CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

THURSDAY 21 JULY 2016 - 9.30 AM
HENRY TUDOR ROOM, AGE UK, STOCKTON ROAD, SUNDERLAND, SR2 7AQ

AGENDA

Item 1	Declaration of Interest		
Item 2	Minutes of the meeting held on 7 June 2016	Enc 1	KWB
	Matters Arising		
	Item 2 Breast Service		KWB
	Item 3 Junior Doctors		KWB
	Item 4 Sustainable Transformation Plan		KWB
Item 3	Chief Executives Update	Verbal	KWB
Item 4	Performance Report	Enc 2	AK
Item 5	Finance Update	Enc 3	JP
Item 6	Quality Risk Assurance Report	Enc 4	MJ
Item 7	Inpatient Survey Results	Enc 5	MJ/GS
Item 8	2016 Governor Elections	Enc 6	CH
Item 9	Date and Time of Next Meeting:		
	Annual General Meeting, Thursday 8th September, 3.30pm The Board Room, Sunderland Eye Infirmary		

Enclosure 1

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

Minutes of the meeting of the Council of Governors held on Tuesday 7 June 2016 at 2:00 pm at The Robinson Suite, Glebe Centre, Murton

Present:
John Anderson (JNA) - Chair
Danny Cassidy (DC)
Ruth Richardson (RR)
Pauline Taylor (PT)
Susan Pinder (SP)
Lindsey Downey (LD)
Pat Taylor (PaT)
Alex Marshall (AM)
Tony Foster (TF)
Margaret Dobson (MD)
John Dean (JD)
Pauline Palmer (PP)
Mandy Bates (MB)
Carol Harries (CH) - Trust Secretary

Apologies:
Rob Allchin (RA)
Mary Pollard (MP)
Michael McNulty (MMcN)
Shahid Junejo (SJ)
Graeme Miller (GM)

In Attendance:
Ken Bremner (KWB)
Stewart Hindmarsh (SH)
Peter Sutton (PS)

Item 1 **Declaration of Interest**
None

Item 2 Minutes of the meeting of the Council of Governors held in public on 24 March 2016 were accepted as a correct record.

PaT commented however, that the word 'depressed' on page 9 seemed an odd word to have been used. CH explained that this had been the term used by GM.

Matters Arising

Vascular Services – KWB confirmed that Durham had contested the outcome of the review and every Trust was now able to confirm their data. This would be considered by the reviewers and they will then make a judgement as to whether the information fundamentally altered the outcome of the review.

Breast Services - KWB advised that the CCG and Gateshead Trust were hopeful that the new service which was to be located at Grindon, would be operational by July.

Junior Doctors – AM queried the statement on page 2 that the Trust did not employ junior doctors. KWB confirmed that apart from the very junior doctors, all other were employed by NHS England. AM assumed that registrars were included in that group. KWB confirmed that this was correct.

Financial Position – PaT queried as to the position at the financial year end. KWB confirmed that it was a £12.5m deficit which was a marked improvement on the plan. A technical accounting adjustment following a revaluation of the Trust site meant a deficit position of £9,138k.

Item 3 Chief Executive's Update

Getting it Right First Time - John Abercrombie, a Senior Surgeon at Queens Hospital, Nottingham, had visited the Trust to look at general surgical services. We had been benchmarked against a peer group which included University College London and Kings College London. KWB advised that some of the data stretched back over a 4/5 year period. The results demonstrated that our elective service was very good, but that our non-elective service had room for improvement. Mr Abercrombie had talked about some of the changes that had occurred in Nottingham and that they had undertaken a lot more 'front door' intervention and he had extolled the virtue of that approach. KWB informed Governors that the surgeons were to pull together an action plan.
The Bariatric Service had also been looked at and we undertook 10% of all the national work and our team had performed very well on cost. Going forward, other sub speciality areas would be recieved.

Junior Doctors - KWB advised that there had been a cessation of the introduction of the new contract and a referendum was to be held of all junior doctors regarding the new proposal – the news of which would be announced on 6th July 2016. KWB advised that if it was accepted, then there was likely to be a phased implementation. It was probable that there would still be an impact on recruitment as a number of doctors had drifted to Scotland and Australia for positions. In Anaesthetics, for example, only 48% of posts were currently filled which would cause problems.

Volunteers Week - KWB advised that Volunteer Week was currently happening until the 12th June. An event had been held in the Chapel to thank volunteers for all that they contribute to the Hospital and patients in particular.

Care Quality Commission – KWB stated that the CQC had just released its five year strategy for consultation about which we had submitted comments. The assessment process was now different to that which we had been subject to.
MD commented that Sir Len Fenwick had promised staff an additional days leave as a result of their 'outstanding' achievement. MD queried as to where they got the funding to be able to do that. KWB commented that it was a significant achievement and such awards had to be weighed up carefully but it was important to remember that Newcastle's turnover was over £1billion. KWB stated that the cost would not be as much as expected and it was a recognition and thank you to staff for their contribution in achieving such a good outcome.
The Chairman advised that if we were making such a gesture, he would seek the views of Governors in the first instance. SP commented that it was very good for staff morale.

Delayed Discharges – KWB advised that a national press release had been issued expressing concern with the number of delayed discharges and problems with Local Authorities. KWB explained that our numbers were much better and in recent years had reduced from an average of 40/50 to 10/15. The Trust worked closely with the Local Authority and in particular, Sunderland Care and Support which was a really good initiative.

Norovirus – The hospital was experiencing high numbers of patients with norovirus and at one point, over 100 beds had been affected. We had restricted visiting as there were a number of cases in the community.

Sustainable Transformation Plan – KWB advised that we were requested to submit our plan by the end of June, although there was a view that nationally, this timescale would be more relaxed. KWB explained that our footprint was Northumberland, Tyne & Wear and Durham went with North Tees, South Tees and Hartlepool. There was a significant financial shortfall and a belief that there were no robust plans to fill the financial gap. The net position including Local Authorities was £270.93m and that needed to be closed over the next five years. It was likely that the submission would now be delayed until September.
KWB stated that it would open a whole new discussion about what do we stop and what we will need to do differently and that would involve Governors going forward. It was also important for the Trust to keep a close watch over what might be happening in Durham. AM queried as to where competition fit. KWB replied that we could not ignore it but the national mood music was to find a way around it. PaT commented that there was an increasing feeling that this was three footprints stitched together – Newcastle/Gateshead CCGs, Sunderland and South

Tyneside and the Northern areas. PaT stated that the approach made sense but it was not a single plan.
KWB replied that whilst there were three distinct separate elements, they all added up to one plan. In Gateshead for example, we provide ENT services etc, but it was an artificial construct.
KWB stated that he did not have the finished version and that there was still work to be done.
SP queried where Durham would fit. KWB explained that they were with South Tees, Hartlepool and Darlington. AM commented that it was becoming reminiscent of the old Regional Health Authorities.

Item 4 **South Tyneside and Sunderland Healthcare Group – Memorandum of Understanding**

KWB presented the paper which set out formally the scope of the collaboration between City Hospitals Sunderland NHSFT and South Tyneside NHSFT. The MOU set out how the collaboration would work, how performance would be measured as well as the governance arrangements for the alliance, known as South Tyneside and Sunderland Health Group. KWB stated that it had been subject to extensive discussion and appropriate legal advice. The regulator had also received a copy and considered whether competition elements needed to be considered in case it restricted choice. Monitor had completed the work and 30% was the limit. Monitor had confirmed that 14 out of 18 areas were not an issue but Trauma and Orthopaedics, Urology, Haematology and Thoracic were potential problem areas. KWB advised that South Tyneside did not provide Urology and CHS was the sole provider. Haematology was very similar but it was unclear as to why Thoracic received more referrals and there was no easy explanation. The issue for Trauma and Orthopaedics was probably that CHS did more specialised work but we were looking at more procedures to try and understand the issue. Monitor did believe however, that this was low risk, but the competition and marketing authority can come in at any time and take a more detailed look.
KWB stated that the document identified a lot of references to governance matters and the Council of Governors very clearly had a role, particularly in the forthcoming service reviews. The document had been approved by both Boards of Directors. PaT queried the investment decision above £1m and whether as costs arises, would they be borne pro-rata to each organisation and its site. KWB replied that it was a range of different factors and where resources are shared, then costs could be split, an example of which was KG who as Director of HR was working two days a week at South Tyneside.

KWB also stated that discussions were still ongoing with the regulator to see whether we could be reviewed as one.
PaT stated that such a new development needed start-up funding given the financial situations of both organisations. KWB replied that IM&T for example was a significant investment for South Tyneside.
DC queried whether the communication issue referred to in the minutes on page 3 had been resolved. KWB apologised that he had not raised this earlier but confirmed that the name had been resolved and the Leader and the Local Authority were aware of and very comfortable with the new name.
AM commented that 'significant transactions' on page 3 seemed a little woolly. KWB replied that it was not defined and that we would need to take a view. There was also a requirement for CCGs to lead any public consultation.
AM also stated that on page 5 it stated that the MOU was not legally binding and therefore had no legal status. KWB confirmed that it did not have legal standing because the alliance was not a separate statutory body. AM queried whether the MOU had a specific legal understanding. TF commented that MOUs specifically exclude legal status.
JD queried the termination clause and whether a time limit of six months was long enough. TF commented that he felt such timescales were fairly common. KWB stated that he was not certain but it was felt to be right.
The Chairman stated that discussions continued and that as we moved towards a joint executive, we needed to be clear of our role as Governors and to be clear about our legal position when services become one. The Chairman commented that he was not sure that Governors in South Tyneside were fully aware of the issues. The CEO was trying to pull together a joint executive team and our executives were very experienced and a document had been developed.
RR queried whether in the future it would be possible for the Council of Governors and NEDs from both organisations to have joint meetings on issues such as stroke services for example. RR stated that she would welcome that approach as there was definitely a need to combine given both current financial situations.
The Chairman stated that involvement at this time was through these meetings and currently he was not clear how the approach worked at South Tyneside. RR commented that a discussion about much closer involvement of services/organisational arrangement was really useful. KWB stated that that had started with the vice chairs of each organisation and also with the Executives on a number of occasions. RR commented that she did not believe that South Tyneside were yet at that point. KWB replied that he probably agreed but it was only a matter of time.
AM suggested that it was more of a co-operative than anything else.

JD stated that as the approach involved clinical services, there was obviously an element of public involvement and Governors needed to be involved in that and particularly to outreach and feedback. JD stated that the approach needed comments from our Governors and those at South Tyneside.
KWB replied that section 7 of the MOU made the role of Governors very clear and a view could only be taken when there was actually something to consult upon. KWB stated that such discussion would happen at a future point.
SP suggested that such involvement may be cumbersome and delay things because it will take longer for decision making.
KWB stated that the view of the regulator was that an important element was service delivery and that needed to be accelerated and our approach was to do that with one management team rather than two and hopefully achieve a better outcome. SP queried whether this would take longer. KWB replied that it may do, but that we needed clinical staff on the front foot to articulate those services and paediatrics was a good example of that approach.
MD commented that change was always threatening. She also suggested that there was a lot of mis-information around and part of her role as a Governor was to disperse those rumours. If both Council of Governors were to join, then that would make it look like a merger which would scare people.
DC queried whether there was any common ground at the moment. KWB replied that there were no service reviews completed as yet but he did believe that for the first service reviews, there was a degree of commonality. It was also important to remember that this was being done for patients and not ourselves.
The Chairman commented that six years ago, three organisations had tried to do this and could not agree. There was, however, a new Chair at South Tyneside who did agree and therefore we were moving forward. The regulator was wanting a joint executive team and they had the power to remove the full Board or the Chairs and the regulator had articulated their desire very clearly. At the end of June we were required to have a joint executive proposal.
KWB stated that the regulator would not have the confidence of delivery if this was not backed up with a single management team.
The Chairman stated that he would continue to press on the role of Governors.

Resolved: To note the memorandum of understanding, the signing of which signals the formal start of the commitment to transform the way services are delivered in South Tyneside and Sunderland with the shared vision of the Group delivering nationally recognised high quality, safe, cost effective, sustainable healthcare.

Item 5 **South Tyneside and Sunderland Healthcare Group – Vision Aims and Values**

KWB presented the paper which set out a joint vision, values and aims for the Healthcare Group to support and reinforce the commitment of the alliance between CHS and South Tyneside NHS Foundation Trusts.
KWB explained that both organisations had well used and established visions which had been used to produce the joint vision, values and aims which were in line with the ethos of the two separate organisations whilst setting out the aspirations of the Group. KWB advised that in addition, the work of the Group would be branded "The Path to Excellence" which was also the mission statement of the group.
PaT commented that the recommendation contained within the paper had omitted the word 'Sunderland'.

Resolved: To note the Vision, Values and Aims of the South Tyneside and Sunderland Healthcare Group

Item 6 **South Tyneside and Sunderland Healthcare Group – Clinical Services Review Group – Terms of Reference**

PS presented the report which outlined the terms of reference for the Annual Service Review Group which had been formed to oversee the review of current service models and configuration and recommend where appropriate, future models to deliver safe, sustainable and high quality care. PS advised that the group was co-chaired by the Medical Director from South Tyneside NHSFT and himself as Director of Strategy and Business Development at CHS. The membership of the group was made up of individuals from both Trusts as well as Clinical Commissioning Groups in South Tyneside and Sunderland. PS highlighted Stroke Services as an example and stated that the two clinical leads from each organisation were involved and that Governors would be involved prior to any consultation once potential solutions had been identified. AM commented that the only reference to patients was in the middle of the appendix. PS replied that patients were at the core of everything and that a period of public consultation was built into the timelines. The stroke teams were presenting options the following day and had already spoken to the Stroke Association. The review team had also gathered a lot of patient feedback to date.
AM also commented that there were a lot of abbreviations within the document. PS replied that this was being used as an internal document. AM stated that all such documents are a matter of public record. PS acknowledged that the document should have identified names in full.
MD asked for clarity on an 'MG' doctor. PS replied that this represents a middle grade doctor.

JD commented that such reviews were essential for a merged approach. PS replied that Pharmacy had not initially been identified, however, the CQC whilst assessing South Tyneside had raised issues about Pharmacy and hence this was highlighted sooner on the work plan.
JD stated that because of those reasons, that it would be helpful with the public consultation as the first areas needed to have strong proposals.
PT queried as to the initials 'PG'. PS replied that this referred to Patrick Garner who had been appointed jointly between the two organisations as Programme Manager. PT also queried why diagnostics were identified twice. PS replied that we needed to look at the effect on phase 1 and phase 2.
PT also queried as to whether there were any impacts being identified from the early reviews. PS replied that stroke were presenting the next day and this would be checked and challenged after which any impact would become clearer.
PaT commented that there was undoubtedly a lot of work to be undertaken in each phase and queried whether there was capacity in the system to be able to do that. PaT also commented that PS had already stated that the timetable was a few weeks behind.
PS replied that it was a challenge but that we needed to put pace in the system. PaT queried who oversaw the output of the work. PS replied it was the group as identified in section 3, and then to the respective Executives and then to the Councils of Governors.
JD commented that there was no impact analysis of peripheral services, such as transport, access and social services identified within the document. PS advised that commissioners were involved and were also looking at the out of hospital model. JD commented that it was important to get it right at the first stage.
PT stated that when she was working at SEI, staff were able to access services from different Local Authorities on a daily basis.
KWB stated that the most significant impact was on NEAS.
PaT stated that it was a real opportunity to think differently of how to have those conversations and everyone would need to be more flexible. The Chairman stated that if Governors needed to be involved, then if necessary, an urgent meeting would be called. PaT also commented that if necessary, Governors could dial in to have that conversation dependent upon the urgency.

Resolved: To note the Terms of Reference for the Clinical Services Review Group.

Item 7 2015 NHS Staff Survey Results

JA presented the paper which summarised the Trusts results from the 2015 NHS staff survey and recommended proposed action.

JA advised that the response rate had been 31% compared to 39% in 2014 and against an NHS response rate of 41%.
SP commented that generally, the scores were improving but the uptake of staff completing the survey was going down and did we have any idea what others were doing to get a higher uptake. JA replied that CCG's were achieving 60% but the acute average was 48% and for specialist hospitals it was 80%. Quality Health who undertook the survey on our behalf were able to give an example of organisations that had done well and we will be able to contact them to try and gain an understanding of what they did differently. KWB commented that some organisations incentivise staff and pay them to do surveys or to have flu injections for example.
JA highlighted that one of the scores that had declined was the number on staff saying that their department regularly updates them of patient feedback (down from 73% to 60%) and on staff agreeing that patient feedback was used to make informed decisions (down from 65% to 55%). JA stated that we needed to look closely at how we informed staff of initiatives and particularly those hard to reach groups such as those that did not have easy access to email, workers off-site and in the community.
JA also highlighted the WRES indicators and the differences for those staff from BME groups which were generally poorer results than those from the white group. MD queried whether we had drilled down into particular staff groups or departments. JA replied that it was very difficult to do that as the survey was confidential and if the results were less than eleven, then it did not identify the area.
MD stated that she had been in the hospital twice this year and the command of the english language for some staff was problematic. JA replied that there was no requirement for EU staff but outside of the EU there was a requirement for staff to have an english language test. JA stated there had been a recent high profile case and the GMC had tightened up in its rules regarding english language competencies.
AM commented whether it was more about accent than perhaps language. AM also stated that perhaps as identified on page six, section 4, was the reporting of bullying more of a cultural perception as there were real differences.

Resolved: To accept the report.

Item 8 2016 Governor Elections

CH presented the paper which outlined process to date for the Governor Elections. CH replied that the final date for the delivery of nomination papers to the returning officer was 12 May 2016. All constituencies were contested other than the public constituency North East and therefore Danny Cassidy and Ruth Richardson were automatically re-elected. CH stated

that the ballot papers for the remaining constituencies would be issued on 1 June 2016 and the poll would close at 5.00pm on 22 June 2016.
The Chairman wished all Governors well in the forthcoming election.

Resolved: To accept the report and to note the automatic re-election of Danny Cassidy and Ruth Richardson to the Public Constituency North East.

JOHN N ANDERSON QA CBE
Chairman

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF STRATEGY AND SERVICE DEVELOPMENT

COUNCIL OF GOVERNORS

JULY 2016

PERFORMANCE REPORT

INTRODUCTION

Please find enclosed the Performance Report for May 2016 which updates Governors on performance against key national targets and local contractual indicators. The report for this year now includes the following additional indicators:

- Diagnostics – the percentage of patients waiting under 6 weeks for a diagnostic test
- Outpatient clinic letters – the percentage sent to GPs within 14 days of an outpatient attendance

EXECUTIVE SUMMARY

Performance – Monitor Governance Indicators

The Trust's position in relation to Monitor's governance indicators is as follows:

Referral to Treatment Time (RTT)

Performance against the incomplete pathway standard, (i.e. percentage of patients waiting under 18 weeks for consultant led treatment) remains comfortably above the 92% target at 95.6%.

The latest published national performance is for April which was below the 92% standard at 91.6%.

A&E 4 hour target – total time in the department

Performance for May was below the 95% target and the STF trajectory (95.87%) at 94.4% which is lower than May last year (-1.2%) with a 9% increase in attendances.

The national performance for April (latest published position) was 90% with a 0.6% decrease in attendances compared to the previous year. We remain in the upper middle 25% of Trusts.

Cancer Waiting Times
(2 week wait from GP referral to first appointment, 31 days from decision to treat to treatment and 62 days from referral to treatment)

Due to cancer reporting timescales being 1 month behind, the performance report includes April's confirmed position. The Trust met all cancer waiting time standards with the exception of cancer 62 days (from GP referral and the local standard for consultant upgrades) which was below standard. This was due to breaches in a number of tumour groups.

Health Care Associated Infections

There were 8 cases of hospital acquired *Clostridium Difficile* (C Diff) in May which is above the trajectory of 3 cases. A number of these are subject to appeal with the CCG.

RECOMMENDATIONS

Governors are asked to accept this report.

Alison King
Acting Director of Performance and Improvement

City Hospitals Sunderland chs

Performance Report
May 2016

City Hospitals Sunderland
Performance Report Overview

The Performance Report / Corporate Dashboard utilises a visual management approach to the Trust's monthly Performance, covering national performance measures from the NHS Standard Contract 2016/17 and 'Delivering the Forward View': NHS Planning Guidance 2016/17 to 2020/21, local contractual indicators as well as internal metrics.

Indicator Group	Group Description
National Operational Standards	National Operational Standards are taken from the 2016/17 NHS Standard Contract. They are national targets that the NHS must achieve, mostly falling under the domain of quality, which are linked to delivery of the NHS Constitution. These include A&E waiting times, waits for consultant led treatment and cancer waiting times. These national standards are used by NHS Improvement as part of the assessment of the Trust's governance.
National Quality Requirements	National Quality Requirements are part of the 2016/17 NHS Standard Contract, which include achievement of the Clostridium Difficile objective, ambulance handover delays and zero tolerance towards MRSA infection, patients waiting 52 weeks or more from referral to treatment and A&E 12-hour trolley waits.
Local Quality Requirements	Local Quality Requirements are agreed locally with commissioners and are included in the local schedules of the Trust's 2016/17 NHS Standard Contract. This includes the timeliness of electronic communications and eReferral indicators.
Internal Indicators	Internal indicators are metrics that do not form part of any of the above categories, but measure delivery of the corporate objectives.

