Reporting to:	**Trust Board Meeting - 29th May 2014**
Title	Integrated Performance Report - April 2014
Sponsoring Director	Peter Herring - Chief Executive
Author(s)	Directors
Previously considered by	Not Applicable
Executive Summary	This report summarises the Trust's performance against all the key quality, finance, compliance, and workforce targets and indicators for 2014-15 to date and considers all elements of performance. It also contains the Board self certifications required to be submitted to the TDA in relation to Governance and Monitor Licence Conditions. SaTH is currently at Escalation Level 4 (of 5) in the NHS Trust Development Authority's Accountability Framework. This is classified as a 'Material issue' requiring interaction led by the Director of Delivery & Development. Regular meetings are held with the TDA to update on SaTH's improvement trajectories. They key areas of focus are highlighted in this report.
Strategic Priorities ☒ Quality and Safety ☒ Healthcare Standards ☒ People and Innovation ☐ Community and Partnership ☒ Financial Strength	**Operational Objectives** QS1 - Reduce avoidable deaths QS2 - Improve the nutritional status of patients and hydration and fluid management QS3 - Enhance communication and information for all patients and their carers QS4 - Eradicate all avoidable grade 3 and 4 pressure ulcers QS5 - Reduce the number of RIDDOR reportable falls HS3 Deliver all key performance targets PI1 - Implement a Staff Engagement Framework that improves employment experience and reduces absence to less than 4% FS1 - Deliver our milestones to achieve NHS Foundation Trust status FS3 - Deliver a financial surplus of £1.2m FS4 - Deliver the Trust 5% implied efficiency target and support delivery of joint QIPP
Board Assurance Framework (BAF) Risks	☒ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience ☒ If we do not implement our **falls** prevention strategy then patients may suffer serious injury ☐ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff ☒ If we do not achieve safe and efficient **patient flow** and improve our processes and capacity and demand planning then we will fail the national quality and performance standards ☐ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients ☐ If we do not get good levels of **staff engagement** to get a culture of continuous

	improvement then staff morale and patient outcomes may not improve ☒ If we are unable to resolve our (historic) shortfall in **liquidity** and the structural imbalance in the Trust's **Income & Expenditure** position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment
Care Quality Commission (CQC) Domains	☒ Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well led
☐ **Receive** ☐ **Review** ☐ **Note** ☐ **Approve**	**Recommendation** **The Trust Board is asked to REVIEW performance for April 2014 and APPROVE the self certification submissions.**

INTEGRATED PERFORMANCE REPORT – APRIL 2014/15

This report provides an overview with supporting analysis of the Trust's performance in the following domains:

- **Quality and Safety**
- **Operational Performance in delivering national healthcare standards**
- **Financial and Activity performance**
- **Workforce Metrics**

1. QUALITY & SAFETY PERFORMANCE

This Integrated Quality & Safety Performance report provides an overview of the key quality performance indicators in order that the Board can review variances to quality performance delivery. This enables the Board to gain assurance that actions for improvement are being pursued to improve patient outcomes and Trust quality performance. For information, the data below relates to **April 2014.**

OVERVIEW

- **Safeguarding Children & Adults**

The latest observational report on the Shropshire Multi-agency Risk Assessment (MARAC) for domestic abuse has been received by the Trust. This is an annual independent review by Coordinated Approach Against Domestic Abuse (CAADA) of the MARAC process across local agencies. The report has highlighted areas of good practice in relation to the referral and assessment of domestic abuse within our ED departments. Particular comments included:

"The referral presentations from A/E were examples of good practice and the increase in referrals from this agency is to be commended. The information they shared about visits to A/E is also important for risk assessment."

"The case had been referred in by A/E on professional judgment and there was clear escalation of domestic abuse prior to the last incident that had resulted in a visit to A/E"

- **Infection Prevention & Control (Estates)**

The completion of planned preventative maintenance across our estate for April was 67% completed at PRH and 86% at RSH. This work supports the prevention of infection and ward cleanliness and performance compares favourably to last months position of 27% and 86% respectively, demonstrating increased liaison between the Estates Department and the Infection Prevention Team.

	Measure	Annual Target 14/15	Monthly Target	YTD	January	February	March	April	Year end 13/14
Patient Safety	*Risk Adjusted Mortality Index (RAMI)*	**TBC**	**TBC**	TBC	SaTH 74	SaTH 77	SaTH 70	TBC	SaTH 80
	RIDDOR/SI Reportable Falls	**TBC**	**TBC**	2	3	5	3	2	34
	Grade 3 Avoidable Pressure	**TBC**	**TBC**	2	3	1	3	2	18

	Ulcers								
	Grade 3 Unavoidable Pressure Ulcers	**N/A**	**N/A**	2	4	3	0	2	17
	Grade 4 Avoidable Pressure Ulcers	**0**	**0**	0	0	0	0	0	0
	Grade 4 Unavoidable Pressure Ulcers	**N/A**	**N/A**	0	1	0	0	0	5
	C. difficile Infections	**38**	**3**	1	3	0	3	1	31
	MRSA Bacteraemia Infections	**0**	**0**	0	0	0	0	0	1
	MSSA Bacteraemia Infections	**TBC**	**TBC**	3	3	0	1	3	23
	E.coli Bacteraemia Infections	**TBC**	**TBC**	6	2	3	1	6	42
	MRSA Screening – Elective	**95%**	**95%**	95.1%	95.1%	96%	95.5%	95.1%	95.2%
	MRSA Screening – Non-Elective	**95%**	**95%**	96.4%	96%	96.8%	96.9%	96.4%	95.6%
	Number of Serious Incidents	**N/A**	**N/A**	6	11	10	12	6	145
	Never Events	**0**	**0**	0	0	0	0	0	0
	Safety Thermometer – Harm Free %	N/A	N/A	90.9%	93.1%	92.3%	93.5%	90.9%	92.6%
	WHO Safe Surgery Checklist	**100%**	**100%**	99.8%	99.5%	99.9%	99.9%	99.8%	99.9%
	VTE Assessment	**95%**	**95%**	TBC	95.1%	95.1%	95.2%	TBC	94.2%
	Maternity Dashboard	**Green**	**Green**	N/A	Amber	Green	Green	Amber	N/A
	Ward to Board – Nursing Performance Score	**95%**	**95%**	93%	93%	95%	95%	93%	93%
Patent Experience	*Number of Complaints*	**N/A**	**N/A**	26	42	33	38	26	444
	Same Sex Accommodation	**0**	**0**	0	0	0	0	0	0
	Friends and Family Response Rate	**NA**	**NA**	11.5%	16%	16%	16%	11.5%	9.9%
	Friends and Family Test Score	**75**	**75**	75	75	76	75	75	75.8
	Ward to Board – Patient Experience Score	**95%**	**95%**	89%	84%	86%	87%	89%	87%

A summary of patient outcome quality measures agreed for the Board are outlined in Table 1 above. These metrics provide the patient experience and outcomes chosen to monitor the impact and quality of care provided for the patient. Where performance Indicators are rated red the key summary points for the Board's attention are provided below.

1.2 RISK ADJUSTED MORTALITY INDEX (RAMI) UPDATE

Current State: The Health and Social Care Information Centre is currently reviewing access to the Hospital Episode Statistics (HES) and other national datasets. The review follows an investigation of the Commons' Health Select Committee into the care data programme. This has left some organisations that rely on standard extracts of HSCIC data, including HES, temporarily unable to refresh the analytics tools they run for NHS customers. As a consequence we do not have any information relating to National RAMI performance after December 2013, and are therefore unable to report our performance against our National peers. The timescales and implications of the review are currently unclear.

Planned Actions: Comparative data for year to date has put SaTH in a positive position against National peers. We will therefore continue to monitor SaTH trends and direction of travel to

ensure we maintain/improve performance within the current range until National information is available again.

1.3 SETTING TARGETS FOR 2014/15

Quality performance targets are identified and agreed at both a national and local level. In previous years; local targets have been agreed using a variety of relatively inconsistent approaches. The list below gives an indication of the national and local targets and how they have been agreed. The local targets for 2014/15 have been considered and agreed by the Quality and Safety Committee and these will be included in the performance report to Trust Board next month.

Falls – Locally agreed using last year's outturn position and applying a percentage decrease.

Pressure ulcers – 2011 target of 0 avoidable was set by Midlands and East SHA – Ambition 1.

Cdiff – Nationally mandated Public Health England.

MRSA - Nationally mandated Public Health England.

MSSA/Ecoli – Locally agreed with DIPC using last year's outturn position and applying a percentage decrease.

MRSA Screening – Nationally mandated via the contract.

Never Events - Nationally mandated via the contract.

WHO checklist – Nationally mandated via the contract.

VTE – Nationally mandated via the contract.

Maternity Dashboard – Part nationally mandated/part locally agreed with commissioners via the contract.

Ward to Board – Locally agreed.

SSA - Nationally mandated via the contract.

FFT - Nationally mandated via the contract.

1.4 EXTERNAL FEEDBACK AND ASSURANCE

Organisation	Visit Date	Where	Outcome	Status
National Trust Development Agency	09/04/2014	PRH and RSH	Immediate actions were requested in relation to: • Domestic cleanliness • Cannulae management and recording	Actions and plan completed providing assurances to the TDA. Further visit planned in May 2014.
Unannounced Telford CCG	31/04/2014	PRH	CCG wanted to understand shift patterns within the Trust. Formal feedback provided. Acceptable staffing levels found. VA alert found to be unsubstantiated.	Actions completed where necessary.

1.5 WARDS SUBJECT TO A QUALITY IMPROVEMENT FRAMEWORK (QIF)

One ward continues to be the focus of a QIF; the ward team is being supported by senior nurses to provide a system of regular quality assurance checks, a decision to review the QIF will be taken by the Head of Nursing for Scheduled care following a period of sustained improvement by the ward. The Director of Nursing & Quality is in discussion with the Head of Nursing in order to expedite the ward coming off the QIF process.

1.6 REGULATION 28 (formerly known as Rule 43)

There were no Regulation 28's during April 2014.

1.7 SAFEGUARDING – ADULTS & CHILDREN

There was 1 adult safeguarding alert made towards the Trust in April. This is a further reduction compared to the final quarter of last year. The alert has been investigated and the outcome was undetermined due to a lack of evidence.

