CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

TUESDAY, 5 JUNE 2018 - 10:00 AM
HOUGHTON LIBRAY, HOUGHTON

AGENDA

Item 1	Declaration of Interest		
Item 2	Minutes of the meeting held 27 March 2018	Enc 1	*Ken Bremner* *Chief Executive*
	Matters Arising		
	Item 4 Path to Excellence		*KWB*
	Item 7 CQC Inspection		*KWB*
Item 3	Chief Executive's Update	Verbal	*Ken Bremner* *Chief Executive*
Item 4	Dementia Strategy	Enc 2	*Louise Burn* *Deputy Director of Nursing* *& Patient Experience*
Item 5	Risk Management Strategy	Enc 3	*Fiona Kay* *Head of Corporate Risk*
Item 6	Quality Strategy	Enc 4	*Diane Palmer* *Assistant Director Of Nursing* *(CHSFT & STFT)*
Item 7	CHS FT Staff Survey Results	Enc 5	*Kath Griffin* *Director of Human Resources* *& Organisational Development*

Date and Time of Next Meeting
Thursday, 13 September 2018 – Annual General Meeting
Tuesday 20 November 2018 at 10:0am – The Robinson Suite, The Glebe Centre, Murton

ENCLOSURE 1

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

Minutes of the meeting of the Council of Governors held in public on Tuesday, 27 March 2018.

Present:
John Anderson (JNA) - Chair
Jackie Burlison (JB)
Danny Cassidy (DC)
Chris Colley (CC)
John Dean (JD)
Lindsey Downey (LD)
Carol Harries (CH) – Trust Secretary
Tom Harris (TH)
Liz Highmore (LH)
Michael McNulty (MMcN)
Susan Pinder (SP)
Gillian Pringle (GP)
Ruth Richardson (RR)
Pauline Taylor (PT)

In Attendance:
Ken Bremner (KWB)
Jim Carroll (JC)
Melanie Johnson (MJ)
Alison King (AK)
Gavin McPake (GMcP)
Peter Sutton (PS)
Alan Wright (AW)

Apologies:
Sue Cooper (SC)
Margaret Dobson (MD)
Kay Hodgson (KH)
Shahid Junejo (SJ)
Cllr Graeme Miller (GM)

Item 1 **Declaration of Interest**

None.

Item 2 **Minutes of the meeting of the Council of Governors held in public on Tuesday, 16 January 2018**

Accepted as a correct record except to amend Pat Taylor to Pauline Taylor.

Item 3 **Matters Arising**

End of Life Workshop – MMcN stated that CH had kindly arranged a workshop for Governors to receive an overview of the Trust's approach to End of Life Care. He had recently attended a PCPEC meeting where a bereavement survey had been shared and he felt that this might be useful for other Governors to have sight of before the workshop. CH advised that she would circulate copies.

Item 4 **Chief Executive's Update**

Medical School – KWB advised that the University of Sunderland had become one of five additional medical schools. The process to become a medical school had started in 2016 and the first students would commence in October 2019. There would be 50 places in year one and a further 50 the following year. The main theme of the school was to identify and support general practice and psychiatry in particular. KWB stated that when graduates started to come out it would be important to keep them in the city and the North East if at all possible. Sunderland itself needed to promote housing etc. and the University was already in discussion with the Local Authority so that hopefully successful students worked, lived and spent their disposable income in the city. KWB also advised that there would be the opportunity for more clinical placements within the Trust.

The Chairman commented that we should not underestimate the importance of the Medical School and it was a great vote of confidence for both the University and the Trust. MMcM stated that staffing a medical school would take a long time. He also suggested that the old Vaux site would have made a wonderful medical school and queried whether a site was identified.

KWB replied that the University already had capacity on their existing site and could grow incrementally. The University was also holding interviews the following week for the post of Dean of the Medical School – other posts would follow soon after.

RR also queried whether the clinical placements would be mainly based South of Tyne. KWB replied that Teesside had not supported the medical school in Sunderland because of the loss of the campus in Teesside. North Tees, Northumbria, Newcastle, Durham, South Tyneside and ourselves had all supported the bid as had all the CCGs.

NHS Pay Award – KWB informed Governors that a new framework agreement for A4C staff had been released. The unions were now consulting until the end of May but it was hoped that there was already broad agreement. The award would be implemented from 1 April 2018

and was a three year deal – it would substantially increase starting salaries and remove a number of pay points. In effect it would take staff less time to get to the top of the bands. Higher pay bands may receive some sort of performance related pay but that wa not yet clear. KWB stated that overall the pay award was 6.5% and phased over three years.

It had been stated that the pay award was fully funded but we were yet to see how that would work through. KWB commented that staff were generally pleased and there was a national recognition that staff are our greatest asset.

SP queried whether there would be an impact on overtime. KWB replied that there were some changes involved but it was difficult to estimate at the moment but clearly it would have an impact.

Path to Excellence – KWB advised Governors that the joint Health and Overview Scrutiny Committee were likely to refer the first stage process of the clinical service reviews to the Secretary of State. There would have to be an attempt at mediation between the Local Authority and the CCGs before that referral could be made. The referral could then go to the Independent Review Panel of NHS England in the North East. KWB stated that the two Trusts and the two CCGs were reasonably confident that the process which had been undertaken was very robust. KWB advised that there was still fragility in the service regarding manpower, and action may have to be taken to maintain safety.

Phase 2 of the clinical service reviews had already commenced and there was greater involvement with staff earlier in the process. There wold also be a checkpoint step over the summer to reflect back on the process to date.

JD commented that clearly lessons had been learned from the previous consultation process as obviously staff had been concerned but those concerns had been taken on board.

KWB replied that it was important to differentiate between consultation and engagement as the two processes were very different – the formal consultation process had given every member of staff the opportunity to give a view.

Winter Pressures – KWB thanked all 5,000 staff for the work they had undertaken during very challenging conditions – many remaining beyond the end of their shift and others staying overnight to ensure that they were able to get on duty the next day. KWB stated that the Trust was still busy and our ED performance was coming under national scrutiny. We were also seeing a greater number of patients arriving after midnight.

MCP – KWB informed Governors that all providers were uncomfortable with the approach being taken by Sunderland CCG with a planned tendering exercise. KWB advised that Peter Sutton and colleagues had had various discussions with the CCG outlining ours, and others concerns and as a consequence an alliance agreement had been put together that would hopefully deliver the desired outcomes. The CCG had however, expressed the right to go out to tender if it was felt that the alliance agreement was not working. It was anticipated that the new system would go live in April 2019. JD commented that the new solution was much better and in his opinion the hospital should lead the process to control flow.

Item 5 **Finance Report**

GMcP presented the report and advised that the overall operational financial position including STF was a net deficit of £7,879k against a planned deficit of £5,499k, and therefore £2,380k behind plan.

GMcP stated that the net deficit of £7,879k included income for £419k as part of the 2016/17 STF funding post accounts reconciliation, plus £5,173k STF for achieving the financial control total for quarters 1, 2 and 3, plus performance targets for Q1 and 2 of this financial year.

The position also included £267k benefit on donated asset income less costs. Therefore the Trust position compared to the control total excluding required adjustments was £13,737k deficit compared to a planned deficit of £12,579k, therefore £1,158k behind plan.

At the end of January CIP delivery was £136k ahead of plan and this was expected to be sustained.

GMcP highlighted that discussions with Commissioners had continued positively and it was expected that the Trust would be about £1.8m better than expected.

In terms of non-pay this was overspent by £4,396k at the end of January. MMcN queried whether the closure of a CT machine had had any impact. GMcP replied that he was not aware of any adverse impact. JD queried the offsite reporting for diagnostic reporting. GMcP replied that it was an external company but that we were looking at ways to be able to do all reporting in-house.

GMcP also highlighted the cash position and advised that because of receiving some STF funding cash was expected to be around £4.5m and the further that we could go then it was much better for us as we would potentially receive more STF funding. GMcP advised that we would be managing expenditure closely over the next few days.

GMcP also stated that the best case scenario also assumed a VAT refund from HMRC of £926k relating to a number of capital schemes

transferred from CHS to CHoICE that became eligible for a Capital Goods Scheme relief. JD queried as to what was the benefit of moving to CHoICE. GMcP explained that pharmacy had moved across three years ago, estates and facilities in February 2017 and procurement most recently and in reality it probably equated to £3-4m. JD queried whether that amount was a 'one-off'. GMcP replied that it would probably be £1-2m year on year.

Resolved: To note the financial position to date.

Item 6 **Performance Report**

AK presented the report which updated Governors on performance against key targets.

AK advised that performance for January failed to achieve the 95% target and had remained stable at 84.1% due to winter pressures. Performance from January onwards continued to be below the 95% standard. AK advised that this was due to ongoing operational pressures – attendances, acuity of patients, admissions, bed occupancy and flu cases. AK stated that currently there was 4 – 4.5% growth, handover delays had increased but that was not a real concern at the moment.

MMcN commented that A&E performance is always difficult over the worst winter months yet the target always remains the same and should there be a seasonality factor built in. AK replied that nationally they were reluctant to change but it was more important to look at other peer comparisons and how that impacted on us.

KWB commented that we were profiled on a quarterly basis and there was some recognition and a degree of acceptance.

SP suggested that it was a little like the postal service who do not guarantee delivery. KWB stated that unfortunately other organisations did deliver and consistently, and there was always a suspicion that we could do more.

North Tees always hit the target but then we were not comparing apples with apples. KWB stated that we had looked at what we were doing differently but we had more attendances between midnight and the morning than North Tees had in a full day.

JD commented that he had been working in seasonal industries all his life and were we using an annualised hours process which was beneficial to staff. KWB replied that we were in some parts of the organisation but in A&E for example there were still pressures in the summer not just winter. It needed more total manpower and then we rely on agency/additional hours – unlike John Lewis we could not recruit 350 students on the 1st of November to support pressures.

KWB commented that doctors did not want onerous on-call commitments and we would love to be able to recruit 40/50 additional nurses on 1st of September to March but it was just not possible.
KWB also stated that action needed to be taken on a collective basis as staff would move to other areas which they believed were more attractive. JB stated that she had one T&O consultant who worked annualised hours and that actually caused problems for RTT. LD commented that winter in the NHS lasts about six months - often until April/May. KWB also added that there was to be no additional funding for winter next year.

AK advised that RTT performance remained above the 92% target at 93-97% with all specialties achieving the target apart from T&O and Thoracic medicine.

Cancer targets and diagnostic performance for the month were all above target.

Resolved: To accept the report.

Item 7 **Care Quality Commission Inspection**

MJ presented the report which outlined the process for the anticipated CQC inspection. MJ stated that we had been advised that our Well-Led Inspection would take place on 15, 16 and 17 May 2018 but there would be an unannounced inspection probably sometime in April.

In terms of the inspection process the CQC would be looking to see that services were safe, effective, caring, responsive and well led. MJ advised that the CQC had submitted a Provider Information Request at the end of December which involved supplying numerous pieces of information and detailed spreadsheets.

MJ stated that the unannounced inspection was probably due within the next three weeks and that we could probably expect thirty inspectors. The Trust would be given twenty minutes notice of the inspection team arriving on site.

MJ advised that a new element of the inspection process was an NHSI assessment of the use of resources which was to take place on the 26 April 2018. The Trust would not receive the formal report and rating until sometime in the summer. MJ explained that briefing sessions had been held with Directorate teams to help them to prepare for the visit.

SP queried whether there would be any conflict with the proposed PLACE inspections. CH replied that hopefully not as we had tried to schedule to ensure that there would be no conflict.

JD queried as to what the use of resources assessment would entail. KWB replied that this was the first time it had been undertaken and it

appeared to be a series of interviews – it also may have been helpful not to be the first Trust to undergo the process.

Resolved: To accept the update.

Item 8 **Quality, Risk and Assurance Report**

MJ advised that she did not intend to present the report as the detail and content was to be amended going forward to link with the new Quality Strategy.

MJ stated that she would be more than happy to take questions outside of the meeting.

