**CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST**

**COUNCIL OF GOVERNORS**

**TUESDAY 7 JUNE 2016 - 2:00 PM**
**ROBINSON SUITE, GLEBE CENTRE, MURTON, SR7 9BX**

**AGENDA**

| | | | |
|---|---|---|---|
| Item 1 | Declaration of Interest | | |
| Item 2 | Minutes of the meeting held on Thursday 24 March 2016 | Enc 1 | KWB |
| | Matters Arising | | |
| | Item 2 Vascular Review | | KWB |
| | Item 2 Breast Service | | KWB |
| | Item 3 Professor Tim Briggs | | KWB |
| Item 3 | Chief Executive's Update<br>(To include an update on the Sustainable Transformation Plan) | Verbal | KWB |
| Item 4 | South Tyneside and Sunderland Healthcare Group - Memorandum of Understanding | Enc 2 | KWB |
| Item 5 | South Tyneside and Sunderland Healthcare Group - Vision, Aims and Values | Enc 3 | KWB |
| Item 6 | South Tyneside and Sunderland Healthcare Group - Clinical Services Review Group – Terms of Reference | Enc 4 | PS |
| Item 7 | 2015 NHS Staff Survey Results | Enc 5 | JA |
| Item 8 | 2016 Governor Elections Update | Enc 6 | CH |

Date and Time of Next Meeting

Thursday 21st July 2016 at 9:30 am in the Henry Tudor Room, Age UK, Stockton Road, Sunderland, SR2 7AQ.

ENCLOSURE 1

**CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST**

**COUNCIL OF GOVERNORS**

**Minutes of the meeting of the Council of Governors held in public on Thursday 24 March 2016 at 10:00 am in the Board Room, Monkwearmouth Hospital, Sunderland.**

**Present:**
Mike Davison (MD) - Chair
Michael McNulty (MMcN)
Danny Cassidy (DC)
Ruth Richardson (RR)
Pauline Taylor (PT)
Susan Pinder (SP)
Shahid Junejo (SJ)
Lindsey Downey (LD)
Pat Taylor (PT)
Alexander Marshall (AM)
Tony Foster (TF)
Margaret Dobson
Mary Pollard (MP)
Graeme Miller (GM)
Carol Harries (CH) - Trust Secretary

**Apologies:**
John Anderson (JNA)
Rob Allchin (RA)
John Dean (JD)
Mandy Bates (MB)

**In Attendance:**
Ken Bremner (KWB)
Stewart Hindmarsh (SH)
Melanie Johnson (MJ)
Alison King (AK)
Andy Hart (AJH)
Gavin McPake (GMcP)

**Item 1 Declaration of Interest**

None.

**Item 2 Minutes of the meeting held on 10 November 2015**

Accepted as a correct record.

**Matters arising**

**Neonatal Review** – KWB advised that the North Tees objection was not yet resolved but that we were still trying to progress the new arrangements north of the patch. KWB stated however, that it was likely that the Network would want to only progress arrangements as a whole.

**Vascular Review** – the outcome of the review had confirmed three centres of which CHS would be one of the centres. The Trust would operate a hub and spoke model with ourselves acting as the hub and Durham as one of the spokes. South Tyneside NHSFT had been very supportive during the review process which had been extremely beneficial. Durham had objected to the outcome of the review and lodged an appeal which was now causing stagnation at a time when transformation was really needed. KWB advised he would keep Governors appraised of progress.

**Court of Human Rights** – KWB informed Governors that the judge was making recommendations but there was nothing further legally at this stage to report.

**Junior Doctors** – KWB stated that the Secretary of State had to try and get the BMA and NHS Employers to an agreed settlement. There had been a number of patient safety issues which had been raised by the BMA and they had been conceded but there was still one sticking point which was how much a junior doctor would get paid on a Saturday and Sunday.

The industrial action to date had had no real impact on emergency care and had been limited to a few elective cancellations and outpatient appointments. Further action was scheduled for the 6th & 8th April. KWB commented that it was always a difficult balance to cancel appointments/surgery at an early stage or to wait nearer the time before doing this in the hope that the action may be called off. The further action planned for the 26th & 28th April would be much more problematic as the intention was that all labour would be withdrawn on those two days and we would need to plan as to how we will cope. KWB stated that the Secretary of State was to impose the new contract from August and there was a real risk that some doctors would not take up posts in August when the new intake was scheduled. KWB commented that it was a really difficult situation as we do not employ junior doctors – only F1s and F2s.

**Breast Service** – KWB informed Governors it was hoped that the new service model would be in place by May 2016.

**Item 3 Chief Executives Update**

**Alliance with South Tyneside** – KWB advised that following the recent announcement the press coverage had been generally very positive other than particular criticism from the South Tyneside MP who had been concerned at the lack of consultation. The Royal College of Nursing and Unison had been very supportive of the proposal. KWB reminded Governors that the two Trusts remained as separate statutory bodies but that it created opportunities to look at better, closer integration. A group Board had been established which included the Chairs and Chief Executives from each organisation. KWB stated that the important work ahead was to look at how we build clinical services and work was being undertaken to draft some timelines going forward.

MMcN commented that all concerned were to be warmly congratulated for the development. He also queried whether or not we needed a budget to take things forward. KWB replied that this was partly covered by Commissioners and that there had also been a request made nationally but that required a transformation plan. KWB explained that if work was to be undertaken in relation to clinical services then that would require the involvement of consultant medical staff and the ability to backfill their posts to ensure clinical involvement and leadership.

AM commented that the whole approach was eminently sensible but what was the risk of competition law? KWB replied that the issue was difficult and needed to be carefully managed but that it was important to remember that we were still two separate statutory organisations. The two Trusts were seeking legal advice on the memorandum of understanding and it had also been shared with Monitor for comment. AM commented that unfortunately good sense did not always apply to competition law.

SJ stated that in his experience the quality of care in CHS was better and very different to that provided at South Tyneside and to align ourselves would be very difficult and could be a risk going forward. KWB acknowledged that it was about different cultures coming together but that we did need standardised working. SJ stated that where mergers happened in the past – generally it was people issues not financial issues that were the problem. KWB reminded everyone that the arrangement was an alliance not a merger.

GM commented that there had been concerns expressed in the Local Authority when the alliance had been announced as no one had had the courtesy of telephoning the Leader before the announcement was made. GM stated that more thought could have been taken as to how the Local Authority were informed as they are key partners. GM advised that it had been suggested to

him that he should resign from the Council of Governors. GM advised that it may be helpful for someone to have a conversation with the Leader. KWB replied that the Local Authority were fully informed and that Sonia Tognarelli had been briefed personally by himself. GM advised that the alliance title was also somewhat of a shock as there was no mention of Sunderland. GM commented that the Leader had been ranting about the name. KWB replied that the Chairman had spoken to the Leader about the name and had asked for a suggestion but apologised that it had caught the Leader off guard.

MD commented that it was important to ensure that such issues/concerns were brought to the table.

RR commented that there had been a meeting at South Shields golf club and the term 'merger' had been used but that she had informed people present otherwise. She did state however, that there were clearly some rumblings in the community and it was only because she was a Governor that she was able to correct the issues. KWB commented that people would take a view on this and currently there was somewhat of a hiatus.

Pauline Taylor stated that she could understand the concerns about the name of the alliance. KWB reminded Governors that it was important to remember that a large proportion of our patients also lived in Durham.

TF stated that Durham CCG got the Northern Echo to print a column each week and it would be helpful if we were to do something similar in the Echo, particularly if KWB were to write it. KWB replied that it was possible to do but the Echo would charge us for the privilege. The circulation of the Echo had also considerably reduced and we would need to consider whether the potential impact would be worth doing.

