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United Lincolnshire Hospitals NHS
NHS Trust

UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 28 FEBRUARY 2017

Document management

Title: Integrated Performance Report

To: Trust Board

From: Rachel Harvey, Head of Planning & Performance

Author: Katherine Etoria, Planning & Performance Manager

Date: 4th April 2017

Purpose of the Report:

To update the committee on the performance of the Trust for the period ended 28th February 2017, provide analysis to support decisions, action or initiate change and set out proposed plans and trajectories for performance improvement.

The Report is provided to the Board for:

Decision	x	Discussion	
Assurance	x	Endorsement	

Recommendations:

The Board is asked to note the current performance and future performance projections. The Board is asked to approve action to be taken where performance is below the expected target.

This is an evolving report and the Board are invited to make suggestions as we continue to develop it.

Strategic Risk Register **New risks that affect performance or performance that creates new risks to be inserted here.**	**Performance KPIs year to date** **As detailed in the report.**

Resource Implications (e.g. Financial, HR) None
Assurance Implications: The report is a central element of the Performance Management Framework
Patient and Public Involvement (PPI) Implications None
Equality Impact None
Information exempt from Disclosure None
Requirement for further review? The Integrated performance dashboard will be updated on a monthly basis.

Integrated Performance Report for the Period to 28th February 2017

1. Executive Summary for period of 28th February 2017

February headlines:

- ☒ 4 hour waiting time target – performance of 75.22%
- ☒ 3 of the 9 national cancer targets were achieved in January 2017
- ☒ 18wk RTT Incomplete Standard –February performance was 88.27%
- ✓ 6wk Diagnostic Standard –February performance was 99.72%
- ☒ Agency Spend – £-2,804k
- ☒ Financial Improvement Plans - £-1,109k

Successes:
31 Day subsequent treatments surgery achieved the standard two months in a row in December and January (cancer is reported a month behind).

Diagnostics met the standard three months in a row with a 0.5% improvement since January. There is a pilot ongoing around a new booking that will reduce the time from referral to diagnostic test. Funding to support reducing CT waiting times has also contributed to sustaining performance in this area.

Sepsis performance has improved over a four month period in particular at Lincoln. Further work is being progressed to ensure remedial action plans provide impact on all sites and this will be presented to the Sepsis Task and Finish Group.

Core learning increased again last month and is now at 90% with an upward trend. This will impact on safety and quality as a result of more staff being competent with key learning being completed.

Staff turnover continues to be within tolerances and there is evidence to support increased staff retention: January performance was 7.21% and February, 7.05% showing a decrease in turnover.

Challenges:
Cancer 62 Day performance has deteriorated in month although some tumour sites are improving such as Breast and Head and Neck. In comparing our performance against our peer group there are signs of deterioration in some other Trusts but this is not shown in all peers, for example Norfolk and Norwich improved their performance in month.

A&E performance to date is 76.91% with year to date performance being 79.18%. some of the key factors affecting the anticipated performance improvement as a result of initiatives such as Red to Green at Lincoln and Pride and Joy at Pilgrim are increasingly variable shift cover with new locums completing single shifts and vulnerability in medical staffing due to locum sickness or last minute absences creating supply issues for the departments. This could be an influencer of the increase in sickness absence performance during the Winter period. During February bed occupancy was regularly over 98% where the national average for enabling patient flow is around 95%. Demand and acuity are still important influencers of not achieving performance we are an outlier for acuity at 7% higher than the national average.

There has been an increase in patient death in stroke by 8% since December. Further analysis is being progressed to understand diagnostic performance as part of the quality team's focus on improvement.

Friends and Family test performance deteriorate by 6% from last month for inpatient response rates which is disappointing where the year to date figure has maintained above the target of 26%.

