

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

There will be a meeting of the Board of Directors 'In Public' on
Thursday, 28 September 2017 at 1.15pm
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 July 2017 **Enc 1**

Matters Arising

- Item 2 Consultation Process **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** Freedom to Speak Up Guardian Annual Report **KG Enc 6**
- Item 7** Assurance Framework **JP Enc 7**
- Item 8** Safeguarding Children Annual Report **MJ Enc 8**

The following items are for information only and have been discussed at Audit Committee and Governance Committee which are formal sub-committees of the Board of Directors

- Item 9** Audit Committee Annual Report 2016/17 **Enc 9**
- Item 10** Mortality Review & Learning from Deaths Policy **Enc 10**

Date and Time of Next Meeting

Board of Directors meeting to be held 'In Public' on Thursday, 30 November 2017 at 3:30pm 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, 25 July 2017.

Present: John Anderson (JNA) - Chair
Ken Bremner (KWB)
Mike Davison (MD)
Davis Barnes (DB)
Pat Taylor (PT)
Alan Wright (AW)
Ian Martin (ICM)
Melanie Johnson (MJ)
Julia Pattison (JP)
Peter Sutton (PS)

Apologies: Stewart Hindmarsh (SH)
Mike Laker (ML)

In Attendance: Carol Harries (CH)
Sean Fenwick (SF)
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, 25 May 2017

Accepted as a correct record.

Matters Arising

Emergency Department: KWB advised that the first patients had been seen in the adult department on 8 June 2017. The additional works in paediatric ED had been completed and the final element, IAU had moved to its new location adjacent to ED the previous week. The facility was excellent – really good for patients and for staff, and all the ED staff, Estates and IT staff had worked hard to ensure everything was in place for it to be opened.

PT commented that her family had had to use the facility twice recently and the process had been extremely smooth. PT also stated that she felt the information boards were really good.

MD commented that the opening of the adult area had been delayed because of the cyber-attack and in his other role at Newcastle University there had been a talk given by an individual from GCHQ which had been extremely informative and our Board needed to be aware of the landscape and to understand the risks – denial of service, compromised systems and the ‘internet of things!’ MD stated that the issues needed to be in the top ten of our risks.

The Chairman queried whether STFT were in the same position as ourselves. KWB replied that they were and in some ways in a more difficult position as they had a multitude of systems etc. KWB stated that we needed to be clear about what we could tackle locally and regionally and what needed to be done nationally. AW queried whether the rising level of such issues was slowing down the approach to being paperless. KWB replied that he felt in some way it was helping and there was an STP bid proposal looking at the North East Care record. There was however, an issue of how it would be resourced at an NHS level – and nobody wanted an issue to paralyse the NHS. ICM commented that in terms of the immediate consequences of any threat that we had downtime procedures and they were regularly used and tested. DB stated that AuditOne had a programme of additional work regarding the interrogation of software.

3. Standard Reports

Item 2 Chief Executive’s Update

Consultation Process – KWB informed Directors that this had started on 5 July 2017 with three launch events. Over 300 people had attended the events and people had to book on to the events which had angered some individuals but was necessary to ensure that fire regulations etc. were not breached.

There had been to date 1000 hits on the website and 60 surveys responded to which was positive so early in the process. KWB advised that there would be a lull in August and the consultation process had been extended to October because of the holiday period. There were more issues being raised in South Tyneside as there was confusion between consultation and engagement. It was also important to remember that this consultation period was for both staff and members of the public. A range of options had been established and there was the opportunity for other options to be put forward.

KWB also stated that there had been concerns raised by some members of the public who were concerned that some of the events were dominated by staff members even though a number of staff briefings had been held as well.

KWB stated that the local MP in South Tyneside had written a formal letter to the joint overview and scrutiny committee asking for the consultation process to cease and a formal referral made to the Secretary of State. It was expected that there were no legal grounds on which consultation could be stopped and the Scrutiny Committee would be responding accordingly.

ICM commented that he had attended a South Tyneside event and there was a degree of angst and a number of mis-truths being stated by staff. The event was also quite an intimidating environment if someone was supportive of the options and how they could express that view. KWB stated that there were other means of gathering views such as email, surveys etc.

Winter – KWB advised that in NHS terms winter officially starts on 1 December 2017. Our plans had to be submitted by 8 September 2017. It was expected that there would be extra funds into social care to reduce delayed transfers of care.

There was also a focus on variation in practice and streaming in ED for which we had received £875k to support the process. We would also be looking at ambulance response times and expected further guidance on flu planning.

AW queried whether there was a danger that with a new ED we would see a larger flow in the winter. KWB replied that we had seen some drift already particularly from Durham because of changes in service. ED were still limited in capacity however because of staffing but flow was much better.

SF commented that we had had diverts already when another hospital was under pressure and we were doing some work with NEAS as we appear to get more ambulances than we should. MD suggested that winter starts in October not December. KWB confirmed that December is the NHS start of winter.

GMC Survey – KWB informed Directors that the GMC undertake a survey of junior doctors every year and this year we were the top North East acute Trust for training and 25th in the country. This was our highest ever achievement and a great success for the Trust and Cathy Emmerson our Director of Education and the training team. KWB commented that it was hoped that it would help with junior doctor placement but we also knew that the situation could change at any time.

There had been some surprises in the survey in ophthalmology and paediatrics – areas traditionally that have always been generally strong.

ICM commented that most of the domains scored well and one area was low because of work intensity.

STP dashboards – KWB informed Directors that the dashboards had been published – Durham had been rated as outstanding and the North East as advanced. STPs were ranked on three areas for assessment and Cumbria were to receive significant investment as they were now out of special

measures. The investment was £30/50m for radiotherapy/chemotherapy and would be linking to Newcastle.

CCG IAF ratings – The CCG ratings had been published and Sunderland had been rated as outstanding and South Tyneside were rated as good. There had also been some deterioration in ratings North of the Tyne.

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 patient story reflected a patient with learning disabilities whose specialist support had ensured a positive experience.

MJ informed Directors that there had been 36 pressure ulcers, which was a significant increase from the 19 reported in April largely due to an increased number of category 2 pressure ulcers. This figure took us back above trajectory which was disappointing given the previous good performance.

PS queried whether there was any 'soft' intelligence about the reasons for this. MJ replied that this had been discussed at Governance Committee and it was noted that community acquired pressure ulcers had come down so that the query was whether there had been some counting issues driving this change.

MD stated that whilst it might be a glitch, it was a future trend that we needed to keep an eye on. AW stated that this had also been discussed at PCPEC and should there be a new category because the patient was vulnerable. MJ replied that we were in a better position now with STFT and Community areas and also a research based project with the University was being undertaken which would help us.

MJ informed Directors that safeguarding referrals to Childrens Services had remained stable for the past 3 months. Further work was being undertaken in relation to the named doctor role which was currently vacant but it was hoped that good news was on the way. Twenty adult safeguarding referrals had been made to the LA during May 2017, an increase of 12 from the previous month.

A LeDer review had been undertaken and an action plan developed and multi-agency actions agreed. One of the issues was signage in the ED of the expected pathways/process. JP queried whether the signage had been addressed. MH replied that it had but access to that for people with learning disabilities was something that needed more development and some explanatory leaflets. AW commented that signage for patients with Alzheimer's was also improving.

MD queried figure 6 on page 6 and commented that previously there was a line for the LA response as there was previously a delay i.e. the gap between

the application and the response. MJ replied that it was now seven days to turn around and 14 days if it was complex whereas the gap at South Tyneside was about twenty five days. There was some audit work to be undertaken so that we could understand the position better.

MJ informed Directors that the fill rate for SRH was 92% and 94% for SEI. MJ advised that at the end of May there were 74.55 wte RN vacancies and 49.53 wte who were currently undergoing pre-employment checks. A positive employment event had been held at SRH as well as a recruitment trip to the Philippines. MJ commented that representation had been made to the NMC with regard to the English language test which was not only causing us problems but an issue across the country.

AW queried the comment that three staff were waiting for curtailment letters from UKUI because they had failed twice. MJ replied that they were working but not as registered nurses and were compliant with the immigration rules.

ICM reported that unfortunately there had been six cases of *C.difficile* and three were on surgical wards which would be looked at with rigour.

ICM also highlighted the MINAP report which was a national clinical audit of the management of heart attack. ICM stated that the clinical team had had problems with the process for data inputting, validation and upload which had impacted on the published results. ICM explained that cardiology had introduced a more robust data collection process and there was now a dedicated data clerk so we should see further improvement.

MD queried as to why it was only 2014/15 data being published now. ICM replied that this was a fairly common problem and recently GIRFT data presented was also two years out of date.

ICM also highlighted a recent patient safety alert which had required an amendment to the Trust's Drug Policy and a system of audit would also be incorporated into the Trust's Assurance Programme to look at this in more detail.

MD commented on the DH consultation on the early resolution scheme which had been discussed at Governance Committee which was potentially a risk financially. The outcome of the consultation would not be known until Autumn 2017.

Resolved: To note the report.

Item 4 Finance Report

JP presented the report and advised that the overall financial position was a net deficit of £5,384k against a planned deficit of £2,718k, and therefore £2,666k behind plan. The Trust had therefore failed the quarter 1 control total and was not liable for STF funding for £1,386k. JP explained that the net deficit included income for £419k as part of 2016/17 STF funding post

accounts reconciliation, and this was a late addition against the bottom line but not the control total. Therefore the financial position reported to NHSI was a net deficit of £5,776k, or £3,058k behind the planned NHSI control total to month 3. PT queried whether STF funding had gone forever. JP replied that it was possible to recoup the funding. JP also advised that clinical income was behind plan by £558k. JP stated that the detail and complexity was identified in appendix 3 and the true under performance was £1.1m which would be discussed in detail at Finance Committee the following Thursday. JP stated that the Trust had block arrangements in place with Sunderland CCG and South Tyneside CCG which ensured certainty in funding flows for the year, however PbR contracts with Durham and NHS England Commissioners were performing lower than expectations.

PT queried in terms of block contracts was there a risk share agreement as there were benefits with one and not with the other. JP replied that there was if there was a major change and a separate risk agreement not contractually driven.

JP stated that activity figures for months 1 and 2 were yet to be fully validated so they may change in the upcoming month.

JP advised that outpatients were £538k behind and elective activity was £500k behind across a number of specialties. Maternity was also behind by £250k. In Durham some demand management was in place which was having some impact in Urology.

JP also highlighted expenditure and non pay was overspent by £1.27m, £490k of which was CIP shortfall.

As at month 3, CIP delivery was under performing by £334k reflective of the unidentified CIP targets.

JP advised that this would be discussed in more detail at Finance Committee. PT queried whether the THQ corporate plan was now on track. JP replied that there was a savings target for each of us of 10% which was at various stages because of sequencing/timing issues.

DB commented that as the date of the Board meeting had been moved there had not been the opportunity to discuss in detail the finance report as Finance Committee was not being held until later that week. DB also stated that his concern was that for the first time CCGs were able to turn off the tap and consequently expenditure was relevant to reduction in receipt of funding as staffing levels could not be easily taken out. DB queried whether agency costs could be targeted and other contractors outside of the hospital. SF replied that he did not want to take staff out and the issue was more as to how we could flex what staff were doing i.e. switch activity. JP commented that the key was understanding the “why” and understanding the drivers and concepts etc.

DB queried whether agency payments were related to a busy part of the hospital. JP replied that it was more about covering gaps. ICM commented that if any payments were to be made over the agency cap then it was for him as Medical Director to sign off those payments.

JP informed Directors that the cash balance at the end of June was £3.95m against a planned £7.91m – the adverse variance of £3.96m predominantly attributable to NHS debtors being significantly higher than plan offset by favourable variances in other areas of working capital.

JP explained that the favourable variance in respect of deferred income was due to the receipt of an advance payment of £3m by Sunderland CCG relating to the July charge in respect of clinical activity. MD commented that the cash profile graph was really helpful and a deficit – best and worst graph might also be helpful. JP confirmed that it would be but at the moment it was difficult to judge. DB suggested that we probably needed clinical scenarios as well, and actions being taken by CCGs now seemed to be biting.

MD commented that in a nutshell it was how you managed conflicting objectives. JP replied that PMG was starting to look at that detail and AK had done a helpful piece of work in relation to performance targets and the financial benefit.

AW queried the VAT refund relating to a number of capital schemes, transferred from CHS to CHoICE and how we kept an overview. JP replied that there was a stakeholder representative which was currently herself. CHoICE were also coming to the August Audit Committee meeting to give an overview. AW sought confirmation that she was comfortable as Finance Director with the CHoICE process. JP confirmed that she was more than comfortable with CHoICE. MD queried whether JP was satisfied that all the anti-avoidance rules were now sorted. JP confirmed this action.

JP stated that the current financial position posed a significant risk in the Trust not achieving the 2017/18 control total – mainly due to the gap in CIP plans and under performance against PbR contracts. Despite the current position the Trust still believed it could achieve the required control total for 2017/18. The Trust needed to focus on identifying £800k of CIPs to achieve the full CIP target of £13m, and next steps on “closing the gap options” were to be discussed at the Finance and Performance Committee meeting.

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 for June 2017.

AK informed Directors that A&E performance for June was above the 95% target at 95.82% in line with agreement from NHSI to view the performance of

the system, reported performance included the urgent care centres in Sunderland.

In A&E we had seen a 10% increase in attendances compared to June 2016 (excluding the mid-year counting change there was a 3% increase) which was above our STF trajectory of 90.3% and 90% for quarter one. There was also a reduction in ambulance handover delays.

AK advised that RTT performance remained above target at 94.67%. T&O, oral surgery and Thoracic medicine remained under target with recovery plans in place for those specialties. Urology were marginally under target this month due to a reducing number of incomplete pathways.

AK explained that the RTT stress test risk rating had reduced in May and was assessed as having a 10% chance of failing the RTT operational standard in the next six months although the Trust's position was good. MD queried how this was calculated. AK replied that it was performance over the last six months but also looking at the backlog as well – the process was quite complex. MD stated that it was obviously a general improvement.

AK advised that for diagnostics, performance for June remained above the 1% standard at 2.58% of patients waiting over 6 weeks for their diagnostic test. A revised trajectory had been provided to NHSI which showed improvement by September - although there were a risk of breaches in neurophysiology which had not been factored into the recovery trajectory.

AK stated that whilst we were hoping to see improvement there would be deterioration in August.

In terms of cancer, the Trust had met all waiting time standards with the exception of 62 days from GP referral and consultant upgrade.

Resolved: To accept the report.

4. Strategy/Policy

Item 6 Safeguarding Adults Annual Report

MJ presented the report which gave an overview of actions in relation to safeguarding adults. MJ stated that this was the first joint report for CHSFT and STFT on the back of creating an integrated team whereby STFT had helped CHSFT with regard to adults and we had helped STFT in relation to children.

MJ stated a joint training session had been held in recent weeks which had been well received. ICM commented that neglect in STFT accounted for half of the referrals whereas for CHS it represented only a quarter. MJ replied that work was happening to understand why etc. and where the referrals were coming from.

MJ advised that the report would be shared with the Safeguarding Adults Board.

Resolved: To accept the report.

Item 7 Information Pack

The Health and Safety Report 2016/17, Fire Safety Annual Report 2016/17 and Security Report were presented for information and had been previously discussed at Governance Committee.

AW queried actions in relation to Grenfell Tower and any further communication from the centre and Fire Service. KWB replied that the communications had been a little confused and messages were not necessarily filtering to the local fire service. We had originally been identified as a priority 1 area and been required to complete another return. All the testing had now been completed with none of the cladding identified.

Item 8 Any Other Business

The Chairman thanked Mike Davison (MD) as this was his last meeting before moving to take up a NED position at South Tyneside.

The Chairman thanked MD for his diligence and commitment over the last ten years.

JOHN N ANDERSON QAEP CBE
Chairman

SOUTH TYNESIDE AND SUNDERLAND HEALTHCARE GROUP

BOARD OF DIRECTORS

QUALITY, RISK AND ASSURANCE REPORT (JULY 2017)

SEPTEMBER 2017

EXECUTIVE SUMMARY

The Quality, Risk and Assurance Report is a summary report to provide assurance to the Board on the key regulatory, quality and safety standards that City Hospitals Sunderland and South Tyneside NHS Foundation Trusts are expected to maintain compliance with and/or improve. The report triangulates various sources of data to enable the detection and mitigation of any emerging risks. The report should be considered alongside the Trust Performance Report which includes mandatory reporting on quality indicators.

This report provides a summary of the key issues considered in more detail by the Governance Committees (and its subgroups the Clinical Governance Steering Groups and Corporate Governance Steering Group) and also information from the Patient, Carer and Public Experience Committee (PCPEC). It includes the monitoring of the Quality Priorities 2017-18 as indicated as part of the Annual Quality Reports. The report is presented to each Board of Directors on a monthly basis.

SUMMARY OF KEY RISKS

- Vacancies in Registered Nurse staffing (CHS/STFT)
- Drop in SI reporting causing concern from Commissioners (CHS/STFT)
- Increased rates in C.difficile in July (STFT)

RECOMMENDATION

Members of the Board are asked to note the report.



MELANIE JOHNSON
Director of Nursing &
Patient Experience

IAN MARTIN
CHSFT Medical Director

SHAZ WAHID
STFT Medical Director



City Hospitals Sunderland
NHS Foundation Trust

South Tyneside
NHS Foundation Trust

Quality, Risk and Assurance Report **for July 2017**

FOR
BOARD OF DIRECTORS
SEPTEMBER 2017

PATIENT STORY – CHSFT

LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

An email was received from the husband of a patient, the purpose of which was to highlight outstanding clinical skills and care provide by a number of members of staff, as well as the excellent infrastructure which is in place. The gentleman appreciated that we may be contacted at times of complaint, but he firmly felt, where service and standards are so high, it should equally be raised:

“By way of background, my wife and I opted to transfer to SRH for delivery of our second child, principally to have the positive birthing experience which Mr Nick Matthews had provided two years previously in delivery of our first child.

When we arrived at hospital on Friday presenting with waters broken and contractions, we were met by midwife Deb Holmes who was incredibly professional and warm, but who provided clear advice and information, thus putting my wife and I at ease. Deb Holmes then continued to provide one-to-one support, enabling my wife to make informed decisions at every stage, and providing key clinical assessments as well as adopting a comprehensive approach to the support she was providing.

When it became necessary for intervention, Mr Matthews attended and presented available options, explaining matters clearly. Again we were able to make an informed decision and my wife provided informed consent. It was refreshing that it was understood that written consent was not required - for someone in the final stages of labour the last thing to expect is for her to read a document and then sign it between contractions. Mr Matthews clearly and comfortably understood the purpose and legal requirements of consent, which from my experience is not always the case even with experienced clinicians. Mr Matthews is a very clear credit to your Trust.

What then occurred was a team-approach being adopted, with Dr Colin McAdam, ST4 in Anaesthetics, arriving and explaining his role and what would happen. He again provided very clear explanations and obtained consent. He was incredibly warm and friendly, which had the resultant effect of making my wife more relaxed. It was also refreshing that he enabled me to be in Theatre as soon as my wife entered, again enabling my wife to be more reassured, as well as me.

Moving on to the clinical intervention, this was carried out with a high level of skill and again ensured my wife was engaged in the procedure. She was given the birthing experience she had hoped for, pulling our new baby up from where she could reach and having immediate skin to skin contact. Mr Matthews provided information throughout as to what he was doing and treated her as an individual. He, too, was warm and caring, yet incredibly professional. All, and I do mean ALL, staff within the Theatre were fantastic, professional and friendly, which broke down traditional perceptions of coldness and fear which can exist in a Theatre environment; I only wish we knew all of their names so we could have thanked them personally. It is also a testament to Deb Holmes, who remained with us throughout, despite her shift having ended and having had no lunch. This ensured a continuity in my wife's care and added to the incredibly positive experience.