KWB stated that CH and her counterpart at South Tyneside had briefed the Echo in advance who printed the brief and discussion more or less in verbatim. The Echo did have limited value and perhaps it would be better to look at social media channels. GM commented that all organisations now needed to look at other media vehicles but that the Echo article had presented a very good message.

**NHS League Table – Learning From Mistakes** – KWB advised that a league table based on the fairness and effectiveness of procedures for reporting errors; near misses and incidents; staff confidence and security in reporting unsafe clinical practice; and the percentage of staff who feel able to contribute towards improvements at their Trust had recently been published.

The information had been drawn together from the 2015 NHS staff survey and from the National Reporting & Learning System.

Northumbria had been ranked one of twelve outstanding Trusts and we were ranked 'good'. Only one other Trust was above us in the North East which was Tees, Esk & Wear Valley. Newcastle had been ranked as poor in the survey.

**Professor Tim** Briggs – KWB advised that Professor Tim Briggs had now taken on an extended role to look at other clinical services which in the first instance would be General Surgery. He had also expressed a desire to look at vascular units but hopefully this would be postponed given the recent review of vascular services. Professor Briggs had undertaken some national work looking at T&O services and in particular the cost of prosthesis which bore no relation to the size of a unit and volume of procedures undertaken.

**Endoscopy Unit –** KWB advised that the unit had formally opened the previous week but that there were some problems with the decontamination unit. KWB stated that the staff were absolutely thrilled with the new facility. SP queried whether the issue of the transparent door had been resolved. KWB confirmed that they had been resolved.

**Item 4 Quality, Risk and Assurance Report**

MJ presented the report which provided assurance that the key regulatory, quality and safety standards that the Trust was expected to maintain compliance with and/or improve.

MJ highlighted the mortality review panel which was a screening process that reviewed all in hospital deaths. At the conclusion of each patient review, the MRP provided a judgement on the preventability of death and whether there were improvements required in any clinical or organisational aspects of care. MJ explained that the Secretary of State was to identify changes to the way in which deaths are reviewed and it was hoped that the new system did not detract from our process which was considered to be really robust.

MJ also highlighted the mid-term review of the Quality Report 2015/16 and stated that the Trust was on target to achieve most of the priorities. In some areas, interim performance suggested that targets were currently not being met and it was unlikely that performance would improve sufficiently. In particular this related to:

- Reducing the incidence of avoidable hospital acquired pressure ulcers by 50%

- Implementing the CQUIN sepsis target regarding patient assessment and rapid administration of antibiotics.

MJ explained that indicator leads had been asked to review or draw up additional plans to improve performance.

MJ informed Governors that there had been 38 complaints in December compared to a year to date average of 45 per month. Since April 2015, the Trust had received 12 requests for information from the Ombudsman in relation to complaints, of which 10 were awaiting a decision. MJ stated that increasingly the Ombudsman had a tendency to recommend a payment to a family as a type of compensation.

MJ advised that the safety thermometer data for January 2016 was 92.24% and in particular 20 patients had hospital acquired pressure ulcers. MJ commented that the Trust was not doing what it needed to do in relation to pressure ulcers. SP commented that this had been an issue for a while and how confident was MJ that the action to be taken would improve performance. MJ replied that the plan being developed was multifactorial and that it would take time to pull everything back into line. The Trust had also invested in new beds with built in pressure relieving facilities which should also help to improve the situation. MJ stated that there was no correlation between those areas with high numbers of pressure ulcers and shortage of staff but that we did take a high proportion of frail, elderly patients. SP queried again whether MJ was confident of progress. MJ replied that she was but only within six months although accepted that changes needed to be made from today. DC commented that only 36.7% of patients had had a two hourly skin check. MJ stated that every patient should have a skin check on admission and then be undertaken by the nurse on a regular basis. MJ explained that other clinicians would be interested in the skin integrity but that the responsibility remained with the registered nurse. High risk patients should be checked every two hours and MJ was at a loss to understand why this did not happen.

GM commented that Governors were concerned at the results of the safety thermometer but in particular that the target had not been achieved in year. GM stated it must be unacceptable to allow harm to patients but that it was helpful to have heard MJ's comments. MJ replied that it was important to remember that the safety thermometer was a snapshot in time but that she was concerned at improving pressure ulcers on a continuing basis.

MD also commented on the audit of fluid balance charts on page 13 and stated that hydration was really important and the results as outlined were really disappointing. MJ confirmed that she agreed with the comments and again work was ongoing to try and

improve this particular area. LD stated that at ward level there was a lot of work happening and there was plenty of educational material available to support nurses.

AM queried appendix 1 on page 17 and asked whether there was any quantification of risk. MD replied that the background to this was Monitor's well led framework and the Board should be able to verbalise the top risks but behind the information presented was a great deal of measurement. MD stated that appendix 1 was a snapshot in time. AM queried whether the list was in any particular order. MD replied that it was not.

MMcN asked for clarity of risk number 2 – "risk around knowing that clinical staff are competent". MD replied that this linked to recruitment and staff who did not have the right skill set. MD stated that revalidation would minimise the possibility of risk. KWB stated that it was also about registration with the GMC and an assumption therefore that an individual was competent to carry out tasks with patients which was not always fact. The NHS was trying to move away from that approach and revalidation was a professional requirement. MMcN commented that staff turnover etc meant that there was always a risk. KWB replied that it was a risk and the NHS relied on agency and locums so the risk remained.

TF stated that as a risk manager himself the document was meaningless and needed more description and the consequences of getting it wrong. KWB replied that this was a summary sheet and behind it all, the risks were quantified by likelihood and impact. TF stated that in business meetings he attended this would be backed up by more detail.

MD informed Governors that he chaired the Governance Committee, a formal sub committee of the Board of Directors and this was gone through in detail and that members were aware of the gaps and control and that he was able to confirm that he had evidence of assurance. The appendix was there so that Board members could articulate the main risks and the Board sub committee looked at the detail.

TF stated that it would be helpful for Governors to see more of the detail. GM expressed his support for that view and that it was important for the Council of Governors to see the detail behind it as without it Governors could not challenge and that was unacceptable. MD stated that we would look at how to present the information and possibly do that at a future workshop.

**Resolved**: To accept the report.

**Item 5 Quality Priorities**

MJ presented the report, which was to seek support from the Council of Governors on the quality priorities for the Trust to take forward during 2016/17. MJ explained that these would be highlighted in the 'forward look' part of Quality Report 2015/16. MJ explained that the paper also summarised the mandated external assurance process which involved substantive testing on two mandated performance indicators by external auditors.

MJ also advised that at the joint Board of Directors/Council of Governors Workshop in February 2016, there had been discussion about the quality issues that Governors felt were important and also the selection of a quality indicator chosen by the Council of Governors for external assurance.

MJ stated that the draft list of priorities was presented to the Clinical Governance Steering Group in January 2016, of which a Governor was a member, and these were further discussed and refined at the Workshop. MJ highlighted page 2 and the information sources which helped to determine the quality priorities.

MJ stated that Governors had already seen the update of progress of monitoring of the Quality Priorities 2015/16, which were in the Quality Risk and Assurance Report presented earlier.

MJ stated that the priorities would be closely monitored throughout the year and further updates brought to Governors.

**Resolved**:

- To note the requirements for setting the quality priorities 2016/17.
- To note the arrangements for the external assurance process and specifically the indicator selected by the Council of Governors.
- To support the Quality Priorities 2016/17.

