Enclosure 4

Report to:	**Trust Board – 27th June 2013**

Title	Integrated Performance Report – May 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 May 2013.

The Shrewsbury and Telford Hospital NHS
NHS Trust

INTEGRATED PERFORMANCE REPORT – MONTH 2 2013/14

1. OVERVIEW OF PERFOMANCE

1.1 This Integrated Performance report provides an overview of the key quality, operational, financial and workforce performance indicators in order that the Board can review any variances to performance delivery. This will enable the Board to gain assurance that actions for improvement are being pursued to improve patient outcomes and Trust performance.

2. REGULATORY REQUIRMENTS

2.1 The Care Quality Commission provides a regulatory overview of all the required outcome measures for which we are registered. 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, clinical effectiveness and patient experience. The report also contains key information relating to clinical care metrics where performance is not meeting the required standard of good practice. For information, there are a number of areas where performance has shown improvements in May 2013.

Table 1

Measure		Standard 2013/14	Year End 2012/13	April 2013	May
	Risk Adjusted Mortality Index (RAMI)	<100	**94**	**Jan 13 Sath = 98 NP = 94**	**Feb 13 Sath = 102 NP = 95**
	RIDDOR reportable Falls (20% reduction)	< 15	**20**	**4**	**1**
	Grade 3 Pressure Ulcer	0	**28**	**3**	**0**
	Grade 4 Pressure Ulcer	0	**13**	**0**	**0**
	C-Diff	27	**45**	**1**	**2**
	MRSA Bacteraemias	0	**1**	**0**	**0**
	MSSA Bacteraemia	21	**24**	**3**	**5**
	E-Coli	40	**45**	**5**	**3**
	Elective MRSA Screening	95%	**N/A**	**93.7%**	**93.9%**
	Non Elective MRSA Screening	95%	**N/A**	**94%**	**94.3%**
	Number of Serious Incidents	<36 per Quarter	**174**	**31**	**8**

	Never Events	0	**2**	**0**	**0**
	WHO Surgical Checklist	100%	**99.96%**	**100%**	**100%**
	VTE Assessment	95%	**90.48%**	**90.10% (Mar)**	**89.3% (Apr)**
	Maternity Dashboard	Green		**Amber**	**Amber**
Patient experience	Number of patient complaints	actual	**671**	**55**	**56**
	Access to Healthcare for people with LD	Yes		**Yes**	**Yes**
	Same Sex Accommodation Breaches	0	**0**	**0**	**0**
	Friends & Family Test	75	**77**	**75**	**82**

A summary of patient outcome measures agreed for the Board are outlined in Table 1 above. Additional patient specific metrics are outlined in Table 5 and 6 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 the key summary points for the Boards attention are as follows:

Patient Safety and Effectiveness

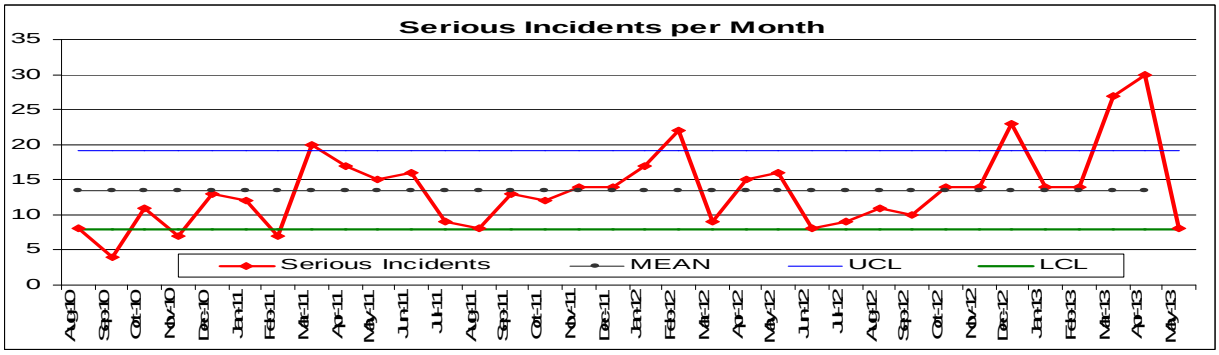
3.2 Serious Untoward Incidents

There were 8 SIs reported in May 2013. This Key performance Indicator is therefore green, falling below the trajectory of 12 established in 2012/13 and the first time that this has been the case since Quarter 2 of 2012/13.

The focus for Clinical teams within the Care groups will be to ensure that for all 8 SI's that a timely RCA process is undertaken and the Trust achieves a 100% compliance with all SI's being reviewed and signed off within the 45 day deadline along with the action plan to ensure improvements highlighted are made.

Of the 8 SIs, 6 related to clinical effectiveness and 2 were operational in nature; relating to information governance, which have been reviewed by the Medical Director as Caldicott Guardian.

Table 2



3.3 Pressure ulcers

There were no grade 3 or 4 trust acquired pressure ulcers reported for May 2013 which is a positive step towards the Trust goal of eliminating all avoidable grade 2,3 & 4 acquired pressure ulcers.

At the date of writing the report:

91 days since a grade 4 has been reported
47 days since a grade 3 has been reported.

The Trust also reported its lowest Trust acquired grade 1 & 2 pressure ulcers for May.

The Pressure ulcer task group chaired by the Associate Director of Patient safety are providing robust Peer review and challenge to any grade 2 or 3 pressure ulcer and a clear focus from senior nurses and ward staff on this priority improvement continues.

3.4 Falls

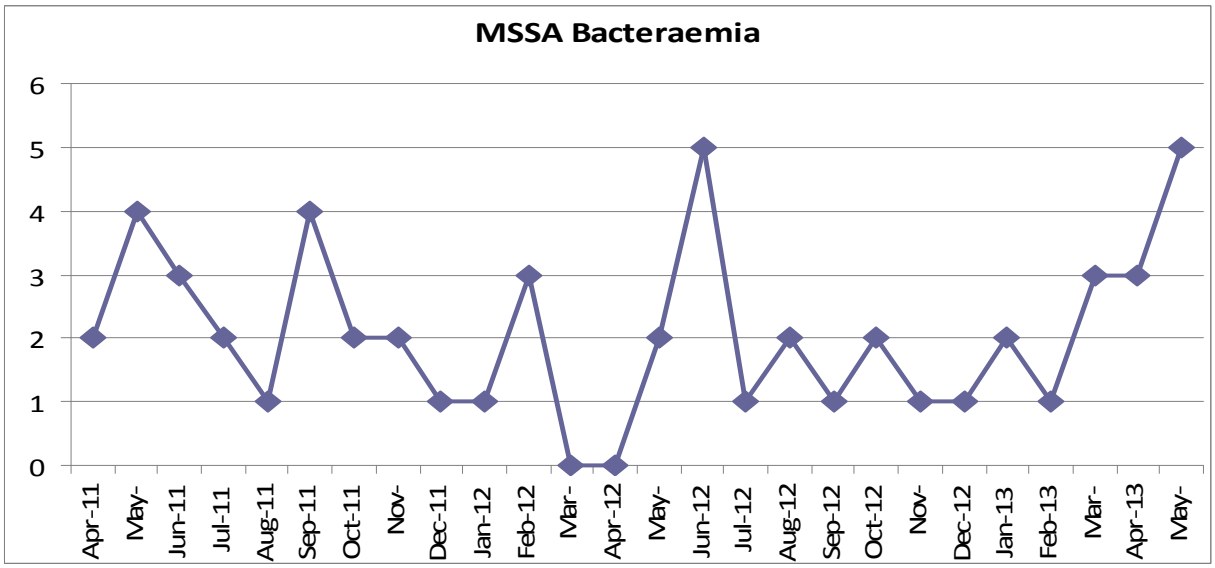
There was a reduction in the number of falls reported from April 2013. 1 SI/RIDDOR related to a patient fall on a ward . The patient suffered harm as a result of the fall and a full RCA is being undertaken and lessons learnt reviewed against other falls outcomes and the Trust wide action plan to ensure ongoing reductions in the number of falls which result in harm.

3.5 Infection Control

C-Difficile

Whilst this performance indicator is green, it is important to note that the first 2 months of performance have been within the monthly trajectory required. The LHE action plan and the Trust wide specific actions for the Trust have been considered by the IPCC Committee and there will be a campaign across the Trust on the various aspects of practice where improvements will impact on this aspect of Infection. The key issue is still on the appropriate use of antibiotics but each RCA undertaken on each case will explore and feedback the appropriateness of antibiotic use and feedback directly to the Clinician responsible for the patients care.

MSSA Bacteraemia



There were 9 cases of MSSA bacteraemia in May of which 5 are apportioned to SATH.

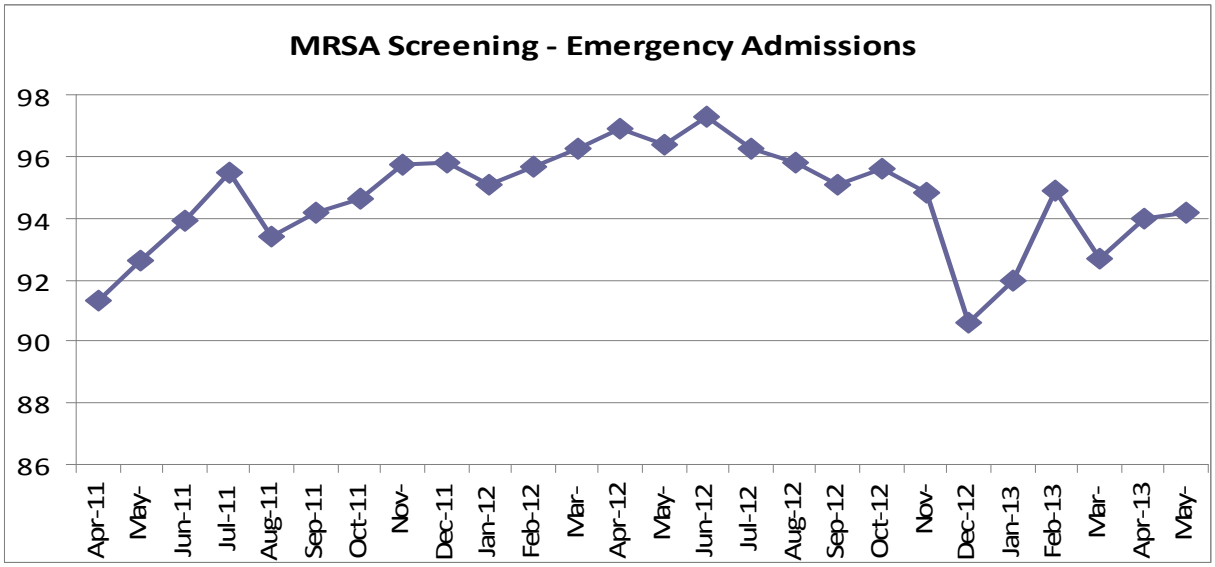
RCAs are currently being completed by Ward Managers but likely sources given below:

Ward A - source probably elbow bursitis – probably unavoidable
Ward B - Infected longstanding knee replacement put in elsewhere – probably admitted with infection
Ward C – CAUTI – longstanding catheter
Ward D – Admitted with fracture neck of femur – source surgical site infection
Ward E – Infected dialysis line

The agreed internal Trust target for 2013/14 is 21 and lessons learned from each RCA will need to be shared with all clinical teams to ensure we achieve the reduction required.

MRSA Screening – Emergency and Elective Admissions

Compliance in both emergency and elective admission screening for MRSA remains below 95%. This is critically important in preventing MRSA acquisition and MRSA bacteraemia so we need to improve. Emergency admission screening is particularly effective in reducing MRSA bacteraemia.



MRSA Screening – Emergency Admissions – 94.3% Target 95%

MRSA screening compliance for emergency admissions is up slightly from 94% in April to 94.3% in May.

