Reporting to:	Trust Board Meeting - 25th July 2013
Title	Integrated Performance Report - June 2013
Sponsoring Director	Peter Herring, Chief Executive
Author(s)	Peter Herring, Chief Executive
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 2013/14 and considers all elements of performance.
Strategic Priorities ☒ Quality and Safety ☒ Healthcare Standards ☒ People and Innovation ☐ Community and Partnership ☒ Financial Strength	**Operational Objectives** QS1 - Reduce avoidable deaths QS2 - Improve the nutritional status of patients and hydration and fluid management QS3 - Enhance communication and information for all patients and their carers QS4 - Eradicate all avoidable grade 3 and 4 pressure ulcers QS5 - Reduce the number of RIDDOR reportable falls HS3 Deliver all key performance targets PI1 - Implement a Staff Engagement Framework that improves employment experience and reduces absence to less than 4% FS1 - Deliver our milestones to achieve NHS Foundation Trust status FS3 - Deliver a financial surplus of £1.2m FS4 - Deliver the Trust 5% implied efficiency target and support delivery of joint QIPP
Board Assurance Framework (BAF) Risks	☒ Deliver Safe Care or patients may suffer avoidable harm and poor clinical outcomes and experience ☒ Achieve safe and efficient Patient Flow or we will fail the national quality and performance standards ☐ Clear Clinical Service Vision or we may not deliver the best services to patients ☒ Good levels of Staff Engagement to get a culture of continuous improvement or staff morale and patient outcomes may not improve ☐ Appoint Board members in a timely way or may impact on the governance of the Trust ☒ Achieve a Financial Risk Rating of 3 to be authorised as an FT

Care Quality Commission (CQC) Domains	Outcomes
☒ Safe ☐ Effective ☒ Caring ☒ Responsive ☒ Well led	SAFE 8: Cleanliness and infection control - People should be cared for in a clean environment and protected from the risk of infection. CARING 4: Care and welfare of people who use services - People should get safe and appropriate care that meets their needs and supports their rights. RESPONSIVE 5: Meeting nutritional needs - Food and drink should meet people's individual dietary needs. WELL- LED 16: Assessing and monitoring the quality of service provision - The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care. 14: Supporting workers - Staff should be properly trained and supervised, and have the chance to develop and improve their skills.
☒ **Receive** ☒ **Review** ☐ **Note** ☒ **Approve**	**Recommendation** The Trust Board is asked to CONSIDER performance for June 2013 and APPROVE the self ceritification submissions.

INTEGRATED PERFORMANCE REPORT – MONTH 3 2013/14

1. OVERVIEW OF PERFORMANCE

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. The Trust currently has a medium concern placed on PRH following an Inspection in April. The report was published in June 2013.

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	June
	Risk Adjusted Mortality Index (RAMI)	<100	**94**	**Jan 13 Sath = 98 NP = 94**	***Feb 13 Sath = 102 NP = 95**	**Mar 13 Sath = 104 NP = 103**
	RIDDOR reportable Falls (20% reduction)	< 15	**20**	**4**	**1**	**1**
	Grade 3 avoidable Pressure Ulcer	0	**28**	**1**	**0**	**1**
	Unavoidable grade 3 pressure ulcers		**11**	**2**	**0**	**2**
	Grade 4 Pressure Ulcer	0	**13**	**0**	**0**	**0**
	C-Diff	27	**45**	**1**	**2**	**2**
	MRSA Bacteraemias	0	**1**	**0**	**0**	**0**
	MSSA Bacteraemia	21	**24**	**3**	**5**	**3**
	E-Coli	40	**45**	**5**	**3**	**10**

	Elective MRSA Screening	95%	**N/A**	**93.7%**	**93.9%**	**94.88%**
	Non Elective MRSA Screening	95%	**N/A**	**94%**	**94.3%**	**95.84%**
	Number of Serious Incidents	<36 per Quarter	**174**	**31**	**8**	**12**
	Never Events	0	**2**	**0**	**0**	**0**
	WHO Surgical Checklist	100%	**99.96%**	**100%**	**100%**	**100%**
	VTE Assessment	95%	**90.48%**	**90.10% (Mar)**	**89.3% (Apr)**	**90.56% (May)**
	Maternity Dashboard	Green		**Amber**	**Amber**	**Green**
Patient experience	Number of patient complaints	Actual	**671**	**55**	**56**	**44**
	Access to Healthcare for people with LD	Yes		**Yes**	**Yes**	**Yes**
	Same Sex Accommodation Breaches	0	**0**	**0**	**0**	**4**
	Friends & Family Test	75	**77**	**75**	**82**	**81**

*RAMI figures for May have changed – this is due to re-submissions in other Trusts of HES data and does sometimes happen.

A summary of patient outcome measures agreed for the Board are outlined in Table 1 above. Additional patient specific metrics are outlined in Table 7 and 8 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 Board's attention are as follows:

Patient Safety and Effectiveness

3.2 **Serious Untoward Incidents**

There were 12 SIs reported in June 2013; of which 11 related to clinical effectiveness and 1 which was operational in nature. The most common SIs by category was; Infection control issues which are outlined in this report.

Of the 3 pressure ulcers reported, 'rapid review' has identified that 2 were unavoidable based on the agreed criteria. The Trust has taken steps to have these downgraded which is subject to Commissioner discussion.

The end of year figures (12/13) for avoidable pressure ulcers have been readjusted following a meeting held between the Trust and the Commissioners in July 2013. Of the 13 pressure ulcers presented in this meeting regarding 12/13, all of these were agreed which adjusts our total of avoidable pressure ulcers from 41 to 28 for 12/13. The number of SIs recorded for this period will remain due to the retrospective nature of the review.

3.3 **Pressure Ulcers (PUs)**

There have been 6 Grade 3 pressure ulcers reported since April 2013; however since being reported and following robust review of the records and PUs, it has been evidenced that:

April 2013 – Of the 3 PUs reported, 1 was unavoidable and 1 was mis-reported. This leaves 1 trust acquired PU for April 2013.

May 2013 – There were 0 Trust acquired PUs.

June 2013 – There were 3 Grade 3 PUs reported of which 2 were identified as unavoidable, leaving 1 trust acquired PU.

The Trust now has a prospective process where all pressure ulcers will be formally reviewed within 24- 72 hrs to agree whether the pressure ulcers were avoidable or unavoidable. All pressure ulcers will therefore be recorded initially as level 0 to enable for this review.

Table 1 has been readjusted to outline the performance of avoidable pressure ulcers as the key Quality Indicator.

There have been no grade 4 pressure ulcers in 2013/14 to date and it is 230 days (as of 15th July 2013) since the last grade 4 pressure ulcer and 34 days (as of 15th July 2013) since the last avoidable grade 3 pressure ulcers.

3.4 **Falls**

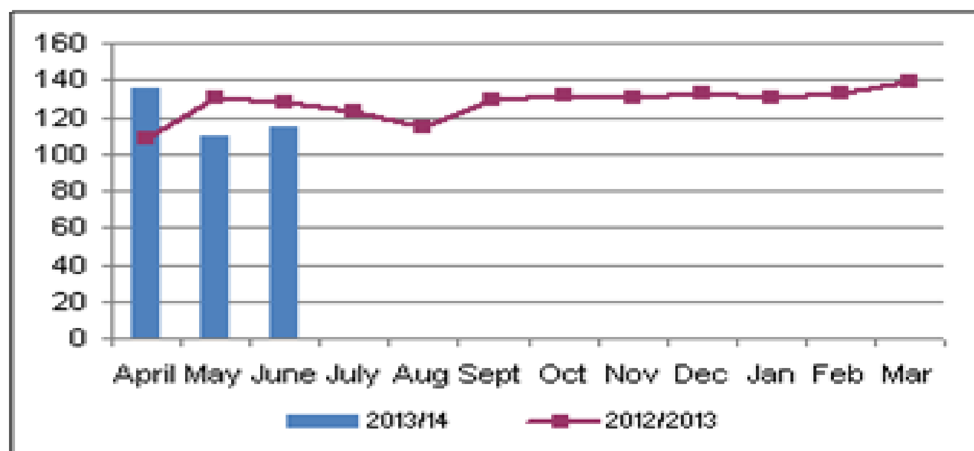
There was a slight increase in the total number of falls reported from May to June 2013; however overall there is a decrease in reporting for the first quarter of 2013/14 when compared with 2012/13.

The measurement of falls per/1000 bed days is being compiled and will be benchmarked against national figures. This information will be presented to the Falls Task Group.

There was 1 RIDDOR/SI reportable fall in June in AMU (RSH) which resulted in the patient sustaining a fracture to her neck of femur. A full investigation and Root cause analysis is being undertaken to gain a full understanding of the circumstances and whether this fall could have been prevented.

For the second consecutive month Ward 4 reported the highest number of falls. As an acute stroke ward which provides initial rehabilitation following stroke, ward 4 does have a number of falls consistently reported, however, this has been escalated to the Ward Manager and Matron for detailed review.

Table 2



3.5 Infection Control

3.5.1 It is 15 months since the last MRSA Bacteraemia.

3.5.2 The Internal action plan to drive the C-Difficile numbers down is being actively managed and current performance is within trajectory.

3.5.3 E-coli outcomes for June are higher than usual figures and the Infection Control Committee review this area of performance closely. Currently, the IPC team and DIPC are analysing the potential rationale for this and benchmarking in relation to previous trends and outcomes. There are no obvious reasons at this time for the increasing numbers for this month.

3.5.4 Compliance in emergency admission screening for MRSA has significantly improved to 95.8% in June. Both AMU ward managers have put systems in place to achieve this improvement. All wards receiving patients from the AMUs and SAU have been instructed to make sure that these patients are screened before transfer and if not to undertake a screen. The daily readout of unscreened patients continues to be sent to Ward Managers for action via the automated SQL report.

3.5.5 Elective MRSA screening has improved in June to 94.88% and the actions being taken to support that increase will continue to achieve the required screening compliance. Each month the list of unscreened elective patients is reviewed by the Infection, prevention and Control team (IPCT) to check that the coding is correctly identifying patients who need screening. There are usually some issues related to new codes being used which do not assist in the collation of our elective figures. The IPCT are also able to identify which areas or procedures are currently missing patients and may require further input from the team. In June Oncology missed 19 patients so IPCT will be discussing this issue with them

3.6 WHO safer surgical check list

Performance remains at 100% and the Board are asked to note that it has been agreed that the audits will move to bi-monthly. The summary table (Table 1) will indicate where it is a non audit month where applicable. The focus in 13/14 will be to sustain the 100% in the check list in Theatres and also drive practice for the WHO safer procedures check list.

3.7 Same Sex Accommodation Breaches (SSA)

There were 4 SSA breaches during June 2013 that occurred on Ward 23H. The breach involved 1 female patient being moved to a bay of 3 male patients; therefore this one move affected 4 SSA breaches. A root cause analysis has been undertaken by the ward Matron to determine the rationale as to why the patient was moved and why the breach occurred. The outcome of the report highlighted that the breach was due to a lack of capacity for female haematology beds on Ward 23H.

3.8 Current Status – Mortality

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

3.8.1 Summary Hospital-level Mortality Indicator (SHMI) (Changes every quarter)

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 3 below shows the rolling 12 months trend in SHMI.