Post-birth the standard of care did not decrease. There was an excellent member of staff who was very attentive and caring in the recovery room, and this extended to the care during the night; nothing was too much trouble for her. She even found and wheeled a chair bed into the room for me to stay. I am again so sorry I cannot recall her name but she will be recorded in the notes and I ask that our thanks be passed to her.

It is not just the high skill level of your staff to be commended, but their whole approach and the manner in which they have executed their roles. The whole infrastructure of the delivery suite is such that all aspects, including discharge, seamlessly functioned, almost effortlessly.

If you have any internal way in which to recognise those I have referred to I would be grateful, or at least if my comments could be reflected in any appraisal process.

The only negative was outside the Trust's control, being someone within the hospital car park having scraped my car whilst I was with my wife in hospital, but even your security office were helpful (despite disappointingly the offending vehicle not being identified).

I once again express my sincere gratitude.”

PRESSURE ULCERS

LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.1 CHSFT and STFT HEALTHCARE DEVELOPED PRESSURE ULCERS (HCDPUs)

A Pressure Ulcer Improvement Plan (PUIP) is currently in place for both Trusts but a revised plan maintaining the same goals and timeframes is currently being rewritten following the alliance of both organisations. This will include alignment of definitions and terminology. The aim of the joint PUIP is to reduce the incidence of avoidable category 2 to 4 Healthcare Developed Pressure Ulcers (HCDPUs) by 25% each year by April 2019. CHSFT data includes the 'rate per 1,000 occupied bed days', to compare improvement over time. The STFT data for acute services also includes the 'rate per 1,000 occupied bed days' and within community services includes the 'rate per 10,000' CCG populations.

Ward Dashboard data for July 2017 - CHSFT

In July, CHSFT reported 22 HDPUs (Hospital Developed PUs), which is a decrease from the 30 reported in June. 18 patients developed a HDPUs, as 4 patients had more than one PU.

Ward and Community Dashboard data for July 2017 – STFT

In July, STFT reported 44 PUs across acute and community services. This is a slight reduction from the 45 reported in June. There were nine reported HDPUs which is an increase from the four reported in June. Seven patients developed one PU and one patient developed two. For community services, 35 Community Developed PUs (CDPUs) were reported in July which is a reduction from the 41 reported in June.

CHSFT - Numbers of HDPUs by category for July:

Severity	Number of HDPUs
Category 2	22
Category 3	0
Category 4	0
Total	22

STFT - Numbers of HCDPUs by category for July:

Severity	Number of HCDPUs	
	Acute	Community
Category 2	9	27
Category 3	0	5
Category 4	0	3
Total	9	35

1.2 ACQUIRED PRESSURE ULCERS (APUs)

CHSFT

Within CHS, the Nursing & Patient Experience team also review data regarding the number of patients admitted to hospital with an Acquired Pressure Ulcer (APU). These APUs 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 APUs.

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

Total number of APUs per month August 2016 to July 2017:

Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17
209	132	161	240	225	271	231	198	187	177	165	153

The TV team are currently doing further work to track and record the origins of these APUs; e.g. nursing home, residential care, District Nurse caseload, domiciliary care providers.

STFT

Community Developed Pressure Ulcers (CDPUs) are PUs which have developed under our care when the patient is on a Community District Nursing caseload, receive weekly or more visits from the DN service and do not reside in residential care.

In June, the rate of Community Developed Pressure Ulcers (CDPUs) developed in our care per 10,000 CCG populations was 1.02 for South Tyneside and 1.08 for Sunderland. The rate for July has decreased for both areas to 0.74 and 0.80 respectively. The numbers of community developed pressure ulcers can be seen in the table below.

Total number of CDPUs per month August 2016 to July 2017:

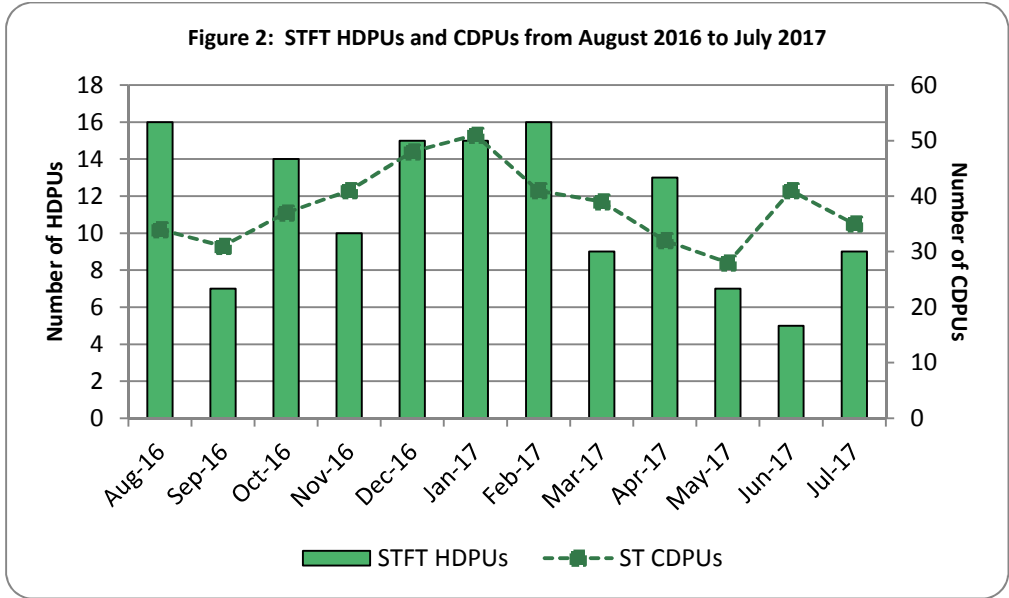
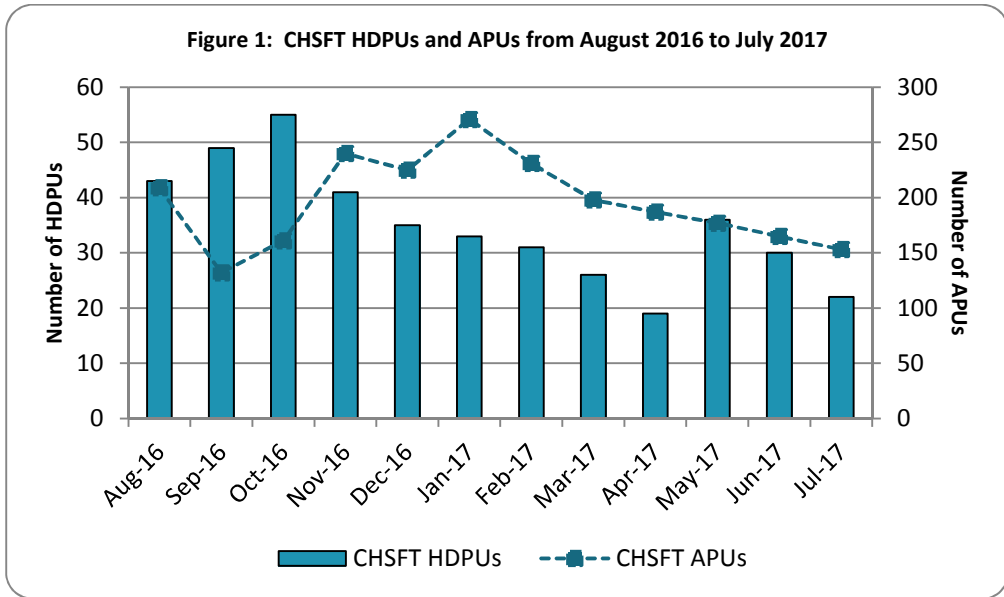
Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	July 17
34	31	37	41	48	51	41	39	32	28	41	35

Data for APUs is not currently available for STFT, but this is under review and will be available for future reports.

PRESSURE ULCERS (continued)
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

Figure 1 shows numbers of HDPUs (primary axis) and APUs (secondary axis) for CHSFT for the period August 2016 to July 2017.

Figure 2 shows numbers of HDPUs (primary axis) and the number of CDPUs (secondary axis) for STFT for the period August 2016 to July 2017.



PRESSURE ULCERS (continued)
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.3 TRUST PERFORMANCE AGAINST IMPROVEMENT TRAJECTORY

CHSFT

The number of HDPUs per 1,000 bed days has decreased from 1.81 in June to 1.32 this month. The Tissue Viability team are using this data to scrutinise practice on the identified wards and target education & training. Figure 3 shows the number of HDPUs per 1,000 bed days, together with the improvement trajectory. This month CHS is back on track with this. Improvement action by Matrons and Ward Managers is being monitored by the Nursing & Patient Experience team as per the Trust Pressure Ulcer Improvement Plan. The highest incidence of HDPUs occurs within the Rehabilitation & Elderly Medicine directorate.

STFT

The number of HDPUs per 1,000 bed days has increased from 0.52 in June to 1.02 in July. There are no identifiable causes to account for this increase. Elderly Care has the highest incidence with six developed PUs.

Figures 3 and 4 show the number of HDPUs per 1,000 bed days, together with the improvement trajectory. Figures 5 and 6 show the number of CDPU per 10,000 CCG population with improvement trajectory.

Figure 3: CHSFT Hospital Developed Pressure Ulcers (HDPUs) per 1,000 bed days from August 2016 to July 2017 with improvement trajectory

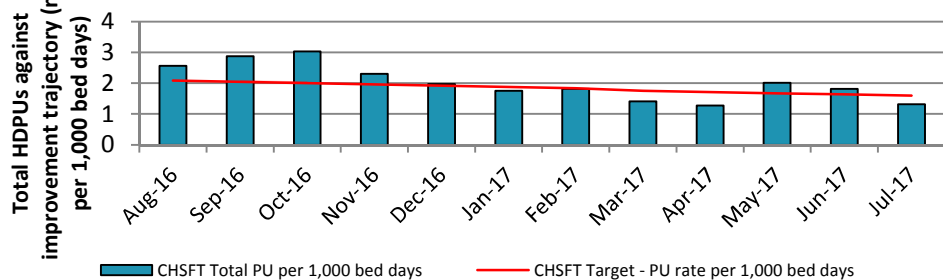


Figure 4: STFT Hospital Developed Pressure Ulcers (HDPUs) per 1,000 bed days from August 2016 to July 2017 with improvement trajectory

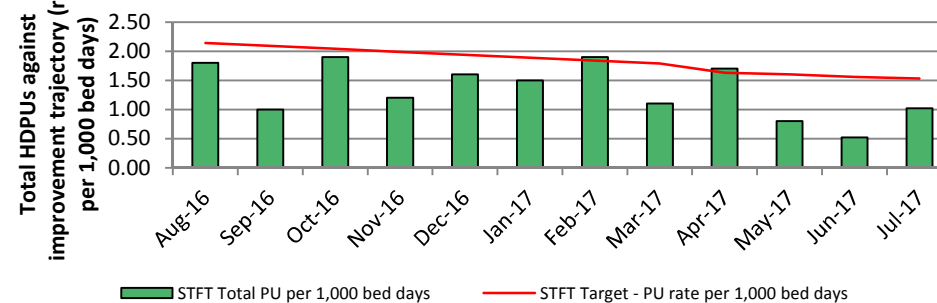


Figure 5: STFT Community PUs per 10,000 CCG for Sunderland locality from August 2016 to July 2017 with improvement trajectory

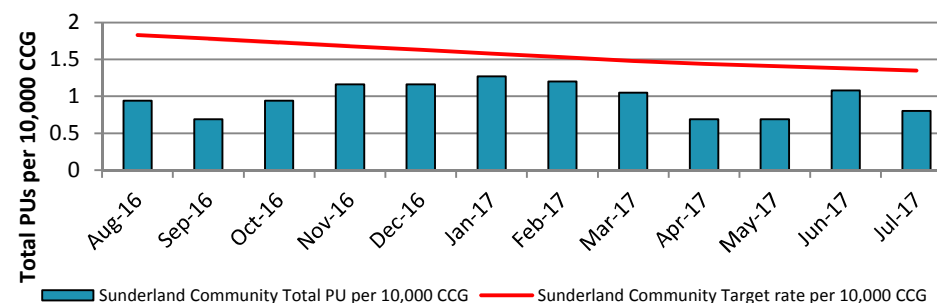
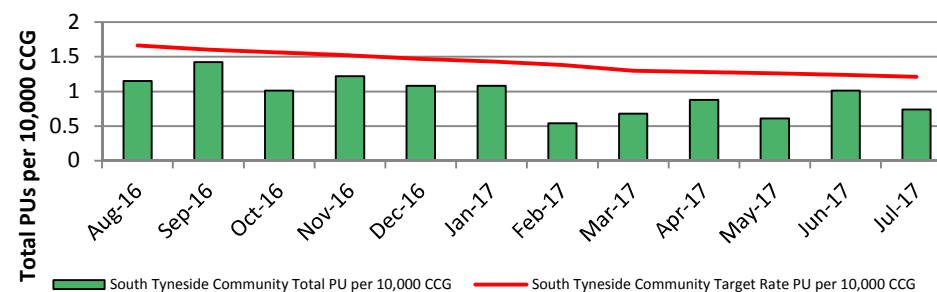


Figure 6: STFT Community Developed PUs per 10,000 CCG for South Tyneside locality from August 2016 to July 2017 with improvement trajectory



SAFEGUARDING CHILDREN
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.4 SAFEGUARDING CHILDREN

CHSFT

Figure 7 shows the breakdown of safeguarding referrals from CHSFT. In comparison to last month, referrals have increased by 30% in Maternity due to an increase in pregnancy booking whereby siblings are already open to Children’s Services. Adult Emergency Department have seen a 61% increase, relating to parents attending due to substance misuse and mental health issues, particularly mothers taking overdoses.

The main themes for referrals from Paediatric Emergency Department are due to mental health issues in the age range 12 to 17 years with intoxication and domestic abuse associated with 50% of the referrals.

A full time Named Midwife was appointed and will commence the post on 1 August 2017.

STFT

Figure 8 shows the breakdown of safeguarding referrals from STFT. In comparison to last month, referrals across acute and community services have remained static, excluding Maternity where there has been a 70% decrease, with only four referrals received in July compared to 13 in June. Although this is a decrease, it is out of sync with previous months where the average number of referrals is six.

The themes for Acute Services are due to parental mental health, domestic abuse and substance misuse which have impacted on the safety of their children, along with teenagers presenting with intoxication and mental health related issues.

The themes relating to Community are due to neglect and emotional abuse on the back of poor parental care.

The Named Nurse Community has been appointed but as yet with no confirmed start date.

CQC attended on 11 and 12 July visiting Adult and Children Accident and Emergency Departments and the Maternity Department within South Tyneside District Hospital. A letter from the CQC following the inspection indicated “we are sufficiently assured that your safeguarding children processes, procedures, and practices have improved to support the identification and protection of children who may be at risk”. A formal report will be issued by the CQC and this will supersede the previous inspection report on the CQC website in due course.

CHSFT & STFT

A full time Assistant Director for Safeguarding for Children and Adults was appointed and will commence the post on 1 August 2017, leaving a vacancy for Named Nurse Children Acute Services. The post was appointed to but as yet with no confirmed start date. Work is ongoing to match referral rates to activity.

Figure 7: CHSFT Safeguarding children referrals August 2016 to July 2017

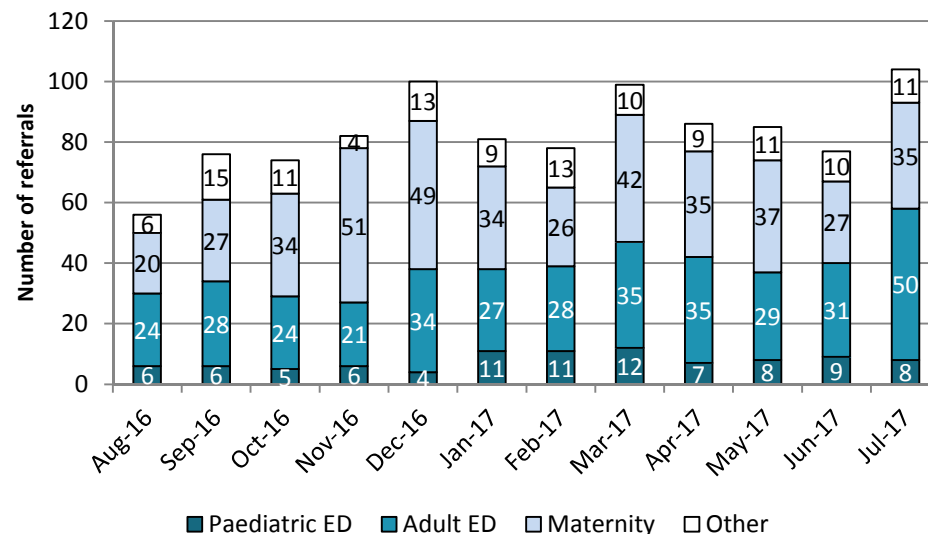
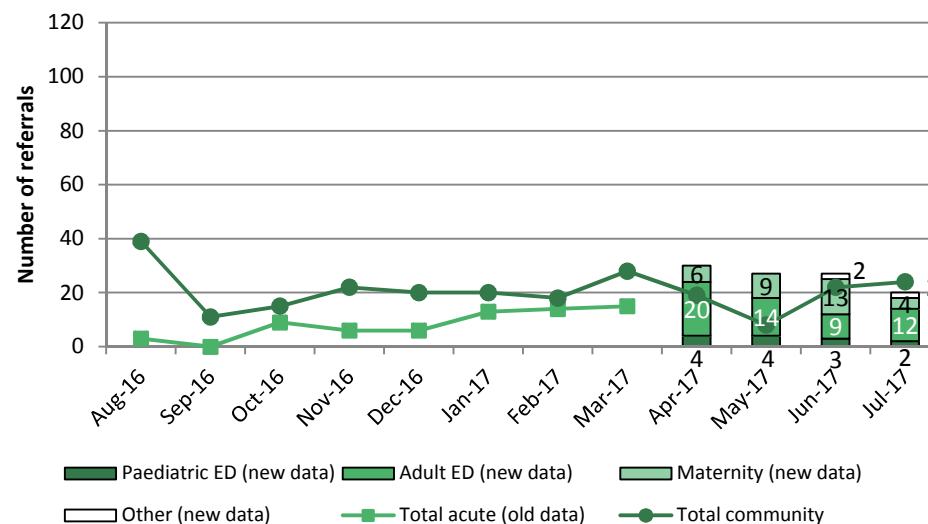


Figure 8: STFT Safeguarding children referrals August 2016 to July 2017



SAFEGUARDING ADULTS
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.5 SAFEGUARDING ADULTS

1.5.1 Safeguarding Adults Reviews (SARs)

No further SARs were commissioned in July 2017. A Sunderland Domestic Homicide Review was commissioned in July 2017. There is no CHS or STFT involvement.

1.5.2 LeDeR Reviews (Learning Disabilities Mortality Reviews)

No further action plans identifying actions for CHS or STFT were received in July 2017.

1.5.3 Referrals

Figure 9 demonstrates that a total of 24 Safeguarding Adult Referrals were made by CHSFT to the Sunderland City Council Safeguarding Adults Team in July 2017, an increase from 10 that were made in June 2017. This is due to the presence of the Safeguarding Adults Advisor within the main hospital site and so readily accessible to staff requiring safeguarding support.

Figure 10 shows that there were 53 adult referrals made by STFT staff, a decrease of 10 from previous month reporting. There is no reason as to the reduction in STFT referral activity this month, however on analysis; it is similar to the amount of referrals made by STFT staff in July 2016, where 52 referrals were submitted.

The categories of abuse reported within both CHS and STFT are neglect, self-neglect, physical abuse, Domestic Abuse, financial abuse, emotional abuse and sexual exploitation.