There were 3 direct referrals to social services made by Trust staff during April; with concerns in relation to safeguarding children within the hospital. 1 referral was for a possible fabricated illness and 2 for suspicious injuries that has resulted in a child going into emergency foster care from hospital. Across the Trust 60 safeguarding forms were completed at PRH and 34 completed at RSH. All actions in relation to a Serious Case Review have also been completed.

1.8 SERIOUS INCIDENTS

There were 6 SIs reported in April 2014; all of which related to clinical effectiveness:

2 – Grade 3 Pressure Ulcers

2 – SI reportable falls

1 – Delayed diagnoses

1 – Infection issue

1.9 REVIEW OF LEARNING FROM ROOT CAUSE ANALYSIS (RCA) COMPLETED IN FEBRUARY 2014

A review of completed RCAs and Action plans for incidents reported in March has been undertaken to explore learning points and potential themes. Of the 12 SIs reported in March, 3 of the investigations are still in progress (2 of which relate to delayed diagnosis) and therefore the outcome of learning is unavailable in this month's report.

There were 3 falls reported that resulted in a fracture and following investigation the evidence found indicates that 2 were considered unpreventable and 1 preventable. This indicates that in 2 cases the documentation showed that all risk assessments and reasonable actions had been implemented in relation to the patients' care whilst regrettably the patient still fell. However, in one case, the evidence indicated that improvements to communication, assessment and the location of the patient may have prevented the fall occurring. To prevent this happening again high risk patients will no longer be placed in this location and will be transferred to an appropriate.

One of the themes relevant to falls is the time that the fall occurred. All 3 of the falls occurred in the evening (between 18:30 and 21:40 hours). Only one of the RCAs identified that staffing may have been a contributory factor; which may have affected the outcome. A review of the staffing levels on the ward has occurred and work is underway to recruit to levels in accordance with the November 2013 staffing review.

Of the remaining incidents investigated; the main learning outcomes, themes and actions identified within the RCA were:

- Some lack of clarity regarding 'closing of the clock' on cancer patients and some issues with the Somerset database. Relevant staff have been made aware of the incident, learning has been shared within the team and a plan is in place to remedy concerns regarding the data base.
- Letter template and windowed envelopes are a potential risk for letters to go to the wrong location (i.e. patient's home address instead of the GP). Relevant staff have been made aware

of the incident; learning has been shared within the team and advised that windowed envelopes are no longer to be used.

- Clarity and accuracy when communicating and documenting Do Not Attempt Resuscitation (DNAR) decision making. This incident has been discussed with the consultant involved and new DNAR documentation is being developed and will include further education on its implementation through the care groups.
- Support for the 7 day working week for Consultant cover. The Trust is working with commissioners to develop an incremental plan for 7 day working across the Trust.

1.10 QUALITY IMPROVEMENT OVERVIEW

Measure	Annual Target	Monthly Target	YTD	January	February	March	April	Year end 13/14
Grade 3 Avoidable Pressure Ulcers	**0**	**0**	2	3	1	3	2	18
Current State	There were 2 avoidable Grade 3 pressure ulcers reported in April 2014. Overall there continues to be an ongoing reducing trajectory in reported avoidable Grade 3 pressure ulcers and there is a 35% reduction in the number of avoidable pressure ulcers across all Grades.							
Planned Actions	A full retrospective review of pressure ulcers for 2013/14 will be reported to the Q&S committee in June 2014. This will include key themes, trends, learning and a baseline position for the coming year using prevalence per 1000 occupied bed days.							
Key Themes/Trends	A key theme of Grade 3 pressure ulcer since January is occurrences on heels and feet. However, there are questions regarding wounds to heels being classified as pressure damage. It is recognised that some of these may be due to a number of different causes, such as; diabetic ulcers, peripheral vascular disease and arterial insufficiency. There have been no mask related pressure ulcers reported since February and this may be attributed to the new mask devices recently introduced.							

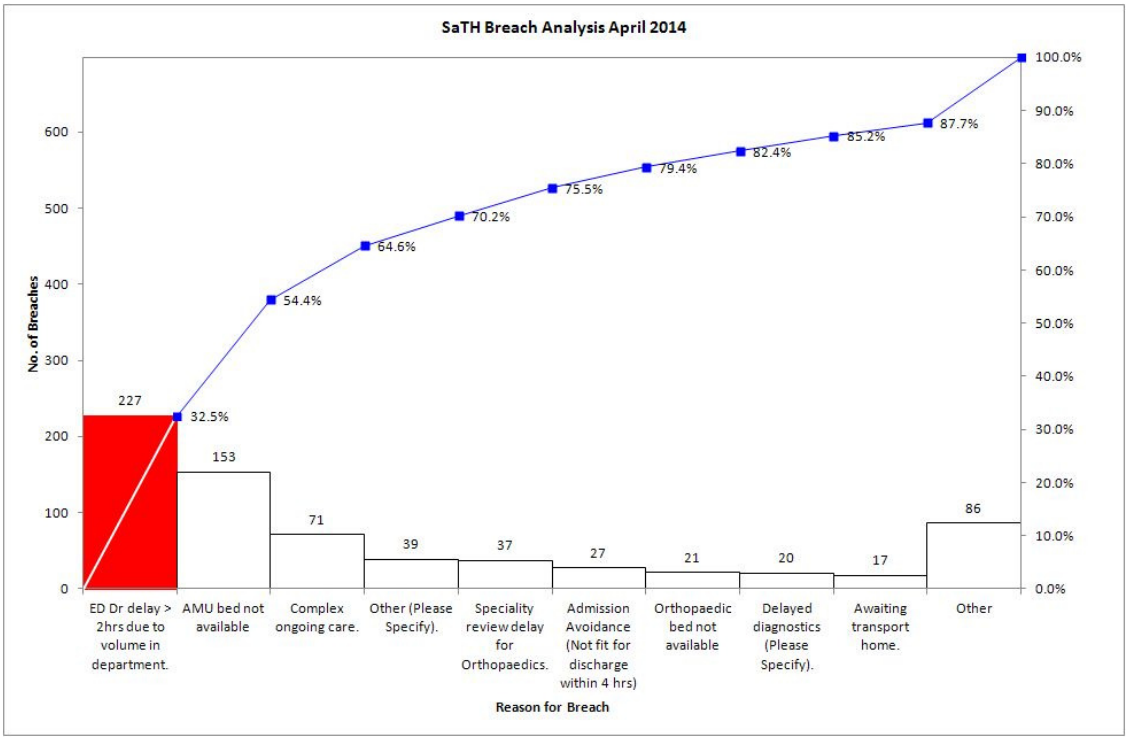
2. OPERATIONAL PERFORMANCE OVERVIEW

OVERVIEW

- **4-hour Access Standard**

  In April 2014 92.51% patients were admitted or discharged within the 4 hour quality target, this is a 0.09% drop in performance compared to the previous month of March, however a 10% improvement compared with April 2013. Year to Date [YTD] performance is reported as 92.51%, this is 0.36% above the Trust projected position of 92% for April. As part of the Emergency Department Remedial Action Plan [RAP] and Unscheduled Care team improvements, work continues in developing ED Co-ordinators relationships with Site Managers. Internal process issues within the ED's in April is leading to a pattern of ED delay breaches as the primary breach reason, rather than no beds. ED breaches occur because there are insufficient cubicles for the volume of patients during surge periods – resolving this will be the focus during May. The first development sessions with the co-ordinators to highlight roles and responsibilities and awareness of internal mechanisms when the department is under pressure took place in April. This is now a monthly meeting.

The graph below details, per breach reason, the number of patients who were not admitted or treated within 4 hours during April 2014.



Healthcare at Home have completed their diagnostic assessment of the potential for a 'recovery at home' service. The proposed model that will underpin a business case will be presented to the Exec Directors for consideration on Wednesday 11th June 2014.

- **Local Health and Social Care Schemes**

The Urgent Care Working Group is temporarily being co-chaired by the Area Team to support the health and social care economy in delivery of the A&E 4 hour target. The strategic direction for urgent care in the local system is still being led by the CCG's.

To further support delivery of the A&E 4 hour target, an Urgent Care Business Meeting has been set up to be held fortnightly.

- **RTT Performance**

Admitted

All specialties are on trajectory to achieve 18 weeks (exception report enclosed within the Trust Board information pack) in accordance with the Remedial Action Plan [RAP]. Overall delivery will be from 1st September 2014. A drop-in day surgery unit will be in place at PRH 16th June 2014. This will be used to clear the backlog of patients in Orthopaedics and Ear, Nose & Throat.

Non admitted

The Trust failed to deliver the overall performance of the non-admitted standard because of the commencement of the reduction in the ophthalmology backlog. A revised trajectory has been completed for ophthalmology and this will require additional capacity from ViewPoint (a provider of ophthalmology services). Discussion is taking place with Viewpoint to ensure we have the right capacity in place.

RTT Clearance Times

RTT clearance times aim to indicate how long in weeks it would take to clear current patients on incomplete pathways, assuming that no new patients are added to the list. Although this is not a national target, a total clearance time of 8 weeks, and an over 18 weeks clearance time of 0.5 weeks is deemed to indicate a sustainable waiting list according to the Department of Health (DH).

As at the end of April the Trust's total clearance times were as follows:

- Admitted 7.8 weeks
- Non- admitted 11.1 weeks

The Trust backlog clearance times for April were as follows:

- Admitted 1.32 weeks
- Non- admitted 0.95 weeks

- **Cancer Performance**

At the end of March, the Trust delivered all of the cancer standards with the exception of the 62-day target.