Actions for Improvements

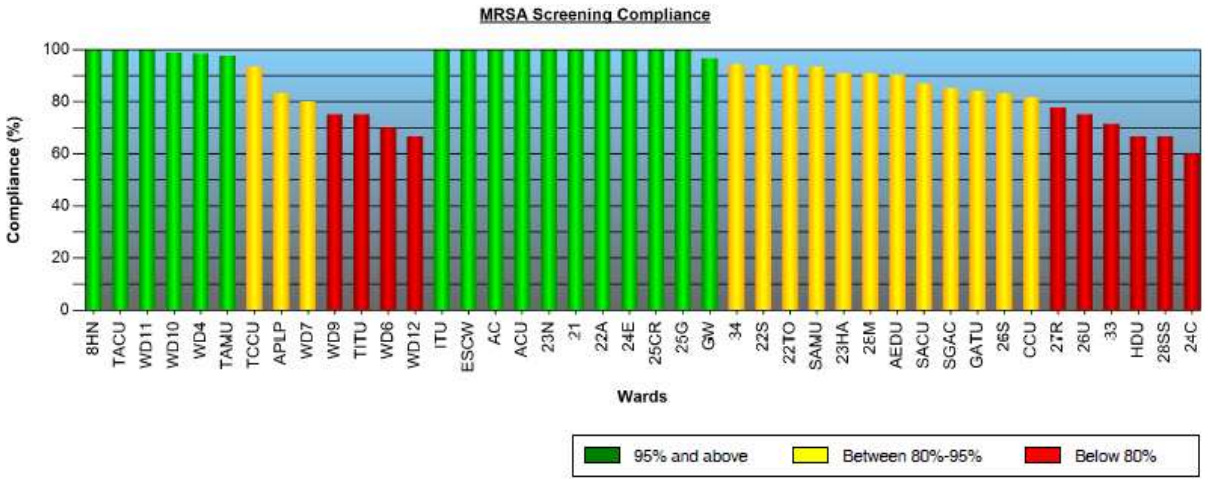
We are now sending lists of patients with missed screens at 48 hours post admissions to all wards but we are still seeing patients unscreened over a week after they have been admitted. All centres need to take responsibility for ensuring patients are screened but this particularly falls on Emergency and Critical Care.

TAMU reported a number of missed emergency screens by agency staff, the Ward Manager will address this with these staff if they work in the Trust again. This will also be addressed with current substantive staff. SAMU are looking into setting up packs with MRSA screens to make it screening easier for staff.

150 patients missed screening overall in May – down slightly from 152 in April.

Wards that are below 80% (on the graph below) had low numbers of emergency admissions.

All wards receiving patients from the AMUs and SAU must make sure that these patients are screened before transfer and if not screen. The daily readout of unscreened patients continues to be sent to Ward Managers for action via the automated SQL report.

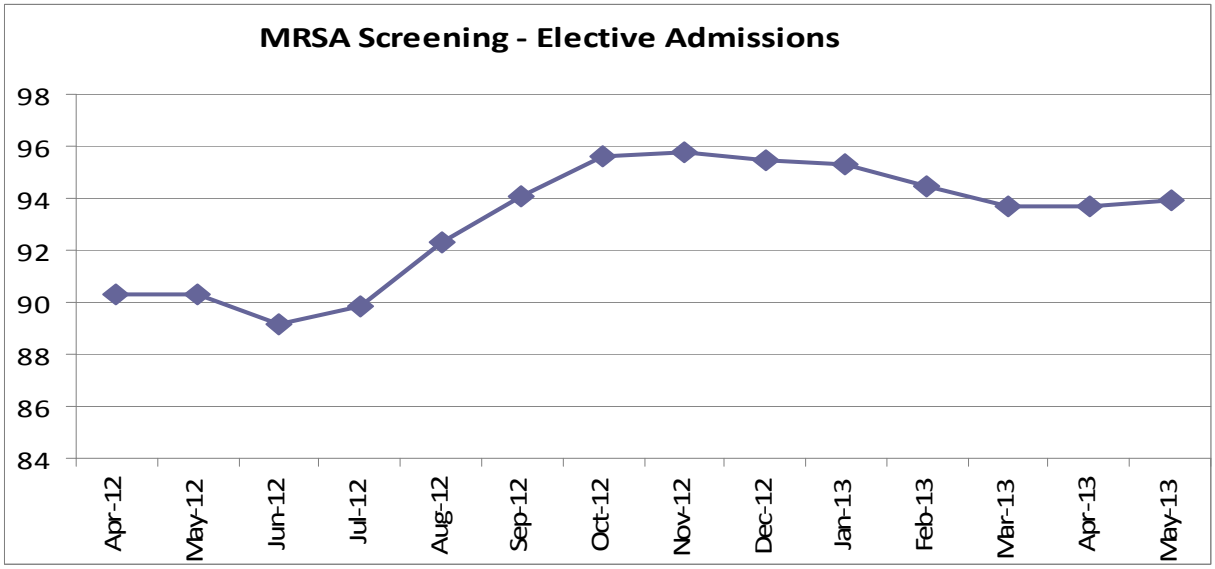


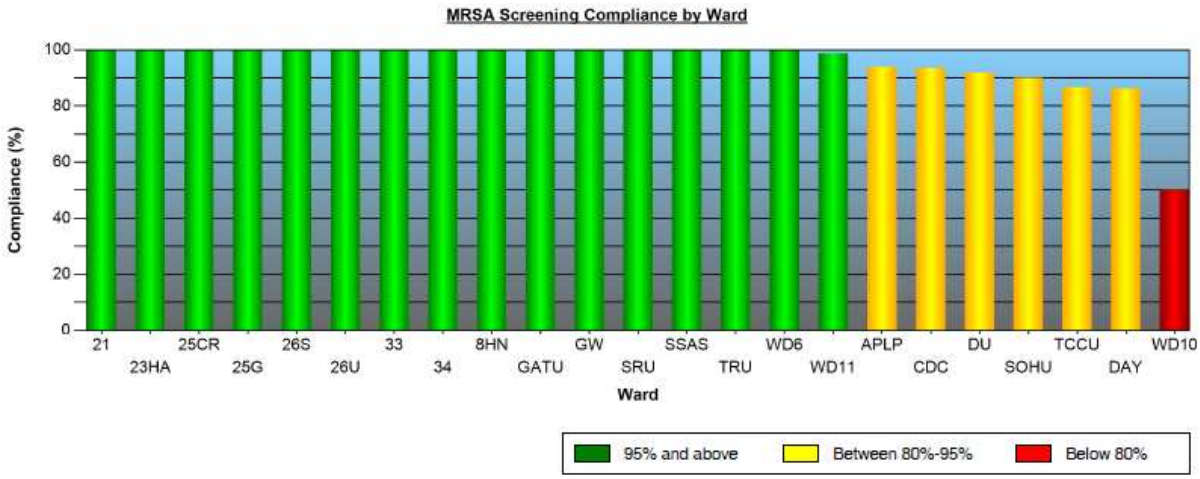
MRSA Screening - Elective Admission Compliance – 93.9% Target 95%

MRSA screening of elective patients this month is 93.9%.
The lowest performing being:

- ENT -22
- Clinical Oncology- 17
- Clinical Haematology- 12
- Trauma and Orthopaedics-12 patients,

These areas are still missing some screens in patients.
Matrons in both T&O and ENT areas are addressing this.
Some of these were related to coding issues which are being addressed by the IPCC team.





3.6 Current Status – Mortality

SaTH uses 3 mortality indicators to monitor changes in mortality; an update on each is given below.

3.6.1 Summary Hospital-level Mortality Indicator (SHMI)

The principle national measure for mortality is now the Summary Hospital-level Mortality Indicator (SHMI). The principle difference between SHMI and other mortality indicators is that it includes deaths in the community within 30 days of discharge.

The latest release – year ending Sept 2012 shows a sharp drop to 105.27 reflecting continued improvements in our mortality rates during this period. Despite this significant drop the rate is still above the national index of 100, although it is well within expected range. A review of the deaths recorded in SHMI, focusing on deaths within 30 days of discharge, is taking place under the direction of the newly formed Formal Mortality Group.

The table below shows the rolling 12 months trend in SHMI.

Table 3

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**	**Oct 11 - Sept 12**
SHMI	111.21	110.51	108.85	107.53	106.68	106.64	105.27

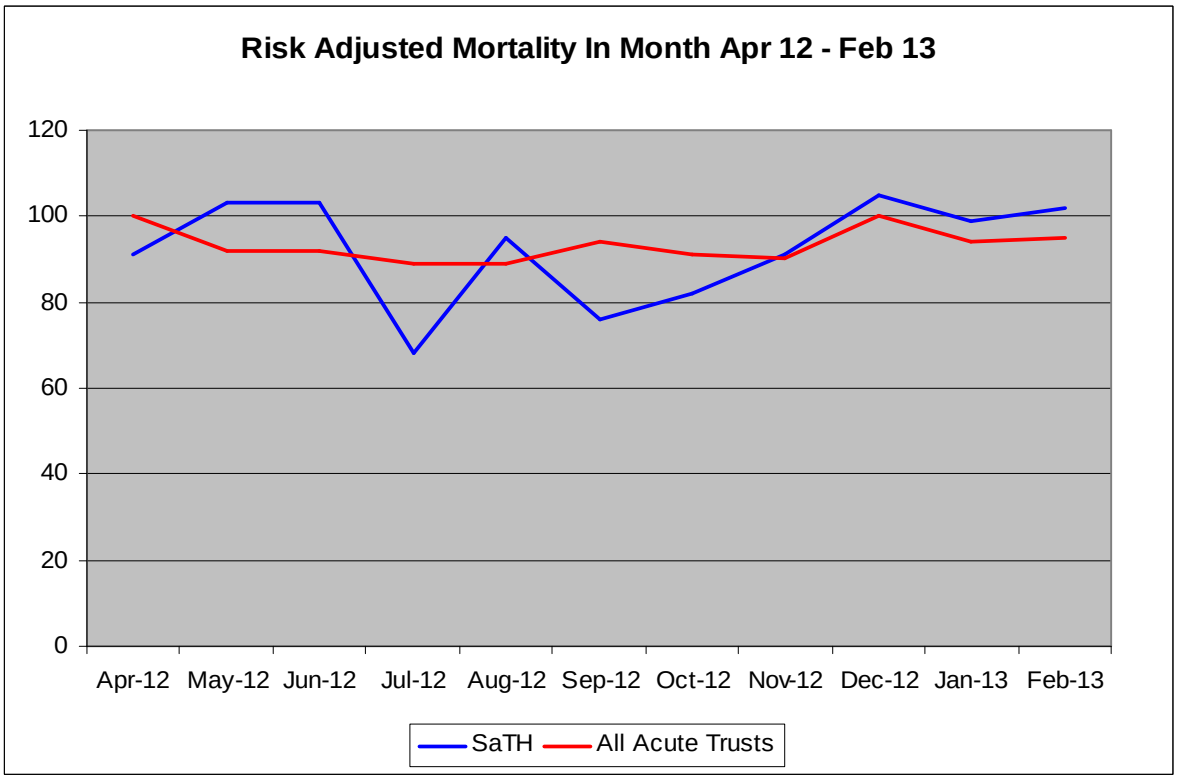
3.6.2 Risk Adjusted Mortality Indicator (RAMI)

We have transferred from Dr Foster to the CHKS reporting tool as of April 2013. The CHKS tool uses a different methodology for reporting mortality called Risk Adjusted Mortality Indicator (RAMI). The RAMI is similar to the HSMR in that it can be used to benchmark progress against other organisations; however RAMI and HSMR should not be compared to each other as they are different measures. The main differences are:

- HSMR uses a group of 56 diagnosis codes and RAMI includes many more diagnosis codes
- RAMI excludes Patients coded as palliative care where as HSMR includes them

The trend for RAMI is below which reflects the latest data available. It shows the in-month figure against the national peer group, which is a benchmark group that includes all the acute Trusts in England. The standard to be achieved each month is for the Trust RAMI to be less than the National Peer RAMI.

Table 4



3.6.3 Crude Death Rate as a Percentage of Spells

The crude death rate is simply the number of people that die at SaTH; it takes no account of the clinical condition, age or any other factor affecting mortality. It is best measured against the number of hospital Patient spells and is used mainly as a supporting indicator to the SHMI and RAMI models.

The graph below gives an indication of the current rate of mortality for Patients admitted as an emergency as a percentage of hospital Patient spells benchmarked against the National Peer group of all acute trusts in England.

Graph showing: Emergency Patient deaths as a percentage of spells for April 2012 – Feb 2013 benchmarked against all acute Trusts in England.

Site = Shrewsbury & Telford Hospitals Trust at 2.92% of spells
Trusts highlighted in green = top quartile 2.7% or less (Top 10% at 2.3% or less)
Highest = 5.3% of spells

3.6.4 Mortality Group

The first meeting of the formal Mortality Group took place on 30th April 2013. The initial focus of the mortality group was agreed as:

- Understand current mortality review processes across all Specialties and make recommendations for using a consistent approach based on CESDI scoring;

- Review top diagnosis reasons for deaths across in-hospital and post discharge deaths as part of SHMI analysis.

