CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

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

AGENDA

1.	**Declaration of Interest**		
2.	**Minutes**		
Item 1.	To approve the minutes of the Board of Directors meeting held 'In Public' on Thursday, 25 May 2017		**Enc 1**
	Matters Arising		
	Item 1 Emergency Department	**KWB**	
3.	**Standard Reports**		
Item 2	Chief Executive's Update	**KWB**	
Item 3	Quality Risk and Assurance Report	**MJ**	**Enc 3**
Item 4	Finance Report	**JP**	**Enc 4**
Item 5	Performance Report	**AK**	**Enc 5**
4.	**Strategy / Policy**		
Item 6	Safeguarding Adults Annual Report 2016/17	**MJ**	**Enc 6**
5.	***The following items are for information only and have been discussed at the Governance Committee which is a formal sub-committee of the Board of Directors***		
Item 7	Health and Safety Report 2016/17		**Enc 7**
Item 8	Fire Safety Annual Report 2016/17		**Enc 8**
Item 9	Security Report 2016/17		**Enc 9**

Date and Time of Next Meeting

Board of Directors meeting to be held 'In Public' on Thursday, 28 September 2017 at 3:30 pm in the Board Room, Sunderland Eye Infirmary.

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Minutes of the meeting of the Board of Directors held in public on Thursday, 25th May 2017.

Present:	John Anderson (JNA) - Chair Mike Davison (MD) Stewart Hindmarsh (SH) Melanie Johnson (MJ) Julia Pattison (JP) Peter Sutton (PS) Pat Taylor (PT) Alan Wright (AW)
Apologies:	Davis Barnes (DB) Ken Bremner (KWB) Ian Martin (ICM)
In Attendance:	Sean Fenwick (SF) Carol Harries (CH) Mike Laker (ML) Simon Joyce (SJ) - Item 2 Alison King (AK) - Item 5

1. Declaration of Interest

None.

2. Minutes

Item 1 Minutes of the meeting of the Board of Directors held on Thursday, 30th March 2017

Accepted as a correct record except to note that JP was present.

Matters Arising

Emergency Department: CH advised that the opening of the new adult ED had been deferred from 18 May until 8 June 2017 as a consequence of the cyber-attack weekend when the IT team were unable to complete their work within the new department. The ED team had asked that the opening be deferred further until after half term when more staff would be available to support the transfer.

3. Standard Reports

Item 2 Chief Executive's Update (CH presented the report on behalf of KWB)

Cyber Attack – CH informed Directors that on the afternoon of the 12 May 2017 the NHS had declared a national major incident following a number of NHS organisations having been infected by "WannaCry". CH stated that the Trust had not at any point been infected but clearly over that weekend it had been affected.

The Trust's command and control system was established by the CEO and at 5.00pm on 12 May a decision was taken to disconnect CHS from external links/agencies to mitigate the risk of infection. This approach was subsequently followed by others and NHSE/Digital confirmed this requirement later that evening.

CH advised that the IT team with the support of many other Trust staff worked around the clock introducing updated antivirus software released by companies to detect and stop the virus running locally, and verifying that software patches across the entire IT estate were in place to contain and prevent anything from spreading.

A decision was also made to take down Meditech and Agfa PACS from 10.00pm to allow patching – the organisation responded extremely well during this process. Over the weekend Meditech was available from 08.00am on the Saturday morning and internal email access was available but no outgoing or incoming emails.

Internet access was suspended along with access to external applications and on this basis everything was controlled/communicated with no significant concerns from end users.

McAfee had released new anti-virus software and over the weekend we endeavoured to turn on as many of the Trust's 3,500 PCs in order that the software update could be performed. The Trust has approximately 350 servers of which 200 were confirmed straight away with no problems. 150 required review, with 100 requiring patching activities over the weekend. By Sunday evening all were patched and older infrastructure which could not be patched was taken off the network.

A decision was also made on the Sunday evening to turn off all email both internal and external and file shares (access to documents on the network) to allow review by IT on the Monday morning.

Region wide advice over the weekend was entirely consistent with CHS plans/intentions.

SJ explained that from Tuesday 16 May systems were gradually re-enabled and by Monday 22 May everything was back up and running with no problems.

CH informed Directors that throughout the weekend and the following week command and control systems had remained in place both locally and nationally.

MD queried in terms of cyber-attacks whether we would know if our systems had been compromised. SJ replied that we do have an intrusion detection system – in reality a “burglar alarm” that alerts us to certain types of suspicious activity but not to everything.

MD also queried our approach to the “Internet of Things”. SJ replied that this was a very broad piece of work. Some medical devices within the Trust are connected to the network, such as Mindray patient monitoring equipment. This could cause issues when there is limited support from the supplier in keeping systems secure. In order to overcome this a range or measures are deployed, including connecting such systems to a secure segment of the network with enhanced protection. SJ stated that we are really careful about what we connect to the wireless network and this was a growing area of work.

MD also queried how many XP systems were in the Trust. SJ replied that there were eight machines, across three departments and all were connected to medical devices. SJ stated that as an example, five out of the eight were located within neuro-physiology and each medical device costs in excess of £40k. AW queried as to how we protected ourselves going forward from having equipment that used an XP system. JP replied that this was already in place through procurement and EBME. SJ stated that it was important to have the right systems in place as often suppliers do not allow you to patch their systems as to do so would negate the guarantee, warranty or device certification.

PT queried whether we were happy with clinical quality not being compromised given we had 8 clinical systems with XP in place. SJ confirmed that such systems undergo a certification process at the point of development and that those systems would not operate any differently now, but acknowledged that these systems may be vulnerable.

SF commented that the vast majority of our medical equipment is 10-12years old and our operating systems 5-6years old. PT stated that we needed to think about future proofing our software systems. The Chairman also commented that we needed a better solution. SJ replied that we needed to work with 3rd party providers and ideally we needed lots of layers of security to try and limit exposure. SJ confirmed that at the present time if there were any concerns then these systems were disconnected from the network.

MD thanked SJ and the team for all their hard work.

CH advised that there were to be a number of de-brief sessions both locally, regionally and nationally and clearly there were a number of lessons to be learnt from the event. MD suggested that it would be helpful to have something at a future workshop.

UK Level Threat: Joint Terrorism Analysis Centre – CH advised that the Trust had been advised that the UK Threat Level should be changed from Severe (an attack is highly likely) to CRITICAL (an attack is expected imminently). As a consequence all NHS organisations were asked to implement a number of actions, including cascading the alert level to all staff, ensuring all staff are aware of the Incident Response Plan, reviewing stock levels, identifying patients who could be discharged safely if needed, and reviewing patient transport.

CH advised that the message had been cascaded to all staff and the Incident Response Plan which had recently been to Governance Committee was easily available on the intranet.

MD commented that in the event of a terrorism incident it would be difficult to have total lockdown. CH replied that in such circumstances the Police would assume Gold Command and they would more than likely enforce a lock down around the hospital site allowing only emergency/life threatening access for patients and access for staff which would be controlled.

CH advised Directors that she would keep them informed of any further action.

Item 3 Quality Risk and Assurance Report

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

MJ advised that the number of PUs per 1,000 bed days had decreased from 1.81 in February to 1.41 in March. The end of year position to March 2017 had also surpassed the improvement target set – this had been a sustained improvement from everyone involved.

MJ also informed Directors that Ofsted would be revisiting as part of their monitoring of Sunderland Children's Services improvements in June 2017, concentrating on leadership. MJ stated that there were no plans for the Trust to be involved at this point, however should CHS be required to be involved due notification would be given. Alex Hopkins from "Together for Children" had given a high level presentation/overview to Governance Committee. He had also given some helpful comments regarding bringing a workforce into the City rather than to individual agencies.

MJ stated that in March a number of referrals were inadvertently made via the Ulysses incident reporting system and were not received as Safeguarding Adults referrals. ML queried what had been the consequences. MJ replied that the system had slightly changed and on the screen it only said Safeguard but was just for children. This had now been resolved and staff advised how to make referrals via the appropriate system. No cases had been missed and the change to the system had intended to be helpful but had caused confusion.

MJ informed Directors that the number of DoLs applications had reduced during March but there was no real reason as to why there had been a reduction but it may have been linked to recent new case law.

MJ stated that the overall fill rate for SRH was 91% and for SEI it was 97%. At the end of March there were 67.20wte RN vacancies which did not include 38.56wte currently undergoing pre-employment checks. MJ commented that this was an improving position and linked to the outturn of students into the workforce. MJ stated that a team was also going out to the Philippines on another recruitment campaign.

In terms of mortality, the outcomes from the Mortality Review Panel consistently show high proportions of deaths reviewed as definitely 'not preventable'. The outcomes for death admitted on a weekend continue to show care of a similar standard to those admitted on a weekday. Mortality performance for certain high risk conditions across some of the indicators showed a decreasing trend, i.e. urinary tract infection and acute kidney injury.

MJ stated that the proposal to turn off the automatic printing of patient results in key modalities to eliminate the duplication resulting from electronic results notification had been implemented with no major concerns.

MJ advised that despite considerable work to look at incidents and to close some of them down – this had still not happened with our commissioners. MD queried as to what were their concerns. MJ replied that commissioners were concerned about falls and the triangulation of complaints/concerns and issues raised by the Coroner.

MD also sought clarification over major harm incidents. MJ replied that four incidents were reported as major or extreme harm, one of which was downgraded by RRG. MJ stated however, that there were no major trends developing.

MJ reported that there had been two never events – one in maternity and the second concerning the wrong route of administration of Oramorph. A comprehensive investigation was underway with regard to the incident in maternity and a number of lessons had been learnt and actions put in place to prevent occurrence of the second incident.

MJ also highlighted the assurance visits and in particular the issues with drug security in clinical areas. Overall the results represented a significant area of concern which needed to be addressed. A task and finish group was being established by the Deputy Director of Nursing which would report back to Governance Committee. MJ stated that we were also trying to learn from South Tyneside who had experienced similar problems and made improvements.

Resolved: To accept the report.

Item 4 Finance Report

JP presented the report which reflected the Trust's Income and Expenditure position as at 30 April 2017. JP stated that given the need to finalise budget setting and contracting activity plans, the month one budgets were summarised with some assumptions having been made for clinical activity.

JP stated that the overall position was a net deficit of £928k against a planned deficit of £936k, £8k ahead of plan. Pay was currently showing a small underspend of £10k against plan mainly due to vacant nursing posts across the Trust. Agency spend was overspent by £116k.

JP informed Directors that the CIP target for 2017/18 was £13m and at this stage plans for £12.3m had been identified, however this value included very high risk rated schemes which needed to be fully developed in the coming months to allow for full achievement in year. AW commented that what had been achieved was important but more important was patient safety and patient care. JP replied that all CIPs were risk assessed regarding patient quality and safety. There was clinical engagement from ICM and MJ but also from the CCGs and the intention was not to compromise or cut quality.
PS commented that it would be interesting when we went to public consultation regarding improving quality and saving money. SF stated that safety was not negotiable and that there were still opportunities to take out costs without compromising quality. SF also stated that duplication with primary care still created a lot of issues and potential savings.

JP informed Directors that cash at month 1 was £9.73m and planned cash levels were £7.86m although a cash payment of £6.3m was paid to HMRC in early May reducing the Trust cash levels. JP stated that this was linked to CHoICE and purely a timing issue.

The real cash position therefore, was £3.4m with no STF incentive monies or Q4 monies. PT queried whether the May position was satisfactory. JP replied that it was fairly tight and that we had to consider our commitments. SH commented that it was deplorable that we were promised monies and not paid on schedule which then made things incredibly tight for us as an organisation.

JP stated that KWB had raised this nationally with Jim Mackey has had a lot of other organisations. JP also advised that it was not necessarily an NHSI issue but more about the Treasury. PT queried whether there had been a conversation with the CCG regarding earlier payment using their cash earlier. JP replied that whilst they were keen to help they could not draw down too much ahead of normal as they could not be seen to be helping.

The Chairman queried whether there was any organisation that had been paid. JP replied none that she was aware of. The Chairman advised that he would be following up this issue further with KWB. PT commented that she assumed cash planning for June was also tight. JP replied that we would manage but that we may have to hold invoices. PT also commented that it

linked to being a “Going Concern”. JP replied that she still believed we were a Going Concern.

AW commented that it was good to hear that the CEO was applying pressure at a national level as the public would struggle to understand how monies owed were not being paid and potentially compromising safety.

ML queried section 2.1 – private patient income which was behind plan by £22k. JP replied that this was a fairly volatile area. SF stated that the Trust did not really do a huge amount of private work and it fluctuated month on month.

Resolved: To note the financial position to date.

Item 5 Performance Report

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

AK informed Directors that A&E performance was only marginally below the 95% target at 94.7% with a 5% increase in attendances compared to April 2016. AK explained that whilst we had exceeded the STF trajectory of 89.2% we were still awaiting confirmation that this had been agreed by NHSI.

The national A&E performance for March was 90% and we remained in the upper middle 25% of Trusts nationally.

AK stated that RTT performance remained above target at 94.3%. National performance was 90.3% and the Trust was ranked 20th nationally.

ML queried why T&O remained behind plan as their performance was only 82.89%. SF explained that spine in particular was a problem because of the volume and the patient pathway. SF stated that in terms of the polling range to see the surgeon and the need to have an MRI, the patient will have already breached. It was about changing the pathway and undertaking the MRI first and recognising that approximately 5% of people would not need an MRI.

AK informed Directors that the Trust had met all cancer waiting times with the exception of cancer 62 waits from GP referral (81.73%) and consultant upgrade (84.6%).

AK stated that the cancer alliance had confirmed a key focus on 62 day performance and an expectation of achievement by the autumn which would be an issue for us,

SH queried the issue in lung of 3.5 patients breaching. AK replied that the half breach was a shared breach because it was a complex process. There was however no problem with the pathway and no ongoing risk.

AK also stated that diagnostic performance remained above the 1% target at 3.04% of patients waiting over 6 weeks for their diagnostic test. Whilst this was an improvement from February and ahead of the trajectory agreed with NHSI, achieving full recovery in July remained a risk due to ongoing pressure across a number of areas.

MD commented that the previous year had been good performance and therefore what was the problem. AK stated that there was an increase in referrals and also some administrative issues. SF commented that it was an arbitrary set of tests and an arbitrary time in which to deliver them. AK also advised that cardiology was on plan with the trajectory however urodynamics was still a risk for May.

Resolved: To accept the report.

4. Strategy/Policy

Item 6 Annual Accounts and Report 2016/17

JP advised that the Annual Accounts and Report had been presented to the Audit Committee on 17 May 2017 as Audit Committee had delegated authority to approve them on behalf of the Board. The deadline for completion had been earlier than normal and following comments received at Audit Committee the reports had been amended. The final submission to NHSI was by the 31 May 2017.

Resolved: To note the submission of the Annual Accounts and Report.

Item 7 Self Certification Declaration

CH presented the report which included the self declarations for Condition G6, CoS7(3) and FT4.

CH advised that this year NHSI had changed their process and as a consequence from July, NHSI would select some organisations to ask for evidence that they had self certified.

CH stated that Condition G6 required the Trust to have a process and system that identified risks to compliance and to be able to take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

MD commented that within the G6 statement he thought “Licence” should be “Licensee”. CH apologised and confirmed that was correct.

CH advised that Condition CoS7(3) required the Trust to confirm whether it would have the resources available over the next financial year to provide designated resources.

Condition F4 was for the Trust to review whether their Governance systems achieved the objectives set out in the Licence condition and also whether

Governors had received enough training and guidance to carry out their duties.

CH advised that it was up to Trusts to determine how they would demonstrate compliance but NHSI had provided a template for use which was attached in the appendix.

PT commented that “OGSM” in section 4 of the template would be better in full. PT also commented that some elements of text appeared to be missing. CH replied that the text was there in the on-line version but was problematic to print off a hard copy for some reason despite a number of attempts.

Resolved: To confirm:

- The Trust continues to meet the criteria for holding a licence to ensure compliance with Condition G6 of the Provider Licence;
- The Board has a reasonable expectation that the Trust will have the required resources available to it for the coming year in line with condition CoS7 of the Provider Licence;
- To approve the corporate governance statement and confirm that the Board has sufficient arrangements in place for compliance with NHSFT governance arrangements;
- Sufficient arrangements have been in place to ensure Governors are equipped with the skills and knowledge to undertake their role; and
- To delegate authority to Julia Pattison, Director of Finance to sign the necessary declarations in the absence of Mr Bremner.