The unvalidated position for April indicates that the Trust failed 6 of the cancer standards. This is extremely disappointing and the following urgent actions have been put in place with immediate effect:

- A revised cancer PTL meeting has been put in place and will be chaired by the Assistant Chief Operating Officer for Scheduled Care. This meeting will be attended by all Centre Managers and is mandatory. Actions from this meeting will minuted and updates will be required twice weekly;

- Every patient on the cancer PTL will be discussed in detail and actions put in place to ensure compliance with the standard;

- All patients who cannot be treated within the timescales will be escalated to the Chief Operating Officer;

- Each of the Cancer MDT leads will attend a meeting with the Lead Clinician for cancer services to ensure that all MDT meetings meet the requirements of the Trust;

- A monthly report will be received from each of the Centres detailing progress against the cancer standard and actions to be taken;

- A full validation of the breast 2 week waits referrals is being undertaken to ensure the categorisation of patients is correct;

- The Patient Access manager is doing a full review of the 2 week wait booking processes and taking action where necessary.

The IST has completed a review of Radiology services and the key recommendations will be reported to Trust Board in June 2014 as the report is currently in draft.

2.1 PERFORMANCE AGAINST NATIONAL STANDARDS, BY EXCEPTION ARE DESCRIBED BELOW.

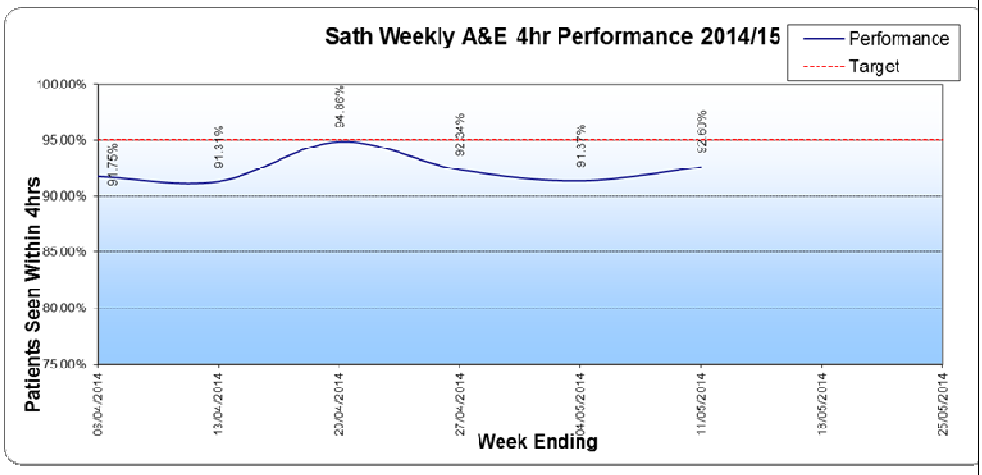
	Month 1 - 2014/15							
	Measure	2013/14 Outturn Period	2013/14 Outturn	2014/15 Threshold	M1 Apr-14	Q1	2014/15 Year to Date	2014/15 Forecast Outturn
Access	A&E 4 Hour Wait	Full Year	93.40%	95%	92.51%		92.51%	
	A&E 12 Hour Trolley Waits	Full Year	17	0	0		0	
	Ambulance Handovers not completed within 30 Minutes (SaTH Validated View)	Full Year	275	0	12		12	
	Ambulance Handovers not completed within 60 Minutes (SaTH Validated View)	Full Year	41	0	4		4	
	18 Week RTT Admitted - English Responsible Only - Part 1A	Mar-14	76.98%	90%	80.19%		80.19%	
	18 Week RTT Non Admitted - English Responsible Only - Part 1B	Mar-14	93.08%	95%	93.95%		93.95%	
	18 Week RTT Incomplete Pathway - English Responsible Only - Part 2	Mar-14	89.71%	92%	89.82%		89.82%	
	18 Week RTT > 52 Weeks - English Responsible Only	Full Year	38	0	0		0	
	% of Patients waiting over 6 Weeks for a Diagnostics Test	Full Year	0.51%	1%	0.24%		0.24%	
	Cancelled 28 Day Readmission Breaches	Full Year	14	0	1		1	
	Number of Urgent operations cancelled more than once	Full Year	0	0	0		0	
Cancer	2 Week GP referral to 1st OP Appointment	Full Year	94.58%	93%	92.01%		92.01%	
	2 Week GP to 1st OP Appointment Breast Symptoms	Full Year	93.35%	93%	88.50%		88.50%	
	31 day diagnosis to treatment	Full Year	97.33%	96%	95.88%		95.88%	
	31 day second or subsequent treatment - Drug	Full Year	99.09%	98%	98.33%		98.33%	
	31 day second or subsequent treatment - Surgery	Full Year	93.35%	94%	89.36%		89.36%	
	31 day second or subsequent treatment - Radiotherapy	Full Year	97.69%	94%	100.00%		100.00%	
	62 days urgent referral to treatment	Full Year	81.48%	85%	83.54%		83.54%	
	62 days referral to treatment from Screening	Full Year	93.98%	90%	76.19%		76.19%	
	62 days referral to treatment from Hospital Specialist (Upgrades)	Full Year	92.13%	85%	90.91%		90.91%	
Patient Experience / Governance	C-Diff	Full Year	31	38	1		1	
	MRSA	Full Year	1	0	0		0	
	Same Sex Accommodation Breaches	Full Year	0	0	0		0	
	Compliance with VTE Assessments	Mar-14	95.20%	95%				
	Publication of Formulary	Mar-14	Yes	Yes	Yes		Yes	
	Duty of Candour	Mar-14	N/A	0	0		0	
	Valid NHS Number in submitted Acute datasets	Mar-14	N/A	99%	99.79		99.79	
	Valid NHS Number in submitted A&E datasets	Mar-14	N/A	95%	98.56		98.56	

2.2 OVERVIEW OF PERFORMANCE STANDARDS BY EXCEPTION

Measure	Annual Target	Monthly Target	YTD (Inc WI)	January	February	March	April	Year end 13/14
A&E 4 Hour Wait	**95%**	**95%**	**92.51%**	**89.45%**	**93.48%**	**92.67%**	**92.51%**	**93.40%**

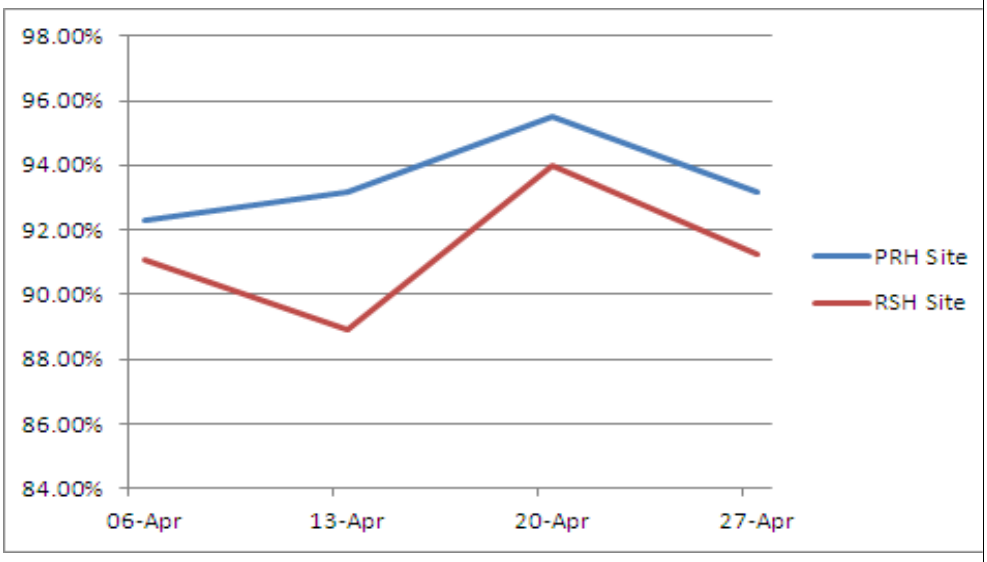
Current State

The following graph best describes the current performance of the Trust:



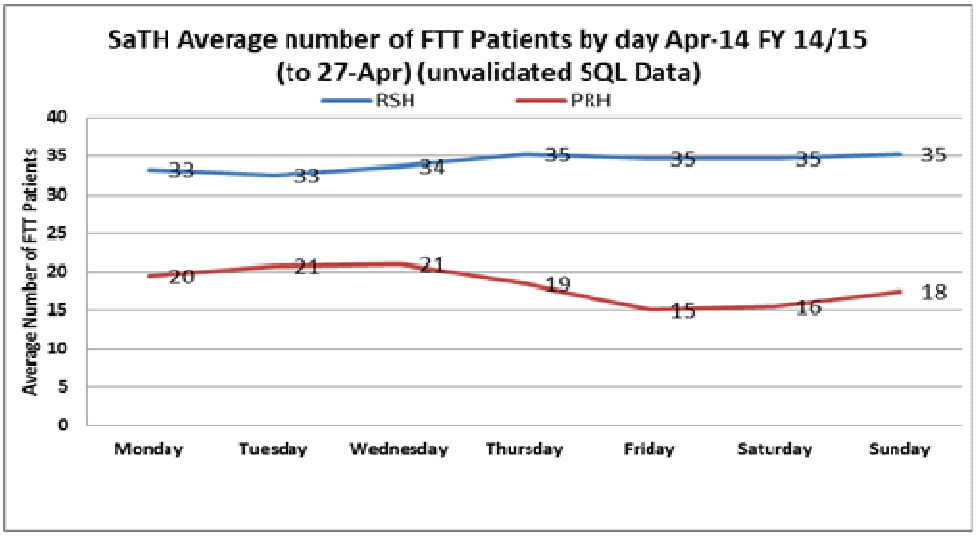
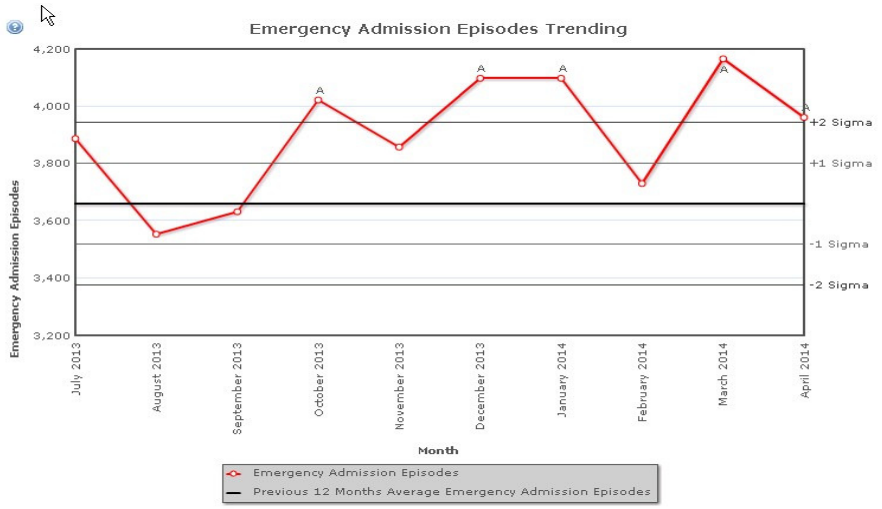
- Target not achieved during April, as a comparison to April 2103. We continue to follow the pattern of improvement with no over 12 hrs breaches (April 2013 the Trust had 16 over 12 hour waits).