3.7 VTE

The rate of reported VTE assessments across the Trust for April 2013 is **89.3%** against a VTE assessment target at 95% from April onwards**.**

Actions being taken to increase the rate to 95% plus are:

- Visibility of standard VTE icons on Patient Status at A Glance (PSAG) screens on all medical wards to enable VTE to form part of daily ward/board rounds - **Complete**
- Publication, twice weekly, of a snapshot of the status of VTE by ward, Consultant and monthly trend to date to all relevant Consultants in the Trust – **Complete**
- Directed communication to all doctors in the Trust, including junior trainees, by the Medical Director, explaining the reasons why they must ensure all assessments are completed and when in the Patients pathway they must be completed by – **Complete**

As a result of the above actions the VitalPAC assessment trend for May 2013 shows an improvement of 4% on April 2013 with a further 4% improvement during the first week of June.

3.8 Maternity Dashboard

Appendix 1 outlines the Trusts Maternity Dashboard. The Board need to note two updates on amber areas of the dashboard.

3.8.1 Midwifery Supervision

Midwifery supervision is a statutory requirement in order to ensure safe midwifery practice and protect the public. The suggested ratio of supervisors to midwives is 1:15 and this ratio is monitored by the West Midlands Local Supervising Authority during an annual review and via monthly submissions to the LSA. The ratio is calculated from the headcount of midwives requiring supervision and these midwives may be external from the Trust, working in the university or working in health visiting roles and their midwifery registration within the County, therefore the number of midwives may vary slightly from the headcount that we show in Trust data.

The average of supervisors to midwives during 2013 has been 1:21. This higher ratio than the target ratio has been discussed with Barbara Kuypers, our Midwifery Officer for the LSA on a regular basis who has assured myself and the Lead of Midwifery that the quality of supervision within Shropshire is of a high standard and she has no concerns relating to this ratio, but encourages us to develop strategies to increase our numbers of supervisors.

During April 2013, we had 14 supervisors of midwives giving us a ratio of 1:21, May 2013 we have been able to increase that number to 17 supervisors and in June 2013 we will have 20 supervisors giving a ratio of 1:14.5, meaning that we will now for the first time be reaching the target of 1:15. This has been achieved through additional recruitment, both from our permanent midwives and through appointing supervisors of midwives to our Bank. The LSA have recognised that 4 of the incumbent supervisors are carrying case loads of 30 and will act as two supervisors. This has been recognised and agreed with Barbara Kuypers and will be subject to ongoing review.

3.8.2 Birth to midwife ratios

Although the RCM have a standard statement which suggests that midwife ratios to births should be 1:28, current guidance suggests that the Birthrate Plus tool should be used which for 2012/13 suggested that SaTH needed a ratio of 1:31.

This is based on a fairly complex calculation requiring the total number of births to be identified into hospital births, including alongside midwifery led units, and also the births that take place at homebirths and free standing midwifery led units.

The outcome of this calculation for 2012 showed a deficit of 4.15 WTE. This calculation has been repeated for 2013 and due to a decrease in births to 5154 and a significant decrease in exports gives a total deficit of 2.6 WTE.

The required ratio for 2013/14 is 1:30 clinical midwives. The service meets this requirement currently but has a deficit of 2.04 WTE specialist midwifery posts.

3.9 Patient Experience and Clinical Outcomes

Table 5 & 6 provide a Board level overview of a range of patient outcome metrics. These are reviewed in detail at Clinical Centre and ward level to determine specific actions for improvement. There have been slight improvements across the majority of patient care metrics. The table also shows the outcome from the first month's review of the agreed composite bundle of questions agreed for reviewing Discharge arrangements, we will now monitor that on a prospective basis.

Overall patient care metrics show consistency over the year with an improved average monthly score of 94%.

- The nutrition score has increased by 6% since April 2013
- Patient observations are also showing an increase of 7%.

The focus will be to continue to improve timeliness and accuracy of observations with particular attention to the management of patient's nutritional and hydration status.

The overall trend for ward to board for patient experience shows an increase in performance of 3% since April 2013. Improvements have been reported in the majority of areas. Based on individual performance, the focus for June 2013 will be on hand and ward cleanliness. All detailed performance discussions with centres take place at the Nursing & Midwifery Forum (NMF) this includes a centre approach to the Quality Review process. This will work along side the high level Key performance Indicators being reviewed at the Operational Performance Group chaired by the Chief Operating Officer. It must be noted however, that there is variability of data quality based on the thoroughness of inputting, further work is therefore being undertaken to improve data quality which is being led by Corporate Nursing.

3.10 External Feedback and Assurance

In May 2013, one unannounced visit was made to Ward 22 (0) and 27. A draft report has been received and responded to with points of accuracy and detail.

3.11 Wards subject to a Quality Improvement Framework

Three wards are subject to a Quality Improvement Framework. These are Wards 10, 12 and 22T/O. Each of the wards are being supported by a team of senior Nurses, Matrons and PEIP members to deliver sustained improvements to the care delivery on the ward. A system of regular quality checks, observations of care and Corporate Quality ward rounds provide an independent assurance framework from which a level of confidence is derived. The centre Matrons provides a weekly summary report to the Chief Nurse.

Table 5: Ward to Board Patient Care Metrics

	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Apr 2013	May 2013
Medication Storage and Administration	98%	99%	96%	97%	96%	97%	99%	98%	98%	95%	97%	97%	98%
Infection Control and Privacy & Dignity	95%	96%	94%	94%	93%	93%	96%	95%	94%	95%	96%	98%	98%
Patient Observations	83%	87%	85%	86%	90%	86%	95%	90%	89%	89%	86%	84%	91%
Pain Management	87%	91%	91%	92%	88%	90%	93%	92%	93%	93%	93%	91%	95%
Tissue Viability	90%	89%	87%	91%	91%	94%	95%	96%	93%	92%	92%	93%	94%
Nutrition	92%	91%	90%	90%	95%	94%	95%	92%	91%	91%	85%	89%	95%
Fluid Management	87%	82%	85%	80%	90%	93%	90%	85%	87%	83%	85%	86%	89%
Falls assessment	96%	98%	97%	98%	96%	98%	99%	98%	97%	95%	94%	94%	94%
Continence	93%	88%	93%	93%	97%	97%	98%	95%	96%	96%	96%	97%	98%
Comfort Rounds			83%	92%	90%	94%	93%	93%	90%	90%	94%	94%	94%
Discharge													81%
Total	**92%**	**92%**	**91%**	**92%**	**92%**	**94%**	**95%**	**94%**	**93%**	**92%**	**92%**	**93%**	**94%**

Table 6: Ward to Board Patient Experience Metrics

	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Apr 2013	May 2013
How clean is this ward (including toilets)?	95%	95%	95%	96%	96%	96%	97%	97%	97%	98%	95%	96%	96%
As far as you know do the staff wash or clean their hands between touching patients?	92%	95%	94%	96%	96%	96%	97%	96%	96%	98%	97%	97%	96%
Do you feel informed about potential medication side effects?	57%	65%	65%	72%	64%	72%	83%	76%	86%	82%	75%	72%	77%
Do you feel you have enough privacy when discussing your condition or treatment with staff?	89%	85%	83%	86%	85%	86%	91%	91%	87%	93%	86%	84%	88%
Do you feel that you have been treated with respect and dignity while you are on this ward?	95%	98%	93%	95%	94%	95%	96%	97%	95%	97%	97%	94%	98%
Do you feel involved in decisions about your treatment and care?	83%	77%	78%	77%	79%	84%	89%	86%	87%	89%	84%	81%	87%
Have hospital staff been available to talk about any worries or concerns you have?	92%	90%	90%	86%	91%	93%	93%	90%	89%	92%	87%	89%	92%
Do you get enough help from staff to eat your meals?	90%	98%	87%	90%	95%	98%	95%	92%	85%	99%	92%	97%	96%
Whilst you have been on this ward have you ever shared a sleeping area with a member of the opposite sex?	96%	98%	99%	99%	97%	97%	98%	99%	97%	100%	98%	96%	100%
Do you think hospital staff do everything they can to help control your pain?	93%	89%	90%	89%	87%	93%	95%	92%	90%	96%	91%	91%	95%
When you use the call buzzer is it answered?	93%	89%	87%	90%	90%	87%	91%	90%	89%	91%	90%	90%	91%
Have staff talked to you about your discharge from hospital?	74%	63%	65%	68%	68%	64%	71%	72%	75%	73%	69%	68%	69%
Total	87%	86%	86%	87%	86%	88%	91%	90%	90%	92%	88%	87%	90%

Appendix 1 Maternity Dashboard

No.	Indicator	Descriptor	Expected	Q4	April		YTD	2012/13
1	Births by Unit	Overall Trust total births	450	1267	406		406	5154
2	Birth rate	% of births in CU	75%	81.1%	79.8%		79.8%	77.8%
		% of births in any MLU	25%	17.0%	19.2%		19.2%	20.1%
		% home births	1%	1.7%	1.0%		1.0%	1.8%
		% BBA / Other	<1%	0.2%	0%		0%	0.4%
3	Normal and Assisted Deliveries	Overall normal birth rate %	65%	70.7%	71.7%		71.7%	71.9%
		Overall assisted birth rate %	10%	10.3%	12.1%		12.1%	10.8%
4	Operative deliveries	Caesarean section rate %	<20%	17.5%	14.8%		14.8%	15.7%
5	Rate of outcomes	Stillbirth rate	<1%	0.7%	0.2%		0.2%	0.5%
		% of deliveries PPH >2000mls	<1%	0.7%	0.8%		0.8%	0.5%
		3rd/4th degree tear rate	<5%	3.1%	4.5%		4.5%	2.4%
		% birthweight <2.5kgs	<8%	7.4%	6.0%		6.0%	6.8%
6	National Smoking and Breastfeeding targets	Breastfeeding within 48 hours of delivery (unvalidated figures)	67%	70.3%	69.5%		69.5%	70.2%
		'Current smoker' at delivery (unvalidated figures)	<20%	18.2%	17.0%		17.0%	18.1%
7	Access to Maternity Services	% of bookings with a gestation of less than 12 weeks and 6 days	90%	89.7%	89.6%		89.6%	90.9%
8	Clinical Effectiveness	Supervisor to Midwife Ratio	1:15					
		Established Midwife to Birth Ratio	1:31	1:32				
9	Patient Safety	No. of CQC mortality alerts	0	0	0		0	
		No. maternal deaths	0	0	1		1	
		No. SIs	<3	4	2		2	

4. OPERATIONAL PERFORMANCE

Month 2 - 2013/14

	Measure	Outturn Period	2012/13 Outturn	2013/14 Standard	M1 Apr-13	M2 May-13	M3 Jun-13	Q1	M4 Jul-13	M5 Aug-13	M6 Sep-13	Q2	M7 Oct-13	M8 Nov-13	M9 Dec-13	Q3	M10 Jan-14	M11 Feb-14	M12 Mar-14	Q4	2013/14 Year to Date	2013/14 Forecast Outturn
Access	A&E 4 Hour Wait	Full Year	90.62%	95%	86.72%	95.51%															91.60%	
	A&E 12 Hour Trolley Waits	Full Year	16	0	16	0															16	
	Ambulance Handovers not completed within 30 Minutes			100%																		
	Ambulance Handovers not completed within 60 Minutes			100%																		
	18 Week RTT Admitted - English Responsible Only - Part 1A	Full Year	81.29%	90%	73.59%	78.74%																
	18 Week RTT Non Admitted - English Responsible Only - Part 1B	Full Year	94.25%	95%	95.51%	95.51%																
	18 Week RTT Incomplete Pathway - English Responsible Only - Part 2	Mar-13	13.43%	8%	10.95%	9.76%																
	18 Week RTT Incomplete > 52 Weeks - English Responsible Only	Mar-13	0	0	0	0															0	
	% of Patients waiting over 6 Weeks for a Diagnostics Test	Mar-13	0.20%	1%	0.22%	0.46%															0.34%	
	% spending >90% of their stay on a Stroke Ward	Full Year	88.30%	80%	76.70%	78.40%															77.60%	
	Cancelled 28 Day Readmission Breaches	Full Year	100	0	3	1															4	
	Number of Urgent operations cancelled more than once			0	0	0																
Cancer	2 Week GP referral to 1st OP Appointment	Full Year	96.00%	93%	92.00%	95.74%															93.95%	
	2 Week GP to 1st OP Appointment Breast Symptoms	Full Year	95.73%	93%	93.13%	95.39%															94.23%	
	31 day diagnosis to treatment	Full Year	97.50%	96%	95.27%	98.26%															96.88%	
	31 day second or subsequent treatment - Drug	Full Year	99.02%	98%	97.26%	98.21%															97.67%	
	31 day second or subsequent treatment - Surgery	Full Year	94.79%	94%	90.30%	94.74%															92.00%	
	31 day second or subsequent treatment - Radiotherapy	Full Year	97.99%	94%	96.84%	95.06%															96.02%	
	62 days urgent referral to treatment	Full Year	85.13%	85%	78.52%	78.66%															78.59%	
	62 days referral to treatment from Screening	Full Year	92.15%	90%	100.00%	100.00%															100.00%	
	62 days referral to treatment from Hospital Specialist	Full Year	94.70%	85%	100.00%	90.36%															94.52%	
Patient Experience / Governance	C-Diff	Full Year	45	27	1	2															3	
	MRSA	Full Year	1	0	0	0															0	
	Same Sex Accommodation Breaches	Full Year	0	0	0	0															0	
	Compliance with VTE Assessments	Mar-13	90.44	95%	89.30%																89.30%	
	PMR Governance Rating	Mar-13	Red	Green	Red	Red															N/A	
	Publication of Formulary	Mar-13	Yes		Yes	Yes															N/A	
	Number of Reds on Maternity Dashboard	Mar-13	0	0	0	0															N/A	