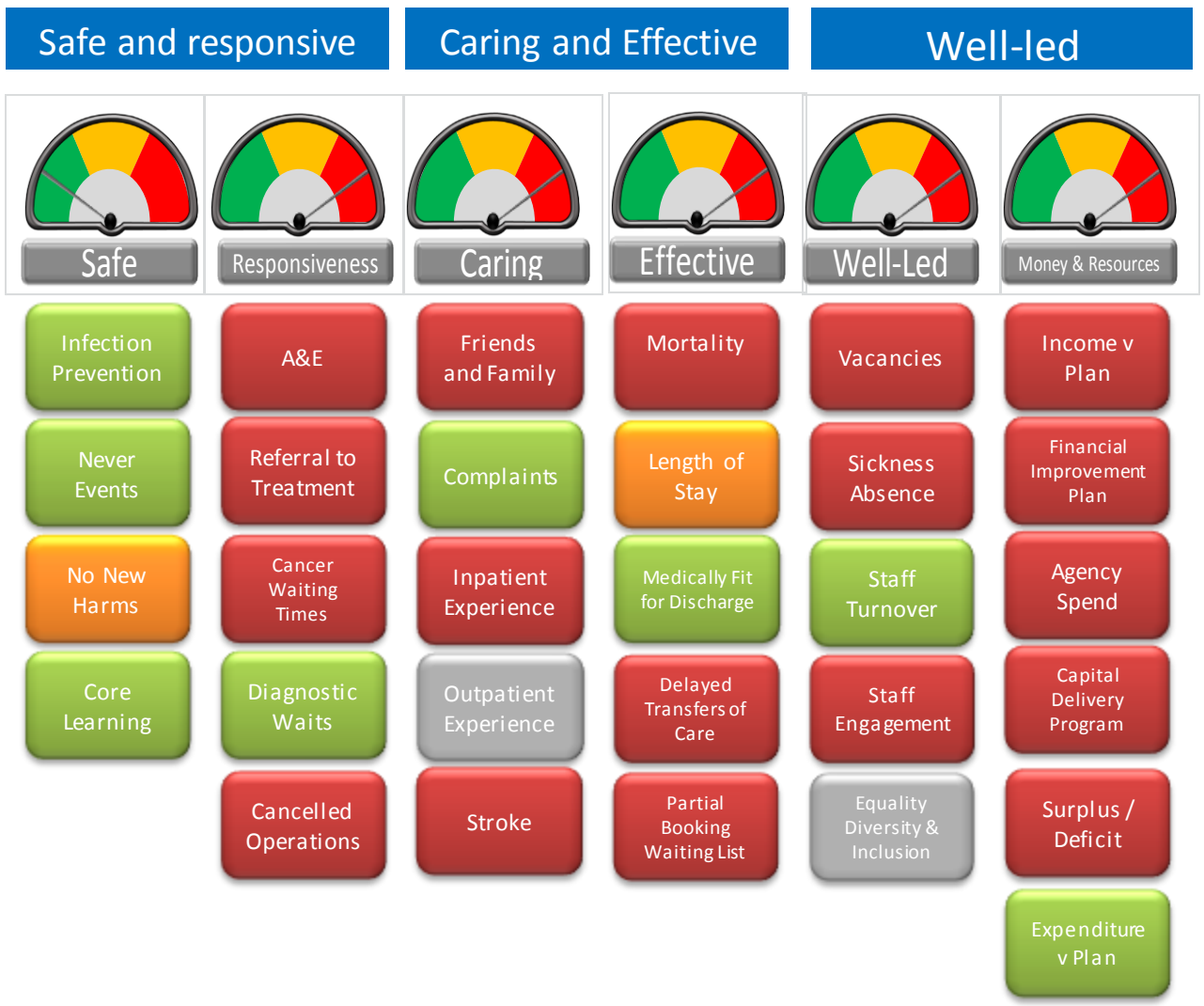
Looking forward:
This section will be covered in risk and recommendation section at the end of the report.

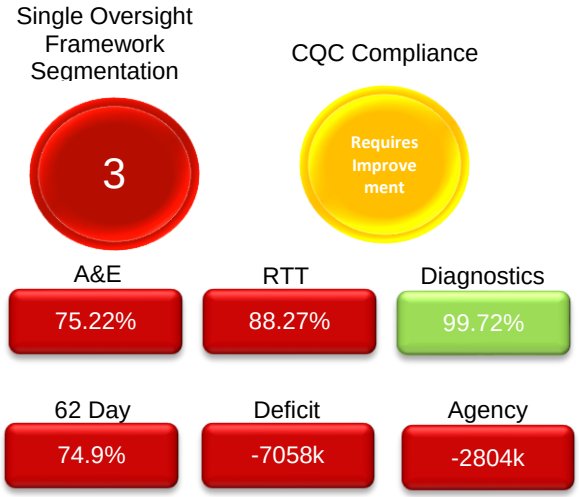
Peter Hollinshead
Interim Director of Finance & Corporate Affairs
March 2017