JOHN N ANDERSON QAEP CBE
Chairman

ENCLOSURE 3

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF QUALITY & TRANSFORMATION

BOARD OF DIRECTORS

JULY 2017

QUALITY, RISK AND ASSURANCE REPORT

Executive Summary

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

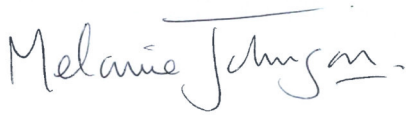
- In May 2017 we reported 36 hospital acquired pressure ulcers, which is a significant increase from the 19 reported in April (an increase from 1.27 to 2.01 per 1000 bed days) largely due to an increased number of category 2 pressure ulcers.
- Safeguarding referrals to children's services have remained stable for the past three months.
- Twenty safeguarding adult referrals were made by the Trust to the local authority in May 2017, an increase from 12 referrals in April. The number of Deprivation of Liberty applications was the same as the previous month.
- There were 35 complaints in May, with a year to date average of 37 per month.
- Wards that have had lower than planned nurse staffing fill rates during May continue to be mainly in the Division of Medicine, which has the highest number of vacancies. Oversees recruitment continues to progress steadily.
- There was an increase in the number of reported patient falls in May (n = 152) compared with 123 in April, with an increase in the number of people sustaining fall related harm.
- Forty excellence reports were received during May.
- Six C. difficile cases were reported as Trust apportioned in June, which is three above monthly trajectory. Three of these cases represented a period of increased incidence on a surgical ward and an elderly care ward.
- Incident management systems analysis demonstrates an increase of 80 reported incidents (7%) in May compared to the previous month. In comparison to the same month in 2016, this is a decrease of 104 (8%).
- During April, Rapid Review Group (RRG) commissioned 7 Root Cause Analysis (RCA) investigations. 62 out of 69 RCAs in process are however overdue. The number of overdue > 3 months RCAs has reduced from 58 in April to 43 in May, reflecting the work being undertaken to manage this demand.
- During May, 13 incidents were reported as resulting in moderate or above harm. These are being validated by directorates and those confirmed as causing moderate or above harm will result in the formal requirements of Duty of Candour being applied.

- We reported 94.82% harm-free care in May 2017 (a 0.47% increase from the 94.35% we reported in April).

Recommendation

Directors are asked to note the report.

Bob Brown
Director of Quality & Transformation



Melanie Johnson
Director of Nursing & Patient Experience

Ian Martin
Medical Director

City Hospitals Sunderland
NHS Foundation Trust

Quality, Risk and Assurance Report for May 2017

PATIENT STORY
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

The following correspondence was sent to the Trust's Learning Disabilities Liaison Nurse from parents following their son's recent hospital stay. While the operation he had – the removal of large bladder stones – was a fairly routine procedure for most young men, this was a terrifying one for a severely brain-damaged 32 year old man with cerebral palsy and spastic quadriplegia, who ended up in ICCU on life support after his last general anaesthetic. Praise and thanks were expressed for the support given and the comprehensive care plan that was put in place for their son:

"We know that my husband thanked you profusely when you rang after our son's operation but we would like to express more formally the difference that your intervention and support made to our hospital stay.

When the surgeon told us that our son had to have his bladder stones removed surgically, we were extremely upset and absolutely terrified, which you immediately understood when we told you that the last time he had a general anaesthetic he was over-sedated and ended up on life support in ICCU for over three weeks and then spent two further weeks on another ward with a further re-admission to ICCU when he relapsed.

During that time we were told three times that he would not survive and that his life-support machine would be turned off, so this time it was very important to us that everyone involved understood our very real fears at the prospect of our boy undergoing another GA.

Through the surgeon, we requested a formal meeting with the Anaesthetists as part of the pre-op appointment in order to discuss past history and seek expert reassurance that it would be a safer procedure for our son this time. All of the information from this meeting was passed on to the Anaesthetist who, we believe, contacted you to ask you to provide support for us - for which we will be forever grateful.

In addition to the circumstances leading to his time in ICCU, we have had very mixed experiences with the NHS since our son was brain-damaged at birth thirty-two years ago - a result of asphyxiation from an undiagnosed, and then mismanaged, breech delivery - which means that we are a family who often finds it difficult to trust medical professionals.

To have someone acting as an experienced, expert liaison between ourselves and the many professionals involved in our son's surgery and hospital stay immediately helped to allay some of our fears. The fact that there was a care plan agreed with us, his parents, (admittedly laypeople but experts on our son and his needs) and circulated to all those involved was an immediate relief.

The most important, practical item was the allocation of a side room which allowed us to be there 24/7 for our son and gave his dad somewhere with a modicum of privacy to stay overnight with him. It is very difficult to handle his complex needs on an ordinary ward - as we know from bitter experience. Having us there also takes some of the workload off nursing staff, making it easier for them.

It was also extremely important to us that the staff were aware that, despite our son being non-verbal, he does have a very definite method of communication and excellent comprehension skills, so thank you for passing that on to all relevant professionals.

It was also very reassuring to be able to tell family and friends (who shared our terrifying experience eight years ago) that we had someone there who was working on our son's behalf and that a very comprehensive care plan was in place. My husband spoke to you several times and he has praised your friendly manner, your very caring attitude and absolute professionalism throughout. We were so relieved to know that you were "batting for us"!

Following our son's amazing recovery eight years ago, we were invited to give feedback to senior staff about his hospital experience and, unfortunately, until this admission we felt that nothing had changed in respect of inpatient care of young people with complex needs, BUT the work that was done on his behalf shows that real progress has been made.

We did not have to repeatedly explain to each member of staff about his communication, personal care or medication requirements, nor did we have to worry about whether or not we would be able to stay with him. The huge difference was that they were expecting our son, and his parents, and knew what to expect!

We really appreciate that Sunderland Royal has put in place a Liaison Service such as yours and they are extremely fortunate to have someone who combines professionalism and experience with understanding and empathy.

Thank you once again for helping to ensure that a very scary experience had a very positive outcome. We did not dare to think that we would be writing to you in such a way exactly one week after the operation.

A final thank you for ringing us at home after he was discharged from hospital. It means a lot to know that your concern for our lovely, brave young man includes his post-op as well as his pre-op care.

We were also given tremendous support from the Consultant Urologist and Consultant Anaesthetist who understood our fears and helped to allay them with their undoubted expertise, positivity and understanding. Similarly, all of the staff on D44, from the Ward Manager to the cleaners, treated our son with great kindness, understanding and respect, looking after him - and us - extremely well throughout our stay.

We have sent our thanks to all concerned but please communicate our sincere appreciation once again if you are in touch with them."

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

1.1 HOSPITAL ACQUIRED PRESSURE ULCERS (HAPUs)

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

Ward Dashboard data for May 2017

In May we reported 36 HAPUs, which is a significant increase from the 19 reported in April. 30 patients developed a HAPU, and six patients had > 1 PU.

Numbers of HAPUs by category for May:

Severity	Number of HAPUs
Category 2	36
Category 3	0
Category 4	0
Total	**36**

1.2 COMMUNITY ACQUIRED PRESSURE ULCERS (CAPUs)

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

The table below 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 to 4 pressure ulcer even with optimal treatment" (National Pressure Ulcer Advisory Panel, 2002).

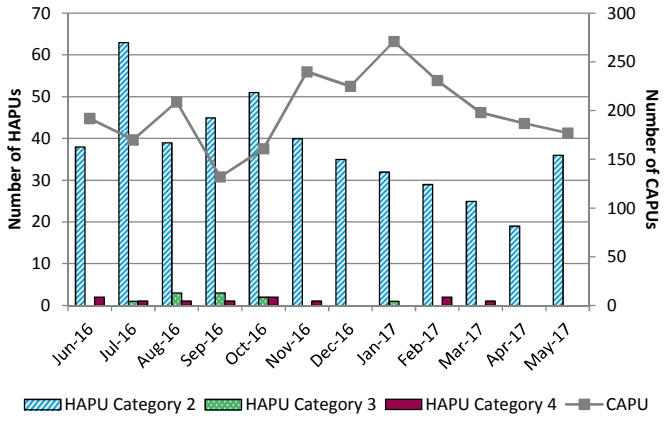
The pre-existence of a PU renders these patients as high risk of developing further PUs or suffering deterioration of their existing sore whilst in hospital, hence proactive preventative strategies are required for these patients to prevent this.

Total number of CAPUs per month June 2016 to May 2017:

Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17
192	170	209	132	161	240	225	271	231	198	187	177

Figure 1 shows numbers of HAPUs (primary axis) and numbers of CAPUs (secondary axis) for the period June 2016 to May 2017.

Figure 1: HAPUs and CAPUs from June 2016 to May 2017



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

1.3 TRUST PERFORMANCE AGAINST IMPROVEMENT TRAJECTORY

The number of PUs per 1,000 bed days has significantly increased from 1.27 in April to 2.01 this month. The Tissue Viability team are using this data to scrutinise practice on the identified wards and target education and training. Figure 2 shows the number of HAPUs per 1,000 bed days, together with the improvement trajectory. The end of year position for 2016-17 surpassed the improvement target/ trajectory for the first year of the 3-year plan. However, this month there has been a significant deterioration in performance against the trajectory. This is due to the increased number of category 2 PUs this month, which may be due to the case mix of patients (i.e. high risk patients). Improvement action by Matrons and Ward Managers is being monitored by the Nursing & Patient Experience team as per the Trust Pressure Ulcer Improvement Plan.

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

Directorate	Category 2	Category 3	Category 4	Total	12 month Trend
REM	13			13	
Trauma & Orthopaedics	5			5	
General Internal Medicine	3			3	
Theatres	4			4	
Medical Specialties	1			1	
General Surgery	5			5	
Emergency Medicine	2			2	
Urology	3			3	
Head & Neck					
Family Care					
Obs & Gynae					
Ophthalmology					
Grand Total	**36**			**36**	

1.4 NEW INITIATIVES

CHS is a key stakeholder in the Sunderland PU Improvement Project which is a research study ("PROACT"), funded by Sunderland and South Tyneside Clinical Commissioning Groups and Sunderland University. The aim of the project is to raise awareness of prevention of PUs with patients, carers and healthcare professionals who work in health and social care settings in out of hospital environments. The project has secured commercial funding so is on the National Institute of Health Research (NIHR) portfolio and is currently going through the ethical approval process.

Figure 2: Hospital Acquired Pressure Ulcers (HAPUs) by category and trend from June 2016 to May 2017 with improvement trajectory

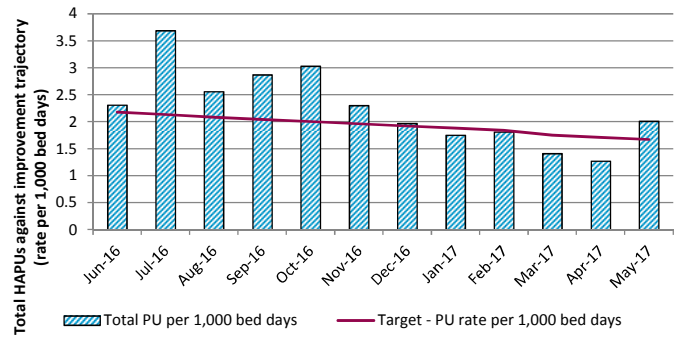
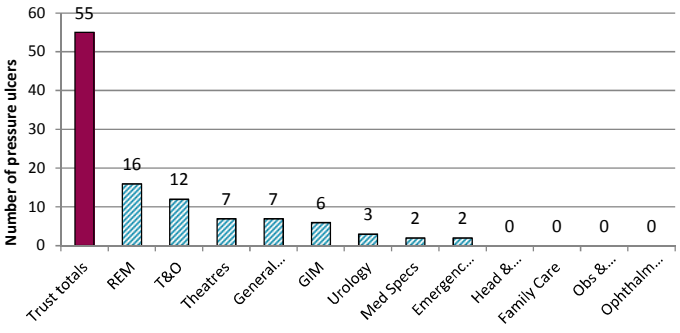


Figure 3: Year to date pressure ulcers (category 2 and above) May 2017



SAFEGUARDING CHILDREN
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.5 SAFEGUARDING CHILDREN

Current position

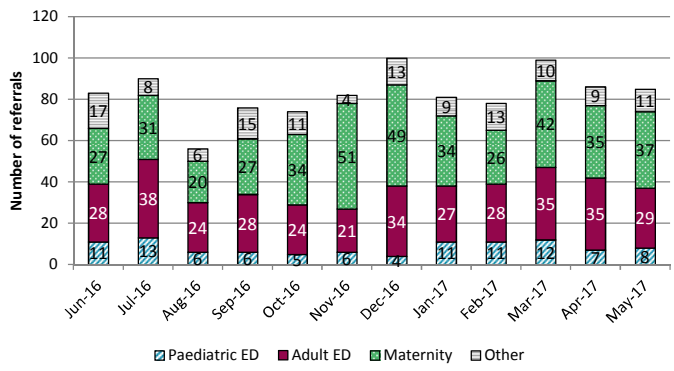
The referrals to Children's Services have remained stable for the past 3 months. See figure 4 for data for the last 12 months. The themes from Adult ED remain to be the safety of children when parents present with substance misuse, mental health and domestic abuse; mental health remains the highest cause group.

It has been noted that missed opportunities on parents presenting into ED where a safeguarding referral should have been made have been identified. The team have a meeting with the Senior Nursing team in Adult ED and alongside this there is increased supervision with nursing staff to address this. The Designated Doctor is also discussing in Peer Review and this will be monitored by the Named Nurse.

The Named Doctor role is vacant and has been added to the Risk Register, with the Designated Doctor covering until the replacement is in post.

There have been no requests for information relating to potential Serious Case Reviews from Sunderland or Durham Local Safeguarding Children Boards, with no current SCRs ready for publication.

Figure 4: Safeguarding children referrals June 2016 to May 2017



SAFEGUARDING ADULTS
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.6 SAFEGUARDING ADULTS

1.6.1 Safeguarding Adults Reviews (SARs)

No further SARs were commissioned in May 2017.

1.6.2 LeDeR Reviews

A LeDeR review has been undertaken involving a 57 year male who was admitted to CHS on 10 May 2016 after a fall down stairs. The patient was living independently, and was not on the Learning Disability register. He was not on the Mental Health register. However, in 2014 it was confirmed that the patient had autism.

An action plan has been developed and multi-agency actions have been agreed. Actions specific to CHS are:

- Within the Emergency Department awareness-raising for staff is required in relation to the care of someone with autism.
- Signage within the Emergency Department needs to advise patients and relatives of expected pathway/process.

1.6.3 Referrals

Figure 5 shows that a total of 20 Safeguarding Adult Referrals were made by CHS to the Sunderland City Council Safeguarding Adults Team in May 2017. This is an increase from 12 referrals the previous month.

The categories of abuse and/or neglect and perpetrators are as follows:

- Neglect and/or acts of omission
- Physical
- Domestic violence/abuse
- Financial abuse
- Self-neglect
- Organisational abuse
- Sexual exploitation

1.6.4 Mental Capacity Act: Deprivation of Liberty Safeguard (DoLS)

May 2017 saw 130 new DoLS applications submitted from CHS to the Local Authority. As shown in figure 6, this is the same figure as the previous month.

Figure 5: Adult safeguarding referrals received June 2016 to May 2017

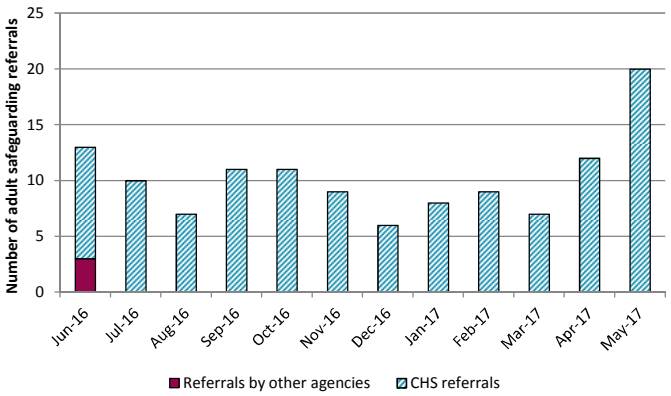
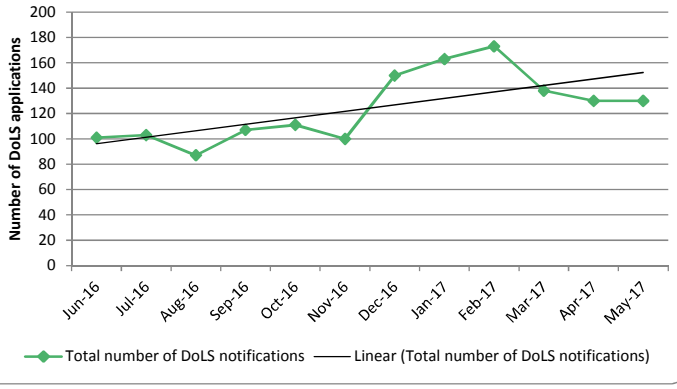


Figure 6: Number of DoLS applications made June 2016 to May 2017



COMPLAINTS
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.7 COMPLAINTS

There were 35 complaints in May, with a year to date average of 37 per month.

The Trust's Complaints Policy expects formal complaints be acknowledged within three working days of the receipt of the complaint. Figure 7 demonstrates that all complaints were acknowledged within this timeframe.

Figure 8 shows 31 formal complaints awaiting a first written response (by working days), compared to 27 last month. There is one complaint that has been awaiting a first response for more than 60 days. This demonstrates that the significant improvements made in 2016/17 are being maintained. Performance is still being closely monitored through weekly meetings.

Figure 9 shows the status of all formal complaints as at the end of May, with 49 open complaints (new and reopened) compared to 47 last month. Of the 36 awaiting a written response (ongoing), 31 are awaiting a first response and five are reopened. Of the 13 awaiting a meeting, nine are new and four are reopened. There are seven complaints currently being reviewed by the PHSO.

