Western Sussex Hospitals
NHS Foundation Trust

Meeting of the Board of Directors

10.00am to 12.25pm, Thursday 1 August 2013

Bateman Room, Chichester Medical Education Centre,
St.Richard's Hospital, Spitalfield Lane,
Chichester, West Sussex, PO19 6SE

AGENDA – MEETING IN PUBLIC

1	10.00	**Welcome and Apologies for Absence**		Chair
2	10.00	**Declarations of Interests**		All
3	10.00	**Minutes of Board Meetings held on 27 June and 9 July 2013** To approve	Enclosure	Chair
4	10.05	**Matters Arising from the Minutes** To note	Enclosure	Chair
5	10.10	**Chief Executive's Report** To receive and agree any necessary action	Enclosure	MG
		PATIENT SAFETY/EXPERIENCE ITEMS		
6	10.20	**Quality Report** To receive and agree any necessary action	Enclosure	CS/ WR
7	10.40	**Annual Complaints Report 2012/13** To receive and agree any necessary action	Enclosure	CS
		OPERATIONAL ITEMS		
9	10.50	**Performance Report** To receive and agree any necessary action	Enclosure	JF
10	11.00	**Organisational Development and Workforce Performance** To receive and agree any necessary action	Enclosure	DF
11	11.10	**Financial Performance** To receive and agree any necessary action	Enclosure	MJ

STRATEGIC ITEMS

12	11.30	**Review of Annual Plan, Board Assurance Framework and Risk Register: Quarter 1, 2013/14** To receive and agree any necessary action	Enclosure	DF AM

OTHER ITEMS

13	11.40	**Appointment of Responsible Officer for Medical Revalidation** To approve	Enclosure	WR
14	11.50	**Other Business**		Chair
15	11.55	**Resolution into Board Committee** To pass the following resolution: "That the Board now meets in private due to the confidential nature of the business to be transacted."	Verbal	Chair
16	11.55	**Date of Next Meeting** The next meeting in public of the Board of Directors is scheduled to take place at 10.00am on Thursday, 3 October 2013 in the Bateman Room, Chichester Medical Education Centre, St.Richard's Hospital, Spitalfield Lane, Chichester, West Sussex, PO19 6SE		Chair
17	11.55	**Close of Meeting**		Chair
	11.55 to 12.00	**Questions from the Public** Following the close of the meeting there will be an opportunity for members of the public to ask questions about the business considered by the Board.		Chair

Ann Merricks
Interim Company Secretary

Minutes of the Board meeting held (in public) at 2.30pm on Wednesday 9 July 2013 in the Mickerson Hall, Chichester Medical Education Centre, St.Richard's Hospital, Spitalfield Lane, Chichester, West Sussex, PO19 6SE

Present:	Dr Phillip Barnes	Medical Director
	Bill Brown	Non-executive Director
	Tony Clark	Non-executive Director
	Joanna Crane	Non-executive Director
	Jane Farrell	Chief Operating Officer
	Jon Furmston	Non-executive Director
	Marianne Griffiths	Chief Executive
	Martin Phillips	Non-executive Director
	Spencer Prosser	Finance Director
	Mike Viggers	Chairman
In Attendance:	Graham Lawrence	Company Secretary
	Ann Merricks	Interim Company Secretary (minutes)

TBP/07/13/1 WELCOME AND APOLOGIES FOR ABSENCE **Action**

1.1 The Chairman welcomed all those present to the meeting.

1.2 Apologies were received from Denise Farmer, Cathy Stone and Bill Brown

TBP/07/13/2 DECLARATIONS OF INTERESTS

2.1 There were no interests to declare.

TBP/07/13/3 Foundation Trust Constitution

3.1 The Board of Directors received the Constitution, and noted that it had been formally received and ratified by the Council of Governors at their meeting, also on 9 July 2013.

3.2 **The Board resolved to note the Constitution**

TBP/07/13/4 Foundation Trust Provider License

4.1 The Board of Directors received the trust's Foundation Trust Provider License, issued to the trust on authorisation as a Foundation Trust. The Board noted that the license had also been shared with Governors at the Council of Governors meeting.

4.2 **The Board resolved to note the license**

TBP/07/13/5 Register of directors

5.1 **The Board resolved to note the Register of Directors**

TBP/07/13/6 Register of Directors Interests

6.1 **The Board resolved to note the Register of Directors Interests**

TBP/07/13/7 Statement of Independence of Non executive Directors

7.1 **The Board resolved to approve the statement of independence of Non executive Directors.**

TBP/07/13/8 Appointment of Senior Independent Director

8.1 The Board of Directors noted that the appointment of a Senior Independent Director is recommended in the Code of Governance. The appointment is made by the Board, following consultation with the Council of Governors. The Council of Governors received the Role Description for the Senior Independent Director at its meeting, also on 9 July 2013, and supported the recommendation of the Board to appoint Jon Furmston as Senior Independent Director for a period of three years.

The Board resolved to approve the appointment of Jon Furmston and the Role Description **GL**

TBP/07/13/9 Terms of Reference for the Board of Directors

9.1 **The Board resolved to approve the Terms of Reference.** These will be reviewed in July 2014. **GL**

TBP/07/13/10 Governance Structure

10.1 The Board of Directors reviewed the Board level committee structure and membership of the committees.

10.2 In response to a question from Tony Clark, Graham Lawrence and Phil Barnes confirmed that the Infection Control Committee should be a formal sub committee of the Quality and Risk Committee. **The Board resolved to approve the committee structure** on this basis.

10.3 **The Board approved** the terms of reference for the Nomination and Remuneration Committee, and **noted** that the terms of reference for the other committees in the structure remain as approved previously by the Board of the NHS Trust.

10.4 The Board noted that all the Non executive Directors should be members of the Nomination and Remuneration Committee. With this amendment **the Board resolved to approve the membership of the committees**. **GL**

TBP/07/13/11 Role descriptions

11.1 The Board noted that the role descriptions for the Chair, Deputy Chair and Non executive Directors had been discussed at the Council of Governors meeting on the morning of 9 July 2013. The governors had asked for some amendments to the role descriptions:

- Under strategy to include ‘achieve’ in the first objective for both the Chairman and the Non executive Directors, to read: “Work with Directors and Governors in **developing, promoting and achieving** the Trust’s vision, values, culture, aims and strategic objectives, within a set strategic planning cycle approved by the Board.
- Under strategy point 4 of the Duties and Responsibilities section of the Chairman’s Role Description, it was proposed to amend the word ‘direct’ to reflect more accurately the procedural intention of the point. The phrase “Proactively to manage the decision-

making process, ensuring …" This point to read **"Pro-actively direct and manage Board and Council decisions, ensuring compliance** with all relevant governance and regulatory requirements, and full and complete consideration has been given to all options during the decision-making process.

- The base for all Non executive Directors would be all the hospital sites

11.2 **The Board resolved to agree** these amendments and **endorsed** the role descriptions. **GL**

TBP/07/13/12 Standing Financial Instructions and Delegated Financial Limits

12.1 **The Board resolved to approve** the revisions to the Standing Financial Instructions and the Delegated Financial Limits as set out in the paper, which recognise the change of status to Foundation Trust

TBP/07/13/13 Other business

13.1 There was no other business

TBP/07/13/14 Date of next meeting

14.1 The next meeting of the Board is scheduled to take place at 10.00am on Thursday 1 August 2013 in the Bateman Room, Chichester Medical Education Centre, St Richard's Hospital.

Ann Merricks
Interim Company Secretary

July 2013

Signed as an accurate record of the meeting

……
Chair

……
Date

Minutes

Minutes of the Board meeting held (in public) at 10.00am on 27 June 2013 in the Boardroom, Worthing Hospital, Lyndhurst Road, Worthing, West Sussex, BN11 2DH

Present:	Dr Phillip Barnes	Medical Director
	Bill Brown	Non-executive Director
	Tony Clark	Non-executive Director
	Joanna Crane	Non-executive Director
	Denise Farmer	Director of Organisational Development and Leadership
	Jane Farrell	Chief Operating Officer and Acting Chief Executive
	Jon Furmston	Non-executive Director
	Martin Phillips	Non-executive Director
	Cathy Stone	Director of Nursing & Patient Safety
	Mike Viggers	Chairman
In Attendance:	Alison Ingoe	Deputy Finance Director
	Ann Merricks	Interim Company Secretary
	Graham Lawrence	Company Secretary (minutes)

TBP/06/13/1 WELCOME AND APOLOGIES FOR ABSENCE

1.1 The Chairman welcomed all those present to the meeting.

1.2 Apologies for absence were received from Marianne Griffiths and Spencer Prosser, who was represented by Alison Ingoe.

TBP/06/13/2 DECLARATIONS OF INTERESTS

2.1 There were no interests to declare.

TBP/06/13/3 MINUTES OF THE BOARD MEETING HELD ON 6 JUNE 2013

3.1 The Board received the minutes of its meeting in public held on 6 June 2013. The following amendments were agreed:

- The minutes did not record the Board's discussion about C.Difficile so it was agreed that the Chairman and Company Secretary would agree the text to be inserted.

  Post-meeting Note: It was agreed that the following text would be inserted as minute TBP/5/13/5.9:
- TBP/5/13/5.5: the last sentence would be amended to read: "The Board noted that particular focus would be needed in respect of Venous Thromboembolism (VTE); this was likely to be an area of development through the Patientrack system, once the new dementia care-related module had been implemented successfully."

3.2 In respect of the actions arising from questions from members of the public, it was noted that a reconciliation of bins had been undertaken on wards to ensure that noise-reducing bins were located correctly. Action had been taken on Eartham Ward to ensure that Productive Ward-related notices were

more visible.

3.3 **The Board resolved that subject to the amendments set out above, the minutes of the meeting held on 6 June 2013 would be approved as an accurate record of the meeting and signed by the Chairman.**

TBP/06/13/4 MATTERS ARISING FROM THE MINUTES

4.1 The Board received and noted the report of matters arising from its meeting held on 6 June 2013.

4.2 Quality Report (TBP/5/13/5.8)

4.2.1 The Chair of the Quality & Risk Committee advised the Board that at its meeting on 17 June the Committee had considered falls in general (as part of the Incident Report).

TBP/06/13/5 CHIEF EXECUTIVE'S REPORT

5.1 The Acting Chief Executive presented the report and the main points of the discussion were as follows:

5.2 The Board agreed that achievement of Foundation Trust status, with effect from 1 July 2013, represented a significant endorsement of the high quality care and good operational and financial performance delivered by the organisation. Arrangements were being made to celebrate the achievement by the Trust's staff.

5.3 The Board's attention was drawn to the recent STAR Awards, which had celebrated very well the achievements of particular staff. The event had been a great success.

5.4 It was noted that an additional birthing pool had been introduced into the maternity unit at Worthing Hospital; it was already in use and was very popular with mothers.

5.5 The Board resolved to note the report.

TBP/06/13/6 QUALITY REPORT

6.1 The Director of Nursing & Patient Safety and the Medical Director presented the report and the main points of the discussion were as follows:

6.2 In respect of infection control, the Trust remained free of MRSA bacteraemia and was performing well in controlling MSSA. The Trust continued to face challenges in relation to C.Difficile. The limit for 2013/14 was 46 cases and to date there had been 25. The Director of Nursing & Patient Safety highlighted the challenges faced by local organisations. However, it was necessary to reduce the rate of cases and the Board discussed the work being undertaken.

6.3 In April it had been decided to invite the Director of Nursing from the National Trust Development Authority (NTDA) to review the Trust's arrangements for controlling C.Difficile. The report had been received in late May but the recommended actions had been implemented swiftly following the review visit. These included daily reviews by Matrons, with action being taken where necessary, and a weekly review of cases by the Chief Executive. The Trust's medication policy had been amended to remove a particular antibiotic

which was known to increase the risk of C.Difficile, though the drug would continue to be prescribed where it was clinically necessary. Advice would be sought from a Consultant Microbiologist in each such case. In respect of isolation of patients with C.Difficile it had been decided that the Director of Nursing & Patient Safety would be informed in any case where a patient was waiting more than two hours for isolation; performance had improved as a result, such that there had been no delays in the most recent six weeks. The Trust's testing policy had also been reviewed to ensure that it was fully aligned with national guidance; the policy was being reviewed by the NTDA and the Regional Microbiologist. It was agreed that the revised policy would be presented to the Board. **CS**

6.4 The issue continued to receive significant focus from the Executive Team, clinical leaders and senior nursing staff, including through a recent meeting which the Director of Nursing & Patient Safety had held with all Ward Sisters. It was agreed that the Sisters had an important role in escalating concerns relating to the implementation of any measures or procedures designed to control C.Difficile.

6.5 The Director of Nursing & Patient Safety was asked to advise the Board as to whether the measures required to prevent and control C.Difficile were being put at risk by any shortage of funds. It was confirmed to the Board that all the required measures were being funded, including an acceleration of a deep-clean process for all ward areas. In respect of financial challenges, it was noted that the recent changes to prescribing policies could result in higher drug costs since some of the (now) preferred antibiotics were more costly than others used previously.

6.6 The Board discussed potential causes for the continued high rate of C.Difficile. It was difficult to be certain of the causes but it was known that the rate had increased across the NHS through quarters three and four of 2012/13. It could be linked to antibiotic prescribing within community care but the demographic of the population served by the Trust. ie. a relatively high number of older people, was also likely to be a factor. It was noted that antibiotic prescribing had historically not been a priority in primary and community care but there was increasing focus on this, not least driven by the CQUIN agreed with Coastal West Sussex Clinical Commissioning Group for 2013/14. The Board agreed that continued focus was required in respect of Board-level engagement with community care colleagues. To support this it was agreed to present to the Board's next meeting the accountability structure. The Director of Nursing & Patient Safety would request this information from Sussex Community Trust, the Local Area Team and Coastal West Sussex Clinical Commissioning Group. **CS**

6.7 The Board moved on to a discussion about other aspects of the quality report. It was noted that the number of falls had reduced in May but there would be continued focus on reducing falls, including through the safety thermometer. The two serious falls which had occurred in May had been discussed by the SIRI Review Panel and would also be considered at the Board's later meeting in committee.

6.8 The Board noted that the Trust had achieved the target of assessing 95% of patients for Venous Thromboembolism (VTE). This required continued focus, to further improve care but also because it was the basis of a CQUIN target for the financial year.

6.9 The Board returned to its previous discussion about screening for dementia. This was a new requirement and one which required focus across all Trusts,

including in respect of engagement from medical staff because, whilst it was not always possible to treat dementia, the screening did allow referral to services which could assist patients in managing the condition. Acute Trusts such as Western Sussex Hospitals were in a good position to identify dementia at an early stage in the condition and to refer patients to services from other providers. It was noted that the Trust's Dementia Nurse Specialists had developed improved care packages and these were being tested before being implemented across relevant wards. It was agreed that the Board would receive a briefing on dementia care. It was also agreed to include in the junior doctor induction programme a session on the importance of dementia screening. **CS** **DF**

6.10 The Board discussed the mortality data within the report, this having also been discussed at a Board Seminar on 26 June 2013. It had been agreed at the Seminar that following the re-basing of the mortality rates, which would take place in August 2013, the Trust would set a trajectory for further reducing mortality. It had also been agreed to align the crude mortality targets for St.Richard's and Worthing Hospitals, though it was noted that the achievement of the target for Worthing Hospital was likely to be dependent upon the emergency floor service development.

6.11 In respect of tissue viability, it was noted that there continued to be relatively high number of patients admitted with pressure ulcers so the Board considered the further action that could be taken to address this with community care providers. The Local Area Team was focusing on this and it was a key target for the Chief Nursing Officer for England.

6.12 There was a discussion about reporting of data from real-time patient experience surveys in out-patient services. It was noted that this was included in a quarterly report to the Management Board and it was agreed that the next such report would be presented to the Board. **JF**

6.13 The Board concluded its discussion by noting that the scorecard continued to include the target for patients with fractured neck of femur being operated on within 24 hours of admission. The external review undertaken by Professor Moran (of Nottingham University Hospitals NHS Trust) had recommended that the Trust should focus on the 36-hour target, not least because it was not always in the interests of patients to have surgery within 24 hours. It was agreed to remove the 24-hour target from the scorecard. **JF**

The Board resolved to note the report.

TBP/06/13/7 COMPLAINTS REPORT: QUARTER 4, 2012/13

7.1 The Director of Nursing & Patient Safety presented the report and the main points of the discussion were as follows:

7.2 The Trust had a low number of complaints relative to national trends but it was noted that Accident & Emergency was an exception within the report. This area had been receiving focus at the Patient Experience & Feedback Committee and it had been agreed that Dr Amanda Wellsley, Clinical Director for Emergency Medicine, would attend the Committee's next meeting to discuss the action being taken to reduce complaints. Tony Clark, Non-executive Director and Chair of the Committee, had recently read a number of complaints files relating to Accident & Emergency (as part of the Committee's review of files prior to each meeting) and was assured of the quality of responses to complaints received. Whilst action was being taken, it was important to be sure that the very good operational performance in **CS**

Accident & Emergency was not being achieved at the expense of patient experience so it was agreed that assurance in this respect would be discussed at the Committee's meeting in September.

7.3 The Board moved on to a discussion about the number of complaints and PALS enquiries and the handling of them. The Customer Relations Team, which included PALS, sought to address complaints and other enquiries swiftly and, where possible, without recourse to the formal complaints process. This was for the benefit of patients and the Trust. PALS had historically been more active at St.Richard's Hospital and the PALS office was more visible so that the number of enquiries (and matters resolved) was higher than at Worthing Hospital. It was agreed that the PALS office needed to be more prominent at Worthing Hospital, to benefit patients by resolving matters more swiftly and easily than through formal, written enquiries, and it was agreed that the Facilities & Estates team should make plans for this. **SP**

7.4 It was noted that a relatively high number of complaints related to "co-ordination of clinical treatment", which was a category used to describe a number of issues such as co-ordination of care across clinical teams. This issue had also been raised at the Patient Experience & Feedback Committee. It was agreed to explore the reasons for complaints in this category, as a basis for action to reduce them. This would be included in the next quarterly report. **CS**

7.5 The Board was asked to comment on the revised format of the report. The Board welcomed the enhanced clarity in the report, particularly the scorecards, and suggested that future reports could be structured to present the data, themes arising from it and then action being taken to address them. **CS**

7.6 The Board resolved to note the report.

TBP/06/13/8 IMPROVING CUSTOMER CARE

8.1 The Director of Organisational Development & Leadership presented the report and the main points of the discussion were as follows:

8.2 It was noted that work on the programme had begun, including to identify priorities for focus.

8.3 It would be necessary to develop behaviour expectations for staff to adopt, linked to the "We care" aspects of the Trust's mission. It was agreed that a training programme would be necessary, tailored where necessary to specific staff groups. Such training was crucial because so many of the Trust's staff interacted constantly with patients and members of the public. It would also be necessary to integrate into recruitment and selection processes the expectations which the Trust has for its staff.

8.4 The Board agreed that managers would need to roll-model the behaviours and to ensure that staff were supported to adopt them, including through appraisals and development plans. The introduction of medical revalidation represented a good opportunity to improve the appraisal of medical staff, including to address the need (as reported through patient surveys and complaints) to improve the quality of consultations.

8.5 The customer care programme would need to be integrated into all relevant aspects of the Trust's business. This would include business cases, which would need to demonstrate the way in which they would promote good customer care.

8.6 **The Board resolved to note the report and to agree that a business case should be developed for the customer care programme.**

TBP/06/13/9 **ANNUAL CLINICAL AUDIT REPORT 2012/13**

9.1 The Medical Director presented the report and the main points of the discussion were as follows:

9.2 The report showed that the programme for 2012/13 had been delivered successfully, though in the context of increasing demands on the Clinical Audit Team. These included contribution to the successful delivery of CQUIN targets and preparation for level three accreditation for the NHS Litigation Authority scheme.

9.3 The Board noted that the Trust had participated in all nationally-mandated audits where it was eligible to do so. There were some national audits which were optional and when the Quality & Risk Committee had reviewed the report it had agreed that more robust arrangements were necessary for decision making in respect of these audits. It had been agreed that the authority of the relevant Chief of Service, the Medical Director or the Director of Nursing & Patient Safety would be needed before the Trust could decide not to participate in a national (optional) audit. The Quality & Risk Committee had identified one audit in particular – cardiac arrest – which was not planned for the Trust. The Committee had decided that the Trust would participate in the audit and it had been added to the plan.

9.4 The Board discussed the proportion of the Clinical Audit Team's time which was spent on national and local audits. The majority of time was spent on national audits and on others designed within the Trust. Clinical teams across the Trust were free to implement their own audits, with advice from the Clinical Audit Team where necessary, but within the resources available no formal support could be provided for these.

9.5 The Board discussed the assurance available in respect of the implementation of audit outcomes. These were subject to re-audit to test implementation but it was agreed that greater assurance was needed in this respect. It was agreed to ask the Quality & Risk Committee to consider this. **WR**

9.6 **The Board resolved to note the report.**

TBP/06/13/10 **PERFORMANCE REPORT**

10.1 The Chief Operating Officer presented the report and the main points of the discussion were as follows.

10.2 The Board noted that although attendances at Accident & Emergency were higher than in 2012, emergency admissions had reduced. The Trust had achieved 97.78% against the 4-hour target for May and 97% for the year to date. The average length of stay for emergency patients was longer due to the higher levels of acuity of patients being admitted. Despite this, through efficiency measures, escalation beds had been reduced.

10.3 There had been a slight drop in performance in waiting times for diagnostics, resulting from capacity constraints in Histopathology. This had been addressed such that performance would return to normal. There had also been some challenges in acute oncology, due to constraints in services at

Brighton & Sussex University Hospitals NHS Trust, but these were being addressed.

10.4 The Trust remained fully compliant at aggregate level with the 18-week referral to treatment time target. The plan for specialty-level compliance was on track for delivery as planned. Therefore, with the exception of the number of cases of C.Difficile, the Trust was fully compliant with the Monitor Compliance Framework.

10.5 The Board discussed metric Q6 (nurse:bed ratio) on the Trust Development Authority scorecard. The ratio had not been reported for some months and this was thought to be the result of the Trust waiting for the TDA to confirm the basis for the metric. This would be clarified for the next meeting. In connection with this it was noted that the content of the performance report would need to be adjusted to take account of the revised accountability arrangements following the organisation's authorisation as a Foundation Trust. **JF**

10.6 The Board discussed performance in respect of stroke services, noting that there had recently been some challenges on both sites. This had been identified by the Executive and was under review by the relevant clinical team. It was agreed to include in the performance report to the next meeting a commentary on the reasons for the performance and the action taken to address it. **JF**

10.7 The Board resolved to note the report.

TBP/06/13/11 ORGANISATIONAL DEVELOPMENT AND WORKFORCE REPORT

11.1 The Director of Organisational Development & Leadership presented the report and the main points of the discussion were as follows:

11.2 The Board discussed the results from real-time surveys of staff. There were plans to increase the number of surveys undertaken so that views could be taken from a greater number of staff but this would require automation of the survey process. Alongside this it was possible to ask a wider range of questions but balance was needed to ensure that the longer surveys did not discourage staff from completing them. It was agreed that future reports should include the number of staff who had answered in the "Strongly disagree" category of the survey.

11.3 The Board discussed staffing levels, noting that the overall demand for temporary staff had fallen but the Trust had been more successful in filling vacancies with temporary staff when required. It was agreed that a forthcoming paper to the Finance & Investment Committee would be used to clarify an apparent anomaly, ie. that the number of temporary staff had fallen but costs had increased. **DF/SP**

11.4 The Board resolved to note the report.

TBP/06/13/12 FINANCIAL PERFORMANCE

12.1 The Deputy Finance Director presented the report and the main points of the discussion were as follows:

12.2 The Board noted that as set out in the financial plan for the year the Trust had made a deficit in month two (May).

12.3 The enhanced cleaning regime was reflected in increased expenditure within general supplies and services and, as discussed earlier in the meeting, drug expenditure was also higher. Further work was necessary in this respect to ensure that the Trust recovered all available income associated with use of drugs.

12.4 In respect of capital expenditure, the programme for the year was being re-phased so that it took account of the profile of project plans.

12.5 The Finance & Investment Committee had noted that the delivery of the cost improvement programme was proving challenging so firm focus was required to ensure that targets were met. This was receiving attention at senior level, including through the Divisional Integrated Performance Review Panel.

12.6 The Board resolved to note the report.

TBP/06/13/13 FUTURE STRATEGIC OPTIONS FOR SOUTHLANDS HOSPITAL: DISCUSSION PAPER

13.1 The Director of Organisational Development & Leadership presented the paper and the main points of the discussion were as follows:

13.2 The paper set out options for the future of services at Southlands Hospital. Further work was necessary to understand the most appropriate option, taking into account clinical need but also financial viability.

13.3 This further work would need to include modeling of demand for services and likely income levels, to be undertaken in partnership with commissioners. As part of this it would be necessary to take in account the extent of backlog maintenance required in the current buildings.

13.4 The Board discussed the options, agreeing that the modelling would need to include costs associated with improving the environmental performance of the buildings, whether through refurbishment or new build.

13.5 The Board agreed that further information was required in relation to the timetable for the project, initially with a date for consideration of a business case. It was agreed to report that to the Board in July. **DF**

13.6 The Board resolved to request the further development of the two options presented so that a full appraisal could be undertaken.

TBP/06/13/14 DATA QUALITY ASSURANCE

14.1 The Medical Director presented the paper and the main points of the discussion were as follows:

14.2 The paper focused on audits of secondary user service (SUS) data, not on audits of data which supported that Patient Aggregate Safety Score (PASS), which the Board had agreed previously would be the basis of a programme of data quality audits. It was noted, however, that the Trust performed ahead of the national average in respect of SUS data quality audits.

14.3 It was agreed that proposals would be developed for a set of metrics through which the Board could be assured of data quality, to include the data relating to the PASS. It was also agreed that there would be a programme of audits of PASS-related data, to be overseen by the Audit Committee and reported to the Board as necessary. **SP**

14.4 **The Board resolved to note the report.**

TBP/06/13/15 **OTHER BUSINESS**

15.1 **Quality Account 2012/13**

15.1 The Medical Director drew attention to a recent request for Directors to approve two changes to the Quality Account 2012/13, approved by the Board on 6 June 2013. The changes had been made at the request of the External Auditor, who had reviewed the Quality Account, and related to references to the Never Events declared by the Trust and to the Internal Audit reviews of medicines management and consent.

15.2 **The Board resolved to approve the amendments as set out in email correspondence to Directors.**

TBP/06/13/16 **RESOLUTION INTO BOARD COMMITTEE**

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

TBP/06/13/17 **DATE OF NEXT MEETING**

17.1 The Board of Directors of Western Sussex Hospitals NHS Foundation Trust would meet in public at 2.30pm on 9 July 2013 in the Mickerson Hall, Chichester Medical Education Centre, St.Richard's Hospital, Spitalfield Lane, Chichester, West Sussex, PO19 6SE.

17.2 The next (month-end) meeting in public of the Board of Directors would take place at 10.00am on Thursday, 1 August 2013 in the Bateman Room, Chichester Medical Education Centre, St.Richard's Hospital, Spitalfield Lane, Chichester, West Sussex, PO19 6SE.

Graham Lawrence
Company Secretary

July 2013

Signed as an accurate record of the meeting

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Chair

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Date

WESTERN SUSSEX HOSPITALS NHS TRUST

BOARD MEETING HELD ON 27 JUNE 2013

QUESTIONS ASKED/COMMENTS MADE BY MEMBERS OF THE PUBLIC ATTENDING THE MEETING

No.	Question/Comment	Response	Action
1	John Gooderham (Shadow Public Governor for Horsham) asked the Board to explain the public and patient involvement in the development of proposals for the Southlands Hospital site.	It was explained that there had been a full public consultation about the Trust's overall plans for the Southlands Hospital. The plans being brought forward would implement the strategy as set out in that consultation. It was intended to engage with patients and the public about the way in which future services would be delivered. It was important to recognise that the proposals represented an investment in the future of services at Southlands Hospital. Following a discussion it was agreed that Denise Farmer and John Gooderham would discuss options for further public and patient involvement, including through potential involvement of Governors.	DF
2	Barbara Porter (Shadow Public Governor for Adur) commended the Board's decision to increase the visibility and accessibility of the PALS service at Worthing Hospital. This would improve patient experience.	The Board thanked Mrs Porter for her support.	None
3	Beda Oliver (Shadow Public Governor for Worthing) described a recent positive experience of using the Accident & Emergency Service at Worthing Hospital.	The Board thanked Mrs Oliver for her feedback. The Trust had recently recruited three very skilled Accident & Emergency Consultants.	None
4	Beda Oliver (Shadow Public Governor for Worthing) recommended that the customer care training programme discussed by the Board should explicitly include the development of listening skills.	The Board thanked Mrs Oliver for her helpful suggestion.	DF
5	Margaret Bamford (Shadow Public Governor for Arun) recommended that there should be continued focus on improving community care and on the integration of this with acute hospital services. Mrs Bamford welcomed the previously-described action plans, agreed with	The Board thanked Mrs Bamford and agreed to consider her suggestion.	JF

No.	Question/Comment	Response	Action
	commissioners, and suggested that these should have outcome measures which are reported regularly to the Board.		
6	Heather Duffield commented on the reduction in MSSA, which was welcome, and on the continued focus on reducing mortality associated with renal failure. Mrs Duffield also commented on the target for Venous Thromboembolism assessments and on screening for dementia. Mrs Duffield reported concerns from some people in the Shoreham area about the future of Southlands Hospital. Mrs Duffield asked for greater clarity about the plans, including to address the community services needed for the area.	It was explained that the Trust remained committed to providing appropriate services at Southlands Hospital, as discussed earlier in the meeting. The Board had decided previously to retain the biggest viable area of the site and to reinvest the capital receipt (from the disposal of the Harness Block and other buildings) into the hospital. It was agreed that the Chairman would discuss this separately with Mrs Duffield.	MV
7	Richard Farmer (Shadow Patient Governor) suggested that the Board should maximise the opportunity of Foundation Trust authorisation to describe the various plans which it had to improve the Trust's services, including service developments and initiatives such as the customer care programme.	The Board thanked Mr Farmer for his comments and confirmed that it had plans for such communications.	None
8	Malcolm Brett advised the Board that from 1 July 2013 the hospital radio service would be available through wireless internet connections in the hospital.	The Board thanked Mr Brett for this welcome development in patient services.	None

MATTERS ARISING FROM BOARD MEETINGS HELD IN PUBLIC

MATTERS ARISING FROM THE MEETING HELD ON 27 JUNE 2013					
Minute Ref	**Description of Action**	**Responsible Person**	**Deadline**	**Report**	**RAG Status**
	Quality Report				
TBP/6/13/6.3	Report to the Board any changes in the C.Difficile Policy.	Cathy Stone	July 2013	This action is addressed in the Quality Report.	G
TBP/6/13/6.6	Brief the Board on the accountability/ governance arrangements within community care, particularly relating to C.Difficile.	Cathy Stone	July 2013	Verbal update to board	G
TBP/6/13/6.9	Update the Board on developments in care for patients with dementia.	Cathy Stone	September 2013	It is proposed to arrange a Board Seminar session to provide the update.	A
TBP/6/13/6.9	Include within induction for junior doctors (joining the Trust in August) the requirement to undertake dementia screening for all patients over 65 years.	Denise Farmer	August 2013	This has been included in the 2013 induction.	G
TBP/6/13/6.12	Following the next quarterly report to Management Board, present data from real-time patient surveys in out-patient services.	Jane Farrell	July 2013	This will be included in the next Quality Report.	G
TBP/6/13/6.13	Remove from the scorecard the target for patients with fractured neck of femur to be operated on within 24 hours of admission.	Jane Farrell	July 2013	This will be completed in July 2013.	G
	Complaints Report: Quarter 4, 2012/13				
TBP/6/13/7.2	Report to the next meeting of the Patient Experience & Feedback Committee to	Cathy Stone	September 2013		

MATTERS ARISING FROM THE MEETING HELD ON 27 JUNE 2013					
Minute Ref	**Description of Action**	**Responsible Person**	**Deadline**	**Report**	**RAG Status**
	provide assurance that the achievement of operational targets in A&E is not at the expense of good patient experience, resulting in the relatively high number of complaints about that service. Report subsequently to the Board.				
TBP/6/13/7.3	Arrange for work to be undertaken to move the PALS office in Worthing Hospital so that it is more visible and accessible for patients and others.	Spencer Prosser	September 2013	A number of possible sites have been identified and options are being developed in conjunction with the PALS office to determine the most appropriate relocation for the function.	
TBP/6/13/7.4	Explore the issues causing complaints about co-ordination of clinical treatment. Include outcomes in the next quarterly report to the Board.	Cathy Stone	September 2013		
TBP/6/13/7.5	Revise the format of the report to present data, leading to themes identified and then action taken to address the themes.	Cathy Stone	September 2013		
	Annual Clinical Audit Report 2012/13				
TBP/6/13/9.5	Report to the Quality & Risk Committee the means by which the Board can be assured that actions from audits are implemented and embedded to ensure effectiveness.	Professor William Roche	September 2013		
	Performance Report				
TBP/6/1310.5	Report to the Board following the clarification of metric Q6 in the TDA scorecard (nurse:bed ratio).	Jane Farrell	July 2013	Addressed in the Performance Report.	G

MATTERS ARISING FROM THE MEETING HELD ON 27 JUNE 2013					
Minute Ref	**Description of Action**	**Responsible Person**	**Deadline**	**Report**	**RAG Status**
TBP/6/13/10.6	Include in the Performance Report a commentary about action taken to address recent challenges in respect of stroke care at both main hospital sites.	Jane Farrell	July 2013	Addressed in the Performance Report.	G
TBP/6/13/11.4	**Organisational Development & Workforce Report** Through a report to the Finance & Investment Committee reconcile a potential discrepancy between reduced usage of, but increased costs for, temporary staff.	Spencer Prosser Denise Farmer	July 2013	An item has been added to a forthcoming F&I agenda.	G
TBP/6/13/13.5	**Future Strategic Options for Southlands Hospital** Report to the Board's next meeting the timetable for developing proposals for services at Southlands Hospital.	Denise Farmer	July 2013	The work to develop our clinical strategy alongside our commissioners is ongoing. We will bring an update on the proposals being developed to the Board in the Autumn	A
TBP/6/13/14.3	**Data Quality Assurance** Develop a programme of audits of data quality (relating to the PASS), together with a dashboard of metrics to provide assurance to the Board. Present this to the Audit Committee for review and then to the Board.	Spencer Prosser	October 2013		

Key

R	No action has been taken to address the action
A	The action is partially complete or has been added to the agenda plan for a future meeting
G	The action has been completed

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board Date: 1 August 2013

From: Marianne Griffiths, Chief Executive Agenda Item: 5

FOR INFORMATION

CHIEF EXECUTIVE'S BOARD PAPER

1.00 Foundation Trust

Last month we announced a series of events to celebrate achieving Foundation Trust status, some of which have now taken place. I am pleased to report that the BBQs for staff and volunteers were well received and I commend our catering teams for providing lunch for a large number people in extremely hot conditions. Members of the Board also visited staff and volunteers in wards and departments across the Trusts.

Membership
We have 7,612 members, which excludes the six staff Governors who are on the database and includes our 242 patient members. Anyone interested in becoming a member can apply securely online; download an application from www.westernsussexhospitals.nhs.uk, or contact Rachel Morris by emailing Rachel.Morris@wsht.nhs.uk or calling 01903 285140.

2.00 Annual Members' Meeting

The Trust held its first-ever Annual Members' Meeting on 17 July. The event featured the formal elements of the Annual General Meeting, most notably the signing off of the Trust accounts for 2012/13, and also included opportunities for the attendees to learn more about the work going on within the Trust.