2012/13 Outturn Performance is RAG rated against the relevant 12/13 Target, i.e. Compliance with VTE Assessments is rated Green as the 12/13 target was 90%

CONTRACTING & ACTIVITY OVERVIEW

Summary Activity Position (Internal Plan)
Month 2 (Initial Data Submission)

Point of Delivery	Care Group	12/13 Outturn	Month Plan	Month Actuals	Variance	Variance %	Year-to-Date Plan	Year-to-Date Actual	Variance	Variance %	13/14 Annual Plan	13/14 Forecast Outturn
Consultant Led/Responsible First Attendance	Scheduled Care		5,075	5,517	442	8.7%	9,540	10,302	762	8.0%	62,788	
	Therapies / Diagnostics		14	18	4	31.5%	26	67	41	160.3%	169	
	Unscheduled Care		1,906	1,982	76	4.0%	3,584	3,993	409	11.4%	23,588	
	Women and Children's		1,252	1,786	534	42.6%	2,355	3,192	837	35.6%	15,497	
Consultant Led/Responsible First Attendance Total			**8,247**	**9,303**	**1,056**	**12.8%**	**15,504**	**17,554**	**2,050**	**13.2%**	**102,041**	
Consultant Led/Responsible Follow Up Attendance	Scheduled Care		9,797	9,368	-429	-4.4%	18,417	18,485	68	0.4%	121,216	
	Therapies / Diagnostics		37	55	18	49.5%	69	120	51	73.6%	455	
	Unscheduled Care		3,563	3,872	309	8.7%	6,698	7,624	926	13.8%	44,086	
	Women and Children's		1,383	2,379	996	72.1%	2,599	4,020	1,421	54.7%	17,107	
Consultant Led/Responsible Follow Up Attendance Total			**14,779**	**15,674**	**895**	**6.1%**	**27,784**	**30,249**	**2,465**	**8.9%**	**182,864**	
Consultant Led/Responsible Outpatient Procedure	Scheduled Care		3,886	4,158	272	7.0%	7,307	8,550	1,243	17.0%	48,094	
	Therapies / Diagnostics		14	-	-14	-100.0%	27	-	-27	-100.0%	179	
	Unscheduled Care		2,328	2,236	-92	-4.0%	4,376	4,721	345	7.9%	28,802	
	Women and Children's		2,032	1,312	-721	-35.5%	3,821	3,729	-92	-2.4%	25,147	
Consultant Led/Responsible Outpatient Procedure Total			**8,261**	**7,706**	**-555**	**-6.7%**	**15,531**	**17,000**	**1,469**	**9.5%**	**102,222**	
Total Outpatients	Scheduled Care		18,758	19,043	285	1.5%	35,264	37,337	2,073	5.9%	232,098	
	Therapies / Diagnostics		65	73	8	12.5%	122	187	65	53.2%	803	
	Unscheduled Care		7,797	8,090	292	3.7%	14,658	16,338	1,680	11.5%	96,475	
	Women and Children's		4,668	5,477	809	17.3%	8,775	10,941	2,166	24.7%	57,750	
Total Outpatients Total			**31,287**	**32,683**	**1,395**	**4.5%**	**58,819**	**64,803**	**5,985**	**10.2%**	**387,127**	
Elective DC	Scheduled Care		2,893	2,896	3	0.1%	5,463	5,362	-101	-1.8%	34,549	
	Unscheduled Care		213	194	-19	-8.8%	401	396	-5	-1.4%	2,539	
	Women and Children's		241	193	-48	-19.8%	460	362	-98	-21.3%	2,388	
Elective DC Total			**3,346**	**3,283**	**-63**	**-1.9%**	**6,324**	**6,120**	**-204**	**-3.2%**	**39,476**	
Elective IP	Scheduled Care		515	410	-105	-20.4%	973	774	-199	-20.5%	6,077	
	Unscheduled Care		20	26	6	31.0%	38	45	7	20.0%	234	
	Women and Children's		82	90	8	9.2%	156	176	20	13.0%	973	
Elective IP Total			**617**	**526**	**-91**	**-14.8%**	**1,166**	**995**	**-171**	**-14.7%**	**7,283**	
Non Elective	Scheduled Care		1,072	1,054	-18	-1.7%	2,132	2,047	-85	-4.0%	12,921	
	Unscheduled Care		1,951	2,073	122	6.3%	3,881	4,062	181	4.7%	23,508	
	Women and Children's		741	678	-63	-8.5%	1,475	1,397	-78	-5.3%	8,932	
Non Elective Total			**3,765**	**3,805**	**40**	**1.1%**	**7,487**	**7,506**	**19**	**0.3%**	**45,361**	
Non Elective Other	Scheduled Care		4	4	-0	-4.1%	11	9	-2	-16.6%	52	
	Unscheduled Care		14	22	8	60.8%	28	42	14	49.0%	164	
	Women and Children's		744	785	41	5.5%	1,425	1,519	94	6.6%	8,830	
Non Elective Other Total			**762**	**811**	**49**	**6.4%**	**1,464**	**1,570**	**106**	**7.2%**	**9,046**	
Total Spells	Scheduled Care		4,485	4,364	-121	-2.7%	8,578	8,192	-386	-4.5%	53,598	
	Unscheduled Care		2,197	2,315	118	5.4%	4,348	4,545	197	4.5%	26,446	
	Women and Children's		1,809	1,746	-63	-3.5%	3,516	3,454	-62	-1.8%	21,122	
Total Spells Total			**8,490**	**8,425**	**-65**	**-0.8%**	**16,442**	**16,191**	**-251**	**-1.5%**	**101,166**	
A&E	Unscheduled Care	110,683	9,670	9,299	-371	-3.8%	19,066	18,499	-567	-3.0%	110,987	
A&E Total		**110,683**	**9,670**	**9,299**	**-371**	**-3.8%**	**19,066**	**18,499**	**-567**	**-3.0%**	**110,987**	

Contract Plan

This internal activity plan as presented here is gross of QIPP (i.e. it assumes that the CCG planned QIPP activity reductions do not happen).

Although an overall demographic growth assumption has now been agreed with our CCG colleagues (broadly 1.3%) this is yet to be effected in the internal activity plans. Further, additional non-recurrent activity has been agreed with various Centres to both deliver the RTT targets and reduce the backlog numbers to sustainable levels. This activity will be phased into the plan from month 3 onwards.

Outpatient Activity

The attached summary represents an overall activity position of 4.5% above contract plan for May, a much lower figure than that reported for April (13%).

The W&C Care Group in particular, for both the month and year-to-date, is showing a significant over performance (nearly 25% year-to-date). There has been a number of contract and coding changes within the Care Group for this year and discussions are taking place with the Care Groups to confirm:

- a) whether there are any errors (e.g. plans not updated to reflect agreed changes) and/or
- b) the reasons for this level of over performance.

Spell Activity

Elective spell activity (i.e. elective inpatient and daycases combined) is 154 spells below plan for May (3.9%) and 375 below plan for the year to date (5%). The majority of specialties are under plan for the year-to-date with regard to elective activity. However, following the capacity challenges witnessed across the Trust in April, there was more elective activity undertaken in May. For example, the Scheduled Care Group treated nearly 500 more patients in May than in April, an increase of 16%. This will need to be increased further moving forwards if the Trust is to deliver its contracted activity levels.

Emergency activity across the Trust during May was 40 spells above plan (1%), with a similar position of 19 spells above plan for the year-to-date (0.3%). As was the case for April, underperformances within Orthopaedics (22 spells) and Gynaecology (53 spells) offset an over performance within Medicine and A&E (122 spells combined).

The introduction of the Clinical Decision Unit during May (i.e. where patients previously admitted to the AMU/SAU are now kept under the care of the A&E consultants rather than the Acute Physicians) has resulted in 87 emergency admissions being recorded under the specialty of A&E in the month, when previously the number would have been 2 or 3 spells per month.

Performance Report – Key Messages & Issues:

- A&E 4 hour target achieved in the month;
- RTT admitted not achieved in the month;
- 8 out of 9 Cancer targets achieve in the month, with 62 day target not achieved;
- C-Diff/MRSA targets achieved in the month.

4.1 Emergency Access Target

The Trust achieved the 95% A&E 4 hour target in May 2013 with 95.51% for the month, giving a year to date position of 91.60%.

Factors affecting performance are:

- A marginal reduction in attendances during the reporting period compared to previous; an average of 300 attendances a day in May compared with 306 a day in April. Total attendances for May reporting period 10,508 (5 week reporting period).

- A decrease in the number of non-elective admissions – this is against all previous increases.

  - January 3,829 Ave 123 a day
  - February 3,585 Ave 129 a day
  - March 4,153 Ave 133 a day
  - April 4,403 Ave 146 a day
  - May 3,955 Ave 128 a day

What is encouraging is that the level of non elective admissions is similar to those in January and February when the target was not being met, whereas now it is being achieved.

- A significant cohort of patients who are fit to transfer but remain in a hospital bed. RSH are still averaging at over 50 patients a day. This was escalated during conference calls, and at one stage on the fit to transfer list there were 67 patients waiting for another provider. This created capacity problems during the final week of May. An increase was also seen in attendance in Powys patients, even though small in number, they contributed to long delays whilst waiting to transfer out of the hospital.

- A lack of available capacity (beds to meet expected demand) at the Royal Shrewsbury Hospital site. This has subsequently been reduced by the ward reconfiguration at the end of April and has also supported a large reduction in medical outliers. This remains a key issue.

The patient flow action plan has begun to address some of the internal performance issues. The first of these actions was implemented at the end of April and we saw improvements during the month of May as a result; showing an overall delivery of the 95% target. A&E performance however remains precarious with only small increases in demand affecting performance and preventing us from delivering 4 hr performance. This has been the case over the last two weeks and proposals to resolve the capacity gap will be considered by the Executive team.

May & June (to date) performance is summarised below:

Week Ending	PRH	RSH	SaTH	SaTH including WIC
28/04/2013	93.84%	82.89%	89.88%	90.66%
05/05/2013	97.45%	89.29%	94.20%	94.63%
12/05/2013	98.53%	92.31%	95.96%	96.30%
19/05/2013	97.65%	95.32%	96.76%	96.98%
26/05/2013	97.11%	93.70%	95.88%	96.18%
02/06/2013	97.75%	89.13%	94.28%	94.86%
09/06/2013	94.17%	92.78%	94.04%	94.57%
16/06/2013	96.59%	96.76%	96.88%	97.18%

There has been an agreement to include the Telford & Wrekin's Walk in Centre activity as part of SaTH's overall performance which will improve performance against target by an average of 0.5% per week. This has been included on a weekly basis since 2nd June 2013 and it has been agreed by Unify, the TDA and the DoH that the Trust can resubmit adjusted historical figures that include Walk in Centre activity with effect from 1st April 2013, however these will not appear within the DoH figures until August 2013.

During the month of May 0 patients breached the 12 hour trolley wait standard and very few patients over the whole month breached the 8 hr wait, this indicates a vast improvement in patient flow.

