at 1.00pm on Thursday 01st February 2018 in the John Bull Room, Worthing Health Education Centre, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH

Present:	Mike Viggers	Non-Executive Director (Chairman)
	Joanna Crane	Non-Executive Director
	Mike Rymer	Non-Executive Director
	Patrick Boyle	Non-Executive Director
	Jon Furmston	Non-Executive Director
	Lizzie Peers	Non-Executive Director
	Karen Geoghegan	Chief Financial Officer
	Denise Farmer	Chief Workforce and OD Officer
In Attendance:	Tim Taylor	Medical Director
	Maggie Davies	Nursing Director
	Alison Ingoe	Finance Director
	David Beattie	Director of Medical Education
	Kirstin Baker	Non-Executive Director Adviser
	Martin Sinclair	Non-Executive Director Adviser
	David Jones	Director of Estates and Facilities (For Item 7)
	Andy Gray	Corporate Governance Director
	Tanya Humphrys	Board Administrator

PB/01/18/01 Welcome and Apologies

1.1 The Chair welcomed all those present to the meeting.

1.2 Apologies were received from Pete Landstrom, Nicola Ranger, Marianne Griffiths and George Findlay.

PB/01/18/02 Declarations of Interests

2.1 There were no declarations of interest.

PB/01/18/03 Minutes of Board Meeting held on 29th November 2017

3.1 The Board received the minutes of the meeting held on 29th November 2017.

3.2 **The Board resolved that the minutes of the Board meeting held on 29th November 2017, would be approved as an accurate record of the meeting and signed by the Chairman.**

PB/01/18/04 Matters arising from Minutes

4.1 The Matters Arising from previous meetings were received.

4.2 All the Matters Arising related to items on the agenda or were on a forward agenda plan.

PB/01/18/05 Serious Incident Requiring Investigation Report

The Serious Incident Requiring Investigation (SIRI) Report for December

was presented by Maggie Davies.

5.1 It was noted that there were 10 serious incidents in December that were declared as SIRIs.

5.2 **SIRI Reference 2017/29458** – Relates to a treatment delay in Ophthalmology of a female who was seen in October 2015 and should have been reviewed six months later, but was 'lost' to follow-up and not seen until November 2017. This patient was picked up as a result of the clinical validation process.

5.3 **SIRI Reference 2017/29471** – Relates to an inpatient fall on the Emergency Floor at Worthing that resulted in a fractured neck of femur and required surgery.

5.4 **SIRI Reference 2017/29509** – Relates to an inpatient fall on Eartham Ward that resulted in the patient sustaining a fractured neck of femur and requiring surgery.

5.5 **SIRI Reference 2017/29519** – Relates to a diagnostic incident of a lady who fell at home and her diagnosis of fractured neck of femur was delayed by five days.

5.6 **SIRI Reference 2017/29523** – Relates to a patient that attended for an Outpatients appointment and fell in the Outpatients department and was admitted for surgery of a left dynamic hip screw.

5.7 **SIRI Reference 2017/29529** – Relates to an inpatient fall on Botolphs Ward. The patient was admitted following a stroke; she subsequently fell and sustained a fractured neck of femur that required surgery.

5.8 **SIRI Reference 2017/29931** – Relates to a maternity a birth on the maternity ward at St Richard's Hospital. A stillbirth occurred following placenta abruption. The case has been to Inquest and is now concluded. Maggie advised the Board that there were no prevention of future deaths actions following the inquest.

5.9 **SIRI Reference 2017/30793** – Relates to a diagnostic incident including delay. The patient was admitted in November 2015 and had a chest X-ray as a result a 'Code Red' which was sent to the acute physician. The patient was admitted in late 2017 and was found to have advanced lung disease that was evident on the X-ray in 2015.

5.10 Mike Viggers commented that there have been many conversations previously in relation to Code Red and how the Trust manages them. He requested that a further update be brought back to the Board meeting in March as part of the SIRI report. **NR/MD**

5.11 **SIRI Reference 2017/30918** – Relates to a treatment delay in Ophthalmology. As part of clinical validation three patients were found to have not received follow up appointments. As a result of these and previous SIRIs, diagnostic clinics have been introduced where Glaucoma patients are called in to have all the appropriate tests performed prior to review. This is to ensure that the patient is on the appropriate care pathway.

5.12 The Board requested that an update on the Clinical Validation process and Ophthalmology backlog be brought back to Board in March **NR/MD**

DRAFT

5.13 **SIRI Reference 2017/31489** – Relates to an inpatient fall on the Emergency Floor at St Richard's Hospital. The patient fell and sustained a fractured neck of femur that required surgery.

5.14 The Trust submitted 5 completed investigation reports to the CCG during December 2017. The Board noted the actions detailed in the report.

PB/01/18/06 Legal Claims – Quarter 2

Maggie Davies introduced the Legal Claims Report for Quarter 2.

6.1 It was noted that there has been an increase in claims received; however, no themes or areas of concern have emerged.

6.2 Mike Rymer commented in relation to the claims that have been dormant for three or more years that they could become active at any time. Maggie confirmed that this was the case.

6.3 Joanna Crane asked in relation to benchmarking, whether the Trust ever reviews the difference between an offer being made and accepted in comparison to what the cost would have been had the claim gone through the legal process.

6.4 In response Alison Ingoe advised that there is a focus on trying to settle out of court when the Trust feels it is at fault. Alison commented that she was unsure how 'easy' it would be to go back and gather such information.

6.5 Karen Geoghegan commented that it would be useful to know what may have caused the reduction in claims in 2016. Particularly as the annual premium for the Clinical Negligence Scheme for Trusts (CNST) has increased considerably. **NR/MD**

6.6 The Chair requested that for the next Quarter's report Katherine Goacher be invited to present the report to Board. In addition that there should be a review of the dip in spend in 2016/17 in relation to Legal Claims and how that was achieved. **NR/MD**

PB/01/18/07 Retail Catering Service Review

David Jones presented the Retail Catering Service Review, copies of which had been previously circulated.

7.1 The Board was advised that following the appointment of Compass Group a six month review has taken place on the mobilisation of the contract.

7.2 The review began in September 2017 and an external consultancy was used to focus upon three key areas, contractual compliance, customer satisfaction and financial.

7.3 David explained that following a number of audits Compass have been achieving above 90% compliance since November 2017.

7.4 David advised the Board that Compass have ensured that staffing in all areas has improved. In addition that they are delivering the contract as specified in terms of Health and Safety.

7.5 It was noted that the Trust is meeting regularly with Compass; having

DRAFT

weekly 'touch base' meetings, monthly formal meetings and quarterly contractual meetings.

7.6 It was highlighted that although in general customer satisfaction was good it is recognised that there are still improvements to be made. In particular, slow service and the variety of food being offered is not what people want to see.

7.7 David advised in relation to the budget, Costa is over-performing against targets and Spice of Life is on target. Both Amigo and Deli Marche are under budget.

7.8 Although overall Compass is on budget, it was noted that currently the Trust is not seeing the profit hoped for

7.9 David explained that following the report being presented to the Board, it will be shared with Compass and they will be asked to provide a formal response to the findings, along with an action plan for 2018 which is already in train.

7.10 It was noted that the department are going to look at how the space in the Spice of Life Restaurants is utilised and try to encourage greater use for one to ones and informal meetings.

7.11 Jon Furmston commented that he had visited the Shoreline Restaurant that morning and had never seen it so quiet. In response David stated that this was sometimes the case, with customers being spread over a wider area due to the introduction of additional areas such as Costa and Amigo.

7.12 Joanna Crane commented that the financials were assuring and asked if Compass had provided assurance that staff whose employment was transferred across to them under the new arrangements are receiving appropriate training. David explained that formal staff training was implemented, a plan put in place and this has been adhered to.

7.13 Patrick Boyle asked when the Trust can expect to see a return on the investment. In response David explained that the Trust has received a guaranteed income through the tender with Compass, it is only delivery of additional income that has not been achieved.

7.14 Denise Farmer commented that the cost of the new electric beds is almost the same as the revenue received from Compass.

7.15 It was noted that a Communication from the Board explaining that the beds are being purchased with this money may be beneficial. Particularly as this was partly the reason for the decision, so staff could draw a direct line between the tender and benefit to the organisation.

7.16 Mike Viggers thanked David for the report and agreed that publishing communications across the Trust to highlight how the money is now being used would be very positive. **KG/DJ**

7.17 Mike noted that Costa is providing considerably longer opening hours than previously and although there is still work to do, highlighted that it was the correct decision considering the ways in which the Trust has benefited.

7.18 Denise suggested that the findings of the review be shared with the Lead Governor and his opinion sought on how the governors could positively **DJ/KG**

DRAFT

help create a good atmosphere in the Restaurants.

PB/01/18/08 External Board Governance Review

Andy Gray presented the External Board Governance Review and highlighted the key points.

8.1 The Board was advised that in order to meet NHS Improvement's (NHSI) expectations that are set out in the 'Developmental reviews of leadership and governance using the well-led framework guidance', the Board has developed a specification for an external Board Governance review.

8.2 The procurement process has been completed and a total of thirteen responses were received. Three stood out both in terms of cost and the number of days that they had allowed for the work and these bids were excluded from further consideration as unaffordable.

8.3 Andy highlighted to the Board that the lowest financial bid was submitted by the Good Governance Institute but that Deloitte are the bidder with the highest overall score.

8.4 In addition it was noted that Deloitte have worked with the Board previously.

8.5 Andy explained that the successful contractor will produce a final report setting out the findings of the review and suggested actions needed to address any issues or risks arising, together with a Board development plan, and will present the report to the Board of Directors.

8.6 The Board **NOTED** the report and **APPROVED** the contract be awarded to Deloitte as the highest scoring bidder.

PB/01/18/09 Reports from Other Meetings

9.1 **Audit Committee – 16th January 2018**
Jon Furmston updated the Board on the Audit Committee that took place in mid-January. Jon advised the Board that the Committee had received a limited assurance internal audit on Mental Health Sectioning. The Audit noted that the Trust's system of internal controls is acceptable; however its effectiveness needs to be improved.

9.2 The recommendations made by the internal auditors have been accepted and are being progressed.

9.3 It was noted that the Committee had also received the IT Disaster Recovery plan audit and the Clinical Coding Report. In relation to the latter report, Jon highlighted that the fourth most frequently missed co-morbidity was renal disease; this is being triangulated to ensure that there are no others that are being missed.

9.4 The Committee also received a paper following an incident of lost radiology images. This provided assurance that all reasonable measures are in place to prevent a similar situation in the future.

PB/01/18/10 Other Business

10.1 Mike Rymer advised the Board of a recent visit from the British Orthopedic Association (BOA). The visit was following publication of data on the

DRAFT

National Joint Register database, showing that the Trust was one of the largest in the country for elective knee and hip surgery - with the poorest outcomes and a high number of revisions.

10.2 Mike highlighted that it was apparent that as a department there was no information or feedback and as a Unit they were not concerned about the overall data.

10.3 It was noted that following the two day visit, the Trust will receive the full report in next week.

10.4 Mike Viggers thanked Mike for raising this issue and requested that a further paper with more detail and assurances be brought back to the February Board. **GF/TT**

PB/01/18/11 Date of Next Meeting

11.1 It was noted that the next Board Meeting would take place on **Thursday 01st March 2018** in the **John Bull Room, Worthing Health Education Centre, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH**

DRAFT

Tanya Humphrys
Board Administrator
01st February 2018

Signed as an accurate record of the meeting

……
Chair

……
Date

MATTERS ARISING
Board in Private

Agenda Item: 4

Meeting	Minute Ref	Action	Responsible Person	Deadline	Status
26th October 2017 29th November 2017	**PB/10/17/5.1 & PB/11/17/4.2**	Include the Population of New Performance (medicines optimisation) metrics in the Quality Report for November Board. ---------- Review of Quality Dashboard	GF	28th March 2018	On the forward agenda plan for March 2018
01st February 2018	**TB/01/18/6.1**	**Stroke Services** - Further information in relation to Staffing levels and performance	GF/TT	01st March 2018	Included as part of the Quality Report
01st February 2018	**TB/01/18/6.2**	Revised RTT recovery trajectory to be included in the next report.	JF	01st March 2018	Included as part of the Performance Report
01st February 2018	**TB/01/18/6.2**	Trust overview of Winter Pressures at the appropriate juncture.	JF	26th April 2018	An in depth presentation on Winter Pressures on the forward agenda plan for April at Public Board.
01st February 2018	**TB/01/18/6.3**	Update on Retention included as part of the Workforce Report	DF	01st March 2018	Included as part of the Workforce Report
01st February 2018	**TB/01/18/9.5**	Some focus on a number of the areas for improvements in the Equality Report and how the Trust intend to address them.	DF	28th March 2018	On the forward agenda plan for March 2018.
01st February 2018	**TB/01/18/9.6**	Update on the gender pay gap	DF	01st March 2018	Item 8 on the agenda.
01st February 2018	**PB/01/18/5.12**	Update on the Ophthalmology Outpatients backlog.	GF/TT	01st March 2018	Included as an appendix to the SIRI Report.
01st February 2018	**PB/01/18/5.10**	Update on the management of Code Reds.	GF/NR	01st March 2018	Included as an appendix to the SIRI Report.
01st February 2018	**PB/01/18/6.6**	Include a review of the dip in spend in 2016/17 in relation to Legal Claims and how that was achieved.	NR	26th April 2018	On the forward agenda plan for April 2018

01st February 2018	**PB/01/18/6.5**	Include some correlation on CNST annual premium cost versus the Trusts claim profile in the next Quarter's Legal Claims Report.	NR	26th April 2018	On the forward agenda plan for April 2018
01st February 2018	**PB/01/18/7.16**	Publish communications across the Trust to highlight how the money from Compass is now being used to purchase Electric Beds	DJ/KG	01st March 2018	To be confirmed.
01st February 2018	**PB/01/18/7.18**	Findings of the Retail Catering Review to be shared with the Lead Governor and his opinion sought on how the governors could positively help create a good atmosphere in the Restaurants.	DJ/KG	01st March 2018	To be confirmed.
01st February 2018	**PB/01/18/10.4**	**British Orthopedic Association Visit**, the Board requested further assurance on the issues highlighted during the visit, and that there is more awareness within the division.	GF/TT	01st March 2018	Item 7 on the agenda.

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board
Date of Meeting: 01st March 2018 Agenda Item: 5.1

Title
Month 10 (January), 2017/18 Monthly Quality Report
Responsible Executive Director
Dr George Findlay (Chief Medical Officer) and Nicola Ranger (Chief Nurse)
Prepared by
Jo Habben (Head of Clinical Governance and Patient Safety)
Status
Disclosable
Summary of Proposal
Not applicable
Implications for Quality of Care
Describes performance against quality outcome KPIs, including safety, infection control, experience, effectiveness and mortality.
Link to Strategic Objectives/Board Assurance Framework
This report pulls together key national, regional and local quality indicators relating to quality and safety providing assurance for the Board and (if necessary) highlighting issues.
Financial Implications
Describes KPIs that have potential financial impact (e.g. CQUIN.)
Human Resource Implications
Describes KPIs linked to workforce.
Recommendation
The Board is asked to: Note the contents of this report.
Communication and Consultation
Not applicable
Appendices
Appendix 1: Quality Scorecard Appendix 2: Ward Staffing Scorecard

1 INTRODUCTION

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

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

2 2017/18 REFRESH

2.1 There will be a refresh of the Monthly Quality Report for 2017/18 to reflect the key quality objectives for the next year aligned to Patient First and our True North objective[1]. For now however, the report follows the same format as previously using the same suite of metrics, with revised targets using similar logic in the interim to that applied for 2016/17:-

- If 2016/17 performance exceeded target, then 2016/17 actuals used as 2017/18 target
- If 2016/17 performance did not meet target then 2016/17 target remains the same for 2017/18
- If there is a national or set target then that will continue as the measure
- Any metrics with no target set continue as before

2.2 The new scorecard is in development and will incorporate a more extensive range of metrics and targets.

3 KEY QUALITY OBJECTIVES

3.1 Scorecard Definitions

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

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

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

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

3.2 Domain scores

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

3 (green) + 3 (green) + 1 (red) = 7

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

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

3.3 Overview of Key Quality Objectives

3.3.1 The following table shows performance against key quality objectives.

Indicator	**Nov 2017**	**Dec 2017**	**Jan 2018**	**2017/18 to date**	**2017/18 Target / limit**
Effectiveness Domain Score	2.35	2.22	2.35	2.52	2.5
Safety Domain Score	2.31	2.28	2.11	2.0	2.5
Experience Domain Score	2.52	2.52	2.52	2.39	2.5
E01 Trust crude mortality rate (non-elective)	3.06%	3.26%	4.25%	2.98%	3.13%
E03 Hospital Standardised Mortality Ratio for top 56 diagnoses (Dr Foster, based on rolling 12 months)				88.2	<92
S06 Number of Serious Incidents Requiring Investigation (number reported in month)	4	10	6	50	60
S14 Numbers of hospital attributable MRSA	0	1	1	2	0
S28 Numbers of hospital C. diff where a lapse in the quality of care was noted	2	1	4	16	16
X38 The Friends and Family Test: Percentage Recommending Inpatients	97.0%	95.7%	97.0%	96.8%	97%
X39 The Friends and Family Test: Percentage Recommending A&E	88.1%	84.5%	88.0%	85.5%	93%
X13 Mixed Sex Accommodation breaches (number of breaches)	0	0	0	0	0
X18 Number of complaints	42	30	34	372	570

4 EFFECTIVENESS

4. 1 Crude Trust Mortality

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

4.1.2 Crude non-elective mortality increased from 3.26% in December to 4.25% in January. This is higher than the equivalent month in 2017 (4.15%) and slightly higher than the normal limits associated with the seasonal variation in crude mortality. This rate is likely to reflect the rise in acuity of patients admitted during January but this will need to be confirmed once risk adjusted data is available. Screening data from the '*Learning from Deaths'* process will also be examined carefully to check there has been no increase in reported problems.

4.1.3 The number of non-elective patients who died in January was 260 (from 6070 discharges). Worthing and Southlands reported 142 deaths of 3104 discharges (4.57%) and St Richards Hospital reported 118 deaths of 2966 discharges (3.98%). The year to date mortality rate is 2.98% and the rolling 12 month mortality rate is 3.07%. The limit for both measures is 3.13.

4.2 Hospital Standardised Mortality Ratio (HSMR)

4.2.1 There is a delay in data being available in Dr Foster tools to allow for coding and processing by the Health and Social Care Information Centre and Dr Foster. The most recent data available is October 2017.

4.2.2 The Trust's HSMR for the twelve months to October 2017 is 88.2 (where 100 is the level predicted by the Dr Foster model using the July 2017 benchmark).

4.2.3 The twelve month HSMR to October 2017 split by site continues to be lower for St Richard's (85.23) than for Worthing and Southlands (90.91). The difference is marginally lower at SRH and higher for Worthing than the previous month and remains well within acceptable variation limits, with both sites remaining below 100.

4.2.4 There is a notable increase in the crude non-elective mortality for renal failure- from 8% in December, to 27.8% in January against an annual target of 15.5%. Year to date mortality is noted as 16.7% against an annual target of 15.5%. In Q4, the Mortality Group will be focusing on the variations in the Crude Mortality data, and reviewing the clinical coding process regarding Renal/Acute Kidney Injury (AKI). As renal failure is a common problem at end of life this is also thought to be associated with the perceived rise in acuity, a re-examination of this group of patients will form part of the learning from deaths work programme.

4.2.5 E10. 30 day mortality rate following hip fracture - continues to rise and in October 2017 was reported at 7.8% against target of 5.70%

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

4.2.7 The Trust has set the goal of achieving a position within the top 20% of Trusts as measured by HSMR. For the twelve months to October 2017 performance using this measure continues to place us well within the top 20% of Trusts on the 15th centile.

4.3 Summary Hospital-Level Mortality Indicator (SHMI)

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

4.4 Exception Reports Relating to Effectiveness

4.4.1 E13. C-Section rate- a decrease in the Trust Caesarean Section rate from December was recorded at 29.4% in January (27.9% YTD) against a target of 26.5%. Each case where a woman has a caesarean delivery undergoes a review process to look for learning opportunities. No systemic causes or trends have been identified and practice is very much in line with national recommendations for safe practice and NICE guidance. Increasing normal birth continues to be an area of focus for the division and rates are closely monitored via monthly divisional performance reviews.

4.4.3 E42. Night time moves in patients with a diagnosis of dementia. In January, 42 patients with a diagnosis of dementia were moved at night (between 23:00-07:00hrs), this is a significant improvement from December when a total of 66 patients were moved at night. However E39- Ward moves for patients flagged with dementia - demonstrated a significant increase from December's total of 217, to January's total of 236.

4.4.4 The dementia team continues to monitor and record/audit the moves and the Kaizen work stream is not only focused on patients with a diagnosis of dementia but also any patient that is moved at night. Ongoing improvement work continues with representation from the Kaizen team, matrons, dementia matron, the site team and the clinical lead for the emergency floors.

4.4.5 E27. Stroke thrombolysis within 60 minutes of arrival (reported December) demonstrates a improvement in performance from November (77.8%) to 88.9% against a target of 95% (YTD actual 72.5%).

4.4.6 E30. The percentage of patients at high risk Transient Ischemic Attack (TIA) seen within 24 hours demonstrates a 0% return. (YTD actual 17% against an annual target of 60%).

4.4.7 E26. CT scans undertaken within 12 hours has decreased in December to 93.6% (YTD actual 95.5%) against an annual target of 95%.

4.4.8 E27. Swallow screen for patients within 4 hours of admission- performance has decreased in December to 71.8% against an annual target of 90%.

4.4.9 Trust performance for stroke continues with Worthing achieving a Sentinel Stroke National Audit Programme (SNAP) score of B, and Chichester a C (A being the highest score and E being the lowest). A recent Kaizen event was held to review the scores and the primary issue appeared to be the service provision out of hours. In Worthing there is an additional resource of a nurse who is responsible for assessing and transferring patients to the stroke unit, this post does not exist at present in Chichester (this is the main part of the business case for supporting 24/7 thrombolysis).

4.4.10 Other main themes being looked with the support from the Kaizen team include- transfer time to CT scan, time to transfer to the stroke unit and the provision of therapies.

4.4.11 In response to system pressures and at the request of the clinical commissioning group the Trust are designing a business case to support 24/7 thrombolysis on both sites- to be implemented in April 2018.

5 SAFETY

5.1 Central Alert System (CAS) Safety Alerts

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

5.2 Serious Incidents Requiring Investigation (SIRIs)

5.2.1 There were 6 reported incidents categorised as a Serious Incident (SI) requiring investigation in January. Two patients fell and sustained a fractured neck of femur requiring further surgery, two Serious Incidents were reported where there was a failure to follow up treatment causing a delay- resulting in serious harm (gynae and orthopaedics), a further Serious Incident was reported regarding an information governance breach and the Influenza outbreak (hospital acquired infection) has also been declared as an SI. A detailed serious incident report is provided to the committee section of the Trust board. The board should note there can be slight variation in the month-by-month numbers between the SIRI report and the number of significant incidents – this is because incidents are attributed to the month in which they occur whereas the SIRI data is based on the month in which the SIRI was reported externally.

5.2.2 Any incidents that are reported as causing significant harm (moderate, severe or resulting in the death of a patient) are notified immediately to the senior team in the Trust including the chief nurse and the

chief medical officer with at least weekly updates on progress. In January 18 incidents were reported, YTD 145 incidents have been reported against a target of 153.

5.2.3 S08. Moderate/severe incidents involving drug/prescribing errors- December and Januarys' data has noted an increase in reporting, making a YTD total of 7 reported incidents against an annual target of 5.

5.2.4 On a monthly basis there is triangulation of information arising out of complaints, claims, incidents and inquests to identify any areas of learning or for focus. The newly revised Triangulation Committee (From January 2018) will focus on how we share learning across the organisation, with a detailed 'Deep Dive' focus on an incident(s) (where the learning for the organisation is significant) being discussed at each meeting.

5.2.5 In January 2018- A two day accredited (RCoP) Serious Incident Investigator training programme sponsored by the Kent Surrey and Sussex Quality and Patient Safety Collaborative (KSS AHSN) was hosted at WSHFT.

5.2.6 The new Health Service Safety Investigation Bill is currently in draft, the proposals in the HSSIB (if passed through parliament) will significantly change how Serious Incidents are investigated in line with the launch of the Health Safety Investigation Branch (HSIB) in 2017. The executive team will be regularly updated by the head of clinical governance and patient safety as the developments continue. A presentation and draft paper will be produced in February 2018.

5.3 Infection control

5.3.1 There was 1 case of MRSA during January where there was a noted lapse in care attributable to the Trust. The Post Infection Review (PIR) concluded bacteremia attributed was contaminant however there were identified learning points/actions taken forward for the clinical and facility areas.

5.3.2 There were 4 cases of Clostridium difficile reported in January where there was a noted lapse in care attributable to the Trust (2 at SRH and 2 at Worthing). YTD there have been 16 reported cases against an annual target of 16. A detailed action plan is being implemented and each case is reviewed in detail, with the sharing of lessons learned at a weekly Root Cause Analysis (RCA) panel chaired by the nurse director.

5.3.3 The allocated Trust target limit for 2017/18 (C/Diff) is set at 39 [2] (unchanged from last year). Incidence in January was 13.2 cases per 100,000 bed days against the national average for 2015/16 of 14.9 cases per 100,000 bed days.[3]

5.3.4 Surgical Site Infection (SSI) -Root Cause Analysis documents for orthopaedic implant SSI's has been further updated to include more detailed preoperative, intraoperative and postoperative actions. The RCA's of any infected joints are now being undertaken by the consultants and presented via the clinical governance meetings. The SSI team is now working as part of the surgical division team which will help with communications. A member of the IPC team has been appointed to work with the team and work on actions re: Nice Quality Standards for reducing SSI's, this will involve the introduction of the One-Together audit programme – (devised by Infection Prevention Society, The Association for Perioperative Practice, the College of Operating Department Practitioners and the Royal College of Nursing) that is being used in many Trusts in UK.

5.4 Falls

5.4.1 In January, inpatient falls increased to a total of 176, of these 46 resulted in harm against a target of 38, and of these 96 were noted at Worthing Hospital and 80 were recorded at St Richards Hospital.

5.4.2 There were 2 falls resulting in a moderate degree of harm to patients. Two of these incidents resulted in a patient injury of a neck of femur fracture requiring surgery and were reported as Serious Incidents as outlined in 5.2.1.

5.4.3 The number of falls in January equates to 5.83 per 1,000 bed days against a national figure of 6.63.[4] Of the 46 falls reported as resulting in harm in December, those causing significant harm (moderate, severe harm/death) equate to 0.06 per 1000 bed days against the national figure of 0.19.

5.4.4 January proved to be challenging month for the Trust and this has been reflected in the number of falls reported. However, in December and January (2016-17) the Trust saw 28 more falls in total demonstrating a year on year reduction of falls in the Trust.

5.4.5 Meetings have been held with the matrons and discussed with the heads of nursing regarding the wards where in patient falls have increased. Wards have been visited by the harm free care team to review current practices in line with best practice. The benefits of Baywatch, bay working and SWARM have also been revisited. In addition, the clinical activities volunteer role description has been finalised and dates for workshops for volunteers and other interested parties have been booked during February and March 2018 at Worthing and Chichester.

---

[2] *NHSI (2017) Clostridium difficile infection objectives for NHS organisations in 2017/18 and guidance on sanction implementation. Page 5*

[3] *https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data.*

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

5.4.6 The *'Let's Get You Home'* campaign (to help prevent de-conditioning- a known risk factor with falls) has been rolled out and the *'Keeping Active'* checklist has been trialled on selected pilot wards and is now is incorporated within the hospital information booklet. A local initiative in partnership with Coastal West Sussex CCG to provide patients with information about getting home and staying active while in hospital to prevent deconditioning has commenced. In addition, the 2018 Annual Clinical Update will include information about activities and deconditioning.

5.5 Tissue Viability

5.5.1 Changes to the way the Trust is required to report pressure ulcers meant that more grade 2 and grade 3 ulcers were reported in 2015/16 than in previous years. This method of reporting changed from October 2016 and grade 3 or greater damage will not be routinely reported as a Serious Incident unless it meets the national threshold for Serious Incident (NHSE SI Framework 2015) reporting. Internal scrutiny of cases continues exactly as before with robust follow through of actions.

5.5.2 During January the Trust reported at total of 43 incidents of pressure damage both equal to and greater than European Pressure Ulcer Advisory Group (EPUAP) category 2- a steady decrease from November/Decembers' data. Of these reported cases- there were 37 category 2 hospital acquired pressure ulcers, 1 category 3, 1 unstageable ulcer and 4 suspected deep tissue injuries (SDTI). No EPUAP category 4 pressure ulcers were reported, which indicates a significant improvement from November, when 4 were reported. Of the overall total of 43, 26 of these incidents occurred at the Worthing Site. YTD the Trust has reported 300 pressure ulcer >Cat 2 against an annual YTD target of 200.

5.5.3 There remains an increased reporting of category 2 pressure injuries in January with a sustained decreased number of category 3 and above skin damage. The numbers of reported category 1 pressure injuries have slightly increased during January. However, further work is being undertaken to reinforce the importance of timely skin assessments to enable the identification of the early signs of pressure damage (non-blanching skin). January's After Action Reviews (AAR) highlighted several lapses in care associated with extended periods of being cared for in the same position, poor skin inspection, and lack of accurate and timely documentation.

5.5.4 A Pressure Ulcer Improvement Event was delivered in January 2018 supported by the Kaizen and tissue viability teams to revise the Trust and local A3 plan. Several wards identified actions to reduce pressure injuries and are now being supported to deliver this and will present their progress and outcomes at a further workshop planned in March 2018.

5.5.5 The incidence of pressure ulcers, category 2 and above including those developing within 72 hours after admission per 1000 bed days in December was 1.4, against a national rate of 0.9 (as per the Safety Thermometer data).

5.5.6 There were 188 patients admitted to the Trust from the community with existing pressure damage, the majority being from the patient's own home.

5.6 NHS Patient Safety Thermometer

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

5.6.2 S02. The harm-free care score for the Trust in January was 94.4%- an improvement from December's score of 92.8%- against the annual target of 95.7%.

5.6.3 The Safety Thermometer includes harms suffered by the patient in healthcare settings prior to admission. The actual number of patients who suffered no new harm during their inpatient stay at WSHFT (indicator S03) in December was 97.9% against a national average of 97.8% and close to achieving the challenging internal target of 99% set by the organisation.

5.6.4 S29. The positive decrease continues to 0% (from Oct/Nov data) in the percentage of patients with urinary catheters and urinary tract infection where best practice was not followed was noted against a trust target of 0.06%.

5.6.5 S11. Compliance with VTE assessment of patients was 93.9% against a target of 95%.

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

6 PATIENT EXPERIENCE

6.3 PALS and Complaints

6.3.1 During January the Trust received 34 complaints, the top five themes (in order) being noted as communication (oral), communication (written), date for appointment, clinical treatment and date of admission/attendance. Complaints about nursing have decreased from November (5) to a total of 2 per month being reported in December and January- YTD 39 complaints have been received about nursing against an annual target of 39. Divisions are beginning to embed a more proactive response to new complaints to try to facilitate resolution quickly for patients and families to avoid the need for escalation to formal complaint.

6.3.2 The complaints team are currently working towards achieving a target of 60% complaints closed within 25 days by the end of January 2018, this has been achieved in women's and children's and core divisions with 100% of complaints closed by January end.

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

6.4 Friends and Family Test (FFT)

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

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

6.4.3 Friends and Family Test Response Rates:

6.4.4 Work continues to improve response rates towards a target this year of 40% (with an interim target for A&E of 23%). The average response rate in 2015/16 for NHS acute trusts was 24.7%. Currently, response rates for Inpatients, A&E and Maternity for December are all below the Trust target.

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

6.4.6

	Percentage recommending WSHFT in January (plus YTD)	**Target**
Inpatient care	97.0% (96.8%)	97%
A&E	88.0% (85.5%)	93%
Maternity: Delivery care	98.9% (97.8%)	97%
Outpatient care	97.7% (97.0%)	97%
Maternity: Antenatal care	100% (97.3%)	97%
Maternity: Postnatal ward	98.9% (97.8%)	97%
Maternity: Postnatal community care	100% (98.6%)	97%

6.5 Maternity

6.5.1 X40. Maternity Friends and Family Recommend %: Antenatal care (36 weeks) demonstrates a rise from Decembers reporting (89.5%) to January 100%.

6.5.2 X33. December 2017 saw a noted decrease in the Maternity Friends and Family Response rate: Delivery Care- to 39.9% against a target of 40%. Following a review as to why there has been a deterioration in compliance in maternity, a number of systems errors have been identified that cumulatively resulted in a reduction of response cards that were completed, but then also compounded by cards that had been filled in failing to arrive with the FFT in time for collation. The ward managers have taken steps to ensure that they have robust systems in place to improve this. These responsive implemented actions have now resulted in an increase in the reported response rate to 87.9% in January 2018.

7 RECOMMENDATION

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

Jo Habben
Head of Clinical Governance and Patient Safety
20th February 2018.

QUALITY SCORECARD

JANUARY 2018

		FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	YTD Actual	YTD Target	Target	Trend
EFFECTIVENESS																	
	Effectiveness domain score	2.26	2.29	2.59	2.41	2.52	2.50	2.50	2.46	2.46	2.35	2.22	2.35	2.52			
	Trust-wide mortality																
E01	Trust crude mortality rate (non-elective)	3.48%	3.46%	2.80%	2.82%	2.56%	2.64%	2.60%	2.65%	3.15%	3.06%	3.26%	4.25%	2.98%	3.13%	3.13%	
E02	Crude mortality rate (non-elective): 12 month rolling	3.22%	3.21%	3.16%	3.11%	3.11%	3.09%	3.09%	3.09%	3.07%	3.06%	3.05%	3.07%	3.07%	3.13%	3.13%	
E03	Trust Hospital Standardised Mortality Ratio (HSMR) (rollin 12M)	91.8	90.4	89.4	87.4	89.0	88.8	88.4	88.7	88.2				88.2	92	92	
E04	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	0.95			0.95									0.95	1	1	
E45	% of Part 1 inpatient deaths reviewed *NEW*																
	Improve mortality in specific conditions																
E07	Crude non-elective mortality for Renal failure	12.1%	20.7%	11.40%	17.4%	12.50%	16.2%	17.4%	11.54%	17.1%	20.0%	8.00%	27.8%	16.7%	15.50%	15.50%	
E46	% Compliance with Sepsis care bundle *NEW*																
E47	% patients with sepsis receiving antibiotic therapy within one hour *NEW*																
E48	Timely identification of sepsis in emergency department and inpatient setting *NEW*																
E49	% patients with 72 hour antibiotic review for sepsis *NEW*																
E50	Hospital acquired AKI mortality within 28 days of AKI diagnosis *NEW*																
	Reduce mortality following hip fracture																
E09	SMR for hip fracture (all diagnoses/procedures) (rolling 12M)	96.8	96.4	88.1	87.0	97.2	101.3	95.7	92.2	89.4				89.4	100	100	
E09a	Worthing SMR for hip fracture (all diagnoses/procedures) (rolling 12M)	103.6	108.5	95.0	94.2	105.0	112.9	104.1	101.5	100.1				100.1	100	100	
E09b	St Richard's SMR for hip fracture (all diagnoses/procedures) (rolling 12M)	87.7	82.1	80.0	78.1	88.1	89.1	87.4	83.3	79.1				79.1	100	100	
E10	30 day mortality rate following hip fracture (rolling 12M)	6.5%	6.8%	6.5%	6.5%	6.8%	7.2%	7.3%	7.1%	7.8%				7.8%	5.70%	5.70%	
	Seven Day Servies *NEW*																
E51	% consultant review within 14 hours of admission: Weekday *NEW*																
E52	% consultant review within 14 hours of admission: Weekend *NEW*																
E53	Access to diagnostics: MRI (split weekday Vs weekend access): *NEW*																
	Reduce the rate of readmission following discharge from the Trust																
E11	Emergency readmissions within 30 days %	13.9%	13.6%	14.4%	14.7%	13.5%	14.7%	13.4%	13.8%	14.4%	14.0%	13.6%	13.2%	14.3%	13%	13%	
	To improve maternity care by encouraging natural chilbirth																
E13	C-Section Rate	28.6%	28.5%	24.3%	27.0%	30.1%	22.8%	27.0%	29.4%	27.1%	28.8%	33.0%	29.4%	27.9%	26.50%	26.50%	
E14	% Mothers requiring forceps for delivery	14.0%	10.9%	14.8%	11.4%	12.1%	12.4%	10.1%	10.5%	11.0%	11.7%	9.4%	10.9%	11.4%	<15%	<15%	
E15	% Deliveries complicated by post-partum haemorrhage	0.3%	0.2%	0.5%	0.9%	0.2%	0.2%	0.2%	0.2%	0.7%	0.2%	0.3%	0.5%	0.4%	1%	1%	
E16	Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
E17	Admission of term babies to neonatal care	3.6%	1.6%	2.4%	3.7%	4.0%	3.4%	3.7%	2.5%	3.5%	2.6%	3.8%	2.1%	3.2%	< 10%	< 10%	

QUALITY SCORECARD

JANUARY 2018

		FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	YTD Actual	YTD Target	Target	Trend
	Caring for the elderly patient																
E18	% Emergency admissions staying over 72h screened for dementia	90.9%	91.0%	90.0%	93.4%	91.0%	90.6%	91.8%	82.9%	94.2%	96.9%	87.0%	94.0%	91.0%	90%	90%	
E19	% Patients identified as at risk of dementia for whom further investigations are carried out	93.9%	97.0%	92.4%	96.9%	91.0%	95.3%	91.6%	85.4%	100.0%	94.0%	96.0%	98.0%	94.0%	90%	90%	
E20	% Patients with identified dementia referred to specialist services	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90%	90%	
E25	Number of admissions for patients with dementia flag	272	270	221	237	203	216	228	192	185	228	237	277	2224	NA	NA	
E39	Ward moves for patients flagged with dementia	270	213	184	235	180	203	180	110	174	163	217	236	1882	1980	2376	
E42	Night-time ward moves for patients flagged with dementia (23:00 - 07:00) : Total	63	33	34	43	46	38	22	23	44	44	66	42	402	417	500	
E42a	Night-time ward moves for patients flagged with dementia (23:00 - 07:00) : From Emergency Floor	77%	88%	77%	73%	79%	81%	90%	75%	69%	75%	80%	74%	78%	NA	NA	
E42b	Night-time ward moves for patients flagged with dementia (23:00 - 07:00) : From all other wards	23%	12%	23%	27%	21%	19%	10%	25%	31%	25%	20%	26%	22%	NA	NA	
E43	Documentation Audit: % patients with dementia with Knowing Me document	78.7%	73.1%	65.8%	71.2%	90.5%	90.1%	97.5%	94.9%	97.8%	92.4%	93.3%	88.8%	86.8%	75%	75%	
E53	% reduction in admission of frail older patients *NEW*																
	Stroke care																
E26	% CT scans undertaken within 12 hours	98.6%	98.8%	97.7%	94.4%	95.5%	97.7%	96.9%	95.1%	90.2%	97.6%	93.6%		95.5%	95%	95%	
E27	% Stroke thrombolysis within 60 minutes of hospital arrival	83.3%	54.5%	52.9%	71.4%	71.4%	69.2%	100.0%	77.8%	81.8%	77.8%	88.9%		72.5%	95%	95%	
E28	% Swallow screen for stroke patients within 4 hours of admission	82.0%	85.3%	79.2%	93.9%	92.2%	87.3%	94.9%	87.9%	83.3%	87.8%	71.8%		87.1%	95%	95%	
E29	% of stroke patients admitted to stroke unit within 4 hours of admission	68.1%	73.8%	70.9%	77.5%	78.8%	70.1%	70.3%	76.8%	74.4%	75.0%	72.3%		72.8%	90%	90%	
E30	% high risk TIA patients seen within 24 hours	33.3%	0.0%	37.5%	20.0%	50.0%	33.3%	5.0%	8.3%	15.4%	7.7%	0.0%		17.0%	60%	60%	
	Ensure active engagement with research																
E21	Patients recruited to interventional studies within CRN portfolio	19	14	17	23	62	22	7	25	34	21	31	28	190	tbc	tbc	
E22	Patients recruited to observational studies within CRN portfolio	152	369	109	119	34	252	47	91	44	24	43	96	696	tbc	tbc	
E23	Local Clinical Research Network (LCRN) Score	741	1446	569	670	801	1124	242	594	528	312	492	622	5953	5223	6268	
	Data Quality																
E24	NHS IC Data validity summary (YTD)	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9		99.9	99.9	99.9	
E37	% inpatients with electronic discharge summaries produced	94.3%	93.3%	94.3%	93.9%	93.3%	94.6%	93.2%	92.7%	93.4%	92.6%	91.5%	92.2%	93.2%	94.2%	94.2%	
	Mental Health Care *NEW*																
E54	Improving services for people with mental health needs who present in A&E *NEW*																

QUALITY SCORECARD

JANUARY 2018

		FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	YTD Actual	YTD Target	Target	Trend
SAFETY																	
	Safety domain score (Patient Aggregate Safety Score - PASS)	2.36	2..12	2.36	2.30	2.33	2.33	2.00	2.19	2.13	2.31	2.28	2.11	2.00			
	Safer staffing																
S36	Safer Staffing: Average fill rate - registered nurses/ midwives (day shifts)	94.0%	94.0%	97.3%	97.1%	97.6%	96.2%	94.2%	94.0%	91.7%	94.3%	94.1%	95.6%	95.2%	95%	95%	
S37	Safer Staffing: Average fill rate - registered nurses/ midwives (night shifts)	95.9%	96.5%	97.7%	98.1%	98.4%	97.0%	94.0%	94.9%	91.2%	95.1%	93.7%	97.1%	95.7%	95%	95%	
S38	Safer Staffing: Average fill rate - care staff (day shifts)	90.2%	90.5%	95.4%	92.9%	95.3%	94.8%	93.4%	94.3%	90.5%	92.7%	93.6%	93.8%	93.6%	95%	95%	
S39	Safer Staffing: Average fill rate - care staff (night shifts)	91.3%	92.4%	96.2%	94.6%	95.2%	96.4%	92.4%	93.8%	91.2%	94.4%	93.3%	95.8%	94.4%	95%	95%	
S41	Care Hours Per Patient Day (CHPPD)	6.30	6.60	6.80	6.60	6.80	6.80	6.90	7.07	6.43	6.50	6.40	6.40	6.70	tbc	tbc	
	NHS safety thermometer																
S02	Safety Thermometer: % of patients harm-free	94.6%	95.5%	94.5%	95.8%	98.2%	96.9%	95.5%	95.5%	94.4%	92.9%	92.8%	94.4%	94.8%	95.70%	95.70%	
S03	Safety Thermometer: % of patients with no new harms	98.8%	98.8%	98.7%	98.7%	98.7%	98.9%	98.7%	98.8%	98.4%	97.1%	97.5%	97.9%	98.4%	99%	99%	
S29	% of patients with catheters and UTIs where best practice protocol was not followed.	0.00%	0.22%	0.23%	0.0%	0.0%	0.0%	0.0%	0.0%	0.11%	0.23%	0.0%	0.0%	0.06%	0.06%	0.06%	
	Monitoring of clinical incidents																
S04	Total incidents	782	715	728	847	775	721	742	686	799	769	759	825	7651	6770-9150	8122 - 10988	
S05	Total moderate, severe or death incidents	9	18	8	12	14	9	18	12	18	22	14	18	145	128	153	
S06	Total serious incidents (SIRIs)	0	3	3	5	8	1	5	6	2	4	10	6	50	50	60	
S07	Number of outstanding CAS alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Improve safety of prescribing																
S08	Total incidents involving drug/prescribing errors	79	85	71	104	83	85	88	73	92	85	82	88	851	880-1190	1056 - 1428	
S09	Moderate/severe incidents involving drug/prescribing errors	0	0	1	1	0	1	2	0	0	0	1	1	7	4	5	
	Reduce incidence of healthcare acquired infections																
S14	Number of hospital attributable MRSA cases	0	0	0	0	0	0	0	0	0	0	1	1	2	0	0	
S15	Number of hospital C.diff cases	4	4	0	3	3	4	4	1	2	3	1	6	27	33	39	
S28	Number of C. diff cases where a lapse in the quality of care was noted	2	3	0	2	1	1	4	1	0	2	1	4	16	13	16	
S16	Number of reportable MSSA bacteraemia cases	13	7	9	6	7	5	12	9	9	9	8	6	74	85	102	
S16a	Number of hosptial attributable MSSA bacteraemia cases	3	1	3	2	1	1	3	2	3	2	2	1	19	tbc	tbc	
S17	Number of reportable E.coli cases	33	40	30	28	27	39	49	31	38	36	25	35	303	313	375	
S17a	Number of hospital attributable E.coli cases		1	8	5	3	5	7	3	6	6	6	8	49	tbc	tbc	

