CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

There will be a meeting of the Board of Directors 'In Public' on
Thursday, 30 November 2017 at 3.30pm
in the Board Room, Sunderland Eye Infirmary

AGENDA

1.	**Declaration of Interest**		
2.	**Minutes**		
Item 1	To approve the minutes of the Board of Directors meeting held 'In Public' on Thursday, 28 September 2017		**Enc 1**
	Matters Arising		
	Item 2 GDE Fast Follower	**KWB**	
	Item 2 Clinical Service Review	**KWB**	
3.	**Standard Reports**		
Item 2	Chief Executive's Update	**KWB**	
Item 3	Quality Risk and Assurance Report	**MJ**	**Enc 3**
Item 4	Finance Report	**JP**	**Enc 4**
Item 5	Performance Report	**AK**	**Enc 5**
4.	**Strategy / Policy**		
Item 6	Learning from Deaths Dashboard	**ICM**	**Enc 6**

Date and Time of Next Meeting

Thursday, 25 January 2018 in the Board Room, Sunderland Eye Infirmary

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Minutes of the meeting of the Board of Directors held in public on Thursday, 28 September 2017.

Present:
Stewart Hindmarsh (SN) – Non Executive Director/Vice Chairman
Alan Wright (AW) - Non Executive Director
David Barnes (DB) – Non Executive Director
Mike Laker (ML) – Non Executive Director
Pat Taylor (PT) – Non Executive Director
Paul McEldon (PMcE) – Non Executive Director
Julia Pattison (JP) – Director of Finance
Peter Sutton (PS) – Director of Strategy and Business Planning
Paul McAndrew (PMcA) – Acting Medical Director

Apologies:
John Anderson (JNA) – Chairman
Ken Bremner (KWB) – Chief Executive
Ian Martin (ICM) – Medical Director
Sean Fenwick (SF) – Director of Operations
Melanie Johnson (MJ) – Director of Nursing and Patient Experience
Carol Harries (CH) – Director of Corporate Affairs and Legal/Trust Secretary

In Attendance:
Andrea Hetherington, Deputy Head of Corporate Affairs (AH)
Alison King, Head of Performance and Information Management (AK)
Kath Griffin, Director of HR and OD (KG)

1. DECLARATION OF INTERESTS

Executive Directors declared an interest in STFT.

2. MINUTES

Item 1 Minutes of the meeting held 25 July 2017

Accepted as an accurate record subject to the date being corrected to read "*Tuesday 25 July 2017*".

Matters Arising

None.

3. STANDARD REPORTS

Item 2 Chief Executive's Update

- **Vascular Services** – JP reminded colleagues on the discussions with Durham regarding CHSFT taking on the vascular service from 2018. She advised that there had been a lot of activity around repatriation of patients and the teams were now working towards implementation of 1 April 2018.
- **STP** – JP advised that as the publication last year of the regional STP was in draft form, it had been agreed to publish a final version in the New Year. Discussions were also taking place around the pathology network for the North East and whether to have two or three pathology services across the region. JP reminded the Board that CHSFT and STFT were already part of a local network as a result of pathology services by Gateshead. It was noted that CHSFT provides the IT infrastructure into Gateshead so longer term it will be important to maintain an interest whatever happens.
- **GDE Fast Follower** – JP reported that STFT had had a visit from NHS Digital and there was now a requirement to progress with a business case in order to support its application for fast follower status. JP confirmed KWB would keep the Board updated.
- **Clinical Service Review Update** – JP informed the Board that the Joint Health Overview and Scrutiny Committee (JHOSC) had met a couple of weeks ago where they had received evidence from local and national experts in the areas under consultation. They were broadly supportive of the direction of travel and indicated the options being put forward were credible ones. JP explained that there had been a pause in the consultation events over the summer period but the remainder of events were now taking place again. She reported that a special session on transport had been arranged to specifically discuss the concerns which had been raised at some of the events. AW commented that he understood that one of the South Tyneside MPs had called for the consultation process to be halted however there were no legal grounds for this at this stage**.** PS confirmed that the JHOSC had taken legal advice which had confirmed that was the case, however it was possible this would be raised again at the end of the consultation. PT asked when consultation formally ended and PS confirmed midnight on 15 10 17. SH asked about the next phase and PS confirmed that the original Phases 2 and 3 will be brought into one Phase Two.
- **Visit by Secretary of State for Health** – JP informed the Board that the Secretary of State for Health, Jeremy Hunt, was due to visit the Trust later in the afternoon. He would also be visiting STFT and a number of other Trusts in the region over a two day programme. The purpose of the visit was for the SoS to talk to a range of staff at a special lecture on patient safety.

Item 3 Quality, Risk and Assurance Report

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

PMcA reported that in terms of pressure ulcer prevention, there was an improving position with a decrease in the number of hospital developed pressure ulcers reported in the month of July. He advised that MJ was undertaking some work to align the Pressure Ulcer Review Panel across both CHSFT and STFT and the TV Team was doing further work to track and record the origin of the acquired pressure ulcers (eg nursing home, residential home etc). ML queried the use of the term

‘acquired’ pressure ulcer as they were all technically acquired and PMcA advised that this was the terminology set by NHSE.

PMcA highlighted the number of safeguarding children referrals and specifically noted the increase in referrals within Maternity due to an increase in pregnancy booking whereby siblings were already known to the safeguarding system. It was noted that a full-time Assistant Director for Safeguarding Children and Adults had been in post since 1 August. In terms of Deprivation of Liberty referrals, PMcA advised that the number of referrals had fallen in July and he suggested that this may be due to a recent high court decision around critical care patients. He reassured the Board that the process around DoLs was robust in the Trust.

With regard to complaints, it was reported that there were no complaints awaiting a first response of more than 60 days. SH asked for clarification regarding the first response and PMcA confirmed this was not an acknowledgement but a response to the complaint following investigation.

PMcA informed Directors that the nursing workforce reflected the national picture in terms of difficulties in recruitment, however MJ and her team had done a significant amount of work to try and improve the position. With regard to the care hours per patient per day table within the report, PT asked whether 7.9 was a good figure and PMcA said this was simply an indicator of number of hours rather than a rating, adding that the Trust staffed wards based on number of patients rather than the level of care.

PMcA reported that the number of incidents reported had reduced in July compared to the previous month. He said there was an unacceptable number of outstanding or delayed RCAs however this was being more actively addressed. He advised that the process was being reviewed in order to obtain more information quickly following an incident in order to make better decisions about commissioning of RCAs. AW noted the report indicated that one of the reasons for a reduction in incidents reported could be due to CHoICE incidents no longer being recorded as CHSFT incidents but it was still important to understand these incidents. PMcA agreed and confirmed that incidents relating to sub-contracted services were monitored. With regard to serious incidents, PMcA was pleased to report an improving position and advised that there was now clinical input into the serious incident panel at the CCG which would be helpful in terms of clarifying clinical aspects of the RCAs. There were 12 patient safety incidents reported in July with two meeting Duty of Candour requirements.

PMcA informed the Board that there had been no new cases of MRSA in July or August but there had been a case of C-difficile in August bringing the year to date position of 12 against an annual target of 34.

Resolved: To accept the report.

Item 4 Finance Report

JP presented the report which provided the Board with an update on the Trust’s the financial position as at the end of August 2017. She reported the overall financial position excluding STF funding to be behind plan at £2.084m which meant the Trust failed its control total and had missed out on additional STF funding of £2.617m.

Pay expenditure was £77k underspent against plan, mainly relating to increased agency spending of £2.432m. She advised that this was significantly higher than the same period last year (£2.005k) and expressed concern that the Trust was only £100k below the ceiling set by NHSI in terms of agency spend and it would be important to keep an eye on that. PT asked whether there were additional penalties if the ceiling was breached and it was clarified that there was not however it would impact on the Trust's financial risk rating. It was noted that the use of NHSP in the Trust had now been extending the medical workforce as well as nursing.

With regard to non-pay, JP reported an overspend of £1.780m mainly as a result of drugs and offsite CT and MRI scans sent to third party providers as a result of radiography capacity at the Trust. JP confirmed that all the areas of overspend highlighted in the report were being looked at in further detail. In response to a question from PT, JP clarified that the £43k overspend on interest related to the loan from the FTFF.

In terms of the CIP position, JP was pleased to report that this had improved from last month to £316k under-delivery behind plan.

JP advised that the forecast continued to increase however at this point she believed the Trust could achieve the required control total for 2017/18. She confirmed that whilst the Trust was working closely with all commissioners to understand their QIPP plans and the impact of income reductions, she felt it was important to highlight this as a risk if costs could not be removed in mitigation. DB confirmed that the Finance and Performance Committee was recommending to the Board that the control would be met.

JP advised the Board that next month's paper would include options on 'closing the gap' following discussions at Finance and Performance Committee.

Resolved: To accept the report.

Item 5 Performance Report

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

She reported that performance against the A&E 4 hour target had been 95.67% in August which was above both the national target and the STF trajectory. This performance had moved the Trust into the top 25 % nationally which was a significant achievement given the increasing number of attendances. AK commented that unfortunately increased pressure so far in September was evident. ML asked whether August was always a better month in terms of performance for the Trust. AK replied that historically it was not and indeed the 4 hour target had not been met in August since 2012/13. AK suggested that the main reason for pressures around this target in August was due to the junior doctor change. The improvement in ambulance handover time was noted and ML commented that this had started before the new ED was opened. AK agreed and confirmed the team had been working with NEAS on improving handover before the new unit opened. SH suggested that new procedures had been put in place in anticipation for the opening in May which was subsequently delayed. The Board acknowledged it was good to see the synergy between new systems/processes and new facilities/environment resulting in improved patient experience.

Cancer performance was noted to be achieved for all standards with the exception of 31 day waits for subsequent surgery as a result of two breaches in Urology. AK said cancer performance continued to be a risk and would be monitored closely. She advised that there had been an increase in two week referrals in lung which had been flagged to the clinical team and an increase in upper GI patients waiting over 62 days due to complex pathways. It was likely therefore that an increase in 62 day breaches in those tumour groups would be seen in the next few months, indicating that for September it was likely to be <85%.

Diagnostics performance was reported to be above the 1% standard and the agreed recovery trajectory with NHSI at 2.4%. AK reminded the Board that this increase had been predicted in last month's paper and was a consequence of breaches in neurophysiology and respiratory physiology. Predicted performance for September shows this to be improved.

AK reported that unfortunately the August STF funding of £185k relating to A&E would not be received due to the financial control total not being met.

Resolved: To accept the report.

4. STRATEGY/POLICY

Item 6 Freedom to Speak Up Guardian Annual Report

KG presented the report which outlined progress to date with the development of Freedom to Speak Up within the Trust. She reminded the Board of the background as to why it was introduced, advising that she had taken on the role of Guardian for the Trust in 2016 and in May this was strengthened with the appointment of nine Freedom to Speak Up Ambassadors and SH as NED lead.

KG reported that since the launch and promotion of the roles in May and June there had been four concerns raised – two with ambassadors and two with the guardian. She drew the Board's attention to the nature of those concerns and explained that two were being dealt with via internal investigation, one was subject to investigation by Counter Fraud and the other was to be returned to the directorate for the senior manager to address. KG clarified that the other ways to raise concerns were still available to staff.

KG reported that nationally over 140 cases had been referred to the national guardian and it was possible for individuals to go directly to the national guardian if they so wished. KG had not been notified of any national referrals from Trust members of staff.

KG reminded the Board of some of the 2016 staff survey results relating to raising concerns, feeling confident and secure in reporting unsafe clinical practice etc, in that the Trust was ranked in the best 20 %. She commented that this was excellent however the Trust must not become complacent and the need to raise the profile of the Freedom to Speak Up Guardian and Ambassadors was important.

KG outlined the next steps including a series of planned 'walkabouts' for the guardian and ambassadors as well as a visit from the national Freedom to Speak Up Guardian.

PT asked how widely the Freedom to Speak Up poster had been circulated and KG confirmed this had been Trust-wide with physical copies in most departments, publication on the intranet and inclusion in Team Brief. PMcE asked whether this was included in the induction programme and KG explained this was the intention, along with information in the staff handbook which is given to all new employees.

In response to a query from SH it was confirmed there was a regional network of guardians where ideas could be shared and benchmarking undertaken.

Resolved: To accept the report.

Item 7 Assurance Framework 2017/18

JP briefly presented the paper and reminded the Board that this was a retrospective look at risks from 2016/17 and also a look forward to 2017/18. In particular she highlighted the key amendments to the document.

The inclusion of a new risk around the impact of the Executives working across the Group was noted and PT clarified that this had been included at the request of Governance Committee. PT asked JP to ensure the key controls, assurance, gaps in control and gaps in assurance columns were completed for this entry.

Approved: To approve the Assurance Framework for 2017/18.

Item 8 Safeguarding Children and Looked After Children Annual Report 2016/17

MJ explained that this report had been presented to Governance Committee and was presented to the Board for information. The report was received. ML commented upon some of the legends within the document, in particular a disconnect between a legend's use of numbers and the text referring to percentages. PMcA agreed to pick this up.

Resolved: To accept the report.

Item 9 Audit Committee Report 2016/17

Report received.

Item 10 Mortality Review and Learning from Deaths Policy

Report received.

STEWART HINDMARSH
VICE CHAIRMAN

AH/bodmins/280917

Enclosure 3

SOUTH TYNESIDE AND SUNDERLAND HEALTHCARE GROUP

DIRECTORATE OF NURSING & PATIENT EXPERIENCE

BOARD OF DIRECTORS

NOVEMBER 2017

QUALITY, RISK AND ASSURANCE REPORT (SEPTEMBER 2017)

EXECUTIVE SUMMARY

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

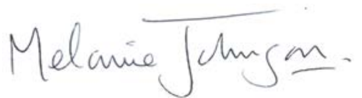
This report provides a summary of the key issues considered in more detail by the Governance Committees (and its subgroups the Clinical Governance Steering Groups and Corporate Governance Steering Group) and also information from the Patient, Carer and Public Experience Committee (PCPEC). It includes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

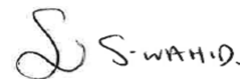
SUMMARY OF KEY RISKS

1. Nurse staffing vacancies as we move into the winter period (CHSFT/STFT)
2. Increasing number of pressure ulcers in STFT acute (STFT)
3. Low levels of incident reporting (STFT)

RECOMMENDATION

Directors are asked to note the report.





MELANIE JOHNSON
Director of Nursing & Patient Experience

IAN MARTIN
Medical Director (CHSFT)

SHAZ WAHID
Medical Director (STFT)

City Hospitals Sunderland
NHS Foundation Trust

South Tyneside
NHS Foundation Trust

Quality, Risk and Assurance Report
for September 2017

PATIENT STORY
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

CHSFT:

The Trust received a letter from a patient complimenting Melanie Robertson, Nurse Consultant – Cancer Services, for the care and compassion shown to her during her treatment for breast cancer. The letter stated:

"I was diagnosed with breast cancer at the age of 34 years old, nearly three years ago and so far I'm doing well after my treatment. I would just like to offer a very big compliment to Melanie Robertson (Oncology Nurse) she has been fantastic with me, after a few months of my diagnosis we lost the lovely breast care Nurse Michelle Derbyshire who was excellent and I relied on her a lot.

When I no longer had a breast care Nurse I became very frightened and felt alone, this resulted in me becoming obsessed with examining my breast 100-150 times per day. Leaving myself very sore and bleeding, until I had an oncology appointment with Melanie. She was amazing from the start giving me lots of time and reassurance; I could ring Melanie whenever I was unsettled and had a worry and she would always ring me back and ask me to pop down the hospital even though she is very busy in her job with her clinics and Phoenix Unit.

Melanie helped me organise counselling and a psychologist to help me but I still wasn't making any real progress so Melanie came up with a plan where I could see her once a month and to ring her anytime if I had any concerns, when I was ready after about 6 months Melanie moved me to 6 weekly appointments then 8 weekly, 3 monthly and now I'm trying the 6 monthly appointments. But Melanie said I can ring her anytime if I have any concerns. I can't believe I have got this far and have my life back, this is all down to Melanie. I cannot thank this lady enough for all her time, patience and understanding of me.

I just wanted to share my story and recognise her for her amazing work I would not have got this far without Melanie's help and support, I'm eternally grateful".

The letter has been forwarded to Melanie Robertson

STFT:

A compliment was received from a mother regarding the care and treatment received by her 34 year old daughter with learning disabilities. She said "My daughter has a learning disability and on 22 June it was necessary for her to be admitted as a day patient for some dental treatment requiring an anaesthetic. I would like to give you some positive feedback on the experience we had."

The lady continued to describe the good service that had been received saying "The service provided was exceptional. The Learning Disabilities Dental Team, led by Julie Fitzgerald, the staff of ward 4, the anaesthetist and theatre team all gave specialist, individualised and compassionate care which made a normally traumatic experience for my daughter and myself so much better.

She was unfortunately unable to recall the name of the anaesthetist, even though he had introduced himself to them, but said "He listened to my concerns and was very considerate." She continued to say "Mark carried out the dental work and he was also so compassionate and professional."

She also said "I cannot fail to mention Pauline Henry, the Learning Disabilities Liaison Nurse, who was extremely gentle, supportive and empathetic. Her professionalism was exemplary and she is a great asset to the service – if only I could have had her in the past."

She ended by saying "My daughter is 34 years old and is frequently difficult to manage in a clinical environment, but thanks to each and every member of a very dedicated team she is safely back at home following completion of her treatment. I would appreciate it if my views could be shared with members of the management team with my very grateful thanks to everyone involved."

PRESSURE ULCERS
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.1 CHSFT and STFT HEALTHCARE DEVELOPED PRESSURE ULCERS (HCDPUs)

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

Ward Dashboard data for September 2017 - CHSFT

In September, CHSFT reported 18 HDPUs (Hospital Developed Pressure Ulcers (PUs), which is a decrease from last month. 17 patients developed a HDPU, as one patient had two PUs. One additional patient developed a category 3 PU in September, but this is currently awaiting review by the Trust's Pressure Ulcer Review Panel (PURP) to ascertain if all the requisite assessments and preventative strategies were in place in order to make a judgement regarding avoidability.

Ward & Community Dashboard data for September 2017 – STFT

In September, STFT reported a total of 67 HCDPUs across acute and community services. This is an increase from the 54 reported last month. There were 23 HDPUs reported compared to the 19 reported in August. 14 patients developed one PU, two patients had two PUs and one patient developed five PUs. This case is awaiting review by the Trust's Pressure Ulcer Review Panel (PURP) to ascertain if all the requisite assessments and preventative strategies were in place in order to make a judgement regarding avoidability. One ward reported a total of 14 developed pressure ulcers this month and improvement actions by the Ward Manager and Matron are being supported by the Tissue Viability Team.

For community services, 44 Community Developed PUs (CDPUs) were reported in September which is an increase from the 35 reported last month. 30 patients developed one PU, four patients developed two PUs and two patients developed three PUs. Work is still underway with the STFT data extraction from the incident reporting system "Datix" to include 'numbers' of reported PUs rather than by incident form submission. Previous data extraction reports have not included numbers of multiple PUs described within one report so again this has been factored in this month and may account in part for the increase.

CHSFT - Numbers of Hospital Developed Pressure Ulcers (HDPUs) by category for September 2017:

Severity	Number of HDPUs
Category 2	18
Category 3	0
Category 4	0
Total	**18**

STFT - Numbers of Hospital (HDPUs) and Community (CDPUs) Developed Pressure Ulcers by category for September 2017:

Severity	Number of Acute (HDPUs)	Number of Community (CDPUs)
Category 2	23	40
Category 3	0	4
Category 4	0	0
Total	**23**	**44**

1.2 ACQUIRED PRESSURE ULCERS (APUs)

Acquired Pressure Ulcers (APUs) are PUs which are either present on admission to hospital or develop within 72 hours (three days) of admission or allocation to a Community District Nurse caseload. The pre-existence of a PU renders these patients as high risk of developing further PUs or suffering deterioration of their existing PU whilst in hospital or at home under the care of District Nursing services, hence proactive preventative strategies are required for these patients to prevent this.

CHSFT

Within CHS, APUs are reported as an incident and the data is reviewed by the Nursing & Patient Experience team. These figures include all categories of APUs.

Total number of APUs per month October 2016 to September 2017:

Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17
161	240	225	271	231	198	187	177	165	153	168	129

STFT

Within STFT, APUs are reported as an incident via the Datix system. These figures include all categories of APUs.

Total number of APUs per month October 2016 to September 2017:

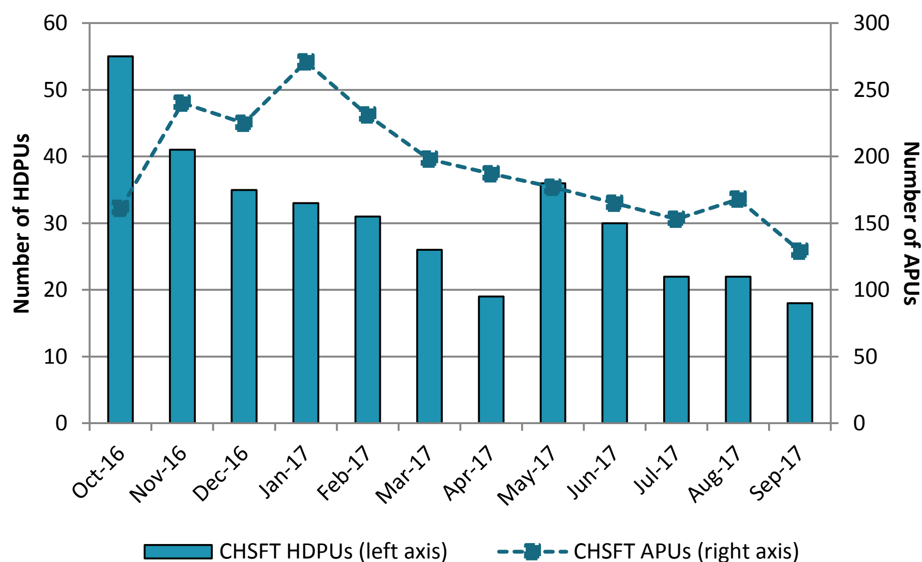
Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sep 17
106	120	122	142	139	123	180	155	135	140	140	132

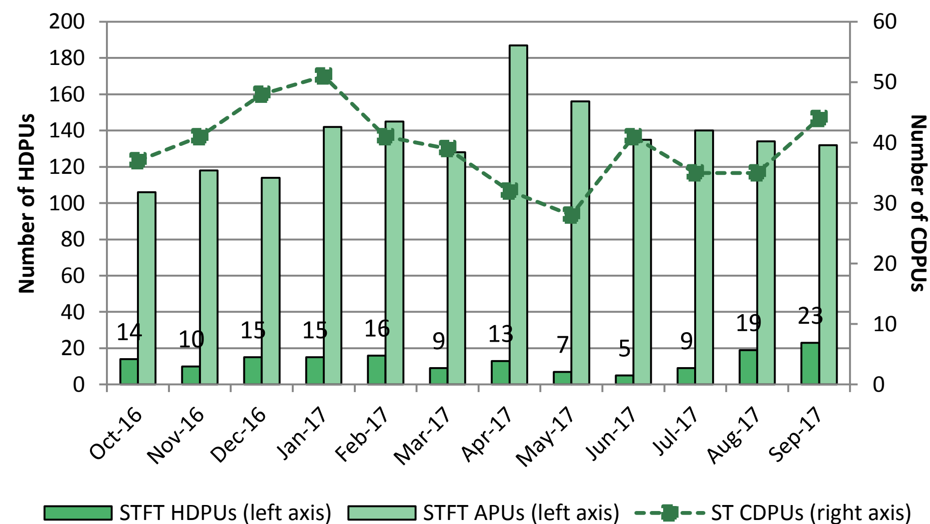
PRESSURE ULCERS (continued)
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.2 ACQUIRED PRESSURE ULCERS (APUs) (continued)

Figure 1 shows numbers of HDPUs (left axis) and APUs (right axis) for CHSFT for the period October 2016 to September 2017.

Figure 2 shows numbers of HDPUs (left axis) and the number of CDPUs (right axis) for STFT for the period October 2016 to September 2017.





Definitions

Acquired Pressure Ulcers (APUs) are existing pressure ulcers that a patient already has when they present to our Trusts (either acute or community services) or which develop < 72 hours of admission to hospital or DN caseload. They apply to both CHSFT and STFT.

Healthcare Developed Pressure Ulcers (HCDPUs) are pressure ulcers that developed in our care (either acute or community services). These comprise:

- ***Hospital Developed Pressure Ulcers (HDPUs)*** are pressure ulcers that patients develop whilst in hospital or > 72 hours following admission). They apply to both CHSFT and STFT.
- ***Community Developed Pressure Ulcers (CDPUs)*** are pressure ulcers that develop when a patient is on a Community District Nursing Caseload. They apply to patients who receive weekly or more visits from the District Nursing service and do not reside in residential care (as the care provider is then deemed to be responsible for the care delivery). They only apply to STFT.

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

1.3 TRUST PERFORMANCE AGAINST IMPROVEMENT TRAJECTORY

CHSFT

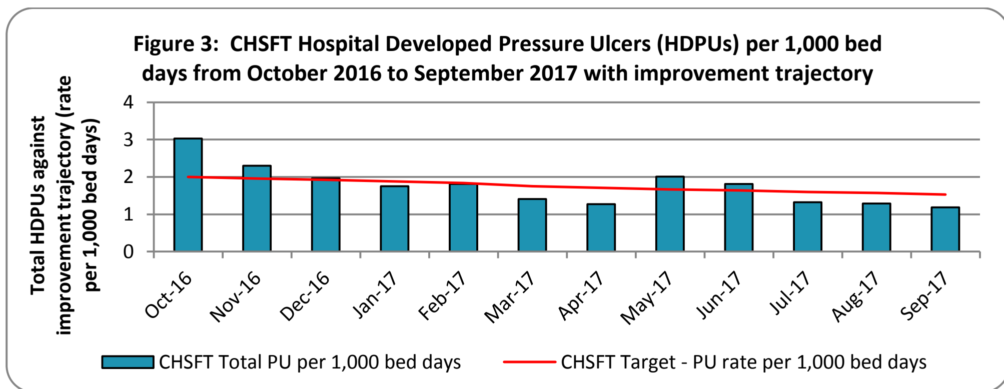
The number of HDPUs per 1,000 bed days has decreased from 1.29 in August to 1.19 this month. Figure 3 shows the number of HDPUs per 1,000 bed days, together with the improvement trajectory which indicates that we remain well on track with our target for this year. The highest incidence of HDPUs this month occurs within Medical Specialties and General Surgery.

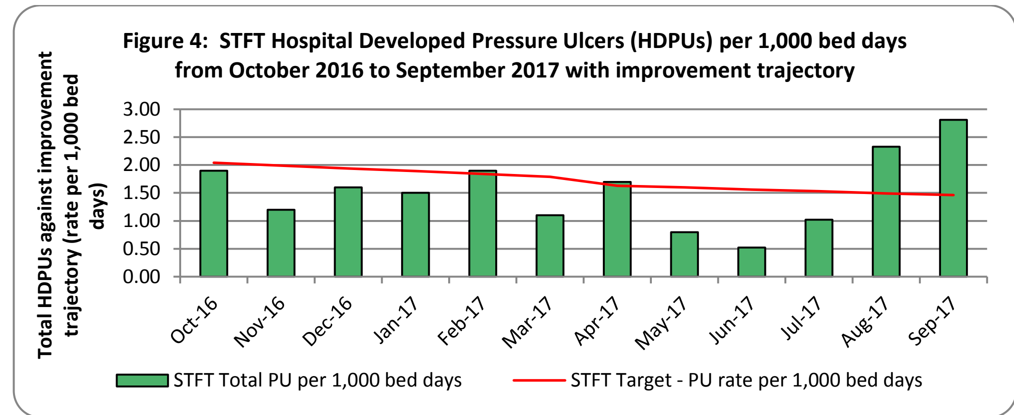
As part of a regional collaborative to reduce PUs, CHSFT has commenced a pilot in conjunction with North East Ambulance Service (NEAS) to identify patients at risk of PUs prior to their admission to hospital. Following a brief assessment by paramedics, those patients identified as being at risk who are admitted via ED will have a green "pressure ulcer risk" alert bracelet applied. This will highlight this risk at the outset and prompt our nursing teams to complete the CHS Pressure Ulcer Risk Assessment as soon as possible (N.B. all patients admitted to hospital must have their PURA completed within six hours of admission).

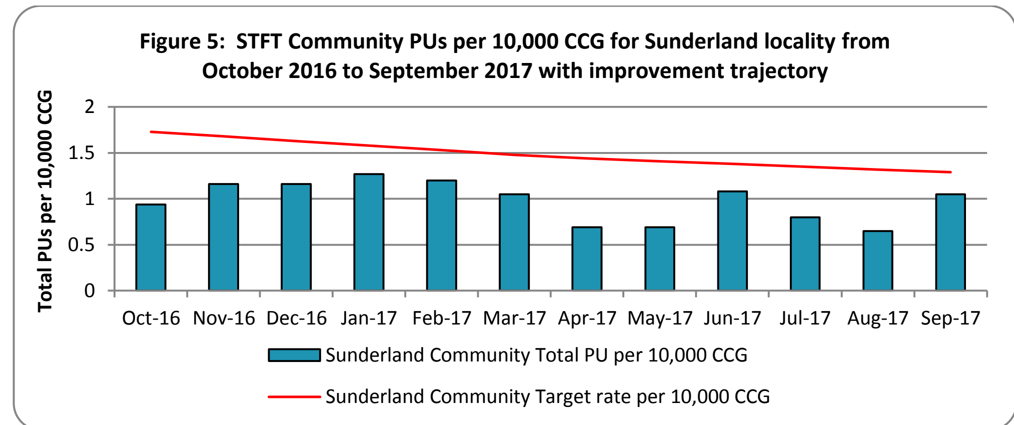
STFT

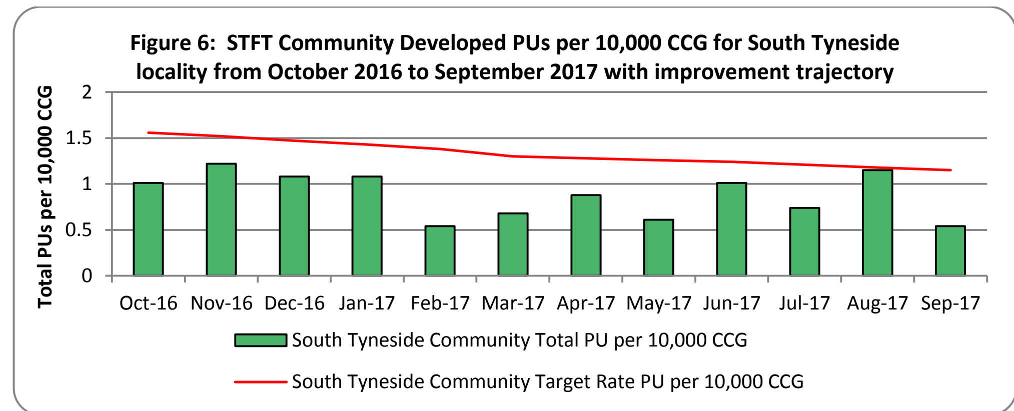
The number of HDPUs per 1,000 bed days has again increased from 2.33 in August to 2.81 in September. Trauma and Orthopaedics has the highest incidence with 14 developed PUs. Improvement actions have been identified by the Matron and Ward Manager and clinical placements have been undertaken by the Tissue Viability team to scrutinise practice and target education and training. Daily SSKIN validation audits have also been undertaken to ensure all preventative actions and strategies are in place.

