CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

There will be a meeting of the Board of Directors in Public on
Thursday, 26th January 2017 at 2:00 pm
in the Board Room, Sunderland Eye Infirmary

AGENDA

Apologise: Ian Martin, Sean Fenwick

1. Declaration of Interest

2. Minutes

Item 1.	To approve the minutes of the Board of Directors meeting held 'In Public' on Thursday, 24 November 2016		**Enc 1**

Matters Arising

Item 3 – Global Digital Exemplar	**KWB**	
Item 4 – specialised Commissioning	**KWB**	

3. Standard Reports

Item 2.	Chief Executive's Update	**KWB**	
Item 3.	Quality Risk and Assurance Report	**BB/MJ**	**Enc 3**
Item 4.	Finance Report	**JP**	**Enc 4**
Item 5.	Performance Report	**AK**	**Enc 5**

Date and Time of Next Meeting

Board of Directors 'In Public', Thursday, 30th March 2017, 3.30pm, 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 24 November 2016 in The Board Room, Sunderland Eye Infirmary

Present: John Anderson (JNA) - Chair
Ken Bremner (KWB)
Mike Davison (MD)
David Barnes (DB)
Stewart Hindmarsh (SH)
Alan Wright (AW)
Peter Sutton (PS)
Melanie Johnson (MJ)
Julia Pattison (JP)
Steve Williamson (SW)

Apologies: Ian Martin (ICM)
Bob Brown (BB)

In attendance: Carol Harries (CH)
Mike Laker (ML)
Sean Fenwick (SF)
Angela Gillham (AG)

ITEM 1 DECLARATION OF INTEREST

None.

ITEM 2 MINUTES OF THE MEETING HELD 29 SEPTEMBER 2016

The minutes of the meeting held on 29 September 2016 were accepted as a correct record, except page 2 – penultimate line which should state 'consultant' and not 'consultation' contract.

ITEM 3 MATTERS ARISING

Sustainability and Transformation Plan (STP) – KWB advised that the STP had now been published and would be subject to a period of consultation. The STP would also be refreshed in 2017 and the issue for us was how we translated those actions etc into our Annual Plan documentation.

Global Digital Exemplar – KWB reminded Directors that the Trust had been successful in being identified as one of twelve global digital exemplar sites. The Trust had been included in tranche 2 which covered a 3½ year timescale. The Trust and Meditech was required to attend a due diligence meeting on 9th December 2016 when it would be important for Meditech to demonstrate what they would be giving to

the process and the wider NHS. It was likely from a practical point of view that the project would not formally start until the New Year. AW commented that he had looked at the detail of the Humber Hospital in Canada which was potentially one of our buddy sites and it seemed very good. KWB stated that this may be a key hospital that we potentially link with but that there may be others as well.

DB queried whether we had taken into account the benefits of this within our Annual Plan. JP replied that we had assumed both the income and cost from both capital and revenue.

DB also queried what level of contingency was being built into the plan. JP replied that it was £10m externally and we were required to match that funding.

MD commented that in his experience, you never actually know the true cost until there is a complete specification of requirement. KWB stated that the final firm figures would be included within the business case.

SW stated that unfortunately it is very difficult to put in a balance sheet the cost of the abstract status such a project gives.

MD commented that it was important that the system worked, but the success of any IT projects are not very good. KWB replied that it had been made very clear nationally that if the project fails, the responsibility will rest with ourselves. He also advised that we do not use Meditech V6 to its full capacity and whilst the kit and infrastructure was already there, it was much more about the cultural aspects.

JP added that we were building on a system / relationship that had been in place for a number of years. MD stated that the plan was however, built on a lot of external interfaces.

KWB advised that he would keep Directors advised of progress.

ITEM 4 CHIEF EXECUTIVE'S UPDATE

Removal of Licence Restrictions – KWB confirmed that we would receive formal notification from NHSI that the restrictions on our licence would be removed which was excellent news for the organisation.
Review of Specialised Vascular Services – KWB advised that the review of vascular services undertaken some months ago had been supported although further discussions were to be held with Durham. It had been advised that an element of proportionate consultation would be required but it was unclear as to how and when that would happen.
Specialised Commissioning – Commissioners had invited expressions of interest for a whole range of services from non designated specialised commissioners to market test services in lots which for us amounted £22.9m worth of income. The services potentially affected were renal and bariatrics. There had been little detail released at the moment and South Tyneside were facing the same issue but on a smaller scale.

Visit by the President of the Royal College of Physicians – The President of the Royal College of Physicians had today visited the Trust and South Tyneside Hospital as part of a visit to the North East. She had been very impressed by the organisation and feedback to her from some of the trainees working here had been excellent. It was hoped that this visit and the positive feedback would allay some of the concerns previously raised by trainees to the college etc.

Radiology Trainees – KWB informed Directors that the Trust had been approached to have three more radiology trainees which was really positive news and meant that the organisation and radiology in particular was seen as a good place in which to work and train. This was a real turnaround for radiology who had experienced problems in the past and a lack of trainee placements. The potential of additional trainees offered real opportunities for future consultant appointments.

Silver Employer Recognition (ERS) Award for 2016 – The Trust had been successful in receiving a silver recognition award for its work at the Tri-Service Regional Employer Engagement Communications Board held within 4 Infantry Brigade at Catterick Garrison and endorsed by the Ministry of Defence. Kath Griffin had attended the event and this was an excellent recognition for the work the Trust had undertaken.

ITEM 5 QUALITY, RISK AND ASSURANCE REPORT

MJ presented the report and advised that the patient story had been included and would be a regular item following discussion at Governance Committee.

MJ advised that the Trust was not on track to reach the improvement trajectory required by the three year Pressure Ulcer Improvement Plan and this was being addressed with Matrons and Ward Managers overseen by the Pressure Ulcer Review Panel. MD commented that it stated on page 4 of the report that 95% of pressure ulcers were avoidable and queried whether that figure was correct. MJ replied that it was, but that we needed to recognise the increasing age and frailty of the population being admitted. ML stated that indicative plans were being implemented and at what point would those plans influence the numbers. MJ replied that it was a three year plan and grade 3 / 4 pressure ulcers were fairly static but the number of grade 2s did fluctuate and it was difficult to understand the reason why.

SH commented that if some pressure ulcers had already been acquired in the community, it was really important to ensure that 100% of patients had been assessed on admission. MJ replied that unfortunately, we were not where we needed to be at the moment. SH stated that it was critical that we assessed on admission. MJ replied that it was and needed to be a comprehensive assessment against all the factors.

MJ also highlighted incidents and advised that the Trust continued to be a high reporter of patient safety incidents, currently ranked 5th out of 136 Trusts.

MJ advised that in the last NRLS Report, CHS was the second highest reporter with an incident rate of 74.52 patient related safety incidents per 1,000 bed days which was felt to be overstated and a review was carried out the drop therefore was largely due to data classification changes rather than a drop either in reporting or in actual adverse events.

ML queried one of the key messages outlined regarding point of care devices and whether that was an underlying issue. MJ replied that it had been in four areas and at times, staff were logged in with other staff and audit had revealed the issue. ML commented that it was obviously a log-on issue.

MJ highlighted complaints and advised that it was an improving picture and there was now none open for over a year. The position in October had also improved further. MJ advised that a significant amount of work had been undertaken in Directorates and there was now no backlog contained within the Help and Advice Service.

AW complemented MJ and Julie McDonald for the work undertaken in relation to complaints and the subsequent improvement. AW also advised that a sub-group had been set up to look at vexatious complainants and a new protocol was in place to support this and the early pilot had worked well.

MJ stated that it was not just her team, but colleagues in Directorates who had worked hard to address the issues.

MJ informed Directors that the nursing fill rate for Sunderland Royal Hospital had been 92% in September 2016 and 93% for Sunderland Eye Infirmary. During the month there had been three wards with RN fill rates of less than 80% and as at the end of September, there were 83.97 wte RN Band 5 vacancies.

MD queried figure 25 – Nursing fill rate and incidents and asked whether there was a correlation. MJ confirmed that whenever there was an issue, we always looked at the incidents. If there were meant to be 7RNs on a ward and only 5 in reality, then clearly this would be difficult. KWB commented that the graph did not separate out SRH and SEI and was therefore not a comprehensive picture.

ML queried whether any incidents related to actual harm. MJ replied that it was not always a clear connection but that the current situation with regard to nurse staffing must impact on patient care.

ML queried page 17 and the failure to achieve the CQUIN target in relation to sepsis. ML queried whether the comment in relation to the rotation of Junior Doctors was just an issue in CHS or prevalent across the patch. MJ replied that she was not certain about elsewhere, but it had clearly been an issue for us. SF commented that nationally, it was a difficult target to deliver and that he would be amazed if the situation was not the same elsewhere.

Resolved: To accept the report.

ITEM 6 FINANCE REPORT

JP presented the report and advised that the overall financial position was a net deficit of £1,373k against a planned deficit of £1,118k, and therefore £255k behind plan.

JP advised that the current position assumed non delivery of key performance targets in October 2016, namely 4 hour A&E in both September and October, plus cancer targets in October.

JP advised that the STP funding had been therefore removed from the financial projection to date.

The deficit position meant that the Trust Use of Resource metrics (UOR) rating score was 3. JP explained that this new measure had come into place from October 2016 and replaced the Financial Sustainability Risk Rating (FSRR). JP stated that had performance targets been met for October, then the actual financial position would have been a small surplus of £10k.

JP also advised that the Trust had assumed non delivery of cancer trajectories between October and March; therefore financially £265k of 'lost' STP funding had been included within the year end forecast relating to that risk.

JP informed Directors that pay was currently showing an underspend of £1,542k against plan due mainly to vacant nursing posts across the Trust. The Trust was, however, below its maximum agency /ceiling level set by NHSI to the end of October 2016.

The CIP position was £13,180k, however, the Trust still had £1,820k of CIP Plans to identify in this financial year. The gap in CIP Plans had largely been offset by delays in leasing equipment and a higher level of vacancies than expected.

The cash balance at the end of October was £4.29m against a planned £10.14m predominantly due to NHS debtors being significantly higher than plan. This consisted of outstanding clinical activity income invoices (£598k), STP funding (£3.42m), an over performance clinical activity income accrual (£197k) and miscellaneous charges (£2.25m).

JP advised that at this early stage, the Trust was marginally ahead of the annual plan submitted to Monitor of £2.167m deficit. A number of one off short term benefits was supporting the financial position. JP stated that it was key that CIPs were identified to close the CIP gap on a recurrent basis and all action was taken to deliver performance targets linked to STF funding.

DB stated that Finance Committee had considered the position of achieving the £2.167m deficit and although there were some risks, but given the work undertaken and assurances there was an expectation that this would be achieved. DB also commented that to get to £13.8m CIP delivery was an achievement and credit to the efficiency of the PMO process.

Resolved: To note the financial position to date.

ITEM 7 PERFORMANCE REPORT

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

PS highlighted RTT performance and advised that performance against the standard remained above target at 92.9%, however, some specialities still remained under target. The only new speciality not to achieve was Rheumatology who had seen an increase in demand, and also a reduction in available capacity. PS advised that a plan was in place to improve performance.

PS informed Directors that the A&E 4 hour target performance was below the 95% target at 93.47% which although lower than last year, there had been a 11% increase in attendances (although the actual growth was 7%, the remainder due to a counting change). PS advised that performance to date for November was 93.13% against an STF trajectory of 94.2%.

ML queried whether the figures in A&E were any worse than expected. SF replied that nationally, performance was not where it should be and there had been a pattern of pressure. SF stated that early January would be the worst weeks in the year. Ambulance handover performance would improve when the department moved into the new development.

The Chairman queried the counting change in A&E. PS replied that if patients from walk-in centres (4 across the City) attended and then came to A&E they must be counted twice. PS stated that patients were now appropriately recorded.

AW commented that it was however not a patient care issue. The Chairman also sought clarification that there were no financial implications. PS confirmed that there were none at this point in time.

PS informed Directors that cancer 31 days was above target at 98.8%. There were however, pressures in urology which as expected, deteriorated in the summer months and therefore a need to treat a backlog of patients. Performance in October was predicted to be just under target.

Outpatient communications performance had decreased during October with only 84.4% of outpatient clinic letters being sent within 2 weeks, which should begin to improve from December onwards. Urology and Trauma and Orthopaedics however, had both seen improved performance.

MD queried whether the diagnostic issues were now resolved. SF confirmed that they were and this was no longer an issue going forward.

Resolved: To accept the report.

ITEM 8 CHS INTERNAL OPERATINAL WINTER PLAN

Angela Gillham presented the plan which was part of the Trust's approach to managing the winter surge and would be issued in conjunction with the CHS North East Escalation Plan (NEEP), Standing Operating Procedure for Trust wide response to Surge (SOP) and the CHS Seasonal Flu Plan and Vaccination Programme.

AG explained that to achieve true resilience, the plan must be part of a wider City approach.

SH queried the fifteen additional acute inpatient beds and how they would be managed. AG replied that they would sit within the directorate of GIM and have an identified CD, Directorate Manager and Matron. SH also queried whether the beds were set up and ready to go. AG confirmed that they were and located in the annexe area to Ward E54.

SH also queried whether they were funded. JP replied that they were not funded and nursing support was difficult as we were spread thinly.

MD queried as to what AG believed was the weakest point in the plan. AG replied that it was capacity and demand. SW commented that NHSI and NHS England recognised how response to surge worked but we had to plan robustly internally.

MJ reminded Directors that our ability to staff wards at some point would run out and then we would possibly have to look at stopping electives, closing our doors and potentially declaring a major incident.

SH commented that we should recognise that an extended period of escalation would cause exhaustion.

MJ stated that unfortunately nursing staff were just not available. A large proportion of our staff were on NHSP and KG and MJ had written out to all part-time staff to possibly increase their hours.

AW commented that it was important to reduce frivolous attendances into A&E and queried whether enough was being done to do that. AG replied that the CCG had done a lot in the past and it was expected that they would be doing some publicity and awareness raising.

The Chairman queried how we tested the standards of other teams, such as the Local Authority. AG replied that the Trust met with then on a weekly basis and whilst we had strong relationships, we did not necessarily have the assurance mechanisms in place.

Resolved: To receive the plan as assurance that the organisation had taken steps to plan for winter pressures and minimise the impact of the additional activity and attendances it is anticipated will occur.

ITEM 9 NURSING AND MIDWIFERY WORKFORCE ASSURANCE – CAPACITY AND CAPABILITY 6 MONTH REVIEW

MJ presented the report which summarised the annual nursing and midwifery workforce review required by the CQC and NHS England. MJ explained that the overall risk remained the ongoing daily operational pressures of managing the available nursing workforce and matching it to patient care needs across the Trust.

MJ stated that at times the risks were significant and wards fell below the planned staffing levels.

MJ stated that vacancies continued to increase despite our best efforts and the situation was compounded by maternity leave and sickness. MJ advised that we continued to hold the line to not use agency nurses and continued to pay for NHSP nurses at the second point of the increment. MJ advised that it was a challenging position but also challenging nationally and unfortunately, there was not a nursing supply available.

MJ informed Directors that whilst care hours per patient day (CHPPD) had been introduced, this did not show the nurse fill rate or patient dependency. The introduction of the 'Allocate' E-Rostering safe care module, would facilitate the monitoring of real time patient numbers and activity and inform the movement of staff going forward.

SH sought clarification of the activity assessment to the expertise of nursing. MJ replied that this was through E-Rostering and the 'Allocate' system in that you could put into the system what the patient needs. SH commented that whilst it was a good concept, were we creating a rod for our own backs. MJ replied that it needed to be carefully monitored but it was a helpful tool and colleagues in South Tyneside already use it and were positive about its use.

MJ outlined the recommendations of the report which included the increase of band 6 nurses to provide improved supervision and leadership across a seven day period but stated that it would be provided at neutral cost. The development of a nursing associate role would be facilitated by using vacant posts in 2017/18 and work was being undertaken with the University of Sunderland.

MJ stated that the Trust did not elect to join the national pilots as the funding implications were not cost effective and therefore we had felt it better to pilot our own new roles. The Chairman queried the funding implications of the national pilot. MJ replied that the Trust would have had to release HCAs and back-fill and we believed that we could do that in a different way.

It was also recommended that all HCAs completed the Care Certificate, to ensure that the non-registered workforce were skilled and competent and best placed to support the depleted registered nurse workforce.

ML queried recommendation 5.1 – reducing the predicated absence allowance to 20%. ML asked whether the reduction had any impact on the wtes or was it just a budgetary measure. MJ confirmed that it was just budgetary.

Resolved: To note the recommendations

ITEM 10 CQC ACTION PLAN

MJ presented the report which outlined the action plan following the CQC inspection in September 2014. MJ explained that the action plan had been reviewed at regular intervals by the Governance Committee and the Executive Committee.

The action plan had been reviewed at a number of meetings with the CQC and evidence provided as requested.

MJ stated that all of the must do actions had been undertaken as outlined in appendix 1. This had been discussed with the CQC and it had been agreed that as the Trust had robust monitoring in place for the key actions of ED targets and staffing levels in particular, that the action plan could be considered as being complete.

Resolved: To accept the report and completion of the CQC Action Plan.

ITEM 11 SAFEGUARDING CHILDREN ANNUAL REPORT 2015/16

MJ presented the report which provided assurance and evidence to the Board that the Trust was fulfilling its statutory responsibilities to safeguard children and young people. The Trust is required under section 11 of the Children Act 2014 to ensure that children are safeguarded and that their welfare is promoted.

The report also provided assurance that the Trust was meeting the CQC Key Lines of Enquiry relating to safeguarding.

MJ apologised that the report issued contained some presentational errors and advised that a new copy would be issued to Directors.

MJ reminded Directors that there had been a detailed safeguarding workshop where many items had been discussed.

KWB commented that it was a thorough report and the team in Sunderland were looking to help South Tyneside on the back of their recent inspection but not at the expense of their work in Sunderland.

SH commented that two areas of level 3 training should be better, i.e paediatrics and child health and emergency medicine. MJ replied that the actual number of people having that level of training was quite small but recognised that more staff could have had that training.

Resolved: To receive the Trust's Safeguarding Children Annual Report

JOHN N ANDERSON
Chairman

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

NURSING & QUALITY DIRECTORATES

BOARD OF DIRECTORS

QUALITY, RISK AND ASSURANCE REPORT (DEC 2016)

JANUARY 2017

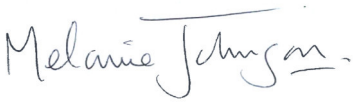
EXECUTIVE SUMMARY

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

- Plan to reduce pressure ulcers is behind trajectory.
- There is still a backlog of complaints although this is reducing.
- Vacancies in nursing are compromising delivery of patient care.

