

## **CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST**

There will be a meeting of the Board of Directors 'In Public' on  
Thursday, 25 January 2018 at 1.00pm  
in the Board Room, Trust HQ, Sunderland Royal Hospital

### **AGENDA**

**1. Declaration of Interest**

**2. Minutes**

**Item 1** To approve the minutes of the Board of Directors meeting held 'In Public' on Thursday, 30 November 2017 **Enc 1**

**Matters Arising**

No matters arising

**3. Standard Reports**

<b>Item 2</b>	Chief Executive's Update	<b>KWB</b>	
<b>Item 3</b>	Quality Risk and Assurance Report	<b>MJ</b>	<b>Enc 3</b>
<b>Item 4</b>	Finance		
	a) Report	<b>JP</b>	<b>Enc 4a</b>
	b) Initial Budget Setting 2018/19	<b>JP</b>	<b>Enc 4b</b>
<b>Item 5</b>	Performance Report	<b>AK</b>	<b>Enc 5</b>

**Date and Time of Next Meeting**

Thursday, 29 March 2018 at 3.30pm in the Board Room, Sunderland Eye Infirmary

**CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST**  
**BOARD OF DIRECTORS**

**Minutes of the meeting of the Board of Directors held in public on Thursday, 30 November 2017.**

**Present:** John Anderson (JNA) - Chair  
Ken Bremner (KWB)  
David Barnes (DB)  
Stewart Hindmarsh (SH)  
Paul McEldon (PMcE)  
Alan Wright (AW)  
Peter Sutton (PS)  
Ian Martin (ICM)  
Melanie Johnson (MJ)  
Julia Pattison (JP)

**Apologies:** Mike Laker (ML)  
Sean Fenwick (SF)  
Pat Taylor (PT)

**In Attendance:** Carol Harries (CH)  
Alison King (AK)

**1. Declaration of Interest**

None.

**2. Minutes**

**Item 1 Minutes of the meeting of the Board of Directors held on Thursday, 28 September 2017**

Accepted as a correct record.

**Matters Arising**

**GDE Fast Follower:** KWB advised that STFT had received a visit from NHS Digital who had spoken to clinicians etc. and had given a very positive assessment. SH queried whether AJH was involved in the process. KWB replied that AJH was leading the process and would be finalising the funding agreement.

**3. Standard Reports**

## Item 2 Chief Executive's Update

**Path to Excellence** – KWB advised that the recommendations of the first clinical service review consultations would be presented to a meeting of the CCG joint Governing bodies on 21 February 2018. KWB stated that the CCG would want a view of both Boards and some detail would come to the Board in the New Year.

PS gave a short overview of some of the headline messages from the public consultation which were strong support for option 1 within stroke services, strong support for a midwifery led unit and an A/E department that was available twelve hours a day for paediatrics.

**Medical School Bid** – KWB informed Directors that Sunderland University had submitted to become a new medical school but would not know the outcome until the end of March 2018. The bid had been supported by other Trusts in the North East and importantly Newcastle Hospitals had also supported the bid – recognising that the area needed more doctors in training who would hopefully remain in the North East as future consultants in our hospitals.

**NHSI – New Chief Executive** – KWB stated that Ian Dalton was to replace Jim Mackey as the new Chief Executive of NHSI. Ian was currently CEO at the Imperial College Healthcare Trust in London having held a number of senior provider, regional and national NHS roles throughout his career, some of which had been in the North East.

**Newcastle NHSFT – New Chairman** – KWB advised that Sir John Burn had become Chairman at Newcastle Hospitals. He was currently Professor of Clinical Genetics at Newcastle University and helped to create the Centre for Life which houses an education and science centre alongside the Institute of Genetic Medicine and Northgene Ltd, the identity testing company he launched in 1995.

Sir John took up the role on 1 December 2017 and the Chairman was arranging to meet with him.

**Budget** – KWB informed Directors that the Chancellor had announced £1.6bn extra revenue for 2018/19, £3.5bn extra capital funded by the treasury, £0.5bn this year and an additional £3bn over the next five years.

The government had also committed to fund with new money an increase to agenda for change staff, subject to the recommendations from the pay review bodies.

The DH budget had increased by £2.8bn however, this was to be made on an 'exceptional' basis so it was not clear whether that would be recurrently carried forward to 2020/21.

KWB stated that this was more than was expected.

PS queried whether the capital monies had to be signed off by STPs. KWB confirmed that was correct but that some monies had been already allocated.

DB queried whether there were any opportunities for ourselves given we were a forerunner of the STP. KWB replied that we had given NHSI an indication nearly a year ago for £30m/40m but not the level of detail and it was still unclear how money would be allocated.

### **Item 3 Quality Risk and Assurance Report**

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

MJ reported that the Trust was well on track to achieve improved performance in relation to pressure ulcers.

MJ also highlighted safeguarding adults and advised that the Trust had been requested to scope a further potential Domestic Homicide Review. MJ stated that there had been 107 DoLs applications submitted from the Trust to the Local Authority, a decrease of 49 from the previous month. The Trust was also awaiting an outcome on 104 of the DoL applications. One application had been withdrawn and two applications were not approved as the patients had regained capacity.

SH queried as to why there was such a gap between our figures submitted and the LA approving the applications. MJ replied that unfortunately the LA could not keep up with the demand. SH also queried whether that meant that patients were falling through the net. MJ replied that they were not as we were still carrying out our processes and often the patient regains capacity and then the DoL is not an issue. MJ stated that unfortunately it was a bureaucratic process and really quite time consuming.

MJ highlighted nursing workforce and stated that at the end of September 2017 there were 84.61 wte (5.28%) approved RN vacancies. The figure did not include 23.21 wte who were currently undergoing pre-employment checks.

MJ advised that there had been some agency spend which was due to demand for 1:1 nursing within Renal for a patient with mental health needs. Fill rates during September had been problematic with 13 wards with less than 80%, the majority of which being in the Division of Medicine. MJ stated that nursing workforce remained a risk as we moved forward to winter and expected increased demand.

MJ informed Directors that in late August 2017 a Regulation 28 report had been received by the Trust in respect of levels of observation of patients at risk of falls. Reassurances had been provided and an action plan developed which was currently being implemented. PS queried what the Coroner was expecting. MJ replied that he was keen that we had some written guidelines

which was why we were piloting a Standard Operating Procedure for Enhanced Care.

**Resolved:** To accept the report.

#### **Item 4 Finance Report**

JP presented the report and advised that the overall financial position including STF was a net deficit of £5,545k against a planned deficit of £4,113k, and therefore £1,432k behind plan.

JP advised that there was an error in the variance table which should state (924) and not (956) for - Less STF 2017/18.

JP stated that clinical income was behind plan by £562k and training and education income was behind plan by £100k to month 7 due to cessation of funding from Health Education North East for a number of schemes this year.

AW queried why there had been a reduction in funding from HENE. JP replied that it had been a growing figure all year –sometimes linked to posts and sometimes HENE changed their minds in how they allocated funding.

JP highlighted pay costs which were currently showing an overspend of £148k against plan reflecting increased agency costs – the main reason being two more agency consultants in Radiology to over substantive staffing gaps.

JP stated that the largest area of concern was non-pay which was overspent by £2,347k relating to clinical supplies and diagnostics. JP stated that she had asked SF to do some detailed work to understand the main causes and importantly the next steps to address the issue. JP also commented that there had been lengthy discussions in Finance and Performance Committee regarding this issue.

At the end of month 7, CIP delivery was £5,880k against a planned delivery of £6,500k, hence an under delivery of £620k. JP stated that current Trust CIP plans had identified £12.5m of the £13m target although much of the delivery especially for procurement would be in the latter stages of the financial year.

JP stated that the two prime risks going forward were the gap in CIP plans and under-performance against PbR contracts with Commissioners. At this stage the Trust had declared to NHSI that control total delivery was achievable in 2017/18, however there were risks.

DB stated that it had been a difficult month following a good month and that undoubtedly there were risks but we were doing all we could to pursue each line.

DB advised that the Finance and Performance Committee had looked in detail at the potential position for the end of the year but we had to recognise that it was now more difficult to find more efficiencies.

KWB commented that the NHS was running another incentive scheme this year for those organisations achieving their control total. JP stated that within the Q2 information if you took out all acute providers without STF monies then only 17/135 were sustainable.

JP also highlighted CHOICE and that the Trust currently wholly owned it with almost 12 million shares. As part of working more closely together it was proposed that STFT be given the opportunity to purchase £1,000 worth of shares. A paper detailing the rationale etc. had gone to Audit Committee who had supported the proposal in principle.

**Resolved:**

- To support the recommendation of the Audit Committee to allow STFT to purchase shares in CHOICE.
- To note the financial position to date.

**Item 5 Performance Report**

AK presented the report which updated Directors on performance against key national targets as at October 2017.

AK explained that A&E performance had failed to achieve the 95% target at 92.7% which was also below the STF trajectory of 93.9%. National A&E performance was 90.1% plus the Trust remained in the upper middle 25% of Trusts nationally.

RTT remained above target at 94.5% with all specialties achieving the target except T&O, Thoracic and OMFS.

AK stated that OFMS were just marginally under but as at 30 November 2017 they were just over 92% and Thoracic Medicine was in a much better position also.

The Trust had met all cancer waiting time standards with the exception of cancer 62 days for patients referred urgently by their GP mainly due to breaches in Urology. The standard had however been achieved for the quarter although this remained an ongoing risk into 2018.

AK informed Directors that diagnostic performance continued to achieve the national standard at 0.22%.

AK also highlighted changes to the NHSI single oversight framework which included implementing an outline of five key themes and what would trigger consideration of a support need. For acute providers, dementia assessment and referral standards would now be incorporated.

**Resolved:** To accept the report and to note the risks going forward.

#### 4. Strategy/Policy

##### Item 6 Learning from Deaths Dashboard

ICM presented the report which was presented as a consequence of new guidance published by the National Quality Board on a new learning from deaths framework. From Q3 2017 onwards Trusts must publish information on deaths and reviews via a quarterly agenda item and paper to its Board meeting in public.

ICM advised that the report and dashboard fulfilled the requirements and the focus was on outcomes and learning from mortality reviews rather than reporting mortality statistics from deaths was a new and evolving national programme and that the dashboard would be adjusted as we further developed our mortality review process in line with Trust policy.

**Resolved:** To note the requirements of the Trust to produce a 'Learning from Deaths Dashboard' within quarter 3, 2017/18 and to accept the report and dashboard.

**JOHN N ANDERSON QAEP CBE**  
Chairman

**SOUTH TYNESIDE NHS FOUNDATION TRUST  
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST**

**DIRECTORATE OF NURSING & PATIENT EXPERIENCE**

**BOARD OF DIRECTORS**

**JANUARY 2018**

**QUALITY, RISK AND ASSURANCE REPORT (NOVEMBER 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.

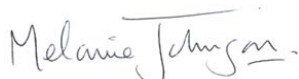
This report provides a summary of the key issues considered in more detail by the Governance Committees (and its subgroups the Clinical Governance Steering Groups and Corporate Governance Steering Group) and also information from the Joint Patient, Carer and Public Experience Committee (PCPEC). It includes 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**

- Nursing vacancies as activity increases over winter
- Pressure ulcers at STFT Acute
- Low incident reporting for STFT

**RECOMMENDATION**

Directors are asked to note the report.



**MELANIE JOHNSON**  
Director of Nursing &  
Patient Experience



**IAN MARTIN**  
Medical Director  
(CHSFT)





**City Hospitals Sunderland**  
NHS Foundation Trust

**South Tyneside**  
NHS Foundation Trust

# **Quality, Risk and Assurance Report for November 2017**

## PATIENT STORY

### LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

#### CHSFT:



A young woman with Rubenstein-Taybi Syndrome who lives locally and is cared for by her parents was referred urgently for assessment with heavy irregular bleeding. She was examined under anaesthetic on 6 March 2017 and biopsies taken demonstrated a cancer of the lining of the womb. All of the staff in various hospital departments were very considerate of the difficulties she had and responded with great care and compassion, this included outpatient and theatre areas.

It was highlighted by the patient's family that the care and effort made by the nurses, HCAs and medical staff on D47 was exceptional.

She was transferred directly back to D47 following her EUA where she received the usual high quality care afforded by the staff on the ward. It is the events prior to and following her major gynaecological surgery that highlight the compassionate care she received.

The patient was admitted to D47 the day prior to her operation, on 22 March 2017. She was understandably anxious but all staff were magnificent in settling her onto the ward, accompanying her to x-ray and taking blood. Again the team on D47 provided high quality care post-operatively, going above and beyond.

The young woman has significant communication difficulties and required several invasive, intimate treatments during her recovery. The staff consciously ensured she received continuity of care by staff who were aware of her needs, and these staff carried out the procedures using a very personalised approach to ensure she felt safe and supported at all times.

The patient's Consultant Gynaecologist, with an aim to calm her on transfer to theatre sang to her, as he knew she would like this and it did work – she was very calm and he is now 'her favourite doctor'.

The family were so impressed with the care their daughter had received and that they were welcomed to stay with her throughout her stay. To convey their thanks they provided afternoon tea for the staff on the ward.

Sheila Ford, Head of Midwifery, said: "This was a wonderful family who just wanted the staff on D47 to know what an amazing job they had done caring for their daughter. The staff went above and beyond to make them feel comfortable and safe and they were so genuinely impressed by the standard of care that they arranged for the team to have afternoon tea. It's situations like this when you appreciate what a difference we can make to patients' lives. Such small things make the biggest difference and I am delighted that the team were recognised in this way."

#### STFT:

The following post regarding the Surgical Inpatient Unit was uploaded on the NHS Choices website anonymously in November 2017:

*"I recently had to stay on the Surgical Inpatient ward as I needed an operation on the emergency Obs and Gynae list.*

*I arrived at 12.00pm and was shown to my room, which was beautifully clean and well equipped. I was checked in by a lovely student nurse and kept informed with what was happening by the team of doctors and nurses.*

*I went down to theatre around 6.00pm and was back at 7.30pm. All of the staff were great looking after me, checking if I was ok or if I needed anything. I can't thank them enough - they made an awful situation bearable. Everyone I met from domestics, porters, pharmacy staff were all very friendly.*

*The staff on the ward are so busy, there is simply not enough of them but sadly this is the way the NHS is today. The staff are worth their weight in gold and could not have done enough for me - they never stopped, constantly up and down the corridors. Their feet must have been on fire and they must have walked miles. Keep up the hard work everyone. You are all an asset to the NHS."*

## 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 November 2017 – CHSFT

In November, CHSFT reported 23 Category 2 HDPUs (Hospital Developed PUs), which is an increase from last month when we reported 15. 21 patients developed a HDPUs, as two patients had multiple PUs this month. The highest incidence of HDPUs this month occurs within General Internal Medicine, who reported a total of 7 PUs.

#### Ward & Community Dashboard data for November 2017 – STFT

In November, STFT reported a total of 49 HCDPUs across acute and community services, which is an increase from the 47 reported last month. There were 26 HDPUs reported compared to the 20 reported in October. 16 patients developed one PU and five patients developed two PUs. The highest incidence of HDPUs this month has occurred within Trauma and Orthopaedics who reported a total of 11 PUs.

For community services, 23 Community Developed PUs (CDPUs) were reported in November which is a reduction from the 27 we reported last month. 16 patients developed one PU, two patients developed two PUs and one patient developed three PUs. In addition, there has been one category 3 PU and one category 4 PU reported for November and both cases are awaiting review.

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

Severity	Number of HDPUs
Category 2	23
Category 3	0
Category 4	0
<b>Total</b>	<b>23</b>

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

Severity	Number of Acute (HDPUs)	Number of Community (CDPUs)
Category 2	26	23
Category 3	0	0
Category 4	0	0
<b>Total</b>	<b>26</b>	<b>23</b>

#### 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 (3 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. These figures include all categories of APUs.

#### Total number of APUs per month December 2016 to November 2017:

Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17
225	271	231	198	187	177	165	153	168	129	165	137

#### STFT

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

#### Total number of APUs per month December 2016 to November 2017:

Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17
122	142	139	123	180	155	135	140	140	132	154	162

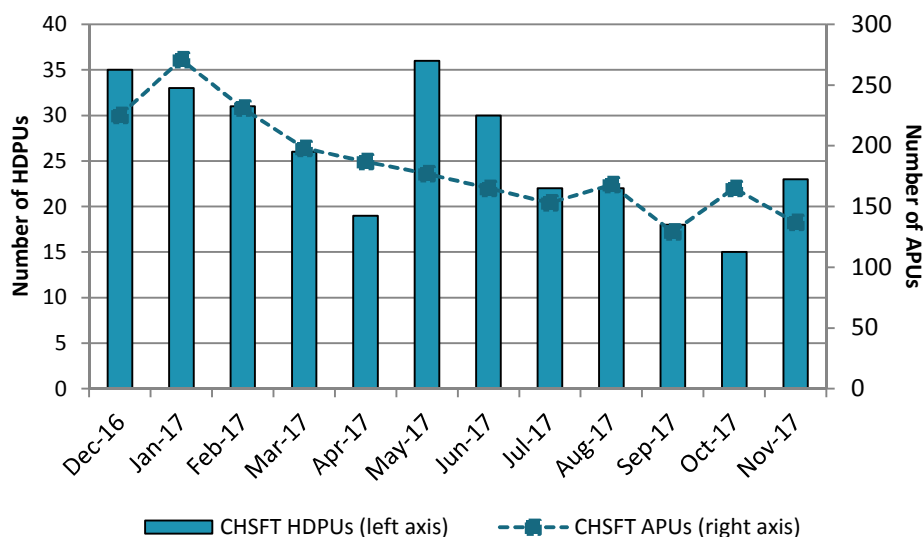
**PRESSURE ULCERS (continued)**  
**LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE**

**1.2 ACQUIRED PRESSURE ULCERS (APUs) (continued)**

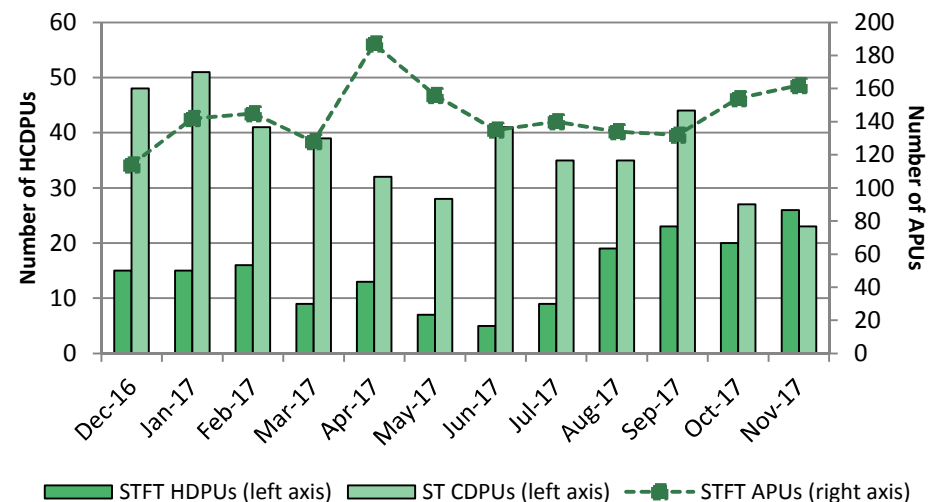
Figure 1 shows numbers of HDPUs (primary axis) and APUs (secondary axis) for CHSFT for the period October 2016 to November 2017.

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

**Figure 1: CHSFT HDPUs and APUs from December 2016 to November 2017**



**Figure 2: STFT HDPUs, APUs and CDPUs from December 2016 to November 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**

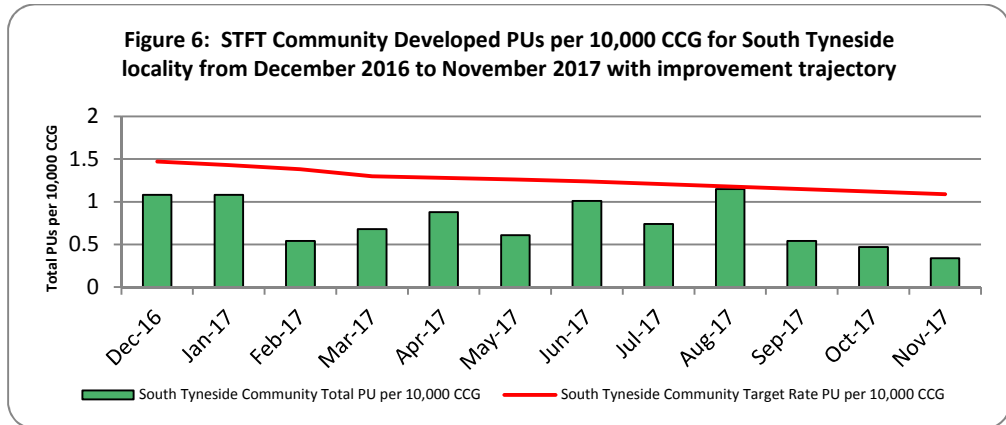
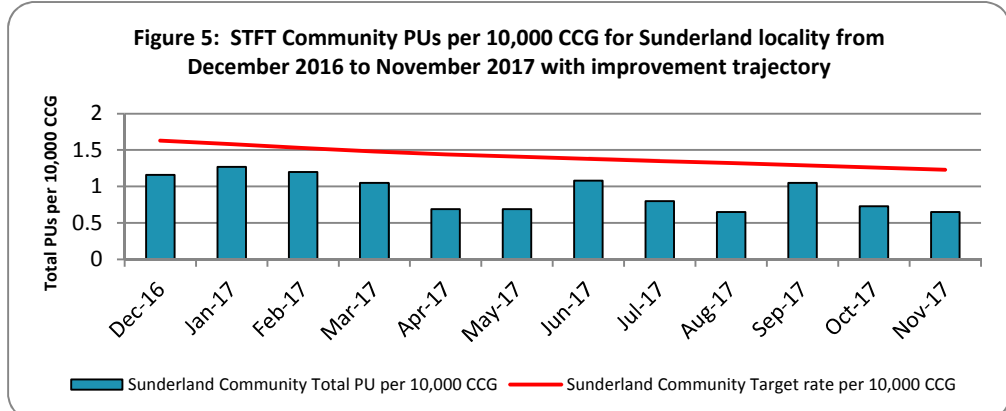
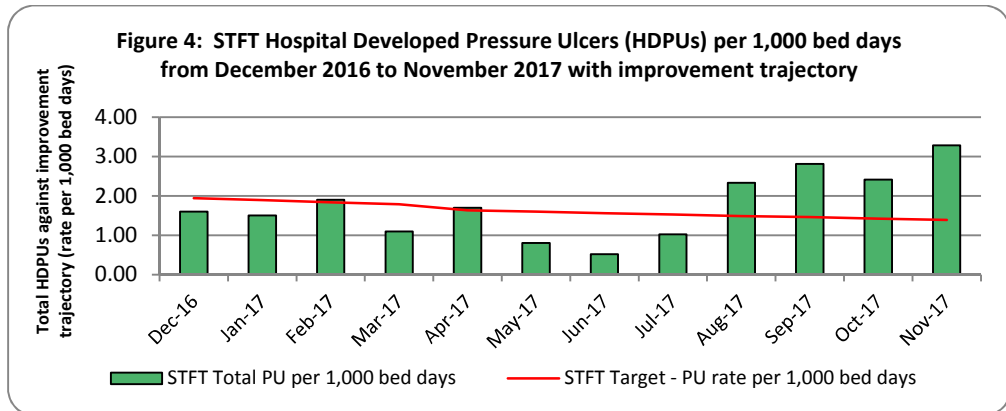
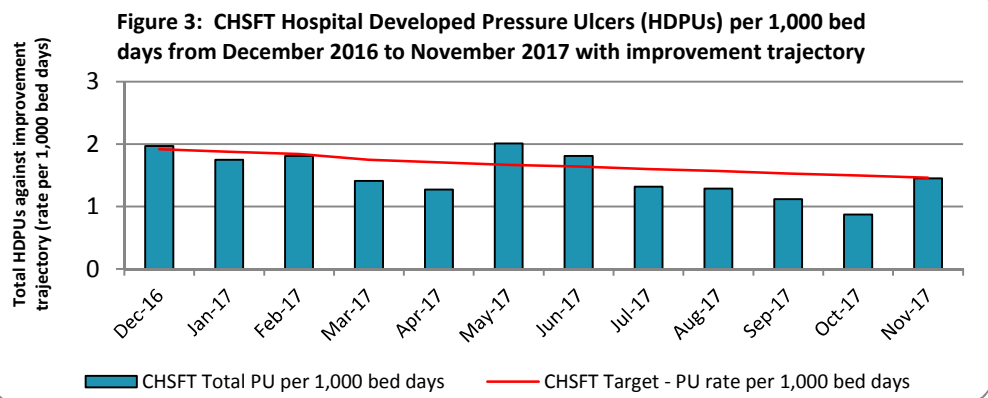
The number of HDPUs per 1,000 bed days has increased from 0.87 in October to 1.45 this month, due to the increased number of PUs reported. The TV team are working alongside the clinical teams in the areas who have reported higher numbers of PUs this month to investigate the reasons for this increase. Figure 3 shows the number of HDPUs per 1,000 bed days, together with the improvement trajectory which indicates that despite this month's increase we remain on track with our target for this year.

**STFT**

The number of HDPUs per 1,000 bed days has this month increased from 2.41 in October to 3.28 this month.

Figure 4 shows the number of HDPUs together with the improvement trajectory. Figures 5 and 6 show the number of CDPUs per 10,000 CCG population with the improvement trajectory for the Sunderland and South Tyneside localities (STFT).

In October the rate of CDPUs developed in our care per 10,000 CCG populations was 0.73 for Sunderland and 0.47 for South Tyneside. The rate for November has reduced for Sunderland to 0.65 and to 0.34 for South Tyneside. 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. November figures demonstrate an increase in referral activity in comparison to activity recorded in October. In total referrals increased by 19. There is no identified cause for this increase.

The main reason for referral is previous involvement with Children’s Services. Parental mental health, substance misuse and domestic abuse continue to be dominant themes. There have been no reported cases of Female Genital Mutilation (FGM).

There are no risks to note within the Looked After Children (LAC) service with all Key Performance Indicators on timescale.

**STFT**

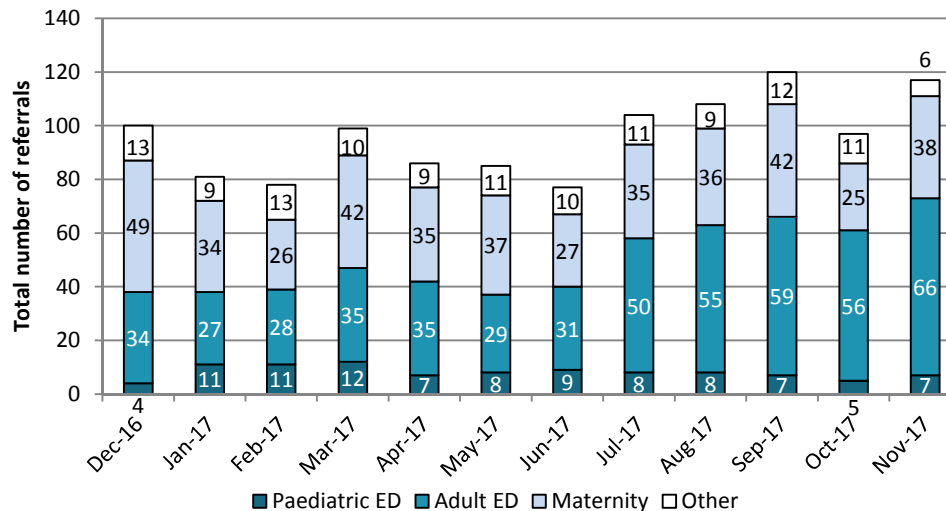
Figure 8 shows the breakdown of safeguarding children referrals from STFT. November figures demonstrate a reduction of one referral in total compared to October.

The themes for the referrals relate to parental domestic abuse, previous child protection plans and parental mental health issues. One referral included concerns around Honour Based Violence (HBV).

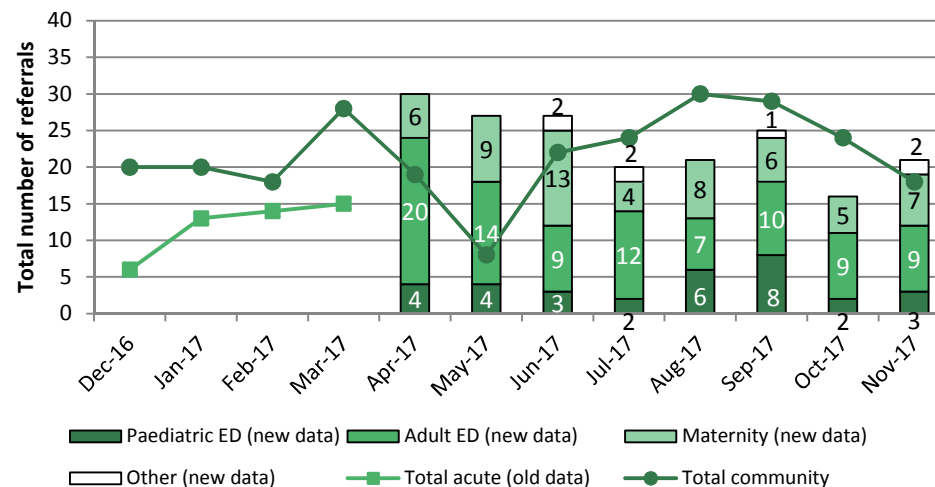
The last three months have demonstrated an overall continued decrease in the numbers of referrals made across Community Services. There are no identified causes for this reduction. STFT Community themes remain similar to the previous month, being mainly physical harm and neglect.

South Tyneside Children’s Services OFSTED inspection report was published this month, rating them as “good” overall with “outstanding” in adoption performance. Areas for improvement include supporting care leavers and ensuring supervision is challenging and reflective. There are no identified risks for STFT.

**Figure 7: CHSFT Safeguarding children referrals December 2016 to November 2017**



**Figure 8: STFT Safeguarding children referrals December 2016 to November 2017**



**SAFEGUARDING ADULTS**  
**LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE**

**1.5 SAFEGUARDING ADULTS**

**CHSFT**

Figure 9 shows the breakdown of Safeguarding Adult Referrals from CHSFT.

