CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

TUESDAY, 31 OCTOBER 2017 - 2:00PM
HOUGHTON LIBRARY

AGENDA

Item 1	Declaration of Interest		
Item 2	Minutes of the meeting held 1st August 2017	Enc 1	*Ken Bremner* *Chief Executive*
	Matters Arising		
	Item 4 Consultation		*Ken Bremner* *Chief Executive*
Item 3	Chief Executive's Update	Verbal	*Ken Bremner* *Chief Executive*
Item 4	Internal Operational Winter Plan	Enc 2	*Angela Gillham* *Divisional General Manager* *Medicine*
Item 5	Inpatient Survey Results	Enc 3	*Denise Horsley* *Head of* *Quality & Improvement*
Item 6	Financial Position	Enc 4	*Julia Pattison* *Director of Finance*
Item 7	Cancer Outcomes	Enc 5	*Melanie Robertson* *Nurse Consultant* *Cancer Services*

Date and Time of Next Meeting

To be advised.

Enclosure 1

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

Minutes of the meeting of the Council of Governors held on 1 August 2017 at the Glebe Centre, Murton.

Present:
John Anderson (JNA) – Chair
Carol Harries (CH) - Trust Secretary
Susan Pinder (SP)
Chris Colley (CC)
Pauline Taylor (PT)
John Dean (JD)
Gillian Pringle (GP)
Liz Highmore (LH)
Michael McNulty (MMcN)
Ruth Richardson (RR)
Graeme Miller (GM)
Danny Cassidy (DC)
Kay Hodgson (KH)
Tom Harris (TH)

Apologies:
Jackie Burlison (JB)
Lindsey Downey (LD)
Margaret Dobson (MD)
Sue Cooper (SC)
Shahid Junejo (SJ)

In Attendance:
Ken Bremner (KWB)
David Barnes (DB)_
Julie Cox (JC)
Melanie Johnson (MJ)
Bob Brown (BB)
Alison King (AK)

Item 1 **Declaration of Interest**

None

Item 2 **Minutes of the Meeting held on 6 June 2017**

Accepted as a correct record.

Item 3 **Matters Arising**

Emergency Department – KWB confirmed that the new adult ED had opened on the morning of the 8 June 2017. There had been some minor teething problems but nothing of any

significance. The paediatric ED had also moved into their expanded accommodation and the Integrated Assessment Unit had moved into its new location adjacent to ED on 20 July 2017.

KWB stated that the department was now fully operational and was a first class facility. The Chairman queried whether we were now receiving business from elsewhere as a consequence of the new facilities. KWB replied that we were not at the moment.

SP commented that she had recently had to take someone to the new ED and could not access the road immediately in front as it was restricted to "ambulances only". KWB advised that he would check this and was unsure as to why those arrangements were still in place.

Hospedia – CH advised that a new reduced payment was being introduced by Hospedia for patients experiencing a longer stay in hospital. CH also informed Governors that the Hospedia contract was up for renewal in 2018 and the Trust would be looking at other alternative approaches in the coming months recognising the current cost to patients and their relatives.

Item 4 **Chief Executives Update**

Consultation – KWB advised that formal consultation for the first of the clinical service reviews had commenced on 5 July 2017. There had been two formal launch events which will be followed by a number of specialty specific events. KWB stated that to date there had been over 300 attendances, over 1000 hits on the website, and 60 completed survey responses.

There were to be a series of dedicated staff consultation events to be held during September.

KWB explained that there had been concerns raised by having to pre-register for an event but this was merely to ensure that the size of the hall was correct and that there were sufficient facilitators and note takers in place. There had also been concerns expressed at the large numbers of staff attending events and dominating the discussion which some members of the public had found intimidating. There had also been concern in South Tyneside regarding the involvement of staff but as KWB explained it was unrealistic to involve 9,000 staff in the discussions. A small design team had been established for each specialty and it was their task to come up with a long list of options to put before staff and members of the public. In reality there had been 40+ members of staff involved across the design groups. It was important to remember however, that consultation was for staff as well as members of the public and it was possible for staff to put forward other suggestions as long as they could be measured against the four key criteria.

KWB stated that the formal consultation process was scheduled to close on 15 October 2017 after which the CCGs would pull together a formal response and a decision was unlikely to be made until sometime in the New Year.

The consultation process had also been assessed by NHS England who were happy with the process etc. and they were required to give approval before consultation could begin.

CC commented that she had attended both the launch events in Jarrow and Sunderland and felt that 80% of people attending in Jarrow were staff whom she felt where quite disruptive at the event. CC stated that a number of members of the public had left early before the end of the meeting as a consequence. SP commented that at one of the events two midwives in particular felt quite aggrieved that they had not been consulted with.

KWB replied that there is a real difference between engagement and involvement and consultation. Unfortunately the more open we are about issues before consultation begins then there is often a real danger that consultation is then undermined.

JD commented that at the event at Tavistock Place he had queried the costs of option 1 for paediatrics which was £375k but felt he did not get a satisfactory answer and what was given was a bit of fudge. KWB replied that the events were not about the technical detail and for each option there are very detailed back up papers.

LH commented that she was concerned regarding the quality of the publicity as it appeared not to have attracted as many members of the public as it should have done. LH also stated that the easy read version of the consultation document was not yet available. LH did state however, that comments had been listened to as the structure and format of some of the subsequent events had changed on the back of those comments.

KWB confirmed that it was an iterative process and any comments were being listened to and taken on board wherever possible. MMcN commented that he had attended the Hope Street Exchange event and was struck by some of the issues raised such as transport and that there was a lot of scepticism and feeling in the room.

KWB replied that transport was a very personal issue and one of the public scrutiny meetings was devoted to transport at which the independent assessors had been invited to attend. KWB stated that he expected that there would be a second meeting required because of the strength of feeling of that issue. The

independent assessors were looking at averages not individual journeys.

SP stated that information regarding transport would be better if it gave more than a mean average as then there is a perception that it is not honest information being presented. KWB replied that the independent travel company had produced a 250 page report which included many permutations.

RR commented that she had attended a meeting regarding maternity services and new mums who were there were not expressing concerns except the availability of having a water birth, and there being sufficient midwives. KWB replied that a second birthing pool was something we were looking at but with all such things there was a cost involved.

SP queried whether a midwifery led unit only took low risk pregnancies. SP also stated that if the vast majority of pregnancies were not low risk in South Tyneside then many women may opt to go to Gateshead. KWB confirmed that these were all issues being raised during the consultation about which there would be further discussion and debate. He did confirm however, that midwifery led units were for low risk births.

JD commented that in terms of consultation there were about 84 stakeholder groups and how were they being involved. JD suggested that a specific event for them would be good to get more involvement. KWB replied that stakeholder groups were involved on a more specialty specific basis so for example the Stroke Association had been actively involved in the stroke clinical service review.

The Chairman queried what LH had meant regarding publicity. LH replied that she felt it was inadequate and people were not aware of the events. LH also stated that registering on line for some people was difficult. KWB replied that members of the public could telephone etc. – registration was not just available on line.

KWB encouraged Governors to attend some of the consultation events.

Item 5 **NHS Winter Plans**

KWB informed Governors that winter plans had to be ready by 1 September 2017 and as far as the NHS was concerned winter started on 1 December 2017. The main focus was about having capacity in the system, an emphasis on delayed transfers of care, and on primary care streaming at the front door of the hospital.

In terms of the latter issue we had been invited to bid for funding and we had received £875k for CHS to support that approach.

KWB also commented that the NHS was trying to be clearer on the names for walk-in centres etc. by calling them urgent treatment centres which would be accessible 12 hours a day, 7 days a week. They would have on site diagnostics and access would be bookable by appointment.

SP queried the urgent care centre in South Tyneside which was an issue raised at the consultation events. KWB replied that there was history about the closure of the Jarrow walk-in centre which had left bitterness and anger amongst the local population and clearly clouded some judgement. There were however, other opportunities in South Tyneside.

The Chairman asked CH to provide details of such centres in Sunderland and South Tyneside to Governors.

Ambulance Response Times – KWB advised that new response times had been published which were 8-7 minutes for life threatening and 8-18 minutes for non-life threatening. The North East Ambulance Service were clearly looking at the implications.

GMC Survey – KWB advised that an annual survey by the GMC had ranked CHS as the top North East acute trust for training. The survey which looked at the quality of postgraduate medical education whilst ranking us 1st in the North East but also 25th nationally out of 207 Trusts. KWB stated that this was a great achievement for the Trust, the Medical Education department and other supporting specialties.

STP – KWB advised that all STPs had been ranked and the North STP had been identified as advanced and the South STP in the region as outstanding. KWB stated that Cumbria had also received considerable investment on the back of their plans.

Item 6 **Medical Education Update**

Dr Julie Cox (JC) presented the update which highlighted progress with Medical Education.

JC informed Governors that three physician associates had commenced at the Trust on 26 June 2017 for an initial 5 week clinical attachment. The students would return to the Trust in September to undertake the rest of their training. JC stated this was a graduate programme and a new and exciting role for individuals and potentially for the organisation.

JC advised that the University of Sunderland had submitted a bid to the GMC to establish a medical school with the first cohort of students potentially commencing in September 2019. MMcN queried as to what had happened to Medicine in Durham. JC

replied that the Stockton campus had now gone and the staff transferred to Newcastle University Medical School.

JC also highlighted the results of the 2017 Foundation School Your School Your Say survey (YSYS) which had achieved 100% response rate and some very positive results with areas for development being working beyond competence/work intensity, e-portfolio and bullying and harassment.

KWB commented that whilst the results were good they vary year on year dependent upon the junior doctor intake and therefore needed to be treat with caution. KWB acknowledged that it was not an easy time for junior doctors particularly over the last year with national concerns about the contract.

The Chairman queried as to how junior doctors were allocated. JC replied that Foundation doctors applied to a national programme and were then allocated placements. The junior doctor level above Foundation doctors were allocated on rotation.

JC also highlighted the results of the GMC national trainee survey which again had shown very positive results for CHS. The main areas of concern being study leave in surgery and urology, supportive environment in respiratory medicine and clinical supervision out of hours in Geriatric Medicine.

PT queried as to how much study leave a junior doctor was allocated. JC replied that their shift patterns were really complicated but in reality this was about 30 days a year. JC explained that this amount of study leave is often difficult to fit in and on many occasions juniors do not request the leave within a sufficient time frame. PT queried whether the study leave was to attend conferences etc, JC confirmed that this was correct.

JD queried whether trainees were allocated between STFT and CHSFT. JC replied that at the moment we were two separate organisations and therefore from a trainee perspective two independent sites. JC advised that as STFT was smaller they had fewer trainees but that the allocation was determined by Health Education North East.

JC also stated that work was ongoing however to combine the medical education departments across both Trusts and a draft upper tier structure had been produced. During the recent ARCP programme both Trusts had worked together with Foundation Programme tutors cross chairing panels and this had been very successful.

Resolved: To accept the update.

Item 7 **Safeguarding Adults Annual Report 2016-17**

MJ presented the report which provided a summary for 2016/17 of the safeguarding adults activity and the arrangements in place with regard to the statutory responsibilities under the Care Act (2014).

The Care Act sets out the statutory framework for adult safeguarding, stipulating local authorities' responsibilities and those with whom they work, to protect adults at risk of abuse or neglect. Partner agencies including CHS have a duty to cooperate which is placed upon them under the Act.

MJ stated that this was the first time for a joint report to be produced for STFT and CHSFT as there was now an integrated safeguarding adults team but she would clearly concentrate on issues at CHS.

MJ explained that the governance arrangements were quite complex and were outlined on page 5 of the report. MJ highlighted page 6 – referral rates and stated that referral rates in Sunderland were lower and that was partly about awareness training for staff. It was also a balance between over referring and referring in the right way.

LH queried whether awareness training included coercion and control. MJ confirmed that this was included.

JD commented that when you looked at the chart on page 7 – Sunderland was an outlier in terms of referrals etc. MJ replied that we were not making enough referrals from CHS and it was about education and raising awareness – now that we had a joint safeguarding team we would learn some of the lessons from STFT and they would benefit from our approach to safeguarding children.

MMcN queried how if individuals were not in receipt of services how they were identified under the broadening of the criteria of the Act. MJ replied that they may attend for treatment and it may be very obvious but we also had to think of the wider family implications.

MJ also highlighted the safeguarding adult review process (SAR) which did provide considerable learning. MJ advised that one SAR had been published in February 2017 and involved concerns regarding domestic abuse. A multi-agency action plan had been implemented to seek assurance that all partner agencies would learn lessons in respect of recognising and responding to domestic abuse.

MJ informed Governors that in December 2016 a full time Independent Domestic Violence Advisor had been given an honorary contract in CHS. The individual employed by Wearside Women in Need provided support and guidance to patients who were suspected of being victims of domestic abuse. The individual works particularly with the ED team but also has a wider awareness raising and education role. The post had originally been funded by the CCG and extended for another year.

JD queried page 13, section 5.19 of the report and the recording of face to face discussions and telephone calls.

MJ replied that this had not happened in Sunderland as there was only 1 person in the team who did not have the capacity to do this – however a priority for 2017/18 would be to commence capturing this information for reporting purposes.

RR commented that it would be helpful for Governors to have a workshop covering areas such as MARAC, IDVA, Mental Capacity etc. CH confirmed that she would arrange a workshop to discuss the issues.

Resolved: To receive the report.

Item 8 **Safeguarding Children and Looked After Children Annual Report**

MJ presented the report which provided assurance that the Trust was fulfilling its statutory responsibilities to safeguard children and young people.

MJ highlighted the roles and responsibilities of key individuals within the Trust in relation to their safeguarding responsibilities.

MH stated that referrals had decreased in 2016/17 although mental health, substance misuse and domestic violence continued to be the significant underlying causes for child protection referrals to Childrens Services. MJ advised that the reduction did not present as an issue, as this was in line with children services improvements of agencies adhering to agreed referral thresholds. An outcome of the recent Ofsted inspection was to ensure that the referral process was correct and appropriate.

MJ also highlighted page 17 of the report – child protection supervision and emphasised how supervision was integral to providing an effective ‘think family’ philosophy. It was also important to ensure that we supported practitioners both professionally and emotionally.

RR queried page 21 and expressed concern at the training level compliances particularly for paediatrics and child health. MJ replied that this had been an issue which was now resolved.

The Chairman queried whether the CQC oversaw child protection arrangements. MJ replied that they did and if we were inspected this would be something that they would look at. Sunderland had been inspected a few years ago but they had recently been to South Tyneside to look at child protection. It was unlikely that there would be a specific review for Sunderland unless there were any concerns which MJ was not aware of. MJ stated however, that she was not complacent and there was always room for improvement.

The Chairman commented that there had been issues regarding safeguarding children within the Local Authority which had previously been reported to the Board.

GM commented that unfortunately the LA had not moved with the times but was now turning a corner. He stated that partnership support was very strong and it was good to see the report and the work that was happening. GM also commented that he had always been concerned across the city that safeguarding adults had not received the level of input that it required but that was changing.

CC stated that she was a Governor at a local school and the headmistress was not happy with the reporting for a child and queried whether GM could help.

GM replied that it was a straight forward referral process as far as he was concerned but that he would speak to CC after the meeting.

Resolved: To accept the update.

Item 9 **<u>Performance Report</u>**

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

AK highlighted performance for cancer targets and advised that the Trust had seen the lowest performance for 62 day referrals in the last 12 months. There had been 16 breaches in Urology because of patients on the prostate pathway although the position was recovering in June/July. AK stated that all patients who did not achieve the 62 day target were subject to a full root cause analysis investigation.

Urology had also had a business case approved which would support additional resource and capacity going forwards.

MMcN queried where data relating to cancer waiting times and survival was published and was it possible for Governors to get that detail. MMcN stated that he had previously asked for this information. AK replied that it was published as part of the CCG performance data. KWB commented that the data would be for the population of Sunderland generally, many of whom would not necessarily be having treatment at CHS and therefore more tricky to get the detail. KWB advised that we would see what was available and apologised if the issue had been raised previously and not responded to.

AK highlighted diagnostic performance and advised that performance remained above the 1% standard at 2.58% and a revised trajectory had been provided for NHSI which shows achievement by September 2017.

AK stated that A&E performance for June was marginally below the 95% target at 94.89%. AK stated that the CCG were in discussions to look at performance for the A&E Delivery Board as a whole and performance on that basis would be above target at 95.82%. The Chairman queried as to what in reality that actually meant. AK replied that it included all the urgent care detail. The Chairman also queried as to how 'live' was the data collection. AK replied that it was down to the minute by individual patient and was very closely managed and validated on a daily basis.

JD queried the impact of the new ED and the optimisation of throughput. AK replied that we were waiting for all the elements to be in place, IAU being the final element which had only recently moved into its new location. JD suggested that there was now clearly an opportunity for further improvement in performance.

Resolved: to accept the report.

Item 10 **Quality Path to Excellence**

Bob Brown (BB) gave an overview of work to date to produce a Quality Strategy for both CHS and STFT. BB explained that whilst both organisations were required and indeed produced an annual Quality Report there was a real need to have an overarching quality strategy. BB stated that it was important to focus on the right issues and to have something that was simple, deliverable, measurable, translatable and affordable.

BB advised it was important to consider whether delivery of the strategy would tackle unwarranted variation in practice as

sometimes variation could be harmful. BB explained that the drivers for improvement within the presentation set the context for the strategy and the whole team had a responsibility for an emphasis on quality.

BB stated that the strategic framework set out four key strands and it was his ambition to be able to publish something in the autumn.

RR commented on the strategic framework and in particular – “building vitality, leadership capability and effective team working” and queried whether there was any in-service training for leadership for all grades of staff.

BB replied that there were some opportunities but that we could go a lot further and that there would be a new leadership plan as part of the organisational development framework. RR suggested that quality will improve if there is good leadership.

JD suggested that an oversight group was needed to look and scan quality areas on a regular basis and queried as to how that was happening. BB replied that this happened in a number of ways for example a weekly rapid review group looking at incidents and trends etc., a Board Assurance Framework setting out what we do and levels of achievement, and that it was more about triangulation.

JD stated that the presentation suggested implementing a risk management framework. BB replied that this was about an opportunity to create a single framework to assess, respond to, and investigate risks. JD queried whether this would be common across both organisations. BB replied that Fiona Kay was hoping to publish something in the autumn.

LH stated that as part of patient experience, support for patients who were admitted for reasons other than any disability they may have was really important and suggested that such issues needed to be part of mandatory training.

BB stated that he was happy to take further comments by email or to have individual discussions.

Resolved: To receive the presentation.

Item 11 **Any other Business**

Honarary Fellowship – LH stated that KWB was to be congratulated on his recent Honorary Fellowship from the University of Sunderland.

Nursing Conference – CC advised that she and PT had attend the recent nursing conference which had been an excellent event.