This month, a funding bid to the Northumbria Police and Crime Commissioner has been successful, securing funding for a 25 hour Domestic Abuse Worker to further support STFT hospital staff to recognise and respond to Domestic Abuse. This will further enhance the 8 hour IDVA post which commenced in June 2017.

Figure 9: CHSFT Adult safeguarding referrals received August 2016 to July 2017

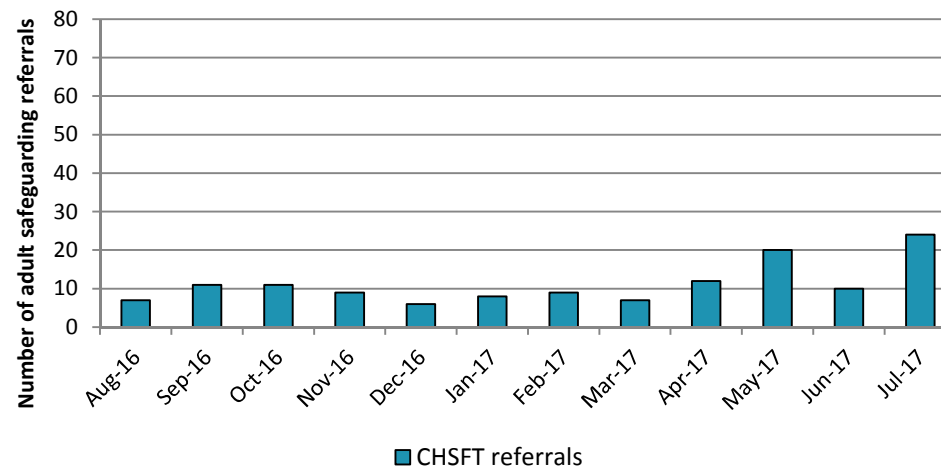
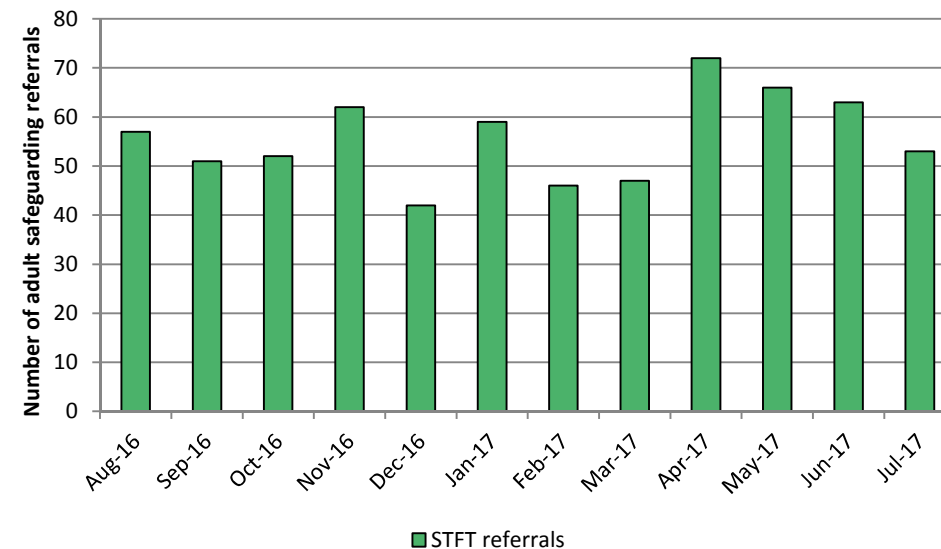


Figure 10: STFT Adult safeguarding referrals received August 2016 to July 2017



SAFEGUARDING ADULTS (continued)
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

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

Figure 11 shows the number of DoLS applications for CHSFT for the previous 12 months, together with the number of DoLS granted by the Local Authority.

Figure 12 shows the number of DoLS applications for STFT for the previous 12 months, together with the number of DoLS granted by the Local Authority.

The MCA/DoLS Advisor continues to work across both Trusts to support staff in the application process and also to address any issues that may arise due to any delay in applications being approved.

There were 48 DoLS applications submitted by STFT in July and 109 DoLS applications submitted from CHSFT to the Local Authority. STFT has 394 beds and CHS has 970 beds and so on analysis of bed capacity within both hospitals, CHSFT and STFT are submitting a similar percentage of DoLS applications.

A briefing note will be circulated to the Board to explain the DoLS process, challenges within the system and risks to patients and the organisation.

Figure 11: Number of DoLS applications made August 2016 to July 2017

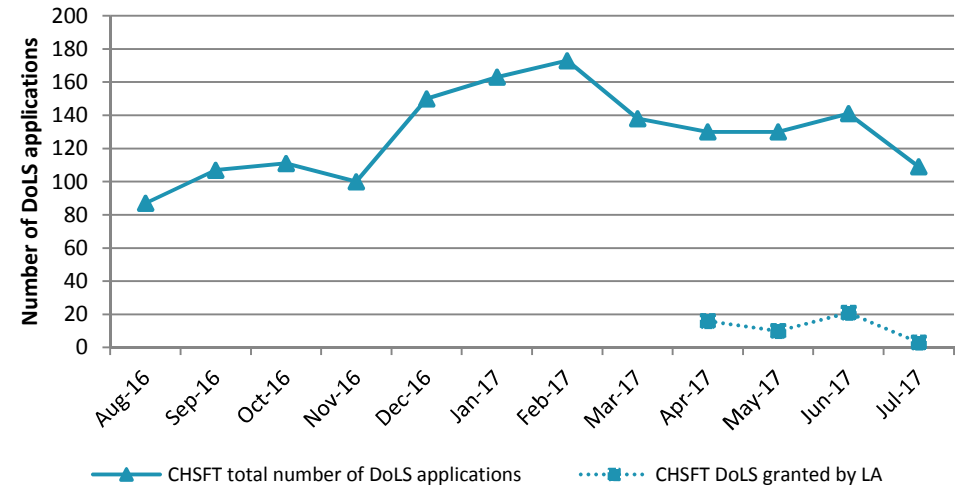
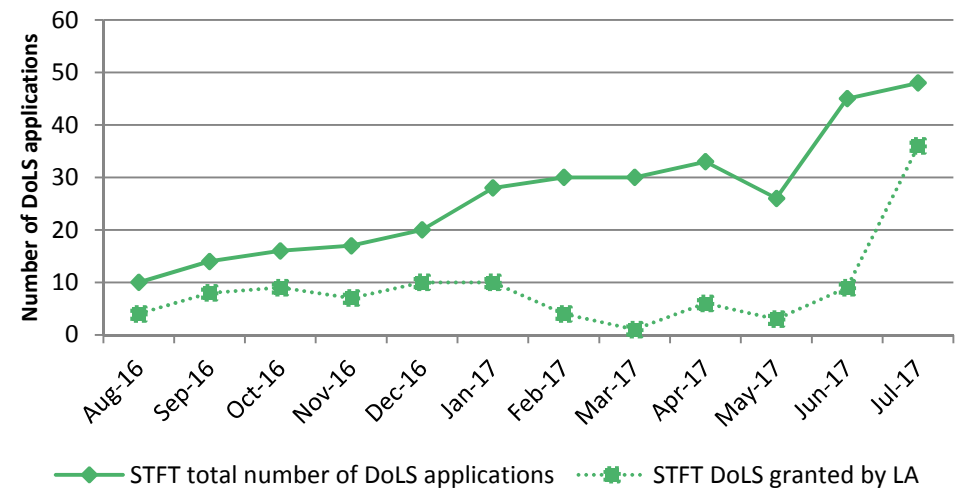


Figure 12: Number of DoLS applications made August 2016 to July 2017



COMPLAINTS

LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.6 COMPLAINTS

CHSFT

There were 26 complaints in July, with a year to date average of 24 per month.

The Trust's Complaints Policy expects formal complaints be acknowledged within three working days of receipt of the complaint. Data for July shows that 100% of complaints were acknowledged within this timeframe.

Figure 13 shows there are 26 formal complaints awaiting a first written response (by working days), compared to 27 last month. There are no complaints 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.

STFT

There were 9 complaints in July, with a year to date average of 13 per month.

The Trust's Complaints Policy expects formal complaints be acknowledged within two working days of receipt of the complaint. Data for July shows that 100% of complaints were acknowledged within this timeframe.

Figure 14 shows there are 25 formal complaints awaiting a first written response (by working days), compared to 22 last month. There are two complaints awaiting a first response for more than 60 days. This delay was due to staffing levels within the Customer Services Department. All complaints outwith 25 working days have received either a holding letter or telephone communication to notify the complainant of the delay. Performance is being closely monitored through weekly meetings and distribution of the weekly situation report.

Figure 13: CHSFT current formal complaints awaiting first response by working days - July 2017

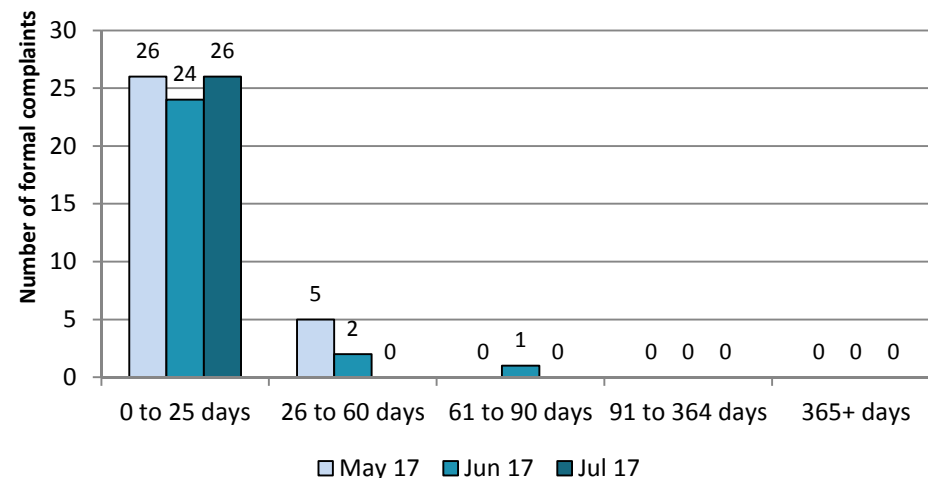
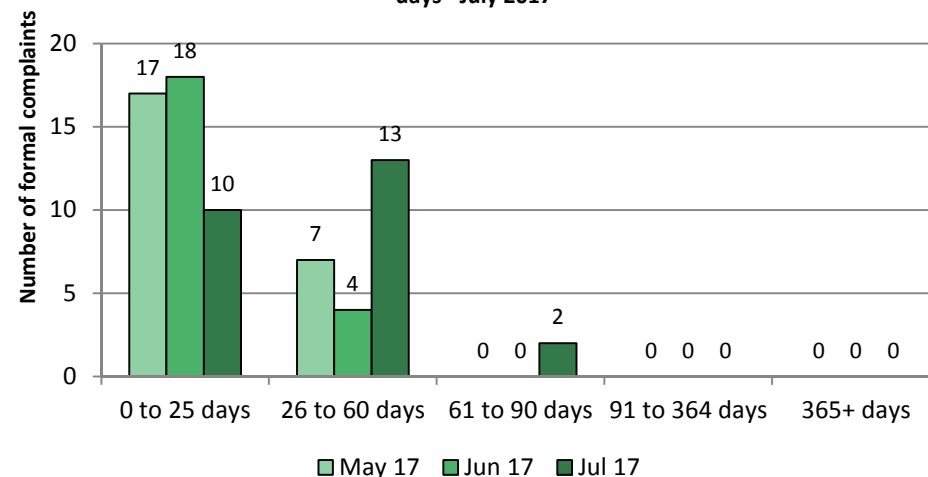


Figure 14: STFT current formal complaints awaiting first response by working days - July 2017



NURSING WORKFORCE

LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.7 NURSING WORKFORCE

1.7.1 National Indicators/Monitor Governance Indicators

During the month of July there were no additional beds open on either site.

The annual ceiling total nursing agency spend for CHSFT and STFT has been set at 3% of total nursing staff spend. At STFT, agency spend in July was £7,955, a significant decrease from June (£48,942).

CHSFT

There were 12 wards in July with RN fill rates of less than 80%. The majority of these remain in the Division of Medicine, which continues to have the highest number of vacancies.

In July there were 21 incident forms relating to nursing and midwifery staffing, a slight decrease from June (35). These were not isolated to ward areas. There were five incident forms submitted by four wards when RN staffing was below “trigger” numbers. This is a slight decrease from June (8). On all occasions the duty matron implemented the nurse staffing escalation plan, and moved staff according to level of risk. Obs & Gynae have submitted the highest number of incident forms this month (9). This is in part due to long term sickness and maternity leave. Maternity escalation plan is always implemented when needed.

NHSP continues to provide support to wards to mitigate shortfalls. There were 17,578 hours supplied in July compared to 14,100 in June. In July, 56.9% of requests were filled compared to 54.9% in June.

At the end of July there were 83.95wte (5.25%) approved RN vacancies. This does not include 46.58wte who are currently undergoing pre-employment checks.

STFT

There was one ward in July with RN fill rate of less than 80%:

- Primrose Ward - fill rate Registered Nurse day duty – 77.5%. Currently have 3.25wte RN vacancies. Skill mix and required establishment will be identified as part of workforce review at STFT.

In July there were 27 incident forms/red flags relating to nursing and midwifery staffing (seven when staffing was below recommended). There were 21 occasions when a red flag (NICE guidance) was raised via health roster, indicating shortfalls in staffing or patient harms. These were not isolated to ward areas.

Matron of the day visits each ward and department on the acute site daily to review staffing and reports concerns and actions at the bed meetings. The nurse staffing escalation plan sets out the expectations of nursing staff at every level to address staffing concerns. Any requirement for agency nurses or allied health professionals must be authorised by the Director/Deputy Director of Nursing before being actioned. Support is given to the ward in the way of bank, agency and overtime.

Vacancies at the end of July showed: acute – 30.13wte (8%) RN vacancies and no HCA vacancies; community - 74.12wte (9.53%) RN vacancies and 7.52wte (4.58%) HCA vacancies, broken down in figure 15.

Figure 15: Community vacancies at the end of July:

	District Nurse	HCA	Health Visitor	HCA	School Nurses	HCA	Urgent Care Team	Recovery at Home
Gateshead	N/A	N/A	3.32	2.13	5.87	0.4	N/A	N/A
South of Tyne	14.44	0.6	4.1	0.3	4.58	0.02	3.12 0.07	N/A
Sunderland	12.32	0	6.04	0.28	2.64	0.37	N/A	5.2

Fill rates – July 2017

SRH	SEI	STDH	Monkton Hospital	St Benedict's Hospice
92.00%	98.00%	96.05%	98.3%	98.2%

Care Hours Per Patient Day (CHPPD) – July 2017

SRH	SEI	STDH	Monkton Hospital	St Benedict's Hospice
7.9	13.5	6.9	17.2	7.9

Figure 16: CHSFT Nursing Fill Rate and Incidents Trend August 2016 to July 2017

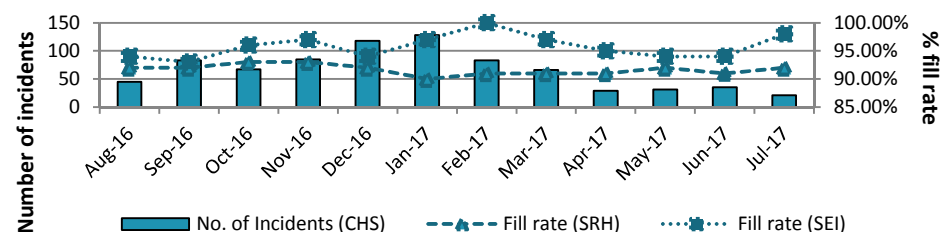


Figure 17: STFT Nursing Fill Rate and Incidents Trend August 2016 to July 2017



PATIENT SAFETY
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.8 INCIDENT REPORT

CHSFT

CHS incidents reported

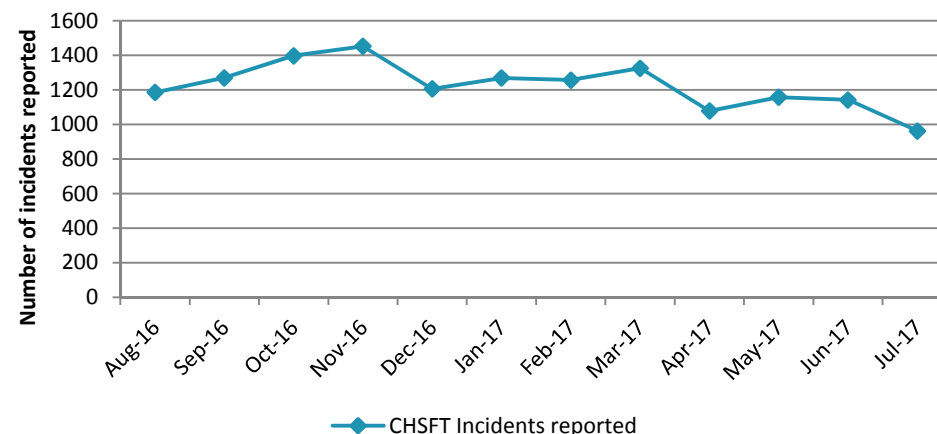
Figure 18 demonstrates the number of CHS related incidents that have been reported via Ulysses each month during the last 12 months. It shows a decrease of 171 reported incidents (15%) in July compared to the previous month. This decrease can be explained by summer holidays, CHOICE incidents no longer being reported as CHSFT incidents and a number of high reporting areas reporting fewer incidents.

Please note, from April 2017 Incidents reported as no harm/near miss have been split into separate figures. The numbers will have changed slightly from those previously reported during this period as the incident reporting system is a live system and through the course of investigation actual impact can be changed after reporting. In addition, upon review, some incidents reported as CHSFT incidents are identified as incidents for different organisations and are reassigned to them.

CHS incidents by impact

The data table for figure 18 shows the incidents reported by impact over the last 12 months. The percentage of no harm and near miss incidents as a proportion of CHS incidents reported is 65% in July, which is in line with the annual average. Three incidents were reported as having caused major or extreme harm in July. These will be reviewed by directorates via the Directorate Initial Review process and will be considered by RRG in due course.

Figure 18: CHSFT Number of incidents reported August 2016 to July 2017



Data for Figure 18: CHSFT Incidents reported by category August 2016 to July 2017

		Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	June 17	July 17
No harm/near miss	CHS	706	859	926	920	730	697	765	839	-	-	-	-
Near miss	CHS	-	-	-	-	-	-	-	-	714	763	667	607
No harm	CHS	-	-	-	-	-	-	-	-	22	21	35	22
Minor harm	CHS	448	346	416	485	413	504	458	434	335	358	410	321
Moderate harm	CHS	22	58	51	43	53	58	30	40	5	13	19	10
Major harm	CHS	8	5	2	3	4	7	3	11	2	1	2	2
Extreme harm	CHS	2	2	3	2	6	3	1	2	0	0	1	1
Total	CHS	1186	1270	1398	1453	1206	1269	1257	1326	1078	1156	1134	963

PATIENT SAFETY
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.8 INCIDENT REPORT (continued)

STFT

Figure 19 demonstrates the number of STFT-related incidents which have been reported via Datix each month during the last 12 months.

The Trust achieved a small increase of 7% in incident reporting in June 2017, and this increase has largely been maintained despite the beginning of the summer quarter, which usually shows a reduction in incident reporting. However, STFT remains a low reporter of incidents when compared to acute Trusts nationally. Work to identify the reasons behind the low level of incident reporting has identified significant user challenges in respect of the Datix system and a required time of up to 20 minutes to complete and file a single incident report.