Figure 4 shows the number of HDPUs per 1,000 bed days, together with the improvement trajectory. Figures 5 and 6 show the number of CDPUs per 10,000 CCG population with improvement trajectory for the Sunderland and South Tyneside localities (STFT). In August the rate of CDPUs developed in our care per 10,000 CCG population was 0.65 for Sunderland (figure 5) and 1.15 for South Tyneside (figure 6). The rate for September has increased for Sunderland to 1.05 and decreased for South Tyneside to 0.54. Both community localities remain well on track with their target for this year.









SAFEGUARDING CHILDREN
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.4 SAFEGUARDING CHILDREN

CHSFT

Figure 7 shows the breakdown of safeguarding children referrals from CHSFT. In comparison to last month, total referrals have increased by 12.

Referrals within Maternity have increased by six with the total number of pregnancy bookings being 262, of which 16% (42) resulted in a referral to Children's Services compared to 11% last month. The reasons for referrals are predominantly previous involvement with Children's Services, with the "toxic trio" being the common denominator (the toxic trio is a term used to describe the issues of domestic abuse, mental ill-health and substance misuse which have been identified as common features of families where harm to children has occurred).

Adult Emergency Department has seen an increase of four referrals compared to the previous month. The themes continue to be parents attending with substance misuse, mental health issues or domestic abuse.

Referrals from Paediatric ED (PED) have remained consistent over the past six months with between seven and nine referrals each month. These referrals are associated with adolescents with mental health issues and young children with non-accidental injuries.

STFT

Figure 8 shows the breakdown of safeguarding children referrals from STFT. In comparison to last month, there has been a decrease in total of three referrals across community services: Sunderland increased by three, South Tyneside decreased by one and Gateshead decreased by five. The themes for the referrals are due to physical, neglect and sexual abuse.

The total referrals from Acute Services have seen an increase of six referrals from last month from all areas. Parents' presentation with mental health, domestic abuse and substance misuse continue to be the reasons for referrals, with an exception of one whereby a child assaulted the parent. The slight increase (two) from Paediatric ED was due to adolescents presenting with substance misuse.

Maternity referrals have decreased by two compared to eight the previous month with the total number of pregnancy bookings (106) of which 5.7% (six) resulted in a referral to Children's Services, compared to eight last month.

CHSFT & STFT

Work is ongoing to align safeguarding data to organisational activity to ensure proportional data across STFT and CHSFT. It is anticipated this will be available for October.

Figure 7: CHSFT Safeguarding children referrals October 2016 to September 2017

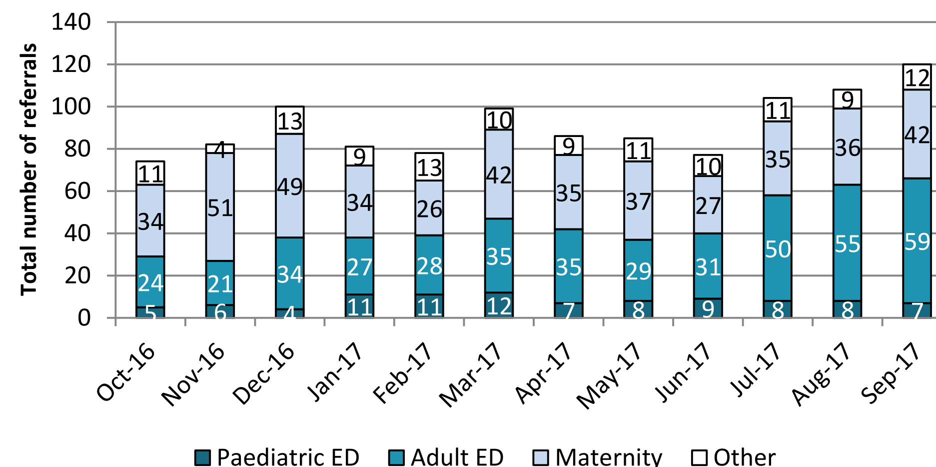
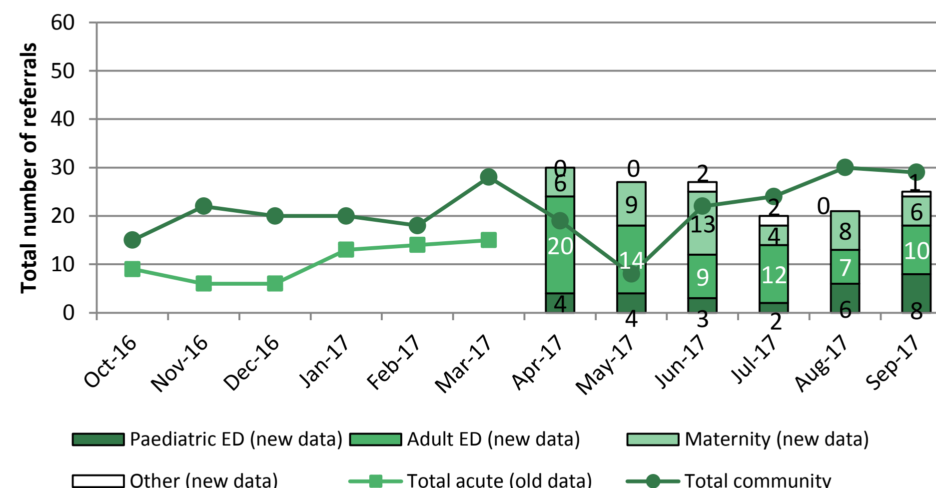


Figure 8: STFT Safeguarding children referrals October 2016 to September 2017



SAFEGUARDING ADULTS
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.5 SAFEGUARDING ADULTS

Referrals

CHSFT

Figure 9 demonstrates the breakdown of referrals from CHS. In comparison to last month, there is a decrease of seven referrals. The Adult Emergency Department submitted eight referrals (a decrease of seven from last month), with the remaining referrals being made by wards (10 referrals), Allied Health Professionals (two referrals) and the Elderly Care Nurse Practitioner (one referral). The categories of abuse reported refer to neglect, self-neglect, physical abuse and domestic abuse. Three CHS referrals noted that the patient had pressure damage due to either neglect (one case) or self-neglect (two cases). These three referrals will also be included in the Patient Safety team pressure ulcer QRA report as either an Acquired (two cases) or Developed (one case) Pressure Ulcer.

STFT

Figure 10 demonstrates the breakdown of referrals from STFT acute and community services. Within STFT acute services, a total of 18 referrals were made, a decrease of 14 referrals in comparison to last month. The reason for this is unknown. The Adult Emergency Department submitted 14 referrals (10 less than last month), with the remaining acute Trust referrals being made by wards (three referrals) and Radiology (one referral). The categories of abuse reported refer to neglect, self-neglect, physical abuse and domestic abuse.

Within STFT community services, 34 referrals were made, an increase of nine from the previous month reporting. Gateshead community submitted seven referrals (increase of five), South Tyneside Community submitted 12 referrals (increase of two), and Sunderland Community submitted 15 referrals (increase of two). The District Nursing service was the main referrer, submitting 13 referrals. The categories of abuse reported refer to neglect, self-neglect, physical abuse and sexual abuse.

Five STFT referrals noted that the patient had pressure damage due to either neglect (three cases) or self-neglect (two cases). These five referrals will also be included in the Patient Safety team pressure ulcer QRA report as either an Acquired (four cases) or Developed (one case) Pressure Ulcer.

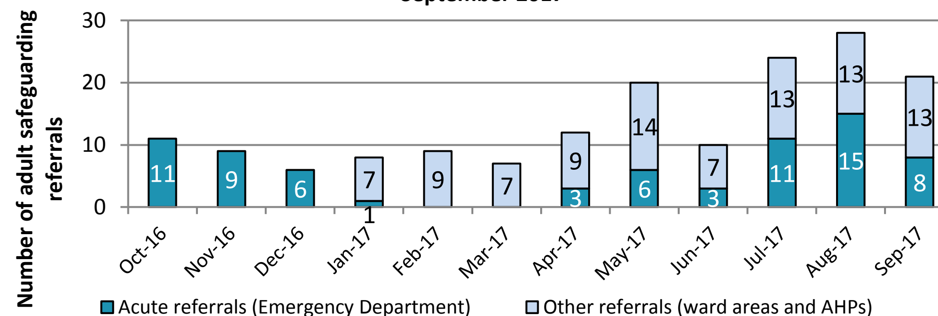
Mr John Clough gave an emotional and inspirational talk to over 70 staff from acute and community services on his personal experience of domestic abuse. His daughter Jenny Clough, a nurse working in ED at Blackpool Hospital was murdered after her shift in the car park by her ex- partner who was a paramedic.

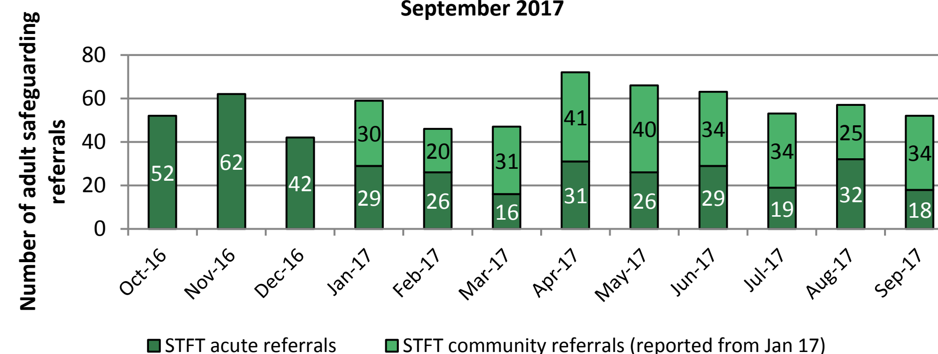
CHSFT and STFT

CHSFT and STFT have been requested to scope a further potential Domestic Homicide Review (DHR 4) in the Sunderland locality. Initial inquiry demonstrates that there is involvement from both CHSFT and STFT services.

A scoping for a further Safeguarding Adult Review (SAR) in the South Tyneside locality has also been requested. Initial inquiry also demonstrates involvement from both CHSFT and STFT services.

The Adult Safeguarding Team attend Multi Agency Public Protection Arrangements (MAPPA) panels across South Tyneside and Sunderland localities. In the Q2 reporting period, there were 21 MAPPA panels in Sunderland (a 14% increase compared to Q1 reporting where 18 panels were held). There have been seven MAPPA panels within STFT, a decrease from Q1 reporting, however, three of these panels were at Level 3. A level 3 panel requires senior management representation due to the high level of risk presented by the individual. MAPPA panel attendance continues to be reviewed at the Business meeting due to the increase in demand on the Safeguarding team to attend a panel and prepare a MAPPA report prior to attendance.





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

Mental Capacity Act: Deprivation of Liberty Safeguard (DoLS)

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

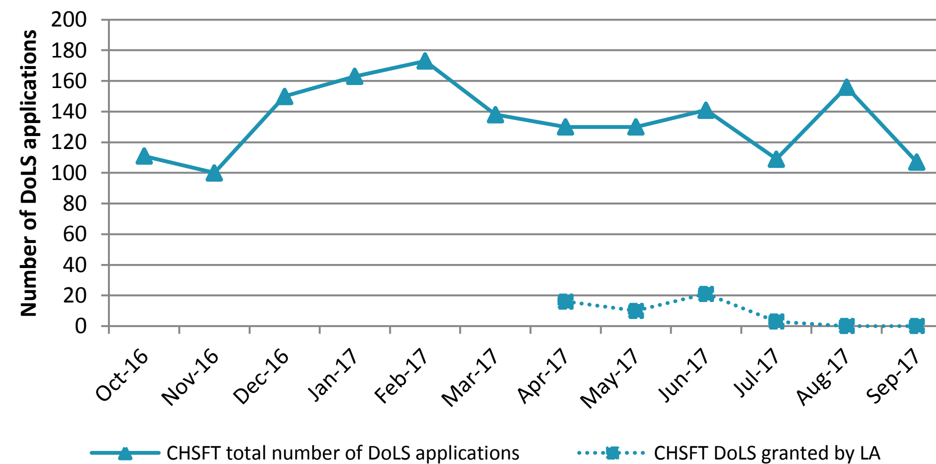
There were 107 DoLS applications submitted from CHSFT to the Local Authority (LA) in September, a decrease of 49 from the previous month's reporting. CHS is currently awaiting an outcome on 104 of these DoLS applications. One application was withdrawn and two applications were not approved as the patient regained capacity.

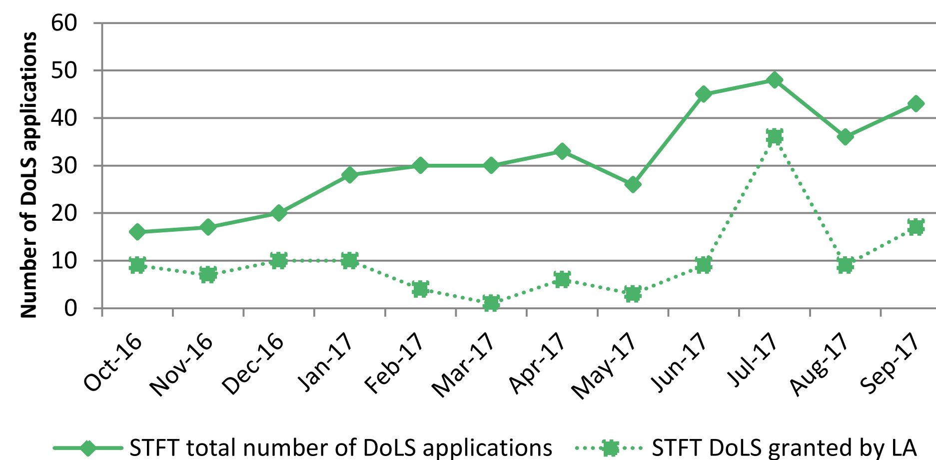
Figure 12 shows the number of DoLS applications made by STFT staff for the previous 12 months, together with the number of DoLS granted by the LA.

There were 43 DoLS applications submitted by STFT in September, an increase of seven from the previous month's reporting. 17 were approved, 18 were either withdrawn or not granted as the patient was either discharged or regained capacity. There are eight applications where a decision is still awaited.

There were no DoLS applications in either STFT or CHSFT in regards to patients aged 16-18 years.

The MCA/DoLS Advisor continues to engage with the LA to address the delays in notifications from both LA areas.





COMPLAINTS
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.6 COMPLAINTS

CHSFT

There were 24 complaints received in September, with a year to date average of 35 per month.

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

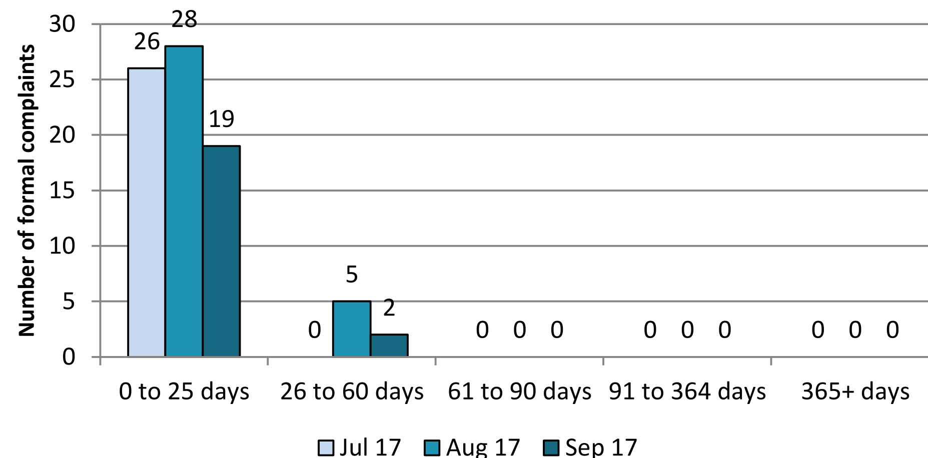
Figure 13 shows there are 21 formal complaints awaiting a first written response (by working days), compared to 33 last month. There are no complaints awaiting a first response for more than 60 days. This demonstrates that the significant improvements made in 2016/17 are being maintained. Performance is still being closely monitored through weekly meetings.

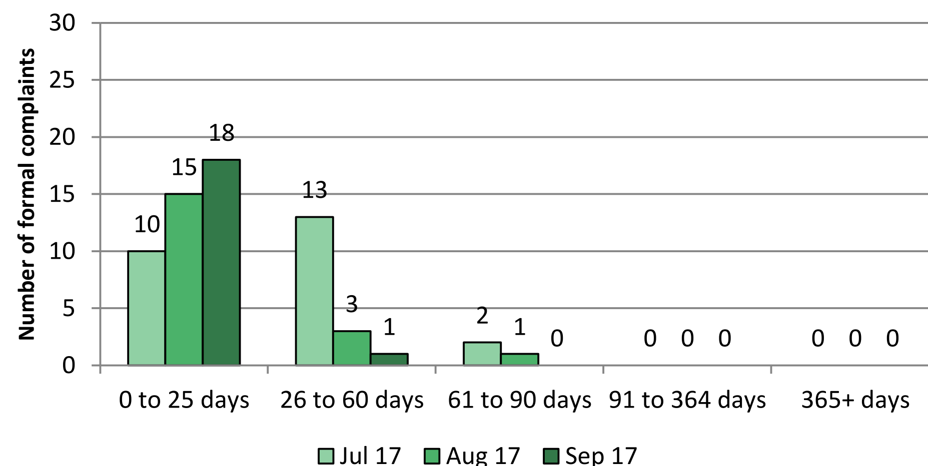
STFT

There were 21 complaints in September, with a year to date average of 13 per month.

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

Figure 14 shows there are 19 formal complaints awaiting a first written response (by working days). There is one complaint awaiting a first response for more than 26 working days compared to four complaints the previous month. This delay is due to the number of issues raised and the complexity of the case. The complaint outwith 25 working days has received a holding letter to notify the complainant of the delay. Performance is being closely monitored through weekly meetings and distribution of the weekly situation report.





NURSING WORKFORCE
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.7 NURSING WORKFORCE

National Indicators/Monitor Governance Indicators

During September there were no additional beds open on CHSFT and STFT. Agency spend at CHSFT was £14,158, an increase from August (£2,205). This was due to an increased demand for 1:1 nursing within Renal for a patient with mental health needs. At STFT, agency spend was £56,529, an increase from August (£39,715).

CHSFT

Fill rates and incident trends can be seen in figure 15. There were 13 wards in September with RN fill rates of less than 80%. The majority of these remain in the Division of Medicine, which continues to have the highest number of vacancies.

There were 43 incident forms relating to nursing and midwifery staffing, a decrease from September (72). There were 11 incident forms submitted by nine wards when RN staffing was below "trigger" numbers. This is a decrease from August (29). On all occasions the duty matron implemented the nurse staffing escalation plan and moved staff according to level of risk. The Division of Medicine have submitted the highest number of incident forms this month (24); this is in part due to long term sickness and vacancies.

Due to insufficient staffing D47 was required to close to admission overnight on 3 September (reopened morning duty 4 September), and closed again overnight on 23 September (reopened morning of 25 September). This was partly due to D47 having long term sickness and RN vacancies.

NHSP continues to provide support to wards to mitigate shortfalls. There were 19,172 hours supplied in September compared to 20,720 in August. In September, 57.1% of requests were filled compared to 57.8% in August.

At the end of September there were 84.61wte (5.28%) approved RN vacancies. This does not include 23.21wte who are currently undergoing pre-employment checks.

STFT

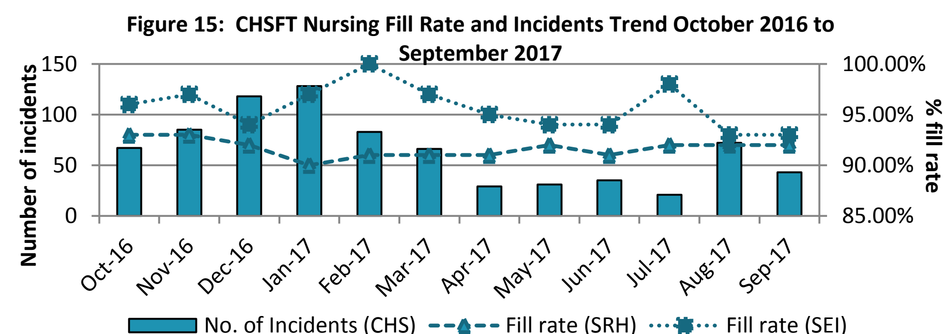
Figure 16 shows fill rates and incident trends. There were three wards in September with RN fill rates less than 80%:

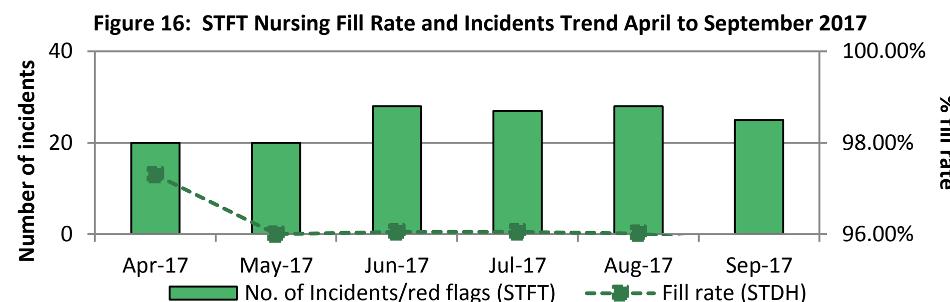
- Ward 6 - fill rate day duty 76.8%, currently have 1.78 RN vacancies.
- Primrose Ward (Ward 20) - fill rate day duty 77.9% and SCBU – fill rate 77.0%. Workforce review has been completed in both areas and work to align budgets will be completed by end of October.

In September there were 25 red flag/incidents relating to nursing and midwifery staffing (11 when staffing was below recommended). There were 21 occasions when a red flag (NICE guidance) was raised via health roster, indicating shortfalls in staffing or patient harms. These were not isolated to ward areas.

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

Vacancies at the end of September showed: Acute – 25.94wte (7.14%) RN vacancies and no HCA vacancies; Community – 60.36wte (7.63%) RN vacancies and 15.17wte (8.67%) HCA vacancies, broken down in figure 17.





Fill rates – September 2017

SRH	SEI	STDH	Monkton Hospital	St Benedict's Hospice
92.00%	93.00%	95.77%	100.98%	97.35%

Care Hours Per Patient Day (CHPPD) – September 2017

SRH	SEI	STDH	Monkton Hospital	St Benedict's Hospice
8.1	20.9	6.8	15.6	9.2

Figure 17: Community vacancies at the end of September 2017:

	District Nurse	HCA	Health Visitor	HCA	School Nurses	HCA	Urgent Care Team	Recovery at Home
Gateshead	N/A	N/A	0	2.33	8.6	1.15	N/A	N/A
South of Tyne	9.38	0	4.9	0.5	4.84	0.02	1.12 0.07	N/A
Sunderland	10.24	0.06	5.01	0.1	3.33	0.37	N/A	7.77

PATIENT SAFETY
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.8 INCIDENT REPORT

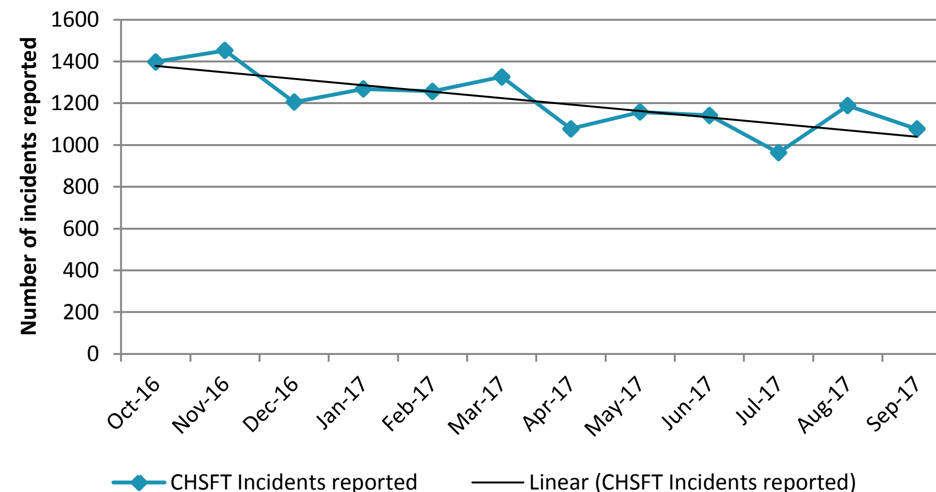
CHSFT

CHS incidents reported

Figure 18 demonstrates the number of CHS-related incidents that have been reported via Ulysses each month during the last 12 months. It shows a decrease of 112 reported incidents (10%) in September compared to the previous month. A linear trend line is incorporated into figure 18 which shows a decreasing trend in incident reporting.

CHS incidents by impact

The data table for figure 18 shows the incidents reported by impact over the last 12 months. The percentage of no harm and near miss incidents as a proportion of CHS incidents reported is 61% in September. Eight incidents were reported as having caused major or extreme harm in September. These will be reviewed by directorates via the Directorate Initial Review process and will be considered by RRG in due course. Three incidents were reported as having caused major harm in August, these are currently under review or investigation and will be considered at RRG.



Data for Figure 18: CHSFT Incidents reported by category October 2016 to September 2017

	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	June 17	July 17	Aug 17	Sep 17
No harm/near miss	926	920	730	697	765	839	-	-	-	-	-	-
Near miss	-	-	-	-	-	-	22	21	35	22	33	26
No harm	-	-	-	-	-	-	714	763	667	607	627	632
Minor harm	416	485	413	504	458	434	335	358	410	321	458	369
Moderate harm	51	43	53	58	30	40	5	13	19	10	23	42
Major harm	2	3	4	7	3	11	2	1	2	2	3	6
Extreme harm	3	2	6	3	1	2	0	0	1	1	0	2
Total	1398	1453	1206	1269	1257	1326	1078	1156	1134	963	1189	1077

PATIENT SAFETY
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.8 INCIDENT REPORT (continued)

STFT

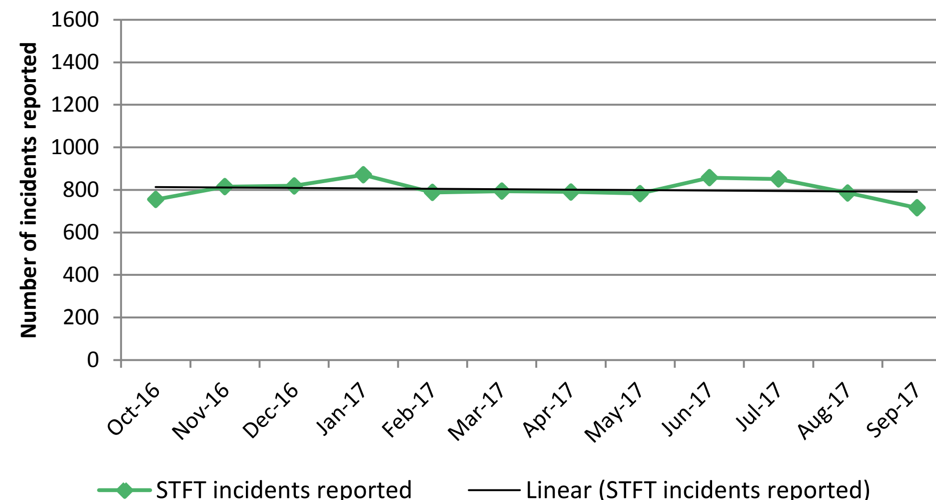
Figure 19 demonstrates the number of STFT-related incidents which have been reported via Datix each month during the last 12 months. A linear trend line is incorporated into figure 19 which shows a fairly steady trend in incident reporting.

STFT remains a low reporter of incidents when compared to acute Trusts nationally. Work to identify the reasons behind the low level of incident reporting has identified significant user challenges in respect of the Datix system and a required time of up to 20 minutes to complete and file a single incident report.

As a result, a Datix User group has been established with the goal of identifying changes to make Datix reporting more streamlined. The first meeting took place in September 2017, where priority actions for improving the system were agreed.

STFT Incidents by Reported Severity Score

The data table for figure 19 shows incidents by reported severity over the last 12 months. The total percentage of near miss and no harm incidents as a proportion of all STFT incidents reported in September is 71%. There was one incident which was reported as having caused major harm in September, this incident raised concerns about Non-Viable Foetus (NVF) tissue samples and following discussion at CIRG has been declared to commissioners as a Serious Incident.



Data for Figure 19: STFT Incidents reported by category October 2016 to September 2017

	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17
Near miss	100	118	125	127	112	111	96	110	122	116	100	105
No harm	396	369	395	399	370	386	396	516	526	519	471	402
Minor harm	221	281	262	291	271	264	268	151	195	200	192	190
Moderate harm	36	46	32	54	35	32	29	6	14	15	23	18
Major harm	0	1	5	0	0	1	1	0	0	1	0	1
Extreme harm	2	0	0	0	0	0	0	0	0	0	0	0
Total	755	815	819	871	788	794	790	783	857	851	786	716

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

1.8 INCIDENT REPORT (continued)

Root Cause Analysis (RCA) investigations

CHSFT

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

During September, RRG commissioned 10 RCAs. Figure 21 indicates the status of RCAs, showing 33 out of 48 RCAs are overdue, a further improvement of 10% on last month. Appropriate escalation of overdue RCAs through operational line management structures is now in place with data in respect of overdue cases being provided to the Director of Operations where appropriate.

STFT

The incident software at STFT has been reconfigured and can now report on RCA performance since June 2017. Figure 22 does not show the backlog of RCAs prior to June 2017, when the system was reconfigured. Because STFT always declared a Serious Incident when commissioning a RCA, the prior to June 2017 backlog of SIs documented elsewhere in this report is also the historic RCA backlog.