JOHN N ANDERSON QA CBE
Chairman

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

INTERNAL OPERATIONAL WINTER PLAN

OCTOBER 2017

EXECUTIVE SUMMARY

Each winter brings with it a number of challenges that affect service delivery, including the balance of emergency and elective activity, together with the flow of patients from admission through to discharge to usual or alternative place of residence. This is further impacted by challenges such as severe weather, seasonal flu, Norovirus and the impact of festive public holidays. Winter surge usually occurs each year from the beginning of January until around April, leading into May, although it is recognised that increasingly surge can happen at any point throughout the year. This year's Winter Plan aims to be operational from November 2017 through to May 2018.

This paper seeks to outline City Hospitals Sunderland NHS Foundation Trust (CHSFT) plans for ensuring proactive management of the patient pathway, maintaining flow, facilitating safe and timely discharge and the efficient use of in-patient bed capacity during the winter surge in addition to utilising support from our external partners.

The paper is part of the Trust's approach to managing the winter surge and will be issued in conjunction with a number of further Standard Operating Procedures and Plans available under separate cover.

This paper outlines the internal operational plan but to achieve true resilience must be part of a wider City approach.

Governors are asked to receive this paper as assurance that the organisation has taken steps to plan for winter pressures and minimise the impact of the additional activity and attendances it is anticipated will occur.

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

INTERNAL OPERATIONAL WINTER PLAN

OCTOBER 2017

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1. Introduction

1.1 Background

Pressure on health care services can occur at any time during the year, but are at their highest and most sustained during the winter period. Expectations of the public are that services will be continued in the usual way and therefore robust resilience planning is required to provide assurance during this challenging period. This plan will outline how CHS will prepare, mitigate and respond to these pressures.

Pressures during this period are across the whole health care system and it must be noted that a whole system approach is required and therefore the CHS plan will work in alignment with all others in the City Wide Health Care system.

1.2 Scope

The plan will cover CHS internal response to the winter period but will require delivery of other agency plans to support overall sustainable delivery.

1.3 Links to other internal policies / procedures

This paper should be considered alongside and supports other policies/procedures such as:

- Hospital Discharge Policy
- Integrated Assessment Unit Operational policy
- Discharge Lounge Standard Operational Procedure
- Escalation Standard Operational Procedure
- Seasonal Flu and vaccination programme
- Directory of services
- Pandemic Flu Plan
- Critical Care Escalation
- Maternity Escalation
- Inclement weather guidance

1.4 Monitoring and Implementation

CHS has a Multi-professional winter planning team which is operational throughout the year and as such falls under the remit of the Safe and Sustainable Emergency Care Group. The group monitors a number of work streams of which winter planning is one. The group is responsible for operational review and implementation of the plan across the organisation and contributes to the content of the final winter plan prior to it being taken forward for Trust Board approval. The work of this group will feed into the external governance structures for Urgent and Emergency Care as part of Winter Planning across the health community.

2. Escalation Plans

2.1 Operational Pressures Escalation Levels Framework (OPEL)

The OPEL Framework was published by NHS England at the end of October 2016 with the aim of providing a single national system to bring consistent approach in times of pressure to local approaches, improve management of system-wide escalation, encourage wider co-operation and make regional and national oversight more effective and less burdensome.

The aims and objectives of the OPEL Framework are to provide a consistent approach in times of pressure, specifically by:

- Enabling local systems to maintain quality and patient safety.
- Providing a nationally consistent set of escalation levels, triggers and protocols for local A and E Delivery Boards to align their existing escalation processes with.
- Setting clear expectations around roles and responsibilities for those involved in escalation in response to surge pressures at local level (provider, commissioners and local authorities), Directors of Commissioning Operations and NHS Improvement sub-regional team level, regional level and national level.
- Setting consistent terminology.

The OPEL level status indicates the level of escalation which an organisation is declaring and is reported on a daily basis reflecting the highest OPEL status. For the purposes of SITREP this reflects the previous 24 hours, however when used operationally this can be almost in 'real' time. OPEL levels are reported 3 times each day throughout the year via the Flight Deck which is collated by NEAS and overseen by North of England Commissioning Support Resilience Planning, Escalation and Surge Management Team.

2.2 Command and Control

The Divisional General Manager has the authority to declare a level or to escalate or de-escalate OPEL levels. Out of hours for the purposes of informing the flight desk the 1st on call senior manager has delegated responsibility to declare.

When the Escalation SOP trigger levels have been reached, Operational Control will be established and this will support the Patient Flow Management team meetings. Operational Control base is located in the operational control room on D level above ED. Operational meetings will be initiated when the Trust is in escalation amber and will be chaired by the Directorate Manager on call.

When SOP trigger levels reach red escalation the Divisional General Manager will be present and will chair the Operational meeting.

When SOP trigger levels reach black escalation the Director of Operations will be present and will chair the Operational meeting. In the absence of the Director of Operations the 2nd on call will assume this role.

Once OPEL level 4 is declared then Tactical command will be established. The Tactical command team for winter pressures will comprise: -

- Lead Director Winter planning/Accountable Emergency Officer
- Director of Nursing
- Director of Operations
- Divisional General Managers
- Medical Director
- Head or Deputy Head of Infection Prevention and Control
- Head of Communications

This team will meet as required to determine the strategic/tactical requirements for winter and to liaise directly with the Clinical Commissioning Group/s (CCGs) and other agencies and manage communications relating to actions required. Operational control can request Tactical command support at any time during a surge in activity and will automatically be established when OPEL level 4 is reached.

Tactical command will authorise any decisions to implement Business Continuity Plans. Tactical command will be led out of hours by the Director (2ND on-call)

2.3 Standard Operating Procedure (SOP) for the 'Trust wide Response to Surge'

A Standard Operational Procedure is in place to ensure staff across the organisation are made aware of increasing pressures at an early stage, to take proactive action to try to prevent further escalation (both back and front of house) and to minimise the impact of the surge on patient care and flow.

The SOP has been designed to highlight meaningful triggers, early identification and proactive intervention, with a view to delaying or stopping further escalation and surge.

The key areas of the SOP include:

- Issue escalation process.
- Defining the escalation status.
- Communication of Trust escalation status.
- Response to escalation status.

The escalation status is currently communicated across the bleep system 3 times daily or with an increase in escalation status e.g. from green to amber. In addition the escalation status is communicated 3 times daily via e-mail and updated on the intranet by Corporate Affairs as soon as possible following receipt of the escalation status.

2.4 City Wide Surge

There is a Sunderland Surge Protocol which enables any provider across the City to call for mutual aid during times of pressure. A Surge command meeting can be called any time within or out of hours upon request of CHS or a partner organisation. This may be in the format of a face to face meeting or telephone conference call. This provides the ability to share resources to mitigate surge pressure and de-escalate effectively. The Surge group also has access to contingency funding to support City wide capacity and flow.

3. Managing Patient Flows

The following section will describe the systems and processes in place to create the capacity required during the winter period and anticipated surge.

3.1 Emergency Department (ED) Capacity

This will be the first winter of the ED working within its final footprint. This provides a purpose built environment for the ED to operate from, offering more flexibility and resilience at times of pressure. Capacity and demand is closely managed using the operational escalation plan which has a trust wide response to the pressure at the front door. Initiatives such as the proactive pull from Emergency Ambulatory Care and North East Ambulance Service (NEAS) Pathfinder ensure that the patient reaches the right place, first time, supporting positive patient flow in the Emergency Department.

3.1.1 Urgent Care Centre (Pallion)

CHS has ownership of the 4th Urgent Care Centre in Sunderland. Appropriate Type 3 patients are steamed from the ED front door to the 4th Urgent Care Centre which supports capacity on the main corridor and ensures effective General Practitioner (GP) streaming consistently 7 days per week. The Urgent Care Centre is GP led and part of the 111 DOS.

3.1.2 Patient flow through the Emergency Department (ED)

CHS ED has both nurse navigator and flow facilitator roles within the Department which support the journey of patients to the most appropriate environment.

The outcome of the patient's journey through ED will result in discharge, emergency ambulatory care or an inpatient admission.

In reach teams support the ED with appropriate timely facilitated discharge including complex discharge nursing team, interface team, OPAL (Older persons assessment liaison), Frailty and NTW Raid Mental Health Team. During the lead time into Winter an “ED Interface Team” will be established, incorporating all of the above teams and developing a Trusted Assessor model.

3.1.3 Ambulatory Care

A significant proportion of adult patients requiring emergency care can be managed safely and appropriately on the same day as a same day care episode. City Hospitals Sunderland has embraced Ambulatory Emergency Care which has become an accepted and recognised treatment modality.

Encompassed within the Emergency Ambulatory Care Unit (EACU) are processes and pathways to ensure accurate and timely assessment and management.

The purpose of the unit is :-

a. To facilitate assessment of patients who deemed as suitable for ambulatory care.

b. To provide rapid assessment, investigation and treatment for patients who do not require admission.
c. To arrange rapid investigations, treatment and post discharge follow up for patients who do not require admission.
d. Assessment and investigation and depending upon outcome referral to dedicated daily clinics for those patients who do not require admission to City Hospitals Sunderland.

EACU is located directly above the ED and Integrated Assessment Unit (IAU) providing a streamlined assessment footprint. This enables greater flexibility between the units and supports admission avoidance, greater interchangeability of admissions and ambulatory care referrals and improved rapid access to senior decision makers.

Medical and Surgical ambulatory care are co-located.

EACU proactively seek and pull patients from the Emergency Department that are deemed suitable for ambulatory management. This takes place on a planned basis three times a day.

Speciality Ambulatory Care

Urology

The Urology rapid access unit (URAU) is led by Nurse practitioners and supported by Urology Medical staff. The unit is open from 08:00 to 20:00 7 days a week. It delivers emergency urology assessment/input to patients that previously would have attended ED or admitted direct to the ward for their initial assessment.

The unit will accept all acute non - life threatening urology emergencies, provide ambulatory urology care, and receive direct referrals from General Practitioners, District Nurses, and ED from all spoke sites in addition to City Hospitals Sunderland.

All telephone calls will be triaged by experienced Urology Nurse Practitioners, accepted and requested to be transported to URAU or alternative advice given depending on presentation or complaint.

Patients will then attend URAU to be assessed, managed and discharged or admitted direct to the Urology ward if further in-patient management is indicated.

ENT

The ENT Ambulatory care unit is situated on ward C33 with 5 Trolley/Chair spaces and a dedicated treatment room for ENT urgent care assessment.
The unit is currently open for referrals between 09:00 – 17:00 and is medically led with Registered nursing support.

The purpose of the unit is:

a. To facilitate assessment of ENT patients referred from GP's, ED or from other hospitals who: are deemed as suitable for ambulatory care or admission.

b. To provide rapid assessment, investigation and initiation of therapy for ENT patients who do not require admission.
c. To arrange rapid investigations, treatment and post discharge follow up for ENT patients who do not require admission.
d. Assessment and investigation and depending upon outcome referral to dedicated daily clinics for those patients who do not require admission to City Hospitals Sunderland.
e. To provide rapid assessment, investigation and initiation of treatment for ENT patients that will require admission to the main ward.

Gynaecology

Patients who present with gynaecological issues are triaged by the ED staff and if appropriate (i.e. patient is stable and does not require resuscitation or immediate transfer to theatre) are referred to Gynaecology. Following agreement between clinical staff, these patients can be transferred to Ambulatory Care on Ward D47 for ongoing investigation and treatment.

Clinical guidelines are in place for patients with a PV bleed related to pregnancy and these should be followed when applicable.

Ambulatory care is open 08:00 to 19:00 but patients can be transferred to the ward subsequently by agreement with the Registrar.

The Directorate are currently working with the NEAS Pathfinder Liaison Officer, to enable D47 ambulatory care to accept direct referrals from NEAS, thus omitting some Gynae admissions to ED.

EPAU is open mornings seven days per week. Patients are seen by appointment.

3.1.4 GP Assessment Area (GPAAS)

The GP Assessment Area is co-located with the ED and IAU; this allows GPs to send patients needing admission in for assessment without having to go via ED. Paramedic Pathfinder also have access to the GPAAS for patients they feel may need an admission. Patients are assessed in GPAAS and then directed as needed either to IAU for an admission or to EACU to be manged via an ambulatory pathway.

3.2 Services to Support Flow

3.2.1 Hospital Interface Team

The team consists of qualified Occupational Therapists, Physiotherapists and Generic Assistant Practitioners. The aim of the team is to provide a rapid multidisciplinary assessment and intervention at Front of House, as well as responding to urgent community referrals via the Intermediate Care Hub. The assessment is aimed at preventing hospital admission and re-admission and facilitating timely discharge. The team work to specific measurable response targets. The service is provided 365 days per year, operating from 08:00 to 19:30.

The team provides a rapid assessment of patients in the ED, the 4th Urgent Care Centre, Fracture Clinic and Ambulatory Care; providing functional assessment, provision of aids and adaptations and assessment for support services in the community.

The team also assess relevant patients on IAU and the short stay ward B20, with the aim of returning patients to their own home, either independently, with aids and adaptations, with support from reablement, or by accessing beds in bed based rehabilitation services.

3.2.2 Complex Discharge Nursing Service:

The complex discharge nursing service works collaboratively with both in hospital and out of hospital services in providing a multi-disciplinary approach to patient flow and appropriate and timely discharge destination.

There are Front of House Complex Discharge Sisters and Back of House Complex Discharge Sisters who provide a seven day service at CHS.

The Front of House Discharge Sisters work in ED and assessment areas to offer specialist advice and assistance in arranging support services in the community rather than an admission to an acute hospital bed. They work closely with the Interface Team, Frailty Team, Community Geriatric Service and the Recovery at Home service.

Back of House Complex Discharge Sisters work closely with the Recovery at Home, Hospital Social Work teams and other members of the Multidisciplinary team to identify patients with complex discharge needs to facilitate a timely discharge for patients who are admitted into the organisation.

3.3 Capacity Modelling

Operational delivery is supported by predictor indicators with the aim of further supporting operational planning on a day to day / week to week basis.

As of the 1st November there will be a weekly prediction meeting to establish pending challenges based on historical predictions. This information will then feed into the weekly Surge meeting with external partners to facilitate wider system planning.

3.3.1 Escalation Capacity:

Escalation Beds

Recent analysis has confirmed that over the winter period inpatient demand exceeds available inpatient bed capacity. In planning for this 15 additional acute inpatient beds are planned to be in the system formally as of 27th December 2017. These beds will be available for acute patients and will sit within the Division of Medicine from an organisational structure perspective.

The escalation area will be part of a larger current ward team with senior leadership to support. The area will be the annexe adjacent to ward E54 and will sit within the Directorate

of General Internal Medicine from a Directorate perspective and as such have identified Clinical Director, Directorate Manager and Matron.

Although modelling clearly indicates the requirement for additional bed capacity; it must be acknowledged that nurse staffing support is a risk. A co-ordinated piece of work has been undertaken to identify nursing workforce support from across the organisation to determine how staff can be deployed in the most efficient and effective way. There will be continual assessment of nursing workforce with the nursing workforce tool being updated on a weekly basis by the matron team. The matron for the escalation area has been given delegated authority to have overall management of this supported by the matron team.

Should further escalation capacity be required during periods of extreme Surge, there are a further 2 bays available; 1 on ward D46 and 1 on ward D47. It is acknowledged this will place further pressures on nurse staffing which will need to be taken into consideration during any decision making processes.

3.3.2 Non-Elective admissions

Division of Surgery

The pressure in terms of non-elective presentations to the Division of Surgery will be managed through command and control to ensure that there is as little impact as possible on elective workload. The teams will promote ambulatory management of patients where possible and access to 'hot clinics' and timely response to both ED and IAU, to promote patient flow.

3.3.3 Elective admissions

The ability to restrict elective activity during the Christmas period is extremely limited due to the nature of the 18-week target and the volume of cancer patients across the Division of Surgery.

The Directorate Managers for each specialty will take responsibility, as part of their actions for surge, to draw up a daily list identifying those patients in series of priority who will have their operations suspended if there is pressure on capacity. These lists will be with the Patient Flow managers by 10am each morning. An additional planning meeting will be held on Thursdays to look ahead at capacity within the Division for over the weekend period. Care will be taken to ensure that this does not impact on the 18-week pathway or patients referred under the 2 week rule for cancer.

For the full month of January 2017, the Division of Surgery will primarily concentrate on Day Case, Cancer and urgent procedures, to reduce the reliance on in-patient beds during this pressurised month of surge, then revert to usual working and case mix. The Division of Theatres will work with the Division of Surgery to help maintain as much elective activity as possible through Day Case Unit and for those patients with an expected length of stay of 1 day. At times of escalation consideration will be given to staff the 23 hour stay unit with the aim to manage these patients without the need for an overnight stay on a base ward.

Each Directorate will produce a capacity and demand plan for this period, detailing what cases will be done and when, the impact on 18-week RTT, any remedial actions required and any areas where increased outpatient activity can take place rather than theatre activity, without a detrimental impact on waiting times.

3.4 External Capacity

3.4.1 Recovery at Home Service

CHS has worked closely with external providers, to identify a number of community options to be made available to us, for those patients who are medically fit for discharge, who may have ongoing nursing needs but are waiting for an element of their discharge arrangements to be complete. One of these key services is the Recovery at Home Service

The Recovery at Home Service provides a 24/7 'Single Point of Access' to time limited health and social care support for patients and carers that will link into and compliment any existing services the patient may have in place.

The Recovery at Home service offers the following services:-

- A Single Point of Access (SPOA) for access to the full range of intermediate, Health and Social care community and bed based services. The SPOA ensures simplicity and clarity for users, through referral to an integrated Intermediate Care hub on 0191 561 6666. There is also provision and agreement in line with a Trusted Assessor Model for each hospital ward to have direct access to Recovery at Home services through the SPOA.

- Step Up/Admission Avoidance – to support individuals to remain in their usual place of residence wherever possible by offering a rapid response to:

    - Individuals in the community experiencing an acute episode of illness or exacerbation of pre-existing condition or illness.
    - Individuals who do not require the level of medical intervention of an acute hospital but may require nursing, therapy and/or medical assessment in their own home or a bed based service (rapid assessment within 2 hours where appropriate)
    - Individuals who would benefit from Rehabilitation/Reablement either within their own home or a bed based service

- Step Down/Facilitated Discharge – to support individuals to return home from Hospital or to an alternative environment appropriate to their needs. This pathway may be appropriate for:

    - Individuals who no longer need hospital care following an episode of acute hospital care (for illness and/ or surgery) but may require further medical, nursing and Rehabilitation/Reablement either within their own home or a bed based service.

Services offered by the Recovery at Home service include:-

- Community Reablement Teams - There are 15 Reablement teams, city wide. This service provides vulnerable people and their carers with high quality personal care, assistance and support; helping them to live as independently as possible at home.