City Hospitals Sunderland Performance Report Overview

This page explains the general layout of the indicator pages that form the bulk of the report

Key:

- Actual performance
- Target, operational standard, threshold or trajectory
- Sustainability & transformation fund (STF) trajectory
- Benchmark (National, Regional or Peer Group)
- Comparative performance for the previous year
- Performance achieving the relevant target
- Performance not achieving the relevant target

Page title representing a key performance indicator or a

Indicator group

Indicator information, including a brief description, the name of the Director lead and consequence of failure

Narrative highlighting recent performance and corrective actions, where applicable

Chart or table relevant to the indicator(s), often displaying Directorate level performance or other supporting information

Cancer 2 Week Waits

National Operational Standards

1. Number of urgent GP referrals for suspected cancer
2. Number of patients seen after more than two weeks following an urgent GP referral for suspected cancer
3. % patients seen within two weeks of an urgent GP referral for suspected cancer

Director Lead: Sean Fenwick

Consequence of failure: Timely access to treatment, patient experience, clinical outcomes & financial sanction

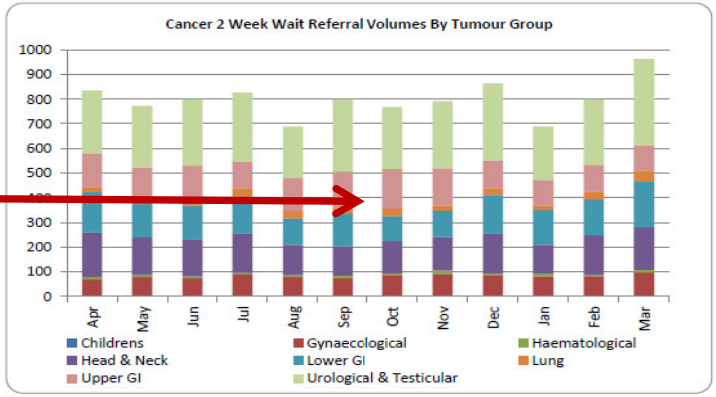
Potential financial sanction if standard not achieved = £200 per breach

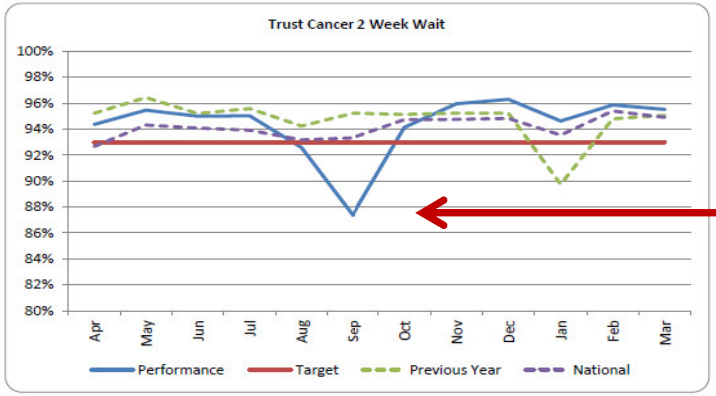
2WW performance has remained stable in March at 95.5%, which continues to perform above target. At tumour site level, all areas achieved the target this month.
March's performance demonstrated that all tumour groups are performing about the same or better than the equivalent national benchmarking position.
The finalised position for quarter 4 was above target at 95.4%.
Referral volumes were higher than usual in March, with significantly more referrals compared to average within Lung, Lower GI and Urological tumour groups.
Indicative 2WW performance for April is slightly below target.

Referrals for Suspected Cancer - March 2016*	Volume	Total Breached	Performance	National Benchmark	YTD
Target			93%	93%	93%
Acute Leukaemia	0	0	-	-	100.00%
Children's Cancer	1	0	100.00%	95.7%	100.00%
Gynaecological	97	1	98.97%	95.1%	97.78%
Haematological (Excluding Acute Leukaemia)	10	0	100.00%	96.6%	99.06%
Head & Neck	173	10	94.22%	95.0%	96.25%
Lower Gastrointestinal	185	11	94.05%	94.3%	93.46%
Lung	44	2	95.45%	95.9%	95.56%
Testicular	15	0	100.00%	96.3%	97.90%
Upper Gastrointestinal	103	7	93.20%	92.4%	86.79%
Urological (Excluding Testicular)	334	12	96.41%	95.0%	96.07%
Total	962	43	95.53%	94.9%	94.40%

*Please note that reporting of official cancer waiting times fall 1 month behind normal reporting timescales

Table showing current performance compared to target (where relevant)





Trend chart displaying the performance over the past 12 months or year to date

Performance Scorecard

Indicator	Director Lead	Target	2015/16	2016/17					12-month trend	Page
			Actual	Month[1,2]	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD	
National Operational Standards										
RTT - % incompletes waiting <18 wks	Sean Fenwick	≥92%	93.82%	95.62%	95.70%				95.70%	5
% Diagnostic tests ≥6 wks	Sean Fenwick	<1%	0.80%	0.82%	1.10%				1.10%	6
A&E - % seen in 4hrs	Sean Fenwick	≥95%	93.57%	94.38%	93.86%				93.86%	7
Cancer waits - % 2ww	Sean Fenwick	≥93%	94.41%	93.26%	93.26%				93.26%	9
Cancer waits - % 31 days	Sean Fenwick	≥96%	98.48%	97.87%	97.87%				97.87%	10
Cancer waits - % 31 days for subsequent treatment - surgery	Sean Fenwick	≥94%	99.47%	100.00%	100.00%				100.00%	10
Cancer waits - % 31 days for subsequent treatment - drugs	Sean Fenwick	≥98%	99.88%	100.00%	100.00%				100.00%	10
Cancer waits - % 62 days	Sean Fenwick	≥85%	83.10%	77.16%	77.16%				77.16%	11
Cancer waits - % 62 days from screening programme	Sean Fenwick	≥90%	82.61%	100.00%	100.00%				100.00%	11
Cancer waits - % 62 days from consultant upgrade	Sean Fenwick	≥85%	81.40%	81.25%	81.25%				81.25%	11
Cancelled operations 28 day breaches	Sean Fenwick	0	13	1	3				3	N/A
National Quality Requirements										
Clostridium difficile cases	Ian Martin	9[3]	30	8	9				9	12
RTT - No. incompletes waiting 52+ weeks	Sean Fenwick	0	2	0	0				0	N/A
A&E / ambulance handovers - no. 30-60 minutes	Sean Fenwick	0	405	25	105				105	7
A&E / ambulance handovers - no. >60 minutes	Sean Fenwick	0	102	1	9				9	7
Duty of Candour	Melanie Johnson	N/A	138	10	32				32	N/A
Local Quality Requirements										
eReferral (C&B) - % slot issues	Sean Fenwick	≤4%[4]	7.38%	7.63%						N/A
eReferral (C&B) - % utilisation	Sean Fenwick	≥85%	88.94%	87.96%						N/A
A&E left without being seen	Sean Fenwick	≤5%	1.94%	1.55%	1.76%				1.76%	7/8
A&E time to initial assessment (median)	Sean Fenwick	≤9min	0:08 (h:mm)	0:08 (h:mm)	0:09 (h:mm)				0:09 (h:mm)	7
A&E time to treatment (median)	Sean Fenwick	≤60mins	0:52 (h:mm)	0:51 (h:mm)	0:51 (h:mm)				0:51 (h:mm)	7/8
% Discharge comms issued <24 Hours	Ian Martin	≥95%	82.02%	85.88%	84.45%				84.45%	13
% Outpatient attendance letters issued <14 days	Ian Martin	≥95%	82.44%	94.01%	93.59%				93.59%	14
% A&E attendance letters issued <24 hours	Ian Martin	≥95%	92.87%	92.67%	93.14%				93.14%	15
A&E / Ambulances diverts & deflections from the Trust	Sean Fenwick	N/A	65	4	4				4	N/A
A&E / Ambulances diverts & deflections to the Trust	Sean Fenwick	N/A	126	9	9				9	N/A
Maternity - smoking at the time of delivery	Melanie Johnson	≤18%	18.41%	15.52%	16.35%				16.35%	N/A
Maternity - breastfeeding initiation	Melanie Johnson	≥58%	54.23%	54.35%	54.32%				54.32%	N/A
Cancer - % diagnosed at an early stage (stages 1 or 2)	Sean Fenwick	≥60%	46.44%	52.81%	52.81%				52.81%	N/A

[1]Monthly performance is one month behind normal reporting for all Cancer indicators, and Ambulance diverts & deflection indicators (April 2016)

[2]Monthly performance is two months behind normal reporting for all eReferral indicators (March 2016)

[3]Cumulative target for *C. diff* as at quarter 1

[4]eReferral slot issue performance is rated as amber between 4% & 6%

Referral to Treatment (RTT)

National Operational Standards

1. Number of patients waiting on an incomplete RTT pathway at month end
2. Number of patients on an incomplete RTT pathway waiting 18 weeks or more
3. Percentage of patients waiting less than 18 weeks on incomplete pathways
4. National RTT Stress Test - % risk of failing the incomplete standard in next 6 months

Director Lead: Sean Fenwick

Consequence of failure: Patient experience, quality, access, reputation & financial sanction

Potential financial sanction if STF not achieved = £300 per breach

The finalised aggregate level performance for incomplete pathways at the end of May was above target at 95.6%.

At specialty level Thoracic Medicine and Oral & Maxillo Facial Surgery failed to achieve the 92% target.

Oral & Maxillo Facial Surgery were working towards their plan to achieve the target at the end of May, however, higher than expected referrals in the last 3 months including cancer has led to lower than anticipated performance. Their recovery plan is being reviewed.

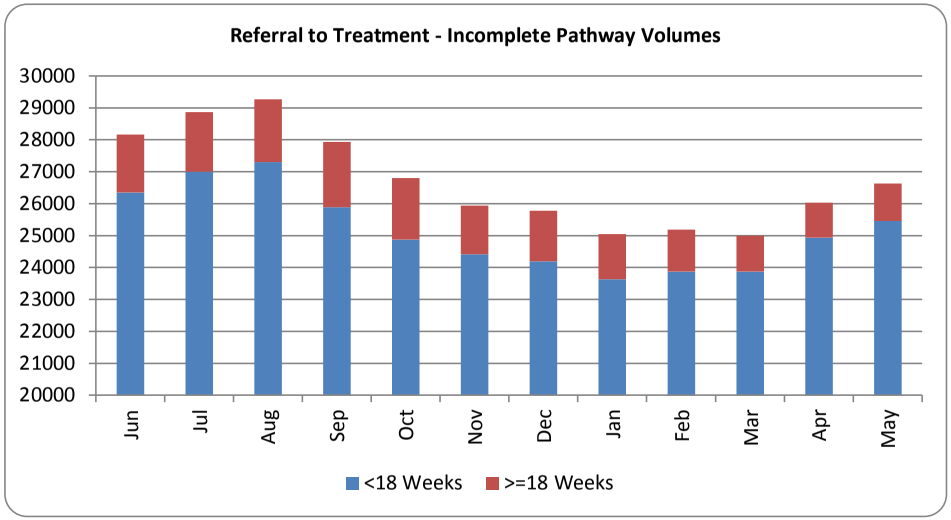
Thoracic Medicine's performance continues to be discussed as part of regular escalation meetings. The specialty are experiencing ongoing increased demand and capacity issues. Plans continue to be discussed with the commissioners.

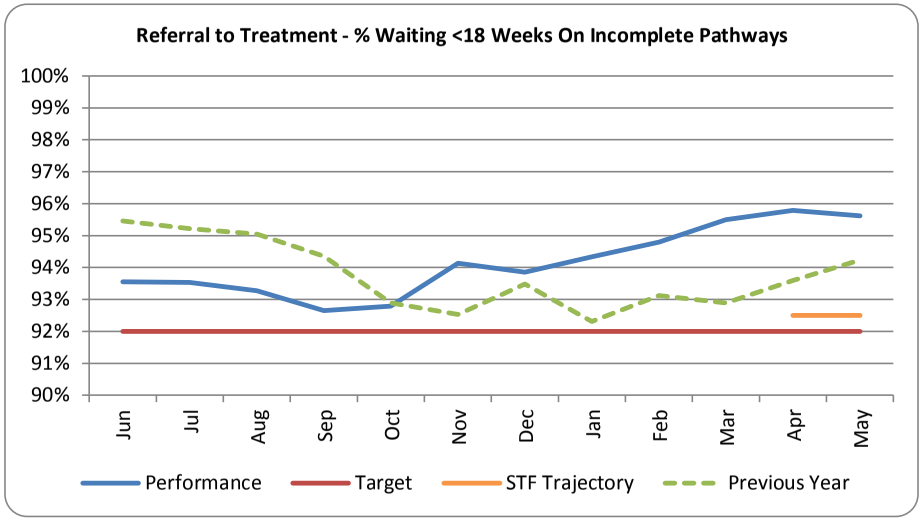
The Trust is performing very well in relation to the RTT stress test, with only a 7% chance of failing the RTT operational standard in the next 6 months, which ranked 19th (best) nationally.

RTT Incompletes - May 2016	Volume	No. ≥18 Weeks	% <18 Weeks*
Target			**≥92%**
Cardiology	720	6	99.17%
Ear, Nose & Throat	3,013	92	96.95%
Gastroenterology	277	0	100.00%
General Surgery	2,061	119	94.23%
Geriatric Medicine	442	6	98.64%
Gynaecology	1,047	27	97.42%
Neurology	921	24	97.39%
Neurosurgery	7	0	-
Ophthalmology	4,309	23	99.47%
Oral & Maxillo Facial Surgery	2,170	220	89.86%
Rheumatology	613	16	97.39%
Thoracic Medicine	873	129	85.22%
Trauma & Orthopaedics	2,902	222	92.35%
Urology	3,091	221	92.85%
Other	4,170	62	98.51%
Trust Total	**26,623**	**1,167**	**95.62%**

**De minimis* level >= 20 pathways in total

RTT Stress Test	Feb-16	Mar-16	Apr-16
% Risk of failure in next 6 months	10.00%	5.39%	7.23%
National rank (1st is best)	26/154	16/154	19/154





Diagnostics

National Operational Standards

1. Number of patients on the diagnostic waiting list at month end
2. Number of patients on the diagnostic waiting list at month end waiting 6 weeks or more
3. % patients waiting 6 weeks or more for a diagnostic test at month end
4. Number of diagnostic tests/procedures carried out in month

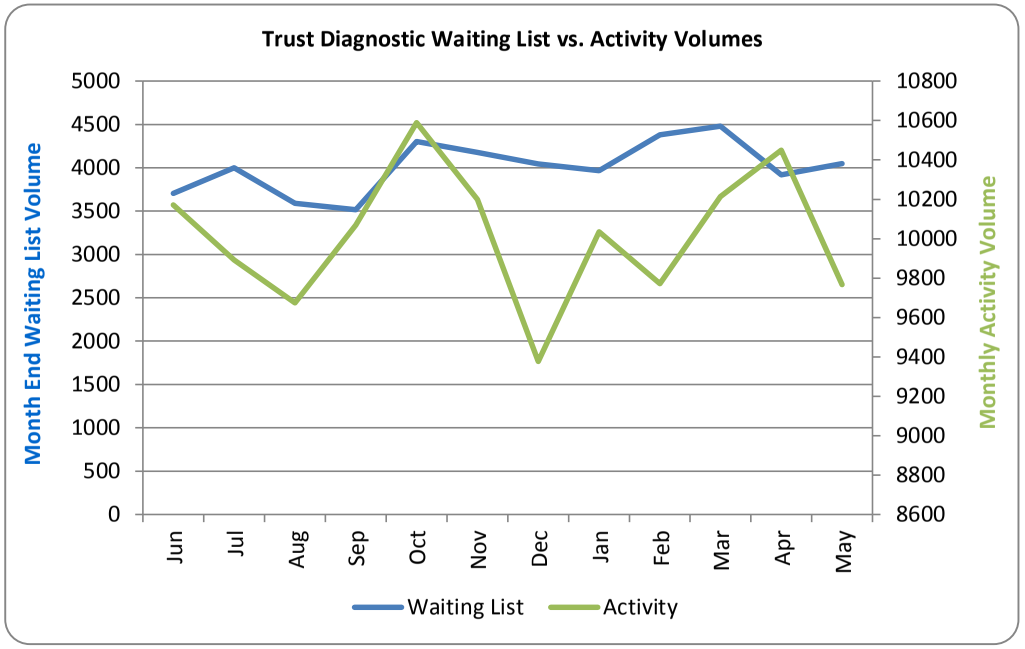
Director Lead: Sean Fenwick

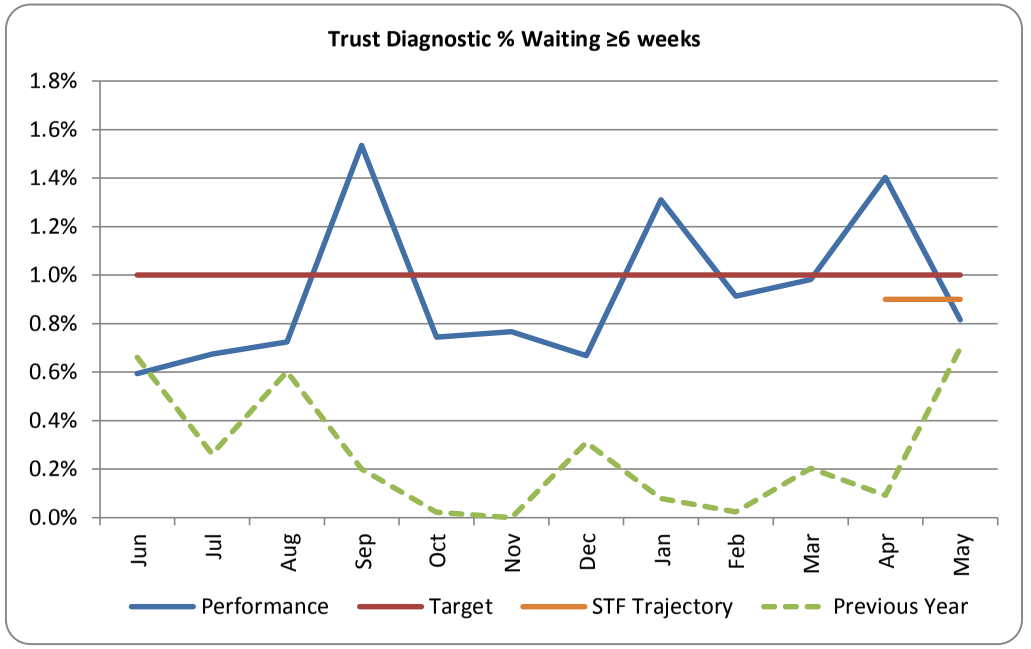
Consequence of failure: Patient experience, quality, access, reputation & financial sanction

Potential financial sanction if STF not achieved = £200 per breach

The proportion of patient waiting 6 weeks or over at month end in May has decreased to 0.8%, which achieves the national operating standard of less than 1% and the Trust's STF trajectory of 0.9%. Cystoscopy and Urodynamics tests failed to acheve the standard this month, with the vast majority of breaches being attributable to Cystoscopy tests in particular. This is a result of ongoing capacity issues within Urology, mainly at offsite locations. The Directorate has increased capacity in order to address the backlog and deliver a sustainable position, the additional capacity in May has had a positive impact in breach numbers.

