Western Sussex Hospitals
NHS Trust

# Trust Board Meeting

10.00am to 12.45pm, Thursday 26 April 2012

Boardroom, Washington Suite, Worthing Hospital,
Lyndhurst Road, Worthing, West Sussex, BN11 2DH

## AGENDA – MEETING IN PUBLIC

| | | | | |
|---|---|---|---|---|
| 1 | 10.00 | **Welcome and Apologies for Absence** | | Chair |
| 2 | | **Declarations of Interests** | | All |
| 3 | 10.00 | **Minutes of Board Meeting held on 29 March 2012** | Enclosure | Chair |
| 4 | 10.05 | **Matters Arising from the Minutes** | Enclosure | Chair |
| 5 | 10.10 | **Chief Executive's Report**<br>To receive and agree any necessary action | Enclosure | JF |
| | | **PATIENT SAFETY/EXPERIENCE ITEMS** | | |
| 6 | 10.20 | **Quality Report**<br>To receive and agree any necessary action | Enclosure | CS |
| 7 | 10.35 | **National In-patient Survey Results**<br>To receive and agree any necessary action | Enclosure<br>(to follow) | CS |
| | | **OPERATIONAL ITEMS** | | |
| 8 | 10.50 | **Improving the Out-patient Experience**<br>To receive and agree any necessary action | Enclosure | JF |
| 9 | 11.05 | **Performance Report**<br>To receive and agree any necessary action | Enclosure | JF |
| 10 | 11.15 | **Organisational Development and Workforce Performance**<br>To receive and agree any necessary action | Enclosure | DF |
| 11 | 11.25 | **Annual Health & Safety Report**<br>To receive and agree any necessary action | Enclosure | DF |
| 12 | 11.35 | **Financial Performance**<br>To receive and agree any necessary action | Presentation | SP |

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| | | **STRATEGIC ITEMS** | | |
| 13 | 11.55 | **Annual Plan 2012/13**<br>To approve | Enclosure | DF |
| 14 | 12.05 | **Board Assurance Framework 2012/13**<br>To approve | Enclosure | GL |
| 15 | 12.15 | **Risk Management Strategies** | | |
| | | a) Trust-wide Strategy | Enclosure | GL |
| | | b) Maternity Services Strategy | Enclosure | CS |
| | | To approve | | |
| | | **GOVERNANCE ITEMS** | | |
| 16 | 12.25 | **Annual Accounts 2011/12: Delegation to Audit Committee**<br>To approve | Enclosure | SP |
| 17 | 12.30 | **Other Business** | | Chair |
| 18 | 12.35 | **Resolution into Board Committee**<br>To pass the following resolution:<br><br>"That the Board now meets in private due to the confidential nature of the business to be transacted." | Verbal | Chair |
| 19 | 12.35 | **Date of Next Meeting**<br><br>The next meeting of the Board is scheduled to take place at 10.00am on Thursday, 31 May 2012 in the Bateman Room, Chichester Medical Education Centre, St.Richard's Hospital, Spitalfield Lane, Chichester, West Sussex, PO19 6SE | | Chair |
| 20 | 12.35 | **Close of Meeting** | | Chair |
| | 12.35 to 12.45 | **Questions from the Public**<br>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 |

Graham Lawrence
**Company Secretary**

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# Minutes



**Minutes of the Board meeting held (in public) at 10.00am on 29 March 2012 in the Boardroom, Worthing Hospital, Lyndhurst Road, Worthing, West Sussex, BN11 2DH**

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| **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 |
| | Marianne Griffiths | Chief Executive |
| | Martin Phillips | Non-executive Director |
| | Spencer Prosser | Finance Director |
| | Cathy Stone | Director of Nursing & Patient Safety |
| | Mike Viggers | Chairman |
| **In Attendance:** | Graham Lawrence | Company Secretary (minutes) |

**TBP/3/12/1 WELCOME AND APOLOGIES FOR ABSENCE**

1.1 The Chairman welcomed all those present to the meeting.

1.2 Apologies for absence were received from Jon Furmston.

**TBP/3/12/2 DECLARATIONS OF INTERESTS**

2.1 There were no interests to declare.

**TBP/3/12/3 MINUTES OF THE BOARD MEETING HELD ON 1 MARCH 2012**

3.1 The Board received the minutes of its meeting held on 1 March 2012 and agreed the following amendment:

- TBP/2/12/8.4 – It was agreed that the third sentence would be amended to read: "It was noted that NHS Sussex had given dispensation for Trusts across the Sussex area to use Clinical Decision Units for mixed-sex accommodation, for the one-week period when activity levels were particularly high."

**3.2 The Board resolved that subject to the amendment set out above, the minutes of the meeting held on 1 March 2012 would be approved as an accurate record of the meeting and signed by the Chairman.**

**TBP/3/12/4 MATTERS ARISING FROM THE MINUTES**

4.1 The Board received and noted the report of matters arising from its meeting held on 1 March 2012.

**TBP/3/12/5 CHIEF EXECUTIVE'S REPORT**

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

5.2 It was reported that following the Department of Health Application Committee meeting on 29 February 2012, the Trust had responded to a number of questions but was near to completing this phase of the Foundation Trust application process.

5.3 The Board's attention was drawn to the recent moves of in-patient beds from Southlands to Worthing Hospital. The move had been completed successfully and the Board commended all staff involved. It was noted that performance had improved since the move.

5.4 The Chief Executive highlighted the forthcoming star awards and encouraged nominations from staff and members of the public.

5.5 The Chairman and Chief Executive presented the Employee of the Month Award to Jane Campbell, commending her dedication and commitment to high quality care for patients. Jane Campbell addressed the Board and the members of the public, promoting the need for continued focus on high-quality care.

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

**TBP/3/12/6 QUALITY REPORT**

6.1 The Director of Nursing and Patient Safety and the Medical Director presented the Quality Report and the main points of the discussion were as follows.

6.2 The Director of Nursing and Patient Safety noted that February 2012 had seen unprecedented levels of activity across the Trust but despite this the levels of care had been consistently high.

6.3 The Trust remained free of MRSA bacteraemia cases at its three hospitals, all now having achieved this position for in excess of one year. There had been an increased focus on reducing the incidence of MSSA bacteraemia, resulting in success such that there had been zero cases of hospital-attributable MSSA in the month of February. In respect of C difficile, there had been zero cases at St Richard's hospital in the month of February, this being the first time that the site had achieved this since the establishment of the Trust, and three at Worthing Hospital. Full root cause analyses had been undertaken in respect of all cases and all had been confirmed as unavoidable. In respect of infection rates more generally, the Trust had been participating in a Europe-wide study which had identified an average of 10% across the NHS. It was noted that both of the Trust's main hospital sites were operating at a significantly lower level. This had been reported to the Trust Infection Control Committee which had met recently.

6.4 The Board's attention was drawn to an in-month increase in the number of women having Caesarean-section births. This continued to receive close attention from the Women & Childrens Divisional management team and from the Executive Team such that good standards of care were maintained. There were no causes for concern in any of the cases, and it was noted that the Trusts peri-natal mortality rate remained extremely low. The Women and

Children Division would be reporting on this issue at the forthcoming meeting of the Quality Board, in particular to explore the extent to which there might be variation in Caesarean section rates between women under the care of different clinical teams within the Trust.

6.5 It was reported that during March the Trust had received two unannounced visits from the Care Quality Commission. This was in response to a request from the Government for the regulator to visit all hospitals and clinics which were licensed to undertake termination of pregnancy. The inspections were to ensure that terminations were only carried out in accordance with the required practice and the law. The Care Quality Commission had visited St Richard's Hospital and Worthing Hospital and the Inspectors were impressed by the level of care provided at both. There were no concerns arising from either inspection.

6.6 The Board discussed performance in respect of metric 2.25 (Achieve 20% reduction in mortality from the VTE cases). This had increased in the month of January but there was no indication of a particular cause for concern. A review had been undertaken which had determined that patients recorded had a deep vein thrombosis at the time of death but there were a number of co-morbidities in these cases. It was noted that Trusts across the country faced challenges in identifying and assessing any harm caused by deep vein thrombosis, in the context of other conditions.

6.7 The Board's attention was drawn to mortality in general, noting that in-month the Trust has been slightly above its trajectory for a 10% reduction. It was noted that the St Richard's Hospital had not experienced the normal increase in mortality over the winter period. It was thought likely that the increased capacity of the Acute Medical Unit had contributed to improved quality of care but also flow of patients through the hospital, all of which contributed to reducing mortality. There were plans for similar improvements at Worthing Hospital.

6.8 The Board was advised that as previously agreed, the patient aggregate safety score would be reviewed and re-based for 2012/13. It was possible that this would result in a short-term increase in the score. It was likely that two measures would be removed from the score. The first was the measure in relation to fractured neck of femur operations being undertaken within 24 hours of admission. This was because information used to inform this measure was taken from the national hip fracture database, which is populated in arrears. This resulted in the patient aggregate safety score being less current than it would otherwise be. It was also likely that the measure in relation to venous thromboembolism would be removed for similar reasons.

6.9 The Board discussed the metrics under section 3.2 of the quality scorecard, noting that these were not demonstrating sufficient improvement in performance. A number of similar issues had been reported through the recent out-patient survey. Out-patient services had been reconfigured and an action plan was being developed for further improvement. This would be presented to the Board in April. **JF**

6.10 The Board moved on to a discussion about falls, as noted in section 4.3 of the paper. It was recognised that it was disappointing to see an increase in falls but this was the result of the particularly high levels of activity experienced during the month of February.

6.11 The Board received the report on the Delivering Dignity publication. The report was at consultation stage and the paper described the Trust's current response to the document. It was recognised that implementation would be difficult to measure in qualitative terms, the improvements being part of the organisation culture which the Board was promoting. This would form part of the Customer Care Programme and it was agreed that a report on this subject would be presented to the Board in May 2012. **DF**

6.12 In relation to the report, the Board discussed the means by which it could measure the effectiveness of the Trust's whistle-blowing arrangements. It was noted that the Quality and Risk Committee had reviewed on two occasions the Trust's arrangements for identifying concerns about quality of care, including through informal means. This would continue to be kept under review to ensure that the Trust promoted a culture of raising concerns.

6.13 In connection with the report, there was a continued need to improve identification of patients who were becoming more unwell during their hospital stay. The Patientrak system was material to this and it was agreed that a seminar would be helpful in order to brief the Board, preferably with Dr Richard Venn, consultant in anaesthesia and intensive care, to present the system. **GL**

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

**TBP/3/12/7 PERFORMANCE REPORT**

7.1 The Chief Operating Officer presented the performance report on the main points of the discussion was follows.

7.2 As identified earlier in the meeting, it was reported that the month of February had seen unprecedented levels of activity across Trust and the county of Sussex. Despite this, the Trust had maintained compliant performance in the majority of metrics, including the 18-week referral to treatment time target.

7.3 The Accident and Emergency service had been particularly busy such that compliance with the four-hour target had reduced to 92.1% for the month and 93.69% for the quarter. Additional focus had been applied such that performance had improved to 98.48% for March to date and 95.25% for the quarter to date. Activity remained high, though not at the levels experienced in the previous month.

7.4 It was noted that despite the high levels of activity, delayed transfers of care had improved to 1.2% for the Trust and 0.6% for the Worthing Hospital site. These were noted as exceptionally good levels of performance. The Trust had also maintained compliance with the 18-week referral to treatment time target and those in relation to cancer care.

7.5 The Trust was therefore reporting compliance with the NHS performance framework and the Monitor compliance frameworks.

7.6 It was noted that there was no date set against the metric 5.11 (Theatre utilisation). It was explained that this was because the measure had been reviewed and identified as not effectively assessing utilisation of operating theatres. Alternative measures were being developed.

7.7 The Board discussed the extent to which the one call, one team project was having an influence on performance. It was noted that emergency admissions had reduced by 1.5% within the year compared to an 11% increase in the two previous years. The reduction had been 5.5% for the last three months prior to the particularly busy period experienced in February. It was noted that a review of the One Call, One Team service would be presented to the Board in April.

7.8 The Chief Executive drew attention to the "The Quarter" publication issued by the Department of Health, which showed that the Trust was one of two throughout the NHS in England to be performing at an excellent level. The Board commended all staff involved in the significant achievement.

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

**TBP/3/12/8 ORGANISATIONAL DEVELOPMENT AND WORKFORCE REPORT**

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

8.2 The Board noted a number of points from the report, as follows:

- use of agency to staff had reduced despite the recently increased levels of activity;
- sickness absence remained high and was an area of focus for the monthly Divisional performance reviews so that this could be reduced;
- completion of appraisals and statutory and mandatory training had not increased from its previously improved levels but this was reasonable in the context of the recent high levels of activity;
- a number of changes had been made to the way in which staff were paid, principally in relation to the premium paid for additional hours worked by staff and also on-call arrangements.

8.3 The Board noted that the Learning and Development service was that day moving into its new premises at Liverpool Gardens. This would allow the team to provide a better service to staff at a location which was more convenient to the majority of staff working at Worthing hospital.

8.4 It was also noted that following the recent introduction of the Trust Brief communication, issued to staff monthly, this was to be reviewed to ensure that it was sufficiently embedded throughout the Divisions. This would be an area of focus for the divisional performance reviews.

8.5 There continued to be some challenges in relation to the Occupational Health service, although this was improving. It was agreed that this would feature in the report to the Board in April. **DF**

8.6 The Board discussed the management of annual leave, noting that staff had been required to take leave by the end of the financial year. This was to address the practice which had been commonly adopted of staff carrying over a significant amount of leave. This did not represent good human resource management since it was important for staff to take holidays, but it also had an impact on the Trust's financial position since it needed to accrue the cost of holidays not taken. The more active approach to annual leave management had therefore been adopted.

8.7 The Board concluded its discussion by reviewing the equality delivery systems and equality objectives 2011. These were approved by the Board.

**8.8 The Board resolved to note the report and approve the equality delivery system and equality objectives 2011**

**TBP/3/12/9 STAFF SURVEY RESULTS**

9.1 The Board was briefed on a number of points arising from the staff survey results, as follows:

- staff had reported improved team working across Trust;
- the number of work-related accidents had increased and was higher than average so this would be an area of focus, including through the health and safety committee;
- there were also concerns in relation to incident reporting, although particularly in relation to staff being unclear as to the action taken following incidents being reported;
- there were also concerns in relation to staffing experiencing discrimination and the diversity matters group would be reviewing this

9.2 The Board discussed the way in which it would oversee progress against the action plan resulting from the survey, agreeing that a report would be presented to the next meeting of the Quality and Risk Committee, in May 2012, and then to the Board in September 2012. **DF**

9.3 It was agreed that the Trust Brief communication would be an important means of advising staff about the way in which the Trust was addressing the results of the survey.

**TBP/3/12/10 FINANCIAL PERFORMANCE**

10.1 The Finance Director presented the financial performance report and the main points of the discussion were follows.

10.2 The Board noted that the Trust was reporting a year to date surplus of £4.8 million, such that it was forecasting achievement of the £5.2 million year-end control total. This would achieve a Monitor financial risk rating of four, which was considered good.

10.3 Income remained strong, principally as a result of increased levels of activity but also because bariatric surgery was increased.

10.4 In respect of expenditure, the use of agency staff had decreased. Non-pay expenditure was in excess of budget, principally as a result of liability costs associated with the IT service. Capital expenditure was behind plan, mainly as a result of delays to the introduction of a additional CT scanner at Worthing hospital.

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

**TBP/3/12/11 FINANCIAL PLAN 2012/13**

11.1 The Finance Director presented the proposed financial plan for 2012/13 and the main points of the discussion was follows:

11.2 The Trust had accurately predicted the levels of activity which it was likely to experiencing 2012/13, and had applied the payment by results tariff in order to develop an income total for the year. The Strategic Health Authority operating framework requirements had been taken into account, as had planned demand reductions through the Sussex Together programme.

11.3 The anticipated income level and expenditure resulted in a balancing cost improvement programme requirement of £19.4 million for the year. This had been risk-adjusted and quality assured.

11.4 It was noted that as discussed at the Finance and Investment Committee on 28 March 2012, the service level agreement represented a good position for the Trust although the financial plan would be a significant challenge to deliver.

11.5 The Board discussed the activity summary in Appendix 1, noting that the plan was based on a full year of activity, not month eight as referenced in the appendix. It was noted that month eight activity was used as a good basis for calculating full-year activity levels.

**11.6 The Board resolved to approve the financial plan 2012/13.**

**TBP/3/12/12 PROPOSAL FOR ENERGY SUPPLY CONTRACT**

12.1 The Finance Director presented a paper which proposed that the Trust should enter into a consortium arrangement to procure in the supply of energy.

12.2 The arrangement would allow the Trust to access discounts available through the bulk purchasing arrangement, although it was not possible to insulate the Trust from fluctuations in the market. The energy supply market was known to be extremely complex and it was therefore advantageous for the Trust utilise the expertise of the agency managing the arrangement.

12.3 The Board discussed the extent to which the new arrangements might impact the ongoing work to improve the robustness of the power supply to Worthing Hospital. It was noted that this work was being undertaken by UK Power, which was responsible for the infrastructure, separate from the energy supplier. There would therefore be no impact on the improvement work.

12.4 It was suggested that alongside this procurement activity in relation to the gas and electricity supply, the Trust should consider efficiencies in relation to water usage as part of its overall cost improvement plans. **SP**

**12.5 The Board resolved to approve the signing of contracts relating to the 2012/16 gas and electricity energy supplies and the government procurement service arrangements.**

**TBP/3/12/13 OTHER BUSINESS**

13.1 There were no items of other business.

**TBP/3/12/14 Resolution into Board Committee**

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

**TBP/3/12/15 DATE OF NEXT MEETING**

15.1 The next meeting of the Board would take place at 10.00 am on Thursday 26 April 2012 in the Boardroom, Worthing Hospital, Lyndhurst Road, Worthing, West Sussex, BN11 2DH

Graham Lawrence
**Company Secretary**

March 2012

Signed as an accurate record of the meeting

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Chair
……
Date

**WESTERN SUSSEX HOSPITALS NHS TRUST**

**BOARD MEETING HELD ON 29 MARCH 2012**

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

| No. | Question/Comment | Response | Action |
|---|---|---|---|
| 1. | In relation to the in-patient survey, it was suggested that the phrasing of the questions should be changed to reduce the risk of 'leading' respondents to certain answers. | It was agreed that this would be fed-back to the Care Quality Commission. | CS |
| 2. | A member of the public commended the Trust in relation to the care given to a particular patient and his immediate family. | The Board thanked the member of the public for the positive feedback. | None |
| 3. | The Board was asked to explain whether it was the Trust's practice to withhold payments to creditors. | It was confirmed that this was not the Trust's practice or policy. | None |
| 4. | A member of the public asked for an explanation of the Trust's working capital position, particularly in relation to the loan necessary to achieve the required Monitor Financial Risk Rating. | It was explained that the Trust had inherited debt from the two predecessor Trusts, which it was paying off. In order to meet Monitor's requirements for working capital, given the Trust's cash position resulting partly from the loan repayments, it would be necessary to take a working capital facility. | None |
| 5. | The Finance Director was asked to provide a breakdown on the capital expenditure planned under lines 23 to 25 in the Capital Plan 2012/13. | It was agreed that this would be sent to the member of the public. | SP |
| 6. | Following the move on in-patient beds from Southlands Hospital to Worthing Hospital, the Board was asked to explain the arrangements for transporting medical files when patients were admitted to Worthing Hospital. | The Trust had identified the need to put arrangements into place. An interim solution was being implemented while a more permanent arrangement was developed. | None |
| 7. | The Board was asked to explain whether the Trust had received any expressions of interests in relation to the Harness Block at Southlands Hospital. | It was explained that two proposals had been received and were being assessed. | None |
| 8. | A member of the public commended the Trust on the quality of its services and on its reputation. | The Board thanked the member of the public for the positive feedback. | None |
| 9. | The Board was asked to explain whether funding would continue to be available for the Productive Ward programme. | It was agreed that the Department of Health would be contacted to clarify this. | SP/CS |

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| 10. | The Board was asked to describe the plans being developed for the laminar flow theatres at Worthing Hospital. | It was explained that the laminar flow theatres were planned for introduction in July. The Trust was reviewing its strategies and plans for elective services, to maximise the quality of care and efficiency. The laminar flow theatres would be part of this although it was likely that there would be some changes to services across the Trust. | None |
| 11. | It was suggested that the Trust should issue a press release in relation to its performance as reported in "The Quarter" publication produced by the Department of Health and highlighted during the meeting by the Chief Executive. | It was agreed that a press release would be prepared. | DF |

**MATTERS ARISING FROM PUBLIC BOARD MEETINGS**

| MATTERS ARISING FROM THE MEETING HELD ON 1 MARCH 2012 | | | | | |
|---|---|---|---|---|---|
| **Minute Ref** | **Description of Action** | **Responsible Person** | **Deadline** | **Report** | **RAG Status** |
| | **Organisational Development & Workforce Report** | | | | |
| TBP/2/12/9.3 | For 2012/13 introduce Division-specific targets for the use of temporary staff, differentiating between bank and agency staff. | Denise Farmer | April 2012 | This information will be included in reporting from April. | A |
| TBP/2/12/9.6 | Arrange for the Diversity Matters Group to review the number of applicants from BME communities who are offered jobs by the Trust. Following the review, provide assurance to the Board. | Denise Farmer | April2012 | This will be reviewed by the Diversity Matters Group on 21st March and action reported to the Board in April. | A |

| MATTERS ARISING FROM THE MEETING HELD ON 29 MARCH 2012 | | | | | |
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| **Minute Ref** | **Description of Action** | **Responsible Person** | **Deadline** | **Report** | **RAG Status** |
| | **Quality Report** | | | | |
| TBC | Report to the Board the action being taken to address improvement in the out-patients service. | Jane Farrell | April 2012 | This item is addressed on the agenda. | G |
| TBC | Report to the Board the action being taken to address the recommendations in the report "Delivering Dignity", as part of plans to promote the "We care" culture for the Trust. | Cathy Stone | See status update | The "Delivering Dignity" report is currently at consultation stage. A paper will be presented to the Board when the final report is published. | A |

| MATTERS ARISING FROM THE MEETING HELD ON 29 MARCH 2012 | | | | | |
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| **Minute Ref** | **Description of Action** | **Responsible Person** | **Deadline** | **Report** | **RAG Status** |
| TBC | Arrange a Board Seminar on the Patientrack system. | Graham Lawrence | May 2012 | The Seminar has been added to the Board Development Plan. | G |
| TBC | **Organisational Development & Workforce Performance Report**<br><br>Report to the Board the progress made with the Occupational Health service. | Denise Farmer | April 2012 | This action is addressed in the Organisation Development report on the agenda. | G |
| TBC | **Staff Survey**<br><br>Report to the Quality & Risk Committee (in May 2012) the action plan to address the Staff Survey results, and report progress to the Board in September 2012. | Denise Farmer | May/Sept 2012 | An item has been added to the agenda plans. | A |

**Key**

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| 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 Trust

To: Trust Board Date: 26 April 2012

From: Jane Farrell, Deputy Chief Executive Agenda Item: 5

**FOR INFORMATION**

# CHIEF EXECUTIVE'S BOARD PAPER

## 1.0 OVERVIEW

### 1.1 Third 'birthday' for Western Sussex Hospitals NHS Trust

April 1 marked three years to the day when Western Sussex Hospitals NHS Trust was created to provide healthcare for approximately 500,000 people living in West Sussex.

The Trust was created through the merger of Worthing and Southlands Hospitals Trust, with Royal West Sussex NHS Trust which ran St Richard's Hospital in Chichester.

The merger was necessary to ensure that the region maintained a strong, local hospital organisation and events since then have more than justified the decision. Although there were no parties to mark the birthday I would like to take this opportunity to acknowledge some of the achievements over the past three years.

- Hospital-acquired infections are low and reducing, and rival any other similar organisation – there have been no new cases of hospital-acquired MRSA bloodstream infections since 2010 at any of the Trust's three hospitals.

- All three hospitals are rated by the independent Patient Experience Action Teams as having an 'excellent' environment and 'excellent' standard of cleanliness.

- All three hospitals were successfully inspected by the Care Quality Commission in 2011 and the most recent unannounced visits at each site found no areas of concern.

- There has been significant investment into improving facilities for patients - a new haematology and oncology day centre has been opened at St Richard's Hospital, and a new clinical block has recently opened at Worthing including two new wards for elderly care and a new outpatient facility. New operating theatres and a new cardiac laboratory are also being built.

- The Trust has employed more nurses, and more healthcare assistants, and has been placed in the CHKS 40Top Hospitals for each of the three years of its existence.

I hope staff are very proud of the progress they have made in the last three years, and we are delighted to reach this landmark having achieved so many of our early goals. We have a great deal more work to do, but working together we are stronger, and more sustainable.

## 1.2 Foundation Trust (FT) update

Our application to become a Foundation Trust is currently with the Department of Heath. Preparations for the next stage in the process – assessment from Monitor – continue including encouraging staff to consider standing for election as one of the six staff representatives on the Council of Governors. The elections are due to take place during the Monitor phase of the application process.

Membership recruitment continues and includes the Trust writing to new patients under the age of 60 who live in our catchment area. Our total membership currently stands at 7,594.

## 1.3 New outpatient facility at Worthing

This month sees another significant milestone being passed in our efforts to upgrade the facilities available in our hospitals, with the opening of the new outpatient department at Worthing Hospital on the ground floor of the new clinical block. The department has been designed with involvement from clinicians and patients, has 24 clinic rooms, covers a wide range of specialties and will see up to 500 patients per day.

This development comes just weeks after the opening of the new inpatient wards, Barrow and Beacon, on the first floor.

The move, which took place over two days, went well and the wards will now be managed as part of Department of Medicine for the Elderly (DOME).

I would like to thank everyone involved in ensuring that such major projects were completed so successfully.

## 1.4 Staff Achievement and Recognition (STAR) Awards

Nominations for this year's staff awards (STARS) have now closed and I would like to thank all those who have put forward colleagues and teams for special recognition. There are 10 award categories, seven of which link to our Vision and Values of 'We Care'. They enable the Trust to recognise work that supports not only our own local objectives, but also the aims of the wider NHS and include:

Award categories

- Caring for Patients Award
- Delivering Quality Award
- Safety Award
- Ambition Award
- Serving Local People/Our Communities Award
- Improvement Award
- Partnership Working Award
- Hospital Hero Award
- Employee of the Year Award
- Chairman's Award

A judging panel made up of members of the Trust Board as well as staff and patient representatives is due to meet next month. Staff who are shortlisted will be invited to attend the award ceremony on 12 July at Fontwell Park Racecourse.

### 1.5 Consultant appointment

We welcome Mr F Attila Vecsei, Consultant in Obstetrics and Gynaecology at St Richard's who joined us on April 16. Mr Vecsei replaces Mr Jonathan Hooker.

### 1.6 Employee of the Month

I am delighted to announce that the winner in April is Philip Warner, Clinical Matron at Worthing Hospital. Philip was nominated by Saffron Mawby, Head of Medicines Management at the Trust for his vigilance and commitment to ensuring the highest standards of patient care.

Western Sussex Hospitals NHS
NHS Trust

To: Trust Board

Date of Meeting: 26 April 2012 Agenda Item: 6

| Title |
|---|
| **Month 12, 2011/12 Quality Report** |
| Responsible Executive Director |
| Dr Phillip Barnes (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 & Head of Clinical Practice), Vicky Daley (Head of Clinical Governance) |
| 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 sets 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 Strategy Scorecard<br>Appendix II: Infection Control Dashboard |

Western Sussex Hospitals NHS
NHS Trust

# Western Sussex Hospitals Trust Board Quality Report

## Contents

## 1. Introduction

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 Trust (WSHT).

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

The full Clinical Quality Dashboard is presented as Appendix I. This includes measures identified in the Trust Quality Strategy. Figures are in month figures (e.g. the number of falls reported in March) 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 a specific target (e.g. tissue viability) is measured according to calendar years, where this is noted. A subset of the key measures from the report is presented at 2.2.

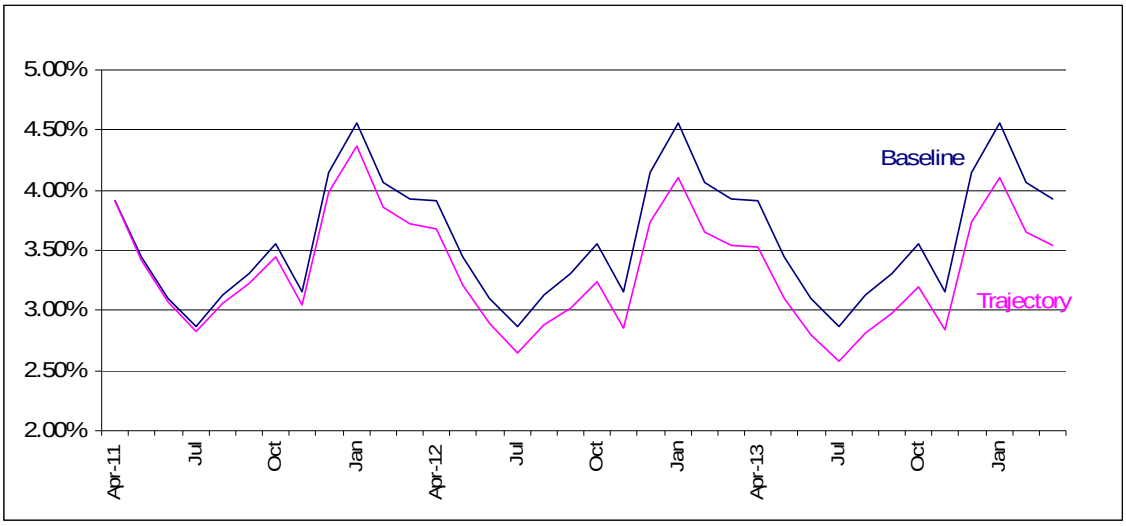
## 2.2 Overview of Key Quality Objectives

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

| Indicator | Jan 2012 | Feb 2012 | Mar 2012 | 2011/12 to date | 2011/12 Target / limit |
|---|---|---|---|---|---|
| 1A Trust crude mortality rate (non-elective) | 4.12% | 3.90% | 3.27% | 3.29% | 3.2% (by end of 2012) |
| 1B Hospital Standardised Mortality Ratio for top 56 diagnoses (Dr Foster, based on rolling 12 months) | 98.9 | | | 98.9 (rolling 12 month) | 103 (by end of 2012) |
| 2A Patient Aggregate Safety Score (PASS) | 54.6 | 60.9 | 66.3 | 74.4 | <100 |
| 3A Proportion of patients who would recommend the Trust | 88% | 87% | 89% | 88% | TbC |
| 3B Proportion of staff who would recommend the Trust | To be implemented once real time patient experience is fully embedded | | | | |
| Proportion of medically fit hip fractures operated on within 24 hours. | 68.3% | 69.8% | | 56.2% | TbC |
| VTE: Compliance with the DoH risk assessment tool | 92.2% | 92.3% | 91.7% | 91.3% | 95% |
| Numbers of hospital attributable MRSA | 0 | 0 | 0 | 0 | 6 |
| Numbers of hospital attributable C. diff | 3 | 3 | 7 | 76 | 90 |
| Number of Serious Incidents Requiring Investigation (number reported in month) | 1 | 0 | 1 | 22 | NA |
| Mixed Sex Accommodation breeches | 0 | 0 | 0 | 0 | 0 |
| Number of complaints | 60 | 54 | 54 | 674 | NA |

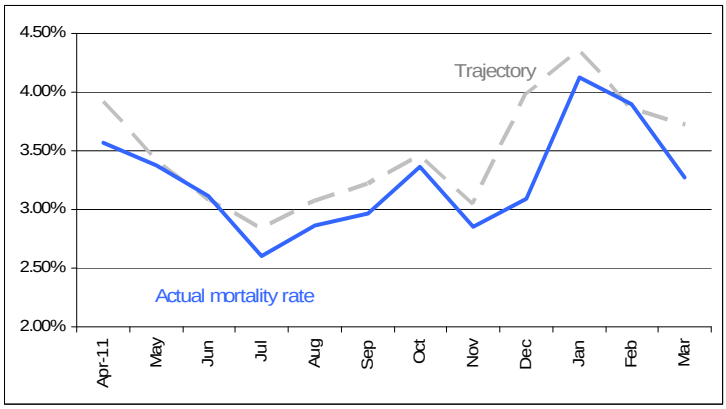
## 2.3 Crude Trust Mortality

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 agreed trajectory for this target (based on a gradual decrease against the profiled 2010/11 rate) is shown below (the 10% reduction is achieved in December 2012 and maintained throughout 2013). The figures are based on non-electives only.




The WSHT trajectory for achieving a 10% reduction in Crude mortality by the end of 2012

Crude non-elective mortality fell from 3.90% in February to 3.27% in March (better than trajectory). During 2011/12 crude (non-elective) mortality was 3.29%, this is a reduction of over 8% against the 2012/13 figure of 3.60%.

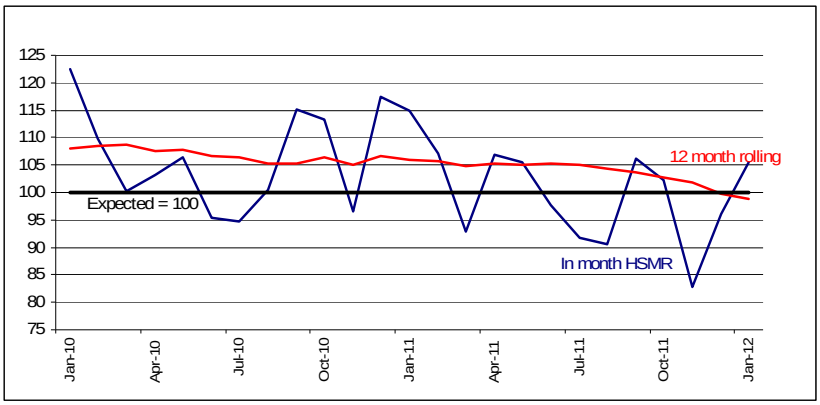



The Trust has been better than trajectory for 10 of 12 months in 2011/12

The Trust is currently on course for delivering the reduction of 10% by December 2012. (As shown above the target is to deliver and sustain 10% from December onwards, not the 12 months to December 2012).

## 2.4 Hospital Standardised Mortality Ratio (HSMR)

There is a two month delay with Dr Foster data (to allow for coding and processing of data) therefore December is the most recent month for which data is available. The Trust has an HSMR for the most recent 12 months of less than 100, meaning that there were fewer deaths at WSHT than predicted by the model. The HSMR for the twelve months up to January 2012 is 98.9.




The Trust 12 month rolling HSMR continues to fall.

There is considerable variation in the in-month HSMR score during the year, however the 12 month rolling position shows a downward trend from above 108 for the 12 months to January 2010 to 98.9 for the 12 months ending January 2012 (all figures are based on the current rebasing of Dr Foster). It should be noted, however, that nationally HSMR levels are also falling and therefore Dr Foster are likely to rebase their model in the autumn which will have the effect of increasing all HSMR levels.

The HSMR split by site is now lower for St Richards Hospital (96.1) than Worthing / Southlands Hospitals (101.1), although both are within expected limits.

A further report is available to the Trust Quality Board showing the underlying areas with high actual versus expected mortality.

## 2.5 Quality Strategy Dashboard

The full Quality Strategy Dashboard is presented at Appendix I.

Exception Report - Indicators 1.21 to 1.24: Hip fracture mortality

Although still above 100 the 12 month HSMR for hip fracture continues to fall. Both the HSMRs for patients with hip fracture and for head of femur replacement are now within the expected range. Key to maintaining this improvement will be the performance in February 2012. Early indications, based on crude mortality for this month, suggest lower mortality in this patient group.

Exception Report – Indicators 3.11 to 3.16: Patient Experience

From January these figures are now from the Real Time Patient Experience monitoring (RTPE) (earlier months are from the productive ward survey, with RTPE scores in brackets). A new questionnaire was launched in January. For indicators 3.11 to 3.13 the new survey allowed a wider range of responses than the previous survey allowed. For example patients were previously asked whether their privacy and dignity was maintained and could respond 'yes' or 'no'; they are now asked to rate the privacy from 'excellent' to 'very poor'. The results are then scored with 'excellent' scoring 100, 'good' scoring 75 etc. As such, the scores from January onwards are not comparable with the scores given for 2011 and the lower values for January are not indicative on a drop in patient satisfaction. Year to date figures given in the scorecard are based on January onwards. The question relating to staff attitude (indicator 3.16) is not asked in the present survey in favour of a series of questions asking about the 'kindness' of individual staff groups which will provider a richer stream of data to provide assurance and drive improvements. In March the Quality Board agreed an updated set of experience metrics and associated targets which will be reported as part of the May Quality Report.

Exception Report – Indicators 2.41, 2.43 and 2.44: Theatre Safety

The Trust reported one never event in March (the first since Trust merger in 2009), this was also reported as a Serious Incident (i.e. indicators 2.43 and 2.44 relate to the same case). A full report was provided to the Committee part of the Trust Board last month.

Exception Report – Indicators 3.31 and 3.32: Nutritional Assessments

Figures for March are currently being validated and will be report next month.

## 3. Patient Aggregate Safety Score (PASS)

### 3.1 Background and Methodology

The PASS is an aggregate score comparing performance against a baseline for a total of 17 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 |
|---|---|---|---|---|
| VTE | VTE Prophylaxis given (syringe packs prescribed) | Positive | 0.50 | 1382.9 |
| | 90 day readmissions for deep vein thrombosis or pulmonary embolism | Negative | 0.50 | 13.25 |
| | VTE risk assessments done | Positive | 1.00 | 90% |
| HCIA | MRSA | Negative | 1.00 | 0.6 |
| | C. diff | Negative | 1.00 | 10.4 |
| Fracture neck of femur (#NOF) | Medically fit fracture neck of femur patients operated on within 24 hrs | Positive | 1.00 | 42% |
| SIRIs | SIRIs | Negative | 2.00 | 3.1 |
| Patient safety incidents | Total incidents | Positive | 1.00 | 786.1 |
| | Moderate, severe and death | Negative | 1.00 | 20.4 |
| Complaints | Complaints about nursing care | Negative | 0.67 | 5.5 |
| | Complaints about communications | Negative | 0.67 | 3.8 |
| | Complaints about staff attitude | Negative | 0.67 | 4.5 |
| Tissue viability | Total grade 2 or higher pressure ulcer incidents | Negative | 1.50 | 23.6 |
| Falls | Falls resulting in harm | Negative | 1.50 | 40.3 |
| Prescribing | Total incidents involving prescribing and drug errors | Positive | 0.50 | 86.3 |
| | Moderate, severe and death errors involving prescribing / drug errors | Negative | 1.50 | 1 |
| Nutrition | Nutritional Assessments in 24 hours | Positive | 1.00 | 82% |

Baselines are from 2010/11 except VTE assessments (which is set to 90%, i.e. the year-end target for 2010/11), complaints (based on October 2010 to March 2011) and #NOF operations (based on September 2010 to March 2011).

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.

### 3.2 PASS Performance 2011/12 to Date

The following table shows the PASS performance for 2011/12 to date.

| Apr 2011 | May 2011 | Jun 2011 | Jul 2011 | Aug 2011 | Sep 2011 | Oct 2011 | Nov 2011 | Dec 2011 | Jan 2012 | Feb 2012 | Mar 2012 | Year to date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 84.96 | 96.14 | 77.89 | 80.39 | 75.37 | 73.41 | 80.74 | 81.89 | 57.25 | 54.58 | 60.9 | 66.3 | 74.4 |

(Figures from previous months may move as the individual indicators on which PASS is based are validated).

The March figure remains below 100 suggesting, based on these metrics, that the Trust is safer than last year. The increase against last month was caused in part by the larger number of falls and complaints about communication.

## 4. Safety Update

### 4.1 Central Alert System (CAS) Safety Alerts

There are no outstanding alerts for the Trust relating to March 2012 or earlier.

### 4.2 Infection control

MRSA

There were zero cases of hospital attributable MRSA bacteraemia reported during March. This represents a zero incidence of MRSA for the financial year 2011/2012 (against a limit of 6 or less).

In 2012/13 WSHT will have a limit of 2 cases of hospital attributable MRSA or less.

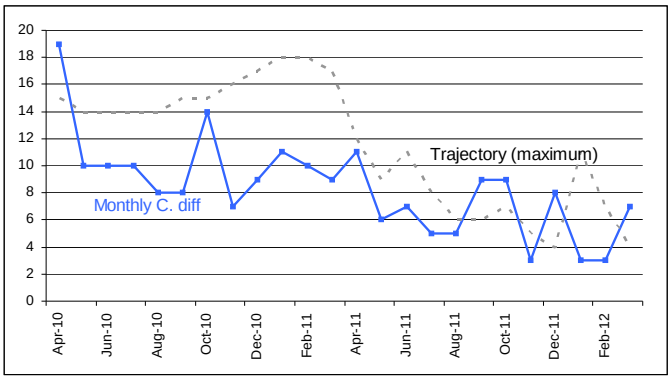
MSSA

There were 7 cases of Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia (3 at St Richards and 4 at Worthing). Of the 7 cases, 5 were within 48 hours of admission and were

therefore not attributed to inpatient hospital care. 2 of the cases were post 48hrs of admission (1 at St Richards and 1 at Worthing). The root cause analysis reflected that these cases were unavoidable.

C. diff

There were 7 cases of C. difficile reported in March (4 reported on the Worthing site and 3 at St Richards).




Although above trajectory for March, for 2011/12 as a whole WSHT achieved its trajectory of 90 cases or less.

The root cause analysis identified that 2 of the cases at St Richards were unavoidable. Regarding the remaining case, antibiotic prescribing may have contributed and the Consultant team have met with the Infection Control team to discuss the case. Of the 4 cases at Worthing, 3 were unavoidable. The fourth case was also considered unavoidable, however a delay in isolation was identified as a lesson of improvement.

The year end position for C. *diff* was 76 against a trajectory of 90 cases which represents 39**%** reduction against the 2010/2011 outturn.

In 2012/13 WSHT will have a limit of 75 cases or less of hospital attributable C. *diff*.

E. coli

The Trust, in line with other NHS Trusts, is now required to report the total number of Escherichia coli (E. coli) cases. There are no national benchmarks or trajectories for E. coli. In February there were 32 cases reported at WSHT (23 at the Worthing Site, 9 at Chichester).

The full infection control dashboard is available as appendix II.

### 4.3 Falls

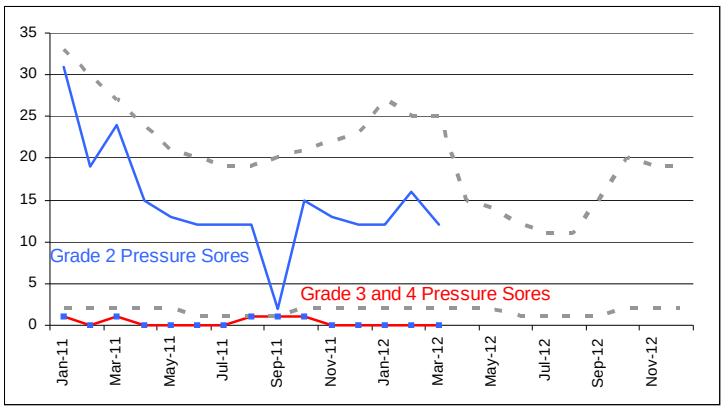
The Strategic Health Authority's Safer Smarter Nursing programme target is to achieve a 15% reduction in the number of falls resulting in low or moderate harm by 2012 against a baseline of financial year 2009/10 (when 629 falls resulting in harm reported). This gives the Trust a limit of 533 falls (the equivalent of 44 per month) for the calendar year 2012.

- In March there were 41 falls resulting in low or moderate harm (1 less than last month).
- There were no falls resulting in serious harm reported during March.

SHA benchmark: This gives a total of 66.07 falls per 10,000 admissions in March against a South East Coast average (for 2010/11) of 171.

### 4.4 Tissue Viability

The Safer Smarter Nursing Programme trajectory requires a 50% reduction in grade 2 and an 80% reduction in grade 3 and 4 pressure ulcer incidents (again comparing with 2009/10 baselines).




Monthly pressure sore incidents are better than trajectory (trajectories shown as dotted lines)

The Trust reported zero grade 3 and grade 4 pressure damage during March. This is the fifth consecutive month of zero grade 3 reporting of ulcers in these groups.

In March the Trust reported 12 patients with grade 2 pressure damage against an in-month trajectory of 25.

The incidence of pressure sores (developing 72 hours after admission) per 1000 bed days in February was 0.49. There are no national benchmarks for this indicator. The Trust continues to be one of the best performing trusts with regard to the maintenance of skin integrity across South East Coast.

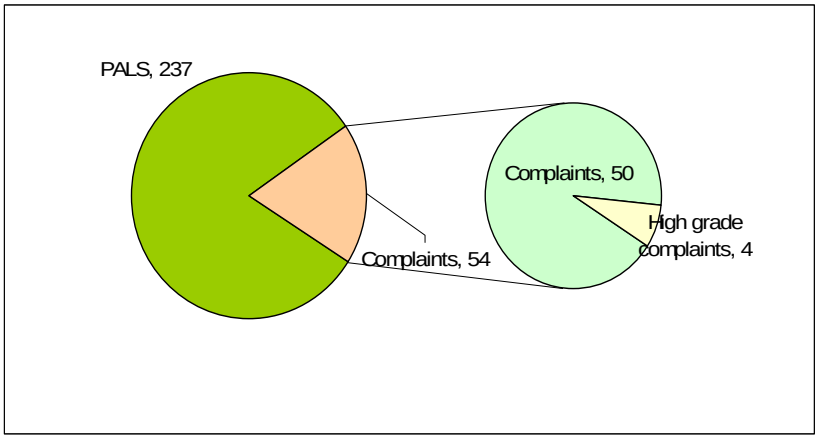
### 4.5 NHS Patient Safety Thermometer

During 2011/12 WSHT took part in a pilot across four wards collecting data using the NHS Patient Safety Thermometer. This tool looks at point prevalence of four key harms – falls, pressure ulcers, urinary tract infections and deep vein thrombosis and pulmonary embolism – in all patients on a specific day in the month. During 2012/13 the Thermometer will be rolled out across all appropriate wards in the Trust in line with regional and national roll-out programmes. In April data will be collected on ten wards (approximately 25% of the total in the Trust). Progress on this roll-out together with some of the key findings will be reported to future Trust Boards over the coming year.

## 5. Patient Experience

### 5.1 PALS and Complaints

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.




Breakdown of PALS / Complaints

During March 2012 the Trust received 54 complaints (the same number as last month). 4 complaints were graded as high, resulting in further investigation (also the same number as last month).

| | Worthing | Southlands | Chichester | Total |
|---|---|---|---|---|
| All complaints | 39 | 2 | 13 | 54 |
| High grade complaints | 2 | 1 | 1 | 4 |
| Nursing complaints | 4 | 0 | 0 | 4 |

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

In March, 4 complaints were received where nursing care was the primary issue (1 more than last month), i.e. 1.48 per 10,000 bed days. This compares favourably against the benchmark of 4.35.

### 5.2 Feedback from Hospital Experience Questionnaires

Following the pilot (running from October 2011 to December 2011), the roll-out of the Real Time Patient Experience project in Inpatients began on 3rd January, with a redesigned set of questions. There were over 450 respondents in March. In addition to those already included in the scorecard, relevant questions and indicators sections that will be routinely reported in this report from May onwards.

A paper based survey is also underway in outpatients, in advance of introducing Real-time Experience monitoring to outpatients.

Information from the Real-time Patient Experience survey will be reported to the Patient Experience Sub-Committee of the Quality Board.

## 6 Care Quality Commission (CQC)

### 6.1 CQC Compliance Reviews

The Secretary of State asked the CQC to inspect termination services across the country during March 2012. The Trust received two unannounced visits on the 22nd and 23rd March to our two major sites: Worthing and St Richards.

The assessor interviewed Senior Nursing and Medical staff and also undertook a random notes audit on both sites

Although written feedback has not yet been received, the discussion and audit provided the assessor with assurance regarding the process. There were no concerns raised either during or following the visit and the assessor was very complimentary on the sensitive nature of the service.

### 6.2 Quality Risk Profile

The Quality Risk Profile is routinely reported to Management Board. No areas of concern currently exist.

## 7 National Reports

### 7.1 Mencap: Death by Indifference Five Years On

Five years ago Mencap published a report called *Death by Indifference* highlighting shortcomings in healthcare services in relation to patients with learning disabilities. An updated report with further recommendations has now been published. Since the original report the Trust has worked closely with partner organizations such as Sussex Community Trust and West Sussex County Council to address the findings and recommendations of this original report. Two specialist nurses employed by the community trust now cover all our three hospitals, offering support to ward staff and outpatient departments caring for patients with learning disabilities. We also now have a database of patients with learning disabilities which - while still needing development - allows these specialists to target their support. A full update will be brought to a future Trust Board.

## 8. Nutrition, Hydration and Feeding

The West Sussex Local Involvement Network (LINk) will undertake a series of visits to St Richards Hospital over a period of approximately two months from April to May 2012 to

review aspects of the level of nutrition, hydration and feeding that patients are receiving. This is a follow up to the visits they commissioned at Worthing hospital in 2011 which were reported to the Trust Board in November 2011.

Findings from these visits to St Richards hospital will be brought to a future Trust Board and any actions required will be monitored via the Trusts Food Strategy Group on behalf of the Quality Board.

## 9. Commissioning for Quality and Innovation (CQUIN)

Since 2009/10 a proportion of the money the Trust receives has been payable on achievement of agreed quality metrics. The measures for 2011/12 were as follows.

| | |
|---|---|
| 1. VTE Assessments | 5. Patient Safety Culture |
| 2. Responsiveness to Patient Views | 6. Timely Outpatient Communications |
| 3. Enhancing Quality Programme | 7. Near-Patient Clinical Recording |
| 4. Care Planning for Discharges | 8. Information for Commissioners |

A regular report on progress within these areas is made to Directors. A final report will be sent to commissioners shortly. Agreements regarding 2012/13 are still being finalised with commissioners.

## 10. Recommendation

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

Mark Dennis, Head of Information Services
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# QUALITY SCORECARD

## MARCH 2012

| | | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | MAR | YTD Actual | YTD Target | Target | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **IMPROVING CLINICAL OUTCOMES** | | | | | | | | | | | | | | | | | | |
| **1A** | **Achieve a 10% reduction in the Trust's crude mortality rate by 2012** | 3.93% | 3.57% | 3.38% | 3.11% | 2.60% | 2.86% | 2.97% | 3.36% | 2.85% | 3.09% | 4.12% | 3.90% | 3.27% | **3.29%** | 3.5% | 3.2% |  |
| **1B** | **Reduce the Hospital Standardised Mortality Rate (HSMR) to 103** | 104.8 | 105.1 | 105.0 | 104.9 | 104.4 | 103.8 | 103.2 | 102.3 | 101.3 | 99.3 | 98.9 | | | 98.9 | 103 | 103 |  |
| **1.1** | **Improve treatment pathway and clinical outcomes for stroke patients** | | | | | | | | | | | | | | | | | |
| 1.11 | Reduce HSMR for cerebrovascular disease | 91.5 | 93.7 | 93.5 | 94.7 | 92.3 | 90.9 | 93.8 | 93.1 | 93.5 | 98.4 | 102.4 | | | 102.4 | 100 | 100 |  |
| 1.12 | Stroke patients are eligible for best practice tariff payment | 79.2% | 87.5% | 88.2% | 83.1% | 89.7% | 92.6% | 85.5% | 88.4% | 92.4% | 93.7% | | | | 89.2% | 80% | 80% |  |
| 1.14 | TIA patients are assessed and comence treatment within 24 hours | 61.1% | 85.7% | 30.0% | 84.2% | 58.3% | 25.0% | 85.7% | 57.1% | 57.1% | 22.2% | 53.8% | 76.5% | | 60.7% | 60% | 60% |  |
| **1.2** | **Reduce mortality following hip fracture** | | | | | | | | | | | | | | | | | |
| 1.21A | Reduce HSMR for hip fracture (head of femur replacement) | 182.4 | 194.4 | 198.5 | 197.0 | 213.0 | 208.3 | 201.6 | 188.8 | 182.0 | 177.8 | 148.8 | | | 148.8 | 147 | 140 |  |
| 1.21B | Reduce HSMR for hip fracture (all diagnoses/procedures) | 138.4 | 141.6 | 135.3 | 130.9 | 130.4 | 135.0 | 136.4 | 136.3 | 135.9 | 131.0 | 120.0 | | | 120.0 | tbc | tbc |  |
| 1.22 | Reduce mortality rate following hip fracture (all diagnoses/procs) | 10.0% | 12.5% | 10.3% | 3.9% | 6.2% | 12.3% | 5.7% | 12.9% | 9.5% | 7.3% | 6.5% | 4.5% | | 8.7% | 8.6% | 8.6% |  |
| 1.25 | 30 day mortaliy rate following hip fracture (all diagnoses/procs) | 9.2% | 12.1% | 4.4% | 6.5% | 6.0% | 8.6% | 6.3% | 11.3% | 10.4% | 6.4% | 5.8% | | | **8.1%** | tbc | tbc |  |
| 1.23 | Medically fit patients are operated on within 24 hours(source: NHFDb) | 50.9% | 35.8% | 36.4% | 45.8% | 64.1% | 50.0% | 61.0% | 46.3% | 62.1% | 77.6% | 68.3% | 69.8% | | **56.2%** | 90% | 90% |  |
| 1.24 | Reduce length of stay to best quartile (all diagnoses/procs) | 22.7 | 22.4 | 25.2 | 20.6 | 16.1 | 19.1 | 20.9 | 18.2 | 18.6 | 19.7 | 18.2 | 18.4 | 16.6 | **19.5** | tbc | tbc |  |
| **1.3** | **Reduce the rate of readmission following discharge from the Trust** | | | | | | | | | | | | | | | | | |
| 1.31 | Achieve 25% reduction in emergency readmissions within 30 days | 569 | 546 | 562 | 608 | 629 | 579 | 581 | 596 | 600 | 608 | 616 | 570 | | 6,495 | 4,885 | 5,330 |  |
| 1.32 | Reduce admissions for patients with over 4 adms in prev 12 mths (data for rolling 12 mths) | 4,200 | 4,174 | 4,192 | 4,143 | 4,203 | 4,121 | 4,096 | 4,088 | 4,229 | 4,177 | 4,211 | 4,264 | 4,217 | 4,217 | 2,100 | 2,100 |  |
| **1.4** | **Reduce HSMR for patients admitted under elderly care medicine** | | | | | | | | | | | | | | | | | |
| 1.41 | Reduced HSMR for elderly care medicine | 106.2 | 107.6 | 106.4 | 105.2 | 104.7 | 105.2 | 104.4 | 104.9 | 103.7 | 102.6 | 103.2 | | | **103.2** | 101 | 100 |  |
| 1.42 | Disease specific HSMR in 5 areas with greatest number of deaths[1] | 109.1 | 110.8 | 108.3 | 107.9 | 107.0 | 107.4 | 105.8 | 106.3 | 105.3 | 103.7 | 104.8 | | | 104.8 | 104 | 103 |  |
| 1.43 | Disease specific HSMR in 5 areas with greatest number of excess death | 129.8 | 129.1 | 125.93 | 126.3 | 126.1 | 127.3 | 125.3 | 125.1 | 122.2 | 119.8 | 118.7 | | | **118.7** | 113 | 110 |  |
| **1.5** | **To improve maternity care by encouraging natural chilbirth** | | | | | | | | | | | | | | | | | |
| 1.51 | Proportion of mothers having their babies delivered by caesarian sectic | 28.5% | 24.5% | 25.0% | 20.0% | 23.0% | 24.0% | 24.0% | 25.0% | 26.7% | 24.3% | 27.5% | 29.0% | 25.0% | **24.8%** | <23% | <23% |  |
| 1.52 | Proportion of mothers requiring forceps for delivery | 10.0% | 11.0% | 11.0% | 14.0% | 10.5% | 10.0% | 13.0% | 12.5% | 12.0% | 13.5% | 12.1% | 11.0% | 12.0% | **11.9%** | <15% | <15% |  |
| 1.53 | Proportion of deliveries complicated by post-partum haemorrhage | 0.43% | 0.91% | 0.82% | 0.40% | 0.79% | 0.85% | 0.00% | 0.21% | 0.22% | 0.84% | 0.85% | 0.24% | 0.43% | **0.57%** | 1% | 1% |  |

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# QUALITY SCORECARD

## MARCH 2012

| | | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | MAR | YTD Actual | YTD Target | Target | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SAFETY** | | | | | | | | | | | | | | | | | | |
| **2A** | **Achieve reduction in the Patient Aggregate Safety Score (PASS)** | - | 84.96 | 96.14 | 77.89 | 80.39 | 75.37 | 73.41 | 80.74 | 81.89 | 57.25 | 54.58 | 60.9 | 66.3 | 74.4 | <100 | <100 | |
| **2.1** | **Improve safety of prescribing** | | | | | | | | | | | | | | | | | |
| 2.11 | Reduction in moderate or severe prescribing incidents | - | 0 | 1 | 1 | 0 | 1 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 6 | 8 | 8 | |
| 2.12 | Reduction proprtion of GTT returns showing a prescribing issue | Data are under development | | | | | | | | | | | | | | tbc | tbc | |
| 2.13 | Reduced errors on zero tolerance anti-microbial prescribing audits | | 39% | 36% | 49% | 56% | 44% | 48% | 47% | 55% | 42% | 46% | 45% | 54% | **47%** | tbc | tbc | |
| **2.2** | **Reduce incidence of healthcare associated VTE** | | | | | | | | | | | | | | | | | |
| 2.21 | 95% compliance with the DoH risk assessment tool | 93.1% | 91.4% | 91.9% | 91.9% | 92.0% | 90.8% | 90.7% | 90.2% | 91.0% | 89.9% | 92.2% | 92.3% | 91.7% | **91.3%** | **95%** | **95%** | |
| 2.22 | 90% compliance with approved VTE prophylaxis in quarterly audits | Data are under development | | | | | | | | | | | | | | tbc | tbc | |
| 2.23 | Reduction in rates of post-admission DVT and PE[4] | 0.13% | 0.08% | 0.18% | 0.20% | 0.18% | 0.26% | 0.15% | 0.10% | 0.13% | 0.17% | 0.13% | | | 0.15% | 0.20% | 0.20% | |
| 2.24 | Reduce readmissions within 90 days due to VTE | 11 | 11 | 15 | 11 | 14 | 17 | 18 | 21 | 11 | 13 | 17 | 15 | | 163 | 121 | 132 | |
| 2.25 | Achieve 20% reduction in mortality from VTE disease | 3 | 4 | 6 | 4 | 3 | 3 | 4 | 5 | 3 | 3 | 10 | 6 | | 51 | 41 | 45 | |
| **2.3** | **Reduce incidence of healthcare acquired infections** | | | | | | | | | | | | | | | | | |
| 2.31 | Number of hospital attributable MRSA cases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 6 | 6 | |
| 2.32 | Number of hospital attributable C. diff cases | 9 | 11 | 6 | 7 | 5 | 5 | 9 | 9 | 3 | 8 | 3 | 3 | 7 | **76** | 90 | 90 | |
| 2.33 | Number of MSSA bacteraemia cases | 7 | 4 | 5 | 4 | 5 | 9 | 9 | 12 | 5 | 7 | 9 | 4 | 7 | **80** | tbc | tbc | |
| 2.34 | Surgical site infection rates for colorectal surgery | Data are under development | | | | | | | | | | | | | | tbc | tbc | |
| 2.35 | Surgical site infection rates for hip replacement surgery | Data are under development | | | | | | | | | | | | | | tbc | tbc | |
| **2.4** | **Improve theatre safety for patients** | | | | | | | | | | | | | | | | | |
| 2.41 | Full compliance with WHO Surgical Safety Checklist | | 89% | | | 97% | | | 96% | | | | | | **94%** | tbc | tbc | |
| 2.42 | Achieve 50% reduction in unexpected returns to theatre | Data are under development | | | | | | | | | | | | | | tbc | tbc | |
| 2.43 | Elimination of all NEVER events | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | |
| 2.44 | Achieve 75% reduction in theatre related SIRIs | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | |
| **2.5** | **Reduce number of falls in hospital** | | | | | | | | | | | | | | | | | |
| 2.51 | Achieve 15% reduction in falls resulting in low or moderate harm[3] | 45 | 46 | 52 | 33 | 40 | 48 | 38 | 40 | 36 | 33 | 35 | 42 | 41 | **118** | 132 | 531 | |
| 2.52 | Achieve 50% reduction in falls resulting in severe harm or death[3] | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0 | 2 | |
| 2.53 | Falls assessment within 24hrs of admission | - | - | - | - | - | - | - | - | 79.85% | 81.75% | 85.0% | 91% | 93% | **86.0%** | 80% | 80% | |
| **2.6** | **Pressure damage** | | | | | | | | | | | | | | | | | |
| 2.61 | Achieve 50% reduction in incidence of grade 2 pressure sores[3] | 24 | 15 | 13 | 12 | 12 | 12 | 2 | 15 | 13 | 12 | 12 | 16 | 12 | **40** | 77 | 213 | |
| 2.62 | Achieve 80% reduction in incidence of grade 3 & 4 pressure sores[3] | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | **0** | 6 | 20 | |

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# QUALITY SCORECARD

MARCH 2012

| | | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | MAR | YTD Actual | YTD Target | Target | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **PATIENT EXPERIENCE** | | | | | | | | | | | | | | | | | | |
| **3A** | **Increase the proportion of patients who would recommend the Trust** | | | | | | | | | | | 87.8% | 87.0% | 88.7% | **88%** | tbc | tbc | |
| **3B** | **Increase the proportion of staff who would recommend the Trust** | | | | | | | | | | | | - | - | **-** | tbc | tbc | |
| **3.1** | **Improved scores in targeted patient survey questions** | | | | | | | | | | | | | | | | | |
| 3.11 | I felt involved in the decisions about my care and treatment[5] | - | - | 94% | 90% | 93% | 89% | 91% | 88%(95%) | 92%(80%) | 88%(80%) | 76% | 77% | 74% | **77%** | tbc | tbc | |
| 3.12 | I felt able to express any fears or anxieties[5] | - | - | 97% | 98% | 97% | 96% | 96% | 95%(95%) | 94%(91%) | 93%(87%) | 62% | 65% | 71% | **64%** | tbc | tbc | |
| 3.13 | My privacy and dignity was maintained at all times[5] | - | - | 97% | 99% | 98% | 99% | 98% | 95%(95%) | 96%(99%) | 95%(98%) | 77% | 76% | 76% | **76%** | tbc | tbc | |
| 3.14 | I was informed of medication side effects | | | | | | | | | | | | | | | tbc | tbc | |
| 3.15 | I was informed who to contact if worried about my condition after leaving hospital | | | | | | | | | | | | | | | tbc | tbc | |
| 3.16 | I felt the attitude of staff was good[5] | - | - | 99% | 99% | 100% | 100% | 98% | 99%(100%) | 100%(98%) | 99%(98%) | | | | **99%** | tbc | tbc | |
| **3.2** | **Reduction in patients suffering a bad experience dealing with the Trust** | | | | | | | | | | | | | | | | | |
| 3.21 | Reduce numbers of re-booked outpatient appointments | 8.3% | 11.1% | 8.9% | 8.8% | 8.6% | 9.0% | 8.6% | 7.8% | 7.8% | 8.4% | 8.7% | 8.5% | 9.4% | **8.8%** | tbc | tbc | |
| 3.22 | Reduce number of clinics cancelled with less than 6 weeks notice | Data are under development | | | | | | | | | | | | | | tbc | tbc | |
| 3.23 | Reduce the average number of ward stays per non-elective admission | 1.82 | 1.74 | 1.76 | 1.80 | 1.79 | 1.82 | 1.84 | 1.74 | 1.79 | 1.75 | 1.80 | 1.80 | 1.76 | **1.78** | tbc | tbc | |
| 3.24 | Reduce the number of complaints relating to administrative processes | - | - | - | 6 | 4 | 11 | 4 | 3 | 5 | 3 | 5 | 7 | 12 | **-** | tbc | tbc | |
| 3.25 | Reduce patients cancelled on the day of surgery for non-clinical reason | 33 | 22 | 43 | 28 | 14 | 25 | 46 | 50 | 75 | 31 | 55 | 44 | 37 | **470** | tbc | tbc | |
| **3.3** | **Nutritional Assessment** | | | | | | | | | | | | | | | | | |
| 3.31 | Compliance with MUST tool after 24 hours | 87.0% | 89.0% | 90.0% | 90.0% | 87.7% | 88.5% | 85.0% | 85.6% | 84.5% | 84.3% | 84.5% | 85.5% | | **86.8%** | 80% | 80% | |
| 3.32 | Compliance with MUST tool after 7 days | - | - | - | 93.0% | 94.0% | 98.5% | 98.0% | 96.8% | 92.1% | 95.5% | 94.0% | 95.0% | | 95.2% | 100% | 100% | |
| 3.33 | Evidence of production and adherence to nutritional action plans | Indicator to be specified | | | | | | | | | | | | | | tbc | tbc | |
| 3.34 | Evidence of success in pre-discharge reassessment audits | Indicator to be specified | | | | | | | | | | | | | | tbc | tbc | |
| **3.4** | **Cleanliness / PEAT Survey** | | | | | | | | | | | | | | | | | |
| 3.41a | Internal PEAT compliance : St Richard's Hospital | - | 90% | 93% | 94% | 93% | 97% | 96% | 98% | 97% | 94% | 98% | 97% | 94% | **95%** | 85% | 85% | |
| 3.41b | Internal PEAT compliance : Worthing Hospital | - | 92% | 93% | 93% | 93% | 91% | 94% | 89% | 96% | 97% | 95% | 98% | 97% | **94%** | 85% | 85% | |
| 3.41c | Internal PEAT compliance : Southlands Hospital | - | 75% | 92% | 90% | 93% | 89% | 92% | 89% | 100% | 98% | 95% | 96% | 97% | **92%** | 85% | 85% | |
| **3.5** | **Improve our customer service and become a more caring organisation** | | | | | | | | | | | | | | | | | |
| 3.51 | Reduction in complaints where staff attitude or behaviour is an issue | | 4 | 3 | 2 | 5 | 2 | 3 | 4 | 7 | 3 | 3 | 3 | 2 | **41** | tbc | tbc | |
| 3.52 | Reduction in complaints where staff communication is an issue | | 8 | 8 | 7 | 4 | 5 | 9 | 7 | 2 | 5 | 4 | 6 | 8 | **73** | tbc | tbc | |
| 3.53 | Positive care and compassion observations in general care | | | - | | | - | | | 87% | | | 76% | | **82%** | tbc | tbc | |
| 3.54 | Positive care and compassion observations in patient / visitor interactions | | | - | | | - | | | 91% | | | 77% | | **84%** | tbc | tbc | |

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# QUALITY SCORECARD

## MARCH 2012

| | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | **MAR** | **YTD Actual** | YTD Target | Target | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**Notes**

1 The five diagnosis groups with the most deaths in 2010/11 are pneumonia, acute cerebrovascular disease, congestive heart failure non-hypertensive, fracture neck of femur and UTI.
2 The five diagnosis groups with the most excess deaths in 2010/11 are Acute and unspecified renal failure, congestive heart failure non-hypertensive, fracture neck of femur, UTI and fluid and electrolyte disorders.
3 Data for these metrics are being monitored against trajectories agreed with the SHA. These are set on a calander year basis.
4 Post operative DVT and PE - Dr Foster Patient Safety Measure
5 Scores given parentheses are taken from the Real Time Patient Experience monitoring system (see Quality Report).

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# INFECTION CONTROL SCORECARD

MAR 2012

| | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 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 | 100% | 100% | 100% | 99% | 95% | 100% | 100% | 99% | 98% | 100% | 100% | 100% | 100% | 99% | 95% | 95% | |
| Ventilation | 97% | 100% | 100% | 94% | 100% | 99% | 100% | 99% | 100% | 100% | 100% | 100% | 100% | 99% | 95% | 95% | |
| Hand hygiene | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 95% | 95% | |
| Peripheral IV Line | 98% | 97% | 97% | 96% | 99% | 98% | 97% | 100% | 97% | 98% | 98% | 99% | 98% | 98% | 95% | 95% | |
| Catheter care | 99% | 98% | 100% | 100% | 100% | 99% | 99% | 98% | 99% | 100% | 100% | 100% | 99% | 99% | 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 | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 99% | 99% | 98% | 98% | 98% | 99% | 100% | 100% | |
| **Hospital cleanliness** | | | | | | | | | | | | | | | | | |
| Very high risk | 98% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 98% | 98% | |
| High risk | 99% | 99% | 98% | 98% | 99% | 99% | 99% | 99% | 99% | 98% | 98% | 99% | 98% | 99% | 95% | 95% | |
| Significant risk | 98% | 98% | 97% | 98% | 96% | 97% | 97% | 98% | 98% | 95% | 98% | 96% | 99% | 97% | 85% | 85% | |
| Low risk | 100% | 98% | 98% | 92% | 94% | 94% | 94% | 98% | 93% | 98% | 98% | 90% | 94% | 95% | 75% | 75% | |
| **Decontamination of equipment** | | | | | | | | | | | | | | | | | |
| Decontamination of equipment | 97% | 98% | 99% | 99% | 99% | 98% | 99% | 95% | 99% | 99% | 98% | 99% | 98% | 98% | | | |

**WESTERN SUSSEX HOSPITALS NHS TRUST**

To: **Trust Board**

Date of Meeting: **26th April 2012** Agenda Item: 8

| **Title** |
|---|
| Improving the Outpatient Experience. |
| Presented by |
| Jane Farrell, Chief Operating Officer |
| Prepared by |
| Adam Creeggan, Director of Performance |
| Status |
| Disclosable |
| Summary of Proposal |
| The purpose of the report is to bring to the attention of the Executive Team summary findings of the National Outpatients Survey 2011, correlating themes between these findings and complaints about the Outpatients service, supported by date from the Real Time Patient Experience surveys and the current work streams in place to address identified improvement themes. |
| Implications for Quality of Care |
| Implementation of identified actions has, and will, ensure the Trust is addressing areas of concern in a timely manner for the purposes of improving the patient experience of users receiving outpatient care. |
| Support for/integration with Corporate Objectives and Strategies |
| *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.<br>*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 |
| None |
| Human Resource Implications |
| None |
| **Recommendation** |
| **The Patient Experience and Feedback Committee is asked to note the report.** |
| Consultation |
| Director of Nursing & Patient Safety, Director of Performance |
| Appendices |
| Appendix A: Care Quality Commission Outpatients Department Survey 2011 – Benchmark report<br>Appendix B: Care Quality Commission Outpatients Department Survey 2011 – Patient Comments<br>Appendix C: Real Time Patient Survey results – February 2012<br>Appendix D: Welcome to Outpatient Leaflet |

This report can be made available in other formats and in other languages. To discuss your requirements please contact Graham Lawrence, Company Secretary, on graham.lawrence@wsht.nhs.uk or 01903 285222 x 4774.

Western Sussex Hospitals NHS
NHS Trust

| | |
|---|---|
| To: Trust Board | Date of Meeting: 26th April 2012 |
| From: Adam Creeggan, Director of Performance | Agenda Item: 8 |
| **FOR INFORMATION** | |

**IMRPOVING THE OUTPATIENT EXPERIENCE**

## 1 INTRODUCTION

1.1 This paper examines a range of outpatient improvement requirements derived via three main sources; formal outputs from to the National Outpatients Survey 2011, informal outputs based on respondents comments collated via the National Outpatients Survey 2011, and correlating themes relating to complaints and/or enquiries to the WSHT PALs service.