2. Integrated Performance Report

Integrated Performance Report - Headlines

The dashboard shows the Trust's current performance against the chosen standards and indicators as a measure of overall Trust performance. The box to the right highlights key changes to performance during the period with priority actions. Further detail follows this summary at Business Unit and Speciality level. Action plans should focus on resolving performance issues or delivering improved performance where required.





Most deteriorated:

Domain: Caring
Friends & Family Test response rates for A&E is 10% less than January and 6% less for inpatients than in January

Patient death in Stroke has increased by 8% since December

Domain: Safe
#NOF 24 performance is -21.7% compared to January

Domain: Responsiveness
Cancer 62 day screening has deteriorated 29% since December

Most improved:

Domain: Responsiveness
Cancer 31 day subsequent treatments surgery achieved 97.1% in January

Domain: Responsiveness
Diagnostics has seen a 0.5% improvement since January

Actions:
See Exception Reports for all amber and red rated Key Performance Indicators.

3. Detailed Trust Board Performance Dashboard

Integrated Performance Report - Detailed

	Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Safe							
Infection Control							
Clostrum Difficile (post 3 days)	59	49	5	6			
MRSA bacteraemia (post 3 days)	0	2	0	2			
MSSA	22	18	0	2			
ECOLI	88	56	3	3			
Never Events	0	1	0	0			
No New Harms							
Serious Incidents reported (unvalidated)	TBC	48		13			
Harm Free Care %	95%	90.92%	90.08%	90.35%			
New Harm Free Care %	98%	97.00%	98.04%	96.74%			
Catheter & New UTIs	2.00	1	1	0			
Falls	95.0%						
Medication errors	1						
Medication errors (mod, severe or death)	1						
Pressure Ulcers (PUNT) 3/4							
VTE Risk Assessment	95%	94.00%	97.86%	97.51%			
Overdue CAS alerts							
SQD %							
Core Learning	85%	82.22%	86.23%	85.62%			

	Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Caring							
Friends and Family Test							
Inpatient (Response Rate)	26%	26.36%	22.00%	28.00%			
Inpatient (Recommend)	96%	88.82%	93.00%	90.00%			
A&E (Response Rate)	14%	21.18%	18.00%	28.00%			
A&E (Recommend)	87%	80.73%	82.00%	84.00%			
% of staff who would recommend care							
% of staff who would recommend work							
Complaints							
No of Complaints received	70	646	53	63			
No of Complaints still Open	0	3383	225	254			
No of Complaints ongoing	0	446	39	41			
Inpatient Experience							
Mixed Sex Accommodation	0	54	8	14			
eDD	95%	77.39%	79.85%	77.90%			
PPCI 90 hrs	100%	96.10%	97.33%	97.33%			
PPCI 150 hr	100%	86.19%	85.33%	85.33%			
#NOF 24	70%	62.43%	52.40%	74.12%			
#NOF 48 hrs	95%	92.67%	88.10%	94.12%			
Dementia Screening	90%	87.45%	91.06%	95.98%			
Dementia risk assessment	90%	94.16%	94.55%	96.97%			
Dementia referral for Specialist treatment	90%	63.97%	93.18%	91.84%			
Stroke							
Patients with 90% of stay in Stroke Unit	80%	85.19%	85.50%	82.60%			
Sallowing assessment < 4hrs	80%	69.90%	64.60%	62.50%			
Scanned < 1 hrs	50%	63.71%	53.70%	55.00%			
Scanned < 12 hrs	100%	95.90%	93.90%	93.80%			
Admitted to Stroke < 4 hrs	90%	66.78%	59.80%	62.50%			
Patient death in Stroke	17%	13.02%	21.00%	13.80%			
Assesments within Deadline							
Thromb < 1hr							

