CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

TUESDAY 6th JUNE 2017 - 2:00 PM
THE ROBINSON SUITE, GLEBE CENTRE
MURTON, SR7 9BX

AGENDA

Item 1	Declaration of Interest		
Item 2	Minutes of the meeting held on Tuesday 21 March 2017	Enc 1	KWB
	Matters Arising		
	Item 4 New Adult Emergency Department		KWB
	Item 5 Consultation – Clinical Service Reviews		KWB
Item 3	Chief Executive's Update	Verbal	KWB
Item 4	Quality, Risk and Assurance Report	Enc 4	MJ
Item 5	Patient Experience Survey 2016/17 – Quarter 3	Enc 5	MJ
Item 6	Outpatient Scheduling Update	Enc 6	AK/LB
Item 7	2016 NHS Staff Survey Results	Enc 7	JA
Item 8	Finance – Year End Position	Verbal	JP

Date and Time of Next Meeting

Tuesday 1st August 2017 at 10:00 am in the Board Room, Sunderland Eye Infirmary, Queen Alexandra Road, Sunderland, SR2 9HP

Enclosure 1

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

Minutes of the meeting of the Council of Governors held on 21 March 2017 at Houghton Library, Newbottle Street, DH4 4AF

Present:
John Anderson (JNA) – Chair
Carol Harries (CH) - Trust Secretary
Danny Cassidy (DC)
Chris Colley (CC)
Sue Cooper (SC)
Lindsey Downey (LD)
Margaret Dobson (MD)
John Dean (JD)
Tom Harris (TH)
Liz Highmore (LH)
Kay Hodgson (KH)
Michael McNulty (MMcN)
Gillian Pringle (GP)
Ruth Richardson (RR)
Pat Taylor (PaT)
Pauline Taylor (PT)

Apologies:
Jackie Burlison (JB)
Shahid Junejo (SJ)
Graeme Miller (GM)
Susan Pinder (SP)

In Attendance:
Ken Bremner (KWB)
Gavin McPake (GMcP)
Alison King (AK)
Gary Schuster (GS)

Item 1 Declaration of Interest

None

Item 2 Minutes of the Meeting held on 22 November 2016

Accepted as a correct record except to remove LD from being present as she had submitted her apologies. JD also stated that on page 4 'USP' should actually be 'UPS'.

Item 3 Matters Arising

Breast Services – KWB confirmed that the service was now up and running at Grindon. Gateshead Trust was providing and running the service but CHS was providing the radiology

service. Les Boobis was also continuing to see a small number of follow-up patients.

STP – KWB advised that whilst there were now a number of STP plans, the Government was struggling as there was no formal vehicle or statutory organisation in place to deliver those plans. The STP process was about getting things done at pace and scale. KWB explained that our contribution to the STP process was the work being undertaken in relation to the Clinical Service Reviews being done jointly with South Tyneside NHS Foundation Trust. KWB commented that as yet there was no detail regarding resources for STPs as identified in the budget.

The Chairman stated that if there was anything that required the consent of Governors in relation to the STP then further detail/information would be brought back to Governors.

MMcN commented that he had read in various press reports that there needed to be pace and scale but that legal teams perceived there to be problems and challenge because of the timelines involved to ensure that there had been due diligence. KWB replied that from the Clinical Service Review process there were no shortcuts where consultation was involved and the outcomes of some reviews would potentially take some time to resolve.

Global Digital Exemplar – KWB advised that the Trust had been successful and we had got through all the processes etc – disappointingly we had not seen any of the funding associated with being a Global Digital Exemplar (GDE). It was also anticipated that South Tyneside NHS Foundation Trust would become a 'fast follower' but it would potentially be much more difficult for them as they did not currently have an integrated system. If South Tyneside were successful in becoming a fast follower then they would potentially receive £5m. KWB suggested that it may be helpful for Governors to have a workshop to understand the background and detail of the GDE process.

Item 4 Chief Executive's Update

Monitor Licence – KWB explained that NHSI (previously Monitor) had now removed any conditions from our licence. As a consequence we were now under no form of scrutiny.

Church View Medical Practice – The Trust had previously taken on the management of Church View Medical Practice in Silksworth from Dr Pam Wortley when she retired. The original concept had been to test integration and focus particularly on the elderly and children. KWB stated that our intentions had been somewhat frustrated by our inability to recruit GPs and having to have a number of locums and agency staff which are expensive. The CCG had also begun to develop new models of care across the city in relation to Vanguard status. The Trust's

focus of work was now very clearly linked to South Tyneside and the clinical service reviews. As a consequence the Trust had taken the decision to no longer have the medical practice as part of its portfolio of services and had informed the CCG accordingly. The CCG were now looking to package Church View and the nearby Colliery Medical practice who were also experiencing recruitment problems, and by putting the two practices together it was hoped that it may attract more interest, some of which may come from the private sector. KWB stated that such decisions are never easy but it was about taking the right decisions for patients. The Trust would continue to run the practice until September after which it was hoped that there would be a new provider in place.

JD commented that he was a patient at Colliery medical group and he understood that locum GPs received £100k for 3 days/week whereas practice doctors only received £70k so there must be something fundamentally wrong. KWB replied that the Government had not yet published the revised GP contract but it was unlikely that it would substantially increase GP salaries.

Durham Treatment Centre – KWB informed Governors that the Trust was to develop a new Diagnostic and Treatment Centre located on the outskirts of Durham City at Belmont. The new centre would increase the services and choice available to patients in the Durham area and give them access to specialist services in one location without having to travel to Sunderland for those services such as urology, ophthalmology, ENT and renal dialysis. The centre would allow us to control services for which we pay a substantial overhead for those services currently located on the UHND site. The treatment centre was due for completion in early 2018.

New Emergency Department – The new adult ED building had been handed over to the Trust by Wilmott Dixon, the main contractor at the beginning of the week. There now followed a period of commissioning and the first patients would come through the department on 18 May 2017. It was hoped that Governors would get the opportunity to see the new facility before it opened to the public.

A&E performance was improving and the North East was the only part of the country hitting the target. The new department had been a two year construction programme.

MD stated that staff were to be commended as they had continued to provide a really good service in difficult times and would like that message to be forwarded on to staff.

KWB commented that he wanted staff to feel proud of the new facility which was replacing something built in the 1970s and represented £20m of public money. LH queried whether the

Trust would be able to meet the A&E targets as outlined by the Secretary of State. KWB replied that it was a requirement to hit the targets by March 2018 and extra money was available for capital funding. It was also about getting primary care to stream patients but it needed primary care physicians to be able to do that. The North East as a whole can collectively deliver the target but it was variable across the patch. KWB stated that he did expect some improved performance as some of our existing problems were linked to capacity and therefore there should be some improvement but there were no guarantees.

DC queried about any staffing shortages and whether we would have to use agency staff which was obviously costly. KWB replied that there was a real danger as the NHS had put restrictions on payments and as a consequence £4bn had been saved nationally but that we were essentially dealing with a market place and trying to manage that market. A number of agencies had not really played fair and it required the whole NHS to follow the line and unfortunately some organisations, Durham being one example often break that line and pay more. The issue for us then is how we plug the gaps. SC commented that presumably the new paediatric and adult ED would be much more attractive to staff wanting to come and work in a new facility. KWB replied that he hoped so and recently we had seen more interest.

LH commented that often there was an inevitable delay with home grown staff and pressure needed to be put on the Secretary of State for recruitment both within and outside the EU in relation to visa changes. KWB replied that such comments had been made nationally from across the NHS and there was evidence that some nurses for example were failing the English language test which was considered too complex for some of our existing staff. LH queried whether this could be incorporated into the University programme. KWB replied that it could but individuals had to get into the country in the first instance.

MD commented that it had been a similar issue thirty years ago and if we educate and train in Sunderland then there is a better chance of recruiting. KWB replied that that was why we were supportive of both the nursing programme and possible medical school in Sunderland. PT stated that on a recent visit to Theatres, the manager in D level had stated that he was fully staffed for the first time in a considerable time.

SC commented that before she retired she had been heavily involved with the first cohorts of overseas nurses and they had struggled with language difficulties and whilst we had used the University it had been more about understanding dialect.

Item 5 Clinical Service Reviews

KWB advised that the first clinical service reviews had been due to be published but these had been deferred because of a number of questions raised by the joint scrutiny committee. KWB stated that whilst it was important to start consultation it was important to get those questions resolved before starting the process. In reality consultation was unlikely to commence until after 1 May 2017.

The Chairman commented that it was important to sort the issues with the scrutiny committee and to understand the questions.

KWB replied that a major theme was transport and access. He stated that whilst centralisation achieved better outcomes it was always difficult if services were no longer on your doorstep.

JD commented that the transport infrastructure was really important and a need to work with agencies to resolve bus routes etc. KWB replied that the LA could resolve some of those issues and the Scrutiny Committee was in a much better position to do that than ourselves.

MMcN commented that he had recently been in Newcastle and a protest meeting had just finished from a pressure group about South Tyneside and the alliance. A lady had asked MMcN to sign a petition to which he had refused stating that he was from Sunderland. The lady had stated that she was also from Sunderland and "did not want people from South Tyneside in our queues". MMcN commented that it was a difficult situation with a number of conflicting opinions and views.

Item 6 Silver Employer Recognition Award – Reserve Forces

The Trust had been successful in receiving a silver award in the Defence Employer recognition award. The scheme launched in 2015 encourages employers to support defence and inspire others to do the same. Bronze, silver and gold awards are given to employers who pledge, demonstrate or advocate support to defence and the armed forces community and align their values with the Armed Forces Convenant. Kath Griffin had attended an event at Catterick Garrison and was presented with the Silver Award by HRH, Prince Michael of Kent.

The NHS had also set up a veterans network and there may be some resources linked to this.

Item 7 Finance Report

GMcP presented the report which provided highlights of the financial position as at the end of January 2017. GMcP stated that the overall financial position was a net deficit of £2,245k against a planned deficit of £2,480k, and therefore £235k behind plan.

The current position assumed non delivery of key performance targets, namely 4 hour A&E in October, December 2016 and January 2017, plus cancer targets in 2017. A total of £375k of STP funding had therefore been removed from the financial projection to date.

GMcP explained that in relation to clinical income some additional funding had been gained by the Trust from Sunderland CCG and discussions were ongoing with other main commissioners to resolve financial values for 2016/17 to allow focus to move into 2017/18.

Pay was currently showing an underspend of £1,684k against plan mainly due to vacant nursing posts across the Trust. Non-pay was overspent by £2,587k, although clinical supplies was underspent by £944k due largely to lower than expected clinical activity, strong CIP performance, and low leasing and maintenance spend to date against plan. JD queried the overall percentage of clinical supplies against budget. GMcP replied that it equated to £34m/£35m per annum and a lot of work had been undertaken by procurement this year.

GMcP informed Governors that the CIP target was £15m and £13.9m would be delivered and a number of one off items had also been identified to mitigate the gap.

GMcP advised that cash flow was causing some concern as STP funding had been expected on a monthly basis but Q2 had been paid two months after the date and Q4 funding was not expected to be received until June 2017.

KWB commented that some Trusts were having to take out short term loans from the government to cover cash flow problems which in reality was an embarrassing own goal.

PaT queried whether cash at the end of March would be alright. GMcP confirmed that whilst the position was tight it would be alright. The STP funding for Q4 which would not be received until June equated to £2.5m. GMcP also confirmed that at this stage the Trust was largely in line with the annual plan

submitted to NHSI of a £2.167m deficit. The focus now would be moving forward to 2017/18.

Resolved: To note the financial position to date.

Item 8 Performance Report

Alison King (AK) presented the report which updated Governors on performance against key national targets and local contractual indicators.

AK highlighted A&E performance and advised that performance for January was below the 95% target at 86.67% which was lower than the previous year with an actual growth of 1%. National performance for December was 86.2% and the Trust remaind in the top middle 25% of Trusts nationally.

AK advised that performance for diagnostics (patients waiting over 6 weeks for a diagnostic test) remained higher than the 1% target at 5.71% of patients waiting over 6 weeks for their diagnostic test. AK explained that this was mainly due to breaches in Echocardiography due to increasing referrals and staff administrative processes. AK advised that a recovery trajectory was in place and performance should return below 1% by July 2017.

RTT performance remained above target at 93.7% although at specialty level orthopaedics, OMFS, thoracic medicine, ENT and rheumatology remained under target. Recovery plans were in place for all the specialties.

AK advised that the Trust had met all cancer waiting time standards with the exception of cancer 62 day waits.

AK commented that the actual number of patients was lowering but it was still a challenge going forward. PaT queried how many of the patients were from Durham. AK replied that approximately 50% of patients were from Durham mainly because of diagnostic delays.

JD queried whether there was any seasonality in relation to the volume of patients approaching their breach date. AK replied that there were lower referrals in December but generally there was an increase in referrals.

JD also commented that he understood the number of secretaries for surgeons had reduced and were now carrying a double/triple workload causing delays in some of the administrative tasks.

KWB replied that there was some factual basis to the comment but it related mainly to Head and Neck. There was now more electronic processes and sometimes consultants were reluctant to change.

Resolved: To accept the report.

Item 9 Quality Report 2016/17 – 6 Month Mid-term Review

GS presented the report which provided a high level update on progress with each of our quality priorities and sought to answer the following questions:

- What is the current position.
- If relevant, what are the reasons for being 'off target', and
- What are the actions agreed to get back on target.

GS informed Governors that the full year end positions would be reported in the Quality Report 2016/17 to be published in June 2017.

GS highlighted those areas which were on track to achieve the targets set out in the quality priorities and also those areas where clinical teams had advised that targets were not currently being achieved and where further action was required and in particular, the reduction of hospital acquired pressure ulcers and improving the assessment and management of patients with sepsis.

JD queried page 6 – reducing the number of patient falls and asked whether the peer average was national or just the North East. GS replied that it was just the North East.

GS advised that the Trust was the most productive Trust in the North East in relation to the mortality panel review process. GS stated that in terms of departmental review there was 100% of responses and consistent front line engagement.

MMcN commented that the CQC had recently published a scathing report into how deaths were investigated by Trusts advising that not one single Trust had got the process correct. MMcN also queried whether the idea of a national programme was to get people up to speed and also what triggered an investigation. GS replied that we were certainly a leader within the North East and have a consistent standard approach. Our mortality lead was to attend a national workshop and this was to be part of a discussion at a future Board of Directors workshop. GS advised that the national picture was very mixed and some of the recommendations did not apply to us. KWB commented that they had only used a sample of 8 Trusts in the country and

from a North East perspective all organisations participated in the mortality process.

MD queried page 8 – process of fluid management and documentation as previously this had not been as robust as it should have been. MD commented that this was an important area that needed to be addressed. PT advised that she was part of a steering group who were looking at a new form to try and support the process.

GS highlighted page 5 – to improve the reporting and investigation of hospital associated VTE events and advised that this was improving as it was now a consultant led process.

KH queried the reporting and investigation of hospital associated VTE events and in particular how the case reviews using a national proforma linked to the Trust's incident reporting system. GS replied that unfortunately it was a national tool and did not fit well with our RCA process. The clinical review was undertaken by the consultant in that team and outcomes fed back to Commissioners to look at trends etc. KH commented that it would probably be helpful to have a change of terminology.

LH stated that there was a typo on page 14 and it should state 'known' not 'know'. LH also queried the definition of OMG. GS apologised and advised that it was Operational Management Group.

MMcN queried page 12 – reducing cancellations of outpatient consultations and whether this related to e-referrals or all cancellations. He also commented that a consultant only needed to give six weeks notice of annual leave and was surprised by that. KWB replied that it was not a contractual obligation and more about best practice. Annual leave had to be agreed with the service and the ruling was instigated to minimise the amount of last minute cancellations.

PaT queried the targets identified on page 9 in relation to sepsis and in particular target b). GS replied that the Empiric review related to ED and in c) it related to the inpatient environment. PaT commented that b) still stated inpatients. GS replied that he would need to check and feedback.

TH also commented that the administration of antibiotics was meant to be within an hour. GS replied that when it is a high level overview then some of the detail is lost in the document.

Resolved:

- To note the position against each of the Trust quality priorities 2016/17.

- To note the actions that are being taken to correct and improve performance, where relevant.

Item 10 Selection of Governor Indicator for External Assurance

GS presented the report and advised that NHSFTs were required to get assurance through substantive sample testing over one local indicator as selected by Governors. GS explained that Governors had the freedom to select an indicator of their choice although previously we had provided a short list of potential indicators that were available and where measurement and reporting systems existed.

GS highlighted the potential shortlist as identified within the report. KWB commented that pressure ulcers and outpatient cancellations were key metrics and were often raised at Council of Governor meetings.

MD stated that cancellations were one of the issues she heard about most as a Governor.

LH suggested complaints. CH replied that complaints were to be part of workshop to be held on 4 April 2017 which would go into significant detail. RR queried whether Governors needed to make a decision today. GS replied that unfortunately they needed too as it was required as part of the external assurance for the Quality Report. CC commented that she felt cancellations would be an appropriate area to choose. SC stated that she too was in agreement as a lot of appointments are cancelled and people become anxious and concerned.

Resolved:

- To note the requirements for external assurance testing.
- To select reducing cancellations of outpatient appointments as the local indicator for external testing that would be included in the Quality Report 2016/17.

Item 11 Information Governance Toolkit

Simon Joyce (SJ) presented the report which provided an overview of IG and the IG toolkit. The paper highlighted the process the Trust had followed in completing the IG Toolkit which had to be submitted by 31 March 2017.

SJ explained that since the March 2016 submission, the Trust had reviewed and refreshed data against all requirements. The total percentage compliance for CHS was 87% and 89% for Church View Medical Practice.

SJ stated that although the process for submission was self-assessment it had been audited by our internal auditors AuditOne who had given a substantial rating on the evidence presented.

A key element of the submission was achieving 95% of IG mandatory training and currently this was just in excess at 95.4% overall but Church View had achieved 100%.

SC queried the process for policies as some had been refreshed and others had new policies. SJ replied that policies are regularly reviewed and subject to internal consultation. They are then submitted to Information Governance Steering Group before approval by Executive Committee and formal ratification by Policy Committee.

JD queried the process for subject access requests. SJ outlined the process which involved a formal request to medical records and an associated cost. JD stated that in primary care a patient can get access on the internet. SJ replied that unfortunately the process is driven by legislation. JD stated that he found the process difficult and if something was not right in a letter then you should have the opportunity for it to be altered.

Resolved: To approve the submission of the IG Toolkit on 31 March 2017 subject to final approval by the Board of Directors.

Item 12 Any other Business

The Chairman thanked PaT for her contribution as an Appointed Governor for the CCG as this would be her last Council of Governor meeting in this capacity having recently been appointed as a Non-Executive Director.

PaT replied thanking the Chairman and stating that she had thoroughly enjoyed her time and was one of the reasons why she had applied to become a Non-Executive Director.

PaT would join the Trust as a Non-Executive Director from 1 April 2017.

