CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

There will be a meeting of the Board of Directors 'In Public' on
Thursday, 29 March 2018 at 3:30 pm
in the Board Room, Sunderland Eye Infirmary

AGENDA

1.	**Declaration of Interest**		
2.	**Minutes**		
Item 1	To approve the minutes of the Board of Directors meeting held 'In Public' on Thursday, 25 January 2018		**Enc 1**
	Matters Arising		
	Item 2 Planning Guidance	**PS**	
	Item 2 Merger Feedback	**KWB**	
	Item 2 Care Quality Commission	**MJ**	
3.	**Standard Reports**		
Item 2	Chief Executive's Update	**KWB**	
Item 3	Quality Risk and Assurance Report	**MJ**	**Enc 3**
Item 4	Finance Report	**GMcP**	**Enc 4**
Item 5	Performance Report	**AK**	**Enc 5**
4.	**Strategy/Policy**		
Item 6	Assurance Framework 2017/18	**MJ**	**Enc 6**
Item 7	Gender Pay Gap Report	**KG**	**Enc 7**
Item 8	Information Governance Toolkit	**AJH**	**Enc 8**
Item 9	Learning from Deaths Dashboard	**ICM**	**Enc 9**
5.	**Date and Time of Next Meeting**		

Thursday 31 May 2018 at 3:30 pm in the Board Room, Sunderland Eye Infirmary.

ENCLOSURE 1

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Minutes of the meeting of the Board of Directors held in public on Thursday, 25 January 2018.

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

In Attendance: Sean Fenwick (SF)
Carol Harries (CH)
Mike Laker (ML)

Apologies: Stewart Hindmarsh

Item 1 **Declaration of Interest**

None.

Item 2 **Chief Executive's Update**

2018/19 Planning Guidance – KWB advised that this had been delayed and not helped by the late announcements for NHS funding in the recent budget statement. KWB stated that it would be well into the financial year by the time the team were submitting our plans.

Possible Merger Feedback – KWB advised that there had been relatively muted comments in the media. A number of staff had assumed we were already merged or in the process of doing it already. It may gather more interest when the CCGs make their recommendations to the Governing bodies on the first phase of the Path to Excellence clinical service reviews.

Winter Update – KWB stated that the Trust had experienced a difficult six weeks with the volume of patients and our new Emergency Department had been tested to the full. It was not

the increased number of those patients attending that was adding pressure but the acuity of those patients which then meant a longer length of stay. Clearly the sustained increase in activity inevitably put pressure on our staff and our facilities. KWB commented that discharges were working well and welcomed the support from community staff and Sunderland Care and Support. We were now also beginning to see increasing cases of norovirus which brought added pressure on top of the number of flu cases presenting and being admitted.

ICM commented that the presentation of flu cases was very different across the region and we have probably detected more cases because of the point of care testing. SF replied that point of care testing had only become live in January 2018 and the threshold had not depreciately changed.

ML queried the types of flu that were presenting. KWB replied 173 type A and 127 type B. ML commented that there were comments in the press that the trivalent vaccine which many organisations were using was not providing the cover that the quadri-valent vaccine provided. CH replied that we wait for a national steer from Public Health England but as yet that was not forthcoming as we place orders for the 2018 winter vaccine within the next few weeks.

KWB commended staff for their hard work during what had been a will undoubtedly continue to be difficult and testing time.

Care Quality Commission (CQC) – KWB advised that STFT had received their inspection before Christmas and were awaiting their report. CHS had received notification between Christmas and New Year of the provider information request which meant that we would likely have an inspection sometime in late April. MJ stated that the first inspection would be unannounced visiting clinical areas and then a month later there would be the planned inspection to look at well led.

The Chairman asked if there was any connection between STFT and our CQC visit.

KWB replied that all Trusts were to receive an inspection and clearly with a single executive team and particularly that they were looking at well led it made sense that our inspection would not be long after the STFT visit.

MJ commented that whilst she was not surprised she would have expected a longer time lag between the two.

KWB stated the CQC had also advised that if the two organisations went to formal merger then that would automatically trigger another formal inspection.

STP/ACO Process – KWB advised that Dr Sara Woolaston, Chair of the Health Select Committee had written to the Secretary of State regarding concerns about consultation of ACOs. This was set against a backdrop of LAs who were critical of the STP process and their involvement. Her review was not likely now to be complete until April at earliest to allow them to take evidence.

The Secretary of State had immediately agreed and consultation would not now be until the Spring of 2018.

The suggestions for ACOs were that there would be a small number of sites and it was unclear as to what that would mean for North Cumbria and Northumbria. KWB stated that clearly there were implications in the North East whilst ever there was a desire for a single STP.

The Chairman queried whether they would just create one entity. KWB replied that one was an organisation whilst the STP was a plan/system but there did need to be clarity.

AW commented that there was a reputational challenge etc of ACOs and giving it away to the private sector.

KWB advised that he would share the letter from the Secretary of State with NEDs.

Stepping into Health – KWB advised that he, Kath Griffin and Gemma Taylor (Workforce Development & Apprentice Manager) had attended an event in London about the Step into Health programme which had been created because the NHS recognised the transferable skills and cultural values that Armed Forces personnel develop when serving, and how they were compatible with those required within NHS roles.

KWB stated that the Trust was one of four who met personally with the Duke of Cambridge as acknowledgement of the work that we have and continue to undertake in relation to the Reserve Forces.

Item 3 **Quality Risk and Assurance Report**

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

report triangulated various sources of data to enable the detection and mitigation of any emerging risks.

MJ advised that there was some work being undertaken to reflect on the style of the report but that she would bring back further details.

MJ highlighted HDPUs and stated that despite an increase for this particular month, the Trust remained on track with its target for the year.

MJ advised that safeguarding children referrals had increased by 19 during the month although there was no identified cause for the increase. The main reason for referral was previous involvement with Children's Services. Parental mental health substance misuse, and domestic abuse continued to be dominant themes.

MJ highlighted nursing workforce issues in particular and advised that the fill rates for SRH and SEI were 94% for both sites. During the month of November, nine additional beds had been opened and there had been a number of incidents raised when RN staffing had been below "trigger" numbers. On these occasions, the duty matron implemented the nurse escalation plan and moved staff according to the level of risk.

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

MJ advised that the team were going out to the Philippines again on a recruitment campaign.

ML queried as to how many staff awaiting pre-employment checks actually translated into taking up posts. MJ replied that hopefully all of them and generally the numbers who did not have successful employment checks were very low indeed. The only real time that we "lost" individuals was in relation to student nurses who take up lots of offers and then decide at the last minute which post they will actually take up.

PMcE queried when the first tranche of student nurses would be available from the University of Sunderland and what effect that might have. MJ replied that it would be 2019 and there was a hope that all 25 of the original intake of 27 would come to CHS.

The next university intake would be up to 100 places and again we hoped that both CHS and STFT would benefit.

DB queried whether any of the university courses were targeted at HCAs. MJ replied that we had excellent pre-nursing courses here set up by Dennis Little and also worked with the university in developing the care certificate.

AW queried whether there was any improvement in the English test for overseas nurses. MJ replied that it had been revised by the NMC following national concerns and hopefully we would see the impact of that with the cohort we recruit in February. MJ stated that although the test had been revised it was not revised as much as we would have liked.

MJ also highlighted p15 and stated that there had been two SIs which we were currently investigating. There had been no never events but there would be one identified for next month for wrong site surgery.

MJ advised that Excellence Reporting continued to be a success and it was hoped to reach the 500th report by 14 February 2018, a year after the scheme was launched.

ICM informed Directors that there were no concerns regarding MRSA and *C. difficile*.

ICM also advised that the VRE outbreak declaration had been lifted following advice from Public Health England. Their advice was that evidence was 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. They had advised that we should concentrate our efforts, not on identifying carriers, but on basic environmental cleanliness and infection control. It was therefore agreed in December to stop screening and to stop attempts to chase down contacts.

ICM also updated Directors on the national audit of dementia and the SSNAP programme for stroke, the results of which for the latter were disappointing. It was expected that we would see improvement in the next round of audit.

MJ highlighted the mid-term review of quality priorities and in particular those areas identified as requiring additional work to achieve targets set:

- Clinical review for hospital associated thrombosis;
- Assessment and management of patients with sepsis in both ED and inpatient environments;
- The quality of DNACPR documentation; and
- The improvement of the recording of fluid management documentation.

MJ stated that feedback would be provided to quality leads in each of the areas to ensure plans were amended to help reach the targets.

MJ also informed Directors that a joint risk management strategy was being prepared and a new joint policy on risk management.

Resolved: To accept the report.

Item 4 **Finance Report**

JP presented the report which identified an overall operational financial position including STF as a net deficit of £5,557k against a planned deficit of £5,473k, and therefore £84k behind plan.

The Trust position compared to the control total excluding any adjustments was £11,431k deficit compared to a plan of £11,475k deficit therefore £44k ahead of plan.

In terms of clinical income the Trust was £1.9m behind with Durham CCG. In 2016/17 we had agreed contracts which were lower than plan because of the introduction of a number of QIPP plans which had not come to fruition. This year the CCG had introduced their plans which were now working and consequently cash wise we were behind plan. Conversely however, we were over-performing on specialised contracts and the temporary variation for stroke.

JP advised that pay was overspent by £613k against plan reflecting increased agency costs to cover medical staff gaps.

PT queried the agency cap and if we were over then what would be the sanctions. JP replied that this would take us to a '4' on the risk rating matrix and then that would mean formal intervention. NHS Improvement recognised however, that agency costs were linked to the step up for winter.

Non pay costs were overspent by £3,062k some of which was related to drugs which was a straight pass through, clinical supplies and diagnostics.

JP advised that the CIP position was currently an over delivery of £136k.

CIP plans to date had identified £12.4m of the £13m target for this year and despite the risk the Trust expected to be in line with the plan of £13m.

JP stated that cash was a significant pressure and our plans assumed that we would receive STF Q3 funding in March. JP stated that we had never received STF funding on time so this was a risk going forward.

JP highlighted the likely, best, and worst case positions. JP advised that a number of assumptions had been made with regard to the funding gap, receipt of STF and the value of the capital programme.

Taking those into account, it was estimated that the Trust could run into cash difficulties in May 2018 with the Group, including CHoICE running out of cash in July or August 2018. JP stated that plans were being put in place to enable the Trust to apply for interim cash support and would be discussed in more detail in the budget setting paper.

JP stated that delivery of the control total for 2017/18 was a risk although we were working through a number of measures to improve this position.

JP also highlighted section 10, Trust guarantee for subsidiary company. CHoICE had recently taken on the responsibility for the procurement and management of goods, including new equipment. As they had a limited trading history, the Trust is often asked to provide indemnity or a guarantee should the company go into liquidation – usually in the form of a letter. JP advised that on this occasion relating to the procurement of Olympus endoscopy equipment the leasing company were asking for a formal agreement by the Board and sign off of the 'Deed of Guarantee'. PT queried whether signing something like that did not compromise the arm's length status. JP replied that this had been checked by the legal team and it did not. KWB commented that it sounded like a blanket indemnity.

PT suggested that we formally minute that it was only for a specific piece of equipment. AW stated that the issue had come up at Competitive Tendering Committee and we did need to keep a watching brief as if we did not sign then it may compromise their pricing structure.

Resolved:

- **To note the financial position to date; and**
- **To sign the 'Deed of Guarantee' acknowledging that this was only for the specific piece of equipment i.e. Olympus endoscopy equipment.**

Item 5 **Initial 2018/19 Budget Setting Paper**

JP presented the paper which provided initial budget setting principles for 2018/19. Further detail including financial impacts would be provided at Divisional level after contractual information for 2018/19 had been finalised.

JP also advised that NHS Improvement would request that all Trusts make an annual planning submission by mid-February although planning guidance was yet to be received. Budgets within the papers were in line with values included within the annual plan submission.

JP stated that the starting point for 2018/19 budgets was roll over of the budgets from 2017/18 with key adjustments made for CIPs, inflation, and contracting charges etc which aligned with the approach used for the past two financial years. At this early stage clinical income levels had been assumed for the Trust based on a mixture of offers received from commissioners plus Trust assumptions on expected contract values for 2018/19.

PT queried whether we were still expecting block contracts from Sunderland and South Tyneside CCGs. PS also stated that an additional £400m was expected to go to CCGs but presumably only those with a forecast deficit and in which case only Northumberland and North Tyneside were likely to get something.

PS queried whether there was any opportunity to access “old” money held centrally by CCGs. KWB replied that there was some potential but it was quite a complicated picture.

PT commented that CCGs would always have had a three year plan with NHS England as to how they would claw back monies.

KWB stated that Alan Foster was keen to get all overspends into CCGs which would then get £110m into the region.

JP highlighted expenditure assumptions and advised that appendix 4 stated a recurrent deficit of £29,267m. There were a range of adjustments including pay awards, reduction of NHSLA premium and developments.

JP stated that appendix 1 detailed the CIP profile over the past five years etc and the detailed allocation of CIP targets to clinical areas would be discussed in greater detail through the Finance and Performance Committee prior to the completion of final budget setting papers.

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

Non achievement of the control total would have a significant impact on the Trust's cash position. JP advised that even after exploring a number of options to mitigate the Trust not having enough cash resource to meet its obligations, it was recommended to submit an application for interim cash support. JP stated that the Trust would need the cash by May 2018 and it was a three month approval process.

JP asked that the Board approve to give delegated authority to KWB to sign off the loan application.

This was confirmed by the Board members. JP commented that the single biggest opportunity was some joint work across the two Trusts and the wider health economy.

DB commented that there were so many "ifs" and "buts" however, we needed to put forward a proposal for the size of the loan which may change but was unlikely to improve. DB also advised that we would not draw down the loan until we actually needed it. 80 out of the 135 Trusts were patently in deficit and therefore it was a national problem. JP stated that she was assuming that the 80 were all acute Trusts.

JP also advised that if we were to get the loan then we could sign off as a going concern whilst there are clear financial risks facing the Trust in 2018/19 and beyond, cash support and gain approval of the financial recovery plan then these risks would not be considered to represent a threat to the continuity of services provided by the Trust and hence its ability to continue as a going concern.

PMcE queried that if 80 Trusts had applied and it was a three month process it was presumably quite tight given our position. JP replied that there was a back-up of distressed funding if we needed that approach but the last time she had looked at this the rate was 6%.

KWB stated that given some of the issues to be resolved he suggested that the recommendation be changed to approve the draft budgets.

Resolved:

- **To approve the draft revenue budgets for 2018/19;**
- **To note the view that the Trust continues to report as a 'Going Concern'; and**

- **To give delegated authority to the Chief Executive to sign off the loan submission.**

Item 6 **Performance Report**

AK presented the report which updated Directors on performance against key national targets for December 2017.

AK advised that A&E failed to achieve the 95% target and deteriorated to 83.7% due to winter pressures. Performance for January stood at 82% reflecting operational pressures. AK stated that in December the Trust had moved to the lower middle quartile of Trusts nationally since December 2015.

ML queried that as we had moved from the second to the third quartile would that effect how the figures were calculated. SF replied that it was about the type of activity that we count where predominantly our activity was type 1 although we did have some type 3 activity from Pallion. The other type 3 centres across the City were not managed by us and therefore we could not count their activity.

AK stated that it was really difficult to know if our performance had deteriorated as we were not comparing apples with apples. KWB commented that North Tees for example are one of those organisations that can count both and that will have a material impact on performance.

SF stated that there was a meeting in Manchester where this issue was discussed but the recommendations from that meeting have never been actioned nationally. He also commented that North Tees see less people than we have number of ambulances arriving and they have the same number of consultants.

SF also informed Directors that to date the total number of flu cases was 65 although not all individuals had been admitted as a result.

AK advised Directors that RTT remained above target at 93.73% whereas national performance was 88.2%.

Cancer targets were also extremely positive with the Trust achieving all cancer waiting time standards.

AK advised that diagnostic performance had failed to achieve the national operating standard at 1.39%. This was because of capacity issues in Audiology. It was expected that performance would improve during January.

Resolved: To accept the report.

John Anderson
Chairman

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DIRECTORATE OF NURSING & PATIENT EXPERIENCE

BOARD OF DIRECTORS

MARCH 2018

QUALITY, RISK AND ASSURANCE REPORT (JANUARY 2018)

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

- High levels of nurse vacancies in CHSFT and STFT

RECOMMENDATION

Directors are asked to note the report.

Melanie Johnson
Director of Nursing & Patient Experience

Ian Martin
Medical Director

City Hospitals Sunderland
NHS Foundation Trust

South Tyneside
NHS Foundation Trust

Quality, Risk and Assurance Report

January 2018

PATIENT STORY
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

CHSFT:

A gentleman sent this letter to the Help and Advice Service to compliment the care and treatment he had received following an injury which required surgical intervention:

"Recently, the NHS has come in for severe criticism in the media regarding delays and cuts, however, I feel that I must comment on my recent experience. On 1 January 2018 I had a domestic accident in which I practically amputated my nose on the glass of a door. I had considerable blood loss. My wife contacted the 999 service requesting an ambulance.

She was given calm and clear advice on how to treat me until the arrival of the ambulance paramedics. They promptly arrived and stabilised me. Another paramedic, a trauma specialist, arrived and together they concluded that the best course of action was to take me to Sunderland Royal Hospital, having been advised that a suitable surgeon was available, rather than take the longer journey to Newcastle RVI.

After transfer to Sunderland Royal Hospital, I was promptly admitted and, since the operating theatre was not immediately available, a start was made on my treatment. When I was transferred to the theatre, I had surgery for three hours. The skill of the surgeons not only saved my nose but probably my life too.

After being moved to Ward C33 to recuperate, I received great care as my condition required.

My wife and I would like to pay a tribute to all the NHS staff who dealt with me, the 999 call centre, paramedics, surgeons, doctors, nurses and health care staff. Their service was first class."

STFT:

A gentleman who has attended the Emergency Department on numerous occasions contacted the Trust to pay a compliment for the way in which he has been looked after over the past year.

He said *"I'm a chronic alcoholic and have been admitted to the A&E department, EAU and ward 3 on numerous occasions with acute withdrawals and chronic sickness. The staff have been caring, kind and considerate and treated me with dignity on nearly every occasion. On A&E the staff were very busy and on most occasions treated me without delay and I believe they have saved my life due to professional work ethic. Excellent nurses, the nurses were always polite and lovely.*

With regard to EAU the staff were fantastic every time I was admitted – caring, always made me feel I wasn't just a number and just a man with a massive problem. Excellent nurses, they were always polite and lovely. On ward 3 the staff were brilliant every time I was admitted and always made me feel I was worth treating and made me feel I wasn't worthless as an alcoholic. Excellent nurses, they were polite and lovely. With regard to the medical staff, the doctors were very professional and treated me with care at all times.

I appreciate that as a chronic alcoholic I'm a drain on your resources when the Trust is under extreme pressure when I've been admitted so many times. I would like to pass on my profound appreciation to all three units. The hospital gets a lot of bad press in the local papers, obviously I don't speak for anyone else but for me if I needed to be treated I would not hesitate to go to South Tyneside."

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 which aims to reduce the incidence of avoidable category 2 to 4 Healthcare Developed Pressure Ulcers (HCDPUs) by 25% each year by April 2019.

1.1.1 Hospital Developed Pressure Ulcers (HDPUs)

Figure 1 indicates the incidence of HDPUs that occurred in January. The rate of HDPUs per 1,000 occupied bed days is also provided to compare improvement over time.

Figure 1: Numbers of HDPUs by category for January 2018

Category	CHSFT		STFT (Acute Services)	
	This month	Last month	This month	Last month
Category 2	32 ↑	24	40↑	27
Category 3	0	0	2	0
Category 4	0	0	2	0
Total PUs	32 ↑	24	44↑	27
No. of patients with PUs	27 ↑	17	25	23
Rate per 1,000 bed days	1.67 ↑	1.35	4.94↑	3.22

Within CHSFT, there has been a significant increase in HDPUs this month, which follows the pattern of increased patient harm noted in January. This relates to winter pressures:- increased patient acuities and nurse staffing shortages across the Trust. The highest incidence of HDPUs this month occurs in Rehabilitation & Elderly Medicine (REM). February data indicates a decrease in HDPUs with 28 being reported.

Within STFT, the number of HDPUs has also increased this month but this relates to one patient who developed multiple HDPUs categories 2 to 4. This case is under review. The highest incidence of HDPUs this month occurs within the Medicine and Elderly Care directorate and as in CHS, winter pressures (increased patient acuities and nurse staffing shortages) across the Trust are having an impact. February data indicates a decrease in HDPUs with 24 being reported.

1.1.2 Community Developed Pressure Ulcers (CDPUs) – STFT

Figure 2 indicates the incidence of CDPUs that occurred in January. The rate of CDPUs per 10,000 CCG population is also provided to compare improvement over time.

Figure 2: Numbers of CDPUs – STFT – by category for January 2018

Category	Sunderland Community Services		South Tyneside Community Services		St Benedict's Hospice		OVERALL TOTALS	
	This month	Last month	This month	Last month	This month	Last month	This month	Last month
Cat 2	27	36	16	1	2	2	45↑	39
Cat 3	0	0	0	0	0	0	0	0
Cat 4	3↑	0	0	0	0	0	3	0
Total PUs	30	36	16↑	1	2	2	48↑	39
No. of patients with PUs	25↑	24	14↑	1	2	2	38↑	27
Rate per 10,000 CCG population	1.13↓	1.38	1.15↑	0.07	-	-	-	-

Within STFT Community Services there has also been an increase in CDPUs this month and the numbers include three category 4 PUs in which omissions in care were identified and further investigation has been recommended.

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. Figure 3 indicates the number of APUs for CHSFT & STFT.

Figure 3: Total number of APUs per month December 2016 to January 2018

	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18
CHSFT	225	271	231	198	187	177	165	153	168	129	165	137	175	177
STFT	114	142	139	123	180	155	135	140	140	132	154	162	195	226

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

Figure 4 shows numbers of HDPUs (primary axis) and APUs (secondary axis) for CHSFT over the last 14 months.

Figure 5 shows numbers of HDPUs and the number of CDPUs (primary axis), and APUs (secondary axis) for STFT over the last 14 months.

Figure 4: CHSFT HDPUs and APUs from December 2016 to January 2018

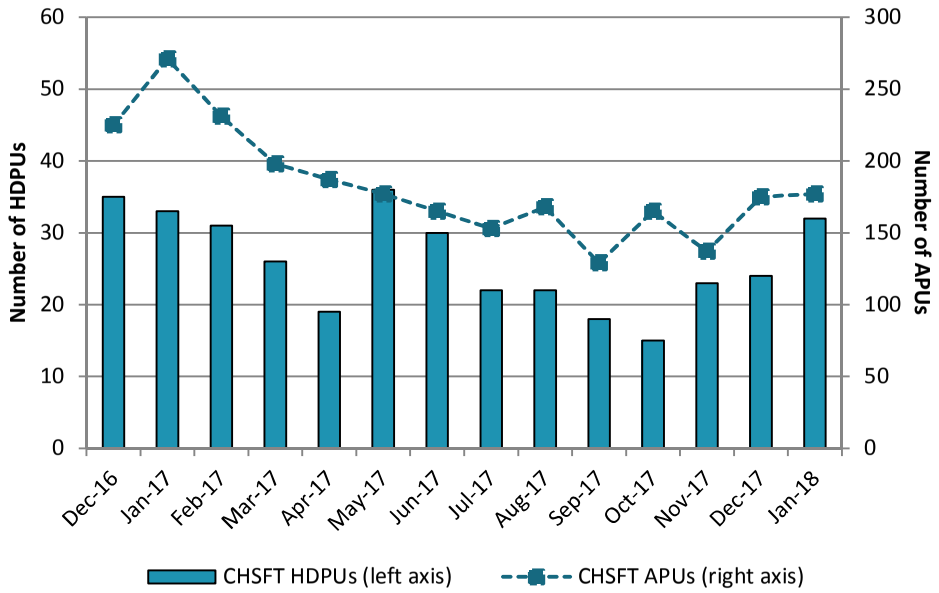
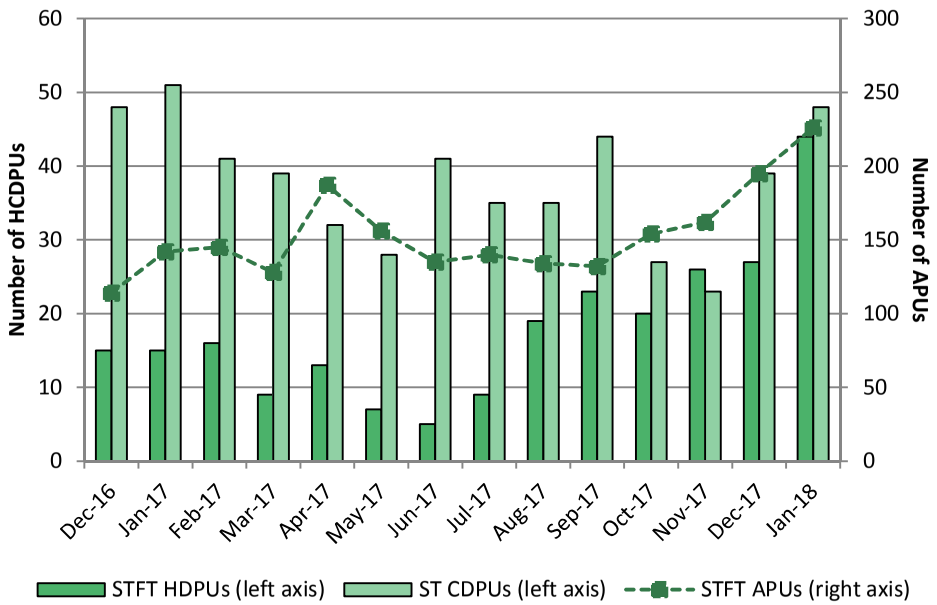


Figure 5: STFT HDPUs, APUs and CDPUs from December 2016 to January 2018



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

1.3 TRUST PERFORMANCE AGAINST IMPROVEMENT TRAJECTORY

Figures 6, 7, 8 and 9 show the rate of PUs together with the improvement trajectories for CHSFT and STFT Acute & Community Services (Sunderland and South Tyneside localities) for the previous 14 months.

Within CHS, performance is currently not on track with the improvement target/trajectory, due to the notable increase in HDPUs this month.

Within STFT, the numbers of HDPUs have significantly increased compared to last month resulting in performance being considerably off track with the improvement/target trajectory at 4.94 per 1,000 bed days. This is likely to be the seasonal winter pressures and increased patient acuity but as the monthly figures continue to rise, the Tissue Viability team are closely reviewing the data to scrutinise practice on the identified wards and target education and training.

For South Tyneside Community Services, the rate of CDPUs per 10,000 CCG population has increased to 1.15 which has put them slightly above their improvement trajectory this month. The rate for Sunderland Community Services has reduced to 1.13 keeping them on track with performance.

Figure 6: CHSFT Hospital Developed Pressure Ulcers (HDPUs) per 1,000 bed days from December 2016 to January 2018 with improvement trajectory

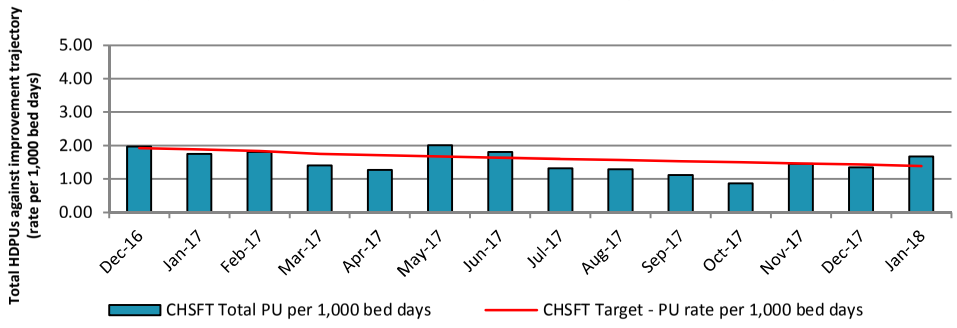


Figure 7: STFT Hospital Developed Pressure Ulcers (HDPUs) per 1,000 bed days from December 2016 to January 2018 with improvement trajectory

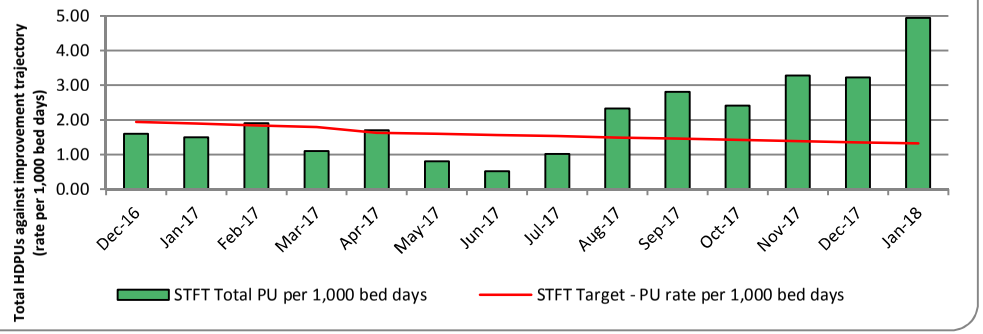


Figure 8: STFT Community PUs per 10,000 CCG for Sunderland locality from December 2016 to January 2018 with improvement trajectory

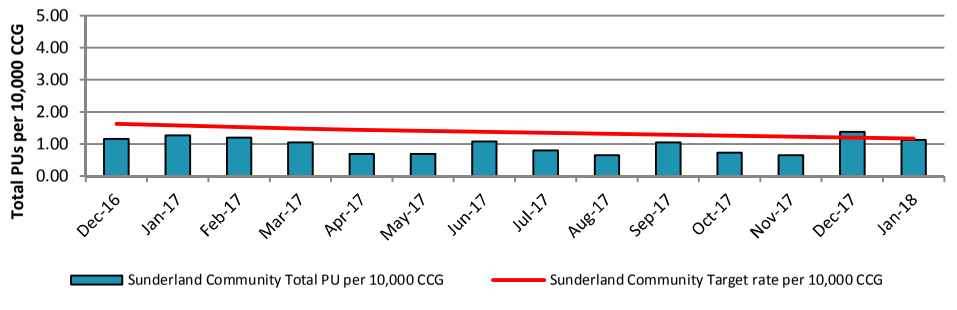
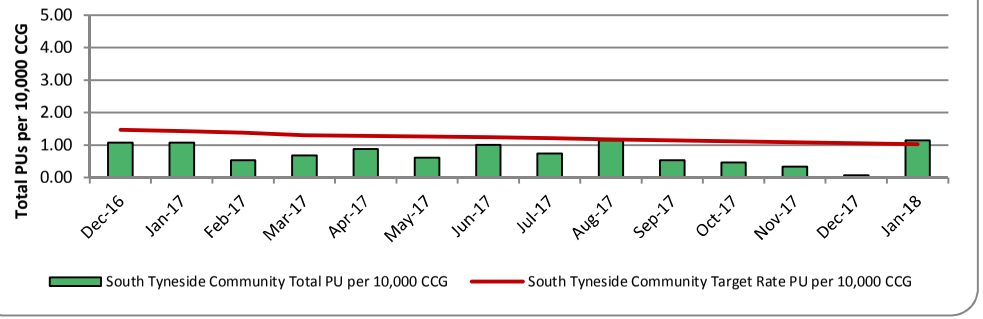


Figure 9: STFT Community Developed PUs per 10,000 CCG for South Tyneside locality from December 2016 to January 2018 with improvement trajectory



SAFEGUARDING CHILDREN
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.4 SAFEGUARDING CHILDREN

CHSFT

Figure 10 demonstrates the breakdown of safeguarding children referrals.

- Of the 13,362 patients attending adult ED, paediatric ED, and SEI, 0.6% (↓) resulted in referrals.
- Of the of 299 pregnancy bookings, 14% (↑) resulted in referrals.

STFT

Figure 11 shows the breakdown of safeguarding children referrals.

- Of the 5,752 patients attending adult ED and paediatric ED, 014% resulted in referrals.
- Of the 138 pregnancy bookings, 5.1% resulted in referrals. The Maternity and SCBU reopened on 22 January, therefore the referrals remain low due to the closure of the departments for the first three weeks of January.

The loss of the 0-19 years contracts for Sunderland and Gateshead will have direct impact on the Safeguarding team in the community, resulting in plans to review the team structure.

STFT and CHSFT

The themes for ALL referrals were due to the Toxic Trio, adolescents presenting with mental health/overdose issues and previous Social Services involvement.

The national Child Protection Information Sharing (CP-IS) systems will be live by March 2018.