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

3.8.2 Risk Adjusted Mortality Indicator (RAMI)

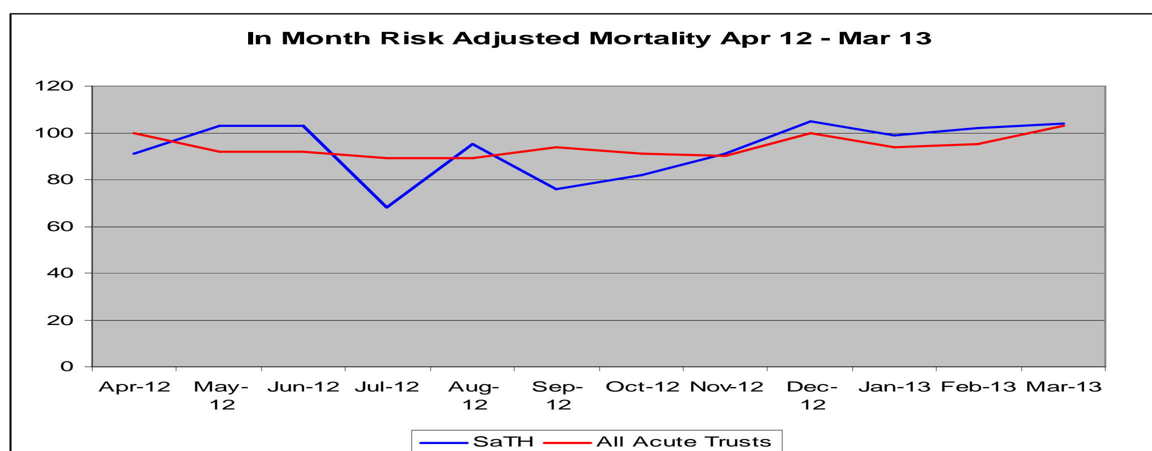
We have transferred from Dr Foster to the CHKS reporting tool as of April 2013. The CHKS tool uses a different methodology for reporting mortality called Risk Adjusted Mortality Indicator (RAMI). The RAMI is similar to the HSMR in that it can be used to benchmark progress against other organisations; 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



The table below shows the actual in month RAMI for SaTH and the National Peer Group of all Acute Trusts in England. The latest 12 months RAMI (Apr 12 – Mar 13) is 94 against the National Peer Group with 94.

Table 5

RAMI Apr 12 - Mar 13		
Time Period (Monthly)	SaTH	All Acute Trusts
Apr-12	91	100
May-12	103	92
Jun-12	103	92
Jul-12	68	89
Aug-12	95	89
Sep-12	76	94
Oct-12	82	91
Nov-12	91	90
Dec-12	105	100
Jan-13	99	94
Feb-13	102	95
Mar-13	104	103

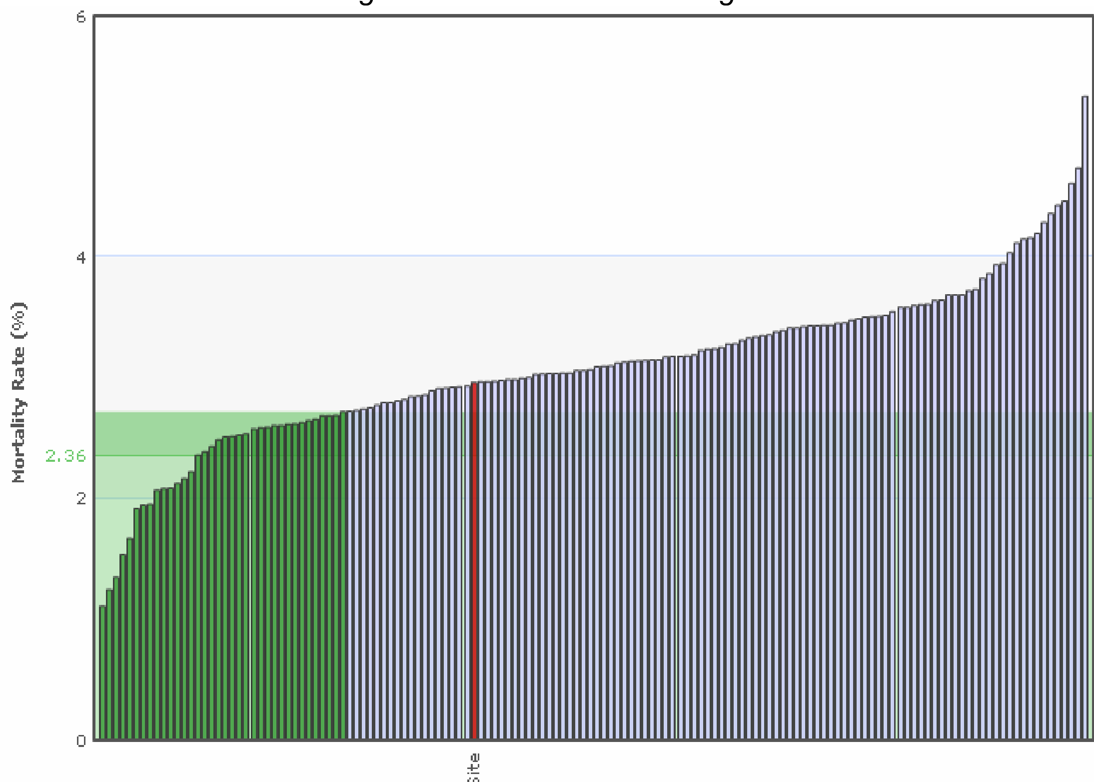
3.8.3 **Crude Death Rate as a Percentage of Spells – Non Elective**

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.

Table 6

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 2.96% of spells
Trusts highlighted in green = top quartile 2.72% or less (Top 10% at 2.36% or less)
Highest = 5.33% of spells

The trends over the last 4 months have shown that nationally there is an increase in crude mortality as a percentage of spells; however the increase has been less at SaTH in comparison. As such our position has slowly moved closer the upper quartile.

3.8.4 Mortality Group

The formal mortality group has been established successfully with membership being all the Governance Leads from each Specialty area, Clinical Coding and CCG/GP representation.

The overall purpose of the group is to:

- Provide an independent review of action plans derived from the Centre governance meetings
- To communicate a consistent view of the status of mortality improvements across SaTH
- Provide a link between Centres for sharing and communicating clinical improvements generated as a result of mortality reviews
- Prioritise and lead action to reduce mortality and associated issues

To fulfil its purpose the group has agreed:

- To develop a consistent and robust review of deaths process across all Specialties with common CESDI outputs
- To establish a small panel to undertake specific targeted reviews of areas of concern or potential concern
- To set up a process for acting on case note reviews with CESDI score of 3 (probable avoidable death)
- To set up a 2 way communications process between Specialty governance meetings and the Mortality group. Specialty governance leads will report to each mortality group meeting any trends and learning from their processes to review deaths. These will be consolidated, along with trends and learning from the specific targeted case note reviews and communicated back to Specialty meetings for discussion/review.

The mortality group has initiated specific targeted case note reviews, which will report back in October 2013 of:

- Deaths with a primary diagnosis of UTI
- ED deaths that are within 30 days of discharge from Hospital as part of the National SHMI mortality indicator analysis
- Microbiology review of deaths within a diagnosis of UTI and Pneumonia

Next targeted case note reviews will focus on:

- 30 day Post discharge deaths in the community as part of the ongoing SHMI analysis
- Deaths with a primary diagnosis of Pneumonia

In addition a statistical analysis is taking place around the impact on mortality of longer waits in the ED.

3.9 **VTE**

The rate of reported VTE assessments across the Trust for May 2013 is **90.1%** 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 June 2013 shows a significant improvement on previous months with a Vitalpac snapshot average of 89.5% which is the highest ever. With the inclusion of the low risk cohort groups and day surgery we expect to be near 95%.

3.10 **Patient Experience and Clinical Outcomes**

Table 7& 8 outline the outcomes from our review of notes on each ward and our discussion with a number of patients each month. Our review of clinical notes demonstrates that fluid management and patient observations continue to be the two key areas that require further discussion to drive improvements
In recognition of this performance, nutrition and fluid management are one of the Trusts priorities for 13/14 and a Nutritional group has been commissioned to progress this.

From our discussion with patients we clearly need to continue to improve the support we provide for patients around their discharge planning and to ensure that patients and their family are fully involved and kept up to date with their treatment plan and discharge arrangements. Both the Scheduled and Unscheduled care groups will be reviewing this in detail over the next 2 months to drive improvements.

The Family and Friends test which has been revised nationally to identify the level of patient's confidence in the care we provide through a star based system. Appendix 1 provides a summary table of the information collated in June and identifies from our patients the best and worst performing wards for this period.

3.11 **External Feedback and Assurance**

There has been no external feedback or assurance visits in June 2013.

3.12 **Wards subject to a Quality Improvement Framework**

Three wards are currently subject to a Quality Improvement Framework, ward 10, 12 and 22T/O. Each of the wards is 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. The summary reports are also reported to the PEIP meeting to provide feedback and assurance to the group. The wards on a QIF also have been visited by members of the corporate nursing team who have conducted Clinical Quality ward rounds. The ward rounds will serve to provide an additional level of assurance as to the standards of clinical care being delivered and provide an opportunity for the corporate team to get feedback from nursing teams on a variety of nursing, quality and safety issues.

Ward 10 and ward 22T/O will be taken through a detailed review in August to determine a collective level of assurance and a de-escalation from the Quality Improvement Framework. Ward 12 will continue on the formal framework and a detailed review undertaken in September.

3.13 **Rule 43**

There have been 2 Rule 43 reports in June 2013. These came from HM Coroner for Bridgend and Glamorgan and also HM Coroner for the Mid & Northwest Shropshire District.

Table 7: Ward to Board Patient Care Metrics June 2012 – June 2013

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

Table 8: Ward to Board Patient Experience Metrics June 2012 – June 2013

	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Apr 2013	May 2013	Jun 2013
As far as you know do the staff wash or clean their hands between touching patients?	95%	94%	96%	96%	96%	97%	96%	96%	98%	97%	97%	96%	97%
Do you feel informed about potential medication side effects?	65%	65%	72%	64%	72%	83%	76%	86%	82%	75%	72%	77%	85%
Do you feel involved in decisions about your treatment and care?	77%	78%	77%	79%	84%	89%	86%	87%	89%	84%	81%	87%	86%
Do you feel that you have been treated with respect and dignity while you are on this ward?	98%	93%	95%	94%	95%	96%	97%	95%	97%	97%	94%	98%	95%
Do you feel you have enough privacy when discussing your condition or treatment with staff?	85%	83%	86%	85%	86%	91%	91%	87%	93%	86%	84%	88%	93%
Do you get enough help from staff to eat your meals?	98%	87%	90%	95%	98%	95%	92%	85%	99%	92%	97%	96%	97%
Do you think hospital staff do everything they can to help control your pain?	89%	90%	89%	87%	93%	95%	92%	90%	96%	91%	91%	95%	93%
Have hospital staff been available to talk about any worries or concerns you have?	90%	90%	86%	91%	93%	93%	90%	89%	92%	87%	89%	92%	91%
Have staff talked to you about your discharge from hospital?	63%	65%	68%	68%	64%	71%	72%	75%	73%	69%	68%	69%	67%
How clean is this ward (including toilets)?	95%	95%	96%	96%	96%	97%	97%	97%	98%	95%	96%	96%	97%
When you use the call buzzer is it answered?	89%	87%	90%	90%	87%	91%	90%	89%	91%	90%	90%	91%	95%
Whilst you have been on this ward have you ever shared a sleeping area with a member of the opposite sex?	98%	99%	99%	97%	97%	98%	99%	97%	100%	98%	96%	100%	100%
Total	**86%**	**86%**	**87%**	**86%**	**88%**	**91%**	**90%**	**90%**	**92%**	**88%**	**87%**	**90%**	**91%**