- Intermediate bed based services - The service offers 76 social care and nursing intermediate care beds

- 24/7 Urgent Care Nursing Team

- 24/7 Intermediate Care Nursing Team

- 24/7 access to Community equipment and Telecare services

Social Work Teams and Community Fieldwork & Assessment (Adult Social Care) Teams provide a care management service to respond to hospital discharge and prevent hospital admission. Services are organised and provided on a 24-hour/7 basis.

4. Patient Access

4.1 Emergency Admissions

Patient flow managers (PFM's) will co-ordinate the flow of emergency patients. There will be two PFM's on duty 24/7, each with distinct areas of responsibility ensuring cover for the whole organisation. This will ensure there is an overview of the current beds state and any issues with capacity. The patient flow managers are mobile and will have real time bed state and capacity available to them via the bed management module.

4.2 Admitted Patient Management

Patient flow needs to be as efficient and effective as possible with no delays in any step of the patient pathway.

All areas within CHS have Safer Bundles in place with a number of these monitored electronically for assurance purposes.

The electronic bed management module is in place providing the benefits of real time bed availability and pending discharge function.

Over the last year the national Red and Green day initiative has been rolled out across a number of in-patient wards within the Division of Medicine and key surgical wards to support patient flow and safe timely discharges.

The purpose of Red and Green days is to identify what patients are waiting for in their journey and to work with our internal and external services to unblock these delays. Internal and external response standards have been developed which support staff in identifying when to escalate delays. The ward level Red and Green day process involves:

- Multi-disciplinary (MDT) team members will identify all patients that are Red (*patients who are waiting for an action to progress their care*) at daily board rounds. Every effort will be made to resolve the problem in real time.

- Any Red delays unresolved from the board round will be proactively managed by the ward manager/deputy with support from the matron and complex discharge nurse.

- Ward manager/deputy attends Red and Green MDT meeting with any unresolved Red patient delays. Meeting is held daily at 12noon and also has the support of external partners via telephone conference facilities.

Key internal MDT staff, along with the Recovery at Home service and the Hospital Social Worker team, will work together on a daily basis to ensure all patients highlighted as being a Red day are proactively managed and resolutions are found.

Discharge Lounge

Next day discharges must be brought to the attention of the Patient Flow Managers and Discharge Lounge, who will facilitate transfer of patients to the lounge early on the day of discharge. The Discharge Lounge staff are able to counsel patients regarding discharge medications and will arrange transport for the patient if necessary and will collect the patient from the ward and transfer to the lounge. There are agreed checklists to confirm all clinical queries resolved e.g. medication further reduces patient delays**.** The Discharge Lounge is open from 08:00 to 20:00 Monday to Friday, Saturday 0800 – 1800 and Sunday 10:00 – 18:00 including Bank Holidays with the exception of Christmas Day which has not seen a value added benefit over recent years to warrant efficient opening hours.

Matrons will carry out at least daily ward rounds to help populate the list above and to resolve EDD or diagnostic delays and to ensure the discharge lounge is being fully utilised.

Palliative Care dedicated ambulance is available Monday to Friday during the hours of 09:00 to 19:00 which has a 1 hour response rate.

4.2.1 Critical Care

Normal procedures for critical care will be maintained with any bed pressures being escalated to the network. A review of current patients will be undertaken by consultant staff to see if any patient's care can be stepped down before issues are escalated to the network. This may include prioritisation of patients for moves out of critical care as well as those awaiting admission to hospital or from the ED.

4.2.2 Control of Infection

Effective communication and teamwork is essential between the Infection Prevention and Control Team (IPCT) and patient flow managers. They must work in close collaboration for admission, transfer, discharge and movement of patients between departments and other health care facilities. Ambulance services will be involved / informed as necessary.

A risk assessment must always be made by the nurse/doctor admitting or caring for the patient in conjunction with the Patient Flow Manager and IPCT. Side room capacity is particularly challenging over the winter period, to assist with appropriate allocation of side rooms patient placement should be assessed on admission to hospital and thereafter depending upon clinical changes or notification of infection (via the V6 Patient Prioritisation assessment) The IPCT will assist with the risk assessment of side rooms during times of extreme bed pressures.

Direct admission onto F62 must be considered (providing medical and microbiology approval) for those patients who are admitted with a known or suspected C. *difficile* infection, these patients may require isolation in a side room or Pod until confirmation of the result and an assessment should be completed to ensure appropriate patient placement. The admitting team would need to clerk the patient on the ward.

The use of F62 for MRSA and 'other' alert organisms/ infections such as viral gastroenteritis is best practice, as is the transfer of patients with a C.*difficile* indeterminate result as these patients cannot be cohorted and require a side room or Pod. This can be facilitated without Microbiologist involvement, provided the ward has sufficient capability to staff the ward.

In times of extreme bed pressures it is acknowledged that there may also be a requirement to use the beds for 'non infective' patients. This can also be facilitated with or without IPC consultation provided every attempt has been made to allocate the beds to patients with infection first. F62 nursing staff will ensure there are no suitable patients for transfer to F62 with alert organisms, such as MRSA, prior to allocation of beds for non-infective patients.

The IPC nurses will be happy to support any risk assessment through attendance at the Operational control meetings. When patients are to move to ward F62 their own consultant (or team) ought to be aware of the suggestion and agree with it. Specifics about why patients are unsuitable (if this is the case) should be noted. Such patients should remain under review in case they can move to F62 at a later date.

Direct admission to ward F62 from the community for patients with C.d*ifficile* should continue to be discussed with the microbiologist.

Within ward F62, 4 'Pods' are in place for the management of patients with infections. These 'pods' allow isolation of a patient within a patient bay, in the absence of side room capacity and provide greater flexibility for the management of infection.

All IPC procedures, guidelines and policy are available electronically via CHS intranet.

5. Workforce

5.1 Nursing Workforce Tool

The nursing workforce tool has value in redeploying nursing staff in the medium term to areas of greatest concern, forming part of a decision making process which also includes the professional judgement of the matrons. It has no role in the daily movement of staff to meet real time change driven by sickness and variable bed capacity. The safer care nursing tool, a module of eRoster, is being rolled out and will, in time, provide intelligence with

regard to the dependency and acuity of patients on each ward as well as their numbers balanced by the number of nurses available to meet their needs which will help support transparent and safe nurse staffing deployment decisions.

5.2 Enhancement of Current Services

NHS Professionals and CHS work closely together to increase NHSP workforce for the winter period 2017/2018.

Currently NHSP do not offer an outbound calling service as part of CHSFT contact however they do have an office on site, opposite the discharge sisters office on staff change corridor. The office is open Monday to Friday 08:00 until 16:00 and there is also a 24/7 telephone number available for CHS Managers / Matrons only which is 03330 143622

They will support wherever possible and ask the service centre to assist CHS.

5.2.1. Pharmacy

Integrated Medicines Management (IMM) is a system whereby pharmacy staff manage the medication pathway from admission throughout the stay and through to discharge with safe and effective transfer and clinical handover for medication back into primary care. It has been shown to reduce the length of stay, reduce readmission rates, improve the appropriate utilisation of medicines, improve patient access to medication both during their stay and on discharge and underlying knowledge of clinical indications and major side effects of their medicines and have reductions of both medical and nursing workload. The Directorate has a 7 day working service in place.

5.2.2 Therapy Services

Occupational Therapy and Physiotherapy provide a 7 day service, however weekend cover does not replicate that of Monday to Friday. The service facilitates timely patient discharge by providing response times of 12 hours to new patients. Concentrating on:

- Treating patients on the acute care wards
- Offering acute respiratory care therapies
- Assisting patients to achieve their rehabilitation goals in a timely way
- Facilitate discharge to support reduction in bed days
- Offer timely communication with MDT and social workers in terms of patient progress, and potential to move patients from the acute care setting back into the community setting
- Liaise with family, carers and community services to ensure successful discharge
- Manage surge in activity, promoting discharge and maintaining flow out of the organisation.

5.2.3 Diagnostic Imaging

Diagnostic imaging currently provides a 7 day service for emergency care and extended existing services, crucially within the cross sectional imaging modalities of CT and MRI. By providing improved access to these diagnostic tests, it is hoped to reduce existing waiting times for both in and out patients. Formal radiological reports are pivotal in diagnosis and treatment planning, thereby streamlining the patient pathway and facilitating early discharge.

5.2.4 Social Worker Team

There is a 7 day social work service, the aim is a positive impact on increasing weekend discharges, and in addition increasing the number of patients discharged earlier in the week on a Monday and Tuesday.

5.3 Senior Clinical, Nursing and Managerial Support

To ensure that the proposed measures are effective in improving and maintaining patient flow, it is imperative that there is an increase in the support provided by senior clinical, nursing and managerial staff during this Winter Period. This will include: -

- Directorate Managers to be a visible presence at times of escalation to provide support to frontline staff, offering advice, guidance and leadership to break down blocks in the system that may be delaying safe and effective discharge.
- 24/7 decision-making regarding management of patient access, including appropriate escalation through 1st and 2nd on call system.
- Directorate Manager presence on site at weekends to provide direction and support.
- Infection Prevention and Control (IPC) nurse available via an on call system at weekends.

To ensure the proposed measures are effective in maintaining a safe service for patients, it is imperative that frontline staff have visible leadership and support. This will be achieved by:

- Daily contact by DM/Matron with clinical teams (as per escalation SOP)
- Visible presence of DM/Matron in key teams
- 24/7 rapid access to senior decision makers

5.4 Support to CHS Staff in Severe Weather Conditions

Inclement weather guidance has been developed for use within the organisation and will be communicated to staff, in particular departmental managers, to guide them in supporting staff during times of inclement weather conditions.

In addition, information relating to severe weather conditions and likely impact on services and public transport will be communicated to all staff via the intranet

The Trust no longer has rooms in Clanny House but has an emergency agreement with Sunderland University whereby they would help to accommodate staff in a crisis. A severe

winter weather plan is in place that includes increased stock piles of gritting salt, real time Met Office weather forecasting, (Open Road 2-5 day forecast & 24 hour site specific weather forecast for CHSFT) 24/7 in-house on-call winter measures team and the provision of four wheel drive taxis.

Advice on safe winter driving will also be provided to staff.

5.5 Flu Vaccination Programme

All staff, and in particular frontline staff, will be strongly encouraged to take up the seasonal flu vaccine wherever possible in order to protect patients and other staff as well as themselves. Flu vaccinations are currently underway and all staff encouraged to partake. Seasonal influenza clinical evidence and why flu vaccination matters have been circulated via all users emails. A greater emphasis has been placed on professional responsibility to be vaccinated in line with professional standards e.g. NMC, GMC. A flu thank you is being offered to all staff having a flu vaccine this year, this entitles the staff member to a free beverage and a biscuit. The Trust's Occupational Health and Wellbeing Manager produces an internal Flu Vaccination Plan, incorporating regional and national guidance around the subject as appropriate. Regular updates around the campaign will be disseminated, via Team Brief, staff meetings and the intranet. The Occupational Health and Wellbeing Manager and Deputy Head of Corporate Affairs have developed posters specific to the Trust, which have been disseminated amongst wards and departments. The Trust has 111 vaccinators trained this year to deliver flu vaccination to staff within clinical areas. In addition flu drop in clinics are undertaken in the Occupational Health and Wellbeing department and staff can also make an appointment if the drop in sessions are not convenient to them. Plans are in place for the Occupational Health and Wellbeing team to attend Trust events, such as inductions, lessons learnt seminars and study events.

Recording of vaccinations will be undertaken by the Occupational Health and Wellbeing department and will support the reports required both regionally and nationally.

The Trust Pandemic Flu Plan has been updated with recent guidance and is available under separate cover.

6. Communication Strategy

6.1 Internal Communications

The Trust will communicate and raise awareness of the Operational Winter Plan by:

- Quarterly staff briefings;
- the intranet;
- Team Brief; and
- Email.

6.2 Escalation Processes

The Trust will communicate clear escalation processes to staff to ensure timely action is taken at all levels to ensure patient flow and therefore capacity is maximised during particular periods of pressure. This will be done by:

- the bleep system;
- update of the escalation traffic light on the intranet home page to provide a quick and visible prompt to all staff regarding pressures faced by the organisation;
- email to relevant staff depending on the issues affecting the Trust

6.3 Support Services (External)

A winter pack is being developed for over the Christmas and New Year period and this will be distributed to all relevant teams as well as being available on the intranet. The pack will detail opening hours of services across the City and where possible across SOTW, access to community pharmacy, on call rotas, escalation plans and key contacts.

The NHS 111 Service, also has a Directory of Services (DOS) which staff are able to access to find appropriate services to meet the needs of their patients, ensuring flow is maintained and discharge continues across 7 days.

6.4 External communications

A regional public awareness campaign will be launched in November 2017 providing advice and guidance to the public on alternatives to ED and signposting to other services, including pharmacy, GP and NHS 111. This work is being delivered through the regional urgent and emergency care network and funded by CCGs and providers. In Sunderland this activity will be up weighted by the CCG to signpost parents to advice using the under 5s 'NHS Child Health' app. In addition to this, weekly proactive media updates giving the position on pressure points across the region / advice for the public will be co-ordinated and issued every week by the NHS England local area team. The Trust will be supporting both of the above activities with local PR activity and via its own social media channels.

6.5 Links with other providers

The Trust's DGM responsible for Winter Planning and CD for Rehabilitation and Elderly Medicine will attend weekly Surge meetings to update other providers on the situation at CHS and ensure effective communication during the peak activity pressures. The DGM team will also partake in the weekly teleconference calls, to discuss pressures on the service and remedial actions being taken.

The CHS and CCG Winter Service Directories will identify formal arrangements in both organisations for service provision and senior emergency on call contacts.

7 Recovery

Command and control will need to be maintained to manage the hospitals recovery from a winter surge. Triggers will be reversed to aid step down.

The start-up of elective capacity needs to be effective as soon as possible which will mean that discharge and flow management will need to be maintained.

A debrief will take place for the current Winter planning group in May 2018, to look at any lessons learned, in preparation for next year's planning

Angela Gillham
Divisional General Manager
Division of Medicine

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

NATIONAL ADULT INPATIENT SURVEY 2016

OCTOBER 2017

EXECUTIVE SUMMARY

On the 31st May 2017 the Care Quality Commission (CQC) published the national and individual Trust results for the Adult Inpatient Survey 2016. The 14th survey included 149 acute and specialist NHS trusts. Eligible patients were aged 16 years or over, who had spent at least one night in hospital during July 2016 and were not admitted to maternity or psychiatric units. Responses were received from 77,850 patients with a response rate of 44% (City Hospitals 554/46%).

The results of the 2016 inpatient survey indicate that there have been small, but statistically significant improvements in a number of questions, compared with results dating back to the 2006, 2011 and 2015 surveys. This includes patients' perceptions of: the quality of communication between medical professionals (doctors and nurses) and patients, the standards of hospital cleanliness and quality of food. However, the results also indicate that the results of some questions have been less positive. This includes patients' perceptions of: being involved in decisions about their care and treatment, information sharing when leaving hospital, waiting times and support after leaving hospital.

For City Hospitals, all 11 aggregated scores in the 'sections' table are rated as 'Amber' (about the same as other Trusts). Out of the 65 individual questions measuring inpatient experience, the Trust achieved 60 (92.3%) scores in the amber 'as expected' category. There were 3 red (worst category) rated questions relating to helping patients with their meals, privacy and provision of information. However the Trust did achieve 2 green (best performing) ratings related to shorter delays in discharge than other hospitals.

When comparing scores to the 2015 survey, there is a significant net decrease of 13.3 points across 60 questions which could be directly compared. This is the first year in which a negative shift in scores has happened. The sections on 'Care and Treatment' and 'Leaving Hospital' carry the heaviest burden of loss and offer potential for the most improvement.

When 'aggregated' performance is compared with other North East Trusts, we have attained the lowest or joint lowest scores in 9 out of the 11 sections. Newcastle and Northumbria are the stand out organisations.

A new Patient Experience Strategy will provide the mechanism for how the Trust responds to the survey rather than the traditional action plan approach. Progress will be monitored by the Patient, Carer and Public Experience Committee.

Gary Schuster
Clinical Governance Manager

1. INTRODUCTION

The 2016 inpatient survey involved 149 NHS acute and NHS foundation trusts in England who sent questionnaires to a total of 185,007 patients. Responses were received from 77,850 people, which is a response rate of 44%. Trusts selected a sample of patients who received care in hospital during July 2016 by including every consecutive discharge counting back from 31 July until they had selected 1,250 patients. Fieldwork for the survey took place between August 2016 and January 2017. The results are primarily used by Trusts to help identify and improve areas of performance across the patient journey. The CQC also use the results as part of their regulation, monitoring and inspection regimes.

The report shows the results for the adult inpatient survey, against national benchmarks, and compares scores from the 2015 survey, where questions are the same. These help identify the greatest opportunities for improvement as well as showing where performance might be slipping. For the first time, the report also summarises NHS England's Overall Patient Experience Scores (linked to the inpatient survey responses) showing where the scores for the Trust are furthest from the good practice benchmark and where all organisations performed relatively poorly.

2. SCORING METHODOLOGY

The full set of results for City Hospitals is enclosed in the **Patient Survey Report 2016** (Appendix 1).

The report shows how the Trust scored for each question in the survey, compared with the range of results from all other Trusts that took part. It uses an analysis technique called the 'expected range' to determine if the Trust is performing 'about the same', 'better' or 'worse' compared with other trusts. For each question, the individual responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst.

- A 'section' score is also provided, labelled S1-S11 (page 5 of the site report) and grouped according to the sections of the questionnaire, for example, 'the hospital and ward,' 'doctors and nurses' and so forth,
- Text to the right of the graphs also states whether the score for the Trust is 'better' or 'worse' compared with most other Trusts in the survey. Scores from last year's survey are also displayed.

3. SUMMARY OF RESULTS FOR CITY HOSPITALS

The following table (Table 1) provides an aggregated score for questions grouped according to the sections in the inpatient questionnaire. A higher score is better, which is out of 10. Each Trust is also assigned a category, to identify whether their score is better, about the same, or worse than most other Trusts who carried out the survey. City Hospitals achieved an 'about the same' rating for each of the 11 sections compared with other Trusts. The public can view this section table on the Care Quality Commission website and drill down in individual questions under each section theme.

Section Theme	Score 2016 (10)	Score 2015 (10)	Change	Rating compared with other Trusts
The ED / A&E Department	**8.3**	8.7	↓	About The Same
Waiting list and planned admissions	**9.1**	8.9	↑	About The Same
Waiting to get to bed on a ward	**7.8**	8.0	↓	About The Same
The hospital and ward	**7.9**	8.2	↓	About The Same
Doctors	**8.6**	8.7	↓	About The Same
Nurses	**7.8**	8.5	↓	About The Same
Care and treatment	**7.5**	7.9	↓	About The Same
Operations and procedures	**8.2**	8.4	↓	About The Same
Leaving hospital	**7.0**	7.2	↓	About The Same
Overall views of care and services	**5.2**	5.5	↓	About The Same
Overall experience	**7.9**	8.1	↓	About The Same

Table 1: Ratings against each Inpatient survey section

The majority of section scores show a small decrease from last year. The only section that has improved its aggregated score is the one related to waiting lists and planned admissions. As will be highlighted later in the report, the sections composed of questions related to 'Nurses' and 'Care and Treatment' have lapsed the most from the patients point of view.

