Reporting to:	**Trust Board Meeting - 26th June 2014**
Title	Integrated Performance Report - May 2014/15
Sponsoring Director	Peter Herring - Chief Executive
Author(s)	Directors
Previously considered by	Not Applicable
Executive Summary	This report summarises the Trust's performance against all the key quality, finance, compliance, and workforce targets and indicators for 2014-15 to date and considers all elements of performance. It also contains the Board self certifications required to be submitted to the TDA in relation to Governance and Monitor Licence Conditions. SaTH is currently at Escalation Level 4 (of 5) in the NHS Trust Development Authority's Accountability Framework. This is classified as a 'Material issue' requiring interaction led by the Director of Delivery & Development. Regular meetings are held with the TDA to update on SaTH's improvement trajectories. They key areas of focus are highlighted in this report.
Strategic Priorities ☒ Quality and Safety ☒ Healthcare Standards ☒ People and Innovation ☐ Community and Partnership ☒ Financial Strength	**Operational Objectives** QS1 - Reduce avoidable deaths QS2 - Improve the nutritional status of patients and hydration and fluid management QS3 - Enhance communication and information for all patients and their carers QS4 - Eradicate all avoidable grade 3 and 4 pressure ulcers QS5 - Reduce the number of RIDDOR reportable falls HS3 Deliver all key performance targets PI1 - Implement a Staff Engagement Framework that improves employment experience and reduces absence to less than 4% FS1 - Deliver our milestones to achieve NHS Foundation Trust status FS3 - Deliver a financial surplus of £1.2m FS4 - Deliver the Trust 5% implied efficiency target and support delivery of joint QIPP
Board Assurance Framework (BAF) Risks	☒ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience ☒ If we do not implement our **falls** prevention strategy then patients may suffer serious injury ☐ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff ☒ If we do not achieve safe and efficient **patient flow** and improve our processes and capacity and demand planning then we will fail the national quality and performance standards ☐ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients ☐ If we do not get good levels of **staff engagement** to get a culture of continuous

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

INTEGRATED PERFORMANCE REPORT – MAY 2014/15

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

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

1. QUALITY & SAFETY PERFORMANCE

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

OVERVIEW

- Clostridium Difficile infections have risen in May and although antibiotic therapy has been a factor in some cases, there are others where a delay in sending a sample may have meant that the infection was attributed to the Trust rather than before admission. This was a theme during 2013/14 and must be improved upon this year.
- Maternity Dashboard has shown amber for two months in a row. The dashboard is made up of a large number of indicators with the last two months being amber for smoking cessation and gestational booking date respectively. Elements of these indicators within organisational control have actions in place.
- Where relevant the below indicators are reported by ward through the use of the Quality Dashboards. These KPIs will be used to triangulate quality of care to nurse staffing levels from July 2014
- Safety thermometer – New Harms has been added to the report. This measures only the harms that have occurred to patients whilst under the Trust's care whilst all harms refers to both new and harms that occurred prior to admission.

	Measure	Annual Target 14/15	Monthly Target	YTD	February	March	April	May	Year end 13/14
Patient Safety	*Risk Adjusted Mortality Index (RAMI)*	**SaTH < NP**	**SaTH < NP**	80/84	80/90	SaTH 69	SaTH 78	TBC	80/82
	RIDDOR/SI Reportable Falls	**29**	**2**	5	5	3	2	3	34
	Grade 4 Avoidable Pressure Ulcers	**0**	**0**	0	0	0	0	0	0
	Grade 4 Unavoidable Pressure Ulcers	**N/A**	**N/A**	0	0	0	0	0	5
	Grade 3 Avoidable Pressure Ulcers	**9**	**0**	2	1	3	2	0	18

	Grade 3 Unavoidable Pressure Ulcers	**N/A**	**N/A**	2	3	0	2	0	17
	Grade 2 Avoidable Pressure Ulcers	**12**	**1**	3	3	0	2	1	17
	Grade 2 Unavoidable Pressure Ulcers	**N/A**	**N/A**	3	4	4	2	1	46
	Grade 2 Unknown (avoidable vs unavoidable)	**N/A**	**N/A**	5	9	8	4	1	79
	C. difficile Infections	**30***	**3**	5	0	3	1	4	31
	MRSA Bacteraemia Infections	**0**	**0**	0	0	0	0	0	1
	MSSA Bacteraemia Infections	**20**	**1**	4	0	1	3	1	23
	E.coli Bacteraemia Infections	**40**	**3**	8	3	1	6	2	42
	MRSA Screening – Elective	**95%**	**95%**	96.5%	96%	95.5%	95.1%	96.1%	95.2%
	MRSA Screening – Non-Elective	**95%**	**95%**	96.4%	96.8%	96.9%	96.4%	96.4%	95.6%
	Number of Serious Incidents	**N/A**	**N/A**	12	10	12	6	6	145
	Never Events	**0**	**0**	0	0	0	0	0	0
	Safety Thermometer – Harm Free %	N/A	N/A	91.7%	92.3%	93.5%	90.9%	92.5%	92.6%
	Safety Thermometer – New Harms %	N/A	N/A	96.3%	94.8%	97.4%	95.8%	96.8%	N/A
	WHO Safe Surgery Checklist	**100%**	**100%**	99.9%	99.9%	99.9%	99.8%	100%	99.9%
	VTE Assessment	**95%**	**95%**	95.1%	95.1%	95.2%	95.1%	95.1	94.2%
	Maternity Dashboard	**Green**	**Green**	N/A	Green	Green	Amber	Amber	N/A
	Ward to Board – Nursing Performance Score	**95%**	**95%**	93%	95%	95%	93%	93%	93%
Patent Experience	*Number of Complaints*	**N/A**	**N/A**	52	33	38	25	27	444
	Same Sex Accommodation	**0**	**0**	0	0	0	0	0	0
	Friends and Family Response Rate	**NA**	**NA**	12.1%	16%	16%	11.5%	12.7%	9.9%
	Friends and Family Test Score	**75**	**75**	76.5	76	75	75	78	75.8
	Ward to Board – Patient Experience Score	**95%**	**95%**	89%	86%	87%	89%	84%	87%

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

1.2 AGREED TARGETS FOR 2014/15

Quality performance targets for 2014/15 have now been agreed at a national and local level. The process for agreeing local targets has been in collaboration with the Director for Infection, Prevention and Control and using the outturn position of last year whilst applying a stretch target for 2014/15. The list below gives the agreed targets nationally and locally where they have changed.

RIDDOR/SI reported falls – 15% reduction (29).
Grade 3 avoidable pressure ulcers – 50% reduction (9).
Grade 2 avoidable pressure ulcers – 30% reduction (12).
**Cdiff* – The agreed local internal *Cdiff* target for 2014/15 is 30. The national externally reported target set by Public Health England is 38.

MSSA – 10% reduction (20).
Ecoli – 10% reduction (40).

For information, the reporting of Grade 2 pressure ulcers has been included this month on the performance dashboard to include avoidable and unavoidable pressure ulcers. The dashboard also includes those Grade 2 pressure ulcers still pending to go through the process of validation via RCA. Historically approximately 50% are amended during this process as a result of identifying that they were found to be on admission to hospital, a moisture lesion and misreported or graded and therefore changed. This complex grading process is in synergy with other Trusts and through discussions with other patient safety teams; it is confirmed that initial misgrading is a common occurrence.

1.3 RISK ADJUSTED MORTALITY INDEX (RAMI) UPDATE

The Health and Social Care Information Centre appear to have completed the review into access to the Hospital Episode Statistics (HES) and other national datasets. The information has now been released to organisations that rely on standard extracts of HSCIC data, including HES, enabling the refresh of the analytics tools that they provide for NHS customers. We are now able to report our performance against our National peers and we are maintaining good performance. However, it has affected the timeliness of the availability of data, with extended delays in the availability of the peer information.

1.4 EXTERNAL FEEDBACK AND ASSURANCE

Organisation	Visit Date	Where	Outcome	Status
NTDA	8th May 2014	PRH	Immediate actions were requested in relation to mattress storage and ward cleaning schedules. Assurances were given to the TDA and demonstrated that we have responded to the issues identified on previous visits with actions in place and timescales adhered to.	Actions and plan completed providing assurances to the TDA. No further visit planned until December 2014.

1.5 REGULATION 28 (formerly known as Rule 43)

There were no Regulation 28's during May 2014.

1.6 SAFEGUARDING – ADULTS & CHILDREN

There were 10 adult safeguarding alerts made towards the Trust during May which is an increase compared to last month. 4 of the alerts have been closed at stage one with the other 6 pending further investigation. A key theme within the alerts is the quality of discharge when the patient is sent home, relating to discharge information provided, amount of care provided at home and medicines management.

There were 4 direct referrals to social services made by Trust staff during May; with concerns in relation to safeguarding children within the hospital. 2 of these referrals resulted in the children being fostered. There were 75 internal alerts raised by ED at PRH and 37 at RSH ED; that in the main related to staff concerns regarding parental capability.

1.7 SERIOUS INCIDENTS

There were 6 SIs reported in May 2014, all of which related to clinical effectiveness:

3 – SI reportable falls (1 was reported under RIDDOR guidance, 1 has been reported as an incident whilst not meeting RIDDOR criteria and 1 remains under consideration)

1 – Delayed treatment

1 – Intrapartum death

1 – Absconsion

Table 1 provides an update on the position of incidents for May; including progress towards closing investigations and completed action plans. There are 6 action plans outstanding for 2012/13 which remains the same as last month; these relate to the medicine, surgical, emergency care and women's and children's care groups. Similarly, there are 36 action plans outstanding for 2013/14 which is an increase of 2 compared to last month and relate to all of the care groups. The Care Group Medical Directors, Assistant Chief Operating Officers and Head's of Nursing are aware and managing the closure of actions and plans.