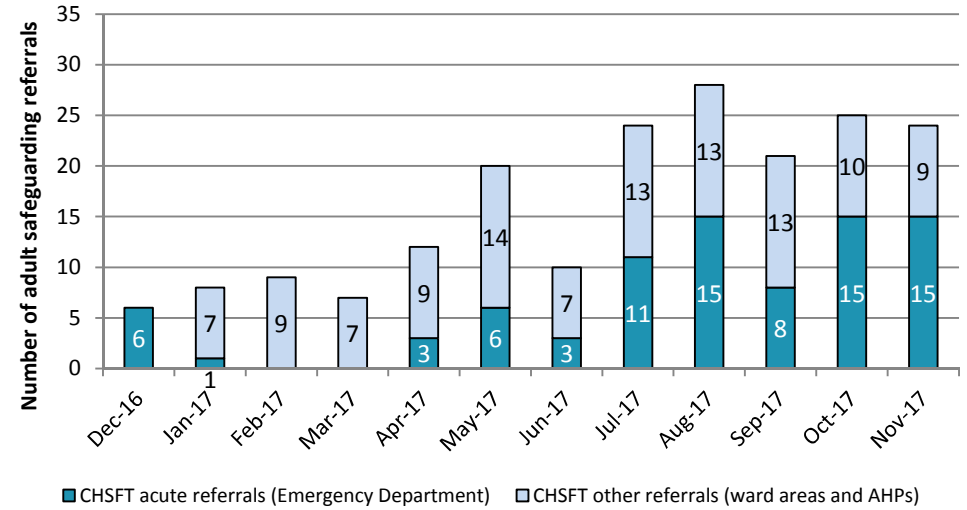
Referral rates remain similar to previous months. Referral themes were physical abuse, self-neglect, neglect, domestic abuse, sexual abuse and psychological abuse.

**STFT**

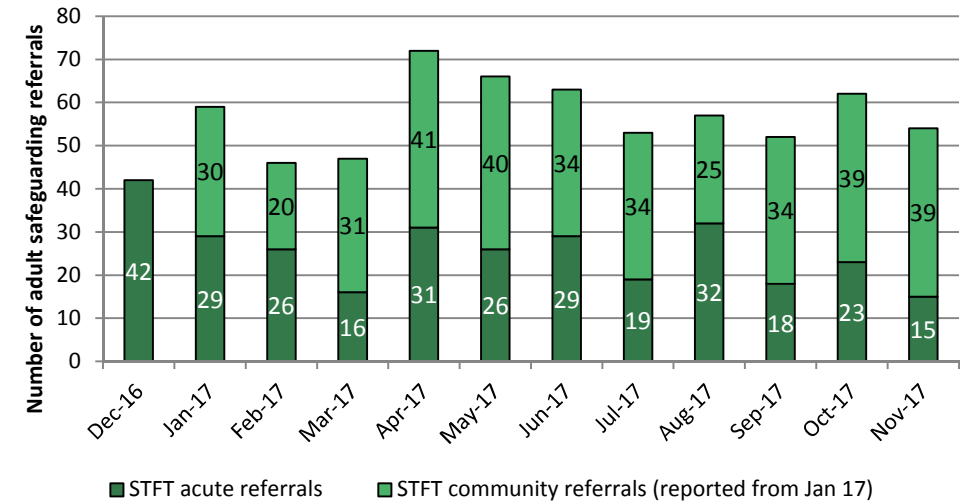
Figure 10 shows the breakdown of Safeguarding Adult Referrals from STFT. November figures demonstrate a decrease of eight referrals to October reporting.

Referral rates remain similar to previous months. Referral themes are neglect, self-neglect, domestic abuse, financial abuse and physical abuse.

**Figure 9: CHSFT Adult safeguarding referrals received December 2016 to November 2017**



**Figure 10: STFT Adult safeguarding referrals received December 2016 to November 2017**



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

**1.5 SAFEGUARDING ADULTS (continued)**

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

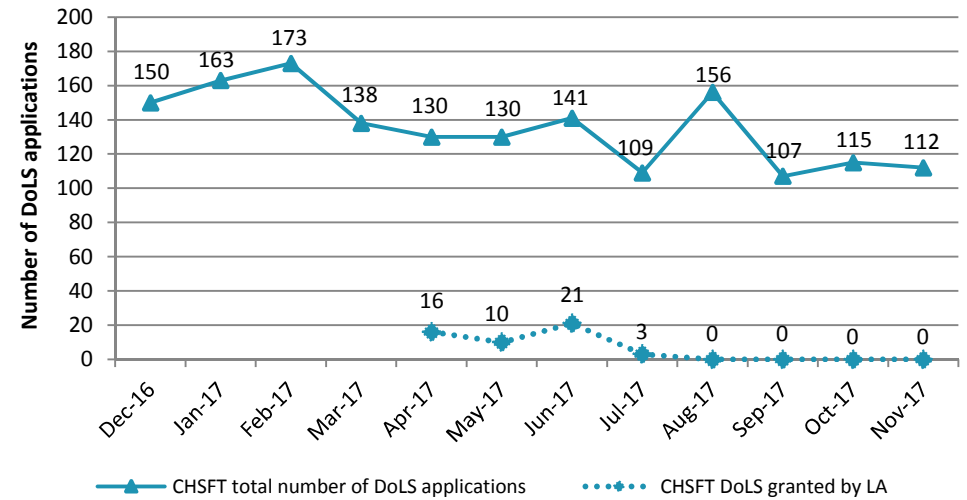
**CHSFT**

Figure 11 shows the number of DoLS applications and the numbers of DoLS applications granted by the Local Authority for CHSFT which equates to 1.07% applications against inpatient activity.

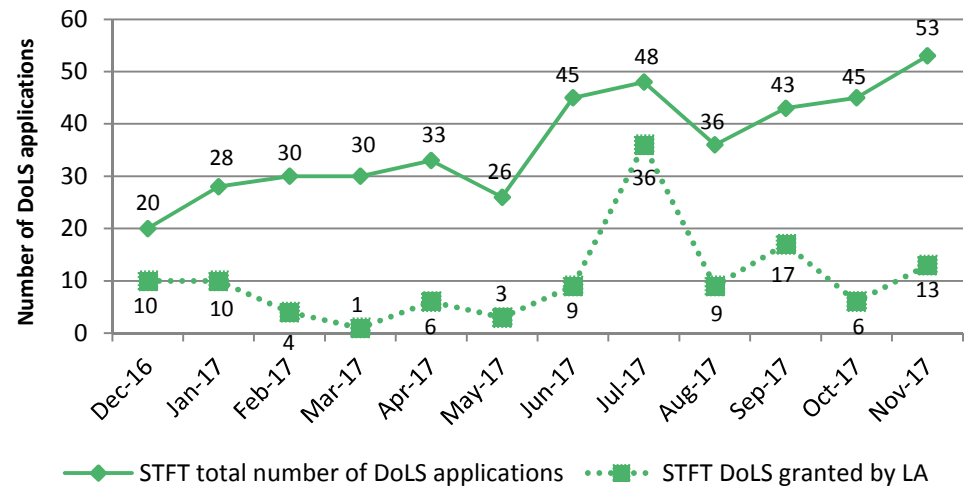
**STFT**

Figure 12 shows the number of DoLS applications and the numbers of DoLS applications granted by the Local Authority for STFT which equates to 2.12% applications against inpatient activity.

**Figure 11: Number of DoLS applications made December 2016 to November 2017**



**Figure 12: Number of DoLS applications made December 2016 to November 2017**





## COMPLAINTS

### LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

#### 1.6 COMPLAINTS

##### CHSFT

There were 40 complaints received in November, with a year to date average of 38 per month.

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

Figure 13 shows there are 32 formal complaints awaiting a first written response (by working days), compared to 24 last month. Two complaints have been awaiting a first response for more than 60 days. The first relates to Estates and the processes involved in obtaining costings for work to be undertaken and this was approved in November. The second complaint over 60 days went to a meeting with additional information to be provided. Clarification is still being sought due to a discrepancy in some of the information provided.

##### STFT

There were 17 complaints in November, 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 November shows that 100% of complaints were acknowledged within this timeframe.

Figure 14 shows there are 17 formal complaints awaiting a first written response (by working days). There are two complaints awaiting a first response for more than 60 days. This delay is due to the number of issues raised and the complexity of the cases.

Figure 13: CHSFT current formal complaints awaiting first response by working days - September to November 2017

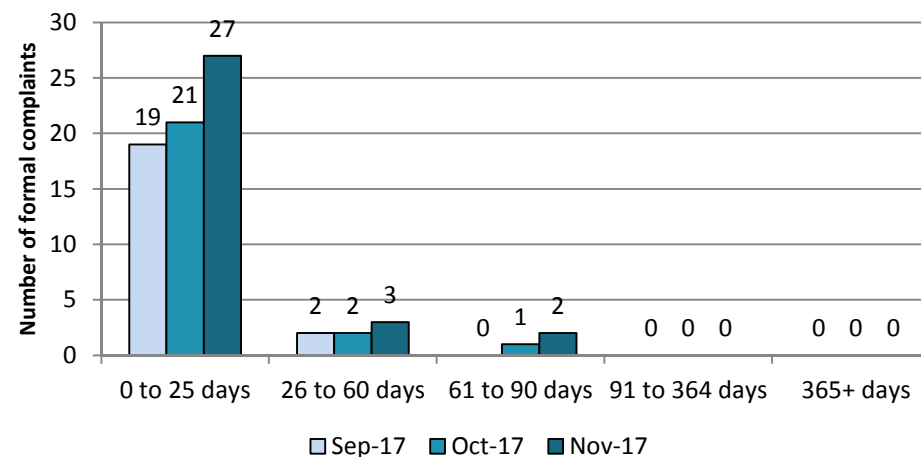
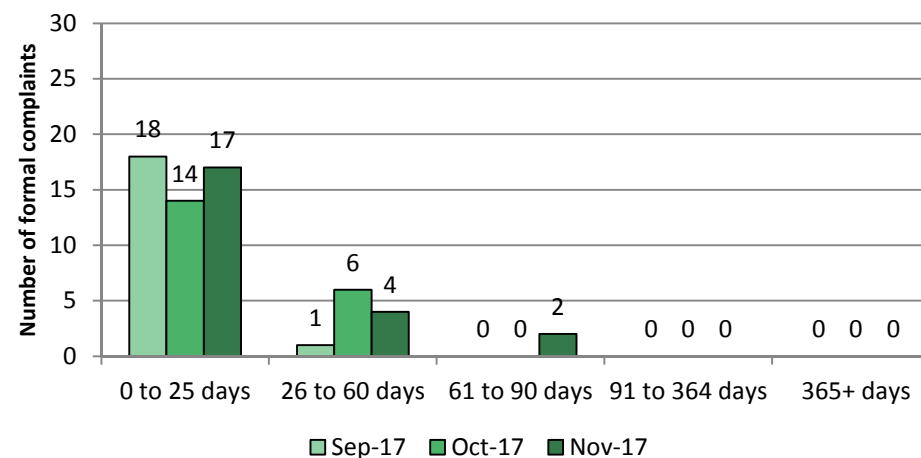


Figure 14: STFT current formal complaints awaiting first response by working days - September to November 2017



**NURSING WORKFORCE**  
**LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE**

**1.7 NURSING WORKFORCE**

**CHSFT**

During the month of November, nine additional beds were opened (21 November) on E54 Annex due to extreme bed pressures. These additional beds were closed on 23 November.

In November, agency spend was £12,288, an increase from October (£5,082). This was due to an increased demand for 1:1 nursing within REM and T&O for patients with mental health needs.

Fill rates and trends can be seen in figure 15. There were 12 wards in November with RN fill rates less than 80%, which is a slight increase from October (11). The majority of these remain within the Division of Medicine, which continues to have the highest number of vacancies.

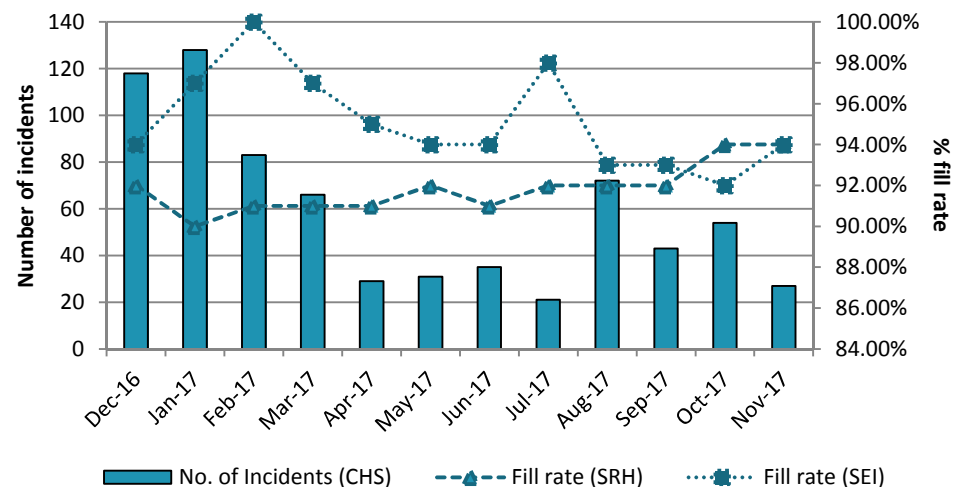
There were 27 incident forms submitted in November (in which 39 red flags were identified – NICE Guidance) relating to Nursing and Midwifery staffing, a decrease from October (54).

There were 18 incident forms submitted by nine different wards/Matron when RN staffing was below “trigger” numbers, an increase from October (14). On all occasions, the duty matron implemented the nurse escalation plan and moved staff according to the level of risk. The Division of Medicine submitted the highest number of incident forms this month (19). This is in part due to the number of vacancies.

NHS Professionals continue to provide support to wards to mitigate shortfalls. There were 20,690 hours supplied in November compared to 19,904 in October. In November, 57.8% of requests were filled compared to 60.5% in October.

At the end of November there were 72.91wte (4.55%) approved RN vacancies. This does not include 44.14wte who are currently undergoing pre-employment checks.

**Figure 15: CHSFT Nursing Fill Rate and Incidents Trend - December 2016 to November 2017**



**Fill rates – November 2017**

SRH	SEI
94.00%	94.00%

**Care Hours Per Patient Day (CHPPD) – November 2017**

SRH	SEI
7.7	14.2

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

**1.7 NURSING WORKFORCE (continued)**

**STFT**

During the month of November, eight additional beds (six on ward 5 and two on ward 20) were opened (20 November) due to extreme bed pressures. All eight beds were closed on 22 November.

On 26 November, eight additional beds (six on ward 5 and two on ward 20) were opened again due to extreme bed pressures. Six beds (ward 5) were closed on 29 November, however, two beds (ward 20) remained open until the end of the month.

In November, agency spend was £46,465, which is a slight decrease from October (£49,093).

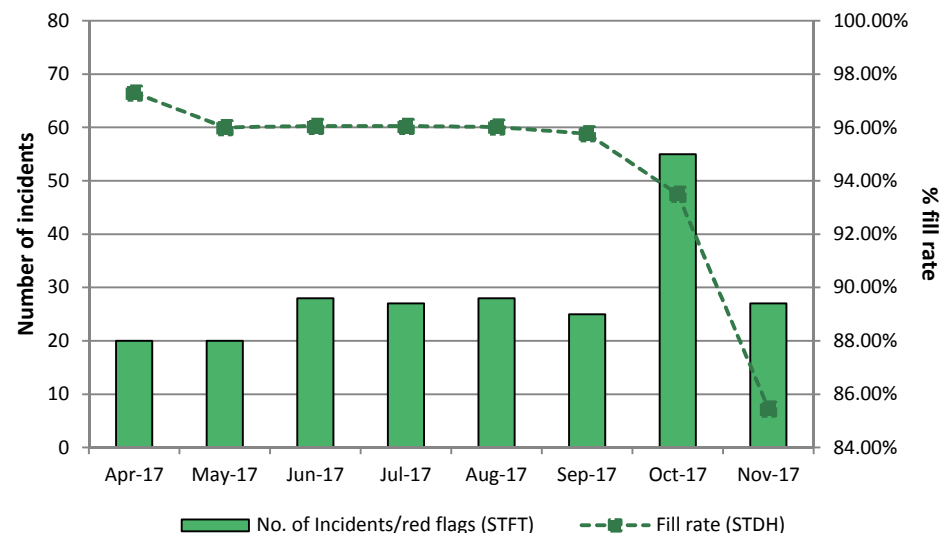
Figure 16 shows fill rates and incident trends. There were nine wards in November with RN fill rates less than 80%, which is an increase from October (2). However, in November e-Rostering was aligned with the staffing budget after each ward had been given an uplift in staffing following workforce reviews. Therefore this has brought the fill rate down at STDH.

In November there were 27 incident forms/safecare incidents submitted (in which 29 red flags were identified – NICE Guidance) relating to nurse staffing, a decrease from October (55). There were two incidents identified by one ward when RN staffing was below “trigger” numbers, a decrease from October (3). Matron of the day visits each ward and department on the acute site daily to review staffing and report concerns and actions at the bed meetings. When indicated, the nurse staffing escalation plan is implemented. The Division of Medicine submitted the highest number of incident forms this month (20), however, this may be in part due to the number of vacancies.

NHS Professionals continue to provide support to wards to mitigate shortfalls. There were 13,467 hours supplied in November compared to 3,398 in October. In November, 73.5% of requests were filled compared to 66.9% in October.

Vacancies at the end of November showed: Acute – 41.67wte (11.38%) RN vacancies and no HCA vacancies; Community – 69.36wte (8.68%) RN vacancies and 16.03wte (9.16%) HCA vacancies, broken down in figure 17.

**Figure 16: STFT Nursing Fill Rate and Incidents Trend - April to November 2017**



**Fill rates – November 2017**

STDH	Monkton Hospital	St Benedict's Hospice
85.45%	106.70%	95.12%

**Care Hours Per Patient Day (CHPPD) – November 2017**

STDH	Monkton Hospital	St Benedict's Hospice
6.4	17.2	7.5

**Figure 17: Community vacancies at the end of November 2017:**

	District Nurse	HCA	Health Visitor	HCA	School Nurses	HCA	Urgent Care Team	Recovery at Home
Gateshead	N/A	N/A	0	2.53	9.35	1.15	N/A	N/A
South of Tyne	5.17	0	4.9	0.5	5.8	0	2.12 0.07	N/A
Sunderland	12.44	0.55	3.35	0.1	4.07	1.06	N/A	7.77

**PATIENT SAFETY**  
**LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE**

**1.8 INCIDENT REPORT**

**CHSFT**

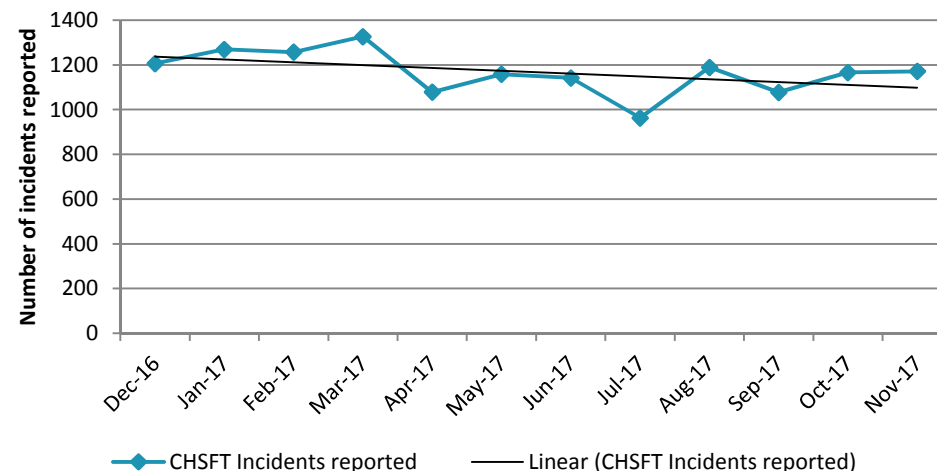
**CHS incidents reported**

Figure 18 demonstrates the number of CHS-related incidents that have been reported via Ulysses each month during the last 12 months. It shows an increase of 5 reported incidents (0.5%) in November 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 minor harm incidents as a proportion of CHS incidents reported is 95% in November. Three incidents were reported as having caused major or extreme harm in November. These will be reviewed by directorates via the Directorate Initial Review process and will be considered by RRG in due course. Five incidents were reported as having caused major or extreme harm in October. Two incidents have been reviewed by directorates, considered at RRG and have had their levels of harm downgraded, and two of the remaining three are currently under review or investigation and will be considered at RRG. One incident was identified as a community acquired pressure ulcer, so is not a CHS incident.

**Figure 18: CHSFT Number of incidents reported December 2016 to November 2017**



**Data for Figure 18: CHSFT Incidents reported by category December 2016 to November 2017**

	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	June 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17
No harm/near miss	730	697	765	839	-	-	-	-	-	-	-	-
Near miss	-	-	-	-	22	21	35	22	33	26	30	26
No harm	-	-	-	-	714	763	667	607	627	632	703	680
Minor harm	413	504	458	434	335	358	410	321	458	369	405	433
Moderate harm	53	58	30	40	5	13	19	10	23	42	23	27
Major harm	4	7	3	11	2	1	2	2	3	6	5	2
Extreme harm	6	3	1	2	0	0	1	1	0	2	0	1
<b>Total</b>	<b>1206</b>	<b>1269</b>	<b>1257</b>	<b>1326</b>	<b>1078</b>	<b>1156</b>	<b>1134</b>	<b>963</b>	<b>1189</b>	<b>1077</b>	<b>1166</b>	<b>1171</b>

## PATIENT SAFETY

### LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

#### 1.8 INCIDENT REPORT (continued)

##### STFT

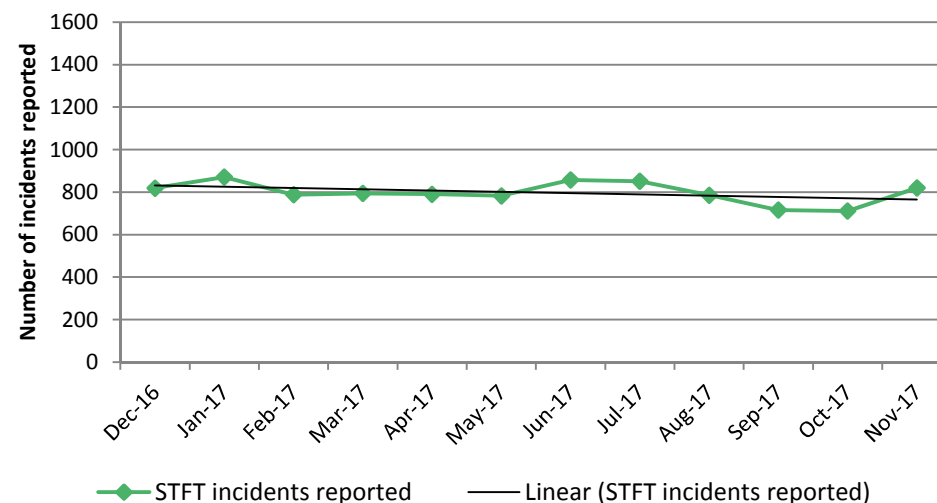
Figure 19 demonstrates the number of STFT-related incidents which have been reported via Datix each month during the last 12 months. A linear trend line is incorporated into figure 19 which shows a fairly steady trend in incident reporting. Although reporting has increased by 15% this month, and this may be due to increased focus on the subject, it is unlikely that reporting rates will routinely increase until Datix functionality improves and staff across the Trust receive training in incident reporting, supported by the provision of a Trust policy specifically relating to incident reporting processes.

##### STFT Incidents by Reported Severity Score

The data table for figure 19 shows incidents reported by severity over the last 12 months. The total percentage of no harm and minor harm incidents as a proportion of all STFT incidents reported in November is 85% compared to 43% last month, but as figure 19 shows, this relates to a higher number than usual incidents in October having been reported as near misses. The accuracy of harm classification should improve once the Trust has an updated incident reporting policy and training in respect of the policy content has been provided.

There were two incidents which were reported as having caused major harm and one reported as extreme in November. The extreme harm was a difficult surgery performed in theatre and additional gynaecology support was needed; this is awaiting Clinical Incident Review Group (CIRG) review to assess the outcome and confirm the level of harm. The first reported major harm was a deterioration of a pressure ulcer in the community to a grade 4; a root cause analysis found no omissions in care and CIRG is awaiting Pressure Ulcer Review Panel assessment of the confirmed level of harm. In the second case, a patient fell and fractured their neck of femur in the surgical centre. This case will be reviewed at CIRG and will be declared as a Serious Incident if appropriate.

Figure 19: STFT Number of incidents reported December 2016 to November 2017



Data for Figure 19: STFT Incidents reported by category December 2016 to November 2017

	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17
Near miss	125	127	112	111	96	110	122	116	100	105	384	111
No harm	395	399	370	386	396	516	526	519	471	402	122	447
Minor harm	262	291	271	264	268	151	195	200	192	190	183	251
Moderate harm	32	54	35	32	29	6	14	15	23	18	22	8
Major harm	5	0	0	1	1	0	0	1	0	1	0	2
Extreme harm	0	0	0	0	0	0	0	0	0	0	0	1
<b>Total</b>	<b>819</b>	<b>871</b>	<b>788</b>	<b>794</b>	<b>790</b>	<b>783</b>	<b>857</b>	<b>851</b>	<b>786</b>	<b>716</b>	<b>711</b>	<b>820</b>

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

**1.8 INCIDENT REPORT (continued)**

**Root Cause Analysis (RCA) investigations**

**CHSFT**

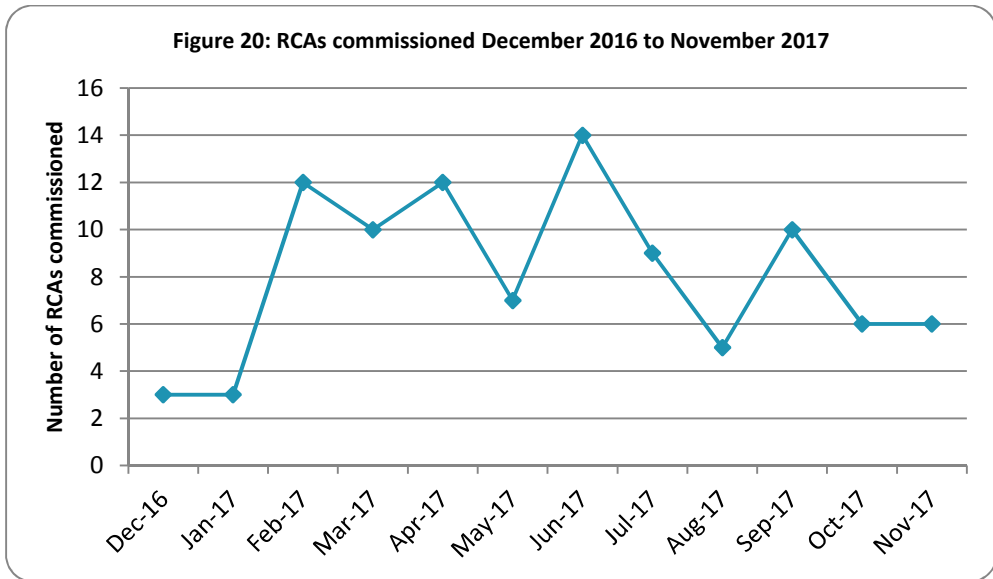
RCA's are prepared by the directorate and are reviewed by Rapid Review Group (RRG) for approval before circulation both internally and, where appropriate, to external organisations. Figure 20 demonstrates the number of RCA's commissioned by RRG per month.

During November, RRG commissioned six RCA's. Figure 21 indicates the status of RCA's, showing 30 out of 36 RCA's are overdue. Appropriate escalation of overdue RCA's through operational line management structures is now in place with data in respect of overdue cases being provided to the Director of Operations where appropriate. In addition, the Executive Director of Nursing and Patient Experience and Deputy Medical Director are currently undertaking a review of the oldest RCA's in order to identify whether their commissioning was appropriate.

**STFT**

The incident software at STFT has been reconfigured and can now report on RCA performance since June 2017. This is shown at Figure 22. 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 five RCA's are now open and within timeframe. No RCA's are currently overdue. RCA production at STFT is managed through CIRG and overdue RCA's are managed through that route.



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

	Comprehensive RCA	Concise RCA	Total
<b>Overdue &gt;3 months</b>	5 (7)	9 (8)	14 (15)
<b>Overdue &lt;3 months</b>	2 (2)	14 (12)	16 (14)
<b>Within timeframe</b>	0 (0)	6 (6)	6 (6)
<b>Total</b>	<b>7 (9)</b>	<b>29 (26)</b>	<b>36 (35)</b>

**Figure 22: STFT Status of current RCA's – November 2017** (previous month in brackets)

	Comprehensive RCA	Concise RCA	Total
<b>Overdue &gt;3 months</b>	0 (0)	0 (0)	0 (0)
<b>Overdue &lt;3 months</b>	0 (0)	0 (0)	0 (0)
<b>Within timeframe</b>	0 (0)	5 (4)	5 (4)
<b>Total</b>	<b>0 (0)</b>	<b>5 (4)</b>	<b>5 (4)</b>

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

**1.8 INCIDENT REPORT (continued)**

**Serious Incidents (SIs)**

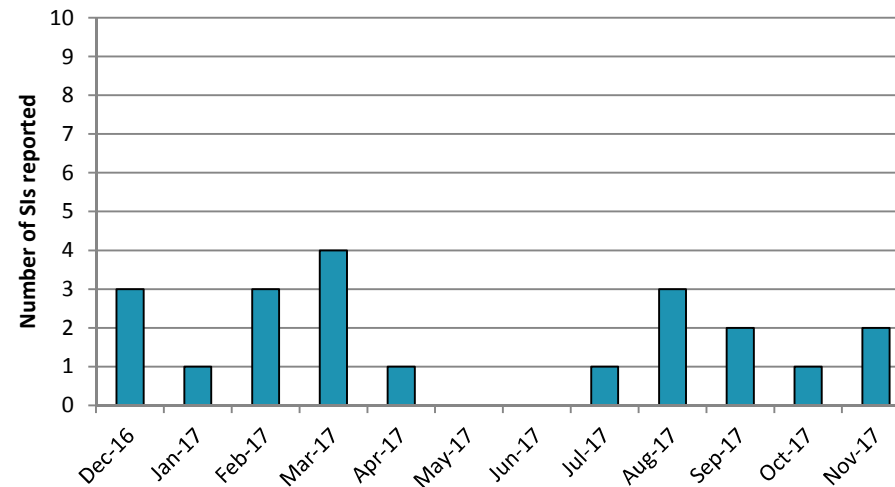
**CHSFT**

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 incidents were reported to NECSU in November. One related to a patient developing sudden onset right sided weakness, the other related to a patient deteriorating following a fall.