RECOMMENDATION

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

Quality, Risk and Assurance Report for November 2016

Presented to Board of Directors
January 2017

PATIENT STORY

The benefits of organ transplantation are hard to dispute. However, the availability of suitable donor organs is the principal determinant of the number of transplants that can be carried out in the UK each year and sadly, despite more and more families agreeing to donation, three people continue to die every day simply because there are insufficient organs available.
The letter below is from a lady whose sister was a patient on ICCU and had previously made the decision to be an organ donor, and is shared with her full consent.

"Walking Christine to theatre before she donated her organs is one of the hardest things I've ever done but I was immensely proud of my little sister. I just didn't want her going on that final journey on her own. I'm a retired paediatric nurse with paediatric intensive care experience and had done that journey as a professional but being on the other side was enlightening and made me think of the all families I'd been with who, whilst grieving for their own loss, were thinking of how they could help others. Again I was so proud of them and their generosity.

Agreeing to organ donation is near to my soul as I have primary biliary cholangitis and have been told I may need a liver transplant in the future. I have seen this now from both sides and my admiration for the donors has only increased.

I also want to thank the staff on ICCU and the two transplant nurse specialists for their compassion and care through a tough time and as a nurse I couldn't fault how myself and my family were dealt with. I'm finding things ok but nights are tough and I still grapple with the suddenness, disbelief and why it happened to Christine. I'm sure time will help so again thank you for taking the time to help me and my family."

Through the work of the Trust's Specialist Nurse in Organ Donation we are trying to make organ donation a usual rather than unusual occurrence and endeavour to make it something that is offered to all families whose loved ones have the potential to donate.

Christine was admitted to ICCU in June of this year, having suffered a cardiac arrest secondary to a huge intracranial haemorrhage and neurosurgeons deemed Christine's bleed inoperable and unsurvivable and she sadly progressed to brain stem death.

In order to help facilitate a patient's end of life care wishes, the Trust's Organ Donation Specialist Nurse will check the organ donation register. Christine had joined the register and her family agreed to go along with her wishes when approached about the possibility of donating her organs for the purpose of transplantation.

With the consent of her family, Christine kindly donated both kidneys, her pancreas, liver and her lungs. In addition her heart was transplanted into a child who urgently needed this life-saving procedure. The difference this has made to not only to the recipients' lives, but to those of their family too, is immeasurable.

You will see from the letter received from Christine's sister that she is immensely proud of Christine and she has gained comfort from knowing that Christine's sad death has helped to save and improve the lives of many.

City Hospitals Sunderland NHS Foundation Trust
Governance Committee
Quality, Risk and Assurance Report (November 2016)
January 2017

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:

- Work on the complaints backlog continues. For the first time, no complaints have been awaiting a first response for over 91 days.
- Rapid Review Group has carried out a 90-day review post-implementation of the use of the Directorate Initial Review form. The implementation has had a positive impact on both the group's effectiveness and on its efficiency.
- The number of hospital-acquired pressure ulcers is the lowest monthly figure since August 2016.

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

1. QUALITY & SAFETY

1.1 PATIENT SAFETY

1.1.1 Safety Thermometer

Current Position

Figure 1 shows Safety Thermometer prevalence data. We reported 92.06% harm-free care in November 2016 (a 3.11% decrease from the 95.17% we reported in October).

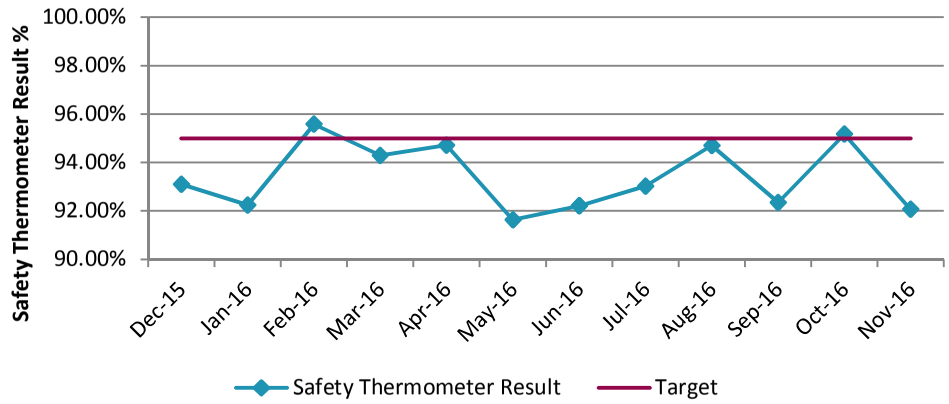
This is below both the national average of 94.22% and the median of 93.10% (range = 86.07% - 100%) of harm-free care reported by acute hospitals.

Our total number of new harms decreased from 24 in October to 21 in November. (N.B. the harm-free care calculation incorporates all reported harms, not just the "new" harms).

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)

Figure 1: Safety Thermometer Results December 2015 to November 2016



1. QUALITY & SAFETY (continued)

1.1 PATIENT SAFETY (continued)

1.1.2 Hospital Acquired Pressure Ulcers (HAPUs)

Pressure Ulcers (PUs) are noted in the report as the Trust is an outlier in the Open and Honest peer group of Trusts. PUs cause significant harm and distress to patients, increase length of stay and increase costs of care.

Open and Honest data for November 2016

In November we reported 41 HAPUs, which is a decrease from the 55 reported in October.

Numbers of HAPUs by category for November (see figure 2):

Severity	Number of HAPUs
Category 2	40
Category 3	
Category 4	1
Total	**41**

Numbers of HAPUs by directorate for November (see figure 3 for year to date numbers):

Directorate	Category 2	Category 3	Category 4	Total
Emergency Care	1			
General Internal Medicine	3			
General Surgery	4			
Head & Neck	1			
Medical Specialties	2			
REM	13			
Trauma & Orthopaedics	16			
Family Care			1	
Grand Total	**40**		**1**	**41**

The number of PUs per 1,000 bed days has decreased from 3.03 in October to 2.30 in November. This places us above the peer maximum (excluding CHS) of 2.00 per 1,000 bed days (reported by the Bridgewater Community Trust).

Figure 2: Hospital Acquired Pressure Ulcers (HAPUs) by category and trend from December 2015 to November 2016

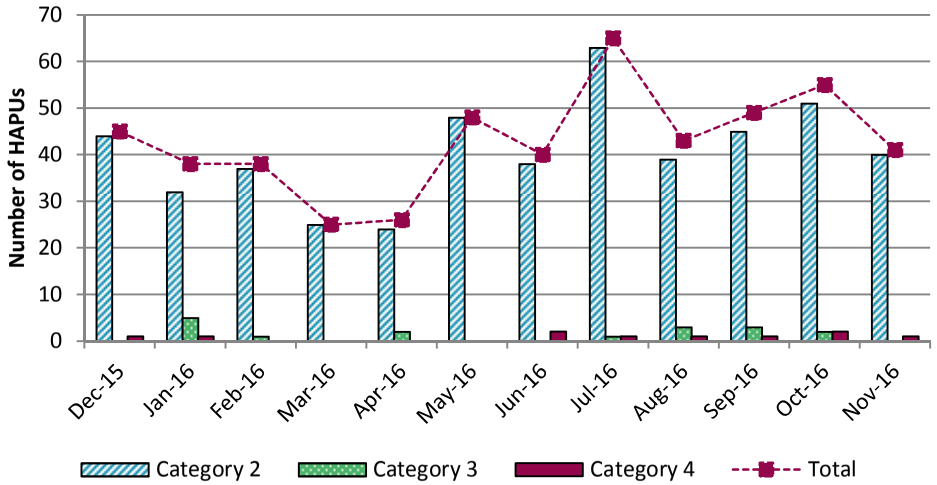
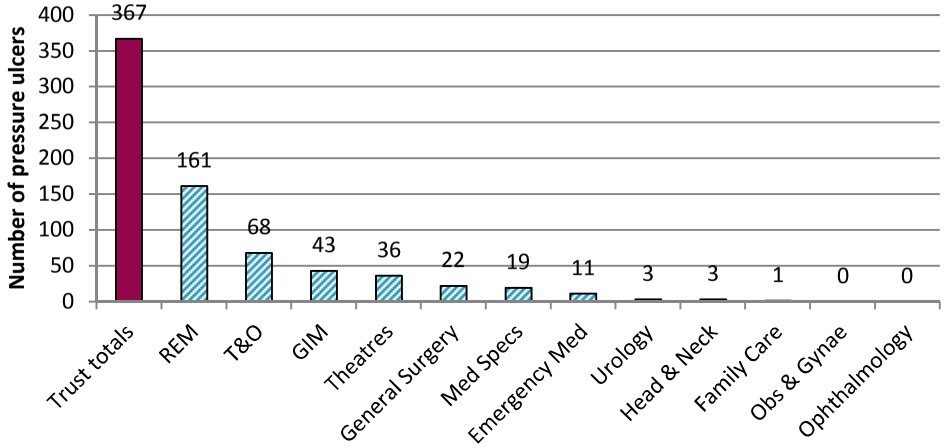


Figure 3: Total number of Pressure Ulcers (category 2 and above) April to November 2016



1. QUALITY & SAFETY (continued)

1.1 PATIENT SAFETY (continued)

1.1.3 Trust performance against improvement trajectory

Figure 4 shows the number of HAPUs per 1,000 bed days, together with the improvement trajectory which, as the graph shows, is not currently on track, but getting closer to the target this month. Corrective action by Matrons and Ward Managers is being monitored by the Nursing & Patient Experience team per the Trust Pressure Ulcer Improvement Plan.

1.1.4 Community Acquired Pressure Ulcers (CAPUs)

The Nursing & Quality team are now reviewing data regarding the number of patients being admitted to CHS with a pressure ulcer (i.e. CAPU).

The table below (and figure 5) 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.

Total number of CAPUs per month December 2015 to November 2016 (see figure 5):

Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16
174	175	160	116	177	154	192	170	209	132	161	240

Figure 4: Hospital Acquired Pressure Ulcers (HAPUs) by category and trend from December 2015 to November 2016 with improvement trajectory up to March 2017

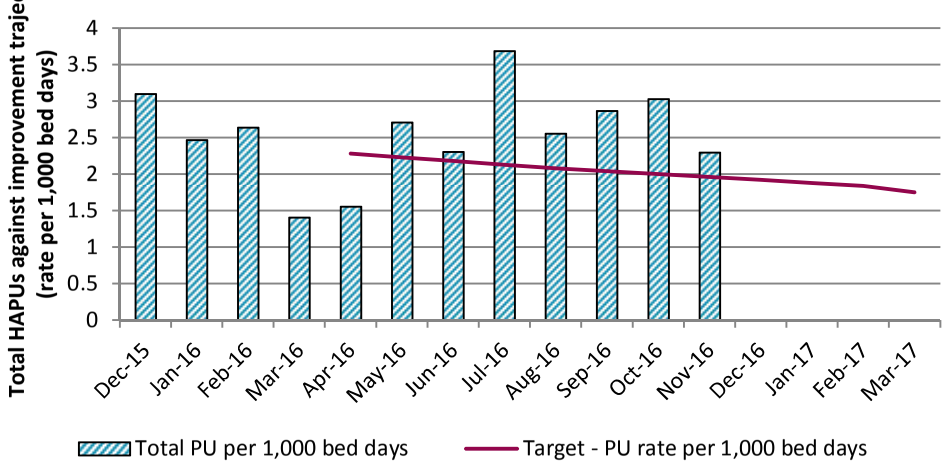
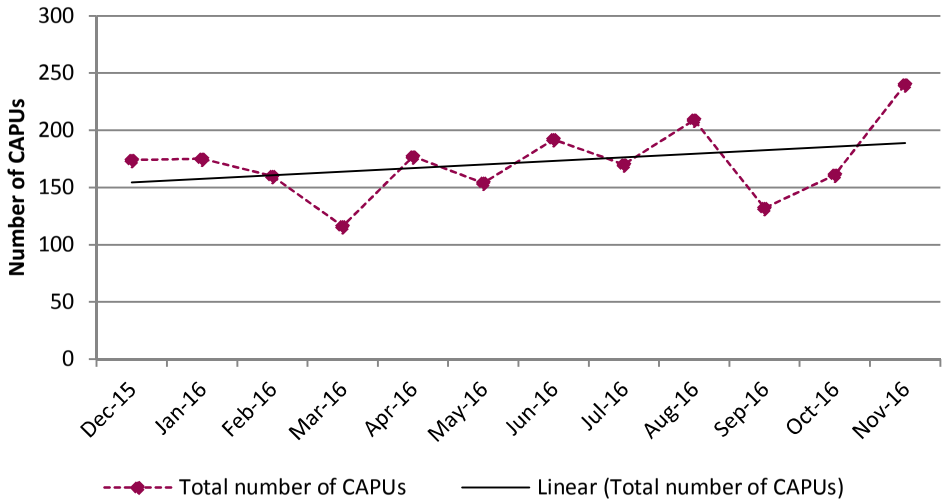


Figure 5: Community Acquired Pressure Ulcers (CAPUs) by category and trend from December 2015 to November 2016



1. QUALITY & SAFETY (continued)

1.1.5 Incident report

Data extracted from the Ulysses (Safeguard) Risk Management system provides details of Rapid Review Group (RRG) activity during November 2016.

CHS incidents reported

Figure 6 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 55 reported incidents (4%) in November compared to the previous month. In comparison to the same month in 2015, this is an increase of 147 (10%).

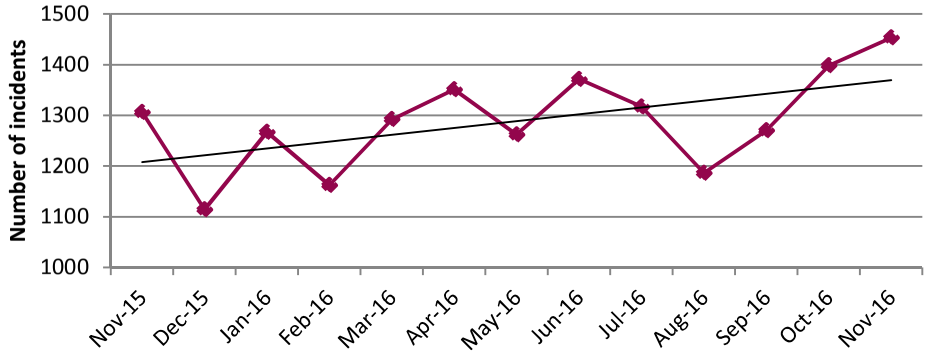
CHS incidents by impact

Figure 7 shows the incidents reported by impact over the last 13 month period. The percentage of no harm/near miss incidents as a proportion of CHS incidents reported is 63% in November, which is in line with the annual average.

There was one incident which was confirmed via the RRG process as having caused major harm in November. It related to a spinal cord infarction. A Root Cause Analysis (RCA) has been commissioned from Theatres and is due to be tabled at RRG by the end of December.

In October, five incidents were reported as having caused major or extreme harm, but all of these were subsequently downgraded following consideration by RRG. Five further incidents were reported as having this severity in November and will be reviewed at RRG during December.

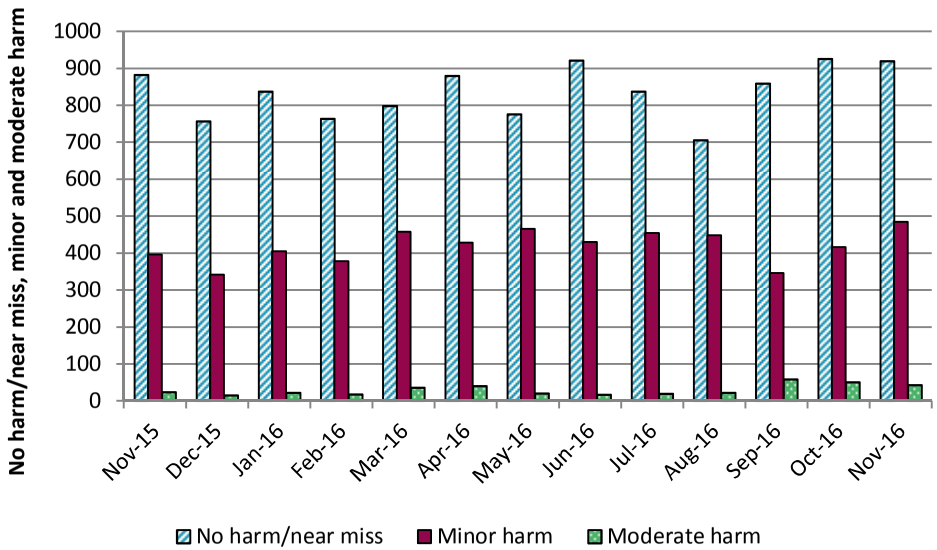
Figure 6: Number of incidents reported November 2015 to November 2016



Data for Figure 7: Incidents reported by category November 2015 to November 2016

	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16
No harm/ near miss	882	757	837	764	798	880	776	921	837	706	859	926	920
Minor harm	396	342	405	378	458	428	466	430	454	448	346	416	485
Moderate harm	24	15	22	18	36	40	20	17	19	22	58	51	43
Major harm	4	0	3	1	0	2	0	3	6	8	5	2	3
Extreme harm	0	0	0	1	0	1	0	0	1	2	2	3	2
Total	1306	1114	1267	1162	1292	1351	1262	1371	1317	1186	1270	1398	1453

Figure 7: Incidents reported by category November 2015 to November 2016



Reported incidents for November 2016 (additional information to accompany fig 7):

Major harm	Extreme harm
3	2

Actual impact of incidents for November 2016:

Major harm	Extreme harm
1	0

1. QUALITY & SAFETY (continued)

1.1.5 Incident report (continued)

High Impact Safety Messages

There were no high impact safety messages issued in November.

Headlines

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

- The importance of early top-to-toe assessments of patients on admission.
- The responsibility of clinical staff of ensuring the safe and effective handover of clinical care.
- The importance of giving critical medications to patients.
- Staff should report incidents of violence and aggression towards them as it allows the Trust to address the issues as they arise.

Top 5 incidents by cause group

Top 5 cause groups for all CHS incidents reported in November 2016 were:

- Tissue viability (14%)
- Falls (13%)
- Consent, communication and confidentiality (10%)
- Documentation and identification (8%)
- Resource and infrastructure (8%)

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 8 demonstrates the number of RCAs commissioned by RRG per month and by level of investigation.

During November, RRG commissioned seven RCAs. Figure 9 indicates the status of RCAs by category, showing 73 out of 85 RCAs are overdue. The proposals from RRG to address the RCA backlog, which have been approved by Clinical Governance Steering Group and Executive Committee and were endorsed by Governance Committee in December 2016, will result in the removal of up to 50 RCAs from the worklist. Governance Committee will be advised of progress.

