CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

There will be a meeting of the Board of Directors 'In Public' on
Thursday, 25 May 2017 at 3:30 pm
in the Board Room, Sunderland Eye Infirmary

AGENDA

Apologies:

1.	**Declaration of Interest**		
2.	**Minutes**		
Item 1.	To approve the minutes of the Board of Directors meeting held 'In Public' on Thursday, 30 March 2017		**Enc 1**
	Matters Arising		
	Item 2 Emergency Department	**CH**	
3.	**Standard Reports**		
Item 2.	Chief Executive's Update	**CH**	
Item 3.	Quality Risk and Assurance Report	**MJ**	**Enc 3**
Item 4.	Finance Report	**JP**	**Enc 4**
Item 5.	Performance Report	**AK**	**Enc 5**
4.	**Strategy / Policy**		
Item 6.	Annual Accounts and Report 2016/17	**JP**	**Enc 6**
Item 7.	Provider Self-Certification 2017/18	**CH**	**Enc 7**

Date and Time of Next Meeting

Board of Directors meeting to be held 'In Public' on Tuesday, 25 July 2017 at 10:00am in the Board Room, Sunderland Eye Infirmary.

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Minutes of the meeting of the Board of Directors held in public on Thursday, 30th March 2017.

Present: John Anderson (JNA) - Chair
David Barnes (DB)
Ken Bremner (KWB)
Stewart Hindmarsh (SH)
Melanie Johnson (MJ)
Ian Martin (ICM)
Peter Sutton (PS)

Apologies: Mike Davison (MD)
Alan Wright (AW)

In Attendance: Sean Fenwick (SF)
Kath Griffin (KG)
Carol Harries (CH) – to Item 5
Andy Hart (AJH)
Andrea Hetherington (AH) – from item 6
Alison King (AK)
Mike Laker (ML)

1. Declaration of Interest

None.

2. Minutes

Item 1 Minutes of the meeting of the Board of Directors held on Thursday, 26th January 2017

Accepted as a correct record.

Matters Arising

Joint Scrutiny Committee: KWB advised that a meeting had been held at the end of January and clearly members were keen to get more detail regarding the clinical service reviews which would not be available until May 2017. The formal consultation process would last for 12 weeks. The committee had been quite focussed about transport and had a number of concerns.

Vascular Services: KWB stated that here had been some movement and meetings had been held between the clinical teams here and at Durham, the latter recognising the additional capacity that was possible. There were to be some meetings with patient groups but the dates of those meetings had not as yet been confirmed.

3. Standard Reports

Item 2 Chief Executive's Update

Pay Award: KWB informed Directors that staff had been awarded 1% for the 7th successive year. The trade unions were clearly not happy and it was understood that the government had gone against the advice of their own advisors.

ICM commented that non public sector organisations were looking at 4-5% increase and in reality NHS staff were facing pay cuts when you looked at the increase in superannuation etc.

DB queried whether the 1% was applicable to all staff. KWB confirmed that it was for all agenda for change staff.

New Cancer Targets: A new target of 28 days for suspected cancer to diagnosis was to be introduced with a 95% target in April 2018 or 2020 but that was not clear. It would be difficult to achieve even with a 5% tolerance. KWB advised that we would be receiving further details.

Budget News: KWB advised that £2bn was to be identified for social care funding of which South Tyneside LA would receive £4.7m and Sunderland LA £14.4m over the next three years. ML queried how that would dovetail with costs already withdrawn from social care. KWB replied that it was to help with that and also there was to be a green paper in the autumn.

STP Funding: KWB advised that there had been some further funding released particularly for A&E which would potentially not help us as we were in the top 25 Trusts. £325m was available to support those STPs that were further advanced than others of which there were only four in the country. It was likely that within the North East, Cumbria would receive the funding because of the work that they have to do.

STPs: KWB stated that nationally they were now gathering some attention and consideration as to how they would be mobilised. There was recognition that CCGs needed to get into a different shape and our footprint may extend into Durham but that was not as yet confirmed.

Emergency Department: The building had been handed over on 27th March 2017. The development was a significant increase in size and looked really good. A visit was planned for Directors and Governors to be able to see the new facility before the first patients accessed services.

Church View Medical Practice: The Trust had given notice to NHS England with regard to the medical practice. The original date for handover was scheduled to be April 2017 but this had now been extended until September 2017. Colliery Medical Group which is located near to Church View was also experiencing similar problems and hopefully a new provider for both practices would be found from 1st October 2017.

Item 3 Quality Risk and Assurance Report

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

MJ advised that the downward trend in HAPUs was being sustained but that the work needed to continue. The number of community acquired pressure ulcers continued to rise and there was more work and information needed to understand the reasons for that increase. ML commented that presumably a CAPU could develop further following admission. MJ confirmed that this was correct and demonstrated the importance of having proactive preventative strategies for these particular patients. MJ stated that a pressure ulcer panel had been introduced so that wards were being held to account and lessons learned and understood.

MJ informed Directors that a 'Think Family' symposium was held on 27th March 2017 regarding safeguarding which had some excellent speakers including the family of Jenny Clough a nurse who was murdered by her abusive partner in the car park of her work place, after she left him due to domestic abuse. The symposium had been well attended and very well received.

SH commented that his nursery had been required to do additional paperwork if a parent was living with someone who offended and had a drug dependency (prescription drugs). SH stated that he had given the paperwork to KG as we were not yet aware of the issue.

A serious case review involving a domestic violence incident had been published on 13th February 2017. There were some actions for CHS which would be monitored by the Safeguarding Children and Adults Group (SCAG) and by the CCG.

In relation to DoLS the Court of Appeal had handed down a judgment that patients in ICCU would not normally be deemed to be deprived of their liberty unless there were exceptional circumstances. MJ advised that the case would go to the Supreme Court for further consultation and it was likely that further guidance would be issued.

MJ informed Directors that it was an improved position for complaints in terms of the timelines of responses. Further work was ongoing to improve the position even further.

The nursing workforce fill rate for January 2017 had been 90% for SRH and 97% for SEI. There had been 13 wards in January 2017 with RN fill rates of less than 80%. As a consequence of the number of vacancies, overtime had been introduced to relieve the pressure. Various initiatives were being undertaken in terms of recruitment and a team had recently been to Dublin and there had been two offers made and 15 expressions of interest.

MJ informed Directors that 23 overseas nurses were in post and 11 had passed their objective structured clinical exam.

ICM informed Directors that the Trust had been given a trajectory of 34 cases for *C. difficile* in 2017/18 which was the same trajectory as 2016/17.

ICM also advised that there had been some progress in relation to improving sepsis practice. There was still an issue of patients receiving antibiotics within one hour but then it was also important not to give antibiotics to those who do not need it which was not always easy to do. As an organisation we were very good at collecting the data whereas other organisations were not as accurate. ML queried as to how significant an issue it was. ICM replied that at front of house it was not too difficult but more problematic back of house but it was slowly improving.

ICM also outlined the process regarding clinical guidelines and stated that there was little evidence of a standard process, document management or archiving arrangements. Dr Paul McAndrew, Deputy Medical Director, had been tasked to review the current governance around guidelines and to prepare a "case for change" document. ML queried whether there was any concern about the uptake of guidelines. ICM replied that at the moment it was fragmented although some pathways were audited but fundamentally there was no overarching system.

Resolved: To accept the report.

Item 4 Finance Report

JP presented the report and advised that the overall financial position was a net deficit of £1,798k against a planned deficit of £2,990k, and therefore £1,192k ahead of plan.

JP advised that as at 1st February 2017, the CHS estates and facilities function had transferred over to the Trust's wholly owned subsidiary company – CHoICE Ltd – forming CHoICE Facilities Services. The financial value of CHoICE was now material and therefore required group consolidation and reporting going forwards. JP explained that all financial commentary from now and beyond would relate to the overall group i.e. CHS and CHoICE added together.

The current financial position, a deficit of £1,798k assumed non delivery of key performance targets, namely the 4 hour A&E target in October, December 2016, January and February 2017, plus cancer targets in January and February 2017. JP stated that total lost income forecasted was £685k.

Pay was currently showing an underspend of £1,324k against plan mainly due to vacant nursing posts. The CIP position as declared to NHS Improvement for 2016/17 was £15,000k although divisional plans to date only totalled £13,786k.

JP informed Directors that cash was more of a concern, in the last few months. At the end of February 2017 the cash balance was £4,745k against a planned £10,305k. The main variance was predominantly due to a timing issue in how the Trust planned for the cash receipt of STP funding, plus delays in the release of STP funding to organisations.