Table 1: Incident Status

	New Incidents for May 2014	**6**
	Incidents being investigated	**16**
	Out of 20 day internal deadline (excludes external deadline)	**2**
	Out of 30 day deadline with CCG/CSU	**0**
	CCG have been asked to close incident	**22**

Table 1 also shows that there are 16 incidents open to investigation; of these, 6 have an agreed extended timeline for completion/clock stops with commissioners as a result of their complexity. 22 incident investigations have been completed with a request sent to commissioners to close these on the STEIS system (of which 2 still require removal as evidence found that they did not meet the criteria of an SI). 2 incidents remain under investigation and are outside of the internal timescale target. There are currently no incidents under investigation that exceed the external closing target for commissioners. There is a continued improvement on the timeliness of completion of each RCA and this will be monitored following changes to the completion target dates agreed with Commissioners as part of the contract negotiations for 2014/15.

1.8 REVIEW OF ROOT CAUSE ANALYSIS (RCA) COMPLETED IN APRIL 2014

A review of the completed RCAs and action plans for SIs reported in April has been undertaken to explore learning and potential themes. Of the 6 RCAs reported in April, 2 have clock stops applied and are therefore still in progress, 1 is near completion and 1 is pending internal approval. Of the 2 remaining investigations, the outcome of an influenza outbreak shows that it is likely to have been external contact and therefore incidental. Investigation and support from the Infection Control team confirm this was a well managed outbreak with the only clear learning is for the influenza policy to be slightly modified and updated.

The RCA into a Grade 3 Pressure ulcer shows that there were several factors within its development. There was a significant element of patient compliance and there was evidence of inconsistency with the use of the repositioning charts, associated with the use of colloquial terms such as 'turned regularly' within the nursing evaluation. The year end review of Pressure ulcers has also highlighted inadequate documentation as one of the key elements that is lacking within all the trust acquired grade 3 pressure ulcers. There is an ongoing education programme in place, and feedback is established through team briefings and also shared at senior nursing forums for Trust wide learning.

1.9 QUALITY IMPROVEMENT OVERVIEW

Measure	Annual Target	Monthly Target	YTD	February	March	April	May	Year end 13/14
C. difficile	**30**	**3**	5	0	3	1	4	31
Current State	The Trust is on trajectory to meet the target for the full year based on the combined first 2 months of performance. However, this assumes that we report within our monthly target each month.							
Planned Actions	• Remind staff of the importance of taking samples early after admission to prevent cases being counted wrongly against the Trust. • Continued RCAs to be undertaken by IPCN. • Focus on cleanliness including commodes. • Compliance with antibiotic prescribing to be audited by pharmacists. • Education of staff on avoiding inappropriate samples.							
Key Themes/Trends	Most cases were considered unavoidable due to necessary and appropriate antibiotic therapy but 2 cases this month were probably admitted with *Cdiff* and there was delay in sending samples The DIPC is undertaking an annual review of all infection outbreaks during 2013/14, in order to understand key themes, trends and risk factors for the year. This will be available for Quality and Safety Committee in July 2014 and will be used to plan the ongoing strategies for IPC and prevention in the coming year.							

2. OPERATIONAL PERFORMANCE OVERVIEW

OVERVIEW

- **Operational Resilience and Capacity Planning for 2014/15**

Monitor, the Trust Development Authority, NHS England and the Association of Directors of Adult Social Services have published guidance on operational resilience and capacity planning for 2014/15.

It describes the need for Urgent Care Working Groups to build upon their existing roles, and expand their remit to include elective as well as urgent care. They will now become a forum where capacity planning and operational delivery across the health and social care system is co-ordinated. This will underline the importance of whole health system resilience and that both parts need to be addressed in order for local health and social care systems to operate as effectively as possible in delivering year-round services for patients. The importance of delivering resilience whilst maintaining financial balance is emphasised.

The document sets out in detail the planning arrangements and requirements for the coming year and the mechanisms for monitoring delivery and the allocation of non-recurrent funding.

	Shropshire CCG	Telford & Wrekin CCG
Elective	£1.17M	£673K
Urgent	£1.92M	£1M

The System Resilience Groups (SRG's) as they will be known are required to submit resilience and capacity plans by 30th July 2014.

Core aspects of good practice which local systems must include in their planning in 2014/15 are included.

SRG's are requested to benchmark themselves against these and then include in their submission plans to achieve the requirement. The funding which has been allocated will be used to support delivering best practice.

The document was published 13th June 2014 and work on the submission has begun in earnest. The guidance is included within the Trust Board information pack.

- **Review of the Local Health and Social Care Economy Winter Plan**

  A pan Shropshire review of 2013/14 Recovery Plan and associated winter schemes was undertaken and a report submitted to the Shropshire and Staffordshire Area Team NHS England at the end of April 2014.

  This is included in the Trust Board Information Pack.

  The themes of the lessons learned included:

  - Planning process to be completed by the end of May;
  - Spot purchasing of beds needs to be in line with specific patient requirements, rather than block booking;
  - Discharges need to occur at the same rate 7 days a week;
  - Developed trusted assessor status with care homes;
  - Consider alternative providers for patient transport;
  - The need for 7 day working 365 days of the year;
  - Focus on admission avoidance schemes in 2014/15;
  - Focus on a few high impact projects rather than multiple small ones.

- **Performance Management**

  The Urgent Care Working Group continues to be co-chaired by the Area Team and CCG's to support the health and social care economy in delivery of the A&E 4 hour target. The strategic direction for urgent care in the local system is still being led by the CCG's.
  Twice monthly whole health economy senior managers meetings continue chaired by the Area Team. This group has the responsibility for developing a SMART plan to deliver improvements in performance against the A&E 4 hour target. As part of this the Emergency Care Intensive Support Team [ECIST] will support delivery of the plan and at SaTH will focus on improving pre 10 and weekend discharges.

  The Trust was also required to submit an A&E recovery plan and trajectory to the Trust Development Authority [TDA] outlining plans to sustainably deliver the 4 hour target. This plan does not show the Trust, through its internal improvement plans being able to do this, as delivery of the target sustainably requires there to be a high performing whole health and social care system to be in place. The development of Urgent Care Centres and emergency ambulatory care this year will support this. We are awaiting feedback from the TDA following submission of the plan and trajectory on 17th June 2014.

  In order to support continued improvement a weekly Health Economy wide A&E exception report has also been requested by the TDA. A dry run took place week commencing 9th June with the live reporting process beginning on 16th June 2014.

  The aim of this exercise, supported by the TDA, is to focus on the whole Health Economy opportunities for improvement as well as the ongoing focus on improvement within the acute

Trust. Towards the end of Q4 2013/14 and into Q1 of 2014/15 SaTH is experiencing the combined pressures of bed capacity shortage, increased demand and an increase in the number of patients who are Fit to Transfer. This coupled with the extreme pressures being felt due to specific issues within Powys have combined to make improvement in performance against the 4 hour patient safety standard extremely challenging.

- **Local Health and Social Care Schemes**

  Development of Urgent Care Centres

  A strategic objective for the Trust and both Shropshire and Telford & Wrekin Commissioners is the development of Urgent Care Centres and emergency ambulatory care models of care on both the Royal Shrewsbury Hospital [RSH] and Princess Royal Hospital [PRH] sites.

  The scheme at RSH is the most advanced. The model of care is expected to be finalised for presentation to the SaTH Executive team and Shropshire CCGs' Clinical Advisory Panel in the first week of July 2014 with the potential for this to progress for discussion at the Overview and Scrutiny Committee on 14th July and then for presentation to the Trust Board at its July meeting.

- **Delayed Transfers of Care**

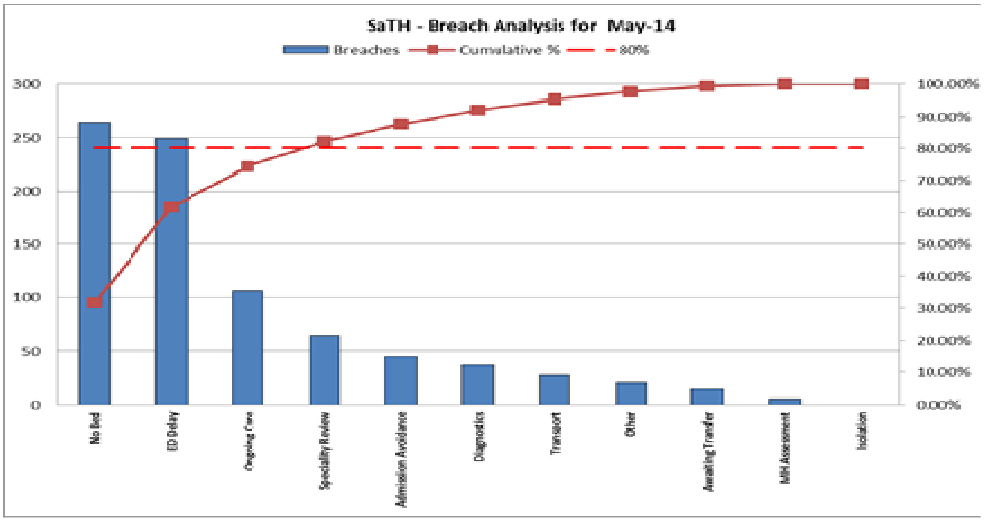
  In May and continuing into June there has been a particular issue with delays in transfer of care for Powys patients. This has been as a direct result of a change in the provider of domiciliary and reablement services at the end of April. This has led to 14 patients being delayed by 111 days.

