Enclosure 4

Report to:	**Trust Board – 28th February 2013**

Title	Integrated Performance Report – January 2013
Sponsoring Executive Director	Peter Herring – Chief Executive
Author(s)	Peter Herring – Chief Executive
Purpose	To inform the Trust Board of performance against Key Performance Indicators in the Trust.
Previously considered by	Not applicable

Executive Summary
This report summarises the Trust's performance against all the key qu ality, finance, compliance, and workforce targets and indicators for 2012-13 and considers all elements of the Pro vider Management Regime.

Related SATH Objectives	**SATH Sub-Objectives**
A – Financial Strength B – Patients and Commissioner C – Quality and Safety	The report covers a range of organisational sub-objectives in the three strategic domains.

Risk and Assurance Issues (including resilience risks)	Ensuring that we develop robust measures to assess strategic performance will minimise the risk associated with the delivery of our strategies and provide a warning system for the Trust Board where further attention is required.
Equality and Diversity Issues	None
Legal and Regulatory Issues	The national standards, CQC and local contractual requirements will form part of the performance framework.

Action required by the Trust Board
The Trust Board is asked to CONSIDER performance for January 2013.

Trust Board
Integrated Performance Report – January 2013

1 Overview of performance

1.1 This Integrated Performance report provides an overview of key quality, operational, financial and workforce performance indicators from which the Board can review any variances to the required performance and identify the actions being pursued to ensure ongoing improvements.

2 Regulatory requirements

2.1 The Care Quality Commission provide a regulatory overview of all the required outcome measures with which we are registered. The Care Quality Commission provide a regulatory overview of all the required outcome measures with which we are registered. Last months Trust Board papers provided the outcomes of four different reviews which provided positive assurance. The Trust liaises regularly with CQC to ensure they are updated on any care related issues of concern.

3 Quality

3.1 The following High level Metrics provides an overview of patient safety, effectiveness and Patient Experience. The report then contains any key information relating to clinical care metrics where performance is not meeting the required standard or particularly good practice noted.

Table 1

Measure		Standard	Q1	Q2	Q3	Jan '13	YTD	Year End
)Patient safety & Effectiveness	HSMR - All Diagnoses	<100%	95.7	95.2	82.4	84.5	91.3	
	RIDDOR reportable Falls	< 20	3	2	11	3	19	
	Grade 3 & 4 Pressure Ulcers	< 22	8	12	12	4	36	
	C-Diff	45	9	8	15	5	37	45
	MRSA Bacteraemias	2	1	0	0	0	1	2
	MSSA Bacteraemia	28	7	5	4	3	19	28
	E-Coli	65	11	18	9	3	41	65
	Elective MRSA Screening	95%	90.03%	92.1%	95.6%	95.3%	92.6%	
	Non Elective MRSA Screening	95%	96.8%	95.69%	92.5%	92%	96%	
	Number of Serious Incidents	<36 per Quarter	38	30	50	14	132	
	Never Events	0	1	1	0	0	2	
	WHO Surgical Checklist Need performance from last Board paper here	100%	100.00%	100%	99.86%	100%	99.96%	
	VTE Assessment	90%	90.97%	90.41%	90.30%	91.06%	90.48%	
	Maternity Dashboard	Green	Green	Green	Green	Amber		
Patient experience	Number of patient complaints	actual	173	165	147	58	543	
	Access to Healthcare for people with LD	Yes	No	Yes	Yes	Yes		
	Same Sex Accommodation Breaches	0	0	0	0	0	0	

Patient Safety and Effectiveness

3.2 A summary of patient outcome measures agreed for the Board are outlined in Table 1 above, with additional patient specific metrics outlined in table 5 and table 6 of this paper providing the patient experience and outcomes metrics chosen to monitor the impact of care provided for the patient. Specific commentary has been made for the Board key performance Indicators which are amber or red and therefore key points for the Boards attention are as follows:

RIDDOR reportable Falls

3.3 The overall rate of falls within the hospital continues to fall although there were 3 RIDDOR Reportable falls in January which are falls which have resulted in some degree of injury/ harm, which is deeply regretted. Two of these three cases were on a Stroke ward where patients are rehabilitating following a stroke. There is Trust wide work which has been implemented and continues to be undertaken to ensure maximum support to patients who have a risk of falls, this includes compliance of the falls assessments and implementation of the appropriate support for each patient. Each case is reviewed through a Root cause analysis to ensure that all aspects of the falls measures have been implemented as reflected and required in best practice and guidance however, there continue to be some improvements that we can make and the multidisciplinary team need to continue to ensure that lessons are learnt and implemented from each and every case.

Grade 3 or 4 pressure ulcers

3.4 There were two grade 3 and two grade 4 (hospital acquired) pressure ulcers reported in January 2013, two of these were reported from the same ward. This ward has already been placed on a formal Quality Improvement Framework due to concerns about care delivery and the Matron and the new Ward Manager (who commenced her post at the beginning of February 2013) are working with corporate nursing to address the fundamentals in care planning, implementation and evaluation which need to be addressed to ensure elimination of all unavoidable pressure ulcers and improve patient outcomes and experience.

3.5 Each of these 4 cases are subject to rigorous Root cause analysis (RCA) to ensure that the ward team are clear about the range of improvements in care and documentation which are required to ensure that these patient harms are eliminated. Where there is a lack of confidence about the care provided or the improvements are not robust enough, then the ward teams and individuals will be held to account where required. If an improvement in systems and processes are highlighted as required in the RCA, then these will be picked up and acted on.

3.6 The Board agreed a target of eliminating grade 4 ulcers from the end of December 2012 and the occurrence of 2 grade four pressure ulcers breaches is deeply regretted and the senior nursing team will be continuing the work with teams where pressure ulcers have been acquired to achieve the eradication of all grade 3&4 pressure ulcers.

C-Difficile and Infection Control synopsis

3.7 There were 5 new cases of C-Difficile in January which is above trajectory for this month although it is noted that no ward had more than one case. In several cases patients were

admitted with diarrhoea but samples were tak en later than the third day after admission, so these cases will now count against t he SaTH target despite being community acquired. The Infection prevention and Co ntrol team (IPCT) will reiter ate to all clinic al staff the importance of taking samples early in patients admitted with diarrhoea.