There was a review of the year, and a clinical presentation by five of the people – surgeon, Mrs Namita Kendall, Dr Roger Tozer, elderly care physician, matron Katrina O'Shea, and physiotherapist Mark White and occupational therapist James Leahy - involved in the transformation of care for people suffering a fractured neck of femur.

3.00 Friends and Family

This week there was the first national publication of data relating to the "Friends and Family" test which has been introduced throughout the NHS.

Results for the Trust compared very well with the figures for the NHS across the South of England as a whole – on average, inpatients and A&E patients at the Trust were notably more likely to recommend the department caring for them to their friends and family than is the case

elsewhere in the south. In the case of A&E patients, results for the Trust were significantly above the average.

There is more work to do in terms of improving the response rate, particularly in A&E, although there are already signs of real progress in terms of increasing the number of respondents.

4.00 Nursing Conference

I had the privilege of attending the Trust's Nursing and Midwifery Summit on July 25 at Fontwell Park Racecourse.

More than 200 colleagues attended the event, hosted by our Director of Nursing and Patient Safety Cathy Stone, to hear from colleagues about their experiences and learning from across our Trust. The summit also welcomed guest speakers Tom Sandford from the Royal College of Nursing and Philippa Potter from NHS South of England.

I took the opportunity to share a review of the year and explain how proud I am of our nursing staff and the care they provide our patients at a time when demand on our services continues to rise. I also highlighted our strong track record in key areas such as reducing the number of patient falls, hospital-acquired infections and pressure ulcers – these improvements are impossible without the tremendous skill and dedication of our nurses.

I also took some time to explain my thoughts on the challenges we face to meet the demands and expectations of our local community and reiterate my commitment to nursing and nurse leadership. The summit was a fantastic opportunity for our nursing staff to get together, share experiences, hear about nursing from a national perspective and it was a pleasure to have taken part.

5.00 New appointments - welcome

Dr Sandeep Mukherjee to the post of Fixed Term Consultant in Rheumatology, based at Worthing Hospital for six months.

Mr Adam Ajis to the post of Consultant in Trauma and Orthopaedics, based at Worthing Hospital.

6.00 "15 Steps" to better care for young people

Worthing Hospital's Bluefin Ward for children has had a vibrant makeover, as just one of a series of changes to freshen up the appearance of the areas used for the care of young people. Installing projectors, or introducing individual 'vanity boxes' for inpatients to store their own toiletries, are also being considered.

These initiatives are just the first changes to be made, after members of the West Sussex Youth Cabinet and the West Sussex Development Service were invited to visit Trust facilities, and to give their views on what was good – and not so good – about the experience of children coming into Worthing Hospital for care.

The invitation came from Matron Catherine Coppard, who wanted to use national 15 Steps challenge toolkit. The "15 Steps" challenge was developed as a national programme, following the observation of a parent: "I can tell what kind of care my daughter is going to get within 15 steps of walking on to a ward." The idea is to use the perspectives of others to help staff to make improvements.

The report was very impressive and very constructive and we have already started to look at the issues they raised. As a result we have started redecorating, making the place brighter, and we will look at having projectors in some areas. We are also considering having little 'vanity boxes' for toiletries, especially for our oncology patients. It is essential that we do what we can to make sure that our young people are relaxed, and feel that this is also a homely environment.

I would like to thank the young people involved for taking the time and trouble to visit the hospital, and giving us their views about what they saw.

7.00 Pharmacy App

A software application known as an app which is accessed from a smart phone, has been developed to ensure that medical staff are only ever a tap of the finger away from knowing the best, safest antibiotic drug to prescribe. Pharmacy staff have worked with an app developer to produce a programme which allows colleagues instant access to the right guidelines, dosages, and advice.

Before now, medical staff needing to prescribe antibiotics to hospital patients would need to leave the bedside and go to a computer to make sure they were writing a prescription for the right drug, in the right amount. Now, however, they can get all the information they need from their mobile phone, without leaving their patient.

Another big advantage of the app is that the Trust's prescribing guidelines for antibiotics used to be updated once a year. Now, as soon as any change is made the new information is instantly 'pushed' out to the users of the app, ensuring they are always using the most up to date information.

The Trust has always had expert pharmacists to monitor the prescribing of their clinical colleagues, but the new app means that staff always have the information they need, right in the palm of their hand, and can access more details immediately.

Such apps have recently begun to be used at a small number of teaching hospitals but the Western Sussex version is the first to be used outside those University Trusts. The Trust is also the first to use the new 'second generation' version of the app which allows prescribers to download different guidelines depending on which Trust they work at.

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board

Date of Meeting: 1 August 2013 Agenda Item: 6

Title
Month 3, 2013/14 Quality Report
Responsible Executive Director
Professor William Roche (Interim Medical Director) and Cathy Stone (Director of Nursing and Patient Safety)
Prepared by
Jamie Cochrane (Planning and Performance Manager), Mark Dennis (Head of Information Services), Sandie Ellard (Deputy Director of Nursing).
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
The WSHT Quality Strategy 2011-2013 set out the strategic objectives for the Trust in relation to quality. 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 I: Quality Scorecard Appendix II: Infection Control Dashboard Appendix III: Fracture Neck of Femur Dashboard Appendix IV: Quality Scorecard: 2013/14 Targets

1 INTRODUCTION

1.1 This report brings together key national, regional and local quality indicators relating to quality 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. Further quality items are shown as dashboards in the appendices.

2. KEY QUALITY OBJECTIVES

2.1 Dashboard Definitions

2.1.1 The full Clinical Quality Dashboard is presented as Appendix II. This includes measures identified in the Trust Quality Strategy. Figures are in month figures (e.g. the number of falls reported in June) unless otherwise stated. The dashboard 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 (e.g. standardised mortality ratios are recorded as 12 month positions). A subset of the key measures from the report is presented at 2.2.

2.1.2 Exception reports are included under the relevant section of this report (i.e. under the broad headings Effectiveness, Safety and Experience).

2.1.3 Targets are based on national or regional benchmarks where available. In the absence of established benchmarks, locally agreed targets or levels have been defined. Where there has been no specific agreement on a target, an improvement on 2012/13 baseline has been used. For this month only an additional spreadsheet has been included as appendix IV showing the basis on which each target was established (this will subsequently be available on the Trust website).

2.1.4 Indicators E13 (C-Section Rate), E16 (Maternal Deaths) and S07 (Outstanding CAS Alerts) have been added this month. These were previously monitored in the Trust Development Agency Framework scorecard.

2.2 Overview of Key Quality Objectives

2.2.1 The following table shows performance against key, top level quality objectives.

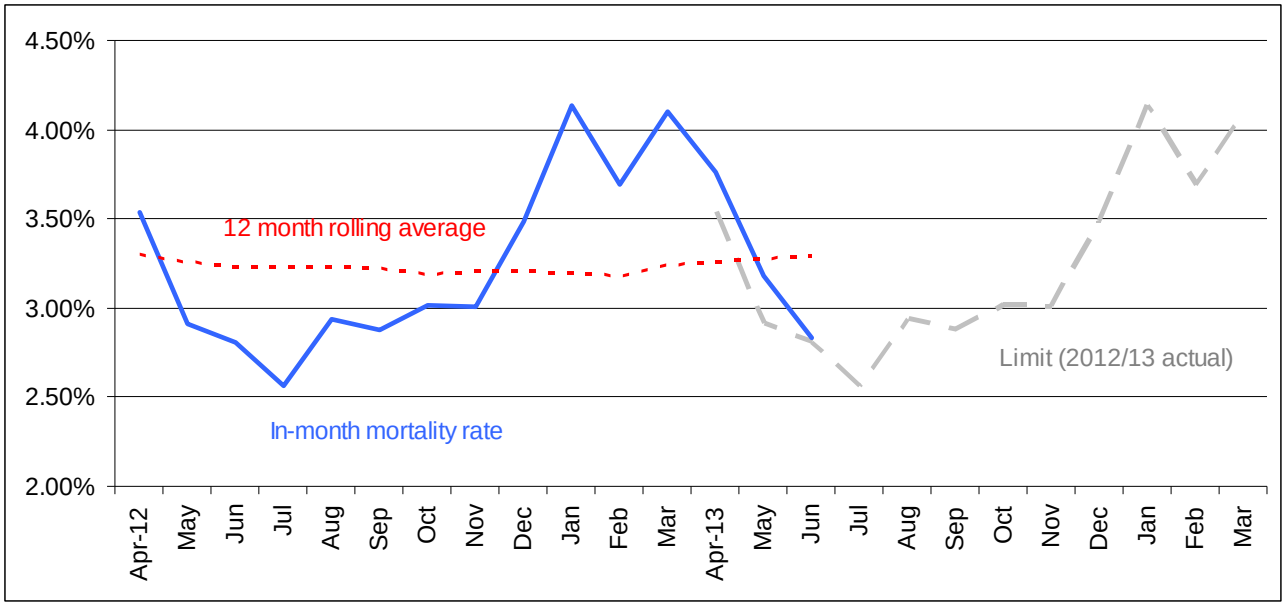
Indicator	Apr 2013	May 2013	Jun 2013	2013/14 to date	2013/14 Target / limit
E01 Trust crude mortality rate (non-elective)	3.76%	3.18%	2.83%	3.26%	3.24%
E02 Hospital Standardised Mortality Ratio for top 56 diagnoses (Dr Foster, based on rolling 12 months)	93.9			-	<100
S01 Patient Aggregate Safety Score (PASS)	89.9	88.9	85.0	87.9	<100
S05 Number of Serious Incidents Requiring Investigation (number reported in month)	2	1	0	3	26
S09 VTE: Compliance with the DoH risk assessment tool	94.4%	95.2%	95.6%	95.0	95%
S14 Numbers of hospital attributable MRSA	0	0	0	0	0
S15 Numbers of hospital attributable C. diff	13	5	7	25	46
X01 The Friends and Family Test Score: Inpatients	Reported from quarter 2				-
X02 The Friends and Family Test Score: A&E	Reported from quarter 2				-
X15 Mixed Sex Accommodation breeches (for clarity the number of breaches is reported here, but in the scorecard, in line with the reporting of this metrics in other Trust scorecards this is expressed as a proportion of Consultant Episodes)	0	0	0	0	0
X20 Number of complaints	39	46	54	139	562

3. EFFECTIVENESS

3.1 Crude Trust Mortality

3.1.1 Due to the low level of mortality experienced in elective care, the Trust measures mortality in relation to non-elective activity. The Trust Quality Strategy set out an objective to reduce its mortality rate by 10% (relative to the year 2010/11) by the end of 2012. The Trust achieved this objective and for 2012/13 non-elective mortality was 3.24% compared to 3.30% in 2012/13. An appropriate new trajectory will be agreed following Dr Foster's rebasing of their model for risk adjusted mortality in the summer, however pending this agreement the trust will seek to demonstrate an improvement against the previous financial year (see the graph below). In addition to this the Trust will seek to reduce the 12 month rolling average (as shown as E02 on the scorecard).

3.1.2 Crude non-elective fell from 3.18% in May to 2.83% in June. This was very slightly higher than the figure for the same month last year (2.81%). As such the 12 month rolling average also increased slightly.



3.1.3 The crude non-elective mortality rate for each of the three months since April 2013 has been higher than the equivalent month in 2012. Despite this there have actually been fewer deaths at Western Sussex Hospitals Foundation Trust during the last quarter than the same period last year. The increased rate is therefore being driven at least in part by the overall reduction in non-elective activity. As described in the Performance Report, non-elective activity has been below that of the equivalent month last year throughout the quarter. In addition to this, the rise in non-elective activity in the over 85 age group (see Performance Report) indicates a shift towards a more elderly patient-mix compared with last year.

3.2 Hospital Standardised Mortality Ratio (HSMR)

3.2.1 There is a two month delay with Dr Foster data (to allow for coding and processing of data); therefore April is the most recent month for which data is available.

3.2.2 The WSHFT HSMR for the twelve months to April 2013 was 93.9. This is significantly better than predicted by the Dr Foster model, although this will be subject to rebasing (see below).

3.2.3 Every year Dr Foster rebase their model to take account of nationally reducing rates (driven by a combination of improved outcomes and increased depth of clinical coding). The 2011/12 benchmark is used throughout the scorecard. Data from April 2012 onwards will be rebased in the summer 2013. This is likely to increase the Trust's HSMR. Dr Foster provided an estimate of the HSMR following rebasing. The current estimate is that following rebasing the 2012/13 HSMR for Western Sussex Hospitals Foundation Trust will be 100.

3.2.4 The twelve month HSMR to April 2013 split by site is higher for Worthing / Southlands Hospitals (95.1) than St Richards (92.2), although both are now below 100.

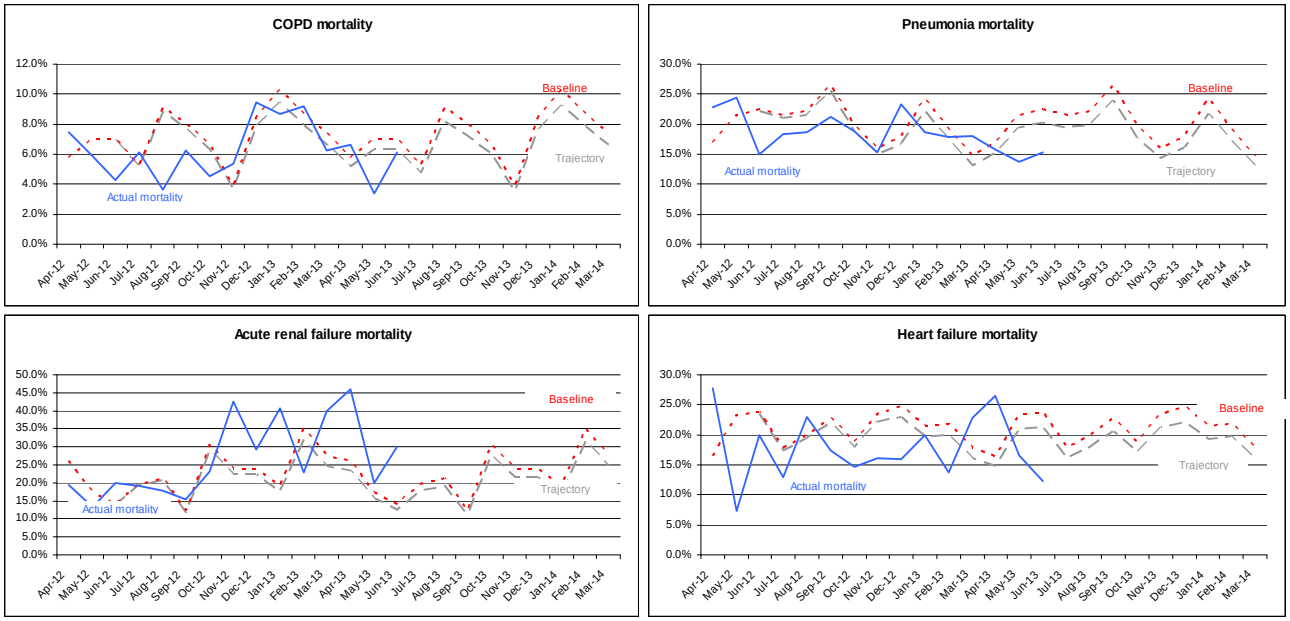
3.2.5 A further report is available to the Trust Quality Board showing the clinical diagnostic areas with high actual versus expected mortality and any mortality CuSum alerts.

3.3 Summary Hospital-Level Mortality Indicator (SMHI)

3.3.1 Due to the timing of the publication of this data a verbal update will be made to the Board.

3.4 Exception Reports Relating to Effectiveness

3.4.1 Exception Report - Indicators E05 to E08 Mortality in Specific Conditions: These measures reflect the pledge set out in the 2011/12 Trust Quality Account to reduce mortality in four key areas amenable to mortality by 10% against 2011/12 levels. Performance against the agreed trajectories is shown below.



3.4.2 In June, performance for three of the four areas were beneath trajectory. In the remaining area, Acute renal failure, mortality remains above trajectory. The results of the note review into mortality in this area have been reported to the Trust Board separately.

3.4.3 Exception Report – E18 to E20: Dementia screening is a key CQUIN target for Western Sussex Hospitals Foundation Trust in 2013/14. The Trust is required to screen all emergency patients aged 75 or over with the national screening question ('have you been more forgetful in the last twelve months?') during the first 72 hours. Performance against this indicator (indicator E15) increased from 20.4% to 31.6% in June, however this remains considerably short of the target 90%. Some refinements to the way the assessment works on the Patientrack system are being made to make the recording of this assessment clearer. A weekly report is produced showing performance by ward and wards and medical staff are being reminded of the importance of carrying out the assessment within the timeframe.

4. SAFETY

4.1 Patient Aggregate Safety Score (PASS): Background and Methodology

4.1.1 The PASS is an aggregate score comparing performance against a baseline for a total of 15 measures. These vary in polarity (i.e. whether a high score indicates a safer environment or not). The methodology was presented to the board in full with worked examples in August 2011:

Group	Measure	Polarity	Weighting	Baseline (2012/13)
VTE	VTE Prophylaxis given (syringe packs prescribed)	Positive	0.50	1943
	VTE risk assessments done	Positive	1.00	93%
HCIA	MRSA	Negative	1.00	0.1
	C. diff	Negative	1.00	6.0
SIRIs	SIRIs	Negative	2.00	2.2
Patient safety incidents	Total incidents	Positive	1.00	674
	Moderate, severe and death	Negative	1.00	7.1
Complaints	Complaints about nursing care	Negative	0.67	3.4
	Complaints about communications	Negative	0.67	6.3
	Complaints about staff attitude	Negative	0.67	4.7
Tissue viability	Total grade 2 or higher pressure ulcer incidents	Negative	1.50	10.3
Falls	Falls resulting in harm	Negative	1.50	40.1
Prescribing	Total incidents involving prescribing and drug errors	Positive	0.50	91.3
	Moderate, severe and death errors involving prescribing / drug errors	Negative	1.50	0.33
Nutrition	Nutritional Assessments in 24 hours	Positive	1.00	85.8%

4.1.1 The measures are unchanged for 2013/14, but all baselines have been updated to 2012/13 figures so that the PASS score for 2013/14 is an indication of whether the Trust in the current month is more or less safe (based on these measures) than 2012/13. All individual elements of the PASS score are also reported in the Quality Scorecard.

4.1.2 Scores can range from 0 to 200, with a lower score indicating a safer Trust and 100 being the equivalent of the Trust last year.

4.2 PASS Performance 2012/13 to Date

	Apr	May	June	Year to date
PASS	89.9	88.9	85.0	87.9

4.2.1 The PASS score for the year as a whole is calculated based on the averages of each of the individual months (this is a change to how this has been calculated in previous years).

4.3 Central Alert System (CAS) Safety Alerts

4.3.1 There are no outstanding alerts for the Trust relating to June 2013 or earlier.

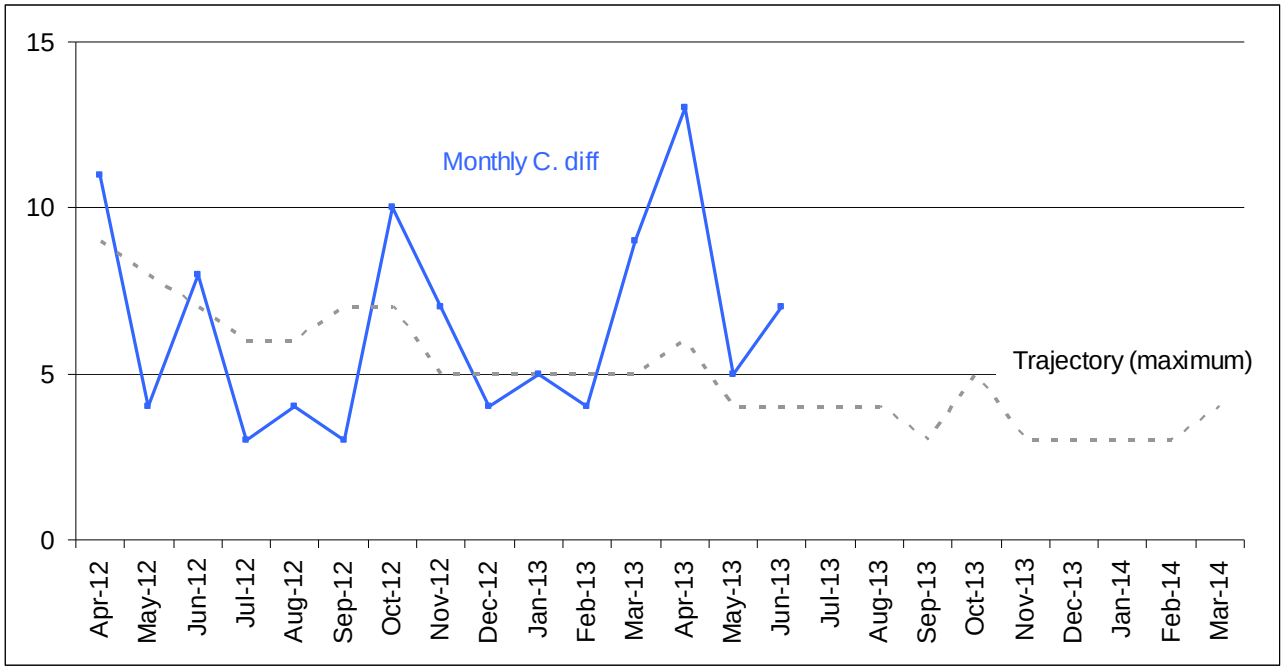
4.4 Infection control

4.4.1 The Trust reported zero cases of Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia during June.

4.4.2 The Trust reported 5 cases of Meticillin-sensitive Staphylococcus Aureus (MSSA) bacteraemia. Of those reported 1 case was post 72 hours and was therefore attributed to care received whilst an inpatient. The Root Cause Analysis (RCA) is still in progress

4.4.3 The Trust reported 7 cases of C. difficile during June, 3 cases on the Worthing site and 4 cases on the St. Richards site. The RCA meeting, chaired by the Chief Executive, now reviews each case against the National C. difficile Care Bundle in addition to existing criteria.

4.4.4 On review 2 cases were reported as unavoidable, 5 cases were reported as avoidable, 1 case related to failure to isolate, 2 cases related to environmental cleaning and 2 cases related to antibiotic management.



4.4.5 The Trust at the time of this report had reported 27 cases against a year end trajectory of 46 cases.

4.4.6 The Trust Development Authority (TDA) and Regional microbiologist have reviewed all the remedial actions implemented by the Trust and have endorsed all the actions in place. Following receipt of the TDA report an action plan has been implemented and the progress to date is monitored by the Chief Executive on a weekly basis.

4.4.7 During June the Trust received external peer review/scrutiny of environmental and technical cleaning standards. Worthing site reported 100% compliance, St. Richards site reported 98% compliance thereby validating the internal reporting presented to the Trust Board. The most recent infection control audits have reflected 100% with ward related cleaning standards.

4.4.8 A formal launch of the recently implemented antimicrobial policy and algorithm for laboratory diagnosis, management and treatment of diarrhoea was undertaken on the 8th July.

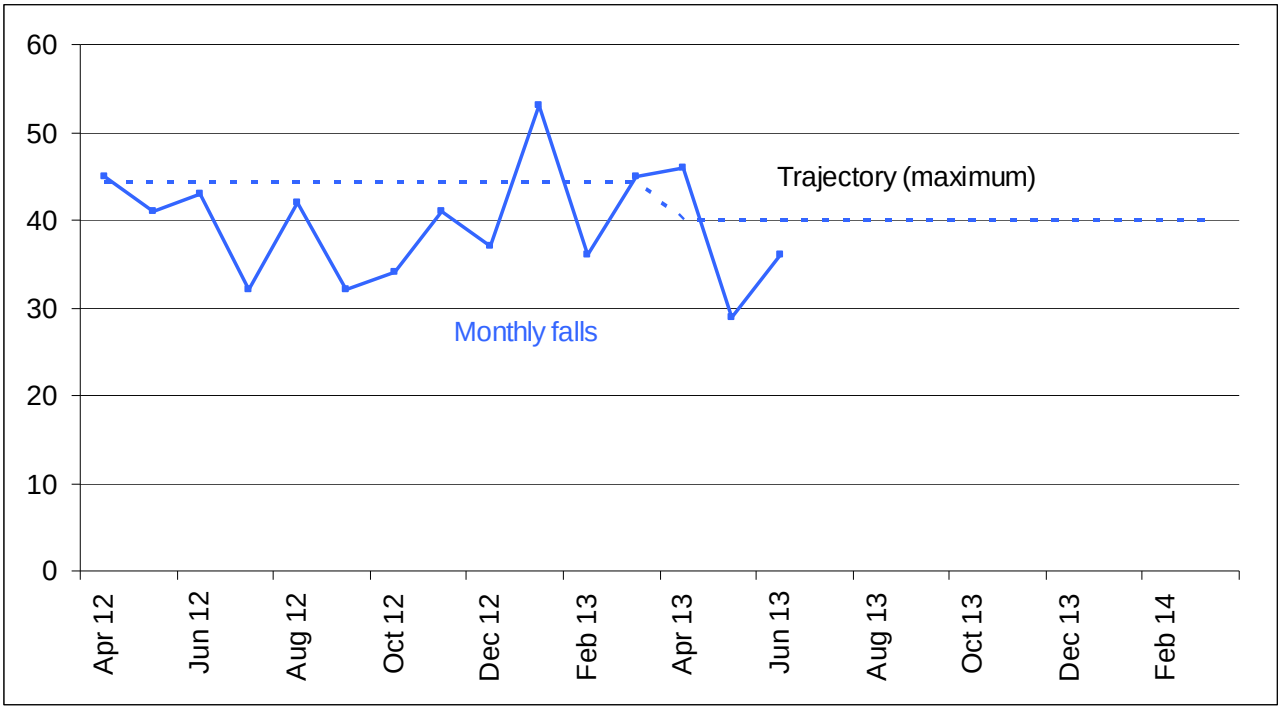
4.4.9 The National teams have recommended closer scrutiny of the community related C.diff and formal contact has been made with the Clinical Commissioning Group (CCG) and the local area team (LAT) to further progress this.

4.4.10 The Trust continues its 100% vigilance in the care and management of C.diff and continues to work in close partnership with both the TDA and Regional microbiologist at Public Health England, who are fully supportive of our actions.

4.5 Falls

4.5.1 Following the completion of the SHA Safer Smarter Nursing Programme, the Trust has continued to aim to reduce the number of falls resulting in harm. The target for 2013/14 seeks a further improvement against the 2012/13 level. As such the limits for 2013/14 are 481 or less falls resulting in harm and 2 falls resulting in severe harm or death.

- In June there were 36 falls resulting in harm against a monthly trajectory of 40.
- There were no falls resulting in severe harm or death.



4.5.2 The 36 falls equate to 1.48 falls resulting in harm per 1000 occupied bed days compared to the national benchmark of 2.5 (Royal College of Physicians Report of the 2011 Inpatient Falls Pilot Audit).

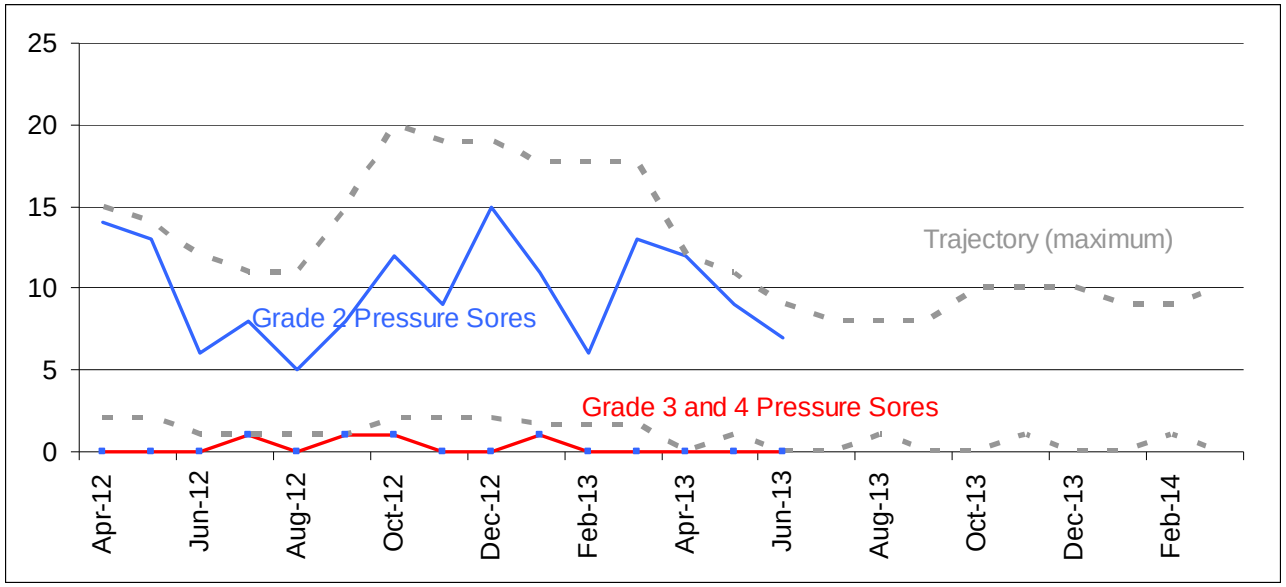
4.5.3 As part of our CQUIN goal for 2013/14 the Trust is undertaking an analysis of all the patients who are identified as fallers on the NHS Patient Safety Thermometer (see indicator S24).

4.6 Tissue Viability

4.6.1 The number of pressure ulcers in the Trust has fallen over the last two years from 283 in 2010/11 to 226 in 2011/12 and further to 124 in 2012/13. The Trust has set a stretch target for 2013/14 of a further 5% reduction against the 2013/14 value. This gives a limit for grade 2 pressure ulcers of 114 (see trajectory below). The Trust will also try to maintain or reduce the number of grade 3 or 4 ulcers (i.e. a limit of 4).

- In June the Trust reported 7 patients with grade 2 pressure damage (better than trajectory).
- There were no hospital acquired grade 3 or 4 pressure ulcers.

4.6.2 The incidence of pressure ulcers (developing 72 hours after admission) per 1000 bed days in June was 0.29.



4.6.3 A hospital-acquired category 2 heel pressure ulcer from May 2013 had progressed to category 3 by discharge in spite of all elements of the skin bundle being evidenced. This was deemed unavoidable.

4.6.4 86 patients were admitted with pressure damage. Of the patients admitted with pressure damage, 5 patients had category 3 pressure ulcers and 3 patients had category 4 pressure damage.

4.6 NHS Patient Safety Thermometer

4.7.1 The NHS Patient Safety Thermometer is now used across all relevant 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 showing Trust-wide and ward-level data for each individual harm as well as the harm-free care score is available to each ward.

4.7.2 The harm-free care score for the Trust in June was 93.9% (indicator S02). This is better than the national average of 91.8% (based on national data Jan 2011 to May 2013).

4.7.3 The Safety Thermometer includes harms suffered by the patient in health care settings prior to admission. The actual number of patients with no new harms during their inpatient stay at WSHFT (indicator S03) was 98.4%

4.8 Exception Reports Relating to Safety

4.8.1 Exception report: S10 VTE Assessment Compliance: The Trust achieved its best performance to date in June with 95.6% of patients being assessed. The aggregate performance for quarter 1 as a whole was also above 95%.

5. PATIENT EXPERIENCE

5.1 PALS and Complaints

5.1.1 All complaints are responded to by the Trust Office. The process is administered by the Customer Relations Team. 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.

5.1.2 During June 2013 the Trust received 54 complaints. Three complaints were graded as high, resulting in further investigation.

	Worthing	**Southlands**	**Chichester**	**Total**
All complaints	37	0	17	54
High grade complaints	2	0	1	3

5.1.3 The majority of complaints in June related to clinical treatment. These were not attributable to one clinical site or area.

5.1.4 In June there were 4 complaints received where nursing care was the primary issue. These were not related to a single area or issue.

5.2 Friends and Family Test

5.2.1 Data collection for the Government's Friends and Family test is currently underway in A&E and the inpatient wards, with maternity due to commence collection later in the year.

5.2.2 Response rates are included on the scorecard (in the CQUIN section). In June a total of 688 patients gave their views in response to the Family and Friends tests.

5.2.3 National guidance details how this question will be scored nationally as follows: The proportion of respondents who would be extremely likely to recommend (response category: 'extremely likely') MINUS the proportion of respondents who would not recommend (response categories: 'neither likely nor unlikely', 'unlikely' and 'extremely unlikely') (the response 'likely' is included in the percentage but does not have a positive or negative impact). This results in scores with a possible range of -100 to 100. Results are currently feedback to wards, however the Friends and Family scores will be reported to the Board from quarter 2.

5.3 Feedback from Hospital Experience Questionnaires

5.3.1 Detailed results from the Real-Time Patient Experience (RTPE) project are routinely fed back to divisions and wards and aggregate scores are included in the Quality Scorecard within the Experience section (indicators X03 to X07). Targets for these measures for 2013/14 are based on an improvement against 2012/13.

5.3.2 All five of these measures (indicators X03 to X07) were above target for May.

5.3.3 375 inpatients gave their views on the Trust using the RTPE system in May.

5.3.4 Real-time data collection is now underway in Maternity, Paediatrics and Outpatients. A paper-based survey is also underway in outpatients to support the information obtained electronically.

5.4 Exception Reports Relating to Experience

5.4.1 Exception Report: Indicator X11 PALS contacts in relation to appointment problems: There was an increase in the number of PALS contacts relating to problems with outpatient appointments in June. As previously identified to the Board, approximately a third of these were relate to the specialty Ophthalmology, reflecting capacity pressure in the specialty is resulting in patients being booked on clinics that are subsequently cancelled. To resolve, a business case has been produced for a new call-centre system to support partial booking from Quarter 4, which will in practically eliminate the cancellation of booked clinics. In addition to overseeing the roll out of partial booking within Ophthalmology, the Head of Outpatient Service has been seconded to the specialty to undertake a service review and improvement programme within the specialty commencing in August 2013.

5.4.2 Exception Report: Indicators X22 and X23: Care and Compassion reviews: These reviews are conducted quarterly (with one quarter being undertaken by a peer organisation to ensure objectiveness of the observations). The reviews were undertaken on six wards (three on each site). The feedback is still being reviewed and will be reported next month, although initial findings are generally positive.

6 CARE QUALITY COMMISSION (CQC)

CQC Compliance: Nothing to report.

6.1 Quality Risk Profile: The Quality Risk Profile is routinely reported to Management Board and the Quality and Risk Committee. No areas of concern currently exist.

7 FRONTLINE FRIDAY

7.1.1 Frontline Friday commenced in May to promote visibility of the Senior Nursing and Midwifery staff across the Trust to observe practice, to act as role models and provide a forum for organisational learning against a National background of failing confidence in the nursing profession by the general public in light of the recently published inquiry by Robert Francis QC into the care of patients at the Mid Staffordshire NHS Foundation Trust.

7.1.2 The aim is to review care against the 5 'E' criteria:

- Engagement
- Experience
- Environment
- Effectiveness
- Evidence

7.1.3 The June Frontline Friday took place on 14th June and focused on Healthcare acquired infections. These events have been positively received by wards.

8 NATIONAL AND LOCAL REPORTS

8.1 The Cavendish Review – An Independent review into Healthcare Assistants and support Workers in the NHS and social care setting: In the wake of the Francis Inquiry into Mid-Staffordshire NHS Foundation Trust, and reports of failings in other hospitals and care homes, the Secretary of State for Health commissioned a review to investigate what can be done to ensure that unregistered staff in the NHS and social care treat all patients and clients with care and compassion. The report was published in July 2013.

8.1.1 There are over 1.3 million frontline staff who are not registered nurses but who now deliver the bulk of hands-on care in hospitals, care homes and the homes of individuals. The Review's terms of reference included recruitment, training, supervision, support and public confidence. It did not include statutory

registration, which the Government felt would not add sufficiently to the general assurance provided by the CQC.