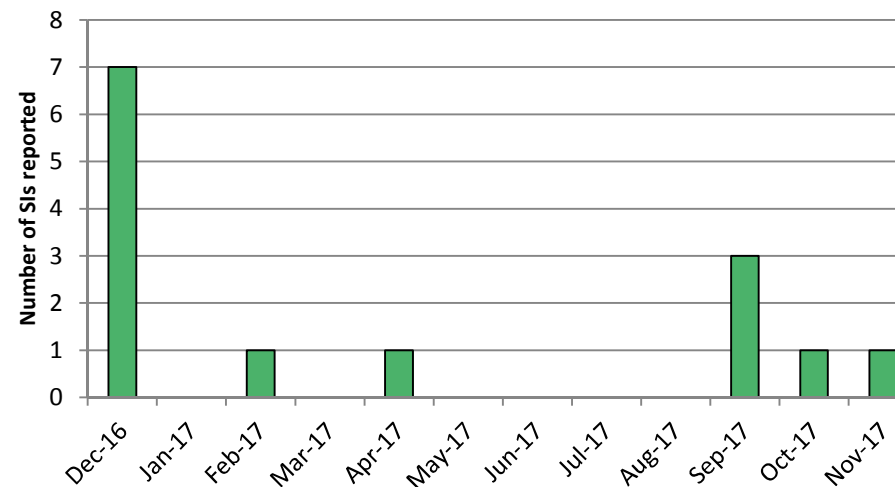
**STFT**

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 was one SI declared in November as seen in Figure 24; this was a fall and resulting fractured neck of femur on Ward 5.

**Figure 23: CHSFT SIs reported to StEIS December 2016 to November 2017**



**Figure 24: STFT SIs reported to StEIS December 2016 to November 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. Six SIs are overdue and, again, appropriate escalation of these cases is now in place. 12 SIs have been considered by Commissioners and are awaiting further information or clarification from the Trust, while 15 are awaiting consideration. The number of SIs within target is currently two.

**STFT**

In November, STFT had 24 open SIs compared to 28 last month. Figure 26 shows that 14 SI reports are overdue for submission to Commissioners; these are being actively managed to closure. Two remain open due to the CCG needing further information before the cases can be closed and three await CCG comment or closure. Five are not yet due a report.

**Figure 25: CHSFT SI status December 2016 to November 2017**

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

**Figure 26: STFT SI status December 2016 to November 2017**

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

**Never Events**

**CHSFT**

No Never Events were reported in November.

**STFT**

No Never Events were reported in November.

**Duty of Candour**

**CHSFT**

During November, 25 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 November, two of the reported incidents were confirmed as meeting the requirements for Duty of Candour.

**STFT**

During November 2017 the Risk Team identified three incidents as requiring Duty of Candour actions to be carried out. One incident was completed within 10 days of the notification being received. The deadline for completion of the other two incidents is December 2017.



**PATIENT SAFETY (continued)****LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE****1.9 FALLS****FALLS**

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 November 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 or major harm.

**Figure 27: Numbers of Falls by category for November**

Severity of Injury	CHSFT Number of Falls	STFT Number of Falls
		Acute
No Harm	86	65
Low Harm	34	18
Moderate Harm	0	0
Severe Harm	0	0
Death	0	0
<b>Total Falls</b>	<b>120</b>	<b>83</b>
<b>Rate/1,000 bed days</b>	<b>7.24</b>	<b>10.4</b>
<b>National Falls</b>	<b>6.63</b>	<b>6.63</b>
<b>Total Moderate or Major Harm</b>	<b>0</b>	<b>0</b>
<b>Rate/1,000 bed days</b>	<b>0</b>	<b>0</b>
<b>National rate for falls with Moderate or Major Harm</b>	<b>0.9</b>	<b>0.9</b>
<b>Rate/1,000 bed days</b>	<b>0.9</b>	<b>0.9</b>

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

**1.9 FALLS (continued)**

**CHSFT**

We reported a total of 120 falls in November, which was a slight decrease from the 124 we reported in October. This equates to a fall rate of 7.24 per 1,000 bed days for all falls which is a slight increase from the 7.23 we reported last month. CHS only started reporting this data in September 2017, which can be seen in figure 28.

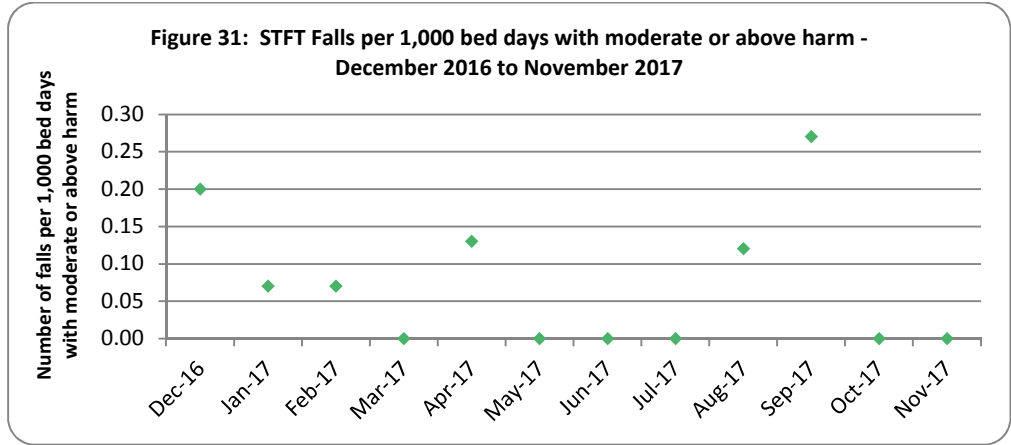
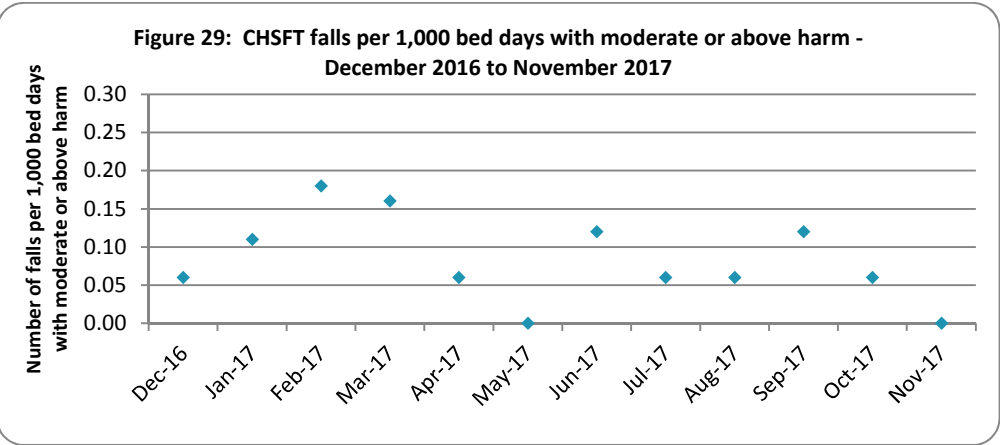
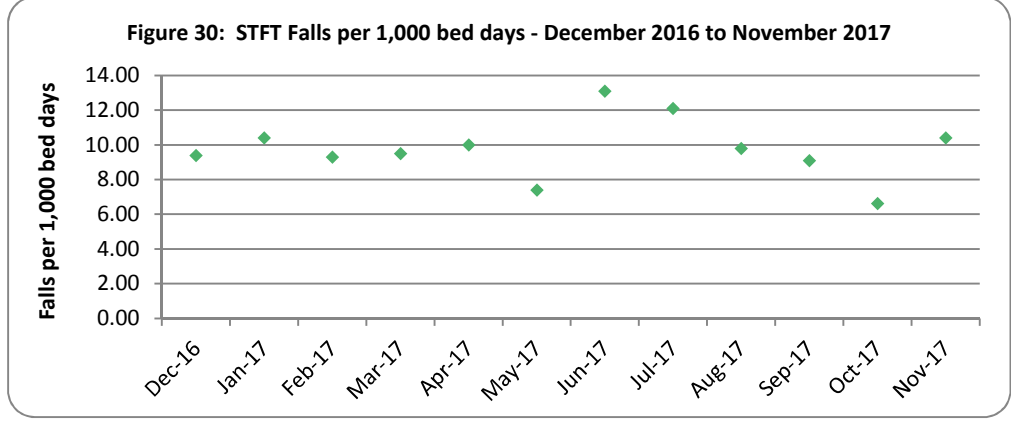
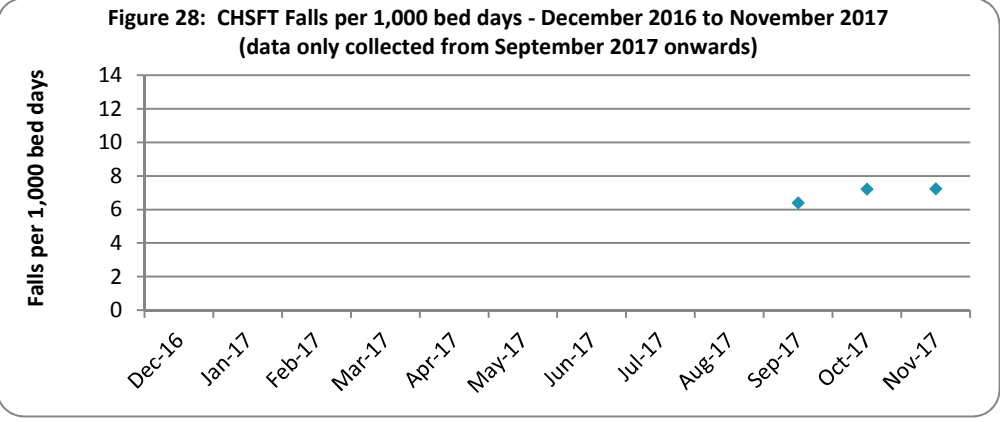
We reported no falls with moderate or major harm which is a decrease from the one we reported in October. This equates to a rate of zero for falls with moderate or major harm, which is a decrease from the 0.06 we reported last month. Data for the previous 12 months can be seen in figure 29.

**STFT**

We reported a total of 83 falls in November, which was an increase from the 68 we reported in October. This equates to a fall rate of 10.4 per 1,000 bed days for all falls, which is an increase from the 6.63 we reported last month. Data for the previous 12 months is shown in figure 30.

We reported no falls with moderate or major harm which is the same as we reported in October. This equates to a rate of zero for falls with moderate or major harm, the same as October, as shown in figure 31.

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**

**1.10 SAFETY THERMOMETER**

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

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

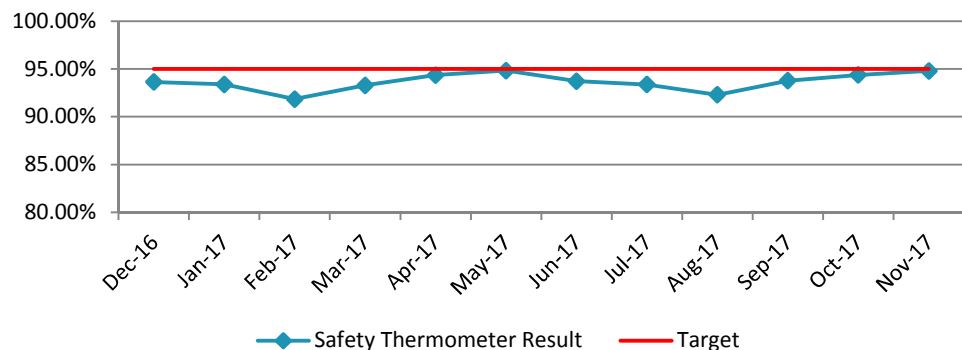
The harm-free care calculation incorporates all reported harms, not just the “new” harms.

**CHSFT**

Figure 32 shows CHSFT Safety Thermometer prevalence data. We reported 94.80% harm-free care in November 2017 (a 0.43% increase from the 94.37% we reported in October).

Our total number of new harms in November was 15, which is an increase from the 11 we reported in October. We had 15 “old” harms this month, which is a decrease from the 23 we reported last month.

**Figure 32: CHSFT Safety Thermometer Results December 2016 to November 2017**



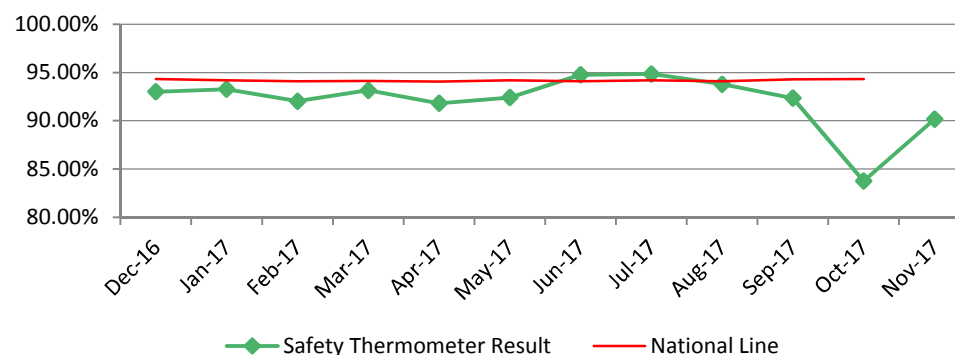
**STFT**

Figure 33 shows Safety Thermometer prevalence data for Acute. We reported 90.16% harm-free care in November (a 6.4% increase from the 83.76% we reported in October). This is below the national average of 94.2% of harm-free care reported by Trusts from December 2016 to November 2017.

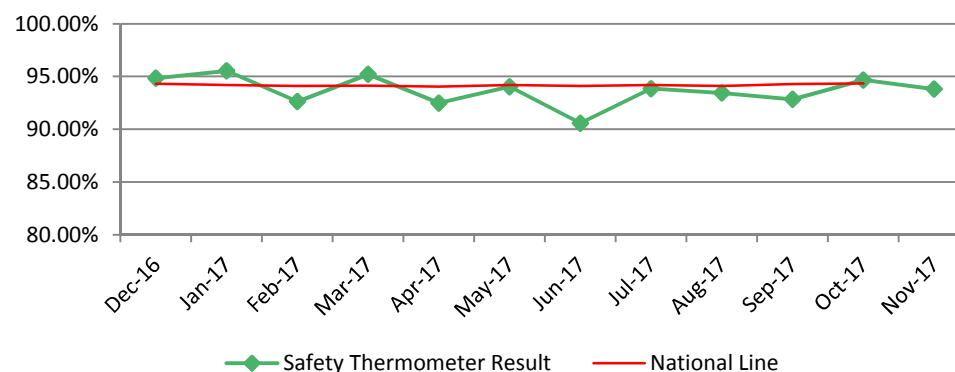
Figure 34 shows Safety Thermometer prevalence data for Community. We reported 93.80% harm-free care in November (a 0.87% decrease from the 94.67% we reported in October). This is below the national average of 94.2% of harm-free care reported by Trusts from December 2016 to November 2017.

Our total number of new harms increased from 16 in October (Acute 8, Community 8) to 22 in November (Acute 4, Community 18). We had less “old harms” this month: 45 compared to 49 in October.

**Figure 33: STFT Safety Thermometer Results December 2016 to November 2017 Acute**



**Figure 34: STFT Safety Thermometer Results December 2016 to November 2017 Community**



## ASSURANCE

### LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

#### 2.1 EXCELLENCE REPORTING

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

	CHSFT	STFT
Excellence Reports submitted (up to the end of November)	425	48
Excellence Reports submitted in November	41	46

Top 5 directorates reporting (cumulative)	CHSFT
Emergency Care	57
Theatres	51
Rehabilitation & Elderly Medicine	40
Paediatrics & Child Health	32
Obstetrics & Gynaecology	30

Top 5 directorates reporting (cumulative)	STFT
Community services	17
Medicine and Care of the Elderly	15
Corporate services	10
Acute and Urgent Care	2
Clinical Support services	2

Reporters have originated from varying professions:

Reporters by job type (November)	CHSFT	STFT
Nursing and Midwifery	18	28
Medical and Dental (Trust)	5	2
Admin and Clerical (including management)	10	15
Allied Health Professionals	4	1
Medical and Dental (Training)	4	1
Patients	0	0
Additional Clinical Services	0	1

Category breakdowns are as follows:

Reporters by job type (November)	CHSFT	STFT
Care and compassion	13	9
Communication	1	4
Competence	4	6
Courage and commitment	0	3
Going the extra mile	13	10
Leadership	3	2
Other	1	1
Service improvement and innovation	2	1
Team working	4	10

#### CHS

The Excellence Reporting at CHS continues to be well received and has maintained a steady number of reports each month.

Margaret Robertson, HCA on ward E53 received the Trust's Excellence Award at the Rewards and Recognition event in November. The excellence report stood out as exceptional, and the reporter was really pleased that Margaret had been recognised formally.

*"On the evening of 30th July, ward E53 were looking after a young, very distressed patient who had learning disabilities/mental health issues and increased anxiety. He was aggressive and hallucinating, and had heightened anxiety and was very frightened. Margaret Robertson, Health Care Assistant, demonstrated great care and compassion towards this patient. She comforted him by talking to him and just by being with him. She was able to 'talk him down' when he became anxious and frightened and she hugged him when he was crying. I saw great strength of character in her and was impressed by her strong resolve and unwavering care despite the difficulty of the situation. Margaret handled the situation amazingly, without her care and attention I think the situation would have escalated further and I was certainly grateful to have had her there. She made me feel very proud - she is a credit to City Hospitals Sunderland."*



#### STFT

Excellence reporting was launched on 31 October at STFT with various promotional activities across the Trust. By the end of November, 48 reports had been received. The divisions will receive a monthly breakdown report of their respective areas to feed into the governance meetings.

**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 November. Total cases for 2017/18 is one unavoidable case against an annual limit of zero avoidable cases.

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

**STFT**

There was one new case of MRSA bacteraemia in November. This has been assigned by the Trust to a third party. The outcome of this assignment is pending acceptance by an appeal panel which is scheduled to meet on 5 December 2017. 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.

*STFT December MRSA update: There were no new cases of MRSA bacteraemia in December. The MRSA bacteraemia reported in November was not upheld at appeal for third party attribution. The intention is to further appeal this decision. Total cases for 2017/18 is two. One case was deemed avoidable, agreed as a contaminant, the second case is pending further appeal. This is against an annual limit of zero avoidable cases.*

**3.1.2 C. difficile infection (CDI)**

**CHSFT**

Two cases were reported in November, which is one below the monthly trajectory. The year to date position at the end of November is 17 cases against an annual target of 34. Two of these will be taken to appeal with Sunderland CCG.

The *C. diff* rate per 100,000 bed days for the previous 12 months up to November 2017 remains within target, at 9.4. By comparison, the national rate for the latest 12 month period available (October 2016 to September 2017) was 10.3 per 100,000 bed days. The Trust's target rate is 15.4.

**CHSFT cases of C. difficile infection per month December 2016 to November 2017:**

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

*CHSFT December C diff update: Two cases were reported in December, which is one below the monthly trajectory. The year to date position at the end of December is 19 cases against an annual target of 34. Two of these will be taken to appeal with Sunderland CCG in January 2018.*

**STFT**

Zero cases were reported as Trust apportioned in November. The year to date position at the end of November is seven cases following successful appeal of one case. This is against an annual target of eight. One case was not upheld at appeal and a third case will be taken to appeal.

The *C. diff* rate per 100,000 bed days for the previous 12 months up to November 2017 has improved but continues to exceed the target, at 7.9. By comparison, the national rate for the latest 12 month period available (October 2016 to September 2017) was 10.3 per 100,000 bed days. The Trust's target rate is 6.5.

**STFT cases of C. difficile infection per month December 2016 to November 2017:**

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

*STFT December C diff update: Zero cases were reported as Trust apportioned in December. The year to date position at the end of December is seven cases following successful appeal of one case. This is against an annual target of eight. One case was not upheld at appeal, the intention is to further appeal this decision. Two additional cases will be taken to appeal in January 2018.*

**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.

## CHSFT & STFT HOSPITAL ACQUIRED INFECTIONS (continued)

LEAD: MEDICAL DIRECTOR

### 3.3 VANCOMYCIN RESISTANT ENTEROCOCCUS (VRE) ON D46, SRH

As detailed previously, the outbreak was declared over on 20 November 2017. Unfortunately though we continued to identify colonised patients via the limited screening that we continued to do. Some of these, but not all, had had negative screens on previous admissions. This caused us great anxiety that hospital transmission was continuing to occur and we felt we had no option but to reconvene the Outbreak Control Group.

Further screening yielded yet more carriers – 17 now, most of which are the ‘same’ strain according to the typing results that have come back from the reference laboratory. However, we are content that infection prevention and control practices on D46 are very good and that the clinical environment is no longer contaminated. Furthermore we were identifying carriers who had little or no history of admission to D46 or even to this hospital, and it remains the case that no patient has developed a clinical infection (with the exception of the first case whose strain turned out to be unrelated). In short, we started to wonder whether we were now detecting a community prevalence of the organism rather than evidence of acquisition in hospital.

We debated this at length and sought the advice of the regional Public Health Microbiologist, Professor Kate Gould. Her advice was that evidence is emerging of a general increase in VRE carriage rates both nationally and in the north east and that it was entirely plausible that our screening efforts were now just evidence of this. She advised that we should concentrate our efforts, not on identifying carriers, but on basic environmental cleanliness and infection control.

This was discussed at a meeting held on 20 December 2017 when it was agreed to stop screening and to stop attempts to chase down ‘contacts’ (the list of contacts had become unwieldy and was causing operational problems for D46 and the Phoenix Unit). We will concentrate on ensuring that the environment is as clean as possible and that staff are scrupulous in their adherence to IP&C guidelines.

This has been controversial at times – the textbook approach to VRE is still very much ‘search and contain’ – but we feel that the changing epidemiology of VRE informs a change of tack.

**CLINICAL GOVERNANCE UPDATE**  
**LEAD: CHSFT MEDICAL DIRECTOR**

**3.3 NATIONAL AUDIT OF DEMENTIA (ROUND 3) 2016/17**

The National Audit of Dementia (care in general hospitals) measures the performance of general hospitals against criteria relating to care delivery which are known to impact upon people with dementia while in hospital. This report presents the results of the third round of the National Audit of Dementia (NAD) with collected data between April and November 2016. The previous (second) round of audit, (reporting in 2013), showed that while significant progress in the care provided to people with dementia in general hospitals had taken place, some aspects of care still needed to improve.

The third round of audit included:

- A survey of carer experience of quality of care
- A case note audit of people with dementia, focusing on key elements of assessment, monitoring, referral and discharge
- An organisational checklist and analysis of routine data collected on delayed discharge, complaints and staff training
- A staff questionnaire examining support available to staff and the effectiveness of training and learning opportunities

In terms of sharing the results for City Hospitals, Dr Lesley Young (Consultant Care of the Elderly & Trust Clinical Dementia Lead) summarised the following:

*What we are good at:*

- Initial screening for delirium/ dementia (94% twice the national average) and clinical assessment (assessment tool on V6)
- Use of standard mental test score (to assess elderly patients for dementia)
- Multidisciplinary assessment – of mobility and continence
- Nutrition generally good
- Support available from specialist dementia services (from staff perspective)

*Where we need to improve:*

- Information recorded about personal routines, distressing factors, calming factors, food preferences, etc. This is despite the availability of “This is Me”
- Carers’ involvement in decisions (less than national average)
- Availability of additional staff according to patient dependency
- Access to dementia training (despite availability)
- Promotion of ‘open’ visiting
- The availability of a named nurse to coordinate discharge

The Trust Dementia Strategy Group will draw up a revised action plan using information from NAD3. This will include the opportunity to link into existing discharge and patient access systems, training issue to be addressed by new mandatory training and the aim to expand

Dementia & Delirium Outreach Team HCA team to support appropriate patients on a 1:1 basis.

**3.4 SENTINEL STROKE NATIONAL AUDIT PROGRAMME (SSNAP) APRIL – JULY 2017**

SSNAP is a prospective, longitudinal audit that measures the quality of care that stroke patients receive throughout the whole care pathway up to 6 months post admission. It provides regular, routine, reliable data to:

- benchmark services nationally and regionally
- monitor progress against a background of change
- support clinicians in identifying where improvements are needed

The table below shows SSNAP results April – July 2017 compared to the previous release.

SSNAP scoring summary		Sunderland Royal Hospital	
Team	Sunderland Royal Hospital		
SSNAP level	D	D (previous)	
SSNAP score	52		
Case ascertainment band	A		
Audit compliance band	A		
Combined total KI level	D		
Combined total KI score	52		
Current Report (April – July 2017)		Previous Report (Dec – March 2017)	
Patient centred KI level		Patient centred KI level	
Patient centred domain scores		Patient centred domain scores	
1 Scanning	B	1 Scanning	B
2 Stroke Unit	C	2 Stroke unit	C
3 Thrombolysis	D	3 Thrombolysis	D
4 Specialist assessments	B	4 Specialist assessment	B
5 Occupational therapy	E	5 Occupational therapy	C
6 Physiotherapy	E	6 Physiotherapy	D
7 Speech and language therapy	E	7 Speech and language therapy	E
8 MDT working	B	8 MDT working	C
9 Standard by discharge	C	9 Standard by discharge	C
10 Discharge process	C	10 Discharge process	A
Patient centred SSNAP level after adjustment	D	Patient centred SSNAP level after adjustment	D
Patient centred SSNAP score	52	Patient centred SSNAP score	60

Nationally, this reporting period has seen a record high amount of teams achieving an ‘A’ SSNAP score, 51 teams have achieved this very best score. In addition, over half of SSNAP teams are now achieving ‘A’ or ‘B’ SSNAP scores (113). For City Hospitals the results are more modest;

- SSNAP level remains at ‘D’ with a drop in SSNAP score (52 from 59)
- Case ascertainment and audit band remain at ‘A’ suggesting that the challenges of data collection are being addressed
- The therapy services domain scores have deteriorated compared to the previous period, particularly Occupational Therapy from ‘C’ to ‘E’
- The discharge process domain has shifted from ‘A’ to ‘C’ in this period

## CLINICAL GOVERNANCE UPDATE (continued)

LEAD: CHSFT MEDICAL DIRECTOR

### 3.4 SENTINEL STROKE NATIONAL AUDIT PROGRAMME (SSNAP) APRIL – JULY 2017 (continued)

In view of this position, the senior therapy staff has met to thoroughly review the national advice given for eligibility criteria and data submission to SSNAP. They have spoken with therapy colleagues elsewhere and found wide variability in interpretation of this national guidance. At national level they have sought clarity and consensus on some of the key data fields which are most open to interpretation. This will help standardise future recording of therapist involvement in stroke care.

The interim stroke service (CHS/FT) has increased new and review activity and changed the ways of therapy working (for the better) which has not yet been translated into the SSNAP scores. In advance of the next SSNAP release the stroke team will 'sense-check' the data for August –November 2017 to see whether it reflects the revised interpretation.

There will be ongoing, regular meetings of the MDT and while there are still some issues to be addressed, the team is confident that performance levels will improve.

### 3.5 QUALITY PRIORITIES – MID TERM REVIEW 2017/18

Every year, the Trust is required to identify its quality priorities, explaining why they are important to patients and how they are expected to be achieved. These are included in the annual Quality Report which must be a visible, public-facing document.

This report provides a high-level overview of progress on each of the quality priorities, guided by responses to the following questions:

- What is our current performance and position against target
- If relevant, what are the reasons for being 'off target'
- What are the actions agreed to get back on target

The report is positive and offers assurance that we are on track to:

- Meet our improvement trajectory for reducing avoidable hospital acquired pressure ulcers
- Sustain our position of being below the national average for patients suffering moderate or major harm from a fall in hospital (which is good)
- Implement the recommendations from the national 'Learning from Deaths' programme
- Achieve the target of reducing cancellations of outpatient consultations
- Consolidate our timeliness of response to formal complaints

The following areas have been identified as requiring additional work to achieve targets set:

- Increase the proportion of completed clinical reviews for hospital associated thrombosis events
- Improve the assessment and rapid management of patients with sepsis in both ED and inpatient environments (currently part of CQUIN)
- Improve the quality of DNACPR documentation
- Following introduction of the new Fluid Monitoring Chart, to improve the recording of fluid management documentation

Feedback will be provided to quality leads in each of the above areas so that they can reflect and amend their plans and take further action to help reach their targets. The full year end position will be reported in the Quality Report 2017/18 to be published in May 2018.



### **3.6 STFT CLINICAL INCIDENT REVIEW GROUP (CIRG)**

19 cases have been discussed at CIRG with learning lessons in 17. Two were reported as an SI and two required a duty of candour.

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

One SI was reported for a patient who developed sepsis as an in-patient. The sepsis was recognised by the junior doctors, but no treatment started. There was no further escalation by the nursing staff. 24-hours later on the Consultant ward round the sepsis was treated appropriately, however the patient died 2 days later. The death was deemed avoidable due to the 24-hour delay in antibiotic and sepsis-6 treatment. A full report is awaited. The team have met with the family and the Coroner informed.

One SI was reported for a patient with delirium who had a fall and sustained a fractured hip. Although the falls care plan was initiated key assessments and reviews were not undertaken. A full report is awaited.

There was a series of incidents where the sepsis protocol was not followed by the foundation year one doctors. This is concerning given they had this training at induction and the e-learning package is mandatory. A reminder has been sent to all junior doctors of the sepsis protocol and a review is being undertaken to make sure all have completed e-learning.

### **3.7 PATIENT RELATED OUTCOME MEASURES**

Since April 2009, South Tyneside patients undergoing elective inpatient surgical procedures for hip replacement, knee replacement and groin hernia have been invited to complete patient reported outcome measures (PROMS) questionnaires both pre-and post-operatively, answering on their general and condition specific health (N.B Groin hernia data will not be included in PROMS data in future). Patient participation in PROMs is voluntary and responses to the questionnaires are analysed to assess the outcomes of the procedures based on patients' self-reported health. Analysis of the differences between the pre-operative and the post-operative PROMs data can be used to determine the outcome of the operation as perceived by the patient in terms of its impact on their self-reported symptoms and functional status.

Latest results demonstrate a marked upturn in participation rates for hip and knee surgery, which is a direct, positive consequence of operational changes to the process. At the end of April 2017, it was agreed to carry out completion of the first stage of the PROMs document at the Hip and Knee school which is supported by the Pre-Assessment Team and the Orthopaedic Outreach Team. Since implementation the numerator values for each procedure significantly increased. In comparison it is noted that there has been a downturn in June in hernia participation and numerator rates. Information from Clinical Governance colleagues suggests that this trend is a direct result of re-provision of general surgical clinical activity from theatre to endoscopy and outpatients.

#### *Total Hip Replacement*

South Tyneside performed similarly to the national picture in improvement and health gain; however as results were 1.5% below the national picture this was outside the 95% control limits, and should be monitored.

#### *Total Knee replacement*

South Tyneside has a smaller health gain than national average and is below the 95% control limit. Processes in place will be reviewed to gain assurance that the pathway is meeting the needs of patients and will be monitored over 2017/2018.