Item 9 **Draft Quality Strategy**

MJ presented the draft strategy which was an overview of the proposed strategic framework and plan of action to improve quality at both City Hospitals Sunderland NHS Foundation Trust and South Tyneside NHS Foundation Trust over the next five years.

The strategy set out how the Trust would deliver high quality care by putting patients at the centre of everything we do. The primary goals were to reduce avoidable harm, provide the best patient experience and achieve the best possible clinical outcomes. There were five priority work streams suggested within each of the domains of patient safety, patient experience and clinical effectiveness.

MMcN commented on improving the recognition and management of deteriorating patients and advised that he used to sit on the deteriorating patient group and one of its concerns was that it felt that it did not have any punch. MJ replied that the issue of NEWS had not gone away and there was a NEWS2 expected which was hoped to be better as it would be electronic documentation.

LH queried clinical effectiveness and particularly of knowledge of a link to understand the recommendations from the GIRFT programme. MJ replied that she would find a reference link for LH.
LH also queried the role of research ambassadors. MJ replied that they were very active and we were combining with South Tyneside to develop an R&I strategy and also to appoint more research ambassadors.

MJ advised that some of our AHPs for example were very research active and we did not promote that sufficiently.

JD referenced the QRA report and queried why there had been a 7% increase in pressure ulcers. MJ replied that we had seen an increase in February which was probably linked to the frailty of patients.

JD also commented on the differences in safeguarding referrals between CHS and South Tyneside. MJ replied that the issue was more about adult referrals although we were making referrals and had a safety net in place – the adult team at CHS were not as experienced as the team at STFT.

The Safeguarding team had been significantly enhanced so hopefully there would be shared learning.

LH also queried whether the decisions on getting DoLs resolved were causing any problems. MJ replied that we had done some more proactive work linked to DoLs but there was no risk to the organisation or to patients.

Resolved: To approve the draft strategy.

Item 10 **Information Governance Toolkit**

Jim Carroll presented the report which highlighted the processes that the Trust had followed in completing the IG Toolkit. JC stated that currently there were 45 requirements and three levels of compliance although there was to be a new toolkit launched for the following year which would have 129 mandatory requirements.

JC explained that the submission had been audited by AuditOne who had confirmed that appropriate governance arrangements were in place and from the evidence, that the submitted IG Toolkit scores were a reasonable assessment of current performance.

JC advised that of the 45 requirements, 19 were assessed at level 2 and 26 at level 3. The total percentage compliance was 85%. The IG training element had achieved an overall 96% take-up which was excellent. RR commented that she assumed such training was mandatory. KWB confirmed that it was mandatory but a new training module had been introduced nationally this year which took at least 1-1.5hours to complete.
PT commented that it was a very good achievement.

JD commented that IG was a difficult issue when looking at integrated systems and asked whether JC was involved. JC replied that he was and ensuring that the legislative requirements were met.

JD queried whether GPs were compliant. JC confirmed that they were but not at the same level as ourselves.

Resolved: To approve the submission of the Information Governance Toolkit.

Item 11 **Annual Plan**

PS presented an overview of the planning guidance and details of national and local assumptions in relation to activity, performance and quality and also about integrated system working.

PS highlighted the assumptions in relation to A&E and advised that there had been a 1% growth in A&E attendances. JD commented that one of the aspirations of the MCP was to reduce attendances by 6%. PS replied that commissioners clearly had one view and we had a different view. PS believed that their ambition of a 6% reduction was not currently possible as plans were not sufficiently robust to get to that point.

PS also advised that there was a national focus on patients with a long length of stay (stranded – 7 days and super stranded patients – 21 days). He thought that the term 'stranded' may now have changed.

GMcP highlighted the financial assumptions and advised that 30% of the provider sustainability fund was linked to A&E performance which was seen as a national 'must do'.

GMcP also advised that more PSF funding was available to FTs but control totals had increased and therefore financial performance needed to be better to access the money.

GMcP outlined the financial plan and advised that the planned deficit for 2018/19 was £23.7m and to balance the books the CIP would need to be £25.5m but we would be setting ourselves up to fail with that figure. There were however, a number of organisations in the same position as ourselves and we needed a whole system change and across the local health economy we were hoping to develop a framework to do that by the end of quarter one.

KWB commented that the NHS needed longer term recurrent funding – whilst additional money had come into the NHS we were not really seeing any of that. SP stated that year on year the deficit was greater and what would happen next. KWB replied that potentially services could be restricted or cut, or more money was needed to sustain the system.

MMcN queried whether any Trust had yet cut or restricted services. KWB replied that it was not necessarily a Trust decision – it needed commissioners to take action.

MMcN also queried whether there was an official line from NHS Providers. KWB replied that they too believed more money needed to be put in the system. PT queried whether any additional funding had gone anywhere. KWB replied that there was a suspicion that it had gone into the south of the country but that was not certain.

JD queried whether growth was not funded. GMcP replied that the block contract was more beneficial to the Trust.

PS advised that the final 2018/19 plan had to be submitted by 30 April 2018 as had 2018/19 winter demand and capacity plans.

Resolved: To accept the update.

John Anderson
Chairman

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST
SOUTH TYNESIDE NHS FOUNDATION TRUST

NURSING AND PATIENT EXPERIENCE

COUNCIL OF GOVERNORS

DEMENTIA STRATEGY

JUNE 2018

1. Introduction

The Dementia Strategy states the strategic aims and objectives with regard to continuing to improve the care given to patients with dementia and their families in both hospital and community services across the Health Care Group.

Five strategic aims are stated which are based in evidence and best practice and align with overall ambition of the Quality Strategy, these are;

- Person Centred Care
- A competent and compassionate work force
- Evidence based pathways of care and assessment
- Partnerships and engagement
- Dementia Friendly Environments

Each strategic aim is underpinned by key objectives and proposed measures of success. Each Trust will have a Dementia Strategy Group chaired by the clinical lead for dementia services. The establishment of a group on each Trust site is currently a sensible approach as it allows for the different starting points of both Trusts in terms of their strengths and weaknesses, building on current innovations, past success and the different resources available for delivery of high quality dementia care.

The Patient Carer and Public Experience Committee will hold the Dementia Strategy Groups accountable for progress against delivering the strategic aims and objectives. Progress will be measured using local measures of success and feedback from the National Dementia Audit. Each group will develop an action plan describing the priority areas for each Trust and the timescales for delivery of improvements. These action plans will build on the National Dementia Audit Action plans already in existence.

2. Recommendation

The Council of Governors is asked to support the draft dementia strategy which is currently out for consultation with both internal governance groups and external groups representing patients and carers.

Melanie Johnson
Executive Director of Nursing and Patient Experience

DRAFT

Dementia Strategy for South Tyneside and Sunderland Healthcare Partnership 2018 - 2021

1. INTRODUCTION

South Tyneside and Sunderland Healthcare Group (the Group) is committed to improving the care for patients with dementia and ensuring that the support given to relatives and carers is tailored to meet their needs. Improving dementia care has been a priority for both trusts for a number of years and the healthcare group provides the opportunity to build on the successes and lessons learned from both trusts to progress along the path to excellence for dementia care.

This document sets out our strategic objectives in relation to improving the care given to patients with dementia. The delivery of the work programme, overseen by a dementia steering group on both sites, will enable the group to continue to improve its services and contribute to the delivery of its dementia strategy.

2. BACKGROUND

Dementia is one of the most important and challenging issues we face as the population ages. Dementia is a collective term for over 100 diseases of the brain that can affect memory, communication skills, reasoning and the ability to carry out daily activities. Dementia causes changes to the structure and chemical balance of the brain affecting the very essence of a person and its progressive nature is devastating both to individuals and to families. Dementia is a life limiting diagnosis the natural course of which leads to increasing dependence and vulnerability.

The prevalence of dementia across the United Kingdom (UK) is rising, in part due to the ageing population; one in six people aged over 80 will experience dementia, which increases with every five-year age group. Two thirds of people with dementia are women and in 2015 there were 850,000 people living with dementia, 25,000 from black and minority ethnic groups and 40,000 were less than 65 years of age. The financial cost of dementia to the UK is £26 billion per annum however there are 670,000 family carers in the UK which saves £11 billion a year (Alzheimer's Society 2014); there is no known cure. In acute hospitals 60% of all hospital beds are occupied by older adults with 40% of these people considered likely to have a dementia diagnosis. 33% of people with dementia live on their own in the community.

In South Tyneside and Sunderland Healthcare Group our vision is to be an outstanding provider of healthcare for everyone who comes into contact with our services, whether they are delivered in hospital or community. We want to be recognised as a learning, responsive and innovative organisation and in agreeing key enablers necessary to achieve this strategic plan we will

develop, support and provide our staff with the skills and resources necessary for success. We aspire to deliver safe and effective care for every patient whilst at the same time ensuring that they are treated with compassion, dignity and respect.

Providing excellent, personalised care for people with dementia and their carers is the litmus test of our determination to drive through improvements in patient care and experience. All staff in our organisations should have a good understanding of the issues faced by dementia patients so that we can all provide exceptional care and support. It doesn't matter whether or not we work with patients directly, the reality is that we will all come across a patient with dementia just by walking down the corridor, into clinics or patients' homes every day and we all need to have the knowledge, confidence and compassion to help.

To succeed we will need to continue strong partnership working with our local clinical commissioning groups, local authorities and our local mental health trusts as well as families and carers.

3. CONTEXT

There have been a number of National policies and best practice guidelines which have helped to shape this strategy (detailed in appendices one and two), these include;

- National Institute of Health and Care Excellence and the Social Care Institute for Excellence(2006;updated in 2016) Dementia; Supporting people with dementia and their carers in health and social care.
- The National Dementia Strategy: Living well with dementia (2009)
- Royal College of Psychiatrists National Audits of Dementia 2010/11;2012/13 and 2016/17
- Prime Minister's Challenge 2012, Prime Minister's Challenge on dementia 2020
- Dementia – Friendly Hospital Charter (Dementia Action Alliance, 2015)
- Department of Health (2016; refreshed edition) Making a difference in dementia; nursing vision and strategy
- Royal College of Nursing, RCN Foundation (2016) The triangle of care. Carers included: a guide to best practice for dementia care

Both Trusts are members of Dementia Action Alliance and have taken part in each round of the National Audits of Dementia which have led to a number of successful local initiatives over the years to improve the care of patients with dementia and their families. Much of the focus has been on acute hospital services; this new strategy will span all services across the Group in recognition that out of all people living with dementia, two thirds live in the community while one third lives in a care home.

4. STRATEGIC AIMS AND OBJECTIVES

In order to succeed in being recognised both locally and nationally, as a centre of excellence in providing integrated dementia care we have developed a set of ambitious strategic aims and objectives.

4.1. PERSON CENTERED CARE

The care we deliver will be person centred, empowering the patient with dementia and their carer as part of a therapeutic relationship with professionals which promotes safety and supports communication and wellbeing. Carers and staff have so much to learn from each other; they need to work together to get the best for the person who has dementia. We will find innovative methods of communication; acting on feedback from people with dementia and their carers to improve the services we deliver.

Patient outcomes:

"The staff who care for me will know about me as a person and communicate appropriately to all those involved in my care and also to me"
"The people who are important to me will be partners in my care with health care professionals and be able to assist with my personal care should they wish to do so".

Key Objectives

- Improve the use of "this is me" document across both trusts in acute and community services, championed by Carers Associations and care homes, encourage people bring this to the attention of health care professionals when receiving care either at home or in hospital.
- Primary carer for patient is clearly identified and a clear carer pathway developed on admission to hospital or on to a community service caseload in line with the Group Carers Strategy.
- Enable flexible/personalised visiting for carers of patients with dementia in line with "John's campaign".
- Enable a positive culture of patient/carer led decision making based on unbiased information and genuine choice.

Measures of Success

- Measure against the six key standards required to achieve better collaboration and partnership with carers[1].
- Increase in percentage of family members involved in care planning process creating a shared plan of care.

[1] Carers Trust 2013: The Triangle of Care; Carers Included: A Guide to Best Practice for Dementia Care

4.2 A COMPETENT AND COMPASSIONATE WORKFORCE

To develop a courageous, skilled and effective workforce, with recognised levels of competency appropriate to their responsibilities, able to champion, compassionate and person centred care.

