Report to:	Trust Board – 25th April 2013

Enclosure 4

Title	Integrated Performance Report – March 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 quality, finance, compliance, and workforce targets and indicators for 2012-13 and considers all elements of the Provider 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 March 2013. Due to ongoing concerns around delivery of a number of key performance targets and financial performance the Board are 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*'

Trust Board – 25 April 2013

Integrated Performance Report – March 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 on-going improvements.

2 Regulatory Requirements

2.1 The Care Quality Commission provides a regulatory overview of all the required outcome measures for which we are registered. Last month's Trust Board papers set out 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: Patient Safety, Effectiveness and Patient Experience

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

Table 1

Measure		Standard	Q1	Q2	Q3	Jan '13	Feb '13	Mar	Year End
	HSMR - All Diagnoses	<100%	95.7	95.2	82.4	84.5 (Nov)	106.1 (Dec)	94.9 (Jan)	93.5
	RIDDOR reportable Falls	< 20	3	2	11	3	1	0	20
	Grade 3 & 4 Pressure Ulcers	< 22	8	12	12	4	1	5	42
	C-Diff	45	9	8	15	5	4	4	45
	MRSA Bacteraemias	2	1	0	0	0	0	0	1
	MSSA Bacteraemia	28	7	5	4	3	1	3	24
	E-Coli	65	11	18	9	3	4	0	45
	Elective MRSA Screening	95%	90.03%	92.1%	95.6%	95.3%	94.5%	93.7	N/A
	Non Elective MRSA Screening	95%	96.8%	95.69%	92.5%	92%	94.9%	92.7	N/A
	Number of Serious Incidents	<36 per Quarter	38	30	50	14	14	28	174
	Never Events	0	1	1	0	0	0	0	2
	WHO Surgical Checklist Need performance from last Board paper here	100%	100.00%	100%	99.86%	100%	100%	100%	99.96%
	VTE Assessment	90%	90.97%	90.41%	90.30%	91.06%	90.03%	90.08%	90.48%

	Maternity Dashboard	Green	Green	Green	Green	Amber	Amber	Amber	
Patient experience	Number of patient complaints	actual	173	165	147	58	60	68	671
	Access to Healthcare for people with LD	Yes	No	Yes	Yes	Yes	Yes	Yes	
	Same Sex Accommodation Breaches	0	0	0	0	0	0	0	0

A summary of patient outcome measures agreed for the Board are outlined in Table 1 above, with additional patient specific metrics outlined in Table 8 and 9 of this paper. These metrics provide the patient experience and outcomes chosen to monitor the impact of care provided for the patient. Where key performance Indicators are amber or red. Key summary points for the Boards attention as follows:

Patient Safety and Effectiveness

3.2 Serious Untoward Incidents

There were 28 Serious Incidents reported in March 2013; which is double the number from February 2013. Of the SI's 11 were related to clinical effectiveness;

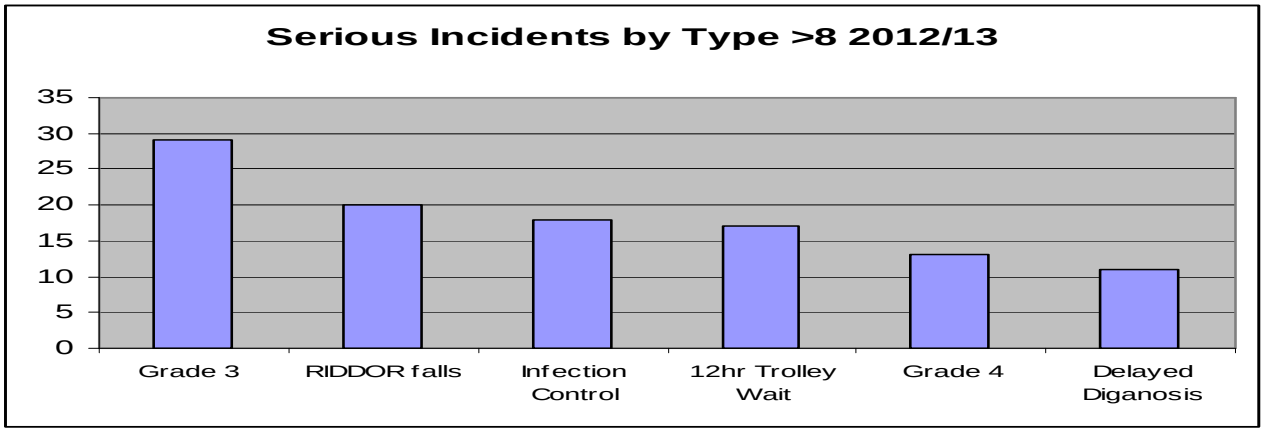
- 4 – grade 3 pressure ulcers
- 2 – Delayed diagnosis
- 1 – grade 4 pressure ulcer
- 1 – Intrapartum Stillbirth
- 1 – PII – infection Control concern (Flu' breakout)
- 1 – Drug error
- 1 – Other (biopsy samples)

The remaining 17 SI's were Operational in nature

- 14 – 12 hour trolley breaches
- 1 – Screening failure
- 1 – Intra hospital transfer concern
- 1 – Outpatient's delay