  Correspondence and negotiations with Powys, supported by the Urgent Care Working Group are ongoing to resolve this situation as soon as possible and a potential solution has been found but will not completely resolve the number of delays.

- **4-hour Access Standard**

  In May 2014 92.04% of patients were admitted or discharged within the 4 hour quality target, representing a slight drop of 0.47% compared to April. This is against a backdrop of an increase in emergency department attendances of 3.7% and non elective admissions of 8.92% in May. In comparison to May 2013 non elective admissions have increased by 8.23%. Year to date the Emergency Department attendances are 4.75% above plan and non elective admissions are 7.9% above plan. Year to Date [YTD] performance is reported as 92.27%, this is 0.27% above the Trust projected position of 92% for May. The Emergency Department Remedial Action Plan [RAP] continues to be the focal point for continued improvement. ED delays in late May and into June have been aligned to overall patient acuity rather than process. The primary breach reasons of ED delay (including acuity) and bed capacity are generally, week by week, running in parallel. In order to address the issue of ED breaches occurring due to insufficient cubicles, there is a focus on areas such as Stroke where a model of direct admission has the potential to be evolved to relieve the ED pressures.

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



As per the April Board Report, Healthcare at Home has completed their diagnostic assessment of the potential for a 'recovery at home' service. This has been received by Executive Directors who are in discussion with Commissioners on the potential for this scheme to ease the pressure on acute bed capacity. Alternative models are also being considered internally, since they may represent a more favourable business model going forward.

- **RTT Performance**

Admitted

All specialties are on trajectory to achieve 18 weeks (exception report enclosed within the Trust Board information pack) in accordance with the Remedial Action Plan [RAP]. Overall delivery will be from 1st September 2014, with the exception of Oral surgery where there is no agreed trajectory. We are working with NHS England to produce a trajectory to deliver within this specialty.

The drop in day surgery theatre is in place and operational on the Princess Royal Hospital site. It is being used to clear the backlog in Orthopaedic and Oral surgery.

Non admitted

The Trust delivered the overall non-admitted performance in May; however, there is still a significant backlog within Ophthalmology. A trajectory for delivery of the standard from September is now in place; however this needs close monitoring with the CCGs to ensure if off trajectory corrective action is immediately taken.

RTT Clearance times

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

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

- Admitted - 8.3 weeks
- Non- admitted – 12.5 weeks

The Trust backlog clearance times for May were as follows:

- Admitted - 1.2 weeks
- Non- admitted - 1.2 weeks

- **Cancer Performance**

The validated position at the end of April was that the Trust failed four of the cancer standards.

The unvalidated position for May indicates that the Trust failed four of the cancer standards. Further work is being undertaken to establish the reasons why and the following actions are being taken:

- Weekly cancer assurance meeting with the CCGs identifying areas for improvement;
- Cancer predictor tool to be reviewed to ensure it is fit for purpose;
- Weekly meetings between MDT coordinators and Centre teams, to improve tracking and delays in the process;
- Ensure that Somerset (cancer information system) is regularly updated and performance is monitored at the weekly PTL meeting;
- Discussion with the Commissioners to understand why there has been a 14% increase in the number of patients being referred on a 2 week wait pathway. Also non compliance of GP's with the pathway.

There has been an improvement in the use of the cancer PTL and the tracking process over the last three weeks. The weekly PTL meetings will continue to take place until there is assurance within the Centre's and Cancer services that all processes are being adhered to.
The IST has completed a review of Radiology services and the themes include:

- The need for visibility of the 6 week diagnostic target breach date through a diagnostic patient tracking list (PTL);
- Capacity constraints in each of the modalities (e.g. ultrasound, CT etc.), detailed capacity and demand analysis is being undertaken;
- The need to develop metrics for the monitoring of service performance to include the establishment of quality indicators;
- To prioritise the electronic vetting of referrals to remove non value added tasks from the process e.g. the manual entry of data.

Following these recommendations, the Radiology department has developed an action plan, which will be updated following the Radiology Board and performance will be monitored at the monthly Cancer Board meeting.

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

OVERVIEW OF PERFORMANCE – MONTH 2 – 2014/15

Month 2 - 2014/15

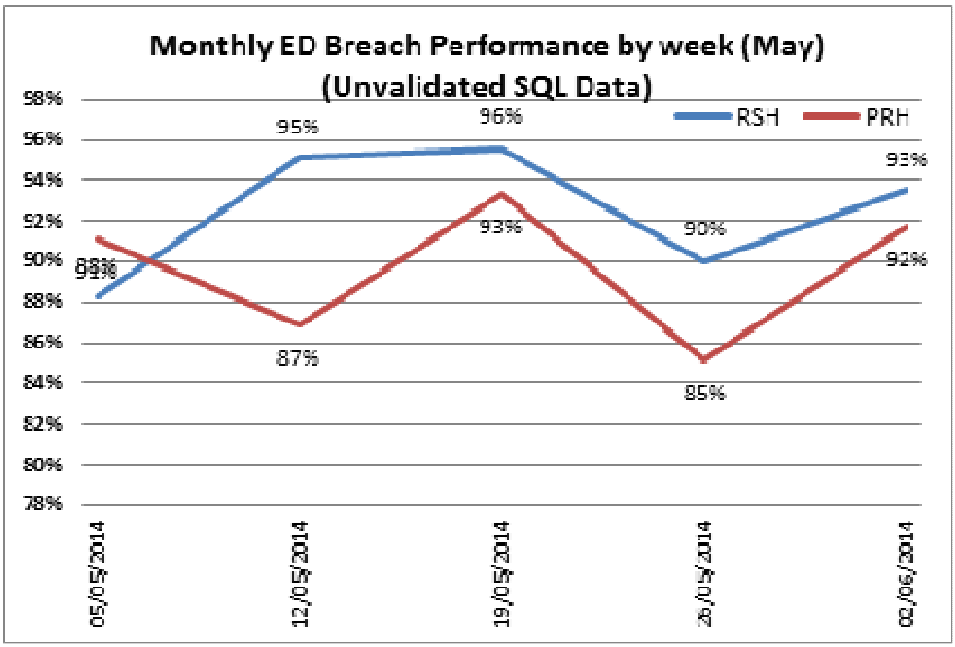
	Measure	Outturn Period	2013/14 Outturn	2014/15 Threshold	M1 Apr-14	M2 May-14	2014/15 Year to Date
Access	A&E 4 Hour Wait	Full Year	93.40%	95%	92.51%	92.04%	92.25%
	A&E 12 Hour Trolley Waits	Full Year	17	0	0	0	0
	Ambulance Handovers not completed within 30 Minutes (SaTH Validated View)	Full Year	275	0	12	14	26
	Ambulance Handovers not completed within 60 Minutes (SaTH Validated View)	Full Year	41	0	4	3	7
	18 Week RTT Admitted - English Responsible Only - Part 1A	Mar-14	76.98%	90%	80.19%	80.07%	
	18 Week RTT Non Admitted - English Responsible Only - Part 1B	Mar-14	93.08%	95%	93.95%	95.04%	
	18 Week RTT Incomplete Pathway - English Responsible Only - Part 2	Mar-14	89.71%	92%	89.82%	89.89%	
	18 Week RTT > 52 Weeks - English Responsible Only	Full Year	38	0	0	0	0
	% of Patients waiting over 6 Weeks for a Diagnostics Test	Full Year	0.51%	1%	0.24%	0.08%	0.16%
	Cancelled 28 Day Readmission Breaches	Full Year	14	0	1	0	1
	Number of Urgent operations cancelled more than once	Full Year	0	0	0	0	0
Cancer	2 Week GP referral to 1st OP Appointment	Full Year	94.58%	93%	92.49%	92.47%	92.48%
	2 Week GP to 1st OP Appointment Breast Symptoms	Full Year	93.35%	93%	86.80%	96.15%	90.00%
	31 day diagnosis to treatment	Full Year	97.33%	96%	97.60%	92.67%	94.97%
	31 day second or subsequent treatment - Drug	Full Year	99.09%	98%	98.44%	98.44%	98.44%
	31 day second or subsequent treatment - Surgery	Full Year	93.35%	94%	95.45%	84.21%	90.91%
	31 day second or subsequent treatment - Radiotherapy	Full Year	97.69%	94%	100%	96.25%	98.05%
	62 days urgent referral to treatment	Full Year	81.48%	85%	84.21%	79.12%	81.59%
	62 days referral to treatment from Screening	Full Year	93.98%	90%	85.71%	95.00%	91.80%
	62 days referral to treatment from Hospital Specialist (Upgrades)	Full Year	92.13%	85%	92.86%	88.51%	90.21%
Patient Experience / Governance	C-Diff	Full Year	31	38	1	4	5
	MRSA	Full Year	1	0	0	0	0
	Same Sex Accommodation Breaches	Full Year	0	0	0	0	0
	Compliance with VTE Assessments	Mar-14	95.20%	95%	95.13%		
	Publication of Formulary	Mar-14	Yes	Yes	Yes	Yes	
	Duty of Candour	Mar-14	N/A	0	0	0	
	Valid NHS Number in submitted Acute datasets	Mar-14	N/A	99%	99.79%	99.76%	99.78%
	Valid NHS Number in submitted A&E datasets	Mar-14	N/A	95%	98.56%	98.64%	98.60%

2013/14 Outturn Performance is RAG rated against the relevant 13/14 Target

2.2 OVERVIEW OF PERFORMANCE STANDARDS BY EXCEPTION

Measure	Annual Target	Monthly Target	YTD (Inc WI)	February	March	April	May	Year end 13/14
A&E 4 Hour Wait	95%	95%	92.27%	93.48%	92.67%	92.56%	92.04%	93.40%

Current State



The above graph shows the ED performance by week in May.