**Item 6 Finance report**

Gavin McPake presented the report and advised that the overall financial position was a net deficit of £12,569k against a planned deficit of £15,030k, £2,461k ahead of plan. GMcP explained that the year end forecast was now £13.3m and not £14.3m as identified within the paper.

GMcP stated that the Trust was reporting a £6,542k over recovery in income for month 10 relating to NHS clinical activity. An agreement had also been reached with Sunderland CCG relating to the year end 2015/16 which would provide a level of certainty in

Trust planning for quarter 4 and would also enable focus to move to 2016/17 contracting.

Pat Taylor commented that it was a really positive report and in relation to work she was doing in other parts of the country was actually unusual.

GM commented that the reality was however, that we were still running a deficit and that needed to be depressed. KWB stated that an extra £1.6b had been put into the NHS for 2016/17 and we were to receive an extra £10m but that we had a control total and ours was £2.1m. GM commented that he felt this was achievable. KWB stated that this would still be a stretch going forward.

AM queried the terminology of 'overperformance' and assumed that meant we had seen more patients than we had originally expected. AM suggested that the last page of appendix 3 presumably meant that it was impossible to make accurate predictions. He also suggested that the CCG as commissioners could presumably simply refuse to pay. KWB replied that they could try and then it is difficult if they run out of money. AM stated that on that basis the hospital was held responsible and that seemed morally wrong. KWB commented that it was not always because of commissioners, activity levels could increase because of national media campaigns such as "blood in pee" urging patients to see a doctor. KWB also commented that some commissioners such as DDES have always under-commissioned and then if patients turn up we feel honour bound to treat them. KWB stated that the Trust believed for every patient who turned up that represented a legally binding contract.

SP queried as to how well we were doing in comparison to other organisations. GMcP replied that it was difficult to compare as we were ahead of plan and others were behind plan and we would really only know the detail when final accounts were published in late summer/early autumn. MD commented that previously we were at the top of Monitor's list but now many other organisations were declaring deficits.

MD queried section 2.1 in relation to private patients and asked about the income from foreign nationals. GMcP replied that he did not have the figures to hand but it was not a large sum of money.

GMcP stated that the Trust was ahead of the annual plan submitted to Monitor of £17.8m deficit for 2015/16 and work was ongoing to improve the position further.

The main focus now was looking forward to 2016/17 and planning for a recurrent improvement to the Trust's finances.

**Resolved**: To note the financial position to date.

**Item 7 Performance Report**

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

AK advised that in relation to RTT, performance was comfortably above the standard for January and the year to date. General Surgery had been below target but were now in February above target. AK explained that OMFS would be back on target by April.

In terms of the A&E target, performance for January was below the 95% target at 89.74% which was an improved position from January 2015 despite a 14% increase in attendances. AK advised that the latest national performance for January was 88.7%, which was the lowest since monthly data became available in August 2010. AK stated that work was ongoing with the team to look at improving the trajectory as this was linked to our funding. In particular the team was looking at flow as generally attendances at their highest were 440/450 but in the last week they had hit 511 on one day which was the highest number ever. AK stated that it was unclear as to what was driving demand but that we were working with partners to try and address this. AK advised however, that despite the increased attendances there had been no impact on incidents and patient safety. AK also informed Governors that the Trust had met all cancer targets with the exception of the 62 day standard. AK advised that the dips in performance were predominantly due to Urology and the volumes of cancers associated with this specialty. AK explained that the new national backstop policy meant that an RCA was undertaken for any patients over 104 days which we did already for any patient over 62 days. AK stated that whilst we benchmarked well nationally, a Trust level action plan was in place to improve performance.

AK also highlighted page 17 – discharge communications which was under the 90% target. AK stated that a lot of effort had gone into the IT solution to support the process but it did rely on junior doctors to do the discharge communication. MMcN commented that the left hand box related to the consequences of failure and general financial penalties but queried why there was no detail and if the performance was red did that automatically mean penalties. AK replied that the financial penalties and value would be in the report going forward.

MD commented on the deterioration in performance in Ophthalmology which was really unusual. AK replied that they had recovered but there was a general dip across all areas.

**Resolved**: To accept the report.

**Item 8 Information Governance Toolkit**

AJH presented the report which provided an overview of Information Governance and the IG toolkit. AJH explained that to achieve a green rating then all elements had to achieve a '2'.

AJH stated that within the Trust we had achieved 18 requirements at level 2 and 27 requirements at level 3.

Requirement 12 – 205 had reduced from a level 3 to 2 due to a change which stipulated 'service users are provided with online access to their electronic care records without charge' which we were currently unable to do.

Requirement 12 – 206 has increased to a level 3 due to the implementation of USB device control with the enforcement of encrypted memory sticks.

AJH explained that the information was discussed at the IG Steering Group and Corporate Governance Committee. Internal audit had independently assessed the evidence and had given a 'good' outcome in terms of their rating. The total percentage score for CHS was 86% and Church View Medical practice 89%.

The scores were predicted on the achievement of a 95% uptake for IG mandatory training and this currently stood at over 95% but it may well be that some staff members may trip over.

**Resolved**: To support the submission of the Information Governance toolkit on the 31st March 2016 on the information presented.

**Item 9 Governor Elections**

CH presented the paper which outlined the process to be undertaken for the forthcoming Governor elections. The term of office for the current Governors expires on 30 June 2016 and all Governors with the exception of Mandy Bates and Mary Pollard were eligible to stand for re-election should they so wish.

CH stated that the election rules which were attached were prescribed by Monitor and had been checked by the Elections Office at the Local Authority who were to undertake the elections on our behalf.

CH advised that the election would be held on 22 June 2016 but that two information sessions were being held in early May for any potential candidates and Governors were very welcome to attend

those events.

**Resolved:**

- To approve the election rules for elections to commence on 25 April 2016 and to conclude on 22 June 2016.
- To approve that the election process is managed and organised by the offices of the electoral team of the City of Sunderland Local Authority.

**MIKE DAVISON**
**Vice-Chairman/**
**Non Executive Director**

**CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST**

**CHAIRMAN & CHIEF EXECUTIVE'S OFFICE**

**COUNCIL OF GOVERNORS**

**JUNE 2016**

# SOUTH TYNESIDE & SUNDERLAND HEALTHCARE GROUP – MEMORANDUM OF UNDERSTANDING

The demand and financial pressures currently facing the NHS are unprecedented and organisations around the country are undertaking some form of transformation with many working in new partnerships to secure the sustainability of services.

Governors will recall that in late February the Trust announced its intention to form an alliance with South Tyneside NHS Foundation Trust and work together as 'South Tyneside and Sunderland Healthcare Group' on an ambitious programme of reconfiguration of services across South Tyneside and Sunderland in order to ensure that the local communities served by both Trusts will continue to receive high quality and sustainable hospital and community services in the future.

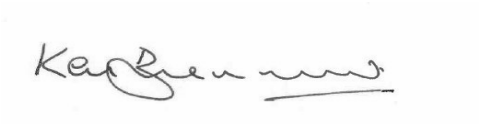
Both Trusts will continue to function as statutory NHS Foundation Trusts, accountable to their local communities through their Governors. Sitting aside the two Foundation Trusts will be a South Tyneside and Sunderland Healthcare Group Board and Executive Team who will govern the transformation and partnership working.

In order to provide an overarching framework for this collaboration a Memorandum of Understanding has been agreed by both Boards and signed by the two Chief Executives on behalf of the organisations. This can be found at Appendix 1.