Figure 8: RCAs commssioned by level of investigation November 2015 to November 2016

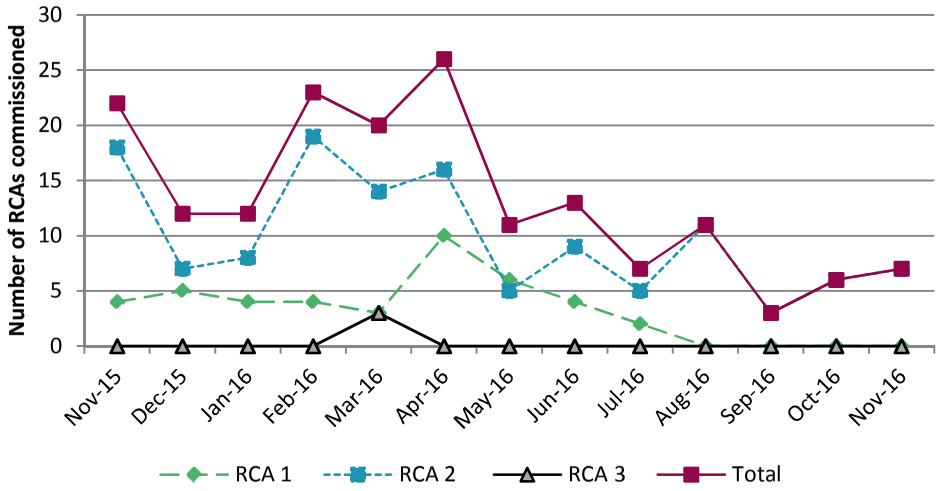


Figure 9: Status of current RCAs – November 2016 (previous month in brackets)

	Overdue >3 months	Overdue <3 months	Within	Total
RCA Level 1	20 (22)	0 (0)	0 (0)	20 (22)
RCA Level 2	45 (49)	8 (11)	12 (7)	65 (67)
RCA Level 3	0 (2)	0 (0)	0 (0)	0 (2)
Total	65 (73)	8 (11)	12 (7)	85 (91)

1. QUALITY & SAFETY (continued)

1.1.6 Serious Incidents (SIs)

SIs are reported via Strategic Executive Information System (StEIS) and monitored through North East Commissioning Support Unit (NECSU). CCG SI panels review completed RCA 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 10 demonstrates the number of incidents logged on STEIS by month.

The current status of SI investigations broken down by directorate is recorded in Figure 11. Figure 12 shows the status of SI investigations over the last 13 month period. Ten SIs are overdue from a high of 36 in May 2016. 17 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 three.

Figure 10: SIs reported to STEIS November 2015 to November2016

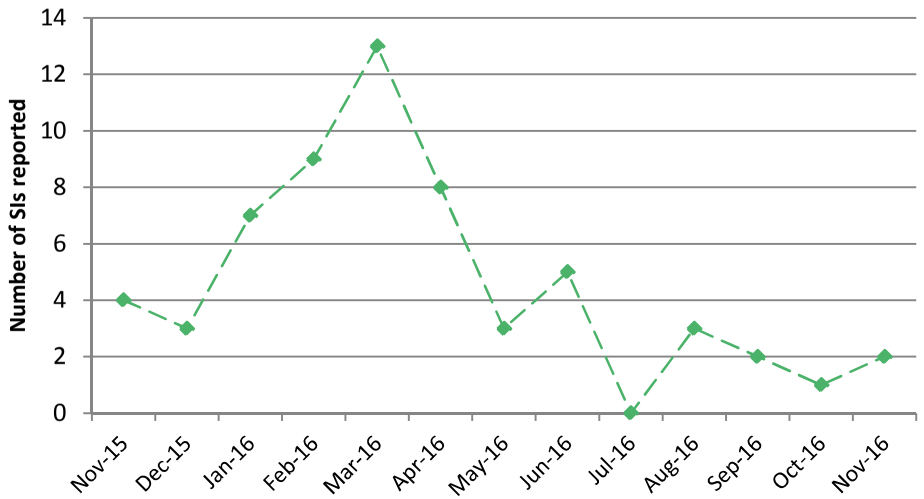


Figure 11: Status of current SIs

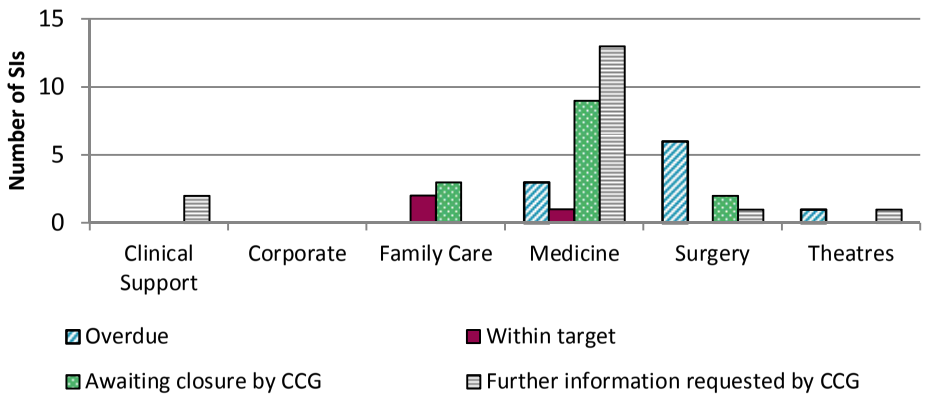
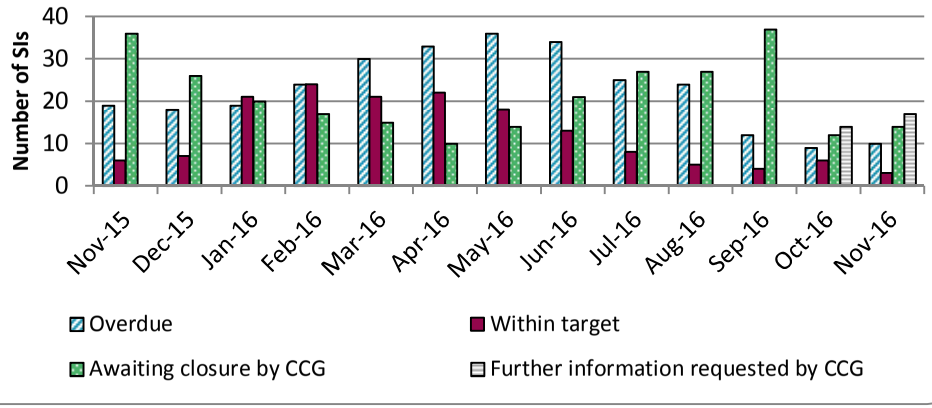


Figure 12: SI Status November 2015 to November 2016



Data for figure 12: SI status November 2015 to November 2016:

	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16
Overdue	19	18	19	24	30	33	36	34	25	24	12	9	10
Within target	6	7	21	24	21	22	18	13	8	5	4	6	3
Awaiting closure by CCG	36	26	20	17	15	10	14	21	27	27	37	12	14
Further info req by CCG	Not collected											14	17

1. QUALITY & SAFETY (continued)

1.1.7 SI quality indicators

Figure 13 demonstrates the compliance with the quality indicators for SIs. The actual compliance against the quality indicators for November 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 since May, the timeliness of submitting these within the target has not yet been met. A low compliance on the indicator relating to requests for further information from CCG SI panel is due to a focus on getting completed SI investigations submitted to the CCG in order to reduce the backlog further. As this backlog reduces, efforts will be made to ensure that the CCG receives responses in a timely manner.

The risk team are working closely with directorates to assist in completing all overdue SI investigations.

Figure 13: SI quality indicators

November 2016	Target	SEP	OCT	NOV
SIs reported on STEIS within 2 working days of identification of incident	90%	50% (1/2)	100% (1/1)	100% (2/2)
Interim reports received for Never Events within 24 hours	90%	N/A	N/A	N/A
Interim reports received for SIs within 72 hours	90%	100% (2/2)	100% (1/1)	100% (2/2)
Completed RCA submitted within 60 working days	90%	0% (0/5)	50% (2/4)	0% (0/1)
% of lessons learned entered on STEIS for completed RCAs	90%	100% (5/5)	100% (4/4)	100% (1/1)
Requests for further information sent to CCG SI panel within one month	85%	0% (0/1)	20% (1/5)	33% (2/6)

1.1.8 Never Events

There were no incidents reported in November 2016 that were classified as Never Events.

1.1.9 Duty of Candour

During November, five 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.

1.2 SAFEGUARDING

1.2.1 Safeguarding Children

Current position

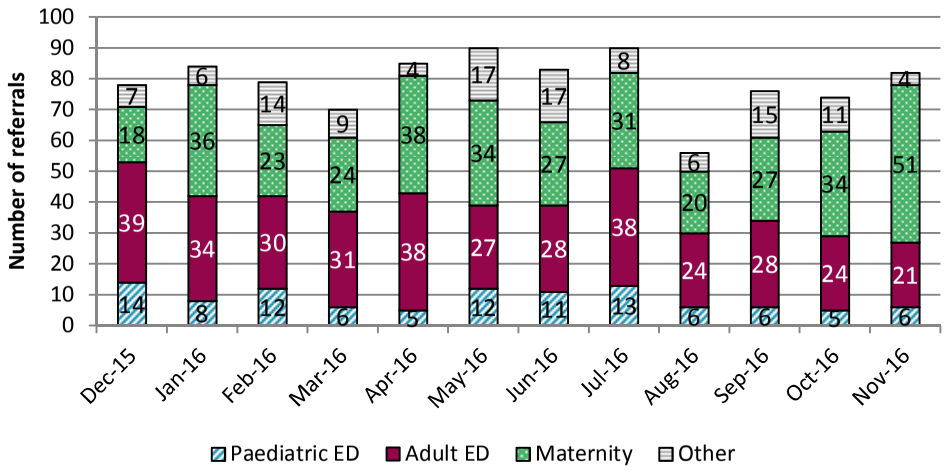
As figure 14 shows, the overall numbers of referrals to Children's Services have remained steady within Emergency Care, however there continues to be a rise with referrals from Maternity. Compared to 2015, there has been a 49% increase and the emerging themes relate to domestic abuse and substance misuse.

The three Serious Case Reviews (SCRs) regarding two young people and a baby, which commenced process in October, have all been concluded in respect of front line staff's involvement. The independent author will provide a multi-agency report which will be shared for comments prior to sign off. As yet, there are no dates for publication.

An SCR involving a family of eight commenced in November. Due to the complexity of this case, the final date for front line staff's involvement will be February 2017. There is long term neglect of the children in this case associated with failed to attend hospital appointments from various specialities.

Sunderland Children's Services had a second review visit by OFSTED which was positive with comments that they are "making steady progress". A planned visit by OFSTED will take place in February 2017.

Figure 14: Safeguarding children referrals December 2015 to November 2016



1. QUALITY & SAFETY (continued)

1.2 SAFEGUARDING (continued)

1.2.2 Safeguarding Adults

Safeguarding Adults Reviews (SARs)

Current Position

There is one open **Serious Adult Review (SAR),** which involved a domestic violence incident. The report has been signed off. A publication date will be set via media planning meetings; it is anticipated that publication will be early January 2017.

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

Referrals

Figure 15 shows that a total of nine Safeguarding Adult Referrals were made by CHS in November 2016. The referrals detailed two allegations concerning care homes - one detailed neglect and the second detailed physical abuse. Six referrals detailed abuse in the patient's own home, one in relation to carers and the remaining five alleged abuse from family members. One referral detailed self-neglect relating to a homeless patient.

Mental Capacity Act: Deprivation of Liberty Safeguard (DoLS)

From 28 November 2016, a new process for the application of MCA DoLS was implemented at CHS. The process has eliminated the requirement of faxing applications to the Safeguarding Adults Team at CHS and to the Local Authority.

Applications are now sent to an MCA DoLS dedicated email address. A quality check is conducted and the application is then sent securely to the relevant Local Authority.

Current position

November 2016 saw 100 new DoLS applications submitted from CHS to the Local Authority. As shown in figure 16, this is a decrease from 111 the previous month.

Figure 15: Adult safeguarding referrals received December 2015 to November 2016

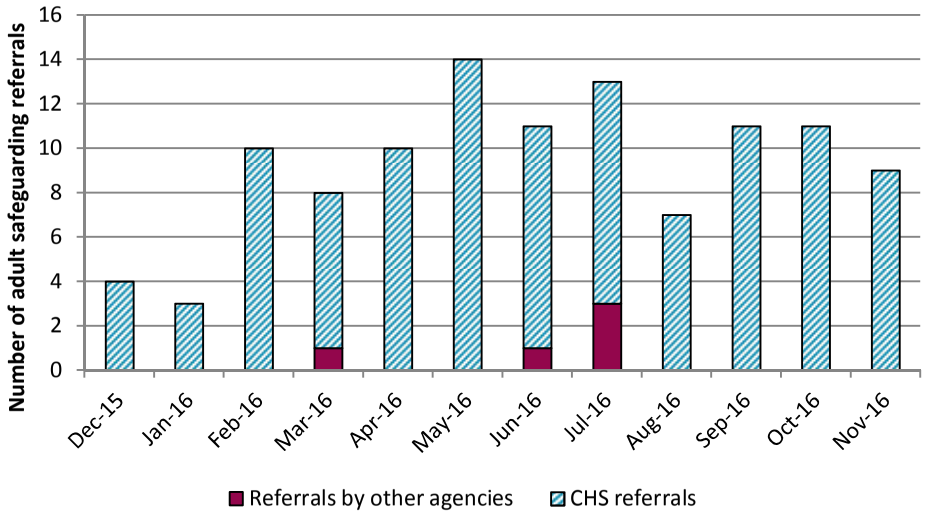
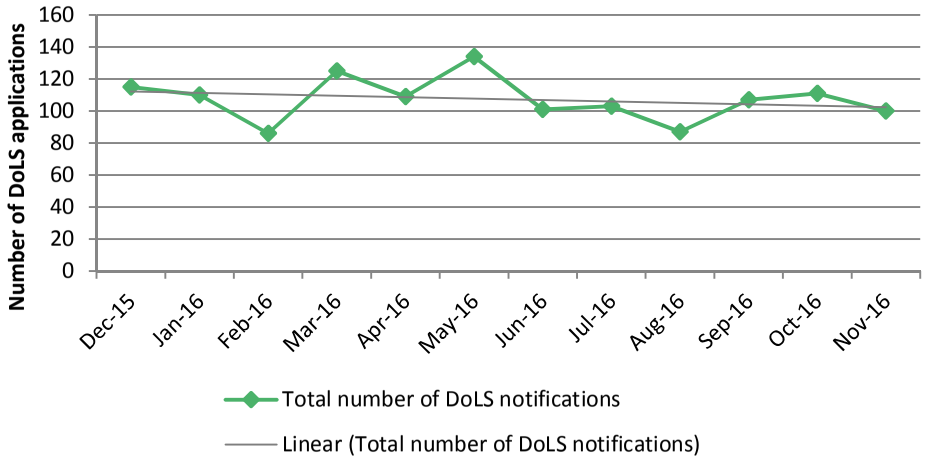


Figure 16: Number of DoLS applications made December 2015 to November 2016



1. QUALITY & SAFETY (continued)

1.3 PATIENT EXPERIENCE

1.3.1 Complaints

In November, 45 formal complaints were received.

The Trust's complaints policy expects formal complaints be acknowledged within 3 working days of the receipt of the complaint. Figure 17 demonstrates 100% compliance.

Figure 18 details the number of formal complaints awaiting a response (by working days) and demonstrates that complaints are, overall, being responded to more quickly, with, for the first time, no complaints awaiting a first response over 91 days.

Figure 19 shows the status of all formal complaints as at the end of November. The total number of open complaints (new and re-opened) is 76, compared to 100 the previous month, demonstrating a positive shift in reducing the number of open complaints.

Figure 17: Acknowledgement of formal complaints December 2015 to November 2016

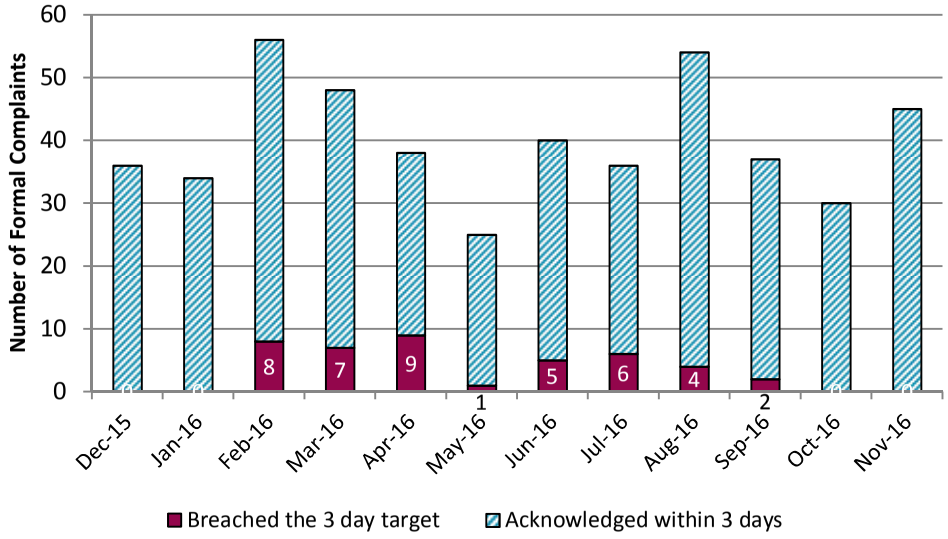


Figure 18: Current Formal Complaints Awaiting Response - Working Days

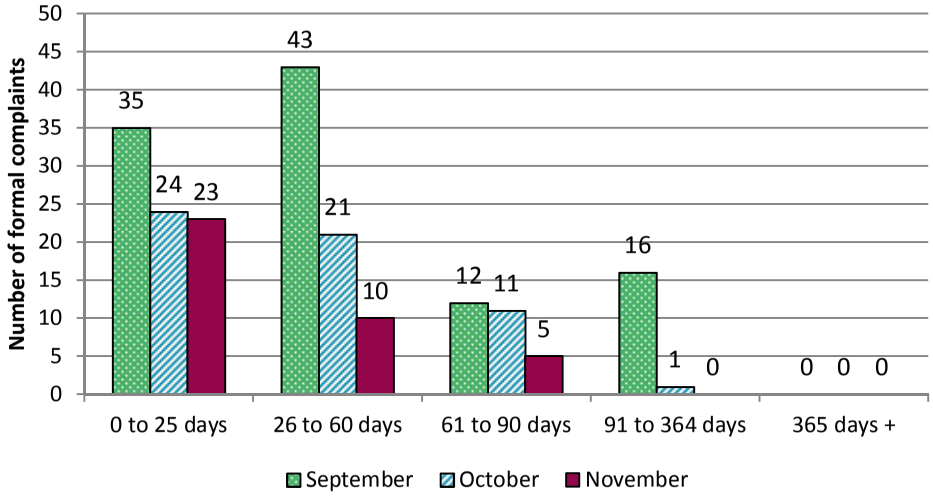
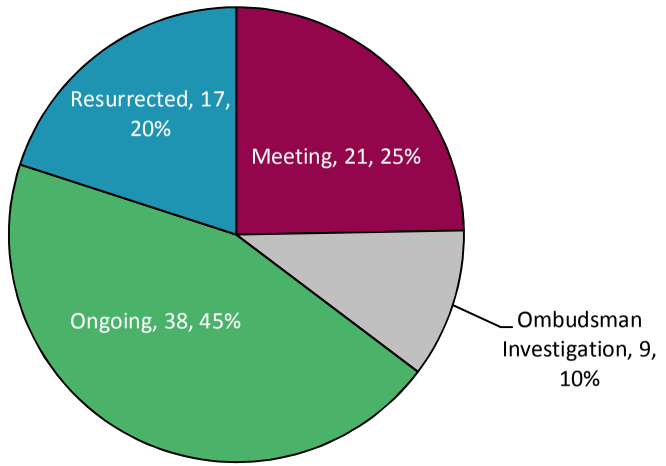


Figure 19: Current Stages of Formal Complaints - November 2016



1. QUALITY & SAFETY (continued)

1.3.1 Complaints (continued)

Figure 20 provides visibility of the number of complaints awaiting a first response (ongoing), identifying those outwith expected timeframes, indicating 38 awaiting a first response compared to 57 last month. 11 of these are outwith expected timeframes, compared to 28 the previous month. This demonstrates continuous improvements in managing the backlog of complaints.