May was a challenging month of increased demand; the data indicates that for most days during the first three weeks of the month there were over 300 attenders across both sites. As a result SaTH averaged 91.5% performance in those first 3 weeks. The pressures were particularly felt at PRH, which in general is the site that performs best. The pattern of overall improvement however compared to the same period last year continues, and no 12 hour breaches occurred.

Planned Actions

The cycle of improvement, which includes progress within discrete ongoing projects in Unscheduled Care, continues. The following actions will be seen throughout the month and continue in to June as part of that planned programme of work:

- Continued focus on both EDs to ensure internal systems and procedures do not contribute to delays. An in depth review of processes and actions in the PRH ED took place in April.
- Continued improvement in direct admission numbers for Trauma & Orthopaedic patients (Ward 11, Bay A).
- MSK to provide a weekend / out of hours plan to enable better management of trauma activity out of hours. This to include reflection and improvement week on week.
- Cardiology at PRH to begin to "test" a greater throughput of ambulatory activity to demonstrate improvement in utilisation of in-patient beds
- Review of stroke pathway and response times to ED took place, however the next step is to explore the potential for direct admission in order to better manage

Stroke and alleviate pressure on the ED.

- Produce formal project plans and PIDs for the 7 major and 4 whole service operational projects that are in progress within the Unscheduled Care Group. These include:
    - Development of an Ambulatory Emergency Care service at PRH in collaboration with Telford and Wrekin CCG to deliver admission avoidance,
    - Collaborating with the Shropshire Country CCG who will lead on an Urgent Care Centre project to be based at RSH,
    - Integrated Care Service roll out in Shropshire,
    - Emergency Ambulatory Care at RSH,
    - Improvement to the existing model ambulatory emergency care model at PRH,
    - Reconfiguration of Medicine Strategy plan includes:
        - Reconfiguration of Cardiology – main service on one site with Chest Pain Assessment on other site;
        - Trialling of an improved Elderly Care Model (Elderly Care Assessment Unit, Frail & Complex) supported by therapies but limited by recruitment challenges in Care of the Elderly workforce;
        - Short stay – both sites;
        - Moving to 7 day Stroke / TIA service;
        - Provision of a Clinical Decision Unit at PRH;
        - Relocation of the Cardiorespiratory Department.

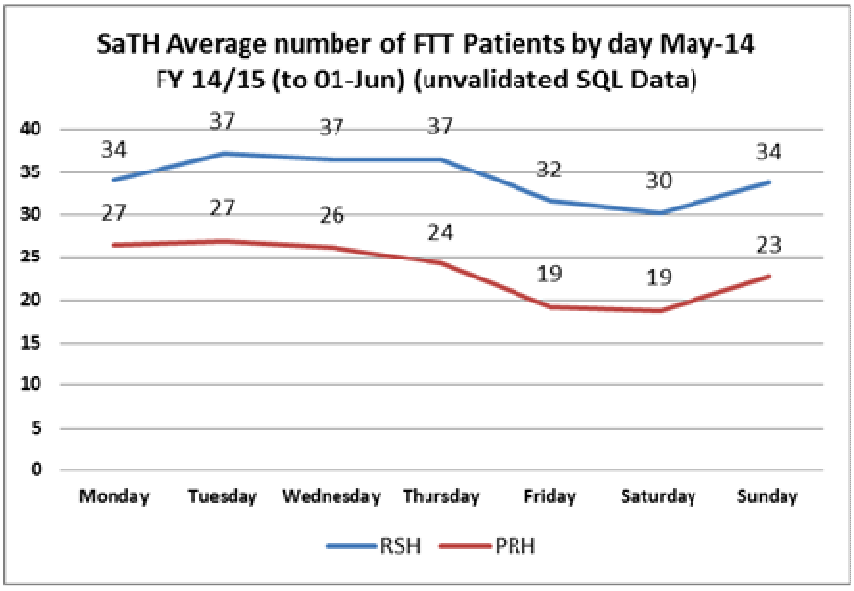
There will be continued exploration of options to develop a "Hospital without Walls" model of care to support safe movement of patients to an alternative non acute based setting.

- The Care Group continues to focus on the need for improvement in patient flow. Work is on-going with wards and ward teams to deliver capacity early in the day by achievement of discharges pre 10, 12 and 3. Work has taken place to identify and understand the constraints to success in this area. All matrons, ward managers, Clinical Directors and clinical leads have been written to in order to emphasise the critical need for capacity early in the day to be identified and focussed work is on-going to support medical and nursing teams to achieve in this area. Whilst the focus is on the internal issues we know and understand – there are still external health economy issues which conspire against us. In the main these are residential and nursing homes having rigid rules about when they will not take patients i.e. later in the day, on Friday, not more than 1 admission per day etc. and community hospital beds not becoming available until late in the day.
- There has been a refocus on Check Chase Challenge during May
- The Capacity team are now fully recruited and will move to a dedicated Discharge Hub in the next two weeks.
- Primary breach reasons continue to be lack of capacity (beds) for a variety of reasons and ED delays due to acuity (over all acuity, not individual complex patients).
- The Fit for Transfer numbers continue to increase and are now compounded by the absolute issues being experienced within Powys. These appear to be contractual and related to service provision in the community. Powys community staff have raised a number of vulnerable adult reports (POVAs) due to a failure to deliver packages of care.

This is not expected to improve until the autumn. A solution has been agreed that Powys will fund patients to occupy Shropshire County community beds to relieve acute bed pressures, however these are existing and not additional beds, therefore the benefit over all is expected to be small.

Key Themes/ Trends

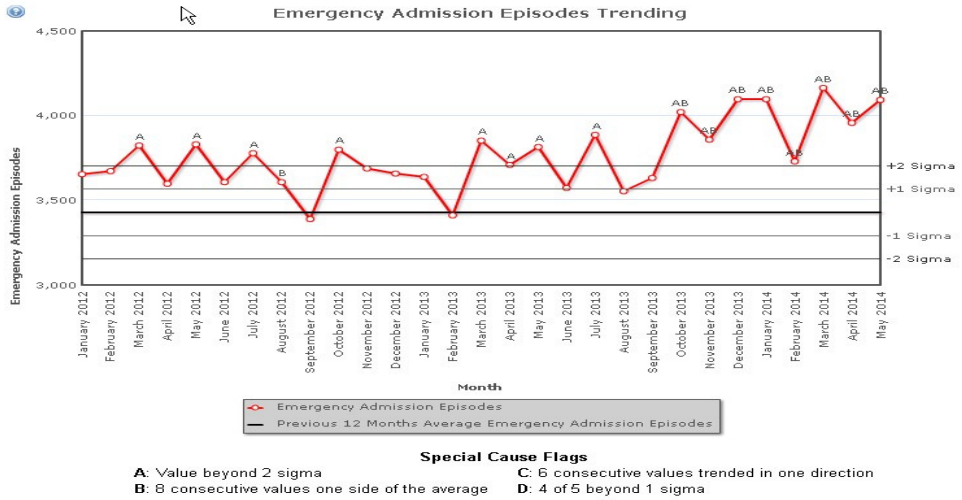
Fit to Transfer Trend Chart – Daily Average by Site/Month



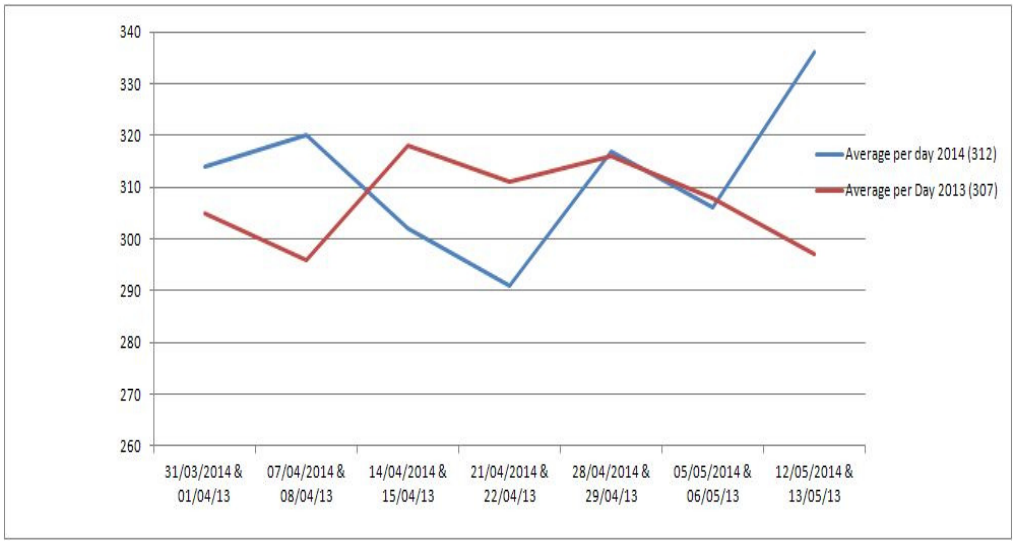
The above graph indicates the Fit for Transfer increase. Post winter these numbers had reduced to approximately 30 but have now increased to the levels experienced during winter.
Discussions have been held with both CCG's about this. The main concern is at Princess Royal Hospital where a change in the brokerage of Care Homes is the cause of the increase in delays.