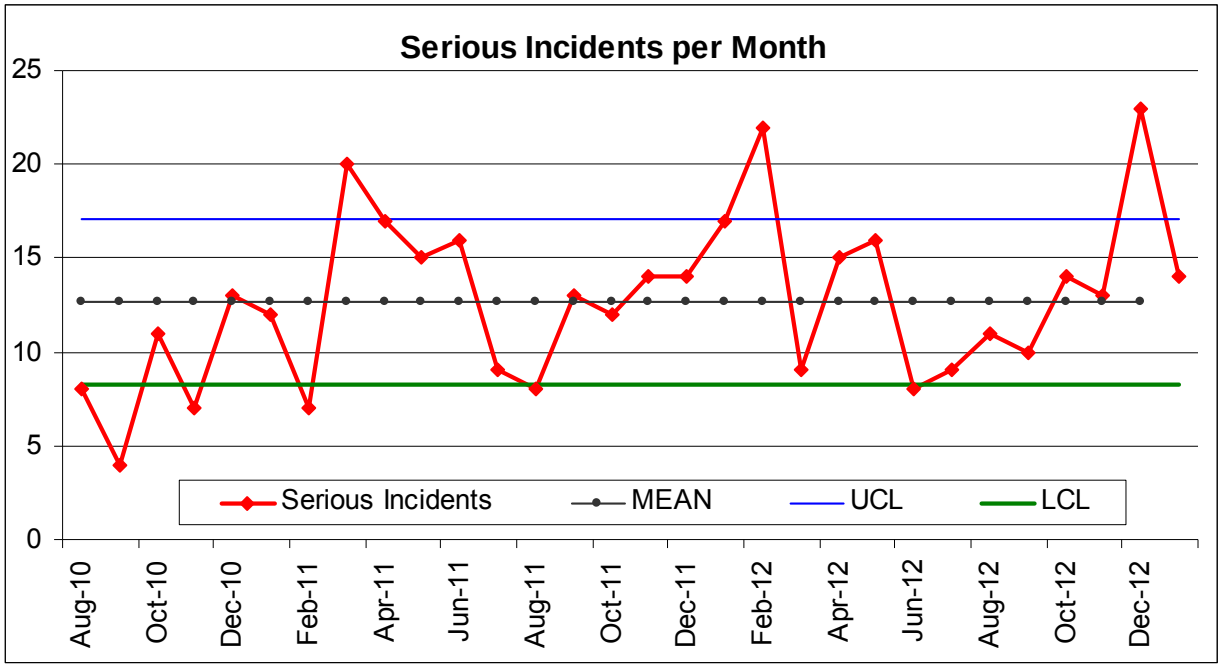
3.8 MRSA screening for Emergency cases has risen from the 90.6% in Decem ber 2012 to 92% in Ja nuary but is still be low the target. This was aga in due to the surgica l assessment unit and the acute medical unit s on both sites missing a high number of patients who required screening. This has been discussed with the teams and actions taken to ensure compliance with screening. These resu lts will be closely monitored each week by the IPCT to ensure the required number.

Serious Untoward Incidents

3.9 In January there have been 14 Serious Incidents of which 4 included the pressure ulcers commented on abov e and the 3 RIDDOR repor table falls. Of the remaining serious incidents, five incidents were related to Infection Control which is being reviewed carefully by the team and 2 unplanned out comes from procedures which will b e discussed in the private Board due to confidentiality requirements.

3.10 Table 2 below outlines the tr end in relation to the monthl y reporting and this month continues to be reported as Red due to being over the thre shold agreed (12 per month) but it is noted that this is a significant decrease from the high figure in December 2012.

Table 2



Maternity Dashboard

3.11 The Midwifery services have a comprehensive dashboard of indicato rs to review the quality and safety of the servic es which it provides. Some of these indicators are loca lly agreed to monitor practice and others are nationally determined. This in formation is shared with Commissioners and within the Trust. In this months performance there are 5 amber performance indicators, which are bei ng monitored internally and one red to note which is the % of mother's breast feeding within 4 8hrs of delivery which is down to

62.7% against a target of **67%.** Appendix 1 outlines the dashboard for the Boards information.

The Francis Report

3.12 The Francis report into the care provided at Mid Staffordshire NHS Foundation Trust was published in February 2013. This will need due and formal consideration by the Board in the next 2-3 months. The Quality and Safety Committee will undertake a detailed review of the published report and its recommendations and the Committee will advice the Board of any other systems and processes which should be considered over and above those recommendations implemented following the initial Francis report in 2010. This will ensure that we review and test out all our Governance systems to ensure that we reflect the recommendations made and required and ensure that all aspects of patient care are maximised and that patients continue to be held central to our core business.

Soft and hard intelligence

3.13 The Board are asked to note that the Trust already uses a number of different methods of soft and hard intelligence to develop a dashboard of information which creates the reality of care provided in wards and departments. Where this has indicated that care has not been delivered to the right standard then measures have been put in place to support improvements. Appendix 2 to this Quality section provides a flow chart summarising methods which are already used by this Trust, which sit at the heart of the "Francis" report. The outcomes from these systems and processes are shared transparently with patient groups, Commissioners, Educational partners and the Care Quality Commission when concerns are highlighted.

Current Status – Mortality

3.14 The Board will note that Mortality data is an important indicator referenced within the Francis report and this information has been regularly provided for the Boards information on an ongoing basis and the Medical Director will continue to be able to comment on the work being undertaken.

- The measure for mortality across England has now been moved from the HSMR to the SHMI model.
- The HSMR will no longer be reported outside of the Trust.

The current SHMI scores are:

Table 3

Standard Hospital Mortality Indicator (SHMI - Rolling 12 months)						
Measure	**Apr 10 - Mar 11**	**Jul 10-Jun 11**	**Oct 10 - Sept 11**	**Jan 11 - Dec 11**	**Apr 11 - Mar 12**	**Jul 11 - Jun 12**
SHMI	111.21	110.51	108.85	107.53	106.68	106.64
HSMR	115	112	107	102	100	98
SHMI (In Hospital)	107.82	106.83	103.38	99.9	97.41	97.17
SHMI Non Elective	111.59	110.72	109.13	107.73	106.82	106.82
SHMI Elective	101.4	104.88	101.42	102.19	102.93	101.58

Table 4

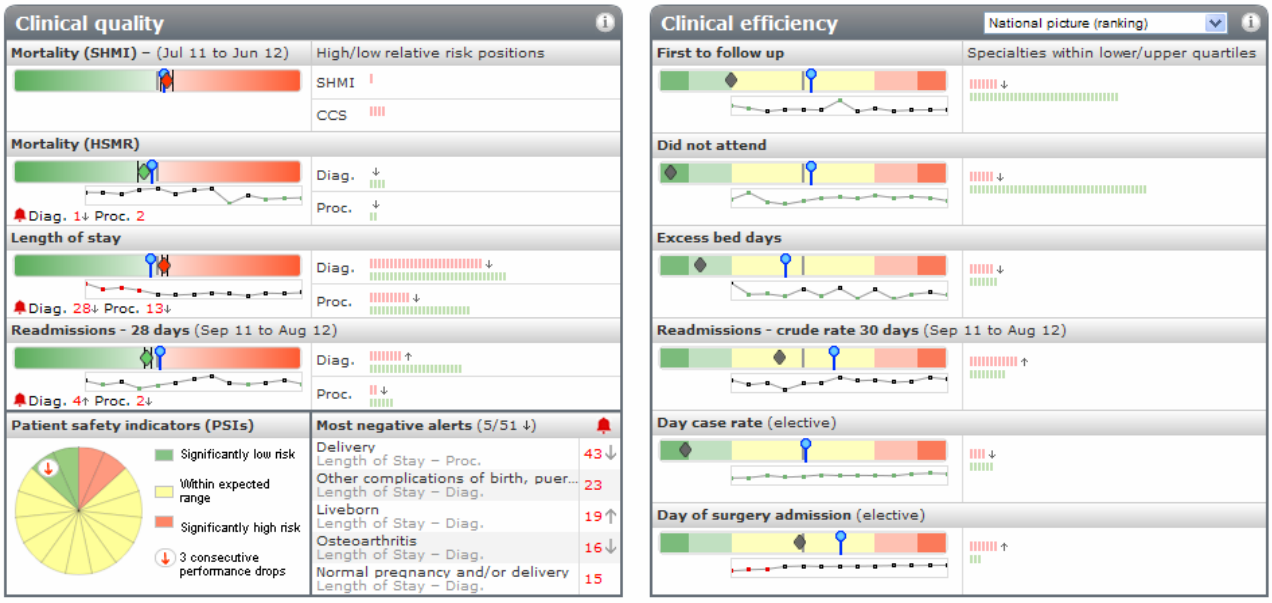
Standard Hospital Mortality Indicator (SHMI - Quarterly)					
	Qtr 1 2011/12	Qtr 2 2011/12	Qtr 3 2011/12	Qtr 4 2011/12	Qtr 1 2012/13
Quarterly Measures - SHMI	112.05	104.25	105.41	105.49	108.09

- Crude deaths remain on target against the objective of 350 less deaths within 2 years.
- As of December 2012 we had 322 less deaths which is an overall reduction of 10.46%.