Following the whole system review of the urgent care system in Shropshire, Telford & Wrekin, five high impact projects have been agreed and are due for delivery by the end of September 2013, this will initially be supported and managed by ATOS.

We now have a functional CDU where patients are admitted under the care of the ED teams. This is helping to prevent unnecessary admissions and further reduce LoS.

The above enabling actions will fully support the further actions in the patient flow action plan over the coming months and will ensure that as a Trust we continue to improve patient quality and safety within the assessment units and ensure delivery of the 4 hour target. The progress of these will be monitored at the new Local Health Economy Urgent Care Board meeting which will be chaired by Caron Morton, CEO of Shropshire CCG.

4.2 Stroke

Stroke performance over the month of April and May has seen a failure of the target primarily on the RSH site. This was due to the inability to keep the Stroke bed free for patients on the Stroke pathway. Since the reconfiguration we anticipate seeing an improvement in this.

During Summer 2013 we face staffing challenges in our Stroke services as a result of a short term vacancy. This post will be filled on a permanent basis in September following a successful recruitment process. We are currently finalising plans for maintaining safe, effective and dignified stroke services in the interim (see Annex).

4.3 Ambulance Handover Performance

At the time of writing this paper no data has been made available in respect of West Midlands Ambulance Service handovers. Further discussions are now required urgently with the relevant operational managers to ensure timely validate data is available on a monthly basis moving forward.

4.4 Scheduled Care Access Targets

The scheduled care report details the Trust's performance at the end of May 2013 against the following standards:

- 18 weeks RTT;
- Cancer;
- Cancelled operations.

Also included is an update on the current Booking and Scheduling Programme.

4.5 18 Weeks Referral to Treatment Target (RTT) – Admitted

In the month of May the Trust failed to achieve the RTT target for Admitted patients with a performance of 78.74% against the 90% standard.

However, this is on trajectory as each of the admitted specialties is currently clearing a backlog of 18 week patients, which came about due to the significant number of cancellations of elective activity between November 2012 and April 2013. The Trust therefore will not see an improvement in Performance until the end of July.

Each centre has constructed a recovery plan which details when the specialty will be sustainable. All specialties will deliver 18 weeks RTT from 1st July 2013, with the following exceptions:

- Orthopaedics (from 1st November 2013);
- Urology (from 1st October 2013).

The overall RTT target will be completely achieved at an organisational level with effect from 1st November 2013. The reason for the delay, with delivery anticipated in quarter 3, is due to challenges within the Orthopaedics specialty.

Remedial Action Plans (RAP) are in place for the above specialties are being monitored via the weekly RTT meetings with the CCG's.

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

The Trust achieved the overall RTT target for Non Admitted patients with 95.51% against the 95% target in May. At specialty level:

- Ophthalmology did not achieve the target in May. Discussions are in place with both CCG's to provide some additional support from optometrists for a cohort of patients;
- Gastroenterology did not achieve the target due to an increase in referrals within hepatology;

Rheumatology also failed the target due to small numbers in the backlog.

4.7 18 weeks Referral to Treatment Target (RTT) – Incompletes

The target for incomplete pathways is that we should have no more than 8% of patients waiting over 18 weeks for treatment. Performance has improved since April due to more Outpatient specialties achieving the 95% target, with May position of 9.76%.

4.8 Cancer Standards

The unvalidated position for May 2013 shows that we failed to deliver one of the nine standard cancer targets; the 62 day traditional target, which was due to waits for diagnostics and complex surgery.

A cancer action plan is in place to ensure delivery of the standards from July and reduce the inconsistency in performance. There has also being considerable refocus on reinvigorated weekly escalation meetings, ensuring full attendance by each Centre and the Assistant Chief Operating Officer for Scheduled Care.

A tracking and reporting process for patients waiting 62-84 days, 85-99 days and patients over 100 days is in place and will be enhanced. Four patients currently waiting beyond 100 days and all of these are due to complex requirements.

4.9 Cancelled Operations

There were 163 cancelled operations in May 2013, of which 43 will need to be readmitted with 28 days. This is a significant improvement due to the reconfiguration of beds and the Day Surgery Unit working as normal. There were 10 patients that were not readmitted within their 28

day standard, after being cancelled in April. Centres have been reminded of the importance of this target and further validation is taking place within each Centre.

4.10 Booking & Scheduling

There are significant challenges within the Booking and scheduling service at present and therefore a Task and Finish group has been established that will drive improvement across following areas:

- Clinic templates and codes;
- Letters to patients;
- IT developments within Outpatients and day surgery;
- Choose & Book.

The introduction of a new appointments telephone system has provided auditable data; numbers of calls received and numbers of calls handled by the call centre teams. Current performance indicates that calls are being answered on first attempt, demonstrating a significant improvement in that area.

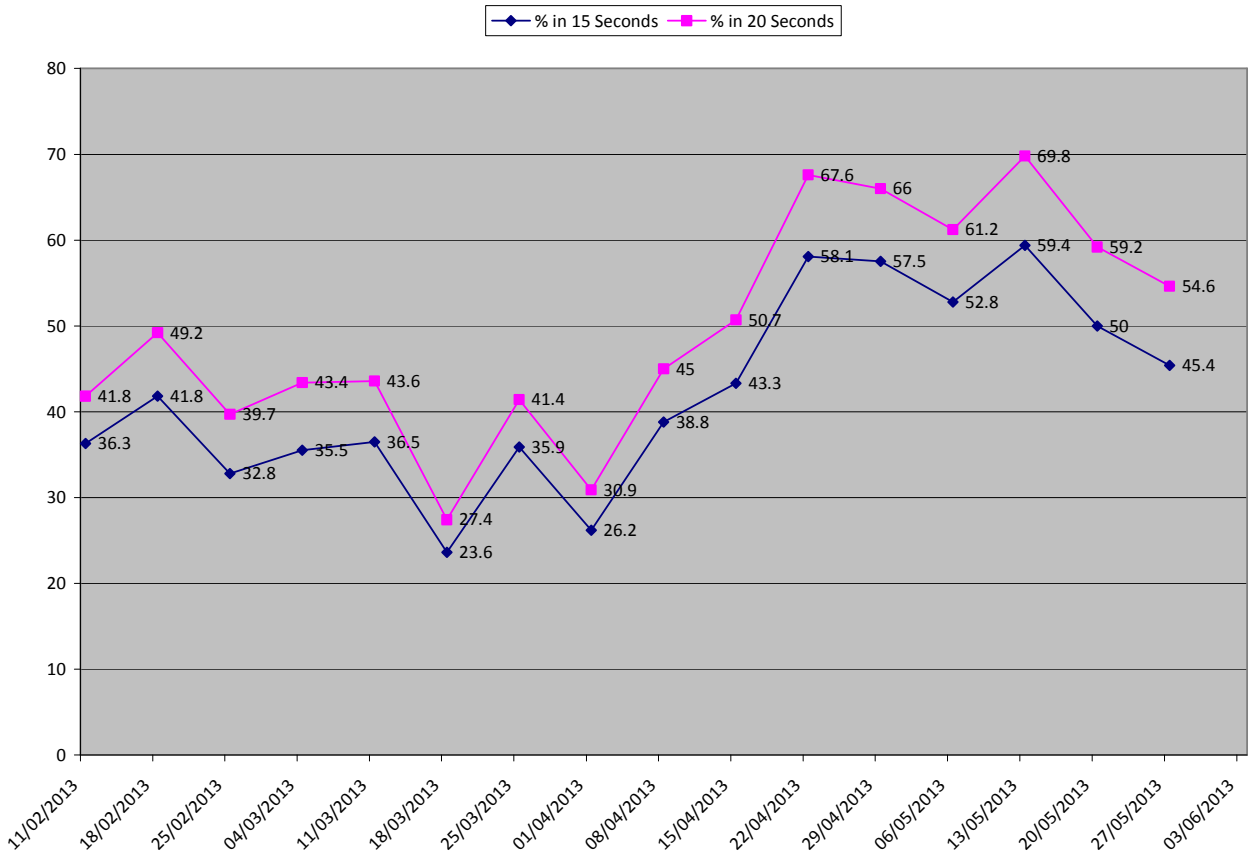
All calls should be answered within 30 seconds of the caller ringing and performance to date indicates that this is improving.

APPOINTMENT CALL PROCESSING LOG

W/C	% in 15 Seconds	% in 20 Seconds		Calls Offered	Calls Handled
11/02/2013	36.3	41.8		3705	2904
18/02/2013	41.8	49.2		3376	2926
25/02/2013	32.8	39.7		3959	3303
04/03/2013	35.5	43.4		3677	3074
11/03/2013	36.5	43.6		3139	2675
18/03/2013	23.6	27.4		3675	2803
25/03/2013	35.9	41.4			
01/04/2013	26.2	30.9		2731	2262
08/04/2013	38.8	45		3215	2811
15/04/2013	43.3	50.7		3273	2947
22/04/2013	58.1	67.6		3275	3102
29/04/2013	57.5	66		3126	2958
06/05/2013	52.8	61.2		2791	2641
13/05/2013	59.4	69.8		3250	3110
20/05/2013	50	59.2		3149	2987
27/05/2013	45.4	54.6		2370	2238
03/06/2013					

Bank Holiday

APPOINTMENT CALL PROCESSING CHART



4.11 Medical Records

23,000 sets of medical records have been merged over the last 18 months which has reduced the number of duplicate records, resulting in the fully amalgamated and correct notes being with the clinician at consultation.

The Trust failed to achieve the Choose and Book target in April, where 95% of patients should be able to book an appointment via the Choose and Book system. At present our performance is at 68%, which is significantly below the national target. A meeting has been set up with the CCG's and relevant Centre Managers to help understand and improve this position from July.

5. FINANCE

Finance Performance Summary – Month 02

Measure		Standard	Quarterly Method	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4	Data Period	Period Actual	YTD
Finance	PMR Finance Risk Rating	4	Q YTD	2	2	2	2	Mar-13	2	2
	EBITDA Achieved	85%	Q YTD	84.20%	88%	98%	87.81%	Mar-13	30.26%	26.67%
	EBITDA Margin	5%	Q YTD	2.8%	4%	4.7%	4.6%	Mar-13	0.3%	-1.3%
	I&E Surplus Margin	1%	Q YTD	-1.90%	-0.50%	0.00%	0.03%	Mar-13	-4.24%	-5.99%
	Return on Assets	5%	Q YTD	0.03%	1.20%	2.60%	3.30%	Mar-13	-0.92%	-1.22%
	Liquidity ratio	15 days	Q YTD	13.5	14.4	12.9	13.3	Mar-13		13.6
	Total Income (actual v plan)	0.5% of plan	Q YTD	99.6%	99.6%	99.90%	99.73%	Mar-13	101.24%	100.64%
	Pay Expenditure (actual v plan)	At or below plan	Q YTD	101%	102.40%	99.90%	100.27%	Mar-13	102.64%	103.69%
	Non Pay Expenditure (actual v plan)	At or below plan	Q YTD	98.04%	95.20%	100.3%	101.03%	Mar-13	104.97%	101.82%
	CIP (actual v plan)	At or below plan	Q YTD	100%	74%	98.00%	100.00%	Mar-13	60.88%	51.74%
	Capital Expenditure (actual v plan)	At or below plan	Q YTD	13%	38%	59.00%	68.00%	Mar-13	89.00%	48.00%

5.1 Budgetary Movements

Since the April Trust Board, a series of budgetary alterations have occurred, these are summarised below.

	Budget April Board March 2013	*Alterations*	*Revised Budget May 2013*
Income	300,083	336	**300,419**
Expenditure			
Pay	(207,876)	119	**(207,757)**
Non Pay	(91,839)	(712)	**(92,551)**
Reserves		-	
Cost Improvement Programme	11,875	(145)	**11,730**
Total Expenditure	(287,839)	(738)	**(288,578)**
EBITDA	12,243	(402)	**11,841**
Dividends and Amortisation	(14,671)	(400)	**(14,270)**
Surplus / (Deficit)	**(2,428)**	**-**	**(2,429)**

As can be seen the budgetary changes introduced in the month have not impacted upon the overall budgetary position of the Trust.