Figure 7: Acknowledgement of formal complaints - June 2016 to May 2017

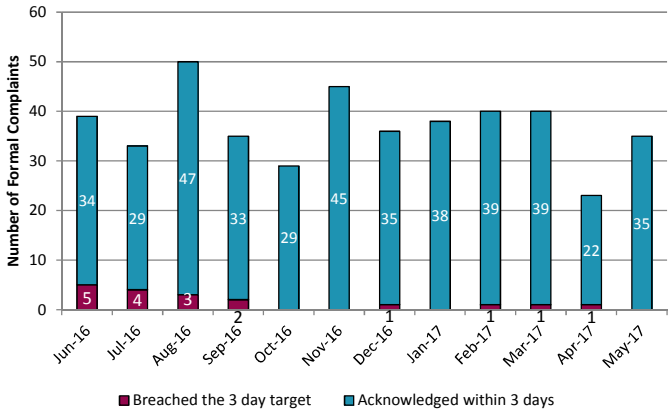


Figure 8: Current formal complaints awaiting first response by working days - May 2017

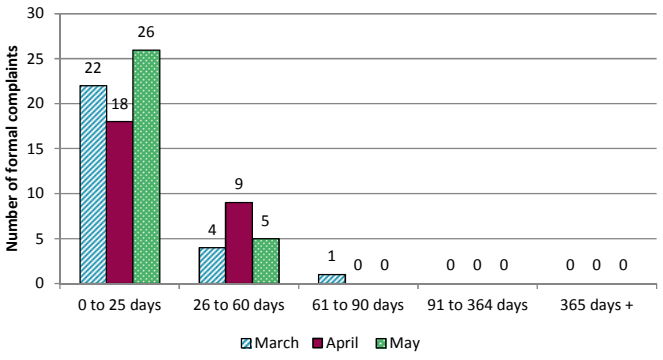
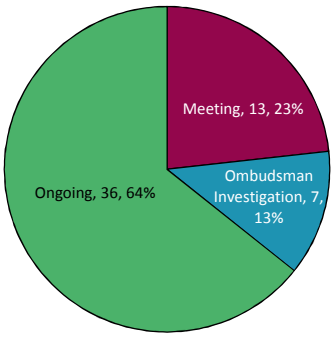


Figure 9: Current stages of formal complaints (new and reopened) - May 2017



NURSING WORKFORCE
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.8 NURSING WORKFORCE

1.8.1 National Indicators/NHS Improvement Governance Indicators

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

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

Number of incidents compared to fill rates for SRH and SEI (see figure 10):

Indicator		Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17
No. of incidents		29	39	45	83	67	85	118	128	83	66	29	31
Fill rate	SRH	93.00	93.00	92.00	92.00	93.00	93.00	92.00	90.00	91.00	91.00	91.00	92.00
	SEI	95.00	94.00	94.00	93.00	96.00	97.00	94.00	97.00	100.00	97.00	95.00	94.00

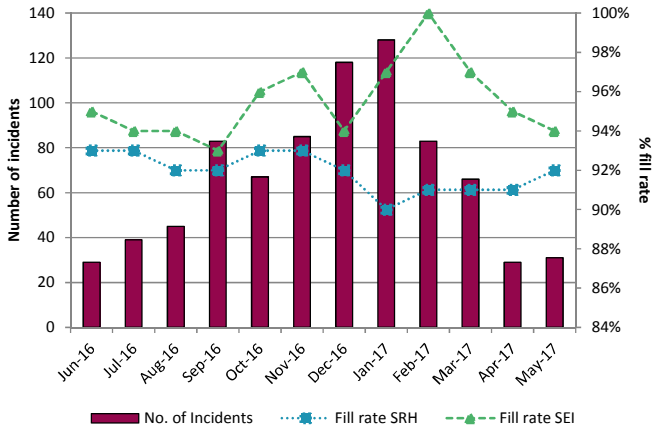
Failure to achieve 100% fill rates can be explained by RN/RM vacancies, maternity leave, sickness, and additional beds open. During the month of May there were additional beds open on D42 for part of the month. There were 11 wards in May with RN fill rates of less than 80%. The majority of these remain in the Division of Medicine, which has the highest number of vacancies. The overall number of falls reported in May was 152, an increase from April (123). The number of patients sustaining harm has increased slightly this month from 40 in April to 50 in May. It should be noted that none of these falls were identified through the staffing incident forms submitted, but via the normal incident reporting route. Work is ongoing to triangulate staffing and falls incidents to identify any correlation.

NHSP continues to provide support to wards to mitigate shortfalls. There were 13,296 hours supplied in May compared to 13,259 in April. 58% of requests were filled compared to 56.6% in April.

At the end of May there were 74.55wte approved RN vacancies. This does not include 49.53wte who are currently undergoing pre-employment checks.

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

Figure 10: Trust Nursing Fill Rate and Incidents Trend June 2016 to May 2017



Fill rates – May 2017	Day		Night	
	RN/RM	Care staff	RN/RM	Care staff
Family Care	94.00%	96.00%	99.00%	79.00%
Medicine	77.00%	113.00%	81.00%	100.00%
Surgery	82.00%	96.00%	85.00%	115.00%
Theatres	100.00%	60.00%	100.00%	95.00%
SRH Total	**92.00%**			
SEI Total	**94.00%**			

Care Hours Per Patient Day (CHPPD) May 2017	SRH	SEI
	7.4	15.2

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

1.8 NURSING WORKFORCE (continued)

1.8.2 Incidents relating to Nursing and Midwifery Staffing

In May there were 31 incident forms relating to nursing and midwifery staffing, a slight increase from April (29). Please note, these were not isolated to ward areas. Figure 11 shows a breakdown of these incidents.

There were 14 incident forms submitted by five wards when RN staffing was below "trigger" numbers. This is a slight increase from April (11). On all occasions, the duty matron implemented the nurse staffing escalation plan, which meant that in some areas skill mix was not as planned but the area had the right number of staff. On some occasions this was not possible and the duty matron risk assessed areas and moved staff according to risk. Duty matron submitted two incident forms this month when staffing across the Trust was difficult with several wards below minimum numbers, either due to sickness, acuity of patients, or to support the additional beds open for winter pressures. On all occasions, duty matron moved staff around to ensure all areas were safe.

Medical Specialities continue to submit the highest number of incident forms this month (8). This is in part due to the number of vacancies and long term sickness, and the moving of Registered Nurses to support other areas on night duty. Support is provided form NHSP and duty matron.

1.8.3 Workforce Update

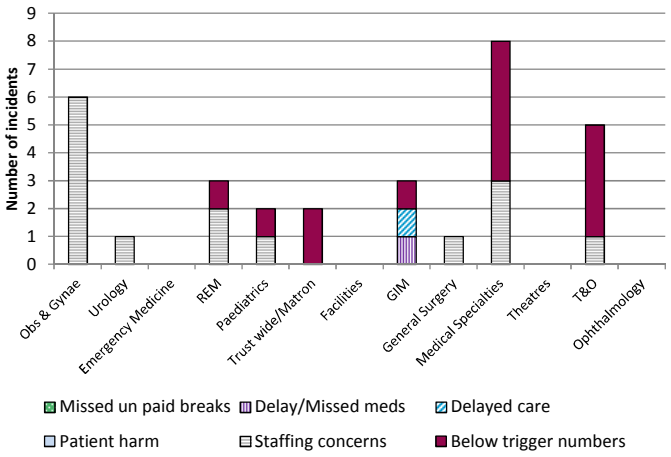
Monthly generic band 5 recruitment continues. Overseas recruitment is planned for June 2017. Work is underway to map out the potential to work with overseas nurses living in the UK, but not NMC registered, to achieve NMC registration.

Overseas nurses continue to arrive. To date we have 28 in post. There are now 19 nurses who have passed Objective Structured Clinical Exam (OSCE). Two have failed and left the Trust, three have failed twice and are continuing to work for the Trust while waiting for curtailment letters from UKVI.

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

The open event in May proved very successful and there are plans to repeat this later in the year.

Figure 11: Incidents relating to Nursing & Midwifery staffing - May 2017



Absence turnover for May 2017:

Absence/ Turnover May 2017	Absence		
	Absence Rate	Short Term Absence	Long Term Absence
HCAs	6.20%	2.13%	4.07%
RNs	3.74%	1.33%	2.41%
RMs	5.30%	1.93%	3.37%
Overall	4.55%	1.60%	2.95%

ASSURANCE
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.9 EXCELLENCE REPORTING

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

- 189 reported from 14 February to 31 May 2017
- Majority of reports were attributed to Theatres (27), Emergency Care (20) and REM (19)
- In May, 40 reports were received. A breakdown of these is shown below:

Reporters have originated from varying professions:

Profession	No of Excellence reports submitted
Nursing & Midwifery	12
Admin & Clerical (including management)	8
Medical	7
Ward/Team manager	7
Senior Nurse	4
Allied Healthcare Professionals	2
Healthcare assistant	0

Category breakdowns are as follows:

Category	No of Excellence reports submitted
Going the extra mile	10
Team working	10
Care and compassion	5
Competence	4
Service improvement	4
Communication	2
Courage and commitment	2
Leadership	2
Other	1

HOSPITAL ACQUIRED INFECTION
LEAD: MEDICAL DIRECTOR

2.1 HOSPITAL ACQUIRED INFECTIONS

2.1.1 MRSA bacteraemia

There was one new case of MRSA bacteraemia in May. The source was identified as soft tissue infection/haematoma. Total cases for 2017/18 is one against an annual limit of zero avoidable cases.

June 2017 update: There were no new cases of MRSA bacteraemia in June. Total cases for 2017/18 is one unavoidable case against an annual limit of zero avoidable cases.

2.1.2 C. difficile infection (CDI)

Two cases were reported as Trust apportioned in May, which is one below monthly trajectory. The year to date position at the end of May is three cases against an annual trajectory of 34.

The C. diff rate per 100,000 bed days for the previous 12 months up to May 2017 remains within target, at 10.1. By comparison, the national rate for the latest 12 month period available (April 2016 to March 2017) was 10.7 per 100,000 bed days.

Cases of C. difficile infection per month June 2016 to May 2017:

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

June 2017 update: Six cases were reported as Trust apportioned in June, which is three above monthly trajectory. Three of these cases represented a period of increased incidence on a surgical ward and an elderly care ward.

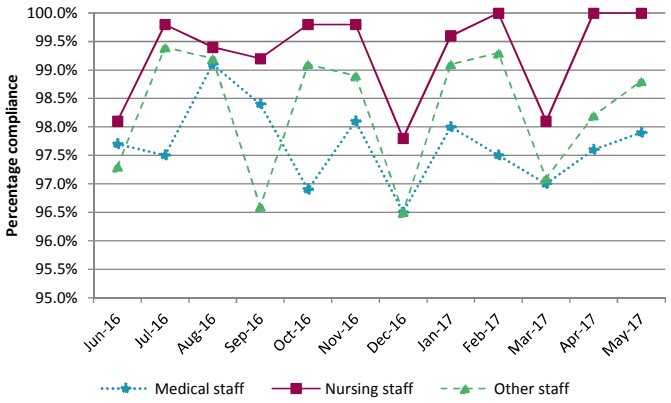
The year to date position at the end of June is nine cases against a quarterly trajectory of nine and an annual trajectory of 34.

2.2 HAND HYGIENE

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

Hand Hygiene results showed 98.8% compliance with hand decontamination for May (1,382 observations). Further analysis of compliance is presented as 97.9% medical staff, 100% nursing staff and 98.8% for other staff. Figure 12 shows compliance across the last 12 months.

Figure 12: Hand hygiene results June 2016 to May 2017



CLINICAL GOVERNANCE UPDATE
LEAD: MEDICAL DIRECTOR

2.3 MYOCARDIAL ISCHAEMIA NATIONAL AUDIT PROJECT (MINAP)

The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attack. It supplies participating hospitals with clinical performance and outcomes data and compares this with nationally and internationally agreed standards. This comparative data is designed to help clinicians and managers to monitor and improve the quality and outcomes of their local services.

The latest report provides a national picture of care for heart attack in 2014/15:

- Highlights five key areas – length of inpatient stay, seen by a cardiologist, admitted to a cardiology ward, prescribing secondary medication and angiography performed prior to discharge.
- CHS submitted MINAP data for 225 patients, although 472 patients were assessed by the Cardiac Rehabilitation Nurse.
- Length of stay – 3 days, which is shorter than most other regional hospitals.
- Seen by Cardiologist – over 98% for CHS. Only Freeman and James Cook have a higher percentage.
- Admitted to a Cardiology ward – in the top centile with Freeman Hospital.
- Secondary Prevention – we are below national average figures which is due to data errors.
- Angiogram as inpatient – performing well with other Trusts.

The clinical team have explained that they have had problems with the process for data inputting, validation and upload, which has impacted on these published results. In terms of addressing the issues, Cardiology have introduced a more robust data collection process and direct entry onto a web portal. There is now a dedicated Data Clerk with a set timetable for MINAP entry and a system of monthly checking of inputted data. However, these changes will not be in time to affect the next public report (2015/16).

2.4 PATIENT SAFETY ALERTS (NHS IMPROVEMENT)

Clinical Governance Steering Group reviewed the evidence for the alert NHS/PSA/D/2016/008 'Restricted use of open systems for injectable medication' in advance of the 7 June 2017 deadline.

The main action within the alert was to put plans in place to ensure that the Trust no longer operates any 'open systems' such as gallipot containers for injectable medications.

The Trust has declared compliance with the alert on the Central Alert System. In the meantime, a further message from the Deputy Medical Director has been sent to all specialties reminding them of this directive. There is to be an amendment to the Trust's Drugs Policy and a system of audit will be incorporated into the Trust's Assurance Programme.

PATIENT SAFETY
LEAD: DIRECTOR OF QUALITY & TRANSFORMATION

3.1 PATIENT SAFETY

3.1.1 Incident report

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

CHS incidents reported

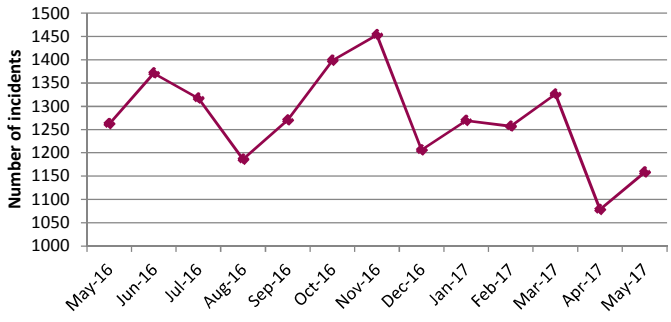
Figure 13 demonstrates the number of CHS related incidents that have been reported via Ulysses each month during the last 13 months. It shows an increase of 80 reported incidents (7%) in May compared to the previous month. In comparison to the same month in 2016, this is a decrease of 104 (8%).

CHS incidents by impact

Figure 14 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 67% in May, which is in line with the annual average.

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

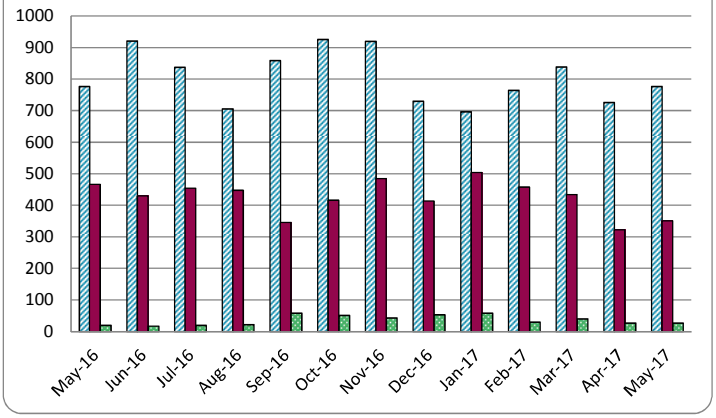
Figure 13: Number of incidents reported May 2016 to May 2017



Data for Figures 13 & 14: Incidents reported by category May 2016 to May 2017

	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17
No harm/ near miss	776	921	837	706	859	926	920	730	697	765	839	726	777
Minor harm	466	430	454	448	346	416	485	413	504	458	434	322	351
Moderate harm	20	17	19	22	58	51	43	53	58	30	40	27	27
Major harm	0	3	6	8	5	2	3	4	7	3	11	2	3
Extreme harm	0	0	1	2	2	3	2	6	3	1	2	1	0
Total	1262	1371	1317	1186	1270	1398	1453	1206	1269	1257	1326	1078	1158

Figure 14: Incidents reported by impact May 2016 to May 2017



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

3.1.1 Incident report (continued)

Headlines

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

- Do not Attempt Cardiopulmonary Resuscitation (DNACPR) regarding documentation and communication

Top 5 incidents by cause group

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

- Falls – 13%
- Tissue Viability – 13%
- Documentation and identification – 10%
- Assessment, Diagnosis and Investigation – 9%
- Consent, communication and confidentiality – 9%

Root Cause Analysis (RCA) investigations

RCAs are prepared by the directorate and are reviewed by RRG for approval before circulation both internally and where appropriate to external organisations. Figure 15 demonstrates the number of RCAs commissioned by RRG per month. The new concise RCA template being used across the Trust has received positive feedback from directorates who have used it. It continues to be refined as feedback is received.