Emergency Admissions

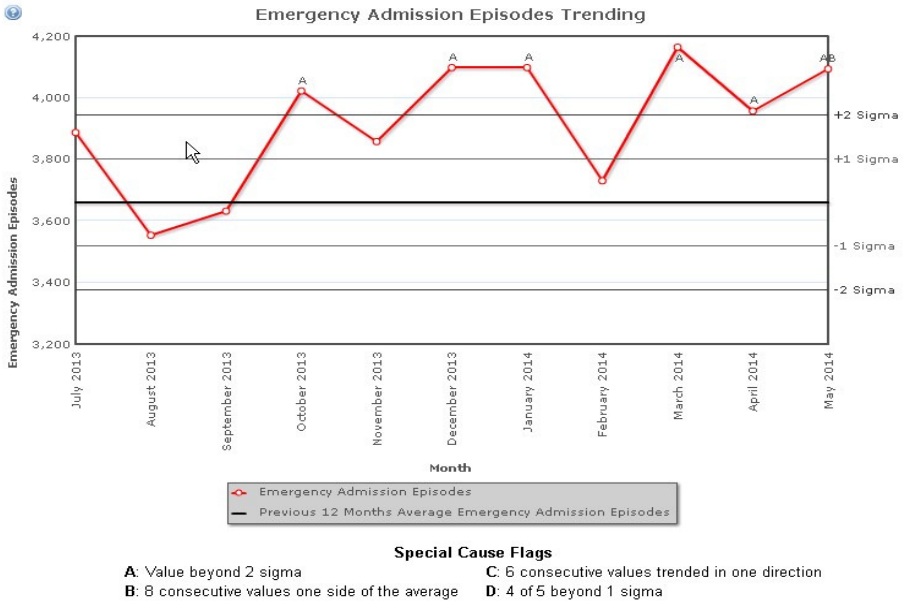
The following graph shows the increasing trend in emergency admissions, including 0 day length of stay, which correlates with the national position. It highlights a continued trend of increased admissions; this is linked to increased attendances. This also links to the increase in ED breach delays which includes delays which occur due to overall acuity of patients in the department at any one time which generally lead to ED doctor / clinical assessment delays due to pressure.



The following Graph highlights a comparison against 2013; indicating as in last month's report an average of 5 additional attendances per day, but a significant increase of 30 attenders per day during the week of 12th May compared to same period last year. This correlates to the increase in admissions and demonstrates how the department felt on the ground.



The graph below highlights the increase in emergency admission episodes – the trend has continued from April; this would include data from AMU and SAU.



2.3 OVERVIEW OF PERFORMANCE STANDARDS BY EXCEPTION

Measure	Annual Target	Monthly Target	January	February	March	Year end 13/14	April	May	Year end 14/15
18 Week RTT Admitted - English Responsible Only	**90%**	**90%**	**81.73**	**79.15**	**76.98**	**76.98**	**80.19**	**80.07**	**%**
Current State	- The admitted performance failed to deliver the overall target in May. The trajectory is on target to deliver admitted performance from September 2014. Oral Surgery still does not have a trajectory in place; we are working with NHS England to achieve this.								
Planned Actions	- Fully utilise the Vanguard unit to clear the backlog within Orthopaedics and Oral surgery.								
Key Themes/Trends	- General surgery, urology, cardiology, general medicine, & gastroenterology continue to deliver the admitted standard								

Measure	Annual Target	Monthly Target	January	February	March	Year end 13/14	April	May	Year end 14/15
18 Week RTT Incomplete Pathway - English Responsible Only	**92%**	**92%**	**89.40**	**87.65**	**89.71**	**89.71**	**89.82**	**89.89**	**%**
Current State	- Target failed in May in line with the Remedial Action Plan (RAP).								
Planned Actions	- To ensure all patients are booked in accordance with the booking profile and trajectories. - Booking profiles to be reviewed at the weekly booing meetings.								
Key Themes/Trends	- Patients should be booked in chronological order unless clinically urgent.								

2.4 OVERVIEW OF PERFORMANCE STANDARDS BY EXCEPTION

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

Measure	Annual Target	Monthly Target	YTD	January	February	March	Year end 13/14	April	May	Year end 14/15
2 Week GP referral to 1st OP Appointment	**93%**	**93%**	**94.10%**	**94.69%**	**95.90%**	**95.93%**	**94.57%**	**92.49%**	**92.47%**	**%**
Current State	- Prediction target failed in May with 103/1367 patients breaching of which only 3 are due to no capacity; - Second episode of non-compliance in the current financial year.									
Planned Actions	- Continue validation of all patients under 2 week wait [2WW] to ensure category assigned is correct and that all appropriate adjustments have been applied; consider the adding of adjustments be undertaken by management as within Cancer Services - Centre Managers to investigate current capacity and demand; look to increase clinic availability earlier in the pathway - Training of 2WW clerks as to Cancer waiting times best practice to continue on a regular basis									
Key Themes / Trends	- Concerns have been raised over the categorisation of the referrals between the two 2WW target groups; and requires continued validation - Increased patient choice around the Bank Holidays period resulting in appointments being booked out of target; - Patient not being informed that they are on a 2 week wait referral pathway; - Patients being referred who are not available in the next 2 weeks to attend for an appointment; - 14% increase in referrals on this pathway in the last 5 months but no change in commission rates to confirmed Cancer.									

Measure	Annual Target	Monthly Target	YTD	January	February	March	Year end 13/14	April	May	Year end 14/15
31 day diagnosis to treatment	**96%**	**96%**	**97.09%**	**97.64%**	**96.93%**	**97.95%**	**97.43%**	**97.60%**	**93.15%**	**%**
Current State	- Predicted target failed in May with 13/190 patients breaching - First episode of non-compliance in the last 12 month period - Predicted position is expected to improve based on the current number of adjustments which require investigating									
Planned Actions	- Low staffing within cancer services contributing to a delay in data completeness of treatment information; temporary staffing in place; further training and support is required. - Further investigation into 8 patients still undergoing to ascertain if adjustments can be applied which may positively affect the final position - Reiterate best practice with regards to pooling surgical resources, ensure relevant information is recorded in the letters to enable appropriate adjustments to be added									

Key Themes / Trends	- 4x urology cases; adjustments on 3 cases are expected if initially offered TCI can be identified, 1 cases are contributed to capacity. - 2x gynaecology; adjustment on 2 cases are expected if initially offered TCI date can be confirmed. - Remaining cases; highlight patient choice, complexity and medical conditions which need resolving prior to treatment

Measure	Annual Target	Monthly Target	YTD	January	February	March	Year end 13/14	April	May	Year end 14/15
31 day second or subsequent treatment – Surgery	94%	94%	93.37%	94.44%	88.57%	100%	93.32%	95.45%	81.82%	%
Current State	- Predicted target failed in May with 4/22 patients breaching - First episode of predicted non-compliance within the current financial year									
Planned Actions	- Low staffing within cancer services contributing to a delay in data completeness of treatment information; temporary staffing in place however further training and support is required - Reiterate best practice with regards to pooling surgical resources, ensure relevant information is recorded in the letters to enable appropriate adjustments to be added - Change to current escalation meeting should enable even earlier detection of possible breaches and identify patients with TCIs booked out of target - Awaiting validation of data to ascertain if pauses can be applied.									
Key Themes / Trends	Surgical capacity: - 1x Breast contributed to consultant availability - 1x Urology was patient choice - 1x Urology was due to patient not being discussed at MDT which requires further investigation. - 1x Skin offered date out of target; requires further investigation however this does reference capacity as an issue									

Measure	Annual Target	Monthly Target	YTD	January	February	March	Year end 13/14	April	May	Year end 14/15
62 days urgent referral to treatment	85%	85%	81.44%	79.48%	80.75%	81.67%	81.58%	84.21%	79.12%	%
Current State	- Target failed in May with 19/91 patients breached - On-going non-compliance with this target in the last 6 month period - Breaches reported are across seven cancer sites; with a number of complex cases impacting the current predicted level (detailed breach reasons are included within the key themes and trends section)									

Planned Actions	- IST recommendation; to document routes to MDT discussions for incidental findings. IST recommendations have now been included into the Cancer RAP for pro-active management - Direct treatment referrals from MDT as per MDT SOP; re-circulate guidance to the clinical teams to ensure best practice - 7 patients currently under review to ascertain if pauses can be applied. - Awaiting further patient additions when histology reports available which will affect the denominator.
Key Themes / Trends	Urology - 1x case; invasive investigation prevented patient attending surgery booked within target due to medication requirements - 1x case; 2WW booking error resulted in patient not being added to SCR and therefore no proactive tracking took place – notification was by histological confirmation of cancer Upper GI - 5x complex cases; multiple diagnostics to be completed, although reported in relatively quick succession the pathway does not provide the flexibility required. Cross MDT discussions for a number of cases also contributed to the length of the treatment pathways Skin - 1x case listed in target but Consultant then not available as in court and patient treated on day 63. - 1x delay due to medical reasons (infection) - 1x patient under review Head & Neck - 4x cases; 3 currently under review Gynaecology - 1x patient choice, - 1x needed additional biopsy Colorectal - 2x highly complex cases; cross MDT discussions and multiple diagnostics required - 1x diagnostic tests requested then deemed not necessary delayed the patient journey Lung - 2x patient choice; cancelled OPAs / TCIs resulted in considerable delays in both cases - 2x under review

3. FINANCE

OVERVIEW

- The Trust recorded an overspend at the end of May of £3.779m, a variance from plan of £864k.
- In the two months, a significant case mix issue has occurred that has meant that despite increased activity, the Trust has recorded a slight underachievement of £43k against plan.
- Pay expenditure in the month was £17.852m and after two months the pay budget had overspent by £1.37m.