#### *Hernia Repair Groin*

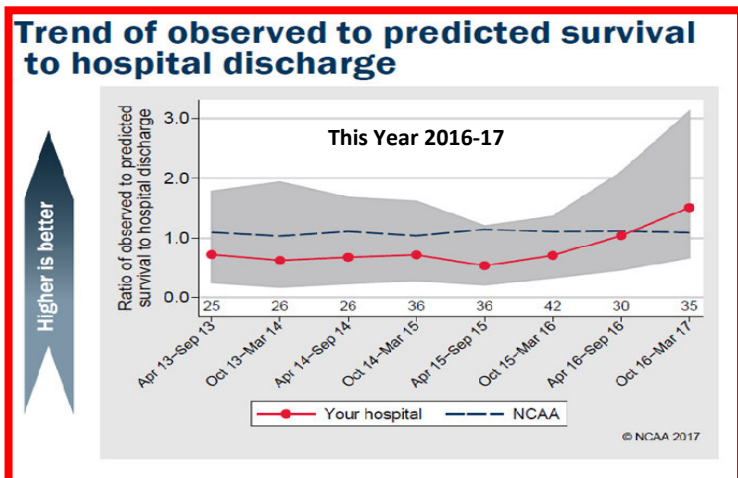
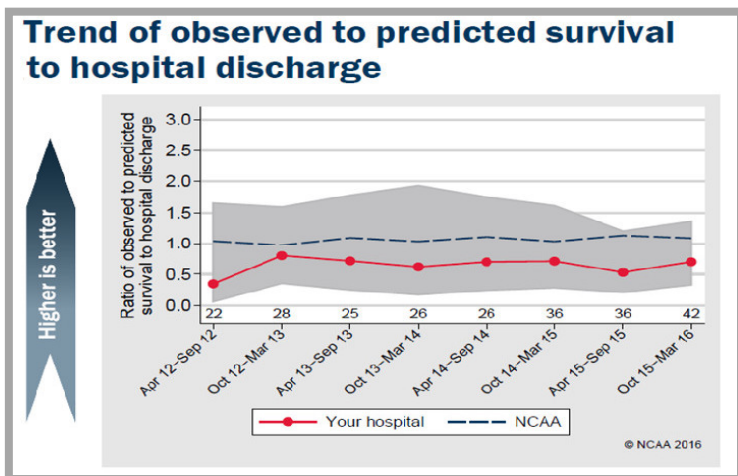
South Tyneside has a 10.9% higher achievement than the national picture for improved health gain. Similarly the number of patients whose health was felt to have worsened was less than the national position

#### *Findings indicate*

Caution should be taken when interpreting the PROMs information due to low participant numbers. Caution should be taken when utilising the national PROMs reports due to the time delays between procedure and report availability. Outcomes on the whole are similar to the national picture. As South Tyneside is outside the 95% control limit for both Knee and Hip replacement scores this will be monitored. Groin hernia repair performs well against the national picture.

**3.8 NATIONAL CARDIAC ARREST AUDIT**

STFT have participated since 2013 – not all hospitals nationally participate. This year’s report is based on data from April 2016 – March 2017. Last year’s report is based on data from April 2015 – March 2016. We have shown an improvement in the number of in-hospital cardiac arrests falling from 80 to 66. There has also been an improvement in survival, particularly from April 2016 as demonstrated in the charts below.



The key influencers for this improvement are:

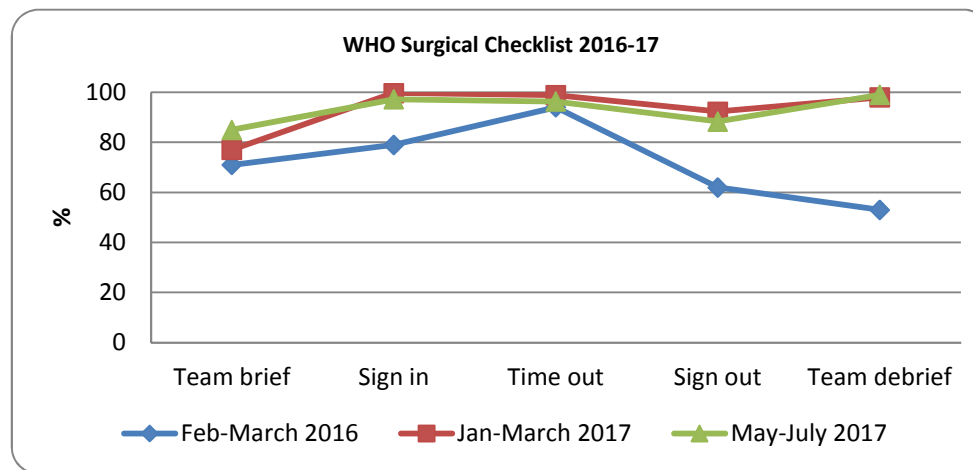
- April 2016 – Revised mandatory training to have a prevention as well as resuscitation focus
- Incorporated use of National Early Warning Score (NEWS) into mandatory training with an example and flagging sepsis awareness
- Trust went live with NEWS documentation across relevant areas in STFT in October 2016
- Monthly peer audit established in 2017

**3.9 WORLD HEALTH ORGANISATION SURGICAL CHECKLIST**

The Surgical safety checklist was introduced by the World Health Organisation (WHO) in 2007. The National Patient Safety Agency (NPSA) released an adapted version in 2009. The WHO checklist was implemented in STFT 2009. The team brief was implemented in STFT 2011. The Team brief/WHO checklist was re-enforced 2012. However the CQC in 2015 raised significant concerns about the patchy use of the check list and the lack of monitoring. What audit was done was not in enough depth. A number of measures were put in place to improve.

As part of the Surgical safety checklist, five important steps are identified: Team Brief, Sign in, Timeout, Sign out and Team debrief are the steps involved. For effectiveness it is expected that all five steps are undertaken and hence 100% compliance is expected.

The chart below shows the performance from 2016 has improved in 2017, but still not achieving the 100% standard.



**3.9 WORLD HEALTH ORGANISATION SURGICAL CHECKLIST (continued)**

Following the unannounced three day CQC inspection 31/10/17 the CQC returned to meet with the management team of surgical specialties for further discussion on the 13/11/17. As part of this meeting Dr Boregowda (Clinical Director) delivered a presentation regarding the journey since the last inspection in May 2015. As part of this presentation Dr Boregowda was able to discuss the fundamental changes taking place to make sustained improvement. Changes have been made to the Checklist document. Learning from CIRG meetings has also been used to inform this change. A re audit is planned to commence on 11/12/17. At this same time the new document will be introduced. Patient safety champions in main theatre have been identified to assist with embedding sustained change in this area. They will have a key role in advising and monitoring compliance. Attention is also being given to ensure a robust audit/data collection methodology. There are plans to introduce a visible dashboard in main theatres to track performance and we are looking at benchmarking ourselves initially to CHS theatres. Performance will be presented regularly via the QRA report going forwards and hence providing board oversight.

## RISK

### LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

#### 4.1 INCIDENT MANAGEMENT

##### CHS

The changes required by Joint Policy Committee to the Trust Incident Reporting Policy and Trust Investigating and Learning from Incidents Policy have been made and the amended, ratified documents are to be released for use across the Trust.

##### STFT

Following ratification of the CHS incident policies, each document has been redrafted to reflect STFT incident management processes. A small group of senior staff have been asked to comment informally on the drafts. The sponsor will then consider whether a formal consultation should be carried out.

#### 4.2 LITIGATION ANALYSIS

##### STFT

A first report on the last six years' claims against STFT through NHS Resolution was submitted to South Tyneside's Corporate Governance Steering Group in November.

#### 4.3 RISK MANAGEMENT STRATEGY

##### CHS and STFT

A joint risk management strategy for the period 2018-2021 will be prepared, setting objectives for risk management across each Trust for the coming three performance years.

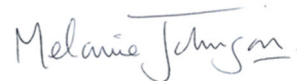
A new joint policy on Risk Management will be drafted to support the implementation of the strategy.

## CONCLUSION

### SUMMARY OF KEY RISKS

1. Nursing vacancies as activity increases over winter
2. Pressure ulcers at STFT Acute
3. Low incident reporting for STFT

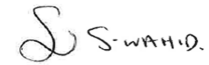
Members are asked to note the report.



**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**

**JANUARY 2018**

**FINANCIAL POSITION AS AT 31<sup>ST</sup> DECEMBER 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 December 2017.

**1.1 KEY HIGHLIGHTS**

Issue or Metric	NHSI Plan	Actual	Variance to NHSI Plan	
	£000s	£000s	£000s	%
Overall Financial Position including STF – Deficit	£5,473k	£5,557k	£84k	0.02%
Overall Financial Position excluding STF – Deficit	£11,475k	£11,431k	£44k	0.4%
Income (including STF)	£262,844k	£266,434k	£3,590k	1.4%
Expenditure	£268,317k	£271,992k	£3,675k	1.4%
EBITDA Position %	2.30%	2.1%		
Cash Position	£2,312k	£7,073k	£4,761k	
<b><u>Clinical Activity:</u></b>				
Variance to plan	£235,582k	£235,342k	£240k	0.1%
<b><u>Cost Improvement Plans</u></b>				
Variance to plan	£9,100k	£9,236k	£136k	1.5%
<b><u>Pay:</u></b>				
Variance to plan	£161,145k	£161,758k	£613k	0.4%
<b><u>Non Pay:</u></b>				
Variance to plan	£107,172k	£110,234k	£3,062k	2.9%
<b><u>Use of Resources Metrics (UOR)</u></b>				
			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

JANUARY 2018

## FINANCIAL POSITION AS AT 31<sup>ST</sup> DECEMBER 2017

### 1 INTRODUCTION

The enclosed financial statements reflect the Trust and its subsidiary companies Income & Expenditure position as at 31st December 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 9		
	NHSI Plan	Actual	Variance
	£000s	£000s	£000s
Deficit for the year before Impairments and Transfers	(5,473)	(5,557)	84
Add: depreciation on donated assets	0	0	
Less: gain on asset disposal	0	0	
Less: income from donated assets	2	(282)	284
Less: 2016/17 STF post accounts allocation		(419)	419
<b>Control Total Surplus/(Deficit) including STF</b>	<b>(5,471)</b>	<b>(6,258)</b>	<b>787</b>
Less: STF 2017/18	(6,004)	(5,173)	(831)
Less: STF Incentive schemes	0	0	
<b>Control Total Surplus/(Deficit) excluding STF</b>	<b>(11,475)</b>	<b>(11,431)</b>	<b>(44)</b>

The overall operational financial position including STF is a net deficit of £5,557k against a planned deficit of £5,473k, and therefore £84k behind plan.

The net deficit of £5,557k included income for £419k as part of 2016/17 STF funding post accounts reconciliation, plus £5,173k STF for the first nine months of this year for achieving its financial control total year to date, and A&E 4 hour performance quarters 1 and 2, the position also included £284k benefit on donated asset income less costs. Therefore Trust position compared to control total excluding required adjustments is £11,431k deficit compared to a plan of £11,475k deficit therefore £44k ahead of plan.

The Trust reported an under performance of £240k in month 9 relating to NHS clinical activity which is due to lower than expected PbR activity.

At the end of December the Cost Improvement Plan (CIP) delivery is £136k ahead of projected plans submitted to NHSI.

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

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

which is in line with plan.

## **2 INCOME AND EXPENDITURE POSITION**

### **2.1 *Patient Related Income:***

Clinical Income to month 9 was £235,342k against a plan of £235,582k, and hence behind plan by £240k.

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. PbR contracts with DDES CCG and NHS England commissioners are over performing against contractual levels, however income levels with these commissioners are lower than Trust annual plan expectations and 2016/17 levels. North Durham continues to under perform against PbR contract, Trust annual plan expectations and 2016/17 levels.

The Trust is engaging with commissioners to close down the 2017/18 position and give certainty to this year's overall financial position, however these conversations are proving difficult on a number of key issues especially with NHS England.

In line with national guidance the Trust has included full 0.5% CQUIN reserve income within its financial position, this was an outstanding risk from prior months. NHSI and NHSE have now reached agreement around the approach and this is consistent with the Trust assumption.

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

Private Patient Income is over recovered against plan by £60k.

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

Training and Education income is behind plan by £93k to month 9 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 continues to overperform by £3k against plan to date.

Other Income was ahead of plan by £4,276k due largely to the Trust accessing £2m from the Sunderland South Tyneside local health economy risk share agreement, in addition funding received for Winter Pressures both nationally and locally has been included within the current month position.

As mentioned earlier, the Trust has achieved its Control Total to month 9 and is therefore able to claim STF funding relating to financial performance for quarter 3, and hence STF funding for 2017/18 totalling £5,172k has been included within the year to date position.

## **3 EXPENDITURE**

### **3.1 *Pay Expenditure:***

Pay is currently showing an overspend of £613k against plan, reflecting:

- Agency costs to month 9 are £4,415k, compared to an overall Trust agency staffing budget to month 9 of £3,217k. Much of this spend is to cover vacant posts. The same period in 2016-17 had agency spend at £3,545k which is £870k less than the current period, the main reason is two more agency consultants in Radiology compared to 2016/17 to cover substantive staffing gaps and increased demand from

the new ED Build. In addition a challenging CIP target was set for agency reduction in 2017-18. The Trust just below its maximum agency/ceiling level set by NHS Improvement to the end of December 2017 as detailed in Appendix 4. To month 9 the ceiling level is set at £4,644k, whereas the total spend to date is £4,415k and hence below by £229k.

- To date the net underspend from vacant nursing posts across the Trust is £997k which is inclusive of the costs paid to NHS Professionals and overtime working.
- Cost Improvement Plans for pay are £173k behind plan to date due to a shortfall in identified CIPs to date.
- Key variances by staff group are detailed as:

<b><u>Key Pay variances by staff group to current month</u></b>	<b><u>£000s</u></b>
Consultants Staff (net of vacancies, additional sessions and agency costs)	1061
Other Medical Staff (net of vacancies, additional sessions and agency costs)	1259
Nursing (net of NHSP Costs)	-997
Other Staff groups	-710
<b>Total Variance</b>	<b>613</b>

Appendix 4 shows details of pay spend on agency, flexi-bank and overtime for the last 12 months from month 9. The decrease in pay this month is mainly attributable to a fall in agency costs partly offset NHS Professional flexi bank working for medical staff, plus backdated arrears for agency staff paid in month 8.

Overall pay costs in December were £17,884k against a budget of £17,799k for the month.

### **3.2 Non Pay Expenditure:**

Non-Pay is overspent by £3,062k. Major areas are highlighted as:

- Drugs overspend this month is £1,508k against plan, £284k of the overspend is due to a shortfall in CIP to date with a large portion of the remainder recovered from the cross charge to clinical commissioners.
- Clinical Supplies is overspent by £594k against plan to date, £362k of the overspend is due to increased offsite diagnostic reporting and tests to third party providers, the remainder is due to higher than expected clinical activity to date.
- Other Non Pay is overspent by £1,591k against plan to date, most of which is owing to offsite CT scans (£160k), rental of the CT Van (£225k) and offsite MRI scans (£165k). 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 £352k of the overspend is due to CIP under delivery against plan to date.
- PDC costs are £583k underspent against plan to date.
- Depreciation costs are £94k underspent against plan to date.
- Interest paid is £46k 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 9, CIP delivery was £9,236k against a planned delivery of £9,100k and hence an over delivery of £136k. This over performance is largely due to a one off £1,035k benefit on transfer of stock to the Trust subsidiary on 1st December 2017 as part of the Trust procurement function being operated through a fully managed healthcare contract.

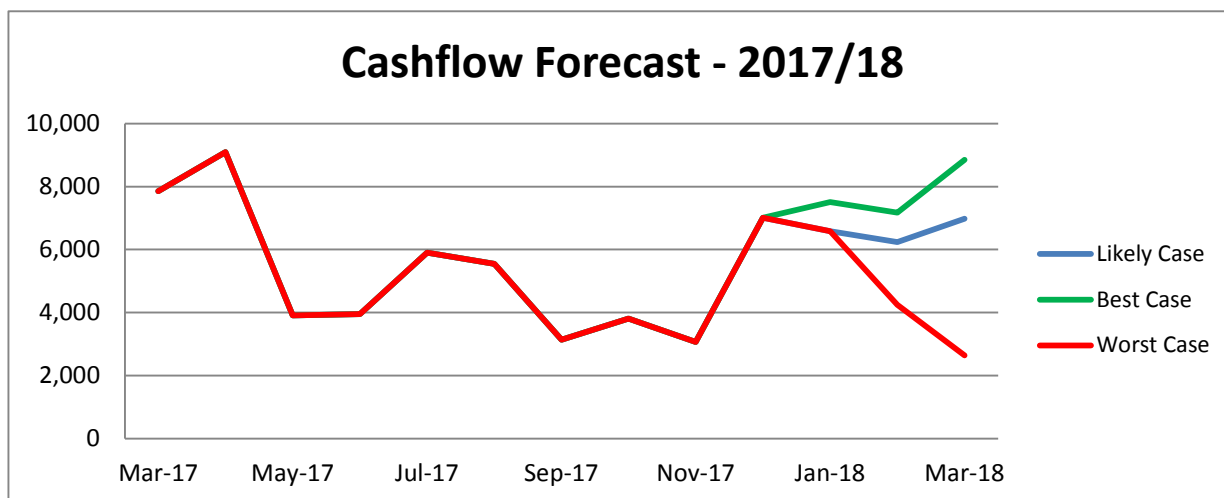
Current Trust CIP plans have identified £12.4m of the £13.0m target this year, much of this delivery especially for procurement will be in the later stages of the financial year. Despite the risks the Trust anticipates total CIP delivery for 2017/18 to be in line with plan of £13m.

Details are provided in Appendix 6.

#### 5 **CASHFLOW AND WORKING CAPITAL**

The cash balance at the end of December 2017 was £7.07m against planned £2.31m. The favourable variance of £4.76m consists of a number of unplanned receipts including £1.16m from S Tyneside CCG (Stroke Contract variation) and £1m from Sunderland CCG (Risk Share), the capital cash profile being behind plan by £1.46m and favourable working capital movements of £1.14m.

The adverse NHS debtor variance of £(10.28m) includes un-invoiced accruals in respect of Q3 STF funding £(2.36m) and additional Winter Pressure funding £(1.20m) and various outstanding invoices including Clinical Activity Income £(1.34m), Risk Share Agreement funding £(1m), Pathology and Medical Physics services £(660k) and other miscellaneous charges etc £(3.72m). All debtors continue to be vigorously pursued.



The graph above shows the Trust's forecast cash position to March 2018. The graph shows the expected monthly cash balances relating to the likely, best and worst case scenarios based on current information. The closing forecast cash balance submitted to NHSI is based upon the likely case scenario.

The likely case assumes that the Q3 STF funding £2.35m will be received in March 2018. NHSI/revised plan assumes achievement of the control total for the year and that all STF funding will be received. The best, likely and worst case scenarios are driven by the overall income and expenditure forecasts in detailed in this paper. The best case scenario assumes achievement £947k 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 worst case scenario assumes the Trust is £4.34m behind the required control total with a like for like cash impact, and therefore does not gain STF funding for quarter 3.

Although the current cash balances have improved they still continue to be a big financial risk. A high level cash flow forecast has been drafted to estimate what cash balances will look like during 2018/19. This does not take into account the projected I&E position (still being developed) but does provide a good indication of balances based on the past nine months of cash income and expenditure.

A number of assumptions have been made with regard to the funding gap, receipt of STF funding and the value of the capital programme. Taking these into account, it is estimated the Trust could run into cash difficulties in May 2018 with the Group including CHOICE running out of cash sometime in July or August 2018. It is therefore necessary at this stage to ensure the Trust continues to have sufficient cash balances to meet its operational requirements. Plans are therefore being put in place to enable the Trust to apply for interim cash support, this will be discussed in detail at the next cash forecasting meeting.

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

## 6 **CAPITAL**

Capital expenditure to date is (£2,366k) and relates mainly to A&E Development (£602k), Back Log Maintenance schemes (£543k), Global Digital Exemplar (£444k), Water Treatment Plant (£229k) and Sewing Room Conversion (£215k).

## 7 **RISKS**

The two prime risks are firstly, the gap in CIP plans especially given the increase in target for Quarter 4 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 and into 2018/19.

## 8 **FORECAST**

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

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	Variance from control total (£m) at Month 9		Variance from control total (£m) at Month 8	
	Forecast deficit (£m)		Forecast deficit (£m)	
Best case	14.034	-0.947	13.635	-1.346
Worst case	19.321	4.340	23.355	8.374
Likely case	15.290	0.309	16.565	1.584

The Trust 'likely' forecast position at month 9 has shown a £1,275k improvement compared to month 8, this is down to three main factors:

- Full inclusion of Tranche 1 winter funding

- An increase in PbR activity forecast across winter following the pattern in months 8 and 9
- Cost reductions as part of the Trust ongoing drive to pull costs down wherever possible across the busy winter period, mainly through the successful move of the Trust procurement function into the subsidiary company of CHOICE.

If the Trust had not included the full £951k of Tranche 1 winter funding within its year end forecast the distance from control total would be greater than detailed above, and thus full control total achievement would be unlikely with knock on consequences for STF funding and cash.

The Trust is working through a number of measures to potentially improve this position such as conversations with commissioners of additional funding and commencing year end conversations to give increased certainty to 2017/18. However the clinical income forecast does contain a number of risks due to challenges from Durham CCGs and NHS England on a number of wide ranging items such as emergency readmissions rates, marginal rate, and various high cost drugs challenged including blueteq compliance. The Trust is aiming to resolve the outstanding items for the month 10 position to support the year end forecasts, but this is dependent on commissioners also agreeing some principles items.

The Trust has also engaged with NHSI's productivity team to identify potential opportunities in 2017/18 and beyond. The Trust has reviewed of possible benefits through national Financial Grip and Control checklist; however any financial savings for 2017/18 have already been realised.

The Trust continues to have significant concerns around the achievement of the control total by the end of the year despite including tranche 1 winter funding to support achievement. We are working closely with the regional NHSI team to ensure all options have been considered ahead of formally declaring non achievement.

A knock on impact regarding risk to delivery of control total is the Trust's cash balance, it is key that we continue to manage cash levels closely for the remainder of 2017/18. Any delays in receipt of central funding for STF or national winter funding will in turn increase the Trust concerns around cash balances.

Due to the concerns about cash levels the Trust is in the process of submitting an application for cash funding support to NHS Improvement.

## **9 NEXT STEPS**

The Trust needs focus on identifying £600k of CIPs to achieve its full £13m CIP target for 2017/18, plus continued focus to reduce costs wherever it is safe to do so across quarter 4 to maximise the Trust potential to achieve the required control total.

## **10 TRUST GUARANTEE FOR SUBSIDIARY COMPANY**

CHOICE has recently taken on the responsibility for the procurement and management of goods, including new equipment. As they have a limited trading history, the Trust as parent is often asked to provide indemnity or a guarantee should the company go into liquidation. Usually this is in the form of a letter, however in relation to a new procurement of Olympus Endoscopy equipment, the leasing company CHG Meridian UK Limited request a formal agreement by the Board and sign off of the 'Deed of Guarantee' (Appendix 7).

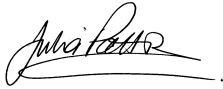
**11** **SUMMARY**

The overall position at the end of December including STF, is a deficit of £5,142k compared to a planned deficit of £5,473k or £331k ahead of plan. The position excluding STF is £44k ahead of plan.

**12** **RECOMMENDATIONS**

The Board is requested to:

- Note the financial position to date.



Julia Pattison  
Executive Director of Finance  
January 2018

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

**Income & Expenditure Position**

£m	Annual		Current Month		Year to Date		
	Plan £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
<b>Income</b>							
NHS Clinical income	-313.58	-25.50	-24.83	0.68	-235.58	-235.34	0.24
PBR Clawback/relief	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Private patient income	-0.35	-0.03	-0.03	0.00	-0.26	-0.32	-0.06
Non-patient income	-37.29	-2.35	-6.15	-3.79	-27.00	-30.77	-3.77
<b>Total income</b>	<b>-351.21</b>	<b>-27.88</b>	<b>-31.00</b>	<b>-3.12</b>	<b>-262.84</b>	<b>-266.43</b>	<b>-3.59</b>
<b>Expenses</b>							
Pay Costs	214.60	17.80	17.884	0.08	161.145	161.758	0.61
Drug costs	38.12	3.16	3.48	0.32	28.64	30.15	1.51
Other Costs	89.03	7.42	7.62	0.20	67.13	69.32	2.19
<b>Total costs</b>	<b>341.76</b>	<b>28.38</b>	<b>28.98</b>	<b>0.60</b>	<b>256.92</b>	<b>261.22</b>	<b>4.31</b>
<b>Earnings before interest, tax, depreciation &amp; amortisation (EBITDA)</b>	<b>-9.45</b>	<b>0.49</b>	<b>-2.03</b>	<b>-2.52</b>	<b>-5.925</b>	<b>-5.210</b>	<b>0.71</b>
Profit/loss on asset disposal	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Depreciation	8.35	0.70	0.67	-0.03	6.26	6.17	-0.09
PDC dividend	5.02	0.42	0.35	-0.07	3.77	3.18	-0.58
Interest	1.83	0.15	0.16	0.01	1.37	1.42	0.05
Corporation tax	0.00	0.00	0.00	0.00	0.00	0.00	0.00
<b>Net surplus (pre exceptionals)</b>	<b>5.74</b>	<b>1.76</b>	<b>-0.84</b>	<b>-2.60</b>	<b>5.47</b>	<b>5.56</b>	<b>0.08</b>
Exceptional items							
<b>Net (surplus)/Deficit (post exceptionals)</b>	<b>5.74</b>	<b>1.76</b>	<b>-0.84</b>	<b>-2.60</b>	<b>5.47</b>	<b>5.56</b>	<b>0.08</b>

<b>EBITDA Margin</b>	<b>2.7%</b>	<b>-1.8%</b>	<b>6.5%</b>	<b>2.3%</b>	<b>2.0%</b>
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**CITY HOSPITALS SUNDERLAND FOUNDATION TRUST**  
**TRUST PERFORMANCE SUMMARY**

PERIOD ENDED 31ST DECEMBER 2017

TRUST SUMMARY

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

	Annual Budget £'000s	Quarter 1 £'000s	Quarter 2 £'000s	Oct actual £'000s	Nov actual £'000s	Dec actual £'000s	Quarter 3 £'000s	YTD actual £'000s	Plan £'000s	Variance £'000s
<b>Income</b>										
Contract Income	(313,575)	(77,970)	(79,770)	(25,992)	(26,781)	(24,828)	(77,601)	(235,342)	(235,582)	240
STF	(9,237)		(3,652)			(1,940)	(1,940)	(5,592)	(6,004)	412
Private Patients	(345)	(93)	(100)	(64)	(31)	(32)	(126)	(319)	(259)	(60)
Training and Education Income	(11,499)	(2,875)	(2,824)	(909)	(958)	(965)	(2,832)	(8,531)	(8,624)	93
Research and Development Income	(1,476)	(370)	(363)	(132)	(146)	(100)	(378)	(1,110)	(1,107)	(3)
Other income	(15,035)	(4,338)	(5,199)	(1,351)	(1,492)	(3,136)	(5,979)	(15,516)	(11,236)	(4,280)
Interest Receivable	(43)	(4)	(6)	(2)	(9)	(4)	(15)	(25)	(32)	7
<b>Total Income</b>	<b>(351,210)</b>	<b>(85,651)</b>	<b>(91,913)</b>	<b>(28,450)</b>	<b>(29,416)</b>	<b>(31,005)</b>	<b>(88,871)</b>	<b>(266,435)</b>	<b>(262,844)</b>	<b>(3,591)</b>
<b>Expenditure</b>										
Pay	214,604	53,897	53,604	18,203	18,169	17,884	54,257	161,758	161,145	613
Clinical Supplies and Services	32,431	8,312	8,526	2,837	2,764	2,553	8,154	24,992	24,398	594
Drug Costs	38,124	10,005	9,896	3,312	3,460	3,477	10,249	30,151	28,643	1,508
Other Costs	56,598	14,901	14,810	4,908	4,642	5,063	14,613	44,324	42,733	1,591
Depreciation	8,348	2,247	1,835	688	729	668	2,085	6,167	6,261	(94)
PDC Dividend	5,022	1,149	974	354	354	353	1,061	3,184	3,767	(583)
Interest	1,827	497	452	151	154	162	468	1,416	1,370	46
<b>Total Expenditure</b>	<b>356,955</b>	<b>91,007</b>	<b>90,098</b>	<b>30,454</b>	<b>30,273</b>	<b>30,160</b>	<b>90,887</b>	<b>271,992</b>	<b>268,317</b>	<b>3,675</b>
<b>(Surplus)/Deficit</b>	<b>5,745</b>	<b>5,357</b>	<b>(1,815)</b>	<b>2,004</b>	<b>857</b>	<b>(845)</b>	<b>2,016</b>	<b>5,557</b>	<b>5,473</b>	<b>84</b>

<b>Cost Improvement Plans</b>	<b>(13,000)</b>	<b>(2,264)</b>	<b>(2,685)</b>	<b>(931)</b>	<b>(1,695)</b>	<b>(1,661)</b>	<b>(4,287)</b>	<b>(9,236)</b>	<b>(9,100)</b>	<b>(136)</b>
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**WTE Analysis (WTEs)**

<b>Total WTEs</b>	<b>4,918.47</b>	<b>4,755.77</b>	<b>4,817.04</b>	<b>4,845.68</b>	<b>4,871.87</b>	<b>4,839.05</b>	<b>4,839.05</b>	<b>4,839.05</b>	<b>4,918.81</b>	<b>-79.76</b>
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**CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST**  
**STATEMENT OF FINANCIAL POSITION - DECEMBER 2017**

<b><u>Assets</u></b>	<b><u>Plan</u></b>	<b><u>Actual</u></b>	<b><u>Variance</u></b>
	<b><u>As At</u></b>	<b><u>As At</u></b>	
	<b><u>31-Dec-17</u></b>	<b><u>31-Dec-17</u></b>	
	<b><u>£m</u></b>	<b><u>£m</u></b>	<b><u>£m</u></b>
<b>Assets, Non-Current:</b>			
Intangible Assets	3.888	4.069	
Property, Plant and Equipment	217.795	188.085	
Trade and Other Receivables	0.918	1.145	
<b>Assets, Non-Current, Total</b>	<b>222.601</b>	<b>193.299</b>	
<b>Assets, Current:</b>			
Inventories	6.400	6.546	-0.146
<b>Trade and Other Receivables:</b>			
NHS Trade and Other Receivables	2.810	13.089	-10.279
Non NHS Trade and Other Receivables	6.641	7.204	-0.563
<b>Trade and Other Receivables, Total</b>	<b>9.451</b>	<b>20.293</b>	
<b>Cash and Cash Equivalents:</b>			
Government Banking Service & Invested	1.912	5.507	
Commercial Bank account	0.400	1.566	
<b>Cash and Cash Equivalents, Total</b>	<b>2.312</b>	<b>7.073</b>	4.761
<b>Assets, Current, Total</b>	<b>18.163</b>	<b>33.912</b>	
<b>ASSETS, TOTAL</b>	<b>240.764</b>	<b>227.211</b>	

**Liabilities****Liabilities, Current:****Interest-Bearing Borrowings, Total**

Loans, non-commercial, Current (DH, FTFF, NLF, etc)	-3.273	-3.273	0.000
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**Interest-Bearing Borrowings, Total**

	-3.273	-3.273	
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**Deferred Income**

	-1.800	-2.931	1.131
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**Provisions**

	-0.212	-0.194	-0.018
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**Trade and Other Payables:**

Trade Payables, Current	-24.848	-31.374	6.526
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Other Financial Liabilities	-1.773	-1.371	-0.402
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Capital Payables, Current	-0.523	-0.803	0.280
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**Trade and Other Payables, Total**

	-27.144	-33.548	
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**Liabilities, Current, Total**

	-32.429	-39.946	
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**NET CURRENT ASSETS (LIABILITIES)**

	-14.266	-6.034	
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**Liabilities, Non-Current****Interest-Bearing Borrowings:**

Loans, Non-Current, non-commercial (DH, FTFF, NLF, etc)	-50.855	-50.855	0.000
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Loans, Non-Current, commercial	0.000	0.000	0.000
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**Interest-Bearing Borrowings, Total**

	-50.855	-50.855	
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**Provisions, Non-Current**

	-0.869	-0.794	-0.075
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**Liabilities, Non-Current, Total**

	-51.724	-51.649	
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**TOTAL ASSETS EMPLOYED**

	<b>156.611</b>	<b>135.616</b>	
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**Taxpayers' and Others' Equity****Taxpayers' Equity**

Public Dividend Capital	102.042	102.248	
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Revaluation Reserve	75.084	52.797	
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Retained Earnings	-20.515	-19.429	
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**TAXPAYERS' EQUITY, TOTAL**

	<b>156.611</b>	<b>135.616</b>	
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	0.000	0.000	
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## Appendix 3 - Clinical Income Report Overview

Table 1: Financial Position (M1-9) per Commissioner agreed Contracts and the NHSI plan

Commissioner contracts	Plan as per	Plan as per	Total	Variance as	Variance	%	%
	NHSI	PbR	Actuals	per NHSI	as perPbr	Against	Against
	£'000s	£'000s	£'000s	£'000s	£'000s	NHSI	PbR
Sunderland	132,027	132,027	132,027	0	0	0.0%	0.0%
South Tyneside	17,705	17,705	17,705	0	0	0.0%	0.0%
Gateshead	3,552	3,235	3,139	413	97	13.2%	3.1%
Sunderland LA	1,802	1,802	1,802	0	0	0.0%	0.0%
DDES	28,397	26,503	26,968	1,428	-465	5.3%	-1.7%
North Durham	12,821	12,520	12,353	469	167	3.8%	1.4%
HAST	2,765	2,596	2,652	112	-56	4.2%	-2.1%
South Tees	189	189	187	2	2	1.2%	1.2%
Specialised	26,889	26,889	27,668	-780	-780	-2.8%	-2.8%
Dental	4,594	4,594	4,757	-163	-163	-3.4%	-3.4%
<b>Sub total</b>	<b>230,740</b>	<b>228,060</b>	<b>229,258</b>	<b>1,482</b>	<b>-1,198</b>	<b>0.6%</b>	<b>-0.5%</b>
Cancer Drug Fund	1,287	1,287	677	610	610	90.1%	90.1%
Hep C drugs	731	731	768	-37	-37	-4.8%	-4.8%
NCA's	2,497	2,497	2,266	231	231	10.2%	10.2%
AQP - all contracts	806	806	765	42	42	5.5%	5.5%
GAP/Stretch target	-1,361	1,319	0	-1,361	1,319	0.0%	0.0%
Other	881	881	1,608	-727	-727		
<b>Total</b>	<b>235,582</b>	<b>235,582</b>	<b>235,342</b>	<b>240</b>	<b>240</b>	<b>0.1%</b>	<b>0.1%</b>

The clinical income target to end month 9 is £235,582k with actual income reported as £235,342k. Therefore the trust is reporting a cumulative under performance against the Clinical Income budget of £240k.