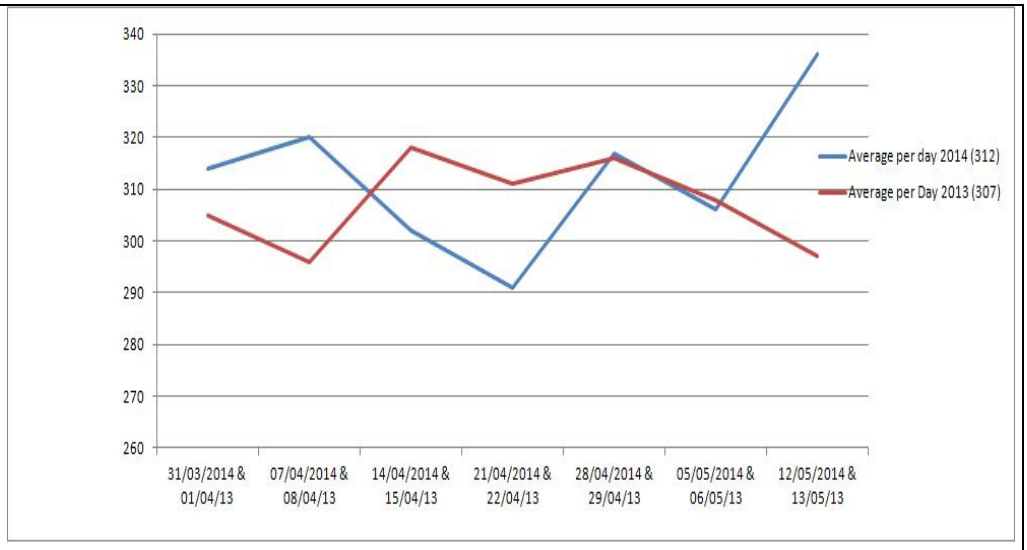
The following graph indicates site performance, PRH site includes walk-in centre activity. RSH site includes ARC activity.



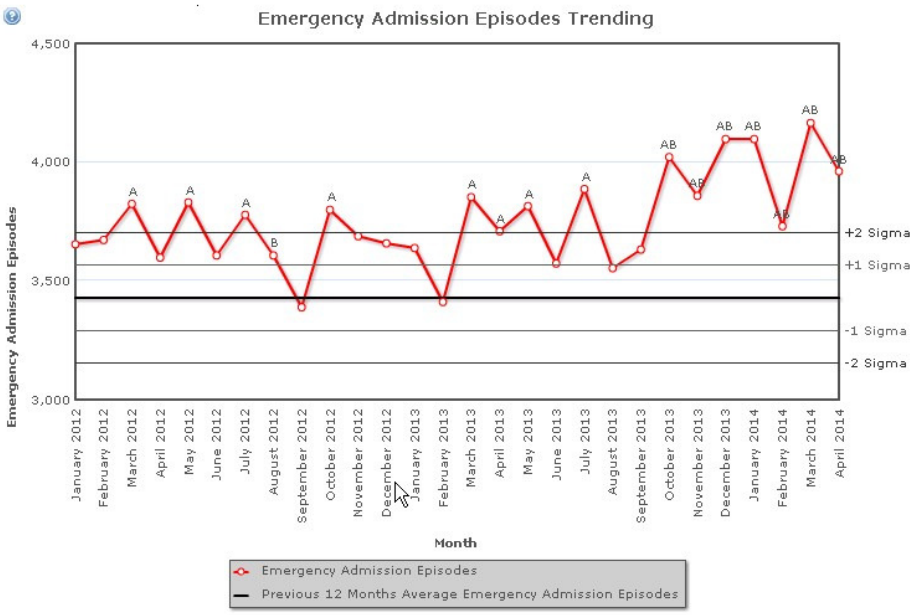
Planned Actions	As part of the continued cycle of improvement during April and into May we should see the following actions take place:
	• Review of ED at PRH to ensure internal system flow and procedures do not have any in-built delays;
	• Direct admission from PRH ED to Ward 11 bay A for Trauma & Orthopaedic patients to prevent excessive waits in ED;
	• Review of stroke pathway and response times to ED;
	• Development of a model of ambulatory emergency care and admission avoidance with Telford & Wrekin CCG;
	• Integrated Care Service rollout in Shropshire
	• Development of Emergency Ambulatory Care at RSH, and initial discussions with PRH showing potential development opportunity PRH currently has an established Ambulatory model of care and this will be refined.
	• Development of Urgent Care Centre at RSH. Initial discussions with PRH showing potential development opportunity;
	• Telford & Wrekin Better Care Fund initiatives – integrated community enablement model;
	• Implementation of SaTH Medicine Strategy;
	  • Cardiology
	  • COE
	  • Stroke/TIA service
	  • Short Stay
	  • Development of Clinical Decision Unit at PRH;
	• Scoping exercise with Private Organisation – Healthcare at Home – to enable sub-acute care for patients who still have a medical need to be managed within a community setting;
	• Development of Hospital without walls in a local Nursing Residential Home, to support interim patients whose needs can be met whilst a permanent placement can be found, 2 large care providers are interested in developing this model.

Key Themes/ Trends	• The Trust continues to function at above 98% bed occupancy daily with all assessment areas full. Improvements in flow by pre 10,12 and 1500 hours discharges are being reviewed. It is becoming clear that where wards fail to deliver it is primarily due to a number of factors:
	  ▪ Transport pre booked not arriving until after 1000 Hrs
	  ▪ Patients' moved to escalation areas that then are not recorded against the ward
	  ▪ All residential and nursing homes refusing to take patients' until the afternoon
	  ▪ Community wards refusing to take patients until the afternoon
	• We are continuing with check chase challenge as part of overall site improvements;
	• Across the month of April the main reason for breaches remains a lack of capacity (beds). We have seen an increase in ED delays which have increased due to a lack of capacity resulting in no room to review patients within the emergency department;
	• The number of patients on the Fit to Transfer list has increased and is now back at the levels seen prior to the winter plan schemes.

Key Themes/ Trends	***Fit to Transfer Trend Chart – Daily Average by Site/Month***  The following graph shows the increasing trend in emergency admissions this includes admissions with a 0 day length of stay. This correlates with the national position. It highlights a continued trend of increased admissions; this is linked to increased attendances.  The following Graph highlights a comparison against 2013; this indicates that an average of 5 additional attendances per day, this correlates to the increase in admissions.



The following graph highlights the increase in emergency admission episodes; this would include data from AMU and SAU.



2.3 OVERVIEW OF PERFORMANCE STANDARDS BY EXCEPTION

Measure	Annual Target	Monthly Target	YTD	July	August	September	October	November	December	January	February	March	April	Year end 13/14
18 Week RTT Admitted - English Responsible Only	90%	90%	80.19	70.51	77.61	75.54	75.82	79.34	78.74	81.73	79.15	76.98	80.19	76.98 %
Current State	- The admitted performance failed to deliver the overall target in April. This is in line with the overall trajectory, and the remedial action plan. Orthopaedics and ENT are ahead of trajectory. Max fax will be delivering from 1st October 2014.													
Planned Actions	- A mobile theatre and ward will be delivered to the PRH site at the end of May and will be operational from 16th June 2014. This will provide additional capacity in orthopaedics and oral surgery.													
Key Themes/Trends	- General surgery, urology, gynaecology, cardiology, general medicine continue to deliver the 90% standard.													

Measure	Annual Target	Monthly Target	YTD	July	August	September	October	November	December	January	February	March	April	Year end 13/14
18 Week RTT Non Admitted - English Responsible Only	95%	95%	93.95	95.77	95.39	95.17	95.29	95.43	95.89	95.96	95.37	93.08	93.95	93.08%
Current State	- The non-admitted performance failed to deliver the overall target in April. This is expected as the Trust is now clearing the backlog in ophthalmology.													
Planned Actions	- A revised trajectory for ophthalmology has been completed. In order for this to trajectory to be delivered additional capacity will be required from View Point (a provider of ophthalmology services), who are currently providing additional follow up capacity to clear our follow up activity. A revised model of referrals for glaucoma is being established with the CCGs. All glaucoma referrals will be triaged within primary care and only those requiring a specialist secondary care opinion will be referred in to SaTH.													
Key Themes/ Trends	- The overall performance against the 95% standard will be compromised until the 18-week backlog is at a more sustainable level, due to the high numbers waiting in the 18-week backlog.													

Measure	Annual Target	Monthly Target	YTD	July	August	September	October	November	December	January	February	March	April	Year end 13/14
18 Week RTT Incomplete Pathway - English Responsible Only	92%	92%	89.82	92.16	89.76	89.94	91.02	90.95	89.75	89.40	87.65	89.71	89.82	89.71%
Current State	- Target failed in April in line with the Remedial Action Plan (RAP).													
Planned Actions	- All specialties to ensure that their booking processes and profiles are being adhered to and all patients are booked in chronological order with the exception of clinical urgency.													
Key Themes/ Trends	- In line with admitted and non admitted performance and trajectories.													

Measure	Annual Target	Monthly Target	YTD	July	August	September	October	November	December	January	February	March	April	Year end 13/14
Cancelled 28 Day Readmission Breaches	0	0	1	0	3	1	1	1	0	0	2	0	1	14
Current State	- There was one patient not admitted within 28 days. This was an error by the ophthalmology team													
Planned Actions	- The team have been reminded of the process to check the cancelled operations database daily. In addition, they have been reminded of their roles and responsibilities as per the performance management framework. This will be monitored on a weekly basis.													
Key Themes/ Trends	- There has been a significant improvement in this performance; however, the operational teams need to be vigilant in ensuring the process for cancelled operations is followed.													