3.1 FINANCE PERFORMANCE SUMMARY – MONTH 02

	Measure	Standard	Data Period	Period Actual	YTD
Finance	PMR Finance Risk Rating	4	May-14	1	2
	EBITDA Achieved	85%	May-14	-12.67%	447.87%
	EBITDA Margin	5%	May-14	0%	-2.4%
	I&E Surplus Margin	1%	May-14	-5.02%	-7.44%
	Return on Assets	5%	May-14	-5.11%	-1.46%
	Liquidity ratio	15 days	May-14	11.6	11.6
	Total Income (actual v plan)	0.5% of plan	May-14	99.92%	99.69%
	Pay Expenditure (actual v plan)	At or below plan	May-14	100.40%	102.19%
	Non Pay Expenditure (actual v plan)	At or below plan	May-14	104.27%	99.93%
	CIP (actual v plan)	At or below plan	May-14	100.00%	100.00%
	Capital Expenditure (actual v plan)	At or below plan	May-14	47.87%	47.87%

3.2 INCOME AND EXPENDITURE POSITION

At the end of May the Trust recorded a deficit amounting to £3.779m

Key areas for the position are when compared to the revised plan above are as follows.

- Income underachievement of £43k,
- Pay £1.370m overspend,
- Non Pay underspend of £101k.

A high level summary of key variances are provided in the tables below:-

		Financial Plan £000s		April - May Budget £000s	April - May Actual £000s	Variance £000s		Forecast April –March Budget £000s	Forecast April –March Actual £000s	Variance £000s
Income		314,422		50,828	50,785	(43)		314,422	314,422	-
Pay		(206,326)		(34,372)	(35,742)	(1,370)		(206,326)	(206,326)	-
Non-pay		(91,375)		(15,395)	(15,294)	101		(91,375)	(91,375)	-
Reserves		(9,033)		(438)		438		(9,033)	(9,033)	-
Phased spend				**(982)**	**(982)**	-				
Total expenditure		**(306,686)**		**(51,187)**	**(52,018)**	**(831)**		**(306,686)**	**(306,686)**	**-**
EBITDA		**7,736**		**(359)**	**(1,233)**	**(874)**		**7,736**	**7,736**	-
Finance costs		(15,936)		(2,556)	(2,546)	10		(15,936)	(15,936)	-
Surplus/(deficit)		**(8,200)**		**(2,915)**	**(3,779)**	**(864)**		**(8,200)**	**(8,200)**	**-**

3.3 INCOME

Activity and Income Variance Analysis

Activity	YTD Planned	YTD Actual	Variance
A&E	18,269	18,891	622
First Attendance	18,337	18,431	94
Follow Up Attendance	29,206	30,259	1,053
Outpatient Procedure	17,057	16,363	(694)
Total Outpatients	**64,600**	**65,053**	**453**
Elective DC	6,872	6,841	(31)
Elective IP	1,142	1,195	53
Non Elective	7,614	8,033	419
Non Elective Other	1,413	1,319	(94)
SaTH Total	**99,911**	**101,332**	**1,421**

				YTD	
£'s	YTD Planned	YTD Actual	Variance	Price Variance	Volume Variance
A&E	1,881,806	1,821,262	(60,544)	(124,576)	64,032
First Attendance	2,671,152	2,694,110	22,958	9,327	13,631
Follow Up Attendance	2,539,477	2,668,118	128,641	37,077	91,564
Outpatient Procedure	2,581,944	2,530,734	(51,211)	53,824	(105,034)
Total Outpatients	**7,792,573**	**7,892,961**	**100,388**	**45,773**	**54,615**
Elective DC	4,920,516	4,707,403	(213,113)	(190,797)	(22,316)
Elective IP	3,008,948	3,214,720	205,771	65,515	140,256
Non Elective	13,806,996	13,828,731	21,735	(738,179)	759,914
Emergency Threshold	(216,667)	(335,637)	(118,971)	(118,971)	
Non Elective Other	2,208,658	2,188,201	(20,457)	126,871	(147,328)
Others (Including Reserves)	17,425,170	17,466,342	41,172	41,172	
SaTH Total	**50,828,000**	**50,783,983**	**(44,017)**	**(838,737)**	**794,720**

An examination of activity into case mix and activity variances has highlighted a case mix issue amounting to £839,000.

3.4 PAY EXPENDITURE

- Pay in the month amounted to £17.852 million
- At the end of May spending exceeded the budget (after allowing for pay CIP) by £1.37 million.
- £310,000 of the overspend is attributable to undelivered Pay CIP.
- Pay budgets for the year when sense checked with the average level of pay spending recorded in the 2013/14 were consistent, and assume spending before the application of CIP savings of £17.4 million per month.
- In the two months April and May pay spending increased by £510,000 per month, of which £310,000 is attributable to nursing staffing and £140,000 consultant and medical staff, when compared with spending levels recorded in the previous financial year.
- After two months nursing had overspent against their budgets by £753,000.
- In the month of May, nurse spending and associated staffing levels reduced by comparison with the month of April. In particular staffing WTE reduced by 26.52 WTE posts and spending reduced by £241,000.
- The reduction in WTE in May is principally associated with reduced WTE performing either additional hours or overtime. Bank and agency staffing levels remained constant.
- In the month of May spending in respect of consultant and medical staff increased by £179,000.

3.5 NON PAY

After two months, non pay budget had recorded an underspend of £101,000. The budgetary position allows for CIP savings in the opening two months of the year amounting to £626,000.

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

	Total Non Pay Spend £000s	**3 month moving average £000s**
April	7,084	7,198
May	7,471	7,307
June	6,992	7,182
July (exc exceptional items HCD)	7,382	7,282
August (exc exceptional items HCD and RTT)	7,036	7,137
September (exc exceptional items HCD and ICD)	7,052	7,157
October (exc exceptional items HCD and ICD)	7,922	7,378
November (exc exceptional items HCD and ICD)	7,430	7,468
December (exc exceptional items HCD and ICD)	7,227	7,526
January (exc exceptional items HCD and ICD)	7,433	7,363
February (exc exceptional items HCD and ICD)	7,794	7,484
March (exc exceptional items HCD and ICD)	8,059	7,762
April (exc exceptional items HCD and ICD)	7,167	7,673
May (exc increased HCD and pass through costs)	7,655	7,627

3.6 COST IMPROVEMENT PROGRAMME

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

	Original Plan £000s	***Revised Annual Plan £000s***	***Assumed savings in Month s 1 -2 £000s***	***Savings achieved in months 1 -2 £000s***
Original CIP Schemes				
Procurement	2,000	2,000	333	333
CNST Contribution	500	400	66	66
Salary Sacrifice	100	100		
Pharmacy gain share	200	100		
Capitalisation	1200	1200	200	200
Outpatient and CNS Nurses	500	-		
Diagnostic staff	300	-		
CQUIN	600	600	100	
Corporate	600	600	100	100
Agency Nursing	600	600		
Nursing review transition	400	400	200	155
Unscheduled care	1,000	1,000	100	43
Medical staff Management	200	-		
Travel expenses	200	200	-	
Non pay controls	600	-	-	
To be identified	500	500	83	

	Original Plan £000s	*Revised Annual Plan £000s*	*Assumed savings in Month s 1 -2 £000s*	*Savings achieved in months 1 -2 £000s*
Pay reduction		1,300	216	
Income based Productivity gains	6,200	6,200	1033	1033
Total	15,200	15,200	2,431	1,930

In setting the plan for the year, savings from the Cost Improvement Programme have been profiled into the April and May budgets amounting £2.431 million. A review of progress suggests that savings amounting to £1.930 million have been realised. It is anticipated that the Trust will fully achieve the CIP by the year end.

3.7 CAPITAL PROGRAMME

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

Scheme	2014/15 Capital Budget	2014/15 Spend to date	Forecast Outturn	Variance under/ (over) spend
	£000's	£000's	£000's	£000's
Future Configuration of Hospital Services	**5,035**	**27**	**5,035**	**0**
IT Technology Fund	**570**	**22**	**570**	**0**
Outstanding Commitments from 2013/14	905	134	915	-10
Creating Additional Capacity at PRH	2,987	270	2,987	0
Bowel Scope Screening Programme	105	0	105	0
Water/RO Plant at RSH	100	0	100	0
Asbestos Removal from Duct	100	0	100	0
Server Replacement Scheme	120	0	120	0
Network Replacement Scheme	120	0	120	0
Estates Replacement Fund	250	0	250	0
Maternity Ultrasound Equipment	140	0	130	10
PRH Cystoscopes	125	0	125	0
PRH Operating Tables (part completed 2013.14)	150	0	150	0
Renal Dialysis Stations Replacement	100	0	100	0
Creation of Surgical Admission and Discharge Suite - PRH	110	0	110	0
Creation of Urgent Care Centre and Ambulatory Care Area - RSH	130	0	130	0
Creation of Clinical Decision Unit - PRH	150	0	150	0
Capital Contingencies	2,300	119	2,300	0
Other Capital Schemes (inc LoF contribution)	558	136	558	0
Total Discretionary Capital Schemes	**8,450**	**659**	**8,450**	**0**
Total Including Reconfiguration	**14,055**	**708**	**14,055**	**0**

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

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

As at M02 £0.708m has been expensed.