Figure 22 shows that two of the RCAs commissioned since June are now overdue. RCA production at STFT is managed through CIRG and the overdue RCAs will be managed through that route.

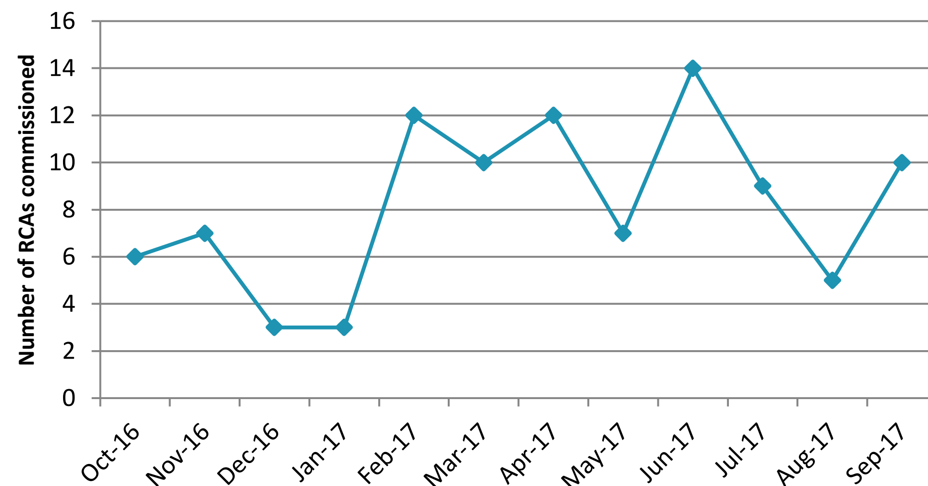


Figure 21: CHSFT Status of current RCAs – September 2017 (previous month in brackets)

	Comprehensive RCA	Concise RCA	Total
Overdue >3 months	11 (13)	11 (13)	22 (26)
Overdue <3 months	0 (0)	11 (10)	11 (10)
Within timeframe	2 (1)	13 (9)	15 (10)
Total	**13 (14)**	**35 (32)**	**48 (46)**

Figure 22: STFT Status of current RCAs – September 2017

	Comprehensive RCA	Concise RCA	Total
Overdue >3 months	0	2	2
Overdue <3 months	0	0	0
Within timeframe	0	3	3
Total	**0**	**5**	**5**

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

1.8 INCIDENT REPORT (continued)

Serious Incidents (SIs)

CHSFT

SIs are reported via the Strategic Executive Information System (StEIS) and monitored through North East Commissioning Support Unit (NECSU). Figure 23 demonstrates the number of incidents logged on StEIS by month. Two SIs were declared by CHSFT in September. One concerned a category 3 Hospital Acquired Pressure Ulcer to a patient's left heel. The other SI related to a patient falling from a chair shortly after their family had finished a visit. The patient suffered a fractured neck of femur.

STFT

The national definition of Serious Incident classification was introduced at STFT in January 2017, hence the significant drop in SI classifications since that date. There were three SIs declared in September. Case one is a 52 year old lady presenting three times at A&E with symptoms of chest pains between 15 June and 20 June 2017 before Myocardial Infarction (MI) was confirmed. At that point the MI pathway was not followed and there was a delay in transfer to CHSFT. Case two is the declaration of inadequate processing and storage of NVF tissue samples. Case three related to the lack/unavailability of suitable instrument resulting in a 90 year old lady having to return to theatre for a second operation resulting in a delay in treatment and recovery.

Figure 23: CHSFT SIs reported to StEIS October 2016 to September 2017

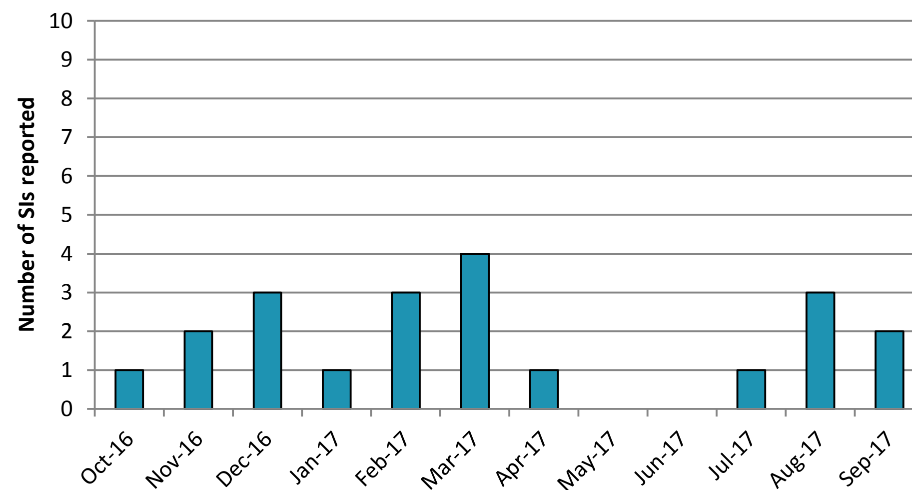
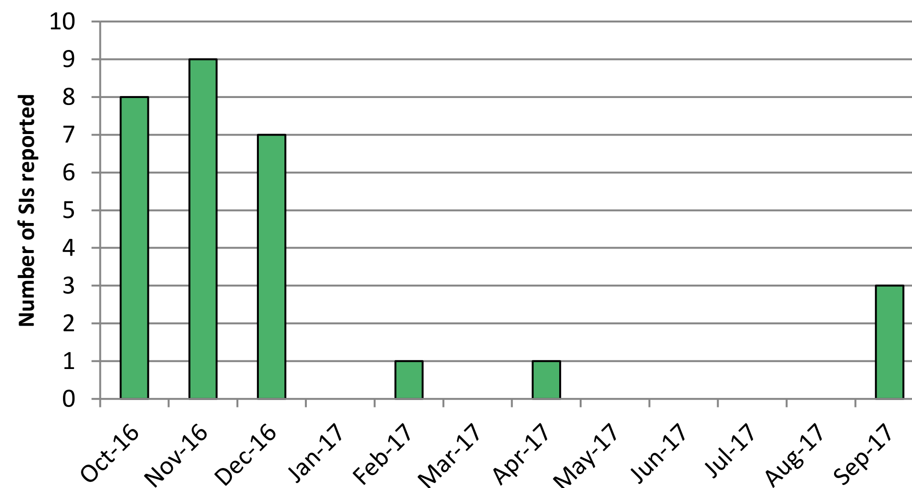


Figure 24: STFT SIs reported to StEIS October 2016 to September 2017



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

1.8 INCIDENT REPORT (continued)

Serious Incidents (continued)

CHSFT

Figure 25 shows the status of SI investigations over the last 12 months. Three SIs are overdue and, again, appropriate escalation of these cases is now in place. Nine SIs have been considered by Commissioners and are awaiting further information or clarification from the Trust, while 16 are awaiting consideration. The number of SIs within target is currently four.

Figure 25: CHSFT SI status October 2016 to September 2017

	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17
Overdue	9	10	11	6	6	4	6	8	5	1	3	3
Within target	6	3	4	4	5	4	4	2	1	2	4	4
Awaiting closure by CCG	12	14	8	13	11	14	14	12	14	21	17	16
Further info req by CCG	14	17	19	14	16	16	15	15	17	10	8	9

STFT

In September, STFT had 31 open SIs compared to 32 in August. Figure 26 shows 13 SI reports remain overdue for submission to Commissioners and these are being actively managed to closure. Eight remain open due to the CCG needing further information before the cases can be closed and seven await comment or closure. Three are not yet due a report.

The Trust met with Commissioners in August to discuss the backlog of SIs. Commissioners agreed to close three cases and also agreed that, going forward, they will consider batches of older cases for closure where they are similar in nature, e.g. falls cases.

CHSFT & STFT

Commissioners voiced their anxiety that both STFT and CHSFT are now outliers in terms of the number of SIs being declared, and both Trusts are continuing to work closely with Commissioners to reassure them that processes for the identification of SIs are robust.

Figure 26: STFT SI status October 2016 to September 2017

	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17
Overdue	6	9	14	8	20	21	21	19	17	15	14	13
Within target	1	1	2	4	1	1	1	0	0	1	0	3
Awaiting closure by CCG	20	23	23	19	11	10	11	15	5	18	7	7
Further info req by CCG	26	26	16	16	16	20	17	15	22	10	11	8

Never Events

CHSFT

No Never Events were reported in September.

STFT

No Never Events were reported in September.

Duty of Candour

CHSFT

During September, 38 patient safety incidents were reported as having resulted in moderate or above harm. The reported levels of harm are validated by directorates. When confirmed as having caused moderate harm or above, the formal requirements of Duty of Candour are applied, i.e. interested parties are informed, receive an apology, advice and support and are offered written feedback following completion of the investigation. During September, seven of the reported incidents were confirmed as meeting the requirements for Duty of Candour.

STFT

Within the Trust, all incidents that are reported as moderate or above harms are reviewed by the Risk & Compliance Team in the team's Rapid Review Group meeting. If, following this review, any of the reported incidents are confirmed as having caused moderate harm or above, the formal requirements of Duty of Candour are applied, i.e. interested parties are informed, receive an apology, advice and support and are offered written feedback following completion of the investigation. During September, one incident was reported as meeting the requirements for Duty of Candour.

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

1.9 INQUESTS (REPORTED BY EXCEPTION)

CHSFT

In late August 2017 a Regulation 28 Report was received by the Trust in respect of levels of observation of patients at risk of falls. Reassurances were provided and an action plan developed which is currently being implemented. This includes piloting a Standard Operating Procedure for Enhanced Care. Effectiveness of the action plan is being monitored.

1.10 LITIGATION (REPORTED BY EXCEPTION)

CHSFT

A high value obstetric claim was closed in this quarter. The claim was connected to the management of the delivery of the claimant's baby in August 2007. The claim has concluded on the basis of no admissions of breach of duty by the Trust, but financial settlement was reached due to litigation risk should the case have proceeded to court. Damages of £1.3m were agreed, well below initial estimates of £4.75m.

STFT

A high value obstetric claim was closed this month. The case related to the provision of antenatal care by STFT and another local Trust. The case settled for £8.7m, split between the two Trusts.

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

1.11 FALLS

CHSFT & STFT

Falls are identified by the National Reporting and Learning System (NRLS) as "an event whereby an individual comes to rest on the ground or another lower level, with or without loss of consciousness". A recent publication from NHS Improvement, "The incidence and costs of Inpatient falls in hospitals" July 2017, illustrates both the financial and personal effects inpatient falls have on Trusts, patients, carers and families.

Falls with harm

Falls are classified according to the severity of injury sustained by the patient:

- No harm (no injury)
- Low: Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons.
- Moderate harm: requiring hospital treatment or a prolonged length of stay but from which a full recovery is expected (e.g. fractured clavicle, laceration requiring suturing, etc.).
- Severe harm: causing permanent disability (e.g. brain injury, hip fractures where the patient is unlikely to regain their former level of independence).
- Death: where the death is directly attributable to the fall.

The information in figure 27 indicates the incidence of falls that occurred in September 2017. Day cases, Maternity, A&E and Paediatrics are excluded from the acute (hospital) data.

The data is broken down by levels of harm. Harm rates in terms of rate/1,000 bed days are provided for all falls and also for falls with ≥ moderate harm.

Figure 27: Numbers of Falls by category for September 2017

Severity of Injury	CHSFT Number of Falls	STFT - Acute Number of Falls
No Harm	66	60
Low Harm	35	6
Moderate Harm	2	2
Severe Harm	0	0
Death	0	0
Total Falls	**103**	**68**
Rate/1,000 bed days	**6.41**	**9.13**
National rate/1,000 bed days	**6.63**	**6.63**
Total ≥ Moderate Harm	**2**	**2**
Rate/1,000 bed days	**0.12**	**0.27**
National rate/1,000 bed days	**0.19**	**0.19**

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

1.11 FALLS (continued)

CHSFT

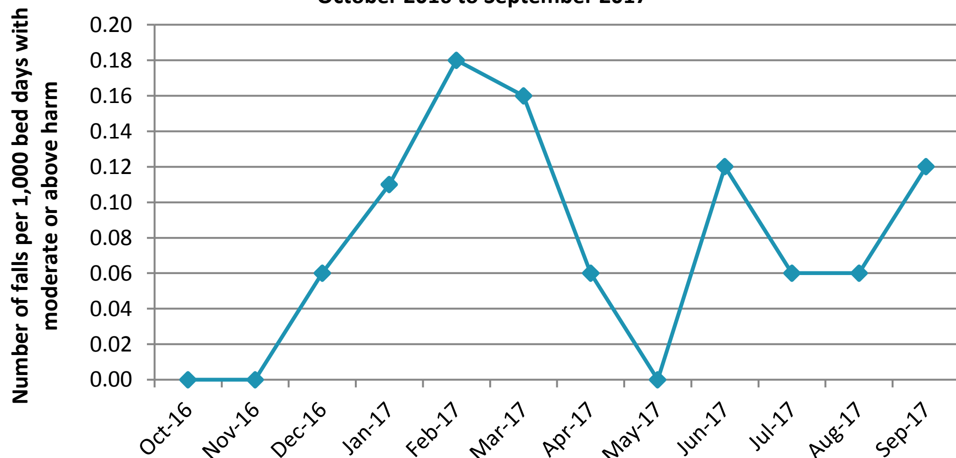
We reported a total of 103 falls in September; of these two were ≥ moderate harm. In August we reported one fall with ≥ moderate harm. This equates to a fall rate of 6.41 per 1,000 bed days for all falls and 0.12 for falls with ≥ moderate harm, which is an increase from the 0.06 we reported in August. The last 12 months of data is shown in figure 28.

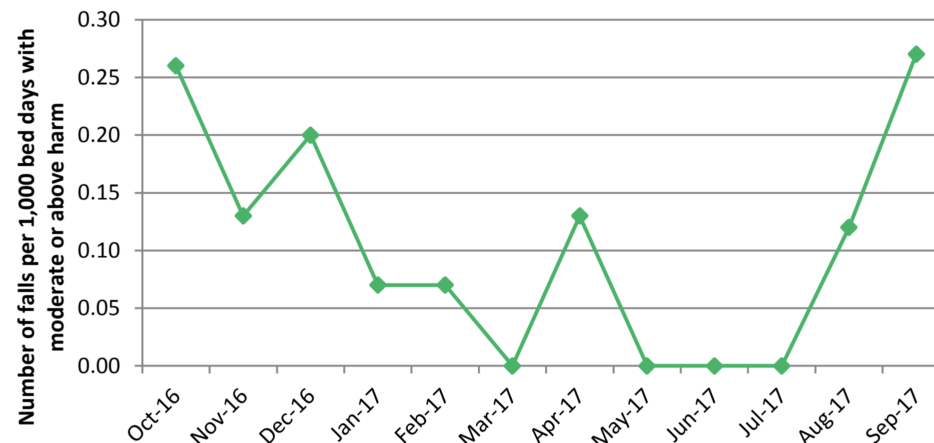
This is the first month we have collated data for all falls, as previously we just reported on falls with ≥ moderate harm. This means that no comparisons can be made for total falls.

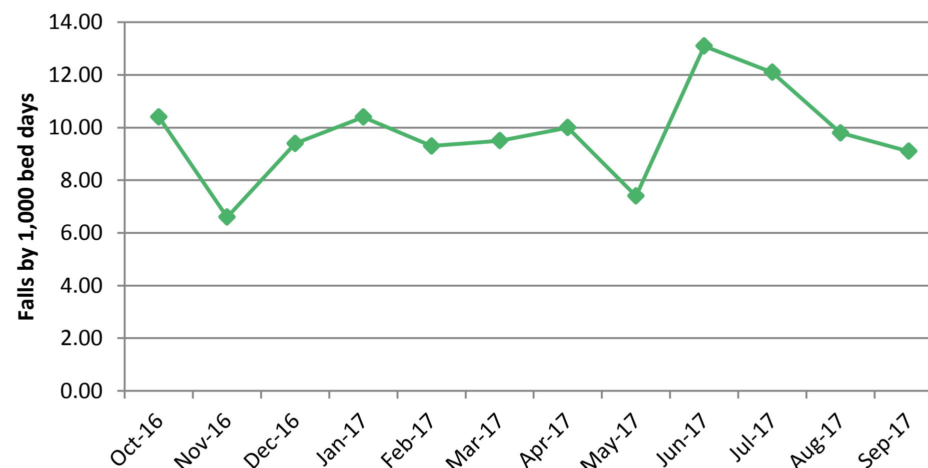
STFT

Within acute services, we reported a total of 68 falls in September. Of these two were ≥ moderate harm. In August we reported a total of 79, one with ≥ moderate harm. This equates to a fall rate of 9.1 per 1,000 bed days for all falls and 0.27 for falls with ≥ moderate harm. This compared to August is a reduction of 0.5 for falls per 1,000 bed days and an increase of falls 1.5 with ≥ moderate harm. Data for moderate or above harm is shown in figure 29 and full falls data in figure 30.

There is no agreed methodology nationally or locally for measurement of falls rates within a community setting.







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

1.12 SAFETY THERMOMETER

Our percentage of harm-free care is based on:

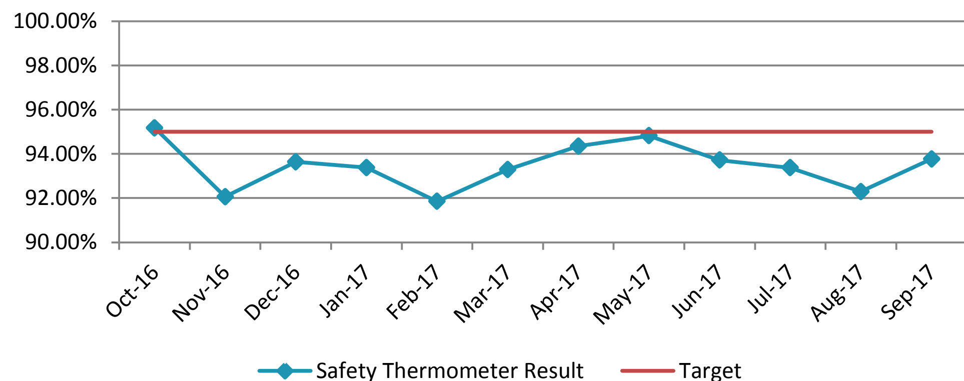
- Pressure Ulcers (PUs)
- Falls in care resulting in ≥ moderate harm
- Catheter-related urinary tract infections (UTIs)
- Venous Thromboembolism (VTE)

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

CHSFT

Figure 31 shows CHSFT Safety Thermometer prevalence data. We reported 93.77% harm-free care in September 2017 (a 1.48% increase from the 92.29% we reported in August).

Our total number of new harms in September was 13, which is a decrease from the 17 we reported in August. We had 23 "old" harms this month, which is a decrease from the 28 we reported last month.

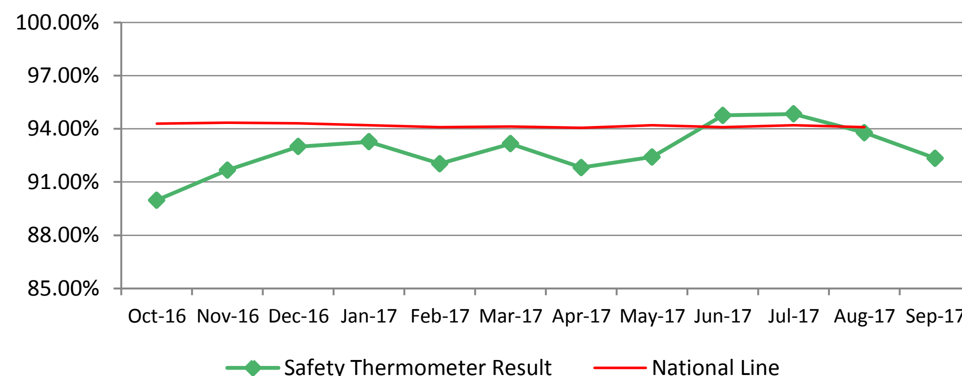


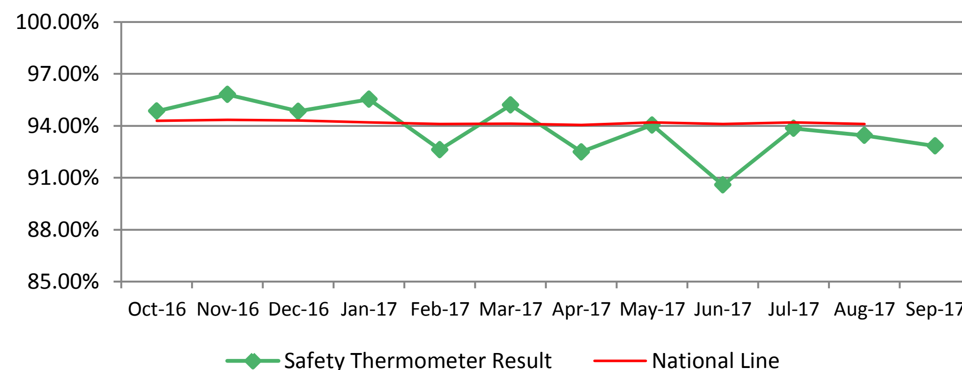
STFT

Figure 32 shows Safety Thermometer prevalence data for Acute. We reported 92.34% harm-free care in September (a 1.44% decrease from the 93.78% we reported in August). This is below the national average of 94.18% of harm-free care reported by Trusts from September 2016 to August 2017. (National September data not available until end of October)

Figure 33 shows Safety Thermometer prevalence data for Community. We reported 92.83% harm-free care in September (a 0.61% decrease from the 93.44% we reported in August). This is also below the national average of 94.18% of harm-free care reported by Trusts from September 2016 to August 2017.

Our total number of new harms increased from 16 in August (Acute six, Community 10) to 22 in September (Acute two, Community 20). We had fewer "old harms" this month: 40 compared to 43 in August.





ASSURANCE
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

2.1 CQC Provider Information Request (PIR)

A PIR is the first step in the CQC inspection process and was received for South Tyneside FT at the beginning of August. This is an extensive document with seventy seven separate worksheets plus specific documents to be provided which was returned to deadline.

Obtaining the information required was challenging in some aspects and it is therefore proposed that the PIR information be gathered and completed for CHSFT in the near future which can then be updated as required when the formal request is received.

2.2 The State of Health Care and Adult Social Care in England 2016/17

The CQC has published their annual "Assessment of Health and Social Care in England" which looks at trends, highlights examples of good and outstanding care, and identifies factors that maintain high quality care. The report can be found via the following link:
http://www.cqc.org.uk/publications/major-report/state-care

2.3 Assurance Programme

The Assurance Programme is now operational across both Trusts. The Assurance Programme is agreed by the Governance Committees and is updated in line with the revised Assurance Framework and emerging issues. The Assurance Programme is now explicitly mapped to both the CQC Fundamental Standards and the five key questions.

The Assurance Visit tools have been revised and finalised and the first joint Assurance Visits have already taken place at both Sunderland Royal and South Tyneside District Hospital.

The current Assurance Programme has only limited applicability to Community Services and so initial discussions have been held with the Head of Nursing for Community Services with a view to developing relevant and effective assurance tools within the next three months.

2.4 Excellence Reporting

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

Excellence Reports submitted (total up to the end of September)	354
Excellence Reports submitted in September	32

Top 5 directorates reporting (cumulative)	No of Excellence reports submitted
Emergency Care	47
Theatres	42
Rehabilitation & Elderly Medicine	33
Obstetrics & Gynaecology	27
Paediatrics & Child Health	21

Reporters have originated from varying professions:

Reporters by job type (September)	No of Excellence reports submitted
Nursing & Midwifery	23
Patients	3
Admin and Clerical (including management)	2
Medical and Dental (Trust)	2
Allied Health Professionals	2
Medical and Dental (Training)	0
Additional Clinical Services	0

Category breakdowns are as follows:

Category of Excellence (September)	No of Excellence reports submitted
Going the extra mile	11
Care and compassion	10
Team working	5
Courage and commitment	2
Other	2
Communication	1
Leadership	1
Competence	0
Service improvement and innovation	0

The Excellence Reporting at CHS continues to be well received and will be launched at STFT on 31 October.

CHSFT & STFT HOSPITAL ACQUIRED INFECTIONS
LEAD: MEDICAL DIRECTOR

3.1 HOSPITAL ACQUIRED INFECTIONS

3.1.1 MRSA bacteraemia

CHSFT

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

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

STFT

There were no new cases of MRSA bacteraemia in September. Total cases for 2107/18 is one avoidable case agreed as a contaminant, against an annual limit of Zero avoidable cases.

STFT October MRSA update: There was one new case of MRSA bacteraemia in October. This has been assigned by the Trust to a third party. The outcome of this assignment is pending acceptance by an appeal panel. Total cases for 2017/18 is two, one case deemed avoidable, agreed as a contaminant. The second case pending appeal. This is against an annual limit of zero avoidable cases.

3.1.2 C. difficile infection (CDI)

CHSFT

Two cases were reported in September, which is one below the monthly trajectory. The year to date position at the end of September is 14 cases against an annual target of 34.

The *C. diff* rate per 100,000 bed days for the previous 12 months up to September 2017 remains within target, at 11.1. By comparison, the national rate for the latest 12 month period available (July 2016 to June 2017) was 10.2 per 100,000 bed days. The Trust's target rate is 15.4.

Cases of C. difficile infection per month October 2016 to September 2017:

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

CHSFT October C diff update: One case was reported in October, which is two below the monthly trajectory. The year to date position at the end of October is 15 cases against an annual target of 34.

STFT

No cases were reported as Trust apportioned in September. The year to date position at the end of September is six cases against an annual target of eight; two of these are pending appeal in October.

The *C. diff* rate per 100,000 bed days for the previous 12 months up to August 2017 is just outside target, at 6.8. By comparison, the national rate for the latest 12 month period available (July 2016 to June 2017) was 10.2 per 100,000 bed days. The Trust's target rate is 6.5.

Cases of C. difficile infection per month October 2016 to September 2017:

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

STFT October C diff update: Two cases were reported as Trust apportioned in October. The year to date position at the end of October is eight cases against an annual target of eight. Two of these have been taken to appeal, outcome awaited. A third case will be taken to appeal.

3.2 HAND HYGIENE

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

3.3 VANCOMYCIN RESISTANT ENTEROCOCCUS (VRE) ON D46

The Infection Prevention & Control (IPC) department is currently managing a large outbreak of Vancomycin-Resistant Enterococcus among Haematology patients. This was first detected on B28 in August and has continued since the Haematology patients were moved temporarily to D46 to accommodate the renal works on B28. One patient has been infected and seven have been found on screening to be colonised. VRE is of particular concern among immunocompromised patients and patients with intravenous lines, such as Haematology and Renal patients. It can cause line infections, urinary tract infections and bacteraemia. Enterococci are intrinsically quite resistant to antimicrobials and the additional resistance to vancomycin and related drugs among VRE strains means that infections must be treated with other agents that are intrinsically less effective, or more toxic, or more expensive. More commonly it causes asymptomatic colonisation rather than infection, but colonised patients represent a reservoir from where it can be passed to other patients, either directly or via environmental contamination. Once acquired by a patient it colonises the bowel from where its departure cannot be hastened – colonisation persists for months, years or even lifelong. An outbreak like this therefore creates a cohort of patients who – even if they haven't come to harm themselves – require strict isolation nursing whenever they are admitted, which in turn will increase demand on our pressured side rooms.

The source of the outbreak remains unclear: the organism was found in the environment on B28 and we assume this was the source of most of the acquisitions, but we don't know how it got there in the first place. Molecular typing shows the outbreak strain to be indistinguishable from one isolate from two patients on E50 last year but we have not identified a convincing link between the two areas. Currently (late October) an Outbreak Control Group is meeting weekly with input from Public Health England. All D46 patients are being barrier nursed and with the help of the Microbiology Laboratory in Gateshead we are screening all patients on admission, weekly after admission, and discharge. G4S have been very helpful in increasing routine cleaning and the IPC team has been doing enhanced disinfection using UV light and hydrogen peroxide vapour, which has been a major call on their resources. The ward is closed to new admissions other than Haematology patients, which contributes to bed pressures as we go into winter. The outbreak has therefore consumed a great deal of resource.

As of 30 October 2017 there has been no evidence of new acquisition for about three weeks.

CLINICAL GOVERNANCE UPDATE
LEAD: CHSFT MEDICAL DIRECTOR

3.4 Patient Reported Outcome Measures – Update

Following discussion at July's Clinical Governance Steering Group (CGSG) meeting and subsequently at the Quality Review Group it was agreed to monitor participation rates for both varicose veins and groin hernia repairs. Previous data releases from NHS Digital had shown low rates for varicose veins and over-completion rates, i.e. in excess of 100%, for groin hernia surgery.

The table below shows the participation rates for the two month monitoring period, July and August 2017, based on local review of patient lists and counts of completed PROMS forms.

Procedure	No. cases identified PREP/clinic lists	No. forms completed	CHS Participation Rate
Varicose Veins (VV)	57	50	88%
The latest available published data from NHS Digital had shown participation rates for VV at CHS as 29.4% and the national rate as 34.1%. After discussion with Rostra Healthcare staff (who run the service at Monkwearmouth) about the PROMS process, we are now more confident that appropriate patients are being invited to take part in PROMS and complete the required questionnaires.			
Groin Hernia	87	56	64%
The latest NHS Digital release showed groin hernia for CHS as above 100% and the national rate as 57%. However, whilst 100% is normally a desirable target/measure of achievement, in this instance the 'over-completion' of questionnaires showed that the Trust needed to re-look at which patients were being included in PROMS. This is not a problem in itself as only the data matching HES is used to calculate health gain scores, but it is a cost to the Trust of additional questionnaires supplied to the Centre but were then not used. We shared the latest inclusion criteria update with the PREP Manager for distribution among staff to ensure that only the correct patients were being included in the programme.			