QUALITY SCORECARD

JANUARY 2018

		FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	YTD Actual	YTD Target	Target	Trend
	Improve theatre safety for patients																
S18	Full compliance with WHO Surgical Safety Checklist	100%	100%	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	100%	
S19	NEVER events	0	0	1	0	0	0	0	1	0	0	0	0	2	0	0	
S30	SSIs: Total hip replacement (YTD is rolling 12 months)	3.0%		0.6%			2.5%							1.5%	1.10%	1.1%	
S33	SSIs: Total knee replacement (YTD is rolling 12 months)	3.4%		2.0%			4.1%							3.0%	1.50%	1.5%	
S34	SSIs: Large bowel surgery (YTD is rolling 12 months)	9.7%		9.8%			15.0%							12.3%	12%	12%	
S35	SSIs: Breast surgery (YTD is rolling 12 months)	6.2%		6.3%			5.2%							5.8%	3.80%	3.80%	
	Reduce number of falls in hospital																
S49	All falls	157	143	137	141	152	136	129	105	133	134	160	176	1403	1210	1452	
S21	Falls resulting in harm	36	29	34	37	44	36	39	31	43	38	48	46	396	376	451	
S22	Falls resulting in severe harm or death	1	0	0	0	1	0	0	1	0	0	0	0	2	1	1	
S40	Repeat falls	9	4	8	9	9	7	12	3	12	9	7	8	84	81	97	
S23	Falls assessment within 24hrs of admission (Surgery only)	84.8%	92.2%	88%	83%	95%	83%	91%	91%	89%	88%	95%	93%	90%	80%	80%	
S24	Avoidable falls identified on the Safety Thermometer	0.33%	0.22%	0.69%	0.34%	0.34%	0.33%	0.32%	0.34%	0.87%	0.47%	0.65%	0.87%	0.52%	0.65%	0.65%	
	Pressure ulcers																
S25	Grade 2 pressure ulcers	26	18	18	23	15								56	39	156	
S26	Grade 3 & 4 pressure ulcers	0	2	1	1	2								4	6	23	
S49	Grade 2+ pressure ulcers			19	24	25	16	17	25	33	52	46	43	300	200	240	
	Other safety metrics																
S11	VTE Assessment Compliance	95.2%	93.7%	95.0%	93.3%	94.7%	94.2%	94.9%	94.1%	94.9%	93.8%	93.0%	93.9%	94.2%	95.30%	95.30%	
	Medicines Optimisation *NEW*																
S44	Antimicrobial stewardship and consumption: 2% Reduction in overall antibiotic consumption *NEW*			11.5%	4.2%	10.6%	9.8%	3.3%	3.5%	8.4%	0.5%	-2.4%		5.0%	-2.0%	-2.0%	
S45	Antimicrobial stewardship and consumption: 1% reduction in the use of carbapenems *NEW*			-13.0%	-2.0%	-5.0%	20.0%	42.0%	10.0%	13.0%	-24.0%	-7.6%		4.0%	-1.0%	-1.0%	
S46	Antimicrobial stewardship and consumption: 1% reduction in the use of Tazocin *NEW*			-23.0%	-69.7%	-67.7%	-36.1%	-26.0%	-1.0%	-43.0%	-37.0%	-44.0%		-39.0%	-1.0%	-1.0%	
S47	Focus on anticoagulants: Patients on Direct Oral Anticoagulants (NOACs) receiving counselling *NEW*			35.0%	36.0%	49.0%	52.0%	50.0%	49.0%	56.0%	52.0%	46.0%		47.0%	50.0%	50.0%	
S48	Focus on anticoagulants: Patients with correct prophylaxis prescribed *NEW*				94.0%									94.0%	100.0%	100.0%	

QUALITY SCORECARD

JANUARY 2018

		FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	YTD Actual	YTD Target	Target	Trend
EXPERIENCE																	
	Experience domain score	2.13	2.19	2.39	2.35	2.39	2.13	2.26	2.48	2.39	2.52	2.52	2.52	2.39			
	Friends and Family Test																
X38	Trust Friends and Family Recommend %: Inpatient	96.6%	96.7%	96.9%	96.9%	96.8%	96.7%	96.9%	96.7%	96.7%	97.0%	95.7%	97.0%	96.8%	97%	97%	
X39	Trust Friends and Family Recommend %: A&E	88.0%	86.6%	84.6%	84.1%	85.6%	84.8%	84.8%	84.0%	85.5%	88.1%	84.5%	88.0%	85.5%	93%	93%	
X40	Maternity Friends and Family Recommend %: Antenatal care (36 weeks)	100.0%	100.0%	100.0%	95.2%	96.3%	95.5%	100.0%	100.0%	96.6%	100.0%	89.5%	100.0%	97.3%	97%	97%	
X41	Maternity Friends and Family Recommend %: Delivery care	100.0%	99.1%	98.8%	98.2%	96.3%	97.9%	97.2%	96.1%	97.5%	98.5%	97.9%	98.9%	97.8%	97%	97%	
X42	Maternity Friends and Family Recommend %: Postnatal ward	100.0%	99.1%	98.8%	98.2%	96.3%	97.9%	97.2%	96.1%	100.0%	98.5%	97.9%	98.9%	97.8%	97%	97%	
X43	Maternity Friends and Family Recommend %: Postnatal community care	100.0%	100.0%	100.0%	100.0%	100.0%	97.3%	96.2%	100.0%	97.5%	100.0%	100.0%	100.0%	98.6%	97%	97%	
X44	Trust Friends and Family Recommend %: Outpatient	96.3%	97.9%	96.8%	96.1%	97.5%	96.4%	96.8%	97.4%	97.1%	97.2%	97.2%	97.7%	97.0%	97%	97%	
	Friends and Family Test response rates																
X24	Trust Friends and Family Response Rate: Inpatient	30.7%	31.0%	31.8%	35.6%	36.9%	32.0%	41.9%	35.4%	42.2%	41.8%	35.2%	34.5%	37.3%	40%	40%	
X25	Trust Friends and Family Response Rate: A&E	8.7%	8.4%	9.0%	9.3%	8.2%	9.9%	11.3%	8.1%	11.6%	13.6%	11.0%	9.1%	10.1%	23%	23%	
X33	Maternity Friends and Family Response Rate: Delivery care	38.9%	56.7%	42.8%	45.4%	34.2%	33.6%	33.9%	58.5%	80.5%	65.2%	39.9%	87.9%	52.4%	40%	40%	
	Reduction in patients suffering a bad experience dealing with the Trust																
X08	Percentage of re-booked outpatient appointments	11.4%	12.1%	12.7%	11.8%	12.5%	13.0%	12.1%	12.4%	12.6%	11.9%	13.0%	12.4%	12.2%	7.80%	7.80%	
X09	Clinics cancelled with less than 6 weeks notice for annual/study leave	15	28	17	12	15	71	70	40	26	23	20	44	338	232	278	
X11	PALS contacts relating to appointment problems (pior % of total appts)	0.10%	0.10%	0.14%	0.09%	0.09%	0.09%	0.08%	0.09%	0.09%	0.09%	0.10%	0.10%	0.10%	0.08%	0.08%	
X12	Reduce patients cancelled on the day of surgery for non-clinical reasons	10	18	14	39	18	23	35	9	56	41	18	29	282	281	337	
X13	Breaches of mixed sex accommodation arrangements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Nutritional Assessment																
X14	Compliance with MUST tool after 24 hours	80.6%	83.8%	81.5%	83.5%	85.6%	86.8%	87.0%	88.3%	88.3%	87.4%	83.4%	83.0%	85.5%	80%	80%	
X15	Compliance with MUST tool after 7 days	98.6%	98.7%	98.1%	98.9%	98.9%	99.1%	99.5%	99.4%	99.2%	99.3%	98.8%	98.1%	98.9%	95%	95%	
	Cleanliness / PLACE Survey																
X16	Internal PLACE compliance : St Richard's Hospital	94%	95%	91%	93%	96%	90%	98%	96%	98%	95%	95%	96%	95%	95%	95%	
X17	Internal PLACE compliance : Worthing Hospital	95%	99%	97%	96%	95%	96%	97%	96%	95%	94%	96%	98%	96%	95%	95%	
	Improve our customer service and become a more caring organisation																
X18	Number of complaints	44	46	35	47	30	44	40	38	32	42	30	34	372	475	570	
X19	Complaints where staff attitude or behaviour is an issue	3	5	4	8	4	5	2	4	6	2	3	1	39	45	54	
X20	Complaints where staff communication is an issue	8	5	2	0	2	6	7	1	1	2	0	2	23	41	49	
X21	Complaints about nursing	4	2	5	3	4	4	5	0	5	9	2	2	39	33	39	
	Staff engagement (indicators/targets not yet agreed) *NEW*																
X47	Local staff engagement score: % of staff agree they can make an improvement *NEW*																
X48	PFIS Health Check *NEW*																
X49	Staff wellbeing programme: % uptake in flu vaccinations for front-line staff *starts Oct-17*																
	EMERGING PROGRAMMES (indicators/targets not yet agreed) *NEW*																
X52	Workforce Transformation Plan *NEW*																

SAFER STAFFING SCORECARD - Registered Nurses

January 2018

	Shift	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD Actual	Trend
WSHFT	**Day**	**95.4%**	**94.0%**	**94.0%**	**97.3%**	**97.1%**	**97.6%**	**96.2%**	**94.2%**	**94.0%**	**91.7%**	**94.3%**	**94.1%**	**95.6%**	**95.2%**	
	Night	**96.1%**	**95.9%**	**96.5%**	**97.7%**	**98.1%**	**98.4%**	**97.0%**	**94.0%**	**94.9%**	**91.2%**	**95.1%**	**93.7%**	**97.1%**	**95.7%**	
Acute Cardiac Unit	Day	95.5%	93.6%	93.5%	98.3%	97.4%	100.0%	98.7%	97.4%	95.3%	95.2%	95.7%	91.3%	98.7%	96.8%	
	Night	96.8%	92.9%	92.7%	99.2%	99.2%	100.0%	100.0%	97.6%	97.5%	96.0%	95.0%	92.7%	98.4%	97.5%	
Ashling	Day	92.5%	85.7%	92.1%	94.8%	99.3%	97.0%	97.8%	91.8%	95.2%	86.7%	95.2%	95.3%	96.8%	95.0%	
	Night	80.6%	71.4%	80.6%	91.7%	100.0%	95.0%	91.9%	82.3%	91.7%	75.8%	91.7%	91.9%	91.9%	90.4%	
Barrow	Day	96.8%	94.0%	95.7%	96.9%	96.5%	98.6%	97.3%	93.8%	96.1%	95.2%	90.8%	96.8%	93.5%	95.6%	
	Night	96.8%	100.0%	100.0%	100.0%	97.6%	99.2%	99.2%	97.6%	98.3%	97.6%	98.3%	95.2%	96.8%	98.0%	
Becket	Day	97.7%	96.4%	97.1%	98.0%	97.7%	95.3%	95.2%	94.5%	96.0%	93.2%	97.3%	100.0%	98.1%	96.5%	
	Night	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.4%	100.0%	96.8%	98.3%	100.0%	100.0%	99.3%	
Beeding	Day	100.0%	100.0%	97.7%	100.0%	92.1%	88.0%	87.7%	100.0%	97.4%	100.0%	97.3%	93.3%	94.9%	94.9%	
	Night	100.0%	100.0%	98.7%	95.1%	83.9%	89.9%	86.8%	100.0%	95.8%	100.0%	94.7%	93.8%	97.3%	93.4%	
Bluefin	Day	100.0%	95.5%	99.2%	100.0%	99.1%	91.4%	96.6%	97.2%	99.0%	100.0%	98.4%	100.0%	100.0%	98.3%	
	Night	99.2%	100.0%	100.0%	100.0%	97.3%	99.0%	99.1%	100.0%	100.0%	96.7%	95.9%	98.4%	97.6%	98.3%	
Bosham	Day	98.0%	95.5%	91.1%	97.9%	100.0%	98.8%	97.6%	97.2%	95.8%	91.1%	99.6%	97.6%	98.4%	97.4%	
	Night	98.4%	91.1%	88.7%	96.7%	100.0%	96.7%	95.2%	95.2%	91.7%	83.9%	100.0%	96.8%	96.8%	95.3%	
Botolphs	Day	95.9%	94.3%	91.9%	95.4%	94.5%	93.5%	94.1%	93.4%	95.4%	93.0%	96.6%	94.8%	95.2%	94.6%	
	Night	95.7%	98.8%	100.0%	100.0%	100.0%	95.6%	95.7%	94.6%	100.0%	92.5%	96.7%	92.5%	94.6%	96.2%	
Boxgrove	Day	94.0%	91.5%	97.2%	99.6%	98.4%	99.6%	97.6%	95.2%	96.7%	87.9%	91.3%	89.9%	98.0%	95.4%	
	Night	90.3%	85.7%	95.2%	100.0%	100.0%	100.0%	95.2%	90.3%	95.0%	83.9%	80.0%	80.6%	95.2%	92.0%	

SAFER STAFFING SCORECARD - Registered Nurses

January 2018

	Shift	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD Actual	Trend
WSHFT	**Day**	**95.4%**	**94.0%**	**94.0%**	**97.3%**	**97.1%**	**97.6%**	**96.2%**	**94.2%**	**94.0%**	**91.7%**	**94.3%**	**94.1%**	**95.6%**	**95.2%**	
	Night	**96.1%**	**95.9%**	**96.5%**	**97.7%**	**98.1%**	**98.4%**	**97.0%**	**94.0%**	**94.9%**	**91.2%**	**95.1%**	**93.7%**	**97.1%**	**95.7%**	
Buckingham	Day	91.8%	91.0%	87.1%	96.0%	93.8%	98.5%	95.7%	98.1%	98.5%	82.7%	90.6%	87.0%	80.4%	92.1%	
	Night	95.2%	100.0%	98.4%	100.0%	100.0%	100.0%	96.8%	100.0%	100.0%	100.0%	100.0%	98.4%	96.8%	99.2%	
Burlington	Day	87.3%	92.8%	88.2%	95.6%	95.3%	99.4%	98.2%	89.4%	95.1%	86.7%	87.2%	94.0%	91.2%	93.2%	
	Night	100.0%	98.2%	98.4%	96.7%	98.4%	100.0%	98.4%	96.8%	100.0%	96.8%	93.3%	98.4%	100.0%	97.9%	
Castle	Day	97.5%	96.4%	96.4%	99.3%	97.8%	100.0%	93.5%	96.1%	96.7%	97.1%	96.3%	96.8%	94.3%	96.8%	
	Night	94.6%	98.8%	98.9%	98.9%	96.8%	98.9%	98.9%	91.4%	93.3%	86.0%	92.2%	95.7%	93.5%	94.6%	
Chichester Emergency Floor	Day	93.7%	92.1%	92.5%	95.8%	98.3%	97.1%	94.7%	90.8%	87.5%	86.2%	93.0%	91.0%	98.1%	93.3%	
	Night	93.9%	91.7%	93.0%	96.8%	98.7%	96.4%	95.6%	87.3%	85.9%	84.6%	93.2%	92.5%	97.8%	92.9%	
Chilgrove	Day	99.5%	99.0%	98.1%	99.0%	100.0%	98.5%	98.1%	96.7%	96.1%	94.8%	99.0%	98.1%	100.0%	98.0%	
	Night	98.4%	96.4%	96.8%	96.7%	100.0%	96.7%	96.8%	88.7%	90.0%	87.1%	98.3%	98.4%	100.0%	95.3%	
Chiltington	Day	96.8%	95.5%	96.8%	98.8%	98.8%	97.9%	94.0%	91.1%	94.2%	91.1%	93.3%	93.1%	95.2%	94.7%	
	Night	100.0%	100.0%	98.4%	100.0%	100.0%	98.3%	96.8%	98.4%	98.3%	95.2%	98.3%	96.8%	98.4%	98.0%	
Clapham	Day	93.5%	96.4%	93.1%	97.9%	99.2%	97.5%	92.3%	92.7%	91.7%	88.7%	95.8%	95.6%	93.5%	94.5%	
	Night	100.0%	96.4%	100.0%	96.7%	98.4%	96.7%	96.8%	93.5%	96.7%	87.1%	93.3%	95.2%	98.4%	95.3%	
Coombes	Day	96.0%	93.8%	94.4%	98.8%	97.2%	95.4%	91.1%	90.7%	90.8%	93.5%	93.3%	96.0%	89.5%	93.6%	
	Night	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	91.9%	91.9%	95.0%	96.8%	98.3%	96.8%	96.8%	96.7%	
Courtlands	Day	97.1%	96.1%	91.9%	97.7%	96.5%	97.3%	94.5%	92.6%	92.7%	92.6%	95.0%	95.2%	95.2%	94.9%	
	Night	100.0%	99.3%	97.4%	99.3%	96.1%	100.0%	98.1%	96.1%	94.7%	92.9%	96.0%	94.2%	95.5%	96.3%	
Ditchling	Day	95.9%	96.4%	95.9%	99.0%	96.3%	98.1%	98.6%	94.9%	91.9%	91.7%	90.5%	94.5%	92.2%	94.8%	
	Night	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	98.4%	100.0%	98.3%	95.2%	98.3%	100.0%	100.0%	99.0%	
Durrington	Day	94.0%	92.9%	94.9%	98.1%	96.3%	97.1%	96.8%	93.5%	95.7%	91.7%	94.3%	96.8%	93.5%	95.4%	
	Night	93.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.4%	98.3%	98.4%	95.0%	98.4%	100.0%	98.9%	
Eartham	Day	91.1%	92.4%	95.6%	97.5%	93.1%	98.8%	96.8%	96.0%	93.8%	91.5%	92.1%	94.8%	96.8%	95.1%	
	Night	97.8%	100.0%	100.0%	100.0%	98.9%	100.0%	98.9%	98.9%	100.0%	97.8%	96.7%	98.9%	100.0%	99.0%	
Eastbrook	Day	95.7%	96.2%	92.2%	97.3%	94.0%	100.0%	97.4%	97.0%	93.7%	91.7%	89.7%	91.2%	92.2%	94.4%	
	Night	98.4%	100.0%	100.0%	100.0%	98.4%	100.0%	98.4%	96.8%	100.0%	96.8%	100.0%	98.4%	98.4%	98.7%	

SAFER STAFFING SCORECARD - Registered Nurses

January 2018

	Shift	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD Actual	Trend
WSHFT	**Day**	**95.4%**	**94.0%**	**94.0%**	**97.3%**	**97.1%**	**97.6%**	**96.2%**	**94.2%**	**94.0%**	**91.7%**	**94.3%**	**94.1%**	**95.6%**	**95.2%**	
	Night	**96.1%**	**95.9%**	**96.5%**	**97.7%**	**98.1%**	**98.4%**	**97.0%**	**94.0%**	**94.9%**	**91.2%**	**95.1%**	**93.7%**	**97.1%**	**95.7%**	
Emergency Floor Worthing	Day	94.2%	91.4%	93.5%	95.8%	95.2%	96.1%	95.7%	92.7%	91.0%	90.9%	89.9%	93.4%	91.1%	93.2%	
	Night	96.8%	98.5%	98.4%	98.9%	98.4%	99.7%	96.8%	93.5%	94.7%	86.6%	95.0%	91.1%	95.2%	95.0%	
Enhanced Surgical Care Unit	Day	96.0%	99.1%	100.0%	99.2%	98.4%	99.2%	100.0%	100.0%	99.2%	100.0%	100.0%	99.2%	100.0%	99.5%	
	Night	96.8%	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%	100.0%	93.3%	96.8%	100.0%	96.8%	100.0%	98.4%	
Erringham	Day	97.7%	94.9%	90.8%	97.6%	94.0%	96.2%	91.7%	94.0%	94.3%	94.5%	94.8%	97.7%	95.4%	95.0%	
	Night	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%	100.0%	100.0%	93.5%	98.3%	98.4%	100.0%	98.7%	
Fishbourne	Day	94.4%	93.8%	92.7%	97.1%	91.5%	97.5%	99.6%	98.8%	93.3%	97.2%	96.7%	88.7%	98.8%	95.9%	
	Night	88.7%	89.3%	91.9%	95.0%	85.5%	100.0%	100.0%	100.0%	86.7%	100.0%	93.3%	79.0%	100.0%	94.0%	
Ford	Day	94.8%	92.5%	93.5%	94.3%	98.7%	99.3%	98.1%	95.2%	95.0%	92.9%	97.7%	95.5%	99.4%	96.6%	
	Night	91.4%	88.1%	90.3%	90.0%	98.9%	98.9%	96.8%	91.4%	92.2%	88.2%	94.4%	92.5%	97.8%	94.1%	
Howard Children's Unit	Day	100.0%	97.3%	96.7%	100.0%	100.0%	97.4%	100.0%	99.0%	99.0%	100.0%	97.5%	99.2%	100.0%	99.2%	
	Night	100.0%	98.2%	99.2%	90.5%	100.0%	93.4%	99.0%	96.9%	98.9%	99.2%	100.0%	99.2%	100.0%	97.8%	
Lavant	Day	91.4%	89.7%	91.4%	94.1%	99.3%	98.5%	97.1%	92.5%	93.7%	90.0%	95.9%	90.3%	96.1%	94.7%	
	Night	79.0%	80.4%	83.9%	91.7%	98.4%	96.7%	96.8%	83.9%	88.3%	83.9%	90.0%	82.3%	88.7%	90.0%	
Middleton	Day	96.4%	95.1%	95.2%	96.7%	97.6%	98.8%	96.0%	88.3%	92.5%	84.3%	92.5%	87.5%	97.6%	93.1%	
	Night	93.5%	91.1%	91.9%	95.0%	95.2%	100.0%	95.2%	64.5%	85.0%	66.1%	86.7%	77.4%	93.5%	85.8%	
Neonatal Unit	Day	98.9%	98.7%	96.3%	100.0%	100.0%	95.2%	100.0%	98.9%	98.6%	100.0%	100.0%	100.0%	97.6%	99.0%	
	Night	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	98.9%	100.0%	100.0%	94.7%	100.0%	97.6%	99.0%	
Petworth	Day	97.8%	96.4%	96.8%	99.4%	97.8%	100.0%	96.8%	91.4%	90.0%	90.3%	92.2%	94.1%	99.5%	95.2%	
	Night	96.8%	96.4%	100.0%	100.0%	100.0%	100.0%	96.8%	91.9%	88.3%	90.3%	90.0%	96.8%	98.4%	95.3%	
Selsey	Day	97.9%	95.8%	92.5%	96.5%	100.0%	99.6%	97.9%	95.4%	93.1%	85.4%	95.7%	90.8%	99.2%	95.3%	
	Night	97.8%	96.4%	92.5%	96.7%	100.0%	100.0%	97.8%	93.5%	92.2%	81.7%	94.4%	89.2%	97.8%	94.3%	
Wittering	Day	98.4%	98.7%	96.0%	99.6%	100.0%	98.8%	96.8%	96.4%	95.0%	94.8%	96.3%	97.6%	98.8%	97.4%	
	Night	100.0%	98.2%	95.2%	100.0%	100.0%	96.7%	93.5%	93.5%	96.7%	91.9%	93.3%	95.2%	98.4%	95.9%	

SAFER STAFFING SCORECARD - Care Staff

January 2018

	Shift	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD Actual	Trend
WSHFT	**Day**	**91.7%**	**90.2%**	**90.5%**	**95.4%**	**92.9%**	**95.3%**	**94.8%**	**93.4%**	**94.3%**	**90.5%**	**92.7%**	**93.6%**	**93.8%**	**93.6%**	
	Night	**92.5%**	**91.3%**	**92.4%**	**96.2%**	**94.6%**	**95.2%**	**96.4%**	**92.4%**	**93.8%**	**91.2%**	**95.2%**	**93.3%**	**95.8%**	**94.4%**	
Acute Cardiac Unit	Day	85.8%	85.0%	88.4%	92.7%	87.1%	96.7%	93.5%	91.0%	94.0%	88.4%	94.7%	91.0%	95.5%	92.4%	
	Night	64.5%	64.3%	74.2%	90.0%	64.5%	90.0%	90.3%	74.2%	86.7%	67.7%	76.7%	90.3%	83.9%	81.4%	
Ashling	Day	91.7%	96.4%	97.2%	97.6%	94.9%	97.1%	96.8%	91.7%	97.6%	93.5%	95.7%	92.2%	98.6%	95.6%	
	Night	85.5%	96.4%	98.4%	95.0%	91.9%	95.0%	96.8%	85.5%	95.0%	88.7%	91.7%	85.5%	98.4%	92.3%	
Barrow	Day	91.1%	86.0%	83.6%	92.8%	87.4%	93.3%	92.2%	95.2%	91.4%	88.2%	89.7%	94.1%	90.1%	91.4%	
	Night	96.8%	95.5%	96.0%	97.5%	97.6%	97.5%	96.8%	97.6%	95.8%	94.4%	99.2%	98.4%	98.4%	97.3%	
Becket	Day	76.0%	89.4%	85.7%	95.7%	85.7%	93.7%	93.8%	87.8%	97.2%	83.6%	90.8%	97.2%	92.5%	91.7%	
	Night	88.7%	96.4%	95.2%	98.3%	91.9%	95.0%	96.8%	93.5%	98.3%	96.8%	100.0%	96.8%	95.2%	96.2%	
Beeding	Day	100.0%	100.0%	92.6%	100.0%	96.8%	97.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.4%	
	Night	100.0%	100.0%	95.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.9%	97.0%	100.0%	99.0%	
Bluefin	Day	96.8%	85.7%	89.7%	100.0%	100.0%	100.0%	90.5%	94.3%	100.0%	100.0%	83.1%	100.0%	100.0%	95.5%	
	Night	96.6%	96.3%	77.8%	72.2%	95.5%	90.3%	96.8%	87.1%	92.9%	100.0%	90.3%	96.8%	93.3%	92.2%	
Bosham	Day	94.2%	95.7%	96.1%	99.3%	100.0%	99.3%	92.3%	92.9%	91.3%	93.5%	96.7%	94.8%	97.4%	95.8%	
	Night	93.5%	96.4%	98.4%	100.0%	100.0%	98.3%	93.5%	90.3%	88.3%	95.2%	98.3%	96.8%	96.8%	95.8%	
Botolphs	Day	94.1%	89.3%	91.5%	93.8%	83.8%	93.9%	95.5%	93.0%	97.7%	90.0%	93.5%	91.8%	89.3%	92.2%	
	Night	93.5%	80.4%	85.5%	93.3%	91.9%	96.7%	90.3%	91.9%	96.7%	96.8%	98.3%	93.5%	91.9%	94.1%	
Boxgrove	Day	89.4%	89.8%	91.2%	93.8%	95.9%	99.5%	96.3%	95.4%	94.3%	93.5%	95.7%	93.1%	95.9%	95.3%	
	Night	80.6%	80.4%	85.5%	91.7%	91.9%	100.0%	95.2%	90.3%	86.7%	93.5%	91.7%	82.3%	91.9%	91.5%	

SAFER STAFFING SCORECARD - Care Staff

January 2018

	Shift	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD Actual	Trend
WSHFT	**Day**	**91.7%**	**90.2%**	**90.5%**	**95.4%**	**92.9%**	**95.3%**	**94.8%**	**93.4%**	**94.3%**	**90.5%**	**92.7%**	**93.6%**	**93.8%**	**93.6%**	
	Night	**92.5%**	**91.3%**	**92.4%**	**96.2%**	**94.6%**	**95.2%**	**96.4%**	**92.4%**	**93.8%**	**91.2%**	**95.2%**	**93.3%**	**95.8%**	**94.4%**	
Buckingham	Day	82.3%	88.5%	87.1%	98.8%	89.0%	95.6%	95.2%	93.9%	96.2%	82.9%	86.7%	88.5%	82.2%	90.9%	
	Night	91.9%	96.4%	98.4%	98.3%	100.0%	95.0%	98.4%	96.8%	100.0%	95.2%	98.3%	95.2%	95.2%	97.2%	
Burlington	Day	92.9%	94.5%	95.8%	98.5%	90.9%	90.6%	88.6%	91.6%	86.2%	91.4%	87.7%	97.1%	96.5%	91.9%	
	Night	87.1%	96.4%	96.8%	100.0%	100.0%	100.0%	100.0%	93.5%	100.0%	90.3%	96.7%	96.8%	100.0%	97.7%	
Castle	Day	89.9%	94.9%	90.3%	98.1%	93.5%	96.2%	94.5%	94.0%	95.2%	94.0%	91.4%	97.2%	95.9%	95.0%	
	Night	96.8%	98.2%	95.2%	96.7%	90.3%	100.0%	96.8%	95.2%	98.3%	98.4%	100.0%	91.9%	91.9%	95.9%	
Chichester Emergency Floor	Day	94.1%	88.2%	89.6%	96.4%	95.5%	97.5%	97.3%	96.0%	93.1%	89.0%	93.9%	89.3%	98.4%	94.6%	
	Night	87.7%	80.3%	83.7%	92.9%	90.5%	94.4%	94.5%	89.1%	87.2%	75.3%	80.3%	73.8%	94.6%	87.2%	
Chilgrove	Day	97.6%	98.2%	96.0%	95.0%	100.0%	99.2%	96.0%	90.3%	92.5%	83.1%	90.8%	96.0%	100.0%	94.3%	
	Night	98.4%	98.2%	98.4%	96.7%	100.0%	100.0%	96.8%	90.3%	91.7%	75.8%	91.7%	95.2%	100.0%	93.8%	
Chiltington	Day	87.6%	88.7%	84.9%	98.9%	96.2%	90.0%	91.4%	93.0%	96.1%	95.2%	90.0%	95.7%	95.7%	94.2%	
	Night	93.5%	96.4%	98.4%	100.0%	91.9%	91.7%	95.2%	88.7%	95.0%	95.2%	96.7%	95.2%	93.5%	94.3%	
Clapham	Day	95.9%	91.8%	87.1%	98.1%	90.8%	94.8%	91.2%	94.9%	97.1%	91.2%	89.0%	92.6%	83.9%	92.3%	
	Night	95.2%	89.3%	93.5%	98.3%	90.3%	95.0%	93.5%	91.9%	95.0%	93.5%	93.3%	90.3%	95.2%	93.6%	
Coombes	Day	84.4%	91.1%	89.2%	95.0%	89.8%	75.6%	91.9%	91.9%	95.6%	89.8%	91.7%	93.0%	96.2%	91.1%	
	Night	93.5%	98.2%	96.8%	96.7%	93.5%	85.0%	96.8%	93.5%	95.0%	96.8%	98.3%	98.4%	90.3%	94.4%	
Courtlands	Day	92.3%	96.4%	96.1%	93.3%	94.2%	96.0%	96.1%	96.8%	98.0%	92.3%	92.0%	94.2%	86.5%	93.9%	
	Night	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Ditchling	Day	87.1%	79.8%	94.1%	95.6%	87.1%	91.7%	90.3%	88.2%	88.3%	80.6%	90.6%	93.0%	93.0%	89.8%	
	Night	93.5%	91.1%	93.5%	96.7%	93.5%	91.7%	95.2%	96.8%	98.3%	98.4%	98.3%	95.2%	96.8%	96.1%	
Durrington	Day	86.3%	87.1%	89.5%	94.2%	91.9%	99.2%	97.6%	95.6%	94.2%	90.7%	93.8%	94.0%	93.1%	94.4%	
	Night	96.8%	94.6%	90.3%	96.7%	95.2%	91.7%	98.4%	96.8%	96.7%	93.5%	100.0%	93.5%	100.0%	96.2%	
Eartham	Day	93.5%	80.0%	75.5%	94.0%	83.2%	89.3%	95.5%	86.5%	89.3%	85.8%	91.3%	93.5%	80.6%	88.9%	
	Night	77.4%	89.3%	83.9%	86.7%	74.2%	96.7%	90.3%	87.1%	90.0%	90.3%	93.3%	100.0%	90.3%	89.9%	
Eastbrook	Day	96.1%	95.0%	87.1%	95.3%	85.8%	100.0%	97.4%	94.2%	97.3%	92.3%	90.7%	96.1%	90.3%	93.9%	
	Night	95.2%	98.2%	88.7%	96.7%	93.5%	95.0%	93.5%	96.8%	93.3%	98.4%	100.0%	96.8%	95.2%	95.9%	

SAFER STAFFING SCORECARD - Care Staff

January 2018

	Shift	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD Actual	Trend
WSHFT	**Day**	**91.7%**	**90.2%**	**90.5%**	**95.4%**	**92.9%**	**95.3%**	**94.8%**	**93.4%**	**94.3%**	**90.5%**	**92.7%**	**93.6%**	**93.8%**	**93.6%**	
	Night	**92.5%**	**91.3%**	**92.4%**	**96.2%**	**94.6%**	**95.2%**	**96.4%**	**92.4%**	**93.8%**	**91.2%**	**95.2%**	**93.3%**	**95.8%**	**94.4%**	
Emergency Floor Worthing	Day	95.2%	93.4%	92.7%	93.3%	91.9%	93.8%	93.1%	96.6%	96.5%	94.0%	93.7%	96.5%	94.2%	94.4%	
	Night	96.8%	96.1%	95.8%	98.7%	94.5%	95.7%	98.7%	98.7%	97.3%	95.2%	99.3%	98.7%	97.4%	97.4%	
Enhanced Surgical Care Unit	Day	98.4%	98.2%	99.2%	98.3%	95.2%	95.0%	99.2%	100.0%	100.0%	99.2%	99.2%	100.0%	98.4%	98.4%	
	Night	100.0%	92.9%	100.0%	96.7%	100.0%	90.0%	100.0%	96.8%	96.7%	100.0%	100.0%	96.8%	93.5%	97.1%	
Erringham	Day	89.0%	84.3%	87.1%	100.0%	90.3%	100.0%	91.0%	78.1%	85.3%	80.6%	76.0%	85.2%	74.8%	86.1%	
	Night	93.5%	91.1%	98.4%	100.0%	91.9%	100.0%	95.2%	91.9%	98.3%	100.0%	100.0%	93.5%	90.3%	96.1%	
Fishbourne	Day	90.3%	82.7%	95.2%	92.8%	98.4%	93.3%	96.8%	89.2%	93.3%	90.3%	95.0%	87.1%	98.9%	93.5%	
	Night	90.3%	76.8%	93.5%	98.3%	100.0%	86.7%	98.4%	82.3%	90.0%	85.5%	91.7%	79.0%	98.4%	91.0%	
Ford	Day	91.6%	77.9%	92.3%	96.0%	94.2%	96.0%	94.8%	93.5%	94.7%	91.6%	92.7%	92.9%	98.1%	94.4%	
	Night	90.3%	78.6%	91.9%	98.3%	93.5%	93.3%	95.2%	91.9%	93.3%	91.9%	88.3%	93.5%	96.8%	93.6%	
Howard Children's Unit	Day	100.0%	100.0%	96.8%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.5%	85.2%	97.6%	
	Night	100.0%	100.0%	74.2%	100.0%	0.0%	66.7%	100.0%	84.0%	73.3%	64.5%	93.3%	96.2%	92.0%	85.5%	
Lavant	Day	92.3%	88.8%	92.7%	92.1%	96.0%	97.5%	97.6%	93.5%	92.1%	92.7%	96.3%	89.9%	97.6%	94.5%	
	Night	85.5%	78.6%	87.1%	88.3%	87.1%	95.0%	95.2%	79.0%	80.0%	83.9%	90.0%	77.4%	95.2%	87.1%	
Middleton	Day	89.0%	94.3%	96.8%	98.0%	100.0%	99.3%	92.3%	92.9%	93.3%	80.0%	94.7%	91.0%	97.4%	93.9%	
	Night	85.5%	96.4%	96.8%	98.3%	100.0%	100.0%	95.2%	88.7%	95.0%	67.7%	90.0%	91.9%	98.4%	92.5%	
Neonatal Unit	Day	86.2%	96.2%	89.3%	100.0%	100.0%	82.6%	93.3%	100.0%	91.7%	100.0%	75.0%	92.3%	96.6%	93.8%	
	Night	82.1%	64.3%	96.4%	96.2%	100.0%	88.0%	100.0%	89.7%	87.5%	90.0%	89.5%	95.8%	93.5%	93.4%	
Petworth	Day	91.0%	92.1%	94.2%	92.7%	100.0%	98.0%	96.8%	98.1%	95.3%	96.8%	96.0%	97.4%	98.7%	97.0%	
	Night	91.9%	89.3%	91.9%	93.3%	100.0%	96.7%	93.5%	95.2%	95.0%	95.2%	91.7%	96.8%	98.4%	95.6%	
Selsey	Day	99.5%	93.0%	92.1%	94.6%	100.0%	98.4%	97.9%	93.2%	97.8%	93.2%	96.7%	99.0%	100.0%	97.1%	
	Night	100.0%	91.1%	91.9%	93.3%	100.0%	96.7%	96.8%	87.1%	96.7%	93.5%	93.3%	96.8%	100.0%	95.4%	
Wittering	Day	98.1%	92.9%	78.7%	94.0%	100.0%	99.3%	100.0%	93.5%	88.0%	80.6%	94.7%	91.6%	99.4%	94.1%	
	Night	98.4%	92.9%	79.0%	98.3%	100.0%	98.3%	100.0%	91.9%	85.0%	75.8%	95.0%	93.5%	100.0%	93.8%	

SAFER STAFFING SCORECARD - CHPPD

January 2018

	Care Hours Per Patient Day (CHPPD)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD Average	Trend
WSHFT	**Nurse**	**3.7**	**3.7**	**3.9**	**4.0**	**3.9**	**4.0**	**4.0**	**4.0**	**4.1**	**3.8**	**3.8**	**3.7**	**3.8**	**3.9**	
	Care	**2.6**	**2.6**	**2.7**	**2.8**	**2.7**	**2.8**	**2.8**	**2.9**	**3.0**	**2.7**	**2.7**	**2.7**	**2.7**	**2.8**	
	Overall	**6.3**	**6.3**	**6.6**	**6.8**	**6.6**	**6.8**	**6.8**	**6.9**	**7.1**	**6.4**	**6.5**	**6.4**	**6.4**	**6.7**	
Acute Cardiac Unit	Nurse	4.6	4.2	4.8	4.6	4.7	4.6	4.9	4.5	4.5	4.7	5.0	4.5	4.4	4.6	
	Care	1.7	1.6	1.9	1.9	1.7	1.9	2.0	1.7	1.9	1.8	2.0	1.9	1.8	1.9	
	Overall	6.2	5.7	6.8	6.5	6.3	6.5	6.9	6.2	6.4	6.4	7.0	6.5	6.3	6.5	
Ashling	Nurse	3.2	3.0	3.3	3.5	3.6	3.5	4.2	5.3	6.0	3.1	3.4	3.3	3.6	3.8	
	Care	2.6	2.8	2.9	2.9	2.8	2.8	3.5	4.4	5.0	2.7	2.8	2.6	3.0	3.1	
	Overall	5.8	5.8	6.1	6.4	6.4	6.3	7.7	9.7	11.0	5.8	6.2	5.9	6.5	6.9	
Barrow	Nurse	3.4	3.4	3.4	3.5	3.5	3.8	3.5	3.3	3.4	3.4	3.3	3.4	3.3	3.4	
	Care	3.2	3.1	3.1	3.3	3.2	3.6	3.3	3.4	3.2	3.2	3.2	3.4	3.2	3.3	
	Overall	6.6	6.5	6.5	6.8	6.7	7.4	6.8	6.7	6.6	6.5	6.5	6.8	6.6	6.7	
Becket	Nurse	4.5	4.4	4.5	4.5	4.5	4.5	4.5	4.4	4.4	4.2	4.4	4.6	4.3	4.4	
	Care	2.0	2.3	2.3	2.5	2.3	2.5	2.5	2.3	2.5	2.2	2.4	2.5	2.3	2.4	
	Overall	6.5	6.8	6.7	7.0	6.7	7.0	7.0	6.7	6.8	6.5	6.8	7.1	6.6	6.8	
Beeding	Nurse	8.3	7.8	9.3	7.2	5.2	4.3	4.8	5.3	4.8	7.4	5.1	5.8	8.1	5.6	
	Care	2.9	2.6	2.8	2.3	2.1	1.8	2.2	2.3	2.2	3.4	2.2	2.3	3.3	2.3	
	Overall	11.2	10.5	12.1	9.5	7.2	6.0	7.0	7.6	7.0	10.8	7.3	8.1	11.4	7.9	
Bluefin	Nurse	5.5	6.1	6.4	6.3	5.5	4.2	4.8	5.9	5.5	5.6	4.6	6.6	5.3	5.3	
	Care	1.3	1.4	1.3	1.1	1.1	1.4	1.5	2.3	1.8	1.4	1.5	1.9	1.3	1.5	
	Overall	6.8	7.5	7.7	7.4	6.6	5.6	6.3	8.2	7.2	7.0	6.1	8.5	6.5	6.8	
Bosham	Nurse	3.3	3.3	3.3	3.5	3.5	3.6	3.3	3.5	3.6	3.3	3.6	3.5	3.4	3.5	
	Care	2.2	2.3	2.5	2.5	2.4	2.5	2.2	2.3	2.4	2.4	2.5	2.4	2.4	2.4	
	Overall	5.4	5.6	5.8	6.0	5.9	6.1	5.6	5.9	6.0	5.7	6.1	5.9	5.8	5.9	
Botolphs	Nurse	3.6	3.6	3.9	3.9	3.8	4.2	3.5	3.8	3.8	3.5	3.7	3.6	3.6	3.7	
	Care	3.2	3.0	3.5	3.5	3.1	3.8	3.2	3.4	3.5	3.2	3.3	3.2	3.1	3.3	
	Overall	6.8	6.7	7.4	7.4	6.9	8.0	6.8	7.3	7.4	6.7	7.0	6.9	6.7	7.1	
Boxgrove	Nurse	2.9	2.8	3.1	3.1	3.0	3.1	3.0	3.7	3.0	2.7	2.8	2.7	3.0	3.0	
	Care	2.4	2.4	2.6	2.6	2.6	2.8	2.7	3.3	2.6	2.6	2.6	2.5	2.7	2.7	
	Overall	5.3	5.2	5.7	5.8	5.7	5.9	5.7	7.0	5.6	5.3	5.4	5.3	5.7	5.7	
Buckingham	Nurse	2.1	2.1	2.0	2.2	2.2	3.1	2.7	3.3	3.3	2.2	2.1	2.1	2.0	2.4	
	Care	1.6	1.7	1.7	1.9	1.7	2.5	2.3	2.6	2.7	1.8	1.7	1.8	1.7	2.0	
	Overall	3.6	3.7	3.7	4.1	3.9	5.6	5.1	5.9	6.0	4.0	3.8	3.9	3.6	4.4	
Burlington	Nurse	3.1	3.4	3.3	3.4	3.4	3.7	3.5	3.3	3.4	3.1	3.1	3.3	3.4	3.4	
	Care	2.4	2.6	2.6	2.6	2.5	2.5	2.4	2.5	2.4	2.4	2.3	2.5	2.6	2.5	
	Overall	5.5	6.0	5.9	6.1	5.9	6.2	5.8	5.8	5.8	5.5	5.5	5.9	6.0	5.8	
	Nurse	3.6	3.6	3.6	3.7	3.8	3.9	3.8	3.7	3.8	3.6	3.7	3.7	3.7	3.8	

SAFER STAFFING SCORECARD - CHPPD

January 2018

	Care Hours Per Patient Day (CHPPD)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD Average	Trend
WSHFT	**Nurse**	**3.7**	**3.7**	**3.9**	**4.0**	**3.9**	**4.0**	**4.0**	**4.0**	**4.1**	**3.8**	**3.8**	**3.7**	**3.8**	**3.9**	
	Care	**2.6**	**2.6**	**2.7**	**2.8**	**2.7**	**2.8**	**2.8**	**2.9**	**3.0**	**2.7**	**2.7**	**2.7**	**2.7**	**2.8**	
	Overall	**6.3**	**6.3**	**6.6**	**6.8**	**6.6**	**6.8**	**6.8**	**6.9**	**7.1**	**6.4**	**6.5**	**6.4**	**6.4**	**6.7**	
Castle	Care	2.6	2.7	2.6	2.8	2.7	2.9	2.9	2.8	2.9	2.7	2.7	2.8	2.8	2.8	
	Overall	6.2	6.3	6.2	6.5	6.5	6.8	6.7	6.5	6.7	6.4	6.4	6.5	6.5	6.5	
Chichester Emergency Floor	Nurse	4.0	4.0	4.6	4.6	4.5	4.4	4.6	4.7	4.5	4.4	4.8	4.1	4.5	4.5	
	Care	2.2	2.1	2.4	2.6	2.4	2.4	2.6	2.8	2.7	2.5	2.7	2.2	2.5	2.5	
	Overall	6.3	6.2	7.0	7.2	6.9	6.8	7.2	7.5	7.2	6.9	7.5	6.3	7.0	7.0	
Chilgrove	Nurse	3.7	3.7	3.8	5.1	6.0	4.2	5.3	5.0	4.3	4.5	4.3	5.2	5.1	4.9	
	Care	2.5	2.5	2.5	3.4	4.0	2.9	3.5	3.2	2.8	2.7	2.7	3.5	3.4	3.2	
	Overall	6.2	6.1	6.3	8.5	10.0	7.1	8.8	8.2	7.2	7.2	7.0	8.7	8.5	8.0	
Chiltington	Nurse	4.0	4.1	4.2	4.4	4.2	4.2	3.9	3.9	4.1	3.8	4.1	4.0	4.0	4.1	
	Care	2.9	3.1	3.1	3.5	3.2	3.1	3.1	3.1	3.3	3.2	3.2	3.3	3.2	3.2	
	Overall	6.9	7.2	7.2	7.9	7.4	7.4	7.0	7.0	7.4	7.0	7.4	7.3	7.1	7.3	
Clapham	Nurse	3.0	3.0	3.0	3.3	3.2	3.3	3.0	3.0	2.9	2.8	3.1	3.1	3.0	3.1	
	Care	2.7	2.6	2.6	3.0	2.6	2.9	2.7	2.7	2.8	2.6	2.6	2.7	2.4	2.7	
	Overall	5.8	5.6	5.6	6.3	5.8	6.2	5.7	5.7	5.7	5.4	5.8	5.8	5.4	5.8	
Coombes	Nurse	3.1	3.2	3.1	3.2	3.0	3.1	2.9	2.8	3.0	2.9	3.0	3.0	2.9	3.0	
	Care	2.2	2.5	2.4	2.5	2.3	2.0	2.3	2.3	2.5	2.3	2.4	2.4	2.4	2.3	
	Overall	5.3	5.7	5.5	5.7	5.3	5.2	5.2	5.2	5.4	5.2	5.4	5.3	5.3	5.3	