For 2016, the results show that across the 65 questions which measure performance from the patient's perspective, 60 (92.3%) are in the amber 'as expected' category, meaning that we are about the same as most other Trusts in the survey. However, unlike last year, we had 3 red (worse category) rated questions, relating to support at mealtimes, patient privacy and provision of information. We did achieve 2 green (best performance) ratings this time related to shorter delays in discharge. Table 2 compares Trust performance from 2008 to the present, with the caveat that the scoring methodology was changed following the 2011 survey.

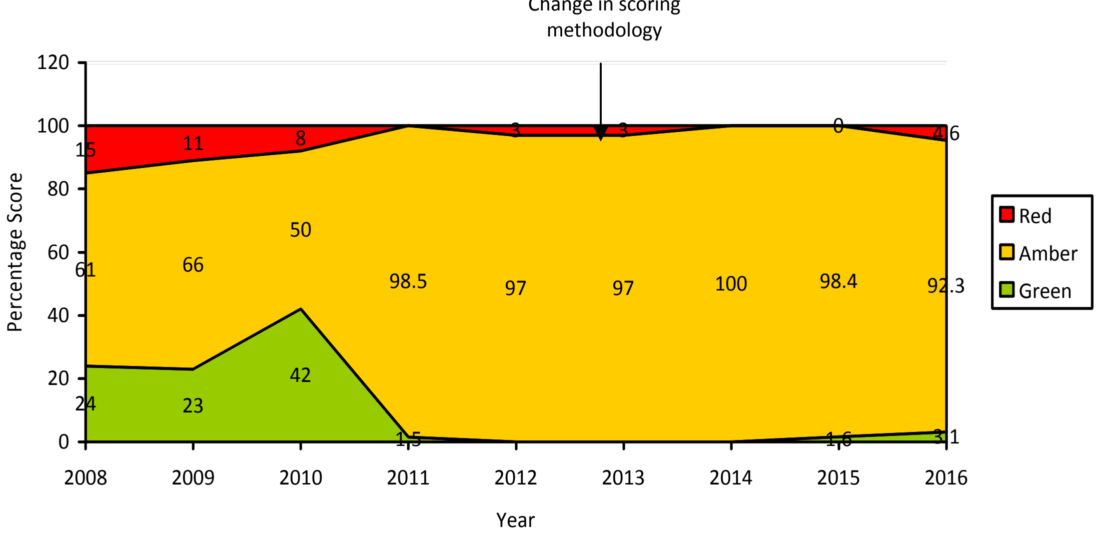


Table 2: Breakdown of Trust performance 2008-2016

4. COMPARISON AMONG LOCAL PEERS (SECTION SCORES AND RATINGS)

The availability of all acute Trust's inpatient survey results enables comparison between aggregated section scores and individual results for each question. The table below shows a summary of section scores (out of 10) and overall ratings for local Trust's:

Section scores	Emergency/A&E Department	Waiting list and planned admissions	Waiting to get to bed on a ward	The hospital and ward	Doctors	Nurses	Care and treatment	Operations and procedures	Leaving hospital	Overall views and experiences	Overall experience
City Hospitals Sun	**8.3L**	**9.1**	**7.8**	**7.9L**	**8.6L**	**7.8L**	**7.5L**	**8.2L**	**7.0L**	**5.2L**	**7.9L**
C. Durham & Darl	8.5	8.7L	7.4L	8.0	8.6L	8.0	7.6	8.4	7.2	5.5	7.9
Gateshead FT	9.0H	9.0	7.6	8.4	8.8	8.2	8.0	8.7	7.4	5.8	8.4
Newcastle Hospitals	8.9	9.1	8.5H	8.5H	9.0H	8.4H	8.4H	8.6	7.7	6.0H	8.5H
Northumbria FT	8.8	9.3	8.1	8.5H	9.0H	8.4H	8.3	8.8H	7.8H	5.8	8.5H
North Tees FT	8.4	8.7L	7.9	8.0	8.7	7.9	7.7	8.5	7.2	5.4	7.9L
South Tees FT	8.9	9.0	8.2	8.2	8.6L	8.3	8.0	8.7	7.3	5.6	8.2
South Tyneside FT	8.7	9.4H	7.8	8.2	8.7	8.3	8.1	8.5	7.5	5.8	8.3

Table 3: Comparison of local NHS Trusts section scores and ratings category

Worse	About the same	Better

H = highest aggregated score in the region

L = Lowest aggregated score in the region

- Northumbria and Newcastle Hospitals NHS Trusts shared the most Green / better ratings,
- No Trusts in the region were rated as Red / Worse in any sections (the same as 2015),
- Out of the 11 sections, City Hospitals had the lowest/ joint lowest aggregated section score in 9 out of the 11 sections (this has increased from 2/11 in 2015),
- Northumbria FT and The Newcastle Hospitals NHS Foundation Trust had the highest / shared highest scores in 9 out of the 11 sections.

5. COMPARISON AGAINST THE HIGHEST AND LOWEST ACHIEVED TRUST SCORE

The benchmarking report provides the highest and lowest Trust scores achieved for each of the survey sections. Table 4 plots the section scores for City Hospitals against the highest and lowest Trust thresholds. The trend line shows closer approximation to many of the lowest aggregated section scores. This is a different and worsening profile than in 2015 where the Trust occupied much of the 'middle' ground.

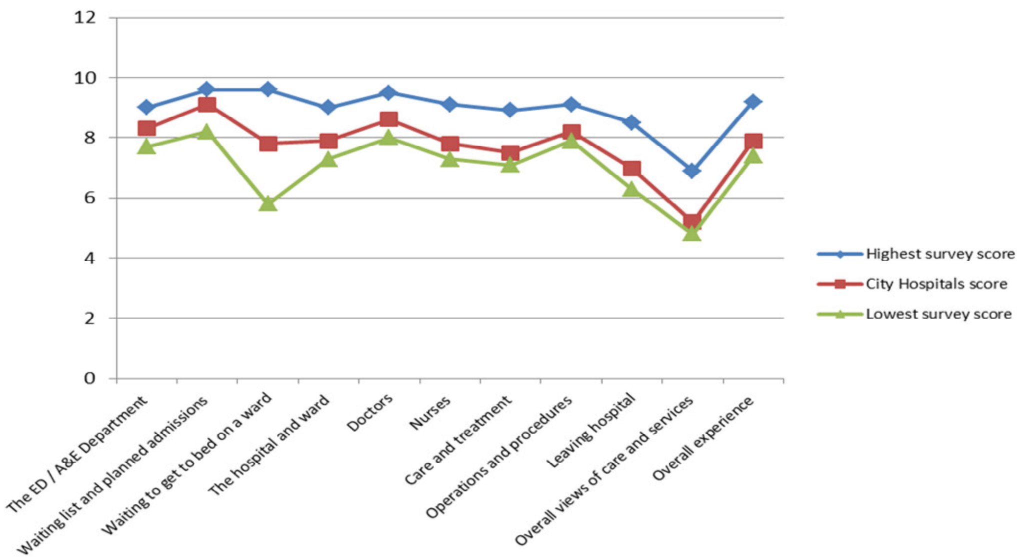


Table 4: Trust comparison against the highest and lowest achieved Trust scores

6. COMPARING RESULTS – HAVE WE IMPROVED SINCE 2015?

When looking at the shift in absolute index scores from the 2015 inpatient survey, there is a net **decrease** of 13.3 points across 60 questions which could be directly compared. This compares and contrasts with a net increase of 3.9 in 2015 and 7.9 in 2014 so clearly a significant decline in overall performance. The breakdown and shift in positive and negative scores are highlighted in Table 5.

Survey theme	Shift in absolute scores compared with 2015		
	Positive	Negative	No change
Emergency / A&E Department	None	-0.7 (2 questions)	
Waiting list/ planned admissions	+0.7 (2 questions)	- 0.1 (1 question)	
Waiting to get to a bed		-0.2 (1 question)	
The hospital and ward	+0.2 (2 questions)	-1.3 (6 questions)	2 questions
Doctors		-0.2 (1 question)	2 questions
Nurses		-0.9 (3 questions)	1 question
Care and treatment		-4.2 (11 questions)	
Operations and procedures		-1.4 (6 questions)	
Leaving hospital	+1.1 (2 questions)	-4.8 (12 questions)	1 question
Overall views of care and services		-1.3 (3 questions)	1 question
Overall experience		-0.2 (1 question)	
Total	**+2.0**	**-15.3**	**7 questions**

Table 5: Shift in absolute index scores compared with 2015 survey results

The tables below show where the Trust has achieved the largest increase and decrease in individual scores compared to the last survey in 2015. For those questions which have 'lost' the most (table 7), it follows that these areas offer the great room for improvement.

Survey questions – comparison of 2015 and 2016 results		2015	2016	
The Trust has improved on the following questions (greatest gain of scores):				
Q56	Discharge delayed due to wait for medicines / to see a doctor / for ambulance (Higher score = less delays)	7.0	7.7	+0.7
Q6	How do you feel about the length of time you were on the waiting list?	8.2	8.7	+0.5
Q57	How long was the delay? (Higher score = shorter delay)	8.3	8.7	+0.4
Q7	Was your admission date changed by the hospital?	9.2	9.4	+0.2

Table 6: Questions which have the largest increase in scores

Survey questions – comparison of 2015 and 2016 results		2015	2016	
The Trust has worsened on the following questions (greatest lose of scores):				
Q39	Do you feel you got enough emotional support from hospital staff during your stay?	7.3	6.5	-0.8
Q75	During your hospital stay, were you ever asked to give your views on the quality of your care?	2.1	1.3	-0.8
Q24	Did you get enough help from staff to eat your meals?	7.0	6.3	-0.7
Q38	Did you find someone on the hospital staff to talk to about your worries and fears?	5.8	5.1	-0.7
Q62	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.6	7.9	-0.7
Q63	Did a member of staff tell you about medication side effects to watch for when you went home?	4.9	4.2	-0.7
Q61	Were you given any written or printed information about what you should or should not do after leaving hospital?	6.6	6.0	-0.6
Q64	Were you told how to take your medication in a way you could understand?	8.5	7.9	-0.6
Q70	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	8.3	7.7	-0.6

Table 7: Questions which have the greatest lose in scores

The two sections which carry the greatest burden of scores lost are 'Care and Treatment' and 'Leaving Hospital'. Using a 'sparkline' presentation, this gives us the ability to show trends across a series of values, in this case, scores from the past 5 published surveys (only questions that have this 5 year reporting series). This will help determine whether the drop in performance in 2016 is part of consistent decline. It can also help identify issues which require our initial focus. The two tables below show:

	Care and treatment	2012	2013	2014	2015	2016	Sparkline
Q34	Did a member of staff say one thing and another say something different?	8	8	8	8.3	8	
Q35	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.2	7	7.5	7.4	7.2	
Q37	How much information about your condition or treatment was given to you?	8	7.6	7.8	8	7.8	
Q38	Did you find someone on the hospital staff to talk to about your worries and fears?	5.8	5.2	5.7	5.8	5.1	
Q39	Do you feel you got enough emotional support from hospital staff during your stay?	7.2	6.7	7.4	7.3	6.5	
Q40	Were you given enough privacy when discussing your condition or treatment?	8.3	7.9	8.3	8.4	7.9	
Q41	Were you given enough privacy when being	9.5	9.3	9.4	9.5	9.3	
Q43	Do you think the hospital staff did everything they could to help control your pain?	7.5	7.8	8.4	8.1	7.9	
Q44	After you used the call button, how long did it usually take before you got help?	6.3	6.2	6.4	6.6	6.2	

	Leaving hospital	2012	2013	2014	2015	2016	Sparkline
Q53	Did you feel you were involved in decisions about your discharge from hospital?	6.9	6.7	7.1	7.3	7.2	
Q54	Were you given enough notice about when you were going to be discharged?	7.2	7.1	7.1	7.5	7.3	
Q56	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	6.6	7.2	6.8	7	7.7	
Q57	How long was the delay?	8	8.3	8.1	8.3	8.7	
Q61	Were you given any written or printed information about what you should or should not do after leaving hospital?	7	6.4	6.5	6.6	6	
Q62	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.5	8	8.2	8.6	7.9	
Q63	Did a member of staff tell you about medication side effects to watch for when you went home?	5.3	5	5.2	4.9	4.2	
Q64	Were you told how to take your medication in a way you	8.5	8	8.3	8.5	7.9	
Q65	Were you given clear written or printed information about your medicines?	8.3	8	8.3	8.4	8	
Q66	Did a member of staff tell you about any danger signals you should watch for after you went home?	5.7	5.5	5.7	5.1	5.1	
Q67	Did hospital staff take your family or home situation into account when planning your discharge?	6.9	7.1	7.2	7.1	6.9	
Q68	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	6	5.6	5.6	5.6	5.2	
Q69	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.9	7.1	7.7	7.6	7.5	
Q70	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	8.4	8.3	8	8.3	7.7	
Q71	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.4	8.7	8.5	8.1	7.9	

From looking at the 'sparkline' trends, we can highlight the following:

- Staff discussions about post-hospital care in terms of additional support needed has deteriorated four years in a row (from 2013 – 2016),
- Other areas show a consistent decline over 3 consecutive years and include;
    - Emotional support given to patients
    - Support with pain control
    - Medication advice to patients
    - Explanation of 'danger signals' to look for
    - Review of home circumstances prior to discharge
    - Contact details after discharge
    - Discussion about equipment / adaptation to supporting return home

7. CONCLUSION

The results from the national Adult Inpatient Survey 2016 have been published by the Care Quality Commission. It remains one of the biggest surveys of the patients' experience in hospital in the UK.

The Trust had a higher than average participation in the survey with all sections scores 'about the same' as other Trusts who took part. Over 92% of the questions were in the amber 'as expected' category with 2 rated green (best performing) and 3 rated in the red, worst category. At this level of reporting the results appear generally satisfactory and at pace with most other NHS organisations.

However, further analysis reveals a more disappointing picture, and the average performance masks some poor individual scoring, particularly in the 'Care and Treatment' and Leaving Hospital' sections. The questions under the 'Nurses' section also show loss of scores compared to last year as do all the questions asked and answered by patients in the section under operations and procedures. These will be at the forefront of our improvement plans, which will be monitored by the Patient, Carer and Public Experience Committee.

Where our performance is compared with other North East Trusts, we do appear to have fallen behind the progress made in other organisations.

8. RECOMMENDATIONS

Governors are asked to:

- Receive and comment on the results from the adult in-patient survey 2016, and in particular any views on what may be driving our less favourable patient experiences,
- Agree that any improvement work is strategically monitored through the Patient, Carer and Public Experience Committee.

Gary Schuster
Clinical Governance Manager

Patient survey report 2016

Survey of adult inpatients 2016

City Hospitals Sunderland NHS Foundation Trust

Survey of adult inpatients 2016

NHS patient survey programme
Survey of adult inpatients 2016

The Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care, and we encourage care services to improve. Our role is to register care providers, and to monitor, inspect and rate services. If a service needs to improve, we take action to make sure this happens. We speak with an independent voice, publishing regional and national views of the major quality issues in health and social care.

Survey of adult inpatients 2016

To improve the quality of services that the NHS delivers, it is important to understand what people think about their care and treatment. One way of doing this is by asking people who have recently used health services to tell us about their experiences.

The fourteenth survey of adult inpatients involved 149 acute and specialist NHS trusts. Responses were received from 77,850 people, a response rate of 44%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts sampled patients discharged during July 2016[1]. Trusts counted back from the last day of July 2016, including every consecutive discharge, until they had selected 1250 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2016). Fieldwork took place between September 2016 and January 2017.

Similar surveys of adult inpatients were also carried out in 2002 and annually from 2004 to 2015. They are part of a wider programme of NHS patient surveys, which cover a range of topics including A&E services, children's inpatient and day-case services, maternity services and community mental health services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

The Care Quality Commission will use the results from this survey in our regulation, monitoring and inspection of NHS acute trusts in England. We will use data from the survey in our system of CQC Insight, which provides inspectors with an assessment of risk in areas of care within an NHS trust that need to be followed up. The survey data will also be included in the data packs that we produce for inspections. NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health will hold them to account for the outcomes they achieve. The NHS Trust Development Authority will use the results to inform quality and governance activities as part of their Oversight Model for NHS Trusts.

Interpreting the report

This report shows how a trust scored for each question in the survey, compared with the range of results from all other trusts that took part. It uses an analysis technique called the '**expected range**' to determine if your trust is performing 'about the same', 'better' or 'worse' compared with other trusts. For more information, please see the 'methodology' section below. This approach is designed to help understand the performance of individual trusts, and to identify areas for improvement.

A 'section' score is also provided, labelled S1-S11 in the 'section scores'. The scores for each question are grouped according to the sections of the questionnaire, for example, 'the hospital and ward', 'doctors', 'nurses' and so forth.

This report shows the same data as published on the CQC website (http://www.cqc.org.uk/surveys/inpatient). The CQC website displays the data in a simplified way, identifying whether a trust performed 'better', 'worse' or 'about the same' as the majority of other trusts for each question and section.

[1] 43 trusts sampled additional months because of small patient throughputs or data quality issues.

Standardisation

Trusts have differing profiles of people who use their services. For example, one trust may have more male inpatients than another trust. This can potentially affect the results because people tend to answer questions in different ways, depending on certain characteristics. For example, older respondents tend to report more positive experiences than younger respondents, and women tend to report less positive experiences than men. This could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of people.

To account for this, we standardise the data. Results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-sex-admission type profile reflects the national age-sex-admission type distribution (based on all of the respondents to the survey). Standardisation therefore enables a more accurate comparison of results from trusts with different population profiles. In most cases this will not have a large impact on trust results; it does, however, make comparisons between trusts as fair as possible.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing.

It is not appropriate to score all questions in the questionnaire as not all of the questions assess the trusts. For example, they may be descriptive questions such as Q1 asking respondents if their inpatient stay was planned in advance or an emergency; or they may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question would be Q45 "During your stay in hospital, did you have an operation or procedure?" For full details of the scoring please see the technical document (see further information section).

Graphs

The graphs in this report show how the score for the trust compares to the range of scores achieved by all trusts taking part in the survey. The black diamond shows the score for your trust. The graph is divided into three sections:

- If your trust's score lies in the orange section of the graph, its result is 'about the same' as most other trusts in the survey.
- If your trust's score lies in the red section of the graph, its result is 'worse' compared with most other trusts in the survey.
- If your trust's score lies in the green section of the graph, its result is 'better' compared with most other trusts in the survey.