1.2 This paper establishes eight improvement themes drawn from the sources above, details relevant improvement programs, and demonstrable improvements linked to these improvements.

## 2 OPERATIONAL CONTEXT

2.1 Annually the Trust undertakes 490,000 outpatient attendances, with the management of WSHT outpatient environments spanning a number divisional management structures;

- Access Management – Outpatient booking/call centres, main outpatient departments including the Chichester Treatment Centre, MFU and ENT.
- Medical Division - Worthing Day Hospital, MDCU, Diabetes, Endoscopy, Haematology, Cardiac Testing
- Surgical Division – Ophthalmology, Surgical pre-assessment, Breast Service.
- Women and Children – Children's Centre
- Core – Audiology, Dietetics, Physio and OT

2.2 Nationally, demand for first outpatient attendance has increased by 38.9% since 2004, during which time the maximum waiting time has reduced from 26 weeks to circa 5 weeks for patients on an admitted referral to treatment pathway.

2.3 Detailed data relating to outpatient complaints and/or PALs enquiries is available from October 2010. The first full 12 month presented to the Patient Experience and Feedback Committee related therefore to October 2010 to September 2011. During that period the trust received 2,552 PALS enquiries and formal complaints, among which 558 (24.8%) related to outpatient clinics and appointments, demonstrating a 0.12% enquiry/complaint contact rate per outpatient attendance. Distribution of complaints/enquires by site broadly aligns to the distribution of activity, with 55% relating to Worthing Hospital, a further 40% to St. Richards Hospital, and the remaining 5% to Southlands Hospital.

2.4 Nationally, formal complaints relating to outpatients are calculated as a rate per 10000 first attendances, and the England benchmark score for the latest published data (Quarter 3, 2011/12) shows a rate of 12.8 per 10,000. During the same quarter WSHT generated a rate of 6.8 per 10,000.

## 3 BACKGROUND TO THE NATIONAL OUTPATIENTS SURVEY

3.1 The National Outpatients Survey is required of all NHS Trusts in England by the Care Quality Commission. The national survey has previously been conducted in 2003, 2004 and 2009.

3.2 The Care Quality Commission report provides the results of the fourth survey of adult outpatients in NHS Trusts in England, and shows how each Trust scored for each question in the survey, compared with national benchmark results. It has been designed to be used to understand the performance of individual trusts, and to identify areas for improvement.

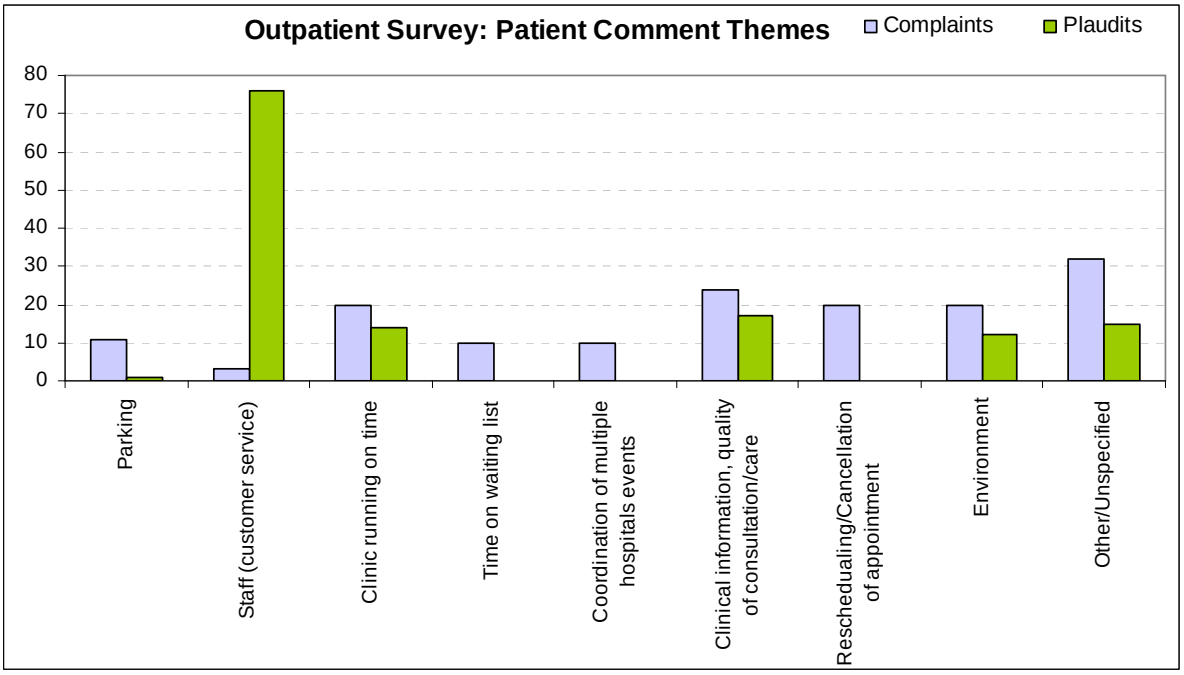
3.3 In Western Sussex Hospitals NHS Trust, the survey was undertaken on a random sample of 850 adult patients having an outpatient appointment in May 2011. Overall, 515 patients completed the questionnaire, with a response rate of 61%. This demonstrates an improvement in response rate of +3.5% on the previous survey response in 2009.

3.4 The final report for Western Sussex Hospitals NHS Trust was received into the organisation on the 19th January 2012 and formally published on the 14th February 2012. The Care Quality Commission benchmark report for the National Outpatient Survey 2011 is provided as **Appendix A**.

3.5 In addition to the outcomes relating to the specific survey questions, the survey report also incorporates free text feedback and this report is attached as **Appendix B**. Analysis of comments identifies 285 separate negative and plaudit comments relating to 216 individual patients.

3.6 Within this 285 complaint/plaudit comments, 83.5% of comments can be grouped into eight improvement themes; Parking, staff/customer service, clinic running times, time on waiting list, coordination of multiple hospitals events, quality of consultation, cancellation/rescheduling appointments, and environment. **Figure 1** outlines negative and plaudit volumes by response theme.

**Figure 1: Outpatient Survey Responses**




3.7 The structured element of survey comprised of 36 questions relating almost exclusively to the improvement theme ‘quality of consultation’ within the eight improvement themes identified above.

3.8 Trust has improved on 11 of the comparable 36 questions since 2009, and remains the same on 2 questions and worse on 23 questions, with an average change of -1.7% per question.

3.9 The main improvement on the 2009 survey has been a 9% increase in Q46 ‘Did you receive copies of letters sent between hospital doctors and your family doctor (GP).

3.10 The Trust could improve in providing information in relation to tests – why they were necessary (Q13), how patients would find out results (Q14) and clear explanation of test results (Q15) where results are worse this year.

3.11 In comparison to other Acute Trusts nationally, Western Sussex Hospitals NHS Trust has been rated ‘about the same’ for each of the six overarching categories in the main survey, however, when

examining responses against individual questions the Trust was rated in the worst performing 20% of Trusts for the following areas:

- Did a member of staff explain why you needed these test(s) in a way you could understand?
- Did a member of staff explain the results of the tests in a way you could understand?
- Were you told about any risks/benefits in a way you could understand before the treatment?
- Did you have enough time to discuss your health or medical problem with the doctor?
- Did the doctor listen to what you had to say?
- How much information about your condition or treatment was given to you?
- Were you given enough privacy when discussing your condition or treatment?
- Did your appointment help you to feel that you could better manage your condition or illness?
- Did a member of staff explain to you how to take the new medications?
- Did a member of staff tell you about medication side effects to watch for?
- Was the reason for changing your medication explained in a way you could understand?
- Were you told what danger signals to watch for after you went home?
- Were you told who to contact if you were worried about your condition or treatment after you left hospital?

3.12 The Trust does not appear in the top 20% of organisations for any of the questions, with the exception of Q35 (Did a member of staff say one thing and another say something different), where the Trust has been graded as borderline between the intermediate 60% of trusts and best performing 20% of trusts.

## 4 COMPLAINTS/PALs ENQUIRIES

4.1 As detailed in 2.3 above, complaint reporting via DATIX has been routinely available from October 2010, and a distribution of the 558 patient contacts relating to outpatients in first 12 months of available data is contained in type in **Table 1**.

4.2 Analysis of data contained in **Table 1** supports the eight improvement themes identified via the National Outpatient Survey, but highlights a significantly higher proportion of contacts relating to the length of time waited for appointments (35.6%) and cancellation/rescheduling (37.9%).

**Table 1: Pals contacts by category and site (Outpatients) Oct 2010 to Sept 2011**

| Issue | Worthing | Southlands | St Richards | Total | % of Total |
|---|---|---|---|---|---|
| Parking | 0 | 0 | 0 | 0 | **0.0%** |
| Staff/Customer Service | 3 | 0 | 3 | 6 | **1.1%** |
| Clinic running times | 10 | 1 | 15 | 26 | **4.7%** |
| Unacceptable time to wait for appt | 121 | 11 | 67 | 199 | **35.9%** |
| Coordination of multiple hospital events | 1 | 0 | 2 | 3 | **0.5%** |
| Quality of consultation | 14 | 1 | 6 | 21 | **3.8%** |
| Cancellation/rescheduling of appointment | 121 | 8 | 83 | 212 | **38.2%** |
| Environment | 0 | 0 | 0 | 0 | **0.0%** |
| Other | 37 | 4 | 47 | 88 | **15.9%** |
| **TOTAL** | **307** | **25** | **223** | **555** | **100.0%** |

## 5 IMPROVEMENT THEMES AND MITIGATING ACTIONS

5.1 Parking

5.1.1 Car parking accounted for 12 responses (3.2%) of the 285 observed in the National Outpatients Survey, with 11 negative responses and 1 plaudit. Negative comments related to cost of parking or volume/availability of parking spaces, particularly for disabled drivers. Conversely, the single plaudit praised the level of disabled parking available, and the disparity in perception can almost certainly be attributed to the variance in outpatient attendance levels by both time of day and day of week and the relative demands placed on public parking capacity.

5.1.2 While capacity and cost links to wider estate strategy themes, to mitigate the sense of frustration patients experience in incurring higher parking charges due to delays in clinics, the Performance and Access division has implemented a process to reimburse parking fees for patients that have been delayed beyond an acceptable waiting time, which is typically determined as a delay greater than 30 mins. While this creates an unplanned in year cost pressure to the division, the cohort of qualifying patients is limited, and the benefit in customer relations terms in mitigating frustration at source clear from patient feedback since implementation.

5.1.3 In year monitoring of both PALs contact rates and financial impact will be maintained, however as the complaint cohort is only 3.2% of total, insufficient data has been collated since implementation in January 2012 to determine the impact in improving the patient experience specifically, although reduced PALs contacts detailed in the latter sections of this paper indicate the success of the wider package of mitigating actions introduced of which this forms part.

5.2 Staff/Customer Service.

5.2.1 Of the written comments collated from the National Outpatient Survey, comments relating to the service received relating to staff interaction made up by far the single largest response theme at 27.4% of total responses. Of the 78 specific comments relating to this theme 76 were plaudits and 2 were negative.

5.2.2 Since the publication of the National Outpatient Survey, real time patient surveys have been conducted monthly to track the impact of improvement actions. The responses to questions are weighted in accordance with the methodology applied by the CQC as part of the National Outpatient Survey, with the more positive responses given a greater weighting. Since implementation, the data received to date has demonstrated positive responses to the overall quality of care, kindness of nurses/receptionists, recommendations of service to others and involvement in decisions about their care.

5.2.3 Data drawn from the February Real Time Patient Experience Survey validates that response. Patients are asked to rate the kindness displayed by trust staff in an outpatient setting, with negative responses (poor or very poor) of 0.96% for nurses, 1.43% for doctors and 0.48% for reception staff. Weak positive responses (fair) made up 1.91% for nurses, 4.29% for doctors and 6.19% for reception staff. All other responses related to firm positive statements (good or very good).

5.2.4 While high satisfaction rates are evident the weak positive response rate for reception staff indicates further opportunity for improvement. Following the transfer of main outpatients to Performance and Access in November 2011, the role of Outpatient Reception Manager was created to provide support and structure to reception teams across all sites. An exceptionally high caliber individual has been recruited to the role, and in addition to immediate improvements generated by this strengthened management arrangements, the Outpatient Reception Manager is currently developing a formal an in-house specialist customer service training package for receptionist staff. In addition, funding has been created within existing headline budgets to provide uniforms for receptionists to present a more professional image in main outpatient department areas.

5.3 Late Running Clinics

5.3.1 Of the comments connected to the National Outpatient Survey, 34 comments (11.9%) related to the length of time the patient waited beyond the allocated appointment time. Within this total, 20 comments were negative feedback relating to adverse waiting times, and 14 were plaudits in which the patient was seen on or before the appointment time.

5.3.2 While late running clinics are a clear source of frustration, it is important to reflect that the most common causes of overruns relate to either delays supporting the specific reactions of individual patients when receiving clinical feedback and/or bad news, or same day staff sickness. Individual clinics are often part

of a wider cluster of clinics provided by middle grade staff under the supervision of one, or more, consultants. In the event of the same day sickness, every attempt is made to provide cover for a clinic from within the remaining clinical pool to ensure patients are able to attend having often made complex arrangements regarding time of work, childcare, transport etc. In this context a delay in clinic is perceived as the best of the available non desirable impacts.

5.3.3 A number of actions have been implemented to improve the patient experience when unavoidable delay occurs:

- Enhanced training of reception staff to ensure all patients are informed as they check in for their appointment if there are any delays.
- Augmented training of reception and nursing staff nursing staff to ensure patients are kept informed throughout the clinic if delays have developed.
- Further support information to patients through the introduction of white boards in main outpatients providing real time visual status of clinic times in the event of delay.
- In conjunction with the PALS service, identify options for the introduction of bleeps for patients allowing the patient to leave the department, and minimising the impact of delay to the patient through increased flexibility to relocate to refreshment areas.

5.4.1 In addition to the immediate actions above, a detailed appraisal of real time information boards is currently in under way in conjunction with the Information Technology department. This system would comprise of strategically placed electronic messaging boards that would serve to both call and direct patients to clinic rooms, while also providing real time updates on clinic running times. Investment would fall outside the capital program allocations for 2012/13 therefore will have to be funded from within existing main outpatient non pay allocations.

5.4.2 Linked to the actions described above, Real Time Patient Experience results for February indicate the weighted score that have increase from 65 at the time of the National Outpatient Survey to 70.8. This improvement now exceeds the threshold score of 69 required to be rated within the upper 20% of Trusts nationally

5.4 <u>Time on waiting list</u>

5.4.1 Ten respondents in the National Outpatient Survey provided negative comments relating to the waiting time for appointment, representing 3.5% of all responses.

5.4.3 In contrast, patient contacts with the WSHT PALs service demonstrate a significantly higher rate of contact for this improvement theme, with 35.6% of contacts in the first 12 months of DATIX data relating to access times.

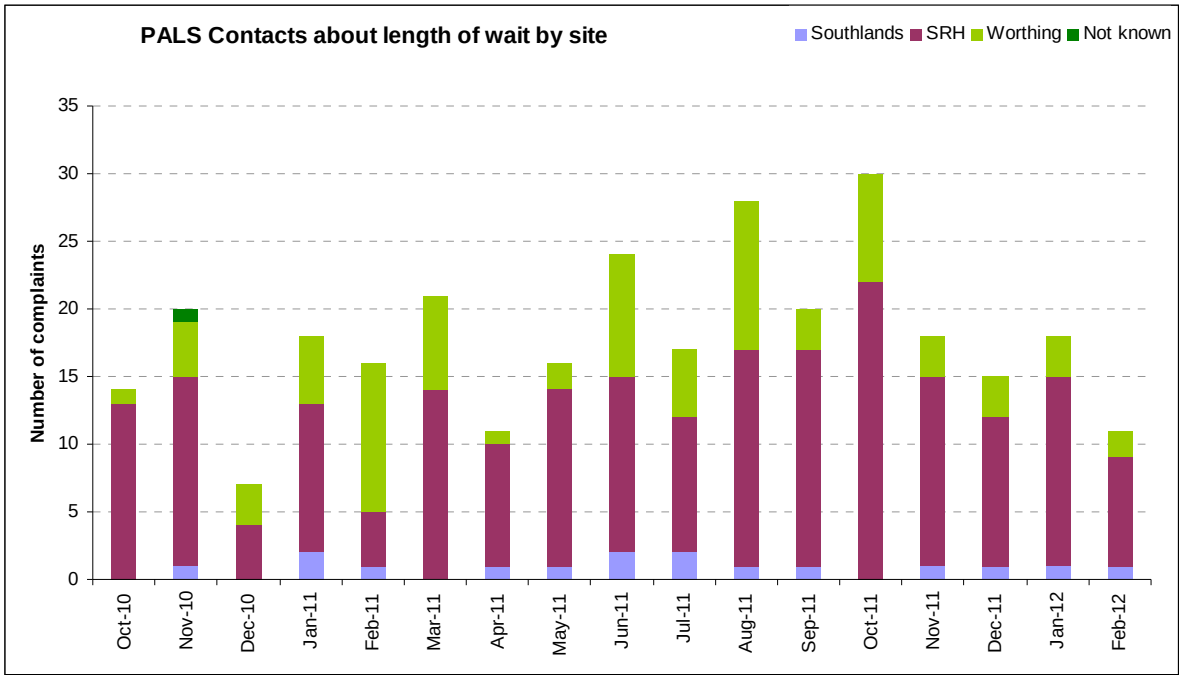
5.4.4 Detailed analysis of PALs contacts relating to access time has been undertaken to establish the actual waiting time for all patients who perceived they had waited excessively. This analysis reveals for patient who completed a referral to treatment pathway, 80.9% of patient did so fully compliant with the 18 week national expectation. Of the remaining patients who did not complete a RTT pathway (patients not requiring treatment) 86.9% of patients were seen and concluded within 18 weeks. While neither element meets 90% minimum compliance level required of the Trust this analysis does reveal that patient expectation rather than failure to comply with national access time thresholds account for the majority of patient contacts relating to waiting time.

5.4.5 Drilling below the aggregate data to specialty level, Orthopaedics makes up the predominant volume of contacts relating to access times. Within the specialty only 65% of contacts in the 12 month period concluded RTT pathways within 18 weeks.

5.4.6 This result is consistent with the aggregate admitted compliance within Orthopaedics which began 2011/12 at 56% in April 2011. Since that time a significant RTT recovery program has been delivered, sustaining 18 week compliance in aggregation but particularly improving orthopaedic compliance to 74.8% in March 2012 and putting the Trust on target to deliver full compliance of >90% for orthopaedic admitted pathways from April 2012.

5.4.7 **Figure 2** demonstrates a reduction in PAL's contacts relating to length of wait following the completion of the recovery exercise in September 2011.

**Figure 2: PAL's contacts relating to cancellation or rescheduling of appointment**



5.5 Coordination of multiple hospital events

5.5.1 Ten respondents within the National Outpatient Survey process stated frustrations relating to the lack of coordination of outpatient appointments with other reasons to attend hospital. No plaudits were received relating to the same theme.

5.5.2 Respondents cited examples of multiple appointments for different complaints and therefore specialties on the same day, but many hours apart, relating to outpatients, diagnostics and therapies. In addition some respondents cited frustration that the Trust did not bring forward and undertake outpatient consultations while the patient was admitted in recent, but unrelated, inpatient spells.

5.6 Quality of Consultation

5.6.1 In addition to the specific areas of concern cited in 3.11 relating to the specific questions in the National Outpatient Survey, 41 additional comments were identified in the informal feedback element of the report making up 14.4% of responses. Within the total 24 comments were negative, and 17 were plaudits.

5.6.2 In contrast, only 3.8% of patient contacts with the WSHT PALs service relate to the quality of consultation, with 21 contacts during the initial annual baseline volume relating to October 2011-September 2012.

5.6.3 Real time patient experience surveys including 5 of the questions conducted as part of the National Outpatient Survey have been conducted since December 2011, and this survey process will be expanded in 2012/13. Data relating to real time patient surveys undertaken in February confirms a number of improvements within these five target areas:

- Q36 - Have you been involved as much as you wanted to be in decisions about your care? February data shows the weighted score has improved from 82 at the time of the National Outpatient Survey to 86.0. This improvement now matches the threshold score of 86 required to be rated within the upper 20% of Trusts nationally

- Q48 - Did a member of staff explain why you needed these tests in a way you could understand? February data shows the weighted score has improved from 58 at the time of the National Outpatient Survey to 72.9. This improvement now exceeds the threshold score of 70 required to be rated within the upper 20% of Trusts nationally

- Q13 - Did hospital staff tell you who to contact if you were worried after you left hospital? February data shows the weighted score has improved from 76 at the time of the National

Outpatient Survey to 84.1. Further improvement is required to exceed the score of 86 required to be rated within the upper 20% of Trusts nationally

- Did a member of staff explain the results of the test(s) in a way that you could understand? February data shows the weighted score 78.1 crudely matches the 78 achieved in the National Outpatient Survey. A score of 86 is required to be rated within the upper 20% of Trusts nationally

- Did a member of staff tell you how you would find out the results of your test(s)? February data shows the weighted score has improved from 68 at the time of the National Outpatient Survey to 87.7. This improvement significantly exceeds the threshold score of 77 required to be rated within the upper 20% of Trusts nationally

5.7 Cancellation/rescheduling of appointments

5.7.1 Both PAL's contact rates and the National Outpatient Survey confirm this improvement theme as a key area of patient concern. The National Outpatient Survey comments section shows 20 negative comments (7.0%) relating to this themes, whereas 38.2% of all PAL's outpatient related contacts are attributable to this theme.

5.7.2 When referrals are received into the Trust, the Access Policy stipulates appointments are made at the earliest convenience to the patient whilst booking in order of clinical priority, mirroring national best practice. Regrettably this means that routine appointments are often booked in advance of clinical leave notifications which have a minimum 6 week notice period. As capacity utilisation is maximised, clinics cancelled because there is no doctor to see patients often leave little operational alternative but to cancel and re-arrange appointments.

5.7.3 Following publication of the National Outpatient Survey results and PALs contact baseline data in **Table 1,** and the transfer of main outpatient departments to Performance and Access Management in November 2011, two significant mitigating actions have been identified to offset these operational constraints, namely (a) improved communication, and (b) implementation of partial booking.

5.7.4 Immediately following the publication of full year baseline DATIX data in September 2011 a detailed review of patient cancellation communication was undertaken. Actions implemented to date include the augmentation of the wording of cancellation letters developed collaboratively with the complaints team, and the development of a wider interaction strategy with patients affected to minimise the adverse impact on experience supported by additional training and support for nursing and reception staff in main outpatient areas.

5.7.5 Further to the themes and associated actions linked to the communication, complaint analysis demonstrates a significant element of complaints received relating to access times specifically relate to ophthalmic follow-up appointments. Due to the planned nature of ophthalmic follow ups appointments these are made up to a year in advance, hence a patient can be displaced several times due to the booked clinic being subsequently cancelled due to leave requests from clinicians.

5.7.6 A project group has been formed to trial the partial booking module in Sema Helix PAS for follow-ups in Ophthalmology. The principle of the process is that patients who require a follow-up appointment more than six weeks in advance will be added to a waiting list and contacted approximately 4-6 weeks prior to the date they are due to be seen. This effectively eliminates the need to cancel any booked appointment unless there is same day sickness or emergency.

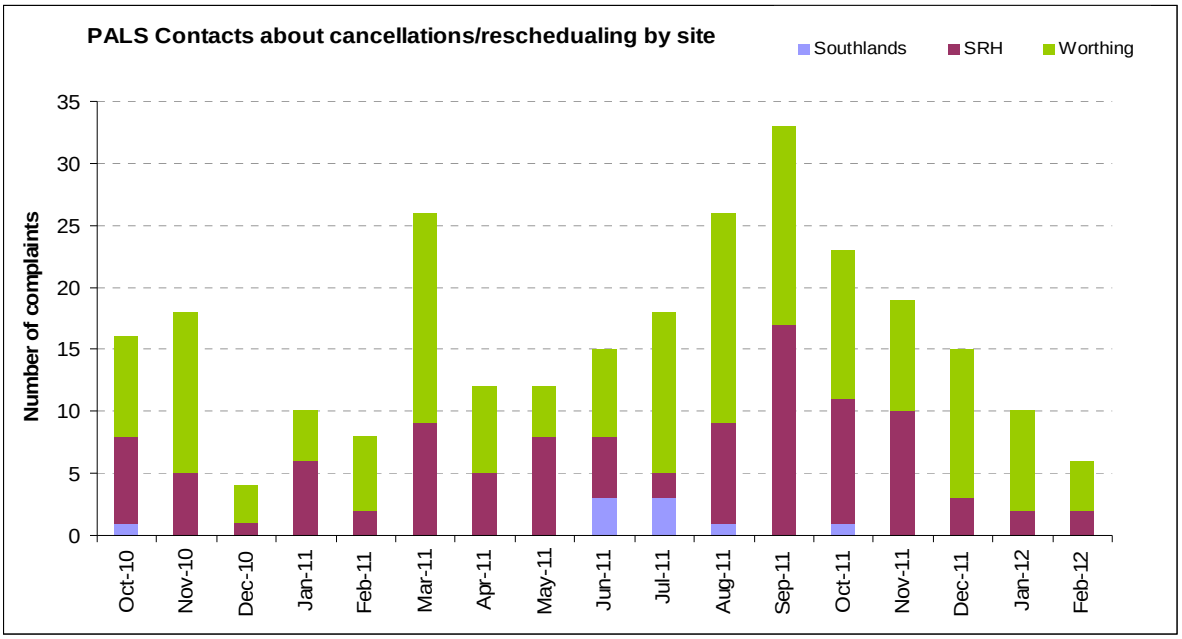
5.7.7 The Ophthalmology pilot began in April 2012 and any patient requiring an appointment is added to the 'pending' list. In tandem, all follow-up appointments booked beyond 1st July 2012 will be cancelled with a covering letter explaining the new booking process sent to patients. This will be supported by dedicated telephone access points for enquiry, and information leaflets will be available in the clinic for patients who are unsure about the new system.

5.7.8 In that context, partial booking process for new patients has already been implemented, however the second element of this project to remove any patient that has previously been booked into a future clinic beyond July 2012 has been delayed due to the deferral of the Sema Upgrade planned for February 2012.

5.7.9 The essential Sema Helix upgrade is planned for Wednesday 18th April followed by immediate testing of the new functions required to facilitate partial booking, as there are several thousand appointments already made which will need to be removed and identified in order to track and book patients back into appropriate clinics post implementation. Subject to successful testing roll within Ophthalmology will commence for currently dated patients phased plans agreed for other specialties over the following three months.

5.7.10 Directly linked to the successful implementation of the action described above, **Figure 3** graphically demonstrates the significant reduction in this contact themes since September 2011.

**Figure 3: PAL's contacts relating to cancellation or rescheduling of appointment**




5.8 Environment

5.8.1 Environment accounted for 32 comments collated as part of the National Outpatient Survey review process, representing 11.2% of all comments received. Of the total volume 20 were negative comments and 12 were plaudits. Key themes in the negative comments related to lack of vending machines, lack of reading material, age of the environment, comfort of seating and heating/air conditioning. Within these comments complaint reasons, many were contradictory i.e. complaints that a department was too hot, while others found it too cold.

5.8.2 Crudely 50% of all Trust outpatient activity relates to the main outpatient department at Worthing Hospital. From April 16 2012 this service is provided via the purpose built new block on the Worthing site which is anticipated will significantly improve patients experience relating to environment. The new unit has been designed to provide a dramatically improved patient flow through reception to waiting areas, and deliver clinical consultations in consulting rooms with fully integrated examination facilities, where the old department had separate rooms for consultation and examination.

5.8.3 In addition to the relocation of Worthing main outpatient services, a successful capital bid was generated to refurbish both main outpatients at St. Richards Hospital and the fracture clinic rooms. This capital programme will address many of the negative responses regarding the décor of these environments.

5.9 Cross cutting outpatient themes- Improving patient information

5.9.1 In addition to the specific improvement themes, improving information to patients prior to, during, and after outpatient attendance supports a number of the initiatives described elsewhere in this paper.

5.9.2 As part of a wider development of patient information supplied pre attendance, Access Management/PALS have developed site specific 'Welcome to Outpatients' leaflet, and an example is attached as Appendix C. This leaflet encourages patients to ask questions whilst attending their consultation, and provides example questions to stimulate these discussions

5.9.3 In support of training on the specific improvements outlined previously, outpatient sisters have undertaken internal reviews to ensure all nursing staff continue to inform each patient on why particular tests are needed, how they will find out the results and clearly explaining the results. In response, staff are activity encouraging questions from patients on tests to ensure full understanding.

5.9.4 In order to further support patient understanding and recollection of clinical consultation, a feasibility assessment is being undertaken regarding routinely sending patients a copy of the outpatient letter from consultant to GP. This initiative needs to be fully assessed against information governance regulations and infrastructure requirement within the Trust to support.

## 6 IMPROVEMENT OUTCOMES

6.1 Analysis of data contained in **Table 1** demonstrates an average of 46.8 enquiries per month in the first full 12 months of data via DATIX. In Quarter 3 (Oct to Dec 2011) this crude average fell to 39.0 enquiries per month, and incomplete Quarter 4 data covering the fist two months of the period shows this average to have reduced again to 25.0 enquiries per month, representing a reduction of 46.6%.

6.2 Adjusting for total outpatient volume in each period the baseline of Oct 2010 to Sept 2011 translates as a contact rate of 0.12% all attendances. In Quarter 3 this reduced to 0.10%, and has reduced further to 0.06% for the two month of Quarter 4 available to date.

6.3 Nationally, the single point of benchmarking derives from the KA41a statutory return process which relates to the number of written complaints about outpatient services at each acute organisation to every 10,000 attended first appointments and attended first telephone appointments. Across the NHS the benchmarked average value was 12.8, for the latest published period (Quarter 3, 2011/12). The weighted rate for WSHT in the first annual baseline (Oct 2010 to Sept 2011) was 6.8, which was subsequently reduced to 5.7 in Quarter 3. Based on the two available months of Q4, this has reduced to 5 formal complaints from 29,635 first attendances, giving an adjusted rate of 1.7.

## 7 MONITORING AND FURTHER IMPOVEMENT

7.1 As part of the oversight and scrutiny arrangements linked to the improvement outlined in this paper, a process of quarterly reporting to the Management Board chaired by the Chief Executive was put in place in February 2012, and will continue throughout 2012/13.

7.2 Augmenting the enhanced executive scrutiny outlined above, the following corporate objective has been incorporated into the 2012/13 Annual Plan, and will be reported against in the Corporate Objectives scorecard shared with the Trust Board monthly via the Performance Report:

> *Reduce the number of complaints relating to staff attitude/behaviour by 10% and the rate of PALS (Patient Advice & Liaison Service) contacts per outpatient appointment from 0.12% to <0.10%.*

7.3 Finally, over and above the system and process improvements required, alongside possible structural change to outpatient services, it is acknowledged that many of the themes identified relate to a wider cross cutting organisational issues of which Outpatient Services form a single element. This relates to the less tangible theme of customer service, and what that means for staff, patients and carers. It touches all areas of service delivery and getting it right is essential to the quality improvements we strive for. It is therefore planned that a dedicated improvement event be undertaken under the joint leadership of the Chief Operating Officer, Director of Nursing and Patient Experience and the Director of Organisational Development and Leadership, from where the formation of a strategic customer service improvement plan will be developed, incorporating feedback from the Inpatient Survey (pending), with reporting directly to the Executive Team.

## 8 RECOMMENDATIONS

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

Adam Creeggan, Director of Performance

12 April 2012

Patient survey report 2011


# Outpatient Department Survey 2011

Western Sussex Hospitals NHS Trust

The national survey of outpatients in the NHS 2011 was designed, developed and co-ordinated by the Co-ordination Centre for the NHS Patient Survey Programme at Picker Institute Europe.


Making patients' views count

# National NHS patient survey programme
# Outpatient department survey 2011

## The Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act. Whether services are provided by the NHS, local authorities or by private or voluntary organisations, we focus on:

- **Identifying risks** to the quality and safety of people's care
- **Acting swiftly** to help eliminate poor-quality care.
- Making sure **care is centered on people's needs** and protects their rights.

## Outpatient department survey 2011

To improve the quality of services that the NHS delivers, it is important to understand what patients think about their care and treatment. One way of doing this is by asking patients who have recently used their local health services to tell us about their experiences.

This report provides the results of the fourth survey of adult outpatients in NHS trusts in England, and shows how each trust scored for each question in the survey, compared with national benchmark results. It is designed to be used to understand the performance of individual trusts, and to identify areas for improvement.

Results for each trust are also displayed in the 'Care Directory' on our website, where it is possible to see whether a trust performed 'better' or 'worse' than the majority of other trusts.

You can also see national overall results for the 2011 survey compared with the 2009 survey, alongside a national summary highlighting the key issues. These documents were produced by the Surveys Co-ordination Centre at Picker Institute Europe.

Similar surveys of adult outpatients were carried out in 2003, 2004 and 2009. They are part of a wider programme of NHS patient surveys, which covers a range of topics including mental health services and maternity services. To find out more about our programme, please visit our website (see further information section).

## About the survey

The survey of adult outpatient services involved 163 acute and specialist NHS trusts. We received responses from more than 72000 patients, a response rate of 53%. People were eligible for the survey if they were aged 16 years or older and attended an outpatients department(s) during any one month period (month chosen by the trust) in either April or May 2011. This included any outpatient clinics run with the emergency department (A&E/casualty) such as fracture clinics. Fieldwork for the survey took place between June and October 2011.

## Interpreting the report

For each question in the survey, the individual responses were converted into scores on a scale of 0 to 100. A score of 100 represents the best possible response. Therefore, the higher the score for each question, the better the trust is performing.[1]

[1]Trusts have differing profiles of patients. For example, one trust may have more male outpatients than another. This can potentially affect the results because people tend to answer questions in different ways, depending on certain characteristics. For example, older respondents tend to report more positive experiences than younger respondents, and women tend to report less positive experiences than men. This could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of patients. To account for this, we 'standardise' the data. Results have been standardised by the age and sex of respondents to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age sex type profile reflects the national age sex type distribution (based on all of the respondents to the survey). It therefore enables a more accurate comparison of results from trusts with different profiles of patients.

Please note: the scores are **not percentages**, so a score of 80 does not mean that 80% of people who have used services in the trust have had a particular experience (e.g. ticked 'Yes' to a particular question), it means that the trust has scored 80 out of a maximum of 100. A 'scored' questionnaire showing the scores assigned to each question is available on our website (see further information' section).

Please also note that it is not appropriate to score all questions within the questionnaire for benchmarking purposes. This is because not all of the questions assess the trusts in any way, or they may be 'filter questions' designed to filter out respondents to whom following questions do not apply. An example of such a question would be Q1 "Have you ever visited this Outpatients Department before for the same condition?"

The graphs in this report display the scores for this trust, compared with national benchmarks. Each bar represents the range of results for each question across all trusts that took part in the survey. In the graphs, the bar is divided into three sections:

- the red section (left hand end) shows the scores for the 20% of trusts with the lowest scores
- the green section (right hand end) shows the scores for the 20% of trusts with the highest scores
- the orange section (middle section) represents the range of scores for the remaining 60% of trusts.

A white diamond represents the score for this trust. If the diamond is in the green section of the bar, for example, it means that the trust is among the top 20% of trusts in England for that question. The line on either side of the diamond shows the amount of uncertainty surrounding the trust's score, as a result of random fluctuation.[2]

Since the score is based on a sample of adult outpatients in a trust rather than all adult outpatients, the score may not be exactly the same as if everyone had been surveyed and had responded. Therefore a confidence interval[3] is calculated as a measure of how accurate the score is. We can be 95% certain that if everyone in the trust had been surveyed, the 'true' score would fall within this interval.

When considering how a trust performs, it is very important to consider the confidence interval surrounding the score. If a trust's average score is in one colour, but either of its confidence limits are shown as falling into another colour, this means that you should be more cautious about the trust's result because, if the survey was repeated with a different random sample of patients, it is possible their average score would be in a different place and would therefore show as a different colour.

The white diamond (score) is not shown for questions answered by fewer than 30 people because the uncertainty around the result would be too great. When identifying trusts with the highest and lowest scores and thresholds, trusts with fewer than 30 respondents have not been included.

At the end of the report you will find the data used for the charts and background information about the patients that responded.

[2] If a score is on the 'threshold' for the highest scoring 20% of trusts (that is, the white diamond is on the line separating green and orange), this means that the score is one of the highest 20% of scores for that question. Similarly, trusts with scores on the threshold for the lowest scoring 20% of trusts are included in this lowest 20% of scores.

[3] A confidence interval is an upper and lower limit within which you have a stated level of confidence that the true mean (average) lies somewhere in that range. These are commonly quoted as 95% confidence intervals, which are constructed so that you can be 95% certain that the true mean lies between these limits. The width of the confidence interval gives some indication of how cautious we should be; a very wide interval may indicate that more data should be collected before making any conclusions.

## Notes on specific questions

**Q2 and Q3:** Q2 “From the time you were first told you needed an appointment to the time you went to the Outpatients Department, how long did you wait for your appointment?” and Q3 “Did your symptoms or condition get worse while you were waiting for your appointment?”.
These questions were only answered by respondents who were attending a first appointment at the outpatients department. Responses are not included from all other respondents. The questions will not be comparable with previous years because of this.

**Q2,Q3 and Q5:** Q2 “From the time you were first told you needed an appointment to the time you went to the Outpatients Department, how long did you wait for your appointment?” and Q3 “Did your symptoms or condition get worse while you were waiting for your appointment?” and Q5 “Were you given a choice of appointment times?”. These questions exclude patients who were not referred for a planned admission to hospital by a GP or health professional in England (i.e. their care was not bought or ‘commissioned’ in England but in Northern Ireland, Scotland or Wales). This is because hospital choice and waiting time policies differ outside of England.

**Q5:** The information collected by Q5 (“Were you given a choice of appointment times”) has been filtered by first appointment only rather than on all appointments, as the choose and book policy around this is only applicable to first appointments. This means that the data for Q5 is not comparable to the previous years.

## Further information

Full details of the methodology of the survey can be found at:
http://www.nhssurveys.org/

More information on the programme of NHS patient surveys is available at:
http://www.cqc.org.uk/public/reports-surveys-and-reviews

The results, questionnaire and scoring of the 2011 survey of outpatient departments can be found at:
www.cqc.org.uk/outpatientsurvey2011

The results, questionnaire and scoring from the 2009 outpatient department survey can be found at:
www.nhssurveys.org/surveys/486

The results, questionnaire and scoring from the 2003 and 2004 outpatient department surveys are available on request from the surveys team:
http://www.nhssurveys.org/surveys/297

You can also see the results for each trust by searching for that organisation on CQC's website:
www.cqc.org.uk

# Outpatient Department Survey 2011
# Western Sussex Hospitals NHS Trust

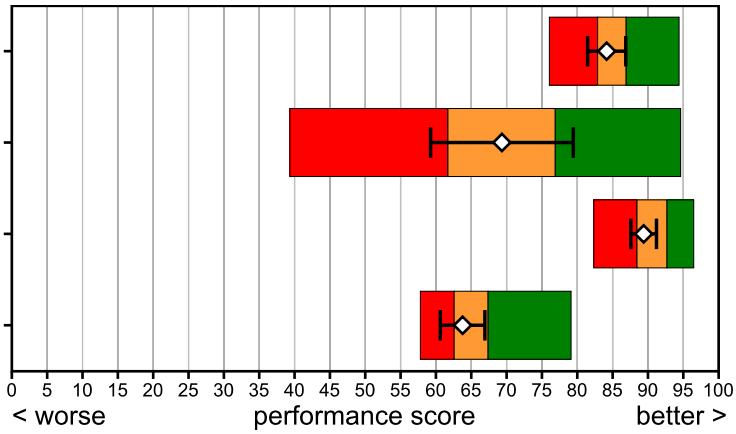
## Before the appointment

From the time you were first told you needed an appointment, how long did you wait for your appointment?

Were you given a choice of appointment times?

Was your appointment changed to a later date by the hospital?

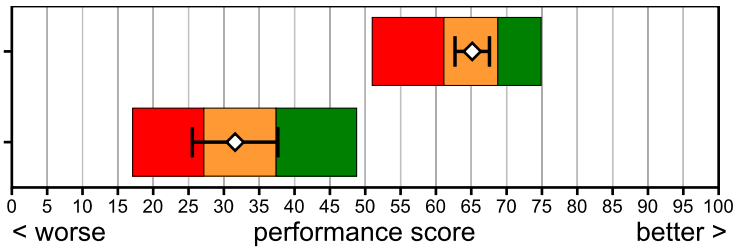
Before your appointment, did you know what would happen to you during the appointment?




## Waiting

How long after the stated appointment time did the appointment start?

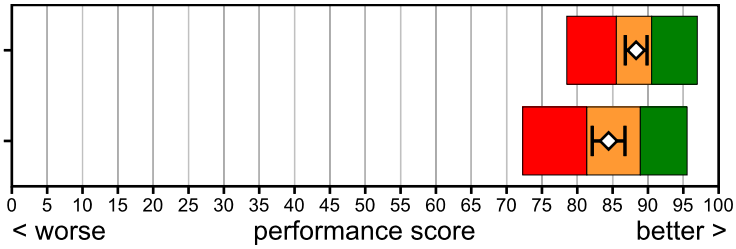
Were you told how long you would have to wait?




## Hospital environment and facilities

In your opinion, how clean was the Outpatients Department?

How clean were the toilets at the Outpatients Department?




Best performing 20% of trusts

Intermediate 60% of trusts

Worst performing 20% of trusts

◇ This trust (vertical lines show amount of uncertainty as a result of random fluctuation)

This trust's results are not shown if there were fewer than 30 respondents.

# Outpatient Department Survey 2011
# Western Sussex Hospitals NHS Trust

## Tests and Treatment

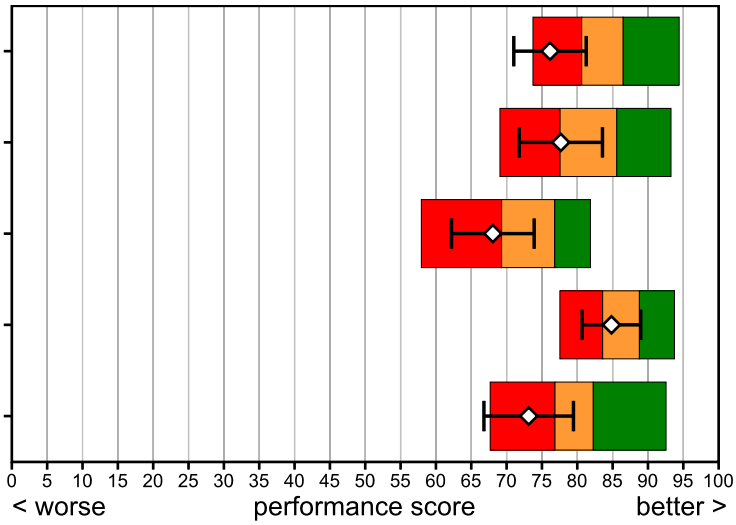
Did a member of staff explain why you needed these test(s) in a way you could understand?

Did a member of staff tell you how you would find out the results of your test(s)?

Did a member of staff explain the results of the tests in a way you could understand?

Before the treatment did a member of staff explain what would happen?

Were you told about any risks/benefits in a way you could understand before the treatment?




## Seeing a doctor

Did you have enough time to discuss your health or medical problem with the doctor?

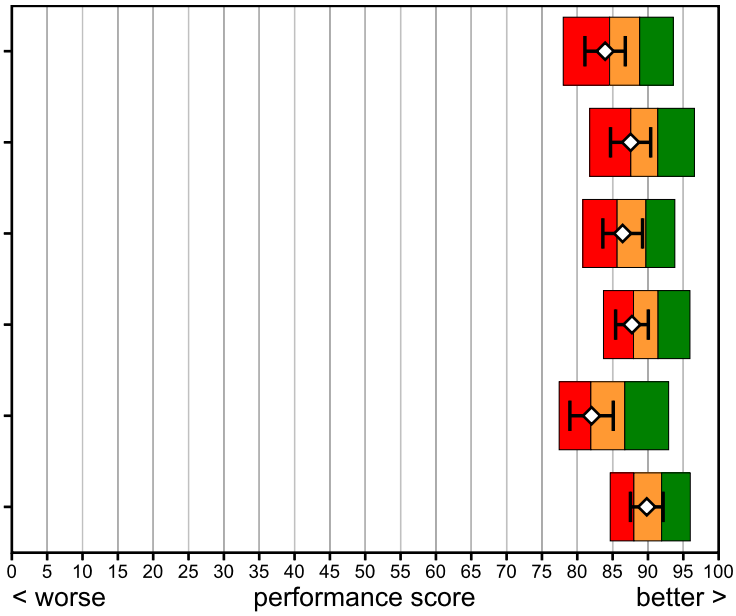
Did the doctor seem aware of your medical history?

Did the doctor explain the reasons for any treatment or action in a way that you could understand?

Did the doctor listen to what you had to say?

If you had important questions to ask the doctor, did you get answers that you could understand?

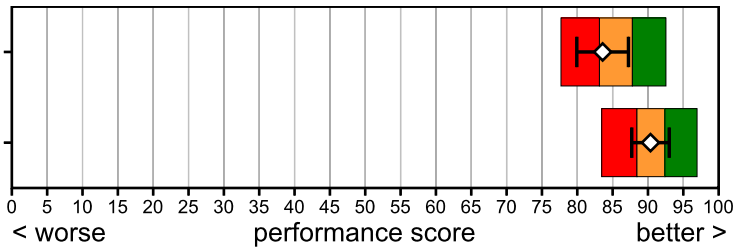
Did you have confidence and trust in the doctor examining and treating you?




## Seeing another professional

If you had important questions to ask him/her, did you get answers that you could understand?

Did you have confidence and trust in him/her?




Best performing 20% of trusts

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# Outpatient Department Survey 2011
# Western Sussex Hospitals NHS Trust

## Overall about the appointment

Did the staff treating and examining you introduce themselves?

Did doctors and/or other staff talk in front of you as if you weren't there?

How much information about your condition or treatment was given to you?

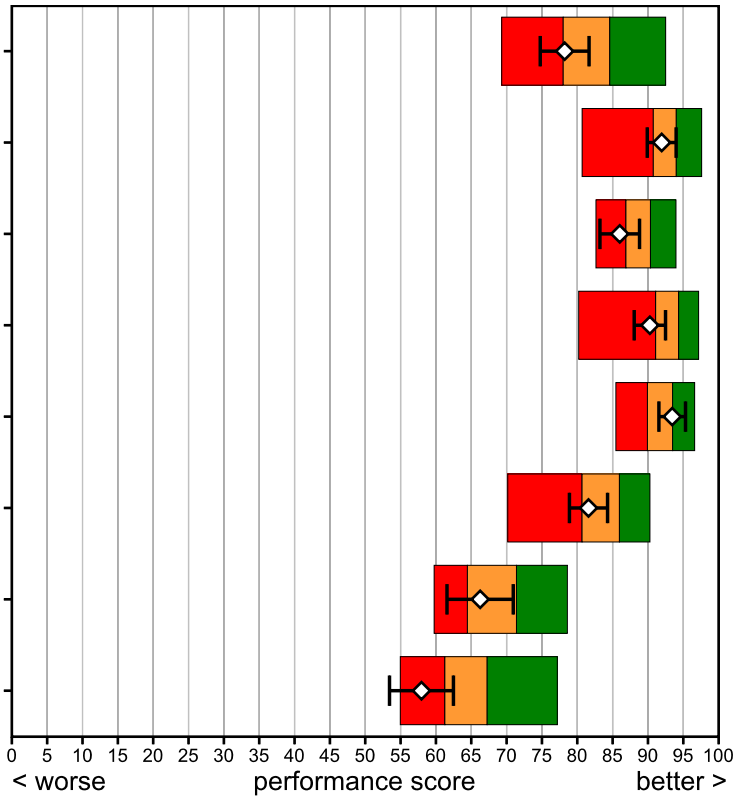
Were you given enough privacy when discussing your condition or treatment?

Did a member of staff say one thing and another say something different?

Were you involved as much as you wanted to be in decisions about your care and treatment?

Did doctors and/or staff ask you what was important to you in managing your condition or illness?

Did your appointment help you to feel that you could better manage your condition or illness?




## Leaving the outpatients department

Did a member of staff explain to you how to take the new medications?

Did hospital staff explain the purpose of the medicines you were to take home?

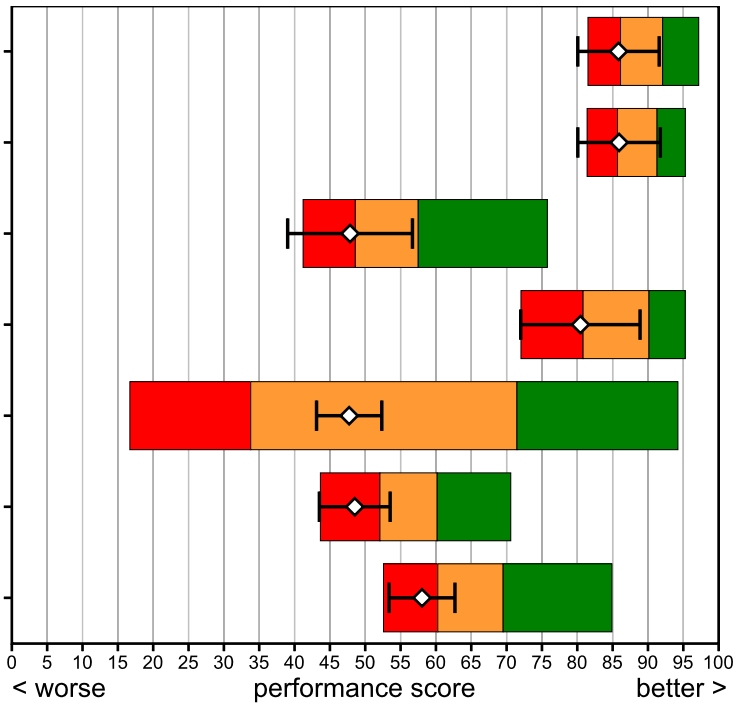
Did a member of staff tell you about medication side effects to watch for?

Was the reason for changing your medication explained in a way you could understand?

Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?

Were you told what danger signals to watch for after you went home?

Were you told who to contact if you were worried about your condition or treatment after you left hospital?




Best performing 20% of trusts

Intermediate 60% of trusts

Worst performing 20% of trusts

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This trust's results are not shown if there were fewer than 30 respondents.

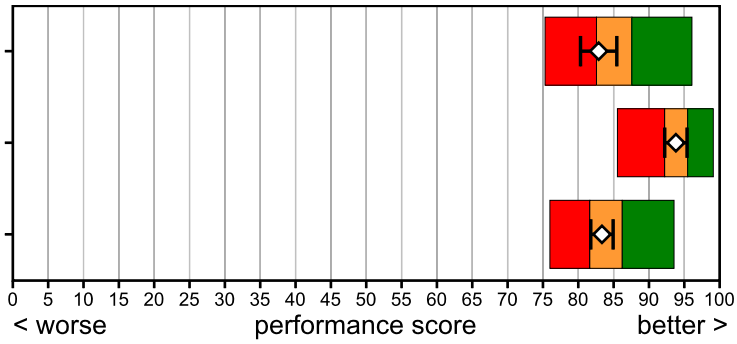
# Outpatient Department Survey 2011
# Western Sussex Hospitals NHS Trust

## Overall impression

Was the main reason you went to the Outpatients Department dealt with to your satisfaction?

Were you treated with respect and dignity at the Outpatients Department?

Overall, how would you rate the care you received at the Outpatients Department?




Best performing 20% of trusts

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Worst performing 20% of trusts

◇ This trust (vertical lines show amount of uncertainty as a result of random fluctuation)

This trust's results are not shown if there were fewer than 30 respondents.

## Outpatient Department Survey 2011
## Western Sussex Hospitals NHS Trust

| | | Scores for this NHS trust | 95% Confidence Interval Lower | 95% Confidence Interval Upper | Threshold for the lowest scoring 20% of NHS Trusts | Threshold for the highest scoring 20% of NHS Trusts | Highest score achieved (all trusts) | Number of respondents (this trust) |
|---|---|---|---|---|---|---|---|---|
| **Before the appointment** | | | | | | | | |
| Q2 | From the time you were first told you needed an appointment, how long did you wait for your appointment? | 84 | 81 | 87 | 83 | 87 | 94 | 170 |
| Q5 | Were you given a choice of appointment times? | 69 | 59 | 79 | 62 | 77 | 95 | 82 |
| Q6 | Was your appointment changed to a later date by the hospital? | 89 | 88 | 91 | 88 | 93 | 96 | 509 |
| Q7 | Before your appointment, did you know what would happen to you during the appointment? | 64 | 61 | 67 | 63 | 67 | 79 | 505 |
| **Waiting** | | | | | | | | |
| Q8 | How long after the stated appointment time did the appointment start? | 65 | 63 | 68 | 61 | 69 | 75 | 503 |
| Q9 | Were you told how long you would have to wait? | 32 | 26 | 38 | 27 | 37 | 49 | 200 |
| **Hospital environment and facilities** | | | | | | | | |
| Q10 | In your opinion, how clean was the Outpatients Department? | 88 | 87 | 90 | 86 | 91 | 97 | 498 |
| Q11 | How clean were the toilets at the Outpatients Department? | 84 | 82 | 87 | 81 | 89 | 96 | 326 |
| **Tests and Treatment** | | | | | | | | |
| Q13 | Did a member of staff explain why you needed these test(s) in a way you could understand? | 76 | 71 | 81 | 81 | 86 | 94 | 194 |
| Q14 | Did a member of staff tell you how you would find out the results of your test(s)? | 78 | 72 | 84 | 78 | 86 | 93 | 202 |
| Q15 | Did a member of staff explain the results of the tests in a way you could understand? | 68 | 62 | 74 | 69 | 77 | 82 | 183 |
| Q17 | Before the treatment did a member of staff explain what would happen? | 85 | 81 | 89 | 84 | 89 | 94 | 148 |
| Q18 | Were you told about any risks/benefits in a way you could understand before the treatment? | 73 | 67 | 79 | 77 | 82 | 93 | 138 |

# Outpatient Department Survey 2011
## Western Sussex Hospitals NHS Trust

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|---|---|---|---|---|---|---|---|
| **Seeing a doctor** | | | | | | | |
| Q20 Did you have enough time to discuss your health or medical problem with the doctor? | 84 | 81 | 87 | 85 | 89 | 94 | 398 |
| Q21 Did the doctor seem aware of your medical history? | 88 | 85 | 90 | 88 | 91 | 97 | 377 |
| Q22 Did the doctor explain the reasons for any treatment or action in a way that you could understand? | 86 | 84 | 89 | 86 | 90 | 94 | 371 |
| Q23 Did the doctor listen to what you had to say? | 88 | 85 | 90 | 88 | 91 | 96 | 403 |
| Q24 If you had important questions to ask the doctor, did you get answers that you could understand? | 82 | 79 | 85 | 82 | 87 | 93 | 340 |
| Q25 Did you have confidence and trust in the doctor examining and treating you? | 90 | 88 | 92 | 88 | 92 | 96 | 399 |
| **Seeing another professional** | | | | | | | |
| Q28 If you had important questions to ask him/her, did you get answers that you could understand? | 84 | 80 | 87 | 83 | 88 | 93 | 228 |
| Q29 Did you have confidence and trust in him/her? | 90 | 88 | 93 | 88 | 92 | 97 | 273 |
| **Overall about the appointment** | | | | | | | |
| Q31 Did the staff treating and examining you introduce themselves? | 78 | 75 | 82 | 78 | 85 | 93 | 375 |
| Q32 Did doctors and/or other staff talk in front of you as if you weren't there? | 92 | 90 | 94 | 91 | 94 | 98 | 505 |
| Q33 How much information about your condition or treatment was given to you? | 86 | 83 | 89 | 87 | 90 | 94 | 504 |
| Q34 Were you given enough privacy when discussing your condition or treatment? | 90 | 88 | 92 | 91 | 94 | 97 | 506 |
| Q35 Did a member of staff say one thing and another say something different? | 93 | 92 | 95 | 90 | 93 | 97 | 507 |
| Q36 Were you involved as much as you wanted to be in decisions about your care and treatment? | 82 | 79 | 84 | 81 | 86 | 90 | 500 |
| Q38 Did doctors and/or staff ask you what was important to you in managing your condition or illness? | 66 | 62 | 71 | 64 | 71 | 79 | 255 |
| Q39 Did your appointment help you to feel that you could better manage your condition or illness? | 58 | 53 | 62 | 61 | 67 | 77 | 285 |

# Outpatient Department Survey 2011
## Western Sussex Hospitals NHS Trust

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|---|---|---|---|---|---|---|---|
| **Leaving the outpatients department** | | | | | | | |
| Q41 Did a member of staff explain to you how to take the new medications? | 86 | 80 | 92 | 86 | 92 | 97 | 108 |
| Q42 Did hospital staff explain the purpose of the medicines you were to take home? | 86 | 80 | 92 | 86 | 91 | 95 | 106 |
| Q43 Did a member of staff tell you about medication side effects to watch for? | 48 | 39 | 57 | 49 | 57 | 76 | 99 |
| Q45 Was the reason for changing your medication explained in a way you could understand? | 80 | 72 | 89 | 81 | 90 | 95 | 63 |
| Q46 Did you receive copies of letters sent between hospital doctors and your family doctor (GP)? | 48 | 43 | 52 | 34 | 71 | 94 | 425 |
| Q47 Were you told what danger signals to watch for after you went home? | 49 | 44 | 54 | 52 | 60 | 71 | 320 |
| Q48 Were you told who to contact if you were worried about your condition or treatment after you left hospital? | 58 | 53 | 63 | 60 | 70 | 85 | 468 |
| **Overall impression** | | | | | | | |
| Q49 Was the main reason you went to the Outpatients Department dealt with to your satisfaction? | 83 | 80 | 85 | 83 | 88 | 96 | 507 |
| Q50 Were you treated with respect and dignity at the Outpatients Department? | 94 | 92 | 95 | 92 | 95 | 99 | 509 |
| Q51 Overall, how would you rate the care you received at the Outpatients Department? | 83 | 82 | 85 | 82 | 86 | 94 | 509 |

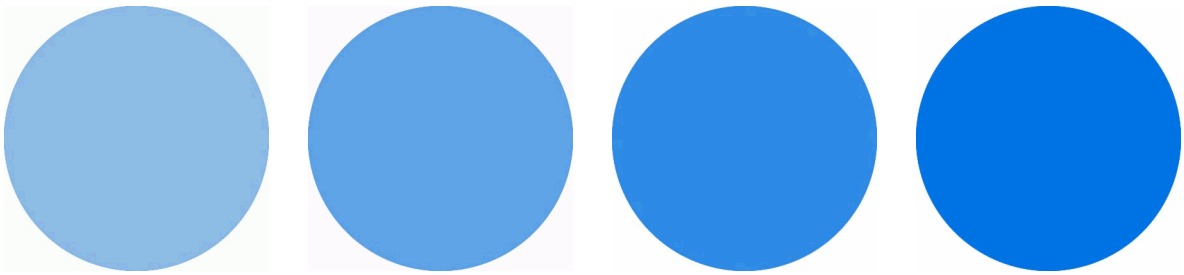
# Outpatient Department Survey 2011
# Western Sussex Hospitals NHS Trust

## Background information

| The sample | This trust | All trusts |
|---|---|---|
| Number of respondents | 513 | 72779 |
| Response Rate (percentage) | 61 | 53 |

| Demographic characteristics | This trust | All trusts |
|---|---|---|
| Gender (percentage) | (%) | (%) |
| Male | 45 | 43 |
| Female | 55 | 57 |
| | | |
| Age group (percentage) | (%) | (%) |
| Aged 35 and younger | 6 | 8 |
| Aged 36-50 | 12 | 15 |
| Aged 51-65 | 22 | 29 |
| Aged 66 and older | 60 | 48 |
| | | |
| Ethnic group (percentage) | (%) | (%) |
| White | 95 | 91 |
| Mixed | 0 | 1 |
| Asian or Asian British | 1 | 3 |
| Black or Black British | 0 | 2 |
| Chinese or other ethnic group | 0 | 0 |
| Not known | 3 | 3 |

patient PERSPECTIVE



# Patient Written Comments

Western Sussex Hospitals NHS Trust

National Outpatient Survey 2011

Patients Attending: MAY 2011

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | GENERAL MEDICINE |
|---|---|
| Anything_good: | Always found the staff very helpful. |
| Anything_improved: | Trying to keep nearer the time's of appointments near the appointment. |
| Other_comments: | Treatment I have received was always very good. Thank you all staff. |
| Anything_good: | There was access to fresh cool water. |
| Anything_improved: | All was excellent. |
| Other_comments: | I cannot say the same about [location removed] and would like if possible to fill-in an identical form, I attended/admitted [location removed] in [date removed]. |
| Anything_good: | Doctors and nurses have been brilliant and I can't speak highly enough of them. The time given to me I would rank 10/10 at Worthing Breast Care Unit. |
| Anything_improved: | Free parking! It's unacceptable to have to pay for parking when one is ill. Who ever introduced should be sacked. People in already stressful situations don't need other pressures or their dependants. It's disgusting. |
| Other_comments: | |
| Anything_good: | I was kept informed as to further treatment available and asked if I wanted surgery. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | It would be helpful if a note was included on file that I received dialysis treatment.<br>On clinic days between 7am and 11.15am and any appointment made for the dialysis Clinic be made after 11.30 am to avoid cancellations, etc. |
| Other_comments: | |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | GENERAL MEDICINE |
|---|---|
| Anything_good: | The number of patients waiting for their appointments was not large and the flow through was good. I felt that I was treated as an individual and not part of a crowd awaiting processing. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | [Name removed], at [location removed], was the first to indicate the likely nature of my illness. |
| Anything_improved: | More openness and honesty. |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | Have always been treated brilliantly. |
| Anything_good: | |
| Anything_improved: | Previous visit was told the person I was seeing was over-booked so nearly an hour wait! |
| Other_comments: | |
| Anything_good: | One time my husband was taken in at 6am for an overnight blood transfusion but was left in A&E until 8am, no-one asked if he was all right or if he wanted a bottle or a drink. He had a stroke, couldn't move without help. He was so upset he wanted to come. |
| Anything_improved: | I feel he could have been checked, plus why take him on at 6pm then not to the transfusion until the next day. |
| Other_comments: | Yes, we have had 3 times problems with cross matching of blood. |
| Anything_good: | All the staff were vey efficient and kind at all times. |
| Anything_improved: | |
| Other_comments: | |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | UROLOGY |
|---|---|
| Anything_good: | [Location removed] dept calm and quiet at the end of the corridor. |
| Anything_improved: | Took far too long to check in at reception, too many people at reception and only one person to deal with enquiries. |
| Other_comments: | |
| Anything_good: | Yes, the professionalism of all the staff I came into contact with. They were also very friendly. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | The W.C. is close by and did not have to rush to find it. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | The consultant was informative, knowledgeable, polite and pleasant. Very professional! I was extremely comfortable and happy with his care style. Well done! |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | Yes, it was on time, all the staff were kind and caring. |
| Anything_improved: | Yes, the time between having a scan on [date removed] and waiting until [date removed] for the results. |
| Other_comments: | I had 4 OP appts in all which was to keep an eye on me as I had been an IP for several weeks at the same hospital. |
| Anything_good: | |
| Anything_improved: | I went to A&E for treatment and they were excellent. 5 appointments were booked in one week: 2 were cancelled, one soon after my appointment time, the other after waiting one hour. |
| Other_comments: | |
| Anything_good: | I have always been on time or earlier. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | Staff nurses very cheerful and helpful - made the short stay much happier. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | I have always felt like a human being and not an object. The staff (including doctors) have always been helpful and friendly. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | Would prefer to be seen by the same doctor each visit but appreciate this is not practical. |
| Other_comments: | |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | UROLOGY |
|---|---|
| Anything_good: | All was efficient. |
| Anything_improved: | |
| Other_comments: | |

| | |
|---|---|
| Anything_good: | |
| Anything_improved: | Waiting time far too long, waste of time. |
| Other_comments: | Doctor told me about my op, but I could not understand him, his English was poor, told Nurse, she said "yes, we are often told this". |

| | |
|---|---|
| Anything_good: | Satisfied with treatment. |
| Anything_improved: | Waiting times very long. |
| Other_comments: | |

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|---|---|
| Anything_good: | Outstanding service. |
| Anything_improved: | |
| Other_comments: | |

| | |
|---|---|
| Anything_good: | No complaints at all, staff are excellent. |
| Anything_improved: | |
| Other_comments: | |

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|---|---|
| Anything_good: | The urology consultants I see always take time to listen and explain things to me and try and provide the best treatment for me at St Richards hospital. |
| Anything_improved: | |
| Other_comments: | |

| | |
|---|---|
| Anything_good: | Whenever I've visited, my experiences with staff and treatment have always been excellent. |
| Anything_improved: | |
| Other_comments: | Just thank God you're there and thank you. |

| | |
|---|---|
| Anything_good: | Staff were very good and understanding. |
| Anything_improved: | |
| Other_comments: | |

| | |
|---|---|
| Anything_good: | All staff from reception to doctors are fantastic. |
| Anything_improved: | |
| Other_comments: | Reading material would be good, don't always remember to bring any. I know this was removed due to health reasons, could there not be a way round this? |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | BREAST SURGERY |
|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | The consultants I have seen over the years are excellent. [name removed] and the [name removed] especially. Also the staff nurses etc.<br>I have used [name removed] for over sixty years (60) and have saved my life through that experience. |
| Anything_good: | Consultant (doctor) was excellent in attitude and support. |
| Anything_improved: | Radiologist came in during session and was arrogant and discussed my appointment as if I wasn't there. |
| Other_comments: | Overall thought very good. |
| Anything_good: | Staff and conditions very good. |
| Anything_improved: | Being given more information. |
| Other_comments: | I was told by a doctor that I would need an Angiogram urgently. Had to stay in ward for a day. Then another doctor said that I could go home and have an Angiogram following week. Appointment came one month later! |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | The appointment system could do with more checking. |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | After routine mammogram, I was ask to attend the assessment centre. Following further investigation, I was diagnosed with early stages of breast cancer. I have now had a mastectomy. The treatment and care I have had in [location removed] and the breast clinic. |
| Anything_good: | Breast clinic - all investigations in clinic explained to both me and my husband by Consultant and breast Nurse. |
| Anything_improved: | More chairs in breast clinic waiting room. |
| Other_comments: | Many thanks for care. |
| Anything_good: | |
| Anything_improved: | Up to date mags to read while waiting! |
| Other_comments: | |
| Anything_good: | Every very caring. |
| Anything_improved: | |
| Other_comments: | I was grateful for the letter I received from the consultant the following week. |
| Anything_good: | I have always found the entire staff at [name removed] very helpful and understanding I have nothing but gratitude for them all. |
| Anything_improved: | |
| Other_comments: | |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | BREAST SURGERY |
|---|---|
| Anything_good: | The receptionist was excellent. She remembered my name from a visit one year previously. I hadn't seen the doctor during previous visits but he was charming and informed. All of the staff are extremely friendly. |
| Anything_improved: | I felt the radiographer was inexperienced. I also felt that all of the radiographer should experience the effect of "getting ready" for a mammogram without the actual x-ray of course. |
| Other_comments: | I had one poor experience with one of the breast case. The nurse, unfortunately, was not informed about the after care of a reconstructed breast. She almost put me off. |
| Anything_good: | |
| Anything_improved: | Had difficulty finding the department. Was unsure where to go, better sign posting needed. |
| Other_comments: | |
| Anything_good: | All members in [location removed], doctors, nurses and other staff are nice and lovely people. They are excellent carers. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | Provisions of a drinks machine. |
| Other_comments: | Get rid of the T.V. The sound is off or so low you cannot hear it for obvious reasons. So what's the point of it. It is also wasting electricity. |
| Anything_good: | The staff at [location removed] are the most caring, courteous and attentive I have ever had treatment from in my entire life! |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | More information on waiting time. |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | I had a CT scan on [date removed] and I was told that I would receive a letter of the results. To date I have not received any letter, not good. |
| Anything_good: | It confirmed that the bowel cancer had not returned but I was given 2 different opinions, which can be confusing. |
| Anything_improved: | |
| Other_comments: | To my mind this survey is a complete waste of funds, surely a better system could be adopted. |
| Anything_good: | On time. Clean environment. Very helpful. |
| Anything_improved: | Waiting time for appointments. |
| Other_comments: | |

| | |
|---|---|
| **Trust Name:** | **Western Sussex Hospitals NHS Trust** |
| Main Specialty: | **VASCULAR SURGERY** |
| Anything_good: | I was seen on time, had procedure done and back in the ward OP for lunch and went home by 4.30pm. I thought the day went well. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | Help by reception. |
| Anything_improved: | More available dressings for ulcers. |
| Other_comments: | |
| Anything_good: | I was always treated with politeness and informed of any problems that might arise. |
| Anything_improved: | |
| Other_comments: | |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | TRAUMA & ORTHOPAEDICS |
|---|---|
| Anything_good: | Everything good. |
| Anything_improved: | More pillows. |
| Other_comments: | |

| | |
|---|---|
| Anything_good: | I'm very pleased. |
| Anything_improved: | I suffer with [condition removed] in my lower back and left knee, awaiting reconstruction of the left knee. As for my back, the seats are very uncomfortable. |
| Other_comments: | |

| | |
|---|---|
| Anything_good: | I'm from Norwich, been to Norfolk and Norwich hospital and found St Richards far better with staff and how I felt being there. |
| Anything_improved: | Not really. |
| Other_comments: | Thank you for the help and time they have given. |

| | |
|---|---|
| Anything_good: | Relaxing, but efficient treatment. All staff are excellent. |
| Anything_improved: | |
| Other_comments: | |

| | |
|---|---|
| Anything_good: | |
| Anything_improved: | Better information about waiting time and a more thorough follow-up to hip operation. |
| Other_comments: | Was not physically examined at all, after hip replacement, asked questions, which were reasonably answered, but no information was forthcoming unless I asked specifically, came out feeling it was rather unsatisfactory. |

| | |
|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | Did not feel relaxed with member of staff. Lack of dialogue and interchange. |

| | |
|---|---|
| Anything_good: | Having been in and out of hospital since birth due to [condition removed], I can say that the way doctors speak and involve you at appt has really improved. The young doctor that I saw at this appt was very reassuring, understanding, very good attitude. |
| Anything_improved: | |
| Other_comments: | |

| | |
|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | Communication really, either post, phone or in person! |

| | |
|---|---|
| Anything_good: | Pleasant and efficient friendly staff. |
| Anything_improved: | |
| Other_comments: | |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | TRAUMA & ORTHOPAEDICS |
|---|---|
| Anything_good: | |
| Anything_improved: | Each time I went I saw a different doctor. I saw the doctor who did my operation, but I did not see him after. |
| Other_comments: | |
| Anything_good: | Whenever I visited the out patients, everyone was always so helpful and friendly. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | I was told I could ring for an urgent appt if I had problems, if I needed an op I would be seen asap. |
| Anything_improved: | More disabled parking. |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | There was at least a 1 and a half hour delay on each of my visits prior to the last one. |
| Other_comments: | |
| Anything_good: | I was referred to physio therapy which has proved very helpful. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | The amount of time waiting to be seen. |
| Other_comments: | |
| Anything_good: | Very glad to have a 'the friends' coffee shop nearby. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | The staff were most helpful and efficient. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | My on-going treatment for arthritis at [location removed] is outstanding and a recent visit with my granddaughter to A&E was equally good, unlike our other local hospital. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | Very happy with all my treatment, thank you. |
| Anything_improved: | |
| Other_comments: | |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | TRAUMA & ORTHOPAEDICS |
|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | 7 weeks after visit I am still waiting for painkillers or injection. |
| Anything_good: | I had broken my wrist whilst on holiday in [location removed]. I was treated there, follow-up at [location removed] was excellent! And I am almost as good as new. |
| Anything_improved: | |
| Other_comments: | Thank you very much indeed for the excellent consultation and treatment I received. |
| Anything_good: | Excellent care, very professional staff. |
| Anything_improved: | |
| Other_comments: | Felt very safe in their care. |
| Anything_good: | |
| Anything_improved: | Communication as apparently a nurse made a decision to cancel my initial app without talking to my consultant who was in clinic. Fortunately my consultant managed to sort it out without too much delay it was still annoying as I lost 2 days work. |
| Other_comments: | |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | ENT |
|---|---|
| Anything_good: | |
| Anything_improved: | Yes. If they checked my history, they would know this happened before about 2 or 3 years ago. I told them this but they didn't seem to care. |
| Other_comments: | |
| Anything_good: | Very helpful and cheerful receptionist in the ENT dept. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | Time waiting for appointment and car park fees. 50 minutes late. |
| Other_comments: | |
| Anything_good: | All doctors very pleasant. |
| Anything_improved: | I had to explain problem to each doctor I saw - going back over a year to when I first visited the department. Doctors could have been given more time to read my medical history. |
| Other_comments: | A problem was found and dealt with, but did not seem to have anything to do with my initial query. Nobody seemed to want to look further into my original symptoms. I had to ask if I could return if problem got worse - was told to visit my GP who would refer me. |
| Anything_good: | On each different visit everyone was very kind. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | The doctor was very good. Explained he had to put a camera up my nose, was very gentle and explained he wanted further tests and another appointment was sent in a few days. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | Reasonable waiting time. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | I was treated with care, politeness and respect by an excellent consultant and his staff and by members of other departments. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | Update training in taking vital sign particularly in taking blood pressure, interval between BP after first taking to be accurate, not in instance after taking. Resulting to high BP or inaccurate. |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | ENT |
|---|---|
| Anything_good: | The nurse was very nice and came across as caring, she also introduced herself and was very helpful and polite. |
| Anything_improved: | The lady I saw before the nurse came across as rude and left the door open whilst swabbing for MRSA and doing blood pressure. As door was open, someone came in to use the staff fridge, this lady did not introduce herself. |
| Other_comments: | I very much dislike the fact that I can't have anybody to wait with me before my op! |