As at 24th March 2017 the Trust had received £2.2m (Q2 and Q3 financial targets) although Q4 was yet to be received and unlikely to be received until June/July 2017. JP explained that despite the gap on the identified CIP plans, a number of one off items through the establishment of CFS and a slightly better than expected clinical income position meant the Trust was confident that a financial position better than the overall control total could be achieved in 2016/17. The Trust expected to be ahead of the control total excluding STF by £850k and therefore had assumed like for like matched STF funding to this value. JP stated that given this funding we may yet get to a break even position but that was not definite. DB stated that this had been discussed in detail at the Finance Committee and the CHoICE consolidation and yearend bonus had been really helpful. The situation also emphasised how difficult it was to get to a year end position. DB also commented that this would not have been achieved without the efficiency of the PMO over the last year.

ICM commented that the situation was not what he would normally expect – good performance being rewarded as opposed to poor performance being bailed out.

Resolved: To note the financial position to date.

Item 5 Performance Report

AK presented the report which updated Directors on performance against key national targets and local contractual indicators. AK explained that RTT remained above target at 93.7% with improvement in ENT and rheumatology.

A&E performance for February 2017 was below the 95% target and STF trajectory at 89.1% which was lower than the previous year with a 2.72% increase in attendance. The national performance for January 2017 was 85.1% and we remained in the upper middle 25% of Trusts nationally. AK stated that the narrative within the report had changed to show more context and also how we compared.

ML commented that whilst ever there were delays in ambulance handover, this had the effect of ambulances not being available for other emergencies. AK replied that there were issues as to what happens even after handover as often the crews do not immediately get back on the road. SF commented that the 30 minute turnaround was more critical and some organisations were high performers and other were greater at clustering. In response to a query from JNA, AK confirmed that the data contained in the Performance Report was NEAS data however agreed to look at providing some additional narrative on handover in future reports.

ICM stated that it appeared that the turnaround times for despatches to 999 calls had also been relaxed. SF replied that NEAS believed that this would have a positive effect. ICM also commented that there was no system of oversight of central control arrangements, i.e. the flight deck and there needed to be more clarity across the system.

DB queried whether the ramp issues in front of the new Emergency Department had now been resolved. SF replied that the team and estates had worked closely with NEAS and the new arrangements had been implemented with full agreement from everyone.

AK also highlighted page 11 – cancer 62 days and advised that we were still about 85%. A new target was being introduced and we were working with urology in particular as to what might be a sustainable position going forward. SH queried whether there were any financial penalties in relation to 62 days. AK replied that there were no penalties and although performance was scrutinised the financial penalties only related to A&E.

AK also stated that outpatient communication was improving which was an encouraging position.

SH commented that diagnostic performance seemed fairly fragile and SF agreed that there was a degree of fragility with some diagnostics. SH asked what the solution was and PS responded by advising that an expensive solution would be to run at lower usage levels. ICM commented that for some of the smaller and more specialist diagnostics, services are outsourced in order to be able to increase/decrease depending on demand. AK advised that an early warning dashboard was used in terms of diagnostic visibility which enables better planning to avoid issues. SH asked whether there was any additional diagnostic capacity at STFT which could assist CHSFT and SF confirmed that STFT had supported CHSFT with some echocardiography capacity. He added that from a clinical perspective, within the 6 week timescale there could be a lot of difference in clinical urgency.

Resolved: To accept the report.

4. Strategy/Policy

Item 6 2016 NHS Staff Survey Results

KG presented the paper which summarised the Trust's results from the 2016 NHS Staff and outlined areas for action for the Board to consider. She advised that the whole workforce had been sent the survey rather than the usual sample and the response rate was 35% (44% nationally). She advised that there were 90 questions in the survey which may explain the response rate, however it had increased from the previous year.

KG reported that overall and compared to the rest of the acute sector, most of the Trust's scores were around or above average with very little movement since the previous year. She highlighted the "*Staff motivation at work"* score was 3.92 and this was one of the Trust's bottom 5 key findings however it was still higher than the national average at 3.94 for the acute sector. She highlighted Appendix 1 of the report which outlined how the Trust compared with other Trusts in the region in terms of overall staff engagement scores, CHSFT scoring 3.81.

KG then drew the Board's attention to the Top and Bottom 5 key findings, noting that some were unchanged from last year. KG highlighted in particular KF11 – the percentage of staff appraised in the last 12 months – which whilst in the Bottom 5 key findings, was a 3% improvement from the previous year. She advised that the survey showed the Trust to be slightly above the national average with regard to support from immediate line manager and colleagues. Workforce race equality standard related questions indicated an improvement.

KG asked Directors to approve the paper, advising that the results, together with other sources of workforce information/staff feedback, will be used to develop a staff engagement plan as part of a new OD Strategy for both CHSFT and STFT. PS said he completely supported this direction of travel but felt the impact would not be seen in the next survey. KG agreed, advising that the survey results had been subject to embargo until March and the next survey would be going out to staff in September. She felt it would be 2018/19 before the full impact of the new OD Strategy and staff engagement plan would be seen.

ML commented that the two questions around staff experiencing bullying and harassment were confusing (K27 and K25) and it was clarified that whilst both related to bullying and harassment, one related to the number of people who had reported such incidents.

Resolved: To accept the report.

Item 7 Information Governance Toolkit - CHS and Church View

AJH presented the paper which provided an overview of the process undertaken by the Trust around the IG Toolkit Assurance process, which also included Church View Medical Practice. He reminded the Board that this was

a requirement to show compliance with central guidance and legislation. He outlined the activities which had taken place, advising that these were largely consistent with the process in previous years.

AJH reported that with regard to CHSFT, the total percentage compliance for all initiatives was 87% - satisfactory (green). This included 17 areas assessed as Level 2 and 28 at Level 3. Only one area had deteriorated since last year – Clinical Coding Audit – which was projected to be scored at Level 2. With regard to CVMP, AJH reported that 4 areas were Level 2 and 9 areas Level 3. Again, with only one area of deterioration – Consent. The overall percentage compliance score for CVMP was 89% - satisfactory (green).

AJH confirmed that 96.6% of staff had completed IG training in the year.

AJH concluded by reporting that since the paper had been written, AuditOne had confirmed Level 2 assurance. PS asked if AJH knew how many organisations were rated as red and whilst AJH was unable to provide an exact figure he did advise that he was aware that such organisations were given a very short period of time to develop an action plan.

Resolved: To accept the report.

JOHN N ANDERSON QAEP CBE
Chairman

ENCLOSURE 3

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DIRECTORATE OF QUALITY & TRANSFORMATION

BOARD OF DIRECTORS

MAY 2017

QUALITY, RISK AND ASSURANCE REPORT

EXECUTIVE SUMMARY

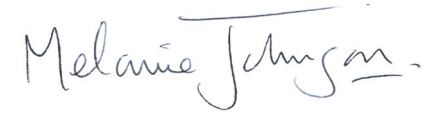
The Quality, Risk and Assurance Report is a summary report to provide assurance to the Board on the key regulatory, quality and safety standards that the Trust is expected to maintain compliance with and/or improve. The summary of key risk activity documented in this report is as follows:

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

Recommendation

Directors are asked to note the report.