Responsiveness							
A&E							
4hrs or less in A&E Dept	89.0%	79.41%	75.22%	75.56%			
12+ Trolley waits	0	0	0	0			
RTT							
52 Week Waiters	1						
18 week incompletes	92.4%	91.45%	88.27%	88.17%			
Cancer - Other Targets							
62 day classic	85%	71.85%	74.40%	71.90%			
2 week wait suspect	93%	90.32%	89.50%	93.40%			
2 week wait breast symptomatic	93%	76.32%	74.30%	88.10%			
31 day first treatment	96%	96.78%	94.10%	98.40%			
31 day subsequent drug treatments	98%	97.06%	99.00%	96.40%			
31 day subsequent surgery treatments	94%	93.94%	100.00%	97.10%			
31 day subsequent radiotherapy treatments	94%	92.31%	89.40%	97.30%			
62 day screening	90%	85.94%	67.90%	96.90%			
62 day consultant upgrade	85%	83.24%	85.70%	82.60%			
104+ Day Waiters		-	34.00	31.00			
Diagnostic Waits							
diagnostics achieved	99.1%	98.87%	99.72%	99.20%			
diagnostics Failed	0.9%	1.13%	0.28%	0.80%			
Cancelled Operations							
Cancelled Operations on the day (non clinical)		2.10%	3.23%	3.15%			
Not treated within 28 days. (Breach)		8.28%	9.42%	5.71%			

	Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Effective							
Mortality							
SHMI	100	111.21	110.07	110.07			
Hospital-level Mortality Indicator	100	99.54	102.30	102.60			
Length of Stay							
Average LoS - Elective	2.8	2.75	2.36	2.63			
Average LoS - Non Elective	3.8	4.57	5.01	4.89			
Medically Fit for Discharge	60	61.36	52.00	60.00			
Delayed Transfers of Care	3.5%	5.07%	5.77%	5.14%			
Partial Booking Waiting List	0	4743	5059	4962			

	Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Well Led							
Vacancies	5.0%	10.25%	10.44%	10.48%			
Sickness Absence	4.0%	4.87%	5.50%	5.50%			
Staff Turnover	2.4%	2.12%	1.73%	1.73%			
Staff Engagement							
Staff Appraisals	95.0%	67.00%	66.00%	67.00%			
Equality Diversity and Inclusion							

	Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Money & Resources							
Income v Plan	35854	400757	33597	36318			
Expenditure v Plan	-39907	-432722	-39313	-40221			
Efficiency Plans	2169	15564	1060	1763			
Surplus / Deficit	-5073	-49946	-7058	-5346			
Capital Delivery Program	3012	8855	0	858			
Agency Spend	824	-14795	-2804	-2834			