4. OPERATIONAL PERFORMANCE

Month 3 - 2013/14

	Measure	2012/13 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%	86.67%	95.51%	96.10%	93.05%													93.05%	
	A&E 12 Hour Trolley Waits	Full Year	16	0	16	0	0	16													16	
	Ambulance Handovers not completed within 30 Minutes	Full Year		100%	330	163	123	616													616	
	Ambulance Handovers not completed within 60 Minutes	Full Year		100%	35	4	1	40													40	
	18 Week RTT Admitted - English Responsible Only - Part 1A	Mar-13	78.00%	90%	73.59%	74.78%	77.93%															
	18 Week RTT Non Admitted - English Responsible Only - Part 1B	Mar-13	95.09%	95%	95.51%	95.51%	95.50%															
	18 Week RTT Incomplete Pathway - English Responsible Only - Part 2	Mar-13	86.57%	92%	89.05%	90.24%	91.07%															
	18 Week RTT Incomplete > 52 Weeks - English Responsible Only	Mar-13	0	0	1	3	1	5													5	
	% of Patients waiting over 6 Weeks for a Diagnostics Test	Mar-13	0.20%	1%	0.22%	0.46%	0.67%	0.66%													0.66%	
	% spending >90% of their stay on a Stroke Ward	Full Year	88.30%	80%	76.70%	78.40%	80.28%	78.45%													78.46%	
	Cancelled 28 Day Readmission Breaches	Full Year	100	0	3	1	0	4													4	
	Number of Urgent operations cancelled more than once			0	0	0	0	0													0	
Cancer	2 Week GP referral to 1st OP Appointment	Full Year	96.00%	93%	92.00%	95.52%	94.07%	93.97%													93.97%	
	2 Week GP to 1st OP Appointment Breast Symptoms	Full Year	95.73%	93%	93.13%	95.39%	97.16%	95.14%													95.14%	
	31 day diagnosis to treatment	Full Year	97.50%	96%	95.27%	98.95%	98.41%	97.63%													97.63%	
	31 day second or subsequent treatment - Drug	Full Year	99.02%	98%	97.26%	98.59%	100.00%	98.26%													98.26%	
	31 day second or subsequent treatment - Surgery	Full Year	94.79%	94%	90.32%	92.31%	88.46%	90.36%													90.36%	
	31 day second or subsequent treatment - Radiotherapy	Full Year	97.99%	94%	96.84%	96.63%	94.94%	96.20%													96.20%	
	62 days urgent referral to treatment	Full Year	85.13%	85%	78.52%	80.11%	80.42%	79.70%													79.70%	
	62 days referral to treatment from Screening	Full Year	92.15%	90%	100.00%	100.00%	88.89%	97.10%													97.10%	
	62 days referral to treatment from Hospital Specialist	Full Year	94.70%	85%	100.00%	87.88%	90.91%	92.23%													92.23%	
Patient Experience / Governance	C-Diff	Full Year	45	27	1	2	2	5													5	
	MRSA	Full Year	1	0	0	0	0	0													0	
	Same Sex Accommodation Breaches	Full Year	0	0	0	0	4	4													4	
	Compliance with VTE Assessments	Mar-13	90.44	95%	89.30%	90.10%																
	PMR Governance Rating	Mar-13	Red	Green	Red	Red	Red															
	Publication of Formulary	Mar-13	Yes	Yes	Yes	Yes	Yes															
	Number of Reds on Maternity Dashboard	Mar-13	0	0	0	0	0															

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 3 (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	60,680	5,485	5,754	269	4.9%	14,997	15,949	952	6.4%	62,980	68,693
	Therapies / Diagnostics	723	14	6	-8	-58.0%	40	37	-3	-7.4%	169	159
	Unscheduled Care	30,335	1,989	2,407	418	21.0%	5,562	6,581	1,019	18.3%	23,588	28,345
	Women and Children's	15,415	1,427	1,459	32	2.3%	3,991	4,227	236	5.9%	16,925	18,206
Consultant Led/Responsible First Attendance Total		**107,153**	**8,915**	**9,626**	**711**	**8.0%**	**24,589**	**26,794**	**2,205**	**9.0%**	**103,662**	**115,403**
Consultant Led/Responsible Follow Up Attendance	Scheduled Care	120,009	10,219	10,022	-197	-1.9%	28,581	28,526	-55	-0.2%	121,216	122,863
	Therapies / Diagnostics	1,516	38	37	-1	-3.6%	107	129	22	20.2%	455	556
	Unscheduled Care	48,081	3,985	3,663	-322	-8.1%	10,663	11,472	809	7.6%	44,890	49,410
	Women and Children's	17,416	1,567	2,108	541	34.6%	4,382	6,477	2,095	47.8%	18,584	27,896
Consultant Led/Responsible Follow Up Attendance Total		**187,022**	**15,809**	**15,830**	**21**	**0.1%**	**43,734**	**46,604**	**2,870**	**6.6%**	**185,145**	**200,725**
Consultant Led/Responsible Outpatient Procedure	Scheduled Care	65,681	4,387	2,770	-1,617	-36.9%	12,311	11,800	-511	-4.2%	54,744	50,823
	Therapies / Diagnostics	430	15	-	-15	-100.0%	42	-	-42	-100.0%	179	-
	Unscheduled Care	28,112	2,428	1,261	-1,167	-48.1%	6,791	5,273	-1,518	-22.4%	28,802	22,712
	Women and Children's	24,953	2,123	1,617	-507	-23.9%	5,939	6,171	233	3.9%	25,186	26,580
Consultant Led/Responsible Outpatient Procedure Total		**119,176**	**8,953**	**5,647**	**-3,306**	**-36.9%**	**25,083**	**23,245**	**-1,839**	**-7.3%**	**108,910**	**100,115**
Total Outpatients	Scheduled Care	246,370	20,091	18,546	-1,545	-7.7%	55,889	56,275	386	0.7%	238,939	242,379
	Therapies / Diagnostics	2,669	68	43	-25	-36.5%	189	166	-23	-12.3%	803	715
	Unscheduled Care	106,528	8,401	7,331	-1,070	-12.7%	23,016	23,326	310	1.3%	97,279	100,467
	Women and Children's	57,784	5,117	5,184	67	1.3%	14,311	16,875	2,564	17.9%	60,695	72,682
Total Outpatients Total		**413,351**	**33,677**	**31,103**	**-2,573**	**-7.6%**	**93,406**	**96,642**	**3,237**	**3.5%**	**397,717**	**416,244**
Elective DC	Scheduled Care	33,151	3,480	2,791	-689	-19.8%	8,794	8,054	-740	-8.4%	36,005	33,380
	Unscheduled Care	2,515	222	174	-48	-21.6%	622	575	-47	-7.6%	2,539	2,383
	Women and Children's	2,008	272	208	-64	-23.4%	679	663	-16	-2.3%	2,621	2,748
Elective DC Total		**37,674**	**3,973**	**3,173**	**-800**	**-20.1%**	**10,095**	**9,292**	**-803**	**-8.0%**	**41,165**	**38,511**
Elective IP	Scheduled Care	5,719	559	499	-60	-10.7%	1,525	1,275	-250	-16.4%	6,180	5,226
	Unscheduled Care	251	21	16	-5	-22.4%	58	62	4	6.9%	234	254
	Women and Children's	959	86	90	4	5.1%	241	265	24	10.0%	973	1,086
Elective IP Total		**6,929**	**665**	**605**	**-60**	**-9.0%**	**1,824**	**1,602**	**-222**	**-12.2%**	**7,387**	**6,566**
Non Elective	Scheduled Care	12,282	1,104	1,029	-75	-6.8%	3,233	3,087	-146	-4.5%	12,922	12,524
	Unscheduled Care	23,342	2,010	1,916	-94	-4.7%	5,883	5,973	90	1.5%	23,517	24,232
	Women and Children's	10,539	755	621	-134	-17.7%	2,209	2,020	-189	-8.6%	8,831	8,195
Non Elective Total		**46,163**	**3,869**	**3,566**	**-303**	**-7.8%**	**11,325**	**11,080**	**-245**	**-2.2%**	**45,270**	**44,951**
Non Elective Other	Scheduled Care		4	7	3	66.6%	12	15	3	26.9%	48	61
	Unscheduled Care		14	15	1	10.8%	38	57	19	49.5%	154	231
	Women and Children's	6,718	762	738	-24	-3.1%	2,163	2,205	42	1.9%	8,711	8,946
Non Elective Other Total		**6,718**	**779**	**760**	**-19**	**-2.5%**	**2,213**	**2,277**	**64**	**2.9%**	**8,912**	**9,238**
Total Spells	Scheduled Care	51,152	5,147	4,326	-821	-16.0%	13,563	12,431	-1,132	-8.3%	55,155	51,191
	Unscheduled Care	26,108	2,266	2,121	-145	-6.4%	6,601	6,667	66	1.0%	26,444	27,100
	Women and Children's	20,224	1,874	1,657	-217	-11.6%	5,292	5,153	-139	-2.6%	21,136	20,974
Total Spells Total		**97,484**	**9,286**	**8,104**	**-1,182**	**-12.7%**	**25,457**	**24,251**	**-1,206**	**-4.7%**	**102,735**	**99,265**
A&E	Unscheduled Care	110,683	10,231	9,070	-1,161	-11.4%	29,245	27,569	-1,676	-5.7%	110,987	106,227
A&E Total		**110,683**	**10,231**	**9,070**	**-1,161**	**-11.4%**	**29,245**	**27,569**	**-1,676**	**-5.7%**	**110,987**	**106,227**

Contract Plan

An overall demographic growth assumption has been agreed with our CCG colleagues (broadly 1.3%). This is yet to be effected in the internal activity plans. The additional non-recurrent activity agreed with various Centres to both deliver the RTT targets and reduce the backlog numbers to sustainable levels highlighted last month has now been phased into the activity plans.

More detailed information by Care Group (e.g. by specialty and point of delivery) is available and will be forwarded to the relevant operational managers. As indicated last month, once the operational realignment of responsibilities is complete, Centre-specific reports will be produced.

Outpatient Activity

As previously reported, the Women & Children Care Group continues to show a significant over-performance (nearly 18% year-to-date). There has been a number of contract and coding changes within the Care Group for this year and discussions with the Care Group to determine:

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 are continuing.

As previously reported, and due to the timing of mandated data submissions, there continues to be a number of outpatient procedures currently uncoded (and therefore showing against new and follow-up activity in the attachments to this Paper). Although a 'catch-up' takes place prior to the 2nd data submission, the data as currently reported for June does not reflect this.

Spell Activity

Elective spell activity (i.e. elective inpatient and daycases combined) is 860 spells below plan for June (18.5%) and 1025 below plan for the year to date (8.6%). As highlighted above, activity plans have been amended from June to reflect the plans put forward by the Centres to increase activity to reduce the backlog and deliver the RTT targets. Although elective inpatient activity increased in the month, daycase activity for June remained consistent with May. The relevant Care Groups are aware that this underperformance needs to be recovered in future months.

Emergency activity across the Trust during June was 303 spells below plan (7.8%), and is 245 spells below plan for the year-to-date (2.2%).

A&E Activity

A&E attendances were below plan for the month (1161 attendances, 11.4%) and remain below plan for the year-to-date (1676 attendances, 5.7%).

Performance Report – Key Messages & Issues:

- A&E 4-hour target achieved for second consecutive month (but not for Q1 taken as a whole)
- RTT admitted target **not** achieved in-month
- There was a single 52 week RTT Breach in June totalling 5 for the quarter

- 6 out of 9 cancer targets achieved in-month, with 2 failures for Q1 on a cumulative basis (31-day second or subsequent treatment - surgery and the overall 62-day target). Please note June data is unvalidated at this stage
- C-Diff / MRSA targets achieved in-month and for Q1
- There was a mixed sex accommodation breach in the month
- VTE target **not** achieved in-month, nor for Q1

4.1 Emergency Access Target

The Trust achieved the A&E 4 hour performance 95% target in June 2013 with 95.83% for the month, giving a Quarter 1 to date position of 92.78% (not including walk in centre activity).

Factors affecting performance are:

- Attendances during the reporting period have remained constant compared to previous months; with an average of 302 attendances per day in June compared with 300 per day in May. Total attendances for the June reporting period were 9,068.