Current Status – Trust View Metrics

3.15 As requested by the Medical Director below is a "Trust View" from Dr Foster showing SaTH's performance (shown by the diamond) against the National index for a number of key metrics. In addition SaTH is benchmarked against the West Midlands performance (shown by a blue post).

The report shows data for the latest 12 months available (Dec 11 to Nov 12).



- The main area of focus is to understand the reasons for the high SHMI.
- A case note review of a proportion of patients who die within 30 days of discharge is being started in Feb 13.

Patient Experience and Outcomes

3.16 Table 5&6 provide a Board level overview of a range of patient outcome measures and these can be reviewed in a more granular manner at Clinical Centre and ward level to determine specific actions for improvement. The Board will note that further work is required to improve the performance of effective fluid management and the timeliness of patient observations.

3.17 The real time patient feedback process continues on each ward every month and this continues to highlight required improvements in discharge arrangements. The Chief Nurse and Chief Operating officer are working together to develop a composite measure for monitoring discharge arrangements in detail and this will be included in the Board reports from April 2013.

External feedback and Assurance

3.18 An announced visit to Ward 8 at PRH was undertaken on the 24th January 2012. This was a planned combined Shropshire and Telford& Wrekin Clinical Commissioning Group (CCG) review of the services reconfigured onto the PRH site from the Royal Shrewsbury site in September 2012. A draft report has been shared with the Trust which identifies their observations, the good practice and positive discussions held during the visit and some actions that required follow up by the clinical team. The report has been acknowledged by the Chief Nurse and an action plan provided for the CCG's which responds to the points raised. When the final report is provided this will be reviewed by the Quality and Safety Committee and the actions tracked by the Executive leads.

Table 5: Ward to Board Patient Metrics for April 2012 – January 2013

	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013
Medication Storage and Administration	97%	98%	99%	96%	97%	96%	97%	99%	98%	98%
Infection Control and Privacy & Dignity	91%	95%	96%	94%	94%	93%	93%	96%	95%	94%
Patient Observations	84%	83%	87%	85%	86%	90%	86%	95%	90%	89%
Pain Management	84%	87%	91%	91%	92%	88%	90%	93%	92%	93%
Tissue Viability	91%	90%	89%	87%	91%	91%	94%	95%	96%	93%
Nutrition	91%	92%	91%	90%	90%	95%	94%	95%	92%	91%
Fluid Management	85%	87%	82%	85%	80%	90%	93%	90%	85%	87%
Falls assessment	98%	96%	98%	97%	98%	96%	98%	99%	98%	97%
Continence	97%	93%	88%	93%	93%	97%	97%	98%	95%	96%
Comfort Rounds				83%	92%	90%	94%	93%	93%	90%
Total	**91%**	**92%**	**92%**	**91%**	**92%**	**92%**	**94%**	**95%**	**94%**	**93%**

Table 6: Ward to Board Patient Experience Metrics for April 2012 – December 2012

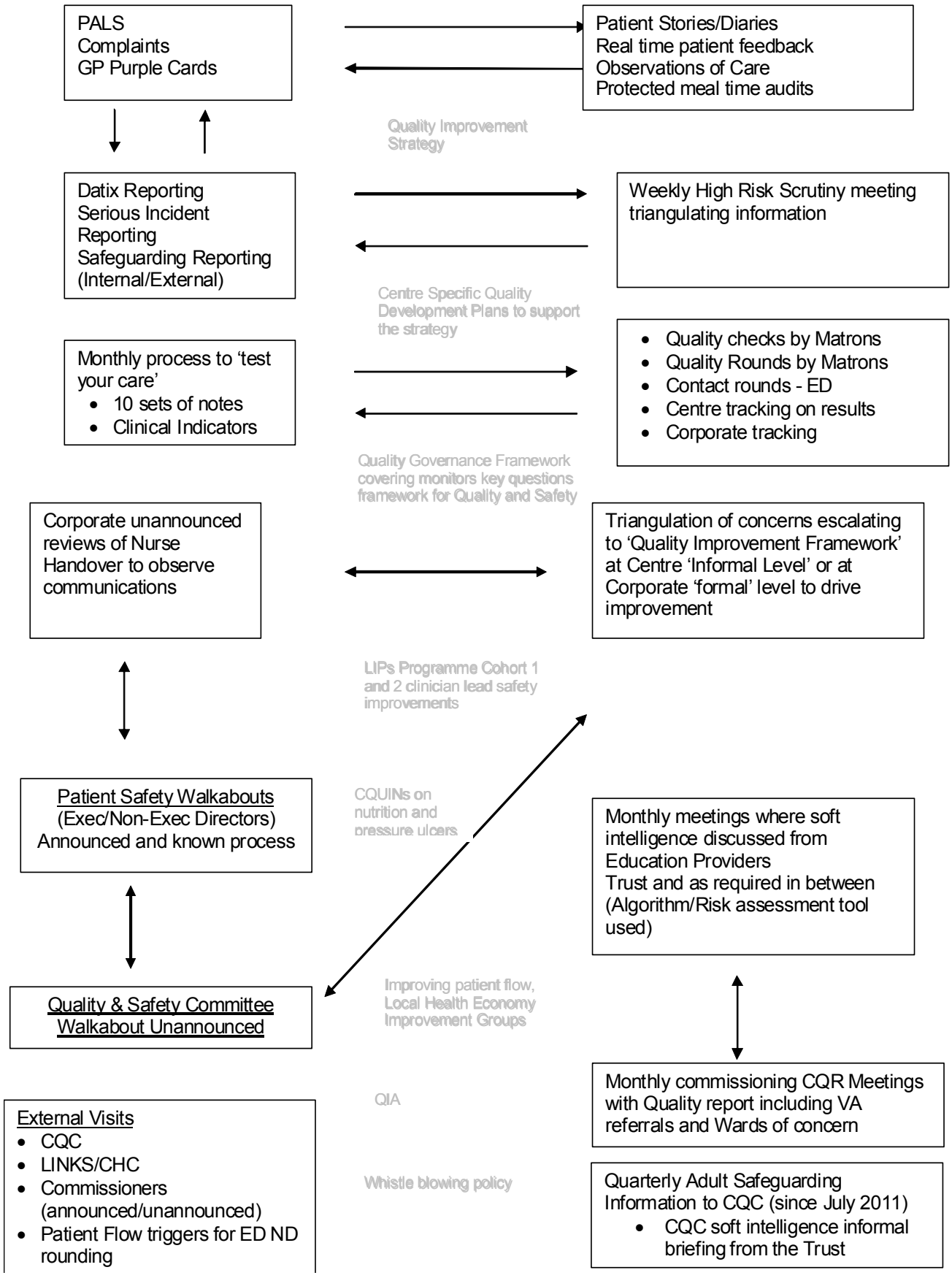
	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013
How clean is this ward (including toilets)?	95%	95%	95%	95%	96%	96%	96%	97%	97%	97%
As far as you know do the staff wash or clean their hands between touching patients?	95%	92%	95%	94%	96%	96%	96%	97%	96%	96%
Do you feel informed about potential medication side effects?	46%	57%	65%	65%	72%	64%	72%	83%	76%	86%
Do you feel you have enough privacy when discussing your condition or treatment with staff?	88%	89%	85%	83%	86%	85%	86%	91%	91%	87%
Do you feel that you have been treated with respect and dignity while you are on this ward?	91%	95%	98%	93%	95%	94%	95%	96%	97%	95%
Do you feel involved in decisions about your treatment and care?	80%	83%	77%	78%	77%	79%	84%	89%	86%	87%
Has hospital staff been available to talk about any worries or concerns you have?	82%	92%	90%	90%	86%	91%	93%	93%	90%	89%
Do you get enough help from staff to eat your meals?	92%	90%	98%	87%	90%	95%	98%	95%	92%	85%
Whilst you have been on this ward have you ever shared a sleeping area with a member of the opposite sex?	100%	96%	98%	99%	99%	97%	97%	98%	99%	97%
Do you think hospital staff do everything they can to help control your pain?	89%	93%	89%	90%	89%	87%	93%	95%	92%	90%
When you use the call buzzer is it answered?	88%	93%	89%	87%	90%	90%	87%	91%	90%	89%
Have staff talked to you about your discharge from hospital?	64%	74%	63%	65%	68%	68%	64%	71%	72%	75%
Total	**83%**	**87%**	**86%**	**86%**	**87%**	**86%**	**88%**	**91%**	**90%**	**90%**