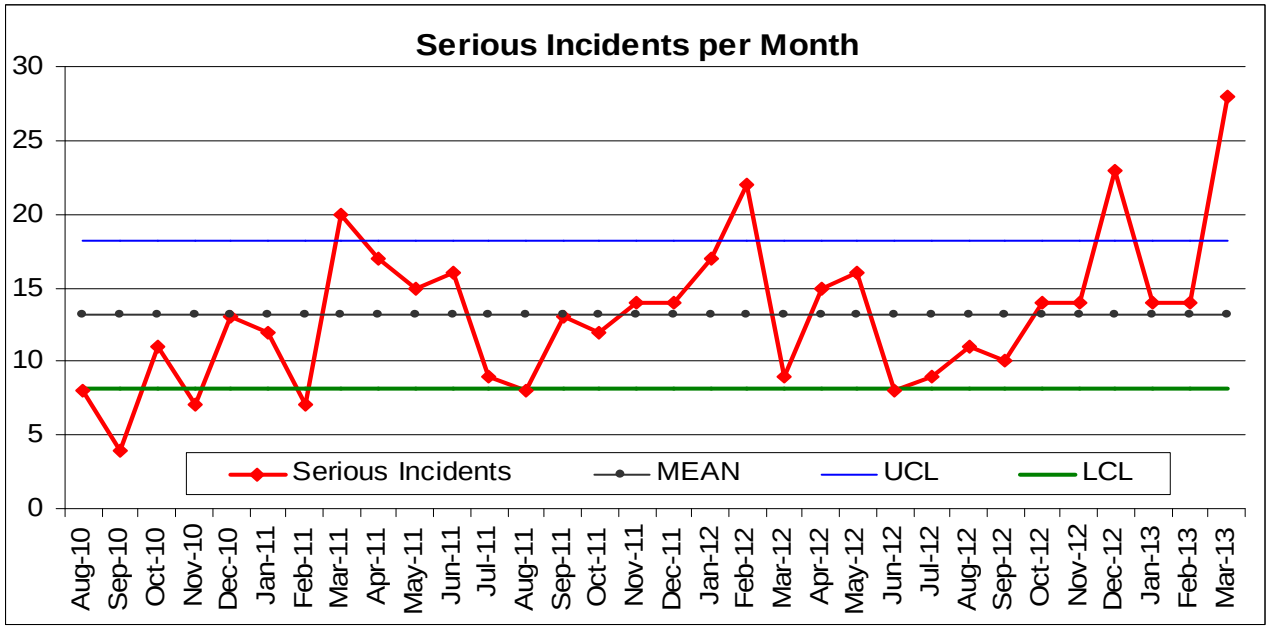
The Trust reported a total of 174 Serious incidents for 2012/13. The top 6 reporting categories are identified in Table 2 (Pressure ulcers are split into 2 categories – Grade 3 and grade 4)

Table 2



All Serious Incidents undergo Root Cause Analysis review within the local area / centre. Common themes are reviewed.