SAFER STAFFING SCORECARD - CHPPD

January 2018

	Care Hours Per Patient Day (CHPPD)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD Average	Trend
WSHFT	**Nurse**	**3.7**	**3.7**	**3.9**	**4.0**	**3.9**	**4.0**	**4.0**	**4.0**	**4.1**	**3.8**	**3.8**	**3.7**	**3.8**	**3.9**	
	Care	**2.6**	**2.6**	**2.7**	**2.8**	**2.7**	**2.8**	**2.8**	**2.9**	**3.0**	**2.7**	**2.7**	**2.7**	**2.7**	**2.8**	
	Overall	**6.3**	**6.3**	**6.6**	**6.8**	**6.6**	**6.8**	**6.8**	**6.9**	**7.1**	**6.4**	**6.5**	**6.4**	**6.4**	**6.7**	
Courtlands	Nurse	7.7	7.4	7.7	8.4	8.2	8.3	7.9	8.3	8.9	7.9	7.7	7.6	7.5	8.0	
	Care	2.4	2.4	2.6	2.7	2.7	2.7	2.6	2.9	3.1	2.6	2.5	2.5	2.3	2.6	
	Overall	10.1	9.8	10.3	11.1	10.9	11.0	10.6	11.2	12.0	10.5	10.2	10.1	9.7	10.7	
Ditchling	Nurse	3.0	3.0	3.2	3.2	3.2	3.1	3.1	3.0	2.9	2.9	2.9	3.1	3.0	3.0	
	Care	2.5	2.3	2.8	2.7	2.6	2.6	2.5	2.5	2.5	2.4	2.6	2.7	2.6	2.6	
	Overall	5.4	5.3	6.0	5.9	5.8	5.7	5.6	5.6	5.4	5.2	5.4	5.8	5.6	5.6	
Durrington	Nurse	3.1	3.1	3.2	3.3	3.2	3.2	3.2	3.1	3.1	3.0	3.1	3.2	3.1	3.2	
	Care	3.2	3.2	3.3	3.5	3.4	3.6	3.6	3.5	3.4	3.3	3.5	3.4	3.4	3.5	
	Overall	6.3	6.3	6.5	6.8	6.6	6.8	6.8	6.7	6.6	6.3	6.6	6.6	6.5	6.6	
Eartham	Nurse	4.1	4.1	4.2	4.3	4.2	4.5	4.3	4.3	4.5	4.3	4.2	4.2	4.4	4.3	
	Care	2.2	2.0	1.8	2.2	2.0	2.2	2.3	2.1	2.3	2.2	2.3	2.3	2.0	2.2	
	Overall	6.2	6.1	6.0	6.5	6.2	6.7	6.7	6.5	6.8	6.5	6.5	6.5	6.4	6.5	
Eastbrook	Nurse	3.3	3.3	3.3	3.4	3.3	3.6	3.3	3.4	6.0	4.4	3.2	3.2	3.4	3.6	
	Care	2.5	2.4	2.2	2.5	2.3	2.6	2.5	2.5	4.5	3.3	2.4	2.5	2.4	2.6	
	Overall	5.8	5.8	5.5	5.8	5.6	6.2	5.8	5.9	10.4	7.6	5.6	5.7	5.8	6.2	
Emergency Floor	Nurse	4.5	4.7	4.9	5.1	5.0	5.4	4.9	5.0	5.0	4.3	4.5	4.4	4.2	4.7	
	Care	3.8	3.9	4.1	4.1	4.0	4.4	4.0	4.3	4.4	3.8	3.9	3.8	3.6	4.0	
	Overall	8.2	8.6	9.0	9.2	9.0	9.7	8.9	9.3	9.3	8.1	8.4	8.2	7.8	8.8	
Enhanced Surgical Care Unit	Nurse	9.0	8.8	9.8	8.9	9.0	9.1	9.5	8.9	9.3	8.8	8.5	8.9	9.3	9.0	
	Care	9.3	8.6	9.7	8.8	8.8	8.6	9.5	8.9	9.5	8.8	8.5	8.9	9.0	8.9	
	Overall	18.3	17.5	19.5	17.7	17.8	17.7	19.0	17.8	18.8	17.6	17.0	17.8	18.3	17.9	
Erringham	Nurse	3.3	3.3	3.2	3.4	3.3	3.4	3.2	3.3	3.3	3.3	3.3	3.3	3.2	3.3	
	Care	2.4	2.3	2.4	2.7	2.4	2.8	2.5	2.2	2.4	2.3	2.2	2.3	2.0	2.4	
	Overall	5.6	5.6	5.6	6.0	5.7	6.2	5.7	5.6	5.7	5.6	5.5	5.7	5.2	5.7	
Fishbourne	Nurse	3.1	3.0	3.2	3.2	3.1	3.2	3.9	3.3	3.2	3.2	3.3	2.9	3.2	3.2	
	Care	2.4	2.1	2.6	2.5	2.7	2.4	3.1	2.4	2.6	2.4	2.6	2.2	2.6	2.5	
	Overall	5.4	5.1	5.8	5.8	5.8	5.5	7.0	5.7	5.8	5.6	5.9	5.1	5.8	5.8	

SAFER STAFFING SCORECARD - CHPPD

January 2018

	Care Hours Per Patient Day (CHPPD)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD Average	Trend
WSHFT	**Nurse**	**3.7**	**3.7**	**3.9**	**4.0**	**3.9**	**4.0**	**4.0**	**4.0**	**4.1**	**3.8**	**3.8**	**3.7**	**3.8**	**3.9**	
	Care	**2.6**	**2.6**	**2.7**	**2.8**	**2.7**	**2.8**	**2.8**	**2.9**	**3.0**	**2.7**	**2.7**	**2.7**	**2.7**	**2.8**	
	Overall	**6.3**	**6.3**	**6.6**	**6.8**	**6.6**	**6.8**	**6.8**	**6.9**	**7.1**	**6.4**	**6.5**	**6.4**	**6.4**	**6.7**	
Ford	Nurse	4.0	3.8	4.3	4.1	4.2	4.3	5.4	4.0	4.1	3.8	4.2	4.0	4.3	4.2	
	Care	2.1	1.8	2.3	2.3	2.2	2.2	2.8	2.1	2.2	2.1	2.1	2.1	2.3	2.2	
	Overall	6.1	5.6	6.6	6.4	6.4	6.5	8.1	6.1	6.2	5.9	6.3	6.1	6.6	6.4	
Howard Children's Unit	Nurse	7.8	6.3	6.4	8.2	7.6	7.5	7.0	7.0	6.9	8.4	5.4	6.6	5.8	6.9	
	Care	2.0	1.5	1.4	1.7	0.0	0.5	1.7	1.9	1.9	1.7	1.3	1.4	1.0	1.3	
	Overall	9.8	7.7	7.9	9.9	7.6	8.0	8.7	8.9	8.9	10.2	6.7	8.0	6.9	8.2	
Lavant	Nurse	3.1	3.1	3.3	3.3	3.5	3.5	4.5	3.5	3.7	3.3	3.7	3.3	3.3	3.5	
	Care	2.8	2.8	3.0	2.9	3.0	3.1	4.1	3.1	3.2	3.1	3.4	2.9	3.0	3.2	
	Overall	5.9	5.8	6.3	6.2	6.6	6.6	8.6	6.6	6.9	6.4	7.0	6.2	6.3	6.7	
Middleton	Nurse	3.0	3.0	3.1	3.2	3.1	3.1	3.1	3.6	3.1	2.7	3.0	2.8	3.1	3.1	
	Care	1.9	2.1	2.3	2.3	2.2	2.2	2.1	2.8	2.2	1.8	2.1	2.1	2.2	2.2	
	Overall	4.9	5.1	5.4	5.5	5.3	5.3	5.2	6.3	5.4	4.5	5.1	4.8	5.2	5.2	
Neonatal Unit	Nurse	7.3	7.7	8.5	10.9	7.7	5.1	6.4	5.8	8.3	8.0	6.4	6.3	6.0	6.7	
	Care	2.0	2.3	2.8	3.7	2.6	1.3	2.3	1.8	2.0	3.0	1.3	1.8	2.1	2.1	
	Overall	9.3	10.0	11.3	14.6	10.3	6.4	8.7	7.6	10.3	11.0	7.7	8.1	8.1	8.8	
Petworth	Nurse	3.3	3.2	3.3	3.3	3.3	3.3	3.5	3.1	11.2	3.1	3.1	3.2	3.3	3.5	
	Care	2.7	2.7	2.8	2.7	2.9	2.8	3.1	2.9	10.5	2.9	2.8	2.9	2.9	3.1	
	Overall	6.0	5.9	6.1	6.0	6.2	6.2	6.6	6.0	21.7	5.9	6.0	6.0	6.2	6.6	
Selsey	Nurse	4.0	4.5	4.7	4.8	3.7	3.9	3.6	3.8	3.7	3.3	3.7	3.5	3.7	3.7	
	Care	3.1	3.3	3.5	3.6	2.8	2.9	2.7	2.8	3.0	2.8	2.8	2.9	2.9	2.9	
	Overall	7.1	7.7	8.2	8.4	6.6	6.8	6.3	6.6	6.6	6.1	6.5	6.3	6.6	6.6	
Wittering	Nurse	3.3	3.5	3.3	3.7	3.5	3.3	3.2	3.6	3.4	3.4	3.6	3.2	3.4	3.4	
	Care	2.3	2.3	1.9	2.5	2.5	2.3	2.3	2.4	2.2	2.0	2.5	2.2	2.4	2.3	
	Overall	5.6	5.8	5.2	6.2	6.0	5.7	5.5	6.0	5.6	5.5	6.0	5.4	5.8	5.8	

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board

Date of Meeting: 1st March 2018 Agenda Item: 5.2

Title
Month 10, 2017-18 Performance Report
Responsible Executive Director
Jane Farrell, Chief Operating Officer
Prepared by
Giles Frost, Interim Director – Performance & Information
Status
Disclosable
Summary of Proposal
The paper sets out organisational compliance against national and local key performance metrics. The report summarises both in year and projected year end performance for Western Sussex Hospitals NHS Foundation Trust, as detailed in dedicated performance scorecards relating to Quality Board indicators aligned to the Quality Strategy, the NHSI Single Oversight Framework and, when relevant, other indicators. This paper describes performance on an exceptional basis determined by RAG rating, key national/regulatory significance, or in year trend analysis.
Implications for Quality of Care
Describes Quality Outcome KPIs
Link to Strategic Objectives/Board Assurance Framework
Trust Strategic Theme B - Provide the highest possible quality of care to our patients. This we will do through focusing on a range of measures to improve clinical effectiveness. *Trust Strategic Theme G* - Ensure the sustainability of our organisation by exceeding our national targets and financial performance and investing in appropriate infrastructure and capacity. *Trust Strategic Theme* F - Improve our performance against a range of quality, access and productivity measures through the introduction and spread of best practice throughout the organisation.
Financial Implications
Describes KPIs linked to financial performance
Human Resource Implications
Describes KPIs linked to workforce
Recommendation
The Board is asked to: NOTE the Trust position against the NHS Single Oversight Framework and STF Performance Monitoring targets.
Communication and Consultation
Not applicable
Appendices
Appendix 1: Key Performance Deliverables, Operational Performance Scorecard, Single Oversight Framework Scorecard, STF Performance Monitoring.

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board	Date: 1st March 2018
From: Jane Farrell, Chief Operating Officer	Agenda Item: 5.2
FOR INFORMATION	

WSHFT PERFORMANCE REPORT: MONTH 10, 2017/18

1. INTRODUCTION

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

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

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

1.3 Introduced as a condition of the National Sustainability and Transformation Programme and Funding, all Trusts have again submitted joint performance trajectories on the key areas of A&E, RTT, and Cancer. The detailed tracking of the Trust's performance against this trajectory is included in an Appendix of this report, and performance against the requirements is summarised for each relevant performance area. The trajectory has changed for 2017/18 based on specific criteria for all indicators, and diagnostic waiters are no longer included. The Sustainability and Transformation Fund payments in 2017/18 are indicatively based on A&E performance against trajectory only as per NHS Improvement guidance.

2. SUMMARY PERFORMANCE

2.1 Under the Single Oversight Framework, the Trust was compliant for Cancer against STF trajectory in January. RTT 18 week compliance and A&E 4 hour performance were below the national constitutional targets and STF trajectories for January. Diagnostics was compliant against national target in January.

2.2 Operationally January saw an increased level of A&E demand, and an increase in emergency admissions relative to the same period in 2017. Severe bed pressure was also experienced over the whole of January with occupancy of 96.9% on average:

- 10,650 A&E attendances compared to 10,502 in January 2017 (representing a 1.4% increase on this time last year). For patients aged 65 and over, there was an increase of 2.0%.
- 5,008 emergency admissions in January 2018 comparison to 4,715 in January 2017, an increase of 6.2%.
- Over 65 emergency admissions increased in January 2018 with a 3.3% increase compared to January 2017. Large increases in particular were seen in the 65 to 74 age group with a 17% increase from last year. Similarly, this age group saw an increase of 9.3% in A&E attendances over the same period.
- Formally reportable Delayed Transfers of Care totalled 3.07% for January 2018. This is an increase from the December figure of 2.73%.
- Average Inpatient Bed Occupancy reached 96.9% in January, an increase on December occupancy of 1%. The highest occupancy the trust reached during the month was 99.6% and the lowest was 94.1%. On average, 53 escalation beds per day were open across the trust during January, ranging from between 35 to 82 beds. This is an increase against the December figure by 23 per day, almost doubling the average. The Trust flexes the number of open beds to respond to fluctuations in demand.

3. KEY AREAS OF PERFORMANCE

3.1 A&E Compliance

3.1.1 The Trust was not compliant against the National target in January, with 89.55% of patients waiting less than four hours from arrival at A&E to admission, transfer, or discharge, a 4.1% improvement against December performance. Cumulative year to date performance for the Trust as of the end of January was 93.19%.

3.1.2 January performance of 89.55% was not compliant with the delivery requirements of the in-month Sustainability and Transformation Fund trajectory for January of 91.08%.

3.1.3 By site, SRH performance in January was 91.66%, with Worthing achieving 86.48%. Emergency admissions at SRH increased by 5.9% from January 2017. Worthing also saw an increase in emergency admissions of 6.5% over the same period, however for the 85+ age group this was an 8.7% increase.

3.1.4 Worthing saw an average of 519 beds occupied in January, which is an increase of 31 from 488 in December. Worthing had an average occupancy of 98.02% in January, reaching 99.81% on 2 occasions in the middle of January. Emergency medical length of stay at Worthing has also increased from 6.9 days in December to 7.6 days for patients in January. Occupancy at SRH averaged 95.5% in January 2018, with occupancy reaching 100% on one day at the start of January. For SRH, emergency medical length of stay has also increased from 6.1 days on average in December to 7.0 days for patients in January.

3.1.5 In January, delayed transfers of care (DTOC) increased to 3.07% compared to 2.73% in December. January DTOCs peaked at 4.14% on 22nd January. In real terms, this reflects an impact in 'lost' beds that fluctuated between a minimum of c19 beds and a high of c39 beds during the month.

3.1.6 Patients who were medically fit for discharge (MFFD) increased to 156 patients on average per day in January. The number of patients medically fit for discharge fluctuated between 116 patients on the 1st January and 178 on 31st January.

3.1.7 The number of adult patients (medical and surgical patients) with a LOS greater than 7 days at the trust increased by 16 patients on average per day (+3.3%) January 2018 compared to January 2017. This is 62 patients on average more than observed January 2016 (+13.7%)

3.1.8 The Trust saw an outbreak of flu throughout January, with a peak of 72 patients on the 21st January, 59 of which at Worthing hospital. As noted in the December report, this had a two-fold impact, both for the patients with flu, but also on constraining the residual bed availability and flexibility for non-flu patients. At time of writing (19th February), the number of patients in hospital who have been diagnosed with flu has reduced to 34 patients.

3.1.9 Nationally and regionally A&E delivery has continued to be challenging. National performance slightly improved to 85.3% for all attendances in January 2018 from 85.1% in December 2017 (+0.2%). Note these figures also include type 3 A&E attendances (such as minor injuries units) for non-acute providers. Regionally, compliance for the South of England was 86.4%, with NHS England South Surrey & Sussex Trusts (excluding WSHFT) generating aggregate compliance of 89.0%.

3.1.10 The publication of national data confirms that WSHFT with 89.5% was the 37th highest performing trust nationally in January 2018, and the 13th best performing trust in NHS South. Note that these figures include type 3 attendances for other non-acute providers in the Coastal West Sussex Acute Trust Footprint.

3.1.11 For type 1 attendances only (major A&E Unit activity, including the Trust's Emergency Floor activity), the Trust's performance for January 2018 was 88.8% and was ranked 19th best performing trust and 14th best performing for the year to date.

3.1.12 Forecasting forward, board members should note that February has shown further improvement first two weeks with improved non-elective flow. However, the half term week has seen a return to heightened levels of demand and bed pressure with 8% more over 65 A&E attendances compared to same period 2017. At the time of writing (19th Feb), A&E Trust performance is 92.82%.

3.1.13 The board should also note that further to revised NHSE guidance with regard to counting of A&E performance received January 2018, the Trust has stopped counting Bognor MIU activity directly in Trust monthly figures, and instead these are being allocated by the central NHS team post submission back to the Coastal West Sussex STP footprint. EF attendances are still reported to the unify team, but as part of a separate report. For consistency and continuity of comparison (and in accordance with daily reporting to NHSi), the A&E figures quoted above are inclusive of both Bognor and Emergency Floor activity.

3.2 Cancer

3.2.1 The Trust was provisionally aggregate compliant against the 62 day metrics relating to the Single Oversight Framework in January, and against 5 of the 7 wider cancer metrics (including metrics outside of the Single Oversight Framework) to the Trust in January.

3.2.2 The trust was non-compliant against the 62 day screening target with 85.45% against a target of 90%, but in aggregate terms remained compliant against 62 day urgent and screening pathways (as monitored as part of the STF and Single Oversight Framework) with 87.1% against 85% target. The board is reminded that there is approximately a six week lag from the end of the reporting period, to publication of final performance for cancer metrics.

3.2.3 There were 4 patients over 62 days from screening in January (of 27.5 patients commencing treatment via screening). As the number of patients is small for this pathway, it is more susceptible to variation. There was 1 tertiary patient referred to WSHFT beyond 38 days recommendation which constrained the ability for the Trust to commence treatment before 62 days, and 2 (non-tertiary) complex patients within this breach cohort. Early provisional performance for February (as of 19th February) shows a return to compliance for this metric (96.3%)

3.2.4 The Trust was also non-compliant for the (non-Single Oversight Framework) metric relating to being seen within 2 weeks for breast symptomatic cancer. There were 16 patients who were seen above 2 weeks for breast symptomatic cancer of 191 patients seen. This represents a 27% increase in patients seen in January 2018 compared to the same period 2017. Patient choice and unavailability due to sickness during the Christmas and New Year period were the main cause of breaches in January. Provisional performance February (as of 19th February) shows a return to compliance (98.02%).

3.2.5 2 week referrals received in January 2018 were 9.3% below the level observed in January 2017. The comparable figure for all referrals was a 6.5% decrease for the same period. However, for the year February 2017 to January 2018, 2 week referrals have increased by 1.7% on the previous year and the comparable figure for all referrals is a 3.7% decrease.

3.2.6 For context, latest comparative nationally published data relating to December 2017 shows national aggregate compliance for cancer attendance to be:

- 84.2% for treatment within 62 days from GP referral (target 85.0%) compared to WSHFT performance of 86.5%. WSHFT is the 23rd best performing trust against this standard nationally in the year to date and the 2nd best in the South of England. In December 2017, 59% of Trusts receiving GP referrals in England were non-compliant against this standard.

3.3 Referral to Treatment (RTT/18 Weeks)

3.3.1 The Trust was non-compliant against the National Constitutional Target of 92% in January with 86.64% of pathways waiting less than 18 weeks. This is 0.36% deterioration in performance since December (87.1%). Numbers of patients waiting over 18 weeks increased by 75 patients between months.

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

3.3.3 When stratified by division as below, there was 1% deterioration in surgical performance, with a 147 increase in surgical backlog. Other clinical divisions saw a marginal improvement in their RTT performance, with medical specialties over 18 weeks reduced by 56 patients compared to Dec-17.

	30/12/2017			31/01/2018			Change between Months	
Division	Backlog	WL Size	%	Backlog	WL Size	%	Backlog	%
Surgery	2620	19758	86.74%	2767	19410	85.74%	147	-1%
Medicine	1518	10013	84.84%	1462	9916	85.26%	-56	0.42%
Women & Children	148	2561	94.22%	139	2518	94.48%	-9	0.26%
Core	39	1108	96.48%	32	1088	97.06%	-7	0.58%
Trust	4325	33440	87.07%	4400	32,932	86.64%	75	-0.43

3.3.4 Trauma & Orthopaedics saw the largest increase in backlog size to 615 in January from 512 at the end of December.

3.3.5 In accordance with NHSi guidance and clinical priority in the context of increased non-elective demand and bed constraints, the Trust continued a planned reduction for elective inpatient activity into January. This was reviewed daily and weekly by directors on call, operational site teams and clinical divisions, with the aim to minimise disruption and maintain treatment for cancer and clinically urgent patients. This particularly impacted elective orthopaedic surgery, which cancelled 120 cases, and the surgical division ran throughout the month at approximately 80% typical surgical elective throughput. Orthopaedics has also observed a 12.5% increase in referral demand over the last 12 months relative to the preceding year.

3.3.6 The surgical division is undertaking focussed work to optimise both quality and productivity within orthopaedics by adopting the GIRFT (Getting it Right First Time) programme methodology, supported by the British Orthopaedic Association (BOA) and Model Hospital recommendations/opportunities. The Trust is also commencing a pan-divisional programme to optimise theatre productivity into 2018/19.

3.3.7 Forecasting forward, and predicated on no additional investment above current levels of activity, the Trust anticipates marginal recovery in the range of 86.7 to 87% in aggregate incomplete performance by March 2017. With implementation of plans associated with short term additional NHSi RTT investment (via WLI premium activity), this forecast may be enhanced further to approximately 87.6%. This work is part of longer term forward planning and assessment of levels of activity required into 2018/19 to improve and/or sustain RTT performance.

3.3.8 The Trust completed 11,382 RTT patient pathways in January 2018.

3.3.9 Latest published national data relates to December 2017 and shows a decrease in national compliance, to 88.2% from 89.5% in November 2017. This figure is exclusive of independent sector providers and does not reflect a number of large acute NHS providers that currently are not reporting RTT positions as part of agreed ‘special measure’ arrangements. Trust performance dipped below the national compliance figure in July and remained below in December with 87.1% for the Trust compared to 88.2% nationally. Just over half of Trusts were non-compliant in December.

3.4 <u>Diagnostic Test Waiting Times</u>

3.4.1 The Trust compliance for January was 0.8% over 6 week waiters across all diagnostic modes, which is compliant against the 1% national target. This represents 40 over 6 week waiters of a total list of 4818 patients.

3.4.2 WSHFT performance compared favourably against regional peers in December (the latest comparable national data); with South of England Region aggregate compliance of 2.3% and

National compliance at 2.2%, compared to WSHFT December performance of 1.3%. Over 40% of Trusts were non-compliant in December 2017.

4 RECOMMENDATION

4.1 The Board is asked to receive the Month 10 position.

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

Giles Frost, Interim Director – Performance & Information.

20th February 2018

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

NHS Improvement Single Oversight Framework

JANUARY 2018

		Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date	Trend
Operational Performance Metrics																
OP1	A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	95.09%	95.50%	94.11%	94.15%	95.05%	95.38%	94.11%	92.70%	85.45%	89.55%			93.16%	
OP2	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	90.74%	91.28%	90.58%	89.41%	88.95%	88.72%	88.42%	89.02%	87.07%	86.64%			89.08%	
OP3A	All cancers : 62-day wait for first treatment following urgent GP Referral	85%	94.09%	90.30%	89.33%	86.22%	86.55%	87.74%	88.92%	91.91%	86.29%	87.41%			87.99%	
OP3B	All cancers : 62-day wait for first treatment following consultant screening service referral	90%	100.00%	93.48%	90.91%	98.08%	94.20%	98.15%	94.23%	94.20%	96.00%	85.46%			94.53%	
OP4	Maximum 6-week wait for diagnostic procedures	1%	0.92%	0.97%	0.92%	1.00%	1.28%	0.99%	0.61%	0.69%	1.31%	0.83%			0.95%	

Notes

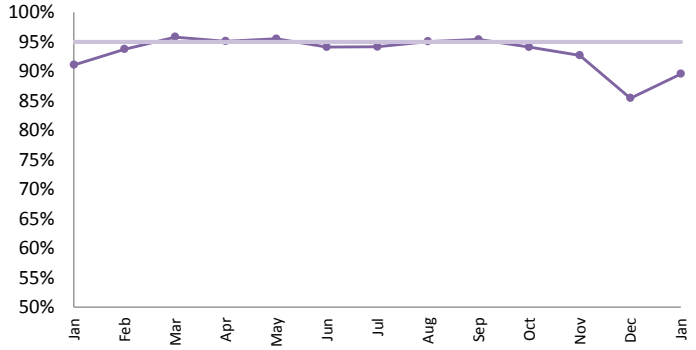
Mark Dennis, Head of Information Services
t: 01903 285273 (ext 5273)

Key Performance Deliverables Report

January 2018

A&E 4-hour waiting time target

Target	Month	YTD	Projected O/T
95%	89.55%	93.16%	>95%



Description / Comments / Actions

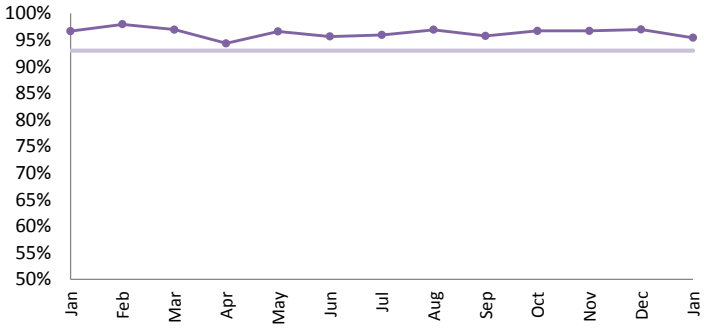
Patients can expect to be admitted, transferred or discharged in 4 hours from arrival in A&E

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

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

Cancer - Two weeks from urgent GP referral to first appointment

Target	Month	YTD	Projected O/T
93.0%	95.42%	96.19%	>93%



Description / Comments / Actions

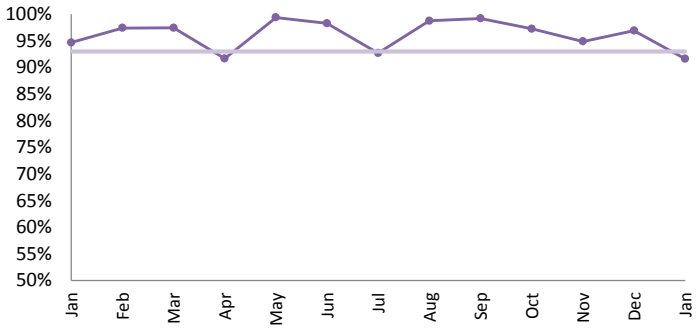
Patients can expect to be seen within 2 weeks following an urgent GP referral for suspected cancer.

Significant and sustained increases in demand level.

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

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

Target	Month	YTD	Projected O/T
93%	91.62%	95.95%	>93%



Description / Comments / Actions

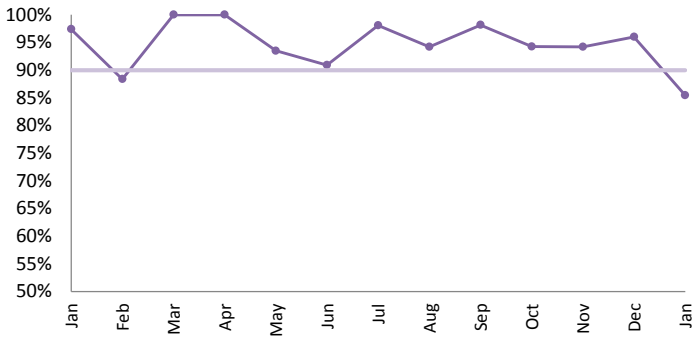
Patients with breast symptoms can expect to be seen within 2 weeks following an urgent GP referral.

Significant and sustained increases in demand level.

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

Cancer - 62 days from referral to treatment following screening contact

Target	Month	YTD	Projected O/T
90%	85.46%	94.53%	>90%



Description / Comments / Actions

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

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

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

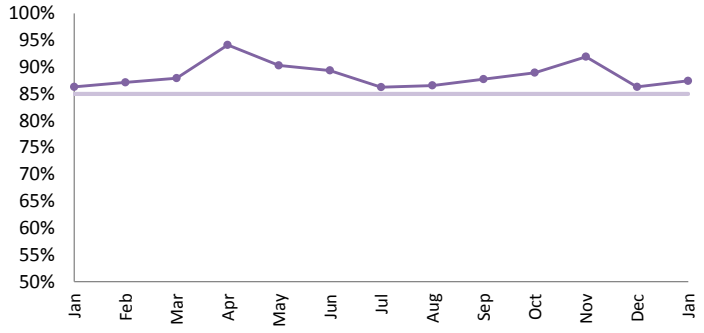
Mark Dennis, Head of Information Services
t: 01903 285273 (ext 5273)

Key Performance Deliverables Report

January 2018

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

Target	Month	YTD	Projected O/T
85%	87.41%	87.99%	>85%



Description / Comments / Actions

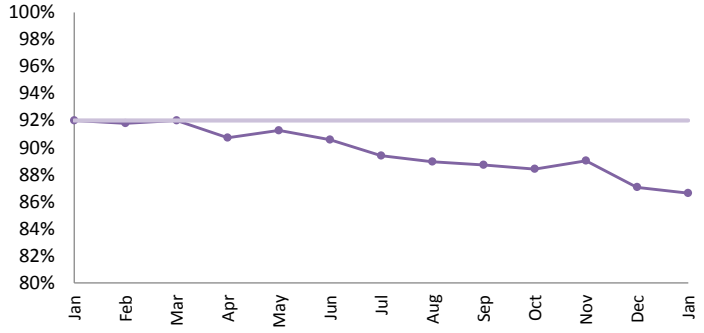
Patients with cancer can expect to commence treatment within 62 days following urgent referral by a GP.

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

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

Referral to treatment - Incomplete Pathways

Target	Month	YTD	Projected O/T
92.0%	86.64%	89.08%	>92%



Description / Comments / Actions

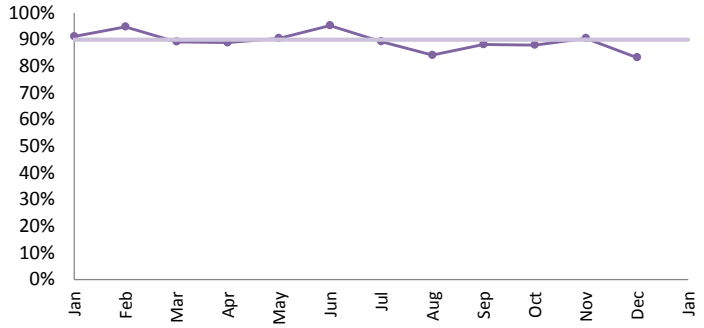
All patients can expect to commence treatment within 18 weeks of a referral to consultant.

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

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

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

Target	Month	YTD	Projected O/T
90%	83.30%	89.48%	>90%



Description / Comments / Actions

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

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

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

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

OPERATIONAL PERFORMANCE SCORECARD

JANUARY 2018

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	JAN	2017/18 YTD	2017/18 Target	Trend
NATIONAL AND OPERATIONAL PERFORMANCE TARGETS																	
O01	A&E : Four-hour maximum wait from arrival to admission, transfer or discharge	91.08%	93.75%	95.81%	95.09%	95.50%	94.11%	94.15%	95.05%	95.38%	94.11%	92.70%	85.45%	89.55%	93.16%	95%	
O02	Cancer: 2 week GP referral to 1st outpatient	96.64%	97.94%	96.94%	94.36%	96.60%	95.65%	95.92%	96.91%	95.75%	96.71%	96.71%	96.97%	95.42%	96.19%	93%	
O03	Cancer: 2 week GP referral to 1st outpatient - breast symptoms	94.67%	97.40%	97.44%	91.67%	99.38%	98.26%	92.67%	98.73%	99.19%	97.24%	94.87%	96.89%	91.62%	95.95%	93%	
O04	Cancer: 31 day second or subsequent treatment - surgery	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.2%	99.58%	94%	
O05	Cancer: 31 day second or subsequent treatment - drug	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98%	
O06	Cancer: 31 day diagnosis to treatment for all cancers	97.54%	100.00%	98.95%	100.00%	100.00%	99.64%	99.65%	100.00%	100.00%	100.0%	100.0%	100.0%	99.6%	99.9%	96%	
O07	Cancer: 62 day referral to treatment from screening	97.37%	88.37%	100.00%	100.00%	93.48%	90.91%	98.08%	94.20%	98.15%	94.23%	94.20%	96.00%	85.46%	94.5%	90%	
O08	Cancer: 62 day referral to treatment from hospital specialist	96.00%	91.67%	88.14%	90.91%	93.33%	94.44%	84.62%	68.75%	67.86%	96.15%	92.86%	89.66%	84.31%	87.4%	N/A	
O09	Cancer: 62 days urgent GP referral to treatment of all cancers	86.29%	87.13%	87.90%	94.09%	90.30%	89.33%	86.22%	86.55%	87.74%	88.92%	91.91%	86.29%	87.41%	88.0%	85%	
O14	RTT - Incomplete - 92% in 18 weeks	92.01%	91.80%	92.01%	90.74%	91.28%	90.58%	89.41%	88.95%	88.72%	88.42%	89.02%	87.07%	86.64%	89.08%	92%	
O15	RTT delivery in all specialties (Incomplete pathways)	5	7	6	8	6	8	9	11	10	11	11	12	13	13	0	
O16	Diagnostic Test Waiting Times	2.33%	1.51%	0.84%	0.92%	0.97%	0.92%	1.00%	1.28%	0.99%	0.61%	0.69%	1.31%	0.83%	0.95%	<1%	
O17	Cancelled operations not re-booked within 28 days	3	4	0	2	0	0	1	1	0	1	2	0	3	10	-	
O18	Urgent operations cancelled for the second time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	
O19	Clinics cancelled with less than 6 weeks notice for annual/study leave	39	15	28	17	11	15	71	71	40	26	23	20	44	338	-	
O20	Mixed Sex Accommodation breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
O33	Delayed transfers of care	3.64%	4.09%	3.16%	3.12%	3.15%	3.15%	3.34%	4.32%	4.15%	3.34%	3.47%	2.73%	3.07%	3.4%	3.0%	
IMPROVING CLINICAL PROCESSES																	
O23	% hip fracture repair within 36 hours	91.2%	94.8%	89.2%	88.9%	90.5%	95.3%	89.3%	84.2%	88.2%	88.0%	90.5%	83.3%		89.5%	90%	
O24	Patients that have spent more than 90% of their stay in hospital on a stroke unit+	87.6%			90.9%				86.3%	88.6%	92.0%	96.6%	94.1%		89.3%	80%	

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

OPERATIONAL PERFORMANCE SCORECARD

JANUARY 2018

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	JAN	2017/18 YTD	2017/18 Target	Trend
OPERATIONAL EFFICIENCY																	
O36	Average length of stay - Elective	3.27	3.22	3.19	3.19	2.94	3.04	3.07	3.09	2.99	3.35	3.22	3.63	2.95	3.14	3.72	
O37	Average length of stay - Non-elective Surgery	5.81	5.49	5.51	5.16	5.61	5.87	5.34	5.76	5.66	5.29	5.93	5.38	5.80	5.58	6.07	
O38	Average length of stay - Non-elective Medicine	8.15	8.36	8.50	7.60	8.07	7.68	7.88	7.61	7.31	7.82	7.79	7.37	8.03	7.72	7.80	
O39	Day case rate (CQC day case basket of procedures) source: Dr Foster (reported 2-3 months in arrears)	93.90%	90.58%	86.88%	90.08%	89.01%	88.38%	86.03%	90.80%	89.70%					89.70%	75.0%	
O40	Elective day of surgery rate (DOSR)	97.5%	98.6%	97.9%	97.2%	98.8%	98.5%	98.1%	98.2%	98.4%	98.5%	99.1%	98.2%	98.9%	98.4%	90.0%	
O41	Did not attend rate (outpatients)	7.19%	6.74%	6.73%	6.85%	6.57%	6.80%	6.36%	6.36%	6.09%	5.80%	5.72%	6.38%	6.11%	6.09%	7.65%	
SUSTAINABILITY																	
O43	Bank staff - % of all staff pay	6.49%	7.67%	9.43%	7.60%	6.97%	6.92%	7.07%	8.40%	8.99%	7.85%	8.29%	8.12%	7.49%	7.29%	7%	
O44	Agency staff - % of all staff pay	6.42%	6.33%	6.03%	5.09%	5.33%	5.58%	5.03%	4.30%	4.51%	3.84%	5.06%	4.28%	4.30%	5.78%	2%	
O45	Nurse : occupied bed ratio	1.689	1.708	1.821	1.843	1.767	1.793	1.785	1.850	1.861	1.805	1.774	1.741	1.690	1.820	-	
O46	% nurses who are registered	69.30%	68.97%	68.75%	68.44%	68.23%	67.99%	67.78%	67.71%	67.67%	68.40%	68.30%	68.34%	68.49%	68.14%	-	
O47	% Staff appraised	83.31%	84.01%	83.95%	83.83%	89.33%	89.50%	86.80%	89.11%	88.05%	88.37%	88.20%	87.60%	87.70%	87.70%	90%	
O48	Sickness Absence: % Sickness (reported one month in arrears)	4.04%	3.78%	3.22%	3.19%	3.17%	3.27%	3.31%	3.20%	3.77%	3.80%	3.60%	3.80%		3.80%	3.3%	
O49	Staff Turnover: Turnover rate (YTD position)	7.97%	8.15%	8.03%	8.46%	8.46%	8.30%	8.10%	8.14%	8.00%	8.24%	8.20%	7.80%	7.70%	7.70%	11%	
ACTIVITY																	
A01	Day Cases	5,429	5,176	5,855	4,395	4,945	4,990	4,707	4,784	4,767	4,900	5,359	4,248	5,057	48,152	40,148	
A02	Elective Inpatients	521	578	683	538	624	660	633	580	614	548	589	456	358	5,600	5,102	
A03	Non-elective inpatients	5,607	5,172	5,767	5,537	5,887	5,779	5,765	5,544	5,622	5,814	5,827	5,842	6,064	57,681	45,421	
A04	Outpatient First attendances	14,716	13,255	14,843	11,890	13,888	13,719	12,822	12,810	12,854	13,797	13,983	10,749	13,553	130,065	113,863	
A05	Outpatient Follow-up attendances	22,313	20,387	23,593	18,491	21,821	21,691	19,629	20,880	20,769	22,222	23,644	18,204	23,427	210,778	172,610	
A06	Outpatients with procedure	5,543	4,853	4,779	5,150	6,282	6,111	5,333	6,217	6,521	7,287	7,131	5,316	6,588	61,936	48,951	
A07	A&E Attendances	10,502	9,705	11,410	11,569	12,093	11,985	12,531	11,960	11,598	11,734	11,566	11,865	12,418	119,319	97,233	

Notes

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

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

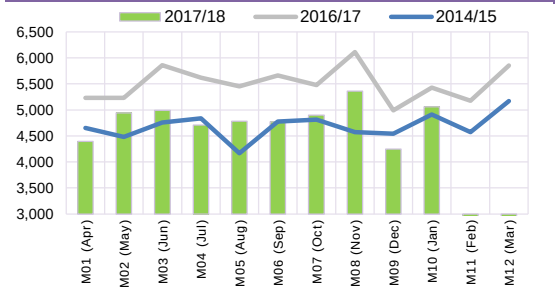
3 Staff sickness is reported one month in arrears.

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

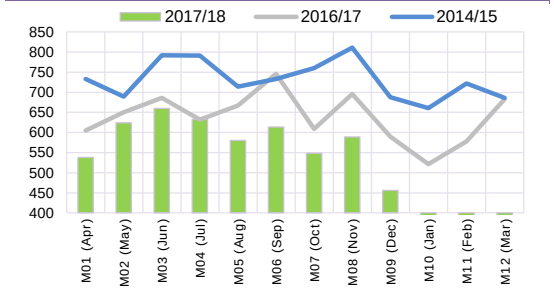
Mark Dennis, Head of Information Services
t: 01903 285273 (ext 85273)

Activity Trends

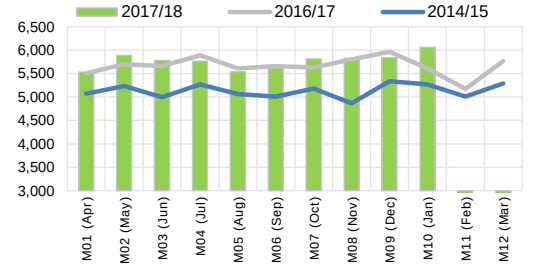
Day Cases



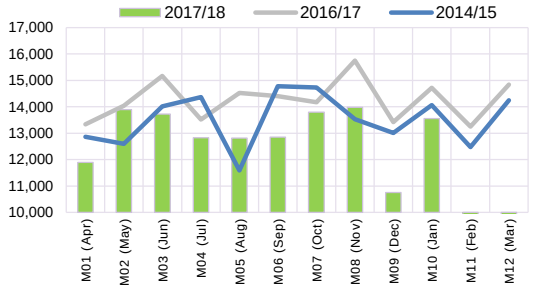
Elective Inpatients



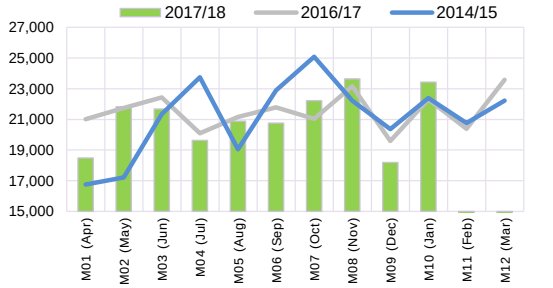
Non-elective Inpatients



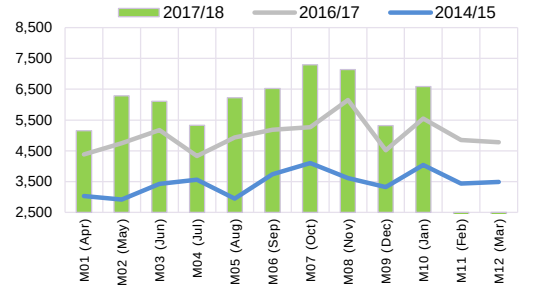
First Outpatients



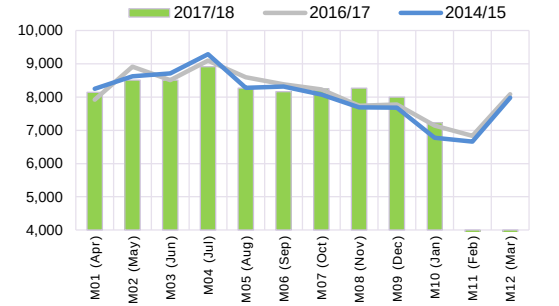
Follow-up Outpatients



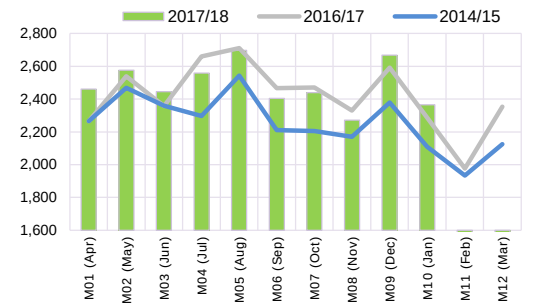
Outpatients with Procedure



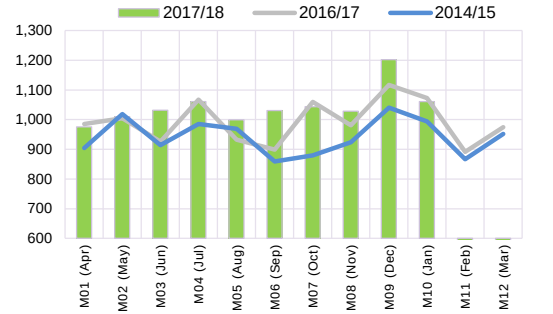
A&E Attendances (age 0-64)



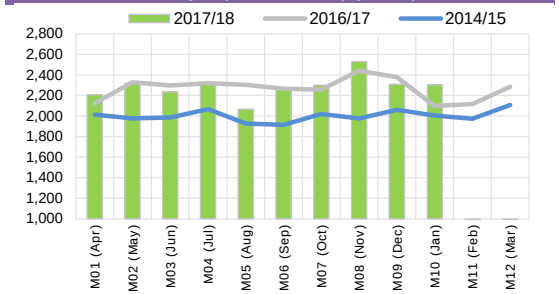
A&E Attendances (age 65-84)



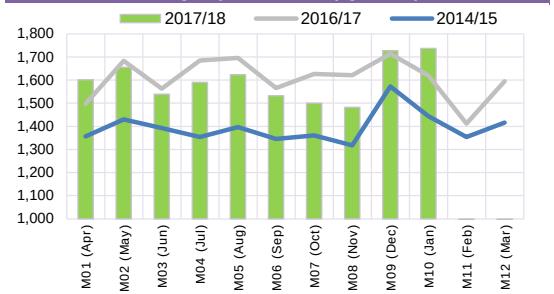
A&E Attendances (age >85)



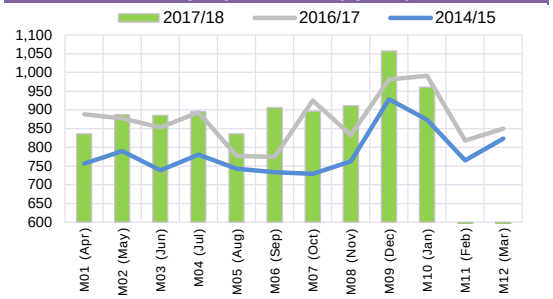
Emergency Admissions (age 0-64)



Emergency Admissions (age 65-84)



Emergency Admissions (age >85)



Giles Frost, AD Operational Planning Performance
TEL: 01903 205111 (85545)

STF PERFORMANCE TRAJECTORY MONITORING

January 2018

A&E : FOUR-HOUR MAXIMUM WAIT FROM ARRIVAL TO ADMISSION, TRANSFER OR DISCHARGE

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	Trust Patients Seen	12,405	13,761	13,093	14,153	13,592	12,998	13,027	12,313	12,746	11,819	10,931	12,597
	>4 Hours	794	881	838	760	730	698	911	861	892	1,054	682	629
	Performance	**93.60%**	**93.60%**	**93.60%**	**94.63%**	**94.63%**	**94.63%**	**93.01%**	**93.01%**	**93.00%**	**91.08%**	**93.76%**	**95.01%**
	Cumulative Performance	**93.60%**	**93.60%**	**93.60%**	**93.87%**	**94.03%**	**94.12%**	**93.97%**	**93.86%**	**93.76%**	**93.52%**	**93.54%**	**93.66%**
Actual	Trust Patients Seen	13,272	13,994	14,012	14,501	13,910	13,562	13,610	13267	13563	12418		
	>4 Hours	639	629	803	848	688	626	802	968	1974	1298		
	Performance	95.19%	95.51%	94.27%	94.15%	95.05%	95.38%	94.11%	92.70%	85.45%	89.55%		
	Cumulative Performance	95.19%	95.35%	94.98%	94.77%	94.82%	94.92%	94.80%	94.55%	93.55%	93.19%		

CANCER 62 DAY PATHWAYS > 62 DAYS

Trajectory	Trust Patients Seen	149.0	170.0	190.0	148.0	152.0	148.0	175.0	195.0	161.0	188.0	198.0	181.0
	>62 days wait	22.0	25.5	28.5	22.0	22.5	22.0	26.0	29.0	24.0	28.0	29.5	27.0
	Performance	**85.23%**	**85.00%**	**85.00%**	**85.14%**	**85.20%**	**85.14%**	**85.14%**	**85.13%**	**85.09%**	**85.11%**	**85.10%**	**85.08%**
Actual	Trust Patients Seen	146.5	157	185.5	177	173	167	195.5	189	171	171		
	>62 days wait	7	14.5	19	21	21.5	19	21.5	14.5	22.5	22		
	Performance	95.22%	90.76%	89.76%	88.14%	87.57%	88.62%	89.00%	92.33%	86.84%	87.13%		

REFERRAL TO TREATMENT INCOMPLETE PATHWAYS > 18 WEEKS

Trajectory	52 Week Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
	Total Patients Waiting	33,949	33,949	33,949	33,949	33,949	33,949	33,949	33,949	33,949	33,949	33,949	33,949
	Patients waiting >18 weeks	2,715	2,715	2,715	2,715	2,715	2,715	2,715	2,715	2,715	2,715	2,715	2,715
	Compliance	**92.00%**	**92.00%**	**92.00%**	**92.00%**	**92.00%**	**92.00%**	**92.00%**	**92.00%**	**92.00%**	**92.00%**	**92.00%**	**92.00%**
Actual	52 Week Trajectory	0	1	0	0	0	0	1	2	0	0		
	Total Patients Waiting	33,985	32,955	32,639	32,838	33,222	33,027	33,097	33,129	33,440	32,932		
	Patients waiting >18 weeks	3,147	2,875	3,074	3,479	3,671	3,760	3,834	3,636	4,325	4,400		
	Cumulatively Ahead(behind trajectory)	-432	-592	-951	-1,715	-2,671	-3,716	-4,835	-5,756	-7,366	-9,051		
	Compliance	90.74%	91.28%	90.58%	89.41%	88.95%	88.62%	88.42%	89.02%	87.07%	86.64%		

	Performance meets Constitutional Standard and STF Trajectory
	Performance meets STF Trajectory but not Constitutional Standard
	Performance doesn't meet STF Trajectory

Western Sussex Hospitals
NHS Foundation Trust

To: Board

Date of Meeting: 1st March 2018 Agenda Item: 5.3

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

This report can be made available in other formats and in other languages. To discuss your requirements please contact Andy Gray, Company Secretary, on Andrew.gray@wsht.nhs.uk or 01903 285288.