During May, RRG commissioned seven RCAs. Figure 16 indicates the status of RCAs, showing 62 out of 69 RCAs are overdue. Appropriate escalation of overdue RCAs through operational line management structures is now in place with data in respect of overdue cases having been provided to the Director of Operations.

Work is ongoing to close relevant RCAs, as can be seen from the overdue >3 months figures in figure 16. Such cases have dropped from 58 in April to 43 in May.

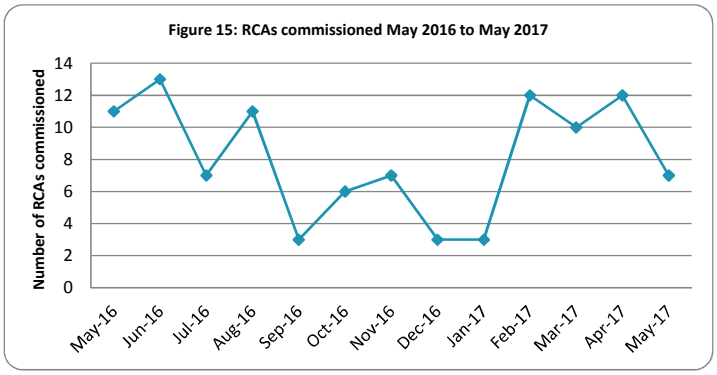


Figure 16: Status of current RCAs – May 2017 (previous month in brackets)

	RCA Level 1	RCA Level 2	RCA Level 3	Concise RCA*	Total
Overdue >3 months	13 (18)	30 (40)	0 (0)	0 (0)	43 (58)
Overdue <3 months	0 (0)	5 (7)	1 (1)	13 (6)	19 (14)
Within	0 (0)	0 (1)	0 (0)	7 (8)	7 (9)
Total	13 (18)	35 (48)	1 (1)	20 (14)	69 (81)

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

3.1.1 Incident report (continued)

Serious Incidents (SIs)

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

The deadline for completing SI investigations is 60 working days from the date reported to STEIS. Figure 17 demonstrates the number of incidents logged on STEIS by month.

The current status of SI investigations broken down by directorate is recorded in Figure 18. Figure 19 shows the status of SI investigations over the last 13 months. Eight SIs are overdue and, again, appropriate escalation of these cases is now in place. 15 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 two.

Figure 17: SIs reported to STEIS May 2016 to May 2017

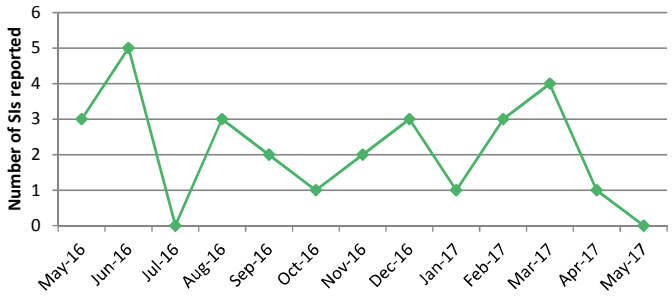


Figure 18: Status of current SIs - May 2017

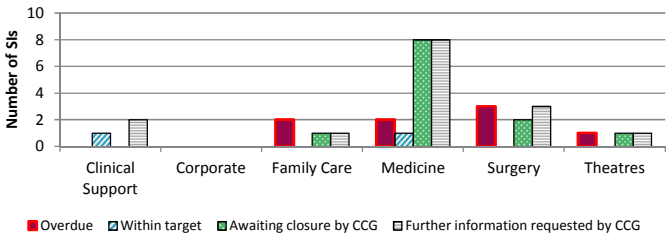
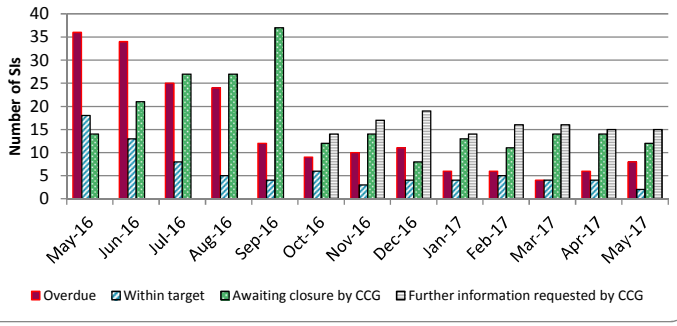


Figure 19: SI status May 2016 to May 2017



Data for figure 19: SI status May 2016 to May 2017

	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17
Overdue	36	34	25	24	12	9	10	11	6	6	4	6	8
Within target	18	13	8	5	4	6	3	4	4	5	4	4	2
Awaiting closure by CCG	14	21	27	27	37	12	14	8	13	11	14	14	12
Further info req by CCG	Not collected					14	17	19	14	16	16	15	15

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

3.1.1 Incident report (continued)

Serious Incidents (SIs) (continued)

Figure 20 demonstrates compliance with the quality indicators for SIs.

Actual compliance against the quality indicators for April demonstrates that the Trust is not yet routinely submitting completed RCAs to the CCG within the 60 working day deadline.

Figure 20: SI quality indicators

	Target	MAR 17	APR 17	MAY 17
SIs reported on STEIS within 2 working days of identification of incident	90%	100% (4/4)	100% (1/1)	100% (1/1)
Interim reports received for Never Events within 24 hours	90%	100% (2/2)	N/A	N/A
Interim reports received for SIs within 72 hours	90%	100% (2/2)	100% (1/1)	100% (1/1)
Completed RCA submitted within 60 working days	90%	20% (1/5)	33% (1/3)	33% (1/3)
% of lessons learned entered on STEIS for completed RCAs	90%	100% (5/5)	100% (3/3)	100% (3/3)
Requests for further information sent to CCG SI panel within one month	85%	100% (1/1)	0% (0/2)	0% (0/2)

Never Events

No Never Events were reported in May.

Duty of Candour

During May, 13 incidents were reported as resulting in moderate or above harm. These reported levels of harm are being validated by directorates. Those confirmed as causing moderate harm or above will result in the formal requirements of Duty of Candour being applied i.e. interested parties have been informed, received an apology and been offered a copy of any investigation reports.

3.2 SAFETY THERMOMETER

Current Position

Figure 21 shows Safety Thermometer prevalence data. We reported 94.82% harm-free care in May 2017 (a 0.47% increase from the 94.35% we reported in April).

We are unable to benchmark our performance again this month due to NHS South Central and West Commissioning taking over the responsibility of data collection, publication and benchmarking NHS Safety Thermometer data from NHS Digital/NHS England. They are in the final phase of testing with normal data flows to resume following this.

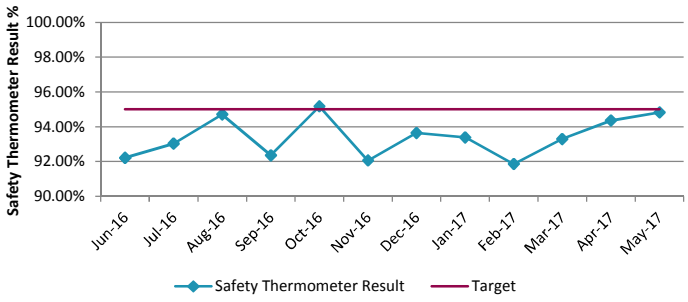
Our total number of new harms in May was 11, which is an increase from the five we reported in April.

Our percentage of harm-free care is based on:-

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

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

Figure 21: Safety Thermometer Results June 2016 to May 2017



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

4.1 CORPORATE RISK

4.1.1 Clinical Contracts

Work is in hand, led jointly by the Deputy Medical Director and Head of Contracting, to minimise an identified risk in respect of the governance of clinical contracts. The work programme will continue through the year with the objective of constructing robust arrangements for monitoring the delivery of the governance elements of clinical contracts, e.g. insurance cover, incident management processes and other issues.

4.1.2 Department of Health Consultation on Early Resolution Scheme

The Trust submitted a response to the above consultation in respect of early resolution of claims relating to injuries suffered by infants at birth. Next steps will be considered once the outcome of the consultation is known, probably in Autumn 2017.

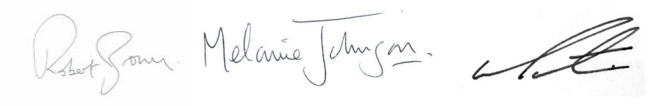
CONCLUSION

SUMMARY OF KEY RISKS

1. The number of nurse staffing vacancies was 74.55 WTE. Recruitment efforts continue.

2. The number of PUs per 1,000 bed days has increased from 1.27 in April to 2.01 this month. Improvement action by Matrons and Ward Managers is being monitored by the Nursing & Patient Experience team as per the Trust Pressure Ulcer Improvement Plan.

Directors are asked to note the report.



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

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF FINANCE

BOARD OF DIRECTORS

JULY 2017

FINANCIAL POSITION AS AT 30TH JUNE 2017 EXECUTIVE SUMMARY

1 INTRODUCTION

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

1.1 KEY HIGHLIGHTS

Issue or Metric	NHSI Plan	Actual	Variance to NHSI Plan	
	£000s	£000s	£000s	%
Overall Financial Position – Deficit	£2,718k	£5,384k	£2,666k	98.1%
Income	£86,974k	£85,643k	£1,331k	1.5%
Expenditure	£89,692k	£91,027k	£1,335k	1.5%
EBITDA Position %	1.20%	(1.70%)		
Cash Position	£7,916k	£3,954k	£3,962k	50.1%
Clinical Activity:				
Variance to plan	£78,528k	£77,970k	£558k	0.7%
Cost Improvement Plans				
Variance to plan	£2,598k	£2,264k	£334k	12.9%
Pay:				
Variance to plan	£53,834k	£53,897k	£63k	0.1%
Non Pay:				
Variance to plan	£35,858k	£37,130k	£1,272k	3.5%
Use of Resources Metrics (UOR)			3	
+ve variance equates to worse than expected; -ve equates to better than expected				

Executive Director of Finance

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF FINANCE

BOARD OF DIRECTORS

JULY 2017

FINANCIAL POSITION AS AT 30TH JUNE 2017

1 INTRODUCTION

The enclosed financial statements reflect the Trust and its subsidiary companies Income & Expenditure position as at 30th June 2017, details of which can be found in Appendices 1 - 6.

1.1 SUMMARY POSITION

Performance against the control total is as follows:

	Position at month 3		
	NHSI Plan	Actual	Variance
	£000s	£000s	£000s
Deficit for the year before impairments and transfers	(2,718)	(5,384)	(2,666)
Add: depreciation on donated assets	50	77	27
Less: gain on asset disposal	0	0	0
Less: income from donated assets	(50)	(50)	0
Less: 2016/17 STF post accounts allocation	0	(419)	(419)
Control Total Surplus/(Deficit) including STF	**(2,718)**	**(5,776)**	**(3,058)**
Less: STF 2017/18	(1,386)	0	1,386
Less: STF Incentice schemes	0	0	0
Control Total Surplus/(Deficit) excluding STF	**(4,104)**	**(5,776)**	**(1,672)**

The overall operational financial position is a net deficit of £5,384k against a planned deficit of £2,718k, and therefore £2,666k behind plan. The Trust has therefore failed Quarter 1 Control Total and is not liable for STF funding for £1,386k.

The net deficit of £5,384k included income for £419k as part of 2016/17 STF funding post accounts reconciliation. This net gain in STF of £419k is not included in the control total calculation and therefore the financial position reported to NHSI is a net deficit of £5,776k, or £3,058k behind the planned NHSI control total to month 3.

During the month a one off net impairment charge of £2,799k relating to the new Emergency Department has been put through to I&E, however this is below the 'bottom line' and will not impact the financial performance of the Trust.

The Trust reported an under performance of £558k in month 3 relating to NHS clinical activity which is due to lower than expected PbR activity.

At the end of June the Cost Improvement Plan (CIP) delivery is £334k behind projected plans submitted to NHSI.

Performance against the EBITDA margin is behind plan to the end of June.

The deficit position means that the Trust Use of Resources Metrics (UOR) rating score is 3, which is in line with plan.

The Trust Financial Position to Month 3 is behind plan due to three key factors, activity under performance against expectations, CIP slippage due to a shortfall in plans, and in turn non achievement of STF funding for Quarter 1.

The deficit position means that the Trust Use of Resources Metrics (UOR) rating score is 3.

2 INCOME AND EXPENDITURE POSITION

2.1 *Patient Related Income:*

Clinical Income to month 3 was £77,970k against a plan of £78,528k, and hence behind plan by £558k.

Trust has block contract arrangements in place with both Sunderland CCG and South Tyneside CCG which ensures certainty in funding flows for the year; however PbR contracts with both Durham CCGs and NHS England commissioners and performing lower than expectations at this stage of the year.

Activity figures for months 1 and 2 are yet to be fully validated so these may change in the upcoming month.

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

Private Patient Income is over recovered against plan by £7k.

2.2 *Non Patient Related Income:*

Training and Education, Research and Development income are both approximately break even against plan to month 3.

Other Income was ahead of plan by £605k, most of which is due to the cross charge to South Tyneside Foundation Trust funding several posts across the trust as part of the cross site shared management team arrangement.

As mentioned earlier, the Trust has failed Quarter 1 Control Total and is not liable for STF funding for £1,386k.

3 EXPENDITURE

3.1 *Pay Expenditure:*

Pay is currently showing an overspend of £63k against plan, reflecting:

- Agency costs to month 3 are £1,453k, compared to an overall Trust agency staffing budget to month 3 of £1,072k. Much of this spend is to cover vacant posts. The same period in 2016-17 had agency spend at £1,370k which is £83k less than the current period, in addition a challenging CIP target was set for agency reduction in 2017-18. The position on agency spend has the Trust below its maximum agency/ceiling level set by NHS Improvement to the end of June 2017, detailed in Appendix 4.
- To date the net underspend from vacant nursing posts across the Trust is £364k

which is inclusive of the costs paid to NHS Professionals and overtime working.

- Cost Improvement Plans for pay are £209k ahead of plan to date mainly due to vacancies across the Trust.
- 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)	249
Other Medical Staff (net of vacancies, additional sessions and agency costs)	289
Nursing (net of NHSP Costs)	-364
Other Staff groups	-111
Total Variance	**63**

Appendix 4 shows details of pay spend on agency, flexi-bank and overtime for the last 12 months from month 3.

Overall pay costs in June were £17,854k against a budget of £17,957k for the month.

3.2 ***Non Pay Expenditure:***

Non-Pay is overspent by £1,272k. Major areas are highlighted as:

- Drugs are overspent by £424k.
- Clinical Supplies is overspent by £129k due largely to CIP under delivery of £149k against plan to date.
- Other Non Pay is overspent by £607k, most of which is due to a shortfall in CIP delivery to date of £234k against plan. A further overspends of £101k is due to offsite CT scans sent to Nuffield Hospital due to shortage of Radiographers at the Trust.
- PDC costs are £107k underspent against plan to date.
- Depreciation costs are £160k overspent against plan to date.
- Interest paid is £59k overspent against plan to date.

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

4 CIP POSITION

At the end of Month 3, CIP delivery was £2,264k against a planned delivery of £2,598k and hence an under delivery of £334k. This shortfall is reflective of the unidentified CIP targets set for the Trust for 2017/18.

Current Trust CIP plans have identified £12.2m of the £13.0m target this year, much of this delivery especially for procurement will be in the later stages of the financial year. At this stage the Trust anticipates total CIP delivery for 2017/18 to be in line with plan of £13m.

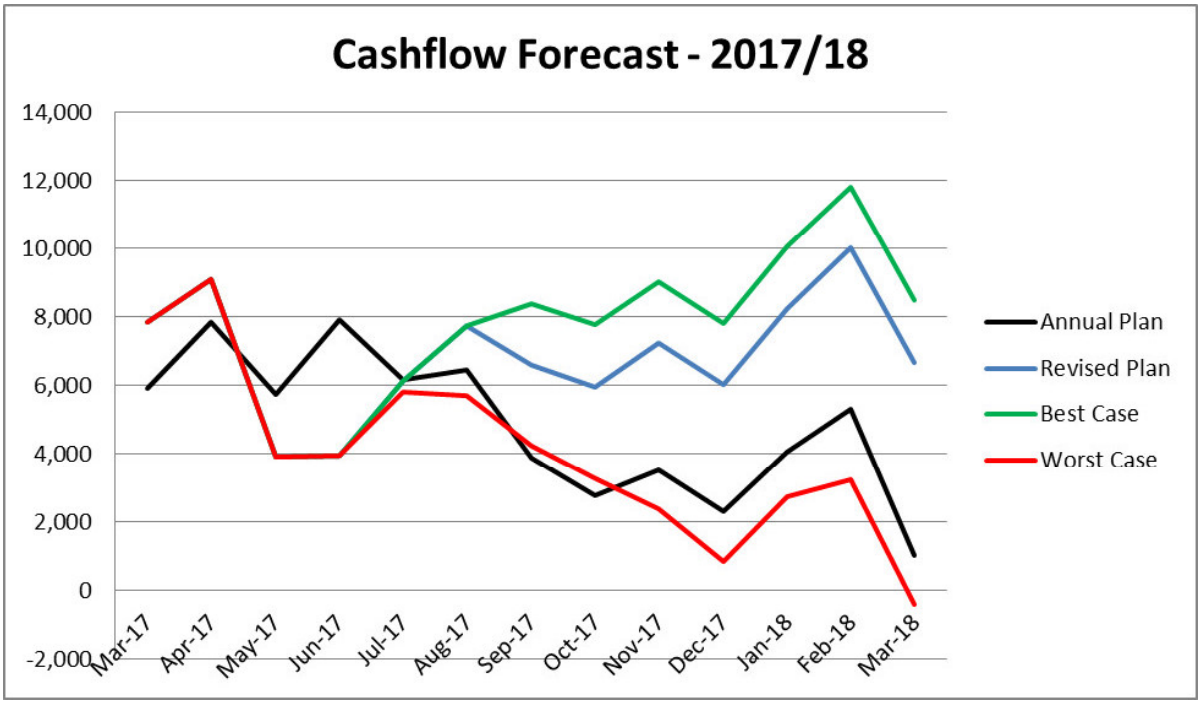
Details are provided in Appendix 6.