3.8 CASH FLOW

Key points regarding cash flow are as follows:

- A cash balance of £2.2 million is required to be held on the Balance Sheet at the end of March 2015.

- PDC Receipts – The Trust will draw down PDC in line with reported expenditure on the Future Configuration of Hospital Services (£5.035m) and IT Technology Fund (£0.570m).

- The Trust held a cash balance of £3.980m on the balance sheet at the end of May 2014 – this sum is required to support outstanding capital creditors.

- The 2014/15 cash plan has been constructed based upon an assumed income and expenditure deficit for the year of £8.2 million. In support of such a plan, the Trust needs to secure a permanent loan of £8.2m. It is projected that there will be a need to secure temporary borrowing from September 2014 of £4.5 million rising to £8.2 million by March 2015.

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

	Actual April Month £000's	Actual May Month £000's	Forecast June Month £000's	Forecast July Month £000's	Forecast August Month £000's	Forecast September Month £000's	Forecast October Month £000's	Forecast November Month £000's	Forecast December Month £000's	Forecast January Month £000's	Forecast February Month £000's	Forecast March Month £000's
Balance B/fwd	**2,150**	**8,168**	**3,928**	**846**	**2,824**	**809**	**613**	**3,896**	**2,500**	**611**	**2,991**	**641**
INCOME												
Income I&E	27,543	24,119	25,315	27,020	24,855	25,810	27,852	26,199	25,361	27,342	25,580	27,124
Income - Total Balance Sheet Movements	253	1,075	(638)	2,416	(270)	(1,054)	1,795	(1,088)	(1,061)	1,938	(1,146)	(1,146)
Total Income Cashflow	**27,796**	**25,194**	**24,676**	**29,436**	**24,585**	**24,755**	**29,646**	**25,110**	**24,299**	**29,279**	**24,433**	**25,977**
PAY												
Pay I&E	(13,428)	(18,145)	(17,363)	(17,563)	(17,570)	(17,484)	(17,539)	(17,722)	(17,802)	(17,918)	(17,956)	(18,140)
Pay - Total Balance Sheet Movements	0	0	(275)	(56)	(56)	(56)	(56)	(56)	(56)	(56)	(56)	(56)
Total Pay Cashflow	**(13,428)**	**(18,145)**	**(17,638)**	**(17,619)**	**(17,626)**	**(17,540)**	**(17,595)**	**(17,778)**	**(17,858)**	**(17,974)**	**(18,012)**	**(18,196)**
NON PAY												
Non Pay I&E	(5,968)	(8,686)	(7,651)	(7,652)	(7,653)	(7,652)	(7,652)	(7,652)	(7,653)	(7,651)	(7,653)	(7,624)
Non Pay - Total Balance Sheet Movements	0	0	(99)	(102)	(102)	(102)	(102)	(102)	(102)	(102)	(102)	(103)
Total Non Pay Cashflow	**(5,968)**	**(8,686)**	**(7,750)**	**(7,754)**	**(7,755)**	**(7,754)**	**(7,754)**	**(7,754)**	**(7,755)**	**(7,753)**	**(7,755)**	**(7,727)**
Finance Costs												
Finance Costs I&E	4	2	1	1	2	(2,950)	2	2	2	2	2	(2,981)
Finance Costs - Total Balance Sheet Movements	0	0	0	0	0	68	0	0	0	0	0	0
Total Finance Costs Cashflow	**4**	**2**	**1**	**1**	**2**	**(2,882)**	**2**	**2**	**2**	**2**	**2**	**(2,981)**
Capital												
Capital Expenditure	(349)	(359)	(977)	(763)	(863)	(950)	(938)	(852)	(574)	(1,170)	(1,014)	(1,191)
Capital - Total Balance Sheet Movements	(2,037)	(2,149)	(1,428)	(1,318)	(354)	(322)	(174)	(120)	0	0	0	1,979
Total Capital Cashflow	**(2,386)**	**(2,509)**	**(2,405)**	**(2,081)**	**(1,217)**	**(1,272)**	**(1,112)**	**(972)**	**(574)**	**(1,170)**	**(1,014)**	**788**
2014/15 Temporary Borrowing/Permanent PDC	**0**	**0**	**0**	**0**	**0**	**4,500**	**0**	**0**	**0**	**0**	**0**	**3,700**
PDC Revenue	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Donated Assets												
Donated Assets Income	0	0	137	96	96	97	96	96	97	96	96	97
Donated Assets Expenditure	0	(96)	(104)	(100)	(100)	(100)	0	(100)	(100)	(100)	(100)	(100)
Total Donated Assets Cashflow	**0**	**(96)**	**33**	**(4)**	**(4)**	**(3)**	**96**	**(4)**	**(3)**	**(4)**	**(4)**	**(3)**
FCHS												
PDC Drawdown re FCHS	0	0	1,250	0	0	1,250	0	0	1,250	0	1,285	0
Capital re FCHS	0	0	(1,250)	0	0	(1,250)	0	0	(1,250)	0	(1,285)	0
Total FCHS Cashflow	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Cashflow	**6,018**	**(4,239)**	**(3,083)**	**1,978**	**(2,015)**	**(196)**	**3,283**	**(1,396)**	**(1,889)**	**2,380**	**(2,350)**	**1,558**
Balance C/fwd	**8,168**	**3,928**	**846**	**2,824**	**809**	**613**	**3,896**	**2,500**	**611**	**2,991**	**641**	**2,200**

Summary Activity Position (Internal Plan)		All Commissioners										
Month 2 (Initial Data Submission)												
Point of Delivery	Care Group	13/14 Outturn	Month Plan	Month Actuals	Variance	Variance %	Year-to-Date Plan	Year-to-Date Actual	Variance	Variance %	14/15 Annual Plan	14/15 Forecast Outturn
First Attendance	Scheduled Care	61,488	5,070	4,790	-280	-5.5%	9,672	9,669	-3	0.0%	60,039	60,020
	Therapies / Diagnostics	187	1,141	1,177	36	3.2%	2,277	2,315	38	1.7%	13,941	14,173
	Unscheduled Care	24,834	2,143	2,035	-108	-5.1%	4,093	4,004	-89	-2.2%	25,401	24,847
	Women and Children's	16,109	1,197	1,239	42	3.5%	2,295	2,443	148	6.4%	14,224	15,139
First Attendance Total		**102,618**	**9,551**	**9,241**	**-310**	**-3.2%**	**18,337**	**18,431**	**94**	**0.5%**	**113,604**	**114,180**
Follow Up Attendance	Scheduled Care	119,717	9,902	9,821	-81	-0.8%	18,890	19,335	445	2.4%	117,261	120,024
	Therapies / Diagnostics	488	40	67	27	65.6%	77	102	25	32.2%	479	633
	Unscheduled Care	43,141	3,855	3,970	115	3.0%	7,378	7,986	608	8.2%	45,753	49,525
	Women and Children's	23,670	1,493	1,557	64	4.3%	2,861	2,836	-25	-0.9%	17,735	17,579
Follow Up Attendance Total		**187,016**	**15,290**	**15,415**	**125**	**0.8%**	**29,206**	**30,259**	**1,053**	**3.6%**	**181,228**	**187,761**
Outpatient Procedure	Scheduled Care	54,855	4,742	4,132	-610	-12.9%	9,047	8,707	-340	-3.8%	56,159	54,050
	Therapies / Diagnostics	0	0	1	1	0.0%	0	1	1	0.0%	0	6
	Unscheduled Care	21,694	2,823	2,726	-97	-3.4%	5,385	5,555	170	3.2%	33,428	34,484
	Women and Children's	24,267	1,360	869	-491	-36.1%	2,625	2,100	-525	-20.0%	16,238	12,988
Outpatient Procedure Total		**100,816**	**8,925**	**7,728**	**-1,197**	**-13.4%**	**17,057**	**16,363**	**-694**	**-4.1%**	**105,824**	**101,529**
Total Outpatients	Scheduled Care	236,060	19,714	18,743	-971	-4.9%	37,609	37,711	102	0.3%	233,459	234,095
	Therapies / Diagnostics	675	1,181	1,245	64	5.4%	2,354	2,418	64	2.7%	14,420	14,813
	Unscheduled Care	89,669	8,821	8,731	-90	-1.0%	16,856	17,545	689	4.1%	104,581	108,856
	Women and Children's	64,046	4,049	3,665	-384	-9.5%	7,782	7,379	-403	-5.2%	48,196	45,707
Total Outpatients Total		**390,450**	**33,766**	**32,384**	**-1,382**	**-4.1%**	**64,600**	**65,053**	**453**	**0.7%**	**400,656**	**403,470**
Elective DC	Scheduled Care	34,696	3,151	3,121	-30	-0.9%	5,990	6,128	138	2.3%	36,163	36,994
	Unscheduled Care	2,507	248	194	-54	-21.6%	470	391	-79	-16.8%	2,857	2,376
	Women and Children's	2,366	217	144	-73	-33.5%	412	322	-90	-21.8%	2,419	1,892
Elective DC Total		**39,569**	**3,615**	**3,459**	**-156**	**-4.3%**	**6,872**	**6,841**	**-31**	**-0.5%**	**41,439**	**41,262**
Elective IP	Scheduled Care	5,940	474	495	21	4.4%	911	966	55	6.0%	5,858	6,209
	Unscheduled Care	326	38	32	-6	-16.6%	73	66	-7	-9.3%	474	430
	Women and Children's	993	83	89	6	7.2%	158	163	5	3.5%	1,026	1,062
Elective IP Total		**7,259**	**596**	**616**	**20**	**3.4%**	**1,142**	**1,195**	**53**	**4.7%**	**7,359**	**7,701**
Non Elective	Scheduled Care	12,649	1,073	1,093	20	1.8%	2,116	2,171	55	2.6%	12,820	13,155
	Unscheduled Care	24,559	2,066	2,187	121	5.9%	4,072	4,310	238	5.8%	24,677	26,117
	Women and Children's	8,843	723	808	85	11.7%	1,426	1,552	126	8.8%	8,640	9,405
Non Elective Total		**46,051**	**3,862**	**4,088**	**226**	**5.8%**	**7,614**	**8,033**	**419**	**5.5%**	**46,138**	**48,677**
Non Elective Other	Scheduled Care	69	6	6	0	2.3%	12	7	-5	-39.5%	70	42
	Unscheduled Care	229	21	22	1	3.4%	42	44	2	4.9%	254	267
	Women and Children's	8,596	690	700	10	1.5%	1,360	1,268	-92	-6.7%	8,240	7,684
Non Elective Other Total		**8,894**	**717**	**728**	**11**	**1.5%**	**1,413**	**1,319**	**-94**	**-6.7%**	**8,564**	**7,993**
Total Spells	Scheduled Care	53,354	4,704	4,715	11	0.2%	9,029	9,272	243	2.7%	54,912	56,401
	Unscheduled Care	27,621	2,373	2,435	62	2.6%	4,657	4,811	154	3.3%	28,263	29,189
	Women and Children's	20,798	1,713	1,741	28	1.7%	3,355	3,305	-50	-1.5%	20,325	20,042
Total Spells Total		**101,773**	**8,790**	**8,891**	**101**	**1.2%**	**17,041**	**17,388**	**347**	**2.0%**	**103,499**	**105,632**
A&E	Unscheduled Care	106,702	9,361	9,642	281	3.0%	18,269	18,891	622	3.4%	107,227	110,876
A&E Total		**106,702**	**9,361**	**9,642**	**281**	**3.0%**	**18,269**	**18,891**	**622**	**3.4%**	**107,227**	**110,876**