JOHN N ANDERSON QA CBE
Chairman

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

NURSING & QUALITY DIRECTORATES

COUNCIL OF GOVERNORS

QUALITY, RISK AND ASSURANCE REPORT

JUNE 2017

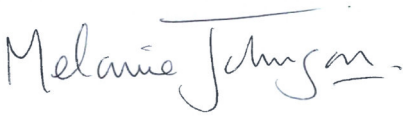
EXECUTIVE SUMMARY

The Quality, Risk and Assurance Report is a summary report to provide assurance to the Board on the key regulatory, quality and safety standards that the Trust is expected to maintain compliance with and/or improve. The summary of key risk activity documented in this report is as follows:

- The number of PUs per 1,000 bed days has decreased from 1.81 in February to 1.41 in March. We are pleased to report that the end of year position to March 2017, surpassed the improvement target set. Thank you and well done to everyone who has contributed to this.
- This month we experienced the first decrease in Deprivation of Liberty safeguarding applications since November 2016.
- The March report demonstrates sustained improvements in managing the number of complaints awaiting a first response. The report now provides visibility of reopened complaints and meetings, which continue to inform improvement work.
- There were 15 wards in March with average Registered Nurse fill rates of less than 80%. The majority of these were in the Division of Medicine which has the highest number of vacancies. NHS Professionals (NHSP) continues to provide support to wards to mitigate shortfalls. There were 14,633 NHSP hours supplied in March compared to 12,690 in February. In March there were 66 incident forms relating to nursing and midwifery staffing, a slight decrease from February (83) and 40% fewer than December and January. Work is ongoing to triangulate staffing and falls incidents to identify any correlation.
- Assurance Visits have continued to identify issues with drug security in clinical areas and therefore an assurance spot check across the Trust was undertaken on one day in February. Trust overall results are provided below and show that the results are unsatisfactory and have deteriorated since the previous audit in January 2016. A task and finish group is being established by the Deputy Director of Nursing to address this significant matter of concern.
- Performance of Sepsis screening in the Emergency Department has continued to improve with 92% of patients being screened in February and 80% in March; this is a strong improvement in comparison to 58% in April. Thanks and well done to all concerned.

RECOMMENDATION

Governors are asked to note the report.


Ian Martin **Medical Director**	**Melanie Johnson** **Director of Nursing & Patient Experience**	**Bob Brown** **Director of Quality & Transformation**

City Hospitals Sunderland
NHS Foundation Trust

Quality, Risk and Assurance Report for March 2017

Presented to Council of Governors
June 2017

PATIENT STORY
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

Mrs R is a 76 year old lady who was diagnosed with bowel cancer in 2004. At that time she had a surgical colostomy performed. She is married and her husband is 81 years old. Unfortunately she developed a hernia from the original surgery which started to cause problems and she was readmitted 11 months ago for a hernia repair and refashioning of her stoma. The surgery went well, however, approximately 3 weeks after having this surgery she was readmitted with a breakdown of the surgical site, including the wound.

On admission she was quite unwell. It is not recommended to re-operate on patients within six weeks of having bowel surgery as further serious complications can occur, so the medical and nursing staff embarked on a long course of intravenous nourishment.

This involved insertion of a peripherally inserted central cannula (PICC) so that the patient could receive total parental nutrition (TPN). Gradually her condition improved and the plan was for her to be discharged home while continuing with TPN. Mrs R suffers from recurrent urinary tract infections and has renal failure, which usually results in requiring intravenous fluids and antibiotics. This prevented her from getting home.

She has had a good experience of care during her stay and was very complimentary of the staff looking after her. “The staff are very busy but don’t rush you and are always telling me what is happening and what they are going to do next.” She has felt well-informed and involved in all care making decisions throughout the time by nursing and medical staff, stating “We keep each other right about my line and feeding times”.

Both the patient and her husband have developed good relationships with all the staff. It has been agreed that Mr R can visit outside of normal visiting times as he relies on family members to take him backwards and forwards for visiting, which is often difficult due to their work commitments. Mr R stated “The staff are very friendly and can’t do enough for us both. I celebrated my birthday here yesterday and staff made our family feel very welcome. My son has been able to meet with the doctor and ask questions about his mother’s condition and treatment.”

Members of the extended family have been able to speak to the Consultant for updates on their mother’s care on a regular basis and have also felt fully informed and involved.

Mrs R decided to pay for use of the Hospedia entertainment system during her stay in hospital. As both Mr and Mrs R are both over 76 years of age they are entitled to a free television license at home. However, during her hospital stay Mrs R has had to pay £50 per month for access to five TV channels. Over the course of her hospital stay (11 months) Mrs R stated “I have paid over £450 in total during my stay.”

Although Mrs R didn’t complain about having to pay for the use of the TV, she is disappointed with the choice of channels and stated “I think that there should be an option to pay a reduced rate for long term patients as it is very expensive, especially for pensioners.”

Update

Mrs R was having major abdominal surgery the next day and would need to spend some time on ICCU afterwards. Unfortunately her recovery has been quite slow and she has suffered a number of setbacks, and she remains on ICCU.

Hospedia, the company who offer the hospital entertainment package service, has been contacted in order to understand their pricing and services offered to inpatients. They have informed us that there is a new package currently available at the call centre which offers 30 days of TV and movies for £60 which works out as less than £2 per day. However, this is not currently advertised for patients and visitors. The Hotel Services Manager is currently in discussion with Hospedia.

HOSPITAL ACQUIRED PRESSURE ULCERS
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.1 HOSPITAL ACQUIRED PRESSURE ULCERS (HAPUs)

CHS has an agreed Pressure Ulcer Improvement Plan in place. The goal of this improvement plan is to reduce the incidence of avoidable category 2 to 4 hospital acquired pressure ulcers (HAPUs) by 25% each year, over the next 3 years (i.e. by April 2019). The data is obtained from the Trust's incident reporting system ("*Ulysses*"), validated by the Tissue Viability Nurse team and incorporated in the Ward Dashboards. The data includes the 'rate per 1,000 occupied bed days', to compare improvement over time. According to the literature, 95% of PUs are avoidable (DH 2011).

Ward Dashboard data for March 2017

In March we reported 26 HAPUs, which is a decrease from the 31 reported in February. 23 patients developed a HAPU, as three patients had >1 PU.

Numbers of HAPUs by category for March (see figure 1):

Severity	Number of HAPUs
Category 2	25
Category 3	0
Category 4	1
Total	**26**

Numbers of HAPUs by directorate for March (see figure 2 for year to date numbers):

Directorate	Category 2	Category 3	Category 4	Total	YTD Trend
REM	9		1	10	
Trauma & Orthopaedics	6			6	
General Internal Medicine	4			4	
Theatres	4			4	
Medical Specialties	1			1	
General Surgery					
Emergency Medicine	1			1	
Urology					
Head & Neck					
Family Care					
Obs & Gynae					
Ophthalmology					
Grand Total	**25**		**1**	**26**	

Figure 1: Hospital Acquired Pressure Ulcers (HAPUs) by category and trend from April 2016 to March 2017

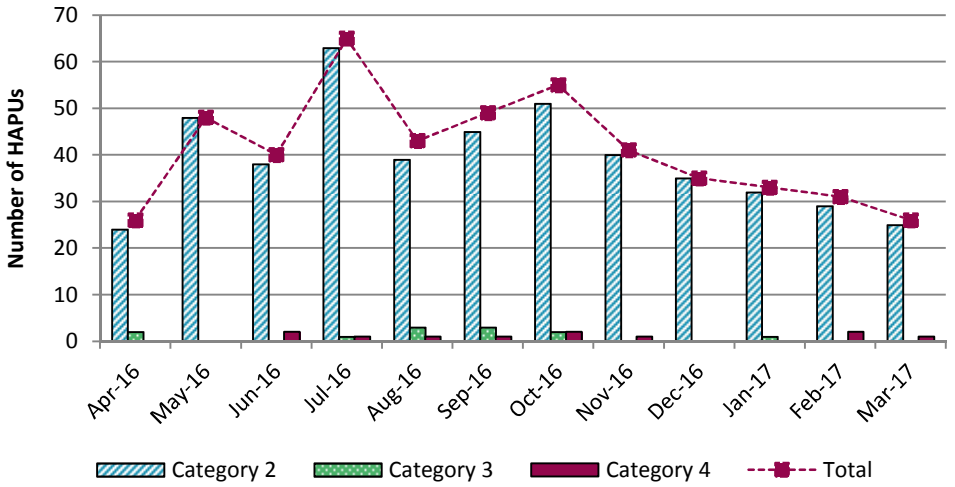
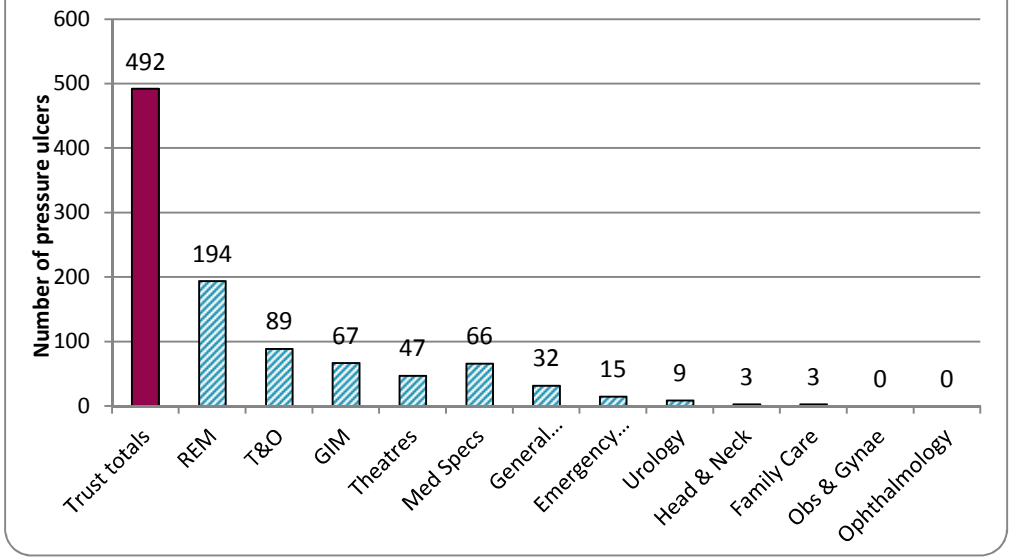


Figure 2: Total number of Pressure Ulcers (category 2 and above) April 2016 to March 2017



HOSPITAL ACQUIRED & COMMUNITY ACQUIRED PRESSURE ULCERS
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.2 TRUST PERFORMANCE AGAINST IMPROVEMENT TRAJECTORY

The number of PUs per 1,000 bed days has decreased from 1.81 in February to 1.41 in March. Figure 3 shows the number of HAPUs per 1,000 bed days, together with the improvement trajectory which, as the graph shows, remains well on track. The end of year position for 2016-2017 surpassed the improvement target / trajectory.

Improvement action by Matrons and Ward Managers is being monitored by the Nursing & Patient Experience team as per the Trust Pressure Ulcer Improvement Plan.

1.3 COMMUNITY ACQUIRED PRESSURE ULCERS (CAPUs)

The Nursing & Patient Experience team also review data regarding the number of patients with a Community Acquired Pressure Ulcer (CAPU). CAPUs are PUs which are either present on admission to hospital or develop within 72 hours (3 days) of admission.

The table below and figure 4 displays this data over the last 12 months. These figures include all categories of CAPUs (category 1 to 4) and Deep Tissue Injuries (DTIs). A DTI is "a pressure-related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise. These lesions may herald the subsequent development of a category 3-4 pressure ulcer even with optimal treatment" (National Pressure Ulcer Advisory Panel, 2002).

The pre-existence of a PU renders these patients as high risk of developing further PUs or suffering deterioration of their existing sore whilst in hospital, hence proactive preventative strategies are required for these patients to prevent this.

Total number of CAPUs per month April 2016 to March 2017 (see figure 4):

Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
177	154	192	170	209	132	161	240	225	271	231	198

Figure 3: Hospital Acquired Pressure Ulcers (HAPUs) by category and trend from April 2016 to March 2017 with improvement trajectory

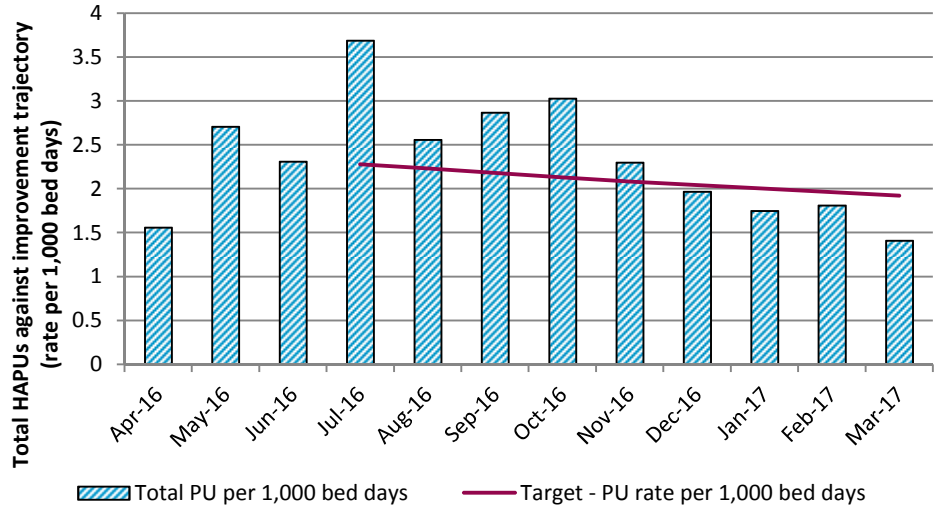
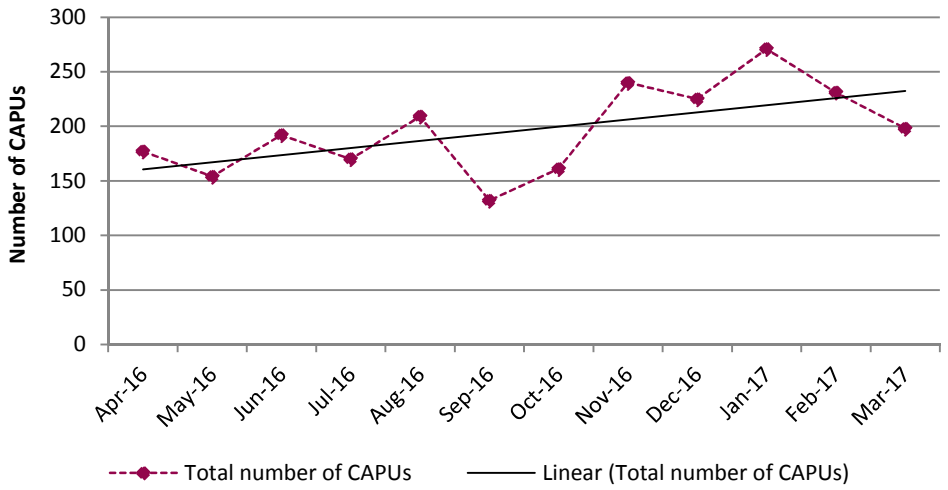


Figure 4: Community Acquired Pressure Ulcers (CAPUs) by category and trend from April 2016 to March 2017



SAFEGUARDING CHILDREN
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.4 SAFEGUARDING CHILDREN

Current position

The referrals to Children's Services have seen an overall increase by 29%, mainly from Adult ED, Paediatrics ED and Maternity Services. See figure 5 for data for the last 12 months.

The themes in Adult ED continue with presentations from parental substance and mental health related issues. Maternity continues with similar themes but these are compounded by previous Children's Services involvement and subsequent removal of children.

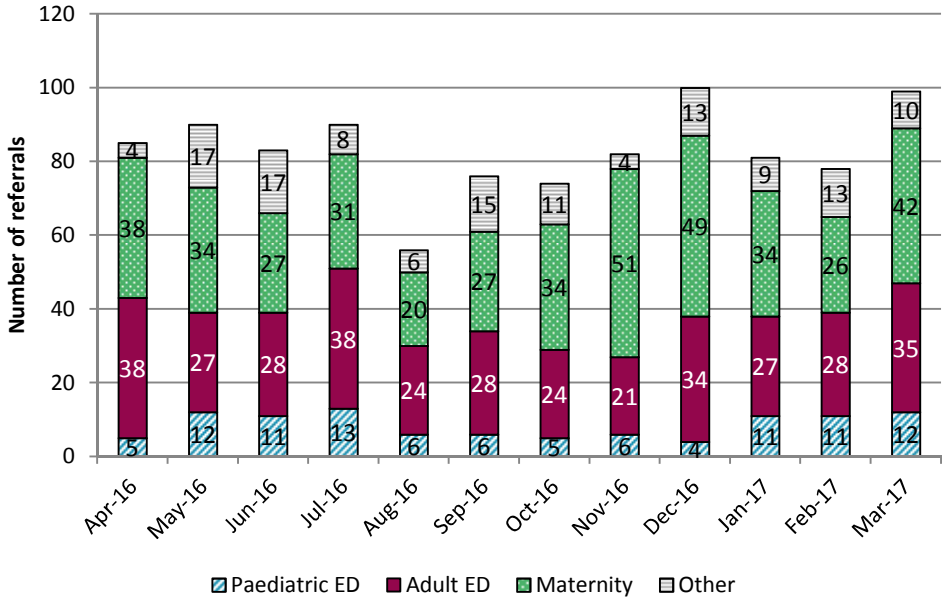
There has been an increase of young people aged 16 to 18 years who have presented into the ED under the influence of substances. The use of class A drugs as opposed to Psychoactive Substances has been noticed. Northumbria Police are aware of the increase in young people accessing class A drugs since the Psychoactive Substances Act 2016 came into force and are taking remedial action. It was anticipated when the act came into place that the purchasing of Psychoactive Substances would go 'underground' and Police intelligence has indicated that class A drugs are easier to obtain.

In May's monthly safeguarding awareness sessions, CHS's Alcohol Specialist Nurse and a worker from Young Drug and Alcohol Project (YDAP) will be delivering a drug and alcohol session.

Ofsted will be revisiting as part of their monitoring of Sunderland Children's Services improvements in June, concentrating on leadership. There are no plans for the Trust to be involved at this point, however should CHS be involved due notification will be given.

There have been no further Serious Case Reviews (SCR) and ongoing audits have been completed in respect of the current SCR action plans. In respect of the current four SCRs in progress, they are all at first draft stage by the independent author for agency feedback.

Figure 5: Safeguarding children referrals April 2016 to March 2017



SAFEGUARDING ADULTS
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.5 SAFEGUARDING ADULTS

1.5.1 Safeguarding Adults Reviews (SARs)

A SAR is in progress focused on a 63 year old who had a past medical history of cerebrovascular accident, dementia and severe contractions. Following discharge from hospital in July 2015, the District Nursing team were visiting the patient to provide pressure area care. There were significant concerns relating to housing, neglect and financial abuse. By December 2015 the patient's pressure areas had deteriorated and admission to CHSFT was required for management of pain and sepsis. The patient died on 9 February 2016.