The Memorandum of Understanding formally sets out the scope of the collaboration, how it will work, how performance will be measured as well as the governance arrangements for the Healthcare Group. Specifically it reiterates the responsibilities of the Councils of Governors of both Foundation Trusts in that they have a statutory duty to hold to account the Non-Executive Directors for the performance of the Foundation Trusts' Boards. To enable the Governors to do so in respect of the collaboration, the Councils of Governors of both Foundation Trusts will be engaged in the review of progress on both current proposals and in any significant policy changes affecting new collaborations.

**Recommendation**

Council of Governors is asked to note the Memorandum of Understanding, the signing of which signals the formal start of the commitment to transform the way services are delivered in South Tyneside and Sunderland with the shared vision of the Group of delivering nationally recognised high quality, safe, cost effective, sustainable healthcare.



**KEN BREMNER**
**Chief Executive**

NHS

City Hospitals Sunderland NHS Foundation Trust
South Tyneside NHS Foundation Trust

South Tyneside and Sunderland Healthcare Group

# MEMORANDUM OF UNDERSTANDING

## 1 THE AGREEMENT

This Memorandum of Understanding ("MoU") is entered into by City Hospitals Sunderland NHS Foundation Trust and South Tyneside NHS Foundation Trust, collectively the "Foundation Trusts".

This MoU will be managed collectively by a joint group called the 'South Tyneside and Sunderland Healthcare Group' made up of representatives from both Foundation Trusts which will have no statutory authority and be managed by the Group Board as further described in clause 8 (Role of Group Board).

This MoU commences on 28 April 2016 and subject to clause 11 (Termination) has an indefinite duration, subject always to annual review between the Foundation Trusts.

## 2 BACKGROUND

There is an unprecedented quality, efficiency and productivity challenge to the NHS as a result of growing demands upon its services and continuing public expenditure constraints.

This calls for a radical re-evaluation of all aspects of the work of NHS organisations, and the Foundation Trusts recognise the opportunities this presents for creating new delivery models for front line clinical services, clinical and non-clinical support services. Their mutual commitment is to collaborate where appropriate for the benefit of patients and communities served by each organisation in Sunderland and South Tyneside.

## 3 PURPOSE

To reflect the commitment described above, this MoU provides an overarching framework for closer working and/or formal collaborations between the Foundation Trusts, intended to bring mutual benefits to the quality, safety and patient experience across both Foundation Trusts. It will also bring mutual benefits to the productivity and efficiency of the healthcare services provided by them.

## 4 SCOPE OF COLLABORATIONS

The Foundation Trusts already work closely together in a number of areas. Upon the commencement of this MoU, the Foundation Trusts will develop a separate schedule of these areas and further specialties/services for future development (the "Clinical Review Programme"). The Clinical Review Programme will be reviewed and updated annually by the Foundation Trusts. The areas initially identified for potential collaboration include:

- Emergency Surgery;
- Trauma;
- Obstetrics & Gynaecology;
- Pharmacy;
- Stroke.

Other clinical and non-clinical services will be reviewed on a rolling programme during 2016/17 and beyond as part of the Clinical Review Programme.

The Foundation Trusts anticipate that future collaborations may take a number of forms. Examples are listed in appendix A.

The Foundation Trusts acknowledge that any collaboration may require formal due diligence, specific legal advice, and preparation and agreement of legal arrangements where this is indicated. The Foundation Trusts also acknowledge the ongoing need for careful examination of vires, procurement and competition law.

The Foundation Trusts may choose to broaden the reach of their activities, through any or all of the following means:

- offering of services to third party entities (whether public or private) –; and/or

- procurement by the Foundation Trusts of external partners, whether public or private, to facilitate the delivery of their joint objectives; and/or

- establishing a broader partnership, which other Trusts could join under the terms of appropriate legal agreements in order further to increase efficiencies, or to enhance the partnership's offer to third parties.

Any steps towards further collaborations will require the consent and positive engagement of the Foundation Trusts, which may or may not be given in the future at the absolute discretion of each of them. Specifically, the Boards of each Foundation Trust shall have primacy and all key decisions arising from actual or proposed collaborations will be reserved to them, supported by recommendations made by the Group Board as appropriate.

## 5 HOW WILL POTENTIAL COLLABORATIONS BE ASSESSED?

In deciding whether to enter into further collaborations, each Foundation Trust intends to consider whether the relevant service(s) will be stronger (of higher quality, more productive and more efficient) as a result of the collaboration than if they had continued to be provided separately. The Foundation Trusts' Boards will, before entering into further collaborations, consider the risks associated with doing so.

More specific indicators of success may include:

- Improved quality, pathways or access to care for patients and carers;
- Improved performance against national performance benchmarks and metrics against which both Foundation Trusts are assessed;
- Improving/improved financial position of both Foundation Trusts.
- Greater breadth and depth of clinical, scientific and managerial expertise by drawing upon the knowledge, skills and experience of staff from both Foundation Trusts;
- Greater resilience in service provision, as demonstrated by scale and staffing levels/rotas;
- Standardisation of practice in accordance with best published evidence;
- Closer integration of clinical service delivery and applied research in the areas of collaboration;
- Evidence of improvements in quality and range of teaching and research activities.

## 6 COMMITMENTS OF THE FOUNDATION TRUSTS UNDER THIS MOU

Regardless of whether the Foundation Trusts proceed to further collaboration, they intend to engage with each other openly on feasibility studies, development, delivery and evaluation of collaborative service delivery arrangements. Such collaborations may be driven by the joint or separate business needs of each Foundation Trust or by the actions of the clinical service commissioners. Open collaboration will include the sharing of all relevant data or information (subject to the Confidentiality Agreement defined in clause 9, and any necessary data sharing arrangements) to better inform a decision in support of the key success factors.

## 7 GOVERNANCE

Subsidiary to the Foundation Trusts' Boards, and specifically in accordance with the governance arrangements established for the collaboration between the Foundation Trusts, the South Tyneside and Sunderland Healthcare Group will meet regularly via the Group Board to review progress on current collaborations and, where appropriate, to specify/commission new ones.

In addition, specific governance arrangements appropriate to each future collaboration, which will define the decision making parameters and levels of authority, will be established to assume responsibility for the objectives and deliverables of that collaboration, and to account to the CEOs and Boards.

The Councils of Governors of both Foundation Trusts have a statutory duty to hold to account the Non-executive Directors for the performance of the Foundation Trusts' Boards. To enable the Governors to do so in respect of the collaboration, the Councils of Governors of both Foundation Trusts will be engaged in the review of progress on both current proposals and in any significant policy changes affecting new collaborations. Subject to the requirements of the Foundation Trusts' constitutions, the Councils of Governors will be asked to approve any proposals developed through the collaboration which would constitute a significant transaction.

The Foundation Trusts' Boards recognise the requirement for robust risk management arrangements in respect of the collaboration. The Boards will each undertake an appraisal of risks relating to the collaboration, which will be consistent with any relevant requirements from regulators, and they will put arrangements into place to ensure that risks are managed on an ongoing basis. The arrangements will include a regular review of risks by the Group Board, reporting to the Foundation Trusts' Boards so that they can monitor risk through the Foundation Trusts' existing risk management processes.

The Foundation Trusts recognise the duties in law and/or under the their Constitutions which their Executive and Non-executive Directors have in respect of conflicts of interests, ie to:

a) avoid situations in which they have, or can have, interests which conflict, or possibly may conflict, with the interests of the Trusts; and
b) to declare the nature and extent of any direct or indirect interests in transactions or arrangements with the Trusts.