Bob Brown
Director of Quality & Transformation



Melanie Johnson
Director of Nursing & Patient Experience

Ian Martin
Medical Director

City Hospitals Sunderland
NHS Foundation Trust

Quality, Risk and Assurance Report for March 2017

Presented to Board of Directors
May 2017

PATIENT STORY
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

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

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

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

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

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

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

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

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

Update

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

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

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

1.1 HOSPITAL ACQUIRED PRESSURE ULCERS (HAPUs)

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

Ward Dashboard data for March 2017

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

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

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

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

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

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

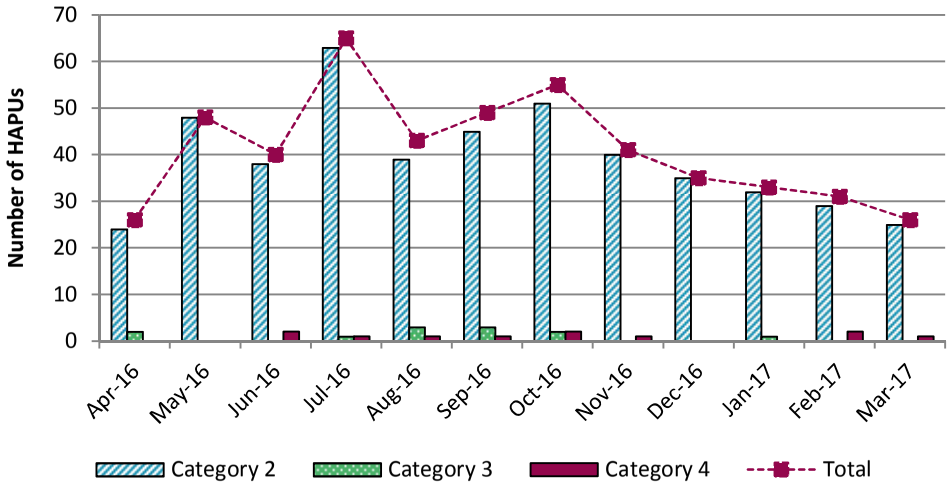
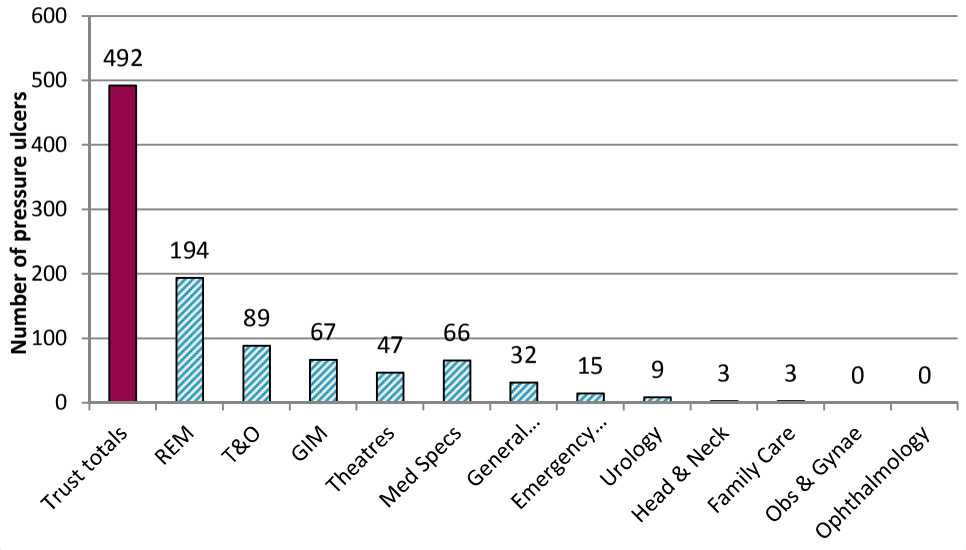


Figure 2: Total number of Pressure Ulcers (category 2 and above) April 2016 to March 2017



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

1.2 TRUST PERFORMANCE AGAINST IMPROVEMENT TRAJECTORY

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

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

1.3 COMMUNITY ACQUIRED PRESSURE ULCERS (CAPUs)

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

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

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

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

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

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

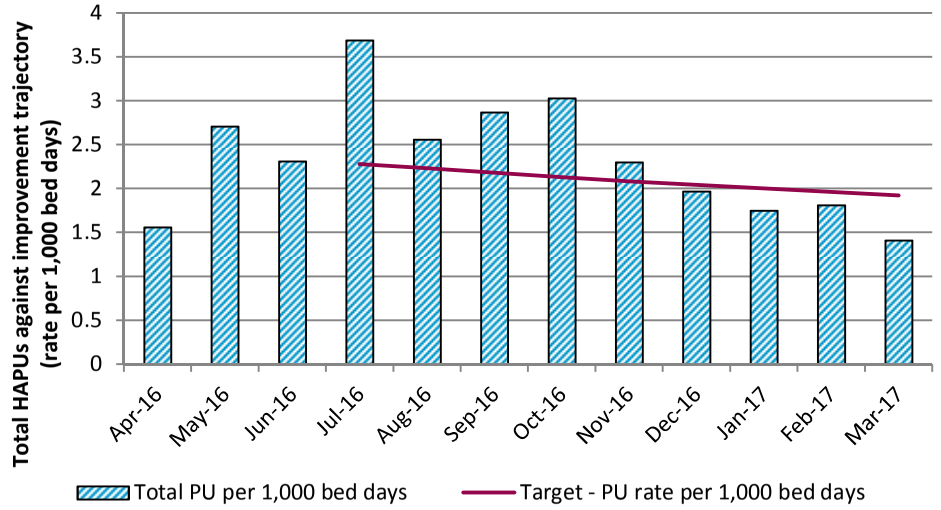
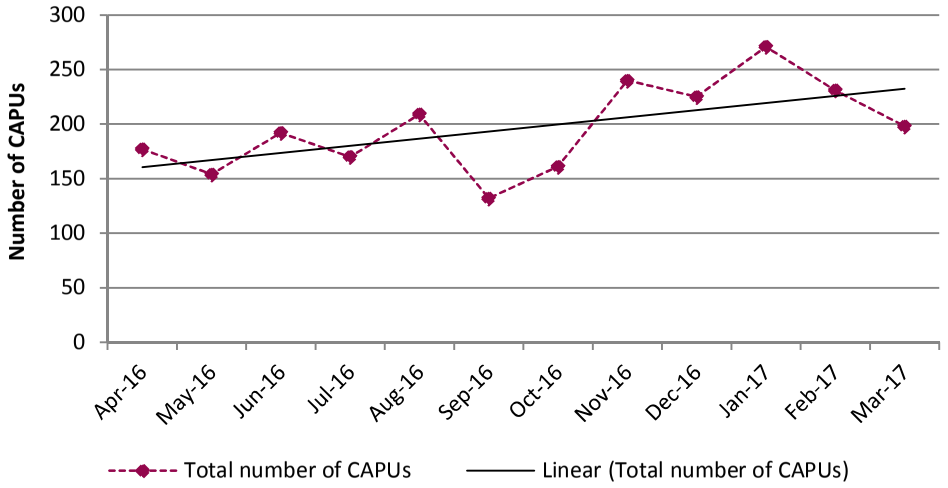


Figure 4: Community Acquired Pressure Ulcers (CAPUs) by category and trend from April 2016 to March 2017



SAFEGUARDING CHILDREN
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.4 SAFEGUARDING CHILDREN

Current position

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

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

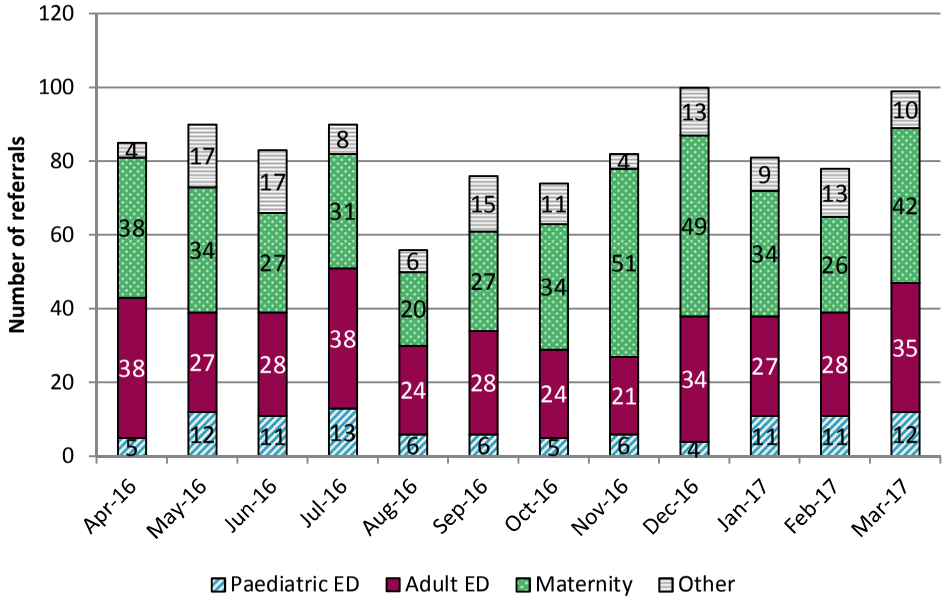
There has been an increase of young people aged 16 to 18 years who have presented into the ED under the influence of substances. The use of class A drugs as opposed to Psychoactive Substances has been noticed. Northumbria Police are aware of the increase in young people accessing class A drugs since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

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

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

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

Figure 5: Safeguarding children referrals April 2016 to March 2017



SAFEGUARDING ADULTS
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.5 SAFEGUARDING ADULTS

1.5.1 Safeguarding Adults Reviews (SARs)

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

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

Referrals

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

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

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

Mental Capacity Act: Deprivation of Liberty Safeguard (DoLS)

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

Currently there are no changes to the DoLS application process.