Diagnostics - May 2016		WL Volume	No. ≥6 weeks	%≥6 weeks	Activity
Target				≤1%	
Imaging	Magnetic Resonance Imaging	420	0	0.00%	1,248
	Computed Tomography	407	0	0.00%	2,539
	Non-obstetric ultrasound	1,189	0	0.00%	2,786
	Barium Enema	0	0	-	2
	DEXA Scan	107	0	0.00%	199
Physiological Measurement	Audiology - assessments	213	1	0.47%	1,128
	Cardiology - echocardiography	721	0	0.00%	797
	Neurophysiology - peripheral	130	0	0.00%	102
	Respiratory physiology - sleep studies	66	0	0.00%	105
	Urodynamics - pressures & flows	255	4	1.57%	25
Endoscopy	Colonoscopy	46	0	0.00%	181
	Flexi sigmoidoscopy	38	0	0.00%	74
	Cystoscopy	392	28	7.14%	279
	Gastroscopy	63	0	0.00%	302
Trust Total		**4,047**	**33**	0.82%	**9,767**





Accident & Emergency

National Operational Standards, Quality Requirements, Local Contractual & Internal Indicators

1. % patients who spent 4 hours or less from arrival to admission, transfer or discharge
2. Ambulance handover delays between 15-30 minutes, 30-60 minutes & over 60 minutes
3. Time (95th percentile) from arrival (by emergency ambulance) to full initial assessment
4. Time (median) from arrival to treatment
5. % unplanned re-attendances within 7 days of discharge from A&E
6. % patients who leave the department without being seen

Director Lead: Sean Fenwick

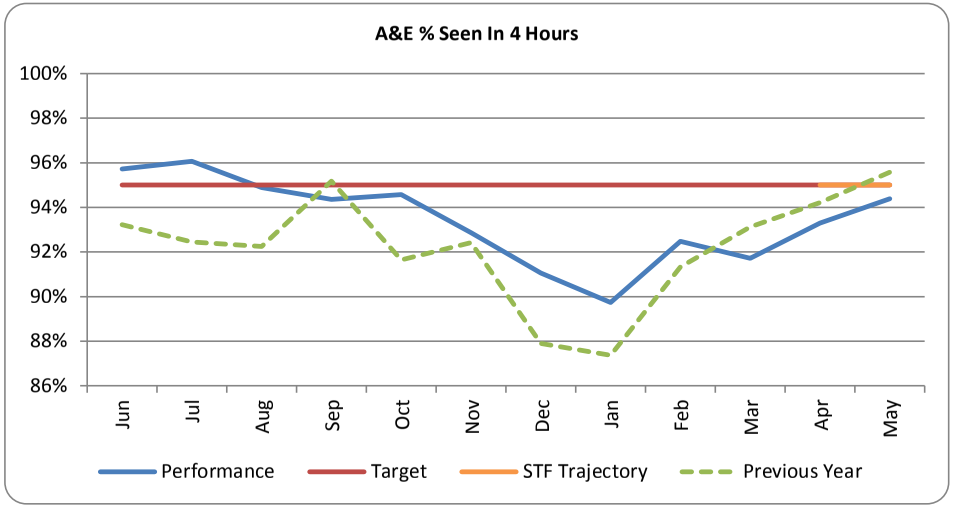
Consequence of failure: Patient experience, quality, access, reputation & financial sanction

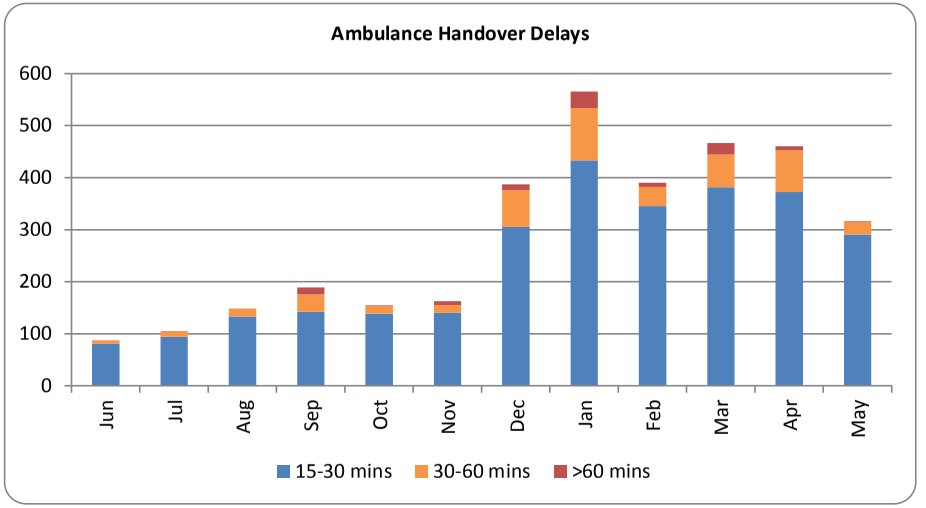
Potential financial sanction if STF not achieved = £120 per 4-hour breach (capped at 85%), £200 and £1,000 per 30-60 and >60 minute ambulance handover delay, respectively

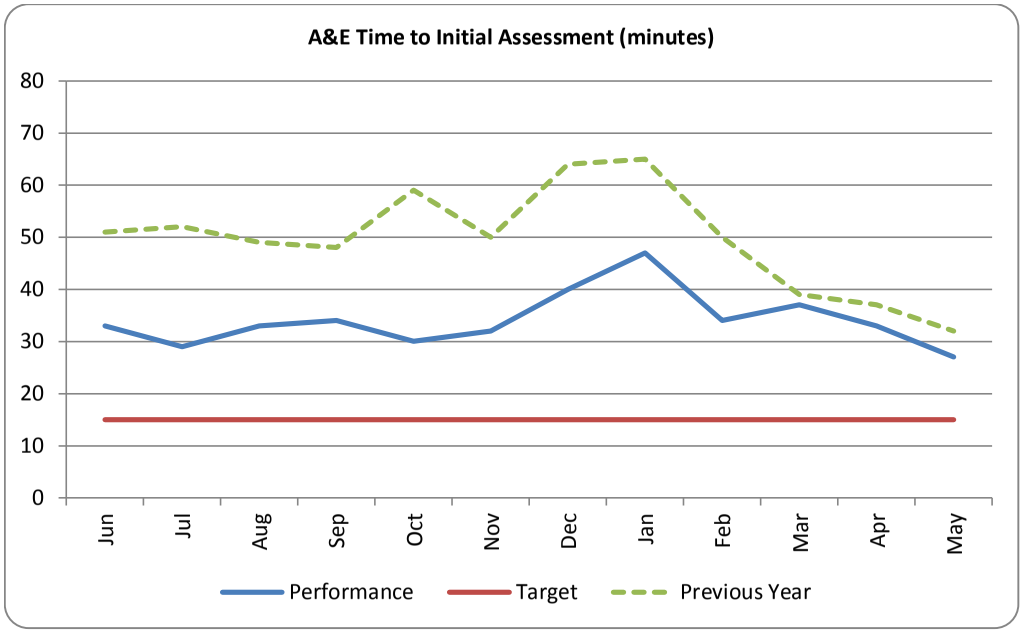
The total proportion of patients seen in A&E within 4 hours has improved during May to 94.4%, however this is slightly below the operating standard and STF trajectory. If the STF trajectory is not met in quarter 1, May's performance will contribute £9,480 (£33,360 quarter to date) towards contractual sanctions. There were 12,688 attendances in total this month, which is 9% higher than May 2015 (type 1 & 2 are about the same, but type 3 is up by 37%). National performance was below target during April 2016 at 90.0% overall and 85.0% for type 1; both are better than previous month.

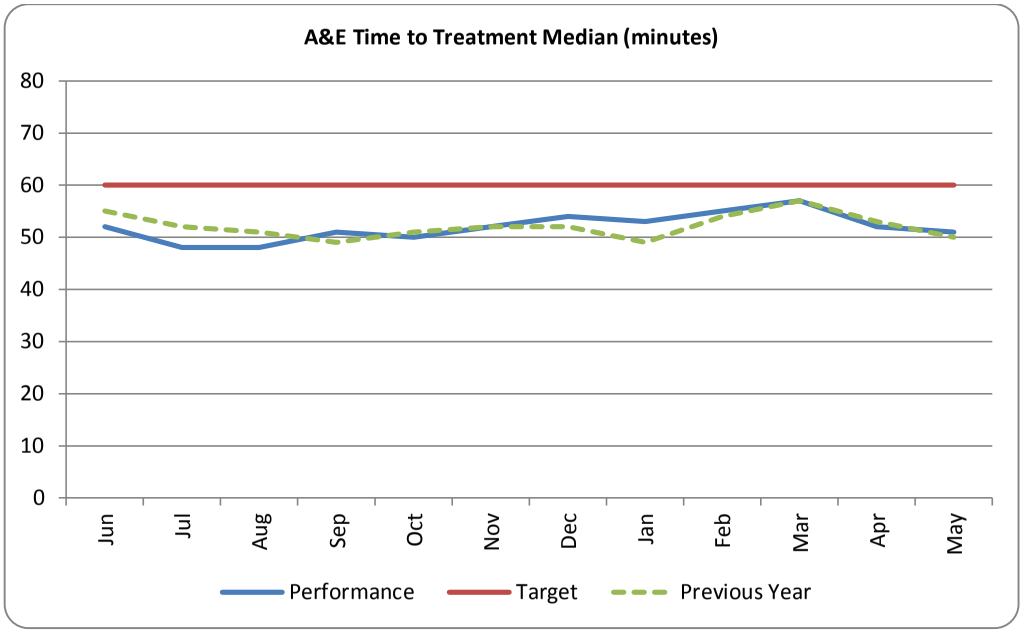
There were 2,598 ambulance arrivals this month, which is 9% lower than April 2015. This continues to represent the third highest volume of ambulance arrivals for any hospital across the North East. There were more 30-60 minute handover delays compared to May 2015 and about the same number of delays lasting 60 minutes or more.If the STF target of improving from quarter 1 15-16 is not achieved then May's performance will contribute £6,00 (£30,000 quarter to date) towards contractual sanctions. This is still to be confirmed. The time to initial assessment is the lowest in the last 12 months at 27 minutes.

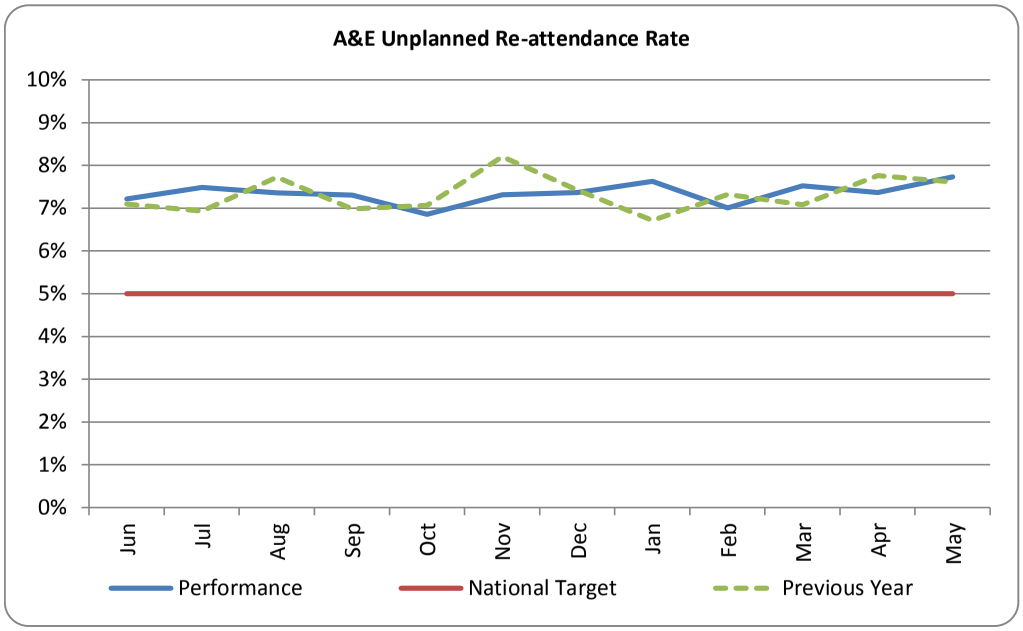
A&E Indicators - May 2016	Target	Month	YTD
A&E % seen in 4hrs - Trust Total	≥95%	94.38%	93.86%
A&E < 4 hrs - Type 1	≥95%	90.85%	89.93%
A&E < 4 hrs - Type 1 - High Acuity	≥95%	80.59%	78.99%
A&E < 4 hrs - Type 1 - Low Acuity	≥95%	90.31%	89.54%
A&E < 4 hrs - Type 1 - Paediatrics	≥95%	98.27%	98.05%
A&E < 4 hrs - Type 2 - SEI	≥95%	99.62%	99.63%
A&E < 4 hrs - Type 3 - Pallion walk in centre	≥95%	99.81%	99.77%
A&E Attendances - Trust Total		12,688	24,388
A&E Attendances - Type 1		7,643	14,576
A&E / ambulance handovers - no. 15-30 minutes	0	290	662
A&E / ambulance handovers - no. 30-60 minutes	0	25	105
A&E / ambulance handovers - no. >60 minutes	0	1	9
A&E time to initial assessment (median)	≤9 mins	0:08 (h:m)	0:09 (h:m)
A&E time to initial assessment (95th percentile)	≤15 mins	0:27 (h:m)	0:31 (h:m)
A&E time to treatment (median)	≤60 mins	0:51 (h:m)	0:51 (h:m)
A&E unplanned reattendance rate	≤5%	7.73%	7.56%
A&E left without being seen	≤5%	1.55%	1.76%






A&E Time to Initial Assessment (minutes)
80
70
60
50
40
30
20
10
0
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Performance
Target
Previous Year


A&E Time to Treatment Median (minutes)
80
70
60
50
40
30
20
10
0
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Performance
Target
Previous Year


A&E Unplanned Re-attendance Rate
10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Performance
National Target
Previous Year


A&E Left Without Being Seen Rate
10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Performance
Target
Previous Year

Cancer 2 Week Waits

National Operational Standards

1. Number of urgent GP referrals for suspected cancer
2. Number of patients seen after more than two weeks following an urgent GP referral for suspected cancer
3. % patients seen within two weeks of an urgent GP referral for suspected cancer

Director Lead: Sean Fenwick

Consequence of failure: Timely access to treatment, patient experience, clinical outcomes & financial sanction

Potential financial sanction if standard not achieved = £200 per breach

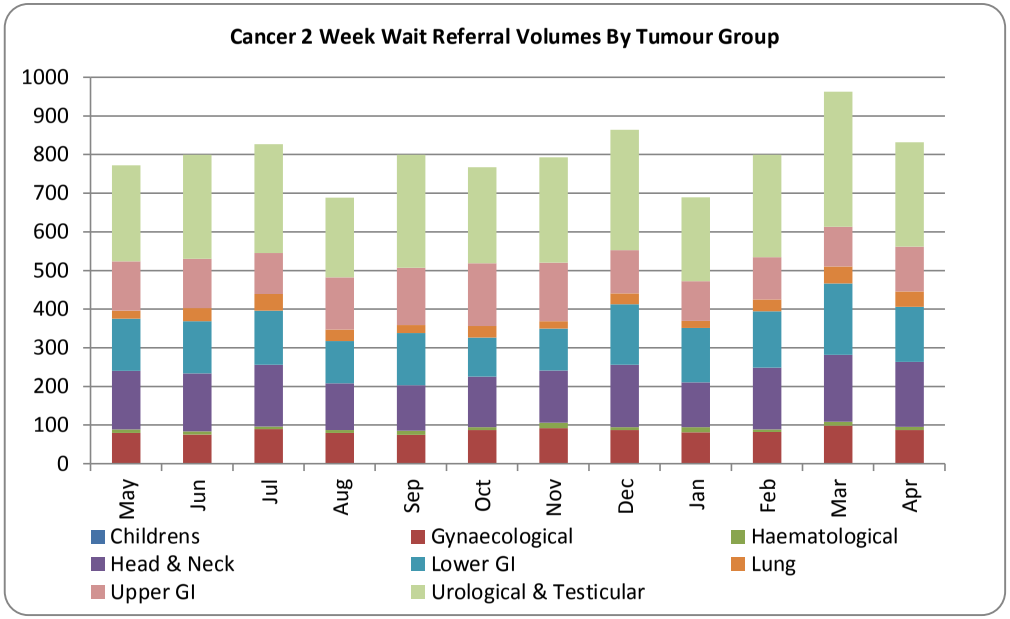
2WW performance has dropped in April to 93.3%, which continues to perform above target. At tumour site level, all areas achieved the target except for Head & Neck and Upper GI. Upper GI had 18 breaches; the majority of which were patient choice. Head & Neck had 12 breaches; all patient choice. April's performance demonstrated that, with the exception of the 2 areas, we are performing marginally better than the equivalent national benchmarking position.

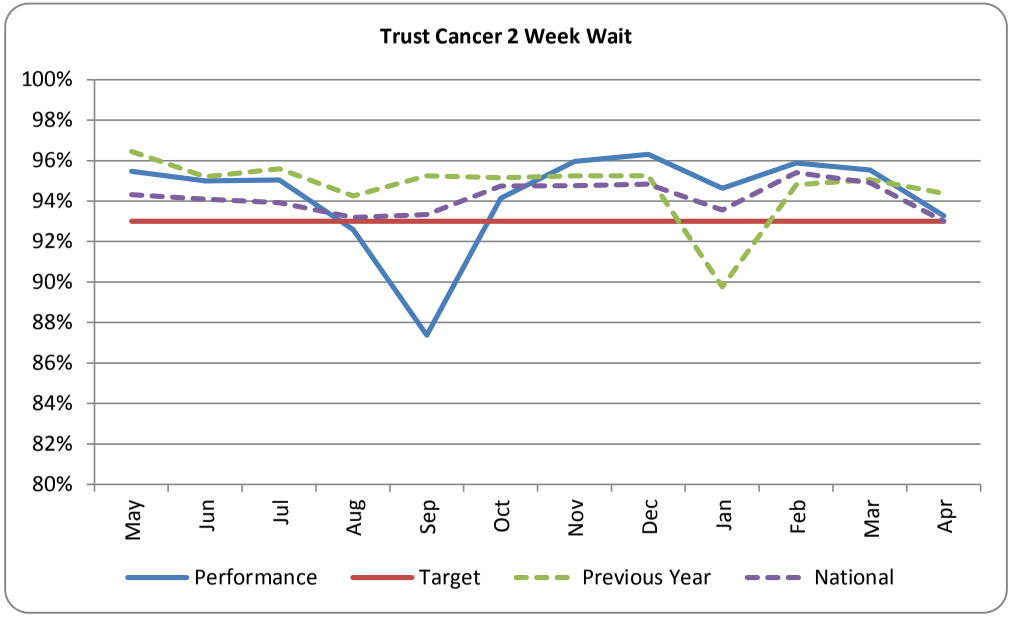
Referral volumes were higher than usual in April, with significantly more referrals compared to the average over the last 12 months within Lung and Head & Neck tumour groups.

Indicative 2WW performance for May is above target.

Referrals for Suspected Cancer - April 2016*	Volume	Total Breached	Performance	National Benchmark	YTD
Target			**93%**	**93%**	**93%**
Acute Leukaemia	0	0	-	-	-
Children's Cancer	0	0	-	95.2%	-
Gynaecological	87	2	97.70%	93.8%	97.70%
Haematological (Excluding Acute Leukaemia)	8	0	100.00%	95.7%	100.00%
Head & Neck	168	12	92.86%	93.4%	92.86%
Lower Gastrointestinal	143	7	95.10%	90.9%	95.10%
Lung	39	1	97.44%	94.5%	97.44%
Testicular	11	0	100.00%	94.5%	100.00%
Upper Gastrointestinal	116	18	84.48%	91.1%	84.48%
Urological (Excluding Testicular)	259	16	93.82%	92.0%	93.82%
Total	**831**	**56**	**93.26%**	**93.0%**	**93.26%**

*Please note that reporting of official cancer waiting times fall 1 month behind normal reporting timescales





Cancer 31 Day Waits

National Operational Standards

1. Number of patients receiving first definitive treatment following a cancer diagnosis
2. Number of receiving first definitive treatment more than one month of a decision to treat following a cancer diagnosis
3. % patients receiving first definitive treatment within one month of a decision to treat following a cancer diagnosis
4. % patients receiving subsequent surgery or drug treatments for cancer within 31 days

Director Lead: Sean Fenwick

Consequence of failure: Timely access to treatment, patient experience, clinical outcomes & financial sanction

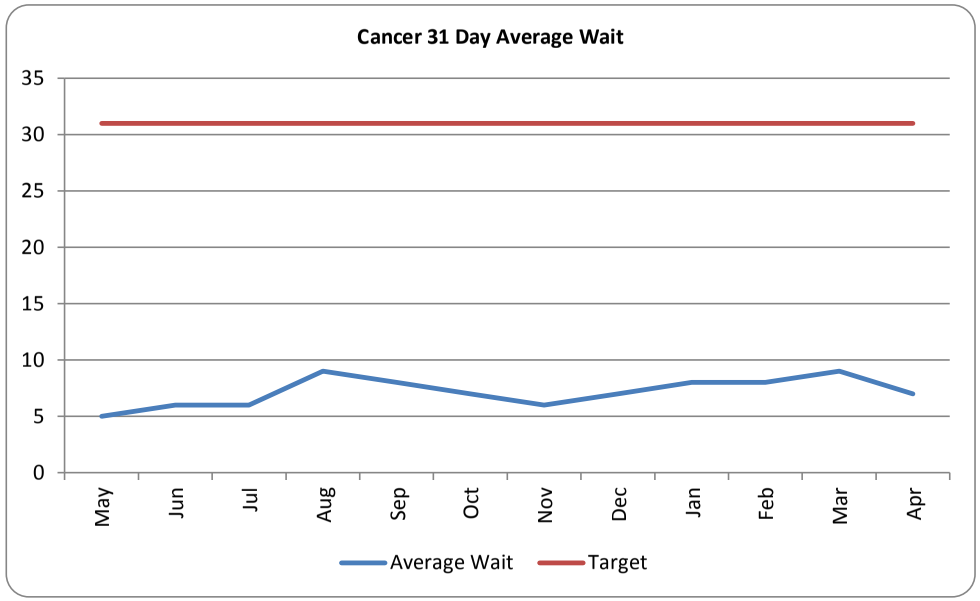
Potential financial sanction if standard not achieved = £1,000 per breach

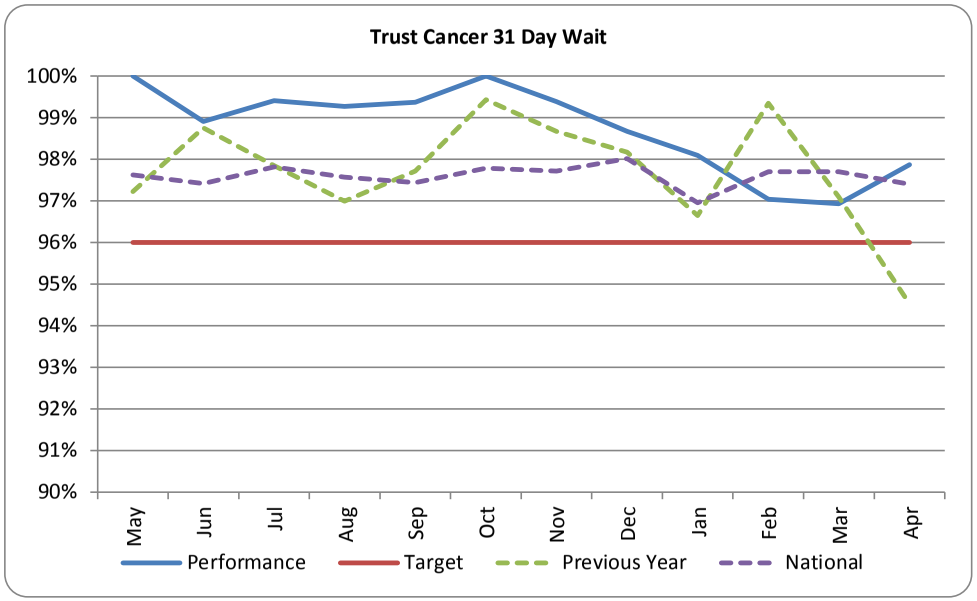
There were three 31 day breaches in total during April. Aggregate level performance was above target at 97.9% and represents the first increase in performance in six months. All tumour groups were above target with the exception of Head& Neck. Aside from Head & Neck, performance was better than the equivalent national average at Tumour site level during April. Average waits for treatment following a decision to treat reduced this month. Indicative performance for May is currently above target. The final performance for subsequent surgical and drug treatments were both above target during April at 100%.