8.1.2 The report included eighteen recommendations grouped under four headings:

- Recruitment, Training and Education
- Making Caring a Carer
- Getting the Best out of People-Leadership, Supervision and Support
- Time to Care

8.1.3 The Trust is currently reviewing the report and will provide an in depth report back to a future Board.

8.2 More Care Less Pathway: A Review of the Liverpool Care Pathway: This report was published on 15th July. A review of the arrangements at WSHFT is being undertaken and a report will be made to a future Trust Board.

9 COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

9.1 Since 2009/10 a proportion of the money the Trust receives has been payable on achievement of agreed quality metrics. A detailed agreement has been reached with commissioners for 2013/14.

In addition to the national CQUINS (Friends and Family, VTE, NHS Safety Thermometer and Dementia) and the regional Enhancing Quality Programme, goals have been agreed in relation to the redesign of the musculoskeletal service, the One Call One Team, anti-biotic prescribing, outpatient experience and assistance with feeding.

A separate section has been added to the scorecard, pulling together CQUIN indicators. Currently this only includes the national CQUIN goals.

11 RECOMMENDATION

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

Mark Dennis, Head of Information Services
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QUALITY SCORECARD

JUNE 2013

		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	YTD Actual	YTD Target	Target	Trend
EFFECTIVENESS																		
E01	**Trust crude mortality rate (non-elective)**	2.82%	2.58%	2.93%	2.88%	3.01%	3.01%	3.49%	4.13%	3.69%	4.10%	3.76%	3.18%	2.83%	3.26%	3.22%	3.24%	
E02	**Crude mortality rate (non-elective): 12 month rolling**	3.23%	3.23%	3.23%	3.22%	3.19%	3.21%	3.21%	3.20%	3.18%	3.24%	3.26%	3.28%	3.29%	3.29%	3.26%	3.24%	
E03	**Trust Hospital Standardised Mortality Ratio (HSMR)**	102.7	101.9	101.7	101.0	99.7	99.2	98.4	96.7	94.5	95.0	93.9			95.0	100	100	
E04	**Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)**	1.07	1.06												1.06	1.00	1.00	
	Improve mortality in specific conditions																	
E05	Crude non-elective mortality for Pneumonia	15.5%	18.4%	19.0%	21.3%	18.8%	14.6%	24.3%	18.4%	15.9%	18.1%	15.8%	13.8%	15.3%	15.0%	17.3%	18.0%	
E06	Crude non-elective mortality for COPD	4.4%	6.2%	3.8%	6.4%	4.5%	5.7%	9.1%	8.7%	8.7%	6.3%	6.7%	3.4%	6.2%	5.5%	5.6%	6.7%	
E07	Crude non-elective mortality for Renal failure	20.0%	19.1%	18.5%	15.4%	20.0%	40.6%	29.2%	40.6%	24.2%	40.0%	45.9%	20.0%	30.0%	31.7%	19.9%	20.4%	
E08	Crude non-elective mortality for Chronic heart failure	20.0%	13.0%	22.9%	17.0%	14.8%	13.5%	16.3%	18.9%	11.1%	22.8%	26.5%	16.7%	12.2%	19.3%	17.6%	18.7%	
	Reduce mortality following hip fracture																	
E09	SMR for hip fracture (all diagnoses/procedures)	125.3	119.9	120.9	123.4	117.9	116.3	118.5	117.8	121.4	116.4	121.0			116.4	100	100	
E10	30 day mortaliy rate following hip fracture	10.8%	9.9%	9.1%	15.4%	6.9%	11.1%	13.5%	12.5%	14.9%	5.5%	15.5%			15.5%	8.3%	8.3%	
	Reduce the rate of readmission following discharge from the Trust																	
E11	Emergency readmissions within 30 days %	12.3%	12.4%	11.3%	12.8%	12.0%	13.5%	11.2%	12.3%	12.6%	11.9%	11.7%	11.3%	12.4%	11.8%	12.2%	12.2%	
E12	Emergency admissions not usually requiring admission	616	604	668	574	675	646	715	669	668	686	677	655		1,332	1324	7,942	
	To improve maternity care by encouraging natural chilbirth																	
E13	C-Section Rate	23.2%	26.1%	24.8%	24.7%	24.0%	25.6%	24.4%	23.0%	26.3%	26.9%	27.9%	23.8%	23.9%	25.2%	24.7%	24.7%	
E14	% Mothers requiring forceps for delivery	13.0%	12.8%	11.3%	12.2%	9.0%	11.8%	11.4%	9.0%	11.7%	9.7%	10.5%	10.5%	12.5%	11.2%	<15%	<15%	
E15	% Deliveries complicated by post-partum haemorrhage	0.41%	0.21%	0.82%	0.62%	0.80%	1.10%	0.21%	0.90%	1.10%	1.00%	0.70%	0.90%	0.90%	0.80%	1%	1%	
E16	Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
E17	Admission of term babies to neonatal care	-	-	-	-	-	-	-	-	-	-	2.50%	2.20%	3.30%	2.70%	<10%	<10%	
	Caring for the elderly patient																	
E18	% Emergency admissions staying over 72h screened for dementia	-	-	-	-	-	-	-	-	-	-	10.2%	20.4%	31.0%	20.5%	90%	90%	
E19	% Patients identified as at risk of dementia for whom further investigations are carried out	-	-	-	-	-	-	-	-	-	-	61.5%	80.9%	72.7%	71.7%	90%	90%	
E20	% Patients with identified dementia referred to specialist services	-	-	-	-	-	-	-	-	-	-	75.0%	95.5%	93.1%	87.9%	90%	90%	
	Ensure active engagement with research																	
E21	Patients recruited to interventional studies within CRN portfolio	40	64	50	54	72	46	21	24	33	45	49	24	27	100	n/a	n/a	
E22	Patients recruited to observational studies within CRN portfolio	35	25	26	40	47	34	29	26	25	41	30	35	8	73	n/a	n/a	
E23	CLRN Score	235	345	276	310	410	264	134	146	190	266	275	155	143	573	326	1305	
	Data Quality																	
E24	NHS IC Data validity summary (YTD)						97.5	97.5	97.5	97.5	97.2				97.4	96	96	

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QUALITY SCORECARD

JUNE 2013

		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	YTD Actual	YTD Target	Target	Trend
SAFETY																		
S01	**Patient Aggregate Safety Score (PASS)**											89.9	88.9	85.0	87.9	<100	<100	
	General Safety																	
S02	Safety Thermometer: % of patients harm-free	96.8%	95.0%	94.4%	94.8%	95.9%	94.4%	94.0%	93.2%	93.4%	92.0%	93.0%	92.5%	93.9%	93.1%			
S03	Safety Thermometer: % of patients with no new harms	98.8%	96.9%	97.3%	97.0%	98.3%	98.2%	97.9%	97.7%	96.9%	97.8%	97.1%	98.1%	98.4%	97.8%			
S04	Total incidents	571	659	726	640	694	737	657	693	714	765	711	722	773	2206	1517-2529	6068 - 10,114	
S05	Total moderate, severe or death incidents	5	5	7	4	10	9	5	9	3	8	6	8	9	23	21	85	
S06	Total serious incidents (SIRI)	5	1	3	1	3	3	1	2	2	3	2	1	0	3	7	26	
S07	Number of outstanding CAS alerts	0	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	86	109	104	95	109	85	64	72	95	92	79	80	87	246	207-344	826 -1376	
S09	Moderate/severe incidents involving drug/prescribing errors	0	1	0	0	0	0	1	1	0	0	0	2	1	3	1	4	
S10	Reduced errors on zero tolerance anti-microbial prescribing audits	55%	42%	45%	47%	48%	63%		67%			76%			76%	80%	80%	
	Reduce incidence of healthcare associated VTE																	
S11	95% compliance with the DoH risk assessment tool	92.5%	93.1%	92.7%	93.1%	93.5%	94.7%	93.4%	95.0%	95.0%	94.0%	94.4%	95.2%	95.6%	95.0%	**95%**	**95%**	
S12	Prescriptions for VTE prophylaxis	1879	1883	1949	1773	1946	2049	1980	1999	2007	2069	1998	2184	1778	5960	5830	23320	
S13	Incidence of VTE	29	36	22	31	24	30	29	25	23	23	33	34	24	91	84	334	
	Reduce incidence of healthcare acquired infections																	
S14	Number of hospital attributable MRSA cases	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	
S15	Number of hospital attributable C.diff cases	8	3	4	3	10	7	4	5	4	9	13	5	7	25	14	46	
S16	Number of reportable MSSA bacteraemia cases	6	6	10	4	4	6	6	6	1	10	6	4	6	16	tbc	tbc	
S17	Number of reportable E.coli cases	14	32	29	22	34	23	22	14	12	21	25	30	23	78	tbc	tbc	
	Improve theatre safety for patients																	
S18	Full compliance with WHO Surgical Safety Checklist	100%	100%			100%			100%			100%	100%	100%	100%	100%	100%	
S19	NEVER events	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	
S20	Theatre related SIRIs	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Reduce number of falls in hospital																	
S21	Falls resulting in harm	43	32	42	32	34	41	37	53	36	45	46	29	36	111	120	481	
S22	Falls resulting in severe harm or death	0	0	0	0	0	1	0	0	0	1	2	0	0	2	1	2	
S23	Falls assessment within 24hrs of admission	85.0%	88.5%	96.0%	91.0%	88.5%	92.5%	91.5%	93.5%	90.0%	91.5%	92.0%	93.5%	94.5%	93.3%	80%	80%	
S24	Avoidable falls identified on the Safety Thermometer								18	12	14	13	12	7	32	Base-line	Base-line	
	Pressure damage																	
S25	Grade 2 pressure sores	6	8	5	8	12	9	15	11	6	13	12	9	7	28	32	114	
S26	Grade 3 & 4 pressure sores	0	1	0	1	1	0	0	1	0	0	0	0	0	0	1	4	

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QUALITY SCORECARD

JUNE 2013

		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	YTD Actual	YTD Target	Target	Trend
EXPERIENCE																		
	Friends and family test																	
X01	Trust Friends and Family Score: Inpatient (reported from Q2)	-	-	-	-	-	-	-	-	-	-	-	-	-		Base-line	Base-line	
X02	Trust Friends and Family Score: A&E (reported from Q2)	-	-	-	-	-	-	-	-	-	-	-	-	-		Base-line	Base-line	
	Use of feedback from the real time patient experience project																	
X03	Realtime feedback on the hospital environment	77	75	77	77	76	74	76	75	73	76	75	77	76	76	75	75	
X04	Realtime feedback on assistance	86	88	86	88	87	86	89	88	86	88	91	90	90	90	87	87	
X05	Realtime feedback on compassion	89	89	89	89	88	87	88	87	87	88	89	90	90	90	88	88	
X06	Realtime feedback on communication	76	77	77	78	77	75	77	76	79	79	75	79	79	78	77	77	
X07	Overall experience of the Trust	91	92	92	93	92	90	91	91	91	92	91	93	93	92	92	92	
	Reduction in patients suffering a bad experience dealing with the Trust																	
X08	Percentage of re-booked outpatient appointments	9.3%	10.1%	10.0%	9.2%	10.1%	10.1%	11.0%	10.9%	10.8%	10.0%	9.9%	8.8%	9.8%	9.5%	9.8%	9.8%	
X09	Clinics cancelled with less than 6 weeks notice	56	34	58	33	18	29	15	47	17	18	19	26	41	86	94	376	
X10	Average number of ward stays per non-elective admission	1.71	1.72	1.74	1.71	1.76	1.75	1.73	1.77	1.82	1.73	1.78	1.78	1.82	1.79	1.75%	1.75%	
X11	PALS contacts relating to appointment problems (% of total appts)	0.14%	0.13%	0.17%	0.11%	0.11%	0.14%	0.11%	0.10%	0.11%	0.11%	0.12%	0.14%	0.16%	0.14%	0.10%	0.10%	
X12	Reduce patients cancelled on the day of surgery for non-clinical reasons	41	41	48	28	42	27	11	46	26	45	31	17	21	69	114	455	
X13	Breaches of mixed sex accommodation arrangements	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0	0	
	Nutritional Assessment																	
X14	Compliance with MUST tool after 24 hours	84.0%	82.5%	82.0%	89.0%	84.0%	91.0%	86.0%	86.5%	87.5%	83.0%	84.0%	85.9%	86.7%	85.5%	80%	80%	
X15	Compliance with MUST tool after 7 days	97.7%	95.0%	94.6%	97.0%	95.5%	98.0%	95.0%	95.5%	92.0%	93.5%	97.5%	98.0%	98.4%	98.0%	95%	95%	
	Cleanliness / PEAT Survey																	
X16	Internal PEAT compliance : St Richard's Hospital	94%	98%	94%	94%	96%	95%	97%	96%	97%	96%	97%	94%	95%	95%	85%	85%	
X17	Internal PEAT compliance : Worthing Hospital	95%	90%	99%	91%	95%	96%	96%	93%	96%	95%	95%	92%	97%	95%	85%	85%	
	Improve our customer service and become a more caring organisation																	
X18	Number of complaints	47	50	50	55	39	54	39	46	36	40	39	46	54	139	141	562	
X19	Complaints where staff attitude or behaviour is an issue	5	7	1	8	4	4	4	4	5	7	6	6	4	16	14	56	
X20	Complaints where staff communication is an issue	6	5	12	7	9	12	2	3	4	5	3	5	2	10	19	75	
X21	Complaints about nursing	7	4	3	2	0	3	1	3	3	6	3	1	4	8	10	41	
X22	Positive care and compassion observations in general care	83%				87%						88%			88%	n/a	n/a	
X23	Positive care and compassion observations in patient / visitor interaction	85%				72%						92%			92%	n/a	n/a	

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QUALITY SCORECARD

JUNE 2013

		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	YTD Actual	YTD Target	Target	Trend
CQUIN SCHEMES																		
	National CQUINS																	
E18	% Emergency admissions staying over 72h screened for dementia											10.2%	20.4%	31.0%	20.5%	90%	90%	
E19	% Patients identified as at risk of dementia for whom further investigations are carried out											61.5%	80.9%	72.7%	71.7%	90%	90%	
E20	% Patients with identified dementia referred to specialist services											75.0%	95.5%	93.1%	87.9%	90%	90%	
S11	95% compliance with the DoH risk assessment tool	92.5%	93.1%	92.7%	93.1%	93.5%	94.7%	93.4%	95.0%	95.0%	94.0%	94.4%	95.2%	95.6%	95.0%	95%	95%	
S27	Root cause analyses carried out for VTE (from Q2)											From Q2	From Q2	From Q2	From Q2	From Q2	From Q2	
S24	Avoidable falls identified on the Safety Thermometer								18	12	14	13	12	7	32	Base-line	Base-line	
X24	Trust Friends and Family Response Rate: Inpatient									7.80%	6.60%	12.30%	13.60%	16.12%	14.01%	15%	20%	
X25	Trust Friends and Family Response Rate: A&E									0.90%	0.70%	1.40%	1.90%	6.83%	3.38%	15%	20%	

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INFECTION CONTROL SCORECARD

JUNE 2013

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Actual	YTD Target	Target	Trend
Compliance with high impact intervention care bundles (HII)																	
Renal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**	**95%**	**95%**	
Central line	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	**99%**	**95%**	**95%**	
Ventilation	100%	100%	100%	97%	99%	100%	96%	97%	100%	100%	100%	100%	99%	**100%**	**95%**	**95%**	
Hand hygiene	98%	99%	98%	97%	97%	97%	97%	98%	96%	97%	97%	98%	99%	**98%**	**95%**	**95%**	
Peripheral IV Line	98%	99%	97%	97%	98%	99%	98%	98%	98%	97%	99%	96%	97%	**97%**	**95%**	**95%**	
Catheter care	98%	100%	98%	99%	99%	100%	99%	100%	99%	100%	100%	100%	100%	**100%**	**95%**	**95%**	
Screening																	
Compliance with elective MRSA screening	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**	**100%**	**100%**	
Compliance with non-elective MRSA screening	98%	98%	98%	98%	98%	98%	98%	97%	98%	98%	98%	98%	99%	**98%**	**100%**	**100%**	
Hospital cleanliness																	
Very high risk	100%	99%	99%	99%	99%	99%	99%	98%	99%	99%	99%	99%	99%	**99%**	**98%**	**98%**	
High risk	98%	99%	99%	98%	98%	98%	98%	98%	98%	97%	97%	97%	98%	**97%**	**95%**	**95%**	
Significant risk	97%	97%	96%	96%	95%	97%	97%	97%	97%	97%	96%	96%	97%	**96%**	**85%**	**85%**	
Low risk	94%	97%	100%	100%	91%	92%	92%	90%	92%	91%	93%	97%	94%	**95%**	**75%**	**75%**	
Decontamination of equipment																	
Decontamination of equipment	99%	99%	97%	99%	99%	99%	97%	100%	100%	98%	98%	98%	99%	**98%**			

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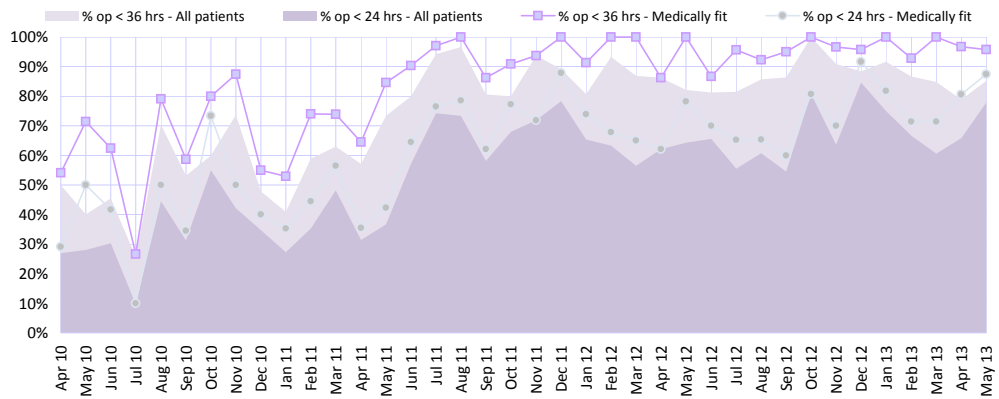
FRACTURED NECK OF FEMUR DASHBOARD

Site: St Richard's Hospital

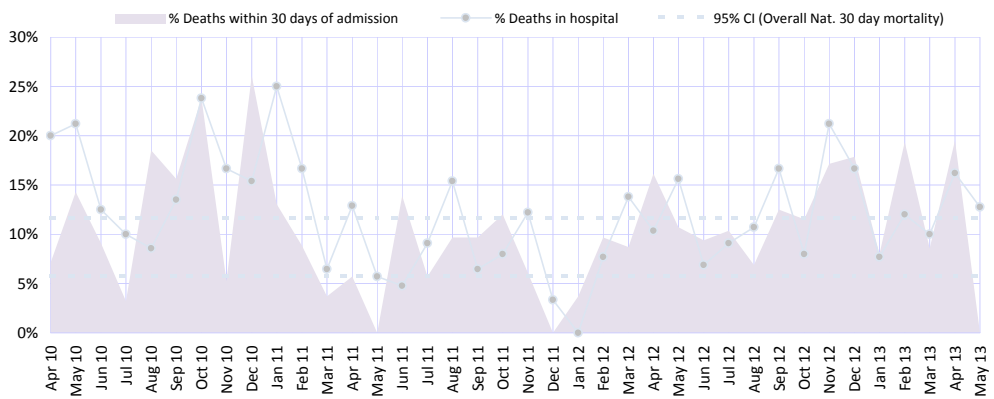
Data for period: May 2013

version 1.5

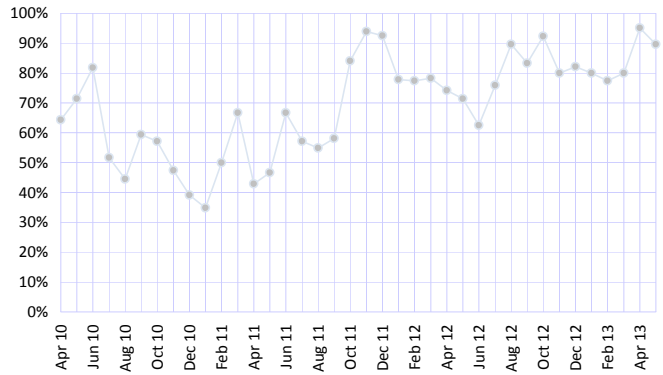
% Patients operated on within 24 and 36 hours of A&E attendance (source: NHFDb)



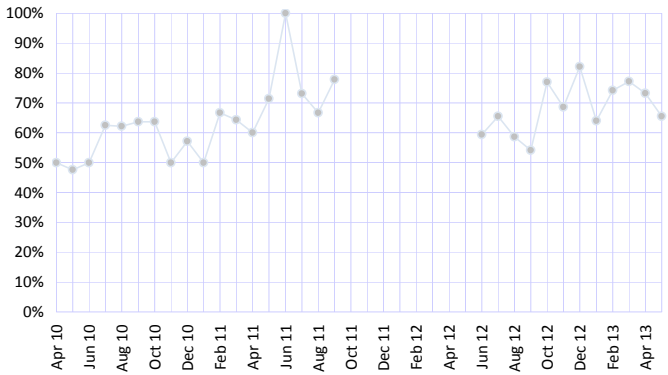
Mortality in hospital and within 30 days of admission (source: NHFDb/Sema Helix)



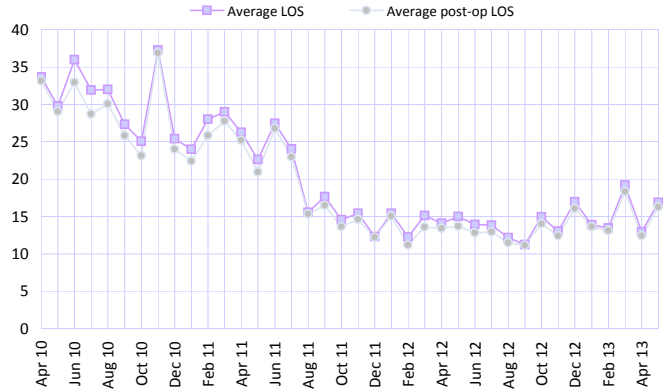
% Patients who saw Consultant Physician Pre-op (source: NHFDb)



% Patients mobilised within 24 hours post-op



Total LOS and LOS on post-op ward (source: NHFDb)



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

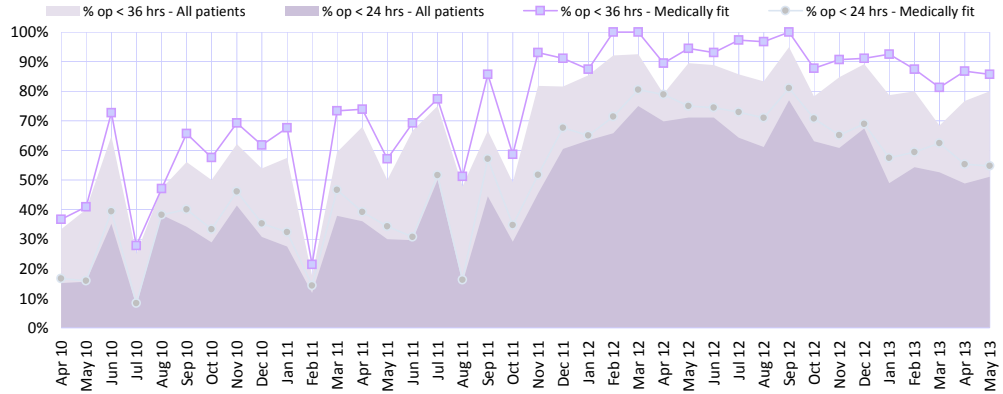
FRACTURED NECK OF FEMUR DASHBOARD

Site: Worthing Hospital

Data for period: May 2013

version 1.5

% Patients operated on within 24 and 36 hours of A&E attendance (source: NHFDb)



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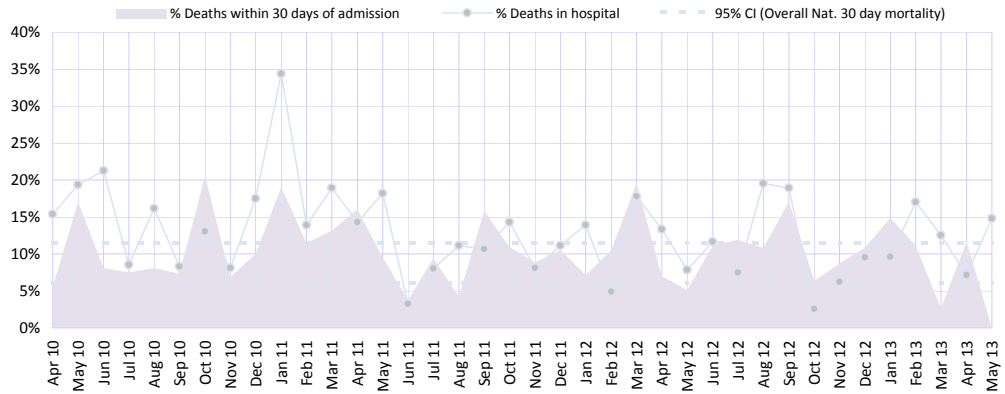

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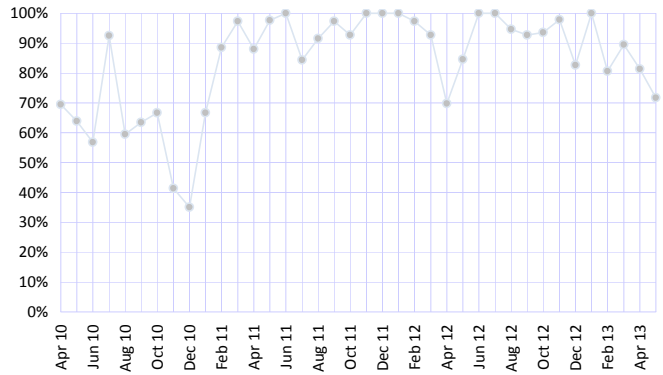

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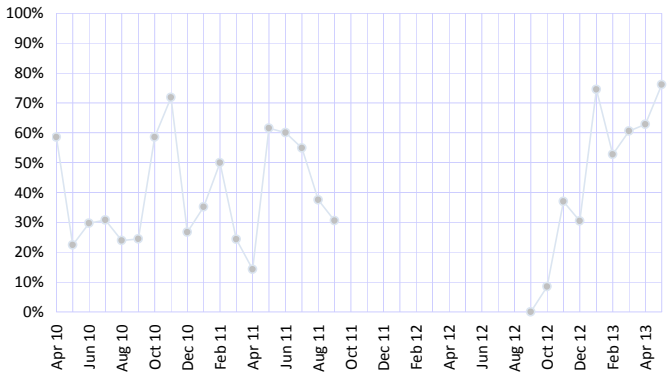

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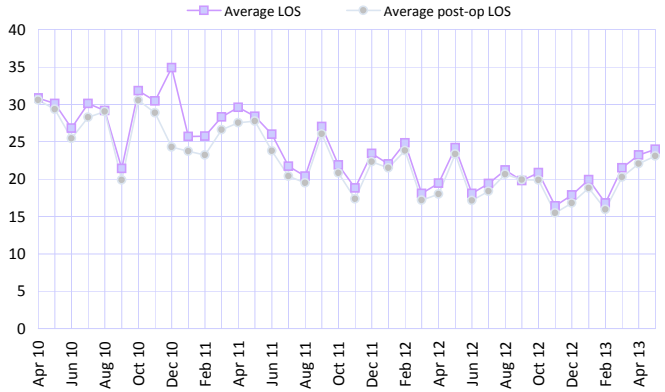

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FRACTURED NECK OF FEMUR DASHBOARD

Site: Western Sussex Hospitals Data for period: May 2013

version 1.5

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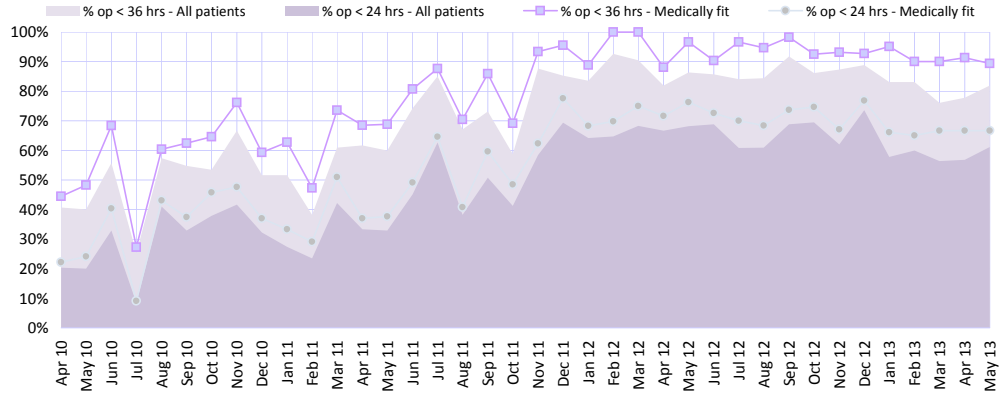

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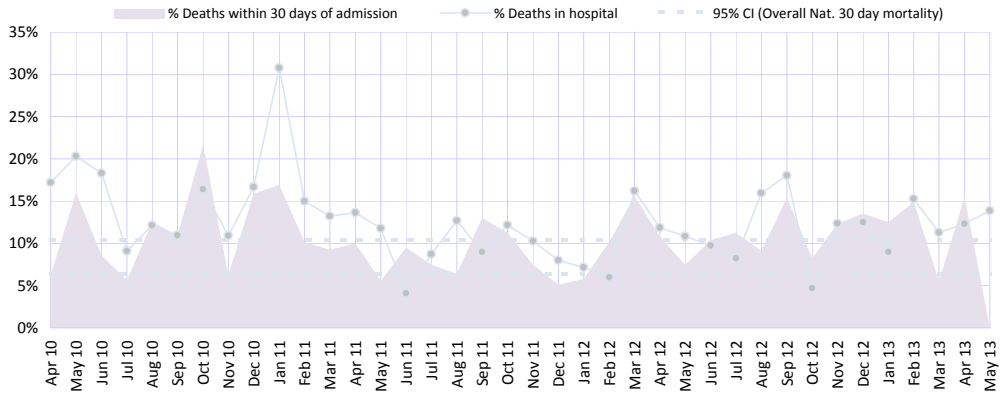

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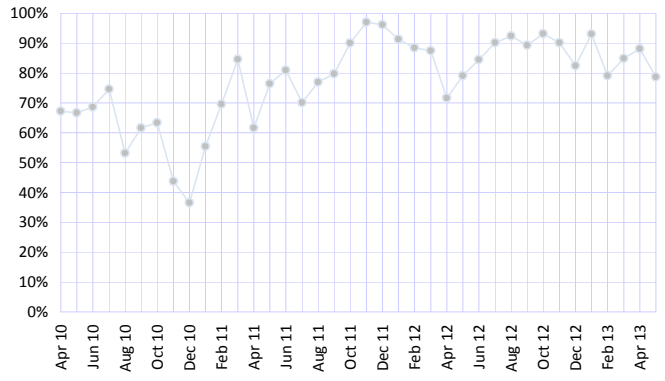

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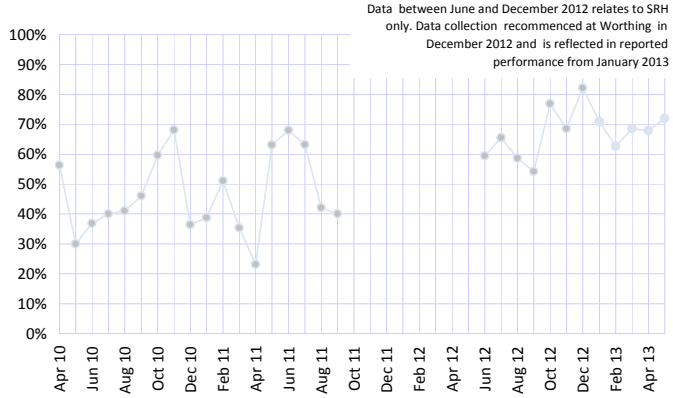

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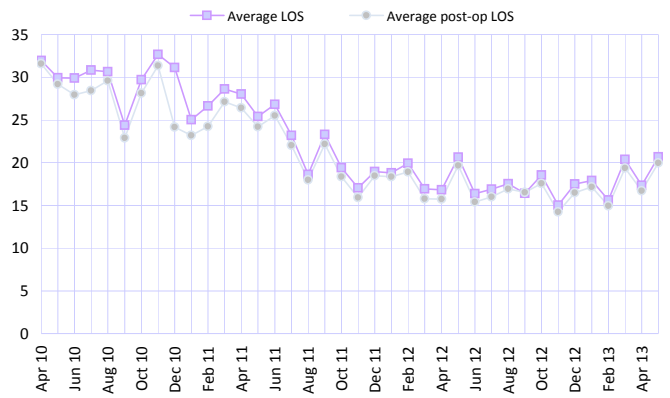


Summary Table - Data from NHFDb
May 2013

	St Richard's	Worthing	WSHT
Admissions	29	46	75
Discharges	47	54	101
Number of deaths in hospital	6	8	14
Hospital mortality rate %	12.8%	14.8%	13.9%
Average LOS	16.9	24.0	20.7
Medically fit patients	24	42	66
Number operated wtihin 24 hours	21	23	44
% operated within 24 hours	87.5%	54.8%	66.7%
Number operated wtihin 36 hours	23	36	59
% operated within 36 hours	95.8%	85.7%	89.4%
All patients	27	45	72
Number operated wtihin 24 hours	21	23	44
% operated within 24 hours	77.8%	51.1%	61.1%
Number operated wtihin 36 hours	23	36	59
% operated within 36 hours	85.2%	80.0%	81.9%