- The Trust achieved in-month performance standards but is still recovering from the challenges encountered in the month of April.

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

January	3,829	Average 123 per day
February	3,585	Average 129 per day
March	4,153	Average 133 per day
April	4,403	Average 146 per day
May	3,955	Average 128 per day
June	3,595	Average 120 per day

- A significant reduction from an average of over 50 per day, has been seen in the number of patients who are safe to transfer but remain in a hospital bed. Over the month of June this has steadily reduced and we are now seeing approximately 30 per day across the Trust. This reduction has helped with improving flow and ensuring a reduction in capacity related breaches.

- A lack of available capacity (beds to meet expected demand); this has subsequently been reduced by the ward reconfiguration implemented at the end of April 2013 and has also supported a large reduction in medical outliers, with the sites' currently averaging approximately 5-8 medical patients.

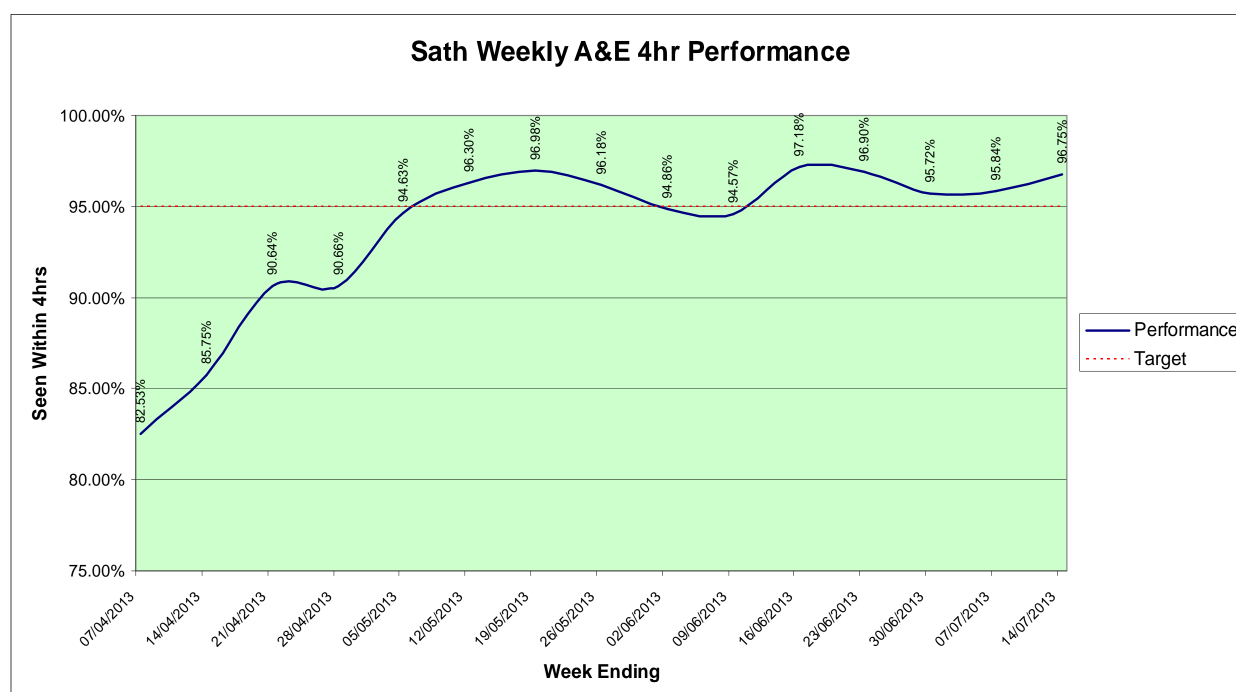
- An increase has been seen in the number of specialty breaches. To support improvement in this area the Operations team, Medical Director and Care Group Medical Directors have reviewed this and will introduce a new process to support the emergency department thereby reducing delays further.

- Transport related breaches have occurred primarily at weekends and early evenings, these have been acknowledged by NSL, who have put on additional transport in the evenings and are also working to improve support to the emergency department around patient discharge.

The patient flow action plan is continuing to deliver the required changes, and will also form part of the ATOS work to support wider pathway improvements. The Trust is still in a precarious position in terms of performance, where any slight increase or surge in demand can, and does, create patient flow issues. These challenges around patient throughput impact directly back within the emergency department, with only relatively small pressures in either demand or diminished discharge affecting our delivery of 4 hour performance.

June A&E performance with July to date is summarised below:

Week Ending	PRH	RSH	SaTH	SaTH including WIC
9/6/2013	94.17%	92.78%	94.04%	94.57%
16/6/2013	96.59%	96.76%	96.88%	97.18%
23/6/2013	97.15%	95.29%	96.31%	96.90%
30/6/2013	95.43%	94.17%	95.28%	95.72%
7/7/2013	97.18%	92.43%	95.07%	95.84%
14/7/2013	96.85%	95.38%	96.19%	96.75%



During the month of June 0 patients breached the 12 hour trolley wait standard and very few patients over the whole month waited more than 8 hours. This indicator shows how flow has vastly improved.

Progress against the five high impact whole health economy is now monitored at the monthly Urgent Care Board meetings.

- ED Flow (Sponsor – Peter Herring)
- Optimising Capacity to support Discharge (Sponsor – Julia Bridgewater)
- SaTH & Community Discharge (Sponsor – Peter Herring)
- Attendance Avoidance (Sponsor – Dave Evans)
- LHE Demand & Capacity Hub (Sponsor – Paul Tulley).

4.2 Stroke

The Stroke target within the Trust has continued to prove problematic during Quarter 1 with delivery on the RSH site the largest problem. In June the Trust achieved the target of 80%, indicating an improvement in the pathways on site. Since the beginning of July the Thrombolysis pathway has been completely delivered at PRH with Shropshire and Powys patients transferring back to RSH for acute rehabilitation. This decision was taken due to lack of Consultant cover due to vacancies and Annual Leave. The transfer of the take has created no problems thus far and the pathway is working well. A positive unexpected outcome of this decision is that staff are able to cross cover and the benefits of improvements by passing knowledge from each site will continue to show improvements in this service.

4.3 Ambulance Handover Performance

Ambulance delays are still being problematic across the sites at key times of pressure.

We are continuing to see improvements in turnaround across both sites with a slight increase in June at PRH. As the CAD system starts the clock before the patients arrive in the ED and the arrivals split out by department are not accurate we are currently manually recording time of arrival and time of crew release. Fines can be imposed by commissioners for failure to meet turnaround times and discussions are ongoing.

4.4 Scheduled Care Access Targets

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

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

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

In the month of June the Trust failed to achieve the RTT target for Admitted patients with a performance of 70.65% against the 90% standard.
However, this is on trajectory as each of the admitted specialties is currently clearing a backlog of 18 week patients.

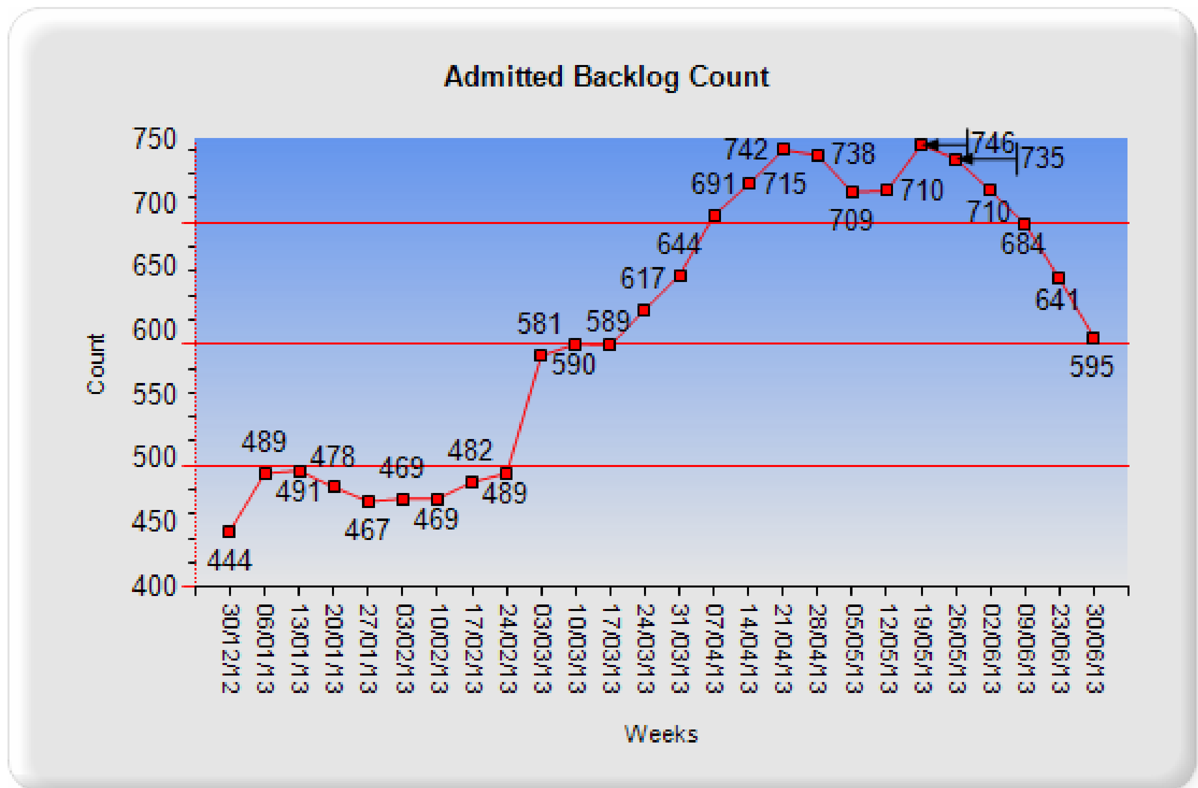
Each centre has constructed a recovery plan which details when the specialty will be sustainable. All specialties will deliver 18 weeks RTT from 1st July 2013, with the following exceptions:

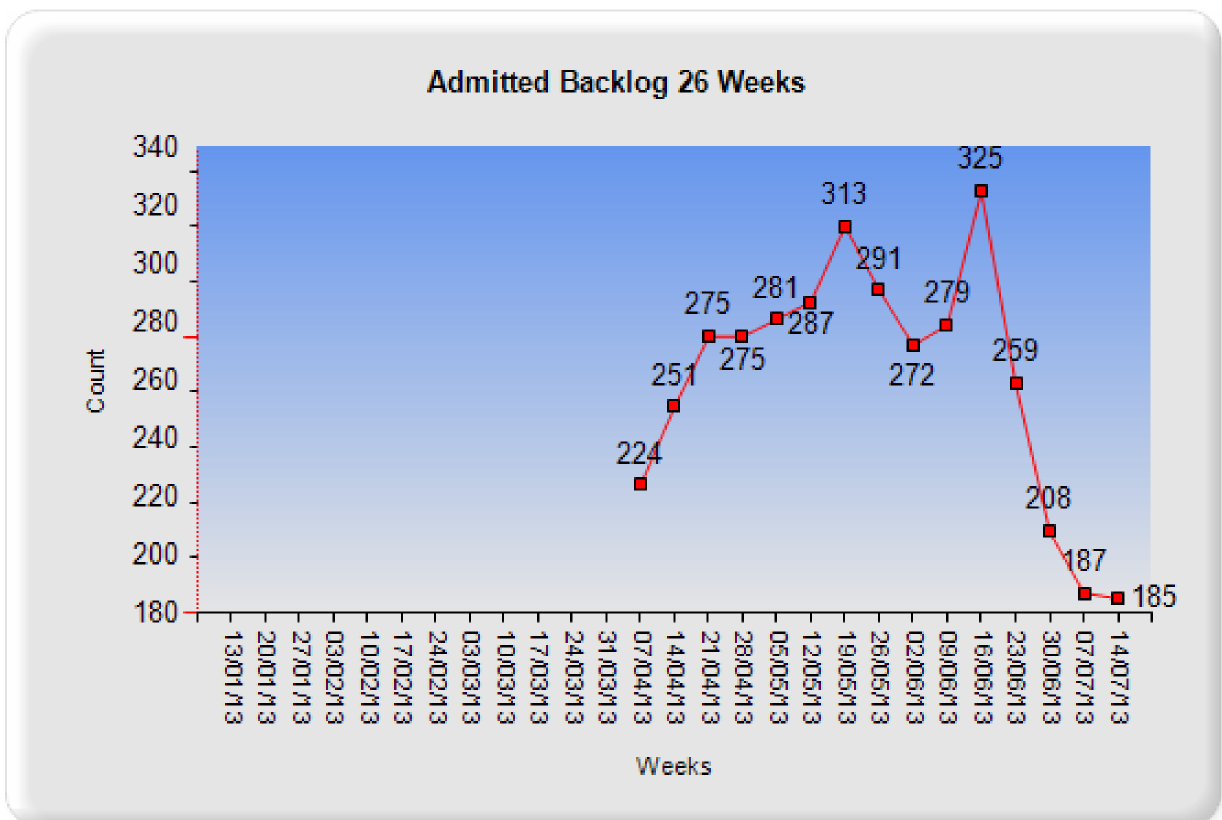
- Orthopaedics (from 1st November 2013);
- Urology (from 1st October 2013).
- Oral Surgery (from 1st August 2013)
- ENT (from 1st September 2013)