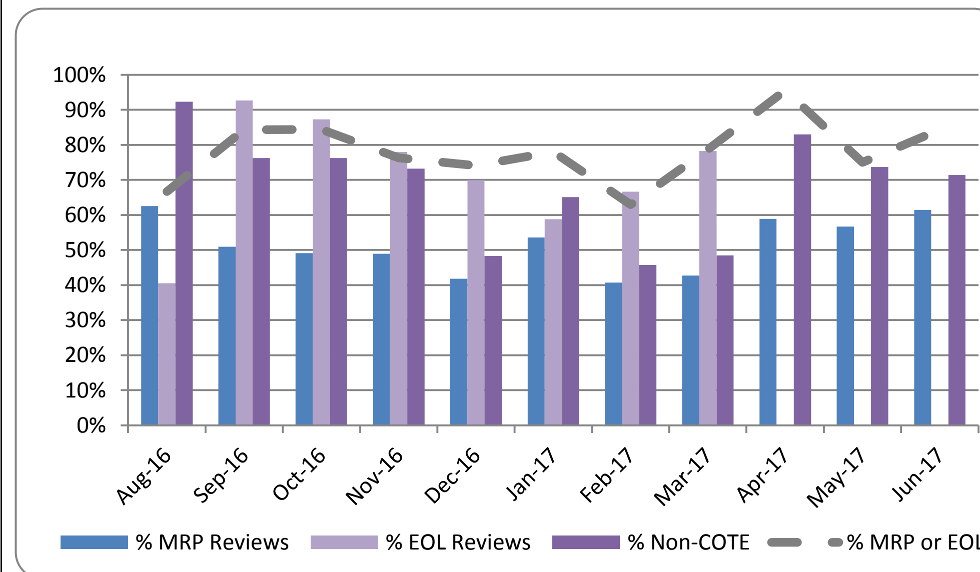
Following the interventions by the Clinical Governance department, the rate of participation for patients with VV has risen and is now higher than the national average, while groin hernia rates are more in line with national figures. These rates will continued to be checked against published data by NHS Digital and Quality Health.

3.5 Mortality Review Panel Report Q1 2017/18

The Quarterly Mortality Review Panel Report provides an overview of preventability judgements and quality of care/improvement scoring from the Mortality Review Panel and the coronial process. It includes the outcomes from reviews of deaths that have either had a standard mortality review or a more targeted end of life care review. The report also presents summaries of standard mortality reviews, through case vignettes, where outcomes were scored as:

- NCEPOD; 4. (Room for improvement – clinical & organisational care), 5. Less than satisfactory.
- Hogan Quality; 4. (Poor), 5. (Very Poor).
- Hogan Score; 4. (Probably preventable, more than 50-50 but close call), 5. (Strong evidence of preventability), 6 (Definitely preventable).

A standard mortality review or specific end of life review has been completed on 86.4% of all adult deaths in Q1. 15 reviews prompted a departmental review and responses have been received for all 15.



Nb. In this Q1 report we are unable to provide the number of EOL deaths to show a proportion of EOL reviews.

CLINICAL GOVERNANCE UPDATE (continued)
LEAD: CHSFT MEDICAL DIRECTOR

3.5 Mortality Review Panel Report Q1 2017/18 (continued)

The table below shows that the average Hogan 'definitely not preventable' judgement scoring was 96.20% between July 2016 and June 2017. For the same period, the Trust achieved a NCEPOD 'Good Practice' score of 75.40%.

	Average July 16 - June 17	Lowest July 16 - June 17	Highest July 16 - June 17
Hogan Preventability: Definitely not preventable	96.20%	94.10%	100%
Hogan Quality: Excellent	24.60%	10.70%	39%
NCEPOD: Good practice	75.40%	64.00%	79%

The Care Quality Commission (CQC) published a report "Learning, candour and accountability; a review of the way NHS Trusts review and investigate the deaths of patients in England" on 13 December 2016. The report describes a review of the process of investigating deaths in a sample of NHS Acute, Mental Health and Community Trusts in England. This was undertaken in response to a review of mental health and learning disability deaths at Southern Health NHS Foundation Trust between April 2011 and March 2015.

The report identified that:

- Families and carers are not treated consistently well when someone they care about dies.
- There is variation and inconsistency in the way that Trusts become aware of deaths in their care.
- There was an inconsistent approach across Trusts to determine when to investigate deaths.
- The quality of investigations is variable and generally poor.
- There are no consistent frameworks that require Boards to keep deaths in their care under review and share learning from these.

In their review, the CQC made a number of recommendations about how the approach to learning from deaths could be standardised across the NHS. These recommendations were accepted by the Secretary of State for Health, who asked the National Quality Board to produce a framework for the NHS on identifying, reporting, investigating and learning from deaths in care. In March 2017, the National Quality Board published the first edition of the 'National Guidance on Learning from Deaths'. One of the key requirements for Trusts was to publish a policy on how it responds to, and learns from, deaths of patients who die under its management and care.

In response to these recommendations several changes will be made to the Mortality Review process at CHSFT in the coming months.

3.6 Sepsis

Background

In 2015/16 NHS England incorporated sepsis screening and treatment in to CQUIN for all patients attending Emergency Departments. In 2016/17 this was extended to include all in patient areas. The standards in the CQUIN guidance are that 90% of appropriate patients are screened and 90% of those with sepsis have antibiotics administered within 60 minutes.

Process

From the outset the decision was made to introduce a Trust-wide electronic solution using Meditech V6. The first NEWS score of 5 or above triggers a prompt on V6 for the sepsis screening tool to be completed. This must be done before the next set of observations are completed. The screening tool uses the NICE Guidance high risk criteria to identify patients with sepsis. Once the screening tool has been completed the outcome is escalated to a Doctor, who then makes the clinical decision of whether the patient has sepsis and completes the sepsis grading tool. Patients suspected as having sepsis must have antibiotics administered within 60 minutes of the NEWS prompting screening. In inpatient areas patients must be rescreened when the NEWS is 5 or above and higher than the previous NEWS.

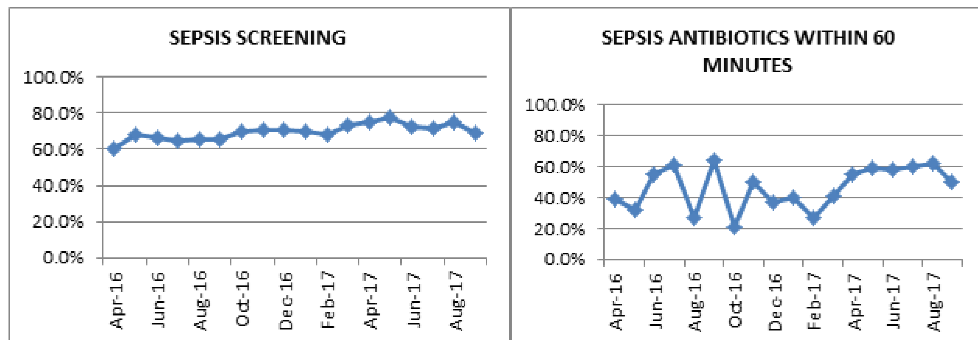
Roll Out and Engagement

- The Trust Sepsis Group provides strategic oversight of the recognition, treatment and management of patients with sepsis.
- Training provided at induction, Lessons Learnt sessions, ad-hoc ward based, CD Forum, CG Leads, and local Governance meetings.
- Areas supported with SOPs and a presentation to be included in local induction.
- Participated in World Sepsis Day; screensavers, posters on each ward, items on the intranet page. Competitions across the month with high performing wards given prizes. A stand in main reception where CCOT, Clinical Governance, the Trust Sepsis Lead and Medical and Surgical Sepsis Leads asked Doctors and Nurses to sign a pledge to the sepsis process.
- there had previously been no formalised sepsis screening process in the Trust - started from a 0% baseline position. ED has strong engagement and leadership and performance reflects this.
- IP has seen good engagement from Matrons and Ward Managers. Senior clinical engagement is needed from Consultants to ensure that Doctors are grading patients with sepsis.
- Communication from the Trust Sepsis Lead to all Consultants and Junior Doctors to reinforce the importance of grading sepsis.
- A presentation to be included in local induction has been sent to Clinical Directors via CD forum and Clinical Governance Leads through CG leads.

CLINICAL GOVERNANCE UPDATE (continued)
LEAD: CHSFT MEDICAL DIRECTOR

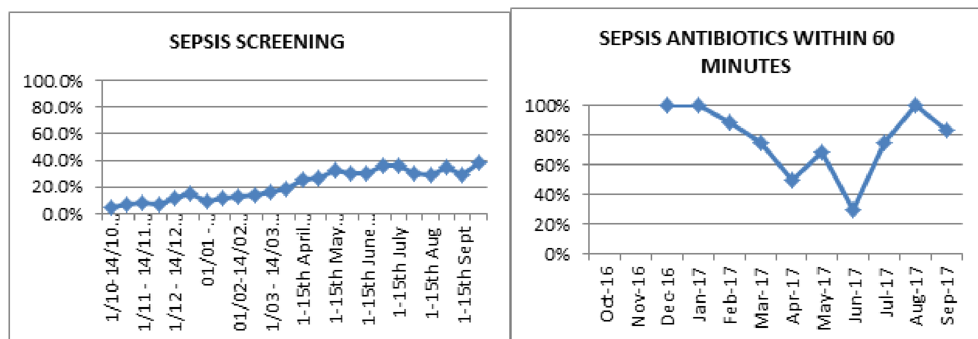
Performance

Emergency Department consistently performs above the target of 50% for partial payment, however it has not achieved the 90% target for full payment in the last 18 months.



In 2016/17 the proportion of antibiotics administered within 60 minutes was measured from time of arrival. In 2017/18 NHS England changed to measurement from the time of the NEWS triggering screening. Since this change ED have been consistently above the partial payment threshold of 50%, however it has not achieved the 90% target for full payment in the last 18 months.

Inpatients - While screening in inpatient areas has been below the 50% target for partial payment, a positive trajectory can be seen since roll out. Work is ongoing to support continuous improvement in screening and this is monitored bi-monthly at the Trust Sepsis Group.



Antibiotics within 60 minutes can be variable due to the low numbers of patients graded with sepsis. Performance is generally positive within 1 month in 10 performing below the threshold of 50% for partial payment.

Reporting

To encourage clinical teams to take ownership and act on areas of low compliance:

- Ward managers and matrons are sent performance fortnightly.
- Clinical Directors, Directorate Managers and Divisional General Managers are sent performance monthly.
- A patient level report is sent to Matrons and Ward Managers fortnightly to identify those screening and people who are missing opportunities to screen.

Comments

Trusts are all approaching the CQUIN using different methodologies as the guidance states "as per local protocol". This includes only screening Inpatients on their first elevated NEWS. CHSFT Trust Sepsis Group decided to focus on patient safety aspects of sepsis recognition and management and therefore have a robust screening process where patients are rescreened for any further increase in their NEWS. This approach is similar to the approach taken with MRSA, where again patient safety was the focus and as with any change management time was required to see improvement. Qualitative feedback is that we are recognising and treating patient with sepsis however the documentation is not being used appropriately. This impacts screening rates as screening prompts continue. Data from ICNARC shows that ICCU are not admitting more septic patients which suggests we are treating sepsis appropriately.

The main issue is buy-in from senior Doctors and Consultants in using the Sepsis Grading Tool on Meditech.

Actions

The Trust Sepsis Lead will be attending CD Forum again to ask for specific actions the Clinical Directors will take to improve this issue of documentation. Clinical Governance and Critical Care Outreach Team Lead will continue to attend weekly handover meetings in key areas to maintain a raised profile.

Key wards are being targeted for further one on one training with all Registered Nurses. Nurses will sign when they have been trained and therefore will be accountable for not screening. Clinical Governance is attending Ward Handover meetings to educate Junior Doctors and ensure that they are aware of the requirement to grade sepsis.

Fortnightly and monthly monitoring reports will continue.

CLINICAL GOVERNANCE UPDATE
LEAD: STFT MEDICAL DIRECTOR

3.7 STFT Clinical Incident Review Group (CIRG)

Seven cases have been discussed at CIRG with learning lessons in six. There was a duty of candour in two. Two Serious Incidents (SI) have been reported.

One SI relates to the Non-Viable Fetus pathway. In summary the process involves a number of teams/individuals with multiple handovers and no one individual/team with overall responsibility. A Kaizen is planned for 12 October 2017 to improve the process and patient experience contributing to the final report.

One SI relates to the delay in diagnosis and treatment of a patient with an acute coronary syndrome. The 72-hour report is complete and the final report is nearing completion. The relevant individuals have reflected and process has been discussed at A&E and EAU huddles.

The above individual related errors have been brought to the attention of the individuals through the appropriate routes and learning plans put in place.

In the current annual year up to 30 September, 96 cases have been discussed at CIRG. Actions have been: completed in 81 (84%); partially completed in nine (10%); and awaiting completion in six (6%).

3.8 "Treat as one-NCEPOD (National Confidential Enquiries into Patient Outcome & Death) report" (STFT)

This report was published in January 2017 to look at the important area of patients 18 years or older with a serious mental health disorder who are admitted to a general hospital and the quality of physical and mental health care provided to them. The standard process is for a baseline assessment to be undertaken by the lead in this area to identify any gaps and actions required to improve. Given the far reaching impact of the report this baseline assessment was undertaken by an Acute Physician who was also allocated the lead for the study at the time of data gathering.

Of the 21 recommendations in the report, 17 are relevant to the Trust, nine have been fully met, four are partially met and four require further work. The particular challenges to full compliance with recommendations revolve around delivering 7-day working in Pharmacy, delivering an integrated IT system and developing more robust Service Level Agreements with NTW Mental Health Trust who provide in-reach into the Trust.

The Medical Director is co-ordinating a view with the NTW lead, Allison Smith, and has asked for operational and clinical input through the Acute Divisional Governance meeting. A report will be presented to Clinical Governance Steering Group.

3.9 National Patient Safety Agency (NPSA) and Chief Medical Officer (CMO) Alerts (STFT)

In 2014 a policy was developed to ensure that the Trust has in place a systematic approach for the receipt, dissemination and implementation of Medical Device Alerts (MDA), Estates & Facilities Alerts (EFA), National Patient Safety Agency Alerts (NPSA) and Chief Medical Officer (CMO) Alerts issued via the Department of Health Central Alerting System (CAS). The key post created to administer the system was the CAS Liaison Officer with the key objectives:

- Maintain contact with the Department of Health.
- Cascade Alerts received by email to the relevant wards and departments across the Trust.
- Collating all of the responses from the wards and departments effected.
- Updating the electronic response form on the Department of Health website with the information regarding progress.
- Completing the electronic response form on the Department of Health website when all of the responses have been received and any action necessary has been taken.

The Risk and Compliance department provided oversight with assurance matrons liaising with relevant departments for the NPSA and CMO alerts. The MDA are reviewed through the Medical Devices Group and the EFA though Estates and Facilities. With the restructures in recent years, the Medical Director has led a review of the current processes. The NPSA, CMO and MDA alerts will have oversight via the Medical Director reporting into the Clinical Governance Steering Group. The EFA alerts will have oversight via the Director of Estates and Facilities reporting into Corporate Governance Steering Group.

The Medical Director has completed a due diligence review of NPSA and CMO alerts for 2016 and 2017 reviewing the quality of action plans and any outstanding actions. Assurance has been provided to Clinical Governance Steering Group.

In 2016 11 NPSA alerts were received with all 11 closed within the deadline and actions completed.

In 2016 three CMO alerts were received with all three closed with actions completed within deadline.

In 2017 up to 30 September 2017, five NPSA alerts have been received with closed and actions completed within deadline and one action ongoing but within deadline, two CMO alerts have been received with both closed and actions completed within deadline.

Work is ongoing with review of the MDA alerts and the policy will be updated to reflect the change in oversight.

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) 2017/18

4. COMMISSIONING FOR QUALITY AND INNOVATION 2017/18

Current Position

CHSFT

The majority of CQUIN indicators remain to be on track for full reconciliation, however non-payment is predicted for 2a ii) Sepsis IP Screening, PH2 Accessible Information Standard and partial payment is predicted for 2a i) Sepsis ED Screening (CHS) and 2b) Timely Treatment of Antibiotics IP and ED. Joint CQUIN information for both CHSFT and STFT can be seen in Appendix 1.

STFT

Partial Payment is predicted for 2b) Timely Treatment of Antibiotics IP and ED with payment likely to be deferred for 6 Advice & Guidance.

Joint CQUIN information for both CHSFT and STFT can be seen in Appendix 1.

Reason for underperformance

CHSFT

2a i) Sepsis ED Screening – during Q2 there were 71.9% (976/1,357) patients screened in accordance with the local protocol (NEWS >=5 Adult or POPS >3 Paediatrics), which is below the 90% target. As performance is >50% and <=89.9% partial payment will be received.

2a ii) Sepsis IP Screening – during Q2 there were 32.8% (1,080/3,297) patients screened in accordance with the local protocol (NEWS >=5 Adult or POPS >3 Paediatrics) which is below the 90% target. As performance is <50% no payment will be received.

2b) Timely Treatment of Antibiotics IP and ED – Q2 is currently being audited however the change from arrival to ED to elevated NEWS has had the anticipated impact in ED with over 50% of patients in Q2 receiving IV antibiotics within 60 minutes. Inpatients are currently being audited to establish whether patients who did not receive antibiotics within 60 minutes were already on appropriate antibiotics. Partial payment is expected as at present the Q2 position is 53.1%.

PH2 Accessible Information -Initial baseline assessment conducted August 2016 identified gaps in provision.

STFT

During July 85.7% (30/35) and August 82.4% (56/68) of sampled patients received antibiotics within 60 minutes it is predicted that with Septembers' audit results partial payment will be received.

6) A&G – during Q2 there has been a delay rolling out the project to include General Surgery and Gynaecology. The proportion of services providing advice and guidance remains static at 9.14%.

Actions to get back on target

CHSFT

Adult ED has maintained high screening compliance maintaining performance around 80%. Paediatric ED saw a drop in performance in August (50.6%) this was communicated to the lead Consultant and has improved to 61.7% in September, however further work is needed in Paediatric ED to improve performance to the level of Adult ED.

Both Adults and Paediatric ED continue to receive monthly reports to target individuals for further training. Adult ED participated in World Sepsis Day with a Sepsis display board targeted at both patients and staff.

The Inpatient screening rate has remained around 32-34% in Q2. The Trust celebrated World Sepsis Day with 'Sepsis September' where competitions between wards on screening rates and sepsis grading tool completion were held. On World Sepsis Day there was stand at main reception attended by the CCOT Lead, Clinical Governance and the Trust, Surgical and Medical Sepsis leads. Nurses were asked to sign a pledge to screen for sepsis as per the trust protocol and Doctors were asked to sign a pledge to complete the sepsis grading tool for all patients diagnosed with sepsis. An email was sent to all Doctors and Matrons on behalf of the Medical Director, Director of Nursing and Trust Sepsis lead thanking teams for their hard work and highlighting the need to continue to improve in the recognition and treatment of patients with sepsis. The Trust Sepsis Lead emailed all Consultants to re-iterate the requirements and highlight poor performance. These approaches have engendered engagement with the process and screening increased to 38.1% in the last two weeks of September. Key wards have also had every member re-trained regarding the process.

The Synertec project which is part of the Global Digital Exemplar programme will address the shortfalls identified in the Trusts accessible information compliance.

STFT

The Sepsis Nurse has reinforced with the clinical teams the need for antibiotics to be given in a timely way.

Alternative specialties have been lined up to go live with Advice and Guidance at STFT during October to bolster the position.

CHFT and STFT

There has been a proposal made on behalf of both Trusts to the CCG Commissioning Teams to reduce the burden of the CQUIN where wider health economy initiatives are already in place. Negotiations are currently ongoing and once agreement has been made further detail will be provided.

RISK
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

5.1 CORPORATE RISK REGISTERS

CHSFT

The CHS Q2 corporate risk register is being produced in line with the requirements of the CHS Risk Management Strategy.

STFT

A proposed process for the production of a formal corporate risk register at STFT has been documented for consideration by the Board.

5.2 LITIGATION ANALYSIS

STFT

Management of the STFT Litigation and Inquest team has moved to the Head of Corporate Risk. An analysis of the last six years' claims against STFT through NHS Resolution has begun, with the expectation that a first report will be made to Corporate Governance Steering Group in early 2018.

5.3 NATIONAL REPORTING AND LEARNING SYSTEM SIX MONTH DATA

CHSFT

5,817 incidents were reported to NRLS in the six months October 2016 – March 2017 compared to 6,947 in the previous six months, a rate of 49.95 incidents per 1,000 bed days (62.51). CHS are now 23rd on the ranking table of reporting organisations, comfortably in the middle of the top quartile. Work is taking place through October to ensure that the drop in reporting rates is due to issues of which the organisation is aware, e.g. changes of reporting methodologies in respect of pressure ulcers.

STFT

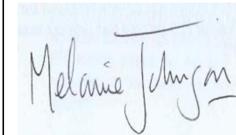
1301 incidents were reported to NRLS in the six months October 2016 – March 2017 compared to 1579 in the previous six months, a rate of 24.6 incidents per 1,000 bed days (29.05). STFT are now third bottom on the ranking table of reporting organisations compared to 12th bottom in the previous six months. Work is continuing to ensure that all patient safety incidents are reported to the NRLS; identification of such cases is currently a manual process.

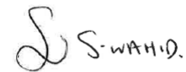
CONCLUSION

SUMMARY OF KEY RISKS

1. Nurse staffing vacancies as we move into the winter period.
2. Increasing number of pressure ulcers in STFT acute.
3. Low levels of incident reporting at STFT.

Members are asked to note the report.





MELANIE JOHNSON
Director of Nursing & Patient Experience

IAN MARTIN
CHSFT Medical Director

SHAZ WAHID
STFT Medical Director

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF FINANCE

BOARD OF DIRECTORS

NOVEMBER 2017

FINANCIAL POSITION AS AT 31ST OCTOBER 2017
EXECUTIVE SUMMARY

1 INTRODUCTION

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

1.1 KEY HIGHLIGHTS

Issue or Metric	NHSI Plan	Actual	Variance to NHSI Plan	
	£000s	£000s	£000s	%
Overall Financial Position including STF – Deficit	£4,113k	£5,545k	£1,432k	34.8%
Overall Financial Position excluding STF – Deficit	£8,267k	£9,223k	£956k	11.6%
Income (including STF)	£204,951k	£206,014k	£1,063k	0.5%
Expenditure	£209,064k	£211,559k	£2,495k	1.2%
EBITDA Position %	2.30%	1.4%		
Cash Position	£2,763k	£3,807k	£1,044k	37.8%
Clinical Activity:				
Variance to plan	£184,295k	£183,733k	£562k	0.3%
Cost Improvement Plans				
Variance to plan	£6,500k	£5,880k	£620k	9.5%
Pay:				
Variance to plan	£125,556k	£125,704k	£148k	0.1%
Non Pay:				
Variance to plan	£83,508k	£85,855k	£2,347k	2.8%
Use of Resources Metrics (UOR)			3	
+ve variance equates to worse than expected; -ve equates to better than expected				

Executive Director of Finance

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF FINANCE

BOARD OF DIRECTORS

NOVEMBER 2017

FINANCIAL POSITION AS AT 31ST OCTOBER 2017

1 INTRODUCTION

The enclosed financial statements reflect the Trust and its subsidiary companies Income & Expenditure position as at 31st October 2017, details of which can be found in Appendices 1-6.

1.1 SUMMARY POSITION

Performance against the control total is as follows:

	Position at Month 7		
	NHSI Plan	Actual	Variance
	£000s	£000s	£000s
Deficit for the year before Impairments and Transfers	(4,113)	(5,545)	(1,432)
Add: depreciation on donated assets	0	0	0
Less: gain on asset disposal	0	0	0
Less: income from donated assets	2	(26)	(28)
Less: 2016/17 STF post accounts allocation		(419)	(419)
Control Total Surplus/(Deficit) including STF	**(4,110)**	**(5,990)**	**(1,880)**
Less: STF 2017/18	(4,157)	(3,233)	(956)
Less: STF Incentice schemes	0	0	0
Control Total Surplus/(Deficit) excluding STF	**(8,267)**	**(9,223)**	**956**

The overall operational financial position including STF is a net deficit of £5,545k against a planned deficit of £4,113k, and therefore £1,432k behind plan.

The net deficit of £5,545k included income for £419k as part of 2016/17 STF funding post accounts reconciliation, and £3,233k for the first six months of this year for achieving it's control total. The Trust position compared to control total excluding STF is £9,223k deficit compared to planned £8,267k deficit therefore £956k behind plan. The Trust has therefore failed to achieve it's Control Total for month 7.

The Trust reported an under performance of £562k in month 7 relating to NHS clinical activity which is due to lower than expected PbR activity.

At the end of October the Cost Improvement Plan (CIP) delivery is £620k behind projected plans submitted to NHSI.

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

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

which is in line with plan.

The decline in financial position in month 7 is largely due to the following:

Key reasons for the movement in variance from last month:
- £450k – CIP requirement £1.3m per month rather than £867k in prior months.
- £250k - QIPP – continued flat lining of income for Durham's means this QIPP target continues to increase.
- £80k - One off redundancy costs
- £80k - Increase in additional sessions and backdated sessions from September.
- £70k - VAT charge linked to backdated VAT charges.

2 INCOME AND EXPENDITURE POSITION

2.1 *Patient Related Income:*

Clinical Income to month 7 was £183,733k against a plan of £184,295k, and hence behind plan by £562k.

The Trust has block contract arrangements in place with both Sunderland CCG and South Tyneside CCG which ensures certainty in funding flows for the year; however PbR contracts with DDES CCG and NHS England commissioners are over performing. North Durham and NHS Dental continue to under perform against contract.

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

Private Patient Income is over recovered against plan by £56k.

2.2 *Non Patient Related Income:*

Training and Education income is behind plan by £100k to month 7 due to cessation of funding from Health Education North East for a number of schemes this year, this is partly matched by a reduction in non pay costs. Research and Development income is marginally ahead of plan to date.

Other Income was ahead of plan by £2,171k due largely to the Trust accessing £2m from the Sunderland South Tyneside local health economy risk share agreement.

As mentioned earlier, the Trust has failed to achieve month 7 Control Total is therefore not eligible for STF funding for £924k.

3 EXPENDITURE

3.1 *Pay Expenditure:*

Pay is currently showing an overspend of £148k against plan, reflecting:
- Agency costs to month 7 are £3,464k, compared to an overall Trust agency staffing budget to month 7 of £2,502k. Much of this spend is to cover vacant posts. The same period in 2016-17 had agency spend at £2,760k which is £704k less than the current period, the main reason is two more agency consultants in Radiology compared to 2016/17 to cover substantive staffing gaps. In addition a challenging CIP target was set for agency reduction in 2017-18. The position on agency spend has the Trust below its maximum agency/ceiling level set by NHS Improvement to the end of October 2017, detailed in Appendix 4. To month 7 the ceiling level is set at £3,612k, whereas the total spend to date is £3,464k and hence below by £148k.

- To date the net underspend from vacant nursing posts across the Trust is £781k which is inclusive of the costs paid to NHS Professionals and overtime working.
- Cost Improvement Plans for pay are £105k ahead of plan to date mainly due to vacancies across the Trust.
- Other Staff group underspend is largely due to vacancies in CHoICE, Theatres and the cross charge to South Tyneside FT for the single management structure.
- Key variances by staff group are detailed as:

Key Pay variances by staff group to current month	£000s
Consultants Staff (net of vacancies, additional sessions and agency costs)	689
Other Medical Staff (net of vacancies, additional sessions and agency costs)	775
Nursing (net of NHSP Costs)	-781
Other Staff groups	-535
Total Variance	**148**

Appendix 4 shows details of pay spend on agency, flexi-bank and overtime for the last 12 months from month 7. The increase in pay this month is mainly attributable to one off redundancy costs, increase in additional sessions and backdated sessions from September.

Overall pay costs in October were £18,203k against a budget of £17,780k for the month.

3.2 *Non Pay Expenditure:*

Non-Pay is overspent by £2,347k. Major areas are highlighted as:

- Drugs overspend this month is £890k against plan, £105k of the overspend is due to a shortfall in CIP to date with the remainder recovered from the cross charge to clinical commissioners.
- Clinical Supplies is overspent by £632k against plan to date, of the overspend £155k is due to a shortfall in CIP delivery to date, and £324k is due to increased offsite diagnostic reporting and tests to third party providers.
- Other Non Pay is overspent by £1,343k against plan to date, most of which is owing to offsite CT scans (£160k), rental of the CT Van (£199k) and offsite MRI scans (£188k). Currently owing to the challenges in recruiting CT radiographers the emergency department CT can only be staffed by closing an existing CT machine. The CT van therefore continues to be used as the most cost-effective alternative to sending scans to private hospitals. Going forward demand for CT scans is forecast to be 8% greater in 2017-18 compared to last year, this mainly additional emergency department demand. Although growth in MRI demand has flattened recently the predicted 2017-18 demand is still expected to be 4,000 over the capacity which CHS can provide with its two in-house MR machines, therefore offsite capacity is still required. A further £435k of the overspend is due to CIP under delivery against plan to date.
- PDC costs are £453k underspent against plan to date.
- Depreciation costs are £100k underspent against plan to date.
- Interest paid is £34k overspent against plan to date.

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

4 CIP POSITION

At the end of Month 7, CIP delivery was £5,880k against a planned delivery of £6,500k and hence an under delivery of £620k. This shortfall is reflective of the unidentified CIP targets set for the Trust for 2017/18, plus slippage against some high level CIP assumptions for

agency cost reductions.

Current Trust CIP plans have identified £12.5m of the £13.0m target this year, much of this delivery especially for procurement will be in the later stages of the financial year. At this stage the Trust anticipates total CIP delivery for 2017/18 to be in line with plan of £13m.

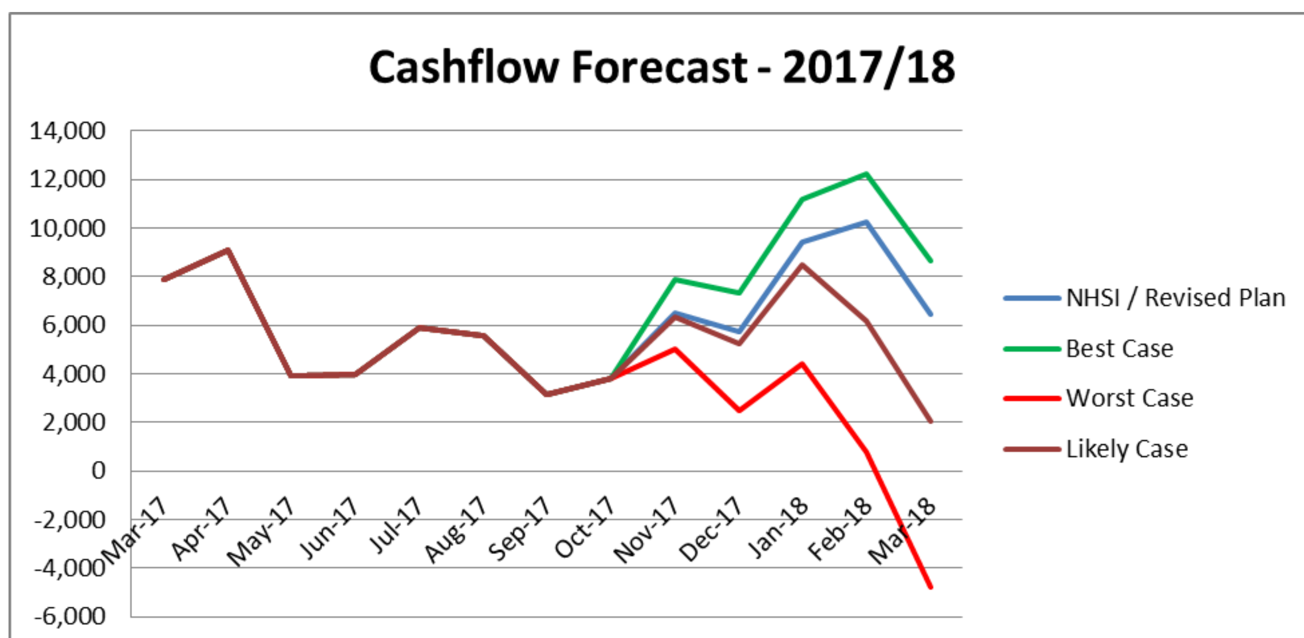
Details are provided in Appendix 6.