APPENDIX 1 **MATERNITY DASHBOARD**

No	Indicator	Descriptor	Expected (Per Month)	APR	MAY	JUN	Q1	JUL	AUG	SEP	Q2	OCT	NOV	DEC	Q3	JAN	YTD	2011/12
1	Births by Unit	Overall Trust total births	450	408	436	456	**1300**	450	418	463	**1331**	427	394	435	**1256**	453	**4340**	**5240**
2	Birth rate by Location Type	% of births in Consultant Unit	75%	73.8%	75.7%	75.0%	**74.8%**	73.6%	77.8%	76.7%	**76.0%**	77.3%	80.5%	80.2%	**79.3%**	82.6%	**77.3%**	**76.0%**
		% of births in any MLU	25%	24.5%	21.6%	22.6%	**22.8%**	22.4%	19.9%	21.4%	**21.3%**	21.1%	17.3%	18.6%	**19.0%**	15.2%	**20.5%**	**22.0%**
		% Home Births	1%	1.2%	2.3%	2.0%	**1.8%**	3.6%	2.2%	1.5%	**2.4%**	0.9%	1.8%	0.5%	**1.0%**	2.2%	**1.8%**	**1.6%**
		% BBA/Other	<1%	0.5%	0.5%	0.4%	**0.5%**	0.4%	0.2%	0.4%	**0.4%**	0.7%	0.5%	0.7%	**0.6%**	0.0%	**0.4%**	**0.3%**
3	Normal and Assisted Deliveries	Overall Normal Births rate %	65%	75.7%	72.7%	72.8%	**73.7%**	72.2%	71.3%	71.1%	**71.5%**	71.9%	73.6%	69.2%	**71.5%**	69.1%	**71.9%**	**73.1%**
		Overall Assisted Births rate %	10%	11.0%	11.7%	9.0%	**10.5%**	11.8%	12.2%	9.5%	**11.1%**	13.1%	11.2%	9.9%	**11.4%**	11.0%	**11.0%**	**10.4%**
4	Operative Deliveries	Caesarean Section rate %	< 20%	13.6%	14.7%	16.3%	**14.9%**	16.1%	14.8%	18.0%	**16.3%**	14.5%	13.2%	14.7%	**14.2%**	16.9%	**15.3%**	**14.8%**
5	Rate of Outcomes	Stillbirths rate	<1%	0.2%	0.7%	0.7%	**0.5%**	0.4%	0.5%	0.2%	**0.4%**	0.2%	0.3%	0.7%	**0.4%**	0.9%	**0.5%**	**0.3%**
		% of deliveries PPH >1500 mls	<1%	1.0%	0.0%	0.4%	**0.5%**	0.7%	1.0%	1.1%	**0.9%**	0.2%	0.5%	0.5%	**0.4%**	0.4%	**0.6%**	**0.8%**
		3rd/4th Degree tears rate	<5%	1.7%	2.1%	1.3%	**1.7%**	3.2%	2.7%	3.1%	**3.0%**	1.9%	1.6%	1.9%	**1.8%**	2.9%	**2.2%**	**2.3%**
6	National Smoking and Breastfeeding Targets	Breastfeeding within 48 hours of delivery (Unvalidated Figures)	67%	73.5%	72.0%	71.3%	**72.2%**	69.3%	71.8%	70.8%	**70.6%**	68.2%	67.0%	67.4%	**67.5%**	62.7%	**69.4%**	**71.6%**
		'Current Smoker' at delivery (Unvalidated Figures)	<20%	17.7%	15.1%	20.4%	**17.8%**	17.3%	18.2%	18.1%	**17.9%**	19.9%	16.2%	19.8%	**18.7%**	20.5%	**18.4%**	**18.6%**
7	Access to Maternity Services	% of bookings with a gestation of less than 12 weeks 6 days	90%	90.9%	91.9%	91.1%	**91.3%**	89.3%	92.9%	91.9%	**91.3%**	91.7%	90.2%	91.5%	**91.1%**	86.5%	**90.7%**	**91.3%**
8	Clinical Effectiveness	Supervisor to Midwife Ratio	1.15	1.22	1.22	1.22	**100.0%**	1.22	1.22	1.22	**300.0%**	1.22	1.22	1.20	**0.0%**	1.22	**1.22**	
		Midwife to Birth Ratio	1.31	1.32	1.32	1.32	**1.22**	1.32	1.32	1.32	**1.20**	1.32	1.32	1.32	**0**	1.32	**1.32**	
9	Patient Safety	Number of CQC Mortality Alerts	0	0	0	0		0	0	0		0	0	0		0	**0**	
		Number of Maternal Deaths	0	0	0	0		0	0	0		0	0	0		0	**0**	
		Number of SI's reported to LSA	0	2	2	2	**0**	1	3	2	**1**	1	3	2	**0**	1	**19**	0

APPENDIX 2

SOFT & HARD INTELLIGENCE SYSTEMS AND PROCESSES AT SATH TO SUPPORT INDENTIFYING CARE ISSUES



4 Operational performance

Emergency Access Target – progress report

4.1 The Trust failed to achieve the 95% target in January 2013 with 91. 43% for the month, giving a year to date position of 91.71%.

Factors continuing to affect performance are:

- **an increase in the number of ED attendances**
- **an increase in the number of non-elective admissions**
- **an increase in the number of patients who are fit to transfer**
- **a mismatch in demand versus available beds**
- **'Escalation' beds open but not efficiently utilised due to their 'temporary' status.**

The individual components of whole health economy remedial action plan to deliver 95% is progressing reasonably well, however, whilst there were signs of improvement during January, since the last week in January and February to date pressure on the hospitals have increased further and given the underlying mismatch between demand and availability of beds, performance has deteriorated significantly as can be seen from the trajectory below.

4.2 At January's Trust Board it was proposed that a plan to achieve the 4 hour target sustainably would be presented at February's Board, however, subsequently an external review has been jointly commissioned to look at whole system issues and improvements in urgent and emergency care ; the diagnostic element of the review is due to start on Monday 18th February 2013 and this will take 6 weeks to complete. It is therefore proposed that this exercise is completed and the results brought back to the Board in April 2013.