Current Position

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

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

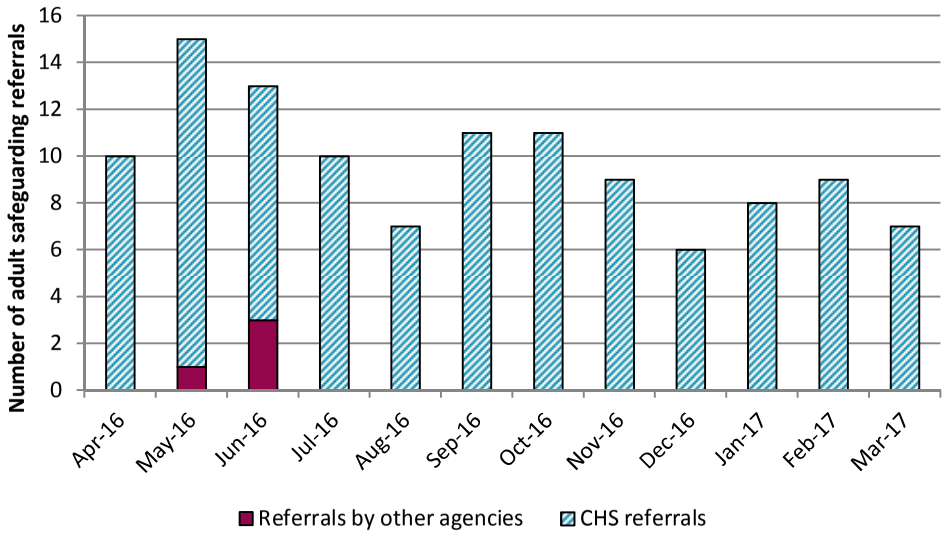
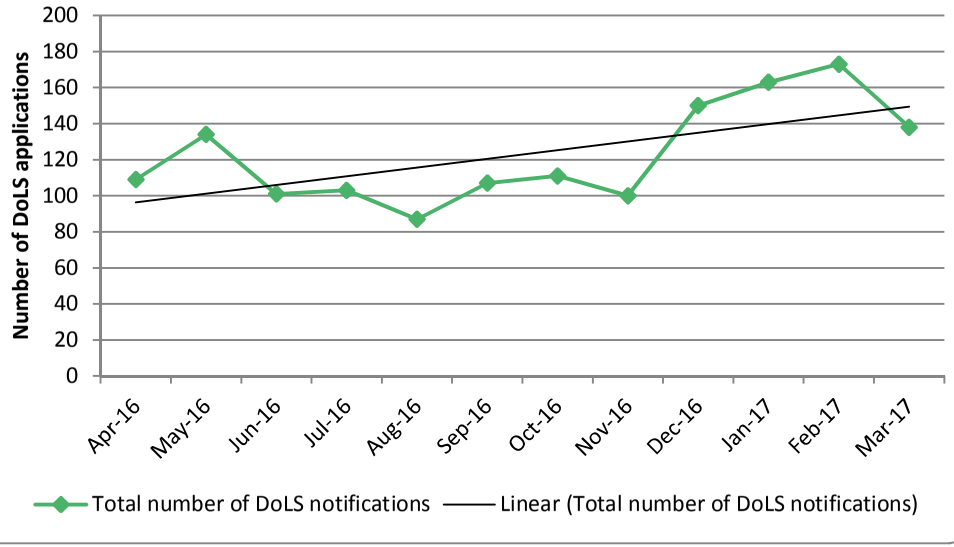


Figure 7: Number of DoLS applications made April 2016 to March 2017



COMPLAINTS
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.6 COMPLAINTS

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

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

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

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

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

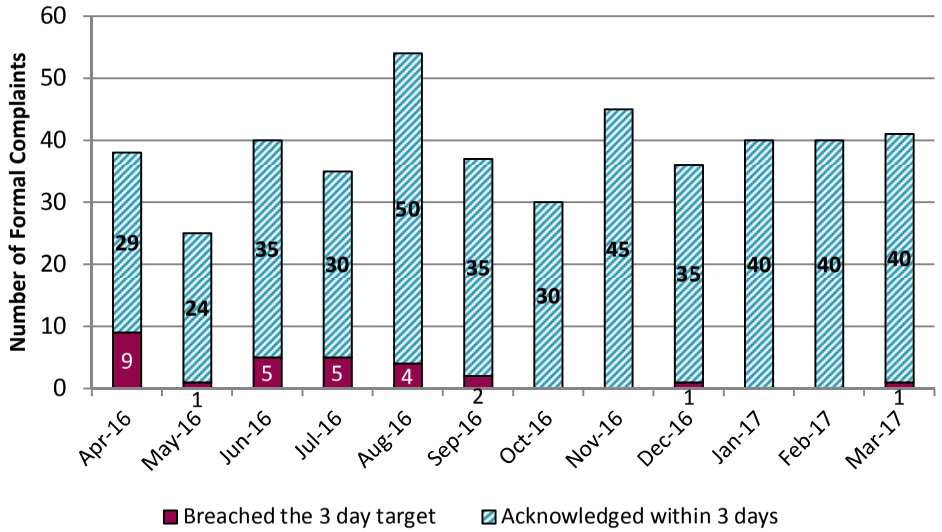


Figure 9: Current formal complaints awaiting first written response by working days - March 2017

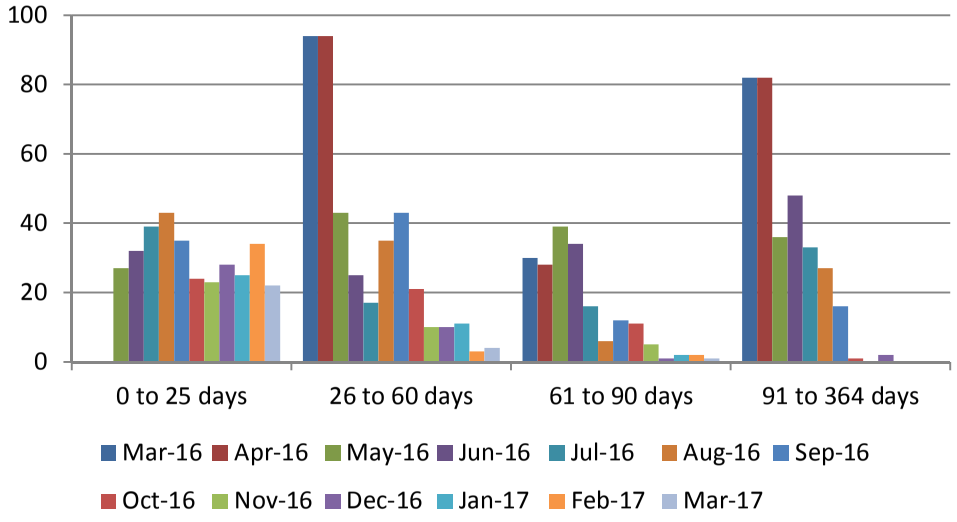
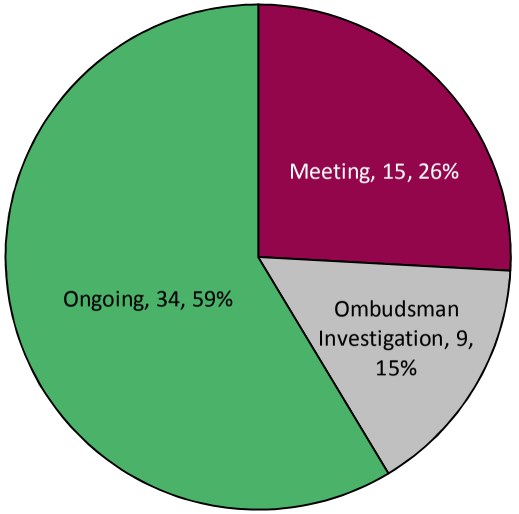


Figure 10: Current Stages of Formal Complaints - March 2017



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

1.6 COMPLAINTS (continued)

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

Figure 12 demonstrates 51 complaints were responded to in March.

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

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

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

The Concerns and Complaints policy is currently being updated.