Patient outcomes:

"*The staff that care for me will be compassionate and competent to enable me to retain my independence within my abilities and ensure that I maintain the best health outcomes possible within the limitations of my condition".*

Key Objectives

- To ensure dementia awareness in all staff across the Group
- Further develop education and training opportunities in dementia care and delirium for all clinical staff based on enabling the delivery of evidence based practice.
- Dementia awareness events held annually in Alzheimer's society Dementia Awareness Week.
- Establish a cohort of volunteers to work with people with dementia both in hospital and in the community to provide social support and interaction.

Measures of Success

- Measure progress against staff working in dementia high intensity areas achieving bespoke training appropriate to that area
- Development of new roles to support a career framework across care of the elderly nursing.
- Reduction in vacancy rates in medicine and older person's wards and team establishments.
- Volunteers in place who will engage in care activities for patients with dementia providing social support and interaction

4.3 EVIDENCE BASED PATHWAYS OF CARE AND ASSESSMENT

To ensure the delivery of evidence based practice with equality of access to specialist services and seamless transfers of care.

Patient outcomes:

"*My care will be individualised to my needs and will be delivered by person with the right skills to ensure I have the best health outcomes".*
"I will be safe when moving between wards, services and when going home from hospital".

Key Objectives

- Meet all national and local performance and quality targets with regard to recording and communicating cognitive assessments completed on admission and appropriate communication with GP on discharge.
- Ensure the Mental Capacity Act (2005) and Deprivation of Liberties is applied appropriately in line with legislation.
- Ensure all appropriate patient assessments are in place in line with best practice guidance and care planning aligned to enhanced care guidance.
- Reduce the number of people with dementia given anti-psychotic medicines.
- Specialist discharge support to ensure seamless discharge with decisions made in partnership with patients and carers.
- To deliver personalised end of life care for people with dementia
- To improve outpatient care for people with dementia and their carers.

Measure of Success

- Reduce the number of inter ward transfers to a minimum other than for clinical need both in and out of hours.
- Reduction in avoidable harms such as pressure ulcers and falls associated with a diagnosis of delirium or dementia.
- Reduction in prescription of anti-psychotic drugs.
- Improved experience of discharge processes and end of life care pathway evidenced through positive patient stories & compliments and a reduction in complaints.
- Improved experience of outpatient services evidenced by a decrease in % of patient's "not brought" to their appointments.

4.4 PARTNERSHIPS AND ENGAGEMENT

We will develop partnerships and pathways to streamline care, prevent admission and support and enable the discharge planning process. People with dementia in the care of our services will be able to access specialist assessment and treatment from psychiatric liaison services which are responsive to their needs.

Patient outcomes:

"I will receive the specialist care I need in a timely fashion whether in hospital or at home in the care of community services"

Key Objectives

- Work in partnership with other providers of health and social care to ensure that patients and their families have access to the help and support they need to enable them to remain living in their place of choice.
- Work with local mental health trusts to share skills, knowledge and innovative pathways of care across acute and community services.
- Develop opportunities for staff to experience and learn from services provided by other health care service providers or other directorates. Develop rotational opportunities to support this process.
- To work in partnership with other directorates and other providers of health and social care, including the third sector to develop a directory of services to support people with dementia to access the support they need.

Measure of Success

- Up to date directory of services available for patients and their carers.
- Opportunities available for staff to shadow or rotate through other health services, both internally and eternal to the Group, in order to learn new skills and appreciate the role other services in providing integrated dementia care.

4.5 DEMENTIA FRIENDLY ENVIRONMENTS

We will become a dementia friendly organisation with environments and processes that support patients with dementia and promote independence and safe care.

Patient outcomes:

"I will be able to find important facilities in ward areas including toilets and bathrooms as they are clearly signposted in a way that is easy to understand"

Key Objectives

All wards and patient areas will be considered for upgrade in line with dementia friendly environments guidance when being refurbished, with the participation of patients and families where possible, to ensure:

- The environment promotes meaningful interaction between patients, their families and staff
- The environment promotes well-being.
  The environment promotes mobility
- The environment encourages eating and drinking
- The environment promotes continence and personal hygiene
- The environment promotes orientation
- The environment promotes calm, safety and security

A business case will be drawn for each upgrade to ensure transparency of, and agreement to, the cost implications.

Measure of Success

- Percentage of service environmental refurbishments undertaken in line with dementia friendly environments guidance
- Positive patient and family feedback on service environments.

5 ACCOUNTABILITY AND GOVERNANCE

Each trust will have Dementia Strategy Group who will own this strategy and take responsibility for the delivery of these aims over the next three years. The establishment of a group on each Trust site is currently a sensible approach as it allows for the different starting points of both Trusts in terms of their strengths and weaknesses, building on current innovations, past success and the different resources available for delivery of high quality dementia care.
There will be a bi annual workshop between both groups to share learning and best practice and it is anticipated that in the fullness of time the groups will merge in line with the outcome of clinical service reviews and the continuing development of the partnership working between the two trusts.

The Patient Carer and Public Experience Committee will hold the Dementia Strategy Groups accountable for progress against delivering the strategic aims and objectives. Progress will be measured using local measures and feedback from the National Dementia Audit. Each group will develop an action plan describing the priority areas for each group and the timescales for delivery of improvements. These action plans will build on the National Dementia Audit Action plans already in existence

6 CONCLUSION

This Dementia Strategy has been developed with the support of clinicians and managers in both Trusts and will be subject to a period of consultation with carer, public and voluntary organisations.

The Strategy sets out our vision for continuously improving services and the care of people living with dementia and their families.

The strategic aims and objectives are set out for the next three years however they will be reviewed at least annually and remain flexible to change as the result of feedback, national guidance and consultation.

Appendix one

SUMMARY OF NATIONAL POLICY RELATING TO DEMENTIA CARE IN ENGLAND

National Institute of Health and Care Excellence and the Social Care Institute for Excellence(2006;updated in 2016) ***Dementia; Supporting people with dementia and their carers in health and social care.***
The guidance sets out the wider remit for health and social care focusing on two key elements;

- The environmental design for people living with dementia
- The clinical investigations required to diagnose dementia and pharmacological interventions for its management

Department of Health (2009) ***Living well with dementia: A national dementia strategy.***
The primary aim of the strategy is ensuring that all people with dementia and their carers are enabled to live well with dementia. The objectives of the strategy can be themed in three broad themes. These are;

- Raising awareness and understanding: Increasing public and professional awareness and understanding of dementia to ensure individuals receive timely diagnosis and care, promote prevention of dementia, and reduce stigma, social exclusion and discrimination.
- Early Diagnosis and support: Early diagnosis and intervention can delay progression of symptoms, help the person remain in their own home and generally improve the quality of life for themselves and their carers.
- Living well with dementia: Developing a range of services for people with dementia and their carers which can meet their changing needs over time maximising independence, dignity and empathy.

Department of Health 2012 ***Using the commissioning for quality and innovation (CQUIN) payment framework. Guidance on new national goals for 2012-13.***
The aspiration of the national CQUIN was to develop a system in acute trusts that incentivised the identification of people with dementia, assessment and prompt referral and follow up after they leave hospital. This remained a national CQUIN until 2015/16. Dementia may be a local CQUIN for 2017/18.

Department of Health (2015), ***Prime Minister's Challenge on dementia 2020***
David Cameron (Prime Minister 2010 to 2016) articulates a vision to create a society by 2020 where every person with dementia their carers and families receive high quality compassionate care from diagnosis to end of life irrespective of background, walk of life, geography, age, gender, sexual orientation, ability or ethnicity. The document sets out the government's key aspirations to deliver this goal including details of plans to improve dementia research.

Health Education England in collaboration with Skills for Health (2015) Dementia core skills education and training framework.
This document sets out a framework to support the implementation of the Health Education England (HEE) mandate and the objectives for education, training and workforce development set out in *the Prime Ministers challenge on dementia 2020.* The aim is to support the development and delivery of appropriate and consistent dementia education and training for the health care workforce.

Department of Health (2016) ***Dementia 2020 citizens' engagement programme: Toolkit for engaging with people with dementia and carers.***
The Department of Health published its implementation plan for the challenge on Dementia 2020 in March 2016. This sets out a number of key commitments to ensure that dementia care, support, risk reduction, awareness and research are transformed by 2020.
One priority action is to establish a Dementia Citizen's Engagement Programme in England to find out first hand from people with dementia and carers if the actions in the plan are making a difference to their day to day lives. The feedback will be used to check progress and to ensure that everything that can be done to make improvements is being done.

Appendix two

REVIEW OF BEST PRACTICE GUIDANCE RELATING TO DEMENTIA CARE.

Dementia Action Alliance (2012); The Right Care: A Call to Action on Improving the Care of People with Dementia in Acute Hospitals

In 2012 Chief Executives were invited to answer the Call to Action and pledge their organisation's commitment to becoming dementia-friendly and this commitment was entered into by both Trusts.

Royal College of Psychiatrists 2013; *National Audit of Dementia Care*

The National Audit of Dementia (general hospitals) was established in 2008. The first round of audit was carried out in 2010/2011 and a second round took place between April and October 2012. Each hospital was asked to complete:

- a hospital organisational checklist to audit service structures, policies, key staff and care processes
- a retrospective audit of 40 sets of patient records against a checklist of standards

The audits provided the opportunity to examine the quality of care received by people with dementia in general hospitals. It also allowed Trusts to track their progress with meeting the standards as well as benchmarking performance against other Trusts. Both Trusts in the Group participated in each round of the National Audit.

Royal College of Nursing (2013) *Dementia: Commitment to the care of people with dementia in hospital setting.*

The Royal College of Nursing (RCN) developed at set of principles for the care of people with dementia in the hospital setting. These principles are referred to collectively as SPACE

- **S**taff who are skilled and have time to care
- **P**artnership working with Carers
- **A**ssessment and early identification
- **C**are that is individualised
- **E**nvironments that are dementia friendly

The Butterfly Scheme

This scheme supports anyone whose memory is not as reliable as it used to be, or whose current medical condition is causing them to feel confused. A butterfly is placed on the board above the patients' bed or on the ward "patient status at a glance" board to denote the patient has advanced care needs. This scheme was created by a carer who consulted with people in early-stage dementia, hundreds of carers of people with dementia and key healthcare professionals over a two-year period, to ensure that the scheme and its response were exactly what they hoped for; the hospitals already using the scheme have found – not surprisingly – that opt-in runs at or near 100%, but patients and carers must still be allowed to make that choice. The Butterfly symbol is an active request for support – empowerment of people with dementia and their carers to personalise the care they receive.

Care Quality Commission (CQC) – Cracks in the Pathway 2014
During 2013-14 the CQC carried out a review of the care of people living with dementia as they moved between care homes and hospitals. This review found more good care than poor care but that its quality varies greatly.
The Care Quality Commission use the findings from this report to set clear standards, assess hospitals and care homes against them and encourage services to improve where this is found necessary

Alzheimer's Society (2014) Forget me not
This is a visual trigger used in some healthcare settings to identify a person who may require more assistance than others. An image of a forget me not is placed above the person's bed, on the medical records, on menus, etc. to ensure all staff recognise the person may need more support.

Dementia – Friendly Hospital Charter (Dementia Action Alliance, 2015)
The Charter is the second phase of the Right Care initiative. It provides high level principles of what a dementia friendly hospital should look like and recommended actions that hospitals can take to fulfil them. It therefore offers a framework to assist hospitals in their self-assessment against the dementia-friendly principles and assists them on achieving their Dementia Action Alliance action plan.

John's campaign
The campaign calls for a policy that welcomes family and carers onto wards outside the normal visiting times, according to the needs of the people with dementia.
Age UK (2016) has worked with John's campaign to produce useful information for organisations, strategy leads and ward leaders looking to better support carers and patients and reduce their sense of disconnection and isolation.