4.3 The objectives of the programme have been agreed by:

- Shrewsbury and Telford Hospital NHS Trust
- Shropshire CCG
- Telford & Wrekin CCG
- NCB Local Area Team

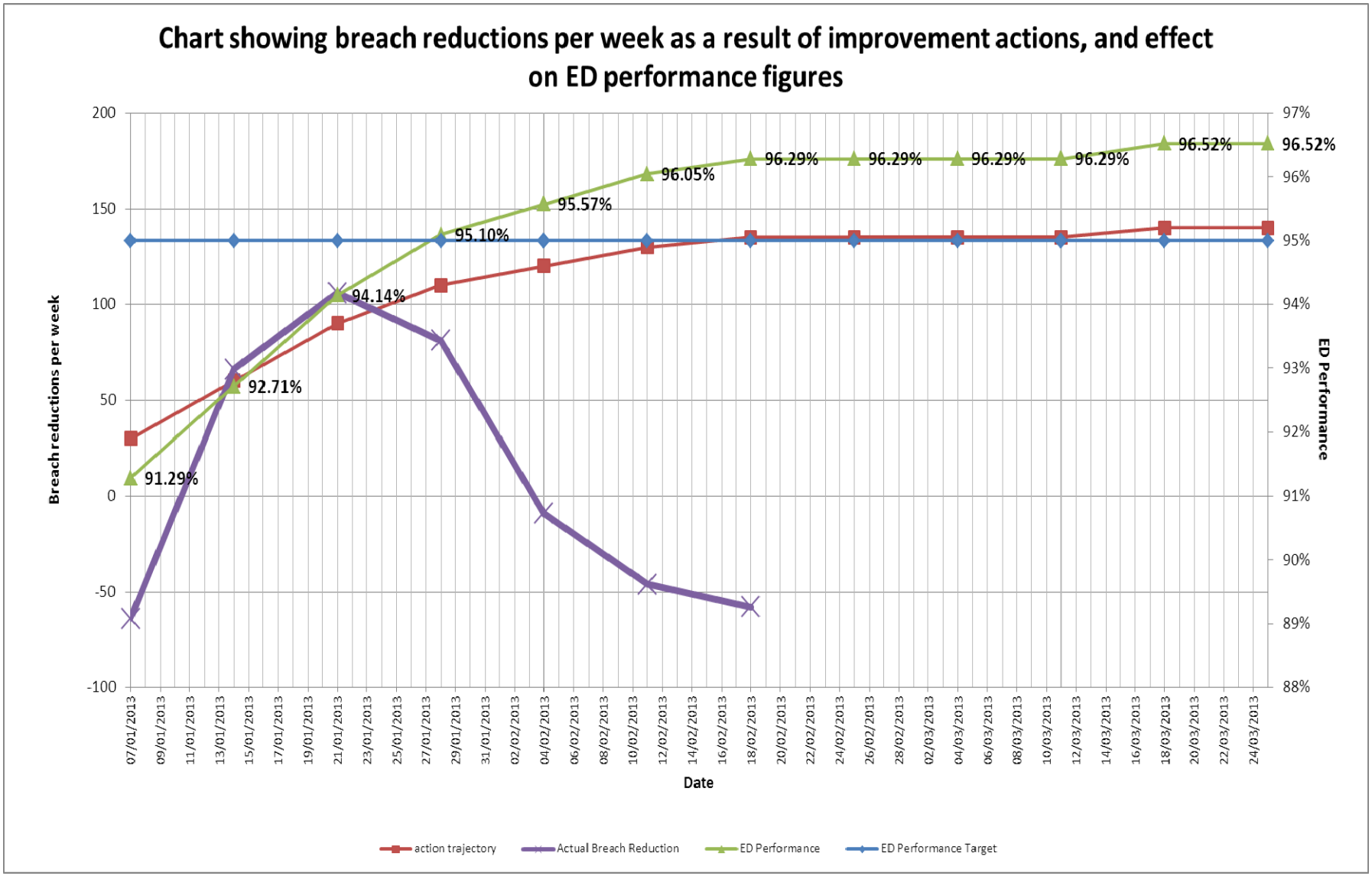
The objectives of the programme are to develop a sustainable solution to meet the 4-hour access target by:

- Adopting a whole system approach in which CCGS, SaTH, the LAT, social services, community services and the ambulance service are engaged in resolving issues identified
- Reducing avoidable attendances at the A&E department by improved use of alternative provision
- Reducing the number of ambulance attendances arriving at A&E where patients may have been safely and more appropriately seen in primary care settings or alternative community services provided
- Improve the patient flow within both the ED and the hospitals as a whole

- Ensuring timely and accurate data is made available to all stakeholders
- Implementing solutions within primary, community and social care care to improve preventive care for long term conditions, particularly respiratory
- Better understanding and improving pathways for frail and elderly patients
- Better understanding and improving pathways for patients with mental health problems e.g.: RAID
- To reduce avoidable admissions, particularly 0-2 day length of stay
- To improve the disc harge of patients by improving internal and external communications and implementation of best practice
- To ensure that the overall cost of the system is acceptable to commissioners
- To assess whether the total available bed capacity in the local health and social care economy meets anticipated demand
- To independently assess the sustainability of the current model of working in the emergency department at both sites.

4.4 The following page shows trajectory to deliver 95% by for the remainder of this financial year.

Trajectory for the delivery 95% by end of financial year 2012-13



18 weeks Referral to Treatment Target (RTT) - Admitted

4.5 The Trust failed the RTT target for Admitted patients with 79.9% against the 90% target in January.

- The non achievement of the target was due to the ongoing work to reduce the numbers of patients on an admitted pathway that have been waiting longer than 18 weeks in the specialties of Ophthalmology and Orthopaedics. Obviously by reducing the number of patients treated who have waited 18 weeks impacts upon the performance for those specialties and the Trust as a whole. Also there have been a significant number of cancellations within January due to the Day Surgery unit being used for escalation. General surgery and ENT also failed to hit the target in January.

- The programme of work to reduce the number of patients waiting over 18 weeks continues in all specialties with particular focus upon ophthalmology and orthopaedics. The Trust has agreed with Commissioners a timescale of the end of March to be compliant across all specialties and at Trust level.

18 weeks Referral to Treatment Target (RTT) – Admitted

4.6 The Trust failed the RTT target for Non Admitted patients with 94.6 % against the 95% target in January. The non achievement of the target was due to a combination of the following reasons:

- Two medical specialties failed to achieve the target which meant it was not possible to achieve the Trust overall target.

    - Neurology where there has been a high number of patients waiting over 18 weeks over the last three months that has been reducing but not yet to a point where they are 18 week compliant.
    - Dermatology where an increase in referral demand which has not been matched by clinical capacity due significant absence and vacancy levels.

- Ophthalmology remains a specialty with a significant number of patients waiting over 18 weeks. The number has reduced over the course of the last 3 months but is still not yet in a position to be 18 week compliant.

- Increased capacity for ophthalmology has been put in place through the appointment of locums to accelerate the clearance of the numbers of patients waiting over 18 weeks. At present, however, this is unlikely to achieve the target for the specialty until the end of March

- In Dermatology changes to administrative processes to ensure referral review and patient booking times are reduced have been put in place, however, the reduction in available clinical capacity remains a significant risk. Capacity is being sought from a partner organisation in order to continue to reduce the waiting times.

Cancer

4.7 The Trust achieved the necessary performance for 10 of the 12 target areas in December. The two areas where the target was not achieved were:

- 62 day target – performance was 79.9 % against a target of 85% in January, there are significant challenges within urology and diagnostic colonoscopy. The surgical centre is addressing this through changes to clinical pathways and additional capacity.
- The target for subsequent chemotherapy is 98% - performance in January was 97.1%. Two patients breached the target.