The trajectory for oral surgery and ENT has been revised with achievement from 1st July 2013 due to higher than expected demand and a bigger backlog than initially identified.

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 [RAPs] are in place for the above specialties are being monitored via the weekly RTT meetings with the CCG's. The Admitted backlog, and of those the number of over 26 week waits is reducing as can be seen in these graphs.





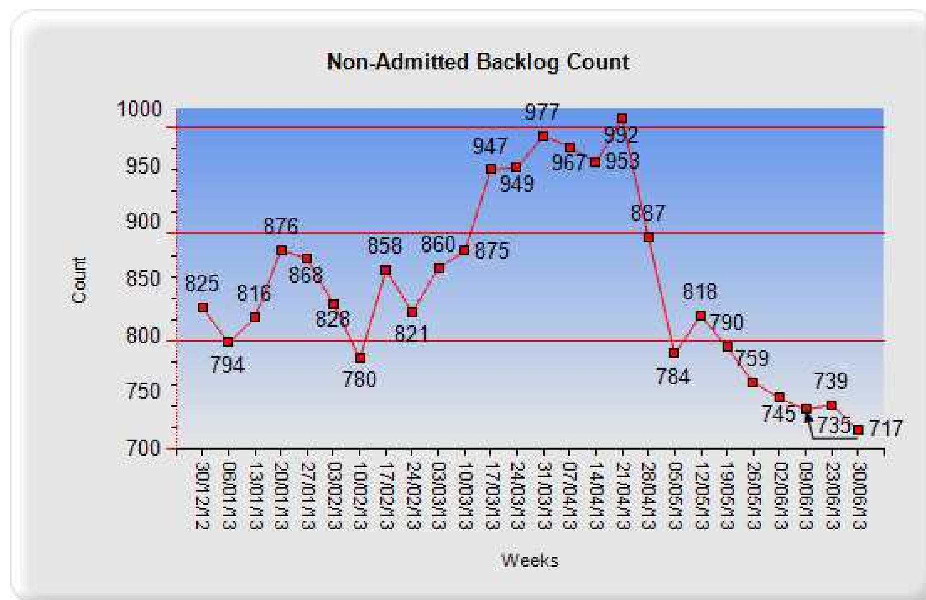
4.6 **18 weeks Referral to Treatment Target (RTT) – Non Admitted**

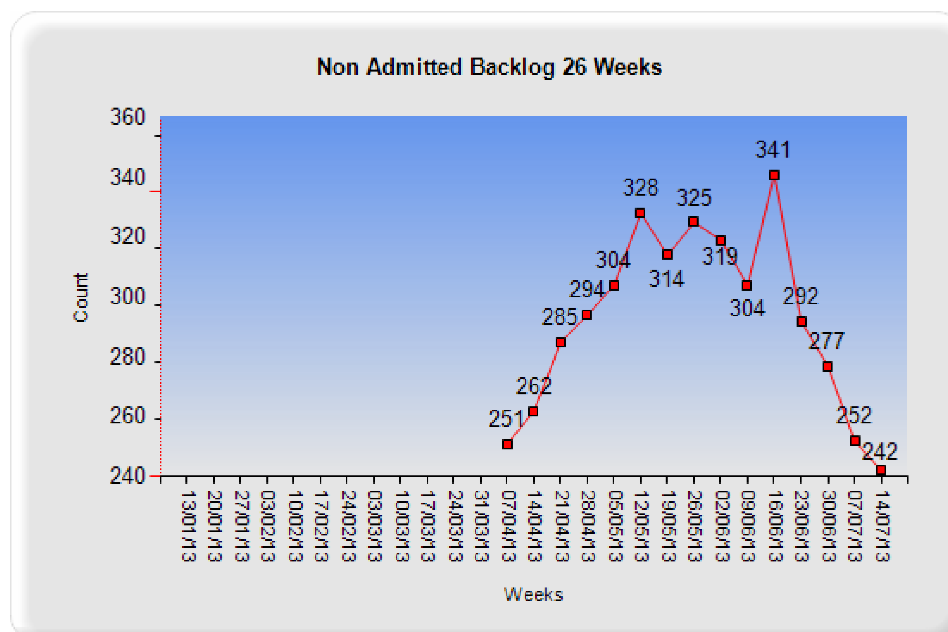
The Trust achieved the overall RTT target for Non Admitted patients with 95.5% against the 95% target in June.

At specialty level:

- Ophthalmology did not achieve the target in June. Discussions are in place with both CCGs to provide some additional support from optometrists for a cohort of patients; and also to engage with Viewpoint, an external provider who will provide additional sessions from 3rd August 2013

The Non Admitted backlog, and of those the number of over 26 week waits is reducing as can be seen in these graphs.





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 May due to more Outpatient specialties achieving the 95% target, the June performance is 8.94%.

4.8 52 Weeks

The Trust will be declaring a 52 week breach this month. This was in Urology and occurred as a result of a missing TCI form. A new process has been put in place to ensure that this does not happen again. In addition, we need to report a number of previously unknown 52 week breaches. There are 4 in total, made up of 3 from the month of May (1 in General Surgery, 1 in Trauma & Orthopaedics and 1 in Ophthalmology), plus 1 from April (General Surgery). Scrutiny has confirmed that these breaches were unknown because they were not visible to the Centres to report because of a technical issue between the SQL reporting and SEMA systems. This technical issue has now been resolved with a temporary fix whilst the permanent solution is devised for the SEMA system. This has been reported to the CCG's, Area Team and Trust Development Authority.

4.9 ECIST Support

The Trust has requested support from the Elective Care Intensive Support Team to review processes to ensure that the action plans in place to achieve a sustainable RTT position are realistic and credible. The team will be on site 29th & 30th July 2013.

4.10 Cancer Standards

The unvalidated position for June 2013 shows that we failed to deliver three of the nine standard cancer targets:

- the 62 day traditional target, which was due to waits for diagnostics and complex surgery;
  - 20 patients (1 x Breast, 2 x Colorectal, 2 x Gynaecology, 1 x Haematology, 4 x Lung, 1 x Skin, 6 x Upper GI and 3 x Urology).
- the 62 day screening target;
  - 1 patient (patient declined repeat biopsy).
- the 31 day target for subsequent surgery;
  - 3 patients (1 x Colorectal, 1 x Skin and 1 x Urology).

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. Despite this, achievement of all the Cancer targets from 1st August 2013 is at risk.

We have introduced a tracking and reporting process for patients waiting 62-84 days, 85-99 days and patients over 100 days. For patients waiting over 100 days there is, in general, a clinical reason for this. The focus in particular, will be those patients in the 62-84 day category who have breached due to poor processes.
There are six patients currently waiting beyond 100 days, 4 x Urology, 1 x Lung and 1 H&N. All of these are due to complex requirements. As at the 18th July, these have all now been treated or are about to be treated.

4.11 **Cancelled Operations**

There were 200 cancelled operations in June 2013, of which 38 will need to be readmitted with 28 days. This is a significant improvement, on previous cancellations. There is a significant increase in throughput of activity as the Trust clears the backlog of patients that were cancelled through winter. All patients were readmitted within the 28 day target in May and therefore we have achieved the target of no more than four breaches for the quarter. This is a significant improvement on the previous quarter's performance.

4.12 **Choose and Book**

The Trust failed to achieve the Choose and Book target in June, where 95% of patients should have been able to book an appointment via the Choose and Book system. At present our performance is approximately 69.5% which is significantly below the national target.

There are currently 1350 patients who have not been able to book an appointment via Choose & Book. There are two specialties that make up 92% of this total

- Ophthalmology
- General Medicine

A revised Remedial Action Plan [RAP] has been produced following a meeting with the CCGs. This will require additional capacity to be released to Choose & Book in the above specialties.
Work is currently taking place with the CCGs to review the pathways and look at alternative capacity.

The action plan consists of 66 actions, of which 33 are still in progress. A copy of this action plan can be made available for members of the Board if required. It is proposed that a quarterly update be taken to the Finance Committee.

5. FINANCE

Finance Performance Summary – Month 03

	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	96.37%	79.90%
	EBITDA Margin	5%	Q YTD	2.8%	4%	4.7%	4.6%	Mar-13	5.40%	1.0%
	I&E Surplus Margin	1%	Q YTD	-1.90%	-0.50%	0.00%	0.03%	Mar-13	0.79%	-3.69%
	Return on Assets	5%	Q YTD	0.03%	1.20%	2.60%	3.30%	Mar-13	4.70%	0.80%
	Liquidity ratio	15 days	Q YTD	13.5	14.4	12.9	13.3	Mar-13		11.9
	Total Income (actual v plan)	0.5% of plan	Q YTD	99.6%	99.6%	99.90%	99.73%	Mar-13	98.20%	99.80%
	Pay Expenditure (actual v plan)	At or below plan	Q YTD	101%	102.40%	99.90%	100.27%	Mar-13	98.90%	102.10%
	Non Pay Expenditure (actual v plan)	At or below plan	Q YTD	98.04%	95.20%	100.3%	101.03%	Mar-13	98.70%	100.80%
	CIP (actual v plan)	At or below plan	Q YTD	100%	74%	98.00%	100.00%	Mar-13	89.90%	52.00%
	Capital Expenditure (actual v plan)	At or below plan	Q YTD	13%	38%	59.00%	68.00%	Mar-13	79.40%	65.30%

5.1 Budgetary Movements

	Budget May Board 2013	*Alterations*	*Revised Budget May 2013*
Income	**300,419**	1,041	**301,461**
Expenditure			
Pay (before CIP)	**(207,757)**	(2,216)	**(209,973)**
Non Pay (before CIP)	**(92,551)**	(15)	**(92,566)**
Reserves		-	
Cost Improvement Programme	**11,730**	3,603	**15,333**
Total Expenditure	**(288,578)**	1,372	**(287,206)**
EBITDA	**11,841**	2,413	**14,254**
Dividends and Amortisation	**(14,270)**		**(14,270)**
Surplus / (Deficit)	**(2,429)**	**2,413**	**(16)**

As can be seen the budgetary changes introduced in the month have reduced the budgetary deficit by £2.413 million. These changes are consistent with the agreement reached with the NTDA, to work towards recovering a £2.4 million deficit, and in doing so achieve a break even position by the year end.