First Definitive Treatment - April 2016*	Volume	Total Breached	Performance	National Benchmark	YTD
Target			96%	96%	96%
Breast	1	0	100.00%	98.3%	100.00%
Gynaecological	1	0	100.00%	97.6%	100.00%
Haematological	12	0	100.00%	99.7%	100.00%
Head & Neck	6	1	83.33%	94.9%	83.33%
Lower Gastrointestinal	14	0	100.00%	97.3%	100.00%
Lung	21	0	100.00%	98.1%	100.00%
Other	2	0	100.00%	99.1%	100.00%
Sarcoma	0	0	-	97.2%	-
Skin	5	0	100.00%	97.8%	100.00%
Upper Gastrointestinal	7	0	100.00%	98.0%	100.00%
Urological	72	2	97.22%	94.9%	97.22%
Total	**141**	**3**	**97.87%**	**97.4%**	**97.87%**

Subsequent Treatments					
Surgery (Target: 94%)	32	0	100.00%	94.6%	100.00%
Drug (Target: 98%)	77	0	100.00%	99.2%	100.00%

*Please note that reporting of official cancer waiting times fall 1 month behind normal reporting timescales





Cancer 62 Day Waits

National Operational Standards

1. Number of patients receiving first definitive treatment for cancer following an urgent GP referral for suspected cancer / NHS Screening Service referral / consultant upgrade
2. Number of patients receiving first definitive treatment for cancer 62 days or more following an urgent GP referral for suspected cancer / NHS Screening Service referral / consultant upgrade
3. % patients receiving first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer / NHS Screening Service referral / consultant upgrade
4. Number of patients receiving first definitive treatment for cancer 104 days or more following an urgent GP referral for suspected cancer / NHS Screening Service referral / consultant upgrade

Director Lead: Sean Fenwick

Consequence of failure: Timely access to treatment, patient experience, clinical outcomes & financial sanction

Potential financial sanction if STF not achieved = £1,000 per breach

The finalised 62 day performance for April was in line with predictions at 77.2%, which was below both the national operational standard and national average. The majority of tumour groups failed to achieve the target this month. There were 18.5 breaches in total, which were due to: complex diagnosis (9), medical reasons (4), capacity (2), late referral (1.5), patient assessment (1) and patient choice (1).

Nationally, most tumour groups continue to perform below target. Trust performance at tumour group level compared to the respective national average is variable, but most groups are subject to low volumes. Urology is the only area with sufficiently high volumes to make a comparison; their performance was in line with the national average during April.

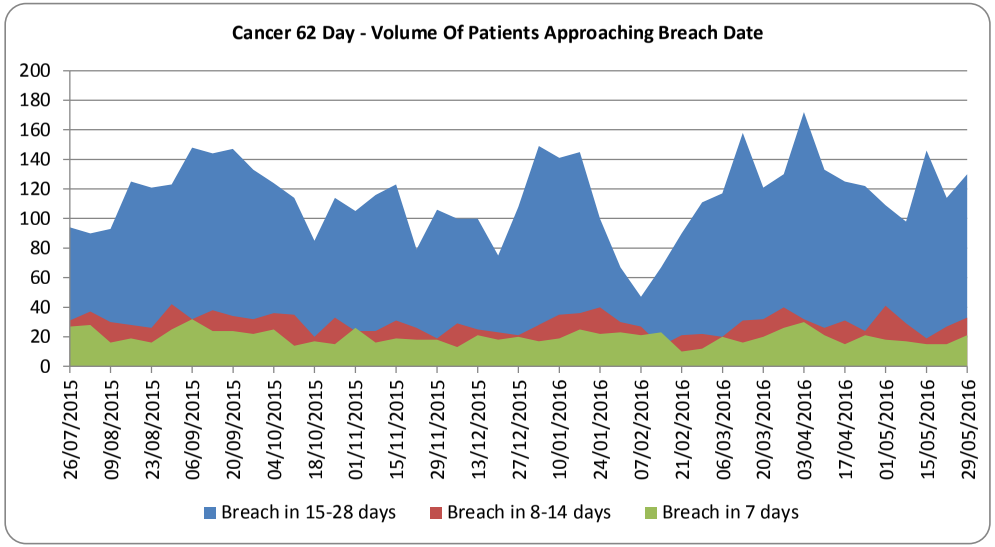
At the end of April, there were 4 patients treated who had waited 104 days or longer, these were as a result of: complex diagnosis (3) and medical reasons. These cases are all subject to a full RCA.

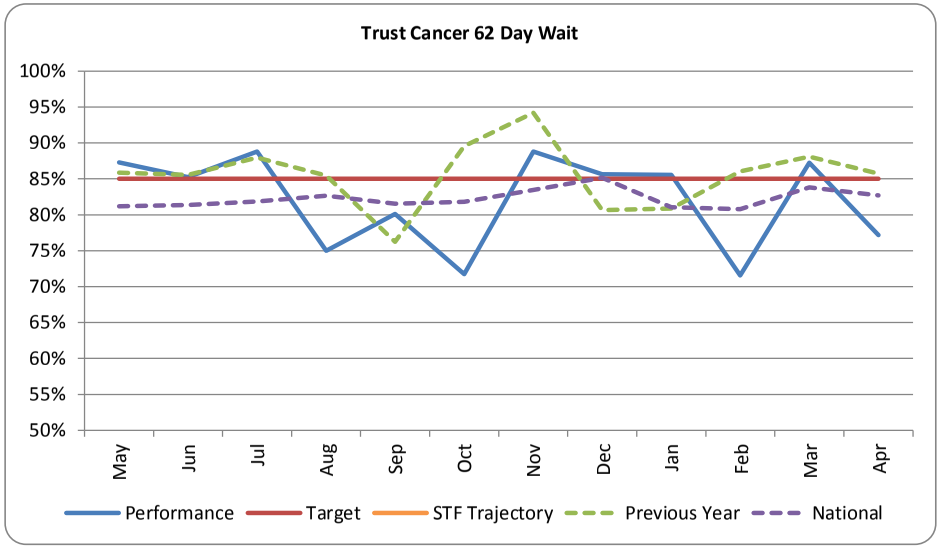
Indicative performance for May is currently below both the national target and the Trust's STF trajectory. Achievement of quarter 1 remains a risk.

Screening and consultant upgrade performance were 100% and 81.3% respectively in April and are subject to low volumes.

GP referrals - April 2016*	Volume	Total Breached	Performance	National Benchmark	YTD	Number ≥104 days
Target			**85%**	**85%**	**85%**	**0**
Breast	0.0	0.0	-	94.8%	-	0
Gynaecological	3.5	0.5	85.71%	77.5%	85.71%	1
Haematological (Excluding Acute Leukaemia)	5.5	2.5	54.55%	79.7%	54.55%	0
Head & Neck	5.5	1.0	81.82%	65.5%	81.82%	0
Lower Gastrointestinal	7.5	2.0	73.33%	71.2%	73.33%	0
Lung	3.0	1.5	50.00%	74.5%	50.00%	0
Other	2.5	0.5	80.00%	78.4%	80.00%	0
Sarcoma	0.5	0.0	100.00%	64.6%	100.00%	0
Skin	5.0	0.0	100.00%	96.4%	100.00%	0
Upper Gastrointestinal	6.0	1.5	75.00%	74.1%	75.00%	0
Urological (Excluding Testicular)	42.0	9.0	78.57%	78.7%	78.57%	3
Total	**81.0**	**18.5**	**77.16%**	**82.7%**	**77.16%**	**4**
Non GP Referrals						
Screening (Target: 90%)	0.5	0.0	100.00%	90.9%	100.00%	0
Consultant Upgrade (Target: 85%)	8.0	1.5	81.25%	89.7%	81.25%	0

*Please note that reporting of official cancer waiting times fall 1 month behind normal reporting timescales





Health Care Associated Infection

National Quality Requirements

1. Number of Trust apportioned Clostridium Difficile cases before & after appeal (Target ≤34, set by NHS England)
2. Trust apportioned Clostridium Difficile rate per 100,000 bed days (Target ≤15.4, set by NHS England)

Director Lead: Ian Martin

Consequence of failure: Patient safety, patient experience, financial sanction & patient flow / LOS

There were 8 hospital acquired *C. diff* infections during May, of which 4 are subject to appeal, against a trajectory of 3 cases or fewer. Should the appeals be successful the performance for Q1 to date would be 5 which is below the trajectory for this period.

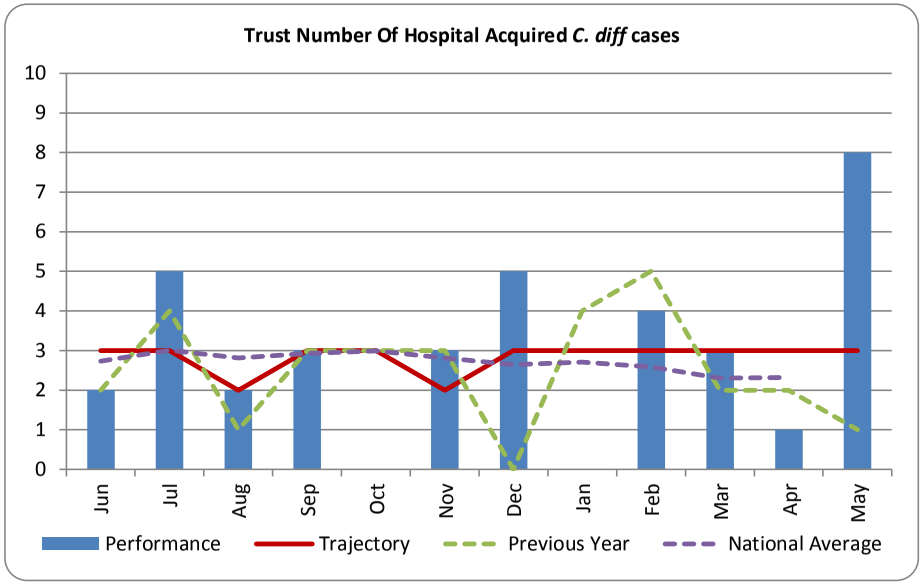
The objective for 2016/17 is set for the Trust by NHS England and it remains the same as 2015/16 at 34 cases or less.

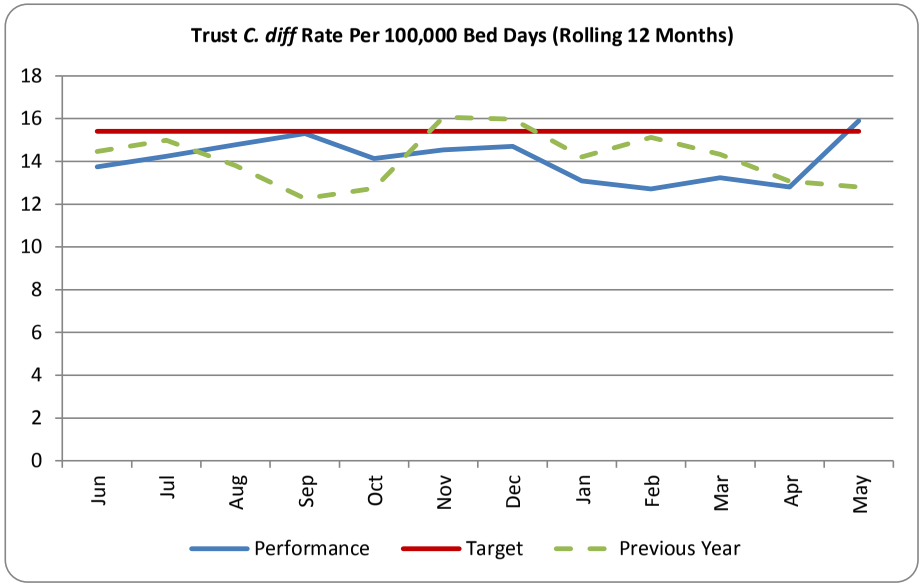
The *C. diff* rate per 100,000 bed days for the previous 12 months up to May 2016 is slightly above the equivalent target, at 15.9 (based on 8 cases). By comparison the national rate for the latest 12 month period available (April 2015 to March 2016) was 13.9 per 100,000 bed days.

C. diff - May 2016	Trajectory	Total Cases	Appeals*	Residual Cases
Apr	3	1	0	1
May	3	8	4	4
Jun	3			
Qtr 1	**9**	**9**	**4**	**5**
Jul	3			
Aug	2			
Sep	3			
Qtr 2	**8**		**0**	
Oct	3			
Nov	2			
Dec	3			
Qtr 3	**8**		**0**	
Jan	3			
Feb	3			
Mar	3			
Qtr 4	**9**		**0**	
Total	**34**	**9**	**4**	**5**

*confirmed / pending

C. diff Bed Rate - May 2016	Target 15/16	Rolling 12 Months
C. diff rate per 100,000 bed days	15.4	15.90





Discharge Communications

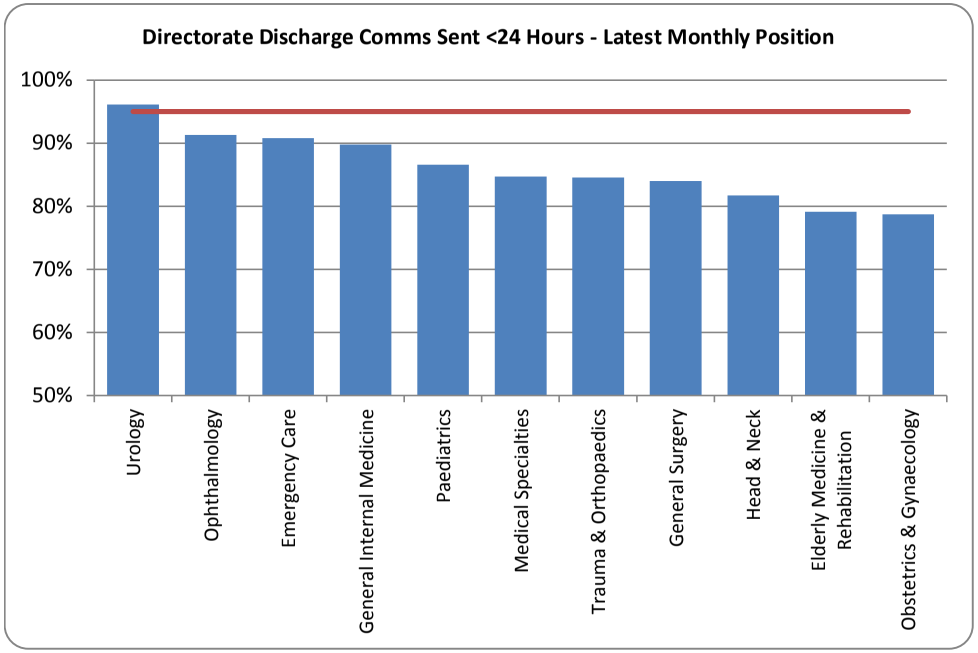
Local Quality Requirements

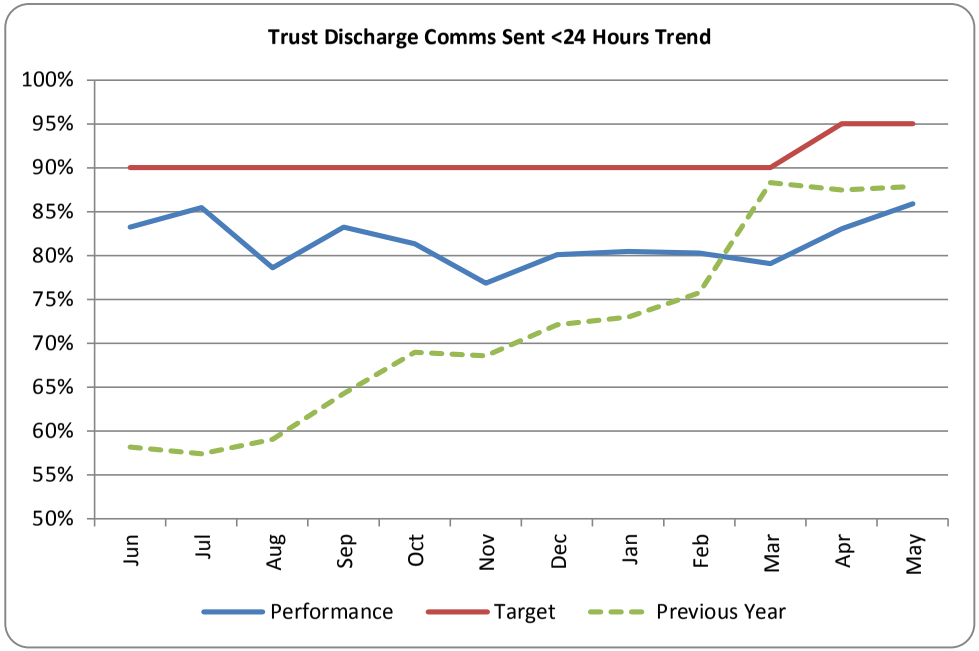
Percentage of electronic discharge communications that were sent to the GPs within 24, 48 & 72 hours of patient discharge
Director Lead: Ian Martin
Consequence of failure: Clinical outcomes, reputation, patient experience & quality of care

Discharge communication performance has improved during May to 85.9% of letters sent within 24 hours, however this is below the increased target of 95% for 2016/17. Nevertheless, performance within 72 hours also increased to 91.7%. A further 5.4% were completed at a later date but 3.0% remained outstanding at the time of reporting; both of which represent an improvement compared to last month. All Directorates are below the increased 95% target, with the exception of Urology achieving 96.1%. The majority improved between April and May, most notably Trauma & Orthopaedics (+13%), General Surgery (+10%) and Medical Specialties (+7%).
Obstetrics & Gynaecology (–9%) and Paediatrics (-1%) were the Directorates to show a decrease in 24 hour performance between April and May, albeit only a marginal variance for Paediatrics. Further work is underway to understand the contributing factors and variance in Obstetric & Gynae performance.