Fix Dementia Care: Hospitals (Alzheimer's Society, 2016)
The document sets out recommendations for the NHS and health regulators to improve the experiences of people affected by dementia in hospitals. The Alzheimer's Society will be campaigning to ensure they are implemented.
Recommendations include:

- All hospitals to publish an annual statement of dementia care
- Monitor to use the annual dementia statement as part of its risk assessment framework to identify and take action in hospitals where dementia is inadequate.
- CQC to appoint a specialist dementia adviser and include care indicators as part of its intelligence monitoring work to improve regulation of dementia services in hospital.

Department of Health (2016; refreshed edition) *Making a difference in dementia; nursing vision and strategy*
The Making a Difference in Dementia: Nursing Vision and Strategy, published in March 2013, set out the vision of how nurses could maximise their unique contribution to high-quality, compassionate care and support for people with dementia and their carers/families. The refreshed 2016 document challenges

the nursing profession to think differently about the person living with dementia, moving from a traditional view that dementia is a 'debilitating condition' to a 'prevalent view' that it is a long-term condition affecting memory, cognitions, health and behaviour experienced by the person and their family/carers. The strategy aims to look at the person with dementia and dementia itself anew, focusing the nursing role toward person-centred, compassionate and proactive care.

Royal College of Nursing, RCN Foundation (2016) ***The triangle of care. Carers included: a guide to best practice for dementia care***
The triangle of care describes a therapeutic relationship between the person with dementia, staff member and carer that promotes safety, supports communication and sustains wellbeing. A meaningful involvement and inclusion of carers can lead to better care for people with dementia, ideally meeting the needs of the person with dementia and their carer. It was designed for use in mental health services, but the standards have been found to apply to other care settings. The guide identifies six key standards required to achieve better collaboration and partnership with carers.

Alzheimer's Society (2016) This is me
This is a practical tool that people with dementia who are receiving professional care in any setting – at home, in hospital, in respite care or a care home – can use to tell staff about their needs, preferences, likes, dislikes and interests.

NHS England (2017); Implementation Guide and Resource Pack for Dementia Care
The purpose of the document is to set out the policy drivers and strategic context for transforming dementia care and articulate why it is important to commissioners, providers and sustainability & transformation partnerships(STPs) in supporting delivery of a number of objectives in the "Prime Ministers Dementia Challenge"(2012) which complement the aim of the Five Year Forward View(2014).It provides evidence of what works well in dementia care, headline access and quality benchmarks to support a reduction in unwarranted variation, drawing on good practice throughout.

NHS Improvement (2017); Dementia assessment and improvement framework
The dementia assessment and improvement framework supports organisational leaders in NHS provider organisations – for example, senior sisters/charge nurses, consultants and allied health professionals (AHPs) – to provide 'outstanding' care for people living with dementia during their stay in an acute, community or mental health setting.
The framework is evidence based and integrates national policy, practice guidance, best practice from organisations achieving an 'outstanding' rating from CQC and the patient and carer voice. The latter was captured through existing resources, including Health watch (2017), Patient Voices, the Alzheimer's Society and meeting people and their carers living with dementia.

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DIRECTORATE OF NURSING & PATIENT EXPERIENCE

COUNCIL OF GOVERNORS

CHS RISK MANAGEMENT STRATEGY 2018 – 2021

JUNE 2018

EXECUTIVE SUMMARY

The Trust Risk Management Strategy sets out goals for the delivery of effective risk management for the period 2018 – 2021.

The strategy has been approved by the Board of Directors.

SUMMARY OF GOALS FOR THE PERIOD 2018 - 2021

- Convergence of clinical and non-clinical risk management functions and activities, by the use of standardised reporting and monitoring methodologies
- Identification of existing risks to patient safety by qualitative analysis of litigation data
- Developing and refining local and corporate risk register processes which identify significant risks to the Trust, and defining responsibility for managing those risks
- Exploitation of the full capability of the Trust's incident reporting system
- Monitoring and, where necessary, improving levels of reporting of incidents through the Trust's incident reporting system
- Creation of risk-based dashboards for the identification of risks from sources including incident data and litigation data, and monitoring of the effectiveness of mitigation activity
- Creation of system for arm's length investigation of incidents where deemed appropriate, including provision of specialist training for specifically identified staff
- Creation of robust and structured systems to ensure learning from incidents, concerns, complaints and litigation, thus minimising the risk of recurrence

Each goal is supported by key deliverables, detailed in the strategy.

Delivery of the strategy will be monitored by way of an annual report to Governance Committee.

RECOMMENDATION

Governors are asked to note the report.

Melanie Johnson.

MELANIE JOHNSON
Director of Nursing, AHPs & Patient Experience

City Hospitals Sunderland NHS Foundation Trust

Risk Management Strategy 2018 - 2021

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Appendices

Appendix 1 Risk Grading Matrix
Appendix 2 Risk Management Framework – Risk Identification, Assessment and Mitigation

1. INTRODUCTION

This Risk Management Strategy states the City Hospitals Sunderland NHS Foundation Trust's (the Trust) objectives for managing risk, and the goals which must be met to achieve those objectives. It defines individual and organisational responsibilities. It describes the Trust's organisational arrangements for risk management, and the systems and processes by which the Trust's aims will be achieved.

While the Trust is committed to the management of all risks to its services, including clinical, organisational and financial risks, this strategy is a statement of its particular commitment to maintaining and improving patient, staff and public safety through performance-driven risk management, supported by an open, fair, transparent and learning culture.

The Trust supports and applies a "fair blame" culture. In the majority of cases where risks arise, they are due to systemic weaknesses rather than to a failing on the part of any individual. Even when an individual can be said to be at fault, this can usually be remedied by full support including retraining where necessary, and this is normally the approach which will be applied. However, exceptional cases sometimes occur, where there is clear evidence of wilful or gross neglect, contravening Trust policies and/or procedures and/or professional codes of conduct, or repeated evidence of poor performance despite intervention and the provision of full support to remedy the issue. Where this is the case, appropriate action is taken.

This strategy is implemented through the policies detailed in the Associated Documentation section, and those wishing to read more on the operational management of risk within the Trust are encouraged to refer to those documents, which can be found on the Trust's intranet.

This strategy will last for a period of three years after approval. Progress against its objectives and goals will be monitored by the Trust's Governance Committee, through the provision of an annual report.

2. DEFINITIONS

Definitions of some of the phrases used within this strategy are as follows:

Adverse Event: Any event which causes harm, such as an incident, or a complaint, or a circumstance which results in litigation against the Trust. Such adverse events can carry risks to an organisation.

Board Assurance Framework: A Board Assurance Framework provides a structure and process which enables an organisation to obtain assurance that the most significant risks to achieving its principal objectives are being adequately controlled. The Board Assurance Framework documents these risks and how assurance is to be obtained that they are being properly managed.

Assurance Programme: A structured and systematic annual programme which checks and monitors compliance with the Board Assurance Framework and a range of quality standards including those set by the Care Quality Commission.

Business Continuity Planning: Planning to ensure that business continues as usual if an unforeseen threat to its processes occurs e.g. flood, or fire damage.

Corporate Risk Register: a risk register showing those risks which have been scored at 15 or more on local risk registers (see definition below), and risks which have been identified as corporate in nature, in that they affect the organisation as a whole, or have effects across more than one business area.

Duty of Candour: an enforceable duty placed on healthcare providers to be open and honest with patients and carers, if moderate or worse harm has befallen a patient.

Litigation Profile: data showing the issues faced by an organisation which are being dealt with through legal proceedings

Local Risk Register: A register showing risks which have been identified in a service area, e.g. a directorate, or a central function such as Human Resources.

Major Incident: A major incident is any incident which requires special plans and cannot be managed by simple scaling up of normal arrangements. It usually involves other services, such as the fire service or the ambulance service.

Mitigation: any action or change which, once applied, reduces the likelihood of a risk recurring.

Residual risk: the risk of an event recurring once all mitigating opportunities have been applied, either locally or corporately.

Risk: the likelihood of injury, damage or harm occurring to a Trust's patients, staff, stakeholders, finances or reputation.

Risk Appetite: A broad based concept, risk appetite is the amount and type of risk which an organisation is willing to accept in order to meet its strategic objectives. It links closely to the concept of risk tolerance (see below).

Risk Grading Matrix: a tool used to calculate the seriousness of a risk, by reference to the likelihood of its occurring, and the consequences if it does. The matrix is attached as **Appendix 1** to this document.

Risk Register Owner: the person whose responsibility it is to maintain a risk register. While Directorate Managers may devolve this responsibility to other staff, they remain accountable for the content and management of the risk register.

Risk Score: the score which the risk grading matrix gives to a risk. **Appendix 1** shows how a risk score is calculated, by multiplying the likelihood of occurrence by the severity of the consequences. Scores range from 1 to 25. Scores which remain higher than 15 once locally mitigated are added to the corporate risk register.

Risk Tolerance: Risk tolerance is the amount of risk to a specific objective which an organisation decides it can cope with. It is a concept which focuses in on each risk to each of an organisation's objectives. In general terms, the more critically important a specific objective is to an organisation's overall mission, the less tolerance an organisation will have of its related risks.

Serious Incident (SI): According to NHS England, SIs include acts or omissions in care which result in:

- Unexpected or avoidable death
- Unexpected or avoidable injury which results in serious harm, or where only the provision of further treatment avoided death or serious harm
- Actual or alleged abuse where healthcare did not take appropriate safeguarding action, or where abuse occurred during the provision of healthcare
- Never Events
- An organisation's delivery of an acceptable quality of healthcare services being prevented or under threat
- Incidents which cause widespread public concern, including prolonged adverse media coverage, resulting in a loss of confidence in healthcare services

3. JUSTIFICATION AND CONTEXT

This risk management strategy supports the Trust's mission to be numbered among the safest healthcare organisations in England. This version of the strategy has been informed by several national reports dating from 2013 onwards.

3.1 Francis Report

Key findings from the Francis Report included the failure of the Mid-Staffordshire NHS Foundation Trust board to ensure that deficiencies which were brought to its attention were corrected, and also identified its failure to tackle a disengagement from managerial and leadership responsibilities.

Through careful setting of objectives and goals, this strategy seeks to ensure that learning loops are fully closed, and that all staff recognise and deliver their responsibilities in respect of risk management within the Trust.

3.2 National Guidance on Learning From Deaths

Following the Keogh Report, the National Quality Board has published its National Guidance on Learning From Deaths (2017). This guidance includes the use of mortality reviews to monitor Trusts' performance and ensure their position as providers of safe care to patients.

3.3 Berwick Review

The government also asked the National Advisory Group on the Safety of Patients in England, led by Professor Don Berwick, to carry out a review of patient safety. The report acknowledged that safety issues exist within the NHS as they do within all other healthcare systems in the world, and that in the majority of cases it is the systems, procedures, conditions, environment and constraints which hospitals face which lead to patient safety problems, rather than failings on the parts of individual staff. The review also observed "When responsibility is diffused, it is not clearly owned: with too many in charge, no-one is."

The identification of systemic weaknesses, and the clear allocation of responsibilities to address those weaknesses, are addressed within the goals underpinning this strategy.

3.4 Freedom to Speak Up Report

The 2015 Freedom to Speak Up Report, also authored by Sir Robert Francis QC, is an independent review of the methods of creating an open and honest reporting culture in the NHS, most particularly in respect of concerns by staff which might be described as "whistleblowing". These types of concern should be captured and treated as a source of learning by any organisation wishing to have a proactive risk management strategy.

4. KEY OBJECTIVES AND GOALS

The goals to be achieved in the lifetime of this strategy are as follows. Achieving these goals will contribute to the Trust's strategic objective of numbering among the safest organisations in England, in terms of the Trust's risk profile.