Main Specialty: **OPHTHALMOLOGY**

| | |
|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | My father's last 2 appts were cancelled and then the follow-up appt was not made. In this time from 2009 to 2011, his eyesight became much worse. I feel he has been let down by this. |
| Anything_good: | Kindness. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | Very satisfactory at this stage but will continue to receive regular check ups. |
| Anything_good: | |
| Anything_improved: | Choice of appointment time would be helpful. |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | Not impressed that routine appts are sent by post, obviously within a time scale, only to invariably be postponed to a later date, means 3 months, not good as regards to ophthalmic appts as drops can be changed often. |
| Anything_good: | Staff were very friendly when booking in. |
| Anything_improved: | |
| Other_comments: | I always seem to get two letters informing me of my appointments. Seems to be a waste of much needed NHS money. |
| Anything_good: | Considerate staff. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | Phone enquiries are very good. |
| Anything_improved: | |
| Other_comments: | On the whole this NHS hospital is very good. |
| Anything_good: | |
| Anything_improved: | No privacy in [location removed] Eye dept.'s pre-op dept. |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | Queuing on completion of appointment for a further appointment (lack of staff). |
| Other_comments: | |

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|---|---|
| **Trust Name:** | **Western Sussex Hospitals NHS Trust** |
| Main Specialty: | **OPHTHALMOLOGY** |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | I had been given an appointment for the wrong clinic day, therefore not my usual tests. The person I saw blamed the 'appointment team' (and vice versa), I had been booked for a glaucoma clinic in error. |
| Anything_good: | With 75 people in the waiting area I was seen quicker than I feared. |
| Anything_improved: | With an ageing population and consequently more demand on the eye clinic, additional appointment times are urgently needed. Being retired I could attend appointments at any time. Perhaps more doctors or consultants are required? |
| Other_comments: | |
| Anything_good: | Yes, the opportunity to have an excellent lunch in the terrace cafe at [location removed], we shall visit again! |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | Yes, when a Dr said he will write to my Dr and Optician why did it take from [date removed] to [date removed] for letters to reach there respective places. I've been waiting for an app with Optician and it was me who had to chase the letters up referring back to the hospital. |
| Other_comments: | |
| Anything_good: | The staff were all excellent. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | The waiting time was not good and I was only in with the doctor for a couple of minutes and when I finally went in, procedures he had requested at a previous appt had not been carried out due to "a long waiting list" so he couldn't update me on my condition. |
| Other_comments: | More contact between departments needed where special appointments have been requested to prevent unnecessary attendance on follow-up depts. |
| Anything_good: | The nurses were extremely kind and attentive. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | Wait time. Sat nearly 2 hours to be told I was booked into wrong clinic and would have to come back another day. |
| Other_comments: | |
| Anything_good: | I wasn't kept waiting for long. |
| Anything_improved: | A diagnosis and treatment plan should have been given to me. |
| Other_comments: | I would prefer to see the Consultant named in the invitation letter rather than a trainee (?) using a text book. |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | OPHTHALMOLOGY |
|---|---|
| Anything_good: | All staff most helpful at all times. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | Yes, finally got an appointment after a lot of stress. |
| Anything_improved: | Waiting time - appointment at 15:50 finally left hospital at 18:10. |
| Other_comments: | This appointment took 12 phone calls to appointments number, 3 phone calls to consultants secretary and one email before I finally got an appointment. |
| Anything_good: | Very friendly staff. |
| Anything_improved: | |
| Other_comments: | Thank you. |
| Anything_good: | Quite efficient in the departments. |
| Anything_improved: | They are so busy you cannot change the way the things are. |
| Other_comments: | The hospital is a lovely place to get treatment in all departments where I have been. |
| Anything_good: | |
| Anything_improved: | More hand gels. Would prefer to see them and use immediately on entering hospital and on exit. |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | Could have told me how long I would have to wait. |
| Other_comments: | I am very grateful for the care that has been taken of me. |
| Anything_good: | Helpful and friendly staff. Thank you. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | Kindness, courtesy, interest, humanity. I've experienced all of these. |
| Anything_improved: | |
| Other_comments: | Over the years, St Richards has been supportive in every way. Sincerest thanks. |
| Anything_good: | |
| Anything_improved: | Cleanliness and decor, paint was peeling, some posters were looking tatty. |
| Other_comments: | |
| Anything_good: | I felt particularly impressed with how kindly and gently I was treated, especially as my mobility and communication issues can make me feel awkward and anxious. I felt this was taken into consideration and I was treated as an individual and like a "human being". |
| Anything_improved: | |
| Other_comments: | |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | ORTHODONTICS |
|---|---|
| Anything_good: | The staff were all really friendly and helpful. |
| Anything_improved: | The seating arrangement in the waiting area, everyone is facing each other. |
| Other_comments: | |

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|---|---|
| Anything_good: | Promptness. I arrived approx 20 minutes ahead of the appointment and was seen approx 10 mins early, my experience makes me rate [location removed] streets ahead of [location removed]. |
| Anything_improved: | |
| Other_comments: | |

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|---|---|
| Anything_good: | |
| Anything_improved: | Waiting room has no information on waiting times or general info on the dept. I was kept waiting around 1/2 hour, some people were waiting over an hour, no-one advised us why. |
| Other_comments: | People with colds and/or other viral conditions were mixed with generally healthy people, this, in my opinion, is stupid and a sure way of spreading disease. Please get it sorted, it's your job to cure not spread. |

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|---|---|
| Anything_good: | |
| Anything_improved: | Found the waiting area very crowded, not enough seating in this particular dept. some patients had to stand. |
| Other_comments: | |

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|---|---|
| Anything_good: | |
| Anything_improved: | Because I was late starting my visit I felt I was bit rushed at the end, as the Dr. wanted to get a prescription made up for me and the pharmacy was getting ready to close. |
| Other_comments: | |

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|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | The visit was for a test. I was told the results would be discussed at a consultation 7 days later. To my annoyance this appt was cancelled by the hospital and I have been given a date in 6 months time! |

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|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | You pay for a selective parking time upon arrival. As I had a long wait for my last appointment, my parking ticket had expired before I was seen by a doctor. I had to find a member of staff who phoned my details to the car park attendants. |

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|---|---|
| Anything_good: | Some of the nurses were pleasant and helpful. The ones in the pain clinic operating theatre were not behaving professionally, giggling and squealing about the Eurovision song contest, when I had to concentrate hard with a needle deep in my back to give feedback to the consultant. I was made comfortable in the anteroom beforehand. |
| Anything_improved: | Yes, instead of block bookings, give appointment times for individual patients. Long, long waits when fasting and nervous are not helpful. People who do not turn up for an appointment without warning or good reason, should be asked to pay. |
| Other_comments: | I have the benefit of being able to compare treatment in other European countries and Australia where I have lived. Other countries do not have waiting times. This needs investigating as to the reasons why. I can think of several myself. |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | GASTROENTEROLOGY |
|---|---|
| Anything_good: | Having a local hospital , very user-friendly [name removed]<br>[name removed] - difficult as quite a walk from station + expensive fares. |
| Anything_improved: | |
| Other_comments: | |

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|---|---|
| Anything_good: | On my first visits I was treated exceptionally well, my fear of hospitals was considered and I was treated with the utmost care, however on the follow-up appts, attitude and friendliness was much to be desired. |
| Anything_improved: | Attitude of staff generally, they all looked utterly miserable most of the time! Hospitals are no party to visit, granted, but a bit of warmth and a smile don't go amiss to help settle others' nerves. |
| Other_comments: | Just thank you for giving me the opportunity to see and accept my condition and how to work and manage it to give me some quality of life back. |

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|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | [Location removed] is more difficult to get to than [location removed]. |

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|---|---|
| Anything_good: | All staff were very polite and helpful. |
| Anything_improved: | |
| Other_comments: | |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | CLINICAL HAEMATOLOGY |
|---|---|
| Anything_good: | |
| Anything_improved: | The wait was far too long, it was a blood clinic day and I could have been sent and appointment outside of the clinic times. |
| Other_comments: | Too many people attending at the same time. |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | Every time there is no car parking. |
| Anything_good: | The staff are always polite and welcoming. Tea and coffee is offered by a "friend of the hospital" as there is a wait whilst bloods are analysed. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | The professional attitude of the staff in haematology where conditions are very crowded made my visit a positive one. |
| Anything_improved: | The cramped conditions in the waiting area means those people on chemo with blood cancers have a long crowded wait to see the doctors. One is already anxious for results and the surroundings are not up to todays standards. |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | All doctors and staff are first class. |
| Anything_good: | Yes, it was deduced quickly that I was not the patient referred to in the notes provided! |
| Anything_improved: | |
| Other_comments: | |

Main Specialty: **CLINICAL PHYSIOLOGY**

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|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | I was very impressed with the building, the cleanliness and my care. |
| Anything_good: | On all my visits to Worthing Cardiac Department I have received prompt and excellent attention. |
| Anything_improved: | None that I am aware of relating to the Cardiac dept. |
| Other_comments: | Without exception, on all 5 of my pre-assessment appts. I was required to repeatedly answer the same questions 2 or 3 times to different people in the space of an hour or two. In my state of health I found this very distressing and extremely tiring. |
| Anything_good: | Staff worked well particular aspect stood out just good approach by the staff to any problems. |
| Anything_improved: | Seats uncomfortable. |
| Other_comments: | Staff very good at dealing with incoming patients. |
| Anything_good: | |
| Anything_improved: | Possibly, waiting time. |
| Other_comments: | |
| Anything_good: | Speed of service. |
| Anything_improved: | The results of the 24 hour ECG have not been conveyed to me. |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | Visit to outpatient were good apart from seeing consultant when waiting times could be up to 1 hr. later than the appointment time. Also no continuity with consultant seen and each had a different view of the condition of patient which is confusing. |
| Anything_good: | Very friendly staff, prompt attention in nearly every visit. Great improvements all round. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | Very friendly, happy and courteous towards me with a smile, very pleased, went out of their way. |
| Anything_improved: | Yes, their wages. They do a very good job not appreciated enough, even when they have difficult patients. |
| Other_comments: | |
| Anything_good: | I was not kept waiting, I was seen promptly. |
| Anything_improved: | As well as receiving very good verbal instructions on how to use the monitor I was fitted with, it might have been helpful to have some written info to take home with me. |
| Other_comments: | |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | CLINICAL PHYSIOLOGY |
|---|---|
| Anything_good: | I feel the treatment I receive in the [location removed] hospital is second to none. |
| Anything_improved: | |
| Other_comments: | Unfortunately, I am also involved with [location removed] and the system for appointments is not as good, cancelled appointments, running late, etc. |
| Anything_good: | Very friendly and helpful. |
| Anything_improved: | |
| Other_comments: | Have only paid one visit to your hospital. |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | Still waiting to see specialist and own doctor. |
| Anything_good: | |
| Anything_improved: | Yes, the doctors attitude. |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | Check-in arrangements. |
| Other_comments: | Not enough disabled car parking. |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | My visits are to the [name removed]. |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | CARDIOLOGY |
|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | The NHS gave me 1st class treatment from the ambulance crew to outpatient dept. Also all the staff at the [location removed] and my surgeon [name removed] who carried out the bypass on me, [date removed]. Really 1st class NHS. |
| Anything_good: | Yes, was explained in detail exactly what treatment I was to undergo step by step and the risk involved. Also, the choice to go ahead with treatment or not, which, I chose to go ahead with despite the risk involved. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | Doctor's failure to familiarize himself with my problems before the appt, not enough time allocated to the consultations. |
| Other_comments: | Awaiting follow-up examination, too much time delay. |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | Highly satisfied with the service of [location removed] who has looked after me for nearly 20 years by the same cardiologist, [name removed] and colleagues. The support and service could not be better, I appreciate all the team have done for me and the hospital. |
| Anything_good: | I've always had faith and confidence in our Health service and following my experiences, this has been maintained. |
| Anything_improved: | Yes. When patients are being called for their consultation, it would be of great benefit if some form of amplification were used. This would enable the hard of hearing to hear when the names are called. |
| Other_comments: | |
| Anything_good: | Good children's play area for my grandchildren. |
| Anything_improved: | Someone tried to take my wheelchair away with my £1 in it while I was with the doctor. A member of staff - my daughter stopped them. |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | Time keeping on appt needs to improve. |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | YES - to be told when an appointment time has been changed, so that I was not kept waiting for over an hour before I saw the Dr once my name was called!! |
| Other_comments: | |
| Anything_good: | Very good professional approach by staff. |
| Anything_improved: | It was noted that some patients with later appointments were not as well informed as I was. |
| Other_comments: | Car parking! Lack of sufficient spaces, parking charges excessive. |

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|---|---|
| **Trust Name:** | **Western Sussex Hospitals NHS Trust** |
| Main Specialty: | **CARDIOLOGY** |
| Anything_good: | I was made to feel comfortable and reassured about my condition. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | New doctors seemed anxious to finish the consultation. Doctors seen before were more patient and considerate. |
| Anything_improved: | Doctors should listen better, especially if the patient is not know to them. Saying "yes, yes" while the patient is trying to raise concerns and then dismissing these concerns is a waste of consultation, for doctor and patient. |
| Other_comments: | |

Main Specialty: **DERMATOLOGY**

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|---|---|
| Anything_good: | |
| Anything_improved: | If the time between first visit and the treatment had been shorter there might have been no need for on-going treatment. |
| Other_comments: | |

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|---|---|
| Anything_good: | Sister [name removed] very helpful. |
| Anything_improved: | Too many patients having the same time appts. |
| Other_comments: | |

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|---|---|
| Anything_good: | The feeling that one was being dealt with by people who knew what they were doing. |
| Anything_improved: | Timing. I was diagnosed with 'borderline' glaucoma during an annual eye test in [date removed]. It took until June to complete 2 ophthalmology appts, 1 should have sufficed. Excessive waiting room time. |
| Other_comments: | |

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|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | My appointment with doctor in the autumn/winter could be done on the phone, it takes 2 mins to discuss my condition. |

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|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | |

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|---|---|
| Anything_good: | Professional and friendly staff. Spacey and clean waiting area. |
| Anything_improved: | Don't put a patient room near to the staff room. You can hear everything and when you are waiting is a little uncomfortable. |
| Other_comments: | Nice staff, I felt like I was being rushed however. There was also three people in the room which made feel uncomfortable. |

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|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | Parking for any length of time is expensive. |

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|---|---|
| Anything_good: | |
| Anything_improved: | This was a follow up appointment. I was quite satisfied. Unfortunately, there was a long delay before I was given a first appointment and the condition worsened during the wait. |
| Other_comments: | |

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|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | I wasn't happy about the number of times my appt was cancelled and rescheduled without adequate explanation, I felt I was being "palmed off". |

Main Specialty: **DERMATOLOGY**

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|---|---|
| Anything_good: | The treatment in OPD was part of a series and has now ended. I was always seen on time, if not early. The "service" was always very good and I would ask if I had concerns. |
| Anything_improved: | No - nothing I could identify or needed. |
| Other_comments: | Box 54. I have ticked 6 because of diabetes, but this was not why I was attending the OPD. |

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|---|---|
| Anything_good: | I have found [location removed] much cleaner than [location removed]. |
| Anything_improved: | |
| Other_comments: | |

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|---|---|
| Anything_good: | The pleasantness, politeness and caring attitude, also being asked how you would like to be addressed, i.e. first name or surname. |
| Anything_improved: | |
| Other_comments: | |

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|---|---|
| Anything_good: | Whenever I visit the hospital which is quite a lot, I am treated with patience and great respect. Everyone does a wonderful job and I have no complaints whatsoever. |
| Anything_improved: | Yes, it is too hot and airless and needs better air conditioning. |
| Other_comments: | |

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|---|---|
| Anything_good: | Overall excellent care, attitude and cleanliness thank you. Also, during other visits with my children-impressive. |
| Anything_improved: | |
| Other_comments: | |

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|---|---|
| Anything_good: | Everybody was very friendly and helpful. |
| Anything_improved: | Prescriptions should be allowed. At outside pharmacy to save time. |
| Other_comments: | |

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|---|---|
| Anything_good: | I found the nursing staff very professional and very friendly and for an old person like myself, very reassuring. |
| Anything_improved: | |
| Other_comments: | |

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|---|---|
| Anything_good: | The hospital was very clean and most staff were helpful. |
| Anything_improved: | The appointment got rearranged so many times it led to confusion on both parties! |
| Other_comments: | |

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|---|---|
| Anything_good: | I would like to say [name removed] has been the only doctor to find a blood pressure tablet to bring my blood pressure down after 25 years. I am very grateful to him. Thank you. |
| Anything_improved: | |
| Other_comments: | |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | MEDICAL ONCOLOGY |
|---|---|
| Anything_good: | I saw doctor [name removed] and he always fully explains procedures he has carried out or will carry out in layman's terms in a way I can understand. He is always very pleasant, always talks directly to me about my condition and he never rushes. |
| Anything_improved: | |
| Other_comments: | |

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|---|---|
| Anything_good: | Excellent treatment at all times. |
| Anything_improved: | |
| Other_comments: | |

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|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | Pharmacy could sort waiting times, much too long. |

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|---|---|
| Anything_good: | All nurses in the chemo therapy department have been excellent. |
| Anything_improved: | |
| Other_comments: | |

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|---|---|
| Anything_good: | The friendliness and helpfulness of the staff. |
| Anything_improved: | Better air conditioning, the dept. always seems to be too hot. |
| Other_comments: | |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | RHEUMATOLOGY |
|---|---|
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | Everyone is always polite and helpful. |
| Anything_good: | |
| Anything_improved: | I would have liked to have had more info at times so I could have informed the HR. |
| Other_comments: | |
| Anything_good: | My first appt with consultant, [name removed], was wasted as I should have had a scan first. My dealing with his secretary have not been very successful, having to wait a long period to rearrange the scan. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | Consultant was excellent kind and he listened. |
| Anything_improved: | Date of followup appointment. |
| Other_comments: | |
| Anything_good: | I have been attending this OP dept for many years and have always found my treatment and care to be of a very high standard. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | Reception staff are always nice and helpful. As are the health care assistants also. |
| Anything_improved: | No, I think your hospital is excellent. |
| Other_comments: | Keep up the good work. |
| Anything_good: | Always well received and on time appointments. Hospital very clean and always friendly staff. |
| Anything_improved: | Would have liked copies of letters sent to GP. |
| Other_comments: | Parking at hospital good for a disabled person. |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | I have visited (name of doctor) for some years and his colleagues have always been very professional and friendly. And it's very unusual to wait longer than appointment time. And you are informed if there is any delay. |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | My first 2 visits for this particular condition were seen by the same doctor. The third visit was a different doctor which seemed to reduce the understanding and spoilt the continuity of possible diagnosis and treatment. |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | RHEUMATOLOGY |
|---|---|
| Anything_good: | All nurses are kindly that I have met. |
| Anything_improved: | The toilet taps in most toilets were a disgrace in that most were dirty. |
| Other_comments: | On the whole Worthing Hospital is good but they do mess you about with appointments but I understand there are emergencies some times. |
| Anything_good: | Intelligent and helpful doctor, listened to me, I felt she had plenty of experience. |
| Anything_improved: | |
| Other_comments: | My problem resolved itself in the end, but I feel I could have gone back to the hospital for further advice or treatment. |
| Anything_good: | Not having been very aware of the causes and the effect of a recent very small [acronym removed], I am very grateful for being referred to [location removed] and for the thorough, excellent "going over" that I received. |
| Anything_improved: | |
| Other_comments: | How lucky we are to have our NHS and in particular we should be thankful for the quality of it in this part of the country! |
| Anything_good: | Amazingly, all was done in appointment time. Kindly, quietly and efficiently. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | Care and consideration. |
| Anything_improved: | Not that I am aware. |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | The waiting time in the pharmacy at the hospital is excessive. |
| Other_comments: | |

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|---|---|
| Main Specialty: | **PHYSIOTHERAPY** |
| Anything_good: | The physiotherapist was brilliant in every aspect. I cannot praise her high enough. She was so thorough and not rushed at all even though the time I was there probably shortened her lunch hour. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | The nurse in the doctor's office was very embarrassed by the way the doctor did not have time to answer all our questions and dismissed us. She followed us down the corridor and gave us a few useful booklets, we had no confidence in the doctor at all. |
| Anything_improved: | Yes. Just because his clinic was running late, the doctor should be as civil to the last few patients as the first. It was not our fault the clinic was running late and we had had to wait longer to see him but there was no apology. |
| Other_comments: | On several other occasions, I have waited more than an hour to be seen. It seems that the NHS thinks that we all have time to sit around and theirs is the only time that is precious. If you have taken time off from work for an appt, it is maddening to have to wait around for hours to be seen. |
| Anything_good: | |
| Anything_improved: | |
| Other_comments: | If this questionnaire concerned A and E, my responses would have been very different! |
| Anything_good: | The staff and their attitude was very good. |
| Anything_improved: | Very limited disabled parking. |
| Other_comments: | |
| Anything_good: | All my contacts were very positive and professional. |
| Anything_improved: | |
| Other_comments: | |
| Anything_good: | |
| Anything_improved: | Waiting time was sometimes a bit longer than the appt time but you do realize there are other problems and accidents going on. |
| Other_comments: | The treatment and care I received was of an excellent standard from the nurses to the doctors and was very much appreciated, thank you. |
| Anything_good: | Yes, I was dealt with in a professional and efficient manner as befits a national health service where medical attention is more important than the quality of the tea! |
| Anything_improved: | |
| Other_comments: | The parking charges are higher at [location removed] than in [location removed] which is a disgrace. |
| Anything_good: | The ease with which I could ask the doctor any concerns. |
| Anything_improved: | |
| Other_comments: | Concerned that I have to wait seven weeks for a test to help doctor determine my next treatment. |

| Trust Name: | Western Sussex Hospitals NHS Trust |
|---|---|

| Main Specialty: | PHYSIOTHERAPY |
|---|---|
| Anything_good: | I have had 3-4 outpatients appointments lately. The diabetes centre being the best. The heart dept and doctors chaotic and the doctor very rude and abrupt. |
| Anything_improved: | The doctors could try reading patients notes so as to have some info of what recent complications or other doctors have written. |
| Other_comments: | It is hard to have any confidence in the NHS when appt come with the wrong hospital number on them and urgent appt one cancelled in the post. |

| | |
|---|---|
| Anything_good: | |
| Anything_improved: | Free disabled parking. |
| Other_comments: | |

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|---|---|
| Anything_good: | Staff all very friendly. |
| Anything_improved: | |
| Other_comments: | |

| | |
|---|---|
| Anything_good: | I was dealt with very 'sympathetically' and put at ease, told if I was worried at all, I could always contact them to talk. I appreciated that, it meant a lot to me. |
| Anything_improved: | |
| Other_comments: | |

| | |
|---|---|
| Anything_good: | Patients were treated with consideration and courtesy. |
| Anything_improved: | The waiting period and some information about it. |
| Other_comments: | Overall it was satisfactory. |

| | |
|---|---|
| Anything_good: | |
| Anything_improved: | Not sure why I was there. It seems the optician referred me but I did not know why. It was explained but I did not need to attend. Someone else could have been more urgent. |
| Other_comments: | |

| | |
|---|---|
| Anything_good: | |
| Anything_improved: | Some of the registrars were not listening or informing about condition - info about care and exercising would have been useful - possibly hand out notes/leaflets, etc. |
| Other_comments: | |

# RTPE Report Outpatients Feb 2012

## Subtitle

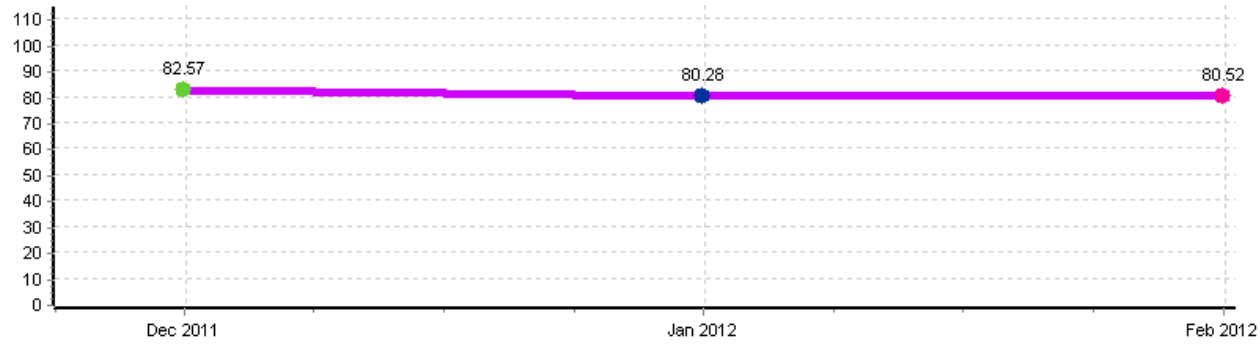
### Outpatient Survey Result Summary

The overall satisfaction rating to date is **80.53%**.

The total number of questionnaires completed to date is **487**.

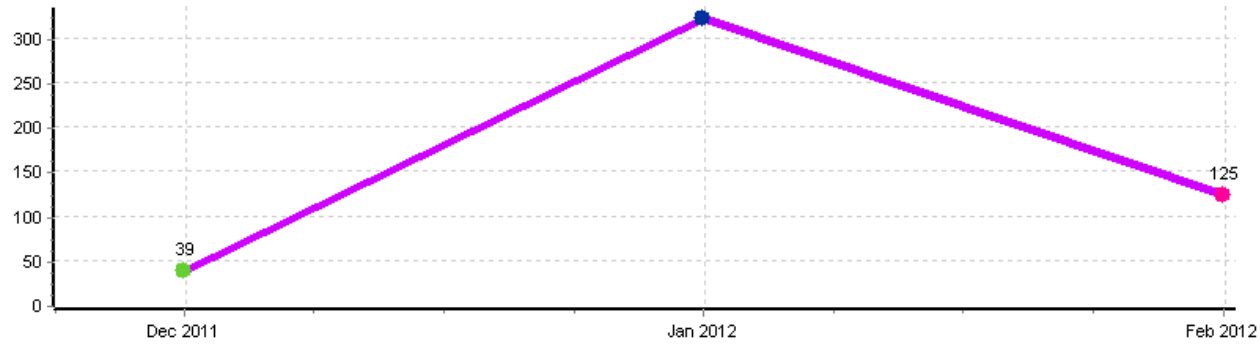
### Result Trends

The chart below shows the result trend for this questionnaire.




### Completed Questionnaires

The chart below shows the monthly volume of questionnaire returns.




### Best / Worst Performing Areas of the Feedback Questionnaire

The table below shows the best and worst performing sections, competencies and questions.

| | Best | | Worst | |
|---|---|---|---|---|
| **Section** | Tests (e.g. x-rays and scans) | 83.74 | Waiting in the hospital | 59.96 |
| **Competency** | | | | |
| **Question** | Please rate the kindness of doctors during your visit to outpatients | 91.40 | Were you told how long you would have to wait? | 25.81 |

# RTPE Report Outpatients Feb 2012

## Subtitle

### Question Analysis

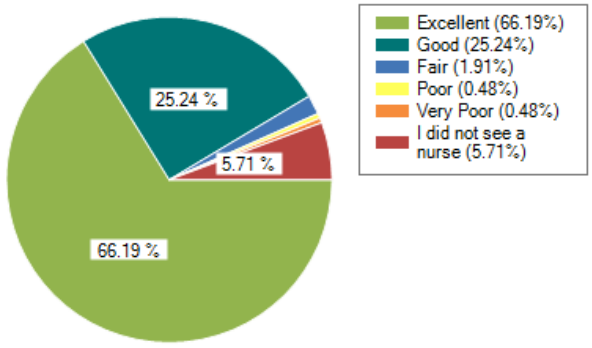
**Please use the filters below to narrow your results.**

**Questionnaire Filters**

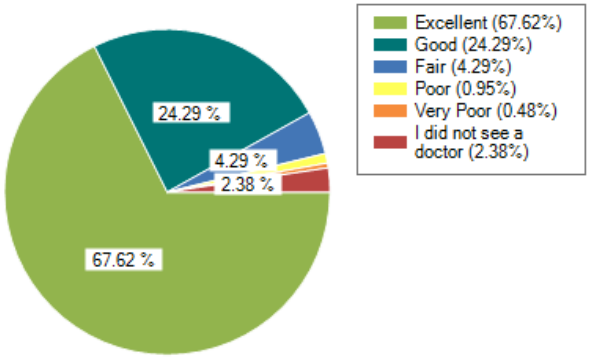
| | |
|---|---|
| **Start Date** | 01 - Feb - 2012 |
| **End Date** | 29 - Feb - 2012 |
| **Question** | All Questions |

### All Questions

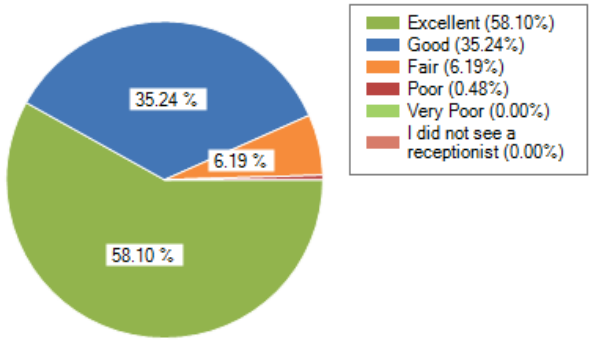
**Question: Please rate the kindness of the nurses during this visit to outpatients (91.41%)**



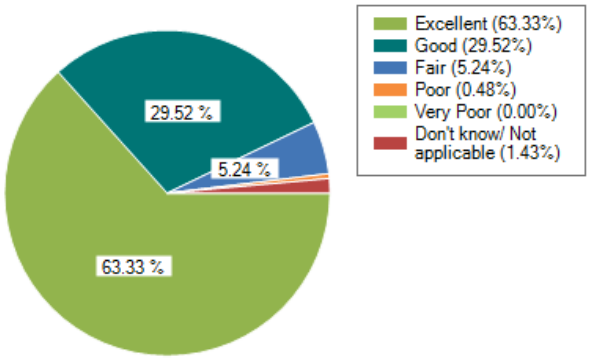

**Question: Please rate the kindness of doctors during your visit to outpatients (90.37%)**




**Question: Please rate the kindness of receptionists during your visit to outpatients (87.74%)**



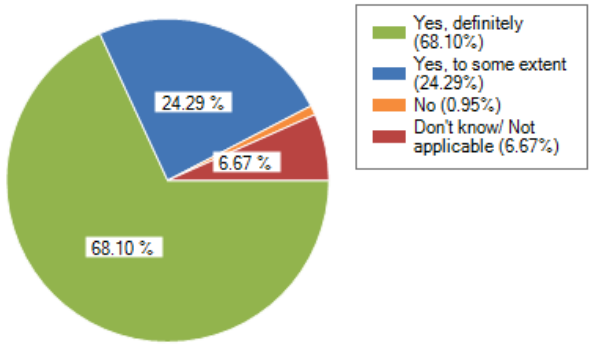

**Question: Please rate the overall quality of care during your visit to outpatients (89.49%)**



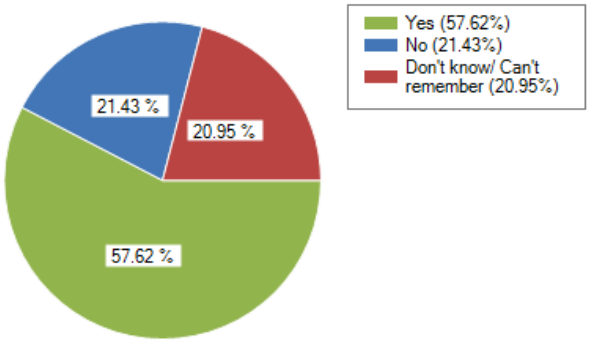
# RTPE Report Outpatients Feb 2012

Subtitle

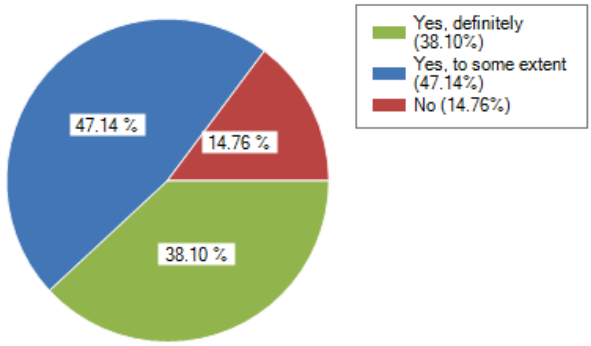
**Question: Have you been involved as much as you wanted to be in decisions about your care? (85.97%)**



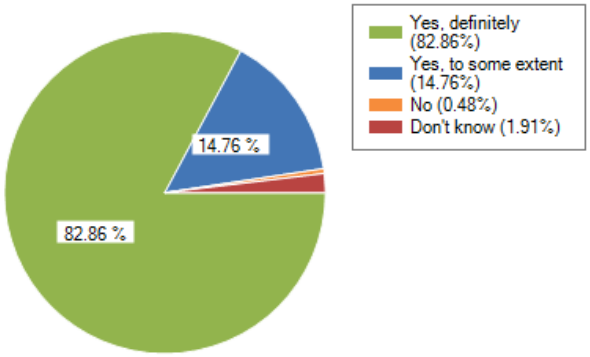

**Question: Did hospital staff tell you who to contact if you were worried after you left hospital? (72.89%)**



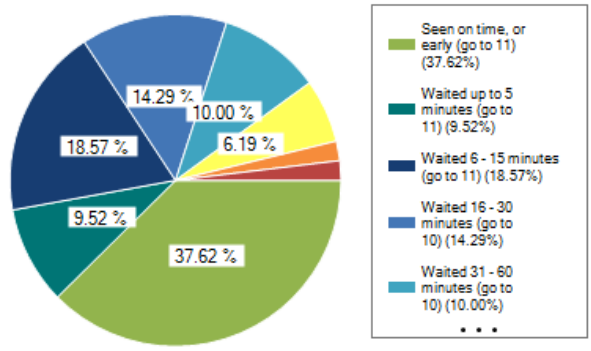

**Question: Before your appointment, did you know what would happen to you during the appointment? (61.67%)**



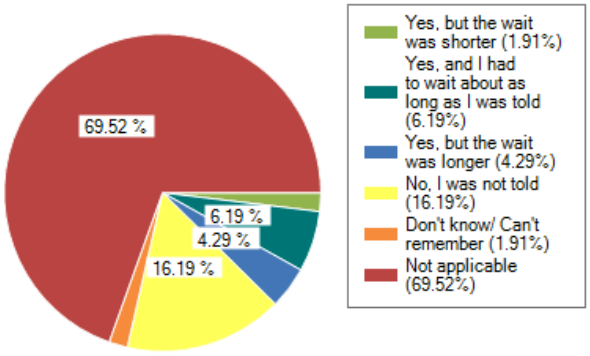

**Question: Would you recommend this hospital to your friends and relatives? (91.99%)**



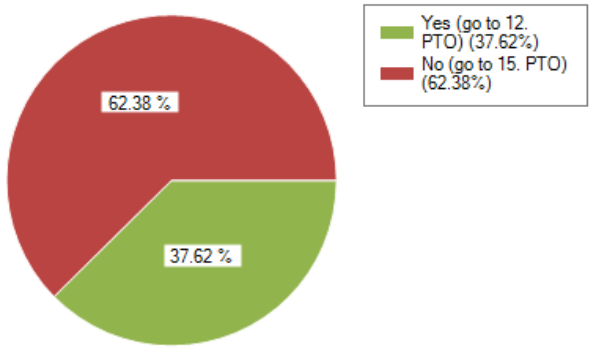

**Question: How long after the stated appointment time did the appointment start? (70.79%)**



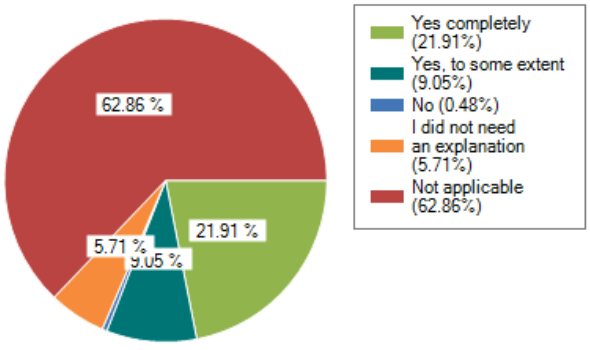

**Question: Were you told how long you would have to wait? (24.48%)**




**Question: Have you had any tests (such as x-rays, scans or blood tests) when you visited the outpatients department? (0.00%)**



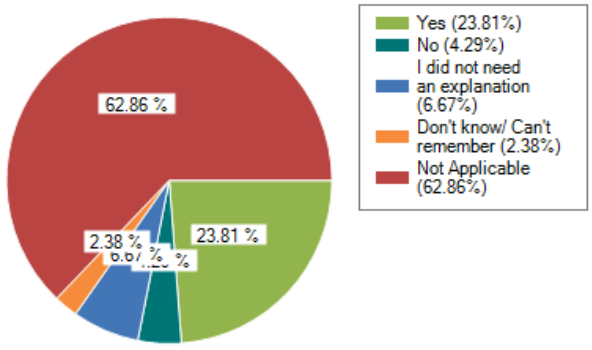

**Question: Did a member of staff explain why you needed these tests in a way you could understand? (84.09%)**



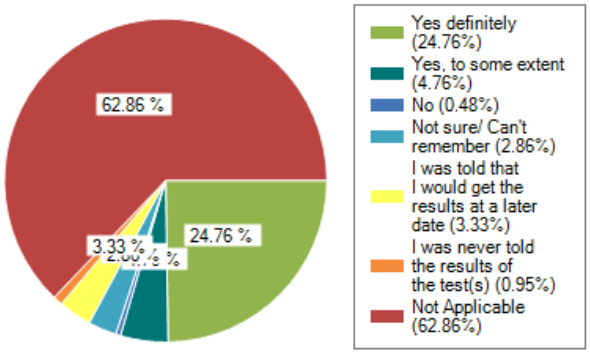
# RTPE Report Outpatients Feb 2012

## Subtitle

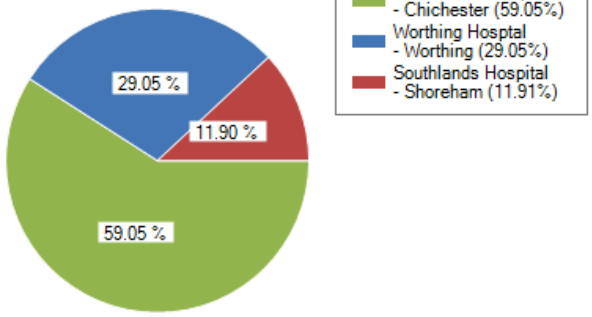
**Question: Did a member of staff tell you how you would find out the results of your test(s)? (78.13%)**




**Question: Did a member of staff explain the results of the test(s) in a way that you could understand? (87.69%)**




**Question: At which of the following hospitals did you have your appointment? (0.00%)**



# RTPE Report Outpatients Feb 2012

## Subtitle

### Response Totals

Welcome to the response totals page. This page is an excellent starting point when analysing your questionnaire data, and provides a concise and easy way to interpret breakdown of how your questionnaires have been completed.

### Filters

Please adjust the filters below to change the search parameters. By default results from the current and previous months are shown.

| | |
|---|---|
| **Start Date** | 01 - Feb - 2012 |
| **End Date** | 29 - Feb - 2012 |
| **Result Type** | Count |

### General

1. Please rate the kindness of the nurses during this visit to outpatients

| Excellent | Good | Fair | Poor | Very Poor | NA | Comments |
|---|---|---|---|---|---|---|
| 85 | 37 | 1 | 0 | 1 | 1 | 0 |

2. Please rate the kindness of doctors during your visit to outpatients

| Excellent | Good | Fair | Poor | Very Poor | NA | Comments |
|---|---|---|---|---|---|---|
| 88 | 28 | 2 | 1 | 1 | 5 | 0 |

3. Please rate the kindness of receptionists during your visit to outpatients

| Excellent | Good | Fair | Poor | Very Poor | NA | Comments |
|---|---|---|---|---|---|---|
| 70 | 46 | 7 | 2 | 0 | 0 | 0 |

4. Please rate the overall quality of care during your visit to outpatients

| Excellent | Good | Fair | Poor | Very Poor | NA | Comments |
|---|---|---|---|---|---|---|
| 76 | 43 | 5 | 0 | 1 | 0 | 0 |

5. Have you been involved as much as you wanted to be in decisions about your care?

| Yes, definitely | Yes, to some extent | No | NA | Comments |
|---|---|---|---|---|
| 94 | 24 | 2 | 5 | 0 |

6. Did hospital staff tell you who to contact if you were worried after you left hospital?

| Yes | No | NA | Comments |
|---|---|---|---|
| 68 | 33 | 24 | 0 |

7. Before your appointment, did you know what would happen to you during the appointment?

| Yes, definitely | Yes, to some extent | No | NA | Comments |
|---|---|---|---|---|
| 51 | 52 | 22 | - | 0 |

8. Would you recommend this hospital to your friends and relatives?

| Yes, definitely | Yes, to some extent | No | NA | Comments |
|---|---|---|---|---|
| 104 | 15 | 2 | 4 | 0 |

### Waiting in the hospital

9. How long after the stated appointment time did the appointment start?

| Seen on time, or early (go to 11) | Waited up to 5 minutes (go to 11) | Waited 6 - 15 minutes (go to 11) | Waited 16 - 30 minutes (go to 10) | Waited 31 - 60 minutes (go to 10) | Waited more than 1 hour but no more than 2 hours (go to 10) | Waited more than 2 hours (go to 10) | NA | Comments |
|---|---|---|---|---|---|---|---|---|
| 39 | 18 | 23 | 14 | 20 | 5 | 3 | 3 | 0 |

10. Were you told how long you would have to wait?

| Yes, but the wait was shorter | Yes, and I had to wait about as long as I was told | Yes, but the wait was longer | No, I was not told | Don't know / Can't remember | NA | Comments |
|---|---|---|---|---|---|---|
| 5 | 7 | 5 | 17 | 6 | 85 | 1 |

## Tests (e.g. x-rays and scans)

| | | | | | |
|---|---|---|---|---|---|
| 11. | Have you had any tests (such as x-rays, scans or blood tests) when you visited the outpatients department? | Yes (go to 12. PTO) | No (go to 15. PTO) | NA | Comments |
| | | 57 | 68 | - | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 12. | Did a member of staff explain why you needed these tests in a way you could understand? | Yes completely | Yes, to some extent | No | I did not need an explanation | NA | Comments |
| | | 37 | 12 | 2 | 6 | 68 | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 13. | Did a member of staff tell you how you would find out the results of your test(s)? | Yes | No | I did not need an explanation | Don't know / Can't remember | NA | Comments |
| | | 35 | 7 | 11 | 2 | 70 | 0 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 14. | Did a member of staff explain the results of the test(s) in a way that you could understand? | Yes definitely | Yes, to some extent | No | Not sure / Can't remember | I was told that I would get the results at a later date | I was never told the results of the test(s) | NA | Comments |
| | | 37 | 8 | 2 | 2 | 4 | 1 | 71 | 0 |

## About your appointment

| | | | | | | |
|---|---|---|---|---|---|---|
| 15. | At which of the following hospitals did you have your appointment? | St Richards Hospital - Chichester | Worthing Hosptal - Worthing | Southlands Hospital - Shoreham | NA | Comments |
| | | 105 | 19 | 1 | - | 0 |

# RTPE Report Outpatients Feb 2012

Subtitle

## Trend Heat Map

Please use the filters below to narrow your results.

| | |
|---|---|
| Search By Location | All |
| Search By Division | All |
| Search By Ward | All |

### General

| Question | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Benchmark |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Please rate the kindness of the nurses during this visit to outpatients | - | - | - | - | - | - | - | - | 91 | 90 | 91 | - | 0 |
| 2. Please rate the kindness of doctors during your visit to outpatients | - | - | - | - | - | - | - | - | 90 | 91 | 92 | - | 0 |
| 3. Please rate the kindness of receptionists during your visit to outpatients | - | - | - | - | - | - | - | - | 92 | 87 | 87 | - | 0 |
| 4. Please rate the overall quality of care during your visit to outpatients | - | - | - | - | - | - | - | - | 88 | 88 | 89 | - | 0 |
| 5. Have you been involved as much as you wanted to be in decisions about your care? | - | - | - | - | - | - | - | - | 89 | 87 | 88 | - | 0 |
| 6. Did hospital staff tell you who to contact if you were worried after you left hospital? | - | - | - | - | - | - | - | - | 66 | 70 | 67 | - | 0 |
| 7. Before your appointment, did you know what would happen to you during the appointment? | - | - | - | - | - | - | - | - | 76 | 63 | 62 | - | 0 |
| 8. Would you recommend this hospital to your friends and relatives? | - | - | - | - | - | - | - | - | 90 | 89 | 92 | - | 0 |
| **Total** | - | - | - | - | - | - | - | - | 85 | 83 | 84 | - | - |

### Waiting in the hospital

| Question | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Benchmark |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 9. How long after the stated appointment time did the appointment start? | - | - | - | - | - | - | - | - | 84 | 70 | 69 | - | 0 |
| 10. Were you told how long you would have to wait? | - | - | - | - | - | - | - | - | 31 | 24 | 28 | - | 0 |
| **Total** | - | - | - | - | - | - | - | - | 58 | 47 | 49 | - | - |

### Tests (e.g. x-rays and scans)

| Question | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Benchmark |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 11. Did a member of staff explain why you needed these tests in a way you could understand? | - | - | - | - | - | - | - | - | 85 | 86 | 84 | - | 0 |
| 12. Did a member of staff tell you how you would find out the results of your test(s)? | - | - | - | - | - | - | - | - | 64 | 79 | 80 | - | 0 |
| 13. Did a member of staff explain the results of the test(s) in a way that you could understand? | - | - | - | - | - | - | - | - | 87 | 89 | 85 | - | 0 |
| **Total** | - | - | - | - | - | - | - | - | 79 | 85 | 83 | - | - |
| **Total Responses** | - | - | - | - | - | - | - | - | 39 | 323 | 125 | - | - |

**What can I expect to happen in my Outpatient Appointment?**

Some of our clinics are very busy and therefore there may be a delay. We will always keep you updated about the waiting time. If you have any concerns, do speak to the clinic staff.
Sometimes there is more than one doctor in the clinic. Therefore patients may not be seen in the order they arrive.
You may see a member of the clinical team rather than the consultant, however your case will have been discussed with the consultant prior to your arrival.
There maybe other members of the team in the room who will be introduced to you. If you have any objections to this, please feel free to let us know.

**Questions you might like to ask in your appointment:**

- Can I make sure I understand what you have told me?
- Is there any other way to treat my condition?
- Are there any risks or side effects to the treatment?
- What happens next? Do I need to come back and see you?
- Why do I need to have further tests and what will it entail?

**Mobile Phones**
Please be considerate and switch your phone off or onto silent while you are in the clinic.

**Patient Advice and Liaison Service (PALS) is here if:**

- You need help
- You need information
- You would like to make a comment on the service you received

**To contact them, you can:**
-Telephone 01243 831822

- Email palschichester.nhs.uk
- Visit them in the PALS office, Monday to Friday 0900 to 1700 hours (In to Main Reception.)

**Further information**
You might also find it useful to visit:
www.wsht.nhs.uk

This leaflet is available in a different language or another format. Please contact our PALS department for further information.

**www.wsht.nhs.uk**
St Richard's Hospital
01243 788122

Issue date: **Dec 2011**
Review date: **Dec 2013**
Department: Outpatients/HIC

Western Sussex Hospitals NHS Trust

# Information Sheet

# Welcome to Outpatients

**St Richard's Hospital**
**Spitalfield Lane**
**Chichester**
**West Sussex**
**PO19 6SE**

## Waiting for your appointment date

We aim to see you as quickly as possible and will do our best not to change the date or time of your appointment. In order to give you the earliest appointment possible, we may offer you an appointment at any of our hospital sites if it means you will be seen more quickly. If your condition seems to be getting worse whilst you are waiting for your appointment, please contact your GP.

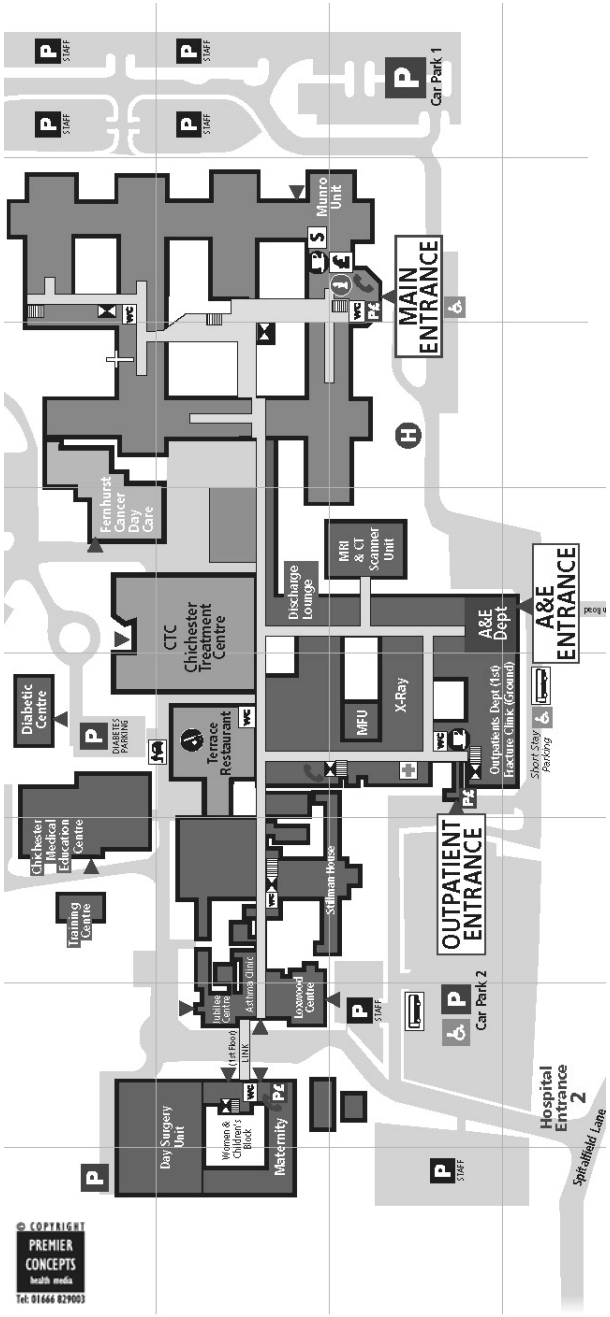
## Unable to make your appointment?

By missing your appointment and not telling us in good time, you make others wait longer and could put your own health at risk.
If you cannot attend, please let us know by ringing the telephone number on your letter or the number given to you. We can give your appointment to another patient and we can re-book yours.

## What to bring with you.

- Your appointment card/letter
- List of questions you want to ask
- A list of all medication that you take/use.

You're appointment letter will include any special instructions (such as whether to bring a urine sample)




Map courtesy of Premier Concepts health media

## Help for people with disabilities

Please call the number on your appointment letter if there is anything more we can do to meet your needs during your visit.

## Can I have a copy of my clinic letter?

A copy of the letter that will be sent to your GP will be sent to you at the same time.

## Facilities at the hospital

Refreshments -
The *Terrace* restaurant is open from 8am to 8pm each day. It is located on the 1st floor of the main hospital.

The Cloisters Cafe in main reception is open from 9.30am to 5.00pm, Monday to Friday.

The WRVS Tea Bar in outpatients is open from 9.30am to 4.30pm.

The Friends Shop is located in the Main Reception.

## We are a 'no smoking' hospital

Smoking is not permitted in any hospital; buildings or grounds. If you want to try to stop smoking, please call the 'Stop smoking service helpline' on 01243 812541.

Western Sussex Hospitals NHS
NHS Trust

To: Trust Board

Date of Meeting: 29 March 2012 Agenda Item: 9

| Title |
|---|
| **Month 12, 2011/12 Performance Report** |
| Responsible Executive Director |
| Jane Farrell, Chief Operating Officer/Deputy Chief Executive |
| Prepared by |
| Adam Creeggan, Director of Performance<br>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 indicators underpinning the WSHT Corporate Objectives, Quality Board indicators aligned to the Quality Strategy, the NHS Performance Framework, the Monitor Compliance Framework, and when relevant, other efficiency indicator mechanisms such as Better Care, Better Value. 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.<br>*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<br>*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, Corporate Objectives Scorecard, NHS Performance Framework Scorecard and Monitor Compliance Framework Scorecard. |

Western Sussex Hospitals NHS
NHS Trust

| | | |
|---|---|---|
| To: | Trust Board | Date: 26 April 2012 |
| From: | Jane Farrell, Chief Operating Officer, Deputy Chief Executive | Agenda Item: 9 |
| **FOR INFORMATION** | | |

**WSHT PERFORMANCE REPORT: MONTH 12, 2011/12**

## 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:

- Overarching delivery of indicators underpinning the WSHT Corporate Objectives
- Quality Board indicators, aligned to the Quality Strategy
- Delivery against the NHS performance Framework against which WSHT is monitored by the Department of Health prior to authorisation as a Foundation Trust.
- The Monitor Compliance Framework, under which the Trust will be performance managed post authorisation as a Foundation Trust.
- External efficiency indicator mechanisms such as Better Care, Better Value, when 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. PERFORMANCE OF NOTE

2.1 A&E

2.1.1 As reported to the Trust Board in the previous Performance Report, February performance fell to 92.1% following heightened demand pressure across Sussex during the month. Detailed analysis of the impact of this atypical pressure was relayed to Board alongside a number of improvement actions aimed at improving whole system patient flow during periods of heightened demand, supported by enhanced scrutiny and oversight by Chief Operating Officer.

2.1.2 Driven by these strengthened arrangements WSHT performance improved significantly in March, with data for the month showing 98.6% being delivered against the 95% target. The significant improvement observed in March contributed to a Quarter 4 aggregate compliance level of 95.5%, ensuring full compliance against both the NHS Performance Framework and Monitor Compliance Framework.

2.2 Cancer

2.2.1 Compliance was achieved across all cancer pathways relevant to WSHT in March, with the exception of 31 day subsequent treatment for surgery which under-performed at 88.24% in March against a target of 94%. Numbers of patients this metric pertains to are very small, and this failure relates to 2 patients who were not seen within 31 days of 17 patients in total in March. Board Members should note that data relating to the standard is provisional at the time of writing.

2.2.2 Both failures against the standard related to the Worthing site, one of which was in Dermatology in which patient non attendance left insufficient time in the path, and the second related to a Urology who patient required a complex surgery procedure undertaken by twin surgical teams and could not be dated within target.

2.2.3 Whilst the Board receives monthly updates to highlight trends in performance, cancer metrics are nationally reported on a quarterly basis for the purposes of the NHS performance Framework and Monitor Compliance Framework. All eight cancer pathways relevant to WSHT were fully compliant in aggregation during Quarter 4 of 2011/12.

2.3 Referral to Treatment (18 Weeks)

2.3.1 March data confirms sustained compliance of all referral to treatment (RTT) targets relating to 18 weeks, median waiting time, and 95th percentile waiting times.

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

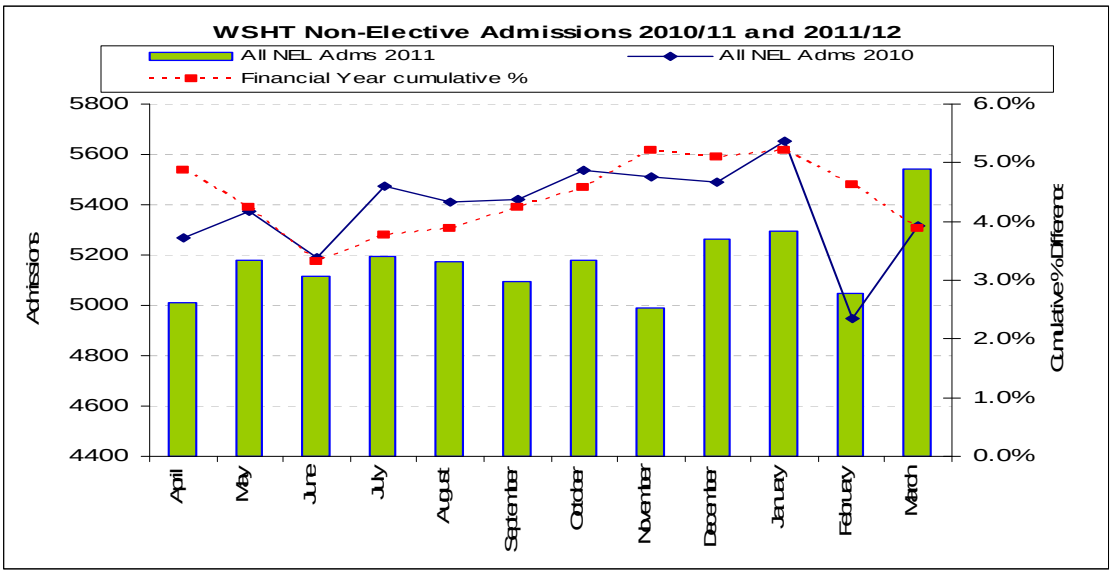
2.4.1 Following sustained delivery of the 36 hour time to the theatre target in the latter half of 2011/12, March data confirms 100% of patients were operated on within the 36 hours target generated the highest level of compliance observed in 2011/12.

## 3 ONE CALL/ONE TEAM: QUARTER 4 2011/12

3.1 The service commenced in April 2011 in Worthing, and from May 2011 in Chichester, and offers complete assessment and management of patients with an urgent care need that may not require admission to hospital. The service consists of a multidisciplinary team of Community Consultant Geriatricians, Acute GPs, Nurses, Paramedic Practitioners, Occupational therapists, Physiotherapists and Social Workers. The multi-agency rapid response teams are based at Worthing and St Richards Hospitals.

3.2 As conveyed to the board in the January Performance Report, there was a reduction in non-elective admissions of approximately 5% between April and December when compared to the same period in 2010/11. Whilst this remained the case in January 2012, there was an observed increase in non-elective admissions in February and March 2012, when compared to 2010/11. Linked to this increase in Quarter 4, the cumulative reduction dropped for the 2011/12 financial year to 3.9%.

**Figure 1: Non Elective Admissions**



3.3 Non-elective admissions comprise of two main activity types: emergency admissions and non-elective non-emergency admissions. The principle element of the observed reduction relates to the emergency admissions, with which activity on the Worthing and Southlands sites reduced by 1022 admissions (3.7%). On the St. Richards site emergency admissions increased by 286 admissions (1.3%) between years, following a significant rise in emergency admissions in February and March (relative to the previous year). The cumulative changes described are illustrated in **Figures 2** and **3** respectively:

**Figure 2: Emergency Admissions on the Worthing and Southlands sites**

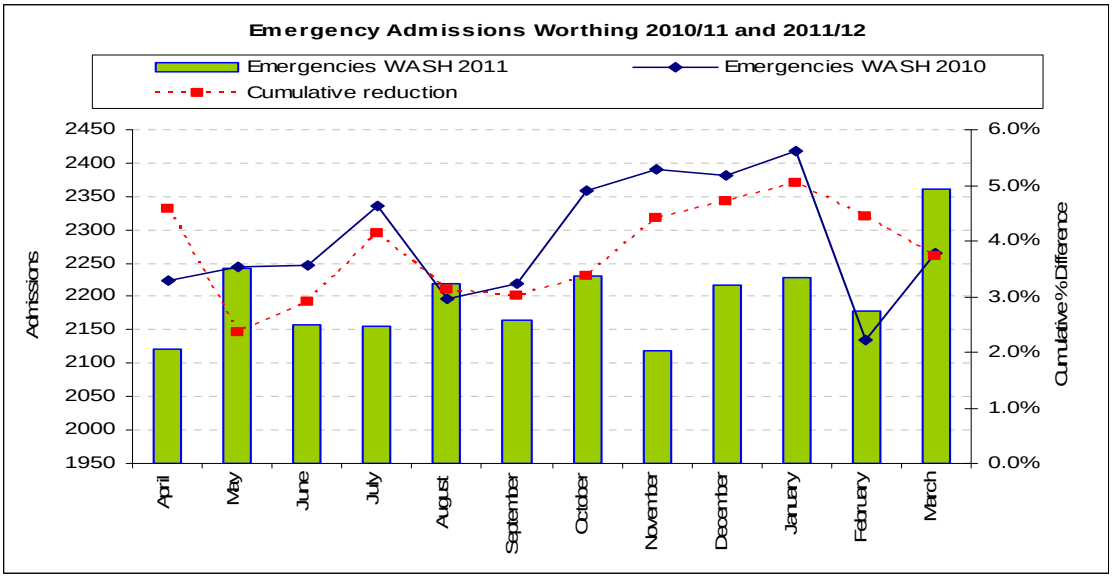
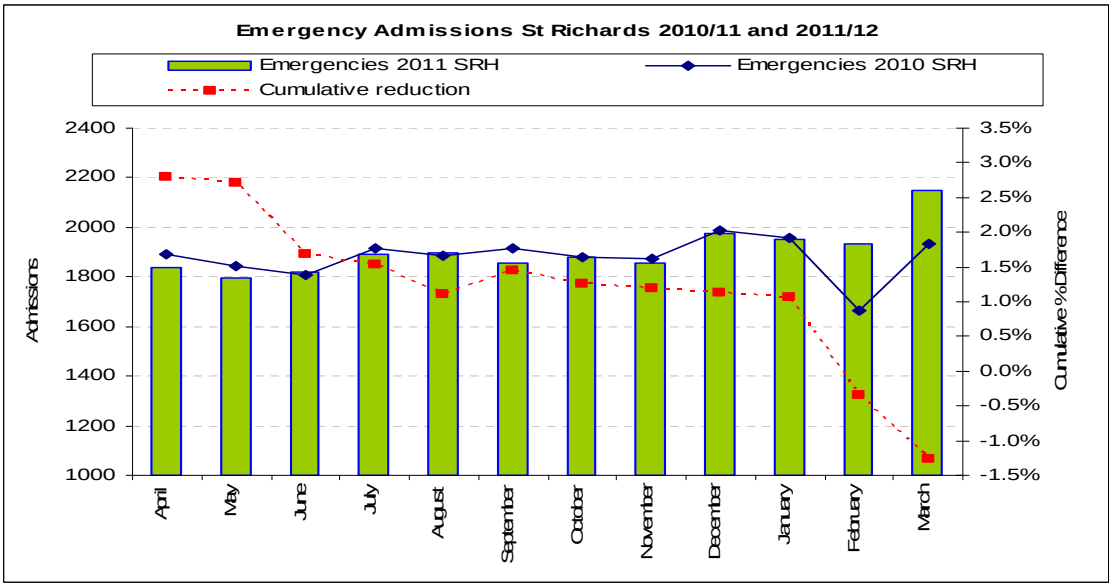



**Figure 3: Emergency Admissions on St. Richards site**



3.4 Detailed examination by Division in **Table 1** reveals differential reduction but aligned to expectation. Medicine forms the largest component with a 2.5% reduction in emergency admissions across the year. This has reduced from a 4.4% reduction between April and December, due to demand pressure observed in Quarter 4.

**Table 1: Emergency admission reduction by division**

| Division | 2010/11 | 2011/12 | Reduction | % Reduction |
|---|---|---|---|---|
| Surgery | 11066 | 11052 | -14 | -0.13% |
| Medicine | 31876 | 31073 | -803 | -2.52% |
| Women & Children | 7030 | 7104 | 74 | 1.05% |
| Total | 49972 | 49229 | -743 | -1.49% |

3.5 If medical emergencies in aggregation are broken down by length of stay, the reduction relates exclusively to 0 day length of stay patients, and therefore the cohort being targeted within the One Call, One Team schemes. The April – December 2011 position showed an overall reduction of 4.4%, however due to an increase in demand in February and March, the total percentage reduction in medical emergencies fell to 2.5%.

**Table 2: Emergency admission reduction by length of stay**

| Medical discharges Length of stay type | 2010-11 | 2011-12 | Reduction | % Reduction |
|---|---|---|---|---|
| 0 day length of stay | 13768 | 12727 | -1041 | -7.6% |
| > 0 day length of stay | 18108 | 18346 | 238 | 1.3% |
| Total | 31876 | 31073 | -803 | -2.5% |

3.6 While the cumulative impact has been hampered in Quarter 4 by sustained high demand, there is still a compelling correlation of reduction linked to the advent of One Call schemes, particularly when comparing 0 day LOS.

## 4. 2012/13 NHS PERFORMANCE FRAMEWORK and MONITOR COMPLIANCE FRAMEWORK

4.1 On 30 March 2012 revised framework documents for both the NHS Performance Framework and Monitor Compliance were formally published with associated assessment thresholds.

4.2 The NHS Performance Framework introduces a number of new and expanded metrics in 2012/13, specifically:

- In addition to existing referral to treatment targets relating to admitted and non-admitted completed pathway, a new metric in which 92% of all incomplete pathways wait less than 18 weeks is introduced. This metric is an aggregation of all patients currently waiting across both admitted and non admitted pathways, and the Trust is on target to report a compliant aggregate position of circa 92.2% in April 2012.
- The requirement to achieve specialty level compliance is re-established in 2012/13 having been removed from the 2011/12 metric set. Specialty compliance is determined by the total volume of non compliant pathways against each of the admitted, non admitted and incomplete metrics. The NHS Performance Framework determines a score of 0 non-compliant specialties as 'Performing', >0 and <20 non-compliant specialties as 'Performance under-review' and greater than 20 non-compliant specialties as 'Under-performing'. Specialty compliance is a significant challenge for acute providers nationally and this is reflected in the threshold value for an 'Under-performing' rating. During Quarter 1 2012/13, WSHT has committed to establishing compliance in seven non-compliant specialty lines relating to five actual specialties (3 specialties in non-admitted pathways and 5 specialties in incomplete).
- Maximum diagnostic test waiting times in which no greater than 1% of diagnostic patients wait greater than 6 weeks for their test.
- Inclusion of Mixed Sex Accommodation breach volumes. No breaches of this standard were reported in 2011/12 and matching compliance is forecast for 2012/13.
- Inclusion of VTE assessment against the retained standard of 90%. Performance in Quarter 4 2011/12 ran at 92.1%, and is forecast to improve in 2012/13 to greater than 95% linked to the roll out of the Patient Track near patient reporting tool.

4.3 Metrics removed from the NHS Performance Framework are:

- The 2011/12 stroke metric (patients who have spent 90% of their stay in hospital on a stroke unit).
- All targets relating to the 95$^{th}$ percentile performance for referral to treatment

4.4 To aid the Board in assessing performance risk linked to the changes in assessment metrics and criteria, **Appendices 2** and **3** demonstrate forecast Quarter 1 positions against the operational standards set for 2012/13 for both the NHS Performance Framework and the Monitor Compliance Framework. This notional assessment shows a projected score of 2.93 against the NHS

Performance Framework mechanism and would therefore achieve the highest possible rating being 'Performing'. Board members should note that the highest possible score is 3, and in that context 2.93 is exceptionally high relative to national benchmarks and significantly ahead of the 2.4 points below which an organisation would be assessed as 'Performance Under Review'

4.5 The Monitor Compliance Framework metric set remains unchanged other than the inclusion of the RTT incomplete pathways metric. Monitor does however differ from the NHS Performance Framework in the way it incorporates the RTT metrics. Whilst Monitor includes incomplete pathways, these are performance managed on an aggregate basis only rather than by specialty. Monitor have also adopted a cap mechanism relating to RTT metrics based on the clear logic that an organisation failing admitted and non admitted pathways would also by default commit an organisation to failure of the incomplete pathway. Should aggregate performance against completed admitted pathways, non-admitted pathways and incomplete pathways not achieve target, the Trust would generate 2 rather than 3 penalty points as performance risk is capped at 2 points.

4.6 As per NHS Performance Framework, Monitor has removed the 2011/12 RTT metrics relating to 95$^{th}$ percentile waiting times.

4.7 The Trust anticipates achieving a Monitor Compliance Framework score of zero points in Quarter 1 of 2012/13 therefore generating a GREEN rating.

**RECOMMENDATION**

5.1 The Board is asked to receive and note the in month performance positions for March 2011/12. Additionally, Board Members are asked to note the score of 0 penalty points against the Monitor Compliance Framework and 2.93 points against the NHS Performance Framework in Quarter 4, both of which represent the highest score able to be achieved by the Trust.