5 CASHFLOW AND WORKING CAPITAL

The cash balance at the end of June 2017 was £3.95m against planned £7.91m. The adverse variance of £3.96m is predominantly attributable to NHS debtors being significantly higher than plan (£9.4m), offset by favourable variances in other areas of working capital (£5.44m).

Total NHS debtors of £13.72m consists of outstanding clinical activity income invoices (£793k), un-invoiced accruals in respect of STF funding (£7.5m),
clinical activity income (£92k), and other miscellaneous charges etc (£5.34m).The £7.5m in respect of the STF funding relating to 16/17 has since been received in July.

The favourable variance in respect of deferred income is due to the receipt of an advance payment of £3m by Sunderland CCG relating to the July charge in respect of Clinical Activity. The advance of funds was requested by the Trust to help ease its current cash flow situation.



The graph above shows the Trust's forecast cash position to March 2018. The graph shows the monthly cash balances submitted as part of the Annual Plan, the revised plan based on current information and the best and worst case scenarios.

The increase in July reflects the settlement of the additional Q4 STF funds (£4,904k) that was not included within the original forecast, capital expenditure being ahead of plan (£700k) and higher than planned working capital balances (£4,252k).

The best case scenario assumes achievement of the control total and CIP targets plus contingency built into the capital programme not being fully required, additional PDC in respect of A&E (875k) and a VAT refund from HMRC (£926k) relating to a number capital schemes transferred from CHS to CHoICE that became eligible for Capital Goods Scheme relief. The worst case scenario includes an underachievement of the CIP target and non-achievement of one quarter STF.

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

6 CAPITAL

Capital spend to date is behind plan, mainly due to delays in receipt of central funding for Global Digital Exemplar. This funding has now been received in July so it is expected that capital costs will be in line with plan for 2017/18.

7 RISKS

The current financial position poses a significant risk in the Trust not achieving 2017-18 control total. In turn this will impact the cash receipt of STF funding and give the organisation a genuine risk of running out of cash this financial year.

The two prime risks are firstly, the gap in CIP plans, secondly under performance against PbR contracts with commissioners and the challenge in pulling like for like costs from the system.

8 FORECAST

Despite the current financial position the Trust still believes that it can achieve the required control total for 2017/18.

The Trust is working closely with all commissioners to understand their QIPP plans and the knock on impact to us as a provider, it is essential that costs are removed to mitigate these income reductions.

9 NEXT STEPS

The Trust needs focus on identifying £800k of CIPs to achieve its full £13m CIP target for 2017/18.

In addition to closing the CIP gap the Trust needs to ensure flexibility to remove costs if income volumes continue to show a downward trend.

Next steps on 'closing the gap options' are to be discussed at this months Finance and Performance Committee.

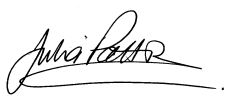
10 SUMMARY

The overall position at the end of June including STF, is a deficit of £5,384k compared to a planned deficit of £2,718k or £2,666k behind plan. The position excluding STF is £1,672k behind plan.

11 RECOMMENDATIONS

The Board is requested to:

- Note the financial position to date.



Julia Pattison
Executive Director of Finance
July 2017

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

Income & Expenditure Position

	Annual	Current Month			Year to Date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
£m	£m	£m	£m	£m	£m	£m	£m
Income							
NHS Clinical income	-313.58	-27.17	-26.39	0.78	-78.53	-77.97	0.56
PBR Clawback/relief	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Private patient income	-0.35	-0.03	-0.03	0.00	-0.09	-0.09	-0.01
Non-patient income	-37.29	-2.32	-2.54	-0.22	-8.36	-7.58	0.78
Total income	**-351.21**	**-29.52**	**-28.95**	**0.57**	**-86.97**	**-85.64**	**1.33**
Expenses							
Pay Costs	214.60	17.96	17.854	-0.10	53.834	53.897	0.06
Drug costs	38.12	3.19	3.53	0.33	9.58	10.01	0.42
Other Costs	89.03	7.44	8.06	0.62	22.48	23.21	0.74
Total costs	**341.76**	**28.59**	**29.44**	**0.85**	**85.89**	**87.11**	**1.22**
Earnings before interest, tax, depreciation & amortisation (EBITDA)	**-9.45**	**-0.93**	**0.49**	**1.42**	**-1.082**	**1.472**	**2.55**
Profit/loss on asset disposal	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Depreciation	8.35	0.70	0.74	0.05	2.09	2.25	0.16
PDC dividend	5.02	0.42	0.38	-0.04	1.26	1.15	-0.11
Interest	1.83	0.15	0.17	0.02	0.46	0.52	0.06
Corporation tax	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net surplus (pre exceptionals)	**5.74**	**0.34**	**1.78**	**1.45**	**2.72**	**5.38**	**2.67**
Exceptional items							
Net (surplus)/Deficit (post exceptionals)	**5.74**	**0.34**	**1.78**	**1.45**	**2.72**	**5.38**	**2.67**

EBITDA Margin	**2.7%**	**3.1%**	**-1.7%**		**1.2%**	**-1.7%**

CITY HOSPITALS SUNDERLAND FOUNDATION TRUST
TRUST PERFORMANCE SUMMARY

PERIOD ENDED 30TH JUNE 2017

TRUST SUMMARY

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

	Annual Budget £'000s	Apr actual £'000s	May actual £'000s	June actual £'000s	Quarter 1 £'000s	YTD actual £'000s	Plan £'000s	Variance £'000s
Income								
Contract Income	(313,575)	(26,376)	(25,207)	(26,387)	(77,970)	(77,970)	(78,528)	558
STF	(9,237)	(462)		462			(1,386)	1,386
Private Patients	(345)	(7)	(61)	(25)	(93)	(93)	(86)	(7)
Training and Education Income	(11,499)	(958)	(947)	(970)	(2,875)	(2,875)	(2,875)	
Research and Development Income	(1,476)	(135)	(98)	(136)	(370)	(370)	(369)	(1)
Other income	(15,035)	(1,029)	(1,369)	(1,932)	(4,330)	(4,330)	(3,719)	(611)
Interest Receivable	(43)	(20)	(19)	34	(4)	(4)	(11)	7
Total Income	**(351,210)**	**(28,987)**	**(27,702)**	**(28,954)**	**(85,643)**	**(85,643)**	**(86,974)**	**1,331**
Expenditure								
Pay	214,604	17,923	18,119	17,854	53,897	53,897	53,834	63
Clinical Supplies and Services	32,431	2,706	2,588	3,018	8,312	8,312	8,183	129
Drug Costs	38,124	3,147	3,331	3,527	10,005	10,005	9,581	424
Other Costs	56,598	5,011	4,849	5,041	14,901	14,901	14,294	607
Depreciation	8,348	590	915	742	2,247	2,247	2,087	160
PDC Dividend	5,022	383	383	383	1,149	1,149	1,256	(107)
Interest	1,827	155	189	172	516	516	457	59
Total Expenditure	**356,955**	**29,915**	**30,374**	**30,738**	**91,027**	**91,027**	**89,692**	**1,335**
(Surplus)/Deficit	**5,745**	**928**	**2,672**	**1,783**	**5,384**	**5,384**	**2,718**	2,666
Cost Improvement Plans	(13,000)	(700)	(789)	(775)	(2,264)	(2,264)	(2,598)	334
WTE Analysis (WTEs)								
Total WTEs	**4,918.47**	**4,766.26**	**4,796.29**	**4,755.77**	**4,755.77**	**4,755.77**	**4,918.47**	**-162.70**

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST
STATEMENT OF FINANCIAL POSITION - JUNE 2017

Assets	**Plan As At 31-Jun-17 £m**	**Actual As At 31-Jun-17 £m**	**Variance £m**
Assets, Non-Current:			
Intangible Assets	4.338	4.685	
Property, Plant and Equipment	217.596	189.616	
Trade and Other Receivables	0.918	1.145	
Assets, Non-Current, Total	222.852	195.446	
Assets, Current:			
Inventories	5.900	5.730	0.170
Trade and Other Receivables:			
NHS Trade and Other Receivables	4.325	13.716	-9.391
Non NHS Trade and Other Receivables	5.341	6.423	-1.082
Trade and Other Receivables, Total	9.666	20.139	
Cash and Cash Equivalents:			
Government Banking Service & Invested	7.516	2.614	
Commercial Bank account	0.400	1.340	
Cash and Cash Equivalents, Total	7.916	3.954	
Assets, Current, Total	23.482	29.823	
ASSETS, TOTAL	**246.334**	**225.269**	

Liabilities

Liabilities, Current:			
Interest-Bearing Borrowings, Total			
Loans, non-commercial, Current (DH, FTFF, NLF, etc)	-3.273	-3.273	0.000
Interest-Bearing Borrowings, Total	-3.273	-3.273	
Deferred Income	-1.800	-4.846	3.046
Provisions	-0.212	-0.240	0.028
Trade and Other Payables:			
Trade Payables, Current	-25.899	-28.394	2.495
Other Financial Liabilities	-1.779	-1.633	-0.146
Capital Payables, Current	-0.648	-0.937	0.289
Trade and Other Payables,Total	-28.326	-30.964	
Liabilities, Current, Total	-33.611	-39.323	
NET CURRENT ASSETS (LIABILITIES)	-10.129	-9.500	
Liabilities, Non-Current			
Interest-Bearing Borrowings:			
Loans, Non-Current, non-commercial (DH, FTFF, NLF, etc)	-52.492	-52.492	0.000
Loans, Non-Current, commercial	0.000	0.000	0.000
Interest-Bearing Borrowings,Total	-52.492	-52.492	
Provisions, Non-Current	-0.869	-0.794	-0.075
Liabilities, Non-Current, Total	-53.361	-53.286	
TOTAL ASSETS EMPLOYED	**159.362**	**132.660**	

Taxpayers' and Others' Equity

Taxpayers' Equity			
Public Dividend Capital	102.042	99.542	
Retained Earnings	-17.764	-19.736	
Revaluation Reserve	75.084	52.854	
TAXPAYERS' EQUITY, TOTAL	**159.362**	**132.660**	
	0.000	0.000	

Clinical Income Report Overview

Table 1: Financial Position (M1-3) per Commissioner agreed Contracts and the NHSI plan

Commissioner contracts	Plan as per NHSI	Plan as per PbR	Total Actuals	Variance as per NHSI	Variance as perPbr	% Against PbR	% Against NHSI
	£'000s	£'000s	£'000s	£'000s	£'000s		
Sunderland	43,990	43,990	43,990	0	0	0.0%	0.0%
South Tyneside	5,907	5,907	5,907	0	0	0.0%	0.0%
Gateshead	1,077	1,183	1,029	154	48	15.0%	4.7%
Sunderland LA	601	601	601	0	0	0.0%	0.0%
DDES	8,831	9,462	8,854	608	-23	6.9%	-0.3%
North Durham	4,169	4,269	3,894	375	275	9.6%	7.1%
HAST	865	921	873	48	-8	5.5%	-0.9%
South Tees	63	63	55	8	8	15.3%	15.3%
Specialised	8,960	8,960	8,758	202	202	2.3%	2.3%
Dental	1,530	1,530	1,448	82	82	5.7%	5.7%
Sub total	75,993	76,886	75,409	1,477	584	2.0%	0.8%
Cancer Drug Fund	429	429	452	-23	-23	-5.1%	-5.1%
Hep C drugs	244	244	485	-241	-241	-49.7%	-49.7%
NCA's	832	832	916	-84	-84	-9.2%	-9.2%
AQP - all contracts	269	269	245	24	24	9.6%	9.6%
GAP/Stretch target	428	-466	0	-466	428	0.0%	0.0%
Other	334	334	463	-129	-129		
Total	78,528	78,528	77,970	558	558	0.7%	0.7%

The clinical income target to end month 3 is £78,528k with actual income reported as £77,970k. Therefore the trust is reporting an under performance against the Clinical Income budget of £558k. As per last year, there are differences at Commissioner level between final agreed PbR plans and NHSI plan. This is due to QIPP targets that have been removed from the majority of CCG plans for which the trust had no evidence of achievability.

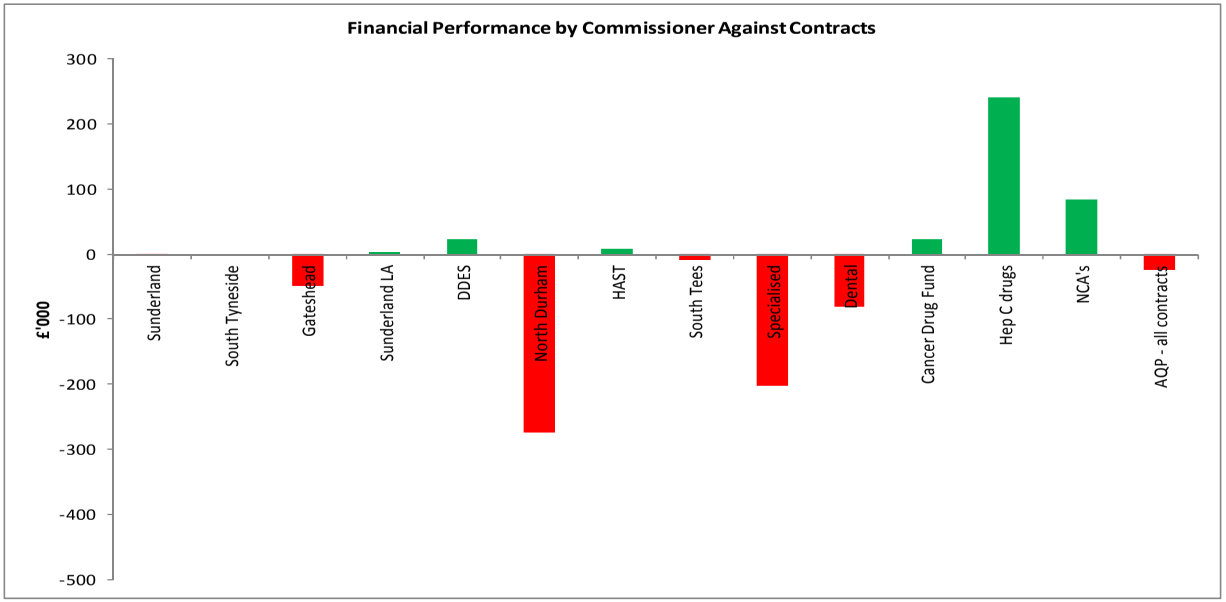
Block arrangements with Sunderland CCG, Sunderland Local authority and South Tyneside CCG for 2017/18, means that income is fixed regardless of under or over performance. Table 1 includes assumed activity for a Contract Variation (CV) between CHS and STFT for the transfer of stroke activity (this increases STCCG budget and actual by the transferred activity). This and several other adjustments were shown in the 'other' category in month 2 but have been moved to the appropriate commissioner line in month 3.