Goal 1 Convergence of clinical and non-clinical risk management functions and activities, by the use of standardised reporting and monitoring methodologies (Key Deliverable: 5.1 below)

Goal 2 Identification of existing risks to patient safety by qualitative analysis of litigation data (Key Deliverable: 5.2 below)

Goal 3 Developing and refining local and corporate risk register processes which identify significant risks to the Trust, and defining responsibility for managing those risks (Key Deliverable: 5.1 below)

Goal 4 Exploitation of the full capability of the Trust's incident reporting system (Key Deliverable: 5.3 below)

Goal 5 Monitoring and, where necessary, improving levels of reporting of incidents through the Trust's incident reporting system (Key Deliverable: 5.3 below)

Goal 6 Creation of risk-based dashboards for the identification of risks from sources including incident data and litigation data, and monitoring of the effectiveness of mitigation activity (Key Deliverable: 5.4 below)

Goal 7 Creation of system for arm's length investigation of incidents where deemed appropriate, including provision of specialist training for specifically identified staff (Key Deliverable: 5.5 below)

Goal 8 Creation of robust and structured systems to ensure learning from incidents, concerns, complaints and litigation, thus minimising the risk of recurrence (Key Deliverables: 5.3 and 5.4 below)

5. KEY DELIVERABLES

The successful achievement of the goals listed above depends on several key deliverables, as follows.

5.1 Systematic Implementation and Monitoring of Risk Management Frameworks

Appendix 2 details a standard risk management framework. Goals 1 and 3 of this strategy will be achieved by introducing and applying the framework rigorously throughout the Trust. Progress will be monitored by the Corporate Governance Steering Group. This will deliver standardised reporting of risk across the Trust, which will provide a high level view of risks and risk mitigation to the Board.

Processes to manage risk at every level within the Trust will be documented in a new Risk Management Policy.

5.2 Qualitative Analysis of Litigation Exposure

NHS Resolution (NHSR) provides litigation information on a secure website and does provide some broad analysis of the data, but the detail is insufficient to allow for specific process weaknesses which are resulting in litigation exposure to be identified and addressed.

This strategy's second goal will be achieved by the preparation and analysis of litigation data in sufficient detail to show trending information on qualitative and quantitative issues. Datasets will include types of claims received, the areas of the hospital where incidents leading to claims occur, and other such issues. This analysis will be carried out on NHSR raw data and will be reported to the Corporate Governance Steering Group.

5.3 Incident Management

Strategic goals 4, 5 and 8 will be achieved by the Trust's continuing to invest in improvements to its incident management system. This will deliver an enhanced ability to analyse data from incidents, complaints, concerns and litigation, and will provide trending qualitative as well as quantitative information.

The Trust has recently entered into a group arrangement with South Tyneside NHS Foundation Trust (STFT). Each Trust currently uses separate and different incident management systems. During the period of this strategy, the Trust Assurance Team will explore whether the Trust's own risk management processes could benefit from adopting the systems used at STFT. Executive Committee will receive the team's recommendations and decisions as to future commissioning of risk management systems (including incident management systems) will be made.

Once this decision has been made, the coding structures within the system will be designed to ensure that the same base coding is used for incident, litigation, complaints and concerns data. This will enable data analysis across all datasets, improving the Trust's ability to identify issues and problems at an earlier stage. Early identification of issues will allow quicker resolution and should ensure less frequent, and less severe, levels of harm within each trend.

More generally, the Trust's risk and incident team will continue to work with all staff groups to ensure that incident reporting rates are at an appropriate level, particularly in respect of incidents where no harm has been caused or the effect has been minor. This will enable the early identification and resolution of issues.

5.4 Risk Based Dashboards

Once qualitative information is flowing from litigation data and the improved risk management system in the Trust, goals 6 and 8 will be achieved by constructing dashboards which identify and monitor metrics which relate to, or indicate the emergence of, key risks. These will include incident, complaints and concerns data which can then be triangulated with other data sources such as clinical audit findings. The dashboards will act as an early warning system of trends in occurrence, and will also provide an efficient tool for the monitoring of the effectiveness of improvement measures.

5.5 Arm's Length Investigations and Provision of Trained Investigators

Goal 7 of this strategy will be achieved by the creation of standard processes for the commissioning of arm's length investigations where appropriate (investigations carried out by staff from a business area other than the area in which the adverse event occurred). The timing of the introduction of these processes will be dependent on the sourcing of external training for a small group of appropriate staff, who will receive training in line with the recommendations of the NHS England Serious Incident Framework**.**

6 RISK APPETITE AND RISK TOLERANCE

Every organisation is willing to accept a certain level of risk within its business, particularly in respect of pursuing its business objectives. Given the nature of healthcare, the Trust has a relatively low appetite for risk. As a result, local risks which score at 15 or more are escalated into corporate workstreams via Corporate and Clinical Governance Steering Groups for information and, where necessary, for consideration of further mitigation.

Where the Assurance Programme shows repeated failures to meet specific standards, the resulting risk flows into the corporate risk register so that mitigation actions can be monitored and reviewed.

During the period of this strategy, the Board will consider whether it wishes to carry out further work in respect of articulating its tolerance of specific corporate risks and monitoring adherence to those tolerances, and whether it wishes to develop closer links between the Board Assurance Framework and its corporate risk register. This work will be supported by the Head of Corporate Risk.

An organisation's risk appetite may change over time. Should this occur during the period of this strategy, the operational processes underpinning risk management within the Trust will be adjusted.

7 THE OPERATIONAL MANAGEMENT OF RISK

Where a risk scores 15 or higher on the Trust's risk matrix (**Appendix 1**) the Corporate Governance Steering Groups and/or Clinical Governance Steering Groups monitor mitigation of those risks and refer them to the Trust's Governance Committee when necessary. Governance Committee considers whether the Board should be advised of those risks and whether it should recommend to the Board that assurance in relation to those risks are added to the Board Assurance Framework.

Further detail in respect of the processes underpinning this operational management of risk appetite can be found at **Appendix 2.**

8 MAJOR INCIDENT AND BUSINESS CONTINUITY PLANNING

Acute hospital trusts are obliged to ensure that their Incident Response Plans are kept up to date and that they reflect and support the plans of other planning partners, such as the ambulance service and fire service, in the event of a major incident caused by events external to the organisation. Of equal importance, however, is the risk posed by a breakdown in "business as usual", as opposed to the risk posed by a specific major incident. These obligations to plan for business disruption are described in the NHS England Standard Contract Service Conditions and also in the NHS England frameworks for Business Continuity Management and Emergency Preparedness. Therefore each business area maintains its own business continuity plan, ensuring that potential risks to its services are considered and that action plans are to hand if required.

If there are risks which affect these plans, they will be added to local risk registers and mitigated by application of the process described at **Appendix 2.**

9 REFERENCES

Francis R. Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 (The First Francis Report)

Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013 (The Final Francis Report)

Keogh B. Freedom to Speak Up Report 2015

Keogh B. Keogh Mortality Review 2013

National Advisory Group on the Safety of Patients in England: A Promise to Learn – A Commitment to Act 2013

National Quality Board: National Guidance on Learning From Deaths 2017

NHS Improvement Serious Incident Framework 2015

NHS England Model Job Description & Competencies for EPRR Officers (Coordinator) 2013

NHS England Emergency Preparedness Framework 2013

NHS England Business Continuity Management Framework 2013

10 ASSOCIATED DOCUMENTATION

The Risk Management Strategy is supported by a significant number of key risk management documents at the Trust. This number includes, but is not limited to, incident reporting and investigation policies, complaints management policies, training policies, disciplinary policies and procedures, health and safety policies, major incident plans and many others. Staff needing to access further information in respect of Trust policies can access all documents via the Trust's intranet.

There are also local documents which staff may access to familiarise themselves with risk management processes within their own area of work. These include, but again are not limited to, local business continuity plans, local risk registers and minutes of local governance meetings.

Appendix 1

Risk Grading Matrix

LIKELIHOOD	IMPACT				
	No Harm 1.	Minor 2.	Moderate 3.	Major 4.	Extreme 5.
5. Almost Certain	5	10	15	20	25
4. Likely	4	8	12	16	20
3. Possible	3	6	9	12	15
2. Unlikely	2	4	6	8	10
1. Rare	1	2	3	4	5

To calculate a risk score, the likelihood score is multiplied by the impact score. Thus a risk which is certain to happen (5) but will only have a minor impact (2) is scored at (5 x 2) 10.

A risk which is almost certain to happen (5) and which will be extreme in its impact (5) is scored at (5 x 5) 25.

Clinical risks scoring 15 or more are monitored by the Trust's Clinical Governance Steering Group.

Non-clinical risks scoring 15 or more are monitored by the Trust's Corporate Governance Steering Group.

Appendix 2

RISK MANAGEMENT FRAMEWORK – RISK IDENTIFICATION, ASSESSMENT AND MITIGATION

Risks have the potential to reduce an organisation's ability to provide safe, accessible, effective, efficient and appropriate services to patients and staff. It is important that the organisation can identify such risks, assess their extent, and mitigate them.

Risk Identification

The Trust identifies risks from a number of sources, including but not limited to:

- organisational objectives
- monitoring processes provided by the Board Assurance Framework and Assurance Programme
- local and corporate risk registers
- routine and *ad hoc* risk assessments
- consultation with, and feedback from, staff and patients
- complaints, incidents and claims data
- internal and external inspections and audits
- national enquiry reports
- external requirements

Risk Assessment

When a risk is identified, the likelihood of its happening, and the severity of the risk if it does occur, are assessed with reference to the risk grading matrix. As the matrix shows, a risk can score at any level from 1 to 25.

Once the risk has been assessed, it is added to a risk register; usually this will be the register held by the business area in which the risk was identified, but risks may be added direct to the corporate risk register or to the Board Assurance Framework.

- Directorate Managers add risks to local risk registers.
- Recommendations to add risks to the corporate risk register are made by the Corporate Risk Register Group and are considered by Corporate Governance Steering Group or Clinical Governance Steering Group, dependent on whether the risk is non-clinical or clinical.
- Recommendations to add risks to the Board Assurance Framework are made by either Steering Group to the Governance Committee.

Assessment and Reporting of Significant and Immediate Risks

Risks scoring 15 or more are deemed so significant that they require immediate escalation to a corporate level. In the event of a significant risk arising in hours, the risk is thoroughly assessed by the relevant Directorate Manager or Head of Service, who adds the risk to the local risk register and informs their DGM if they feel that escalation to divisional level is required. If their DGM is unavailable, they inform an alternate DGM. The DGM considers the risk, and if they feel that further escalation is appropriate, they discuss the risk and any required action with the Director of Operations (or other director if the Director of Operations is not available). The Director of Operations considers whether the risk and actions being

taken to mitigate it should be reported to the Chief Executive. In his turn, the Chief Executive considers whether the Board of Directors should be informed.

Out of hours a similar process of escalation is followed: the manager who is first on call escalates to the person second on call as necessary. Second on call is a member of the Executive Committee and they consider whether the Chief Executive should be informed.

While all risks are scored using the matrix at **Appendix 1,** the score of a risk which is escalated from a local risk register to the corporate risk register, or from the corporate risk register to the Board Assurance Framework, will almost certainly change as it escalates. This is due to context; for example, a financial risk of £1million is more significant to a directorate than it is to the Trust as a whole. The Corporate Risk Register Group is responsible for considering any risks which have been scored at 15 or higher within local risk registers. While all risks which score at this level are included within the corporate risk register, the Corporate Risk Register Group is responsible for re-scoring those risks from a corporate perspective, before adding them to the draft corporate risk register for approval by Corporate Governance Steering Group.

Risk Mitigation

Risk management within the Trust is based on a continuous cycle which identifies risks, records them, mitigates them to the extent that they can be mitigated and manages the residual risk.

Where a risk is identified, it is entered onto the relevant local risk register by the risk register owner, usually the Directorate Manager. Initial mitigation of a risk is carried out locally.

Where a local risk scores 15 or higher on the risk grading matrix (**Appendix 1)**, the Corporate Risk Register Group re-scores the risk from a corporate perspective and includes the risk on the draft corporate risk register. The corporate risk register is considered quarterly at the Corporate and Clinical Governance Steering Groups.

If local actions mitigate the risk to a risk score of less than 15, the risk is removed from the corporate risk register. If the risk cannot be mitigated locally to a risk score of less than 15, management of the risk is escalated, as follows.

- If the risk is clinical in nature, it is considered by the Clinical Governance Steering Group. If the risk is non-clinical, it is considered by the Corporate Governance Steering Group. Some risks may be both clinical and non-clinical in nature; in such cases, the Chairs of each steering group liaise to ensure that the risk is being effectively managed both from a clinical and non-clinical perspective.