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

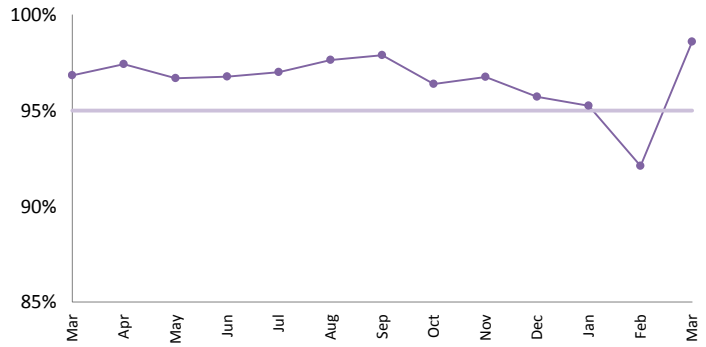
18 April 2012

# Key Performance Deliverables Report

MARCH 2012

## A&E 4-hour waiting time target

| Target | Month | YTD | Projected O/T |
|---|---|---|---|
| 95% | 98.60% | 96.57% | >95% |




**Description / Comments / Actions**

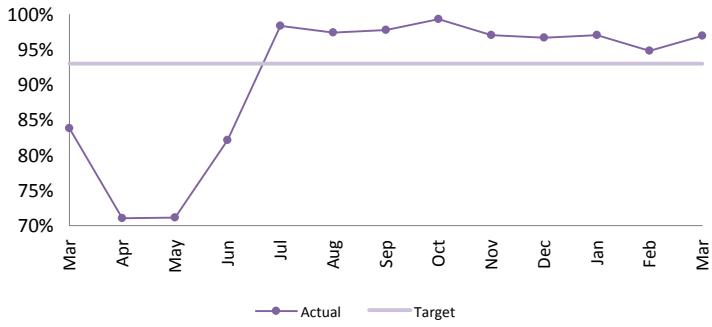
Patients can expect to be admitted, tranfered or discharged in 4 hours from arrival in A&E

Significant increase in crude demand and underlying acuity

**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 appt - Breast symptoms

| Target | Month | YTD | Projected O/T |
|---|---|---|---|
| 93% | 96.97% | 91.33% | >93% |




**Description / Comments / Actions**

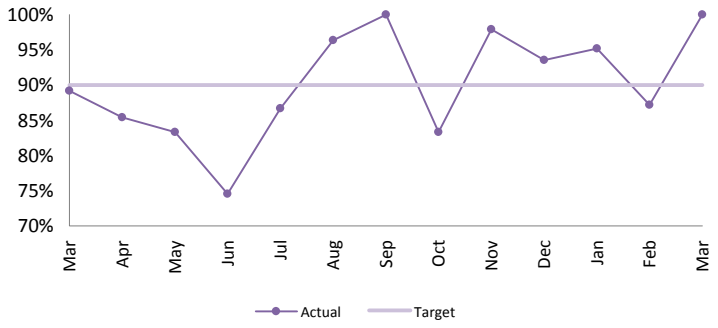
Patients with breast symptoms can expect to be seen within 2 weeks following an urgent GP referral.

Imbalance of demand by site, and ability to align available capacity to that demand . Patients offered to attend St Richards whilst capacity constrained at Worthing, but many choose to wait beyond two weeks to stay at Worthing.

Actions:
1. Fundimental re-design of 2 week rule processes intoduced in June 2011. Complinance since introduction improved by circa 10%, and fully compliance expected from July 2011.
2. Close working with the screening service to maximise the time available to the Trust to secure capacity
3. Dedicated weekly action focused delivery meeting under the leadership of the Chief Operating Officer

## Cancer - 62 days from referral to treatment following screening contact

| Target | Month | YTD | Projected O/T |
|---|---|---|---|
| 90% | 100% | 90.87% | >90% |




**Description / Comments / Actions**

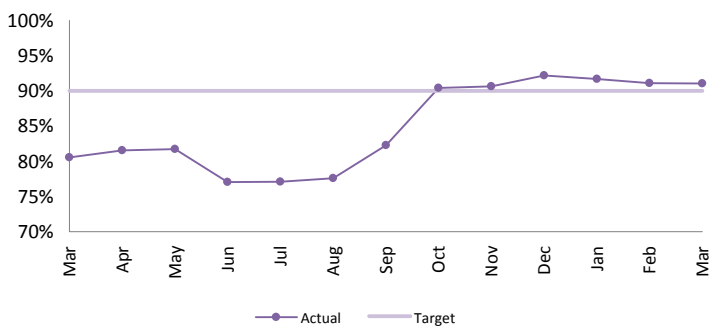
Patients with cancer can expect to commence treatment within 62 days following referral after a positive screening test.

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

Actions:
1. Ongoing capacity and process review being undertaken by the Cancer team
2. Close working with the screening service to maximise the time available to the Trust to secure capacity
3. 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% | 91.04% | 85.41% | > 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, and consequent reduction in compliant pathways. Detailed action programme submitted to SECSHA.

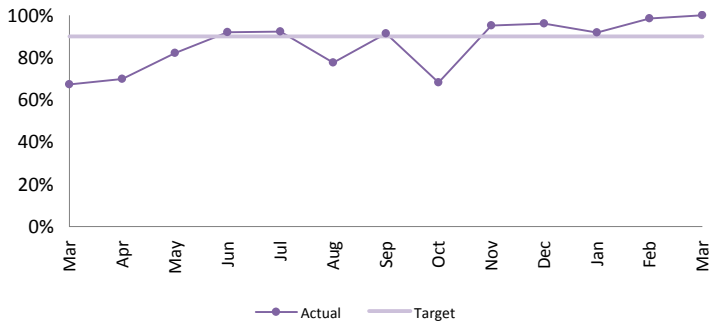
Actions:
1. Short term increase in internal and external capacity
2. LHC review of referral protocols
3. Change of Pathways to expand direct access diagnostics
4. Engagement with Local health economy stakeholders with QIPP plans to reduce referral demand
5. Streamlining of MSK triage services
6. Dedicated weekly action focused delivery meeting under the leadership of the Chief Operating Officer

# Key Performance Deliverables Report

MARCH 2012

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

| Target | Month | YTD | Projected O/T |
|---|---|---|---|
| 90% | 100.0% | 87.6% | >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 significantly impacted sustained compliance. Mitigating actions implemented by the Surgical Division have significantly improved performance, with provisional June data showing full compliance.

Actions:

1. An increase of 60% in trauma capacity to help mitigate demand pressure.
2. Improvement in escalation processes 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
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# OPERATIONAL PERFORMANCE SCORECARD

## MARCH 2012

| | Key performance Indicators | | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | MAR | 2011/12 YTD | 2011/12 Target | FOT | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **PATIENT EXPERIENCE** | *NB* | | | | | | | | | | | | | | | | | |
| 1.11 | A&E : Four-hour maximum wait from arrival to admission, transfer or discharge | | 96.84% | 97.43% | 96.68% | 96.77% | 97.01% | 97.65% | 97.90% | 96.39% | 96.76% | 95.72% | 95.24% | 92.10% | 98.60% | 96.57% | 95% | 98% | |
| 1.12 | A&E : Left without being seen (Shadow monitoring - Targets effective from Q2) | | - | 3.72% | 3.16% | 2.88% | 2.58% | 2.26% | 2.11% | 2.42% | 2.18% | 2.57% | 2.15% | 2.71% | 2.30% | 2.36% | 5% from Q2 | <5% | |
| 1.13 | A&E : Time to initial assessment (95th percentile mins) (Shadow monitoring - Targets effective from Q2) | | - | 116 | 66 | 29 | 11 | 10 | 11 | 11 | 11 | 12 | 12 | 8 | 3 | 10 | 15 from Q2 | 15 | |
| 1.14 | A&E : Time to treatment decision (median mins) (Shadow monitoring - Targets effective from Q2) | | - | 66 | 63 | 56 | 61 | 56 | 57 | 58 | 54 | 52 | 52 | 53 | 56 | 56 | 60 from Q2 | <60 | |
| 1.15 | A&E : Total time in A&E (95th percentile mins) (Shadow monitoring - Targets effective from Q2) | | - | 239 | 239 | 239 | 239 | 239 | 238 | 240 | 239 | 240 | 240 | 331 | 237 | 239 | 240 from Q2 | <240 | |
| 1.16 | A&E : Unplanned reattendance rate (Shadow monitoring - Targets effective from Q2) | | - | 3.49% | 3.28% | 2.83% | 2.69% | 2.67% | 2.65% | 2.41% | 2.32% | 2.07% | 2.29% | 2.44% | 2.75% | 2.48% | 5% from Q2 | <5% | |
| 1.17 | A&E Data completeness : Attendances reported on weekly SITREP vs attendances reported via SUS | | - | 100.0% | 99.4% | 100.0% | 99.6% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.8% | 90-110% | 100% | |
| 1.21 | Cancelled ops - breaches of 28 days readmission guarantee | 1 | 0.00% | 9.09% | 4.65% | 3.57% | 14.29% | 0.00% | 0.00% | 6.00% | 2.67% | 0.00% | 1.82% | 4.55% | 0.00% | 3.19% | 5% | <5% | |
| 1.31 | 2 week GP referral to 1st outpatient | 1 | 93.35% | 91.85% | 85.80% | 94.35% | 98.39% | 98.65% | 97.79% | 97.55% | 98.24% | 97.01% | 96.22% | 97.70% | 97.23% | 95.93% | 93% | 93% | |
| 1.32 | 2 week GP referral to 1st outpatient - breast symptoms | 1 | 83.84% | 71.1% | 71.1% | 82.1% | 98.37% | 97.39% | 97.78% | 99.30% | 97.02% | 96.67% | 97.06% | 94.80% | 96.97% | 91.33% | 93% | 93% | |
| 1.33 | Cancer: 31 day second or subsequent treatment - surgery | 1 | 97.92% | 100.0% | 100.0% | 97.06% | 100.0% | 97.78% | 100.0% | 100.0% | 97.1% | 100.0% | 100.0% | 96.8% | 88.2% | 98.21% | 94% | 100% | |
| 1.34 | Cancer: 31 day second or subsequent treatment - drug | 1 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 95.83% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.62% | 98% | 100% | |
| 1.35 | Cancer: 31 day diagnosis to treatment for all cancers | 1 | 98.12% | 97.94% | 98.48% | 98.25% | 98.54% | 99.03% | 99.1% | 95.07% | 96.08% | 98.17% | 98.17% | 99.53% | 100.0% | 98.18% | 96% | 98% | |
| 1.36 | Cancer: 62 day referral to treatment from screening | 1 | 89.17% | 85.42% | 83.33% | 74.55% | 86.67% | 96.36% | 100.0% | 83.33% | 97.92% | 93.55% | 95.16% | 87.18% | 100.0% | 90.87% | 90% | 90% | |
| 1.38 | Cancer: 62 day referral to treatment from hospital specialist | 1 | 89.09% | 100.0% | 64.29% | 100.0% | 79.17% | 96.55% | 90.48% | 100.0% | 100.0% | 100.0% | 96.9% | 100.0% | 88.6% | 93.84% | 85% | 85% | |
| 1.39 | Cancer: 62 days urgent GP referral to treatment of all cancers | 1 | 88.05% | 86.63% | 79.40% | 83.47% | 89.20% | 91.10% | 92.15% | 93.21% | 93.12% | 92.06% | 90.83% | 87.39% | 91.11% | 89.01% | 85% | 85.0% | |
| 1.41 | Number of complaints relating to staff attitude or behaviour/10,000 admissions | | - | 4.37 | 3.02 | 1.97 | 5.00 | 1.88 | 2.90 | 3.91 | 6.71 | 3.05 | 2.94 | 2.95 | 7.58 | 3.86 | tbc | | |
| 1.42 | Number of nursing complaints per 10,000 bed days | | 2.40 | 3.78 | 3.85 | 3.27 | 1.47 | 1.85 | 2.29 | 2.56 | 1.15 | 0.76 | 0.38 | 1.16 | 1.54 | 2.07 | 4.35 | | |
| 1.51 | DSSA - Breaches of mixed sex accomodation guidance | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| 1.61 | Patient survey: How good was the overall quality of care you received? | | - | 8/10 | | | | | | | | | | | | | n/a | | |
| 1.71 | RTT - admitted - 90% in 18 weeks | | 80.6% | 81.6% | 81.7% | 77.0% | 77.1% | 77.6% | 82.3% | 90.4% | 90.6% | 92.2% | 91.7% | 91.1% | 91.0% | 85.4% | 90% | 90% | |
| 1.72 | RTT - admitted - 95th percentile | | 26.8 | 28.5 | 27.3 | 31.6 | 29.5 | 28.0 | 25.8 | 21.9 | 22.1 | 20.9 | 21.8 | 22.8 | 21.8 | 25.5 | 23 | 23 | |
| 1.73 | RTT - incomplete - 95th percentile | | 28.6 | 27.8 | 26.6 | 24.7 | 24.2 | 24.3 | 23.8 | 22.7 | 22.8 | 23.9 | 24.4 | 23.8 | 22.3 | 24.4 | 28 | 28 | |
| 1.74 | RTT - non-admitted - 95% in 18 weeks | | 95.5% | 95.7% | 96.0% | 96.9% | 95.7% | 95.6% | 96.3% | 95.9% | 96.2% | 95.9% | 96.1% | 95.0% | 95.1% | 95.9% | 95% | 95% | |
| 1.75 | RTT - non-admitted - 95th percentile | | 17.6 | 17.1 | 16.7 | 15.6 | 16.9 | 17.0 | 16.3 | 16.9 | 16.7 | 16.9 | 17.0 | 18.0 | 17.9 | 16.9 | 18.3 | 18 | |
| 1.81 | Composite patient experience score (national CQUIN) | | - | | | | | | | | | | | | | 67.3 | | 67.3 | |

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# OPERATIONAL PERFORMANCE SCORECARD

## MARCH 2012

| | Key performance Indicators | | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | MAR | 2011/12 YTD | 2011/12 Target | FOT | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **OUTCOMES** | | | | | | | | | | | | | | | | | | | |
| 2.11 | Crude mortality (Trust-wide) rate | | 3.93% | 3.57% | 3.38% | 3.11% | 2.60% | 2.86% | 2.97% | 3.36% | 2.85% | 3.09% | 4.12% | 3.90% | 3.27% | 3.29% | 3.40% | 3.20% | |
| 2.12 | HSMR (Trust-wide) | | 104.8 | 105.1 | 105.0 | 104.9 | 104.4 | 103.8 | 103.2 | 102.3 | 101.3 | 99.3 | 98.9 | | | 98.9 | 104 | | |
| 2.21 | HSMR #NOF | | 138.4 | 141.6 | 135.3 | 130.9 | 130.4 | 135.0 | 136.4 | 136.3 | 135.9 | 131.0 | 120.0 | | | 120.0 | | | |
| 2.22 | % hip fracture repair within 36 hours | | 67.2% | 69.8% | 82.1% | 91.9% | 92.3% | 77.6% | 91.4% | 68.1% | 95.1% | 96.0% | 91.8% | 98.5% | 100.0% | 87.6% | 90% | 90% | |
| 2.41 | Patients that have spent more than 90% of their stay in hospital on a stroke unit+ | 1 | 80.6% | 87.7% | 84.8% | 81.3% | 80.6% | 80.0% | 75.8% | 84.8% | 81.3% | 85.5% | 81.6% | 84.5% | | 82.5% | 80% | 80.0% | |
| 2.42 | % Higher risk TIA patients scanned & treated within 24 hrs+ | 1 | 61.1% | 85.7% | 30.0% | 84.2% | 58.3% | 25.0% | 85.7% | 57.1% | 57.1% | 22.2% | 53.8% | 76.5% | | 60.7% | 60.0% | 60.0% | |
| **SAFETY** | | | | | | | | | | | | | | | | | | | |
| 3.11 | Number of reported patient falls per 10,000 bed days | | 15.5 | 17.4 | 18.22 | 11.98 | 15.39 | 17.76 | 14.50 | 14.64 | 13.75 | 12.60 | 13.36 | 16.22 | 18.92 | 15.10 | tbc | | |
| 3.21 | Incidence of C Diff. | | 9 | 11 | 6 | 7 | 5 | 5 | 9 | 9 | 3 | 8 | 3 | 3 | 7 | 76 | 90 | 90 | |
| 3.22 | Incidence of MRSA | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 6 | |
| 3.31 | Number of prescribing-associated incidents graded moderate or severe | | - | 0 | 1 | 1 | 0 | 1 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 6 | 8 | | |
| 3.41 | Pressure Ulcer Incidence per 1000 occupied bed days | | 0.79 | 0.52 | 0.42 | 0.44 | 0.44 | 0.44 | 0.11 | 0.59 | 0.50 | 0.46 | 0.46 | 0.62 | 0.46 | 0.45 | 3.3 | 1 | |
| 3.42 | % inpatients assessed for VTE risk using national tool | 2 | 93.1% | 91.4% | 91.9% | 91.9% | 92.0% | 90.8% | 90.7% | 90.2% | 91.0% | 89.9% | 92.2% | 92.3% | 91.7% | 91.3% | 90% | 95% | |
| **BEING JOINED UP** | | | | | | | | | | | | | | | | | | | |
| 4.11 | Delayed transfers of care | 2 | 3.2% | 3.9% | 4.5% | 3.1% | 4.1% | 3.1% | 4.0% | 3.3% | 4.5% | 1.8% | 2.5% | 1.8% | 1.8% | 3.2% | 3.5% | 3.5% | |
| 4.21 | Number of Emergency admissions | | 4,196 | 3,960 | 4,116 | 3,896 | 4,056 | 4,138 | 3,954 | 4,171 | 3,967 | 4,165 | 4,205 | 4,167 | 4,412 | 49,207 | < 10/11 | | |
| **IMPROVEMENT** | | | | | | | | | | | | | | | | | | | |
| 5.11 | Theatre utilisation | | 95.0% | 94.5% | 93.1% | 94.8% | 88.1% | 87.1% | | | | | | | | 91.4% | 90.0% | 93% | |
| 5.21 | Average length of stay - Elective | | 3.44 | 3.82 | 3.38 | 3.55 | 3.63 | 3.19 | 3.16 | 3.79 | 3.04 | 3.44 | 3.45 | 3.55 | 3.46 | 3.45 | 3.72 | 3.6 | |
| 5.22 | Average length of stay - Non-elective Surgery | | 6.23 | 4.97 | 5.78 | 5.47 | 5.43 | 4.91 | 5.81 | 5.02 | 5.13 | 5.88 | 5.49 | 5.95 | 5.13 | 5.41 | 6.07 | 6.0 | |
| 5.23 | Average length of stay - Non-elective Medicine | | 7.87 | 7.74 | 7.84 | 7.98 | 7.51 | 7.47 | 7.58 | 7.26 | 7.48 | 7.18 | 7.48 | 7.37 | 7.40 | 7.52 | 7.80 | 7.8 | |
| 5.31 | Day case surgery rate (BADS Directory 2010 source: CHKS) | | 79.4% | 77.1% | 78.8% | 80.9% | 76.9% | 79.1% | 77.0% | 77.9% | 78.4% | 78.6% | 82.3% | | | 78.7% | 75.0% | 80% | |
| 5.61 | Elective day of surgery rate (DOSR) | | 96.7% | 95.7% | 95.6% | 96.4% | 96.5% | 95.4% | 95.6% | 95.4% | 94.9% | 93.6% | 94.7% | 95.7% | 95.9% | 95.4% | 90.0% | 95% | |
| 5.41 | Did not attend rate (outpatients) | | 5.82% | 6.06% | 6.07% | 5.74% | 5.94% | 5.76% | 6.25% | 6.06% | 5.65% | 5.81% | 6.25% | 5.40% | 5.81% | 5.79% | 7.65% | 6.0% | |
| 5.51 | Clinical Data Quality | | 93.3% | 93.0% | 93.3% | 93.3% | 93.3% | 93.4% | 93.3% | 93.0% | 94.1% | 94.1% | 93.6% | | | 93.7% | 90.9% | 93% | |

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# OPERATIONAL PERFORMANCE SCORECARD

## MARCH 2012

| | Key performance Indicators | | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | MAR | 2011/12 YTD | 2011/12 Target | FOT | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SUSTAINABILITY** | | | | | | | | | | | | | | | | | | | |
| 6.11 | Bank and Agency Utilisation Rate | | 11.5% | 11.8% | 8.0% | 10.4% | 10.6% | 10.4% | 10.2% | 9.6% | 10.1% | 10.1% | 8.8% | 9.3% | 10.7% | 10.0% | 5.0% | | |
| 6.12 | Sickness Absence: % Sickness (reported one month in arrears) | 3 | 3.62% | 3.10% | 2.93% | 3.27% | 3.12% | 2.99% | 3.57% | 3.57% | 3.70% | 4.03% | 4.42% | 4.09% | | 3.53% | 3.6% | | |
| 6.13 | Staff Turnover: Turnover rate (YTD position) | | 7.38% | 7.13% | 7.19% | 7.39% | 7.65% | 7.76% | 7.86% | 7.95% | 8.07% | 8.18% | 8.08% | 8.40% | 8.60% | 8.60% | 11.0% | | |

Notes

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

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

3 Staff sickness is reported one month in arrears.

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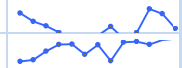
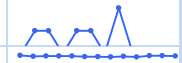
# CORPORATE OBJECTIVES

## MARCH 2012

| | Key performance Indicator(s) | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | MAR | This year to date | YTD Target | Target | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **PATIENT EXPERIENCE** | | | | | | | | | | | | | | | | | | |
| PE1 | Patient survey: How good was the overall quality of care you received? | - | - | - | - | - | - | - | - | - | - | - | | | 8/10 | | | |
| PE2 | Number of complaints relating to staff attitude or behaviour/10,000 admissions | - | 4.37 | 3.02 | 1.97 | 5.00 | 1.88 | 2.90 | 3.91 | 6.71 | 3.05 | 2.94 | 2.95 | 7.58 | 3.86 | tbc | tbc | |
| PE3 | Composite patient experience score (national CQUIN) | - | - | - | - | - | - | - | - | - | - | - | | | 67.3 | | | |
| **OUTCOMES** | | | | | | | | | | | | | | | | | | |
| OC1 | HSMR (Trust-wide) | 104.8 | 105.1 | 105.0 | 104.9 | 104.4 | 103.8 | 103.2 | 102.3 | 101.3 | 99.3 | | | | 99.3 | 104 | 103 |  |
| OC2 | Crude mortality (Trust-wide) rate | 3.93% | 3.57% | 3.38% | 3.11% | 2.60% | 2.86% | 2.97% | 3.36% | 2.85% | 3.09% | 4.12% | 3.90% | 3.27% | 3.29% | 3.3% | 3.2% |  |
| OC4 | % hip fracture repair within 36 hours | 67.2% | 69.8% | 82.1% | 91.9% | 92.3% | 77.6% | 91.4% | 68.1% | 95.1% | 96.0% | 91.8% | 98.5% | 100.0% | 87.6% | 90% | 90% |  |
| OC5 | HSMR #NOF (all diagnoses / procedures) | 138.4 | 141.6 | 135.3 | 130.9 | 130.4 | 135.0 | 136.4 | 136.3 | 135.9 | 131.0 | | | | **131.0** | | |  |
| **SAFETY** | | | | | | | | | | | | | | | | | | |
| SY1 | Incidence of MRSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 6 | 6 | |
| SY2 | Incidence of C Diff. | 9 | 11 | 6 | 7 | 5 | 5 | 9 | 9 | 3 | 8 | 3 | 3 | 7 | **76** | 90 | 90 |  |
| SY3 | Number of prescribing-associated incidents graded moderate or severe | - | 0 | 1 | 1 | 0 | 1 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 6 | 6 | 8 |  |
| SY5 | % inpatients assessed for VTE risk using national tool | 93.1% | 91.4% | 91.9% | 91.9% | 92.0% | 90.8% | 90.7% | 90.2% | 91.0% | 89.9% | 92.2% | 92.3% | 91.7% | 91.3% | 95% | 95% | |
| **LOCAL SERVICES** | | | | | | | | | | | | | | | | | | |
| LS1 | Service Redesign for Quality | - | | | | | | | | | | | | | | | | |
| LS2 | Pathway Redesign | | | | | | | | | | | | | | | | | |
| LS3 | Clinical Service Strategy | | | | | | | | | | | | | | | | | |
| **BEING JOINED UP** | | | | | | | | | | | | | | | | | | |
| JU1 | Achievement of Local and Regional CQUIN goals | | | | | | | | | | | | | | | | | |
| JU2 | % patient eligible episodes attracting Best Practice Tariffs | - | 52.3% | 57.1% | 54.7% | 53.6% | 58.1% | 56.5% | 59.7% | 59.6% | 59.5% | | | | 55.0% | 80% | 80% |  |
| JU3 | Reduction in Number of Emergency Admissions | 4,196 | 3,960 | 4,116 | 3,896 | 4,056 | 4,138 | 3,954 | 4,171 | 3,967 | 4,165 | 4,205 | 4,167 | 4,412 | **49,207** | < 2010/11 | < 2010/11 |  |

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# CORPORATE OBJECTIVES

## MARCH 2012

| | Key performance Indicator(s) | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | MAR | This year to date | YTD Target | Target | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **IMPROVEMENT** | | | | | | | | | | | | | | | | | | |
| I1 | Overall staff engagement score (covers motivation, improvement and recommending trust to others) | | | | | | | | | | | | | | | | | |
| I2 | Staff appraisal rate (YTD position) | - | 85% | 84% | 75% | 68% | 64% | 62% | 68% | 74% | 77% | 79% | 80% | 81% | 81% | 95% | 95% |  |
| I3 | Improve our service improvement capacity | | | | | | | | | | | | | | | | | |
| I4 | WHO Theatre Safety Checklist | | 89% | | | 97% | | | 96% | | | | | | **94%** | tbc | tbc | |
| **SUSTAINABILITY** | | | | | | | | | | | | | | | | | | |
| S1 | Service Line Management Roll out | - | | | | | | | | | | | | | | | | |
| S2 | Financial Risk Rating | - | - | - | - | - | 2 | 3 | 3 | 3 | 3 | 3 | 3 | | 3 | 3 | 3 | |
| S3 | CIP savings - % saved against plan | - | - | - | - | - | 81% | 82% | | 97% | 98% | 101% | 98% | | 0% | 100% | 100% | |
| S4 | Foundation Trust status approved | - | | | | | | | | | | | | | | Approved | Approved | |
| S5 | Monitor quality governance risk | - | | | | | | | | | | | | | | | | |
| S6 | Monitor performance compliance framework score | - | 2.5 | 2.5 | 2.5 | 2.0 | 1.0 | 1.0 | 1.0 | 0.5 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | <1.0 | <1.0 | |

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# NHS Performance Framework

## MARCH 2012

| | Key performance Indicators | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | MAR | 2011/12 YTD | 2011/12 Target | Under Pf Threshold | Weighting | Q1 PF Score | Q2 PF Score | Q3 PF Score | Q4 PF Score | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| N1 | Four-hour maximum wait in A&E from arrival to admission, transfer or discharge | 96.84% | 97.43% | 96.68% | 96.77% | 97.01% | 97.65% | 97.90% | 96.39% | 96.76% | 95.72% | 95.24% | 92.10% | 98.60% | **96.57%** | 95% | 94% | 1.00 | 3 | 3 | 3 | 3 | |
| N2 | A&E Data completeness : Attendances reported on weekly SITREP vs attendances reported via SUS | - | 100.0% | 99.4% | 100.0% | 99.6% | 100.0% | 100.0% | 99.9% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | **99.8%** | 90-110% | >120% or <80% | 0.00 | 3 | n/a | n/a | n/a | |
| N3 | AAE Data Quality | - | PASS | PASS | PASS | PASS | PASS | PASS | PASS | PASS | PASS | PASS | PASS | PASS | **PASS** | Range of DQ checks applied to CDS data | | 0.00 | 3 | | | | Trend data n/a |
| N3 | Unplanned re-attendance rate - Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by | - | Targets applicable from Quarter 2 2011/12 | | | 2.69% | 2.67% | 2.65% | 2.41% | 2.32% | 2.07% | 2.29% | 2.44% | 2.75% | **2.48%** | See notes (1) | | 2.00 | n/a | 3 | 3 | 3 | |
| N4 | Left department without being seen rate | - | | | | 2.58% | 2.26% | 2.11% | 2.42% | 2.18% | 2.57% | 2.15% | 2.71% | 2.30% | **2.36%** | | | | | | | | |
| N5 | Time to initial assessment - 95th percentile | - | | | | 11 | 10 | 11 | 11 | 11 | 12 | 12 | 8 | 3 | **10** | | | | | | | | |
| N6 | Time to treatment in department - median | - | | | | 61 | 56 | 57 | 58 | 54 | 52 | 52 | 53 | 56 | **56** | | | | | | | | |
| N26 | Total time in departement - 95th percentile | - | | | | 239 | 239 | 238 | 240 | 239 | 240 | 240 | 331 | 237 | **239** | | | | | | | | |
| N7 | Cancelled ops - breaches of 28 days readmission guarantee as % of cancelled ops | 0.00% | 9.09% | 4.65% | 3.57% | 14.29% | 0.00% | 0.00% | 6.00% | 2.67% | 0.00% | 1.82% | 4.55% | 0.00% | **3.19%** | 5% | 15% | 1.00 | 2 | 2 | 3 | 3 | |
| N8 | MRSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 6 | >1SD* | 1.00 | 3 | 3 | 3 | 3 | |
| N9 | C Diff | 9 | 11 | 6 | 7 | 5 | 5 | 9 | 9 | 3 | 8 | 3 | 3 | 7 | **76** | 90 | >1SD | 1.00 | 3 | 3 | 3 | 3 | |
| N10 | RTT - admitted - 95th percentile | 26.8 | 28.5 | 27.3 | 31.6 | 29.5 | 28.0 | 25.8 | 21.9 | 22.1 | 20.9 | 21.8 | 22.8 | 21.8 | **25.5** | 23 | >27.7 | 0.50 | 0 | 0 | 3 | 3 | |
| N11 | RTT - non-admitted - 95th percentile | 17.6 | 17.1 | 16.7 | 15.6 | 16.9 | 17.0 | 16.3 | 16.9 | 16.7 | 16.9 | 17.0 | 18.0 | 17.9 | **16.9** | 18.3 | | 0.50 | 3 | 3 | 3 | 3 | |
| N12 | RTT - incomplete - 95th percentile | 28.6 | 27.8 | 26.6 | 24.7 | 24.2 | 24.3 | 23.8 | 22.7 | 22.8 | 23.9 | 24.4 | 23.8 | 22.3 | **24.4** | 28 | >36 | 0.50 | 3 | 3 | 3 | 3 | |
| N13 | RTT - admitted - 90% in 18 weeks | 80.6% | 81.6% | 81.7% | 77.0% | 77.1% | 77.6% | 82.3% | 90.4% | 90.6% | 92.2% | 91.7% | 91.1% | 91.0% | 85.4% | 90% | 85% | 0.75 | 0 | 0 | 3 | 3 | |
| N14 | RTT - non-admitted - 95% in 18 weeks | 95.5% | 95.7% | 96.0% | 96.9% | 95.7% | 95.6% | 96.3% | 95.9% | 96.2% | 95.9% | 96.1% | 95.0% | 95.1% | 95.9% | 95% | 90% | 0.75 | 3 | 3 | 3 | 3 | |
| N15 | Cancer: 2 week GP referral to 1st outpatient | 93.35% | 91.85% | 85.80% | 94.35% | 98.39% | 98.65% | 97.79% | 97.55% | 98.24% | 97.01% | 96.22% | 97.70% | 97.23% | **95.93%** | 93% | 88% | 0.50 | 2 | 3 | 3 | 3 | |
| N16 | Cancer: 2 week GP referral to 1st outpatient - breast symptoms | 83.84% | 71.1% | 71.1% | 82.1% | 98.37% | 97.39% | 97.78% | 99.30% | 97.02% | 96.67% | 97.06% | 94.80% | 96.97% | 91.33% | 93% | 88% | 0.50 | 0 | 3 | 3 | 3 | |
| N17 | Cancer: 31 day second or subsequent treatment - surgery | 97.92% | 100.0% | 100.0% | 97.06% | 100.0% | 97.78% | 100.0% | 100.0% | 97.1% | 100.0% | 100.0% | 96.77% | 88.24% | **98.21%** | 94% | 89% | 0.25 | 3 | 3 | 3 | 3 | |
| N18 | Cancer: 31 day second or subsequent treatment - drug | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 95.83% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | **99.62%** | 98% | 93% | 0.25 | 3 | 3 | 3 | 3 | |
| N19 | Cancer: 31 day diagnosis to treatment for all cancers | 98.12% | 97.94% | 98.48% | 98.25% | 98.54% | 99.03% | 99.1% | 95.07% | 96.08% | 98.17% | 98.17% | 99.53% | 100.00% | **98.18%** | 96% | 91% | 0.25 | 3 | 3 | 3 | 3 | |
| N21 | Cancer: 62 day referral to treatment from screening | 89.17% | 85.42% | 83.33% | 74.55% | 86.67% | 96.36% | 100.0% | 83.33% | 97.92% | 93.55% | 95.16% | 87.18% | 100.00% | 90.87% | 90% | 85% | 0.50 | 0 | 3 | 3 | 3 | |
| N23 | Cancer: 62 days urgent GP referral to treatment of all cancers | 88.05% | 86.63% | 79.40% | 83.47% | 89.20% | 91.10% | 92.15% | 93.21% | 93.12% | 92.06% | 90.83% | 87.39% | 91.11% | **89.01%** | 85% | 80% | 0.50 | 2 | 3 | 3 | 3 | |
| N24 | Patients that have spent more than 90% of their stay in hospital on a stroke unit | - | 57.5% (2009/10 CQC assessment) | | | | | | | | | | | | 57.5% | 60% | 30% | 1.00 | 2 | 2 | 2 | 2 | |
| N25 | Delayed transfers of care | 3.2% | 3.9% | 4.5% | 3.1% | 4.1% | 3.1% | 4.0% | 3.3% | 4.5% | 1.8% | 2.5% | 1.8% | 1.8% | 3.2% | 3.5% | 5.0% | 1.00 | 2 | 2 | 3 | 3 | |
| | TOTAL WEIGHTED PERFORMANCE | | | | | | | | | | | | | | | | | | 2.09 | 2.51 | 2.93 | 2.93 | |

Individual measures are scored as follows: Underperforming 0 Performance under review 2 Performing 3

Overall performance threshold: Underperforming when weighted score less than 2.1 (Red) Performance under review when weighted score between 2.1 and 2.4 (Amber) Performing when weighted score above 2.4 (Green)

Notes

1. Achieve the thresholds for at least one indicator in each of the two groups (timeliness - time to initial assessment, time to treatment and patient impact- left without being seen and re-attendance).

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# Monitor Compliance Framework

MARCH 2011

| | Key performance Indicator(s) | Threshold | Weighting | Apr | May | Jun | Q1 | Weighted Score | Jul | Aug | Sep | Q2 | Weighted Score | Oct | Nov | Dec | Q3 | Weighted Score | Jan | Feb | Mar | Q4 | Weighted Score | 2011/12 YTD | FOT Weighted score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Safety** | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 | Clostridium Difficile – meeting the Clostridium Difficile objective | 90 | 1.0 | 11 | 6 | 7 | 24 | 0.0 | 5 | 5 | 9 | 19 | 0.0 | 9 | 3 | 8 | 20 | 0.0 | 3 | 3 | 7 | 13 | 0.0 | 76 | 0 |
| 1.2 | MRSA – meeting the MRSA objective | 6 | 1.0 | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 |
| **Patient Experience** | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2.1 | Referral to treatment waiting times – admitted patients (95th percentile wks) | 23 | 1.0 | 28.5 | 27.3 | 31.6 | 29.3 | 1.0 | 29.5 | 28.0 | 25.8 | 27.8 | 1.0 | 21.9 | 22.1 | 20.9 | 21.6 | 0.0 | 21.8 | 22.8 | 21.8 | 22.3 | 0.0 | 25.5 | 0 |
| 2.1 | Referral to treatment waiting times – non-admitted patients (95th percentile wks) | 18.3 | 1.0 | 17.1 | 16.7 | 15.6 | 16.4 | 0.0 | 16.9 | 17.0 | 16.3 | 16.7 | 0.0 | 16.9 | 16.7 | 16.9 | 16.8 | 0.0 | 17.0 | 18.0 | 17.9 | 17.5 | 0.0 | 16.9 | 0 |
| 2.3 | Certification against compliance with requirements re access to healthcare for people with a learning disability | YES | 0.5 | | | | | | | | | | | | | | | | | | | | | 0 | 0 |
| **Quality** | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3.1 | All cancers : 31-day wait for second or subsequent treatment - surgery treatments | 94% | 1.0 | 100% | 100% | 97.06% | 98.97% | 0.0 | 100% | 97.78% | 100% | 99.19% | 0.0 | 100% | 97.06% | 100% | 97.75% | 0.0 | 100% | 96.77% | 88.24% | 96.34% | 0.0 | 98.21% | 0.0 |
| 3.2 | All cancers : 31-day wait for second or subsequent treatment - drug treatments | 98% | 1.0 | 100% | 100% | 100% | 100% | | 100% | 100% | 95.83% | 98.78% | | 100% | 100% | 100% | 100% | | 100% | 100% | 100% | 100% | | 99.62% | |
| 3.3 | All cancers : 62-day wait for first treatment following urgent GP Referral | 85% | 1.0 | 86.63% | 79.40% | 83.47% | 82.46% | 1.0 | 89.20% | 91.10% | 92.15% | 90.88% | 0.0 | 93.21% | 93.12% | 92.06% | 92.78% | 0.0 | 90.83% | 87.39% | 91.11% | 89.68% | 0.0 | 89.01% | 0 |
| 3.4 | All cancers : 62-day wait for first treatment following consultant screening service referral | 90% | 1.0 | 85.42% | 83.33% | 74.55% | 80.89% | | 86.67% | 96.36% | 100% | 95.59% | | 83.33% | 97.92% | 93.55% | 92.36% | | 95.16% | 87.18% | 100.00% | 95.09% | | 90.87% | 0 |
| 3.5 | All cancers : 31-day wait from diagnosis to first treatment | 96% | 0.5 | 97.94% | 98.48% | 98.25% | 98.26% | 0.0 | 98.54% | 99.03% | 99% | 98.90% | 0.0 | 95.07% | 96.08% | 98.17% | 96.42% | 0.0 | 98.17% | 99.53% | 100.00% | 99.20% | 0.0 | 98.18% | 0 |
| 3.6 | Cancer : two week wait from referral to date first seen - All patients | 93% | 0.5 | 91.85% | 85.80% | 94.35% | 90.74% | 0.5 | 98.39% | 98.65% | 97.79% | 98.28% | 0.0 | 97.55% | 98.24% | 97.01% | 97.63% | 0.0 | 96.22% | 97.70% | 97.23% | 97.08% | 0.0 | 95.93% | 0 |
| 3.7 | Cancer : two week wait from referral to date first seen - Symptomatic breast patients | 93% | 0.5 | 71.05% | 71.14% | 82.14% | 75.05% | | 98.37% | 97.39% | 97.78% | 97.86% | | 99.30% | 97.02% | 96.67% | 97.61% | | 97.06% | 94.80% | 96.97% | 96.20% | | 91.33% | 0 |
| 3.8 | A&E : Total time in A&E (95th percentile mins) | 240 | 1.0<br>3 or more<br><br>0.5<br>2 or less | 239 | 239 | 239 | 239 | 0.0 | 239 | 239 | 238 | 239 | 0.0 | 240 | 239 | 240 | 240 | 0.0 | 240 | 331 | 237 | 303 | 0.0 | 240 | 0 |
| 3.9 | A&E : Time to initial assessment (95th percentile mins) | 15 | | | | | | | 11 | 10 | 11 | 11 | | | | | | | | | | | | - | |
| 4.0 | A&E : Time to treatment decision (median mins) | 60 | | | | | | | 61 | 56 | 57 | 58 | | | | | | | | | | | | - | |
| 4.1 | A&E : Unplanned reattendance rate | 5% | | | | | | | 2.69% | 2.67% | 2.65% | 2.67% | | | | | | | | | | | | - | |
| 4.2 | A&E : Left without being seen | 5% | | | | | | | 2.58% | 2.26% | 2.11% | 2.32% | | | | | | | | | | | | - | |
| 4.3 | Stroke Infdicator (TBC) | TBC | 0.5 | tbc | | | | - | - | | | | - | | | | | - | | | | | - | tbc | tbc |
| | **Monitor Compliance Framework Score** | | | | | | | 2.5 | | | | | 1.0 | | | | | 0.0 | | | | | 0.0 | | 0 |

Green : 0 to < 1.0 | Amber/Green 1.0 to < 2.0 | Amber/Red : 2.0 to < 4.0 | Red : 4.0 or more

## Appendix 2: Quarter 1 Forecast Performance using 2012/13 Performance Framework
## Acute Trusts

### Service Performance for 2012/13

| | Thresholds | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Performance Indicator | Performing | Under-performing | Weighting for PF | WSHT Expected Q1 Performance | Weighted Score | Data frequency | Monthly/QTD/YTD | Data Source |
| Total time in A&E - 95% of patients should be seen within four hours | 95% | 94% | 1 | >95% | 1 | Weekly | QTD | Weekly SitReps |
| MRSA | 0 | >1SD* | 1 | 0 | 1 | Monthly | YTD | HPA, prov |
| C Diff | 75 | >1SD | 1 | < = plan trajectory | 1 | Monthly | YTD | HPA, prov |
| RTT - admitted - 90% in 18 weeks | 90% | 85% | 1 | >90% | 1 | Monthly | Month Actual | Monthly RTT, prov |
| RTT - non-admitted - 95% in 18 weeks | 95% | 90% | 1 | >90% | 1 | Monthly | Month Actual | Monthly RTT, prov |
| RTT - incomplete 92% in 18 weeks | 92% | 87% | 1 | >92% | 1 | Monthly | Month Actual | Monthly RTT, prov |
| RTT delivery in all specialties | 0 | >20 | 1 | 3 specialties non compliant (incomplete pathways) | 0.67 | Monthly | Month Actual | Monthly RTT, prov |
| Diagnostic Test Waiting Times | <1% | 5% | 1 | <1% | 1 | Monthly | Month Actual | Monthly diagnostics data collection - DM01, prov |
| All Cancer Two Week Wait | 93% | 88% | 0.5 | >93% | 0.5 | Monthly | Month Actual | Cancer waits database |
| 2 week GP referral to 1st outpatient - breast symptoms | 93% | 88% | 0.5 | >93% | 0.5 | Monthly | Month Actual | Cancer waits database |
| 31-Day Standard for Subsequent Cancer Treatments-Surgery | 94% | 89% | 0.25 | >94% | 0.25 | Monthly | Month Actual | Cancer waits database |
| 31 day second or subsequent treatment - drug | 98% | 93% | 0.25 | >98% | 0.25 | Monthly | Month Actual | Cancer waits database |
| Percentage of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat') | 96% | 91% | 0.25 | >96% | 0.25 | Monthly | Month Actual | Cancer waits database |
| Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments) | 94% | 89% | 0.25 | >94% | 0.25 | Monthly | Month Actual | Cancer waits database |
| 62-Day Wait for First Treatment Following Referral from an NHS Cancer Screening Service | 90% | 85% | 0.50 | >90% | 0.5 | Monthly | Month Actual | Cancer waits database |
| All Cancer Two Month Urgent Referral to Treatment Wait | 85% | 80% | 0.50 | >85% | 0.5 | Monthly | Month Actual | Cancer waits database |
| Delayed transfers of care | 3.5% | 5.0% | 1 | <3.5% | 1 | Quarterly | Quarter Actual | MSitDT, KH03 and QNCBeds |
| Mixed Sex Accommodation Breaches | 0.0% | 0.5% | 1 | 0 | 1 | Monthly | Month Actual | MSA UNIFY2 Collection, & Inpatient HES |
| VTE Risk Assessment | 90.0% | 80.0% | 1 | >90% | 1 | Quarterly | Quarter Actual | UNIFY2 mandatory quarterly census data return |

| | | | |
|---|---|---|---|
| **Sum of weights** | 14.00 | 13.67 | |
| **Expected Score Q1** | | 2.93 | |
| **Scoring values** | | | |
| | Underperforming: | | 0 |
| | Performance under review: | | 2 |
| | Performing: | | 3 |

| | |
|---|---|
| **Overall performance score threshold** | |
| Underperforming if less than | 2.1 |
| Performance under review if between | 2.1 and 2.4 |

Trusts and PCTs with an outturn number of cases at the level of or better than their plan number will be performance-managed as 'green' or 'achieving'.
Trusts and PCTs whose outturn number of cases is less than or equal to 1 standard deviation above their plan will be performance-managed as 'amber' or 'underachieving', unless one of two special rules apply:
a. if this number is also less than or equal to the best quartile rate, the trust will be performance-managed as 'green' or 'achieving'
or
b. if a trust's outturn number of cases is 5 or more above its plan, it will be performance-managed as 'red' or 'failing'. For a PCT, if the outturn number of cases is 6 or more above its plan, it will be performance-managed as 'red' or 'failing'.
Trusts and PCTs whose outturn number of cases is greater than 1 standard deviation above their plan will be performance-managed as 'red' or 'failing', unless this number is also less than or equal to the best quartile rate, in which case the trust will be performance-managed as 'green' or 'achieving'.

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

**Appendix 3: Quarter 1 Forecast Performance using 2012/13 Performance Framework**

**Acute Trusts**

## Monitor Compliance Framework 2012/13 — Quarter 1 2012/13 Projection

| | Key performance Indicator(s) | Threshold | Weighting | Q1 Projection |
|---|---|---|---|---|
| **Safety** | | | | |
| 1.1 | Clostridium Difficile – meeting the Clostridium Difficile objective | 75 | 1.0 | 0 |
| 1.2 | MRSA – meeting the MRSA objective | 0 | 1.0 | 0 |
| **Patient Experience** | | | | |
| 2.1 | Referral to treatment waiting times – admitted patients (90% seen within 18 weeks) | 90% | 1.0 | 0 |
| 2.1 | Referral to treatment waiting times – non-admitted patients (95% seen within 18 weeks) | 95% | 1.0 | 0 |
| 2.2 | Referral to treatment waiting times - incomplete pathways (92% waiting no longer than 18 weeks) | 92% | 1.0 | 0 |
| 2.3 | Certification against compliance with requirements re access to healthcare for people with a learning disability | YES | 0.5 | 0 |
| **Quality** | | | | |
| 3.1 | All cancers : 31-day wait for second or subsequent treatment - surgery treatments | 94% | 1.0 | 0 |
| 3.2 | All cancers : 31-day wait for second or subsequent treatment - drug treatments | 98% | 1.0 | |
| 3.3 | All cancers : 62-day wait for first treatment following urgent GP Referral | 85% | 1.0 | 0 |
| 3.4 | All cancers : 62-day wait for first treatment following consultant screening service referral | 90% | 1.0 | 0 |
| 3.5 | All cancers : 31-day wait from diagnosis to first treatment | 96% | 0.5 | 0 |
| 3.6 | Cancer : two week wait from referral to date first seen - All patients | 93% | 0.5 | 0 |
| 3.7 | Cancer : two week wait from referral to date first seen - Symptomatic breast patients | 93% | | 0 |
| 3.8 | A&E : Maximum waiting Time of Four Hours from arrival to admission/transfer/discharge (95%) | 95% | 1.0 | 0 |
| **Monitor Compliance Framework Score** | | | | 0 |

**WESTERN SUSSEX HOSPITALS NHS TRUST**

To: Board

Date of Meeting: 26th April 2012 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. |
| Implications for Quality of Care |
| High Quality Care<br>Investing in development of the workforce<br>Sustainable services |
| Financial Implications |
| Supports good financial performance |
| Human Resource Implications |
| As described |
| **Recommendation** |
| **The Board is asked to NOTE the report and APPROVE the Equality Objectives** |
| Consultation |
| n/a |
| Appendices |
| n/a |

This report can be made available in other formats and in other languages. To discuss your requirements please contact Graham Lawrence, Company Secretary, on graham.lawrence@wsht.nhs.uk or 01903 285288.

Western Sussex Hospitals NHS
NHS Trust

To: Trust Board Date: 26 April 2012

From: Denise Farmer, Director of Organisational Development and Leadership Agenda Item: 10

**FOR INFORMATION**

## ORGANISATIONAL DEVELOPMENT AND WORKFORCE REPORT

### 1.00 INTRODUCTION

1.01 This report sets out the key OD and workforce issues at 31 March 2012.

### 2.00 SUMMARY OF PROPOSAL

2.01 In the last 12 months, a significant amount of organisational change impacting on staff has taken place supported by the HR team. This is anticipated to continue as we reconfigure services in line with our clinical strategy and to deliver cost savings. Current change programmes are set out below:

Service Redesign for Quality – the move of inpatient beds from Southlands to Worthing was completed and all staff affected, including facilities staff, transferred to new wards areas and vacancies within the divisions.

The social work support team moved from Southlands to Worthing at the beginning of April

Back Office Review in HR – the new management arrangements which formed the back office review in HR were implemented on 1 April. This has resulted in the co-location of the recruitment functions to St Richards Hospital and medical HR functions to Worthing Hospital. The transfer of medical recruitment and locums will take effect from 1 May.

Patient Transport – the TUPE transfer of 2 staff from the Trust to Brighton and Hove PCT was completed on 1 April.

Potential bed reduction at SRH – over the last 2 years the Medical Division has developed ways of working which has reduced the length of stay for patients on the acute wards at St Richards. This enabled the division to close 21 beds across 3 wards last summer and has also avoided an escalation ward opening this winter. In order to reduce pay costs associated with these bed closures without impacting on clinical quality, plans are now being developed to consolidate beds and reduce the number of wards. Consultation will commence with staff shortly. It is anticipated that whilst there will be a reduction in the number of posts within the Division, redeployment within the Trust will mean there are no staff redundancies.

Sexual Health – the outcome of the tendering process to award the Sexual Health contract to Virgin Health with effect from 1 July 2012 has a significant impact on staff. It is anticipated that, subject to clarification regarding the HIV service, over 160 staff will TUPE transfer to the new provider.

Sussex HIS – work continues with the Sussex HIS to determine how services will be provided to the Trust in future. Four staff will be transferring to the Trust under TUPE during May and a further 2 staff are likely to transfer soon after.

Postgraduate Medical Education Centre – An away day to discuss the future service provision of the two PGME centres is arranged for early May with a view to identifying potential savings through the co-location of teams and the centralisation of services.

2.02 It has been confirmed that staff earning up to £21,000 per year will receive a flat rate pay increase of £250 from 1 April 2012. This will affect staff on Agenda for Change Bands 1-3 and some staff on Band 4. Other staff will be subject to the two-year pay freeze announced in the emergency budget in June 2010.

2.03 A series of workshops for staff on the proposed changes to the NHS Pension scheme in April 2015 have been scheduled for 30 April, 1 May and 10 May. These drop-in sessions aim to provide staff with greater understanding about the reforms. It is anticipated that prior to 2015 a further Choices exercise, similar to that recently undertaken in respect of the 1995 and 2008 scheme, will be undertaken.

2.04 A staff census is currently being undertaken on the Electronic Staff Record (ESR) enabling staff to update their personal record. This supports our obligations under the Data Protection Act of maintaining up to date and accurate records and the Equality Act in monitoring equality data.

2.05 A revised data report is being developed that will link activity, finance and workforce data. This is expected to be in place from May i.e. using April data.

## 3.00 RECOMMENDATION[S]

**The Board is asked to NOTE this paper**

## 4.00 WORKFORCE CAPACITY

4.01 During March the organisation remained under significant pressure to maintain services particularly at Worthing. Erringham ward (escalation area) remains open with 22 beds and is currently being staff by registered nurses from ward areas. This has increased the demand for temporary staff.

4.02 Temporary staffing accounted for 11% of overall workforce capacity during March and the pay spend on agency staff equated to 148 wte compared to 84.73 wte last month. There was a significant increase in month on the pay spend for medical agency staff.

4.03 The Facilities and Estates division continues to rely heavily on the use of temporary staffing and during March this represented 22% of overall workforce capacity. The use of agency staff in the division also increased in month.

## 5.0 WORKFORCE RESOURCING

5.01 At the end of March, the cumulative turnover rate across the Trust was 8.6% with 557 leavers in 2011/12. This is within the Trust's ceiling of 11%. The number of retirements represented 26% of all leavers and was proportionately higher for medical staff and estates/administrative and clerical staff. This will continue to be monitored against known and planned retirements to ensure that clinical quality is not compromised.

## 6.0 WORKFORCE EFFICIENCY

6.01 Sickness absence increased again in February to 3.53%. It is anticipated that the Trust's ceiling of 3.6% by end of March will be met.

6.02 Work to address sickness absence management continues to be a focus within the Divisions. This is a key workstream for 2012/13 where the sickness absence ceilings have been re-set by Divisions with a view to achieving the national ceiling of no more than 3% by 31 March 2014.

6.03 The new Occupational Health and Wellbeing contract with Portsmouth Hospitals commenced on 1 January 2012. Despite 3 unexpected staff vacancies experienced at the time of transfer, a backlog of over 200 management referrals and a number of operational difficulties including IT access on the Worthing site, these have now been resolved. Between 1 January and 31 March 2012, there were 454 management referrals with 20% DNA rate. This will be addressed as briefings to managers take place during May. There were 865 clinical episodes including immunisations, vaccinations, management referrals and workplace assessments.

It has been agreed that formal monitoring against the contractual KPI's will commence from 1 April.

Anecdotal feedback from managers and staff about the new service has been largely positive. A satisfaction survey will be undertaken in due course.

Remedial works to ensure that Horton Court meets the Equality Act is scheduled to start shortly.

6.02 81% of staff had a completed appraisal at the end of March. This is a marginal improvement on last month despite the significant pressure on operational services.

6.03 Overall rate of attendance on statutory and mandatory training as of 31.03.12 is 80% This is a slight decrease of 1.2% from the previous month which is mainly due to the large numbers of staff having to take annual leave in March before the end of the leave year. Attendance on courses has been significantly higher in April and it is therefore anticipated that attendance figures will be up again at the end of the month.

6.04 The new e-learning package has now been launched to provide statutory and mandatory training for all Medical Staff and has been developed to replace both the Induction and Annual Update for medical staff. This training has 15 modules, which can all be completed within 10-15 minutes. Medical Staff will be able to log on and access the training from any computer with internet access (at work or at home). It is hoped that this will provide them with a more flexible training package and them to spend more time providing patient care.

## 7.0 WORKFORCE SKILLS AND DEVELOPMENT

7.01 The Trust's new Learning and Development Centre at 3 Liverpool Gardens in Worthing opened on 9 April. This new facility is a vast improvement on the previous venue, Thakeham House, and provides a high quality environment for learning. Leasing this site will also save the Trust £135,000 per annum running costs.

## 8.0 COMMUNICATIONS AND ENGAGEMENT

8.01 Latest media analysis for the Trust (February) showed a further increase in positive media coverage. More recently this has included coverage of a new maternity teaching aid at Worthing Hospital which allows staff to simulate births. BBC Sussex featured a "birth" using the training aid which is designed to help maternity staff prepare for difficult deliveries and improve their communications skills with women who are in labour.

8.02 A Trust facebook page has been established which includes news and information updates, audio and visual excerpts from media coverage, as well as the opportunity for feedback

8.03 The Trusts first Leaders Network events were held this month – these are a forum for senior figures across the Trust to share experience and learning with colleagues and keep up to date with news, information and developments.

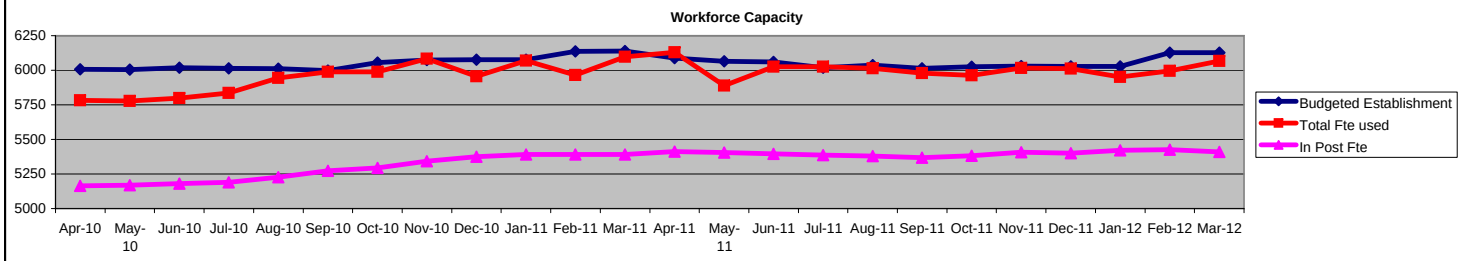
## 9.0 HEALTH AND SAFETY

9.01 Stress surveys are now underway in four areas of the trust. The surveys are designed to identify and prevent stressors that affect the wellbeing of staff. The Health & Safety Executive accept that most staff will experience stress and that stress is part of life. The concern is the potentially harmful effects stress can have on staff if it is not managed appropriately. The surveys are the first step in that management process. Subject to the survey score the HR department will intervene with focus group engagement in an effort to get a clear picture of the problems staff are experiencing and bring about controls to reduce the harmful effects of staff stress.

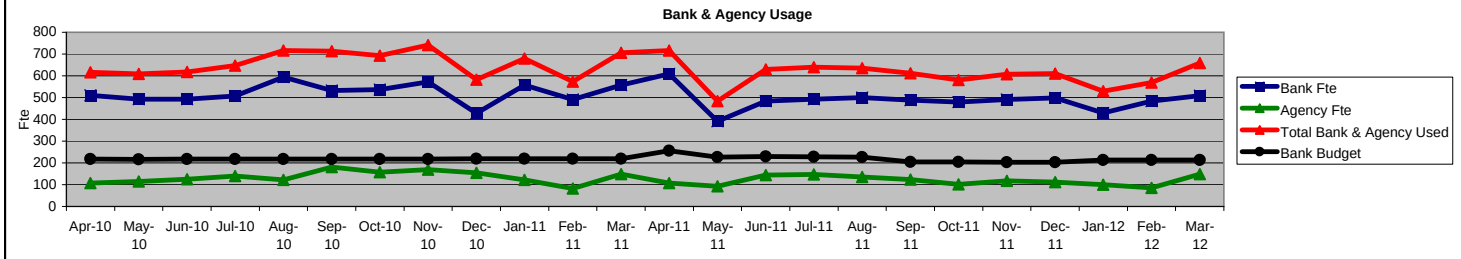
9.02 The Health Safety and Risk policy format has been updated to include a new “easy to read” style. The old policy document has been broken down into very short regulatory led policy statements that cover governance and Approved Codes of Practice which are management driven and cover the means context of Health & Safety management. For the purpose of ratification the policy statements are the only ratified section of the document while the Approved Codes of Practice will be reviewed by the Health & Safety Committee. This will facilitate longer review periods, a shorter ratification process and flexibility to change processes through the Health & Safety Committee quickly.

# Western Sussex Hospitals Trust Workforce Scorecard as at 31st March 2012

**Workforce Capacity**
**Trust Overall Capacity**




| | | Actual | | | | | Substantive | % Temp | |
|---|---|---|---|---|---|---|---|---|---|
| | Budget | Substantive | Bank | Agency | Total Used | Variance | Staff % | Staff used | % Capacity |
| Medicine | 1602.66 | 1411.76 | 166.32 | 65.40 | 1643.48 | 40.82 | **88.09%** | **14.46%** | **102.55%** |
| Surgery | 1323.52 | 1159.32 | 86.40 | 37.65 | 1283.37 | -40.15 | **87.59%** | **9.37%** | **96.97%** |
| Women & Children | 654.87 | 621.16 | 34.58 | 5.83 | 661.57 | 6.70 | **94.85%** | **6.17%** | **101.02%** |
| Core | 1154.12 | 1088.11 | 29.29 | 10.64 | 1128.04 | -26.08 | **94.28%** | **3.46%** | **97.74%** |
| Facilities & Estates | 715.29 | 518.82 | 158.33 | 14.36 | 691.51 | -23.78 | **72.53%** | **24.14%** | **96.68%** |
| Corporate | 676.93 | 609.95 | 34.59 | 15.09 | 659.63 | -17.30 | **90.11%** | **7.34%** | **97.44%** |
| **Trust Total** | **6127.39** | **5409.13** | **509.51** | **148.97** | **6067.61** | **-59.78** | **88.28%** | **10.75%** | **99.02%** |




**% of Total workforce Used - Agency Staff used by Group**

| | Apr-11 | May-11 | Jun-11 | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 | Jan-12 | Feb-12 | Mar-12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical & Dental | 6.59% | 6.21% | 6.77% | 6.48% | 6.51% | 6.01% | 5.84% | 3.42% | 3.13% | 5.15% | 3.85% | 5.78% |
| Qual. Nurses & Midwives | 2.00% | 1.76% | 2.41% | 2.66% | 3.17% | 2.62% | 2.25% | 3.07% | 3.58% | 3.11% | 2.29% | 3.53% |
| Qualified Scientists | 4.36% | 1.20% | 5.41% | 5.36% | 1.85% | 0.61% | -0.10% | 0.79% | 0.88% | 0.65% | 1.78% | 3.57% |
| Qualified AHP's | 0.00% | 0.46% | 0.28% | 1.20% | 0.53% | 0.48% | 0.44% | 0.49% | 0.49% | 0.59% | 0.87% | 1.04% |
| HCA's & Support Staff | 0.44% | 0.41% | 0.67% | 0.64% | 0.62% | 0.37% | 0.29% | 0.25% | 0.20% | 0.14% | 0.14% | 0.84% |
| Managers & Snr Mgrs | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| Administration & Estates | 0.85% | 0.72% | 2.96% | 2.45% | 1.52% | 2.30% | 1.20% | 2.79% | 1.59% | 0.19% | 0.59% | 1.56% |
| Others | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| **Total** | **1.76%** | **1.59%** | **2.40%** | **2.43%** | **2.25%** | **2.06%** | **1.69%** | **1.95%** | **1.85%** | **1.69%** | **1.41%** | **2.46%** |

**Workforce Resourcing**
**Trust Overall Turnover**

| | Vacancy Factor | | Turnover | | | | |
|---|---|---|---|---|---|---|---|
| | Substantive | Total Workforce Used | Cumulative Turnover Target | Cumulative Turnover Actual | Permanent staff YTD Leavers | Permanent staff YTD Joiners | Ethnicity |
| Medicine | **11.91%** | **-2.55%** | 11.00% | **9.22%** | 148 | 77 | 24.12% |
| Surgery | **12.41%** | **3.03%** | 11.00% | **7.03%** | 99 | 66 | 27.67% |
| Women & Children | **5.15%** | **-1.02%** | 11.00% | **7.82%** | 62 | 39 | 14.82% |
| Core | **5.72%** | **2.26%** | 11.00% | **8.63%** | 117 | 65 | 17.08% |
| Facilities & Estates | **27.47%** | **3.32%** | 11.00% | **11.27%** | 72 | 24 | 22.48% |
| Corporate | **9.89%** | **2.56%** | 11.00% | **8.62%** | 59 | 34 | 7.02% |
| **Trust Total** | **11.72%** | **0.98%** | **11.00%** | **8.60%** | **557** | **305** | **20.31%** |

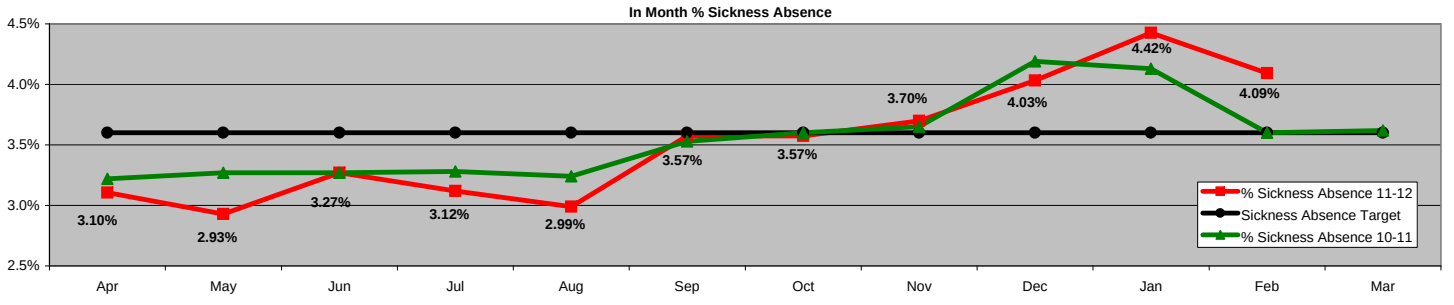
**Leavers by Staff Group (Heads)**

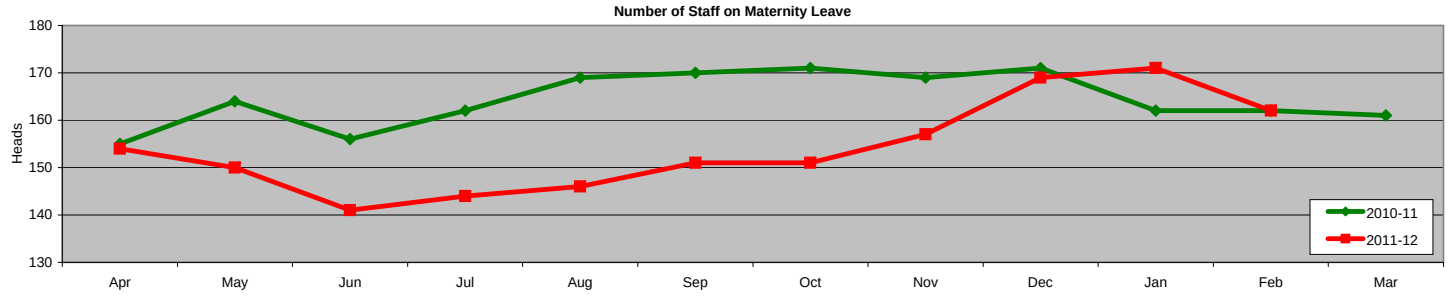
| | Apr-11 | May-11 | Jun-11 | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 | Jan-12 | Feb-12 | Mar-12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical & Dental | 1 | 3 | 1 | 2 | 4 | 2 | 2 | 1 | 6 | 2 | 1 | 1 |
| Qual. Nurses & Midwives | 13 | 10 | 13 | 8 | 16 | 16 | 11 | 14 | 14 | 13 | 17 | 10 |
| Qualified Scientists | 0 | 0 | 1 | 0 | 3 | 3 | 0 | 1 | 1 | 2 | 0 | 3 |
| Qualified AHP's | 5 | 9 | 5 | 7 | 2 | 7 | 1 | 2 | 8 | 3 | 3 | 6 |
| HCA's & Support Staff | 8 | 11 | 10 | 15 | 10 | 15 | 14 | 19 | 10 | 13 | 12 | 24 |
| Managers & Snr Mgrs | 1 | 1 | 0 | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 1 | 0 |
| Administration & Estates | 6 | 20 | 16 | 18 | 10 | 17 | 7 | 7 | 5 | 5 | 10 | 14 |
| Others | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **34** | **54** | **46** | **50** | **47** | **63** | **35** | **44** | **44** | **38** | **44** | **58** |

**Reasons for Leaving**

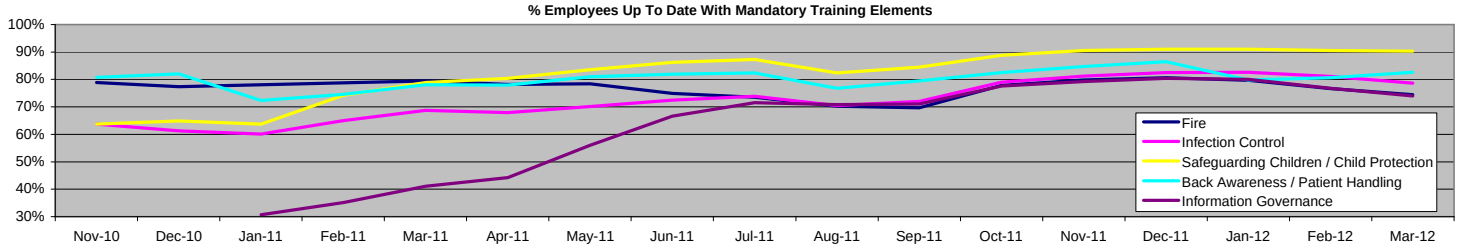
| | Relocation | Promotion | Work Life Balance | Health | Retirement | Redundancy | Dismissal | Other/Not Known | **Total Leavers YTD** | **Total Leavers 10-11** |
|---|---|---|---|---|---|---|---|---|---|---|
| Medical & Dental | 2 | 2 | 0 | 1 | 11 | 0 | 0 | 10 | 26 | 20 |
| Qual. Nurses & Midwives | 37 | 11 | 16 | 6 | 36 | 0 | 2 | 47 | 155 | 132 |
| Qualified Scientists | 4 | 2 | 3 | 0 | 3 | 0 | 0 | 2 | 14 | 8 |
| Qualified AHP's | 13 | 9 | 7 | 2 | 13 | 0 | 0 | 14 | 58 | 49 |
| HCA's & Support Staff | 18 | 5 | 28 | 12 | 32 | 0 | 6 | 60 | 161 | 122 |
| Managers & Snr Mgrs | 0 | 1 | 0 | 0 | 5 | 0 | 0 | 1 | 7 | 8 |
| Administration & Estates | 8 | 11 | 17 | 2 | 46 | 4 | 1 | 46 | 135 | 133 |
| Others | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 |
| **Total** | **82** | **41** | **71** | **23** | **147** | **4** | **9** | **180** | **557** | **472** |
| **% 11-12** | **14.72%** | **7.36%** | **12.75%** | **4.13%** | **26.39%** | **0.72%** | **1.62%** | **32.32%** | | |
| **% 10-11** | **15.68%** | **13.35%** | **16.10%** | **5.72%** | **22.88%** | **1.91%** | **3.60%** | **20.76%** | | |

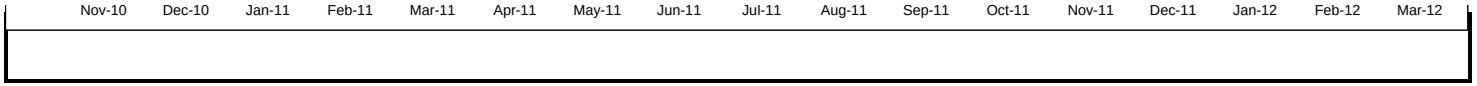
**Workforce Efficiency**
**Trust Overall Sickness**




| | Sickness | | Maternity | | Appraisals | | Training | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2011/12 Cumulative Sickness Ceiling | Cumulative Sickness (as at 29/02/12, >Target = red; <(target-0.1%) = green) | Maternity % (as at 31/03/12) | Maternity Heads (as at 31/03/12) | Divisional Target | Appraisal Actual (>90% green; 80-90% amber; <80% red) | Fire | Infection Control | Back Awareness / Patient Handling | Safeguarding Children / Child Protection | Information Governance |
| Medicine | 3.30% | **3.80%** | 2.24% | 40 | 95% | **75%** | 68.30% | 76.68% | 77.11% | 87.03% | 65.48% |
| Surgery | 3.89% | **3.91%** | 2.71% | 40 | 95% | **79%** | 70.70% | 80.34% | 80.57% | 85.87% | 67.86% |
| Women & Children | 3.30% | **3.22%** | 2.51% | 23 | 95% | **87%** | 72.48% | 78.73% | 79.75% | 90.96% | 74.90% |
| Core | 3.00% | **2.71%** | 2.52% | 36 | 95% | **83%** | 81.39% | 84.84% | 90.66% | 97.01% | 82.85% |
| Facilities & Estates | 3.81% | **4.58%** | 0.90% | 8 | 95% | **93%** | 86.76% | 86.60% | 86.76% | 94.61% | 90.69% |
| Corporate | 2.65% | **2.99%** | 1.57% | 15 | 95% | **81%** | 76.66% | 81.27% | 92.07% | 95.24% | 78.39% |
| **Trust Cumulative Total** | **3.60%** | **3.53%** | **2.52%** | **162** | **95%** | **81%** | **74.51%** | **78.69%** | **82.56%** | **90.26%** | **73.93%** |

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Mar-12

**WESTERN SUSSEX HOSPITALS NHS TRUST**

To: Board

Date of Meeting: 26th April 2012 Agenda Item: 11

| Title: |
|---|
| **Annual Health and Safety Report** |
| Responsible Executive Director |
| Denise Farmer, Director of OD and Leadership |
| Prepared by |
| Keith Peskett, Risk Manager (non clinical) |
| Status |
| Disclosable |
| Summary of Proposal |
| The report describes the progress made in relation to management of Health and Safety matters this year and highlights areas of note. |
| Implications for Quality of Care |
| High Quality Care<br>Investing in development of the workforce<br>Sustainable services |
| Financial Implications |
| No specific implications |
| Human Resource Implications |
| No specific implications |
| **Recommendation** |
| **The Board is asked to NOTE the report and APPROVE the Equality Objectives** |
| Consultation |
| n/a |
| Appendices |
| 2 attached |

This report can be made available in other formats and in other languages. To discuss your requirements please contact Graham Lawrence, Company Secretary, on graham.lawrence@wsht.nhs.uk or 01903 285288.