Western Sussex Hospitals
NHS Foundation Trust

To: Trust Board Date: March 2018

From: Denise Farmer, Chief Workforce and OD Officer Agenda Item: 5.3

FOR INFORMATION

WORKFORCE AND ORGANISATIONAL DEVELOPMENT REPORT

1.00 Introduction

1.01 This sets out the key headlines relating to the Trust's workforce at 31 January 2018.

2.00 Workforce Capacity

2.01 Despite significant operational pressures experienced throughout January, the overall workforce capacity used was contained within the budgeted establishments. Whilst the Medicine Division had an improved position for a third month, the funded position continues to be exceeded by 60.7 wte.

2.02 Substantive staff accounted for 89% of total capacity used in the Trust and although this is small decrease from last month it is noteworthy that since January 2017, the actual number of staff in-post has increased by an additional 28.50 wte medical staff and 77.20 wte.

2.03 The vacancy rate is currently at 9%, compared to 10% at the same time last year, and within the medicine division this has improved from 15.1% to 11.1% in the same time period.

2.03 At month 10, there was an adverse pay spend of £931k in month and £8.17m YTD. In January medical pay accounted for 88% of this overspend and continues to be driven by agency use predominately within medicine, radiology, haematology and paediatrics. Overall pay spend in nursing was contained with agency expenditure falling to £219k in month and representing its lowest level in a number of years.

2.04 The amount of temporary staff used in month continues to fall and during January circa 647 wte was used compared to 665 wte in December and 744 wte in November. It is of growing concern that overall proportion of capacity worked through the staff bank is reducing and in month this fell from 88% to 81%, with a commensurate increase in agency staff from 12% to 19%.

2.05 A significant amount of work has been undertaken in the last 12 months to drive nursing agencies to cap compliance with a range of successful interventions. Unfortunately this is now being undermined by the high demand for registered nurses in neighbouring trusts which is resulting in the supply migrating to higher pay rates. Whilst cap compliance has yet to be achieved for medical agency, the market continues to drive rates up. This was reported last month but during February, there was a paucity of supply to the organisation with agency staff who have regularly worked in our hospitals working elsewhere. Alternative strategies are being urgently developed.

3.00 Workforce Efficiency

3.01 The rolling 12 month sickness absence rate at 31 December remained static at 3.5% with a sharp increase in month to 3.8%. This was anticipated following the high number of staff reporting absent by reason of cold, flu or respiratory symptoms. Staff experienced higher absence in month than in the preceding year and there were 200 more episodes than in November. Whilst the numbers of episodes rose across all divisions, the sickness rates in month within the Core and Medicine divisions fell. This suggests that the duration of absence from staff in these areas was lower than other areas and may correlate with the uptake of the flu vaccine where the effects of respiratory symptoms are reduced.

3.02 Long term absence continues to represent circa 1.4% of total absence and ranges from 0.8% in the Core division to 2.9% within the Estates and Facilities division.

3.03 The rolling 12 month staff turnover rate has fallen to 7.7% across the Trust, with the exception of the Core division which saw an increase to 10.2%. A staff retention improvement project is currently underway within the division in order to better understand the issues and to inform interventions required.

4.00 Flu Vaccinations

4.01 At 16 February, 4,426 of our staff have been vaccinated. This equates to 64.5% of all staff. 78% of staff have been approached. This includes 3391 frontline staff which equates to 66.5%. 82% of frontline staff have been approached.

4.02 With two weeks left of the campaign, a further 177 staff will need to be vaccinated to meet the 70% CQUIN target. Workplace vaccinators, Occupational Health and divisional teams are focusing their efforts to meet this target.

4.03 Set out below is the uptake of frontline staff by division:

Front line staff Division	Declined	Received elsewhere	Received in Trust	Yet to be approached	Grand Total	Percentage Vaccinated	Percentage Approached
Core Services	205	63	790	190	1248	68.35%	84.78%
Corporate	23	11	111	59	204	59.80%	71.08%
Medicine	299	81	1059	268	1707	66.78%	84.30%
Surgery	179	51	720	211	1161	66.41%	81.83%
Facilities & Estates	7	12	33	27	79	56.96%	65.82%
Women & Children	106	44	416	132	698	65.90%	81.09%
Grand Total	**819**	**262**	**3129**	**887**	**5097**	**66.53%**	**82.60%**

5.00 Appraisals

5.01 Appraisal compliance remains good with 87.7% of staff having had an appraisal within the last 12 months. Uptake of appraisal within the Core and Women and Children Divisions is over 90% and Estates and Facilities has achieved 94.4%.

5.02 Improvement of appraisal rates has been driven through the divisional Strategy Deployment Review process and the Lean methodologies that have been applied.

6.00 Clinical Excellence Awards (CEA)

6.01 The national CEA round for 2017/18 opened on 13 February and closes on 12 April. All eligible consultants have been notified and invited to make an application in accordance with the national guidance and timeframe by 12 March.

6.02 NHS Employers have also announced reforms to the local CEA's, agreed with the BMA, for an interim 3 year period from 1 April 2018 to 31 March 2021. A public announcement is expected imminently after which resources will be available to the Trust.

The key reforms are:

- Trusts must run annual Local CEA rounds (anticipated to become contractual)
- The minimum investment ratio will increase from current 0.2 to 0.3 per eligible consultant (no additional central funding identified but awaiting DDRB review outcome)
- Consultants with Local Clinical Excellence Awards will keep them as pensionable and these will not be reviewed until April 2021
- New awards from April 2018 will be non-consolidated and non-pensionable
- New awards from April 2018 will be payable up to 3 years but no uplift to Additional PA's (therefore capped to a maximum of 10 PA's)
- National award holders that lose their award with no current pay protection arrangements will revert to a Local CEA of level 7 or 8 (not funded from the 0.3 ratio Trust investment)

7.00 Staff Engagement

7.01 At the time of writing, the national 2017 Staff Survey results have not yet been received. Results are expected imminently and will be reported as soon as possible. It is noted that an embargo on publication will be in place until 6 March.

7.02 In the meantime the monthly engagement score collated from the Your Health and Safety Days was 3.84. This is lower than in previous months and reflects the reduction in the number of participants in month due to operational pressures.

7.03 Staff engagement continues to be a driver metric for the divisions resulting in a range of interventions to improve the position. These include the roll out of improvement boards and huddles to non-PFIS areas (eg. maternity, sexual health, typing pool, housekeeping and portering at St Richards Hospital), introduction of a Leadership Academy (see 8.00 below), increasing the visibility of the senior team at department huddles and meetings.

8.00 Estates and Facilities Leadership Academy

8.01 An internal Leadership Academy has been launched within the Estates and Facilities Division, designed to equip staff with core skills relevant to their roles in the division and designed for personal development.

8.02 The content of the Academy, led by Suzanne Fisher, Associate Director of Facilities, has been developed from engagement workshops with aspiring team leaders and supervisors and is made up of a 4 hour pre-academy course followed by 14 bite-size sessions (60-90 minutes each). The programme to be delivered by subject matter experts, includes appraisals, difficult conversations/conflict resolution, coaching, motivation and leadership skills, emotional resilience, budget management, risk assessments and staff rotas. Delegates are required to complete an emotional intelligence course "Know your colour" in advance which is aimed at improving communication skills both with self and others.

8.03 Three cohorts will run over the next 12 months, and cohort 1, running from March to June, is already fully booked.

8.04 The first academy will run for team leaders and supervisors before being rolled out to all staff in the division.

8.05 Delegates will also be offered post-academy extras including Yellow Belt training, IT skills, functional skills in English and Maths.

8.06 This is the first phase of a Management and Leadership Development Framework within the division and is aligned to the key competencies and skills required to deliver the Patient First Programme and True North objectives.

10.00 Statutory and Mandatory Training

10.01 Attendance on all mandatory training modules remains above the Trust target of 90% for the sixth consecutive month, despite a number of nursing staff being withdrawn from training due to business continuity.

10.02 The number of staff who have never completed any training is three. All of these are Medical staff , two of whom have not yet to completed their on-line Induction training since they joined the Trust 4 months ago. The names of the three individuals have been escalated to Chiefs/ DDOs and we will continue to work with Divisions to ensure that these individuals completed their training as soon as possible.

11.00 Widening Participation

11.01 <u>Skills Scan for HCA's</u>

In order to identify what qualifications our health care assistants have, a skills scan document has been sent to all HCAs. Approximately 48% have now completed and returned this. Initial analysis of data as at December 2017 demonstrates:

- 187 members of staff have their Maths GCSE C-A*
- 217 members of staff have their English GCSE C-A*
- 100 members of staff have completed the access course in the last 5 years
- 134 have completed a Level 3 Health related qualification
- 148 have completed the care certificate
- 29 are registered nurses overseas
- 11 are nurses in the UK but not on the NMC register

Interest in undertaking further qualifications from those who completed the skills scan was as follows:

- 137 interested in completing the bridging module
- 150 interested in doing the nursing associate apprenticeship
- 140 interested in completing a degree- 140 staff

We are encouraging managers to support the remainder of their staff to complete the skills scan regardless of whether they wish to progress in their careers. This data will be used to plan future career and development opportunities in the Trust.

11.02 Apprenticeships

Apprenticeship and functional skills activity Quarter 3 (October-December 2017)

29 Apprentice starts includes new and existing staff
14 staff enrolled onto in house Literacy classes
15 staff enrolled onto in house Numeracy classes

A further 14 apprentice starts are planned for quarter 4, as well as 20 numeracy and literacy starts.

11.03 Work Experience

In February there have been two Work Experience students in Occupational Therapy, one in ICT and two in Dietetics.

Earlier in the month, three Level 3 health and social care students finished their last placement All three students are exploring an application to undertake a nursing degree.. This placement has contributed to their overall grade for Level 3 Health and Social Care.

On 1-2 February the Trust ran its first Career Motivation Day which was delivered in partnership with the clinical skills team. Delegates included students from Angmering Sixth form, Southdown and Havant College and Worthing College, The two days consisted of a mixture of practical sessions and careers information. The programme was fast paced and engaging for students to get hands on experience with professional, experienced staff. The sessions included role play in a SIMbulance with a qualified paramedic, learning airways with an anaesthetist and scrubbing up with an ODP. Some students developed an interest in new career options e.g. radiography. Feedback on the programme was positive from both the students and careers coordinators at the schools. The two-day programme covered in an article in the Chichester Post.

12.00 COMMUNICATIONS, ENGAGEMENT AND FUNDRAISING

12.01 Campaigns

The communications team has continued to work with colleagues from across the trust, to provide support for a number of long-term campaigns and initiatives. This includes the Health and Wellbeing Wednesdays, and “Let’s Get You Home”, a Sussex-wide initiative designed to support the safe and timely discharge of patients from acute and other hospital settings.

February’s Wellbeing Wednesday was the most successful yet with more staff than ever involved in activities such as yoga and singing classes, receiving massages. The Wellbeing MOTS continue to be fully booked each month.

The team has continued to support the trust’s aim to vaccinate more than 80% of front-line staff against flu.

12.02 Winter pressures

Working closely with the operational teams, regular updates have been provided to staff relating to the increase in demand for urgent care and designed to support improvements in the flow of patients through our hospitals. This has included email, desktop and StaffNet updates as well as information shared in the weekly staff newsletter, *Headlines*, available online and in print.

The team has continued to promote the appropriate use of emergency services via our social media channels, as well as on screens in the hospital, phone messages and appointment letters.

Coverage of the increase in demand has included praise for staff in our local media.

12.03 News

The communications team worked with the Department of Health to welcome the Secretary of State for Health to Worthing Hospital on February 1. Colleagues from a range of teams and departments gathered at the education centre to hear from Mr Hunt and his invited guest speaker Martin Bromiley. Mr Hunt went on to visit neighbouring hospitals in Sussex and news of the visits received coverage across local TV, radio and print.

12.04 Fundraising

Corporate and Community Target £169K v Actual £189K

Rolls Royce at Goodwood has agreed to host Love Your Hospital's first corporate networking event on 8 November 2018.

Supporters' wall - Love Your Hospital is designing a campaign to encourage donors to remember loved ones via a 'memory tree' at both St Richard's and Worthing.

GAYE - the charity is scoping out a Payroll Giving scheme to all staff.

Quiz n' Curry Night - Friday 9 March, Worthing Rugby Club.

12.05 Grants and Foundations

£6,500 received from Prostate Cancer Support Organisation (PCaSO) to support the purchase of a new Bladder Scanner.

12.06 Marketing

Donation Stations - Love Your Hospital is researching new ward donation stations. Hospital maps and lift wraps - the charity will have branding on new trust maps being replaced in February and new lift wraps at Worthing and St Richard's.

13.00 RECOMMENDATION

The Board is asked to NOTE the report.

WSHFT WORKFORCE SCORECARD

January 2018

Key performance Indicators	NB	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	2017/18 YTD	Target/ Ceiling	Amber Limit	Trend
1) WORKFORCE CAPACITY	NB																	
Budgeted FTE		6732.2	6734.6	6734.6	6584.8	6586.6	6591.3	6609.3	6610.5	6614.8	6619.1	6619.1	6634.6	6634.6	**6610.5**	N/A	N/A	
Total FTE Used		6539.8	6678.7	6692.3	6529.6	6545.0	6632.5	6564.5	6596.5	6560.6	6602.6	6666.4	6597.7	6570.7	**6586.6**	N/A	N/A	
Total FTE Used Variance from Budget		-192.4	-55.9	-42.3	-55.2	-41.6	41.2	-44.8	-14.0	-54.2	-16.5	47.3	-36.9	-63.9	**N/A**	N/A	N/A	
Total FTE Used Vacancy Factor		2.9%	0.8%	0.6%	0.8%	0.6%	-0.6%	0.7%	0.2%	0.8%	0.2%	-0.7%	0.6%	1.0%	**0.4%**	N/A	N/A	
Substantive Contracted FTE		6055.7	6061.5	6064.6	6033.4	6011.0	6029.2	6011.6	6188.9	6046.9	6062.1	6036.5	6040.4	6037.2	**6049.7**	N/A	N/A	
Substantive FTE Worked		5856.9	5877.0	5909.4	5881.5	5870.8	5883.5	5868.5	5888.7	5877.4	5917.9	5922.9	5932.9	5923.9	**5896.8**	N/A	N/A	
Substantive FTE Used Vacancy Factor		10.0%	10.0%	9.9%	8.4%	8.7%	8.5%	9.0%	6.4%	8.6%	8.4%	8.8%	9.0%	9.0%	**8.5%**	N/A	N/A	
Bank Usage As % Of Total FTE Used		7.3%	8.8%	8.8%	7.3%	7.5%	8.6%	8.1%	8.6%	8.4%	8.5%	8.9%	8.4%	7.9%	**8.2%**	N/A	N/A	
Agency Usage As % Of Total FTE Used		3.2%	3.2%	2.9%	2.6%	2.8%	2.7%	2.5%	2.1%	2.1%	1.9%	2.3%	1.7%	1.9%	**2.3%**	N/A	N/A	
2) WORKFORCE EFFICIENCY	NB																	
Rolling 12 Month Sickness Absence	1	3.8%	3.8%	3.7%	3.7%	3.6%	3.6%	3.6%	3.5%	3.6%	3.6%	3.5%	3.5%		**N/A**	3.3%	3.3%	
In Month Sickness Absence %		4.0%	3.8%	3.2%	3.2%	3.2%	3.3%	3.3%	3.2%	3.8%	3.8%	3.6%	3.8%		**3.5%**	3.3%	3.3%	
In Month Maternity Leave %		2.4%	2.4%	2.4%	2.4%	2.3%	2.3%	2.4%	2.3%	2.3%	2.4%	2.4%	2.4%		**2.4%**	N/A	N/A	
In Month Other Absence %		1.5%	1.7%	1.8%	1.5%	1.8%	1.7%	1.5%	1.2%	1.8%	1.9%	2.2%	1.5%		**1.7%**	N/A	N/A	
In Month Total Absence %		7.9%	7.8%	7.4%	7.1%	7.3%	7.2%	7.2%	6.7%	7.9%	8.1%	8.2%	7.7%		**7.5%**	N/A	N/A	
Sickness Episodes		1709	1376	1285	1114	1149	1128	1157	1145	1317	1435	1535	1753		**N/A**			
Maternity Heads		187	190	196	189	187	187	199	195	188	196	194	199		**N/A**	N/A	N/A	
In Month Long Term Sickness Absence % (28 Days Or More)		1.5%	1.5%	1.4%	1.6%	1.5%	1.5%	1.5%	1.6%	1.7%	1.7%	1.5%	1.4%		**1.6%**	N/A	N/A	
In Month Short Term Sickness Absence % (<28 days)		2.5%	2.3%	1.8%	1.6%	1.6%	1.8%	1.8%	1.6%	2.1%	2.0%	2.2%	2.5%		**1.9%**	N/A	N/A	
In Month Stress Related Sickness Absence %		0.5%	0.5%	0.6%	0.5%	0.6%	0.7%	0.6%	0.6%	0.8%	0.8%	0.7%	0.7%		**0.7%**	N/A	N/A	
In Month Musculo Skeletal Sickness Absence %		0.7%	0.6%	0.6%	0.8%	0.8%	0.7%	0.7%	0.7%	0.7%	0.7%	0.6%	0.7%		**0.7%**	N/A	N/A	
Number of Staff breaching Management Triggers for sickness absence		1085	1090	1051	1036	1032	1037	1020	998	995	1009	1016	1026		**N/A**			
% of Staff (headcount)		15.4%	15.4%	15.0%	14.7%	14.7%	14.7%	14.5%	14.2%	14.1%	14.3%	14.4%	14.5%		**N/A**			
Rolling 12 Month Turnover		7.8%	8.0%	7.9%	8.2%	8.2%	8.3%	8.1%	8.1%	8.0%	8.2%	8.2%	7.8%	7.7%	**N/A**	8.5%	8.5%	
3) TRAINING & PERSONAL DEVELOPMENT	NB																	
% Appraisals Up To Date		83.3%	84.0%	83.9%	83.8%	89.3%	89.5%	86.8%	89.1%	88.1%	88.4%	88.2%	87.6%	87.7%	**N/A**	90.0%	80.0%	
% In Date - All Mandatory Training	2	82.3%	82.3%	82.5%	81.7%	82.3%	83.2%	81.9%	83.4%	83.6%	83.7%	86.1%	85.2%	86.6%	**N/A**	90.0%	80.0%	
% In Date - Fire		92.0%	92.4%	92.2%	91.2%	92.1%	92.6%	89.9%	92.2%	92.2%	92.4%	93.0%	92.3%	93.0%	**N/A**	90.0%	80.0%	
% In Date - Infection Control (Role Specific)		89.8%	89.5%	89.9%	89.6%	90.6%	90.6%	88.2%	90.9%	90.8%	90.8%	91.9%	91.4%	92.2%	**N/A**	90.0%	80.0%	
% In Date - Back Training (Role Specific)		93.4%	93.2%	92.9%	92.8%	92.9%	93.1%	91.6%	92.3%	92.0%	92.4%	93.8%	93.7%	94.1%	**N/A**	90.0%	80.0%	
% In Date - Child Protection (Role Specific)		96.7%	96.6%	96.6%	96.5%	96.9%	97.4%	96.0%	96.5%	96.7%	96.9%	97.7%	97.7%	98.0%	**N/A**	90.0%	80.0%	
% In Date - Information Governance		90.4%	90.4%	90.3%	89.7%	90.3%	90.6%	89.0%	91.1%	91.3%	91.1%	91.9%	91.2%	92.2%	**N/A**	90.0%	80.0%	
% In Date - Adult Protection		95.4%	95.2%	95.9%	95.9%	96.1%	96.5%	94.7%	95.3%	95.3%	95.4%	96.9%	96.9%	96.7%	**N/A**	90.0%	80.0%	
Number of Staff with no mandatory training		2	3	8	6	6	6	8	5	4	5	5	3	3	**N/A**			
Number of Staff > 12 months since any mandatory training		0	0	0	0	0	0	0	0	0	0	0	0	0	**N/A**			
4) REAL-TIME STAFF FEEDBACK	NB																	
Total Respondents To Survey		229	184	266	246	274	386	258	212	300	257	276	239	155	**2603**	N/A	N/A	
% Respondents who would recommend this trust as a place to work		83.8%	88.3%	83.4%	84.7%	84.3%	84.9%	83.1%	82.5%	84.3%	86.4%	89.8%	85.3%	82.5%	**84.9%**	N/A	N/A	
% Respondents happy with standard of care if a friend/relative needed treatment		89.5%	95.9%	89.2%	92.9%	90.8%	91.5%	91.6%	92.7%	91.2%	90.8%	94.7%	91.5%	90.2%	**91.8%**	N/A	N/A	
Overall Staff Engagement Composite Score	3	3.76	4.00	3.76	3.92	3.98	3.98	3.89	3.93	3.88	3.94	3.91	3.91	3.84	**N/A**	4.02	3.78	

Notes:

1 Absence data is available one month in arrears.
2 An employee is counted as being up to date with all their mandatory training if their Fire, Infection Control, Back, Child Protection and Information Governance training is up to date.
3 Overall indicator for staff engagement is a composite score using 3 key finding questions, friend and family recommendation, motivation and making improvements.
3 WSHT Total Respondents To Survey is greater than the sum of the divisional Total Respondents To Survey as some staff did not select a division when completing the survey.
3 Baseline Data from 2016 Staff Survey, Overall Staff Engagement Score - 3.88

Western Sussex Hospitals
NHS Foundation Trust

To: Trust Board

Date of Meeting: 1st March 2018 Agenda Item: 5.4

Title
Financial Performance - January 2018
Presented by
Karen Geoghegan, Chief Financial Officer
Prepared by
Alison Ingoe, Finance Director; David Lowe, Assistant Director of Finance
Status
Confidential
Summary of Proposal
The Trust reported a deficit of £1.06m (before STF) in January bringing the total surplus to £1.21m. As at the end of M10, the Trust was £1.86m behind plan for the year to date. Due to the impact of significant pressures experienced by the Trust in Q3 and continuing into Q4, the Trust is now reporting a year end forecast surplus of £0.583m. Including STF income earned in Q1-Q3, this brings the forecast outturn to £8.096m. The Trust continues to report an FSSR rating of '1'. The Financial Performance paper provides further detail on the Trust's financial position.
Implications for Quality of Care
Financial planning principles have been established to ensure that expenditure budgets reflect anticipated activity levels and that agreed staffing levels are maintained.
Support for/integration with Corporate Objectives and Strategies
G1. Maintain an acceptable financial risk rating
Financial Implications
These are noted within the Financial Performance Report
Human Resource Implications
N/A
Recommendation
The Finance and Investment Committee is asked to NOTE the Financial Performance Report for January 2018.
Consultation
N/A
Appendices
Financial Performance Report

This report can be made available in other formats and in other languages. To discuss your requirements please contact Andy Gray, Company Secretary, on andrew.gray@wsht.nhs.uk or 01903 285288.

Finance Report M10 2017/18

Western Sussex Hospitals
NHS Foundation Trust

Summary
The Trust reported a deficit of £1.06m in January (before STF) reducing the cumulative surplus to £1.209m. Due to the impact of significant pressures experienced by the Trust in Q3 and continuing into Q4, the Trust is now reporting a year end forecast surplus of £0.583m. Including STF income earned in Q1-Q3, brings the forecast outturn to £8.096m. The Trust has referred its outstanding dispute with Coastal West Sussex CCG for expert determination. The forecast position excludes any impact from the outcome of this process. The Trust continues to report an FSSR rating of '1'.

SOF Finance Rating — G

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

At the end of January, the finance rating has a remained a '1'. Individual metrics are line with the plan, excluding distance from financial plan.

Control Total (exc STF) Surplus £k — A

	Plan	Actual / Forecast
Year to Date £k	3,064	1,209
Year End Forecast £k	3,363	583

At the end of January the Trust is reporting a surplus of £1.209m against a planned surplus of £3.064m. The Trust has declared a year end forecast of £0.583m due to the considerable pressures experienced during Q3 and continuing into Q4. Delivery of this forecast surplus means the Trust will not be eligible for a further £4.04m of STF income. Elective activity remains below plan in January, however, non-elective admissions increased accompanied by high drug and consumables expenditure.

Premium Pay Spend £k — G

	Plan	Actual
Agency Ceiling (YTD) £k	14,499	11,022
WLI Payments (YTD) £k	1,891	2,330
Total Premium Pay (YTD) £k	16,390	13,352

Premium pay expenditure is £3.0m below the target level at the end of January, primarily due to agency spend continuing to be below the ceiling level, mitigating overspends within waiting list initiatives. Expenditure on Waiting List Initiative payments is above plan by £0.3m.

Income £k — G

	Plan	Actual / Forecast
Year to Date £k	353,374	358,418
Year End Forecast	424,857	429,040

Cumulatively income is £5.0m above plan. Both the volume and complexity of non-elective admissions have increased in January which has meant that beds have not been available for elective patients. This has resulted in a reduction in elective activity this month. Private patient income remains behind plan year to date.

Operating Costs £k — R

	Plan	Actual / Forecast
Year to Date £k	(330,485)	(338,709)
Year End Forecast £k	(397,698)	(406,031)

Total Pay expenditure continued at the same level as seen in December and is now £5.4m above plan at the end of January. Nursing pay did decrease in month across all staff types, most significantly within bank pay with fewer shifts being undertaken in comparison to December. This was offset by an increase in Medical pay within substantive, locum and WLI's with agency staff remaining broadly at the level experienced in December. Non pay remains above plan and increased by £1.3m as a result of high levels of Emergency activity, £0.4m of this related to drugs and a further £0.5m related to PbR exclusions which are matched with income.

Agency Ceiling £k — G

	Plan	Actual/Forecast
Year to Date £k	14,499	11,022
Year End Forecast £k	17,249	13,088

Cumulatively agency expenditure is £3.48m below the ceiling target. In aggregate, expenditure was at a similar level to December's underlying run rate, with reduced demand in elective areas and reduced supply during the first half of the month. The Trust has forecast a year end expenditure of c.£13m.

Cash £k — A

	Plan	Actual
Year to Date £k	11,288	6,517
Year End Forecast £k	7,306	7,306

The cash position is behind plan by £4.8m. Increased trade receivables due outstanding invoices from 2016/17 activity with the Trust's main commissioner have been partially offset by slippage on the capital plan.

Capital £k — A

	Plan	Actual / Forecast
Year to Date £k	15,991	9,569
Year End Forecast £k	20,427	20,427

December capital expenditure totalled £1.5m, the largest contributor being £0.3m for IT infrastructure. Cumulatively the capital programme is now £6.4m behind plan, reflecting a delay in commencing schemes. As a number of these are now train, slippage is forecast to be recovered by year-end.

Efficiency and Transformation Programme £k — A

	Plan	Actual / Forecast
Year to Date £k	16,117	15,803
Year End Forecast £k	19,949	19,770

At the end of January the efficiency programme has delivered savings of £15.8m (98.1% of YTD plan). The shortfall within transformation and workforce schemes is being partially mitigated by over performance within Medicines Management, Commercial and Procurement schemes. The year end forecast remains £19.8m.

Key Risks:

1. The Trust and Coastal West Sussex CCG have signed a contract variation for 2017/18 which will allow the Trust and CCG to work more closely to promote clinical innovation, reduce activity and deliver services in different ways and settings which are better for patients. The contract variation has mitigated some financial risk present at the planning stage for both parties but there remains affordability and delivery risk for both parties that will be managed through a Joint Delivery Board. The outstanding items from 2016/17 have been referred for Expert Determination.
2. Alignment of capacity to non-elective and elective activity levels and responsiveness to changes in levels of demand. The Trust is experiencing significant operational pressures. Close management of capacity and flow will be required.
3. Achievement of financial control on a quarterly basis and delivery of access trajectories to secure access to the Sustainability and Transformation Funds. The Trust has delivered its Q3 financial control total but further improvements in financial performance will be required in order to secure the remaining STF income. The Q4 forecast is being reviewed and will be discussed with the Finance and Investment Committee.
4. Ability to exit premium rate workforce arrangements, Medical agency remains the most significant risk. The Workforce Transformation Group is overseeing action plans to increase recruitment, redesign workforce roles and manage sickness, rostering and retention issues. Opportunities to move to framework agencies and reduce rates paid per shift are also being explored.

Finance Report M10 2017/18 — SOF Finance Rating — G

At the end of January, the finance rating has a remained a '1'. Excluding the distance from the financial the individual metrics are line with the financial plan. Due to the reforecast that has taken place during Q3 and Q4, this metric will continue to below the plan value at '2'.

YTD	Plan Metric	Plan Rating	Actual Metric	Actual Rating
Capital Service Capacity	3.4	1	3.1	1
Liquidity	(2.4)	2	0.6	1
I&E Margin	3.3%	1	2.4%	1
Distance from Financial Plan	0.0%	1	(0.9)%	2
Agency Spend	(12.3)%	1	(24.0)%	1
2017/18 Finance Rating		**1**		**1**

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

Finance Report M10 2017/18 — Surplus — A

In January the Trust reported a deficit of £1.06m (before STF) bringing the cumulative surplus to £1.21m. The Trust has advised NHSI that we will be reporting a year end forecast surplus of £0.583m.

	Year To Date		
	Plan	Actual	Variance
	£k	£k	£k
Surplus (Deficit) including STF	**3,064**	**1,209**	**(1,855)**
less Sustainability and Transformation Fund	8,860	7,513	(1,348)
Underlying Performance against Control Total excluding STF	**11,924**	**8,721**	**(3,203)**

	Year Forecast		
	Plan	Forecast	Variance
	£k	£k	£k
Surplus (Deficit)	**3,363**	**583**	**(2,780)**
less Sustainability and Transformation Fund	**11,557**	**7,512**	(4,045)
Underlying Performance against Control Total excluding STF	**14,920**	**8,095**	**(6,825)**

Non-elective admissions remained high in January, with operational pressures continuing, this lead to over-performance in NEL income but was offset by reduced elective income.

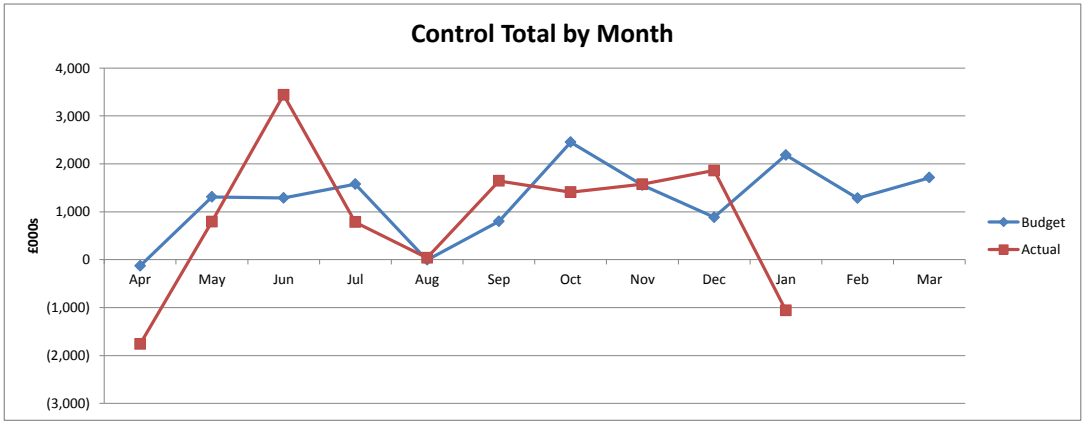
Nursing pay decreased by £0.32m in comparison with December. Substantive and bank nursing costs both reduced significantly with staff ending their supernumerary periods and reduced availability of staff working bank shifts. In contrast Medical staffing expenditure increased by £0.3m in comparison to December. The cause of the increase was new substantive appointments, alongside an increase in the usage of both locum, WLI and agency staff.

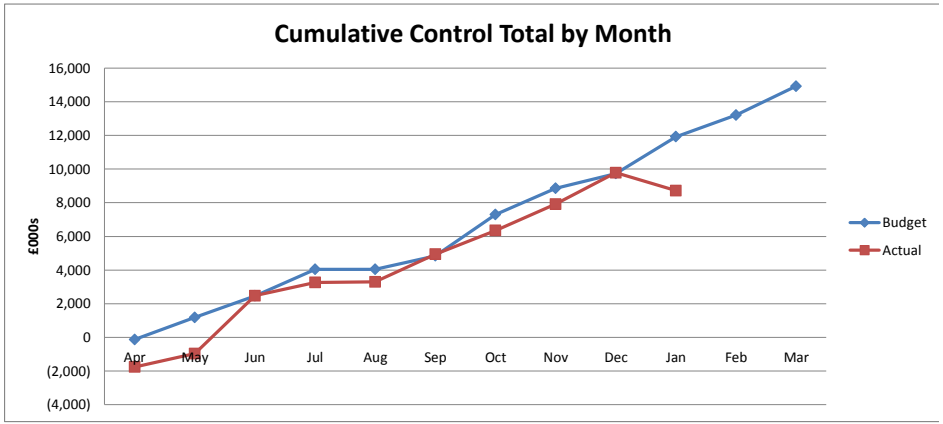
Non Pay Expenditure increased by £1.3m compared to December. Seasonal increases in Non Elective activity predominantly within drugs accounted for £0.9m of the non pay movement. Clinical supplies and services expenditure continues to be incurred above plan.

	Year to Date			
	Prev Yr Actual	Plan	Actual	Variance
	£k	£k	£k	£k
Income	*356,349*	353,374	358,418	5,044
Pay	*(233,795)*	(231,594)	(237,006)	(5,412)
Non-Pay (tariff)	(74,971)	(71,831)	(75,823)	(3,992)
Non-Pay (PbR exc)	(26,212)	(27,059)	(25,881)	1,179
EBITDA *	***21,371***	**22,890**	**19,709**	**(3,181)**
Profit / Loss on Disposal of Fixed Assets	*5*	-	7	7
Interest Payable	*(774)*	(740)	(676)	64
Interest Receivable	*22*	27	18	(9)
Depreciation	*(11,606)*	(12,112)	(11,597)	516
Impairments	-	-	-	-
Public Dividend Capital Dividend	*(6,299)*	(6,660)	(6,493)	167
Net Surplus / (Deficit)	***2,720***	**3,404**	**968**	**(2,436)**
less: Impairment	-	-	-	-
Retained Surplus/(Deficit)	**2,720**	**3,404**	**968**	**(2,436)**
Donated Assets	*(1,335)*	(1,234)	(529)	705
Donated Asset Depreciation and Amortisation	*904*	894	777	(117)
less Profit/Loss on Disposal of Fixed Assets	*(5)*	-	(7)	(7)
Control Total excluding STF	**2,284**	**3,064**	**1,209**	(1,855)
add Sustainability and Transformation Fund	11,000	8,860	7,513	(1,348)
Control Total including STF	**13,284**	**11,924**	**8,721**	**(3,203)**

* EBITDA Earnings before Interest Taxation Depreciation and Amortisation

	Full Year		
	Plan	Actual	Variance
	£k	£k	£k
Income	424,857	429,040	4,183
Pay	(277,945)	(284,563)	(6,618)
Non-Pay (tariff)	(87,566)	(90,580)	(3,014)
Non-Pay (PbR exc)	(32,187)	(30,888)	1,299
EBITDA *	**27,159**	**23,010**	**(4,149)**
Profit / Loss on Disposal of Fixed Assets	-	-	-
Interest Payable	(888)	(756)	132
Interest Receivable	33	23	(10)
Depreciation	(14,536)	(14,187)	349
Impairments	-	-	-
Public Dividend Capital Dividend	(7,989)	(7,791)	198
Net Surplus / (Deficit)	**3,779**	**299**	**(3,480)**
less: Impairment	-	-	-
Retained Surplus/(Deficit)	**3,779**	**299**	**(3,480)**
Donated Assets	(1,481)	(641)	840
Donated Asset Depreciation and Amortisation	1,065	925	(140)
less Profit/Loss on Disposal of Fixed Assets	-	-	-
Control Total excluding STF	**3,363**	**583**	(2,780)
add Sustainability and Transformation Fund	11,557	7,512	(4,045)
Control Total including STF	**14,920**	**8,095**	**(6,825)**





Finance Report M10 2017/18 — Sustainability and Transformation Fund — A

The financial performance in January was behind plan by £1.9m. The Trust's forecast has been revised to £0.6m surplus (exc STF) and therefore the Trust has not included any STF funding in M10. Trajectories are required and are monitored for RTT and Cancer waiting times but have no financial value associated with them.

			Q1	Q2	Q3	Jan-17	Feb-17	Mar-17	Q4	2017/18
	Plan	£000s	**737**	**803**	**2,228**	3,065	3,000	3,363	**3,363**	3,363
Financial Control Total (exc STF)	Actual	£000s	**741**	**897**	**2,265**	1,209			**0**	0
Eligible for STF Funding				Yes	**Yes**	No				
STF Income Available		£000s	**1,734**	**2,311**	**3,468**	-	1,348	1,349	**2,697**	10,210
Delivery of Financial Control Total	Achieved?			Yes	**Yes**	No				
	Income	70.0%	**1,213**	**1,618**	**2,428**	-			**1,888**	7,147
A&E Waiting Times	Achieved?			Yes	**Yes***	No				
	Income	30.0%	**520**	**693**	**1,040**				**809**	3,063
RTT	Achieved?			No	**No**	**No**				
	Income	0.0%	**0**						**0**	0
Cancer	Achieved?			Yes	**Yes**	**Yes**				
	Income	0.0%	**0**						**0**	0
Total STF Income Achieved (£000s)			**1,734**	**2,311**	**3,468**	**0**	**0**	**0**	**2,697**	10,210

Finance Report M10 2017/18	Income	G

Total income continues to overperform year to date and is £5.0m favourable to plan. Over-performance on commissioned income is being offset by lower non-contract income and private patient activity.

Year To Date

	Prev Yr. Actual £k	Plan £k	Actual £k	Variance £k
Total Income	**356,349**	**353,374**	**358,418**	**5,044**

Year End Forecast

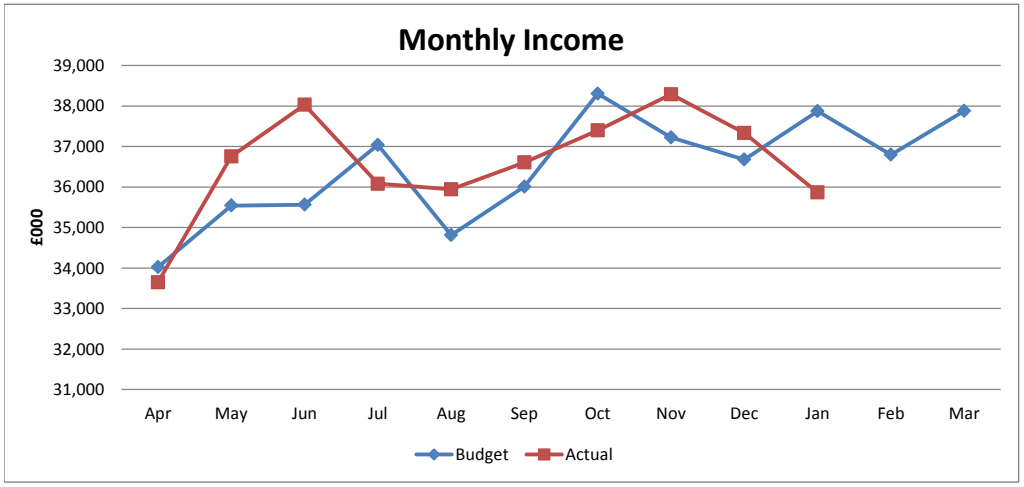
	Plan £k	Actual £k	Variance £k
Total Income	**424,857**	**429,040**	**4,183**

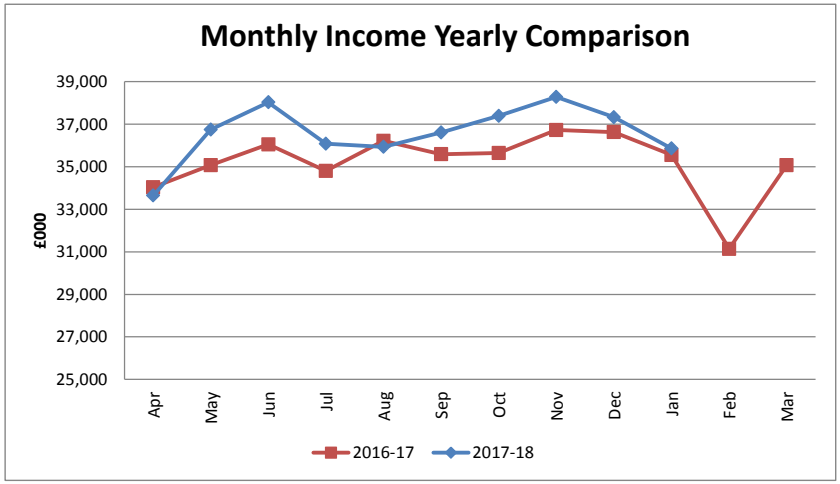
Cumulatively income is £5.0m above plan. Non-elective admissions have increased in activity and complexity in January, however numbers of elective admissions have reduced significantly.

Private patient income remains behind plan year to date. Planned increases in income from overseas visitors are continuing. Donated asset income is behind plan and is forecast to remain so, however, this is excluded from calculation of the control total.

		Year to Date		
Income	***Prev Yr Actual £k***	**Plan £k**	**Actual £k**	**Variance £k**
Coastal West Sussex	*249,231*	248,703	255,370	6,667
Other Clinical Commissioning Groups	*15,284*	16,564	15,735	(829)
Specialist LAT	*43,942*	41,231	40,819	(412)
WSCC - Sexual Health	*4,091*	4,347	4,288	(59)
NCA	*5,337*	5,147	4,871	(276)
Other Trust Income	*3,073*	1,570	1,996	426
Income From Activities	***320,959***	**317,562**	**323,079**	**5,517**
Private Patients	*5,597*	6,813	6,501	(312)
Education, Training and Research	*12,180*	11,929	12,623	694
Donated Asset / Grant Income	*1,335*	1,234	529	(705)
Other Income	*16,278*	15,836	15,686	(150)
Other Operating Income	***35,390***	**35,812**	**35,339**	**(473)**
Total Income	**356,349**	**353,374**	**358,418**	**5,044**
Sustainability and Transformation Funding (STF)	*11,000*	8,861	7,512	(1,349)
Total Income including STF	**367,349**	**362,235**	**365,930**	**3,695**
of which : PbR Drugs/Devices	*26,212*	*27,059*	*25,881*	*(1,179)*

		Full Year	
Income	**Plan £k**	**Actual £k**	**Variance £k**
Coastal West Sussex	298,443	304,560	6,117
Other Clinical Commissioning Groups	19,938	21,695	1,757
Specialist LAT	49,762	46,826	(2,936)
WSCC - Sexual Health	5,200	5,296	96
NCA	6,294	5,483	(811)
Other Trust Income	2,339	2,547	208
Income From Activities	**381,976**	**386,407**	**4,431**
Private Patients	6,977	6,487	(490)
Education, Training and Research	14,299	15,132	833
Donated Asset Income	1,481	641	(839)
Other Income	20,124	20,373	249
Other Operating Income	**42,881**	**42,633**	**(248)**
Total Income	**424,857**	**429,040**	**4,183**
Sustainability and Transformation Funding (STF)	11,557	7,512	(4,045)
Total Income including STF	***436,414***	**436,552**	**138**





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

1) Context

The Trust has signed contracts with all of its major commissioners. The Trust signed an Aligned Incentives contract variation with Coastal West Sussex Clinical Commissioning Group for 2017/18 in October.