5.2 Month 02 Position

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

	Months 1 - 3 Budget £000's	***Month 1- 3 Actual £000's***	***Variance £000's***	***Planned Forecast Outturn £000's***	***Forecast Outturn £000's***	***Variance £000's***	***Month 1 -3 2012/13 £000's***
Income	74,403	74,245	(158)	301,461	301,461	-	**71,676**
Expenditure							
Pay	(51,163)	(52,215)	(1,052)	(201,767)	(201,767)	-	**(50,469)**
Non Pay	(21,380)	(21,547)	(167)	(87,095)	(87,095)	-	**(21,321)**
Reserves	(1,194)	-	1,194	1655	1655	-	**-**
Phased Spend			-	-	-	-	
Finance Cost	(3,467)	(3,468)	(1)	(14,270)	(14,270)	-	**(3,666)**
Total Expenditure	(77,204)	(77,230)	(26)	(300,977)	(300,977)	-	**(75,456)**
Under /	(2,801)	(2,985)	(184)	(16)	(16)	-	**(3,780)**

	Months 1 - 3 Budget £000's	*Month 1- 3 Actual £000's*	*Variance £000's*	*Planned Forecast Outturn £000's*	*Forecast Outturn £000's*	*Variance £000's*	*Month 1 -3 2012/13 £000's*
Over spend							
Phased Spend	244	244	-				**126**
Transitional support	-	-	-	-	-	-	**2,127**
Surplus / (deficit)	(2,557)	(2,741)	(184)	(16)	(16)	-	**(1,527)**

At the end of June the Trust had recorded a cumulative deficit amounting to £2.74 million and planned to record a deficit amounting to £2.557 million. The Trust is presently working to deliver a balanced financial position by the year end.

5.3 Income

At the end of June, the Trust had underachieved against the Income target by £158,000.

Elective, Emergency and A & E activity declined considerably within the month of June.

5.4 Pay Expenditure

In the first quarter Pay budgets overspent by £1.052 million, as a consequence of:

	£000's
Shortfall as compared with Planned CIP savings	568
Budget overspending	484
Total Overspend	1,052

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 June 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
June	17,194	17,405	
Average monthly Pay budget (before CIP) April 2013 – March 2014	17,529		

	In month £000's	*3 month moving average Pay spend £000's*	*Spending Range £000's*
Average Monthly Pay Budget July – March after allowing for CIP	16,617		

Pay spending has reduced in the month to £17.193 million.

In order for the Trust to successfully achieve a balanced financial position by the year end, Pay spending has to reduce to an average of £16.6 million per month over the period July 2013 – March 2014.

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 June, the net level of over establishment after allowing for vacancies had reduced from 127.55 WTE posts to 107.88 WTE posts.

The over established posts are located predominantly across nursing budgets. At the end of June the level of over establishment within Nursing amounted to 118.04 WTE posts. (Previous month 150.31 WTE posts).

The reduction in the level of over establishment within Nursing, as compared with the previous month, has arisen principally because Agency Nursing levels have reduced by 28.85 WTEs.

Total Agency spending in the month amounted to £866,000, a reduction of £235,000 when compared with the month of May.

Reduced Agency nursing levels has reduced spending in the month by £139,000.

Despite this reduction the level of Agency Nursing spending still amounted to £347,000 in the month and is £226,000 greater than the levels spent in the comparable period in the previous financial year.

5.5 Non Pay

In the first quarter of the year the Trust overspent in respect of non pay budgets by £167,000.

The overspend is after applying CIP savings in the period amounting to £965,000.

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 £7.283 million. Presently the Trust is spending at an average rate of £7.182 million.

5.6 Capital Programme

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

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**	**2,354**	**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	2,999	501	3,009	0
Capital contingencies	4,000	345	3,990	0
Total Discretionary Capital Schemes	**8,450**	**846**	**8,450**	**0**
Total including reconfiguration	**29,080**	**3,200**	**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**

5.7 Cash Flow

The cash profile for the Trust is as follows:

	2013/14											
	Apr £000s	May £000s	Jun £000s	Jul £000s	Aug £000s	Sep £000s	Oct £000s	Nov £000s	Dec £000s	Jan £000s	Feb £000s	Mar £000s
Cash position	2,102	4,741	2,357	1,016	2,267	4,490	3,787	4,676	5,534	5,863	4,492	4,216
Cash receipts	28,429	26,090	25,997	29,656	29,355	25,920	28,156	25,385	25,130	28,208	25,929	27,332
Cash outgoings	25,790	28,473	27,341	28,405	27,132	26,623	27,267	24,528	24,800	29,580	26,205	29,347
Closing Cash position	4,741	2,357	1,016	2,267	4,490	3,787	4,676	5,534	5,863	4,492	4,216	2,200

The above plan is based upon the following assumptions:

- The Trust is able to deliver a breakeven income and expenditure position in the year consistent with the forecast outturn.
- Temporary Borrowing Limit support of £3m is received in August.
- 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.

Pressure within the cash position will be mitigated through working capital management.

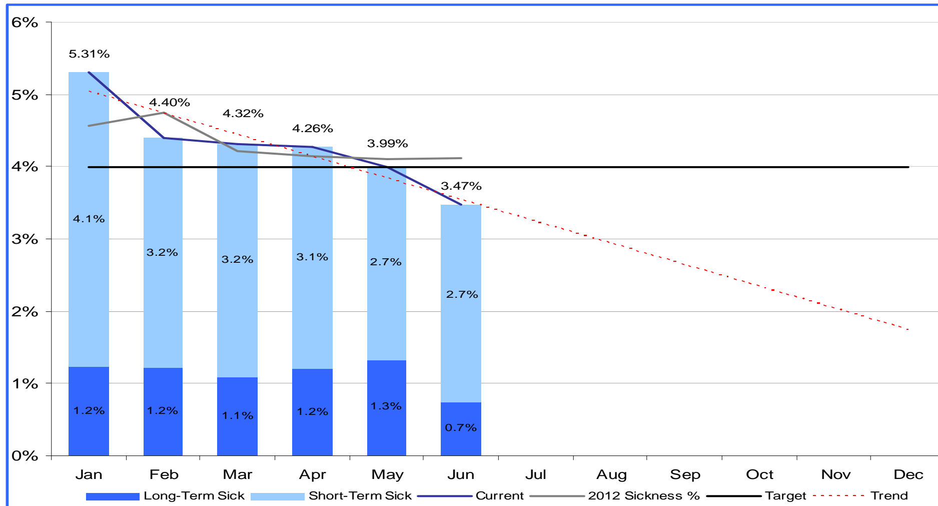
Better Payment Practice Code delivery is challenging given the underlying liquidity difficulties within the Trust.

	BPPC compliance value	BPPC compliance volume
Non NHS Spend	73%	55%
NHS	85%	75%

6. WORKFORCE

6.1 Sickness Absence

Table 7: Sickness Absence



Absence reduced again in June to 3.47%, this is a further reduction which is very encouraging. It should be noted that significant improvement this month has been seen in long term absence, with a reduction 0.6%. Year to date performance is 3.74%, whilst it is anticipated that absence rates will be lower in summer months the organisation has seen improvement when compared to last year, a reduction of 0.65%.

Improved performance supports the organisations ability to deliver great care, in addition low absence rates are an indicator of supporting our workforce. It also supports financial performance as the table below illustrates the direct cost of absence.

Table 8: Direct cost of absence

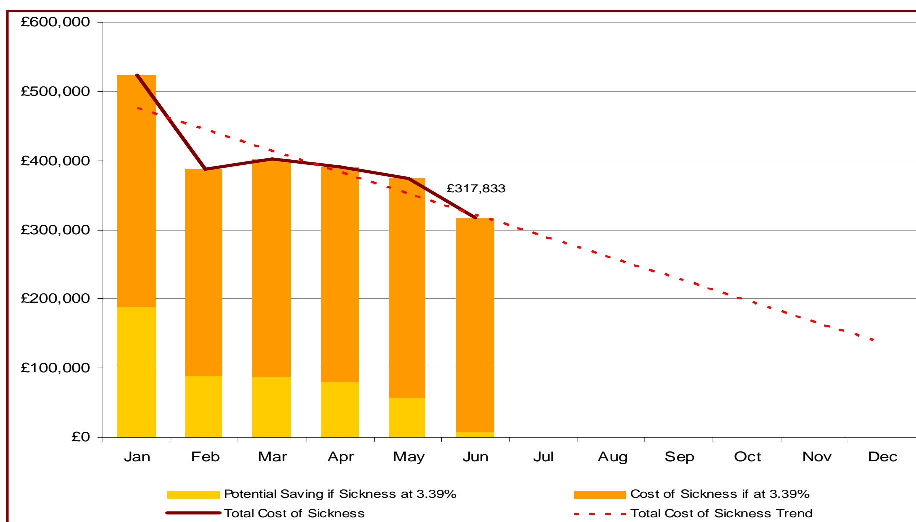
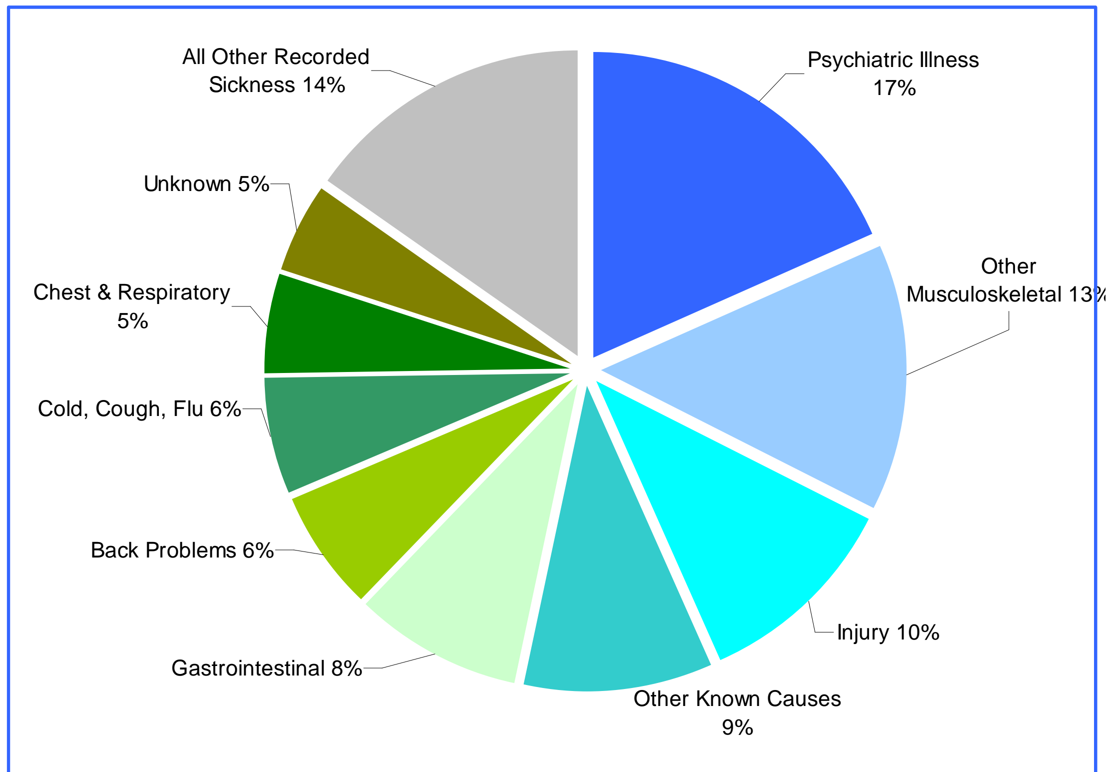


Table 9: Reasons for absence

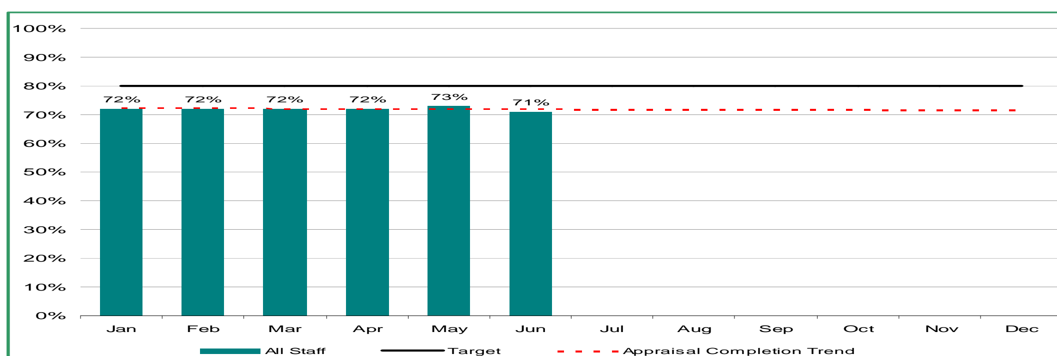


Improvements in absence rates are pleasing however the organisation continues to see both stress and musculoskeletal as the two highest reasons for absence. The organisations Health and Wellbeing action plan is progressing well however a review will be required to understand could more be done to support staff and prevent absence for these reasons.