Table 3

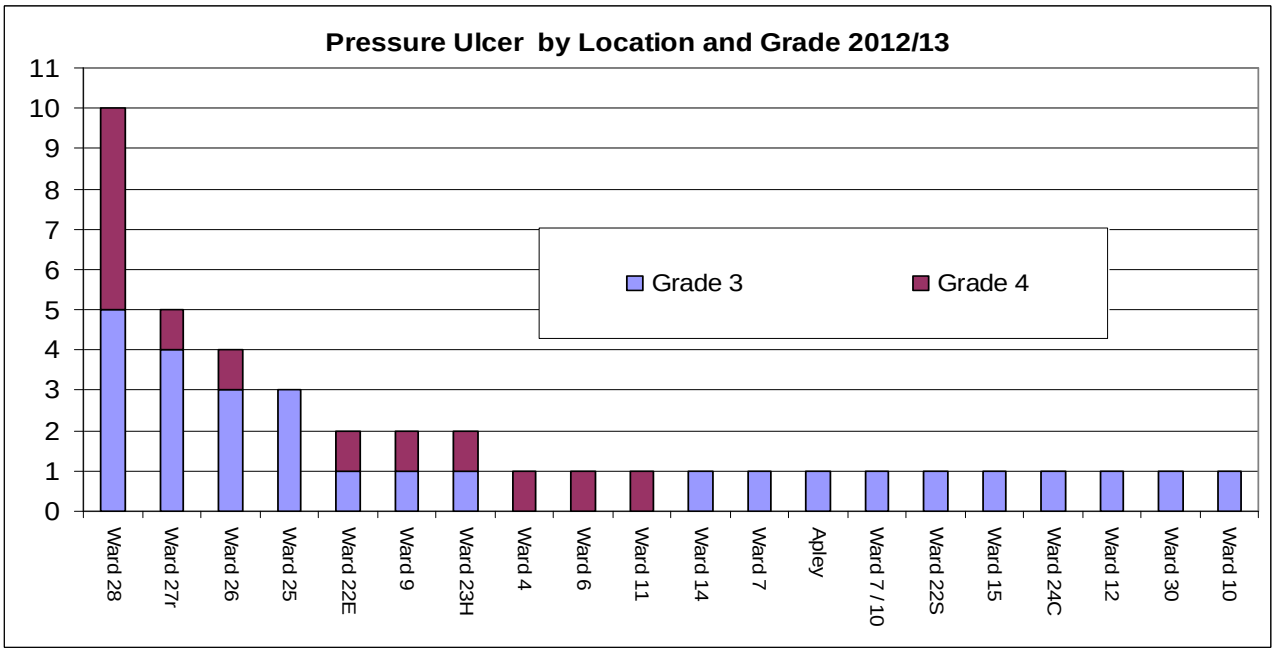


3.3 *Pressure ulcers*

The Board agreed a target of eliminating grade 4 ulcers from the end of December 2012 and grade 3 from the end of March '13. The occurrence of 1 grade four pressure ulcer and 4 grade 3 pressure sore ulcers breaches is deeply regrettable. 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.

The action plan in place to reduce pressure ulcers was reviewed by the Quality and Safety Committee in March and will continue to be monitored closely.

Table 4 - Pressure Ulcers by Location



The Chief Nurse meets with all areas that report a Trust acquired grade 3 or 4 pressure ulcer. This reinforces with the clinical areas how seriously the Trust views maintenance of skin integrity within the organisation. Themes are reviewed and shared learning is included within the meeting.

For more frequent reporters, further action can be taken and formal performance processes can be included to ensure support and compliance to maintain best practice.

The Trust has reported a total of 42 grade 3 and 4 Pressure ulcers for the financial year. Of these, at present 13 have been confirmed by the Trust as unavoidable (several are still in the process of investigation), the Trust has utilised national guidance on the criteria for unavoidability to make these decisions. The Commissioners have yet to fully implement their systems of confirming their agreement therefore the current figure remains unchanged. Once the Commissioners agree that a pressure ulcer is unavoidable, this is removed from the Trust's total.

Of the 10 pressure ulcers reported since January 2013, over half, on initial review, appear to meet the unavoidable criteria. The full RCA's will confirm this prediction in due time.

3.4 Falls

The Trust monitor the falls rates within the organisation closely. All falls that meet the RIDDOR reportable criteria, are escalated as Serious Incidents. The Trust saw a decrease in the number of falls over all within the organisation.

Year	**Number of falls**	**RIDDOR Reportable**
2011/12	1590	30
2012/13	1538	20

The Trust reduced the number of falls resulting in serious harm by 33% however, this does not reflect that there was an increase in the number of falls that had their injury identified as contributing to the patient's cause of death. In 2012/13 this increased to 4 patients from the 1 reported in 2011/12.

A full review of the falls was completed in February 2013 alongside a detailed action plan and reported to the Commissioners, the Quality and Safety Committee and the Board. A corporate action plan was devised and is in the process of being implemented.

There are 3 wards that have experienced more than one RIDDOR reportable fall.

3.5 Infection Control

Across the year there have been a total of 18 reportable Serious Incidents that have been completed in relation to infection control concerns. The vast majority of these are Periods of Increased Incidence (PII). The Infection control team swiftly review the relevant standards on the area identified and maintain a review of common themes. Action plans based on initial review are implemented promptly, to ensure that the area is safe to continue working in. Often ahead of the full RCA investigation.

At present it is rare to have any common themes identified in relation to specific wards and repeated incidents. The Trust reported 1 MRSA bacteraemia for the year (on a patient who had been positive at another Trust, but was tested outside of the usual time frame to be classed as the same incident. There have been no further incidence of MRSA Bacteraemia within the Trust therefore under achieving its year end trajectory of 2. It is of note that the Trust has not reported any incidence of MRSA Bacteraemia for over 12 months.

The Trust has reported 2 ward closures for the period identified, both associated with Norovirus outbreaks.

There were 4 new cases of C-Difficile reported in March 2013. This has enabled the Trust to stay within the year end trajectory of 45.

The Elective and Non-Elective MRSA screening relates to a standard target of 95%. Performance in this area continues to show under-performance of between 0.1% and 3%. The year end position therefore indicates that performance in this area fluctuates month by month, the IPC team with the DIPC continue to audit practice and process which forms part of the overall IPC Trust plan.

3.6 12 Hour Trolley Breaches

In the latter part of the financial year, the Trust saw an increase in reporting of 12 Hour Trolley breaches, particularly at the Royal Shrewsbury site. The pressures within the organisation have been reviewed and the Trust is working closely with the Commissioners to ensure that patient safety is put first, and developed a series of joint actions to ensure patient flow throughout the organisation, as it is recognised, that extended trolley waits can lead to increased patient safety incidents.