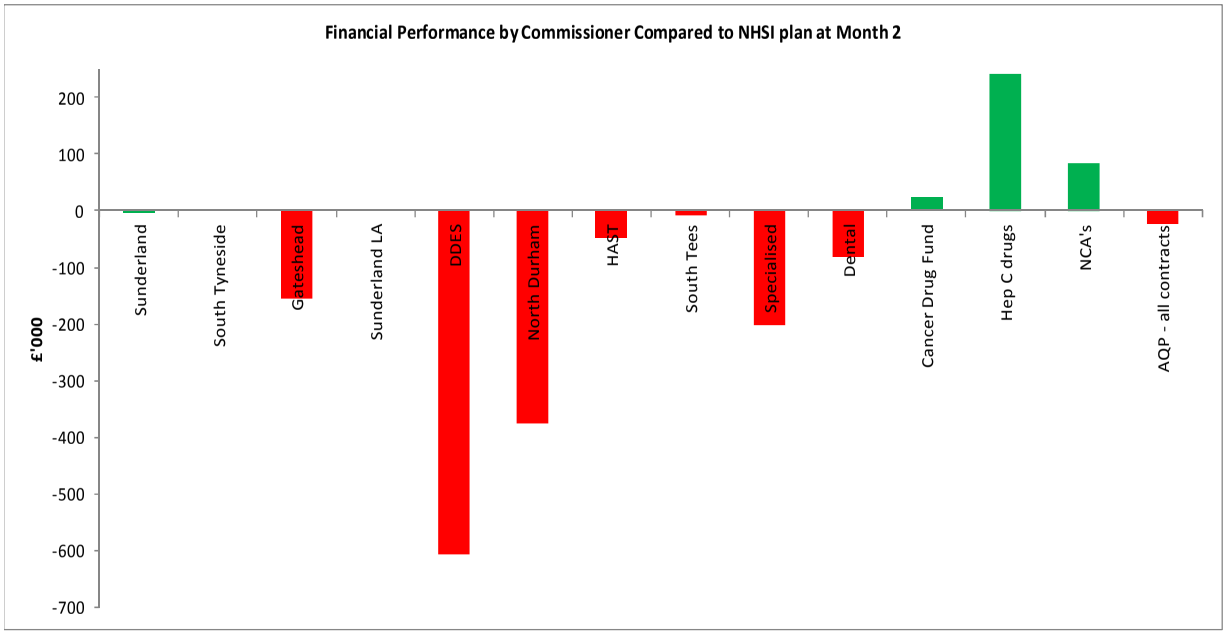
An under performance against NHS Specialised commissioners of £202k will be explored in further detail later in the report.

The Clinical income actuals are based on M2 PbR files with the exception of drugs income which is directly matched to expenditure for month 3. Regular activity and finance meetings are held with the CCGs where challenges and/or risks are discussed and where appropriate and these have been built into the position.

Significant movement by commissioner and point of delivery is explained on the following page.

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





Summary of main PbR variance by commissioner

Sunderland CCG : This contact is block for 17/18 so we report a nil variance. If PbR was to be transacted it would show a £392k under performance. This is largely due to maternity pathway and elective under performance within obstetrics, ophthalmology and general surgery.

South Tyneside CCG : This contract is also a block for 2017/18, so we are reporting a nil variance. However, if the PbR was to be transacted, there would be an over performance of £334k; this predominately due to stroke activity transferred from STFT but not yet formally transferred into the contract and since avastin was commissioned (not the current, more expensive Lucents drug) but not yet clinically used. Once the Stroke CV is transacted, this over-performance would reduce.

North Durham CCG : Reporting an under performance of £275k against plan. This is an increase in activity vs M1 but underperformance remain in multiple specialities and POD's especially urology day cases and outpatient procedures (Lucentis).

DDES CCG : Reporting an over performance of £23k against plan. This is due to the non-implementation of QIPP schemes and a slight over recovery of high cost drugs (linked to expenditure).

NHSE Specialised: Reporting an underperformance of £202k against plan. This will be examined further in the report

NHSE Dental – Under performance of £82k due to elective and day case activity being under plan

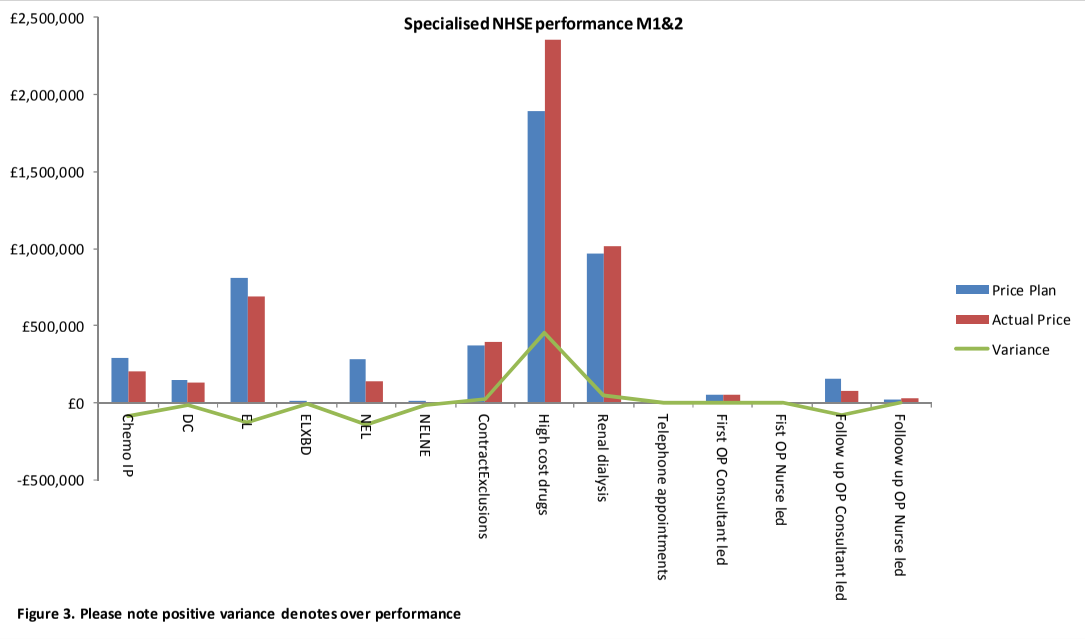


Figure 3. Please note positive variance denotes over performance

Risk to income

As yet, no significant risks have been built into the income position. We are reporting PbR and blocks where relevant.
We have received challenges from all commissioners and where appropriate these have been built into the financial position. Drugs challenges have not been material which is an improvement on last year. CDF drugs which need to be allocated to NHSE (due to becoming NICE approved) as could charges to NHSE that should be CDF could be a risk if not captured and charged to commissioners as could charges to NHSEin a timely manner. Also there is a risk of non-payment for oncology activity, we are in communication with NHSE to mitigate this risk
It has been assumed that CQUIN is in line with plan, which could be a risk bearing in mind current under-performance. A provision for MRSA and cancelled operations penalties incurred to date (but not yet transacted) has been made
There are several contract variations which impact the trust income & cash position. These were identified in last month's board report and will be adjusted when transacted.

NHSE Specialised activity performance M1&2

NHSE (adjusting for known challenges) is currently underperforming by £202k. As figure 3 shows, the main area of over performance is high cost drugs where NHSE 'QIPP' plans are gradually being achieved.

Drugs are direct pass through costs and will be linked to expenditure. There are several changes where some drugs have been removed from the cancer drug fund and become NICE approved (mid-month). We have informed NHSE and will charge for these drugs, however, there may be a risk regarding timing.

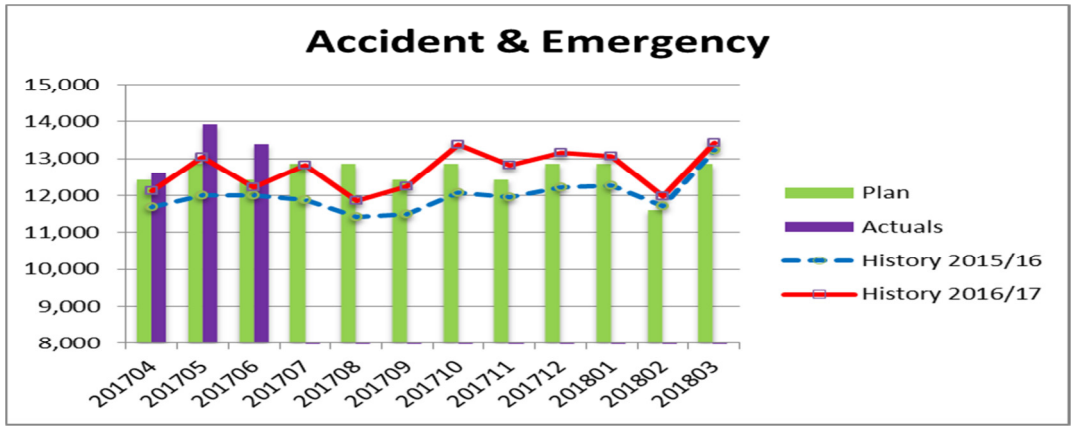
Chemo IP's are an area of underperformance which is causing some contention with commissioners. A new oncology module was implemented at the back end of last financial year (at the request of NHSE) which resulted in a back log of coding this activity. This is likely to increase chemo IP for NHSE when coded and also increase activity to CCG's.
Elective and day case activity is under performing in vascular, specialised ophthalmology plus a high plan within cardiology that may not be achievable.

First OP attendances are close to plan but we are under performing in follow up appointments. This is particularly evident within Oncology which was highlighted last month as a specialty with a particularly low new to review ratio.

There is also an over performance within renal dialysis. We have been discussing this with commissioners as the contract was increased by £90k to cover increased activity in this area due to increased home dialysis usage.

The intention is to reconcile financial positions with NHSE on a quarterly basis alongside CCGs. This should ensure triangulation between all commissioners therefore minimising the risk that the trust will be penalised financially for commissioner differences.

Accident & Emergency



Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
A&E Attendances	**37,751**	**39,952**	**37,400**	**2,201**	**2,552**
Type1	21,462	23,173	21,741	1,711	1,432
Type2	8,305	8,193	7,990	-112	203
Type4	7,985	8,586	7,669	601	917
Grand Total	**37,751**	**39,952**	**37,400**	**2,201**	**2,552**

The new ED footprint opened on June 8th 2017. While Type 1 attendances did not reach the levels they reached in May, the number of attendances and subsequent admissions hit peak numbers on certain days – hitting a maximum of 308 attendances on June 14th. Prior to new ED opening, the average number of Type 1 attendances was 248 per day, which rose to 259 per day post ED opening. Monday continues to be the busiest day in Type 1, with an average of 290 attendances compared to an average of 251 attendances Tues – Sun.

Despite the high volume of attendances, performance measures relating to ambulance handover delays has improved, decreasing from an average of 3 per day in May and early June, to 1 per day post ED opening. The number of delays post ED hit the lowest level since May 2016.

As highlighted last month, attendances at Pallion for Durham patients has been increasing due to change in provision in MIU services in Peterlee and Seaham. Attendances from SR7/SR8 postcodes between April and June have increased 45% over Jan – March. Any over performance on these contracts will be on a PbR basis.

A&E activity is 6.8% above historical levels and 5.8% above plan. Type 1 A&E (main site) is 7.9% above plan; Type 2 (Eye Infirmary) is 1.3% below plan and Type 4 (Pallion) is 7.5% above plan.

In June, SEI has seen the highest number of attendances in 17/18 with an increase of 279 attendances over April.
For both Main Site and Pallion, June's attendances were lower than May, but still 619 and 222 attendances over the monthly plan respectively.

Type 1 and Type 4 (CHS site) planned attendances have been commissioned at a level 2,731 below 16/17 outturn, and 8,464 under the Trust forecast for 17/18. A&E has experienced growth in attendances year on year, which Commissioners have chosen not to recognise in 17/18.

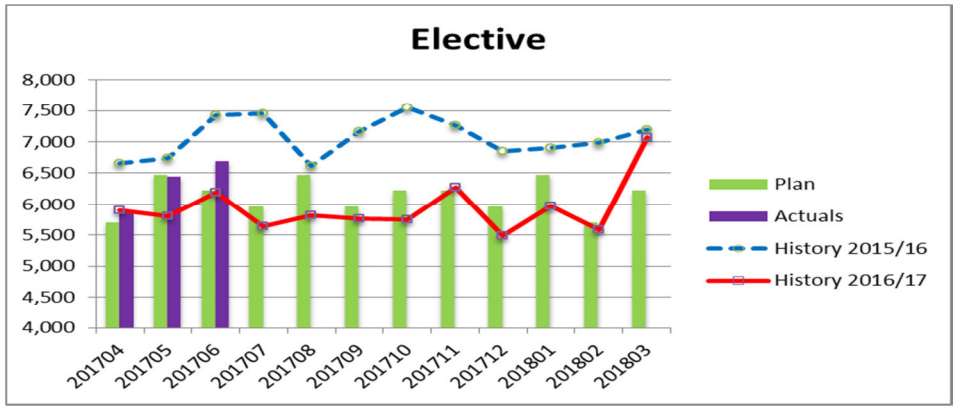
Sunderland CCG is the main commissioner of A&E activity with 79.8% of the contract. As this contract is blocked, there is a financial risk to over performing against plan if attendances continue at this level.

Conversely, the plan for SEI A&E has been commissioned at 1,988 above 16/17 actuals, which is 919 over the Trust recommendation for 17/18.

There is concern over the recent closure of the out of hours Eye Casualty at CDDFT. The impact of this on SEI is to be worked through. Any over performance on this contract is due to DDES CCG, therefore will be on a PbR basis.

Position for Activity by POD (Month 3)

Elective



Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
Clinical Haematology	1,379	1,872	1,370	493	502
Ophthalmology	3,453	3,733	3,444	280	289
Respiratory Medicine	442	505	458	63	47
Medical Oncology	1,620	1,676	1,187	56	489
Paediatrics	99	153	120	54	33
Nephrology	165	210	162	45	48
Neurology	183	218	211	35	7
Pain Management	218	245	222	27	23
Diabetic Medicine	13	39	18	27	21
Endocrinology	56	72	55	16	17
Gynaecology	431	446	414	15	32
Geriatric Medicine	16	25	9	9	16
Accident & Emergency	74	79	92	5	-13
Rehabilitation	4	6	6	3	0
Well Babies	1	3		2	3
Obstetrics	26	27	19	1	8
Rheumatology	342	335	393	-7	-58
Upper Gastrointestinal Surgery	43	21	45	-22	-24
Trauma & Orthopaedics	1,441	1,414	1,450	-27	-36
Gastroenterology	1,522	1,494	1,446	-28	48
ENT	1,085	1,047	1,098	-38	-51
Oral & Maxillo Facial Surgery	1,283	1,225	1,312	-58	-87
Cardiology	570	504	465	-66	39
Vascular Surgery	434	349	440	-85	-91
General Surgery	1,457	1,372	1,483	-85	-111
Urology	2,060	1,931	1,994	-129	-63
Grand Total	**18,416**	**19,001**	**17,913**	**585**	**1,088**

Elective Spells Summary

Elective activity is up 1,088 spells (6%) vs 16/17 history and also up 585 spells (3.2%) vs plan. The reason for what looks to be a large underperformance against 15/16 history on the graph was the reclassification of Lucentis injections in Ophthalmology from daycases to OP procedures from 16/17

Activity appears to be climbing back up to 15/16 levels due to the increase in the numbers of recorded procedures following the implementation of the Oncology module in V6 (see Specialty focus below).

Ophthalmology activity has increased significantly in June, however this corresponds to a decrease in OP Procedures, and is being validated.

Urology continues to underperform in June against plan and history. Analysis of referrals shows that there has been a decrease since the start of the year

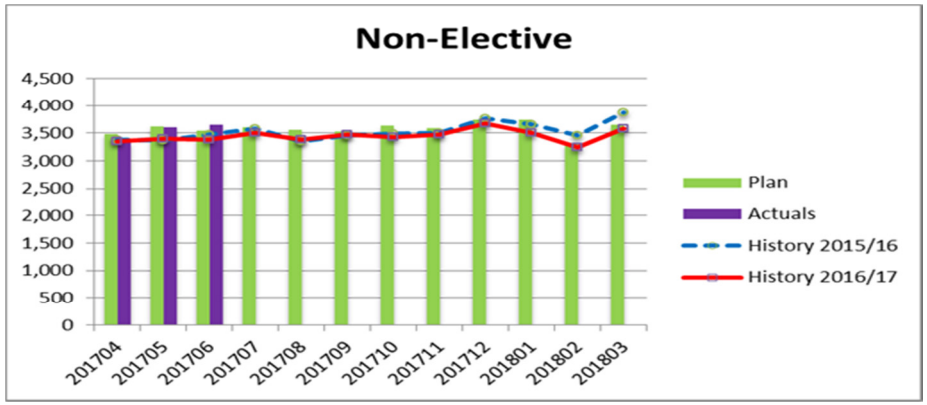
Specialty in focus – Clinical Haematology

Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
Clinical Haematology	**1,379**	**1,872**	**1,370**	**493**	**502**
NHS SUNDERLAND CCG	662	1,086	810	424	276
NHS DURHAM DALES, EASINGTON AND SEDGEFIELD CCG	86	210	82	124	128
NHS SOUTH TYNESIDE CCG	70	125	68	55	57
NHS NEWCASTLE GATESHEAD CCG	21	65	17	44	48
NHS NORTH DURHAM CCG	16	29	23	13	6
NON CONTRACT ACTIVITY	2	8	2	6	6
NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG	1	5		5	5
NHS SOUTH TEES CCG	0	0		0	0
CUMBRIA AND NORTH EAST COMMISSIONING HUB	522	344	368	-178	-24
Grand Total	**1,379**	**1,872**	**1,370**	**493**	**502**

There is a significant over performance over both plan and history for Clinical Haematology, which is due to a change in recording as a result of implementing the new Oncology module in V6. Some of this activity is expected to be removed to Ward Attenders. The current process is also leading to a backlog in coding, which means that the activity cannot be allocated to the relevant commissioner in a timely manner. As default these are showing against Sunderland CCG but it is expected that the majority of these spells will move to NHS England.