- The Steering Groups consider those risks which have a local risk score of 15 or over and which have been fully mitigated at a local level. If the risk is considered acceptable from a corporate perspective, no further action is taken, although the risk remains on the corporate risk register for regular review. If the risk falls outwith risk tolerance, the Steering Groups consider and direct further mitigation activity until the risk is eliminated, the residual risk is acceptable, or the Groups can identify no further available mitigation.

- The Steering Groups advise the Governance Committee of any risks being managed in this fashion. The Governance Committee considers whether the Board should be

advised of those risks, and whether the risks should be added to the Board Assurance Framework.

Process Monitoring

To ensure that all risks are being appropriately managed locally, a review of local risk registers is carried out at least quarterly by an appropriate local group such as the directorate clinical governance group or the directorate meeting. The review includes the identification and addition of new risks, a review of all existing risks including their current risk score, and the closing and moving to archive of any fully mitigated risks whose residual score is less than 15. Action plans support the risk registers, and minutes taken at these meetings are stored electronically for audit purposes.

Local risk registers are submitted quarterly to the Corporate Risk Register Group, to ensure that they are being appropriately managed, and so that identified local risks can be considered for inclusion within the corporate risk register.

Board Assurance Framework

A Board Assurance Framework provides a Trust with a comprehensive framework for obtaining assurance that the principal risks which may threaten the organisation's objectives are being appropriately managed. It also provides a structure to support the evidence for the Annual Governance Statement.

The Board reviews the Board Assurance Framework every six months to inform itself of all significant risk exposures, the nature of controls and action plans. High risks which are identified as being a threat to the organisation's objectives are added to the Board Assurance Framework on the recommendation of the Governance Committee. They are then included in the Board Assurance Programme for compliance monitoring.

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST
SOUTH TYNESIDE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

QUALITY STRATEGY 2018-2023

JUNE 2018

SUMMARY

This Quality Strategy has been developed following extensive consultation across both Trusts with key stakeholders including clinicians and managers, Governance Committee, Corporate Governance Committee, Patient Carer and Public Experience Group, Patient Carer and Public Experience Committee, Council of Governors, Staff side Committee and South of Tyne and Sunderland Clinical Commissioning Groups.

The strategy highlights our framework and focus for the next five years. We are committed to providing high quality, safe and effective care for our patients and this strategy represents our long term commitment to achieve sustained improvements.

We have included some bold aims and we intend to measure and monitor progress through triangulation of data, some of which is already available and some which will be developed during the life of this strategy. In addition we will utilise information from sources such as the CQC, Royal College reports, patient complaints, staff and patient surveys and incident reports. We want to encourage and adopt versatile systems for measurement which are timely and responsive to the needs of our organisation and our patients and their families. Reporting will be in the form of quantitative measurable data but we will also describe how we are developing and supporting our workforce to attain the necessary skills to support success. As such we will provide a monthly Quality Report on progress and also report annually in our Quality Accounts and Annual Report.

This strategy clearly illustrates our vision and desire to be a safe, effective, reflective and responsive organisation where person centred care is inherent throughout.

RECOMMENDATION

Governors are asked to note this Quality Strategy.

Melanie Johnson.

Melanie Johnson
Executive Director of Nursing

City Hospitals Sunderland NHS Foundation Trust
South Tyneside NHS Foundation Trust

Quality Strategy

2018 - 2023

Introduction

In developing this strategy we aim to create a strategic framework and plan of action to improve quality by focussing on; Patient Safety, Patient Experience and Clinical Effectiveness.

Our vision is to be an outstanding provider of healthcare for everyone who comes into contact with our services, whether they are delivered in hospital or community. We want to be recognised as a learning, responsive and innovative organisation and in agreeing key enablers necessary to achieve this strategic plan we will develop, support and provide our staff with the skills and resources necessary for success.

We aspire to deliver safe and effective care for every patient whilst at the same time ensuring that they are treated with compassion, dignity and respect. This Quality Strategy sets out how we will deliver high quality care by putting patients at the centre of all we do.

Our primary goals are to:

- Reduce avoidable harm
- Achieve the best clinical outcomes
- Provide the best patient experience
- Support patients to be actively involved in their own care and treatment.

To achieve our primary goals we have agreed to focus on five priority work streams within each of the domains of Patient Safety, Patient Experience and Clinical Effectiveness.

Patient Safety

Aims:

We aim to be recognised as one of the safest healthcare organisations both nationally and internationally. Our priority is to deliver safe, reliable and effective care to patients, but we recognise that harm does occur and that there is no single intervention which will improve patient safety. Our intention therefore is to focus on five salient areas of risk, to implement the recognised strategies to reduce the risk and to measure and monitor for reduction in avoidable harm.

Priority work streams:

1. Reduce the incidence of category 2-4 pressure ulcers which have developed in our care by 25%

2. Reduce the incidence of severe of harm from patient falls, such that we are in the lower quartile of reporting Trusts nationally

3. Improve the recognition and management of deteriorating patients in hospital by:

    - accurate and timely recording of Early Warning Scores for all (100%) patients
    - 5% reduction in the number of cardiac arrests
    - ensuring high-quality timely communication, decision-making and recording in relation to decisions about Cardio Pulmonary Resuscitation

4. Achieve at least 90% compliance with:
    - nutritional screening on admission to hospital
    - compliance with recording of fluid input and output

5. Improve medicines management by:
    - ensuring that medicines reconciliation is achieved for 95% of patients within 24 hours of admission to our hospitals
    - reducing the incidence of missed doses of medicine by 50%.

Patient Experience

Aims:

Whilst safe, high quality clinical care must always be guaranteed in the NHS, this isn't enough by itself. Patients want and deserve to be treated with compassion, dignity and respect in a safe and caring environment, with staff putting their needs first to ensure a consistent positive patient experience. Our aim is to improve the patient and carer/family experience, from their very first contact with us right through to their safe discharge from our care.

Priority work streams:

1. Learn from patient feedback and aim to be in the top quartile in the national patient survey

2. Ensure that patients are involved as much as they want to be in decisions about their care and treatment by monitoring, audit and feed-back from Multi-Agency Partners

3. Provide a safe, secure, clean and comfortable environment for our patients and their carers/families by monitoring hand hygiene compliance and infection rates

4. Ensure that patients receive adequate information and support for safe discharge from hospital by monitoring and audit

5. Ensure that all patients and specifically those with physical, mental health and learning disabilities receive person-centred care based on their needs and preferences and that we work within the Mental Capacity Act (2005) and consult with others where appropriate.

Clinical Effectiveness

Aims:

We aim to ensure that the care we give or the service we deliver is explicitly evidence based, with the goal of achieving better outcomes. We want every patient contact to be a clinically effective contact wherever possible. We also want patients to be aware of clinical recommendations and options in discussing and agreeing pathways of care.

Priority work streams:

1. Implement the recommendations from the National Maternity Safety Strategy

2. Improve the outcomes for patients with serious infection by ensuring timely identification and treatment of sepsis

3. Improve quality and efficiency and reduce variations in our services by implementing relevant recommendations from the Getting It Right First Time programme

4. Learn and act on the results from participation in national clinical audits and the reviews of patient deaths

5. Aspire to achieving the four priority standards for seven day working.

Key enablers to achievement

To be successful in achieving our aims we will need to also focus on the following key enablers and driving principles:

- **Culture of Safety**

Our aim is to promote a culture where openness and transparency is the comfortable norm for all of our staff. We will continue to encourage our staff to report adverse events and to take action when it is needed and to seek assistance when they are concerned. We will also continue with our Trust Board of Directors led Patient Safety Walk Rounds. Additionally we will advance our plans to utilise human factors principles system-wide in our processes, procedures, learning and design of our services.

- **Continuous Learning**

The skills and competencies of our staff are key to the delivery of safe, high quality, cost effective healthcare in both the hospital and community setting. Professional capabilities and behaviours profoundly impact on the patient experience therefore we remain committed to a process of focused continuous professional development for our staff.

- **Recruitment and Retention of Staff**

It is essential that we have sufficient staff to care for the number and acuity of our patients. We recognise that in particular, numbers of training grade doctors, non-consultant grade doctors and nurses and midwives are low and we are committed to investing in recruitment and where necessary delivering care in new ways in partnership with our patients and their carers.

- **Person-centred Care**

We will strive to ensure that the care or treatment we provide is tailored to meet the needs and preferences of our patients and their carers. We will encourage patient involvement and shared decision making in care and treatment wherever possible and always ensure that we include the patient's abilities, resources, wishes, health and wellbeing in our assessment and agreed plan of care. Putting the patient and their family at the forefront of every decision and supporting them to be genuine partners in their care will be our primary focus.

- **Quality Improvement and Measurement**

It is well recognised that by applying quality improvement (QI) methodology, quality and safety can be improved and costs can be reduced. We will promote QI principles throughout the implementation of this Quality Strategy. We have identified our aims for improvement and every aim will be supported by a project and measurement plan and team of experts to implement and monitor changes to achieve success. We recognise however, that we need to ensure that our staff have the necessary improvement capability to support this ambitious plan, and where necessary we will expand the capability and skills of our staff.

- **Research and Innovation**

We are committed to using knowledge, learning and innovation to develop care and treatments. We recognise that research systems and participation brings benefits for patients and our healthcare community, therefore we will look to further develop our infrastructure in relation to clinical research and innovation. In developing our research environment we will also look for further opportunities to partner with commercial and academic learning institutions.

- **Effective Communication**

The benefits of effective communication and health outcomes for patients are well known and include adherence to treatment and self-care. In addition good systems for communication can significantly improve patient safety and reduce adverse events. We will continue our work at CHS as a Digital Global Exemplar and ensure that STFT has the necessary support to be a fast follower.

- **Leadership**

There is a well recognised and strong association between leadership and positive clinical outcomes, therefore we will work to foster a culture where all of our staff recognise their role as leaders in delivering our services to patients, their carers and their families. Additionally we will ensure that our senior leaders promote involvement and participation as core values and that they are supportive, available, fair, respectful and empowering in their behaviours.

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

MAY 2018

2017 STAFF SURVEY RESULTS

1. INTRODUCTION

This paper summarises the results of the 2017 NHS Staff Survey for City Hospitals Sunderland (CHS) and identifies key areas for follow-up and next steps.

The annual NHS Staff Survey gives an opportunity to survey staff in a consistent and systematic way and over time, to build up a picture of staff experience, which can then be compared with previous results, monitor any changes and identify variations between different staff groups and areas of the organisation.

Feedback from staff is vital in helping to improve the quality and experience of everyone's working life and supporting us to deliver better patient care. The survey results are also used by the Care Quality Commission (CQC) to monitor ongoing compliance with essential standards of quality and safety and by the Secretary of State for Health and Social Care to monitor delivery of the NHS Constitution

316 NHS organisations took part in the 2017 survey, which ran between October and December 2017. Nearly one million NHS staff were invited to participate with over 430,000 completing the survey – a national response rate of 43%.

2. HOW THE SURVEY WAS IMPLEMENTED

For the first time, CHS used Picker Institute Europe as survey contractor and, as in 2016, all staff were invited to take part in the survey – a full censes approach, rather than a randomised sample and the survey was carried out via on-line / e-survey.

3. RESPONSE RATE

A total of 1,925 CHS staff took part in the survey, giving an overall **response rate of 42.3%**. (The average response rate for Acute Trusts was 46%). Previous response rates are shown below:

2015	2016
31%	35%

4. **SIGNIFICANT CHANGES SINCE THE 2016 SURVEY**

Compared to the 2016 survey, staff responses to the 2017 survey indicate the following;

Significantly **BETTER** on the following 3 questions.

Question		2016	2017
Q4g	Enough staff at organisation to do my job properly	30%	37%
Q11b	In last month, have not seen errors/near misses/incidents that could hurt patients	74%	77%
Q13b	Would feel secure raising concerns about unsafe clinical practice	71%	76%

Significantly **WORSE** on the following 6 questions.