5.2 Month 02 Position

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

	Months 1 - 2 Budget £000s	*Month 1- 2 Actual £000s*	*Variance £000s*	*Planned Forecast Outturn £000s*	*Forecast Outturn £000s*	*Variance £000s*	*Month 1 -2 2012/13 £000s*
Income	48,800	49,112	312	300,419	300,419	-	**47,484**
Expenditure							
Pay	(34,365)	(35,021)	(656)	(207,757)	(207,757)	-	**(33,902)**
Non Pay	(14,546)	(14,555)	(9)	(92,551)	(92,551)	-	**(14,403)**
Approved Cost Improvement Programme	841	-	(841)	11,730	11,730	-	**-**
To be identified Cost Improvement Programme						-	**-**
Reserves	(1,062)	-	1,062	-	-	-	**-**
Phased Spend	(163)	(163)	-	-	-	-	**266**

	Months 1 - 2 Budget £000s	Month 1- 2 Actual £000s	Variance £000s	Planned Forecast Outturn £000s	Forecast Outturn £000s	Variance £000s	Month 1 -2 2012/13 £000s
Finance Cost	(2,310)	(2,313)	(3)	(14,270)	(14,270)	-	**(2,503)**
Total Expenditure	(51,605)	(52,052)	(447)	(302,848)	(302,848)	-	**(50,542)**
Under / Over spend	(2,805)	(2,940)	(135)	(2,428)	(2,428)	-	**(3,058)**
Transitional support	-	-	-	-	-	-	**1,483**
Surplus / (deficit)	(2,805)	(2,940)	(135)	(2,428)	(2,428)	-	**(1,575)**

At the end of May the Trust had recorded a cumulative deficit amounting to £2.94 million and planned to record a deficit amounting to £2.805 million. The Trust is presently forecasting a deficit in the year of £2.428 million. The deficit position is presently under review by the NTDA.

5.3 Pay Expenditure

The table below presents the level of Pay spending over the past twelve months. As can be seen in the period up to the end of November the 3 month moving average monthly pay spend operated within a range £16.7 to £16.8 million. Over the period December – March average monthly spend increased from £16.8 to £17.2 million. At the end of May average Pay spend increased still further to £17.4 million.

	In month £000's	3 month moving average Pay spend £000's	Spending Range £000's
April	17,033		
May	16,869		
June	16,567	16,823	
July	16,898	16,778	
August	16,742	16,736	
Sept	16,561	16,734	
October	17,020	16,774	
November	16,766	16,782	16.7 – 16.8
December	16,952	16,912	
January	17,229	16,982	
February	16,992	17,057	
March	17,298	17,173	17.0 – 17.2
April	17,591	17,294	
May	17,430	17,440	17.3 -17.4
Average monthly Pay budget (before CIP) June 2013 – March 2014	17,274		
Average Monthly Pay Budget June – March after allowing for CIP	16,431		

During the month of May Pay spending reduced to £17.43 million. The budget for the month of May, excluding the expected impact of the Trust 2013/14 Cost Improvement Programme, amounted to £17.173 million. Accordingly, in the month of May the Pay budget has overspent by £447,000.

In the two months April and May actual Pay spending has exceeded budgeted levels by £1.246 million. The average level of monthly Pay spend over the period March 2013 – May 2013 amounts to £17.44 million, in order for the Trust to deliver the Trust forecast Outturn Pay over the period June 2013 to March 2014 has to reduce to an average per month of £16.431 million.

Achievement of the Trust forecast Outturn is dependant upon the Trust reducing pay spending to budgeted levels and also delivering upon the Pay elements of the Cost Improvement Programme.

At the end of May, the net level of over establishment after allowing for vacancies amounted to 127.55 posts.

The over established posts are located predominantly across nursing budgets within the Unscheduled Care Group.

5.4 Non Pay

In the two months of April and May, the Trust overspent in respect of non pay budgets, after adjusting for CIP, by £260,000.

Using the three month average spending to establish the underlying rate of Non Pay spending indicates that the Trust has spent within a range of £7.1 to £7.3 million per month over the last twelve months.

The available monthly Non Pay budget, for the remaining months of the 2013/14 financial year, after allowing for the achievement of a Non Pay Cost Improvement Programme, amounts £7.469 million. Presently the Trust is spending at an average rate of £7.307 million.

5.5 Capital Programme

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

The Shrewsbury and Telford Hospital NHS Trust
Capital Programme 2013/14

Scheme	2013/14 Capital Budget £000's	2013/14 Spend to date £000's	Forecast Outturn £000's	Variance (under)/ over spend £000's
Reconfiguration	**20,630**	**1,136**	**20,630**	**0**
Patient Monitoring equipment	350	0	350	0
LINAC Installation works	69	0	69	0
Enabling work to implement Gender Separation	332	0	332	0
Path lab Reconfiguration	400	0	400	0
Solution re non-closure of beds to enable Recon	300	0	300	0
Other Capital Schemes	3,009	19	3,009	0
Capital contingencies	3,990	49	3,990	0
Total Discretionary Capital Schemes	**8,450**	**68**	**8,450**	**0**
Total including reconfiguration	**29,080**	**1,204**	**29,080**	**0**

The CRL for 2013/14 remains at:

- £8.450m Internally Generated CRL
- £20.630m PDC Future Configuration of Hospital Services
- **£29.080m CRL**

5.6 Cash Flow

The cash profile for the Trust is as follows:

	20013/14											
	Apr £000s	May £000s	Jun £000s	Jul £000s	Aug £000s	Sep £000s	Oct £000s	Nov £000s	Dec £000s	Jan £000s	Feb £000s	Mar £000s
Opening cash position	2102	4741	2358	1844	2655	2786	614	1398	2766	3147	3027	2326
Cash receipts	28430	26090	25691	28885	26125	26039	28617	25797	25660	28321	25612	28598
Cash outgoings	25790	28474	26205	28044	25994	28211	27833	24429	25279	28441	26313	28724
Closing cash position	4741	2358	1844	2655	2786	614	1398	2766	3147	3027	2326	2200

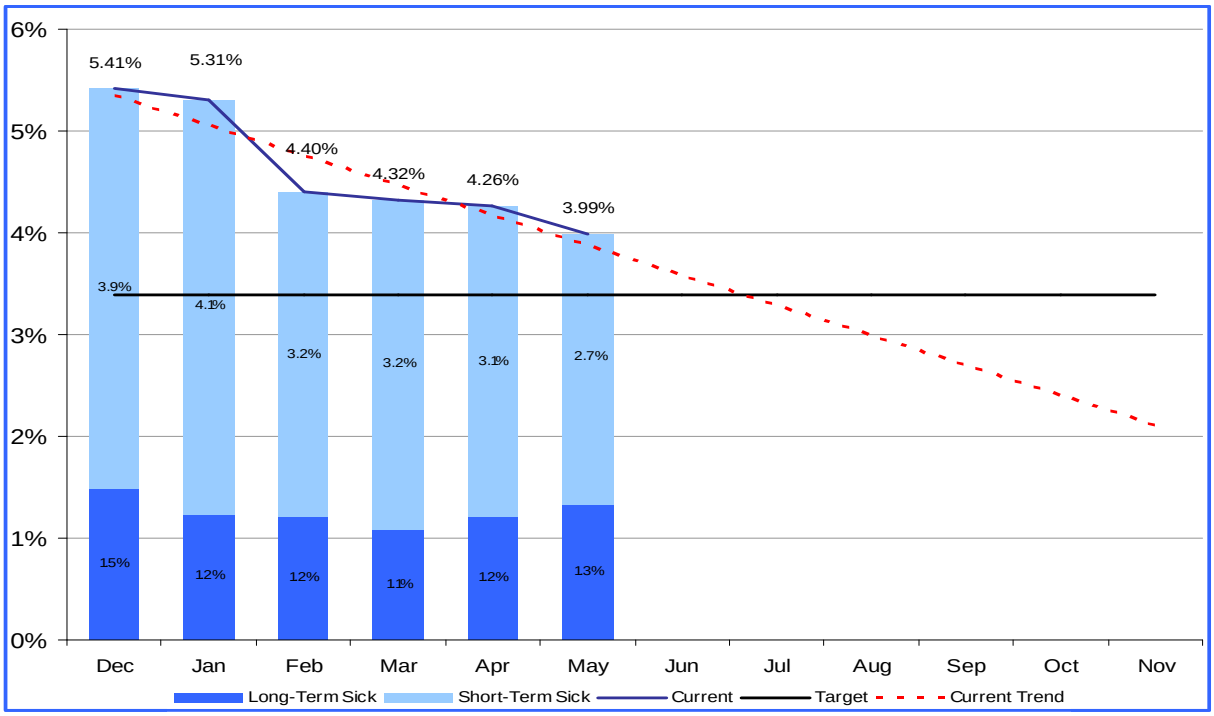
The above plan is based upon the following assumptions:

- The Trust is able to deliver an income and expenditure position in the year consistent with the forecast outturn deficit amounting to £2.4 million.
- Cash support is provided in year to cover the deficit in full.
- PDC support is provided in full to cover the costs associated with the Reconfiguration capital scheme.
- The Trust commits in full capital resources in year as presented within the Capital Programme.

6. WORKFORCE

6.1 Sickness Absence

Table 7



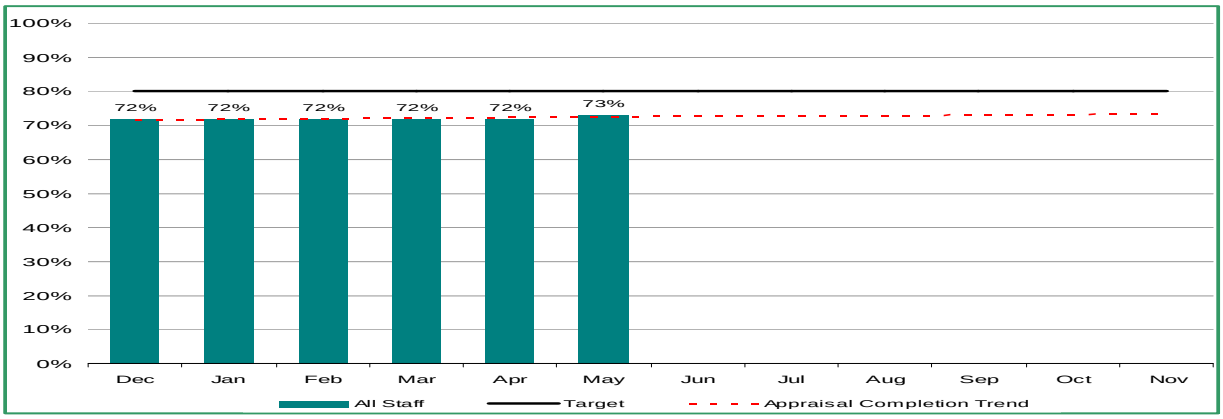
It is encouraging to see a further reduction in absence rates, absence fell to 3.99% in May. This is the first time in over two years that absence has fallen below 4% which is encouraging; this reduction has occurred in short term absence. The challenge remains further reduction and ensuring this is maintained.

15 departments within the organisation have achieved zero absence and 32 departments have an absence rate of less than 4%. The Workforce team continue to work with areas that are experiencing high absence to ensure managers and staff are supported. This focused effort is seeing a positive impact as illustrated in table 7.