The Trust continues to achieve within all the standards for the year to date period.

Cancelled Operations

4.8 There were 191 cancelled operations in January, 39 of which were for medical reasons and 152 for non medical reasons. The cancellation for non-medical reasons represent an increase on the previous months and reflects the additional pressures placed upon our hospitals as a result of the numbers of emergency admissions. The reduction of cancelled operations is wholly dependant on delivery of the recovery plan for the improvement in patient flow.

Work continues to ensure patients are re-admitted with 28 days of the cancellation, an action plan has been agreed with each centre to track and escalate individual cases where re-admission is proving challenging

4.9 Summary report on access and cancer performance

	Measure	Standard	2012/13 Q1	2012/13 Q2	2012/13 Q3	Month Actual	YTD
Access	A&E 4 Hour Wait	95%	93.80%	92.81%	90.41%	91.12%	92.03%
	18 Week RTT Admitted	90%	81.63%	83.71%	81.97%	79.90%	81.78%
	18 Week RTT Non Admitted	95%	95.90%	95.68%	94.20%	94.59%	94.24%
	18 Week RTT - Incomplete	8%	5.36%	6.78%	8.05%	10.31%	8.25%
	% spending >90% of their stay on a Stroke Ward	90%	82.0%	94.00%	88.00%	95.00%	88.00%
	Delayed transfers as a % of Admission	3.50%	3.38%	3.13%	2.48%	3.45%	3.23%
	Last Minute non-clinical Cancelled Ops (Elective)	tbc	225	180	276	152	833
	Previous months 28 Day Readmission Breaches	5%	25.49%	36.25%	28.00%	3.98%	26.23%
Cancer	2 Week GP referral to 1st OP Appointment	93%	96.74%	95.36%	96.11%	94.67%	95.95%
	2 Week GP to 1st OP Appointment Breast Symptoms	93%	97.67%	93.20%	95.01%	96.40%	95.22%
	31 day diagnosis to treatment	96%	97.44%	97.39%	97.48%	97.14%	97.48%
	31 day second or subsequent treatment - Drug	98%	98.62%	99.30%	99.01%	97.10%	98.83%
	31 day second or subsequent treatment - Surgery	94%	95.59%	95.20%	95.06%	95.45%	95.10%
	31 day second or subsequent treatment - Radiotherapy	94%	99.09%	97.92%	97.51%	100.00%	97.80%
	62 days urgent referral to treatment	85%	85.18%	85.15%	86.02%	79.66%	85.60%
	62 days referral to treatment from Screening	90%	91.40%	92.73%	92.25%	88.89%	91.88%
	62 days referral to treatment from Hospital Specialist	85%	95.49%	95.86%	95.01%	86.27%	94.29%

5 Financial Performance

Month 10 – January 2013

	Measure	Standard	Quarterly Method	2012/13 Q1	2012/13 Q2	2012/13 Q3	Data Period	Period Actual	YTD	Forecast Next Month
Finance	PMR Finance Risk Rating	4	Q YTD	2	2	2		2	2	
	EBITDA Achieved	85%	Q YTD	84.20%	88%	98%		60.90%	93%	
	EBITDA Margin	5%	Q YTD	2.8%	4%	4.7%		4.3%	4.6%	
	I&E Surplus Margin	1%	Q YTD	-1.90%	-0.50%	0.00%		0.02%	0.02%	
	Return on Assets	5%	Q YTD	0.03%	1.20%	2.60%		0.20%	2.80%	
	Liquidity ratio	15 days	Q YTD	13.5	14.4	12.9		13.6	13.6	
	Total Income (actual v plan)	0.5% of plan	Q YTD	99.6%	99.6%	99.90%		95.65%	99.48%	
	Pay Expenditure (actual v plan)	At or below plan	Q YTD	101%	102.40%	99.90%		101%	100%	
	Non Pay Expenditure (actual v plan)	At or below plan	Q YTD	98.04%	95.20%	100.3%		91.37%	99.36%	
	CIP (actual v plan)	At or below plan	Q YTD	100%	74%	98.00%		98%	98.00%	
	Capital Expenditure (actual v plan)	At or below plan	Q YTD	13%	38%	59.00%		40%	56.00%	

Income and Expenditure Position

5.1 The Income and Expenditure position of the Trust is presented in the table below:

	Months 1-10 Budget £000s	Month 1- 10 Actual £000s	Variance £000s	Planned Forecast Outturn £000s	Forecast Outturn £000s	Variance £000s
Income	248,248	246,922	(1,326)	299,594	297,160	(2,434)
Expenditure						
Pay	(168,587)	(168,637)	(50)	(202,636)	(203,065)	(429)
Non Pay	(71,782)	(71,870)	(88)	(86,606)	(86,883)	(277)
Reserves	214	756	542	615	1,408	793
Finance Cost	(11,641)	(11,603)	(38)	(13,967)	(13,902)	65
Total Expenditure	(251,796)	(251,353)	443	(302,594)	(302,442)	152
Under / Over spend	(3,548)	(4,431)	(883)	(3,000)	(5,282)	(2,282)
Transitional support	4,484	4,484	-	4,900	4,900	-
	936	53	(883)	1,900	(382)	(2,282)
Management Actions					382	382
Surplus / (deficit)	936	53	(883)	1,900	-	(1,900)

The Planned (Budget) has been adjusted to allow for additional Income and Expenditure, associated with:

- Winter Pressures Funding
- Frail and Complex Project
- Early Supported Discharge Project,
- Warfarin Service Funding; and
- Additional support funded by the Shropshire and Staffordshire LAT.

The total Increase in the Income amounts to £1.307 million, and has allowed for Pay budgets to increase by £594,000, Non Pay budgets by £113,000 and reserves to increase by £600,000.

As can be seen from the above at the end of January the Trust had recorded a cumulative surplus amounting to £53,000. The Trust had planned to record a cumulative surplus at the end of January amounting to £936,000. The Trust is presently assuming a break even position (after allowing for management actions) at the year end.

Income

5.2 Significantly, in reporting a forecast Outturn surplus of £1 million in the previous board paper, there existed a gap between the levels of funding requested by the Trust and the sums offered by the two local CCG's, the gap amounted to £2 million.

Following negotiations involving the two CCG's, the Shropshire and Staffordshire Local Area Team and the East and West Midlands SHA it has become possible to close the gap. Specifically:

- Further funding amounting to £1.0 million has been made available by Telford and Wrekin CCG,
- Shropshire and Staffordshire have agreed to provide non recurrent funding amounting to £600,000; and
- East and West Midlands SHA have agreed to reduce the control total for the Trust by £1 million, and as such the Trust is now required to achieve a break even position by the year end.

Accordingly, in resetting the budget for the remaining two months of the financial year, the Trust has assumed the following Income profile.

	£000s	Variation from Average to date
Estimated Income per month in February and March	25,119	-
Average Income per month April – January	24,692	855

5.3 In adopting the Income profile for the period February – March 2013, the Trust is assuming within the forecast Outturn an increase in the level of Income over the remaining two months, when compared with the average level of Income received in the period to date, of £855,000. In order to test the robustness of this Income assumption it is necessary to more fully understand the level of risk associated with the Income. The table below provides a description of the level of risk.