QUALITY SCORECARD

2013/14 Targets

		2012/13	Target	Rationale for target
EFFECTIVENESS				
E01	**Trust crude mortality rate (non-elective)**	3.24%	3.24%	Local: reduction against 2012/13
E02	**Crude mortality rate (non-elective): 12 month rolling**	3.24%	Month on month	Local: reduction against 2012/13
E03	**Trust Hospital Standardised Mortality Ratio (HSMR)**	95	100	National benchmark
E04	**Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)**	1.06	1.00	National benchmark
	Improve mortality in specific conditions			
E05	Crude non-elective mortality for Pneumonia	19.4%	18.0%	Local: 10% reduction against 2011/12
E06	Crude non-elective mortality for COPD	6.7%	6.7%	Local: 10% reduction against 2011/12
E07	Crude non-elective mortality for Renal failure	24.3%	20.4%	Local: 10% reduction against 2011/12
E08	Crude non-elective mortality for Chronic heart failure	17.7%	18.7%	Local: 10% reduction against 2011/12
	Reduce mortality following hip fracture			
E09	SMR for hip fracture (all diagnoses/procedures)	100	100	National benchmark
E10	30 day mortaliy rate following hip fracture	8.3%	8.3%	National benchmark
	Reduce the rate of readmission following discharge from the Trust			
E11	Emergency readmissions within 30 days %	12.2%	12.2%	Local: improvement against 2012/13
E12	Emergency admissions not usually requiring admission	7,942	7,942	Local: improvement against 2012/13
	To improve maternity care by encouraging natural chilbirth			
E13	C-Section Rate	24.70%	24.70%	Local: improvement against 2012/13
E14	% Mothers requiring forceps for delivery	11%	<15%	Regional target
E15	% Deliveries complicated by post-partum haemorrhage	0.7%	1.0%	Regional target
E16	Maternal deaths		0	
E17	Admission of term babies to neonatal care	2.70%	<10%	Regional target
	Caring for the elderly patient			
E18	% Emergency admissions staying over 72h screened for dementia	n/a	90%	National target
E19	% Patients identified as at risk of dementia for whom further investigations are carried out	n/a	90%	National target
E20	% Patients with identified dementia referred to specialist services	n/a	90%	National target
	Ensure active engagement with research			
E21	Patients recruited to interventional studies within CRN portfolio	540		Aggregate CLRN target only
E22	Patients recruited to observational studies within CRN portfolio	417		Aggregate CLRN target only
E23	CLRN Score	3120	1305	CLRN agreed target
	Data Quality			
E24	NHS IC Data validity summary (YTD)	tbc	96	National benchmark
SAFETY				
S01	**Patient Aggregate Safety Score (PASS)**	NA	<100	Local: improvement against 2012/13
	General Safety			
S02	Safety Thermometer: % of patients harm-free			
S03	Safety Thermometer: % of patients with no new harms			
S04	Total incidents	8091	6068 - 10,114	2012/13 +/ - 25% (red at +/-40%)
S05	Total moderate, severe or death incidents	85	85	Local: improvement against 2012/13
S06	Total serious incidents (SIRI)	26	26	Local: improvement against 2012/13
S07	Number of outstanding CAS alerts	0	0	Local target (zero tollerance)
	Improve safety of prescribing			
S08	Total incidents involving drug/prescribing errors	1101	826 -1376	2012/13 +/ - 25% (red at +/-40%)
S09	Moderate/severe incidents involving drug/prescribing errors	4	4	Local: improvement against 2012/13
S10	Reduced errors on zero tolerance anti-microbial prescribing audits	80%	80%	Local: Stretch target
	Reduce incidence of healthcare associated VTE			
S11	95% compliance with the DoH risk assessment tool	95%	95%	National target
S12	Prescriptions for VTE prophylaxis	23320	23320	Local: improvement against 2012/13
S13	Incidence of VTE	334	334	Local: improvement against 2012/13
	Reduce incidence of healthcare acquired infections			
S14	Number of hospital attributable MRSA cases	0	0	National target
S15	Number of hospital attributable C.diff cases	46	46	National target
S16	Number of reportable MSSA bacteraemia cases	72		
S17	Number of reportable E.coli cases	274		
	Improve theatre safety for patients			
S18	Full compliance with WHO Surgical Safety Checklist	100%	100%	Local target (100%)

QUALITY SCORECARD

2013/14 Targets

		2012/13	Target	Rationale for target
S19	NEVER events	0	0	Local target (zero tollerance)
S20	Theatre related SIRIs	0	0	Local target (zero tollerance)
	Reduce number of falls in hospital			
S21	Falls resulting in harm	483	483	Local: improvement against 2012/13
S22	Falls resulting in severe harm or death	2	2	Local: improvement against 2012/13
S23	Falls assessment within 24hrs of admission	80%	80%	Previously agreed target
S24	Avoidable falls identified on the Safety Thermometer	n/a	Baseline	New measure
	Pressure damage			
S25	Grade 2 pressure sores	120	114	Local stretch target
S26	Grade 3 & 4 pressure sores	4	4	Local stretch target
EXPERIENCE				
	Friends and family test			
X01	Trust Friends and Family Score: Inpatient (reported from Q2)	n/a	Baseline	New measure
X02	Trust Friends and Family Score: A&E (reported from Q2)	n/a	Baseline	New measure
	Use of feedback from the real time patient experience project			
X03	Realtime feedback on the hospital environment	75	75	Local: improvement against 2012/13
X04	Realtime feedback on assistance	87	87	Local: improvement against 2012/13
X05	Realtime feedback on compassion	88	88	Local: improvement against 2012/13
X06	Realtime feedback on communication	77	77	Local: improvement against 2012/13
X07	Overall experience of the Trust	92	92	Local: improvement against 2012/13
	Reduction in patients suffering a bad experience dealing with the Trust			
X08	Percentage of re-booked outpatient appointments	9.8%	9.8%	Local: improvement against 2012/13
X09	Clinics cancelled with less than 6 weeks notice	376	376	Local: improvement against 2012/13
X10	Average number of ward stays per non-elective admission	1.75	1.75	Local: improvement against 2012/13
X11	PALS contacts relating to appointment problems (% of total appts)	0.12%	0.10%	Local CQUIN target
X12	Reduce patients cancelled on the day of surgery for non-clinical reasons	455	455	Local: improvement against 2012/13
X13	Breaches of mixed sex accommodation arrangements	0.02%	0.00%	National target
	Nutritional Assessment			
X14	Compliance with MUST tool after 24 hours	86%	80%	Previously agreed local target
X15	Compliance with MUST tool after 7 days	95%	95%	Previously agreed local target
	Cleanliness / PEAT Survey			
X16	Internal PEAT compliance : St Richard's Hospital	95%	85%	National benchmark
X17	Internal PEAT compliance : Worthing Hospital	95%	85%	National benchmark
	Improve our customer service and become a more caring organisation			
X18	Number of complaints	562	562	Local: improvement against 2012/13
X19	Complaints where staff attitude or behaviour is an issue	56	56	Local: improvement against 2012/13
X20	Complaints where staff communication is an issue	75	75	Local: improvement against 2012/13
X21	Complaints about nursing	41	41	Local: improvement against 2012/13
X22	Positive care and compassion observations in general care	n/a	n/a	
X23	Positive care and compassion observations in patient / visitor interactions	n/a	n/a	
CQUIN SCHEMES				
	National CQUINS			
E18	% Emergency admissions staying over 72h screened for dementia	n/a	90%	National target
E19	% Patients identified as at risk of dementia for whom further investigations are carried out	n/a	90%	National target
E20	% Patients with identified dementia referred to specialist services	n/a	90%	National target
S11	95% compliance with the DoH risk assessment tool	93%	95%	National target
S27	Root cause analyses carried out for VTE (from Q2)	n/a	tbc	Local CQUIN target
S24	Avoidable falls identified on the Safety Thermometer (from May)	n/a	tbc	Local CQUIN target
X24	Trust Friends and Family Response Rate: Inpatient	n/a	20%	National target
X25	Trust Friends and Family Response Rate: A&E	n/a	20%	National target

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board

Date of Meeting: 01st August 2013 Agenda Item: 7

Title
Customer Feedback – PALS and Complaints, Annual report 2012 - 2013
Responsible Executive Director
Cathy Stone, Director of Nursing and Patient Safety
Prepared by
Tracey Nevell, Customer Relations Manager
Status
Disclosable
Summary of Proposal
The purpose of this report is to provide an annual report of customer feedback from PALS and Complaints 2012 – 2013.
Implications for Quality of Care
1. Failure to deliver quality care. 2. Loss of public confidence. 3. Failure of compliance with Care Quality Commission standards and Health & Social Care Act 2008. To consider areas of concern, high grade complaints and themes/trends in service and patient care.
Link to Strategic Objectives/Board Assurance Framework
Support of Board Assurance Framework B1, C1
Financial Implications
1. Financial penalties may be incurred as a result of poor quality care. 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 and Consultation
Communication with Trust Risk and Patient Safety, Complaints, Tissue Viability and Matrons.
Appendices

This report can be made available in other formats and in other languages. To discuss your requirements please contact Ann Merricks, Interim Company Secretary, on ann.merricks@wsht.nhs.uk or 01903 285288.

Western Sussex Hospitals NHS
NHS Foundation Trust



Customer Feedback
PALS & Complaints
Learning the Lessons and Improving

Annual Report 2012-13

"I would like to thank you for the depth of investigation given to my complaint which your letter conveys. It was never my intention to bring reproach on the staff who cared for me but rather to bring awareness to the management of how improvements to the system of care could be implemented for the benefit of patients."
(Mr X – July 2012)

Western Sussex Hospitals NHS
NHS Foundation Trust

CONTENTS

Foreword

This report should be read in conjunction with and supports the analytical quarterly report which is in the public domain.

Careful handling of comments, concerns and complaints is an essential requirement of the organisation in terms of patient safety, patient experience and reputation. The trust cares passionately about providing the best quality care for its local population and effective management of PALS enquiries and formal complaints is key to the trust's vision and objectives **"We care: about the patient, quality, safety, local services, being joined up, improvement and sustainability"**

There is a lot of evidence of positive culture at Western Sussex Hospitals (the National Patient Survey and inspections from the Care Quality Commission) which promotes patient safety, which seeks to drive improvements, and which is prepared to listen and learn. Following publication of the Francis Report into the failures of hospital care at Mid Staffordshire Hospitals, the trust identified eight work-streams as a means of addressing the report's recommendations within the trust. Featured in the report was the importance of effective handling of complaints, being open and honest about mistakes and sharing feedback with the public. As a result, we are reviewing how we respond, listen and take action as a result of PALS enquiries and formal complaints across the organisation with a view to strengthening clinical engagement and ownership of complaints at ward/departmental level. During the year, our handling of complaints was reviewed by South Coast Audit, the trust's internal auditors and we received significant assurance that our processes are robust and effective. Over the coming months, the trust will concentrate on ensuring that the lessons learned from complaints are truly embedded within the culture of the organisation.

The role of the Customer Relations department

We provide a service for everyone who contacts us from providing advice on how and where to complain, to investigating matters of concern and resolving things that have gone wrong. Not every complaint needs to be resolved by investigation if the concerns are about current treatment where action can be taken quickly to resolve problems.

The Patient advice and Liaison service (PALS) is situated in the main entrances of Worthing Hospital and St Richard's Hospital to carry out:

- Signposting i.e. providing information, advice or reassurance
- Management of smaller issues that can be resolved quickly
- Assisting patients/relatives who need time to discuss concerns
- A triage service for telephone and face to face enquiries

Formal Complaints

- The complaints team work on behalf of the Chief Executive based at Worthing Hospital and St Richard's Hospital to investigate more complex and serious concerns raised that require a formal investigation and written response.

This report summarises the way we worked last year to listen to those who use our services and sought ways to improve services for patients.

Engaging with the public: what our users said and how we responded

There are always learning outcomes from every complaint received and in 2012/13 69% of formal complaints were upheld in part or fully. During the year we examined in detail the PALS enquiries and formal complaints received to listen and learn when things went wrong.

We responded in a variety of ways including:

- providing advice and information to people on healthcare and general matters.
- a triage service to respond to all telephone calls and visitors and provide advice and support.
- we provided written explanations about treatment that patients received as part of our formal complaints procedure.
- we met with patients and relatives about their concerns together with senior management (and in some cases the Chief Executive) to ensure issues were resolved and actions required followed through.

The Customer Relations team had **7,217** contacts during the year from patients, relatives and other users of our services. In **92%** of cases, we helped put things right via our PALS service.

53% of enquiries (3,845) were on the spot advice and information requests. 2,807 were individual issues or concerns dealt with by the PALS team within one working day, most involving the relevant staff/divisions to facilitate answers and/or a meeting where appropriate.

565 cases (8% of all enquiries) required a formal investigation under the NHS Complaints Procedure due to their complexity or the seriousness of the issues raised.

POSITIVE OUTCOMES/LESSONS LEARNT

The trust implemented over 100 improvements as a result of PALS enquiries and formal complaints throughout the year. The following examples are a selection of these:

POLICY CHANGE

- ✓ The discharge process for maternity patients has been improved to ensure women have a chance to speak to someone about their care before leaving the hospital.

- ✓ The protocols within the Ultrasound department have been reviewed. There is a new information leaflet for patients regarding pelvic ultrasound scanning and the possible intimate nature of this examination. The outpatient appointment letter has also been revised to include this information.

- ✓ The Acute Medical Unit is obtaining a supply of outdoor clothing for patients to travel home in if they arrived in nightwear.

- ✓ A review will now take place three days prior to planned surgery for patients where specific equipment is required to ensure that this is in place. A review is also to take place of provision of taxi transport in urgent cases where equipment can be sought between sites.

- ✓ Patients who require a follow up appointment after their surgery have been flagged on the trust's computerised database to ensure that an appointment is booked within an appropriate timeframe.

COMMUNICATION

- ✓ Letters to patients awaiting eye clinic appointments following surgery have been improved regarding instructions of how to prepare.

- ✓ The literature provided to patients and in particular those attending the Day Surgery Unit has been reviewed to better explain the discharge process and advise on what to do should complications occur once at home.

- ✓ The literature given to patients with eczema by the dermatology department has been reviewed.

- ✓ A new information leaflet is in the process of being produced for parents whose babies are born with developmental dysplasia.

ENVIRONMENT

- ✓ Directions to the Diabetes Centre at Worthing Hospital have been enlarged for better signposting.

- ✓ Plans are underway to redevelop the Chanctonbury Suite at Worthing Hospital to provide more space, privacy and dignity. In the interim, a temporary additional admission area has been opened to improve the patient experience.

TRAINING

- ✓ Pharmacy training has been implemented to ensure that staff fully understand the consequences of omitting Parkinson's disease treatment even for short periods of time and that they know how to manage individual cases to ensure that correct treatment is maintained.

- ✓ Specialist dementia training is being provided to wards to develop and increase skills in looking after patients suffering from this condition.

- ✓ A learning event has been organised with the paediatric teams to reinforce the importance of good communication with families of young patients during a hospital admission.

CHANGE IN CLINICAL PRACTICE

- ✓ A number of actions have been taken to improve the quality of care to patients admitted to hospital with Parkinson's disease:
  - o Pharmacy is working with the neurology specialists to ensure that a full range of appropriate anti-Parkinson's medicines are always held in stock
  - o A multidisciplinary team of senior doctors, nurses and pharmacists is being assembled to look at the particular needs of patients with Parkinson's disease and how we can ensure these needs are met consistently in our hospitals.

- ✓ The trust's Lead Macmillan Nurse is working with the clinical nurse specialists to improve the pathway for patients diagnosed with more than one cancer who are seeing multiple teams and being referred to other hospitals.

- ✓ An improved communication pathway is being put in place for patients recalled to hospital following colposcopy procedures.

- ✓ The process for paediatric referrals to adult services has been strengthened for young teenagers. Additional safeguards have been introduced to ensure a smoother transition between the two services.

PLAUDITS

We measured the number of plaudits received within the organisation during the year to identify what was working well through compliment trends so that good practice could be shared. Plaudits were received in a variety of ways by letter, cards, e-mails, telephone calls, donations, cakes, chocolates, biscuits and sweets.

5,010 patients and relatives made a special effort to thank the staff who looked after them or their loved ones and compliment their standards of care. The trust shares this information on a compliments board with staff on its intranet site and on notice boards around the hospital sites for the public to read.

When we reviewed the feedback from PALS and complaints, most people wanted reassurance that we are an organisation with staff that respect others, who care, are professional, kind, sympathetic/compassionate, cheerful/friendly and that the environment is clean. We know from our plaudits that the most important thing for patients and relatives was that they were made to feel special and relaxed and treated in an efficient and timely way.

Patient Experience & Feedback Committee

During the year, the committee met on behalf of the Trust Board to examine and discuss the feedback received as a result of PALS enquiries and formal complaints. The Non-Executive Directors of the committee audited 10% of the formal complaints received in 2012-13 to ensure that the process of investigation and response to complaints was effective. In the majority of cases, the process was managed appropriately and in accordance with the trust's complaints policy. Positive outcomes were evident and the committee invited divisions to present to the meeting throughout the year to discuss the development of their services.

Case Studies

Patient A was a new mum admitted to A&E. A breast pump was not available and the patient's husband had to go home and fetch one for his wife to use in hospital whilst she was away from her baby. The A&E Sister has obtained a breast pump for the department to prevent any other nursing mothers suffering discomfort.

* * *

Patient B had an accident in the outpatient clinic and his clothing became soiled. The department was unable to offer any change of clothing. The outpatient Sister has ensured that there are items in place in the outpatients clinic to be used should a similar episode arise so that patients are not placed in such a difficult position.

* * *

Statistics

The following tables give a statistical breakdown of information regarding PALS and complaints activity during the last year.

Figure 1: Enquiries received

	2012-13	2011-12	2010-11
PALS	**2,807**	**2,072**	1,711
Formal complaints	**565**	**671**	630
Total	**3,372**	**2,743**	2,341

Figure 2: Formal complaints received by site

	2012-13	2011-12	2010-11
Worthing	**336**	**361**	373*
Southlands	**19**	**54**	-
St Richard's	**210**	**256**	257
Total	**565**	**671**	630

* Figures were collected together for Worthing & Southlands prior to October 2010

Figure 3: Top 5 enquiries (PALS & complaints) received by category

	2012-13	2011-12	2010-11
Clinical treatment	**791**	**709**	522
Appointments	**605**	**561**	387
Communication	**789**	**510**	409
Admissions, discharges, transfers		**163**	192
Attitude of staff	**183**	**159**	-
Date of admission	**285**	-	79

Figure 4: Formal complaints referred to the Parliamentary Health Service Ombudsman (PHSO)

	2012-13	2011-12	2010-11
Declined	**9**	**12**	6
Further local resolution taken	**3**	**-**	3
Complaint upheld	**-**	**-**	5
Decision awaited	**5**	**3**	-
Total	**17**	**15**	14

Figure 5: Number of upheld formal complaints

	2012-13
Upheld	**159**
Partially upheld	**229**
Not upheld	**168**
Total	**565**

Figure 6: National Benchmark

Point of delivery	Complaints Average for last 12 months	Complaints National	PALS Average for last 12 months	PALS National
Inpatients (per 1000 admits)	**2.16**	**2.26**	5.28	No benchmark
Outpatients (per 10,000 OP attends)	**8.32**	**13.50**	37.29	
A&E (per 10,000 A&E attends)	**5.76**	**4.36**	11.83	

***** excludes DNAs and cancellations in outpatients

* includes day cases for inpatients

CONCLUSION

The Department of Health collect annual data regarding written hospital and community health services complaints received by the NHS each year. Activity for Western Sussex Hospitals NHS Trust in relation to complaints is in line with other acute Trusts of a similar size and the above national benchmark data confirms that the trust scores below the national average in most areas.

The recent Francis report identified failings in the services provided and complaints processes within the Mid Staffordshire NHS Foundation Trust. The report's recommendations focused on a key suite of recommendations relating to the role of complaints, the investigation process and organisational learning. The trust's own review of its current position in relation to the report identified that in the majority of the recommendations and criterion the trust is compliant. However the trust is never complacent as an organisation and always striving to improve patient care through receiving and listening to complaints.

In response to the Francis Inquiry, the government launched a review into complaints procedures throughout the NHS, headed by Ann Clwyd MP and Professor Tricia Hart, Chief Executive of South Tees Hospitals NHS Foundation Trust. Additionally, the Patient's Association report into complaints handling identified ten criteria against which the trust should assess their current complaints processes.

The significant areas which require improvement with regard to the recommendations and criteria are the formal process for initiating external review combined with a review of training regarding the complaints process. During the year the trust's complaints policy was reviewed and audited by two external assessors. The trust achieved level 2 compliance with the NHS Litigation Authority standard regarding complaints and South Coast Audit gave significant assurance regarding the process. However, over the coming year the trust will concentrate on putting systems in place to measure and audit improvements as a result of complaints and ensure that the trust is working towards meeting the Francis Inquiry recommendations.

RECOMMENDATIONS

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

Tracey Nevell
Customer Relations Manager
July 2013

WESTERN HOSPITALS NHS FOUNDATION TRUST

To: Trust Board

Date of Meeting: 1st August 2013 **Agenda Item: 9**

Title
Month 3, 2013/14 Performance Report
Responsible Executive Director
Jane Farrell, Chief Operating Officer/Deputy Chief Executive
Prepared by
Adam Creeggan, Director of Performance Giles Frost, Head of Operational Planning and Performance
Status
Public Domain
Summary of Proposal
The purpose of this paper is to inform the Trust Board of 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 Trust, as detailed in dedicated performance scorecards relating to Quality Board indicators aligned to the Quality Strategy, the Monitor Compliance Framework, and when relevant, other efficiency indicators. This paper describes performance on an exceptional basis determined by RAG rating, national 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
Communication and Consultation
Not applicable
Appendices
Appendix 1: Key Performance Deliverables, Operational Performance Scorecard, TDA Performance Framework Scorecard and Monitor Compliance Framework Scorecard.

To:	Trust Board	Date: 1st August 2013
From:	Jane Farrell, Chief Operating Officer, Deputy Chief Executive	**Agenda Item: 9**
FOR INFORMATION		

WSHT PERFORMANCE REPORT: MONTH 3, 2013/14

1. INTRODUCTION

1.1 This report summarises both in year and projected year end performance for Western Sussex Hospitals NHS Trust, detailed in dedicated performance scorecards relating to:

- The Monitor Compliance Framework, under which the Trust is performance managed following authorisation as a Foundation Trust July 1st 2013.
- Other efficiency indicators, where relevant.

1.2 This paper describes performance on an exceptional basis determined by RAG rating, national significance, or in year trend analysis.

1.3 In addition to the performance exception narrative, each exception is examined in detail in the Key Performance Deliverables section of this report. Each metric under review examines detailed trending, prevailing cause and effect, and summarises recovery programme actions.

2. SUMMARY PERFORMANCE

4.4.1 The Trust generated a notional Monitor Compliance Framework score of 1 point cumulatively to June, relating to C.difficile variance to trajectory. Compliance against this metric is covered in detail in the Quality Report. Board members are reminded that the Compliance Framework is assessed on an aggregated quarterly basis. At the time of writing the Trust is in line with the in-month trajectory for July, however, the Quarter 2 cumulative performance will breach the cumulative plan for Quarter 2.

2.1 Key indicators of operational pressure during June include:

- 11,445 A&E attendances compared to 11,528 in June 2012 (-0.7%).
- 3667 emergency admissions compared to 4067 in June 2012 (-9.8%)
- When scrutinised by age group: there was a 12.6% decrease in <65 years, a 11.1% decrease in 65-84 years and a 0.4% increase in >=85 years June 2013 compared to June 2012.
- 135 elective waiting list admissions per working day in June 2013 compared to 137.6 in June 2012 (-1.9%)
- Bed occupancy during June was 89.0%.
- Delayed transfers of care were 3.2% for June.
- Referrals from all sources were 767 per working day in June 2013 compared to 800 in June 2012 (-4.2%). In the same period, there were 642 new outpatient attendances per working day June 2013 compared to 618 in June 2012 (+4.0%).

3. PERFORMANCE EXCEPTIONS

3.1 A&E

3.1.1 Compliance in June was 97.01% of patients waiting less than four hours from arrival at A&E to admission, transfer, or discharge.

3.1.2 For context and comparison, weekly national data for the period 2nd - 28th June relating to Type 1 (Major A&E) departments, shows compliance of 95.38%, therefore WSHT operated 1.63% ahead of the national average during the month. Compliance for Surrey and Sussex Area providers (excluding WSHT) for the same period showed 96.76% for Type 1 A&E attendances, with WSHT being the third highest performer within the sector.

3.2 Cancer

3.2.1 The Trust achieved compliance across six of seven cancer metrics for the month of June 2013 in isolation, but was fully compliant in all seven metrics for Quarter 1 in aggregate, as per national compliance requirements.

3.2.2 The Trust was provisionally non-compliant in June against the 62 days from referral to treatment target for urgent GP referrals, with performance of 84.5% against a compliance target of 85%.

3.2.3 The Monitor Compliance Framework assess compliance on an aggregated basis for each financial quarter; however provisional compliance is reported to the Trust Board monthly to

ensure visibility of delivery relative to the quarterly compliance requirement. The Board should also note that as the performance is reported quarterly, performance is subject to minor changes retrospectively up to the point of the quarterly reporting submission.

3.3 Referral to Treatment (18 Weeks)

3.3.1 The Trust maintained full compliance against both admitted and non admitted aggregate RTT pathway targets in June with reported positions of 90.11% (2433 of 2700 completed pathways) and 96.90% (5728 of 5911 completed pathways) respectively. The Trust also delivered full compliance against the requirement of >92% aggregate compliance for incomplete pathways with 94.43% reported for the month (23,581 of 24,971 patients waiting). Compliance against these aggregate metrics fully meets all RTT elements of the Monitor Compliance Framework.

3.3.2 The Trust was also compliant in June against the maximum waiting time for diagnostic tests in which no greater than 1% of diagnostic patients wait greater than 6 weeks for their test, with the Trust achieving 0.57% for the month (30 patients of 5230 patients waiting).

3.3.3 In terms of RTT specialty level compliance, the Trust has reduced to just 3 non-compliant specialty lines in June. This comprised of two non-compliant specialties for incomplete pathways (Orthopaedics which improved to 85.3%, and Cardiology 87.9%). There was also one non-compliant admitted specialty in June (T&O 68.9%)

3.3.4 The non-compliant incomplete specialty line is a direct consequence of the structured reduction of the admitted backlog. Since the introduction of Board approved recovery actions in January 2013, the backlog has been reduced as per plan to 482 cases at the end of June from a peak of 1088 cases. As at the point of writing the backlog had fallen to 426 patients. Within this Trust aggregate, the orthopaedic admitted backlog has reduced to 249.

3.3.5 From 1st April 2013 patients waiting longer than 52 weeks became a national never event. The Month 3 Unify2 RTT return for WSHT shows no patients in excess of 52 weeks, and all admitted patients that could theoretically become long waiters up to the end of August are dated.

3.3.6 Despite the positive reduction in patients waiting for admission, sustained in year specialty level compliance is becoming challenged by greater than planned referral demand. While June 2013 saw comparatively fewer referrals than the same month of 2012, the cumulative position for Quarter 1 significantly exceeds plan in a number of challenged RTT specialty areas:

- Total referrals from all sources are up by 4.2% on plan

- Total referrals from A&E are up by 7.4% on plan (predominately orthopaedic trauma)
- Total referrals from GPs and MSK are up by 3.9% on plan
- GP/MSK referrals to Orthopaedics are up 24.4% on plan
- A&E referrals to Orthopaedics (trauma) are up 6.1% on plan
- GP referrals to Ophthalmology are up 15.1% on plan
- GP referrals to Respiratory Medicine are up 44.2% on plan
- GP referrals to Dermatology remain unchanged, contrary to 65% reduction in CWSCCG QIPP plans for 2013/14

3.3.7 Increased referral pressure places significant pressure on the Trust ability to meet both RTT and cancer pathway commitment', and concerns regarding the observed variances have been formerly escalated to CWS CCG in the Single Performance Conversation meeting. In response, CWSCCG have provided outline agreement to allow continued access to additional independent sector capacity while the formal utilisation review process laid out in the National Contract is undertaken.

3.4 Fractured Neck of Femur (#NOF) operation within 36 hours of admission.

3.4.1 During June 98.84% of medically fit Fractured Neck of Femur patients were operated on within 36 hours of admission against a target of 90%.

3.5 Stoke Care

3.5.1 Both time spent on an acute stroke unit (metric O24) and higher risk TIA patients seen within 24 hours (metric O25) were fully compliant in the most recent month of available data.

3.5.2 While the most recent months confirm the sustained compliance in place throughout the past 12 months, the 2012 SSNAP Audit identified a number of areas of action with relation to Stroke services. In response the Medicine is currently producing a detailed action programme, based on a number of key interventions:

- In response to the lack of 7day specialised ward rounds, the Division is undertaking an appraisal of centralised service provision, and will incorporate options appraisal and impact assessment to wider corporate proposals for provision of 7 day working in emergency services.
- Similar assessments for 7 day therapy and psychology service support are also being undertaken.
- In response to early supported discharge the Division are undertaking a prospective audit of the percentage of patients who could have been discharged with ESD, and

the probable bed opportunity. This is seen as essential in engaging commissioners in the development of a community ESD service.

- TIA was identified as an area of concern, linked to specific capacity constraints on the St. Richards site. With the exception of April 2013 which missed the 60% requirement by 0.2%, full aggregate compliance has been achieved consistently since June 2012.
- To improve the follow up of results from national audits, the Trust has received provisional approval from the Kent, Surrey, Sussex Deanery for a Trust Stroke Fellow. The Medicine Division are in the process of providing evidence of internal funding to progress.
- Stroke service remains a standing item of monthly divisional Elderly Care performance and planning meetings, and regularly review the Real Time Patient Experience survey conducted routinely on stoke units, and outcomes of Friends and Family monitoring.

4 RECOMMENDATION

4.1 The Board is asked to receive and note the notional score of 1 point against the Monitor Compliance Framework cumulatively to the end of June.

Adam Creeggan, Director of Performance
Giles Frost, Head of Operational Planning and Performance

24th July 2013

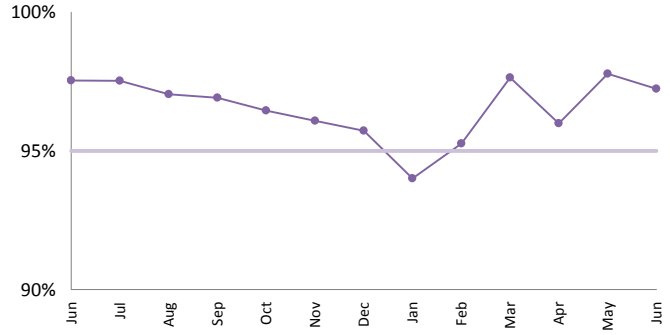
Mark Dennis, Head of Information Services
t: 01903 285273 (ext 5273)

Key Performance Deliverables Report

JUNE 2013

A&E 4-hour waiting time target

Target	Month	YTD	Projected O/T
95%	97.24%	97.01%	>95%



Description / Comments / Actions

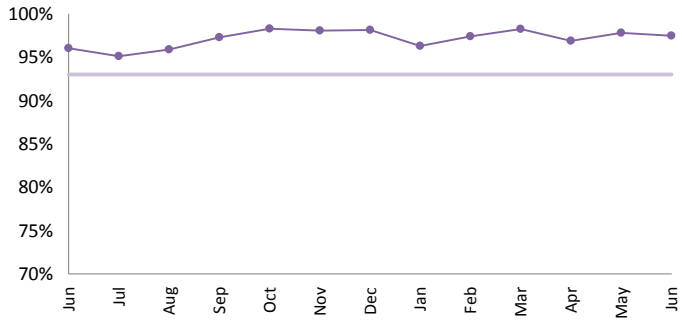
Patients can expect to be admitted, tranfered or discharged in 4 hours from arrival in A&E

Significant increase in crude demand and underlying acuity observed in 2012/13.

Actions:
1. Enhanced discharge planning arrangements
2. Augmented patient flow arrangements in conjunction with external partners
3. Dedicated operational delivery plan in place 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%	97.47%	97.41%	>93%



Description / Comments / Actions

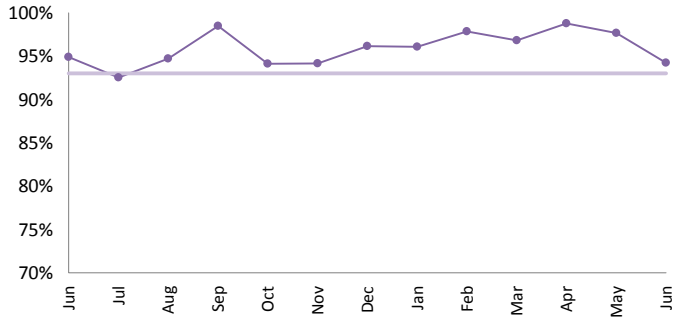
Patients can expect to be seen within 2 weeks following an urgent GP referral for suspected cancer. This target is part of the NHS and Monitor performance frameworks for 2011/12.

Significant increases in demand level observed in 2012/13.

Actions:
1. Dedicated weekly action focused delivery meeting under the leadership of the Chief Operating Officer
2. Mitigation actions agreed with health partners including enhanced advice and guidance for GP's from WSHT consultant staff prior to referral, improved feedback mechanism for GP on appropirateness of referral, and real time access to referral data by GP practice, conversion to a cancer pathways and volumes recieving definative treatment for malignancy.

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

Target	Month	YTD	Projected O/T
93%	94.24%	97.05%	>93%



Description / Comments / Actions

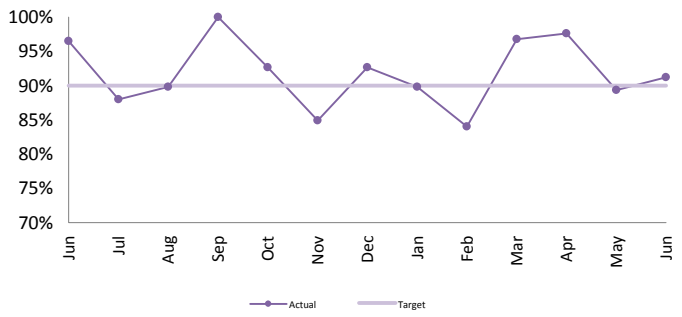
Patients with breast symptoms can expect to be seen within 2 weeks following an urgent GP referral.

Increase in demand level, and heightened rate of patients exercising choice to wait beyond 14 day maximum.

Actions:
1. Dedicated weekly action focused delivery meeting under the leadership of the Chief Operating Officer
2. Mitigation actions agreed with health partners including enhanced advice and guidance for GP's from WSHT consultant staff prior to referral, improved feedback mechanism for GP on appropirateness of referral, and real time access to referral data by GP practice, conversion to a cancer pathways and volumes recieving definative treatment for malignancy.

Cancer - 62 days from referral to treatment following screening contact

Target	Month	YTD	Projected O/T
90%	91.23%	92.47%	>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. Transitional leadership for MDT/tracking passed to GM - Access.
2. Augmented pathway management/tracking with enhanced oversight through DCS led Cancer Delivery Group
3. Close working with the screening service to maximise the time available to the Trust to secure capacity
4. Dedicated weekly action focused delivery meeting under the leadership of the Chief Operating Officer

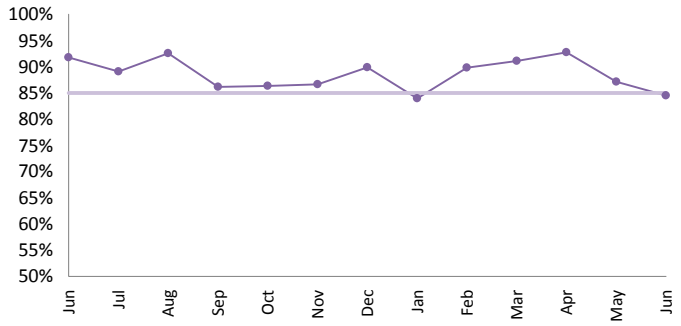
Mark Dennis, Head of Information Services
t: 01903 285273 (ext 5273)

Key Performance Deliverables Report

JUNE 2013

Cancer - 62 days from referral to treatment for all cancers.

Target	Month	YTD	Projected O/T
85%	84.47%	88.01%	>85%



Description / Comments / Actions

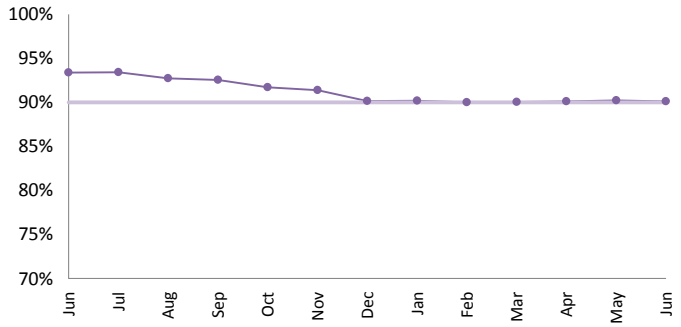
Patients with cancer can expect to commence treatment within 62 days following urgent referral by a GP.