A Health Only Review identified an action for health (CHS and CCG). This involves the developing and embedding of a safe process for sharing information between primary care and secondary care. This action has now been completed.

Referrals

In March, a number of referrals were inadvertently made via the Ulysses incident reporting system and were not received as Safeguarding Adults referrals. This system is currently only used for Safeguarding Children referrals with plans to implement at a later date for adults. This has now been resolved and staff have been advised how to make referrals via the appropriate system. This has resulted in a slight decrease in the number of referrals. These referrals have since been made retrospectively.

Figure 6 shows that a total of seven Safeguarding Adult Referrals were made by CHS to the Sunderland City Council Safeguarding Adults Team in March 2017. Four referrals detailed Nursing Care Homes - no theme identified; the remaining three referrals detailed self- neglect, neglect from a carer and neglect from a family member (brother).

Referral forms were received from acute ward areas predominantly, Podiatry, and Cardiology.

Mental Capacity Act: Deprivation of Liberty Safeguard (DoLS)

The Law Commission has delivered its final recommendations to ministers on replacing the Deprivation of Liberty Safeguards. The Government asked the Commission to review the DoLS process. The Commission has now published its final report and draft legislation for a new system to authorise care placements involving deprivation of liberty for people lacking capacity. The Commission believes its proposed Liberty Protection Safeguards (LPS) scheme will be less onerous than the DoLS whilst still offering human rights protections.

Currently there are no changes to the DoLS application process.

Current Position

March 2017 saw 138 new DoLS applications submitted from CHS to the Local Authority. As shown in figure 7, this is a significant decrease from the previous month.

Figure 6: Adult safeguarding referrals received April 2016 to March 2017

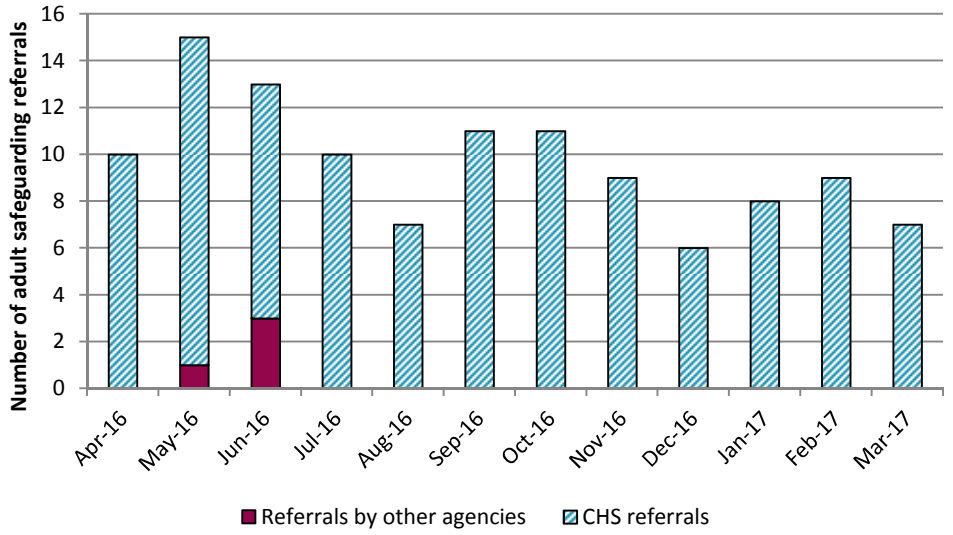
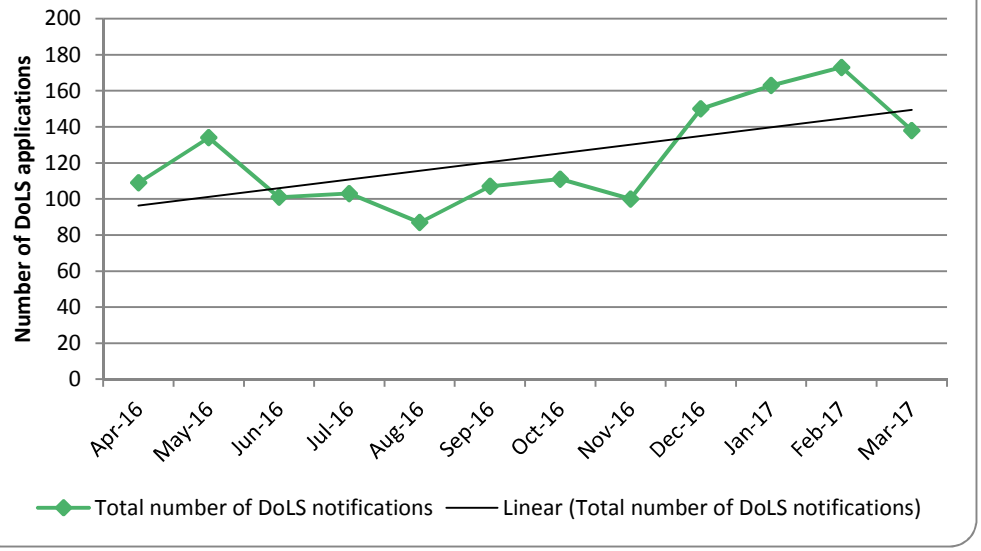


Figure 7: Number of DoLS applications made April 2016 to March 2017



COMPLAINTS
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.6 COMPLAINTS

There were 41 complaints in March, consistent with the year to date average of 37 per month.

The Trust's Complaints Policy expects formal complaints be acknowledged within 3 working days of the receipt of the complaint. Figure 8 demonstrates one complaint was not acknowledged within this timeframe.

Figure 9 shows 27 formal complaints awaiting a first written response (by working days), compared to 39 last month. The most outstanding being one complaint >61 days, and plans are in place to expedite this response. The chart demonstrates the significant improvements in timeliness of first written response during 2016/17.

Figure 10 shows the status of all formal complaints as at the end of March with 49 open complaints (new and re-opened) compared to 58 last month. Of the 34 awaiting a written response (ongoing), 27 are awaiting a first response and seven are reopened. Of the 15 awaiting a meeting, nine are new and six reopened. There are nine complaints currently being reviewed by the PHSO.

Figure 8: Acknowledgement of formal complaints April 2016 to March 2017

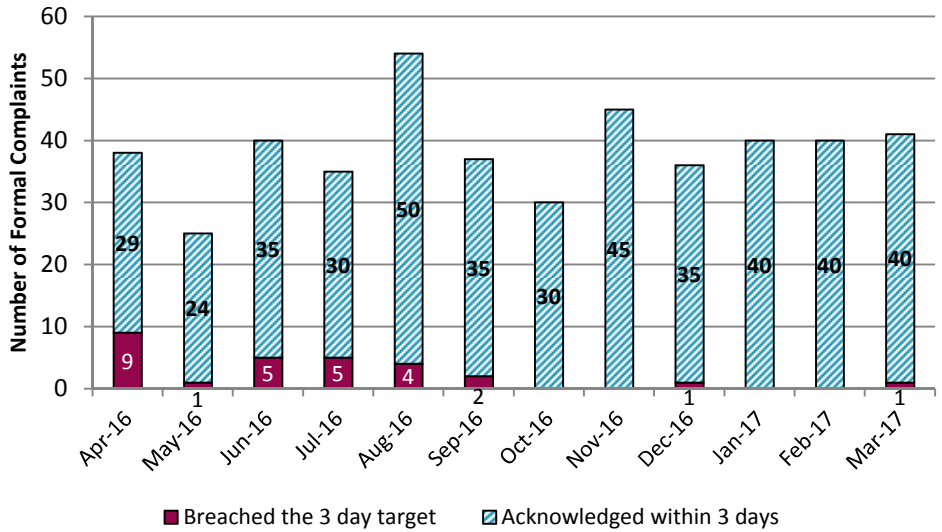


Figure 9: Current formal complaints awaiting first written response by working days - March 2017

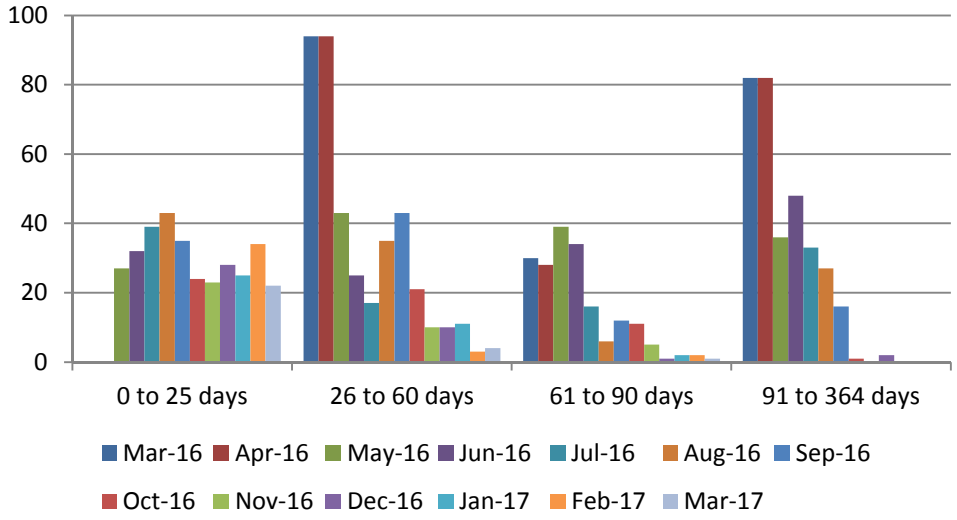
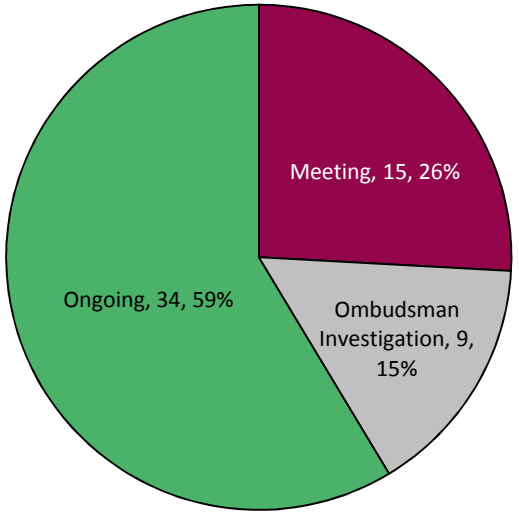


Figure 10: Current Stages of Formal Complaints - March 2017



COMPLAINTS (continued)
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.6 COMPLAINTS (continued)

Figure 11, provides visibility of the number of complaints awaiting a first response. Some complainants request a meeting before a written response and this graph includes **all** awaiting a first response (written and meeting). The chart shows five of the 36 complaints awaiting a first response are outwith expected timeframes.

Figure 12 demonstrates 51 complaints were responded to in March.

Figure 13 provides a breakdown of the complaints awaiting first response, within and outwith timeframe. No one directorate is an outlier in terms of numbers of complaint responses outwith timeframe.

Figure 14 provides visibility of the 13 re-opened complaints. Currently there are no identified timescales for response and this will be addressed in the policy update. Over time, this data will be analysed to inform further improvement work.

In summary, the March report demonstrates sustained improvements in managing the number of complaints awaiting a first response. The report now provides visibility of reopened complaints and meetings, which continue to inform improvement work.

The Concerns and Complaints policy is currently being updated.

Figure 11: All complaints awaiting first response within and outwith timeframes in accordance to policy - March 2017

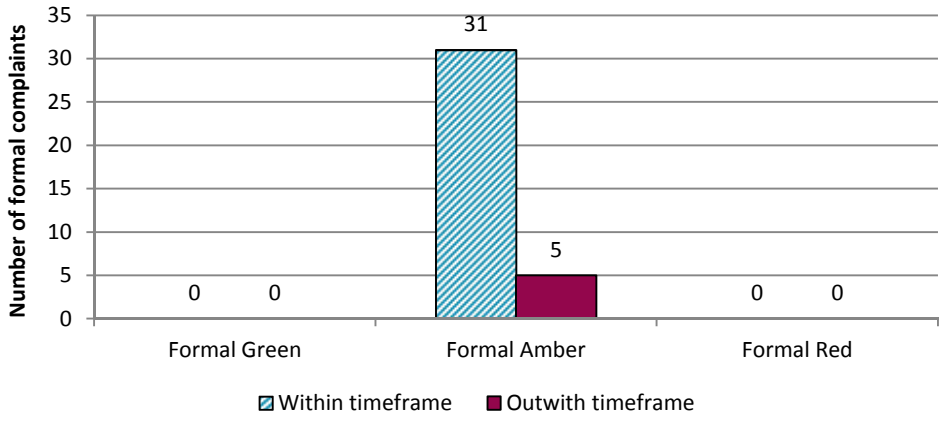


Figure 12: Number of formal complaints responded to by month - April 2016 to March 2017

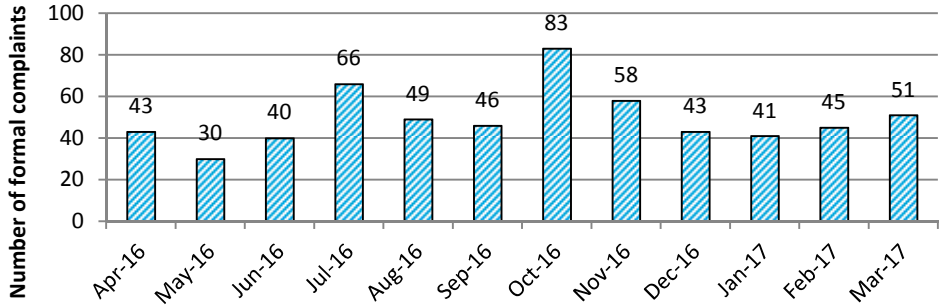


Figure 13: All complaints awaiting first response within and outwith timeframes by directorate - March 2017

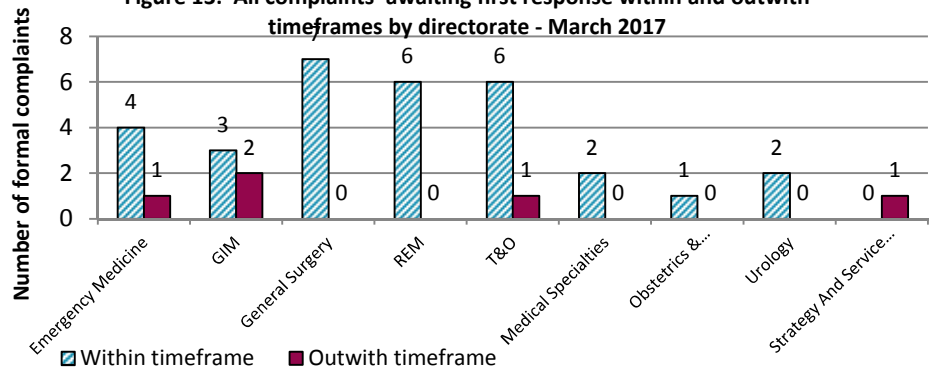
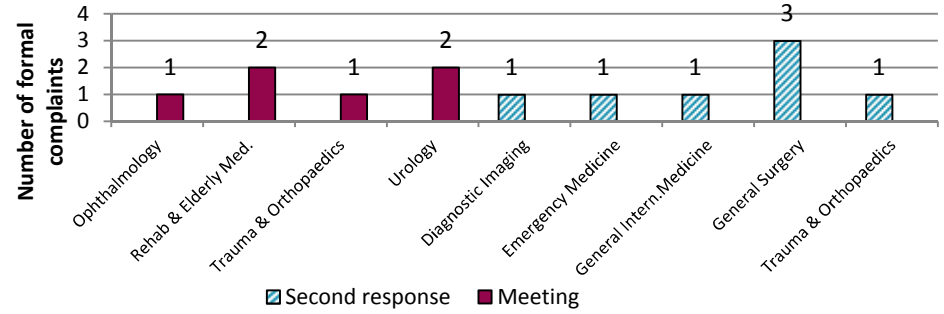


Figure 14: Reopened complaints by directorate



NURSING WORKFORCE
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.7 NURSING WORKFORCE

1.7.1 National Indicators/Monitor Governance Indicators

- Fill rate is the percentage of actual hours out of planned hours for Registered Nurses (RN) and Registered Midwives (RM) and Care Staff on day shifts and night shifts.
- Care Hours Per Patient Day (CHPPD) is a ratio of staff hours to patient count at midnight.
- Number of incidents relating to nursing and midwifery staffing recorded on Ulysses Incident Reporting system.
- Turnover is the percentage of leavers out of all nursing and midwifery staff employed, as recorded on ESR.
- Sickness absence is the percentage of full time equivalent days lost out of all contracted full time equivalent days available, as recorded on ESR.

Consequence of failure: Patient safety, patient experience, quality/outcomes & reputation

Number of incidents compared to fill rates for SRH and SEI (see figure 15):

Indicator		Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
No. of incidents		26	30	29	39	45	83	67	85	118	128	83	66
Fill rate	SRH	94.00	93.00	93.00	93.00	92.00	92.00	93.00	93.00	92.00	90.00	91.00	91.00
	SEI	94.00	96.00	95.00	94.00	94.00	93.00	96.00	97.00	94.00	97.00	100.00	97.00

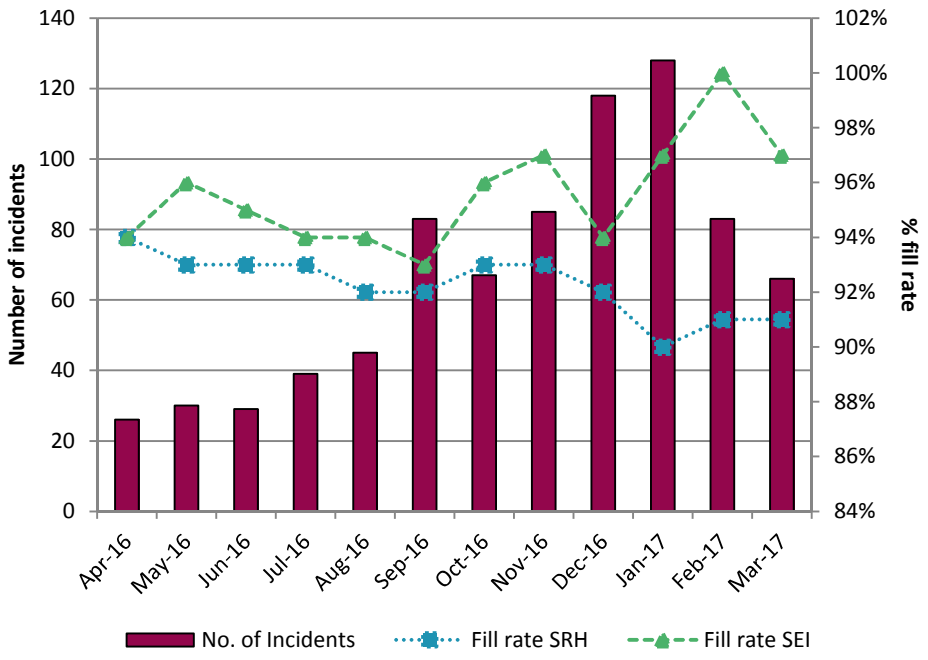
Failure to achieve 100% fill rates can be explained by RN/RM vacancies, maternity leave, sickness and additional beds open. During the month of March there were 36 additional beds open on D42, D44, D47 and E54 for most of the month to support winter pressures, the last of the additional beds closed 26 March. There were 15 wards in March with RN fill rates of less than 80%. The majority of these were in the Division of Medicine which has the highest number of vacancies. The overall number of falls reported in March (164) was higher than February (139), the number of patients sustaining harm has also increased from 71 in February to 74 in March. It should be noted that only two of these falls were identified through the staffing incident forms submitted, the remainder were through discussion at RRG. Work is ongoing to triangulate staffing and falls incidents to identify any correlation.