6.2 Appraisals

6.2.1 Non Medical Appraisal coverage

Table 10: Non Medical Appraisals



Appraisal coverage fell in June to 71%, the organisation has not seen any significant improvement in appraisal coverage for the last six months. A discussion has been held this month at the Operational Performance Group highlighting the importance of appraisals and asking each care group to progress this.

6.2.2 **Medical Appraisals**

Medical Appraisal coverage as fallen to 59% in June as highlighted by the Medical Director this area is being closely managed with a clear expectation of improvement as highlighted in the Medical Directors report.

7. DECLARATION AGAINST PROVIDER MANAGEMENT REVIEW FRAMEWORK

7.1 Quality, Safety and National Targets

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

- 18 Weeks RTT Target (Admitted) – 1 penalty point
- 18 Weeks RTT Target (Open Clocks) – 1 penalty point
- Cancer 31 Day Subsequent Treatment (Surgery) – 1 penalty point
- Cancer 62 day wait for first treatment – 1 penalty point

Against the Governance Risk Rating the Trust is rated as Red with 4 penalty points compared to 3 in May, further we have an additional 4 points from the A&E override totalling 8 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 May.

7.2 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 May and June covering the months of April and May respectively, 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

From July onwards the Trust is required to submit these templates, along with the PMR return at the end of each month for the previous month.

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

The Shrewsbury and Telford Hospital NHS Trust

Date

01 June - 30 June

Average score this period

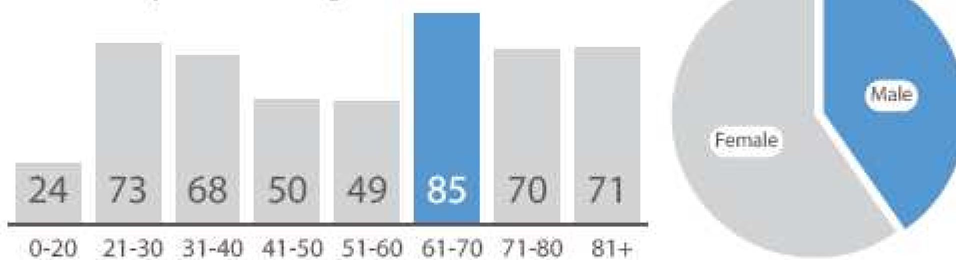
1 2 3 4 5 **4.8**

Reviews this period

505

	This period		Last 6 months	
Ward Name	Reviews	Score	Score	Trend
A&E	7	5.00	4.64	
A&E	3	3.67	4.69	
AMU	5	5.00	4.90	
AMU	8	4.29	4.56	
Apley	15	5.00	4.90	
Bridgnorth Maternity	6	5.00	5.00	
Discharge Lounge	21	4.63	4.49	
Gynae (32)	52	4.80	4.88	
Head & Neck	38	4.92	4.90	
ITU/HDU	0	-	-	
ITU/HDU	0	-	-	
Ludlow Maternity	11	4.91	4.96	
MLU	20	4.79	4.77	
Oswestry Maternity	15	5.00	5.00	
S26U/S/ICA	5	4.60	4.84	
SAU	4	4.67	4.79	
Surgical Short Stay (SSS)	21	4.74	4.60	
Ward 10	7	4.86	4.79	
Ward 11	25	4.92	4.90	
Ward 12E	41	4.90	4.75	
Ward 15	18	5.00	4.96	
Ward 16	22	4.91	4.79	
Ward 18	4	3.75	4.52	
Ward 19	20	4.74	4.74	

	This period		Last 6 months	
Ward Name	Reviews	Score	Score	Trend
Ward 20	0	-	-	
Ward 21	7	5.00	4.83	
Ward 22 O	8	4.88	4.89	
Ward 22 S/R	1	4.00	4.67	
Ward 23H	18	4.78	4.76	
Ward 23N	5	4.00	4.62	
Ward 24	0	-	4.86	
Ward 24E	2	4.50	4.92	
Ward 25	7	4.86	4.68	
Ward 27	15	4.36	4.65	
Ward 28	9	3.88	4.40	
Ward 32E	34	4.67	4.65	
Ward 4	13	4.85	4.90	
Ward 6 CCU	1	4.00	4.88	
Ward 7	7	5.00	4.80	
Ward 9	1	5.00	4.83	
Wrekin Maternity	9	4.89	4.85	



Top three wards	
A&E	5.00
Ward 9	5.00
AMU	5.00

Bottom three wards	
Ward 28	3.88
Ward 18	3.75
A&E	3.67

Appendix 2

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 3

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 has reported a Financial Risk Rating of 2 for the month of June.
- A&E performance in the month of June was 96.10% against the 95% target.
- Admitted RTT in June was 77.93% against the target of 90%. Trajectories have been agreed with the NTDA to deliver the relevant targets at a speciality level between July and November 2013.
- Non-Admitted RTT achieved at 95.50%.
- Cancer under-achieved against the 62 day pathway in month with 79.70% against a target of 85%.
- Cancer under-achieved against the 31 day subsequent treatment (Surgery) pathway in month with 90.36% against a target of 94%
- Unvalidated VTE compliance in June was 90.10 below the target of 95%.
- Action plans are in place to recover all the above targets.

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.

Appendix 4

PLAN FOR FULL IMPLEMENTATION OF JOB PLANNING AND APPRAISAL

1. Assessment of the current situation

Ten years after the "new" contract for Consultants was agreed and five years after the new contract for Staff and Associate Specialist (SAS) doctors, their implementation during 2012/13 in SaTH was significantly less than ideal.

For Consultants, Job Plan Review was performed for just over 50% and Appraisal for 78%. For SAS doctors both of these were around 10%.

These are average figures: some specialities achieved near 100%; others clearly did not.

More positive features are that SaTH has a trained cohort of just under 50 Appraisers, with 7 more doctors having expressed an interest in being trained. Of the trained group, some have confirmed their competence through practice, others have expressed the need for refresher training.

2. A phased implementation plan

Four phases are envisaged for this plan:

i) Fact finding and analysis

This phase – of assessing the current situation, and of understanding the causes for this – already has been completed.

Conclusions drawn include:

- an organisational culture that has not supported these contractual requirements;
- a lack of consistency in implementation: between specialities and grades;
- a culture of lack of consequences for lack of engagement;
- a specific and urgent need to address the needs of SAS doctors;
- despite individual efforts, lack of organisational commitment to this objective;
- other than in the case of the trained Appraisers, insufficient education to support full implementation.

ii) Education

The plans for this phase have been finalised (see *appendix 2*) and all senior doctors have been encouraged to attend one of the education sessions that will provide refresher training on Job Planning and Appraisal (see *appendix 1*). While these education sessions will not be mandatory, doctors who have not signed up to attend one of these will receive specific reminders to do so.

To ensure consistency of message, hence of understanding and, ideally, of implementation, all sessions will be based on the same educational materials.

As a further means of ensuring consistency in implementation, all Appraisers will have "top-up" training, with case scenarios, and all Centre Clinical Directors and Care Group Medical Directors will have training in Job Planning.

iii) General implementation

The Gantt chart (appendix 1) shows how, speciality by speciality, implementation of both Job Planning and Appraisal will be delivered for the large majority of senior doctors. In the case of Job Planning this will be by the Centre Clinical Directors and Care Group Medical Directors, each having responsibility for approximately twenty senior doctors and, for Appraisal, each trained Appraiser having responsibility for six or seven senior doctors.

It is planned that in most specialities this will follow the training delivered in phase ii) as above but, in those specialities – Womens' and Childrens' Care Group, a high performing area last year – where job planning already has been commenced, it has been agreed that this should continue.

The timescale for implementation of this general implementation, for most specialities, will be during quarters two and three.

iv) Directed implementation

It is anticipated that some individuals and, potentially, some specialities, may need more intensive focus and support in order to fulfill the requirement for full implementation of Job Planning and Appraisal.

On the basis that education has been provided in quarter one, that the large majority of senior doctors will have engaged in and completed these requirements in quarters two and three, in the final quarter of the year all resources will be focused of the group that has been given these opportunities, and received reminders, but has yet to engage.

While supportive measures will still be encouraged, is anticipated that more directive measures also will be required at this stage.

3. Phase two, in more detail: education

DEEP: the Doctors' Essential Education Programme

i) Introduction

This education programme has been developed to address identified gaps in the knowledge of senior doctors working in SaTH. It is important to note that this knowledge gap is one of the reasons why full implementation of contractual commitments has not been achieved in past years.

ii) Purpose of the programme

The first two modules of an ongoing programme will be delivered in mid-June and early July, and will focus on the Job Plan Review and Appraisal. While all of the doctors within the Trust should be familiar with the need for these, the first two modules of this ongoing programme will aim to expand on this by:

- ensuring that all doctors understand their responsibilities and what will be expected of each of them

- emphasising that a standard set of rules and guidelines will be used to ensure Job plan Reviews and Appraisals are delivered consistently
- enabling the defined outcomes for each to be met

While planning for the next two modules is still being developed, it has been determined that these will focus on:

- the ethics of medical practice
- national clinical targets – what are they and why they matter

iii) Programme plan and reporting progress

The plan for communicating and implementation of the first two modules is detailed in the Gantt chart at *Appendix 2*.

Modules 1 and 2 will be communicated in two formats and, in both cases, as already agreed with the Local Negotiating Committee, delivered by the Medical Director.

- specific refresher training for those delegated to deliver job plan reviews and appraisals
- a broad seminar, for all doctors, to ensure a consistent message is disseminated

The dates for the Seminars and specific training are:

- Princess Royal Hospital 11th June Specific Appraisal Training followed by General Seminar
- Royal Shrewsbury Hospital 13th June Specific Appraisal Training followed by General Seminar
- Royal Shrewsbury Hospital 18th June Specific Job Plan Review training
- Princess Royal Hospital20th June Specific Appraisal Training followed by General Seminar
- Royal Shrewsbury Hospital 2nd July Specific Appraisal Training followed by General Seminar

All senior doctors are being strongly encouraged (see *appendix 1*) to attend one of the general seminars and all Appraisers will be required to attend one of the specific appraisal training sessions. The Job Plan Review training will be given to all the Clinical Care Group Medical Directors and Centre Clinical Directors.