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

Actions:
1. Transitional leadership for MDT/tracking passed to GM - Access.
2. Augmented pathway management/tracking with enhanced oversight through DCS led Cancer Delivery Group
3. Close working with the screening service to maximise the time available to the Trust to secure capacity
4. Dedicated weekly action focused delivery meeting under the leadership of the Chief Operating Officer

Referral to treatment - Admitted patients

Target	Month	YTD	Projected O/T
90.0%	90.11%	90.15%	> 90%



Description / Comments / Actions

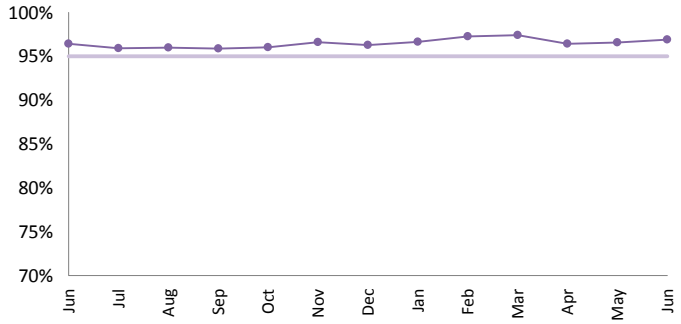
All patients can expect to commence treatment within 18 weeks of a referral to consultant. This standard continues to be monitored within the 2011/12 NHS Performance Framework.

An imbalance of demand and capacity has resulted in an increase in the backlog of patients waiting over 18 weeks. Detailed recovery options submitted to SECSHA, NHS Sussex and CWS CCG.

Actions:
1. Short term increase in internal capacity
2. Additional capacity commissioned by CWSCCG in private sector
3. Further mitigation actions agreed with health partners including further roll of of enhanced triage
4. Dedicated weekly action focused delivery meeting under the leadership of the Chief Operating Office

Referral to treatment - Non Admitted patients

Target	Month	YTD	Projected O/T
95.00%	96.90%	96.63%	> 95%



Description / Comments / Actions

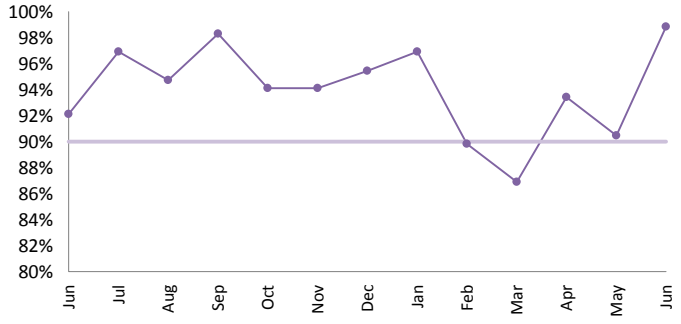
All patients can expect to commence treatment within 18 weeks of a referral to consultant. This standard continues to be monitored within the 2011/12 NHS Performance Framework.

An imbalance of demand and capacity has resulted in an increase in the backlog of patients waiting over 18 weeks. Detailed recovery options submitted to SECSHA, NHS Sussex and CWS CCG.

Actions:
1. Short term increase in internal capacity
2. Launch of Triage + to enhance orthopaedic referral routing to appropriate treatment options in LHE
3. Further mitigation actions agreed 14 August 2012 with health partners including further roll of of enhanced triage options in Colorectal Surgery, Gastroenterology and Upper GI surgery.
4. Dedicated weekly action focused delivery meeting under the leadership of the Chief Operating Office

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

Target	Month	YTD	Projected O/T
90%	98.84%	94.67%	>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' payment process under PbR.

Increased levels of demand have impacted sustained compliance. Mitigating actions implemented by the Surgical Division have significantly improved performance.

Actions:
1. 60% increase in trauma capacity to mitigate demand pressure.
2. Improved tracking and escalation processes in place to manage fluctuations in demand on daily basis
3. Dedicated weekly action focused delivery meeting under the leadership of the Chief Operating Officer

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

OPERATIONAL PERFORMANCE SCORECARD

JUNE 2013

		NB	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	2013/14 YTD	2013/14 Target	FOT	Trend
PATIENT EXPERIENCE																			
O01	A&E : Four-hour maximum wait from arrival to admission, transfer or discharge		97.54%	97.53%	97.04%	96.91%	96.45%	96.08%	95.73%	94.00%	95.26%	97.65%	95.99%	97.78%	97.24%	97.01%	95%	>95%	
O02	Cancer: 2 week GP referral to 1st outpatient	1	96.05%	95.13%	95.90%	97.31%	98.31%	98.09%	98.15%	96.30%	97.41%	98.25%	96.89%	97.83%	97.47%	97.41%	93%	>93%	
O03	Cancer: 2 week GP referral to 1st outpatient - breast symptoms	1	94.89%	92.55%	94.71%	98.48%	94.12%	94.15%	96.15%	96.08%	97.84%	96.84%	98.77%	97.69%	94.24%	97.05%	93%	>93%	
O04	Cancer: 31 day second or subsequent treatment - surgery	1	93.94%	92.59%	100.0%	97.67%	95.45%	100.0%	97.14%	100.0%	100.0%	93.8%	100.0%	100.0%	96.97%	98.85%	94%	>94%	
O05	Cancer: 31 day second or subsequent treatment - drug	1	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%	100.00%	98%	100%	
O06	Cancer: 31 day diagnosis to treatment for all cancers	1	97.38%	98.30%	99.14%	97.14%	99.57%	98.58%	99.16%	99.10%	97.75%	99.43%	99.48%	100.0%	100.0%	99.84%	96%	>96%	
O07	Cancer: 62 day referral to treatment from screening	1	96.49%	88.00%	89.80%	100.0%	92.68%	84.91%	92.68%	89.80%	84.00%	96.77%	97.62%	89.36%	91.23%	92.47%	90%	>90%	
O08	Cancer: 62 day referral to treatment from hospital specialist	1	89.47%	88.46%	100.0%	100.0%	88.89%	96.43%	93.18%	74.19%	76.00%	85.71%	77.78%	80.00%	80.77%	79.41%	N/A	>85%	
O09	Cancer: 62 days urgent GP referral to treatment of all cancers	1	91.75%	89.08%	92.53%	86.12%	86.35%	86.61%	89.86%	83.94%	89.81%	91.11%	92.73%	87.13%	84.47%	88.01%	85%	>85%	
O10	Number of complaints relating to staff attitude or behaviour/10,000 admissions		5.03	6.80	0.97	8.13	3.74	3.95	4.16	4.02	5.45	7.35	6.21	6.08	4.23	5.52			
O11	Number of nursing complaints per 10,000 bed days		2.75	1.55	1.19	0.80	0.00	1.15	0.38	1.07	1.16	2.26	1.12	0.38	1.65	1.04	4.35		
O12	RTT - Admitted - 90% in 18 weeks		93.38%	93.43%	92.73%	92.56%	91.72%	91.37%	90.13%	90.19%	90.01%	90.04%	90.11%	90.22%	90.11%	90.15%	90%	>90%	
O13	RTT - Non-admitted - 95% in 18 weeks		96.43%	95.92%	96.00%	95.87%	96.03%	96.61%	96.28%	96.64%	97.28%	97.40%	96.43%	96.56%	96.90%	96.63%	95%	>95%	
O14	RTT - Incomplete - 92% in 18 weeks		92.16%	92.23%	92.48%	92.29%	92.59%	92.72%	92.10%	92.27%	92.17%	92.91%	93.69%	94.34%	94.43%	94.16%	92%	>92%	
O15	RTT delivery in all specialties		10	10	8	12	14	12	9	9	9	6	4	5	3	4	0	0	
O16	Diagnostic Test Waiting Times		0.70%	0.14%	0.35%	0.04%	0.10%	0.17%	0.31%	0.22%	0.09%	0.39%	0.16%	0.86%	0.57%	0.54%	<1%	<1%	
O17	Cancelled operations re-booked within 28 days		0	1	1	1	1	1	2	1	6	1	4	2	0	2	-		
O18	Urgent operations cancelled for the second time		0	0	0	0	0	0	0	0	0	0	0	0	0	0	-		
O19	Mixed Sex Accommodation breaches		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
OUTCOMES																			
O20	Crude mortality (Trust-wide) rate		2.82%	2.58%	2.93%	2.88%	3.01%	3.01%	3.49%	4.13%	3.69%	4.10%	3.76%	3.18%	2.83%	3.26%	3.24%	3.29%	
O21	HSMR (Trust-wide)		102.7	101.9	101.7	101.0	99.7	99.2	98.4	96.7	94.5	95.0	93.9			93.9	100	<100	
O22	SMR #NOF		125.3	119.9	120.9	123.4	117.9	116.3	118.5	117.8	121.4	116.4	121.0			121.0	100	<100	
O23	% hip fracture repair within 36 hours		92.1%	96.9%	94.7%	98.3%	94.1%	94.1%	95.5%	96.9%	89.8%	86.9%	93.4%	90.5%	98.8%	94.7%	90%	>90%	
O24	Patients that have spent more than 90% of their stay in hospital on a stroke unit+	1	85.5%	82.1%	85.5%	88.1%	84.4%	86.8%	87.0%	87.9%	79.3%	78.3%	78.2%	81.7%		79.9%	80%	>80%	
O25	% Higher risk TIA patients scanned & treated within 24 hrs+	1	81.0%	70.4%	83.3%	68.8%	73.9%	76.5%	77.8%	68.4%	85.7%	70.0%	58.8%	75.0%	80.0%	70.2%	60.0%	>60%	
O26	30 day emergency readmissions		12.3%	12.4%	11.3%	12.8%	12.0%	13.5%	11.2%	12.3%	12.6%	11.9%	11.7%	11.3%	12.4%	11.9%	12.2%		

Mark Dennis, Head of Information Services
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OPERATIONAL PERFORMANCE SCORECARD

JUNE 2013

			Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	2013/14 YTD	2013/14 Target	FOT	Trend
SAFETY																			
O27	Number of reported patient falls per 10,000 bed days		16.90	12.44	16.62	12.82	13.28	16.09	14.01	18.89	13.90	17.30	17.87	11.12	14.87	14.65	15.41	< 12/13 baseline	
O28	Incidence of C Diff.		8	3	4	3	10	7	4	5	4	9	13	5	7	25	75	75	
O29	Incidence of MRSA		0	0	0	0	0	0	0	0	1	0	0	0	0	0	2	<2	
O30	Number of prescribing-associated incidents graded moderate or severe		0	1	0	0	0	0	1	1	0	0	0	2	1	3	8	<8	
O31	Pressure Ulcer Incidence per 1000 occupied bed days		0.24	0.35	0.20	0.36	0.51	0.34	0.57	0.43	0.23	0.49	0.45	0.35	0.29	0.36	0.36	<0.36	
O32	% inpatients assessed for VTE risk using national tool	2	92.47%	93.10%	92.71%	93.09%	93.45%	94.70%	93.40%	95.03%	95.00%	94.01%	94.40%	95.23%	95.60%	95.02%	95%	>90%	
BEING JOINED UP																			
O33	Delayed transfers of care	2	3.2%	2.7%	2.4%	2.5%	1.9%	2.2%	2.8%	3.1%	2.7%	3.4%	3.9%	3.7%	3.2%	3.6%	3.5%	<3.5%	
O34	Number of Emergency admissions		4,067	4,218	4,186	4,014	4,171	3,931	4,094	4,002	3,638	4,005	3,863	3,876	0	7,739	<12/13	<11/12	
IMPROVEMENT																			
O35	Theatre Utilisation			80.2%	83.6%	80.6%	80.8%	81.6%	76.6%	0.0%	77.8%	73.3%	77.0%	77.5%	78.6%	77.73%	tbc		
O36	Average length of stay - Elective		3.17	3.33	3.37	3.10	3.36	3.12	3.49	3.28	3.03	3.43	3.04	3.27	3.16	3.16	3.72	3.6	
O37	Average length of stay - Non-elective Surgery		4.95	4.80	4.98	5.07	6.14	5.44	5.43	5.48	5.77	5.03	5.22	5.58	5.21	5.35	6.07	6.0	
O38	Average length of stay - Non-elective Medicine		7.28	7.20	7.10	7.13	7.11	7.66	7.50	7.92	8.01	7.87	8.02	8.01	7.90	7.98	7.80	7.8	
O39	Day case surgery rate (BADS Directory source: Dr Foster)	4	81.03%	79.81%	80.93%	80.39%	81.97%	82.49%	82.29%	84.10%	82.13%	81.85%	82.49%			82.49%	75.0%	80%	
O40	Elective day of surgery rate (DOSR)		97.2%	95.3%	95.7%	94.7%	94.8%	95.9%	95.7%	95.6%	95.4%	96.4%	96.1%	96.5%	97.1%	96.5%	90.0%	95%	
O41	Did not attend rate (outpatients)		7.01%	6.43%	6.28%	6.21%	6.21%	5.80%	6.14%	6.71%	6.26%	6.89%	6.25%	6.39%	6.31%	6.29%	7.65%	6.0%	
O42	HSCIC Data validity summary (YTD)		-	-	-	-	-	97.5	97.5	97.5	97.5	97.2				97.2	96.0	97.0	
SUSTAINABILITY																			
O43	Bank staff - % of all staff pay		-	-	-	-	-	-	-	-	-	-	6.93%	4.54%	4.78%	0.00%	7%		
O44	Agency staff - % of all staff pay		-	-	-	-	-	-	-	-	-	-	2.70%	3.96%	3.84%	0.00%	2%		
O45	Nurse:bed ratio		1.6366	1.6191	1.6275	1.6212	1.627	1.6139	1.5837	1.5846							-		
O46	% nurses registered nurses		-	-	-	-	-	-	-	-	-	-	73.80%	73.93%	74.15%	73.95%	-		
O47	% Staff appraised		84.70%	87.80%	89.00%	88.10%	85.50%	86.06%	86.53%	87.42%	87.79%	85.14%	84.90%	86.70%	85.00%	85.00%	95%		
O48	Sickness Absence: % Sickness (reported one month in arrears)	3	3.22%	3.37%	3.17%	3.02%	3.80%	4.33%	4.18%	4.06%	3.70%	3.5%	3.64%	3.46%		3.63%	3.3%		
O49	Board Turnover		-	-	-	-	-	-	-	-	-	-	0.00%	0.00%	0.00%	0.00%	0%		
O50	Staff Turnover: Turnover rate (YTD position)		8.66%	8.66%	8.86%	8.79%	8.82%	8.74%	8.92%	8.80%	8.57%	8.54%	8.63%	8.48%	8.10%	8.10%	11%		

Notes

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OPERATIONAL PERFORMANCE SCORECARD

JUNE 2013

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	2013/14 YTD	2013/14 Target	FOT	Trend

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 Data for April - December has been compiled from the new Dr Foster PPM module.

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Monitor Compliance Framework

JUNE 2013

		Threshold	Apr	May	Jun	Q1	Weighted Score	Jul	Aug	Sep	Q2	Weighted Score	Oct	Nov	Dec	Q3	Weighted Score	Jan	Feb	Mar	Q4	Weighted Score
ACCESS																						
M1	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90%	90.11%	90.22%	90.11%	**90.11%**	0.0															
M2	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95%	96.43%	96.56%	96.90%	**96.43%**	0.0															
M3	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	93.69%	94.34%	94.43%	**93.69%**	0.0															
M4	Diagnostic waits	99%	99.84%	99.14%	99.43%	**99.84%**	0.0															
M5	A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	95.99%	97.78%	97.24%	**97.01%**	0.0															
M6a	All cancers : 62-day wait for first treatment following urgent GP Referral	85%	92.73%	87.13%	84.47%	**88.01%**	0.0															
M6b	All cancers : 62-day wait for first treatment following consultant screening service referral	90%	97.62%	89.36%	91.23%	**92.47%**																
M7a	All cancers : 31-day wait for second or subsequent treatment - surgery treatments	94%	100.00%	100.00%	96.97%	**98.85%**	0.0															
M7b	All cancers : 31-day wait for second or subsequent treatment - drug treatments	98%	100.00%	100.00%	100.00%	**100.00%**																
M8	All cancers : 31-day wait from diagnosis to first treatment	96%	99.48%	100.00%	100.00%	**99.84%**	0.0															
M9a	Cancer : two week wait from referral to date first seen - All patients	93%	96.89%	97.83%	97.47%	**97.41%**	0.0															
M9b	Cancer : two week wait from referral to date first seen - Symptomatic breast patients	93%	98.77%	97.69%	94.24%	**97.05%**																
OUTCOMES																						
M17	Clostridium Difficile – meeting the Clostridium Difficile objective	46	13	5	7	**25**	1.0															
M18	MRSA – meeting the MRSA objective	0	0	0	0	**0**	0.0															
M27	Certification against compliance with requirements re access to healthcare for people with a learning disability	YES	YES	YES	YES	**YES**	0.0															
Monitor Compliance Framework Score							1.0															

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

Risk Assessment Indicators (outcome of consultation)																						
M19	30 Day readmissions %	tbc	11.7%	11.3%	12.4%	**11.9%**																
M20	Incidence of newly acquired pressure ulcers	tbc	12	9	0	**21**																
M21	Medication errors causing serious harm	tbc	0	2	1	**3**																
M22	Admission of term babies to neonatal care	tbc	2.5%	2.2%	3.3%	**2.7%**																
M23	Incidence of health care-related venous thromboembolism	tbc	33	34	24	**91**																

WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST

To: Board

Date of Meeting: 1st August 2013 Agenda Item: 10

Title:
Report on Organisational Development and Workforce performance
Responsible Executive Director
Denise Farmer, Director of OD and Leadership
Prepared by
Jennie Shore, Deputy Director of HR
Status
Disclosable
Summary of Proposal
The report describes the organisations performance against the delivery of the Workforce and OD strategies It highlights key activities in month in relation to organisation and workforce development issues and provides data related to HR matters at Trust and Divisional level It includes a report on progress against the key priorities identified in the 2012 National Staff Survey
Implications for Quality of Care
Supports the delivery and sustainability of safe, high quality care through investment in the development of the workforce
Financial Implications
Supports good financial performance
Human Resource Implications
As described
Recommendation
The Board is asked to NOTE the report
Consultation
N/A
Appendices
Workforce data report 2012 National Staff survey update

This report can be made available in other formats and in other languages. To discuss your requirements please contact Ann Merricks, Interim Company Secretary, on ann.merricks@wsht.nhs.uk or 01903 285288.

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board Date: July 2013

From: Denise Farmer, Director of Organisational Development and Leadership Agenda Item: XXX

FOR INFORMATION

ORGANISATIONAL DEVELOPMENT AND WORKFORCE REPORT

1.00 INTRODUCTION

1.01 This report sets out the key OD and workforce issues at 30 June 2013.

2.00 SUMMARY OF PROPOSAL

2.01 Recruitment activity across the Trust remains high and efforts to fill vacancies not filled by KSS Deanery as part of the changeover of over 300 doctors from August continues to remain a priority. Controls to mitigate the risks are being put in place and actions include the use of temporary staff, switching rotations and extending contracts for those yet to secure another post.

A proposal to increase the pay rate for the internal bank of medical staff has been developed as an incentive for staff to cover vacant shifts. The rates have been benchmarked against external locum agencies and it is hoped that this will be attractive to staff particularly during the changeover period.

2.02 Events celebrating the Trust's achievements, culminating in us being licensed as a foundation trust, have taken place during July with staff BBQs held across the three sites. These have been very well received with hundreds of staff attending.

2.03 Preparation for the Trust's annual education event is underway. This year's theme is How We Care … Delivering excellent customer care for patients and staff. The main conference, taking place on Tuesday 17 September, will include key note speakers, presentations and workshops with a 'fringe' programme being held at St Richard's and Worthing hospitals on Wednesday 18 September.

2.05 A proposal in support of the Trust's Health and Wellbeing strategy has been approved by the Trust's Charitable Funds Committee. This includes specific interventions to address and reduce stress and muscular-skeletal disorders.

2.06 Workforce information reports have been enhanced further this month and include the extension of the Real-Time Staff Feedback at all health and safety days and collection of data by Division, and a breakdown of absence to include sickness attributed to stress and muscular skeletal disorders in order to enable us to monitor key elements of our Health and Wellbeing strategy.

2.07 Professor William Roche has been appointed as the interim Medical Director from 1 July until a substantive appointment is made. This follows the resignation of Dr Phillip Barnes who joins Medway NHS Trust at the end of August.

Anne Merricks also joined us as the interim Company Secretary at the beginning of July following the departure of Graham Lawrence to a new role outside of the NHS.

2.08 At the end of June, nine doctors, for whom we are the designated body, were recommended for revalidation with the GMC, with two deferrals. This is against 86 doctors who are due to be revalidated in 2013/14.

2.09 An update on the progress of the 2012 Staff Survey results is attached as a separate report to the Board. Preparation for the 2013 survey is anticipated to commence again in late September.

3.00 RECOMMENDATION

The Board is asked to NOTE this paper

4.00 WORKFORCE CAPACITY

4.01 Workforce capacity during June was 98% of establishment, with substantive staff accounting for 90% of overall capacity and temporary staff accounting for 8%. With the exception of the Medicine Division, demand for temporary staff in the last two months has been at is lowest since June 2012.

4.02 The use of agency staff overall fell to 1.6% although within the Medicine Division this was much higher at 3.6%.

5.00 WORKFORCE RESOURCING

5.01 Recruitment

As noted in section 2.01 recruitment activity has been high and this includes non-medical staff. During June, we successfully recruited 56 newly qualified nurses including 10 midwives. Paediatrics are currently making arrangements for interviews and selection. These new joiners are anticipated to start in early October when they complete their training.

A recent campaign at the RCN congress and in Civvy Street (a publication sent to all military staff in the UK) also attracted 216 candidates and arrangements to appoint are currently in progress. Divisions are now reviewing the number of remaining vacancies and determining their anticipated needs in preparation for the winter months.

There are currently 200 posts at pre-appointment stage, 382 candidates at pre-employment check stage. 122 new/internal staff have July start dates with a further 13 staff due to start in August.

The capacity of the recruitment team is currently compromised due to the continuing level of demand and unforeseen staff absences. Whilst actions to address this are being taken, including a review of the staffing levels required, the time to hire has increased.

5.03 Rostering

The team are currently implementing across the Women and Children's Division namely Maternity Integrated Services and SCUBU at St Richards, Maternity and Community Midwives Worthing. It is intended these areas will be live in September.

A demonstration is taking place 25th July to the Urology department with a view to implementing across Urology Medical staff.

Migration to version 10 of the software has been delayed until October 2013 due to resources needed for further, preparatory, data cleansing: it is anticipated this will be completed by the end of July. Steps have been taken to mitigate the efficiency impact on some users of the system.

6.00 WORKFORCE EFFICIENCY

6.01 At 8.1% turnover across the Trust remains below the ceiling of 11%. Within Core, the levels remain a concern particularly within Pharmacy, such that the service will be under significant pressure during September. The annual turnover of students employed in their final year pre-qualification (from October) has been higher than normal as students have secured employment elsewhere earlier. Coupled with some unexpected resignations in other grades, turnover has therefore been higher than anticipated.

6.02 Whilst sickness absence fell in month, the cumulative year to date remained at 3.6% against a ceiling of 3.3%.

The percentage of staff on long term sickness absence (i.e. more than one month) and those experiencing higher than average levels of stress or muscular-skeletal (MSK) conditions differs significantly by Division.

Stress is highest amongst the corporate division and correlates with a higher proportion of staff on long term sickness.

Within the Facilities and Estates Division, MSK accounts for 28% of all absence and a correlation of 60% of staff on long term sickness.

The “healthiest” Division in respect of its reported metrics is the Core Division, which has the lowest percentage of staff on long term sickness and staff off due to stress and MSK.

Targeted interventions noted in paragraph 2.05 above, therefore need to be focused within the Corporate and Facilities and Estates Divisions.

6.03 Appraisal rates at the end of June remained at 85%.

7.00 WORKFORCE SKILLS AND DEVELOPMENT

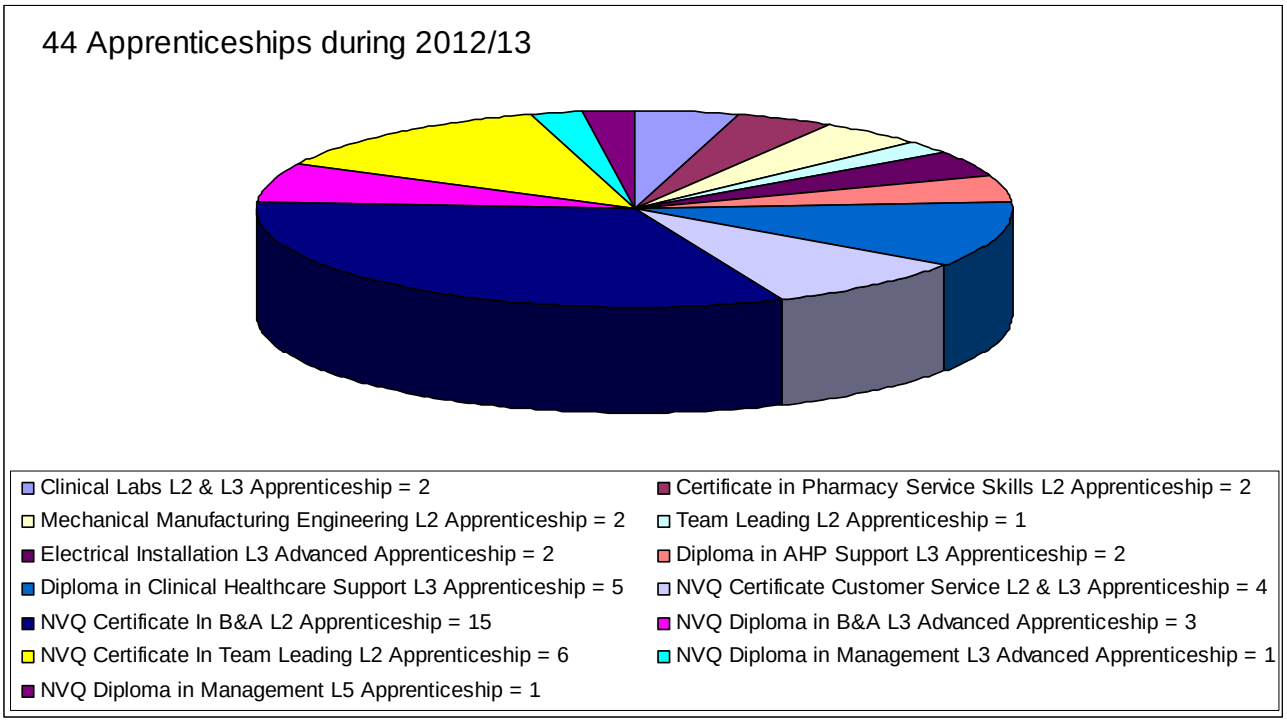
7.01 Mandatory and Statutory Training

Overall attendance on the five core Mandatory and Statutory training modules continues to increase.

Adult Protection, which has only been recently added to the Board reports, is currently at 75.0%. An action plan to increase the number of Adult Protection training sessions has now been implemented.

7.02 Widening Participation

During 2012-2013 there have been 44 apprenticeships in the Trust. Of the 44 staff members who undertook an apprenticeship, 11 were brand new staff coming into the Trust while the other 33 were existing staff who chose to undertake and complete an apprenticeship. Details of these are as follow:



The Trust's first Higher Apprentice is currently being advertised in HR and study will be undertaken as part of a professional qualification with the CIPD. This is an exciting development for the Trust and it is hoped will encourage further apprenticeships to be considered in the Trust.

8.0 COMMUNICATIONS, ENGAGEMENT AND FUNDRAISING

8.01 Proactive media releases this month included the promotion of a new app, designed to ensure our medical staff have instant access to information about the best, safest antibiotic drug to prescribe. Trust pharmacy staff worked with an app developer to produce the software, designed for use on mobile phones and tablets. This attracted widespread coverage.

As a result of media releases there was also coverage locally and on social media of the work staff in Women and Children's, had done with a group of young people. The youngsters from the West Sussex Youth Cabinet and the West Sussex Development Service were invited to visit Worthing Hospital's Bluefin Ward (Children's ward), Paediatric A&E and the Children's Centre and to give their views on what was good – and not so good – about the experience of children coming into the hospital for care. The youngsters praised the friendly and caring staff and made some suggestions for improvement including freshening up the décor and ensuring information is more readily available. This work is already underway.

8.02 Engagement with GPs and other clinical colleagues in the region has continued, in order to support the successful delivery of One Call One Team. The third update has now been sent to GPs, giving them easy access to performance data and other relevant news.

The Communications team, working with the Company Secretary and Membership Officer, staged the Annual Members Meeting on 17 July, at the Chichester Medical Education Centre. This was the first such event held by the Trust as a Foundation Trust, and included the required elements which used to be included in the Annual General Meeting, such as the formal acceptance of the accounts for the 2012/13 financial year. The event, which was attended by members of the public, Governors and staff included a review of the year from Chief Executive, Marianne Griffiths as well as a clinical presentation on the improvements in care for patients with a broken hip.

8.03 The number of followers of the Trust's Twitter feed continues to rise along with an increase in the number of 'likes' of the Trust's Facebook page.

WSHT WORKFORCE SCORECARD

JUNE 2013

Key performance Indicators			Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	2013/14 YTD	2013/14 Target/ Ceiling	Amber Limit	Trend
1) WORKFORCE CAPACITY		*NB*																	
WC-BF	Budgeted FTE		5994.5	5979.1	5979.7	5972.3	5965.6	5992.9	5989.6	5995.8	5995.8	5988.8	6038.0	6038.8	6041.6	**6039.5**	N/A	N/A	
WC-FU	Total FTE Used	1	5896.5	5968.5	5938.3	5915.0	5927.2	6003.7	6013.3	5954.9	6058.2	6052.7	6002.2	5880.5	5899.5	**5927.4**	N/A	N/A	
WC-VB	Total FTE Used Variance from Budget	1	-98.0	-10.6	-41.4	-57.2	-38.4	10.8	23.7	-40.9	62.4	63.9	-35.8	-158.3	-142.2	**N/A**	N/A	N/A	
WC-TV	Total FTE Used Vacancy Factor	1	1.6%	0.2%	0.7%	1.0%	0.6%	-0.2%	-0.4%	0.7%	-1.0%	-1.1%	0.6%	2.6%	2.4%	**1.9%**	N/A	N/A	
WC-SF	Substantive Contracted FTE		5377.6	5415.3	5369.5	5375.9	5374.3	5433.9	5416.7	5425.1	5448.1	5426.4	5434.2	5440.6	5442.0	**5438.9**	N/A	N/A	
WC-SV	Substantive FTE Used Vacancy Factor		10.3%	9.4%	10.2%	10.0%	9.9%	9.3%	9.6%	9.5%	9.1%	9.4%	10.0%	9.9%	9.9%	**9.9%**	N/A	N/A	
WC-BP	Bank Usage As % Of Total FTE Used	1	7.3%	7.6%	7.6%	7.6%	7.5%	7.5%	7.8%	6.8%	7.8%	8.2%	8.3%	5.5%	6.0%	**6.6%**	N/A	N/A	
WC-AP	Agency Usage As % Of Total FTE Used	1	1.5%	1.7%	2.0%	1.5%	1.9%	2.0%	2.1%	2.1%	2.3%	2.1%	1.2%	2.0%	1.7%	**1.6%**	N/A	N/A	
2) WORKFORCE EFFICIENCY		*NB*																	
WE-SA	In Month Sickness Absence %	2	3.3%	3.4%	3.2%	3.2%	3.8%	4.4%	4.2%	4.2%	3.9%	3.6%	3.8%	3.5%		**3.6%**	3.3%	3.3%	
WE-ML	In Month Maternity Leave %	2	2.6%	2.7%	2.7%	2.7%	2.8%	2.8%	2.7%	2.6%	2.6%	2.5%	2.4%	2.4%		**2.4%**	N/A	N/A	
WE-OA	In Month Other Absence %		0.9%	0.9%	0.7%	1.0%	1.1%	1.4%	0.8%	0.8%	1.0%	1.1%	1.1%	1.1%		**1.1%**	N/A	N/A	
WE-TA	In Month Total Absence %		6.8%	7.0%	6.7%	6.8%	7.7%	8.5%	7.7%	7.6%	7.4%	7.2%	7.3%	6.9%		**7.1%**	N/A	N/A	
WE-LT	% Total Sickness Days Lost Due To Long Term Sickness Absence (28 Days Or More)	2	57.9%	54.6%	55.3%	55.8%	52.6%	49.0%	47.5%	47.8%	48.4%	50.2%	51.4%	51.3%		**51.3%**	N/A	N/A	
WE-SR	% Of Total Sickness Attributed To Stress	2	15.9%	13.6%	14.6%	13.9%	13.3%	14.4%	13.3%	10.8%	13.4%	15.6%	15.7%	16.5%		**16.1%**	N/A	N/A	
WE-MS	% Of Total Sickness Attributed To Musculo Skeletal	2	19.8%	19.9%	22.0%	24.0%	22.4%	20.3%	18.1%	19.7%	18.7%	18.3%	16.4%	21.4%		**18.8%**	N/A	N/A	
WE-RT	Rolling 12 Month Turnover		8.7%	8.5%	8.9%	8.8%	8.8%	8.7%	8.9%	8.8%	8.6%	8.5%	8.6%	8.5%	8.1%	**N/A**	11.0%	11.0%	
3) TRAINING AND PERSONAL DEVELOPMENT		*NB*																	
TD-AP	% Appraisals Up To Date		84.7%	87.8%	89.0%	88.1%	85.5%	86.1%	86.5%	87.4%	87.8%	85.1%	84.9%	85.7%	85.0%	**N/A**	95.0%	85.0%	
TD-MP	% In Date - All Mandatory Training	3	72.8%	74.6%	76.0%	77.1%	75.1%	74.1%	76.8%	78.8%	77.7%	76.7%	79.8%	80.4%	82.2%	**N/A**	95.0%	85.0%	
TD-FP	% In Date - Fire		81.2%	81.3%	83.7%	83.6%	81.7%	82.1%	84.3%	85.5%	85.3%	86.0%	88.0%	87.8%	89.7%	**N/A**	95.0%	85.0%	
TD-IC	% In Date - Infection Control		83.0%	83.2%	86.5%	85.5%	84.1%	84.0%	85.8%	87.1%	86.8%	84.3%	86.4%	86.7%	88.3%	**N/A**	95.0%	85.0%	
TD-BT	% In Date - Role Specific Back Training		85.7%	85.4%	86.6%	86.9%	86.2%	85.0%	86.8%	87.5%	86.5%	90.1%	91.7%	91.9%	92.9%	**N/A**	95.0%	85.0%	
TD-CP	% In Date - Child Protection		92.0%	91.7%	94.0%	93.2%	93.5%	93.9%	94.8%	95.4%	95.2%	95.2%	95.6%	95.2%	96.1%	**N/A**	95.0%	85.0%	
TD-IG	% In Date - Information Governance		78.3%	79.2%	82.6%	81.7%	80.6%	81.0%	83.6%	85.1%	85.0%	85.7%	87.7%	87.5%	89.3%	**N/A**	95.0%	85.0%	
TD-AP	% In Date - Adult Protection	3											75.8%	76.1%	75.0%	**N/A**	95.0%	85.0%	
4) REAL-TIME STAFF FEEDBACK		*NB*																	
SF-TR	Total Respondents To Survey						88	85	85	59	39	52	58	68	127	**253**	N/A	N/A	
SF-Q1	% Respondents who would recommend this trust as a place to work	4					71.6%	43.5%	74.1%	72.9%	82.1%	82.7%	75.9%	76.5%	85.8%	**81.0%**	N/A	N/A	
SF-Q2	% Respondents happy with the standard of care provided by WSHT if a friend or relative needed treatment	4					70.5%	74.1%	75.3%	79.7%	79.5%	84.6%	75.9%	75.0%	81.1%	**78.3%**	N/A	N/A	

Notes

1 Bank FTE used figures are not available for April and May and been approximated as follows: Monthly Bank Spend / June Average Cost Per Bank FTE

2 Absence data is available one month in arrears

3 Adult Protection is not currently included in the criteria when determining whether an employee is up to date with their mandatory training