Plans include:

- Using beds in nursing and residential homes for patients waiting for their packages of care or for their home of choice to become available
- Ensuring elective medical patients do not come into inpatient beds, but are placed in day case beds instead
- Extending the use of day surgery to provide short stay surgery beds
- Establish a clinical decision unit at both hospital sites to manage patients who do not need to be admitted to hospital, but still need further investigation before being discharged
- Improving discharge skills and competencies to support timely discharge

3.7 Current Status – Mortality

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 current SHMI scores are:

Table 5

Summary Hospital-Level 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 6

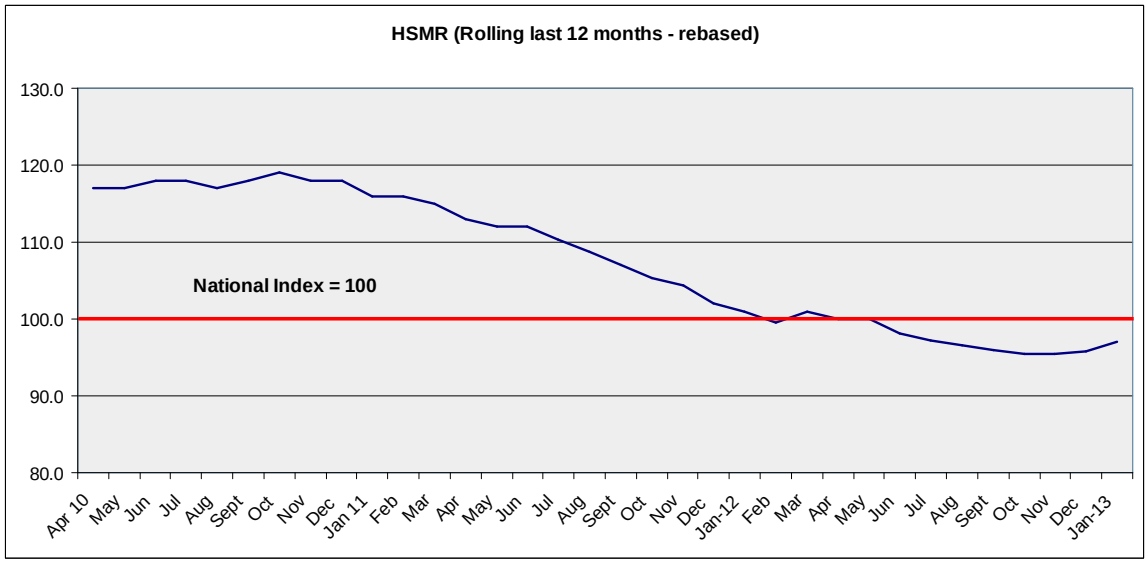
Summary Hospital-Level Mortality Indicator (SHMI - Quarterly)					
	Qtr 1 2011/12	Qtr 2 2011/12	Qtr 3 2011/12	Qtr 4 2011/12	Qtr 1 2011/12
Quarterly Measure SHMI	112.05	104.25	105.41	105.49	108.09

- As a result of the high number of in hospital deaths during March 2013 we have missed our target of 350 less deaths within 2 years. However we have achieved 302 less deaths against the 2010/11 baseline year.
- In March 2013 we had 175 in-hospital deaths against the baseline month of 141 in March 2011. The crude deaths in March are being analysed to identify any areas of concern. It is relevant to note that as a result of the Dementia screening process implemented in April 2013, we are seeing nearly a 100% increase in the number of emergency inpatients aged 75 years old and over who are staying longer than 48 hrs as compared with the average number during 2012.

- Although the HSMR, as the standard national measure, no longer is being reported officially outside the Trust we shall continue to use an additional mortality indicator alongside the SHMI.

The current HSMR trend is:

Table 7



- The trend over the last 2 months is up, with December showing a sharp rise to 104 and January reducing to 97. Monthly HSMR scores have been in the 80's during the financial year so far.
- The Mortality Group will review the rising trend at their April meeting and decide on next steps.

3.8 Patient Experience and Outcomes

Table 8&9 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 patient observations and nutrition whilst a slight improvement is noted with fluid management.

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 early 13/14.

Significant work is required to ensure that this area improves over the next few months. An increasing number of referrals relating to discharge arrangements have been made in March through the vulnerable adult safeguarding process. Whilst not all of these have been substantiated, the need for careful planning and documentation relating to all aspects of discharge arrangements are being discussed with matrons and Ward Managers.

The real time patient feedback is discussed each month with Matrons regarding areas for improvement and within centres. It is deeply regretted that the overall score has gone down, particularly linked

- Privacy when discussing treatment or care
- Involvement of patient in their care
- Patients being able to discuss worries or concerns

Consideration of how all these indicators will be improved will be discussed alongside the Inpatient Survey (in board papers) and will be discussed with all clinical teams.

3.9 External feedback and Assurance

Shropshire Link conducted an enter and view assurance and monitoring visit to the AMU at RSH on the 6th March 2013. A draft report has been shared with the trust and acknowledged by the Associate Director of Patient Quality and Experience, the report identifies positive patient observations taken and discussions held with various members of the ward team. Overall the draft report is positive; the points raised within the report will be responded by an action plan owned by the AMU, which will be reported via the PEIP and Q&S Committee.