4. Phase three, in more detail: general implementation

Full delivery of Appraisal and Job Plan Reviews in 2013/14 will be achieved through a prescriptive approach. The aim being to assign to each appraiser, a list of up to 7 colleagues for appraisal, each of which will be expected to be completed within specific time scales. Centre Clinical Directors or other named reviewers will also be given named colleagues with whom they will be responsible for completing a Job Plan Review, again for completion within specific timescales.

A record of completed appraisals and job plan reviews will be kept centrally within Medical Staffing and progress reports against the planned completion rate will be sent, on a monthly basis to the Medical Director and Clinical Care Group Medical Directors.

5. Phase four, in more detail: directed implementation

It is recognised that, despite the above, more supportive and enabling means of achieving full implementation, some senior doctors may not engage in these contractual requirements. It is important to note that, in previous years, little or no action was taken to address these outliers. It is further appreciated that, to some extent, this absence of consequences likely contributed to the culture, prevalent in SaTH, of not prioritising these requirements.

It is therefore planned that, in the first instance, during the general implementation phase, encouragement and reminders will be sent to those senior doctors who have not, in accordance with their planned dates, engaged in their Job Plan Review and their Appraisal. Should they continue not to engage, these reminders will become more directed.

If, after repeated reminders, the senior doctor still has not engaged, during the fourth quarter of the year, specific dates will be set for compliance, with specific emphasis on the potential for contractually-permitted sanctions to be applied.

6. Conclusion

It is envisaged that this balanced approach – of educational support, logistic support and a directive approach (if needed) – provides the means by which full delivery of Job Plan Review and Appraisal will be achieved at SaTH.

It also has the potential, through the communication of a clear set of management messages, of starting to change the culture in this important component of the workforce to one that recognises contractual responsibilities as much as contractual rights.

Edwin Borman
Medical Director
130520

Appendix 1.

The Shrewsbury and Telford Hospital NHS
NHS Trust

The Princess Royal Hospital
Apley Castle
TELFORD
Shropshire
TF1 6TF
01952 641222 ext. 4374

The Royal Shrewsbury Hospital
Mytton Oak Road
SHREWSBURY
Shropshire
SY3 8XQ
01743 261262

To Consultants, Staff and Associate Specialists,

20th May 2013

Dear Colleague

I have already introduced myself as SaTH's new Medical Director and, over the last 7 weeks, have been kept very busy dealing with a wide range of issues and meeting many of my new colleagues.

I am writing on this occasion to introduce an initiative that will be an important part of our engagement at SaTH over the next year.

Welcome to DEEP!
The Doctors' Essential Education Programme.

I have identified areas that, as senior medical staff responsible for leading the clinical development of care of patients in SaTH, need to be done better. These include job planning and appraisal.

I know that many colleagues are familiar with both of these, but not everyone is. I also know that it will be a requirement during the year 2013/14 for all doctors to have completed a job plan review, and to have completed an appraisal, particularly as this will be essential for your revalidation.

As one of the BMA's negotiators for both the new consultant contract and implementation of appraisal, I trust that you will feel that I am reasonably able to provide refresher training on these. Having discussed this matter with both the LNC and SMSC, and come to agreement with regard to the need for this, I have arranged for four meetings to be held, during which these topics will be covered.

It is planned that the top-up training in job planning and appraisal will provide the first two modules in a continuing refresher course that we will run over the next year at SaTH. *Whilst your attendance is not mandatory*, given that these two subjects are essential parts of your contractual responsibility with the Trust, *you are very strongly encouraged to take part in* ***one*** *of the* ***four*** *seminars:*

- **11th June 1730** hrs Lecture Theatre, **PRH** Education Centre
- **13th June 1730** hrs Seminar room 5, SECC **RSH**
- **20th June 1730** hrs Lecture Theatre, **PRH** Education Centre
- **2nd July 1730** hrs Dinwoodie Theatre, SECC **RSH**

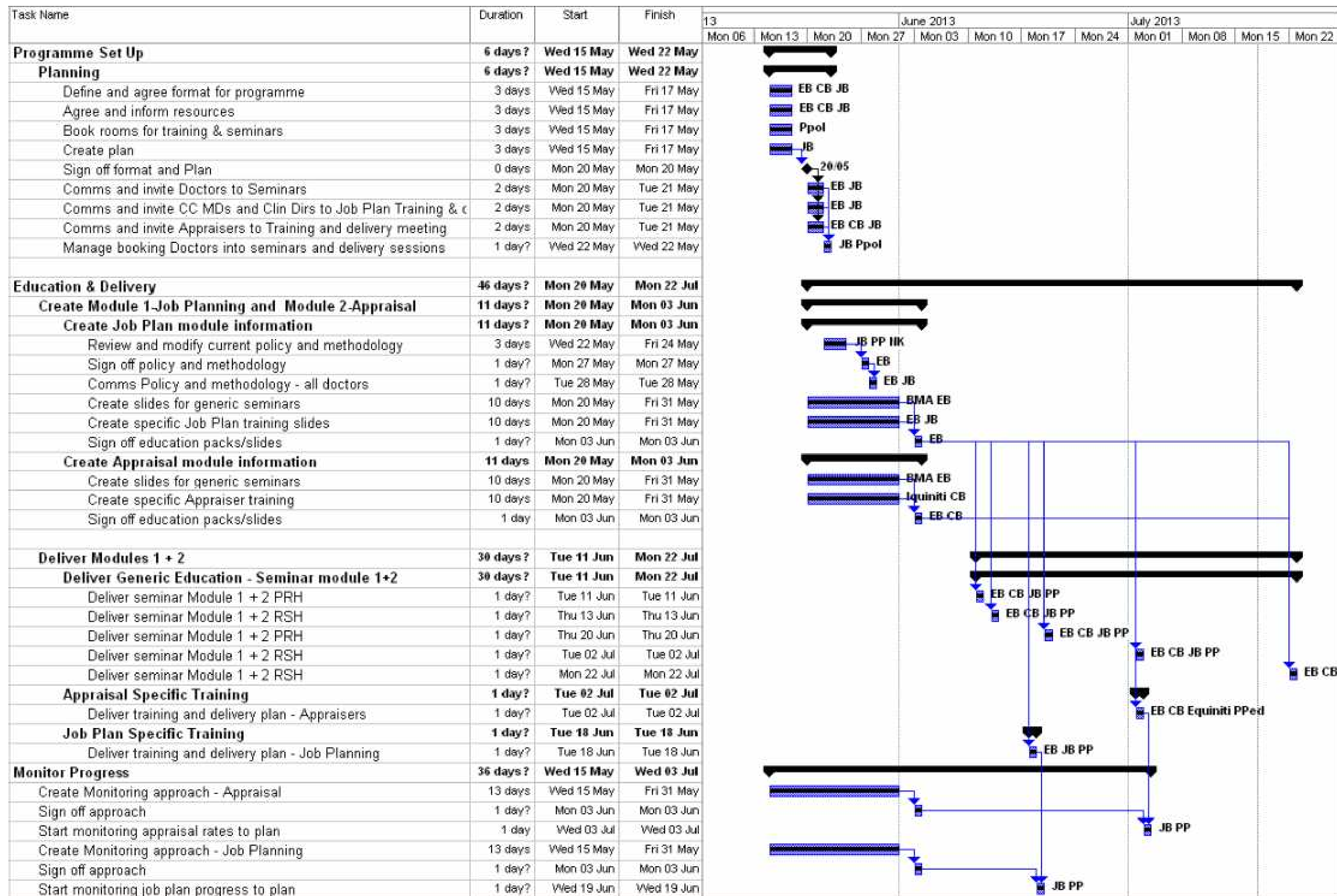
On each of these four occasions both job planning and appraisal will be covered so that everyone has an opportunity to understand the approach that will be taken in SaTH for these two contractual responsibilities.

In order to avoid overcrowding at any single event, please could you inform Justin Barnes which particular date you wish to attend by either e-mail Justin.barnes@sath.nhs.uk or ext 1145.

Yours sincerely

Edwin Borman
Medical Director

Appendix 2. Programme Plan and Time Plan



Task Name	Duration	Start	Finish
Programme Set Up	**6 days?**	**Wed 15 May**	**Wed 22 May**
Planning	**6 days?**	**Wed 15 May**	**Wed 22 May**
Define and agree format for programme	3 days	Wed 15 May	Fri 17 May
Agree and inform resources	3 days	Wed 15 May	Fri 17 May
Book rooms for training & seminars	3 days	Wed 15 May	Fri 17 May
Create plan	3 days	Wed 15 May	Fri 17 May
Sign off format and Plan	0 days	Mon 20 May	Mon 20 May
Comms and invite Doctors to Seminars	2 days	Mon 20 May	Tue 21 May
Comms and invite CC MDs and Clin Dirs to Job Plan Training & c	2 days	Mon 20 May	Tue 21 May
Comms and invite Appraisers to Training and delivery meeting	2 days	Mon 20 May	Tue 21 May
Manage booking Doctors into seminars and delivery sessions	1 day?	Wed 22 May	Wed 22 May
Education & Delivery	**46 days?**	**Mon 20 May**	**Mon 22 Jul**
Create Module 1-Job Planning and Module 2-Appraisal	**11 days?**	**Mon 20 May**	**Mon 03 Jun**
Create Job Plan module information	**11 days?**	**Mon 20 May**	**Mon 03 Jun**
Review and modify current policy and methodology	3 days	Wed 22 May	Fri 24 May
Sign off policy and methodology	1 day?	Mon 27 May	Mon 27 May
Comms Policy and methodology - all doctors	1 day?	Tue 28 May	Tue 28 May
Create slides for generic seminars	10 days	Mon 20 May	Fri 31 May
Create specific Job Plan training slides	10 days	Mon 20 May	Fri 31 May
Sign off education packs/slides	1 day?	Mon 03 Jun	Mon 03 Jun
Create Appraisal module information	**11 days**	**Mon 20 May**	**Mon 03 Jun**
Create slides for generic seminars	10 days	Mon 20 May	Fri 31 May
Create specific Appraiser training	10 days	Mon 20 May	Fri 31 May
Sign off education packs/slides	1 day	Mon 03 Jun	Mon 03 Jun
Deliver Modules 1 + 2	**30 days?**	**Tue 11 Jun**	**Mon 22 Jul**
Deliver Generic Education - Seminar module 1+2	**30 days?**	**Tue 11 Jun**	**Mon 22 Jul**
Deliver seminar Module 1 + 2 PRH	1 day?	Tue 11 Jun	Tue 11 Jun
Deliver seminar Module 1 + 2 RSH	1 day?	Thu 13 Jun	Thu 13 Jun
Deliver seminar Module 1 + 2 PRH	1 day?	Thu 20 Jun	Thu 20 Jun
Deliver seminar Module 1 + 2 RSH	1 day?	Tue 02 Jul	Tue 02 Jul
Deliver seminar Module 1 + 2 RSH	1 day?	Mon 22 Jul	Mon 22 Jul
Appraisal Specific Training	**1 day?**	**Tue 02 Jul**	**Tue 02 Jul**
Deliver training and delivery plan - Appraisers	1 day?	Tue 02 Jul	Tue 02 Jul
Job Plan Specific Training	**1 day?**	**Tue 18 Jun**	**Tue 18 Jun**
Deliver training and delivery plan - Job Planning	1 day?	Tue 18 Jun	Tue 18 Jun
Monitor Progress	**36 days?**	**Wed 15 May**	**Wed 03 Jul**
Create Monitoring approach - Appraisal	13 days	Wed 15 May	Fri 31 May
Sign off approach	1 day?	Mon 03 Jun	Mon 03 Jun
Start monitoring appraisal rates to plan	1 day	Wed 03 Jul	Wed 03 Jul
Create Monitoring approach - Job Planning	13 days	Wed 15 May	Fri 31 May
Sign off approach	1 day?	Mon 03 Jun	Mon 03 Jun
Start monitoring job plan progress to plan	1 day?	Wed 19 Jun	Wed 19 Jun