6.2 Appraisals

6.2.1 Non Medical Appraisal coverage

Table 8



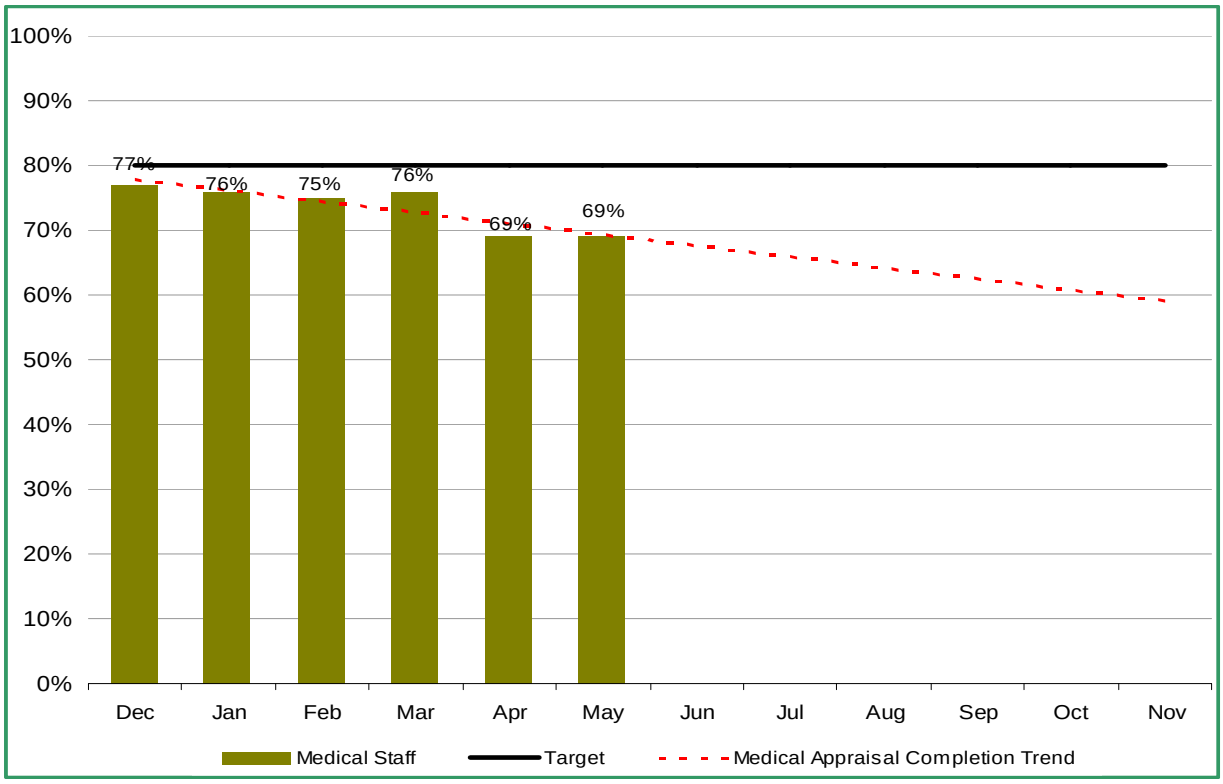
During May Non Medical Appraisal increased by 1% whilst this is a small increase it is the first time in over 5 months that an increase has occurred. This metric will be a key performance metric that will be monitored through by the Chief Operating Officer through the Operational Performance group.

Medical Appraisal Coverage

6.2.2 Medical Appraisals

Medical Appraisals remained at 69% during May, as described in April's paper the Medical Director has set clear guidance on increasing coverage which is anticipated over the firth coming months.

Table 9



7. MONTHLY SELF-CERTIFICATIONS – NTDA REQUIREMENT

7.1 Quality, Safety and National Targets

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

- 18 Weeks RTT Target (Admitted) – 1 penalty point
- 18 Weeks RTT Target (Open Clocks) – 1 penalty point
- 62 day wait for first treatment – 1 penalty point

Against the Governance Risk Rating the Trust is rated as Amber / Red with 3 penalty points compared to 6 in April, further we have an additional 4 points from the A&E override totalling 7 penalty points and an overall Governance Risk Rating of Red.

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 April.

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'***

7.4 Monthly self-certifications – NTDA requirement

The NTDA have introduced a new mandatory requirement for monthly self certifications in relation to the FT application process. The Trust has submitted self certification templates in June covering the month of May relating to:

1 Monitor Licensing Requirements – covering Monitor licence requirements. A summary of the submission is included at Appendix 2.

2 Trust Board Statements – covering a number of Board statements. A summary of the submission is included at Appendix 3.

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.

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 from time to time.

5 GOVERNANCE – NO.

The Trust had reported deficit position of £1.8 Million in April.

RTT in May was 78.74% for Admitted. Trajectories have been agreed with the NTDA to deliver the relevant targets at a speciality level between July and November 2013. RTT for non-admitted was achieved at 95.51%.

Cancer under-achieved against the 62 day pathway in month with 78.66%.

Unvalidated VTE compliance in May was below 95% target, action plans are in place to recover all the above targets.

A&E performance improved in the month of May and was achieved at 95.51% with improved performance during June to date

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.

Annex to the Integrated Performance Report

The Shrewsbury and Telford Hospital NHS
NHS Trust

Maintaining Safe, Effective and Dignified Stroke Services during Summer 2013

Benefits and continuity plan for safe and timely services

Version 1.0, 19 June 2013

Summary

- The most important message for anyone with a suspected stroke is

  "When Stroke Strikes, Act F.A.S.T."

  - FACE: Has their face fallen on one side? Can they smile?
  - ARMS: Can they raise both arms and keep them there?
  - SPEECH: Is their speech slurred?
  - TIME: Time to call 999 if you see any one of these signs

- The way that people access stroke services in an emergency will not change. As now:
  - If you dial 999 you will be taken straight to the best place to provide your care.
  - If you are referred urgently by your GP then you will be referred straight to the best place to provide your care.
  - If you walk in to A&E or another urgent care service you will be assessed and they will arrange treatment or transfer to the best place to provide your care.

- Where people receive some of their stroke care will change for a temporary period:
  - Hyper acute and acute stroke services will be provided at the Princess Royal Hospital in Telford
  - Stroke rehabilitation in an acute setting will be provided at both the Royal Shrewsbury Hospital and the Princess Royal Hospital
  - A&E services will be provided at the Princess Royal Hospital and the Royal Shrewsbury Hospital

- This is a temporary change only and we plan to return to a two site stroke service in September 2013.

- The Shrewsbury and Telford Hospital NHS Trust has taken prompt action to secure safe, dignified stroke services in the county because of short term consultant vacancies. We have already taken action to fill the vacancy and a new consultant will join the Trust in September. In the interim our doctors and nurses believe that this is the safest way to provide hyper-acute and acute stroke services in the county.

Context

Patients and communities across Shropshire, Telford & Wrekin and mid Wales expect and deserve the highest standards of stroke care that increase survival rates, improve quality by reducing disability and shortening recovery times, and improve patient experience.

The Shrewsbury and Telford Hospital NHS Trust strives for the highest standards of care, and working with patients and partner organisations we have already begun to develop a vision for the future of stroke services in the county.

However, in the short term, the services we provide for our patients face some challenges.

Specifically, following the departure of one of our specialist stroke consultants at the Royal Shrewsbury Hospital we have not been able to fill this post on a short term basis to cover the summer. **The post has been filled on a permanent basis with the new consultant joining the Trust in September.**

The challenges for the summer are compounded by a further consultant vacancy in care of the elderly and prior annual leave commitments which will reduce available staffing over the summer months. This means that unless changes are made to the service and workforce model, at times during the summer there would not be a permanently employed specialist stroke consultant at the Royal Shrewsbury Hospital.

As a result, we need to consider carefully how best to provide safe, effective, dignified stroke services in the county during July and August 2013.

What are the main features of the stroke service at the Princess Royal Hospital and the Royal Shrewsbury Hospital?

The main features of the stroke service are:

- **Hyper Acute Stroke Units** (HASU) at the Princess Royal Hospital and the Royal Shrewsbury Hospital. These provide expert specialist clinical assessment, rapid imaging and the ability to deliver intravenous thrombolysis 24/7. Patients typically need this higher level of support for up to 72 hours after admission. During this period of their treatment, patients should typically receive an early multidisciplinary assessment, including swallow screening and, for those that continue to need it, have prompt access to high-quality stroke care.
- **Acute Stroke Units (ASU)** at the Princess Royal Hospital and the Royal Shrewsbury Hospital. These provide care immediately following the hyper-acute phase, usually after the first 72 hours following admission (the hyper-acute phase) for 3 to 7 days. Acute stroke care services provide continuing specialist and multidisciplinary care, continued access to stroke trained consultant care, access to physiological monitoring and access to urgent imaging as required. In-hospital rehabilitation continues or is initiated, with rehabilitation goals identified to support planning for discharge from the acute hospital setting.
- **Stroke Rehabilitation** at the Princess Royal Hospital and the Royal Shrewsbury Hospital. This provides specialist rehabilitation tailored to the needs of the individual, supporting them to leave acute hospital.

Stroke services are supported by a wide range of other care professions including radiography, dietetics, speech and language therapy, occupational therapy, physiotherapy and many other specialties depending on individual needs.

Options

Given these short term challenges, stroke clinicians working with wider clinicians, managers and partners developed a “long list” of possible options for ensuring safe, effective and dignified stroke services during Summer 2013:

Option	Description	Assessment
Do Nothing	Take no action to address the short term consultant vacancy at the Royal Shrewsbury Hospital.	This option should be excluded as there would be no pathway or service in place for patients currently attending the Royal Shrewsbury Hospital for hyper-acute and acute stroke services.
Closure of the stroke service	Temporary closure of the Trust’s stroke services with all patients being transferred to other hospitals.	This option is not required as a local stroke service can be maintained, although temporary changes would be needed.
Permanent single site service	Move permanently to a single site service	Local clinicians agree that the best way to provide hyper-acute and acute stroke services in the longer term would be a single site, as this will offer the best opportunities to increase survival rates, and to improve quality by reducing disability and shortening recovery times. However, this should not happen in response to a short term vacancy and should instead be part of a wider plan for high quality clinical services built on engagement with patients and communities. This option was therefore excluded.
Temporary single site for all stroke services	All hospital-based stroke services (hyper-acute, acute and rehabilitation) should be based on a single site for a temporary basis	This option is not required as stroke rehabilitation can continue to be provided at both hospitals.
Temporary single site for hyper-acute and acute stroke services for three to four months	Either PRH or RSH becomes the temporary location for single site hyper-acute or acute stroke services for an extended period to enable recruitment.	This option can be discounted as the Trust has successfully recruited to the vacancy and the new consultant will join the Trust in September.
Temporary single site for hyper-acute and acute stroke services for two months	Either PRH or RSH becomes the temporary location for single site hyper-acute or acute stroke services for the minimum period. Both hospitals provide stroke rehabilitation.	This was agreed as the preferred option as it was feasible and would support service continuity. It would support more patients to receive more of their care nearer to home with the retention of rehabilitation at both hospitals, and return the service to its current shape as swiftly as possible.

Consideration of a Temporary Single Site for Hyper-Acute and Acute Stroke Services for Two Months

The preferred option is for a temporary single site for hyper-acute and acute stroke services for two months during July and August 2013. Under this option, either PRH or RSH becomes the temporary location for single site hyper-acute or acute stroke services for the minimum period. Both hospitals continue to provide stroke rehabilitation.

This was agreed as the preferred option as it was feasible and would support service continuity. It would support more patients to receive more of their care nearer to home with the retention of rehabilitation at both hospitals, and return the service to its current shape as swiftly as possible.

Following identification of a preferred option, the focus for consideration becomes the location of the single site. The following factors have been considered in reviewing options for a single site.

	Criterion	Description	Factors
1	Access and Clinical Outcomes	A fast response to stroke reduces the risk of mortality and disability. The identification of potential stroke patients and their timely admission to an appropriate stroke centre is a critical stage of the care pathway. Reduced door to needle time for stroke thrombolysis patients increases the chances of survival, recovery and reduced disability.	Ambulance service transfer time from Shropshire, Telford & Wrekin and mid Wales to Hyper Acute Stroke Service Ability to maintain clinical outcomes at current levels if not better
2	Patient experience	Our aspiration is to provide high standards of dignified care for every patient and the people who care for them, which includes maximising opportunities for joined up care.	Accessibility for carers and relatives Satisfaction of joined up care between home, hospital, community Number of steps in the pathway (e.g. same or separate locations for HASU/ASU and rehabilitation)
3	Feasibility and deliverability	It must be feasible to deliver the temporary service, taking into account factors such as capacity (e.g. physical space), capability (e.g. specialist skills) and business continuity (e.g. maintaining service standards during any period of change).	Capacity to accommodate the service Effectiveness of business continuity plans Opportunity cost
4	Wider impact	The wider impact on other services must also be considered (for example, if another service would need to move to accommodate a single site stroke service then this will have additional risks and benefits)	Impact on safety and sustainability of other services

Assessment of Single Site Options

The opportunity for temporary provision of single site hyper-acute and acute stroke services has been considered at both the Princess Royal Hospital and the Royal Shrewsbury Hospital. The high level impact assessment is summarised below.