The Foundation Trusts have in place arrangements to address conflicts of interests and will ensure that these are adopted in respect of the collaboration between the Trusts, including in respect of the Directors who will be members of the Group Board as defined in section 8 of this document. The Foundation Trusts' Boards will thereby ensure that no conflicts of interests prevent them from holding to account the Group Board or otherwise to monitor the collaboration.

In respect of conflicts of interests more generally, the Foundation Trusts will declare to each other the full particulars of any real or perceived conflict of interest which arises or may arise in connection with this MoU. Such declarations shall be made immediately upon becoming aware of the conflict of interest. Through these arrangements the Foundation Trusts will not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this MoU (without the prior consent of the other Parties) before participating in any action in respect of that matter.

## 8 ROLE OF GROUP BOARD

For practical purposes, the functioning of the South Tyneside and Sunderland Healthcare Group will be managed by a Group Board. The Group Board will comprise the Chairman (Chairman of South Tyneside NHS Foundation Trust), Deputy Chairman (Chairman of City Hospitals Sunderland NHS Foundation Trust), Chief Executive (Chief Executive of City Hospitals Sunderland NHS Foundation Trust), Deputy Chief Executive (Chief Executive of South Tyneside NHS Foundation Trust) and two Non-Executive Directors (one from each Foundation Trust).

The responsibilities of the Group Board will be defined in Terms of Reference to be approved by the Boards of both Foundation Trusts. The Foundation Trusts' Boards will specify the authority delegated to the members of the Group Board, which will be recognised in the Foundation Trusts' Schemes of Delegation (or similar) as appropriate. The Foundation Trusts' Boards will also specify their requirements for reports from the Group Board, and in respect of the collaboration generally, so that they can fulfil their responsibilities.

The role of the Group Board does not undermine the primacy or legal standing of the individual Foundation Trust Boards, and will not be able to bind the Foundation Trusts' Boards contrary to their instructions or authority delegated to the members, but will provide a management function to support decisions around the collaborative working arrangements. Specifically, the Group Board will ensure the delivery of this MoU and will oversee the delivery of:

- Joint strategic plans encompassing the Sunderland and South Tyneside planning footprint including supporting the development of the Sunderland and South Tyneside component of the 5 year Sustainability and Transformation plan on behalf of both Foundation Trusts;
- Consult and recommend to the respective Boards on any proposed major capital investment decisions above £1m with the intention to coordinate any capital expenditure plans of the Foundation Trusts where the Foundation Trusts are considering similar investments/plans;
- Managing the transition towards a common management team recognising that the Boards of each Foundation Trust still retain their statutory responsibility for their respective Trusts, including separate Accounting Officers.
- Manage the alignment towards:
    - Common principal operational policies and operating models;
    - Common workforce control processes including recruitment, retention and organisational development;
    - An IM&T approach to support a common operational model of services across the two Foundation Trust where appropriate;
    - A consistent approach to Standing Financial Instructions/Standing Orders;
- Produce and publish a short annual overview of the South Tyneside and Sunderland Healthcare Group’s activities and performance for the year.

- Support the appointment process for any external advisors/auditors, subject where relevant to the responsibilities of the Foundation Trusts' Audit Committees and Councils of Governors;
- Manage a shared risk and benefit approach to support the implementation of any agreed clinical or support service changes;
- South Tyneside and Sunderland Healthcare Group overview of the key performance aspects of each respective organisation, particularly those that are related to delivery of the 5 year Sustainability and Transformation Plan, and the associated transformation funding which is linked to the achievement of these performance aspects;
- A Communications strategy to engage with patients, residents, staff and partner organisations as appropriate to support the aims of the South Tyneside and Sunderland Healthcare Group.

## 9 CONFIDENTIALITY

The Foundation Trusts have entered into a confidentiality agreement dated 28 April 2016 in relation to their obligations for the mutual exchange of certain information strictly for the purposes of the potential collaborations under this MOU ("Confidentiality Agreement").

## 10 DISPUTE RESOLUTION

Every effort will be made to resolve disputes through the established Programme/Project structures established for each collaboration. Should such efforts prove unsuccessful, the Strategy and Business Development leads will attempt second line resolution. Any unresolved issues will be escalated to the CEOs and where appropriate reported promptly to both Foundation Trust Boards and the South Tyneside and Sunderland Healthcare Group Board.

If either Foundation Trust receives any formal inquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the potential collaborations, the matter shall be promptly referred to the Group Board.

## 11 TERMINATION

In the unlikely event that this MoU will require termination, but if at any time either Foundation Trust does wish to exit the MoU, then it can be terminated by 6 months' notice in writing addressed to the Chief Executive Officer of the other Foundation Trust. This termination notice must clearly set out the reasons for any such termination.

For individual collaborations, the MoU will partially terminate in respect of the individual collaboration only in accordance with the separate documents in place which will detail the specific arrangements between the Foundation Trusts in respect of that particular collaboration, and the MoU will continue in respect of the other service collaborations.

## 12 LEGAL STATUS

Notwithstanding the good faith consideration that each Foundation Trust has afforded the terms set out in this MoU, this MoU shall not be legally binding and neither Foundation Trust will seek redress through any legal process.

## 13 GENERAL

### Variation

This MoU, may only be varied by written agreement of the Foundation Trusts signed by, or on behalf of, each of the Foundation Trusts.

### Charges and liabilities

Each Foundation Trust will bear its own costs and expenses incurred in complying with its obligations under this MoU, including in respect of any losses or liabilities incurred due to its own or its employee's actions.

Neither Foundation Trust intends that the other Foundation Trust shall be liable for any loss it suffers as a result of this MoU.

### No partnership

Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the Foundation Trusts, constitute either Foundation Trust as the agent of the other Foundation Trust, or authorise either Foundation Trust to make or enter into any commitments for or on behalf of the Foundation Trust.

### Signatories

**AGREED by the Parties:**
Signed by the Chief Executive on behalf of the Board of the following:

City Hospitals Sunderland NHS Foundation Trust

**Ken Bremner**
**Chief Executive**

Dated: 28 April 2016

South Tyneside NHS Foundation Trust

**Steve Williamson**
**Chief Executive**

Dated: 28 April 2016

## Appendix A

Examples of forms of collaboration:

- Full integration of clinical services to create Sunderland and South Tyneside-wide services that are jointly governed by the Foundation Trusts; and/or

- Either Foundation Trust providing services to the other under the terms of a contract or service level agreement; and/or

- Shared services arrangements(s) for clinical or non-clinical support services, with the Foundation Trusts carrying out one or more functions jointly under joint governance arrangements; and/or

- The Foundation Trusts delegating functions to each other which may include, but is not limited to, the sharing of staff and creation of joint roles; and/or

- The creation of companies or other legal entities to pursue their mutual objectives.

**CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST**

**CHAIRMAN & CHIEF EXECUTIVE'S OFFICE**

**COUNCIL OF GOVERNORS**

**JUNE 2016**

# SOUTH TYNESIDE & SUNDERLAND HEALTHCARE GROUP – VISION, AIMS AND VALUES

To support and reinforce the commitment of the alliance between City Hospitals Sunderland NHS Foundation Trust and South Tyneside NHS Foundation Trust through the South Tyneside and Sunderland Healthcare Group, the two respective Board of Directors have agreed a joint Vision, Values and Aims.

The purpose of these statements is to set out the Group's goals and aspirations clearly and concisely. A vision statement is intended to inspire and motivate teams by providing a picture of where the group is heading, whilst also providing a focus for those who are leading on the reconfiguration of services (be that clinical or non-clinical) so that emerging models are in keeping with the vision, the values and the aims.