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 a number of other CV's which have now been signed and will be transacted, the impact of this is detailed later.

The Clinical income actuals are based on M8 PbR files with the exception of drugs income which is directly matched to expenditure for month 9 for those on PBR contracts. Discussions with NECS represented commissioners are still ongoing and positive with the intention being to agree a year end agreement. This has been based on positive discussions throughout the year and based on the Q1&2 feedback received. The Marginal rate and readmissions rate calculations are still to be agreed, this has been escalated to Directors of Finance to agree.

Discussions with NHSE regarding the Q1&Q2 positions are still ongoing and still proving difficult. In line with previous months, the reported position has been adjusted for any known challenges; however it continues to be the case that NHSE are not adhering to the national timetable for challenges.

We still hope to reach an agreement for Q1 and Q2 with NHSE and are hopeful that this will inform year end settlements if the main issues are resolved.

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



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

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

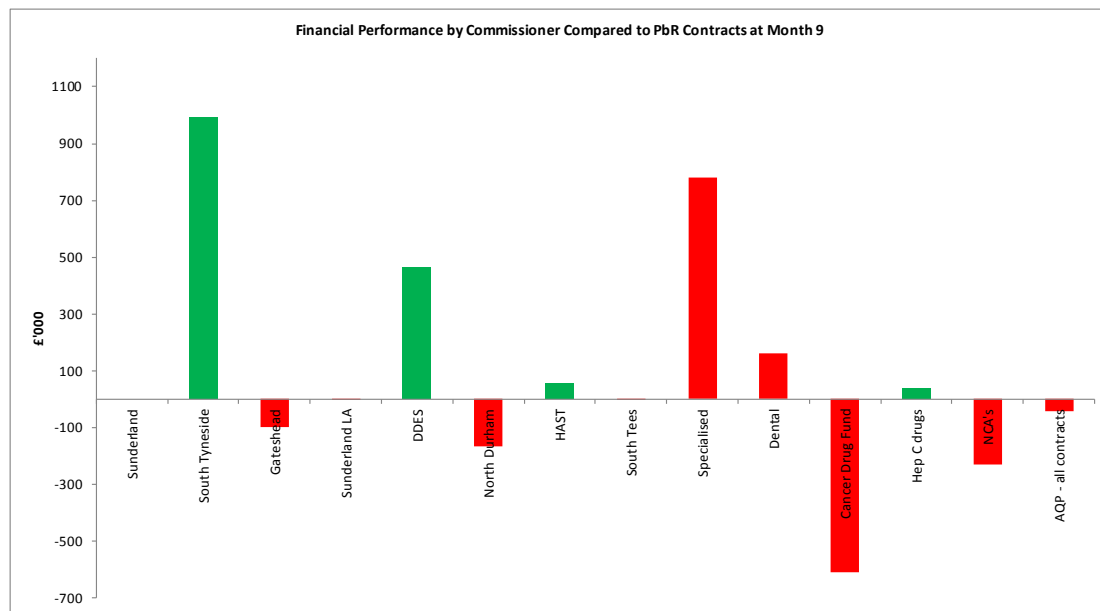
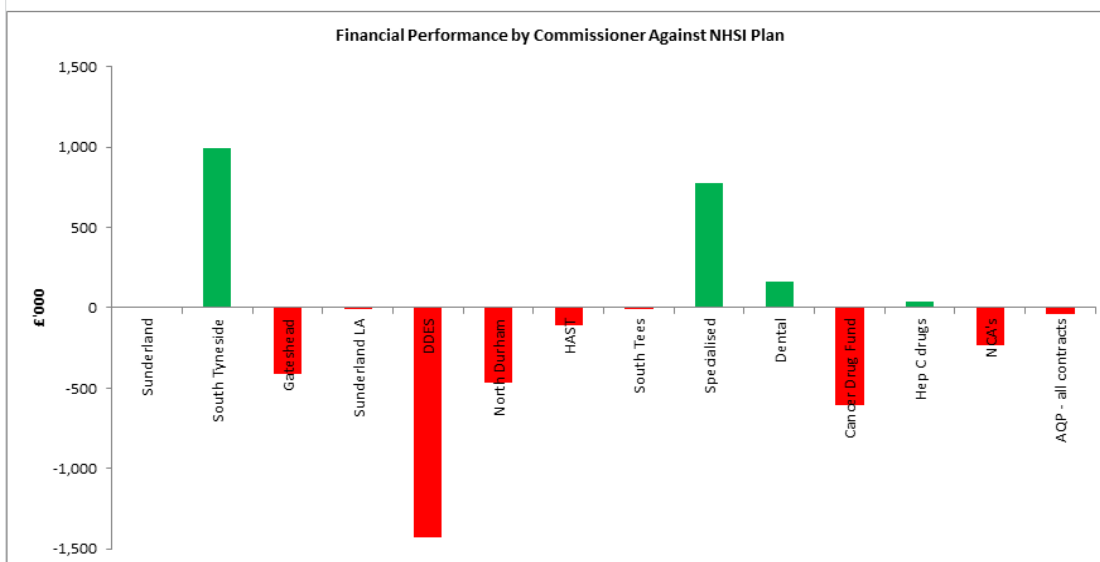


Figure 2: Variance per Commissioner Against the Monitor Plan



### Summary of main PbR variance by commissioner

**Sunderland CCG :** This contract is block for 2017/18. If PbR was to be transacted it would show a £2.64m over performance, mainly due to non-elective over-performance within medical specialities, Cardiology, Endocrinology and elderly medicine being the main areas. The above figure does not include the bariatric contract variation, which will reduce this figure.

**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 £2.36m, this is predominately due to stroke activity transferred from STFT (an invoice has been raised for this) as well as avastin drugs commissioned but clinically an option.

**North Durham CCG :** Reporting an underperformance of 167k against PbR plan (£256k at m8) and £468k against NHSI 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 £1.49m (£1.34m at m8) but over performing against the PbR plan by £465k. The over performance can be mainly attributed to non-elective activity, day cases and high cost drugs.

**NHSE Specialised :** Reporting an over performance of £779k against PBR & NHSI plan (£667k at m8). 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 :** Over performance of £163k, an increase in performance compared with m8 which showed an under performance of £79k. We are in the process of discussing a forecast year end position with dental commissioners.

## Contract Variations update

Contract variations were highlighted in depth in last month's board report. These have all now been agreed & signed off with the intention to transact financially and adjusted in the PbR plans from M10. The Table below shows the values of each contract variation and the commissioner with whom it has been agreed, along with the impact on the gap/stretch target. The decision has been taken to transact this at a speciality level with the impact on expenditure targets also being adjusted. This should ensure that speciality financial positions do not drastically change due to the impact of these.

Commissioner	Contract values before CY's	CY - STCCG QIPP	Income CY ENT	Income CY Diabetes	Income CY Bariatrics	Income CY - Stroke	Income BAHA CV	Income Drugs CV	Northumberland CV	Total income impact
			£'000s	£'000s	£'000s	£'000s	£'000s	£'000s		£'000s
Sunderland	£175,700				£311		£0	£0		£176,011
STCCG	£22,463	-£428			£218	£1,537				£23,790
Newcastle/Gateshead	£4,309		-£842		-£197					£3,270
Sunderland LA	£2,403									£2,403
DDES	£35,247			£22	-£224					£35,045
North Durham	£16,680			-£1	-£335					£16,344
HAST	£3,460				-£220					£3,240
South Tees	£251				-£65					£186
Specialised	£35,843						-£259	£687		£36,271
Northumberland									£943	£943
Hep C drugs	£975									£975
Dental	£6,123									£6,123
NCA	£3,320									£2,377
AQP contracts	£1,075									£1,075
Cancer drug Fund	£1,715									£1,715
Church View	£880									£880
New Born Screening	£111									£111
Offender health	£136									£136
Stretch Target/Reserves	£2,883	£428	£842	-£21	£512	-£1,537	£259	-£687	-£943	£2,679
<b>Grand Total as per NHSI plan</b>	<b>£313,574</b>	<b>£0</b>	<b>£0</b>	<b>£0</b>	<b>£0</b>	<b>£0</b>	<b>£0</b>	<b>£0</b>	<b>£0</b>	<b>£313,574</b>

- ENT – reduction on Gateshead CCG contract value as Newcastle Trust have displaced CHS in providing ENT at Gateshead Trust therefore IP activity lost
- Diabetes – adjustment arising from CHS' support for a DDES project to enhance community care
- Bariatrics – long awaited CV which adds bariatric services to CCG contracts as PbR contracts
- Stroke – the reciprocal CV transferring stroke activity for STCCG from STFT to CHS
- BAHA - these hearing aids are now on the "zero cost programme" where CHS call off the aid with the supplier invoice paid direct by the commissioner
- Drugs – Increase on contract value by NHS Specialised, to reflect new drugs approved since contract agreement. As drugs are pass through, no direct benefit

## **Risk to income**

The main risk with the clinical income position remains the NHSE challenges. As per last month, the issues remain the quantity and the timeliness of these challenges. The issue has been raised formally at contract meetings as well as being escalated to a senior level. We are still aiming to agree all issues relating to Q1 and Q2. However, it is anticipated that once these issues are agreed then discussions can start regarding a for a year end settlement. The challenges are mainly drugs related. However, NHSE have recently challenged some high cost excluded devices as well as the concept of a dispensing fee for outpatient drugs, the latter agreed during the contracting round.

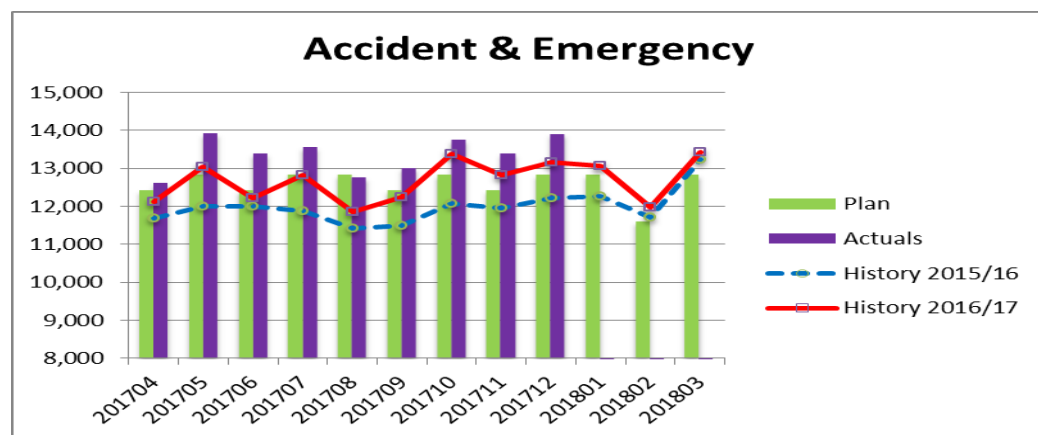
There are several Contract Variations that have now been signed off which (discussed previously in this report) which will now be transacted with contract plans and invoicing changed accordingly. Overall this should not impact upon the overall income position, although variances with individual commissioners will change with the balance adjusted against the gap/stretch target. However there will be an overall adverse impact on cash flow to the trust, once monthly invoices & Q1 & Q2 positions are agreed.

An agreement of a Q1 and Q2 position for CCG's represented by NECS is close. Forecast outturn positions have been shared with most commissioners in order to start discussions for a year end settlement. Commissioners were required to submit a return to NHSE/NHSI on the 12<sup>th</sup> January regarding their year end forecast year end outturn and to work with providers to see if there are differences to providers forecast outturn positions, a narrative being required if the difference was in excess of £1m. Trust forecast figures were shared on the 12<sup>th</sup> of January and we are awaiting feedback from Commissioners. The only Commissioner that may breach the £1m threshold is NHSE (Specialised).

NHSI have now confirmed that CCG's do not need to withhold 5% of the CQUIN value. This means that the Trust should now receive cash for the full years CQUIN and benefits cash flow.

## Position for Activity by POD (Month 9)

### Accident & Emergency



Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
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	13,761	13,388	914	373
201711	12,433	13,409	12,820	976	589
201712	12,847	13,918	13,169	1,071	749
<b>Grand Total</b>	<b>113,966</b>	<b>120,405</b>	<b>113,700</b>	<b>6,439</b>	<b>6,705</b>

Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
Type 1	64,821	71,464	67,175	6,643	4,289
Type 2	25,023	22,676	23,591	-2,347	-915
Type 4	24,122	26,265	22,934	2,143	3,331
<b>Grand Total</b>	<b>113,966</b>	<b>120,405</b>	<b>113,700</b>	<b>6,439</b>	<b>6,705</b>

ED attendances in December were extremely high compared to plan, with Type 1 attendances overperforming by 21%. The number of ED attendances resulting in an Emergency Admission rose to 23%, which is the highest in 17/18. The greatest number of admissions remain into Geriatric Medicine, Accident & Emergency and Paeds.

A&E activity is 5.9% above historical levels and 5.6% above plan. Type 1 A&E (main site) is 10.2% above plan; Type 2 (Eye Infirmary) is 9.4% below plan and Type 4 (Pallion) is 9% above plan.

In December, the number of attendances at SEI are the lowest in 17/18 with 2,014 attendances compared to a previous monthly average of 2,583. SEI have invested a significant amount of time in ensuring that patients are seen in the correct area, and have therefore stopped bringing review patients back into A&E for particular conditions as was previous practice and are better utilising availability in Non Consultant led clinics

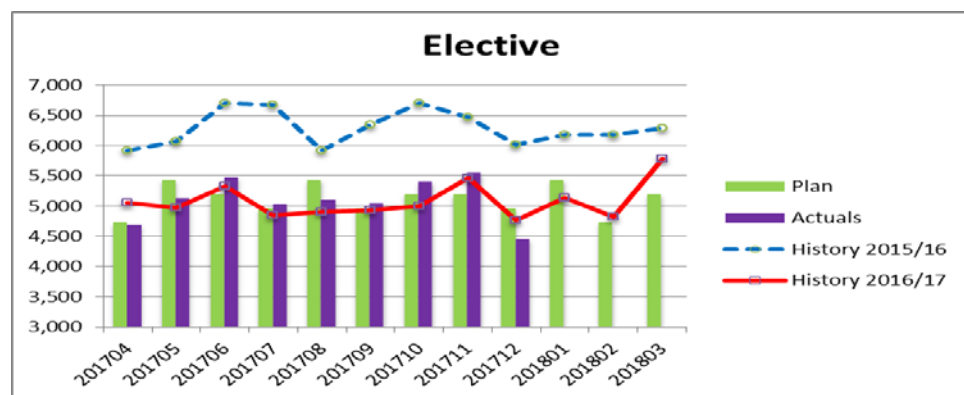
Type 1 and Type 4 (CHS site) planned attendances have been commissioned at a level 2,731 below 16/17 outturn, and 8,464 under the Trust forecast for 17/18. A&E has experienced growth in attendances year on year, which Commissioners have chosen not to recognise and fund in 17/18.

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 associated with over performance 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.

## Position for Activity by POD (Month 9)

### Elective



Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
<b>Elective</b>	<b>46,112</b>	<b>45,942</b>	<b>45,264</b>	<b>-170</b>	<b>678</b>
Ophthalmology	10,315	11,447	10,293	1,132	1,154
Colorectal Surgery	0	942		942	942
Upper Gastrointestinal Surgery	129	596	126	467	470
Anaesthetics	0	202		202	202
Nephrology	495	630	543	135	87
Paediatrics	296	399	354	103	45
Endocrinology	168	254	179	86	75
Respiratory Medicine	1,325	1,393	1,294	68	99
Gynaecology	1,293	1,344	1,221	51	123
Oral & Maxillo Facial Surgery	3,848	3,886	3,903	38	-17
Diabetic Medicine	38	65	48	28	17
Neurology	547	573	590	26	-17
Geriatric Medicine	47	65	45	18	20
Accident & Emergency	221	226	220	5	6
Well Babies	3	5	2	2	3
Clinical Neurophysiology	0	2		2	2
Orthodontics	0	1		1	1
Rehabilitation	11	8	11	-3	-3
Obstetrics	77	58	67	-19	-9
Pain Management	651	588	705	-63	-117
Rheumatology	1,020	923	1,008	-97	-85
Trauma & Orthopaedics	4,312	4,142	4,343	-170	-201
Cardiology	1,708	1,498	1,427	-210	71
Urology	6,147	5,852	5,973	-295	-121
ENT	3,240	2,925	3,029	-315	-104
Vascular Surgery	1,294	968	1,151	-326	-183
Gastroenterology	4,564	4,174	4,334	-390	-160
General Surgery	4,364	2,776	4,398	-1,588	-1,622
<b>Grand Total</b>	<b>46,112</b>	<b>45,942</b>	<b>45,264</b>	<b>-170</b>	<b>678</b>

### Elective Spells Summary

Elective activity is up 678 spells (1.5%) vs 16/17 history but down 170 spells (0.5%) vs plan YTD. Medical Oncology and Clinical Haematology have been removed from Elective numbers above due to their recategorisation as Chemo, as per the request of NHS England.

Decembers actuals for the remainder of the specialties were 506 under plan. This is mainly due to phasing of the plan profile. The Elective plan is phased using working days in the month, however no further impact of the Christmas period is factored into this.

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

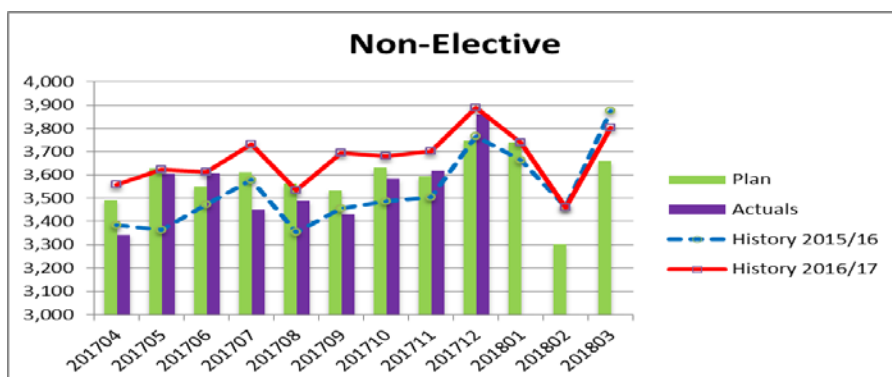
### Directorate in focus – General Surgery

General Surgery as a specialty has the greatest level of under performance on the Elective Contract. However, this is due to the actuals being recorded at a further disaggregated level than the plan. 1,538 spells for Colorectal and Upper GI are included in the data whereas the plan is set for these under General Surgery. As part of 18/19 forecast discussions with Commissioners, the aim is to also get plans disaggregated out to Specialty level.

Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
<b>General Surgery</b>	<b>5,788</b>	<b>5,282</b>	<b>5,675</b>	<b>-506</b>	<b>-399</b>
Colorectal Surgery	0	942		942	942
Upper Gastrointestinal Surgery	129	596	126	467	470
Vascular Surgery	1,294	968	1,151	-326	-183
General Surgery	4,364	2,776	4,398	-1,588	-1,622
<b>Grand Total</b>	<b>5,788</b>	<b>5,282</b>	<b>5,675</b>	<b>-506</b>	<b>-399</b>

## Position for Activity by POD (Month 9)

### Non Elective



Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
<b>Non Elective</b>	<b>32,358</b>	<b>31,997</b>	<b>33,025</b>	<b>-361</b>	<b>-1,028</b>
Upper Gastrointestinal Surgery	0	565		565	565
Colorectal Surgery	0	521		521	521
Geriatric Medicine	4,373	4,887	4,813	514	74
Endocrinology	446	907	539	461	368
Respiratory Medicine	1,277	1,584	1,559	307	25
Obstetrics	13	85	63	72	22
Ophthalmology	420	472	435	52	37
Medical Oncology	44	94	70	50	24
Clinical Haematology	257	300	277	43	23
Nephrology	882	914	892	32	22
Anaesthetics	0	29		29	29
Gastroenterology	1,484	1,502	1,502	18	0
Neurology	53	71	78	18	-7
Well Babies	5	17	12	12	5
Oral & Maxillo Facial Surgery	278	280	254	2	26
Critical Care Medicine	0	0		0	0
General Medicine	2	0		-2	0
Rehabilitation	59	47	59	-12	-12
Pain Management	32	7	42	-25	-35
Rheumatology	49	23	28	-26	-5
Vascular Surgery	214	167	191	-47	-24
Urology	1,901	1,838	1,770	-63	68
Cardiology	2,376	2,312	2,436	-64	-124
Paediatrics	3,250	3,185	3,279	-65	-94
Gynaecology	872	751	770	-121	-19
Diabetic Medicine	443	270	459	-173	-189
Trauma & Orthopaedics	1,907	1,731	1,842	-176	-111
ENT	1,206	1,029	1,197	-177	-168
Accident & Emergency	6,797	6,342	6,784	-455	-442
General Surgery	3,719	2,067	3,674	-1,652	-1,607
<b>Grand Total</b>	<b>32,358</b>	<b>31,997</b>	<b>33,025</b>	<b>-361</b>	<b>-1,028</b>

### Non Elective Spells Summary

**Non Elective** activity is down 1,028 spells (3.1%) vs history and down 361 spells (1.1%) vs plan.

December had the highest rate of Non Elective admissions in 17/18, and only slightly lower than December 16. The Non Elective plan is phased using calendar days; therefore the overperformance is truly due to demand.

23% (3,173) of ED attendances resulted in an Emergency admission in December. These were initially mainly 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.

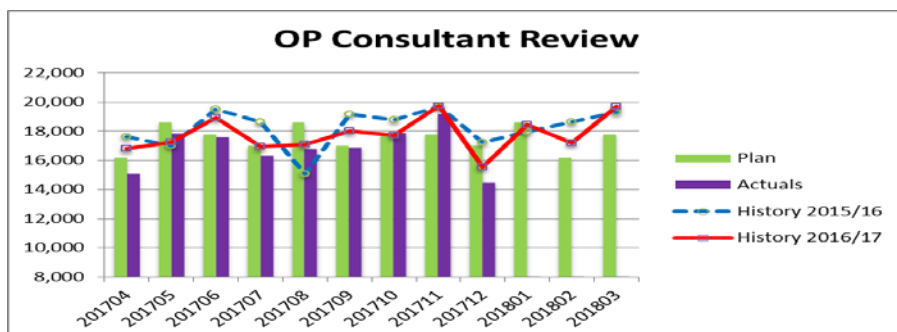
### Commissioner Focus

Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
<b>Non Elective</b>	<b>32,358</b>	<b>31,997</b>	<b>33,025</b>	<b>-361</b>	<b>-1,028</b>
NHS SOUTH TYN ESIDE CCG	1,487	1,735	1,501	248	234
NON CONTRACT ACTIVITY	265	324	298	59	31
NHS NORTH DURHAM CCG	1,153	1,153	1,004	0	149
NHS CUMBRIA CCG	0	0	13	0	-13
NHS SOUTH TEES CCG	20	20	21	0	-1
NHS ENGLAND NORTH (CUMBRIA AND NORTH EAST)	271	266	249	-5	17
NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG	69	58	59	-11	-1
NHS NEWCASTLE GATESHEAD CCG	346	275	400	-71	-125
CUMBRIA AND NORTH EAST COMMISSIONING HUB	469	297	357	-172	-60
NHS SUN DERLAND CCG	23,408	23,226	24,141	-177	-915
NHS DURHAM DALES, EASINGTON AND SEDGEFIELD CCG	4,877	4,643	4,987	-234	-344
<b>Grand Total</b>	<b>32,358</b>	<b>31,997</b>	<b>33,025</b>	<b>-361</b>	<b>-1,028</b>

Non Elective activity at month 9 is only 1.1% under plan. CCGs with the some of the greatest under and over performance against plan are Sunderland and South Tyneside respectively, both of which have block contracts. DDES is currently the CCG with the highest level of underperformance, and operate a PbR contract.

## Position for Activity by POD (Month 9)

### Consultant Led Outpatients



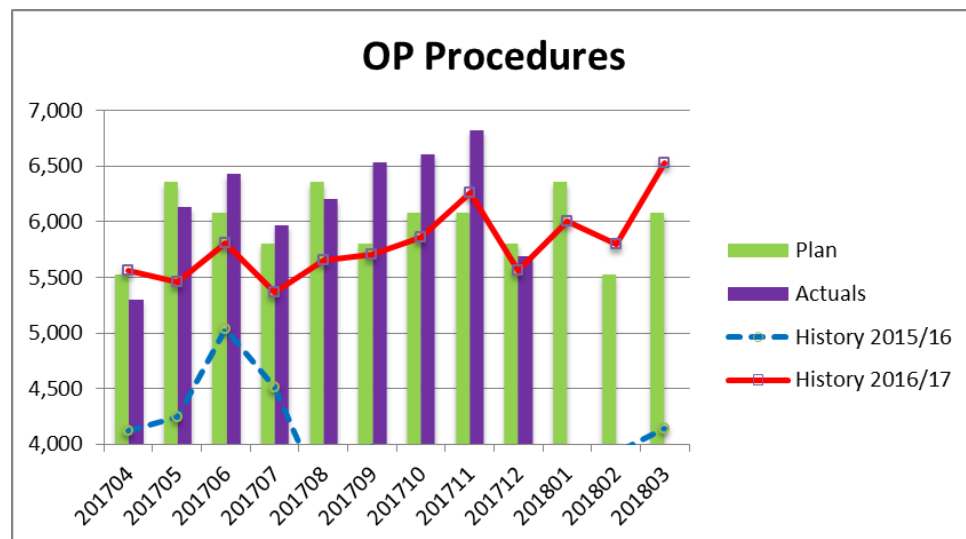
**First Outpatient (consultant led)** activity is 4,312 attendances (5.2%) below history and 5,176 attendances (6%) below plan. Directorates with the most significant variance against plan include Paediatrics, Urology and General Surgery.

**Review Outpatient (consultant led)** activity is 6,177 attendances (3.9%) below history and 5,766 attendances below plan (4%). Directorates with the greatest variance against plan include Paediatrics, Theatres, Emergency Care and Urology.

All Outpatient plans are phased using the working day profile as per Electives. This has not been reduced any further than the Bank Holidays, and therefore does not take into account any further impact of Christmas. Therefore low actuals for December are against an artificially high plan.