Table 8: Ward to Board Patient Metrics for April 2012 – March 2013

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

Table 9: Ward to Board Patient Experience Metrics for April 2012 – March 2013

	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013
How clean is this ward (including toilets)?	95%	95%	95%	95%	96%	96%	96%	97%	97%	97%	98%	95%
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%	98%	97%
Do you feel informed about potential medication side effects?	46%	57%	65%	65%	72%	64%	72%	83%	76%	86%	82%	75%
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%	93%	86%
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%	97%	97%
Do you feel involved in decisions about your treatment and care?	80%	83%	77%	78%	77%	79%	84%	89%	86%	87%	89%	84%
Have hospital staff been available to talk about any worries or concerns you have?	82%	92%	90%	90%	86%	91%	93%	93%	90%	89%	92%	87%
Do you get enough help from staff to eat your meals?	92%	90%	98%	87%	90%	95%	98%	95%	92%	85%	99%	92%
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%	100%	98%
Do you think hospital staff do everything they can to help control your pain?	89%	93%	89%	90%	89%	87%	93%	95%	92%	90%	96%	91%
When you use the call buzzer is it answered?	88%	93%	89%	87%	90%	90%	87%	91%	90%	89%	91%	90%
Have staff talked to you about your discharge from hospital?	64%	74%	63%	65%	68%	68%	64%	71%	72%	75%	73%	69%
Total	83%	87%	86%	86%	87%	86%	88%	91%	90%	90%	92%	88%

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APPENDIX 1 **MATERNITY DASHBOARD**

SHA Monitoring Dashboard for Maternity - 2012/13

No	Indicator	Descriptor	Expected (Per Month)	APR	MAY	JUN	Q1	JUL	AUG	SEP	Q2	OCT	NOV	DEC	Q3	JAN	FEB	MAR	Q4	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	371	443	**1267**	**5154**	**5240**
2	Birth rate by Location Type	% of births in Consultant Unit	75%	74.0%	75.7%	75.0%	**74.9%**	73.6%	77.8%	76.7%	**76.0%**	77.3%	80.5%	80.2%	**79.3%**	82.6%	80.1%	80.6%	**81.1%**	**77.8%**	**76.0%**
		% of births in any MLU	25%	24.3%	21.6%	22.6%	**22.8%**	22.4%	19.9%	21.4%	**21.3%**	21.1%	17.3%	18.6%	**19.0%**	15.2%	18.1%	17.8%	**17.0%**	**20.1%**	**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%	1.3%	1.6%	**1.7%**	**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%	0.5%	0.0%	**0.2%**	**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%	70.1%	72.9%	**70.7%**	**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%	11.1%	9.0%	**10.3%**	**10.8%**	**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%	17.7%	18.1%	**17.5%**	**15.7%**	**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%	0.8%	0.5%	**0.7%**	**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%	0.5%	1.1%	**0.7%**	**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%	4.1%	2.5%	**3.1%**	**2.4%**	**2.3%**
6	National Smoking and Breastfeeding	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%**	63.8%	76.0%	72.2%	**70.3%**	**70.2%**	**71.6%**

	Targets	'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%	18.1%	16.0%	**18.2%**	**18.1%**	**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%**	88.0%	89.9%	91.5%	**89.7%**	**90.9%**	**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	1.22	**0.0%**	**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	1.32	**0**	**1.32**	
9	Patient Safety	Number of CQC Mortality Alerts	0	0	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	1	0		**1**	
		Number of SI's reported to LSA	0	2	2	2		1	3	2		1	3	2		1	2	1		**22**	

4 Operational Performance

Emergency Access Target

4.1 The Trust failed to achieve the 95% target in March 2013 with 82.73% for the month, giving a year to date position of 90.62%.

Factors contributing to affect performance are:

- an increase in the number of ED attendances - an average of 307 attendances a day in March compared with 295 a day in February, an increase of 4.1%. This increase follows the same pattern as January,
- an increase in the number of non-elective admissions – this average also follows a similar pattern.
  - Jan 3829 Ave 123 a day
  - Feb 3585 Ave 129 a day, a 4.9% growth on previous month
  - March 4153 Ave 133 a day, a 3.1% growth on previous month

- a significant cohort of patients who are fit to transfer but remain in a hospital bed, RSH can average at over 50 patients a day, primary responsibility belonging to the Shropshire Social and Health and Economy
- a lack of available capacity (beds to meet expected demand)

The individual components of the whole health economy remedial action plan to deliver 95% are in the main, in place. However, these have not led to an improvement in performance which underpins the overriding factor which is contributing to the failure of the target which is insufficient beds. These extreme pressures are being felt regionally and nationally and until the capacity shortfall is addressed performance will remain below the performance standard.

4.2 During the month of March 14 patients (10 in one day) breached the 12 hour trolley wait standard on the RSH site all due to significant capacity challenges on the days in question. There were no immediate patient safety concerns whilst the patients were in the department. RCAs and an investigative meeting took place on Monday 08th April attended by the CCG's Director of Nursing

4.3 The Whole System Review of urgent care in Shropshire and Telford & Wrekin has been completed by ATOS. The first phase (data analysis) has been completed and the results were presented at a workshop on Friday 12th April 2013. This highlighted a number of that needed addressing, and which the lack of capacity was one. The action plan from this workshop is being developed.

4.4 A new short and medium term action plan with the aims of improving internal efficiencies has been implemented, which includes a reconfiguration of the AMU/SAU and additional ward swaps.