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

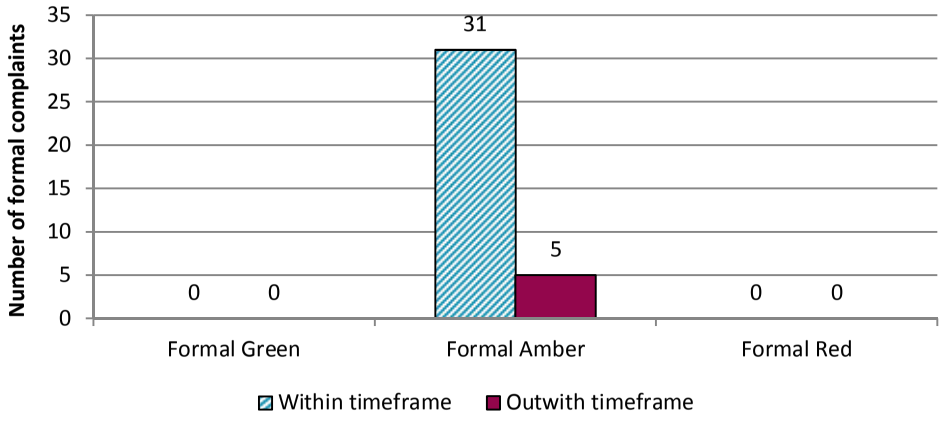


Figure 12: Number of formal complaints responded to by month - April 2016 to March 2017

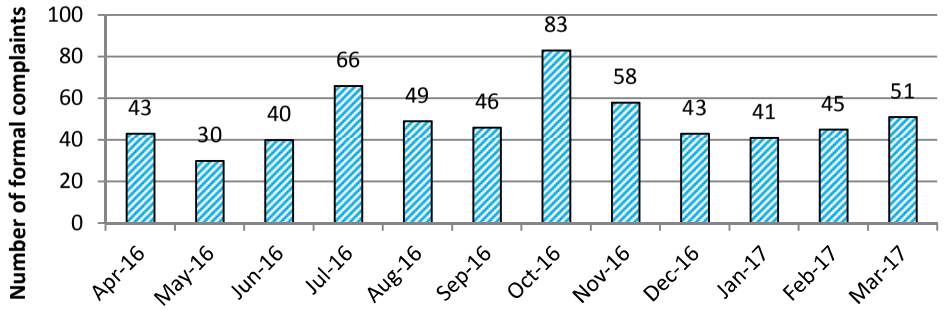


Figure 13: All complaints awaiting first response within and outwith timeframes by directorate - March 2017

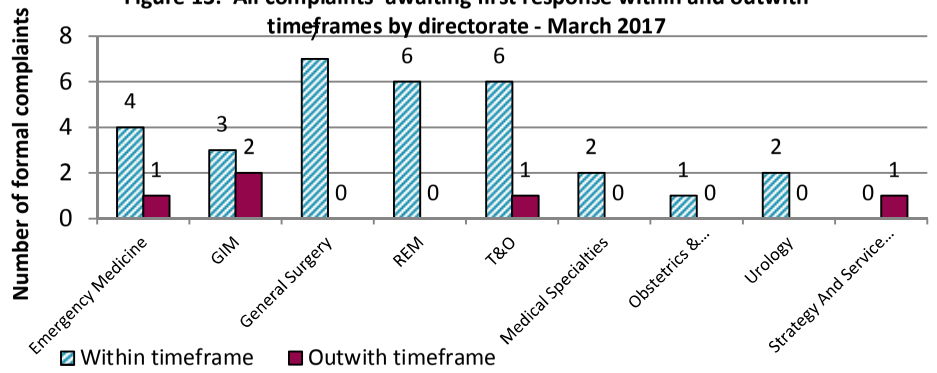
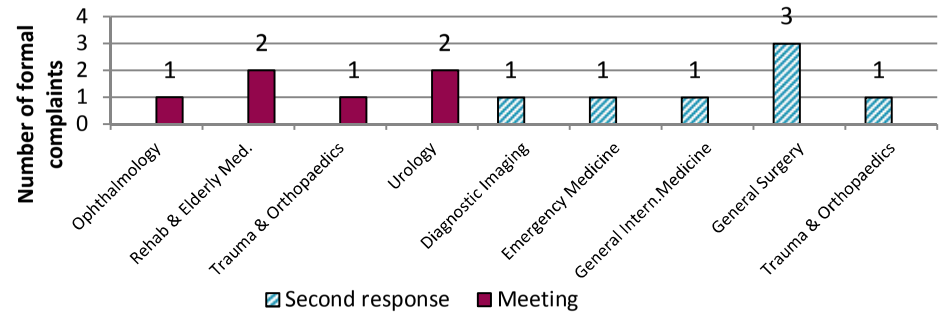


Figure 14: Reopened complaints by directorate



NURSING WORKFORCE
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.7 NURSING WORKFORCE

1.7.1 National Indicators/Monitor Governance Indicators

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

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

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

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

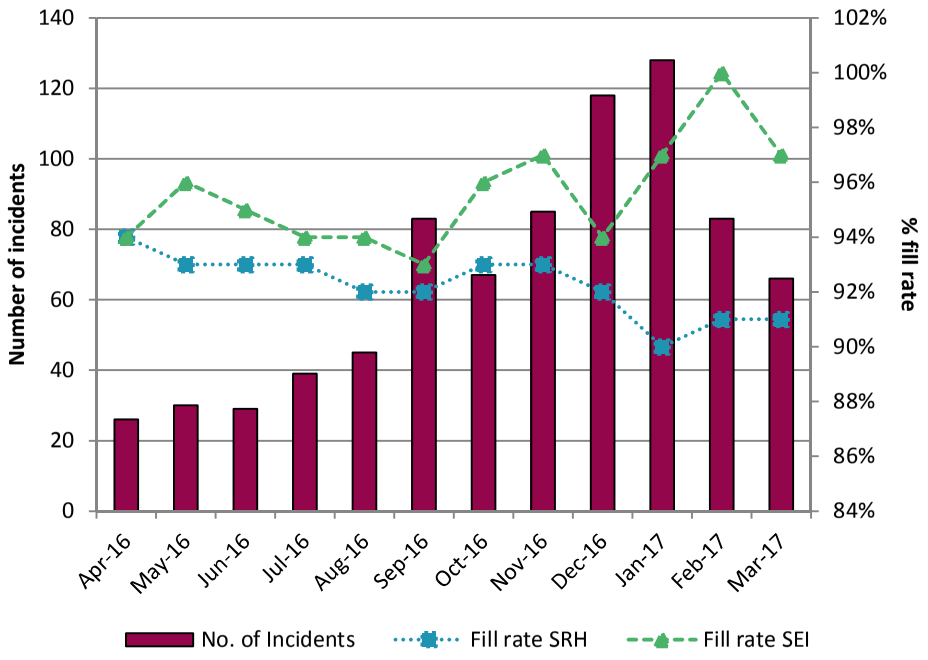
Failure to achieve 100% fill rates can be explained by RN/RM vacancies, maternity leave, sickness and additional beds open. During the month of March there were 36 additional beds open on D42, D44, D47 and E54 for most of the month to support winter pressures, the last of the additional beds closed 26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

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

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

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

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



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

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

1.7 NURSING WORKFORCE (continued)

1.7.2 Incidents relating to Nursing and Midwifery Staffing

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

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

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

1.7.3 Workforce Update

Monthly generic band 5 recruitment continues.

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

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

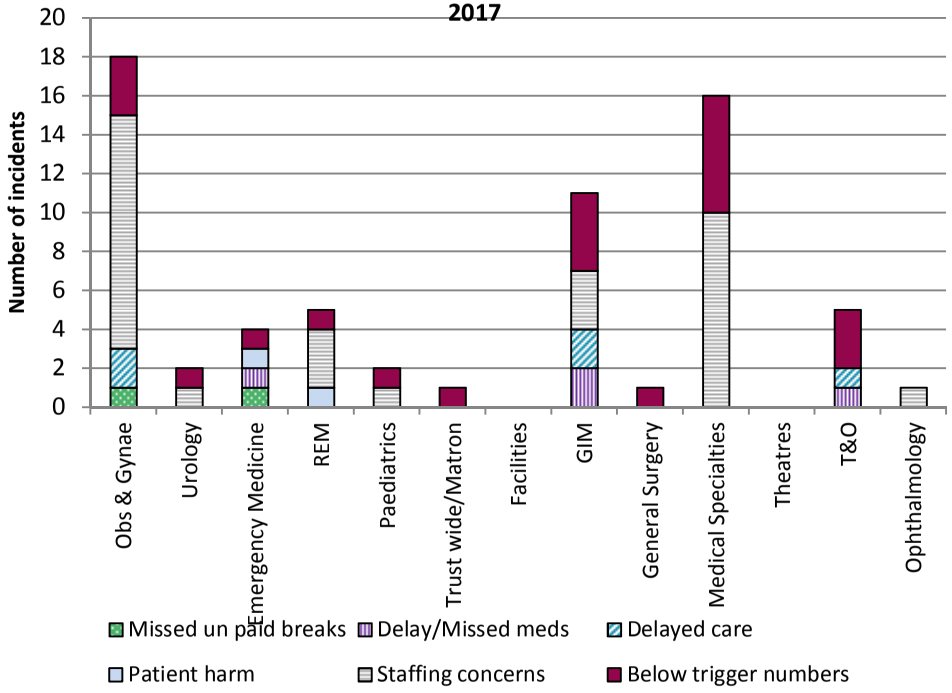
Overseas recruitment is planned for June 2017.