Row Labels	Plan	Actuals	Var Vs Pla	Var vs pla	History 2016/17	Var Vs His
<b>OP CONSULTANT LED - NEW</b>	<b>83,381</b>	<b>78,205</b>	<b>-5,176</b>	<b>-6%</b>	<b>82,517</b>	<b>-4,312</b>
Emergency Care	2,794	2,889	95	3%	2,747	142
General Internal Medicine	6,470	5,987	-483	-7%	6,996	-1,009
General Surgery	6,416	5,226	-1,190	-19%	5,826	-600
Head & Neck	12,256	11,165	-1,091	-9%	11,964	-799
Medical Specialties	4,265	4,086	-179	-4%	4,395	-309
Obstetrics & Gynaecology	9,475	9,129	-346	-4%	9,871	-742
Ophthalmology	10,255	10,349	94	1%	10,392	-43
Other	2	4	2	78%	5	-1
Paediatrics	5,301	4,360	-941	-18%	4,226	134
Rehab & Elderly Medicine	5,529	5,637	108	2%	5,434	203
Theatres	1,030	1,039	9	1%	1,016	23
Trauma & Orthopaedics	11,076	11,255	179	2%	11,758	-503
Urology	8,512	7,079	-1,433	-17%	7,887	-808
<b>OP CONSULTANT LED - REVIEW</b>	<b>157,600</b>	<b>151,834</b>	<b>-5,766</b>	<b>-4%</b>	<b>158,011</b>	<b>-6,177</b>
Emergency Care	7,432	6,801	-631	-8%	7,358	-557
General Internal Medicine	16,534	16,404	-130	-1%	16,592	-188
General Surgery	9,631	10,502	871	9%	11,290	-788
Head & Neck	17,878	17,216	-662	-4%	17,142	74
Medical Specialties	23,179	22,020	-1,159	-5%	23,195	-1,175
Obstetrics & Gynaecology	6,165	5,810	-355	-6%	6,191	-381
Ophthalmology	30,129	28,882	-1,247	-4%	30,090	-1,208
Other	110	0	-110	-100%	40	-40
Paediatrics	8,263	6,791	-1,472	-18%	7,822	-1,031
Rehab & Elderly Medicine	6,095	5,808	-287	-5%	6,064	-256
Theatres	1,633	1,443	-190	-12%	1,574	-131
Trauma & Orthopaedics	16,511	17,218	707	4%	17,500	-282
Urology	14,039	12,939	-1,100	-8%	13,153	-214
<b>Grand Total</b>	<b>240,981</b>	<b>230,039</b>	<b>-10,942</b>	<b>-5%</b>	<b>240,528</b>	<b>-10,489</b>

## Outpatient Procedures



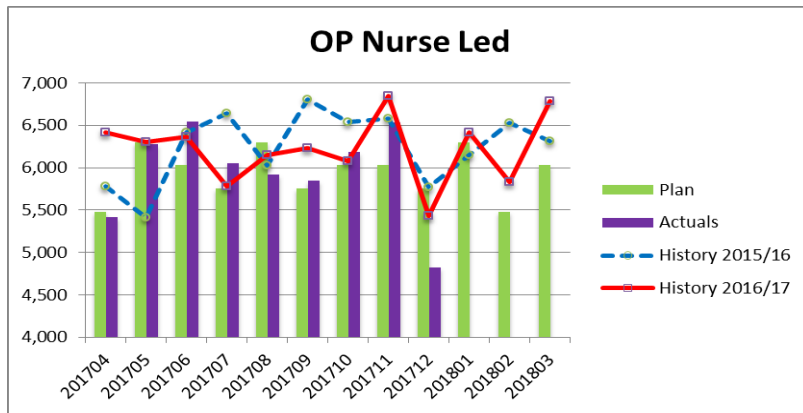
**Outpatient Procedures** are 4,477 procedures above history (8.7 %) and 1,802 procedures above plan (3%). The variance against plan has improved significantly over the past few months and compared to history. This is largely due to improvements in the recording of Lucentis procedures within Ophthalmology and laser and hygiene procedures in OMFS (graph below). OP Procedures have also been affected by the drop in activity over Christmas but are higher than December 16.



Row Labels	Plan	Actuals	Var Vs Pla	Var vs Pla	History 2016/17	Var Vs His
<b>OP PROCEDURE</b>	<b>53,906</b>	<b>55,708</b>	<b>1,802</b>	<b>3%</b>	<b>51,231</b>	<b>4,477</b>
Accident & Emergency	91	125	34	38%	39	86
Anaesthetics	0	40	40	0%	35	5
Breast Surgery	2	0	-2	-100%		0
Cardiology	693	634	-59	-9%	612	22
Clinical Neurophysiology	2,237	2,366	129	6%	2,246	120
Colorectal Surgery	190	173	-17	-9%	505	-332
Diabetic Medicine	0	37	37	0%	25	12
ENT	9,346	9,196	-150	-2%	9,133	63
Gastroenterology	4	4	0	-9%	4	0
General Surgery	84	41	-43	-51%	66	-25
Geriatric Medicine	5	0	-5	-100%		0
Gynaecology	2,823	2,804	-19	-1%	2,532	272
Medical Oncology	3	6	3	79%	3	3
Nephrology	2	1	-1	-33%	1	0
Neurology	4	0	-4	-100%		0
Obstetrics	154	494	340	220%	627	-133
Ophthalmology	26,500	27,338	838	3%	25,538	1,800
Oral & Maxillo Facial Surgery	1,410	1,648	238	17%	103	1,545
Orthodontics	684	854	170	25%	286	568
Paediatrics	263	240	-23	-9%	256	-16
Pain Management	0	1	1	0%	2	-1
Rehabilitation	1	0	-1	-100%		0
Respiratory Medicine	48	40	-8	-17%	15	25
Rheumatology	502	983	481	96%	550	433
Stroke Medicine	1	0	-1	-100%		0
Transient Ischaemic Attack	0	0	0	0%		0
Trauma & Orthopaedics	2,402	2,161	-241	-10%	2,010	151
Upper Gastrointestinal Surgery	0	13	13	0%	20	-7
Urology	6,457	6,509	52	1%	6,621	-112
Vascular Surgery	0	0	0	0%	2	-2
<b>Grand Total</b>	<b>53,906</b>	<b>55,708</b>	<b>1,802</b>	<b>3%</b>	<b>51,231</b>	<b>4,477</b>

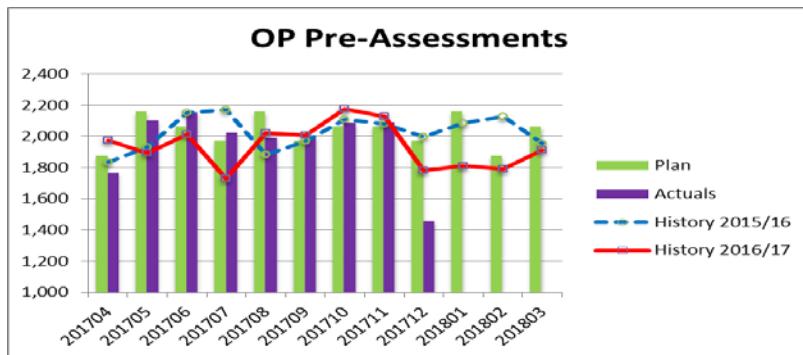


## Other Outpatient Areas

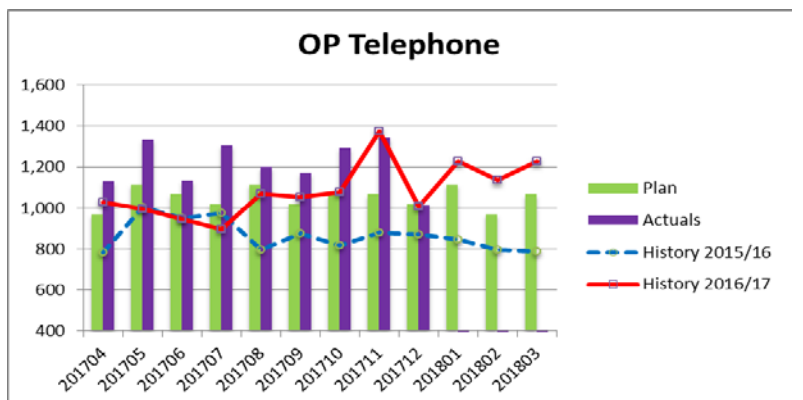


**Non Consultant Led Outpatient** activity is 1,979 attendances (3.6%) below history however 163 attendances (0.3%) above plan. Specialties with the greatest over-performance against plan include Rheumatology and Paediatrics.

Most of the underperformance against plan for December specifically has been generated by Ophthalmology, T&O and Urology. Paediatrics and Rheumatology have continued to over perform in December.



**Pre-Assessment activity** is 615 attendances (3.4%) down against plan and 37 attendances (0.2%) below history. The numbers of PAAC appointments are consistently in proportion to Electives. Not all Elective spells require PAAC.

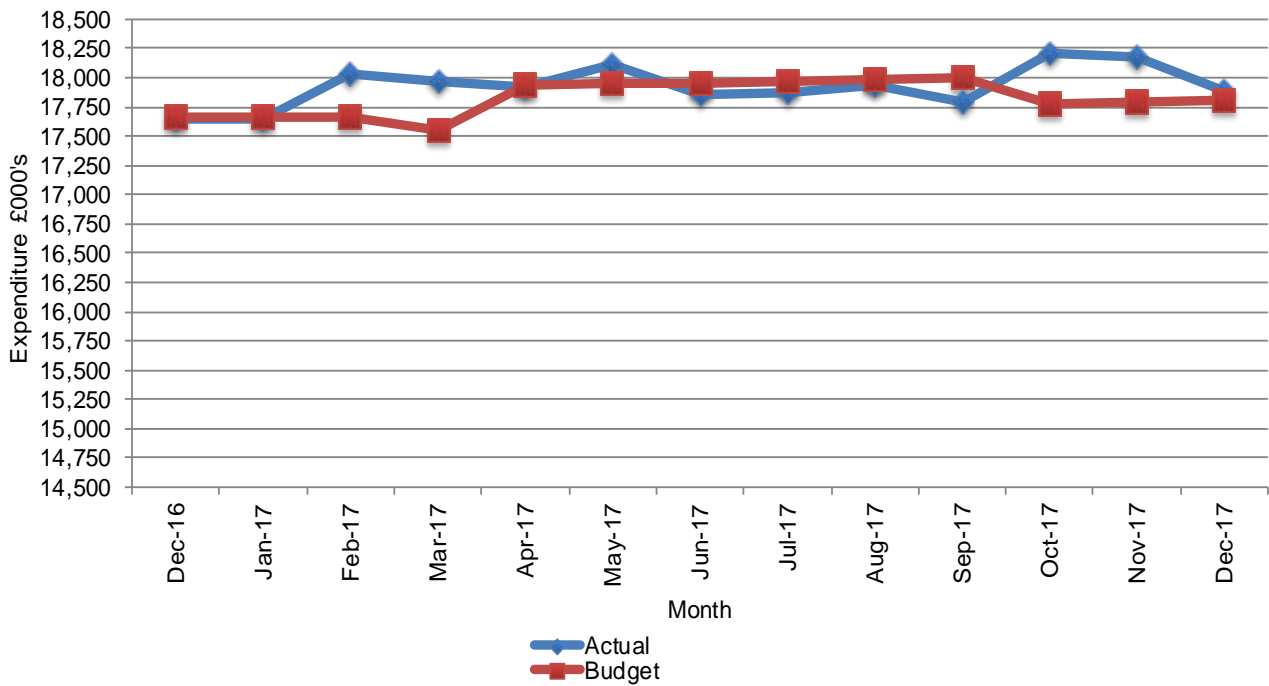


**Non-Face to Face Outpatient** contacts are 1,484 contacts (15.7%) above history and 1,468 contacts above plan (15.5%).

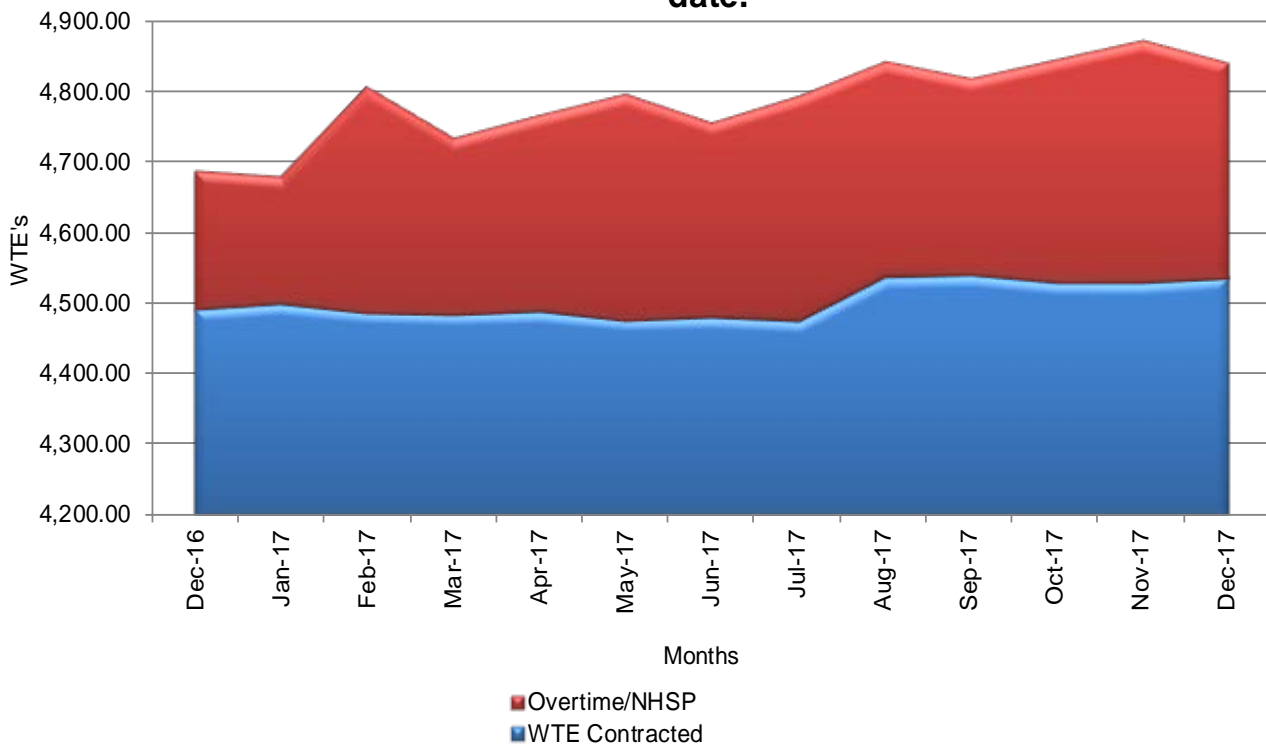
Specialties with the greatest variance against plan include Trauma & Orthopaedics, Gastroenterology, and Genitourinary Medicine.

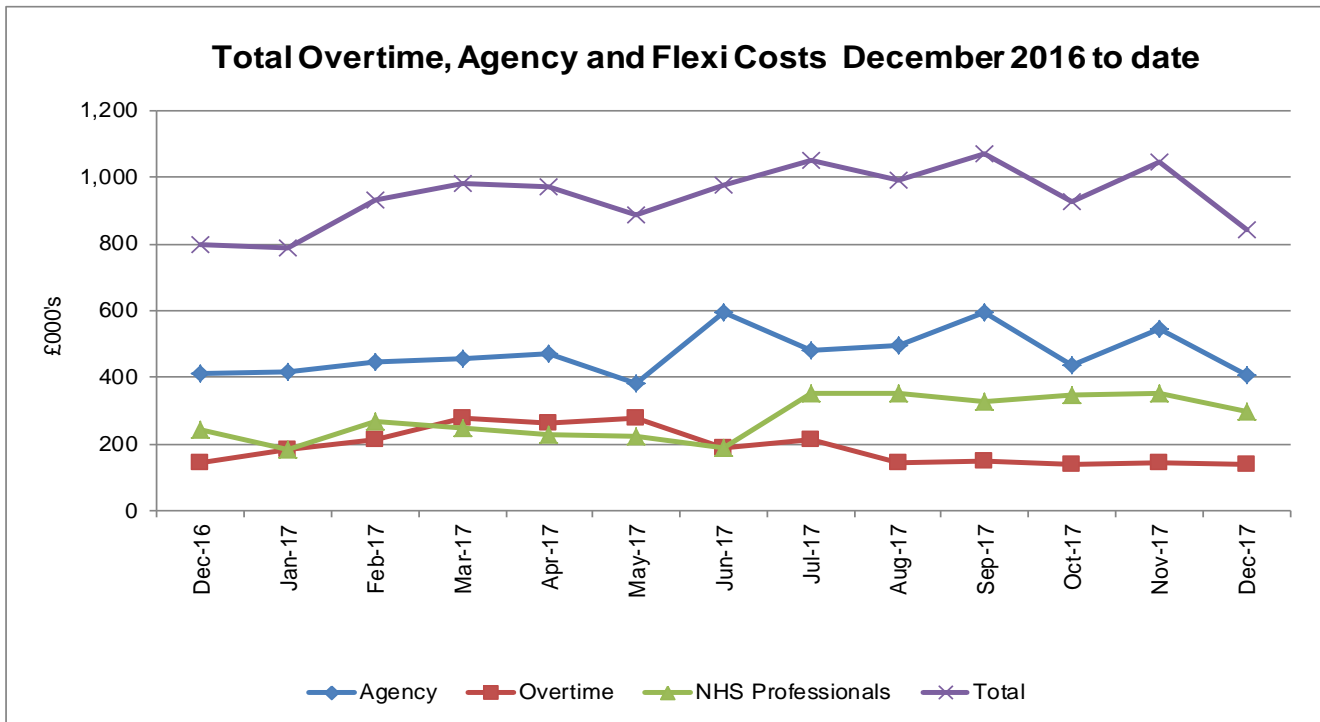
Commissioners have included planned contacts for areas such as Ophthalmology, who did not start to record telephone contacts until November 16, using the figures provided by DMs during the forecasting process.

**Total Pay Costs for Month December 2016 to date**



**Contracted WTE's vs. WTE's worked by Month December 2016 to date.**



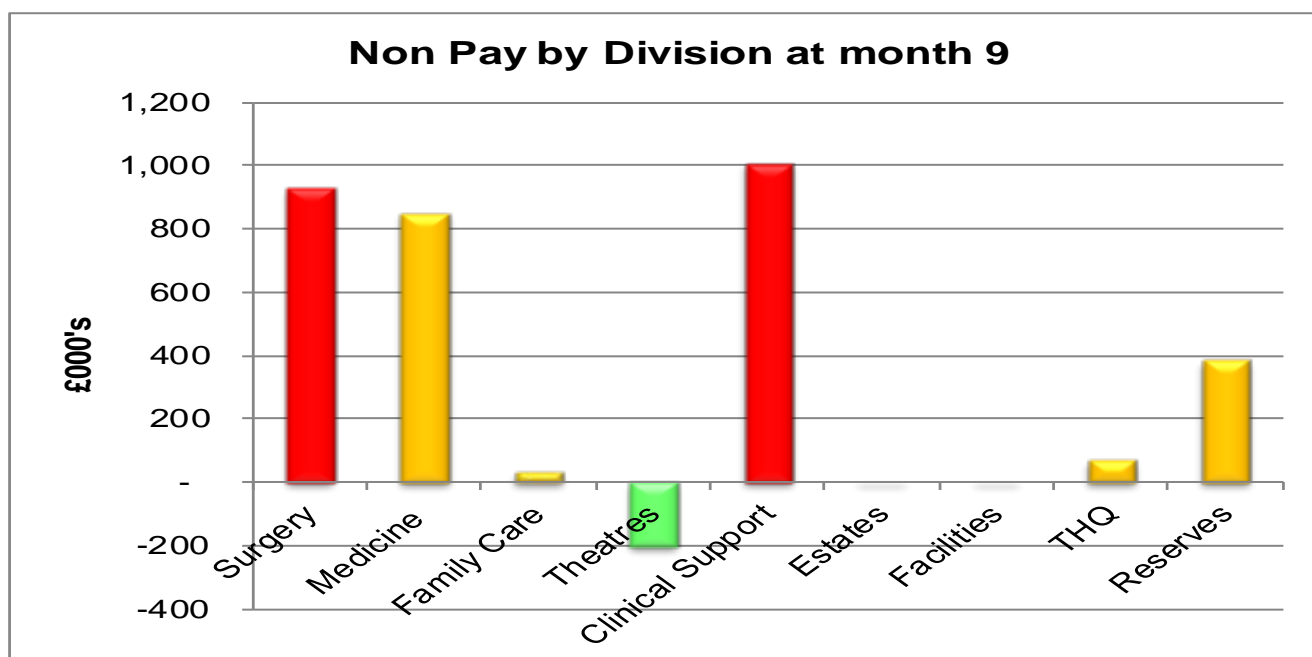
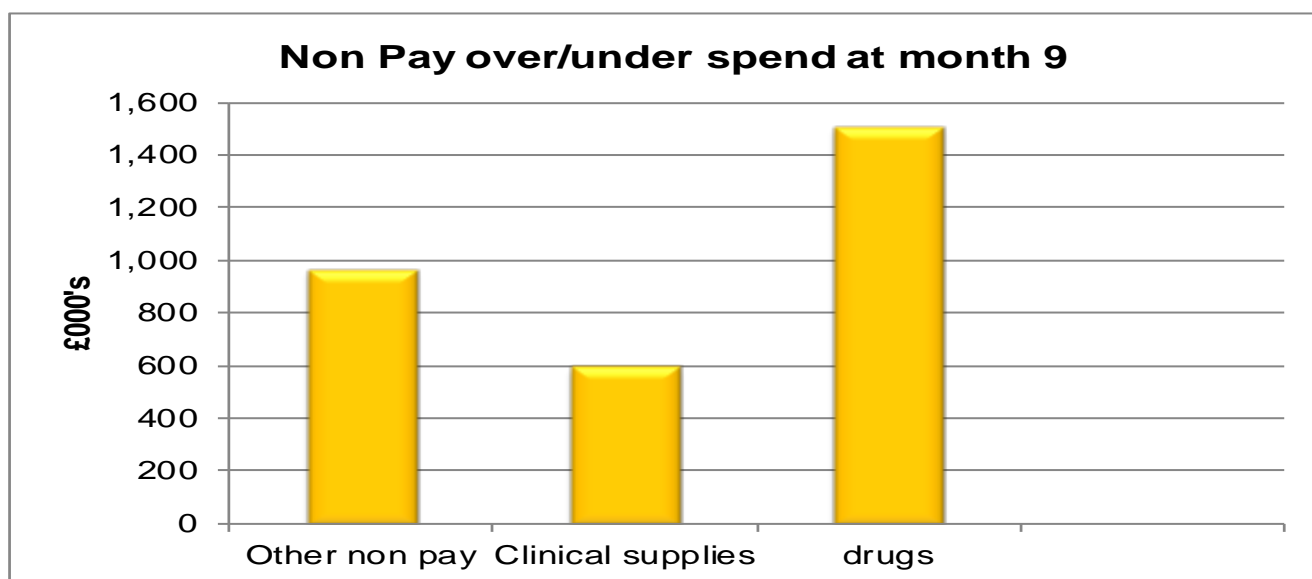


#### NHS Improvement Agency cap ceiling compliance City Hospitals Sunderland

<u>Month</u>	<u>Monthly Expenditure Ceiling</u>	<u>CHS Annual Plan</u>	<u>Actual in month agency cost</u>
	<u>£000s</u>	<u>£000s</u>	<u>£000s</u>
Oct-16	497	417	390
Nov-16	497	417	373
Dec-16	485	407	412
Jan-17	461	387	416
Feb-17	461	387	449
Mar-17	460	386	457
Apr-17	516	357	473
May-17	516	357	386
Jun-17	516	357	594
Jul-17	516	357	485
Aug-17	516	357	494
Sep-17	516	357	593
Oct-17	516	357	439
Nov-17	516	357	546
Dec-17	516	357	405
Jan-18	516	357	
Feb-18	516	357	
Mar-18	516	357	
Jun-18	516	357	
<b>Total</b>	<b>9,570</b>	<b>7,045</b>	<b>6,912</b>

#### Key Issues on pay

- WTE numbers as at month 9 are 4,839, a decrease of 33 WTEs compared to the previous month. This is predominantly due a fall in demand for additional nursing shifts compared to the previous month.
- Agency spend to December 2017 was £4,415k against a budget of £3,217k.
- Against the ceiling the Trust is £229k under (ceiling to month 9 is £4,644k, actual was £4,415k).



#### **Key issues on non-pay**

- Drugs are £1,508k overspent against plan to date, a £284k 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 £594k against plan to date, of which £362k is due to increased offsite diagnostic reporting and tests to third party providers, the remainder is due higher than expected clinical activity which is partially recovered through the cross charge back to commissioners.
- Other Non Pay is overspent by £1,163k against plan to date, most of which is due to £533k 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 £351k of the overspend is due to CIP under delivery against plan to date.

#### **Key actions on non-pay**

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

## CIPs Performance

### Overall Financial Position & CIP Position - Month 9

	Surgery	Theatres	Medicine	Family Care	Clinical Support	THQ Division	THQ Corporate	Gap	Total
<b>Divisional CIP's 17/18 £000's</b>	-2,257	-463	-2,375	-811	-1,308	-1,647	-4,141		<b>-13,000</b>
Plan to date £000's	-1,626	-358	-1,714	-582	-899	-1,245	-2,675		<b>-9,100</b>
Actual to date £000's	-2,100	-478	-1,459	-635	-654	-1,470	-2,440		<b>-9,236</b>
Variance 17/18 £000's	-474	-120	255	-53	245	-225	236		<b>-136</b>
<b>Variance %</b>	29%	34%	-15%	9%	-27%	18%	-9%		1%

### Key Issues with the CIP

To the end of December the planned savings are £9,100k, actual savings for the period are £9,236k, and hence ahead of plan by £136k.

#### **Headline CIPs**

- Surgery's nursing vacancies CIP savings amounted to £730k against a target of £268k, and hence an over delivery of £462k to date.
- Medicine's CIP under delivery of £255k 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 £245k 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 £120k is driven by vacant posts across all areas within Nursing and ODPs.
- Family Care's CIP delivery is £53k over delivered against plan to date due to non recurrent vacant posts.
- THQ Division's CIP delivery is ahead of plan by £225k due largely to additional income received from South Tyneside FT from the single management structure and vacancies to date.
- The Trust has forecasted £12,400k of CIP delivery by the end of the year, and hence £600k still remains to be identified to match the £13m plan.

### CIP - original Annual Plan vs. actual delivery plan today

	<u>Identified</u> <u>Plans</u>	<u>Unidentified</u> <u>Target</u>	<u>Total per</u> <u>APR</u>	<u>This is as</u> <u>per Monitor</u>		
				<u>Plan to</u> <u>Month 9 £</u>	<u>Actual to</u> <u>Month 9 £</u>	<u>Variance</u> <u>£</u>
Revenue Generation	748	52	800	560	575	-15
Pay	6,168	832	7,000	4,900	4,727	173
Clinical Supplies	2,503	-1,003	1,500	1,050	1,980	-930
Drugs	676	324	1,000	700	416	284
Other Non Pay	1,722	978	2,700	1,450	1,098	352
Depreciation	583			439	440	-1
<b>Total £</b>	<b>12,400</b>	<b>1,183</b>	<b>13,000</b>	<b>9,100</b>	<b>9,236</b>	<b>-136</b>

**RESOLUTION for the passing of a blanket guarantee**

At a meeting of the Board of Directors of City Hospitals Sunderland NHS Foundation Trust (the "Trust") duly convened and held on 25 January 2018 at which all interests required to be declared pursuant to *[Section 317 of the Companies Act 1985 or such applicable Act – please delete / record details as applicable]* were duly declared, it was resolved that the giving of a blanket Guarantee and Indemnity in favour of CHG-MERIDIAN Computer Leasing UK Limited under which the Trust will guarantee liabilities of the Trust's subsidiary City Hospitals Independent Commercial Enterprises Limited was considered to be in the best commercial interests of the Trust and that the terms of the blanket Guarantee and Indemnity be approved and that the Guarantee and Indemnity be executed as a Deed of the Trust by two directors of the Trust and that the executed Guarantee and Indemnity be delivered to CHG-MERIDIAN Computer Leasing UK Limited.

Either [ ] and [ ] or any one/two/three of [ ] and [ ] and [ ] be and are hereby authorised to sign the blanket Guarantee and Indemnity on behalf of the Trust.

Signed: ..... Chairman of Meeting

Dated: .....

**CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST**

**DIRECTORATE OF FINANCE**

**BOARD OF DIRECTORS**

**JANUARY 2018**

**INITIAL 2018/19 BUDGET SETTING PAPER**

**1 INTRODUCTION**

The purpose of this paper is to provide initial budget setting principles for 2018/19. Further detail including financial impacts will be provided at Divisional level after contractual information for 2018/19 has been finalised.

In addition it is expected that NHS Improvement (NHSI) will request that all Trusts make an annual planning submission by mid-February, although planning guidance is yet to be received.

Budgets are at Trust level within this paper and are in line with values included within the annual plan submission.

**2 CONTROL TOTAL 2018/19**

In line with the past 2 financial years an income and expenditure position 'control total' requirement has been set for all Foundation Trusts by NHS Improvement as a condition of Sustainability and Transformational Programme (STP) funding.

For City Hospitals Sunderland the control total after the benefit of STF funding in 2017/18 was a deficit of £5.744m, for 2018/19 this has changed to a deficit of £1.670m. Therefore in addition to underlying pressures and CIP deliver the Trust needs to identify a further £4.1m of efficiency to achieve the required in year control total and gain access to STP funding.

The Trust has been allocated a general element of the Sustainability and Transformation Fund (STF) of £9.2m for 2018/19 which is the same as the value for 2017/18. The funding is again subject to agreeing a number of conditions placed upon the Trust including accepting a control total deficit of £1.670m in 2018/19.

**3 KEY PRINCIPLES**

It is proposed that the starting point for 2018/19 budgets is roll over budgets from 2017/18 with key adjustments made for CIPs, inflation, contracting changes, etc. This aligns with the approach used for the past 2 financial years.

In the main divisional financial variances to budgets are largely down to under/over performance against clinical contract and under/over achievement of CIP targets in 2017/18. This therefore gives a level of confidence that underlying budget positions for divisional areas are accurate. For this reason it has been decided to not rebase budgets on prior year out turn again, but to use 2017/18 budgets as the start point for 2018/19.

NHS Improvement annual planning requirements for 2018/19 income and expenditure are developed using a start point of outturn 2017/18, with key adjustments similar to internal budget setting. To align the two methods work has been carried out to ensure the internal Trust budget setting method and NHSI planning values match one another.