Option	Princess Royal Hospital	Royal Shrewsbury Hospital
Access and Clinical Outcomes	• Based on ambulance journeys for suspected stroke patients between 1 July 2011 and 30 June 2012, 92% live within 1 hour of the Princess Royal Hospital. • Stroke service performance is currently better at the Princess Royal Hospital and clinicians have identified steps that could reduce door-to-needle time for thrombolysis patients to mitigate increased travel time for some patients. • There is greater continuity of staffing at the Princess Royal Hospital during the summer, supporting continuity of clinical care.	• Based on ambulance journeys for suspected stroke patients between 1 July 2011 and 30 June 2012, 99% live within 1 hour of the Royal Shrewsbury Hospital. • Stroke service performance at the Royal Shrewsbury Hospital is lower than at the Princess Royal Hospital. Continued pressures on emergency services may create risks in relation to timeliness of assessment on arrival to hospital if stroke services moved to a single site at RSH. • There are significant gaps in continuity of staffing at the Royal Shrewsbury Hospital during the summer.
Patient Experience	• Both options would present a similar impact on patient experience (other than the issues identified above in relation to access). • More patients will be receiving more of their stroke care from a single-site hyper-acute and acute stroke service, and therefore more patients will be further from home and their local services than now. This will impact on links with local services and accessibility for carers and relatives. However, the opportunity to transfer patients to their most local hospital for stroke rehabilitation will continue to be available as both hospitals will continue to provide this service. This means that many patients will continue to be in the same hospital as now for this rehabilitation phase prior to their return home or to local residential/nursing support.	
Feasibility and delivery	• There is scope to create short-term capacity for single site stroke services at the Princess Royal Hospital swiftly and safely with minimal impact on other services. • There are currently no consultant staffing gaps in the stroke service at the Princess Royal Hospital, and there are clinical and risk benefits from building on this continuity.	• Currently there would not be sufficient capacity to enable a single-site stroke service to be accommodated at the Royal Shrewsbury Hospital without also making changes to other services. • The Royal Shrewsbury Hospital faces the most significant challenges during the summer in relation to stroke consultant staffing.
Wider impact	• The service can be accommodated within the Princess Royal Hospital within minimal impact on other services.	• Changes to other services would also be needed to accommodate a single-site hyper-acute and acute stroke service at the Royal Shrewsbury Hospital. It is unlikely that additional service moves could be achieved appropriately in time for the temporary move to single-site hyper-acute and acute stroke services.

The issues of clinical outcomes and feasibility were identified as critical factors in making a decision on a short-term single site. Given the continuity of staffing at the Princess Royal Hospital, and the significant challenges and risks in the RSH option, clinical and operational managers have recommended the temporary establishment of a single-site hyper-acute and acute stroke service at the Princess Royal Hospital.

This recommendation has been subject to detailed scrutiny and challenge by the Trust's clinical and management executive who have endorsed this recommendation.

Longer Term Plans for Stroke Services

The recent review of stroke services across the Midlands and East of England recommended that hyper-acute stroke services should be provided by services seeing at least 600 stroke patient admissions each year, supported by a seven day a week specialist stroke workforce.

Locally, hyper-acute stroke services are provided from two sites each seeing in the region of 450 stroke patient admissions each year. There is a strong view amongst our clinical staff that moving to a single centre of excellence for hyper-acute and acute stroke services will create the conditions for improved clinical outcomes for stroke patients through increased survival, and increased quality by reducing disability and shortening recovery times. It will support the local NHS to develop and maintain a specialist 7-day workforce (currently 5-day) ensuring rapid and daily access to specialist expertise for stroke patients during a critical period of their treatment and recovery.

Providing services from two smaller sites reduces the ability of the local NHS to recruit and retain sufficient specialist workforce to develop and maintain a 7-day service, including having the capacity and resilience within the workforce to cover periods of short term vacancies and other leave. The current short-term challenges facing our stroke services are a further indication of the potential benefits from moving to a single site service in the longer term.

However, we do not propose that a decision to move to a permanent single site service (and the location of that service) should be made in response to a short term staffing gap. Instead, the clinically-led recommendations developed with patient and community engagement following the Midlands and East Stroke Services Review need to be debated and tested more widely, and considered alongside wider challenges and opportunities for improving clinical outcomes, patient safety and patient experience in the county's hospital services and beyond.

This should therefore be a short-term change to stroke services at this stage, but all opportunities should be taken for reviewing and learning to shape future stroke services.

Note that during this short-term change the service will continue to operate on the current 5-day consultant-staffing model (as now) whilst our aspirations for a longer-term single-site model are for a 7-day consultant service.

Despite pursuing multiple approaches to recruiting to the short term vacancy at the Royal Shrewsbury Hospital, the Trust has not been successful in filling this post during the summer. We have been successful in making a permanent appointment to the role, and the new consultant will join the Trust in September. However, in the meantime it has not been possible to guarantee locum cover with specialist stroke skills and alternative measures need to be taken to secure safe, effective and dignified stroke services during the summer.

Quality Assurance and Benefits Realisation

The key features of quality assurance and benefits realisation include:

- Striving always to be relentless in our pursuit of the patient's interests.
- Ensuring rapid delivery of a single site stroke service, including effective project delivery and risk management.
- Identifying opportunities for pathway improvement for those patients who will face a longer transfer time to hospital (e.g. reduced "door to needle time").
- Ensuring minimal adverse impact on service continuity both within stroke services and beyond.
- Developing and agreeing interim protocols both "in hospital" and with partners (e.g. ambulance services).
- Engaging with our patients and the people who care for them to ensure that we learn and improve continuously.

Theme	Commentary
Project delivery and risk management	Project and risk management is being led by our Unscheduled Care Group under the leadership of Care Group Medical Director Dr Kevin Eardley and Assistant Chief Operating Officer (Unscheduled Care) Ian Donnelly with day-to-day delivery by the Trust's stroke clinicians and operational managers. A project plan is in place to achieve the short term change and the return to two site delivery, with regular reporting to Care Group and executive level. A clinical workforce plan provides assurance in relation to the levels of stroke/BASP-accredited consultant physicians and specialty doctors available during the summer. A Quality Impact Assessment has been developed for review and scrutiny by the Trust Medical Director and Chief Nurse. This guides the priorities of the service and the Trust as a whole to maintain standards of quality of care during this temporary change. Updates on progress and delivery will be provided to commissioners on a monthly basis (or by exception).
Thrombolysis	Around 1 in 10 stroke patients are identified as clinically suitable for stroke thrombolysis. During this change we estimate that there will be in the region of 120-150 stroke patients attending our hospitals, of which 12-15 would be appropriate for thrombolysis (for example, from our Montgomeryshire catchment we would expect in the region of 10 stroke patients and on average around 1 of these would be appropriate for thrombolysis). Stroke thrombolysis will be provided at the Princess Royal Hospital (with out-of-hours support from the regional telemedicine rota). Thrombolysis accredited physicians will remain in place at the Royal Shrewsbury Hospital to provide support in an emergency situation. Clinicians are identifying opportunities to further reduce the "door to needle" time at the Princess Royal Hospital during the temporary change to further mitigate any potential impact from increased travel time for patients from the west of the Trust's catchment.

Triage, transfer and ambulance protocols	Temporary protocols are being developed with West Midlands Ambulance Service and Welsh Ambulance Service to support identification and transfer of suspected stroke patients. Similar protocols will be in place with other referring services (e.g. Care Co-ordination Centre, ShropDoc and other urgent care providers). Information about the changes will be cascaded to local GPs via Clinical Commissioning Groups, and also shared with other key partners in the delivery and planning of local health and care services (e.g. Shropshire Community Health NHS Trust).
TIA services	Currently patients are referred to the next day TIA clinic slot, so regardless of where they live this may be PRH or RSH depending on the location of TIA clinics that day. Patients will still be referred to the next available clinic slot, which will be at PRH during this temporary move.
Specialist nursing support and consistency of practice	The Trust's two specialist stroke nurses will work on a hub and spoke basis from the single-site hyper-acute and acute stroke service at the Princess Royal Hospital, providing senior support for the Royal Shrewsbury Hospital to ensure appropriate identification, stabilisation, transfer and repatriation of patients – particularly those that attend RSH (e.g. A&E walk-in patients). This will support consistency of practice, and where patients do arrive at RSH (e.g. walk-in patients, or where stroke had not previously been suspected) there will be clinical input from a stroke specialist bleep holding nurse providing assessment, stabilisation and transfer if required. The majority of patients attending in this way are "stroke mimics" rather than actual stroke, and pathways will be in place for the both stroke and non-stroke patients attending RSH.
Specialty support	Relevant support services such as therapies and radiology are integral to the planning and delivery process. For example, radiology services will be providing a specialist trained sonographer on each shift to support rapid diagnosis of suspected stroke patients. CT capacity is sufficient at PRH following the move of acute surgical services to RSH in July 2012. Planned downtime and maintenance will be avoided during July and August to ensure maximum capacity and continuity of access to CT diagnostics. Clinical workforce planning has also encompassed availability of therapy input for acute stroke patients.
Repatriation following acute phase	Pathways are in place for the transfer of patients as appropriate from the Princess Royal Hospital to the Royal Shrewsbury Hospital following their initial acute care for their stroke rehabilitation. Patients local to the Royal Shrewsbury Hospital will continue to be able to receive their stroke rehabilitation at the RSH[1].

[1] Note that on occasions this may not be possible or appropriate, for example where there are clinical benefits for the patient's recovery and continuity of care to remain at the Princess Royal Hospital.

PbR Impact	The temporary change will have a cost-neutral impact for local commissioners in relation to the contract with The Shrewsbury and Telford Hospital NHS Trust.
Benefits potential	Whilst this is a short-term change to address a clinical service continuity risk during Summer 2013, there are potential unintended opportunities or benefits for the ongoing development of stroke services in the county: • The delivery on a temporary basis of single site stroke services provides opportunities for learning and review that will contribute to future consideration of the longer term model of safe, effective stroke services in the county. • We intend to offer every patient / relative / carer the opportunity to engage with the Trust to review their experience both to ensure early identification and action in relation to patient experience or wider quality issues in relation to their own care. This drives patient-led improvements at three levels: firstly, for the individual patient; secondly, for all patients through the two month temporary period; and thirdly, to identify lessons in the event of a future move to single site hyper-acute and acute stroke services. • When individual hospitals face surges in demand or capacity challenges there is on occasion a temporary transfer of ambulance arrival (e.g. overnight) for stroke patients to the site that has the capacity and capability to ensure best access to specialist care. A fixed-term move for two months provides learning for these occasions to continue to strengthen the quality of the services we provide and improve resilience.

This is a summary of our plan for maintaining, safe effective and dignified stroke services during summer 2013. We welcome your feedback and input to help us ensure that patients and communities across Shropshire, Telford & Wrekin and mid Wales continue to receive the highest standards of stroke care that increase survival rates, improve quality by reducing disability and shortening recovery times, and improve patient experience.

Contact details for feedback:

- In writing: Ian Donnelly, Assistant Chief Operating Officer, Unscheduled Care Group, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ

- By email: consultation@sath.nhs.uk

Communications and Engagement

Communication and engagement with patients and communities, and with the individuals and organisations that provide their services and represent them, is vital.

- The most important message for anyone with a suspected stroke is

  "When Stroke Strikes, Act F.A.S.T."

  - FACE: Has their face fallen on one side? Can they smile?
  - ARMS: Can they raise both arms and keep them there?
  - SPEECH: Is their speech slurred?
  - TIME: Time to call 999 if you see any one of these signs

- The way that people access stroke services in an emergency will not change. As now:
  - If you dial 999 you will be taken straight to the best place to provide your care.
  - If you are referred urgently by your GP then you will be referred straight to the best place to provide your care.
  - If you walk in to A&E or another urgent care service you will be assessed and they will arrange treatment or transfer to the best place to provide your care.

- Where people receive some of their stroke care will change for a temporary period:
  - Hyper acute and acute stroke services will be provided at the Princess Royal Hospital in Telford
  - Stroke rehabilitation in an acute setting will be provided at both the Royal Shrewsbury Hospital and the Princess Royal Hospital
  - A&E services will be provided at the Princess Royal Hospital and the Royal Shrewsbury Hospital

- We are committed to working with patients and their loved ones during this temporary change to ensure that they continue to provide the highest standards of care. Let us know your experiences of stroke services during the summer so that we can use this to improve the way we provide your stroke care now and in the future.

- This is a temporary change during summer 2013 only. This is not a permanent change to the way we provide stroke services. Whilst our clinicians believe that providing hyper-acute and acute stroke services from a single site in future will offer benefits for patients in terms if increased survival, reduced disability and shorter recovery times, a decision on the longer term shape of stroke services should be based on a wider debate across the county.

Key audiences include patients and the individuals/organisations who support and represent them, Trust staff, individual and bodies representing the public interest in health services (e.g. Local Healthwatch, Community Health Councils, Health Overview and Scrutiny Committees), partners in the delivery and planning of health and care services.

			
Has their face fallen on one side? Can they smile?	**Can they raise both arms and keep them there?**	**Is their speech slurred?**	**Time to call 999 if you see any one of these signs**

The Shrewsbury and Telford Hospital NHS Trust

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