The text to the right of the graph states whether the score for your trust is 'better' or 'worse' compared with most other trusts in the survey. If there is no text the score is 'about the same'. These groupings are based on a rigorous statistical analysis of the data, as described in the following 'methodology' section.

Methodology

The 'about the same,' 'better' and 'worse' categories are based on an analysis technique called the '**expected range**' which determines the range within which the trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust and the scores for all other trusts. If the trust's performance is outside of this range, it means that it performs significantly above/below what would be expected. If it is within this range, we say that its performance is 'about the same'. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, it is very unlikely to have occurred by chance.

In some cases there will be no red and/or no green area in the graph. This happens when the expected range for your trust is so broad it encompasses either the highest possible score for all trusts (no green section) or the lowest possible for all trusts score (no red section). This could be because there were few respondents and / or a lot of variation in their answers.

Please note that if fewer than 30 respondents have answered a question, no score will be displayed for this question (or the corresponding section). This is because the uncertainty around the result is too great. A technical document providing more detail about the methodology and the scoring applied to each question is available on the CQC website (see further information section).

Tables

At the end of the report you will find tables containing the data used to create the graphs. These tables also show the response rate for your trust and background information about the people that responded.

Scores from last year's survey are also displayed. The column called 'change from 2015' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2015. A statistically significant difference means that the change in the results is very unlikely to have occurred by chance. Significance is tested using a two-sample t-test.

Where a result for 2015 is not shown, this is because the question was either new this year, or the question wording and/or the response categories have been changed. It is therefore not possible to compare the results as we do not know if any change is caused by alterations in the survey instrument, or variation in a trust's performance. Comparisons are also not able to be shown if a trust has merged with other trusts since the 2015 survey, or if a trust committed a sampling error in 2015. Please note that comparative data are not shown for sections as the questions contained in each section can change year on year.

Notes on specific questions

Please note that a variety of acute trusts take part in this survey and not all questions are applicable to every trust. The section below details modifications to certain questions, in some cases this will apply to all trusts, in other cases only to some trusts.

All trusts

Q11 and Q13: The information collected by Q11 "When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?" and Q13 "After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?" are presented together to show whether the patient has ever shared a sleeping area with patients of the opposite sex. The combined question is numbered in this report as Q11 and has been reworded as "Did you ever share a sleeping area with patients of the opposite sex?" Please note that the information based on Q11 cannot be compared to similar information collected from surveys prior to 2006. This is due to a change in the question's wording and because the results for 2006 onwards have excluded patients who have stayed in a critical care area, which almost always accommodates patients of both sexes.

Q20: This question (Q20 in 2015 inpatient questionnaire), "Were hand-wash gels available for patients and visitors to use?" was removed from the 2016 survey because it was found there was very little differentiation between trusts, as well as the fact that there had been little movement over time.

Q20, Q21 and Q32: "Did you get enough help from staff to wash or keep yourself clean?", "If you brought your own medication with you to hospital, were you able to take it when you needed to?" and "Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)" are new questions in 2016 and it is therefore not possible to compare with 2015.

Q55 and Q56: The information collected by Q55 "On the day you left hospital, was your discharge delayed for any reason?" and Q56 "What was the main reason for the delay?" are presented together to show whether a patient's discharge was delayed by reasons attributable to the hospital. The combined question in this report is labelled as Q56 and is worded as: "Discharge delayed due to wait for medicines/to see doctor/for ambulance."

Q57: Information from Q55 and Q56 has been used to score Q57 "How long was the delay?" This assesses the length of a delay to discharge for reasons attributable to the hospital.

Q60: "When you left hospital, did you know what would happen next with your care?" was part of the 2015 survey and was redeveloped for 2016 (Q58 in the 2015 inpatient questionnaire).

Trusts with female patients only

Q11, Q13 and Q14: If your trust offers services to women only, a trust score for Q11 "Did you ever share a sleeping area with patients of the opposite sex?", Q13 "After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?" and Q14 "While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?" is not shown.

Trusts with no A&E Department

Q3 and Q4: The results to these questions are not shown for trusts that do not have an A&E Department.

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):
http://www.cqc.org.uk/inpatientsurvey

The results for the adult inpatient surveys from 2002 to 2015 can be found at:
http://www.nhssurveys.org/surveys/425

Full details of the methodology of the survey can be found at:
http://www.nhssurveys.org/surveys/935

More information on the programme of NHS patient surveys is available at:
http://www.cqc.org.uk/content/surveys

More information about how CQC monitors hospitals is available on the CQC website at:
http://www.cqc.org.uk/content/monitoring-nhs-acute-hospitals

Survey of adult inpatients 2016

City Hospitals Sunderland NHS Foundation Trust

Section scores

S1. The Emergency/A&E Department (answered by emergency patients only)

S2. Waiting list and planned admissions (answered by those referred to hospital)

S3. Waiting to get to a bed on a ward

S4. The hospital and ward

S5. Doctors

S6. Nurses

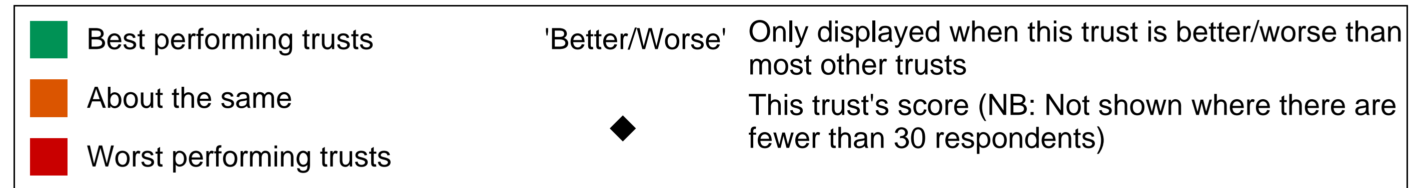
S7. Care and treatment

S8. Operations and procedures (answered by patients who had an operation or procedure)

S9. Leaving hospital

S10. Overall views of care and services

S11. Overall experience

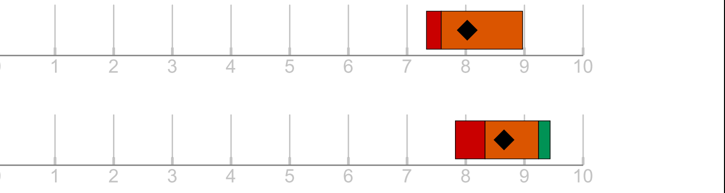


Survey of adult inpatients 2016
City Hospitals Sunderland NHS Foundation Trust

The Emergency/A&E Department (answered by emergency patients only)

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?

Q4. Were you given enough privacy when being examined or treated in the A&E Department?

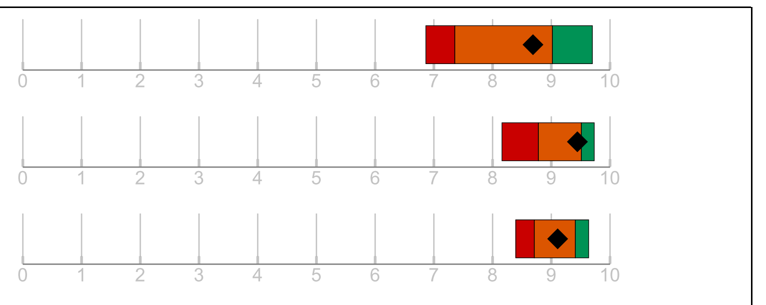


Waiting list and planned admissions (answered by those referred to hospital)

Q6. How do you feel about the length of time you were on the waiting list?

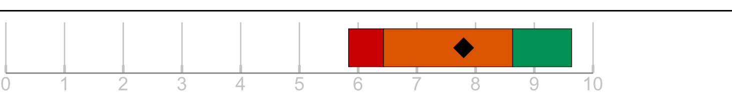
Q7. Was your admission date changed by the hospital?

Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?



Waiting to get to a bed on a ward

Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?



Best performing trusts

About the same

Worst performing trusts

'Better/Worse' Only displayed when this trust is better/worse than most other trusts

This trust's score (NB: Not shown where there are fewer than 30 respondents)

Survey of adult inpatients 2016
City Hospitals Sunderland NHS Foundation Trust

The hospital and ward

Q11. Did you ever share a sleeping area with patients of the opposite sex?

Q14. Did you ever use the same bathroom or shower area as patients of the opposite sex?

Q15. Were you ever bothered by noise at night from other patients?

Q16. Were you ever bothered by noise at night from hospital staff?

Q17. In your opinion, how clean was the hospital room or ward that you were in?

Q18. How clean were the toilets and bathrooms that you used in hospital?

Q19. Did you feel threatened during your stay in hospital by other patients or visitors?

Q20. Did you get enough help from staff to wash or keep yourself clean?

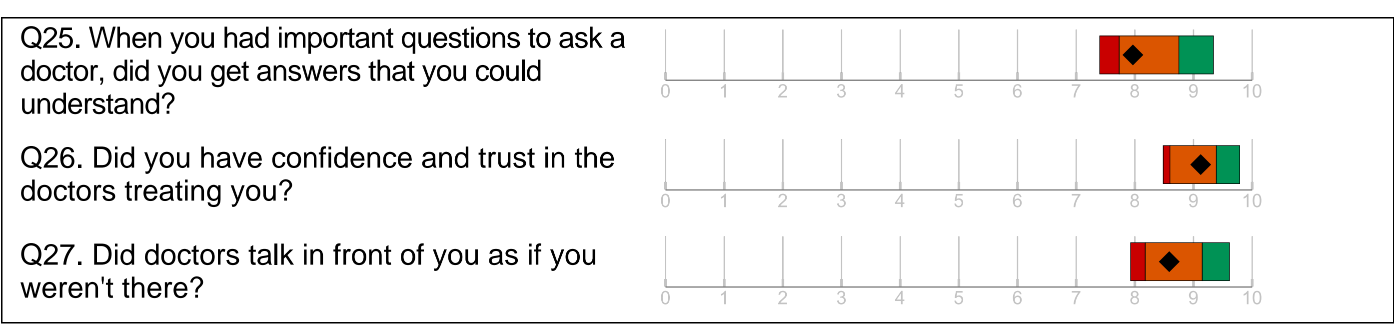
Q21. If you brought your own medication with you to hospital, were you able to take it when you needed to?

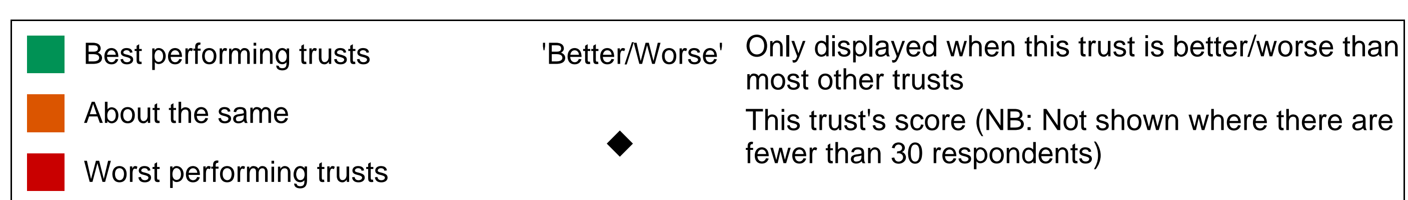
Q22. How would you rate the hospital food?

Q23. Were you offered a choice of food?

Q24. Did you get enough help from staff to eat your meals? Worse

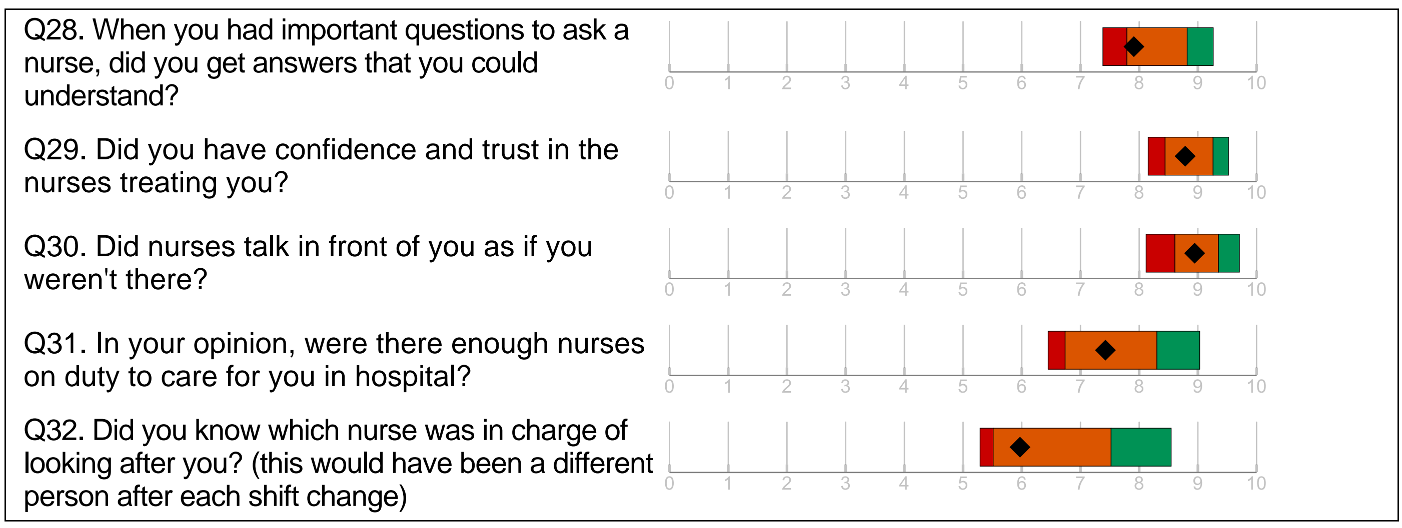
Doctors

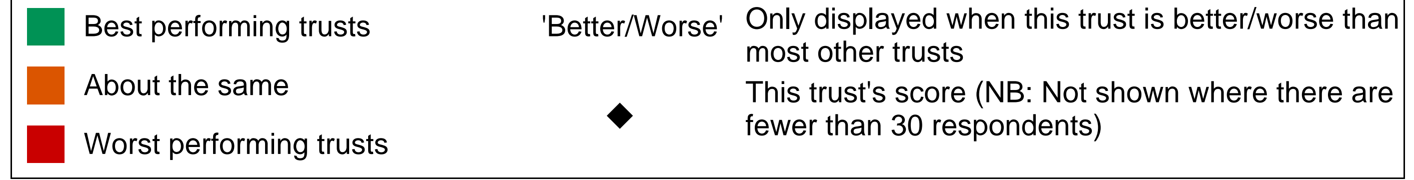




Survey of adult inpatients 2016
City Hospitals Sunderland NHS Foundation Trust

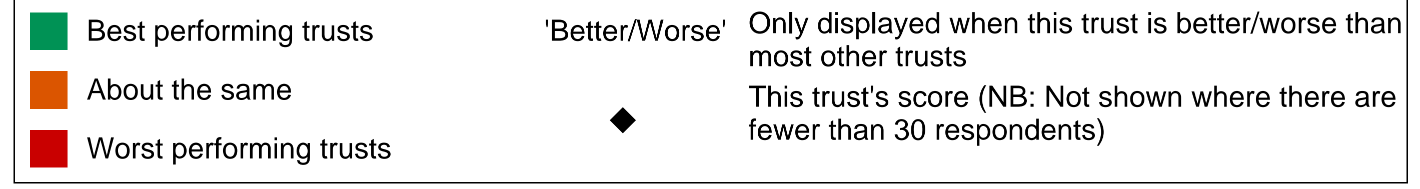
Nurses



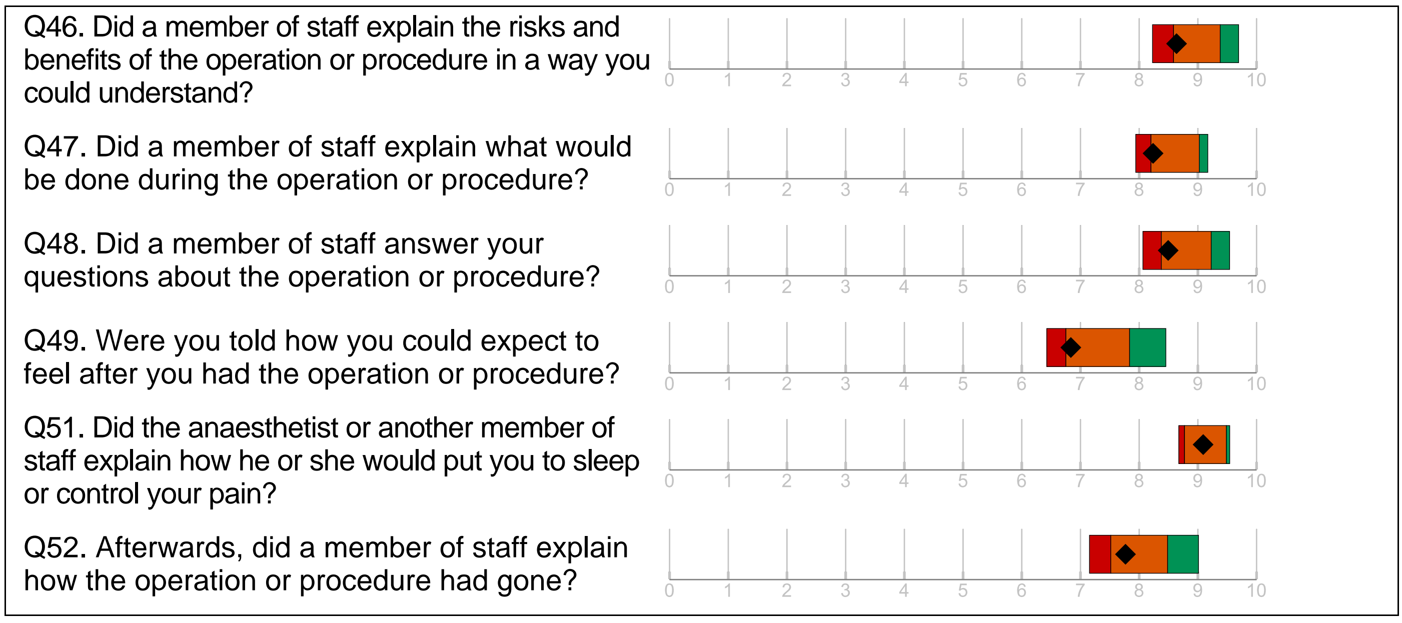


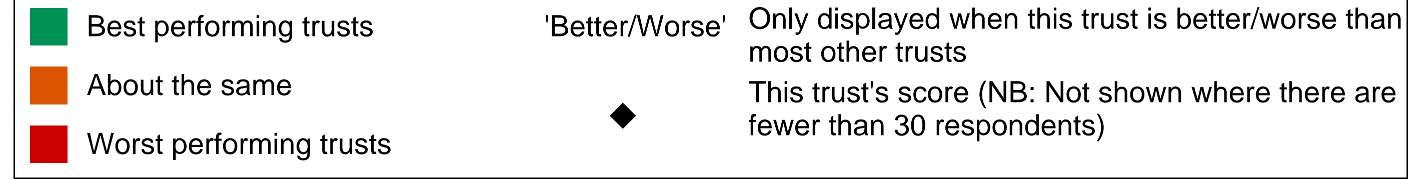
Care and treatment

Question	
Q33. In your opinion, did the members of staff caring for you work well together?	
Q34. Did a member of staff say one thing and another say something different?	
Q35. Were you involved as much as you wanted to be in decisions about your care and treatment?	
Q36. Did you have confidence in the decisions made about your condition or treatment?	
Q37. How much information about your condition or treatment was given to you?	
Q38. Did you find someone on the hospital staff to talk to about your worries and fears?	
Q39. Do you feel you got enough emotional support from hospital staff during your stay?	
Q40. Were you given enough privacy when discussing your condition or treatment?	Worse
Q41. Were you given enough privacy when being examined or treated?	
Q43. Do you think the hospital staff did everything they could to help control your pain?	
Q44. After you used the call button, how long did it usually take before you got help?	