NHSP continues to provide support to wards to mitigate shortfalls. There were 14,633 hours supplied in March compared to 12,690 in February. 49.7% of requests were filled compared to 52% in February.

At the end of March there were 67.20wte approved RN vacancies; this does not include 38.56wte who are currently undergoing pre-employment checks.

The annual ceiling total nursing agency spend for CHS has been set at 3% of our total nursing staff spend. Historically, nursing and midwifery agency spend within the Trust has been minimal. Agency spend year to date is 0.13%.

Figure 15: Trust Nursing Fill Rate and Incidents Trend March 2016 to February 2017



Fill rates – March 2017	Day		Night	
	RN/RM	Care staff	RN/RM	Care staff
Family Care	92.00%	94.00%	97.00%	72.00%
Medicine	75.00%	111.00%	81.00%	100.00%
Surgery	81.00%	96.00%	82.00%	119.00%
Theatres	100.00%	63.00%	100.00%	95.00%
SRH Total	**91.00%**			
SEI Total	**97.00%**			

Care Hours Per Patient Day (CHPPD) March 2017	SRH	SEI
	7.6	18.0

1.7 NURSING WORKFORCE (continued)

1.7.2 Incidents relating to Nursing and Midwifery Staffing

In March there were 66 incident forms relating to nursing and midwifery staffing, a slight decrease from February (83). These were not isolated to ward areas. Figure 16 shows a breakdown of these incidents.

There were 22 incident forms submitted by 11 wards when RN staffing was below "trigger" numbers. This is a slight decrease from February (25). On all occasions the duty matron implemented the nurse staffing escalation plan, which meant that in some areas skill mix was not as planned but the area had the right number of staff. On some occasions this was not possible and the duty matron risk assessed the areas and moved staff according to risk. Duty matron submitted one incident form this month when staffing across the Trust was difficult with several wards below minimum numbers either due to sickness, acuity of patients or to support the additional beds open for winter pressures. On all occasions, duty matron moved staff around to ensure all areas were safe.

The Division of Medicine continues to submit the highest number of incident forms this month (37). This is in part due to the high number of vacancies and long term sickness, and the moving of Registered Nurses to support the additional beds open for winter pressures. Support is provided form NHSP and duty matron.

1.7.3 Workforce Update

Monthly generic band 5 recruitment continues.

An advert was placed in the RCN Jobs Bulletin and Public Sector Jobs Bulletin, with closing date of 29 March. 19 have been shortlisted for interview, six of whom are already registered, the remainder are student nurses qualifying in September.

Attended a jobs fair in Dublin on 25 March, interest was very good, however conversion to jobs is poor with only one confirmed to date. Again a number of those interested were qualifying in September.

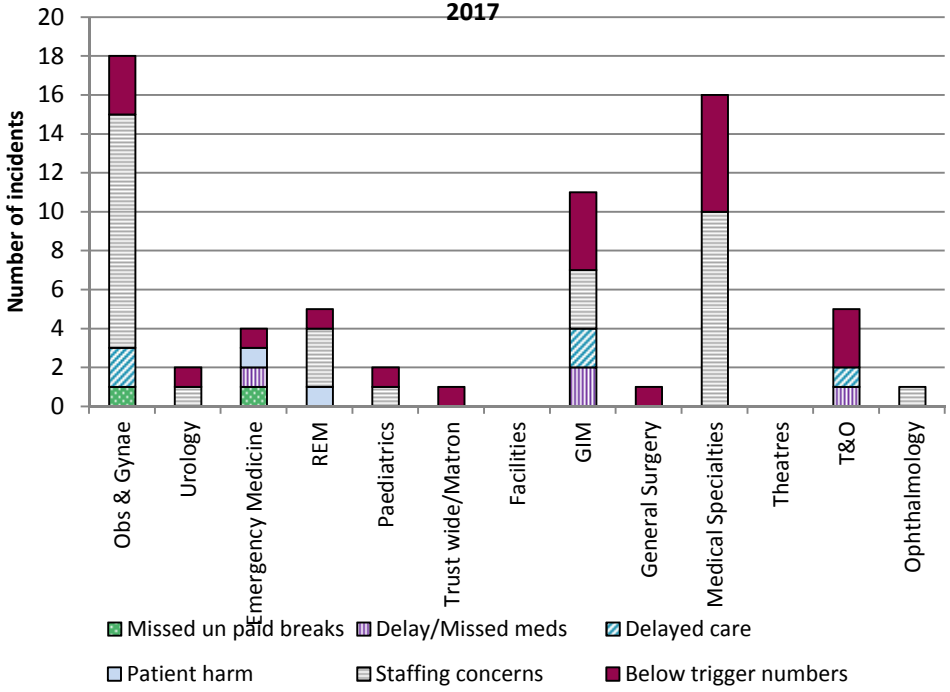
Overseas recruitment is planned for June 2017.

Work is underway to map out the potential to work with overseas nurses living in the UK, but not NMC registered, to achieve NMC registration.

Overseas nurses continue to arrive, with 24 in post to date. There are now 14 nurses who have passed the Objective Structured Clinical Exam (OSCE). There were four booked for the end of March, three of whom had a partial fail and one full fail. All are to re-sit in May, one re-sit is planned for the end of April, with three still awaiting a decision letter from the Nursing and Midwifery Council. We also have two who have failed twice and are now awaiting curtailment letters from UK Visas and Immigration.

To support winter pressures, the pay rate for NHSP staff was increased one pay point to spine point 3. Significantly, overtime has also been offered to all staff working additional hours with effect from 18 January 2017. Figures suggest that band 2 staff have continued to work via NHSP, whereas qualified nurses have worked more overtime., with the NHSP spend in March higher than the overtime spend. The plan is to review overtime in May. There are occasions when some wards are still working below predetermined minimum numbers.

Figure 16: Incidents relating to Nursing & Midwifery staffing - March 2017



Absence turnover for March 2017:

Absence/ Turnover March 2017	Absence					Turnover	
	Absence FTE	Available FTE	Absence Rate	Short Term Absence	Long Term Absence	Headcount	WTE
HCAs	1278.92	19623.14	6.52%	2.33%	4.19%	-	-
RNs	1784.40	41951.55	4.25%	1.95%	2.30%	-	-
RMs	271.07	3538.35	7.66%	2.21%	5.45%	-	-
Overall	3334.39	65113.04	5.12%	2.08%	3.04%	0.81%	0.68%

HOSPITAL ACQUIRED INFECTIONS
LEAD: MEDICAL DIRECTOR

2.1 HOSPITAL ACQUIRED INFECTIONS

2.1.1 MRSA bacteraemia

There were no new cases of MRSA bacteraemia in March. Total cases for 2016/17 are five against an annual limit of zero avoidable cases.

April 2017 update: There were no new cases of MRSA bacteraemia in April. Total cases for 2017/ 2018 is zero against an annual limit of zero avoidable cases.

2.1.2 C. difficile infection (CDI)

No cases were reported as Trust apportioned in March, which is three below monthly trajectory. The year to date position at the end of March is twenty since three cases were upheld at appeal this month. Nine cases have been upheld in total against an annual trajectory of thirty four.

The *C. diff* rate per 100,000 bed days for the previous 12 months up to March 2017 is below the target, at 11.6. By comparison the national rate for the latest 12 month period available (January 2016 to December 2016) was 12.8 per 100,000 bed days.

Cases of C. difficile infection per month March 2016 to February 2017:

Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
1	8	2	1	2	2	3	4	2	3	1	0

April 2017 update: One case was reported as Trust apportioned in April which is two below monthly trajectory. The year to date positon at the end of April is one against an annual trajectory of 34.

2.2 HAND HYGIENE

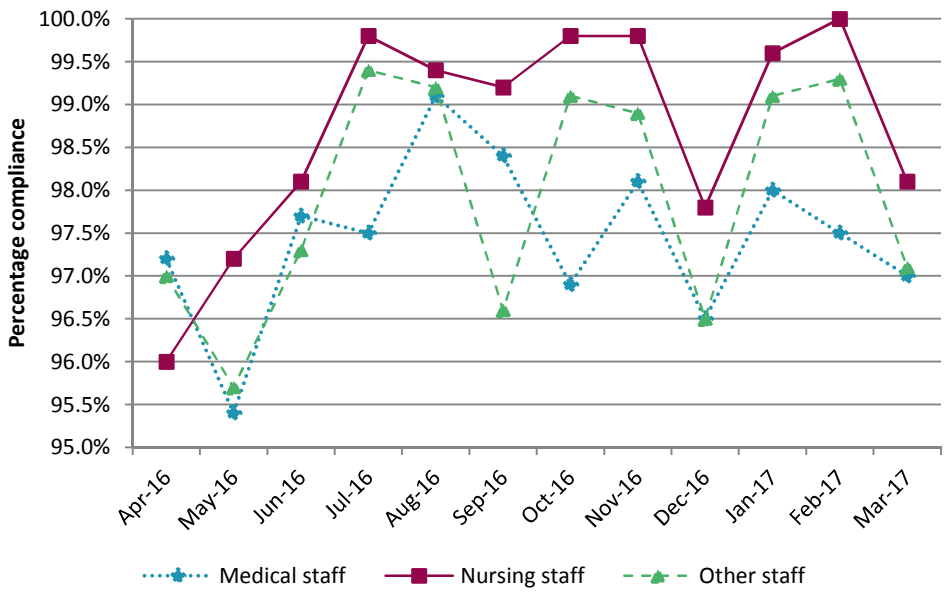
Monthly hand hygiene compliance audit data is presented on ward/department dashboards Trustwide. Areas which fail to attain 98% compliance will be escalated to action plan in accordance with the Trust hand hygiene procedure.

Hand Hygiene results showed 97.4% compliance with hand decontamination for March (1367 observations). Further analysis of compliance is presented as 97.0% medical staff, 98.1% nursing staff and 97.1% for other staff. Figure 17 shows compliance across the last 12 months.

2.3 BARE BELOW ELBOWS

'Bare below the elbows' monitoring for March demonstrated 97.8% compliance from 1373 observations.

Figure 17: Hand hygiene results April 2016 to March 2017



CLINICAL GOVERNANCE UPDATE
LEAD: MEDICAL DIRECTOR

2.4 MORTALITY REPORT Q3 2016/17

The quarterly 'dashboard' Mortality Report provides a high-level overview of Trust mortality performance using the national risk adjusted mortality indicators and the outcomes from the Trust Mortality Review Panel process. It highlights important contextual factors such as depth of clinical coding, use of the palliative care code, incidents, readmissions, nursing fill rates etc., as proxy measures of organisational activity and pressure. The report goes on to reflect the debate over weekday versus weekend mortality and finally provide a focus on high risk diagnostic groups that generally have contributed most to mortality, i.e. pneumonia, heart failure, sepsis, stroke, #neck of femur etc.

Main positive areas of assurance

- The SHMI (classified as the 'official' mortality statistic) measure continues to show fewer observed deaths than the model predicts. We have been under the index of 100 for four consecutive releases in a row and consolidated our position in Band 2 (as expected),
- Outcomes from the Mortality Review Panel show consistently high proportions of deaths reviewed as 'definitely not preventable'. The proportion of deaths with 'excellent' or 'good' care on the Hogan quality scale was above 90% in October and December 2016,
- The introduction of repeat coding software has had a noticeable impact on the rate of average diagnosis per coded episode (depth of coding) since its introduction in July 2016. We are moving in the direction of our North East peers,
- The Trust has a low rate of sign and symptom coding as a primary diagnosis (which is good), and below the North East, English acute trusts and mortality peer groups averages,
- Mortality Review Panel outcomes for deaths admitted on a weekend continue to show care of a similar standard to those admitted on a weekday, and
- For certain high risk conditions mortality performance across some of the indicators show a decreasing trend, i.e. urinary tract infection, acute kidney injury.

Areas of mortality performance requiring further investigation and action

- Deaths coded as specialist palliative care (Z515) is on a noticeable downward trend compared with peers. This has a negative impact on HSMR reporting. However, we have met with palliative care colleagues to agree a method to improve utilisation of the code,
- Pneumonia mortality is higher than the index and the peers for risk adjusted indices and a downward "statistical lives lost" trend can be seen using Variable Life Adjusted Displays. 28% of reviews by the MRP had room for improvement in organisational or clinical care (NCEPOD) such as accuracy of death certification, the quality of clerking in clinical documentation, senior response to patient deterioration and better resuscitation status management. We currently take part in the Regional Serious Infection project, with other local trusts, which includes community acquired pneumonia, and
- Stroke mortality is also higher than the index and the peer for risk adjusted indices. An upward trend can be seen most noticeably on crude mortality and HSMR. On a related issue the findings from the recent Sentinel Stroke National Audit Programme (SSNAP) shows some poor composite scoring on key aspects of stroke management. The stroke team have been invited to attend a future Clinical Governance Steering Group meeting to discuss their performance in this audit as well as stroke mortality in general.

The Mortality Report is shared with Commissioners as part of information assurance and exchange and presented at the joint Quality Review Group.

2.5 V6 NOTICES – PROPOSAL TO SWITCH OFF AUTOMATIC PRINTING OF CLINICAL RESULTS

The proposal made by the Associate Medical Director (Health Informatics) is to turn off the automatic printing of patient results in key modalities (Radiology, Histology, Microbiology, Medical Physics) to eliminate the duplication resulting from electronic results notification.

Notifications are an electronic function within the Meditech V6 system to deliver results in real time to end users at the point they become available. They were deployed as part of the broader Meditech V6 Go-live in May 2013 and to meet GMC/NHS Ombudsman and NPSA recommendations. Ongoing paper delivery is resulting in significant duplication of work with results returning in both electronic and paper based formats to clinicians/secretaries. This waste needs to be eliminated now the electronic process is established.

Extensive validation of the new system has been undertaken by a combination of both discrete planned testing, investigation of individual clinician concerns (>100) and inadvertent audit (>7500 reports) in 2016 in response to a significant incident resulting from printer failure. These validation steps have offered assurance that the system behaves as intended, consistently and reliably to mitigate risk.

Concern has been raised by some regarding misdirection of notices due to incorrect Consultant allocation in V6. This issue is under review and is the focus of ongoing work. The issue is not specific to the electronic communication and exactly mirrored the existing paper based process for results management. The notices system has helped to illuminate the source of some errors and defined actions to establish resolution. Continued paper generation does not mitigate this risk.

However, one current outstanding Meditech task requires resolution. A small number of radiology reports are being auto-acknowledged by the system after delivery. This is a system error acknowledged by Meditech. This issue needs to be addressed before paper turn off is safe/supported. This task is in an escalated status receiving priority focus from Meditech partners.

CLINICAL GOVERNANCE UPDATE (continued)
LEAD: MEDICAL DIRECTOR

2.5 V6 NOTICES – PROPOSAL TO SWITCH OFF AUTOMATIC PRINTING OF CLINICAL RESULTS (continued)

Some specialities (Renal/Rheumatology) have sought permission to restrict results return further to reflect working practices within speciality and parallel safety mechanisms. The existing infrastructure and project governance dictates local agreement through departmental CG forums and consistent application of restrictions across all members of the speciality senior team. The risk is to be owned and managed by the directorate with minuted rationale for decisions reached.

CGSG has agreed to support the proposal on the understanding that the Meditech 'fix' should be sorted. An update is scheduled in 6 months' time to reassure CGSG that the system is operating as intended.

PATIENT SAFETY
LEAD: DIRECTOR OF QUALITY & TRANSFORMATION

3.1 PATIENT SAFETY

3.1.1 Incident report

This report provides details of the activities of the Rapid Review Group (RRG) during March 2017.

CHS incidents reported

Figure 18 demonstrates the number of CHS related incidents that have been reported via Ulysses each month during the last 13 months. It shows an increase of 69 reported incidents (5%) in March compared to the previous month. In comparison to the same month in 2016, this is an increase of 34 (3%).

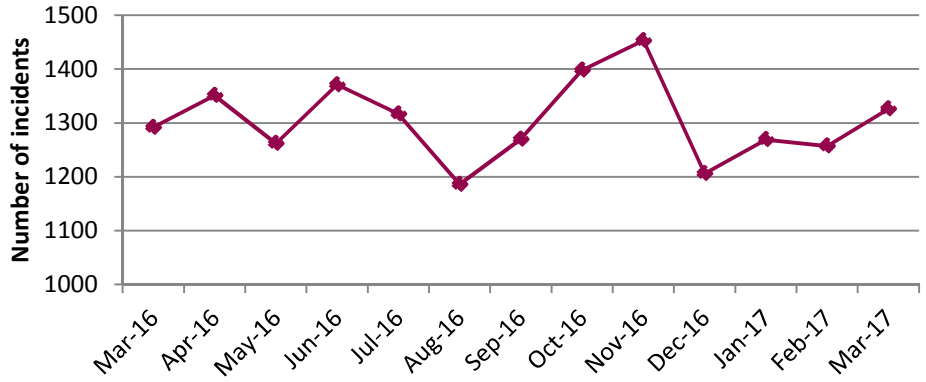
CHS incidents by impact

Figure 19 shows the incidents reported by impact over the last 13 months. The percentage of no harm/near miss incidents as a proportion of CHS incidents reported is 63% in March, which is in line with the annual average.

13 incidents were reported as having caused major or extreme harm in March. These will be reviewed by directorates via the Directorate Initial Review process and will be considered by RRG.

In February, four incidents were reported as having caused major or extreme harm, one was downgraded following consideration by RRG. The remaining incidents were confirmed as major or extreme harm and root cause analyses are currently being undertaken by directorates.