Figure 21 demonstrates 57 complaints were responded to in November, which does not achieve the target 63 responses expected in the month. The target of three responses per day is no longer useful in managing the backlog, as there are smaller numbers of complaints to respond to.

Figure 20: All ongoing complaints within and outwith timeframes in accordance to policy - November 2016

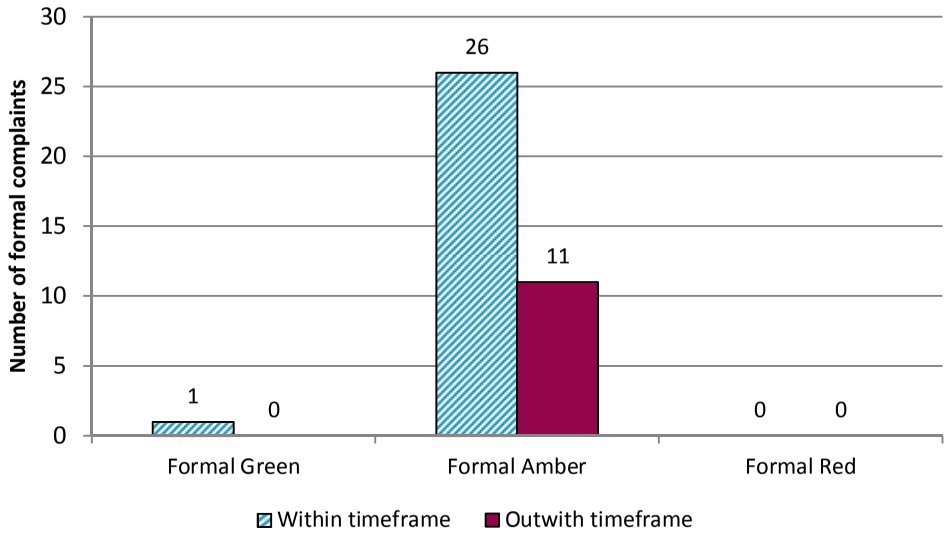
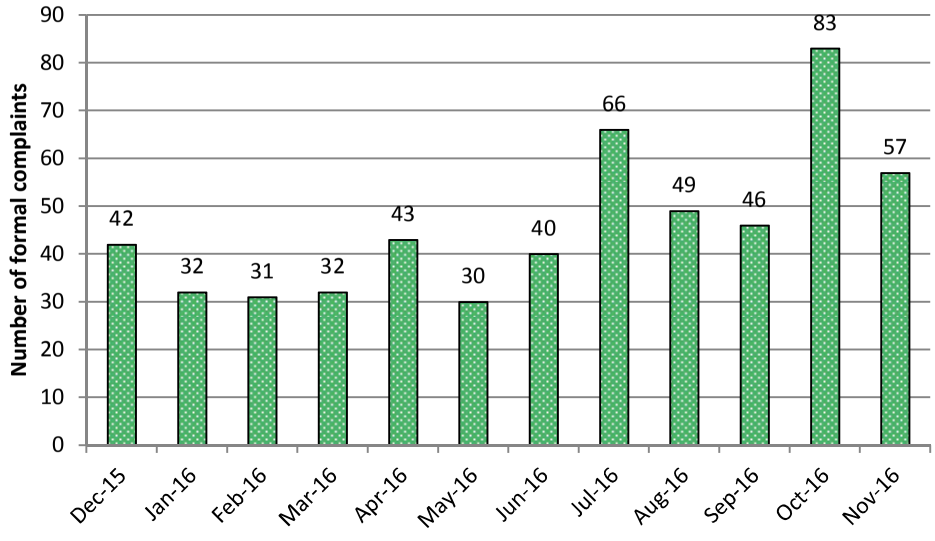


Figure 21: Number of formal complaints responded to by month - December 2015 to November 2016



1. QUALITY & SAFETY (continued)

1.3.1 Complaints (continued)

Figure 22 provides a breakdown of the data presented in figure 20 (on previous page) by directorate and demonstrates that Trauma & Orthopaedics have the highest number of outstanding complaints. However, all directorates have made progress in reducing the backlog. This data will continue to inform the action plan and assist in prioritising resources.

In summary, the November report demonstrates further improvements in managing the backlog of complaints awaiting a first response. In addition to the actions previously described, improvement work is now focusing on additional aspects of the process.

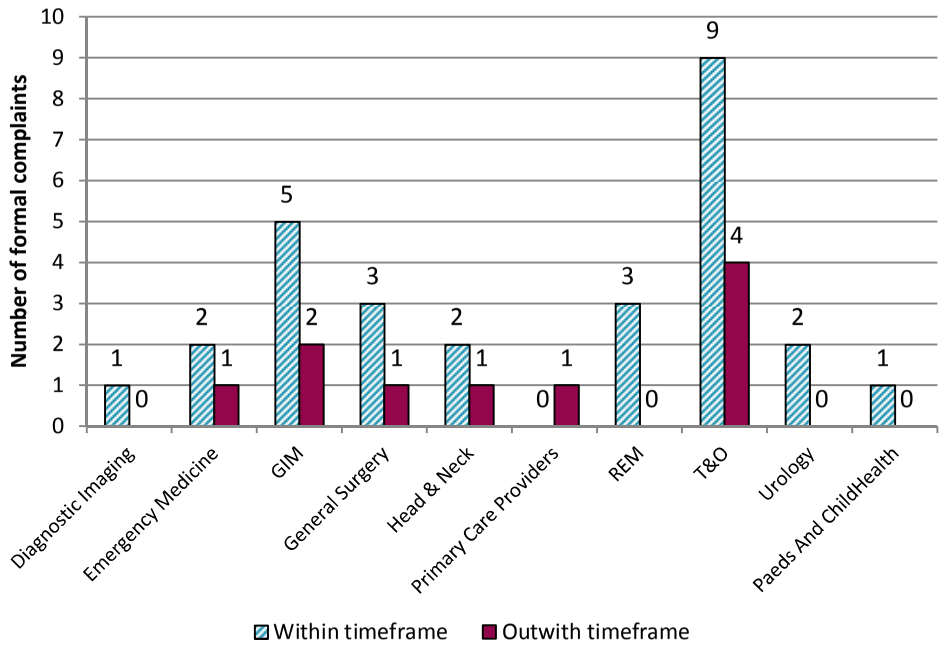
A visual monitoring tool has been implemented to ensure that the increase in requests for meetings are acted upon in a timely way. The directorates are responsible for providing dates and attendees, and the HAAS team books the venue and notifies the complainant. The visual tool enables HAAS to record the date of the meeting and when the notes have been sent out to the complainant after the meeting. Meetings are routinely recorded and the downloaded disc is sent to the complainant with a covering letter within 10 days.

Visual monitoring of daily responses has also been implemented to ensure the formal responses and cover letters are monitored on a daily basis.

A target of three days for turnaround of responses from receipt into HAAS, has been agreed and is monitored.

More refined reporting continues to inform the service review and action plan. The workshop to review the complaints process, planned for December, has been rearranged for early February 2017.

Figure 22: All complaints within and outwith timeframes by directorate - November 2016



1.4 MORTALITY REVIEW PANEL

The Mortality Review Panel is to be reported on a quarterly basis as a separate agenda item.

1. QUALITY PRIORITIES (continued)

1.5 HOSPITAL ACQUIRED INFECTIONS

1.5.1 MRSA bacteraemia

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

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

1.5.2 C. *difficile* infection (CDI)

Four cases were reported as Trust apportioned in November 2016 which is two cases above monthly trajectory. The year to date position at the end of November is 17 since six cases were upheld at appeal (April to October) against a trajectory of 22. One further case will be taken to appeal in December 2016. See figure 23 for more details.

December update: Two cases were reported as Trust apportioned in December 2016 which is one case below monthly trajectory. The year to date position at the end of December is 19 since six cases were upheld at appeal (April to October) against a trajectory of 25. One further case remains outstanding at appeal from December 2016.

1.5.3 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 99.0% compliance with hand decontamination for November (1251 observations). Further analysis of compliance is presented as 98.1% medical, 99.8% nursing and 98.9% for other staff. See figure 24 for compliance across the last 12 months.

Figure 23: Clostridium difficile cases for year to date April to November 2016 with successful appeals up to September 2016

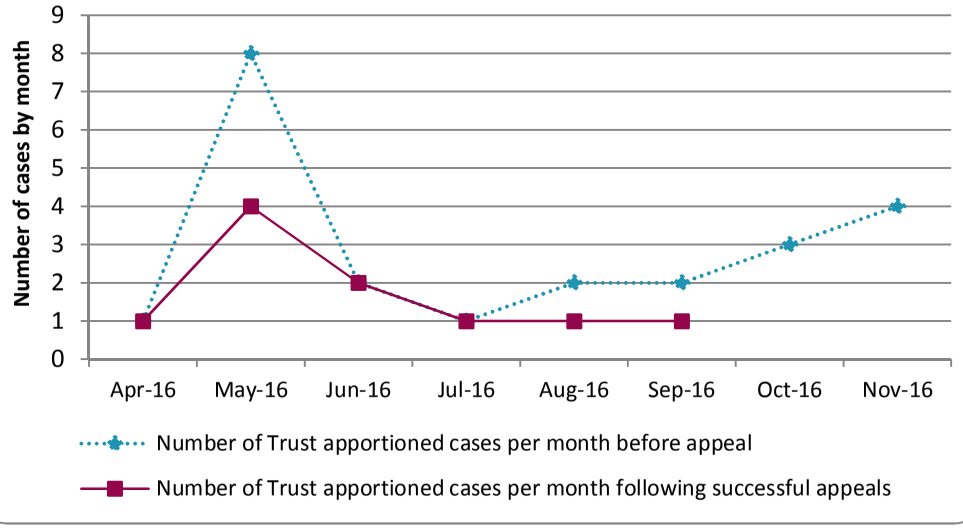
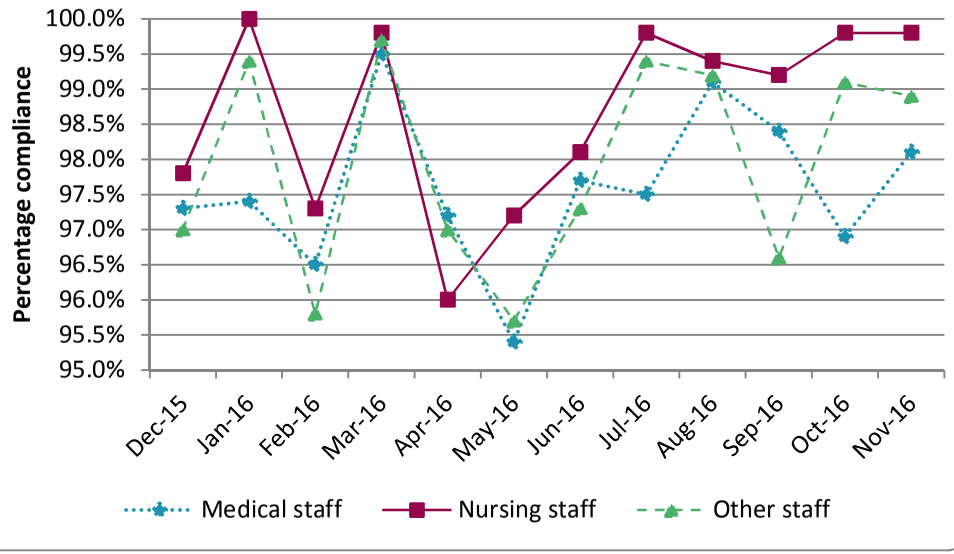


Figure 24: Hand hygiene results December 2015 to November 2016



1. QUALITY & SAFETY (continued)

1.6 NURSING WORKFORCE

1.6.1 National Indicators/Monitor Governance Indicators

- Fill rate is the percentage of actual hours out of planned hours for Registered Nurses (RN)/ Midwifes (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 & midwifery staffing recorded on Safeguard 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 in ESR

Director Lead: Melanie Johnson
Consequence of failure: Patient safety, patient experience, quality/outcomes & reputation

Fill rates for SRH and SEI (see figure 25):

Indicator		Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16
No. of incidents		42	57	50	69	26	30	29	39	45	83	67	85
Fill rate	SRH	93.00	92.57	92.00	94.00	93.00	93.00	93.00	92.00	93.00	92.00	93.00	93.00
	SEI	92.00	94.04	95.00	94.00	96.00	95.00	94.00	94.00	94.00	93.00	96.00	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 November there were additional beds open on D42 and E54 for the whole month. There were three wards in November with RN fill rates of less than 80%:

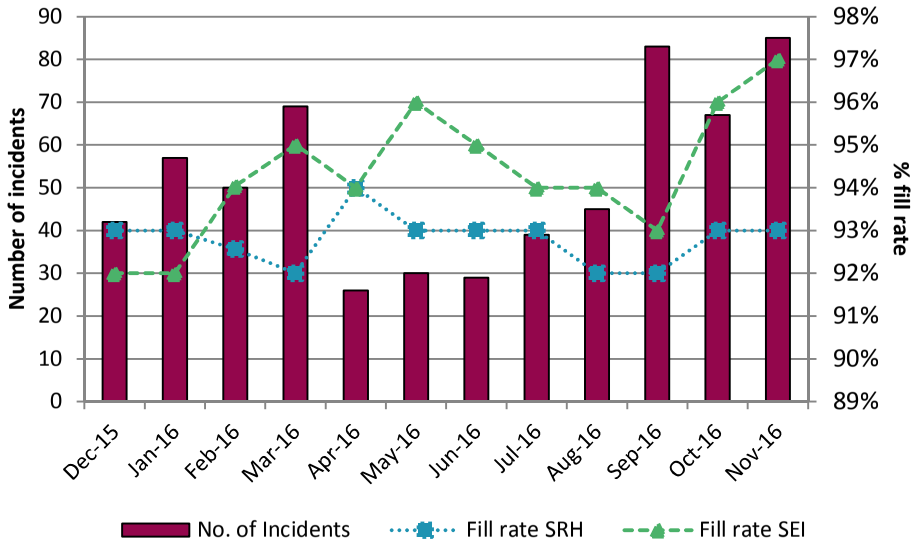
- F61 (Hume Unit) - RN day duty fill rate 74%. They currently have 1.84wte RN vacancies and one RN on maternity leave. Mitigation includes support from E58 and NHSP. During November there were four patient falls (three no harm and one minor harm) and two grade 2 pressure ulcers reported.
- D43 - RN day duty fill rate 76%. They currently have 4.55wte RN vacancies. Support is given from NHSP and D48. During November there were 10 patient falls (seven no harm and three minor harm), seven grade 2, and four grade 1 pressure ulcers reported.
- E52 - RN day duty fill rate 76%. They currently have 3.43wte RN vacancies, one RN on maternity leave and one RN on long term sick. Support is given from other Care of the Elderly wards and NHSP. During November there were 10 patient falls (six no harm and four minor harm) and two grade 2 pressure ulcers reported.

NHSP continues to provide support to wards to mitigate shortfalls. There were 15,617 hours supplied in November compared to 15,948 in October. 52.8% of requests were filled compared to 54.9% in October.

At the end of November there were 84wte approved RN vacancies. This does not include 32wte who are currently undergoing pre-employment checks.

The annual ceiling total nursing agency spend for CHS has been set at 3% of total nursing staff spend. Historically nursing and midwifery agency spend within the Trust has been minimal. Agency spend year to date remains at 0%.

Figure 25: Trust Nursing Fill Rate and Incidents Trend December 2015 to November 2016



Fill rates – November 2016	Day		Night	
	RN/RM	Care staff	RN/RM	Care staff
Family Care	94.00%	87.00%	101.00%	92.00%
Medicine	82.00%	109.00%	83.00%	97.00%
Surgery	85.00%	99.00%	87.00%	115.00%
Theatres	100.00%	81.00%	100.00%	55.00%
SRH Total	**93.00%**			
SEI Total	**97.00%**			

Care Hours Per Patient Day (CHPPD) November 2016	SRH	SEI
	7.1	14.7

1. QUALITY & SAFETY (continued)

1.6 NURSING WORKFORCE (continued)

1.6.2 Incidents relating to Nursing and Midwifery Staffing

In November there were 85 incident forms relating to nursing and midwifery staffing, an increase from 67 in October (note these were not isolated to ward areas).

There were 36 incident forms submitted by 11 wards when RN staffing was below "trigger" numbers. This is a significant increase from October (23). On the majority of 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. However, on some occasions this was not possible and the duty matron risk assessed areas and moved staff according to risk. Duty matron submitted seven incident forms this month when staffing across the Trust was difficult with several wards below minimum numbers, either due to sickness or acuity of patients. On all occasions, duty matron moved staff around to ensure all areas were safe.

Medical Specialities submitted the highest number of incident forms this month (18) – see figure 26. 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 from NHSP and the duty matron.

Staff have now been identified for escalation areas creating a core team for these beds which should result in less RNs being moved from base wards.