Please note that validated Cancer breaches for March are reported here **(figures for April are predicted as further patients and subsequent cancer information may be added resulting in a variance to the current reporting position)**

Measure	Annual Target	Monthly Target	YTD	November	December	January	February	March	Year end 13/14	April
2 Week GP to 1st OP Appointment Breast Symptoms	93%	93%	88.50%	91.53%	89.94%	92.75%	93.83%	93.51%	93.35%	88.50 %
2 Week GP referral to 1st OP Appointment	93%	93%	92.01%	95.33%	93.15%	94.69%	95.90%	95.93%	94.58%	92.01 %

Current State	*Breast Symptomatic* - Prediction target failed in April with 13/113 patients breaching (11.50% representative) - Fourth episode of noncompliance in the last 6 month period - Predicted noncompliance for year end 2014/15 at -4.5% - *2 Week Standard* - Prediction target failed in April with 123/1540 patients breaching (7.98% representative) - First episode of noncompliance in the last 12 month period (previous episode of non-compliance April 2013 – 92.00%) - Predicted noncompliance for year end 2014/15 at -0.99%
Planned Actions	- Validation of all patients under 2WW to ensure category assigned is correct and that all appropriate adjustments have been applied - Centre Managers to investigate current capacity and demand; look to increase clinic availability earlier in the pathway - Development of a 2WW SOP to provide guidance to booking clerks to ensure best practice; feedback provided by cancer services and document now in use - GP education; raise with commissioning the updating of referral forms to indicate when the patient is available to attend first OPA (e.g. holidays); breast is for review after the completion of colorectal - Meeting between booking & scheduling and cancer services 09.05.14; identifying responsibility for tracking and escalating of patients (2WW targets only) with booking & scheduling *Meeting recommendations* - Review and document current escalation process for 2WW - Undertake cross checks on a daily basis - Remove the responsibility of applying adjustments to patients from band 3 clerks to a supervisory / managerial level
Key Themes / Trends	- Breast symptomatic figures are less than expected when compared to previous months (April figures were -72 on the previous month of March) - 2 week wait standard figures are increasing month on month; however April figures were +165 on the previous month of March - Initial concerns have been raised over the categorisation of the referrals between the two target groups; and requires further investigation - Increased patient choice around the Easter period resulting in appointments being booked out of target - Capacity issues which were raised by booking & scheduling to the relevant Operational and Centre Managers for resolution; high levels of non-compliance for Upper GI, Urology, Colorectal and Breast

Measure	Annual Target	Monthly Target	YTD	November	December	January	February	March	Year end 13/14	April
31 day diagnosis to treatment	96%	96%	97.98%	97.08%	96.65%	97.64%	96.93%	97.95%	97.43%	95.88 %
Current State	- Predicted target failed in April with 7/170 patients breaching (4.11% representative) - First episode of non-compliance in the last 12 month period - Predicted non-compliance for year end 2014/15 at -0.12%									
Planned Actions	- Low staffing within cancer services contributing to a delay in data completeness of treatment information; request for temporary staffing to provide additional support - Investigate current skin pathways and ensure best practice is adopted by the clinical team - Review current guidance on admitted and non-admitted treatments; develop local policy to be able to apply adjustments where appropriate to radiotherapy in-patient cases (low percentage / incidental)									
Key Themes / Trends	- 3x skin cases; histology from treatment was the first notification of each patient to the appropriate coordinator, all treatments conducted outside of target date - 2x capacity (head & neck and skin); cases escalated as per policy however no resolution provided - 2x highly complex cases									

Measure	Annual Target	Monthly Target	YTD	November	December	January	February	March	Year end 13/14	April
31 day second or subsequent treatment – Surgery	94%	94%	94.57%	91.43%	93.75%	94.44%	88.57%	100%	93.32%	89.36 %
Current State	- Predicted target failed in April with 5/47 patients breaching (10.63% representative) - Fourth episode of predicted non-compliance in the last 6 month period - Predicted non-compliance for year end 2014/15 at -4.64%									
Planned Actions	- Consultant surgeons are advised to pool surgical cases and offer patients alternative appointments within target (letter distributed March 2014 to all clinical leads) - Disseminate best practice (updated MDT SOP / continued presentation of breach analysis) to MDT teams - Surgical capacity: alternative appointments are not being offered to the patient within target.									
Key Themes / Trends	3x capacity consultant availability; escalated as per policy however centre unable to provide resolution									

Key Themes / Trends	Urology - 1x capacity; escalated as per policy however centre unable to provide resolution - 1x no notification of patient on waiting list, identified by surgical coordinator after treatment completed out of target

Measure	Annual Target	Monthly Target	YTD	November	December	January	February	March	Year end 13/14	April
62 days urgent referral to treatment	**85%**	**85%**	**81.84%**	**83.52%**	**80.20%**	**79.48%**	**80.75%**	**81.67%**	**81.58%**	**83.54 %**
Current State	- Target failed in March with 13.5/82 patients breached (16.46% representative) - Sixth consecutive episode of non-compliance in the last 6 month period - Predicted non-compliance for year end 2014/15 by -1.46% - Breaches reported are across seven cancer sites; with a number of complex cases impacting the current predicted level (detailed breach reasons are included within the key themes and trends section)									
Planned Actions	- IST recommendation; to document routes to MDT discussions for incidental findings. Timetable to deliver IST recommendations to be agreed and submitted to the executive team - Direct treatment referrals from MDT as per MDT SOP; re-circulate guidance to the clinical teams to ensure best practice									
Key Themes / Trends	Urology - 1x diagnostic delay to TRUSB; escalated as per policy however centre unable to provide resolution due to capacity issue Upper GI - 1x no available oncology appointment within target; escalated as per policy Haematology - 1x complex case; cross MDT discussions with referral to haematology team after target date had elapsed Skin - 1x complex case - 2x capacity (skin) consultant availability; escalated as per policy however centre unable to provide resolution Head & Neck - 3x delays to diagnostics (FNAs) capacity issues escalated as per policy; resolution could not be provided by the centre; executive team informed									

Key Themes / Trends	Gynaecology - 3x highly complex cases; required multiple surgeons for single operation to perform multiple procedures, patient choice, DNA'd multiple appointments despite frequent contact by the clinical team complex disease Colorectal - 1x highly complex case - 1x data entry issue within 2WW; patient added to Somerset after target date

Measure	Annual Target	Monthly Target	YTD	November	December	January	February	March	Year end 13/14	April
62 days referral to treatment from screening	**90%**	**90%**	**85.56%**	**75.00%**	**100%**	**97.14%**	**91.67%**	**100%**	**94.56%**	**76.19%**
Current State	- Predicted target failed in April with 2.5/10.5 patients breaching (23.80% representative) - Second episode of non-compliance in the last 6 month period - Predicted non-compliance for year end 2014/15 at -13.81%									
Planned Actions	- Low staffing within cancer services contributing to a delay in data completeness of treatment information; request for temporary staffing to provide additional support - Investigate current skin pathways and ensure best practice is adopted by the clinical team - Review current guidance on admitted and non-admitted treatments; develop local policy to be able to apply adjustments where appropriate to radiotherapy in-patient cases (low percentage / incidental)									
Key Themes / Trends	- 2x complex cases across (gynaecology and colorectal) cancer sites; cross MDT discussions / robotic surgery (infrequent lists) - 1x surgical capacity / patient availability – requires further investigation possible adjustment to be applied preventing breach									

3. FINANCE

OVERVIEW

- The Trust overspent in the month of April by £2.47 million; the Trust had planned for an overspend of £1.98 million. The Trust is predicting an overspend for the year of £8.2 million.
- Activity levels recorded in the month are consistent with the planned levels. An income underperformance of £138,000 has however been recorded, because of a need to provide for potential contractual penalties.
- Pay spending in the month amounted to £17.87 million and is compared with a budget for the month, after allowing for required CIP savings, of £17.19 million. The overspend is principally associated with overspending within nurse staffing.
- The Trust has delivered £1.077 million in the month as cost savings/efficiencies. The target for the month was £1.217 million. It is believed that the under achievement will be recorded in future months.
- Cash balances at the end of the month amounted to £8.2 million. Immediately recognisable liabilities in respect of capital creditors and Post Graduate Education Centre amounting to £8.0 million are however distorting the underlying cash position of the Trust.

3.1 FINANCE PERFORMANCE SUMMARY – MONTH 01

Measure		Standard	Data Period	Period Actual
Finance	PMR Finance Risk Rating	4	Apr-14	1
	EBITDA Achieved	85%	Apr-14	175.75%
	EBITDA Margin	5%	Apr-14	-5%
	I&E Surplus Margin	1%	Apr-14	-10.01%
	Return on Assets	5%	Apr-14	-12.34%
	Liquidity ratio	15 days	Apr-14	13.1
	Total Income (actual v plan)	0.5% of plan	Apr-14	99.44%
	Pay Expenditure (actual v plan)	At or below plan	Apr-14	103.98%
	Non Pay Expenditure (actual v plan)	At or below plan	Apr-14	95.41%
	CIP (actual v plan)	At or below plan	Apr-14	100.00%
	Capital Expenditure (actual v plan)	At or below plan	Apr-14	47.87%

3.2 INCOME AND EXPENDITURE POSITION

The level of Income receivable in the month is estimated at £24.684 million, and in doing so creates an Income shortfall amounting to £138,000. In estimating the Income figure for the month, an allowance has been made for potential penalties that could be levied against the Trust by the CCG's.