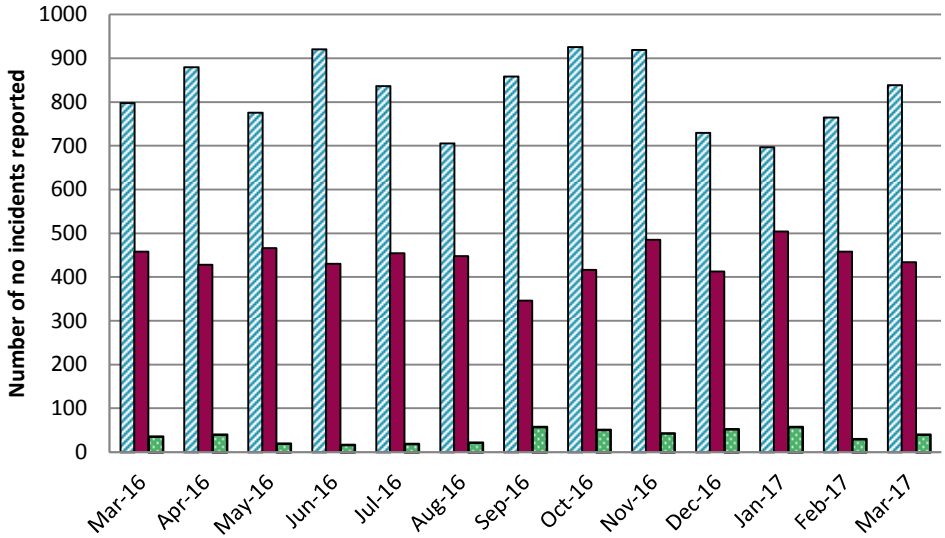
Figure 18: Number of incidents reported March 2016 to March 2017



Data for Figure 18: Incidents reported by category March 2016 to March 2017

	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
No harm/ near miss	798	880	776	921	837	706	859	926	920	730	697	765	839
Minor harm	458	428	466	430	454	448	346	416	485	413	504	458	434
Moderate harm	36	40	20	17	19	22	58	51	43	53	58	30	40
Major harm	0	2	0	3	6	8	5	2	3	4	7	3	11
Extreme harm	0	1	0	0	1	2	2	3	2	6	3	1	2
Total	1292	1351	1262	1371	1317	1186	1270	1398	1453	1206	1269	1257	1326

Figure 19: Incidents reported by impact March 2016 to March 2017



Reported incidents for March 2017 (additional information to accompany fig 19):

Major harm	Extreme harm
11	2

Actual impact of incidents for February 2017:

Major harm	Extreme harm
3	1

PATIENT SAFETY (continued)
LEAD: DIRECTOR OF QUALITY & TRANSFORMATION

3.1.1 Incident report (continued)

Headlines

Key messages from RRG are cascaded across the Trust on a regular basis. The headlines this month focused on:

- Falls – staff were reminded about requirements for falls risk assessments in line with the Prevention and Management of Hospital-Based Falls policy.

Top 5 incidents by cause group

Top 5 cause groups for all CHS incidents reported in March 2017 were:

- Assessment, Diagnosis and Investigation – 12%
- Falls – 12%
- Documentation and Identification – 10%
- Tissue Viability – 9%
- Human Resources – 7%

Root Cause Analysis (RCA) investigations

All completed RCAs are agreed by the directorate and are reviewed by RRG for approval before circulation both internally and, where appropriate, to external organisations. Figure 20 demonstrates the number of RCAs commissioned by RRG per month. The new concise RCA template being used across the Trust has received positive feedback from directorates who have used it.

During March, RRG commissioned ten RCAs. Figure 21 indicates the status of RCAs, showing 71 out of 82 RCAs are overdue. Following acceptance of the RCA backlog paper by Executive Committee, work is ongoing to review and then close RCAs which do not warrant in-depth investigation. Before closure, each case is being cross-checked to verify that a formal investigation is not required as part of a complaint response or inquest investigation.

Figure 20: RCAs commissioned March 2016 to March 2017

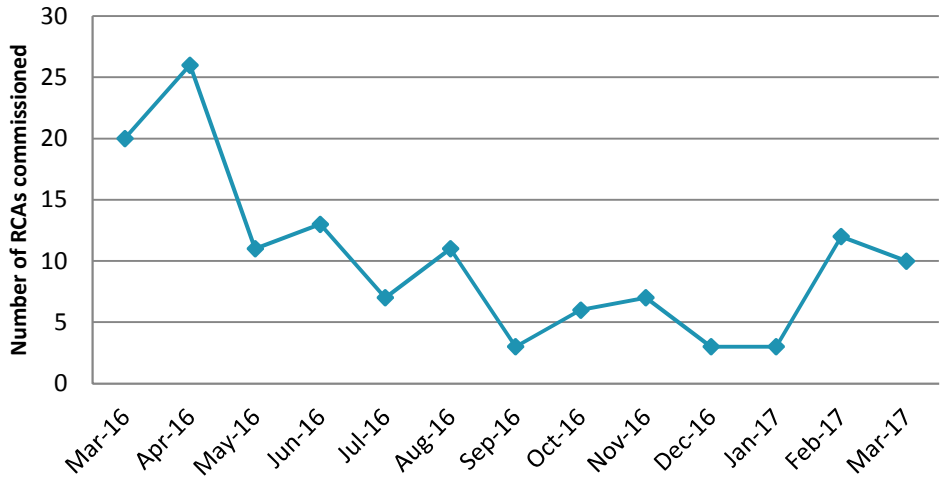


Figure 21: Status of current RCAs – March 2017 (previous month in brackets)

	RCA Level 1	RCA Level 2	RCA Level 3	Concise RCA*	Total
Overdue >3 months	18 (18)	44 (47)	0 (0)	0 (0)	62 (65)
Overdue <3 months	0 (0)	2 (5)	0 (0)	7 (0)	9 (5)
Within	0 (0)	5 (2)	0 (0)	6 (10)	11 (12)
Total	18 (18)	51 (54)	0 (0)	13 (10)	82 (82)

PATIENT SAFETY (continued)
LEAD: DIRECTOR OF QUALITY & TRANSFORMATION

3.1.1 Incident report (continued)

Serious Incidents (SIs)

SIs are reported via the Strategic Executive Information System (StEIS) and are monitored through the North East Commissioning Support Unit (NECSU). CCG SI panels review completed investigation reports, consider downgrade requests and close the investigations.

The deadline for completing SI investigations is 60 working days from the date reported to StEIS. Figure 22 demonstrates the number of incidents logged on StEIS by month.

The current status of SI investigations broken down by directorate is recorded in Figure 23. Figure 24 shows the status of SI investigations over the last 13 months. Four SIs are overdue. 16 SIs have been considered by commissioners and are awaiting further information or clarification from the Trust, while 14 are awaiting consideration. The number of SIs within target is currently four.

Figure 22: SIs reported to STEIS March 2016 to March 2017

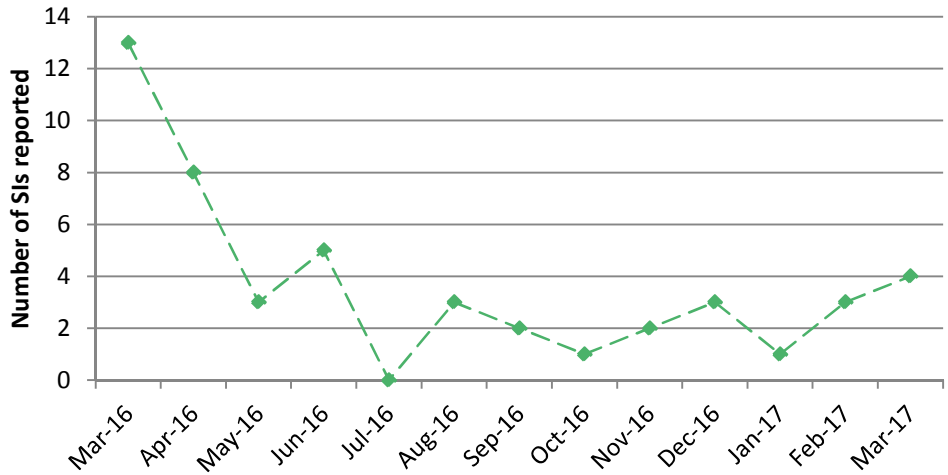


Figure 23: Status of current SIs - March 2017

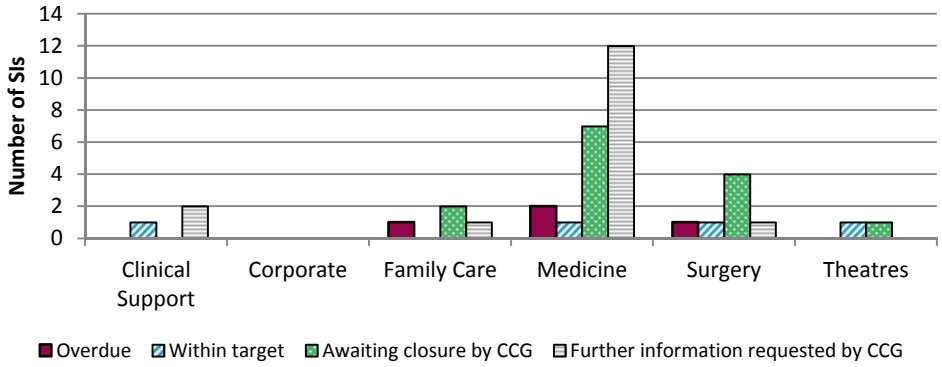
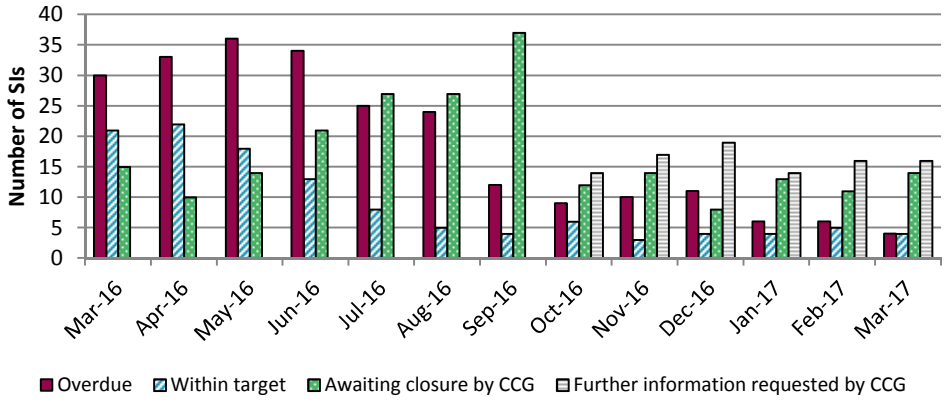


Figure 24: SI status March 2016 to March 2017



Data for figure 24: SI status March 2016 to March 2017:

	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Overdue	30	33	36	34	25	24	12	9	10	11	6	6	4
Within target	21	22	18	13	8	5	4	6	3	4	4	5	4
Awaiting closure by CCG	15	10	14	21	27	27	37	12	14	8	13	11	14
Further info req by CCG	Not collected							14	17	19	14	16	16

PATIENT SAFETY (continued)
LEAD: DIRECTOR OF QUALITY & TRANSFORMATION

3.1.1 Incident report (continued)

Serious Incidents (SIs) (continued)

Figure 25 demonstrates the compliance with the quality indicators for SIs.

The only quality indicator which is not routinely met is the submission of completed RCAs within 60 working days.

The actual compliance against the quality indicators for March demonstrates that the Trust is not submitting completed RCAs to the CCG within the 60 working day deadline. Although the number of outstanding SI investigations has reduced, the timeliness of submitting these within the target has not yet been met.

Almost half the outstanding SIs are open because further information is required by Commissioners. From April, the Trust Adverse Events Manager will provide a formal report to Rapid Review Group on what further information has been required. Those where the request is pertinent to the investigation's findings will be actioned; those which require information which is not directly pertinent to the adverse event will be flagged to Commissioners in case they wish to address these wider issues via the Quality Review Group.

Figure 25: SI quality indicators

	Target	JAN 17	FEB 17	MAR 17
SIs reported on STEIS within 2 working days of identification of incident	90%	100% (1/1)	100% (3/3)	100% (4/4)
Interim reports received for Never Events within 24 hours	90%	N/A	100% (1/1)	100% (2/2)
Interim reports received for SIs within 72 hours	90%	100% (1/1)	100% (3/3)	100% (2/2)
Completed RCA submitted within 60 working days	90%	0% (0/1)	25% (1/4)	20% (1/5)
% of lessons learned entered on STEIS for completed RCAs	90%	100% (1/1)	100% (3/3)	100% (5/5)
Requests for further information sent to CCG SI panel within one month	85%	100% (1/1)	100% (2/2)	100% (1/1)

Never Events

Two never events were reported in March.

In the first case, a woman had an instrumental delivery in maternity. She had been complaining of a foul smelling discharge and a heavy sensation in her vagina for two days, when she was 19 days postnatal. The community midwife examined the woman and observed what appeared to be a swab protruding from the introitus. She referred her for immediate medical review.

The woman was reviewed by an Obstetric ST6 on the Antenatal Day Unit who examined the woman and removed a swab from the vagina.

This incident was graded as having caused minor harm, however a comprehensive investigation is under way, since the retention of a foreign object post-procedure which should have been subject to a formal count is included in the NHS England 2015 list of Never Events.

The second Never Event in March occurred when a 5mm incision was made for Tension-free Vaginal Tape surgery when a Transobturator tape procedure was planned. Both of these procedures are similar but have different locations for incision. The error was immediately identified and corrected. RRG discussed this case at length before declaring a Never Event, since the relevant Never Event classification was wrong site surgery: a surgical intervention performed on the wrong site, e.g. the wrong eye or the wrong knee. However, RRG concluded that whether the error was immediately recognised or not, the underpinning processes which should have precluded the incision being made had failed, and thus a Never Event had occurred.

This incident was graded as having caused minor harm and a comprehensive investigation is under way.

The investigation into the Never Event which was reported last month concerning the wrong route of administration of oramorph has been concluded and is currently awaiting consideration at the CCG Serious Incident Panel. The investigation found that the root cause was the use of incorrect (IV) syringe to measure out oral medication, which permitted the medication to be erroneously injected into the patient's IV cannula. Had the correct oral syringe been utilised, this would have provided a physical "stop" and the incident would not have occurred. Alternatively, if a medicine pot had been used instead of the syringe to measure out the drug, then it would not have mistakenly been administered parenterally by the student nurse.

A number of lessons have been learnt from this incident and actions put in place to prevent reoccurrence.

Duty of Candour

During March, nine incidents were confirmed as resulting in moderate or above harm, resulting in the formal requirements of Duty of Candour to be applied, i.e. interested parties have been informed, received an apology and been offered a copy of any investigation reports.

PATIENT SAFETY (continued)
LEAD: DIRECTOR OF QUALITY & TRANSFORMATION

3.2 INQUESTS

Current position

There are currently 33 open cases.

Case type	Dec	January			February			March		
	Ongoing cases	Opened	Closed	Total ongoing	Opened	Closed	Total ongoing	Opened	Closed	Total ongoing
Enquiry	**8**	3	5	**6**	2	4	**4**	1	1	**4**
Investigation	**6**	4	3	**7**	2	3	**6**	3	2	**7**
Inquest	**11**	4	0	**15**	4	0	**19**	3	5	**17**
Police investigation/ Court of Protection	**6**	0	1	**5**	0	1	**4**	0	1	**3**
External reviews	**1**	1	1	**1**	0	0	**1**	1	0	**2**
Total	**32**			**34**			**34**			**33**

Reason if off target

Disclosure was delayed with respect to submission of two RCA reports required for inquest; both cases were being investigated by the matron and were delayed due to the matron being required to assist with escalation measures.

Actions to get back on target

Additional support was provided centrally to ensure investigation reports were completed and submitted for ratification. During April disclosure was achieved in both cases. Practices have been reviewed to ensure that those investigation reports required for inquest are flagged with the Directorate Manager responsible at the earliest possible opportunity to assist them in ensuring workload is prioritised accordingly.

Lessons Learned

The majority of inquests that closed during this period were related to falls and complications of necessary surgical procedures resulting from falls.

- Falls – a key area of learning with regard to ensuring that all risk assessments are carried out correctly and in accordance with Trust policy, which requires an assessment to be made following admission and then to be repeated a minimum of every seven days thereafter, or sooner if the patient's condition changes or a fall occurs.

  In a number of cases presented before the Coroner during the last quarter the falls risk assessments have either been incorrectly completed or have not been reviewed. This is a significant risk area and work has been carried out to ensure that:
  - visual prompts are now in place to remind staff when reviews are due
  - further targeted education has been delivered with regard to completing assessments.

  The falls group meanwhile continues to look to identify any further possible improvements. Reassurances have been provided to the Coroner with regard to the steps we are taking at CHS to mitigate this risk and the Coroner has confirmed that the reassurances provided were sufficient that a Regulation 28 Report (Preventing Future Deaths) was not warranted, however this specific area of practice will continue to be monitored closely going forward.

Specific key learning from inquests during this period:

- *Notifications and responsibility for acting upon investigations* – there has been a significant piece of work led by the Associate Medical Director for Informatics to ensure that notifications are effectively used within the Trust. This work was prompted by an inquest which led to a GMC investigation, and last quarter there was a further inquest relating to delayed recognition and acting on a radiological abnormality. The completed work, together with verbal evidence from clinicians who are now using the revised systems, provided sufficient reassurance to the Coroner that appropriate lessons have been learned and effective mitigating action has now been taken.

- *Failure to act on PSA levels leading to delayed recognition of recurrence of urological cancer* – this case highlighted a number of issues including:
  - Use of addendums with regard to clinical information
  - Inherent risks of electronic recording systems in use at satellite hospitals which staff may not be fully conversant / familiar with
  - Expected professional standards of communication with regard to content of clinic letters
  - Delayed investigation processes and acting upon concerns raised at directorate level.

  Whilst the inquest closed, as it was possible to provide reassurance that the patient's outcome was not affected by the above issues, there was sufficient concern with regard both to practices and systems for the Medical Director to commission a detailed case review and investigation. This is being led by the Deputy Medical Director and will be presented to CGSG on completion.

PATIENT SAFETY (continued)
LEAD: DIRECTOR OF QUALITY & TRANSFORMATION

3.3 SAFETY THERMOMETER

Current Position

Figure 26 shows Safety Thermometer prevalence data. We reported 93.29% harm-free care in March 2017 (a 1.44% increase from the 91.85% we reported in February).

This is below the national average of 93.79%, but above the median of 93.14% (range: 83.80% to 98.88%) of harm-free care reported by acute hospitals in February.

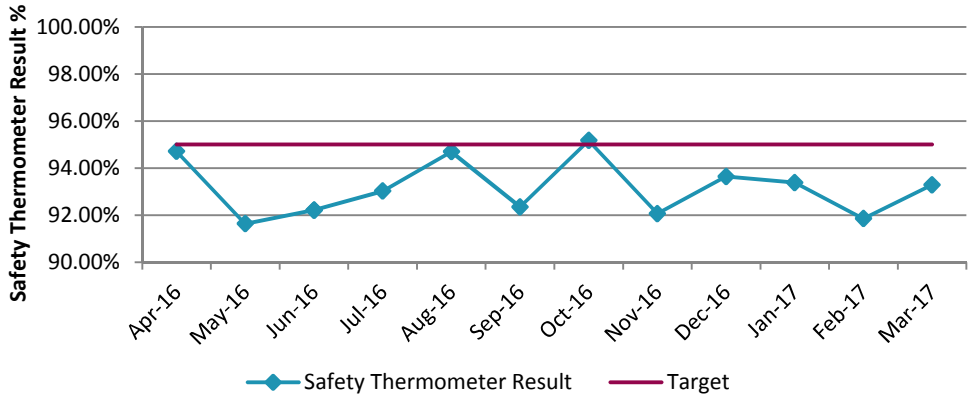
Our total number of new harms in March was 18, which is the same as we reported February.