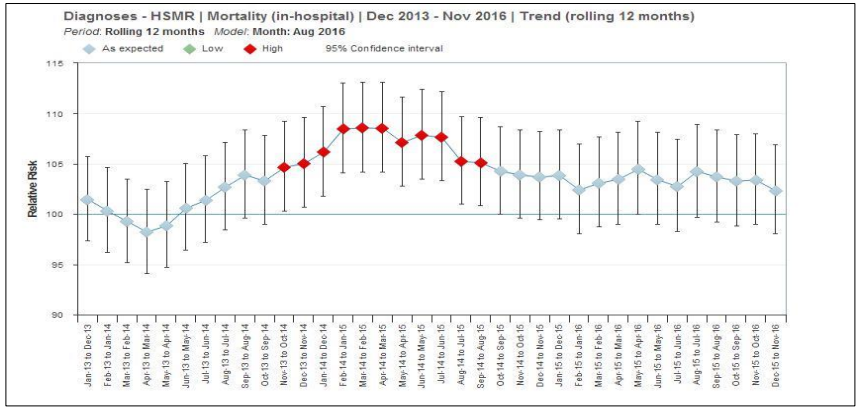
4. Quality

SAFE AMBITION 1: Reduction of Harm Associated with Mortality

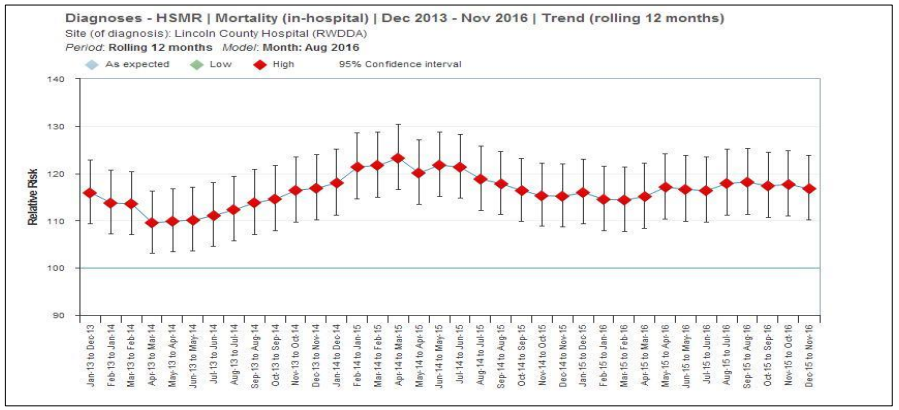
Trust/Site	ULHT HSMR Dec 15-Nov 16 12 month	ULHT HSMR Apr 16-Nov 16 YTD	ULHT HSMR Nov-16	ULHT SHMI Jul 15 – Jun 16	Trust Crude Mortality YTD Internal source Apr 16-Feb 17
Trust	102.3	101.5	92.7	110.07	1.82%
LCH	116.7	114.3	105.0	111.37	1.88%
PHB	92.5	93.2	84.9	109.49	1.93%
GDH	71.7	72.7	65.0	97.81	1.10%

Hospital Standardised Mortality Ratio (HSMR)

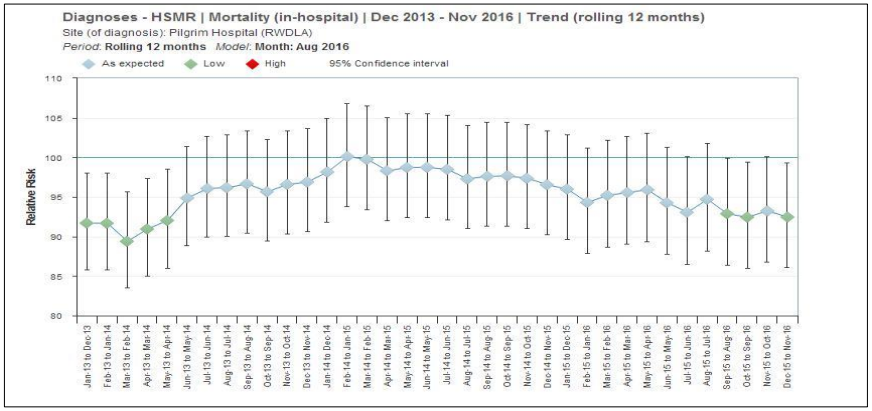
ULHT HSMR Rolling Year (36 Months)



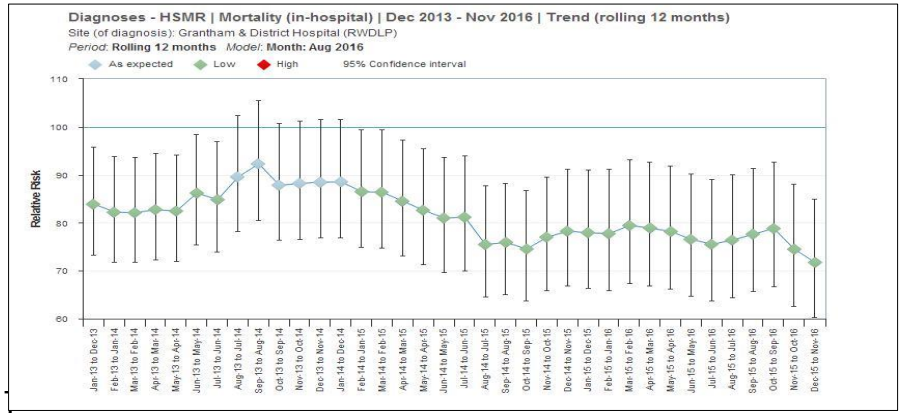
Lincoln HSMR Rolling Year (36 Months)



Pilgrim HSMR Rolling Year (36 Months)



Grantham HSMR Rolling Year (36 Months)



Alerts

The Trust is not organisationally alerting on any diagnosis groups year to date. Ongoing work with Dr Foster; Derek Smith will be meeting with the Respiratory and Stroke to go through the data as these are our top observed diagnosis.