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

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

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

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



Absence turnover for March 2017:

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

HOSPITAL ACQUIRED INFECTIONS
LEAD: MEDICAL DIRECTOR

2.1 HOSPITAL ACQUIRED INFECTIONS

2.1.1 MRSA bacteraemia

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

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

2.1.2 C. difficile infection (CDI)

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

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

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

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

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

2.2 HAND HYGIENE

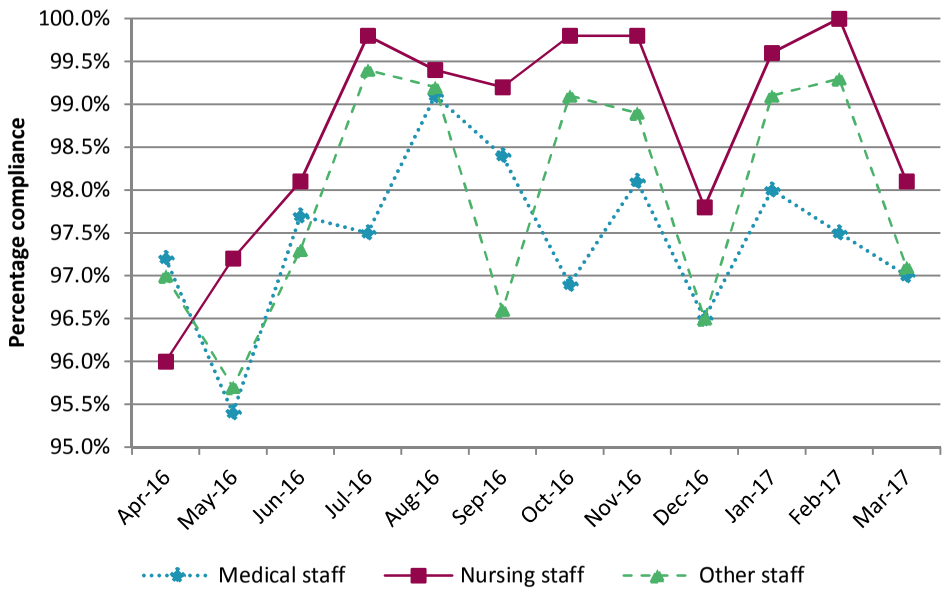
Monthly hand hygiene compliance audit data is presented on ward/department dashboards Trustwide. Areas which fail to attain 98% compliance will be escalated to action plan in accordance with the Trust hand hygiene procedure.

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

2.3 BARE BELOW ELBOWS

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

Figure 17: Hand hygiene results April 2016 to March 2017



2.4 MORTALITY REPORT Q3 2016/17

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

Main positive areas of assurance

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

Areas of mortality performance requiring further investigation and action

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

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

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

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

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

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

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

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

CLINICAL GOVERNANCE UPDATE (continued)
LEAD: MEDICAL DIRECTOR

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

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

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

PATIENT SAFETY
LEAD: DIRECTOR OF QUALITY & TRANSFORMATION

3.1 PATIENT SAFETY

3.1.1 Incident report

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

CHS incidents reported

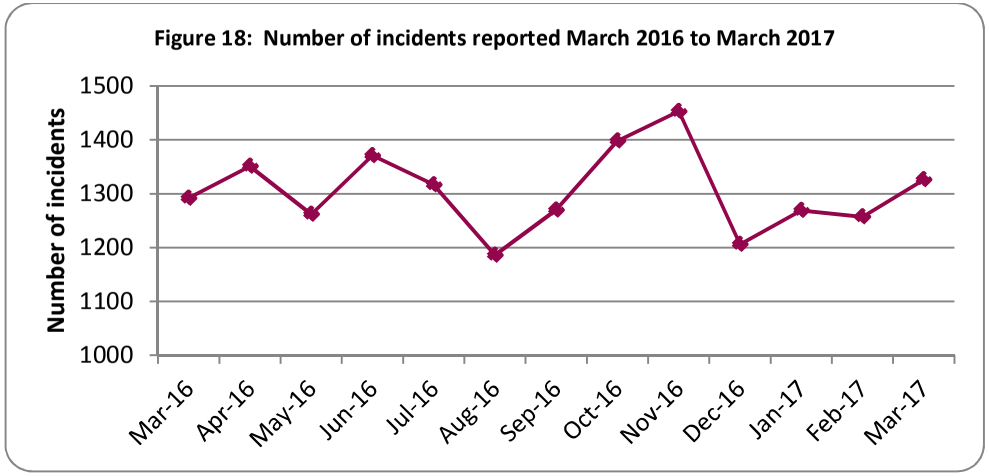
Figure 18 demonstrates the number of CHS related incidents that have been reported via Ulysses each month during the last 13 months. It shows an increase of 69 reported incidents (5%) in March compared to the previous month. In comparison to the same month in 2016, this is an increase of 34 (3%).

CHS incidents by impact

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

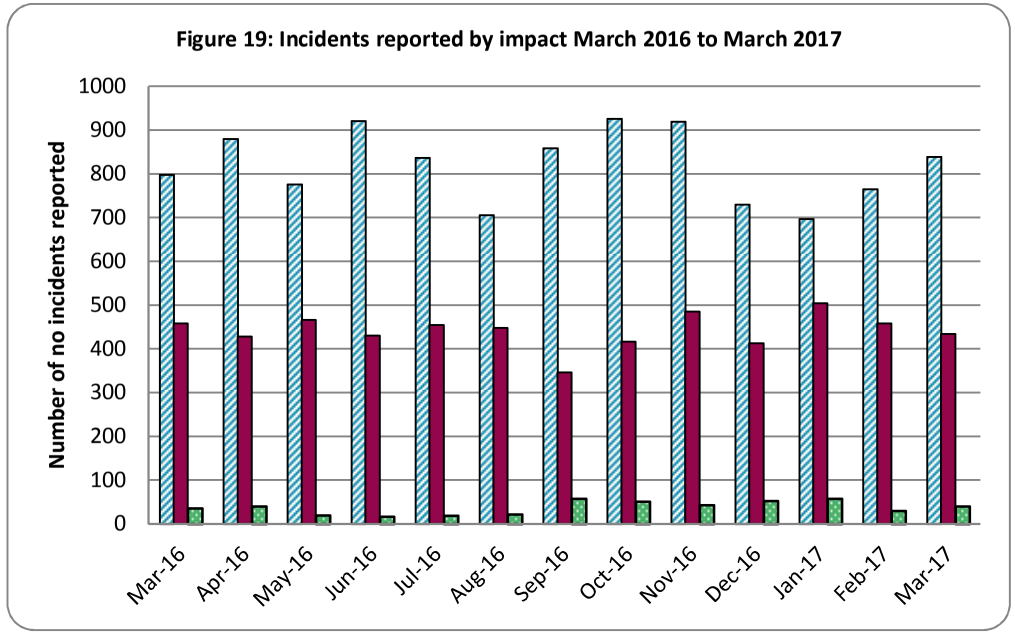
13 incidents were reported as having caused major or extreme harm in March. These will be reviewed by directorates via the Directorate Initial Review process and will be considered by RRG.