5 CASHFLOW AND WORKING CAPITAL

The cash balance at the end of October 2017 was £3.81m against planned £2.76m. The favourable variance of £1.05m consists of a shortfall in cash relating to the delayed receipt of quarter 1 STF funding £1.39m and negative working capital movements of £420k, offset by a favourable variance resulting from the capital cash profile being behind plan £1.81m.

The adverse NHS debtor variance of £9.99m consists of an un-invoiced accruals in respect of STF funding £3.23m and clinical activity income £1.67m and various outstanding invoices relating to Risk Share agreement funding £2m, Pathology and Medical Physics services £920k, clinical activity income £380k and other miscellaneous charges etc £1.79m. All debtors continue to be vigorously pursued.

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



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

The NHSI/revised plan assumes achievement of the control total for the year and that all STF funding will be received. A key change compared to the annual plan value for cash is approximately £2.4m of non-cash items within the income and expenditure position for 2017/18, for example stock revaluation and lower than planned depreciation. The best, likely and worst case scenarios are driven by the overall income and expenditure forecasts in detailed in this paper but also account for the noted £2.4m non-cash items.

In all scenarios it is assumed the Trust will receive CQUIN funding in full and the agreed Risk Share funding from the CCG. The best case scenario assumes achievement £1.3m over delivery against income and expenditure control total with a like for like cash impact, therefore full STF funding, plus contingency built into the capital programme not being fully required, and a VAT refund from HMRC £(926k) relating to a number capital schemes transferred from CHS to CHoICE that became eligible for Capital Goods Scheme relief.

The likely case scenario assumes the Trust is £1.8m behind the required control total with a like for like cash impact, and therefore does not gain STF funding for quarter 3 (note quarter 4 STF cash would be into 2018/19).

The worst case scenario assumes the Trust is £8.4m behind the required control total with a like for like cash impact, and therefore does not gain STF funding for quarter 3.

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

6 CAPITAL

Capital expenditure to date is £1,313k and relates A&E Development (£586k), Back Log Maintenance schemes £(348k), Sewing Room Conversion £(194k) and IMT Costed Profile £(46k).

7 RISKS

The two prime risks are firstly, the gap in CIP plans especially given the increase in target for Quarters 3 and 4 later this year, secondly under performance against PbR contracts with commissioners and the challenge in pulling like for like costs from the system. The increase in pay costs, through agency, additional sessions and bank compared to 2016/17 is an area that needs to be focussed on for the remainder of 2017/18.

8 FORECAST

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

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

Scenario	Forecast deficit (£m)	Variance from control total (£m)
Best Case	13.635	-1.346
Worst Case	23.355	8.374
Likely Case	16.765	1.784

The Trust is working through a number of measures to potentially improve this position such as conversations with commissioners of additional funding, and a review of possible benefits through national Financial Grip and Control checklist. In addition we continue to work closely with all commissioners to understand their QIPP plans and the knock on impact to us as a provider, it is essential that costs are removed to mitigate these income reductions. The Trust has significant concerns around the achievement of the control total by the end of the year, however is working closely with the regional NHSI team to ensure all options have been considered ahead of formally declaring non achievement.

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

9 CHoICE SHAREHOLDING

The Trust currently wholly owns a subsidiary company 'CHoICE' and has almost 12 million shares. As part of working more closely together it is proposed that South Tyneside Foundation Trust be given the opportunity to purchase £1,000 worth of shares. A paper detailing the rationale and the proposal was taken to CHS Audit Committee in November who supported the proposal in principle. The Board is requested to approve their recommendation.

10 NEXT STEPS

The Trust needs focus on identifying £500k of CIPs to achieve its full £13m CIP target for 2017/18, plus renewed focus on pay cost increases is required.

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

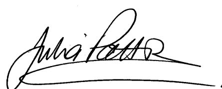
11 SUMMARY

The overall position at the end of October including STF, is a deficit of £5,545k compared to a planned deficit of £4,113k or £1,432k behind plan. The position excluding STF is £956k behind plan.

12 RECOMMENDATIONS

The Board is requested to:

- Support the recommendation of the Audit Committee to allow STFT to purchase shares in CHoICE.
- Note the financial position to date.



Julia Pattison
Executive Director of Finance
November 2017

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

Income & Expenditure Position

	Annual	Current Month			Year to Date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
£m	£m	£m	£m	£m	£m	£m	£m
Income							
NHS Clinical income	-313.58	-27.10	-25.99	1.11	-184.30	-183.73	0.56
PBR Clawback/relief	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Private patient income	-0.35	-0.03	-0.06	-0.04	-0.20	-0.26	-0.06
Non-patient income	-37.29	-2.35	-2.39	-0.04	-20.46	-22.02	-1.57
Total income	**-351.21**	**-29.48**	**-28.45**	**1.03**	**-204.95**	**-206.01**	**-1.06**
Expenses							
Pay Costs	214.60	17.78	18.203	0.42	125.556	125.704	0.15
Drug costs	38.12	3.16	3.31	0.15	22.32	23.21	0.89
Other Costs	89.03	7.39	7.74	0.36	52.32	54.29	1.98
Total costs	**341.76**	**28.33**	**29.26**	**0.93**	**200.20**	**203.21**	**3.01**
Earnings before interest, tax, depreciation & amortisation (EBITDA)	**-9.45**	**-1.15**	**0.81**	**1.96**	**-4.753**	**-2.802**	**1.95**
Profit/loss on asset disposal	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Depreciation	8.35	0.70	0.69	-0.01	4.87	4.77	-0.10
PDC dividend	5.02	0.42	0.35	-0.06	2.93	2.48	-0.45
Interest	1.83	0.15	0.15	0.00	1.07	1.10	0.03
Corporation tax	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net surplus (pre exceptionals)	**5.74**	**0.12**	**2.00**	**1.89**	**4.11**	**5.55**	**1.43**
Exceptional items							
Net (surplus)/Deficit (post exceptionals)	**5.74**	**0.12**	**2.00**	**1.89**	**4.11**	**5.55**	**1.43**
EBITDA Margin	**2.7%**	**3.9%**	**-2.8%**		**2.3%**	**1.4%**	

CITY HOSPITALS SUNDERLAND FOUNDATION TRUST
TRUST PERFORMANCE SUMMARY

PERIOD ENDED 31ST OCTOBER 2017

TRUST SUMMARY

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

	Annual Budget £'000s	Quarter 1 £'000s	Jul actual £'000s	Aug actual £'000s	Sep actual £'000s	Oct actual £'000s	YTD actual £'000s	Plan £'000s	Variance £'000s
Income									
Contract Income	(313,575)	(77,970)	(26,283)	(26,664)	(26,824)	(25,992)	(183,733)	(184,295)	562
STF	(9,237)		(419)		(3,233)		(3,652)	(4,157)	505
Private Patients	(345)	(93)	(32)	(36)	(32)	(64)	(257)	(201)	(56)
Training and Education Income	(11,499)	(2,875)	(935)	(981)	(908)	(909)	(6,608)	(6,708)	100
Research and Development Income	(1,476)	(370)	(139)	(139)	(85)	(132)	(865)	(861)	(4)
Other income	(15,035)	(4,338)	(762)	(1,191)	(3,245)	(1,351)	(10,888)	(8,704)	(2,184)
Interest Receivable	(43)	(4)	(1)	(1)	(4)	(2)	(12)	(25)	13
Total Income	**(351,210)**	**(85,651)**	**(28,571)**	**(29,012)**	**(34,330)**	**(28,450)**	**(206,014)**	**(204,951)**	**(1,063)**
Expenditure									
Pay	214,604	53,897	17,875	17,932	17,797	18,203	125,704	125,556	148
Clinical Supplies and Services	32,431	8,312	2,796	2,961	2,769	2,837	19,675	19,043	632
Drug Costs	38,124	10,005	2,938	3,681	3,277	3,312	23,213	22,323	890
Other Costs	56,598	14,901	4,850	5,014	4,946	4,908	34,619	33,276	1,343
Depreciation	8,348	2,247	598	633	603	688	4,770	4,870	(100)
PDC Dividend	5,022	1,149	216	404	354	354	2,477	2,930	(453)
Interest	1,827	497	154	153	144	151	1,100	1,066	34
Total Expenditure	**356,955**	**91,007**	**29,428**	**30,779**	**29,889**	**30,454**	**211,559**	**209,064**	**2,495**
(Surplus)/Deficit	**5,745**	**5,357**	**858**	**1,767**	**(4,441)**	**2,004**	**5,545**	**4,113**	**1,432**
Cost Improvement Plans	(13,000)	(2,264)	(935)	(819)	(931)	(931)	(5,880)	(6,500)	620

WTE Analysis (WTEs)

	Annual Budget	Quarter 1	Jul actual	Aug actual	Sep actual	Oct actual	YTD actual	Plan	Variance
Total WTEs	**4,918.47**	**4,755.77**	**4,794.86**	**4,841.10**	**4,817.04**	**4,845.68**	**4,845.68**	**4,897.55**	**-51.87**

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

Assets	Plan As At 31-Oct-17 £m	Actual As At 31-Oct-17 £m	Variance £m
Assets, Non-Current:			
Intangible Assets	4.038	4.354	
Property, Plant and Equipment	218.169	188.082	
Trade and Other Receivables	0.918	1.145	
Assets, Non-Current, Total	223.125	193.581	
Assets, Current:			
Inventories	5.900	5.892	0.008
Trade and Other Receivables:			
NHS Trade and Other Receivables	3.260	13.248	-9.988
Non NHS Trade and Other Receivables	6.635	7.478	-0.843
Trade and Other Receivables, Total	9.895	20.726	
Cash and Cash Equivalents:			
Government Banking Service & Invested	2.363	2.735	
Commercial Bank account	0.400	1.072	
Cash and Cash Equivalents, Total	2.763	3.807	1.044
Assets, Current, Total	18.558	30.425	
ASSETS, TOTAL	**241.683**	**224.006**	

Liabilities

Liabilities, Current:			
Interest-Bearing Borrowings, Total			
Loans, non-commercial, Current (DH, FTFF, NLF, etc)	-3.273	-3.273	0.000
Interest-Bearing Borrowings, Total	-3.273	-3.273	
Deferred Income	-1.800	-2.277	0.477
Provisions	-0.212	-0.217	0.005
Trade and Other Payables:			
Trade Payables, Current	-25.480	-29.518	4.038
Other Financial Liabilities	-0.630	-0.549	-0.081
Capital Payables, Current	-0.592	-1.352	0.760
Trade and Other Payables,Total	-26.702	-31.419	
Liabilities, Current, Total	-31.987	-37.186	
NET CURRENT ASSETS (LIABILITIES)	-13.429	-6.761	
Liabilities, Non-Current			
Interest-Bearing Borrowings:			
Loans, Non-Current, non-commercial (DH, FTFF, NLF, etc)	-50.855	-50.855	0.000
Loans, Non-Current, commercial	0.000	0.000	0.000
Interest-Bearing Borrowings,Total	-50.855	-50.855	
Provisions, Non-Current	-0.869	-0.794	-0.075
Liabilities, Non-Current, Total	-51.724	-51.649	
TOTAL ASSETS EMPLOYED	**157.972**	**135.171**	

Taxpayers' and Others' Equity

Taxpayers' Equity		
Public Dividend Capital	102.042	102.248
Revaluation Reserve	75.084	52.797
Retained Earnings	-19.154	-19.874
TAXPAYERS' EQUITY, TOTAL	**157.972**	**135.171**
	0.000	0.000

Appendix 3 - Clinical Income Report Overview

Table 1: Financial Position (M1-7) per Commissioner agreed Contracts and the NHSI plan

Commissioner contracts	Plan as per NHSI	Plan as per PbR	Total Actuals	Variance as per NHSI	Variance as perPbr	% Against NHSI	% Against PbR
	£'000s	£'000s	£'000s	£'000s	£'000s		
Sunderland	102,329	102,329	102,329	0	**0**	0.0%	0.0%
South Tyneside	13,764	13,764	13,764	0	**0**	0.0%	0.0%
Gateshead	2,763	2,516	2,412	350	**104**	14.5%	4.3%
Sunderland LA	1,402	1,402	1,402	0	**0**	0.0%	0.0%
DDES	22,090	20,618	21,063	1,027	**-445**	4.9%	-2.1%
North Durham	9,972	9,737	9,434	537	**303**	5.7%	3.2%
HAST	2,151	2,019	2,020	131	**-1**	6.5%	0.0%
South Tees	147	147	138	9	**9**	6.6%	6.6%
Specialised	20,904	20,904	21,105	-201	**-201**	-1.0%	-1.0%
Dental	3,574	3,574	3,495	79	**79**	2.3%	2.3%
Sub total	**179,094**	**177,009**	**177,162**	**1,932**	**-152**	1.1%	-0.1%
Cancer Drug Fund	1,001	1,001	600	400	**400**	66.7%	66.7%
Hep C drugs	569	569	648	-79	**-79**	-12.2%	-12.2%
NCA's	1,961	1,961	1,674	287	**287**	17.1%	17.1%
AQP - all contracts	627	627	572	55	**55**	9.6%	9.6%
GAP/Stretch target	-901	1,030	0	-901	**1,030**	0.0%	0.0%
Other	1,944	2,097	3,077	-1,133	**-979**		
Total	**184,294**	**184,294**	**183,733**	**562**	**562**	0.3%	0.3%

The clinical income target to end month 7 is £184,294k with actual income reported as £183,733k. Therefore the trust is reporting a cumulative under performance against the Clinical Income budget of £562k.

Block arrangements with Sunderland CCG, Sunderland Local Authority and South Tyneside CCG for 2017/18, mean that income is fixed regardless of under or over performance. Table 1 includes an allowance of activity for a Contract Variation (CV) between CHS and STFT for the transfer of stroke activity (this increases STCCG budget and actual activity & reduces the gap/stretch target accordingly). There are several other CV's, still to be finalised that will affect the financial position and cash flow when completed.

The Clinical income actuals are based on M6 PbR files with the exception of drugs income which is directly matched to expenditure for month 7 for those on PBR contracts. Discussions with NECS commissioners regarding a Q1 cash up are all but finalised with finances shared and agreed by both parties. Emergency Marginal rate and Emergency readmissions penalties are still proving to be a barrier to completion; the matter has been escalated to Director level.

Discussions with NHSE are still ongoing but (as per last month) NHSE are still not following the national rules and submitting challenges after the financial closedown and outside of the national timetable.

This issue has again been raised both at formal contract meetings and raised to Director level within NHSE. The commissioner performance will be explored in certain detail within this report.

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

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

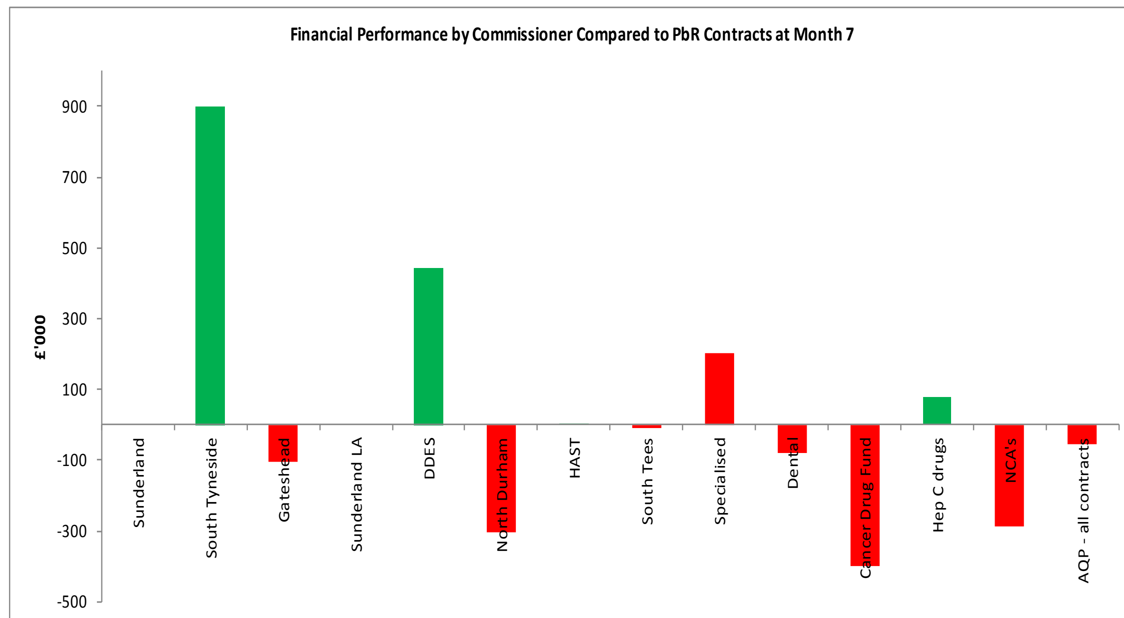
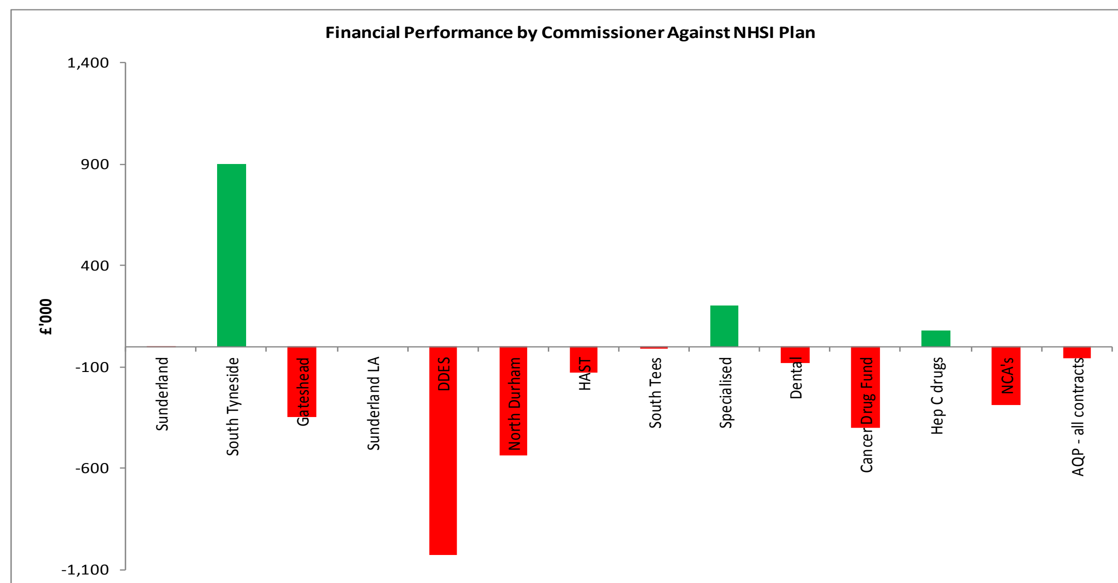


Figure 2: Variance per Commissioner Against the Monitor Plan



HEP C: Are expensive drugs funded nationally for the treatment of Hepatitis. CHS is exploring lower cost dispensing at the request of commissioners.

Summary of main PbR variance by commissioner

Sunderland CCG : This contract is block for 2017/18. If PbR was to be transacted it would show a £1.2m over performance (£737k at m6), mainly due to A&E Attendances. However, there are still bariatric plans to adjust for as mentioned above, which when signed will likely reduce the over performance.

South Tyneside CCG : This contract is also a block for 2017/18. If the PbR was to be transacted, there would be an over performance of £1.6m (£1.3m at m6); this is predominately due to stroke activity transferred from STFT but not yet formally transferred into the contract and also on drugs as the lower priced Avastin was commissioned but is not yet clinically used.

North Durham CCG : Reporting an under performance of £303k against PBR plan (£342k at m6) and £537k against NHSI plan. Although considerably better than m6 where we recorded £594k against plan, underperformance remains in multiple specialities and mainly within outpatients which has been a theme all year.

DDES CCG : DDES is underperforming against the NHSI plan by £1m but over performing against the PbR plan by £425k.

NHSE Specialised: Reporting an over performance of £201k against PBR & NHSI plan (£226k at m6). This position takes the Trusts view of challenges into account. The main area of over performance is drugs however these are a pass through matching expenditure.

NHSE Dental: Under performance of £79k which is a decline in performance compared with M6 (£48k) Maxillo-Facial Surgery is an average of 32% below plan for 17/18 activity over all PODs.

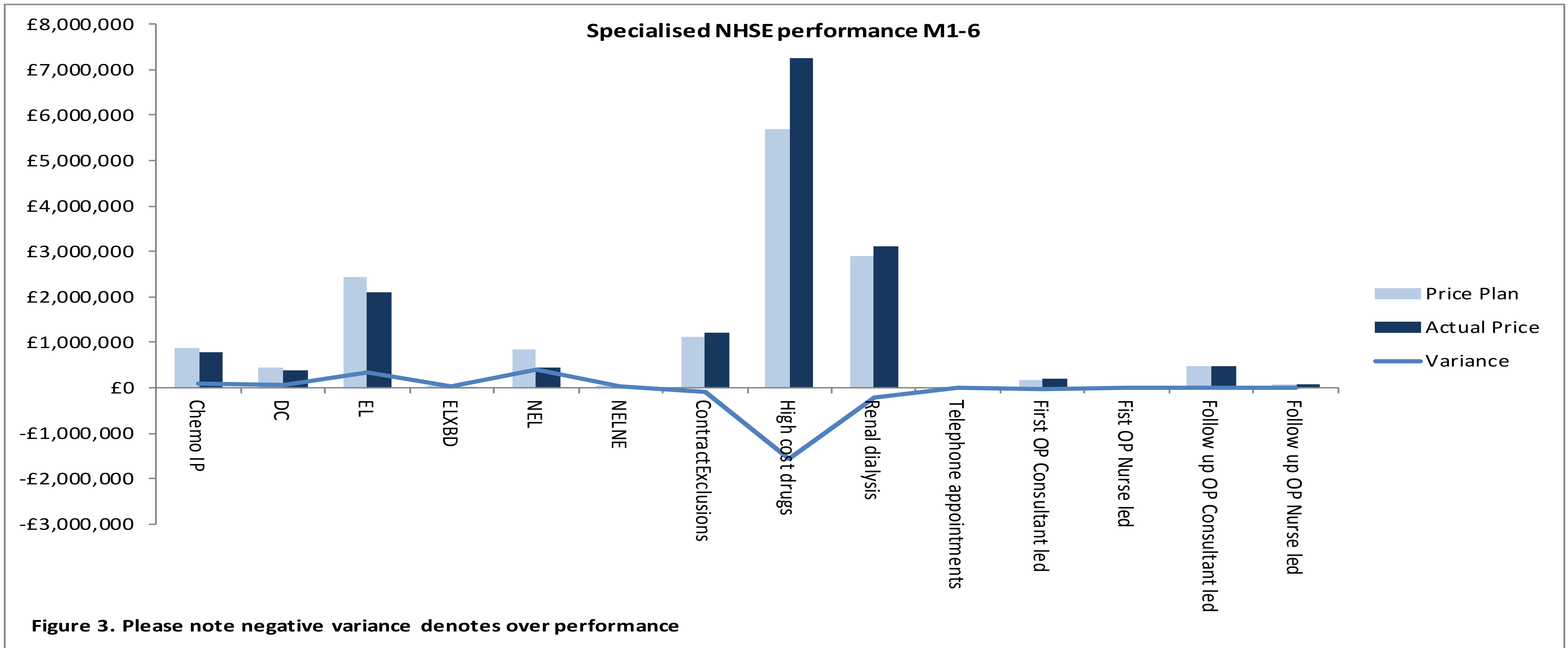


Figure 3. Please note negative variance denotes over performance

NHSE performance and issues

The graph above relates to the latest M6 PbR file and the overall reported position of £201k over performance for NHSE. To note, the £1.5m over recovery of drugs includes expensive hepatitis C drugs which are charged to a central area of NHSE circa £650k. Excluding this, NHSE drugs are over recovered by £1m, the majority of which are cancer drugs, renal and antivirals. There is a contract variation to be actioned for NHSE to increase the baseline by circa £600k for new nice approved drugs which will reduce the variance against plan but the income actuals will not change.

We continue to have great difficulty with NHSE in terms of following the national timetables for data challenges. NHSE are refusing to pay for living donor transplant service despite a letter of support from transplant centre (NUTH). This matter is set to be escalated. This means that as a Trust we have uncertainty around the reported financial position for NHSE due to the fluidity of their challenges. This has been noted and formally recorded at last month's contract meeting and this month escalated to director level. The intention was always to cash up quarterly but due to the issues mentioned we have been unable to achieve this with quarter 2 freeze information due this month. We are only accounting for those challenges which we feel are valid and are fighting to resolve those which we still believe are incorrect, regardless of the level of feedback received from NHSE counterparts.

The drugs matter is also further complicated by the mandated use of a Blueteq which is a system used for the preregistering of a patients drugs regime before they are prescribed. This is taking clinical staff away from their daily duties and requiring them to fill in online forms for certain drugs dispensed. This is causing some challenges if they are not entered onto the system and there is a risk of non-payment because of this.

The rollout of zero cost devices also continues. So far this has been a smooth process with teething problems ironed out regarding stock and timings. However, NHSE did not issue the mandated return for four months (rather than monthly) which required a greater use of admin time to backdate the information and submit. This was not so much of an issue as only BAHA's were online but now that a large volume of stents are purchased through zero cost, this could prove to be problematic if it happens again.

	inflectra (biosimilar)	remiCade (Original)	Grand Total
April	74%	26%	81
May	72%	28%	85
June	77%	23%	64
July	70%	30%	81
August	63%	37%	114
September	75%	25%	81

Drug	benepali (biosimilar)	enbrel (original)	Grand Total
April	5%	95%	171
May	7%	93%	140
June	13%	88%	224
July	53%	47%	68
August	28%	72%	219
September	45%	55%	163

Biosimilar drugs

The tables above show an update of available biosimilar drugs to date. Data represents the number of patients (as a percentage and total column) who are using biosimilars compared to the original drug from the beginning of the financial year. These are highlighted as they are very important part of regional QIPP plans for CCG's and NHSE as their savings can be large over the original drug price. The intention is to increase the use of these and we have a gain share in place with NECs CCG's for half of the savings. More drugs will be coming online in the coming months and this paper will be updated to show their uptake.

Table shows a very positive uptake or Inflectra from the start of the year and a continued high usage to date. The usage of Benepali has been somewhat slower but is starting to increase (and should hopefully continue). There are some barriers to patient switch including; consultant choice, patient choice and residual stock of the original .drug needing to be used, which have all been the case with Benepali.

Risk to income

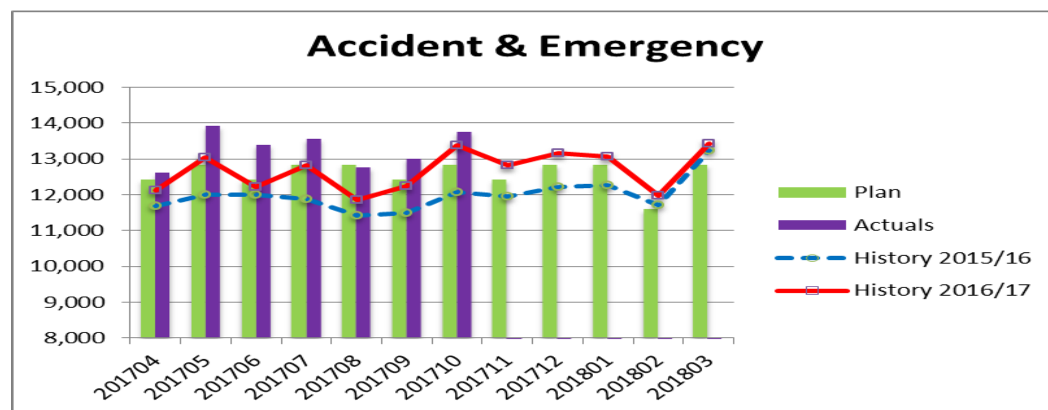
The main risk with the clinical income position remains NHSE challenges. As per last month, the issues are both the quantity and the timeliness of these challenges. The issue has been raised formally and tabled at contract meetings as well as being escalated to a senior level. This impacts upon the Trusts ability to report an agreed position as well as cash flow as there have been no agreed over performance invoices raised with NHSE because of this. Challenges, which are mainly drug related, which we see as a risk to date have been built into the position, but the final agreed position may be different to this. Some CCG's have made 'risk pool' payments in advance of reconciling the Q1 position, due to lower than anticipated activity (as reported), this means credit notes are likely to be significant, circa £1m for Q1. They have now requested these payments stop and will send formal notification shortly.

There are several Contract Variations still to be finalised which will impact on the reported positions and cash flow. With the Bariatrics CV, there is an added risk that the CCG's and NHSE have entered into a risk share on this which will be transacted on a PbR basis and not block arrangements with SCCG and STCCG.. As discussed previously, we are very close to agreeing a Q1 position for NEC's represented CCG's with the only significant barriers to this being emergency marginal rate and emergency readmissions calculations, likely to be carried forward for resolution later.

A risk for penalties and the non-achievement of CQUIN has been built in for CCG's where appropriate. NHSI are to advise on accounting for the 0.5% CQUIN held back for the 'risk share, which could adversely affect both the income and cash position. The Trust has not adjusted clinical income values to reflect the 0.5% CQUIN risk reserve. The trust is still awaiting further clarity from NHSI regarding this position and cash implications.