Lincoln County Hospital
No alerting diagnosis groups.

Pilgrim hospital
No alerting diagnosis groups.

Grantham Hospital
No alerting diagnosis groups.

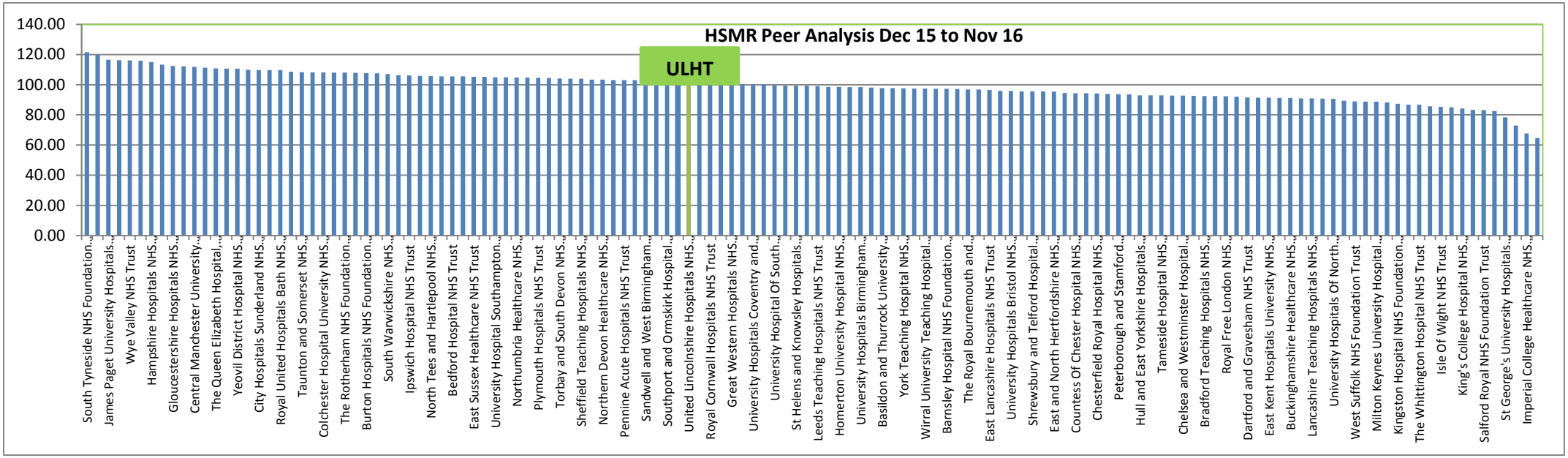
All diagnosis are closely monitored where an alert is consecutive for more than 3 months an in-depth analysis of data will be undertaken.