#### **4 GROUP CONSOLIDATION**

On 1<sup>st</sup> February 2017 the Trust successfully established CHOICE Facility Services (CFS) an additional service area working within the Trust subsidiary company of CHOICE. In addition the Trust procurement function transferred into CHOICE from 1<sup>st</sup> December 2017. This has increased the turnover in CHOICE to c£42m which is a material value and requires the Trust to report on a group accounting basis going forward.

This paper will therefore identify the initial 2018/19 budget for the 'group' City Hospitals Sunderland plus CHOICE. Final budget setting papers will show the position of each of the two parties separately.

#### **5 INCOME ASSUPTIONS**

At this early stage clinical income levels have been assumed for the Trust based on a mixture of offers received from commissioners plus Trust assumptions on expected contract values for 2018/19.

Offers to date have been received from both Sunderland CCG and South Tyneside CCG which are significantly lower than Trust expectations.

It is expected that contract offers from Durham commissioners and NHS England will include significant elements of QIPP schemes, effectively reducing the contract envelopes gained in 2017/18 into 2018/19. Some QIPP schemes from Durham CCGs in 2017/18 did see activity reductions at the Trust however full details are yet to be fully understood.

For non-clinical income the Trust is assuming similar levels to 2017/18 with adjustments made for known one off items received in year, such as winter support funding.

Full details on the impacts for income budgets within service areas will be detailed in subsequent budget setting papers.

Further to this £0.8m of additional income has been included for revenue generation CIPs for 2018/19.

All of the above assumptions are high risk at this stage but are based on the best data known at this point.

Further information is awaited on how the additional £1.6bn funding announced in the Budget will be allocated within 2018/19. Details of this are expected to be received in January. Consequently nothing has been included within the Annual Plan as yet.

#### **6 EXPENDITURE ASSUMPTIONS**

Key expenditure budget calculations at Trust level:

Adjustments to 2017/18:

- Recurrent 2017/18 budgets
- Removal of one off costs
- Increases/decreases to reflect 2017/18 out turn
- Addition/Removal for the full year effect of CIPs and/or non-recurrent 2017/18 CIPs
- Removal of unidentified CIP targets allocated to divisional areas in 2017/18

2018/19 Specific adjustments:

- Inflationary uplifts in line with national guidance from prior years, including 1.5% for pay



- NHS Resolution (formerly CNST) decrease. This is £1.1m lower than 2017/18.
- Full year impact costs of Trust investments in improving patient care
- Nursing pay budgets remain at previously approved safe staffing levels
- Increased costs to align to clinical activity increases, for example full year effect for Stroke
- Funding of known new pressure changes since 2017/18 such as rate increases
- Capital charge increase in line with ITFF loans interest payment schedules and depreciation for recent new builds
- CIPs to the level of £12.2m for expenditure have been removed (note £0.8m under revenue generation)
- No estimate for the impact of service change (e.g. Redundancy costs) have been included

All of the above assumptions are high risk at this stage but are based on the best data known at this point.

## **7 COST IMPROVEMENT PLANS**

Appendix 1 details the value of CIP delivered by the Trust over the past 5 years.

It shows that using the national efficiency of 2.00% the recurrent CIP required by the Trust to 'stand still' each year is approximately £7.4m (assuming 18/19 inflation costs match 17/18).

Over the past 5 years the Trust has regularly delivered to this level although it is becoming increasingly challenging. Previous delivery plus non recurrent CIP achievement of approximately £4m each year through vacancies and £1m through other routes means that a reasonable CIP target for 2018/19 is £13m. This CIP value would represent c3.6% of Trust expenditure base as a CIP. To note, the Trust expenditure base includes a number of fixed costs such as NHS Resolution charges, and capital costs so the reality is the percentage CIP of controllable costs is much higher.

Historic performance within Appendix 1 shows that delivery of CIP above £13m in year is not feasible, hence agreeing a savings target in excess would be setting the Trust up to fail.

Unfortunately based on initial workings an efficiency value far greater than £13m is required to achieve the 2018/19 control total.

The only solution for the Trust to deliver financial balance must therefore be assessed over a long time period than one financial year.

To date high level CIP plans totalling around £10.2m have been identified, within Appendix 2. These are a combination of local schemes, vacancy factor plus corporate projects such as procurement and through CHOICE.

Detailed allocation of CIP targets to clinical areas will be discussed in greater detail through Finance and Performance Committee prior to the completion of final budget setting papers.

The CIP profile for 2018/19 across quarters has been set in line with STF funding profiles at:

- Q1 – 15%
- Q2 – 20%
- Q3 – 30%
- Q4 – 35%

## 8 SUMMARY 2018/19 BUDGET SETTING POSITION

At this point the Trust budgets for 2018/19 fall short of achieving the required NHS Improvement control total of £1.670m deficit for the year, even after assuming delivery of £13.0m CIP. Detail showing best, worst and likely case scenario is included within Appendix 3 with key assumptions around the differences.

At this stage the 'likely' case position for 2018/19 (excluding STF) is £24.8m deficit compared to requirement of £10.9m deficit before STF funding, so £13.9m short. This position is after assuming full delivery of £13m CIP in year.

Summary below:

### Summary of 2018/19 and beyond

	<u>2017/18</u>		<u>2018/19</u>			<u>2019/20</u>
	<u>Forecast Out</u>	<u>turn</u>	<u>Worst</u>	<u>Best</u>	<u>Likely</u>	
	<u>As at Month 8</u>					
	£000s		£000s	£000s	£000s	£000s
Clinical Income (inc Private Patients, excl. STP)	-312,492		-308,541	-312,274	-310,450	-310,810
Other Income	-33,720		-27,488	-27,783	-27,702	-30,405
<b>Total Income</b>	<b>-346,212</b>		<b>-336,029</b>	<b>-340,057</b>	<b>-338,152</b>	<b>-341,215</b>
Pay	216,336		220,369	219,607	219,878	219,729
Non Pay Costs	131,694		127,060	127,060	127,253	124,587
Capital Costs (Depreciation/PDC/Interest)	14,128		14,359	14,359	14,328	14,166
Gap at month 8	-965					
<b>Total Costs</b>	<b>361,193</b>		<b>361,788</b>	<b>361,027</b>	<b>361,459</b>	<b>358,482</b>
<b>Overall Position Deficit/(Surplus) (Excl STF)</b>	<b>14,981</b>		<b>25,759</b>	<b>20,970</b>	<b>23,308</b>	<b>17,267</b>
STF Income	-9,237		-9,237	-9,237	-9,237	0
<b>Overall Position Deficit/(Surplus) (inc. STF)</b>	<b>5,744</b>		<b>16,522</b>	<b>11,733</b>	<b>14,071</b>	<b>17,267</b>

Appendix 4 shows the summary Trust position with key movements from the 2017/18 budget position.

The summary shows that even after assuming the delivery of £13m CIPs, the likely financial deficit excluding STF for 2018/19 is £23.3m against a required control total excluding STF of £12.9m deficit so £12.4m away from requirement.

## 9 BUDGET SETTING PROFILE

Under Clinical Income, elective admissions are profiled on adjusted working days and non-elective is in line with last year's actual performance. Outpatient income has also been profiled on adjusted working days. Other income is generally profiled on an even profile.

Pay costs and non-pay costs are generally profiled evenly over the year, exceptions to this relate to energy costs and rates. Pay enhancements and increments have been profiled when they are incurred in 2018/19 rather than equally across the year, this will allow the trusts pay position to be monitored against a more accurate budget. In addition CIPs have been profiled in line with STF funding profiles

## 10 CASH

Non achievement of the control total will have a significant impact on the Trust's cash position.

The Trust is currently forecasting a 2017/18 year-end cash balance of £2.5m. A deficit in 2018/19 together with a capital programme in excess of internally generated resources and the need to make repayments on existing loans totalling £3.7m will result in the Trust not having enough cash resource to meet its obligations.

The Trust has explored options to mitigate against this which include:

- Approval of only essential capital schemes
- Deferral of any non-urgent expenditure

Unfortunately the above measures will not provide the levels of cash necessary for the Trust to pay its staff and suppliers. It is therefore recommended that the Trust submits an application to Department of Health via NHSI to agree a facility for interim cash support. It is recommended that the level of funding applied for should be £19m this would cover:

- A 2018/19 deficit of £16m
- Loan repayments due in 2018/19 of £4.6m
- The difference between the expected capital requirement in 2018/19 and the level of internally generated resources £(6.2m)
- The budgeted 2018/19 PDC interest of £4m

If approved the interim cash support would be available for the Trust to drawdown from on a monthly basis. It is expected that the interest rate on the support will be 3.5%.

Following submission of a Financial Recovery Plan to NHS Improvement and its subsequent approval the interim support may be replaced with cash support to cover the period of the recovery plan.

## 11 **CAPITAL**

Capital schemes for 2018/19 are approved via the Capital Development Steering Group (CDSG), at this stage plans total £5m. Funding of £11.200m is expected to be available which will leave a surplus of £6.200m. A breakdown of this is provided in the table below:

<b>Description</b>	<b>£000</b>
Estates development schemes	500
Estates maintenance schemes	500
Medical equipment schemes	750
IT GDE schemes	3,000
IT non-GDE schemes	250
<b>Total</b>	<b>5,000</b>
<b>Funding Sources</b>	
Depreciation	8,000
GDE funding	3,000
Charitable donations	200
<b>Total</b>	<b>11,200</b>
<b>Funding surplus</b>	<b>6,200</b>

## 12 **RISKS**

The risks to the Trust at this stage are vast and the single biggest concern is the recurrent underlying deficit, driving the immediate shortfall of cash.

Current contract offers from lead commissioners fall significantly short of Trust expectations for 2018/19. Furthermore it is expected contract offers from other commissioners including NHS England will have funding retractions which will further increase the risk on the current financial estimates for the upcoming year.

A vast number of one off benefits have been realised by the Trust during 2016/17 and 2017/18 to achieve the required control total, such as stock counts, site revaluation, and other balance sheet adjustments all of which have helped Income and Expenditure but have limited cash benefits. Unfortunately this means that no further big ticket one off benefits are now available to the organisation to support the bottom line financial position, thus all savings going forward need to be genuine cost reductions or additional income.

Additional income opportunities are limited within the Sunderland and South Tyneside health economy due to changes in national allocations to local CCGs hence the only viable solution is cost reductions through ceasing or restricting certain services to patients.

Whilst previous CIP performance by the Trust has been strong the volume of opportunities going forward are becoming less and less with 'low hanging fruit' having been picked many years ago.

### **13 OPPORTUNITIES**

Commissioners have removed significant values from 2017/18 contracts and are likely to do so within 2018/19 offers for QIPP. Whilst this does pose a risk for clinical income any successful reductions in hospital admissions will provide the Trust with opportunities to pull costs out of the system. This process will need to be carefully managed, however reductions could be in areas where high agency costs are required to deliver current patient numbers.

The Trust continues to work through the opportunities within in the Lord Carter report and has already engaged with NHS Improvements Productivity team to explore further options.

The Trust will be continuing to work closely with South Tyneside Foundation Trust during 2018/19 to review both clinical and non-clinical services, although it is anticipated that most of these clinical service financial benefits will be in 2019/20 and beyond. Significant back office benefits have already been realised within 2017/18.

### **14 NEXT STEPS**

All leaders across the Sunderland and South Tyneside health economy are signed up to a 'working together' Local Health Economy (LHE) Efficiency programme to deliver long term financial balance across the system.

It is key that this LHE Group can work closely together to realise challenging savings targets across the whole South of Tyne footprint. Work is ongoing to establish strong governance to underpin the long term aims for financial balance and provide momentum to work already started. A separate paper will detail the suggested process for the development of a 3 year financial recovery plan.


### **15 GOING CONCERN**

Whilst this report outlines that there are clear financial risks facing the Trust in 2018/19 and beyond, if the Trust is able to secure interim cash support and gain approval of the financial recovery plan then these financial risks would not be considered to represent a fundamental threat to the continuity of services provided by the Trust and hence its ability to continue as a going concern.

## 16 **RECOMMENDATIONS**

The Board is requested to:

- Approve the revenue budgets for 2018/19
- Note the view that the Trust continues to report as a 'Going Concern'.



Julia Pattison  
Director of Finance  
January 2018

### **List of Appendices**

No.	Title of Appendix
1.	Prior year CIP delivery
2.	High Level CIP plans 2018/19
3.	Summary Budgets for 2018/19 – best, worst and likely case scenarios
4.	Trust summary reconciliation from 2017/18 final budget to 2018/19 initial budget

**City Hospitals CIP delivery over the last 5 years**

	<u>2013/14</u> £000s	<u>2014/15</u> £000s	<u>2015/16</u> £000s	<u>2016/17</u> £000s	<u>2017/18 -</u> <u>forecast</u> £000s	<u>Total</u> £000s
<b>CIP in Year Target</b>	<b>£12,165</b>	<b>£16,279</b>	<b>£13,000</b>	<b>£15,000</b>	<b>£13,000</b>	<b>£69,444</b>
<b>Actual Delivery methods</b>						
Productivity/improved efficiency	£1,159	£450	£1,299	£200	£500	<b>£3,608</b>
Ward/Service Closure	£1,208	£400	£1,601	£468	£1,000	<b>£4,677</b>
Price benefits (procurement, drugs, CHOICE)	£2,100	£2,750	£2,500	£3,600	£4,000	<b>£14,950</b>
Income increases	£500	£350	£2,022	£400	£700	<b>£3,972</b>
Balance sheet benefits	£0	£300	£300	£1,200	£1,050	<b>£2,850</b>
Non recurrent vacancy holding	£3,750	£1,000	£2,715	£4,583	£3,875	<b>£15,923</b>
Other	£3,321	£4,728	£3,482	£3,428	£1,382	<b>£16,341</b>
<b>Total</b>	<b>£12,038</b>	<b>£9,978</b>	<b>£13,919</b>	<b>£13,879</b>	<b>£12,507</b>	<b>£62,321</b>

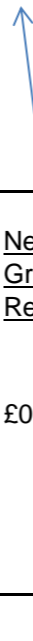
<b>Delivery breakdown</b>						
Recurrent	£6,533	£8,739	£9,663	£7,438	£6,922	<b>£39,295</b>
Non Recurrent	£5,505	£1,239	£4,256	£6,441	£5,585	<b>£23,026</b>
<b>Total</b>	<b>£12,038</b>	<b>£9,978</b>	<b>£13,919</b>	<b>£13,879</b>	<b>£12,507</b>	<b>£62,321</b>

**Tariff Efficiency Requirement**

	<b>Percentage</b>			<b>Financially</b>		
	<u>Tariff</u> <u>Efficiency</u> <u>Factor</u> <u>i.e. net income</u> <u>growth</u>	<u>Inflation</u> <u>factor</u>	<u>Net</u> <u>Growth/Retra</u> <u>ction</u>	<u>Tariff</u> <u>Efficiency</u> <u>Factor</u> <u>i.e. net</u> <u>income</u> £000s	<u>Inflation</u> <u>factor</u> £000s	<u>Net</u> <u>Growth/</u> <u>Retraction</u> £000s
2013/14	-1.10%	1.50%	2.60%	£4,250	£11,500	£7,250
2014/15	1.00%	3.37%	2.37%	£4,000	£10,500	£6,500
2015/16	0.30%	1.90%	1.60%	£1,200	£7,300	£6,100
2016/17	1.10%	3.10%	2.00%	£4,006	£9,620	£5,615
2017/18	0.10%	2.10%	2.00%	£334	£7,696	£7,362

Total - financially this value of efficiency has been required to stand still. This is before any investment

**32,827**



**Savings Scheme Summary - High Level 2018/19**

	<b>CHS</b>	
	<b>£m</b>	<b>RAG</b>
<b>Corporate led</b>		
Procurement - cost reduction drive (Not CHOICE benefits)	1.50	Medium
Fully Managed Healthcare Facility model/ Estates and Facilities CIPs	1.00	Low
Clinical Service Reviews (likely to be 19/20 at CHS)	0.00	N/A
Back Office service collaboration CHS/STFT (c/f from 17/18)	0.50	Medium
Global Digital Exemplar benefits	0.50	High
Lease Car benefits	0.30	Medium
Estates Rationalisation across the patch	0.10	Medium
<b>Operational area led</b>		
Vacancies (Non Recurrent)	3.50	Low
Biosimilars (mainly c/f from 17/18)	0.50	Low
Biosimilars (additional into 18/19)	0.50	Medium
Joint work for Meds Ops teams (above Biosimilar work)	0.25	Medium
Agency 10% spend reduction compare to 18/19 (net of new costs)	0.50	High
Avastin	0.13	High
Spinal top up and/or activity reduction/cease	0.45	Medium
MSK - implement spinal ASAP. Sun CCG	0.50	Medium
Outpatient Reviews new/review ratios	TBC	High
Activity and/or contracting decreases (VBC, Decommissioned services, contract variations, etc.) cost base reductions	TBC	
<b>Total Identified Plans</b>	<b>10.23</b>	
Unidentified Plans	2.77	High
<b>Total CIP Target</b>	<b>13.00</b>	

**Summary of 2018/19 and beyond**

	<b>2017/18 Forecast</b>		<b>2018/19</b>		<b>2019/20</b>
	<b>Out turn</b>		<b>Worst</b>	<b>Best</b>	
	<b>As at Month 8</b>				
	£000s	£000s	£000s	£000s	£000s
Clinical Income (inc Private Patients, excl. STP)	-312,492	-308,541	-312,274	-310,450	-310,810
Other Income	-33,720	-27,488	-27,783	-27,702	-30,405
<b>Total Income</b>	<b>-346,212</b>	<b>-336,029</b>	<b>-340,057</b>	<b>-338,152</b>	<b>-341,215</b>
Pay	216,336	220,369	219,607	219,878	219,729
Non Pay Costs	131,694	127,060	127,060	127,253	124,587
Capital Costs (Depreciation/PDC/Interest)	14,128	14,359	14,359	14,328	14,166
Gap at month 8	-965				
<b>Total Costs</b>	<b>361,193</b>	<b>361,788</b>	<b>361,027</b>	<b>361,459</b>	<b>358,482</b>
<b>Overall Position Deficit/(Surplus) (Excl STF)</b>	<b>14,981</b>	<b>25,759</b>	<b>20,970</b>	<b>23,308</b>	<b>17,267</b>
STF Income	-9,237	-9,237	-9,237	-9,237	0
<b>Overall Position Deficit/(Surplus) (inc. STF)</b>	<b>5,744</b>	<b>16,522</b>	<b>11,733</b>	<b>14,071</b>	<b>17,267</b>

**Differences between likely and best/worst case scenarios 2018/19**

	<b>Worst</b>	<b>Best</b>
	£000s	£000s
Likely position	14,071	14,071
<b>Differences</b>		
Contracting expectations - work is still ongoing for 2018/19 values	1,800	-1,800
Retraction/(Growth) for R&D and Training income	100	-100
Vacancy fill levels more/(less) than likely expectation	500	-400
Other	51	-38
<b>Worst/Best case positions</b>	<b>16,522</b>	<b>11,733</b>

**CIP target for each year**

Income	-800	-800	-800	-800
Pay - recurrent	-4,000	-4,000	-4,000	-4,000
Pay - Non Recurrent	-3,000	-3,000	-3,000	-3,000
Drugs	-1,000	-1,000	-1,000	-1,000
Clinical Supplies	-2,000	-2,000	-2,000	-2,000
Other Non Pay	-2,200	-2,200	-2,200	-2,200
<b>Total</b>	<b>-13,000</b>	<b>-13,000</b>	<b>-13,000</b>	<b>-13,000</b>



**City Hospitals Sunderland NHS Foundation Trust Budget Setting - 2018/19**

	Clinical Income inc Private Patients	STP	Other Income	Interest Rec'ble	Total Income	Pay	Drugs	Clinical Supplies	Non Pay	Capital Charges	Total Expenditure	Net Position
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
<b>2017/18 Recurrent Budget</b>	-313,931		-27,000	-43	<b>-340,974</b>	217,604	37,625	32,181	56,348	15,197	<b>358,955</b>	<b>17,981</b>
<b>Alignment to opening position annual plan 2018/19</b>					<b>0</b>							<b>0</b>
Removal of Non Recurrent items in contract offers	6,212		0		<b>6,212</b>	-350			-50		<b>-400</b>	<b>5,812</b>
One off items in year (Stretch target - delivered non rec)			0		<b>0</b>		1,500	1,000	1,000		<b>3,500</b>	<b>3,500</b>
Alignment to opening position annual plan 2018/19 (Mainly non recurrent items in year i.e. Materials Management)			460	12	<b>472</b>	1,498	859	1,325	1,443	-1,038	<b>4,086</b>	<b>4,558</b>
Alignment to expected contract offers	-2,584				<b>-2,584</b>						<b>0</b>	<b>-2,584</b>
					<b>0</b>						<b>0</b>	<b>0</b>
<b>Opening 2018/19 Budgets</b>	<b>-310,303</b>	<b>0</b>	<b>-26,540</b>	<b>-31</b>	<b>-336,874</b>	<b>218,752</b>	<b>39,984</b>	<b>34,506</b>	<b>58,741</b>	<b>14,159</b>	<b>366,141</b>	<b>29,267</b>
Income inflation at 0.1%	-307		-26		<b>-333</b>						<b>0</b>	<b>-333</b>
FYE increments					<b>0</b>	500					<b>500</b>	<b>500</b>
Pay Inflation and Increments (@ TBC% per national guidance)					<b>0</b>	3,310					<b>3,310</b>	<b>3,310</b>
Non Pay Inflation (Drugs 2.8%, other 1.8% exc. CNST)					<b>0</b>		1,120	624	794		<b>2,538</b>	<b>2,538</b>
CNST decrease					<b>0</b>				-1,194		<b>-1,194</b>	<b>-1,194</b>
					<b>0</b>						<b>0</b>	<b>0</b>
<b>Other changes:</b>					<b>0</b>						<b>0</b>	<b>0</b>
Growth in MPET income re tariff transision			-100		<b>-100</b>						<b>0</b>	<b>-100</b>
GDE Revenue funding/costs			-338		<b>-338</b>	250		0	150	200	<b>600</b>	<b>262</b>
G4S - changes - £TBC					<b>0</b>	3,218			-3,218		<b>0</b>	<b>0</b>
FYE costs from 17/18					<b>0</b>	750					<b>750</b>	<b>750</b>
BAHA - income and cost changes	260				<b>260</b>			-260			<b>-260</b>	<b>0</b>
FYE costs re Renal Dialysis					<b>0</b>	17		184	9		<b>210</b>	<b>210</b>
Removal of Church View costs 17/18					<b>0</b>	-382	-6	-2	-51		<b>-441</b>	<b>-441</b>
Other	-100		133		<b>33</b>	463	183	-42	50	-29	<b>625</b>	<b>658</b>
					<b>0</b>						<b>0</b>	<b>0</b>
<b>Divisional Pressures</b>					<b>0</b>						<b>0</b>	<b>0</b>
Cath Lab business case					<b>0</b>			58			<b>58</b>	<b>58</b>
Renal Water lab BC pressure					<b>0</b>				60		<b>60</b>	<b>60</b>
Ongoing Diagnostic pressure offsite cost growth estimate					<b>0</b>				466		<b>466</b>	<b>466</b>
ED Maintenance pressures					<b>0</b>			77	0		<b>77</b>	<b>77</b>
Rates increase					<b>0</b>			0	70		<b>70</b>	<b>70</b>
CQC fee increase					<b>0</b>				50		<b>50</b>	<b>50</b>
Corp Tax provision increase re CHOICE					<b>0</b>				100		<b>100</b>	<b>100</b>
					<b>0</b>						<b>0</b>	<b>0</b>
CIP target			-800	0	<b>-800</b>	-7,000	-1,000	-2,000	-2,200		<b>-12,200</b>	<b>-13,000</b>
CIP in CHOICE					<b>0</b>						<b>0</b>	<b>0</b>
					<b>0</b>						<b>0</b>	<b>0</b>
STP funding		0			<b>0</b>						<b>0</b>	<b>0</b>
					<b>0</b>						<b>0</b>	<b>0</b>
Stretch target					<b>0</b>						<b>0</b>	<b>0</b>
					<b>0</b>						<b>0</b>	<b>0</b>
					<b>0</b>						<b>0</b>	<b>0</b>
<b>TOTAL ADJUSTMENTS</b>	<b>-147</b>	<b>0</b>	<b>-1,131</b>	<b>0</b>	<b>-1,278</b>	<b>1,126</b>	<b>297</b>	<b>-1,361</b>	<b>-4,914</b>	<b>171</b>	<b>-4,681</b>	<b>-5,959</b>
<b>TOTAL 18/19 BUDGET (Excluding STF)</b>	<b>-310,450</b>	<b>0</b>	<b>-27,671</b>	<b>-31</b>	<b>-338,152</b>	<b>219,878</b>	<b>40,281</b>	<b>33,145</b>	<b>53,827</b>	<b>14,330</b>	<b>361,460</b>	<b>23,308</b>

**CONTROL TOTAL (EXCLUDING STF) FOR 2018/19**

**10,907**

**SHORTFALL (I.E. STRETCH TARGET)**

**12,401**

**CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST**  
**DEPARTMENT OF PLANNING AND BUSINESS DEVELOPMENT**  
**BOARD OF DIRECTORS**  
**JANUARY 2018**  
**PERFORMANCE REPORT**

**INTRODUCTION**

Please find enclosed the Performance Report for December 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 December failed to achieve the 95% target and has deteriorated to 83.7% due to winter pressures. This was also below the STF trajectory of 91.8%. Performance for January currently stands at 82.0% (as at 15<sup>th</sup> January). This is due to ongoing operational pressure (attendances, acuity of patients, admissions, bed occupancy and flu).

The national performance for December has dropped to 85.1%. The Trust has moved into the lower middle 25% of Trusts nationally and are currently ranked 94th out of 160 Trusts.

**Referral to Treatment Time (RTT)**

Performance remains above target at 93.73% with all specialties achieving the target apart from T&O and Thoracic Medicine.

National performance for November has stabilised and remains below the standard at 88.2%.

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

Due to cancer reporting timescales being 1 month behind, the performance report includes November's confirmed position. The Trust has achieved all cancer waiting time standards this month.

National performance against the 62 day standard remains below target at 82.3%.

### Diagnostics

Performance for December has failed to achieve the national operating standard at 1.39%. This is due to recent capacity issues for Dexa scans as well as ongoing capacity issues in Audiology. It is expected that the Dexa capacity issues will improve during January and that performance will recover. January performance at Trust level is expected to be above target.

National performance in November remains stable at 1.7% and continues to fail the target.

### Delayed Transfers of Care

The North Winter Office have set the Trust a target of 0.43% for delayed transfers of care (DTC) over the winter period, which equates to our performance during June 2017, at which point there were 73 delayed days. During December the DTC target was achieved with a rate of 0.23% from 43 delayed days.

## **FINANCIAL IMPLICATIONS**

For December, there are minimal local penalties to be applied.

We are now meeting the financial control total for Q3, however the STF funding relating to A&E 4-hour performance will not be received as performance was below trajectory for the month (£138.6k) and this will not be recovered in the quarter as performance was also below trajectory, equating to £415.7k in total.

## **RECOMMENDATIONS**

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



**Alison King**  
**Head of Performance and Information Management**

# Performance Report December 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

Narrative highlighting recent performance and corrective actions, where applicable

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

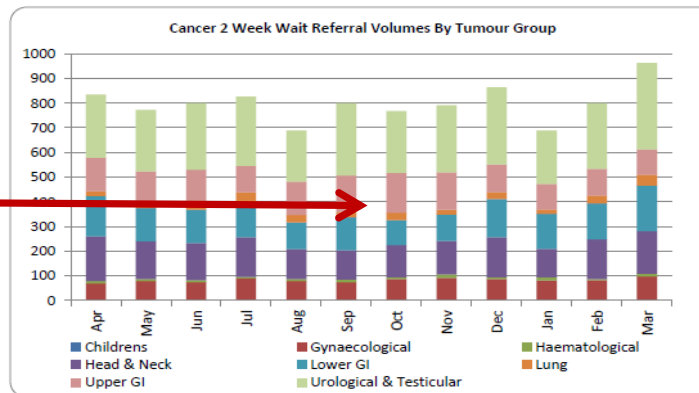
## Cancer 2 Week Waits

**National Operational Standards**

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

Director Lead: Sean Fenwick  
 Consequence of failure: Timely access to treatment, patient experience, clinical outcomes & financial sanction  
 Potential financial sanction if standard not achieved = £200 per breach

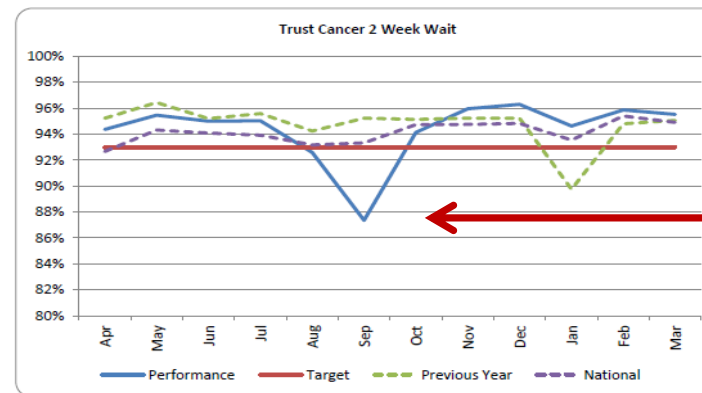
2WW performance has remained stable in March at 95.5%, which continues to perform above target. At tumour site level, all areas achieved the target this month. March's performance demonstrated that all tumour groups are performing about the same or better than the equivalent national benchmarking position.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



Referrals for Suspected Cancer - March 2016*	Volume	Total Breached	Performance	National Benchmark	YTD
<b>Target</b>			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 Leukemia)	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%
<b>Total</b>	<b>962</b>	<b>43</b>	<b>95.53%</b>	<b>94.9%</b>	<b>94.40%</b>

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

Table showing current performance compared to target (where relevant)



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

# 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 <sup>1</sup>	Qtr 1	Qtr 2	Qtr 3	Qtr 4			YTD
<b>Operational Performance Measures - NHSI SOF:</b> 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%	83.68%	94.47%	95.00%	89.96%		93.10%		4
RTT - % incompletes waiting <18 wks	Sean Fenwick	≥92%	94.00%	93.73%	94.55%	94.41%	94.36%		94.44%		5
Cancer waits - % 62 days	Sean Fenwick	≥85%	84.00%	88.27%	76.99%	85.18%	84.40%		81.84%		6
% Diagnostic tests ≥6 wks	Sean Fenwick	<1%	2.14%	1.39%	2.75%	1.39%	0.67%		1.63%		7
<b>National Operational Standards:</b> 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	3	11	12	5		28		N/A
Cancer waits - % 2ww	Sean Fenwick	≥93%	95.91%	96.65%	96.86%	96.36%	97.03%		96.74%		8
Cancer waits - % 31 days	Sean Fenwick	≥96%	98.67%	99.40%	97.43%	98.34%	98.05%		97.93%		9
Cancer waits - % 31 days for subsequent treatment - surgery	Sean Fenwick	≥94%	98.40%	100.00%	96.43%	96.51%	96.83%		96.57%		9
Cancer waits - % 31 days for subsequent treatment - drugs	Sean Fenwick	≥98%	99.90%	98.81%	100.00%	100.00%	99.41%		99.85%		9
Cancer waits - % 62 days from screening programme	Sean Fenwick	≥90%	100.00%	100.00%	100.00%	87.50%	100.00%		94.44%		6
Cancer waits - % 62 days from consultant upgrade	Sean Fenwick	NA	88.20%	81.82%	75.44%	76.39%	87.50%		77.78%		6
<b>National Quality Requirements:</b> 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	195	239	50	283		572		4
A&E / ambulance handovers - no. >60 minutes	Sean Fenwick	0	381	69	41	4	80		125		4
% VTE risk assessments	Ian Martin	≥95%	98.49%	95.44%	98.64%	98.79%	96.80%		98.06%		N/A

1. Performance is one month behind normal reporting for all Cancer indicators (November 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

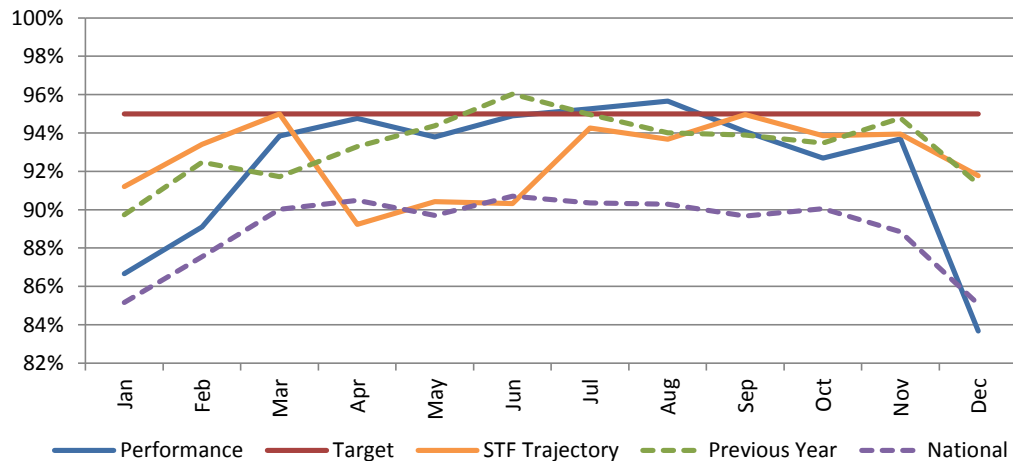
The total proportion of patients seen in A&E within 4 hours reduced during December to 83.68%, which is below the national operating standard and STF trajectory. Winter pressures have intensified in December resulting in 14 instances of escalated OPAL status. There has been an increase inpatients suffering from high acuity conditions and a significant increase in flu related attendances towards the end of the month which was further compounded by staffing pressures. For December the trust moved to the lower middle quartile of trusts nationally for the first time since December 2015.