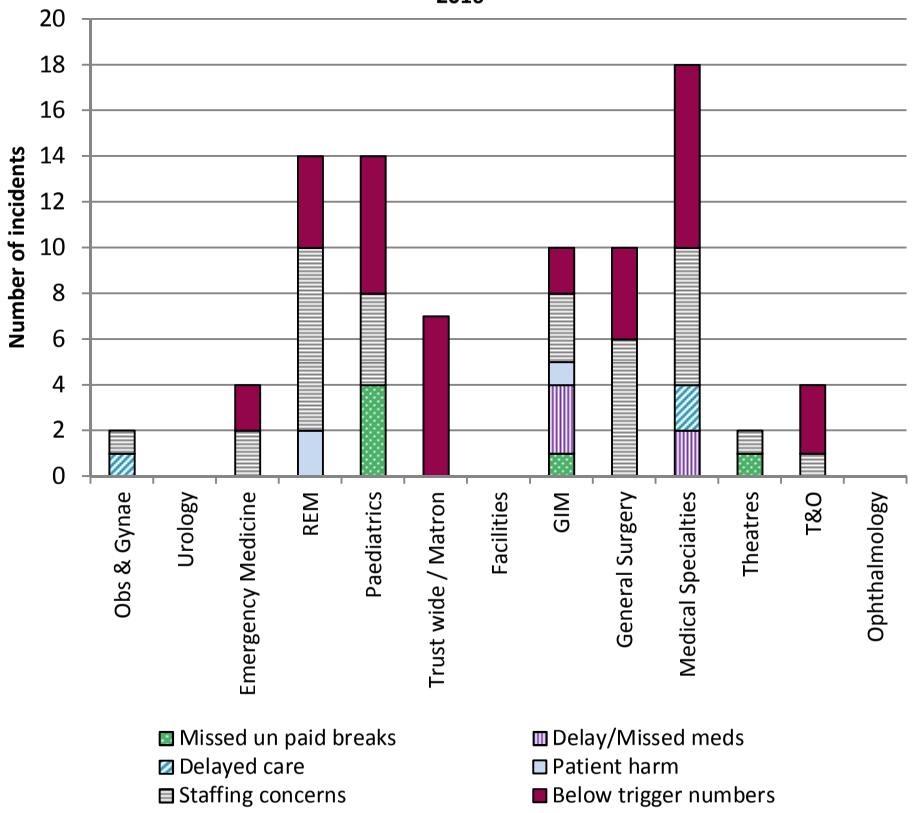
1.6.3 Workforce Update

Monthly generic band 5 recruitment continues. Maternity services recently appointed three midwives to substantive posts and four at risk to support existing vacancies, an increase in demand, and a large amount of maternity leave in coming months.

HCA recruitment has been successful with 64 appointed. This will support winter planning as well as fill vacancies and place HCAs in areas which have significant RN vacancies.

Overseas nurses continue to arrive. To date 18 are in post with a further four due to arrive by the end of November. Eight nurses took the Objective Structured Clinical Exam (OSCE) in early December, however six are required to do a full or partial resit, planned for early January 2017. There are three nurses taking OSCE in January 2017 and three in February 2017, with further dates to be booked for others once they have received a decision letter from the Nursing and Midwifery Council. The wait for the letter is delaying more nurses completing the OSCE.

Figure 26: Incidents Relating to Nursing & Midwifery staffing - November 2016



Absence turnover for November 2016:

Absence/ Turnover November 2016	Absence					Turnover	
	Absence FTE	Available FTE	Absence Rate	Short Term Absence	Long Term Absence	Headcount	WTE
HCAs	1203.89	18684.84	6.46%	1.87%	4.59%	-	-
RNs	1868.06	41162.61	4.54%	1.60%	2.94%	-	-
RMs	236.47	3445.31	6.86%	2.63%	4.23%	-	-
Overall	3308.42	63292.76	5.22%	1.75%	3.47%	0.86%	0.86%

2. CORPORATE RISK

2.1 CORPORATE RISK REGISTER

The Q2 corporate risk register was approved by Corporate Governance Steering Group in November.

2.2 RAPID REVIEW GROUP

A three month review of the implementation of the Directorate Initial Review form (DIR) has been carried out. The review showed that 82% of incidents reported as having an impact of 3 or worse were over-scored. This means that directorates are having to prepare DIRs for RRG which are unnecessary. Feedback has been given to the three directorates with the highest levels of over-scoring so that reporters can be briefed in respect of appropriate scoring of incidents. In order to assist, the Ulysses incident report form is to be amended to include a definition of each level of harm.

A concise investigation form (CIF) has been drafted and is being considered by RRG. Once finalised, the CIF will be used whenever an RCA of an adverse event which does not meet the Serious Incident definition is commissioned. A review of effectiveness will be carried out after three months' use.

3. CONCLUSION

3.1 SUMMARY OF KEY RISKS

- Plan to reduce pressure ulcers is behind trajectory.
- There is still a backlog of complaints although this is reducing.
- Vacancies in nursing are compromising delivery of patient care.

Members are asked to note the report.

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

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DIRECTORATE OF FINANCE

BOARD OF DIRECTORS

JANUARY 2017

FINANCIAL POSITION AS AT 31ST DECEMBER 2016
EXECUTIVE SUMMARY

1 INTRODUCTION

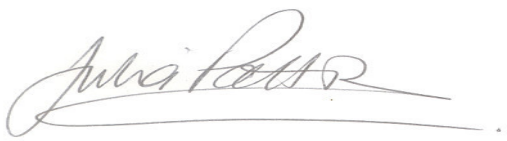
This Executive Summary provides the summary highlights of the financial position as detailed in the main report to the end of December 2016.

1.1 KEY HIGHLIGHTS

Issue or Metric	Budget	Actual	Variance	%
Overall Financial Position – Deficit	£1,923k	£2,222k	£299k	15.5%
Income	£265,595k	£265,978k	(£383k)	0.1%
Expenditure	£267,518k	£268,200k	£682	0.3%
EBITDA Position %	3.6%	3.6%		
EBITDA Position £'s	£9,607k	£9,444k	(£163k)	1.7%
Cash Position	£9,758k	£4,208k	£5,550k	56.9%
Clinical Activity:				
Variance to plan	£244,782k	£245,688k	£906k	0.4%
Cost Improvement Plans				
Variance to plan	£10,528k	£10,127k	£401k	3.8%

Pay:				
Variance to plan	£159,593k	£157,972k	(£1,621k)	1.0%

Non Pay:				
Variance to plan	£107,928k	£110,227k	£2,299k	2.1%
Use of Resources Metrics (UOR)			3	
+ve variance equates to worse than expected; -ve equates to better than expected				



Julia Pattison
Director of Finance

DIRECTORATE OF FINANCE

BOARD OF DIRECTORS

JANUARY 2017

FINANCIAL POSITION AS AT 31st DECEMBER 2016

1 INTRODUCTION

The enclosed financial statements reflect the Trust's Income & Expenditure position as at 31st December 2016 details of which can be found in Appendices 1 - 6.

1.1 SUMMARY POSITION

The overall financial position is a net deficit of £2,222k against a planned deficit of £1,923k, and therefore £299k behind plan.

The Trust reported an over performance of £906k in month 9 relating to NHS clinical activity which is due to higher than expected PbR activity.

At the end of December the Cost Improvement Plan (CIP) delivery is £401k behind projected plans submitted to NHSI.

Performance against the EBITDA margin is in line with plan to the end of December.

The current financial position, a deficit of £299k, assumes non delivery of key performance targets, namely 4hour A&E in October and December, plus Cancer targets in October and December. Therefore £310k of STP funding has been removed from the financial projection to date. If performance targets had been met then the actual financial position would be a small value ahead of plan of £11k. The below table summarises this:

	Plan YTD ending 31-Dec-16 £m	Actual YTD ending 31-Dec-16 £m	Variance YTD ending 31-Dec-16 £m
Control Total Basis Surplus / (Deficit)	(1.922)	(2.222)	(0.299)
Sustainability & Transformation Fund (STF) included	7.950	7.640	(0.310)
Control Total Basis Surplus / (Deficit) exc. STF vs Plan	(9.872)	(9.862)	0.011
Control Total Basis Surplus / (Deficit) exc. STF vs Control Total	(9.873)	(9.862)	0.011

The deficit position means that the Trust Use of Resources Metrics (UOR) rating score is 3. This new measure came into place from October 2016 and replaces Financial Sustainability Risk Rating (FSRR).

2 INCOME

2.1 *Patient Related Income:*

Clinical Income to month 9 was £245,688k against a plan of £244,782k, and hence ahead of plan by £906k. At this stage of the year the Trust is benefiting from the

block contract arrangement with Sunderland CCG as activity and therefore costs are less than planned yet income due to the contract nature is still being gained. It is expected that this position will even out by the end of the financial year.

The Trust has had a number of conversations with our lead commissioner Sunderland CCG around additional funding support within 2016/17. At this stage some additional funding has been gained by the Trust from Sunderland CCG which has been included within the month 9 position.

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

Clinical income is particularly complex this year due to:

- Block contract with Sunderland CCG
- Differences between the plan and agreed contracts, particularly relating to commissioner's treatment of QIPP/savings assumptions (c£5.8m in total). Whilst contracts have been set at a lower level, most of the CCGs have agreed to fund these QIPP reductions for cash flow purposes.
- A 'Stretch' target required to achieve the overall control total

The impact of the above is summarised below:

Summary	**Annual Plan**	**Total to date**
	£000's	**£000's**
Sunderland contract lower than plan	1,160	870
Other contracts lower than plan	0	-1278
Gap/Stretch target (to achieve control total)	936	701
Phasing Adjustment	0	-113
Other and Non Contract	0	-1490
STP Risk	0	310
CQUIN	0	95
Total	**2,096**	**-905**

STP Funding at for 2016/17

Despite the risks in the last 3 months and throughout winter the Trust anticipates A&E performance to be in line with year to date trajectory by the end of quarter 4 and has duly included 'back payment' of STP funding relating to A&E performance i.e. assumed full STP funding with the 2016/17 annual forecast.

At this stage the Trust has assumed non delivery of cancer trajectories between October and March; therefore financially £221k of 'lost' STP funding has been included within the year end forecast for October, December, January, February and March 2017.

Appendix 3 provides further details around patient related income to date.

Private Patient Income is under recovered against plan by £57k.

2.2 ***Non Patient Related Income:***

Training and Education income is £314k ahead of plan due to additional backdated funding received from Health Education England NHS this month. Research and Development Income is showing an under recovery against plan of £233k due to lower than expected activity to date.

Other Income is behind plan by £546k largely due to CIP shortfall to date through unidentified plans in this category.

3 EXPENDITURE

3.1 *Pay Expenditure:*

Pay is currently showing an underspend of £1,621k against plan, reflecting:

- Agency costs to month 9 are £3,546k, compared to an overall Trust agency staffing budget to month 9 of £4,000k. Much of this spend is to cover vacant posts. The same period in 2015-16 had agency spend at £4,519k which is £973k more than the current period. This position on agency spend means the Trust is below its maximum agency/ceiling level set by NHS Improvement to the end of November 2016, detailed in Appendix 4.
- The main underspend is due to vacant nursing posts across the Trust. To date the underspend is £1,532k which is inclusive of the costs paid to NHS Professionals.
- Vacant Radiographer, Clinical Support Therapist and Operating Theatre staffing posts have contributed largely to £713k underspend under Other Staffing category to date.
- Cost Improvement Plans for pay are £636k ahead of plan to date mainly due to these vacancies.
- Key variances by staff group are detailed as:

Key Pay variances by staff group to current month	£000s
Consultants Staff (net of vacancies, additional sessions and agency costs)	294
Other Medical Staff (net of vacancies, additional sessions and agency costs)	330
Nursing (net of NHSP Costs)	-1,532
Other Staff groups	-713
Total Variance	**-1,621**

Appendix 4 shows details of pay spend on agency, flexi-bank and overtime for the last 12 months from month 9.

Overall pay costs in December were £17,646k against a budget of £17,669k for the month.

3.2 *Non Pay Expenditure:*

Non-Pay is overspent by £2,299k. Major areas are highlighted as:

- Drugs are overspent by £1,274k.
- Clinical Supplies is underspent by £680k due largely to lower than expected clinical activity, strong CIP performance to date and low leasing and maintenance spend to date against plan.
- Other Non Pay is over spent by £1,574k due largely to unidentified 'Stretch' plans to date.
- PDC costs are £163k overspent against plan to date.

As noted within previous Financial papers the Trust original annual plan for 2016/17 included a £1.7m 'stretch' target within the category of 'other non-pay', this value has now been largely offset by various unrequired growth provisions made during annual planning, these were largely caused by timing differences between annual plan submission and final contract agreements.

Appendix 5 shows details of non pay spend for Clinical Supplies, Drugs and Other Non-Pay for the month.

4 CIP POSITION

The Cost Improvement Plan (CIP) target as declared to NHS Improvement (NHSI) for 2016/17 is £15,000k, however Divisional plans to date total £13,425k, meaning the Trust still has £1,575k of CIP plans to identify in this financial year.

The plan to date is £10,528k per our Monitor plan, against which actual delivery is £10,127k, so behind plan by £401k.

Details are provided in Appendix 6.

5 CASHFLOW AND WORKING CAPITAL

The cash balance at the end of December 2016 was £4.21m against planned £9.76m. The adverse variance of £5.55m is predominantly attributable to NHS debtors being significantly higher than plan (£6.91m), the capital cash profile being slightly ahead of plan (£90k), and offset by favourable variances within other areas of working capital (£1.45m).

The adverse NHS debtor variance of £6.91m consists of outstanding clinical activity income invoices (£216k), un-invoiced accruals in respect of STP funding (£2.65m), clinical activity income (£1.05m), additional winter support (£900k) and miscellaneous charges (£2.09m). All debtors continue to be vigorously pursued.

The adverse NHS debtor variance of £6.91m is summarised in the table below:

NHS Debtor Variance to current month	£000s
Delays in payment for clinical contract	216
Non Clinical contract income from other NHS bodies	2,994
STP Funding	2,650
Clinical Activity Over performance Accruals/Timing	1,050
Total Variance	**6,910**

The Statement of Financial Position detail is provided in Appendix 2.

6 CAPITAL

Capital expenditure to date is £7,379k and relates mainly to A&E Development (£5,954k), IMT Costed Profile (£537k), Endoscopy/Scope Cleaning (£222k) and Theatre Image Intensifiers (£221k).

7 RISKS

The financial plan and the actual position include a number of risks. The Trust is in the process of agreeing financial position with all key commissioners this should enable us mitigate risks associated with delivering year end control total. The key risk at this stage is the shortfall in CIP delivery. At this stage it anticipated that the Trust will fall short of the full £15m target set for 2016-17, however a number of one off financial benefits mean that the required CIP in year will be £13.9m. So against plans identified so far, the Trust needs to identify a further £0.50m of CIPs to achieve control totals.

In addition the Trust has assumed a 'catch up' in STP funding linked to A&E trajectories by the end of quarter 4, should the necessary A&E target not be achieved then this funding is unlikely to be gained.

At this stage and taking into account the level of risks detailed above the Trust faces a significant challenge in achieving the required control total of £2.167m deficit for 2016/17.

8 RISK RATING

The Financial Sustainability Risk Rating (FSRR) has now been replaced with a new 'Use of Resources' metric. The rating of '3' is consistent with the prior rating of '2'.

9 NEXT STEPS

At this stage the Trust is largely in line with the annual plan submitted to Monitor of £2.167m deficit.

A number of one off short term benefits is supporting the financial position. It is key that CIP's are identified to close the CIP gap on a recurrent basis.

10 DECLARATION

For information, NHS Improvement no longer requires declarations to be made going forwards.

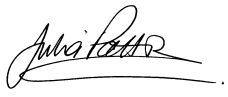
11 SUMMARY

The overall position at the end of December is a deficit of £2,222k compared to a planned deficit of £1,923k or £299k worse than plan, however the position with the STP included is £11k ahead of plan.

12 RECOMMENDATIONS

The Board is requested to:

- Note the financial position to date.



Julia Pattison
Director of Finance
January 2017

CITY HOSPITALS SUNDERLAND FOUNDATION TRUST
CORPORATE FINANCIAL MONITORINU REPORT
SUMMARY TRUST POSITION - MONITOR ANALYSIS
PERIOD ENDED 31ST DECEMBER 2016/17

Income & Expenditure Position

	Annual	Current Mnnth			Year tn Date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
£m	£m	£m	£m	£m	£m	£m	£m
Incnme							
NHS Clinical income	-325.79	-26.18	-26.86	-0.68	-244.78	-245.69	-0.91
PBR Clawback/relief	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Private patient income	-0.41	-0.03	-0.02	0.02	-0.31	-0.25	0.06
Non-patient income	-27.39	-2.29	-2.25	0.05	-20.50	-20.04	0.46
Total income	**-353.59**	**-28.51**	**-29.12**	**-0.62**	**-265.60**	**-265.98**	**-0.38**
Expenses							
Pay Costs	212.501	17.669	17.646	-0.02	159.593	157.972	-1.62
Drug costs	38.92	3.21	3.41	0.20	29.28	30.55	1.27
Other Costs	88.97	7.45	8.00	0.55	67.12	68.01	0.89
Total costs	**340.39**	**28.34**	**29.06**	**0.72**	**255.99**	**256.53**	**0.55**
Earnings before interest, tax, depreciation & amortisation (EBITDA)	**-13.20**	**-0.17**	**-0.07**	**0.10**	**-9.607**	**-9.444**	**0.16**
Profit/loss on asset disposal	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Depreciation	8.60	0.72	0.72	0.00	6.45	6.46	0.00
PDC dividend	4.81	0.40	0.42	0.02	3.60	3.77	0.16
Interest	1.97	0.16	0.16	0.00	1.48	1.44	-0.03
Corporation tax	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net surplus (pre exceptionals)	**2.17**	**1.11**	**1.23**	**0.12**	**1.92**	**2.22**	**0.30**
Exceptional items				0.00			
Net (surplus)/Deficit (post exceptionals)	**2.17**	**1.11**	**1.23**	**0.12**	**1.92**	**2.22**	**0.30**