Discharge Comms - May 2016	<24 hours*	<48 hours*	<72 hours*	<24 hours YTD*
Target	≥95%			≥95%
Emergency Care	90.76%	91.81%	93.28%	89.68%
General Internal Medicine	89.76%	91.95%	94.15%	89.49%
General Surgery	84.00%	90.74%	93.47%	79.16%
Head & Neck	81.72%	84.95%	87.63%	81.73%
Medical Specialties	84.71%	86.62%	87.26%	80.91%
Obstetrics & Gynaecology	78.70%	86.11%	87.96%	83.03%
Ophthalmology	91.27%	95.24%	97.62%	89.84%
Paediatrics	86.59%	92.42%	94.17%	87.26%
Rehabilitation & Elderly Medicine	79.12%	83.33%	86.14%	79.08%
Trauma & Orthopaedics	84.55%	88.79%	90.91%	78.44%
Urology	96.12%	96.55%	97.41%	95.18%
Trust Total	**85.88%**	**89.57%**	**91.66%**	**84.45%**

**De minimis* level >= 20 patient discharges





Outpatient Communications

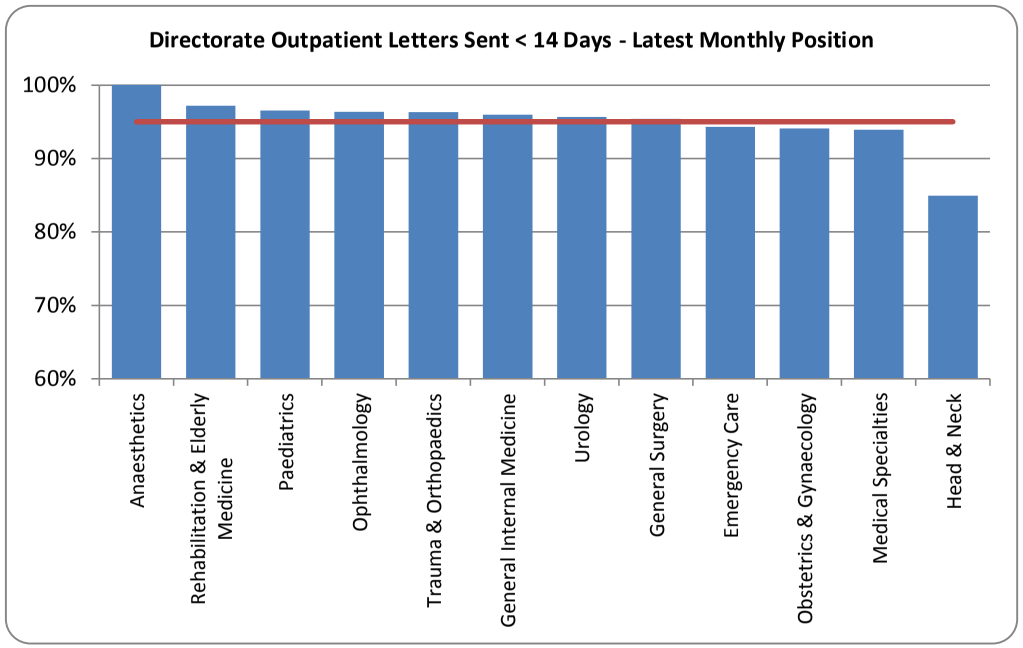
Local Quality Requirements

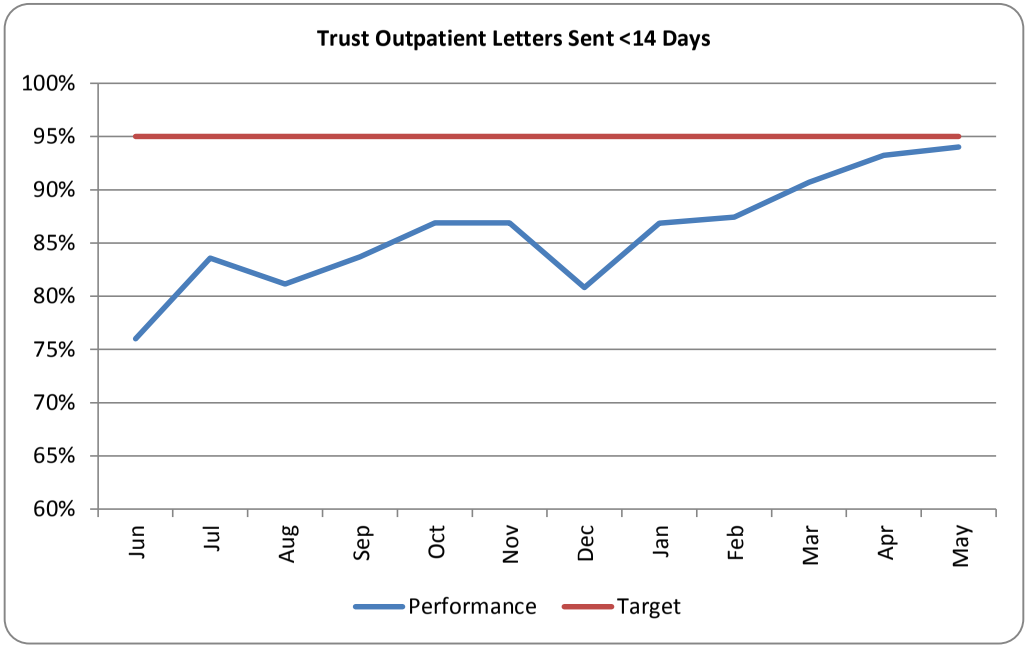
Percentage of electronic clinic letters that were sent to the GPs within 7 and 14 days of an outpatient attendance (consultant led)
Director Lead: Ian Martin
Consequence of failure: Clinical outcomes, reputation, patient experience & quality of care

During May, 94.0% of outpatients clinic letters were sent within 2 weeks, which is the highest performance achieved since monitoring of this indicator commenced. However, the performance is slightly below the contractual target of 95%. A further 4.0% required sign off at the time of reporting.
The majority of Directorates achieved the 95% target within 14 days, with the exception of Head & Neck, Medical Specialties, Obstetrics & Gynaecology and Emergency Care. Performance at Directorate level either improved or remained about the same between April and May. Most improved was Emergency Care (+17%) and largest decrease was Urology (4%). Further work is underway with the Admin Managers and the Service Improvement team to understand address the reasons for the shortfall in performance. The Trust continues to work towards our internal standards set as part of clinic on the day, whereby letters are sent to GPs the same day the patient attends or the following morning when results are available.

Outpatient Comms - May 2016	<7 days*	<14 days*	<14 days YTD*
Target		>=95%	>=95%
Anaesthetics	99.58%	100.00%	99.78%
Emergency Care	86.18%	94.30%	84.96%
General Internal Medicine	82.95%	95.97%	95.69%
General Surgery	90.08%	95.37%	95.45%
Head & Neck	75.98%	84.92%	83.07%
Medical Specialties	84.40%	93.91%	94.06%
Obstetrics & Gynaecology	79.24%	94.07%	94.96%
Ophthalmology	94.57%	96.35%	96.30%
Paediatrics	87.77%	96.53%	96.65%
Rehabilitation & Elderly Medicine	88.58%	97.15%	97.03%
Trauma & Orthopaedics	91.41%	96.27%	96.19%
Urology	87.51%	95.62%	97.38%
Trust Total	**86.46%**	**94.01%**	**93.59%**

**De minimis* level >= 20 letters





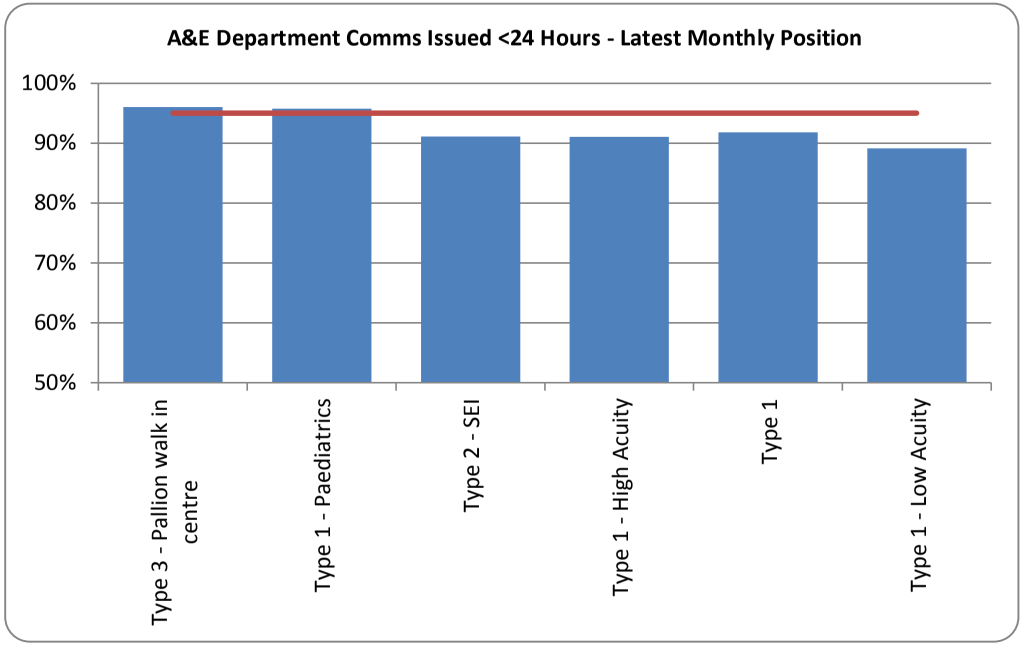
A&E Communications

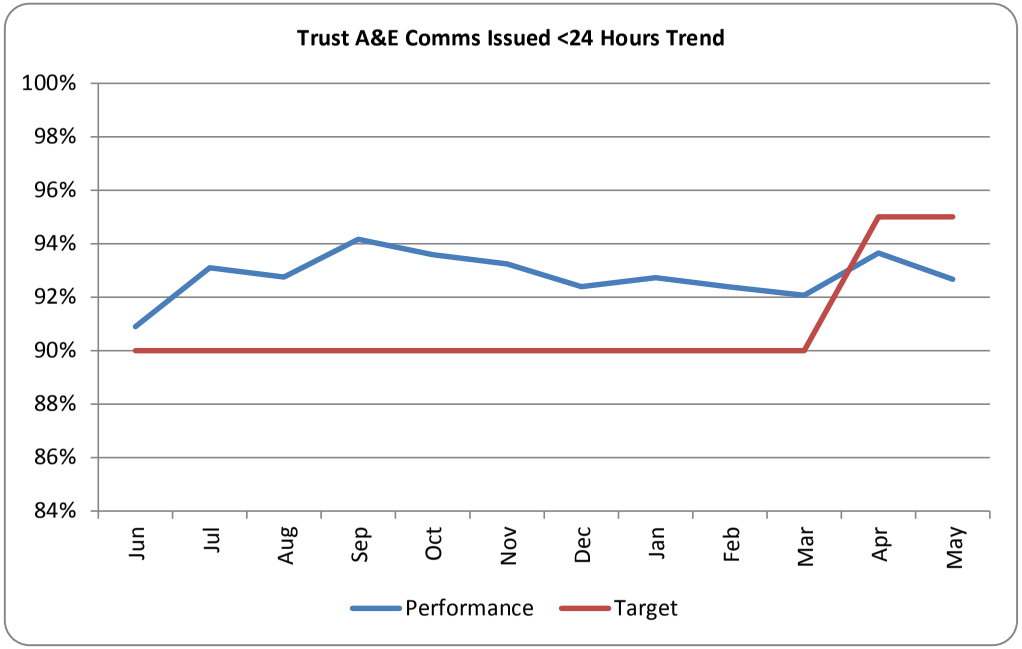
Local Quality Requirements

Percentage of electronic clinical communications that were sent to GPs within 24 hours following an A&E attendance, excluding those patients who are admitted as a result of their attendance.
Director Lead: Ian Martin
Consequence of failure: Clinical outcomes, reputation, patient experience & quality of care

A&E Comms - May 2016	Month	YTD
Target	**≥95%**	**≥95%**
Type 1	91.76%	91.48%
Type 1 - High Acuity	91.01%	91.28%
Type 1 - Low Acuity	89.12%	88.67%
Type 1 - Paediatrics	95.72%	95.59%
Type 2 - SEI	91.06%	92.74%
Type 3 - Pallion walk in centre	96.01%	96.67%
Trust Total	**92.67%**	**93.14%**

During May, 92.7% of A&E letters were sent within 24 hours of patients being discharged from the respective department, which is a small decrease of (-1%) compared to recent performance. The contractual target for 2016/17 has been increased to 95%, which now means that current performance is below target.
Type 1 (Emergency Department) and type 2 (SEI) departments are currently below target.
Performance and actions for improvement are discussed at the monthly Primary Care Communications Oversight Group.





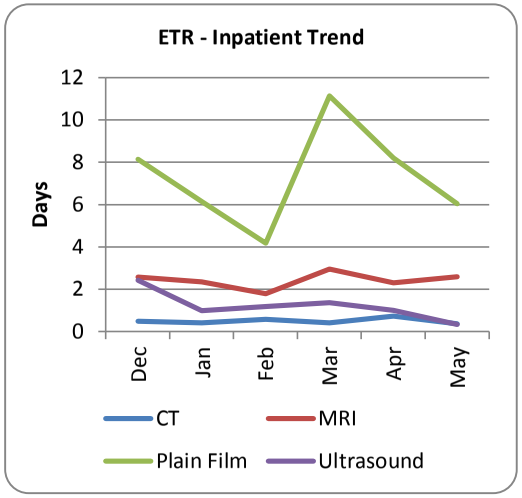
Radiology Exam to Report Times

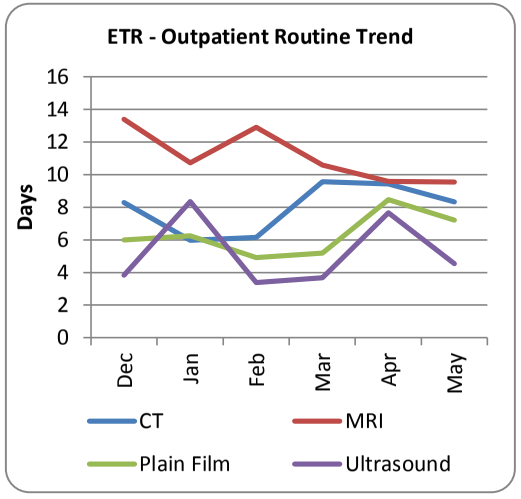
Internal Indicator

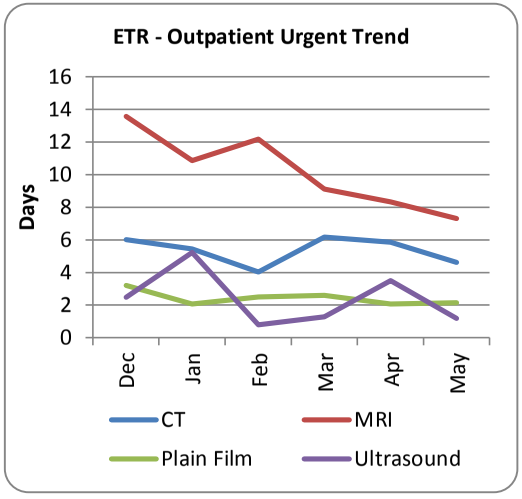
Average exam to report time and activity for MRI, CT, Plain Film and Ultrasound scans, derived from the time elapsed between the exam date and the date the results were reported. The reporting month is based upon the reported date
Director Lead: Sean Fenwick
Consequence of failure: Timely access, outcomes, LOS, reputation & patient flow

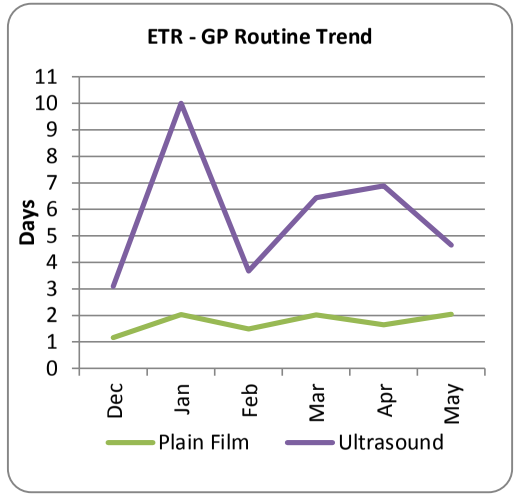
Exam Type - May 2016	MRI		CT		Plain Film		Ultrasound	
Type	No	Ave EtR	No	Ave EtR	No	Ave EtR	No	Ave EtR
Inpatient	182	2.6	876	0.4	2,455	6.0	551	0.3
Outpatient Routine	734	9.5	635	8.3	1,396	7.2	634	4.5
Outpatient Urgent	178	7.3	585	4.6	328	2.1	257	1.2
GP					2,749	2.0	912	4.6

All reporting remains in line with recent performance or is improving.
Outpatient routine and urgent exams have all improved or maintained performance.
The specialist offsite reporting company is now in place and slowly increasing capacity. The reporting of older exams is not expected to have a significant effect on performance in future months.
GP exam to report times in relation to ultrasound scans continue to recover as sonographer capacity increases.
Plain film reporting is stable currently. There continues to be an impact on reporting in this area due to vacancies however mitigation will be provided by offsite reporting companies.
There is a risk around timescales from referral to exam times due to radiographer gaps, this is not currently impacting on exam to reporting times, however may cause delays in pathways.









CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DIRECTORATE OF FINANCE

COUNCIL OF GOVERNORS
JULY 2016

FINANCIAL POSITION AS AT 31st MAY 2016
EXECUTIVE SUMMARY

1 INTRODUCTION

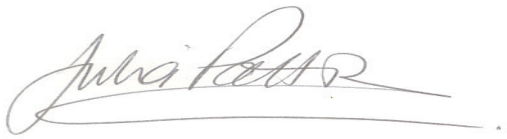
This Executive Summary provides the summary highlights of the financial position as detailed in the main report to the end of May 2016.

1.1 KEY HIGHLIGHTS

Issue or Metric	Budget	Actual	Variance	%
Overall Financial Position – Deficit	£2,020k	£1,771k	(£249k)	12.3%
Income	£57,945k	£57,543k	£402k	0.7%
Expenditure	£59,965k	£59,314k	(£651k)	1.1%
EBITDA Position %	0.9%	1.4%		
EBITDA Position £'s	£541k	£807k	(£266k)	49.1%
Cash Position	£13,747k	£9,484k	£4,263k	31.0%
Clinical Activity:				
Variance to plan	£53,337k	£53,118k	£219k	0.4%
Cost Reduction Plans				
Variance to plan	£1,818k	£1,769k	£49k	2.7%

Pay:				
Variance to plan	£35,781k	£35,415k	(£366k)	1.0%

Non Pay:				
Variance to plan	£24,185k	£23,900k	(£285k)	1.2%
Monitor Continuity of Services Risk Rating (CoSRR)			2	
+ve variance equates to worse than expected; -ve equates to better than expected				



Julia Pattison
Director of Finance/Deputy Chief Executive

DIRECTORATE OF FINANCE

COUNCIL OF GOVERNORS

JULY 2016

FINANCIAL POSITION AS AT 31st MAY 2016

1 INTRODUCTION

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

1.1 SUMMARY POSITION

The overall financial position is a net deficit of £1,771k against a planned deficit of £2,020k, and therefore £249k ahead of plan.

The Trust reported an under performance of £219k in month 2 relating to NHS clinical activity which is due to lower than expected PbR activity, a 'Stretch' target in the trust clinical income plan and known differences between the plan and agreed contracts.

At the end of May the Cost Improvement Plan (CIP) deliver is £49k behind projected plans submitted to Monitor.

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

The deficit position means that the Trust financial risk rating score is 2. This score remains in line with the expected position.

2 INCOME

2.1 *Patient Related Income:*

As mentioned in section 1.1, the Trust is reporting an underperformance of £219k against clinical income for month 2. This is due to lower than expected PbR activity, a 'Stretch' target in the trust clinical income plan and known differences between the plan and agreed contracts.

Income has not been profiled in twelfths and therefore the monthly planned surplus or deficit position will vary according to income profiles. The May income profile takes account of lower elective activity as a result of bank holidays.

Clinical income is complex this year due to:

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

The impact of the above is summarised below:

	Annual Impact £000s	Impact at Month 2 £000s
Sunderland CCG difference	£1,160	£194
Stretch Target *	£934	£156
Total	£2,094	£350

Other adj at month 2:		
Phasing differences		-266
PbR under perf, Predominately Bariatrics		89
Other non PbR under perf		46
Month 2 income under perf position		**£219**

* Note the stretch was initially £855k but moved based on final contracts

Month 2 position assumes the Trust will gain the full STP funding to date.

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

Private Patient Income is under recovered against plan by £24k.

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

Training and Education income is in line with plan, Research and Development Income is showing a small under recovery against plan to month 2.

Other Income is behind plan by £106k largely due to CIP shortfall to date, some of which is 'Stretch' plans with the remainder as slippage against the original plan.

3 EXPENDITURE

3.1 ***Pay Expenditure:***

Pay is currently showing an underspend of £366k against plan, reflecting:

- Agency costs to month 2 are £936k, compared to an overall Trust agency staffing budget to month 2 of £938k. Much of this spend is to cover vacant posts. The same two month period in 2015-16 had agency spend at £940k which is £2k more than the current period.
- The main underspend is due to vacant nursing posts across the trust. To date the underspend is £386k which is inclusive of the costs paid to NHS Professionals.
- Cost Improvement Plans for pay are £210k behind plan to date, however unidentified Stretch plans amount to £369k, therefore identified plans are £159k ahead of plan (these are mainly vacancies).

Appendix 4 shows details of pay spend on agency, flexi-bank and overtime for the last 12 months from month 2.

Overall pay costs in May were £17,716k against a budget of £17,738k for the month.

3.2 ***Non Pay Expenditure:***

Non-Pay is underspent by £285k. Major areas are highlighted as:

- Drugs are underspent by £173k against plan.
- Clinical Supplies is underspent by £366k due largely to reduced clinical activity using contract excluded devices such as Paediatric Sleep Suits, Vascular and

Metal Stents which are offset with an under recovery with Clinical Income to date.

- Other Non Pay is over spent by £262k due largely to unidentified 'Stretch' plans to date.
- Capital costs are showing a small overspend 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

The Cost Improvement Plan (CIP) target as declared to NHS Improvement (NHSI) for 2016/17 is £15,000k, however Divisional plans to date total £10,288k, meaning the Trust still has £4,712k of CIP plans to identify in this financial year.

The plan to date is £1,818k per our Monitor plan, against which actual delivery is £1,769k, so behind plan by £49k.