4. WORKFORCE

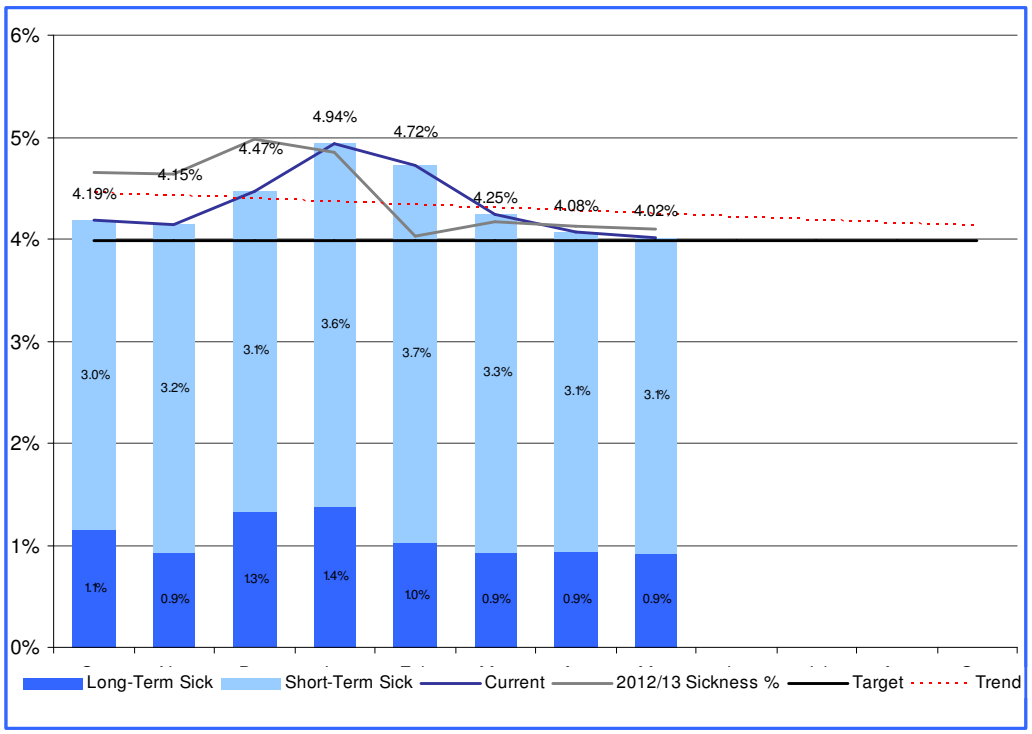
OVERVIEW

- 48 leaders from across the organisation began their Leadership Development programme this month. The first module focuses on self awareness and leadership behaviours.

- Centralised Recruitment is now live for all non medical roles; the centralisation of the service will bring improved governance and a streamlined process.

- Whilst slightly above target, absence continues to improve. A health and wellbeing plan is now being implemented to support our employees. This includes enhanced Occupational Health services, Health and Wellbeing Road shows and health kiosks.

4.1 SICKNESS

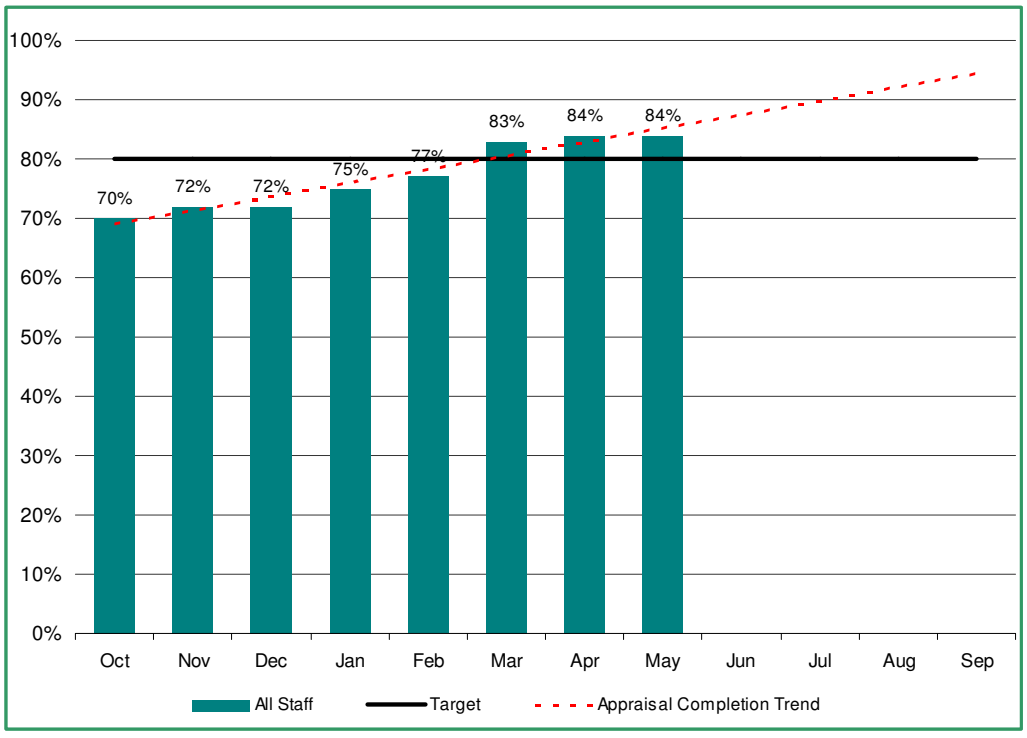


Sickness absence fell marginally to 4.02% with absence in Estates and Facilities staff falling from 8% to 5.4%. All other staff groups remained the same, with the exception of Healthcare Scientists, which increased from 4% to 4.8%.

Despite improved performance the cost of absence rose in May to £402,168, from £398,230 due to the more working being days available in May than in April.

Measure	Annual Target	Monthly Target	YTD	February	March	April	May	Year end 13/14
Sickness Absence	**Less than 4%**	**Less than 4%**	**4.07%**	**4.72**	**4.25%**	**4.08%**	**4.02%**	4.12%
Current State	- Target just missed in May, .02% above.							
Planned Actions	- From 1 May extended Occupational Health services include early intervention for musculoskeletal and stress, support in areas of high absence, on line advice and support and support at Health and wellbeing events. - A new monthly process has been developed to support effective absence management within the Care Groups; this is being driven by the HR Business Partners.							
Key Themes/Trends	- Highest reasons for absence remain unchanged musculoskeletal (MSK) and stress. - Year to date above 4%							

4.2 APPRAISALS



Appraisals remained at 84% May for the organisation as a whole, as a professional group medical appraisals have increased by 4% to 89%. This increase supports medics to revalidate.

Measure	Annual Target	Monthly Target	YTD	February	March	April	May	Year end 13/14
Appraisals	**100%**	**100%**	**84%**	**77%**	**83%**	**84%**	**84%**	80%
Current State	- Performance is below revised target of 100%. - Medical Appraisals rose to 89% in May.							
Planned Actions	- A new appraisal process has been piloted in Women and Childrens and Radiology with positive feedback. - New process to be approved by the executive team in July.							
Themes/Trends	- Consistent improvement since January - Whilst below target biggest improvement seen for over 2 years.							

5. MONTHLY SELF-CERTIFICATIONS – NTDA REQUIREMENT

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

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

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

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

6. RECOMMENDATION

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