EBITDA Margin	**3.7%**	**0.6%**	**0.2%**		**3.6%**	**3.6%**

CITY HOSPITALS SUNDERLAND FOUNDATION TRUST
TRUST PERFORMANCE SUMMARY

PERIOD ENDED 31ST DECEMBER 2016

TRUST SUMMARY

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

	Annual Budget £'000s	Quarter 1 £'000s	Quarter 2 £'000s	Oct actual £'000s	Nov actual £'000s	Dec actual £'000s	Quarter 3 £'000s	YTD actual £'000s	Plan £'000s	Variance £'000s
Income										
Contract Income	(325,786)	(81,194)	(82,490)	(26,918)	(28,226)	(26,860)	(82,003)	(245,688)	(244,782)	(906)
Private Patients	(412)	(85)	(59)	(42)	(49)	(16)	(107)	(252)	(309)	57
Training and Education Income	(10,989)	(2,749)	(2,998)	(902)	(986)	(933)	(2,820)	(8,567)	(8,253)	(314)
Research and Development Income	(1,712)	(386)	(336)	(156)	(73)	(99)	(329)	(1,051)	(1,284)	233
Other income	(14,619)	(3,385)	(3,492)	(1,207)	(1,086)	(1,217)	(3,510)	(10,386)	(10,918)	532
Interest Receivable	(74)	(15)	(17)	(1)	(1)	(1)	(3)	(35)	(49)	15
Total Income	**(353,592)**	**(87,814)**	**(89,393)**	**(29,226)**	**(30,422)**	**(29,124)**	**(88,772)**	**(265,978)**	**(265,595)**	**(383)**
Expenditure										
Pay	212,501	52,964	52,398	17,492	17,471	17,646	52,610	157,972	159,593	(1,621)
Clinical Supplies and Services	34,343	7,996	8,550	2,712	2,797	3,103	8,612	25,158	25,838	(680)
Drug Costs	38,920	10,072	10,172	3,328	3,569	3,412	10,309	30,553	29,279	1,274
Other Costs	54,624	14,089	14,164	4,832	4,870	4,897	14,599	42,852	41,278	1,574
Depreciation	8,600	2,150	2,150	717	717	721	2,155	6,455	6,450	5
PDC Dividend	4,805	1,234	1,277	419	419	419	1,256	3,767	3,604	163
Interest	1,968	481	481	160	161	160	481	1,443	1,476	(33)
Total Expenditure	**355,760**	**88,986**	**89,192**	**29,660**	**30,004**	**30,357**	**90,021**	**268,200**	**267,518**	**682**
(Surplus)/Deficit	2,168	1,171	(200)	434	(418)	1,233	1,249	2,222	1,923	299
Cost Improvement Plans	(15,000)	(2,915)	(3,854)	(1,210)	(818)	(1,330)	(2,028)	(10,127)	(10,528)	401
ISLAs										
Income	(42,901)	(11,028)	(3,730)	(3,731)	(3,618)	(3,826)	(7,349)	(22,107)	(32,175)	10,068
Expenditure	42,901	11,028	3,730	3,731	3,618	3,826	7,349	22,107	32,174	(10,068)
Divisional Total										
WTE Analysis (WTEs)										
Total WTEs	**4,918.47**	**4,680.82**	**4,677.72**	**4,766.23**	**4,734.03**	**4,690.00**	**4,690.00**	**4,690.00**	**4,915.82**	**-225.82**

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST
STATEMENT OF FINANCIAL POSITION - DECEMBER 2016

Assets	Plan As At 31-Dec-16 £m	Actual As At 31-Dec-16 £m	Variance £m
Assets, Non-Current			
Intangible Assets, Net	4.788	4.864	
Property, Plant and Equipment, Net	218.262	217.599	
Investments in Subsidiaries, at Cost (CHoICE)	0.850	0.850	
Trade and Other Receivables, Net, Non-Current			
Other Receivables, Non-Current	1.304	1.178	0.126
Impairment of Receivables, Non-Current	-0.287	-0.260	-0.027
Trade and Other Receivables, Net, Non-Current, Total	1.017	0.918	
Assets, Non-Current, Total	224.917	224.231	
Assets, Current			
Inventories	5.800	6.382	-0.582
Trade and Other Receivables, Net, Current			
NHS Trade Receivables, Current	2.801	9.706	-6.905
Non NHS Trade Receivables, Current	0.850	0.899	-0.049
Other Related Party Receivables, Current	0.150	0.000	0.150
Other Receivables, Current	0.800	1.344	-0.544
Impairment of Receivables, Current	-0.499	-0.527	0.028
Trade and Other Receivables, Net, Current, Total	4.102	11.422	
Prepayments, Current	4.982	4.682	0.300
Cash and Cash Equivalents	9.758	4.208	5.550
Assets, Current, Total	24.642	26.694	
ASSETS, TOTAL	**249.559**	**250.925**	

Liabilities

Liabilities, Current			
Interest-Bearing Borrowings, Current			
Loans, non-commercial, Current (DH, FTFF, NLF, etc)	-3.273	-3.273	0.000
Interest-Bearing Borrowings, Current, Total	-3.273	-3.273	
Deferred Income, Current	-1.575	-1.848	0.273
Provisions, Current	-0.260	-0.212	-0.048
Trade and Other Payables, Current			
Trade Payables, Current	-11.500	-14.273	2.773
Amounts Due to Other Related Parties, Current	0.000	-0.043	0.043
Other Payables, Current	-9.000	-9.207	0.207
Capital Payables, Current	-0.870	-0.332	-0.538
Trade and Other Payables, Current, Total	-21.370	-23.855	
Other Financial Liabilities, Current			
Accruals, Current	-6.567	-5.469	-1.098
PDC dividend creditor, Current	-1.200	-1.256	0.056
Interest payable on non-commercial interest bearing borrowings, current	-0.525	-0.488	-0.037
Interest payable on commercial interest bearing borrowings, current	0.000	0.000	0.000
Other Financial Liabilities, Current, Total	-8.292	-7.213	
Liabilities, Current, Total	-34.770	-36.401	
NET CURRENT ASSETS (LIABILITIES)	-10.128	-9.707	
Liabilities, Non-Current			
Interest-Bearing Borrowings, Non-Current			
Loans, Non-Current, non-commercial (DH, FTFF, NLF, etc)	-54.130	-54.129	-0.001
Loans, Non-Current, commercial	0.000	0.000	0.000
Interest-Bearing Borrowings, Non-Current, Total	-54.130	-54.129	
Deferred Income, Non Current	0.000	0.000	0.000
Provisions, Non-Current	-0.869	-0.869	0.000
Trade and Other Payables, Non-Current			
Trade Payables, Non-Current	-1.082	-1.127	0.045
Other Payables, Non-Current	0.000	0.000	0.000
Trade and Other Payables, Non-Current, Total	-1.082	-1.127	
Liabilities, Non-Current, Total	-56.081	-56.125	
TOTAL ASSETS EMPLOYED	**158.708**	**158.399**	

Taxpayers' and Others' Equity

Taxpayers' Equity			
Public Dividend Capital	99.542	99.542	
Retained Earnings	-15.918	-16.227	
Revaluation Reserve	75.084	75.084	
TAXPAYERS' EQUITY, TOTAL	**158.708**	**158.399**	
	0.000	0.000	

Clinical Income Report

Overview

As at the end of Month 9, the Monitor Clinical Income budget was £244,782k with the actual clinical income being £245,688k, equating to an over-performance of £906k (0.5%).

The differences between the Monitor plan budget and Commissioner plans for the full year are shown below in Table 1.

Table 1: Reconciliation of PBR Plans to Monitor Plans

Commissioner Contracts	Plan as per PbR (£'000s)	QIPP/Vanguard Targets (£'000s)	Balance (£'000s)	Plan as per Monitor (£'000s)
Sunderland	179,500	1,686	-526	180,660
South Tyneside	22,914	294	150	23,359
Gateshead	3,491	113	51	3,655
Cumbria	361	0	0	360
Sunderland LA	2,436	0	-62	2,374
DDES	34,341	1,952	108	36,401
North Durham	15,744	696	28	16,468
HAST	2,904	151	179	3,234
South Tees	172	25	0	197
Specialised	34,229	0	224	34,453
Dental	6,284	0	23	6,307
Sub Total	**302,376**	**4,917**	**175**	**307,468**
Cancer Drug Fund	2,422		0	2,422
Hepatitis C Drugs	465		0	465
NCA's	1,900		-94	1,806
AQP - All Contracts	1,086		-5	1,081
Offender Health	87		-87	0
New Born Screening	130		0	130
Church View	880		0	880
Gap/Stretch Target	5,840		-4,905	934
STP Funding	10,600		0	10,600
Total	**325,786**	**4,917**	**-4,916**	**325,786**

The Month 9 figures were derived from the Month 8 PBR report, which reflects Q1 and Q2 freeze, Month 07 freeze and Month 08 flex position. We have assumed break even to PBR plan for Month 9, less the stretch target, the phasing adjustment, and an adjustment for Month 9 drugs income based on expenditure as the actual PBR information is not yet available for Month 9.

Table 2 below shows the performance at contract/Commissioner level compared to the agreed contracts and also the Monitor plan (to month 9).

Table 2: Financial Position per Commissioner as per Agreed Contract and the Monitor plan

Commissioner contracts	Plan as per Monitor	Plan as per PbR	Total Actuals	Variance as per PbR	Variance as per Monitor	% Against PbR	% Against Monitor
	£'000s	£'000s	£'000s	£'000s	£'000s		
Sunderland	135,852	134,982	134,982	0	**870**	0.0%	0.6%
South Tyneside	17,559	17,225	17,899	-673	**-340**	-3.8%	-1.9%
Gateshead	2,749	2,625	2,847	-221	**-98**	-7.8%	-3.4%
Cumbria	271	271	329	-57	**-58**	-17.4%	-17.5%
Sunderland LA	1,780	1,827	1,827	0	**-47**	0.0%	-2.6%
DDES	27,369	25,824	27,323	-1,498	**47**	-5.5%	0.2%
North Durham	12,382	11,839	12,620	-781	**-239**	-6.2%	-1.9%
HAST	2,431	2,184	2,673	-489	**-242**	-18.3%	-9.1%
South Tees	148	129	174	-44	**-26**	-25.5%	-14.8%
Specialised	25,868	25,700	26,179	-478	**-311**	-1.8%	-1.2%
Dental	4,747	4,729	4,712	17	**35**	0.4%	0.7%
Sub total	**231,156**	**227,338**	**231,564**	**-4,226**	**-408**	-1.0%	-0.2%
Cancer Drug Fund	1,817	1,817	1,116	700	**700**	62.7%	62.7%
Hep C drugs	349	349	651	-302	**-302**	-46.4%	-46.4%
NCA's	1,354	1,425	1,304	121	**50**	9.3%	3.9%
AQP - all contracts	811	814	835	-20	**-24**	-2.5%	-2.9%
Gap/Stretch target	701	4,380	0	4,380	**701**		
Phasing adjustment	-113	-113	0	-113	**-113**		
STP funding	7,950	7,950	7,640	310	**310**	4.1%	4.1%
CQUIN risk			-95	95	**95**		
Other	757	823	2,671	-1,848	**-1,914**		
Total	**244,782**	**244,782**	**245,687**	**-905**	**-905**	0.5%	-0.4%

Table 2.1 : Summary of position to date

Summary	Annual £000's	To date £000's
Sunderland lower than plan	1,160	870
Other contracts lower than plan	0	-1,278
Gap/Stretch target	936	701
Phasing Adjustment	0	-113
Other & Non contract	0	-1,490
STP Risk	0	310
CQUIN & Penalties	0	95
Total	**2,096**	**-905**

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Figures 1 and 2 below show the variance per Commissioner against the final agreed contract values and variance per Commissioner against the Monitor Plan.

Figure 1: Variance per Commissioner Against the Final Agreed Contract Values

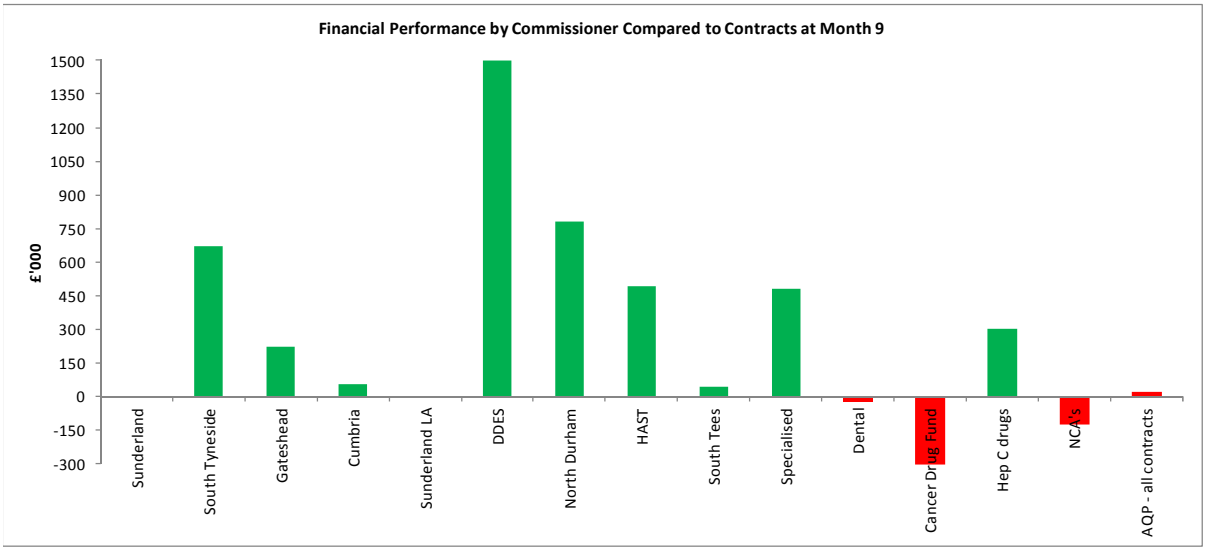
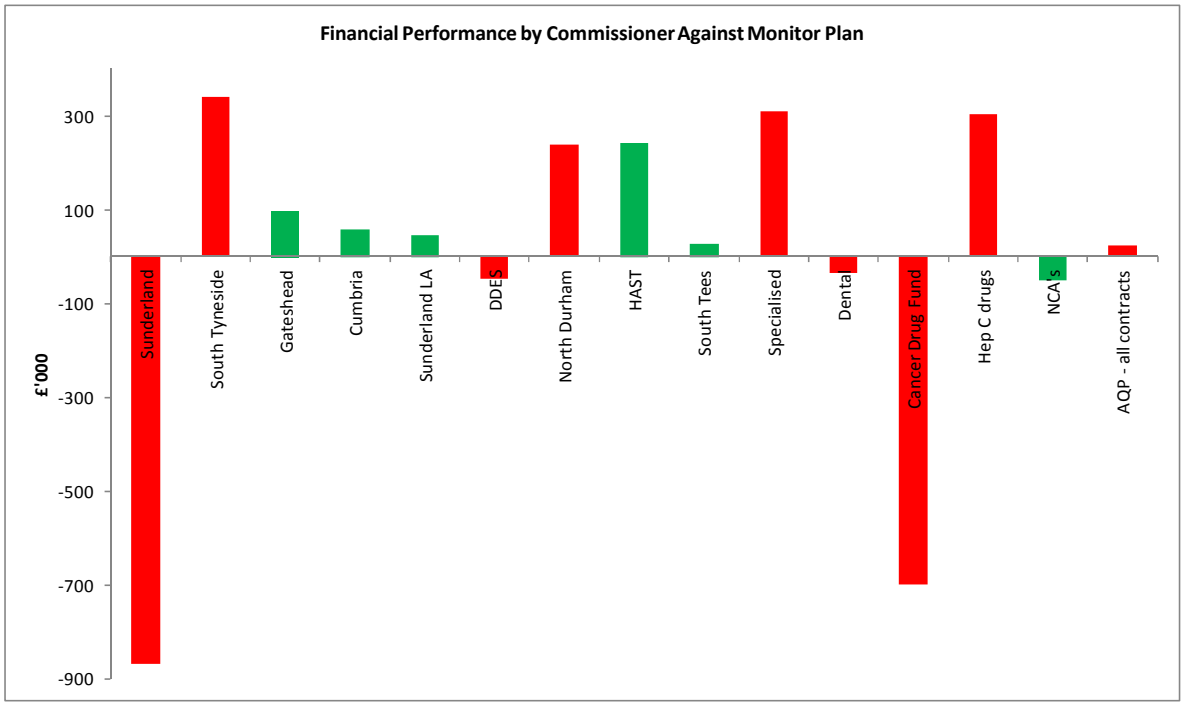


Figure 2: Variance per Commissioner Against the Monitor Plan



Position by Significant Commissioner (Month 1-9)

- **Sunderland CCG** is shown as a break even position as it is a block contract. The actual PBR/contract position for Month 8 (adjusted for known issues & challenges) is an estimated £1.3m under performance. The reasons for this are detailed later. Against the Monitor plan there is £870k underperformance.
- **South Tyneside CCG** is £673k ahead of contract plan (3.8%), with general over performance across day cases and electives, outpatient procedures, and devices. There is under performance on high cost drugs and the miscellaneous contract, primarily Audiology. Against Monitor plan there is a 340k under performance.
- **Newcastle/Gateshead CCG** is ahead of contract plan by £221k (7.8%), in most points of delivery as expected (due to ambitious QIPP targets removed from baseline), apart from drugs and devices. There is a £98k over performance against Monitor plans.
- **DDES CCG** is ahead of plan by £1,498k (5.5%) across most points of delivery, particularly A&E, emergency admissions and outpatients. Against the Monitor plan there is £46k shortfall.
- **North Durham CCG** is ahead of plan by £781k (6.2%), mainly on outpatients and high cost drugs. Against the Monitor plan there is a £239k over performance.
- **Hartlepool and Stockton CCG** is ahead of plan by £489k (18.3%). This is across most points of delivery. Against the Monitor plan there is £242k over performance.
- **South Tees CCG** is showing an £44k over performance against PbR and a £26k over performance against Monitor, largely driven by ophthalmology.
- **NHS England (Dental**) is currently behind plan by £17k (0.4%), predominantly due to under-performance in electives. Against the Monitor plan there is a £34k shortfall.
- **NHS England (Specialised)** is ahead of plan by £478k (1.8%) which is primarily driven by under-performance in elective admissions and outpatients, offet by a large overspend on high cost drugs.
- **Hepatitis C drugs** are currently ahead of plan by £402k. These are drugs that are charged to NHS England (Specialised) but do not form part of their contract as they pass these costs through to their central team. There are ongoing problems (dating back to 2015/16) regarding full payment of invoices which must be resolved.
- **Cancer Drug Fund** is currently showing an under performance based on an estimate of potential drugs spend for Month 9. This is combined with the fact that many drugs were removed from the fund at the beginning of 2016 after budget was set means there is a large under recovery developing. This does not affect the financial balance.
- **Gap/Stretch Target:** this represents 9 months of the £5.8m gap against the contracts and 9 months of the £934k gap against the Monitor Plan (see Table 1).
- **Phasing adjustment:** this represents the difference between the phasing in the final demand plans and the original phasing in the Monitor plan submission - this is due to timing differences of demand plans being received and the Monitor plan submission and the fact that different points of delivery have different phasing. In particular there has been a change to chiropody, originally phased in twelfths, but subsequently phased as first contact in the financial year (FCFY) which accounts for the majority of the difference.
- **STP funding:** it has been assumed that full STP funding less £310k will be received to Month 9 due to potential non achievement of A&E 4 hour wait in October, December and cancer targets for October & December.
- **Other:** some additional winter funding has been assumed in the Month 09 position.