A full list of Divisional CIP plans was presented to Finance Committee during June.

The gap in identified CIP plans has largely been offset at this point of the year by a number of one off items such as delays in leasing equipment. This provides a short term saving at the front end of the financial year only.

Details are provided in Appendix 6.

5 CASHFLOW AND WORKING CAPITAL

The cash balance at the end of May 2016 was £9.48m against planned £13.75m. The adverse variance of £4.27m is predominantly attributable to NHS debtors being significantly higher than plan (£6.71m), offset by favourable variances in other areas of working capital (£2.02m) and the capital cash profile being behind plan (£0.42m).

The adverse NHS debtor variance of £6.71m consists of outstanding clinical activity income invoices (£2.46m), April and May 2016 clinical activity income accrual adjustments (£2.52m) which have been raised in June 16 and miscellaneous charges etc. (£1.73m). All debtors continue to be vigorously pursued. Therefore the majority of the difference is purely timing.

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

6 CAPITAL

Capital expenditure to date is £1,315k and relates mainly to the ED Development (£1,006k) and IMT Costed Profile (£160k).

7 NEXT STEPS

At this early stage the Trust is marginally ahead of the annual plan submitted to NHSI of £2.168m deficit.

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

recurrent basis.

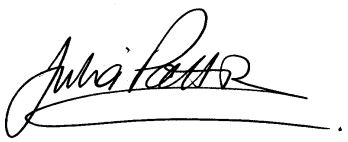
8 SUMMARY

The overall position at the end of May is a deficit of £1,771k compared to a planned deficit of £2,020k or £249k better than plan.

9 RECOMMENDATIONS

The Council of Governors are requested to:

- Note the financial position to date.



Julia Pattison
Director of Finance/Deputy Chief Executive

July 2016

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

Income & Expenditure Position

	Annual	Current Mnnth			Year tn Date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
£m	£m	£m	£m	£m	£m	£m	£m
Incnme							
NHS Clinical incnme	-325.79	-26.43	-26.35	0.07	-53.34	-53.12	0.22
PBR Clawback/relief	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Private patient income	-0.41	-0.03	-0.02	0.01	-0.07	-0.04	0.02
Non-patient income	-27.39	-2.27	-2.20	0.07	-4.54	-4.38	0.16
Total income	**-353.59**	**-28.73**	**-28.58**	**0.16**	**-57.94**	**-57.54**	**0.40**
Expenses							
Pay Costs	212.501	17.738	17.716	-0.02	35.781	35.415	-0.37
Drug costs	38.92	3.28	3.15	-0.13	6.56	6.39	-0.17
Other Costs	88.97	7.51	7.33	-0.18	15.06	14.93	-0.13
Total costs	**340.39**	**28.53**	**28.19**	**-0.34**	**57.40**	**56.74**	**-0.67**
Earnings before interest, tax, depreciation & amortisation (EBITDA)	**-13.20**	**-0.20**	**-0.39**	**-0.19**	**-0.541**	**-0.807**	**-0.27**
Profit/loss on asset disposal	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Depreciation	8.60	0.72	0.72	0.00	1.43	1.43	0.00
PDC dividend	4.81	0.40	0.41	0.01	0.80	0.82	0.02
Interest	1.97	0.16	0.16	0.00	0.33	0.32	-0.01
Corporation tax	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net surplus (pre exceptionals)	**2.17**	**1.08**	**0.90**	**-0.18**	**2.02**	**1.77**	**-0.25**
Exceptional items				0.00			
Net surplus (post exceptionals)	**2.17**	**1.08**	**0.90**	**-0.18**	**2.02**	**1.77**	**-0.25**

EBITDA Margin	**3.7%**	**0.7%**	**1.3%**		**0.9%**	**1.4%**

CITY HOSPITALS SUNDERLAND FOUNDATION TRUST
TRUST PERFORMANCE SUMMARY

PERIOD ENDED 31ST MAY 2016

TRUST SUMMARY

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

	Annual Budget £'000s	Apr actual £'000s	May actual £'000s	YTD actual £'000s	Plan £'000s	Variance £'000s
Income						
Contract Income	(325,786)	(26,763)	(26,354)	(53,118)	(53,337)	219
Private Patients	(412)	(24)	(20)	(45)	(69)	24
Training and Education Income	(10,989)	(919)	(919)	(1,837)	(1,832)	(5)
Research and Development Income	(1,712)	(95)	(133)	(228)	(285)	58
Other income	(14,619)	(1,160)	(1,144)	(2,304)	(2,410)	106
Interest Receivable	(74)	(6)	(6)	(12)	(12)	
Total Income	**(353,592)**	**(28,968)**	**(28,576)**	**(57,543)**	**(57,945)**	**402**
Expenditure						
Pay	212,501	17,699	17,716	35,415	35,781	(366)
Clinical Supplies and Services	34,343	2,798	2,656	5,454	5,820	(366)
Drug Costs	38,920	3,243	3,148	6,391	6,564	(173)
Other Costs	54,624	4,806	4,671	9,477	9,238	240
Depreciation	8,600	717	717	1,434	1,433	1
PDC Dividend	4,805	411	411	823	801	22
Interest	1,968	160	160	320	328	(8)
Total Expenditure	**355,760**	**29,835**	**29,480**	**59,314**	**59,965**	**(651)**
(Surplus)/Deficit	2,168	867	904	1,771	2,020	(249)
Cost Improvement Plans	(15,000)	(604)	(1,165)	(1,769)	(1,818)	49
ISLAs						
Income	(42,792)		(7,396)	(7,396)	(7,131)	(265)
Expenditure	42,792		7,396	7,396	7,131	265
Divisional Total						

WTE Analysis (WTEs)

Total WTEs	**4,918.47**	**4,712.57**	**4,699.61**	**4,699.61**	**4,918.47**	**-218.86**

Assets	Plan As At 31-May-16 £m	Actual As At 31-May-16 £m	Variance £m
Assets, Non-Current			
Intangible Assets, Net	5.313	5.320	
Property, Plant and Equipment, Net	216.516	216.084	
Investments in Subsidiaries, at Cost (CHoICE)	0.900	0.900	
Trade and Other Receivables, Net, Non-Current			
Other Receivables, Non-Current	1.304	1.178	0.126
Impairment of Receivables, Non-Current	-0.287	-0.260	-0.027
Trade and Other Receivables, Net, Non-Current, Total	1.017	0.918	
Assets, Non-Current, Total	223.746	223.222	
Assets, Current			
Inventories	5.400	5.425	-0.025
Trade and Other Receivables, Net, Current			
NHS Trade Receivables, Current	2.707	9.419	-6.712
Non NHS Trade Receivables, Current	0.850	0.864	-0.014
Other Related Party Receivables, Current	0.150	0.150	0.000
PDC Receivable, Current	0.000	0.000	0.000
Other Receivables, Current	0.800	0.950	-0.150
Impairment of Receivables, Current	-0.499	-0.527	0.028
Trade and Other Receivables, Net, Current, Total	4.008	10.856	
Prepayments, Current	3.440	3.660	-0.220
Cash and Cash Equivalents	13.747	9.484	4.263
Assets, Current, Total	26.595	29.425	
ASSETS, TOTAL	**250.341**	**252.647**	

Liabilities

Liabilities, Current			
Interest-Bearing Borrowings, Current			
Loans, non-commercial, Current (DH, FTFF, NLF, etc)	-3.273	-3.272	-0.001
Interest-Bearing Borrowings, Current, Total	-3.273	-3.272	
Deferred Income, Current	-1.575	-1.808	0.233
Provisions, Current	-0.260	-0.269	0.009
Trade and Other Payables, Current			
Trade Payables, Current	-11.500	-12.171	0.671
Amounts Due to Other Related Parties, Current	0.000	0.000	0.000
Other Payables, Current	-9.250	-9.513	0.263
Capital Payables, Current	-0.870	-0.867	-0.003
Trade and Other Payables, Current, Total	-21.620	-22.551	
Other Financial Liabilities, Current			
Accruals, Current	-5.825	-6.698	0.873
PDC dividend creditor, Current	-0.800	-0.823	0.023
Interest payable on non-commercial interest bearing borrowings, current	-0.365	-0.356	-0.009
Interest payable on commercial interest bearing borrowings, current	0.000	0.000	0.000
Other Financial Liabilities, Current, Total	-6.990	-7.877	
Liabilities, Current, Total	-33.718	-35.777	
NET CURRENT ASSETS (LIABILITIES)	-7.123	-6.352	
Liabilities, Non-Current			
Interest-Bearing Borrowings, Non-Current			
Loans, Non-Current, non-commercial (DH, FTFF, NLF, etc)	-55.766	-55.766	0.000
Loans, Non-Current, commercial	0.000	0.000	0.000
Interest-Bearing Borrowings, Non-Current, Total	-55.766	-55.766	
Deferred Income, Non Current	0.000	0.000	0.000
Provisions, Non-Current	-0.869	-0.869	0.000
Trade and Other Payables, Non-Current			
Trade Payables, Non-Current	-1.376	-1.376	0.000
Other Payables, Non-Current	0.000	0.000	0.000
Trade and Other Payables, Non-Current, Total	-1.376	-1.376	
Liabilities, Non-Current, Total	-58.011	-58.011	
TOTAL ASSETS EMPLOYED	**158.612**	**158.859**	

Taxpayers' and Others' Equity

Taxpayers' Equity			
Public Dividend Capital	99.542	99.542	
Retained Earnings	-16.014	-15.767	
Revaluation Reserve	75.084	75.084	
TAXPAYERS' EQUITY, TOTAL	**158.612**	**158.859**	
	0.000	0.000	

Appendix 3

Clinical Income Report

Introduction

This appendix offers a greater insight into clinical income and contract activity and reflects the income and activity position up until the end of month 2, May 2016.

All contracts have now been signed with Commissioners and detailed activity plans received – these have been translated into the normal PBR file format and has allowed a Month 01 PBR file to be run, unlike previous years, and sent to Commissioners in line with the agreed timetable.

The Monitor plan had to be submitted in early April, in advance of all contracts being finally agreed and therefore final contracts and demand plans are different to the Monitor submission for the majority of Commissioners in 16/17.

The contracts for Sunderland CCG and Sunderland LA have been agreed as block contracts, that is a fixed sum independent of actual activity for 16/17 and all other Commissioner contracts will operate on a variable PBR basis.

Financial Overview

As at the end of month 2, the clinical income budget was £53,336k with the actual clinical income of £53,117k, equating to an under-performance of £219k (0.4%).

Due to the significant difference in the financial values in the final contracts and those estimated when setting the Monitor plan – this report will show both the variance against the Monitor plan and the variance against the agreed contract values at Commissioner level.

The main differences relate to QIPP/Vanguard targets that have been removed from the majority of CCG contracts in 16/17 – these reductions were not factored into the Monitor plan, nor does the Trust believe at this stage that the majority of these are deliverable in the short term or even longer term.

In order to mitigate any adverse impact in cash as a result of this removal of activity and funding from the majority of CCG contracts, an agreement has been made to invoice monthly for the value of the QIPP reductions with those CCG's supported by NECS – which will be adjusted for, if necessary as part of the normal quarterly financial reconciliation discussions.

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

Appendix 3

Table 1 Reconciliation of PBR plans to Monitor plans - Annual Position.

	Plan as per Contracts	QIPP/Vanguard targets	Balance	Plan as per Monitor
Commissioner contracts	£'000s	£'000s	£'000s	£'000s
Sunderland	179,500	1,686	-526	180,660
South Tyneside	22,914	294	150	23,359
Gateshead	3,491	113	51	3,655
Cumbria	361		0	360
Sunderland LA	2,436		-62	2,374
DDES	34,341	1,952	108	36,401
North Durham	15,744	696	28	16,468
HAST	2,904	151	179	3,234
South Tees	172	25	0	197
Specialised	34,229	0	224	34,453
Dental	6,284	0	23	6,307
Sub total	302,377	4,916	175	307,468
Cancer Drug Fund	2,422		0	2,422
Hep C drugs	465		0	465
NCA's	1,900		-94	1,806
AQP - all contracts	1,086		-5	1,081
Offender Health	87		-87	0
New Born Screening	130		0	130
Church View	880		0	880
Gap/Stretch target	5,840		-4,905	934
STP funding	10,600		0	10,600
Total	325,786	4,916	-4,916	325,786

The Month 2 figures were derived from the Month 1 PBR report, which reflects the Month 1 flex position only. We have assumed break even to plan for Month 2, less the stretch target and the phasing adjustment, as the actual information is not yet available for Month 2.

Table 2 shows the over-performance at contract/commissioner level compared to the agreed contracts and also the Monitor plan.

Table 2 - financial position per Commissioner as per agreed contract and Monitor Plan at Month 02

Commissioner contracts	Plan as per Contract £'000s	Plan as per Monitor £'000s	Total Actuals £'000s	Variance against Contract £'000s	Variance as against Monitor Plan	% against Contract	% against Monitor Plan
Sunderland	29,576	29,769	29,576	**0**	**193**	0.0%	0.7%
South Tyneside	3,735	3,809	3,796	**-61**	**13**	-1.6%	0.3%
Gateshead	568	595	593	**-25**	**2**	-4.3%	0.3%
Cumbria	59	58	61	**-3**	**-3**	-4.2%	-4.3%
Sunderland LA	406	396	406	**0**	**-10**	0.0%	-2.6%
DDES	5,640	5,983	5,918	**-278**	**65**	-4.7%	1.1%
North Durham	2,564	2,685	2,741	**-177**	**-56**	-6.5%	-2.1%
HAST	472	527	514	**-42**	**13**	-8.2%	2.5%
South Tees	28	32	28	**0**	**4**	-0.9%	13.8%
Specialised	5,637	5,675	5,585	**52**	**89**	0.9%	1.6%
Dental	1,016	1,020	967	**49**	**53**	5.1%	5.5%
Sub total	**49,701**	**50,550**	**50,187**	**-485**	**363**	-1.0%	0.7%
Cancer Drug Fund	404	404	404	**0**	**0**	0.0%	0.0%
Hep C drugs	78	78	106	**-29**	**-29**	-27.0%	-27.0%
NCA's	317	301	291	**26**	**10**	9.0%	3.6%
AQP - all contracts	181	180	181	**0**	**-1**	-0.1%	-0.5%
Offender Health	15	0	15	**0**	**-15**	0.0%	-100.0%
New Born Screening	22	22	22	**0**	**0**	0.0%	0.0%
Church View	147	147	147	**0**	**0**	0.0%	0.0%
Gap/Stretch target	973	156	0	**973**	**156**	0.0%	0.0%
Phasing adjustment	-266	-266	0	**-266**	**-266**	0.0%	0.0%
STP funding	1,767	1,767	1,767	**0**	**0**	0.0%	0.0%
Total	**53,337**	**53,337**	**53,118**	**219**	**219**	0.4%	0.4%

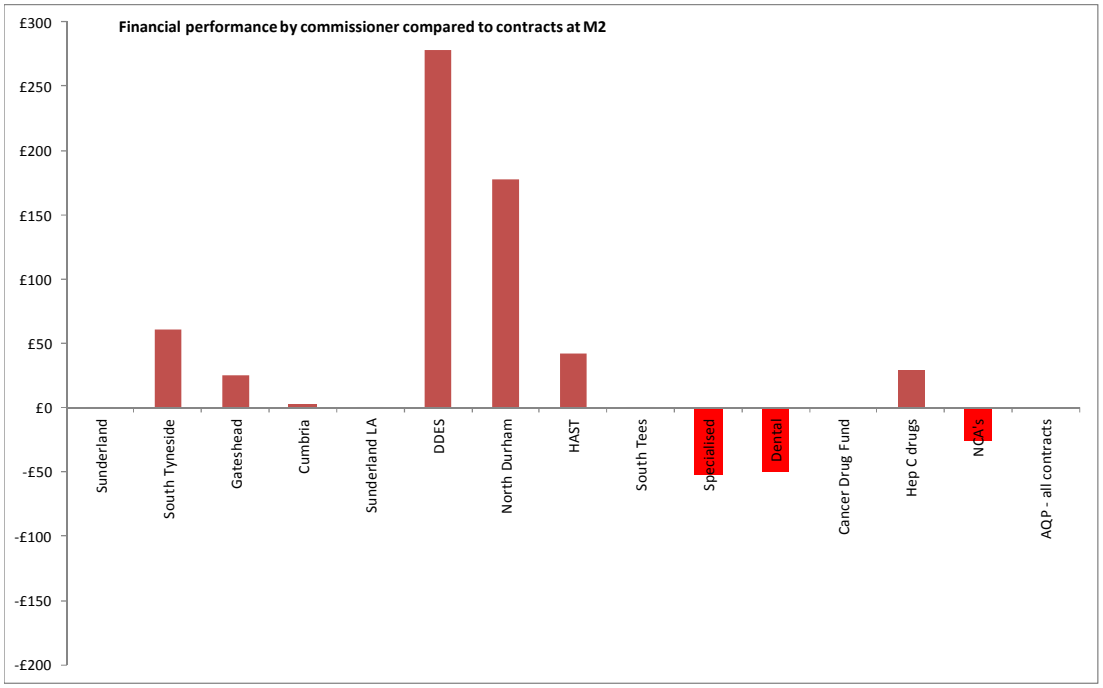
Summary	**Annual £'000s**	**Month 02 £'000s**
Sunderland lower than Plan	1,160	193
Other Contracts lower than Monitor plan	0	136
Gap/Stretch Target	936	156
Phasing Adjustment	0	-266
Month 02 position	**2,096**	**219**

Stretch target previously £855k - adjusted following agreement of final contracts

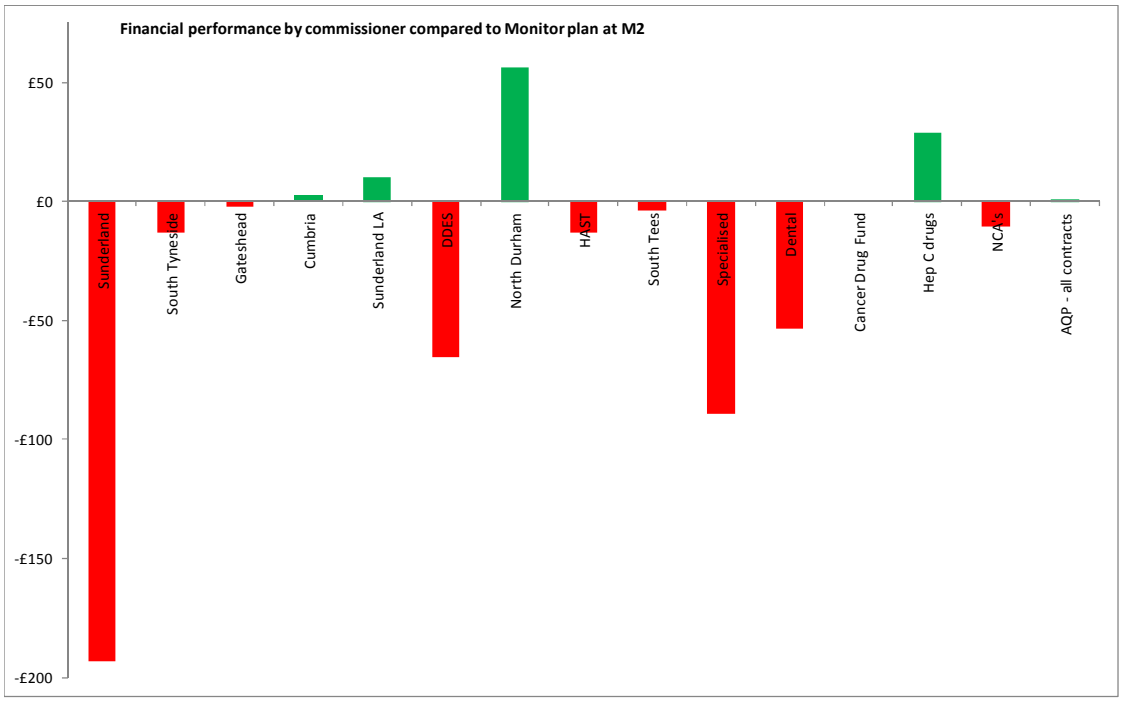
The variances differ at Commissioner/Contract level as the Monitor plan assumed higher levels of income than was bought by Commissioners – the main difference is due to the QIPP/Vanguard schemes that CCG's have built into their final demand plans – see Table 1.

Some challenges from Commissioners have now been received and will be reviewed and actioned where necessary for the Month 1 freeze PBR report. This may impact on the position reported, but no material movement is expected at this stage.

The chart below shows the variance per Commissioner against the final agreed contract values.



The chart below shows the variance per Commissioner against the Monitor plan.



Position by Significant Commissioner (Month 1-2)

- **Sunderland CCG** - is showing a break even position as it is on a block contract in 16/17. The actual PBR/contract position for Month 1 (adjusted for known challenges) – is a £516k underperformance, mainly on non-elective admissions, high cost drugs and contract exclusions. Against the Monitor plan there is a £193k shortfall.
- **South Tyneside CCG** - is £61k ahead of contract plan (1.6%), with general over performance across day cases, outpatient procedures, nurse led outpatients and on

devices. There is under performance on high cost drugs. Against the Monitor plan there is £13k shortfall.