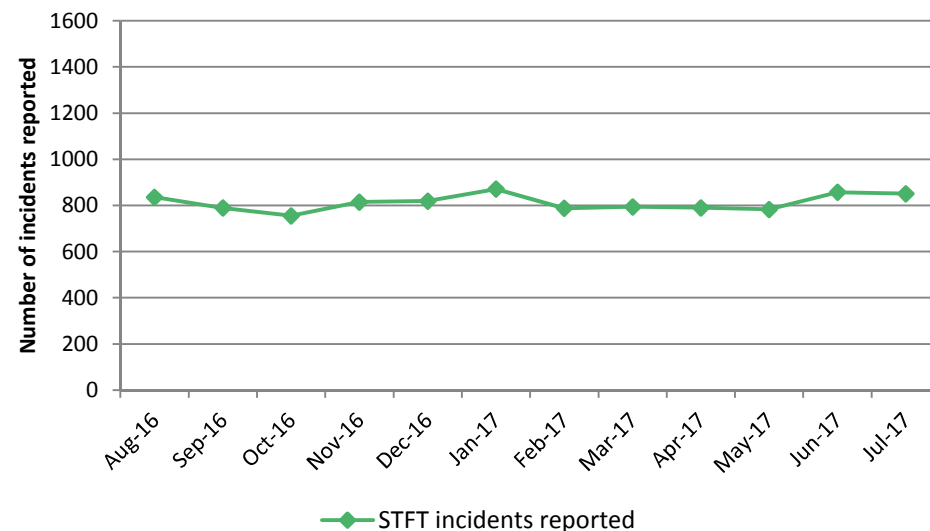
As a result, a Datix User group has been established with the goal of identifying changes to make Datix reporting more streamlined. The first meeting will take place in September 2017.

STFT Incidents by Reported Severity Score

The data table for figure 19 shows incidents by reported severity over the last 12 months. The total percentage of near miss (13.6%) and no harm (60.9%) incidents as a proportion of all STFT incidents reported in July is 74.6%.

The levels of harm shown in this data are as reported by staff at the time of the incident. Levels of harm according to reporters tend to be overstated. However, all incidents reported as having caused moderate or worse harm are all investigated. Those cases are considered by CIRG (Clinical Incident Review Group).

Figure 19: STFT Number of incidents reported August 2016 to July 2017



Data for Figure 19: STFT Incidents reported by category August 2016 to July 2017

		Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	June 17	July 17
Near miss	ST	134	109	100	118	125	127	112	111	96	110	122	116
No harm	ST	366	407	396	369	395	399	370	386	396	516	526	519
Minor harm	ST	303	235	221	281	262	291	271	264	268	151	195	200
Moderate harm	ST	32	38	36	46	32	54	35	32	29	6	14	15
Major harm	ST	1	0	0	1	5	0	0	1	1	0	0	1
Extreme harm	ST	0	0	2	0	0	0	0	0	0	0	0	0
Total	ST	836	789	755	815	819	871	788	794	790	783	857	851

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

1.8 INCIDENT REPORT (continued)

Root Cause Analysis (RCA) investigations

CHSFT

RCA's are prepared by the directorate and are reviewed by Rapid Review Group for approval before circulation both internally and, where appropriate, to external organisations. Figure 20 demonstrates the number of RCA's commissioned by RRG per month.

During July, RRG commissioned nine RCA's. Figure 21 indicates the status of RCA's, showing 44 out of 50 RCA's are overdue. Appropriate escalation of overdue RCA's 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 continues to close relevant RCA's, as can be seen from the overdue >3 months figures in figure 21. Such cases have dropped from 58 in April to 29 in July.

STFT

RCA's at South Tyneside have not been commissioned on the basis of harm in the past, but by type of incident. Thus, for example, falls causing any level of harm would trigger an RCA but a moderate harm clinical incident would not. Thus historic data in respect of RCA's would be misleading.

In the current reporting period, the Trust Risk Team has identified that the Datix system is currently incapable of routinely producing data to show the number of cases where RCA's have been commissioned. Future QRA reports will show these figures once the Datix system has been adjusted to be capable of identifying which cases have an RCA requirement and which do not.

Figure 20: CHSFT RCA's commissioned August 2016 to July 2017

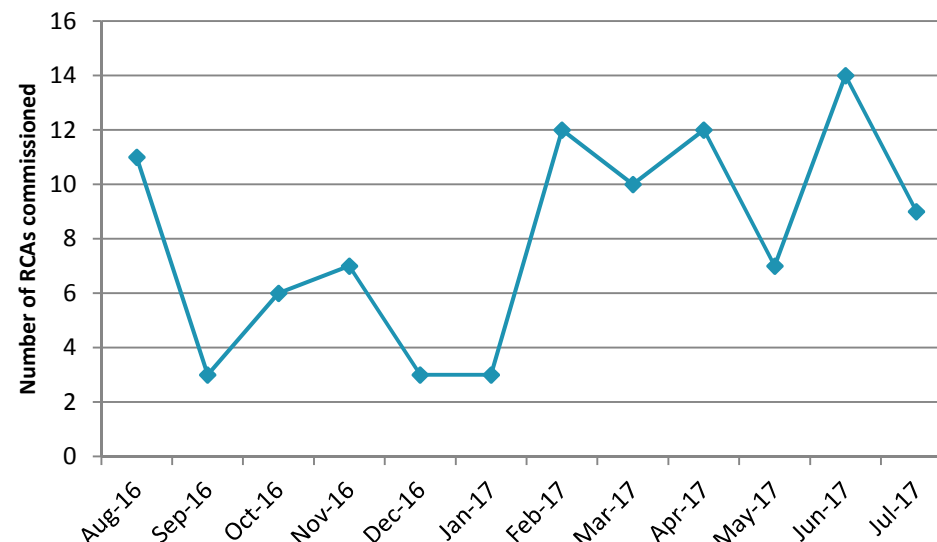


Figure 21: CHSFT Status of current RCA's – July 2017 (previous month in brackets)

	RCA Level 1	RCA Level 2	RCA Level 3	Concise RCA*	Total
Overdue >3 months	6 (6)	19 (21)	0 (0)	4 (6)	29 (33)
Overdue <3 months	0 (0)	0 (1)	0 (1)	15 (9)	15 (11)
Within	0 (0)	0 (0)	0 (0)	6 (12)	6 (12)
Total	6 (6)	19 (22)	1 (1)	25 (27)	50 (56)

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

1.8 INCIDENT REPORT (continued)

Serious Incidents (SIs)

CHSFT

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 22 demonstrates the number of incidents logged on StEIS by month.

STFT

Figure 23 shows data in respect of adverse events which meet the national criteria of Serious Incidents (SIs) and were therefore declared as such. This national definition was put into use at STFT in January, hence the significant drop in SI classifications since that date. There were no SIs confirmed in July. However, two cases originally reported as moderate impact may have caused permanent harm. These cases are currently being investigated. If permanent harm is confirmed, clinical incident review group will declare the relevant case or cases as Serious Incidents.

Figure 22: CHSFT SIs reported to StEIS August 2016 to July 2017

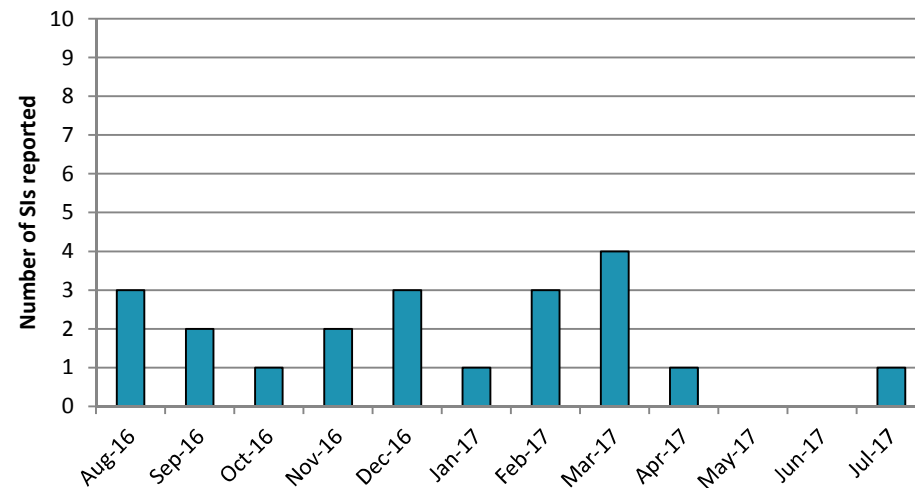
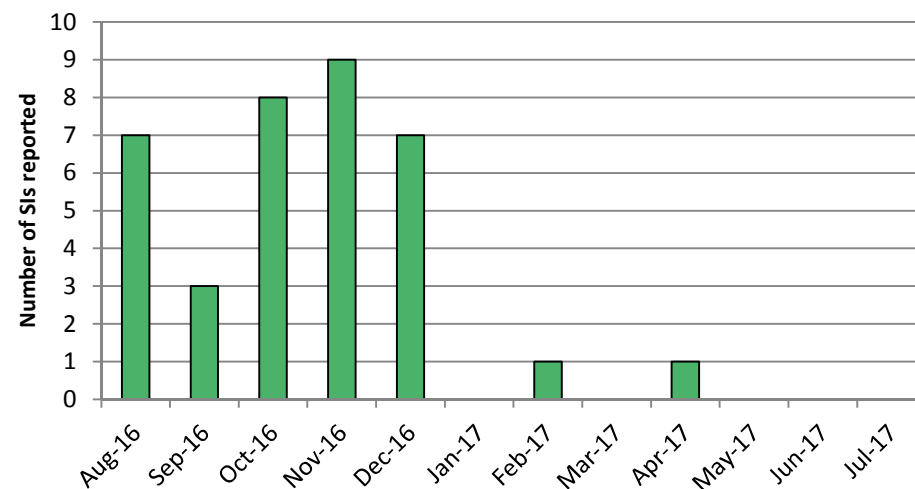


Figure 23: STFT SIs reported to StEIS August 2016 to July 2017



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

1.8 INCIDENT REPORT (continued)

Serious Incidents (continued)

In this report, information/data for incident reporting has been reduced by removing Directorate/Divisional performance SI quality indicators. This information will now be monitored monthly by RRG (CHSFT) and RRG (STFT) and reported by exception.

CHSFT

Figure 24 shows the status of SI investigations over the last 12 months. One SI is overdue and, again, appropriate escalation of this case is now in place. Ten SIs have been considered by Commissioners and are awaiting further information or clarification from the Trust, while 21 are awaiting consideration. The number of SIs within target is currently two.

Figure 24: CHSFT SI status August 2016 to July 2017

	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17
Overdue	24	12	9	10	11	6	6	4	6	8	5	1
Within target	5	4	6	3	4	4	5	4	4	2	1	2
Awaiting closure by CCG	27	37	12	14	8	13	11	14	14	12	14	21
Further info req by CCG	Not collected		14	17	19	14	16	16	15	15	17	10

STFT

Figure 25 shows that in July there were 44 open SI investigations. 15 SI reports remain overdue for submission to Commissioners and these are being actively managed to closure. 10 remain open due to the CCG needing further information before the cases can be closed.

The Trust is working closely with the CCG's Serious Incident Review Panel to identify SIs which are open but where the underlying incident did not meet the criteria for SI declaration. Commissioners were asked to consider decommissioning such cases and agreed to call an extraordinary meeting of the SI Panel to discuss the proposal. The outcome of that meeting will be reported in the August data.

Figure 25: STFT SI status August 2016 to July 2017

	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17
Overdue	2	8	6	9	14	8	20	21	21	19	17	15
Within target	8	8	1	1	2	4	1	1	1	0	0	1
Awaiting closure by CCG	Not collected		20	23	23	19	11	10	11	15	5	18
Further info req by CCG	Not collected		26	26	16	16	16	20	17	15	22	10

Never Events

CHSFT

No Never Events were reported in July.

STFT

No Never Events were reported in July.

Duty of Candour

CHSFT

During July, 12 patient safety incidents were reported as having resulted in moderate or above harm. The reported levels of harm are validated by directorates. When confirmed as having caused moderate harm or above, the formal requirements of Duty of Candour are applied, i.e. interested parties are informed, receive an apology, advice and support and are offered written feedback following completion of the investigation. During July, two incidents were confirmed as meeting the requirements for Duty of Candour and this was applied appropriately.

STFT

In July, no incidents were confirmed as having met the requirements for Duty of Candour.

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

1.9 SAFETY THERMOMETER

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.

CHSFT

Figure 26 shows CHSFT Safety Thermometer prevalence data. We reported 93.37% harm-free care in July 2017 (a 0.35% decrease from the 93.72% we reported in June).

Our total number of new harms in July was 12, which is a decrease from the 18 we reported in June. However, we had more “old” harms this month: 28 compared to 19 in June.

STFT

Figure 27 shows STFT Safety Thermometer prevalence combined data (acute and community). We reported 93.72% harm-free care in July 2017 (a 1.78% increase from the 91.94% we reported in June). This is below the national average of 94.21% of harm-free care reported by Trusts from July 2016 to June 2017.

Our total number of new harms in July was 13 (Acute 3, Community 10), which is an increase from 12 in June (Acute 5, Community 7). We had fewer “old harms” this month: 46 compared to 54 in June.

Figure 26: Safety Thermometer Results August 2016 to July 2017

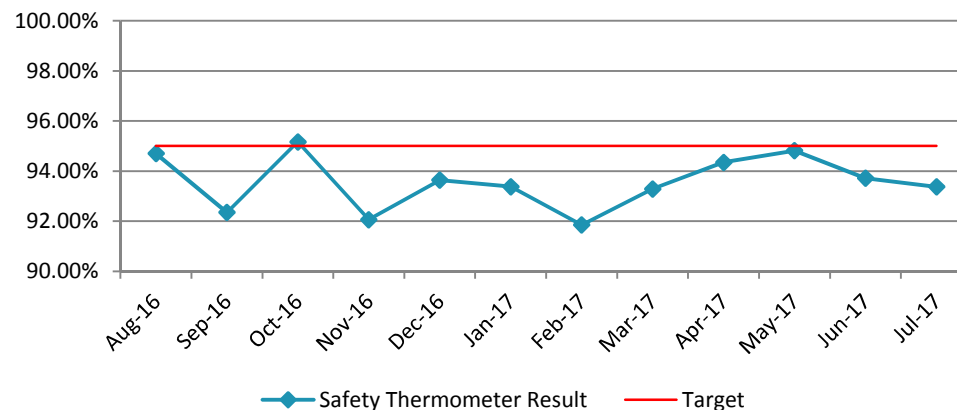
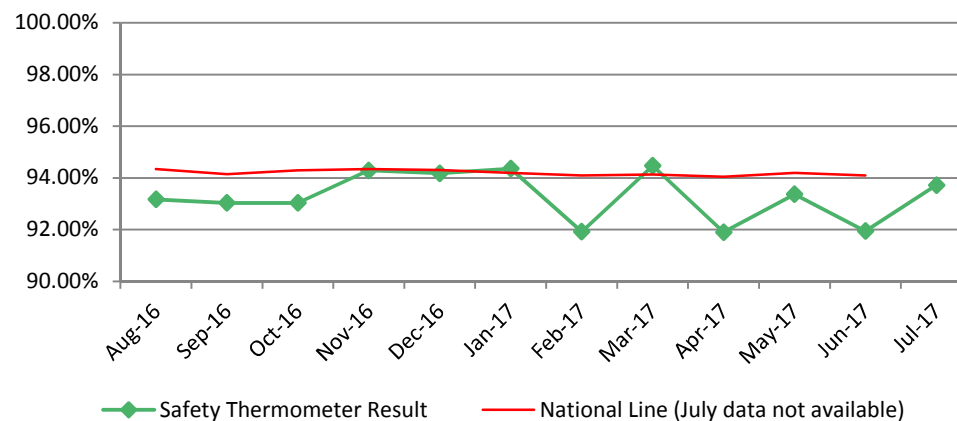


Figure 27: STFT Safety Thermometer Results August 2016 to July 2017



ASSURANCE

LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

2. ASSURANCE

2.1 Excellence Reporting

Excellence Reporting continues to be effective with figures reported to date as below:

Excellence Reports submitted (total up to the end of July)	285
Excellence Reports submitted in July	51

Top 5 directorates reporting (cumulative)	No of Excellence reports submitted
Emergency Medicine	43
Theatres	36
Rehabilitation & Elderly Medicine	28
Obstetrics & Gynaecology	17
General Internal Medicine & Nursing and Patient Experience	16 each

Reporters have originated from varying professions:

Reporters by job type (July)	No of Excellence reports submitted
Nursing & Midwifery	34
Admin and Clerical (including management)	9
Medical and Dental (Trust)	5
Medical and Dental (Training)	2
Allied Health Professionals	1
Additional Clinical Services	0

Category breakdowns are as follows:

Category of Excellence (July)	No of Excellence reports submitted
Going the extra mile	17
Care and compassion	11
Team working	7
Communication	6
Competence	6
Service improvement and innovation	2
Courage and commitment	1
Leadership	1
Other	0

The Excellence Reporting system at CHS continues to be well received, with over 300 reports submitted to date from a range of staff. It was promoted as a plenary session at this year's Nursing Conference which encouraged further reporting. An interim system is being developed for implementation at STFT, whilst discussions are taking place with Datix to see if this can mirror the CHS system.

CHSFT & STFT HOSPITAL ACQUIRED INFECTIONS
LEAD: MEDICAL DIRECTOR

3.1 HOSPITAL ACQUIRED INFECTIONS

3.1.1 MRSA bacteraemia

CHSFT

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

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

STFT

The Trust target is zero MRSA bacteraemia - classed as avoidable due to lapses in care provided. In July there was one MRSA hospital attributable bacteraemia cases reported. This isolate was reported as a contaminant, to be agreed by Independent Investigations (North) NHS England.

August STFT update: There were no new cases of MRSA bacteraemia in August. Total cases for 2017/18 is one avoidable case agreed by the Independent Investigations (North) NHS England as a contaminant.

3.1.2 C. difficile infection (CDI)

CHSFT

Two cases were reported as Trust apportioned in July, which is one below the monthly trajectory. These cases were on two different Care of the Elderly wards and do not appear linked.

The year to date position at the end of July is 11 cases against an annual trajectory of 34.

The C. diff rate per 100,000 bed days for the previous 12 months up to July 2017 remains within target, at 10.2. 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 August 2016 to July 2017:

Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17
2	2	3	4	2	3	1	0	1	2	6	2

August CHSFT update: One case was reported in August, which is one below the monthly trajectory. The year to date position at the end of August is 12 cases against an annual target of 34.

STFT

C.difficile target is no more than eight cases from April 2017 to the end of March 2018. For July there were four hospital attributable CDI cases reported – two of these will be taken to appeal in October 2017.

Cases of C. difficile infection per month August 2016 to July 2017:

Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	April 17	May 17	June 17	July 17
0	1	0	2	1	1	1	0	0	0	0	4

August STFT update: Two cases were reported as Trust apportioned in August. The year to date position at the end of August is six cases against an annual target of eight, two of these are pending appeal.

3.2 HAND HYGIENE

Given continued reporting of high performance of hand hygiene, data has been omitted from this report. However, the Infection Prevention and Control team (IPC) are reviewing the process and undertaking independent audits which will be reported in due course.

CLINICAL GOVERNANCE UPDATE
LEAD: STFT MEDICAL DIRECTOR

3.2 STFT CLINICAL INCIDENT REVIEW GROUP (CIRG)

14 cases have been discussed at CIRG with learning lessons in 10. There was 1 duty of candour. There were no SIs to report. This may change following the return of complete investigation reports to CIRG.

The above individual related errors have been brought to the attention of the individuals through the appropriate routes and learning plans put in place. A training need for paediatric staff involved in preparing children for a micturating cystourethrogram procedure has been identified. Further procedures have been put on hold until the training plan is complete supported by a formal Standard Operating Procedure. Patient transfer processes are being reviewed.