Western Sussex Hospitals NHS
NHS Trust

To: **Trust Board** Date: 26 April 2012

From: **Denise Farmer** Agenda Item: 11

**Director of Organisational Development and Leadership**

**FOR Information**

# Annual Health, Safety & Non-Clinical Risk Report 2011/12

## 1.0 Introduction

The Trust's commitment to Health & Safety continues as the Risk Team (Non-Clinical) are well on the way to completing the first W.S.H.T. Biennial Safety Audit. This is a significant milestone for Trust safety and for Board assurance. The Trust is expected to be compliant with existing statutory requirements and the completed audit will provide proof of our level of compliance. This exercise is expected to identify a number of areas requiring attention and the results will be shared with Divisional Leads to ensure focus on any compliance shortfall.

Key achievements in year:

- Introduction of new policy format which will make the policies more accessible, the ratification process easier and extend the review time.
- The Health & Safety Committee has sought to improve attendance with some limited success.
- The Launching of Policy Pot flyer this year has raised managers' and staff awareness of Non-Clinical policy requirements leading to increased compliance particularly in areas such as DSE (See appendix 1).
- The Non Clinical Risk Team have been busy training staff in the use of the SHE programme in order to populate the software with increasing numbers of departmental risk assessments being completed. Currently there are 447 users and approvers trained in the use of the system. The system is currently managing 2021 risk assessments which cover COSHH, Manual Handling, Display Screen Equipment (DSE) and Activity Risk Assessment (See example- Activity Risk, Appendix 4)

Areas now managed by the SHE programme:

- Detailed risk assessments of systems and tasks that exhibit multiple risks.
- The inspection programme that compliments the Biennial Audit.
- The Equipment Register of all of the manual handling equipment in the Trust.
- The document library that includes 29 sets of regulations and a bank of tool box training talks that can be printed out by any of the users or approvers.
- Material Safety Data Sheets library for agents/hazardous substances used in the Trust.

## 2.0 Key issues

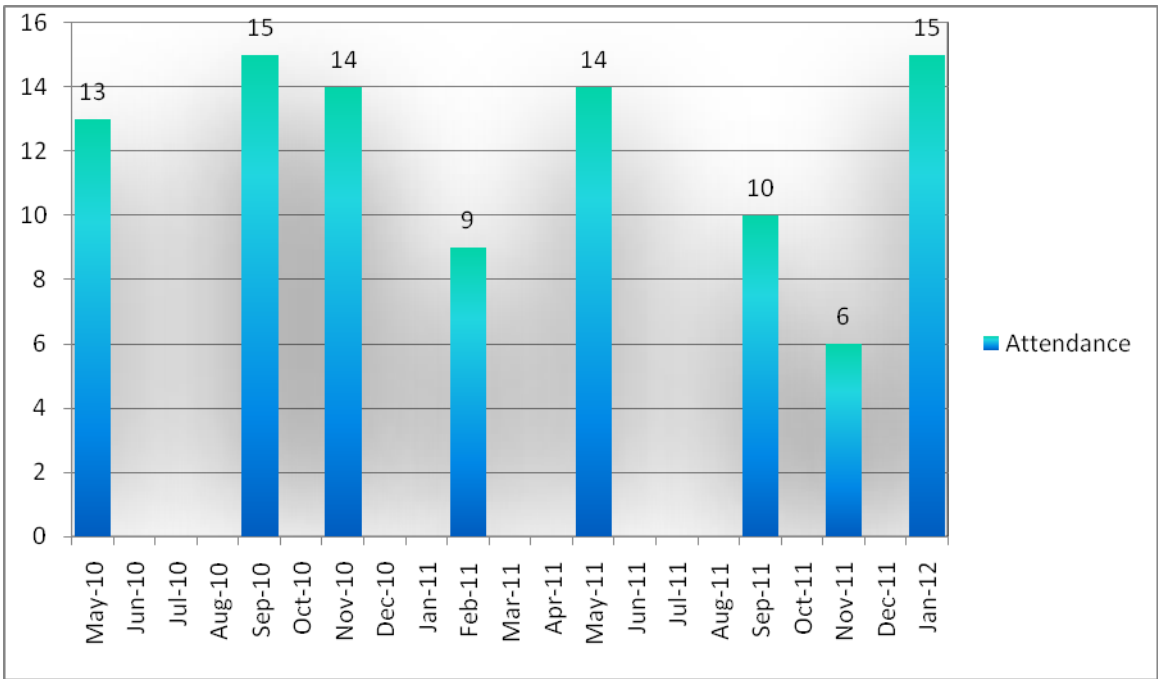
### Concerns

The success of Policy Pot on DSE assessments has been noted, however, it is clear that this is an area still in need of more commitment on the part of the staff. In spite of continued publicity the staff using Display Screen Equipment are not completing their on-line risk assessment for the use of this equipment. All staff considered users of the equipment (someone who uses a computer continuously for up to an hour each day or 2 hours start/stop) should complete a DSE assessment however there are currently 494 assessments on the SHE system. The exact number of users is not known, but as there are in excess of 3500 (Sussex HIS) computers in the Trust there is more work to be done.

**2.01 Health & Safety Committee**

Attendance figures for the Health & Safety Committee continue to cause concern,

Attendance Figures and Dates for Health & Safety Committee meetings:




The Committee oversees compliance by way of reports from:

Security, Fire, Facilities/Estates, Manual Handling, Occupational Health, Learning & Development, Datix accident reporting system and, as of this year, the Radiation Group.

Issues of attendance will be addressed through the quarterly governance meetings.

**3.0 Accident Reports**

The Non-Clinical Risk Team has liaised with the Patient Safety Team to design a new accident form that is more user-friendly. The result of the consultation will see the development, by the Patient Safety Team, of two accident forms for clinical and non clinical applications. The coding problems (there is no code for Health & Safety) that result in a great deal of manual interrogation of Datix (the “Graphic Incident Report” report submitted to the H&S Committee, is a result of approx 70 separate searches) should be resolved when the new forms are in place. A degree of potential confusion may remain with the use of two different accident forms, however this is expected to be resolved by increased training of staff by the Patient Safety Team for accident form users.

**3.01 Accident figures**

While it is not possible to extract Health & Safety Incident figures directly from the Datix system as there is no existing code for Health & Safety, (the system has numerous safety categories such as manual Handling, slip trip fall etc.), a cross tab report of these is available in Appendix 2 (short version) and Appendix 3 for the complete Datix report. The Datix Riddor report is available in Appendix 4

The accident record indicates that Slip Trip Fall is the most common incident followed by Sharps and then lifting incidents. The Slip Trip Fall incidents are a focus for the Risk Team (Non-Clinical) and closer examination of the Datix register indicates that wet floors caused by cleaning are the main reason. This has also led to a slight increase in RIDDOR reportable incidents (up from 14 to 20). The Risk Team (Non-Clinical) is liaising with the Facilities cleaning team to reduce the amount of falls caused by the cleaning process. The HSE’s Slip Trip Fall training programme is now available on Staff-Net.

**4.0 Training**

The Health & Safety training will move to two yearly intervals in 2012. This will help manage a growing training burden on staff, managers and budgets and still meet our legal requirements. The change will be reviewed after the two year period.

Health & Safety training for Medical staff will move to the more flexible option of e-learning in April.

### 5.0 Audit

The rate of return for the Biennial Audit has been disappointing. We have received 119 of an expected 299. Many of 119 logged on the system have been started but are not yet complete. The figures produced at this interim stage do not give a true reflection on the level of compliance due to managers halting progress on their audits as they make changes in order to improve their compliance. Give eth pressures on management time at ward level, the deadline has been extended to the end of May. Performance will be reviewed through quarterly governance meetings and reported to the next Health and Safety committee meeting in July.

### 6.0 Stress Action Group

The management of stress is overseen by the Stress Action Group and while the group has taken time to carefully decide the approach best suited for the Trust the surveys are now up and running in a sustainable fashion. The SHE programme has the Stress Audit as part of the audit modules but it has not been possible to convince staff of their anonymity while entering stress related data. The Risk Team (Non-Clinical) will conduct the surveys on paper and enter the details manually. The HR lead has identified areas of potential need and while the system will move a little slower than hoped we are underway. The key drivers in relation to stress appear to be 'Demands' and 'Control' followed by 'Change'. Whilst acknowledging the difficulty in reducing the demands inherent in many roles, it is clear that we can support staff in having some control of their working lives. The HR team are organising focus groups in these areas to identify potential actions to reduce stress and feed back to the Stress Action Group.

### 6.01 Example of results in two ward areas

| Stressors | 'A' Ward | 'C' ward |
|---|---|---|
| Change | 59.4 | 77.5 |
| Demands | 55.9 | 61.7 |
| Control | 60.3 | 69.8 |
| Relationships | 71.9 | 85.2 |
| Manager's Support | 72.8 | 85.7 |
| Peer Support | 69.5 | 82.1 |
| Role | 88.4 | 92.7 |

| | |
|---|---|
| | Doing very well - need to maintain performance |
| | Represents those at, above or close to the 80th percentile |
| | Good, but need for improvement |
| | Represents those better than average but not yet at, above or close to the 80th percentile |
| | Clear need for improvement |
| | Represents those likely to be below average but not below the 20th percentile† |
| | Urgent action needed |
| | Represents those below the 20th percentile |

The HR lead for stress sits on the group and actions the aforementioned focus group response or risk assessment subject to the survey score. In this case (6.01) a focus group will be organized for "A" ward and the results fed back to the Stress Action Group on the 9th July. The activity of the Stress Action Group is overseen by the Health & Safety Committee.

**7.0 Policies**

The policies have a new format for 2012 and some have changes:

- Responsibility for the Lone Worker Policy has been transferred to the Security operational group
- The Biennial Audit and Inspection policies have been merged.
- The Safe Systems of Work Policy has been removed as this is now covered by the Activity Risk Assessment on the SHE programme.
- The Driving Policy is inappropriately placed with Health & Safety and will be removed from the Safety policy portfolio at the next review, which is imminent. The policy should be managed by a competent person with sufficient knowledge in road traffic law and VOSA regulations. This report suggests the policy should sit with the Transport Department.

**8.0 Health & Safety Executive**

The Trust has received one visit from the HSE this year which has resulted in advice. The visit was from a field agent who was concerned about an incident which involved a slip trip fall. The advice received was to purchase bigger mats for the hospital entrances and to remove cleaner's hazard warning cones promptly once the floor is dry.

Changes to the RIDDOR regulations came into force on 6th April; which means the Trust now only have to report incidents where the injured party has had 7 or more days off work, before it was three days. This should see a reduction in the amount of RIDDOR reportable incidents.

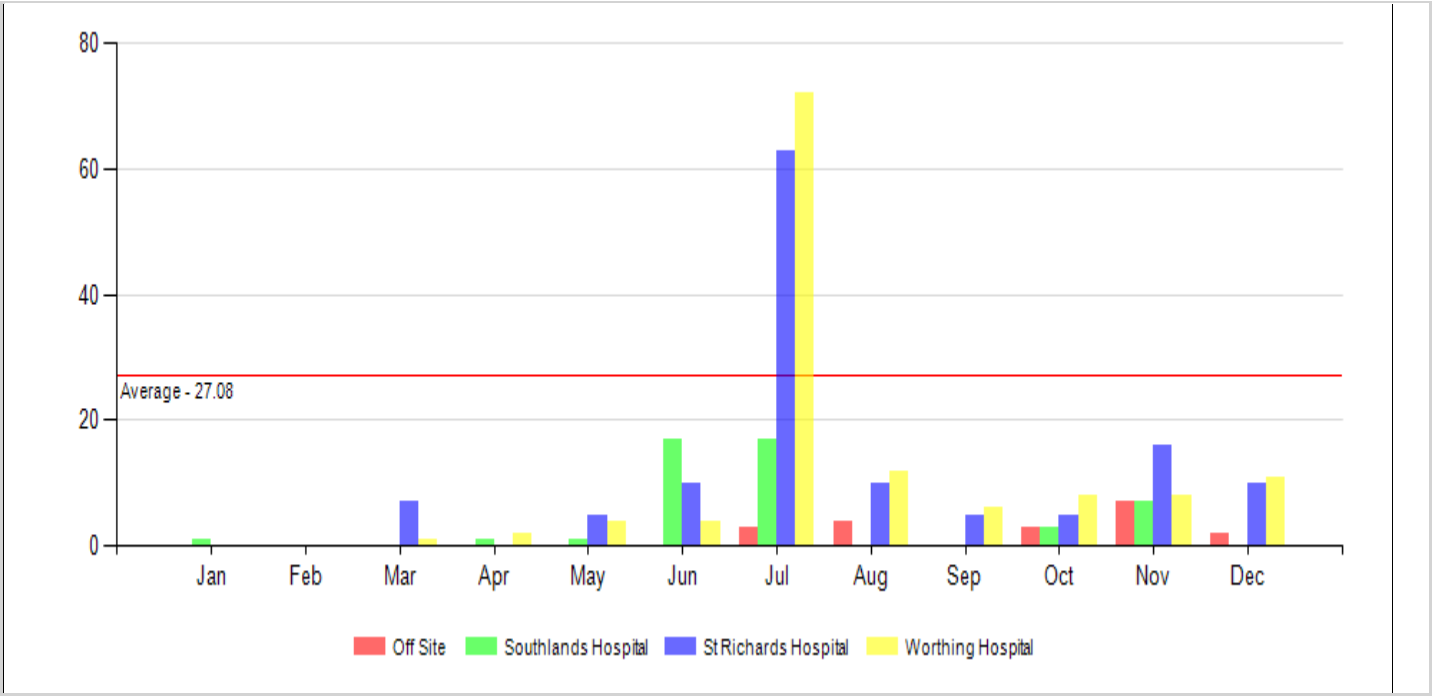
HSE have announced their cost recovery programme will not come into force until the autumn not as previously planned in April.

**The Board is asked to approve the Annual Health Safety & Risk Report.**

Denise Farmer
Director of Organisational Development and Leadership

Appendix 1

Effect of the July policy pot on DSE Assessments




| 2011 - Site by Assessment Date | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Off Site | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 4 | 0 | 3 | 7 | 2 | 19 |
| Southlands Hospital | 1 | 0 | 0 | 1 | 1 | 17 | 17 | 0 | 0 | 3 | 7 | 0 | 47 |
| St Richards Hospital | 0 | 0 | 7 | 0 | 5 | 10 | 63 | 10 | 5 | 5 | 16 | 10 | 131 |
| Worthing Hospital | 0 | 0 | 1 | 2 | 4 | 4 | 72 | 12 | 6 | 8 | 8 | 11 | 128 |
| Totals | 1 | 0 | 8 | 3 | 10 | 31 | 155 | 26 | 11 | 19 | 38 | 23 | 325 |

| 2010 - Site by Assessment Date | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Southlands Hospital | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 1 | 0 | 0 | 4 |
| St Richards Hospital | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10 | 2 | 3 | 0 | 15 |
| Worthing Hospital | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 3 |
| Totals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 15 | 4 | 3 | 0 | 22 |

Appendix 2 (abridged version)

Crosstab Report - Staff Incidents - Detail and Incident Date (Financial Month)

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Accident caused by some other means | 11 | 5 | 9 | 6 | 7 | 7 | 11 | 9 | 14 | 18 | 11 | 6 | 114 |
| Environmental matters | 2 | 1 | 2 | 2 | 2 | 1 | 3 | 4 | 0 | 0 | 0 | 2 | 19 |
| Exposure to electricity, hazardous substance, infection etc | 4 | 2 | 3 | 2 | 4 | 1 | 2 | 2 | 4 | 2 | 1 | 0 | 27 |
| Infection control | 0 | 0 | 0 | 1 | 2 | 0 | 0 | 1 | 0 | 1 | 0 | 1 | 6 |
| Information - other | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 3 |
| Information Technology | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 4 |
| Injury caused by physical or mental strain | 3 | 5 | 6 | 5 | 5 | 9 | 4 | 3 | 10 | 3 | 5 | 2 | 60 |
| Lifting accidents | 6 | 9 | 8 | 2 | 5 | 1 | 3 | 4 | 4 | 4 | 2 | 1 | 49 |
| Medical device/equipment | 7 | 5 | 4 | 2 | 11 | 5 | 0 | 4 | 4 | 4 | 4 | 4 | 54 |
| Needle-stick injury or other incident connected with Sharps | 14 | 17 | 17 | 15 | 12 | 14 | 21 | 20 | 16 | 11 | 8 | 8 | 173 |
| Skin | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Slips, trips, falls and collisions | 13 | 26 | 11 | 20 | 12 | 15 | 18 | 15 | 17 | 10 | 8 | 5 | 170 |
| Total | 60 | 70 | 61 | 57 | 61 | 54 | 63 | 62 | 70 | 53 | 39 | 30 | 680 |

Western Sussex Hospitals NHS
NHS Trust

To: Trust Board

Date of Meeting: 26th April 2012 Agenda Item: 13

| Title |
|---|
| **Annual Plan 2012-13** |
| Responsible Executive Director |
| Denise Farmer, Director of OD & Leadership |
| Prepared by |
| Oliver Phillips, Head of Strategic Planning |
| Status |
| Public |
| Summary of Proposal |
| An integrated Trust plan business plan outlining corporate objectives and corporate and divisional delivery programmes for 2012-13 |
| Implications for Quality of Care |
| Positive – implementation of the Quality Strategy and impacts on patient experience, outcomes and safety |
| Link to Strategic Objectives/Board Assurance Framework |
| Plans for delivery of the strategic objectives |
| Financial Implications |
| Financial planning is integrated within the Plan, which aims to achieve a financial surplus and CIP (cost improvement plan) |
| Human Resource Implications |
| Workforce planning is integrated within the Plan, and HR implications are outlined in divisional planning |
| **Recommendation** |
| **The Board is asked to: APPROVE the Annual Plan for 2012-13** |
| Communication and Consultation |
| Internal review at corporate and divisional level. Patient and public involvement specific to relevant programmes of work. |
| Appendices |
| A. Corporate Scorecards<br>B. Activity, Finance and Workforce Plans<br>C. Divisional Delivery Programme contributions to Corporate Objectives |

Western Sussex Hospitals NHS
NHS Trust

To: Trust Board Date: [insert date of meeting]

From: Denise Farmer, Director of OD & Leadership Agenda Item: 13

**FOR APPROVAL**

**Annual Plan 2012-13**

## 1.00 INTRODUCTION

1.01 The Annual Plan 2012-13 outlines the Trust's agreed corporate objectives, together with a range of corporate and divisional programmes to ensure delivery. It also includes integrated financial, activity, capacity and workforce information.

## 2.00 SUMMARY OF PROPOSAL

2.01 The Annual Plan 2012-13 is presented to the April Trust Board meeting for discussion and approval. It has been reviewed by the Executive Team and the Board Committee.

2.02 The Plan outlines a range of challenging corporate and divisional objectives, together with financial, activity, capacity and workforce planning summaries. These are based on the Trust's vision and commitment to deliver high quality and continuously improving patient care. This is in the context of a challenging local and national situation within the NHS, with tighter public spending and increasing need, particularly among older people and those with long-term conditions.

2.03 Crucial to the successful delivery of our plans are all our members of staff. This Plan highlights how we aim to support and engage staff to ensure that we deliver the improvements in safety, outcomes and experience for patients that we aspire to, whilst ensuring that the Trust is viewed as an excellent place to work.

2.04 The Plan also outlines the Trust Performance Framework and the mechanisms we will use to provide assurance of delivery and set the Trust in a strong position in its move to Foundation Trust status.

## 3.00 RECOMMENDATION

**The Board is asked to APPROVE the Annual Plan for 2012-13**

Western Sussex Hospitals NHS
NHS Trust

# Annual Plan 2012-13

# Contents

## 1. Trust Vision and Strategic Objectives

1.1 At Western Sussex Hospitals NHS Trust we care passionately about providing the best quality care for our local population.

1.2 Our strategy for the next five years is set out in our *Integrated Business Plan* 2011-17, which was revised in September 2011. The purpose of this *Annual Business Plan* is to summarise our corporate objectives and goals for 2012-13 and set out how we aim to achieve them, in the year that we plan to become a Foundation Trust.

1.3 Our vision as a Trust is simple – we care. Our seven strategic themes show how we aim to deliver our vision to the highest possible standards.

| We Care – Our Strategic Themes |
|---|
| **A. We care about you:**<br>Embed a culture of customer focus throughout the Trust to ensure that we treat patients with kindness, dignity and respect.<br>This will be evidenced through improvements in our patient survey, and in real-time feedback from patients and carers. |
| **B. We care about quality:**<br>Provide the highest possible quality of care to our patients.<br>This we will do through focusing on a range of measures to improve clinical effectiveness. |
| **C. We care about safety:**<br>Ensure that our services are the safest we can make them.<br>We will do this by eradicating avoidable hospital acquired infections, investing to provide the right environment for patient services, and continually striving to improve our clinical outcomes. |
| **D. We care about serving local people:**<br>Ensure that we can meet the needs of our local population, both now and in the future by providing the right range of services, improving accessibility and providing care closer to home where possible. |
| **E. We care about being stronger together:**<br>Work closely in partnership with our commissioners and other providers in order to provide streamlined, integrated care for patients, removing duplication and improving the quality and efficiency of the care we provide. |
| **F. We care about improvement:**<br>Improve our performance against a range of quality, access and productivity measures through the introduction and spread of best practice throughout the organisation. |
| **G. We care about the future:**<br>Ensure the sustainability of our organisation by continuing to meet our national targets and financial performance and investing in appropriate infrastructure and capacity. |

1.4 Our Vision and Strategic Objectives are supported by two important Trust strategies - our Clinical Services and Quality strategies. Our *Clinical Services Strategy* is focused on the integration and redesign of clinical services within the current commissioning and financial climate. Our *Quality Strategy* outlines the basis and principles on which we will make these changes, guided by our commitment to continuously improve patient experience, outcomes and safety. Both strategies are being reviewed and refreshed in light of local and national priorities.

1.5 To support the delivery of our vision and strategic objectives, we have identified a number of corporate objectives for 2012-13. Our specific aims, together with the actions we will take to deliver them, are described in Section 4.

1.6 The achievement of our ambitious objectives cannot be achieved without continued investment in our most important asset – our staff. The hard work, skill and dedication of all our staff is at the heart of the delivery of high quality care for all our patients. We will seek to better communicate with, develop and support our staff to deliver quality improvement and innovation.

1.7 The Trust recognises the value of a diverse workforce capable of understanding the needs and cultures of all patients, and of communicating effectively with them. With this in mind, the Trust has a separate comprehensive list of objectives and actions in relation to equality and diversity which can be found on both the intranet and Trust website.

## 2. Trust Achievements and Challenges in 2011-12

2.1 The year 2011-12 was one of significant achievements for Western Sussex Hospitals Trust across a range of measures. This section outlines those achievements, set against the stretching aspirations we set ourselves in our Annual Plan for 2011-12

2.2 Our Annual Plan for 2011-12 specified our corporate objectives in some detail; our achievements and remaining challenges against each of these are summarised below:

| Corporate Objective | Achievements & Challenges |
|---|---|
| **Increase the number of patients who would recommend the Trust to family and friends** | Successful introduction of Real Time Patient Experience Tracker to identify and address concerns immediately.<br><br>The Trust is awaiting comparative results of the 2011 Patient Survey. |
| **Improve customer care by embedding a culture of caring across the Trust** | Successful launch of our new vision and values 'We Care', with a poster and video campaign.<br><br>The Trust received very positive feedback from the privacy and dignity review, and has had received positive reports from the Care Quality Commission (CQC) throughout the year. |
| **Reduce our mortality rates** | On both the measure of crude mortality and on Hospital Standardised Mortality Rates (HSMR), the Trust has seen a significant reduction during 2011-12.<br><br>However, on both the HSMR and new Summary Hospital Mortality Indicator (SHMI) measure, the Trust remains above the average. |
| **Reduce our rates of unplanned readmissions** | The Trust has worked with partners in the community to improve pathways in unscheduled care; however, the numbers of unplanned readmissions has not fallen during 2011-12 and will require further action in 2012-13. |
| **Improve outcomes for patients admitted following hip fracture (fractured neck of femur)** | Introduction of new pathway for patients with fractured neck of femur to improve outcomes.<br><br>The waiting time from admission with fracture to surgery has improved significantly during 2011-12, moving from 67% of patients treated within 36 hours in 2010-11 to over 87% for 2011-12, and 100% achievement in March 2012.<br><br>It is currently too early to tell from national comparative data whether the outcomes for patients have improved as a result of pathway changes. |
| **Eradicate avoidable HCAIs (healthcare-associated infections)** | No cases of avoidable HCAIs for MRSA during 2011-12. For Clostridium Difficile, the Trust was within its trajectory at the end of the year. |

| | |
|---|---|
| **Improve prescribing performance** | Moderate/high grade incidents in line with trajectory.<br>Anti-microbial audit data being reviewed. |
| **Reduce healthcare-associated VTE (venous thromboembolism)** | The national target of 90% for VTE assessment was exceeded for the year 2011-12 at 91%. However, the Trust remains short of the internal stretch target of 95%. |
| **Complete the Service Redesign for Quality consultation and, subject to the outcomes, develop and commence a plan for implementation** | Consultation successfully concluded and implementation begun.<br>Successful opening of new wing at Worthing Hospital and transfer of patients from Southlands in March 2012. |
| **Redesign six planned care pathways, in collaboration with the Coastal Cabinet** | Work to redesign pathways in Dermatology, Orthopaedics, Ophthalmology and Rheumatology is progressing well in line with plans. |
| **Define and begin to deliver plans to implement the Clinical Services Strategy** | Significant progress in both defining and beginning to implement the next stage of our *Clinical Services Strategy*, such as the move of acute inpatient beds from Southlands to Worthing, new theatres at Worthing and Ophthalmology development at St. Richard's (SRH). |
| **Develop and manage our relationship with commissioners, particularly in respect of commissioning intentions and service developments** | As NHS Sussex cluster has become established, and the Coastal West Sussex Clinical Commissioning Group has developed, the relationship has markedly improved, resulting in much closer collaboration on our plans for Proactive and Planned Care. |
| **Work with partners to deliver the QIPP agenda, in particular to develop schemes to manage demand** | We have been a very active partner in the PCT-led 'Sussex Together' programme, in particular in relation to the ambitious goals to reduce non-elective admissions, which are reflected in our 2012-13 plans. |
| **Develop and implement a strategy for engagement with staff, members and other community stakeholders** | We launched a new internal communications programme to ensure that we communicate more effectively with all staff. We have also produced posters and a video to more clearly communicate our vision with staff. |
| **Develop our service improvement capacity and produce and implement clear plans for delivery** | Divisional service improvement plans are outlined through annual planning and monitored quarterly.<br>Service improvement methods piloted in a number of areas (Theatres, Enhanced Recovery, fractured neck of femur). |
| **Complete the development of and implement Service Line Management (SLM) across the organisation** | Continuous progress made towards SLM implementation, with improved Service Line Reporting (SLR) information, Divisional Integrated Performance meetings, and the piloting of SLM within one Division. |

| | |
|---|---|
| **Achieve our target financial performance for 2011-12 and build a sustainable financial position** | On trajectory to achieve target surplus for 2011-12 and achievement of Cost Improvement Programme (CIP). |
| **Achieve Foundation Trust status** | SHA stage completed and application with DH for consideration. Monitor stage expected to start in early 2012-13. |
| **Achieve the required Monitor quality governance rating** | Refreshed independent review of our quality governance arrangements assessed us as achieving the rating required by Monitor. |
| **Achieve the required rating against the Monitor Compliance Framework** | Continuous improvement throughout the year, particularly on 18 week waits and cancer waits, has resulted in us achieving the required rating from Quarter 2 onwards. |

2.3 In the last year, we have worked towards a wide range of standards and requirements, which cover national, regional and local priorities. Some of these specifically related to the regulatory requirements of the Care Quality Commission (CQC – the quality regulator, with whom all service providers must be registered) and Monitor (the financial and overall regulator of Foundation Trusts), as well as the overall NHS Performance Framework. Scorecards covering our achievements against the full range of performance and quality requirements are included at Appendix A. Our performance against a selection of the key indicators is outlined below:

| Key performance Indicators | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | MAR | 2011/12 YTD | 2011/12 Target/ threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Four-hour maximum wait in A&E from arrival to admission, transfer or discharge | 97.43% | 96.68% | 96.77% | 97.01% | 97.65% | 97.90% | 96.39% | 96.76% | 95.72% | 95.24% | 92.10% | 98.60% | **96.57%** | 95% |
| Cancelled ops - breaches of 28 days readmission guarantee as % of cancelled ops | 9.09% | 4.65% | 3.57% | 14.29% | 0.00% | 0.00% | 6.00% | 2.67% | 0.00% | 1.82% | 4.55% | 0.00% | **3.19%** | 5% |
| MRSA incidence | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 6 |
| C Diff incidence | 11 | 6 | 7 | 5 | 5 | 9 | 9 | 3 | 8 | 3 | 3 | 7 | **76** | 90 |
| RTT (referral to treatment time) - admitted patients - 90% in 18 weeks | 81.6% | 81.7% | 77.0% | 77.1% | 77.6% | 82.3% | 90.4% | 90.6% | 92.2% | 91.7% | 91.1% | 91.0% | 85.4% | 90% |
| RTT (referral to treatment time) - non-admitted patients - 95% in 18 weeks | 95.7% | 96.0% | 96.9% | 95.7% | 95.6% | 96.3% | 95.9% | 96.2% | 95.9% | 96.1% | 95.0% | 95.1% | 95.9% | 95% |
| Cancer: 2 week GP referral to 1st outpatient | 91.85% | 85.80% | 94.35% | 98.39% | 98.65% | 97.79% | 97.55% | 98.24% | 97.01% | 96.22% | 97.70% | 97.23% | **95.93%** | 93% |
| Cancer: 31 day diagnosis to treatment for all cancers | 97.94% | 98.48% | 98.25% | 98.54% | 99.03% | 99.1% | 95.07% | 96.08% | 98.17% | 98.17% | 99.53% | 100.00% | **98.18%** | 96% |
| Cancer: 62 days urgent GP referral to treatment of all cancers | 86.63% | 79.40% | 83.47% | 89.20% | 91.10% | 92.15% | 93.21% | 93.12% | 92.06% | 90.83% | 87.39% | 91.11% | **89.01%** | 85% |
| Delayed transfers of care | 3.9% | 4.5% | 3.1% | 4.1% | 3.1% | 4.0% | 3.3% | 4.5% | 1.8% | 2.5% | 1.8% | 1.8% | 3.2% | 3.5% |

2.4 Each of the divisions within the Trust (Medicine, Surgery, Women & Children and Core) has made significant progress against a range of specific divisional objectives that were outlined in 2011-12, as well as contributing to the delivery of the corporate objectives. This is due to the continued effort of staff at all levels to promote service and quality improvement and innovation.

## 3. Drivers for Change

3.1 Our Annual Business Plan has been developed, and must be delivered, in the context of a rapidly changing NHS. A range of external factors will impact on the Trust's future and the environment in which we operate. These have helped to inform our corporate objectives and priorities for 2012-13. Our objectives have also been influenced by our own internal values.

3.2 The NHS reforms in the Health & Social Care Bill signal significant change to both the commissioning and provision of services in the future. As well as these significant structural changes within many parts of the NHS, 2012-13 will see a continuation of an austere financial climate for the NHS in general and the Acute sector in particular. Demographic changes, particularly an increase in older people and those with long-term conditions, will continue to present challenges to traditional models and pathways of care.

3.3 Our *Integrated Business Plan* provides a detailed PESTLE analysis of the local and national context, covering the political, economic, sociological, technological, legal and environmental factors relevant to the Trust. Specific internal and external factors which have influenced the development of our objectives for 2012-13 are summarised below:

| | **National and Local Drivers** |
|---|---|
| **National and Regional policy** | ***Operating Framework 12/13:*** the national requirements for the NHS laid down in the *NHS Operating Framework* show a focus on maintaining a tight grip on financial performance and access, improving quality for patients, delivering the reform agenda and making the necessary QIPP (Quality, Innovation, Productivity and Prevention) improvements.<br><br>***NHS South of England Operating Framework***: the new clustered Strategic Health Authority (SHA) has issued its *Operating Framework* for 2012/13. This reinforces a number of the messages in the national *Operating Framework*, and outlines the roles and responsibilities, financial framework and requirements and timetable for NHS organisations within the SHA area.<br><br>***Clinical outcomes and quality standards*:** The publication of the *NHS Outcomes Framework* places a greater emphasis on overall patient outcomes (such as mortality and readmissions) and will require greater transparency of reporting from providers.<br><br>***Provider environment changes*:** The NHS reforms propose a potentially more competitive provider environment, with a strong move towards Foundation Trust status for NHS Trusts, increased competition from non-NHS Providers, and more frequent competitive procurements.<br><br>***Commissioning changes*:** The proposed abolition of SHAs and PCTs has been anticipated through the clustering of SHAs and PCTs into larger groups to ensure the resilience of the system in transition. Although the Provider environment is less subject to change, the uncertainty of commissioning in the transition is a consideration for providers. |

| | |
|---|---|
| **Regulatory regime** | ***Foundation Trust status:*** On the successful completion of our application to become a Foundation Trust, the Trust will move from a managed to a regulatory system, as laid down in Monitor's *Compliance Regime*.<br><br>***Care Quality Commission:*** the Trust will need to continue to be registered with the quality regulator without conditions and seek to improve in any areas of concern identified with respect to quality. |
| **Local health economy changes** | ***PCT transition:*** PCTs in Sussex have successfully clustered and are providing resilience during the transition to the new system. However, the ongoing uncertainty over future forms and functions may lead to instability locally. As a relatively stable part of the local health economy, the Trust will need to play a strong leadership role.<br><br>***Clinical Commissioning Groups:*** We have developed strong relationships with Coastal West Sussex, our local Clinical Commissioning Group (CCG), as it enters its preparatory year prior to assuming full commissioning responsibility in April 2013. Engagement will be crucial to help deliver joint QIPP initiatives, such as Proactive care, Planned care and admissions avoidance.<br><br>***Role of Local Authority:*** the Local Authority will develop a more active role in public health and health strategy and continuing active engagement from the Trust is required. |
| **Social and demographic changes** | ***Demographic changes:*** the rapidly ageing local population in West Sussex, together with the impact of lifestyle factors such as alcohol and obesity, continue to present a challenge for the health economy and mean that focusing on the pathways for elderly people and those with long-term conditions must remain a priority. |
| **Economic environment** | ***National financial pressures*:** the NHS in England is required to secure efficiencies of £20bn by 2014/15 in the context of no significant real-term increase to NHS budgets. The picture is likely to be worse for Acute Trusts as commissioners seek to invest in upstream initiatives to prevent admission. Other parts of the public sector, including social services, have received significant budget reductions.<br><br>***Local pressures:*** The challenges faced by the NHS in Sussex have been mapped out by the 'Sussex Together' programme, which forecasts a significant deficit in the coming years if current trends in demand and expenditure continue. The Trust will need to deliver both challenging Cost Improvements and participate in programmes to manage demand better in order for the local health economy to thrive.<br><br>***Local competition:*** In the face of increased local competition and choice is crucial that we make our services attractive and accessible to all local patients and GPs. |
| **Trust strategy and priorities** | ***Patient experience:*** national surveys show that our patients generally report a positive and improving experience but we want to do better. We have made it a corporate priority to continue to focus on patient experience, to be at the heart of everything we do.<br><br>***Patient outcomes***: Our HSMR and crude mortality rates are reducing, but remain above average across England. We are determined to improve on this and need to ensure we have the improvement programmes in place to do this. |

***Foundation Trust development:*** we are anticipating being in the Monitor assessment phase at the beginning of 2012-13. Successful achievement will mean we have greater independence but we will also be subject to a rigorous regulatory regime – we will need to continue to demonstrate strong performance and improvement across all our services.

***Sussex Together and Service Redesign for Quality*****:** following our successful consultation, we are proceeding at pace with implementation of our Service Redesign for Quality plans, which support the wider 'Sussex Together' programme across the Local Health Economy. Following the build of the new wing at Worthing and the transfer of inpatient services from Southlands, we are developing our plans for an Emergency Floor at Worthing and an ambulatory care centre at Southlands Hospital.

***Access:*** Maintaining the huge improvements seen during 2011-12 in access for 18 weeks, and ensuring that we continue to offer excellent access for Cancer services and through our Accident & Emergency department will be crucial for our success.

***Infection prevention and control:*** although we have been very effective at reducing HCAIs (healthcare-associated infections), particularly MRSA, the national requirements for 2012-13 are very challenging, particularly with respect to Clostridium Difficile. We will need to ensure that our infection prevention and control measures remain robustly embedded throughout the Trust.

## 4. Corporate Objectives and Priorities 2012-13

4.1 Our priorities for 2012-13 have been developed in response to the drivers outlined above. They aim to support the delivery of our seven strategic objectives within the complex and challenging national and local context. They take into account a range of specific requirements from a number of sources, including Monitor, CQC, *The NHS Operating Framework, The Framework for Preparing the Operating Plan for NHS South of England 2012/13* and the PCT cluster and emerging Clinical Commissioning Group, as well as the priorities identified by local people. The priorities also reflect the 2012-13 delivery expectations of our Clinical Services and Quality strategies, which are described in greater detail in our *Integrated Business Plan.* Detailed analysis of the strengths and weaknesses of the Trust has informed the development of the objectives; a full SWOT analysis can be found in the *Integrated Business Plan.*

4.2 Our objectives each have a number of measurable indicators or milestones so that we can monitor progress throughout the year. The Trust Board will receive regular reports on progress against the *Annual Business Plan* objectives and will hold directorates and divisions to account through the Performance Framework, which is described in further detail in Section 8.

4.3 A Trust Scorecard will be used to monitor progress at corporate level, whilst each division will have access to detailed divisional versions. A copy of the Trust Scorecard is available at Appendix A.

4.4 Our objectives for 2012-13 are:

| Strategic Theme | Corporate Objective | Executive Lead | Measures of Success |
|---|---|---|---|
| **A. We Care About You** | A1 Increase the number of patients who would recommend the Trust to family and friends | Director of Nursing & Patient Safety | National Inpatient and Outpatient surveys – improve the score for patient rating of overall quality of care in-year, with the longer-term aim of being in the top 20%<br><br>Improve our results in real-time patient monitoring: increase the score for patients who would recommend the Trust from 90 to 92 by March 2013<br><br>Reduce the number of complaints relating to staff attitude/behaviour by 10% and the rate of PALS (Patient Advice & Liaison Service) contacts per outpatient appointment from 0.12% to 0.1%<br><br>Improve performance in the patient experience national composite CQUIN indicator *[dependent on agreement of trajectory with Commissioners]*<br><br>Maintain excellent rating in Care and Compassion peer review |

| Strategic Theme | Corporate Objective | Executive Lead | Measures of Success |
|---|---|---|---|
| **B. We Care About Quality** | B1 Deliver the quality outcome gains specified in the Trust's Quality Strategy, in particular a reduction in the Trust's mortality rate | Medical Director | Reduce our HSMR from 103 to 100 by the end of 2012-13<br>To target the most significant areas of care resulting in high mortality, through pathway specific standardisation using the care bundle approach, focusing on hip fracture, pneumonia, COPD and heart failure, monitored through HSMR<br>To reduce 30-day mortality following hip fracture so that the trust lies within the middle two quartiles of mortality in the National Hip Fracture Database<br>To improve maternity care by encouraging natural childbirth wherever it is safe to do so and reducing the Caesarean Section rate from 24.4% (Q1-3 2011-12) to 23% in 2012-13 |
| | B2 Reduce our rates of unplanned readmissions | Chief Operating Officer | Reduce the Trust 30-day readmission rate in line with our agreement with Commissioners |
| **C: We Care About Safety** | C1 Deliver the patient safety gains specified in the Quality Strategy | Director of Nursing & Patient Safety | Improve safety of prescribing by making demonstrable improvement in three specific aspects of prescribing, as identified in the annual baseline full prescribing audit<br>Reduce incidence of healthcare associated VTE, including increasing the level of VTE assessment from 91% (2011-12) to 95% in 2012-13<br>Reduce incidence of HCAI and keep below the nationally-set thresholds for incidence of C. Difficile (75 cases) and avoidable MRSA (2 cases), taking measures to protect the patient and aiming to remain free of avoidable MRSA<br>Improve theatre safety for patients, including achieving 99% compliance with the World Health Organisation (WHO) Surgical Safety Checklist in 2012-13<br>Reduce numbers of falls in hospital by 15% for those resulting in low or moderate harm and 50% for severe harm by 2012 (compared to 2009-10 |

| Strategic Theme | Corporate Objective | Executive Lead | Measures of Success |
|---|---|---|---|
| | | | baseline)<br>Improve overall Trust Patient Aggregate Safety Score (PASS) score, achieving continuous improvement (a score of <100 compared to baseline in 2011-12) |
| **D: We care about serving local people** | D1 Continue to implement the improvements to local services as envisaged in our clinical services strategy, in particular our 'Service Redesign for Quality' programme | Chief Operating Officer/ Director of Leadership & OD | Successful opening of the new theatres at Worthing by July 2012<br>Board approval of the Business Case for an Emergency Floor at Worthing in Q1<br>Fully develop plans for an ambulatory care centre at Southlands by December 2012 |
| **E: We care about being stronger together** | E1 Work with our LHE partners to help deliver the 'Sussex Together' programme, including jointly developing and implementing our plans for Planned Care and Proactive Care | Chief Operating Officer | Achieve the reductions in unscheduled care admissions and the changes to planned pathways in line with 'Sussex Together' accountability agreement |
| **F: We care about improvement** | F1 Implement a strategy for engagement with staff, members and other community stakeholders | Director of OD and Leadership | Improve annual staff survey aggregate score for engagement, with longer-term aim of being in top 20% of trusts<br>Improve annual staff survey question score for perception of communication with senior managers<br>Active, engaged membership: increase membership to 8,000 and elect full council of governors |
| | F2 Continue to improve the patient environment through investment in the Trust's Estate. | Director of Finance | Improve the condition of the Trust's Estate by raising standards to category B through investment into routine maintenance and the Trust's Capital programme |

| Strategic Theme | Corporate Objective | Executive Lead | Measures of Success |
|---|---|---|---|
| | | | Maintain Excellent PEAT Scores |
| | F3 Improve productivity and the quality of patient care through the introduction of a service improvement function | Director of OD and Leadership | Agree Trust-wide service improvement approach<br>Produce demonstrable service improvement in at least one service |
| **G: We care about the future** | G1 Achieve Foundation Trust status | Director of Finance | Achievement of FT status by Q3 |
| | G2 Achieve a Financial Risk Rating of 3 or above | Director of Finance | Deliver the required year-end financial position of £5.2m surplus<br>Deliver the Trust's CIP target of £19.4m<br>Achieve a Financial Risk Rating of 3 or above |
| | G3 Achieve a Monitor Governance rating of at least Amber Green throughout the year | Chief Operating Officer | Perform at Amber Green level or above consistently throughout the year |
| | G4 Continue the development and implementation of Service Line Management (SLM) | Chief Operating Officer | Implement new clinical leadership arrangements by the end of Q1<br>Development of SLM information and infrastructure in line with agreed programme |

## 5. Corporate Delivery Programmes

5.1 The delivery of our corporate objectives for 2012-13 will be achieved through a combination of Trust-wide corporate delivery programmes, together with a range of divisionally-led programmes. These programmes all align with our strategic themes and corporate objectives.

5.2 Our success as an organisation depends on all members of staff understanding and supporting our objectives and working towards the same challenging goals. This includes clinical and managerial staff working in the clinical divisions, together with colleagues who work in a range of enabling functions, such as Finance, IM&T, Performance, Facilities & Estates and HR. Members of staff will have clear personal objectives which support the corporate objectives and are reviewed within annual appraisals. Specific education, development and support will be given to enable staff to deliver improvements to patients, such as customer care and service improvement technique training.

5.3 The delivery of our corporate objectives includes a number of complex programmes of work, which sometimes contribute to more than one objective and have links to overarching strategies, primarily the Clinical Services and Quality strategies.

5.4 The key corporate delivery programmes for 2012-13 and their contribution to our corporate objectives are summarised in the matrix below. This is followed by an overview of each programme.

**DELIVERED THROUGH**

**Corporate Delivery Programmes**

| Corporate Objectives | 1. Improving Patient Experience | 2. Improving Clinical Outcomes | 3. Improving Patient Safety | 4. Service Improvement Programme | 5. Implementing Service Redesign for Quality | 6. Develop and implement our clinical servs. strategy | 7. Developing Effective Engagement | 8. Achieving Foundation Trust Status | 9. Ensuring Sustainability | 10. Implementing Service Line Management |
|---|---|---|---|---|---|---|---|---|---|---|
| A1 Increase the number of patients who would recommend the Trust to family and friends | ▲ | ▲ | ▲ | | | | | | | |
| B1 Deliver the quality outcome gains specified in the Trust's Quality Strategy, in particular a reduction in the Trust's mortality rate | | ▲ | | | | | | | | |
| B2 Reduce our rates of unplanned readmissions | | ▲ | | | ▲ | | | | | |
| C1 Deliver the patient safety gains specified in the Quality Strategy. | | | ▲ | | | | | | | |
| D1 Continue to implement the improvements to local services as envisaged in our clinical services strategy, in particular our 'Service Redesign for Quality' programme | | | | | ▲ | ▲ | | | | |
| E1 Work with our LHE partners to help deliver the 'Sussex Together' programme, including jointly developing and implementing our plans for Planned Care and Proactive Care | | | | | ▲ | ▲ | | | | |
| F1 Implement a strategy for engagement with staff, members and other community stakeholders | | | | | | | ▲ | | | |
| F2 Continue to improve the patient environment through investment in the Trust's Estate. | | | | | ▲ | ▲ | | | ▲ | |
| F3 Improve productivity and the quality of patient care through the introduction of a service improvement function | | | | ▲ | | | | | | |
| G1 Achieve Foundation Trust status | | | | | | | | ▲ | | |
| G2 Achieve a Financial Risk Rating of 3 or above | | | | | | | | | ▲ | ▲ |
| G3 Achieve a Monitor Governance rating of at least Amber Green throughout the year | ▲ | ▲ | ▲ | | | | | | ▲ | |
| G4 Continue the development and implementation of Service Line Management. | | | | | | | | | | ▲ |

<table>
<tr><th colspan="2">1. Improving Patient Experience</th><th colspan="2">Lead: Director of Nursing & Patient Safety</th></tr>
<tr><td colspan="2">Aims:<ul><li>To promote a culture of customer care throughout the Trust</li><li>To ensure that patients and their families have a positive experience of the Trust</li><li>To ensure that patient experience is core to quality care</li><li>To improve communication with patients and their families, particularly in outpatients and regarding conditions and treatments</li><li>To improve patient experience of discharge</li><li>To improve patient nutrition</li><li>To maintain an excellent patient environment</li></ul></td><td colspan="2">Key work streams:<ul><li>Customer Care Programme</li><li>Real-time patient experience tracker (RTPET) full roll out, analysis and response</li><li>Inpatient, Outpatient and Cancer survey action plans (linked to customer care programme)</li><li>Care and Compassion peer review</li><li>Productive Ward programme</li><li>Dementia Care strategy</li><li>Energising for Excellence programme</li><li>PEAT (Patient Environment Action Team) improvement</li><li>Board scrutiny, including executive walkabouts and use of patient stories</li></ul></td></tr>
<tr><td>Q1:<br>Roll out of RTPET to Maternity & Children’s Services<br><br>Complete roll out of productive ward programme</td><td>Q2:<br>Free standing kiosks for RTPET<br>Roll out Dementia Care strategy<br>Initiate ‘Energising for Excellence’ programme</td><td>Q3:<br>External peer review Care and Compassion</td><td>Q4:<br>National PEAT inspection<br><br>2012 Inpatient Survey results<br><br>Internal peer review – Care and Compassion</td></tr>
<tr><td colspan="2">Measures of success:<ul><li>National Inpatient, Outpatient and Cancer surveys – improved score for patient rating of overall quality of care in-year, with the longer-term aim of being in the top 20%</li><li>Improve our results in real-time patient monitoring: increase the score for patients who would recommend the Trust from 90 to 92 by March 2012</li><li>Improve performance against the CQUIN composite patient experience score and the internal composite measure</li></ul></td><td colspan="2"><ul><li>Reduce the number of complaints relating to staff attitude/behaviour by 10% and the rate of PALS (Patient Advice & Liaison Service) contacts per outpatient appointment from 0.12% to 0.1%</li><li>Maintain ‘excellent’ in Care and Compassion Peer Review</li><li>Maintain ‘excellent’ PEAT scores</li><li>Full compliance with all CQC visits</li><li>Increase in number of recorded compliments</li></ul></td></tr>
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<table>
<tr><th colspan="2">2. Improving Clinical Outcomes</th><th colspan="2">Lead: Medical Director</th></tr>
<tr><td colspan="2">Aims:<ul><li>Reduce mortality following hip fracture</li><li>Reduce the rate of unplanned readmissions following discharge from the Trust</li><li>Review and attempt to reduce mortality for patients admitted under Elderly Care Medicine</li><li>Improve the treatment pathway and clinical outcomes for patients with Stroke or TIA</li></ul></td><td colspan="2">Key work streams:<br>The improvements expected in clinical outcomes are delivered through a number of service/pathway-specific change programmes within divisions or through continuous improvement and everyday performance and quality management within each division and service. Specific areas of work include:<ul><li>Stroke and TIA (Medicine – Programme 4)</li><li>Orthogeriatrics and hip fracture – embedding 11/12 changes (Medicine)</li><li>Unplanned readmissions (Delivered by all divisions)</li><li>Implementation of care bundles (Medicine – pathway work, including Programmes 5 and 9 – Ambulatory Care and Proactive Care)</li><li>Safe Maternity Care (Women & Children – Programme 1 CNST and 4 Medical Staffing)</li></ul></td></tr>
<tr><td>Q1:</td><td>Q2:</td><td>Q3:</td><td>Q4:</td></tr>
<tr><td colspan="4">Contained within Divisional Delivery Plans</td></tr>
<tr><td colspan="2">Measures of success:<ul><li>Reduce our HSMR from 103 to 100 by the end of 2012-13 (subject to rebasing)</li><li>Reduction crude mortality from 3.6% to 3.2% by end 2012</li><li>Significant reduction in the Trust’s 30-day readmission rates</li><li>Increase in the percentage of hip fracture repairs carried out within 24 hours from 77.6% (Dec 2011) to 90% by the end of 2012-13</li></ul></td><td colspan="2"><ul><li>To reduce mortality following hip fracture so that the trust lies within the middle two quartiles of mortality in the National Hip Fracture Database and HSMR is within the expected range</li><li>Achieve the Stroke and TIA indicators, including improving the percentage of patients with suspected TIA being seen and treated in 24 hours to 60%</li><li>Demonstrate improvements in the Enhancing Quality measures</li></ul></td></tr>
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<tr><th colspan="2">3. Improving Patient Safety</th><th colspan="2">Lead: Director of Nursing & Patient Safety</th></tr>
<tr><td colspan="2">Aims:<br>To reduce the avoidable harm suffered by patients in connection with their hospital care, including to:<ul><li>Reduce the number of HCAIs</li><li>Improve the safety of prescribing</li><li>Reduce the incidence of healthcare-associated VTE</li><li>Improve theatre safety</li><li>Reduce the number of in-hospital falls</li></ul></td><td colspan="2">Key work streams:<ul><li>Safety Thermometer</li><li>E-Prescribing (led by Core Division)</li><li>Near-patient monitoring</li><li>VTE compliance</li><li>Theatre safety (delivered by Surgery Division)</li><li>Falls prevention</li></ul></td></tr>
<tr><td>Q1:<br>C diff testing for all patients<br>Introduction of Patient Safety Thermometer<br>Near-patient monitoring implementation begins</td><td>Q2:<br>Implement output of falls working group<br>E-prescribing implementation</td><td>Q3:<br>E-prescribing implementation</td><td>Q4:<br>Full roll-out of near-patient monitoring</td></tr>
<tr><td colspan="2">Measures of success:<ul><li>Reduced incidence of healthcare associated VTE, including increasing the level of VTE assessment from 91% (2011-12) to 95% in 2012-13</li><li>Reduce incidence of HCAI and keep below the nationally-set thresholds for incidence of C. Difficile (75 cases) and avoidable MRSA (2 cases), taking measures to protect the patient and aiming to remain free of avoidable MRSA</li><li>Improve safety of prescribing by making demonstrable improvement in three specific aspects of prescribing, as identified in the annual baseline full prescribing audit</li><li>99% compliance with the WHO theatre safety checklist</li></ul></td><td colspan="2"><ul><li>Reduction in incidence of falls in hospital by 15% for those resulting in low or moderate harm and 50% for severe harm by 2012 (from 09-10 baseline)</li><li>Zero Never Events</li><li>Improve overall Trust Patient Aggregate Safety Score (PASS) score, achieving a continuous reduction in the score from 77 (Q1-3 2011-12)</li><li>Compliance with national reporting of Safety Thermometer data</li><li>Maintain and improve 80% compliance with nutritional assessment tool (MUST) after 24 hours and improve compliance after 7 days from 95% (Q1-3 2011-12) to 100% in 2012-13</li></ul></td></tr>
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<tr><th colspan="2">4. Service Improvement</th><th colspan="2">Lead: Director of Leadership & Organisational Development</th></tr>
<tr><td colspan="2">Aims:<ul><li>Improve the quality and productivity of patient care through the introduction of a service improvement function</li><li>Provide training, development and support to clinical and non-clinical staff to identify opportunities for service improvement and implement sustainable change using tried and tested techniques and approaches</li></ul></td><td colspan="2">Key work streams:<ul><li>Programme establishment</li><li>Project delivery and evaluation</li></ul></td></tr>
<tr><td>Q1:<br>Agree budget, remit, structure and accountabilities for programme<br><br>Agree areas of focus and delivery for programme for 2012/13<br><br>Initiate any recruitment necessary</td><td>Q2:<br>Complete any recruitment necessary<br><br>Commence the first service improvement project<br><br>Commence training and development programme</td><td>Q3:<br>Service improvement project underway</td><td>Q4:<br>Undertake initial evaluation of service improvement project<br><br>Undertake initial evaluation of training and development programme<br><br>Determine priorities for service improvement in 2013/14</td></tr>
<tr><td colspan="2">Measures of success:<ul><li>Establishment of programme</li><li>Tangible delivery of service improvement in chosen area</li><li>Skills development across the organisation</li><li>Value for money of intervention</li></ul></td><td colspan="2"></td></tr>
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<tr><th colspan="2">5. Implementing Service Redesign for Quality</th><th colspan="2">Lead: Chief Operating Officer/Director of Leadership and Organisational Development</th></tr>
<tr><td colspan="2">Aims:<ul><li>To implement the major service changes agreed in the Service Redesign for Quality programme, including new theatres and an Emergency Floor at Worthing, Ophthalmology at St Richard's and ambulatory care at Southlands</li><li>To contribute to the Sussex Together programme to ensure high quality, sustainable services</li></ul></td><td colspan="2">Key work streams:<ul><li>Admissions avoidance and early supported discharge</li><li>Capital programme at Worthing to provide 2 new laminar flow theatres (link to Surgery programme 2)</li><li>Emergency Floor implementation at Worthing (link to Medicine programme 1)</li><li>Ambulatory care development at Southlands, including Ophthalmology</li><li>Ophthalmology development at SRH</li></ul></td></tr>
<tr><td>Q1:<br>Board approval of Emergency Floor development<br>Scoping of ambulatory care development at Southlands</td><td>Q2:<br>SHA approval of Emergency Floor (if required)<br>Laminar flow theatres open in Worthing<br>Ophthalmology development opens at SRH</td><td>Q3:</td><td>Q4:<br>Sign-off for start of building work early 2013</td></tr>
<tr><td colspan="2">Measures of success:<ul><li>Successful opening of the new theatres at Worthing by July 2012</li><li>Board approval of the Business Case for an Emergency Floor at Worthing in Q1 and start of building work by Q4</li></ul></td><td colspan="2"><ul><li>Opening of Ophthalmology development at SRH by Q2</li><li>Fully develop plans for an ambulatory care centre at Southlands by December 2012</li></ul></td></tr>
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<tr><th colspan="2">6. Developing and Implementing our Clinical Services Strategy</th><th colspan="2">Lead: Chief Operating Officer/Director of Leadership & Organisational Development</th></tr>
<tr><td colspan="2">Aims:<ul><li>To develop the Trust's Clinical Services Strategy in order to provide a clear basis for future priorities for service development</li><li>To ensure the implementation of the next steps of the Clinical Services Strategy through the Divisional programmes</li></ul></td><td colspan="2">Key work streams:<ul><li>Work with the Board to develop and confirm strategic intent</li><li>Continue to engage with each of the clinical divisions to ensure ownership and consistency of Clinical Services Strategy</li><li>Ensure alignment with the Trust business planning process, including the Trust's Capital Programme</li><li>Work with Local Health Economy stakeholders to ensure congruence of strategy with the aims of Sussex Together</li></ul></td></tr>
<tr><td>Q1:<br>Revised Clinical Services Strategy approved by Board</td><td>Q2:</td><td>Q3:<br>Updated Annual Plan and Corporate Objectives reflecting the Clinical Services Strategy</td><td>Q4:<br>Integrate Clinical Services Strategy with the service developments and programmes contained within the Trust's 2013-14 Annual Plan</td></tr>
<tr><td colspan="4">Specific service developments contained within Divisional Delivery Plans</td></tr>
<tr><td colspan="2">Measures of success:<ul><li>Board-approved Clinical Services Strategy in place</li><li>Revised Annual Plan which reflects these changes</li><li>Updated Corporate Objectives which reflect the Strategy</li><li>Annual Plan for 2013-14 which demonstrates ongoing implementation of the Strategy</li></ul></td><td colspan="2"></td></tr>
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<tr><th colspan="2">7. Developing Effective Engagement</th><th colspan="2">Lead: Director of Leadership & Organisational Development</th></tr>
<tr><td colspan="2">Aims:<br>Internal and external programme to:<ul><li>Improve staff, member and public engagement with, and perceptions of, the organisation</li><li>Improve staff communication and engagement, including through more timely feedback and response actions</li><li>Develop partnership working further with staff representatives</li><li>Improve engagement in relation to the protected characteristics of the Equality Act</li></ul></td><td colspan="2">Key work streams:<ul><li>Promulgate vision and values and translate into expectations of staff; communications and marketing material; and performance management processes.</li><li>Improve staff engagement through implementation of divisional action plans focusing on specific areas of concern/improvement highlighted in the staff survey</li><li>Engagement of membership and improved engagement opportunities for public and stakeholders.</li><li>Public profile and media handling</li></ul></td></tr>
<tr><td>Q1:<br>Vision and values tested with staff – leading to key trust messages<br>Communication processes reviewed and refined<br>Divisional staff engagement/survey priorities identified<br>Face-to-face briefing/engagement sessions between ET and senior managers (ongoing)<br>Expand use of social media as a means both of communication and engagement<br>MP, HOSC, LINk briefings (ongoing)<br>Engagement plan for members commenced<br>Promote election of FT governors</td><td>Q2:<br>Audit of new team briefing to determine effective forms of communication<br>Divisional staff focus groups conducted<br>Divisional staff engagement/survey action plans agreed<br>Develop role of Stakeholder Forum post-FT<br>Support skills development of FT Governors</td><td>Q3:<br>Engagement events for members continued<br>Engagement/marketing strategy with GPs developed<br>Begin roll-out of handheld technology to gain timely staff views at divisional/service level<br>Implementation of divisional staff engagement action plans<br>Re-launch InTouch (members' magazine)<br>Support FT Governors to engage effectively with wider membership<br>Promote participation in Staff Survey</td><td>Q4:<br>Support FT Governors to engage effectively with wider membership<br>Implementation of divisional staff engagement action plans</td></tr>
<tr><td colspan="2">Measures of success:<ul><li>Improve annual staff survey aggregate score for engagement, with longer-term aim of being in top 20% of trusts</li><li>Improve annual staff survey question score for perception of communication with senior managers</li><li>Increase positive perceptions in SHA media analysis</li></ul></td><td colspan="2"><ul><li>Active, engaged membership: increase membership to 8,000 and elect full council of governors</li><li>Reduced patient complaints related to staff attitude (see Programme 1)</li><li>Run compliant consultations as required</li></ul></td></tr>
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| 8. Achieving Foundation Trust Status | | Lead: Director of Finance | |
|---|---|---|---|
| **Aims:**<br>• To achieve Foundation Trust for the Trust by Q3 | | **Key Work Streams**<br>• Programme Management of FT process | |
| ***Q1:***<br>*Begin Monitor Assessment Phase* | ***Q2:***<br>*Election and appointment of Governors* | ***Q3:***<br>*Completion of Monitor Assessment Phase*<br>*Achievement of FT status*<br>*Council of Governors convenes* | ***Q4:*** |
| **Measures of success:**<br>• Initiation of Monitor Assessment Phase<br>• FT authorisation awarded | | | |

<table>
<tr><th colspan="2">9. Ensuring Sustainability</th><th colspan="2">Lead: Chief Operating Officer, Director of Finance and Director of Leadership & Organisational Development</th></tr>
<tr><td colspan="2">Aims:<br>To ensure delivery and robust management of the Trust's financial and operational requirements, including:<ul><li>The Monitor Compliance Framework/ National Performance Framework</li><li>Cost Improvement Plans/QIPP</li><li>Integrated workforce plan to ensure delivery of operational requirements, including the appropriate capacity and skills</li></ul></td><td colspan="2">Key work streams:<ul><li>Cost Improvement</li><li>Coastal Cabinet - QIPP</li><li>Integrated performance</li><li>Integrated workforce planning and assurance</li><li>Service Line Management (see programme 10)</li><li>Service/pathway service improvement – Cancer, 18 Weeks, Stroke, HCAI, A&E</li></ul></td></tr>
<tr><td>Q1:<br>Agreed workforce plan in place (12/13)</td><td>Q2:</td><td>Q3:<br>Identify education and CPD requirements to inform future</td><td>Q4:<br>Agreed workforce plan in place (13/14)</td></tr>
<tr><td colspan="4">Please refer to CIP/QIPP plans for specific milestones</td></tr>
<tr><td colspan="2">Measures of success:<ul><li>Achieve a score of less than 2 against the Monitor Compliance Framework</li><li>Achieve an overall financial surplus of £5.2m</li><li>Achieve Cost Improvement Plan (CIP) savings of £19.4m</li><li>Continuously improve Trust RAG rating in SHA workforce assurance framework</li></ul></td><td colspan="2"><ul><li>Continuous improvement and sustained achievement of workforce KPIs relating to capacity, resourcing and efficiency</li><li>Improve appraisal rates (81% at March 12) and statutory/mandatory training rates (in the range 74%-90% for different training modules at March 12) to ensure compliance with the national standard of 95% by March 2013</li></ul></td></tr>
</table>

<table>
<tr><th colspan="2">10. Implementing Service Line Management (SLM)</th><th colspan="2">Lead: Chief Operating Officer</th></tr>
<tr><td colspan="2">Aims:<ul><li>To develop and implement SLM across the Trust</li></ul></td><td colspan="2">Key work streams:<ul><li>Clinical leadership and education</li><li>Increasing availability and awareness of SLR information</li><li>Improve the information infrastructure to support SLM implementation, including spread of patient-level costing</li><li>Implementation planning revision</li></ul></td></tr>
<tr><td>Q1:<br>Introduce revised clinical leadership structure, which support SLM</td><td>Q2:<br>Design clinical leaders' programme to support SLM<br><br>Complete roll-out of SLM pilot to all divisions</td><td>Q3:<br>Commence education programme for clinical leaders<br><br>Single point of access for SLM established<br><br>Detailed implementation plan designed and agreed</td><td>Q4:<br>Commence delivery of detailed implementation plan</td></tr>
<tr><td colspan="2">Measures of success:<ul><li>Integrated SLM reports in place in all services</li><li>Clinical leadership structure and education programme in place</li><li>Detailed implementation designed and agreed</li></ul></td><td colspan="2"></td></tr>
</table>

## 6. Divisional Delivery Programmes

6.1 The four clinical divisions (Medicine, Surgery, Women & Children and Core) have a crucial role to play in delivering our Corporate Objectives for 2012-13, as well as the Trust's overall strategy. Each division has carried out business planning for 2012-13 to outline the division's priorities, key delivery programmes and their contribution to the corporate objectives.

6.2 Each division contributes to each of the corporate objectives in a number of different ways. The corporate programmes all have a divisional impact and will not be successful without being embedded throughout divisional operations. Each division has mapped the specific contribution of its identified programmes to the corporate objectives at Appendix C. However, much of the work to achieve the corporate objectives is a core part of 'everyday business', such as patient outcomes, initiatives to improve patient safety, operational performance and contributing to financial sustainability.

6.3 As well as ensuring effective delivery of corporate objectives, divisions have their own specific areas of focus, based on the services that they offer and the needs of the patients whom they serve. Where the Clinical Services or Quality strategies have a specific divisional implication, these are outlined within the divisional delivery programmes.

6.4 A number of divisional plans are dependent on the outcomes of options appraisals, business case reviews, wider health economy decisions and/or, potentially, consultation. The plans are, therefore, subject to amendment and development during the year.

6.5 The delivery of corporate and divisional plans is also often dependent on the contributions and actions of other clinical divisions, non-clinical teams (such as Estates & Facilities, IM&T or HR) or other local health economy partners. This is outlined in the detailed plans supporting each work programme.

6.6 The key objectives of each clinical division are outlined below:

| Division | Objectives 2012-13 |
|---|---|
| **Medicine** | 1. Gain approval for, and plan the development of, an Emergency Floor at Worthing Hospital<br>2. To develop a fully integrated Rheumatology Service for patients in West Sussex<br>3. Implement Specialty Business Units in Medicine<br>4. Implement improvements in Stroke and TIA pathways<br>5. Avoid unnecessary non-elective admissions through Ambulatory and other care pathways<br>6. Open a second cardiac catheter lab at Worthing Hospital and repatriate appropriate activity from other providers<br>7. If appropriate, achieve success in Dermatology procurement<br>8. Maintain Endoscopy accreditation and improve efficiency of service |

| | |
|---|---|
| | 9. Work with commissioners to refine the Proactive Care and One Call/One Team to reduce unscheduled emergency admissions and provide care closer to home |

| Division | Objectives 2012-13 |
|---|---|
| **Surgery** | 1. Theatres: improve operating theatre productivity and efficiency<br>2. To develop, recommend and implement preferred option for the optimisation of day surgical facilities across Worthing and Southlands Hospitals<br>3. Theatre non-pay efficiency : Stock management, rationalisation and standardisation<br>4. Deliver Service Redesign for Quality Changes in Trauma and Elective Orthopaedic Services<br>5. Develop and implement strategy for Breast Services<br>6. Further develop and implement strategy for Ophthalmology Services<br>7. Introduce and roll out Medical Staffing Electronic rostering system TAR<br>8. Implement Specialty Business Units in Surgery |

| Division | Objectives 2012-13 |
|---|---|
| **Women & Children** | 1. Deliver evidence for assessment to Maternity CNST (Clinical Negligence Scheme for Trusts) Level 2 in year<br>2. Implement Gynaecology service improvements<br>3. Children and Young People: Beach and Barn Ward reconfiguration<br>4. Medical staffing redesign to ensure sustainability<br>5. Develop case for a Maternity Led Unit at Worthing Hospital<br>6. Strategic review of Paediatric and Maternity services<br>7. Neonatal Services: strengthening and developing services and workforce to meet neonatal standards |

| Division | Objectives 2012-13 |
|---|---|
| **Core** | 1. Transform service delivery: service review and redesign<br>2. Ensure appropriate information management systems, applications, processes and supporting infrastructure to enable all staff to work efficiently, effectively and safely<br>3. Improve the way in which the Division uses information received from patients, users and the public to inform practice and improve service delivery<br>4. Develop our staff to their full potential: capacity and capability to deliver high quality, professional care, including Medicines Management improvements<br>5. To transform how we work to deliver services: productivity in Pharmacy, Radiology and Pathology<br>6. Work in partnership and integrate services with other agencies to deliver multidisciplinary care and flexible care pathways<br>7. Ensure best practice in the safe handling of medicines throughout prescribing, supply and administration |

6.7 Each division has produced detailed plans for the delivery programmes which support each objective. These plans include clear aims and objectives, milestones, resource implications and measurable impacts. They also have clearly identified clinical and managerial leads.

6.8 Progress against the divisional plans and risks to delivery will be monitored in line with the Performance Framework, outlined in Section 8. The Framework includes robust processes by which divisions are held to account for their delivery and provide assurance to the Board.

6.9 The successful delivery of divisional plans relies on the commitment and skill of staff in all disciplines and at all levels. Significant work has been and is taking place to ensure that staff receive the appropriate training, development and support to achieve both divisional and corporate objectives and to empower staff to make real improvements to patient care.