HSMR Top Observed Diagnosis Groups- April 2016 to November 2016

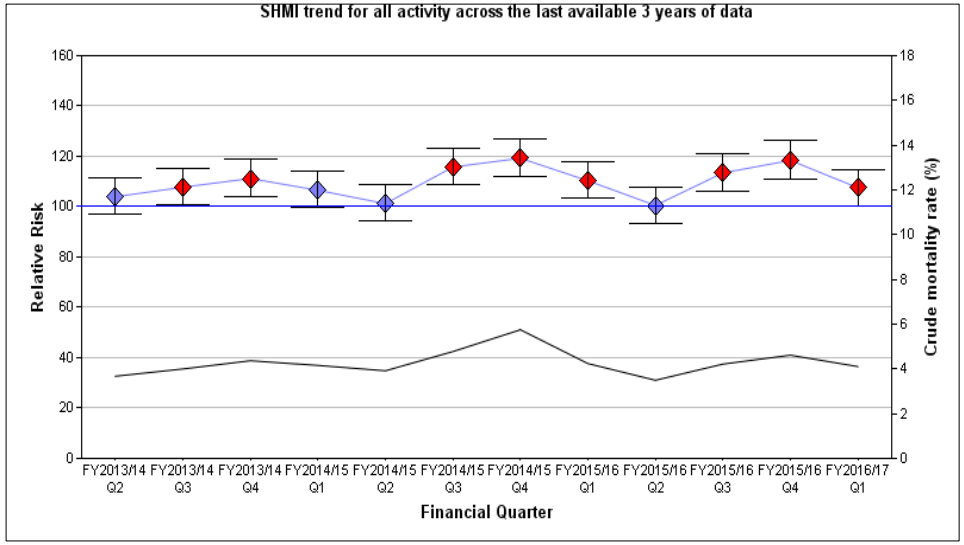
Rank	Diagnosis group	Spells	Actual deaths	Actual % of all deaths	Expected deaths	Excess Deaths	Crude (%)	HSMR
1	Pneumonia	1524	272	20%	281.02	-9.02	17.89	96.79
2	Acute cerebrovascular disease	792	109	8%	114.00	-5.00	13.87	95.61
3	Septicaemia (except in labour)	524	103	8%	99.08	3.92	19.69	103.96
4	Acute and unspecified renal failure	530	66	5%	66.39	-0.39	12.55	99.42
5	Urinary tract infections	1565	57	4%	62.16	-5.16	3.64	91.70
6	Congestive heart failure, non-hypertensive	601	50	4%	64.89	-14.89	8.32	77.06
7	Secondary malignancies	1306	47	4%	38.18	8.82	3.61	123.09
8	Acute myocardial infarction	609	46	3%	41.32	4.68	7.58	111.33
9	Aspiration pneumonitis, food/vomitus	113	42	3%	32.70	9.30	37.17	128.45
10	Chronic obstructive pulmonary disease and bronchiectasis	931	42	3%	36.81	5.19	4.52	114.10

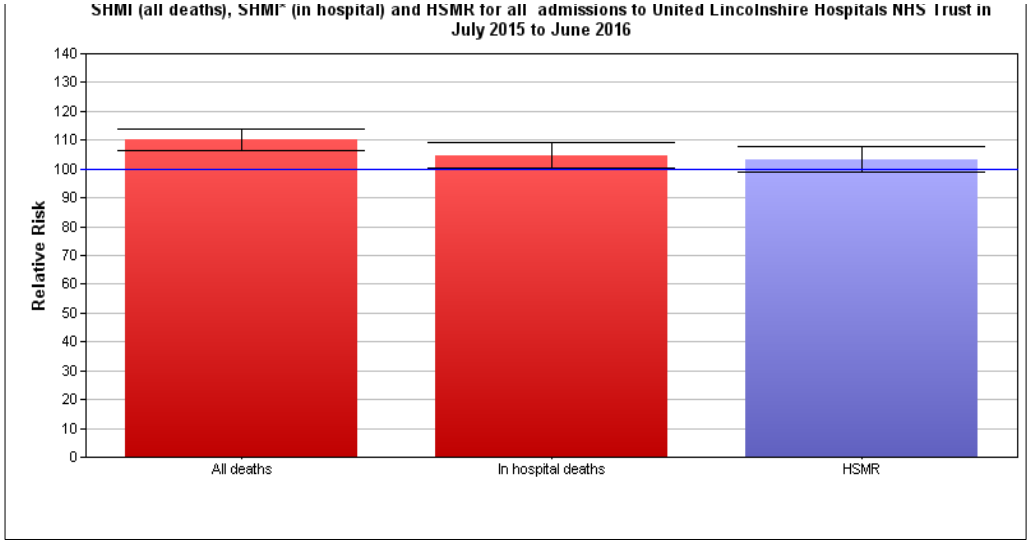
The above diagnosis groups show the top 60% of all deaths within the Trust

HSMR – Peer analysis



SHMI





The Trust is undertaking numerous strategies to understand why the SHMI data is not aligning to the HSMR data