4 % of staff who responded "Agree" or "Strongly Agree" to the question

CORE WORKFORCE SCORECARD

JUNE 2013

Key performance Indicators			Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	2013/14 YTD	2013/14 Target/ Ceiling	Amber Limit	Trend
1) WORKFORCE CAPACITY		*NB*																	
WC-BF	Budgeted FTE		1147.0	1148.3	1149.2	1148.0	1142.0	1146.1	1144.8	1145.3	1145.3	1146.3	1169.4	1172.0	1173.2	**1171.5**	N/A	N/A	
WC-FU	Total FTE Used	1	1101.9	1115.7	1123.1	1123.8	1117.1	1136.1	1122.9	1133.7	1138.8	1136.9	1125.8	1127.7	1157.0	**1136.8**	N/A	N/A	
WC-VB	Total FTE Used Variance from Budget	1	-45.2	-32.6	-26.1	-24.1	-24.8	-10.0	-21.9	-11.5	-6.4	-9.4	-43.7	-44.3	-16.2	**N/A**	N/A	N/A	
WC-TV	Total FTE Used Vacancy Factor	1	3.9%	2.8%	2.3%	2.1%	2.2%	0.9%	1.9%	1.0%	0.6%	0.8%	3.7%	3.8%	1.4%	**3.0%**	N/A	N/A	
WC-SF	Substantive Contracted FTE		1065.9	1072.3	1073.9	1074.5	1072.0	1083.1	1072.6	1083.0	1088.2	1079.4	1089.5	1092.7	1099.8	**1094.0**	N/A	N/A	
WC-SV	Substantive FTE Used Vacancy Factor		7.1%	6.6%	6.6%	6.4%	6.1%	5.5%	6.3%	5.4%	5.0%	5.8%	6.8%	6.8%	6.3%	**6.6%**	N/A	N/A	
WC-BP	Bank Usage As % Of Total FTE Used	1	2.4%	3.0%	3.2%	3.6%	3.3%	3.6%	3.5%	3.1%	3.3%	3.3%	2.2%	1.4%	2.8%	**2.1%**	N/A	N/A	
WC-AP	Agency Usage As % Of Total FTE Used	1	0.9%	0.9%	1.2%	0.8%	0.7%	1.0%	1.0%	1.4%	1.2%	1.7%	1.0%	1.7%	2.2%	**1.6%**	N/A	N/A	
2) WORKFORCE EFFICIENCY		*NB*																	
WE-SA	In Month Sickness Absence %	2	3.0%	2.2%	2.0%	2.6%	3.0%	4.0%	3.3%	2.8%	3.0%	2.9%	2.9%	2.3%		2.6%	2.8%	2.8%	
WE-ML	In Month Maternity Leave %	2	2.8%	2.8%	2.8%	3.1%	3.1%	3.1%	2.9%	3.0%	2.9%	2.9%	3.0%	3.0%		**3.0%**	N/A	N/A	
WE-OA	In Month Other Absence %		0.5%	0.5%	0.5%	0.5%	0.7%	1.1%	0.6%	0.6%	0.7%	1.0%	1.0%	1.1%		**1.1%**	N/A	N/A	
WE-TA	In Month Total Absence %		6.3%	5.5%	5.4%	6.2%	6.8%	8.3%	6.8%	6.4%	6.6%	6.8%	6.8%	6.4%		**6.6%**	N/A	N/A	
WE-LT	% Total Sickness Days Lost Due To Long Term Sickness Absence (28 Days Or More)	2	55.8%	46.3%	46.2%	55.3%	50.1%	41.5%	46.2%	39.5%	36.6%	43.8%	39.2%	40.3%		**39.7%**	N/A	N/A	
WE-SR	% Of Total Sickness Attributed To Stress	2	23.8%	22.0%	21.1%	19.6%	19.2%	17.8%	14.5%	9.4%	8.1%	17.4%	9.9%	11.7%		**10.7%**	N/A	N/A	
WE-MS	% Of Total Sickness Attributed To Musculo Skeletal	2	20.3%	15.0%	19.5%	20.9%	18.9%	14.7%	12.4%	12.9%	14.6%	12.9%	10.0%	20.7%		**14.9%**	N/A	N/A	
WE-RT	Rolling 12 Month Turnover		9.5%	9.1%	9.9%	9.9%	10.2%	10.9%	11.3%	11.7%	11.8%	11.8%	12.7%	12.4%	11.3%	**N/A**	11.0%	11.0%	
3) TRAINING AND PERSONAL DEVELOPMENT		*NB*																	
TD-AP	% Appraisals Up To Date		85.9%	88.6%	90.8%	90.0%	87.7%	87.3%	88.5%	86.6%	87.4%	85.3%	87.0%	86.3%	84.8%	**N/A**	95.0%	85.0%	
TD-MP	% In Date - All Mandatory Training	3	82.1%	83.8%	82.6%	84.2%	83.8%	82.3%	84.1%	84.3%	83.5%	82.5%	84.9%	85.3%	87.4%	**N/A**	95.0%	85.0%	
TD-FP	% In Date - Fire		86.5%	87.8%	88.2%	88.7%	88.5%	88.4%	89.4%	88.9%	88.9%	88.5%	90.1%	90.2%	91.1%	**N/A**	95.0%	85.0%	
TD-IC	% In Date - Infection Control		88.6%	89.9%	90.1%	90.5%	90.5%	89.9%	90.7%	90.4%	90.3%	86.6%	88.3%	89.0%	90.1%	**N/A**	95.0%	85.0%	
TD-BT	% In Date - Role Specific Back Training		92.0%	92.8%	91.3%	92.1%	91.9%	90.7%	91.8%	92.1%	91.0%	93.8%	95.0%	95.3%	96.7%	**N/A**	95.0%	85.0%	
TD-CP	% In Date - Child Protection		97.2%	97.6%	97.5%	96.9%	97.4%	97.0%	97.5%	97.9%	98.0%	98.1%	97.9%	98.2%	98.6%	**N/A**	95.0%	85.0%	
TD-IG	% In Date - Information Governance		85.2%	86.8%	87.0%	87.5%	87.8%	87.5%	89.0%	88.6%	88.9%	88.3%	89.8%	89.8%	90.8%	**N/A**	95.0%	85.0%	
TD-AP	% In Date - Adult Protection	3											79.7%	79.0%	78.4%	**N/A**	95.0%	85.0%	
4) REAL-TIME STAFF FEEDBACK		*NB*																	
SF-TR	Total Respondents To Survey														22	**22**	N/A	N/A	
SF-Q1	% Respondents who would recommend this trust as a place to work	4													81.8%	**81.8%**	N/A	N/A	
SF-Q2	% Respondents happy with the standard of care provided by WSHT if a friend or relative needed treatment	4													72.7%	**72.7%**	N/A	N/A	

Notes

1 Bank FTE used unavailable for April and May and been approximated as follows: Monthly Bank Spend / June Average Cost Per Bank FTE

2 Absence data is available one month in arrears

3 Adult Protection is not currently included in the criteria when determining whether an employee is up to date with their mandatory training

4 % of staff who responded "Agree" or "Strongly Agree" to the question

CORPORATE WORKFORCE SCORECARD

JUNE 2013

Key performance Indicators			Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	2013/14 YTD	2013/14 Target/ Ceiling	Amber Limit	Trend
1) WORKFORCE CAPACITY		*NB*																	
WC-BF	Budgeted FTE		668.5	674.5	674.3	673.3	672.6	691.7	691.7	691.7	691.7	691.7	677.2	677.2	685.9	**680.1**	N/A	N/A	
WC-FU	Total FTE Used	1	666.7	673.0	684.5	684.0	681.1	691.6	689.7	684.6	689.5	668.9	664.4	644.6	651.9	**653.6**	N/A	N/A	
WC-VB	Total FTE Used Variance from Budget	1	-1.8	-1.5	10.2	10.8	8.5	-0.1	-1.9	-7.0	-2.1	-22.7	-12.7	-32.5	-34.0	**N/A**	N/A	N/A	
WC-TV	Total FTE Used Vacancy Factor	1	0.3%	0.2%	-1.5%	-1.6%	-1.3%	0.0%	0.3%	1.0%	0.3%	3.3%	1.9%	4.8%	5.0%	**3.9%**	N/A	N/A	
WC-SF	Substantive Contracted FTE		622.2	629.3	638.5	640.0	638.6	654.3	651.3	652.3	648.6	624.6	628.0	624.2	624.1	**625.4**	N/A	N/A	
WC-SV	Substantive FTE Used Vacancy Factor		6.9%	6.7%	5.3%	4.9%	5.1%	5.4%	5.8%	5.7%	6.2%	9.7%	7.3%	7.8%	9.0%	**8.0%**	N/A	N/A	
WC-BP	Bank Usage As % Of Total FTE Used	1	5.9%	5.9%	5.9%	6.1%	5.6%	5.2%	5.2%	4.1%	5.1%	6.0%	5.7%	2.7%	4.4%	**4.3%**	N/A	N/A	
WC-AP	Agency Usage As % Of Total FTE Used	1	0.8%	0.6%	0.8%	0.4%	0.6%	0.2%	0.4%	0.7%	0.8%	0.6%	-0.1%	0.5%	0.0%	**0.1%**	N/A	N/A	
2) WORKFORCE EFFICIENCY		*NB*																	
WE-SA	In Month Sickness Absence %	2	3.4%	3.7%	3.1%	3.1%	3.7%	3.9%	3.8%	3.7%	3.4%	3.5%	3.3%	3.8%		**3.5%**	2.9%	2.9%	
WE-ML	In Month Maternity Leave %	2	2.0%	2.1%	1.9%	2.1%	2.4%	2.2%	2.0%	1.8%	2.0%	1.9%	1.6%	1.7%		**1.7%**	N/A	N/A	
WE-OA	In Month Other Absence %		0.1%	0.1%	0.3%	0.2%	0.2%	0.3%	0.1%	0.1%	0.2%	0.1%	0.1%	0.2%		**0.2%**	N/A	N/A	
WE-TA	In Month Total Absence %		5.5%	5.9%	5.3%	5.4%	6.2%	6.4%	5.9%	5.7%	5.6%	5.6%	5.0%	5.7%		**5.4%**	N/A	N/A	
WE-LT	% Total Sickness Days Lost Due To Long Term Sickness Absence (28 Days Or More)	2	63.0%	54.8%	58.5%	57.2%	54.4%	50.2%	45.1%	42.6%	52.0%	58.0%	59.5%	56.2%		**57.7%**	N/A	N/A	
WE-SR	% Of Total Sickness Attributed To Stress	2	16.1%	16.9%	23.2%	21.7%	14.0%	23.9%	12.5%	10.9%	18.3%	22.8%	21.6%	21.4%		**21.5%**	N/A	N/A	
WE-MS	% Of Total Sickness Attributed To Musculo Skeletal	2	17.5%	20.1%	6.1%	19.2%	29.3%	15.9%	14.7%	16.7%	18.0%	14.1%	9.5%	14.0%		**11.9%**	N/A	N/A	
WE-RT	Rolling 12 Month Turnover		9.4%	8.8%	9.5%	9.0%	9.1%	9.1%	9.0%	9.1%	9.3%	10.0%	9.8%	10.2%	9.8%	**N/A**	11.0%	11.0%	
3) TRAINING AND PERSONAL DEVELOPMENT		*NB*																	
TD-AP	% Appraisals Up To Date		88.9%	87.4%	87.5%	87.1%	83.5%	87.4%	88.2%	89.9%	89.8%	83.0%	85.0%	89.4%	86.9%	**N/A**	95.0%	85.0%	
TD-MP	% In Date - All Mandatory Training	3	82.9%	83.2%	84.3%	86.8%	83.3%	82.4%	84.8%	86.5%	82.2%	81.3%	85.3%	85.0%	85.5%	**N/A**	95.0%	85.0%	
TD-FP	% In Date - Fire		87.7%	87.3%	88.8%	90.2%	87.6%	86.8%	88.7%	91.1%	89.0%	88.0%	90.7%	89.2%	90.8%	**N/A**	95.0%	85.0%	
TD-IC	% In Date - Infection Control		88.4%	88.6%	90.3%	91.5%	88.0%	86.8%	89.0%	90.7%	89.4%	86.3%	88.9%	89.2%	90.9%	**N/A**	95.0%	85.0%	
TD-BT	% In Date - Role Specific Back Training		93.0%	92.6%	93.5%	94.2%	93.1%	93.1%	94.2%	93.5%	91.2%	94.5%	94.5%	94.4%	94.8%	**N/A**	95.0%	85.0%	
TD-CP	% In Date - Child Protection		96.5%	95.9%	97.1%	97.0%	96.6%	97.0%	96.9%	96.9%	97.0%	95.1%	95.5%	96.1%	96.2%	**N/A**	95.0%	85.0%	
TD-IG	% In Date - Information Governance		86.7%	86.9%	88.6%	90.0%	88.0%	86.8%	88.7%	90.9%	89.0%	88.1%	90.8%	89.0%	89.5%	**N/A**	95.0%	85.0%	
TD-AP	% In Date - Adult Protection	3											77.6%	77.5%	77.9%	**N/A**	95.0%	85.0%	
4) REAL-TIME STAFF FEEDBACK		*NB*																	
SF-TR	Total Respondents To Survey														9	**9**	N/A	N/A	
SF-Q1	% Respondents who would recommend this trust as a place to work	4													77.8%	**77.8%**	N/A	N/A	
SF-Q2	% Respondents happy with the standard of care provided by WSHT if a friend or relative needed treatment	4													77.8%	**77.8%**	N/A	N/A	

Notes

1 Bank FTE used unavailable for April and May and been approximated as follows: Monthly Bank Spend / June Average Cost Per Bank FTE

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4 % of staff who responded "Agree" or "Strongly Agree" to the question

FACILITIES & ESTATES WORKFORCE SCORECARD

JUNE 2013

Key performance Indicators			Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	2013/14 YTD	2013/14 Target/ Ceiling	Amber Limit	Trend
1) WORKFORCE CAPACITY		*NB*																	
WC-BF	Budgeted FTE		677.2	677.2	677.7	677.7	677.7	678.7	679.7	679.7	679.7	679.7	683.0	683.0	683.0	**683.0**	N/A	N/A	
WC-FU	Total FTE Used	1	651.0	656.8	651.1	640.2	636.7	646.8	641.8	620.9	635.9	664.8	663.4	600.9	647.3	**637.2**	N/A	N/A	
WC-VB	Total FTE Used Variance from Budget	1	-26.2	-20.4	-26.5	-37.5	-41.0	-31.9	-37.9	-58.8	-43.8	-14.8	-19.6	-82.1	-35.8	**N/A**	N/A	N/A	
WC-TV	Total FTE Used Vacancy Factor	1	3.9%	3.0%	3.9%	5.5%	6.0%	4.7%	5.6%	8.6%	6.4%	2.2%	2.9%	12.0%	5.2%	**6.7%**	N/A	N/A	
WC-SF	Substantive Contracted FTE		515.1	515.2	513.7	505.1	503.8	507.2	501.2	494.4	492.6	512.2	515.4	515.7	511.1	**514.1**	N/A	N/A	
WC-SV	Substantive FTE Used Vacancy Factor		23.9%	23.9%	24.2%	25.5%	25.7%	25.3%	26.3%	27.3%	27.5%	24.6%	24.5%	24.5%	25.2%	**24.7%**	N/A	N/A	
WC-BP	Bank Usage As % Of Total FTE Used	1	20.4%	21.1%	20.8%	21.1%	20.5%	21.1%	21.5%	19.8%	22.2%	22.6%	22.2%	13.4%	20.4%	**18.8%**	N/A	N/A	
WC-AP	Agency Usage As % Of Total FTE Used	1	0.4%	0.5%	0.3%	0.0%	0.4%	0.5%	0.4%	0.6%	0.3%	0.4%	0.1%	0.7%	0.7%	**0.5%**	N/A	N/A	
2) WORKFORCE EFFICIENCY		*NB*																	
WE-SA	In Month Sickness Absence %	2	4.9%	5.9%	5.3%	4.9%	5.8%	5.9%	5.6%	6.2%	5.6%	5.5%	6.1%	6.0%		**6.0%**	4.0%	4.0%	
WE-ML	In Month Maternity Leave %	2	0.7%	0.9%	0.5%	0.8%	0.9%	0.9%	0.7%	0.5%	0.4%	0.5%	0.5%	0.5%		**0.5%**	N/A	N/A	
WE-OA	In Month Other Absence %		0.3%	0.7%	0.7%	0.7%	0.4%	0.7%	0.7%	1.0%	0.6%	0.6%	0.4%	0.2%		**0.3%**	N/A	N/A	
WE-TA	In Month Total Absence %		5.9%	7.4%	6.5%	6.4%	7.1%	7.5%	7.1%	7.7%	6.7%	6.6%	7.0%	6.7%		**6.9%**	N/A	N/A	
WE-LT	% Total Sickness Days Lost Due To Long Term Sickness Absence (28 Days Or More)	2	58.3%	62.0%	66.9%	63.0%	62.2%	55.9%	48.8%	55.7%	61.3%	64.4%	63.1%	55.5%		**59.2%**	N/A	N/A	
WE-SR	% Of Total Sickness Attributed To Stress	2	7.4%	11.0%	9.7%	9.9%	15.2%	11.4%	12.0%	9.2%	13.6%	18.4%	16.1%	16.3%		**16.2%**	N/A	N/A	
WE-MS	% Of Total Sickness Attributed To Musculo Skeletal	2	33.3%	32.4%	39.7%	33.6%	30.2%	29.4%	27.2%	32.2%	33.0%	32.7%	28.0%	28.0%		**28.0%**	N/A	N/A	
WE-RT	Rolling 12 Month Turnover		10.7%	10.1%	10.3%	11.5%	12.2%	11.3%	11.8%	12.1%	10.9%	9.3%	9.1%	8.7%	8.5%	**N/A**	11.0%	11.0%	
3) TRAINING AND PERSONAL DEVELOPMENT		*NB*																	
TD-AP	% Appraisals Up To Date		97.4%	97.1%	95.0%	93.0%	88.4%	91.5%	92.2%	94.4%	95.6%	96.9%	92.5%	94.6%	90.6%	**N/A**	95.0%	85.0%	
TD-MP	% In Date - All Mandatory Training	3	84.4%	85.8%	84.8%	90.2%	87.9%	89.2%	90.4%	91.1%	91.5%	87.8%	87.7%	90.7%	93.5%	**N/A**	95.0%	85.0%	
TD-FP	% In Date - Fire		89.9%	90.2%	93.0%	94.2%	90.7%	92.2%	93.1%	94.0%	94.0%	93.4%	90.9%	93.9%	95.4%	**N/A**	95.0%	85.0%	
TD-IC	% In Date - Infection Control		89.4%	89.4%	92.6%	93.7%	90.7%	92.0%	92.9%	93.9%	94.0%	93.6%	91.1%	94.1%	95.6%	**N/A**	95.0%	85.0%	
TD-BT	% In Date - Role Specific Back Training		92.7%	94.6%	90.7%	95.5%	95.9%	96.2%	96.6%	96.4%	95.7%	93.2%	95.5%	95.8%	97.1%	**N/A**	95.0%	85.0%	
TD-CP	% In Date - Child Protection		97.7%	98.2%	98.7%	98.8%	98.5%	98.7%	99.0%	99.1%	98.3%	98.8%	98.5%	99.0%	99.2%	**N/A**	95.0%	85.0%	
TD-IG	% In Date - Information Governance		90.1%	89.4%	92.6%	93.7%	90.7%	92.0%	92.9%	93.9%	94.0%	93.4%	90.9%	93.9%	95.4%	**N/A**	95.0%	85.0%	
TD-AP	% In Date - Adult Protection	3											81.9%	82.4%	83.2%	**N/A**	95.0%	85.0%	
4) REAL-TIME STAFF FEEDBACK		*NB*																	
SF-TR	Total Respondents To Survey														11	**11**	N/A	N/A	
SF-Q1	% Respondents who would recommend this trust as a place to work	4													90.9%	**90.9%**	N/A	N/A	
SF-Q2	% Respondents happy with the standard of care provided by WSHT if a friend or relative needed treatment	4													81.8%	**81.8%**	N/A	N/A	

Notes

1 Bank FTE used unavailable for April and May and been approximated as follows: Monthly Bank Spend / June Average Cost Per Bank FTE

2 Absence data is available one month in arrears

3 Adult Protection is not currently included in the criteria when determining whether an employee is up to date with their mandatory training

4 % of staff who responded "Agree" or "Strongly Agree" to the question

MEDICINE WORKFORCE SCORECARD

JUNE 2013

Key performance Indicators			Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	2013/14 YTD	2013/14 Target/ Ceiling	Amber Limit	Trend
1) WORKFORCE CAPACITY		*NB*																	
WC-BF	Budgeted FTE		1557.7	1536.2	1533.6	1533.6	1533.7	1533.7	1535.5	1541.2	1541.2	1541.2	1553.9	1552.1	1553.4	**1553.1**	N/A	N/A	
WC-FU	Total FTE Used	1	1596.9	1614.0	1587.2	1586.0	1616.8	1619.8	1658.3	1626.1	1679.5	1709.1	1623.7	1603.9	1630.9	**1619.5**	N/A	N/A	
WC-VB	Total FTE Used Variance from Budget	1	39.3	77.9	53.6	52.3	83.1	86.1	122.9	84.9	138.3	167.9	69.8	51.8	77.5	**N/A**	N/A	N/A	
WC-TV	Total FTE Used Vacancy Factor	1	-2.5%	-5.1%	-3.5%	-3.4%	-5.4%	-5.6%	-8.0%	-5.5%	-9.0%	-10.9%	-4.5%	-3.3%	-5.0%	**-4.3%**	N/A	N/A	
WC-SF	Substantive Contracted FTE		1410.6	1422.3	1390.7	1404.2	1408.0	1422.0	1425.8	1427.3	1449.0	1466.6	1433.2	1437.6	1428.1	**1432.9**	N/A	N/A	
WC-SV	Substantive FTE Used Vacancy Factor		9.4%	7.4%	9.3%	8.4%	8.2%	7.3%	7.1%	7.4%	6.0%	4.8%	7.8%	7.4%	8.1%	**7.7%**	N/A	N/A	
WC-BP	Bank Usage As % Of Total FTE Used	1	8.5%	8.9%	8.6%	8.9%	8.8%	8.5%	9.8%	8.3%	9.5%	9.5%	10.2%	7.3%	8.9%	**8.8%**	N/A	N/A	
WC-AP	Agency Usage As % Of Total FTE Used	1	3.2%	3.0%	3.7%	2.6%	4.1%	3.7%	4.2%	3.9%	4.2%	4.7%	1.6%	3.1%	3.6%	**2.7%**	N/A	N/A	
2) WORKFORCE EFFICIENCY		*NB*																	
WE-SA	In Month Sickness Absence %	2	3.3%	3.6%	3.4%	3.2%	4.1%	4.8%	4.7%	4.6%	3.9%	3.3%	4.2%	3.7%		**3.9%**	3.3%	3.3%	
WE-ML	In Month Maternity Leave %	2	2.5%	2.8%	2.9%	2.8%	2.9%	3.1%	3.3%	3.1%	3.2%	2.9%	2.7%	2.5%		**2.6%**	N/A	N/A	
WE-OA	In Month Other Absence %		1.4%	1.3%	1.2%	1.6%	1.9%	2.1%	1.0%	1.1%	1.4%	1.7%	1.7%	1.7%		**1.7%**	N/A	N/A	
WE-TA	In Month Total Absence %		7.3%	7.7%	7.5%	7.6%	9.0%	9.9%	9.1%	8.9%	8.4%	7.9%	8.6%	7.9%		**8.3%**	N/A	N/A	
WE-LT	% Total Sickness Days Lost Due To Long Term Sickness Absence (28 Days Or More)	2	54.3%	50.0%	48.9%	51.7%	53.8%	51.9%	47.9%	46.4%	45.3%	42.1%	48.8%	51.1%		**49.9%**	N/A	N/A	
WE-SR	% Of Total Sickness Attributed To Stress	2	13.3%	6.9%	9.9%	9.6%	10.6%	10.6%	13.0%	11.3%	11.6%	12.4%	15.6%	17.2%		**16.4%**	N/A	N/A	
WE-MS	% Of Total Sickness Attributed To Musculo Skeletal	2	18.1%	17.9%	24.9%	28.9%	21.8%	21.2%	20.9%	21.7%	18.1%	17.8%	20.6%	22.8%		**21.7%**	N/A	N/A	
WE-RT	Rolling 12 Month Turnover		8.4%	8.5%	8.3%	7.8%	7.9%	7.9%	7.7%	7.2%	6.8%	7.0%	7.0%	7.0%	6.7%	**N/A**	11.0%	11.0%	
3) TRAINING AND PERSONAL DEVELOPMENT		*NB*																	
TD-AP	% Appraisals Up To Date		81.4%	86.3%	88.9%	90.6%	86.3%	86.3%	85.3%	85.3%	86.6%	83.5%	82.9%	82.6%	81.8%	**N/A**	95.0%	85.0%	
TD-MP	% In Date - All Mandatory Training	3	66.6%	72.6%	74.9%	73.3%	70.2%	67.9%	70.6%	73.7%	74.6%	71.6%	77.5%	80.0%	79.9%	**N/A**	95.0%	85.0%	
TD-FP	% In Date - Fire		76.8%	79.1%	82.4%	81.1%	78.6%	78.4%	79.8%	81.0%	81.4%	82.3%	85.7%	87.2%	88.7%	**N/A**	95.0%	85.0%	
TD-IC	% In Date - Infection Control		81.5%	83.5%	87.9%	86.0%	84.9%	83.4%	84.5%	86.0%	86.3%	80.2%	84.0%	86.5%	86.2%	**N/A**	95.0%	85.0%	
TD-BT	% In Date - Role Specific Back Training		81.8%	82.9%	85.2%	83.7%	82.1%	79.2%	82.0%	84.3%	84.9%	88.3%	90.0%	90.7%	89.8%	**N/A**	95.0%	85.0%	
TD-CP	% In Date - Child Protection		90.3%	89.0%	92.5%	91.5%	91.7%	92.2%	93.4%	93.9%	93.6%	94.2%	95.4%	95.8%	94.7%	**N/A**	95.0%	85.0%	
TD-IG	% In Date - Information Governance		73.8%	78.1%	82.3%	80.2%	78.1%	77.7%	79.3%	80.8%	81.7%	82.2%	85.7%	87.0%	88.3%	**N/A**	95.0%	85.0%	
TD-AP	% In Date - Adult Protection	3											76.9%	76.9%	75.6%	**N/A**	95.0%	85.0%	
4) REAL-TIME STAFF FEEDBACK		*NB*																	
SF-TR	Total Respondents To Survey														48	**48**	N/A	N/A	
SF-Q1	% Respondents who would recommend this trust as a place to work	4													87.5%	**87.5%**	N/A	N/A	
SF-Q2	% Respondents happy with the standard of care provided by WSHT if a friend or relative needed treatment	4													91.7%	**91.7%**	N/A	N/A	

Notes

1 Bank FTE used unavailable for April and May and been approximated as follows: Monthly Bank Spend / June Average Cost Per Bank FTE

2 Absence data is available one month in arrears

3 Adult Protection is not currently included in the criteria when determining whether an employee is up to date with their mandatory training

4 % of staff who responded "Agree" or "Strongly Agree" to the question

SURGERY WORKFORCE SCORECARD

JUNE 2013

Key performance Indicators			Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	2013/14 YTD	2013/14 Target/Ceiling	Amber Limit	Trend
1) WORKFORCE CAPACITY		*NB*																	
WC-BF	Budgeted FTE		1282.2	1281.1	1283.0	1272.9	1270.9	1274.4	1275.1	1275.1	1275.1	1275.1	1280.0	1280.0	1276.3	**1278.8**	N/A	N/A	
WC-FU	Total FTE Used	1	1228.7	1260.2	1248.8	1237.6	1231.7	1258.0	1250.2	1239.6	1253.6	1240.0	1267.1	1248.6	1249.1	**1255.0**	N/A	N/A	
WC-VB	Total FTE Used Variance from Budget	1	-53.5	-20.9	-34.2	-35.3	-39.2	-16.4	-24.9	-35.5	-21.5	-35.1	-12.9	-31.4	-27.2	**N/A**	N/A	N/A	
WC-TV	Total FTE Used Vacancy Factor	1	4.2%	1.6%	2.7%	2.8%	3.1%	1.3%	2.0%	2.8%	1.7%	2.8%	1.0%	2.5%	2.1%	**1.9%**	N/A	N/A	
WC-SF	Substantive Contracted FTE		1150.4	1164.2	1148.0	1145.8	1146.8	1154.8	1153.9	1157.1	1155.9	1141.6	1156.3	1160.4	1166.8	**1161.2**	N/A	N/A	
WC-SV	Substantive FTE Used Vacancy Factor		10.3%	9.1%	10.5%	10.0%	9.8%	9.4%	9.5%	9.3%	9.3%	10.5%	9.7%	9.3%	8.6%	**9.2%**	N/A	N/A	
WC-BP	Bank Usage As % Of Total FTE Used	1	5.4%	5.4%	5.7%	5.4%	5.1%	5.5%	5.1%	4.1%	4.9%	5.7%	6.6%	4.7%	5.0%	**5.4%**	N/A	N/A	
WC-AP	Agency Usage As % Of Total FTE Used	1	0.9%	2.2%	2.3%	2.1%	1.8%	2.7%	2.6%	2.5%	2.9%	2.3%	2.2%	2.4%	1.5%	**2.0%**	N/A	N/A	
2) WORKFORCE EFFICIENCY		*NB*																	
WE-SA	In Month Sickness Absence %	2	3.2%	3.6%	3.5%	3.4%	4.1%	4.3%	4.4%	4.6%	4.7%	3.9%	3.7%	3.2%		**3.5%**	3.5%	3.5%	
WE-ML	In Month Maternity Leave %	2	3.2%	3.2%	3.4%	3.0%	2.9%	2.9%	2.6%	2.3%	2.1%	2.1%	2.2%	2.1%		**2.1%**	N/A	N/A	
WE-OA	In Month Other Absence %		1.3%	1.2%	0.8%	1.2%	1.4%	1.7%	0.9%	1.0%	1.3%	1.5%	1.1%	1.3%		**1.2%**	N/A	N/A	
WE-TA	In Month Total Absence %		7.7%	8.1%	7.6%	7.6%	8.5%	8.9%	7.9%	7.9%	8.1%	7.4%	7.1%	6.6%		**6.8%**	N/A	N/A	
WE-LT	% Total Sickness Days Lost Due To Long Term Sickness Absence (28 Days Or More)	2	58.6%	58.9%	60.9%	55.9%	46.5%	49.8%	46.7%	50.4%	48.6%	52.4%	48.9%	49.5%		**49.2%**	N/A	N/A	
WE-SR	% Of Total Sickness Attributed To Stress	2	15.3%	12.3%	12.8%	10.7%	8.3%	10.8%	9.8%	7.2%	13.4%	12.7%	15.0%	17.0%		**15.9%**	N/A	N/A	
WE-MS	% Of Total Sickness Attributed To Musculo Skeletal	2	16.5%	18.8%	19.7%	24.9%	23.3%	27.7%	20.5%	19.4%	16.1%	15.1%	12.2%	17.6%		**14.7%**	N/A	N/A	
WE-RT	Rolling 12 Month Turnover		7.4%	7.5%	7.7%	7.6%	7.2%	7.0%	7.3%	7.0%	6.9%	6.9%	6.6%	6.2%	6.0%	**N/A**	11.0%	11.0%	
3) TRAINING AND PERSONAL DEVELOPMENT		*NB*																	
TD-AP	% Appraisals Up To Date		80.7%	85.1%	88.7%	88.7%	85.0%	84.4%	84.4%	87.0%	86.1%	84.5%	84.3%	85.1%	86.1%	**N/A**	95.0%	85.0%	
TD-MP	% In Date - All Mandatory Training	3	66.8%	68.3%	71.5%	72.0%	68.7%	67.9%	69.5%	73.0%	73.7%	75.3%	77.7%	76.8%	77.2%	**N/A**	95.0%	85.0%	
TD-FP	% In Date - Fire		77.9%	78.9%	82.1%	81.6%	79.7%	81.0%	81.9%	84.9%	86.6%	86.7%	88.0%	87.0%	88.6%	**N/A**	95.0%	85.0%	
TD-IC	% In Date - Infection Control		81.4%	82.1%	86.2%	85.4%	84.4%	85.8%	86.5%	87.9%	89.1%	85.8%	87.3%	85.4%	86.6%	**N/A**	95.0%	85.0%	
TD-BT	% In Date - Role Specific Back Training		81.1%	79.2%	82.1%	82.7%	79.9%	78.1%	79.6%	81.4%	81.3%	87.3%	88.7%	89.7%	90.2%	**N/A**	95.0%	85.0%	
TD-CP	% In Date - Child Protection		88.2%	88.5%	92.1%	91.9%	92.2%	93.2%	94.0%	94.9%	95.1%	96.1%	96.6%	96.4%	96.6%	**N/A**	95.0%	85.0%	
TD-IG	% In Date - Information Governance		73.9%	75.0%	80.1%	78.8%	77.9%	79.7%	81.1%	84.3%	86.3%	86.4%	87.8%	86.9%	88.5%	**N/A**	95.0%	85.0%	
TD-AP	% In Date - Adult Protection	3											79.5%	78.4%	78.7%	**N/A**	95.0%	85.0%	
4) REAL-TIME STAFF FEEDBACK		*NB*																	
SF-TR	Total Respondents To Survey														30	**30**	N/A	N/A	
SF-Q1	% Respondents who would recommend this trust as a place to work	4													83.3%	**83.3%**	N/A	N/A	
SF-Q2	% Respondents happy with the standard of care provided by WSHT if a friend or relative needed treatment	4													73.3%	**73.3%**	N/A	N/A	

Notes

1 Bank FTE used unavailable for April and May and been approximated as follows: Monthly Bank Spend / June Average Cost Per Bank FTE

2 Absence data is available one month in arrears

3 Adult Protection is not currently included in the criteria when determining whether an employee is up to date with their mandatory training