Position for Activity by POD (Month 3)

Non Elective

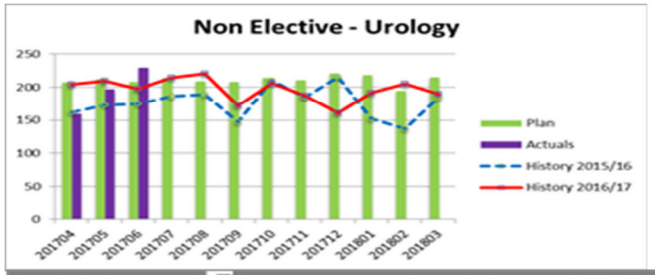


Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
Geriatric Medicine	1,439	1,638	1,542	199	96
Endocrinology	147	245	158	98	87
Respiratory Medicine	420	506	454	86	52
Obstetrics	4	40	25	36	15
Clinical Haematology	85	119	88	34	31
Cardiology	788	813	796	25	17
Gastroenterology	488	507	491	19	16
Pain Management	11	28	11	17	17
Well Babies	2	16	2	14	14
Medical Oncology	14	21	32	7	-11
Ophthalmology	139	142	144	3	-2
Rehabilitation	19	22	26	3	-4
Neurology	18	20	26	2	-6
Oral & Maxillo Facial Surgery	92	92	79	0	13
Upper Gastrointestinal Surgery	0	0		0	0
Critical Care Medicine	0	0		0	0
General Medicine	1	0		-1	0
Diabetic Medicine	146	140	165	-6	-25
Rheumatology	16	9	7	-7	2
Vascular Surgery	71	62	75	-9	-13
Gynaecology	288	278	264	-10	14
Nephrology	291	275	290	-16	-15
ENT	400	376	424	-24	-48
Urology	628	587	610	-41	-23
Trauma & Orthopaedics	628	559	598	-69	-39
Accident & Emergency	2,247	2,154	2,071	-93	83
Paediatrics	1,075	919	506	-156	413
General Surgery	1,226	1,044	1,252	-182	-208
Grand Total	**10,683**	**10,612**	**10,136**	**-71**	**476**

Non Elective Spells Summary

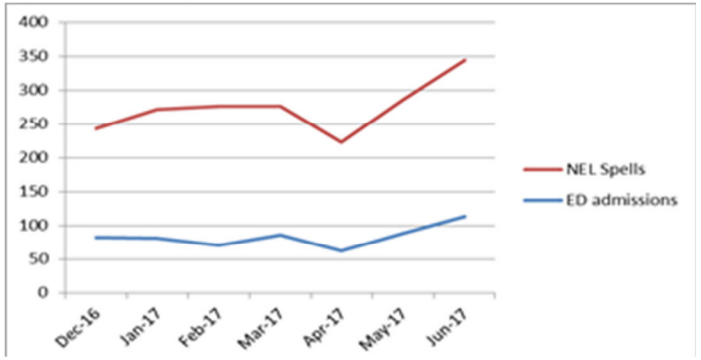
Non Elective activity is up 476 spells (4.7%) vs history and down 71 spells (0.7%) vs plan. The volume of activity in June has increased the YTD position as we were underperforming against plan at Month 2.
Geriatric Medicine continues to be the Specialty with the highest overperformance, due to the transfer of Stroke activity from S Tyne to CHS, which still needs the activity levels to be varied into the Contract.

Specialty in focus – Urology



Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
201704	208	160	204	-48	-44
201705	213	197	209	-16	-12
201706	208	230	197	22	33
Grand Total	**628**	**587**	**610**	**-41**	**-23**

Urology Non Elective activity has been steadily increasing, from an underperformance of 48 spells against plan in Month 1 to an over performance of 22 spells in Month 3. This is consistent with the rise in number of admissions from ED directly to Urology. Admissions directly to Urology from ED were 63 in April, 89 in May and 114 in June.



Position for Activity by POD (Month 3)

Consultant Led Outpatients

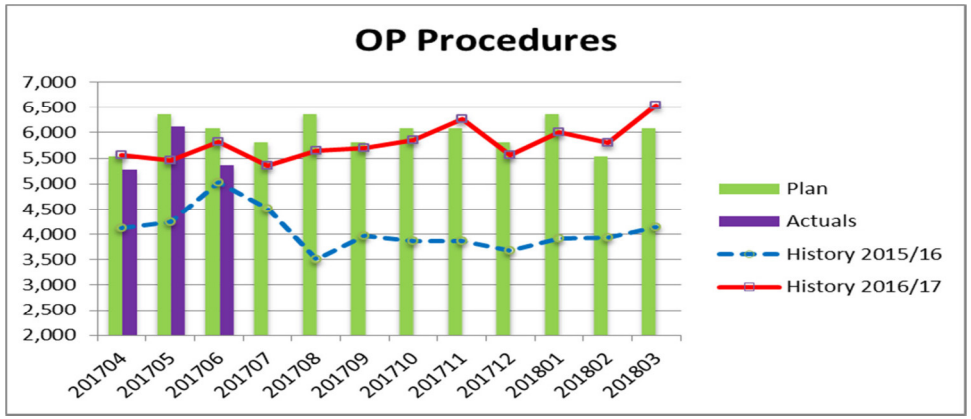
First Outpatient (consultant led) activity is 1,615 attendances (5.9%) below history and 1,928 attendances (6.9%) below plan. Specialties with the most significant variance against plan include Paediatrics, Nephrology, Upper Gastrointestinal Surgery and Vascular Surgery.

Review Outpatient (consultant led) activity is 2,914 attendances (5.5%) below history and 2,616 attendances below plan (5%). Specialties with the greatest variance against plan include Medical Oncology, Paediatrics, OMFS and Neurosurgery.

Row Labels	Plan	Actuals	Var Vs Plan	Var Vs Plan %	History 2016/17	Var Vs History
OP CONSULTANT LED - NEW	**27,847**	**25,919**	**-1,928**	**-7%**	**27,534**	**-1,615**
Emergency Care	932	956	24	3%	920	36
General Internal Medicine	2,159	2,138	-21	-1%	2,387	-249
General Surgery	2,144	1,694	-450	-21%	2,001	-307
Head & Neck	4,091	3,681	-410	-10%	4,035	-354
Medical Specialties	1,427	1,276	-151	-11%	1,445	-169
Obstetrics & Gynaecology	3,159	3,370	211	7%	3,232	138
Ophthalmology	3,427	3,086	-341	-10%	3,415	-329
Other	1	3	2	300%	2	1
Paediatrics	1,768	1,207	-561	-32%	1,437	-230
Rehab & Elderly Medicine	1,847	1,883	36	2%	1,859	24
Theatres	345	360	15	4%	359	1
Trauma & Orthopaedics	3,698	3,875	177	5%	3,765	110
Urology	2,849	2,390	-459	-16%	2,677	-287
OP CONSULTANT LED - REVIEW	**52,653**	**50,037**	**-2,616**	**-5%**	**52,951**	**-2,914**
Emergency Care	2,479	2,469	-10	0%	2,330	139
General Internal Medicine	5,517	5,609	92	2%	5,727	-118
General Surgery	3,217	3,499	282	9%	3,806	-307
Head & Neck	5,967	5,616	-351	-6%	5,894	-278
Medical Specialties	7,750	5,854	-1,896	-24%	7,398	-1,544
Obstetrics & Gynaecology	2,056	1,984	-72	-4%	2,100	-116
Ophthalmology	10,072	10,345	273	3%	10,250	95
Other	37	0	-37	-100%		0
Paediatrics	2,757	2,207	-550	-20%	2,754	-547
Rehab & Elderly Medicine	2,036	1,913	-123	-6%	1,958	-45
Theatres	547	506	-41	-8%	570	-64
Trauma & Orthopaedics	5,517	5,759	242	4%	5,710	49
Urology	4,701	4,276	-425	-9%	4,454	-178
Grand Total	**80,500**	**75,956**	**-4,544**	**-6%**	**80,485**	**-4,529**

Position for Activity by POD (Month 3)

Outpatient Procedures



Outpatient Procedures are 38 procedures below history (0.2%) and 1,224 procedures below plan (6.8%).

Specialties with the greatest variance against plan include Trauma & Orthopaedics, Ophthalmology and ENT.

Trauma & Orthopaedics are currently 235 procedures below plan (29.3%) and 34 procedures below history (5.7%). In a bid to improve data capture, work has been ongoing to update the booking out slip that is used within Trauma & Orthopaedics. This has resulted in a temporary mapping issue which in turn has brought about a reduction in activity in June. The Data Quality team are currently working to resolve this issue.

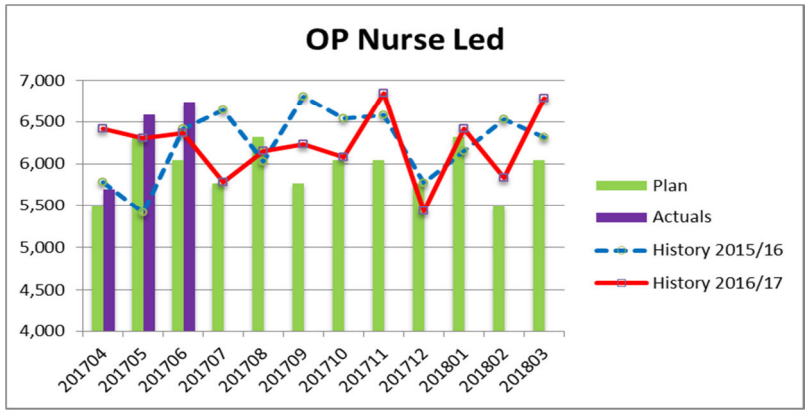
Ophthalmology is 1,039 procedures below plan (11.7%) and 344 procedures below history (4.2%). This is due to Commissioner's increasing their plans for 17/18, and a reduction in the number of procedures carried out, as mentioned above in relation to Elective activity.

ENT is currently 328 procedures below plan (10.5%) and 197 procedures below history (6.6%). Commissioners increased their plans in 17/18 to account for approximately 2,500 procedures that were incorrectly recorded in 16/17. Work is ongoing to ensure that procedures are correctly captured.

Row Labels	Plan	Actuals	Var Vs Plan	Var Vs Plan %	History 2016/17	Var Vs History
OP PROCEDURE	**18,013**	**16,789**	**-1,224**	**-7%**	**16,827**	**-38**
Accident & Emergency	30	38	8	25%	9	29
Anaesthetics	0	23	23	-	0	23
Breast Surgery	1	0	-1	-100%	0	0
Cardiology	231	245	14	6%	221	24
Clinical Neurophysiology	749	789	40	5%	716	73
Colorectal Surgery	64	64	0	1%	154	-90
Diabetic Medicine	0	16	16	-	0	16
ENT	3,126	2,798	-328	-10%	2,995	-197
Gastroenterology	1	0	-1	-100%	2	-2
General Surgery	28	18	-10	-36%	32	-14
Geriatric Medicine	2	0	-2	-100%	0	0
Gynaecology	942	931	-11	-1%	960	-29
Medical Oncology	1	2	1	79%	1	1
Nephrology	1	0	-1	-100%	0	0
Neurology	1	0	-1	-100%	0	0
Obstetrics	51	199	148	287%	225	-26
Ophthalmology	8,856	7,817	-1,039	-12%	8,161	-344
Oral & Maxillo Facial Surgery	470	420	-50	-11%	29	391
Orthodontics	228	296	68	30%	0	296
Paediatrics	88	77	-11	-12%	88	-11
Pain Management	0	1	1	-	1	0
Rehabilitation	0	0	0	-	0	0
Respiratory Medicine	16	13	-3	-19%	1	12
Rheumatology	168	308	140	83%	221	87
Stroke Medicine	0	0	0	-	0	0
Transient Ischaemic Attack	0	0	0	-	0	0
Trauma & Orthopaedics	801	566	-235	-29%	600	-34
Upper Gastrointestinal Surgery	0	1	1	-	9	-8
Urology	2,158	2,167	9	0%	2,400	-233
Vascular Surgery	0	0	0	-	2	-2
Grand Total	**18,013**	**16,789**	**-1,224**	**-7%**	**16,827**	**-38**

Position for Activity by POD (Month 3)

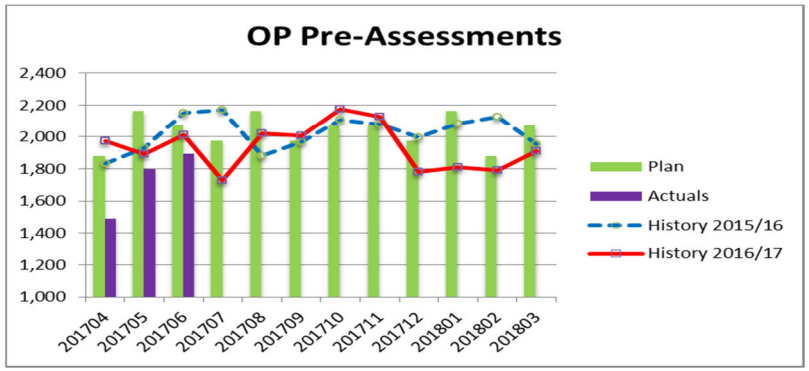
Other Outpatient Areas



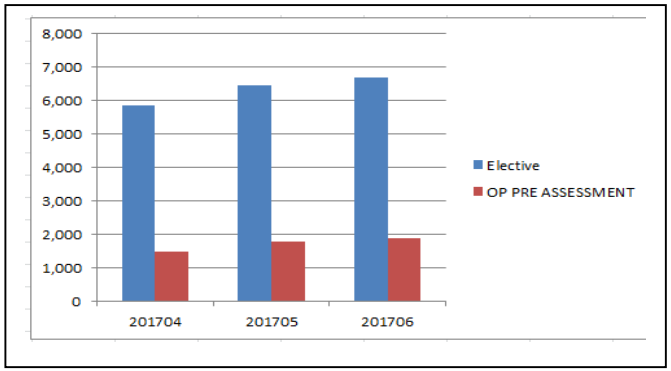
Non Consultant Led Outpatient activity is 69 attendances (0.4%) below history however 1,154 attendances (6.5%) above plan. Specialties with the greatest over-performance against plan include Rheumatology, Ophthalmology and Paediatrics.

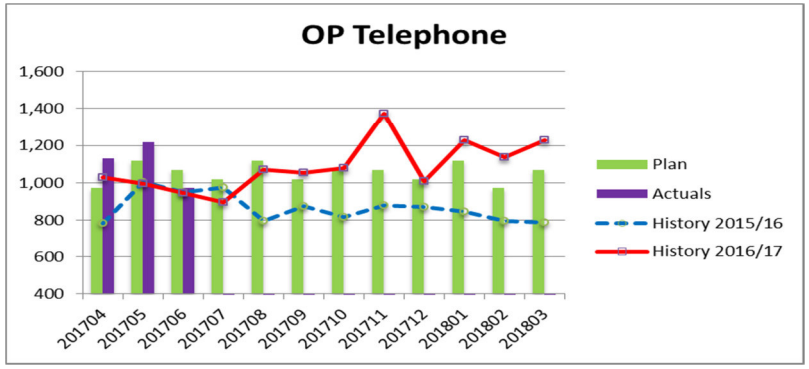
Rheumatology is currently 623 attendances above plan (70.1%). The over performance in Rheumatology is largely due to Commissioners contracting at levels well below outturn.

In contrast, the over performance in Ophthalmology is due to a clinic mapping error. Consequently, a considerable number of Pre-Assessments have been incorrectly recorded as Nurse Led attendances. The clinic mapping has since been corrected and changes will be reflected in next month's report.



Pre-Assessment activity is 937 attendances (15.3%) down against plan and 692 attendances (11.8%) down against history. The numbers of PAAC appointments are consistently in proportion to Electives. Not all Elective spells require PAAC.