Position for Activity by POD (Month 7)

Accident & Emergency



A&E activity is 6.1% above historical levels and 5% above plan. Type 1 A&E (main site) is 7.8% above plan; Type 2 (Eye Infirmary) is 5.8% below plan and Type 4 (Pallion) is 8.4% above plan.

In October, the number at attendances at SEI are the second lowest in 17/18 with 2,498 attendances compared to a previous monthly average of 2,640.

Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
A&E Attendances	**88,687**	**93,081**	**87,711**	**4,394**	**5,370**
201704	12,433	12,618	12,136	185	482
201705	12,847	13,929	13,054	1,082	875
201706	12,433	13,405	12,210	972	1,195
201707	12,847	13,571	12,822	724	749
201708	12,847	12,771	11,864	-76	907
201709	12,433	13,023	12,237	590	786
201710	12,847	13,764	13,388	917	376
Grand Total	**88,687**	**93,081**	**87,711**	**4,394**	**5,370**

Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
A&E Attendances	**88,687**	**93,081**	**87,711**	**4,394**	**5,370**
Type1	50,443	54,386	51,149	3,943	3,237
Type2	19,472	18,340	18,753	-1,132	-413
Type4	18,772	20,355	17,809	1,583	2,546
Grand Total	**88,687**	**93,081**	**87,711**	**4,394**	**5,370**

ED attendances in October were the second highest in 17/18, with Type 1 attendances overperforming by 13%. The number of ED attendances resulting in an Emergency Admission rose back up to 21%, with the greatest number of admissions being into Geriatric Medicine and Accident & Emergency.

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

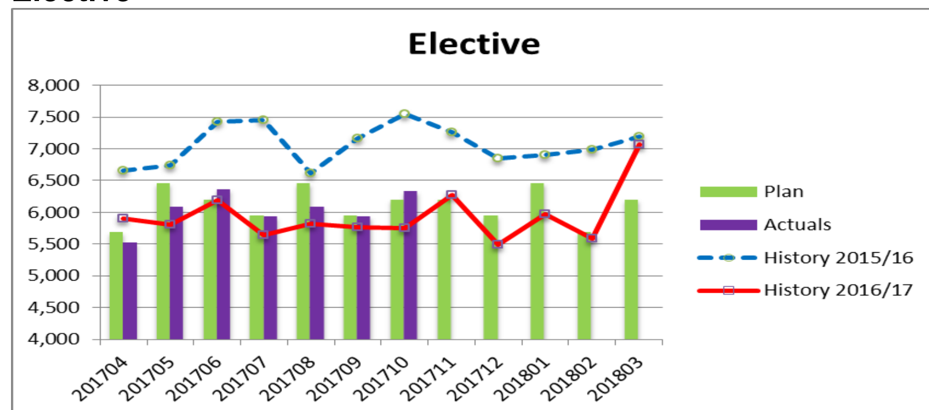
Sunderland CCG is the main commissioner of A&E activity with 79.8% of the contract. As this contract is blocked, there is a financial risk to over performing against plan if attendances continue at this level.

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

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

Position for Activity by POD (Month 7)

Elective



Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
Elective	42,945	42,311	40,896	-634	1,415
Ophthalmology	8,040	8,808	7,951	768	857
Colorectal Surgery	0	748		748	748
Upper Gastrointestinal Surgery	101	460	102	359	358
Anaesthetics	0	140		140	140
Respiratory Medicine	1,032	1,164	981	132	183
Paediatrics	231	331	278	100	53
Nephrology	386	475	413	89	62
Endocrinology	131	200	138	69	62
Gynaecology	1,008	1,042	966	34	76
Neurology	427	455	457	28	-2
Oral & Maxillo Facial Surgery	2,999	3,026	2,983	27	43
Diabetic Medicine	29	56	30	27	26
Geriatric Medicine	37	52	34	15	18
Well Babies	2	4	2	2	2
Accident & Emergency	173	174	176	1	-2
Rehabilitation	8	7	9	-1	-2
Obstetrics	60	45	52	-15	-7
Pain Management	508	466	536	-42	-70
Rheumatology	795	745	820	-50	-75
Trauma & Orthopaedics	3,361	3,298	3,365	-63	-67
Cardiology	1,331	1,198	1,102	-133	96
ENT	2,525	2,357	2,438	-168	-81
Clinical Haematology	3,220	3,019	2,783	-201	236
Vascular Surgery	1,009	771	917	-238	-146
Urology	4,791	4,504	4,486	-287	18
Gastroenterology	3,557	3,252	3,444	-305	-192
Medical Oncology	3,782	3,275	3,084	-507	191
General Surgery	3,402	2,239	3,349	-1,163	-1,110
Grand Total	42,945	42,311	40,896	-634	1,415

Elective Spells Summary

Elective activity is up 1,415 spells (3.5%) vs 16/17 history but down 634 spells (1.5%) vs plan YTD.

Octobers actuals were 130 above plan. This is over and above an increased plan compared to September, due to the number of working days in the month of October. Actuals are the second highest month YTD.

The reason for what looks to be a large underperformance against 15/16 history on the graph was the reclassification of Lucentis injections in Ophthalmology from daycases to OP procedures from 16/17

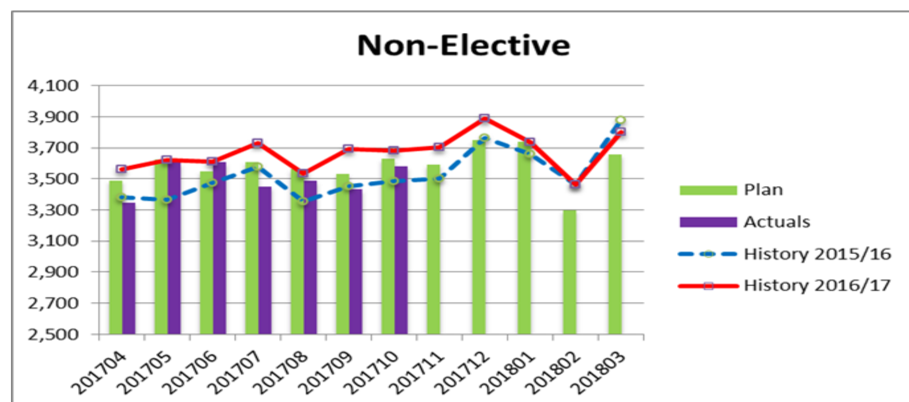
Specialty in focus – General Surgery

There have been some changes at a Specialty level this month due to changes made to allocate Inpatient activity out to Surgical Sub Specialties. Previously, all General Surgery Directorate activity was allocated to General Surgery specialty, with only a small amount of Bariatric offsite being attributed to Upper GI and Vascular being counted seperately. This month, activity has been split out to Colorectal Surgery and Upper GI for all CHS activity. The plan for 17/18 sits under General Surgery so this looks like a large underperformance as the actuals have been swept back to April. There is no tariff implication for this shift in activity as all Inpatient activity is priced at HRG level

Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
Elective	4,511	4,218	4,368	-293	-150
Colorectal Surgery	0	748		748	748
Upper Gastrointestinal Surgery	101	460	102	359	358
Vascular Surgery	1,009	771	917	-238	-146
General Surgery	3,402	2,239	3,349	-1,163	-1,110
Grand Total	4,511	4,218	4,368	-293	-150

Position for Activity by POD (Month 7)

Non Elective



Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
Upper Gastrointestinal Surgery	0	441		441	441
Colorectal Surgery	0	422		422	422
Endocrinology	344	738	421	394	317
Geriatric Medicine	3,369	3,758	3,592	389	166
Respiratory Medicine	984	1,182	1,138	198	44
Nephrology	681	748	675	67	73
Clinical Haematology	198	251	198	53	53
Ophthalmology	325	367	330	42	37
Medical Oncology	34	73	46	39	27
Anaesthetics	0	39		39	39
Obstetrics	10	26	48	16	-22
Neurology	41	49	58	8	-9
Cardiology	1,844	1,852	1,897	8	-45
Critical Care Medicine	0	1		1	1
Well Babies	4	5	10	1	-5
Oral & Maxillo Facial Surgery	216	216	197	0	19
General Medicine	2	0		-2	0
Gastroenterology	1,144	1,142	1,180	-2	-38
Rehabilitation	45	36	43	-9	-7
Pain Management	25	14	27	-11	-13
Rheumatology	38	18	20	-20	-2
Vascular Surgery	166	128	153	-38	-25
Urology	1,471	1,405	1,422	-66	-17
Gynaecology	674	576	602	-98	-26
ENT	934	792	903	-142	-111
Trauma & Orthopaedics	1,470	1,312	1,492	-158	-180
Diabetic Medicine	341	169	355	-172	-186
Paediatrics	2,523	2,280	2,435	-243	-155
Accident & Emergency	5,260	4,850	5,270	-410	-420
General Surgery	2,871	1,637	2,923	-1,234	-1,286
Grand Total	**25,014**	**24,527**	**25,435**	**-487**	**-908**

Non Elective Spells Summary

Non Elective activity is down 908 spells (3.6%) vs history and down 487 spells (1.9%) vs plan.

21% (2,826) of ED attendances resulted in an Emergency admission in October. These were initially admitted into Geriatric Medicine or Accident & Emergency as specialties, but the specialty for the spell is driven by the patients specialty on discharge, which is what the numbers in the table on the left represent.

Performance against plan at a specialty level remains largely consistent with previous months. There have been some changes at a Specialty level this month due to changes made to allocate Inpatient activity out to Surgical Sub Specialties, as detailed above.

Commissioner Focus

Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
CUMBRIA AND NORTH EAST COMMISSIONING HUB	365	228	269	-137	-41
NHS CUMBRIA CCG	0	0	12	0	-12
NHS DURHAM DALES, EASINGTON AND SEDGEFIELD CCG	3,796	3,587	3,888	-209	-301
NHS ENGLAND NORTH (CUMBRIA AND NORTH EAST)	211	204	193	-7	11
NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG	53	43	49	-10	-6
NHS NEWCASTLE GATESHEAD CCG	269	194	289	-75	-95
NHS NORTH DURHAM CCG	897	875	788	-22	87
NHS SOUTH TEES CCG	16	17	15	1	2
NHS SOUTH TYNESIDE CCG	1,157	1,322	1,132	165	190
NHS SUNDERLAND CCG	18,044	17,831	18,573	-213	-742
NON CONTRACT ACTIVITY	206	226	227	20	-1
Grand Total	25,014	24,527	25,435	-487	-908

Non Elective activity at month 7 is only 1.9% under plan. The CCGs with the greatest under and over performance against plan are Sunderland and South Tyneside respectively, both of which have block contracts.

Position for Activity by POD (Month 7)

Consultant Led Outpatients

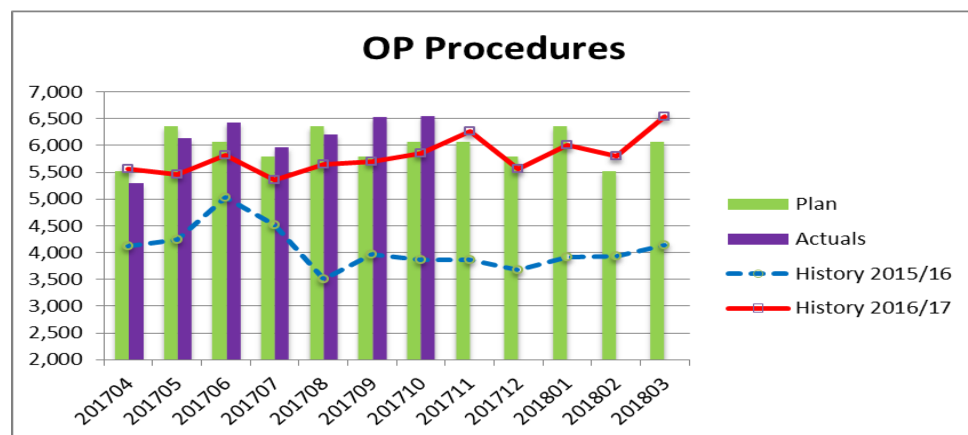
First Outpatient (consultant led) activity is 2,964 attendances (4.6%) below history and 3,524 attendances (5.4%) below plan. Directorates with the most significant variance against plan include Paediatrics, Urology and General Surgery.

Review Outpatient (consultant led) activity is 4,375 attendances (3.6%) below history and 4,480 attendances below plan (3.6%). Directorates with the greatest variance against plan include Paediatrics, Theatres, Emergency Care and Urology.

Row Labels	Plan	Actuals	Var Vs Plan	Var vs plan %	History 2016/17	Var Vs History
OP CONSULTANT LED - NEW	**64,993**	**61,469**	**- 3,524**	**-5%**	**64,433**	**- 2,964**
Emergency Care	2,178	2,228	50	2%	2,073	155
General Internal Medicine	5,044	4,810	- 234	-5%	5,468	- 658
General Surgery	5,001	4,090	- 911	-18%	4,570	- 480
Head & Neck	9,553	8,714	- 839	-9%	9,366	- 652
Medical Specialties	3,325	3,206	- 119	-4%	3,420	- 214
Obstetrics & Gynaecology	7,385	7,391	6	0%	7,640	- 249
Ophthalmology	7,994	8,061	67	1%	8,094	- 33
Other	2	33	31	1782%	3	30
Paediatrics	4,130	3,383	- 747	-18%	3,373	10
Rehab & Elderly Medicine	4,310	4,396	86	2%	4,252	144
Theatres	803	821	18	2%	779	42
Trauma & Orthopaedics	8,634	8,789	155	2%	9,290	- 501
Urology	6,635	5,547	- 1,088	-16%	6,105	- 558
OP CONSULTANT LED - REVIEW	**122,847**	**118,367**	**- 4,480**	**-4%**	**122,742**	**- 4,375**
Emergency Care	5,793	5,259	- 534	-9%	5,788	- 529
General Internal Medicine	12,888	12,950	62	0%	12,932	18
General Surgery	7,507	8,211	704	9%	8,788	- 577
Head & Neck	13,936	13,639	- 297	-2%	13,501	138
Medical Specialties	18,067	16,815	- 1,252	-7%	17,710	- 895
Obstetrics & Gynaecology	4,806	4,578	- 228	-5%	4,774	- 196
Ophthalmology	23,485	22,720	- 765	-3%	23,382	- 662
Other	86	75	- 11	-13%	34	41
Paediatrics	6,441	5,353	- 1,088	-17%	6,034	- 681
Rehab & Elderly Medicine	4,751	4,471	- 280	-6%	4,703	- 232
Theatres	1,273	1,099	- 174	-14%	1,229	- 130
Trauma & Orthopaedics	12,870	13,213	343	3%	13,821	- 608
Urology	10,943	9,984	- 959	-9%	10,046	- 62
Grand Total	**187,840**	**179,836**	**- 8,004**	**-4%**	**187,175**	**- 7,339**

Position for Activity by POD (Month 7)

Outpatient Procedures



Outpatient Procedures are 3,722 procedures above history (9 %) and 1,111 procedures above plan (3%). The variance against plan has improved significantly over the past few months. This is largely due to improvements in the recording of Lucentis procedures within Ophthalmology.

A breakdown of activity by Commissioner is shown in the table below:

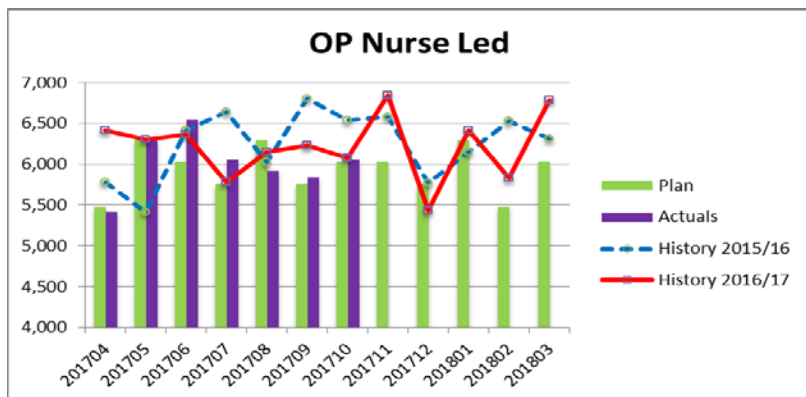
Row Labels	Plan	Actuals	Var Vs Pla	Var vs Plar
OP PROCEDURE	**42,019**	**43,130**	**1,111**	**3%**
CUMBRIA AND NORTH EAST COMMISSIONING HUB	3	6	3	129%
NHS CUMBRIA CCG	0	0	0	-
NHS DURHAM DALES, EASINGTON AND SEDGEFIELD CCG	5,845	6,185	340	6%
NHS ENGLAND NORTH (CUMBRIA AND NORTH EAST)	1,625	1,841	216	13%
NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG	1,748	1,866	118	7%
NHS NEWCASTLE GATESHEAD CCG	638	918	280	44%
NHS NORTH DURHAM CCG	5,817	6,065	248	4%
NHS SOUTH TEES CCG	38	51	13	34%
NHS SOUTH TYNESIDE CCG	5,753	5,992	239	4%
NHS SUNDERLAND CCG	19,914	19,596	-318	-2%
NON CONTRACT ACTIVITY	639	610	-29	-5%
Grand Total	**42,019**	**43,130**	**1,111**	**3%**

Sunderland CCG and NCA's are marginally under plan year to date. The remaining Commissioners are currently over plan. Newcastle and Gateshead CCG are significantly over performing against plan. The over performance relates to ENT, Obstetrics and Ophthalmology. Any over performance with Newcastle and Gateshead CCG will be reimbursed on a PbR basis.

Row Labels	Plan	Actuals	Var Vs Plan	Var vs plan %	History 2016/17	Var Vs History
OP PROCEDURE	**42,019**	**43,130**	**1,111**	**3%**	**39,408**	**3,722**
Accident & Emergency	71	96	25	36%	29	67
Anaesthetics	0	31	31	0%	29	2
Breast Surgery	1	0	-1	-		0
Cardiology	540	531	-9	-2%	513	18
Clinical Neurophysiology	1,744	1,841	97	6%	1,713	128
Colorectal Surgery	148	144	-4	-3%	393	-249
Diabetic Medicine	0	29	29	-	18	11
ENT	7,285	7,089	-196	-3%	6,864	225
Gastroenterology	3	4	1	17%	2	2
General Surgery	65	34	-31	-48%	63	-29
Geriatric Medicine	4	0	-4	-100%		0
Gynaecology	2,200	2,164	-36	-2%	1,979	185
Medical Oncology	3	6	3	129%	2	4
Nephrology	1	0	-1	-100%	1	-1
Neurology	3	0	-3	-100%		0
Obstetrics	120	406	286	237%	520	-114
Ophthalmology	20,657	21,020	363	2%	19,527	1,493
Oral & Maxillo Facial Surgery	1,099	1,208	109	10%	77	1,131
Orthodontics	533	640	107	20%	207	433
Paediatrics	205	180	-25	-12%	188	-8
Pain Management	0	1	1	-	2	-1
Rehabilitation	1	0	-1	-100%		0
Respiratory Medicine	38	29	-9	-23%	12	17
Rheumatology	392	753	361	92%	434	319
Stroke Medicine	1	0	-1	-100%		0
Transient Ischaemic Attack	0	0	0	-		0
Trauma & Orthopaedics	1,872	1,714	-158	-8%	1,582	132
Upper Gastrointestinal Surgery	0	8	8	-	20	-12
Urology	5,033	5,202	169	3%	5,231	-29
Vascular Surgery	0	0	0	-	2	-2
Grand Total	**42,019**	**43,130**	**1,111**	**3%**	**39,408**	**3,722**

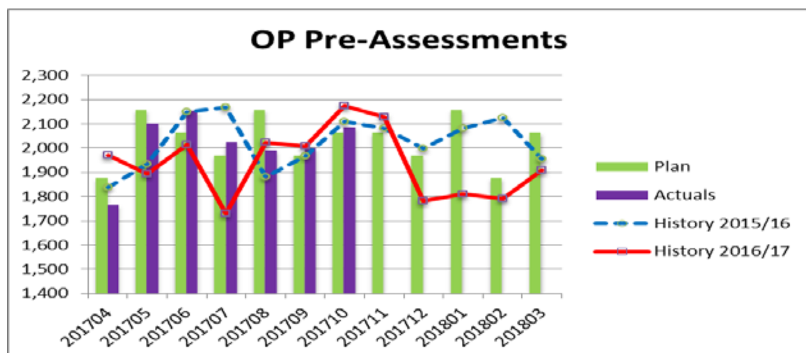
Position for Activity by POD (Month 7)

Other Outpatient Areas

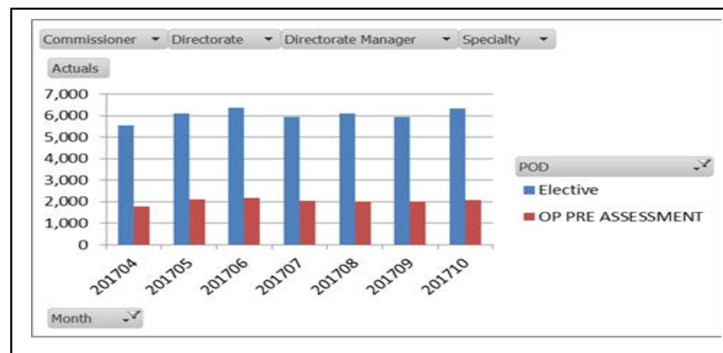


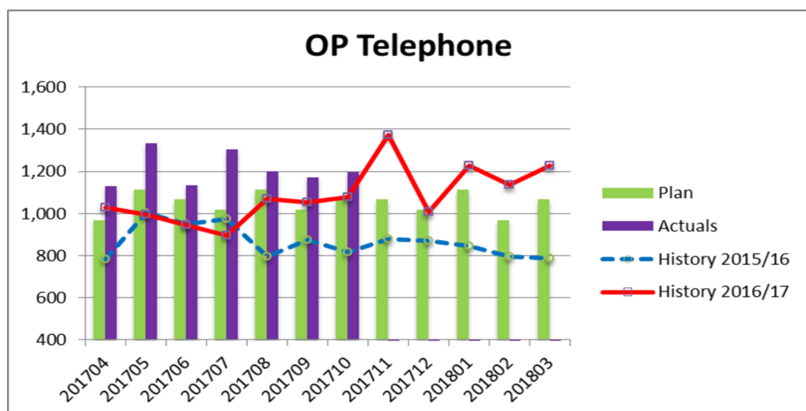
Non Consultant Led Outpatient activity is 1,208 attendances (2.8%) below history however 451 attendances (1%) above plan. Specialties with the greatest over-performance against plan include Rheumatology and Paediatrics.

Paediatrics is currently 2,031 above plan (215%). This is due to the activity previously being excluded from billing as it was covered by Child Health Block. In 17/18 we have changed process to bill for this activity in actuals and the block has been reduced.
Rheumatology is currently 1,826 attendances above plan (88.7%). The over performance in Rheumatology is largely due to Commissioners contracting at levels well below outturn.
Urology are currently 837 under plan (26%)but there are steps in place to improve recording at CHS and all offsite locations



Pre-Assessment activity is 135 attendances (1%) down against plan however 316 attendances (2.3%) above history. The numbers of PAAC appointments are consistently in proportion to Electives. Not all Elective spells require PAAC.



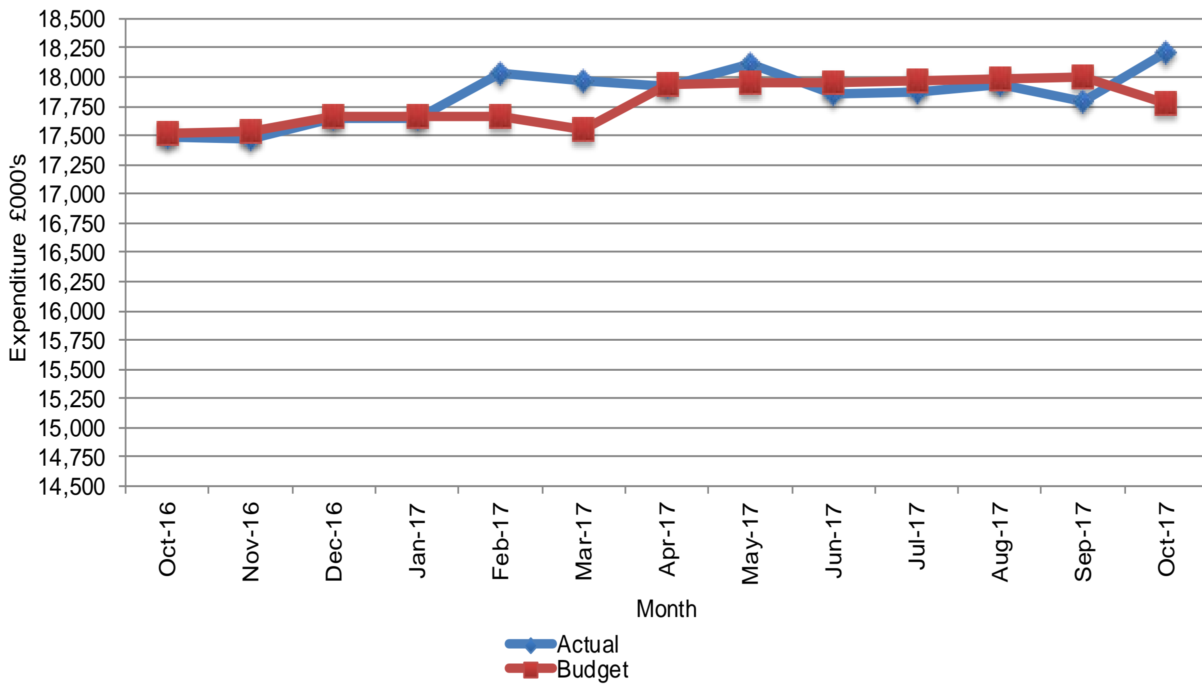


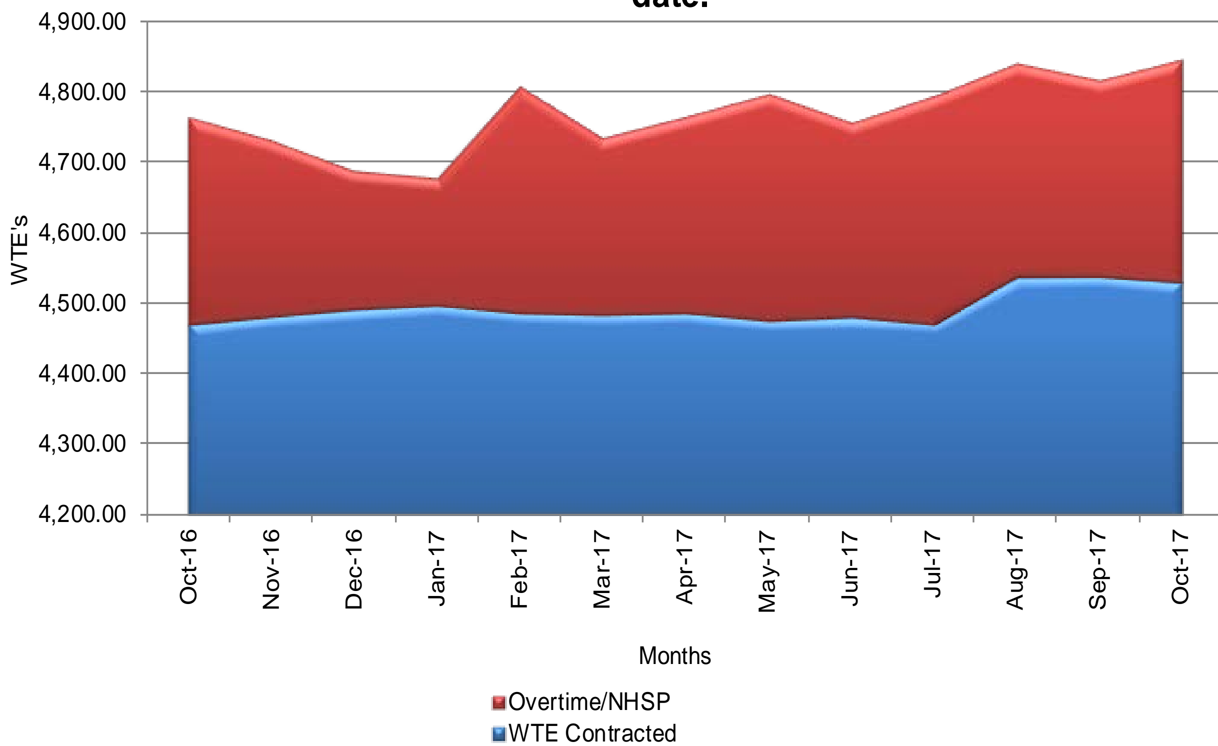
Non-Face to Face Outpatient contacts are 1,409 contacts (19.9%) above history and 1,098 contacts above plan (14.8%).

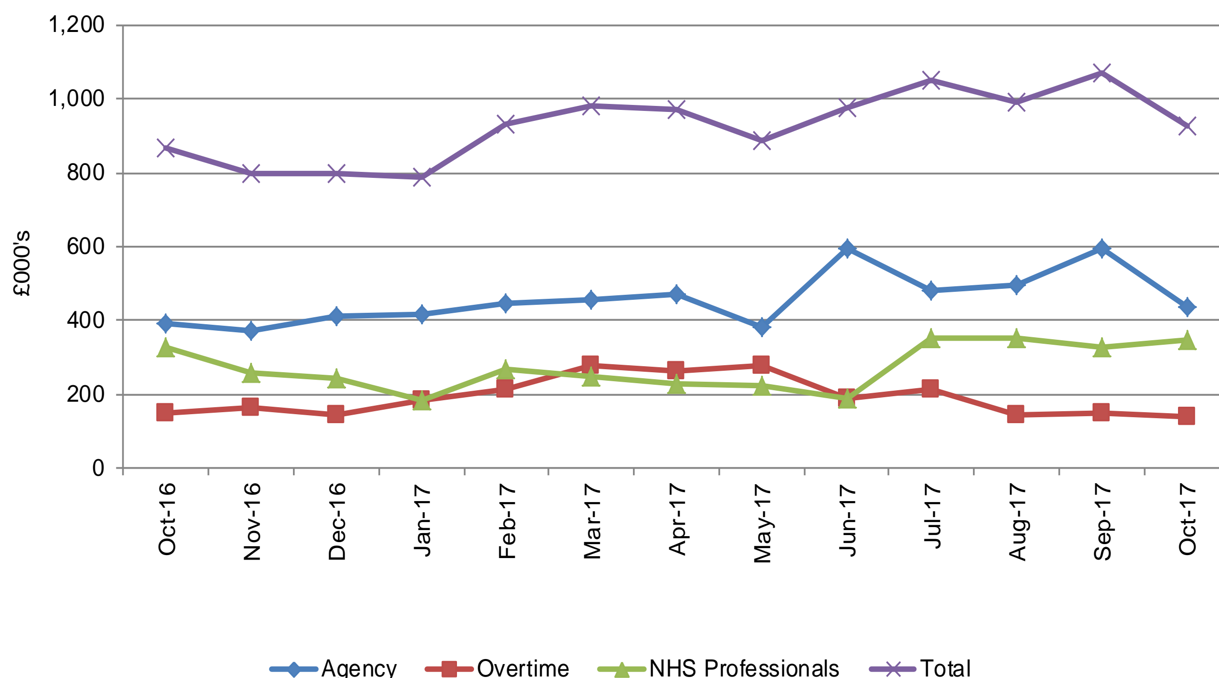
Specialties with the greatest variance against plan include Trauma & Orthopaedics, Gastroenterology, and Genitourinary Medicine.