2) YTD Report

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

Table 1. Total Financial Values by Contract

	Estimated Values YTD (inc CQUIN) £'000			
	FYE Plan	YTD Plan	YTD Actual	YTD Var
Coastal West Sussex	298,443	248,703	255,370	6,667
Other CCG Acute contracts	19,938	16,564	15,735	(829)
NHS England	49,762	41,231	40,819	(412)
Integrated Sexual Health Services	5,200	4,347	4,288	(59)
Non Contract Activity	6,294	5,147	4,871	(276)
Total	**379,637**	**315,991**	**321,082**	**5,091**

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

Table 2. Activity and Income by Point of Delivery

	Activity Volumes			£'000		
Point of Delivery	YTD Plan	YTD Actual	YTD Var	YTD Plan	YTD Actual	YTD Var
Daycases	50,662	48,134	(2,528)	32,220	30,841	(1,380)
Elective Spells	6,236	5,595	(641)	19,497	18,704	(792)
Elective Excess Bed days	1,178	777	(401)	292	193	(100)
Non Elective Spells	46,390	46,832	442	100,194	104,165	3,972
Non Elective short-stay	10,913	10,835	(78)	8,010	8,285	275
Non Elective Excess Bed days	5,324	13,515	8,191	1,353	3,460	2,108
Outpatients	507,679	491,722	(15,957)	52,842	51,308	(1,534)
A&E	119,464	117,114	(2,350)	15,139	15,182	43
PbR exclusions				27,059	25,881	(1,179)
Critical Care				13,600	12,283	(1,317)
Maternity Pathway				9,154	8,864	(289)
OP Diagnostic Imaging				6,338	6,143	(195)
Sexual Health				4,245	4,204	(41)
Direct Access Pathology				7,967	7,647	(320)
Other Direct Access (Imaging and Dietetics)				2,197	1,955	(242)
Breast Screening				2,525	2,525	-
Other				7,676	13,627	5,951
CQUIN				5,683	5,814	130
Total				315,991	321,082	5,091

Table 3. - Reconciliation to Income Reporting

	£000s		
	FYE Plan	YTD Plan	YTD Actual
Contract Monitoring Performance	372,796	310,309	315,269
CQUIN 2.0%	6,841	5,683	5,814
Total Contracted Income	**379,637**	**315,991**	**321,082**
Income Recharged non-contract			
Seasonal Resilience funding	2,208	1,104	1,104
Horsham Older People's service	370	308	308
Maternity pathway payment	(156)	(129)	(109)
Cystic Fibrosis	346	287	122
Other invoicing	(429)	0	334
Work-in-progress adjustment	0	0	237
Total Income from Activities	**381,976**	**317,561**	**323,078**
Strategic Transformation Fund	11,557	8,861	7,512
Total Income from Activities plus STF	**393,533**	**326,422**	**330,590**

Table 4. Contract Income by CCG and NHS England

SUSSEX CCGs and NHS ENGLAND	£'000		
	YTD Plan	YTD Actual	YTD Var
NHS COASTAL WEST SUSSEX CCG	248,703	255,370	6,667
NHS HORSHAM AND MID SUSSEX CCG	3,997	3,894	(103)
NHS BRIGHTON AND HOVE CCG	4,772	4,437	(335)
NHS HIGH WEALD LEWES HAVENS CCG	419	454	35
NHS CRAWLEY CCG	261	334	73
NHS EASTBOURNE, HAILSHAM AND SEAFORD CCG	404	368	(36)
NHS HASTINGS AND ROTHER CCG	215	234	19
NHS SOUTH EASTERN HAMPSHIRE CCG	5,288	4,858	(430)
NHS PORTSMOUTH CCG	549	473	(76)
NHS FAREHAM AND GOSPORT CCG	230	287	57
NHS GUILDFORD AND WAVERLEY CCG	429	397	(32)
Subtotal CCG Acute Contracts	**265,267**	**271,106**	**5,839**
NHS England	41,231	40,819	(412)
Total	**306,498**	**311,925**	**5,427**

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

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

Finance Report M10 2017/18	Operating Costs	R

Pay and non pay expenditure exceeds plan by £8.2m. Pay remained at a similar level to December in aggregate; however there was significant increases in Medical staff expenditure mitigated by reduced Nursing spend. Following completion of successful orientation periods for new starters, substantive nursing pay decreased and far fewer bank shifts were worked in comparison to December. Substantive medical pay increased further in month following further appointments. Premium rate medical pay increased to support operational pressures and is forecast to continue in Q4. Due to higher levels of emergency activity, drug expenditure showed an increase compared to the previous month. Clinical supplies and services expenditure remained comparable to the previous month, but cumulatively non pay expenditure remains above plan.

		Year To Date		
	Prev Yr Actual	Plan	Actual	Variance
		£k	£k	£k
Pay	***(233,795)***	**(231,594)**	**(237,006)**	**(5,412)**
Non Pay	***(101,183)***	**(98,890)**	**(101,703)**	**(2,813)**
Operational Costs	***(334,978)***	**(330,485)**	**(338,709)**	**(8,225)**

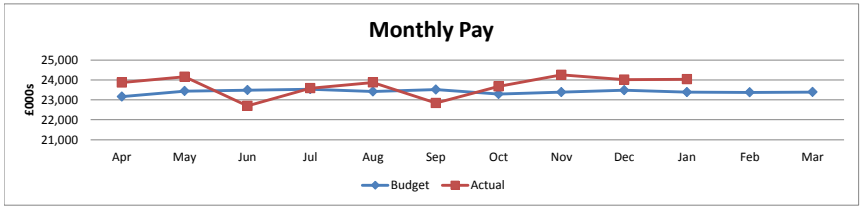
		Year Forecast	
	Plan	Actual	Variance
	£k	£k	£k
Pay	**(277,945)**	**(284,563)**	**(6,618)**
Non Pay	**(119,753)**	**(121,468)**	**(1,715)**
Operational Costs	**(397,698)**	**(406,031)**	**(8,333)**

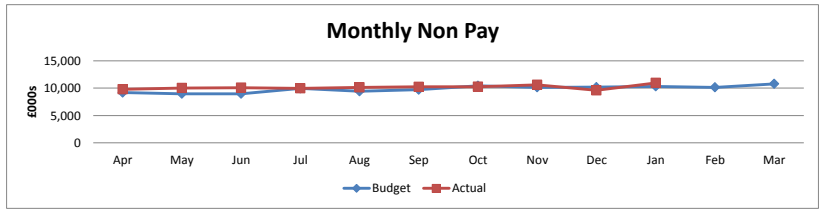
Pay: Expenditure in January remained at a comparable level with December in totality, however there were movements between the clinical staffing groups. Medical pay continued to increase within substantive staff following successful recruitment. In addition locum, WLI and agency expenditure all increased following short term mitigation in temporary staff usage over the Christmas period combined with increased numbers of emergency patients resulting in the Trust operating under business continuity measures for most of January. Nursing pay decreased across all staff headings, following a successful orientation period of new starters, substantive and agency expenditure decreased. Bank expenditure also decreased following unavailability of staff. In addition WLI and agency expenditure was also lower than the previous month as Elective activity remains below plan.

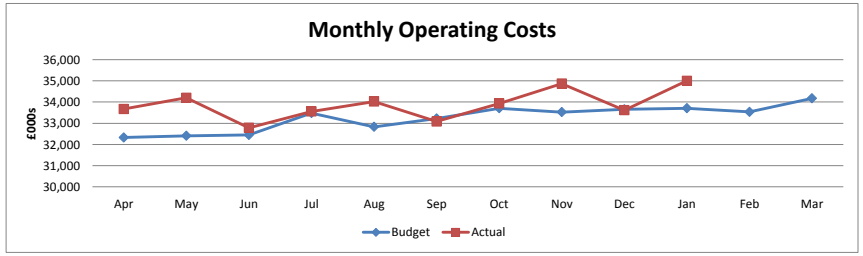
Non Pay: In aggregate expenditure was £1.3m higher than in December. High cost drug usage increased by £0.5m, accompanied by an offsetting increase within income. Clinical supplies and services remained at a similar level to December and tariff drugs also increased following a high month of Emergency activity. Cumulatively expenditure remains above plan with Pathology consumables continuing to impact adversely on the position.

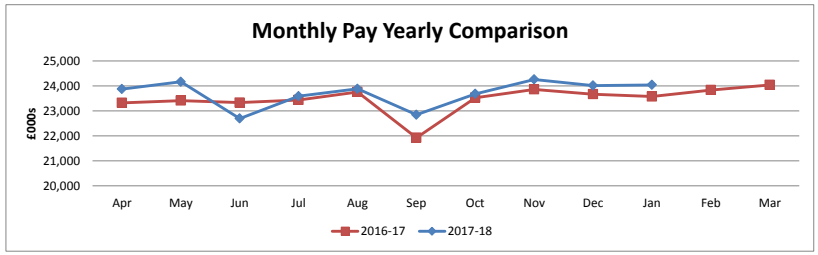
		Year to Date		
	Prep Yr. Actual	Plan	Actual	Variance
	£k	£k	£k	£k
Pay				
Management & Admin	(31,800)	(34,270)	(33,524)	746
Medical and Dental Staff	(66,339)	(64,939)	(68,693)	(3,754)
Nursing & Midwifery	(88,898)	(87,840)	(90,220)	(2,380)
Other Healthcare	(33,431)	(32,948)	(33,418)	(470)
Estates	(13,325)	(12,922)	(12,543)	378
Other Staff	(1)	1,325	1,393	68
Total Pay	**(233,795)**	**(231,594)**	**(237,006)**	**(5,412)**
Non-Pay				
Services from Other NHS Bodies	(2,979)	(1,914)	(2,378)	(464)
Purchase of Healthcare from Non NHS Bodies	(2,099)	(1,955)	(1,721)	233
Drugs & Medical Gases - tariff	(10,103)	(10,261)	(10,730)	(469)
Drugs & Medical Gases - PbR excluded	(21,439)	(21,646)	(21,512)	134
Drugs & Medical Gases - Cancer Drug Fund	(2,199)	(2,445)	(1,346)	1,100
Supplies and Services - Clinical	(29,073)	(27,036)	(28,876)	(1,839)
Supplies and Services - Clinical PbR Excluded	(2,575)	(2,968)	(3,023)	(55)
Supplies and Services - General	(3,707)	(2,978)	(3,226)	(248)
Establishment Expenses	(5,040)	(4,330)	(4,862)	(532)
Premises	(12,765)	(13,112)	(13,199)	(87)
Education and Training	(684)	(1,056)	(749)	307
Clinical Negligence Premium	(6,051)	(8,619)	(8,470)	148
Other Non-Pay	(2,469)	(571)	(1,612)	(1,041)
Total Non-Pay	**(101,183)**	**(98,890)**	**(101,703)**	**(2,813)**
Total Expenditure	**(334,978)**	**(330,485)**	**(338,709)**	**(8,225)**

		Full Year	
	Plan	Actual	Variance
	£k	£k	£k
Pay			
Management & Admin	(41,111)	(38,896)	2,215
Medical and Dental Staff	(77,981)	(81,967)	(3,986)
Nursing & Midwifery	(105,391)	(108,471)	(3,080)
Other Healthcare	(39,510)	(40,130)	(620)
Estates	(15,399)	(15,044)	355
Other Staff	1,447	(55)	(1,502)
Total Pay	**(277,945)**	**(284,563)**	**(6,618)**
Non-Pay			
Services from Other NHS Bodies	(2,291)	(2,764)	(473)
Purchase of Healthcare from Non NHS Bodies	(2,350)	(2,032)	318
Drugs & Medical Gases	(12,437)	(12,557)	(120)
Drugs & Medical Gases - PbR excluded	(22,884)	(21,520)	1,364
Drugs & Medical Gases - Cancer Drug Fund	(5,792)	(5,792)	0
Supplies and Services - Clinical	(32,621)	(34,646)	(2,025)
Supplies and Services - Clinical PbR Excluded	(3,511)	(3,576)	(65)
Supplies and Services - General	(3,561)	(3,766)	(205)
Establishment Expenses	(5,198)	(6,598)	(1,400)
Premises	(15,784)	(16,184)	(400)
Education and Training	(1,246)	(1,192)	54
Clinical Negligence Premium	(10,342)	(10,342)	0
Other Non-Pay	(1,736)	(499)	1,237
Total Non-Pay	**(119,753)**	**(121,468)**	**(1,715)**
Total Expenditure	**(397,698)**	**(406,031)**	**(8,333)**





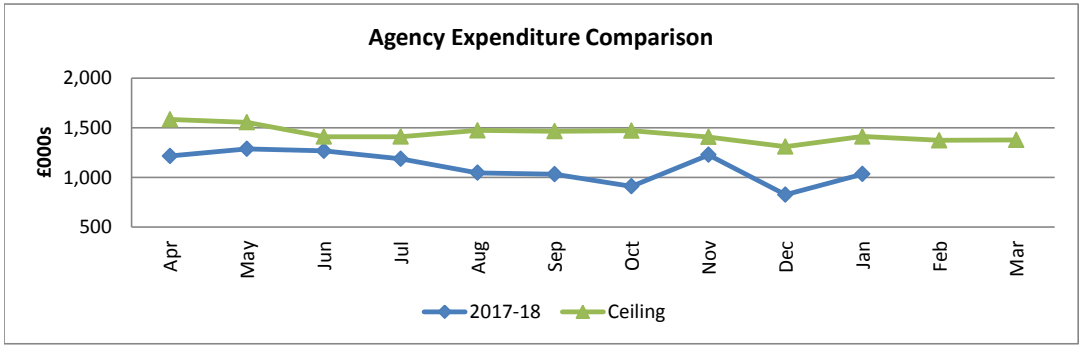




Finance Report M10 2017/18 — Payroll & Premium Pay Costs — R

Agency	Year To Date				
	2015/16	*2016/17*	Ceiling	Actual	Variance
	£k	*£k*	£k	£k	£k
Medical and Dental Staff	*(8,877)*	*(5,529)*	(5,617)	(5,707)	(90)
Nursing & Midwifery	*(7,140)*	*(8,096)*	(7,271)	(4,008)	3,263
Other Healthcare	*(2,454)*	*(1,934)*	(1,594)	(1,212)	383
Management & Admin	*(362)*	*(195)*	-	(89)	(89)
Estates	*(398)*	*(181)*	(17)	(7)	10
	-				
	(19,231)	***(15,934)***	***(14,499)***	**(11,022)**	**3,477**

Waiting List Initiative Payments	Year to Date		
	Budget	Actual	Variance
Division			
Surgery	(1,047)	(1,181)	(134)
Medicine	(123)	(371)	(248)
Core	(806)	(736)	70
Women & Children	(10)	(42)	(32)
Corporate	*95*	*(0)*	(95)
	(1,891)	***(2,330)***	**(439)**



Medical Locum	Year to Date		
	Budget	Actual	Variance
Division			
Surgery	(547)	(561)	(13)
Medicine	(1,196)	(4,038)	(2,842)
Core	(400)	(304)	96
Women & Children	(86)	(725)	(638)
Corporate	*10*	*(19)*	(29)
	(2,220)	***(5,646)***	**(3,426)**

Payroll	Year To Date			
	Prev Yr Actual	Plan	Actual	Variance
	£k	£k	£k	£k
Medical and Dental Staff	*(60,810)*	*(58,295)*	*(55,640)*	2,655
Nursing & Midwifery	*(80,802)*	*(84,554)*	*(85,830)*	(1,275)
Other Healthcare	*(31,497)*	*(32,075)*	*(32,010)*	65
Management & Admin	*(31,605)*	*(34,223)*	*(33,386)*	837
Estates	*(13,144)*	*(12,896)*	*(12,533)*	363
Other Staff	*(1)*	*1,325*	*1,393*	68
	(217,861)	**(220,718)**	**(218,006)**	**2,712**

Staff in post incl Bank	Year To Date			
	Prev Yr Actual	Plan	Actual	Variance
	WTE	WTE	WTE	WTE
Medical and Dental Staff	*752*	791	797	(6)
Nursing & Midwifery	*2,625*	2,807	2,757	50
Other Healthcare	*1,003*	1,047	1,011	37
Management & Admin	*1,308*	1,328	1,299	29
Estates	*643*	660	624	35
Other Staff	-	-	-	-
	6,331	**6,633**	**6,488**	**145**

Finance Report M10 2017/18 — Divisional Performance — R

Surgery: Operational pressures in January resulted in the cancellation of the majority of elective surgery for the first three weeks of the month. The associated contract income was partly offset by high levels of non elective demand, including high acuity patients in critical care, but overall income remains below plan. Cancelled elective activity, particularly in T&O, led to an associated reduction in non pay including prosthesis and other high cost implants, though recruitment fees were also incurred in month as the division addresses significant shortfalls in the junior doctor workforce. Despite these new starters, medical staffing and admin vacancies seen throughout the year remain and continue to support a favourable position within pay.

	Year To Date				
	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Contract Income	92,588	89,110	85,918	(3,191)	R
Other Income	1,851	1,794	1,949	155	G
Total Income	**94,440**	**90,903**	**87,867**	**(3,036)**	R
Pay	(53,563)	(53,069)	(52,825)	244	G
Non Pay	(18,900)	(18,423)	(18,342)	81	G
Total Expenditure	**(72,463)**	**(71,492)**	**(71,168)**	**324**	G
EBITDA Surplus/(Deficit)	**21,977**	**19,412**	**16,700**	**(2,712)**	R

Medicine: In January performance on non-elective activity was significantly above plan predominantly within General Medicine, Cardiology and Respiratory which is contributing to the favourable contract income position. Continued premium spend pressures relating to nursing vacancies and medical rota gaps caused expenditure to remain above plan, although Nursing spend in month was lower than planned due to escalation facilities running below full capacity due to restricted availability of Nursing resource. non pay relating to clinical consumables accelerated in line with increased non elective activity mainly reflected in the drugs and clinical supplies financial position.

	Year To Date				
	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Contract Income	132,840	136,937	138,940	2,003	G
Other Income	2,477	2,343	2,363	21	G
Total Income	**135,318**	**139,280**	**141,304**	**2,024**	G
Pay	(73,674)	(71,629)	(75,794)	(4,166)	R
Non Pay	(28,922)	(28,876)	(28,779)	98	G
Total Expenditure	**(102,596)**	**(100,505)**	**(104,573)**	**(4,068)**	R
EBITDA Surplus/(Deficit)	**32,722**	**38,775**	**36,731**	**(2,044)**	R

Core: Contract income continues to be behind plan levels with direct access activity below plan due to staffing constraints. Other income is on plan during January but lower private patient activity and reduced NMET income earlier in the year are driving the cumulative adverse variance to plan. Pay expenditure continues above plan predominantly within Medical Imaging, as vacancies remain covered by temporary staff at premium rates. Lack of agency availability has increased WLI premium payments within Radiology. Non pay expenditure remains above plan predominantly in Pathology where consumable expenditure remains a key driver.

	Year To Date				
	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Contract Income	34,134	37,349	36,606	(743)	R
Other Income	9,971	10,002	9,752	(250)	R
Total Income	**44,105**	**47,351**	**46,358**	**(993)**	R
Pay	(46,546)	(46,757)	(47,210)	(454)	R
Non Pay	(20,675)	(19,622)	(21,067)	(1,444)	R
Total Expenditure	**(67,220)**	**(66,379)**	**(68,277)**	**(1,898)**	R
EBITDA Surplus/(Deficit)	**(23,116)**	**(19,027)**	**(21,919)**	**(2,891)**	R

Women & Children: Contract activity is favourable to plan predominantly due to high levels of maternity activity which saw a peak in January. The number of babies delivered during January was higher than seasonal expectation based on the last five years. Neonatal activity was also high contributing to the favourable plan variance. Increased levels of activity have driven higher than expected expenditure on both drugs and cinical supplies in non pay. There are ongoing staffing pressures within medical staffing, resulting in a continued overspend on pay.

	Year To Date				
	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Contract Income	49,134	50,888	51,285	398	G
Other Income	693	702	827	125	G
Total Income	**49,827**	**51,589**	**52,112**	**523**	G
Pay	(26,034)	(25,777)	(26,619)	(842)	R
Non Pay	(9,064)	(9,637)	(9,735)	(99)	R
Total Expenditure	**(35,098)**	**(35,413)**	**(36,355)**	**(941)**	R
EBITDA Surplus/(Deficit)	**14,729**	**16,176**	**15,758**	**(418)**	R

Facilities & Estates: Income continues to deliver below plan predominantly due to lower income earlier in the year following problems with the car parking barriers. Pay remains favourable to plan with a number of roster improvements being implemented which has reduced premium rate . Non pay remains adverse to plan with utilities charges being higher than plan levels, increased patient catering costs and approx £0.1m of repair and maintenance costs relating to the fire earlier in the year.

	Year To Date				
	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Contract Income	0	-	-	-	
Other Income	4,299	3,605	3,433	(172)	R
Total Income	**4,299**	**3,605**	**3,433**	**(172)**	R
Pay	(13,530)	(12,979)	(12,512)	467	G
Non Pay	(12,118)	(11,888)	(12,196)	(308)	R
Total Expenditure	**(25,648)**	**(24,868)**	**(24,708)**	**160**	G
EBITDA Surplus/(Deficit)	**(21,349)**	**(21,262)**	**(21,275)**	**(13)**	R

Corporate: The high levels of emergency activity continue to compromise delivery of private patient activity and income continues to be behind plan due to the demand for beds by NHS patients. Admin and managerial expenditure continues to be below plan.

	Year To Date				
	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Contract Income	3	(0)	0	0	G
Other Income	12,577	12,814	13,740	926	G
Total Income	**12,580**	**12,813**	**13,740**	**926**	G
Pay	(21,956)	(23,139)	(22,891)	248	G
Non Pay	(11,847)	(12,111)	(12,265)	(154)	R
Total Expenditure	**(33,803)**	**(35,250)**	**(35,156)**	**95**	G
EBITDA Surplus/(Deficit)	**(21,223)**	**(22,437)**	**(21,416)**	**1,021**	G

Finance Report M10 2017/18 — Statement of Financial Position

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

	Year to Date			
	Plan	Actual	Variance	Notes
	£k	£k	£k	
Property, Plant and Equipment	281,454	265,791	(15,663)	1
Intangible Assets	390	4,830	4,440	
Other Assets	-	-	-	
Non Current Assets	**281,844**	**270,621**	**(11,223)**	
Inventories	6,637	7,029	392	
Trade and Other Receivables	36,926	41,740	4,813	2
Cash and Cash Equivalents	11,288	6,517	(4,771)	
Non Current Assets Held for Sale	-	-	-	
Current Assets	**54,852**	**55,287**	**435**	
Trade and Other Payables	(48,392)	(45,979)	2,413	3
Borrowings	(1,724)	(1,128)	596	
Other Financial Liabilities	-	-	-	
Provisions	(756)	(443)	313	
Other Liabilities	-	-	-	
Current Liabilities	**(50,872)**	**(47,550)**	**3,322**	
Borrowings	(21,643)	(22,185)	(542)	
Trade and Other Payables	-	-	-	
Provisions	(2,585)	(2,958)	(373)	
TOTAL ASSETS EMPLOYED	**261,596**	**253,215**	**(8,381)**	
Financed by:				
Public Dividend Capital	239,210	240,260	1,050	
Retained Earnings	(22,603)	(34,866)	(12,263)	
Surplus/(Deficit) for Year	-	-	-	
Revaluation Reserve	44,989	47,821	2,832	
TOTAL TAXPAYERS EQUITY	**261,596**	**253,215**	**(8,381)**	

	Full Year			
	Plan	Actual	Variance	Notes
	£k	£k	£k	
Property, Plant and Equipment	277,373	274,596	(2,777)	1
Intangible Assets	390	4,830	4,440	
Other Assets	-	-	-	
Non Current Assets	**277,763**	**279,426**	**1,663**	
Inventories	6,450	6,673	223	
Trade and Other Receivables	43,268	32,494	(10,774)	
Cash and Cash Equivalents	7,306	7,306	(0)	
Non Current Assets Held for Sale	-	-	-	
Current Assets	**57,024**	**46,473**	**(10,551)**	
Trade and Other Payables	(48,292)	(40,441)	7,851	
Borrowings	(2,224)	(2,207)	17	
Other Financial Liabilities	-	-	-	
Provisions	(811)	(412)	399	
Other Liabilities	-	-	-	
Current Liabilities	**(51,327)**	**(43,060)**	**8,267**	
Borrowings	(20,564)	(20,564)	-	
Trade and Other Payables	-	-	-	
Provisions	(2,530)	(2,958)	(428)	
TOTAL ASSETS EMPLOYED	**260,366**	**259,317**	**(1,049)**	
Financed by:				
Public Dividend Capital	239,210	240,634	1,424	
Retained Earnings	(19,833)	(29,138)	(9,305)	
(Surplus)/Deficit for Year	-	-	-	
Revaluation Reserve	40,989	47,821	6,832	
TOTAL TAXPAYERS EQUITY	**260,366**	**259,317**	**(1,049)**	

1. The out-turn position includes the full delivery of the capital programme. The variance to plan is due to the impact of year-end valuations in 2016/17.
2. The trade and other receivables balance continues to be higher than plan due to higher trade receivables due to 2016/17 invoices raised to the Trust's main commissioner that remain outstanding.
3. Trade payables are lower than plan due to the Trust being able to reduce the outturn creditor numbers in 2016/17 by £4.2m, however the restriction of supplier payments continues in Q4 2017/18, which is being mitigated by slippage on the capital plan.

Finance Report M10 2017/18 — Cash — A

The cash position is behind plan by £4.8m. This is predominantly due to a reduction in working capital due to outstanding invoices for 2016/17 resulting from the disputed balance with the Trust's main commissioner. The Trust's financial position has contributed to an adverse cash variance of £3.3m. These items have been partially offset by slippage on the capital plan.

	Year To Date		
	Plan	Actual	Variance
	£k	£k	£k
Cash Balance	**11,288**	**6,517**	**(4,771)**

	Full Year		
	Plan	Actual	Variance
	£k	£k	£k
	7,306	**7,306**	**(0)**

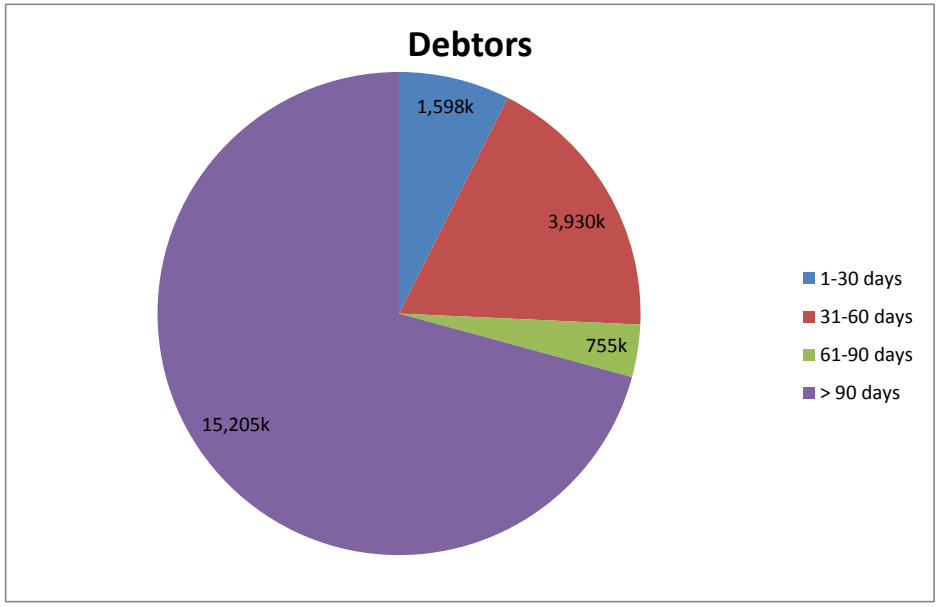
	Year to Date		
	Plan	Actual	Variance
	£k	£k	£k
EBITDA	30,519	27,239	(3,280)
Movement in Working Capital	(1,666)	(11,254)	(9,588)
Provisions	-	45	45
Cashflow from Operations	**28,853**	**16,030**	**(12,823)**
Capital Expenditure	(15,989)	(9,678)	6,311
Cash receipt from asset sales	-	-	-
Cashflow before financing	**12,864**	**6,352**	**(6,512)**
PDC Received	-	1,050	1,050
PDC Repaid	-	-	-
Dividends Paid	(3,996)	(4,697)	(701)
Interest on Loans and leases	(740)	(667)	73
Interest received	27	18	(9)
Donations received in cash	-	-	-
Drawdown on debt	-	-	-
Repayment of debt	(1,579)	(1,579)	-
Cashflow from financing	**(6,288)**	**(5,874)**	**414**
Net Cash Inflow / (Outflow)	**6,576**	**477**	**(6,099)**
Opening Cash Balance	4,712	6,040	1,328
Closing Cash Balance	**11,288**	**6,517**	**(4,771)**

	Full Year		
	Plan	Forecast	Variance
	£k	£k	£k
EBITDA	37,233	36,683	(550)
Movement in Working Capital	(4,635)	(5,566)	(931)
Provisions	-	13	13
Cashflow from Operations	**32,598**	**31,130**	**(1,468)**
Capital Expenditure	(19,003)	(20,427)	(1,424)
Cash receipt from asset sales	-	-	-
Cashflow before financing	**13,595**	**10,703**	**(2,892)**
PDC Received	-	1,424	1,424
PDC Repaid	-	-	-
Dividends Paid	(7,987)	(7,791)	196
Interest on Loans and leases	(888)	(939)	(51)
Interest received	33	27	(6)
Donations received in cash	-	-	-
Drawdown on debt	-	-	-
Repayment of debt	(2,158)	(2,158)	-
Cashflow from financing	**(11,000)**	**(9,437)**	**1,563**
Net Cash Inflow / (Outflow)	**2,595**	**1,266**	(1,329)
Opening Cash Balance	4,712	6,040	1,328
Closing Cash Balance	**7,306**	**7,306**	**(0)**

Finance Report M10 2017/18 — Aged Debtors

The Trust debtors are a mixture of invoiced debtors, accrued income and prepayments as set out in the table below. The Trust has outstanding debtors of 31 days or more of £19.9m, which is an increase since December of £1.9m, predominantly relating to NHS England (which was paid on the 15th February). The most significant debtors greater than 90 days also relate to invoices for 2016/17 over-performance with the Trust's lead CCG and outstanding balances with three foundation trusts for provider to provider agreements and specialist drugs/services.

	Within Terms	Overdue				Total
		1-30 days	31-60 days	61-90 days	> 90 days	
	£k	£k	£k	£k	£k	£k
CCG's	56	432	208	120	10,027	10,843
NHS England (in Health Education England)	415	782	1,195	25	257	2,674
NHS Trusts	249	83	1,271	296	1,364	3,262
Foundation Trusts	623	102	580	140	2,349	3,795
Other NHS	10	3	14	7	107	141
Non-NHS	240	197	662	166	1,101	2,367
Total	**1,593**	**1,598**	**3,930**	**755**	**15,205**	**23,081**
	7%	**7%**	**17%**	**3%**	**66%**	
Provision for Bad Debts (including RTA Provision)					(731)	
Accrued Income (including Work in Progress)					10,024	
Prepayments					4,623	
Other Debtors					4,743	
Total Trade & Other Receivables					**41,740**	



Other debtors includes £2.2m of RTA debtors, £1.0m of Private Patients, £0.7m relates to Charity funding (of which £0.4m relates to the League of Friends) and £0.7m relating to VAT and other debtors. Accrued income consists of £5.4m of commissioner income (which includes £3.5m of Q3 STF income), £0.4m of provider to provider income, non-contracted activity £0.4m, drugs/pharmacy £0.6m, private patients £0.3m, work-in-progress £2.7m and £0.3m of other income recharges including radiology, catering and clinical excellence awards.

Finance Report M10 2017/18 — Capital — A

December capital expenditure totalled £1.5m, the largest contributors being £0.3m for IT infrastructure, £0.3m for GP A&E streaming, £0.2m on ward reconfiguration and £0.2m of expenditure on the Southlands masterplan. Cumulatively the capital programme is now £6.4m behind plan, reflecting a delay in commencing the schemes relating to ward reconfiguration (£1.8m), patient catering services (£1.4m) and other service development schemes (£1.3m). An updated forecast was presented and discussed at the last Capital Investment Group. The Trust is continuing to forecast full delivery of the capital plan.

Year To Date	Plan £k	Actual £k	Variance £k
Total Capital	**15,991**	**9,569**	**6,422**

Year End Forecast	Plan £k	Actual £k	Variance £k
Total Capital	**20,427**	**20,427**	**-**

Capital	Year to Date Budget £k	Year to Date Actual £k	Year to Date Variance £k
Source of Funds			
Depreciation (net of IFRIC 12)	12,112	11,597	(515)
Loan Repayments	-	-	-
Charitable Funds	667	112	(555)
Donation/Grants	321	417	96
GP A&E Streaming PDC Funding	-	1,050	1,050
Cash Reserves		509	
	13,099	**13,685**	**77**
Application of Funds			
Southlands Ophthalmology	498	746	(248)
MSK	500	-	500
Equipment Replacement - Imaging	550	221	329
Other Service Developments	10,509	3,654	6,855
Medical Equipment	1,834	1,072	762
Facilities & Estates	3,673	1,188	2,485
Information Technology	2,785	2,441	344
Misc	-	247	(247)
Overprogramming	(4,359)	-	(4,359)
Total Expenditure	**15,991**	**9,569**	**6,422**

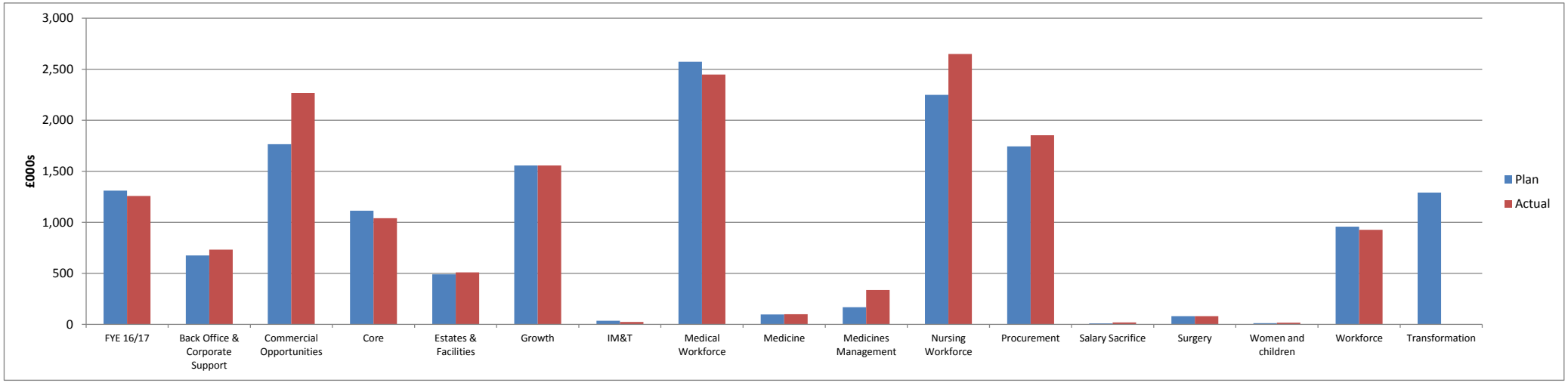
	Full Year Plan £k	Full Year Actual £k	Full Year Variance £k
Source of Funds			
Depreciation (net of IFRIC 12)	15,180	15,180	-
Loan Repayments	(1,158)	(1,158)	-
Charitable Funds	1,000	1,000	-
Donation/Grants	481	481	-
GP A&E Streaming PDC Funding	-	1,424	1,424
Cash Reserves	3,500	3,500	-
	19,003	**20,427**	**1,424**
Application of Funds			
Southlands Ophthalmology	498	498	-
MSK	500	500	-
Equipment Replacement - Imaging	1,050	1,050	-
Other Service Developments	12,800	12,800	-
Medical Equipment	2,096	2,096	-
Facilities & Estates	4,894	4,894	-
Information Technology	3,581	3,581	-
Misc	-	-	-
Overprogramming	(4,992)	(4,992)	-
Total Expenditure	**20,427**	**20,427**	**-**

Finance Report M10 2017/18 — Efficiency and Transformation Programme — A

At the end of January, efficiency savings of £15.8m (98.1% of YTD plan) have been achieved. Under-performance in workforce and transformation schemes has been mitigated by over-performance in Medicines Management, Commercial and Procurement work-streams. The forecast out-turn position is £19.8m.

	Year to Date			Forecast Out-turn		
Workstream	**Plan**	**Actual**	**Variance**	**Plan**	**Forecast**	**Variance**
	£k	**£k**	**£k**	**£k**	**£k**	**£k**
FYE 16/17	1,309	1,258	(51)	1,348	1,293	(56)
Back Office & Corporate Support	674	733	59	847	877	30
Commercial Opportunities	1,764	2,267	503	2,174	3,197	1,023
Core	1,112	1,039	(73)	1,418	1,298	(120)
Estates & Facilities	490	509	19	583	633	50
Growth	1,556	1,556	-	2,000	2,000	-
IM&T	35	22	(13)	53	32	(20)
Medical Workforce	2,574	2,448	(125)	3,246	3,116	(130)
Medicine	97	98	1	100	100	0
Medicines Management	168	335	167	200	390	189
Nursing Workforce	2,250	2,650	400	2,866	3,266	401
Procurement	1,743	1,852	109	2,150	2,269	119
Salary Sacrifice	8	17	9	10	15	5
Surgery	79	79	-	94	94	-
Women and children	11	16	5	16	13	(3)
Workforce	956	925	(31)	1,230	1,177	(53)
Transformation	1,291	-	(1,291)	1,614	-	(1,614)
Efficiency Plan Total	**16,117**	**15,803**	**(314)**	**19,949**	**19,770**	**(180)**

Month 10 Plan vs Actual



Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board

Date of Meeting: February 2018 Agenda Item: 6

Title
Report on Serious Incidents Requiring Investigation – Executive Summary February 2018
Responsible Executive Director
Nicola Ranger, Executive Director of Nursing and Patient Safety Maggie Davies, Nursing Director
Prepared by
Mary Evans, Patient Safety and Risk Manager
Status
Non disclosable
Summary of Proposal
The purpose of this report is to provide an update and analysis of reported serious untoward incidents currently open and undergoing investigation in January 2018.
Implications for Quality of Care
1. Failure to report SIRI may compromise patient care. 2. Incomplete reporting may result in recurrence of patient safety incident. 3. Loss of public confidence in the Trust.
Link to Strategic Objectives/Board Assurance Framework
Support of Board Assurance Framework number B1, C1
Financial Implications
1. Financial penalties may be incurred in the event of a reported Never Event. 2. Subsequent patient litigation claims may occur. 3. Loss of Commissioner confidence may result in loss of Trust business.
Human Resource Implications
1. Professional performance management issues for individuals. 2. Learning and development requirements. 3. Organisational, behavioural and cultural issues.
Recommendation
The Board is asked to note the contents of the report.
Communication
The SIRI RCAs are reviewed by the CCG Scrutiny Committee.
Appendices
Serious Incidents Requiring Investigation – Executive Summary February 2018 Appendix 1 Code Red Update Report

This report can be made available in other formats and in other languages. To discuss your requirements please contact Andy Gray, Company Secretary, on andrew.gray@wsht.nhs.uk or 01903 285288.

Serious Incidents Requiring Investigation – Executive Summary February 2018 (reported in January 2018)

This report aims to provide the board of directors with assurance that serious incidents (SIRIs) including Never Events are identified, reported, investigated fully and lessons learnt across WSHFT. The Trust's approach to SIRIs is to be open and transparent and to use incidents as an opportunity for the Trust to learn and improve care for patients.

Monthly Update

Current SIRI Position 2017-18

SIRI	Jan 17	Feb 17	Mar 17	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18
New - Excluding Pressure Ulcers	8	0	4	3	5	8	1	5	6	2	4	10	6
New - Pressure Ulcers reported as SIRIs	0	0	0	0	0	0	0	0	0	0	0	0	0
Under investigation	12	10	8	6	6	13	9	9	10	9	12	15	18
Submitted to CCG	8	3	5	5	3	3	5	2	4	4	2	5	4
Closed by CCG	8	8	6	3	4	6	1	3	5	3	3	5	7
De-Escalated as an SI by CCG	0	0	0	1	0	0	0	0	0	0	0	0	0

Current Never Event Position
The previous Never Event occurred in Oct 2017

Never Event	Jan 17	Feb 17	Mar 17	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18
New	1	0	0	1	0	0	0	1* *de-escalated as NE	1	0	0	0	0
Under investigation	1	1	1	0	1	1	1	0	0	1	1	0	0
Submitted to CCG	1	0	0	1	0	0	0	0	0	0	0	1	1
Closed by CCG	0	0	0	0	1	0	0	1	0	0	0	0	0

New incidents

During February 2018, 6 serious incidents were declared (SIRIs). The table below provides initial information on the incident, initial grading and the due date for submission of the investigation report to Coastal West Sussex Clinical Commissioning Group (CCG).

Incident Date/ STEIS Number	Incident Summary and Location	Initial Grading	Date due for Submission to CCG
30/12/17 2018/127	Fall resulting in #NOF and surgery –**Wittering (SRH)**	Moderate	March 18
09/06/2017 2018/1038	Failure to diagnose Lung ca – **Orthopaedics SRH**	Severe	April 18
17/01/2018 2018/1681	Infection control (Flu outbreak)- **various wards**	Moderate	April 18
29/12/2010 2018/1721	Diagnostic incident – **Gynae Worthing**	Severe	April 18
12/01/2018 2018/2109	IG Breach **– Breast screening**	Moderate	April 18
27/01/2018 2018/2499	Collision with lift door resulting in #NOF and surgery - **O/P for dialysis Dixon ward**	Moderate	April 18

Incidents under investigation

Currently 18 SIRIs remain under investigation and there is no concern that these will not meet their submission timescale.

Submitted and closed incidents

The Trust submitted 4 completed investigation reports to the CCG during February 2018 and the following actions were identified as a result of the investigations. These actions will be monitored for completion by the relevant Division and the Triangulation Committee.

Incident **2017/24692**	
Maternity Incident – baby only	Actions: • Women with high risk pregnancies should receive appropriate obstetric input and continuous electronic fetal monitoring when attending the unit with regular uterine contractions. This ensures appropriate management plans are made in conjunction with the woman's wishes, clinical picture and aids in appropriate communication across the multidisciplinary team members. • The SBAR tool should be highlighted both in respect of handover from clinician to clinician but also during the ward handovers. This ensures that effective communication is carried out with the appropriate information is being shared. The panel also felt that

	when transferring women from one ward to another that the woman should not be left until the receiving clinician acknowledges the handover within the maternity records. • That ineffective communication between the multidisciplinary team meant that no method was considered to rectify loss of contact of the fetal heart rate on the CTG. Led to no personal obstetric review being undertaken and that concerns were either not recognised or escalation of these were not carried out in a timely way. • The emergency bell should have been activated rather than the call bell, this would have communicated to the team on the labour ward that help was immediate help was being requested and earlier intervention initiated if required.
Incident **2017/25098**	
Inpatient fall resulting in dislocation requiring surgery	Actions: • Falls risk assessments completed on admission. • Falls prevention care plans completed on admission for patients with a history of falls or those being admitted following a fall • Falls assessments to be reviewed weekly and or if patients condition changes • Bedrail assessment to be completed on admission • Matrons to undertake documentation audits of ward area • Falls risk assessment and documentation to be discussed daily at huddle • Falls prevention action plans and initial risk assessments theme at daily ward safety huddles. • Use of sensor mat for at risk patients • Discuss admission assessment with the admitting nurse. • Admitting nurse to complete assessments in full and document retrospective submission. • Patients at risk to be assessed for use of sensor mat in bed and whilst out in the chair • Undertake a review of actions taken after 18 months and report back to SIRI committee
Incident **2017/29529**	
Inpatient fall resulting in #NOF	Actions: • Ensure relatives fully aware of falls risk and mobilisation goals. • Wards sister to share with nursing team. • Physiotherapy lead to share with physiotherapy team.
Incident **2017/29509**	
Inpatient fall resulting in #NOF	• Mental Capacity assessments to be performed and recorded in medical notes. Feedback to medical teams • Staff to attend Mental Capacity Act training • Capacity or lack of to be discussed Multi-disciplinary meetings • Patient handling assessment and bed rails assessment to be fully completed and reviewed regularly or when patients condition changes. Feedback to Emergency Floor regarding assessment, and Ward Team regarding re-assessment and/or reviews. • Highlight at Safety huddles. • Ensure assessments completed on arrival to the ward to ensure a baseline completed and any risk has been assessed and highlighted • Physiotherapy referrals to be followed up by the Physiotherapy

	team. Discussion with Physiotherapy Team regarding reasons for this not being completed. • Ensure Physiotherapy referrals to be followed up by Nursing Staff at daily board rounds • NEWS and BP to be reviewed when clinically indicated to ensure any decrease in blood pressure is actioned. Feedback to nursing team. • To discuss at safety huddles to ensure staff aware of the need to monitor low blood pressure and refer to medics at appropriate time • Improved communication between ward team regarding safety and use of Baywatch Use of safety huddles and MDT meetings to discuss all patients who are at risk of falling and to ensure appropriate assessments have been carried out. • Discuss safety at board rounds as MDT in attendance.

Following a review at the incident review panel of reports submitted by WSHFT to the CCG, 7 incidents were closed during January 2018.

De- escalated SIRI's

There were 0 de-escalated SIRIs during January 2018.

1 UPDATE ON CODE RED

1.1 This update considers the current situation with Code Red reporting, including reported Serious Incidents (Q1-3), and the associated improvement programme.

1.2 Code red was introduced in 2013 following National Patient Safety Agency and Royal College of Radiologists recommendations.

"*Code Red is limited to radiology and is necessary for rapid communication of findings that are both significant and unexpected findings. It is not simply based on the seriousness or acuity of a result. In other words, if a clinician has requested a test with a possible diagnosis in mind, then there is an expectation that those results will be pursued and managed by the ordering clinician (or team) and a Code Red will not be raised regardless of how significant the findings are*" WSHFT Code Red Policy 2016.

1.3 In short- there should be a defined fail-safe alert procedure for significant unexpected radiological findings for all requesting healthcare professionals and an efficient and effective tracking system in place 24 hours a day.

2 SERIOUS INCIDENTS (Reported 2017)

Incident date	Reported date	STEIS category	Description	Department	Site	Division	Outcome
04/04/2017	06/04/2017	Diagnostic incident including delay	Failure to act on Code red report	Gynaecology	Worthing	W+C	This lady is currently having ongoing oncology treatment in MDCU
07/09/2016	17/05/2017	Diagnostic incident including delay	Failure to act on code red (Lung ca)	Surgery	SRH	Surgery	This Gentleman is having chemotherapy treatment for Metastatic Bronchogenic Ca
12/11/2015	07/11/2017	Diagnostic incident including delay	Code red CXR not followed up	Radiology	SRH	Core	Pt sadly passed away as an in-patient on 19/11/2017

3. FINDINGS FROM AUDITS AND RCA'S

3.1 Root cause analyses and two separate audits were undertaken in 2017 providing an understanding of the issues behind these serious incidents. Problems included the vulnerability of a paper based imaging request system to errors identifying the responsible clinician and the risks inherent in an open loop reporting system without checks in place

confirming action is taken where necessary. Delays in diagnoses are also frequent in this group of patients due to the reporting backlog that results from radiology workforce shortages.