There were 13,722 attendances this month, which is 7% higher than December 2016 (type 1 was up by 8%, type 2 was down by 11% and type 3 was up by 20%). Attendances have been higher on average compared to previous months.

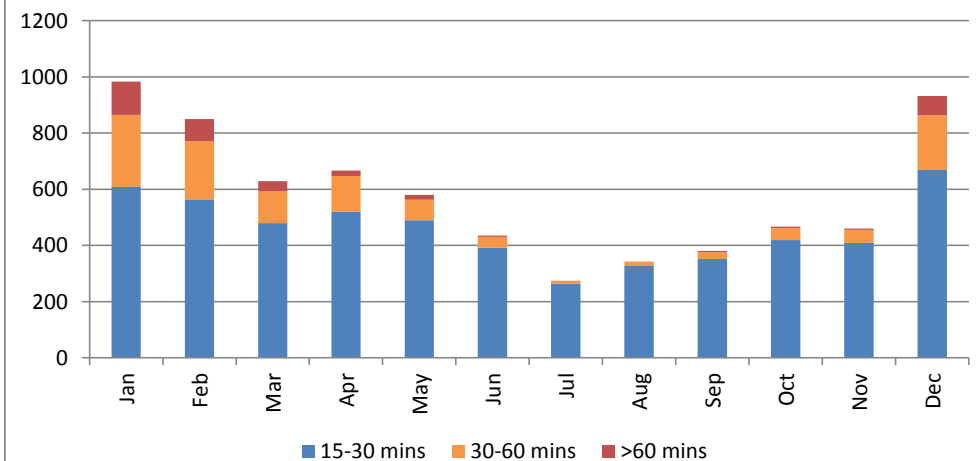
There were 2,794 ambulance arrivals this month, which is less than December 2016. This represents the second highest volume of ambulance arrivals for any hospital across the North East. The number of over 30 minute handover delays increased this month reflecting the issues with patient flow in the trust. This equates to 9.4% of all arrivals. This is slightly higher than the regional average.

A&E Indicators - December 2017	Target	Month	YTD
A&E % seen in 4hrs - Trust Total	≥95%	83.68%	93.10%
A&E < 4 hrs - Type 1	≥95%	74.78%	88.84%
A&E < 4 hrs - Type 1 - High Acuity	≥95%	47.13%	77.60%
A&E < 4 hrs - Type 1 - Low Acuity	≥95%	72.41%	88.31%
A&E < 4 hrs - Type 1 - Paediatrics	≥95%	97.26%	98.22%
A&E < 4 hrs - Type 2 - SEI	≥95%	99.46%	99.36%
A&E < 4 hrs - Type 3 - Pallion walk in centre	≥95%	99.58%	99.77%
A&E Attendances - Trust Total		13,722	117,965
A&E Attendances - Type 1		8,785	71,300
A&E / ambulance handovers - no. 15-30 minutes	0	668	3,839
A&E / ambulance handovers - no. 30-60 minutes	0	195	572
A&E / ambulance handovers - no. >60 minutes	0	69	125

A&E % Seen In 4 Hours



Ambulance Handover Delays



# 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 December but has reduced from November's position.

At specialty level Trauma & Orthopaedics (T&O) and Thoracic Medicine failed to achieve the 92% target. T&O remains in formal escalation and performance is monitored closely. They are unlikely to recover fully without additional capacity/funding. Winter pressures impacted on their position with cancelled operations affecting performance.

Thoracic Medicine failed to achieve standard due to capacity challenges and achievement in January is also a risk.

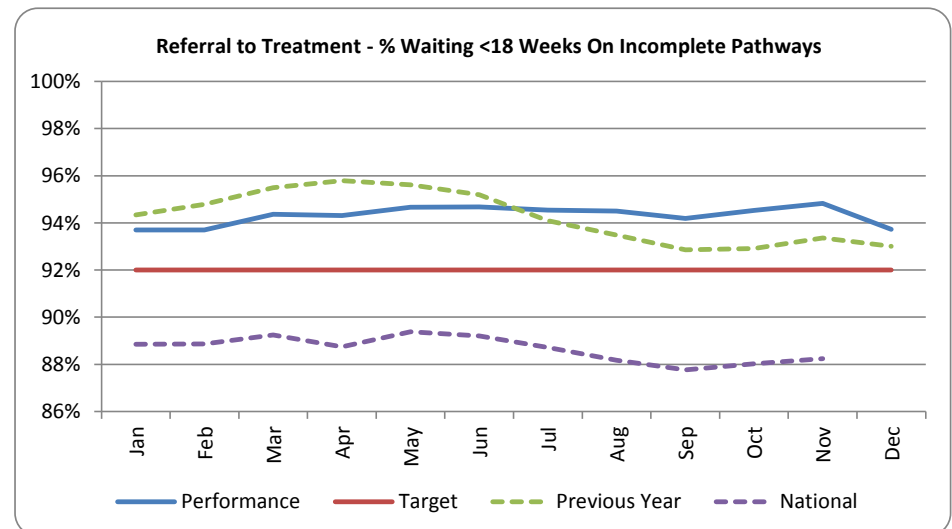
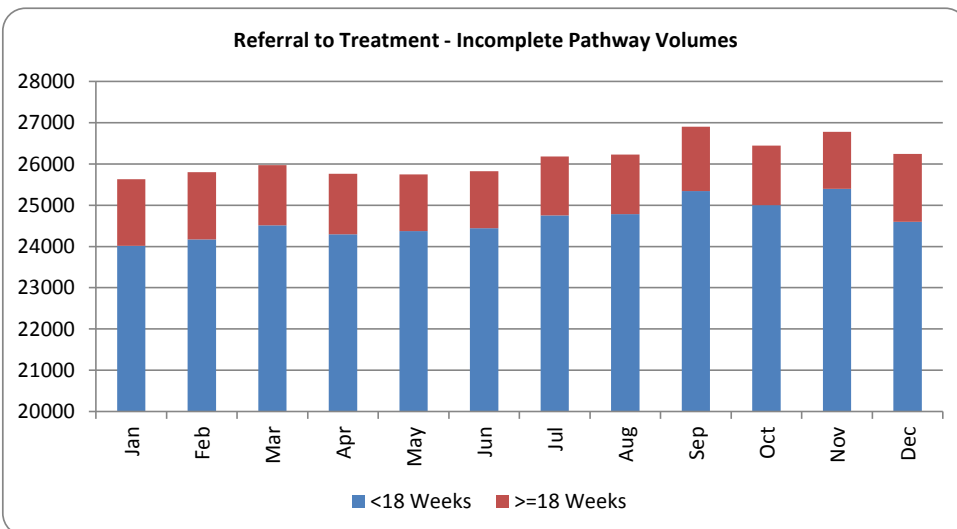
Rheumatology are a risk going forwards due to capacity issues. Work is ongoing to improve their position.

The Trust's RTT stress test risk rating improved in November and the trust has been assessed as having a 9% chance of failing the operational standard in the next 6 months. We are ranked 17th (best) nationally out of 152 trusts.

RTT Incompletes - December 2017	Volume	No. ≥18 Weeks	% <18 Weeks*
<b>Target</b>			<b>≥92%</b>
Cardiology	616	21	96.59%
Ear, Nose & Throat	2,515	157	93.76%
Gastroenterology	350	0	100.00%
General Surgery	1,848	121	93.45%
Geriatric Medicine	392	3	99.23%
Gynaecology	1,018	16	98.43%
Neurology	737	8	98.91%
Ophthalmology	4,002	86	97.85%
Oral & Maxillo Facial Surgery	2,093	143	93.17%
Rheumatology	735	43	94.15%
Thoracic Medicine	795	79	90.06%
Trauma & Orthopaedics	3,117	604	80.62%
Urology	2,364	147	93.78%
Other	5,664	218	96.15%
<b>Trust Total</b>	<b>26,246</b>	<b>1,646</b>	<b>93.73%</b>

\*De minimis level ≥ 20 pathways in total

RTT Stress Test	Sep-17	Oct-17	Nov-17
% Risk of failure in next 6 months	15.83%	10.05%	9.11%
National rank (1st is best)	19/153	16/152	17/152





# 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 improved in November. Both the national target and STF trajectory were achieved and performance was better than national average. All tumour groups achieved the target with the exception of Breast, Lung and Haematological. There were 9.5 breaches in total.

The Consultant Upgrade breach was attributable to Lung and Haematological tumour groups.

The volume of patients who are approaching their breach date has increased recently. The main increase was seen in the 15-28 day group which has recently started to reduce. This is partially related to reduced tracking and information sharing but also due to patient factors, such as patients choosing to delay their pathways around Christmas and New Year. The main areas of risk going forwards are Head & Neck, Haematology, Lung and Upper GI. Indicative performance for December is currently above the national target. Achievement of the STF trajectory and operational standard at aggregate level remains a risk going forwards.

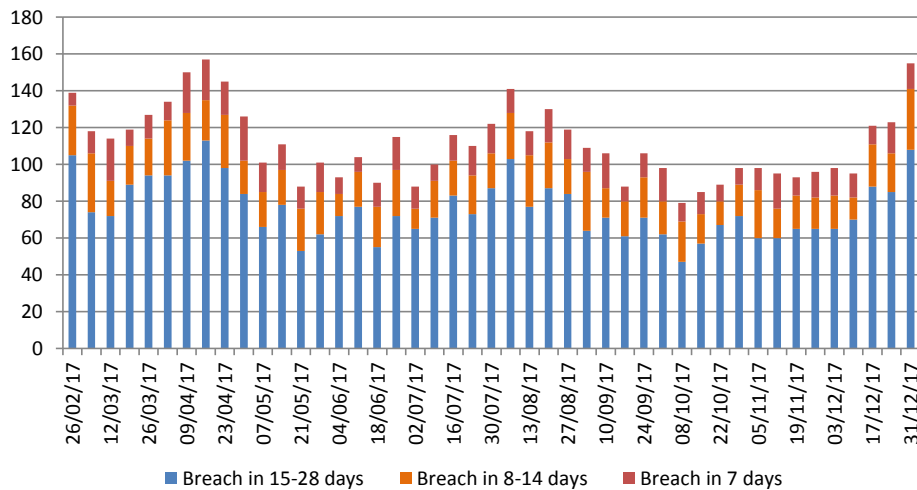
First Definitive Treatment - November 2017*	Volume	Total Breached	Performance	National Performance	YTD	Number ≥104 days
<b>Target</b>			<b>85%</b>	<b>85%</b>	<b>85%</b>	<b>0</b>
Breast	0.5	0.5	0.00%	95.2%	85.71%	0
Gynaecological	4.5	0.0	100.00%	77.0%	91.84%	0
Haematological (Excluding Acute Leukaemia)	5.5	1.0	81.82%	79.6%	83.58%	0
Head & Neck	5.0	0.0	100.00%	67.1%	76.32%	0
Lower Gastrointestinal	11.0	1.0	90.91%	72.6%	85.00%	1
Lung	2.5	1.5	40.00%	71.9%	59.65%	0
Other	0.0	0.0	-	72.0%	85.71%	0
Sarcoma	0.0	0.0	-	65.7%	33.33%	0
Skin	4.5	0.0	100.00%	95.4%	86.11%	0
Upper Gastrointestinal	4.0	0.5	87.50%	75.2%	73.85%	0
Urological (Excluding Testicular)	43.5	5.0	88.51%	78.0%	83.62%	1
<b>Total</b>	<b>81.0</b>	<b>9.5</b>	<b>88.27%</b>	<b>82.3%</b>	<b>81.84%</b>	<b>2</b>

### Non GP Referrals

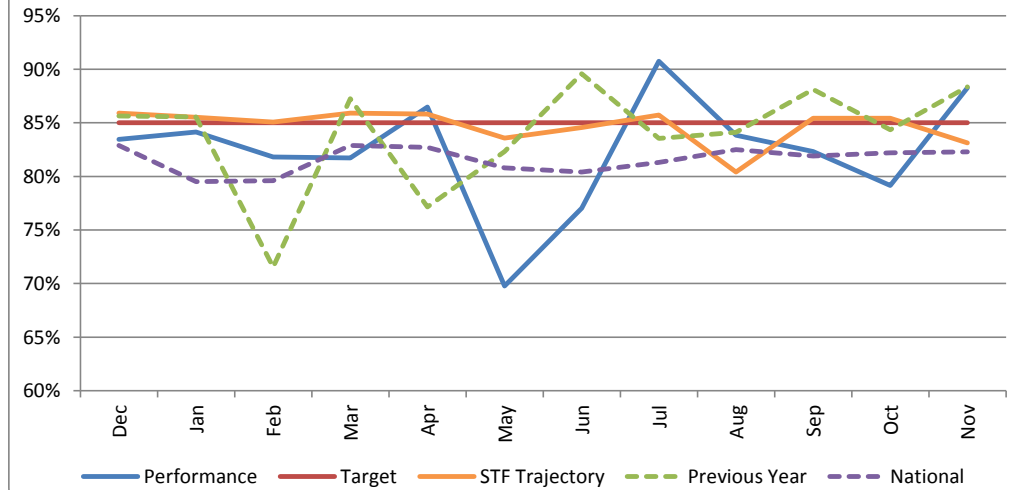
Screening (Target: 90%)	1.0	0.0	100.00%	91.0%	94.44%	0
Consultant Upgrade	5.5	1.0	81.82%	88.4%	77.78%	0

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

Cancer 62 Day - Volume Of Patients Approaching Breach Date



Trust Cancer 62 Day Wait



# 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

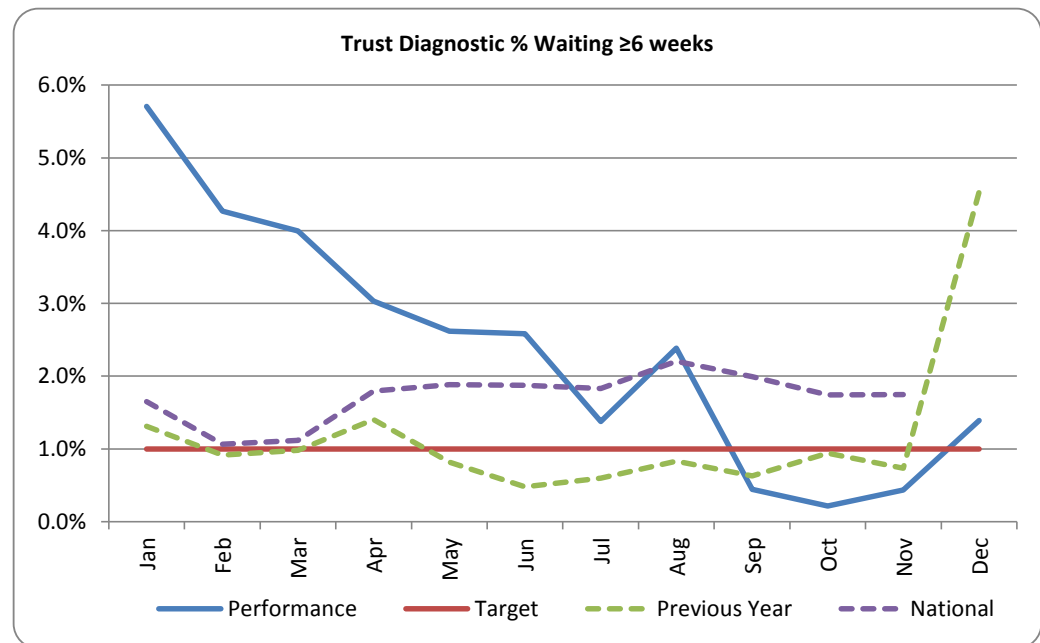
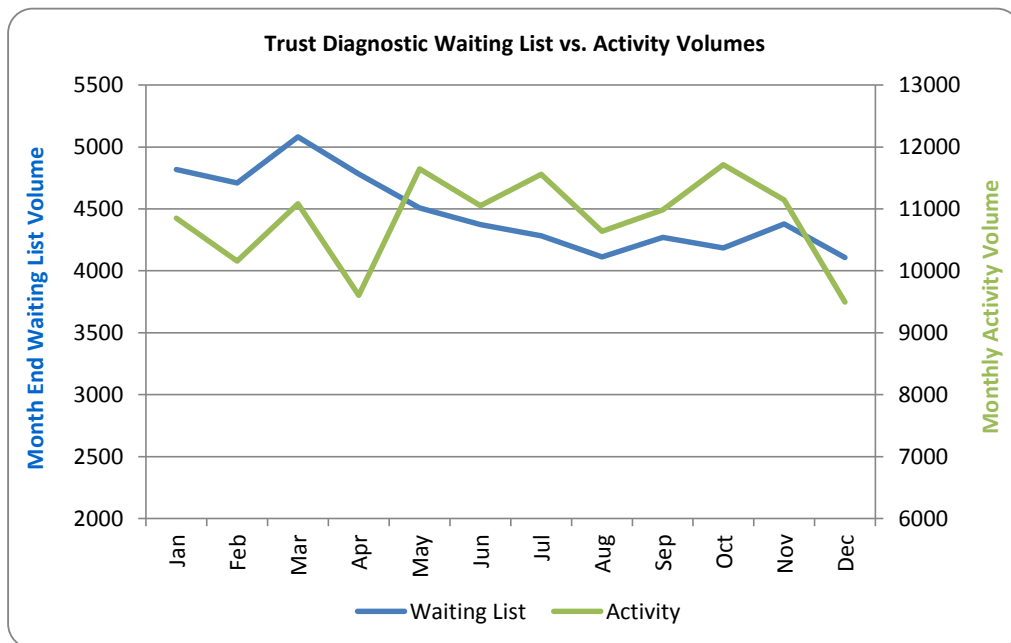
Director Lead: Sean Fenwick

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

The proportion of patients waiting 6 weeks or more at the end of December has increased to 1.39% and exceeds the national operating standard of <1%. However, it is better than the latest national average. This increase is a result of a short term reduction in capacity due to staffing issues in DEXA and ongoing capacity issues in Audiology. It is expected that DEXA capacity will improve and performance will recover in January.

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

Diagnostics - December 2017		WL Volume	No. ≥6 weeks	%≥6 weeks	Activity
<b>Target</b>				≤1%	
Imaging	Magnetic Resonance Imaging	684	0	0.00%	1,341
	Computed Tomography	212	0	0.00%	2,898
	Non-obstetric ultrasound	1,631	0	0.00%	2,218
	Barium Enema	25	0	0.00%	2
	DEXA Scan	217	30	13.82%	218
Physiological Measurement	Audiology - assessments	180	14	7.78%	794
	Cardiology - echocardiography	279	0	0.00%	824
	Neurophysiology - peripheral	104	0	0.00%	127
	Respiratory physiology - sleep studies	64	0	0.00%	61
	Urodynamics - pressures & flows	30	7	23.33%	20
Endoscopy	Colonoscopy	148	0	0.00%	206
	Flexi sigmoidoscopy	51	1	1.96%	60
	Cystoscopy	292	5	1.71%	418
	Gastroscopy	190	0	0.00%	311
<b>Trust Total</b>		<b>4,107</b>	<b>57</b>	<b>1.39%</b>	<b>9,498</b>



# 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

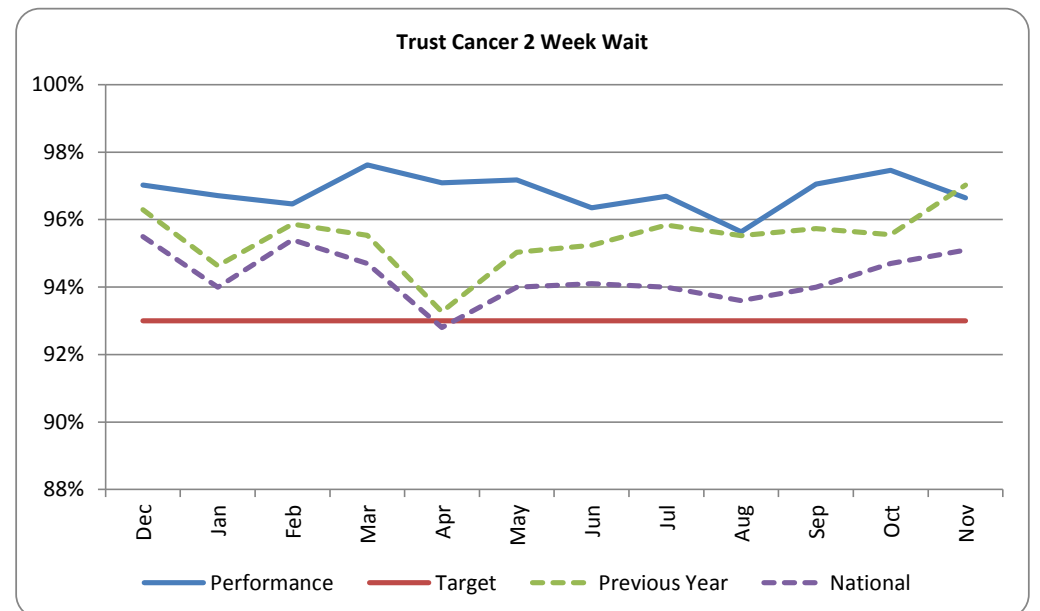
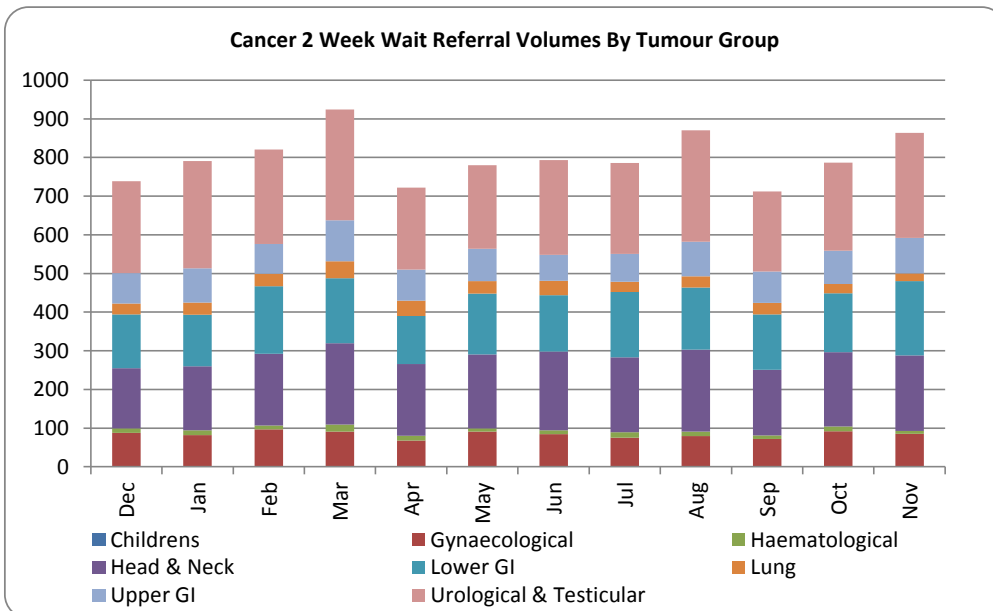
2WW performance reduced during November but remains above both the operating standard and the national average. At tumour site level, all areas achieved the target with the exception of Haematological (low volume). Most breaches were related to patient choice this month. November's performance demonstrated that all tumour groups, with the exception of Haematological, performed about the same or better than the equivalent national performance position.

Overall referral volumes increased during November. The tumour sites showing the largest increases compared to the average over the last 12 months, were Testicular (+55.7%, low volume) and Lower GI (+23.9%).

Indicative 2WW performance for December is above target.

Referrals for Suspected Cancer - November 2017*	Volume	Total Breached	Performance	National Performance	YTD
<b>Target</b>			<b>93%</b>	<b>93%</b>	<b>93%</b>
Acute Leukaemia	1	0	100.00%	100.0%	100.00%
Breast	0	0	-	96.8%	-
Children's Cancer	0	0	-	96.7%	100.00%
Gynaecological	85	4	95.29%	95.8%	96.74%
Haematological <small>(Excluding Acute Leukaemia)</small>	8	1	87.50%	96.4%	96.47%
Head & Neck	195	4	97.95%	96.5%	96.83%
Lower Gastrointestinal	192	11	94.27%	93.4%	95.42%
Lung	20	1	95.00%	96.0%	98.33%
Other	0	0	-	94.3%	100.00%
Testicular	17	0	100.00%	-	100.00%
Upper Gastrointestinal	92	3	96.74%	93.2%	95.55%
Urological <small>(Excluding Testicular)</small>	255	5	98.04%	96.2%	97.62%
<b>Total</b>	<b>865</b>	<b>29</b>	<b>96.65%</b>	<b>95.1%</b>	<b>96.74%</b>

\*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 improved during November and achieved the target at 99.4%. All tumour groups achieved the target and were better than the equivalent national average.

The average wait time in November remained the same at 8 days.

Indicative performance for December is currently above target.

The final performance for November for subsequent surgery and drug treatments were 100% and 98.81% (1 Urology) respectively.

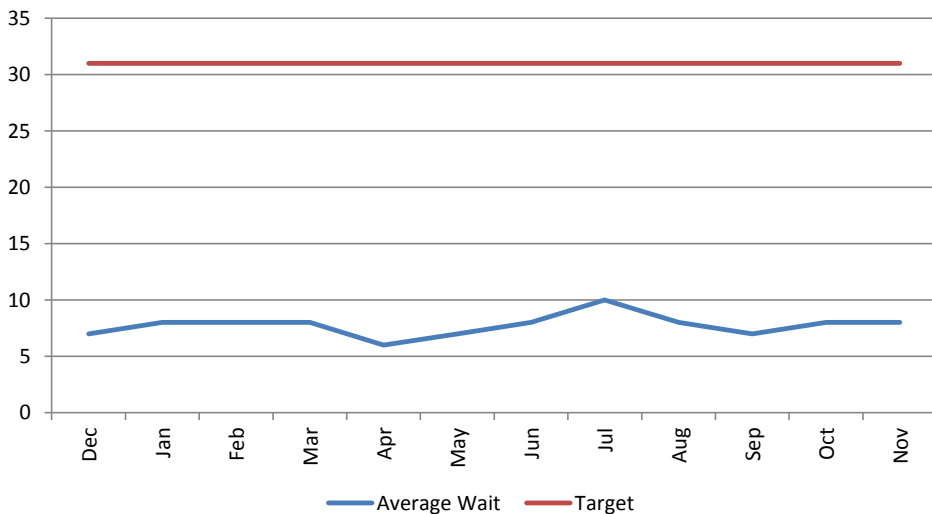
First Definitive Treatment - November 2017*	Volume	Total Breached	Performance	National Performance	YTD
<b>Target</b>			<b>96%</b>	<b>96%</b>	<b>96%</b>
Breast	0	0	-	98.7%	100.00%
Gynaecological	6	0	100.00%	96.5%	100.00%
Haematological	18	0	100.00%	99.7%	100.00%
Head & Neck	7	0	100.00%	94.6%	93.06%
Lower Gastrointestinal	22	0	100.00%	98.0%	100.00%
Lung	21	0	100.00%	98.0%	100.00%
Other	0	0	-	100.0%	100.00%
Sarcoma	2	0	100.00%	93.5%	100.00%
Skin	12	0	100.00%	97.0%	92.21%
Upper Gastrointestinal	5	0	100.00%	98.6%	100.00%
Urological	74	1	98.65%	96.1%	97.41%
<b>Total</b>	<b>167</b>	<b>1</b>	<b>99.40%</b>	<b>97.6%</b>	<b>97.93%</b>

## Subsequent Treatments

Surgery (Target: 94%)	37	0	100.00%	95.5%	96.57%
Drug (Target: 98%)	84	1	98.81%	99.5%	99.85%

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

Cancer 31 Day Average Wait



Trust Cancer 31 Day Wait