CQUIN and Penalties

A risk for non-delivery of CQUIN has been built into the overall positions where prudent. The STP risk has been based on the assumption that A&E trajectories have not been met for October and November and there is a risk on the cancer 62 day target for October & November. Commissioners have now confirmed their view on penalties to be applied for Q1, NHSE and Dental are still yet to share their views. The CQUIN risk has been based on the latest estimate, Commissioners are still to confirm their position for Q2

Position for Activity by POD (Month 1 – 9)

Activity at Trust level is shown in Figure 5 in which month's 1-9 actual activity is compared with 24 months of history and to Commissioner plans. Note that activity levels are a good indication of contract performance however case mix (tariff therefore income) is equally important.

A&E activity is 6.5% above historical levels and 6.5% above plan. Type 1 A&E (main site) is 10.4% above plan; Type 2 (Eye Infirmary) is 3.2% below plan and Type 4 (Pallion) is 6.6% above plan.

Emergency activity is up 1,700 spells (5.4%) vs history and 431 spells above plan (1.3%).

Elective activity is down 10,868 spells (17.1%) vs history and also down 987 spells (1.8%) vs plan. Specialties with the greatest variance against history are Ophthalmology (due to the reclassification of Lucentis activity to Outpatient Procedures from April 2016), Gastroenterology and Geriatric Medicine.

First Outpatients (consultant led) activity is 4,229 attendances (5.3%) above history however 2,970 attendances (3.4%) below plan. Specialties with the most significant over-performance against history include Colorectal Surgery, Endocrinology and General Surgery.

Review Outpatients (consultant led) activity is 4,297 attendances (2.6%) below history and 5,086 attendances below plan (3.1%). Specialties with the greatest variance against plan include Colorectal Surgery, Rheumatology and Gynaecology.

Non Consultant Led Outpatients activity is 375 attendances (0.7%) above history and 2,621 attendances (4.9%) above plan. Specialties with the greatest over-performance against both history and plan include Urology, Rheumatology and Gastroenterology.

Outpatient Procedures are 14,063 attendances (38.2%) up vs history, the majority of which is attributable to the shift of Ophthalmology Lucentis injections from Day cases to OP procedures, and 3,739 spells (7.9%) above plan.

Non-Face to Face Outpatient Contacts are 1,428 contacts (18%) above history. Specialties with a significant over-performance against plan include Gastroenterology, Respiratory Medicine and Diabetic Medicine.

Drugs are currently under plan by £495k against Monitor, however over plan by £1,511k against contract. CHS is invoicing commissioners for volume dispensed on a pass through basis so non achievement does not impact net income. This position also does not include any further specific drugs challenges received and under investigation. There is a break even assumption to match expenditure for month 9.

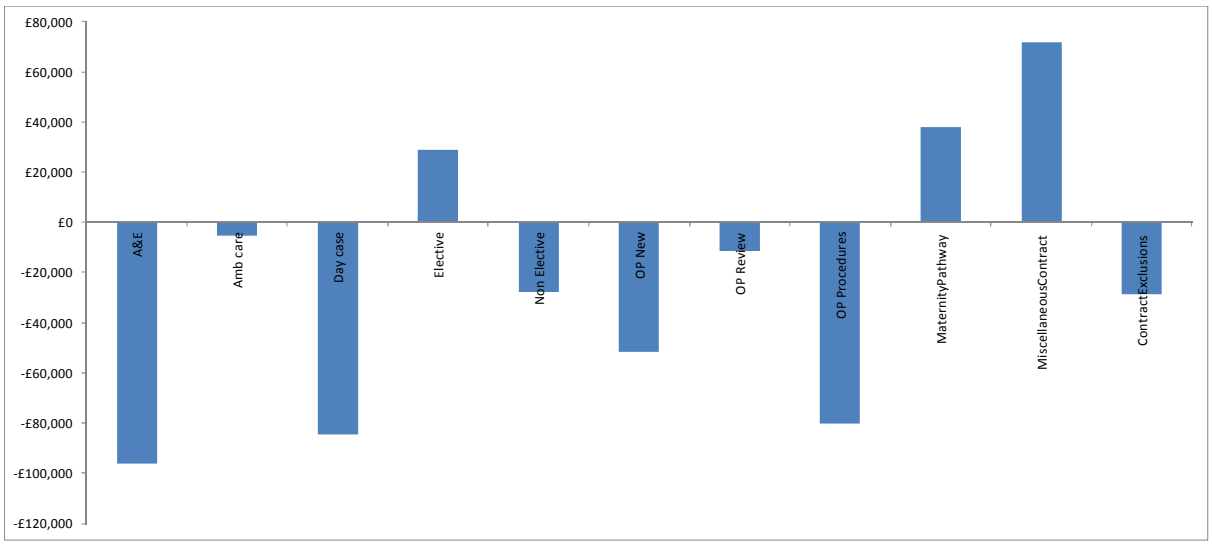
Devices are currently under plan by £285k. As with drugs these are a pass through cost, meaning that volume has no net impact on the income position. The main area of under spend is within vascular consumables which is in line with the elective procedures.

Sunderland CCG – Month 9 Position

The reported PbR position for SCCG, as at M8 flex, is £1.4m under the contracted budget. Note that there are estimated to be £361k of uncoded spells (as a result of a change in the national grouper) to be added back in. There is also an adjustment for both OP Diagnostics (£139k) and Adult Critical Care (£74k) that although they are being shadow monitored in 16/17, should be treated as block for 2016/17. This gives an estimated adjusted position for SCCG of over £983k under-recovery.

The details per point of delivery (POD) are shown in Table 3 and Figure 3 below;

POD	Activity Plan	Activity Actual	Activity (Variance)	Price Plan	Adjustments/challenges	Price Actual	Price Actual	Total Income (Variance)
A&E	68,959	73,274	-4,315	6,876,496		7,340,172	£7,340,172	-£463,676
Critical Care	2,237	2,207	30	2,780,624	74,853	2,705,772	£2,780,625	£0
Amb care	3,253	3,576	-323	1,398,202		1,494,625	£1,494,625	-£96,424
Day case	18,735	18,105	630	12,947,261		13,069,229	£13,069,229	-£121,968
Elective	6,601	5,309	1,292	11,351,171	134,355	10,059,073	£10,193,428	£1,157,743
Non Elective	28,301	27,909	392	34,550,231	360,947	33,865,506	£34,226,453	£323,778
OP New	38,162	44,040	-5,878	6,181,630	0	6,829,902	£6,829,902	-£648,273
OP Review	116,988	112,405	4,583	10,259,097	0	9,732,107	£9,732,107	£526,990
OP Procedures	21,170	20,984	186	3,847,541	0	3,934,800	£3,934,800	-£87,259
MaternityPathway	5,513	5,361	152	6,886,726	-38,183	6,685,105	£6,646,922	£239,804
HighCostDrugs	0	0	0	5,285,353	0	5,522,170	£5,522,170	-£236,817
MiscellaneousContract	95,298	116,314	-21,016	6,663,835	-139,658	6,595,560	£6,455,902	£207,933
ContractExclusions	4	0	4	1,178,814	0	927,340	£927,340	£251,474
Additions	0	0	0	0	0	0	£0	£0
BLOCK	100	230	-130	9,521,413	0	9,591,296	£9,591,296	-£69,883
	405,321	429,714	-24,393	£119,728,395	£392,314	£118,352,658	£118,744,972	£983,424



Challenges up to Month 08

The agreed timetable for PbR challenges continues to be adhered to, through activity and finance meetings as well as info and DQ meetings. A final Q1 position was agreed with NECS commissioners and invoices have been paid in full. Discussions have been opened regarding Q2 and should be concluded soon, with the aim of also concluding a year end agreement with commissioners.

The main queries for Specialised continue to be drug related, although these are much reduced from previous years. Service queries still to be resolved include antenatal payments and renal day case activity. Once concluded, this may change the reported position.

Risks

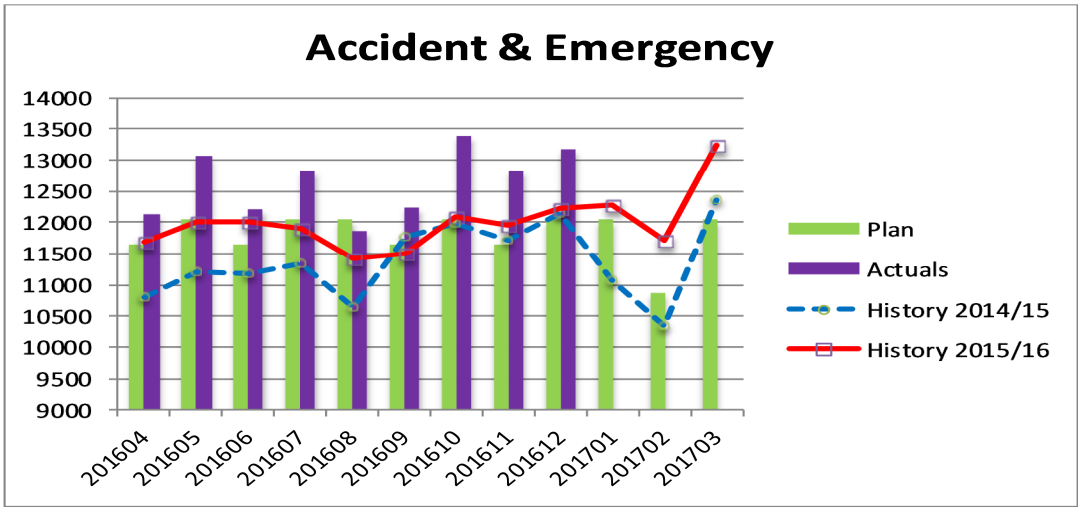
The following risks to income need to be considered:

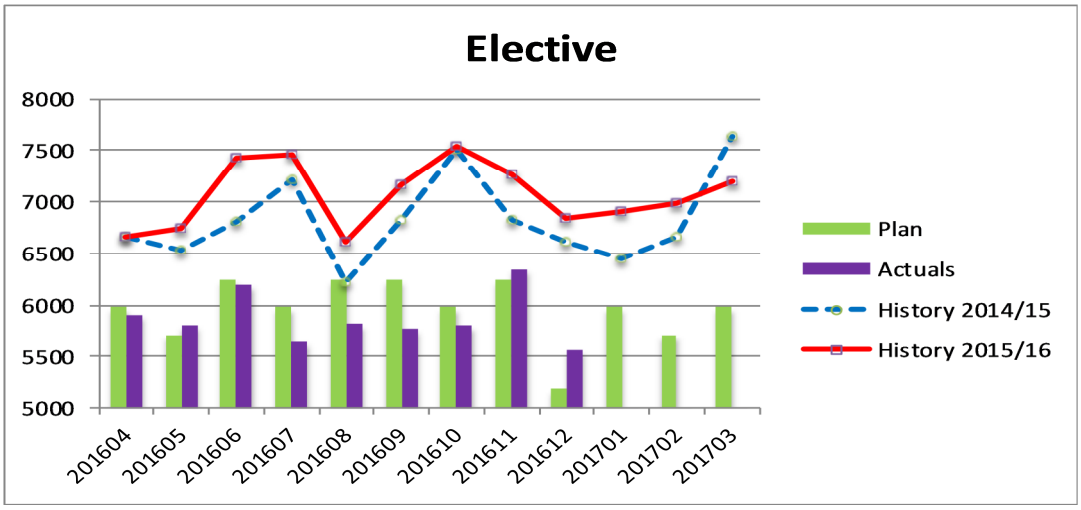
- There are issues with oncology reporting due to the introduction of a new Meditech module. This was introduced for patient safety and better recording. However, is causing some delays in coding.
- Affordability: the majority of CCGs are over-performing against contract therefore the level of scrutiny and challenge on the charges continues to be high which is time consuming to resolve
- If QIPP/Vanguard schemes do start to deliver in 2016/17 therefore CHS income reduces, expenditure cannot reduce in proportion.
- The application of penalties and the link to STP trajectories/funding has a recently published complex National rule set. Retainsion of the full level of STP less £310k for the year to date has been assumed in the position.
- The main risk to CQUIN delivery for 2016/17 is non-achievement of the sepsis target. A new methodology has been agreed with the Commissioners. An estimate for risk of non-delivery has been built into the position.

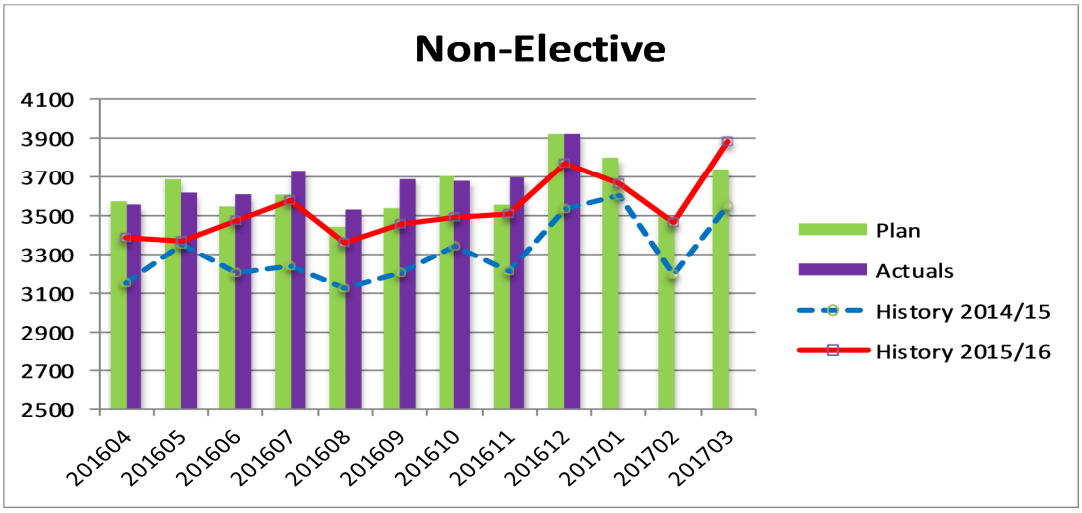
Contracting Team

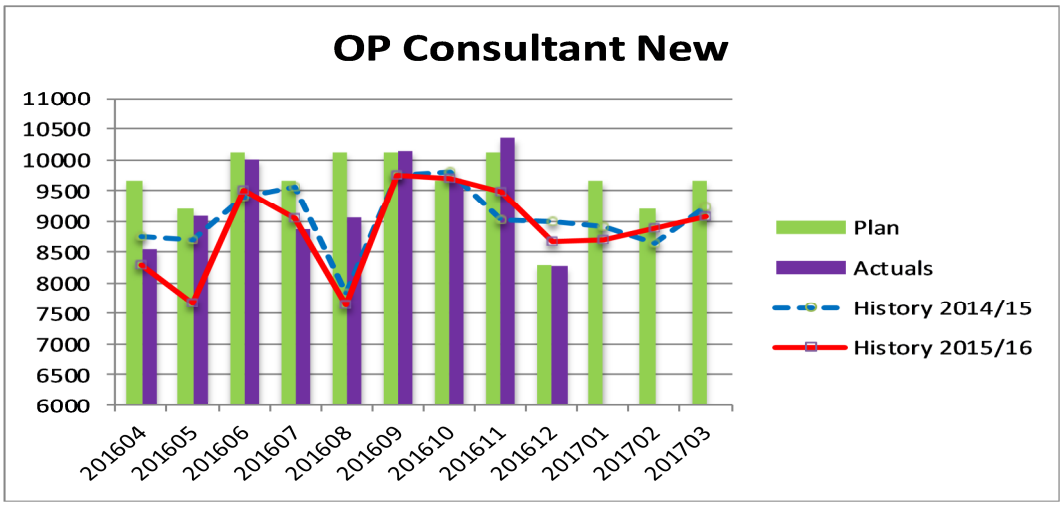
January 2017

Figure 5: Activity by POD








OP Consultant New
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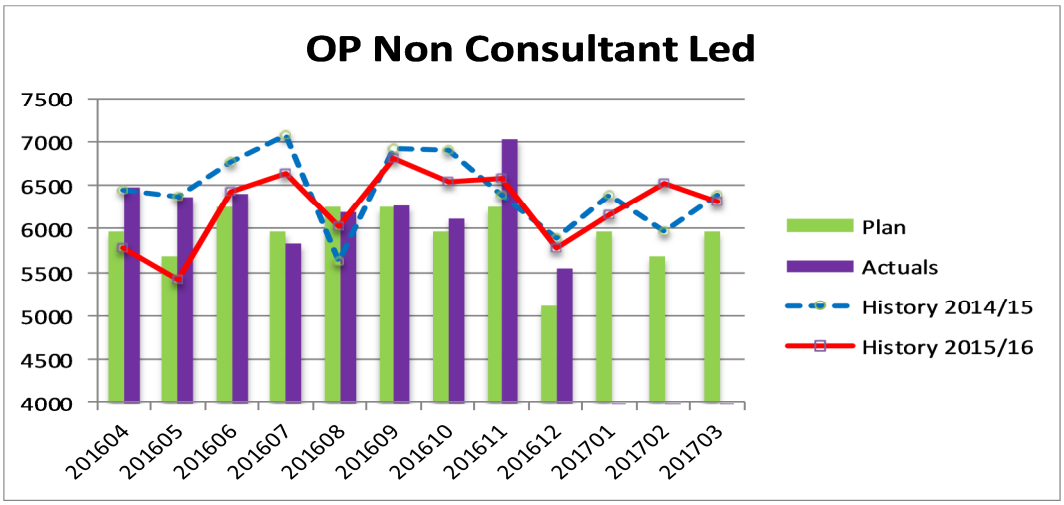
10500
10000
9500
9000
8500
8000
7500
7000
6500
6000
201604
201605
201606
201607
201608
201609
201610
201611
201612
201701
201702
201703
Plan
Actuals
History 2014/15
History 2015/16


OP Consultant Review
21000
20000
19000
18000
17000
16000
15000
14000
13000
201604
201605
201606
201607
201608
201609
201610
201611
201612
201701
201702
201703
Plan
Actuals
History 2014/15
History 2015/16