4. IMPROVEMENT PROGRAMME

4.1 Implementation of the actions from the RCA's and audits undertaken in 2017 has been underway with targeted education and training within the radiology department and interventions such as the introduction of standardised request forms to improve the quality of imaging requests.

4.2 The diagnostic Reporting group that has been working on improving the management of results is being reconvened following a pause due to the absence of key members and competing operational priorities. However the recent appointment of the new chief of core will give this group fresh impetus.

5. CLOSED LOOP REPORTING

5.1 To ensure full closure of the reporting loop for the existing system for code red reporting would require investment in an administrative resource that manages the process. This would ensure code red communications are received and acted upon where necessary (a band 5 post is proposed to manage the clinical governance process and facilitate the current backlog of reporting). This additional resource is being considered by the core division.

5.2 A proposal exploring an electronic solution for the internal communication of code reds to avoid missed communication has been underway with testing of the GP communicator system for internal communication of code reds for primary care. However this has proved more challenging to implement than expected.

5.3 The implementation of the Order-Comms system will reduce the risks associated with the current system but this is not expected for a further 6-18 months. This will automate communication with clinicians and teams but is likely to only monitor whether code red communications are received and acknowledged rather than acted upon.

Jo Habben
Head of Clinical Governance and Patient Safety
February 2018

Inspected and rated Outstanding Care Quality Commission

NHS Western Sussex Hospitals NHS Foundation Trust

To: Trust Board

Date of Meeting: 1st March 2018 Agenda Item: 6.2

Title
Ophthalmology Follow-up Waiting List
Presented by
George Findlay, Chief Medical Officer
Prepared by
Natasha Martin, Divisional Director of Operations, Surgery
Status
Confidential
Summary of Proposal
This report provides an overview of the current position in relation to the waiting list for Ophthalmology follow-up appointments and associated risk and actions.
Implications for Quality of Care
There are 4 patients who are known to have come to harm as a result of this issue. The risk of further serious incidents transpiring is unknown and the potential for further harm is not yet fully mitigated.
Link to Strategic Objectives/Board Assurance Framework
This issue directly links to the Strategic Theme of Quality Improvement with intent to reduce patient harm.
Financial Implications
The capacity required to fully mitigate the full backlog of delayed follow-up appointments would cost approximately £220,000 if delivered through premium activity in totality. This is the worst case forecast.
Human Resource Implications
None
Recommendation
Report to be noted
Consultation
Appendices
n/a

Ophthalmology Follow-Up Waiting List

1. INTRODUCTION

1.1. This paper presents the background and current position in relation to Ophthalmology follow-ups which are not part of an RTT pathway but are planned for a future date following a clock stop. There have been long standing issues with insufficient capacity for follow-ups in a number of specialties over recent years with varying interventions that have taken place to try to control or resolve this. However, the clinical risk in Ophthalmology is such that harm to patients has occurred and therefore requires escalation.

2. BACKGROUND

2.1. There have been long standing issues with insufficient capacity for follow-ups in a number of specialties over recent years with varying interventions that have taken place to try to control or resolve this. The issue is however complicated and obscured by the fact that there is no Trust standard process for managing follow up waiting lists outside of RTT.

2.2. Sema, the trust patient administration system, does have the functionality to hold a pending list for follow-ups and there are a handful of specialties that use this facility but historically it has not been possible for this to be used widely across the Trust due to known impact on Sema performance. Extending the use of Sema pending has, until now, caused slowing of the system to unacceptable levels. In the absence of a single process, most specialties use local systems including spreadsheets, written lists and email inboxes.

2.3. Adding further complication is that it is impossible to determine whether planned follow-ups are being booked at the appropriate interval as there is no policy on booking beyond the planned date. At present, all administrative staff book follow-ups into the next nearest appointment slot, even if this is several weeks or months beyond the date requested. There is no limit on how many times a patient may be cancelled and rebooked and no data on what impact this is having on wait times. It also means that specialties cannot control whether patients are being seen in date order or by clinical priority.

2.4. In specialties where the Sema pending waiting list is being used, it is not being used effectively to treat patients in turn as lack of training and instruction for the Outpatient Booking team is impacting on their ability to identify the correct priorities at specialty level.

2.5. There are around 30,000 patients in total on the Sema pending list, of which circa 16,000 patients are showing as overdue for their planned interval of follow-up. Ophthalmology accounts for 42% of overdue patients.

3. OPHTHALMOLOGY CURRENT POSITION

3.1. There has been a long standing issue with capacity for follow-up within the Ophthalmology department over several years, with demand and capacity being imbalanced by around 700 fewer appointments than required each month available. The total number of patients overdue for an appointment within the Ophthalmology department has fluctuated over the past 12 months between 4500 and 6500. The department currently has a workforce gap of 2 consultants and 3 junior doctors, which if fully recruited to would deliver approximately 550 additional follow-up appointments per month.

3.2. As at the time of writing this report there are 6584 patients overdue for follow-up by the Ophthalmology service. The breakdown of the length of time overdue for scheduled appointment is as per the table below:

Overdue					Due					
More than 6 months overdue	3-6 months overdue	1-3 months overdue	0-4 weeks overdue	**Total Overdue**	Due in next 4 weeks	Due in 1-3 months	Due in 3-6 months	Due in over 6 months	**Total due**	**Overall Total**
2238	1570	1643	1133	**6584**	2141	1933	1718	1289	**7081**	**13665**

Table 1

3.3. The distribution of the date of scheduled appointment is as follows:

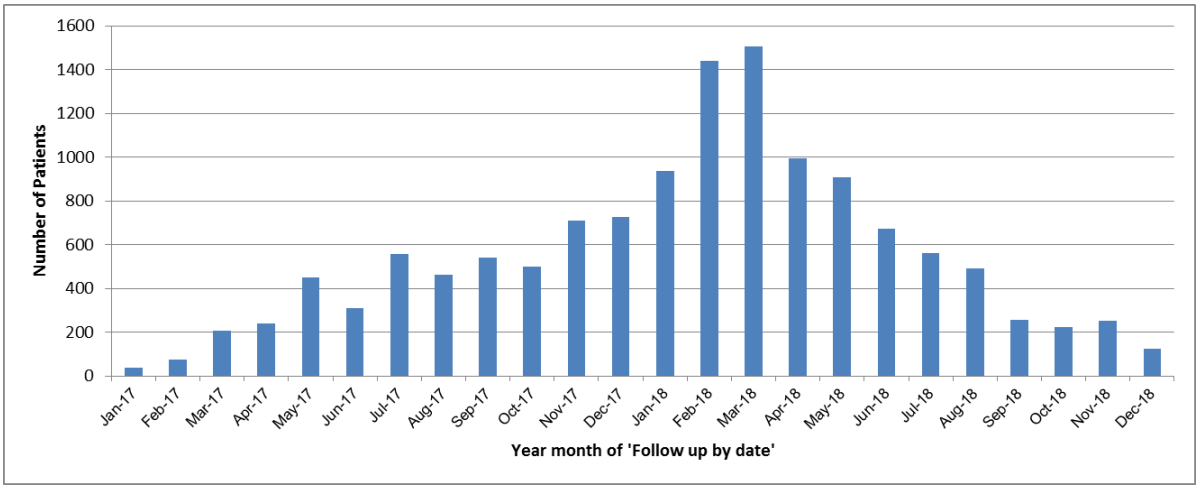


Fig 1

3.4. The urgency at which the original appointment was listed is also known for the majority of overdue appointments and is as follows:

	Overdue				
Urgency of requested appt	More than 6 months overdue	3-6 months overdue	1-3 months overdue	0-4 weeks overdue	**Total Overdue**
0-4 weeks	0	6	87	220	**313**
5-13 weeks	343	259	522	283	1407
14 weeks to 1 year	1690	1062	837	551	4140
Over 1 year	27	23	31	5	86
Unknown	178	220	166	74	638

Table 2

3.5. The specialty has re-profiled the available outpatient capacity to increase throughput of follow-up appointments in recent months and this can be seen in the increasing shift in the new to follow-up ratio which is now significantly above the top quartile target of 1 to 2.10. All additional premium capacity made available through waiting list initiatives has been targeted at follow-up appointments over recent months in recognition of the significant clinical risk associated.

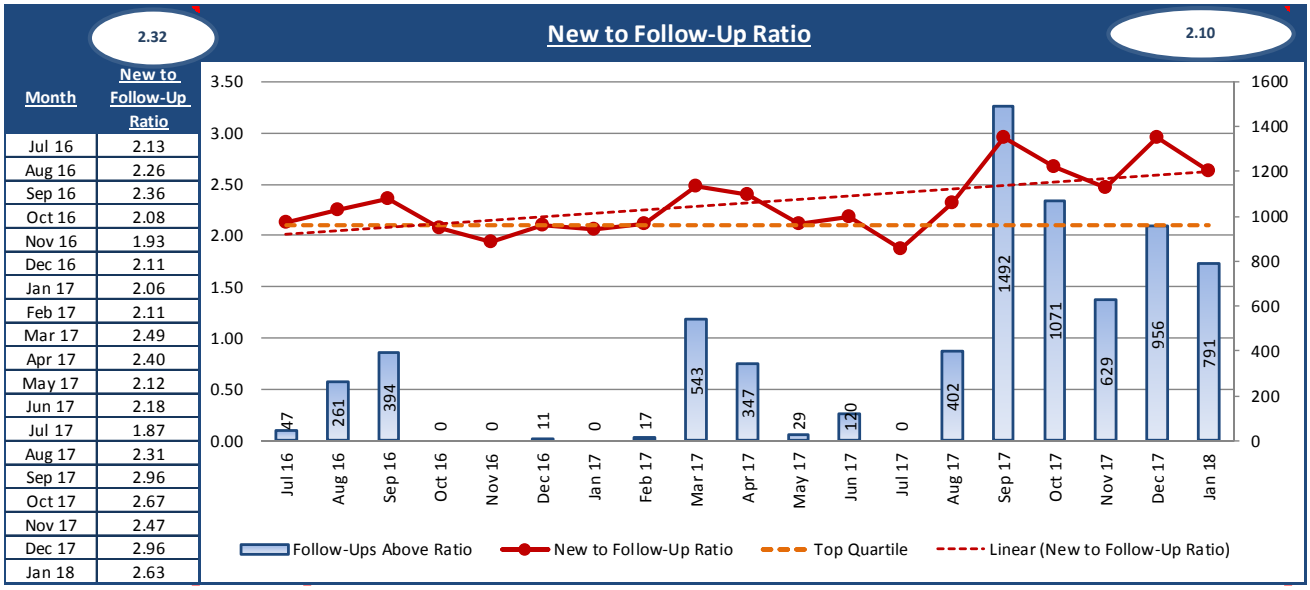


Fig 2

4. **RISK**

4.1. In November 2017, a Datix incident report was submitted, detailing a delay in treatment secondary to being delayed to follow-up. This incident was reported to the CCG as a Serious Incident (SIRI) and the Trust commenced a full investigation which is due for submission on 28/02/2018. Three further Datix incidents have subsequently been raised and are being reported as one combined SIRI with a full investigation underway. As the investigation progresses and systems are put in place, it is expected that the process will capture other people who may also have been lost to follow-up. The level to which this risk exists is unquantified.

SI number	Datix number	Incident date	Reported date	Department	Level of harm	STEIS category	Submission date
2017/29458	104035	27/11/2017	27/11/2017	Ophthalmology	Severe	Treatment delay	28/02/2018
2017/30918	104852	15/12/2017	15/12/2017	Ophthalmology	Severe	Treatment delay	16/03/2018
2017/30918	105527	31/12/2017	01/01/2018	Ophthalmology	Severe	Treatment delay	16/03/2018
2017/30918	106139	15/01/2018	15/01/2018	Ophthalmology	Severe	Treatment delay	16/03/2018

4.2. The issue of a backlog of ophthalmology pending follow-ups is on the Surgery Risk Register and has been since July 2017. It was originally rated at a risk of 12, based on the mitigations in place at the time which included significant additional capacity through premium payments at the rate of up to sixty additional clinics per month. The Division has reviewed this risk in February 2018 and have increased the risk rating to 20 based on the current known level of harm incurred, the inability to clear the backlog within a reasonable timeframe and the inability to accurately assess whether any future harm to patients will occur and if so, at what volume.

4.3. Currently there is a Bank Consultant who has been working in the department since December 2017 who undertakes 6 clinics per week seeing predominantly glaucoma patients, who make up the largest volume of the existing undated patients. The Consultant is due to leave the trust on 12th March 2018 which will reduce the available capacity for these patients.

5. ACTIONS

There has been a programme of both short term and long term actions in progression since June 2017. The current action plan is attached at appendix A.

Actions to date

5.1. Non clinical validation has been undertaken for all patients who were to be seen in 2016 and those due before June 2017 which was the overdue cohort of patients at the start of this project. Following non-clinical validation, approximately 3,000 patients were then clinically validated to assess priority and further action required within SPA time by the consultant team. This validation has been undertaken for all sub-specialties except for Glaucoma as clinical need dictates these patients will require appointments regardless. These are being booked where capacity is available, much of the follow-up appointment capacity is required for urgent follow-ups following treatment which limits the availability of appointments and only four Consultants routinely review glaucoma cases.

5.2. Diagnostic clinics have been set up for Glaucoma patients to have required tests at regular intervals with a virtual review to determine priority and appropriate clinician. There is currently limited opportunity to facilitate this type of clinic due to the conflicting requirement of equipment needed for routine activity.

5.3. Nurse Practitioner clinics have been set up for patients identified with stable glaucoma to release capacity in the Consultant clinic for the complex and new referrals.

5.4. Orthoptists have commenced training at the end of November 2017 to support the diagnostic clinics and provide multidisciplinary team working for glaucoma services. It is anticipated that by the beginning of April they will be able to support the diagnostic workload at both sites.

5.5. The service has recruited three Optometrists totalling 1WTE (one now in post, two start in April 18) to undertake follow-up glaucoma clinics and increase available capacity.

5.6. Urgent follow-ups (1-2 weeks) have been identified and are being booked by the access team. There are currently 29 patients on the pending list with this interval of follow-up who are overdue by more than 1 month. All patients that were due to be seen in 2016 and January 2017 have been booked into capacity between February and May 2018. If additional capacity becomes available these patients will be brought forward to earlier appointments.

Future actions

5.7. There is a review of booking processes in collaboration with the Access team to ensure that patients are booked from the pending list or have a correct entry dependent on clinical need and timeframe to be seen.

5.8. There is an ongoing programme of training for clinical support staff to enhance practical and technical skills. This will, over time, enhance capacity within the wider clinical team using both internal and external training opportunities.

5.9.The department is about to re-advertise the two vacant Consultant posts (recruitment has previously been unsuccessful at three separate attempts) to bring the workforce establishment to full capacity. Both posts are being advertised with a clear requirement to see glaucoma patients.

5.10. All premium sessions (WLI) are being targeted to book the overdue follow-up patients. At present, this is currently capped at 20 sessions per month (320 appointments).

5.11. This issue has been escalated and discussed at the following forums for oversight and governance.

- Ophthalmology weekly Business Meeting
- Monthly Ophthalmology Special Measures
- Monthly Divisional Board
- Monthly Divisional Clinical Governance
- Quarterly Exec Clinical Governance
- Quality board

6. RECOMMENDATION

6.1.The Trust Board is asked to note the content of this report.

Natasha Martin
Divisional Director of Operations
20th February 2018

Appendix A

Action Plan

Recommendation	Action required	Person responsible	Start date	Evidence of progress and completion	Completion sign off
Review of the current follow up waiting list to identify & prioritise over-due patient appointments.	• Medical Secretaries to validate all waiting list entries on the pending list to ensure all patients require an appointment and haven't already received one • Review of booking process to ensure that patients are booked correctly from the pending list to ensure removal of entry on the pending list and no duplication of patients	Care Group Manager/ACGM	01/07/17	Follow-up appointment pending list and associated reports	31.03.18
Process for regular monitoring of follow up demand	• Regular review of follow-up pending list to monitor demand and identify capacity required to assess patients at specified intervals	Care Group Manager/ACGM	01/07/17	Follow-up pending list report	Ongoing
Identify extra Capacity to meet demand	• Recruitment of Optometrists to see follow-up Glaucoma patients • Training of departmental orthoptists to undertake stable glaucoma clinics • Implementation of Nurse Practitioner	Care Group Manager/ ACGM/Matron/ Lead Consultant	01/07/17	Additional activity	Ongoing

	Clinics to see stable glaucoma patients • Arrange additional clinics targeting overdue patients to minimise waiting time • Review of booking process to ensure that appropriate patients are seen by Senior Doctors and supporting staff • Introduction of Diagnostic Clinics with virtual review by Consultant to determine priority and timeframe for review of patients • Project starting with CCG to identify other potential alternatives for long term management of glaucoma patients • Recruitment of 2 vacant Consultant posts aimed at increasing Glaucoma Consultant WTE				
Implementation of standard process for all follow up appointments.	• Standard Operating Procedures for the management of Glaucoma patients • Training for supporting staff to supplement Consultant Clinics • Continuous validation of pending list to ensure patients have a correct entry dependent on clinical need and timeframe	Care Group Manager/ACGM/ Matron/Lead Consultant	01/07/17	Standard Operating Procedure and staff training sessions	In place and ongoing

Service development to agree best practice and improve patient experience.	• Working Group in place to identify improved pathway and protocols for the management of glaucoma patients • Yellow Belt Project focussing on Glaucoma Pathway	Care Group Manager/ACGM/ Matron/Lead Consultant/Orthoptist/Optometrists	01/07/17	Documentation from project group notes A3 for Yellow Belt Project	In place and Ongoing
Staff development to ensure Patient First Values are always applied.	• External Training at Moorfields for Orthoptists and Nurse Practitioners • Internal training on practical skills (Slit lamp and Goldmann Tonometry) for staff groups • Technical skills (imaging) for Nurse Practitioners • Gonioscopy training for Optometrists	Care Group Manager/ACGM/ Matron/Lead Consultant/ Orthoptists/ Optometrists	01/07/17	Skill Competency sign-off for appropriate staff Groups	In place and Ongoing

Inspected and rated Outstanding Care Quality Commission

NHS Western Sussex Hospitals NHS Foundation Trust

To: Trust Board

Date of Meeting: 01st March 2018 Agenda Item: 7

Title
Orthopaedic Elective Care Visit (British Orthopaedic Association)
Presented by
George Findlay, Chief Medical Officer
Prepared by
Natasha Martin, Divisional Director of Operations, Surgery
Status
Confidential
Summary of Proposal
This report provides an overview of the elective care review undertaken by the British Orthopaedic Association in relation to the WSHT orthopaedic arthroplasty service in January 2018.
Implications for Quality of Care
The recommendations of the report relate to the quality of the arthroplasty service, with particular reference to infection and revision rates.
Link to Strategic Objectives/Board Assurance Framework
Financial Implications
Not defined as yet.
Human Resource Implications
None
Recommendation
Report to be noted
Consultation
Appendices
British Orthopaedic Association draft report

Orthopaedic Elective Care Review

1. INTRODUCTION

1.1. This paper presents the background and current position in relation to an advisory visit from the British Orthopaedic Association to Western Sussex Hospital Elective Orthopaedic Service in January 2018.

1.2. The orthopaedic department has been visited twice as part of the 'Getting It Right First Time' national programme, in October 2014 and February 2017. These visits were followed by a series of recommendations in relation to the provision of arthroplasty services which the orthopaedic department have been working through over the past twelve months.

1.3. The orthopaedic department is required to submit data through the National Joint Registry (NJR) in relation to all arthroplasty and has recently been certificated as a NJR Quality Data Provider, following compliance in 2016 with 6 metrics including a 95% compliance rate for hip & knee data.

1.4. Following review of submitted data by the NJR, Western Sussex Hospitals were flagged as an outlier in relation to revision hip & knee arthroplasty rates at 1,3,5,7 &10 years and it was recommended that we participate in a trial of elective care reviews offered by the British Orthopaedic Association (BOA). We undertook to participate in this review and a visit was held in January 2018.

2. ELECTIVE CARE REVIEW

2.1. There were two main parts to the BOA Elective Care Review:

- In advance of the visit, there was a preparatory stage in which the BOA sought detailed information from the unit, such as relevant data and policies. This information was used to assist in planning the approach the BOA took in relation to the visit and (2) provided background information to aid the discussion.
- A review visit, in which a team coordinated by the BOA visited the unit. The aim of the visit was agreed in advance and was to discuss and review issues occurring at the unit.

2.2. The visiting team were provided with a comprehensive pack of information prior to the visit, including:

- Detailed responses to the pre-visit questionnaire
- The last three NJR Hospital Level reports
- NJR Consultant Level Reports for consultants
- For Associate specialists, figures related to their practice were provided either from the NJR or from personally-collected data
- Enhanced Recovery Protocols
- Data Quality correspondence with the NJR

2.3. The BOA Team visited St Richards Hospital over two days on the 15th and 16th January 2018. The visit team was made up of 5 Consultant Orthopaedic Surgeons, including the Chair and Vice Chair of the BOA, and WSHT Non-Executive Director, Michael Rymer. The visit team met with and interviewed a wide range of the orthopaedic team including Consultants, non-Consultant medics, ward nursing, theatre teams, infection control and divisional management.

3. OUTCOME

3.1. The draft report was received from BOA on 5th February 2018 and is expected to be finalised within the next week with no significant change requested by WSHT.

3.2. The BOA has made a total of nineteen recommendations under the following headings:

3.2.1. MDT
- Creation of additional MDT meetings to discuss complex/revision arthroplasty and primary arthroplasty

3.2.2. Infection
- Creation of a joint infection MDT
- Refreshed protocol for standard theatre discipline

3.2.3. Estates and Theatres
- Review of the maintenance and quality of the theatre environment
- Assessment of the potential to make use of anaesthetic rooms
- Evaluation of the adjacency of theatres to ward

3.2.4. Data
- Complete audit of all NJR records where patients have been transferred between surgeons
- Forum for discussion of NJR Consultant/Lead Surgeon reports at least annually

3.2.5. Teamwork & Mentoring
- Mentoring arrangements, named consultants and arthroplasty clinical lead

3.2.6. Patient Care
- Follow-up by operating surgeon post-op and buddy system

3.3. The Surgery Division is combining the recommendations outstanding from GIRFT reviews and from the BOA report into a single improvement programme with a weekly oversight meeting to ensure rapid progress and delivery. The Divisional Director of Operations and Chief of Service are undertaking this weekly review and progress will be reported monthly to the Surgery Divisional Board and to the Executive Team at the monthly Strategy Deployment Review.

3.4. A follow up visit from the BOA is anticipated 6 months after the finalised report and a future GIRFT visit is currently being arranged for late spring/early summer 2018.

4. RECOMMENDATION

4.1. The Board is asked to note the content of this report.

Natasha Martin
Divisional Director of Operations
20th February 2018

St Richard's Hospital Chichester

BOA Elective Care Review incorporating data review and on-site meetings (15/16 January 2017)

Contents

About the review 2
Reviewers 2
Aims of the Review 2
Background 2
Discussions 2
Information 3
Overview of Data from most recent NJR report 4
Findings from our Data Review and Visit 7
Data review 7
Surgical site infections 13
Culture within the unit 15
Recommendations from Data Review and Visit 16
Infection recommendations. 17
Estates and Theatres Recommendations 17
Data-related recommendations 18
Team/Mentoring Recommendations 19
Patient Care Recommendation: Follow-up arrangements. 19
Final comments and further follow-up 20

DRAFT

About the review

Reviewers

Mr Ananda Nanu	City Hospitals Sunderland Foundation NHS Trust	Consultant Orthopaedic Surgeon
Prof Philip Turner	Stockport NHS Foundation Trust	Consultant Orthopaedic Surgeon
Mr Timothy Wilton	Derby Teaching Hospitals NHS Foundation Trust	Consultant Orthopaedic Surgeon
Prof John Skinner	Royal National Orthopaedic Hospital, Stanmore	Consultant Orthopaedic Surgeon
Mr Bob Handley	John Radcliffe Hospital - Oxford University Hospitals	Consultant Orthopaedic Surgeon
Mr Michael Rymer	St Richard's Hospital, Chichester	Non-Executive Director, Lay member

Aims of the Review

This hospital commissioned this review on the basis of a recommendation from the National Joint Registry (NJR) to take up a BOA Elective Care Review relating to its hip and knee arthroplasty service. The hospital is an outlier for revision rates at 1,3,5,7 and 10 years.

The following objectives apply to the review:

- To evaluate the relevant data from the Trust (including National Joint Registry and locally collected data).
- To assess standards of care, as set down by current NICE guidelines, NICE quality standards, BOA elective care standards and the Best Practice Tariff against the delivered service from the Trust.
- To recommend changes in the care pathway to aid an improvement in care.

Background

Western Sussex Hospitals NHS Trust serves a population of around 450,000 people who live in 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. There is orthopaedic trauma activity undertaken at both St Richard's and Worthing Hospitals; however, for elective hip and knee replacement, all surgery now takes place at St Richard's, which has a 22-bed ring-fenced ward, Chilgrove Ward.

Discussions

The visiting team met formally with:

Christopher Pring	T&O Clinical Director & Bariatric/Upper GI Surgeon
Madhu Rao	Consultant & NJR Lead
Aneel Ansari	Consultant
Laurie Dodd	Consultant

DRAFT

Mike Moss	Consultant
Ruy DaAssuncao	Consultant
Lee James Taylor	Consultant
Nirav Shah	Consultant
Adhish Avasthi	Speciality doctor
Vinod Hegde	Associate Specialist
Tarang Tandon	Speciality doctor
Bob Dennes	Theatre service manager
Jackie Cooper	Theatre nurse
Bridget Baron	Theatre nurse
Kari Dahl-Kingston	Infection Control Nurse
Helen Richards	Infection Control Nurse
Natasha Martin	Deputy Divisional Director of Operations, Surgical Division
Katie Beel	Care group manager/ Operational manager for Trauma & Orthopaedics
Gerrie Roberts	Assistant Care Group Manager – Trauma & Orthopaedics
Yvonne Thorp	Matron for Trauma & Orthopaedics
Jennifer Wright	Ward Sister Chilgrove Ward

In addition, during the visit, the panel met informally with a number of members of staff while on walkabout, including:

- Consultant and nurse practitioner involved in a clinic
- Theatre staff
- Ward nursing & therapy staff
- Consultant microbiologist

During the final feedback meeting, the panel also met Colin Spring, Chief of Service for Surgery Division (Consultant Anaesthetist).

Due to measures in place to cope with winter pressures during our visit, the ring-fenced orthopaedic ward was being used for medical patients and no elective arthroplasty was taking place. As a result it was not possible to speak to any arthroplasty patients on the ward. This did demonstrate the Trust's commitment to keeping the beds ring-fenced for orthopaedics when possible, but also the fact that at this time of the year at any rate the bed provision is not adequate to allow treatment of needy orthopaedic cases. However, this is at a time of unprecedented winter demand during a flu epidemic and would be entirely representative of what was happening nationally. The fact that the ring fence held is a good thing with regard to elective orthopaedics.

Information

The visiting team were provided with a comprehensive pack of information prior to the visit, including:

- Detailed responses to the pre-visit questionnaire
- The last three NJR Hospital Level reports

DRAFT

- NJR Consultant Level Reports for consultants.
- For Associate specialists, figures related to their practice were provided either from the NJR or from personally-collected data.
- Enhanced Recovery Protocols
- Data Quality correspondence with the NJR

Overview of Data from most recent NJR report

Based on the NJR report, the data consent rate for the organisation was better than average and the data linkability was outstandingly good. The NJR compliance rate was not available through the NJR Annual Clinical Report; however, separate evidence was seen of the Trust's NJR data quality, in which the NJR states for the Trust that "99% of eligible records were submitted –this is an excellent audit result. There appear to be excellent systems in place for the capture & submission of eligible NJR procedures." The standardised mortality rate was within the normal range and not a concern (See Figure 1).

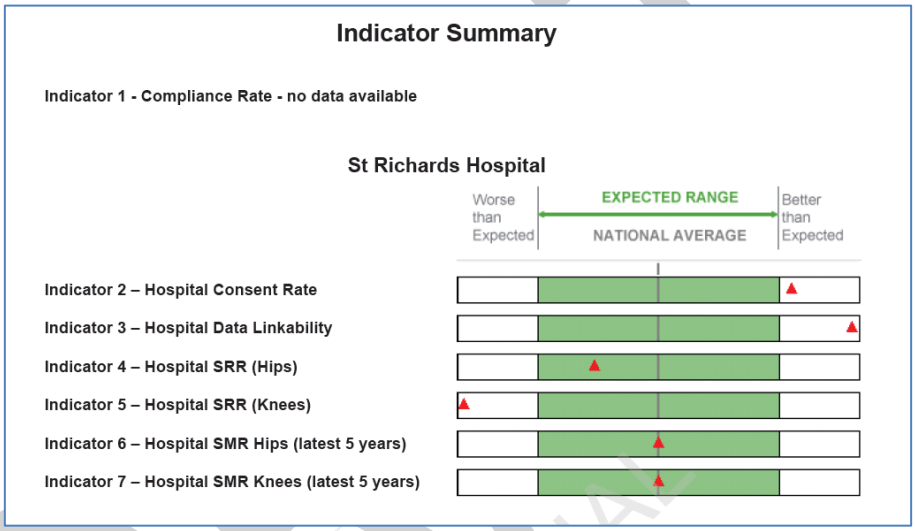


Figure 1: Extracted from NJR Annual Clinical Report, For the Financial Year 2016/17

The standardised revision rate for knees (Figure 1, Indicator 5) was to the extreme left of the abnormal range (worse than expected) and therefore among the worst in the country.

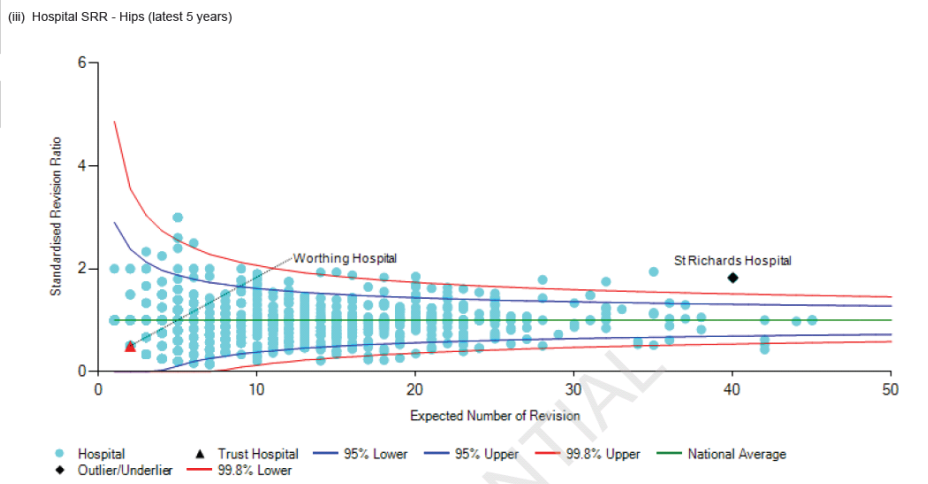
While the hip revision rate was within the normal range but towards the bottom end of the range in the NJR overview in Figure 1, other data in the NJR report reveal a serious cause for concern in this area also. It is important to highlight that:

> 1 - the hip revision rate has got progressively worse in the analysis completed for each of the last three years (Figure 2a), and
>
> 2 - when looking at a plot of the last 5 years of data only, the hip revision rate is outside of the normal range and well in to the 'worse than expected' range (Figure 2b).

If the position remains unchanged, in the next 2 years, the unit could become an outlier for hips for the lifetime of the NJR, i.e. for all the cases recorded in the last 15 years nationally.

Figure 2a (left): Hospital SRR – Hips excluding withdrawn implants. Figure 2b (right): Hospital SRR – Hips (latest 5 years). Black triangle representing St Richard's, red triangle representing Worthing Hospital. Source: NJR Annual Clinical Report, For the Financial Year 2016/17

St Richard's is a high volume unit for both hip and knee replacement and it is expected that patients going through a unit of this nature would do very well and given the numbers going through the unit, this is of considerable concern. For both hips and knees, funnel plots for the latest five years of data show that the hospital has a revision rate that is actually twice or nearly twice the national average (Figures 3a and 3b). Given this is a high volume unit, this represents a large number of patients needing a revision procedure when set against the average. Based on the funnel plots, there were 40 more hip revisions than expected and nearly 40 more knee revisions than expected over the past 5 years of data.



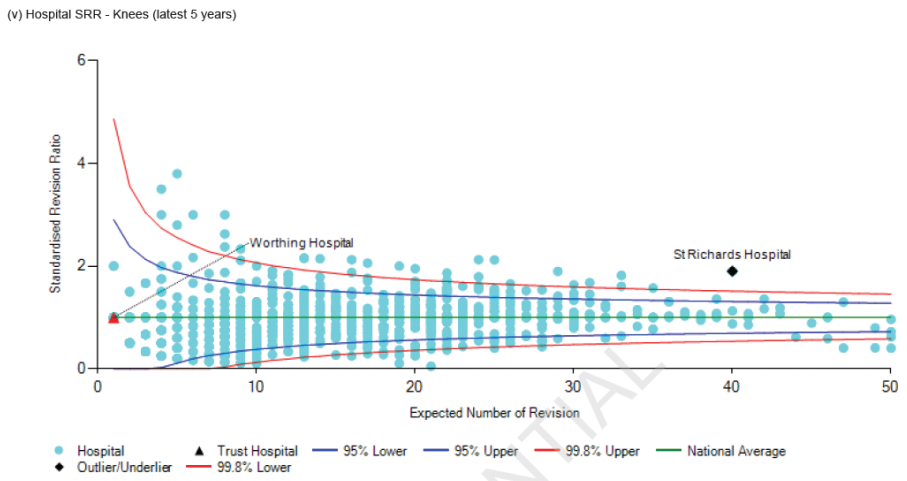


Figure 3a (top): Hip SRR funnel plot; Figure 3b (bottom): Knee SRR funnel plot. Source: NJR Annual Clinical Report, For the Financial Year 2016/17

Regarding hips

Cemented hips have an expected PTIR (patient time incidence rate)[1] of 0.31. Cementless hips have an expected PTIR of 0.43. Cemented hips in the unit have diminished from 60% to 30% of practice. Hybrid hips were 47% of the total and cementless hips have moved up to 37%. Given the productivity of the unit, large volumes or proportions of cementless hips would be likely to push the Trust results towards the unsatisfactory end of the spectrum even if the performance of the cementless hips is reasonable compared to other units doing the same sort of implants.

Regarding knees

A particular area of focus for this review was the knee revision outcomes for individual surgeons, based on the NJR plots for 'consultant in charge' and 'lead surgeon' (see Figure 4).

On the NJR graph of individual surgeon revision rates for 'Consultant in Charge', there were four markers (i.e. surgeons) above the red line (which indicates the 99.8% upper control limit). One of these markers was 10x the average expected in terms of standardised revision rates. On the right of this graph are two surgeons sitting at or above the 1SD mark (95% upper limit) who are performing very large volumes of procedures. Meanwhile, the 'lead surgeon' analysis shows four surgeons performing fairly large volumes who lie above the 99.8% upper band – three of these are the same surgeons that also appeared as outliers in the 'Consultant in charge' plot. However, there are some important issues about the data/reporting aspects of these plots – these are discussed in more detail later in the report in a section on 'record re-allocation'. The particular issue is the transfer of NJR data from one surgeon to another under the "consultant in charge' heading on the basis of a good or bad operative outcome: this is a serious issue which has to be resolved in the interests of the patients, the surgeons, and the utility of the NJR data.

[1] NB For the revision rates of the sub-types of hip and knee replacement, each one has a different underlying revision rate which is the Patient Time Incidence Rate (PTIR).

Overall the Lead Surgeon data for knees show that around a third of the active surgeons in the Trust are either outside the 99.8% control limit or are on or close to the 95% limit. This suggests a general problem rather than one relating to one or two surgeons' practice.

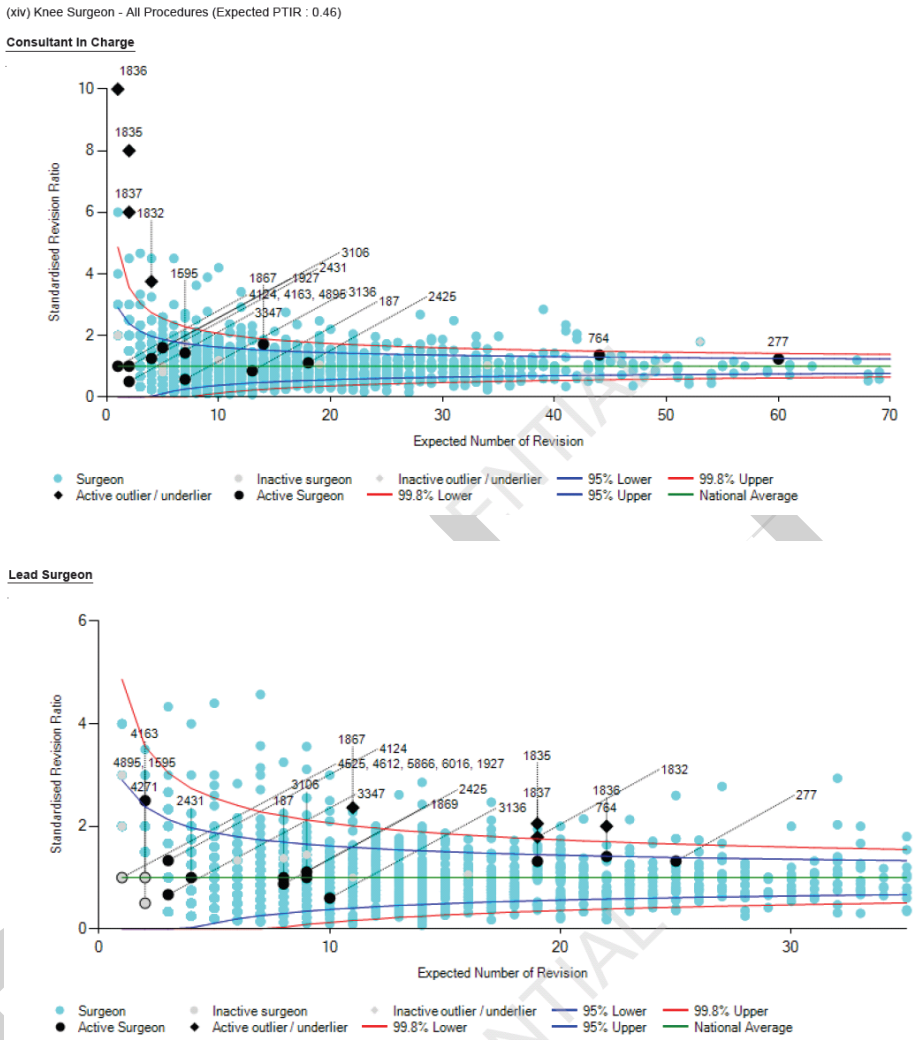


Figure 4 – Knees 'Consultant in Charge' (top) and 'Lead surgeon' (bottom) plots

The question of whether large volumes of uni-compartmental knee replacements could be a significant causative factor in the unit being an outlier was explored and it was noted that only 10% of cases were uni-compartmental knees, which was not particularly large. This is not therefore likely to have been a significant factor in the overall high revision rate for knees.

Findings from our Data Review and Visit

Data review

The data review was carried out as a detailed session with the focus on a thorough examination and review of the graphs and data that the Trust had provided in the lead-up to the review. The intention was to look at matters in detail to identify reasons for the unit being labelled an outlier in successive years, commencing with the latest report.

It was noted that there were considerable discrepancies between the graphs showing data grouped by consultant and lead surgeon and these discrepancies and the reasons for their occurrence were explored. There were particular discussions about 'record reallocation', which had been raised in the submission from St Richard's prior to the visit (and which is discussed further later):

> "in the past Associate specialists and Staff grades NJR data was submitted under the umbrella of the consultants [the] patient came under. Some consultants scrutinised their personal data and excluded the revised procedures where primary surgeon wasn't them from their individual name and put them under lead surgeons, whereas the ones which have not been revised are still under the consultant's name." p46, BOA questionnaire

In specific regard to hip replacements, St Richard's was noted to be a very high volume unit and though the marker for hips was not above the red (upper) line for revisions in the full NJR dataset, it was above this line for the latest five years of data. There was a cause for concern as given the number of patients involved, many more are being revised than would have been the case if the unit had been within a close range of the average shown by the green line. Of further concern was the fact that the data plot showed the situation for hips was worsening over the last 3 years (see Figure 2) and if the same trend continues as depicted in this graph the unit would become an outlier on the NJR on the full dataset. The data indicated the unit had been performing reasonably for hips in 2015 but the performance figures over the last 2 years were significantly outside the envelope. When questioned about the cause of the deterioration in performance, the possible reasons were mooted in three categories;

1) Infection with increased DAIR procedures.

2) Possible revisions from historically poor procedures/surgeons who have now retired or left the trust.

3) An ageing population with the third oldest cohort in the United Kingdom with a subsequent increase in peri-prosthetic fractures which then increase their revision rate. The local clinical team had looked at this issue and volunteered the information that the infection rate for hips at St Richard's was 10.7% when the national rate was 3.5%. They also pointed out that NJR, GIRFT and NHFD data had shown that 20% of their population was over 75 whereas the national average was 15%.

The population change was not thought to have been of sudden recent onset however, and was thus considered unlikely to have influenced the current data set. It should also be noted that NJR hip and knee revision rates are 'standardised', i.e. "The number of expected revisions has been calculated after adjustment for patient characteristics (age, gender and ASA grade of patients)." As a result, the revision rates should (largely) take into account the relatively elderly population served by this Trust.

In terms of infection, the visiting team were interested in whether the suspected infection was verified at operation, and it was confirmed that specimens were routinely sent from theatres during revisions. The St Richard's team speculated whether a factor in the

DRAFT

infection figures was patients being admitted over the weekend period from the Accident and Emergency department with suspected infection, which was not proven. This was thought to lead to perceived artificially high PHE figures regarding infection (which warrants further checking) but in the opinion of the review team, could not explain the increased number of revisions for infection. The fact that someone is admitted with a possible infection from A+E would not affect the revision rate unless the surgeon admitting the patient thought the joint was truly infected. The surgical site infections for knees were noted to be twice the national average, and again a serious patient safety issue. The Local clinical team was well aware of the figures indicating a high infection rate. This had been raised locally and then again by the GIRFT team in their visits and reports. Prof Briggs's visit had urged that a ring-fenced ward be introduced and this had recently been fully enacted (April 2017).

Concern was raised by surgeons at the Unit that their data for revision numbers might be being artificially elevated due to double counting of the revisions done for infection, if they have two or more revision forms submitted for two-stage procedures.

Mr Wilton agreed to check this with the NJR but felt that was very unlikely to be the case.

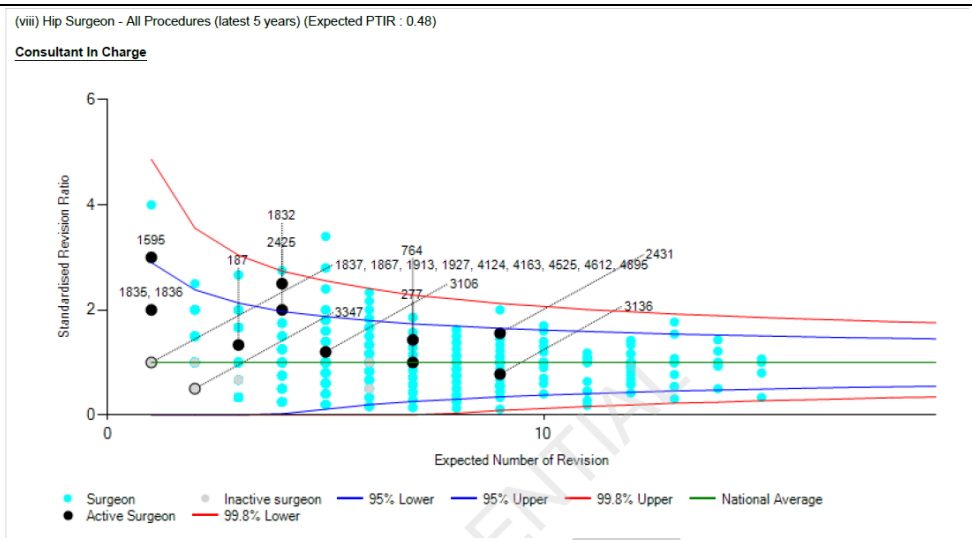
Mr Wilton has subsequently heard back from the NJR Statistician that such double counting would not occur for any of the comparative output data such as the funnel plots with individual Unit or Surgeon data, as the registration of a revision is taken from the first revision form submitted against an individual patient's NHS number for that particular joint.

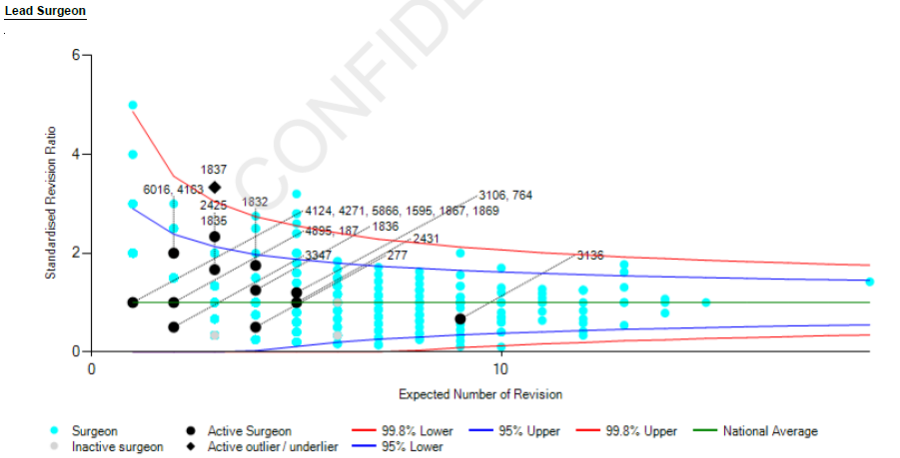
It is possible that some other data sources such as HES data could reflect such double counting for 2-stage revisions and some overall data from the NJR such as the download of individual cases which a surgeon can request from the NJR, but this would not affect the data which has been used for the discussions during the BOA Review.