	Income April – January £000s	Forecast Outturn £000s	Variation in the remaining two months form the average £000s	Level of risk
Shropshire County CCG	110,143	131,578	(594)	Low
Telford and Wrekin CCG	77,040	93,352	904	Low
Shropshire and Staffordshire Local Area Team	-	600	600	Low
Powys LHB	18,223	21,880	-	Medium
Specialised services	13,244	15,893	-	Low
Cancer Network Funding		300	300	Low
Non Contracted Activity	2,221	2,554	(110)	Medium
Education Funding	8,641	10,369	-	Low
Other CCG / PCT Income	5,367	6,740	-	Medium
Other Income	12,043	13,895	(243)	Medium
	246,922	297,160	855	

Expenditure

5.4 *Pay Expenditure*

- Pay spending in the month of January amounted to £17.229 million and is £217,000 above the planned level for the month.
- In January three Clinical Centres approved Pay spending considerably in excess of their revised budget, these being Medicine, Emergency and Critical Care and Surgery.
- During the month the level of spending in respect of Nursing Agency costs amounted to £469,000. In the quarter July to September the average level of Agency spend for nursing staff amounted to £185,000 per month.
- In forecasting an outturn for the year, it has been assumed that Pay spending will amount to £17.214 million per month. In the year to date the average level of monthly Pay spend amounts to £16.864 million.
- At the year end the Trust will have overspent against the revised budgets by £429,000.

5.5 *Non Pay*

- In the month of January the Trust underspent by £118,000.
- The three month average spending covering the period November – January amounts to £7.212 million, in forecasting an outturn it is assumed that Non Pay will spend at the rate of £7.507 million per month throughout the period February – March. The increased level reflecting costs associated with the delivery of Waiting list Targets.

Long Term Financial Position

5.6 Contract negotiations with the Local CCG's are continuing. CCG's are being supported through their Commissioning s upport Unit (CSU). Initial calculations between the CSU and the Trust have focused upon establishing a baseline contract figure for t he 2013/14 using an estimate of the fore cast outturn converted into a value for the 2013/14 ye ar using the revised Payment By Results (P BR) National Tariffs. This wor k has bee n completed and a common view has been agreed upon.

Local Commissioners are then required to use this information to make a contract offer to the Trust, which reflects their expectations in respect of:

- Impact of Demographic growth,
- Required Health economy QIPP savings.

5.7 The Trust is presently awaiting contract offers, from the two local CCG's. In advance of receiving such an offer the Trust has presented to the two CCG's an initial estimate of the value of the contract for the 2013/14 year. This estimate reflects the Trusts understanding of the PBR guidance and incorpor ates areas where t he Trust believes it is legitimate for Income to be received in the 2013/14 year that is not presently being recharged.

	Recurrent Surplus /(deficit) £000s	Non Recurrent Surplus/ (deficit) £000s	Total Surplus /(deficit) £000s
2010/11	(14,400)	14,426	26
2011/12	200	(200)	-
2012/13	(3,300)	3,300	-
2013/14	1,700	700	2,400
2014/15	2,900		2,900
2015/16	3,900		3,900
2016/17	4,700		4,700
2017/18	5,300		5,300

The effect of the recurrent deficit, negative t ariff and Pay and No n Pay Inflationary is t o create a £16 million def icit in t he 2013/14 year. Ac hieving a 6% Cost I mprovement Programme in the year generates savings to offset the deficit amounting to £16.4 million.

Applying working ass umptions as presented by Telford and Wrekin CCG in respect of demographic growth, general activity increases and Commissioner QIPP savings enables the Trust to record a surplus in t he 2013/14 year of £2.4 million rising to £5.3 million b y 2017/18.

Capital Programme

5.8 The position in respect of the Capital programme is presented in the table below.

Scheme	2012/13 Capital Budget £000's	Spend To date £000's	Forecast Outturn £000's	Variance (under) / over spend £000's
Reconfiguration	16,225	7,885	7,885	(8,340)
Patient Monitoring equipment	321	334	334	13
Telecommunications upgrade	86	83	86	-
Acute surgery consolidation	1,675	1,578	1,675	-
LINAC Installation works	664	533	605	(59)
Mammography development	524	330	330	(194)
Patient status at a glance Project	30	14	15	(15)
Centralising Booking	319	242	319	-
Head and Neck service transfer	650	588	588	(62)
Enhanced Car Parking facilities – PRH	369	-	369	-
Capital contingencies	3,886	3,837	4,195	309
Total Discretionary Capital Schemes	8,524	7,529	8,516	(8)
Total including reconfiguration	24,749	15,414	16,401	(8,348)

The Capital Programme is expected to under spend when compared with the total Capital Budget (Capital Resource Limit) by £8.348 million by the year end, as a result of the phasing of the Reconfiguration project. The SHA have been notified of the Capital Resource Limit underspend.

Cash flow

5.9 The Trust is planning to end the year with a cash balance of £2.2 million. In order to satisfactorily achieve the year end position, the following actions need to be put in place:

- Cash receipts for contractual over performance - Reaching agreement with the two Local CCG's in respect of the contractual over performance needs to be translated into an increased cash payment to the Trust in the month of March.

- Cash receipt from the Shropshire and Staffordshire LAT – Similarly, the Trust needs to ensure that cash funds are received from the LAT equivalent to their agreed contribution.

- PDC Drawdown – Discussion to be had to ensure that further PDC funding is released to reflect the level of cash payments associated with the reconfiguration project.

- Reduced level of Creditor suppression – Delivering upon the three actions above provides the opportunity to reduce the scale of creditor suppression in the month of March by £7.1 million.

Overall financial risks

5.10 The key risks are:

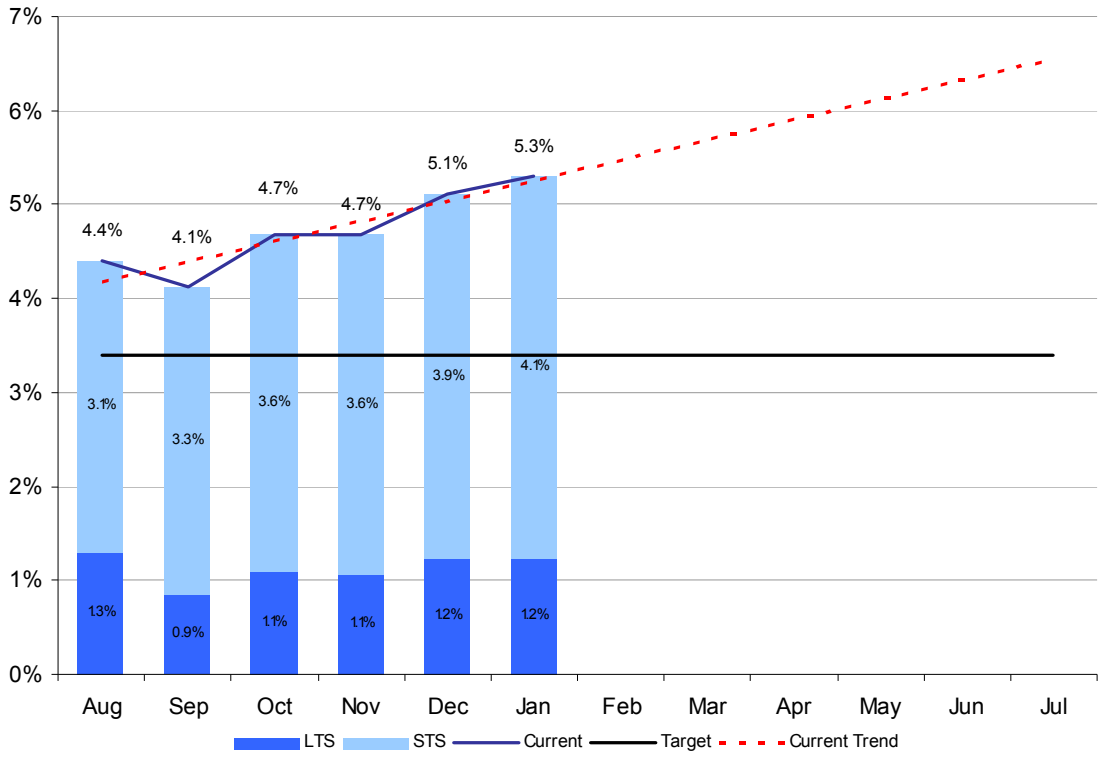
- Patient Flow – Ensuring that costs of delivering increased activity over the winter period are contained within revised budgeted levels. Doing so necessitates the achievement of improved Patient flow.