3.3 POST-GRAD TRAINING

September 2017 will see the establishment of a Medical Simulation Faculty in the Trust through the appointment of a Clinical Simulation Lead and Clinical Simulation Fellow to support the development of post-graduate training via medical simulation. There are plans to link lessons learnt from CIRG into simulation training for individuals and teams involved in incidents.

3.4 STROKE

In December 2016 the Trust temporarily relocated stroke inpatient services from South Tyneside District Hospital to Sunderland Royal Hospital, with the proposed permanency to these arrangements being subject to an ongoing public consultation.

Sentinel Stroke National Audit Programme (SSNAP) results for the period December 2016 – March 2017 were published on 26th June 2017. The results for this reporting period include the first four months of data since the temporary relocation of services.

In the SSNAP clinical results, there are 10 domains, of which 4 relate mostly to acute care delivered within the first 72 hours, 4 relate mostly to rehabilitation provided in hospital after 72 hours and 2 relate to discharge processes.

For South Tyneside patients, there have been improvements in all four of the acute care domains since December 2016, with the other six domains remaining about the same as previously. The four acute care domains relate to CT scanning, stroke units, thrombolysis and specialist assessments.

In terms of CT scanning, comparing August 2016-November 2016 with December 2016 - March 2017 there have been increases in the proportion of patients receiving scans: within 1 hour (which are not indicated for all patients) 21.5% to 50%; within 12 hours (which should be the case for all patients) 88.2% to 98.8%; and consequently a decrease in the median time that patients waited to have a scan from 2 hours to 1 hour.

Comparing August 2016-November 2016 with December 2016-March 2017 there has been an increase in the proportion of patients directly admitted to a stroke unit within 4 hours (31.5% to 57.6%) and consequent decrease in the median time to admission to stroke unit (6-hours to 3.5-hours). There has also been an increase in the proportion of stroke patients spending at least 90% of their hospital stay in a dedicated stroke unit (71.3% to 88%).

Comparing August 2016-November 2016 with December 2016-March 2017 the proportion of patients receiving thrombolysis has improved substantially to 12.8% (above the national average, having previously been around half the national average) and, in particular, the proportion of patients receiving their thrombolysis within 1 hour has improved dramatically (0% to 63.6%). Consequently, the average time taken to thrombolysed patients has decreased markedly (2 hours to 1 hour). Furthermore, the proportion of patients actually eligible to receive thrombolysis who received it improved from 26.7% to 76.9%.

Comparing August 2016-November 2016 with December 2016 to March 2017 the proportion of patients seen by a stroke consultant within 24hrs has improved (53.8% to 87.2%), as well as for patients seeing a nurse specialist within 24hrs (66.7% to 94.2%). Also, more patients had their swallowing screened within 4 hours (31.1% to 57.3%) and formally assessed within 72 hours (72.7% to 92.3%).

These results represent substantial improvements in the quality of stroke services received by patients from South Tyneside since December 2016, likely to result in much better outcomes.

RISK

LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

4.1 CORPORATE REPORTING

- 4.1.1 The Q1 CHS corporate risk register was received and approved by CHS Corporate Governance Steering Group in July, and the organisational top risks for Q1 were approved by STFT Corporate Governance Steering Group.
- 4.1.2 The STFT Corporate Governance Steering Group received and approved the Q1 Risk Management Report. For the first time, CHS Corporate Governance Steering Group received and approved a quarterly report in respect of adverse event reporting.

4.2 POLICIES

- 4.2.1 Following formal consultation, changes have been made to the CHS Incident Reporting and Investigating and Learning from Incidents policies. The final draft will now proceed to the Executive Committee and Policy Committee.
- 4.2.2 Once ratified, these policies will form the basis of two similar policies for use at STFT.

4.3 RISK MANAGEMENT STRATEGY

The third and final report on the CHS 2014 – 2017 Risk Management Strategy is being written. Executive Committee will meet to discuss options for the next strategy in August. It is likely that any future version will apply across both STFT and CHS.

CONCLUSION

SUMMARY OF KEY RISKS

1. Vacancies in Registered Nurse staffing (CHS/STFT)
2. Drop in SI reporting causing concern from Commissioners (CHS/STFT)
3. Increased rates of C.diff in July (STFT)

Members are asked to note the report.



MELANIE JOHNSON
Director of Nursing &
Patient Experience

IAN MARTIN
CHSFT Medical Director

SHAZ WAHID
STFT Medical Director

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF FINANCE

BOARD OF DIRECTORS

SEPTEMBER 2017

FINANCIAL POSITION AS AT 31ST AUGUST 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 August 2017.

1.1 KEY HIGHLIGHTS

Issue or Metric	NHSI Plan	Actual	Variance to NHSI Plan	
	£000s	£000s	£000s	%
Overall Financial Position including STF – Deficit	£3,720k	£7,982k	£4,262k	114.6%
Overall Financial Position excluding STF – Deficit	£6,335k	£8,419k	£2,084k	32.9%
Income (including STF)	£145,793k	£143,234k	£2,559k	1.8%
Expenditure	£149,513k	£151,216k	£1,703k	1.1%
EBITDA Position %	1.80%	(1.30%)		
Cash Position	£6,442k	£5,548k	£894k	13.9%
<u>Clinical Activity:</u>				
Variance to plan	£131,412k	£130,917k	£495k	0.4%
<u>Cost Improvement Plans</u>				
Variance to plan	£4,334k	£4,018k	£316k	7.3%
<u>Pay:</u>				
Variance to plan	£89,781k	£89,704k	£77k	0.09%
<u>Non Pay:</u>				
Variance to plan	£59,732k	£61,512k	£1,780k	3.0%
<u>Use of Resources Metrics (UOR)</u>				
			3	

+ve variance equates to worse than expected; -ve equates to better than expected



Julia Pattison
Executive Director of Finance

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF FINANCE

BOARD OF DIRECTORS

SEPTEMBER 2017

FINANCIAL POSITION AS AT 31ST AUGUST 2017

1 INTRODUCTION

The enclosed financial statements reflect the Trust and its subsidiary companies Income & Expenditure position as at 31st August 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 5		
	<u>NHSI Plan</u>	<u>Actual</u>	<u>Variance</u>
	<u>£000s</u>	<u>£000s</u>	<u>£000s</u>
Deficit for the year before impairments and transfers	(3,720)	(7,982)	(4,262)
Add: depreciation on donated assets	0	0	0
Less: gain on asset disposal	0	0	0
Less: income from donated assets	2	(18)	(20)
Less: 2016/17 STF post accounts allocation	0	(419)	(419)
Control Total Surplus/(Deficit) including STF	(3,718)	(8,419)	(4,701)
Less: STF 2017/18	(2,617)	0	2,617
Less: STF Incentive schemes	0	0	0
Control Total Surplus/(Deficit) excluding STF	(6,335)	(8,419)	(2,084)

The overall operational financial position is a net deficit of £7,982k against a planned deficit of £3,720k, and therefore £4,262k behind plan. The Trust has therefore failed its Control Total to date and is not liable for STF funding for £2,617k.

The net deficit of £7,982k 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 £8,419k, or £2,084k behind the planned NHSI control total to month 5.

The Trust reported an under performance of £495k in month 5 relating to NHS clinical activity which is due to lower than expected PbR activity.

At the end of August the Cost Improvement Plan (CIP) delivery is £316k behind projected plans submitted to NHSI.

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

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 5 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 the period April to August 2017.

2 INCOME AND EXPENDITURE POSITION

2.1 Patient Related Income:

Clinical Income to month 5 was £130,917k against a plan of £131,412k, and hence behind plan by £495k.

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 Quarter 1, July and August 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 £19k.

2.2 Non Patient Related Income:

Training and Education income is break even to plan to month 5. Research and Development income is ahead of plan by £32k to month 5.

Other Income was ahead of plan by £82k, most of which is due to the cross charge to South Tyneside Foundation Trust funding several posts across the trust.

As mentioned earlier, the Trust has failed the year to date Control Total and is not liable for STF funding for £2,617k.

3 EXPENDITURE

3.1 Pay Expenditure:

Pay is currently showing an underspend of £77k against plan, reflecting:

- Agency costs to month 5 are £2,432k, compared to an overall Trust agency staffing budget to month 5 of £1,787k. Much of this spend is to cover vacant posts. The same period in 2016-17 had agency spend at £2,005k which is £427k 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 August 2017, detailed in Appendix 4.
- To date the net underspend from vacant nursing posts across the Trust is £523k which is inclusive of the costs paid to NHS Professionals and overtime working.
- Cost Improvement Plans for pay are £369k ahead of plan to date mainly due to vacancies across the Trust.
- Key variances by staff group are detailed as:

<u>Key Pay variances by staff group to current month</u>	<u>£000s</u>
Consultants Staff (net of vacancies, additional sessions and agency costs)	489
Other Medical Staff (net of vacancies, additional sessions and agency costs)	454
Nursing (net of NHSP Costs)	-523
Other Staff groups, porters, admin & clerical	-497
<u>Total Variance</u>	<u>-77</u>

Appendix 4 shows details of pay spend on agency, flexi-bank and overtime for the last 12 months from month 5.

Overall pay costs in August were £17,932k against a budget of £17,978k for the month.

3.2 Non Pay Expenditure:

Non-Pay is overspent by £1,780k. Major areas are highlighted as:

- Drugs overspend this month is £656k against plan which is £488k worse than the previous month's position. The large step up in costs this month is due to the previous month's costs being unusually low and not representative of the normal monthly level of spend. To understand why this has happened, Finance and Pharmacy are analysing all data flows for July's drug costs and will provide an explanation later this month.
- Clinical Supplies is overspent by £431k due largely to CIP under delivery of £495k against plan to date.
- Other Non Pay is overspent by £973k, of which £368k is due to offsite CT and MRI scans sent to third party providers due to shortage of Radiographers and capacity at the Trust. A further £78k of the overspend is due to CIP under delivery against plan to date.
- PDC costs are £324k underspent against plan to date.
- Depreciation costs are in line with plan to date.
- Interest paid is £43k 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 5, CIP delivery was £4,018k against a planned delivery of £4,334k and hence an under delivery of £316k. This shortfall is reflective of the unidentified CIP targets set for the Trust for 2017/18, plus slippage against some high level CIP assumptions for agency cost reductions.

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.

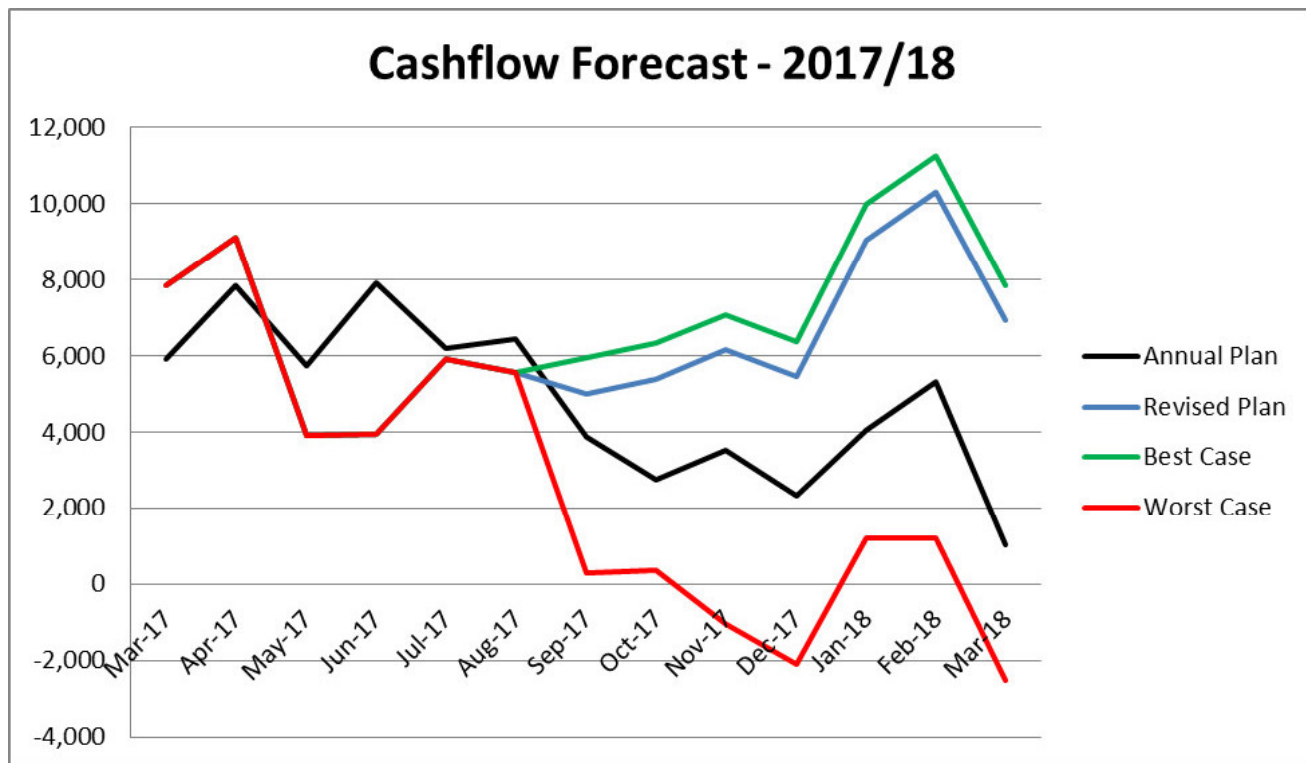
5 CASHFLOW AND WORKING CAPITAL

The cash balance at the end of August 2017 was £5,548k against planned £6,442m. The adverse variance of £894k is predominantly attributable to timing difference in income accruals relating to clinical activity to be reimbursed clinical commissioners.

The adverse NHS debtor variance of £2.93m consists of outstanding clinical activity income invoices £997k, pathology service invoices £393k and miscellaneous charges etc £1.54m.

All debtors continue to be vigorously pursued.

Principal and interest repayments, £316k and £98k respectively, were paid against the Trust's capital borrowing facility, effectively reducing the total value of outstanding loans to £55.35m.



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 best case scenario assumes achievement of the control total and CIP targets plus contingency built into the capital programme not being fully required 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 of £2.28m and nil STF funding (of which the target was £4.15m). The revised plan assumes achievement of the control total for the year and that all STF funding will be received.

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

6 CAPITAL

Capital expenditure to date is £776k and relates mainly to A&E Development (£456k), Sewing Room Conversion (£124k) and IMT Costed Profile (£78k). Capital spend is behind plan to date, this is mainly due to delays in the Trust receiving NHSE funding for the Global Digital Exemplar project, hence expenditure has also been delayed.

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.

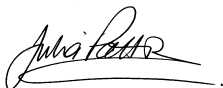
10 **SUMMARY**

The overall position at the end of August including STF, is a deficit of £7,982k compared to a planned deficit of £3,720k or £4,262k behind plan. The position excluding STF is £2,084k behind plan.

11 **RECOMMENDATIONS**

The Board is requested to:

- Note the financial position to date.



Julia Pattison
Executive Director of Finance
September 2017

CITY HOSPITALS SUNDERLAND FOUNDATION TRUST
CORPORATE FINANCIAL MONITORING REPORT
SUMMARY TRUST POSITION - MONITOR ANALYSIS
PERIOD ENDED 31ST AUGUST 2017/18

Income & Expenditure Position

£m	Annual		Current Month		Year to Date		
	Plan £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income							
NHS Clinical income	-313.58	-27.32	-26.66	0.66	-131.41	-130.92	0.49
PBR Clawback/relief	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Private patient income	-0.35	-0.03	-0.04	-0.01	-0.14	-0.16	-0.02
Non-patient income	-37.29	-2.32	-2.31	0.01	-14.24	-12.16	2.08
Total income	-351.21	-29.68	-29.01	0.66	-145.79	-143.23	2.56
Expenses							
Pay Costs	214.60	17.98	17.932	-0.05	89.781	89.704	-0.08
Drug costs	38.12	3.19	3.68	0.49	15.97	16.62	0.66
Other Costs	89.03	7.49	7.98	0.49	37.43	38.84	1.40
Total costs	341.76	28.66	29.59	0.93	143.18	145.16	1.98
Earnings before interest, tax, depreciation & amortisation (EBITDA)	-9.45	-1.02	0.58	1.59	-2.612	1.930	4.54
Profit/loss on asset disposal	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Depreciation	8.35	0.70	0.63	-0.06	3.48	3.48	0.00
PDC dividend	5.02	0.42	0.40	-0.01	2.09	1.77	-0.32
Interest	1.83	0.15	0.15	0.00	0.76	0.80	0.04
Corporation tax	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net surplus (pre exceptionals)	5.74	0.25	1.77	1.52	3.72	7.98	4.26
Exceptional items							
Net (surplus)/Deficit (post exceptionals)	5.74	0.25	1.77	1.52	3.72	7.98	4.26
EBITDA Margin	2.7%	3.4%	-2.0%		1.8%	-1.3%	

CITY HOSPITALS SUNDERLAND FOUNDATION TRUST
TRUST PERFORMANCE SUMMARY

PERIOD ENDED 31ST AUGUST 2017

TRUST SUMMARY

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

	Annual Budget £'000s	Apr actual £'000s	May actual £'000s	June actual £'000s	Quarter 1 £'000s	Jul actual £'000s	Aug actual £'000s	YTD actual £'000s	Plan £'000s	Variance £'000s
Income										
Contract Income	(313,575)	(26,376)	(25,207)	(26,387)	(77,970)	(26,283)	(26,664)	(130,917)	(131,412)	495
STF	(9,237)	(462)		462		(419)		(419)	(2,617)	2,198
Private Patients	(345)	(7)	(61)	(25)	(93)	(32)	(36)	(161)	(142)	(19)
Training and Education Income	(11,499)	(958)	(947)	(970)	(2,875)	(935)	(981)	(4,791)	(4,791)	
Research and Development Income	(1,476)	(135)	(98)	(136)	(370)	(139)	(139)	(647)	(615)	(32)
Other income	(15,035)	(1,029)	(1,369)	(1,940)	(4,338)	(762)	(1,191)	(6,292)	(6,198)	(94)
Interest Receivable	(43)	(20)	(19)	34	(4)	(1)	(1)	(7)	(18)	11
Total Income	(351,210)	(28,987)	(27,702)	(28,962)	(85,651)	(28,571)	(29,012)	(143,234)	(145,793)	2,559
Expenditure										
Pay	214,604	17,923	18,119	17,854	53,897	17,875	17,932	89,704	89,781	(77)
Clinical Supplies and Services	32,431	2,706	2,588	3,018	8,312	2,796	2,961	14,069	13,638	431
Drug Costs	38,124	3,147	3,331	3,527	10,005	2,938	3,681	16,624	15,968	656
Other Costs	56,598	5,011	4,849	5,041	14,901	4,850	5,014	24,767	23,794	973
Depreciation	8,348	590	915	742	2,247	598	633	3,479	3,478	1
PDC Dividend	5,022	383	383	383	1,149	216	404	1,769	2,093	(324)
Interest	1,827	155	189	153	497	154	153	804	761	43
Total Expenditure	356,955	29,915	30,374	30,718	91,007	29,428	30,779	151,216	149,513	1,703
(Surplus)/Deficit	5,745	928	2,672	1,756	5,357	858	1,767	7,982	3,720	4,262
Cost Improvement Plans	(13,000)	(700)	(789)	(775)	(2,264)	(935)	(819)	(4,018)	(4,334)	316

WTE Analysis (WTEs)

Total WTEs	4,918.47	4,766.26	4,796.29	4,755.77	4,755.77	4,794.86	4,841.10	4,841.10	4,897.55	-56.45
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CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST
STATEMENT OF FINANCIAL POSITION - AUGUST 2017