Operations and procedures (answered by patients who had an operation or procedure)

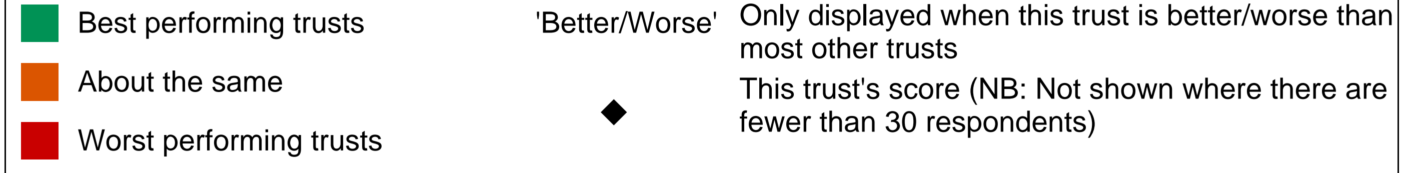




Survey of adult inpatients 2016
City Hospitals Sunderland NHS Foundation Trust

Leaving hospital

Question	
Q53. Did you feel you were involved in decisions about your discharge from hospital?	
Q54. Were you given enough notice about when you were going to be discharged?	
Q56. Discharge delayed due to wait for medicines/to see doctor/for ambulance.	Better
Q57. How long was the delay?	Better
Q59. Did you get enough support from health or social care professionals to help you recover and manage your condition?	
Q60. When you left hospital, did you know what would happen next with your care?	
Q61. Were you given any written or printed information about what you should or should not do after leaving hospital?	
Q62. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	
Q63. Did a member of staff tell you about medication side effects to watch for when you went home?	
Q64. Were you told how to take your medication in a way you could understand?	
Q65. Were you given clear written or printed information about your medicines?	
Q66. Did a member of staff tell you about any danger signals you should watch for after you went home?	
Q67. Did hospital staff take your family or home situation into account when planning your discharge?	
Q68. Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	Worse
Q69. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	

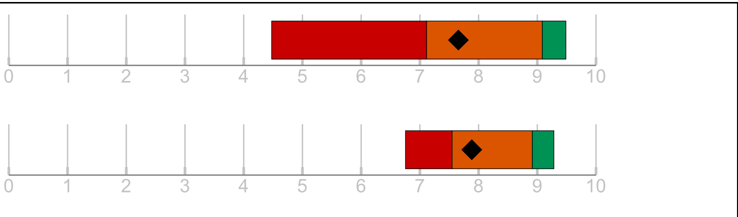


Survey of adult inpatients 2016

City Hospitals Sunderland NHS Foundation Trust

Q70. Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?

Q71. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?



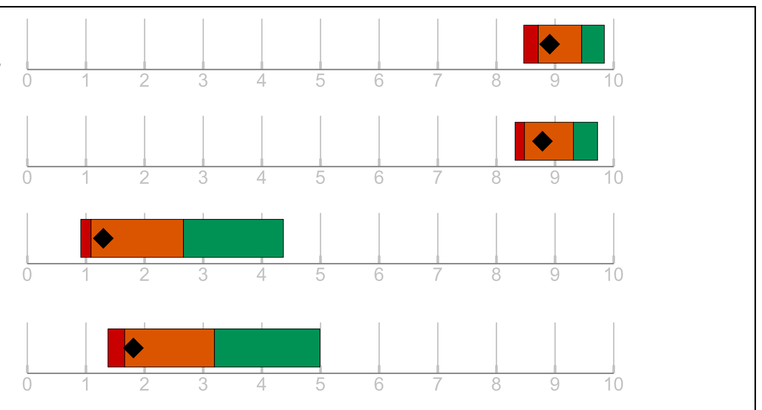
Overall views of care and services

Q72. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Q73. During your time in hospital did you feel well looked after by hospital staff?

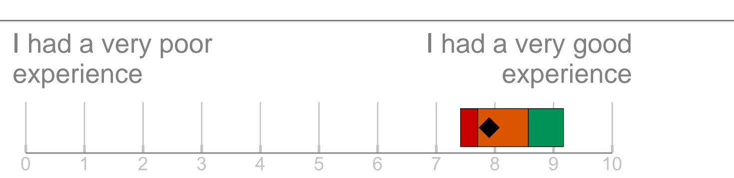
Q75. During your hospital stay, were you ever asked to give your views on the quality of your care?

Q76. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Overall experience

Q74. Overall...



■	Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
■	About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
■	Worst performing trusts		

Survey of adult inpatients 2016
City Hospitals Sunderland NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
The Emergency/A&E Department (answered by emergency patients only)							
S1	Section score	8.3	7.7	9.0			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.0	7.3	8.9	237	8.4	
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	8.7	7.8	9.4	263	9.0	
Waiting list and planned admissions (answered by those referred to hospital)							
S2	Section score	9.1	8.2	9.6			
Q6	How do you feel about the length of time you were on the waiting list?	8.7	6.9	9.7	235	8.2	
Q7	Was your admission date changed by the hospital?	9.4	8.2	9.7	236	9.2	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.1	8.4	9.6	230	9.2	
Waiting to get to a bed on a ward							
S3	Section score	7.8	5.8	9.6			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.8	5.8	9.6	544	8.0	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

City Hospitals Sunderland NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
The hospital and ward							
S4	Section score	7.9	7.3	9.0			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	9.4	8.6	9.8	460	9.3	
Q14	Did you ever use the same bathroom or shower area as patients of the opposite sex?	8.5	6.2	9.8	474	8.5	
Q15	Were you ever bothered by noise at night from other patients?	6.6	4.8	8.5	546	6.7	
Q16	Were you ever bothered by noise at night from hospital staff?	8.2	7.1	9.2	543	8.1	
Q17	In your opinion, how clean was the hospital room or ward that you were in?	8.9	8.2	9.7	543	9.0	
Q18	How clean were the toilets and bathrooms that you used in hospital?	8.7	7.4	9.5	520	8.9	↓
Q19	Did you feel threatened during your stay in hospital by other patients or visitors?	9.7	9.1	10.0	541	9.7	
Q20	Did you get enough help from staff to wash or keep yourself clean?	7.9	7.0	9.2	303		
Q21	If you brought your own medication with you to hospital, were you able to take it when you needed to?	6.7	6.0	8.8	311		
Q22	How would you rate the hospital food?	5.3	4.5	7.7	513	5.4	
Q23	Were you offered a choice of food?	8.3	7.7	9.5	531	8.4	
Q24	Did you get enough help from staff to eat your meals?	6.3	5.5	9.3	112	7.0	
Doctors							
S5	Section score	8.6	8.0	9.5			
Q25	When you had important questions to ask a doctor, did you get answers that you could understand?	8.0	7.4	9.3	460	8.2	
Q26	Did you have confidence and trust in the doctors treating you?	9.1	8.5	9.8	535	9.1	
Q27	Did doctors talk in front of you as if you weren't there?	8.6	7.9	9.6	537	8.6	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

City Hospitals Sunderland NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Nurses							
S6	Section score	7.8	7.3	9.1			
Q28	When you had important questions to ask a nurse, did you get answers that you could understand?	7.9	7.4	9.3	464	8.3	
Q29	Did you have confidence and trust in the nurses treating you?	8.8	8.2	9.5	542	8.9	
Q30	Did nurses talk in front of you as if you weren't there?	8.9	8.1	9.7	540	8.9	
Q31	In your opinion, were there enough nurses on duty to care for you in hospital?	7.4	6.4	9.0	540	7.8	
Q32	Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	6.0	5.3	8.5	542		
Care and treatment							
S7	Section score	7.5	7.1	8.9			
Q33	In your opinion, did the members of staff caring for you work well together?	8.5	7.9	9.5	521	8.9	↓
Q34	Did a member of staff say one thing and another say something different?	8.0	7.4	9.1	541	8.3	
Q35	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.2	6.3	8.8	537	7.4	
Q36	Did you have confidence in the decisions made about your condition or treatment?	8.2	7.4	9.5	537	8.5	
Q37	How much information about your condition or treatment was given to you?	7.8	7.3	9.3	546	8.0	
Q38	Did you find someone on the hospital staff to talk to about your worries and fears?	5.1	4.5	8.0	316	5.8	↓
Q39	Do you feel you got enough emotional support from hospital staff during your stay?	6.5	6.1	8.8	322	7.3	↓
Q40	Were you given enough privacy when discussing your condition or treatment?	7.9	7.9	9.4	541	8.4	↓
Q41	Were you given enough privacy when being examined or treated?	9.3	9.2	9.9	544	9.5	↓
Q43	Do you think the hospital staff did everything they could to help control your pain?	7.9	7.4	9.5	356	8.1	
Q44	After you used the call button, how long did it usually take before you got help?	6.2	5.2	7.6	302	6.6	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

City Hospitals Sunderland NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Operations and procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.2	7.9	9.1			
Q46	Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	8.6	8.2	9.7	327	8.8	
Q47	Did a member of staff explain what would be done during the operation or procedure?	8.2	7.9	9.2	323	8.6	
Q48	Did a member of staff answer your questions about the operation or procedure?	8.5	8.1	9.5	276	8.6	
Q49	Were you told how you could expect to feel after you had the operation or procedure?	6.8	6.4	8.5	333	7.2	
Q51	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	9.1	8.7	9.5	285	9.3	
Q52	Afterwards, did a member of staff explain how the operation or procedure had gone?	7.8	7.2	9.0	331	7.9	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016
City Hospitals Sunderland NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Leaving hospital							
S9	Section score	7.0	6.3	8.5			
Q53	Did you feel you were involved in decisions about your discharge from hospital?	7.2	6.1	8.9	522	7.3	
Q54	Were you given enough notice about when you were going to be discharged?	7.3	6.3	9.0	542	7.5	
Q56	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	7.7	4.8	8.2	488	7.0	↑
Q57	How long was the delay?	8.7	6.2	9.1	484	8.3	↑
Q59	Did you get enough support from health or social care professionals to help you recover and manage your condition?	6.9	5.7	8.3	292	7.2	
Q60	When you left hospital, did you know what would happen next with your care?	6.8	6.1	8.7	456		
Q61	Were you given any written or printed information about what you should or should not do after leaving hospital?	6.0	5.0	9.2	529	6.6	↓
Q62	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	7.9	7.6	9.6	384	8.6	↓
Q63	Did a member of staff tell you about medication side effects to watch for when you went home?	4.2	3.5	7.7	316	4.9	↓
Q64	Were you told how to take your medication in a way you could understand?	7.9	7.4	9.5	320	8.5	↓
Q65	Were you given clear written or printed information about your medicines?	8.0	6.8	9.2	349	8.4	
Q66	Did a member of staff tell you about any danger signals you should watch for after you went home?	5.1	4.0	7.6	386	5.1	
Q67	Did hospital staff take your family or home situation into account when planning your discharge?	6.9	6.1	9.2	355	7.1	
Q68	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	5.2	4.8	8.2	359	5.6	
Q69	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.5	6.4	9.7	486	7.6	
Q70	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	7.7	4.5	9.5	165	8.3	
Q71	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	7.9	6.8	9.3	282	8.1	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

City Hospitals Sunderland NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Overall views of care and services							
S10	Section score	5.2	4.8	6.9			
Q72	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	8.9	8.5	9.8	542	8.9	
Q73	During your time in hospital did you feel well looked after by hospital staff?	8.8	8.3	9.7	540	8.9	
Q75	During your hospital stay, were you ever asked to give your views on the quality of your care?	1.3	0.9	4.4	469	2.1	↓
Q76	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	1.8	1.4	5.0	429	2.2	
Overall experience							
S11	Section score	7.9	7.4	9.2			
Q74	Overall...	7.9	7.4	9.2	519	8.1	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016
City Hospitals Sunderland NHS Foundation Trust

Background information

The sample	This trust	All trusts
Number of respondents	554	77850
Response Rate (percentage)	46	44

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	54	47
Female	46	53
Age group (percentage)	(%)	(%)
Aged 16-35	7	5
Aged 36-50	9	9
Aged 51-65	26	23
Aged 66 and older	58	63
Ethnic group (percentage)	(%)	(%)
White	96	90
Multiple ethnic group	0	1
Asian or Asian British	1	3
Black or Black British	0	1
Arab or other ethnic group	0	0
Not known	3	5
Religion (percentage)	(%)	(%)
No religion	13	16
Buddhist	0	0
Christian	84	77
Hindu	0	1
Jewish	0	0
Muslim	1	2
Sikh	0	0
Other religion	1	1
Prefer not to say	1	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	94	94
Gay/lesbian	1	1
Bisexual	0	0
Other	1	1
Prefer not to say	4	4

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF FINANCE

COUNCIL OF GOVERNORS

OCTOBER 2017

FINANCIAL POSITION AS AT 30TH SEPTEMBER 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 September 2017.

1.1 KEY HIGHLIGHTS

Issue or Metric	NHSI Plan	Actual	Variance to NHSI Plan	
	£000s	£000s	£000s	%
Overall Financial Position including STF – Deficit	£3,996k	£3,451k	£455k	11.4%
Overall Financial Position excluding STF – Deficit	£7,227k	£7,219k	£8k	0.1%
Income (including STF)	£175,472k	£177,564k	£2,092k	1.8%
Expenditure	£179,468k	£181,105k	£1,637k	0.9%
EBITDA Position %	2.10%	2.0%		
Cash Position	£3,886k	£3,138k	£748k	19.2%
Clinical Activity:				
Variance to plan	£158,120k	£157,741k	£379k	0.2%
Cost Improvement Plans				
Variance to plan	£5,200k	£4,949k	£251k	4.8%
Pay:				
Variance to plan	£107,776k	£107,501k	£275k	0.3%
Non Pay:				
Variance to plan	£71,692k	£73,604k	£1,912k	2.7%
Use of Resources Metrics (UOR)			3	
+ve variance equates to worse than expected; -ve equates to better than expected				

Executive Director of Finance

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF FINANCE

COUNCIL OF GOVERNORS

OCTOBER 2017

FINANCIAL POSITION AS AT 30TH SEPTEMBER 2017

1 INTRODUCTION

The enclosed financial statements reflect the Trust and its subsidiary companies Income & Expenditure position as at 30th September 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 6		
	NHSI Plan	Actual	Variance
	£000s	£000s	£000s
Deficit for the year before Impairments and Transfers	(3,996)	(3,541)	455
Add: depreciation on donated assets	0	0	0
Less: gain on asset disposal	0	0	0
Less: income from donated assets	2	(26)	(28)
Less: 2016/17 STF post accounts allocation		(419)	(419)
Control Total Surplus/(Deficit) including STF	(3,994)	(3,986)	8
Less: STF 2017/18	(3,233)	(3,233)	0
Less: STF Incentice schemes	0	0	0
Control Total Surplus/(Deficit) excluding STF	(7,227)	(7,219)	8

The overall operational financial position is a net deficit of £3,541k against a planned deficit of £3,996k, and therefore £455k ahead of plan. The Trust has therefore achieved it's Control Total to date and is liable for STF funding of £3,233k.

The net deficit of £3,541k included income for £419k as part of 2016/17 STF funding post accounts reconciliation, and £3,233k for the first six months of this year for achieving it's control total. This gain in STF is not included in the control total calculation and therefore the financial position reported to NHSI is a net deficit of £7,219k, or £8k ahead of the planned NHSI control total to month 6.

The Trust reported an under performance of £379k in month 6 relating to NHS clinical activity which is due to lower than expected PbR activity.

At the end of September the Cost Improvement Plan (CIP) delivery is £251k behind projected plans submitted to NHSI.

Performance against the EBITDA margin is marginally ahead of plan to the end of September.

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

Improvement in month 6 is largely due to the Trust accessing £2m from the Sunderland South Tyneside local health economy risk share agreement.

2 INCOME AND EXPENDITURE POSITION

2.1 *Patient Related Income:*

Clinical Income to month 6 was £157,741k against a plan of £158,120k, and hence behind plan by £379k.

The 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 DDES CCG and NHS England commissioners are over performing. North Durham and NHS Dental continue to under perform against contract.

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

Private Patient Income is over recovered against plan by £21k.

2.2 *Non Patient Related Income:*

Training and Education income is behind plan by £50k to month 6 due to cessation of funding from Health Education North East for a number of schemes this year, this is partly matched by a reduction in non pay costs. Research and Development income is £8k behind plan to date.

Other Income was ahead of plan by £2,099k due largely to the Trust accessing £2m from the Sunderland South Tyneside local health economy risk share agreement.

As mentioned earlier, the Trust has achieved the year to date Control Total and is eligible for STF funding for £3,233k.

3 EXPENDITURE

3.1 *Pay Expenditure:*

Pay is currently showing an underspend of £275k against plan, reflecting:

- Agency costs to month 6 are £3,025k, compared to an overall Trust agency staffing budget to month 6 of £2,145k. Much of this spend is to cover vacant posts. The same period in 2016-17 had agency spend at £2,370k which is £655k less than the current period, the main reason is 2 more agency consultants in Radiology compared to 2016/17 to cover substantive staffing gaps. 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 September 2017, detailed in Appendix 4. To month 6 the ceiling level is set at £3,096k, whereas the total spend to date is £3,025 and hence below by £71k.
- To date the net underspend from vacant nursing posts across the Trust is £636k which is inclusive of the costs paid to NHS Professionals and overtime working.
- Cost Improvement Plans for pay are £251k ahead of plan to date mainly due to vacancies across the Trust.
- Other Staff group underspend is largely due to vacancies in CHoICE, Theatres and the cross charge to South Tyneside FT for the single management structure.

- Key variances by staff group are detailed as:

Key Pay variances by staff group to current month	£000s
Consultants Staff (net of vacancies, additional sessions and agency costs)	577
Other Medical Staff (net of vacancies, additional sessions and agency costs)	538
Nursing (net of NHSP Costs)	-636
Other Staff groups	-754
Total Variance	**-275**

Appendix 4 shows details of pay spend on agency, flexi-bank and overtime for the last 12 months from month 6.