A high level summary of the key variances is provided in the table below:-

	Financial Plan £000s	April Budget £000s	April Actual £000s	Variance £000s	Forecast April –March Budget £000s	Forecast April –March Actual £000s	Variance YTD £000s
Income	312,241	24,822	24,684	(138)	312,241	312,241	-
Pay	(204,970)	(17,191)	(17,870)	(679)	(204,970)	(204,970)	-
Non-pay	(85,947)	(7,075)	(7,289)	(214)	(85,947)	(85,947)	-
Reserves	(13,647)	(566)	(28)	538	(13,647)	(13,647)	-
Phased spend		**(810)**	**(810)**	-			
Total expenditur	**(304,905)**	**(25,642)**	**(25,997)**	**(493)**	**(304,905)**	**(304,905)**	**-**
EBITDA	**7,736**	**(820)**	**(1,313)**	**(493)**	**7,736**	**7,736**	-
Finance costs	(15,936)	(1,157)	(1,157)	-	(15,936)	(15,936)	-
Surplus/(deficit)	**(8,200)**	**(1,977)**	**(2,470)**	**(493)**	**(8,200)**	**(8,200)**	**-**

3.3 INCOME

Activity and Income Variance Analysis

	Annual Budget	April Budget	April Actual	Variance	Variance %	Annual Budget	April Budget	April Actual	Financial Variance Value	Price Variance	Volume Variance
	Activity	Activity	Activity	Activity		£000s	£000s	£000s	£000s	£000s	£000s
Accident and Emergency (Attendances)	108,542	9,018	9,249	231	2.6%	11,137	925	857	(68)	(92)	24
Outpatient Appts (Attendances)	452,044	34,668	34,065	(603)	(1.7%)	49,972	3,838	3,981	143	210	(67)
Elective Day Cases	41,488	3,076	3,376	300	9.8%	29,030	2,152	2,282	129	(81)	210
Elective Inpatient (Spells)	7,628	554	580	26	4.7%	19,462	1,413	1,623	210	144	66
Emergency (Spells)	45,830	3,726	3,951	225	6.0%	82,775	6,730	6,619	(111)	(518)	406
Maternity	8,525	693	685	(8)	(1.2%)	13,371	1,087	1,087	(0)	12	(13)
Emergency Threshold						0	0	0	0	0	
Others (Inc Reserves)						84,455	6,839	6,606	(234)	(234)	
Non Clinical Income						22,039	1,837	1,630	(207)	(207)	
Total	**664,057**	**51,735**	**51,906**	**171**	**0.3%**	**312,241**	**24,822**	**24,684**	**(138)**	**(765)**	**627**

3.4 PAY EXPENDITURE

- During the month of April, pay overspent as compared with budget by £679,000. The budget for the month of April assumes the achievement of CIP savings amounting to £300,000.
- Over the last two months the number of WTE staff increased by 92.82 WTE posts increasing costs by £350,000. The cost increase is largely attributable to nurse staffing.

3.5 NON PAY

During the month of April Non Pay overspent as compared with budget by £214,000. The budget for the month of April assumes the achievement of CIP savings amounting to £400,000.

Detailed below are the current run rates for non pay, which continues to illustrate consistent expenditure levels.

	Total Non Pay Spend £000s	***3 month moving average £000s***
April	7,084	7,198
May	7,471	7,307
June	6,992	7,182
July (exc exceptional items HCD)	7,382	7,282
August (exc exceptional items HCD and RTT)	7,036	7,137
September (exc exceptional items HCD and ICD)	7,052	7,157
October (exc exceptional items HCD and ICD)	7,922	7,378
November (exc exceptional items HCD and ICD)	7,430	7,468
December (exc exceptional items HCD and ICD)	7,227	7,526
January (exc exceptional items HCD and ICD)	7,433	7,363
February (exc exceptional items HCD and ICD)	7,794	7,484
March (exc exceptional items HCD and ICD)	8,059	7,762
April	7,289	7,714

3.6 COST IMPROVEMENT PROGRAMME

The Trust has developed a Cost Improvement Programme with the the objective of delivering a combination of cash releasing / productivity gains that amount to £15.2 million. The programme has been reshaped since the Board meeting held in March 2014. The table below provides a description of the progress in respect of the CIP programme

	Original Plan £000s	***Revised Annual Plan £000s***	***Assumed savings in Month 1 £000s***	***Savings achieved in month 1***
Original CIP Schemes				
Procurement	2,000	2,000	167	167
CNST Contribution	500	400	33	33

	Original Plan £000s	*Revised Annual Plan £000s*	*Assumed savings in Month 1 £000s*	*Savings achieved in month 1*
Salary Sacrifice	100	100		
Pharmacy gain share	200	100		
Capitalisation	1200	1200	100	100
Outpatient and CNS Nurses	500	-		
Diagnostic staff	300	-		
CQUIN	600	600		
Corporate	600	600	50	60
Agency Nursing	600	600		
Nursing review transition	400	400	100	100
Unscheduled care	1,000	1,000	100	100
Medical staff Management	200	-		
Travel expenses	200	200		
Non pay controls	600	-		
To be identified	500	500	42	
Pay reduction		1,300	108	
Income based Productivity gains	6,200	6,200	517	517
Total	15,200	15,200	1,217	1,077

In setting the plan for the year, savings from the Cost of Improvement Programme have been profiled into the April budgets amounting £1.217 million. A review of progress suggests that savings amounting to £1.077 million have been realised. It is anticipated that the Trust will fully achieve the CIP by the year end.

3.7 CAPITAL PROGRAMME

The position in respect of the Capital programme as at April 2014 is presented in the table below.

Scheme	2014/15 Capital Budget	2014/15 Spend to date	Forecast Outturn	Variance (under)/ over spend
	£000's	£000's	£000's	£000's
Future Configuration of Hospital Services	**5,035**	**14**	**5,035**	**0**
IT Technology Fund	**570**	**22**	**570**	**0**
Outstanding Commitments from 2013/14	905	44	905	0
Creating Additional Capacity at PRH	2,987	164	2,987	0
Bowel Scope Screening Programme	105		105	0
Water/RO Plant at RSH	100		100	0
Asbestos removal from Duct	100		100	0
Server replacement scheme	120		120	0
Network replacement scheme	120		120	0
Estates Replacement Fund	250		250	0
Maternity Ultrasound Equipment	140		140	0
PRH Cystoscopes	125		125	0
PRH Operating Tables (part completed 2013.14)	150		150	0
Renal dialysis stations replacement	100		100	0
Creation of Surgical Admission and Discharge Suite - PRH	110		110	0
Creation of Urgent Care Centre and Ambulatory Care Area - RSH	130		130	0
Creation of Clinical Decision Unit - PRH	150		150	0
Capital contingencies	2,300	49	2,300	0
Other Capital Schemes (inc LoF contribution)	558	56	558	0
Total Discretionary Capital Schemes	**8,450**	**313**	**8,450**	**0**
Total Including Reconfiguration	**14,055**	**349**	**14,055**	**0**

The CRL for 2014/5 of £14.055m comprising of:

- £8.450m Internally Generated CRL
- £0.570m IT Technology Fund
- £5.035m PDC Future Configuration of Hospital Services

3.8 CASH FLOW

Key points regarding cash flow are as follows:

- A cash balance of £2.2 million is required to be held on the Balance Sheet at the end of March 2015.
- PDC Receipts – The Trust will draw down PDC in line with reported expenditure on the Future Configuration of Hospital Services (£5.035 million) and IT Technology Fund (£0.570 million).
- The Trust held a cash balance of £8.203m at the end of April 2014 – this sum is earmarked to support outstanding capital creditors of £6.1 million and a provision in respect of Post Graduate Education of £1.9 million.
- The 2014/15 cash plan has been constructed based upon an assumed income and expenditure deficit for the year of £8.2 million. In support of such a plan, the Trust needs to secure a permanent loan of £8.2 million. It is projected that there will be a need to secure temporary borrowing from September 2014 of £4 million rising to £8.2 million by March 2015.

The Shrewsbury and Telford Hospital NHS Trust – Cashflow 2014/15

	Actual April Month £000's	Forecast May Month £000's	Forecast June Month £000's	Forecast July Month £000's	Forecast August Month £000's	Forecast September Month £000's	Forecast October Month £000's	Forecast November Month £000's	Forecast December Month £000's	Forecast January Month £000's	Forecast February Month £000's	Forecast March Month £000's
Balance B/fwd	**2,150**	**8,168**	**5,281**	**2,886**	**3,931**	**1,256**	**720**	**3,870**	**2,340**	**817**	**3,745**	**1,261**
INCOME												
Income I&E	27,637	25,824	25,343	27,048	24,883	25,838	27,880	26,227	25,389	27,370	25,608	27,152
Income - Total Balance Sheet Movements	253	(81)	(101)	1,849	(873)	(838)	1,717	(1,166)	(1,139)	1,860	(1,224)	(1,224)
Total Income Cashflow	**27,890**	**25,743**	**25,242**	**28,898**	**24,011**	**25,001**	**29,598**	**25,062**	**24,251**	**29,231**	**24,385**	**25,929**
PAY												
Pay I&E	(13,480)	(17,692)	(17,388)	(17,588)	(17,595)	(17,509)	(17,564)	(17,747)	(17,827)	(17,943)	(17,981)	(18,165)
Pay - Total Balance Sheet Movements	0	(311)	(311)	(311)	0	0	0	0	0	0	0	0
Total Pay Cashflow	**(13,480)**	**(18,003)**	**(17,699)**	**(17,899)**	**(17,595)**	**(17,509)**	**(17,564)**	**(17,747)**	**(17,827)**	**(17,943)**	**(17,981)**	**(18,165)**
NON PAY												
Non Pay I&E	(6,583)	(7,704)	(7,704)	(7,705)	(7,706)	(7,705)	(7,705)	(7,705)	(7,706)	(7,704)	(7,706)	(7,677)
Non Pay - Total Balance Sheet Movements	0	375	147	(153)	(153)	(153)	(153)	(153)	(153)	(153)	(153)	(153)
Total Non Pay Cashflow	**(6,583)**	**(7,329)**	**(7,557)**	**(7,858)**	**(7,859)**	**(7,858)**	**(7,858)**	**(7,858)**	**(7,859)**	**(7,857)**	**(7,859)**	**(7,830)**
Finance Costs												
Finance Costs I&E	4	0	2	2	2	(2,950)	2	2	2	2	2	(2,981)
Finance Costs - Total Balance Sheet Movements	0	0	0	0	0	68	0	0	0	0	0	0
Total Finance Costs Cashflow	**4**	**0**	**2**	**2**	**2**	**(2,882)**	**2**	**2**	**2**	**2**	**2**	**(2,981)**
Capital												
Capital Expenditure	(349)	(938)	(981)	(763)	(863)	(950)	(938)	(852)	(574)	(489)	(1,014)	(1,289)
Capital - Total Balance Sheet Movements	(1,463)	(2,385)	(1,428)	(1,318)	(354)	(322)	(174)	(120)	0	0	0	1,591
Total Capital Cashflow	**(1,812)**	**(3,323)**	**(2,409)**	**(2,081)**	**(1,217)**	**(1,272)**	**(1,112)**	**(972)**	**(574)**	**(489)**	**(1,014)**	**302**
2014/15 Temporary Borrowing/Permanent PDC	**0**	**0**	**0**	**0**	**0**	**4,000**	**0**	**0**	**500**	**0**	**0**	**3,700**
PDC Revenue	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Donated Assets												
Donated Assets Income	0	125	126	83	83	84	83	83	84	83	83	84
Donated Assets Expenditure	0	(100)	(100)	(100)	(100)	(100)	0	(100)	(100)	(100)	(100)	(100)
Total Donated Assets Cashflow	**0**	**25**	**26**	**(17)**	**(17)**	**(16)**	**83**	**(17)**	**(16)**	**(17)**	**(17)**	**(16)**
FCHS												
PDC Drawdown re FCHS	0	0	1,250	0	0	1,250	0	0	1,250	0	1,285	0
Capital re FCHS	0	0	(1,250)	0	0	(1,250)	0	0	(1,250)	0	(1,285)	0
Total FCHS Cashflow	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Cashflow	**6,019**	**(2,887)**	**(2,395)**	**1,044**	**(2,674)**	**(536)**	**3,149**	**(1,530)**	**(1,523)**	**2,927**	**(2,484)**	**940**
Balance C/fwd	**8,168**	**5,281**	**2,886**	**3,931**	**1,256**	**720**	**3,870**	**2,340**	**817**	**3,745**	**1,261**	**2,200**