Our percentage of harm-free care is based on:

- Pressure Ulcers (PUs)
- Falls in care resulting in harm
- Catheter-related urinary tract infections (UTIs)
- Venous Thromboembolism (VTE)

The harm-free care calculation incorporates all reported harms, not just the "new" harms.

Figure 26: Safety Thermometer Results April 2016 to March 2017



ASSURANCE

4.1 DRUG SECURITY AUDIT

The Assurance Visits have continued to identify issues with drug security in the clinical areas and therefore a spot check across the Trust was undertaken on one day in February.

Trust overall results are as below and show that the results are largely poor and have deteriorated since the previous audit in January 2016.

- 10 (37%) of clean utility rooms were unlocked
- 23 (85%) of wards had drugs left out on the bench in clean utilities
- 11 (40%) of drug fridges were unlocked
- 12 (44%) of wards had one or more drug cupboards which were unlocked
- 2 (33%) of the drug trolleys seen were unlocked

In relation to the clean utility doors, six of the 10 which were unlocked were also propped open.

Six wards: B22, IAU, D47, E51, E52 and F61 had unlocked clean utility rooms and drugs on the bench.

Four wards: B22, IAU, E51 and E52 had a combination of unlocked clean utility rooms, drugs on the bench and unlocked drug cupboards. The first three also had unlocked drug fridges.

Where drug cupboards were found to be unlocked this was brought to the attention of Registered Nurses immediately who then secured the cupboards.

Overall the results represent a significant area of concern which needs to be addressed. A task and finish group is being established by the Deputy Director of Nursing, discussions have taken place with both Matrons and Ward Managers and the audit results have been sent to the directorate teams for information and response.

4.2 EXCELLENCE REPORTING

Excellence reporting was launched in the Trust on February 14th 2017 and has been positively received. Current numbers of reports to date are:

- 108 reported
- Majority of reports were attributed to Theatres (15) and REM (14)

Reporters have originated from varying professions:

Profession	No of Excellence reports submitted
Nursing	37
Admin & Clerical (including management)	22
Medical	17
Ward/Team manager	17
Senior Nurse	9
Allied Healthcare Professionals	6

Category breakdowns are as follows:

Category	No of Excellence reports submitted
Going the extra mile	32
Care and compassion	27
Team working	17
Service improvement	13
Communication	7
Competence	4
Leadership	3
Other	3
Courage and commitment	2

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) 2016/17

5.1 CURRENT POSITION

The majority of CQUIN indicators continue to be on track for full reconciliation, however non – payment is predicted for 2a i) Sepsis ED Screening, 2a ii) Sepsis ED Antibiotics given within 60 minutes of attendance 3a i) % of antibiotics by DDD per 1,000 admissions, 3b % of antibiotic prescriptions with empiric review within 72 hours and Spec1 To reduce delayed discharges from ICU to ward level care and transfers back to host hospital. See Appendix 1 for further information.

5.2 REASON FOR UNDERPERFORMANCE

2a i) Sepsis ED Screening – during Q4 there were 78.7% (118/150 sampled) patients screened in accordance with the local protocol (NEWS >=5 Adult or POPS >3 Paediatrics), which is below the 90% target. As performance is <80% no payment will be received.

2a ii) Sepsis ED Antibiotics within 60 minutes – during January and February 30.0% (18/60 sampled) patients received antibiotics with 1 hour, which remains below target for partial or full payment.

3a i) % of antibiotics by DDD per 1,000 admissions - early indications ahead of SUS publication of volume of admissions suggest we are unlikely to be able to demonstrate an overall reduction of 1%.

3b % of antibiotic prescriptions with empiric review within 72 hours previous high performance will be sustained. The Q4 audit is underway however the reconciliation threshold will not be achieved.

Spec 1 Reduction in delayed discharges from ICU to ward level care and transfers back to host hospital – during Q4 the profile of delays to discharge was 45.5% (111/209) of patient discharges delayed <4 hours, 33.2% (67/209) of patient discharges delayed 4-24 hours and 21.3% (43/209) of patient discharges delayed 24 + hours, which remains below target (65%, 18% and 17%).

5.3 ACTIONS TO GET BACK ON TARGET

Performance of Sepsis screening in the Emergency Department has continued to improve with 92% of patients being screened in February and 80% in March; this is a huge improvement in comparison to 58% in April. ED sepsis leads continue to educate staff on the importance of sepsis screening and antibiotics administration and reports identifying staff requiring further intervention are provided.

While the rate of antibiotics administration is low and no payment is expected in Q4, it is in-line with other Trusts in the Region. NHS England has changed guidance for the time that clock starts ticking for 2017/19 and therefore it is predicted that partial payment will be achieved in 2017/18 (by comparison 2016/17 partial payment would have been received in 2 quarters based on the new methodology).

The Microbiology Stewardship Group are working with IT to explore whether an electronic solution can be deployed to prompt clinical teams to conduct an empiric review of antibiotics >24 hours and <72 hours as the goal remains within the framework.

There has been increased and sustained pressure on beds within the Trust over the winter period and, priority is given to maintain patient safety at all times. It has consequently became increasingly challenging to strike a balance between those patients being admitted as an emergency and those which require step down/discharge from ICCU. Despite best efforts to discharge patients and implementation of a new Discharge SOP, the improvement target set for quarter 4 has been beyond reach.

5.4 CQUIN 2017/19

The two year scheme has been published by NHS England with the weighting remaining at 2.5 per cent value of the contract, but 1% has been apportioned to the STP (0.5% paid to support STP engagement with a further 0.5% at start of 17/18 if STP control total delivered in 16/17 in reserve) and 2% for specialised commissioners. This equates to approx. £6.3M (based on 2016/17 contract value) of the NHS Standard Contact, excluding high cost drugs, devices and listed procedures. A small number of high impact goals have been nationally prescribed with details of the 7 overarching themes being included in the CCG contracts:

- **Goal 1 Improving Staff Health & Wellbeing** – improving health and wellbeing results in the Staff survey, healthy food for staff, visitors and patients and improving the uptake of flu vaccinations for front line clinical staff.
- **Goal 2 Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)** Timely identification and treatment of Sepsis – screening, initiation of treatment , 3 day empiric review of all patients attending ED and directly admitted, and acute inpatients by senior clinician and reduction of 1per cent on total antibiotic consumption, carbepanem and piperacillin-tazobactam per 1,000 admissions.
- **Goal 4 Improving services for people with mental health needs in ED** – identification of cohort of patients with 10+ attendances during 12 months, develop a plan, working with external agencies to implement and share care plans which will support patients and reduce attendances.
- **Goal 6 Offering Advice & Guidance -** set up and offer A&G services for non-urgent GP referrals, allows GPs to access consultant advice prior to referring to secondary care. With 35% of the total volume of non-urgent -GP referrals services to be available by Q4 and 80% of requests to be responded to within 2 days.
- **Goal 7 NHS e-Referral –** increasing the volume of consultant led 1st OPD available through the e-referral service platform and taking practical steps to reduce the proportion of slot issues to <=4% (2017/18 only).
- **Goal 8 Supporting proactive and safe discharge –** mapping and refining pathways to increase the proportion of patients discharged to their usual place of residence. Planning and implementation of the Emergency Care Data Set in order to commence submission of data by 1st October.

Goal 9 Preventing ill health from risky behaviours –alcohol and tobacco. Screening, advice and referral (alcohol) and screening, brief advice, referral and medication offer (tobacco). Plan for staff training to be developed and implemented to ensure engagement with patients (2018/19 goal only).

CORPORATE RISK

6.1 CORPORATE RISK REGISTER

The Q4 corporate risk register has been prepared and will be presented to Corporate Governance Steering Group in June.

A copy of the report will then be tabled at Governance Committee for assurance purposes, as previously agreed.

6.2 NHS LITIGATION AUTHORITY UPDATE

From April 2017 the NHS Litigation Authority has been renamed as NHS Resolution. It has published a five year strategy for its work and a paper summarising that document will be presented to Corporate Governance Steering Group in June.

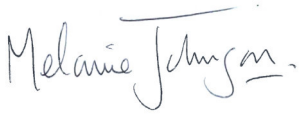
NHS Resolution has changed its requirements for notification of potential high cost claims. While NHS Resolution has not yet confirmed the practicalities for that notification, the Trust has noted the requirement to notify and is maintaining a record of all cases which could require early notification. The information will be submitted to NHS Resolution as soon as processes for doing so are confirmed.

CONCLUSION

SUMMARY OF KEY RISKS

- The number of PUs per 1,000 bed days has decreased from 1.81 in February to 1.41 in March. We are pleased to report that the end of year position to March 2017, surpassed the improvement target set. Thank you and well done to everyone who has contributed to this.
- This month we experienced the first decrease in Deprivation of Liberty safeguarding applications since November 2016.
- The March report demonstrates sustained improvements in managing the number of complaints awaiting a first response. The report now provides visibility of reopened complaints and meetings, which continue to inform improvement work.
- There were 15 wards in March with average Registered Nurse fill rates of less than 80%. The majority of these were in the Division of Medicine which has the highest number of vacancies. NHS Professionals (NHSP) continues to provide support to wards to mitigate shortfalls. There were 14,633 NHSP hours supplied in March compared to 12,690 in February. In March there were 66 incident forms relating to nursing and midwifery staffing, a slight decrease from February (83) and 40% fewer than December and January. Work is ongoing to triangulate staffing and falls incidents to identify any correlation.
- Assurance Visits have continued to identify issues with drug security in clinical areas and therefore an assurance spot check across the Trust was undertaken on one day in February. Trust overall results are provided below and show that the results are unsatisfactory and have deteriorated since the previous audit in January 2016. A task and finish group is being established by the Deputy Director of Nursing to address this significant matter of concern.
- Performance of Sepsis screening in the Emergency Department has continued to improve with 92% of patients being screened in February and 80% in March; this is a strong improvement in comparison to 58% in April. Thanks and well done to all concerned.

Members are asked to note the report.



IAN MARTIN **Executive Medical Director**	**MELANIE JOHNSON** **Executive Director of Nursing & Patient Experience**	**BOB BROWN** **Director of Quality & Transformation**

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

PATIENT EXPERIENCE SURVEY – QUARTER 3 2016/17

JUNE 2017

1 INTRODUCTION

This report provides Governors with an update on progress and performance with the new Patient Experience Survey. The format combines selected questions from the local real time feedback questionnaire with the mandated Friends & Family Test question. We introduced the new design across all adult in-patient wards, with the remaining areas, i.e. paediatrics wards, maternity, ICCU continuing to use separate formats. The practicalities and complexity of transitioning wards to the new design has made reporting difficult over the pilot and testing phases. Quarter 3 now provides a more stable period in which to continue our reporting of patient experience feedback, which has been presented at the Patient, Carer and Public Experience Committee. The report also includes a breakdown by key themes from 'word cloud' analysis of patient comments.

2 OVERVIEW AND SCOPE OF THE NEW PROCESS

In June 2016, it was agreed to change and amalgamate the existing Friends and Family Test (FFT) and Real Time Feedback (RTF) data collection methods within adult in-patient services (*see example in Appendix 1*). The main drivers for the change included the desire to streamline and introduce efficiencies into both processes, the difficulties in securing ongoing volunteer involvement and the decision not to renew the contract with 'I Want Great Care' as our FFT provider.

In the new format, all in-patients will be offered a short Patient Experience Survey on discharge and so replacing the FFT postcard. The FFT question is asked alongside other familiar questions from our local real time feedback survey and patients still have the opportunity for adding any free text comments. The survey is no longer administered by Trust volunteers and the Community Panel but is self-reported by patients, although help and support is still available to those who require it.

Completed surveys are posted in a collection box on the ward and analysed in house by the Clinical Governance Department. The department ensures that all participating wards receive timely Individual reports, trend analysis and transcriptions of any free text comments. Trust wide thematic analysis of comments is also undertaken. The expectation remains for wards to review, reflect and act on the feedback provided in the report and share these as widely as possible within each team. The decision to offer the new survey to all discharged patients means that there will be a large increase in patient experience intelligence available to the Trust.

The new combined format for adult in-patient wards sits alongside the implementation of separate FFT and RTF collections elsewhere in the Trust;

- Maternity, Paediatrics and in-patients at Sunderland Eye Infirmary will continue to collect data from the FFT and RTF separately,
- Parents of children are also given the opportunity to complete a separate RTF survey from their perspective,
- Patients attending out-patient departments, surgical day case units, ambulatory care and the emergency department will complete FFT only, and
- ICCU patients complete RTF only.

3 SURVEY RESULTS

The full set of ward performance scores for Q3 2016/17 is included in *Appendix 2*. These are based on 2463 fully completed and valid questionnaires from 25 participating wards. The breakdown for relevant months is highlighted below. This is a substantial increase to the Trust-wide collection and analysis compared to previous quarterly periods which averaged 750 - 800.

October 881	2463
November 855	
December 727	

The main positive headlines from the data include;

- An average 94% of patients reported that they were likely to recommend our services to friends and family if they needed similar care or treatment. No wards scored less than 80% although F62 were close to this threshold,
- The performance thresholds for some of the key questions are high, i.e. Q5 (Involvement in decisions 90%), Q6 (Talking to staff about a concern 95%), Q7 (Privacy when discussing treatment 94%), Q8 (Treated with kindness & compassion 97%), and
- The two questions related to pain management show high performance across all wards (Q14 – Staff asking about pain – 96%, Q15 – Staff managing pain – 95%)

The main negative headlines from the data include;

- When compared with others D40 scored very low (66%) in Q9 – Did you always have access to the call bell when you needed it,
- The questions related to hospital food have the lowest average scores (Q12 – Individual menu 74%, Q13 – Rating of hospital food 73%). D40 had the lowest score by far (14%) for ensuring that patients had an individual menu, and
- Most variation about performance can be found in Q16 – Staff telling patients who to contact if they were worried about their condition after discharge. The range is from 100% (B28, D40, F61,F62, SEI) to 67% (E50).

4 PATIENT COMMENTS

In previous reports we have created word clouds to show the prominent terms used in patient comments. The word clouds below show the top 50 ‘tags’ in a positive and negative context for

the period Oct – Dec 2016. A breakdown of some of the dominate words is provided to help understand the nature of the patient feedback and direct any future actions.

What was good about your care?

Staff

35% (850) patients commented about staff:

- Attention all the time from very professional staff as well as being friendly. Cleaning staff very thorough.
- Fantastic care by ward staff. High levels of cleanliness. Staff going 'above and beyond' to help.
- Day staff were fabulous and extremely helpful and supportive. I thank them very much. Amazing!
- The staff, night shift especially, were extremely helpful and kind, nothing was too much bother for anyone, thank you so much.
- The service was excellent from start to finish. Everything was done in a professional manner to the highest of standards and staff were a pleasure!
- No complaints in any way. Very caring and considerate nursing. Being an inpatient for the first time in a number of years I am astonished at the amount of variety of the work all the staff are expected to undertake and the hours they have to work. It is time the authorities booked in for weekend stay and saw for themselves.
- The staff are very cheerful and know what they doing for you, good crew.
- Genuine concern and compassion by all staff. Bathroom and toilets always scrupulously clean and tidy, domestic staff work really hard.
- Doctors, staff and all concerned were very caring, clean and courteous. Would not have any hesitation in coming back.

Everything

15% (358) of patients commented that everything was good about their stay.

- Everything the staff were great from the top to the bottom.
- Everything, great staff. First class Consultants.
- Everything - continuous and supported at all times. Kind and courteous, kept informed.
- Everything, the nurses, doctors and even the food.
- Being on first name terms with the nursing staff helped foster an informal atmosphere which made me feel comfortable in what, for me, is a totally new environment. Everything relating to the operation was made known to me in advance and steps taken to minimise my anxiety and concerns.
- Everything from the support to the lovely cups of tea.

Friendly

15% (357) of patients commented about friendliness during their stay.

- People always on hand and checking on us, very friendly.
- Quick, efficient, friendly.
- Friendly, helpful, attentive.
- Extremely friendly, felt like they went the extra mile and nothing was a bother for them.
- Well trained and extremely knowledgeable staff. Very friendly personnel for whom the phrase "nothing is too much trouble" fits to perfection. The Eye Infirmary already has a first class reputation - the taxi driver told me "you're going to the finest eye place in Britain mate"!!
- Everything including ambulatory care, everyone from domestic staff to doctors were friendly, kind and professional. A lovely team of people, thanks for your help.

What could be improved?

Nothing

21% (515) of patients said that nothing could be improved. 40% (994) of patients left no comment at all.

Staff

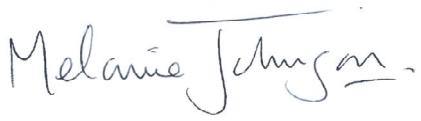
8% (189) patients commented about staff.

- Need more staff.
- More staff to help ease the workload. Support from the Government. Help save and protect our NHS.
- Length of time when pain relief is needed, there is usually not enough staff at certain times.
- I think more staff would be good.
- More staff - while they are dedicated sometimes they can't respond to urgent issues and one can see they are overworked yet still going at it.
- More nursing staff to reduce patient waiting e.g. visiting the toilet or asking for help dressing etc.

6 RECOMMENDATION

This report provides Governors with an update on progress with the new Patient Experience Survey for Quarter 3 2016/17.

Council of Governors is asked to note Trust performance within the report.



Melanie Johnson
Director of Nursing & Patient Experience

Gary Schuster
Clinical Governance Manager

Q11 **Did you get the care you felt you required when you needed it most?**

- Yes, completely ☐
- Yes, to some extent ☐
- No ☐

Q12 **On this ward have you been provided with an individual menu?**

- Yes ☐
- No ☐
- Don't know / Can't remember ☐

Q13 **How would you rate the hospital food?**

- Very good ☐
- Good ☐
- Fair ☐
- Poor ☐
- Very poor ☐
- I did not have any hospital food ☐

Q14 **On this ward do staff ask often enough if you have any pain?**

- Yes, definitely ☐
- Yes, to some extent ☐
- No ☐
- Not been in pain ☐

Q15 **Do you feel staff do everything they can to manage your pain?**

- Yes, definitely ☐
- Yes, to some extent ☐
- No ☐
- Not been in pain ☐

Ward (for office use only)

B20 ☐	C30 ☐	C36 ☐	D47 ☐	E53 ☐
B21 ☐	C31 ☐	D41 ☐	D48 ☐	E54 ☐
B22 ☐	C33 ☐	D42 ☐	E50 ☐	E56 ☐
B26 ☐	C34 ☐	D43 ☐	E51 ☐	E58 ☐
B28 ☐	C35 ☐	D46 ☐	E52 ☐	F61 ☐

Month ☐

chs *Excellence in Health, putting People first*

chs

City Hospitals Sunderland NHS
NHS Foundation Trust

Patient Experience Survey

Including the Friends and Family Test Question

Your experience matters to us

This information will help us to understand what we do well and what we could do better.

Your responses will be combined with all other feedback for the service and shared with teams anonymously.