Figure 10: CHSFT Safeguarding children referrals February 2017 to January 2018

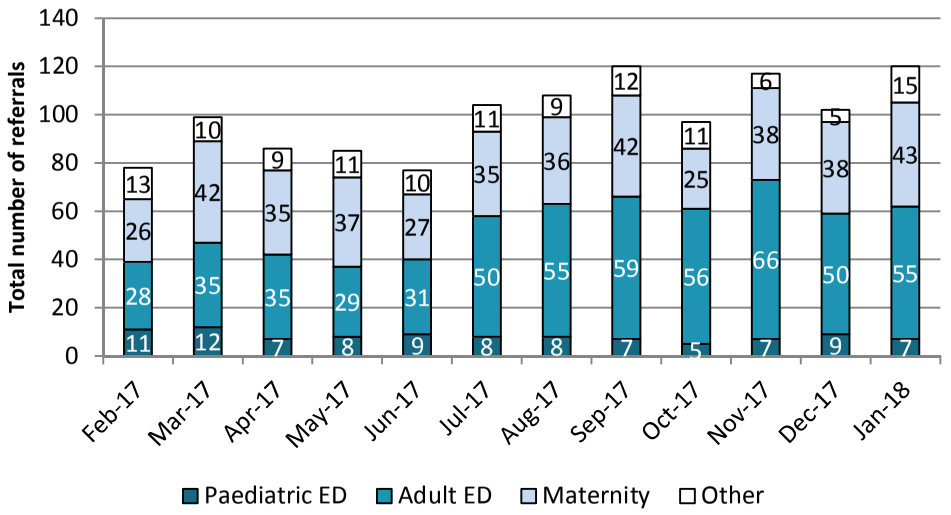
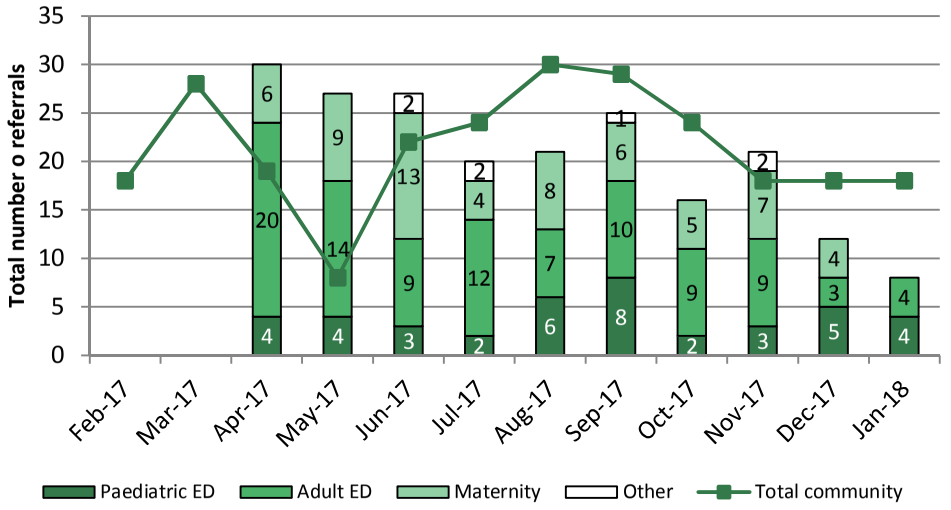


Figure 11: STFT Safeguarding children referrals February 2017 to January 2018 (acute data collected from April 2017)



SAFEGUARDING ADULTS
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.5 SAFEGUARDING ADULTS

CHSFT

Figure 12 shows the breakdown of safeguarding adult referrals.

- Of the 10,418 patients, attending adult ED, SEI and 0.18% (↑) resulted in referrals.

STFT

Figure 13 shows the breakdown of safeguarding adult referrals.

- Of the 4,352 patients (over the age of 18) attending adult ED, 0.2% (↓) resulted in referrals.

STFT and CHSFT

The themes for ALL referrals were due to neglect, self-neglect, physical abuse, domestic abuse, financial abuse, sexual abuse and modern slavery.

A hospital IDVA is available within both CHSFT and STFT to support staff in recognising and responding to disclosures of domestic abuse. The Office of the Police & Crime Commissioner has confirmed additional funding to support the STFT IDVA and additional funding is being sought for CHSFT.

The Homelessness Reduction Act (HRA) was introduced to the House of Commons as a Private Members Bill in summer 2016 and secured Royal Assent in April 2017. The Act will come into effect on 3 April 2018. A briefing on the issue will be presented separately.

Figure 12: CHSFT Adult safeguarding referrals received February 2017 to January 2018

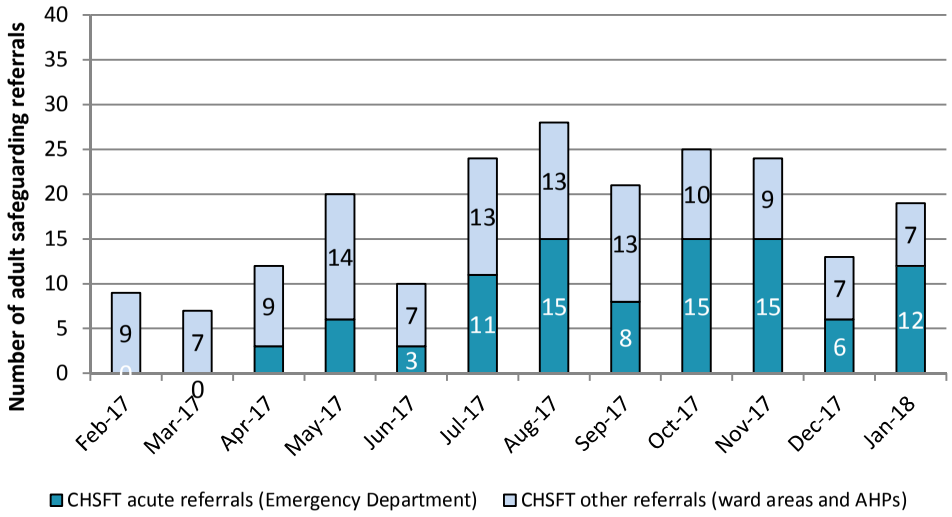
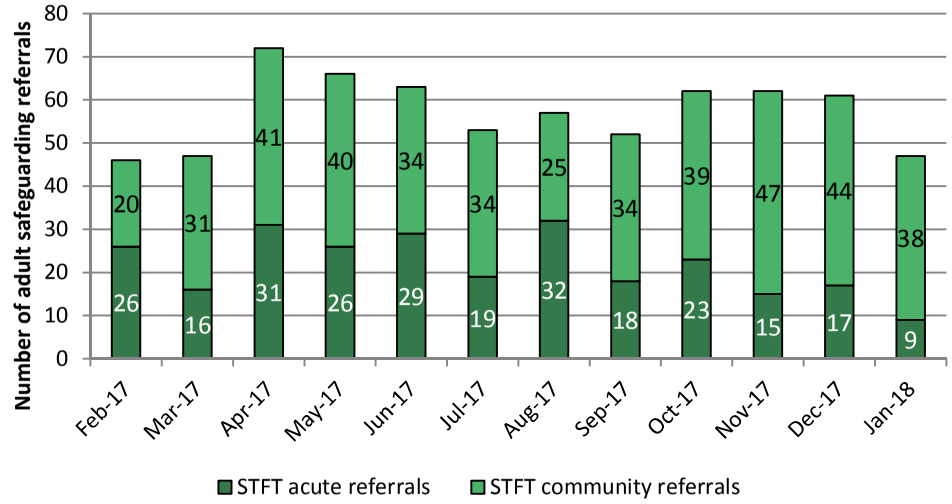


Figure 13: STFT Adult safeguarding referrals received February 2017 to January 2018



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

1.5 SAFEGUARDING ADULTS (continued)

Mental Capacity Act: Deprivation of Liberty Safeguard (DoLS)

CHSFT

Figure 14 demonstrates the number of DoLS applications and the numbers of DoLS granted by the Local Authority.

- Of the 9,525 inpatients, 139 applications were completed (1.45%).
- Nine approved with three awaiting an outcome.
- All others (127) were not approved due to the patient being discharged, regaining capacity or deceased.

The DoLS process has been reviewed to proactively seek information on discharge, transfer, death and regaining of capacity internally rather than waiting for notification from the Local Authority. Further work will now progress across both Trusts to ensure all referrals are robust and appropriate.

STFT

Figure 15 demonstrates the number of DoLS applications and the numbers of DoLS granted by the Local Authority.

- Of the 2,332 inpatients, 39 applications were completed (1.67%).
- 17 approved with three awaiting an outcome.

All others not progressed due to patients discharged, regaining capacity or deceased.

Figure 14: CHSFT Number of DoLS applications made February 2017 to January 2018

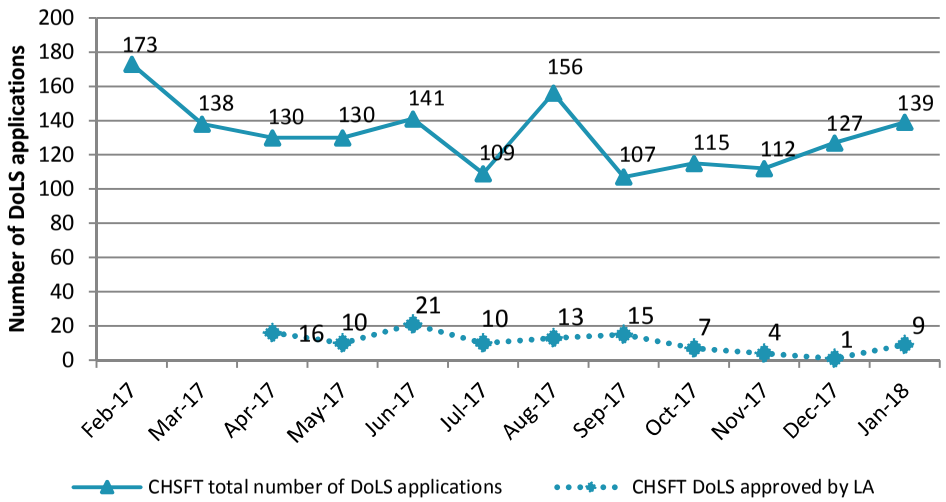
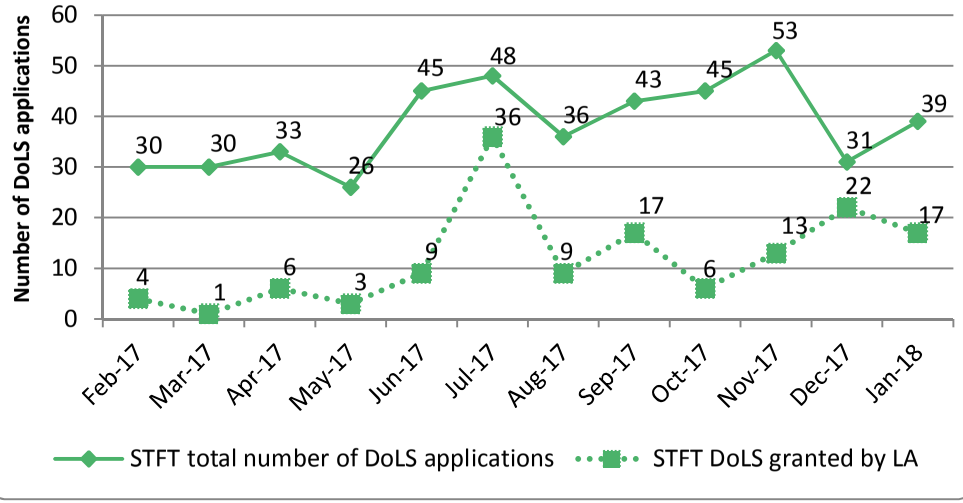


Figure 15: STFT Number of DoLS applications made February 2017 to January 2018



COMPLAINTS
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.6 COMPLAINTS

CHSFT

There were 39 complaints received in January 2018, with a year to date average of 36 per month.

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

Figure 16 shows there are 34 formal complaints awaiting a first written response (by working days), compared to 25 last month. There are no complaints awaiting a first response for more than 60 days. The four complaints in the 26-60 days category are delayed due to comments being requested from other Trusts or organisations. We continue to maintain the significant improvements made in 2016/17 and performance is still being closely monitored through weekly meetings.

Figure 17 shows CHS formal complaints by category.

There has been one new PHSO case received in January at CHSFT.

Figure 16: CHSFT current formal complaints awaiting first response by working days - November to January 2018

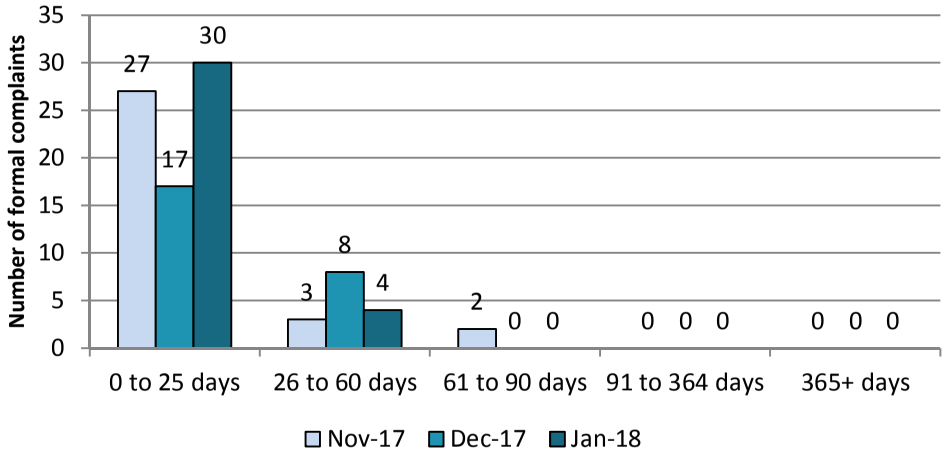
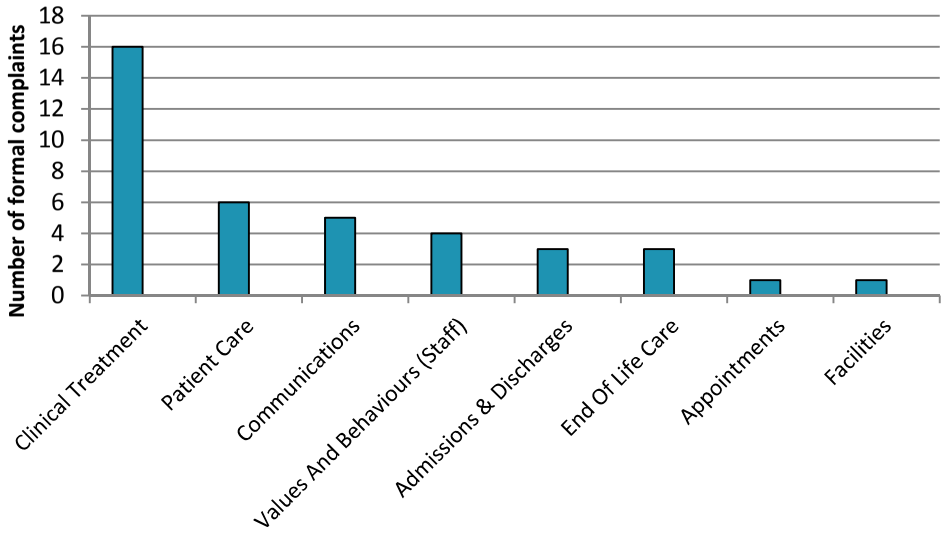


Figure 17: CHSFT Formal complaints by category - January 2018



COMPLAINTS
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.6 COMPLAINTS

STFT

There were 18 complaints received in January, 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 January shows that 100% of complaints were acknowledged within this timeframe.

Figure 18 shows there were 19 formal complaints awaiting a first written response (by working days). There were three complaints awaiting a first response for more than 26 working days and holding letters were sent to the complainants. The delays were due to the number of issues raised and the complexity of the cases.

Figure 19 shows STFT formal complaints by category.

There have been no new PHSO cases received in January at STFT.

Figure 18: STFT current formal complaints awaiting first response by working days - November 2017 to January 2018

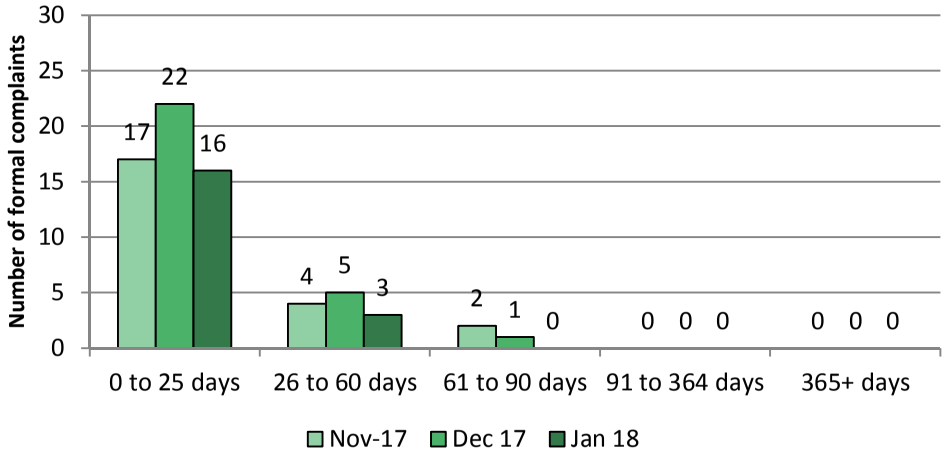
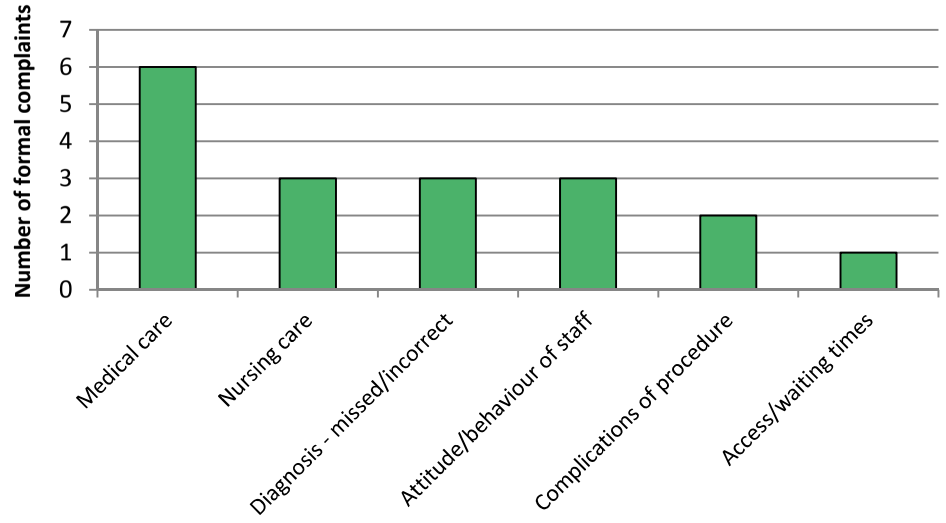


Figure 19: STFT Formal complaints by category - January 2018



SOCIAL MEDIA AND ONLINE PATIENT FEEDBACK
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.7 SOCIAL MEDIA AND ONLINE PATIENT FEEDBACK

All feedback from patients and carers is important to both Trusts and should be seen as an opportunity to learn and continually improve the quality of services.

Work is currently progressing to develop more robust processes for monitoring and responding to all online comments and making sure that the wealth of patient feedback about the Trusts' services, which is regularly shared online, can be routinely captured and fed back into both Trusts as part of the 'quality, risk and assurance' reporting process and acted on as appropriate by directorates and divisions. This will include patient feedback from ratings websites such as NHS Choices and Care Opinion, as well as social media platforms such as Facebook (which has its own ratings system) and Twitter.

A more structured approach will form a critical part of the Trusts' quality strategy moving forward and will allow early identification of any potential emerging issues, or recurring themes, which will often first manifest online given the immediacy of social media and tendency for people to use it to express opinions.

This work is in its infancy, however, this section of the QRA report will develop in future months as work progresses to reflect this important source of patient experience feedback. The ultimate ambition is to bring all sources of qualitative feedback (positive and negative) together to highlight any themes and trends in the following areas:

- Patient complaints
- Social media and online sources
- Patient experience measurement programme
- Help and advice service (CHS)
- Customer services team (STFT)

Data for December includes NHS Choices and Care Opinion feedback only.

City Hospitals Sunderland NHS Foundation Trust – December 2017

Date posted	Source	Directorate	Site	Overall tone	Key themes
6.12.17	Care Opinion	Bariatric	Sunderland Royal	Positive	Care, aftercare, compassion
27.12 17	NHS Choices / Care opinion	C33	Sunderland Royal	Positive and negative	Good care and food, poor discharge information
19.12.17	NHS Choices / Care opinion	Children's A&E	Sunderland Royal	Negative	Delay in receiving follow-up appointment
18.12.17	NHS Choices / Care opinion	Diabetic Medicine	Sunderland Royal	Negative	Unsafe discharge
21.12.17	NHS Choices / Care opinion	Emergency Department	Sunderland Royal	Positive	Praise for receptionist
21.12.17	NHS Choices	Emergency Department	Sunderland Royal	Positive	Professionalism of staff
22.12.17	NHS Choices / Care opinion	Emergency Department	Sunderland Royal	Positive	Helpful, caring and understanding staff
29.12.17	NHS Choices / Care opinion	Emergency Department	Sunderland Royal	Negative	Slowness of response
14.12.17	Care Opinion	Urgent Care	Pallion	Negative	Complaint about difficulty being seen and treated
27.12.17	NHS Choices / care opinion	Emergency Department, orthopaedics, radiology, urology and discharge departments	Sunderland Royal	Positive and negative	Care, compassion, efficiency. Some negative comments about Chairs in urology
7.12.17	Care Opinion	F63	Sunderland Royal	Positive	Care, compassion
15.12.17	NHS Choices	Haematology	Sunderland Royal	Positive	Staff going above and beyond
7.12.17	Care Opinion	Head and Neck	Sunderland Royal	Positive	Care / compassion, quality
9.12.17	Care Opinion	Maternity	Sunderland Royal	Positive	Care, Teamwork

City Hospitals Sunderland NHS Foundation Trust – December 2017					
Date posted	Source	Directorate	Site	Overall tone	Key themes
16.12.17	Care Opinion	Maternity	Sunderland Royal	Positive	Outstanding care, staff going above and beyond, compassion
28.12.17	Care opinion	Maternity	Sunderland Royal	Positive	Care, compassion
13.12.17	Care Opinion	Mental Health Services	Sunderland Royal	Negative	Complaint about care and response
24.12.17	NHS Choices / Care opinion	Phoenix Unit	Sunderland Royal	Positive	Care , compassion, staff going above and beyond
13.12.17	NHS Choices	Urology	Sunderland Royal	Positive and negative	Praise for efficiency of staff, complaint about the accommodation
13.12.17	Care Opinion	Urology	Sunderland Royal	Positive and negative	Care, compassion, complaint about accommodation move
19.12.17	NHS Choices / Care opinion	Ward 22	Sunderland Royal	Positive	Pleasant and professional staff
22.12.17	Care opinion	A&E	Sunderland Eye	Positive	Professional and caring staff / excellent care
8.12.17	NHS Choices / Care Opinion	Mayling Ward	Sunderland Eye	Positive	Professional, caring staff
9.12.17	NHS Choices / Care Opinion	Ophthalmology (cataract surgery)	Sunderland Eye	Positive	Efficient, professional, patient-focused care
12.12.17	NHS Choices / Care Opinion	Ophthalmology (cataract surgery)	Sunderland Eye	Positive	Reassuring, pleasant, approachable staff,
14.12.17	Care Opinion	Opthalmology	Sunderland Eye	Positive	Care, compassion, treatment
19.12.17	NHS Choices / Care opinion	Haygarth Ward (Macular)	Sunderland Eye	Positive	Good care
19.12.17	NHS Choices / Care opinion	Emergency Department	Sunderland Eye	Positive	Good care

South Tyneside NHS Foundation Trust – December 2017					
Date posted	Source	Directorate	Site	Overall tone	Key themes
10.12.17	NHS Choices / Care Opinion	A&E / AEU / Ward 5	South Tyneside District Hospital	Positive and negative	Good care / complaint about heating system
27.12.17	NHS Choices / Care Opinion	A&E	South Tyneside District Hospital	Negative	Rudeness of staff, lack of professionalism

NURSING WORKFORCE
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.8 NURSING WORKFORCE

CHSFT

During the month of January, 15 additional beds were opened on E54 annexe, as part of the winter plan, and nine additional beds on D46 continue to be open. These beds are over and above those identified in the winter plan.

In January the total absences for RNs was 12.89%. This was due to vacancies, sickness and maternity leave. The table below shows a breakdown of this data and shows the RN starters and leavers in January. NHSP continues to provide support to wards to mitigate shortfalls. There were 20,226 hours supplied in January compared to 17,690 in December.

	Dec 17	Jan 18
Maternity leave	3.40%	2.64%
Sickness	4.23%	5.08%
RN vacancies	4.71%	5.17%
Available RNs	87.66%	87.11%
Starters	2	6
Leavers	9	17

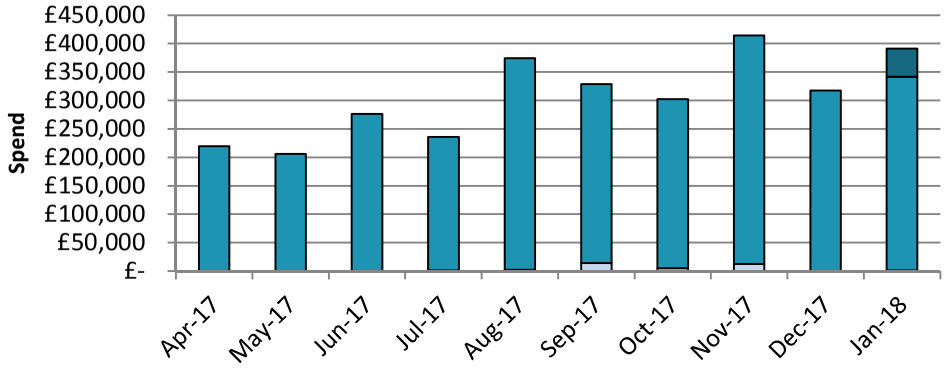
In January the total spend on agency, NHSP and overtime for nursing was £391,145. This has been broken down in figure 20 (overtime has just started to be included this month). NB This spend is offset by vacancies.

Figure 21 shows nurse to patient ratio that exceeds 1:8 (day duty) and 1:10 (night duty) within divisions in January 2018. There were 13 wards (B26, D46, E53, E54, B21, E50, E51, E52, E56, E58, F61, C30 and C36) that exceeded 1:8 (Day Duty) nurse to patient ratios, and 15 wards (same wards that exceeded 1:8 with the addition of C31 and D41) that exceeded 1:10 (Night Duty).

In January there were 190 incidents relating to patient harms (falls and pressure ulcers). There were 158 reported falls, with 107 resulting in no harm, 50 minor harm and one moderate harm. There were 32 reported pressure ulcers; all 32 were reported as category 2.

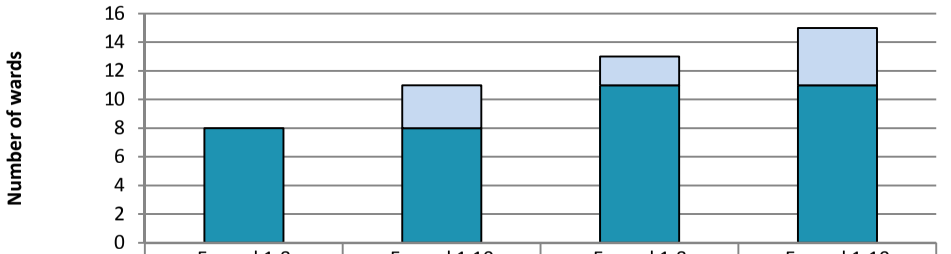
There were 86 incident forms submitted in January relating to nursing and midwifery staffing, an increase from December (76). There were 37 incidents forms submitted by wards/Matron when RN staffing was below minimum numbers, with Medicine submitting 22 of these. E58, D46 and D48 submitted the majority of incidents when staffing was below minimum numbers. This is in part due to staff sickness, staff being moved to support other wards where numbers of RNs are below two and an increase in bed occupancy.

Figure 20: CHSFT Spending on Nursing Agency, Nursing Bank and overtime - April 2017 to January 2018



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Overtime	£-	£-	£-	£-	£-	£-	£-	£-	£-	£49,348
Nursing Bank	£219,624	£205,966	£276,430	£234,564	£372,237	£314,582	£297,479	£401,933	£317,423	£340,835
Agency Nursing	£-	£-	£210	£1,072	£2,205	£14,158	£5,082	£12,288	£-	£967

Figure 21: CHSFT Nurse to patient ratios showing 2 month trend December 2017 to January 2018



	Exceed 1:8 (Dec 17)	Exceed 1:10 (Dec 17)	Exceed 1:8 (Jan 18)	Exceed 1:10 (Jan 18)
Theatres	0	0	0	0
Family Care	0	0	0	0
Surgery	0	3	2	4
Medicine	8	8	11	11

1.8 NURSING WORKFORCE (continued)

STFT

During the month of January there were 24 additional beds open on several wards (wards 5, 9-winter ward; and 20) at STDH due to winter pressures. SCBU and Maternity services remained closed for most of January, re-opening on 22 January 2018.

In January the total absences for RNs were: Acute 22.86% and Community 14.06%, this was due to vacancies, sickness and maternity leave. The table below shows a breakdown of this data. There was an increase in vacancies in the Acute side this month, due to budgets being aligned following workforce reviews in 2017. The table also shows the RN starters and leavers in January. NHSP continues to provide support to wards to mitigate shortfalls. There were 17,212 hours supplied in January compared to 14,678 in December.

	Dec 17		Jan 18	
	Acute	Community	Acute	Community
Maternity leave	3.30%	3.61%	5.96%	3.65%
Sickness	5.12%	5.74%	6.49%	2.54%
RN vacancies	12.19%	8.37%	13.83%	8.10%
Available RNs	79.39%	82.28%	73.72%	85.71%
Starters	1	9	6	13
Leavers	5	7	7	12

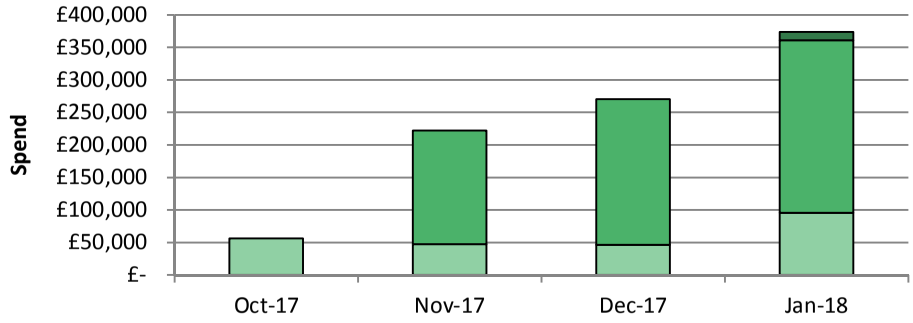
In January the total spend on agency, NHSP and overtime for nursing was £373,875. Figure 22 shows the breakdown (overtime has just started to be included this month). NB This spend is offset by vacancies.

Figure 23 shows nurse to patient ratio that exceeded 1:8 (day duty) and 1:10 (night duty) within Divisions in January 2018. There were five wards (wards 3, 5, 6, 19 and 20) that exceeded 1:8, and five wards (same wards that exceeded 1:8) that exceeded 1:10 ratio.

In January there were 122 patient harm incidents reported (falls and pressure ulcers). There were 101 reported falls, with 10 resulting in near miss, 68 in no harm, and 23 in minor harm. There were 21 reported pressure ulcers; all 21 were reported as category 2.

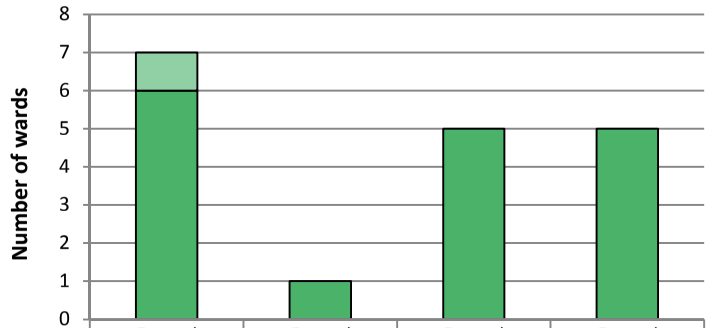
There were 105 safe care/incident forms submitted in January relating to nursing and midwifery staffing, an increase from December (48). There were four incident forms submitted by wards when RN staffing was below minimum numbers, with ward 5 submitting two and surgical specialities submitting the remaining three. This is part due to staff sickness, staff being moved to support other wards and an increase in bed occupancy.