Summary Activity Position (Internal Plan)		All Commissioners										
Month 1 (Initial Data Submission)												
Point of Delivery	**Care Group**	**13/14 Outturn**	**Month Plan**	**Month Actuals**	**Variance**	**Variance %**	**Year-to-Date Plan**	**Year-to-Date Actual**	**Variance**	**Variance %**	**14/15 Annual Plan**	**14/15 Forecast Outturn**
First Attendance	Scheduled Care	61,488	4,767	5,263	496	10.4%	4,767	5,263	496	10.4%	60,519	68,670
	Therapies / Diagnostics	187	1,099	1,142	43	3.9%	1,099	1,142	43	3.9%	15,886	14,900
	Unscheduled Care	24,834	2,340	2,128	-212	-9.1%	2,340	2,128	-212	-9.1%	28,648	27,765
	Women and Children's	16,109	2,288	2,154	-134	-5.9%	2,288	2,154	-134	-5.9%	29,853	28,105
First Attendance Total		**102,618**	**10,494**	**10,687**	**193**	**1.8%**	**10,494**	**10,687**	**193**	**1.8%**	**134,905**	**139,440**
Follow Up Attendance	Scheduled Care	119,717	9,114	9,830	716	7.9%	9,114	9,830	716	7.9%	118,915	128,259
	Therapies / Diagnostics	488	73	35	-38	-52.2%	73	35	-38	-52.2%	956	457
	Unscheduled Care	43,141	3,416	4,070	654	19.1%	3,416	4,070	654	19.1%	44,570	53,104
	Women and Children's	23,670	2,898	2,778	-120	-4.1%	2,898	2,778	-120	-4.1%	37,807	36,246
Follow Up Attendance Total		**187,016**	**15,501**	**16,713**	**1,212**	**7.8%**	**15,501**	**16,713**	**1,212**	**7.8%**	**202,247**	**218,066**
Outpatient Procedure	Scheduled Care	54,855	4,381	3,511	-870	-19.9%	4,381	3,511	-870	-19.9%	57,165	45,810
	Therapies / Diagnostics	0	0	0	0	0.0%	0	0	0	0.0%	0.0%	-
	Unscheduled Care	21,694	2,420	2,531	111	4.6%	2,420	2,531	111	4.6%	31,571	33,024
	Women and Children's	24,267	1,872	623	-1,249	-66.7%	1,872	623	-1,249	-66.7%	24,423	8,129
Outpatient Procedure Total		**100,816**	**8,673**	**6,665**	**-2,008**	**-23.1%**	**8,673**	**6,665**	**-2,008**	**-23.1%**	**113,159**	**86,963**
Total Outpatients	Scheduled Care	236,060	18,262	18,604	342	1.9%	18,262	18,604	342	1.9%	236,599	242,739
	Therapies / Diagnostics	675	1,172	1,177	5	0.4%	1,172	1,177	5	0.4%	16,841	15,357
	Unscheduled Care	89,669	8,176	8,729	553	6.8%	8,176	8,729	553	6.8%	104,788	113,893
	Women and Children's	64,046	7,057	5,555	-1,502	-21.3%	7,057	5,555	-1,502	-21.3%	92,082	72,480
Total Outpatients Total		**390,450**	**34,667**	**34,065**	**-602**	**-1.7%**	**34,667**	**34,065**	**-602**	**-1.7%**	**450,311**	**444,469**
Elective DC	Scheduled Care	34,696	2,690	3,001	311	11.6%	2,690	3,001	311	11.6%	36,280	40,475
	Unscheduled Care	2,507	210	195	-15	-7.1%	210	195	-15	-7.1%	2,830	2,630
	Women and Children's	2,366	176	180	4	2.1%	176	180	4	2.1%	2,377	2,428
Elective DC Total		**39,569**	**3,076**	**3,376**	**300**	**9.8%**	**3,076**	**3,376**	**300**	**9.8%**	**41,488**	**45,533**
Elective IP	Scheduled Care	5,940	454	471	17	3.7%	454	471	17	3.7%	6,255	6,488
	Unscheduled Care	326	21	35	14	68.3%	21	35	14	68.3%	286	482
	Women and Children's	993	79	74	-5	-6.2%	79	74	-5	-6.2%	1,087	1,019
Elective IP Total		**7,259**	**554**	**580**	**26**	**4.7%**	**554**	**580**	**26**	**4.7%**	**7,628**	**7,989**
Non Elective	Scheduled Care	12,649	1,042	1,073	31	3.0%	1,042	1,073	31	3.0%	12,813	13,196
	Unscheduled Care	24,559	1,995	2,133	138	6.9%	1,995	2,133	138	6.9%	24,539	26,233
	Women and Children's	8,843	689	745	56	8.1%	689	745	56	8.1%	8,478	9,163
Non Elective Total		**46,051**	**3,726**	**3,951**	**225**	**6.0%**	**3,726**	**3,951**	**225**	**6.0%**	**45,830**	**48,592**
Non Elective Other	Scheduled Care	69	5	1	-4	-80.8%	5	1	-4	-80.8%	64	12
	Unscheduled Care	229	19	22	3	13.0%	19	22	3	13.0%	239	271
	Women and Children's	8,596	668	662	-6	-1.0%	668	662	-6	-1.0%	8,221	8,142
Non Elective Other Total		**8,894**	**693**	**685**	**-8**	**-1.2%**	**693**	**685**	**-8**	**-1.2%**	**8,525**	**8,425**
Total Spells	Scheduled Care	53,354	4,191	4,546	355	8.5%	4,191	4,546	355	8.5%	55,412	60,172
	Unscheduled Care	27,621	2,245	2,385	140	6.2%	2,245	2,385	140	6.2%	27,896	29,616
	Women and Children's	20,798	1,613	1,661	48	3.0%	1,613	1,661	48	3.0%	20,163	20,751
Total Spells Total		**101,773**	**8,049**	**8,592**	**543**	**6.7%**	**8,049**	**8,592**	**543**	**6.7%**	**103,470**	**110,539**
A&E	Unscheduled Care	106,702	9,018	9,249	231	2.6%	9,018	9,249	231	2.6%	108,542	111,328
A&E Total		**106,702**	**9,018**	**9,249**	**231**	**2.6%**	**9,018**	**9,249**	**231**	**0**	**108,542**	**111,328**

4. WORKFORCE

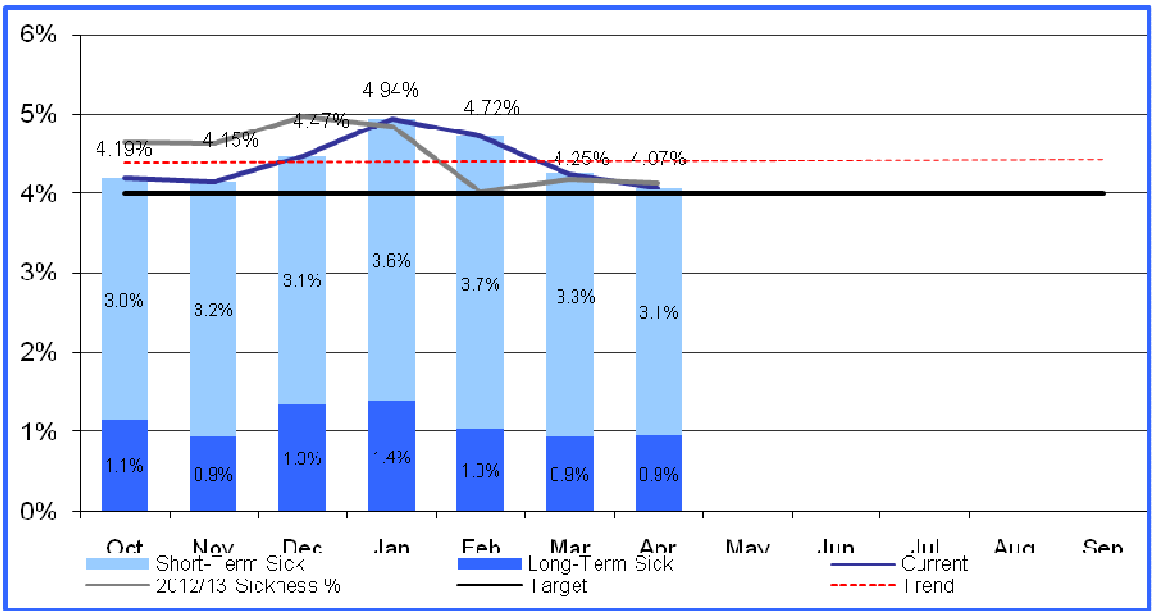
OVERVIEW

- Strong progress is being made in implementing the **People Strategy**; work to embed our values is gaining pace they include management briefing sessions, increased visualisation and changes to the appraisal process. We have also committed to increasing our apprenticeship numbers this year.