You will not be identifiable from the feedback and it will not affect the care you receive.

This form and the responses you give will not be linked to your personal record.

If there is anything you would like to discuss about your care and treatment please speak to a member of your care team or contact the Help and Advice Service:

- Telephone: 0191 569 9855 or Freephone 0800 587 6513
- Email: helpandadviceservice@chsft.nhs.uk
- Opening Hours: 8 am to 5 pm – Monday to Friday

Please post in the Friends and Family box on the ward.

The Friends and Family Test Question

Whilst we understand that you would not wish your friends and family to be unwell we'd like you to think about whether you would recommend our services, if they were needed by them.

We would like you to think about your recent experiences of our service:

Q1 **How likely are you to recommend our service to friends and family if they needed similar care or treatment?**

- Extremely likely ☐
- Likely ☐
- Neither likely or unlikely ☐
- Unlikely ☐
- Extremely unlikely ☐
- Don't know ☐

Q2 **What was good about your care?**

Q3 **What could be improved?**

Q4 **Please tick this box if you DO NOT wish your Friends and Family Test comments to be made public.** ☐

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Q5 **Were you involved as much as you wanted to be in the decisions about your care and treatment?**

- Yes, definitely ☐
- Yes, to some extent ☐
- No ☐

Q6 **If you were concerned or anxious about anything while you were in hospital, did you find a member of staff to talk to?**

- Yes ☐
- No ☐
- Was not concerned or anxious ☐

Q7 **Were you given enough privacy when discussing your condition or treatment?**

- Yes, always ☐
- Yes, sometimes ☐
- No ☐
- Don't know ☐

Q8 **During your stay were you treated with kindness and compassion by the people caring for you?**

- Always ☐
- Mostly ☐
- Sometimes ☐
- Rarely ☐
- Never ☐

Q9 **Did you always have access to the call bell when you needed it?**

- Yes ☐
- No ☐

Q10 **Have your relatives or friends who support you (carers) been as involved in your care as much as you would have liked them to have been?**

- Yes, always ☐
- Yes, sometimes ☐
- No ☐
- Don't have a carer ☐
- Don't know/can't remember ☐

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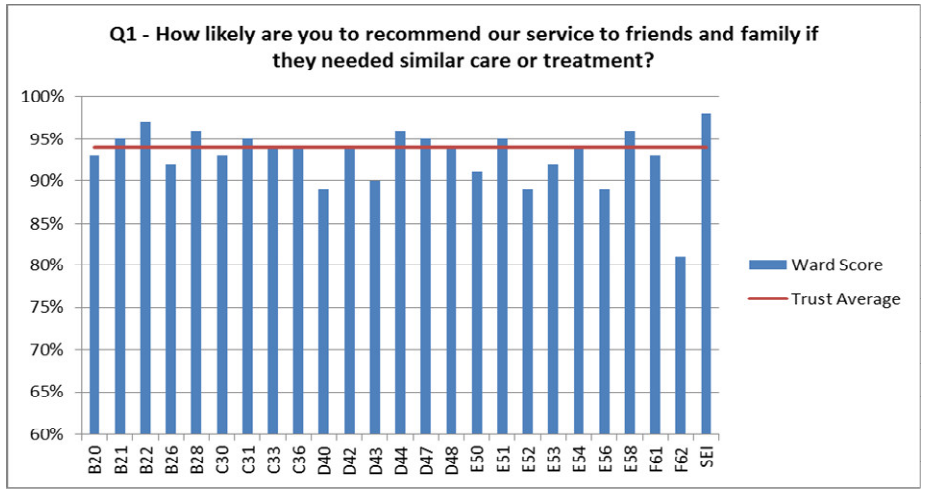
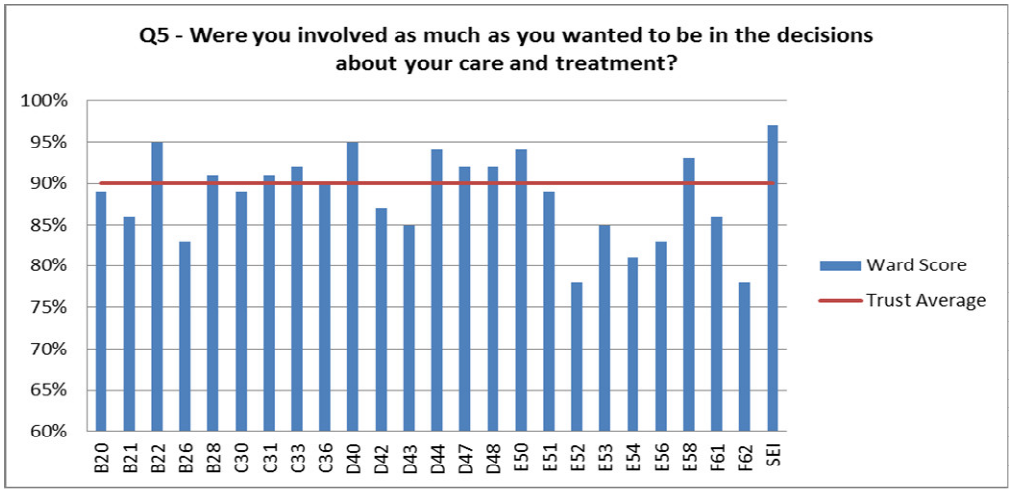
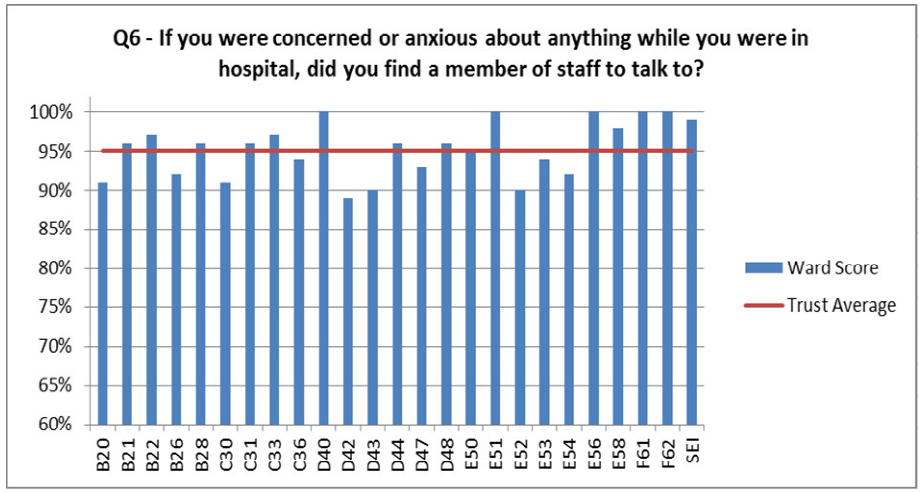
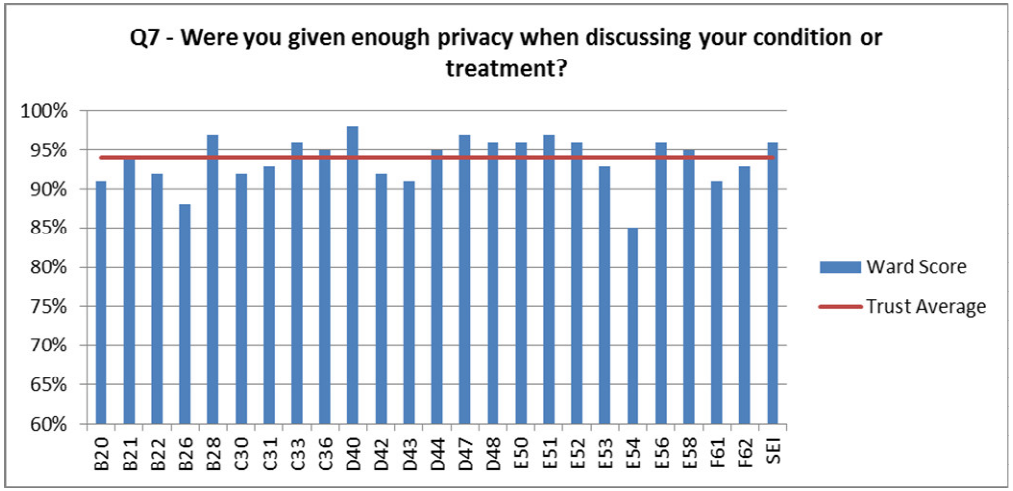
Patient Experience Survey : Oct – Dec 2016 - 1

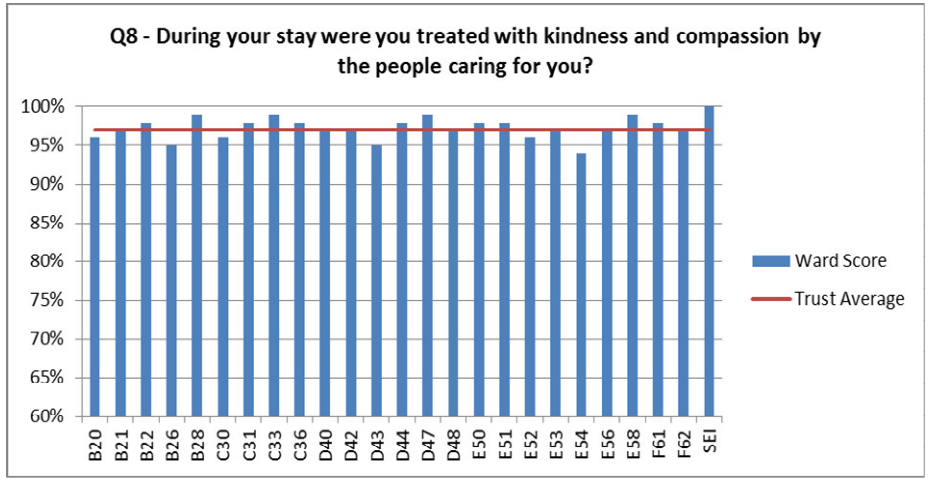


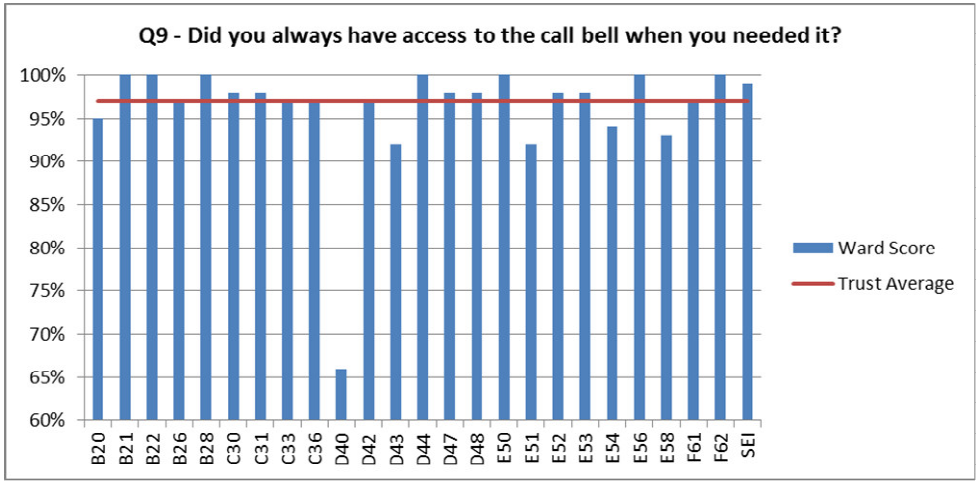


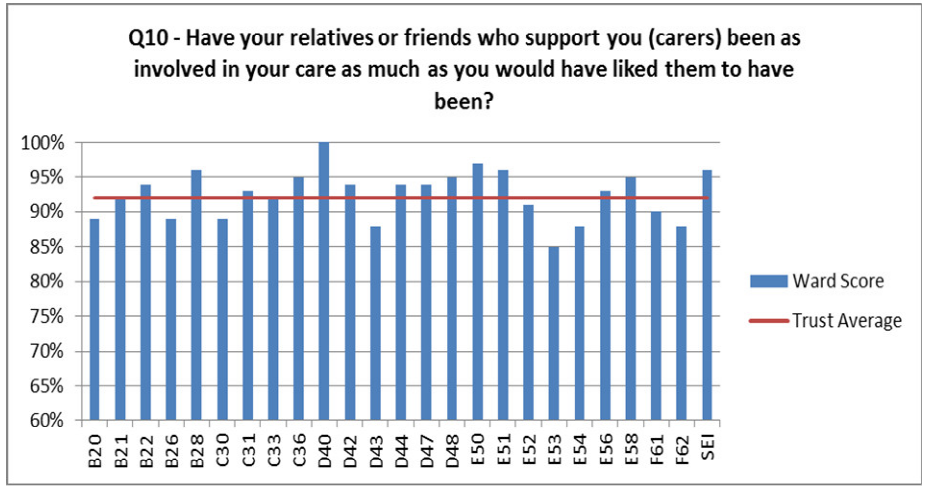


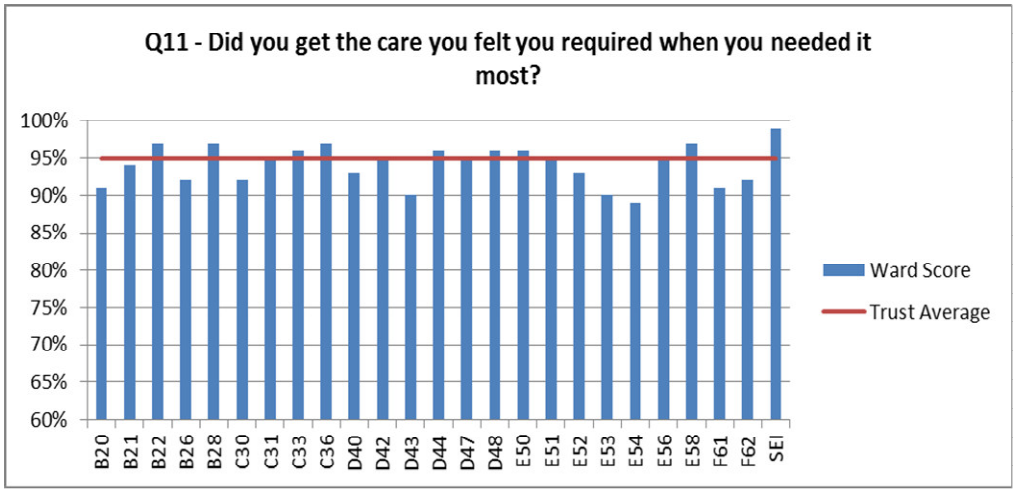


Patient Experience Survey : Oct – Dec 2016 - 2

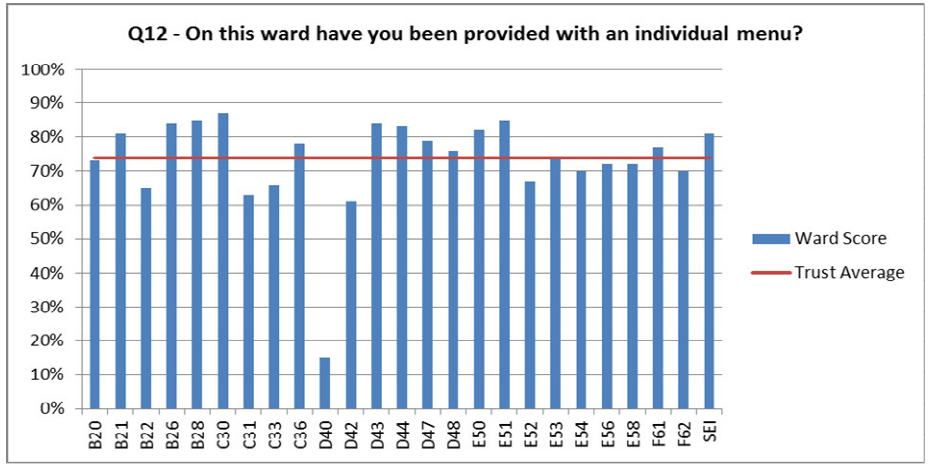


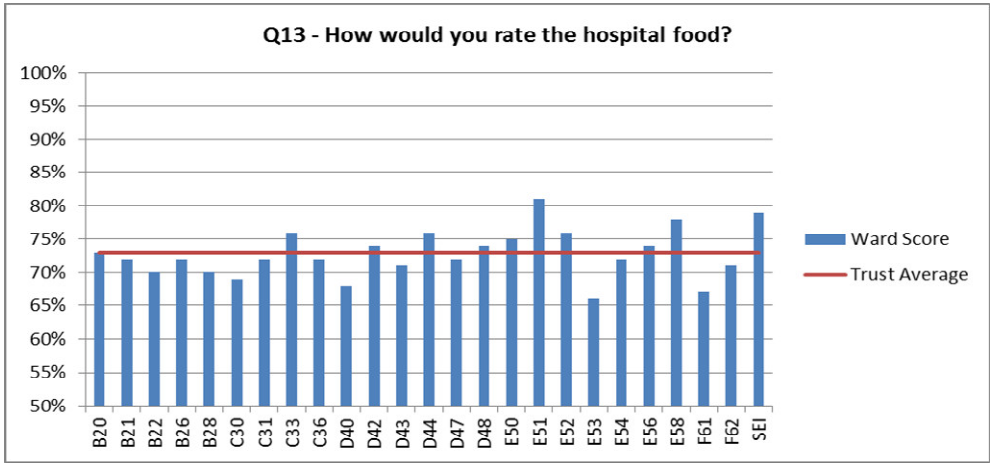


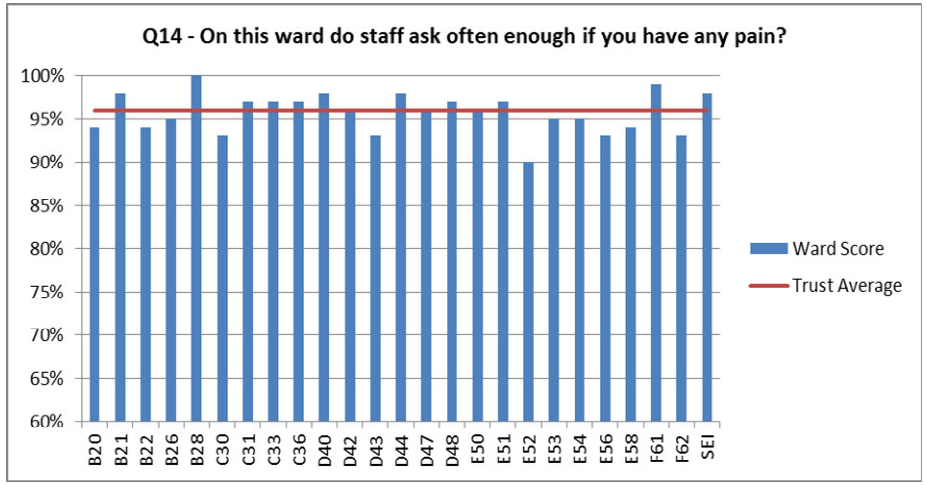




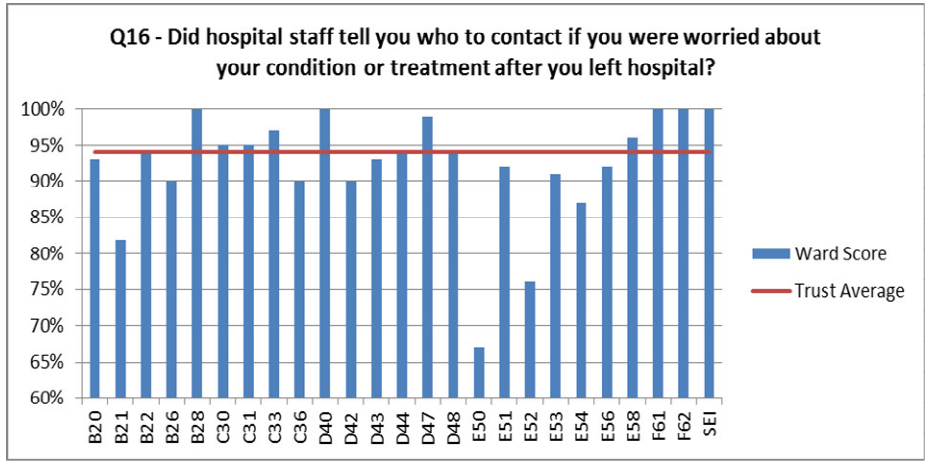
Patient Experience Survey : Oct – Dec 2016 - 3







Patient Experience Survey : Oct – Dec 2016 - 4



Ward Legend

B20 - Medicine / Short Stay Medicine
B21 - Cardiology
B22 - Cardiology
B26 – General Medicine / Gastroenterology
B28 – Renal / Rheumatology/ Endocrinology
C30 – General Surgery
C31 – General Surgery
C33 – Head & Neck
C36 – Vascular Surgery
D40 – Integrated Assessment Unit
D42 – Short Stay Surgical
D43 – Trauma & Orthopaedics
D44 – Urology
D47- Gynaecology
D48 - Trauma & Orthopaedics (elective)
E50 – Care of the Elderly
E51 - Care of the Elderly
E52 - Care of the Elderly
E53 – Metabolic Medicine
E54 – Thoracic Medicine
E56 – Care of the Elderly (Dementia)
E58 – Stroke Unit
E61 – Neurorehabilitation
F62 – Control of Infection
SEI – Sunderland Eye Infirmary

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF PLANNING AND BUSINESS DEVELOPMENT

COUNCIL OF GOVERNORS

JUNE 2017

OUTPATIENT SCHEDULING UPDATE

Introduction

This briefing provides an update to the Council of Governors on the improvements made to the scheduling of outpatient services over the last 3 years.