6.10 A number of non-clinical teams play a significant role in ensuring the effective delivery of both corporate programmes and the objectives and programmes of the clinical divisions. These teams each have their own annual plans, partly to ensure the maintenance of 'business as usual' and partly to contribute to, or lead, major change programmes. The key areas of work that contribute to the corporate and divisional objectives for 2012-13 are:

| | Support for Corporate Programmes | Support for Divisional Programmes |
|---|---|---|
| **Facilities & Estates** | 1. Maintain the Excellent standard achieved for food, environment and privacy and dignity in the national PEAT | 1. Implement specific changes in line with divisional service developments to deliver the Clinical Services Strategy and Service Redesign for |

| | Support for Corporate Programmes | Support for Divisional Programmes |
|---|---|---|
| | assessments<br>2. Continue to develop the Patient Environment Action Groups and Food Strategy, in conjunction with clinical divisions<br>3. Develop and deliver a Catering Strategy for the whole Trust<br>4. Develop a Sustainability Delivery Management strategy for the Trust<br>5. Develop waste management and recycling targets for the Trust<br>6. Deliver estate capital projects as approved in the Trusts annual Capital programme<br>7. Review the Estates Strategy in line with clinical strategy and divisional developments | Quality<br>2. Support and develop plans with Clinical Divisions to support CIP and QIPP programmes<br>3. Continue to implement the improvements to local services as envisaged in our clinical services strategy, in particular our 'Service Redesign for Quality' programme<br>4. Continue to improve the patient environment through investment in the Trust's Estate. |
| **IM&T** | 1. Develop a business case for document scanning/'paper light' for approval in Q2 and link with Office Automation across the Trust<br>2. Contribute to patient safety by completing the implementation of Near-patient Monitoring in Q1<br>3. Progress implementation of electronic assessments for VTE and other patient safety initiatives<br>4. Roll-out of White Board functionality across the Trust, following e-Whiteboard implementation in the Acute Medical Unit (AMU)<br>5. Support Service Line Reporting and Monitoring implementation<br>6. Development of a business case to support the creation and implementation of a 'Clinical Desktop' to provides | 1. Surgery<br>• Theatres system replacement to go live in Worthing in Q1, following implementation in 11-12 at SRH and Southlands<br>• Theatre stock control: to provide a central stock control solution for all consumables and trays.<br>• Electronic pre-assessment<br>2. Women & Children<br>• Maternity Information System replacement/implementation by Q2<br>3.Core<br>• E-Prescribing implementation<br>• Pharmacy systems merger in Q1<br>• Order Comms implementation within Pathology<br>• Pathology system replacement<br>• Radiology system replacement or renewal: complete the Sussex wide collaborative procurement |

| | Support for Corporate Programmes | Support for Divisional Programmes |
|---|---|---|
| | a patient centric view of all available clinical information held on our patients<br>7. Continuation of clinical coding improvements to support the delivery of the Quality Strategy | and implementation of the new PACS, RIS and vendor neutral archive<br>• Radiology vendor neutral archive solution: implementation by Q2 |
| **Human Resources** | 1. Ensure contracts with university and education providers are used effectively to support Trust objectives, including monitoring uptake<br>2. Ensure active monitoring of professional and study leave<br>3. Facilitate process to improve quality and uptake of appraisals and PDP to ensure all staff are working towards the delivery of the corporate and divisional objectives<br>4. Improve staff involvement and engagement, in line with the staff survey and improve recognition across the Trust<br>5. Support medical revalidation across the Trust<br>6. Ensure compliance with the public sector duties in the Equality Act 2010 by achieving the agreed five objectives for equality and diversity, developed using the equality delivery system.<br>7. Pilot customer care training and progress pathway of leadership development for managers<br>8. Agree and implement a staff wellbeing strategy<br>9. Improve workforce productivity through the implementation of time/attendance/rostering software<br>10. Lead staff consultation process for Service Redesign for Quality or other proposed service changes<br>11. Complete review and negotiations on the revised on- | 1. Support divisions in the identification of the workforce implications associated with service changes e.g. management of change, TUPE transfer, job design, job planning, training and development needs identified, recruitment and selection<br>2. Support divisions to ensure workforce plans in place that supports CIPs and improves workforce productivity over next 5 years<br>3. Support divisions to ensure robust job planning is in place<br>4. Facilitate development and implementation of divisional plans to improve staff satisfaction (staff survey action plans)<br>5. Support divisions to identify productivity opportunities and achieve workforce KPIs (sickness absence, turnover, reduction in temporary staff, skill mix review, statutory and mandatory training)<br>6. Hold divisions to account on workforce outcomes and performance through the integrated approach of the Trust Performance Framework |

| | Support for Corporate Programmes | Support for Divisional Programmes |
|---|---|---|
| | call arrangements<br>12. Increase the number of e-learning modules available to reduce staff release | |

# 7 Integrated Activity, Capacity, Workforce and Financial Plan

## Integrated Plan 2012-13: Summary

7.1 The table, below, summarises our activity, capacity, financial and workforce plans for 2012-13 for each Clinical Division.

| Division | Activity Plan (spells) | Capacity Plan (beds) | Expenditure Plan (£000) | CIP (£000) | Workforce Plan (WTE) |
|---|---|---|---|---|---|
| **Medicine** | 52,528 | 557 | 84,510 | 3,591 | 1,453 |
| **Surgery** | 43,963 | 303 | 75,324 | 4,195 | 1,264 |
| **Women & Children** | 17,350 | 95 | 40,283 | 2,134 | 631 |
| **Core** | 225 | 1 | 61,729 | 3,084 | 1,126 |

7.2 More detailed tables covering organisational activity and financial planning, together with an outline of the Cost Improvement Programme, are available at Appendix B. These are based on the plan and assumptions signed off by the Trust Board in March 2012. Private patient activity is not included in the numbers above.

7.3 Activity projections for 2012/13 have been based on 2011/12 forecast outturn activity with uplift for estimated population growth using data from the Office of National Statistics. Other known changes and pressures around 18 weeks, plus service changes in the Divisions have been included. The Trust is working with NHS Sussex and other health partners to refine the demand management plans for 2012/13 and to deliver emergency admission reductions.

7.4 Income projections have been based on the activity projections described above. They are based on the payments by Results expected tariff for 2012/13, which has seen a deflation of 1.8% on prices from the previous year. The non-payment for readmissions has been included.

7.5 A further reduction has been included for the effect of demand management, resulting in a Sussex PCT healthcare income figure of £295.6m. This figure is consistent with the memorandum of understanding between the Trust and NHS Sussex. Demand management plans for reducing emergency admissions have been devised by the PCT, and work is continuing within the local health economy to refine these plans to ensure a sustainable health system.

7.6 Pay and Non Pay budgets have been derived from the 2011/12 expenditure budgets. This baseline has then been adjusted for inflationary pressures, and for cost pressures resulting from activity and other known changes.

7.7 The Capital Programme includes schemes that are funded by internally generated cash and schemes that are proposed to be funded by long-term borrowing.

7.8 The Trust has an efficiency requirement of 5.4%, based on projected income and expenditure. This is higher than the 4% efficiency requirement assumed in the NHS Operating Framework for 2012/13 due to an estimated increase in readmission payments made in 2011/12 and the reduction from demand management.

7.9 A Cost Improvement Programme has been developed with divisional input. It includes major components from the Trust clinical strategy. All cost improvement schemes are quality impact assessed to ensure that the implications for patient outcomes, patient safety and patient experience are understood, and can be measured. Cost improvement schemes have been risk rated based on the degree of influence that the Trust has over the scheme and the expected progress during the year. The risk rated efficiencies expected to be delivered by the programme are £18.3m.

7.10 Liquidity and cash flow remain key issues for the Trust and are a risk to the success of our Foundation Trust application. The Trust is currently working with the Department of Health to develop a solution that will allow the Trust to be authorised as a Foundation Trust.

| Metric | 2012/13 | |
|---|---|---|
| | Plan | Risk Rating |
| **EBITDA Margin (%)** | 8.2% | **3** |
| **EBITDA Plan Achieved (%)** | 100% | **5** |
| **I&E Surplus Margin (%)** | 1.5% | **3** |
| **Return on Assets (%)** | 2% | **4** |
| **Liquid Ratio (days)** | 24 | **3** |
| **Overall Risk Rating** | | **3** |

## 8. Ensuring Success

8.1 Our Annual Plan is ambitious and its successful delivery will depend on active work towards the corporate objectives at all levels of the Trust.

8.2 The Trust's Performance Framework is in place to help ensure that performance reporting and review is embedded at each level of the organisation and can be tracked from specialty to Board level. This integrates with Service Line Management and the annual plans of each division.

8.3 The Performance Framework aligns corporate objectives, the NHS Operating Framework and Constitution, associated contractual requirements, and the elements of the Monitor Compliance Framework through all levels of the organisation.

8.4 The Trust Board is responsible for agreeing the organisation's plans, which the Executive have responsibility to implement. The Trust Board reviews progress against the Corporate Objectives on a monthly basis, supported by a Corporate Objectives dashboard. Every quarter the a report on progress against delivery of the Annual Plan is reviewed by the Trust Board

8.5 The Trust Executive oversees a comprehensive performance governance structure. The Trust Executive Board reviews Divisional performance across quality, performance and finance through a monthly Divisional Integrated Performance review. Each of the Divisions has a Divisional Management Board which supports this process. On a quarterly basis, the Divisional Integrated Performance meetings review progress against the quarterly milestones contained within the Divisional Programmes within the Annual Plan. The Divisional Executive Performance meetings are supported by Divisional dashboards which provide a comprehensive picture of performance at a Divisional level.

8.6 Our governance framework has developed to support our future requirements as a Foundation Trust. On achieving Foundation Trust status, we will incorporate quarterly reporting requirements to Monitor within our governance framework and will be well-prepared to work in an environment in which Governors will hold the Board to account on its delivery against the Trust's corporate objectives.

8.7 Risk management is embedded within the Trust's processes. The Board Assurance Framework describes the key risks to delivery of the corporate objectives and outlines relevant controls and assurances, together with any further actions required to mitigate the risks. The Board Assurance Framework for the 2012-13 objectives was approved by the Trust Board in April 2012. The more significant risks are summarised below. Those with a residual risk of 12 are colour-coded orange and those at 15 or above are red, based on the assessed impact, likelihood and impact of the controls.

| Ref | Corporate Objective | Description of Risk (Risk Register ref.) | Gross Risk Rating | | Controls | Net Risk Rating | |
|---|---|---|---|---|---|---|---|
| | | | L | I | | L | I |
| A1 | Increase the number of patients who would recommend the Trust to family or friends | **2. Patients have a poor experience of our services** | **4** | **5** | **1. Provision of patient monthly safety metrics to provide public assurance.**<br><br>**2. Monthly review of RTPE feedback to ensure that public concerns are identified and resolved in a timely fashion.**<br><br>**3. Monthly Divisional Performance Review Panel meetings**<br><br>**4. Stakeholder engagement and feedback**<br><br>**5. Peer reviews of Care & Compassion** | **3** | **5** |
| B1 | Deliver the quality outcome gains specified in the Trust's Quality Strategy, in particular a reduction in the Trust's mortality rate | **2. We fail to provide to staff timely and accurate information on mortality and other quality issues, impeding the tracking of improvement actions.** | **5** | **3** | **1. Patientrack data are reviewed at monthly project meetings**<br><br>**2. New role of Trust-wide Clinical Lead for clinical quality improvement: early objective is to develop mortality information system.** | **4** | **3** |
| E1 | Work with our LHE partners to help deliver the 'Sussex Together' programme, including jointly developing and implementing our plans for Planned Care and Proactive Care. | **1. External partners fail to help deliver programmes (293) (LHE)** | **5** | **4** | **1. Ongoing engagement with our Commissioners to ensure success of Sussex Together programme**<br><br>**2. Manage Divisional planned and proactive care programmes to improve access and discharge arrangements** | **4** | **4** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| G1 | Achieve Foundation Trust status | **1. The Department of Health does not pass the application to Monitor in timely fashion** | **4** | **5** | **1. Providing assurance to DH regarding 12/13 SLA.** | **4** | **5** |

8.8 The Annual Plan has been developed within the framework of the agreed business planning cycle within the Trust. Effective business planning helps to ensure that we have the capacity to deliver our future business objectives in a sustainable manner.

8.9 Improvements have been made to the process to ensure integrated and aligned financial, activity and workforce planning for 2012-13, which is reflected at both organisational and divisional level.

8.10 We will continue embedding our business planning cycle during 2012-13 and will incorporate the outputs of our refresh of the Clinical Services Strategy. This will allow us to identify our major schemes by September 2012 and the work up of related business cases by December 2012. It will be integrated with Service Line Management to ensure that each service and division has a robust Annual Plan which supports the Trust's objectives. The process will also be aligned with emerging commissioning intentions and delivery plans across the local health economy.

# 9 Appendices

## Appendix A: Corporate Scorecards

The Trust has developed a number of corporate scorecards to enable robust monitoring and performance management of the range of national and local performance and quality requirements, in support of the Trust's objectives. These will be underpinned by divisional scorecards as part of an integrated Performance Framework, as described in Section 8. The scorecards have been developed extensively in 2011-12 and will be augmented as further data and information becomes available.

The examples here are from March 2012.

The scorecards examples included here are:

- Monitor Compliance Framework
- NHS Performance Framework
- Quality
- Corporate Objectives Overview

## Monitor Compliance Framework

MARCH 2012

| | Key performance Indicator(s) | Threshold | Weighting | Apr | May | Jun | Q1 | Weighted Score | Jul | Aug | Sep | Q2 | Weighted Score | Oct | Nov | Dec | Q3 | Weighted Score | Jan | Feb | Mar | Q4 | Weighted Score | 2011/12 YTD | FDT Weighted score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Safety** | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 | Clostridium Difficile – meeting the Clostridium Difficile objective | 90 | 1.0 | 11 | 6 | 7 | 24 | 0.0 | 5 | 5 | 9 | 19 | 0.0 | 9 | 3 | 8 | 20 | 0.0 | 3 | 3 | 7 | 13 | 0.0 | 76 | 0 |
| 1.2 | MRSA – meeting the MRSA objective | 6 | 1.0 | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 |
| **Patient Experience** | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2.1 | Referral to treatment waiting times – admitted patients (95th percentile wks) | 23 | 1.0 | 28.5 | 27.3 | 31.6 | 29.3 | 1.0 | 29.5 | 28.0 | 25.8 | 27.8 | 1.0 | 21.9 | 22.1 | 20.9 | 21.6 | 0.0 | 21.8 | 22.8 | 21.8 | 22.3 | 0.0 | 25.5 | 0 |
| 2.1 | Referral to treatment waiting times – non-admitted patients (95th percentile wks) | 18.3 | 1.0 | 17.1 | 16.7 | 15.6 | 16.4 | 0.0 | 16.9 | 17.0 | 16.3 | 16.7 | 0.0 | 16.9 | 16.7 | 16.9 | 16.8 | 0.0 | 17.0 | 18.0 | 17.9 | 17.5 | 0.0 | 16.9 | 0 |
| 2.3 | Certification against compliance with requirements re access to healthcare for people with a learning disability | YES | 0.5 | | | | | | | | | | | | | | | | | | | | | 0 | 0 |
| **Quality** | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3.1 | All cancers : 31-day wait for second or subsequent treatment - surgery treatments | 94% | 1.0 | 100% | 100% | 97.06% | 98.97% | 0.0 | 100% | 97.78% | 100% | 99.19% | 0.0 | 100% | 97.06% | 100% | 97.75% | 0.0 | 100% | 96.77% | 88.24% | 96.34% | 0.0 | 98.21% | 0.0 |
| 3.2 | All cancers : 31-day wait for second or subsequent treatment - drug treatments | 98% | 1.0 | 100% | 100% | 100% | 100% | | 100% | 100% | 95.83% | 98.78% | | 100% | 100% | 100% | 100% | | 100% | 100% | 100% | 100% | | 99.62% | |
| 3.3 | All cancers : 62-day wait for first treatment following urgent GP Referral | 85% | 1.0 | 86.63% | 79.40% | 83.47% | 82.46% | 1.0 | 89.20% | 91.10% | 92.15% | 90.88% | 0.0 | 93.21% | 93.12% | 92.06% | 92.78% | 0.0 | 90.83% | 87.39% | 91.11% | 89.68% | 0.0 | 89.01% | 0 |
| 3.4 | All cancers : 62-day wait for first treatment following consultant screening service referral | 90% | 1.0 | 85.42% | 83.33% | 74.55% | 80.89% | | 86.67% | 96.36% | 100% | 95.59% | | 83.33% | 97.92% | 93.55% | 92.36% | | 95.16% | 87.18% | 100.00% | 95.09% | | 90.87% | 0 |
| 3.5 | All cancers : 31-day wait from diagnosis to first treatment | 96% | 0.5 | 97.94% | 98.48% | 98.25% | 98.26% | 0.0 | 98.54% | 99.03% | 99% | 98.90% | 0.0 | 95.07% | 96.08% | 98.17% | 96.42% | 0.0 | 98.17% | 99.53% | 100.00% | 99.20% | 0.0 | 98.18% | 0 |
| 3.6 | Cancer : two week wait from referral to date first seen - All patients | 93% | 0.5 | 91.85% | 85.80% | 94.35% | 90.74% | 0.5 | 98.39% | 98.65% | 97.79% | 98.28% | 0.0 | 97.55% | 98.24% | 97.01% | 97.63% | 0.0 | 96.22% | 97.70% | 97.23% | 97.08% | 0.0 | 95.93% | 0 |
| 3.7 | Cancer : two week wait from referral to date first seen - Symptomatic breast patients | 93% | 0.5 | 71.05% | 71.14% | 82.14% | 75.05% | | 98.37% | 97.39% | 97.78% | 97.86% | | 99.30% | 97.02% | 96.67% | 97.61% | | 97.06% | 94.80% | 96.97% | 96.20% | | 91.33% | 0 |
| 3.8 | A&E : Total time in A&E (95th percentile mins) | 240 | | 239 | 239 | 239 | 239 | 0.0 | 239 | 239 | 238 | 239 | 0.0 | 240 | 239 | 240 | 240 | 0.0 | 240 | 331 | 237 | 303 | 0.0 | 240 | 0 |
| 3.9 | A&E : Time to initial assessment (95th percentile mins) | 15 | 1.0 3 or more | | | | | | 11 | 10 | 11 | 11 | | | | | | | | | | | | - | |
| 4.0 | A&E : Time to treatment decision (median mins) | 60 | 0.5 2 or less | | | | | | 61 | 56 | 57 | 58 | | | | | | | | | | | | - | |
| 4.1 | A&E : Unplanned reattendance rate | 5% | | | | | | | 2.69% | 2.67% | 2.65% | 2.67% | | | | | | | | | | | | - | |
| 4.2 | A&E : Left without being seen | 5% | | | | | | | 2.58% | 2.26% | 2.11% | 2.32% | | | | | | | | | | | | - | |
| 4.3 | Stroke Infdicator (TBC) | TBC | 0.5 | tbc | | | | - | - | | | | - | | | | | - | | | | | - | tbc | tbc |
| | **Monitor Compliance Framework Score** | | | | | | | 2.5 | | | | | 1.0 | | | | | 0.0 | | | | | 0.0 | | 0 |

Green : 0 to < 1.0 | Amber/Green 1.0 to < 2.0 | Amber/Red : 2.0 to < 4.0 | Red : 4.0 or more

## NHS Performance Framework

MARCH 2012

| | Key performance Indicators | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | MAR | 2011/12 YTD | 2011/12 Target | Under Pf Threshold | Weighting | Q1 PF Score | Q2 PF Score | Q3 PF Score | Q4 PF Score | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| N1 | Four-hour maximum wait in A&E from arrival to admission, transfer or discharge | 96.84% | 97.43% | 96.68% | 96.77% | 97.01% | 97.65% | 97.90% | 96.39% | 96.76% | 95.72% | 95.24% | 92.10% | 98.60% | 96.57% | 95% | 94% | 1.00 | 3 | 3 | 3 | 3 | |
| N2 | A&E Data completeness : Attendances reported on weekly SITREP vs attendances reported via SUS | - | 100.0% | 99.4% | 100.0% | 99.6% | 100.0% | 100.0% | 99.9% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.8% | 90-110% | >120% or <80% | 0.00 | 3 | n/a | n/a | n/a | |
| N3 | A&E Data Quality | - | PASS | PASS | PASS | PASS | PASS | PASS | PASS | PASS | PASS | PASS | PASS | PASS | PASS | Range of DQ checks applied to CDS data | | 0.00 | 3 | | | | Trend data n/a |
| N3 | Unplanned re-attendance rate - Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by | - | | | | 2.69% | 2.67% | 2.65% | 2.41% | 2.32% | 2.07% | 2.29% | 2.44% | 2.75% | 2.48% | | | | | | | | |
| N4 | Left department without being seen rate | - | | | | 2.58% | 2.26% | 2.11% | 2.42% | 2.18% | 2.57% | 2.15% | 2.71% | 2.30% | 2.36% | | | | | | | | |
| N5 | Time to initial assessment - 95th percentile | - | Targets applicable from Quarter 2 2011/12 | | | 11 | 10 | 11 | 11 | 11 | 12 | 12 | 8 | 3 | 10 | See notes (1) | | 2.00 | n/a | 3 | 3 | 3 | |
| N6 | Time to treatment in department - median | - | | | | 61 | 56 | 57 | 58 | 54 | 52 | 52 | 53 | 56 | 56 | | | | | | | | |
| N26 | Total time in departement - 95th percentile | - | | | | 239 | 239 | 238 | 240 | 239 | 240 | 240 | 331 | 237 | 239 | | | | | | | | |
| N7 | Cancelled ops - breaches of 28 days readmission guarantee as % of cancelled ops | 0.00% | 9.09% | 4.65% | 3.57% | 14.29% | 0.00% | 0.00% | 6.00% | 2.67% | 0.00% | 1.82% | 4.55% | 0.00% | 3.19% | 5% | 15% | 1.00 | 2 | 2 | 3 | 3 | |
| N8 | MRSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | >1SD* | 1.00 | 3 | 3 | 3 | 3 | |
| N9 | C Diff | 9 | 11 | 6 | 7 | 5 | 5 | 9 | 9 | 3 | 8 | 3 | 3 | 7 | 76 | 90 | >1SD | 1.00 | 3 | 3 | 3 | 3 | |
| N10 | RTT - admitted - 95th percentile | 26.8 | 28.5 | 27.3 | 31.6 | 29.5 | 28.0 | 25.8 | 21.9 | 22.1 | 20.9 | 21.8 | 22.8 | 21.8 | 25.5 | 23 | >27.7 | 0.50 | 0 | 0 | 3 | 3 | |
| N11 | RTT - non-admitted - 95th percentile | 17.6 | 17.1 | 16.7 | 15.6 | 16.9 | 17.0 | 16.3 | 16.9 | 16.7 | 16.9 | 17.0 | 18.0 | 17.9 | 16.9 | 18.3 | | 0.50 | 3 | 3 | 3 | 3 | |
| N12 | RTT - incomplete - 95th percentile | 28.6 | 27.8 | 26.6 | 24.7 | 24.2 | 24.3 | 23.8 | 22.7 | 22.8 | 23.9 | 24.4 | 23.8 | 22.3 | 24.4 | 28 | >36 | 0.50 | 3 | 3 | 3 | 3 | |
| N13 | RTT - admitted - 90% in 18 weeks | 80.6% | 81.6% | 81.7% | 77.0% | 77.1% | 77.6% | 82.3% | 90.4% | 90.6% | 92.2% | 91.7% | 91.1% | 91.0% | 85.4% | 90% | 85% | 0.75 | 0 | 0 | 3 | 3 | |
| N14 | RTT - non-admitted - 95% in 18 weeks | 95.5% | 95.7% | 96.0% | 96.9% | 95.7% | 95.6% | 96.3% | 95.9% | 96.2% | 95.9% | 96.1% | 95.0% | 95.1% | 95.9% | 95% | 90% | 0.75 | 3 | 3 | 3 | 3 | |
| N15 | Cancer: 2 week GP referral to 1st outpatient | 93.35% | 91.85% | 85.80% | 94.35% | 98.39% | 98.65% | 97.79% | 97.55% | 98.24% | 97.01% | 96.22% | 97.70% | 97.23% | 95.93% | 93% | 88% | 0.50 | 2 | 3 | 3 | 3 | |
| N16 | Cancer: 2 week GP referral to 1st outpatient - breast symptoms | 83.84% | 71.1% | 71.1% | 82.1% | 98.37% | 97.39% | 97.78% | 99.30% | 97.02% | 96.67% | 97.06% | 94.80% | 96.97% | 91.33% | 93% | 88% | 0.50 | 0 | 3 | 3 | 3 | |
| N17 | Cancer: 31 day second or subsequent treatment - surgery | 97.92% | 100.0% | 100.0% | 97.06% | 100.0% | 97.78% | 100.0% | 100.0% | 97.1% | 100.0% | 100.0% | 96.77% | 88.24% | 98.21% | 94% | 89% | 0.25 | 3 | 3 | 3 | 3 | |
| N18 | Cancer: 31 day second or subsequent treatment - drug | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 95.83% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.62% | 98% | 93% | 0.25 | 3 | 3 | 3 | 3 | |
| N19 | Cancer: 31 day diagnosis to treatment for all cancers | 98.12% | 97.94% | 98.48% | 98.25% | 98.54% | 99.03% | 99.1% | 95.07% | 96.08% | 98.17% | 98.17% | 99.53% | 100.00% | 98.18% | 96% | 91% | 0.25 | 3 | 3 | 3 | 3 | |
| N21 | Cancer: 62 day referral to treatment from screening | 89.17% | 85.42% | 83.33% | 74.55% | 86.67% | 96.36% | 100.0% | 83.33% | 97.92% | 93.55% | 95.16% | 87.18% | 100.00% | 90.87% | 90% | 85% | 0.50 | 0 | 3 | 3 | 3 | |
| N23 | Cancer: 62 days urgent GP referral to treatment of all cancers | 88.05% | 86.63% | 79.40% | 83.47% | 89.20% | 91.10% | 92.15% | 93.21% | 93.12% | 92.06% | 90.83% | 87.39% | 91.11% | 89.01% | 85% | 80% | 0.50 | 2 | 3 | 3 | 3 | |
| N24 | Patients that have spent more than 90% of their stay in hospital on a stroke unit | - | 57.5% (2009/10 CQC assessment) | | | | | | | | | | | | 57.5% | 60% | 30% | 1.00 | 2 | 2 | 2 | 2 | |
| N25 | Delayed transfers of care | 3.2% | 3.9% | 4.5% | 3.1% | 4.1% | 3.1% | 4.0% | 3.3% | 4.5% | 1.8% | 2.5% | 1.8% | 1.8% | 3.2% | 3.5% | 5.0% | 1.00 | 2 | 2 | 3 | 3 | |
| TOTAL WEIGHTED PERFORMANCE | | | | | | | | | | | | | | | | | | | 2.09 | 2.51 | 2.93 | 2.93 | |

Individual measures are scored as follows: Underperforming 0 Performance under review 2 Performing 3

Overall performance threshold: Underperforming when weighted score less than 2.1 (Red) Performance under review when weighted score between 2.1 and 2.4 (Amber) Performing when weighted score above 2.4 (Green)

Notes

1. Achieve the thresholds for at least one indicator in each of the two groups (timeliness - time to initial assessment, time to treatment and patient impact- left without being seen and re-attendance).

# QUALITY SCORECARD

MARCH 2012

| | | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | MAR | YTD Actual | YTD Target | Target | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **IMPROVING CLINICAL OUTCOMES** | | | | | | | | | | | | | | | | | | |
| 1A | **Achieve a 10% reduction in the Trust's crude mortality rate by 2012** | 3.93% | 3.57% | 3.38% | 3.11% | 2.60% | 2.86% | 2.97% | 3.36% | 2.85% | 3.09% | 4.12% | 3.90% | 3.27% | 3.29% | 3.5% | 3.2% | |
| 1B | **Reduce the Hospital Standardised Mortality Rate (HSMR) to 103** | 104.8 | 105.1 | 105.0 | 104.9 | 104.4 | 103.8 | 103.2 | 102.3 | 101.3 | 99.3 | 98.9 | | | 98.9 | 103 | 103 | |
| 1.1 | **Improve treatment pathway and clinical outcomes for stroke patients** | | | | | | | | | | | | | | | | | |
| 1.11 | Reduce HSMR for cerebrovascular disease | 91.5 | 93.7 | 93.5 | 94.7 | 92.3 | 90.9 | 93.8 | 93.1 | 93.5 | 98.4 | 102.4 | | | 102.4 | 100 | 100 | |
| 1.12 | Stroke patients are eligible for best practice tariff payment | 79.2% | 87.5% | 88.2% | 83.1% | 89.7% | 92.6% | 85.5% | 88.4% | 92.4% | 93.7% | | | | 89.2% | 80% | 80% | |
| 1.14 | TIA patients are assessed and comence treatment within 24 hours | 61.1% | 85.7% | 30.0% | 84.2% | 58.3% | 25.0% | 85.7% | 57.1% | 57.1% | 22.2% | 53.8% | 76.5% | | 60.7% | 60% | 60% | |
| 1.2 | **Reduce mortality following hip fracture** | | | | | | | | | | | | | | | | | |
| 1.21A | Reduce HSMR for hip fracture (head of femur replacement) | 182.4 | 194.4 | 198.5 | 197.0 | 213.0 | 208.3 | 201.6 | 188.8 | 182.0 | 177.8 | 148.8 | | | 148.8 | 147 | 140 | |
| 1.21B | Reduce HSMR for hip fracture (all diagnoses/procedures) | 138.4 | 141.6 | 135.3 | 130.9 | 130.4 | 135.0 | 136.4 | 136.3 | 135.9 | 131.0 | 120.0 | | | 120.0 | tbc | tbc | |
| 1.22 | Reduce mortality rate following hip fracture (all diagnoses/procs | 10.0% | 12.5% | 10.3% | 3.9% | 6.2% | 12.3% | 5.7% | 12.9% | 9.5% | 7.3% | 6.5% | 4.5% | | 8.7% | 8.6% | 8.6% | |
| 1.25 | 30 day mortaliy rate following hip fracture (all diagnoses/procs) | 9.2% | 12.1% | 4.4% | 6.5% | 6.0% | 8.6% | 6.3% | 11.3% | 10.4% | 6.4% | 5.8% | | | 8.1% | tbc | tbc | |
| 1.23 | Medically fit patients are operated on within 24 hours (source: NH | 50.9% | 35.8% | 36.4% | 45.8% | 64.1% | 50.0% | 61.0% | 46.3% | 62.1% | 77.6% | 68.3% | 69.8% | | 56.2% | 90% | 90% | |
| 1.24 | Reduce length of stay to best quartile (all diagnoses/procs) | 22.7 | 22.4 | 25.2 | 20.6 | 16.1 | 19.1 | 20.9 | 18.2 | 18.6 | 19.7 | 18.2 | 18.4 | 16.6 | 19.5 | tbc | tbc | |
| 1.3 | **Reduce the rate of readmission following discharge from the Trust** | | | | | | | | | | | | | | | | | |
| 1.31 | Achieve 25% reduction in emergency readmissions within 30 day | 569 | 546 | 562 | 608 | 629 | 579 | 581 | 596 | 600 | 608 | 616 | 570 | | 6,495 | 4,885 | 5,330 | |
| 1.32 | Reduce admissions for patients with over 4 adms in prev 12 mths (data for rolling 12 mths) | 4,200 | 4,174 | 4,192 | 4,143 | 4,203 | 4,121 | 4,096 | 4,088 | 4,229 | 4,177 | 4,211 | 4,264 | 4,217 | 4,217 | 2,100 | 2,100 | |
| 1.4 | **Reduce HSMR for patients admitted under elderly care medicine** | | | | | | | | | | | | | | | | | |
| 1.41 | Reduced HSMR for elderly care medicine | 106.2 | 107.6 | 106.4 | 105.2 | 104.7 | 105.2 | 104.4 | 104.9 | 103.7 | 102.6 | 103.2 | | | 103.2 | 101 | 100 | |
| 1.42 | Disease specific HSMR in 5 areas with greatest number of deaths | 109.1 | 110.8 | 108.3 | 107.9 | 107.0 | 107.4 | 105.8 | 106.3 | 105.3 | 103.7 | 104.8 | | | 104.8 | 104 | 103 | |
| 1.43 | Disease specific HSMR in 5 areas with greatest number of excess | 129.8 | 129.1 | 125.93 | 126.3 | 126.1 | 127.3 | 125.3 | 125.1 | 122.2 | 119.8 | 118.7 | | | 118.7 | 113 | 110 | |
| 1.5 | **To improve maternity care by encouraging natural chilbirth** | | | | | | | | | | | | | | | | | |
| 1.51 | Proportion of mothers having their babies delivered by caesarian | 28.5% | 24.5% | 25.0% | 20.0% | 23.0% | 24.0% | 24.0% | 25.0% | 26.7% | 24.3% | 27.5% | 29.0% | 25.0% | 24.8% | <23% | <23% | |
| 1.52 | Proportion of mothers requiring forceps for delivery | 10.0% | 11.0% | 11.0% | 14.0% | 10.5% | 10.0% | 13.0% | 12.5% | 12.0% | 13.5% | 12.1% | 11.0% | 12.0% | 11.9% | <15% | <15% | |
| 1.53 | Proportion of deliveries complicated by post-partum haemorrhag | 0.43% | 0.91% | 0.82% | 0.40% | 0.79% | 0.85% | 0.00% | 0.21% | 0.22% | 0.84% | 0.85% | 0.24% | 0.43% | 0.57% | 1% | 1% | |
| **SAFETY** | | | | | | | | | | | | | | | | | | |
| 2A | **Achieve reduction in the Patient Aggregate Safety Score (PASS)** | - | 84.96 | 96.14 | 77.89 | 80.39 | 75.37 | 73.41 | 80.74 | 81.89 | 57.25 | 54.58 | 60.9 | 66.3 | 74.4 | <100 | <100 | |
| 2.1 | **Improve safety of prescribing** | | | | | | | | | | | | | | | | | |
| 2.11 | Reduction in moderate or severe prescribing incidents | - | 0 | 1 | 1 | 0 | 1 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 6 | 8 | 8 | |
| 2.12 | Reduction proprtion of GTT returns showing a prescribing issue | Data are under development | | | | | | | | | | | | | | tbc | tbc | |
| 2.13 | Reduced errors on zero tolerance anti-microbial prescribing audits | | 39% | 36% | 49% | 56% | 44% | 48% | 47% | 55% | 42% | 46% | 45% | 54% | 47% | tbc | tbc | |
| 2.2 | **Reduce incidence of healthcare associated VTE** | | | | | | | | | | | | | | | | | |
| 2.21 | 95% compliance with the DoH risk assessment tool | 93.1% | 91.4% | 91.9% | 91.9% | 92.0% | 90.8% | 90.7% | 90.2% | 91.0% | 89.9% | 92.2% | 92.3% | 91.7% | 91.3% | 95% | 95% | |
| 2.22 | 90% compliance with approved VTE prophylaxis in quarterly audi | Data are under development | | | | | | | | | | | | | | tbc | tbc | |
| 2.23 | Reduction in rates of post-admission DVT and PE[4] | 0.13% | 0.08% | 0.18% | 0.20% | 0.18% | 0.26% | 0.15% | 0.10% | 0.13% | 0.17% | 0.13% | | | 0.15% | 0.20% | 0.20% | |
| 2.24 | Reduce readmissions within 90 days due to VTE | 11 | 11 | 15 | 11 | 14 | 17 | 18 | 21 | 11 | 13 | 17 | 15 | | 163 | 121 | 132 | |
| 2.25 | Achieve 20% reduction in mortality from VTE disease | 3 | 4 | 6 | 4 | 3 | 3 | 4 | 5 | 3 | 3 | 10 | 6 | | 51 | 41 | 45 | |
| 2.3 | **Reduce incidence of healthcare acquired infections** | | | | | | | | | | | | | | | | | |
| 2.31 | Number of hospital attributable MRSA cases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 6 | |
| 2.32 | Number of hospital attributable C. diff cases | 9 | 11 | 6 | 7 | 5 | 5 | 9 | 9 | 3 | 8 | 3 | 3 | 7 | 76 | 90 | 90 | |
| 2.33 | Number of MSSA bacteraemia cases | 7 | 4 | 5 | 4 | 5 | 9 | 9 | 12 | 5 | 7 | 9 | 4 | 7 | 80 | tbc | tbc | |
| 2.34 | Surgical site infection rates for colorectal surgery | Data are under development | | | | | | | | | | | | | | tbc | tbc | |
| 2.35 | Surgical site infection rates for hip replacement surgery | Data are under development | | | | | | | | | | | | | | tbc | tbc | |
| 2.4 | **Improve theatre safety for patients** | | | | | | | | | | | | | | | | | |
| 2.41 | Full compliance with WHO Surgical Safety Checklist | | 89% | | | 97% | | | 96% | | | | | | 94% | tbc | tbc | |
| 2.42 | Achieve 50% reduction in unexpected returns to theatre | Data are under development | | | | | | | | | | | | | | tbc | tbc | |
| 2.43 | Elimination of all NEVER events | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | |
| 2.44 | Achieve 75% reduction in theatre related SIRIs | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | |
| 2.5 | **Reduce number of falls in hospital** | | | | | | | | | | | | | | | | | |
| 2.51 | Achieve 15% reduction in falls resulting in low or moderate harm | 45 | 46 | 52 | 33 | 40 | 48 | 38 | 40 | 36 | 33 | 35 | 42 | 41 | 118 | 132 | 531 | |
| 2.52 | Achieve 50% reduction in falls resulting in severe harm or death[3] | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | |
| 2.53 | Falls assessment within 24hrs of admission | - | - | - | - | - | - | - | - | 79.85% | 81.75% | 85.0% | 91% | 93% | 86.0% | 80% | 80% | |
| 2.6 | **Pressure damage** | | | | | | | | | | | | | | | | | |
| 2.61 | Achieve 50% reduction in incidence of grade 2 pressure sores[3] | 24 | 15 | 13 | 12 | 12 | 12 | 2 | 15 | 13 | 12 | 12 | 16 | 12 | 40 | 77 | 213 | |
| 2.62 | Achieve 80% reduction in incidence of grade 3 & 4 pressure sores | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 20 | |
| **PATIENT EXPERIENCE** | | | | | | | | | | | | | | | | | | |
| 3A | **Increase the proportion of patients who would recommend the Trust** | | | | | | | | | | | 87.8% | 87.0% | 88.7% | 88% | tbc | tbc | |
| 3B | **Increase the proportion of staff who would recommend the Trust** | | | | | | | | | | | | - | - | - | tbc | tbc | |
| 3.1 | **Improved scores in targeted patient survey questions** | | | | | | | | | | | | | | | | | |
| 3.11 | I felt involved in the decisions about my care and treatment[5] | - | - | 94% | 90% | 93% | 89% | 91% | 88%(95%) | 92%(80% | 88%(80%) | 76% | 77% | 74% | 77% | tbc | tbc | |
| 3.12 | I felt able to express any fears or anxieties[5] | - | - | 97% | 98% | 97% | 96% | 96% | 95%(95%) | 94%(91% | 93%(87%) | 62% | 65% | 71% | 64% | tbc | tbc | |
| 3.13 | My privacy and dignity was maintained at all times[5] | - | - | 97% | 99% | 98% | 99% | 98% | 95%(95%) | 96%(99% | 95%(98%) | 77% | 76% | 76% | 76% | tbc | tbc | |
| 3.14 | I was informed of medication side effects | | | | | | | | | | | | | | | tbc | tbc | |
| 3.15 | I was informed who to contact if worried about my condition after leaving hospital | | | | | | | | | | | | | | | tbc | tbc | |
| 3.16 | I felt the attitude of staff was good[5] | - | - | 99% | 99% | 100% | 100% | 98% | 99%(100% | 00%(98% | 99%(98%) | | | | 99% | tbc | tbc | |
| 3.2 | **Reduction in patients suffering a bad experience dealing with the Trust** | | | | | | | | | | | | | | | | | |
| 3.21 | Reduce numbers of re-booked outpatient appointments | 8.3% | 11.1% | 8.9% | 8.8% | 8.6% | 9.0% | 8.6% | 7.8% | 7.8% | 8.4% | 8.7% | 8.5% | 9.4% | 8.8% | tbc | tbc | |
| 3.22 | Reduce number of clinics cancelled with less than 6 weeks notice | Data are under development | | | | | | | | | | | | | | tbc | tbc | |
| 3.23 | Reduce the average number of ward stays per non-elective admi | 1.82 | 1.74 | 1.76 | 1.80 | 1.79 | 1.82 | 1.84 | 1.74 | 1.79 | 1.75 | 1.80 | 1.80 | 1.76 | 1.78 | tbc | tbc | |
| 3.24 | Reduce the number of complaints relating to administrative proc | - | - | - | 6 | 4 | 11 | 4 | 3 | 5 | 3 | 5 | 7 | 12 | - | tbc | tbc | |
| 3.25 | Reduce patients cancelled on the day of surgery for non-clinical r | 33 | 22 | 43 | 28 | 14 | 25 | 46 | 50 | 75 | 31 | 55 | 44 | 37 | 470 | tbc | tbc | |
| 3.3 | **Nutritional Assessment** | | | | | | | | | | | | | | | | | |
| 3.31 | Compliance with MUST tool after 24 hours | 87.0% | 89.0% | 90.0% | 90.0% | 87.7% | 88.5% | 85.0% | 85.6% | 84.5% | 84.3% | 84.5% | 85.5% | | 86.8% | 80% | 80% | |
| 3.32 | Compliance with MUST tool after 7 days | - | - | - | 93.0% | 94.0% | 98.5% | 98.0% | 96.8% | 92.1% | 95.5% | 94.0% | 95.0% | | 95.2% | 100% | 100% | |
| 3.33 | Evidence of production and adherence to nutritional action plans | Indicator to be specified | | | | | | | | | | | | | | tbc | tbc | |
| 3.34 | Evidence of success in pre-discharge reassessment audits | Indicator to be specified | | | | | | | | | | | | | | tbc | tbc | |
| 3.4 | **Cleanliness / PEAT Survey** | | | | | | | | | | | | | | | | | |
| 3.41a | Internal PEAT compliance : St Richard's Hospital | - | 90% | 93% | 94% | 93% | 97% | 96% | 98% | 97% | 94% | 98% | 97% | 94% | 95% | 85% | 85% | |
| 3.41b | Internal PEAT compliance : Worthing Hospital | - | 92% | 93% | 93% | 93% | 91% | 94% | 89% | 96% | 97% | 95% | 98% | 97% | 94% | 85% | 85% | |
| 3.41c | Internal PEAT compliance : Southlands Hospital | - | 75% | 92% | 90% | 93% | 89% | 92% | 89% | 100% | 98% | 95% | 96% | 97% | 92% | 85% | 85% | |
| 3.5 | **Improve our customer service and become a more caring organisation** | | | | | | | | | | | | | | | | | |
| 3.51 | Reduction in complaints where staff attitude or behaviour is an issue | | 4 | 3 | 2 | 5 | 2 | 3 | 4 | 7 | 3 | 3 | 3 | 2 | 41 | tbc | tbc | |
| 3.52 | Reduction in complaints where staff communication is an issue | | 8 | 8 | 7 | 4 | 5 | 9 | 7 | 2 | 5 | 4 | 6 | 8 | 73 | tbc | tbc | |
| 3.53 | Positive care and compassion observations in general care | | | - | | | - | | | 87% | | | 76% | | 82% | tbc | tbc | |
| 3.54 | Positive care and compassion observations in patient / visitor interaction | | | - | | | - | | | 91% | | | 77% | | 84% | tbc | tbc | |

**Notes**

1 The five diagnosis groups with the most deaths in 2010/11 are pneumonia, acute cerebrovascular disease, congestive heart failure non-hypertensive, fracture neck of femur and UTI.
2 The five diagnosis groups with the most excess deaths in 2010/11 are Acute and unspecified renal failure, congestive heart failure non-hypertensive, fracture neck of femur, UTI and fluid and electrolyte disorders.
3 Data for these metrics are being monitored against trajectories agreed with the SHA. These are set on a calander year basis.
4 Post operative DVT and PE - Dr Foster Patient Safety Measure
5 Scores given parentheses are taken from the Real Time Patient Experience monitoring system (see Quality Report).

## CORPORATE OBJECTIVES

MARCH 2012

| | Key performance Indicator(s) | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | MAR | This year to date | YTD Target | Target | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **PATIENT EXPERIENCE** | | | | | | | | | | | | | | | | | | |
| PE1 | Patient survey: How good was the overall quality of care you received? | - | - | - | - | - | - | - | - | - | - | - | | | 8/10 | | | |
| PE2 | Number of complaints relating to staff attitude or behaviour/10,000 admissions | - | 4.37 | 3.02 | 1.97 | 5.00 | 1.88 | 2.90 | 3.91 | 6.71 | 3.05 | 2.94 | 2.95 | 7.58 | 3.86 | tbc | tbc | |
| PE3 | Composite patient experience score (national CQUIN) | - | - | - | - | - | - | - | - | - | - | - | | | 67.3 | | | |
| **OUTCOMES** | | | | | | | | | | | | | | | | | | |
| OC1 | HSMR (Trust-wide) | 104.8 | 105.1 | 105.0 | 104.9 | 104.4 | 103.8 | 103.2 | 102.3 | 101.3 | 99.3 | | | | 99.3 | 104 | 103 | |
| OC2 | Crude mortality (Trust-wide) rate | 3.93% | 3.57% | 3.38% | 3.11% | 2.60% | 2.86% | 2.97% | 3.36% | 2.85% | 3.09% | 4.12% | 3.90% | 3.27% | 3.29% | 3.3% | 3.2% | |
| OC4 | % hip fracture repair within 36 hours | 67.2% | 69.8% | 82.1% | 91.9% | 92.3% | 77.6% | 91.4% | 68.1% | 95.1% | 96.0% | 91.8% | 98.5% | 100.0% | 87.6% | 90% | 90% | |
| OC5 | HSMR #NOF (all diagnoses / procedures) | 138.4 | 141.6 | 135.3 | 130.9 | 130.4 | 135.0 | 136.4 | 136.3 | 135.9 | 131.0 | | | | **131.0** | | | |
| **SAFETY** | | | | | | | | | | | | | | | | | | |
| SY1 | Incidence of MRSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 6 | 6 | |
| SY2 | Incidence of C Diff. | 9 | 11 | 6 | 7 | 5 | 5 | 9 | 9 | 3 | 8 | 3 | 3 | 7 | **76** | 90 | 90 | |
| SY3 | Number of prescribing-associated incidents graded moderate or severe | - | 0 | 1 | 1 | 0 | 1 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 6 | 6 | 8 | |
| SY5 | % inpatients assessed for VTE risk using national tool | 93.1% | 91.4% | 91.9% | 91.9% | 92.0% | 90.8% | 90.7% | 90.2% | 91.0% | 89.9% | 92.2% | 92.3% | 91.7% | 91.3% | 95% | 95% | |
| **LOCAL SERVICES** | | | | | | | | | | | | | | | | | | |
| LS1 | Service Redesign for Quality | - | | | | | | | | | | | | | | | | |
| LS2 | Pathway Redesign | | | | | | | | | | | | | | | | | |
| LS3 | Clinical Service Strategy | | | | | | | | | | | | | | | | | |
| **BEING JOINED UP** | | | | | | | | | | | | | | | | | | |
| JU1 | Achievement of Local and Regional CQUIN goals | | | | | | | | | | | | | | | | | |
| JU2 | % patient eligible episodes attracting Best Practice Tariffs | - | 52.3% | 57.1% | 54.7% | 53.6% | 58.1% | 56.5% | 59.7% | 59.6% | 59.5% | | | | 55.0% | 80% | 80% | |
| JU3 | Reduction in Number of Emergency Admissions | 4,196 | 3,960 | 4,116 | 3,896 | 4,056 | 4,138 | 3,954 | 4,171 | 3,967 | 4,165 | 4,205 | 4,167 | 4,412 | **49,207** | < 2010/11 | < 2010/11 | |
| **IMPROVEMENT** | | | | | | | | | | | | | | | | | | |
| I1 | Overall staff engagement score (covers motivation, improvement and recommending trust to others) | | | | | | | | | | | | | | | | | |
| I2 | Staff appraisal rate (YTD position) | - | 85% | 84% | 75% | 68% | 64% | 62% | 68% | 74% | 77% | 79% | 80% | 81% | 81% | 95% | 95% | |
| I3 | Improve our service improvement capacity | | | | | | | | | | | | | | | | | |
| I4 | WHO Theatre Safety Checklist | | | 89% | | | 97% | | | 96% | | | | | **94%** | tbc | tbc | |
| **SUSTAINABILITY** | | | | | | | | | | | | | | | | | | |
| S1 | Service Line Management Roll out | - | | | | | | | | | | | | | | | | |
| S2 | Financial Risk Rating | - | - | - | - | - | 2 | 3 | 3 | 3 | 3 | 3 | 3 | | 3 | 3 | 3 | |
| S3 | CIP savings - % saved against plan | - | - | - | - | - | 81% | 82% | | 97% | 98% | 101% | 98% | | 0% | 100% | 100% | |
| S4 | Foundation Trust status approved | - | | | | | | | | | | | | | | Approved | Approved | |
| S5 | Monitor quality governance risk | - | | | | | | | | | | | | | | | | |
| S6 | Monitor performance compliance framework score | - | 2.5 | 2.5 | 2.5 | 2.0 | 1.0 | 1.0 | 1.0 | 0.5 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | <1.0 | <1.0 | |

# Appendix B: Activity and Finance Plans

## Activity Plan 2012-13: Elective and Non-elective Spells

| Division | Specialty Name | Day Cases | | Elective Inpatients | | Non-Electives | | Total Spells | |
|---|---|---|---|---|---|---|---|---|---|
| | | 2011/12 | 2012/13 | 2011/12 | 2012/13 | 2011/12 | 2012/13 | 2011/12 | 2012/13 |
| Surgical | General Surgery | 2608 | 2554 | 1703 | 1558 | 6483 | 6529 | 10793 | 10642 |
| | Urology | 6261 | 6503 | 1550 | 1402 | 262 | 264 | 8073 | 8169 |
| | Breast Surgery | 278 | 292 | 528 | 529 | 23 | 23 | 829 | 843 |
| | Colorectal Surgery | 3234 | 3498 | 242 | 189 | 33 | 33 | 3509 | 3720 |
| | Upper Gastrointestinal Surgery | 391 | 394 | 15 | 34 | 13 | 13 | 419 | 442 |
| | Vascular Surgery | 248 | 196 | 195 | 103 | 48 | 0 | 491 | 299 |
| | Trauma & Orthopaedics | 3633 | 3789 | 3033 | 2792 | 3562 | 3587 | 10228 | 10167 |
| | ENT | 809 | 872 | 388 | 349 | 193 | 194 | 1389 | 1416 |
| | Ophthalmology | 3457 | 3016 | 71 | 60 | 97 | 98 | 3624 | 3175 |
| | Oral Surgery | 2647 | 2805 | 284 | 207 | 135 | 136 | 3066 | 3148 |
| | Maxillo-Facial Surgery | 936 | 1080 | 24 | 21 | 168 | 172 | 1128 | 1273 |
| | Anaesthetics | 9 | 9 | 0 | 0 | 10 | 10 | 19 | 19 |
| | Pain Management | 574 | 645 | 6 | 6 | 1 | 1 | 581 | 652 |
| **Surgical Total** | | **25084** | **25653** | **8038** | **7250** | **11028** | **11060** | **44150** | **43963** |
| Medical | Accident & Emergency | 0 | 0 | 0 | 0 | 9218 | 9304 | 9218 | 9304 |
| | General Medicine | 1296 | 1297 | 92 | 92 | 17732 | 17870 | 19119 | 19259 |
| | Gastroenterology | 7252 | 7241 | 209 | 212 | 73 | 73 | 7534 | 7526 |
| | Endocrinology | 0 | 0 | 2 | 2 | 5 | 5 | 7 | 7 |
| | Clinical Haematology | 5212 | 5265 | 167 | 168 | 194 | 195 | 5573 | 5627 |
| | Diabetic Medicine | 2 | 2 | 0 | 0 | 24 | 24 | 26 | 26 |
| | Cardiology | 1936 | 2002 | 505 | 537 | 222 | 290 | 2663 | 2829 |
| | Paediatric Cardiology | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 1 |
| | Dermatology | 8 | 3 | 0 | 0 | 1 | 1 | 9 | 4 |
| | Respiratory Medicine | 392 | 393 | 105 | 107 | 40 | 40 | 537 | 541 |
| | Nephrology | 2 | 2 | 0 | 0 | 0 | 0 | 2 | 2 |
| | Medical Oncology | 3025 | 3031 | 8 | 8 | 211 | 212 | 3244 | 3250 |
| | Neurology | 134 | 131 | 0 | 0 | 0 | 0 | 134 | 131 |
| | Rheumatology | 576 | 574 | 2 | 2 | 34 | 34 | 611 | 610 |
| | Geriatric Medicine | 0 | 0 | 0 | 0 | 3367 | 3412 | 3367 | 3412 |
| | Dental Medicine Specialties | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 1 |
| **Medical Total** | | **19833** | **19940** | **1088** | **1127** | **31123** | **31461** | **52044** | **52528** |
| W&C | Paediatric Diabetic Medicine | 0 | 0 | 0 | 0 | 2 | 2 | 2 | 2 |
| | Paediatrics | 0 | 0 | 0 | 0 | 5310 | 5331 | 5310 | 5331 |
| | Neonatology | 0 | 0 | 0 | 0 | 23 | 23 | 23 | 23 |
| | Obstetrics | 0 | 0 | 0 | 0 | 5457 | 5549 | 5457 | 5549 |
| | Gynaecology | 1861 | 1751 | 1108 | 1076 | 1455 | 1470 | 4423 | 4297 |
| | Gynaecological Oncology | 0 | 2 | 0 | 0 | 2 | 2 | 2 | 4 |
| | Midwife Episode | 0 | 0 | 0 | 0 | 2102 | 2145 | 2102 | 2145 |
| **Women & Children Total** | | **1861** | **1752** | **1108** | **1076** | **14351** | **14523** | **17319** | **17350** |
| Core | Interventional Radiology | 174 | 183 | 42 | 42 | 0 | 0 | 216 | 225 |
| **Core Total** | | **174** | **183** | **42** | **42** | **0** | **0** | **216** | **225** |
| **Trust Total** | | **46952** | **47528** | **10276** | **9495** | **56502** | **57044** | **113730** | **114067** |

The activity modelling excludes bariatric services and private patients.

# Activity Plan 2012-13: Outpatients

| Division | Specialty Name | New Outpatients | | Follow Up Outpatients | | Outpatient Procedures | | Total Outpatients | |
|---|---|---|---|---|---|---|---|---|---|
| | | 2011/12 | 2012/13 | 2011/12 | 2012/13 | 2011/12 | 2012/13 | 2011/12 | 2012/13 |
| Surgical | General Surgery | 4760 | 4788 | 5169 | 5199 | 308 | 310 | 10237 | 10297 |
| | Urology | 6858 | 6920 | 12886 | 13003 | 2406 | 2428 | 22151 | 22351 |
| | Breast Surgery | 4797 | 4803 | 7324 | 7333 | 506 | 507 | 12628 | 12644 |
| | Colorectal Surgery | 3845 | 4046 | 3799 | 4005 | 1282 | 1354 | 8926 | 9405 |
| | Upper Gastrointestinal Surgery | 682 | 686 | 830 | 834 | 0 | 0 | 1512 | 1520 |
| | Vascular Surgery | 1545 | 1558 | 1927 | 1943 | 14 | 14 | 3485 | 3514 |
| | Trauma & Orthopaedics | 21387 | 21485 | 32764 | 32915 | 231 | 233 | 54383 | 54632 |
| | ENT | 4754 | 4780 | 5941 | 5973 | 4964 | 4991 | 15659 | 15744 |
| | Ophthalmology | 13104 | 13213 | 30103 | 30352 | 2621 | 2643 | 45828 | 46208 |
| | Oral Surgery | 1480 | 1493 | 4886 | 4928 | 401 | 405 | 6768 | 6826 |
| | Restorative Dentistry | 295 | 296 | 481 | 483 | 78 | 78 | 854 | 857 |
| | Orthodontics | 535 | 536 | 1450 | 1452 | 4725 | 4729 | 6711 | 6717 |
| | Maxillo-Facial Surgery | 4713 | 4756 | 4906 | 4950 | 567 | 572 | 10186 | 10279 |
| | Cardiothoracic Surgery | 2 | 2 | 2 | 2 | 0 | 0 | 3 | 3 |
| | Paediatric Surgery | 108 | 109 | 120 | 121 | 0 | 0 | 228 | 230 |
| | Thoracic Surgery | 81 | 82 | 146 | 147 | 0 | 0 | 227 | 229 |
| | Anaesthetics | 842 | 852 | 33 | 33 | 0 | 0 | 875 | 885 |
| | Pain Management | 609 | 610 | 1719 | 1723 | 2 | 2 | 2330 | 2334 |
| **Surgical Total** | | **70397** | **71014** | **114486** | **115395** | **18106** | **18266** | **202990** | **204675** |
| Medical | Accident & Emergency | 1229 | 1238 | 128 | 129 | 0 | 0 | 1357 | 1367 |
| | General Medicine | 8771 | 8834 | 8457 | 8525 | 558 | 562 | 17786 | 17921 |
| | Gastroenterology | 3821 | 3847 | 4401 | 4424 | 11 | 11 | 8232 | 8282 |
| | Endocrinology | 547 | 550 | 1338 | 1344 | 0 | 0 | 1885 | 1893 |
| | Clinical Haematology | 2193 | 2210 | 10557 | 10632 | 159 | 160 | 12909 | 13003 |
| | Clinical Physiology | 8332 | 8374 | 6104 | 6147 | 3140 | 3162 | 17576 | 17683 |
| | Diabetic Medicine | 1595 | 1599 | 3667 | 3695 | 0 | 0 | 5262 | 5294 |
| | Audiological Medicine | 1135 | 1145 | 144 | 145 | 0 | 0 | 1279 | 1290 |
| | Rehabilitation | 156 | 158 | 540 | 544 | 0 | 0 | 696 | 701 |
| | Cardiology | 5148 | 5280 | 6102 | 6263 | 1578 | 1625 | 12828 | 13168 |
| | Paediatric Cardiology | 42 | 42 | 149 | 150 | 96 | 97 | 287 | 289 |
| | Anticoagulant Service | 935 | 943 | 191 | 192 | 0 | 0 | 1126 | 1135 |
| | Dermatology | 6618 | 6662 | 9118 | 9180 | 7560 | 7611 | 23296 | 23452 |
| | Respiratory Medicine | 3158 | 3173 | 5191 | 5217 | 914 | 918 | 9263 | 9308 |
| | Nephrology | 555 | 559 | 621 | 626 | 0 | 0 | 1175 | 1185 |
| | Medical Oncology | 1153 | 1157 | 4847 | 4865 | 0 | 0 | 6000 | 6023 |
| | Neurology | 3960 | 3982 | 4874 | 4901 | 0 | 0 | 8834 | 8883 |
| | Rheumatology | 5140 | 5157 | 7697 | 7722 | 368 | 369 | 13205 | 13248 |
| | Geriatric Medicine | 1030 | 1040 | 1513 | 1529 | 702 | 709 | 3245 | 3277 |
| | Dental Medicine Specialties | 0 | 0 | 5 | 5 | 0 | 0 | 5 | 5 |
| | Cardiac Rehabilitation Worthing | 657 | 663 | 3421 | 3472 | 0 | 0 | 4078 | 4135 |
| **Medical Total** | | **56173** | **56612** | **79063** | **79706** | **15085** | **15224** | **150321** | **151541** |
| W&C | Paediatric Urology | 0 | 0 | 5 | 5 | 0 | 0 | 5 | 5 |
| | Paediatric Pain Management | 30 | 30 | 141 | 141 | 0 | 0 | 171 | 171 |
| | Paediatric Gastroenterology | 113 | 113 | 177 | 178 | 0 | 0 | 290 | 292 |
| | Paediatric Endocrinology | 20 | 20 | 41 | 41 | 0 | 0 | 60 | 60 |
| | Paediatric Clinical Immunology And Allergy | 63 | 64 | 11 | 11 | 3 | 3 | 77 | 77 |
| | Paediatric Dermatology | 248 | 249 | 158 | 159 | 44 | 44 | 449 | 451 |
| | Paediatric Respiratory Medicine | 263 | 265 | 458 | 461 | 17 | 17 | 738 | 742 |
| | Paediatric Rheumatology | 12 | 12 | 12 | 12 | 0 | 0 | 24 | 24 |
| | Paediatric Diabetic Medicine | 17 | 17 | 17 | 17 | 0 | 0 | 33 | 33 |
| | Community Paediatrics | 1757 | 1767 | 909 | 915 | 0 | 0 | 2666 | 2682 |
| | Paediatrics | 8693 | 8735 | 8789 | 8832 | 278 | 279 | 17760 | 17846 |
| | Paediatric Neurology | 11 | 11 | 14 | 14 | 0 | 113 | 24 | 137 |
| | Neonatology | 1067 | 1073 | 852 | 857 | 0 | 0 | 1919 | 1930 |
| | Obstetrics | 5118 | 5212 | 9962 | 10146 | 4323 | 4403 | 19402 | 19761 |
| | Gynaecology | 9762 | 9839 | 6410 | 6461 | 5078 | 5119 | 21250 | 21418 |
| | Gynaecological Oncology | 340 | 342 | 392 | 394 | 240 | 242 | 972 | 978 |
| | Midwife Episode | 8725 | 8900 | 3793 | 3870 | 0 | 0 | 12518 | 12770 |
| | Community Midwifery | 3419 | 3489 | 28407 | 28989 | 0 | 0 | 31827 | 32478 |
| **Women & Children Total** | | **39656** | **40136** | **60548** | **61500** | **9983** | **10219** | **110186** | **111855** |
| Core | Physiotherapy | 1078 | 1087 | 5385 | 5431 | 0 | 0 | 6463 | 6518 |
| | Occupational Therapy | 753 | 757 | 2741 | 2756 | 0 | 0 | 3494 | 3513 |
| | Speech And Language Therapy | 200 | 201 | 528 | 530 | 0 | 0 | 727 | 730 |
| | Dietetics | 959 | 963 | 902 | 906 | 0 | 0 | 1861 | 1869 |
| | Orthoptics | 2430 | 2447 | 3113 | 3134 | 717 | 722 | 6260 | 6304 |
| | Orthotics | 2961 | 2976 | 2288 | 2299 | 0 | 0 | 5248 | 5275 |
| | Interventional Radiology | 15 | 15 | 5 | 5 | 275 | 276 | 295 | 295 |
| | Chemical Pathology | 394 | 395 | 395 | 396 | 0 | 0 | 789 | 791 |
| | Clinical Physiology Locally Priced | 510 | 515 | 1518 | 1536 | 0 | 0 | 2027 | 2051 |
| | Echo Direct Access | 2284 | 2307 | 640 | 650 | 0 | 0 | 2925 | 2957 |
| **Core Total** | | **11583** | **11664** | **17514** | **17643** | **992** | **998** | **30089** | **30304** |
| **Trust Total** | | **177809** | **179426** | **271612** | **274244** | **44166** | **44706** | **493587** | **498376** |

## Financial Plan 2012-13: Income and Expenditure

| Western Sussex Hospitals NHS Trust<br>Income and Expenditure Account | | |
|---|---|---|
| | 2012/13 | |
| | 2011-12 Forecast Outturn £000s | 2012-13 Budget £000s |
| **Income** | | |
| Income from Activities | 316,187 | 314,111 |
| Other Income for Patient Care | 7,824 | 9,366 |
| Education Training and Research | 18,159 | 17,907 |
| Other Operating Income | 24,929 | 20,118 |
| **Total Income** | **367,099** | **361,502** |
| **Pay** | | |
| Medical Staff | (60,978) | (65,407) |
| Nursing Staff | (87,348) | (90,480) |
| Professions Allied to Medicine | (15,004) | (16,197) |
| Professional and Technical Staff | (16,440) | (17,116) |
| Admin and Managerial Staff | (32,101) | (32,432) |
| Estates Staff | (14,763) | (14,673) |
| Agency Staff | (9,916) | (1,911) |
| Other Pay Costs | 275 | 7,440 |
| **Total Pay Costs** | **(236,276)** | **(230,761)** |
| **Non-Pay** | | |
| Drugs | (23,970) | (22,813) |
| Clinical Supplies and Services | (34,150) | (34,145) |
| General Supplies and Services | (3,687) | (3,659) |
| Establishment Expenses | (6,128) | (7,646) |
| Premises Costs | (12,702) | (13,206) |
| Services from NHS Bodies | (13,822) | (11,754) |
| Services from Non NHS Providers | (708) | (572) |
| Other Operating Costs | (8,274) | (7,380) |
| **Total Non-Pay Costs** | **(103,440)** | **(101,175)** |
| **EBITDA** | **27,383** | **29,550** |
| **Non Operating Items** | | |
| Depreciation and Amortisation | (13,741) | (15,624) |
| Profit/(Loss) on Disposal | (712) | |
| Impairment | (455) | |
| Finance Costs | (776) | (1,452) |
| Interest Receivable | 29 | 32 |
| Public Dividend Capital Dividend | (6,950) | (7,283) |
| **Total Non-Operating Items** | **(22,604)** | **(24,327)** |
| **Net Surplus/(Deficit)** | **4,779** | **5,224** |
| NB - 11/12 FOT includes impairment of £455k which is not part of our control total | | |

# Financial Plan 2012-13: Capital Programme

**Western Sussex Hospitals NHS Trust**

**Capital Programme and Capital Cash Management Plan - 2012/13**

| | Scheme name | 2012/13 £'000 |
|---|---|---|
| 1 | General Medical Equipment | 897 |
| 2 | Ophthalmology Department - Year 2 | 900 |
| 3 | Laminar Flow Theatres | 900 |
| 4 | IM&T Basic Expenditure | 750 |
| 5 | Minor Works and Small Schemes | 900 |
| 6 | Other IT schemes | 578 |
| 7 | Backlog Maintenance & High Risk | 405 |
| 8 | Sustainability - Carbon reduction schemes, built environment. | 600 |
| 9 | Other Estates schemes | 1,640 |
| 10 | West Wing Refurbishment inc. decant | 1,300 |
| 11 | Catering Project | 360 |
| 12 | Pathology Reconfiguration | 750 |
| 13 | Second CT Scanner at Worthing Building Cost (Carried forward from 11/12) | 969 |
| 14 | Interventional Room (SRH Room 5) Building Cost | 600 |
| 15 | Interventional Room (Worthing) Building Cost | 150 |
| 16 | Medical Equipment Library | 126 |
| 17 | Beach & Barn Reconfiguration | 700 |
| 18 | Consolidated MFU/ENT/Urology | 750 |
| 19 | E-prescribing | 400 |
| 20 | Non-medical equipment | 50 |
| 21 | Pharmacy Robot | 95 |
| 22 | Day Surgery, Worthing | 1,000 |
| 23 | Other schemes | (444) |
| 24 | Other schemes carried forward from 11/12 | 3,279 |
| 25 | Other Schemes funded by donated funds | 1,407 |
| 26 | Emergency Floor - 12/13 element (not yet approved) | 1,600 |
| 27 | Breast Unit | 7,486 |
| | | |
| | **Gross Capital Expenditure (incl IFRS Impact)** | **28,148** |

| | |
|---|---|
| **Financing of Capital Resource Limit** | |
| **Internal Sources** | |
| Depreciation (non IFRIC12 related) | 14,100 |
| Grants and Donations | 1,607 |
| Unspent Capital Cash from Previous Years | 11,734 |
| **Internally generated capital cash** | **27,441** |
| | |
| **External Sources** | |
| New Capital Investment Loan - Emergency Floor - 12/13 element (not yet approved) | 1,600 |
| Capital Investment Loan Principal Repayments | (893) |
| **External capital cash requirement** | **707** |
| | |
| **Total Capital Cash Financing** | **28,148** |

## Financial Plan 2012-13: Statement of Financial Position

**Western Sussex Hospitals NHS Trust**
**Statement of Financial Position**
**as at**
**31st March 2013**

| | Opening Balance 1st April 2012 £000s | Closing Balance 31st March 2013 £000s |
|---|---|---|
| **Non-Current Assets** | | |
| Property, Plant and Equipment | 243,582 | 255,947 |
| Intangible Fixed Assets | 1,298 | 1,298 |
| Trade and Other Receivables | 552 | 552 |
| **Total Non-Current Assets** | **245,432** | **257,797** |
| **Current Assets** | | |
| Inventories | 4,491 | 4,491 |
| Trade and Other Receivables | 24,781 | 24,781 |
| Cash and Cash Equivalents | 2,341 | 2,556 |
| Non-Current Assets Held for Sale | 600 | 0 |
| **Total Current Assets** | **32,213** | **31,828** |
| **Current Liabilities** | | |
| Trade and Other Payables | (27,577) | (38,095) |
| Working Capital Loan | (3,655) | (2,420) |
| Capital Investment Loan | (612) | (676) |
| Borrowings | (445) | (445) |
| Provisions for Liabilities and Charges | (781) | (781) |
| **Total Current Liabilities** | **(33,070)** | **(42,417)** |
| **Net Current Assets/(Liabilities)** | **(857)** | **(10,589)** |
| **Non Current Liabilities** | | |
| Working Capital Loan | (4,834) | (2,414) |
| Capital Investment Loan | (14,459) | (15,102) |
| Borrowings | (2,439) | (1,871) |
| Provisions for Liabilities and Charges | (2,420) | (2,174) |
| **Total Non Current Liabilities** | **(24,152)** | **(21,561)** |
| **Net Assets** | **220,423** | **225,647** |
| **Taxpayers' Equity** | | |
| Public Dividend Capital | 237,785 | 237,785 |
| Retained Earnings | (37,831) | (32,607) |
| Revaluation Reserve | 20,469 | 20,469 |
| **Total Taxpayers' Equity** | **220,423** | **225,647** |

## Financial Plan 2012-13: Cash Flow

**Western Sussex Hospitals NHS Trust**
**Cash Flow (Receipts and Payments) Forecast**
**for the year ending**
**31st March 2013**

| | Apr £000s | May £000s | Jun £000s | Jul £000s | Aug £000s | Sep £000s | Oct £000s | Nov £000s | Dec £000s | Jan £000s | Feb £000s | Mar £000s |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Income** | | | | | | | | | | | | |
| Operating Income, Other NHS/non-NHS income & Interest | 29,237 | 31,741 | 29,017 | 31,257 | 31,440 | 29,958 | 31,427 | 30,964 | 29,921 | 30,579 | 28,564 | 29,796 |
| Capital investment loan received | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,600 |
| | **29,237** | **31,741** | **29,017** | **31,257** | **31,440** | **29,958** | **31,427** | **30,964** | **29,921** | **30,579** | **28,564** | **31,396** |
| **Expenditure** | | | | | | | | | | | | |
| Pay | (11,163) | (12,071) | (11,344) | (11,617) | (11,070) | (11,409) | (11,140) | (11,140) | (10,801) | (11,408) | (10,740) | (11,703) |
| PAYE/NI | 0 | (5,091) | (4,784) | (4,899) | (4,669) | (4,812) | (4,698) | (4,698) | (4,555) | (4,811) | (4,529) | (4,936) |
| Superannuation | (2,519) | (2,725) | (2,560) | (2,622) | (2,498) | (2,575) | (2,514) | (2,514) | (2,438) | (2,575) | (2,424) | (2,641) |
| Suppliers - revenue | (6,745) | (7,517) | (6,117) | (9,610) | (10,649) | (8,601) | (10,393) | (9,978) | (9,741) | (9,427) | (9,027) | (7,600) |
| Suppliers - capital | (6,294) | (4,394) | (1,554) | (1,331) | (1,759) | (1,979) | (2,229) | (1,789) | (1,504) | (1,004) | (1,679) | (2,432) |
| Capital investment loan repayment | 0 | 0 | 0 | 0 | 0 | (447) | 0 | 0 | 0 | 0 | 0 | (447) |
| Working capital loan repayment | 0 | 0 | 0 | 0 | 0 | (1,352) | 0 | 0 | 0 | 0 | 0 | (2,303) |
| Loan interest/finance costs | 0 | 0 | 0 | 0 | 0 | (699) | 0 | 0 | 0 | 0 | 0 | (699) |
| PDC dividend | 0 | 0 | 0 | 0 | 0 | (3,645) | 0 | 0 | 0 | 0 | 0 | (3,645) |
| | **(26,721)** | **(31,798)** | **(26,359)** | **(30,079)** | **(30,645)** | **(35,518)** | **(30,975)** | **(30,120)** | **(29,039)** | **(29,225)** | **(28,399)** | **(36,406)** |
| Opening balance | 2,341 | 4,856 | 4,799 | 7,457 | 8,635 | 9,429 | 3,869 | 4,321 | 5,165 | 6,047 | 7,400 | 7,565 |
| Movement in month | 2,516 | (57) | 2,658 | 1,178 | 795 | (5,560) | 452 | 844 | 882 | 1,354 | 165 | (5,010) |
| **Closing balance** | **4,856** | **4,799** | **7,457** | **8,635** | **9,429** | **3,869** | **4,321** | **5,165** | **6,047** | **7,400** | **7,565** | **2,556** |

## Cost Improvement Programmes

The Cost Improvement Plan savings for 2012-13 are shown below by divisional area. The plans are incorporated into the objectives and plans of the relevant divisions, directorates and teams.

| Directorate | WTEs identified from Schemes | Risk Rated CIP | Identified CIP % of cost base |
|---|---|---|---|
| | WTEs | £k | % |
| Core Services | 20.12 | 3,084 | 5.25% |
| Women & Children | 24.00 | 2,134 | 6.04% |
| Medicine | 81.00 | 3,591 | 5.00% |
| Surgery | 46.90 | 4,195 | 5.79% |
| Facilities | 31.55 | 1,495 | 5.13% |
| Perf. Access | 4.00 | 288 | 5.32% |
| Corporate | 27.63 | 3,552 | 19.77% |
| **Total** | **235.20** | **18,338** | **6.03%** |

## Appendix C: Divisional Delivery Programme contributions to Corporate Objectives

There are four clinical divisions within the Trust: Medicine, Surgery, Women & Children and Core. Each division has identified its priorities for 2012-13, in support of the corporate objectives. A portfolio of specific projects and programmes has been devised within each division, which support the achievement of both corporate and divisional objectives. Other priorities form part of 'everyday business' throughout the divisions, such as a focus on infection prevention and control or the development of a culture of customer care.