- AMU swap with SAU RSH,
  - New AMU will be 20 bedded AMU assessment and 9 beds CDU
- Ward 22E swap with Ward 28, Ward 28 will become Acute Med Short Stay and Gen Med LOS 2-5 days
- Ward 27G to ward 25 leaving ward 27 as completely Respiratory

The recent ATOS work should also provide a medium to long term action plan that will be jointly owned

by the Trust, LA and the Health Community.

4.5 A new model of care for patients who are fit to discharge to release inpatient bed capacity is being discussed with the Shropshire Local Health Economy. This would offer a new model of care for patients who no longer require treatment in an acute hospital bed. Patients would be discharged into a re-enablement setting.

Scheduled Care

4.6 **18 weeks Referral to Treatment Target (RTT) – Admitted**

The Trust failed the RTT target for Admitted patients with 77.99% against the 90% target in March.
The Trust has again failed to deliver the admitted pathway for 18 weeks RTT. This was as a result of the day case unit being used as an escalation and therefore any routine elective day cases were cancelled.

Plans are now in place to reconfigure the inpatient Wards which will enable us to open to day case surgery again with effect from Monday 29th April 2013.

Each centre is constructing a recovery plan that will detail when each specialty will be in a sustainable position. At present, plans are indicating that this will be from quarter 2.

4.7 **18 weeks Referral to Treatment Target (RTT) – Non Admitted**

The Trust achieved the RTT target for Non Admitted patients with 95.08% against the 95% target in March.

- Two medical specialties failed to achieve the target but are on plan to deliver in quarter 1.

- Urology again failed to deliver the non admitted target in March. The Urology team's workforce has reduced by 40% as a result of 2 consultant vacancies. These posts have now been recruited to and they will commence in post June 2013. Surgical Centre has a plan in place to deliver RTT sustainability from July 2013.

The validation process for 18 weeks is becoming a concern as the team has reduced in number over the past month. Centre teams are being reminded of the need to ensure all PTLs are validated and to work with their booking teams to address any patient access issues.

4.8 **Cancer**

The Trust achieved the overall year end target for the Cancer standard, however in March four standards failed to deliver the required national target, these were:

- 31 day diagnosis to treatment
- 31 day subsequent treatment
- 62 day referral to treatment
- 62 day screening

This is of concern as this will follow through into April as there have been significant challenges within the

Urology specialty for reasons that are mentioned above in 18 Week RTT. A remedial action plan is being drawn up with the Value Stream Lead and the relevant Centres.

4.9 Cancelled Operations

There were 277 cancelled operations in March 2013 as a result of increased levels of escalation on the day surgical unit. There were 6 patients in March that were not readmitted within their 28 day standard, this is a significant improvement on the previous month. Centres have been reminded of the importance of this target.

5 Finance

Finance Performance Summary – Month 12

	Measure	Standard	Quarterly Method	2012/13 Q1	2012/13 Q2	2012/13 Q3	Data Period	Period Actual	YTD
Finance	PMR Finance Risk Rating	4	Q YTD	2	2	2	Mar-13	2	2
	EBITDA Achieved	85%	Q YTD	84.20%	87.70%	98.00%	Mar-13	59.35%	87.82%
	EBITDA Margin	5%	Q YTD	2.8%	4%	4.7%	Mar-13	4.2%	4.6%
	I&E Surplus Margin	1%	Q YTD	-1.90%	-0.50%	0.00%	Mar-13	0.00%	0.03%
	Return on Assets	5%	Q YTD	0.03%	1.20%	2.60%	Mar-13	2.80%	3.30%
	Liquidity ratio	15 days	Q YTD	13.5	14.4	12.9	Mar-13		14.8
	Total Income (actual v plan)	0.5% of plan	Q YTD	99.6%	99.6%	99.90%	Mar-13	101.27%	99.84%
	Pay Expenditure (actual v plan)	At or below plan	Q YTD	101%	102.40%	99.90%	Mar-13	99.86%	100.07%
	Non Pay Expenditure (actual v plan)	At or below plan	Q YTD	98.04%	95.20%	100.00%	Mar-13	101.54%	115.04%
	CIP (actual v plan)	At or below plan	Q YTD	100%	74%	98.00%	Mar-13	100.00%	100.00%
	Capital Expenditure (actual v plan)	At or below plan	Q YTD	13.00%	37.80%	59.00%	Mar-13	147.00%	68.00%

Income and Expenditure Position

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

	Forecast Outturn as presented at previous Board Meeting £000s	Actual £000s	Variance £000s
Income	297,478	297,952	474
Expenditure			
Pay	(203,024)	(202,926)	98
Non Pay	(86,530)	(87,190)	(660)
Reserves	1,082	1,142	60
Finance Cost	(13,907)	(13,858)	49
Total Expenditure	(302,378)	(302,832)	(454)
Under / Over spend	(4,900)	(4,880)	20
Transitional support	4,900	4,960	60
Surplus / (deficit)	-	80	80

Income

5.2 At the end of the financial year the Trust recorded a total level of income amounting to £297.952 million. This exceeded the previously estimated sum by £20,000. The movement was attributable to the following:

- Health Economy External Review - £250,000

  A Health Economy External Review was undertaken at the end of the year by ATOS. The Trust received £250,000 from the NHS Area Team and local CCG's to support the cost of this work.