Figure 22: STFT Spending on Nursing Agency, NHS Professionals and overtime - October 2017 to January 2018



	Oct-17	Nov-17	Dec-17	Jan-18
Overtime	£-	£-	£-	£13,065
NHS Professionals	£-	£175,072	£223,979	£265,263
Agency Nursing	£56,529	£47,219	£46,465	£95,547

Figure 23: STFT - Nurse to patient ratios showing 2 month trend December 2017 to January 2018



	Dec 17 Exceed 1:8	Dec 17 Exceed 1:10	Jan 18 Exceed 1:8	Jan 18 Exceed 1:10
Surgical Specialities & Maternity	1	0	0	0
Medicine & COTE	6	1	5	5
Acute & Urgent Care	0	0	0	0

PATIENT SAFETY
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.9 INCIDENT REPORT

CHSFT

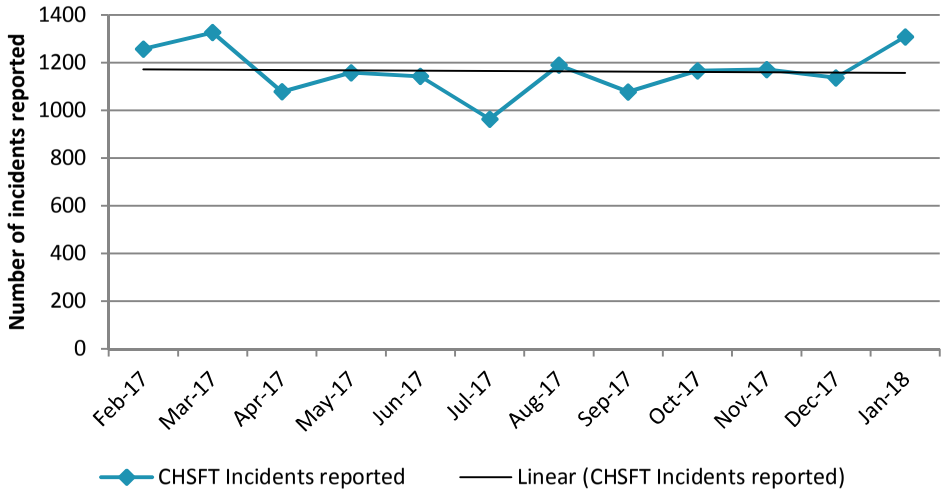
CHS incidents reported

Figure 24 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 172 reported incidents (15%) in January compared to the previous month. There has been a slight increase in the numbers of falls incidents (↑23) and tissue viability incidents (↑24) as well as increases in documentation and identification incidents (↑27) and consent, communication and confidentiality incidents (↑28). These small increases in some of the cause groups have led to the overall higher figure rather than a spike in one particular area.

CHS incidents by impact

The data table for figure 24 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 96% in January. Six incidents were reported as having caused major or extreme harm in January. These will be reviewed by directorates via the Directorate Initial Review process and will be considered by RRG in due course. Six incidents were reported as having caused major or extreme harm in December. Three incidents have been reviewed by directorates, have been considered at RRG and have had their levels of harm downgraded. The remaining incidents are currently under review and will be considered at RRG.

Figure 24: CHSFT Number of incidents reported February 2017 to January 2018



Data for Figure 24: CHSFT Incidents reported by category February 2017 to January 2018

	Feb 17	Mar 17	Apr 17	May 17	June 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18
No harm/near miss	765	839	-	-	-	-	-	-	-	-	-	-
Near miss	-	-	22	21	35	22	33	26	30	26	21	24
No harm	-	-	714	763	667	607	627	632	703	680	595	788
Minor harm	458	434	335	358	410	321	458	369	405	433	481	469
Moderate harm	30	40	5	13	19	10	23	42	23	27	33	21
Major harm	3	11	2	1	2	2	3	6	5	2	3	2
Extreme harm	1	2	0	0	1	1	0	2	0	1	3	4
Total	**1257**	**1326**	**1078**	**1156**	**1134**	**963**	**1189**	**1077**	**1166**	**1171**	**1136**	**1308**

PATIENT SAFETY
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

1.9 INCIDENT REPORT (continued)

STFT

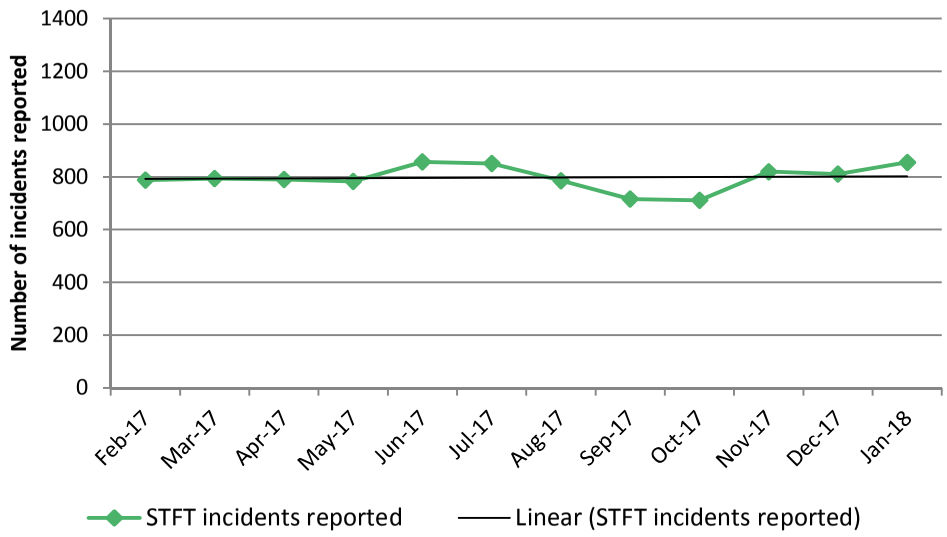
Figure 25 demonstrates the number of STFT-related incidents which have been reported via Datix each month during the last 12 months. Reporting has increased this month by 44 cases (5%) with the increase being across non clinical functions such as Estates and Facilities. It is likely that reporting rates will increase as 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 25 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 January is 84%.

There was one incident reported as having caused major harm or worse in January, relating to a patient who may have benefited from an x-ray which was not carried out. The patient subsequently died in hospital. A report will be submitted to the Trust Clinical Incident Review Group (CIRG), which will consider whether the incident contributed in any way to the death. CIRG will then decide on the actual level of harm.

Figure 25: STFT Number of incidents reported February 2017 to January 2018



Data for Figure 25: STFT Incidents reported by category February 2017 to January 2018

	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18
Near miss	112	111	96	110	122	116	100	105	384	111	134	118
No harm	370	386	396	516	526	519	471	402	122	449	403	426
Minor harm	271	264	268	151	195	200	192	190	183	251	260	295
Moderate harm	35	32	29	6	14	15	23	18	22	8	14	14
Major harm	0	1	1	0	0	1	0	1	0	2	0	1
Extreme harm	0	0	0	0	0	0	0	0	0	1	0	0
Total	**788**	**794**	**790**	**783**	**857**	**851**	**786**	**716**	**711**	**822**	**811**	**855**

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

1.9 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 26 demonstrates the number of incidents logged on StEIS by month. Two incidents were reported to NECSU in January. Of these two SIs, one was the Never Event that is detailed within this report. The other relates to a patient admitted from a care home with a fractured neck of femur. The care home stated that the patient had had no fall, but did fall during a previous admission to CHSFT which resulted in a significant decrease in mobility. This investigation has been approved by RRG and with the CCG for consideration at SI panel.

STFT

One SI was declared in January, as shown in Figure 27. The case related to a patient who presented in A&E with a cough and possible pneumonia and a diagnosis of sepsis was not made in a timely fashion.

Figure 26: CHSFT SIs reported to StEIS February 2017 to January 2018

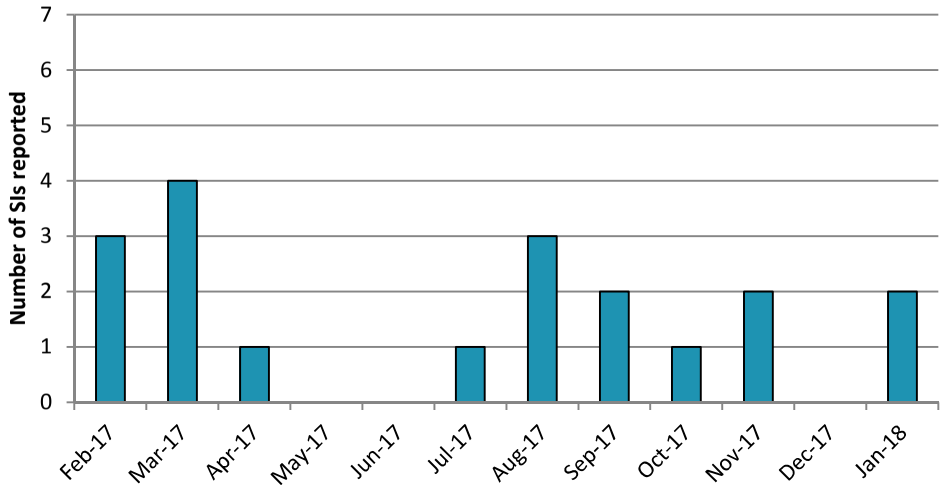
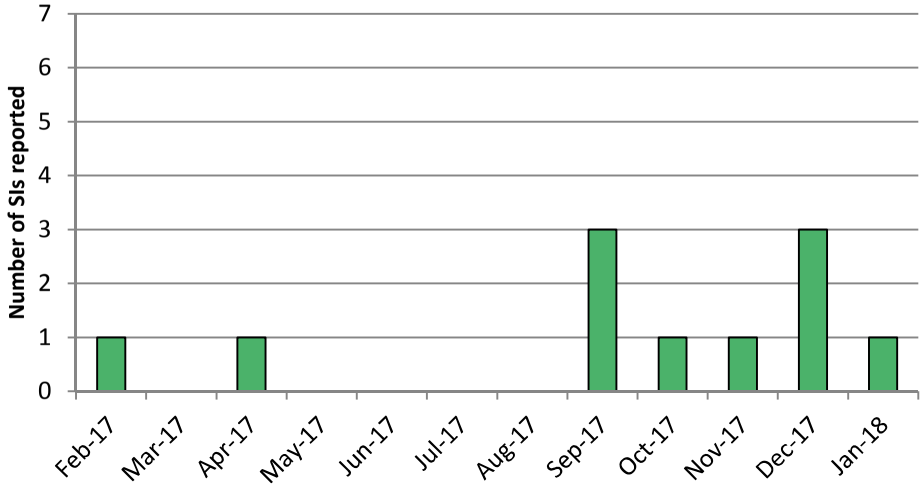


Figure 27: STFT SIs reported to StEIS February 2017 to January 2018



CHSFT - Headlines from RRG

- A reminder about completing death certificates correctly. A number are being completed stating "frailty of old age" when the patient is too young for this classification.
- Staff who are involved in the transportation of patients with oxygen cylinders are reminded to ensure that they know how to operate the oxygen cylinders correctly.

STFT - Lessons Learnt from CIRG

- CIRG have noted a number of misplaced male catheters. This has been picked up with individuals. The Medical Director has sent a widespread reminder to all staff advising that when inserting a urethral catheter in a male patient, they should remember:

  1. No resistance and then relief as navigating the sphincter
  2. No urine
  3. Do not blow up catheter balloon
  4. Remove catheter

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

1.9 INCIDENT REPORT (continued)

Never Events

CHSFT

One Never Event was reported in January. It related to a patient being booked for elective surgery for left middle finger trigger release. The operator made a 10cm skin incision at the elbow. The mistake was recognised immediately, the patient received an apology and the incorrect incision was sutured. A comprehensive investigation has been commissioned.

STFT

No Never Events were reported in January.

Duty of Candour

CHSFT

During January, 24 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 January, four of the reported incidents were confirmed as meeting the requirements for Duty of Candour.

STFT

No incidents met the requirements of Duty of Candour in January.

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

1.10 FALLS

Figure 28 indicates the incidence of falls that occurred in January 2018.

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 resulting in moderate or severe harm or death.

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

Figure 28: Numbers of Falls by Category for January 2018

Severity of Injury	CHSFT Number of Falls		STFT: Acute Number of Falls	
	This month	Last month	This month	Last month
No Harm	107 ↑	93	79↑	71
Low Harm	50 ↑	42	24 ↑	15
Moderate Harm (no. resulting in fractures)	1 ↓ (1)	3 (3)	1↔ (1)	1 (1)
Severe Harm	0 ↔	0	0	0
Death	0 ↔	0	0	0
Total Falls Rate/1,000 bed days	158 ↑ 8.25 ↑	138 7.79	104 ↑ 10.8↑	87 10.4
National Falls Rate/1,000 bed days	6.63	6.63	6.63	6.63
Total with Moderate / Severe Harm or Death Rate/1,000 bed days	1 ↓ 0.05 ↓	3 0.17	1↔ 0.11	1 0.1
National rate for falls with ≥ Moderate Harm Rate/1,000 bed days	0.19	0.19	0.19	0.19

Figure 29: Falls per 1,000 bed days with moderate or above harm December 2016 to January 2018

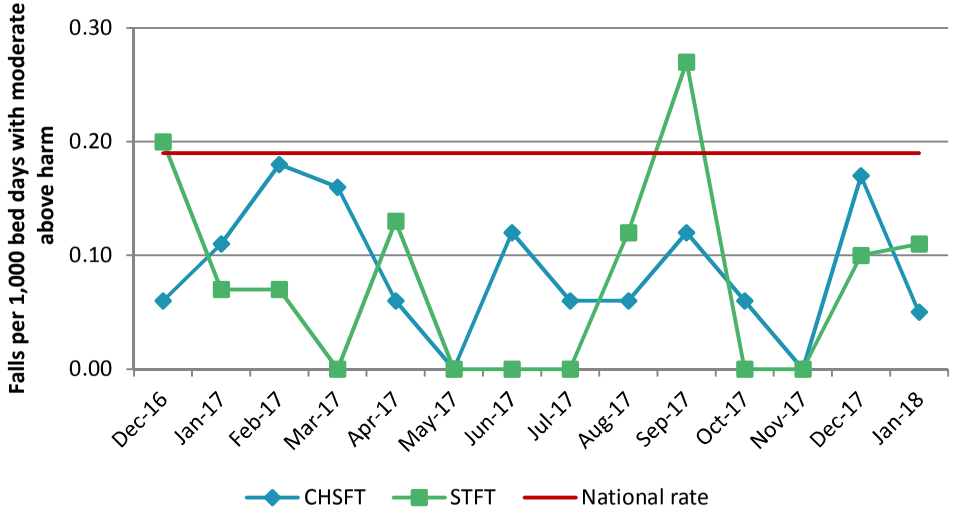
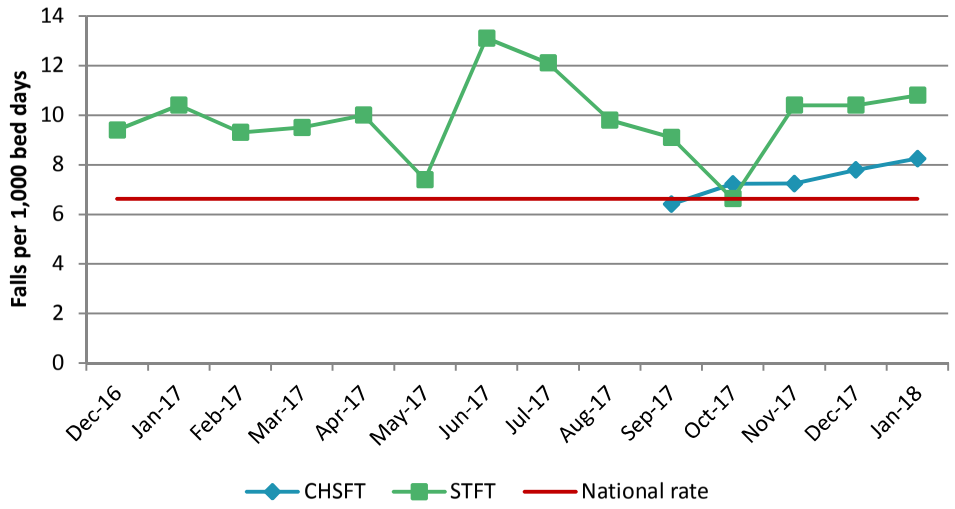


Figure 30: Falls per 1,000 bed days September 2017 to January 2018 (CHS) December 2016 to January 2018 (ST)



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

1.11 SAFETY THERMOMETER

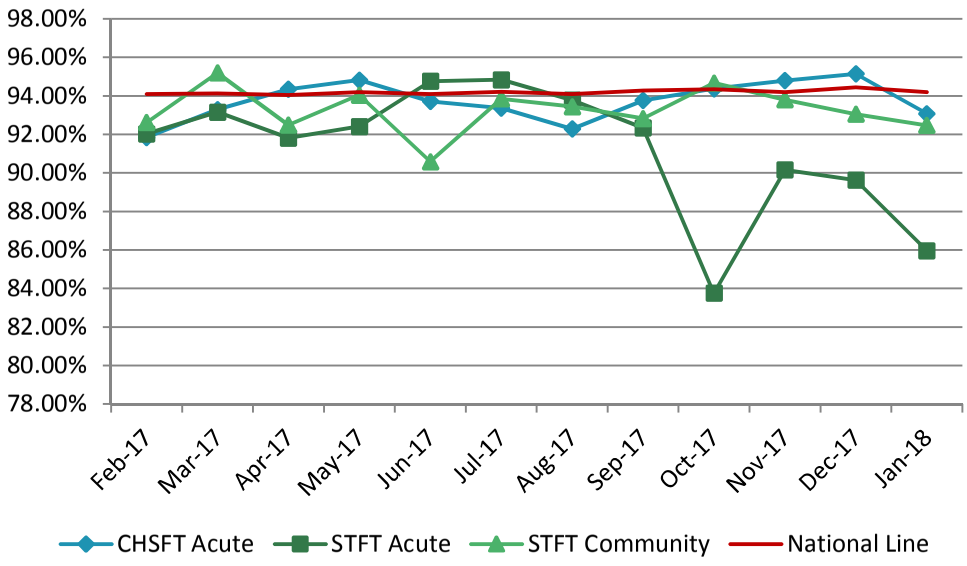
Our percentage of harm-free care is based on:

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

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

	Harm Free Care		New Harms		Old Harms	
	This month	Last month	This month	Last month	This month	Last month
CHS Acute	93.08% ↓	95.15%	13 ↑	12	29 ↑	16
STFT Acute	85.96% ↓	89.63%	13 ↑	10	28 ↑	19
STFT Community	92.47% ↓	93.05%	12 ↑	9	34 ↑	26

Figure 31: Safety Thermometer Results February 2017 to January 2018



ASSURANCE
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

2.1 CQC INSPECTION

CQC Inspection CHSFT

A CQC Provider Information Request (PIR) for CHSFT was received on 28th December 2017 as the first step in the inspection process.

The PIR was completed and submitted to the CQC to the deadline set. The CQC have confirmed that CHSFT will be advised in March of the dates for the three day announced well led inspection which is planned for 15/16/17 May. They have also advised that an unannounced inspection of at least one core service will take place prior to the announced visit so likely to be April and we will receive 30 minutes notice of this. This has been communicated to senior managers and further information will be circulated in the near future.

Briefing sessions for staff and meetings with Directorate teams are now being scheduled with further communications planned where staff will be reminded of the CQC Key Lines of Enquiry and the Trust standards.

CQC Inspection STFT

Following the recent Well Led inspection at STFT, the final report is still awaited.

ASSURANCE
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

2.2 Excellence Reporting

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

	CHS	STFT
Excellence Reports submitted (up to the end of January)	486	87
Excellence Reports submitted in January	19	24

Top 5 directorates reporting (cumulative)	CHS
Emergency Care	62
Theatres	61
Rehabilitation & Elderly Medicine	54
Paediatrics & Child Health	35
Obstetrics & Gynaecology	34

Top 5 directorates reporting (cumulative)	STFT
Community services	37
Medicine and Care of the Elderly	18
Corporate services	12
Acute and Urgent Care	8
Clinical Support services	4

Reporters have originated from varying professions:

Reporters by job type (December)	CHSFT	STFT
Nursing and Midwifery	7	14
Medical and Dental (Trust)	2	0
Admin and Clerical (including management)	4	6
Allied Health Professionals	6	2
Medical and Dental (Training)	2	1
Patients	0	1
Additional Clinical Services	1	0

Category breakdowns are as follows:

Reporters by job type (December)	CHSFT	STFT
Care and compassion	5	6
Communication	5	0
Competence	0	0
Courage and commitment	0	0
Going the extra mile	7	5
Leadership	0	4
Other	0	0
Service improvement and innovation	0	3
Team working	2	6

CHSFT

The Excellence Reporting at CHS continues to be well received, despite a slight drop in numbers reported in January 2018. The system will have been active for a year in February, so further promotion will be made to maintain the momentum.

A submission detailing the ER system at CHS was entered for the Patient Safety Awards 'Recognising and rewarding excellence in healthcare', in which the shortlisting will commence shortly.

STFT

Excellence reporting numbers at STFT have increased by 60% (15 reports in December) which is encouraging. A new hyperlink button is now available on the intranet, making it more accessible for staff to report.

CHSFT & STFT HOSPITAL ACQUIRED INFECTIONS
LEAD: MEDICAL DIRECTOR

3.1 HOSPITAL ACQUIRED INFECTIONS

3.1.1 MRSA bacteraemia

CHSFT

Total cases for 2017/18 is one unavoidable case. There were no avoidable cases against an annual trajectory of zero avoidable cases.

CHSFT February MRSA update: *Total cases for 2017/18 is one unavoidable case. There were no avoidable cases reported in February against an annual trajectory of zero avoidable cases.*

STFT

There were no new cases of MRSA bacteraemia in January. The MRSA bacteraemia reported in November was not upheld at appeal for third party attribution. The intention is to further seek agreement with STCCG in February that this case was unavoidable. Total cases for 2017/18 is two. One case was deemed avoidable, the second case is pending further discussion. This is against an annual limit of Zero avoidable cases.

STFT February MRSA update: *Total cases for 2017/18 is three avoidable cases. This is against an annual trajectory of zero avoidable cases. The Trust accepted an avoidable case in February which was originally apportioned to STCCG in January. This was informed by RCA. The intention remains to seek agreement from STCCG for a case from November to be deemed as unavoidable. The outcome of this will be decided at a meeting in March.*

3.1.2 MSSA Bacteraemia

There is no national target for Trust apportioned MSSA bacteraemia.

CHSFT

MSSA = 22 hospital acquired cases this year to date. The rate per 100,000 bed days for the past 12 months up to January 2018 is 10.7. The national rate up to November 2017 is 9.0.

STFT

MSSA = 7 hospital acquired cases this year to date. The rate per 100,000 bed days for the past 12 months up to January 2018 is 7.0. The national rate up to November 2017 is 9.0.

3.1.3 E Coli Bacteraemia

A 50% reduction of gram negative bloodstream infections is expected by 2020.

CHSFT

E. coli = 57 hospital acquired cases this year to date. The rate per 100,000 bed days for the past 12 months up to January 2018 is 29.5. The national rate up to November 2017 is 22.4.

STFT

E. coli = 19 hospital acquired cases this year to date. The rate per 100,000 bed days for the past 12 months up to January 2018 is 22.9. The national rate up to November 2017 is 22.4.

3.1.2 C. difficile infection (CDI)

CHSFT

One case was reported in January, which is two below the monthly trajectory. The year to date position at the end of January is 20 cases against an annual target of 34 cases. Three of these will be taken to appeal with Sunderland CCG in February 2018.

The *C. diff* rate per 100,000 bed days for the previous 12 months up to January 2018 remains within target, at 9.4. The Trust's target rate is 15.4.

CHSFT cases of C. difficile infection per month April 2017 January 2018:

Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18
1	2	6	2	1	2	1	2	2	1

CHSFT February C diff update: *One case was reported in February, which is two below the monthly trajectory. The year to date position at the end of February is 21 cases against an annual target of 34 cases. Four of these will be taken to appeal with Sunderland CCG in March 2018.*

STFT

Zero cases were reported as Trust apportioned in January. The year to date position at the end of January is seven cases following successful appeal of one case. This is against an annual target of eight. Three cases will be taken to appeal in February 2018. This includes further appeal of one case previously rejected.

The *C. diff* rate per 100,000 bed days for the previous 12 months up to January 2018 has improved but continues to exceed the target, at 7.0. By comparison, the national rate for the latest 12 month period up to November 2017 was 13.4 per 100,000 bed days. The Trust's target rate is 6.5.

STFT cases of C. difficile infection per month February 2017 to January 2018:

Feb 17	Mar 17	April 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18
1	0	0	0	0	4	2	0	2	0	0	1

STFT February C diff update: *One case was reported as Trust apportioned in February. The year to date position at the end of February is eight cases following successful appeal of one case. This is against an annual target of eight. Three cases will be taken to appeal in March. This includes further appeal of one case previously rejected.*

3.2 HAND HYGIENE

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

3.3 NATIONAL HIP FRACTURE DATABASE 2017

The National Hip Fracture Database (NHFD) is a clinically led web-based audit of hip fracture care and secondary prevention. It collects data on all patients admitted to hospital with hip fractures and improves their care through auditing which is fed back to hospitals through targeted reports.

The current service model at City Hospitals for managing hip fractures benefits from having:

- Orthogeriatric input as part of an integrated service (full time cover on wards including weekend).
- Named consultant Anaesthetics cover for each trauma list and a weekend trauma rota.
- True multidisciplinary clinical working involving T&O, Geriatrics and Anaesthetics (the TOGA meeting).
- 7-day physiotherapy service with trauma commitment.
- A Fracture Liaison Service.

The table below shows clinical performance for City Hospitals against peers and shows outcome positions in the top quartiles (NHFD 2017).

Name	Code	Number of cases submitted	Admitted to orthopaedic ward within 4 hours	Mental test score recorded on admission	Perioperative medical assessment	Physiotherapy assessment by the day after surgery	Mobilised out of bed by the day after surgery	Nutritional risk assessment	Delirium assessment	Received falls assessment*	Received bone health assessment*	Met best practice criteria
Darlington Memorial Hospital	DAR	341	44.6	98.8	81.2	99.7	79.1	88.0	84.5	98.2	97.4	63.7
James Cook University Hospital	SCM	445	80.9	98.9	91.2	97.7	97.2	84.9	97.3	100.0	99.1	54.6
Northumbria Specialist Emergency Care Hospital	NSE	670	62.3	99.7	97.2	98.0	91.9	62.5	97.0	99.0	99.0	82.8
Queen Elizabeth Hospital, Gateshead	QEG	305	75.9	98.7	95.1	99.0	98.7	99.7	94.8	99.3	99.7	78.3
Royal Victoria Infirmary	RVN	385	33.1	95.1	90.4	91.0	63.0	93.8	75.6	97.7	98.7	68.8
South Tyneside District Hospital	STD	195	56.3	97.9	96.9	91.0	72.0	95.4	91.3	95.9	99.0	69.3
Sunderland Royal Hospital	SUN	439	68.0	99.1	99.3	99.8	88.0	95.0	96.4	99.8	99.8	81.3
University Hospital of North Durham	DRY	373	45.8	98.4	94.6	77.8	73.6	94.6	89.5	98.4	98.1	67.5
University Hospital of North Tees	NTG	383	80.5	99.2	88.3	98.1	99.2	99.5	95.8	100.0	99.0	69.6
All NHFD		65,633	39.9	95.6	88.7	90.2	77.3	84.5	54.7	96.1	96.7	59.2
England		59,848	40.9	97.5	91.4	90.4	77.6	86.0	57.4	97.7	97.4	64.4
Northern Ireland		1,906	28.7	71.4	82.3	96.7	88.3	85.6	44.5	94.8	98.0	0.0
Wales		3,879	29.9	77.4	49.9	84.0	66.0	62.1	18.0	71.5	84.8	6.1

Showing 1 to 9 of 9 entries Previous 1 Next

Quartiles: Top quartile | 2nd quartile | 3rd quartile | 4th quartile | * <90%

It is worth observing that City Hospitals is in the top quartile (81.3%) for meeting the best practice tariff criteria. This criteria is based on national guidance and expert opinion on what constitutes best practice in fracture management and is designed to drive improvements in processes of care from admission to discharge.

In other clinical extracts from the NHFD (2017) it shows:

- Our overall length of stay (16 days) is in the top quartile and better than the NHFD average of 21.6 days.
- Discharge to original residence within 120 days is in the 2nd quartile (72% of patients compared with NHFD of 67.4%).
- 120 day follow-up is also in one of the top quartiles (60.4% compared with the average of 37.4%).

However, a few areas are outside the top quartiles. These are:

- Hip fractures which were sustained as an inpatient – all cases have been reviewed by the orthopaedic team. Some change to the clinical pathway have been made, including 'hot' reporting, early MRI/CT if there is a high suspicion of fracture, review of the non-weight bearing pathway and education re: expediency of diagnosis, referral and interventions.
- Documented NOT to have had a pressure ulcer – in response, the directorate raised awareness of the SSKIN bundle and intentional rounding and involved on a more frequent basis the Trust Tissue Viability Team.

In summary, hip fracture care has improved measurable with the development of the orthogeriatrician role and the enhancement of MDT working. Service development is ongoing, in areas such as managing dementia and delirium, nutrition, therapy and the new fragility fracture bulletin. The South Tyneside partnership will hopefully enable the service to continue to develop and meet the new challenges ahead.

3.4 NATIONAL JOINT REGISTRY

The National Joint Registry provides a complete contemporary record of joint replacement surgery for hips, knees, elbows, shoulders and ankles in England and Wales. It includes data on the full range of mechanical, clinical and social factors influencing the outcome of joint replacement surgery. Every year the Trust is presented with a clinical report and the main findings were shared at Clinical Governance Steering Group in January 2018.

In terms of demographic profile, patients presenting for joint surgery are generally overweight or obese, physically inactive, have osteoarthritis (for those over 45 years), are in the top deprivation quintile and have generally multiple co-morbidities.

In spite of this profile, the clinical outcomes data shows that for hip replacement surgery over a 10 year period, the revision rate (surgery performed to replace or compensate for a failed implant) is consistently better than the national average. Revision rate is one of the most important outcome measures of joint replacement surgery.

Hip Replacements Data collection started April 2003

	1 year			3 years			5 years			7 years			10 years		
	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate
Sunderland Royal Hospital	2,977	31	1.04%	2,199	32	1.46%	1,550	30	1.94%	1,035	23	2.22%	599	18	3.01%
City Hospitals Sunderland NHS Foundation Trust	2,977	31	1.04%	2,199	32	1.46%	1,550	30	1.94%	1,035	23	2.22%	599	18	3.01%
Whole NJR	828,360	6,400	0.77%	652,465	10,084	1.55%	493,475	12,022	2.44%	345,731	12,568	3.64%	146,744	6,995	4.77%

A similar longitudinal profile exists for knee placement surgery over the same time period:

Knee Replacement Data collection started April 2003

	1 year			3 years			5 years			7 years			10 years		
	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate	Linkable cases	Revisions	Revision Rate
Sunderland Royal Hospital	4,174	11	0.26%	3,033	34	1.12%	2,089	34	1.63%	1,234	29	2.35%	568	15	2.64%
City Hospitals Sunderland NHS Foundation Trust	4,174	11	0.26%	3,033	34	1.12%	2,089	34	1.63%	1,234	29	2.35%	568	15	2.64%
Whole NJR	905,324	4,282	0.47%	710,024	13,030	1.84%	536,530	14,155	2.64%	371,705	12,213	3.29%	150,558	5,928	3.94%

In addition:

- All hip surgeons standardised revision ratio's is well within the funnel plot curves; this is the same for resurfacing procedures (although not often carried out in CHS).
- Standardised mortality ratio is at the national average (in spite of the previously stated demographic characteristics of the patients).
- PROMS scoring (using the condition specific Oxford score) is at the national average.
- All surgeons carrying out knee surgery have standardised revision ratio's within the funnel plot curves with again the mortality ratio at the national average.

Reflecting on the outcomes of the GIRFT review of adult orthopaedic surgery, the table below shows the excellent performance in surgical site infection for hip and knee joint surgery compared with the England average.

8. Infections and complications

8.1 Surveillance of surgical site infection (SSI) - orthopaedics - percentage of procedures with an infection

Metric	Source and Year of current report	Value	England	Position	Variation chart
Procedure spell					
Hip replacement	PHE 2015/16	0.00%	0.17%	1 of 124	
Knee replacement	PHE 2015/16	0.00%	0.11%	1 of 116	
Repair of neck of femur	PHE 2015/16	0.55%	0.75%	34 of 73	
Procedure and readmission spell					
Hip replacement	PHE 2015/16	0.00%	0.58%	1 of 124	
Knee replacement	PHE 2015/16	0.68%	0.51%	79 of 116	
Repair of neck of femur	PHE 2015/16	0.82%	1.03%	34 of 73	

Within the same programme the Trust is cost efficient and cost effective in its implant procurement and in its reference costs per procedure. The litigation profile and cost for adult trauma and orthopaedics is also better than average.

City Hospitals has a complex and challenging case mix for its joint replacement surgery. Revision rates are low and better than the national average in addition to low infection and admission rates. In terms of cost and productivity, the Trust is cost effective and has a low litigation profile for its orthopaedic surgery.

3.5 QUALITY REPORTS – REPORTING ARRANGEMENTS 2017/18

Other minor changes include a refresh of the list of indicators required to be disclosed in Part 3 of the quality report to reflect developments in the Single Oversight Framework.

Trusts are also asked to obtain external assurance on Quality Reports in a similar manner to previous years. These include:

- A brief description of the key controls in place to prepare and publish a quality report in the annual governance statement in the published accounts.
- The signed limited assurance report provided by their auditors on the content of the quality report and the mandated indicators in the quality report.
- The copy of the auditors' report on the outcome of the external work performed on the content of the quality report, and the mandated and local indicators, to NHS Improvement and to the council of governors. This is referred to as the governors' report to distinguish it from the limited assurance report.

The Quality Report should be uploaded on the NHS Choices website by 30 June 2018.

NHS Improvement has now confirmed details of the contents and assurance requirements for Foundation Trusts preparing their 2017/18 quality reports. These can be found at: https://improvement.nhs.uk/uploads/documents/Detailed_requirements_for_quality_report_final.pdf

The format and content are broadly similar to previous years, and includes:

- Part 1: Statement on quality from the chief executive of the NHS foundation trust,
- Part 2: Priorities for improvement and statements of assurance from the board, and
- Part 3: Other information and two annexes:
  - statements from NHS England or relevant clinical commissioning groups, local Healthwatch organisations, and overview and scrutiny committees.
  - a statement of directors' responsibilities for the quality report.