Overall pay costs in September were £17,797k against a budget of £17,998k for the month.

3.2 *Non Pay Expenditure:*

Non-Pay is overspent by £1,912k. Major areas are highlighted as:

- Drugs overspend this month is £739k against plan, £130k of the overspend is due to a shortfall in CIP to date with the remainder recovered from the cross charge to clinical commissioners.
- Clinical Supplies is overspent by £473k against plan to date, of the overspend £142k is due to a shortfall in CIP delivery to date, £242k is overspend due to increased offsite diagnostic reporting and ultrasound tests provided by third parties. The latter is the most cost effective way to meet demand compared to the alternatives of employing an agency sonographer or using a core consultant to perform scans.
- Other Non Pay is overspent by £700k against plan to date, most of which is owing to offsite CT scans (£129k), rental of the CT Van (£158k) and offsite MRI scans (£188k). Currently owing to the challenges in recruiting CT radiographers the emergency department CT can only be staffed by closing an existing CT machine. The CT van therefore continues to be used as the most cost-effective alternative to sending scans to private hospitals. Going forward demand for CT scans is forecast to be 8% greater in 2017-18 compared to last year, this mainly additional emergency department demand. Although growth in MRI demand has flattened recently the predicted 2017-18 demand is still expected to be 4,000 over the capacity which CHS can provide with its two in-house MR machines, therefore offsite capacity is still required. A further £380k of the overspend is due to CIP under delivery against plan to date.
- PDC costs are £388k underspent against plan to date.
- Depreciation costs are £92k underspent against plan to date.
- Interest paid is £35k 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 6, CIP delivery was £4,949k against a planned delivery of £5,200k and hence an under delivery of £251k. 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 £12.4m 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.

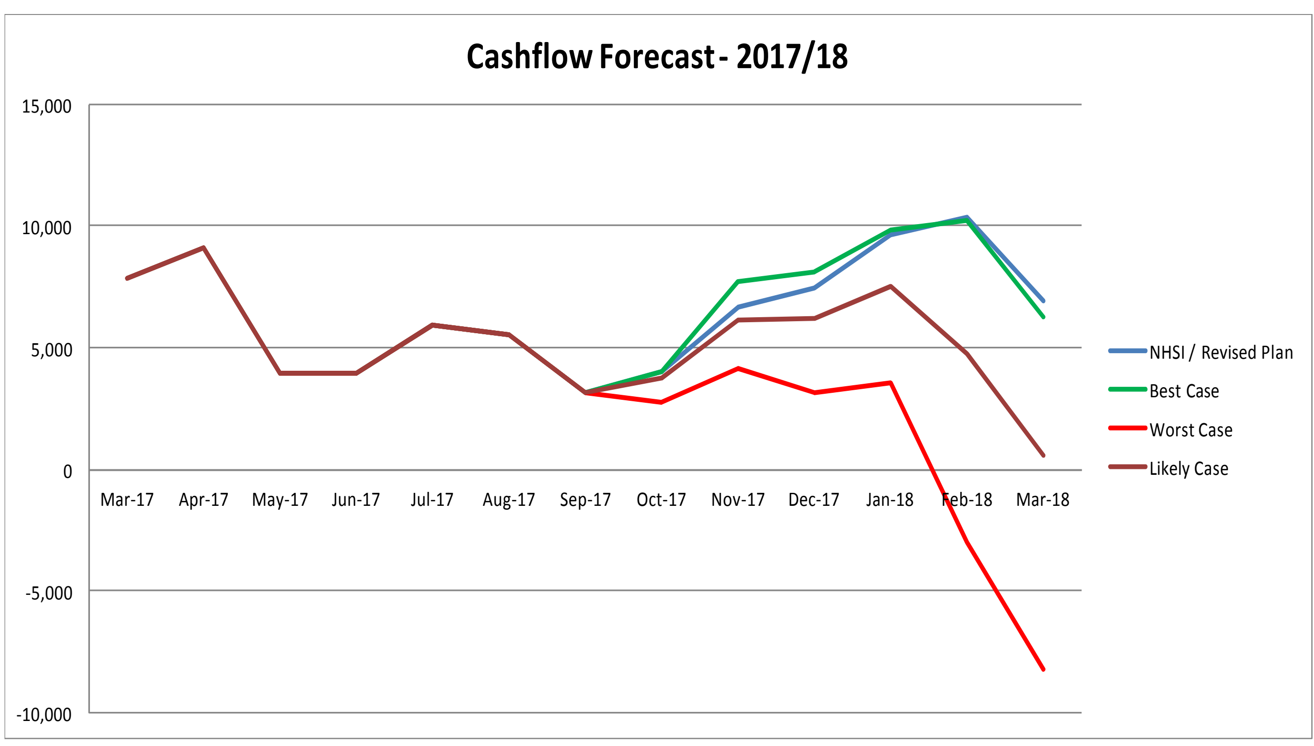
Details are provided in Appendix 6.

5 CASHFLOW AND WORKING CAPITAL

The cash balance at the end of September 2017 was £3.14m against planned £3.89m. The adverse variance of (£750k) consists of a shortfall in cash relating to the non achievement of STF funding (£1.39m) and negative working capital movements of (£700k), offset by a favourable variance resulting from the capital cash profile being behind plan £1.34m.

The adverse NHS debtor variance of (£10.63m) consists of un-invoiced accruals in respect of STF funding £(3.23m), Risk Share agreement funding £(2m), Q2 Over-performance (£1.5m), Vanguard funding - Sunderland CCG (£750k), clinical activity income invoices (£987k), pathology service invoices (£279k) and other miscellaneous charges etc (£1.88m). All debtors continue to be vigorously pursued.

Principal and interest repayments of £623k and £341k respectively were paid against the Trust's capital borrowing facility, effectively reducing the total value of outstanding loans to £54.72m.



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

The NHSI/revised plan assumes achievement of the control total for the year and that all STF funding will be received. A key change compared to the annual plan value for cash is approximately £2.5m of non-cash items within the income and expenditure position for 2017/18, for example stock revaluation and lower than planned depreciation. The best, likely and worst case scenarios are driven by the overall income and expenditure forecasts in detailed in this paper but also account for the noted £2.5m non cash items.

The best case scenario assumes achievement £1.3m over delivery against income and expenditure control total with a like for like cash impact, therefore full STF funding, 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 likely case scenario assumes the Trust is £1.6m behind the required control total with a like for like cash impact, and therefore does not gain STF funding for quarter 3 (note quarter 4 STF cash would be into 2018/19).

The worst case scenario assumes the Trust is £8.4m behind the required control total with a like for like cash impact, and therefore does not gain STF funding for quarter 3, plus does not gain cash settlement of Q3 & Q4 CQUIN of approximately £1.5m.

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

6 CAPITAL

Capital expenditure to date is £736k and relates mainly to A&E Development (£446k), Sewing Room Conversion (£144k), Back Log Maintenance schemes (£45k) and IMT Costed Profile (£23k).

7 RISKS

The two prime risks are firstly, the gap in CIP plans especially given the increase in target for Quarters 3 and 4 later this year, secondly under performance against PbR contracts with commissioners and the challenge in pulling like for like costs from the system. In addition, the Trust has received support from Sunderland CCG under the 'risk share' agreement process however the formal sign-off process is required by the CCG to confirm this and it is unlikely that there will be further funding available later in the year.

8 FORECAST

Delivery of the required control total for the Trust is a risk in 2017/18.

Current forecasts indicate *(measured against control total excluding STF i.e. £14.981m deficit):*

Scenario	Forecast deficit (£m)	Variance from control total (£m)
Best case	13.635	-1.346
Worst case	23.355	8.374
Likely case	16.565	1.584

The Trust is working through a number of measures to potentially improve this position such as conversations with commissioners of additional funding, and a review of possible benefits through national Financial Grip and Control checklist. In addition we continue to work 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. The Trust has significant concerns around the achievement of the control total by the end of the year, however is working closely with the regional NHSI team to ensure all options have been considered ahead of formally declaring non achievement.

At this stage therefore, the Trust has declared to NHSI that control total delivery is achieveable in 2017/18, however there are risks.

9 NEXT STEPS

The Trust needs focus on identifying £600k 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.

10 SUMMARY

The overall position at the end of September including STF, is a deficit of £3,541k compared to a planned deficit of £3,996k or £455k ahead of plan. The position excluding STF is £8k ahead of plan.

11 RECOMMENDATIONS

The Council of Governors is requested to:

- Note the financial position to date.

Julia Pattison
Executive Director of Finance
October 2017

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF PLANNING AND BUSINESS DEVELOPMENT

COUNCIL OF GOVERNORS

OCTOBER 2017

CANCER INCIDENCE AND SURVIVAL REPORT

INTRODUCTION

Following a request from Governors the attached paper identifies cancer survival rates for Sunderland and demonstrates how they compare nationally.

EXECUTIVE SUMMARY

Trend data shows that cancer incidence in the North East of England is consistently higher than the England average. Stage at presentation is one of the key prognostic factors for survival. For all cancers combined, Sunderland Clinical Commissioning Group (CCG) has fewer patients presenting with stage 1 and 2 disease and a greater percentage presenting at stage 4.

1 year survival has been improving consistently over the last 10 years both nationally and locally. Sunderland CCG's 1 year survival has been lower than the national average over this period; however the gap between Sunderland and the national average has decreased in recent years. Sunderland CCG has recently received recognition from the All Party Parliamentary Group on Cancer as one of the most improved CCGs measured by annual one-year cancer survival rates (2017).

Data shows that the North East 3 year survival rate is consistently poorer than the national average for breast, colorectal and lung cancer. It should be noted that the improvement in 1 year survival would be expected to be observed in 3 year survival in future publications of this data.

CHS are working closely with the CCG and Cancer Alliance to seek to improve the proportion of patients that initially present with early stage disease. This work is multi-factoral ranging from health promotion work around healthier lifestyles, increasing the uptake of screening, raising awareness of signs and symptoms, ensuring appropriate early referrals from primary care to secondary care and easier access for GPs to specific diagnostics.

Introduction

The CHS Council of Governors requested information detailing cancer survival rates for Sunderland in order to understand how these compare nationally. Publicly

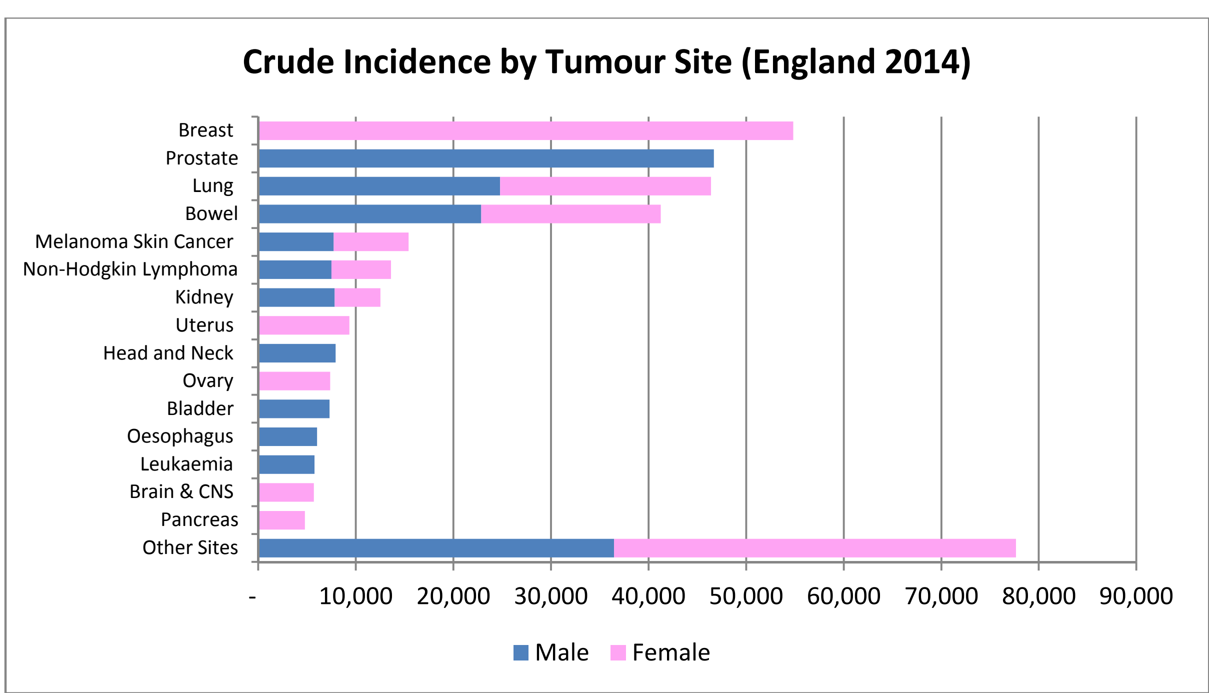
available data has been used to produce this report so that risk adjustment for the cohort is consistent and benchmarking accurate. Cancer survival data is only available at CCG level (rather than hospital of diagnosis/treatment) and for this reason Sunderland CCG has been used as the local area where possible. This paper details incidence and survival by all cancers and is broken down at tumour site level for the 3 most common cancers (breast, lung and colorectal).

Data within this paper is taken from the Office of National Statistics (ONS) and cancer statistics website. Unless otherwise stated the data relates to adults (15-99 years) that were diagnosed with a first, primary invasive malignancy.

Incidence

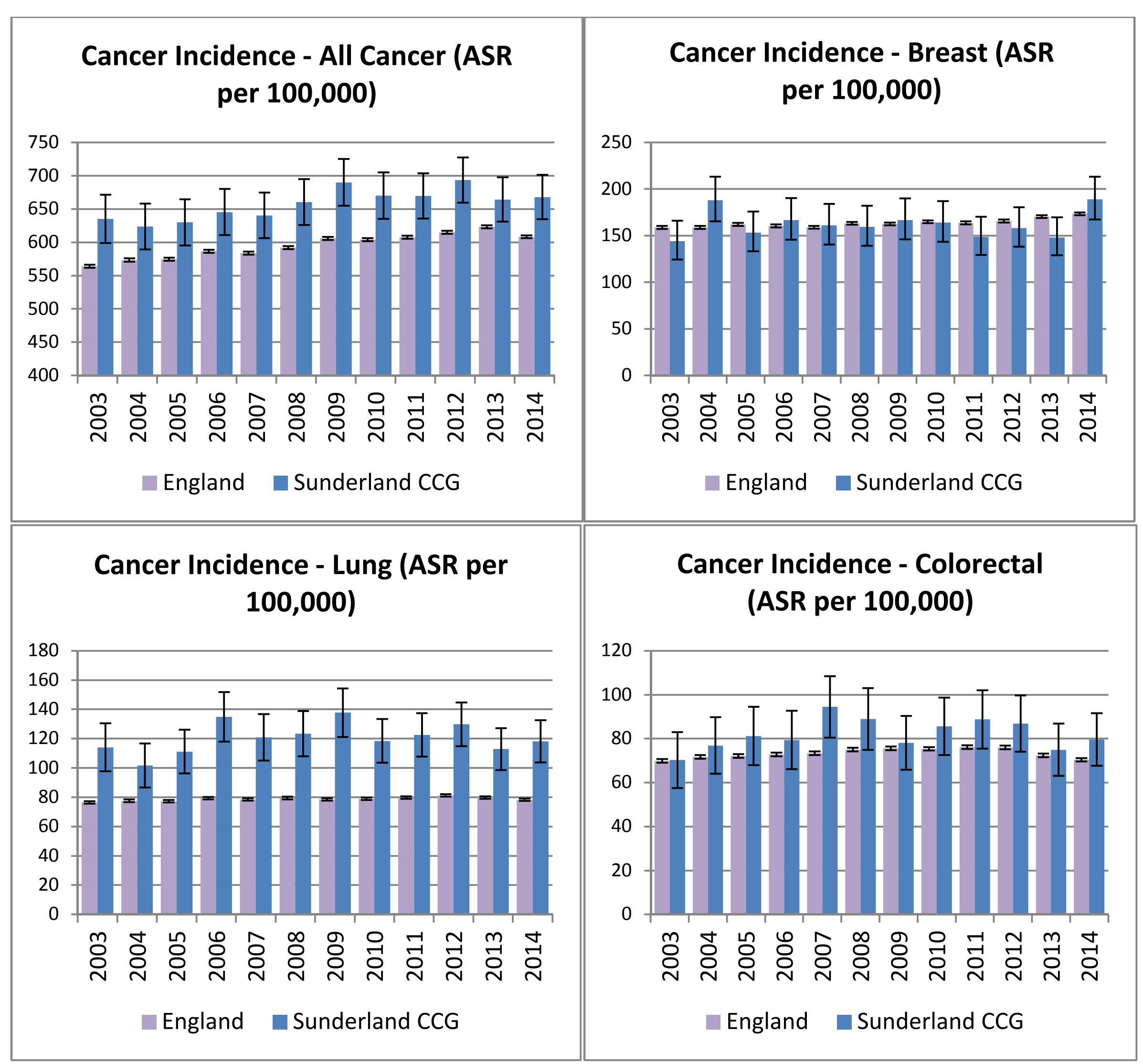
The most common cancers which are included in this paper are breast, lung and colorectal, while prostate cancer is actually the second most common cancer it is often excluded from such analysis as the disease characteristically differs from most other cancers (also in terms of incidence Prostate Specific Antigen(PSA) monitoring has meant that trend data is not comparable). Chart 1 shows incidence by tumour site and demonstrates that the 4 most common cancers have significantly higher incidence rates than other cancers.

Chart 1 – Incidence by Tumour Site (crude, England)



Trend data shows that cancer incidence in the North East of England is consistently higher than the England average. The Sunderland CCG age standardised rate (ASR) for incidence per 100,000 population is 668 (2014) compared to an England average of 608. Data shows that Sunderland CCG has consistently had a significantly high incidence rate than the national average (2003-2014). National and local data over the same time period demonstrate an overall increase in incidence.