Both City Hospitals Sunderland NHS Foundation Trust and South Tyneside NHS Foundation Trust have well used and established visions which have been used to come up with the attached (Appendix 1) which are in line with the ethos of the two separate organisations whilst setting out the aspirations of the Group.

In addition, the work of the Group will be branded "*The Path to Excellence"* which is the Mission Statement of the Group.

**Recommendation**

Council of Governors is asked to note the Vision, Values and Aims of the South Tyneside and Sunderland Healthcare Group.

**KEN BREMNER**
**Chief Executive**

City Hospitals Sunderland NHS Foundation Trust
South Tyneside NHS Foundation Trust

South Tyneside and Sunderland Healthcare Group

# VISION, VALUES & AIMS

Appendix 1

*The path to excellence*

# OUR VISION

To deliver nationally recognised high quality, cost effective, sustainable healthcare for the people we serve with staff who are proud to recommend our services to friends and families.

**“The path to excellence”**

# AIMS

- To provide a wide range of high quality, safe and accessible healthcare services
- To ensure financial performance provides value for money
- To recruit, retain and motivate skilled and compassionate staff who are proud to act as ambassadors of the services they provide
- To be the employer of choice in the North East of England
- To listen, learn and innovate

# VALUES

- Compassionate and dignified, high quality, safe patient care always the first priority
- Working together for the benefit of our patients and their families or carers
- Openness and honesty in everything we do
- Respect and encouragement for our staff
- Continuous improvement through research and innovation

ENCLOSURE 4

**CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST**

**DEPARTMENT OF STRATEGY AND BUSINESS DEVELOPMENT**

**COUNCIL OF GOVERNORS**

**JUNE 2016**

# SOUTH TYNESIDE & SUNDERLAND HEALTHCARE GROUP – CLINICAL SERVICES REVIEW GROUP – TERMS OF REFERENCE

To ensure the delivery of successful transformation of services through the work of the South Tyneside and Sunderland Healthcare Group, a Clinical Services Review Group has been formed to oversee the review of current service models and configuration and recommend where appropriate future models to deliver safe, sustainable and high quality care.

The Group is Co-Chaired by the Medical Director from South Tyneside NHS Foundation Trust and the Director of Strategy and Business Development at City Hospitals Sunderland NHS Foundation Trust and membership is made up of individuals from both Trusts as well as Clinical Commissioning Groups in South Tyneside and Sunderland

Terms of Reference (Appendix 1) have been developed which describe the purpose and scope of the Group as well as the reporting structure. Indicative timescales for the clinical service review projects are also noted within the document with an indication of potential consultation phases.

## Recommendation

Council of Governors is asked to note the Terms of Reference for the Clinical Services Review Group.

**PETER SUTTON**
**Director of Strategy & Business Development**

Appendix 1

City Hospitals Sunderland NHS Foundation Trust
South Tyneside NHS Foundation Trust

South Tyneside and Sunderland Healthcare Group

# CLINICAL SERVICE REVIEW GROUP
# MAY 2016

## 1 Group Purpose

- To review existing clinical services and make recommendations to the 'South Tyneside and Sunderland Healthcare Group' on the future configuration of services.

- Develop a strategic plan in relation to clinical services that covers the populations of South Tyneside and Sunderland and the organisations of STFT and CHSFT.

## 2 Role/Function/Duties

- Review current service model/configuration and recommended where appropriate a future model/configuration that:
  - Achieves relevant quality/safety standards and delivers all regulatory requirements
  - Delivers a sustainable service – workforce, population, competencies
  - Ensures the service(s) are efficient and cost effective
  - Takes into account and where possible addresses local, regional and national issues
- To produce a review timetable and ensure reviews are completed within the agreed timescales, ensuring blockages are removed where appropriate
- To produce and ensure the delivery of a communication and engagement plan (where applicable) that supports any service change, covering both internal and external stakeholders
- To facilitate discussions as part of the review process between teams to support implementation of agreed models of care
- Reviews all associated major risks and recommends mitigating actions.

## 3 Membership & Appointment

- Medical Director (STFT) – Joint Chair
- Executive Director of Strategy and Business Development (CHSFT) – Joint Chair
- Director of Operations (CHSFT)
- Chief Operating Officer (STFT)
- Director of Nursing (STFT)
- Director of Finance (CHSFT)
- Programme Manager (PG)
- Communication and Engagement Lead (CHSFT)
- Director of HR (CHSFT & STFT)
- Finance and Analyst Support (TBC)
- Commissioner lead(s)

The relevant clinical and management leads for each service will be heavily involved in their respective review and will present their recommendations to the group, but they will not be formal members of the group.

## 4 Detail - Service Reviews

All reviews will be approached from a 'group' and total population perspective, not individual organisations and will cover the following as a minimum. More details of the type of information contained in the report is included as Appendix 1.

- Current service model
- Proposed service model
- Quality/Safety benefits
- Learning from other organisations
- Financial benefits
- Performance impact
- Capacity requirements and demand predictions (high level)
- Capability to deliver the service change
- Other benefits - Sustainability
- Risks and mitigating actions
- Proposed Engagement Plan
- Commissioner and Network support
- Wider group issues to consider
- Declarations of Interest

## 5 Arrangements for the Conduct of Business

- Quorum: Four members, one of whom has to be the joint Chair, plus a representative from STFT and CHSFT
- Frequency of meetings: Monthly
- Members should be in attendance for at least 75% of meetings.
- Where urgent matters arise between meetings these will be raised with the Chairs of the group for approval and discussed with other members of the group at the first opportunity.
- Secretariat support: Joint Chairs

## 6 Relationships & Reporting

- Monthly report to the Executive Group

## 7 Proposed Timescale

It is proposed that the review of clinical services is undertaken in phases, with relevant time allocated for consultation.

| Phase 1 | Phase 2 | Phase 3 | Phase 4 | Phase 5 | Phase 6 |
|---|---|---|---|---|---|
| Stroke (May 16) | Paediatrics (Sep 16) | Diagnostics (Dec 16) | Cardiology (Apr 17) | Emergency Care (Jul 17) | Diagnostics (Dec 17) |
| Pharmacy (partial) (May 16) | Elective Surgery- including endoscopy (Sep 16) | Anaesthetics/ Theatres (Dec 16) | Gastroenterology (Apr 17) | Critical Care (Jul 17) | Therapy Services (Dec 17) |
| Trauma & Orthopaedics- including Orthogeriatrics | Increasing delivery of elective work at STFT, e.g. | Pharmacy (full) (Dec 16) | Respiratory (Apr 17) | Acute Medicine (Jul 17) | Support Services (Dec 17) |

| Phase 1 | Phase 2 | Phase 3 | Phase 4 | Phase 5 | Phase 6 |
|---|---|---|---|---|---|
| (May 16) | ophthalmology (Sep 16) | | | | |
| Emergency Surgery (Jun 16) | | Therapy Services (Dec 16) | Diabetes (Apr 17) | | |
| Obstetrics (maternity) & Gynaecology (Jun 16) | | | Care of the Elderly (Apr 17) | | |
| | | | Specialist Rehab (Apr 17) | | |

This list covers the core clinical services provided by both CHS and STFT. As the review programme progresses there may be other services that are considered as part of this review process and also some of the timescales may change where there is an impact from another service review.