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

Appendix 4







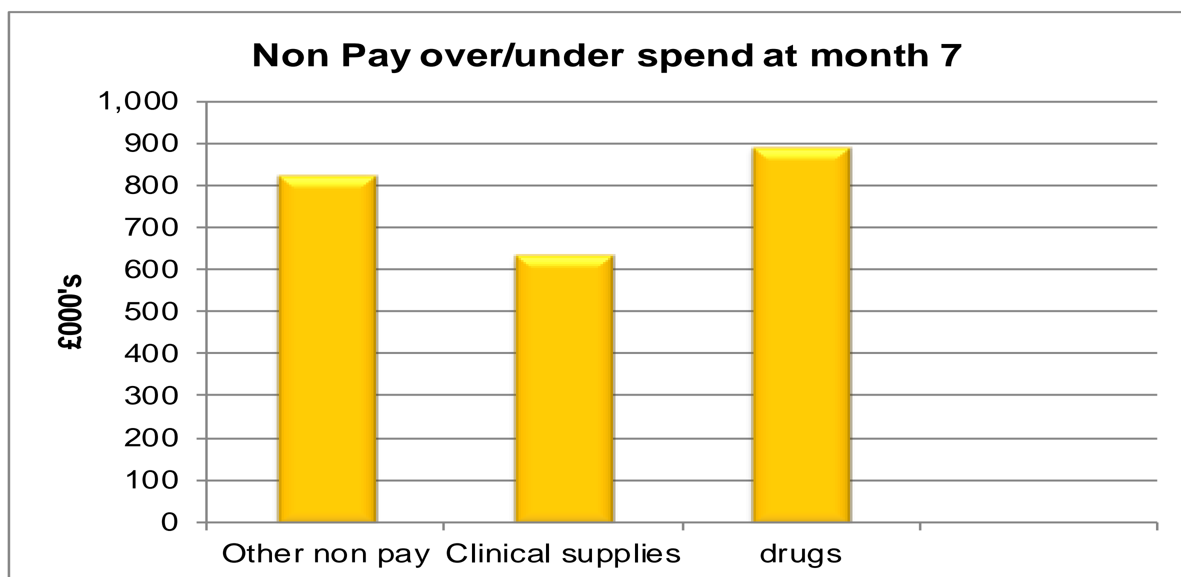
NHS Improvement Agency cap ceiling compliance City Hospitals Sunderland

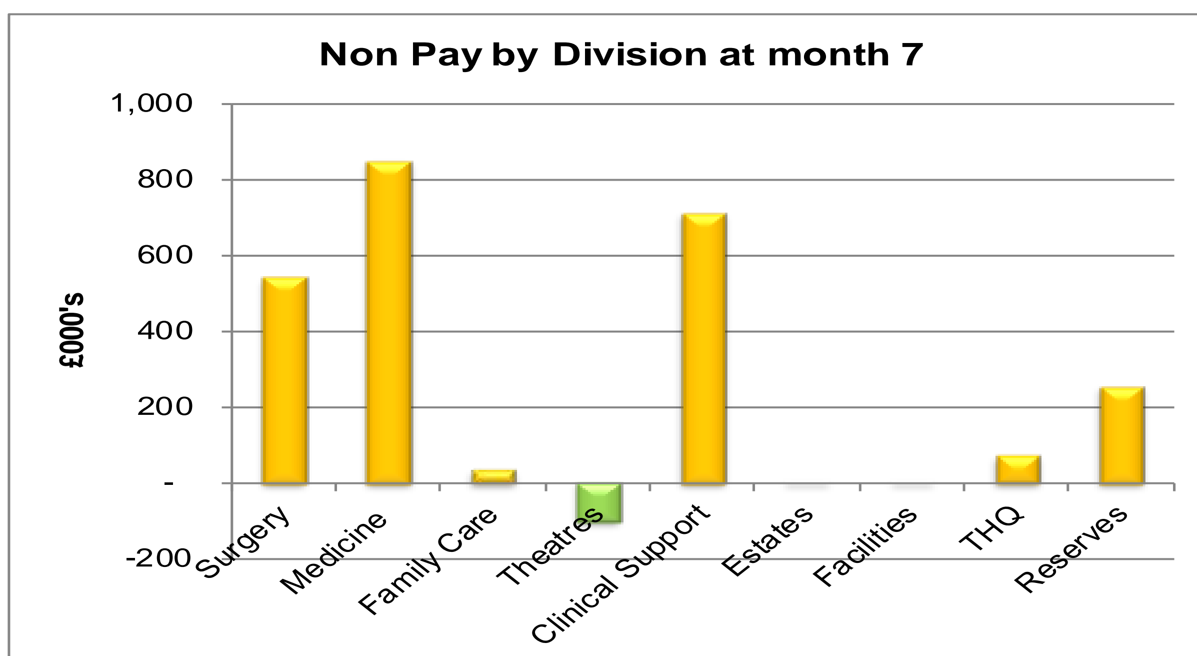
	Month Monthly Expenditure Ceiling £000s	CHS Annual Plan £000s	Actual in month agency cost £000s
Oct-16	497	417	390
Nov-16	497	417	373
Dec-16	485	407	412
Jan-17	461	387	416
Feb-17	461	387	449
Mar-17	460	386	457
Apr-17	516	357	473
May-17	516	357	386
Jun-17	516	357	594
Jul-17	516	357	485
Aug-17	516	357	494
Sep-17	516	357	593
Oct-17	516	357	439
Nov-17	516	357	
Dec-17	516	357	
Jan-18	516	357	
Feb-18	516	357	
Mar-18	516	357	
Jun-18	516	357	
Total	**9,570**	**7,045**	**5,961**

Key Issues on pay

- WTE numbers as at month 7 are 4,846, an increase of 29 WTEs compared to the previous month. This is predominantly due a rise in demand for additional nursing shifts compared to the previous month.
- Agency spend to October 2017 was £3,464k against a budget of £2,502k.
- Against the ceiling the Trust is £148k under (ceiling to month 7 is £3,612k, actual was £3,464k).

Appendix 5





Key issues on non-pay

- Drugs are £890k overspent against plan to date, a £105k of this overspend is due to a shortfall in CIP delivery to date, the remainder is offset with the cross charge back to clinical commissioners.
- Clinical Supplies is overspent by £632k against plan to date, of the overspend £155k is due to a shortfall in CIP delivery to date, and £324k is due to increased offsite diagnostic reporting and tests to third party providers.
- Other Non Pay is overspent by £824k against plan to date, most of which is due to £444k is due to offsite CT scans and MRI scans sent to third party providers due to shortage of Radiographers and capacity at the Trust. A further £435k of the overspend is due to CIP under delivery against plan to date.

Key actions on non-pay

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

Appendix 6

CIPs Performance

Overall Financial Position & CIP Position - Month 7

	Surgery	Theatres	Medicine	Family Care	Clinical Support	THQ Division	THQ Corporate	Gap	Total
Divisional CIP's 17/18 £000's	-2,238	-463	-2,375	-811	-1,308	-1,647	-4,160		**-13,000**
Plan to date £000's	-1,201	-233	-1,273	-429	-623	-964	-1,776		**-6,500**
Actual to date £000's	-1,634	-328	-1,004	-527	-481	-993	-913		**-5,880**
Variance 17/18 £000's	-433	-95	269	-98	142	-29	863		**620**
Variance %	36%	41%	-21%	23%	-23%	3%	-49%		-10%

Key Issues with the CIP

To the end of October the planned savings are £6,500k, actual savings for the period are £5,880k, and hence behind plan by £620k.

Headline CIPs

- Surgery's nursing vacancies CIP savings amounted to £586k against a target of £208k, and hence an over delivery of £378k to date that are unidentified at this stage.
- Medicine's CIP under delivery of £269k to date is due to unidentified additional CIPs allocated in the month 5, most of which remains unidentified at this stage.
- Clinical Support's CIP delivery is £142k behind plan to date due to unidentified additional CIPs allocated in the month 5, most of which remains unidentified at this stage.
- Theatre's CIP over delivery of £95k is driven by vacant posts across all areas within Nursing and ODPs.
- Family Care's CIP delivery is £98k over delivered against plan to date due to non recurrent vacant posts.
- THQ Division's CIP delivery is ahead of plan by £29k due largely to additional income received from South Tyneside FT from the single management structure.
- The Trust has forecasted £12,505k of CIP delivery by the end of the year, and hence £495k still remains to be identified to match the £13m plan.

CIP - original Annual Plan vs. actual delivery plan today

	Identified Plans	Stretch Target	Total per APR	This is as per Monitor Plan to Month 7 £	Actual to Month 7 £	Variance £
Revenue Generation	672	128	800	400	370	30
Pay	5,769	1,231	7,000	3,500	3,605	-105
Clinical Supplies	2,394	-894	1,500	750	595	155
Drugs	961	39	1,000	500	395	105
Other Non Pay	2,709	-9	2,700	1,008	571	437
Depreciation				342	344	-2
Total £	**12,505**	**495**	**13,000**	**6,500**	**5,880**	**620**

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF PLANNING AND BUSINESS DEVELOPMENT

BOARD OF DIRECTORS

NOVEMBER 2017

PERFORMANCE REPORT

INTRODUCTION

Please find enclosed the Performance Report for October 2017 which updates Directors on performance against key national targets.

EXECUTIVE SUMMARY

Performance – NHS Improvement (NHSI) Operational Performance Indicators

The Trust's position in relation to NHSI's operational performance indicators is as follows:

A&E 4 hour target

Performance for October failed to achieve the 95% target at 92.7%. This was also below the STF trajectory of 93.9%. Performance has recovered in November and is currently above STF trajectory.

The national performance for October was 90.1%. The Trust remains in the upper middle 25% of Trusts nationally.

Referral to Treatment Time (RTT)

Performance remains above target at 94.5% with all specialties achieving the target apart from T&O, Thoracic and OMFS.

National performance for September has deteriorated further and remains below the standard at 87.8%.

Cancer targets (2 week, 31 and 62 day waits)

Due to cancer reporting timescales being 1 month behind, the performance report includes September's confirmed position. The Trust met all cancer waiting time standards with the exception of cancer 62 day waits for patients referred urgently by their GP, mainly due to breaches in Urology. However the standard was achieved for the quarter. Achievement of the target remains an ongoing risk into 2018. There are a number of cross-tumour site breaches

in October and these are being discussed with the clinical teams (Colorectal and Upper GI).

National performance against the 62 day standard remains below target at 81.9%.

The Trust achieved all other national targets in quarter 2, except for 62 day waits for patients referred from national screening programmes; however this was subject to low volumes.

Diagnostics

Performance for October achieved the national standard at 0.22% with only 9 patients waiting 6 weeks or more. National performance in September failed to achieve the target at 2.0%.

FINANCIAL IMPLICATIONS

For October, there are no local penalties to be applied. STF funding relating to A&E performance (£277K) is at risk, due to the risk of meeting the financial control total.

NHSI SINGLE OVERSIGHT FRAMEWORK

NHSI has published an updated version of the Single Oversight Framework following a recent consultation exercise.

In summary the changes include:

- Improving the structure and presentation of the document.
- Implementing an outline of the five key themes and what would trigger consideration of a support need.
- Changes to metrics that are used to assess provider's performance and trigger a potential support need.
- Providing clarity that other material concerns arising from NHSI intelligence or other organisations could trigger consideration of a support need
- Including explicit instruction that providers are expected to notify NHSI of any significant changes or risk to performance.

The changes to the operational performance theme are mainly focused on Ambulance and Mental Health Trusts, however for acute providers, dementia assessment and referral standards will now be incorporated. NHSI also clarified that performance against national standards will be used to trigger potential support needs rather than Trust's STF trajectories. It is also worth noting that E. coli bacteraemia and MSSA rates have been included as part of the Quality of Care theme.

Ultimately the framework itself has not changed; the five themes, approach to monitoring, identification of support needs and provider segmentation all remain the same.

RECOMMENDATIONS

Directors are asked to accept this report and note the risks going forwards.

Alison King
Head of Performance and Information Management

City Hospitals Sunderland chs

Performance Report October 2017

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

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

Narrative highlighting recent performance and corrective actions, where applicable

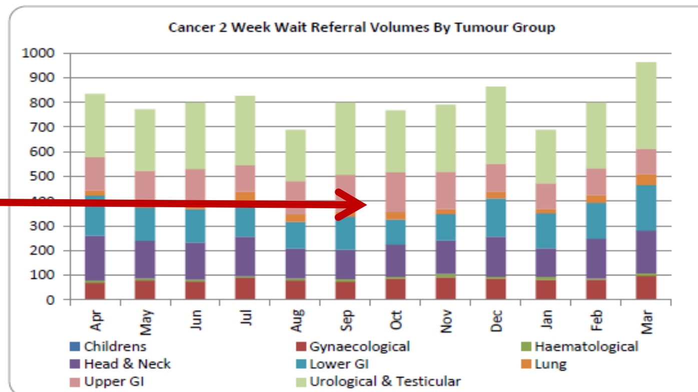
2WW performance has remained stable in March at 95.5%, which continues to perform above target. At tumour site level, all areas achieved the target this month.
March's performance demonstrated that all tumour groups are performing about the same or better than the equivalent national benchmarking position.
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.

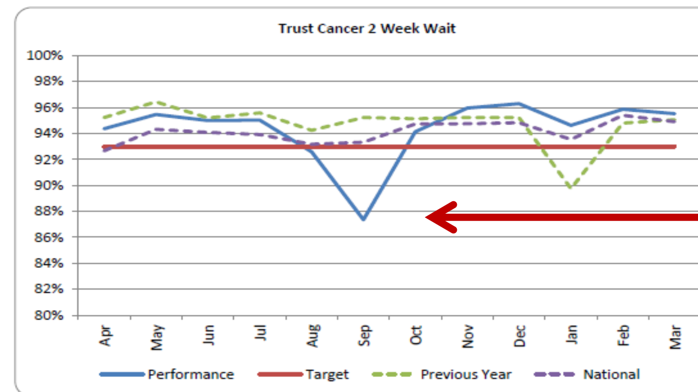
Table showing current performance compared to target (where relevant)

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

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





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

City Hospitals Sunderland Performance Scorecard

The Performance Report / Corporate Dashboard utilises a visual management approach to the Trust's monthly Performance, covering NHS Improvement Single Oversight Framework metrics as well as national performance measures from the NHS Standard Contract 2017/18 and 'NHS Operational Planning and Contracting Guidance 2017 to 2019'.

Indicator	Director Lead	Target	2016/17	2017/18						12-month trend	Page
			Actual	Month[1]	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD		
Operational Performance Measures - NHSI SOF: These metrics are used by NHS Improvement and form one of the five themes from the Single Oversight Framework, which is used to assess our operational performance. This will influence our segmentation and level of support. They also form part of the 2017/18 NHS Standard Contract.											
A&E - % seen in 4hrs	Sean Fenwick	≥95%	92.97%	92.68%	94.47%	95.00%	92.68%		94.43%		4
RTT - % incompletes waiting <18 wks	Sean Fenwick	≥92%	94.00%	94.53%	94.55%	94.41%	94.53%		94.49%		5
Cancer waits - % 62 days	Sean Fenwick	≥85%	84.00%	82.31%	76.99%	85.18%			81.02%		6
% Diagnostic tests ≥6 wks	Sean Fenwick	<1%	2.14%	0.22%	2.75%	1.39%	0.22%		1.84%		7
National Operational Standards: These are national targets that the NHS must achieve, mostly falling under the domain of quality, which are linked to delivery of the NHS Constitution. They also form part of the 2017/18 NHS Standard Contract.											
Cancelled operations 28 day breaches	Sean Fenwick	0	34	0	11	12	0		23		N/A
Cancer waits - % 2ww	Sean Fenwick	≥93%	95.91%	97.05%	96.86%	96.36%			96.64%		8
Cancer waits - % 31 days	Sean Fenwick	≥96%	98.67%	98.80%	97.43%	98.34%			97.89%		9
Cancer waits - % 31 days for subsequent treatment - surgery	Sean Fenwick	≥94%	98.40%	100.00%	96.43%	96.51%			96.47%		9
Cancer waits - % 31 days for subsequent treatment - drugs	Sean Fenwick	≥98%	99.90%	100.00%	100.00%	100.00%			100.00%		9
Cancer waits - % 62 days from screening programme	Sean Fenwick	≥90%	100.00%	-	100.00%	87.50%			92.86%		6
Cancer waits - % 62 days from consultant upgrade	Sean Fenwick	NA	88.20%	73.91%	75.44%	76.39%			75.97%		6
National Quality Requirements: These also form part of the 2017/18 NHS Standard Contract. In addition there are a number of zero tolerance indicators that are reported by exception, including Mixed Sex Accommodation breaches, A&E 12-hour trolley waits and urgent operations cancelled for the second time											
RTT - No. incompletes waiting 52+ weeks	Sean Fenwick	0	0	0	0	0	0		0		N/A
A&E / ambulance handovers - no. 30-60 minutes	Sean Fenwick	0	1349	42	239	50	42		331		4
A&E / ambulance handovers - no. >60 minutes	Sean Fenwick	0	381	6	41	4	6		51		4
% VTE risk assessments	Ian Martin	≥95%	98.49%	98.38%	98.64%	98.79%	98.38%		98.66%		N/A

1. Performance is one month behind normal reporting for all Cancer indicators (September 2017)

Accident & Emergency

NHSI SOF Operational Performance, National Operational Standard & National Quality Requirements

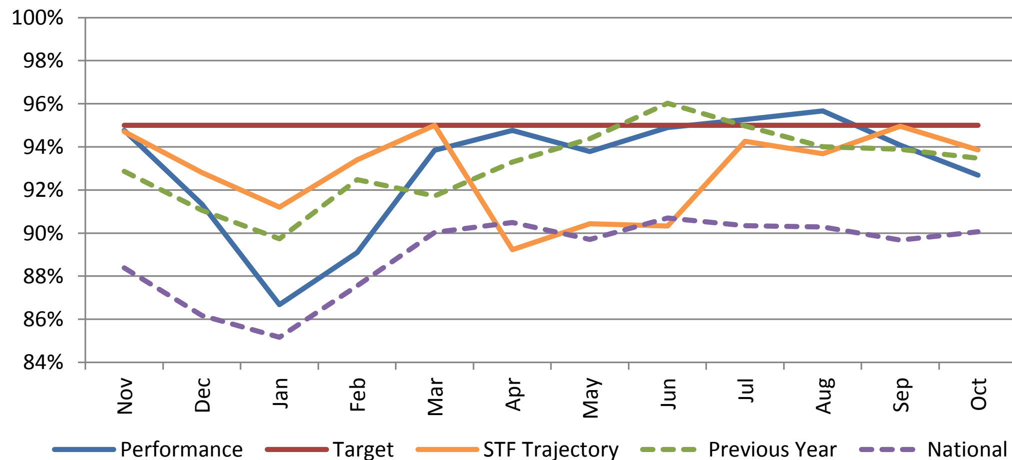
1. % patients who spent 4 hours or less from arrival to admission, transfer or discharge
2. Ambulance handover delays between 15-30 minutes, 30-60 minutes & over 60 minutes

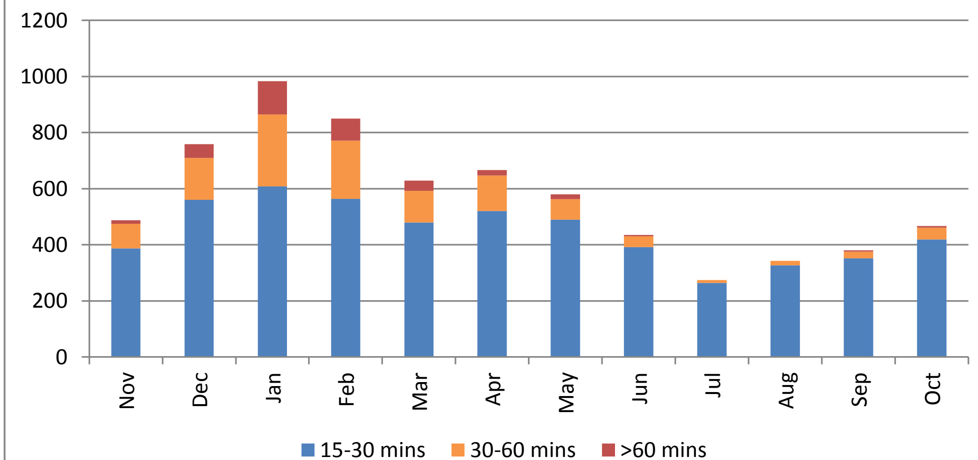
Director Lead: Sean Fenwick

Consequence of failure: Patient experience, quality, access, reputation & financial impact if the STF trajectory is not achieved, which equates to £277k per month during quarter 3

A&E Indicators - October 2017	Target	Month	YTD
A&E % seen in 4hrs - Trust Total	≥95%	92.68%	94.43%
A&E < 4 hrs - Type 1	≥95%	88.28%	90.93%
A&E < 4 hrs - Type 1 - High Acuity	≥95%	77.07%	81.87%
A&E < 4 hrs - Type 1 - Low Acuity	≥95%	87.55%	90.68%
A&E < 4 hrs - Type 1 - Paediatrics	≥95%	97.90%	98.35%
A&E < 4 hrs - Type 2 - SEI	≥95%	99.42%	99.33%
A&E < 4 hrs - Type 3 - Pallion walk in centre	≥95%	99.80%	99.82%
A&E Attendances - Trust Total		13,478	91,011
A&E Attendances - Type 1		8,253	54,261
A&E / ambulance handovers - no. 15-30 minutes	0	419	2,762
A&E / ambulance handovers - no. 30-60 minutes	0	42	331
A&E / ambulance handovers - no. >60 minutes	0	6	51

The total proportion of patients seen in A&E within 4 hours reduced during October to 92.68%, which is below the national operating standard and STF trajectory. Operational pressures have increased during the month with 3 instances of escalated OPAL status. There were several days during the month where attendances peaked causing waiting times to increase and instances where bed availability lead to pressures in ED. There has generally been a higher proportion of breaches related to clinical need this month.
For September the trust remained in the upper middle quartile of trusts nationally.
There were 13,478 attendances this month, which is 3% higher than October 2016 (type 1 was up by 2%, type 2 was about the same and type 3 was up by 11%). Attendances have been higher on average compared to previous months.
There were 2,678 ambulance arrivals this month, which is the second highest month across the YTD, but is less than October 2016. This continues to represent the third highest volume of ambulance arrivals for any hospital across the North East. The number of over 30 minute handover delays increased this month, however this equates to 1.8% of all arrivals which is better than the regional average.





Referral to Treatment (RTT)

NHSI SOF Operational Performance & National Operational Standard

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.

The finalised aggregate level performance for incomplete pathways at the end of October was above target and improved from September's position.

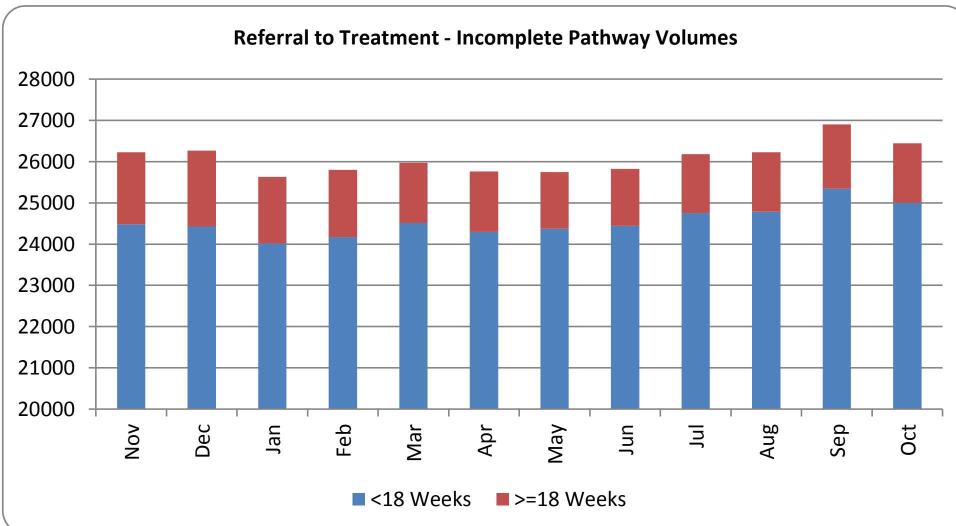
At specialty level Trauma & Orthopaedics (T&O), Thoracic Medicine and Oral & Maxillo Facial Surgery (OMFS) failed to achieve the 92% target.
T&O and OMFS remain in formal escalation. Performance is monitored closely and both specialties are supported by weekly PTL processes. Marginal gains are being made. OMFS have improved slightly this month and were close to target. Thoracic Medicine also made improvements in October and their final position was 90.27%. However, T&O is unlikely to recover fully without additional capacity/funding .

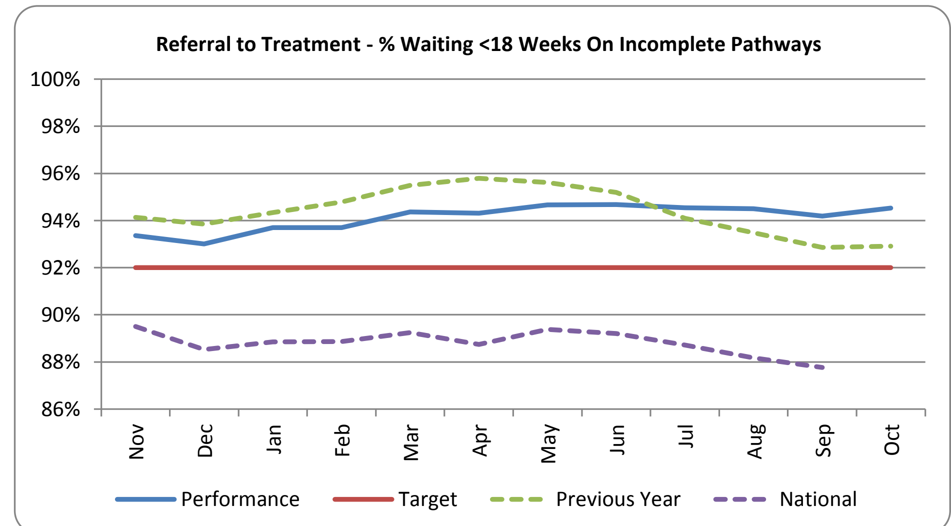
The Trust's RTT stress test risk rating increased slightly in September and the trust has been assessed as having a 16% chance of failing the operational standard in the next 6 months. We are ranked 19th (best) nationally out of 153 trusts.

RTT Incompletes - October 2017	Volume	No. ≥18 Weeks	% <18 Weeks*
Target			≥92%
Cardiology	662	8	98.79%
Ear, Nose & Throat	2,518	137	94.56%
Gastroenterology	309	0	100.00%
General Surgery	1,864	103	94.47%
Geriatric Medicine	457	5	98.91%
Gynaecology	1,058	22	97.92%
Neurology	834	5	99.40%
Ophthalmology	4,175	77	98.16%
Oral & Maxillo Facial Surgery	1,993	167	91.62%
Rheumatology	772	24	96.89%
Thoracic Medicine	842	82	90.26%
Trauma & Orthopaedics	3,082	506	83.58%
Urology	2,602	157	93.97%
Other	5,280	155	97.06%
Trust Total	**26,448**	**1,448**	**94.53%**

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

RTT Stress Test	Jul-17	Aug-17	Sep-17
% Risk of failure in next 6 months	12.06%	12.67%	15.83%
National rank (1st is best)	19/153	15/153	19/153





Cancer 62 Day Waits

NHSI SOF Operational Performance & National Operational Standard

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

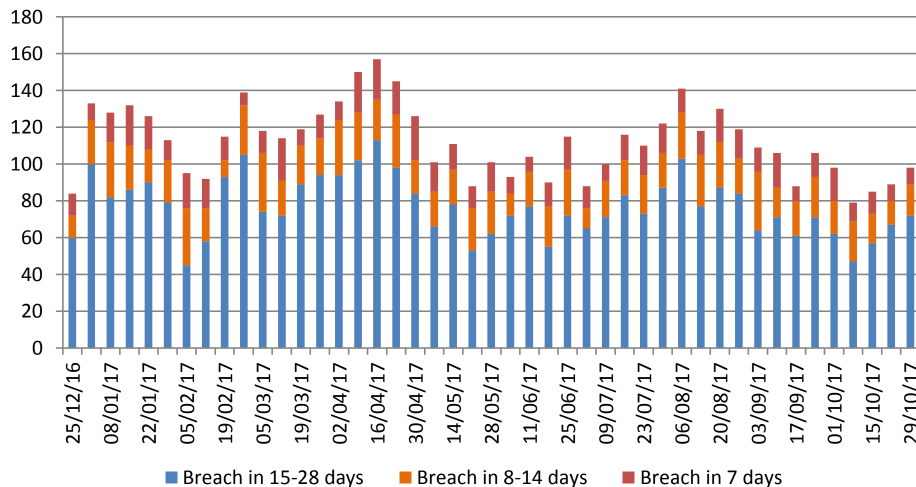
Consequence of failure: Timely access to treatment, patient experience & clinical outcomes.