Question		2016	2017
Q5g	Satisfied with level of pay	41%	36%
Q11c	Last error/near miss/incident seen that could hurt staff and/or patients/service users reported.	99%	93%
Q14c	Not experienced physical violence from other colleagues	99%	98%
Q15d	Last experience of harassment/bullying/abuse reported	54%	47%
Q17b	Not experienced discrimination from managers/team leaders or other colleagues	95%	93%
Q20a	Had appraisal in last 12 months	88%	85%

5. **CQC STAFF SURVEY FEEDBACK REPORT**

The CQC staff survey feedback report, groups responses into 32 Key Findings. These are mostly summary scores for sets of questions which, when taken together, give more information about each area of interest. Key Findings are presented 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

A summary of results by each theme is in **Appendix 1.**

As in previous years, there are two types of Key Finding; percentage scores showing the proportion of respondents who gave a specific answer to a question and scale scores, which are calculated by assigning numbers to a series of responses and calculating the average score, as follows:

If a respondent answers . . .	Their response scores . . .
Strongly disagree	1
Disagree	2
Neither agree or disagree	3
Agree	4
Strongly agree	5

6. STAFF RECOMMENDATION AS A PLACE TO WORK OR RECEIVE TREATMENT

The tables below show the scores for Qs 21a, 21b, 21c and 21d, which feed into Key Finding 1 – ***'Staff recommendation of the organisation as a place to work or receive treatment'.*** Scores have improved since the 2016 survey.

Question	**CHS 2017**	**CHS 2016**	**CHS 2015**	**Average for all acute trusts**
21a - Care of patients/service users is my organisation's top priority	**77%↑**	75%	71%	76%
21b - My organisation acts on concerns raised by patients / service users	**77%↔**	77%	75%	73%
21c - I would recommend my organisation as a place to work	**64%↑**	61%	63%	61%
21d - If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	**71%↑**	70%	70%	71%
KF1 Staff recommendation of the organisation as a place to work or receive treatment	**3.81↑**	**3.76**	**3.78**	**3.76**

7. OVERALL STAFF ENGAGEMENT SCORE

The table below shows the staff engagement score compared with all other similar trusts in the relevant national category. Possible scores range from 1-5, where 1 = staff are poorly engaged and 5 = staff are highly engaged.

2017 NHS average staff engagement score for all acute trusts →	3.79
CHS Overall Staff Engagement Scores	
2017	3.82
2016	3.81
2015	3.84

A comparison of CHS Staff Engagement Score with other NHS organisations in the North East is shown in **Appendix 2.**

8. TOP KEY FINDINGS

The **top 5 Key Findings** where **CHS** compared most favourably with other acute trusts in England are:

1. KF16. Percentage of staff working extra hours = 64% compared to 72% for acute sector, (the lower the score better).

2. KF31. Staff confidence and security in reporting unsafe clinical practice = 3.78 compared to 3.65 for the acute sector, (the higher the score the better).

3. KF2. Staff satisfaction with the quality of work and care they are able to deliver = 4.06 compared to 3.91 for the acute sector, (the higher the score the better).

4. KF15. Percentage of staff satisfied with the opportunities for flexible working patterns = 55% compared to 51% for the acute sector, (the higher the score the better)

5. KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months = 21% compared to 25% for the acute sector, (the lower the score the better).

The **bottom 5 Key Findings** where **CHS** compared least favourable with other acute trusts in England are:

1. KF4. Staff motivation at work = 3.89 compared to 3.92 for the acute sector, (the higher the score the better).

2. KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month = 89% compared to 90% for the acute sector, (the higher the score the better).

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

4. KF11. Percentage of staff appraised in last 12 months = 84% compared to 86% for the acute sector, (the higher the score the better).

5. KF22. Percentage of staff experience physical violence from patients, relatives or the public in last 12 months = 16% compared to 15% for the acute sector, (the lower the score the better).

9. HSE STRESS AUDIT

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

	2017	2016	2017 average for acute trusts
Q5b - The support I get from my immediate manager	68%↔	68%	67%
Q5c - The support I get from my work colleagues	82%↔	82%	80%

10. 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.

Key Findings	Ethnicity	2017	2016	Acute trust average scores
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White BME	28% 35%	29% 28%	27% 28%
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White BME	20% 32%	19% 26%	25% 27%
KF21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White BME	89% 74%	89% 74%	87% 75%
17b. In the last 12 months have you personally experienced discrimination at work from managers, team members / other colleagues?	White BME	6% 19%	4% 14%	7% 15%

11. CQUIN 2017/19 HEALTH AND WELLBEING TARGETS

There are a number of targets in the 2017/19 CQUIN Guidance relating to improving staff health and wellbeing, some of which are 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 out of the 3 NHS Staff Survey questions relating to health and wellbeing (Qs 9a, 9b & 9c below) as follows:

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

Achievement of the targets is rewarded on a sliding scale with less than a 3% point improvement receiving 0% payment. The results for 2017, against the 2015 baseline scores are shown below. It should be noted that as the Trust failed to achieve the 2017/18 CQIN targets, this means there is a risk of losing income in the region of £192,512. .

Question	2017 target score	2017 actual score	2016 score	2015 score	2018 target score
9a - % of staff saying the Trust takes positive action on health and wellbeing	>=36%	33% 1% better than last year, but 3% below target	32%	31%	>=37%
9b - % of staff saying they have experienced work related MSK problem	<=20%	27% 2% better than last year, but 7% below target	29%	25%	<=24%
9c - % of staff saying they had work related stress	<=24%	33% 1% worse than last year and 9% below target	32%	29%	<=27%

12. ACTION FOLLOWING 2016 STAFF SURVEY FEEDBACK

Analysis of staff feedback in the 2016 staff survey and gathered via a series of focus groups that took place last summer, identified 5 areas where staff experience is poor and further work was identified. A summary of these and examples of action taken in response is in **Appendix 3.**

A copy of the 'Listening to Staff' 2016 staff survey leaflet shared with staff giving more detail is in **Appendix 4.**

13. CONCLUSIONS

Overall there are many areas where staff feedback has improved. (A diagram showing the historical changes to all questions is on page 9.

CHS results show scores above the national average on a number of indicators including the number of staff recommending the Trust as a place to work or receive care / treatment and the Trust achieved one of the best scores for staff feeling confident and secure in reporting unsafe clinical practice.

That said, there are a number of areas where staff experience has not improved or has worsened and which need more attention. These are as follows:-

- **Health and wellbeing** and the number of staff experiencing musculoskeletal problems and work related stress.

- **Behaviour – particularly bullying, harassment and physical violence** from staff, managers and patients/public.

- **Equality issues** and the experience of colleagues from BME heritage.

- **Appraisals** and the number of staff who have not had one.

- **Reporting of incidents** and near misses.

14. NEXT STEPS

A press statement giving an overview of the survey results has already been released. Feedback will be shared with staff via the following:-

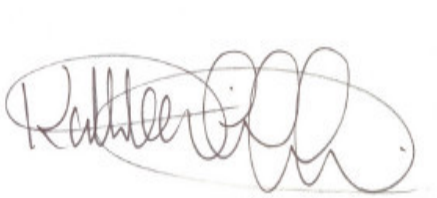
- Senior Manager Forum;
- Quarterly Staff Briefings;
- Team Brief;
- Intranet;
- Staff side colleagues via JCG meetings;
- Consultant Briefings;

Locality (Directorate / Department) reports will also be shared with relevant managers. These give an overview of the results by survey section, local benchmarks, comparing results with other localities in the organisation and a detailed breakdown of the results.

A number of engagement events will also take place during April and May to which all staff will – as in 2016 - be invited to attend. These will involve a mixture of presentation, table discussions and interactive exercises, with a focus on listening to staff experience and developing ideas for taking action to address the issues identified. These will be led by the OD Team who will also be sharing the OD Plan for 18-19 with staff. This consists of a number of initiatives / interventions designed to give a better understanding of our culture, people, needs and challenges, e.g. development of a behavioural standards framework, leadership training and BME colleague engagement.

RECOMMENDATIONS

Governors are asked to note the contents of this paper and approve the next steps as outlined above.



Kathleen Griffin
Director of Human Resources and Organisational Development

APPENDIX 1

SUMMARY OF RESULTS BY SURVEY THEMES

Appraisals and support for development

- Coverage of appraisals has decreased from 87% to 84% and is below the acute sector average of 86%.
- The quality of the appraisals is rated by staff at 3.14, slightly better than the acute sector average of 3.11.

Equality and diversity

- The percentage of staff experiencing discrimination at work has increased from 8% to 10%, but is lower than the acute average of 12%.
- The percentage of staff who believe the Trust provides equal opportunities for career progression has not changed at 87%, which is better than the acute sector average of 85%.

Errors and incidents

- The percentage of staff witnessing potentially harmful errors, near misses or incidents has reduced from 31% to 28% and is better than the acute sector average of 31%.
- The number of staff reporting errors, near misses or incidents they witnessed has reduced from 95% to 89%, which is slightly below the acute sector average of 90%.
- Staff confidence in reporting unsafe clinical practice is better than the average for acute trusts and the fairness and effectiveness of procedures for reporting errors/incidents has remained the same at 3.82, which is better than the acute sector average of 3.73.

Health and Wellbeing

- The percentage of staff reporting feeling unwell due to stress has remained unchanged at 33%, though this is better than the acute sector average of 36%.
- The percentage of staff reporting feeling pressure to attend work despite feeling unwell has increased from 48% to 50%, which is slightly better than the acute sector average of 52%.
- Management interest in staff health and wellbeing is rated at 3.64, which is just above the acute trust average of 3.62.

Working Patterns

- 55% of staff said they were satisfied with opportunities for flexible working compared with the acute sector average of 51%.
- The percentage of staff working extra hours has at 64% not changed and is below the acute sector average of 72%.

Job satisfaction

- The extent to which staff would recommend the Trust as a place to work or receive treatment improved from 3.75 to 3.81 and is above the acute sector average of 3.75.
- Responses from staff 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, have remained stable and are average or better than average in relation to the acute sector.

Managers

- The extent to which staff feel recognised and valued by managers and the organisation remains the same at 3.45.
- There is no change in the percentage of staff reporting good communication between senior management and staff (37%), which is above the acute trust average of 33%. (48% is the 'best score' for this key finding).

Patient care & experience

- Staff satisfaction with the quality of work and care they are able to deliver was scored at 4.06, which is above the acute trust average of 3.91.
- Effective use of patient feedback is rated the same as in 2016 at 3.72, which is also the average for acute trusts, as is the percentage of who staff who agree that their role makes a difference to patients (90%).

Violence, harassment and bullying

- Overall responses relating to violence, harassment and bullying at work have remained fairly static since last year.
- There is 'no change' to the number of staff reporting violence at work since 2016, which is comparably better than the acute trust average.
- The percentage of staff experiencing harassment, bullying or abuse from other staff or their manager has stayed the same as in 2016 and the reporting of such incidents has decreased from 54% to 46%.