Regarding surgeons who had retired or left the Trust, these were shown on the funnel plots as grey dots, and could be identified and distinguished from active surgeons. From reviewing the NJR funnel plots:

- In the case of the hip funnel plots for the last five years of data for both lead surgeon and consultant in charge, all the grey dots appear to be either on the average line or better than average – therefore these inactive surgeons do not appear to be contributing to the outlier status that is evident in the same time period (see Figure 5).

DRAFT





Hospitals at which a consultant's data indicates potential outlier performance		
Hospital Name	**Active Consultants Outlier**	**Inactive Consultants Outlier**
St Richards Hospital	1	0
Worthing Hospital	1	0
Western Sussex Hospitals NHS Trust	**1**	**0**
Note: A surgeon may be associated with multiple units, and will be listed for each unit against which they have activity.		

Figure 5: Hip revision funnel plots using last five years of data for 'consultant in charge' (top) and 'lead surgeon' (bottom)

- In the case of the knee funnel plots (for the full dataset) for both lead surgeon and consultant in charge plots, there are inactive surgeons whose data raises concerns. There is one inactive surgeon who is marked in an outlier position (on both plots) and there are other grey dots above the average, which will also be pulling the data overall to indicate poorer outcomes (see Figure 4).

While there are these potential issues around previous, now inactive surgeons, it is important to highlight that, for both knees and hips, there are current, active surgeons with data points that show concerning revision rates – and in both cases these outnumber concerns about inactive surgeons.

- In the case of hips, looking at the latest 5 year data funnel plot, there is one active surgeon with a revision rate above the red line in the latest 5 year data as 'lead

surgeon' (though not as 'consultant in charge'). There are other active surgeons between the blue and red lines.

- In the case of knees, looking at the full dataset funnel plot, there are several surgeons well above the upper red line and more that are close to it, in both the 'consultant in charge' and 'lead surgeon' plots.

Some key points in relation to these plots:

- Comparison of the plots matched for consultant in charge versus lead surgeon shows that some people are responsible for twice as many operations as they are doing themselves as lead surgeon. It would appear that SAS surgeons/surgeons in training were doing half the joint replacement surgery listed under the responsible consultant.

- The issue of 'record re-allocation' that was declared in the pre-visit submission has a very important bearing on these plots. It would normally be expected that any given surgeon would have more cases recorded in their name as 'consultant in charge' than as 'lead surgeon'. In these plots, however, there are examples, particularly in the knee data, of surgeons who have many more cases as 'lead surgeon' than as 'consultant in charge'. This includes the four 'outliers' who have very small numbers of cases as 'consultants' but many more as 'lead surgeon'. These four individual surgeons all appear above the red line (99.8% upper limit), with one data point showing a surgeon with a revision rate 10x the average. However, it is suspected that these surgeons are examples where procedures that were subsequently revised have been reattributed (to SAS or Staff Grade surgeons from Consultants), while procedures that were not subsequently revised have, apparently, not been re-attributed. There are several very important consequences of this, and this is an urgent area for validation and record checking:
    - The effect of this practice has been to skew the data for both donor and recipient. The donor has rid himself of the revisions but has not attributed the good, unrevised arthroplasties back to the lead surgeon, thus making the donor surgeon's data better than it should be. The recipient (lead surgeon's) data is worse than it should be as the denominator has not changed with receipt of only the failed cases.
    - It is important to investigate this further, in order to determine the true revision rates for the apparent 'outliers', to establish whether they are genuine outliers or not.
    - Any surgeons who have relinquished predominantly revision cases have a revision rate that is artificially low. It is important to investigate this further, in order to identify whether any of these surgeons in fact have revision rates that are at a level that could be a concern. There are two surgeons in the unit who are near the top of the funnel for knees but not quite at the level of the red line – it may be possible that these individuals have been affected by

DRAFT

reallocation of past patients and that once this is disentangled, their revision rate increases, potentially across the red, upper line.

- These issues place both the surgeons and the Trust at significant risk and the data needs to be cleaned up. Particularly close consideration should be given to the data for all individuals whose points are plotted at, around or above the red line, for this reason. These figures need to be disentangled swiftly as these are leading to a distortion of the data for a discrete number of individuals. For all individuals affected this should be an urgent priority.

As well as these funnel plots, the trends and individual surgeon plots are equally important. For the individuals who are over the red, upper line or close to it, the trajectory plot (or 'snail trail') of their successive data points should be carefully reviewed. (NB These plots can be obtained on request from the NJR for all surgeons - including non-Consultants who don't have access currently to a Consultant Level Report – and the BOA can support any such request if needed.) These successive plots should be reviewed by the team in regular, co-operative, collegiate meetings that should be scheduled (see recommendations) to watch progress so that any essential changes in practice can be instituted.

The significance of the PTIR of cemented (0.31 expected) against uncemented (0.43 expected) is to be considered in this unit given the huge volumes of replacements performed. A single large volume performer of uncemented hips could push the unit data upwards and this is highlighted by the increase in the use of cementless hips (reportedly to 37%) and the fall-off in the rate of cemented hips (reportedly from 60% to 30%) with a further reported increase in the use of Hybrids to 47%.

Regarding the issue of NJR record reallocation, this was first highlighted in the St Richard's submission prior to the visit (quoted on p8 above). It transpired during discussion in the review that several surgeons were affected as surgery was performed by SAS surgeons under the aegis of a consultant and these figures had initially been compiled under the consultant surgeon's figures. Consultant surgeons had then received an individual outlier letter and examined the revisions attributed to them. There it was found that the revisions had been performed by a different lead surgeon, the NJR co-ordinator was contacted and the consultant in charge was changed to the lead surgeon. This was apparently done by re-allocating primaries that were subsequently revised to the lead surgeon (SAS). The lead surgeon remained the same in both data sets. As mentioned above, this requires careful consideration to disentangle fully.

In relation to uni-compartmental knees, it is certainly the case that if a large number of uni-knees were being performed this could give rise to a problem with excess revisions: however in this unit only 10% of the cases are uni's and on balance will not have shifted the unit towards the negative end of the scale. In terms of the concerns regarding resurfacing the patella, this cannot be identified with the data plots sent by the Trust and is an issue that only the surgeon can address. However, there are two issues related to this. Firstly, one consultant who always resurfaces the patella still has a relatively high revision rate, so clearly the secondary resurfacing of patellae does not contribute to his/her rate of revision. Secondly one other consultant who does NOT resurface the patella at the primary operation then suggests his/her revisions rate might be being adversely affected by the secondary

resurfacing of patellae. One might question the logic of performing secondary resurfacing if one is so sure that primary resurfacing is unnecessary. Furthermore, if significant numbers of secondary resurfacing procedures are being done, it would be important to show that the secondary procedure is in fact proving useful to the patient.

Surgical site infections

During the visit, it was reported that St Richard's staff and managers are aware that for many years they have had slightly high rates of infection with 2015 onwards seeing a bigger increase and this has been a source of concern locally. This issue will be dealt with under five headings;

1) Ring fenced beds.

Since April 2017, the Trust has agreed and instituted a policy where Arthroplasty cases are admitted to a 22 bedded ring fenced ward (Chilgrove Ward). There is a clear written policy where no breaches with unscreened patients are allowed and if such were to occur, all arthroplasty surgery would cease immediately. This was borne out during the visit of the BOA where all arthroplasty surgery had stopped at St Richard's Hospital because of an influx of medical patients admitted through the Accident and Emergency into Chilgrove Ward. On a walk around the unit, it became evident that Chilgrove Ward is immediately adjacent to the Chichester Treatment Centre laminar flow theatres. The current patient journey, however, requires patients to be transported through this facility and out into a long corridor to a set of theatres much further down the hospital. It would appear that Bariatric patients from a ward close to theatres where Orthopaedic procedures are currently taking place are transported in the opposite direction down the same corridor and into the laminar flow theatres adjacent to Chilgrove Ward.

2) Theatre facilities

The review team had noted during the interview process that there was adverse criticism from all members of the team about the state of the theatres in which arthroplasty surgery was currently being performed. The criticism ranged from the standard of the estates, damage to the doors, walls and maintenance, temperature control in theatres, response times to complaints from within theatres in regard to temperature and other matters, and the clinicians and surgeons themselves had complaints in regard to the functionality of the filters in the laminar flow, their maintenance, upkeep and reliability.

Those members of the visiting team who were able to view the theatres were able to confirm that the fabric of the theatres did leave something to be desired, particularly with respect to damaged doors and walls which had not been repaired for some time. It was not possible to assess the delays in repair work after repeated notifications, nor to assess or comment about whether the Laminar Flow was tested insufficiently frequently or with less than adequate rigour. The review team did gain the impression of a very dedicated and knowledgeable senior nursing team within the orthopaedic theatres. They as well as the surgeons felt frustrated with the poor condition of some of the fabric of the theatres, and also with the geography of the ward and theatres, which was widely felt to be unsatisfactory.

DRAFT

3) Multi-disciplinary audit.

There is a root cause analysis done by the surgeons involved and presented to infection control. There is an MDT of Prosthetic Joint Infections (PJIs) led by Microbiology. This is attended by surgeons and in addition, there is a dedicated nurse-run wound-check clinic twice a week where all patients with any concerns regarding their wound attend for supervised protocol driven checks.

All team members agree that the clinic and the infection control and nursing role are a great success. Despite this, it was reported that after an initial downturn in the surgical site infections over a 3 month period immediately after the implementation of the ring-fenced Chilgrove Ward, the infection rate still remains unacceptably high.

In March 2016, Public Health England came to the Trust and presented data from the national SSI audit. The visiting team did not see written evidence on this, but were advised that PHE highlighted that one surgeon had a very high infection rate, and another was on the cusp of concerns. In April 2016, a working party walked through the patient pathway following which a consensus meeting was held to agree accountability. After an audit of the surgical site infections, a surgeon was suspended from practice and was subsequently mentored on his/her return.

A root cause analysis process was instituted in October 2016 for all surgical site infections based on a pro forma to be completed by the lead surgeon and senior clinical staff involved in the care of that particular patient. Data is gathered and examined every quarter and presented to the Clinical Governance forum. It was admitted that this was not being done reliably and further action to revamp the forum was being undertaken. No record of attendance at these meetings has been maintained.

4) Theatre process.

It would appear that the anaesthetic room is not used.

The patient is anaesthetised in the laminar flow area and positioned appropriately. In the meantime, before the patient is anaesthetised, the relevant trays of instruments are uncovered and checked to ensure that all required instruments are available and there are no holes in the sterile packaging or wet instruments. Once this is confirmed, the trays are left open in the prep area, which can be accessed through a door leading into a corridor and the instruments wait there for a period of at least 15 to 30 minutes (but potentially much longer) while the patient is being anaesthetised. The review team were given to understand that where there is an extended delay, the trays are covered up but left in the prep room (but this practice was not verified). The trays were wheeled through into the laminar flow area, potentially uncovered. No audit has been performed of the time frame from opening the trays to the trays being wheeled into the laminar flow area for the procedure. This is concerning, as leaving instrument trays open in a non-laminar flow area and then moving them on wheeled trollies through airflow eddies and turbulent air at the interface between non-laminar and laminar flow may negate the benefit of operating in a laminar air flow theatre. In addition, leaving the trays uncovered in one room while the patient is anaesthetised in a laminar flow area rather than opening the trays in the laminar flow area and the patient being anaesthetised elsewhere appeared illogical.

5) Theatre traffic and sterility.

Following a discussion with all members of the care teams, there was a concern expressed by various members of the department that there was considerable unnecessary human traffic in and out of theatres. This is accompanied by partly covered hair, personnel not wearing masks and social visiting during implant surgery. Concern was also raised about the standard of scrubbing and training of all personnel in the operating theatres. While the senior band 6 staff were quite clear about maintaining standards, they felt that when they personally were not in theatre, more junior members of the theatre staff may not feel empowered to challenge more senior members of the surgical care team for infringements of what they considered standard operating protocol in theatres. There appeared to be concern that this was more noticeable in the senior anaesthetic staff. There did not appear to be a clear-cut policy on the use of Tranexamic Acid, the timing of administration and the number of doses to be used routinely in primary hip and knee replacements. The antibiotic prophylaxis policy appeared to be clear and it was generally understood that it was adhered to.

Culture within the unit

The Department includes 18 Consultants, 4 Associate specialists, 3 Specialty Doctors, 8 Trainee Registrars (ranging from ST3 to ST8), 1 clinical Fellow, and Juniors (Core Trainees/FY2/Trust Doctor's) across both sites.

The review team was able to talk to all the clinicians listed above in relation to these matters. The following is a summary of our findings in relation to the Clinical Governance matters that may impinge on the reason for the visit.

1. Not all the surgeons had seen the unit figures indicating that the Trust had been outliers for 1,3,5,7 and 10 year figures for revision and not all of them were aware of the graph showing their position within the final plots. None of the surgeons had discussed their consultant level reports with colleagues and there was no process of a unit review of this data.

2. Clinician appraisal was carried out sometimes across specialities and the detailed discussion of the NJR Consultant Level Report would not appear to be a matter of priority for some of the clinicians and is not mandated.

3. The decision to revise hips and knees is an individual one and does not appear to be part of a process for unit review and there is no systematic analysis of the reasons for revision or agreed parameters for revision across the unit. It was suggested to the Review team that some surgeons had a lower threshold to revise primary joint replacements performed by other surgeons.

4. It would appear that there are seven surgeons performing revision knee arthroplasty and six surgeons performing revision hip arthroplasty in this unit.

5. There has been a rationalisation of hip and knee replacement implant systems with two cemented hip replacements and two uncemented systems. Knee replacements are largely NexGen (Zimmer) which accounts for 80 to 90% of the prostheses and Genesis II (Smith and Nephew) approximately 96 cases per year.

DRAFT

6. It appears patients were seen independently by Associate Specialists and put on lists nominally under the care of a consultant, with some of the SAS surgeons working independently seeing patients, putting them on lists and operating on them. Three of the SAS surgeons are large volume surgeons, with one of them performing the largest number of joint replacements in the unit. There does not appear to be a fixed linkage between a consultant and an SAS surgeon. The structure appears to be very fluid and supervision/mentoring of the SAS surgeons seems to be minimal.

7. Surgeons sometimes operate on patients never having seen them before. This is apparently caused by waiting list pressures where patients are harvested from long waiting lists and redistributed to SAS surgeons.

8. It would appear that no business case has been made for the appointment of more consultants. Currently consultants act as lead surgeon in only around 50% of the cases performed, with a large proportion of the remainder performed independently by SAS surgeons. The Clinical Director is a Bariatric Surgeon and the Chief of Surgery is an Intensive Care Anaesthetist. Two surgeons have been appointed within the department as orthopaedic leads for each of the two Trust sites (St Richard's and Worthing) – in both cases these are hand surgeons. There appears to be a degree of unhappiness that the Trauma and Orthopaedic Unit Consultants have not been chosen to lead their own department.

Recommendations from Data Review and Visit

Recommendation 1. All revisions as well as all complex primary joint replacements should be discussed at a Complex Arthroplasty MDT meeting. This should include:

- Why revision is needed.
- What exactly needs to be done.
- What lessons were learnt from the primary operation, if any, to avoid the situation arising in the future.

There should be documented outcomes from these MDTs and a record maintained of participants. This meeting could occur fortnightly during Wednesday afternoon SPAs for one hour each time.

Recommendation 2. Given the seriousness of the current situation, regular arthroplasty meetings (separate from a discussion of revisions and/or complex primaries) should occur with all arthroplasty colleagues to discuss all cases as routine. The aim is to look at pre and post-operative x-rays and to discuss the lessons learnt. Time needs to be allocated for this (suggested one hour per week) and it should be attended by all consultants and SAS surgeons. The decisions made should be written up by clerical staff and a record of attendance maintained. The Review Team recognises that introducing this meeting is likely to reduce the time available for clinical activities, but believes that this is an important step in order to ensure consistently good standards of care and support team reflection and learning.

DRAFT

Infection recommendations.

During our visit it was apparent that the team attribute the high revision rate to possible infection issues across the Trust. The data does not fully support this view, but nevertheless there are clearly concerns in this area and recommendations are warranted. Overall the approach taken on surgical site infection so far is welcomed, in particular regarding a ring fenced ward. However, the Review Team also feels that the atmosphere whereby the team appears to feel justified in attributing the revision problem to the high incidence of infection appears to be deflecting them from conducting any useful reflection about the many other potential causes of the high revision rate.

Recommendation 3. A specific joint infection MDT should be set up to discuss the management of patients with possible infection. This could look at superficial versus deep infection, and ensures these patients are carefully managed early on. Radiology, Surgery and Infection Specialists are all to be involved. (RCA is currently happening but this appears to be a generalised infection audit with all specialities involved and is too diffuse). Given the SSI problem in Trauma and Orthopaedics, there should be a meeting held solely for Orthopaedics. This meeting could occur fortnightly during existing Wednesday afternoon SPAs, for one hour each time – in this way it could alternate with the Complex Arthroplasty MDT (see Recommendation 1 above).

Recommendation 4. A robust standard protocol for theatre discipline should be in place and adhered to. There should be a theatre process refresher training provided for all staff involved in theatres. Issues to be addressed must include theatre traffic, scrubbing and a staff culture in which any member of the team is empowered to challenge any other member of the team. While the surgical site infection rates are high, a protocol should be established for infected joints. The BOA team can provide an example protocol from another Trust *[to follow with final version of report]*.

Estates and Theatres Recommendations.

Recommendation 5. The quality of theatre facilities should be reviewed, including the walls, doors, lighting, cleaning but particularly the laminar flow and the temperature control. It has been stated to us that the response to maintenance issues is not always adequate – both in timeliness and full reassurance that the problems raised have been suitably dealt with.

Recommendation 6. Location/usage of facilities. The review team were very concerned about the process for anaesthetising the patient in the laminar flow area and bringing uncovered instruments that have been resting in a non-laminar flow side-room across turbulent air into theatres after a period of up to 30 minutes (an audit needs to be done to see if this is a true figure as it is entirely possible that the periods may be much longer). A Theatre Committee should be convened to explore the requirement for trays to be opened only within the laminar flow and to be kept covered, while the patient is being anaesthetised in the anaesthetic room.

Recommendation 7. The logistics of travel of a patient post anaesthesia, while vulnerable to temperature changes, through a populated area to a post-operative bed needs to be revisited. The theatre facility and the ward need to be adjacent to each other, especially as there is a concern regarding the maintenance of normothermia and its effect on infection. It is suggested that the Trust management and the relevant surgeons should meet and

DRAFT

decide whether the facilities could be placed adjacent to each other (it would appear that there is a difference of four beds between the two wards which has led to this decision).

Data-related recommendations

The Review Team understands that some patients have been passed from one staff member to another in terms of the NJR record. In particular, primaries that were subsequently revised have been moved, but primaries not subsequently revised have not been moved. This will result in the recipients having revision rates that are artificially high and those relinquishing cases a revision rate that is artificially low.

Recommendation 8. There needs to be an urgent and complete audit of all cases for those staff affected – both those relinquishing patients and those acquiring patients with regard to the NJR record. This should include all primaries and all revisions for the past 7 years. This is to ensure that the patients are correctly attributed. This will then reveal an accurate picture of the surgeon's data which will be reflected in their appraisal and allow meaningful personal reflection. This does not alter the overall position of the Trust which still represents a high failure rate for hips and knees.

This practice of arranging to re-allocate cases to another consultant is supposed to be used, rarely if ever, to correct genuine mistakes in the allocation of a case to a consultant. The Review Team is concerned that the wholesale transfer of 'failed' cases to another consultant has been allowed to occur. The Review Team are also at a loss to understand how that transfer could occur to a surgeon who was not a consultant at the time of the procedure, as this undermines the whole concept of differentiating records within the NJR system based on whether the surgeon was the 'Consultant in charge', the Lead surgeon, or both.

Ideally all cases should be put back under the Consultant who was originally responsible for their care, whether he/she performed the operation or not and whether the operation was a success or not. This should also be verified for the Lead Surgeon data. This would then allow a fair assessment of all surgeons according to their own verified Lead Surgeon data. The review team accepts that the Lead Surgeon data will give much more meaningful assessment of a surgeon's practice than the 'Consultant in charge' data.

Recommendation 9. There should be a forum for all surgeons (Consultants and SAS Surgeons) to share and discuss the individual NJR Consultant Level Reports (and equivalent data for SAS surgeons) and for open discussion of these and the Trust NJR annual report. This should occur at least annually but the first occasion for doing so should be at the next quarterly Clinical Governance meeting. They should be supported by someone with external expertise at least in the first meeting and as part of this, the NJR should be contacted and the snail trial plots requested as "lead surgeon" for all consultants and staff grades, and discussed as part of this meeting. The snail trial plots show the last 5 years of revision outcomes for each surgeon and provide an indication as to whether revision rates are improving or deteriorating, year on year. The Review Team believes these are an important component of any discussion.

Recommendation 10. Historical cases that have been revised for the reason listed as "other" in the NJR should be investigated and categorised. Those revised for the reason labelled "infection" should be confirmed or refuted using microbiological investigation, blood test results and note review for each case, and based on agreed criteria in the

international consensus document. Were these cases indeed infected? Once these historical cases have been categorised, this should further assist in understanding the reasons for the high revision rates, and this should be part of the discussion at the next quarterly Clinical Governance meeting (as per Recommendation 9).

Recommendation 11. At appraisal, it must be mandatory for surgeons to have shown that they have discussed their CLR in open forum, that they have reflected on it and that any conclusions reached as a result are fed into their appraisal. Where non-speciality appraisal is involved they must be aware of the importance of this requirement. If the appraiser is a non-arthroplasty clinician then a standard, easily-understood summary must be agreed with the Orthopaedic Clinical Lead of the unit and presented during appraisal.

Team/Mentoring Recommendations

Recommendation 12. SAS Surgeons should all have a consultant mentor.

Recommendation 13. New consultants should all have a consultant mentor.

Recommendation 14. Any new consultants taking on a more complex practice, for example revision surgery, should have particular support which could include a shared session with a more experienced surgeon for an initial period when they start. It is recommended that this period be for a minimum of one year.

Recommendation 15. All patients should be recorded against a responsible consultant. The consultant in charge should be attributable to ensure that the mentorship process is working. A consultant who is responsible for the care of the patient should know the treatment each patient attributed to him is receiving and that the outcome is likely to be as acceptable as if the treatment were being carried out by the consultant him/herself.

Recommendation 16. There should be a departmental discussion held on issues of work streams. In particular, expertise in specific areas allowing consolidation of small teams performing revisions. There should be an internal referral system to ensure that these areas of focus are delivered in practice.

Recommendation 17. Collaborative working should be encouraged and it is recommended that complex cases are performed by two-surgeon operating teams.

Recommendation 18. To support the Clinical Director, consideration should be given to appointing an Arthroplasty Clinical Lead within Orthopaedics. This person needs to be supported by his colleagues and peers and have due acknowledgment of the time commitment in his/her job plan.

Patient Care Recommendation: Follow-up arrangements.

Recommendation 19. It is recommended that there is at least one contact point with the surgeon post-operatively who sees his/her own patients or those of a colleague who works in tandem with him/her (buddy system).

DRAFT

Final comments and further follow-up

This report is provided as a draft to St Richard's, in order to allow any questions, clarifications or initial feedback. The draft report has been issued on 5th February 2018, and the Review Team requests a response to this report within 2-3 weeks.

The Review Team suggests that a re-visit should be planned in 6 months time to review progress and discuss the data further once it has been corrected. The terms and cost of any re-visit can be discussed.

DRAFT

Western Sussex Hospitals
NHS Foundation Trust

To: Trust Board

Date of Meeting: 1st March 2018 Agenda Item: 8

Title:
Report on Gender Pay Gap – March 2017
Responsible Executive Director:
Denise Farmer, Chief Workforce and Organisational Development Director
Trust Director:
Jennie Shore, HR Director
Prepared by:
Andy Hughes Business Partner and Nikki Kriel Organisational Development Manager
Status:
Disclosable
Summary of Proposal:
This report summarises the findings and analysis of the Gender Pay Gap review based on salary and bonus payments for all Trust Employees as of 31 March 2017. This information needs to be uploaded to the WSHFT website and to the Government Gender Pay site by the mandated date of 31 March 2018.
Implications for Quality of Care:
Staff who are treated fairly and engaged has a direct and positive impact on the quality of care.
Financial Implications:
Supports good financial and commercial performance.
Human Resource Implications:
Recognised by others as a fair and progressive Employer
Recommendation
The Board is asked to NOTE the report Discuss the content of this paper and make recommendations
Consultation:
n/a
Appendices:
n/a

This report can be made available in other formats and in other languages. To discuss your requirements please contact Andy Gray, Company Secretary, on Andrew.gray@wsht.nhs.uk or 01903 285288.

Western Sussex Hospitals
NHS Foundation Trust

To: Trust Board

Date: 22 February 2018

From: Andy Hughes, HR Business Partner – Core Division and Trust Pay and Reward Lead,

Nikki Kriel, Organisational Development Manager

Agenda Item: 8

FOR INFORMATION

Draft

GENDER PAY GAP (GPG) REPORTING

1.0 INTRODUCTION

All Public Sector organisations listed in Schedule 2 of The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 are subject to the new mandatory Gender Pay Gap (GPG) reporting requirements, if they have more than 250 employees under a contract of employment. This includes all staff under Agenda for Change, Medical & Dental and Very Senior Managers (VSM).

Data relating to the pay period in which the snapshot date of 31 March 2017 is required, with full publication on by 31 March 2018 and annually thereafter.

There are six basic calculations the Trust is required to report on:

- Mean gender hourly pay gap
- Median gender hourly pay gap
- Mean bonus gender pay gap
- Median bonus gender pay gap
- Proportion of male and female staff receiving a bonus payment
- Proportion of male and female staff in each of the four equal quartiles

The pay period is a snapshot of the gross hourly pay rate of all employees, excluding bank workers on the 31 March 2017 and includes the following elements:

- Basic pay including other allowances
- Paid leave, including annual leave, sick leave, maternity, paternity, adoption or parental leave (except where an employee is paid less than usual because of being on leave)
- Bonus pay (if paid in the pay period) ie: VSM bonus or Clinical Excellence Award (CEA)

The report does not include:

- Overtime pay, waiting list initiatives (WLI), expenses, value of salary sacrifice schemes, benefits in kind, redundancy pay and tax credits

2.0 PURPOSE

GPG reporting has been introduced to show the difference in average hourly pay and bonus payments between men and women.

WSHFT are required to analyse the information to identify any underlying root causes for GPG and put in place remedial actions to address and mitigate this. The results will be used to assess:

- the level of gender equality
- the balance of male and female employees in each of the four quartiles
- how effectively talent is being maximised and rewarded

The benefits of reporting GPG include building a reputation for being known as a fair and progressive employer, attracting a wider pool of recruits, enhancing productivity and creating a culture committed to tackling inequality.

3.0 ANAYLSIS

Gender mean and median - hourly pay gap

The table below shows the mean and median hourly rates for male and female employees in the Trust and the actual gap in monetary and percentage terms.

There is a 19.62% difference in favour of male employees when using the mean hourly rate, this moves 0.89% in favour of female employees when the median hourly rate is used.

Gender	Mean Hourly Rate	Median Hourly Rate
Male	£ 18.32	£ 13.06
Female	£ 14.73	£ 13.18
Difference	£ 3.59	-£ 0.12
Pay Gap %	19.62%	-0.89%

A total of 7,226 employees (non-medical and Medical & Dental) are included in this report, broken down as 5,524 (76.45%) female employees and 1,702 (23.55%) male employees.
This is comparable with the NHS workforce nationally which has a 77% female and 23% male split.

The Medical & Dental staff group in this Trust consists of 24.62% male employees and 6.89% female employees. This is comparable to 22% and 5% respectively in the wider NHS nationally.

Gender mean and median – bonus pay gap

The table below includes Medical and Dental employees who received a Clinical Excellence Award (CEA) and Very Senior Managers (VSM) who received a bonus.

Gender	Mean Bonus	Median Bonus
Male	£ 13,200.79	£ 8,950.75
Female	£ 6,438.90	£ 3,804.34
Difference	£ 6,761.89	£ 5,146.41
Pay Gap %	51.22	57.50

Proportion of male and female receiving a bonus payment

Draft

A total of 139 employees in the Trust received a bonus payment, this is shown as a percentage of the overall workforce.

Gender	Employees Paid Bonus (% of this group)	VSM Staff Paid bonus	Medical & Dental Staff Paid Bonus	Total WSHFT workforce	% of WSHFT workforce
Female	42 (30.2)	4	38	5,524	0.76
Male	97 (69.8)	0	97	1,702	5.70

Proportion of male and female staff in each quartile band

The Trust is required to rank every employee by rate of pay on the 31 March 2017 (not by pay banding). The data has been presented in 4 equal quartiles in the table below:

Quartile	**Bracket/Band**	**Female**	**Male**	**Total**	**Female %**	**Male %**
Top	£18.00 - £ 75.00 ph B7 (SP29) & above	1,278	572	1,850	69.08	30.92
Upper Middle	£13.00 - £ 18.00 ph B5 (SP20) to B7 (SP29)	1,493	271	1,764	84.64	15.36
Lower Middle	£ 9.70 - £13.00 ph B3 (SP10) to B5 (SP20)	1,401	406	1,807	77.53	22.47
Lower	£ 5.30 - £9.69 ph B1, B2 & B3 (SP10)	1,352	453	1,805	74.90	25.10
WSHFT Total		5,524	1,702	7,226	76.45	23.55

4.0 PUBLICATION OF DATA

The Trust is required to publish information and make it accessible on the Trusts website. The published information is then uploaded to the government website with a written statement the calculations are accurate. This must be signed by an appropriate senior person, such as a Director or Chief Executive.

Organisations are required to provide written narrative to support understanding of why a gender pay gap is present and what the organisation intends to do to reduce the gap.

5.0 RECOMMENDATION(S)

This paper highlights the gender pay gap data as of 31 March 2017 and the proposed actions and next steps that need to be taken in response to the requirement of the GPG. In the next 12 months we will focus on:

- Undertake a review of the 2018 CEA applications to ensure both female and male employees are encouraged to apply and outcomes treated fairly.

The Board is asked to:

a) **Note** this paper

b) **Discuss** the content of this paper and make recommendations

Draft

Draft

Western Sussex Hospitals
NHS Foundation Trust

To: Trust Board

Date of Meeting: 1st March 2018 Agenda Item: 9

Title
Domestic Services Review – Phase 2
Responsible Executive Director
Karen Geoghegan, Director of Finance
Prepared by
David Jones, Director of Facilities & Estates
Status
For Noting
Summary of Proposal

This paper summarises the consultation process for phase two of the domestic service review:

- Standardisation of Band 1 Job Descriptions
- Transfer of Work from Unsocial Hours to Day Shift

Implications for Quality of Care
There are clear and direct links to the quality of patient care, maintaining safe and compliant organisational performance
Link to Strategic Objectives/Board Assurance Framework
5A: Improve the use of our infrastructure and work with our staff to meet and exceed our financial, operational and clinical performance targets
Financial Implications
Based on the recommendations within the report and finance appraisal, there would be a cost benefit of £100,000 within 18/19 with no risk of redundancy
Human Resource Implications
There are significant changes required to the workforce which are being managed through the Management of Change Policy

Western Sussex Hospitals
NHS Foundation Trust

Domestic Services

Trust Board Briefing Document

At the point of Trust merger very few of the departments within Estates & Facilities were harmonised to act as one department. In the last three years, the departments of Estates, Portering, Telephony and Security have been amalgamated to function Trust wide. However there are still some departments within the division that remain site specific in how they operate. Domestic Services is the largest of these. The Domestic services not being aligned across site creates cost inefficiencies, service variations, confusion and inherent risks that could ultimately affect patient care. Each site provides 24 hr, 7 days per week, 365 days per year specialist and general cleaning. However, therein the similarities end. From job descriptions, standard operating procedures and hostess duties, each site is different.

The alignment of the domestic services will bring efficiencies in patient services, processes and management practice and cost efficiencies. A business case was presented to the Trust Executive Committee on 23rd November 2017. The panel approved the proposal to consult with staff. This paper summarises the review process that has taken eight months, involving all stakeholders from domestics to nurses, matrons and allied health professionals. It looks at the standardisation and efficiencies within the department.

Background

The Domestic Services department provides all cleaning at St Richards, Worthing and Southlands hospitals. The department currently relies heavily on bank staff (c20% of the workforce) due to freezing recruitment pending the outcome of this review. The department works to the National Specification for Cleanliness 2007, requiring it to achieve an average standard (across varying standard levels) of 92% of which over 95% is achieved. In February 2017 the division commenced the review of Domestic Services. While the department was on budget and achieving higher than the standards required, there were significant cross-site variances creating operational and financial inefficiencies.

Across the Trust there are a number of duties undertaken on weekends and evenings that could and should be undertaken during the working week, allowing for greater supervision and support for staff at reduced cost.

Department Review Process

A domestic review took place consisting of domestic staff, clinical staff and managers. The Domestic department met with representatives from all of the clinical divisions including senior clinical and ward staff, senior A&E and imaging staff with the aim of standardising the domestic service through identifying any shortfall in service provision and identifying any fluctuation in work flow during a 24hr period. Over 300 clinical and non-clinical staff was involved with the review process.

In addition to the meetings and clinical engagement, the team undertook a value stream mapping exercise (overleaf) which identified potential service improvements. With support from the Kaizen team an A3 was produced (overleaf) as above that outlined the problem statement, current situation and the Root Cause Analysis. The goals and actions were identified as follows:

- Departmental Interaction
- Review of Service
- Service Planning
- Compliance
- Managing Resource

Recommendations

The recommendations proposed to TEC provide alignment of services to effectively support the clinical aims and operational capabilities of the division. The options also offer an increased level of supervision, and provide a consistent, cost effective service delivery with patients at the fore-front of all activities:

- Standardise Job Descriptions
- Transfer 50% of Night Duties to Day Shifts

Standardise Job Descriptions

There are four different job descriptions currently in use for a band 1 Domestic Assistant role. These were reviewed during the process by members of the Domestic staff and Trades Union. The new job description has been assessed by the banding panel and the outcome was to keep the role at Band 1.

As a result of the review and alignment of job descriptions it is not anticipated that there will be any redundancies. The standardised job description will ensure consistency and clarity for staff and service users alike. The standardised job description will allow for easier management of the +300 staff across the Trust

Transfer of Night Duties

During the workshops it was highlighted where work could be transferred from unsocial hours to day shift. Examples of areas where this was deemed achievable were Physio; Outpatient Departments and Public & Office Areas

The movement of these duties to day time work would result in the transfer of 15 wte's to non-enhanced hours. The remaining staff would be responsible for Theatre cleaning, Delivery and Rapid Response work including Full Cleans and Hydrogen Peroxide Vapour Cleaning.

Whilst it is essential that some clinical areas are cleaned during night enhanced hours i.e. Theatres, it is not operationally efficient to clean the majority of areas during these times. As such, it is recommended that 50% of the cleaning duties be transferred to the day shift. The cleaning input will not be affected. However, to enact this would require redeployment of 15 wte staff. The Trust is proposing four options on how this can be achieved.

PTO

Cont…

The four options on how we can achieve this switch are:

A)***Develop into other Vacancies***: The members of staff affected by this consultation will be given the opportunity and support to apply for an alternative roles (eg. HCA /Admin roles) Such support will be offered during the 12 months transitional period. If alternative work has not been sought during this time, staff will be expected to transfer onto the day shift.

B)***Natural Staff Turnover***: The current cross site turnover within the Domestics Department is 6%. Based on this figure staff numbers at night will reduce by 1.8 WTE per year, taking over 8 years to implement the full transfer of work from unsocial hours to day shift.

C) Transitional Period (w/ Pay Protection): The current 30 members of staff will continue to work the same unsocial hours for a 12 month period receiving their same pay. During this time, individuals will be expected to make arrangements to alter commitments to enable the transfer to day work.

D) Apply Short Term Pay Protection: This option proposes to select 15 staff to move from unsocial hours to day shift. In line with the managing change policy all staff will receive 12 weeks contractual notice and a further 12 weeks short term pay protection.

Financial Benefit

While there is no benefit or cost impact to moving all staff to one job description, there is a significant saving from moving night duties to day. The table below summarises this cost benefit.

Rota changes £'000		Total
Nights Rota (Current)		1,118,931
Nights Rota (new)	485,876	
New cost to move to day rota	342,784	828,660
Savings from proposed changes		**290,271**

Recommendation

The recommendations accepted by TEC were:

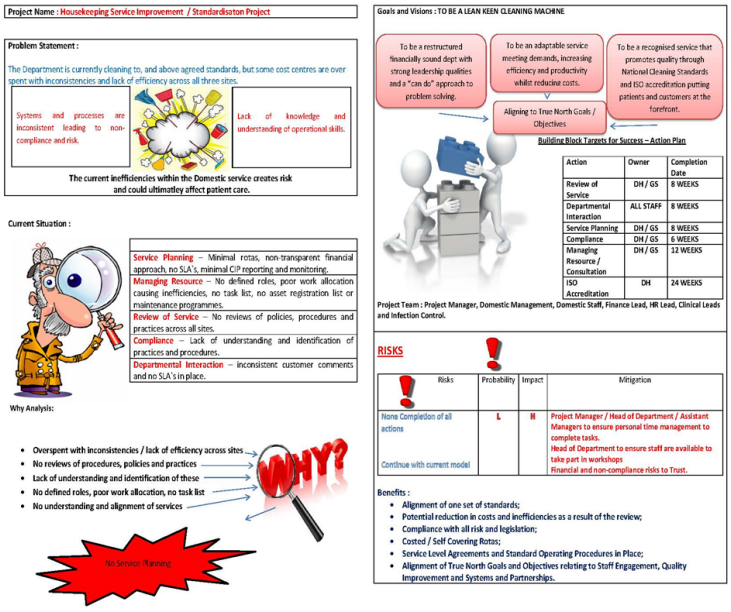
- To proceed with the consultation to standardise the B1 job description
- To proceed with the consultation to move of duties from nights to days but with using a combination of options A, B & C—and not short term pay protection (Option D).

It has been agreed that the outcome of the consultation will come back to TEC prior to implementation.

A full copy of the consultation document and TEC paper are available upon request.

Potential Service Improvements Value Stream Map

Domestic Service Review A3



Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board

Date of Meeting: 1st March 2018 Agenda Item: 10.

Title
2017/18 – Patient / Visitor Parking Cost Increase
Responsible Executive Director
Karen Geoghegan 'Chief of Finance'
Prepared by
David Jones, Director of Estates and Facilities
Status
For Noting
Summary of Proposal
The patient and visitor car parking charges are not aligned across the Trust nor have been reviewed for a number of years. The review and alignment to local councils will ensure the facilities are only used for visitors and patients of the Trust and will create an income generation of £250k per annum. The proposal is linked to, but not dependant on, a capital investment requirement of £230k in 2018/19 to bring the car parking equipment to a modern standard
Implications for Quality of Care
There are clear and direct links to maintaining safe and compliant organisational performance.
Link to Strategic Objectives/Board Assurance Framework
The increase in patient / visitor parking costs is directly linked to the Trust estates strategy.
Financial Implications
The approved increases would generate an additional ££250k income per annum.
Human Resource Implications
There will be no human resource implication as the increase in levy will not apply to Trust staff.
Recommendation
The Trust Board is asked to: I. **Note** the contents of this paper
Communication and Consultation
A communication plan will be developed by the Car Parking Services and the communications team to notify patients and visitors of the increase in parking tariff rates.

Western Sussex Hospitals
NHS Foundation Trust

Car Park Tariff Review

Trust Board Briefing Document

On the 23rd November a paper was presented and approved at TEC recommending an increase on the tariff charges to the Patient and Visitor Car parking. The scope of this paper was to look at all patient, visitor and disabled car parking facilities across the Trust, compare to the local environment and with other local healthcare providers. The paper detailed the income generated for the Trust currently and as a result of the proposed alignment and any risks and benefits associated with this.

Background

With the improvements taking place across the Trust, there is a requirement to develop a sustainable parking tariff strategy for all sites to support the Trust in managing Parking Services. Since the merger of the Trust there has been a significant growth in patient activity which has put added pressure on car park facilities:

- Outpatients attendances increased by 67%
- Day Cases increased by 63%
- Accident and Emergency Cases increased by 15%

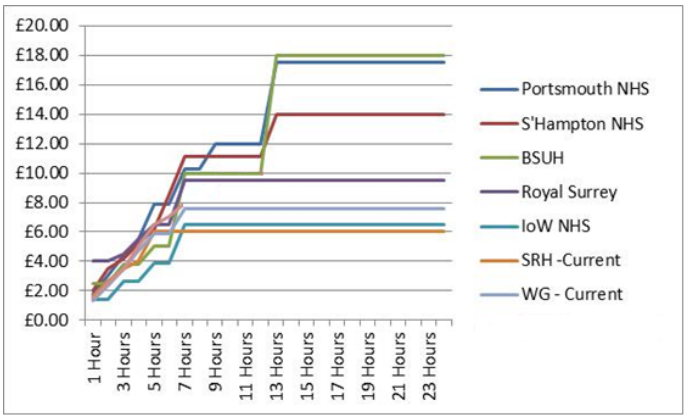
The Trust has owned and managed all parking services across all three sites since 1st January 2015. Prior to this the public parking service at Worthing and Southlands was managed by an external management company .The service has always remained an in house service since its introduction at Chichester in the mid to late 1990's. Tariffs have not been increased at Worthing and Southlands since 2011, while at St. Richards there has been no increase since 2008.

In addition disabled parking charges currently only apply within the main public car park and breast care centre car park at Worthing and in the main public car park at Southlands. No Disabled charges currently apply on the Chichester site

Review Process

With the improvements taking place across the Trust, there is a requirement to develop a sustainable parking tariff strategy for all sites to support the Trust in managing Parking Services.

In order to test the current tariff, and any proposed increases, a bench marking exercise was carried out using five regionally located acute NHS trusts: Portsmouth, Southampton, BSUH, Royal Surrey and the Isle of Wight (see overleaf for the actual charges). The chart below clearly indicates where the trust tariffs currently sits



Options

Other than 'do nothing', five options were put to TEC on the potentials for tariff alignments and charge increases:

Option	Benefit	Risk	Benefit / (Cost)
Do nothing	• Reduce risk on PR	• Issues with parking pressure go unresolved and could continue to increase with activity trends. • Disparity of charges within WSHFT sites	• £0
Introduce new Blue Badge charges at Chichester	• Increase income • New revenue source from disabled parking charges at Chichester (expected to be around £2k per month) • Fairness and equality to all users • Reduce EBB holders queuing to access free bays and blocking access into main car parks	• PR media • Complaints • Cost to implement sufficient number of machines is around £50k	• £24k p/a • (£50k) non recurrent capital
Remove existing Blue Badge charges at Worthing & Southlands	• Positive PR	• Loss of income • Complaints from able bodied users having to pay • Cost to redesign egress points	• (£48k) (loss of income)
Introduce standardise tariff across WSHFT sites – Excluding disabled charges at Chichester	• Increase in income • Deter those that may use the cheaper parking for alternative purposes other than that off visiting the hospital/clinic/patient • Standardised tariffs across sites	• Users seek alternative parking reducing income generation • PR (media) • Non standardised disabled user tariffs • Risk to trusts reputation	• £158k p/a
Introduce site specific 7.5% tariff increases	• Income generation for Trust. • Locally set tariffs	• Review of tariffs annually in line with local providers • Disparity of charges within WSHFT sites	• £116k
Align site specific increase in line with Council charges	• Income generation for Trust • Locally set tariffs in line with council parking	• Review of Tariffs annually in line with local councils • Inconsistent of tariff across WSHFT sites • Worthing site the same tariff as local council which could encourage use of site for non NHS business.	• £252k

Outcome

The option accepted by the Trust was to align site specific Increases in line with council charges. In contrast with the other options, it was argued that that the tariffs should align with the local economy as opposed to be Trust wide. With both councils increasing their Tariffs in 2018 the Trust is at greater risk of being used as a 'Park and Ride' if no action is taken.

In addition to the alignment of tariff, work will be undertaken on the Worthing carparks to allow for the alignment of free parking for blue badge holders.

PTO

Cont…

Frequent/ Vulnerable Users

In addition to the alignment of disabled access, the trust currently provides free parking for users that require frequent visits to the Trust for treatment (eg. Oncology / EoLC / Dialysis) . In addition, long stay patients receive significant reductions in car parking charges. This will continue with the new tariff arrangements.

Also, the Trust currently offers free parking on an ad hoc basis at ward / clinic level (eg in the event of a bereavement). This is currently charged back to the ward. However, under the new arrangements this will be a cost borne by the car parking budget.

It is recognised that a small handful of staff (c15-20) use the car park on an ad hoc basis. While the staff may be affected by the increased charges, the trust is working on how to introduce alternatives as part of the green travel review.

Financial Benefit

Below is a summary of the parking changes by tariff across the Trust.

Option 6 - Align with Council Charges

St Richard's Finance Review					Worthing Finance Review					Overall Impact
	Occupancy	Current	Change		Occupancy	Current	Change			
0.5 Hour										
1 Hours	125,512	£1.60	-£0.30	- 37,654	94,688	£ 1.30	£0.00	-	-	37,654
2 Hours	134,032	£2.60	£0.00	-	101,116	£ 2.30	£0.00	-		-
3 Hours	47,973	£3.50	£0.80	38,378	36,192	£ 3.50	£0.00	-		38,378
4 Hours	20,662	£4.00	£2.70	55,788	15,588	£ 4.70	£0.00	-		55,788
5 Hours	10,995	£6.00	£2.00	21,989	8,295	£ 5.90	£0.00	-		21,989
6 Hours	11,432	£6.00	£3.40	38,868	8,624	£ 5.90	£0.00	-		38,868
7 Hours	8,330	£6.00	£5.20	43,317	6,284	£ 7.60	£0.00	-		43,317
8 Hours	2,429	£6.00	£5.20	12,628	1,832	£ 7.60	£0.00	-		12,628
>8 Hours	19,207	£6.00	£7.40	142,135	14,490	£ 7.60	£0.00	-		142,135
				315,450				-		
			less VAT	- 63,090				-	-	63,090
				252,360				-		
Per month				21,030				-		21,030
Full Year										252,360

Car Park Improvements

While the proposed increases are not dependant on improvements in the car park environment, it is recognised that the equipment currently used is ageing and does not accept modern monetary transactions (eg. Contactless payment). As part of the 2018/19 capital plan, the division has requested funds for a replacement of all barriers and payment machines across the Trust. The tender has just completed with an ask on the capital plan of £235k.

Communications

It is imperative that an effective communications strategy is implemented well in advance of any tariff changes as this may prove to be a contentious project.