However, following an update to the quality account regulations in 2017, two new mandatory disclosures are required. These relate to 'Learning From Deaths' and the number of deaths subject to case record review and whether any of these were more likely than not to have been due to problems in care. In addition, there is a narrative requirement to state what has been learnt from the mortality review process. The other new area requires a statement regarding how the Trust is implementing the priority clinical standards for seven day hospital services.

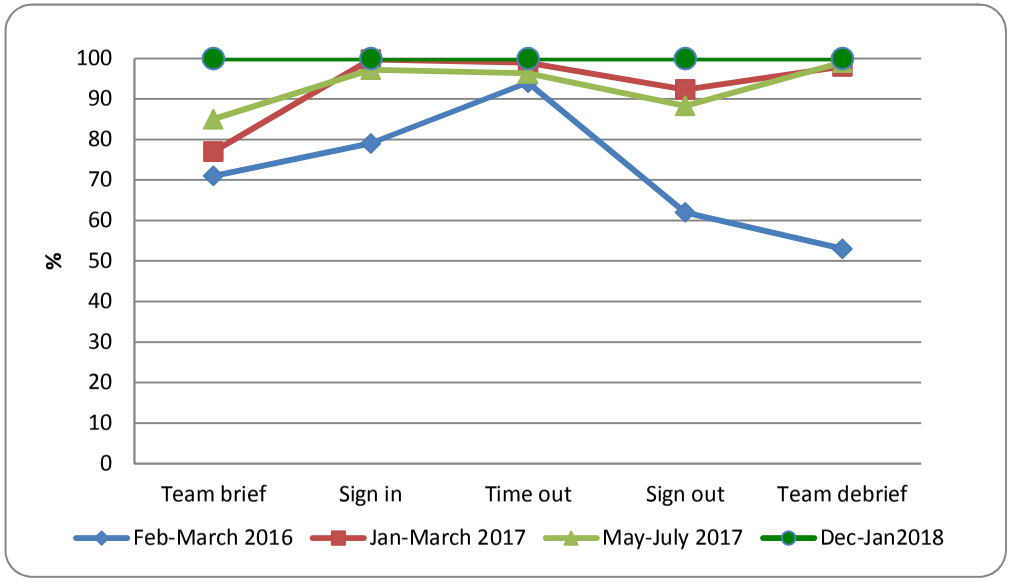
CLINICAL GOVERNANCE UPDATE
LEAD: STFT MEDICAL DIRECTOR

3.6 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 STFT2011. 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 and early 2018, and in the latest audit has achieved the 100% standard.



3.7 OXYGEN

Oxygen is the most commonly administered medication in hospitals. Since 2010 there have been clear guidelines on when to and not to use oxygen in the treatment of patients. The Trust has undertaken training initiatives to improve the safe administration of oxygen by staff and implemented changes with the medication chart to support safe prescribing of oxygen. In the British Thoracic Society national audit of Emergency Oxygen use, only 40% of patients administered oxygen in the Trust had this prescribed. This compares with the national average of 57.5%. The Respiratory department has worked with the Clinical Director for Medicine and Emergency Care and operational teams to implement the action plan below.

Recommendation	Actions Required	Action by Date	Person Responsible
All patients who are requiring oxygen should have it prescribed in EAU	Training to be provided by Dr Macnair – include in morning brief	1st March 2018	Andrew Macnair
Include mention of oxygen prescribing at daily SIMS brief on all wards	Mark Shipley to update SIMS sheet for wards	1st March 2018	Mark Shipley
Oxygen prescription to be signed at each drugs round – if not prescribed – doctor to be called to prescribe immediately	Update to all clinicians via email	1st March 2018	Mark Shipley
Patients on Oxygen should be flagged at huddle and if not prescribed it should be raised as an urgent action	Ward managers	1st March 2018	Lee Whitfield
Wards to perform bimonthly audits of oxygen prescription, presented at medical governance meeting	Ward managers	1st March 2018	Lee Whitfield
Quarterly audit report to be sent to Clinical Governance Steering Group	Lee Whitfield	30th June 2018	Lee Whitfield

CLINICAL GOVERNANCE UPDATE
LEAD: STFT MEDICAL DIRECTOR

3.8 MEDICAL CLINICAL HANDOVER

Clinical shift handover and the transfer of responsibilities during the transfer of individual patients between hospital departments is recognised as a critical part of patient care and pathway management. A number of departments have well developed SOPs for medical handover that are discussed at Trust and department induction. The Medical Director asked Internal Audit to audit medical handover in a number of settings. This involved observing a sample of Trust ward/department shift handovers, as they occurred in real-time over November to December 2017, and based upon the handovers observed Internal Audit evaluated whether processes were operating in accordance with nationally recommended good practice. The findings are based on observations, which were noted against 10 standards as follows:

Standard Reference	Description
1	All incoming and outgoing teams arrived on time. All staff who were expected to attend were present.
2	Multi-disciplinary attendance/input.
3	Structured using standard documentation, such as a handover template to prompt the user on key points to be covered.
4	Clear leadership of the handover process.
5	Two-way interactive process between two teams.
6	Handover involves access and reference to patient notes / relevant IT systems.
7	Medically unstable patients highlighted and prioritised.
8	Outstanding tasks are highlighted and allocated.
9	Held in a designated area/room and adequate time was allowed.
10	The handover was free from distractions, noise and interruptions.

Each area had a RAG rating:

Satisfactory	Handover observed demonstrated compliance with standard
Reasonable	Improvements needed to meet standard and/or inconsistent approach on some handovers observed (e.g. between AM and PM handovers)
Unsatisfactory	Significant improvements needed to meet standard / no evidence of compliance with standard

The pastel chart demonstrates compliance across the areas audited.

Ward	Surgery		EAU		Anaesthetics	ITU		R	A	G
Std Ref.	AM	PM	AM	PM	AM	AM	PM			
1								0	5	1
2								0	4	2
3								0	5	1
4								0	1	5
5								0	1	5
6								0	4	2
7								0	1	5
8								0	6	0
9								0	1	5
10								0	1	5

Reassuringly no standards were rated as RED, but there is inconsistency across departments. The 2 Clinical Directors in the Acute Division will develop an overarching medical handover policy that takes into account national guidance from the British Medical Association and Royal College of Physicians. This policy will allow departments to review their current SOPs for medical handover or develop SOPs. This will then allow consultation with relevant staff with an aim to introduce updated practical training around medical handover with the junior doctor change over in August 2018.

RISK
LEAD: DIRECTOR OF NURSING & PATIENT EXPERIENCE

4.1 INCIDENT MANAGEMENT

STFT and CHSFT

NHS Improvement released a new Never Events Policy and Framework in January 2018. Briefing papers have been provided to all appropriate corporate groups including both Trusts' Clinical and Corporate Governance Steering Groups.

STFT

Work to refine the reporting of incidents to the National Reporting and Learning System continued in January. The categories of incident to be reported as carrying patient safety implications are now congruent with those reported by CHSFT.

Executive Committee approved the draft STFT Incident Reporting Policy and Investigating and Learning Lessons from Incidents Policy. Both documents will be presented for ratification to Joint Policy Committee in March.

4.2 RISK MANAGEMENT

STFT and CHSFT

A period of consultation in respect of the draft CHSFT/STFT Joint Risk Management Strategy concluded in January. A further draft will be discussed at Executive Committee in February.

4.3 LITIGATION ANALYSIS

STFT and CHSFT

Reports on the creation by NHS Resolution of a Maternity Safety Incentive Fund in 2018/2019 were submitted to both Trusts' Clinical and Corporate Governance Steering Groups in January.

STFT

The maternity service has been provided with its first litigation analysis and is reviewing the data to identify any trends within cases brought against the Trust in the last six years. This will inform a meeting which the national Getting It Right First Time team has called with the maternity service, which will take place in March 2018. Reports on progress will be made to Corporate and Clinical Governance Steering Groups.

4.4 CORPORATE RISK REGISTER

STFT

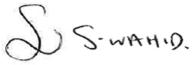
A review of local risk register entries scoring 15 or higher at STFT has begun, with the objective of producing a first comprehensive corporate risk register in Q1 of 2018/2019.

CONCLUSION

SUMMARY OF KEY RISKS

- High levels of nurse vacancies in CHSFT and STFT
- Low levels of incident reporting in STFT

Members are asked to note the report.



MELANIE JOHNSON	IAN MARTIN	SHAZ WAHID
Director of Nursing & Patient Experience	CHSFT Medical Director	STFT Medical Director

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF FINANCE

BOARD OF DIRECTORS

MARCH 2018

FINANCIAL POSITION AS AT 28TH FEBRUARY 2018 EXECUTIVE SUMMARY

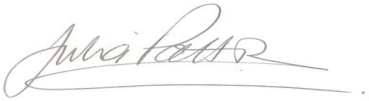
1 INTRODUCTION

This Executive Summary provides the summary highlights of the financial position as detailed in the main report to the end of February 2018.

1.1 KEY HIGHLIGHTS

Issue or Metric	NHSI Plan	Actual	Variance to NHSI Plan	
	£000s	£000s	£000s	%
Overall Financial Position including STF – Deficit	£5,883k	£9,098k	£3,215k	54.6%
Overall Financial Position excluding STF – Deficit	£14,042k	£14,943k	£901k	6.4%
Income (including STF)	£321,576k	£324,322k	£2,746k	0.9%
Expenditure	£327,459k	£333,420k	£5,961k	1.8%
EBITDA Position %	2.50%	1.2%		
Cash Position	£5,303k	£6,866k	£1,563k	
Clinical Activity:				
Variance to plan	£287,400k	£290,781k	£3,381k	1.2%
Cost Improvement Plans				
Variance to plan	£11,700k	£11,774k	£74k	0.6%
Pay:				
Variance to plan	£196,772k	£198,070k	£1,298k	0.7%
Non Pay:				
Variance to plan	£130,687k	£135,351k	£4,664k	3.6%
Use of Resources Metrics (UOR)			3	

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



Executive Director of Finance

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF FINANCE

BOARD OF DIRECTORS

MARCH 2018

FINANCIAL POSITION AS AT 28TH FEBRUARY 2018

1 INTRODUCTION

The enclosed financial statements reflect the Trust and its subsidiary companies Income & Expenditure position as at 28TH February 2018, 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 11		
	NHSI Plan	Actual	Variance
	£000s	£000s	£000s
Deficit for the year before Impairments and Transfers	(5,883)	(9,098)	3,215
Add: depreciation on donated assets	0	0	
Less: gain on asset disposal	0	0	
Less: income from donated assets		(253)	253
Less: 2016/17 STF post accounts allocation		(419)	419
Control Total Surplus/(Deficit) including STF	**(5,883)**	**(9,770)**	**3,887**
Less: STF 2017/18	(8,159)	(5,173)	(2,986)
Less: STF Incentive schemes	0	0	
Control Total Surplus/(Deficit) excluding STF	**(14,042)**	**(14,943)**	**901**

The overall operational financial position including STF is a net deficit of £9,098k against a planned deficit of £5,883k, and therefore £3,215k behind plan.

The net deficit of £9,098k included income for £419k as part of 2016/17 STF funding post accounts reconciliation, plus £5,173k STF for achieving its financial control total for Quarters 1, 2 and 3 plus performance targets for quarters 1 and 2 of this financial year. The position also included £253k benefit on donated asset income less costs. Therefore Trust position compared to control total excluding required adjustments is £14,943k deficit compared to a planned deficit of £14,042k, therefore £901k behind plan.

The Trust reported an over performance of £3,381k in month 11 relating to NHS clinical activity, a majority of which is due to the re-categorisation of funding (totalling £3,947k) received by the Trust for risk share, plus local and national winter funding from “Other non-patient income” to “Clinical Income” this month as per request from NHS Improvement.

At the end of February 2018, the Cost Improvement Plan (CIP) delivery is £74k ahead of projected plans submitted to NHSI.

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

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 11 was £290,781k against a plan of £287,400k, and hence ahead of plan by £3,381k. As noted above £3,947k of income has been re-categorised into "clinical income" this month from "other non-patient income".

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. The Trust is currently working with Commissioners with whom we have PbR contracts namely DDES CCG, North Durham CCG and NHS England to finalise year end positions for 2017-18, however these conversations are proving difficult on a number of key issues.

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 assumptions.

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

Private Patient Income is over recovered against plan by £81k.

2.2 *Non Patient Related Income:*

Training and Education income is ahead of plan by £194k to month 11 due to additional funding received from Health Education North East for a number of schemes this year, this is partly matched by an increase in pay and non pay costs. Research and Development income continues to over perform by £29k against plan to date.

Other Income was ahead of plan by £1,639k due largely to the revenue funding streams linked to Global Digital Exemplar costs.

As mentioned earlier, the Trust has failed in achieving its Control Total for this month (Month 11) and is therefore unable to claim STF finance or performance funding of £2,155k.

3 EXPENDITURE

3.1 *Pay Expenditure:*

Pay is currently showing an overspend of £1,298k against plan, reflecting:

- Agency costs to month 11 are £5,272k, compared to an overall Trust agency staffing budget to month 11 of £3,923k. Much of this spend is to cover vacant posts. The same period in 2016-17 had agency spend at £4,411k which is £861k 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 is just below its maximum agency/ceiling level set by NHS Improvement to the end of February 2018 as detailed in Appendix 4. To month 11

the ceiling level is set at £5,676k, whereas the total spend to date is £5,272k and hence below by £404k.

- To date the net underspend from vacant nursing posts across the Trust is £1,266k which is inclusive of the costs paid to NHS Professionals and overtime working.
- Cost Improvement Plans for pay are £158k behind plan to date due to a shortfall in identified CIPs to date.
- Key variances by staff group are detailed as:

Key Pay variances by staff group to current month	£000s
Consultants Staff (net of vacancies, additional sessions and agency costs)	1,314
Other Medical Staff (net of vacancies, additional sessions and agency costs)	1,907
Nursing (net of NHSP Costs)	-1,266
Other Staff groups	-657
Total Variance	**1,298**

Appendix 4 shows details of pay spend on agency, flexi-bank and overtime for the last 12 months. The increase in pay this month is mainly attributable to a step up in NHS Professional flexi bank working for medical and Nursing staff, and additional cross charge from South Tyneside FT for redundancies.

Overall pay costs in February were £18,144k against a budget of £17,817k for the month.

3.2 *Non Pay Expenditure:*

Non-Pay is overspent by £4,664k. Major areas are highlighted as:

- Drugs overspend this month is £2,267k against plan, £300k 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 (£2.3m with NHS England Specialised Commissioner).
- Clinical Supplies is overspent by £542k against plan to date, £410k of the overspend is due to increased offsite diagnostic reporting and tests to third party providers.
- Other Non Pay is overspent by £1,855k against plan to date, most of which is owing to offsite CT scans (£144k), rental of the CT Van (£265k), offsite MRI scans (£174k) and an NHSLA claim (£68k). 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 £370k of the overspend is due to CIP under delivery against plan to date.
- PDC costs are £620k underspent against plan to date.
- Depreciation costs are £226k underspent against plan to date.
- Interest paid is £33k 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 11, CIP delivery was £11,774k against a planned delivery of £11,700k and hence an over delivery of £74k. 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.

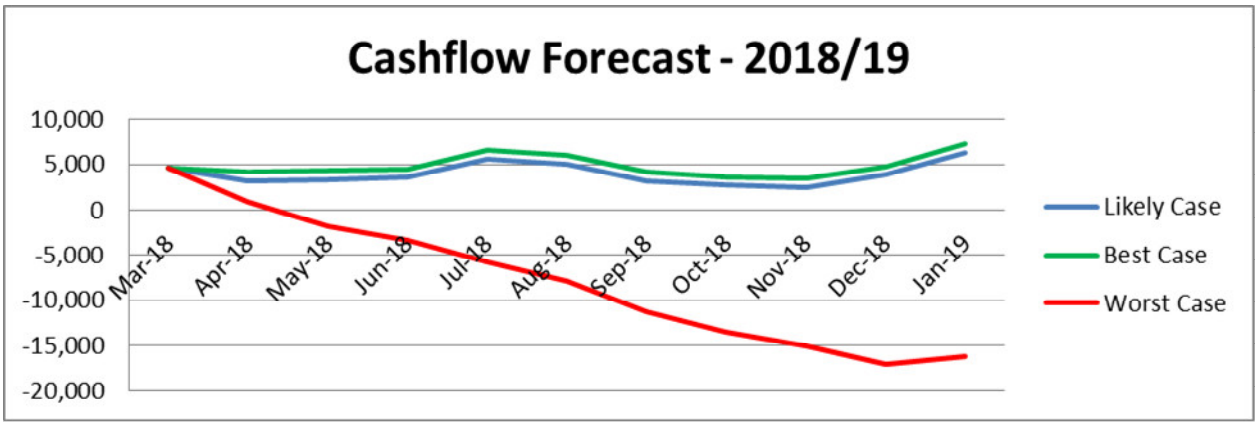
Current Trust CIP plans have identified £13.075m of the £13.0m target this year. The Trust anticipates total CIP delivery for 2017/18 to be in line with plan of £13m by the end of March 2018.

Details are provided in Appendix 6.

5 CASHFLOW AND WORKING CAPITAL

The cash balance at the end of February 2018 was £6.87m against planned £5.30m. The favourable variance of £1.57m includes the capital cash profile being behind plan by £1.53m and favourable working capital movements of £440k.

The adverse NHS debtor variance of £(7.95m) includes un-invoiced accruals in respect of Q3 STF funding £(1.94m) and AQP Funding (1.5m) and various outstanding invoices including Pathology and Medical Physics services to Gateshead £(697k), Clinical Activity Income £(343k) and other miscellaneous charges etc £(3.47m). All debtors continue to be vigorously pursued.



The graph above shows the Trust's forecast cash position to January 2019 based upon the expected monthly cash balances relating to the likely, best and worst case scenarios reflecting current information and are driven by the overall income and expenditure forecasts in detailed in this paper.

The closing forecast cash balance at 31st March 2018 exceeds the figure submitted to NHSI by £1.94m, representing the settlement of Q3 STF funding that was not expected to be received until April 2018. However, this is £831k less than anticipated and consequently will have an adverse impact upon the 2018/19 cash position of the Trust.

The likely case assumes that the Trust will receive deficit support loans equivalent to the value of the 2018/19 planned deficit position as submitted to NHSI, reduced by (i) any STF funding relating to 2017/18 that was planned to be received in 2018/19 and (ii) any surplus cash over and above its working capital balance requirement of £1.87m as calculated by NHSI. The likely case scenario would result in a January 2019 closing cash forecast of £6.32m.

The best case scenario continues to assume 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. This would result in a January 2019 closing cash forecast of £7.25m.

The worst case scenario assumes the Trust fails to acquire the deficit support loans from NHSI and that it also fails to achieve 2017/18 Q4 STF funding. This would result in a closing cash forecast deficit of £(16.23m).

An application has been submitted to NHSI with the aim of securing a deficit support loan for Apr 2018. All loans will be drawn down monthly in advance of need and will carry a 3.5% interest charge on a full year basis.

The Statement of Financial Position detail is provided in Appendix 2

6 CAPITAL

Capital expenditure to date is £3,333k and relates mainly to Global Digital Exemplar (£1,138k), Back Log Maintenance schemes (£763k), ED Development (£559k), Water Treatment Plant (£281k) and Sewing Room Conversion (£215k).

7 RISKS

As the Trust approach year end the primary risk to deliver the required control total is the clinical income position with NHSE specialised commissioner and Durham CCGs due to both the quantity and timeliness of challenges. The additional risk is the c£350k shortfall against control total that needs to be closed.

8 FORECAST

Delivery of the required control total for the Trust is a risk in 2017/18. Current forecasts indicate *(measured against control total excluding STF i.e. £14.981m deficit):*

Scenario	Forecast deficit (£m)	Variance from control total (£m) at Month 11	Forecast deficit (£m) at Month 10	Variance from control total (£m) at Month 10
Best case	13.243	-1.738	13.401	-1.580
Worst case	18.455	3.474	19.488	4.507
Likely case	15.348	0.367	15.357	0.376

The Trust 'likely' forecast position at month 11 is comparable to the position at month 10.

The Trust is working through a number of measures to potentially improve this position such as conversations with commissioners to close down contracting challenges and to gain year end financial agreements.

The biggest risk to the delivery for 2017/18 year end is the clinical income forecast contains risks due to challenges from Durham CCGs on a number wide ranging items such as emergency readmissions rates, marginal rate, and value based commissioning. The Trust is aiming resolve outstanding items as soon as possible to support 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.

At this stage therefore, the Trust has declared to NHSI that control total delivery is achievable in 2017/18.

9 NEXT STEPS

The Trust needs to close down the various contracting challenges from commissioners to provide certainty to the year end position, plus give continued focus to reduce costs wherever it is safe to do so across the remaining weeks of the year to maximise the Trust potential to achieve the required control total.

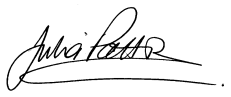
10 SUMMARY

The overall operational financial position including STF is a net deficit of £9,098k against a planned deficit of £5,883k, and therefore £3,215k behind plan. The position excluding STF is £901k behind plan.

11 RECOMMENDATIONS

The Board is requested to:

- Note the financial position to date.



Julia Pattison
Executive Director of Finance
March 2018

CITY HOSPITALS SUNDERLAND FOUNDATION TRUST
CORPORATE FINANCIAL MONITORING REPORT
SUMMARY TRUST POSITION - MONITOR ANALYSIS
PERIOD ENDED 28TH FEBRUARY 2017/18

Income & Expenditure Position

	Annual	Current Month			Year to Date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
£m	£m	£m	£m	£m	£m	£m	£m
Income							
NHS Clinical income	-313.58	-26.72	-25.72	1.01	-287.40	-290.78	-3.38
PBR Clawback/relief	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Private patient income	-0.35	-0.03	-0.04	-0.01	-0.32	-0.40	-0.08
Non-patient income	-37.29	-2.35	-3.10	-0.75	-33.86	-33.14	0.72
Total income	**-351.21**	**-29.10**	**-28.86**	**0.24**	**-321.58**	**-324.32**	**-2.75**
Expenses							
Pay Costs	214.60	17.82	18.144	0.33	196.772	198.070	1.30
Drug costs	38.12	3.16	3.29	0.13	34.96	37.23	2.27
Other Costs	89.03	7.24	7.67	0.43	81.79	85.00	3.21
Total costs	**341.76**	**28.22**	**29.10**	**0.89**	**313.53**	**320.30**	**6.77**
Earnings before interest, tax, depreciation & amortisation (EBITDA)	**-9.45**	**-0.88**	**0.25**	**1.13**	**-8.048**	**-4.019**	**4.03**
Profit/loss on asset disposal	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Depreciation	8.35	0.70	0.47	-0.23	7.65	7.43	-0.23
PDC dividend	5.02	0.42	0.36	-0.06	4.60	3.98	-0.62
Interest	1.83	0.15	0.15	-0.01	1.68	1.71	0.03
Corporation tax	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net surplus (pre exceptionals)	**5.74**	**0.38**	**1.22**	**0.84**	**5.88**	**9.10**	**3.22**
Exceptional items							
Net (surplus)/Deficit (post exceptionals)	**5.74**	**0.38**	**1.22**	**0.84**	**5.88**	**9.10**	**3.22**

EBITDA Margin	**2.7%**	**3.0%**	**-0.8%**	**2.5%**	**1.2%**

CITY HOSPITALS SUNDERLAND FOUNDATION TRUST
TRUST PERFORMANCE SUMMARY

PERIOD ENDED 28TH FEBRUARY 2018

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	Jan actual £'000s	Feb actual £'000s	Quarter 4 £'000s	YTD actual £'000s	Plan £'000s	Variance £'000s
Income													
Contract Income	(313,575)	(77,970)	(79,770)	(25,992)	(26,781)	(24,828)	(77,601)	(29,723)	(25,716)	(55,439)	(290,781)	(287,400)	(3,381)
STF	(9,237)		(3,652)			(1,940)	(1,940)				(5,592)	(8,159)	2,567
Private Patients	(345)	(93)	(100)	(64)	(31)	(32)	(126)	(35)	(43)	(78)	(397)	(316)	(81)
Training and Education Income	(11,499)	(2,875)	(2,824)	(909)	(958)	(965)	(2,832)	(978)	(1,225)	(2,203)	(10,734)	(10,540)	(194)
Research and Development Income	(1,476)	(370)	(363)	(132)	(146)	(100)	(378)	(157)	(115)	(272)	(1,382)	(1,353)	(29)
Other income	(15,035)	(4,338)	(5,199)	(1,351)	(1,492)	(3,136)	(5,979)	1,865	(1,757)	108	(15,408)	(13,769)	(1,639)
Interest Receivable	(43)	(4)	(6)	(2)	(9)	(4)	(15)	(1)	(3)	(3)	(28)	(39)	11
Total Income	**(351,210)**	**(85,651)**	**(91,913)**	**(28,450)**	**(29,416)**	**(31,005)**	**(88,871)**	**(29,029)**	**(28,858)**	**(57,887)**	**(324,322)**	**(321,576)**	**(2,746)**
Expenditure													
Pay	214,604	53,897	53,604	18,203	18,169	17,884	54,257	18,168	18,144	36,312	198,070	196,772	1,298
Clinical Supplies and Services	32,431	8,312	8,526	2,837	2,764	2,553	8,154	2,703	2,600	5,303	30,295	29,753	542
Drug Costs	38,124	10,005	9,896	3,312	3,460	3,477	10,249	3,794	3,286	7,080	37,231	34,964	2,267
Other Costs	56,598	14,901	14,810	4,908	4,642	5,063	14,613	5,309	5,074	10,383	54,707	52,039	2,668
Depreciation	8,348	2,247	1,835	688	729	668	2,085	791	467	1,259	7,426	7,652	(226)
PDC Dividend	5,022	1,149	974	354	354	353	1,061	438	362	800	3,984	4,604	(620)
Interest	1,827	497	452	151	154	162	468	146	145	292	1,708	1,675	33
Total Expenditure	**356,955**	**91,007**	**90,098**	**30,454**	**30,273**	**30,160**	**90,887**	**31,350**	**30,078**	**61,429**	**333,420**	**327,459**	**5,961**
(Surplus)/Deficit	**5,745**	**5,357**	**(1,815)**	**2,004**	**857**	**(845)**	**2,016**	**2,321**	**1,220**	**3,541**	**9,098**	**5,883**	**3,215**
Cost Improvement Plans	**(13,000)**	**(2,264)**	**(2,685)**	(931)	(1,695)	(1,661)	**(4,287)**	**(1,300)**	**(1,238)**	**(2,538)**	**(11,774)**	**(11,700)**	**(74)**

WTE Analysis (WTEs)

Total WTEs	**4,918.47**	**4,755.77**	**4,817.04**	**4,845.68**	**4,871.87**	**4,839.05**	**4,839.05**	**4,856.95**	**4,866.80**	**4,866.80**	**4,866.80**	**4,924.11**	**-57.31**

APPENDIX 2

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST
STATEMENT OF FINANCIAL POSITION - FEBRUARY 2018

Assets	Plan As At 28-Feb-18 £m	Actual As At 28-Feb-18 £m	Variance £m
Assets, Non-Current:			
Intangible Assets	3.738	4.762	
Property, Plant and Equipment	217.587	186.693	
Trade and Other Receivables	0.918	1.145	-0.227
Assets, Non-Current, Total	222.243	192.600	
Assets, Current:			
Inventories	5.900	6.384	-0.484
Trade and Other Receivables:			
NHS Trade and Other Receivables	3.395	11.339	-7.944
Non NHS Trade and Other Receivables	5.596	8.370	-2.774
Trade and Other Receivables, Total	8.991	19.709	
Cash and Cash Equivalents:			
Government Banking Service & Invested	4.903	6.866	
Commercial Bank account	0.400	0.000	
Cash and Cash Equivalents, Total	5.303	6.866	1.563
Assets, Current, Total	20.194	32.959	
ASSETS, TOTAL	**242.437**	**225.559**	

Liabilities

Liabilities, Current:			
Interest-Bearing Borrowings, Total			
Loans, non-commercial, Current (DH, FTFF, NLF, etc)	-3.273	-3.273	0.000
Interest-Bearing Borrowings, Total	-3.273	-3.273	
Deferred Income	-1.800	-3.304	1.504
Provisions	-0.212	-0.171	-0.041
Trade and Other Payables:			
Trade Payables, Current	-24.082	-30.760	6.678
Other Financial Liabilities	-2.756	-2.216	-0.540
Capital Payables, Current	-0.310	-0.856	0.546
Trade and Other Payables,Total	-27.148	-33.832	
Liabilities, Current, Total	-32.433	-40.580	
NET CURRENT ASSETS (LIABILITIES)	-12.239	-7.621	
Liabilities, Non-Current			
Interest-Bearing Borrowings:			
Loans, Non-Current, non-commercial (DH, FTFF, NLF, etc)	-50.435	-50.435	0.000
Loans, Non-Current, commercial	0.000	0.000	0.000
Interest-Bearing Borrowings,Total	-50.435	-50.435	
Provisions, Non-Current	-0.869	-0.794	-0.075
Liabilities, Non-Current, Total	-51.304	-51.229	
TOTAL ASSETS EMPLOYED	**158.700**	**133.750**	

Taxpayers' and Others' Equity

Taxpayers' Equity		
Public Dividend Capital	104.542	104.289
Revaluation Reserve	75.084	52.665
Retained Earnings	-20.926	-23.204
TAXPAYERS' EQUITY, TOTAL	**158.700**	**133.750**

Appendix 3 - Clinical Income Report Overview

Table 1: Financial Position (M1-11) per Commissioner agreed Contracts and the NHSI plan

Commissioner contracts	Plan as per NHSI	Plan as per PbR	Total Actuals	Variance as per NHSI	Variance as perPbr	% Against NHSI	% Against PbR
	£'000s	£'000s	£'000s	£'000s	£'000s		
Sunderland	160,874	160,874	160,874	0	**0**	0.0%	0.0%
South Tyneside	21,735	21,735	21,735	0	**0**	0.0%	0.0%
Gateshead	3,373	2,986	3,607	-234	**-621**	-6.5%	-17.2%
Sunderland LA	2,195	2,195	2,195	0	**0**	0.0%	0.0%
DDES	34,330	32,016	32,743	1,587	**-727**	4.8%	-2.2%
North Durham	15,302	14,933	14,981	321	**-47**	2.1%	-0.3%
HAST	3,167	2,961	3,172	-5	**-211**	-0.1%	-6.6%
South Tees	170	170	210	-40	**-40**	-19.2%	-19.2%
Specialised	33,196	33,196	34,122	-927	**-927**	-2.7%	-2.7%
Dental	5,607	5,607	5,700	-93	**-93**	-1.6%	-1.6%
Sub total	**279,950**	**276,674**	**279,340**	**610**	**-2,666**	0.2%	-1.0%
Cancer Drug Fund	1,572	1,572	836	737	**737**	88.2%	88.2%
Hep C drugs	894	894	899	-5	**-5**	-0.5%	-0.5%
NCA's	3,042	3,042	2,684	358	**358**	13.3%	13.3%
AQP - all contracts	986	986	904	81	**81**	9.0%	9.0%
GAP/Stretch target	-821	2,455	0	-821	**2,455**	0.0%	0.0%
Other	1,777	1,777	6,119	-4,342	**-4,342**		
Total	**287,400**	**287,400**	**290,781**	**-3,381**	**-3,381**	-1.2%	-1.2%

The clinical income target to end month 11 is £287,400k with actual income reported as £290,781k. Therefore the trust is reporting a cumulative over performance against the Clinical Income budget of £3,381k.

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. The.Contract Variations (CV) discussed in previous months have all been signed and transacted with the relevant commissioner and are now reflected in this table

The Clinical income actuals are based on M10 flex PbR files with the exception of drugs income which is directly matched to expenditure for month 11 for those on PBR contracts.

There has been little change to the positions in Month 11 to those reported last month & the focus has now moved to trying to agree the year end positions with as many Commissioners as possible to try & gain certainty on the reported 2017/18 year end position & to minimise risk moving into 2018/19.

The details of the position to date are shown in the next section.