4 % of staff who responded "Agree" or "Strongly Agree" to the question

WOMEN & CHILDRENS WORKFORCE SCORECARD

JUNE 2013

Key performance Indicators			Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	JUN	2013/14 YTD	2013/14 Target/ Ceiling	Amber Limit	Trend
1) WORKFORCE CAPACITY		*NB*																	
WC-BF	Budgeted FTE		662.0	662.0	662.0	666.8	668.7	668.4	663.0	663.0	663.0	655.0	667.8	667.8	669.8	**668.5**	N/A	N/A	
WC-FU	Total FTE Used	1	651.3	648.8	642.6	641.0	643.7	651.3	650.4	650.0	660.9	632.1	668.6	653.6	647.6	**656.6**	N/A	N/A	
WC-VB	Total FTE Used Variance from Budget	1	-10.7	-13.2	-19.4	-25.8	-25.0	-17.1	-12.6	-13.0	-2.0	-22.9	0.8	-14.2	-22.2	**N/A**	N/A	N/A	
WC-TV	Total FTE Used Vacancy Factor	1	1.6%	2.0%	2.9%	3.9%	3.7%	2.6%	1.9%	2.0%	0.3%	3.5%	-0.1%	2.1%	3.3%	**1.8%**	N/A	N/A	
WC-SF	Substantive Contracted FTE		613.3	612.2	603.6	604.2	605.0	612.6	611.7	611.0	613.9	600.9	612.0	609.9	610.1	**610.7**	N/A	N/A	
WC-SV	Substantive FTE Used Vacancy Factor		7.3%	7.5%	8.8%	9.4%	9.5%	8.4%	7.7%	7.8%	7.4%	8.3%	8.4%	8.7%	8.9%	**8.7%**	N/A	N/A	
WC-BP	Bank Usage As % Of Total FTE Used	1	4.6%	4.7%	4.7%	4.4%	4.9%	5.0%	4.8%	4.8%	5.8%	5.8%	7.5%	5.2%	3.5%	**5.4%**	N/A	N/A	
WC-AP	Agency Usage As % Of Total FTE Used	1	1.2%	0.9%	1.4%	1.3%	1.1%	1.0%	1.1%	1.2%	1.4%	-0.9%	0.9%	1.5%	2.3%	**1.6%**	N/A	N/A	
2) WORKFORCE EFFICIENCY		*NB*																	
WE-SA	In Month Sickness Absence %	2	2.7%	2.4%	2.8%	2.4%	2.6%	3.4%	3.7%	3.6%	3.1%	3.4%	3.3%	3.1%		**3.2%**	3.0%	3.0%	
WE-ML	In Month Maternity Leave %	2	3.5%	3.3%	3.5%	3.5%	3.5%	3.6%	3.5%	3.7%	3.7%	3.7%	3.7%	3.7%		**3.7%**	N/A	N/A	
WE-OA	In Month Other Absence %		0.9%	0.8%	0.4%	0.7%	0.8%	1.1%	0.8%	0.8%	1.0%	0.7%	0.9%	0.9%		**0.9%**	N/A	N/A	
WE-TA	In Month Total Absence %		7.0%	6.5%	6.6%	6.6%	6.9%	8.1%	8.1%	8.1%	7.9%	7.8%	7.9%	7.6%		**7.8%**	N/A	N/A	
WE-LT	% Total Sickness Days Lost Due To Long Term Sickness Absence (28 Days Or More)	2	63.9%	56.2%	49.4%	54.6%	51.2%	42.5%	51.0%	51.9%	53.9%	46.8%	56.6%	57.3%		**57.0%**	N/A	N/A	
WE-SR	% Of Total Sickness Attributed To Stress	2	22.1%	27.1%	21.1%	21.4%	21.7%	20.5%	22.5%	22.3%	21.5%	15.5%	19.7%	14.7%		**17.2%**	N/A	N/A	
WE-MS	% Of Total Sickness Attributed To Musculo Skeletal	2	13.5%	11.2%	12.3%	3.0%	4.5%	3.1%	5.6%	9.6%	14.4%	19.4%	11.4%	23.8%		**17.4%**	N/A	N/A	
WE-RT	Rolling 12 Month Turnover		7.7%	7.8%	8.5%	8.5%	8.2%	7.5%	7.6%	7.5%	7.3%	7.2%	7.1%	7.1%	7.4%	**N/A**	11.0%	11.0%	
3) TRAINING AND PERSONAL DEVELOPMENT		*NB*																	
TD-AP	% Appraisals Up To Date		82.6%	87.4%	83.1%	75.4%	80.5%	80.8%	83.5%	86.5%	86.1%	82.6%	81.3%	82.1%	83.9%	**N/A**	95.0%	85.0%	
TD-MP	% In Date - All Mandatory Training	3	76.7%	75.5%	75.9%	74.0%	70.9%	69.3%	75.9%	75.6%	75.2%	67.4%	68.8%	76.5%	74.7%	**N/A**	95.0%	85.0%	
TD-FP	% In Date - Fire		83.7%	82.0%	82.2%	79.6%	77.2%	77.6%	84.5%	82.3%	82.2%	80.8%	84.9%	89.0%	86.4%	**N/A**	95.0%	85.0%	
TD-IC	% In Date - Infection Control		84.3%	82.8%	83.9%	80.4%	77.4%	75.8%	81.9%	82.8%	81.7%	77.4%	80.9%	86.3%	84.7%	**N/A**	95.0%	85.0%	
TD-BT	% In Date - Role Specific Back Training		85.0%	84.2%	84.6%	82.9%	81.4%	81.7%	86.0%	83.4%	84.1%	86.1%	89.0%	91.9%	92.6%	**N/A**	95.0%	85.0%	
TD-CP	% In Date - Child Protection		92.7%	93.9%	93.9%	92.9%	93.0%	93.5%	95.9%	96.8%	96.5%	87.8%	87.9%	90.4%	91.4%	**N/A**	95.0%	85.0%	
TD-IG	% In Date - Information Governance		81.3%	79.5%	80.3%	76.5%	74.9%	75.0%	83.2%	81.6%	80.7%	79.5%	82.9%	88.3%	85.8%	**N/A**	95.0%	85.0%	
TD-AP	% In Date - Adult Protection	3											54.6%	51.7%	52.3%	**N/A**	95.0%	85.0%	
4) REAL-TIME STAFF FEEDBACK		*NB*																	
SF-TR	Total Respondents To Survey														3	**3**	N/A	N/A	
SF-Q1	% Respondents who would recommend this trust as a place to work	4													100.0%	**100.0%**	N/A	N/A	
SF-Q2	% Respondents happy with the standard of care provided by WSHT if a friend or relative needed treatment	4													66.7%	**66.7%**	N/A	N/A	

Notes

1 Bank FTE used unavailable for April and May and been approximated as follows: Monthly Bank Spend / June Average Cost Per Bank FTE

2 Absence data is available one month in arrears

3 Adult Protection is not currently included in the criteria when determining whether an employee is up to date with their mandatory training

4 % of staff who responded "Agree" or "Strongly Agree" to the question

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board Date: July 2013

From: Jennie Shore, Deputy Director of HR Agenda Item: 10

FOR INFORMATION

NATIONAL STAFF SURVEY 2012 – UPDATE ON PROGRESS

1.0 INTRODUCTION

Actions resulting from the National Staff Survey 2012 were clustered into four key themes. These were errors, near misses and incidents; health and wellbeing; violence, bullying and harassment; staff engagement and communication.

Divisional action plans have been updated and reviewed.

2.0 PROGRESS

Progress made to date is set out below under the four key themes.

2.1 Errors, near misses and incidents

Following feedback from the staff survey which suggests staff receive limited feedback when they have reported an incident and that they are not always involved in any changes the Clinical Governance Team have dedicated resource allocated to reviewing the Datix system. Recommendations will be made and the team will be working on how the organisation can better engage staff to report incidents, involve them in investigations, feedback to staff on incidents reported and share learning across the organisation. At a more local level the Medicine division now include themes from the Clinical Governance report in the monthly ward sister's newsletter and at operational and consultant meetings. They also plan to undertake monthly spot audits to ensure appropriate action is taken in relation to reported incidents.

2.2 Violence, bullying and harassment

The issue of violence is being considered by Security Group to address the issues Trust wide. Corporately the Trust will continue to promote behaviours associated and in accordance with the Trust values. The medicine and surgery division plan to promote the zero tolerance message for patients and visitors with medicine reviewing the factors that may cause violent behaviours such as information sharing and environmental factors, ensuring staff training on prevention and focusing on priority areas. Surgery will be working on cultures and already have work underway within theatres with the TPOT programme. They will also use existing engagement events to involve staff in further initiatives to tackle bullying and harassment. Some of the corporate areas will be promoting expected standards of behaviour, linking this promotion to existing documents initially aimed at clinical staff to ensure a consistent message.

2.3 Staff engagement and Communication

Listening events took place across the Trust earlier in the year with the executive team ensuring staff feedback was received and considered in relation to future plans for service improvement. Communication has improved, with many areas reporting the use of localised newsletters and bulletins as well as the on-going promotion of the Trust Brief. The surgical division have been holding engagement events over the last month such as the "Surgery Tea Break". The sessions have proved popular, allowing staff to meet the senior management team and make suggestions which will be developed into an action plan and followed up again with staff later in the year. Additional engagement meetings have tackled issues such as communication and use of notice boards etc. The staff BBQ's, recognising staff efforts that culminated in FT status, have taken place during July on the Worthing and Chichester sites and have been well attended.

2.4 Health and Wellbeing

A significant action arising from the Staff Survey 2012 was the need to address staff health and wellbeing. In the last 6 months a Health and Wellbeing Strategy has been developed and agreed. Progress against the strategy will be monitored by a newly established Health and Wellbeing Steering Group, with its first meeting on 1 August. A proposal setting out specific intervention to reduce stress and muscular skeletal disorders is being considered by the Trust's Charitable Funds Committee and will inform the Trust's annual Health Improvement Plan.

This proposal includes the introduction of stress reduction courses for staff and stress management courses for our managers in order that they are more equipped to identify signs of stress and support staff. In addition we are looking to introduce a Staff Physiotherapy service. Staff events at the upcoming conference in relation to Health and Wellbeing are being organised. At a more local level further work is being undertaken within the divisions to look at additional hours; the reliance on staff , the reasons and the impact as well as continued promotion of the Staff Counselling Service.

3.0 NEXT STEPS

Findings within the Staff Survey will continue to be addressed as we prepare for the 2013 Staff Survey anticipated to take place in late September. We are currently developing communications to ensure staff are able to make the connection between what they have told us in the survey with the actions that have taken place.

We will increasingly correlate the data received 'real time' with the national messages to enable us to be more responsive to staff views.

4.0 RECOMMENDATION

The Trust Board is asked to NOTE this paper.

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board (Public)

Date of Meeting: 1st August 2013 Agenda Item:11

Title
Financial Performance Report (Month 3)
Responsible Executive Director
Spencer Prosser, Director of Finance
Prepared by
Chris Nevell, Assistant Director of Finance
Status
Public
Summary of Proposal
The financial position against the Trust's control total is a deficit of £1,457k against a planned deficit of £192k. This includes an increase to the accrual for annual leave outstanding at the end of the period of £959k. The accrual has had to be reviewed as part of the production of the closure of the NHS Trust accounts. The increase appears to be seasonal and is expected to reverse by the end of the financial year. The underlying position excluding this increase is a deficit of £498k The forecast out-turn remains a £5.2m surplus. The year to date deficit has impacted on the Trust's Financial Risk Rating. As two individual metrics score "2" this month, the over-riding rules reduce the performance score to "2" even though the average score is "3." There is no change to the forecast outturn which remains at "3".
Implications for Quality of Care
Not applicable
Link to Strategic Objectives/Board Assurance Framework
G1: Maintain an acceptable Financial Risk Rating
Financial Implications
Financial Performance Report
Human Resource Implications
Not applicable
Recommendation
The Board is asked to note the financial performance report for June 2013
Communication and Consultation
Not applicable
Appendices
None

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Trust Board (Public) Date: 1st August 2013

From: Spencer Prosser, Director of Finance Agenda Item:

FOR INFORMATION

Financial Performance Report

1 Introduction

1.1. The Board is presented with the Trust's Financial Performance for June 2013.

2 Summary

2.1. The financial position against the Trust's control total for June is a deficit of £1,457k against a planned deficit of £192k. This includes an increase to the accrual for annual leave outstanding at the end of the period of £959k. The accrual has had to be reviewed as part of the production of the closure of the NHS Trust accounts. The increase appears to be seasonal and is expected to reverse by the end of the financial year.

2.2. Excluding the increase in the annual leave accrual, the in-month performance is a deficit of £498k, which is an undershoot of £306k against the in-month plan. While the year to date performance against the Trust's control total has increased to an undershoot of £323k against Plan, the forecast out-turn remains a £5.2m surplus. This remains dependent on achieving both the cost improvement programme and quality and patient safety targets, thereby reducing the risk of financial penalties.

2.3. The position by division is shown below:

	Annual	In Month			Year to Date		
	Budget £000s	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s
Operations							
Core Services	(45,891)	(3,857)	(4,251)	(394)	(11,548)	(11,862)	(314)
Medicine	(72,316)	(5,752)	(6,009)	(256)	(17,804)	(18,126)	(323)
Surgery	(71,244)	(5,909)	(5,911)	(2)	(17,927)	(18,076)	(149)
Women and Children	(35,451)	(2,501)	(2,578)	(77)	(8,703)	(8,911)	(208)
Performance & Access	(5,165)	(426)	(424)	2	(1,281)	(1,260)	21
Operations Total	**(230,068)**	**(18,445)**	**(19,174)**	**(729)**	**(57,262)**	**(58,234)**	**(972)**
Corporate Total	**235,268**	**18,253**	**17,642**	**(611)**	**56,908**	**56,360**	**(549)**
Trust Total	**5,200**	**(192)**	**(1,532)**	**(1,340)**	**(354)**	**(1,875)**	**(1,521)**
Add back:							
Impact of Donated Asset Accounting			75	75		238	238
Impact of Impairments							
Performance against Control Total	**5,200**	**(192)**	**(1,457)**	**(1,265)**	**(354)**	**(1,637)**	**(1,282)**
Add back: Increase in annual leave accrual			959	959		959	959
Underlying position excluding increase in annual leave accrual		(192)	(498)	(306)	(354)	(678)	(323)

2.4. The Trust's performance against the financial risk rating metrics used by Monitor is as follows. Although the in-year performance has fallen the forecast is as before with the Trust achieving a rating of 3.

	Year to Date Actual		Forecast Out-turn	
	Actual	Rating	Forecast	Rating
EBITDA Margin	4.7%	2	7.2%	3
EBITDA % Achieved	76.9%	3	100.0%	5
Net Return after Financing	-0.4%	3	1.4%	3
I&E Surplus Margin	-0.7%	2	1.4%	3
Liquidity Ratio	22 days	3	23 days	3
Overall Risk Rating (after over-riding rules)		**2**		**3**

The liquidity ratio includes a Working Capital Facility of £26m

3 Recommendation

3.1 The Board is asked to note the financial performance report for June 2013.

4 Financial Performance

4.1 The table following shows the income and expenditure account for June 2013.

Western Sussex Hospitals NHS Foundation Trust
Income and Expenditure Account
for the period ending
30 June 2013

	Annual Budget £000s	In Month Budget £000s	In Month Actual £000s	In Month Variance £000s	Year to Date Budget £000s	Year to Date Actual £000s	Year to Date Variance £000s
Income							
Income from Activities	322,860	26,117	26,538	421	79,754	79,584	(171)
Other Income for Patient Care	8,783	669	562	(107)	1,977	1,812	(165)
Education Training and Research	17,948	1,494	1,549	55	4,474	4,511	37
Other Operating Income	21,606	1,790	1,614	(176)	5,336	5,036	(300)
Total Income	**371,197**	**30,070**	**30,263**	**193**	**91,541**	**90,943**	**(598)**
Pay							
Medical Staff	(66,216)	(5,571)	(5,675)	(104)	(16,483)	(16,288)	196
Nursing Staff	(94,920)	(7,803)	(7,569)	234	(23,505)	(22,430)	1,076
Professions Allied to Medicine	(17,850)	(1,482)	(1,484)	(3)	(4,432)	(4,201)	230
Professional and Technical Staff	(16,403)	(1,359)	(1,363)	(4)	(4,072)	(3,961)	111
Admin and Managerial Staff	(33,091)	(2,769)	(2,733)	35	(8,373)	(8,186)	187
Estates Staff	(15,425)	(1,286)	(1,298)	(12)	(3,863)	(3,837)	26
Agency Staff	(538)	(80)	(803)	(723)	(163)	(2,138)	(1,974)
Other Pay Costs	6,499	191		(191)	556		(556)
Total Pay Costs	**(237,944)**	**(20,158)**	**(20,925)**	**(767)**	**(60,336)**	**(61,040)**	**(704)**
Non-Pay							
Drugs	(27,004)	(2,263)	(2,019)	244	(6,788)	(6,936)	(148)
Clinical Supplies and Services	(34,306)	(2,495)	(3,023)	(528)	(8,352)	(8,465)	(113)
General Supplies and Services	(2,793)	(230)	(318)	(88)	(695)	(1,004)	(309)
Establishment Expenses	(6,775)	(649)	(622)	27	(1,740)	(1,594)	146
Premises Costs	(15,133)	(1,244)	(1,251)	(7)	(3,729)	(3,540)	188
Services from NHS Bodies	(10,101)	(780)	(868)	(87)	(2,525)	(2,544)	(19)
Services from Non NHS Providers	(1,812)	(145)	(194)	(49)	(434)	(510)	(76)
Other Operating Costs	(6,642)	(340)	(903)	(563)	(1,425)	(2,017)	(593)
Total Non-Pay Costs	**(104,566)**	**(8,146)**	**(9,198)**	**(1,052)**	**(25,688)**	**(26,611)**	**(923)**
EBITDA	**28,687**	**1,765**	**139**	**(1,626)**	**5,517**	**3,291**	**(2,226)**
Non Operating Items							
Depreciation and Amortisation	(14,986)	(1,249)	(992)	257	(3,747)	(3,128)	618
Profit/(Loss) on Disposal			16	16		21	21
Impairment of fixed assets							
Finance Costs	(1,029)	(86)	(85)	1	(257)	(204)	53
Interest Receivable			13	13		13	13
Public Dividend Capital Dividend	(7,472)	(623)	(623)	()	(1,868)	(1,868)	()
Total Non-Operating Items	**(23,487)**	**(1,957)**	**(1,671)**	**286**	**(5,872)**	**(5,167)**	**705**
Net Surplus/(Deficit)	**5,200**	**(192)**	**(1,532)**	**(1,340)**	**(354)**	**(1,875)**	**(1,521)**
Add back:							
Donated Asset Income	(1,048)	(87)	(8)	80	(262)	(8)	254
Donated Asset Depreciation	1,048	87	82	(5)	262	246	(16)
Impact of Donated Asset Accounting	0		75	75		238	238
Impairment of Fixed Assets	0	0			0		
Performance against Control Total	**5,200**	**(192)**	**(1,457)**	**(1,265)**	**(354)**	**(1,637)**	**(1,283)**
Add back: Increase in annual leave accrual			959	959		959	959
Underlying position excluding increase in annual leave accrual		(192)	(498)	(306)	(354)	(678)	(324)

4.2 Income: The income from activities position reflects actual activity in the year to date.

4.3 A shortfall in income relating to injury cost recovery (£75k) contributed towards the overall adverse variance on other income for patient care.

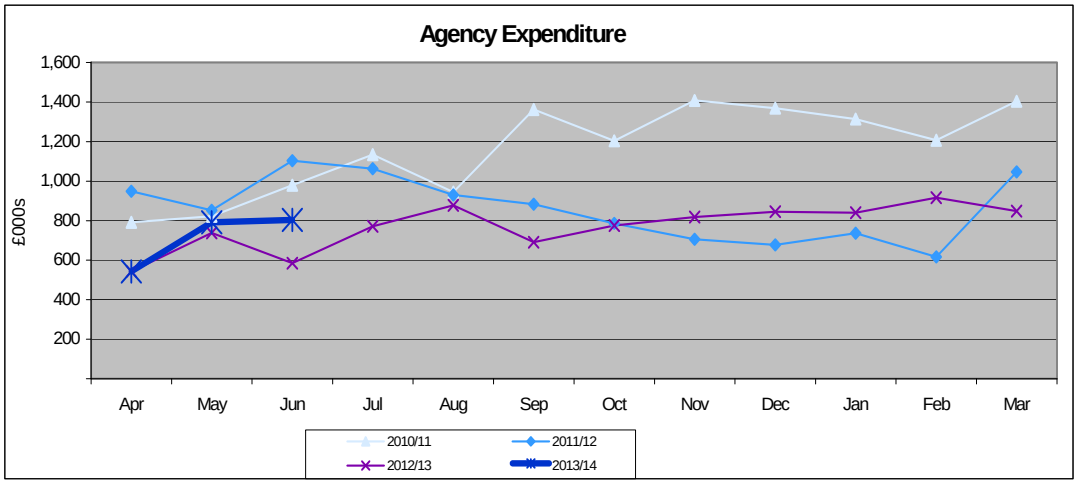
4.4 Other than an adverse variance on the value of donated assets received (£80k), the in-month variance on other operating income is an accumulation of income shortfalls across the divisions. The impact of donated asset accounting, including depreciation, is deducted

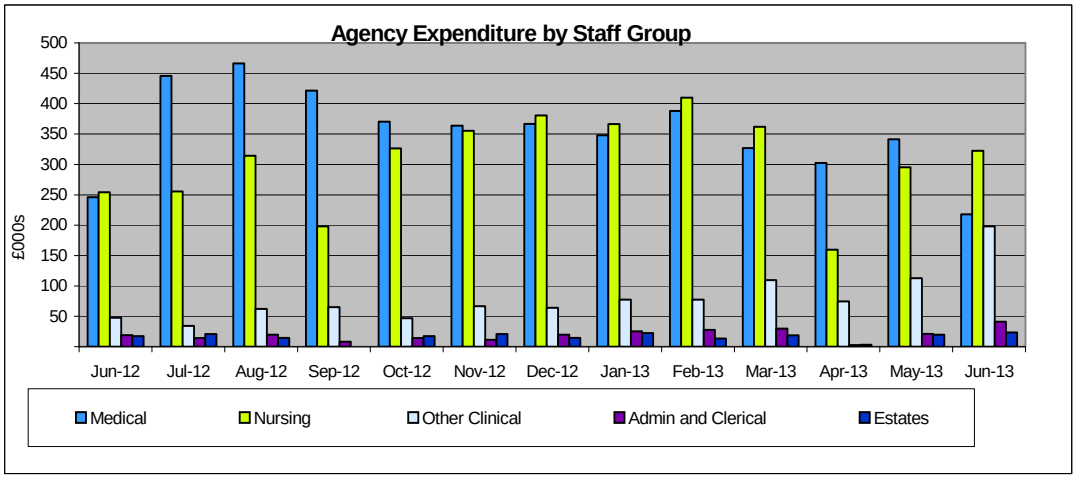
from the net surplus in calculating the Trust's financial performance against its control total.

4.5 Pay: Consistent with the first two months of the year, total pay expenditure in June (after deducting the increase in the annual leave accrual of £959k) was in line with budget.

4.6 The increase in the annual leave accrual arises from a requirement to report the outgoing NHS Trust's financial position in line with international accounting standards. It represents the financial liability arising from annual leave entitlement not taken by the end of the accounting period. An underlying representative amount is always included within the financial position but a seasonal adjustment has been made as staff typically accumulate leave to take in Summer. The figure is supported by a sample of annual leave records reviewed. This accrual is expected to reverse by the year-end.

4.7 Agency costs are slightly higher than last month. The total cost is represented by the following graphs.





4.8 As reported last month, some pay aspects of the cost improvement programme are still being worked through and so the in-month planned savings foregone are recorded under other pay costs.

4.9 Non-Pay: The adverse variance on clinical supplies and services falls across several divisions. For example, within Core division a replacement CT tube has been purchased (£80k) as well as replacement parts in Imaging (£35k). Also a purchase of minor endoscopic equipment has occurred in the Medicine division (£89k). Within Surgery the overall level of supplies within month is high in part due to the purchase of theatre

instruments as part of the T&O upsize scheme (£92k). An additional maintenance contract (£40k) and net stock adjustment (£33k) have also contributed.

5 Statement of Financial Position

5.1 The Statement of Financial Position is shown below.

	In Month			Year to Date		
	Opening Balance £000s	Closing Balance £000s	Movement £000s	Opening Balance £000s	Closing Balance £000s	Movement £000s
Non-Current Assets						
Property, Plant and Equipment	240,889	241,933	1,044	241,139	241,933	794
Intangible Fixed Assets	1,035	1,284	249	1,413	1,284	(129)
Trade and Other Receivables						
Total Non-Current Assets	**241,924**	**243,218**	**1,294**	**242,552**	**243,218**	**666**
Current Assets						
Inventories	5,598	6,564	966	6,060	6,564	504
Trade and Other Receivables	4,001	13,830	9,829	11,889	13,830	1,941
Prepayments & Accrued income	11,106	6,362	(4,744)	4,279	6,362	2,083
Cash and Cash Equivalents	18,632	13,373	(5,258)	12,528	13,373	845
Total Current Assets	**39,337**	**40,130**	**793**	**34,756**	**40,130**	**5,374**
Current Liabilities						
Trade and Other Payables	(31,290)	(34,918)	(3,628)	(26,921)	(34,918)	(7,997)
Working Capital Loan	(2,421)	(2,421)		(2,421)	(2,421)	
Capital Investment Loan	(900)	(900)		(900)	(900)	
Borrowings	(182)	(140)	42	(239)	(140)	99
Provisions for Liabilities and Charges	(617)	(655)	(38)	(640)	(655)	(15)
Total Current Liabilities	**(35,410)**	**(39,034)**	**(3,624)**	**(31,121)**	**(39,034)**	**(7,913)**
Net Current Assets/(Liabilities)	**3,927**	**1,096**	**(2,831)**	**3,635**	**1,096**	**(2,539)**
Non Current Liabilities						
Working Capital Loan	(2,413)	(2,413)		(2,413)	(2,413)	
Capital Investment Loan	(13,271)	(13,271)		(13,271)	(13,271)	
Borrowings	(2,498)	(2,493)	4	(2,493)	(2,493)	()
Provisions for Liabilities and Charges	(2,574)	(2,574)	()	(2,574)	(2,574)	
Total Non Current Liabilities	**(20,755)**	**(20,751)**	**4**	**(20,751)**	**(20,751)**	
Net Assets	**225,095**	**223,563**	**(1,532)**	**225,436**	**223,563**	**(1,873)**
Taxpayers' Equity						
Public Dividend Capital	237,785	237,785	()	237,785	237,785	()
Retained Earnings	(41,422)	(42,954)	(1,532)	(41,082)	(42,954)	(1,872)
Revaluation Reserve	28,732	28,732	()	28,733	28,732	(1)
Total Taxpayers's Equity	**225,095**	**223,563**	**(1,532)**	**225,436**	**223,563**	**(1,873)**

5.2 A Trust-wide stock-take took place at the end of June as part of the producing the part-year accounts. The increase in stock value is shown in the Statement of Financial Position.

5.3 The £10m working capital loan referred to last month has been received in July, thereby improving the Trust's liquidity.

5.4 The capital position as at the end of June is presented below. A review of how capital projects will be delivered over the remainder of the year has been undertaken with budgets reprofiled to reflect the outcome. In month, expenditure has been ahead of plan but is behind for the year to date. Current forecasts indicate that the outturn will be exceeded by £495k. This includes expenditure on the IM&T refresh project.

CAPITAL PROGRAMME 2013/14: as at 30th June 2013

Capital Resource	2013/14 Plan £000s
Capital Programme "core" resource	13,837
Capital resource brought forward	6,402
Capital resource brought forward - Breast Unit	6,286
New Capital Investment Loan - Emergency Floor	4,224
less: Capital Investment Loan Repayments on:	
Existing loans	(900)
New loans	(169)
Improving the birthing environment (PDC receivable in 13/14)	350
Donations - Love Your Hospital	375
Donations - Friends	375
Donations - CT Scanner (Friends/Love Your Hospital)	(850)
Net receipts from disposal of surplus assets - Thakeham House	545
	32,175

Expenditure	2013/14 Plan £000s	In Month Budget £000s	In Month Actual £000s	In Month Variance £000s	Year to Date Budget £000s	Year to Date Actual £000s	Year to Date Variance £000s	Forecast Outturn £000s
Charitable additions								
Charitable donation expenditure	**(750)**	**(53)**	**(8)**	**45**	**(53)**	**(8)**	**45**	**(750)**
CT Scanner								
CT Scanner	(850)	(835)	(835)	0	(835)	(835)	0	(850)
CT Scanner - Building works	(369)	(50)	(51)	(1)	(150)	(91)	59	(300)
	(1,219)	**(885)**	**(886)**	**(1)**	**(985)**	**(926)**	**59**	**(1,150)**
Emergency Floor								
Emergency Floor	**(4,224)**	**(53)**	**(8)**	**45**	**(53)**	**(53)**	**0**	**(4,224)**
Breast Care Centre								
Breast Screening - New Build	(4,000)	(350)	(343)	7	(1,608)	(917)	691	(4,000)
Breast screening - New Build Equipping	(2,500)	0	0	0	0	0	0	(2,500)
	(6,500)	**(350)**	**(343)**	**7**	**(1,608)**	**(917)**	**691**	**(6,500)**
Medical equipment								
General medical equipment	(1,508)	(50)	(36)	14	(489)	(41)	448	(1,508)
Theatre high priority capital items	(258)	(150)	(170)	(20)	(150)	(192)	(42)	(258)
Equip a theatre at Worthing (proposed CIP to increase T&O income)	(173)	0	0	0	0	0	0	(173)
Endoscopy scopes	(17)	0	0	0	0	0	0	(17)
Ultrasound (obstetric) equipment replacement	(240)	0	0	0	0	0	0	(240)
SSD - centralisation of ENT probes	(139)	0	0	0	0	0	0	(139)
	(2,335)	**(200)**	**(206)**	**(6)**	**(639)**	**(233)**	**406**	**(2,335)**
Pre-Admissions								
Day Surgery Conversions - pre admission Chanctonbury	(770)	30	2	(28)	(120)	(11)	109	(825)
MFU / ENT consolidation	(267)	(200)	(196)	4	(200)	(383)	(183)	(383)
Day Surgery dependency - Refurb ENT for DOME offices	(330)	0	0	0	0	0	0	(357)
	(1,367)	**(170)**	**(194)**	**(24)**	**(320)**	**(394)**	**(74)**	**(1,565)**
Southlands								
Southlands Ophthalmology	(600)	(20)	(9)	11	(20)	(19)	1	(600)
Southlands Infrastructure	(660)	0	0	0	0	0	0	(660)
	(1,260)	**(20)**	**(9)**	**11**	**(20)**	**(19)**	**1**	**(1,260)**

Expenditure	2013/14 Plan £000s	In Month Budget £000s	In Month Actual £000s	In Month Variance £000s	Year to Date Budget £000s	Year to Date Actual £000s	Year to Date Variance £000s	Forecast Outturn £000s
Imaging - Interventional Radiology								
Interventional Room - Equipping	(489)	0	0	0	0	0	0	(489)
Interventional Room - Reporting rooms	(903)	0	(249)	(249)	(395)	(252)	143	(953)
Interventional Rroom - Build costs	(500)	0	0	0	0	0	0	(500)
Interventional Room - Equipping	(489)	0	0	0	0	0	0	(489)
	(2,381)	**0**	**(249)**	**(249)**	**(395)**	**(252)**	**143**	**(2,431)**
Endoscopy								
Endoscopy	(600)	0	0	0	0	0	0	(400)
Endoscopy	(642)	0	0	0	0	0	0	(42)
Pre-assessment relocation (dependency for Endoscopy programme Worthing	(350)	0	0	0	0	0	0	(350)
	(1,592)	**0**	**0**	**0**	**0**	**0**	**0**	**(792)**
Worthing Health Education Centre								
Post Graduate Medical Centre	**(250)**	**0**	**(1)**	**(1)**	**0**	**(14)**	**(14)**	**(250)**
Pathology								
Diagnostic Block Roofs	(300)	0	0	0	0	0	0	(300)
Move Chemistry into Haematology Lab, incl. consultants & secretaries	(100)	0	0	0	0	0	0	(100)
Order Comms: Tablets / hardware only	(50)	0	0	0	0	0	0	(50)
Worthing refurbishment	(214)	0	0	0	0	0	0	(214)
Worthing Maintenance	(70)	0	0	0	0	0	0	(70)
Purchase of Blood Track Courier Fridge Control System	(26)	0	0	0	0	0	0	(26)
Pathology re-modelling of vacant space	(474)	0	(7)	(7)	(180)	(7)	173	(474)
	(1,234)	**0**	**(7)**	**(7)**	**(180)**	**(7)**	**173**	**(1,234)**

Expenditure	2013/14 Plan £000s	In Month Budget £000s	In Month Actual £000s	In Month Variance £000s	Year to Date Budget £000s	Year to Date Actual £000s	Year to Date Variance £000s	Forecast Outturn £000s
Estates enabled schemes								
Sustainability Initiatives	(550)	0	(42)	(42)	(70)	(88)	(18)	(550)
West Wing Refurbishment - Infrastructure	(1,273)	0	322	322	(188)	(87)	101	(1,273)
Main Ward Block upgrades (lighting upgrades etc)	(350)	0	0	0	0	0	0	(350)
Lift refurbishment programme	(270)	0	0	0	0	0	0	(270)
Outpatient department	(345)	0	0	0	0	0	0	(345)
ITU refurbishment	(50)	0	0	0	0	0	0	(50)
Targeted Backlog: High risk remedial	(265)	(100)	(373)	(273)	(317)	(374)	(57)	(374)
Targeted Backlog: Built environment infrastructure	(405)	0	0	0	0	0	0	(405)
Targeted backlog: M&E backlog	(270)	0	0	0	0	0	0	(270)
Fire: Compliance with standards	(289)	0	0	0	0	0	0	(272)
Residential Accommodation improvements	(50)	0	0	0	0	0	0	0
Catering Project	(240)	0	(31)	(31)	(40)	(90)	(50)	(240)
Minor works and small schemes	(925)	(80)	(117)	(37)	(294)	(122)	172	(942)
Security	(15)	0	0	0	0	0	0	0
PLACE (was PEAT)	(120)	0	0	0	(50)	0	50	(50)
Non Medical Equipment	(50)	0	1	1	0	1	1	(50)
	(5,467)	**(180)**	**(240)**	**(60)**	**(959)**	**(760)**	**199**	**(5,441)**
IM&T enabled solutions								
IM&T infrastructure and resilience (procurement)	(1,802)	0	(9)	(9)	(50)	(36)	14	(3,571)
PACS	(125)	0	(126)	(126)	0	(126)	(126)	(126)
IT maintenance / PC refresh etc	(377)	0	0	0	0	0	0	(50)
Clinical systems	(19)	0	(18)	(18)	(19)	(18)	1	(18)
Medical Revalidation and Appraisal	(150)	0	0	0	0	0	0	(150)
E-prescribing	(416)	0	0	0	0	0	0	(416)
Maternity Information system (community solution)	(75)	0	0	0	0	(42)	(42)	(75)
Critical Care Information System	(312)	0	0	0	0	0	0	(312)
Theatre system	(20)	0	0	0	0	0	0	(20)
	(3,296)	**0**	**(153)**	**(153)**	**(69)**	**(222)**	**(153)**	**(4,738)**
Unallocated	**(300)**							
	(32,175)	**(1,911)**	**(2,304)**	**(393)**	**(5,281)**	**(3,805)**	**1,476**	**(32,670)**

WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST

To: Board

Date of Meeting: 1 August 2013 Agenda Item: 12

Title
Annual Plan and Board Assurance Framework 2013/14: Quarter 1 Review
Responsible Executive Directors
Marianne Griffiths, Chief Executive Denise Farmer, Director of Organisational Development & Leadership
Prepared by
Ann Merricks, Interim Company Secretary Oliver Philips, Head of Strategic Planning
Status
Disclosable
Summary of Paper
At its meeting in April 2013 the Board approved the Trust's Annual Plan for 2013/14, which detailed how the Trust would achieve the corporate objectives it had set itself for the year, delivered through a range of programmes, each with key aims, work-streams, milestones and measures of success identified. The Board also approved a Board Assurance Framework (BAF) for the financial year. The BAF sets out and rates the principal risks to the achievement of the Trust's corporate objectives for the year, together with the controls and sources of assurance through which the risks are managed. The BAF states that it will be subject to review following the end of each quarter and that in-depth risk reviews will be undertaken through a schedule approved by the Board. This paper jointly presents a review at the end of quarter one of the Annual Plan delivery, reviewing progress against delivery of the corporate objectives, and the BAF which assesses the risks to the achievement of these objectives
Implications for Quality of Care
A number of the risks within the register extract present implications for care. The BAF is an inherent part of the arrangements through which management addresses those implications.
Link to Strategic Objectives/Board Assurance Framework
The BAF forms an important part of the Trust's risk management arrangements, linked to the Risk Register.
Financial Implications
A number of the risks within the BAF present financial implications. The BAF is an inherent part of the arrangements through which management addresses those implications.
Human Resource Implications
A number of the risks within the BAF present human resource implications. The BAF is an inherent part of the arrangements through which management addresses those implications.