- Agency costs – Requirement to significantly reduce Agency costs through the recruitment of Nursing staff into vacant posts and also to improve sickness levels across the Trust.

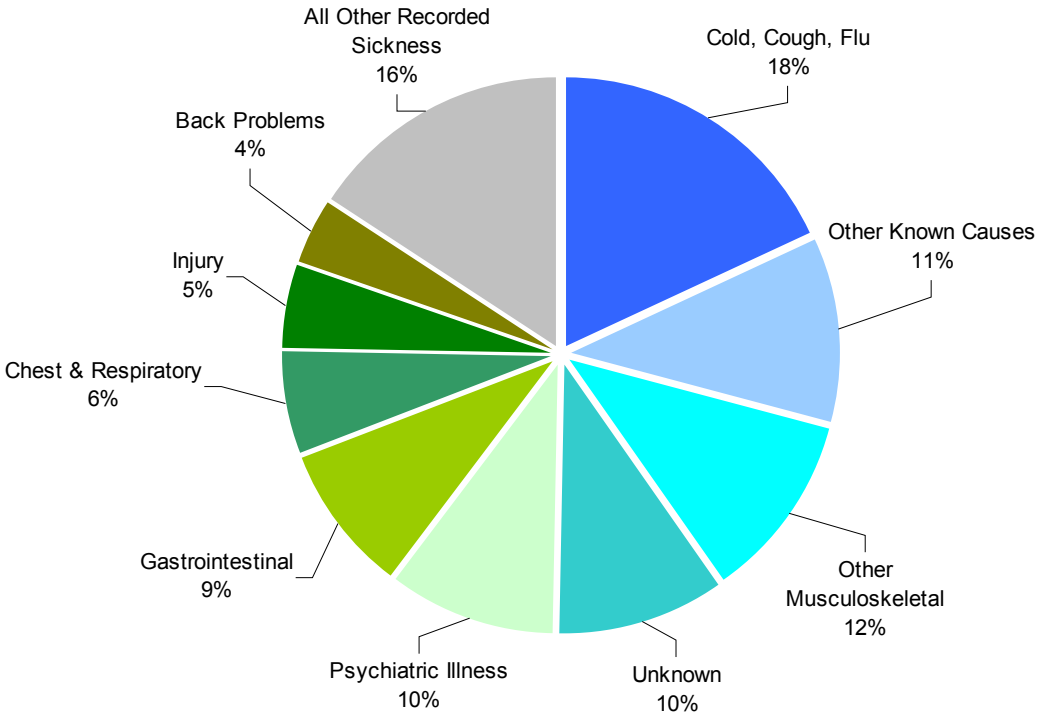
- Clinical Centre overspending – Centres need to ensure that they are putting in place the corrective actions to ensure a balanced Pay/Non pay Centre position is achieved by year end.

6 Workforce

6.1 Absence

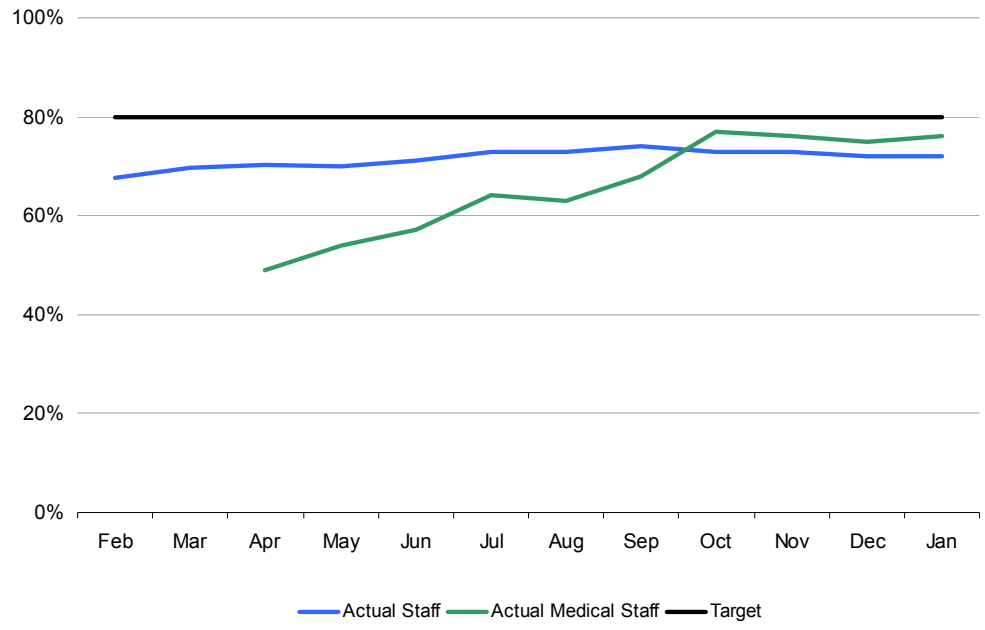


Absence continues to be a concern as current levels are significantly above target, high absence impacts not only on staff health and wellbeing but morale as well as such this is a strategic workforce priority. Absence has risen slightly in January, 30% of absence related to cold symptoms and gastrointestinal. The Trust has now worked with NHS Employers to develop an action plan to improve health and wellbeing. This plan will be discussed at this month's Workforce Committee and reviewed on a regular basis by the committee.



6.2 Appraisals

The Trust remains at 74%, 6% below the target for appraisals discussions with centres have included plans to achieve 80% by April. It should be noted that operational pressures are making appraisals difficult to achieve.



7 Declaration Against Provider Management Review Framework

7.1 Quality, safety and national targets

The Trust fell short of the monthly target in the following areas:

A&E 4 hour wait standard – 1 penalty point

18 Weeks RTT Target (Admitted) – 1 penalty point

18 Weeks RTT Target (Non Admitted) - 1 penalty point

18 Weeks RTT Target (Open Clocks) – 1 penalty point

31 day second or subsequent treatment – Drug – 1 penalty point

62 day wait for first treatment – 1 penalty point

Clostridium Difficile – 1 penalty point

Against the Governance Risk Rating the Trust is rated as RED with 7 penalty points compared to 6.5 in December. We also have an additional 4 points as a result of the A&E override, leading to an overall Governance Risk Rating of "7 plus 4".

7.2 Financial performance

Against the Finance Risk Rating the Trust is rated as RED with a score of 2. This is the same score as in December

7.3 Governance declaration recommendation

Due to ongoing concerns around delivery of the ED 4 hour wait target and financial performance the Board will be asked to authorise the Chair and Chief Executive to sign declaration 2: ' ***There is insufficient assurance available to ensure continuing compliance with all existing targets'***