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

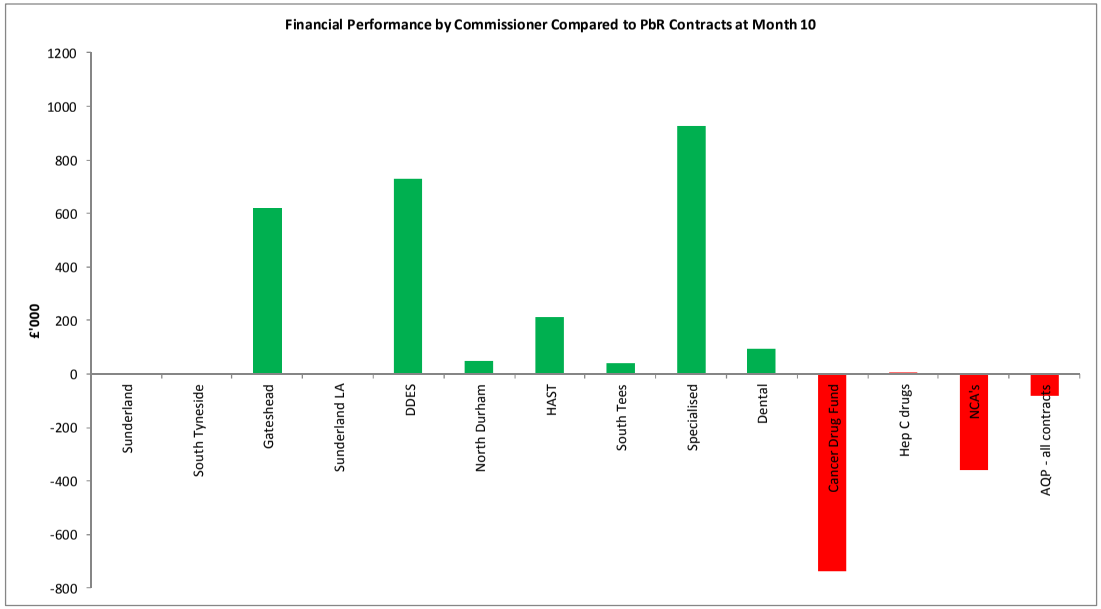
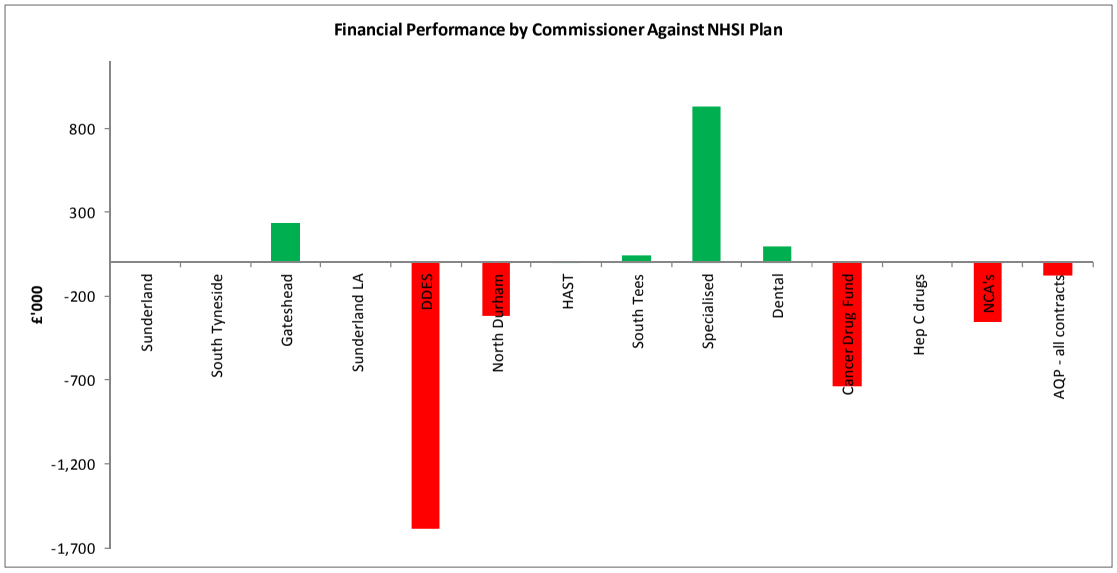


Figure 2: Variance per Commissioner Against the Monitor Plan



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 £2.4m over performance.. Over performance still exists for non electives in medical specialities.

South Tyneside CCG : This contract is also a block for 2017/18. If the PbR was to be transacted, there would be an over performance of £1.8m. This has reduced due to stroke activity CV having been transacted. The balance is mainly the lower price Avastin drugs that were commissioned but the higher price Lucentis being used plus small pockets of over performance in other specialities.

North Durham CCG : Reporting an over performance of 47k against PbR plan (£48k at m10) and an underperformance of £321k 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 £1.58m (£1.39m at m10) but over performing against the PbR plan by £727k. The over performance can be mainly attributed to non-elective activity, day cases and high cost drugs.

NHSE Specialised : Reporting an over performance of £927k against PBR & NHSI plan (£902k at m10). This position takes the Trusts view of challenges into account. The main area of over performance are drugs however these are a pass through matching expenditure.

NHSE Dental : Over performance of £93k, an increase in performance compared with M9 which showed an over performance of £129k.

Year End & Risks to Income

Discussions for year end are taking place with all commissioners to try to ensure certainty of both the reported 2017/18 financial position & cash flow for the Trust and to minimise the risk moving into 2018/19.

As at the time of writing, Newcastle/Gateshead, Hartlepool (HAST), Northumberland and South Tees CCG's have agreed a year end outturn position.

Despite the difficulties with NHSE all year, both the late & unresolved challenges, a reasonable settlement has just been agreed for 2017/18 year end – this avoided resolution of specific issues and is a global sum without prejudice on 2018/19 negotiations which remains deadlocked.

The Dental team have stated they do not wish have a year end agreement but have agreed the forecast outturn position as at Month 10, this could be a risk to the 2018/19 position if outturn activity is below that of the Month 10 forecast.

All AQP positions for 2017/18 have now been agreed with all CCG's.

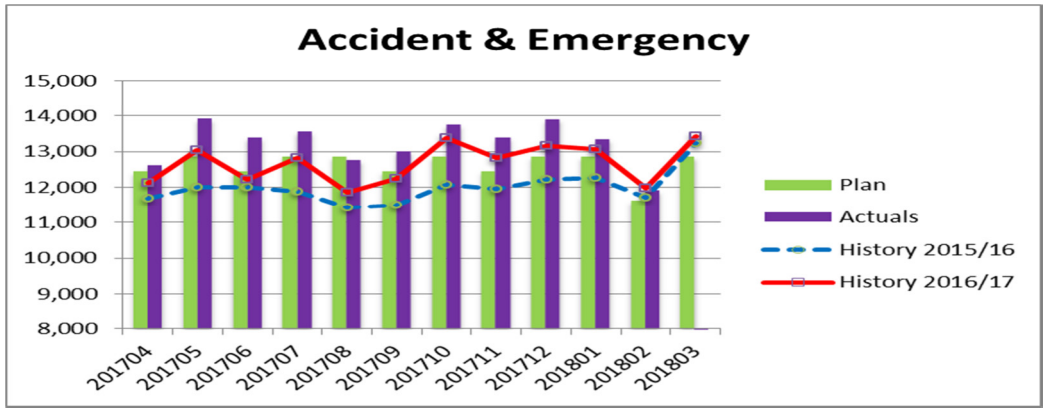
The Durham commissioners' positions have been escalated to Director of Finance level. Contracting teams have agreed the forecast outturn position in principle but 3 main differences remain, readmissions, value based commissioning and marginal rate which still need to be agreed. These take on a greater importance as any agreement now could likely set precedence for next year's contract values regarding the same three issues. The difference between the CHS view & Commissioner view at present is £679k for DDES & £152k for North Durham.

Estimates for income flows such as Cancer Drug Fund (CDF), Non Contracted Activity (NCA's) & Hep C drugs will need to be made, but it is likely that the actuals for these will be different, which could be a benefit or a risk in 2018/19.

All efforts will continue to agree as many commissioner positions as possible for 2017/18.

Position for Activity by POD (Month 11)

Accident & Emergency



Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
A&E Attendances	**138,685**	**145,685**	**138,738**	**7,000**	**6,947**
201704	12,457	12,618	12,136	161	482
201705	12,872	13,929	13,054	1,057	875
201706	12,457	13,405	12,210	948	1,195
201707	12,872	13,571	12,822	699	749
201708	12,872	12,771	11,864	-101	907
201709	12,457	13,023	12,237	566	786
201710	12,872	13,761	13,388	889	373
201711	12,457	13,409	12,820	952	589
201712	12,872	13,918	13,169	1,046	749
201801	12,872	13,360	13,069	488	291
201802	11,626	11,920	11,969	294	-49
Grand Total	**138,685**	**145,685**	**138,738**	**7,000**	**6,947**

Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
A&E Attendances	**138,685**	**145,685**	**138,738**	**7,000**	**6,947**
Type 1	78,996	86,883	82,304	7,887	4,579
Type 2	30,391	26,915	28,490	-3,476	-1,575
Type 4	29,298	31,887	27,944	2,589	3,943
Grand Total	**138,685**	**145,685**	**138,738**	**7,000**	**6,947**

ED attendances continue to over perform in February compared to plan, with Type 1 attendances overperforming by 11%. The number of ED attendances resulting in an Emergency Admission was 22.4%. The greatest number of admissions remain into Geriatric Medicine, Accident & Emergency and Paeds.

A&E activity is 5% above historical levels and 5% above plan. Type 1 A&E (main site) is 9.9% above plan; Type 2 (Eye Infirmary) is 11% below plan and Type 4 (Pallion) is 8.8% above plan.

A&E plans are phased using calendar days therefore plan and actuals are both low due to February being a short month.

In February, the number of attendances at SEI are the second lowest in 17/18 with 2,038 attendances compared to a previous monthly average of 2,583 Apr – Nov. 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.

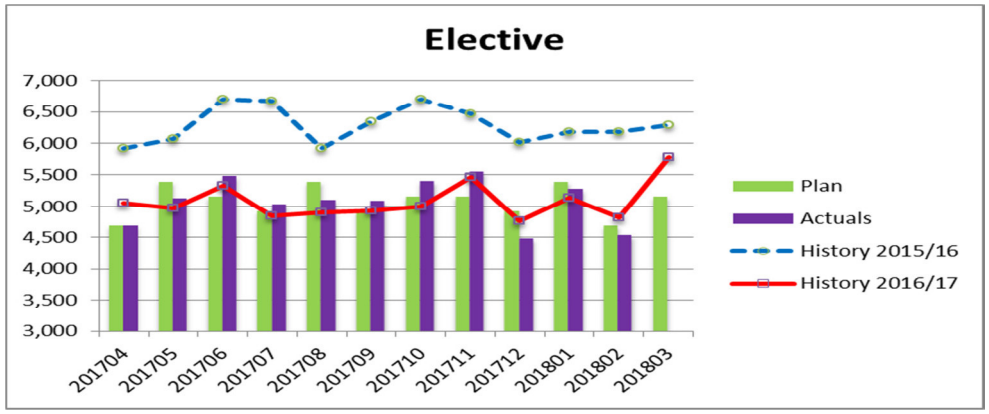
Type 1 and Type 4 (CHS site) planned attendances have been commissioned at a level 2,731 below 16/17 outturn, and 8,464 under the Trust forecast for 17/18. A&E has experienced growth in attendances year on year, which Commissioners have chosen not to recognise and fund in 17/18.

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 to the over performance against plan of £434K to Month 9

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 11)

Elective



Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
Elective	**55,871**	**55,845**	**55,219**	**-26**	**626**
Ophthalmology	12,590	13,974	12,555	1,384	1,419
Colorectal Surgery	0	1,168		1,168	1,168
Upper Gastrointestinal Surgery	266	692	145	426	547
Anaesthetics	0	240		240	240
Nephrology	603	744	668	141	76
Paediatrics	362	482	430	120	52
Endocrinology	205	309	223	104	86
Oral & Maxillo Facial Surgery	4,696	4,789	4,833	93	-44
ENT	3,461	3,549	3,659	88	-110
Gynaecology	1,578	1,651	1,477	73	174
Diabetic Medicine	46	75	73	29	2
Geriatric Medicine	58	78	54	20	24
Well Babies	4	7	4	3	3
Clinical Neurophysiology	0	2		2	2
Neurology	668	670	675	2	-5
Orthodontics	0	1		1	1
General Medicine	0	0	1	0	-1
Diagnostic Imaging	0	0		0	0
Rehabilitation	13	9	13	-4	-4
Accident & Emergency	269	262	258	-7	4
Respiratory Medicine	1,617	1,590	1,590	-27	0
Obstetrics	94	65	81	-29	-16
Rheumatology	1,245	1,179	1,208	-66	-29
Pain Management	795	715	867	-80	-152
Trauma & Orthopaedics	5,263	5,053	5,177	-210	-124
Cardiology	2,084	1,793	1,795	-291	-2
Urology	7,502	7,184	7,460	-318	-276
Vascular Surgery	1,579	1,191	1,376	-388	-185
Gastroenterology	5,570	5,055	5,272	-515	-217
General Surgery	5,304	3,318	5,325	-1,986	-2,007
Grand Total	**55,871**	**55,845**	**55,219**	**-26**	**626**

Elective Spells Summary

Elective activity is up 626 spells (1.1%) vs 16/17 history and down 26 spells (0.04%) vs plan YTD. Medical Oncology and Clinical Haematology have been removed from plan and actual Elective numbers above due to their re-categorisation as Chemo, as per the request of NHS England.
February's actuals for the remainder of the specialties was 157 under plan.

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

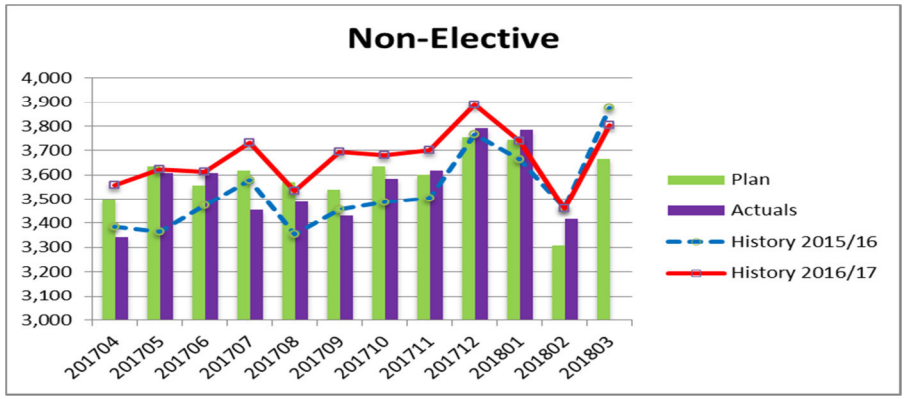
Specialty in focus – Respiratory Medicine

December, January and February have been the most challenging months YTD for Respiratory Medicine regarding performance against activity plan. Between April and November the directorate were running at 94 spells over plan, however the previous 3 months have pushed this to 27 spells under plan.
The specialty has been a consultant down since mid December, which is impacting on both Elective and New OP activity. Plans are in place for locum cover starting in February so this position is expected to begin recover from M12

Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
Elective	**1,617**	**1,590**	**1,590**	**-27**	**0**
Respiratory Medicine	**1,617**	**1,590**	**1,590**	**-27**	**0**
201704	136	115	180	-21	-65
201705	156	164	139	8	25
201706	149	169	139	20	30
201707	143	133	135	-10	-2
201708	156	155	130	-1	25
201709	143	196	150	53	46
201710	149	165	108	16	57
201711	149	179	174	30	5
201712	143	119	139	-24	-20
201801	156	101	170	-55	-69
201802	136	94	126	-42	-32
Grand Total	**1,617**	**1,590**	**1,590**	**-27**	**0**

Position for Activity by POD (Month 11)

Non Elective



Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
Non Elective	**39,466**	**39,136**	**40,223**	**-330**	**-1,087**
Upper Gastrointestinal Surgery	0	638		638	638
Colorectal Surgery	0	628		628	628
Endocrinology	537	1,116	670	579	446
Geriatric Medicine	5,477	6,037	5,990	560	47
Respiratory Medicine	1,553	1,943	1,956	390	-13
Gastroenterology	1,805	1,903	1,823	98	80
Medical Oncology	53	130	85	77	45
Obstetrics	16	81	75	65	6
Clinical Haematology	312	370	348	58	22
Nephrology	1,074	1,131	1,139	57	-8
Ophthalmology	510	564	532	54	32
Anaesthetics	0	49		49	49
Neurology	65	94	94	29	0
Paediatrics	3,949	3,962	3,967	13	-5
Well Babies	6	17	15	11	2
Critical Care Medicine	0	0		0	0
General Medicine	2	0		-2	0
Oral & Maxillo Facial Surgery	337	332	294	-5	38
Rehabilitation	72	54	71	-18	-17
Pain Management	39	12	46	-27	-34
Rheumatology	60	26	30	-34	-4
Urology	2,313	2,278	2,166	-35	112
ENT	1,326	1,275	1,439	-51	-164
Vascular Surgery	261	201	229	-60	-28
Stroke Medicine	108	0		-108	0
Diabetic Medicine	540	406	557	-134	-151
Cardiology	2,896	2,741	2,954	-155	-213
Gynaecology	1,062	882	865	-180	17
Trauma & Orthopaedics	2,322	2,073	2,163	-249	-90
Accident & Emergency	8,247	7,659	8,295	-588	-636
General Surgery	4,523	2,534	4,420	-1,989	-1,886
Grand Total	**39,466**	**39,136**	**40,223**	**-330**	**-1,087**

Non Elective Spells Summary

Non Elective activity is down 1,087 spells (2.7%) vs history and down 330 spells (0.8%) vs plan. This is an improvement on the YTD position from Month 10.

The Non Elective plan is phased using calendar days, therefore plan and actuals are both appear to be low due to February being a short month. However, February has had the greatest percentage overperformance against plan of Non Elective admissions in 17/18 (3%).
22% (2,672) of ED attendances resulted in an Emergency admission in January. These were initially mainly admitted into Geriatric Medicine or Accident & Emergency as specialties, but the specialty reported for the inpatient activity is driven by the patients specialty on discharge, which is shown in the table on the left.

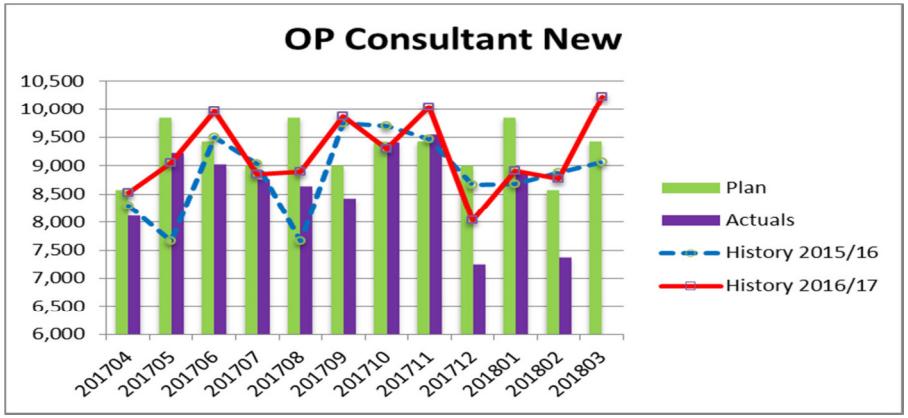
Commissioner Focus

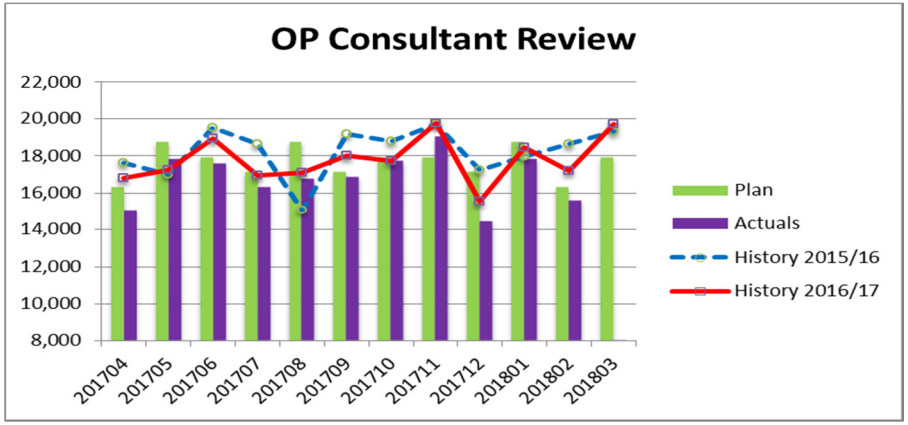
Row Labels	Plan	Actuals	History 2016/17	Var Vs Plan	Var Vs History
Non Elective	**39,466**	**39,136**	**40,223**	**-330**	**-1,087**
NON CONTRACT ACTIVITY	282	383	342	101	41
NHS SOUTH TYNESIDE CCG	2,071	2,151	1,840	80	311
NHS NEWCASTLE GATESHEAD CCG	276	340	473	64	-133
NHS CUMBRIA CCG	0	0	13	0	-13
NHS SOUTH TEES CCG	24	21	28	-3	-7
NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG	83	74	82	-9	-8
NHS ENGLAND NORTH (CUMBRIA AND NORTH EAST)	329	316	286	-13	30
NHS NORTH DURHAM CCG	1,398	1,383	1,211	-15	172
NHS NORTHUMBERLAND CCG	39	0		-39	0
NHS SUNDERLAND CCG	28,517	28,444	29,488	-73	-1,044
NHS DURHAM DALES, EASINGTON AND SEDGEFIELD CCG	5,876	5,667	6,031	-209	-364
CUMBRIA AND NORTH EAST COMMISSIONING HUB	570	357	429	-213	-72
Grand Total	**39,466**	**39,136**	**40,223**	**-330**	**-1,087**

Non Elective activity at month 11 is only 0.8% under plan. Sunderland and South Tyneside are under and over performing respectively, both of which have block contracts. DDES and NHS E Specialised are currently the CCGs with the highest level of underperformance, and operate a PbR contract.

Position for Activity by POD (Month 11)

Consultant Led Outpatients





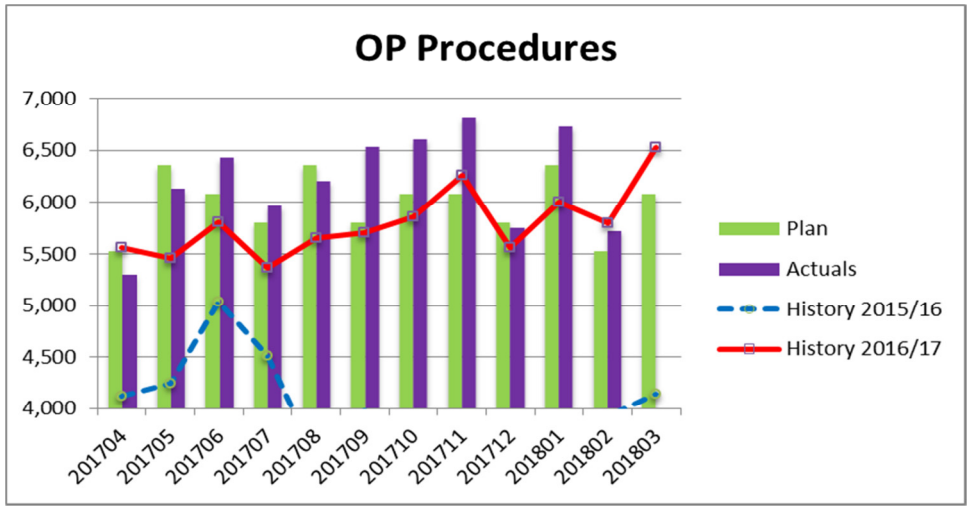
First Outpatient (consultant led) activity is 5,613 attendances (5.6%) below history and 7,335 attendances (7%) below plan. Directorates with the most significant variance against plan include Paediatrics, Urology and General Surgery.

Review Outpatient (consultant led) activity is 8,690 attendances (4.5%) below history and 8,978 attendances below plan (4.6%). Directorates with the greatest variance against plan include Paediatrics, Theatres, Emergency Care and Obs & Gynae.

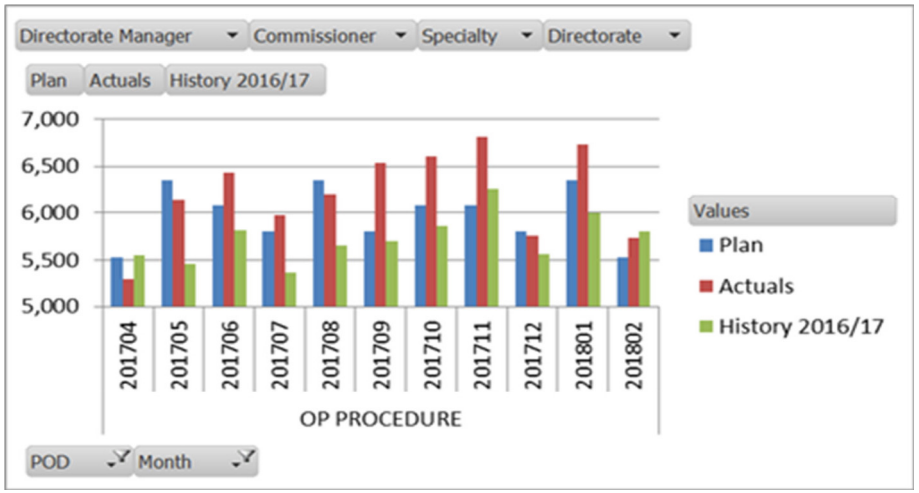
Row Labels	Plan	Actuals	Var Vs Plan	Var vs Plan %	History 2016/17	Var Vs History
OP CONSULTANT LED - NEW	**101,914**	**94,579**	**-7,335**	**-7%**	**100,192**	**-5,613**
Emergency Care	3,410	3,445	35	1%	3,427	18
General Internal Medicine	7,758	7,223	-535	-7%	8,668	-1,445
General Surgery	8,115	6,394	-1,721	-21%	6,984	-590
Head & Neck	14,958	13,495	-1,463	-10%	14,278	-783
Medical Specialties	5,206	4,952	-254	-5%	5,423	-471
Obstetrics & Gynaecology	11,564	11,042	-522	-5%	12,285	-1,243
Ophthalmology	12,516	12,549	33	0%	12,643	-94
Other	3	5	2	82%	10	-5
Paediatrics	6,471	5,180	-1,291	-20%	5,063	117
Rehab & Elderly Medicine	6,748	6,759	11	0%	6,613	146
Theatres	1,257	1,278	21	2%	1,254	24
Trauma & Orthopaedics	13,519	13,718	199	1%	13,967	-249
Urology	10,389	8,539	-1,850	-18%	9,577	-1,038
OP CONSULTANT LED - REVIEW	**193,920**	**184,942**	**-8,978**	**-5%**	**193,632**	**-8,690**
Emergency Care	9,071	8,156	-915	-10%	8,926	-770
General Internal Medicine	19,653	20,032	379	2%	20,710	-678
General Surgery	13,850	12,937	-913	-7%	13,812	-875
Head & Neck	21,820	21,068	-752	-3%	20,905	163
Medical Specialties	28,290	26,929	-1,361	-5%	28,706	-1,777
Obstetrics & Gynaecology	7,525	6,959	-566	-8%	7,547	-588
Ophthalmology	36,773	34,997	-1,776	-5%	36,701	-1,704
Other	135	5	-130	-96%	53	-48
Paediatrics	10,085	8,370	-1,715	-17%	9,596	-1,226
Rehab & Elderly Medicine	7,440	7,028	-412	-6%	7,337	-309
Theatres	1,993	1,746	-247	-12%	1,899	-153
Trauma & Orthopaedics	20,152	20,829	677	3%	21,599	-770
Urology	17,134	15,886	-1,248	-7%	15,841	45
Grand Total	295,835	279,521	-16,314	-6%	293,824	-14,303

Position for Activity by POD (Month 11)

Outpatient Procedures



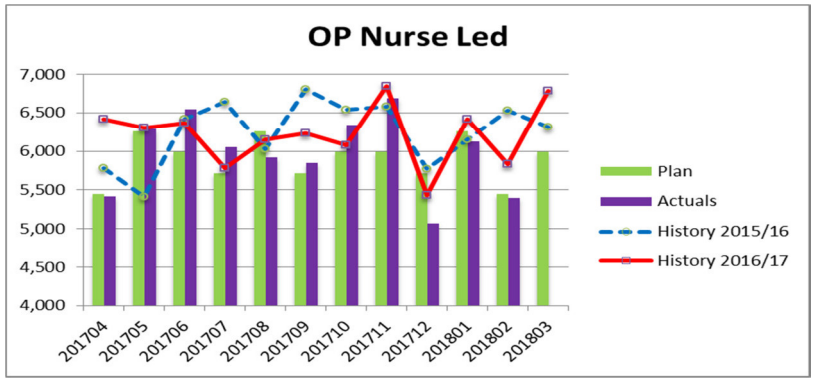
Outpatient Procedures are 5,187 procedures above history (8.2 %) and 2,430 procedures above plan (3.7%). The variance against plan has improved since August and compared to history (graph below). This is largely due to improvements in the recording of Lucentis procedures within Ophthalmology and laser and hygienist procedures in OMFS/Orthodontics.



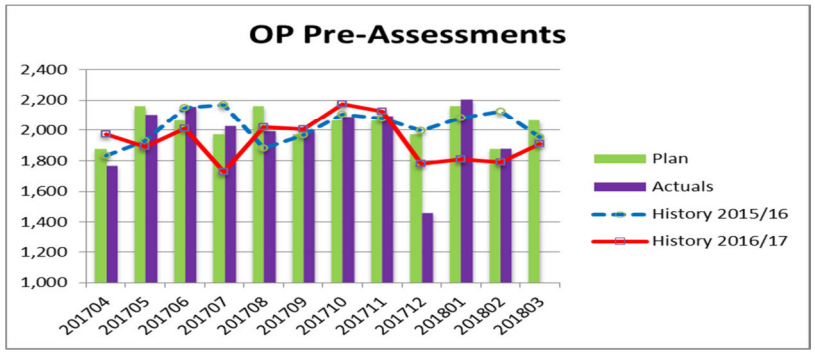
Row Labels	Plan	Actuals	Sum of Var Vs Plan	Var vs Plan %	History 2016/17	Sum of Var Vs History
OP PROCEDURE	**65,793**	**68,223**	**2,430**	**4%**	**63,036**	**5,187**
Accident & Emergency	111	149	38	34%	42	107
Anaesthetics	0	46	46	0%	47	-1
Breast Surgery	2	0	-2	-100%		0
Cardiology	846	749	-97	-11%	728	21
Clinical Neurophysiology	2,730	2,983	253	9%	2,749	234
Colorectal Surgery	232	201	-31	-13%	624	-423
Diabetic Medicine	0	41	41	0%	32	9
ENT	11,407	11,273	-134	-1%	11,552	-279
Gastroenterology	5	7	2	31%	9	-2
General Surgery	102	48	-54	-53%	78	-30
Geriatric Medicine	6	0	-6	-100%		0
Gynaecology	3,446	3,370	-76	-2%	3,088	282
Medical Oncology	4	8	4	95%	4	4
Nephrology	2	1	-1	-45%	1	0
Neurology	5	0	-5	-100%		0
Obstetrics	188	562	374	198%	764	-202
Ophthalmology	32,344	33,579	1,235	4%	31,344	2,235
Oral & Maxillo Facial Surgery	1,721	2,039	318	18%	253	1,786
Orthodontics	835	1,028	193	23%	381	647
Paediatrics	322	304	-18	-5%	304	0
Pain Management	0	1	1	0%	3	-2
Rehabilitation	1	0	-1	-100%		0
Respiratory Medicine	59	43	-16	-27%	21	22
Rheumatology	613	1,160	547	89%	661	499
Stroke Medicine	1	0	-1	-100%		0
Transient Ischaemic Attack	0	0	0	0%		0
Trauma & Orthopaedics	2,931	2,614	-317	-11%	2,382	232
Upper Gastrointestinal Surgery	0	14	14	0%	20	-6
Urology	7,881	8,003	122	2%	7,947	56
Vascular Surgery	0	0	0	0%	2	-2
Grand Total	65,793	68,223	2,430	4%	63,036	5,187

Position for Activity by POD (Month 11)

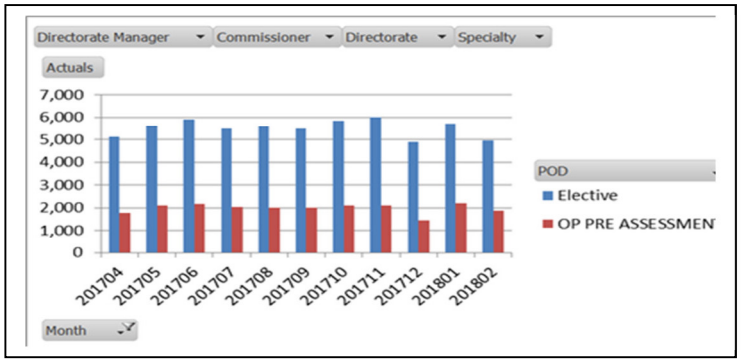
Other Outpatient Areas

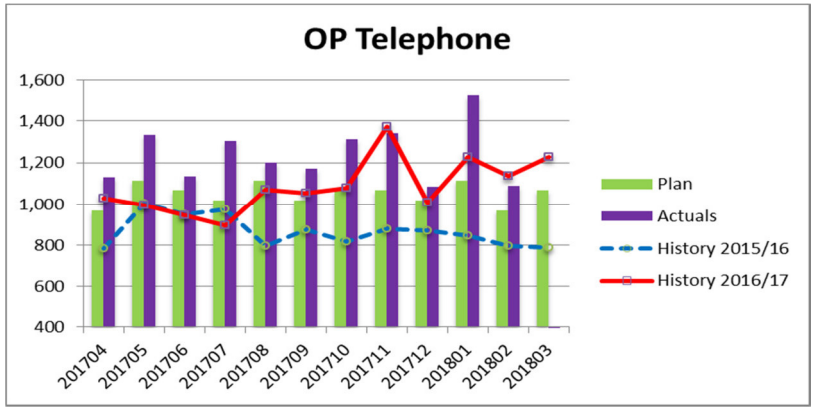


Non Consultant Led Outpatient activity is 1,811 attendances (2.8 %) below history however 1,416 attendances (2.3%) above plan. Specialties with the greatest over-performance against plan include Rheumatology and Paediatrics. Specialties with the greatest under performance are T&O and Urology.