- The Vocational Learning Team was recently inspected by the Awarding Body Edexcel for the Assessment and Verification Vocational Awards. The assessment went very well and feedback from the assessor included 'There are no significant failings in the delivery of the programmes sampled. My congratulations to the team this year on an excellent delivery of the programmes'. Over 100 members of staff completed vocational learning in the last twelve months with a further 115 currently undertaking awards.

- We have asked Health Education West Midlands for feedback on our Health Care Assistant Induction Programme 'Putting patients first' which has been very positive, as this meets the requirements of the Cavendish review and supports the Trust to receive formal accreditation of the programme.

4.1 ABSENCE



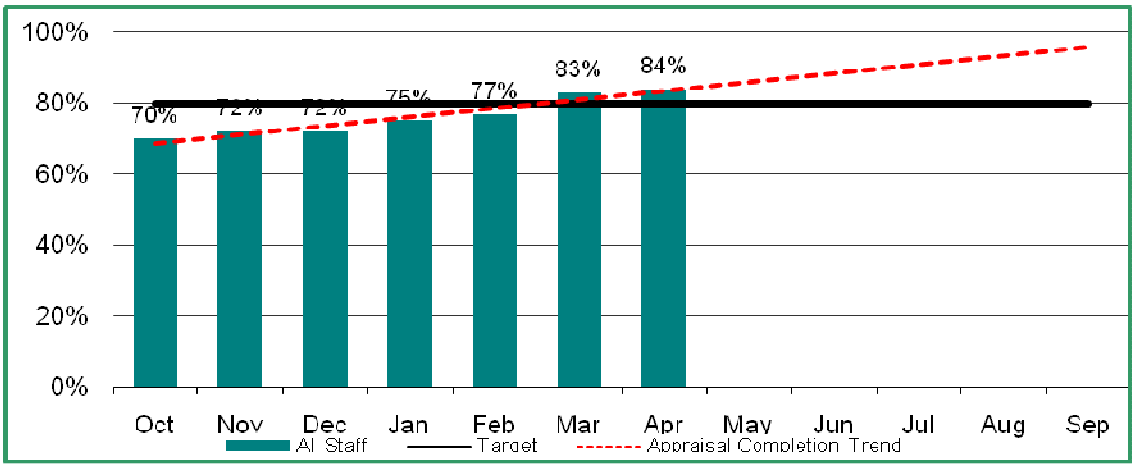
Sickness absence fell by 0.18% in April to 4.07%. However, it remains above our target 4% and is slightly lower than the same month last year.

Indicative cost of sickness absence fell to £398k compared to £428k in March.

Measure	Annual Target	Monthly Target	YTD	January	February	March	April	Year end 13/14
Sickness Absence	**Less than 4%**	**Less than 4%**	**4.07%**	**4.94%**	**4.72%**	**4.25%**	**4.07%**	4.12%
Current State	- Target failed in April, however decrease was seen.							
Planned Actions	- Enhanced Occupational Health service from June. - Enhanced HR support being provided to highest area of absence.							
Key Themes/ Trends	- Highest reasons for absence remain musculoskeletal (MSK) and stress. - Year to date above 4%							

4.2 APPRAISALS

Considerable progress has been made in ensuring at least 80% of all staff have an appraisal, resulting in the Trust's target for the year being achieved. A review of the appraisal process is currently being undertaken, the focus of the review is to improve coverage towards 100% of eligible staff and to ensure appraisals are meaningful.



Measure	Year-end Target	Monthly Target	YTD	January	February	March	April	Year end 12/13
Appraisals	**100%**	**80%**	**84%**	**75%**	**77%**	**83%**	**84%**	78%
Current State	Continued improvement in appraisal coverage							
Planned Actions	- A review of appraisals is currently being completed.							
Key Themes/Trends	- Consistent improvement since January - Biggest improvement seen for over 2 years.							

5. MONTHLY SELF-CERTIFICATIONS – NTDA REQUIREMENT

The NTDA introduced a mandatory requirement for monthly self certifications in relation to the FT application process. The Trust has submitted self certification templates since May relating to:

1 Monitor Licensing Requirements – covering Monitor licence requirements. A summary of the submission is included at Appendix 1.

2 Trust Board Statements – covering a number of Board statements. A summary of the submission is included at Appendix 2.

For each statement, the Trust has to declare 'Yes' (compliant), or 'No' (not compliant) or 'Risk' (of non-compliance). For areas of non-compliance, or risk of non-compliance a short commentary is required along with a timescale for completion of actions. The timescale for submission each month is around the middle of the month. A third form relating to Progress Towards FT Status is in development by the NTDA and will be issued later in the year.

6. RECOMMENDATION

The Trust Board is asked to ***REVIEW*** performance for April 2014 and ***APPROVE*** the self certification submissions.

Appendix 1 Summary of each relevant licence condition

General Conditions & Trust response

G4: Fit and proper persons - YES
This condition requires that licensees do not allow unfit persons to become or continue as governors or directors. 'Unfit persons' are: undischarged bankrupts, individuals who have served a prison sentence of three months or longer during the previous five years, and disqualified directors. A company may also be an unfit person.

G5: Having regard to Monitor guidance - YES
The Licensee shall at all times have regard to guidance issued by Monitor and where the Licensee decides not to follow the guidance it shall inform Monitor of the reasons for that decision.

G7: Registration with the Care Quality Commission - YES
This condition reflects the obligation in the Act for licensees to be registered with the CQC. This condition allows Monitor to withdraw the licence from providers whose CQC registration is cancelled and who therefore cannot continue to lawfully provide services.

G8: Patient eligibility and selection criteria – N/A:
This condition requires licensees to set and publish transparent patient eligibility and selection criteria and to apply these in a transparent manner. This includes criteria for determining patient eligibility for particular services, for accepting or rejecting referrals, or determining the manner in which services are provided to that person.

Pricing Conditions & Trust response

P1: Recording of information - YES
Under this licence condition, Monitor may require licensees to record information, particularly information on their costs, in line with approved guidance. [Monitor] recently published a draft of this guidance for the collection of 2012/13 costs. The licence condition is worded in a way that any cost and other information that may be required can be collected from both licensees and their sub-contractors.

P2: Provision of information - YES
Having recorded the information in line with Pricing Condition 1 above, Monitor can then require licensees to submit this information.

P3: Assurance report on submissions to Monitor - YES
Monitor may require licensees to submit an assurance report confirming the accuracy of the information they have provided.

P4: Compliance with the National Tariff - YES
The Health and Social Care Act 2012 requires commissioners to pay prices corresponding to those in the National Tariff and, where prices aren't specified, to pay prices in line with the rules contained in the National Tariff. This licence condition imposes a similar obligation on licensees, that is, the obligation to charge for NHS health care services in line with the National Tariff.

P5: Constructive engagement concerning local tariff modifications - YES
[Monitor] will seek to make prices more reflective of the efficient cost of providing a service, but even so, in some circumstances it may be uneconomic for a provider to offer a particular service without additional funding over and above that allowed for in the National Tariff. For this purpose, the Act allows for local modifications, or adjustments, to prices.

Choice and Competition & Trust response

C1: Patient choice - YES
This condition:

- requires licensees to notify their patients when they have a choice of provider, and to tell them where they can find information about the choices they have. This must be done in a way that is not misleading;
- requires that information and advice that licensees provide to patients about their choice of provider does not unfairly favour one provider over another and is presented in a manner that helps patients to make well-informed choices; and
- prohibits licensees from offering gifts and benefits in kind for patient referrals or for the commissioning of services.

C2: Competition oversight - YES
This condition prohibits the licensee from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.

Integrated Care Condition & Trust response

IC1: Provision of integrated care - YES
In most cases, [Monitor] would expect integrated care to be delivered locally by commissioners specifying their requirements and working with providers. The requirement for care to be delivered in an integrated way would be captured in contracts… [Monitor's] policies in areas such as pricing would act as our main tools for enabling integrated care. The purpose of this licence condition is to enable Monitor to step in where integrated care is not being delivered, in spite of decisions and efforts made by commissioners.

Appendix 2 Self-Certification Board Statements

1 CLINICAL QUALITY – YES

The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

2 CLINICAL QUALITY – YES

The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

3 CLINICAL QUALITY – YES

The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

4 **FINANCE – YES**

The board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force at the time and subject to continuing support from the Trust Development Authority.

5 GOVERNANCE – NO.

- The Trust has reported a Financial Risk Rating of 1.
- A&E performance against the 95% target in April was 92.51%
- Admitted RTT in April was 80.19% against the target of 90%, with non-admitted being 93.95% against the target of 95%.
- RTT Open Clocks under 18 Weeks was 89.82% in April against the target of 92%
- Trajectories have been agreed the NTDA and Commissioners to deliver the relevant RTT targets at a specialty level.
- Cancer under-achieved against the 2 week wait 1st Appointment, 2 week wait 1st Appointment Breast, the 31 day Diagnosis to Treatment, 31 day Subsequent Treatment Surgery, 62 Day Referral to Treatment and 62 Day Referral to Treatment – Screening during April.

The Board will ensure that the Trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.

6 GOVERNANCE – YES

All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.

7 GOVERNANCE – YES

The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

8 GOVERNANCE – YES

The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

9 **GOVERNANCE – YES**

An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

10 GOVERNANCE – YES

The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.

11 GOVERNANCE – YES

The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

12 GOVERNANCE – YES

The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.

13 GOVERNANCE – YES

The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.

14 GOVERNANCE – YES

The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.