- **Newcastle/Gateshead CCG** - ahead of contract plan by £25k (4.3%), in most points of delivery as anticipated, apart from drugs. Against the Monitor plan there is a £2k shortfall.
- **DDES CCG** - ahead of plan by £278k (4.7%) – across most points of delivery, particularly A&E, elective and non-elective admissions. Against the Monitor plan there is £65k shortfall.
- **North Durham CCG** - ahead of plan by £177k (6.5%), mainly in non-elective and elective admissions and high cost drugs. Against the Monitor plan there is £56k overperformance
- **Hartlepool CCG** – is ahead of plan by £42k (8.2%). This is across most points of delivery. Against the Monitor plan there is £13k shortfall.
- **South Tees CCG** – this contract is in line with both the contract and the Monitor plan.
- **NHS England (Dental**) – Currently behind plan by £49k (5.1%) – this is predominantly down to under-performance in day cases. Against the Monitor plan there is £53k shortfall.
- **NHS England (Specialised)** – this contract is behind plan by £52k (0.9%) which is primarily driven by under-performance in elective admissions and outpatients (Bariatrics), but partially compensated by an overspend against high cost drugs. Against the Monitor plan there is £89k shortfall.
- **Hep C drugs** - is currently ahead of plan by 29k – these are drugs that are charged to NHS England (Specialised) – but do not form part of their contract as they pass these costs through to the their central team.
- **Gap/Stretch Target** – this represents 2 months of the £5.8m gap against the contracts and 2 months of the £934k gap against the Monitor Plan (see Table 1).
- **Phasing adjustment –** this represents the difference between the phasing in the final demand plans and the original phasing in the Monitor plan submission - this is due to timing differences of demand plans being received and the Monitor plan submission and the fact that different points of delivery have different phasing. In particular there has been a change to Chiropody, originally phased in twelfths, but subsequently phased as first contact in the financial year (FCFY) – which accounts for the majority of the difference.
- **STP funding –** it has been assumed that full STP funding will be received to Month 2.

CQUIN and Penalties

It is too early in the year to have any information as to whether CQUIN schemes are achieving.

The performance team have calculated Month 1 penalties – some figures are still to be confirmed and conformation is still awaited on the way penalties will be treated for those targets covered by STP trajectories – at this stage the Month 2 position excludes the impact of penalties.

Activity [Month 1 and 2]

Activity at Trust level is shown in Figure 2. Month's 1 and 2 actual activity is compared against 12 months of history and to Commissioner plans. The aspiration is the combination of plan, actual and history will enhance the utility of this report.

Note that activity levels are a good indication of contract performance however case mix (tariff therefore income) is equally important. Comments below pertain to months 1 and 2 only.

A&E - Total activity is 6.2% above historical levels and 6.2% above plan. Type 1 (main site) A&E is 8.5% above plan; eye infirmary (type 2) is 1.8% below plan, Type 4 (Pallion) is 9% above plan.

Non-Electives - Up 436 spells (6.5%) vs history however 95 spells down against plan (1.3%). Specialties with the greatest variance against history include Accident & Emergency, General Surgery, Urology and Geriatric Medicine.

Electives - Down 1,623 spells (12.1%) vs history however up 873 spells (8%) vs plan. Specialties with the greatest variance against history include Ophthalmology (mainly due to the reclassification of Lucentis activity to Outpatient Procedures from April 2016) and Gastroenterology. Specialties with the greatest variance against plan include Medical Oncology and Clinical Haematology.

First Outpatients (consultant led) - Is 1,403 spells (8.8%) above history however 519 spells (2.9%) below plan. Specialties with the greatest variance against history include Paediatrics and Neurology.

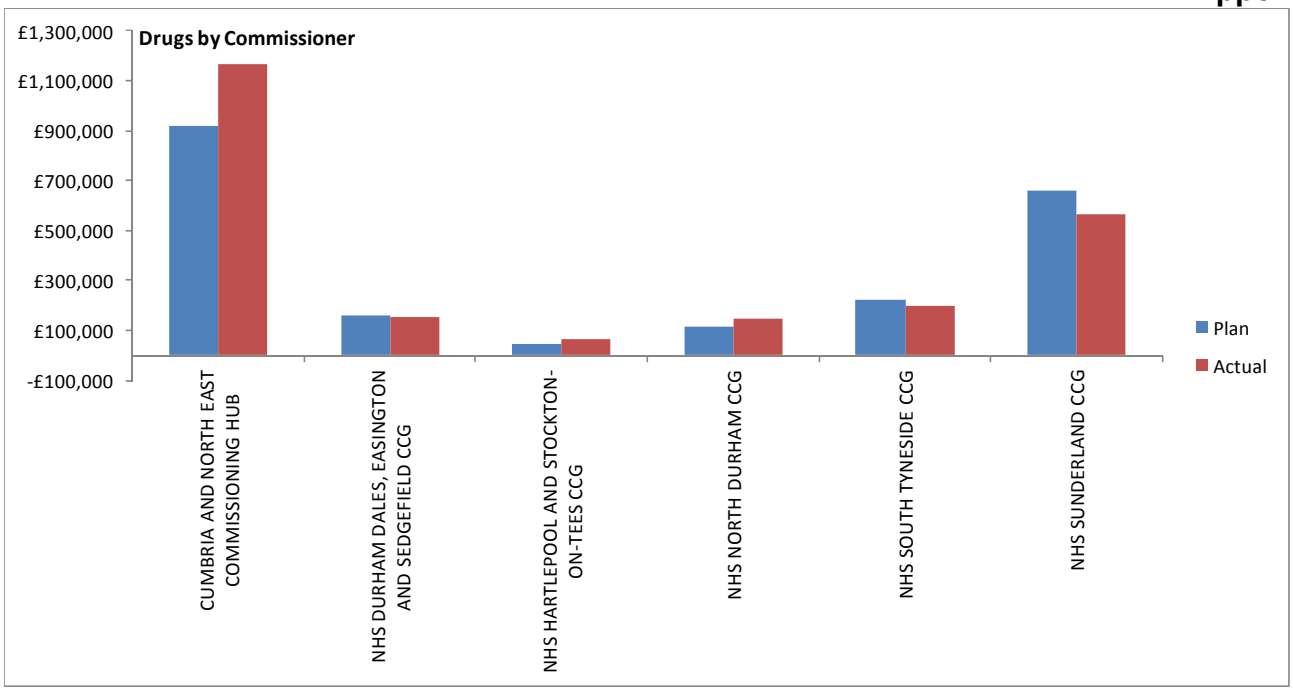
Review Outpatients (consultant led) - Is 82 spells (0.2%) below history and 404 spells (1.2%) below plan.

Non Consultant Led Outpatients - Is 1,693 spells (15.1%) above history and 1,231 spells (10.6%) above plan. Specialties with the greatest variance against both history and plan include Urology and Rheumatology.

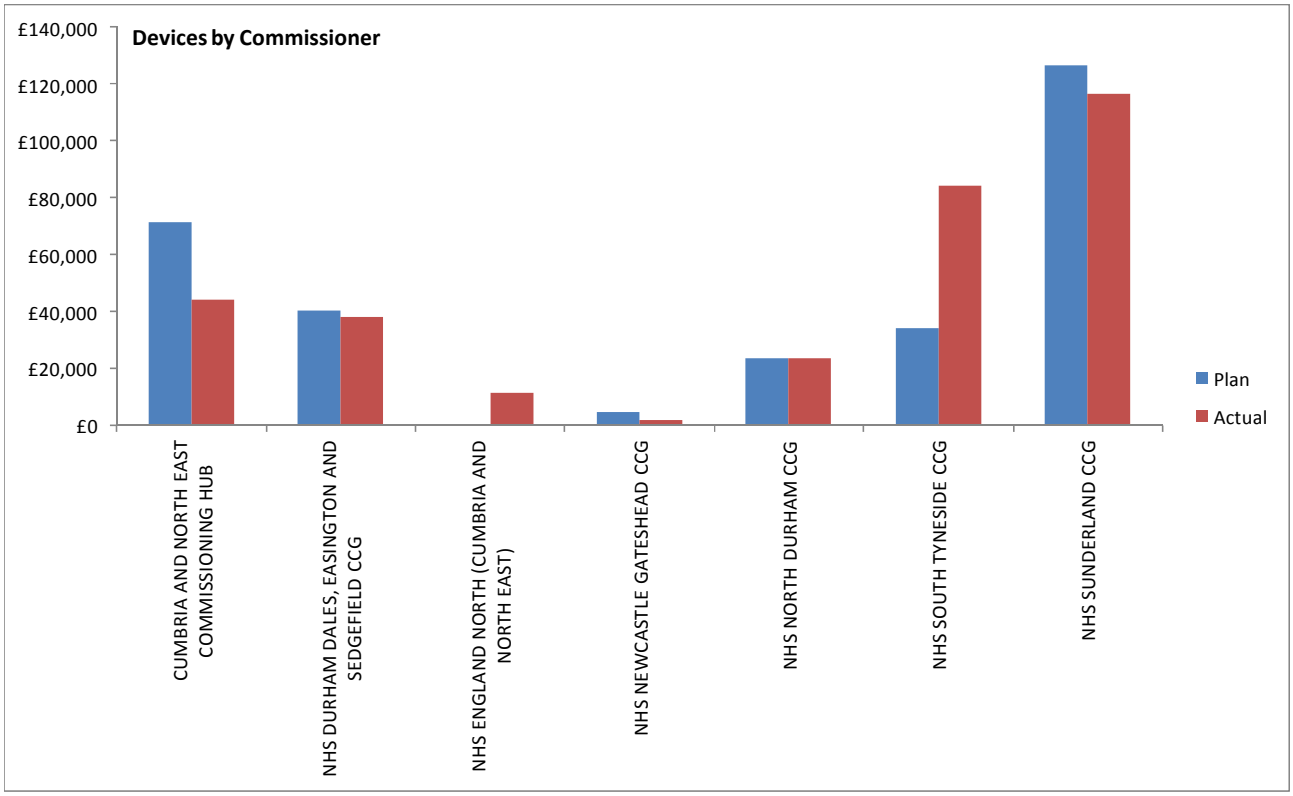
Outpatient Procedures – Is 2,007 spells (24%) up vs history and 160 spells (1.6%) above plan, the majority of which is attributable to the shift of Ophthalmology Lucentis injections from Daycases to OP procedures.

Non-Face to Face OP - YTD contacts are 793 spells (70.2%) above plan. This is mainly due to Gastroenterology recording of Telephone clinics since April 2016 (which has resulted in significant over-performance due to very small plan and history figures). Other specialties with the greatest variance against plan include Genitourinary Medicine, Gastroenterology and Diabetic Medicine.

Drugs - Drugs are currently over recovered by £63k which will be directly linked to expenditure. Sunderland CCG drugs however are under recovered by £93k. The main shortfall in Month 1 is against Infliximab and there have been some challenges from NHSE that may reduce this figure in M1 freeze.



Devices - Currently over recovered by £42k particularly custom fixator frames and maxio facial prostheses



Detailed Insight - Accident & Emergency

Months 1 & 2 are showing significant over-performance in A&E Types 1 (main site) and 4 (Pallion). SEI (type 2), is running close to plan but is 4% down against historical levels.

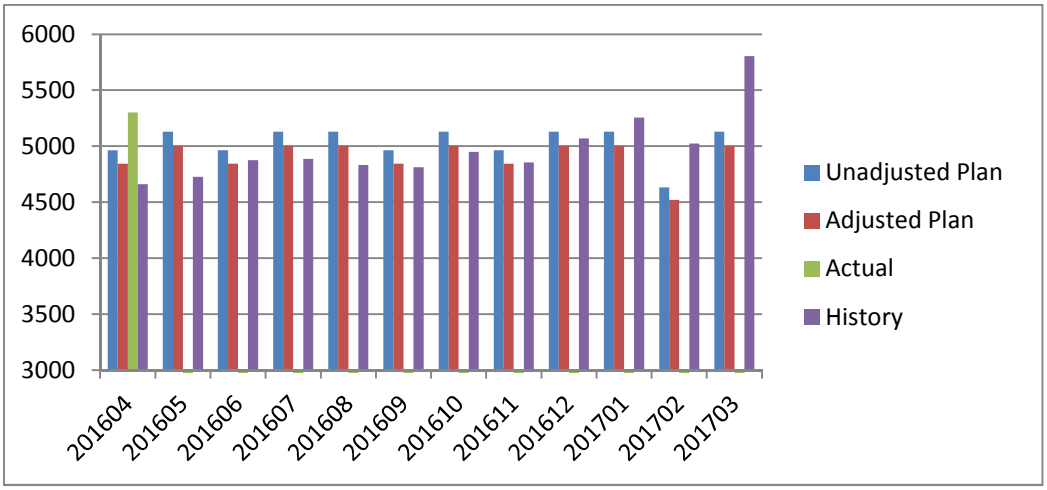
Site Code	Plan Activity	Actual Activity	Historical Activity	Variance vs Plan	Variance vs History
Type1	13,502	14,653	14,173	8.5%	3%
Type2	5,408	5,308	5,513	-1.9%	-4%
Type4	4,773	5,202	4,005	9.0%	30%
Grand Total	**23,684**	**25,163**	**23,691**	**6.2%**	**6%**

Where most of the over-performance YTD is due to increased attendance numbers in Pallion; the variance against the plan has also been affected by the reduction of planned attendances in Type 1 and Type 4. This is part of the Commissioners Vanguard/QIPP schemes, which has seen the commissioned number of attendances for 16/17 reduce by 1,456.

The table and graph below show Month 1 performance against the specific cohort of Vanguard/QIPP attendances, against the reduced and also unadjusted plan. These attendances are running at a higher level than in 15/16, possibly indicating that there has not yet been any impact from these schemes.

Accident and Emergency performance against Vanguard/QIPP Month 1

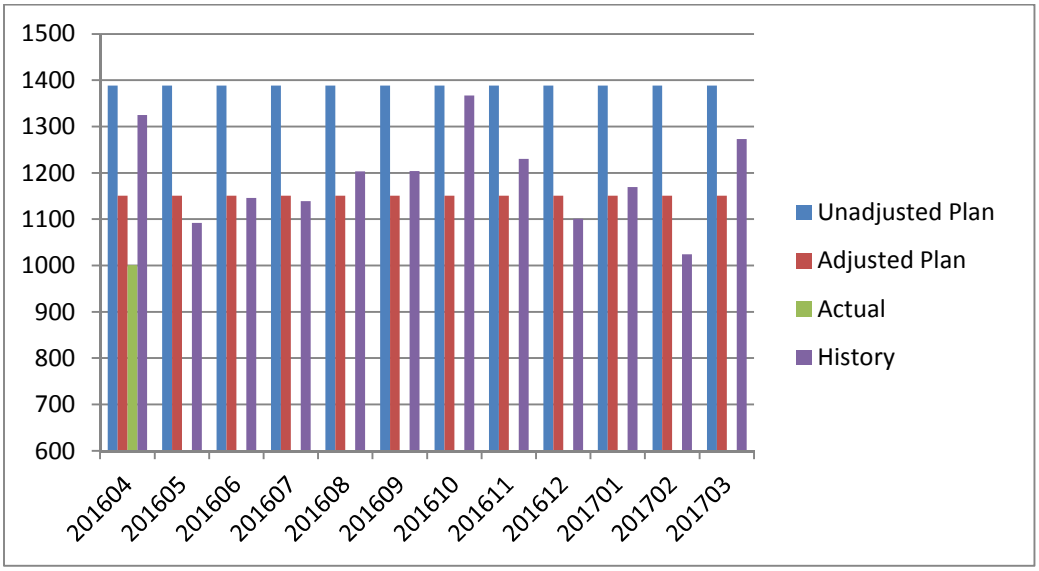
Month	Unadjusted Plan	Adjusted Plan	Actual	History	Var Vs Unadj Plan	Var Vs Adjusted Plan
201604	4,963	4,843	5,300	4,660	-337	-457



Detailed Insight - Vanguard/QIPP

Month 1 is showing a mix of under and over performance against the specific HRGs that the Commissioners have indicated should reduce as a result of their QIPP/Vanguard schemes.
A&E is as discussed above. Non Electives are underperforming against the adjusted plan – however this may be affected by a change to the National Coding system, which has meant that a proportion of spells are unable to be grouped to HRGs for Month 1, and therefore not included with the actuals in these figures.

Non Elective performance against QIPP Schemes Month 1



Risks

The following risks to income need to be considered:

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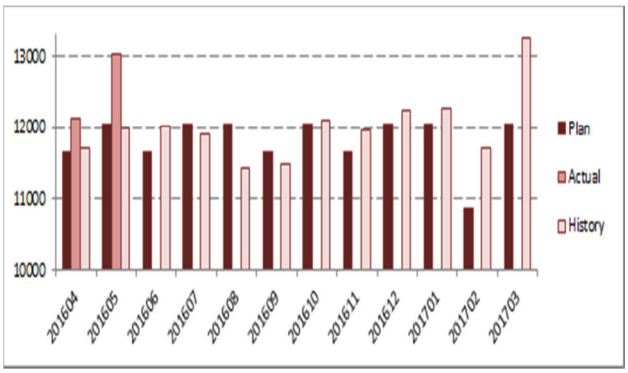
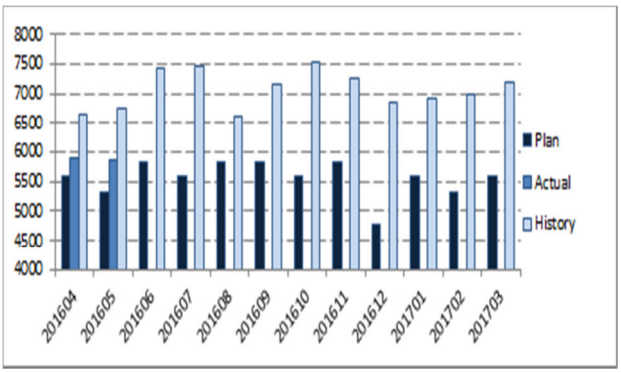
- As a result of the introduction of a new National grouper, there are uncoded spells in Month 1 (and potentially subsequent months) – these will require local agreement for payment.
- As part of the A&E/Lucentis contracted agreement for 16/17 – a monthly reconciliation of the benefit to both CCG/CHS is being calculated – this may result in additional income or cost to CHS, depending on balance between A&E and Lucentis.
- Affordability of over-performance to Commissioners – the majority of CCGs are over-performing against contract up to Month 1 (Table 2) – Commissioners are concerned about affordability and therefore the level of scrutiny and challenge on the figures is likely to be high.
- Initial challenges on Month 1 PBR reports were due back on the 8th June – the responses due 15th June, may result in some changes for Month 1 freeze and Month 2 flex.
- If QIPP/Vanguard schemes do start to deliver in 16/17 – and CHS income reduces, expenditure may not reduce in proportion.
- The application of penalties and the link to STP trajectories/funding still needs to be confirmed.
- The full level of STP funding for the year to date has been assumed in the position –this still needs to be confirmed.