Pre-Assessment activity is 569 attendances (2.5%) down against plan but 443 attendances (2%) above history. The numbers of PAAC appointments are consistently in proportion to Electives. Not all Elective spells require PAAC.



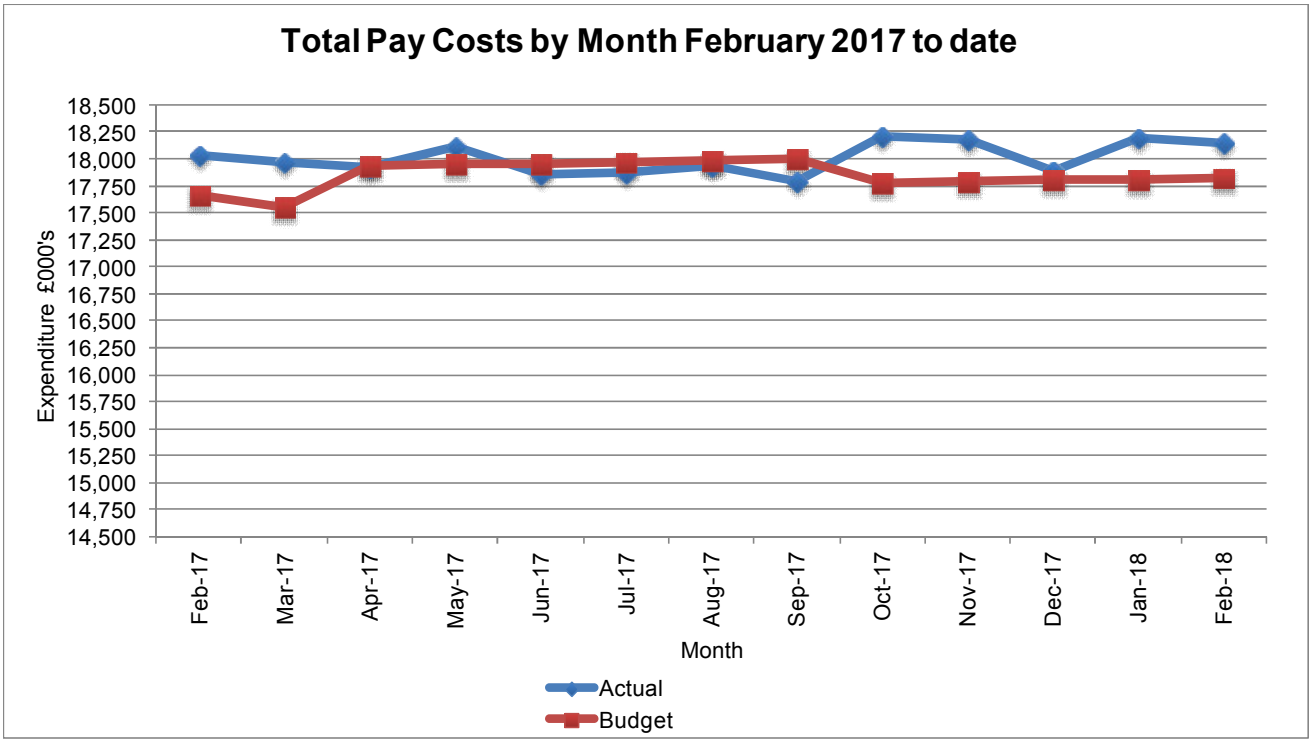


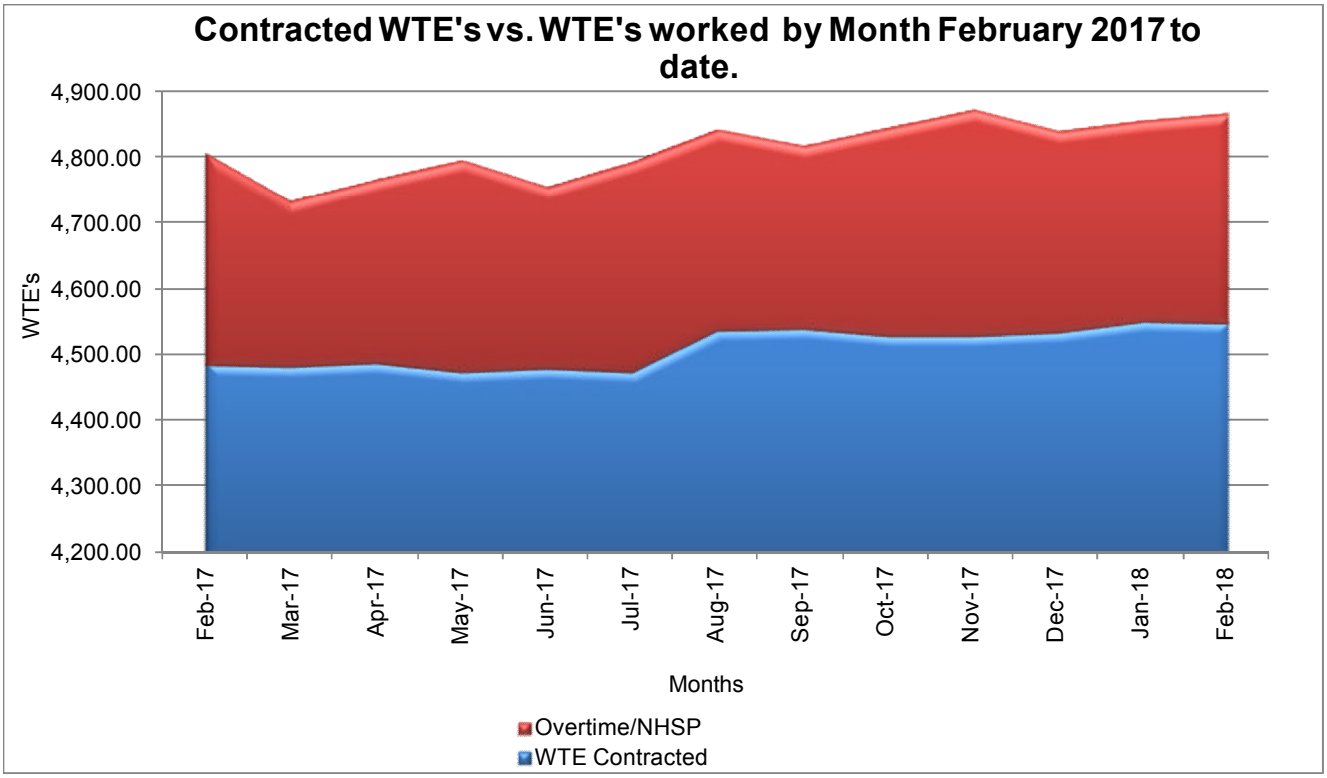
Non-Face to Face Outpatient contacts are 1,510 contacts (13%) above history and 1,770 contacts above plan (15.5%).

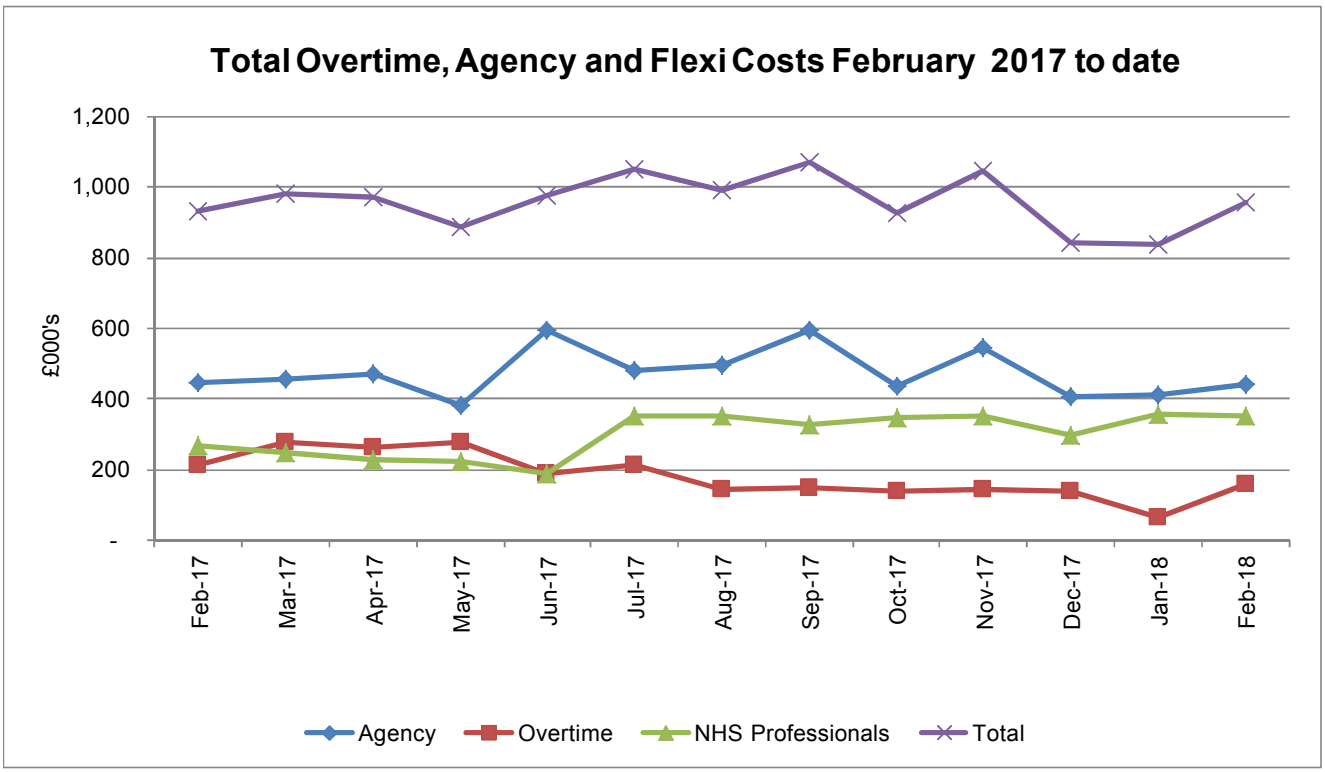
Specialties with the greatest variance against plan include Trauma & Orthopaedics, Gastroenterology, and Genitourinary Medicine.

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.

Appendix 4


Total Pay Costs by Month February 2017 to date
Expenditure £000's
18,500
18,250
18,000
17,750
17,500
17,250
17,000
16,750
16,500
16,250
16,000
15,750
15,500
15,250
15,000
14,750
14,500
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Month
Actual
Budget


Contracted WTE's vs. WTE's worked by Month February 2017 to date.
WTE's
4,900.00
4,800.00
4,700.00
4,600.00
4,500.00
4,400.00
4,300.00
4,200.00
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Months
Overtime/NHSP
WTE Contracted



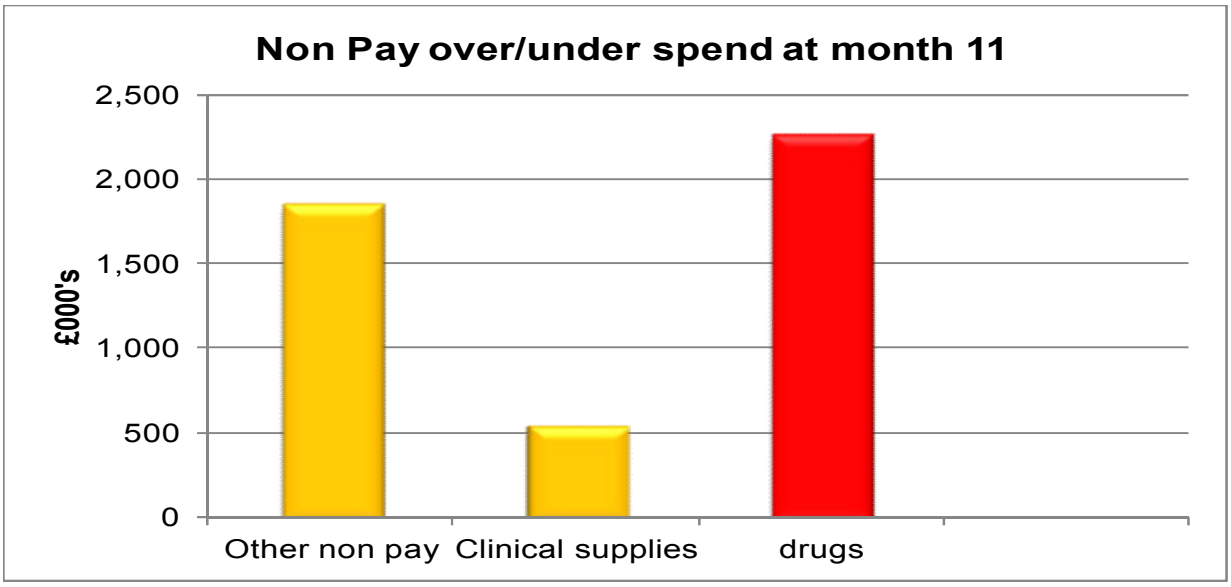
NHS Improvement Agency cap ceiling compliance City Hospitals Sunderland

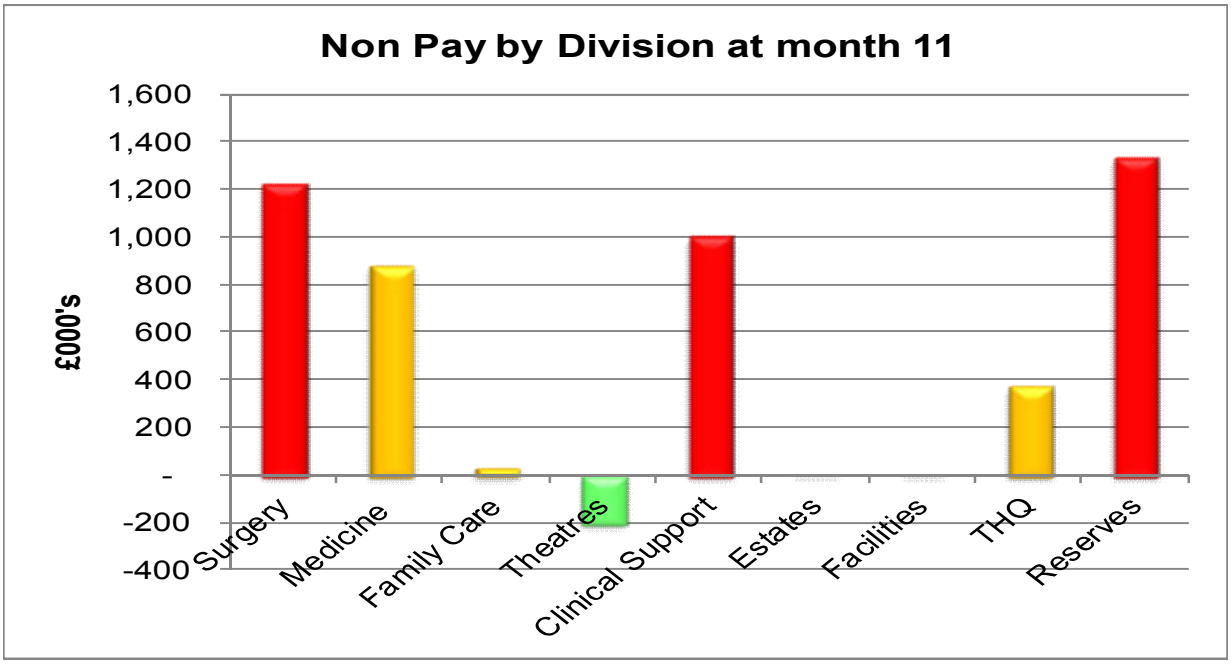
	Month Monthly Expenditure Ceiling £000s	CHS Annual Plan £000s	Actual in month agency cost £000s
Oct-16	497	417	390
Nov-16	497	417	373
Dec-16	485	407	412
Jan-17	461	387	416
Feb-17	461	387	449
Mar-17	460	386	457
Apr-17	516	357	473
May-17	516	357	386
Jun-17	516	357	594
Jul-17	516	357	485
Aug-17	516	357	494
Sep-17	516	357	593
Oct-17	516	357	439
Nov-17	516	357	546
Dec-17	516	357	405
Jan-18	516	357	413
Feb-18	516	357	444
Mar-18	516	357	
Jun-18	516	357	
Total	**9,570**	**7,045**	**7,769**

Key Issues on pay

- WTE numbers as at month 11 are 4,867, an increase of 10 WTEs compared to the previous month. This is predominantly due to an increase in demand for additional nursing shifts compared to the previous month.
- Agency spend to February 2018 was £5,272k against a budget of £3,932k.
- Against the ceiling the Trust is £404k under (ceiling to month 11 is £5,676k, actual was £5,272k).

Appendix 5





Key issues on non-pay

- Drugs are £2,267k overspent against plan to date, a £300k 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 £542k against plan to date, of which £410k 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 £1,855k against plan to date, most of which is due to £583k 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 £370k of the overspend is due to CIP under delivery against plan to date.

Key actions on non-pay

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

Appendix 6

CIPs Performance

Overall Financial Position & CIP Position - Month 11

	Surgery	Theatres	Medicine	Family Care	Clinical Support	THQ Corporate	Programme 12	Gap	Total
Divisional CIP's 17/18 £000's	-2,257	-463	-2,375	-811	-1,308	-1,647	-4,141		**-13,000**
Plan to date £000's	-2,047	-430	-2,155	-734	-1,174	-1,522	-3,638		**-11,700**
Actual to date £000's	-2,661	-563	-2,019	-681	-843	-1,971	-3,036		**-11,774**
Variance 17/18 £000's	-614	-133	136	53	331	-449	602		**-74**
Variance %	30%	31%	-6%	-7%	-28%	30%	**-17%**		1%

Key Issues with the CIP

To the end of February the planned savings are £11,700k, actual savings for the period are £11,774k, and hence ahead of plan by £74k.

Headline CIPs

- Surgery's nursing vacancies CIP savings amounted to £989k against a target of £327k, and hence an over delivery of £662k to date.
- Medicine's CIP under delivery of £136k to date is due to unidentified additional CIPs allocated in the month 5, most of which remains unidentified at this stage, however the shortfall has reduced from previous month.
- Clinical Support's CIP delivery is £331k 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 £133k is driven by vacant posts across all areas within Nursing and ODPs.
- Family Care's CIP delivery is £53k under delivered against plan to date due to unidentified additional CIPs allocated in month 5, most of which remains unidentified at this stage.
- THQ Division's CIP delivery is ahead of plan by £449k due largely to additional income received from South Tyneside FT from the single management structure and vacancies to date.
- The Trust has forecasted £13,075k of CIP delivery by the end of the year, and hence £75k more than the £13m plan set.

CIP - original Annual Plan vs. actual delivery plan today

	Identified Plans	Unidentified Target	Total per APR	This is as per Monitor Plan to Month 11 £	Actual to Month 11 £	Variance £
Revenue Generation	772	28	800	696	711	-15
Pay	6,489	511	7,000	6,161	6,003	158
Clinical Supplies	2,932	-1,432	1,500	1,530	2,417	-887
Drugs	670	330	1,000	893	593	300
Other Non Pay	1,639	1,061	2,700	1,885	1,524	361
Depreciation	574	-574		535	526	9
Total £	**13,075**	**-75**	**13,000**	**11,700**	**11,774**	**-74**

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF PLANNING AND BUSINESS DEVELOPMENT

BOARD OF DIRECTORS

MARCH 2018

PERFORMANCE REPORT

INTRODUCTION

Please find enclosed the Performance Report for February 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 February has improved slightly to 85.2% but continues to under-perform against the 95% target due to ongoing winter pressures. Performance was also below the STF trajectory of 90.3%.

Performance for March currently stands at 87.1% (as at 20th March). This is due to ongoing operational pressures (acuity of patients, emergency admission and bed pressures).

National performance for February has remained stable at 85.0%. The Trust has returned to the upper middle 25% of Trusts nationally and we were ranked 80th out of 160 acute Trusts.

Referral to Treatment Time (RTT)

Performance remains above target at 93.7% with all specialties achieving the target apart from T&O, Thoracic Medicine and Oral & Maxillo Facial Surgery.

National performance for January remains stable and continues to fail the standard at 86.6%.

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

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

National performance for the 62 day standard reduced in January and remains below target at 81%.

Indicative performance for February is currently below the 62 day standard as volumes of treatments are relatively low.

2WW performance is at risk of failing the operating standard of 93% in March due to the adverse weather conditions in late February, whereby a large numbers of patients were unable to attend.

Diagnostics

Performance for February has continued to achieve the national operating standard at 0.2%. National performance in January has deteriorated further to 2.4% 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 (DTOC) over the winter period, which equates to our performance during June 2017, at which point there were 73 delayed days relating to 9 patients. During February the DTOC target was not achieved with a rate of 1.11% from 193 delayed days relating to 17 patients.

RISKS

The following areas are considered to be risks that could impact upon achievement of the targets going forwards:

- A&E 4-hour for March due to the current level of performance.
- Cancer 62 days going forwards due to Urology capacity for mapping and fusion biopsies.
- Cancer 2WW for March due to impact of adverse weather.
- Diagnostics in March due to ongoing increases to the non-obstetric ultrasound waiting list and cystoscopy equipment failure at Shotley Bridge, which is currently being assessed.

FINANCIAL IMPLICATIONS

For February, there are minimal local penalties to be applied. The ambulance diverts and deflections information for January was not received in time for February's report; whilst there was a penalty of £4k (2 diverts/deflections

away from the Trust), the Trust received 16 ambulances from other Trusts, which equates to an incentive of £24k.

We are not currently meeting the financial control total for Q4. STF funding relating to A&E 4-hour performance is based solely on achieving 95% in March 2018, which is a risk, whereby £970k (including funding linked to achievement of the streaming target) is at stake subject to achievement of the control total.

RECOMMENDATIONS

Directors are asked to accept this report.

Alison King
Head of Performance and Information Management

City Hospitals Sunderland chs

Performance Report
February 2018

City Hospitals Sunderland Performance Report Overview

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

Key:

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

Page title representing a key performance indicator or a

Indicator group

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

Narrative highlighting recent performance and corrective actions, where applicable

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

Cancer 2 Week Waits

National Operational Standards

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

Director Lead: Sean Fenwick

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

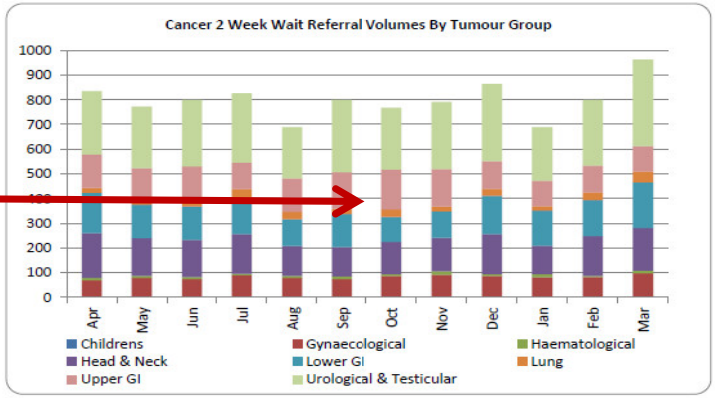
Potential financial sanction if standard not achieved = £200 per breach

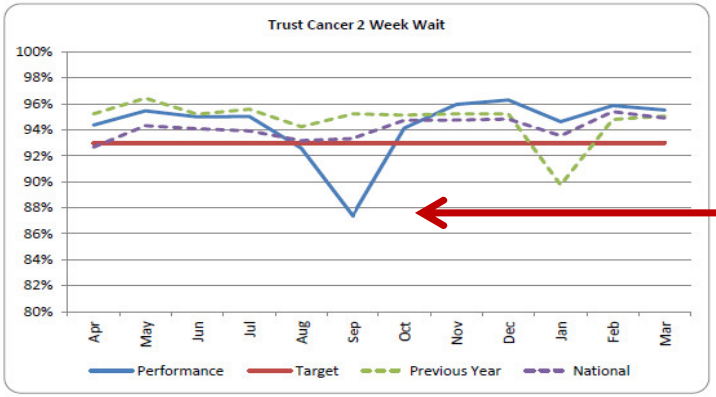
2WW performance has remained stable in March at 95.5%, which continues to perform above target. At tumour site level, all areas achieved the target this month.
March's performance demonstrated that all tumour groups are performing about the same or better than the equivalent national benchmarking position.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

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

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

Table showing current performance compared to target (where relevant)





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

City Hospitals Sunderland Performance Scorecard

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

Indicator	Director Lead	Target	2016/17	2017/18					12-month trend	Page
			Actual	Month[1]	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD	
Operational Performance Measures - NHSI SOF: These metrics are used by NHS Improvement and form one of the five themes from the Single Oversight Framework, which is used to assess our operational performance. This will influence our segmentation and level of support. They also form part of the 2017/18 NHS Standard Contract.										
A&E - % seen in 4hrs	Sean Fenwick	≥95%	92.97%	85.18%	94.47%	95.00%	89.96%	84.60%	91.61%	4
RTT - % incompletes waiting <18 wks	Sean Fenwick	≥92%	94.00%	93.72%	94.55%	94.41%	94.36%	93.79%	94.32%	5
Cancer waits - % 62 days	Sean Fenwick	≥85%	84.00%	88.70%	76.99%	85.18%	85.91%	88.70%	83.37%	6
% Diagnostic tests ≥6 wks	Sean Fenwick	<1%	2.14%	0.19%	2.75%	1.39%	0.67%	0.23%	1.37%	7
National Operational Standards: These are national targets that the NHS must achieve, mostly falling under the domain of quality, which are linked to delivery of the NHS Constitution. They also form part of the 2017/18 NHS Standard Contract.										
Cancelled operations 28 day breaches	Sean Fenwick	0	34	4	11	12	5	12	40	N/A
Cancer waits - % 2ww	Sean Fenwick	≥93%	95.91%	96.53%	96.86%	96.36%	96.95%	96.53%	96.72%	8
Cancer waits - % 31 days	Sean Fenwick	≥96%	98.67%	98.65%	97.43%	98.34%	98.70%	98.65%	98.20%	9
Cancer waits - % 31 days for subsequent treatment - surgery	Sean Fenwick	≥94%	98.40%	97.37%	96.43%	96.51%	96.63%	97.37%	96.63%	9
Cancer waits - % 31 days for subsequent treatment - drugs	Sean Fenwick	≥98%	99.90%	100.00%	100.00%	100.00%	99.58%	100.00%	99.87%	9
Cancer waits - % 62 days from screening programme	Sean Fenwick	≥90%	100.00%	100.00%	100.00%	87.50%	100.00%	100.00%	96.15%	6
Cancer waits - % 62 days from consultant upgrade	Sean Fenwick	NA	88.20%	72.73%	75.44%	76.39%	86.44%	72.73%	78.89%	6
National Quality Requirements: These also form part of the 2017/18 NHS Standard Contract. In addition there are a number of zero tolerance indicators that are reported by exception, including Mixed Sex Accommodation breaches, A&E 12-hour trolley waits and urgent operations cancelled for the second time										
RTT - No. incompletes waiting 52+ weeks	Sean Fenwick	0	0	0	0	0	0	0	0	N/A
A&E / ambulance handovers - no. 30-60 minutes	Sean Fenwick	0	1349	156	239	50	283	392	964	4
A&E / ambulance handovers - no. >60 minutes	Sean Fenwick	0	381	34	41	4	80	108	233	4
% VTE risk assessments	Ian Martin	≥95%	98.49%	98.71%	98.64%	98.79%	98.57%	98.82%	98.69%	N/A

1. Performance is one month behind normal reporting for all Cancer indicators (January 2018)

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

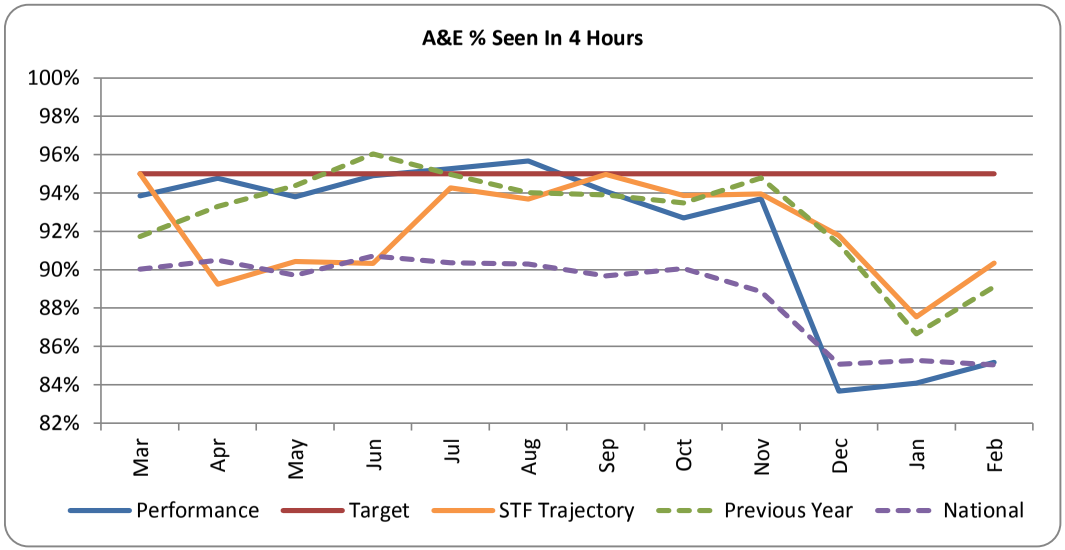
Consequence of failure: Patient experience, quality, access, reputation & financial impact if the STF trajectory is not achieved, which equates to £970k for achievement in March 2018

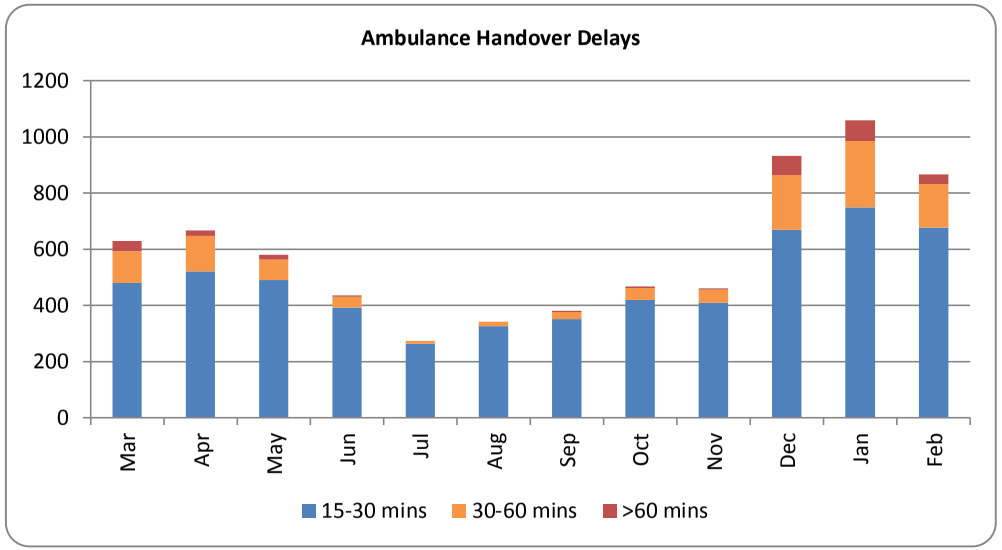
The total proportion of patients seen in A&E within 4 hours increased during February to 85.18%, which is below the national operating standard and STF trajectory. Winter pressures continued in February with the majority of the month operating at escalated OPAL status. There continues to be increased levels patients suffering from high acuity conditions compounded by staffing pressures. Flu related attendances reduced during the month. For February the trust returnsto the upper middle quartile of trusts nationally and is ranked 80th out of 160 acute trusts, compared to 75th in February 2017.

There were 11,806 attendances this month, which is 1% higher than February 2017 (type 1 was up by 2%, type 2 was down by 10% and type 3 was up by 8%). There was an increase in adult ED attendances (+3.1%). Admitted patient breaches were predominantly due to waiting to be seen and bed waits.

There were 2,336 ambulance arrivals this month, which is less than February 2017. This represents the third highest volume of ambulance arrivals for any hospital across the North East. The number of over 30 minute handover delays decreased this month reflecting fewer ambulance arrivals and improvements in patient flow in the trust. This equates to 8.1% of all arrivals, which is about the same as the regional average.

A&E Indicators - February 2018	Target	Month	YTD
A&E % seen in 4hrs - Trust Total	≥95%	85.18%	91.61%
A&E < 4 hrs - Type 1	≥95%	76.53%	86.48%
A&E < 4 hrs - Type 1 - High Acuity	≥95%	54.74%	72.99%
A&E < 4 hrs - Type 1 - Low Acuity	≥95%	74.53%	85.70%
A&E < 4 hrs - Type 1 - Paediatrics	≥95%	96.50%	98.08%
A&E < 4 hrs - Type 2 - SEI	≥95%	99.37%	99.26%
A&E < 4 hrs - Type 3 - Pallion walk in centre	≥95%	99.34%	99.70%
A&E Attendances - Trust Total		11,806	142,998
A&E Attendances - Type 1		7,334	86,740
A&E / ambulance handovers - no. 15-30 minutes	0	676	5,263
A&E / ambulance handovers - no. 30-60 minutes	0	156	964
A&E / ambulance handovers - no. >60 minutes	0	34	233





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 February has remained about the same as January's position.