<u>Assets</u>	<u>Plan</u> <u>As At</u> <u>31-Aug-17</u> <u>£m</u>	<u>Actual</u> <u>As At</u> <u>31-Aug-17</u> <u>£m</u>	<u>Variance</u> <u>£m</u>
Assets, Non-Current:			
Intangible Assets	4.188	4.462	
Property, Plant and Equipment	217.970	188.663	
Trade and Other Receivables	0.918	1.145	
Assets, Non-Current, Total	223.076	194.270	
Assets, Current:			
Inventories	5.900	5.784	0.116
Trade and Other Receivables:			
NHS Trade and Other Receivables	4.070	7.005	-2.935
Non NHS Trade and Other Receivables	5.950	7.862	-1.912
Trade and Other Receivables, Total	10.020	14.867	
Cash and Cash Equivalents:			
Government Banking Service & Invested	6.042	-0.122	
Commercial Bank account	0.400	5.670	
Cash and Cash Equivalents, Total	6.442	5.548	-0.894
Assets, Current, Total	22.362	26.199	
ASSETS, TOTAL	245.438	220.469	

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	-1.920	0.120
Provisions	-0.212	-0.217	0.005
Trade and Other Payables:			
Trade Payables, Current	-25.776	-25.971	0.195
Other Financial Liabilities	-2.762	-2.547	-0.215
Capital Payables, Current	-0.311	-0.866	0.555
Trade and Other Payables, Total	-28.849	-29.384	
Liabilities, Current, Total	-34.134	-34.794	
NET CURRENT ASSETS (LIABILITIES)	-11.772	-8.595	

Liabilities, Non-Current

Interest-Bearing Borrowings:			
Loans, Non-Current, non-commercial (DH, FTFF, NLF, etc)	-52.072	-52.072	0.000
Loans, Non-Current, commercial	0.000	0.000	0.000
Interest-Bearing Borrowings, Total	-52.072	-52.072	
Provisions, Non-Current	-0.869	-0.794	-0.075
Liabilities, Non-Current, Total	-52.941	-52.866	
TOTAL ASSETS EMPLOYED	158.363	132.809	

Taxpayers' and Others' Equity**Taxpayers' Equity**

Public Dividend Capital	102.042	102.248	
Revaluation Reserve	75.084	52.854	
Retained Earnings	-18.763	-22.293	
TAXPAYERS' EQUITY, TOTAL	158.363	132.809	
	0.000	0.000	

Appendix 3 - Clinical Income Report Overview

Table 1: Financial Position (M1-5) per Commissioner agreed Contracts and the NHSI plan

Commissioner contracts	Plan as per	Plan as per	Total	Variance as	Variance	%	%
	NHSI	PbR	Actuals	per NHSI	as perPbR	Against	Against
	£'000s	£'000s	£'000s	£'000s	£'000s	NHSI	PbR
Sunderland	73,065	73,065	73,065	0	0	0.0%	0.0%
South Tyneside	9,789	9,789	9,789	0	0	0.0%	0.0%
Gateshead	1,973	1,797	1,718	255	79	14.8%	4.6%
Sunderland LA	1,001	1,001	1,001	0	0	0.0%	0.0%
DDES	15,783	14,731	15,040	742	-310	4.9%	-2.1%
North Durham	7,122	6,954	6,680	442	274	6.6%	4.1%
HAST	1,536	1,443	1,449	87	-7	6.0%	-0.5%
South Tees	105	105	97	7	7	7.6%	7.6%
Specialised	14,919	14,919	14,895	24	24	0.2%	0.2%
Dental	2,554	2,554	2,495	58	58	2.3%	2.3%
Sub total	127,847	126,358	126,230	1,616	128	1.3%	0.1%
Cancer Drug Fund	715	715	470	245	245	52.0%	52.0%
Hep C drugs	406	406	476	-70	-70	-14.6%	-14.6%
NCA's	1,396	1,396	1,233	163	163	13.3%	13.3%
AQP - all contracts	448	448	384	64	64	16.7%	16.7%
GAP/Stretch target	-714	774	0	-714	774	0.0%	0.0%
Other	1,313	1,313	2,124	-811	-811		
Total	131,411	131,411	130,917	494	494	0.4%	0.4%

The clinical income target to end month 5 is £131,411k with actual income reported as £130,917k. Therefore the trust is reporting a cumulative under performance against the Clinical Income budget of £494k.

As per last year, there are differences at Commissioner level between final agreed PbR plans and NHSI plan, due to QIPP targets that were removed from the majority of CCG plans. At month 05 this equates to £1,488k for all CCG's.

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 an allowance of 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 & reduces the gap/stretch target accordingly). There are several other CV's, still to be finalised that will affect the financial position and cash flow when completed.

The Clinical income actuals are based on M4 PbR files with the exception of drugs income which is directly matched to expenditure for month 5 for those on PBR contracts. There is an intention to agree a Q1 position with NECS supported CCG's this month and discussions have been positive to date, although there is still disagreement over the cost of the marginal rate & emergency re-admissions. Q1 discussions have commenced with NHSE, but uncertainty remains on their position for both Q1 & month 04.

We are still awaiting a CCG CV for bariatric activity which will replace estimated budget with firmer numbers. Some budgets will increase and some will reduce.

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.

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

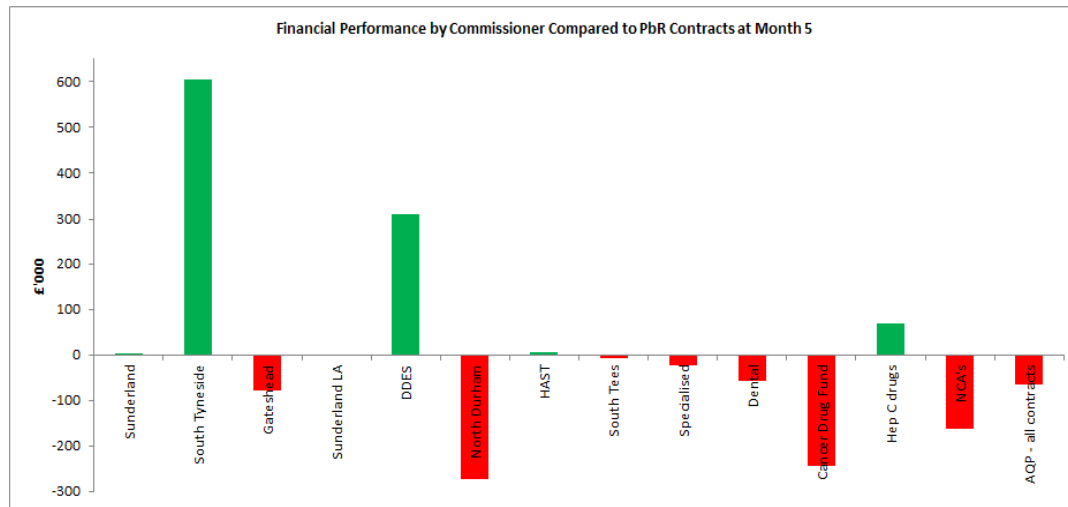
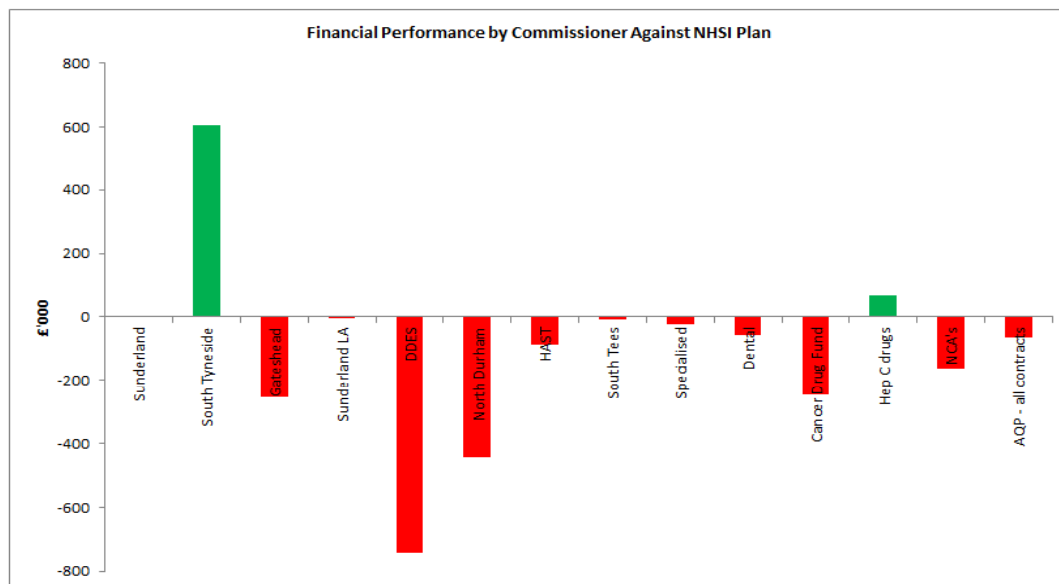


Figure 2: Variance per Commissioner Against the Monitor Plan



Summary of main PbR variance by commissioner

Sunderland CCG : This contract is block for 17/18. If PbR was to be transacted it would show a £412k over performance (£781k at month 4), mainly due to NEL activity. There has been some double counting of bariatric activity, which once corrected should reduce this over performance.

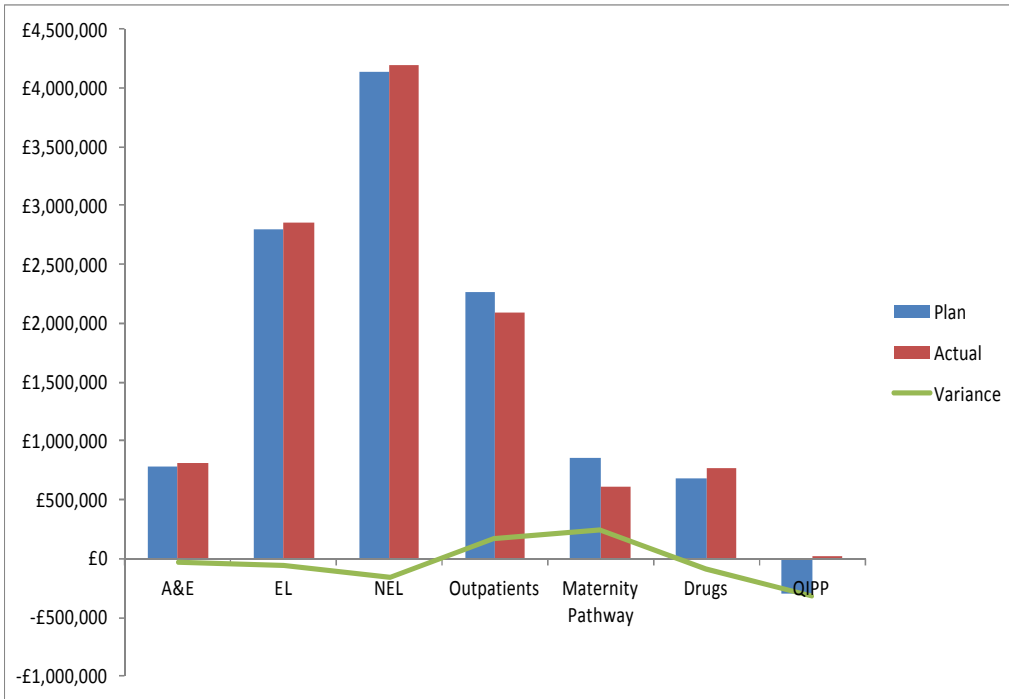
South Tyneside CCG : This contract is also a block for 2017/18. If the PbR was to be transacted, there would be an over performance of £1.1m (617k at month 4); this is predominately due to stroke activity transferred from STFT (£605k) but not yet formally transferred into the contract and also on drugs as the lower priced Avastin was commissioned but is not yet clinically used (£400k).

North Durham CCG : Reporting an under performance of £274k against PBR plan and £442k against NHSI plan. Underperformance remains in multiple specialities and POD's. This is examined further on the following page.

DDES CCG : Reporting an over performance of £310k against PbR plan & £742 under against the NHSI plan. This is examined further on the following page.

NHSE Specialised: Reporting an underperformance of £24k against PBR & NHSI plan. This position takes the Trusts view of challenges into account. We are working to finalise a Q1 position however there are both challenges and process issues to resolve with NHSE. The main area of over performance is drugs however these are a pass through with expenditure.

NHSE Dental – Under performance of £58k which is an improvement of £30k from M4

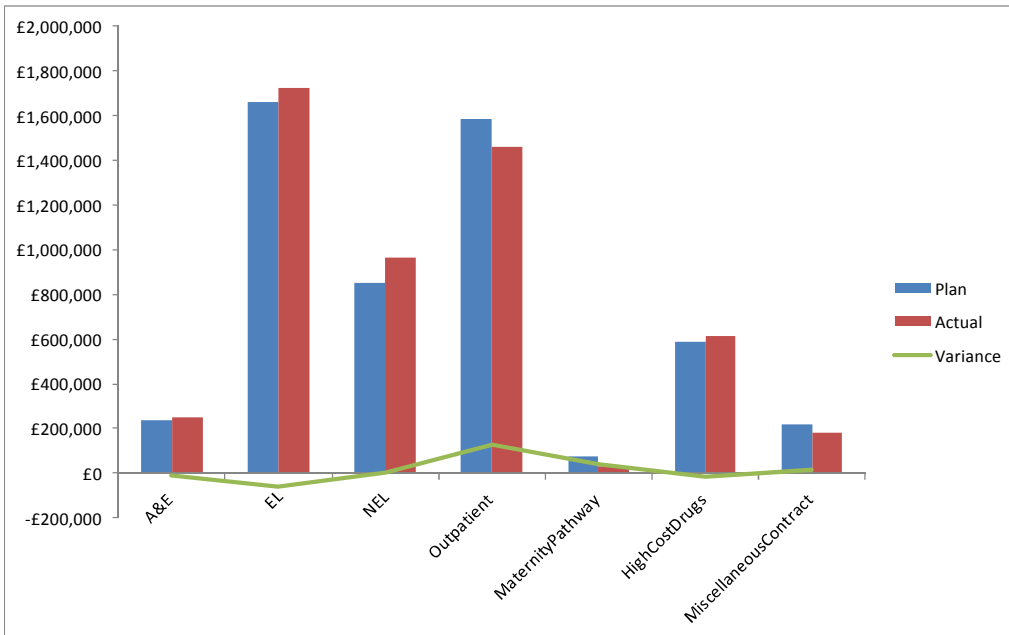


DDES CCG Performance

There are different plans for PbR contracts and NHSI, due to the fact that 16/17 CCG QIPP plans did not come to fruition so the decision was taken to assume the same for this year and add these back on the PBR plan to give the adjusted NHSI plan. For DDES CCG, the annual value is £2,524k.

DDES is underperforming against the NHSI plan by £742k but over performing against the commissioned contract by £310k, the difference being due to QIPP plans. Once the Bariatric CV is agreed, then the plan will be reduced & over-performance on the PBR plan will increase.

Regarding the PbR contract; the Trust is over performing against NEL particularly within T&O and elective within Ophthalmology and Cardiology. However, underperformance within maternity pathways and outpatients (Urology, ENT and T&O) reduces this over performance. Drugs, principally Ophthalmology, are also over recovered but are a pass through cost against expenditure. The switch to biosimilar drugs (Rheumatology and Gastro) reduces expenditure and represents a health economy efficiency.



North Durham CCG Performance

As with DDES, North Durham QIPP plans have been added back into the NHSI contract. For North Durham, annual value is £402k. North Durham are underperforming against the NHSI contract by £442 but also under performing against the PbR agreed contract by £274k. Once the Bariatric CV is agreed, then the plan will be reduced & under-performance on the PBR plan will decrease.

The main areas of underperformance as with DDES are maternity pathways and outpatients.

Outpatient under-performance mainly relates to Ophthalmology, Urology & ENT. Since October 2016 there have been demand management schemes in place affecting Ophthalmology & ENT with significant reductions in referrals in both these areas that were not reduced in the 17/18 contract.

Risk to income

The main risk with the clinical income position remains NHSE challenges, both the quantity and the timeliness of these challenges. Drug challenges particularly remain ad-hoc and are not in line with national timescales. This impacts upon the Trusts ability to report an agreed position, but also has potential impacts on the CCG reported positions. Challenges, which are mainly drug related, which we see as a risk to date have been built into the position, but the final agreed position may be different to this. There has also been a challenge from NHSE regarding the oncology module activity and income that has now been included in the M4 PBR files, a briefing note has been circulated to both NHSE and CCG's on this without agreement, but the impact to Q1 is circa £100k for NHSE, this risk is not built into the current position.

There is still some element of risk of challenges for CCG's, but these should be all agreed for Q1 by next month financial closedown.

There are several Contract Variations still to be finalised which will impact on the reported positions and cash flow. With the Bariatrics CV, there is an added risk that the CCG's and NHSE have entered into a risk share on this which may need to be transacted outside of the block arrangements with SCCG and STCCG.

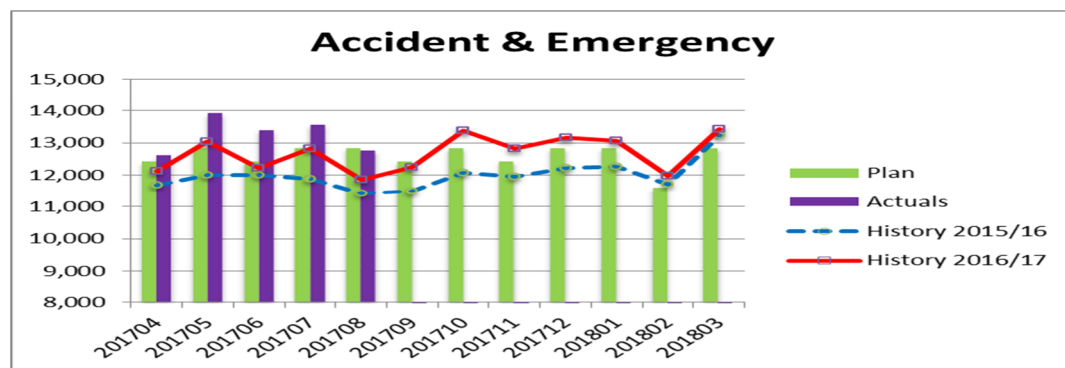
CCG's have said that marginal rate and emergency thresholds will be transacted this year as part of the PbR contracts. The reported position assumes that these remain blocked, so this is a potential risk to the current reported position of £260k. However, these cannot yet be quantified as the re-admissions rate percentage is disputed plus we are awaiting detail of the Commissioner calculations.

A risk for penalties and the non-achievement of CQUIN has been built in for CCG's where appropriate. NHSI are to advise on accounting for the 0.5% CQUIN held back for the 'risk share, which could adversely affect both the income and cash position. The Trust has not adjusted clinical income values to reflect the 0.5% CQUIN risk reserve, the current position includes circa £478k of income for this item.

Some CCG's have made 'risk pool' payments in advance of reconciling the Q1 position, due to lower than anticipated activity (as reported), this means credit notes are likely to be significant, circa £1m for Q1.

Position for Activity by POD (Month 5)

Accident & Emergency



Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
A&E Attendances	63,407	66,295	62,086	2,888	4,209
201704	12,433	12,618	12,136	185	482
201705	12,847	13,929	13,054	1,082	875
201706	12,433	13,405	12,210	972	1,195
201707	12,847	13,571	12,822	724	749
201708	12,847	12,772	11,864	-75	908
Grand Total	63,407	66,295	62,086	2,888	4,209

Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
A&E Attendances	63,407	66,295	62,086	2,888	4,209
Type1	36,064	38,461	35,933	2,397	2,528
Type2	13,922	13,347	13,562	-575	-215
Type4	13,421	14,487	12,591	1,066	1,896
Grand Total	63,407	66,295	62,086	2,888	4,209

A&E attendances in August were almost in line with plan. This is in direct contrast to the period between April and July where attendances were consistently over plan. A comparison by Commissioner has highlighted that both DDES and Sunderland have seen the greatest reduction in activity in August, with DDES reporting a 7% reduction on the previous monthly average, and Sunderland down by 4%.