The grids below outline the main ways in which each division's identified delivery programmes contribute to the corporate objectives. All the programmes have detailed plans, including aims and objectives, milestones, resource implications and measurable benefits. They will be monitored through the Performance Framework, which is summarised in Section 8.

## MEDICINE

**CONTRIBUTED TO BY**
**Divisional Delivery Programmes**

| Corporate Objectives | 1. Emergency Floor | 2. Rheumatology | 3. Specialty Business Units | 4. Stroke and TIA | 5. Ambulatory Care | 6. Catheter Lab | 7. Dermatology | 8. Endoscopy | 9. Proactive Care/ One Call |
|---|---|---|---|---|---|---|---|---|---|
| A1 Increase the number of patients who would recommend the Trust to family and friends | ▲ | | ▲ | ▲ | | | | | |
| B1 Deliver the quality outcome gains specified in the Trust's Quality Strategy, in particular a reduction in the Trust's mortality rate | ▲ | | ▲ | ▲ | | | | | ▲ |
| B2 Reduce our rates of unplanned readmissions | ▲ | | ▲ | ▲ | ▲ | | | | ▲ |
| C1 Deliver the patient safety gains specified in the Quality Strategy. | | | ▲ | | | | | ▲ | |
| D1 Continue to implement the improvements to local services as envisaged in our clinical services strategy, in particular our 'Service Redesign for Quality' programme | ▲ | | | | | ▲ | | | |
| E1 Work with our LHE partners to help deliver the 'Sussex Together' programme, including jointly developing and implementing our plans for Planned Care and Proactive Care | | | | | ▲ | | ▲ | | ▲ |
| F1 Implement a strategy for engagement with staff, members and other community stakeholders | | | | | | | | | |
| F2 Continue to improve the patient environment through investment in the Trust's Estate. | ▲ | | | | | ▲ | | | |
| F3 Improve productivity and the quality of patient care through the introduction of a service improvement function | | | | | | | | | |
| G1 Achieve Foundation Trust status | | | | | | | | | |
| G2 Achieve a Financial Risk Rating of 3 or above | | | ▲ | ▲ | | ▲ | ▲ | | ▲ |
| G3 Achieve a Monitor Governance rating of at least Amber Green throughout the year | ▲ | | | ▲ | | | | | |
| G4 Continue the development and implementation of Service Line Management. | | | ▲ | | | | | | |

**CONTRIBUTED TO BY**
**Divisional Delivery Programmes**

| Corporate Objectives | 1. Theatre efficiency | 2. Day surgery | 3. Theatres – non-pay | 4. Trauma & Orthopaedics | 5. Breast Services | 6. Ophthalmology | 7. Electronic rostering | 8. Specialty Business Units |
|---|---|---|---|---|---|---|---|---|
| A1 Increase the number of patients who would recommend the Trust to family and friends | | ▲ | | ▲ | ▲ | ▲ | | |
| B1 Deliver the quality outcome gains specified in the Trust's Quality Strategy, in particular a reduction in the Trust's mortality rate | ▲ | ▲ | | ▲ | ▲ | | | |
| B2 Reduce our rates of unplanned readmissions | | | | ▲ | | | | ▲ |
| C1 Deliver the patient safety gains specified in the Quality Strategy. | ▲ | ▲ | | | | | | |
| D1 Continue to implement the improvements to local services as envisaged in our clinical services strategy, in particular our 'Service Redesign for Quality' programme | | ▲ | | ▲ | | ▲ | | |
| E1 Work with our LHE partners to help deliver the 'Sussex Together' programme, including jointly developing and implementing our plans for Planned Care and Proactive Care | | | | ▲ | ▲ | ▲ | | |
| F1 Implement a strategy for engagement with staff, members and other community stakeholders | | ▲ | | ▲ | ▲ | ▲ | | |
| F2 Continue to improve the patient environment through investment in the Trust's Estate. | ▲ | ▲ | | ▲ | ▲ | ▲ | | |
| F3 Improve productivity and the quality of patient care through the introduction of a service improvement function | | ▲ | | ▲ | ▲ | ▲ | | ▲ |
| G1 Achieve Foundation Trust status | | | | | | | | |
| G2 Achieve a Financial Risk Rating of 3 or above | ▲ | | ▲ | | | | ▲ | ▲ |
| G3 Achieve a Monitor Governance rating of at least Amber Green throughout the year | | | | ▲ | | ▲ | | |
| G4 Continue the development and implementation of Service Line Management. | | | ▲ | | | | ▲ | ▲ |

## WOMEN & CHILDREN

**CONTRIBUTED TO BY**
**Divisional Delivery Programmes**

| Corporate Objectives | 1. Maternity CNST Level 2 | 2. Gynaecology improvements | 3. Beach and Barn ward | 4. Medical staffing redesign | 5. Maternity Led Unit - Worthing | 6. Strategic review Paeds/Maternity | 7. Neonatal services |
|---|---|---|---|---|---|---|---|
| A1 Increase the number of patients who would recommend the Trust to family and friends | ▲ | ▲ | ▲ | | ▲ | | ▲ |
| B1 Deliver the quality outcome gains specified in the Trust's Quality Strategy, in particular a reduction in the Trust's mortality rate | ▲ | | | ▲ | ▲ | ▲ | ▲ |
| B2 Reduce our rates of unplanned readmissions | | ▲ | | ▲ | | | ▲ |
| C1 Deliver the patient safety gains specified in the Quality Strategy. | ▲ | | | ▲ | | | ▲ |
| D1 Continue to implement the improvements to local services as envisaged in our clinical services strategy, in particular our 'Service Redesign for Quality' programme | | | | | ▲ | ▲ | |
| E1 Work with our LHE partners to help deliver the 'Sussex Together' programme, including jointly developing and implementing our plans for Planned Care and Proactive Care | | ▲ | | | | ▲ | |
| F1 Implement a strategy for engagement with staff, members and other community stakeholders | | ▲ | | | ▲ | ▲ | |
| F2 Continue to improve the patient environment through investment in the Trust's Estate. | | ▲ | ▲ | | ▲ | ▲ | |
| F3 Improve productivity and the quality of patient care through the introduction of a service improvement function | | | | | | | |
| G1 Achieve Foundation Trust status | | | | | | | |
| G2 Achieve a Financial Risk Rating of 3 or above | ▲ | | ▲ | ▲ | | ▲ | |
| G3 Achieve a Monitor Governance rating of at least Amber Green throughout the year | ▲ | ▲ | | ▲ | | ▲ | |
| G4 Continue the development and implementation of Service Line Management. | | ▲ | | | | | |

**CORE**

**CONTRIBUTED TO BY**
**Divisional Delivery Programmes**

| Corporate Objectives | 1. Transform service delivery | 2. Information systems | 3. Use of information | 4. Staff dev't/ Medicines Management | 5. Pharmacy, Radiology, Pathology transformation | 6. Partnership and integration | 7. Safe handling of medicines |
|---|---|---|---|---|---|---|---|
| A1 Increase the number of patients who would recommend the Trust to family and friends | | | ▲ | | ▲ | | |
| B1 Deliver the quality outcome gains specified in the Trust's Quality Strategy, in particular a reduction in the Trust's mortality rate | | ▲ | ▲ | | | | |
| B2 Reduce our rates of unplanned readmissions | | ▲ | | | | | |
| C1 Deliver the patient safety gains specified in the Quality Strategy. | ▲ | | ▲ | ▲ | | | ▲ |
| D1 Continue to implement the improvements to local services as envisaged in our clinical services strategy, in particular our 'Service Redesign for Quality' programme | ▲ | | | | | ▲ | |
| E1 Work with our LHE partners to help deliver the 'Sussex Together' programme, including jointly developing and implementing our plans for Planned Care and Proactive Care | | | | | | ▲ | |
| F1 Implement a strategy for engagement with staff, members and other community stakeholders | | | | ▲ | | | |
| F2 Continue to improve the patient environment through investment in the Trust's Estate. | | | | ▲ | ▲ | | |
| F3 Improve productivity and the quality of patient care through the introduction of a service improvement function | | | | | | | |
| G1 Achieve Foundation Trust status | | | | | | | |
| G2 Achieve a Financial Risk Rating of 3 or above | | | | | ▲ | ▲ | |
| G3 Achieve a Monitor Governance rating of at least Amber Green throughout the year | | | | | ▲ | | |
| G4 Continue the development and implementation of Service Line Management. | | ▲ | | | | | |

**EQUALITY IMPACT ASSESSMENT**

| | |
|---|---|
| **Name of Policy, Service, Function, Project or Proposal** | **Trust Annual Plan 2012-13** |
| **Department** | **Directorate of Leadership and Organisational Development** |
| **Lead Officer for Assessment** | **Oliver Phillips** |
| **What is the main Purpose of the Policy/Service/Function/Project/Proposal?** | **To outline the Trust's business plan for 12-13, including corporate and divisional objectives and schemes, together with integrated financial, activity and workforce data** |
| **List the main activities of the policy or service re-design (e.g. Manual Handling would relate to health and safety of patients; health and safety of staff; compliance with NHS and Government legislation or standards etc)** | **Compliance with NHS Performance Framework and Monitor Compliance Framework**<br><br>**Quality and safety of services**<br><br>**Staff and patient engagement** |
| **Is the policy or service relevant to:**<br><br>**Promoting Good Relations between different people?**<br><br>**Eliminating discrimination?**<br><br>**Promoting Equality of Opportunity?** | <br><br>**Yes**<br><br>**Yes**<br><br>**Yes** |
| **Which groups of the population do you think may be affected by this proposal?**<br><br>**Minority Ethnic People**<br>**Women and Men**<br>**People in religious/faith groups**<br>**Disabled people**<br>**Older people**<br>**Children and young people**<br>**Lesbian, gay, bisexual and transgender people**<br>**People of low income**<br>**People with mental health problems**<br>**Homeless people**<br>**Staff**<br>**Any other group (please detail)** | <br><br>**No**<br>**Yes**<br>**No**<br>**No**<br>**Yes**<br>**Yes**<br>**No**<br>**No**<br>**No**<br>**No**<br>**Yes**<br>**Yes - Carers** |

**Do you have any information that tells you of the current use of this service? Yes/No (if yes please detail)** This varies by service, however we do collect information on the equality and diversity of our patients.

**Is it broken down by ethnicity, gender, disability, age, religion and sexual orientation? Yes/No (please detail)** This varies by service and this area is part of our latest E&D objectives as an area for improvement.

**Does this information reflect the proportions from the 2001 Census?**
**Yes/No (If no, can you explain why)**
Yes, in general and as far as we collect data for, the patients we serve reflect the local community.

**If there is no information available or if this is patchy, specify the arrangements that will make this available**
As described, plans in place to improve level of equality and diversity data obtained from patients over the coming two year period.

**Using the information above, please complete the grids below:**

**How will the Policy etc affect Men and Women in different ways?**

| Gender | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| **Women** | **YES** | | | **Some of the specific objectives outlined relate to Maternity, Obstetrics and Gynaecology** | |
| **Men** | | | **YES** | **Other elements of the plan are designed to benefit all patients and staff, regardless of gender** | |

**How will the Policy etc affect Black and Minority ethnic people?**

| Race | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| **White** | | | **YES** | **The Trust plan is designed to benefit all patients and staff, regardless of ethnicity** | |
| **Mixed** | | | **YES** | **The Trust plan is designed to benefit all patients and staff, regardless of ethnicity** | |
| **Other Ethnic Group** | | | **YES** | **The Trust plan is designed to benefit all patients and staff, regardless of ethnicity** | |
| **Black/Black British** | | | **YES** | **The Trust plan is designed to benefit all patients and staff, regardless of ethnicity** | |
| **Asian/Asian British** | | | **YES** | **The Trust plan is designed to benefit all patients and staff, regardless of ethnicity** | |

**How will the policy affect people with disabilities?**

| Disability | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| Visually Impaired | | | YES | The Trust plan is designed to benefit all patients and staff, regardless of disability status | |
| Hearing Impaired | | | YES | The Trust plan is designed to benefit all patients and staff, regardless of disability status | |
| Physically Disabled | | | YES | The Trust plan is designed to benefit all patients and staff, regardless of disability status | |
| Learning Disability | | | YES | The Trust plan is designed to benefit all patients and staff, regardless of disability status | |
| Mental Health Related | | | YES | The Trust plan is designed to benefit all patients and staff, regardless of disability status | |

**How will the policy affect people of different ages?**

| Varying ages | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| Older people and babies | YES | | | Certain schemes and divisional objectives relate specifically to services for older people (e.g. fractured hip pathway) and to younger people (e.g. maternity and neonatal). However, this is not at the expense of improvements in services for all patients. | |

**How will the policy affect people of different sexual orientation?**

| Sexual Orientation | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| | | | YES | The Trust plan is designed to benefit all patients and staff, regardless of sexual orientation | |

**How will the policy affect Transgender or transsexual people?**

| | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| Transgender | | | YES | The Trust plan is designed to benefit all patients and staff | |
| Transsexual | | | YES | The Trust plan is designed to benefit all patients and staff | |

**How will the policy affect people of varying religious beliefs?**

| Varying | Positive | Negative | Neutral | Reason/Evidence | Don't |
|---|---|---|---|---|---|

| beliefs | Impact | Impact | | | know |
|---|---|---|---|---|---|
| | | | YES | The Trust plan is designed to benefit all patients and staff, regardless of religion or belief | |

**How will the policy affect those with carer responsibilities or impact on basic human rights?**

| Carers / Human Rights | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| Carers | YES | | | A specific focus on customer care and patient/carer communication should have a positive impact on carers | |
| Basic human rights | YES | | | A specific focus on dignity and respect should ensure that all basic human rights are upheld | |

**Considering your responses above, what are the areas that are have a positive and / or negative impact?**

| | Positive + / Negative - | Reason Given for Impact |
|---|---|---|
| Gender | + | Some of the specific objectives outlined relate to Maternity, Obstetrics and Gynaecology |
| Race | | |
| Disability | | |
| Age | + | Certain schemes and divisional objectives relate specifically to services for older people (e.g. fractured hip pathway) and to younger people (e.g. maternity and neonatal). However, this is not at the expense of improvements in services for all patients. |
| Sexual Orientation | | |
| Religious Belief | | |

**Has there been any consultation about this Policy etc? If there has, what were the key issues identified?**

*No but specific service developments/schemes will be/have been subject to consultation, where relevant.*

| Consultation | Date | Summary of Key Issues to be addressed |
|---|---|---|
| Gender | | |
| Race | | |
| Disability | | |
| Age | | |
| Sexual Orientation | | |
| Religious Belief | | |

**If consultation is planned, when will it happen and what are the key themes for consultation?**

*This varies by scheme. Service Redesign for Quality has been subject to significant consultation.*

**How do you intend to consult staff?**

*This varies by scheme.*

**What does Local / Regional / National research show with regards to these groups and the likely impact?**

*This varies by scheme and is not applicable at the level of a Trust Annual Plan.*

| Group | Source | Key Issues |
|---|---|---|
| **Gender** | | |
| **Race** | | |
| **Disability** | | |
| **Age** | | |
| **Sexual Orientation** | | |
| **Religious Belief** | | |

**As a result of consultation / information gathering, what changes do you intend to make to the policy etc? If 'None', please state as relevant:**

None

**Gender**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**Race**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**Disability**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**Sexual Orientation**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**Religious Belief**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**Age**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

Please outline the monitoring and reviewing process and timescale

Progress against the delivery of the Annual Plan will be monitored by the Board and with divisions through the Trust Performance Framework. The Annual Plan will be reviewed and updated in April 2013.

Agreed Review Date: April 2013

Signed by: Policy / Service Author – Oliver Phillips

Trust Equality & Diversity Lead: Natalie Mowbray

Date: 17th April 2012

Western Sussex Hospitals NHS
NHS Trust

To: Board

Date of Meeting: 26 April 2012 Agenda Item: 14

| Title |
|---|
| **Board Assurance Framework 2012/13** |
| Responsible Executive Director |
| Marianne Griffiths, Chief Executive |
| Prepared by |
| Graham Lawrence, Company Secretary |
| Status |
| Disclosable |
| Summary of Proposal |
| Following the Board's discussion on 29 March 2012, this paper presents for approval the proposed Board Assurance Framework (BAF) for 2012/13. The paper briefs the Board on the principal content of the BAF, and the arrangements for reviewing it during the year. In connection with this, the paper presents a schedule for in-depth reviews of the risks set out in the BAF. |
| Implications for Quality of Care |
| Although there are no direct implications for quality of care a number of the corporate objectives and risks within the BAF relate to improvement in quality. |
| Link to Strategic Objectives/Board Assurance Framework |
| The paper sets out the proposed Board Assurance Framework for the year. |
| Financial Implications |
| Although there are no direct financial implications a number of the corporate objectives and risks within the BAF relate to the Trust's financial position in-year and in the longer term. |
| Human Resource Implications |
| Although there are no direct human resources implications a number of the corporate objectives and risks within the BAF relate to staff development, training and performance. |
| **Recommendation** |
| **The Board is asked to:**<br>**a) APPROVE the Board Assurance Framework 2012/13; and**<br>**b) APPROVE the risk review schedule.** |
| Communication and Consultation |
| Executive Team, Head of Strategic Planning |
| Appendices |
| A. Board Assurance Framework<br>B. Review Schedule |

This report can be made available in other formats and in other languages. To discuss your requirements please contact Graham Lawrence, Company Secretary, on graham.lawrence@wsht.nhs.uk or 01903 285288.

**WESTERN SUSSEX HOSPITALS NHS TRUST**

To: BOARD Date: 26 April 2012

From: Graham Lawrence, Company Secretary Agenda Item: 14

**FOR DECISION**

# BOARD ASSURANCE FRAMEWORK 2012/13

## 1.00 PURPOSE OF REPORT

1.01 Following the Board's discussion on 29 March 2012, this paper presents for approval the proposed Board Assurance Framework (BAF) for 2012/13. The paper briefs the Board on the principal content of the BAF, and the arrangements for reviewing it during the year. In connection with this, the paper presents a schedule for in-depth reviews of the risks set out in the BAF.

## 2.00 RECOMMENDATIONS

**The Board is asked to:**

**a) <u>APPROVE</u> the Board Assurance Framework 2012/13; and**

**b) <u>APPROVE</u> the risk review schedule.**

## 3.00 BOARD ASSURANCE FRAMEWORK

3.01 At its meeting in February 2012 the Board approved the corporate objectives for 2012/13. The objectives are the basis of the Annual Plan, which is presented for approval concurrently, and the Board Assurance Framework, attached. The draft BAF was reviewed by the Board in March 2012. There have been minor changes to the drafting and ratings for some risks but most significantly, as set out in 3.05 below, the most significant risks have been identified. The Board's attention is drawn to risk A1/2 – this has been re-drafted to reflect the need to focus on improving patients' experiences, as identified through survey feedback and Board discussions (including in March 2012) about communication and customer care.

3.02 Executive Directors have re-assessed and described the risks associated with achievement of the corporate objectives. Reflecting experience from 2011/12, care has been taken to contain the number of risks and to ensure that they are directly relevant to the objectives and the operating position and environment.

3.03 The BAF assigns each risk to a member of the Executive Team. The Directors responsible for the risks have identified the controls and sources of assurance through which the risks will be managed, and have set out any areas for improvement in respect of those controls and sources of assurance. (In order to continue the practice developed during 2011/12, the sources of assurance identified in the BAF include Internal Audits and Clinical Audits.) Through these arrangements, the gross risk-rating is translated into a net risk-rating.

3.04 As in 2011/12, the tabular part of the BAF is prefaced by an introduction which describes roles and responsibilities, and the arrangements through which the BAF will be reviewed and updated regularly. These arrangements are outlined in the following section of this paper.

3.05 Importantly, the BAF sets out the four risks which the Executive Team considers to be the most significant for the Trust at the present time. These are shown in **bold type**, within heavy-lined

cells in the table, and they are set out below. Through the quarterly reviews of the BAF, the four most significant risks will be kept under review. The risks will be reflected in the Integrated Business Plan.

| Ref | Corporate Objective | Description of Risk | Gross Rating | Net Rating |
|---|---|---|---|---|
| A1/2 | Increase the number of patients who would recommend the Trust to family or friends | Patients have a poor experience of our services | 20 | 15 |
| B1/2 | Deliver the quality outcome gains specified in the Trust's Quality Strategy, in particular a reduction in the Trust's mortality rate | We fail to provide to staff timely and accurate information on mortality and other quality issues, impeding the tracking of improvement actions. | 15 | 12 |
| E1/1 | Work with our LHE partners to help deliver the 'Sussex Together' programme, including jointly developing and implementing our plans for Planned Care and Proactive Care. | External partners fail to help deliver programmes | 20 | 16 |
| G1/1 | Achieve Foundation Trust status | The Department of Health does not pass the application to Monitor in timely fashion | 20 | 20 |

## 4.00 RESPONSIBILITY, REVIEW AND REPORTING

4.01 As stated above, each of the objectives and risks is assigned to a member of the Executive Team. A number of the objectives and risks will require particularly strong collaboration between Directors and other colleagues but in order to ensure attention to risk management and to promote clear accountability, good practice recommends that responsibility is assigned to an individual.

4.02 It is proposed to continue the process of in-depth reviews of BAF risks. This will be achieved through the review schedule which is attached for the Board's approval. The risks have been assigned to either the Board, Quality & Risk Committee or Finance Committee, reflecting the responsibilities of those fora.

4.03 The risk owners will prepare reports about the risks under analysis (and progress made in addressing any areas for improvement in controls), to be presented for discussion by the Board or Committee. In addition to the in-depth reviews the BAF will be subject to a review once per quarter. This will ensure that all risks are reviewed for relevance, accuracy, etc, and that a whole-document approach is taken. The quarterly reviews will continue to be presented to the Board alongside progress reports in respect of the Business Plan.

## 5.00 INTERNAL AUDIT REVIEWS OF THE BOARD ASSURANCE FRAMEWORK

5.01 In addition to reviews by the Executive Team, the BAF will be assessed twice during the year by the Trust's Internal Auditors. This will ensure that it is compliant with requirements but, more importantly, that it remains a reasonable basis for assurance that strategic risks are being managed. The review will inform the Internal Auditor's year-end opinion and thereby the Annual Governance Statement.

**WESTERN SUSSEX HOSPITALS NHS TRUST**

**BOARD ASSURANCE FRAMEWORK 2012/13**

(Reviewed in draft by the Board, 29 March 2012)
(Approved by the Board, 26 April 2012)

## 1.00 BACKGROUND TO AND PURPOSE OF BOARD ASSURANCE FRAMEWORK

1.01 For each financial year the Board defines a set of corporate objectives. The objectives are derived from the Trust's long-term strategy, defined at the present time in the Integrated Business Plan and any significant objectives set out in supporting strategies. In order to promote achievement of the corporate objectives, it is essential that the Trust identifies and manages the strategic risks which could frustrate or prevent achievement of them. The Board Assurance Framework ("the BAF") is the principal means by which the Board does this.

## 2.00 FORM OF BOARD ASSURANCE FRAMEWORK

2.01 The BAF sets out against each corporate objective the risk(s) identified by the Executive Team and agreed by the Board. The risks are linked explicitly to related entries in the Risk Register (which are rated 15 and above), the risk number being noted against each risk in the BAF. Appendix A provides a brief description of the linked entries in the Risk Register at the current time. In order that risks are managed effectively, it is necessary for each risk to be assigned to a member of the Executive Team, this being shown in the BAF.

2.02 For each risk the BAF defines a gross risk-rating, which is an assessment of the likelihood of it crystalising and the impact which it would have in the event that it did so. The risk-rating is derived from the matrix below. Risks rated at 12 and 15 are colour-coded orange and red respectively to assist identification of these more significant risks within the BAF.

| | **Likelihood** | | | | |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| **Impact** | **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost certain** |
| **5 Catastrophic** | 5 | 10 | 15 | 20 | 25 |
| **4 Major** | 4 | 8 | 12 | 16 | 20 |
| **3 Moderate** | 3 | 6 | 9 | 12 | 15 |
| **2 Minor** | 2 | 4 | 6 | 8 | 10 |
| **1 Negligible** | 1 | 2 | 3 | 4 | 5 |

2.03 The Board has identified four of the risks within the BAF which it considers to be the most significant for the organisation. These are shown in **bold type**, within a heavy-lined cell in the table.

2.04 In respect of each risk, the BAF sets out the controls which the responsible Directors have or will put into place to manage the risks, together with sources of assurances which will inform the Board as to the effectiveness of the controls. Where relevant, the BAF shows at Appendix C the clinical audits (planned for 2012/13) which provide assurance in respect of risks. The outcomes of clinical audits are addressed through the Divisional clinical governance structure (which includes meetings attended by Non-executive Directors). The programme is approved by the Quality & Risk Committee, which also receives reports of progress and any significant issues arising. The BAF also identifies as sources of assurance relevant Internal Audit reviews, which are reported to the Audit Committee. The BAF identifies any areas in which the controls or sources of assurance require improvement in order to be fully effective, and sets out the action necessary to address the improvement required.

2.05 In the context of the controls and sources of assurances utilised in managing the risks within the BAF, a net rating is ascribed to each risk. The net rating should in most cases be lower than the gross risk rating since this will indicate that the controls are effective. In some cases, such as risks arising from aspects of the operating environment, it is not possible for the Trust to mitigate the risk to any material extent, resulting in the net risk rating being equal or almost equal to the gross rating.

2.05 The BAF includes (in brackets, adjacent to the majority of risk descriptions) a notation for the Foundation Trust domain which is considered to be relevant. The domains, which are taken from the Monitor publication "A Guide for Applicants" are described in Appendix B.

2.06 The BAF format described above complies with the guidance and requirements issued by the Department of Health and the Audit Commission.

## 3.00 RISK MANAGEMENT

3.01 The BAF is a significant part of the Trust's arrangements for managing risk, which are defined in detail in the Risk Management Strategy ("the strategy"). The strategy is reviewed and re-approved by the Board each year.

3.02 The strategy assigns responsibility for managing risk, both in respect of specific risks but also responsibility for leading risk management corporately and the role which all staff have in managing risk.

3.03 The Trust's risk management arrangements are centred on the Risk Register (the Register). The Register includes risks which have been identified by staff as frustrating or preventing the achievement of Divisional or Departmental objectives, and it also includes risks which were not identified proactively but which have crystalised.

3.04 The BAF focuses on strategic risks. As stated above, these are identified by Executive Team members as part of the process of developing the Annual Plan on which the BAF is based. Executive Directors use their knowledge of the Trust and its operating environment to identify and rate risks for inclusion in the BAF. Appropriate controls and sources of assurance are also identified.

## 4.00 BOARD ASSURANCE FRAMEWORK: REVIEW, REPORTING AND RESPONSIBILITY

Review and Reporting

4.01 As stated above, the BAF is approved by the Board prior to the beginning of each financial year, alongside the corporate objectives to which it relates. If the BAF is to be an effective risk management tool then it is essential that it is kept under regular review, and updated when necessary.

4.02 In order that this is achieved and seen to be achieved the BAF will be reviewed by management in the month following the end of each quarter, ie. in July, October, January and April of each financial year.

4.03 Additionally, a number of risks will be subject to in-depth review each quarter, the schedule for these reviews having been approved by the Board. The Executive Directors responsible for the risks under analysis will present to the Board or the Quality & Risk or Finance & Investment Committees (according to the areas of responsibility, defined in their Terms of Reference) a concise report about changes to the risk, action taken in respect of the changes, etc. These reports will be presented alongside the BAF, which will be reviewed by the Committees.

4.04 The BAF will be presented to the Board following review by the Committees, together with a report highlighting the principal points arising from the Committees' detailed analysis of the risks selected for review that quarter. The report will also describe the action taken to address gaps in controls or sources of assurance which are rated amber or red in the BAF. The Board has agreed that at the mid-point of the financial year, October, the BAF, and the Annual Plan from which it is derived, will be subject to comprehensive review to determine the continued relevance and accuracy of the corporate objectives and risks.

4.05 The Board will be asked to review the BAF and the accompanying reports, focusing on any points highlighted by Committees and/or management. Board Members will challenge the content of

the BAF, particularly the risks identified and the effectiveness of controls, using as context their knowledge of the operating environment and the Trust's operational performance and strategy.

4.06 Subject to the outcomes of its review, the Board will be asked each quarter to approve the BAF such that it provides an accurate statement of the risks facing the organisation and its arrangements for managing them.

Responsibility

4.07 It is the responsibility of the **Board** to consider and approve the BAF prior to the commencement of each financial year. In doing so, the Board will confirm its agreement to the risks identified within the BAF and challenge robustly the completeness and effectiveness of the controls and sources of assurance set out within the BAF. The Board will review the BAF after the end of each quarter and will hold the Executive to account for the effectiveness of controls and progress made in addressing areas for improvement. In doing so, the Board will use the BAF as its principal means of managing the strategic risks facing the organisation.

4.08 The Board will be supported by the **Quality & Risk and Finance & Investment Committees** ("the Committees"). The Committees will each quarter undertake a thorough review of a number of risks (within the Committees' areas of responsibility), on the basis of the reports described in 4.03 above. The Committees will assure the Board of the robustness of the sections of the BAF which they review, highlighting to the Board any areas which require attention at that level. The Audit & Governance Committee will also provide assurance as to the robustness of the BAF and the Trust's risk management arrangements generally.

4.09 The **Chief Executive** will have responsibility for ensuring that the BAF is developed and re-presented to the Board each year, and for ensuring that it is updated quarterly. The Chief Executive will ensure that the BAF is of sufficient quality for presentation to the Board, taking into account the central role which the BAF has as evidence for the effectiveness of the control environment, as described in the Annual Governance Statement which the Chief Executive signs each year.

4.10 The **Company Secretary** will manage the process through which the BAF is developed and updated, ensuring engagement from Executive Directors and, where necessary, independent advisors such as the Internal Audit service. The Company Secretary will maintain all necessary records in relation to the BAF.

4.11 The **Executive Directors** will be the owners of risks identified within the BAF, and will therefore be responsible for managing the risks. Executive Directors will ensure that the associated controls are adequate and effective, and that any areas for improvement in respect of controls are addressed in a timely manner. Executive Directors will be responsible for preparing quarterly risk monitoring reports, as described in 4.03 above, and for reporting generally in respect of issues connected with the risks for which they are responsible.

4.12 The **Internal Audit Service** will review the BAF twice during the year and will report its findings to the Executive Team, the Committees and the Board. The Internal Audit Service will as a minimum confirm the extent to which the BAF complies with the requirements of the Department of Health and the Audit Commission.

| Ref | Corporate Objective | Description of Risk (Risk Register ref.) | Responsible Executive Director | Gross Risk Rating | | Controls | Sources of Assurance | Areas for Improvement & Action Required | Net Risk Rating | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | L | I | | | | L | I |
| **A** | **We care about you** | | | | | | | | | |
| A1 | Increase the number of patients who would recommend the Trust to family or friends | 1. We experience reputational damage due to adverse media coverage or feedback within our community (275) (GSP) | DN&PS | 3 | 4 | 1. Provision of patient monthly safety metrics to provide public assurance.<br><br>2. Monthly review of RTPE feedback to ensure that public concerns are identified and resolved in a timely fashion.<br><br>3. Monthly Divisional Performance Review Panel meetings<br><br>4. Stakeholder engagement and feedback<br><br>5. Peer reviews of Care & Compassion | 1. National in-patient and out-patient surveys, and monitoring of action plans at Board and/or Quality & Risk Committee<br><br>2. Monthly Quality report and Board, including RTPE data<br><br>3. Reports to Management Board and Quality & Risk Committee about CQC Quality Risk Profile<br><br>4. Patients' visits to the Board<br><br>5. CQC visit Trust on six occasions since June 2009. No current concerns. Positive feedback received in reports<br><br>6. Activity trends increase, unless planned otherwise<br><br>7. Increased referrals into the organisation through the choose and book process or other routes | *Note: RTPE = Real-time Patient Experience*<br><br>1. Enhanced roll-out of RTPE.<br><br>2. Improved information to public regarding complaint process.<br><br>3. Improved partnership working with public regarding discharge information and medication.<br><br>4. Review and improvements in the Outpatient and booking service.<br><br>5. Further development of engagement strategy, including through Council of Governors | 3 | 3 |

| Ref | Corporate Objective | Description of Risk (Risk Register ref.) | Responsible Executive Director | Gross Risk Rating | | Controls | Sources of Assurance | Areas for Improvement & Action Required | Net Risk Rating | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | L | I | | | | L | I |
| | | **2. Patients have a poor experience of our services** | **DN&PS** | **4** | **5** | **1. Provision of patient monthly safety metrics to provide public assurance.**<br><br>**2. Monthly review of RTPE feedback to ensure that public concerns are identified and resolved in a timely fashion.**<br><br>**3. Monthly Divisional Performance Review Panel meetings**<br><br>**4. Stakeholder engagement and feedback**<br><br>**5. Peer reviews of Care & Compassion** | **1. National in-patient and out-patient surveys, and monitoring of action plans at Board and/or Quality & Risk Committee**<br><br>**2. Monthly Quality report and Board, including RTPE data**<br><br>**3. Reports to Management Board and Quality & Risk Committee about CQC Quality Risk Profile**<br><br>**4. Patients' visits to the Board each quarter**<br><br>**5. CQC visit Trust on six occasions since June 2009. No current concerns. Positive feedback received in reports**<br><br>**6. Activity trends increase, unless planned otherwise**<br><br>**7. Increased referrals into the organisation through the choose and book process or other routes** | ***Note: RTPE = Real-time Patient Experience***<br><br>**1. Enhanced roll-out of RTPE.**<br><br>**2. Improved information to public regarding complaint process.**<br><br>**3. Improved partnership working with public regarding discharge information and medication.**<br><br>**4. Review and improvements in the Outpatient and booking service.**<br><br>**5. Further development of engagement strategy, including through Council of Governors** | **3** | **5** |

| Ref | Corporate Objective | Description of Risk (Risk Register ref.) | Responsible Executive Director | Gross Risk Rating | | Controls | Sources of Assurance | Areas for Improvement & Action Required | Net Risk Rating | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | L | I | | | | L | I |
| **B** | **We care about quality** | | | | | | | | | |
| B1 | Deliver the quality outcome gains specified in the Trust's Quality Strategy, in particular a reduction in the Trust's mortality rate | 1. We fail to engage staff with the importance of mortality as a quality measure | MD | 3 | 4 | 1. Regular Clinical Governance Half-Days within Divisions, with mortality as key topic.<br><br>2. Scrutiny at Quality Board and Divisional Performance Review Panel<br><br>3. Regular Consultant briefings by Medical Director.<br><br>4. Regular scrutiny of data through Dr Foster system | 1. Monthly reporting of mortality to Board through Quality Report<br><br>2. Quarterly in-depth review on mortality at Board<br><br>(1 and 2 include data from Dr Foster system) | 1. Need to improve organisation-wide acceptance of responsibility for improvement actions and changes in practice at individual and team level. | 2 | 4 |

| Ref | Corporate Objective | Description of Risk (Risk Register ref.) | Responsible Executive Director | Gross Risk Rating | | Controls | Sources of Assurance | Areas for Improvement & Action Required | Net Risk Rating | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | L | I | | | | L | I |
| | | **2. We fail to provide to staff timely and accurate information on mortality and other quality issues, impeding the tracking of improvement actions.** | **MD** | **5** | **3** | **1. Patientrack data are reviewed at monthly project meetings**<br><br>**2. New role of Trust-wide Clinical Lead for clinical quality improvement: early objective is to develop mortality information system.** | **1. Monthly Quality Report to Board**<br><br>**2. Quarterly Mortality Report to Board**<br><br>**3. Reports to Quality & Risk Committee on implementation of Quality Strategy, including in relation to information** | **1. Need to develop widely-accessible system with near-to-real-time mortality data.**<br><br>**2. Need to develop near real-time output of Patientrack output for front line clinicians and for assurance.** | **4** | **3** |
| | | 3. We fail to develop capability in quality improvement methodology to ensure a systematic approach to mortality improvement | MD | 4 | 4 | 1. Development of service improvement capacity (see F3) to include clinical quality improvement<br><br>2. Regular review of quality metrics at Divisional Performance Review Panel meetings, Quality Board and Trust Board. | 1. Quarterly mortality report to Board<br><br>2. Tracking of these service improvements in quality strategy via Quality & Risk Committee. | Dissemination of service improvement skills through organisation (see F3) | 2 | 4 |

| Ref | Corporate Objective | Description of Risk (Risk Register ref.) | Responsible Executive Director | Gross Risk Rating | | Controls | Sources of Assurance | Areas for Improvement & Action Required | Net Risk Rating | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | L | I | | | | L | I |
| | | 4. The transition process for the Sussex Health Informatics Service de-stabilises the services and increases costs for the Trust in Quarters 1 and 2 | FD | 4 | 3 | 1. A transition Board is in place<br><br>2. Internal Audit opinion on the transition arrangements and associated risks<br><br>3. Transfer of some services in-house – initially in the short-term and further transfers are planned | 1. Oversight by the NHS Sussex Audit Committee<br><br>2. Trust-commissioned Internal Audit of the service and transition arrangements<br><br>3. Finance Director is a member of the Transition Board and will report to Audit Committee and/or Board | It is intended that the transition will be complete by the end of quarter two. This risk will be kept under active review during this period in order to test the effectiveness of the controls. The risk will be amended as necessary. | 3 | 3 |
| B2 | Reduce our rates of unplanned re-admissions | 1. External partners do not deliver the plans necessary to reduce re-admissions (LHE) | COO | 4 | 4 | 1. Work with partners through the Coastal Cabinet and other fora to ensure joined up approach<br><br>2. Manage Divisional unscheduled care programmes to improve access and discharge arrangements<br><br>3. Progress the development of the Emergency Floor at Worthing | 1 Rate of readmissions, monitored though the monthly Trust Board<br><br>Coastal Cabinet papers<br><br>2. Quarterly review of Annual Plan progress at Divisional Integrated Performance and at Board meetings<br><br>3. Development and approval of business case for Emergency Floor | *Note: the Trust's contract with NHS Sussex for the financial year 2012/13 mitigates the impact of risk B2/1 from 4 to 3.*<br><br>1. Ensure sufficient resource and support for Emergency Floor Business Case | 3 | 3 |
| | | 2. We fail to improve access and discharge arrangements (GSP) | COO | 4 | 3 | | | | 3 | 3 |

| Ref | Corporate Objective | Description of Risk (Risk Register ref.) | Responsible Executive Director | Gross Risk Rating | | Controls | Sources of Assurance | Areas for Improvement & Action Required | Net Risk Rating | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | L | I | | | | L | I |
| **C** | **We care about safety** | | | | | | | | | |
| C1 | Deliver the patient safety gains specified in the Quality Strategy | 1. Delivery of sub-optimal patient care (275) (GSP) | DN&PS | 3 | 4 | 1. Provision of patient monthly safety metrics to Quality Board provide public assurance.<br><br>2. Monthly RTPE to ensure that public concerns are identified and resolved in a timely fashion.<br><br>3. Monthly integrated performance reviews.<br><br>4. Stakeholder feedback.<br><br>5. Quarterly Care & Compassion reviews | 1. Quality Board report.<br><br>2. SHA patient safety metrics.<br><br>3.Quality performance scorecard.<br><br>4. NRLS reporting framework.<br><br>5. SHA peer reviews<br><br>6. CQC unannounced visit.<br><br>7. QRP report. | 1. Achievement of internal V.T.E. benchmark.<br><br>2. Theatre safety programme, 100% compliance with WHO checklist.<br><br>3. Implementation of zero tolerance for prescribing incidents. | 2 | 4 |
| | | 2. Financial penalties due to failure to deliver services. (FV) | DN&PS | 3 | 5 | | | | 2 | 3 |
| **D** | **We care about local services.** | | | | | | | | | |
| D1 | Continue to implement the improvements to local services as envisaged in our clinical services strategy, in particular our Service Redesign for Quality programme | 1. The Trust does not have the capacity to deliver changes at the scale and pace envisaged | COO | 3 | 4 | 1. Greater integration of corporate and divisional planning functions to maximise resource<br>Secure additional ad hoc resource on specific | 1. Revised clinical strategy agreed by the Board and shared with external partners<br><br>2. Emergency Floor Business Case approved by the Board | 1. Revised scope for Service Redesign for Quality Programme Board to integrate more closely with Divisions and broaden scope to incorporate revised Clinical Services Strategy | 2 | 4 |
| | | 2. The Trust does not secure the external and internal support | COO | 3 | 4 | | | | 2 | 4 |

| Ref | Corporate Objective | Description of Risk (Risk Register ref.) | Responsible Executive Director | Gross Risk Rating | | Controls | Sources of Assurance | Areas for Improvement & Action Required | Net Risk Rating | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | L | I | | | | L | I |
| | | for the changes it is proposing | | | | projects when necessary<br><br>2. Engagement with the HOSC and Commissioners through the Coastal Cabinet and other fora | 3. Board approved plans for the R&R Block in place<br><br>4. Coastal Cabinet papers<br><br>5. Internal Audit of Service Re-design for Quality Programme | | | |
| **E** | **We care about being joined up** | | | | | | | | | |
| E1 | Work with our LHE partners to help deliver the 'Sussex Together' programme, including jointly developing and implementing our plans for Planned Care and Proactive Care. | **1. External partners fail to help deliver programmes (LHE)** | **COO** | **5** | **4** | **1. Ongoing engagement with our Commissioners to ensure success of Sussex Together programme**<br><br>**2. Manage Divisional planned and proactive care programmes to improve access and discharge arrangements** | **1. Accountability agreement between LHE partners outlining responsibilities for each organisation**<br><br>**2. Coastal Cabinet papers**<br><br>**3. Review of Annual Plan progress at Divisional Integrated Performance and at Board meetings** | | **4** | **4** |

| Ref | Corporate Objective | Description of Risk (Risk Register ref.) | Responsible Executive Director | Gross Risk Rating | | Controls | Sources of Assurance | Areas for Improvement & Action Required | Net Risk Rating | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | L | I | | | | L | I |
| **F** | **We care about improvement** | | | | | | | | | |
| F1 | Implement a strategy for engagement with staff, members and other community stakeholders | 1. The scale and pace of service change disengages staff, public, members and others (LC) | DOD&L | 3 | 4 | 1. Engagement strategy.<br><br>2. Communications plan – internal and external.<br><br>3. Clinical Commissioning Group/ Coastal Cabinet plans. | 1. Media reports<br><br>2. Board to ward visits and communications<br><br>3. Reports to Board and Quality & Risk Committee on staff survey results and action plan<br><br>4. Board to Board meetings with PCT/CCG/HOSC<br><br>5. Council of Governors meetings<br><br>6. Members and stakeholder meetings | 1. Both engagement and communication plans need to be updated.<br><br>2. Process for media review to be developed.<br><br>3. Trust Brief needs embedding<br><br>4. Real-time staff satisfaction data to be developed<br><br>5. Process for collecting & responding to members' views to be developed | 2 | 4 |
| F2 | Continue to improve the patient environment through investment in the Trust's estate | 1. Capital and human resources are insufficient to achieve all objectives leading to a compromise in improving patient facing estate. | FD | 3 | 4 | 1. Capital investments prioritised in line with clinical strategy.<br><br>2. Capital plan discussed and signed off at Management Board, Finance & Investment Committee and Board | 1. Patient Environment Action Team assessment results<br><br>2. In-patient Patient Survey<br><br>3. Out-patient Survey<br><br>4. Real-time patient experience.monitoring data<br><br>5. PALS feedback | 1. Following Foundation Trust authorisation, there will be a need for Governor engagement and discussion in prioritisation of resources. | 2 | 4 |

| Ref | Corporate Objective | Description of Risk (Risk Register ref.) | Responsible Executive Director | Gross Risk Rating | | Controls | Sources of Assurance | Areas for Improvement & Action Required | Net Risk Rating | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | L | I | | | | L | I |
| F3 | Improve productivity and the quality of patient care through the introduction of a service improvement function | 1. Service improvement plans are not congruent with operational priorities and delivery is compromised | DOD&L | 3 | 4 | 1. Service Improvement plan & delivery monitoring reports | 1. Performance reports to Board and/or Quality & Risk Committee for service improvement deliverables<br><br>2. Quarterly service improvement reports to Management Board | 1. Service improvement programme and reporting arrangements to be developed with Operations directorate | 2 | 4 |
| **G** | **We care about the future** | | | | | | | | | |
| G1 | Achieve Foundation Trust status | **1. The Department of Health does not pass the application to Monitor in timely fashion** | **FD** | **4** | **5** | **1. Providing assurance to DH regarding 12/13 SLA.** | **1. Verbal feedback from DH, reported to the Board** | **Risk to be reviewed after Q1.** | **4** | **5** |
| | | 2. We are unable to maintain a state of Monitor readiness indefinitely (FV) (GSP) | FD | 3 | 5 | 1. FT Project Group infrastructure in place.<br><br>2. Board briefings through Seminars<br><br>3. Member information sessions<br><br>4. Internal and external communications plans | 1. Financial Risk published monthly.<br><br>2. Monitor Compliance Framework published monthly.<br><br>3. Monthly Quality Report to Board | | 2 | 5 |

| Ref | Corporate Objective | Description of Risk (Risk Register ref.) | Responsible Executive Director | Gross Risk Rating | | Controls | Sources of Assurance | Areas for Improvement & Action Required | Net Risk Rating | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | L | I | | | | L | I |
| G2 | Achieve a Financial Risk Rating of no lower than 3 | 1. We fail to deliver our Cost Improvement Plans (FV) | FD | 3 | 5 | 1. Defined process for scrutiny of proposed CIPs<br><br>2. Monthly monitoring within financial reports.<br><br>3. Monthly Divisional Integrated Performance Meetings | 1. Review at monthly Finance & Investment Committee<br><br>2. Monthly reports to the Board<br><br>3. Cash balances<br><br>4. Internal Audit of Cost Improvement Planning | | 2 | 5 |
| G3 | Achieve a Monitor governance rating of no worse than Amber-Green throughout the year | 1. A mismatch between demand and capacity leads to access targets not being met (GSP, WG) | COO | 3 | 4 | 1. Ongoing engagement with our Commissioners to ensure success of Sussex Together programme | 1. Performance meeting papers with PCT and CCG Sussex Together Papers<br>Monitoring of activity | | 2 | 4 |
| | | 2. The planned productivity and efficiency improvements do not deliver the required capacity | COO | 3 | 4 | 1. Monitoring and management of performance through the Divisional Integrated Performance meetings and the Trust Board | 1. Divisional Integrated Performance papers and Board papers<br><br>2. Internal Audit of Performance Reporting | | 2 | 4 |
| G4 | Continue the development and implementation of Service Line Management | 1. A failure to secure the necessary capacity to deliver Service Line management, including IT | COO | 3 | 4 | 1. Clear programme plan owned and managed by the SLM Programme Board | 1. SLM Board Papers Divisional Integrated Performance Papers<br><br>2. Internal Audit of Service Line Management | 1. Securing sufficient resources (both revenue, capital and human) to deliver the changes necessary<br><br>2. Roll out of SLM pilot in Divisional Integrated Performance meetings to all Divisions | 2 | 4 |

| Ref | Corporate Objective | Description of Risk (Risk Register ref.) | Responsible Executive Director | Gross Risk Rating | | Controls | Sources of Assurance | Areas for Improvement & Action Required | Net Risk Rating | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | L | I | | | | L | I |
| | | infrastructure, information management and training | | | | 2. Service Line review at Divisional Integrated Performance review | | | | |
| | | 2. Ownership and leadership of the programme throughout the organisation | COO | 3 | 4 | | | | 2 | 4 |

## EXTRACT OF THE TRUST RISK REGISTER AT APRIL 2012

This extract of the Risk Register shows risks (with a gross rating of 15 or above) which are relevant to risks within the BAF.

| Register Number | Description of Risk | Risk Owner | Initial (Gross) Risk Rating | Current (Net) Risk Rating |
|---|---|---|---|---|
| 275 | Failure to achieve compliance with C.Diff trajectory. | Director of Nursing & Patient Safety | 16 | 12 |

## KEY TO FOUNDATION TRUST DOMAIN NOTATION

The table below describes the seven domains in which Trusts are assessed for Foundation Trust status, as set out in Monitor's "Guide for Applicants".

| Domain | Notation |
|---|---|
| **Legally constituted and representative**<br><br>The trust's proposed NHS foundation trust application is compliant with current legislation<br>The trust has carried out due consultation process<br>Membership is representative and sufficient to enable credible Governor elections | LC |
| **Good business strategy**<br><br>Strategic fit with SHA direction of travel<br>Commissioner support to strategy<br>Takes account of local/national issues<br>Good market, PEST and SWOT analyses | GBS |
| **Financially viable**<br><br>FRR of at least 3 under a downside scenario<br>Surplus by year three under a downside scenario and reasonable level of cash<br>Above underpinned by a set of reasonable assumptions e.g. CIPs, capex plans, IFRS treatment for trusts with PFIs, impact of tariff changes e.g. HRG4, etc.<br>Commissioner support for activity and service development assumptions | FV |
| **Well governed**<br><br>Evidence of meeting statutory targets<br>Declaring full compliance or robust action plans in place<br>Robust, comprehensive and effective risk management and performance management systems in place, which are proven to effect decision-making | WG |

| Domain | Notation |
|---|---|
| **Capable Board to deliver**<br><br>Evidence of reconciliation of skills and experience to requirements of the strategy<br>Evidence of independent analysis of board capability/capacity<br>Evidence of learning appetite via NHS foundation trust processes<br>Evidence of effective, evidence based decision making processes | Bd |
| **Good service performance**<br><br>Evidence of meeting all statutory and national/local targets<br>Evidence of no issues, concerns, or reports from third parties, e.g. HCC and in future CQC<br>Evidence that delivery is meeting or exceeding plans | GSP |
| **Local health economy issues/external relations**<br><br>If local health economy financial recovery plans in place, does the application adequately reflect this?<br>Any commissioner disinvestment or contestability not reflected<br>Effective and appropriate contractual relations in place<br>Other key stakeholders such as local authorities, SHAs, other trusts, etc. | LHE |

## CLINICAL AUDIT ASSURANCE FOR CORPORATE OBJECTIVES AND BAF RISKS

Note: The table below lists the clinical audits (taken from the Trust's draft Clinical Audit Programme 2012/13) which are considered to be relevant to the Corporate Objectives and risks listed. Relevance has been assessed by the Director of Research & Innovation, the lead for the Department which oversees the Clinical Audit Programme.

| Ref | Corporate Objective | Description of Risk | Relevant Clinical Audits |
|---|---|---|---|
| B1 | Deliver the quality outcome gains specified in the Trust's Quality Strategy, in particular a reduction in the Trust's mortality rate | 1. We fail to engage staff with the importance of mortality as a quality measure<br><br>2. We fail to provide timely and accurate information on mortality and other quality issues, impeding the tracking of improvement actions.<br><br>3. We fail to develop capability in quality improvement methodology to ensure a systematic approach to mortality improvement | Stroke National Audit Programme ( combined Sentinel and SINAP )<br><br>ICNARC CMPD: adult critical care<br><br>ICNARC NCAA: cardiac arrest<br><br>Asthma Deaths - confidential enquiries<br><br>Hip Fracture Database<br><br>Child Health - confidential enquiries<br><br>Audit of the health record (NHSLA)<br><br>Eclampsia - continuous CNST<br><br>Post Partum Haemorrhage (PPH) > 1500mls or symptomatic following blood loss<br><br>Snapshot of Gentamicin Use in St Richard's Hospital August 2011 |

| Ref | Corporate Objective | Description of Risk | Relevant Clinical Audits |
|---|---|---|---|
| C1 | Deliver the patient safety gains specified in the Quality Strategy | 1. Delivery of sub-optimal patient care (275, 340)<br><br>2. Financial penalties due to failure to deliver services. | Falls & Bone Health - Organisational/Clinical.<br><br>Audit of the health record (NHSLA)<br><br>Improving and maintaining safe prescribing "check and correct"<br><br>Venous thromboembolism VTE (NHSLA) |

**WESTERN SUSSEX HOSPITALS NHS TRUST**

**BOARD ASSURANCE FRAMEWORK 2012/13**

**RISK REVIEW SCHEDULE**

Note: risks in **bold type** within a heavy-lined cell are the Trust's four most significant risks, as decided by the Board.

| Ref | Corporate Objective | Description of Risk | Risk Review Assigned to: | | |
|---|---|---|---|---|---|
| | | | Board | Q&RC | F&IC |
| **A** | **We care about you** | | | | |
| A1 | Increase the number of patients who would recommend the Trust to family or friends | 1. We experience reputational damage due to adverse media coverage or feedback within our community | Half-yearly (with progress report on Annual Plan) | | |
| | | **2. Patients have a poor experience of our services** | Quarterly (with progress report on Annual Plan) | | |
| **B** | **We care about quality** | | | | |
| B1 | Deliver the quality outcome gains specified in the Trust's Quality Strategy, in particular a reduction in the Trust's mortality rate | 1. We fail to engage staff with the importance of mortality as a quality measure | | Quarterly (combined with report on implementation of Quality Strategy) | |
| | | **2. We fail to provide to staff timely and accurate information on mortality and other quality issues, impeding the tracking of improvement actions.** | | | |
| | | 3. We fail to develop capability in quality improvement methodology to ensure a systematic approach to mortality improvement | | | |
| | | 4. The transition process for the Sussex Health Informatics Service de-stabilises the services and increases costs for the Trust in Quarters 1 and 2 | | | Quarterly |

| Ref | Corporate Objective | Description of Risk | Risk Review Assigned to: | | |
|---|---|---|---|---|---|
| | | | Board | Q&RC | F&IC |
| B2 | Reduce our rates of unplanned re-admissions | 1. External partners do not deliver the plans necessary to reduce re-admissions | | Quarterly | |
| | | 2. We fail to improve access and discharge arrangements | | | |
| **C** | **We care about safety** | | | | |
| C1 | Deliver the patient safety gains specified in the Quality Strategy | 1. Delivery of sub-optimal patient care (275, 340) (GSP) | | Quarterly (combined with report on implementation of Quality Strategy) | |
| | | 2. Financial penalties due to failure to deliver services. | | | |
| **D** | **We care about local services** | | | | |
| D1 | Continue to implement the improvements to local services as envisaged in our clinical services strategy, in particular our Service Redesign for Quality programme | 1. The Trust does not have the capacity to deliver changes at the scale and pace envisaged | Quarterly (with progress report on Annual Plan) | | |
| | | 2. The Trust does not secure the external and internal support for the changes it is proposing | | | |
| **E** | **We care about being joined up** | | | | |
| E1 | Work with our local health economy partners to jointly deliver a 15% reduction in emergency admissions by March 2013 | **1. External partners fail to help deliver programmes** | Quarterly (with progress report on Annual Plan) | | |
| **F** | **We care about improvement** | | | | |
| F1 | Implement a strategy for engagement with staff, members and other community stakeholders | 1. The scale and pace of service change disengages staff, public, members and others | Quarterly (with progress report on Annual Plan) [Following FT authorisation, reference in reports to Council of Governors] | | |
| F2 | Continue to improve the patient environment through investment in the Trust's estate | 1. Capital and human resources are insufficient to achieve all objectives leading to a compromise in improving patient facing estate. | | | Quarterly |

| Ref | Corporate Objective | Description of Risk | Risk Review Assigned to: | | |
|---|---|---|---|---|---|
| | | | Board | Q&RC | F&IC |
| F3 | Improve the quality and productivity of patient care through the introduction of a service improvement function | 1. Service improvement plans are not congruent with operational priorities and delivery is compromised | | Quarterly | |
| **G** | **We care about the future** | | | | |
| G1 | Achieve Foundation Trust status | **1. The Department of Health does not pass the application to Monitor in timely fashion** | Quarterly (as part of progress report on FT programme) | | |
| | | 2. We are unable to maintain a state of Monitor readiness indefinitely | Quarterly (as part of progress report on FT programme) | | |
| G2 | Achieve a Financial Risk Rating of no lower than 3 | 1. We fail to deliver our Cost Improvement Plans | | | Quarterly (as part of progress report on FT programme) |
| G3 | Achieve a Monitor governance rating of no worse than Amber-Green throughout the year | 1. A mismatch between demand and capacity leads to access targets not being met | Quarterly (as part of Performance Report) | | |
| | | 2. The planned productivity and efficiency improvements do not deliver the required capacity | | | |
| G4 | Continue the development and implementation of Service Line Management | 1. A failure to secure the necessary capacity to deliver Service Line management, including IT infrastructure, information management and training | | | Quarterly |
| | | 2. Ownership and leadership of the programme throughout the organisation | | | |

Approved by the Board on 26 April 2012

Western Sussex Hospitals NHS
NHS Trust

To: Board

Date of Meeting: 26 April 2012 Agenda Item: 15

| Title |
|---|
| **Risk Management Strategies** |
| Responsible Executive Directors |
| Marianne Griffiths, Chief Executive<br>Cathy Stone, Director of Nursing & Patient Safety |
| Prepared by |
| Graham Lawrence, Company Secretary<br>Vicky Daley, Head of Clinical Governance<br>Carole Garrick, Associate Director and Head of Midwifery |
| Status |
| Disclosable |
| Summary of Proposal |
| The Board has previously approved an organisation-wide Risk Management Strategy, a document which is required for compliance with the NHS Litigation Authority (NHSLA) requirements but which also represents good practice.<br>The document is due for annual review but in any event the need to update the document has been identified through discussions at the Quality & Risk Committee and elsewhere. The revised strategy will contribute to the evidence supporting the Foundation Trust General Self-certification which the Board is required to submit to Monitor.<br>This paper presents for the Board's approval the revised strategy and an action plan for further development of risk management practice. (The strategy is presented alongside the Maternity Risk Management Strategy. A maternity-specific strategy is a requirement of the Clinical Negligence Scheme for Trusts, part of the NHSLA.) |
| Implications for Quality of Care |
| The further development of risk management as set out in the strategy and action plan will mitigate risk and thereby enhance quality of care. |
| Link to Strategic Objectives/Board Assurance Framework |
| The strategy references and supports the Board Assurance Framework, as part of the Trust's risk management arrangements. |
| Financial Implications |
| There are no direct financial implications. The paper does not propose any additional investment in respect of staff or systems. |
| Human Resource Implications |
| The action plan sets out requirements for ongoing training and support to risk managers and other staff within corporate teams and the clinical Divisions, to support the implementation of improved risk management practice. |

| Recommendation |
| --- |
| **The Board is asked to APPROVE the:**<br>**a) Trust-wide Risk Management Strategy;**<br>**b) Maternity Risk Management Strategy;**<br>**c) Action Plan for Development of Risk Management.** |
| Communication and Consultation |
| Director of Nursing & Patient Safety, Medical Director, Director of Organisational Development & Leadership, Head of Clinical Governance, Risk & Patient Safety Manager, Risk Manager (Non-clinical), Associate Director and Head of Midwifery, Director of Clinical Services – Women & Children |
| Appendices |
| Trust-wide Risk Management Strategy<br>Maternity Risk Management Strategy<br>Action Plan |

Western Sussex Hospitals NHS
NHS Trust

To: Board Date: 26 April 2012

From: Graham Lawrence, Company Secretary Agenda Item: 15

**FOR DECISION**

## RISK MANAGEMENT STRATEGIES

### 1.00 INTRODUCTION

1.01 The Board has previously approved an organisation-wide Risk Management Strategy, a document which is required for compliance with the NHS Litigation Authority (NHSLA) requirements but which also represents good practice.

1.02 The document is due for annual review but in any event the need to update the document has been identified through discussions at the Quality & Risk Committee and elsewhere. The revised strategy will contribute to the evidence supporting the Foundation Trust General Self-certification which the Board is required to submit to Monitor.

1.03 This paper presents for the Board's approval the revised strategy and an action plan for further development of risk management practice. (The strategy is presented alongside the Maternity Risk Management Strategy. A maternity-specific strategy is a requirement of the Clinical Negligence Scheme for Trusts, part of the NHSLA.)

### 2.00 RISK MANAGEMENT STRATEGY

2.03 The strategy has been reviewed by colleagues responsible for compliance with the NHSLA standards and has been confirmed as compliant. It has also been reviewed alongside the Risk Management Policy, which sets out operational processes for risk management to support the strategy. A number of minor amendments are required to ensure that the policy remains consistent with the revised strategy; this will be processed through the Executive governance structure.

### 3.00 RISK MANAGEMENT DEVELOPMENT

3.01 As the Board and Quality & Risk Committee has recognized, whilst operational risk management and reporting is effective, there is scope for improvement in a number of areas. An action plan has been developed to address this, alongside the strategy which sets out the current arrangements.

3.02 The action plan focuses on developing and further embedding the recording of information associated with risks, and the way in which the Datix and SHE systems are integrated. (The SHE system supports health and safety management, and contains advanced risk management functionality.) This development work will provide a basis for risk management information to inform investment decisions – for example, in respect of work on the estate and purchase of equipment – and for it to be used to identify any themes and trends in risks across the organisation. Any such risks could therefore be addressed in a more considered and co-ordinated approach.

3.03 The action plan also identifies the need to more proactively identify and address risks associated with Trust-wide and/or Divisional business plans. These risks are managed by at corporate level and through Divisional Boards but the plan envisages more active recording

and reporting of this information. This would facilitate more explicit links between the operational risk register and the Board Assurance Framework, which is compiled around the Annual Plan.

3.04 Finally, the action plan identifies the need to develop a more formal risk appetite at organisational and, where appropriate, Divisional level. This addressed in more detail below.

## 4.00 MONITORING OF IMPLEMENTATION

4.01 The Company Secretary will retain responsibility for the strategy and for ensuring delivery of the action plan through the Risk & Patient Safety Team and the Head of Strategic Planning. Progress will be monitored by the Company Secretary and the Director of Nursing & Patient Safety.

4.02 It is proposed that there should be quarterly reports to the (executive) Management Board and, for purpose of Board-level assurance, to the Quality & Risk Committee. (The latter will be asked to discuss the further development of risk management as described below.) The Board will be briefed through reports from the Committee and through quarterly reports on risk management and the Board Assurance Framework. The strategy will be presented for re-approval not later than March 2013.

## 5.00 RECOMMENDATION

**The Board is asked to APPROVE the:**

**a) Trust-wide Risk Management Strategy;**
**b) Maternity Risk Management Strategy;**
**c) Action Plan for Development of Risk Management.**

| RISK MANAGEMENT STRATEGY | |
|---|---|
| **Summary statement: How does the document support patient care?** | The strategy sets out the Trust's current arrangements for risk management, and includes an action plan for further development. This will enhance identification and mitigation of risks to patient care. |
| **Staff/stakeholders involved in development:**<br>*Job titles only* | Director of Nursing & Patient Safety<br>Medical Director<br>Director of Organisational Development & Leadership<br>Members of the Quality & Risk Committee<br>Head of Clinical Governance<br>Risk & Patient Safety Manager<br>Risk Manager (Non-clinical) |
| **Division:** | Chief Executive's Office |
| **Department:** | Company Secretarial |
| **Responsible Person:** | Company Secretary |
| **Author:** | Company Secretary |
| **For use by:** | All staff |
| **Purpose:** | This document summarises the structures and processes through which the Trust manages operational risk, linked to strategic risk management where appropriate. |
| **This document supports:**<br>*Standards and legislation* | This document supports compliance with:<br>➢ NHSLA Risk Management<br>➢ CNST Standards<br>➢ legislation, particularly in respect of health and safety<br>➢ Care Quality Commission Outcome 16 Regulation 10 |
| **Key related documents:** | Risk Management Policy<br>Board Assurance Framework<br>Maternity Risk Management Strategy<br>Event, Investigation Management and Analysis<br>Learning and Development Policy<br>Health& Safety Policy |
| **Approved by:**<br>*Divisional Governance/Management Group* | Director of Nursing & Patient Safety<br>Company Secretary |

| | |
|---|---|
| **Approval date:** | 18 April 2012 |
| **Ratified by Board of Directors/ Committee of the Board of Directors** | Trust Board |
| **Ratification Date:** | 26 April 2012 |
| **Expiry Date:** | May 2014 |
| **Review date:** | December 2012 |
| **If you require this document in another format such as Braille, large print, audio or another language please contact the Trusts Communications Team** | |
| **Reference Number:** | S1 |

| Version | date | Author | Status | Comment |
|---|---|---|---|---|
| 1.0 | March 2010 | Deputy Director of Nursing | Archived | |
| 2.0 | February 2011 | Company Secretary | Archived | |
| 3.0 | December 2011 | Deputy Company Secretary | Archived | Strategy updated in relation to the changes in Governance Structures and setup of the Trust Board's Sub-Committees. |
| 4.0 | March/April 2012 | Company Secretary | Live | Annual review of Strategy. Updated to reflect current practice and plans for development. |

## 1.00 INTRODUCTION: STATEMENT OF INTENT FOR STRATEGY

1.01 Western Sussex Hospitals NHS Trust is committed to achieving excellent patient care. It places great emphasis upon encouraging communication and developing high quality services, which are flexible and innovative in their approach to meet the needs of patients and staff alike. The Trust's organisational values support this commitment.

1.02 This Risk Management Strategy will support these objectives. The ongoing development of risk management will ensure that the objectives are realised in an environment that is safe and secure for patients, visitors and staff.

1.03 The systematic identification, analysis and control of risk is afforded a high priority within the Trust. An education process supported by an open and learning culture encourages all staff to report potential or actual risks and incidents, as a basis for organisational learning and improvement.

## 2.00 BACKGROUND AND PURPOSE

2.01 Western Sussex Hospitals NHS Trust was formed on 1 April 2009, from a merger of Royal West Sussex NHS Trust and Worthing and Southlands Hospitals NHS Trust. The Board and Executive Team put into place appropriate risk management arrangements for the period post-merger and beyond, and these have operated effectively to date and been the subject of development. At this time, approximately three years since the merger, the Board has decided to refresh this Risk Management Strategy to provide a basis for ongoing development of practise throughout the organisation.

2.02 This document summarises the structures and processes through which the Trust manages operational risk, linked to strategic risk management where appropriate. In these respects, the strategy complies with the requirements of the NHS Litigation Authority (NHSLA) and thereby contributes to the Trust's compliance with the standards. The strategy also supports compliance with the requirements of relevant legislation, including in relation to health and safety. The strategy also sets out a plan for the development of operational risk management practise throughout the Trust, and aspirations for further improvement thereafter.

## 3.00 EXECUTIVE SUMMARY

3.01 The Trust Board is responsible for ensuring that the organisation consistently follows the principles of good governance applicable to NHS organisations. Through the Board Assurance Framework and risk management arrangements, risks are identified and actions are taken to eliminate or reduce the potential impact on patients, staff and the Trust as a whole.

3.02 The Chief Executive as Accountable Officer of the Trust has overall accountability and responsibility for ensuring it meets its statutory and legal requirements, and adheres to guidance issued by the Department of Health. The Risk Management Strategy and related procedures have been developed to support the Trust's Board Assurance Framework and its Risk Management Systems, ensuring risk are identified and actions are taken to eliminate or reduce the potential impact on patients, staff and the Trust as a whole.

3.03 The Trust's primary aim is underpinned by a number of organisation values relating to its intention of providing high quality care to the people it serves in a modern and safe environment. The Trust Board is committed to an open and honest approach in all matters. The Board expects staff to acknowledge that risks within the Trust can be identified and managed, if all staff adopt an attitude of openness and honesty. The overall approach expected within the organisation is one of help and support rather than recrimination and

blame. The procedure for this is explained within the Trust's policy on Raising Concerns, available to all staff via the Staffnet.

## 4.00 DEFINITION OF RISK MANAGEMENT

4.01 Western Sussex Hospitals NHS Trust is committed to the effective management of risks. Such risks can arise in any part of the Trust's activities or services, in both the clinical and non-clinical environments.

4.02 The Trust regards risk management as:

"The activity and process by which the organisation identifies, assesses, mitigates and manages any actual or potential event or issue which could threaten the achievement of the organisations objectives and plans, its ability to provide services of the required quality, or its compliance with legal, regulatory and policy requirements."

## 5.00 APPROACH TO RISK MANAGEMENT

5.01 The Trust approaches risk management in two ways:

- proactively identifying risks to the achievement of its objectives set at corporate, divisional and departmental level.
- identifying risks (principally operational) arising at any time.

5.02 A proactive approach is be taken to identification and management of risk. In respect of corporate objectives, the associated risks (and the means of mitigating and managing) them are set out in the Trust's Board Assurance Framework (BAF) which is approved by the Board alongside the Annual Plan each year, and reviewed with the Annual Plan each quarter.

## 6.00 RISK MANAGEMENT OBJECTIVES

6.01 The Trust Board has agreed the following objectives for risk management aligned to its corporate aims:

- To manage risks to the quality of services, information governance, and the safety of patients, their carers and visitors
- To manage risks to staff
- To manage the risk of failing to meet national and local priority targets
- To manage risks to the financing and efficiency of services
- Implement a management and leadership structure with the capability to deliver the organisational strategy
- Achieve targets, standards and financial plans
- To manage risks to the reputation of the Trust
- Develop a robust organisational and clinical strategy that effectively enables delivery of a Foundation Trust status

6.02 These risk management objectives are incorporated into the risk management system and governance arrangements.

## 7.00 STRATEGIC AIMS

7.01 The Trust's Risk Management Strategy and Risk Management Policy represent its corporate philosophy towards management of risk and its treatment.

7.02 **The Process**

7.03 The Trust Board recognises that risk management is an integral part of the normal management process. This strategy provides the framework for risk management, which:

- Is based on best practice, national guidance and compliance with the standards for the National Health Service Litigation Authority (NHSLA) risk standards and Care Quality Commission Requirements for registration.

- Integrates risk management across the Trust and supports convergence of all aspects of Governance.