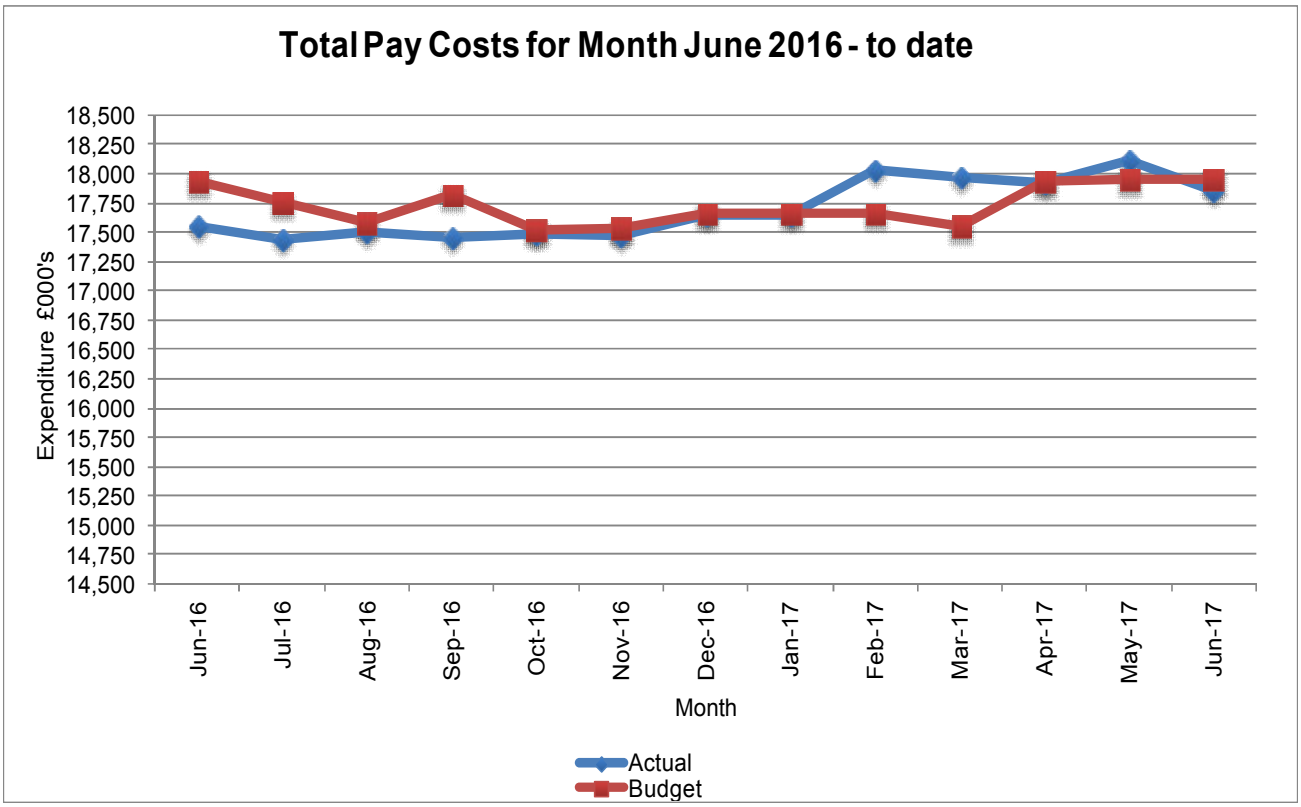


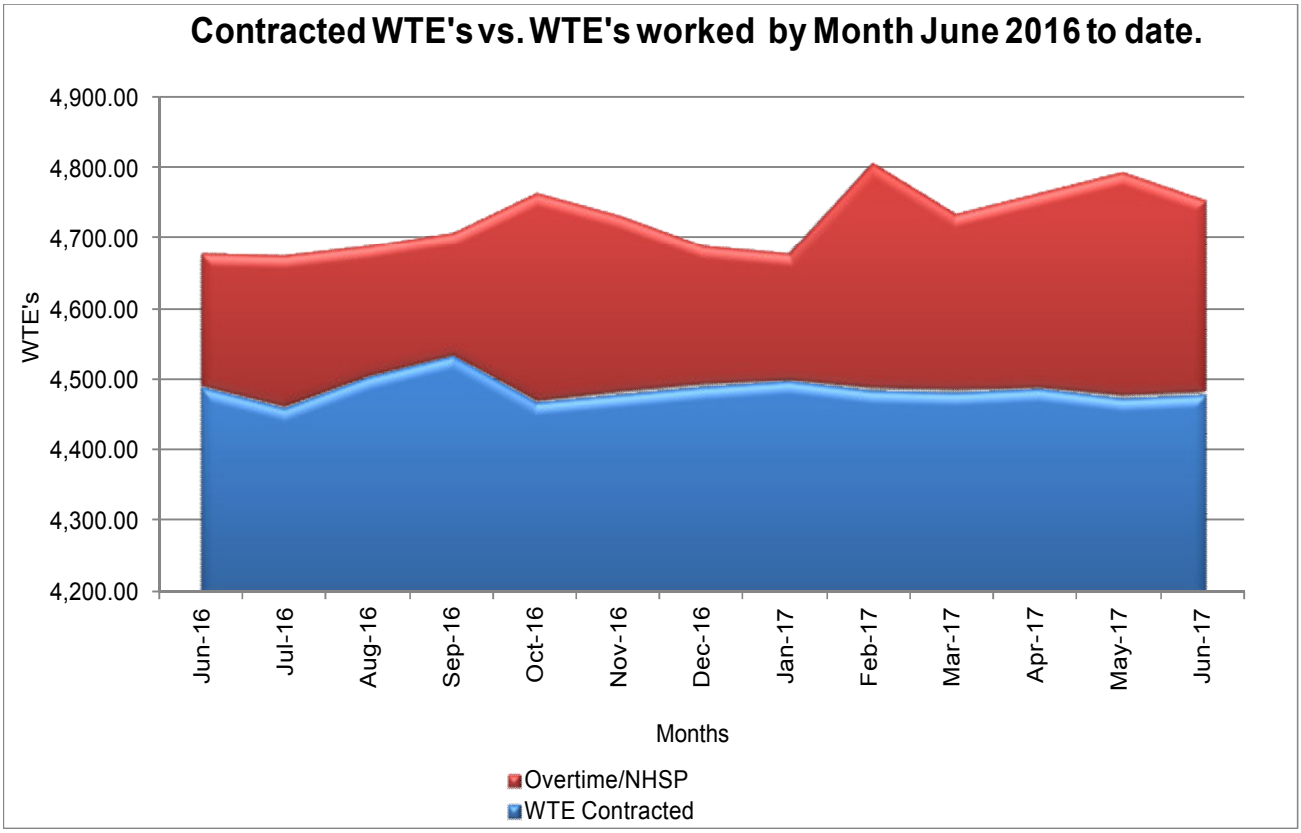
Non-Face to Face Outpatient contacts are 350 contacts (11.8%) above history and 160 contacts above plan (5.1%).

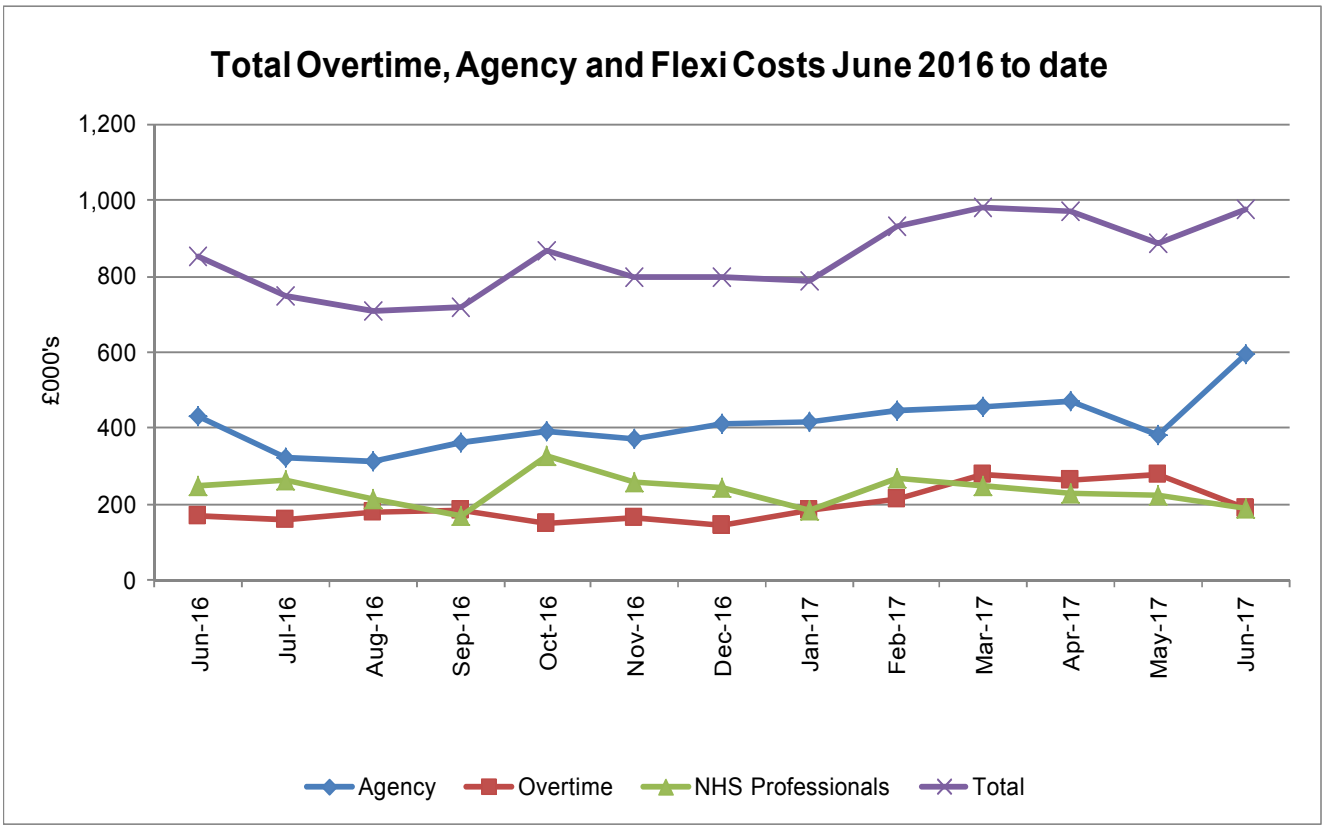
Specialties with the greatest variance against plan include Trauma & Orthopaedics, Gastroenterology and Genitourinary Medicine.

Commissioners have included planned contacts for areas such as Ophthalmology, who did not start to record telephone contacts until November 16, using the figures provided by DMs during the forecasting process.

Appendix 4


Total Pay Costs for Month June 2016 - to date
Expenditure £000's
18,500
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
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Month
Actual
Budget


Contracted WTE's vs. WTE's worked by Month June 2016 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
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Months
Overtime/NHSP
WTE Contracted



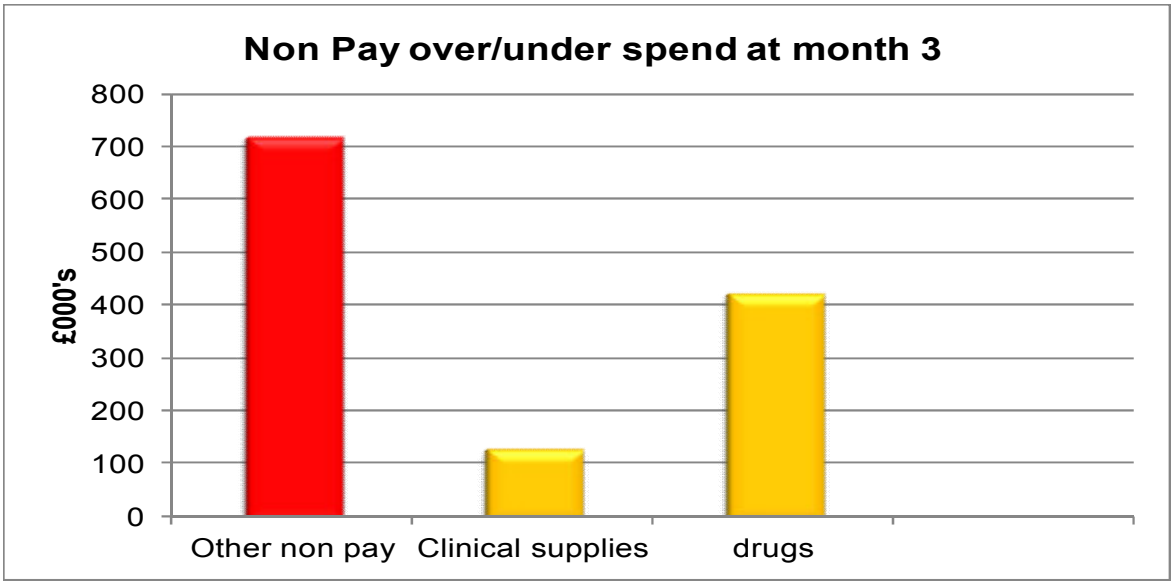
NHS Improvement Agency cap ceiling compliance City Hospitals Sunderland

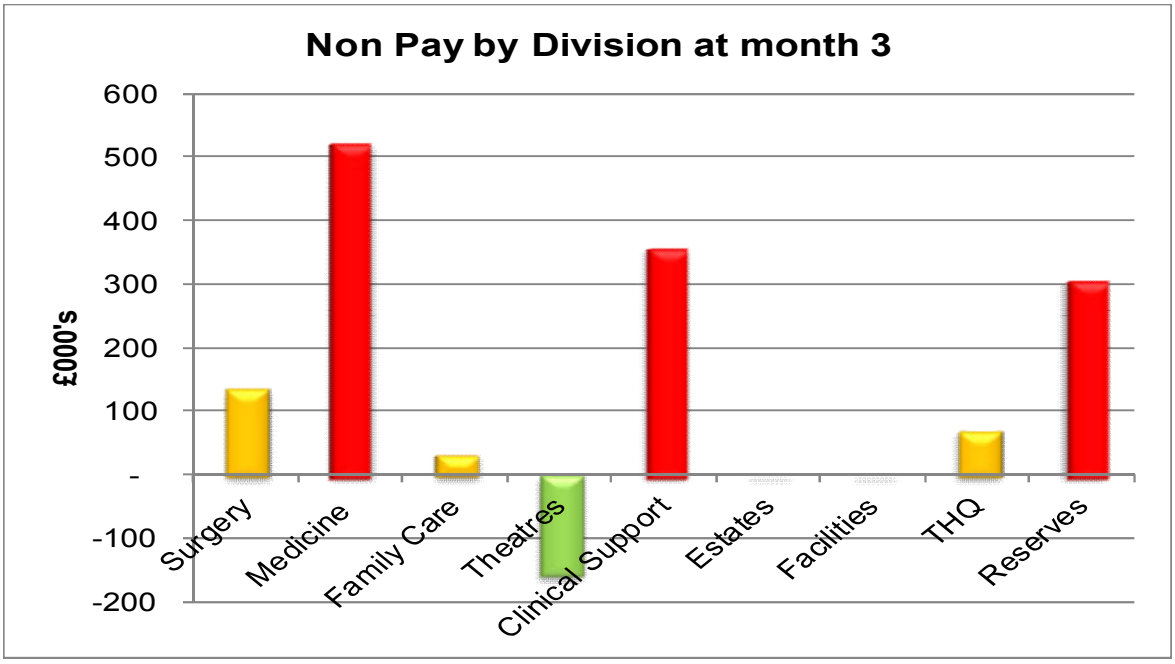
	Month Monthly Expenditure Ceiling £000s	CHS Annual Plan £000s	Actual in month agency cost £000s
Oct-16	497	417	390
Nov-16	497	417	373
Dec-16	485	407	412
Jan-17	461	387	416
Feb-17	461	387	449
Mar-17	460	386	457
Apr-17	516	357	473
May-17	516	357	386
Jun-17	516	357	594
Total	**4,410**	**3,471**	**3,950**

Key Issues on pay

- WTE numbers as at month 3 are 4,756, a decrease of 40 WTEs compared to the previous month. This is predominantly due an increase in the number of vacant nursing posts across the trust and lower Flexi Bank working in the month.
- Agency spend to June 2017 was £1,453k against a budget of £1,072k.
- 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 2017/18 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.

Appendix 5





Key issues on non-pay

- Drugs are £424k overspent against plan to date.
- Clinical Supplies is overspent by £129k due largely to CIP under delivery of £149k against plan to date.
- Other Non Pay is overspent by £607k against plan to date, most of which is due to a shortfall in CIP delivery to date of £234k against plan. A further overspends of £101k is due to offsite CT scans sent to Nuffield Hospital due to shortage of Radiographers at the Trust.

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 3

	Surgery	Theatres	Medicine	Family Care	Clinical Support	THQ Division	THQ Corporate	Gap	Total
Divisional CIP's 17/18 £000's	-2,003	-463	-1,515	-767	-833	-1,600	-5,233	-587	**-13,000**
Plan to date £000's	-450	-108	-371	-165	-126	-402	-975		**-2,598**
Actual to date £000's	-599	-191	-414	-175	-253	-388	-244		**-2,264**
Variance 17/18 £000's	-149	-83	-43	-10	-127	14	731		**333**
Variance %	33%	77%	12%	6%	101%	**-3%**	**-75%**		**-13%**

Key Issues with the CIP

To the end of June the planned savings are £2,598k actual savings for the period are £2,264k, and hence behind plan by £333k.

Headline CIPs

- Surgery's nursing vacancies CIP savings amounted to £234k against a target of £87k, and hence an over delivery of £147k to date.
- Medicine's CIP over delivery of £43k to date is due to a number of vacancies across the division especially within nursing posts.
- A number of vacant posts within Therapies and Diagnostics remains to date, and has contributed Clinical Support's over delivery of £127k against plan to date.
- Theatre's CIP over delivery of £83k is driven by vacant posts across all areas within Nursing and ODPs.
- Family Care's over delivery of £10k is driven by vacant posts across the division to date.
- THQ Division's under delivery of £14k to date is due to unidentified CIPs to achieve the 10% Corporate CIP savings in 2017-18.

CIP - original Annual Plan vs. actual delivery plan today

	Identified Plans	Stretch Target	Total per APR	This is as per Monitor Plan to Month 3 £	Actual to Month 3 £	Variance £
Revenue Generation	501	299	800	160	115	-45
Pay	5,282	1,718	7,000	1,398	1,607	209
Clinical Supplies	2,309	-809	1,500	300	151	-149
Drugs	787	213	1,000	200	85	-115
Other Non Pay	3,321	-621	2,700	540	306	-234
Depreciation			0			
Total £	**12,200**	**800**	**13,000**	**2,598**	**2,264**	**-334**