Contracting Team
June 2016

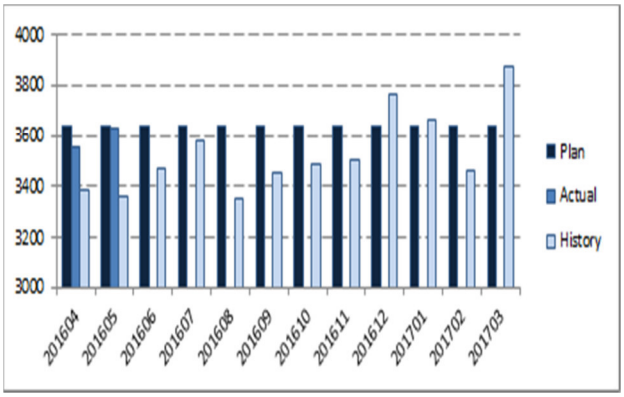
Accident and Emergency



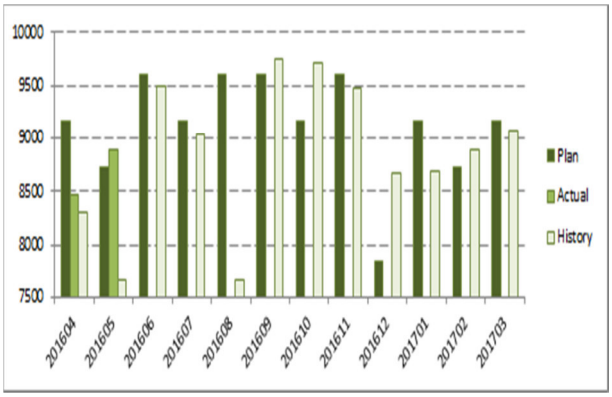
Elective Admissions



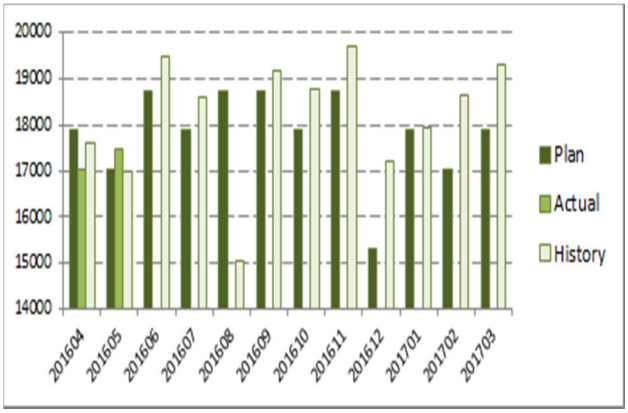
Non Elective Admissions



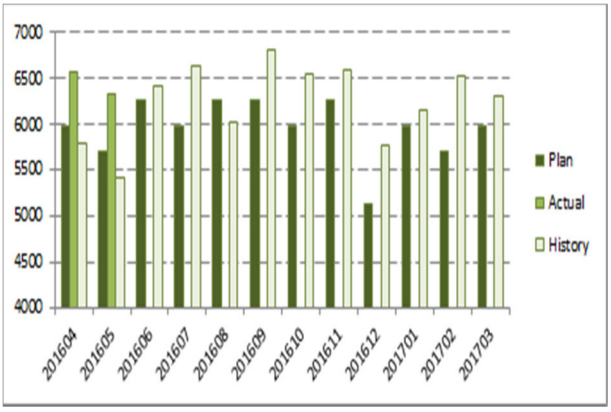
OP Consultant New



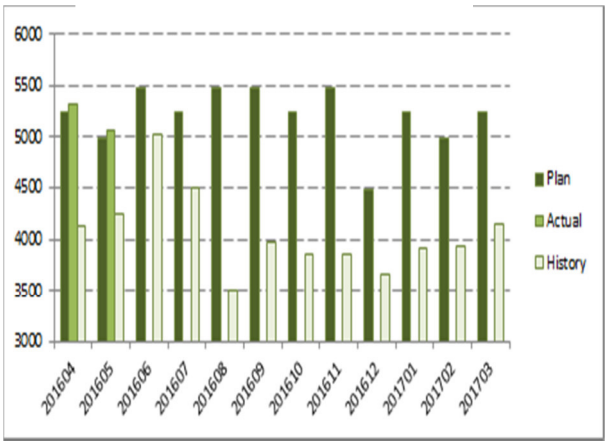
OP Consultant Review



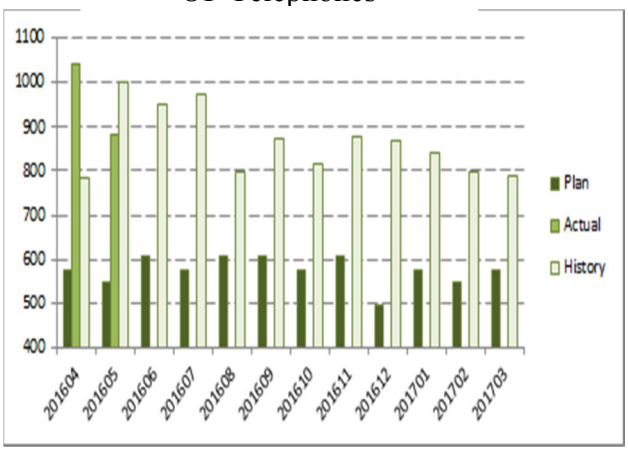
OP Non Consultant Led



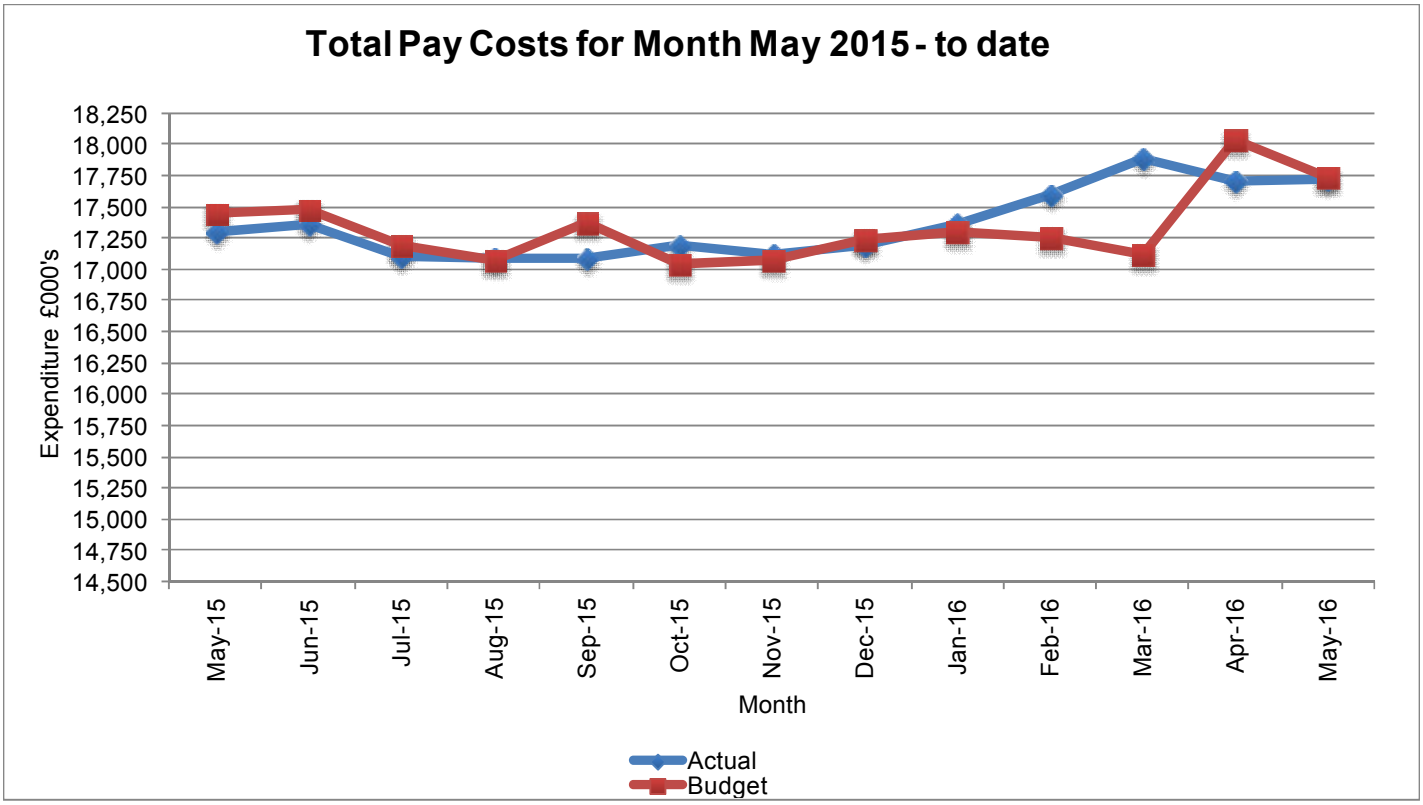
OP Procedures

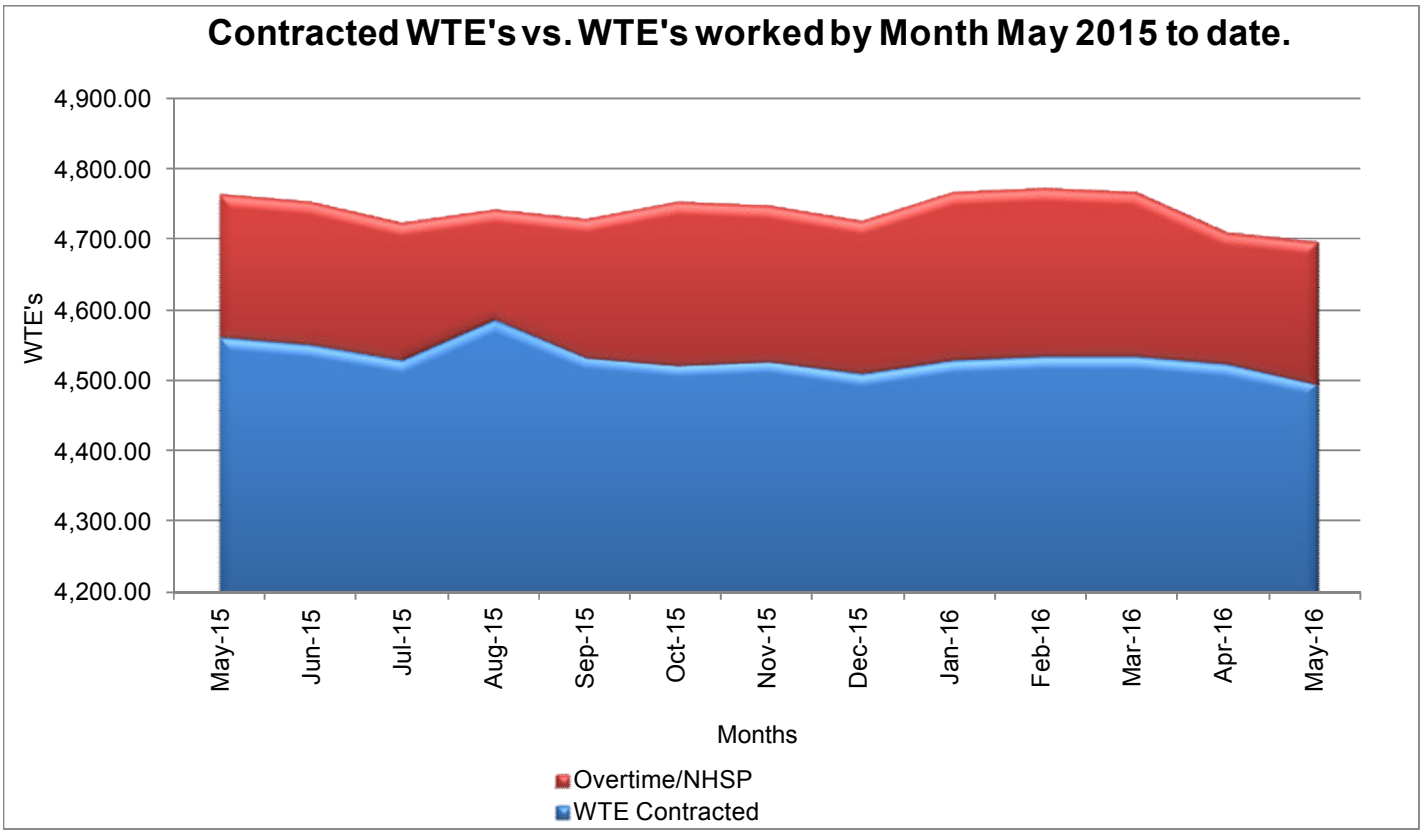


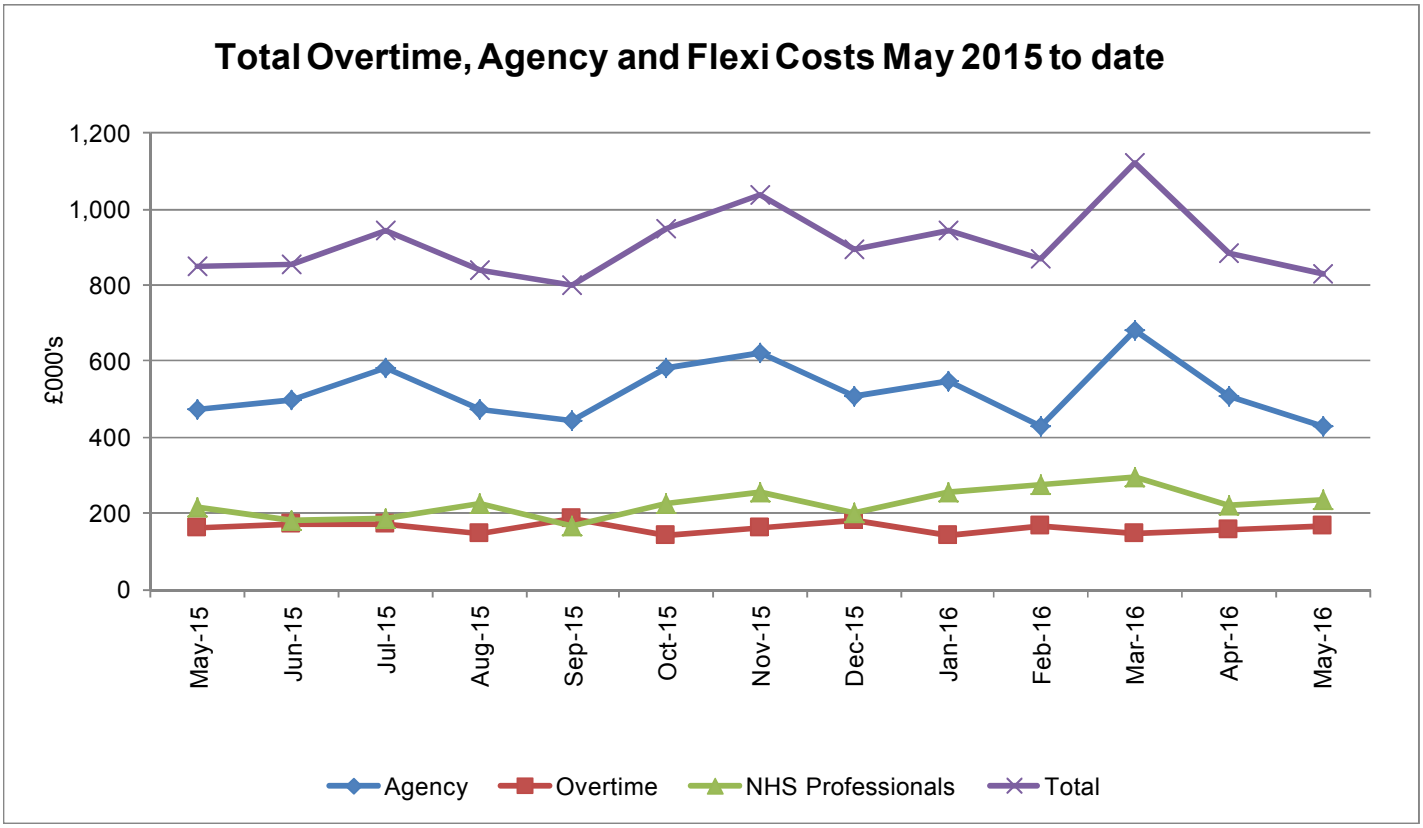
OP Telephones



Appendix 4


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


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



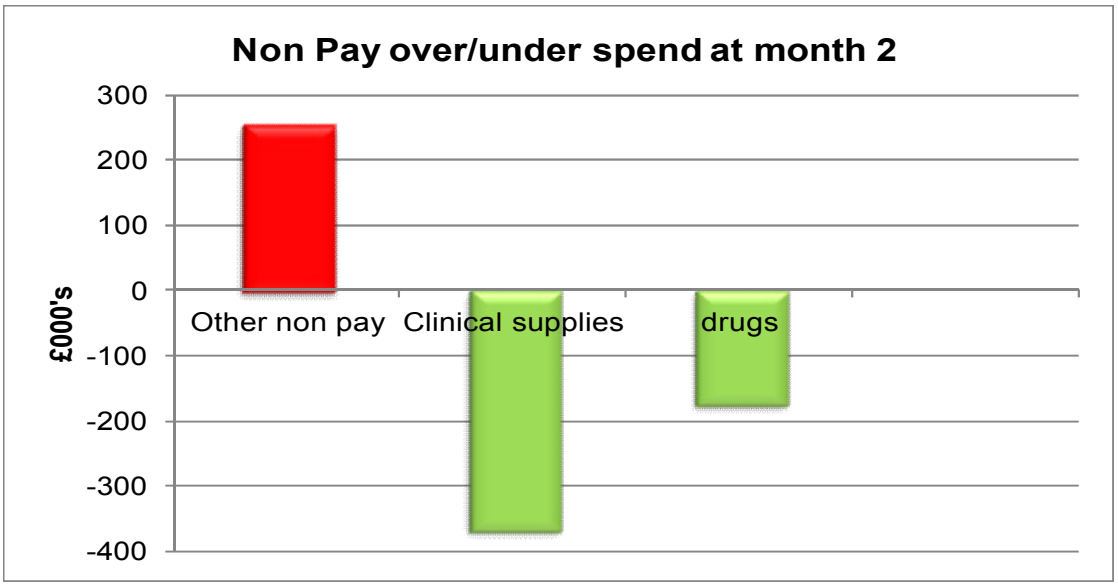
Key Issues on pay

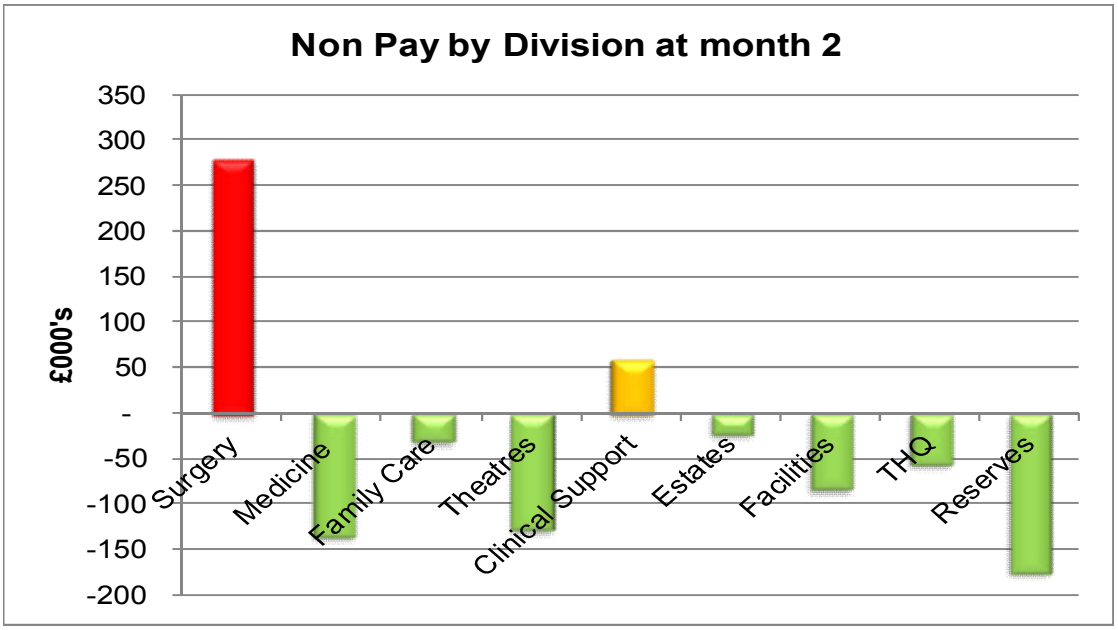
- WTE numbers as at month 2 are 4,700, a reduction of 13 WTEs compared to the previous month.
- Agency spend to May 2016 was £936k against a budget of £938k.

Key Actions on Pay

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

Appendix 5





Key issues on non-pay

- Drugs are £173k underspent against plan.
- Clinical Supplies is underspent by £366k due largely to reduced clinical activity using contract excluded devices such as Paediatric Sleep Suits, Vascular and Metal Stents which are offset with an under recovery with Clinical Income to date.
- Other Non Pay is over spent by £262k due largely to unidentified 'Stretch CIP' to date.

Key actions on non-pay

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

Appendix 6

CIPs Performance

Overall Financial Position & CIP Position - Month 2

	Surgery	Theatres	Medicine	Family Care	Clinical Support	Estates	Facilities	THQ Division	THQ Corporate	Total
Divisional CRP's 16/17 £000's	-3,888	-460	-4,289	-1,316	-1,574	-402	-531	-861	-1,679	**-15,000**
Plan to date £000's	-477	-49	-460	-163	-229	-36	-89	-155	-161	**-1,818**
Actual to date £000's	-254	-98	-419	-10	-312	-16	-83	-144	-433	**-1,769**
Variance 16/17 £000's	223	-49	41	153	-83	20	6	10	-272	**49**
Variance %	-47%	99%	-9%	-94%	36%	-55%	-6%	-6%	168%	-3%
Financial Position Plan to date £000's	-4,131	239	-2,087	195	833	1,871	1,607	2,906	588	**2,020**
Financial Position Actual to date £000's	-3,338	8	-2,146	303	487	1,867	1,542	2,849	199	**1,771**
Financial Position Variance to date £000's	794	-232	-58	108	-346	-4	-65	-57	-389	-249

Key Issues with the CIP

To the end of May the planned savings are £1,818k actual savings for the period are £1,769k.

Headline CIPs

- A number of one off short term financial benefits held in 'corporate' are supporting the current CIP deliver position.
- The plan to date for Medical Staffing costs was £93k against actual savings delivered of £77k and hence an under delivery of £16k to May 2016.
- Bed Hire contract savings are break even to plan to date.
- Medicine's closure of Ward F61 and relocation to Ward D42 savings are break even to plan to date.

CIP - original Annual Plan vs. actual delivery plan today

	Identified Plans	Procurement Plans	Stretch Target	Total per APR	This is as per Monitor Plan to Month 2 £	Actual to Month 2 £	Variance £
Revenue Generation	1,000			1,000	140	70	-70
Pay	4,757		2,743	7,500	844	1,054	210
Clinical Supplies	1,535		965	2,500	321	376	55
Drugs	927		573	1,500	173	38	-135
Other Non Pay	2,069		431	2,500	341	231	-110
Depreciation				0			0
Total £	**10,288**	**0**	**4,712**	**15,000**	**1,818**	**1,769**	**-49**