## Appendix 1: Details to be included in the Service Review reports

| Report section | Details of what will be included |
|---|---|
| **Current Service Model** | - Current activity levels.<br>- Where the activity is delivered *e.g. bed/ward footprint, outpatient facilities used.*<br>- Workforce models including *medical, nursing, AHPs and other associated staff*. |
| **Proposed Service Model** | - Description of the new service model(s).<br>- Outline changes in where the care will be delivered from and what that would mean for current service footprint/facilities.<br>- Details of any proposed changes in workforce numbers and skill mix. |
| **Quality and Safety Benefits** | - Evidence base for the choice of the proposed model(s).<br>- Learning from other organisations/networks who have carried out similar changes.<br>- Impact on service specific quality standards *e.g. SSNAP levels for Stroke.*<br>- Any known impact on clinical outcomes.<br>- Any known patient experience considerations in relation to the new model(s). |
| **Performance impact** | - Highlight any potential impact on performance metrics including: RTT, A&E 4 hours, 6 weeks diagnostics & Cancer waiting time targets. |
| **Financial Benefits** | - Outline any changes in relation to income or costs from the proposed changes. *E.g. Stroke; reduced locum spend and potential bed reductions.* |
| **Capacity requirements and demand predictions** | - Re-modelled bed numbers.<br>- Highlight what impact the proposal would have on total Consultant PAs (for that service).<br>- Any changes in Length of stay that can be modelled e.g. *impact of ESDT for Stroke.* |
| **Key co-dependencies to consider** | - What the proposed model change will mean for diagnostic capacity, *e.g. CT/MRI activity changes for Stroke, Trauma and Emergency Surgery.*<br>- Quantify the impact on A&E, Theatres , Critical Care and NEAS<br>- Highlight any critical co-dependent clinical services, *e.g. there should be co-located Critical Care for any unselected take (even if only medical).*<br>- Highlight non-clinical co-dependencies such as IT, Estates and Transport. |
| **Capability for the service to change** | - To confirm or not:<br>1. There is strong clinical agreement on the proposed change,<br>2. There is managerial commitment to make the changes,<br>3. There aren't any insurmountable gaps that will stop successful implementation. E.g. insufficient physical capacity or significant investment required.<br>4. Whether commissioners support the proposed change. |
| **Any other benefits (sustainability)** | - Highlight any changes that may improve sustainability of the service, e.g. the need for less MG level doctors in pressurised service areas (if applicable). |

| | |
|---|---|
| **Risks and mitigating actions** | - Highlight the high level risks and any mitigating actions, e.g. Length of Stay reduction work in both organisations to mitigate any bed reduction and associated capacity risks. |
| **Proposed engagement plan** | - The engagement plan will be specific to each service area and will outline:<br>1. Who are the stakeholders?<br>2. What are we telling them? (and what is important to them)<br>3. How are we going to engage with them? (delivery mechanisms and different interventions)<br>4. When to engage with the different stakeholders? (plan and timetable) |
| **Commissioner and network support** | - Summary of what guidance has been given by local/national commissioners and if there is clinical network support for any changes. E.g. Stroke; Commissioners are agreed that all Acute Strokes should go to CHS and this has been supported by the network in terms of the proposal that there should be 6 HASUs across the NE and Cumbria region.<br>- Include advice from HENE/Deanery in terms any potential movement of trainees. |
| **Wider group issues to consider** | - Does the proposal(s) fit in with the overall vision for the Group?<br>- Does the favoured proposal have any impact on the review timetable? |
| **Declarations of Interests** | - Include any declarations of interest in terms of the clinical/managerial leads carrying out the service review. |

**CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST**

**HUMAN RESOURCES DIRECTORATE**

**COUNCIL OF GOVERNORS**

**JUNE 2016**

# 2015 NHS STAFF SURVEY RESULTS

## INTRODUCTION

This paper summarises the Trust's results from the 2015 NHS Staff Survey and recommends areas for action for Executive Committee to consider.

The 2015 NHS Staff Survey, which was carried out between September and December 2015, involved 297 NHS organisations in England. Over 741,000 NHS staff were invited to take part using a postal questionnaire or via online survey. 299,000 NHS staff responded (an NHS response rate of 41%, compared to 42% in 2014).

850 CHS staff were randomly selected and invited to take part via online survey. 264 staff responded (a Trust response rate of 31% compared to 39% in 2014).

## OVERVIEW OF SURVEY RESULTS

Overall our survey results are positive, with some significant improvements, particularly on some of the 'Your Job' and 'Your Manager' questions / scores.

Areas that need further attention are appraisal coverage and effectiveness, reporting of incidents of harassment, bullying and abuse and using feedback from patients / service users to make decisions.

The table below shows the scores for Qs21a, c and d, which feed into Key Finding 1 - *"Staff recommendation of the organisation as place to work or receive treatment".*

| Question | CHS 2015 | Average for acute trusts | CHS 2014 |
|---|---|---|---|
| 21a - Care of patients/service users is my organisation's top priority. | 71% ↔ | 75% | 71% |
| 21b - My organisation acts on concerns raised by patients / service users. | 75% ↔ | 73% | 75% |
| 21c - I would recommend my organisation as a place to work. | 63% ↑ | 61% | 61% |
| 21d - If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation. | 70%↑ | 70% | 65% |
| KF1 - Staff recommendation of the organisation as a place to work or receive treatment. | 3.78↑ | 3.76 | 3.71 |

**Your Job**
The scores in this section of the survey are generally positive with some scores improving significantly and most being above average levels for the sector. Some of the most improved scores include:

- Staff saying that they look forward to going to work (up from 50% last year, to 60% this year)
- Staff saying that they feel enthusiastic about their job (up from 68% last year, to 75% this year).
- **Overall Staff Engagement score, which is above average (3.84) compared to other acute trusts (3.77) and up from last year's 3.73.**
- Staff saying that they are satisfied with the quality of care they give and are able to deliver the care that they aspire to, are both in the top 20% of scores in the sector.

**Your Managers**
There are some positive scores in this section of the survey, with a number in the top 20% for the sector, including:-

- Staff agreeing that immediate managers ask their opinion before making decisions, which affect their work (up from 47% last year, to 54% this year)
- Staff saying that their immediate manager is supportive in a crisis (up from 71% last year, to 77% this year.

In addition, the senior manager scores are very positive, some of which are in the top 20% for the sector, including:-

- Staff agreeing that communication between senior managers and staff is effective (up from 37% last year, to 45% this year)
- Staff agreeing that senior managers involve them in important decisions (up from 27% last year, to 34% this year).

**Your Health and Well-being**
The scores in this section are generally very positive.

- The percentage of staff who said they had felt unwell due to work-related stress is below average (29%, compared to 36% acute trust average).
- The number of staff who say they have attended work despite feeling unwell has fallen (down from 60% last year, to 46% this year).
- The percentage of staff saying they had experienced muscular-skeletal problems is average at 25%.

**Personal Development**
Most of the scores on training are around average for the sector, e.g.:-

- Staff agreeing that the training they received helped them do their job more effectively is average (82%).
- Coverage of appraisals is down a little since last year (85%, compared to 89% last year).
- Staff agreeing that their appraisal helped improve how they did their job is above average (73%, compared to 68% average); however other scores on effectiveness are below average, e.g. staff saying that they identified training and development needs in their appraisal (59%, compared to 66% average).

**Your Organisation**
The scores in this section have changed slightly since last year and are around average for the sector.

- Staff saying they would recommend the Trust as a place to work is up slightly from 61% last year, to 63% and above the acute trust average of 61%
- Staff saying they would be satisfied with the quality of care if a friend or relative needed it is up from 65% last year, to 70% (average for the sector).
- There has been a significant decline in the number of staff saying that their department regularly updates them on patient feedback (down from 73% last year, to 60%) and on staff agreeing that patient feedback is used to make informed decisions (down from 65% last year, to 55%).