However, the number of admissions from ED in August is proportionally higher than previous months, with 21% of ED presentations resulting in an Emergency admission. Specialties with the most admissions from ED in August include Accident & Emergency, Geriatric Medicine, General Surgery and Paediatrics.

A&E activity is 6.8% above historical levels and 4.6% above plan. Type 1 A&E (main site) is 6.6% above plan; Type 2 (Eye Infirmary) is 4.1% below plan and Type 4 (Pallion) is 7.9% above plan.

In August, the number at attendances at SEI are the lowest in 17/18 with 2,509 attendances compared to a previous monthly average of 2,710.

For both Main Site and Pallion, August's attendances are the lowest since May, but are still 106 and 131 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.

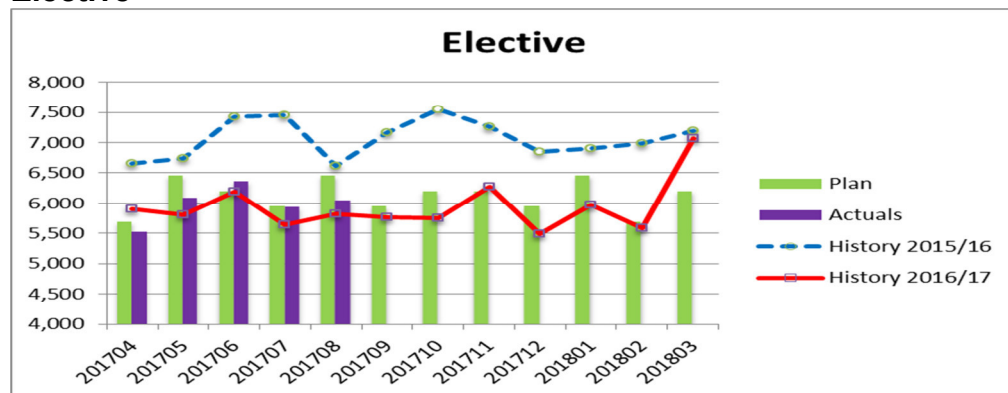
Sunderland CCG is the main commissioner of A&E activity with 79.8% of the contract. As this contract is blocked, there is a financial risk to over performing against plan if attendances continue at this level.

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 5)

Elective



Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
Ophthalmology	5,766	6,119	5,601	353	518
Paediatrics	166	239	211	73	28
Nephrology	277	339	284	62	55
Respiratory Medicine	740	798	723	58	75
Diabetic Medicine	21	62	28	41	34
Pain Management	364	401	384	37	17
Neurology	306	332	321	26	11
Endocrinology	94	119	98	25	21
Gynaecology	723	736	653	13	83
Geriatric Medicine	26	31	25	5	6
Well Babies	2	4	1	2	3
Accident & Emergency	124	126	126	2	0
Rehabilitation	6	8	8	2	0
Trauma & Orthopaedics	2,410	2,402	2,416	-8	-14
Obstetrics	43	34	42	-9	-8
Oral & Maxillo Facial Surgery	2,151	2,133	2,176	-18	-43
Upper Gastrointestinal Surgery	72	40	70	-32	-30
Rheumatology	570	538	604	-32	-66
Gastroenterology	2,551	2,461	2,474	-90	-13
Clinical Haematology	2,306	2,204	2,126	-102	78
ENT	1,811	1,707	1,758	-104	-51
Cardiology	955	846	772	-109	74
General Surgery	2,439	2,319	2,455	-120	-136
Vascular Surgery	723	510	668	-213	-158
Urology	3,436	3,209	3,204	-227	5
Medical Oncology	2,704	2,268	2,141	-436	127
Grand Total	30,785	29,985	29,369	-800	616

Elective Spells Summary

Elective activity is up 616 spells (2.1%) vs 16/17 history but down 800 spells (2.6%) vs plan YTD.

August's actuals were higher than July; however the plan for August is high because it is based on the number of working days in the month, resulting in a large underperformance.

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

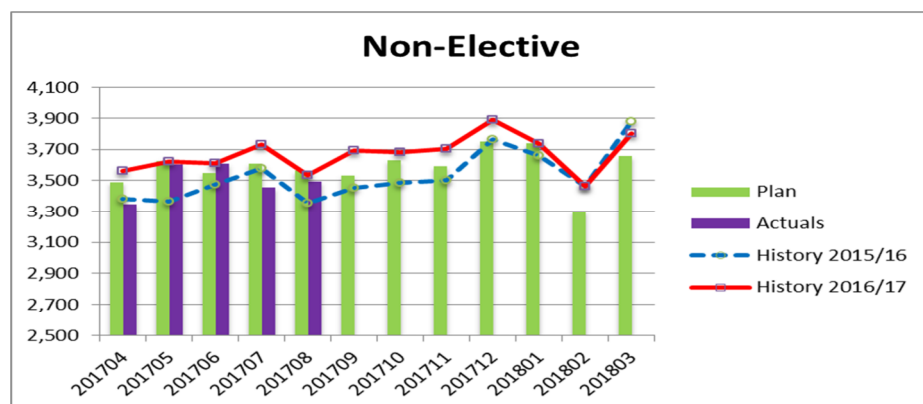
Commissioner in focus – NHS England Specialised

Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
CUMBRIA AND NORTHEAST COMMISSIONING HUB	3,816	3,271	3,055	-545	216
Ophthalmology	578	478	408	100	75
Respiratory Medicine	14	67	31	53	36
Urology	147	164	20	17	144
Gastroenterology	6	10	4	4	6
Paediatrics	0	3		3	3
Gynaecology	2	4	2	2	2
Diabetic Medicine	0	1		1	1
Upper Gastrointestinal Surgery	0	0	68	0	-68
Rehabilitation	0	0	1	0	-1
ENT	99	99	24	0	75
Accident & Emergency	2	0		-2	0
Trauma & Orthopaedics	8	5	7	-3	-2
Oral & Maxillo Facial Surgery	58	55	24	-3	31
General Surgery	28	17	157	-11	-140
Vascular Surgery	47	27	17	-20	10
Nephrology	43	17	50	-26	-33
Clinical Haematology	870	758	675	-112	83
Cardiology	148	1	1	-147	0
Medical Oncology	1,968	1,565	1,576	-403	-11
Grand Total	3,816	3,271	3,055	-545	216

The major underperformance at a Commissioner level to Month 5 is NHS England Specialised. Most of this is due to the underperformance of Medical Oncology as a result of the changes in recording and an increase in plan following the implementation of the Oncology Module in V6. Cardiology has also been commissioned from Specialised as it was modelled that some of this activity would move from CCG but this has not been the case. The cost of this is approximately £1.01m.

Position for Activity by POD (Month 5)

Non Elective



Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
Non Elective	17,849	17,518	18,060	-331	-542
Geriatric Medicine	2,401	2,552	2,539	151	13
Respiratory Medicine	701	827	781	126	46
Endocrinology	245	360	281	115	79
Clinical Haematology	141	200	140	59	60
Ophthalmology	232	282	242	50	40
Diabetic Medicine	243	274	261	31	13
Medical Oncology	24	48	35	24	13
Pain Management	18	39	18	21	21
Gastroenterology	815	831	841	16	-10
Obstetrics	7	17	31	10	-14
Cardiology	1,319	1,325	1,322	6	3
Rehabilitation	32	38	32	6	6
Well Babies	3	5	6	2	-1
Orthodontics	0	1	1	1	1
Upper Gastrointestinal Surgery	0	0	0	0	0
Critical Care Medicine	0	0	0	0	0
General Medicine	1	0	0	-1	0
Neurology	29	28	40	-1	-12
Nephrology	486	484	457	-2	27
Rheumatology	27	14	13	-13	1
Oral & Maxillo Facial Surgery	155	140	140	-15	0
Vascular Surgery	118	93	109	-25	-16
Urology	1,049	1,018	1,044	-31	-26
Gynaecology	481	435	439	-46	-4
ENT	667	596	674	-71	-78
Accident & Emergency	3,756	3,669	3,730	-87	-61
Trauma & Orthopaedics	1,048	937	1,084	-111	-147
General Surgery	2,048	1,788	2,104	-260	-316
Paediatrics	1,803	1,517	1,697	-286	-180
Grand Total	17,849	17,518	18,060	-331	-542

Non Elective Spells Summary

Non Elective activity is down 542 spells (3%) vs history and down 331 spells (1.8%) vs plan. This is an increase against the YTD position at Month 4.

Geriatric Medicine continues to be the Specialty with the highest over performance, due to the transfer of Stroke activity from S Tyne to CHS, which still needs the activity levels to be varied into the Contract.

Performance against plan at a specialty level remains consistent with Month 4.

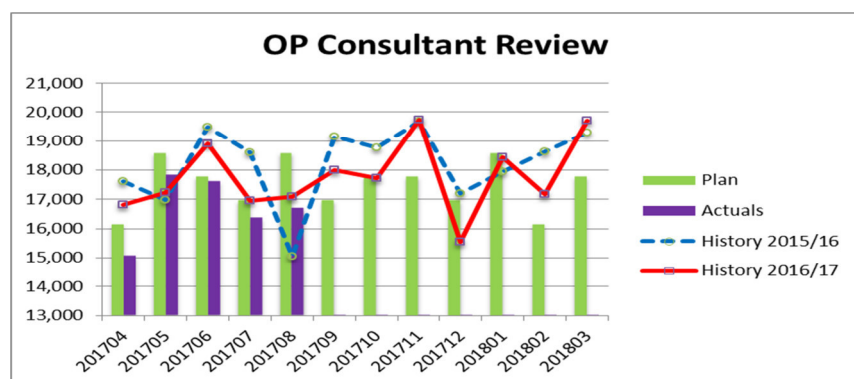
Commissioner Focus

Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
Non Elective	17,849	17,518	18,060	-331	-542
CUMBRIA AND NORTH EAST COMMISSIONING HUB	261	171	199	-90	-28
NHS CUMBRIA CCG	0	0	9	0	-9
NHS DURHAM DALES, EASINGTON AND SEDGEFIELD CCG	2,715	2,630	2,760	-85	-130
NHS ENGLAND NORTH (CUMBRIA AND NORTH EAST)	0	0	138	0	-138
NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG	38	28	32	-10	-4
NHS NEWCASTLE GATESHEAD CCG	192	138	195	-54	-57
NHS NORTH DURHAM CCG	642	621	570	-21	51
NHS SOUTH TEES CCG	11	11	14	0	-3
NHS SOUTH TYNESIDE CCG	827	940	808	113	132
NHS SUNDERLAND CCG	12,863	12,698	13,173	-165	-475
NON CONTRACT ACTIVITY	298	281	162	-17	119
Grand Total	17,849	17,518	18,060	-331	-542

Non Elective activity at month 5 is almost in line with plan and remains broadly in line with ED attendances (21% of ED attendances result in an Emergency Admission). The CCGs with the greatest under and over performance against plan are Sunderland and South Tyneside respectively, both of which have block contracts.

Position for Activity by POD (Month 5)

Consultant Led Outpatients



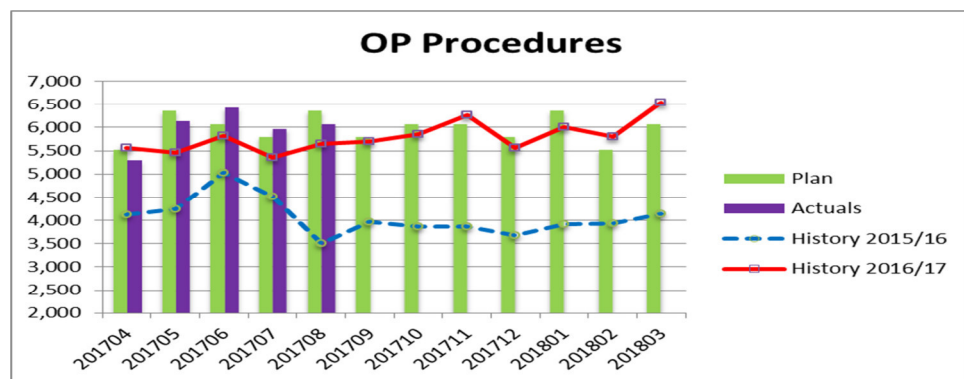
First Outpatient (consultant led) activity is 1,679 attendances (3.7%) below history and 3,013 attendances (6.5%) below plan. Specialties with the most significant variance against plan include Paediatrics, Nephrology, Urology and Vascular Surgery.

Review Outpatient (consultant led) activity is 3,436 attendances (3.9%) below history and 4,523 attendances below plan (5.1%). Specialties with the greatest variance against plan include Paediatrics, Accident & Emergency, Diabetic Medicine and Neurosurgery.

Row Labels	Plan	Actuals	Var Vs Plan	Var Vs Plan %	History 2016/17	Var Vs History
OP CONSULTANT LED - NEW	46,605	43,592	-3,013	-6.5%	45,271	-1,679
Emergency Care	1,562	1,597	35	2.2%	1,477	120
General Internal Medicine	3,617	3,507	-110	-3.0%	3,916	-409
General Surgery	3,586	2,884	-702	-19.6%	3,293	-409
Head & Neck	6,851	6,256	-595	-8.7%	6,589	-333
Medical Specialties	2,384	2,244	-140	-5.9%	2,376	-132
Obstetrics & Gynaecology	5,296	5,476	180	3.4%	5,265	211
Ophthalmology	5,732	5,426	-306	-5.3%	5,591	-165
Other	1	3	2	138.5%	3	0
Paediatrics	2,960	2,410	-550	-18.6%	2,378	32
Rehab & Elderly Medicine	3,091	3,122	31	1.0%	3,076	46
Theatres	576	554	-22	-3.7%	538	16
Trauma & Orthopaedics	6,191	6,228	37	0.6%	6,522	-294
Urology	4,758	3,885	-873	-18.3%	4,247	-362
OP CONSULTANT LED - REVIEW	88,094	83,571	-4,523	-5.1%	87,007	-3,436
Emergency Care	4,155	3,831	-324	-7.8%	4,122	-291
General Internal Medicine	9,242	9,234	-8	-0.1%	9,310	-76
General Surgery	5,384	5,728	344	6.4%	6,181	-453
Head & Neck	9,993	9,766	-227	-2.3%	9,703	63
Medical Specialties	12,956	11,687	-1,269	-9.8%	12,482	-795
Obstetrics & Gynaecology	3,446	3,185	-261	-7.6%	3,367	-182
Ophthalmology	16,842	15,990	-852	-5.1%	16,761	-771
Other	62	1	-61	-98.4%	15	-14
Paediatrics	4,619	3,833	-786	-17.0%	4,253	-420
Rehab & Elderly Medicine	3,407	3,191	-216	-6.3%	3,250	-59
Theatres	913	790	-123	-13.4%	899	-109
Trauma & Orthopaedics	9,229	9,263	34	0.4%	9,595	-332
Urology	7,847	7,072	-775	-9.9%	7,069	3
Grand Total	134,699	127,163	-7,536	-5.6%	132,278	-5,115

Position for Activity by POD (Month 5)

Outpatient Procedures



Outpatient Procedures are 2,075 procedures above history (7.5 %) however 211 procedures below plan (0.7%). The variance against plan has improved significantly this month (previously it was averaging approximately 6%). This is largely due to improvements in the recording of Lucentis procedures within Ophthalmology.

Specialties with the greatest variance against plan include Trauma & Orthopaedics, Oral & Maxillo Facial Surgery and ENT.

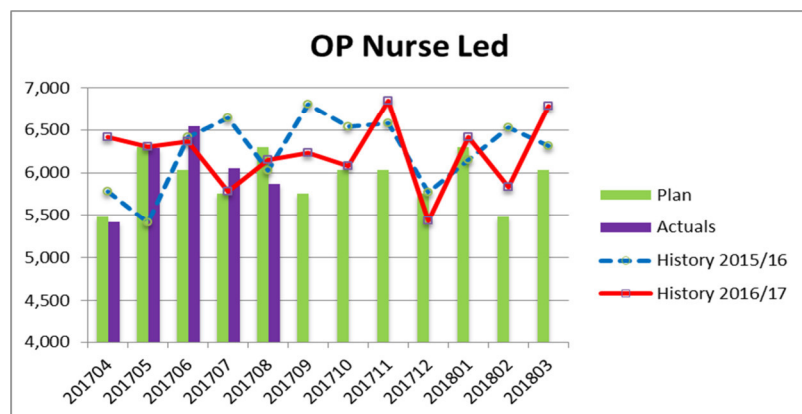
Trauma & Orthopaedics are currently 110 procedures below plan (8.2%) however 158 procedures above history (14.7%). In June, amendments were made to the booking out slip in an attempt to improve data capture. This resulted in a clinic mapping issue causing a temporary reduction in activity. The relevant corrections have since been made and the remaining under performance appears to be due to an optimistic plan as opposed to a reduction in activity.

ENT are currently 412 procedures below plan (7.9%) however 26 procedures above history (0.5%). Commissioners increased their plans in 17/18 to account for an additional 2,500 procedures that were incorrectly recorded in 16/17. Work is still 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	30,132	29,921	-211	-0.7%	27,846	2,075
Accident & Emergency	51	63	12	24.0%	20	43
Anaesthetics	0	30	30	-	18	12
Breast Surgery	1	0	-1	-100.0%	0	0
Cardiology	387	386	-1	-0.4%	397	-11
Clinical Neurophysiology	1,250	1,251	1	0.1%	1,215	36
Colorectal Surgery	106	107	1	0.6%	265	-158
Diabetic Medicine	0	23	23	-	10	13
ENT	5,224	4,812	-412	-7.9%	4,786	26
Gastroenterology	2	3	1	22.4%	2	1
General Surgery	47	26	-21	-44.6%	46	-20
Geriatric Medicine	3	0	-3	-100.0%		0
Gynaecology	1,578	1,524	-54	-3.4%	1,484	40
Medical Oncology	2	3	1	60.0%	2	1
Nephrology	1	0	-1	-100.0%	0	0
Neurology	2	0	-2	-100.0%	0	0
Obstetrics	86	320	234	270.7%	371	-51
Ophthalmology	14,813	14,660	-153	-1.0%	13,704	956
Oral & Maxillo Facial Surgery	788	723	-65	-8.3%	59	664
Orthodontics	382	460	78	20.3%	109	351
Paediatrics	147	109	-38	-26.0%	138	-29
Pain Management	0	1	1	-	1	0
Rehabilitation	0	0	0	-	0	0
Respiratory Medicine	27	21	-6	-22.1%	5	16
Rheumatology	281	513	232	82.7%	328	185
Stroke Medicine	0	0	0	-	0	0
Transient Ischaemic Attack	0	0	0	-	0	0
Trauma & Orthopaedics	1,342	1,232	-110	-8.2%	1,074	158
Upper Gastrointestinal Surgery	0	5	5	-	17	-12
Urology	3,609	3,649	40	1.1%	3,793	-144
Vascular Surgery	0	0	0	-	2	-2
Grand Total	30,132	29,921	-211	-0.7%	27,846	2,075

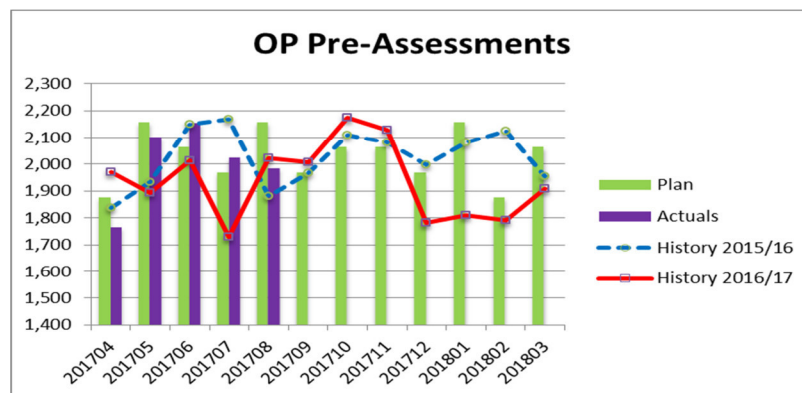
Position for Activity by POD (Month 5)

Other Outpatient Areas

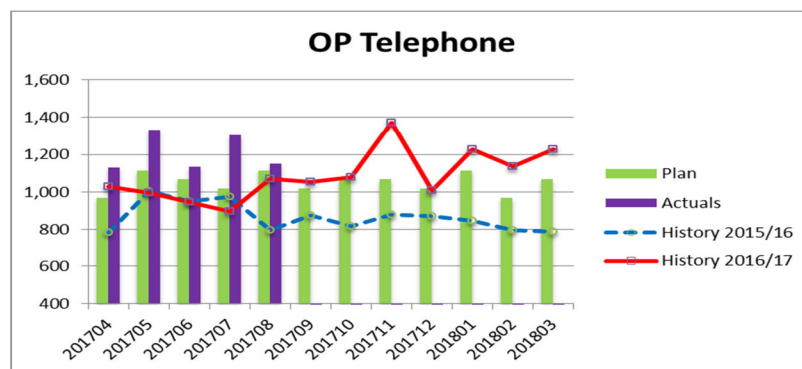
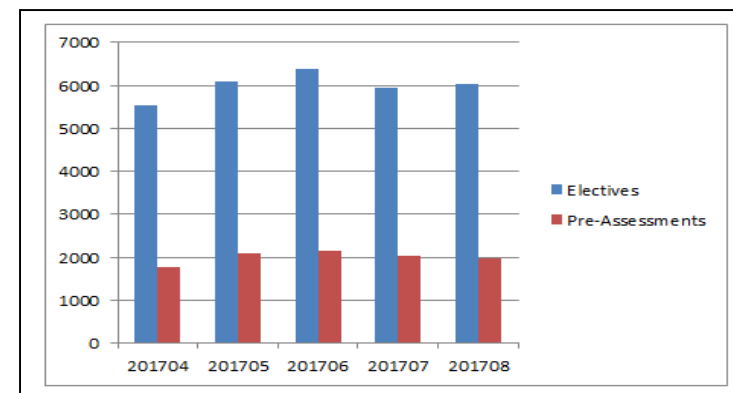


Non Consultant Led Outpatient activity is 844 attendances (2.7%) below history however 295 attendances (1%) above plan. Specialties with the greatest over-performance against plan include Rheumatology, Colorectal Surgery and Paediatrics.