Recommendation
The Board is asked to: **a) <u>REVIEW and NOTE</u> progress against the Annual Plan 2013/14;** **b) <u>REVIEW and NOTE</u> the Board Assurance Framework.**
Communication and Consultation
Chief Executive, Executive Directors, Directors of Clinical Services
Appendices
Corporate Objectives Progress Report Board Assurance Framework

This report can be made available in other formats and in other languages. To discuss your requirements please contact Ann Merricks, Interim Company Secretary, on ann.merricks@wsht.nhs.uk or 01903 285288.

WESTERN SUSSEX HOSPITALS NHS TRUST

To: Board Date: 1 August 2013

From: Oliver Phillips, Head of Strategic Planning Agenda Item: 12

Ann Merricks, Interim Company Secretary

FOR DECISION

ANNUAL PLAN AND BOARD ASSURANCE FRAMEWORK 2013/14: QUARTER 1 REVIEW

1.00 INTRODUCTION

1.01 At its meeting in April 2013 the Board approved the Trust's Annual Plan for 2013/14, which detailed how the Trust would achieve the corporate objectives it had set itself for the year, delivered through a range of programmes, each with key aims, work-streams, milestones and measures of success identified.

1.02 The Board also approved a Board Assurance Framework (BAF) for the financial year. The BAF sets out and rates the principal risks to the achievement of the Trust's corporate objectives for the year, together with the controls and sources of assurance through which the risks are managed. The BAF states that it will be subject to review following the end of each quarter and that in-depth risk reviews will be undertaken through a schedule approved by the Board.

1.03 This paper jointly presents a review at the end of quarter four (year-end) of the Annual Plan delivery, reviewing progress against delivery of the corporate objectives, and the BAF which assesses the risks to the achievement of these objectives.

2.00 RECOMMENDATIONS

The Board is asked to:

a) <u>REVIEW and NOTE</u> outcomes against the Annual Plan 2013/14;

b) <u>REVIEW and NOTE</u> the Board Assurance Framework.

3.00 PROGRESS ON DELIVERING THE ANNUAL PLAN

3.01 Every year the Trust publishes its Annual Plan, which outlines how the Trust will achieve its corporate objectives for the year. For 2013-14 the Trust agreed corporate objectives for the year, linked back to the strategic themes of patient experience, outcomes, safety, providing local services, being joined-up, improvement and sustainability.

3.02 Corporate delivery programmes were put in place to ensure that these corporate objectives were delivered. Each of these corporate delivery programmes were detailed in the Annual Plan, outlining the aims of the programme, the key work streams, the measures of success to be used and the corporate objectives supported. Where appropriate, quarterly milestones were also identified.

3.03 This report will be provided to Board quarterly to update the Board on progress against each of the corporate delivery programmes. This report (Appendix 1) summarises the key aims and work-

streams of each programme to the end of quarter 1, reporting on progress and the programme status. Please refer to the Trust's Dashboards where outcome measures are reported.

4.00 CORPORATE OBJECTIVES - AT A GLANCE

4.01 This quarterly report is structured against our seven strategic objectives 'We Care'. There are 14 corporate objectives (labeled A1 to G3) – which in turn are supported by 25 groups of delivery programmes. Each group of delivery programmes has been RAG rated.

4.02 Good progress has been made across the range of objectives. There is only 1 Red rating where progress is significantly behind expectation. This relates to corporate objective C1 - Deliver the patient safety gains specified in the Quality Strategy. The Trust has reported a C.Difficle rate at the end of Q1 of 25 cases. The upper limit is 46 for the 2013-14 year. A number of actions and improvements have been put into place during Q1 to improve performance.

5.00 REVIEW OF THE BOARD ASSURANCE FRAMEWORK

5.01 Executive Directors have reviewed the risks assigned to them, assessing the validity of the risks, their gross and net ratings, and the effectiveness of the controls and sources of assurance used to manage the risks.

5.02 As would be expected in Q1, the review has not resulted in material changes to the BAF.

5.03 Alongside the review of the BAF, in accordance with the schedule approved by the Board, two risks have been subject to in-depth reviews:

- E1.1 External partners fail to help deliver demand management programmes (LHE) and capacity / demand alignment is compromised
- E2: We don't reap the benefits of a Council of Governors as part of our development as an FT

5.04 The in-depth review reports are presented for discussion alongside the amended BAF.

Corporate Objectives 2013-14 – Quarter 1 Progress Report

We care about….		…you			
Corporate Objective	**Primary delivery programmes**	**Measures of success**	**Q1 Milestones - April - June 2013**	**Progress to date**	**RAG**
[A1] Increase the number of staff and patients who would recommend the Trust to family and friends Executive Lead: DNPS	National Surveys and Actions Plans for: 1. Maternity services 2. Inpatients 3. Cancer Patient Experience 4. Chemotherapy Patient Experience	1. Improved score for patient rating of overall quality of care in national surveys (outpatient and inpatient), with the longer-term aim of being in the top 20%	1. National Inpatient Survey results published - Improvement areas identified and improvement plan approved at Trust Board	1. National surveys - Trust scored Amber for overall quality of care which improved from the Red score in the 2011 survery. Improvement areas identified and approved by Management Board. Reported to Trust Board in April 2013. Improvement priorities for 2013-14 are: Provision of information on discharge home, Pain control for patients, appointment and admission time changes, patient consent and patient nutrition. 2012-13 priority areas achieved by increased scores in 2013-14 relating to: patients being asked their views on the quality of care provided, patients receiveing information about how to raise a complaint and whether patients were bothered by noise at night.	Green
	Real-time patient feedback programmes to include: Inpatient, Outpatient, Maternity & Children's services and Cancer experience pilot	2. Improved patient experience feedback using real-time feedback for overall quality of service [2013-14 Improvement targets to be agreed in Q1 at Quality Board]	1. Additional handheld units purchased for wards & kiosks for outpatient settings, subject to approvals 2. Real-time feedback data presented to Quality Board and improvement areas/ targets agreed for 13/14 3. Real-time pilot designed and implemented for lung, skin and urology cancer patients	1. Proposals for charitable funds were unsuccessful in Q1. Currently scoping a business plan for purchase of more hand held and kiosk devices from Trust funds. 2. Real-time feedback report submitted to Quality Board in April '13. Identification of priority areas outstanding - awaiting appointment of new Head of Patient Experience. 3. Pilot for lung and skin cancer patients commenced in Q1. Over 50 patient responses to date with an overall positive outcome. Urology to pilot in Q2. Overall, our patient feedback regarding overall quality of care in Q1 told us that we were providing safe and compassionate care.	Amber
	1. Inpatient Friends & Family survey programme 2. A&E Friends & Family survey programme	3. Improved Friends and Family national survey results with the aim of achieving upper quartile performance 2013-14 Improvement targets to be agreed in Q1 at Quality Board when comparative data is available	1. Continue to develop baseline data building on pilot, and submit first national submission 2. Present WSHT analysis from pilot to F&F Working Group to agree WSHT response rate baseline and aspiration	1. First national F&F submission completed in Q1. Awaiting publication of first national responses in July 2013 to benchmark and compare. Responses are lower than antitipcated for Q1. Research has been conducted into how neighbouring Trust's are implementing the survey and an action plan being devised to increase participation.	Amber

We care about….		…you			
Corporate Objective	**Primary delivery programmes**	**Measures of success**	**Q1 Milestones - April - June 2013**	**Progress to date**	**RAG**
[A1] Increase the number of staff and patients who would recommend the Trust to family and friends Executive Lead: DLOD	1. Staff Survey Action Plan (refreshed for 13/14) 2. Management & Leadership Development Programme (MLDP)	4. Improved staff survey results – top quartile for national surveys 5. 10% improvement in staff who know how to raise a concern (2012-13 baseline 70%) and are confident to do so (2012-13 baseline 55%)	1. Divisional Action Plans in response to staff survey developed and agreed 2. Health & Wellbeing strategy approved and implementation commenced 3. MLDP reviewed and improved according to evaluation feedback 4. Business case approved to secure investment to create a designated staff area	1. Divisional Action Plans updated with 2012 findings and progress against actions monitored quarterly 2. Health and Wellbeing strategy agreed. H&WB Board established. Health Improvement Plan developed and key initiatives approved to include Rapid Access to Physiotherapy, Fit2Work programme, stress management training and additional counselling. 3. MLDP reviewed and new programme to commence from early 2014. 4. Designated staff area identified and notice served and accepted on current spaceholders. Detailed designs to be developed in Q2. 5. Review of the reporting system 'Datix' underway to enable effective feedback to staff who raise concerns.	Green
[A1] Increase the number of staff and patients who would recommend the Trust to family and friends Executive Lead: COO	1. Improving the Outpatient Experience 2. Referral to Treatment pathway management	6. Improve perception of staff attitude and behaviour resulting in a reduced number of complaints in hotspot areas from 2012-13 baseline, with a focus on Ophthalmology and Trauma & Orthopaedic appointments in the first instance 7. Outpatient concern rate reduced to 0.098 per 10,000 outpatient attendances (from 0.10 in 2012-13), against an agreed demand plan and resource allocation	1. Business case approved to upgrade the Outpatient Call Centre call handing system, enabling partial booking 2. Business case approved for improvements in 18 week surgical pathways for Trauma & Orthopaedics. Solution implemented.	1. Business case developed and ET approval secured during Q1. Tender process and contract award planned during Q2. 2. Business case approved and additional theatre sessions online during Q1. Equipment ordered and being received to deliver the increased activity.	Green

We care about….		…quality			
Corporate Objective	**Primary delivery programmes**	**Measures of success**	**Q1 Milestones - April - June 2013**	**Progress to date**	**RAG**
[B1] Deliver the quality outcome gains specified in the Trust's Quality Strategy, and demonstrate full compliance against Monitor's Quality Governance Framework Executive Lead: MD	1. CQUIN delivery 2. Enhanced Recovery Programmes 3. Enhancing Quality 4. Implementing care bundles 5. Fractured Hip Improvement Programme 6.Mortality & Morbidity Reviews 7. Safe Maternity Care (CNST Level 2)	1. Achieve a HSMR of <100 by the end of 2013-14. 2. CQUIN indicators achieved that relate to quality of care (as agreed by commissioners) 3. Most significant areas of care resulting in high mortality targeted, through pathway specific standardisation using the care bundle approach, focusing on hip fracture, pneumonia, COPD and heart failure, monitored through HSMR 4. Reduced 30-day mortality following hip fracture so that the trust lies within the middle two quartiles of mortality in the National Hip Fracture Database 5. Continued achievement of maternity CNST level 2 indicators	1. Develop CQUIN / EQ: oversight function; delivered in line with agreed schedule 2. Implement all actions from Moran Report regarding fractured hip pathway 3. M&M ToR reviewed and agreed 4. Maintained CNST level 2 indicators	Please refer to Q1 Quality Report regarding HSMR and mortality outcomes. 1. CQUINS agreed with additional local quality indicators. Internal governance structure agreed and implemented for delivery. 2. Progress against the Moran recommendations on track and submitted to Board in June 2013. Next progress report due for Board September 2013. 3. M&M TOR reviewed, updated and agreed by Board. 4. CNST level 2 indicators continue to be attained and preparations underway to assess requirements and benefits of achieving level 3.	Green
	Implementation of the Trust's Quality Governance Action Plan	6. Continue to improve our assessment score against the ten areas in Monitor's Quality Governance Framework	1. CIP quality dashboard introduced 2. Implement changes to risk management following external review 3. Appoint substantive NED with clinical background	1. Monitor re-assessment of quality govenrnance framework gave score of 3.5, sufficient for authorisation. CIP Dashboard introduced during Q1. 2. Changes to risk management processes introduced during Q1. 3. Appointment of clinical NED will now be considered in conjunction with the Council of Governors	Green
[B2] Reduce our rates of avoidable readmissions Executive Lead: COO	1. Reducing avoidable readmissions Service Improvement Programme| 2. OneCall OneTeam lead provider programme	1. Reduced 30-day readmission rate in line with our agreement with Commissioners	1. Methodology and framework agreed 2. Multi-professional clinical audit completed to ascertain 13/14 contractual readmission threshold	1. Framework developed and agreed with commissioners for 2013 clinical review. 2. Audit at Worthing Hospital completed involving 18 clinicians from primary and secondary care. 100 case notes reviewed. Second audit scheduled in Chichester on 24.07.2013. Audit outcome analysis anticipated to be complete by August / September 2013 to agree thresholds and identify areas for improvement and reinvestment in the health economy.	Green

We care about….		…safety			
Corporate Objective	**Primary delivery programmes**	**Measures of success**	**Q1 Milestones - April - June 2013**	**Progress to date**	**RAG**
[C1] Deliver the patient safety gains specified in the Quality Strategy Executive Lead: DNPS	Safety Thermometer Programme including: Catheter care VTE Falls Pressure Ulcers	1. Internal Safety Thermometer - 95% harm free, 97% no new hospital acquired harms 2. Improved Trust Patient Aggregate Safety Score (PASS) score, of <100 compared to 13-14 baseline 3. No Never Events recorded	1. Indwelling catheter action plan developed and implemented 2. Agree Inpatient falls and pressure ulcer incident trajectories with commissioners 3. Develop a pressure ulcer incident improvement plan for maternity services	98% Harm free care at the end of quarter 1 - exceeding target. 1. Catheter action plan yet to be actioned due to operational priorities. To be taken forward in Q3. 2. Trajectories agreed with commissioners via CQUINS programme. 3. Pressure ulcer plan for maternity currently being developed to include care of birthing women during labour and birthing mothers receiving epidurals. To be agreed and implemented in Q2. 4. VTE nurse specialists appointed on both sites and in post from July 2013 to deliver VTE assessments; a key Safety Thermometer metric. Safety Thermometer newletter published on nursenet in June 2013.	Amber
	Electronic Prescribing and Medicines Management	4. Implementation of an Electronic Prescribing and Medicines Management system	1. Procurement commenced for EPMA system	1. Procurement process underway in line with schedule. Supplier presentations and evaluation of responses scheduled during Q2 . National 'Safer hospitals safer wards' funding to be applied for during Q2.	Green
	Infection Control programme	5. Zero avoidable MRSA bloodstream infections that are hospital acquired, taking measures to protect the patient and aiming to remain free of avoidable MRSA 6. Reduced Clostridium Difficile cases to within a revised limit of 46 for 2013/14 (from a limit of 75 in 2013/14)	1. Environment audits continued and results reviewed, with improvement plans developed where appropriate	1. MRSA bacteraemia - zero for 2013/14 C.difficile rates above trajectory (25 cases in Q1). Weekly C.difficile task force meetings in place since March. Ongoing focus on the environment with deep cleaning programme, ward repair work, and use of Vapourised Hydrogen Peroxide (Bioquell) on all wards. Antibiotic policy and C.Difficle guidelines launched early July 2013. Environmental audits continue.	Red
[C1] Deliver the patient safety gains specified in the Quality Strategy Executive Lead: DNPS	Facilities and estates environment assessments	7. Demonstrated compliance with national water standards & guidance on water sampling	1. Review Trust compliance against current water hygiene standards; develop mitigation plan as appropriate	1. Compliance with national water standards and water sampling monitored through Estates and Infection Control operational Group.	Green
	1. Food Strategy Group programme 2. Intentional Rounding	8. Achieved MUST scores of 80% at 24 hours & 95% at 7 days	1. Implement improvements to improve MUST screening indicators including intentional (comfort) rounding, provision of additional weight scales and pictorial menus	1. Intentional rounding audits in place and report to be presented at September 2013 Heads of Nursing meeting. 2. More scales brought and improvements made made to paperwork to aid recording of weight. 3. Menus now live on SRH site. Delay to actioning on WH site due to building delays, however anticipated completion by 1st week of September or earlier if possible. 4. Positive feedback received from Youth Council regarding paediatric nutrition, and PLACE audits rated food very highly.	Amber
	Theatres Action Plan	9. 100% compliance with World Health Organisation (WHO) Theatre Checklist 10. Continued improvement in staff satisfaction measured through appraisal, sickness and leadership development programme	1. Priority 1 equipment items purchased and received 2. Phase II Theatre Service Improvement Plan developed signed off	1. Priority equipment items have been ordered with 75% of items received in Q1. 2. Theatre Service Improvement plan agreed and implementation commenced in line with schedule.	Green

We care about….		…serving local people			
Corporate Objective	**Primary delivery programmes**	**Measures of success**	**Q1 Milestones - April - June 2013**	**Progress to date**	**RAG**
[D1] Implement our long-term Clinical Services Strategy Executive Leads: COO / DODL	Emergency Floor development	1. Emergency Floor - External funding secured and main construction phase commenced	1. Main phases of emergency floor commenced following external funding confirmation - 15 month programme due for completion by winter 2014.	Preliminary works underway to main phase of the development. Estimated completion winter 2014 and opportunities to accellerate will be reviewed throughout the construction phase.	Green
	Breast Screening Unit development	2. Breast Screening Unit - opening of building in line with agreed schedule; deployment of mobile screening units in line with business case; ability to screen an age extended population resulting in early screening/detection	1. Construction in line with agreed schedule 2. Imaging equipment ordered	Breast Care Centre construction on track with an estimated completion date November 2013. Opening ceremony planned for early 2014 following commissioning of the building and staff training. Imaging equipment procurement underway with contract award anticipated in early Q2.	Green
	Southlands ambulatory care development	3. Ophthalmology - Board approval for investment into Southlands and construction phase commenced	1. Market assessment for ophthalmology concluded 2. Strategic Outline Case approved	Market assessment concluded. Strategic Outline Case for Southlands redevelopment received by Board June 2013. Next steps to develop detailed service strategy for the site and development of an Outline Business Case. Progress slower than anticipated due to complex natuire of the development.	Amber
	Interventional Radiology	4. Interventional Radiology - Opening of rooms at both SRH & Worthing improving patient experience, outcomes and service resillience	1. Continue construction at SRH & conduct a feasibility study for possible IR options at Worthing Hospital 2. Commence development of OBC for Worthing IR	IR developmnet on track and due for completion in Q2 as planned. Options appraisal for Worthing IR underway. Due to unforseen opportunity to improve adjacent areas, scope has widened and an outline business case is now planned for Q2.	Green
	Theatre pre-admission environment	5. Theatre Pre-Admissions - Completion of agreed programme resulting in improved patient experience feedback	1. Trust Board approval to proceed with pre-admission solution at Worthing; construction commences	Board approval secured in April 2013 and programme of works has commenced. Estimated completion date August for main phase; end of 2014 for subsequent 2 phases.	Green
	Endoscopy services	6. Endoscopy - Board approval to invest into endoscopy services at both Worthing & SRH; Continued accreditation by JAG (EXPAND);	1. Continued development of activity and workforce modelling	Endoscopy business case has received intensive focus during Q1. Significant scoping of options has been undertaken and activity modelling complete. Submission of a Strategic Outline Case to Finance & Investment scheduled for July 2013.	Amber
	Deliver alignment between the Clinical Services Strategy and Capital Investment	7. Improved Trust capability to manage a forecast increase in demand	1. Capital expenditure reviewed against forecast	Capital forecast intentionally not developed during Q1 due to known risks with the programme. Expenditure monitored and financial report submitted to Finance & Investment committee for Q1.	n/a

We care about….		…being stronger together			
Corporate Objective	**Primary delivery programmes**	**Measures of success**	**Q1 Milestones - April - June 2013**	**Progress to date**	**RAG**
[E1] In partnership with our emerging CCG, develop our lead role in the local health economy for unscheduled and planned care pathways Executive Lead: COO	1. Unscheduled care pathways 2. Planned care pathways	1. Achieve agreed milestones in line with programme Plans	1. Joint strategic planning underway with CCG & local partners to agree programme plans for both unscheduled and planned care 2. In partnership with the CCG, develop service specification and commissioning framework for OneCall OneTeam	1. OCOT programme and implementation plan in place and monitored weekly, Performance improving month on month. Trust has actively responded in Q1 to recent CCG Requests for Information regarding MSK & Dermatology provision to inform future commissioning and provision models. Await outcome of this information gathering process in Q2. 2. OCOT service specification reviewed with CCG and will be agreed as part of the new commissioning arrangements. Evaluation of OCOT completed to inform commissioning and specification changes. New commissioning arrangements and contractual changes to be completed in Q2.	Green
[E2] Ensure a successful and engaged Council of Governors Executive Lead: DODL	Council of Governors Development Programme	1. Induction Programme delivered with positive evaluation 2. Membership engagement and recruitment events held in line with agreed 13-14 schedule. 3. Positive evaluation feedback from the Annual Member Event	1. Conduct short survey among governors to understand level of awareness about the trust in terms of services provided, priorities, the role of governors and their opinion of the organisation 2. Agree development & communications plans	- Council met three times in shadow form prior to FT authorisation, each meeting including seminar-style development presentations for Governors. - Number of informal 'drop-in' meetings were held with the Chairman. - Council held its first post-authorisation meeting on 9 July 2013 and the Annual Member Meeting, which was well attended, was held on 17 July. - A facilitated Governor development awayday is planned for September, to agree the development programme and to discuss the role of the Lead Governor. - The development programme will be implemented thereafter, including the development of a member recruitment and engagement strategy.	Green

We care about….		…improvement			
Corporate Objective	**Primary delivery programmes**	**Measures of success**	**Q1 Milestones - April - June 2013**	**Progress to date**	**RAG**
[F1] Continue to improve the patient environment through net investment in the Trust's Estate Executive Lead: DoF	1. Capital investment programme 2. Refurbishment programme 3. PLACE programme	1. Improved condition of the Trust's Estate by raising standards to category B through investment into routine maintenance and the Trust's Capital programme 2. Achieved standards for 'Patient-led Assessments of our Care Environment' (PLACE) covering food, environment and privacy & dignity	1. Demonstrate progress on key initiatives including: Emergency Floor, Breast Screening Unit, Interventional Radiology, Worthing Health Education Centre, 2. PLACE - Undertake the 2013 external PLACE inspections	1. Capital programme budgets to refurbish the Trust's estate fully allocated and works underway. Significant progress on key capital build programmes with no noteworthy exceptions to report. Capital progamme due for review in Q2 following conclusion of endoscopy business case and Worthing refurbishment options. 2. PLACE audits completed at SRH & Worthing in Q1 in line with schedule. Scores anticipated in Q2 to inform potential improvements.	Green
[F2] Deliver coordinated service improvement programmes across the Trust Executive Lead: DODL	Improving Customer Care Service Improvement Programme	1. Increased Staff Engagement indicator in the national staff survey from 3.68 to 3.75, with the longer-term aim of achieving upper quartile performance 2. Improved patient feedback (national surveys & real-time) regarding their experience	1. Customer care priorities developed and agreed 2. Review of catering and retail services conducted	1. Set of Staff Pledges developed from staff feedback Papers on these Pledges have been to both Management Board and Trust Board in Q1. Programme direction presented to Management Board; recommendation for the Trust to develop a comprehensive programme to focus on developing the right culture in Customer Care received. Business case to be developed in Q2 to set out the scope and concept of a comprehensive customer care programme. Anticipated presentation to Board in the Autumn. 2. Retail and catering facilites reviewed in Q1 and notice served and accepted served and accepted on current providers in Worthing North Wing to create a designated staff area. Wider review scheduled for Q2.	Green
	1. Reducing avoidable readmissions Service Improvement Programme 2. OneCall OneTeam lead provider programme	3. Reduced 30-day readmission rate in line with our agreement with Commissioners	1. Methodology and framework agreed 2. Multi-professional clinical audit completed to ascertain 13/14 contractual readmission threshold	1. Framework developed and agreed with commissioners for 2013 clinical review. 2. Audit at Worthing Hospital completed involving 18 clinicians from primary and secondary care. 100 case notes reviewed. Second audit scheduled in Chihcester on 24.07.2013. Audit outcome analysis anticipated to be complete by August / September 2013 to agree thresholds and identify areas for improvement and reinvestment in the health economy.	Green
	Improving Imaging and Diagnostic pathways Service Improvement Programme	4. Improved operational performance relative to peers 5. Integrated business meetings held for all modalities	1. Commencement of MRI modality service improvement programme 2. Benchmarking completed, analysis of demand and capacity to inform improvement plan	1. MRI programme commenced in Q1 and interim service improvement resource secured (after numerous attempts) at end of Q1 to accellerate the proigramme for 3 months. 2. Initial analysis of demand and capacity undertaken and process mapping session between 2 main sites commenced. Improvement plan and road map to be developed early in Q2.	Amber
	Development of future initiatives and programme management function	6. Identification of service improvement areas 7. Support to programme manage available: initiatives delivered on time and within allocated resources; timely escalation of risk	1. Service Improvement Board agreed scope for 2013-14, following benchmarking and scoping potential areas for improvement	1. Final Service Improvement Board held and revised Service Change Executive (SCE) scheduled for inaugural meeting July 2013. Change programme for the Trust identified following discussions with Divisions to agree priorities. Programme will be developed during Q2 and reported to SCE on a monthly basis.	Green

We care about….		…improvement			
Corporate Objective	**Primary delivery programmes**	**Measures of success**	**Q1 Milestones - April - June 2013**	**Progress to date**	**RAG**
[F3] Develop a comprehensive Information Management & Technology strategy and start implementation Executive Lead: DoF	Procurement programme to replace the current IT core server hardware and software infrastructure	1. Provision of a resilient IT environment capable of adequate disaster recovery 2. 100% of all users have a single sign-on by Q3	1. Core IT hardware procured, installed on-site and configured	1. Order Placed with supplier on 01.07.2013 due to delays with specification and approvals. 2. Work now being commissioned to provide the new computer room to take the kit, expected completion date for build October 13. 3. Harware will be ready for installation when room compete and commissioning expected to take 6 - 9 months to complete (for all phases)	Amber
	Develop a portal to enable a single point of access called 'Gateway'	3. Implementation of a portal to enable reporting through a single point of access 4. 100% of users have appropriate portal access in Q2	1. Launch new Gateway across the Trust and decommission redundant server	1. The basic portal functionality has been developed and demonstrated. Full roll-out has been delayed due to resource constraints and dependencies with SLR and Information Strategy.	Amber
	Electronic Document & Records Management and a Clinical Portal procurement	5. Clinical efficiency benefits realised from 2014/15 Q1 as documents migrate from paper to electronic storage. 6. Treasury funding secured, in partnership with local partners to procure and subsequently successfully deploy the system in line with agreed schedule	1. Commence procurement stage (subject to Treasury funding)	1. Treasuary approval to commence procurment was granted in late June. 2. Procurment and project management expertise has been sourced and the aim is to publish the procurement documentation by the end of August.	Amber
	1. Development of agreed quality metrics and audit tool	7. Improved data quality metrics and a data quality audit tool developed 8. Improved data quality across 3 areas: 1) 'Outpatients not arrived', 2) 'To come in dates in the past', 3) 'Ward spot checks'	1. Reports and audit tool agreed and developed for initial 3 metrics	1. New metrics agreed and developed 2. Ward audits now taking place and results being published 3. Full automation of the reports planned for Q2/3 as resoursing allows	Green
[F4] Optimise the contribution of our staff in the planning and delivery of our services Executive lead: DODL	1. Staff appraisal 2. Medical Revalidation 3. Management & Leadership Development Programmes	1. Increased Staff Engagement Indicator from 3.68 to 3.75, with the longer-term aim of achieving upper quartile performance 2. Increased Staff Survey Response rate from 47% (2012) to 55% (2013)	1. Behaviour standards developed with staff, in conjunction with Customer Care service improvement programme 2. Appraisal process updated to facilitate meaningful engagement 3. Deliver improvements to communication channels and demonstrate ongoing engagement with staff.	1/2. Behaviour standards developed and agreed. Appraisal policy to be updated by end of Q2. Real time staff feedback reviewed and programme of work updated. Work includes breakdown by Divisions to inform staff survey action plans. Management and leadership development programmes reviewed, new programmes to commence from early 2014 following approvals. 3. Improvements to communications in Q1 include: - Delivering Board recommendations for Trust Brief - Improvements to Headlines and internal posters. - Initial mapping team meetings across the organisation. - Holding staff meetings at Southlands Hospital each month. From August , Chair & Executives will attend individual team meetings, rather than hold a collective briefing - Commencing the transfer of StaffNet and Trust's websites to an open source environment. The first stage is due for completion at the end of July with developments planned for the rest of the year. - Holding CEO meetings with employees at six months service - Distributing the One Call One Team email to service users across West Sussex including WSHFT staff, community staff and GPs. The third edition is due out on July 18.	Green

We care about….		…the future			
Corporate Objective	**Primary delivery programmes**	**Measures of success**	**Q1 Milestones - April - June 2013**	**Progress to date**	**RAG**
[G1] Maintain an acceptable Financial Risk Rating Executive Lead: DoF	CIP Programme	1. Achievement of required year end £5,2m surplus and Trust's £12m Cost Improvement Programme	1. Achieve key financial metrics (financial risk score, CIP delivery, debt repayment)	As at M3, the Trust is showing a marginal underperformance against plan. The planned M3 deficit is £354k, and the actual is £678k - gap of £324k on £90.943m of year to date income. Financial Risk Rating is a 3 as planned. CIP is slightly behind target at 84.1% achievement. The bottom line is being supported by fortuitous underspends that are not currently being shown as CIP schemes. Work is underway to identify supplementary CIP schemes to ensure the target is met.	Amber
[G2] Maintain a Monitor Governance rating of no worse than Amber Green throughout the year Executive Lead: COO	Divisional performance monitored through Divisional Integrated Performance meetings	1. Perform consistently well across all of Monitor Governance rating criteria	1. Ensure performance against key metrics (A&E, MRSA, Cdiff, 18 weeks, Diagnostics and Cancer waits)	All targets compliant for quarter 1 apart from Cdiff, which exceeded the quarterly trajectory.	Amber
[G3] Continue the development and implementation of Service Line Management (SLM) Executive Lead: COO	SLM Programme assured through SLM Board and supported by SLM Technical Group	1. Development of SLM information and infrastructure in line with agreed programme	1. Development of SLM programme for 2013-14 including piloting of service line financial information through DIP meetings	Reassessment of programme undertaken by SLM Board. Self -assessment against Monitor critiera undertaken, stock take of SLR activity carried out and away half day for Executive team planned. All milestones being reassessed in the light of this away half day	Amber

BOARD ASSURANCE FRAMEWORK 2013/14

RISK REVIEW REPORT: QUARTER 1 2013/14

Risk Description:	
Corporate Objective:	E1: In partnership with our emerging CCG, develop our lead role in the local health economy for unscheduled and planned care
BAF Reference:	E1.1: External partners fail to help deliver demand management programmes (LHE) and capacity / demand alignment is compromised
Last reporting date:	Q4 2012/13 (related risk)

Risk review - consider at least the following questions:

1. is the risk still valid?
2. has the risk changed/is it described accurately?
3. has the risk occurred?
4. are there any links to the Risk Register?

Risk: External partners fail to help deliver demand management programmes (LHE) and capacity / demand alignment is compromised.

The risk is still valid. Across both 'planned', 'unscheduled' and 'proactive' care, strengthened governance arrangements were put in place in Q4 2012/13, reporting through to Coastal Cabinet. Alongside, "Lead Provider" arrangements have been established for unscheduled (WSHT) and proactive (SCT) care, and in relation to the WSHT LP role, a new contractual model under discussion to enable the trust to optimise delivery and performance further.

One Call/One Team (OCOT) does appear to be having an impact. Whilst attendances at A&E remain higher than Q1 2012/13, emergency admissions have reduced incrementallyover the last 3-4 months overall, and across all age groups bar 85+.

Under planned care, both MSK and Dermatology services have been put out to the market, and WSHT participating in this process appropriately

As part of the revised governance arrangements, the CCG has improved Programme Management support to all three LHE programmes, and alongside the actions above, is reviewing other work streams and prioritising according to scope and impact. The full and final set of programmes for 2013/14 have yet to be fully identified by the CCG, hence evaluation in Q1 limited.

Impact – consider at least the following questions:

1. if the risk has occurred, what impact did it have on the organisation?
2. if not, what impact would the risk have if it occurred?

The risk has not occurred.

Controls – consider at least the following questions:

1. are the controls still relevant and sufficient?
2. are the controls operating effectively?
3. what progress has been made with the improvement action described in the BAF?
4. what improvements are required, if any?
5. is it possible to evidence the controls?

Ongoing engagement with LHE partners and commissioners through Coastal Cabinet and Single Performance Conversation (SPC) to ensure success of integrated work streams including the Lead Provider development.

Manage Divisional planned and unscheduled care programmes to improve access and discharge arrangements.

Reporting to Coastal Cabinet monthly and to Service Delivery Boards where established, to monitor the delivery and effectiveness of demand management schemes. Senior clinical and operational management teams are linked directly to each work stream where relevant, ensuring engagement appropriate and two-way communication effective.

There is good evidence for the controls – meeting minutes, correspondence, agreed plans for services, etc.

Assurance – consider at least the following questions: 1. are the sources of assurance still relevant and sufficient? 2. are the sources of assurance in place? 3. are there any additional sources of assurance which can now be introduced? 4. what progress has been made with the improvement action described in the BAF? 5. what improvements are required, if any? 6. is it possible to evidence the sources of assurance?	
Sources of assurance relevant, sufficient, and in place. Evidence available: Revised Accountability Agreement between LHE partners outlining responsibilities for each organisation (pending). Coastal Cabinet, and Service Delivery Board meeting papers where relevant. EG OCOT Steering Board (monthly) and OCOT Operational Meeting (weekly). Review of Annual Plan progress at Divisional Integrated Performance Review Panel and Board meetings.	
Risk Owner:	Date:
Jane Farrell, Chief Operating Officer / Deputy Chief Executive.	12 07 2013

BOARD ASSURANCE FRAMEWORK 2013/14

RISK REVIEW REPORT: QUARTER 1, 2013/14

Guidelines for completion: Please complete each of the sections below, ensuring that the entries are concise but sufficiently descriptive to facilitate a Board/Committee discussion about the risk. The report should be no longer than two A4 pages.

Risk Description:	
Corporate Objective:	E2: Support our Council of Governors to fulfil its role.
BAF Risk:	We don't reap the benefits of a Council of Governors as part of our development as an FT.
Last reporting date:	None. This report has been prepared for the first quarter so there have been no previous reviews of the risk.

Risk review

The work done with the Council of Governors in advance of licensing has laid useful foundations for the future work of the Council and relationships with the Board.

Impact

No specific risk has emerged as FT licensing delayed to 1st July.

Controls

Controls are appropriate and will now be expedited.

A number of sessions have been held to develop working arrangements in advance of the council being formed , a further session, to include arrangements for the appointment of Lead governor, is scheduled for 30th September 2013.

The AGM was used as further engagement opportunity with good feedback.

Assurance

Assurance appears adequate, but will be further developed as the Council starts to operate.

Risk Owner:	Date:
Denise Farmer, Director of OD & Leadership	22nd July 2013

Western Sussex Hospitals NHS
NHS Foundation Trust

To: Board of Directors

Date of Meeting: 1st August 2013 Agenda Item: 13

Title
Appointment of Responsible Officer
Responsible Executive Director
Marianne Griffiths – Chief Executive Officer
Prepared by
Phillip Barnes – Medical Director
Status
Disclosable
Summary of Proposal
The Board is asked to approve the appointment of Dr Timothy Taylor, Assistant Medical Director for Revalidation and Chief of Women's & Children's Services as Responsible Officer for Western Sussex Hospitals NHS Foundation Trust with effect from August 27th 2013.
Implications for Quality of Care
The role of Responsible Officer includes statutory responsibilities in relation to the appointment and revalidation of medical practitioners, and ensuring that systems and processes to underpin these responsibilities – including systems of clinical governance – are maintained.
Link to Strategic Objectives/Board Assurance Framework
None but the Trust is required by statute to appoint formally a registered medical practitioner as Responsible Officer
Financial Implications
None
Human Resource Implications
None
Recommendation
The Committee is asked to: APPROVE the appointment of Dr Timothy Taylor as Responsible Officer.
Communication and Consultation
Interim Medical Director, Executive Directors, GMC (through Employer Liaison Service)
Appendices
None