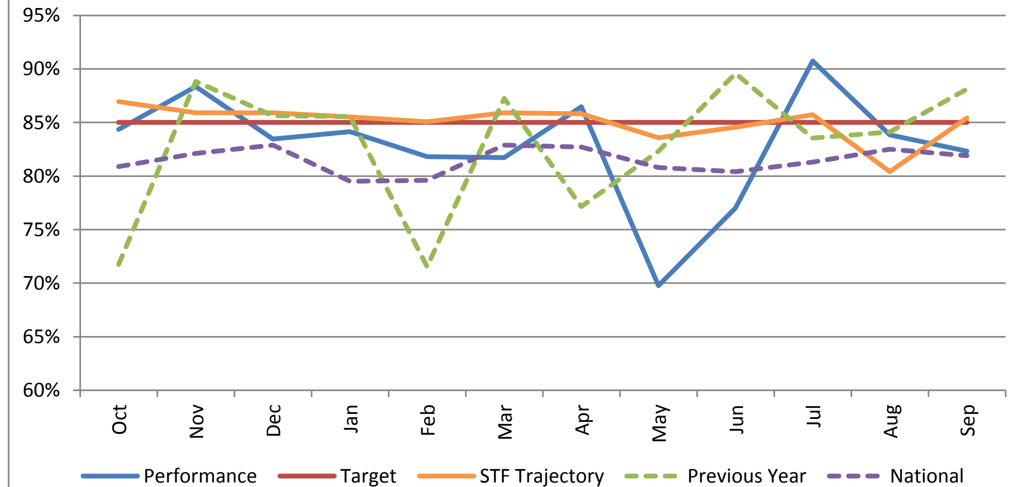
Trust performance reduced slightly in September and failed to meet both the national target and STF trajectory, however, performance was better than national average. All tumour groups achieved the target with the exception of Lung, Haematological, Skin and Urological. There were 13 breaches in total. There were no screening patients applicable in September. The Consultant Upgrade breaches were attributable to Upper Gastrointestinal (1.5) and Lung (1.5) tumour groups.
The volume of patients who are approaching their breach date remains relatively low. The main areas of risk going forwards are Haematology, Lung and Urology. Indicative performance for October is currently below the national target. Achievement of the STF trajectory and operational standard at aggregate level remains a risk going forwards. Actions are ongoing for Urology in particular with improvements expected in early 2018.
The Trust achieved both 62 day standards during quarter 2.

First Definitive Treatment - September 2017*	Volume	Total Breached	Performance	National Performance	YTD	Number ≥104 days
Target			85%	85%	85%	0
Breast	1.0	0.0	100.00%	93.3%	91.67%	0
Gynaecological	3.5	0.5	85.71%	76.0%	87.50%	0
Haematological (Excluding Acute Leukaemia)	3.0	1.0	66.67%	81.6%	87.50%	1
Head & Neck	3.5	0.5	85.71%	64.2%	74.60%	0
Lower Gastrointestinal	8.0	0.0	100.00%	72.3%	88.64%	0
Lung	6.0	2.0	66.67%	68.9%	61.54%	1
Other	0.0	0.0	-	68.9%	80.00%	0
Sarcoma	0.0	0.0	-	64.5%	33.33%	0
Skin	4.0	1.0	75.00%	94.8%	84.00%	0
Upper Gastrointestinal	5.0	0.5	90.00%	75.2%	80.00%	1
Urological (Excluding Testicular)	39.5	7.5	81.01%	78.8%	81.63%	2
Total	**73.5**	**13.0**	**82.31%**	**81.9%**	**81.02%**	**5**

Non GP Referrals						
Screening (Target: 90%)	0.0	0.0	-	92.1%	92.86%	0
Consultant Upgrade	11.5	3.0	73.91%	86.9%	75.97%	0

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





Diagnostics

NHSI SOF Operational Performance & National Operational Standard

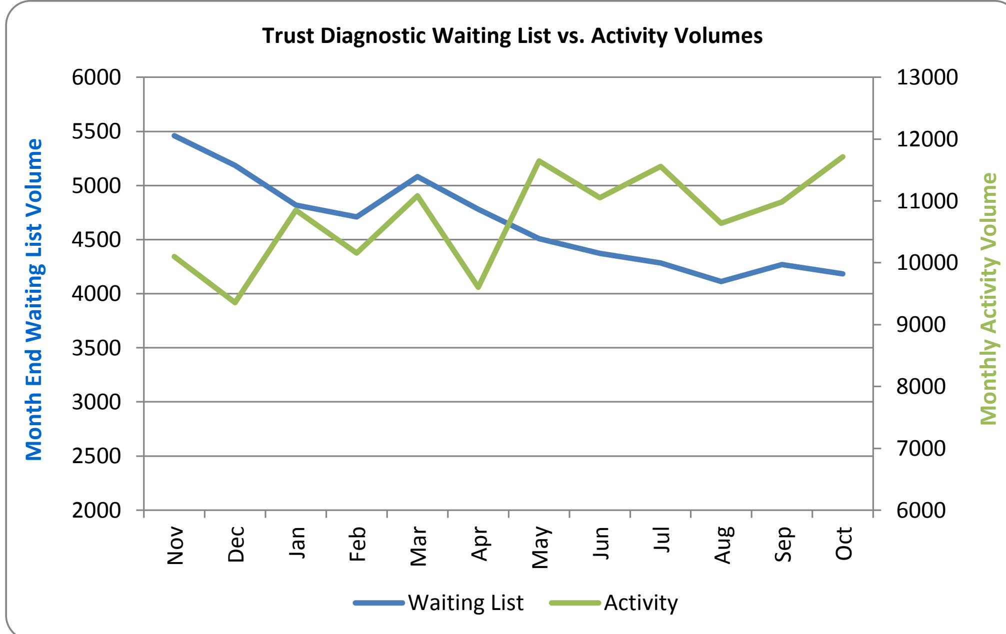
1. Number of patients on the diagnostic waiting list at month end
2. Number of patients on the diagnostic waiting list at month end waiting 6 weeks or more
3. % patients waiting 6 weeks or more for a diagnostic test at month end
4. Number of diagnostic tests/procedures carried out in month

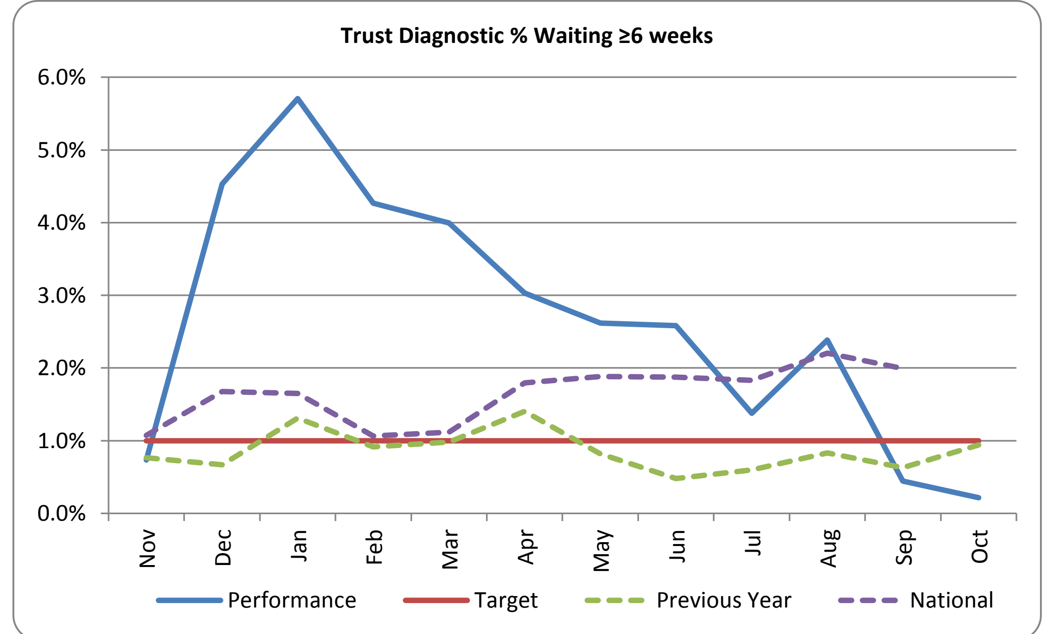
Director Lead: Sean Fenwick
Consequence of failure: Patient experience, quality, access & reputation

The proportion of patients waiting 6 weeks or more at the end of October reduced to 0.2%. This achieved both the national operating standard of <1% and the revised NHSI recovery trajectory of 0.8%. It is also better than the latest national average. This is represents the best performance since April 2015. The trust is expected to continue to achieve national standard in November.

The number of patients waiting for a diagnostic test at the end of the month has reduced mainly due to reductions in Cardiology. Activity increased in October, with the main increases seen with Non-obstetric ultrasound, Cardiology and Computed Tomography tests.

Diagnostics - October 2017		WL Volume	No. ≥6 weeks	%≥6 weeks	Activity
Target				≤1%	
Imaging	Magnetic Resonance Imaging	539	0	0.00%	1,411
	Computed Tomography	347	0	0.00%	3,152
	Non-obstetric ultrasound	1,374	1	0.07%	3,134
	Barium Enema	25	0	0.00%	2
	DEXA Scan	158	0	0.00%	277
Physiological Measurement	Audiology - assessments	212	5	2.36%	1,047
	Cardiology - echocardiography	506	0	0.00%	1,109
	Neurophysiology - peripheral	127	0	0.00%	150
	Respiratory physiology - sleep studies	144	1	0.69%	98
	Urodynamics - pressures & flows	47	0	0.00%	29
Endoscopy	Colonoscopy	160	2	1.25%	282
	Flexi sigmoidoscopy	49	0	0.00%	87
	Cystoscopy	297	0	0.00%	598
	Gastroscopy	200	0	0.00%	339
Trust Total		**4,185**	**9**	0.22%	**11,715**





Cancer 2 Week Waits

National Operational Standard

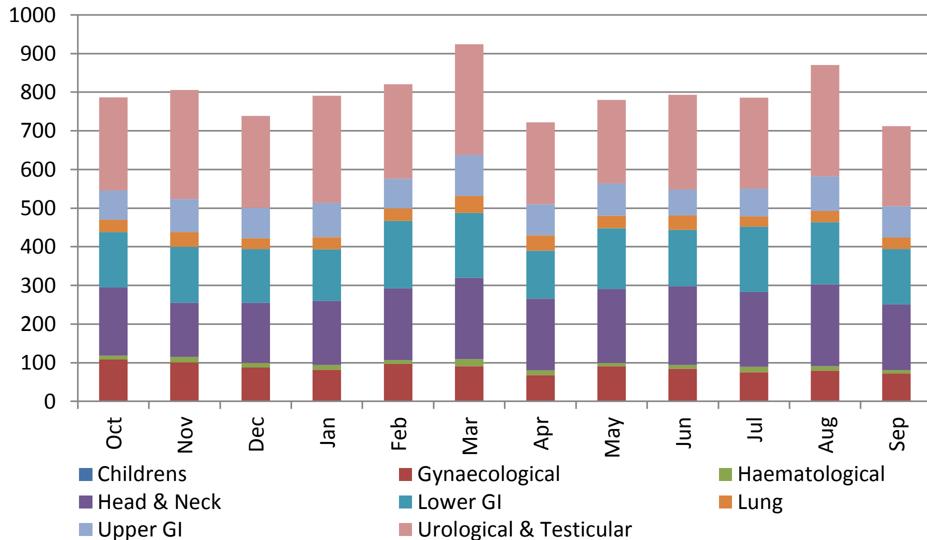
1. Number of urgent GP referrals for suspected cancer
2. Number of patients seen after more than two weeks following an urgent GP referral for suspected cancer
3. % patients seen within two weeks of an urgent GP referral for suspected cancer

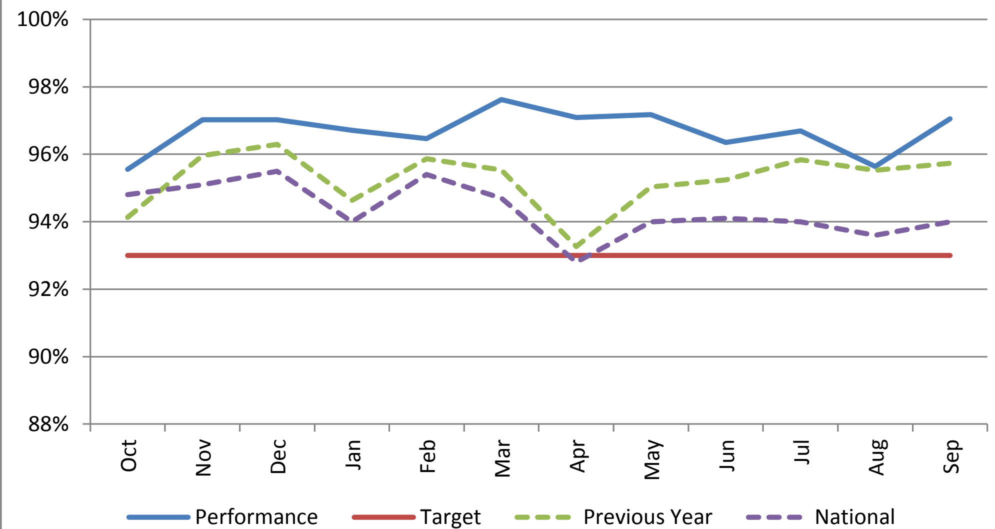
Director Lead: Sean Fenwick
Consequence of failure: Timely access to treatment, patient experience & clinical outcomes

2WW performance improved during September and remained above both the operating standard and the national average. At tumour site level, all areas achieved the target. All breaches were related to patient choice this month.
September's performance demonstrated that all tumour groups performed about the same or better than the equivalent national performance position.
Overall referral volumes reduced during September. All tumour sites showed a reduction compared to the average over the last 12 months, particularly within the Urological tumour group (-16%).
Indicative 2WW performance for October is above target.
Finalised quarter 2 performance achieved the national standard at 96.36%.

Referrals for Suspected Cancer - September 2017*	Volume	Total Breached	Performance	National Performance	YTD
Target			93%	93%	93%
Acute Leukaemia	0	0	-	-	100.00%
Breast	0	0	-	96.6%	-
Children's Cancer	0	0	-	96.4%	100.00%
Gynaecological	72	3	95.83%	94.9%	96.79%
Haematological (Excluding Acute Leukaemia)	9	0	100.00%	96.1%	98.46%
Head & Neck	170	3	98.24%	95.4%	96.29%
Lower Gastrointestinal	143	7	95.10%	91.1%	95.67%
Lung	30	0	100.00%	94.9%	98.97%
Other	0	0	-	89.5%	100.00%
Testicular	8	0	100.00%	-	100.00%
Upper Gastrointestinal	81	4	95.06%	92.7%	95.14%
Urological (Excluding Testicular)	199	4	97.99%	95.6%	97.45%
Total	**712**	**21**	**97.05%**	**94.0%**	**96.64%**

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





Cancer 31 Day Waits

National Operational Standard

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.

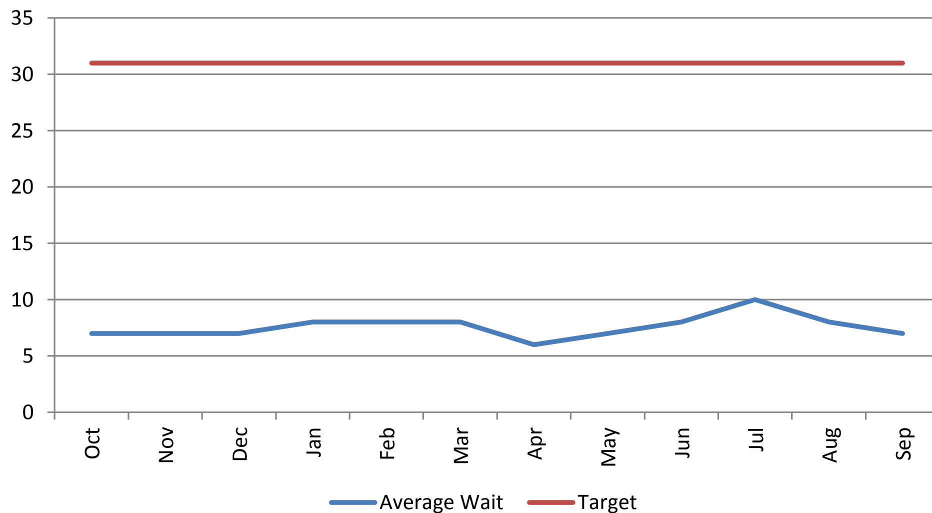
Aggregate level performance achieved the target at 98.8%. All tumour groups achieved the target and performance for all tumour groups was better than the equivalent national average. Indicative performance for October is currently above target.

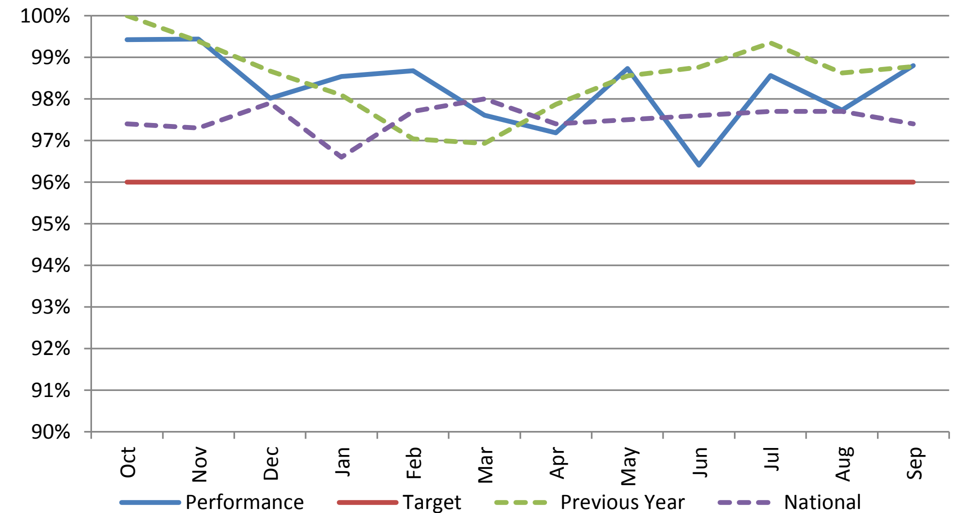
The final performance for September for subsequent surgery and drug treatments were both above target at 100%.

The Trust achieved all 31-day operational standards in quarter 2.

First Definitive Treatment - September 2017*	Volume	Total Breached	Performance	National Performance	YTD
Target			**96%**	**96%**	**96%**
Breast	5	0	100.00%	98.3%	100.00%
Gynaecological	4	0	100.00%	96.1%	100.00%
Haematological	8	0	100.00%	99.7%	100.00%
Head & Neck	12	0	100.00%	93.4%	91.23%
Lower Gastrointestinal	23	0	100.00%	98.1%	100.00%
Lung	23	0	100.00%	98.1%	100.00%
Other	0	0	-	99.4%	100.00%
Sarcoma	1	0	100.00%	94.4%	100.00%
Skin	11	0	100.00%	97.0%	91.84%
Upper Gastrointestinal	10	0	100.00%	98.8%	100.00%
Urological	70	2	97.14%	96.0%	97.55%
Total	**167**	**2**	**98.80%**	**97.4%**	**97.89%**
Subsequent Treatments					
Surgery (Target: 94%)	27	0	100.00%	95.3%	96.47%
Drug (Target: 98%)	92	0	100.00%	99.2%	100.00%

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





CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS IN PUBLIC

NOVEMBER 2017

LEARNING FROM DEATHS DASHBOARD

INTRODUCTION

In December 2016 the Care Quality Commission published its report "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England". The report found that learning from deaths was not given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed.

In response, the National Quality Board (NQB) published guidance on a new learning from deaths framework https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf, which included the mandate that from Q3 2017 onwards, Trusts must publish information on deaths and reviews via a quarterly agenda item and paper to its public board meeting.

The following report and dashboard fulfils these requirements. The focus is on the outcomes and learning from mortality reviews rather than reporting mortality statistics or ratios.

Learning from deaths is a new and evolving national programme; the dashboard will be adjusted as we further develop our mortality review processes in line with Trust policy.

LEARNING FROM DEATHS DASHBOARD – AN OVERVIEW

NHS England have created a dashboard template for Trusts to support the systematic recording of deaths, review of outcomes and learning from care provided. We have amended this format to reflect the mortality review process and methods used at City Hospitals (see Appendix 1).

The NQB guidance recommends that all Trusts take a consistent and evidence-based approach to reviewing case records of adults who have died in hospital. In common with peer Trusts within the North East Regional Mortality Network we use an adaptation of PRISM methodology (Hogan and colleagues) for undertaking mortality reviews. This clinician-led approach helps to identify 'problems in care' and informs judgements on avoidability of death.

The method also allows clinicians to provide an overall quality of care rating and the dashboard captures those deaths whose care during the last admission was graded as excellent or good.

Section 1 includes information about the total number of adult in-patient deaths and those deaths reviewed by an 'independent' mortality review panel (stage 2 mortality review).

The data completeness column indicates whether the information is either provisional or final. Where reviews are ongoing this will affect the final reported figures. The graphs denote the dynamic nature of the reported data and 'markers' are used to distinguish the status of the information. If there is a white marker, the data is provisional, if the data is final then a solid marker in the same colour is used.

A stage 2 mortality review is an independent review of the notes carried out by the Mortality Review Panel, and in all cases none of the reviewers will have been directly involved in the clinical care of the deceased.

Section 2 of the dashboard provides information about end of life reviews, which are carried out separate to or in addition to a stage 2 mortality review. These specific reviews are based on the 5 core elements of care from the national implementation of "Care of the Dying Patient" documentation. The outcomes of these reviews are used to target staff awareness and training sessions in care of the dying.

Section 3 includes data about deaths involving patients with a learning disability. It shows those deaths with a completed or ongoing review as part of the national Learning Disabilities Mortality Review (LeDeR) Programme. LeDeR aims to make improvements to the lives of people with learning disabilities by highlighting potentially modifiable factors associated with death. The section also highlights deaths with a completed stage 2 mortality review panel review, the judgements of which are included within the data in section 1.

INTERPRETATION OF DASHBOARD DATA

The percentage of deaths that have had either a standard mortality review (Stage 2 review) or a specific end of life review for Quarter 1 2017/18 is 86.4% with the provisional figure for Quarter 2 at 80.1%.

Since publication of the national guidance the proportion of stage 2 mortality reviews has fallen as we adjust our processes to align with the new recommendations.

Following ratification of the local policy in September, the Mortality Review Panel is now collecting information about the qualifying inclusion criteria and this will be included in the next published dashboard.

In Quarter 1, 90.8% of deaths reviewed were graded as excellent or good care during the last admission, in Quarter 2 this was 91.7%.

Deaths reviewed and judged as definitely not preventable have remained above 90% throughout the year; 96.2% in Quarter 1 and 94.5% in Quarter 2. In Quarter 1 0.8% of deaths reviewed were judged with a greater than 50% likelihood of avoidability (April 2017). This is well below the published avoidable death rate of 3.6% in the PRISM 2 research (often referenced by the Department of Heath).

EVIDENCE OF LEARNING AND ACTION – FOCUS ON DEATHS ASSOCIATED WITH SEPSIS

The Learning from Deaths guideline specifically states that mortality reviews should include a structured review of patients whose death is related to sepsis. Sepsis is one of the leading causes of avoidable death. The aim is to ensure that patients with suspected sepsis are being identified, treated and reviewed in a timely and comprehensive manner.

Consensus guidelines for the definition of sepsis and septic shock were updated in February 2016. The process of nurse-led screening for sepsis and physician confirmation of infection/sepsis is built into the Trust's clinical information systems, namely Meditech V6.

National guidance for coding of sepsis and sepsis-related conditions does not align with the updated definitions and the Trust Clinical Coding Department has been required to make local adjustments to their processes. Coding accuracy is dependent upon reliable and clear documentation within the case record for each patient. The presence or absence of sepsis is ultimately a clinical decision made by or on behalf of the responsible consultant based upon the clinical evidence available.

The Mortality Review Panel has identified that we need to align definitions of infection and sepsis between coders and clinicians in order to reliably identify deceased patient records for mortality review.

Clinicians could improve the accuracy of their documentation in patients presenting with infections and sepsis. For example, the Panel has found that some patients with a simple urinary tract infection have been recorded as having had 'urosepsis' without supporting evidence. Conversely, some patients with sepsis are not formally captured by coding as sepsis has not been formally documented. Therefore our action plan is to:

- insist that clinicians use the sepsis grading document on V6 in all patients screened for sepsis (or those suspected of having sepsis),
- encourage the Clinical Coding Department to query cases where sepsis is recorded in the general text of the medical case record when supporting evidence is lacking (no supporting clinician grading and a lack of positive criteria on sepsis screening),
- suggest that Clinical Coders code for sepsis when evidence of infection and organ injury is apparent (guidance has been provided on the criteria, e.g. infection with evidence of acute kidney injury, serum lactate above 2mmol/l etc.),
- conduct an audit of the recognition, screening and initial management of sepsis in all patients who die in hospital following suspected sepsis to inform future actions, and
- recommend that patients with a specific form of sepsis, known as neutropenic sepsis, will be excluded from a mandated mortality review as these patients have unique underlying conditions and they often present with sepsis in a non-typical fashion.

RECOMMENDATIONS

Executive Committee is asked to:

- note the requirements of the Trust to produce a 'Learning from Deaths Dashboard' within Quarter 3 2017/18; and
- comment on the format of the Dashboard and the supporting narrative.

Ian Martin
Medical Director

Learning from Deaths Dashboard

NHS | Department of Health

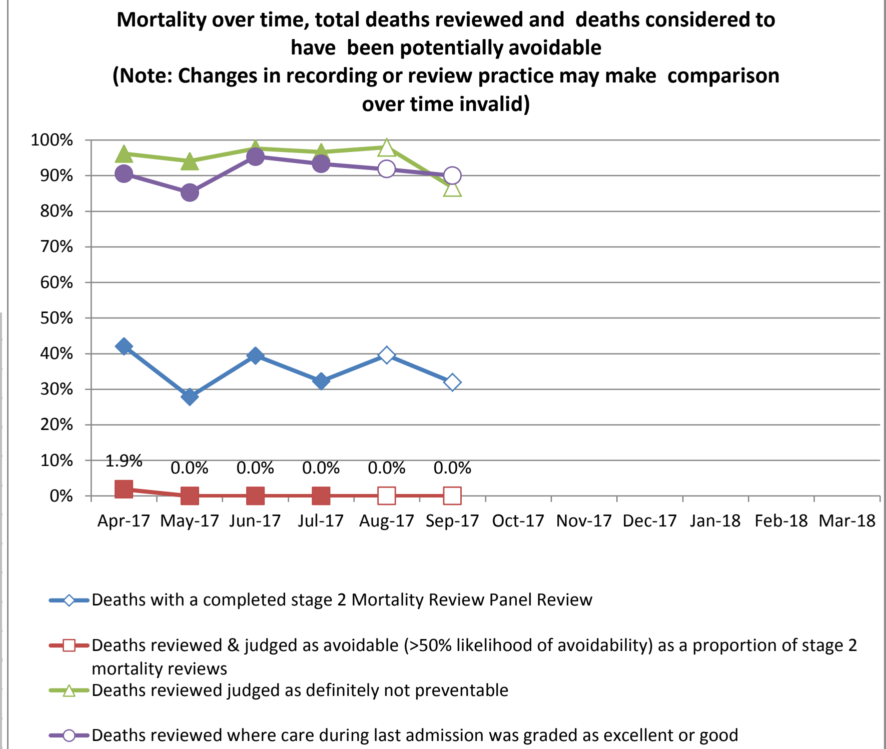
Organisation	City Hospitals Sunderland Foundation Trust
Financial Year	2017-18
Month	April - September

City Hospitals Sunderland Foundation Trust: Learning from Deaths Dashboard - April - September 2017-18

Section 1: Summary of total number of deaths and total number of cases reviewed

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable, definitely not preventable and excellent or good care (does not include patients who died in the Emergency Department)

Month of death	Data completeness	Total Number of deaths	% Deaths with a Mortality Review Panel or End of Life review	Deaths investigated as a Serious Incident	Deaths meeting inclusion criteria (NA = not available)		Deaths with a completed stage 2 Mortality Review Panel Review		Deaths reviewed & judged as avoidable (>50% likelihood of avoidability) as a proportion of stage 2 mortality reviews		Deaths reviewed judged as definitely not preventable		Deaths reviewed where care during last admission was graded as excellent or good	
					Number	%	Number	%	Number	%	Number	%	Number	%
Apr-17	Final	126	95.6%	0	NA	-	53	42%	≤ 5	1.9%	51	96%	48	91%
May-17	Final	122	75.0%	0	NA	-	34	28%	0	0.0%	32	94%	29	85%
Jun-17	Final	109	84.3%	0	NA	-	43	39%	0	0.0%	42	98%	41	95%
Jul-17	Final	93	87.1%	0	NA	-	30	32%	0	0.0%	29	97%	28	93%
Aug-17	Provisional	124	87.1%	0	NA	-	49	40%	0	0.0%	48	98%	45	92%
Sep-17	Provisional	94	63.8%	0	NA	-	30	32%	0	0.0%	26	87%	27	90%
Oct-17														
Nov-17														
Dec-17														
Jan-18														
Feb-18														
Mar-18														
Q1 17/18	Final	357	86.4%	0	NA	-	130	36.4%	≤ 5	0.8%	125	96.2%	118	90.8%
Q2 17/18	Provisional	311	80.1%	0	NA	-	109	35.0%	0	0.0%	103	94.5%	100	91.7%
Q3 17/18														
Q4 17/18														



Section 2: End of Life Review

Total Number of Deaths, Deaths Reviewed and Deaths with 5 Core Elements Delivered

Month of death	Data completeness	Number of deaths where patients was in receipt of End of Life care	Deaths with an End of Life Review		End of Life reviews with all 5 core elements delivered	
			Number	%	Number	%
Apr-17	Final	85	53	62%	NA	-
May-17	Final	81	15	19%	NA	-
Jun-17	Final	68	20	29%	NA	-
Jul-17	Final	70	52	74%	NA	-
Aug-17	Provisional	91	67	74%	NA	-
Sep-17	Provisional	67	40	60%	NA	-
Oct-17						
Nov-17						
Dec-17						
Jan-18						
Feb-18						
Mar-18						
Q1 17/18	Final	234	88	37.6%	NA	
Q2 17/18	Provisional	228	159	69.7%	NA	
Q3 17/18						
Q4 17/18						

Section 3: Learning Disability Review

Total Number of Deaths, Deaths Deemed Avoidable by the LeDeR process and deaths reviewed by the Mortality Review Panel

2017/18 Quarter	Data Completeness	Number of deaths	LeDeR reviews completed	LeDeR reviews in progress	LeDeR Outcome: Deaths judged as avoidable (>50% likelihood of avoidability)	Deaths with a completed stage 2 Mortality Review Panel Review
1	Provisional	≤ 5	0%	100%	NA	40%
2	Provisional	≤ 5	0%	100%	NA	100%
3						
4						