Rheumatology is currently 1,191 attendances above plan (80.6%). The over performance in Rheumatology is largely due to Commissioners contracting at levels well below outturn. In contrast, the over performance in Colorectal Surgery is due to a change in the coding of various colorectal procedures following the implementation of HRG4+. This has resulted in activity switching from an outpatient procedure to a nurse led attendance. This was highlighted in forecasting however Commissioners failed to recognise the changes in their Nurse Led plans for 17/18.



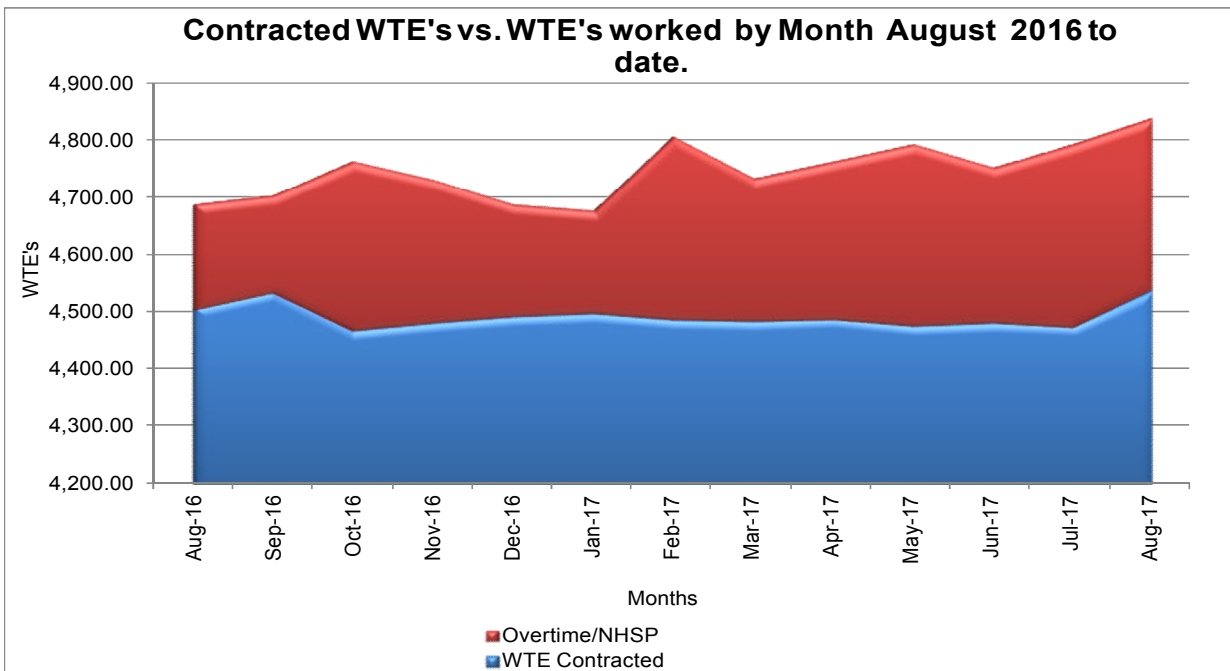
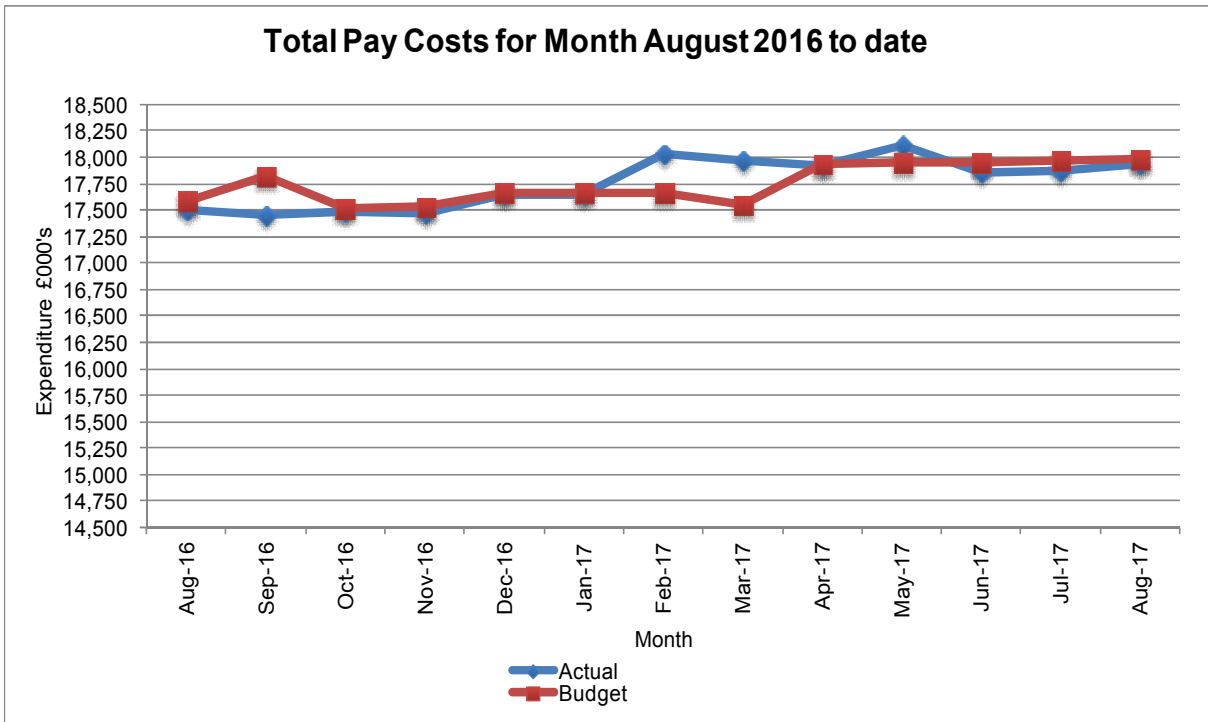
Pre-Assessment activity is 193 attendances (1.9%) down against plan and 405 attendances (4.2 %) down against history. The numbers of PAAC appointments are consistently in proportion to Electives. Not all Elective spells require PAAC.

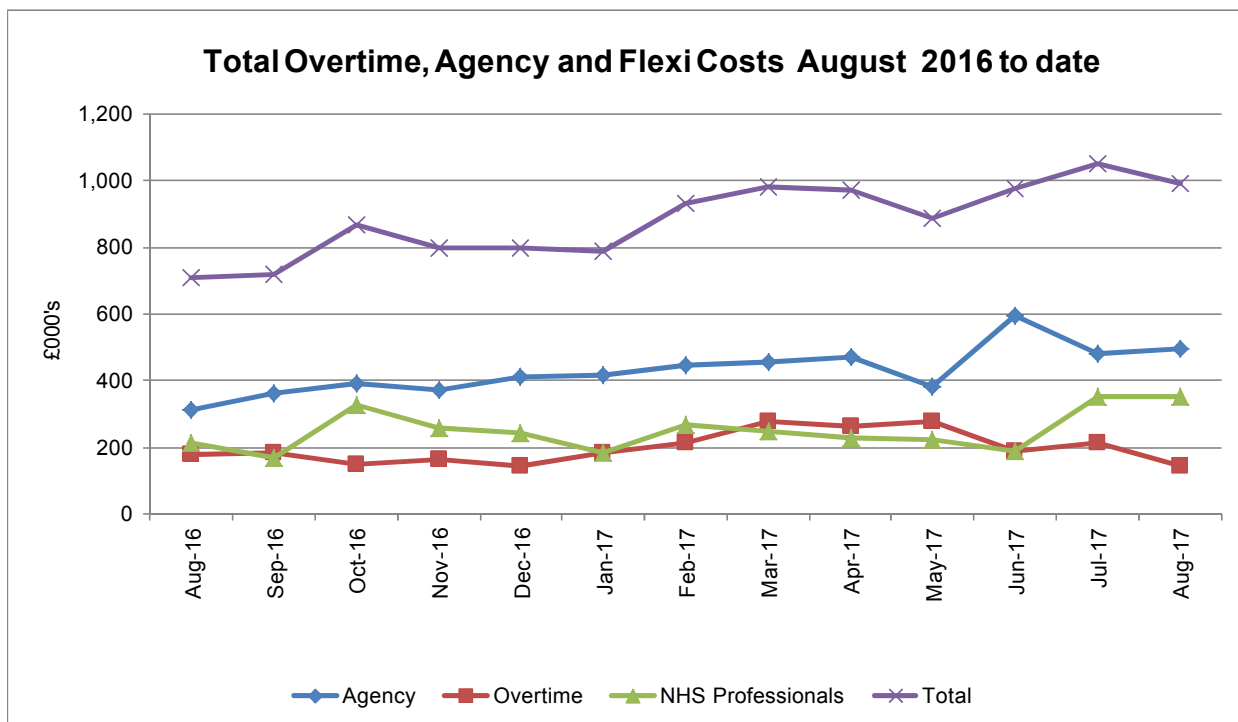


Non-Face to Face Outpatient contacts are 1,121 contacts (22.7%) above history and 767 contacts above plan (14.5%).

Specialties with the greatest variance against plan include Trauma & Orthopaedics, Endocrinology, 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.



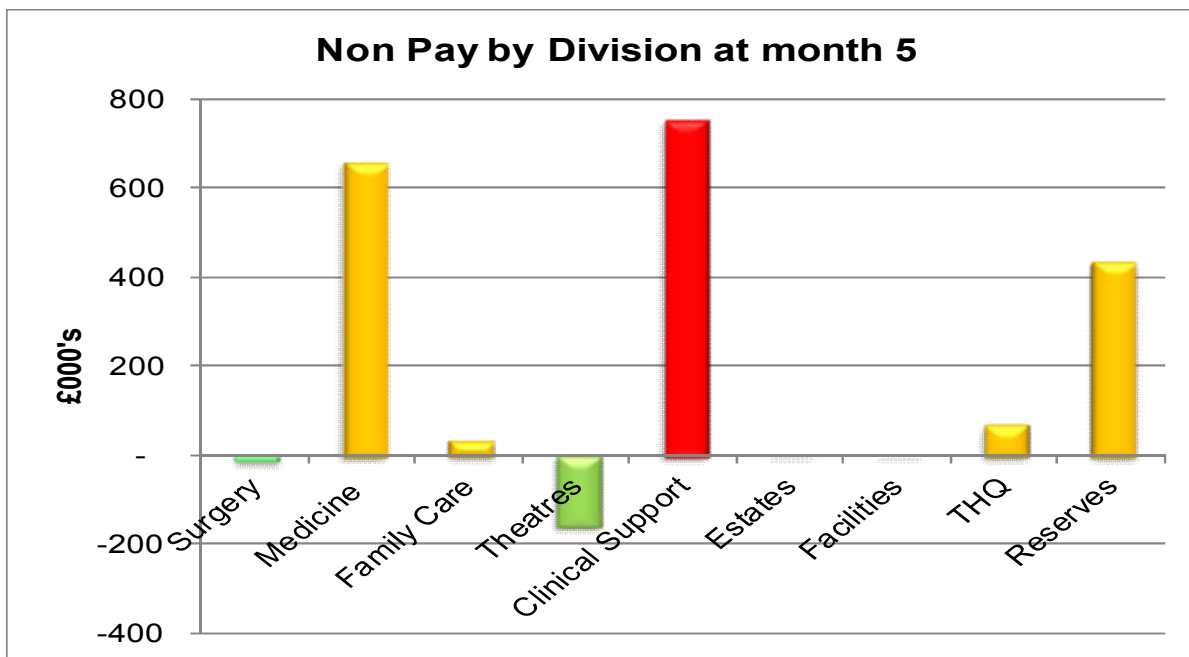
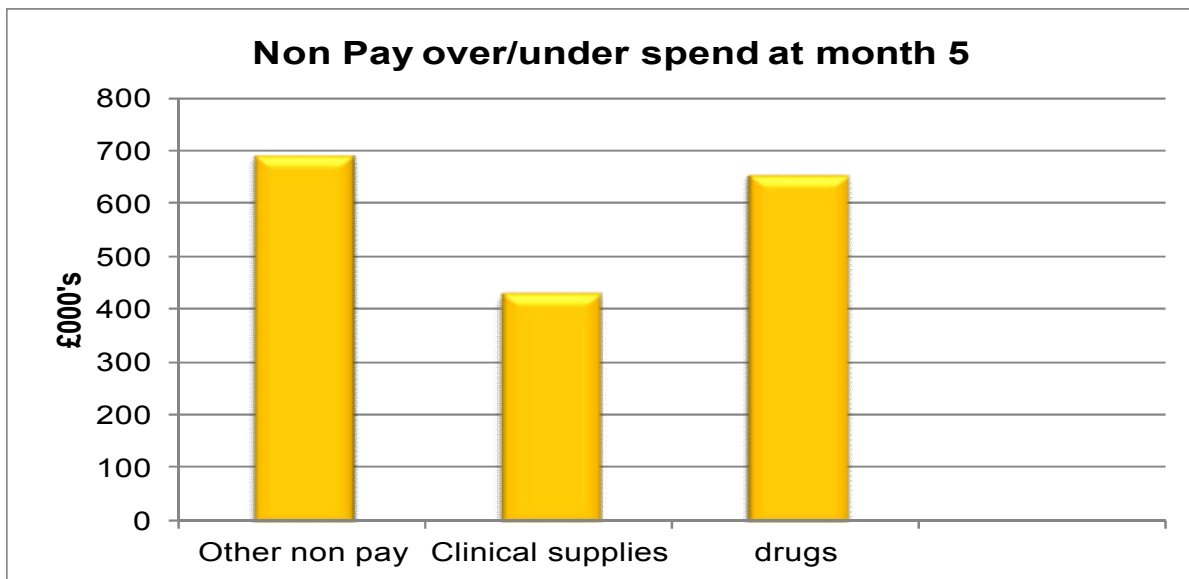


NHS Improvement Agency cap ceiling compliance City Hospitals Sunderland

	<u>Month Monthly</u> <u>Expenditure</u> <u>Ceiling</u> <u>£000s</u>	<u>CHS Annual</u> <u>Plan</u> <u>£000s</u>	<u>Actual in</u> <u>month agency</u> <u>cost</u> <u>£000s</u>
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
Jul-17	516	357	485
Aug-17	516	357	494
Total	5,442	4,186	4,929

Key Issues on pay

- WTE numbers as at month 5 are 4,841, an increase of 46 WTEs compared to the previous month. This is predominantly due an increase in NHS Professional 'bank' working in the month to cover for both Nursing vacancies and holiday cover across the trust.
- Agency spend to August 2017 was £2,432k against a budget of £1,787k.
- 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.



Key issues on non-pay

- Drugs are £656k overspent against plan to date.
- Clinical Supplies is overspent by £431k due largely to CIP under delivery of £495k against plan to date.
- Other Non Pay is overspent by £693k against plan to date, most of which is due to £368k is due to offsite CT scans and MRI scans sent to third party providers due to shortage of Radiographers and capacity at the Trust. A further £78k of the overspend is due to CIP under delivery against plan to date.

Key actions on non-pay

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

CIPs Performance

Overall Financial Position & CIP Position - Month 5

	Surgery	Theatres	Medicine	Family Care	Clinical Support	THQ Division	THQ Corporate	Gap	Total
Divisional CIP's 17/18 £000's	-2,166	-463	-2,375	-811	-1,308	-1,647	-4,231	0	-13,000
Plan to date £000's	-853	-191	-875	-294	-408	-688	-1,025		-4,334
Actual to date £000's	-1,092	-303	-649	-309	-399	-688	-577		-4,018
Variance 17/18 £000's	-239	-112	226	-15	9	0	448		316
Variance %	28%	59%	-26%	5%	-2%	0%	-44%		-7%

Key Issues with the CIP

To the end of August the planned savings are £4,334k, actual savings for the period are £4,018k, and hence behind plan by £316k.

Headline CIPs

- Surgery's nursing vacancies CIP savings amounted to £389k against a target of £147k, and hence an over delivery of £242k to date that are unidentified at this stage.
- Medicine's CIP under delivery of £226k to date is due to £600k (full year) of additional CIPs allocated this month, most of which remains unidentified at this stage.
- Clinical Support's CIP delivery is marginally behind against plan to date.
- Theatre's CIP over delivery of £112k is driven by vacant posts across all areas within Nursing and ODPs.
- Family Care's over delivery of £15k is driven by vacant posts across the division to date.
- THQ Division is break even against plan to date.

CIP - original Annual Plan vs. actual delivery plan today

	<u>Identified</u> <u>Plans</u>	<u>Stretch</u> <u>Target</u>	<u>Total per</u> <u>APR</u>	<u>This is as</u> <u>per Monitor</u>		
				<u>Plan to</u> <u>Month 5 £</u>	<u>Actual to</u> <u>Month 5 £</u>	<u>Variance</u> <u>£</u>
Revenue Generation	657	143	800	240	257	-17
Pay	5,440	1,560	7,000	2,265	2,634	-369
Clinical Supplies	2,563	-1,063	1,500	859	364	495
Drugs	893	107	1,000	337	208	129
Other Non Pay	2,662	38	2,700	387	309	78
Depreciation				245	246	-1
Total £	12,215	785	13,000	4,334	4,018	316