- CCG end of year settlement - £860,000

  In agreeing the end of year settlement with the CCG's, Shropshire County CCG provided funding amounting to £200,000 and Telford & Wrekin CCG, £660,000.

- Underperformance – elective activity

  The effect of reduced elective activity in the month of March 2013 as a consequence of responding to operational pressures resulted in an underperformance in the month of £436,000.

Expenditure

5.3 ***Pay Expenditure***

The Trust had planned to spend £17.395 million in the month of March 2013. The actual level of spending amounted to £17.298 million. The level of recurrent spending in the month amounted to £17.184 and is consistent with the average level of monthly pay spend recorded in the financial year.

5.4 ***Non Pay***

The Trust had planned to spend £7.5 million in the month and recorded a level of spend amounting to £8.146 million. This overspend is distorted by the following:

- Health Economy External Review - £300,000

  In addition to the funds received from the Area Team and the CCG's, the Trust contributed £50,000 towards the cost of the Health Economy External Review.

- non-recurrent spending - £481,000

  During the month the Trust provided for the cost of legal fees (£110,000), purchasing of equipment in support of winter pressures (£20,000) and was required to absorb a levy in respect of carbon reduction (£189,000). In addition, drug stocks reduced by £116,000.

Adjusting for the above items results in a recurrent level of spending in the month of £6.719 million.

Long Term Financial Position

5.5 The Trust has continued to negotiate with Commissioners. At the time of writing this paper there continued to be an imbalance between the expectations of Commissioners and the Trust. This is summarised in the table below

	Trust view of contract value for 2013/14 £000's	View presented by the CCGs £000's	Variance £000's
Telford and Wrekin CCG	94,863	93,025	1,838
Shropshire County CCG	135,996	133,816	2,180

The long term financial plan is then as follows:

	Recurrent Surplus /(deficit) £000s	Non Recurrent Surplus/ (deficit) £000s	Total Surplus /(deficit) £000s
2012/13	(3,600)	3,600	-
2013/14	3,100	(2,100)	1,000
2014/15	3,400	-	3,400
2015/16	4,600	-	4,600
2016/17	5,800	-	5,800
2017/18	6,800	-	6,800

Capital Programme

5.6 The Trust Capital Resource Limit for the year amounted to £24.749 million. Expenditure commitments amounted to £16.399 million and as a consequence the Trust underspent as compared with the CRL by £8.35 million. The underspend was attributable to the development work at the Princess Royal Hospital as part of the Reconfiguration Project.

Cash flow

5.7 The expenditure in Month 12 was planned to enable the Trust to successfully achieve its External Financing Limit for the year and in so doing conclude the year with a cash balance of £2.2 million. This cash balance is an increase of £1.0 million from the prior year. In line with plan, cash balances increased from £1.5 million at the end of February to £2.2 million at the end of March.

This cash balance was achieved due to the receipt of overperformance monies from Shropshire County CCG (£3.328 million) and Telford and Wrekin CCG (£2.0 million). The Trust also received £1.1 million as a release of cash resource from Shropshire and Staffordshire Local Area Team. The receipt of this additional cash, and a lower level of creditor payments due than planned, allowed the Trust to clear the previous creditor suppression.