- Supports the Trust Board, in agreeing the Statement of Internal Control and Assurance Framework and realising the significant quality, financial and organisational benefits from minimising risk.

- Embeds risk management practices into the day-to-day function of the Trust and within the role of every staff member.

This strategy states the:

- Roles, responsibilities and structure for risk management.

- Arrangements for integrating the approach to risk management which includes complaints, legal claims, health and safety, and patient safety.

- Approach to training and education to make the risk management process effective and ensure a safety culture.

- Risk management monitoring, auditing and review process.

7.04 The strategy links with and supports a number of other strategies and policies, including the Maternity Risk Management Strategy.

7.05 The Trust actively supports risk management to improve the quality of patient care and the safety of its staff and visitors to the Trust, as well as reduce the likelihood of claims and costs arising from mistakes and possible negligence.

7.06 The Trust endeavours to prevail a pro-active reporting and management of Risks culture within all areas of the organisation. It is acknowledged that Risks occur daily in every activity undertaken within the Trust. It is within this scenario that this strategy has been developed. There are a number of different risks that can impact on the health, safety and welfare of patients, visitors and staff and on the effective running of the Trust. These can be divided into five prime areas:

- non-clinical
- clinical
- reputation
- business
- financial

7.07 By approaching the control of such risks in a strategic and organised manner the risks are reduced. This results in better quality care for patients, a safer environment and, by minimising loss, maximises the available resources for patient services and care.

7.08 The strategy is therefore to identify hazards and risks that exist within the Trust and control, eliminate or reduce to an acceptable level all risks which have any adverse effect on:

- the quality of care
- the ability of the Trust to provide and constantly improve existing services
- the health, safety and welfare of patients, staff and visitors
- the ability of the Trust to meet its contractual commitments
- the Trust to meet its statutory and obligatory duties.

7.09 In order to deliver the strategy the Trust will therefore need to:

- establish the frequency with which risks are likely to occur
- establish severity and the potential consequences of risks
- establish a system for prioritising the risks, in order that some objectivity can be applied to any decisions regarding necessary control measures
- develop systems to protect the services, reputation and finances of the Trust
- establish and maintain links with specialist centres and others to assist in reducing risk
- establish a process of identification, assessment, control, elimination and transfer of risk
- create an environment that is conducive to raising awareness and understanding thus minimising risks by involving every member of staff in the risk management process
- minimise the costs diverted to risk funding and maximise the resources available for patient services and care
- reduce risks to patients, employees and others by managing and controlling them where acceptable, but transfer risk where unacceptable or unavoidable and ensure that the process is monitored and reviewed and changes implemented to improve the system when necessary

## 8.00 RISK MANAGEMENT STRUCTURES AND RESPONSIBILITIES

8.01 The Trust's approach to risk management makes it clear that the process of managing risk is inherent to management of services and all other aspects of the Trust's business. Reflecting this, it is the Trust's position that all Boards, Committees and groups within the Trust's structure have some level of responsibility for managing risk, dependent upon their roles and authority. It is also the Trust's policy that all staff have a role in good risk management practice across the organisation.

8.02 Whilst this is the case, there are Boards, Committees and groups which have particular, clearly defined responsibilities in respect of risk management. These include the (Trust) Board, which reviews and approves the BAF, and receives reports on high-rated operational risks, ie. those rated at 15 or above, and the Quality & Risk Committee (QRC) and Audit Committee (AC) which support the Board in this area. The QRC and AC review relevant sections of the BAF and they review operational risks rated at 12 or above. The Finance & Investment Committee considers risk as part of its remit to oversee strategic and operational financial management. The particular responsibilities for these Boards and Committees are set out in their Terms of Reference. The structure is further illustrated in the chart at Appendix B.

8.03 Reporting from the Risk Register will be in accordance with this section of the strategy and Appendix C but, over time, the information contained within reports will be developed

through the attached action plan. This it to support the ongoing development of risk management practice, as set out in section 11.00 below.

8.04 The review process for the BAF is defined within that document; it includes a schedule of in-depth reviews, this schedule being approved by the Board each year. At more operational level the clinical and principal corporate Divisions within the Trust review r relevant risks, both clinical and non-clinical, at Management Board, Health & Safety Committee and/or Governance Review meetings. The detailed processes by which this takes place are set out in the Risk Management Policy and in policies and procedures relating to health and safety management, which supplement this strategy.

8.05 Whilst all staff have some responsibility for risk management, staff in certain roles have particular duties in respect of managing risk and these are defined in Appendix A.

## 9.00 RISK MANAGEMENT TRAINING

9.01 The Board recognises that for risk management to be effective, particularly operationally, it is essential for all staff to understand their responsibilities and be trained to use the systems and processes which the Trust has in place to identify, record, manage and report risks.

9.02 Staff training begins at the point of induction and continues thereafter with training at defined points. This is defined through the Learning and Development Policy which includes induction, mandatory training and on-going risk management training, both clinical and non-clinical. The Policy makes clear the responsibilities of managers and all staff in meeting the requirements of key training programmes. Attendance for staff training is coordinated by The Trust's Learning and Development Unit. The Company Secretary arranges, co-ordinates and records attendance at training for Board members.

4.03 The Risk and Patient Safety Manager and the Risk Manager (Non-clinical) work with the Head of Learning and Development on risk management education and training, which supports specific service needs and the sharing of lessons learned from the risk management process.

9.04 As identified in section 7.00 below, this strategy defines an action plan for the further development of risk management practice throughout the Trust. The plan includes work to further define and ensure consistent implementation of risk management practice, and it identifies the need to deliver associated training. The specific training will, at the appropriate time, be reflected in induction and refresher course described above.

## 10.00 COMMUNICATIONS

10.01 This strategy and the Risk Management Policy will be put onto the Trust's intranet for access by all staff.

10.02 This will be supplemented by more active communication as part of the action plan attached to this strategy, to ensure that all relevant staff are aware of, and have the training and information necessary to, discharge their responsibilities in respect of risk management.

## 11.00 FURTHER DEVELOPMENT OF RISK MANAGEMENT

11.01 The above sections of this strategy set out existing risk management arrangements within the Trust. The Board, Quality & Risk Committee and the Executive recognise the need to further develop risk management practice so this strategy is accompanied by an action plan which addresses this requirement.

11.02 The action plan focuses initially on the Trust's use of the Datix and SHE systems to record, rate and manage risks, and to report from the Risk Register. This will require the Trust to further develop use of the systems and to ensure that risk managers across the organisation use the system in a consistent way. It is intended that these developments, particularly in respect of the way in which risks are rated and categorised, will allow the Trust to develop an 'appetite' for risk.

11.03 Risk appetite can be defined as follows: "The amount of risk that an organisation is prepared to accept, tolerate or be exposed to at any point in time". By setting a risk appetite the Trust will put in place a framework for addressing risk in a range of areas. This is important because risk is inherent in the Trust's business and there are finite resources (principally human and financial) to apply to managing risk so it is necessary for the Trust to decide its areas of focus for resource utilisation.

11.04 It will be necessary to set a risk appetite strategically and operationally, reflecting the very different nature of risks in these two areas. In respect of operational risk the appetite will provide a framework within which senior managers can decide the most appropriate resource utilisation – for example, to decide the way in which to apply limited capital funds to address the need for new equipment or improvements to the Trust's estate. A similar approach will be possible at strategic level, set through the BAF.

11.05 Whilst the appetite will set a framework as described here, given the size of the organisation and the range of strategic and operational issues it addresses, it is likely that some risk management will continue to be informed in general terms by the risk strategy, rather than by applying specific thresholds for risk. For example, the Executive and the Board will be required to make judgements as to the extent and type of risk which is acceptable in respect of business cases or service developments, in the context of the risk appetite and the Trust's operating position generally.

11.06 The action plan which accompanies this strategy recognises that setting a risk appetite will necessarily follow further development in respect of using risk management systems, particularly in relation to recording and reporting information. At the time of writing the Trust is expecting an upgrade of the Datix system to be implemented in June 2012; this will make possible the recording of more useful information about risks and thereby facilitate the development of a risk appetite. This strategy will be revised by December 2012 to reflect the setting of a risk appetite.

## 12.00 IMPLEMENTATION, MONITORING AND REVIEW OF THIS STRATEGY

12.01 This strategy reflects existing practice within the organisation and, in respect of further development, delivery will be through the attached action plan.

12.02 Implementation of the action plan will be assessed quarterly and reported to the Executive, the Quality & Risk Committee and, to the extent necessary, to the Board. The Company Secretary will be responsible for producing these progress reports, in consultation with the Director of Nursing & Patient Safety.

12.03 The quarterly reports will set out the extent to which risk management activity, principally in relation to reporting and review, has complied with this strategy and the action plan. These

reports will be summarised into an annual assessment, presented alongside a review of this strategy each year. This will be presented to the Executive, the Quality & Risk Committee and the Board.

## 13.0 FURTHER INFORMATION/REFERENCES

13.1 For further information, refer to the following documents:

- Event, Investigation Management and Analysis Policy
- Complaints Policy
- Learning and Development Policy
- Health & Safety Policy
- Raising Concerns Policy
- Claims Policy
- Being Open Policy
- Risk Management Policy
- Maternity Risk Management Strategy
- Board Assurance Framework

## APPENDIX A: RESPONSIBILITIES FOR RISK MANAGEMENT

### Chief Executive

The Chief Executive is the Accountable Officer of the Trust and as such has overall accountability and responsibility for ensuring that it meets its statutory and legal requirements, and adheres to guidance issued by the Department of Health. This responsibility encompasses risk management, health and safety, financial and organisational controls and clinical governance.

The Chief Executive will ensure that the responsibilities for the management and co-ordination of risk are clear and that the structure for risk management outlined in this document are maintained.

The Chief Executive has delegated responsibility for the strategic development of risk to the Company Secretary. However, in order to fulfil the responsibilities of Accountable Officer the Chief Executive will ensure risk management features are a standing item on the agenda of the full Trust Boards and will discuss issues and progress with the Company Secretary and with Executive Directors (and other risk owners) as necessary.

### Company Secretary

The Company Secretary has responsibility for the controls and processes through which the Trust manages its strategic risks. In particular, the Company Secretary facilitates the development, review and reporting of the Board Assurance Framework. The Company Secretary is responsible for producing, updating and reporting progress against this strategy. This will be undertaken in consultation with the Director of Nursing & Patient Safety, reflecting the responsibilities set out below.

### Director of Nursing and Patient Safety

The Director of Nursing is responsible for the Patient Safety Team, who administers the Trust's risk recording and management system (Datix), support the identification, recording and reporting of incidents and generally facilitate risk management practice.

The Director of Nursing and Patient Safety is the lead Executive Director for complaints, claims, incidents and patient and public involvement.

The Director of Nursing will ensure:

- the convergence of clinical and non-clinical risk management with control of complaints, claims and incidents, working with managers within all Divisions to achieve this approach.

- that, in accordance with this strategy, risk management practice is developed and reviewed regularly.

### Executive Directors

Executive Directors are responsible for promoting good risk management practice generally. They will also ensure active management of risks within their areas of responsibility, ensuring that they are identified and managed on a pro-active basis. In their roles as members of the Board, Executive Directors will ensure that managers fulfil their responsibilities in respect of risk management, and they will promote the need for continuous development of risk management practice.

**Head of Clinical Governance**

The Head of Clinical Governance is responsible for leading and co-ordinating clinical governance activity across the Trust, which supports the Director of Nursing and Patient Safety, the Medical Director, Non-Executive Directors, Directorate Governance Leads, and other healthcare professionals in delivering the Trust's Clinical Governance Strategy.

The Head of Clinical Governance is also responsible for the management of the Risk and Patient Safety Team, Clinical Governance Team and Compliance Team functions for the organisation, including the preparedness of the Trust for the achievement and maintenance of the NHSLA Risk Management Standards accreditation and compliance with the Care Quality Commissions Essential Standards of Quality and Safety. The Head of Clinical Governance will, therefore, lead the implementation of the action plan associated with this strategy.

**Risk and Patient Safety Manager**

The Risk and Patient Safety Manager is the Trust-wide lead for risk and is accountable to the Director of Nursing and Patient Safety through the Head of Clinical Governance. The key responsibilities of the post include:

- (with the Company Secretary) co-ordinating the implementation and auditing of the Trust's Risk Management Strategy and processes for risk management predominantly clinical risk. This will ensure staff practice high standards of risk management and that there is maximum reporting of incidents/potential risks

- supporting the integration of risk management and the convergence of all aspects of Governance

- developing and maintaining the Trust's Event, Investigation Management and Analysis Policy

- co-ordinating internal investigations into clinical incidents

- providing expert risk management advice, including high level trend analysis and the provision of Trust level reports generated through the IT system to the Director of Nursing and Patient Safety and Medical Director and to the Chief Executive and Trust Board

- developing, maintaining and monitoring the risk register

- working with risk management leads at corporate and Divisional/ department level to identify education needs for staff

- developing and implementing training programmes in risk management with the Head of Learning and Development

- day-to-day responsibility for co-ordinating and auditing the Trust's system for incident management

- ensuring the Trust's approach to risk management is compliant with good practice, national regulatory legislation, and national standards – NPSA, NHSLA and the Care Quality Commission

**Patient Safety Team**

The core patient safety team provides the specialist support and advice to Directors, managers and staff and keeps abreast of best practice, legal and statutory requirements and national guidance relevant to their role.

**Patient Safety Facilitator**

The Patient Safety Facilitator provides support to the patient safety manager and the key responsibilities for the post includes.

- Supporting the Risk and Patient Safety Manager in all aspects of risk management and patient safety within the Trust.
- Support Divisional teams with patient safety initiatives and trends analysis.
- Work with Divisions and clinical audit to support clinical effectiveness changes and lessons learnt
- Ensuring the Trust's approach to incident management is compliant with good practice, national and regulatory requirements, legislation, national standards – NPSA, NHSLA risk standards, the Care Quality Commission regulations.

**Patient Safety Administration**

The administration team will support the manager and facilitators. The posts include:

- The day to day responsibility for the Trust's risk management system.
- Staff training in the use of the risk management system

**Risk Manager (Non-clinical)**

The Risk Manager (Non-clinical), who is accountable to the Director of Organisational Development and Leadership works closely with the Patient Safety Manager on scoping the organisational risks. The Risk Manager (Non-clinical)also provides risk management advice, including high-level trend analysis and the provision of reports generated through the SHE Software to the Health and Safety Committee, the Director of Nursing and Patient Safety and Medical Director and to the Chief Executive and Trust Board. The Risk Manager (Non-clinical) works very closely with the Moving & Handling Advisor/Trainers and Occupational Health.

**Emergency Planning Officer**

The Emergency Planning Officer, who is accountable to the Chief Operating Officer, co-ordinates all emergency and major incident plans, including pandemics, exercises, training and dissemination of documentation, works closely with the Risk and Patient Safety Manager and identifies risks associated with emergency planning.

**Chiefs of Service and Directors of Clinical Services**

Chiefs of Service and Clinical Service Directors are responsible for implementation of the Trust's relevant strategies and policies which support the risk management approach. Specifically they will:

- ensure a patient safety forum is maintained within the Division/departments, which will continue to encourage integration of risk management.

- identify a designated risk co-ordinator for the Division/departments who co-ordinate risk assessments, incident reporting, the investigation of incidents/near misses and the management of the Divisional and departmental risk registers.

Ensure that local risk management procedures are maintained based on the Trust-wide strategy and procedures including risk assessment, incident reporting and the risk register.

- Ensure there is a system for monitoring the application of risk management, including mitigation, within Divisions/departments

- Ensure the division undertake Risk Assessments in accordance with the Health and Safety Policy and Security Policy.

- Provide reports that will contribute to the Trust-wide monitoring and auditing of risk.

- Ensure staff attend relevant mandatory and local training programmes and records of staff attendance are monitored at Divisional meetings.

- Training in risk management will include information relating to issues raised and lessons learned and records of attendance are maintained.

- Work with the patient safety team to ensure that a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting within the Division.

- Ensure the specific responsibilities of managers and staff in relation to risk management, CQC registration and patient safety are identified within the job description for posts and those key objectives are reflected in the individual performance review/staff appraisal process.

- Contribute to the Trust patient safety newsletter

- Report to the Quality Board and Divisional Performance Review Panel on patient safety in the Division.

**Head of Learning & Development**

The Head of Learning & Development will:

- Develop and maintain a Training Needs Analysis that includes all risk management training

- Produce an annual training prospectus and ensure that all staff are aware of it

- Ensure that risk management training is provided as part of the Trust's Statutory & Mandatory Training (S&MT) programme

- Monitor attendance at induction and other training sessions to ensure that staff receive training in accordance with the Training Needs Analysis

**Managers and Other Staff**

It is important that managers at all levels in the organisation encourage, support and facilitate staff in the application of good risk management practice and that they ensure staff are provided with the education and training to enable them to do so.

Managers must be fully conversant with the Trust's approach to patient safety, risk management and compliance with regulatory requirements. They will support the application of this strategy and its related processes and participate in the monitoring and auditing process.

Managers must also manage risks within their areas of responsibility and within the authority delegated to them through Job Descriptions and by agreement with their superiors. These duties include the identification and assessment of risk, and the completion of actions through which risks are mitigated or eliminated. Managers must also report and record their risk management activities as required by the Trust's policies and procedures.

Managers must also attend mandatory risk management training, including risk essentials, SHE system, and root cause analysis training, in accordance with the Trust's Learning and Development Policy.

Undertake and manage Risk Assessments in accordance with the Health and Safety Policy.

**All staff are required to:**

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the Trust's business.

- Comply with the incident and near miss reporting procedures.

- Be responsible for attending mandatory and relevant education and training events.

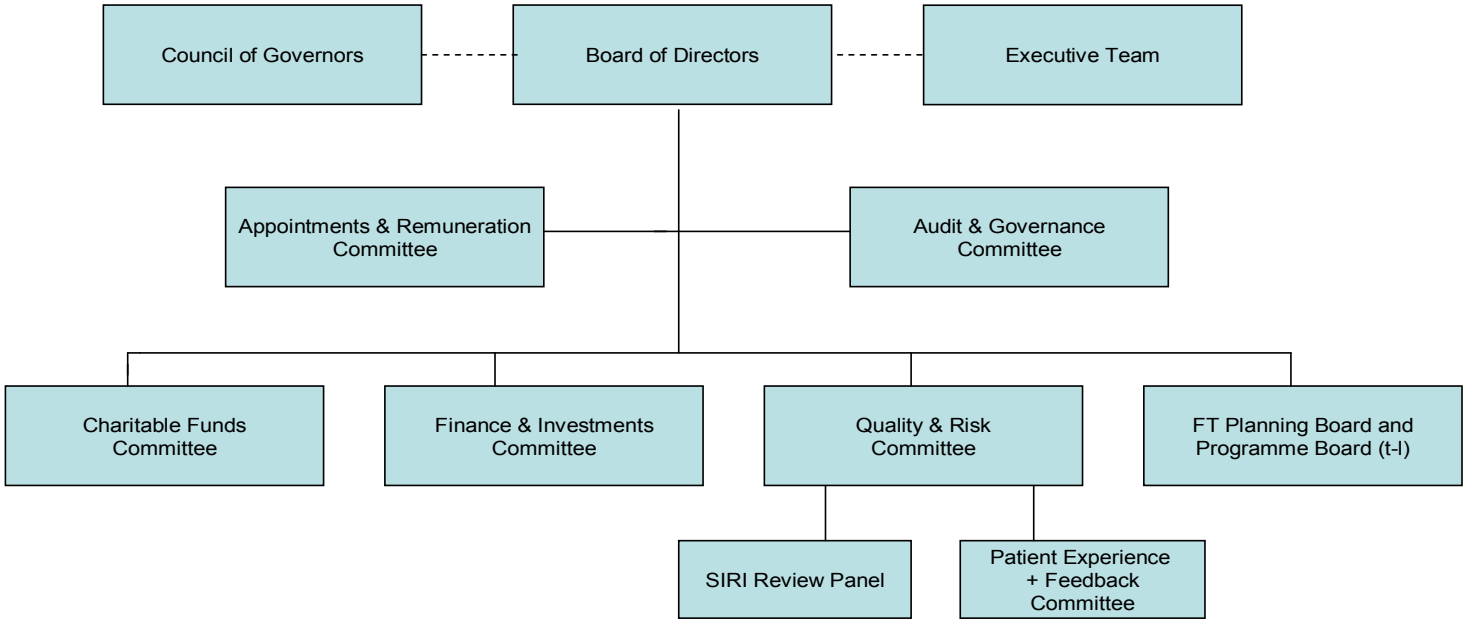
- Participate in the Risk Management System, including the risk assessments within their area of work and notify their line manager of any perceived risk which may not have been assessed.

- Be aware of the Trust's Risk Management Strategy and processes and the Division/department local strategy and procedures and comply with them.

- Report all incidents

**APPENDIX B: GOVERNANCE STRUCTURE**

## Western Sussex Hospitals NHS Trust Board-level Governance Structure



**APPENDIX C: RISK REGISTER REPORTING AND REVIEW ARRANGEMENTS**

| Forum | Reporting/Risk Review Requirements | Frequency | Responsibility | |
|---|---|---|---|---|
| | | | Lead | Support |
| Divisional Management Boards | Reports from Divisions for all risks. Reports to include current score, target score and review dates. | Monthly | Divisional Directors | Head of Clinical Governance |
| Divisional Governance Reviews | Report from Divisions for all risks. Reports to include current score, target and review dates.<br><br>Additional exception report to provide an overview of any new risk, or issues identified with existing risks on the register. | Quarterly | Divisional Directors | Head of Clinical Governance |
| Divisional Performance Review Panel | Exception Reports from Divisional management teams to highlight any issues which relate to risks (with an initial rating of 12 or above) on the Risk Register.<br><br>Reports to include risks related to Divisional Business Plans, alongside reports on progress against the plans. | Monthly | Divisional Directors | Head of Clinical Governance |
| Management Board | Reports to list by Division all open, approved risks with an initial rating of 12 or above which have cross-Divisional implications or mitigation measures. Reports to include control measures, target scores and review dates. | Quarterly | Head of Clinical Governance | Risk & Patient Safety Manager |
| Quality & Risk Committee | Reports to list by Division all open, approved risks with an initial rating of 12 or above. Reports to distinguish between risks with current ratings above and below 12, and include control measures, target scores and review dates. | Quarterly | Head of Clinical Governance | Risk & Patient Safety Manager |

| Forum | Reporting/Risk Review Requirements | Frequency | Responsibility | |
|---|---|---|---|---|
| | | | Lead | Support |
| (Trust) Board | Reports to list by Division all open, approved risks with an initial rating of 15 or above. Reports to distinguish between risks with current ratings above and below 15, and include control measures, target scores and review dates. | Quarterly | Head of Clinical Governance | Risk & Patient Safety Manager |

**APPENDIX D: EQUALITY IMPACT ASSESSMENT**

| | |
|---|---|
| **Name of Policy, Service, Function, Project or Proposal** | Risk Management Strategy |
| **Department** | Company Secretarial |
| **Lead Officer for Assessment** | Company Secretary |
| **What is the main Purpose of the Policy/Service/Function/Project/Proposal?** | This document summarises the structures and processes through which the Trust manages operational risk, linked to strategic risk management where appropriate. |
| **List the main activities of the policy or service re-design (e.g. Manual Handling would relate to health and safety of patients; health and safety of staff; compliance with NHS and Government legislation or standards etc)** | The strategy sets out the Trust's current arrangements for risk management, and includes an action plan for further development. This will enhance identification and mitigation of risks to patient care. |
| **Is the policy or service relevant to:**<br><br>**Promoting Good Relations between different people?**<br><br>**Eliminating discrimination?**<br><br>**Promoting Equality of Opportunity?** | <br><br>Not specifically<br><br>Not specifically<br><br>Not specifically |
| **Which groups of the population do you think may be affected by this proposal?**<br><br>**Minority Ethnic People**<br>**Women and Men**<br>**People in religious/faith groups**<br>**Disabled people**<br>**Older people**<br>**Children and young people**<br>**Lesbian, gay, bisexual and transgender people**<br>**People of low income**<br>**People with mental health problems**<br>**Homeless people**<br>**Staff**<br>**Any other group (please detail)** | <br><br>No<br>No<br>No<br>No<br>No<br>No<br>No<br>No<br>No<br>No<br>Yes |

**Do you have any information that tells you of the current use of this service? Yes/No (if yes please detail)**

N/A

**Is it broken down by ethnicity, gender, disability, age, religion and sexual orientation?**

No

**Does this information reflect the proportions from the 2001 Census?**

N/A

**If there is no information available or if this is patchy, specify the arrangements that will make this available**

N/A

**Using the information above, please complete the grids below:**

**How will the Policy etc affect Men and Women in different ways?**

| Gender | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| **Women** | | | √ | | |
| **Men** | | | √ | | |

**How will the Policy etc affect Black and Minority ethnic people?**

| Race | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| **White** | | √ | | | |
| **Mixed** | | √ | | | |
| **Other Ethnic Group** | | √ | | | |
| **Black/Black British** | | √ | | | |
| **Asian/Asian British** | | √ | | | |

**How will the policy affect people with disabilities?**

| Disability | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| Visually Impaired | | √ | | | |
| Hearing Impaired | | √ | | | |
| Physically Disabled | | √ | | | |
| Learning Disability | | √ | | | |
| Mental Health Related | | √ | | | |

**How will the policy affect people of different ages?**

| Varying ages | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| | | √ | | | |

**How will the policy affect people of different sexual orientation?**

| Sexual Orientation | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| | | √ | | | |

**How will the policy affect Transgender or transsexual people?**

| | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| Transgender | | √ | | | |
| Transsexual | | √ | | | |

**How will the policy affect people of varying religious beliefs?**

| Varying beliefs | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| | | √ | | | |

**How will the policy affect those with carer responsibilities or impact on basic human rights?**

| Carers / Human Rights | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| | | √ | | | |

**Considering your responses above, what are the areas that are have a positive and / or negative impact?**

| | Positive + / Negative - | Reason Given for Impact |
|---|---|---|
| **Gender** | N/A | |
| **Race** | N/A | |
| **Disability** | N/A | |
| **Age** | N/A | |
| **Sexual Orientation** | N/A | |
| **Religious Belief** | N/A | |

**Has there been any consultation about this Policy etc? If there has, what were the key issues identified?**

| Consultation | Date | Summary of Key Issues to be addressed |
|---|---|---|
| **Gender** | N/A | Note: the contents of the strategy were subject to consultation as described on the cover page but this did not identify any issues relating to equality or diversity. |
| **Race** | N/A | |
| **Disability** | N/A | |
| **Age** | N/A | |
| **Sexual Orientation** | N/A | |
| **Religious Belief** | N/A | |

**If consultation is planned, when will it happen and what are the key themes for consultation?**

N/A

**How do you intend to consult staff?**

N/A

**What does Local / Regional / National research show with regards to these groups and the likely impact?**

| Group | Source | Key Issues |
|---|---|---|
| **Gender** | N/A | |
| **Race** | N/A | |
| **Disability** | N/A | |
| **Age** | N/A | |
| **Sexual Orientation** | N/A | |
| **Religious Belief** | N/A | |

**As a result of consultation / information gathering, what changes do you intend to make to the policy etc? If 'None', please state as relevant:**

**Gender**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| N/A | | | | | |
| N/A | | | | | |

**Race**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| N/A | | | | | |
| N/A | | | | | |

**Disability**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| N/A | | | | | |
| N/A | | | | | |

**Sexual Orientation**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| N/A | | | | | |
| N/A | | | | | |

**Religious Belief**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| N/A | | | | | |
| N/A | | | | | |

**Age**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| N/A | | | | | |
| | | | | | |

Please outline the monitoring and reviewing process and timescale

Agreed Review Date:

Signed by: Policy / Service Author ……..…

Trust Equality & Diversity Lead……

Date:

**WESTERN SUSSEX HOSPITALS NHS TRUST**

**RISK MANAGEMENT ACTION PLAN**

This plan sets out the agreed action required to further develop risk management practice across the Trust.

| Description of Action | Lead Responsibility | Deadline | Evidence/Assurance |
|---|---|---|---|
| 1. Reinforce agreed processes for recording, reporting and appraising risks, including:<br><br>➢ use of the risk rating matrix<br>➢ recording initial, current and target scores, and relevant controls and actions for improvement<br>➢ process for recording and approving risks<br>➢ review (and recording of review) of risks | Patient Safety & Risk Manager | Initial focus to 31 May 2012 and then ongoing support to risk managers | Risk Management Policy<br><br>Reports to Board and Quality & Risk Committee |
| 2. As part of the Datix system upgrade, review and implement descriptors to allow enhanced categorisation of risks and thereby inform financial management/mitigation | Patient Safety & Risk Manager | 31 July 2012 | Risk Management Policy<br><br>Reports to Board and Quality & Risk Committee |
| 3. Develop with risk managers, particularly in the clinical Divisions, improved processes for proactive identification, recording and management of risks associated with Divisional business plan targets and actions identified in any significant improvement plans developed in-year. | Head of Strategic Planning | September 2012 (for business plans for 2013/13) | Divisional Business Plans<br><br>Risk Register Reports |
| 4. Following the completion of the actions 1 and 2 above, and after a period of consistent risk reporting, lead the development a risk appetite for the Trust, both operationally and strategically. | Company Secretary | September 2012 | Report to Board |

Western Sussex Hospitals NHS
NHS Trust

| Maternity Risk Management Strategy | |
|---|---|
| **Summary statement: How does the document support patient care?** | This document supports patient care by outlining the maternity service approach to managing risk within the service and compliments the Trust Risk Management Strategy |
| **Staff/stakeholders involved in development:** | Chief Of Service Women & Child Health Division<br>Director of Clinical Services<br>Associate Director of Maternity Services & Head of Midwifery<br>Head of Children's Services<br>Integrated Clinical Lead Obstetrics<br>Clinical Governance (CNST) Midwife |
| **Division:** | Women and Child Health Division |
| **Department:** | Maternity |
| **Responsible Person:** | Chief of Service |
| **Author:** | Head of Midwifery and Clinical Governance (CNST) Lead |
| **For use by:** | All Staff within Maternity Services |
| **Purpose:** | This document establishes the risk strategy for the Maternity Service within the Western Sussex Hospitals NHS Trust |
| **This document supports:** | In accordance with NHS Litigation Authority/CNST Standards/ NHS best practice |
| **Key related documents:** | This document to be read in conjunction with the Maternity Learning from Incidents, Complaints and Claims and the **following Trust wide documents**:<br>Trust Risk Management Strategy<br>Risk Management Policy<br>Board Assurance Framework<br>Event, Investigation Management and Analysis Policy<br>Learning and Development Policy<br>Health & Safety Policy |
| **Approved by:** | Divisional Governance Group |
| **Approval date:** | 23/3/2012 |
| **Ratified by Board of Directors/ Committee of the Board of Directors** | TBC pending Trust Board |
| **Ratification Date:** | TBC pending 26th April |
| **Expiry Date:** | TBC Suggestive May 2014 |
| **Review date:** | December 2012 |
| **If you require this document in another format such as Braille, large print, audio or another language please contact the Trusts Communications Team** | |
| **Reference Number:** | To be added by the Compliance Unit |

| Version | date | Author | Status | Comment |
|---|---|---|---|---|
| 1.0 | January 2011 | Head of Midwifery and Clinical Governance (CNST) Lead | Archived | |
| 2.0 | March 2011 | Clinical Governance (CNST) Lead | Archived | Monitoring & Equality Impact Assessment tables updated |
| 3.0 | March & April 2012 | Head of Midwifery and Clinical Governance (CNST) Lead | Live | Annual Review of Strategy. Updated to reflect current practice and plans for development |
| 4.0 | | | | |

## Index

**Background And Purpose**

1.0 Western Sussex Hospitals NHS Trust (WSHT) was formed on 1 April 2009, from a merger of Royal West Sussex NHS Trust and Worthing and Southlands Hospitals NHS Trust. The Board and Executive Team put into place appropriate risk management arrangements for the period post-merger and beyond, and these have operated effectively to date and been the subject of development. At this time, approximately three years since the merger, the Board has decided to refresh this Risk Management Strategy to provide a basis for ongoing development of practise throughout the organisation.

The Maternity Service approach to risk management compliments the Trust approach but in addition outlines specific risk management objectives, leadership arrangements and management/reporting structures in order that everyone working within the service understands how the risk management objectives will be achieved .

This document will relate to the additional and specific demands of the maternity service and it is recommended that this is read in conjunction with the Trust Risk Strategy to fully reflect the whole system approach to managing risk at WSHT.

## 2. Aims of Risk Management Strategy

The maternity service is committed to achieving excellent care to women and their babies. It places great emphasis upon encouraging communication and an open and honest approach in all matters in order to develop high quality services, which are flexible and innovative in their approach to meet the needs of women, their families and staff alike.
It expects all staff to acknowledge that risks within the service can and should be identified and managed if everyone adopts an attitude of openness and honesty. The overall approach expected within the organisation is one of help and support to each other, rather than recrimination and blame.

The maternity service recognises that a risk management strategy will support these declared objectives. The ongoing development of this approach to risk management will ensure that the objectives are realised in an environment that is safe and secure for users, visitors and staff.

## 3 Framework for Risk Management

The maternity service recognises that risk management is an integral part of the normal management process. This strategy provides the framework for risk management, which:

- **Is based** on best practice, national guidance and compliance with the standards for the National Health Service Litigation Authority (NHSLA) CNST maternity risk standards and Care Quality Commission Requirements for registration.
- **Integrates** risk management across the maternity service and supports convergence of all aspects of Governance.
- **Supports** the Trust Board Assurance Framework and realising the significant quality, financial and organisational benefits from minimising risk.
- **Embeds** risk management practices into the day-to-day function of the service and within the role of every staff member.

This strategy states the:

- Roles, responsibilities and structure for risk management.
- Arrangements for integrating the approach to risk management which includes complaints, legal claims, health and safety, and patient safety.
- Approach to training and education to make the risk management process effective and ensure a safety culture.

- Risk management monitoring, auditing and review process.

3.3 Risks occur daily in every activity undertaken within the service. It is within this scenario that this strategy has been developed. There are a number of different risks that can impact on the health, safety and welfare of patients, visitors and staff and on the effective running of the service. These can be divided into four prime areas:

• non-clinical risk
• clinical risk
• reputation risk
• business risk

3.6 By approaching the control of such risks in a strategic and organised manner the risks are reduced. This results in better quality care for patients, a safer environment and, by minimising loss, maximises the available resources for patient services and care.

3.7 The Strategy is therefore to identify hazards and risks that exist within the service and control, eliminate or reduce to an acceptable level all risks which have any adverse effect on:

- the quality of care
- the ability of the service to provide and constantly improve existing services
- the health, safety and welfare of patients, staff and visitors
- the ability of the service to meet its contractual commitments

In order to deliver the strategy the service will therefore need to:

- establish the frequency with which risks are likely to occur
- establish severity and the potential consequences of risks
- establish a system for prioritising the risks, in order that some objectivity can be applied to any decisions regarding necessary control measures
- develop systems to protect the services, reputation and finances of the service
- establish and maintain links with specialist centres and others to assist in reducing risk
- establish a process of identification, assessment, control, elimination and transfer of risk
- create an environment that is conducive to raising awareness and understanding thus minimising risks by involving every member of staff in the risk management process
- minimise the costs diverted to risk funding and maximise the resources available for patient services and care
- reduce risks to patients, employees and others by managing and controlling them where acceptable, but transfer risk where unacceptable or unavoidable and ensure that the process is monitored and reviewed and changes implemented to improve the system when necessary

The maternity service by the nature of the complexity of care that is demanded recognises that in order to fulfil the elements described in the framework a process must exist to escalate when appropriate risk management issues directly to board level.

The Director of Nursing is the maternity service lead Director at Board level which is jointly shared with the Medical Director. Should there be a need to escalate issues to the board; direct access is available to the leads by use of mobile phone, pagers and through the Executive office. This will secure a one to one verbal conversation which is then followed up by email communication. For audit and monitoring purposes E mail communication is stored with the Head of Midwifery in a central repository on the hospital server and is accessible for assessment and assurance purposes.

In addition to the process for escalating urgent issues the Head of Midwifery and Director of Nursing meet on a 1:1 basis monthly where routine and non urgent review of maternity related issues are discussed. These meetings in conjunction with quarterly reviews contribute to providing assurance to the board on maternity matters Deputies are nominated at times of annual leave, or other unavailability

## 4. Risk Management Objectives

The Maternity service objectives for risk management reduction for the period April 2012 – March 2013

| Risk Reduction Objective | Actions to Achieve | Committee /Person Responsible | Date to be achieved by |
|---|---|---|---|
| CNST Level 2 | Development and Integration of all CNST criterion across both sites | Maternity Department led by Maternity Management and CNST Steering Group | Within quarter 3 2012. |
| Maternity Information System is Implemented Across both sites | Work with relevant Trust Departments to secure suitable software systems | Head of Midwifery, Head of IT and Trust Business Leads | July 2012 |

## 5. Risk Management Responsibilities

5.1 The responsibility for all risk management issues lies jointly with the Associate Director of Maternity services and Head of Midwifery and the Obstetric Clinical Lead

5.2 All members of staff have an individual responsibility for the management of risk and all levels of management must understand and implement the Maternity Service and Trust's Risk Management Strategy and supporting processes.

5.3 For the service to be effective in its approach to risk it must have the full support, involvement and commitment of all staff by stimulating interest in the identification and reporting of hazards and risks. The service will encourage managers to respond positively and report immediately through the agreed reporting systems any adverse incident.

5.4 The Women and Child Heath Division will be accountable for risks arising in their area of control; they will be accountable for recording all risk issues and have a managed process for mitigating risks, wherever possible, or reporting it through the governance structure within the Trust.

5.5 The Patient Safety Manager, Non clinical Risk Adviser, Fire Officer, Assistant Director of Facilities (Estates) and Security Officer and Information Governance team will provide advice and assistance in co-ordinating Risk Management activities in their areas of responsibility and expertise.

### 5.6 Risk Management Roles within Maternity Services

**Director of Nursing and Patient Safety**

The Director of Nursing and Patient Safety is the lead executive at board level for maternity services

The Director of Nursing will ensure that:

- The development of relevant maternity documents supports and compliments Trust strategies, policies and frameworks which support risk management and monitor their application through the lead managers.
- There is convergence of all aspects of risk management by working with managers within the Women and Child Health Division to achieve this approach.
- The Trust Board receives regular risk management information and that the Chief Executive and Board are kept abreast of changes in requirements.

**Medical Director**

The Medical Director, with the Director of Nursing and Patient Safety, is accountable to the Chief Executive for the strategic development and implementation of patient safety including risk management.

The Medical Director with the Director of Nursing and Patient Safety will provide the leadership to ensure the Trust undertakes this function in accordance with best practice, legal and statutory duties.

The Medical Director, with the Director of Nursing and Patient Safety, will lead the Trust's approach on achieving compliance with the NHSLA risk standards and Care Quality Commission regulations and registration.

**Clinical Lead /Obstetric Consultant**

Specifically will:

- Support the COS and DCS in delivering patient safety agenda to maternity services
- Act as a professional obstetric lead providing expert clinical advice within the maternity services
- Ensure that outcomes/recommendations are cascaded throughout the framework of clinical governance through clinical governance training days / presentations
- Provide feedback to individuals and implement any recommended changes to clinical practice

**Head of Midwifery - Associate Director**

Specifically will be:

- Professionally accountable to the Director of Nursing & Patient Safety
- Operationally accountable to the Divisional Chief of Service and Clinical Service Director
- A professional lead for midwifery providing expert midwifery clinical advice within the service
- Responsible where necessary to provide feedback to individuals and implement any recommended changes to clinical practice
- Involved in SUI investigations and recommendations
- Responsible for protecting the safety and well being of women, infants and the organisation.
- Professionally responsible for ensuring that staff working within the service are legally registered and clinically competent to practice.
- Required to work closely with the senior midwifery team to ensure standards of care offered are clinically appropriate and safe.
- Required to ensure the clinical guidelines used by the service are current and evidence based, where the evidence exists, to reflect best practice.
- Required to ensure risks are escalated to the risk register as appropriate and ensure that they are monitored through Divisional Governance Group and Trust Board

**Consultant Lead for Obstetric Risk Management and Labour Ward**

Specifically will:

- Monitor implementation of this strategy
- Give expert clinical advice within the maternity setting
- Be involved in SUI Obstetric investigations and recommendations
- Ensure that outcomes/recommendations are cascaded throughout the framework of clinical governance
- Escalate issues to the Integrated Clinical Lead and Chief of Service. and provide feedback on Risk Management issues to staff on Labour Ward and other areas of the Unit/Trust as appropriate

**Consultant Obstetric Anaesthetist**

Specifically will:

- Provide expert clinical advice within this field
- Provide feedback to individuals and implement any recommended changes to clinical practice
- Escalate issues to the committee and provide feedback on Risk Management issues to staff on Labour Ward and other areas of the Unit/Trust as appropriate

**Senior Clinical Midwifery Manager for Labour Ward and Inpatient Services**

Specifically will:

- Provide expert midwifery clinical advice within this field
- Provide feedback to individuals and implement any recommended changes to clinical practice
- Escalate issues and provide feedback on Risk Management issues to staff on Labour Ward and other areas of the Unit/Trust as appropriate

**Patient Safety Lead Midwife**

Specifically will:

- Provide expert clinical midwifery advice within this field and expert risk management advice, including high level trend analysis and the provision of Trust level reports generated through the IT system to the Head of Midwifery and Director of Nursing and Patient Safety
- Co-ordinate the implementation and auditing of the maternity risk management strategy and processes for risk management
- Co-ordinate internal investigations into clinical incidents.
- Develop, maintain and monitor the maternity service element within the divisional risk register.

**Midwifery Co-ordinator (band 7)**

Specifically will:

- Provide expert clinical advice within the group
- Escalate issues to the committee and provide feedback on Risk Management issues to staff on Delivery Suite and other areas of the Unit/Trust as appropriate

**Supervisor of Midwives**

Specifically will:

- Be involved in the investigation of incidents and provides feedback, support and training to midwives in line with her/his statutory role to protect the public
- Monitor standards within every midwife's individual practice to ensure the provision of a safe and quality service
- Be involved in regular audits
- Be involved in mandatory and statutory training
- Fulfil statutory role of protection of Mother and Baby

In addition to the above roles the service receives expert clinical advice from other key post holders including Consultant Neonatologist, Senior Clinical Midwifery Manager for Community and Chichester Birth Centre, Senior Midwifery Manager Public Health, Fetal & Maternal Medicine Sonographer Midwife, Antenatal Screening Midwife and Practice Development Midwife

**Managers and Other Staff**

It is important that managers at all levels in the organisation encourage, support and facilitate staff in the application of good risk management practice and that they ensure staff are provided with the education and training to enable them to do so.

Managers must be fully conversant with the service and Trust's approach to patient safety, risk management and CQC regulations. They will support the application of this strategy and its related processes and participate in the monitoring and auditing process.

**All staff will:**

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the service and Trust business.

- Comply with the incident and near miss reporting procedures.

- Be responsible for attending mandatory and relevant education and training events.

- Participate in the Risk Management System, including the risk assessments within their area of work and notify their line manager of any perceived risk which may not have been assessed.

- Be aware of the Maternity Service and Trust's Risk Management Strategies, processes and procedures and comply with them.

## 6. Risk Management Meeting Structure

### Patient Safety Incident Review Meeting

This involves the Consultant labour ward lead who has a responsibility for patient safety and the patient safety midwife, senior midwife for inpatients and labour ward, and other managers who have a responsibility for risk. This purpose of the meeting each week is to review reported patient safety incidents. Detailed investigations/root cause analysis is undertaken for the more serious or complex incidents, reports/action plans generated and staff feedback published. The outcome of these reviews are reported to the monthly Patient Safety Group, Midwifery Operational Management Team, the Divisional Governance Group and Supervisors of Midwives meeting. In addition verbal feedback is given to individuals and other fora as requested . All clinicians are welcome to attend this review meeting.

### Patient Safety Group

The multidisciplinary Group has representation from statutory supervision for midwives, clinical audit, clinical practice, protocols and guideline development, neonatology, anaesthesia and practice development; the group works to agreed terms of reference **(Appendix 2)**. Governance issues are reported to and from the group by the Divisional Integrated performance Group **(Appendix 3).** Feedback is shared with the Midwifery Management Team, and Supervisors of Midwives.

6.1 The maternity governance reporting structure is included as **Appendix 1**

6.2 The following Board level committees have responsibilities with regard to the management of risk and the Terms of Reference for these are to be found in the Trust Risk Management Strategy
The following Board- level Committees have responsibilities with regard to the management of risk:

- Audit & Governance Committee
- Quality & Risk Committee
- Finance and Investments Committee

6.3 In order to ensure communication between these committees and the Board, reports/ minutes of the meetings will be shared as follows:

| Board/Committee | Reports Received from |
|---|---|
| Board | All Board level Committees |
| Audit & Governance Committee | Quality & Risk Committee |
| Quality & Risk Committee | Divisional Governance Reviews<br>Patient Experience & Feedback Committee<br>SIRI Review Panel |

6.4 In addition to the above, membership of committees include a number of executive and non-executive directors who act as links between the Trust Board and its risk management sub-committees. Risk management forms an integral part of the overall management process. It is the responsibility of all staff and is integrated into mainstream clinical governance arrangements

## 7. Education & Training

7.1 Maternity service remains committed to the education and development of all staff and recognises its legal and ethical responsibility to create and maintain a work environment that will ensure the welfare, health and safety of staff, patients and the public.

7.2 A programme of education supports the launch of the Maternity Risk Management Strategy and related documents. Targeted education for those staff who are to take a specific role in risk management is also undertaken, these department risk leads.

7.3 The Trust Learning and Development Policy includes induction, mandatory training and on-going risk management training. The Policy makes clear the responsibilities of managers and all staff in meeting the requirements of key training programmes. Attendance at Trust level training is coordinated by the Trust's Learning and Development Unit. The maternity Training attendance is held within the maternity service database.

7.4 The Patient Safety Midwife works with the Practice Development Midwife, clinical and operational managers on risk management education and training, which supports specific service needs and the sharing of lessons learned from the risk management process.

7.5 Specialist training advisors in moving and handling also contribute to the high profile placed upon and the commitment to, comprehensive risk management training.

7.6 The Trust will provide training at the appropriate level in risk for Managers and Supervisors' of Midwives. The Trust will ensure through training that staff awareness is raised with regard to personal liability and responsibilities for taking all reasonable care to protect the Trust's property and liability. The Trust Patient Safety Team provide training on web-based incident reporting and the use of electronic risk assessment forms and the Risk Management software for Divisions. This training is being cascaded through Divisions. Risk Management training is part of the Trust's training prospectus and is part of induction for all new staff.

## 8. Monitoring Audit & Review

8.1 In the context of this strategy the maternity service uses a variety of internal and external mechanisms to monitor, audit and review its risk management systems **(APPENDIX 4)**

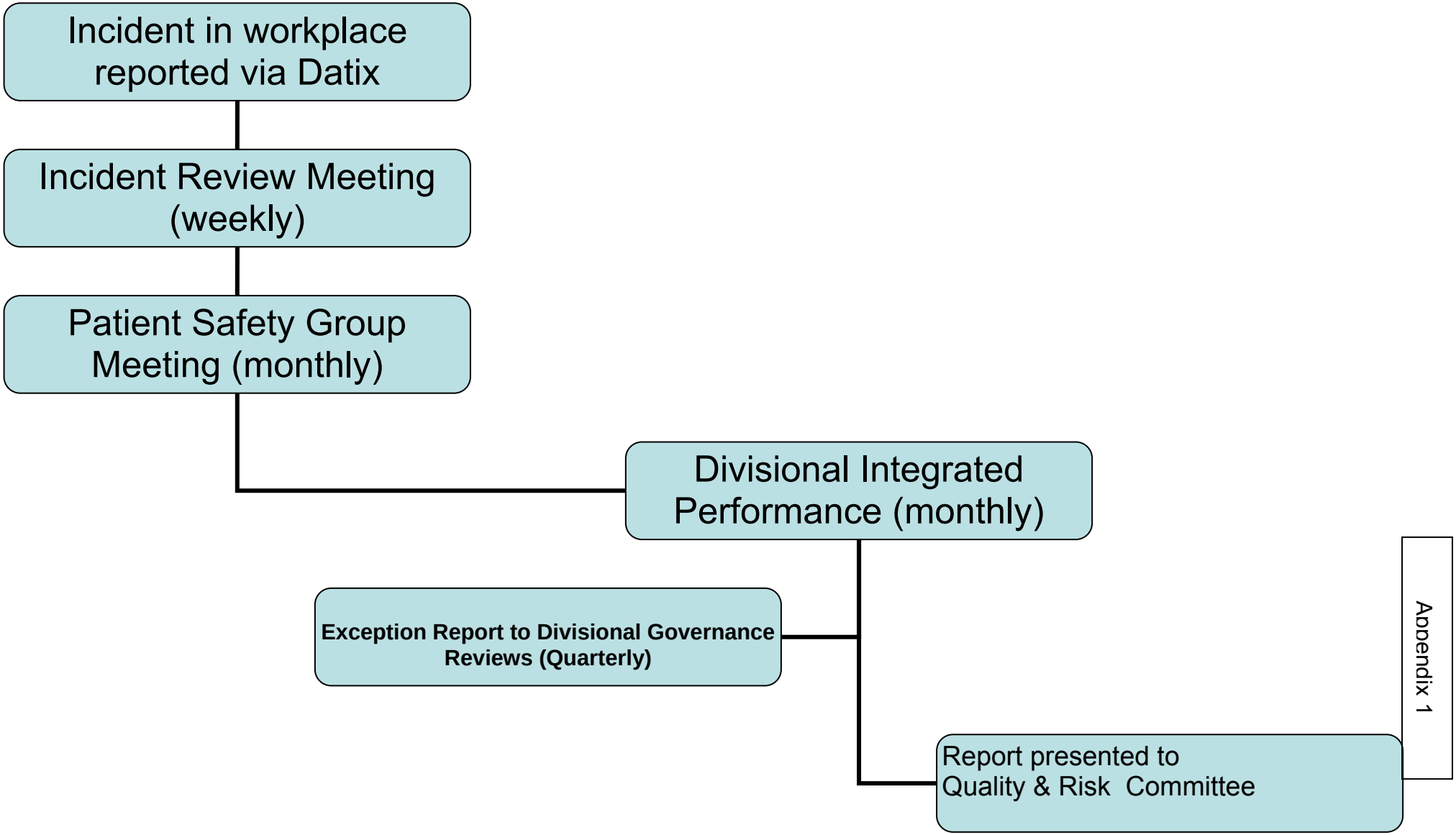
These include:

- Clinical Negligence Scheme for Trusts (CNST) Care Quality Commission, (CQC), Health & Safety Executive (HSE) NHSLA Risk Standards,
- Regular review of the division/department level risks on the risk register. At operational level the departmental managers review the risks on the register relevant to their area, decreasing or increasing the rating as appropriate. The risk register is discussed monthly at the patient safety group with a view to determining any additional controls or measures to reduce the risk. Following this review the software system is updated. The Divisional Integrated Performance Group is presented with a summary of the risks monthly, which is captured and presented quarterly through the Divisional Clinical Governance Review. This review is chaired by the Director or Nursing in conjunction with the Medical Director and a Non – executive Director and with the senior Divisional Leads. In addition any risks scoring 12 or more are escalated and reviewed by the Board.
- Annual review of the Risk Management Strategy and related documents and monitoring of the Risk Management Strategy Action Plan.

## 9. Implementation

9.1 The Strategy will be implemented by:

- Communicating with all staff (initiated by the ward/department induction process for new staff which is the responsibility of managers).
- Developing and maintaining an initial and ongoing training programme.
- Recording and monitoring risk using the Trust wide Incident Reporting and Risk Management software database


Incident in workplace reported via Datix
Incident Review Meeting (weekly)
Patient Safety Group Meeting (monthly)
Divisional Integrated Performance (monthly)
Exception Report to Divisional Governance Reviews (Quarterly)
Report presented to Quality & Risk Committee
Appendix 1

**Appendix 2**

## Women and Child Health Division

### Terms of Reference

# MATERNITY PATIENT SAFETY GROUP

**1. PURPOSE**

1.1 The Maternity Patient Safety Group is a formal sub group of the Women and Child Health and as such will report to the Divisional Clinical Governance Group on a monthly basis.

1.2 The Maternity Patient Safety Group will undertake to ensure that actions are taken to promote a patient safety focused culture and that incidents and clinical risks are managed in a systematic and proactive manner.

**2. FUNCTION AND DUTIES**

2.1 To review and monitor clinical incidents and make recommendations accordingly with follow up action.

2.2 To ensure that lessons learnt from incidents and systems are reviewed and changed where necessary, and dissemination from incidents individually and cross site.

2.3 To identify actions as a result of external inspections and reviews and ensure progress.

2.4 To ensure that reporting is open and there are high levels of incident reporting.

2.5 To ensure that all alerts are progressed and actions taken, e.g NPSA

2.6 To identify trends and hot spots

2.7 To develop a severity indicator and action accordingly

2.8 To encourage pro-active audit ensuring links with other indicators of risk e.g. complaints

2.9 To consider and take action or make recommendations on areas of potential risk

2.10 To ensure appropriate feedback mechanisms to ward areas, staff and other areas affected by maternity risk matters

2.11 To review/instigate the development of clinical guidelines in response to the clinical incidents /serious incidents / internal enquiry recommendations / incident review panel outcomes or notable trends.

2.12 To highlight high impact issues outside the scope of the group

2.13 To ensure compliance with Clinical Negligence Scheme for Trusts/NHS Litigation Authority Standards

2.14 To ensure compliance with Care Quality Commission

2.15 To monitor and take action on National Clinical Indicators

2.16 To receive a regular report on legal claims to ensure lessons learned

**3. QUORUM**

3.1 The Maternity Patient Safety Group shall be deemed quorate if there is representation of not less than six members, including Chair and/or Vice Chair. A duly convened meeting of the Group at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Maternity Patient Safety Group.

**4. AUTHORITY**

4.1 The Maternity Patient Safety Group is invested with the delegated authority to act on behalf of the Clinical Governance Group. The limit of such delegated authority is restricted to the areas outlined in the duties of the Group (above) and subject to the rules on reporting, as defined below. The Group is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are requested to co-operate with the Maternity Patient Safety Group.

**5. FREQUENCY OF MEETINGS**

5.1 Meetings of the Maternity Patient Safety Group shall be monthly.

5.2 The Chair may request an extraordinary meeting if it is considered necessary.

**6. MINUTES AND REPORTING**

6.1 Papers for consideration by the Maternity Patient Safety Group will be required 7 working days before the next meeting.

6.2 Minutes of the Maternity Patient Safety Group meetings should be formally recorded and distributed to Group members within 5 working days of the meetings. Subject to the approval of the Chair, the minutes will be submitted to the Divisional Integrated Performance Group at its next meeting with an exception monitoring report presented by the Group Chair or nominated deputy

**MEMBERSHIP**

Lead Consultant for Labour Ward – Worthing Site (Co-Chair)
Lead Consultant for Labour Ward – Chichester Site – (Co-Chair)
Consultant Paediatrician
Consultant Anaesthetist
Head of Midwifery
Senior Clinical Midwifery Manager – Worthing Site
Senior Clinical Midwifery Manager – Chichester Site
Clinical Governance (CNST) Midwife
Patient Safety Midwife – Worthing Site
Patient Safety Midwife – Chichester Site
Supervisor of Midwives
Team Leader – Community
Theatre Sister ( Worthing site only)
Ward Manager – Bramber Ward
Ward Manager – Tangmere Ward
Antenatal Clinic Manager
IT, Audit & Clinical Effectiveness Midwife
CNST Midwife
Practice Development Midwife
Neonatal Matron

| | |
|---|---|
| Staff Representatives from Service Area | Open Invite |
| Junior Doctors fro all specialities | Open invite |
| Students: Nursing/Midwife/Medical | Open invite |
| Obstetric Ultrasonographer | minutes and as required |

# Terms of Reference
# Women and Child Health Division Integrated Performance Group
## (Previously Clinical Governance & Board Meeting)

## 1.00 PURPOSE

1.01 The Divisional team of clinical and operational managers is required to monitor, review and action all operational and governance performance requirements in order to assure safe and effective services to patients are in place.
The group receives monthly reports by exception, ratifies policies and procedures, receives and steers action plans, clinical or operational, on behalf of the W&C division
In receiving all operational and clinical performance the divisional management team provides an integrated approach to divisional business and governance.
The group oversees all operational and clinical strategy and service change, ensuring effective patient safety measures are in place and robust links are maintained with corporate and professional bodies as appropriate.

## 2.00 MEMBERSHIP

2.01 The membership of the Group shall be as follows:

- Chief (Chair)
- Director Clinical Services ( co- chair)
- Head of Midwifery
- Head of Children's Nursing
- Clinical Lead – Obstetrics
- Clinical Lead -Gynaecology
- Clinical Lead Paediatrics
- Clinical Lead Sexual Health (SH) Services
- Operational Manager – W&C
- Operational Manager SH
- Divisional HR Manager
- Divisional Finance Manager
- Clinical Governance (CNST) Lead
- Senior Clinical Midwives
- Senior Paediatric Nurses

## 2.02 Quorum

Chair / DCS
Head of Nurse/Head of Midwifery
Clinical lead x 1
Senior Nurses/Midwives x 2

## 3.0 ROLE AND RESPONSIBILITIES

### AUTHORITY

3.01 The Group is ratified by the Executive Team as the principal means by which the business of the clinical Divisions can be managed

3.02 The Group shall have delegated authority to manage within Divisional operational management limits. Any significant deviation or change request would require to be reported to the Management Board or executive team for ratification.

3.0.2 The Group will also provide comprehensive reports for the Divisional Performance Review Panel, Quality and Risk Committee, Quarterly Clinical Governance Review and any other Trust committee if required

### PERFORMANCE REVIEW

3.03 The Group shall review the performance in the following areas

a) the Division-specific elements of the Trust's Annual Plan and any (separate) service improvement plans or programmes under organisation-wide strategies;

b) plans, priorities and performance targets derived from the NHS Operating Framework, the Monitor Compliance Framework, CQUINs, and Division-specific operational plans and targets;

c) the Trust's Quality Scorecard and other measures ( to be decided from time to time by the Trust Panel for the Trust generally or specific Divisions) in respect of patient safety and experience, and clinical outcomes;

- Patient safety actions
- Maternity Dashboard
- CNST implementation and audits
- Infection Control
- Patient Experience

d) budgets and Cost Improvement Plans (including associated plans in respect of workforce) agreed for the financial year;

e) requirements in respect of completion of statutory and mandatory training, performance appraisals and personal development plans, and any other workforce-related processes and priorities including clinical training and education

f) plans developed in response to any surveys, significant inspections or assessments by regulators, or, where particularly significant, reviews by the Clinical or Internal Audit services;

g) action plans developed at the direction of the Panel to address any variance from performance in the areas described above.

3.04 The Group shall generally take an exception-based approach to receive performance reports and reviews focusing on variances from strategies, plans, targets, budgets and other requirements.

### RISK MANAGEMENT

3.05 The Group shall:

a) monitor and direct the effectiveness of the Divisions' arrangements for managing risk, focusing on risks to delivery in the areas of performance described above but including Division-specific elements of risks identified within the Board Assurance Framework;

b) in reviewing performance and directing action (as set out below), ensure that it effectively manages risks to the Trust, particularly in respect of achievement of principal targets for quality of care and operational and financial performance.

**DIRECTION AND CONTROL**

3.06 The Group shall on the basis of its monthly business reviews of performance in the areas described above:

a) direct the Divisions the priorities for focus in respect of quality of care and operational and financial performance;

b) direct the Divisions actions to correct any variance from targets, plans and priorities.

c) identify corrective action needed to support to ensure that plans are developed and implemented;

d) where necessary, refer matters for discussion at the Management Board, Clinical Governance Group or any other relevant forum

## 4.00 CONDUCT OF BUSINESS

4.01 The Panel shall at all times act to maintain and promote high-quality care for patients.
4.02 The group shall normally meet monthly though it may meet at any other time at its discretion.
4.03 Agendas and briefing papers should be prepared and circulated not less than one working day before each meeting.
4.04 Minutes of Panel meetings should be formally recorded and distributed to members within 5 working days of the meetings.
4.05 The Divisional Business support manager shall be the Secretary to the Panel.

## 5.00 STATUS OF THESE TERMS OF REFERENCE

**Approved by the ……. TBC**
**The next review of these Terms of Reference is due in April 2013**

**Appendix 4**

## Monitoring Compliance

This Risk Management Strategy will be reviewed where necessary but additionally on an annual basis to ensure timely evaluation of the measurable objectives listed within the document to ensure that they remain relevant to the service.

Monitoring of key chosen objectives is demonstrated in the table below. This will enable the maternity service to measure objectives and elements within this strategy to give robust assurances that risk management systems and arrangements are working fully to support the safety of patients' staff and others

**Risk Management Strategy**

Monitoring of the key objectives and key elements within this strategy

| Element to be monitored | Lead | Tool | Frequency | Reporting arrangements | Action Lead(s) | Change in practice and lessons to be shared |
|---|---|---|---|---|---|---|
| Incident reporting | Patient Safety Group | Datix | As required Monday to Friday | Department Risk Leads<br>Incident Review Meeting<br>Patient Safety Group | Patient Safety Group | Required changes to practice will be identified and actioned within an agreed specific time frame. A lead member of the team will be identified to take each change forward where appropriate and lessons will be shared with relevant stakeholders |
| SUI's | Patient Safety Group | Datix<br>STEIS | As required Monday to Friday | Department Risk Leads<br>Incident Review Meeting<br>Patient Safety Group<br>Divisional Integrated Performance Group /Supervision /LSA | Patient Safety Group | |
| Strategy objectives in relation to progress of maternity information systems | Patient Safety Group | Minutes of meetings from relevant information technology meetings | As required Monday to Friday | Senior Management Team<br>Midwifery Management Team<br>Patient Safety Group<br>Divisional Integrated | Patient Safety Group | |

| Element to be monitored | Lead | Tool | Frequency | Reporting arrangements | Action Lead(s) | Change in practice and lessons to be shared |
|---|---|---|---|---|---|---|
| | | | | Performance Group | | Required changes to practice will be identified and actioned within an agreed specific time frame. A lead member of the team will be identified to take each change forward where appropriate and lessons will be shared with relevant stakeholders |
| CNST Progress to Level 2 | Clinical Governance (CNST) & Professional leads | CNST Steering Group | Monthly | Patient Safety Group Divisional Integrated Performance Group | CNST Steering Group | |
| Risk Assessments' and Risk Register | Patient Safety Group | The Datix risk register including outstanding risks and completed risks | Monthly | Senior management team Patient Safety Group Divisional Integrated Performance Group Quarterly Divisional Governance Review, Quality & Risk Committee | Lead identified according to risk | |
| Risks and Issues that have been escalated to the board through a normal route and immediate route | Head of Midwifery and Director of Nursing | Escalation Plan, Business Continuity Plan, e mails, minutes of meetings | Monthly as part of Patient Safety Standing Agenda | Patient Safety Group, Quality & Risk Committee | Patient Safety Group | |
| Structure of relevant Risk Management Meetings | Patient Safety Group | Schedule of Meetings<br><br>Terms of Reference<br><br>Attendance register<br><br>Agenda's<br><br>Meeting minutes<br><br>External Committee reporting | The frequency will depend on the meeting and in addition where necessary | Quarterly to Clinical Governance Team | Senior Management Team<br><br>Patient Safety Group<br><br>Divisional Integrated Governance Group | |

EQUALITY IMPACT ASSESSMENT

| | |
|---|---|
| **Name of Policy, Service, Function, Project or Proposal** | Maternity Risk Management Strategy |
| **Department** | Women and Child Health Division |
| **Lead Officer for Assessment** | Carole Garrick & Joy Mc Faul |
| **What is the main Purpose of the Policy/Service/Function/Project/Proposal?** | To document the maternity service approach to risk management |
| **List the main activities of the policy or service re-design (e.g. Manual Handling would relate to health and safety of patients; health and safety of staff; compliance with NHS and Government legislation or standards etc)** | Patient Safety, Staff Safety & to meet Trust, NHSLA and other external agencies |
| **Is the policy or service relevant to:**<br><br>**Promoting Good Relations between different people?**<br><br>**Eliminating discrimination?**<br><br>**Promoting Equality of Opportunity?** | <br><br>Yes<br><br>Yes<br><br>Yes |
| **Which groups of the population do you think may be affected by this proposal?**<br><br>**Minority Ethnic People**<br>**Women and Men**<br>**People in religious/faith groups**<br>**Disabled people**<br>**Older people**<br>**Children and young people**<br>**Lesbian, gay, bisexual and transgender people**<br>**People of low income**<br>**People with mental health problems**<br>**Homeless people**<br>**Staff**<br>**Any other group (please detail)** | <br><br>Yes<br>Yes<br>Yes<br>Yes<br>Yes<br>Yes<br>Yes<br>Yes<br>Yes<br>Yes<br>Yes<br>Yes<br>Yes<br>Service users in general |

**Do you have any information that tells you of the current use of this service? Yes/No (if yes please detail)**
Yes - National Standards and Trust Risk Management Strategy
**Is it broken down by ethnicity, gender, disability, age, religion and sexual orientation?**

N/A

**Does this information reflect the proportions from the 2001 Census?**
**Yes/No (If no, can you explain why)**

N/A

**If there is no information available or if this is patchy, specify the arrangements that will make this available**
N/A

**Using the information above, please complete the grids below:**

**How will the Policy etc affect Men and Women in different ways?**

| Gender | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| **Women** | | | √ | This strategy is aimed at minimising risk for all groups of people | |
| **Men** | | | √ | | |

**How will the Policy etc affect Black and Minority ethnic people?**

| Race | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| **White** | | | √ | | |
| **Mixed** | | | √ | Recognition for the potential for interpreting and communication with those whose first language is not English | |
| **Other Ethnic Group** | | | √ | | |
| **Black/Black British** | | | √ | | |
| **Asian/Asian British** | | | √ | | |

**How will the policy affect people with disabilities?**

| Disability | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| **Visually Impaired** | | | √ | This document could be provided in large print if required | |
| **Hearing Impaired** | | | √ | Should this document be presented there may be a requirement to have a hearing loop facility discussed | |
| **Physically Disabled** | | | √ | Should be a consideration if the document is presented at meetings | |
| **Learning Disability** | | | √ | | |
| **Mental Health Related** | | | √ | | |

**How will the policy affect people of different ages?**

| Varying ages | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| | | | √ | | |

**How will the policy affect people of different sexual orientation?**

| Sexual Orientation | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| | | | √ | | |

**How will the policy affect Transgender or transsexual people?**

| | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| **Transgender** | | | √ | | |
| **Transsexual** | | | √ | | |

**How will the policy affect people of varying religious beliefs?**

| Varying beliefs | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| | | | √ | | |

**How will the policy affect those with carer responsibilities or impact on basic human rights?**

| Carers / Human Rights | Positive Impact | Negative Impact | Neutral | Reason/Evidence | Don't know |
|---|---|---|---|---|---|
| | | | √ | | |

**Considering your responses above, what are the areas that are have a positive and / or negative impact?**

| | Positive + / Negative - | Reason Given for Impact |
|---|---|---|
| **Gender** | | |
| **Race** | | |
| **Disability** | | |
| **Age** | | |
| **Sexual Orientation** | | |
| **Religious Belief** | | |

**Has there been any consultation about this Policy etc? If there has, what were the key issues identified?**

This document has had consultation at Departmental, Divisional and Trust level. No issues have been raised in relation to Equality and Diversity

| Consultation | Date | Summary of Key Issues to be addressed |
|---|---|---|
| **Gender** | | |
| **Race** | | |
| **Disability** | | |
| **Age** | | |
| **Sexual Orientation** | | |
| **Religious Belief** | | |

**If consultation is planned, when will it happen and what are the key themes for consultation?**

Not Applicable

**What does Local / Regional / National research show with regards to these groups and the likely impact?**

Not Applicable

| Group | Source | Key Issues |
|---|---|---|

| | | |
|---|---|---|
| **Gender** | | |
| **Race** | | |
| **Disability** | | |
| **Age** | | |
| **Sexual Orientation** | | |
| **Religious Belief** | | |

**As a result of consultation / information gathering, what changes do you intend to make to the policy etc? If 'None', please state as relevant:**

**Gender**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| None | | | | | |

**Race**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| None | | | | | |

**Disability**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| None | | | | | |

**Sexual Orientation**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| None | | | | | |

**Religious Belief**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| None | | | | | |

**Age**

| Issue | Action Required | Lead Officer | Timescale | Outcome Measure | Review Date |
|---|---|---|---|---|---|
| None | | | | | |

**Please outline the monitoring and reviewing process and timescale**

This strategy will be reviewed and updated yearly in line with Trust guidance or according to national standards as they arise

**WESTERN SUSSEX HOSPITALS NHS TRUST**

To: Trust Board

Date of Meeting:26th April 2012 Agenda Item: 16

| **Title** |
|---|
| **Annual Accounts 2011/12: Delegation to Audit Committee** |
| Presented by |
| Spencer Prosser, Director of Finance |
| Prepared by |
| Mike Jennings, Deputy Director of Finance |
| Status |
| May be disclosed |
| Summary of Proposal |
| To delegate responsibility for approving the annual accounts for 2011/12 to the Audit Committee, due to the timing of the required submission |
| Implications for Quality of Care |
| Not applicable |
| Support for/integration with Corporate Objectives and Strategies |
| G2: Achieve our target financial performance for 2011/12 and build a sustainable financial position |
| Financial Implications |
| N/A |
| Human Resource Implications |
| Not applicable |
| **Recommendation** |
| **The Trust Board is asked to DELEGATE authority to approve the Annual Accounts for 2011/12 to the Audit Committee.** |
| Consultation |
| Not applicable |
| Appendices |
| N/A |

Western Sussex Hospitals NHS
NHS Trust

To: Trust Board Date: 26th April 2012

From: Spencer Prosser, Director of Finance Agenda Item: 16

**FOR INFORMATION**

## ANNUAL ACCOUNTS 2011/12: DELEGATION TO THE AUDIT COMMITTEE

### 1.00 INTRODUCTION

1.01 The Trust is completing its 11/12 annual accounts, the first draft of which will be will be complete by 23rd April 2012.

1.02 After this first draft, the final accounts, with a final audit opinion, will be ready during the week ending the 8th June. This enables approval during this week, ready for submission on the 11th June 2012.

1.03 Due to the timing of the Trust Board meeting in May, the trust Board will not be able to approve the accounts. It is acceptable for this responsibility to be delegated to the Audit Committee.

### 2.00 SIGN OFF ARRANGEMENTS

2.01 The draft accounts will be submitted to the Department of Health and Audit Commission on 23rd April 2012. As with previous years it is expected that work will be performed on the accounts right up to the point of submission, including a review by the Director of Finance.

2.02 Draft copies of the accounts will be provided to Audit Committee members prior to the end of the month so that questions can be raised and answered during the period up to authorisation.

2.03 As with previous financial years, it is planned that the Audit Committee will approve the accounts on behalf of the Board. However for future years it is proposed that the Board itself should approve the final accounts.

2.04 The Company Secretary has arranged the approval meeting for 7th June. The Chief Executive and Director of Finance will sign the accounts the following day prior to the accounts being passed to the Audit Commission for submission by 11th June.

2.05 These arrangements were discussed at the Audit Committee on the 12th April, and were agreed as the recommended course of action to the Trust Board.

**The Trust Board is asked to DELEGATE authority to approve the Annual Accounts for 2011/12 to the Audit Committee.**