Background

The Scheduling improvement programme was established in 2014 following feedback from patients and Governors around issues linked to our outpatient scheduling process such as duplicate appointment letters, cancellations and difficulty getting through on the telephone to the contact centre.

The objectives of the programme were:

1) To improve patient experience and satisfaction – through reducing cancellations and multiple appointment letters, and ensuring patients have the right information about their care at the right time

2) To reduce wasted clinical capacity – through ensuring robust demand and capacity planning and maximising clinic utilisation through reducing unfilled slots and reducing DNAs

3) To optimise the clinic appointment and follow up process to minimise delays in the patient pathway and ensure appropriate follow up is in place

Improvements to our processes

The main improvements of the programme so far have been:

Area	Improvement
Outpatient clinic outcome	The outpatient clinic letter to the GP and patient, where appropriate, is produced on the day of the clinic and if a follow up appointment is required in less than 6 weeks this is made with the patient before they leave the hospital .

	For patients who require surgery, they have the option to have their pre-assessment appointment on the same day therefore reducing the need for multiple visits to the hospital and potentially reducing the time that they need to wait for their procedure.
Letters	We do not book patient follow up appointments over 6 weeks i.e. if a patient needs a review appointment in 6 months they are placed on the waiting list until their appointment is scheduled. We do not send letters until 5 weeks before an appointment therefore reducing multiple letters being sent to patients due to any cancellations.
Contacting us	Implemented extended hours for the contact centre on an evening until 7 pm and Saturday morning so that patients can contact us outside of normal working hours. Implemented a form accessible via the web to allow patients to cancel and reschedule appointments as an alternative to telephoning the contact centre. > 500 patients per month use this service.
Contacting patients	We have extended the service we use to remind patients about their appointment We have implemented the text reminder process across most specialities 7 days ahead of the appointment. Patients without a mobile phone number recorded receive an automated voice call. Patients > 75 receive an agent (human) call. We are using a text process to contact patients at short notice, about clinic appointments which have become free when other patients cancel their appointment. We are piloting a service where patients

	can access their letters via a web link on a text message. This will help patients with additional communication requirements. We are at the forefront of developing this service.

Achievements

The improvements in process have led to the following achievements:

Indicator	Target	Baseline*	March 2017
Letters sent in 24 hours	100%	0%	34%
Hospital cancellations overall (rework)	5%	8.3% .	6.6%
Local hospital cancellation indicator – impact on patients	2.89%	3.21%	2.28%
DNA rate	5%	12.7%	9.18%
Complaints per month linked to appointments	0	14	1

**The baseline period varies depending on the indicator*

Further improvements to be made

There are further improvements planned such as:

1. Improving the process through the e-referral service (formerly choose and book) where we can access the referral letter before the patient is booked into a slot. This is important where the clinician needs to triage to decide the most appropriate appointment type for a patient e.g. straight to test or outpatient appointment. We are waiting for changes to the national e-referral system before we can progress with this.

2. Improving the scheduling processes within Therapy services which have recently transferred to the main outpatient scheduling department.

3. Further work on tackling cancellations in under six weeks where this is avoidable (not related to sickness and unforeseen circumstances).

4. Further work to improve the Contact Centre capability and ensure that staffing levels meet call demand

Conclusions and Recommendations

Governors are asked to note the improvements made to the scheduling of our outpatient services, many of which have been acknowledged by other Trusts as best practice.

Alison King
Head of Performance and Improvement

Laura Bond
Service Improvement Manager

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

JUNE 2017

2016 NHS STAFF SURVEY RESULTS

INTRODUCTION

This paper summarises the Trust's results from the 2016 NHS Staff Survey.

The NHS Staff Survey provides an opportunity for organisations to survey staff in a consistent and systematic way, making it possible to build up a picture of staff experience and to compare and monitor change over time and identify variations between different staff groups.

Feedback from our staff is vital in being able to improve their experience and so that in turn, they are able to provide better patient care. The survey results are used by the CQC to monitor ongoing compliance with essential standards of quality and safety and by the Secretary of State for Health to monitor delivery of the NHS Constitution.

316 NHS organisations took part in the 2016 survey, with questionnaires distributed between late September and early December 2016. Nearly a million NHS staff were invited to participate with over 423,000 completing the survey – a response rate of 44%.

For the 2016 survey the Trust used Quality Health as its survey contractor with all of our eligible staff being invited to take part compared to the last 2 years, when a random sample of 850 staff were chosen. For the second year in a row, the survey was conducted online / via email and the overall response rate increased from 31% in 2015 to 35%.

SURVEY FEEDBACK REPORT

The CQC feedback report focuses on 32 key areas (known as 'Key Findings'). These are mostly summary scores for groups of questions which, when taken together, give more information about each area of interest. This year there are 32 Key Findings, presented in the feedback report under the following 9 themes:

1. Appraisals & support for development
2. Equality & diversity
3. Errors & incidents
4. Health & wellbeing
5. Working patterns
6. Job satisfaction
7. Managers
8. Patient care & experience
9. Violence, harassment & bullying

As in previous years, there are two types of Key Finding - percentage scores and scale summary scores. Percentage scores were calculated as the percentage of respondents who gave a specific answer to a question, or a defined set of responses to a series of questions and scale scores were worked out by assigning numbers to a series of responses and calculating the average score, as follows:

If a respondent answered…	Their response would score…
Strongly disagree	1
Disagree	2
Neither agree nor disagree	3
Agree	4
Strongly agree	5

OVERVIEW OF SURVEY RESULTS

Overall and compared to the rest of the acute sector, most of the Trust's scores are around or above average, with very little movement since the previous year.

The table below shows the scores for 2016 and the previous 2 years, or Qs 21a-d, which feed into Key Finding 1 - *"Staff recommendation of the organisation as place to work or receive treatment".*

Question	2016	2015	2014	Average for all acute trusts
21a - Care of patients/service users is my organisation's top priority.	75%↑	71% ↔	71%	76%
21b - My organisation acts on concerns raised by patients / service users.	77%↑	75% ↔	75%	74%
21c - I would recommend my organisation as a place to work.	61%↓	63% ↑	61%	62%
21d - If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	70%↔	70%↑	65%	70%
KF1 - Staff recommendation of the organisation as a place to work or receive treatment.	3.76↓	3.78↑	3.71	3.77

Appendix 1 shows a comparison of the above results and the overall staff engagement scores for other NHS acute trusts in the north east.

OVERALL INDICATOR OF STAFF ENGAGEMENT

The table below shows how the Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, team and organisation) and 5 indicating that staff are highly engaged.

Survey Year	Overall Staff Engagement Score
2016	3.81
2015	3.84
2014	3.73
National 2016 average for acute trusts	3.81

There has been no real change (0.03) in the Trust's overall staff engagement score since last year and at 3.81 is average when compared with all other acute trusts in the NHS.

TOP AND BOTTOM KEY FINDINGS

The **top 5 Key Findings** where we compare most favourably with other acute trusts in England are:-

1. KF29 – Percentage of staff reporting errors, near misses or incidents witnessed in the last month – the higher the score the better - (95% compared to 90% for the acute sector).

2. KF27 – Percentage of staff who have experienced harassment, bullying or abuse and who have reported this – the higher the score the better – (54% compared to 45% for the acute sector).

3. KF23 – Percentage of staff experiencing physical violence from staff in the last 12 months – the lower the score the better - (1% compared to 2% for the acute sector).

4. KF18 – Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves – the lower the score the better – (48% compared to 56% for the acute sector).

5. KF26 – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months – the lower the score the better – (20% compared to 25% for the acute sector).

The **bottom 5 Key Findings** where we compare least favourably with other acute trusts in England are:-

1. KF4 – Staff motivation at work – the higher the score the better – (3.92 compared to 3.94 for the acute sector).

2. KF25 – The percentage of staff experiencing harassment, bullying or abuse from patients, relatives of the public in last 12 months – the lower the score the better – (28% compared to 27% for the acute sector).

3. KF1 – Staff recommendation of the organisation as a place to work or receive treatment – the higher the score the better – (3.76 compared to 3.77 for the acute sector).

4. KF32 – Effective use of patient / service user feedback – the higher the score the better – (3.72 - ***the same score as for all other acute trusts***).

5. KF11 – Percentage of staff appraised in last 12 months – the higher the score the better - (87% - ***the same score as all other acute trusts***).

   NB: - The percentage of staff stating they had had an appraisal in the last 12 months increased by 3% in 2016 from 84% in 2015.

SUMMARY OF RESULTS BY SURVEY THEMES

Appraisals & Support for Development

- The coverage of appraisals (87%) is average for the acute sector and has improved from 84% last year.
- The quality of appraisals is rated by staff as 3.15, which is slightly better than the acute sector average of 3.11.

Equality & Diversity

- The percentage of staff experiencing discrimination at work has reduced from 9% last year to 8% and is lower than the acute trust average of 11%.
- The percentage of staff who believe that the Trust provides equal opportunities for career progression is average for the acute sector (87%), but has reduced slightly from 89% last year.

Errors & Incidents

- The number of staff witnessing potentially harmful errors/incidents is average for the acute sector (31%).
- The percentage of staff reporting incidents they have witnessed has increased to 95% and is in the 'best score' category for acute trusts.
- Staff confidence in reporting unsafe clinical practice is better than the average for other acute trusts and the fairness and effectiveness of procedures for reporting errors/incidents has improved and at 3.84 is above the average / almost in the 'best score' category for acute trusts.

Health & Wellbeing

- The percentage of staff feeling unwell due to stress has increased from 29% to 33% but is less than the 35% average for acute trusts.
- Although the percentage of staff feeling pressure to attend work despite feeling unwell increased slightly to 48%, this is almost in the 'best score' category for acute trusts and is well below the average of 56%.
- Management interest in health and wellbeing is rated at 3.65, which is just above the average for acute trusts.

Working Patterns

- 53% of staff said they were satisfied with opportunities for flexible working, slightly higher than the 51% acute trust average.
- The percentage of staff working extra hours has not changed (64%) and is well below the acute trust average (72%)

Job Satisfaction

- The extent to which staff would recommend the Trust as a place to work or receive treatment is average for the acute sector (3.75), though this has reduced slightly from 3.80 last year.
- Responses from staff about them regarding their ability to contribute towards improvement, their satisfaction with the level of involvement, resources and support they have and the effectiveness of team working are either stable or have improved and are average or better than average in relation to the acute trust sector.

Managers

- The percentage of staff reporting good communication between senior management and staff has increased and at 37% is above the 33% average for the acute sector. (46% is the 'best score' for this Key Finding).

Patient care & experience

- Staff satisfaction with the quality of work / care they are able to deliver is above average for the acute sector (3.96) and at 4.08 is almost in the 'best score' category of 4.28.
- Effective use of patient feedback is rated as 3.72, which is average for the acute trust sector, as is the percentage (90%) of staff who agree that their role makes a difference to patients.

Violence, harassment & bullying

- Overall staff responses / scores relating to violence, harassment and bullying at work have all remained static or improved since last year, suggesting that staff are aware of how to report such incidents and feel confident to do so. A number of scores are in the highest / 'best score' category for acute trusts.
- The number of staff reporting violence at work has increased from 56% to 73%, which is above the average for acute trusts.
- The percentage of staff experience harassment or bullying from other staff has reduced and is below the acute sector average and reporting of such incidents has increased from 41% to 54%

HSE STRESS AUDIT

The HSE has indicated that, for the purposes of analysing the levels of stress in hospitals, the output from the National Staff Survey can be used as a substitute for undertaking a separate survey. In this connection, the results of Qs 5b and 5c are shown below.

Comparison with last year's results shows some improvement and better than average scores against all other acute trusts.

	2016	**2015**	**2014**	**2016 average for acute trusts**
Q5b - The support I get from my immediate manager	68%↔	68%	66%	67%
Q5c - The support I get from my work colleagues	82%↑	80%	79%	81%

WORKFORCE RACE EQUALITY STANDARDS

All NHS organisations are required to demonstrate through the Workforce Race Equality Standard how they are addressing race equality issues in a range of staffing areas. Together with the Equality Delivery System they form part of the mandatory requirements in the 2015/16 standard NHS contract, which came into effect on 1 April 2015.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

Comparison with last year's results shows improvements in the responses from BME staff across all key findings.

In addition, the Trust's overall Equality and Diversity Key Finding score (KF20 – Percentage of staff experiencing discrimination at work in the last 12 months), improved and is better than the national average for the acute sector (8% compared to 11%).

Key Finding	Ethnicity	2016	2015	2014	2016 average for acute trusts
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White BME	29%↑ 28%↓	25% 29%	26% 40%	27% 26%
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White BME	19%↓ 26%↓	20% 27%	19% 20%	24% 27%
KF21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White BME	89%↔ 74%↑	89% -	92% 50%	88% 76%
17b. In the last 12 months have you personally experienced discrimination at work from managers, team members / other colleagues?	White BME	4%↓ 14%↓	7% 21%	5% 21%	6% 14%

CQUIN 2017- 19 HEALTH AND WELLBEING TARGETS

A number of targets have been retained and/or revised in the 2017-19 CQUIN Guidance relating to improving staff health and wellbeing some of which will be measured via responses to the annual NHS Staff Survey.

The requirement is to achieve a 5% point improvement over the 17/18 and 18/19 years in 2 of the 3 NHS annual staff survey questions regarding health and wellbeing, MSK and stress related illness (See Qs 9a – 9c below), as follows:-

- Year 1 (17/18) - a 5% point improvement should be achieved over a period of 2 years, with the baseline survey being the 2015 staff survey.
- Year 2 (18/19) – a 5% point improvement should be achieved over a period of 2 years, with the baseline survey being the 2016 staff survey.

Having baselined the relevant scores this means that the Trust needs to achieve at least the scores shown below in the 2017 and 2018 NHS Staff Surveys:-

Survey Question	Baseline 2015	Target 2017/18	Baseline 2016	Target 2018/19
9a: Does your organisation take positive action on health and well-being? – Response Yes, definitely.	31%	**36%**	32%	**37%**
9b: In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Response No.	**75%**	**80%**	**71%**	**76%**

9c: During the last 12 months have you felt unwell as a result of work related stress? Response: No	**71%**	**76%**	**68%**	**73%**

RECOMMENDATIONS

The Council of Governors are asked to note the contents of this paper.

The detailed Staff Survey results will, together with other sources of workforce information and staff feedback, be used to develop a staff engagement plan as part of a new OD Strategy for South Tyneside and City Hospitals Sunderland NHS Foundation Trusts.

This will set out how we will develop the Trusts over the next three years, including our commitment to staff, our undertaking to develop the Trusts as organisations of which we can all be proud and that staff want to be part of.

The NHS challenge is to deliver more with less whilst maintaining and continuing to improve the safety, effectiveness and efficiency of our services. We will need staff who are capable not only of leading and delivering transformational changes in our services, but also able to demonstrate the Trust's values and behaviours.

The OD Strategy will be aligned with national and local priorities for healthcare and focus on both the outcomes from external reports such as Francis and Carter and internal objectives such as leading change effectively and driving research / innovation. It will build on the progress we have made so far, e.g. Annual Reward and Recognition Event, Excellence Reporting, new Trade Union Partnership Agreement, Employee Benefits Days, Innovation Events and Lessons Learnt Seminars.

Kathleen Griffin
Director of Human Resources and Organisational Development

Appendix 1

COMPARISON OF NORTH EAST NHS ACUTE TRUSTS' ORGANISATION RATINGS AND STAFF ENGAGEMENT SCORES

Trust	Q21a "Care of patients / service users is my organisation's top priority"	Q21b "My Organisation acts on concerns raised by patients / service users"	Q21c "I would recommend my organisation as a place to work"	Q21d "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	KF1. Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21 c-d)	Overall Staff Engagement Score
City Hospitals Sunderland Foundation Trust	75%	77%	61%	70%	3.76	**3.81**
South Tyneside NHS Foundation Trust	67%	69%	49%	59%	3.55	**3.80**
Newcastle Hospitals NHS Foundation Trust	90%	86%	74%	91%	4.19	**3.97**
County Durham & Darlington NHS Foundation Trust	62%	68%	49%	59%	3.48	**3.68**
Gateshead NHS Foundation Trust	82%	80%	69%	81%	3.96	**3.89**
North Tees and Hartlepool NHS Foundation Trust	76%	73%	64%	64%	3.75	**3.82**
Northumbria Healthcare NHS Foundation Trust	83%	83%	74%	82%	4.05	**3.96**
South Tees NHS Foundation Trust	67%	69%	55%	73%	3.67	**3.76**