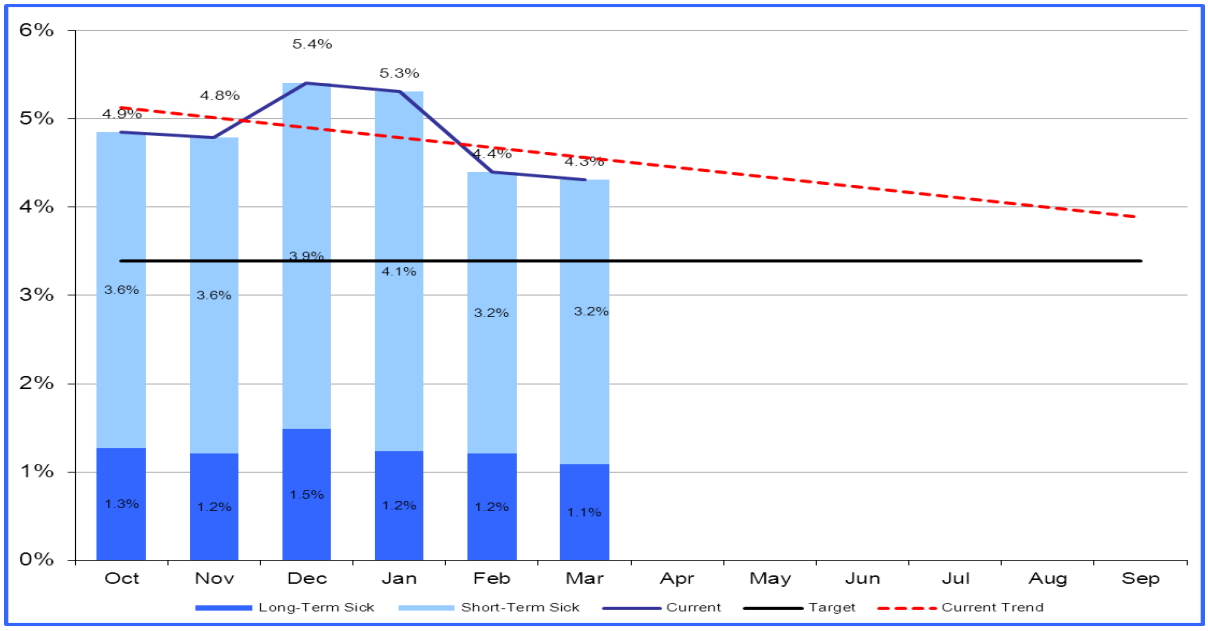
6 Workforce

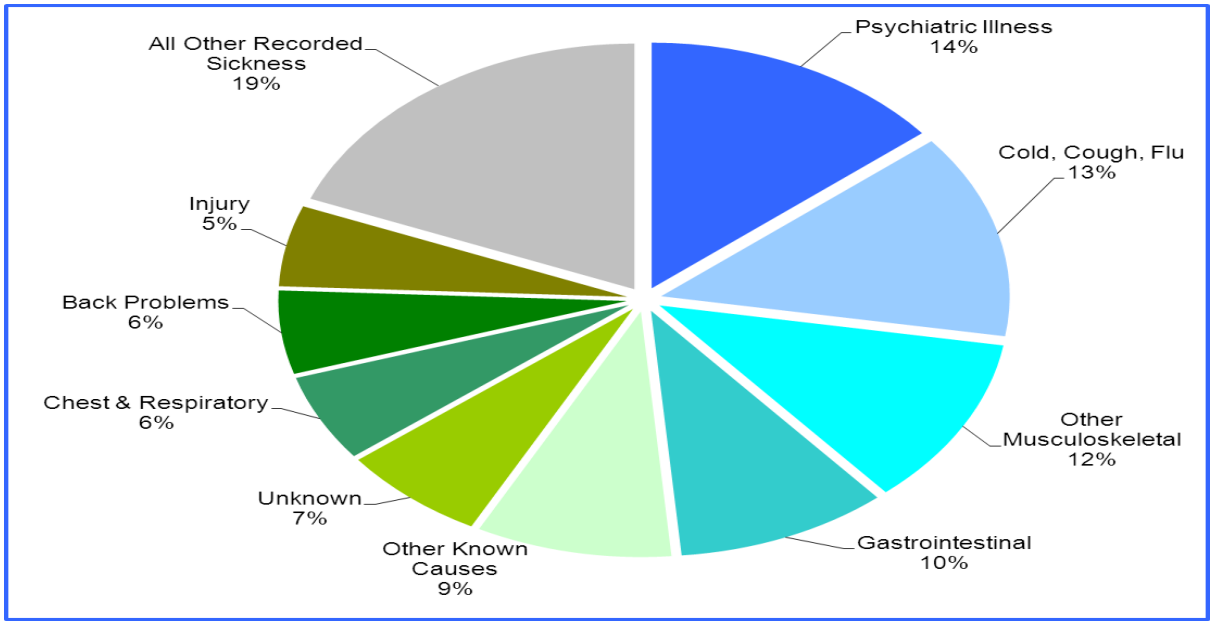
6.1 Sickness Absence

Despite an outbreak of flu amongst the workforce in March, sickness absence rates continue to fall, albeit slowly. Absence in March was 4.32%, down from 4.40% in February and 5.31% in January. However, this

remains unacceptably high as an estimate of just over £400k was paid during the month to staff not attending work due to sickness. Psychiatric illness continues to be the most common reason for absence at 14% and the highest absence levels being seen amongst the Estates and Ancillary workforce

Sickness Graphs





6.2 Appraisals

Non-medical staff appraisal rates continue at 72%, which is below our 80% target. To keep the profile of appraisal high throughout the organisation, the appraisal figure is reported through all levels of the organisation. HR advisors highlight the target and actual figures monthly with managers and in department and centre meetings.

Medical staff appraisal rates have fallen to 74% from 76% in March. This overall figure is an average of consultant and non-consultant appraisal; consultant appraisal rates are at 78% with non-consultant appraisal rates at 66%. Medical appraisal is currently being migrated to the Equiniti 360 electronic appraisal system enabling easier completion and monitoring - as well as automated reminders – to assist in improving

completion rates.

7 Declaration Against Provider Management Review Framework

7.1 Quality, Safety and National Targets

The Trust fell short of the monthly targets 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
- 62 day wait for first treatment – 1 penalty point
- 31 day diagnosis to treatment – 0.5 penalty Point
- 31 day second or subsequent treatment 1 penalty point
- Clostridium Difficile – 1 penalty point

Against the Governance Risk Rating the Trust is rated as RED with 7.5 penalty points compared to 7 in February, further we have an additional 4 points from the A&E override totalling 11.5 penalty points.

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 February.

7.3 Governance Declaration Recommendation

Due to on-going 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'***