COMPARISON OF NORTH EAST ORGANISATION 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	**Overall Staff Engagement Score**
Newcastle Hospitals	88%	82%	70%	89%	4.1	**3.91**
Gateshead	85%	83%	72%	81%	4.02	**3.91**
Northumbria Healthcare	81%	80%	67%	77%	3.94	**3.91**
Tees, Esk & Wear Valley	74%	82%	62%	68%	3.74	**3.84**
Northumberland Tyne & Wear	80%	81%	62%	68%	3.81	**3.83**
City Hospitals Sunderland	77%	77%	64%	71%	3.81	**3.82**
North Tees and Hartlepool	77%	76%	62%	67%	3.79	**3.81**
South Tees	66%	69%	54%	69%	3.59	**3.73**
South Tyneside	70%	69%	51%	62%	3.61	**3.68**
County Durham & Darlington	64%	66%	49%	58%	3.51	**3.67**

APPENDIX 2

APPENDIX 3

SUMMARY OF 5 KEY AREAS AND ACTIONS FOLLOWING 2016 STAFF SURVEY FEEDBACK

Bullying and Harassment	**Progress Update**
• Ensure we have the same policy / a consistent zero tolerance approach to bullying and harassment across both trusts.	• Director of HR and OD appointed as Freedom to Speak Up Guardian across both Trusts. Ambassadors appointed and available in both Trusts to support colleagues in raising concerns. Widely promoted to staff through induction and internal communications. • Awareness raised about our zero tolerance policies regarding bullying, harassment and unacceptable behaviours at Trust Induction, in Staff Handbook and included in Leadership Development Programmes. • Dignity at Work Advisors available for staff to contact regarding bullying or harassment issues. • Workshops underway to engage staff in the process of developing a behavioural standards framework for all staff.
• Make it clear who staff can talk to if they have any concerns and the processes that are in place.	
• Promote the fact that all concerns will be taken seriously and looked into.	
• Be clear about what behaviours are acceptable linked to our values and those that will not be tolerated.	
• Raise awareness of what bullying and harassment are from the moment staff join the organisation.	
• Try to resolve things quickly, wherever possible and appropriate to do so, by making the process clearer and simpler.	
Communication	**Progress Update**
• Review mechanisms for regular internal communications.	• Monthly Team Brief takes place in both Trusts. • Quarterly staff briefings held in both trusts by Executive Committee. • Board visibility at 'Welcome' slot on trust induction in both trusts. • Weekly E-Bulletin/Newsletter published in both trusts. • Active news pages on both Trusts intranets. • Launch of new 'Path to Excellence' branding
• Develop an internal communications and engagement strategy.	
• Increase visibility of senior leadership team.	
• Make it as easy as possible for managers to deliver Team Brief.	
• Develop a programme of internal engagement and publicise this in advance.	
• Create a regular newsletter / e-bulletin	

• Increase the volume of internal communications. • Ensure staff have all the information they need about clinical service reviews.	• Launch and publicity of new vision and values. • Staff consultation, engagement and regular communication updates in place for Clinical Service Reviews.
Management Behaviours	**Progress Update**
• Further publicise and be clear about which behaviours are / are not acceptable. • Review how we recruit managers and what skills, personal qualities and leadership traits we want them to have. • Tighten processes around appraisals. • Make sure senior management team 'walk the floor' more often / are more visible. • Ensure everyone is treated equally and fairly with transparent processes.	• New Leadership and Talent Management Strategy agreed and Year 1 Delivery Plan underway. • Engagement currently underway with staff across both trusts to develop a behavioural standards framework, starting with review of consultant recruitment at STFT. • Talent Management based appraisal model piloted in both trusts as part of HR Graduate Trainee placement. New Appraisal Policy to be implemented for both trusts by June 2018 and to include process for checking / auditing appraisal quality - not just compliance rates. • New 1 and 2 day Leadership Development Programmes in place across both trusts. Well received / positive feedback. Approximately 200 staff have attended to date. • Handling Difficult Conversations Workshops being delivered across both trusts. Well received / positive feedback. • Appraisal training now in place at CHS as well as STFT. • 3 pilot Leadership Apprenticeship programmes are underway.
Personal Development	**Progress Update**
• Ensure everyone has a personal development plan. • Provide more flexible / blended learning opportunities.	• Appraisal training for managers now includes skills development in leading effective discussions and agreeing personal development objectives with all staff.

• Introduce coaching and mentoring. • Look at how we can use venues other than the main hospital sites for training. • Support equal opportunity for all to access training and development. • Seek feedback on current e-Learning packages to help improve for the future.	• A range of hospital and community sites across both Trusts are being used for training and engagement activity for 2018/19 and beyond. • Review of study leave policies across both trusts underway to ensure consistency and equal opportunities for all staff to access training and development. • Currently working with training providers to develop a mentoring scheme for our Leadership Apprentices.
Health and Wellbeing	**Progress Update**
• Ensure that Trust policies and procedures are applied fairly. • Be clear about how requests for equipment / improvements to working environment can be made. • Raise awareness around psychological wellbeing of staff including resilience and stress awareness.	• Employee Benefits Days held at CHS and for the first time, at STFT. • Free Health Checks / MOTs for staff introduced in October 2017 and well received.

APPENDIX 4

Listening to Our Staff

NHS
City Hospitals Sunderland
NHS Foundation Trust

LISTENING TO OUR STAFF

OUR COMMITMENT TO YOU

September 2017

The path to excellence

Sharing what we've done since the last staff survey.

After listening to the views you shared in the 2016 Staff Survey, much work has begun to improve the working environment and culture across both City Hospitals Sunderland and South Tyneside NHS Foundation Trusts.

We are now at the start of an important journey as we work together as part of the South Tyneside and Sunderland Healthcare Group. Whilst we have made some progress in the past 12 months, we know there is still much to do. Over the summer we held a number of staff focus groups across both trusts to 'drill down' beneath the survey results and find out what issues colleagues felt were having the most impact on their working lives.

The leaflet summarises some of the steps we have already taken, the feedback from the focus groups and, most importantly, what we still need to improve moving forward. We have based this around five key themes that you told us were most important to you:

- Bullying and harassment
- Management behaviour
- Personal development and support
- Communication
- Health and Wellbeing

OUR VALUES

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

BULLYING AND HARASSMENT

What you told us...

"There needs to be more clear communication that bullying and harassment will not be tolerated"

"Build staff confidence that actions will be followed up with no repercussions"

"Important that you are taken seriously when raising concerns and fully supported"

"Staff need to know there are people they can speak to early to enable help"

"Managers need to be aware of acceptable and unacceptable behaviours"

"Better promotion of bullying and harassment, listening advisors, dignity at work advisors and freedom to speak up advisors"

"Exit interviews should be standard"

What we have already done:

- Implemented our 'Dignity at Work Policy' with 'Dignity at Work Advisors' in place to support colleagues who have concerns about bullying or harassment.
- Appointed Kath Griffin as our Freedom to Speak Up (FTSU) Guardian along with a team of FTSU Ambassadors to support staff in raising concerns.
- Set up the 'Care First Employee Assistance Programme', providing 24/7 confidential telephone or face-to-face counselling as well as access to free legal advice, debt counselling and consumer rights.
- As part of our partnership working with trade union colleagues, our Chief Executive Ken Bremner has signed up to a new national initiative to stamp out bullying in the NHS.

What we need to do:

- Ensure we have the same policy and a consistent zero tolerance approach to bullying and harassment across both trusts .
- Make it really clear who you can talk to if you have any concerns and the processes that are in place.
- Promote the fact that all concerns will be taken seriously and looked into.
- Be clear about what behaviours are acceptable linked to our values and those that will not be tolerated.
- Raise awareness of what bullying and harassment is from the moment you join the organisation.
- Try to resolve things quickly, wherever possible and appropriate to do so, by making the process clearer and simpler.

COMMUNICATION

What you told us...

"More face-to-face communication, there is too much reliance on email"

"More open, honest communication to avoid rumours / scaremongering"

"Communication should be two way and include listening / feedback"

"Visibility of senior managers within teams to aid communication"

"Cascade of monthly Team Brief needs to be consistent by all managers"

"More detailed information about the clinical service reviews and timings"

"Staff roadshows booked in advanced and arranged with consideration given to shift times and community staff"

"A guaranteed regular / timely communication for staff"

What we have already done:

- Introduced Team Brief and regular staff briefings / roadshows.
- Improved our social media presence on Twitter and Facebook to share good news and information.
- Developed a new website (launching soon!) to make finding out information about the Trust easier.
- Appointed a Head of Communications across both trusts to help us improve how we communicate and engage with staff and stakeholders.

What we need to do:

- Review mechanisms for regular internal communications.
- Develop an internal communications and engagement strategy.
- Increase visibility of senior leadership team.
- Make it as easy as possible for managers to consistently deliver Team Brief.
- Develop a programme of internal engagement and publicise this in advance with colleagues.
- Create a regular newsletter / e-bulletin for colleagues.
- Increase volume of internal communications for colleagues.
- Ensure staff have all the information they need about clinical service reviews.

MANAGEMENT BEHAVIOUR

What you told us...

"More leadership and development for managers at all levels"

"Need to ensure that appraisals happen"

"Succession planning – develop staff / talent management"

"Inner circle culture needs challenge (Ivory Tower)"

"Line managers need to be consistent in how they manage staff"

"Negative management behaviour needs to be addressed"

"Senior managers: need to understand what is happening, be visible, not so target led, need good people skills and need to be inclusive"

"Consistency in following trust policies"

What we have already done:

- A new 'Leadership and Talent Management' strategy has been approved and an operational plan is being developed to improve leadership, development and training across both trusts.
- A new 'Appraisal Policy' and process has been piloted in two wards at CHS and STFT and will be rolled out across both trusts over the next 12 months.
- Values based recruitment training is being developed for recruiting managers to make sure that we recruit individuals whose personal values and behaviours align with our values and those outlined in the NHS Constitution.
- New leadership apprenticeships are being developed and have already been advertised to help us to develop our future managers.
- A new joint senior management team is in place across both trusts to provide clear leadership and support and ensure consistency.
- A number of colleagues have attended North East Leadership Academy Programmes and Clinical Leader Programmes.

What we need to do:

- Further publicise and be clear about which behaviours are acceptable and which are not.
- Review how we recruit managers and what skills, personal qualities and leadership traits we want them to have.
- Tighten processes around appraisals as there is no reason why these should not be happening.
- Make sure our new joint senior management team 'walk the floor' more often and are more visible.
- Ensure everyone is treated equally and fairly with transparent processes.

PERSONAL DEVELOPMENT & SUPPORT

What you told us...

"Managers to actively encourage development – not entirely autonomous to the staff"

"Making training opportunities available for all across the alliance"

"Appraisal – tick box exercise and not used to support personal development in the way it should"

"Perception of culture not to ask for development due to staffing and no money for external training"

"Sharing information - internal training and development and support for regular sessions to go ahead"

"Develop lower band staff who have shown commitment and want to develop"

"E-learning access – need clearer instructions"

What we have already done:

- Our new 'Leadership and Talent Development' strategy has now been agreed to set out how we will support and develop leaders across both trusts.
- Reviewed the current appraisal process so all colleagues can discuss personal work objectives and development needs and future talent can be identified no matter what role they have in the organisation.
- Invested in apprenticeship opportunities across a number of areas, including administration, healthcare and leadership.
- Organise our annual 'Reward and Recognition Awards' to ensure that we have a formal way to recognise outstanding achievement.
- Positive feedback from patients is now being regularly highlighted through the use of our social media channels.

What we need to do:

- Ensure that everyone has a personal development plan.
- Provide more flexible / blended learning opportunities, e.g. use of mobile. technology / self- directed learning.
- Introduce coaching and mentoring.
- Look at how we can use other venues for training and development other than the main hospital sites.
- Support equal opportunity for all colleagues to access training and development.
- Seek feedback on our current use of e-Learning packages to help us improve for the future.

HEALTH & WELLBEING

What you told us...

"Unfair application of annual leave policy i.e. having to take annual leave for GP / dentist appointments"

"Payment schemes for annual leave if not taken"

"Need more health and wellbeing information"

"Working conditions to be better – need adequate space to work and take breaks"

"Promoting wellbeing activities better"

"Tell people about the benefits / discounts / incentives"

"Wellbeing / Occupational Health Team to be more visible and out and about more"

"Recognising stress in other staff and yourself"

What we have already done:

- Implemented a fast track physiotherapy service, health MOTs and ergonomic assessments for staff.
- Provided an on-site Health and Fitness Centre for staff.
- Organise an annual Employee Benefits Day to give information on what staff benefits, discounts and support services are available.
- Our Care First Employee Assistance Programme is available 24/7 and offers confidential counselling as well as free advice around debt, legal and financial issues.
- We have a dedicated Occupational Health and Wellbeing Team and a comprehensive package of employee benefits (look on the intranet for the full list).
- Introduced a cycle salary sacrifice scheme.
- Introduced a Childcare Co-ordinator and Childcare Vouchers scheme.

What we need to do:

- Ensure that Trust policies and procedures are applied fairly.
- Be clear about how requests for equipment / improvements to working environment can be made.
- Raise awareness around psychological wellbeing of staff including resilience and stress awareness.