OP Non Consultant Led
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7000
6500
6000
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5000
4500
4000
201604
201605
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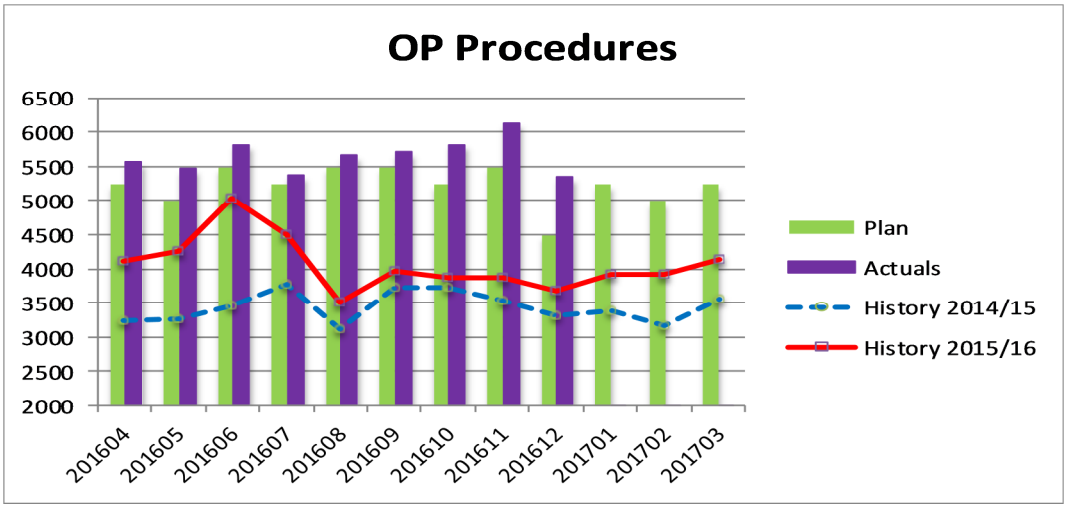
201610
201611
201612
201701
201702
201703
Plan
Actuals
History 2014/15
History 2015/16


OP Procedures
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5000
4500
4000
3500
3000
2500
2000
201604
201605
201606
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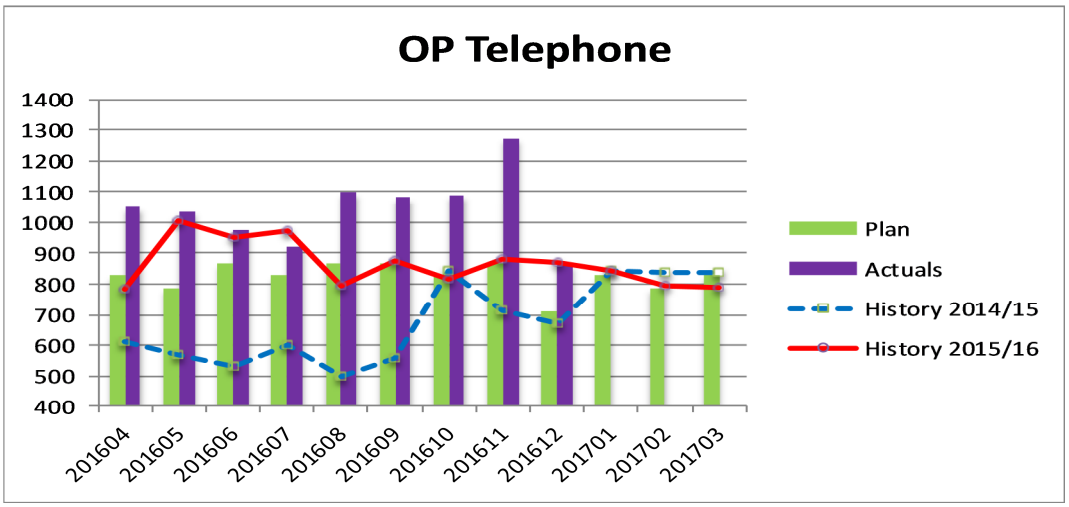
201610
201611
201612
201701
201702
201703
Plan
Actuals
History 2014/15
History 2015/16


OP Telephone
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1300
1200
1100
1000
900
800
700
600
500
400
201604
201605
201606
201607
201608
201609
201610
201611
201612
201701
201702
201703
Plan
Actuals
History 2014/15
History 2015/16

Appendix 4


Total Pay Costs for Month December 2015 - to date
Expenditure £000's
18,250
18,000
17,750
17,500
17,250
17,000
16,750
16,500
16,250
16,000
15,750
15,500
15,250
15,000
14,750
14,500
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
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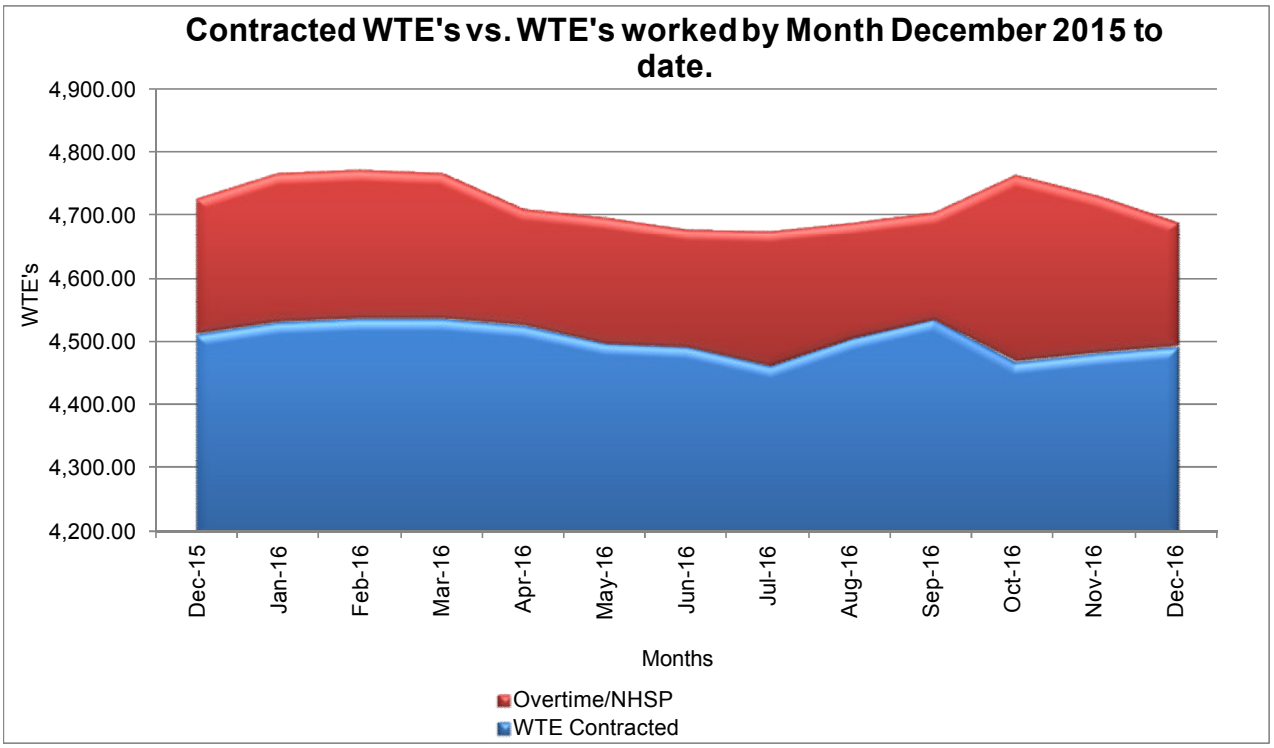
Sep-16
Oct-16
Nov-16
Dec-16
Month
Actual
Budget


Contracted WTE's vs. WTE's worked by Month December 2015 to date.
WTE's
4,900.00
4,800.00
4,700.00
4,600.00
4,500.00
4,400.00
4,300.00
4,200.00
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
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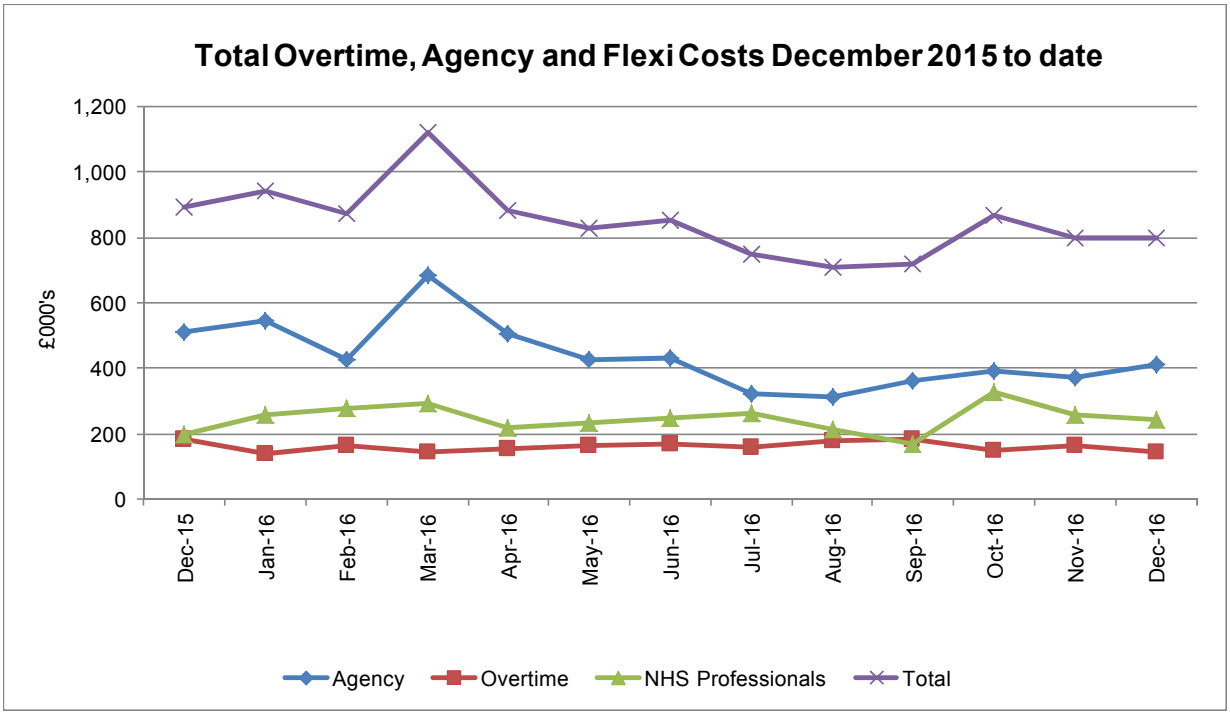
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Months
Overtime/NHSP
WTE Contracted



NHS Improvement Agency cap ceiling compliance City Hospitals Sunderland

	Month Monthly Expenditure Ceiling	CHS Annual Plan	Actual in month agency cost
	£000s	£000s	£000s
Apr-16	577	472	479
May-16	563	467	430
Jun-16	563	462	461
Jul-16	551	457	324
Aug-16	545	457	311
Sep-16	533	447	365
Oct-16	497	417	390
Nov-16	497	417	373
Dec-16	485	407	412
Jan-17	461	387	
Feb-17	461	387	
Mar-17	460	386	
Total	**6,194**	**5,159**	**3,545**

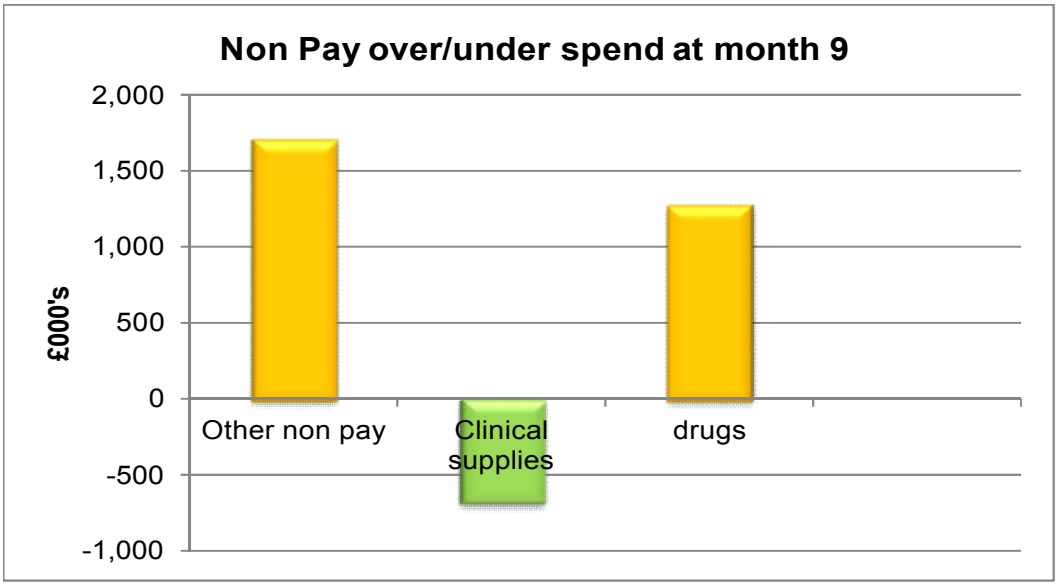
Key Issues on pay

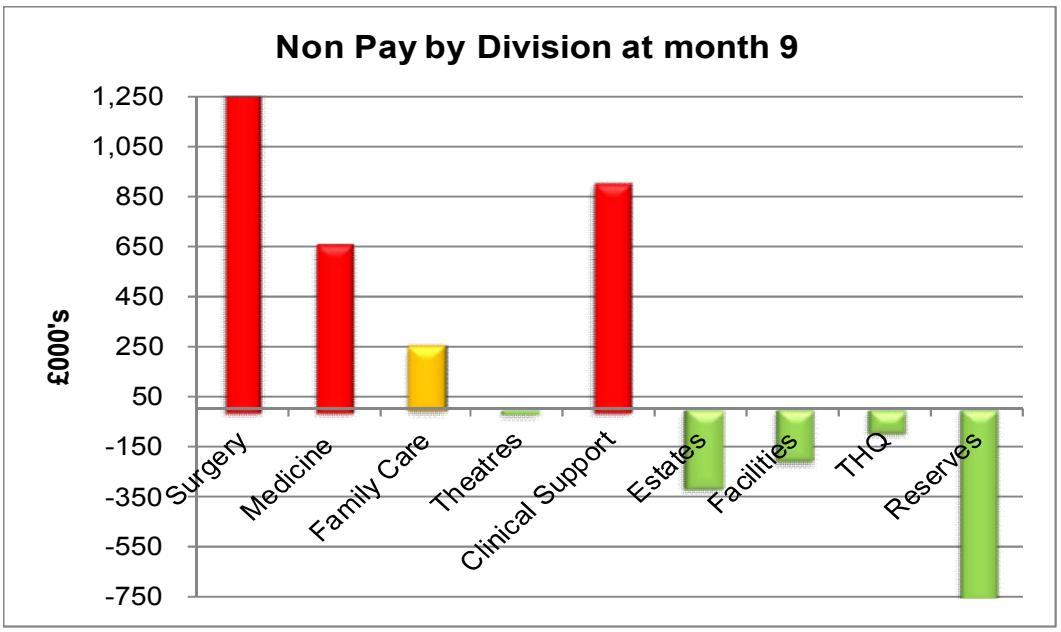
- WTE numbers as at month 9 are 4,690, a decrease of 44 WTEs compared to the previous month. This is predominantly due to lower NHS Professional bank working in the month.
- Agency spend to December 2016 was £3,545k against a budget of £4,000k.
- The good work carried out by the Trust to control and reduce agency costs has been reflected in a recent NHSI agency performance report. City Hospital was ranked as the 7th best performer in the Northern region which measured actual agency cost compared to NHSI agency cap.
- Appendix 4 now includes the above table that outlines the spend on Agency costs month on month. This has been done on the request from NHS Improvement who will hold all NHS Trusts to account for delivering 2016/17 agency expenditure for all staff in line with their expenditure ceiling. This ceiling is a maximum level for all agency staff expenditure, and they encourage all trusts to reduce agency expenditure below this level..

Key Actions on Pay

- Further staff groups (Allied Health Professionals) come onto the STAFFflow system will enable efficiency savings in agency staffing costs in these areas.
- In addition delays in getting key agency onto the STAFFflow system has now been overcome. So further saving will be made going forward.

Appendix 5





Key issues on non-pay

- Drugs are £1,274k overspent against plan mainly due to CIP under delivery of £791k against plan to date.
- Clinical Supplies is underspent by £680k due largely to lower than expected clinical activity and over delivery of CIP to date of £163k.
- Other Non Pay is over spent by £1,708k due largely to unidentified 'Stretch CIP' to date.

Key actions on non-pay

- Continued focus on the 'CIP' programme relating to procurement across all areas of the Trust with a key focus on clinical supplies.

Appendix 6

CIPs Performance

Overall Financial Position & CIP Position - Month 9

	Surgery	Theatres	Medicine	Family Care	Clinical Support	Estates	Facilities	THQ Division	THQ Corporate	Total
Divisional CRP's 16/17 £000's	-3,883	-460	-4,286	-1,316	-1,574	-402	-531	-861	-1,687	**-15,000**
Plan to date £000's	-2,632	-335	-2,935	-924	-1,146	-289	-418	-641	-1,210	**-10,528**
Actual to date £000's	-1,263	-573	-2,234	-525	-1,810	-300	-481	-763	-2,178	**-10,127**
Variance 16/17 £000's	1,369	-238	701	399	-664	-11	-63	-122	-968	**401**
Variance %	-52%	71%	-24%	-43%	58%	4%	15%	19%	80%	-4%
Financial Position Plan to date £000's	-20,348	876	-9,620	759	4,569	7,612	5,487	15,654	-3,065	**1,923**
Financial Position Actual to date £000's	-16,672	548	-9,630	1,620	4,102	7,225	5,356	15,191	-5,519	**2,222**
Financial Position Variance to date £000's	3,677	-328	-10	861	-467	-387	-131	-462	-2,454	299

Key Issues with the CIP

To the end of December the planned savings are £10,528k actual savings for the period are £10,127k.

Headline CIPs

- A number of one off short term financial benefits held in 'corporate' are supporting the current CIP deliver position.
- The plan to date for Medical Staffing costs was £472k against actual savings delivered of £296k and hence an under delivery of £176k to December 2016.
- Bed Hire contract savings are in line with plan to date, circa £198k to date.
- Medicine's closure of Ward F61 and relocation to Ward D42 savings are in line with plan to date circa £165k.
- Clinical Support's vacancy levels across all directorates has increased significantly to date, and has contributed to an over delivery of £664k against plan to date.

CIP - original Annual Plan vs. actual delivery plan today

	Identified Plans	Stretch Target	Total per APR	This is as per Monitor Plan to Month 9 £	Actual to Month 9 £	Variance £
Revenue Generation	489	511	1,000	711	305	-406
Pay	7,468	32	7,500	5,284	5,920	636
Clinical Supplies	2,500		2,500	1,794	1,957	163
Drugs	573	927	1,500	1,036	245	-791
Other Non Pay	2,395	105	2,500	1,703	1,700	-3
Depreciation			0			0
Total £	**13,425**	**1,575**	**15,000**	**10,528**	**10,127**	**-401**