At specialty level Trauma & Orthopaedics (T&O), Oral Surgery 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 continue to impact on their position with cancelled operations affecting performance.

Both Oral Surgery and Thoracic Medicine failed to achieve standard due to capacity challenges. Oral Surgery are providing additional sessions in March and April, with improvements expected by April.

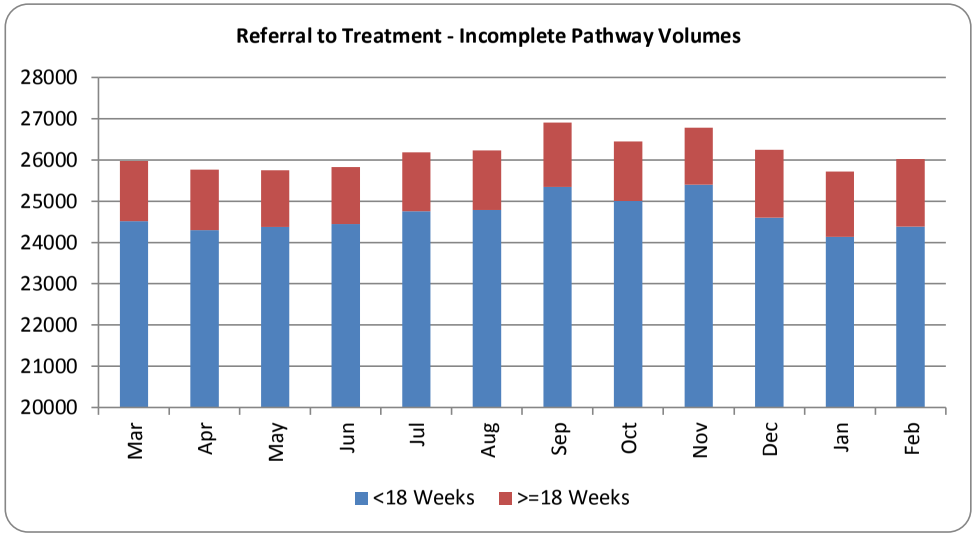
Thoracic Medicine have implemented changes to their clinics to improve performance. Weather conditions in late February will impact upon March's RTT performance (cancelled clinics and reduced referrals).

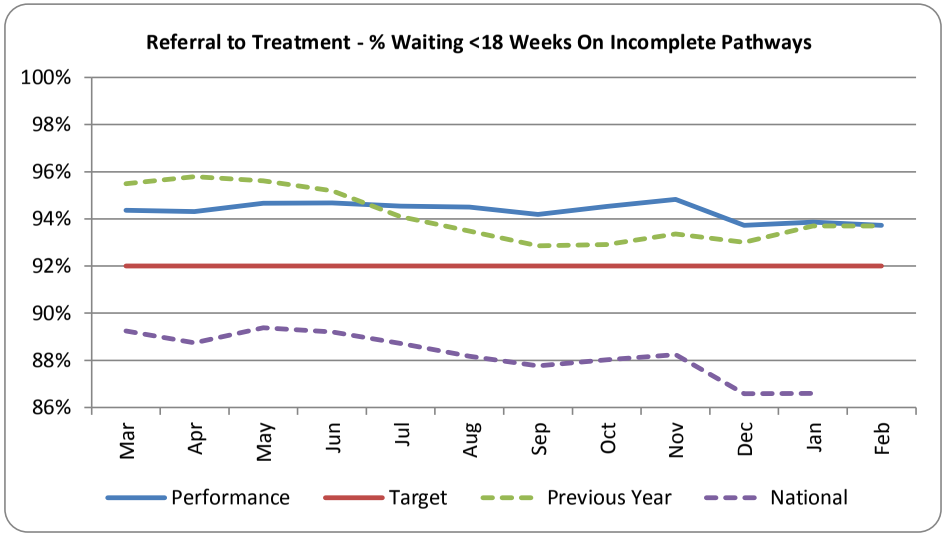
The Trust's RTT stress test risk rating improved in January and the trust has been assessed as having a 15% chance of failing the operational standard in the next 6 months. We are ranked 15th (best) nationally out of 152 trusts.

RTT Incompletes - February 2018	Volume	No. ≥18 Weeks	% <18 Weeks*
Target			**≥92%**
Cardiology	589	12	97.96%
Ear, Nose & Throat	2,511	151	93.99%
Gastroenterology	386	0	100.00%
General Surgery	1,899	108	94.31%
Geriatric Medicine	406	14	96.55%
Gynaecology	980	17	98.27%
Neurology	725	9	98.76%
Ophthalmology	3,911	109	97.21%
Oral & Maxillo Facial Surgery	2,073	194	90.64%
Rheumatology	701	30	95.72%
Thoracic Medicine	673	63	90.64%
Trauma & Orthopaedics	3,149	571	81.87%
Urology	2,720	152	94.41%
Other	5,293	203	96.16%
Trust Total	**26,016**	**1,633**	**93.72%**

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

RTT Stress Test	Nov-17	Dec-17	Jan-18
% Risk of failure in next 6 months	9.11%	16.88%	15.32%
National rank (1st is best)	17/152	18/152	15/152





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 achieved both the national target and STF trajectory and performance was better than national average. All tumour groups achieved the target with the exception of Breast (low volume), Head & Neck (low volume) and Lung (low volume). There were 10 breaches in total, mainly due to capacity and patient choice.

The Consultant Upgrade breaches were attributable to the Lung tumour group.

The volume of patients who are approaching their breach date has reduced recently. The main reduction was seen in the 15-28 day group. The main areas of risk going forwards are Head & Neck, Urology and Lung.

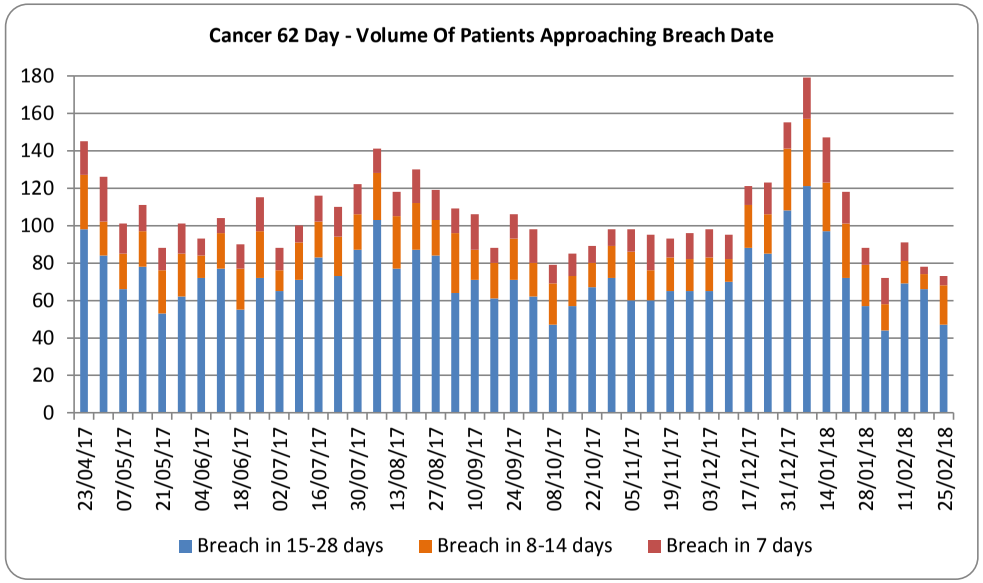
There are capacity issues in Urology relating to mapping and fusion biopsies which may impact on 62 day performance going forwards. This is being looked into by the operational team.

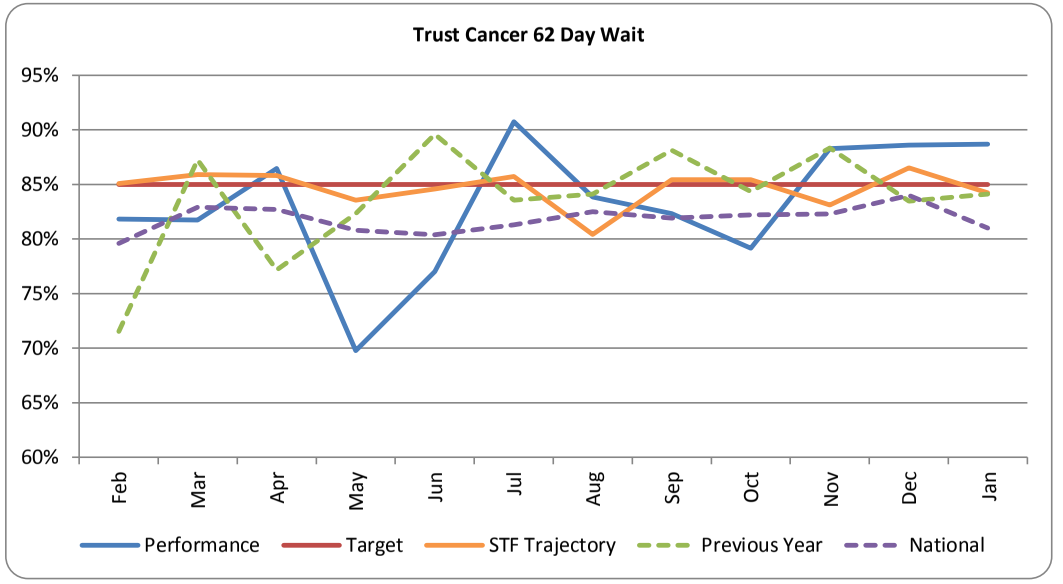
Indicative performance for February is currently below the national target.

First Definitive Treatment - January 2018*	Volume	Total Breached	Performance	National Performance	YTD	Number ≥104 days
Target			85%	85%	85%	0
Breast	1.0	0.5	50.00%	93.5%	84.21%	0
Gynaecological	4.5	0.5	88.89%	76.9%	90.77%	0
Haematological (Excluding Acute Leukaemia)	4.0	0.0	100.00%	81.2%	83.12%	0
Head & Neck	6.0	3.0	50.00%	61.4%	73.33%	0
Lower Gastrointestinal	5.0	0.0	100.00%	73.8%	87.05%	0
Lung	1.5	0.5	66.67%	70.9%	58.06%	0
Other	1.0	0.0	100.00%	70.6%	92.31%	0
Sarcoma	0.5	0.0	100.00%	71.8%	42.86%	0
Skin	8.0	0.0	100.00%	94.5%	89.69%	0
Upper Gastrointestinal	8.0	0.5	93.75%	72.1%	79.55%	1
Urological (Excluding Testicular)	49.0	5.0	89.80%	76.4%	85.21%	2
Total	**88.5**	**10.0**	**88.70%**	**81.0%**	**83.37%**	**3**

Non GP Referrals						
Screening (Target: 90%)	1.5	0.0	100.00%	87.7%	96.15%	0
Consultant Upgrade	5.5	1.5	72.73%	87.0%	78.89%	0

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





Diagnostics

NHSI SOF Operational Performance & National Operational Standard

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

Director Lead: Sean Fenwick

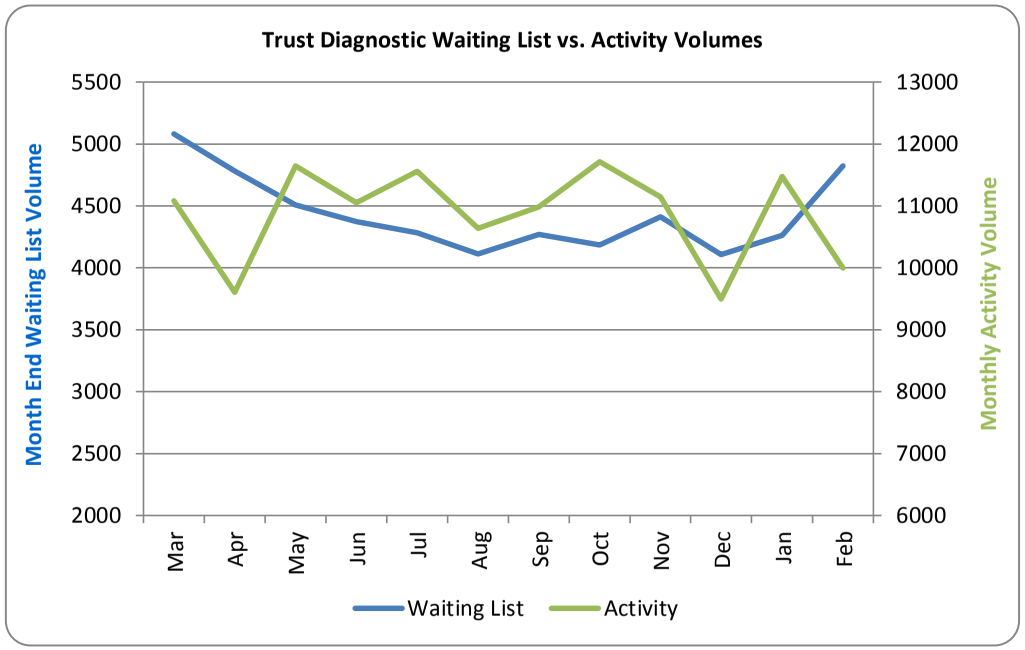
Consequence of failure: Patient experience, quality, access & reputation

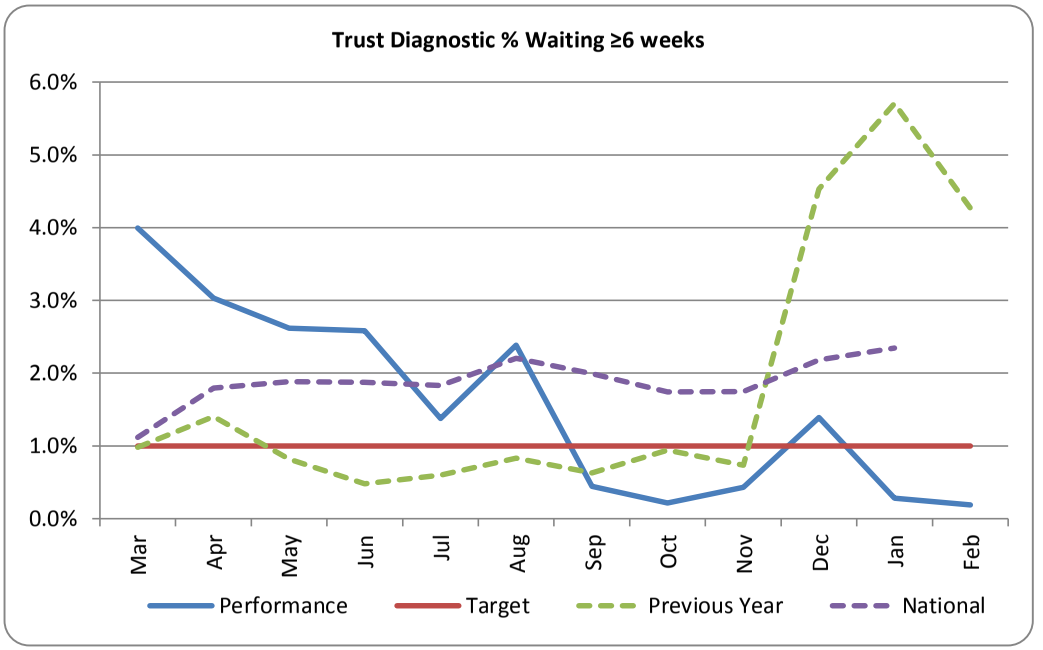
The proportion of patients waiting 6 weeks or more at the end of February has reduced to 0.19% , which achieves the national operating standard of <1% and is better than the latest national average.

Activity has decreased in February, with the main reductions seen in Computed Tomography (CT), Non-Obstetric Ultrasound and Cardiology tests. This is reduction is in line with historical trends. As a result, the number of patients waiting for a diagnostic test at the end of the month has increased, mainly for Non-Obstetric Ultrasounds and CTs.

The increase in Ultrasound waiting list is as a result of cancelled sessions in December. Assurance has been provided that there is capacity to manage the increase in the waiting list.

Diagnostics - February 2018		WL Volume	No. ≥6 weeks	%≥6 weeks	Activity
Target				≤1%	
Imaging	Magnetic Resonance Imaging	585	0	0.00%	1,291
	Computed Tomography	521	0	0.00%	2,851
	Non-obstetric ultrasound	1,934	1	0.05%	2,675
	Barium Enema	29	0	0.00%	4
	DEXA Scan	174	0	0.00%	156
Physiological Measurement	Audiology - assessments	231	0	0.00%	931
	Cardiology - echocardiography	315	0	0.00%	777
	Neurophysiology - peripheral	93	0	0.00%	149
	Respiratory physiology - sleep studies	132	0	0.00%	58
	Urodynamics - pressures & flows	39	0	0.00%	24
Endoscopy	Colonoscopy	167	2	1.20%	241
	Flexi sigmoidoscopy	66	1	1.52%	71
	Cystoscopy	281	4	1.42%	455
	Gastroscopy	256	1	0.39%	313
Trust Total		**4,823**	**9**	0.19%	**9,996**





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 continues to achieve the operating standard and remains higher than the national average.

At tumour site level, all areas achieved the target with the exception of Upper Gastrointestinal. Most breaches were related to patient choice this month.

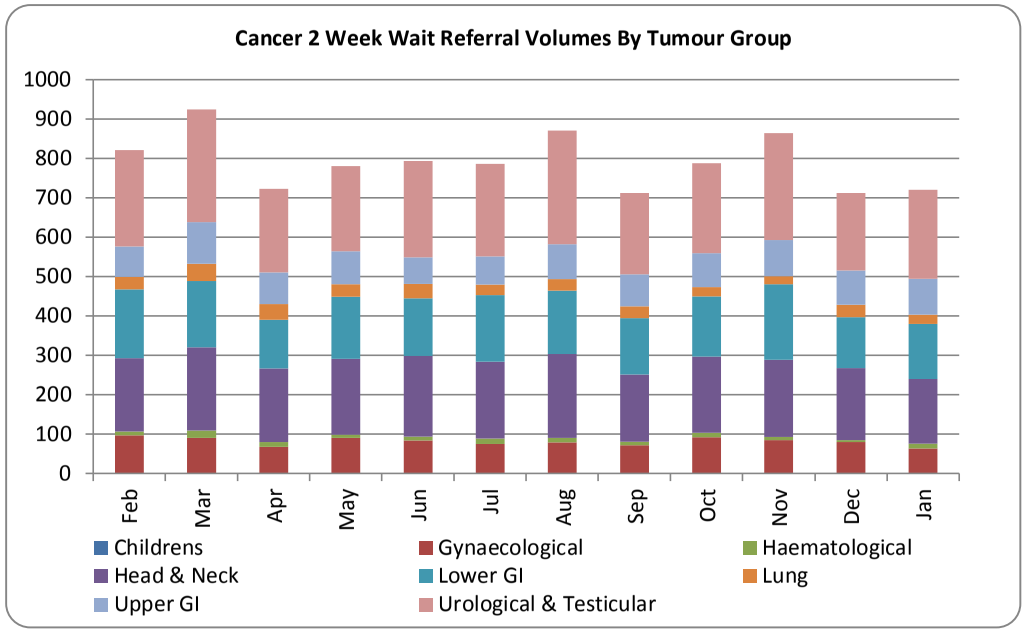
January's performance demonstrated that all tumour groups performed about the same or better than the equivalent national performance position.

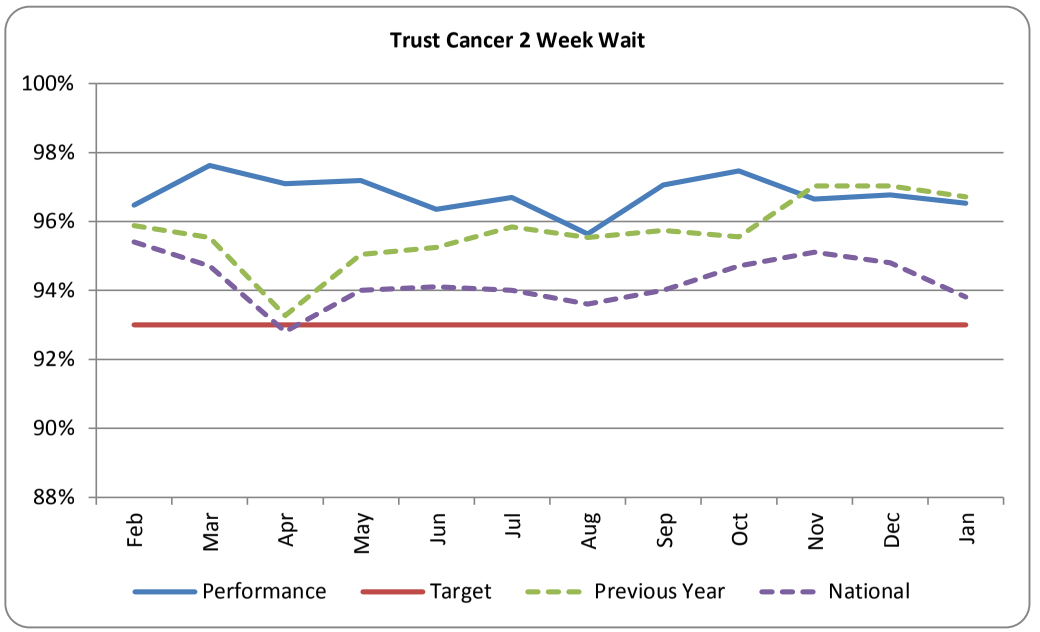
Overall referral volumes were about the same as the previous month during January.

Indicative 2WW performance for February is above target.

Referrals for Suspected Cancer - January 2018*	Volume	Total Breached	Performance	National Performance	YTD
Target			**93%**	**93%**	**93%**
Acute Leukaemia	0	0	-	-	100.00%
Breast	0	0	-	94.8%	-
Children's Cancer	0	0	-	95.8%	100.00%
Gynaecological	64	0	100.00%	95.8%	97.34%
Haematological (Excluding Acute Leukaemia)	12	0	100.00%	95.0%	96.08%
Head & Neck	163	3	98.16%	94.8%	96.93%
Lower Gastrointestinal	140	7	95.00%	91.0%	95.51%
Lung	24	0	100.00%	95.8%	98.64%
Other	0	0	-	85.6%	100.00%
Testicular	23	0	100.00%	-	100.00%
Upper Gastrointestinal	91	10	89.01%	91.1%	94.57%
Urological (Excluding Testicular)	203	5	97.54%	94.4%	97.55%
Total	**720**	**25**	**96.53%**	**93.8%**	**96.72%**

*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

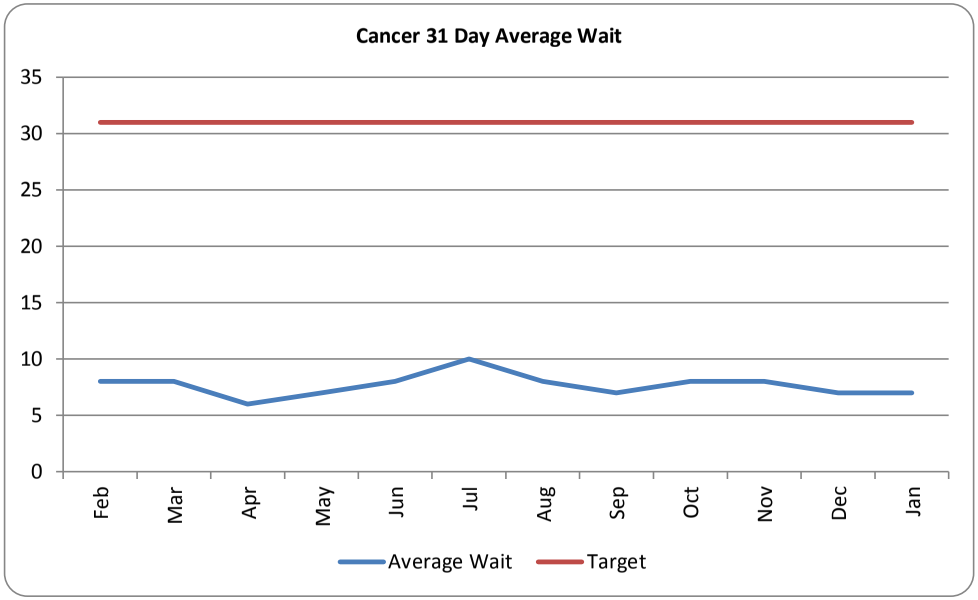
Consequence of failure: Timely access to treatment, patient experience & clinical outcomes.

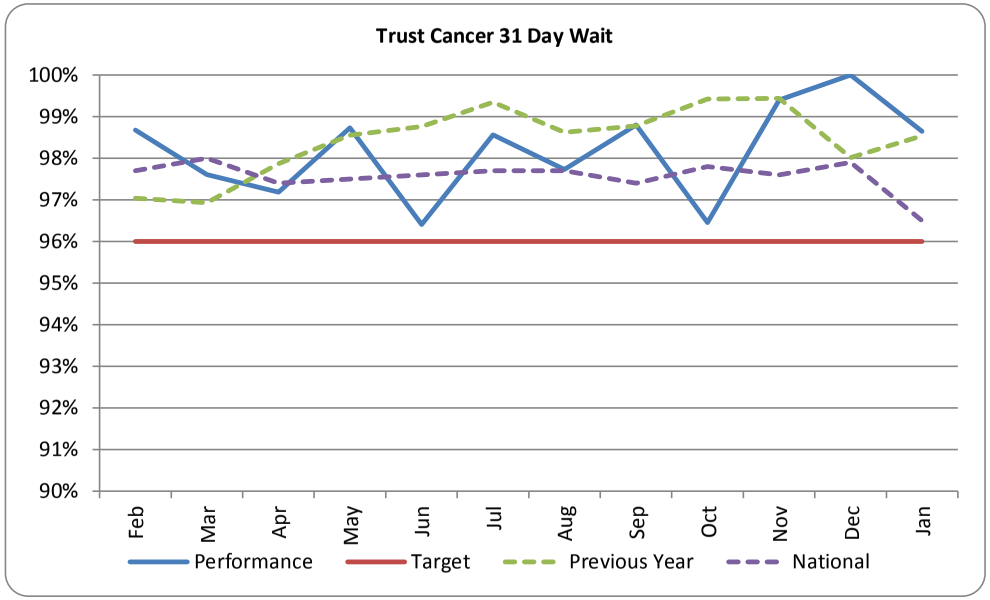
Aggregate level performance reduced slightly during January but continues to achieve the national target at 98.7%. All tumour groups achieved the target with the exception of Head & Neck (low volume). January's performance demonstrated that all tumour groups performed about the same or better than the equivalent national performance position.

The average wait time in January remained stable at 7 days.
Indicative performance for February is currently above target.
The final performance for subsequent surgery and drug treatments in January was 97.4% (1 x Skin breach) and 100% respectively.

First Definitive Treatment - January 2018*	Volume	Total Breached	Performance	National Performance	YTD
Target			**96%**	**96%**	**96%**
Breast	2	0	100.00%	98.0%	100.00%
Gynaecological	5	0	100.00%	96.2%	100.00%
Haematological	9	0	100.00%	99.3%	100.00%
Head & Neck	12	1	91.67%	90.0%	93.75%
Lower Gastrointestinal	9	0	100.00%	96.7%	100.00%
Lung	15	0	100.00%	97.0%	100.00%
Other	2	0	100.00%	98.2%	100.00%
Sarcoma	0	0	-	95.1%	100.00%
Skin	9	0	100.00%	95.9%	93.75%
Upper Gastrointestinal	11	0	100.00%	98.4%	100.00%
Urological	74	1	98.65%	95.1%	97.81%
Total	**148**	**2**	**98.65%**	**96.5%**	**98.20%**
Subsequent Treatments					
Surgery (Target: 94%)	38	1	97.37%	93.6%	96.63%
Drug (Target: 98%)	79	0	100.00%	99.0%	99.87%

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





ENCLOSURE 6

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

MARCH 2018

ASSURANCE FRAMEWORK 2017/18

Introduction

The attached document (Appendix 1) provides an update on the progress around managing the key risks identified within the 2017/18 Assurance Framework. This is an important document as it provides assurances around the work being undertaken by the Trust to manage major risks faced by the Trust during the year and supports the 'Annual Governance Statement' requirements as part of the Annual Report process.

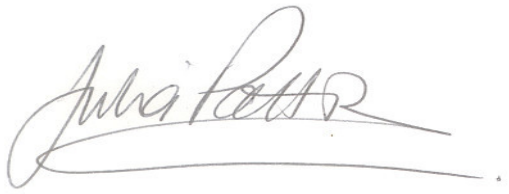
Updates

The attached appendix details updates provided by Director leads:

- Directors have reviewed their own sections and have taken proposals via the relevant Committee such as Finance & Performance Committee and Workforce Committee during January/February 2018.
- Governance Committee have then considered these updates at their meeting in February 2018 and recommend to the Board of Directors that they approve the final Assurance Framework document for 2017/18.

Conclusion

The Board of Directors are asked to approve the Assurance Framework document for 2017/18.



Julia Pattison
Exceutive Director of Finance

March 2018

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

MARCH 2018

GENDER PAY GAP REPORT

Introduction

This report details the Trust's obligations to report on the Gender Pay Gap.

Background and Context

The Gender Pay Gap Information Regulations introduced in April 2017 require all employers of 250 or more employees to publish their gender pay gap annually commencing 31 March 2018 with data as at 31 March 2017.

As part of the NHS, the Trust uses the national job evaluation framework for Agenda for Change to determine appropriate pay bandings for the vast majority of staff. This provides a clear and consistent process for paying employees equally for the same or equivalent work. Each grade has a set of pay points for annual progression. The longer the period of time someone has been employed in a particular grade, the higher their salary is likely to be, irrespective of their gender.

It should be noted that gender pay gap reporting is different to equal pay, which deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value.

The gender pay gap report is intended to show whether there is any the difference in **average pay** between men and women and the regulations require both 'mean' and 'median' average figures to be reported.

*A **mean** average involves adding up all of the numbers and dividing the result by how many numbers are in the list.*

*A **median** average involves listing all of the numbers in numerical order. If there is an odd number of results; the median average is the middle number. If there is an even number of results, the median will be the mean of the two central numbers.*

As required by the legislation the following information has been calculated for all employees:

1. The mean gender pay gap;
2. The median gender pay gap;
3. The mean bonus gender pay gap;
4. The median bonus gender pay gap;
5. The proportion of men receiving a bonus payment;
6. The proportion of women receiving a bonus payment;
7. The proportion of men and women in each pay quartile.

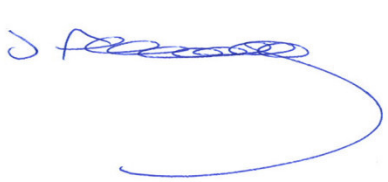
Gender Pay Gap Data for City Hopsitals Sunderland Foundation Trust

To help NHS organisations report on their gender pay gap, the NHS ESR Central Team has created a standard report within the ESR Business Intelligence reporting tool, which is designed to provide the results of all of the calculations detailed in the gender pay gap reporting regulations and uses data created and used in ESR, based on average hourly pay rates (excluding overtime).

The report for City Hospitals Sunderland Foundation Trust detailed in Appendix 1 has been produced using data as at 31 March 2017 and the default settings within the BI reports as set up by the NHS ESR Central Team.

Recommendations

Directors are asked to note the contents of this report and agree that this data can be submitted to the Government Gateway website for publication and published on the Trust's' website.



PP:

Kathleen Griffin
Director of Human Resources and Organisational Development

Appendix 1

GENDER PAY GAP REPORTING INFORMATION

CITY HOSPITALS SUNDERLAND

The data below has been collated by running the National Gender Pay Gap reports within the ESR Business Intelligence reporting tool. The data has been produced at 31 March 2017 to ensure compliance with the Gender Pay Reporting Regulations.

GENDER PAY GAP – AVERAGE HOURLY RATES

Mean Average Rates

- The mean average hourly rate for City Hospitals Sunderland is £16.50.
- The mean average hourly rate for men is £23.78.
- The mean average hourly rate for women is £14.90.
- **Women's hourly rate based on the mean average is therefore 37.36% lower than men's.**

Median Average Rates

- The median average hourly rate for City Hospitals Sunderland is £14.42.
- The median average hourly rate for men is £16.52.
- The median hourly rate for women is £13.69.
- **Women's hourly rate based on the median average is therefore 17.15% lower than men's.**

GENDER PAY GAP – BONUS PAY

The regulations require employers to report on any gender pay gaps in relation to bonus pay received. For City Hospitals Sunderland the only bonus pay included for the purposes of gender pay gap reporting is Clinical Excellence Awards (CEA), which are awarded only to Consultant Medical and Dental staff. To receive a CEA, Consultants must apply for the award and must meet certain criteria. To calculate the Bonus Gender Pay Gap, the mean and median averages have been used again, but this time based on the total amount of annual bonus received.

Mean Average Bonus Rates

- The mean bonus payment for City Hospitals Sunderland is £15,558.21.
- The mean bonus payment for men is £16,814.53.
- The mean bonus payment for women is £11,640.98.
- **Women's bonus pay based on the mean average is 30.77% lower than men's**.

Median Average Bonus Rates

- The median bonus payment for City Hospitals Sunderland is £11,934.30.