A Communications strategy is currently in draft form and is being worked on with the Communications and Facilities teams.

Comparison of Current Car Parking Charges

	1 Hour	2 Hours	3 Hours	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Portsmouth NHS	£1.80	£3.00	£4.40	£5.50	£7.90	£7.90	£10.30	£10.30	£12.00	£12.00	£12.00	£12.00
S'Hampton NHS	£2.00	£3.50	£4.20	£5.20	£6.20	£8.50	£11.10	£11.10	£11.10	£11.10	£11.10	£11.10
BSUH	£2.50	£2.50	£3.80	£3.80	£5.00	£5.00	£10.00	£10.00	£10.00	£10.00	£10.00	£10.00
Royal Surrey	£4.00	£4.00	£4.50	£5.50	£6.50	£6.50	£9.50	£9.50	£9.50	£9.50	£9.50	£9.50
IoW NHS	£1.40	£1.40	£2.60	£2.60	£3.90	£3.90	£6.50	£6.50	£6.50	£6.50	£6.50	£6.50
SRH -Current	£1.60	£2.60	£3.50	£4.00	£6.00	£6.00	£6.00	£6.00	£6.00	£6.00	£6.00	£6.00
WG - Current	£1.30	£2.30	£3.50	£4.70	£5.90	£5.90	£7.60	£7.60	£7.60	£7.60	£7.60	£7.60

Western Sussex Hospitals
NHS Foundation Trust

To: Trust Board in Private

Date of Meeting: 01 March 2018 Agenda Item: 11

Title
Board Self-Assessment - outcome
Responsible Executive Director
Mike Viggers - Chair
Prepared by
Andy Gray – Director of Corporate Governance
Status
Disclosable
Summary of Proposal
As part of its preparation for an External Well-Led Review the Board has undertaken its own self-assessment which was broad in its coverage and based on best practice from within the NHS and elsewhere. The attached paper sets out the responses to the self-assessment which will be shared with the external Well-Led review team with any actions being incorporated into a Board development programme.
Implications for Quality of Care
An effective Board is key to delivery of sustained high quality care.
Link to Strategic Objectives/Board Assurance Framework
Links to good governance requirements.
Financial Implications
An effective Board is key to delivery of a sustainable financial position.
Human Resource Implications
None identified.
Recommendation
The Board is asked to: **a. discuss the results from the self-assessment and consider any appropriate actions to be taken.** **b. Note that the results of the review will form part of the broader External Well-Led Review and feed into an overall Board Development Plan.**
Communication and Consultation Trust Board

This report can be made available in other formats and in other languages. To discuss your requirements please contact Andy Gray, Company Secretary, on andy.gray@wsht.nhs.uk or 01903 284774.

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board Date: 01st March 2018

From: Andy Gray, Director of Corporate Governance Agenda Item: 11

Board Self – Assessment – December 2018

1.00 INTRODUCTION

1.1 As part of its preparation for a External Well-Led Review the Board has undertaken its own self-assessment. The self-assessment was broad in its coverage and based on best practice from within the NHS and elsewhere.

1.2 All Board members and Board Advisors were offered the opportunity to respond to the self-assessment.

1.3 Questions were a range of statements against which respondents were asked to state if they Strongly Agreed, Agreed, Disagreed, Strongly Disagreed or neither Agreed or Disagreed. There were also a number of questions with free text to provide opportunity for respondents to raise any specific items they wished.

2.00 OUTCOMES FROM REVIEW

2.3 The results table at Appendix A shows in full the responses across each statement.

2.4 Table 1 below shows the overall distribution of responses:

Table 1 :

	Strongly Agree	Agree	Disagree	Strongly Disagree	Neither Agree or Disagree
No. Reponses	337	252	10	0	43
% Value	52.50%	39.30%	1.60%	0	6.70%

2.5 It is clear the majority of responses received were a positive response and there zero responses stating that anyone ‘Strongly Disagreed’ with the statement.

2.6 However, some respondents stated they ‘disagreed’ with the statement made and these require consideration by the Board as to how to mitigate the concerns these raise. In addition where there a number of responses stating ‘neither agree or disagree’ this can indicate uncertainty and the Board should consider what cations can be taken to address this.

Table 2 summary of responses ‘disagreed’ and ‘neither agree or disagree’:

Table B	Strongly Agree	Agree	Disagree	Strongly Disagree	Neither Agree or Disagree
The Board manages its time well	6	5	0	0	2
The Board has processes in place to ensure that the work of the Board as a whole is regularly assessed, and these assessments are appropriately followed up	3	7	0	0	2
The Board has processes in place to ensure that the contribution of individual Board members is regularly reviewed and that reviews are appropriately followed up	3	7	0	0	2
The Board is mindful of its need to review and improve its working and has a Board development plan in place	2	7	1	0	2
The Board has sufficient time to meet in private to debate future strategy	0	7	2	0	3
The Board has succession plans in place to ensure the future membership and leadership of the Trust Board	1	3	2	0	6
The Board has sufficient corporate time outside of Board meetings (away days, workshops) to look at issues broadly	2	6	2	0	2
The Board has processes in place to induct new Board members	4	5	0	0	3
The Board has succession plans in place for the future leadership of the Trust	1	2	3	0	6

2.7 There are two key themes that derive from the above responses and these relate to (i) the Board having sufficient space for discussions on future strategy and broader issues outside of the formal meeting content and structures; and (ii) a concern regarding succession planning for Board members.

2.8 Appendix B provides the full statements from the 'Free Text' questions. While responses are quite broad they do also reflect the two key themes highlighted in 2.7 above.

3.00 RECOMMENDATIONS

The Board is asked to:

a) discuss the results from the self-assessment and consider any appropriate actions to be taken.

b) Note that the results of the review will form part of the broader External Well-Led Review and feed into an overall Board Development Plan.

Appendix A – Responses to self-assessment questionnaire in full – December 2017

WSHT Board Self Assessement Survey	Strongly Agree	Agree	Disagree	Strongly Disagree	Neither Agree or Disagree
The Board has a credible strategy to provide high quality, sustainable services to patients and there is a robust plan to deliver	11	1	0	0	1
The Board is sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services	8	3	0	0	1
The Board has the skills and capability to lead the organisation	12	1	0	0	0
The Board shapes an open, transparent and quality-focused culture	11	1	0	0	0
The Board supports continuous learning and development across the organisation	5	7	0	0	1
There are clear roles and accountabilities in relation to Board governance (including quality governance)	8	6	0	0	0
There are clearly defined, well understood processes for escalating and resolving issues and managing performance	6	7	0	0	0
The Board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance.	4	8	0	0	1
The Board agendas appropriately reflect the organisational priorities and issues.	7	6	0	0	0
The Board manages its time well	6	5	0	0	2
The Board receives appropriate information on organisational and operational performance in order to analyse and challenge	5	7	0	0	0
The Board is assured of the robustness of information provided	2	10	0	0	0
The Board has clear articulated core values	9	3	0	0	0
The Board is clear about the purpose of the Trust and intentionally works to ensure that the Trust focuses on achieving its purpose	10	2	0	0	0
The Board holds the CEO to account to lead and develop the Trust so that it focuses on its purpose and lives out the purpose and core values	9	2	0	0	1
The Board has a clear set of strategic priorities that are discussed with and understood by clinicians and leaders	7	4	0	0	1
The Board is proactive in seeking the input and advice of Trust senior leaders as it forms and reviews strategy	5	7	0	0	0
The Board holds the CEO to account to achieve its strategic priorities	8	4	0	0	0
The Trust Board ensures that internal processes support and reinforce the achievement of strategic priorities	7	4	0	0	1
The Board regularly monitors and reviews strategic priorities	6	5	0	0	1
The Board has processes in place to ensure that the work of the Board as a whole is regularly assessed, and these assessments are appropriately followed up	3	7	0	0	2
The Board has processes in place to ensure that the contribution of individual Board members is regularly reviewed and that reviews are appropriately followed up	3	7	0	0	2
All Board members take on and execute responsibilities as required by the Board	7	5	0	0	0
The Board is mindful of its need to review and improve its working and has a Board development plan in place	2	7	1	0	2
Board members are satisfied that the Trust fulfils its regulatory and statutory responsibilities	11	1	0	0	0
The current structure of the Board Committees and Board Sub Committees enables the Board to fulfil its functions more effectively	7	5	0	0	0

The amount of time spent in formal meetings is appropriate to enable the Board to fulfil its functions	4	7	0	0	1
The Board has sufficient time to meet in private to debate future strategy	0	7	2	0	3
The Board has access to the reports and information it needs, in the form it needs it, to be able to make good, timely decisions	8	4	0	0	0
The Board has succession plans in place to ensure the future membership and leadership of the Trust Board	1	3	2	0	6
Board meetings are managed in a timely way so that the agenda is completed and there is time for members to express their views	7	5	0	0	0
Papers are circulated sufficiently in advance of meetings so that members are able to prepare for meetings	4	8	0	0	0
The Board effectively divides its time to cover both its monitoring and oversight strategic responsibilities	6	6	0	0	0
There are adequate number of Board meetings held in order for the Board to get through its work with due care and attention	6	6	0	0	0
The Board has sufficient corporate time outside of Board meetings (away days, workshops) to look at issues broadly	2	6	2	0	2
The Board is structured and organises itself in such a way that it is able to fulfil the full range of its responsibilities	7	5	0	0	0
The skills, talent and experience of the Board are such that the Board is able to fulfil its responsibilities	9	3	0	0	0
The Board is able to use differences and disagreements constructively to arrive at better decisions for those that the Trust serves	7	4	0	0	1
Individual Board members are comfortable to raise issues and know they will be listened to	8	4	0	0	0
When there is a disagreement in the meeting, all members support the Board view outside of the meeting	9	2	0	0	1
Individual Board members feel able to fulfil the functions expected of them in the time given	7	5	0	0	0
Board members feel they receive sufficient information in order to fulfil their role and be effective	7	4	0	0	1
Non Executive Directors constructively challenge Executive Directors	7	5	0	0	0
Non Executive Directors sufficiently balance their obligations to support and challenge Executive Directors	7	5	0	0	0
The Board is proactive in its own governance, leadership, education and development	2	9	0	0	1
The Board has processes in place to induct new Board members	4	5	0	0	3
The Board and Executive Team are clear about their respective relationships in leadership and governance	6	5	0	0	1
The Board does not interfere with the day to day management of the Trust	5	7	0	0	0
The Board is appropriately accessible to senior staff in the Trust	5	6	0	0	1
The Board has succession plans in place for the future leadership of the Trust	1	2	3	0	6
Levels of trust and mutual respect between the Non Executive Directors and the Executives of the Trust are strong	9	2	0	0	0
The Board demonstrates confidence in the professional experience of the Executive team	11	0	0	0	0
The Board provides constructive and supportive challenge to the Executive team and the strategies, policies and plans submitted to the Board	9	2	0	0	0
	337	252	10	0	43
	52.5%	39.3%	1.6%	0.0%	6.7%

Appendix B – Responses to 'Free Text' questions from self-assessment – December 2018

Can you identify any gaps or do you have any suggestions for improvement?	• More time for informal discussion of longer term strategic issues and challenges • As discussed at Board at times we have wondered if we have enough time and visibility on people issues but we are sighted on this and looking at various ways to ensure the people issues get the time needed • Board sessions are very structured - and need to be. However sometimes unstructured time is needed to surface issues bubbling under the surface. For example the pre-Board NEDs chats were useful opportunities and could be reinstated? • Not yet bought differentiation at Board level between watch measures and KPIs outside of true north. It would be good to see the divisional SDR view rolled up into Board level. • No • Review of Clinical Governance to reflect Patient First System • Opportunity for NEDs to better share insights from attendances at Quarterly Governance meetings • No • Increasingly we need to think about both site level, but also system (wider than just the secondary care service level) information • The Board agenda is driven almost exclusively by its executive members. Whilst this is understandable I would welcome an occasional opportunity for a more open, less scripted discussion about the Trust's longer term strategy and options.
How, if at all, could Board meetings further encourage equal contribution, open discussion and critical thinking?	• More time for strategic issues • Sometimes time pressures mean we perhaps don't have time to reflect as much as we might like. Board seminars are excellent and allow us to deep dive into areas that concern us/are of major interest. Sometimes the volume of papers where we have a number of business cases feels heavy but using F&I pre board seems to work well in overcoming this • For business cases execs have already signed off when it comes to Board. Would be interesting to hear the key challenges raised by execs when they discussed (and the answers). They will be better able to understand potential weaknesses. NEDs can then check they are happy with the answer given to the challenge and provide independent oversight. • I am ok with where we are on discussion today. I think there is potential to bring into the board more discussion in evolving issues. These feel as if they are discussed robustly at TEC and then outcomes /solutions come to Board alongside the issue. The joint board/governors forum last week was actually quite a good example of discussion on STP evolving landscape, as an example were already decided!

	• The board and executive have an open and transparent relationship. The chair ensures that all members have the opportunity to contribute and that all concerns are followed up. • Board seminars and planned time outside of the formal meeting structure enables discussion and debate • Open discussion already encouraged • Ensuring everyone is encouraged to contribute • A good team culture, all of whom contribute and have open discussions. • We run quite a tight and standard agenda - I think the away days we have are the best vehicle for that debate and discussion • Sometimes I feel the NEDs are catching up with events at Board meetings with the result that they may not be fully sighted on all the information necessary to make an effective contribution. A regular flow of information on key events and actions between Board meetings would create a more level playing field between executive and non-executive members.
What are the things that the Board does well and should do more of?	• Discuss and review True North objectives. Engage with clinical leaders • Respect and shared values are strong. We challenge and support each other. This is a mature and highly effective board. I very much welcome active senior clinician input into private board when they are able to come. • Have a real patient come and talk about their experience/complaint at the start of the Board once or twice a year (as we used to). Very grounding! • Openness around behaviours and values expected; supporting each other; acting as a unitary Board; constructive challenge; buy-in and support to Strategy after appropriate discussion. • The board has a good balance in terms of effective challenge and positively encouraging the executive to delve high quality, safe patient care. • Collective accountability for patient care and performance • Identifies areas requiring more detailed examination by seminar or briefings • Challenges itself and organisation to continuously improve • Working as a unitary team focusing on patients and excellent governance • United and healthy approach which is always values and outcome based • See previous comments

What should the Board do less of or stop doing?	• Could delegate more to committees • Nothing springs to mind. • Use facility of noting papers without discussion to free up time for agenda items that need discussion • Scheduling short notice meetings or changing timing of meet8ngs at short notice • Nothing that I am aware of. • Understanding that we cannot operate in isolation, we must continue to not be overly distracted by national programmes (STP) which are not directly impacting patient care and service delivery • Areas of repetition in Committees and Board • Try to shorten meetings • Nothing • Occasionally the levels of detail are too granular and we all need to maintain the discipline of appropriately triangulating individual incidents and anecdote with data and other sources of information • Nothing to add
Other comments that will support the Board to be even more effective in its work	• More time! • The questions around talent management and formal effectiveness reviews made me reflect that we have processes in place but these may need to be more explicit and articulated than they currently are. • Have a B2B with another acute Board to swap ideas and experiences • Structure of meetings below board sub-committee needs a refresh along with NED and Exec presence at same • The board operates very effectively as a unitary board. However, a bit more private informal time for non-executives to consider issues of development and space for reflection would be welcome. • Agree the long term structural direction for WSHT and BSUH • Specific NED time with the Chair to review possible areas of concern • No • High performing board and organisation, in an ever increasingly difficult national framework and situation - we need to be mindful and perhaps accept our need to influence and manage the external agenda in order to enable us to continue to support and drive the organisation forward

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board

Date of Meeting: 1st March 2018 Agenda: 1.

Title
Love Your Hospital Charity Investment Policy
Responsible Executive Director
Lizzie Peers, Non-executive Director
Prepared by
David Lowe, Assistant Director of Finance
Status
Disclosable
Summary of Proposal
The annual review of the Love Your Hospital Charity Investment Policy
Implications for Quality of Care
Not applicable
Link to Strategic Objectives/Board Assurance Framework
Charitable Funds are used in a manner consistent with the Trust's objectives
Financial Implications
N/A
Human Resource Implications
N/A
Recommendation
The Committee is asked to **REVIEW** the amendments and recommend for **APPROVAL** by the Trustees.
Communication and Consultation
N/A
Appendices
1. Investment Policy

LOVE YOUR HOSPITAL CHARITY INVESTMENT POLICY

1.0 INTRODUCTION

1.1 At the last Charitable Funds Committee meetings on the 13th November 2017, this policy was considered alongside the Charity's policy. In discussing the investment policy the Committee considered a number of factors including risk and the need to balance liquidity against securing a fair return on funds that are not required for immediate use. It was agreed that the policy and investment approach would be kept under review as spending plans mature to ensure it remains appropriate.

1.2 As part of this review, the Assistant Director of Finance was asked to make amendments to paragraphs 5.3 and 5.4.

1.3 This paper sets out the changes to the investment policy and the amended version is contained within **Appendix 1**

1.4 The Trustees are asked to **APPROVE** the amended policy as recommended by the Charitable Funds Committee.

2.0 AMENDMENTS

2.1 In paragraph 5.3, adding to bullet point 4, that the Charity will allow investment in U.K. regulated common investment funds, which may be invested in markets outside the U.K., but must have good liquidity of underlying assets i.e. be readily realisable

2.1.1 Original - 5.3 Investments must be based on the following:

- interest bearing cash deposits in the following banks: Natwest, Barclays, HSBC, Lloyds TSB or CAF
- shares in a FTSE listed company (listed equities)
- interest bearing loans to a FTSE listed company or the UK government (bonds or gilts)
- UK regulated common investment funds and other collective investment schemes
- Commodities

2.1.2 Amended – 5.3 Investments must be based on the following:

- interest bearing cash deposits in the following banks: Natwest, Barclays, HSBC, Lloyds TSB or CAF
- shares in a FTSE listed company (listed equities)
- interest bearing loans to a FTSE listed company or the UK government (bonds or gilts)
- UK regulated common investment funds, which may be invested in markets outside the U.K., but must have good liquidity of underlying assets i.e. be readily realisable
- Commodities

2.2 In paragraph 5.4, adding a bullet point to include known illiquid trusts and amending bullet point 5 to add direct investment in

2.2.1 Original – 5.4 For clarity, investments to be excluded from the strategy include:

- non traded equity in private companies
- hedge funds
- derivatives

- tobacco, alcohol and defence
- Buildings or land

2.2.2 Amended – 5.4 For clarity, investments to be excluded from the strategy include:

- non traded equity in private companies
- hedge funds
- derivatives
- tobacco, alcohol and defence
- direct investment in buildings or land
- Known illiquid trusts

2.3 Paragraph 5.7 has been updated to include further clarification on why the Charity invests more than the FCFS protection limit with the Charitable Aid Foundation (CAF) Bank.

2.3.1 Original - For cash invested, the benefit of getting a higher rate of interest for depositing a single large sum must be balanced against the risks involved with depositing with a single institution. Large deposits should be split between banking institutions, reducing the risk of large losses due to institutional failure. No one institution should hold deposits of more than £0.5m.

2.3.2 Amended - For cash invested, the benefit of getting a higher rate of interest for depositing a single large sum must be balanced against the risks involved with depositing with a single institution. Large deposits should be split between banking institutions, reducing the risk of large losses due to institutional failure. No one institution should hold deposits of more than £85k (which is the Financial Services Compensation Scheme limit applicable from the 1st January 2017). Excluded from this are the accounts held with the Charitable Aid Foundation bank (CAF) due to their conservative investment strategy whereby it has 63% of its assets invested with the Bank of England/UK Government and in multilateral development institution bonds (these are institutions set up by countries i.e. World Bank, Asian Development Bank etc). The Committee will be presented with an update at each meeting (based on publicly available information) in relation to the investment strategy of CAF to review its suitability.

CHARITY INVESTMENT POLICY APPENDIX 1

1 Index 2 Introduction 3 Objectives 4 Duties 5 Risk 6 Investment Manager 7 Cash Management 8 Compliance

2 Introduction

2.1 The Trustee Act 2000 confers a general power of investment on the Charity's Trustee (the Western Sussex Hospitals NHS Foundation Trust Board).

2.2 Charity Commission requirements are that a charity must have an investment policy.

2.3 This investment policy sets out the Charity's investment objectives and how they will be achieved.

3 Objectives

3.1 The Charity's investment objective is to provide the best financial return, after any ethical considerations, to assist in achieving the charity's aims, subject to section 3.2 and the provisions in section 5.

3.2 A broad risk adverse approach will be taken such that the Charity holds a range of investments to achieve both capital and income growth over the medium term. The medium term shall be defined as a two year period for the purposes of this policy.

3.3 The Trustee will use the services of an investment manager to advise on investments, including some cash deposits.

4 Duties

4.1 The Trustee, Western Sussex Hospitals NHS Foundation Trust Board, (WSHFT) has overall responsibility for the investment of the charity's funds, assisted by the Charity's investment manager. WSHFT Charity Committee acts on behalf of the Trustee, and must:

- use its skills and knowledge in a way that is reasonable in the circumstances, exercising care
- consider how suitable any investment is and be satisfied that: an investment type or class is appropriate for the charity (for example, shares)
- the investment within that type or class is appropriate for the charity (for example, shares in a specific bank)
- diversify investments (for example, owning shares in a number of different companies)
- take advice from someone experienced in investment matters, including cash deposits unless there is a good reason not to do so – see section 6 below
- review investments (and the investment manager) from time to time, setting their reporting requirements and changing them if necessary.

4.2 The Charitable Funds Committee shall monitor investments which may include making decisions between meetings. Decisions will be reported back to the following Charitable Funds Committee meeting.

4.3 The Committee shall decide:

- how much is available for investment, timing of returns and the charity's liquidity needs
- the types of investment it wants to make, including ethical considerations
- how investments will be managed and which benchmarks will be utilised to ensure the performance of the investment portfolio is adequate.

4.4 Investment decisions may also be made by the by the appointed investment manager, operating within the guidelines laid down within this policy.

4.5 The Trustees must ensure that any decision that they take about adopting an investment approach can be justified such that:

- a particular investment does not conflict with the aim of enhancing health care and improving the health for the patients of Western Sussex Hospitals NHS Foundation Trust
- there is no significant financial detriment
- any decisions is congruent with the stated aims of the charity.

4.6 In pursuing the policy in section 4.5 above, the committee must ensure that there is no direct investment with any organisation that conflicts with the aims of improving the health of the local population, including those responsible for the production of tobacco or alcohol products.

4.7 Any member of the Corporate Trustee must declare any connection from which they, their family or a business interest might benefit directly or indirectly from any financial advice provided to the charity.

5 Risk

5.1 Investments can be a major source of funding but risk has to be recognised as not only can capital and potential income be lost but also the confidence of the charity's stakeholders, including donors.

5.2 The Committee will set an investment strategy that will take a broad risk adverse approach with a range of investments to achieve both capital and income growth over a two year time period.

5.3 Investments must be based on the following:

- interest bearing cash deposits in the following banks: Natwest, Barclays, HSBC, Lloyds TSB or CAF
- shares in a FTSE listed company (listed equities)
- investment grade interest bearing loans to a FTSE listed company or the UK government (bonds or gilts)
- UK regulated common investment funds, which may be invested in markets outside the U.K., but must have good liquidity of underlying assets i.e. be readily realisable
- Commodities

5.4 For clarity, investments to be excluded from the strategy include:

- non traded equity in private companies
- hedge funds
- derivatives
- tobacco, alcohol and defence
- direct investment in buildings or land
- known illiquid trusts

5.5 Any change to those investments listed in sections 5.3 and 5.4 shall be made by the Charitable Funds Committee only.

5.6 For approved investments, the Charitable Funds Committee must retain overall control of decision making and investment decisions.

5.7 For cash invested, the benefit of getting a higher rate of interest for depositing a single large sum must be balanced against the risks involved with depositing with a single institution. Large deposits should be split between banking institutions, reducing the risk of large losses due to

institutional failure. No one institution should hold deposits of more than £85k (which is the Financial Services Compensation Scheme limit applicable from the 1st January 2017). Excluded from this are the accounts held with the Charitable Aid Foundation bank (CAF) due to their conservative investment strategy whereby it has 63% of its assets invested with the Bank of England/UK Government and in multilateral development institution bonds (these are institutions set up by countries i.e. World Bank, Asian Development Bank etc). The Committee will be presented with an update at each meeting (based on publicly available information) in relation to the investment strategy of CAF to review its suitability.

6 Investment Manager

6.1 Where an investment manager manages the Charity's investments, there must be a written agreement or contract with any investment manager appointed. The investment manager must be regulated by the FSA or successor organisations.

6.2 The written agreement must set out the responsibilities and remit of the investment manager. The investment manager must select investments in line with these instructions, and in line with those set out within this policy.

6.3 If giving the investment manager discretionary powers, trustees must not enter into an agreement that:

- allows the investment manager to appoint a substitute or select their own successor
- reduces the investment manager's normal duty of care, or places a cap on his liability for breach of contract
- allows the investment manager to act in situations that might give rise to a conflict of interest.

6.4 The Trustee shall always remain responsible for:

- setting out and reviewing their charity's investment policy on a regular basis
- deciding whether, to whom, and on what terms to delegate management of a charity's investments
- reviewing the suitability and performance of investment managers regularly
- if necessary, ending appointments
- Trustee reviewing how investments are performing.

7 Cash Management Outside of the Investment Portfolio

7.1 The Charity Committee shall set out arrangements over cash management, including appropriate delegation (e.g. use of bank accounts, length of cash investments).

7.2 For any level of cash maintained the highest level of return must be sought within the risk framework established by the Charity Committee (see section 5).

7.3 Cash should only be deposited with those institutions listed in section 5.

7.4 Cash deposits should be in an interest bearing account, unless placed on deposit in the short term or invested elsewhere for the longer term.

7.5 Accounts should be regularly reviewed to ensure that a competitive return is being made.

7.6 The opening or closing of bank accounts should be authorised by the whole trustee body, but can be delegated where appropriate subject to reasonable limits. Cash movements and bank mandates should reflect good practice as defined by the Standing Financial Instructions and Delegated Limits of Western Sussex Hospitals NHS Foundation Trust Finance Department.

7.7 An appropriate level of reserves should be held to ensure the Charity has sufficient resources to support ongoing operations and deliver the approved strategy (see separate Reserves Policy)

8 Compliance

8.1 Compliance with this policy will be monitored by:

- the Charity Committee
- the Trust's Internal Auditors via departmental audits and detailed reviews

8.2 The investment policy will be reviewed annually and approved by the Committee and any changes noted by the Board of Trustees.

Approved by the Charitable Funds Committee

Signed ……..

Dated…….

Reference Minute…….

Noted by the Board of Trustees

Dated…….

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board

Date of Meeting: 1st March 2018 Agenda: 1.

Title
Love Your Hospital Charity Reserve Policy
Responsible Executive Director
Lizzie Peers, Non-executive Director
Prepared by
David Lowe, Assistant Director of Finance
Status
Disclosable
Summary of Proposal
The annual review of the Love Your Hospital Charity Reserves Policy
Implications for Quality of Care
Not applicable
Link to Strategic Objectives/Board Assurance Framework
Charitable Funds are used in a manner consistent with the Trust's objectives
Financial Implications
N/A
Human Resource Implications
N/A
Recommendation
The Committee is asked to **REVIEW** the amendments and recommend for **APPROVAL** by the Trustees.
Communication and Consultation
N/A
Appendices
1. Reserves Policy

Charity Reserves Policy

1.0 Introduction

1.1 A reserves policy explains to existing and potential funders, donors and other stakeholders why a charity is holding a particular amount of reserves. A good reserves policy gives confidence to stakeholders that the charity's finances are being managed and can also provide an indicator of future funding needs.

1.2 It is also an important part of financial management and forward financial planning. Holding excessive reserves can limit the amount spent on charitable activities, thus reducing the potential benefits a charity can provide. However, if reserves are too low then the charity's solvency and its future activities can be put at risk.

1.3 Under SORP (FRS102), the charity is required to explain its policy for holding reserves and state the amount and why they are held.

2.0 Level of Reserves

2.1 Reserves are that part of a charity's unrestricted funds that is freely available to spend on any of the charity's purposes. This definition excludes restricted funds.

2.2 In setting its reserves the charity will consider:

- Restricted funds which are not available for general purposes.
- Uncertainties that the charity may face in the future.
- Material amounts in designated funds earmarked for a particular future project. Note that the SORP states that by earmarking funds in this way, designated funds remain within unrestricted funds because the designation has an administrative purpose only and does not legally restrict the trustees' discretion in how to apply the unrestricted funds that they have earmarked.
- The time-frame for considering going concern, which under FRS 102, is at least twelve months from the date the accounts are approved.

2.3 The level of reserves should be based on the funds required for the charity's operations to continue. In order for operations to continue, funds will be required for the following:

- Management costs (charity office)
- Finance admin/support costs
- Lottery costs
- Investment managers fees
- Other fundraising costs
- Audit fees

2.4 The charity will hold minimum reserves equivalent to twelve months cost of the above to meet the requirement for going concern.

3.0 Review of Reserves

At the end of the financial year, the charity will review its reserves and will include the following in its annual report:

- the amount of total funds the charity holds
- the amounts of restricted funds the charity holds
- identify and explain material amounts that have been designated or otherwise committed and indicate the likely timing of such amounts
- identify the amount of any fund that can only be realised by disposing of tangible fixed assets
- amount of reserves the charity holds
- compare the amount of actual reserves against the reserves policy and explain, where relevant, the steps being taken to bring the amount in line with the policy

4.0 Compliance

4.1 Compliance with this policy will be monitored by the Charity Committee

4.2 The reserves policy will be reviewed annually and approved by the Committee and any changes noted by the Board of Trustees.

Approved by the Charitable Funds Committee Noted by the Trustee Board

Signed ……..

Dated…….

Dated…….

Reference Minute……

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board

Date of Meeting: 1st March 2018 Agenda Item: 2

Title
Love Your Hospital Budget 2018/19
Responsible Executive Director
Lizzie Peers, Non-Executive Director
Prepared by
Sarah Mercer, Divisional Finance Manager and Amanda Tucker, Head of Charitable Operations
Status
Disclosable
Summary of Proposal
Update the Board on the strategic and financial progress of Love Your Hospital
Implications for Quality of Care
Used appropriately and effectively Charitable Funds enhance the quality of care provided in the Trust.
Link to Strategic Objectives/Board Assurance Framework
Charitable Funds are used in a manner consistent with the Trust's objectives.
Financial Implications
This paper sets out the proposed budget for LYH 2018-19
Human Resource Implications
N/A
Recommendation
The Board of Trustees is asked to: **APPROVE** the 2018/19 budget and the Management and Administration Costs for 2018/19 in section 5.4, and to **NOTE** that the budgeted available funds for 2018/19 are **£2,075k.**
Communication and Consultation
N/A
Appendices
1: Budget 2018/19 2: Phased Budget 2018/19

This report can be made available in other formats and in other languages. To discuss your requirements please contact Andrew Gray, Company Secretary, on andrew.gray@wsht.nhs.uk or 01903 205111.

To: Trust Board

Date: 1st March

From: Lizzie Peers, Non-Executive Director

Agenda Item: 2

FOR APPROVAL

2018/19 CHARITABLE FUNDS BUDGET

1.0 INTRODUCTION

1.1 This paper presents the annual 2018/19 budget for the Love Your Hospital Charity. The budget has been discussed at the Charitable Funds Committee and is recommended to the Board for approval.

2.0 RECOMMENDATION

2.1 The Board is asked to **APPROVE** the budget for 2018/19 shown in Appendix 1, **APPROVE** the management and administration costs in section 5.4 and **NOTE** the budgeted available funds for 2018/19 are £2,075k.

3.0 CHARITABLE FUNDS BUDGET 2018/19

3.1 Budget uplift 18/19 Bridge

3.2 The 18/19 budgeted income (including legacies) is £1,374k; this represents a year on year uplift net of non-recurrent and 'other' items of £118k, a 23% increase in voluntary income. This is benchmarked against The Institute of Fundraising Website which quotes a sector weighted average increase in voluntary income at 4%. This is to be expected in a period of investment and growth but will over time move towards the sector average. The detailed phased budget can be found in **Appendix 2**.

Description	17/18 forecast £'000	Non Recurrent	Charity of the year	Growth	Staff Costs	Other	18/19 draft budget
Donations	252	(23)		36			265
Fundraising	169	(7)		73		10	246
Investment Income	41						41
Total Income	462	(30)	-	109		10	552
Lottery Prizes	(18)			(3)			(21)
Fundraising Costs	(63)	21			(75)	5	(111)
Management Costs	(185)			(46)	75	(19)	(176)
Finance and Admin Costs	(44)						(44)
Total Cost of Generating Funds	(310)	21	0	(49)		(13)	(351)
Audit Fees	(8)						(8)
Governance Costs (incld investment management fee)	(18)						(18)
Total Governance Costs	(26)	0	0	0	0	0	(26)
Total Income less Total Cost (excl. Legacies)	126	(9)	0	60	0	(3)	175
Legacies	41			9		772	822
Total Income less Total Cost (incl. Legacies)	167	(9)	0	69	0	769	997
Total Income (incl. Legacies)							1,374

3.3 Management costs are showing growth of £46k, £39k of which relates to the full year effect of the vacancies against the forecast. The £75k movement in the staff costs column relates to apportionment of salaries to direct fundraising activity.

3.4 The £19k increase in management costs other relates to additional expenditure in relation to marketing, training, travel and regulatory subscriptions.

3.5 The most significant uplift in 18/19 is as a result of the movement of the Woodham legacy from 17/18 to 18/19. Non recurrent adjustments to 17/18 income are as a result of Ben Nevis and the Ball.

	Total £'000
Original Available Funds Budget 2017/18	1,590
Income	503
Cost of Generating Funds (incl governance costs)	(336)
Direct Charitable Expenditure	(344)
Gains/losses on disposal	42
Draft Accounts Fund Balance 2017/18	1,455
Variance between fund balance Budget 17/18 and f'cast	135

3.6 The brought forward fund balance of £1,455k is based on the 2017/18 full year forecast as at the end of Quarter 3, 17/18.

3.7 Direct charitable expenditure relates to staff education and patient support expenditure.

4.0 STATEMENT OF FINANCIAL ACTIVITIES 2018/19 – INCOME

Budget 2018/19	Total £'000	General	Hypothecated
Incoming resources from generated funds			
Voluntary Income			
Donations	265	97	169
Legacies	822	822	-
Fundraising	246	229	17
Sub total voluntary income	1,333	1,147	186
Investment income	41	41	-
Total Income	1,374	1,189	186

The main assumptions around income are as follows:

4.1 Donations. The budget is set at £265k which is £110k higher than the 2017/18 budget. This is predominantly due to the increase in Community activity especially in relation to community sponsorship which is seeing a sector wide uplift which is reflected in our figures. We are also anticipating uplift in Ward donations as a result of a specific campaign to place “donation stations” in all wards.

4.2 Legacies. The budget of £822k is predominantly due to the delay in receipt of the advised legacy of £735k. The Charity continues to receive information on future legacies from Smee and Ford, a legacy notification service and the budget is based on Income we are notified as being within the pipeline. This does not include any other assumed income.

4.3 Fundraising. The budget is £246k is £8k higher than 2017/18 budget. The increased income is predominantly as a result in the delivery of anticipated corporate income as a result of the anticipated roll out in the Give as You Earn Campaign. This is offset by a reduction in income from direct marketing.

4.4

Budget 2018/19	Total £'000
Fundraising	
Lottery	35
Direct Marketing	27
Corporate Fundraising	92
Applications to grant-making bodies	91
	246

4.5 Lottery - the value of the lottery in 2018/19 is budgeted to be £35k, this is showing a static year on year figure, but is based on the assumption that should the model remain the same we will be able to actively recruit a small number of players due to additional resource but will also continue with the current levels of attrition

4.6 Direct Marketing – this is budgeted to be £27k in 2018/19 and is predominantly as a result of the introduction of the new newsletter which is anticipated to be income generating and an annual 15k gift aid income

4.7 Corporate fundraising (£92k): This income is primarily made up of corporate partnership and includes income from the introduction of a staff wide Give as You Earn scheme which is targeted to raise £39k. The corporate income stream also includes uplift in corporate sponsorship as a result of the introduction of the "giving tree" campaign

4.8 Applications to grant-making bodies (£91k):. This is based on having additional administration resource which will enable us to complete the equivalent of one trust application per week of which 10% would be successful, applications would range in value from 40k to £1k but this is dependent on having key attractive Capital items to fundraise for.

4.9 Investment Income. This is based on historical average is anticipated to be £41k.

5.0 EXPENDITURE

Budget 2018/19	Total £'000
Costs of generating funds	
Lottery Prizes	(21)
Fundraising costs	(111)
Management costs	(176)
Finance admin costs	(44)
Sub total costs of generating funds	(351)

5.1 Cost of generating funds. The cost of generating funds is based on similar levels of spend in the 2017/18 budget except due to the full year effect of the new fundraising posts and increased direct fundraising costs due to increased activity. Note that Pay costs for Direct Marketing & Community posts are included within Fundraising Costs rather than Management Costs.

5.2 Lottery costs £21k. The lottery expenditure is based on the continuation of the current model with an associated uplift in costs relating to the small uplift in players and additional costs per transaction for processing online payments.

5.3 Fundraising costs £111k. This includes pay and non-pay costs of delivering the new LYH newsletter, additional investment in Corporate and Community Fundraising particularly in relation to rolling out GAYE and the donation stations.

5.4 Management and administration costs.

All costs including governance costs are shown under cost of generating funds.

5.4.1 Charity office. £176k. The proposed staffing budget includes 1% inflation, based on the expected 2018/19 pay award for NHS staff plus the full year effect of the staff that have been recruited during 2017/18 including any increments that are due. This equates to the £132k plus £44k of expenditure (which is ongoing overhead expenditure of running the Trust including web maintenance, social media general leaflets etc.). Note that pay costs relating to Direct Marketing and Community (totalling £75k) are shown within Fundraising costs.

5.4.2 Finance support cost. £44k. The proposed budget is based on the budgeted time expected to be spent and is £895 lower in real terms than 2017/18, due to process improvements that the Finance team and Charity office have implemented during 2017/18.

Management and Admin Costs	WTE or %	£
Salaries		
Charity Office		
Head of Charity	1.00	65,243
Community & Corparate Partnership Officer	1.00	30,234
Individual Giving Fundraiser	1.00	44,465
Marketing Officer	1.00	36,086
Admin Support	1.00	30,389
Total		**206,418**
2017/18 forecast for info		184,911
Change 1% inflation)		1,389
Change FYE of charity staff, WTE increase and increments		*20,119*
Finance Support		
Chief Financial Officer	1%	2,474
Finance Director	1%	1,542
Assistant Director of Finance	5%	4,421
Senior Finance Manager	25%	14,758
Senior Finance Officer	85%	20,817
Total		**44,012**
2017/18 forecast for info		44,459
Change 1% inflation		448
Change (Process improvements)		*(895)*

5.5 Governance Costs

Budget 2018/19	Total £'000
Governance costs	
Audit fees	(8)
Governance costs (incl investment costs)	(18)
Sub total costs of governance costs	(26)

5.5.1 Audit Fees - the budget has been set at £8k as per the charge for 2017/18.

5.5.2 Investment manager's fee - this is an estimated costed based on 2017/18. The Charity is currently asking for a confirmation of the fee from the charity's investment manager, but early conversations suggest the value will be broadly similar.

5.6 **Gains/losses on investment assets**

- Predicting any gains or losses in 18/19 due to market value changes is extremely difficult and therefore the budget assumes that any losses or gains will net off to a nil value.

5.7 **Fund Generation Costs**

The Charitable Funds Committee discussed the ratio of income (excluding legacies) and fund generation costs, which appears to be higher than the average within the charity sector. The Committee agreed to review the appropriateness of the budgeted cost base and report back to the Trustees when this was concluded.

6.0 FUND BALANCES AND RESERVE LEVELS

6.1 The Charitable Funds Committee had previously agreed that the General funds should maintain a balance at the end of each year that is equal to or greater than the annual running costs of the charity. This will ensure that the charity is able to support its running costs and also able to invest in new staff and processes to increase and diversify its income streams and support future sustainability. For 2018/19 this requires a balance of £377k in the general funds to support the estimated costs in 2018/19 and ongoing into 2019/20.

The proposed reserves value is in line with the reserves policy approved by the Committee in 2017/18.

7.0 Available Funds for Direct Charitable Expenditure

7.1 General items to support staff welfare and patients - the level of funds available for application for funding is £2,075k. This is after taking reserves into account required to cover the running costs of the charity for 2018/19 and 2019/20. Of the £2,075k, £640k is from general funds and £1,435k from hypothecated funds.

Description	Total	General Funds	Hypothecated Funds
	£'000	**£'000**	**£'000**
Opening Balance forecast at 1st April 2018	1,455	206	1,249
Total Income	1,374	1,189	186
Total Cost of Generating Funds (including governance costs)	(377)	(377)	0
Balance available for application	2,452	1,017	1,435
Total committed expenditure			
Total reserves	(377)	(377)	0
Available for application	2,075	640	1,435

8.0 Recommendation

The Trustees are asked to:-

8.1 **APPROVE** the 2018/19 budget for the Love Your Hospital Charity;

8.2 **APPROVE** the management and administration costs for 2018/19 (section 5.4.2)

8.3 **NOTE** that based on current assumptions £2,075k of funds are available for application.

Appendix 1

Budget 2018/19

Description	Total	General Funds	Hypothecated Funds
	£'000	£'000	£'000
Opening Balance at 1st April 2018 (forecast)	1,455	206	1,249
Incoming resources from generated funds			
Voluntary Income			
Donations	265	97	168
Legacies	822	822	
Fundraising	246	228	17
Sub total voluntary income	**1,333**	**1,147**	**186**
Investment income	41	41	
Total Income	**1,374**	**1,189**	**186**
Resources expended			
Costs of generating funds			
Lottery Prizes	(21)	(21)	
Fundraising costs	(111)	(111)	(0)
Management costs	(176)	(176)	
Finance admin costs	(44)	(44)	
Sub total costs of generating funds	**(351)**	**(351)**	**(0)**
Other costs			
Audit fees	(8)	(8)	
Governance Costs	(18)	(18)	
Gains and Losses	0		
Subtotal audit fees, governance costs and gains and losses	**(26)**	**(26)**	**0**
Total cost of generating funds, audit fees, governance costs and gains and losses	**(377)**	**(377)**	**0**
Balance available for application	**2,452**	**1,017**	**1,435**
Committed Expenditure	**0**	**0**	**0**
Contingency and Reserves			
Cost of generating funds reserve	**(377)**	**(377)**	**0**
Total Contingency Reserve	**(377)**	**(377)**	**0**
Available for Application	**2,075**	**640**	**1,435**

These figures are subject to rounding

Appendix 2

Statement of Financial Activities - Phased Budget 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	Total
Incoming resources													
Incoming resources from generated funds													
Voluntary Income													
Donations	24	23	38	20	18	20	24	20	21	18	18	19	265
Legacies	100	20	640	0	50	0	2	0	10	0	0	0	822
Fundraising	8	12	22	17	8	24	13	13	22	32	37	37	246
Sub total voluntary income	132	55	700	37	77	44	39	34	53	50	56	57	1,333
Investment income	3	3	3	3	3	3	3	3	3	3	3	3	41
Total resources from generated funds	136	58	703	40	80	47	43	37	57	54	59	60	1,374
Incoming resources from charitable activities	0	0	0	0	0	0	0	0	0	0	0	0	0
Total incoming resources	**136**	**58**	**703**	**40**	**80**	**47**	**43**	**37**	**57**	**54**	**59**	**60**	**1,374**
Resources expended													
Costs of generating funds													
Lottery Prizes	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(21)
Fundraising costs	(13)	(11)	(16)	(6)	(6)	(10)	(6)	(7)	(10)	(7)	(9)	(8)	(111)
Management costs	(22)	(13)	(13)	(13)	(14)	(18)	(16)	(13)	(13)	(13)	(15)	(13)	(176)
Finance admin costs	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(44)
Total costs of generating funds	(41)	(30)	(35)	(25)	(25)	(33)	(27)	(26)	(29)	(25)	(29)	(26)	(351)
Direct charitable expenditure													
Patient support activities													0
Staff education and welfare													0
Total direct charitable expenditure	0	0	0	0	0	0	0	0	0	0	0	0	0
Governance costs													
Audit fees	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(8)
Governance costs	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(18)
Total governance costs	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(26)
Total resources expended	**(43)**	**(32)**	**(37)**	**(27)**	**(27)**	**(35)**	**(30)**	**(28)**	**(31)**	**(27)**	**(31)**	**(29)**	**(377)**
Net incoming/outgoing resources before transfers and other recognised gains and losses	**93**	**27**	**666**	**14**	**53**	**11**	**13**	**9**	**25**	**27**	**28**	**31**	**997**
Gross transfer between funds	0	0	0	0	0	0	0	0	0	0	0	0	0
Net incoming/(outgoing) resources before other recognised gains and losses	**93**	**27**	**666**	**14**	**53**	**11**	**13**	**9**	**25**	**27**	**28**	**31**	**997**
Gain & (losses) on revaluation and disposal of investment assets	0	0	0	0	0	0	0	0	0	0	0	0	0
Net movement in funds	**93**	**27**	**666**	**14**	**53**	**11**	**13**	**9**	**25**	**27**	**28**	**31**	**997**
Reconciliation of funds													
Total funds brought forward	1,455												
Total funds carried forward	**1,548**	**1,574**	**2,241**	**2,255**	**2,307**	**2,319**	**2,332**	**2,341**	**2,366**	**2,393**	**2,421**	**2,452**	**2,452**
General Funds													
General Funds bfwd	206	285	297	949	944	982	980	978	968	980	992	1,006	206
General Funds - net movement	79	12	652	(5)	39	(3)	(1)	(10)	11	12	14	12	812
General Funds cfwd	**285**	**297**	**949**	**944**	**982**	**980**	**978**	**968**	**980**	**992**	**1,006**	**1,018**	**1,018**
Hypothecated Funds													
Hypothecated Funds bfwd	1,249	1,263	1,278	1,292	1,311	1,325	1,339	1,354	1,373	1,387	1,401	1,415	1,249
Hypothecated Funds - net movement	14	14	14	19	14	14	14	19	14	14	14	19	185
Hypothecated Funds cfwd	**1,263**	**1,278**	**1,292**	**1,311**	**1,325**	**1,339**	**1,354**	**1,373**	**1,387**	**1,401**	**1,415**	**1,435**	**1,435**

These figures are subject to rounding