Chart 2 – Cancer incidence



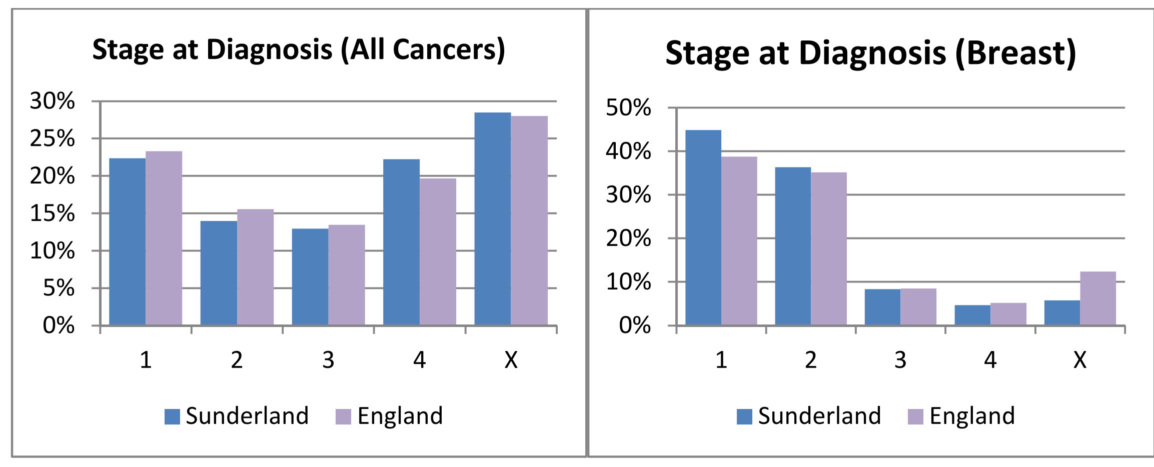
Breast cancer incidence for Sunderland CCG is in line with the national rate. The Sunderland CCG breast cancer incidence rate for 2014 is higher than the national average; however this remains within the confidence limits. The incidence of Lung cancer is consistently significantly higher than the national average; data for 2014 shows the Sunderland CCG incidence rate for lung cancer was 118.2 compared to the national rate of 78.3. Colorectal cancer incidence rates are higher than national averages but not consistently significantly different; for 2014 the Sunderland incidence of colorectal cancer was 79.6 compared to a national rate of 70.4

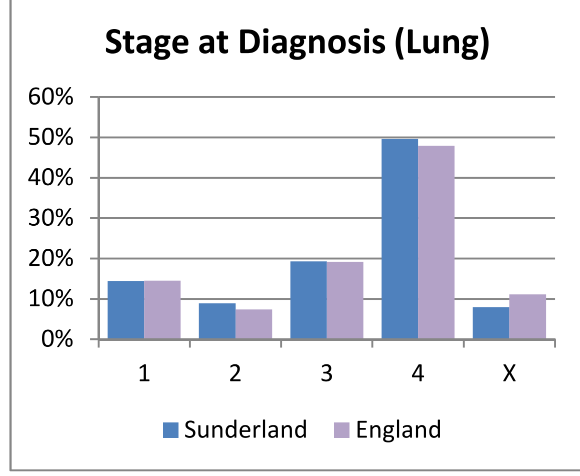
Stage at Presentation

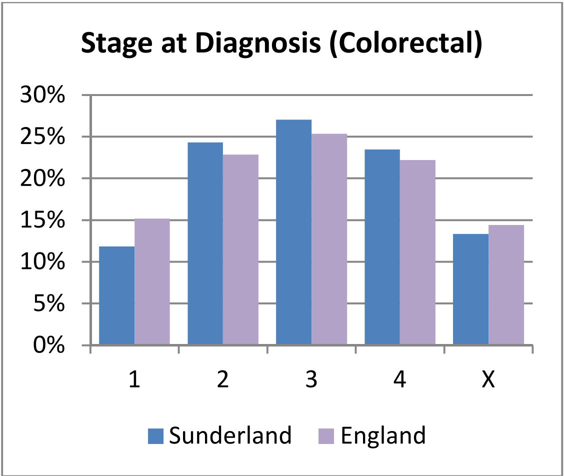
Stage at presentation is one of the key prognostic factors for survival. For all cancers combined, Sunderland CCG has fewer patients presenting with stage 1 and 2 disease and a greater percentage presenting at stage 4. Sunderland CCG has more breast cancer patients presenting at stage 1 than the national average and fewer that are un-staged. Stage at presentation for lung cancer is comparable to the national averages with almost 50% presenting with stage 4 disease. Sunderland

CCG has fewer patients presenting at stage 1 for colorectal cancers than the national average with a greater number presenting with stage 2, 3 and 4 disease.

Chart 3 – Stage at Presentation





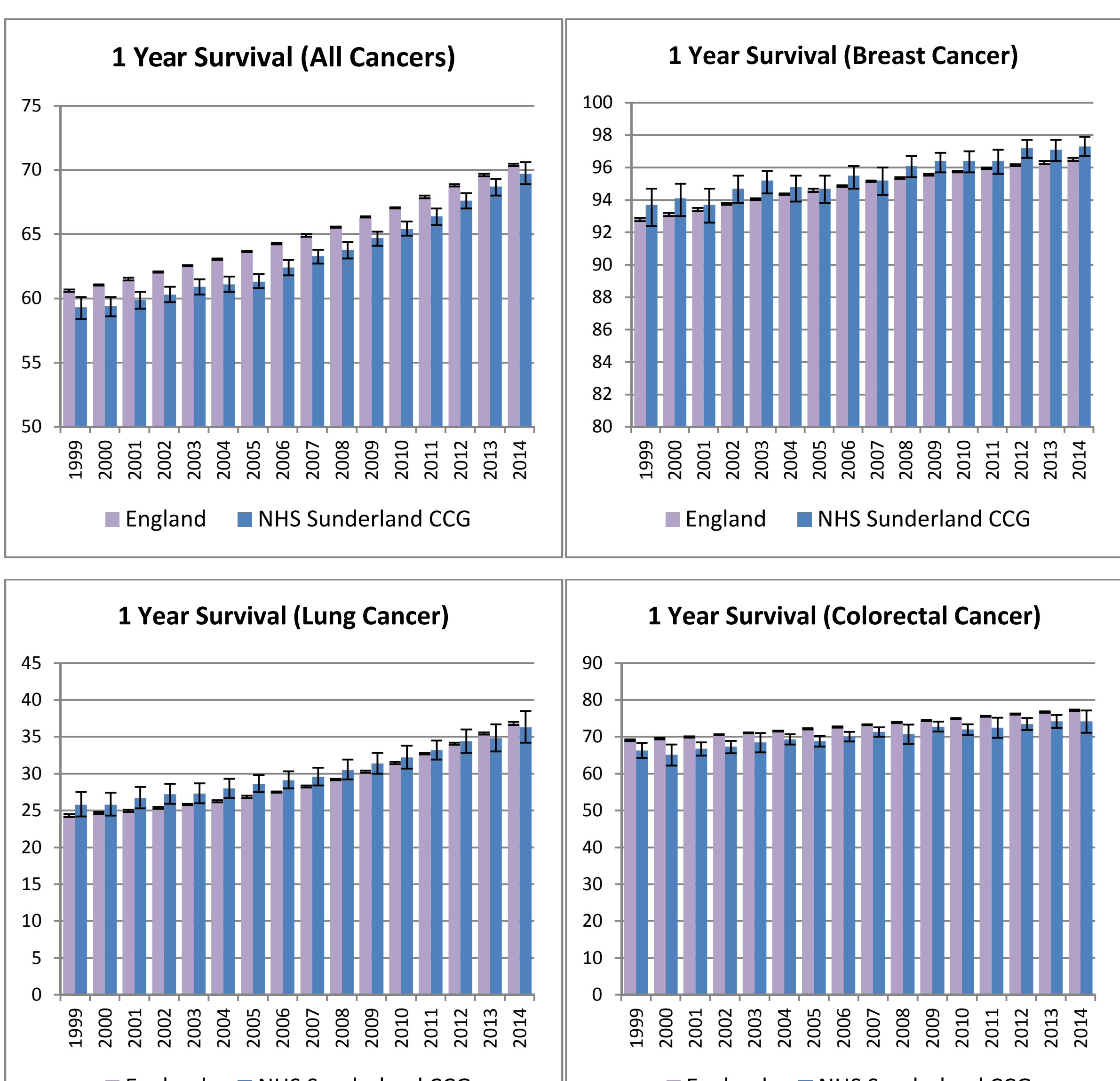


Survival

1 Year Survival

1 year survival has been improving consistently over the last 10 years both nationally and locally. Sunderland CCG's 1 year survival has been lower than the national average over this period; however the gap between Sunderland and the national average has decreased in recent years. Sunderland CCG has recently received recognition from the All Party Parliamentary Group on Cancer as one of the most improved CCGs measured by annual one-year cancer survival rates (2017). Breast cancer 1 year survival for Sunderland CCG is generally better than the national average. Lung cancer 1 year survival for Sunderland CCG was historically slightly better than national average, however the gap has decreased and over the last 2 years (2013/2014) has been marginally below the national average. 1 year colorectal cancer survival for Sunderland CCG has been consistently below the national average for the last 10 years.

Chart 4 – 1 Year Survival



3 and 5 Year Survival

3 and 5 year survival data is less readily available at geographical and tumour site level. Survival varies significantly by tumour site as shown in the chart below. Cancer survival decreases over time, but reductions tend to tail off after 5 years.

Chart 5 – 1, 5 and 10 Year Cancer Survival by Tumour Type (England)

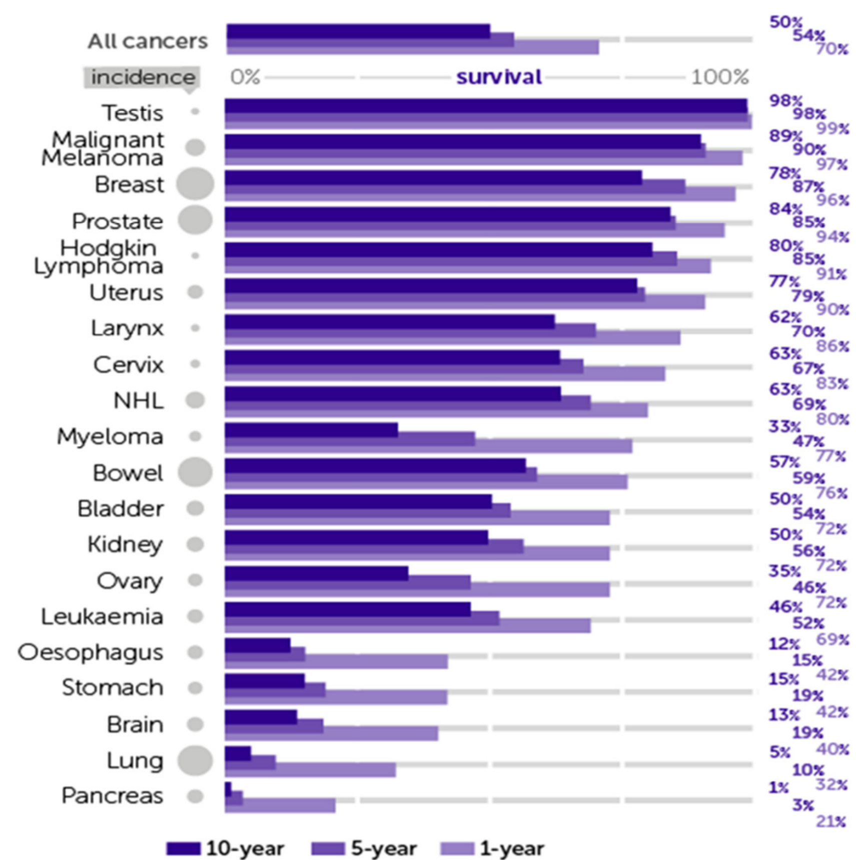
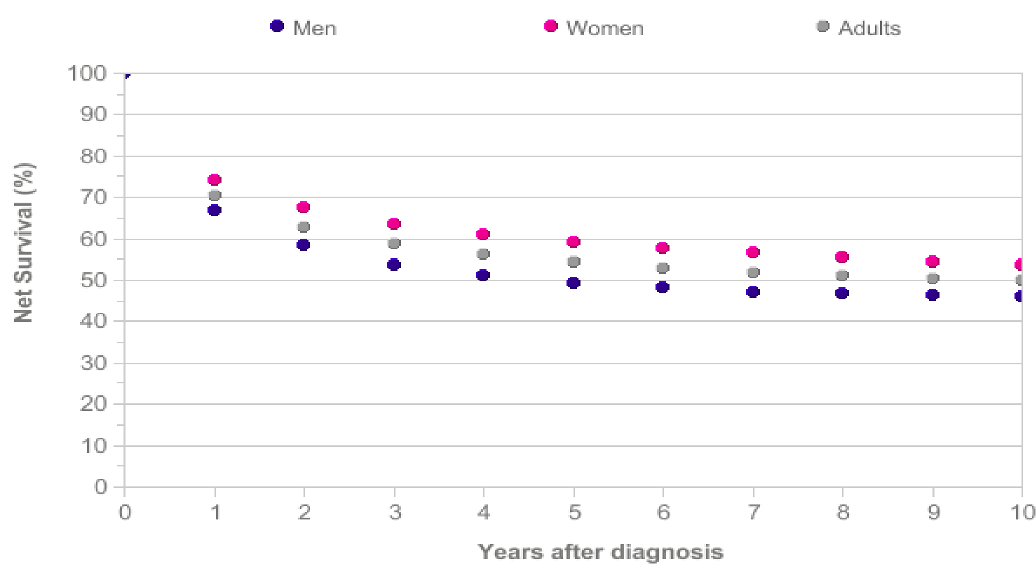


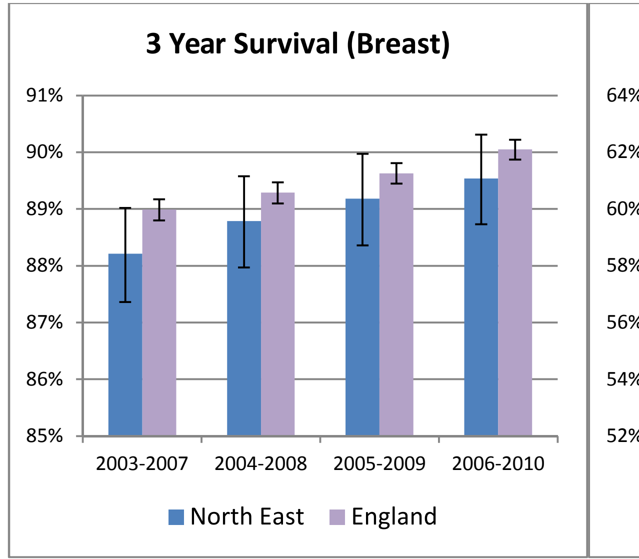
Chart 6 – Cancer survival Over Time (All cancers, England)

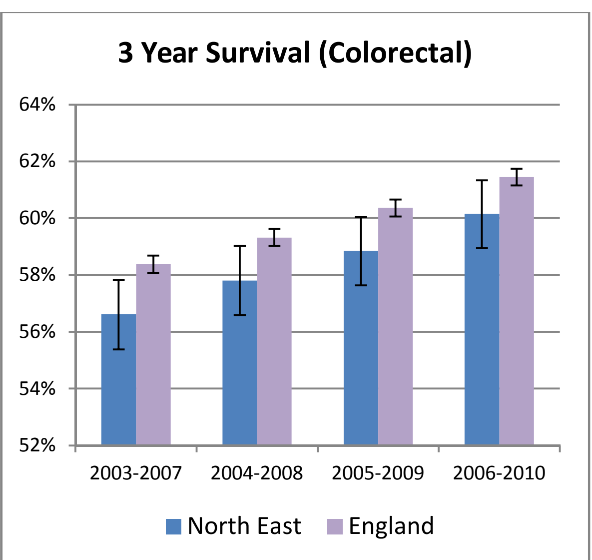


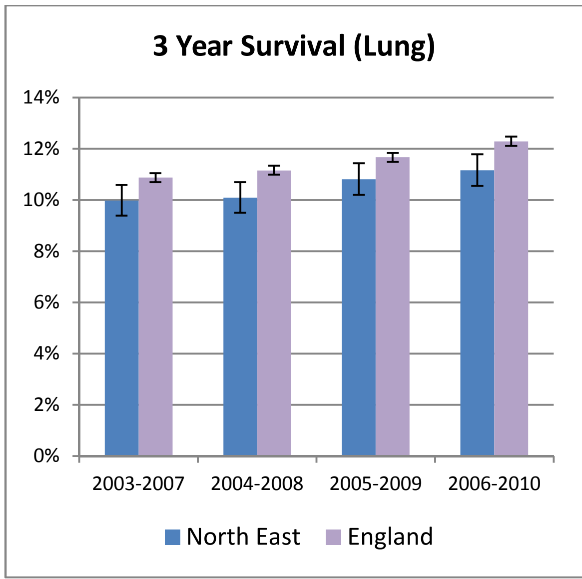
3 year survival data is only available at super regional level due to data limitations and decreasing volumes in cohorts. 3 year survival trends for the most common cancers all demonstrate improving survival rates over time at both national and regional level. Data shows that the North East 3 year survival rate is consistently

poorer than the national average for breast, colorectal and lung cancer. It should be noted that the improvement in 1 year survival would be expected to be observed in 3 year survival in future publications of this data.

Chart 7 – 3 Year Survival







Action

CHS are working closely with the CCG and Cancer Alliance to seek to improve the proportion of patients that initially present with early stage disease. This work is multi-factoral ranging from health promotion work around healthier lifestyles, increasing the uptake of screening, raising awareness of signs and symptoms, ensuring appropriate early referrals from primary care to secondary care and easier access for GPs to specific diagnostics.

Specific areas of work include:

- Cancer taskforce established, developed action plan.
- Cancer Alliance successful in 'Early diagnosis' bid for funding seeking to appoint 4 posts across Sunderland and South Tyneside.
- Making every contact count, working with Live life Well and FRESH to promote healthier life styles and smoking cessation.
- GP Direct access to CT scan for patients with worrying but vague symptoms that don't fit within tumour specific 2WW referral. Onward direct pathway to the appropriate multi-disciplinary team.
- GP Direct access to MRI Brain for patients with suspected Brain malignancy.
- Lung escalation pathway, GP referral for Chest X-Ray, direct escalation to CT scan and Chest physician referral for any suspicious findings.
- Pancreatic escalation pathway GP referral for Ultra sound scan, direct escalation to CT scan and Gastroenterology referral for any suspicious findings.
- Scoping further escalation pathways (possibly renal cancers)
- Cancer Research UK (CRUK) practice based cancer audits to identify and sharing best practices. Specific action plans for each Practice being prepared and implemented.
- CRUK pilot clinics within 7 practices who have lowest uptake of bowel screening
- Implementation of Optimal Lung pathway – including Ambulatory CT guided lung biopsy.
- Specific pathway re-design work.

Summary

- Cancer incidence is higher in the North East of England and Sunderland CCG for all cancers combined than the England average.
- Patients generally present at a later stage in Sunderland CCG than the England average.
- 1 year survival for Sunderland CCG is lower than the England average, however the gap has reduced in recent years.
- 3 year survival for the North East of England is lower than the England average for the 3 highest volume tumour sites.
- CCG Cancer task have comprehensive action plan to lead early diagnosis work.

Recommendation

Governors are asked to receive the report.

Melanie Robertson
Consultant Nurse Oncology
Cancer Lead Clinician

Dan Spelman
Senior Performance Analyst

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