## TOP AND BOTTOM KEY FINDINGS

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

1. KF18 – Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell (46% compared to 59% for the sector)

2. KF23 – Percentage of staff experiencing physical violence from staff in the last 12 months (0% compared to 2% for the sector).

3. KF 16 - Percentage of staff working extra hours (63% compared to 72% for the sector).

4. KF15 – Percentage of staff satisfied with the opportunities for flexible working patterns (57% compared to 49% for the sector).

5. KF8 – Staff satisfaction with the level of responsibility and involvement (4.01 compared to 3.91 for the sector).

The 3 Key Findings where **staff experience has improved the most** since the 2014 survey are:-

1. KF18 – Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell (46% compared to 59% for the sector).

2. KF4 – Staff motivation at work (3.94 compared to 3.80 for the sector).

3. KF6 – Percentage of staff reporting good communication between senior management and staff (36% compared to 28% for the sector).

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

1. KF24 – Percentage of staff / colleagues reporting most recent experiences of violence - *the higher the score the better*, (50% compared to 53% for the sector).

2. KF27 – Percentage of staff / colleagues reporting most recent experiences of harassment, bullying or abuse - *the higher the score the better*, (34% compared to 37% for the sector).

3. KF11 – Percentage of staff appraised in last 12 months (84% compared to 86% for the sector).
4. KF4 – Staff motivation at work (3.94 the same as the national average for acute trusts). ***Note – this score has improved from 3.79 last year.***

***5.*** KF28 – Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (31% the same as the national average for acute trusts). ***Note – this score has improved from 32% last year.***

**NB: - There were no statistically significant negative changes in the Key Findings since the 2014 survey.**

## OVERALL STAFF ENGAGEMENT

The table below shows how we compare 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, their team and their trust) and 5 indicating that staff are highly engaged.

| | |
|---|---|
| Trust score 2015 | **3.84** |
| Trust score 2014 | **3.73** |
| National 2015 average for acute trusts | **3.79** |

The trust's score of 3.84 was above (better than) average when compared with trusts of a similar type.

## 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 summarised below. Comparison with last year's results, shows relatively stable / positive scores and little deviation between us and other acute trusts.

| **% of staff satisfied or very satisfied with the following aspects of their job** | **CHS 2015** | **Average for acute trusts 2015** | **CHS 2014** |
|---|---|---|---|
| Q5b - The support I get from my immediate manager | 68% | 66% | 66% |
| Q5c - The support I get from my work colleagues | 80% | 80% | 79% |

## WORKFORCE RACE EQUALITY STANDARDS

All NHS organisations are required to demonstrate through the Workforce Race Equality Standard (WRES), 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.

Overall there are nine indicators that make up the NHS WRES. These comprise workforce indicators (1 – 4), Staff Survey Indicators (5 – 8) and an indicator focused on board representation.

Where the respondent group in the Staff Survey is 11 or more, the Standard compares the responses from White and BME staff for each survey question – see table below for details.

| Question / Key Finding | CHS 2015 results (White) | CHS 2015 results (BME) |
|---|---|---|
| KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. | 25% | 29% |
| KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. | 20% | 27% |
| KF21. Percentage believing that trust provides equal opportunities for career progression or promotion. | 89% | 75% |
| 17b. In the last 12 months have you personally experienced discrimination at work from managers, team members / other colleagues? | 7% | 21% |

## RECOMMENDATIONS

Executive Committee is asked to consider the following recommended actions and identify an Executive Lead to address those areas where our survey results compare least favourably with last year and/or against other acute trusts in England.

1. **Your Health and Well-being**
   Our score for staff reporting incidents of harassment, bullying and abuse has fallen by 6% (from 40% to 34%) and the score for staff reporting incidents of violence has remained static at 50%. The latter score is below the acute trust average of 53% and significantly below the best score for acute trusts of 72%.

***Recommended Action:*** *Improve awareness of the need to report incidents of violence, harassment, bullying and abuse and ensure that staff know how to do this / who they can speak to / contact for advice and support.*

2. **Personal Development**
   Coverage of appraisals is down since the last survey (85% compared to 89% last year). Staff agreeing that their appraisal helped improve how they did their job is above average (73% compared to 68% average) however other scores on effectiveness are below average, e.g. staff saying that they identified training and development needs in their appraisal (59% compared to 66% average).

***Recommended Action:*** *Check / audit the coverage of appraisals particularly amongst hard to reach groups and take steps to increase coverage and to monitor the provision of appraisals.*

***Recommended Action:*** *Assess the way in which appraisals are conducted to ensure staff feel their work is valued and improve their usefulness in identifying training, learning* and development needs.

3. **Your Organisation**
   There has been a significant decline in the number of staff saying that their department regularly updates them on patient feedback (down from 73% last year, to 60% this year) and on staff agreeing that patient feedback is used to make informed decisions (down from 65% last year, to 55% this year).

***Recommended Action:*** *Ensure that patient experience data, which highlights staff/ work/ areas that are positive (and should be celebrated and those that require improvement are regularly shared with staff as well as areas for improvement. Ensure that staff at all levels are involved in improvement work where appropriate and have responsibility for maintaining the momentum of positive change.*

4. **Workforce Race Equality Standards**
   Indicators 5 and 6 show that, according to the National NHS Staff Survey, BME staff are more likely to report bullying and harassment from relatives/service users and from other staff members.

   Indicator 7 shows that, according to the National NHS Staff Survey, BME staff are less likely feel that the Trust offers equal opportunities in career progression.

   Indicator 8 shows that, according to the National NHS Staff Survey, BME staff report that they are more likely to have suffered discrimination by managers, team members or other colleagues.

***Recommended Action:*** *Ensure that our response to to the nine standards is published and key areas of focus in relation to WRES for the coming year are identified, including equity within our recruitment process, with particular emphasis on the face to face interview and make up of interview panels, protocols for identifying and addressing bullying, harassment and discrimination concerns are reviewed and a range of communication opportunities are developed for hearing from BME staff and sharing learning.*

**Kathleen Griffin**
**Director of Human Resources**

ENCLOSURE 6

**CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST**

**COUNCIL OF GOVERNORS**

**JUNE 2016**

# 2016 GOVERNOR ELECTIONS UPDATE

## Background

The Trust is currently holding an election for all elected Governors whose current term of office expires on 30th June 2016.

The election is being managed and organised by the offices of the electoral team of the City of Sunderland Local Authority.

The publication of the notice of election was 25 April 2016 and the final day for delivery of nomination papers to the returning officer was 12th May 2016.

## Current Status

Patients Constituency
There are four candidates for two Governor positions

Public Constituency - Sunderland
There are 12 candidates for seven Governor positions

Public Constituency - North East
There were only two nominations for the two Governor positions and therefore Danny Cassidy and Ruth Richardson were automatically re-elected

Staff Constituency - Clinical Class
There are three candidates for two Governor positions

Staff Constituency - Medical & Dental
There are two candidates for one Governor position

Staff Constituency - Other
There are four candidates for two Governor position

## Next Steps

The ballot papers for each of the constituencies will be issued on 1st June 2016 and individuals will need to have made their vote either by returning it to Electoral Services at the Civic Centre or by using the ballot box at Trust Headquarters by no later than 5:00 pm on Wednesday 22nd June 2016.

The votes will be counted in the Refectory in the Education Centre at 6:00 pm on 22nd June 2016.

**Recommendation**

Governors are asked to accept the report and to note the automatic re-election of Danny Cassidy and Ruth Richardson to the Public Constituency – North East.

**CAROL HARRIES**
**Trust Secretary**