- The median bonus payment for men is £11,934.30.
- The median bonus payment for women is £5,730.17
- **Women's bonus pay based on the median average is 51.99% lower than men's**

As at 31 March 2017, there were a total of 274 Consultants within the organisation of which 76 (27.73%) were women.

A total of 114 Consultants received a CEA of which, 27 (23.68%) were women.

The total number of men in the organisation was 818 and of these, 87 (10.63%) received a CEA / bonus payment.

The total number of women in the organisation was 3,730 and of these, 27 (0.72%) received a CEA / bonus payment.

PAY QUARTILES BY GENDER

As part of the Regulations, organisations must split the hourly rate for each employee into four quarters (or 'Quartiles'), with the top earners being in the upper quarter. They must then report on how many men and women are in each quarter.

The table below shows the number and percentage of men and women in each quartile of City Hospitals Sunderland payroll:

Quartile	Women	Men	Women %	Men %
1 (lower)	986	151	86.72	13.28
2	988	149	86.9	13.1
3	973	164	85.58	14.42
4 (upper)	783	354	68.87	31.13

CONCLUSIONS - WHAT THE FIGURES TELL US

A gender pay gap has been identified for City Hospitals Sunderland. As at 31 March 2017, women accounted for 82% of the workforce and men 18%.

The table below shows the proportion of men and women by band or pay grade.

This shows that in Band 5 and Band 2, the highest proportion of staff are women - 89.69% and 87.17% respectively, whereas in the Consultant and Associate Specialist band / pay grade, 71.59% of staff are men.

This data helps to understand the reasons for the gender pay and bonus pay gaps reported above.

Band / Pay Grade	Women		Men		Total	
	Headcount	% of the workforce	Headcount	% of the workforce	Headcount	% of the workforce
Band 1	10	0.27%	6	0.73%	16	0.35%
Band 2	**1026**	**27.51%**	**151**	**18.46%**	**1177**	**25.88%**
Band 3	244	6.54%	43	5.26%	287	6.31%
Band 4	279	7.48%	13	1.59%	292	6.42%
Band 5	**1027**	**27.53%**	**118**	**14.43%**	**1145**	**25.18%**
Band 6	494	13.24%	93	11.37%	587	12.91%
Band 7	362	9.71%	72	8.80%	434	9.54%
Band 8A	86	2.31%	31	3.79%	117	2.57%
Band 8B	39	1.05%	6	0.73%	45	0.99%
Band 8C	2	0.05%	5	0.61%	7	0.15%
Band 8D	4	0.11%	4	0.49%	8	0.18%
Band 9	0	0.00%	1	0.12%	1	0.02%
Personal Salary	12	0.32%	15	1.83%	27	0.59%
Foundation Doctors	50	1.34%	38	4.65%	88	1.93%
Trust Doctors & Specialty Doctors	14	0.38%	18	2.20%	32	0.70%
Consultants & Associate Specialists	**81**	**2.17%**	**204**	**24.94%**	**285**	**6.27%**
Grand Total	**3730**	**100.00%**	**818**	**100.00%**	**4548**	**100.00%**

FIGURES TO BE PUBLISHED

The figures, which the Trust is required to publish on the Government Gateway and Trust website are as follows :-

Hourly Rate

Women's hourly rate is

- 37.36% lower than men's (mean average)
- 17.15% lower than men's (median average)

Bonus pay

Women's bonus pay is

- 30.77% lower than men's (mean average)
- 51.99% lower than men's (median average)

Who received bonus pay

- 10.63% of men received a bonus
- 0.72% of women received a bonus

Pay quartiles

The proportion of men and women in each pay quartile is shown in the table below:

Quartile	Women	Men	Women %	Men %
1 (lower)	986	151	86.72	13.28
2	988	149	86.9	13.1
3	973	164	85.58	14.42
4 (upper)	783	354	68.87	31.13

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF INFORMATION MANAGEMENT AND TECHNOLOGY

INFORMATION GOVERNANCE TOOLKIT

BOARD OF DIRECTORS

MARCH 2018

1. INTRODUCTION AND BACKGROUND

The purpose of this paper is to provide an overview of Information Governance (IG) and the IG Toolkit. The paper will then highlight the processes that City Hospitals Sunderland (CHS) has followed in completing the IG Toolkit, and will summarise the scores for the end of March 2018. Subject to approval, the final submission is to be made on 31st March 2018.

The Information Governance Toolkit is now in its fifteenth year, and has evolved to the point where it is being used by over 25,000 organisations. This is the last year that the IG Toolkit will be in its current format. The IG Toolkit has been substantially revised and updated, and from April 2018 will be known as the 'Data Security & Protection (DSP) Toolkit'. The emphasis of the new DSP Toolkit will be on organisational compliance with the National Data Guardian's 10 Data Security Standards, compliance with the General Data Protection Regulation, and ensuring Cyber Security within the organisation.

2. WHAT IS INFORMATION GOVERNANCE?

Information Governance is to do with the way organisations process or handle information. It covers personal information (ie that relating to patients/service users and employees), and corporate information (eg financial and accounting records).

Information Governance provides a way for employees to deal consistently with the many different rules about how information is handled, including those set out in:

- The Data Protection Act 1998;
- The Common Law Duty of Confidentiality;
- The Confidentiality NHS Code of Practice;
- The NHS Care Records Guarantee for England;
- The Social Care Records Guarantee for England;
- The international information security standard: ISO/IEC 27002: 2013 and ISO/IEC 27001:2013;
- The Information Security NHS Code of Practice;
- The Records Management NHS Code of Practice;
- The Freedom of Information Act 2000;
- The Human Rights Act article 8;

- The '*Report on the Review of Patient Identifiable Information (The Caldicott Report*)' and the '*Information: To share or not to share? The Information Governance Review (Caldicott 2 Review)*';
- Information: To share or not to share - Government Response to the Caldicott 2 Review.

Whilst a key focus of Information Governance is the use of information about service users, it applies to information and information processing in its broadest sense, and underpins both clinical and corporate governance. Accordingly it should be afforded appropriate priority.

The four fundamental aims of Information Governance are:

- To support the provision of high quality care by promoting the effective and appropriate use of information;
- To encourage responsible staff to work closely together, preventing duplication of effort and enabling more efficient use of resources;
- To develop support arrangements and provide staff with appropriate tools and support to enable them to discharge their responsibilities to consistently high standards;
- To enable organisations to understand their own performance and manage improvement in a systematic and effective way.

3. WHAT IS THE INFORMATION GOVERNANCE TOOLKIT?

The Information Governance Toolkit is a Department of Health (DH) Policy delivery vehicle that the Health and Social Care Information Centre (HSCIC) is commissioned to develop and maintain. It draws together the legal rules and central guidance set out by DH policy and presents them in in a single standard as a set of information governance requirements. The organisations in scope of this are required to carry out self-assessments of their compliance against the IG requirements.

4. WHAT ARE THE IG TOOLKIT REQUIREMENTS?

NHS Foundation Trusts

For Acute Trusts (including FTs), the IG Toolkit consists of 45 requirements divided across 6 initiatives:

- Information Governance Management;
- Confidentiality and Data Protection Assurance;
- Information Security Assurance;
- Clinical Information Assurance;
- Secondary Uses Assurance;
- Corporate Information Assurance.

5. WHAT IS THE PURPOSE OF THE IG ASSESSMENT?

The purpose of the assessment is to enable organisations to measure their compliance against the law and central guidance, and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

Where partial or non-compliance is revealed, organisations must take appropriate measures (eg assign responsibility, or put in place policies, procedures, processes & guidance for staff), with the aim of making cultural changes and raising Information Governance standards through year-on-year improvements.

The ultimate aim is to demonstrate that the organisation can be trusted to maintain the confidentiality and security of personal information. This in turn increases public confidence that the NHS and its partners can be trusted with personal data.

6. WHO HAS TO CARRY OUT THE IG ASSESSMENT?

All health and social care service providers, commissioners and suppliers must have regard to the Information Governance Toolkit Standard approved by the Standardisation Committee for Care Information (SCCI), which replaces the Information Standards Board (ISB) for Health and Social Care (ISB), and is a sub-group of the National Information Board (NIB).

All organisations that have access to NHS patient data must provide assurances that they are practising good information governance and use the IG Toolkit to evidence this. Where services are commissioned for NHS patients, the commissioner is required to obtain this assurance from the provider organisation and this requirement should be set out in the commissioner-provider contract.

It remains Department of Health policy that all bodies that process NHS patient information, for whatever purpose, should provide assurance via the IG Toolkit.

'Personalised Health and Care 2020: a framework for action' published by the National Information Board reinforces the need to build and sustain the trust and confidence of the public in the collection, storage and use of their sensitive personal data. The framework requires that the IG Toolkit is further developed to reflect enhanced Information Governance and data security requirements.

IG Toolkit assessments must be completed and published by all bodies that process the personal confidential data of citizens who access health and adult social care services. These include, but are not limited to:

- NHS organisations (Acute Trusts, Ambulance Trusts, Mental Health Trusts, Clinical Commissioning Groups) including Foundation Trusts and NHS Community Health Providers;
- NHS England;
- The Health and Social Care Information Centre (HSCIC);
- Local Authority Adult Social Care;
- Local Authority Public Health;
- Primary Care providers (Community Pharmacies/Dispensing Appliance Contractors, Dental Practices, Eye Care Services, General Practices);

- DH arms' length bodies that closely support care services (ie executive agencies such as the Medicines and Healthcare Products Regulatory Agency; special health authorities such as the NHS Business Services Authority);
- Bodies commissioned or otherwise contracted to provide services by any of the above;
- Public Health England.

In addition to the NHS mandate above, other organisations are required to provide IG assurances via the IG Toolkit as part of business/service support processes or contractual terms. That is, for these organisations annual IG Toolkit assessments are required for either or both of two purposes:

- To provide IG assurances to the Department of Health or to NHS commissioners of services;
- To provide IG assurances to HSCIC as part of the terms and conditions of using national systems and services including N3, Choose and Book etc.

7. WHO WILL ACCESS THE IG TOOLKIT SUBMISSION?

One of the primary aims of the IG Toolkit process is to force a change in the culture of NHS organisations. In order to do so, the results of the IG Toolkit will be made widely available. Likely scenarios are summarised below:

- The Public: Results and scores for all NHS organisations are now available via the internet for the public, media and other organisations to view;
- The Information Commissioners office (ICO): The ICO may choose to access this information to judge IG maturity as part of their investigation into any issue, complaint or incident;
- Care Quality Commission (CQC): The CQC now use the IG Toolkit to assess outcomes in their wider assessments;
- Internal Audit: Accessed as part of assurance on IG and information security programmes;
- External Audit: It is possible that the IG Toolkit submission could be audited externally;
- Commissioners: It is expected that increasingly commissioning bodies will pay further attention to an organisation's IG status as they assess the quality of an organisation and its processes.

8. INFORMATION GOVERNANCE TOOLKIT VERSION 14.1

Submission Deadlines

Interim submissions have been made, as required, by the following deadlines:

- Performance update by 31 October 2017.

The submission deadline for the final Version 14.1 assessment for all organisations is:

- Final submission by 31 March 2018.

Evidence Upload

The system allows you to specify evidence to support your assessment (eg a policy or procedure document). You can either upload evidence files directly to the IG Toolkit or reference an internet/intranet address or other location. The system tells you what evidence is expected for each requirement but there is inbuilt flexibility so you can also specify your own additional evidence.

Assessment Scoring

An organisation can see its current (and target) percentage score on the Assessment Summary page. The grading scheme is as follows:

- **Satisfactory** (coloured green): level 2 or level 3 achieved on all requirements.
- **Not Satisfactory** (coloured red): level 2 or level 3 not achieved on all requirements.

The main purpose of the IG Toolkit is to drive improvement, and a 'Not Satisfactory' (red) status is an effective way to get IG high up on the corporate agenda.

9. INFORMATION GOVERNANCE TOOLKIT – 2017/18 ACTIVITIES

CHS has again undertaken a full review of performance against the Information Governance Toolkit ready for the year-end submission to HSCIC for the end of March 2018 (To be approved by Executive Committee, Council of Governors and Board of Directors). This has been reviewed and approved by the joint CHS and STFT Information Governance Strategy Group (IGSG) on 5th March 2018.

During 2017/18, there has been a continued focus on:

- CHS – Reviewing and refreshing/updating all evidence to sustain at least level 2 performance against all requirements;
- CHS – Embedding a structured approach for external Clinical Coding audits spread across the year to assist with compliance of Requirement 505;
- CHS – Focusing on requirement 112 which pertains to ensuring that 95% of all staff have received Information Governance training during the year.

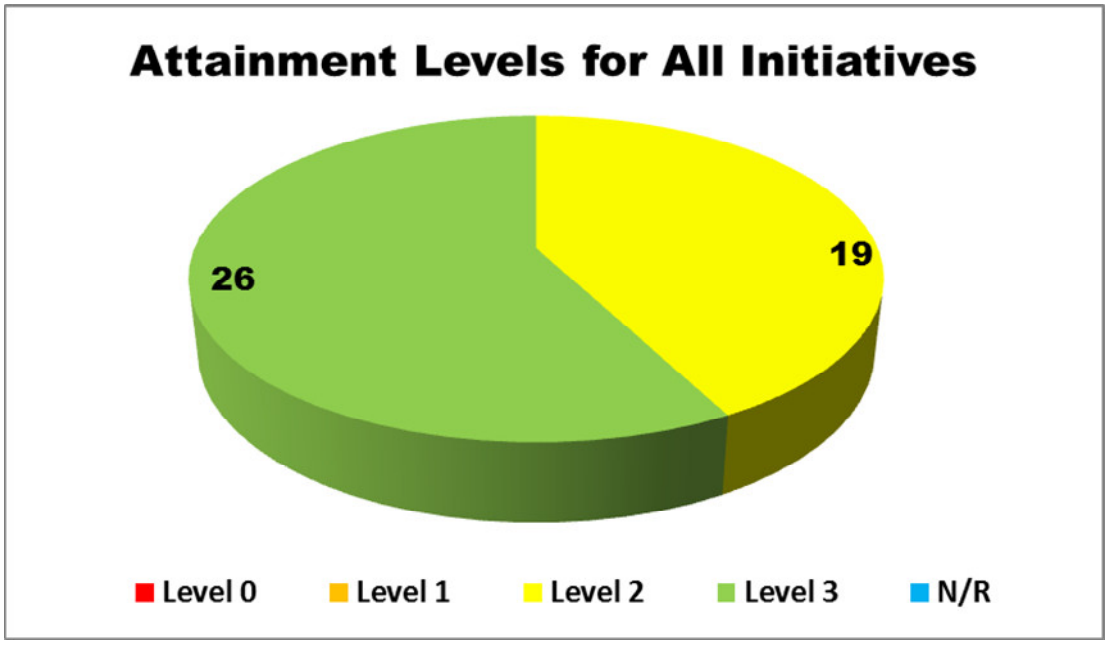
AuditOne have undertaken their audit of the Trust's IG Toolkit prior to submission this financial year and is in the process of finalising the audit report. AuditOne are assessing that:

- Appropriate governance arrangements are in place;
- From the evidence, that the submitted IG Toolkit scores are a reasonable assessment of current performance.

Approval is to also be acquired from Executive Committee, Council of Governors and Board of Directors prior to making the final submission.

10. INFORMATION GOVERNANCE TOOLKIT – END MARCH 2018 STATUS

The following represents the performance level evidenced for CHSFT for the March 2018 submission:



The table shows that of the 45 requirements, all 45 are assessed as being at Level 2 or Level 3. In detail:

- 19 show evidence that complete to Level 2;
- 26 show evidence to Level 3.

To achieve this performance, since the March 2017 submission, the Trust has reviewed and refreshed data against all requirements. Scores have been maintained against all requirements, with the exception of:

- **505 – Clinical Coding Audit** – This rating has increased from Level 2 to 3. This is due to the Clinical Coding Department achieving an improved accuracy score during this year's annual audit;
- **112 – IG Training and Awareness** – This rating has reduced from Level 3 to 2. This is due to compliance checks and routine monitoring not being conducted in this financial year – These were previously undertaken by AuditOne;;
- **309 – Business Continuity Plans** – This rating has reduced from Level 3 to Level 2. Although the Trust's IT Business Continuity plans have been reviewed in year (Including MEDITECH), some specific elements of evidence required to sustain Level 3 were not possible;
- **404 – Multi-Professional Audit of Clinical Records Across all Specialties** – This rating has reduced from Level 3 to 2. This is due to the lack of awareness sessions, briefing materials and training programme from the audits undertaken.

The total percentage compliance for all initiatives is **85%** = **Satisfactory** (coloured **green**).

11. CONCLUSIONS & RECOMMENDATIONS

Directors are asked to note the contents of this report and comment accordingly.

Subject to assurance being provided by AuditOne, and approval from Executive Committee, Council of Governors and Board of Directors, the scores to be submitted as part of the March 2018 submission are as follows:

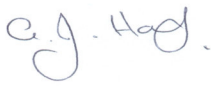
This showed that of the 45 requirements, 45 were assessed as being in at Level 2 or Level 3. In detail:

- 19 show evidence that complete to Level 2;
- 26 show evidence to Level 3.

The total percentage compliance for all initiatives is **85%** = **Satisfactory** (coloured **green**).

Directors are asked to approve the submission of the Information Governance Toolkit on 31st March 2018 on this basis.

James Carroll
Head of Information Governance & I.T. Security, Data Protection Officer
March 2018



Andrew Hart
Director of Information Management and Technology
March 2018

Appendix A – City Hospitals Sunderland's Requirements/Scores

Information Governance Management						
Req No	**Key Req**	**Description**	**IGT v14 March 17**	**IGT v14.1 March 18**	**Sponsor**	**Lead**
14.1-101	**Y**	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	**3**	**3**	**J Pattison**	**A J Hart**
14.1-105		There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	**3**	**3**	**J Pattison**	**A J Hart**
14.1-110	**Y**	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	**3**	**3**	**J Pattison**	**D Brown**
14.1-111	**Y**	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	**3**	**3**	**K Griffin**	**J Armstrong**
14.1-112	**Y**	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	**3**	**2**	**K Griffin**	**D Little**

Confidentiality and Data Protection Assurance						
Req No	**Key Req**	**Description**	**IGT v14 March 17**	**IGT v14.1 March 18**	**Sponsor**	**Lead**
14.1-200	**Y**	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	**3**	**3**	**J Pattison**	**A J Hart**
14.1-201	**Y**	The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner	**2**	**2**	**I Martin**	**A J Hart**
14.1-202	**Y**	Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected	**2**	**2**	**I Martin**	**A J Hart**
14.1-203	**Y**	Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use	**2**	**2**	**A J Hart**	**J Carroll**
14.1-205		There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	**2**	**2**	**A J Hart**	**A Anderson**
14.1-206		Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request	**3**	**3**	**A J Hart**	**K Walvin**
14.1-207		Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	**2**	**2**	**I Martin**	**A J Hart**
14.1-209	**Y**	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	**2**	**2**	**A J Hart**	**J Carroll**
14.1-210	**Y**	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	**2**	**2**	**A J Hart**	**J Carroll**

Information Security Assurance						
Req No	**Key Req**	**Description**	**IGT v14 March 17**	**IGT v14.1 March 18**	**Sponsor**	**Lead**
14.1-300	**Y**	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	**3**	**3**	**A J Hart**	**J Carroll**
14.1-301	**Y**	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	**2**	**2**	**J Pattison**	**A J Hart**
14.1-302	**Y**	There are documented information security incident / event reporting and management procedures that are accessible to all staff	**3**	**3**	**M Johnson**	**F Kay**
14.1-303	**Y**	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	**3**	**3**	**K Griffin**	**J Armstrong**
14.1-304	**Y**	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	**2**	**2**	**K Griffin**	**J Armstrong**
14.1-305	**Y**	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	**3**	**3**	**A J Hart**	**S Joyce**
14.1-307	**Y**	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	**3**	**3**	**J Pattison**	**A J Hart**
14.1-308	**Y**	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	**2**	**2**	**J Pattison**	**A J Hart**

14.1-309		Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	**3**	**2**	**J Pattison**	**A J Hart**
14.1-310		Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	**3**	**3**	**A J Hart**	**S Joyce**
14.1-311		Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	**3**	**3**	**A J Hart**	**S Joyce**
14.1-313	**Y**	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	**3**	**3**	**A J Hart**	**S Joyce**
14.1-314	**Y**	Policy and procedures ensure that mobile computing and teleworking are secure	**2**	**2**	**A J Hart**	**S Joyce**
14.1-323	**Y**	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	**2**	**2**	**J Pattison**	**A J Hart**
14.1-324		The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	**2**	**2**	**A King**	**L Mason**

Clinical Information Assurance						
Req No	**Key Req**	**Description**	**IGT v14 March 17**	**IGT v14.1 March 18**	**Sponsor**	**Lead**
14.1-400		The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	**3**	**3**	**A J Hart**	**A Anderson**
14.1-401	**Y**	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	**3**	**3**	**A King**	**M Walls**
14.1-402		Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	**3**	**3**	**A King**	**M Walls**
14.1-404		A multi-professional audit of clinical records across all specialties has been undertaken	**3**	**2**	**I Martin**	**G Schuster**
14.1-406		Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	**3**	**3**	**A J Hart**	**A Anderson**

Secondary Use Assurance						
Req No	**Key Req**	**Description**	**IGT v14 March 17**	**IGT v14.1 March 18**	**Sponsor**	**Lead**
14.1-501		National data definitions, standards, values and data quality checks are incorporated within key systems and local documentation is updated as standards develop	**3**	**3**	**A King**	**M Walls**
14.1-502		External data quality reports are used for monitoring and improving data quality	**3**	**3**	**A King**	**M Walls**
14.1-504		Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	**3**	**3**	**A King**	**M Walls**
14.1-505		An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months	**2**	**3**	**A King**	**M Walls**
14.1-506		A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	**3**	**3**	**A King**	**M Walls**
14.1-507		The secondary uses data quality assurance checks have been completed	**3**	**3**	**A King**	**M Walls**
14.1-508		Clinical/care staff are involved in quality checking information derived from the recording of clinical/care activity	**2**	**2**	**A King**	**M Walls**
14.1-510		Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards	**3**	**3**	**A King**	**M Walls**

Corporate Information Assurance						
Req No	**Key Req**	**Description**	**IGT v14 March 17**	**IGT v14.1 March 18**	**Sponsor**	**Lead**
14.1-601		Documented and implemented procedures are in place for the effective management of corporate records	**2**	**2**	**C Harries**	**A Hetherington**
14.1-603		Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	**3**	**3**	**C Harries**	**A Hetherington**
14.1-604		As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	**2**	**2**	**C Harries**	**A Hetherington**
		Overall Score / Current Score	**89%**	**85%**		

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

MARCH 2018

LEARNING FROM DEATHS DASHBOARD

INTRODUCTION

The National Quality Board (2017) published national guidance on learning from deaths which sets out a framework for Trusts on identifying, reporting, investigating and learning from deaths in care. Boards need to be assured that deaths are reviewed and changes are made in response to learning to improve pathways of care.

Trusts are required to collect and publish quarterly reports with specified information on deaths and demonstrate learning. The report must be presented to a public Board meeting.

This report provides Governance Committee with the second mortality dashboard to be presented at the Board of Directors on the 29th March 2018.

LEARNING FROM DEATHS DASHBOARD – AN OVERVIEW

We have used but amended the NHS England dashboard template to support the recording of deaths, review of outcomes and learning from care provided. A similar approach seems to have been adopted by other Trusts.

In common with peer Trusts within the North East Regional Mortality Network we use an adaptation of PRISM methodology (Hogan and colleagues) for undertaking mortality reviews. This clinician-led approach helps to identify 'problems in care' and informs judgements on avoidability of death.

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

Section 1 includes information about the total number of adult in-patient deaths, those deaths that have had a stage 1 screening review (to identify a sub-set of patients for stage 2 independent review) and those deaths that had this stage 2 review completed. In all these cases none of the reviewers will have been directly involved in the clinical care of the deceased.

The data completeness column indicates whether the information is either provisional or final reflecting the dynamic nature of the mortality review process and information capture.

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

Section 3 includes data about deaths involving patients with a learning disability. It shows those deaths with a completed or ongoing review as part of the national Learning Disabilities Mortality Review (LeDeR) Programme. In view of the multi-professional and cross-boundary nature of working these types of reviews take much longer to complete and identify learning.

INTERPRETATION OF DASHBOARD DATA

We continue to adapt our existing mortality review arrangements following publication of the Trust Mortality Review & Learning From Deaths Policy. From Oct 2017 onwards we are able to include information on the number of patients that had a stage 1 screening assessment (against nationally set criteria; see appendix 1) to determine the need for a more in-depth and independent stage 2 mortality review.

During this quarter, 73.2% of patients were screened and 80 (28.7%) patients completed a stage 2 mortality review.

We have consolidated our position regarding death reviewed and preventability scoring using the Hogan methodology. For those patients reviewed in Q3, 95% were judged as definitely not preventable.

In addition for this quarter, there was no patient deaths judged as avoidable (using the Hogan criteria greater than 50% likelihood of avoidability) as a proportion of stage 2 reviews.

There is a slight improvement in our previous position on the grading of care reported as either excellent or good. For Q3, this has increased to 92.5% although this involves a smaller number of cases. To date, we can show that this have never reduced below 90%.

Just over half (52.9%) of those deaths where patients were in receipt of End of Life Care (in Q3) had had a special End of Life Review. The majority of these reviews (92.1%) had the 5 core elements delivered. These are the priorities of care that should reflect the needs and preferences of the dying person, i.e. ‘recognise’ (the possibility that a person may die within the next few days or hours), communication, involvement, support, and ‘plan and do’ (that an individual plan of care is agreed, coordinated and delivered with compassion).

EVIDENCE OF LEARNING AND ACTION

When patients are predicted to be approaching death it is appropriate for medical professionals to discuss resuscitation measures in the event of a cardio-respiratory arrest with the patient and their relatives.

These discussions are challenging for all concerned. City Hospitals mortality reviews have noted the difficulties that health professionals experience when this issue is discussed for the first time following an acute deterioration, despite clear indications that such discussions ought to have taken place during the weeks or months prior to the acute hospital admission.

The Trust is liaising with community services to explore how these necessary discussions and decisions are conducted and recorded in a more timely and proactive way.

In a wider context, the Trust has also identified the completion, documentation and visibility of Do Not Attempt Cardio Pulmonary Resuscitation decisions as a quality priority and an integral part of its Quality Strategy.

The quality of End Of Life Care is facilitated through use of the 'Northern England Clinical Network's Care of the Dying' booklet. We aim to make this document available in a digital format on our hospital information system. This will improve accessibility to End of Life Care best practices and assist all hospital ward staff to deliver high quality End of Life Care.

REPORTING IN TRUST QUALITY REPORTS 2017/18

NHS Improvement has now confirmed details of the contents and assurance requirements for Foundation Trusts preparing their 2017/18 Quality Reports.

One of the new mandatory disclosures relates to the national learning from deaths programme and requires Trusts to highlight the number of deaths subject to case record review and whether any of these were more likely than not to have been due to problems in care. In addition, there is a narrative requirement to state what has been learnt from the mortality review process.

City Hospitals will take note of this additional requirement when drafting the Quality Report 2017/18.

RECOMMENDATIONS

Directors are asked to note the dashboard.

Ian Martin
Medical Director

Mortality Review Panel Activity Record – Select ALL qualifying criteria

	Death referred to the coroner - death was **unexpected**	A
	Death referred to the coroner - death is **unexplained**	B
	Death referred to the coroner – death associated with an **invasive procedure**	C
	Patient had a known **Learning Disability**	D
	Patient had a **severe mental illness** and died in hospital – Those patients formally receiving Mental Health Care provision during admission prior to death – i.e. Under care of liaison psychiatry services at time of death	E
	Death associated with a **cardiac arrest call** in hospital (***death within 24 hours*** of cardiac arrest call)	F
	Death associated with a reported **significant clinical incident** relating to the quality of care	G
	Death associated with a ***concern about problems in care*** (acts of omission or commission leading to death)	H
	Death where **bereaved families and carers have raised a significant concern** about the quality of care provision	I
	Death associated with an **active formal area of concern** within the Trust (i.e. identified by external bodies – CQC alerts, SHMI data, audit data)	J
	Death within a **designated clinical area of improvement** e.g. sepsis (sepsis in patients considered for escalation in care)	K
	Death associated with any other issue which in the opinion of the responsible consultant is worthy of further review (e.g. meets departmental criteria for review)	L
	Death selected for review for **other** reasons	M
	Death Selected for **End Of Life Review**	N
	No MRP or EoL Review performed	O

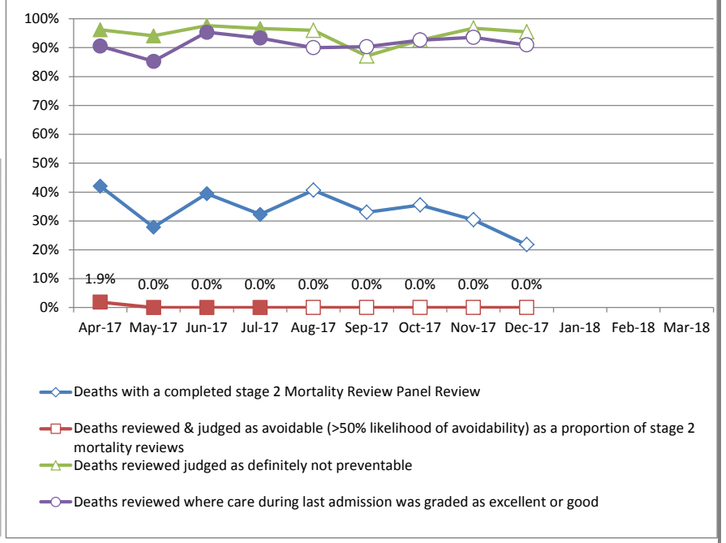
City Hospitals Sunderland NHS Foundation Trust: Learning from Deaths Dashboard - April - December 2017-18

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

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

Month of death	Data completeness	Total Number of deaths	Deaths investigated as a Serious Incident	Stage 1 Reviews - Screening		Deaths meeting inclusion criteria (NA = not available)		Deaths with a completed stage 2 Mortality Review Panel Review		Deaths reviewed & judged as avoidable (>50% likelihood of avoidability) as a proportion of stage 2 mortality reviews		Deaths reviewed judged as definitely not preventable		Deaths reviewed where care during last admission was graded as excellent or good	
				Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Apr-17	Final	126	0	NA	-	NA	-	53	42%	≤5	1.9%	51	96%	48	91%
May-17	Final	122	0	NA	-	NA	-	34	28%	0	0.0%	32	94%	29	85%
Jun-17	Final	109	0	NA	-	NA	-	43	39%	0	0.0%	42	98%	41	95%
Jul-17	Final	93	0	NA	-	NA	-	30	32%	0	0.0%	29	97%	28	93%
Aug-17	Final	123	0	NA	-	NA	-	50	41%	0	0.0%	48	96%	45	90%
Sep-17	Final	94	0	NA	-	NA	-	31	33%	0	0.0%	27	87%	28	90%
Oct-17	Provisional	104	0	76	73%	19	25%	27	36%	0	0.0%	25	93%	25	93%
Nov-17	Provisional	124	0	102	82%	14	14%	31	30%	0	0.0%	30	97%	29	94%
Dec-17	Provisional	153	0	101	66%	11	11%	22	22%	0	0.0%	21	95%	20	91%
Jan-18															
Feb-18															
Mar-18															
Q1 17/18	Final	357	0	NA	-	NA	-	130	36.4%	≤ 5	0.8%	125	96.2%	118	90.8%
Q2 17/18	Final	310	0	NA	-	NA	-	111	35.8%	0	0.0%	104	93.7%	101	91.0%
Q3 17/18	Provisional	381	0	279	73.2%	44	15.8%	80	28.7%	0	0.0%	76	95.0%	74	92.5%
Q4 17/18															

Mortality over time, total deaths reviewed and deaths considered to have been potentially avoidable
(Note: Changes in recording or review practice may make comparison over time invalid)



Section 2: End of Life Review

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

Month of death	Data completeness	Number of deaths where patients was in receipt of End of Life care	Deaths with an End of Life Review		End of Life reviews with all 5 core elements delivered	
			Number	%	Number	%
Apr-17	Final	85	53	62%	NA	-
May-17	Final	81	15	19%	NA	-
Jun-17	Final	68	20	29%	NA	-
Jul-17	Final	70	52	74%	NA	-
Aug-17	Final	91	67	74%	58	64%
Sep-17	Final	67	40	60%	40	60%
Oct-17	Provisional	70	33	47%	28	40%
Nov-17	Provisional	83	59	71%	55	66%
Dec-17	Provisional	85	34	40%	33	39%
Jan-18						
Feb-18						
Mar-18						
Q1 17/18	Final	234	88	37.6%	NA	-
Q2 17/18	Final	228	159	69.7%	98	43.0%
Q3 17/18	Provisional	238	126	52.9%	116	48.7%
Q4 17/18						

Section 3: Learning Disability Review

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

2017/18 Quarter	Data Completeness	Number of deaths	LeDeR reviews completed	LeDeR reviews in progress	LeDeR Outcome: Deaths judged as avoidable (>50% likelihood of avoidability)	Deaths with a completed stage 2 Mortality Review Panel Review
1	Provisional	≤ 5	0%	100%	NA	40%
2	Provisional	≤ 5	0%	100%	NA	100%
3	Provisional	≤ 5	25%	75%	NA	25%
4						