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



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

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



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

Major harm	Extreme harm
11	2

Actual impact of incidents for February 2017:

Major harm	Extreme harm
3	1

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

3.1.1 Incident report (continued)

Headlines

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

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

Top 5 incidents by cause group

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

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

Root Cause Analysis (RCA) investigations

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

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

Figure 20: RCAs commissioned March 2016 to March 2017

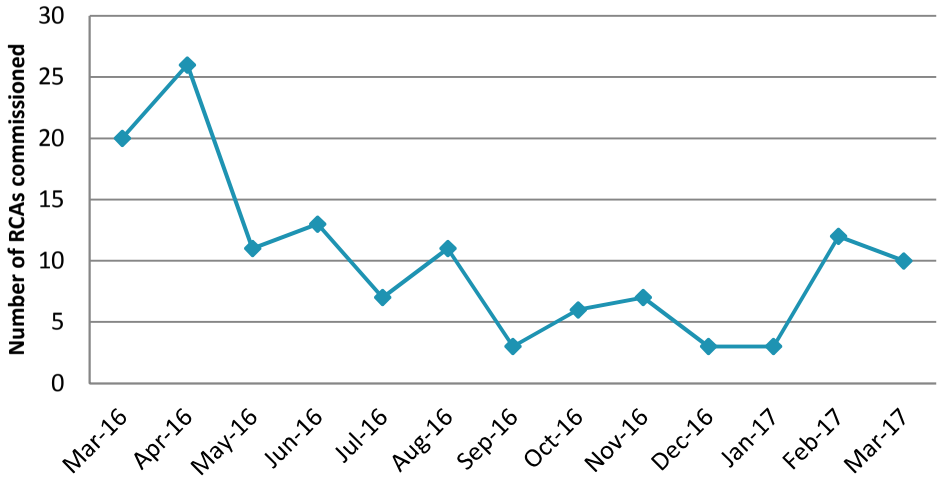


Figure 21: Status of current RCAs – March 2017 (previous month in brackets)

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

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

3.1.1 Incident report (continued)

Serious Incidents (SIs)

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

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

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

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

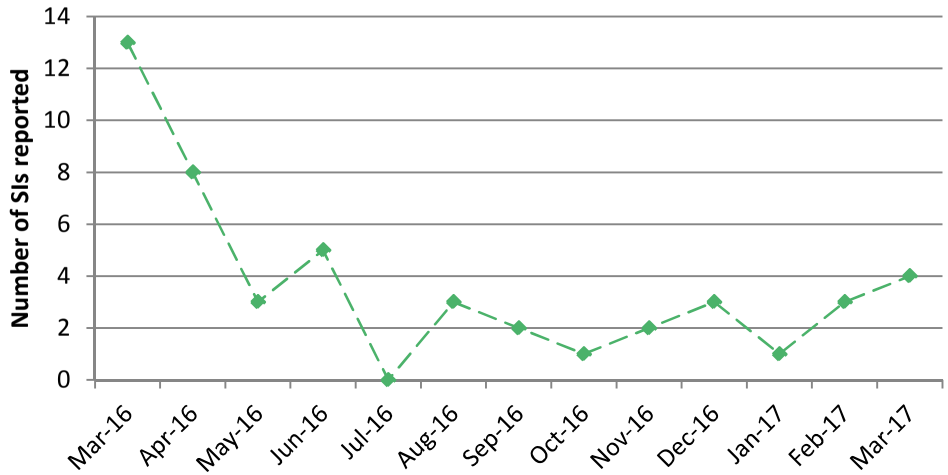


Figure 23: Status of current SIs - March 2017

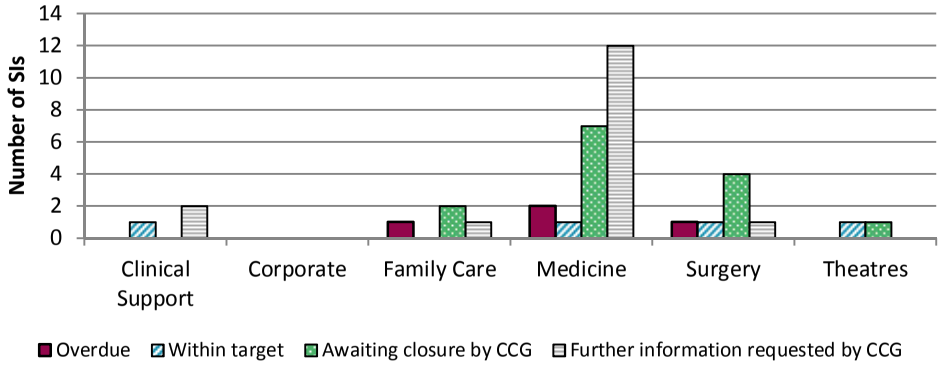
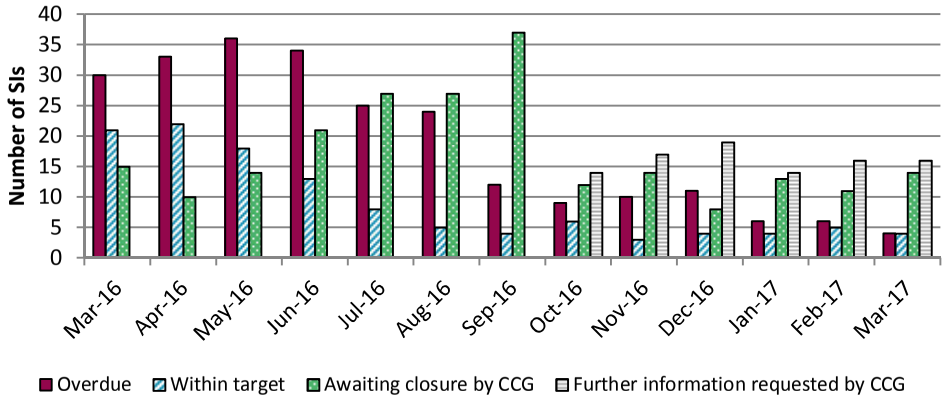


Figure 24: SI status March 2016 to March 2017



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

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

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

3.1.1 Incident report (continued)

Serious Incidents (SIs) (continued)

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

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

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

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

Figure 25: SI quality indicators

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

Never Events

Two never events were reported in March.

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

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

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

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

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

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

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

Duty of Candour

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

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

3.2 INQUESTS

Current position

There are currently 33 open cases.

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

Reason if off target

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

Actions to get back on target

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

Lessons Learned

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

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

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

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

Specific key learning from inquests during this period:

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

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

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

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

3.3 SAFETY THERMOMETER

Current Position

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

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

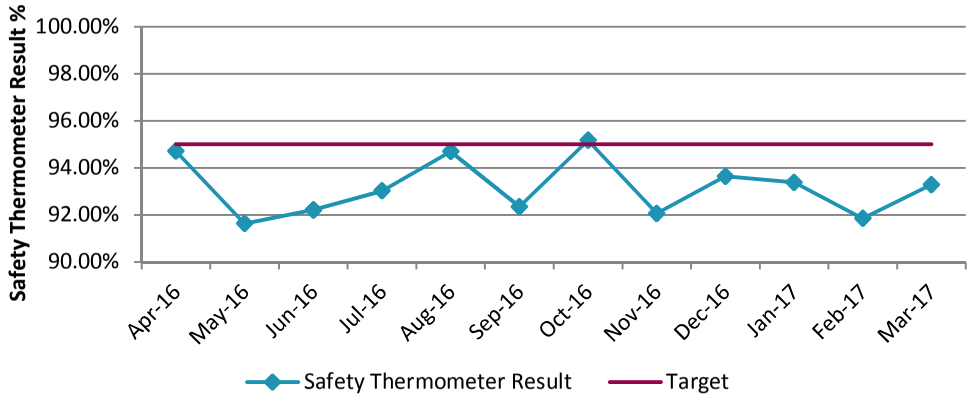
Our total number of new harms in March was 18, which is the same as we reported February.

Our percentage of harm-free care is based on:

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

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

Figure 26: Safety Thermometer Results April 2016 to March 2017



ASSURANCE

4.1 DRUG SECURITY AUDIT

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

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

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

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

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

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

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

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

4.2 EXCELLENCE REPORTING

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

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

Reporters have originated from varying professions:

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

Category breakdowns are as follows:

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

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) 2016/17

5.1 CURRENT POSITION

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

5.2 REASON FOR UNDERPERFORMANCE

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

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

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

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

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

5.3 ACTIONS TO GET BACK ON TARGET

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

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

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

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

5.4 CQUIN 2017/19

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

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

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

CORPORATE RISK

6.1 CORPORATE RISK REGISTER

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

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

6.2 NHS LITIGATION AUTHORITY UPDATE

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

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

CONCLUSION

SUMMARY OF KEY RISKS

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

Members are asked to note the report.

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

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DIRECTORATE OF FINANCE

BOARD OF DIRECTORS
MAY 2017

FINANCIAL POSITION AS AT 30th APRIL 2017
EXECUTIVE SUMMARY

1 INTRODUCTION

This Executive Summary provides the summary highlights of the financial position as detailed in the main report to the end of April 2017.

1.1 KEY HIGHLIGHTS

Issue or Metric	Budget	Actual	Variance	%
Overall Financial Position - Deficit	£936k	£928k	£8k	0.85%
Income	£28,992k	£28,987k	£5k	0.02%
Expenditure	£29,928k	£29,915k	£13k	0.04%
EBITDA Position %	1.1%	0.7%		0.4%
EBITDA Position £'s (deficit)	£331k	£200k	£131k	39.6%
Cash Position	£7,860k	£9,730k	£1,870k	23.8%
Cost Reduction Plans				
Variance to plan	£764k	£700k	£64k	8.4%
Pay:				
Over spend against plan	£17,933k	£17,923k	£10k	0.06%
Non Pay: Over spend against plan	£11,995k	£11,992k	£3k	0.03%

Julia Pattison
Executive Director of Finance

DIRECTORATE OF FINANCE

BOARD OF DIRECTORS

MAY 2017

FINANCIAL POSITION AS AT 30th APRIL 2017

1 INTRODUCTION

The enclosed financial statements reflect the Trust's Income & Expenditure position as at 30th of April 2017 details which can be found in Appendices 1-2. At this stage of the year, given the need to finalise budget setting and contracting activity plans, the month one budgets are summarised with some assumptions having been made for clinical activity.

1.1 SUMMARY POSITION

The overall financial position is a net deficit of £928k against a planned deficit of £936k, £8k ahead of plan.

Income and Expenditure budgets reflect the final annual plan submission made to NHS Improvement.

2 INCOME

2.1 *Patient Related Income:*

Clinical income for the first month of the year is ahead of plan by £200k. Clinical income was profiled to reflect anticipated performance with elective activity based on working days and non-elective based on calendar days.

Income has not been profiled in twelfths and therefore the monthly planned surplus or deficit position will vary according to income profiles.

Month 1 position is in line with agreed contracts and Trust assumptions for a number of QIPP items.

Private Patient Income is behind plan by £22k.

2.2 *Non Patient Related Income:*

Training and Education income is in line with plan, Research and Development is slightly ahead of plan. Other Income is behind plan at this early stage of the year.

3 EXPENDITURE

3.1 *Pay Expenditure:*

Pay is currently showing a small underspend of £10k against plan. This is predominantly down to vacant nursing posts across the Trust.

Agency spend in April 2017 was £473k against a plan of £357k, and hence an overspend of £116k.

At this stage WTE budgets are being finalised as part of the Annual Plan process. These will be reported from month 2 onwards.

Appendix 2 shows details pay spends on agency, flexi and overtime for the last 12 months.

3.2 ***Non Pay Expenditure:***

Non-Pay is showing a small underspend of £3k. Major areas are highlighted as:

- Clinical Supplies – underspend of £22k.
- Drug Costs – underspend of £47k.
- Other costs –overspend of £66k.

4 CIP POSITION

The CIP target for 2017/18 is £13,000k, at this stage plans have been identified totalling £12.3m, however this value includes very high risk rated schemes at present. These saving schemes need to be fully developed in the coming months to allow for full achievement in year.

In addition, the gap between plans and targets need to be closed. Full details of existing CIP plans and next steps will be discussed at Finance and Performance Committee later this month.

The CIP target to month 1 was £764k, actual delivery was £700k and hence an under delivery of £64k.

The Trust CIP target for 2017-18 has been profiled as 20% in both quarters 1 and 2, and 30% in quarters 3 and 4.

5 CASHFLOW AND WORKING CAPITAL

Cash at month 1 was £9.73m, planned cash levels were £7.86m. However a cash payment of £6.3m was paid to HMRC in early May which has greatly reduced the Trust cash levels.

6 SUMMARY

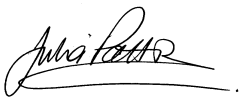
The overall position at the end of April is a deficit of £928k compared to a planned deficit of £936k or £8k better than plan. This position is before accounting for over/under performance in April.

The Trust needs to ensure that all CIPs need to be developed and fully worked upon in the next two months.

7 RECOMMENDATIONS

The Board is requested to:

- Note the financial position to date



Julia Pattison
Executive Director of Finance

May 2017

CITY HOSPITALS SUNDERLAND FOUNDATION TRUST
CORPORATE FINANCIAL MONITORING REPORT
SUMMARY TRUST POSITION - MONITOR ANALYSIS
PERIOD ENDED 30TH APRIL 2017/18

Income & Expenditure Position

	Annual	Current Month			Year to Date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
£m	£m	£m	£m	£m	£m	£m	£m
Income							
NHS Clinical income	-322.81	-26.64	-26.84	-0.20	-26.64	-26.84	-0.20
PBR Clawback/relief	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Private patient income	-0.35	-0.03	-0.01	0.02	-0.03	-0.01	0.02
Non-patient income	-28.05	-2.32	-2.14	0.18	-2.33	-2.14	0.18
Total income	**-351.21**	**-28.99**	**-28.99**	**0.00**	**-28.99**	**-28.99**	**0.01**
Expenses							
Pay Costs	214.604	17.933	17.923	-0.01	17.933	17.923	-0.01
Drug costs	38.12	3.19	3.15	-0.05	3.19	3.15	-0.05
Other Costs	89.03	7.53	7.72	0.18	7.53	7.72	0.18
Total costs	**341.76**	**28.66**	**28.79**	**0.13**	**28.66**	**28.79**	**0.13**
Earnings before interest, tax, depreciation & amortisation (EBITDA)	**-9.45**	**-0.33**	**-0.20**	**0.13**	**-0.331**	**-0.200**	**0.13**
Profit/loss on asset disposal	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Depreciation	8.35	0.70	0.59	-0.11	0.70	0.59	-0.11
PDC dividend	5.02	0.42	0.38	-0.04	0.42	0.38	-0.04
Interest	1.83	0.15	0.15	0.00	0.15	0.15	0.00
Corporation tax	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net surplus (pre exceptionals)	**5.74**	**0.94**	**0.93**	**-0.01**	**0.94**	**0.93**	**-0.01**
Exceptional items				0.00			
Net (surplus)/Deficit (post exceptionals)	**5.74**	**0.94**	**0.93**	**-0.01**	**0.94**	**0.93**	**-0.01**

EBITDA Margin	**2.7%**	**1.1%**	**0.7%**		**1.1%**	**0.7%**

CITY HOSPITALS SUNDERLAND FOUNDATION TRUST
TRUST PERFORMANCE SUMMARY

PERIOD ENDED 3OTH APRIL 2017

TRUST SUMMARY

'( )'	denotes a surplus
' + '	denotes a deficit

	Annual Budget £'000s	Apr actual £'000s	Quarter 1 £'000s	YTD actual £'000s	Plan £'000s	Variance £'000s
Income						
Contract Income	(322,812)	(26,838)	(26,838)	(26,838)	(26,638)	(200)
Private Patients	(345)	(7)	(7)	(7)	(29)	22
Training and Education Income	(11,499)	(958)	(958)	(958)	(958)	
Research and Development Income	(1,476)	(135)	(135)	(135)	(123)	(12)
Other income	(15,035)	(1,029)	(1,029)	(1,029)	(1,240)	211
Interest Receivable	(43)	(20)	(20)	(20)	(4)	(16)
Total Income	**(351,210)**	**(28,987)**	**(28,987)**	**(28,987)**	**(28,992)**	**5**
Expenditure						
Pay	214,604	17,923	17,923	17,923	17,933	(10)
Clinical Supplies and Services	32,431	2,706	2,706	2,706	2,728	(22)
Drug Costs	38,124	3,147	3,147	3,147	3,194	(47)
Other Costs	56,598	5,011	5,011	5,011	4,806	205
Depreciation	8,348	590	590	590	696	(106)
PDC Dividend	5,022	383	383	383	419	(36)
Interest	1,827	155	155	155	152	3
Total Expenditure	**356,955**	**29,915**	**29,915**	**29,915**	**29,928**	**(13)**
(Surplus)/Deficit	5,745	928	928	928	936	(8)
Cost Improvement Plans	(13,000)	(700)	(700)	(700)	(764)	64

Appendix 2

PAY