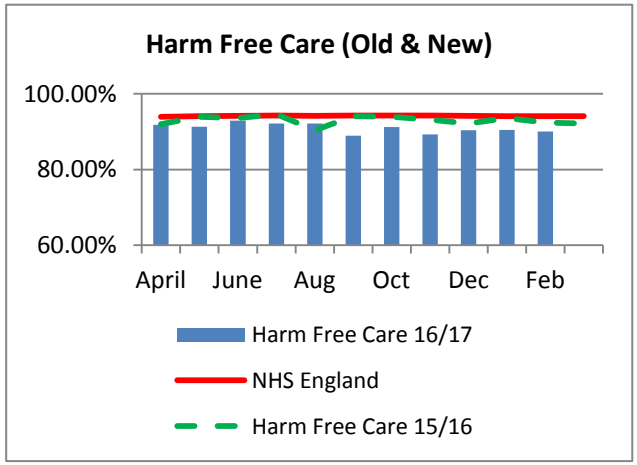
- A meeting was held on the 22nd February, it was agreed that audits of a selection of patients who passed away over 80 years of age within 30 days and 48 hours of discharge will be reviewed every 6 weeks at Lincoln and also a 6 weekly meeting at Pilgrim with representation of ULHT, CCG and GP staff. The purpose of these reviews is to gather intelligence on the patients pathway to confirm if the patients were appropriately admitted/discharged, if there are learnings from within the hospital/community and look at the whole transition pathway for the patient. These meetings will consist of reviewing ULHT and CCG notes.
- ULHT are also reviewing the comorbidities for patients with a 0 charlson score over the age of 75.
- Governance in correlation with Information Support, Dr Foster and Coding are reviewing deaths that have occurred to ensure all comorbidities from prior admissions have been pulled through to the final admission and coded appropriately.

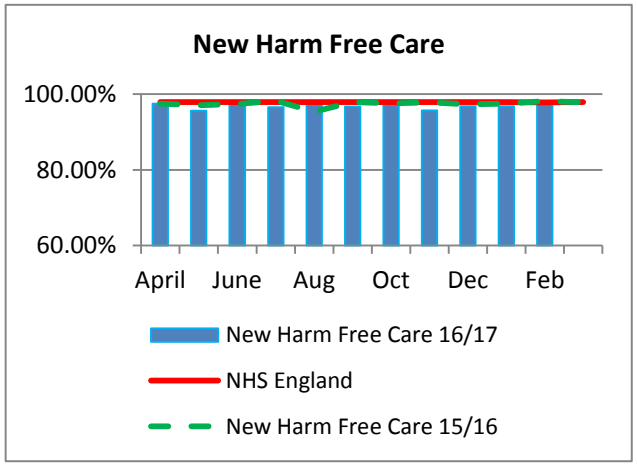
Mortality Reviews

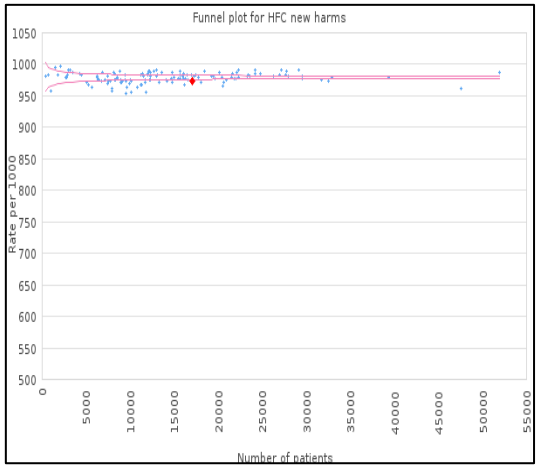
Reviews January 2016 – January 2017

Site	Deaths	Awaiting notes/Notes in Quality Governance	Notes Sent for Review	Review Complete	Review completion Compliance	Review Completion Target	Total Death % Reviewed
ULHT Total	3385	837	2541	1795	**71%**	**75%**	53%
Lincoln Total	1856	402	1447	956	**66%**	**75%**	52%
Pilgrim Total	1314	372	942	699	**74%**	**75%**	53%
Grantham Total	215	63	152	140	**92%**	**75%**	65%

SAFE AMBITION 2 Reduction of Harm Associated with Harm free Care







Performance Data Overview – January 2017 (February data not released by GEM Arden)

Site	No Patients	Harm Free	New Harm Free	PU-All	PU - New	Falls with harm	Cath & all UTI	Cath & New UTI	New VTEs
National Average		94.1%	97.9%	4.4%	0.9%	0.6%	0.7%	0.3%	0.4%
Grantham	86	88.4%	97.7%	8.1%	1.2%	0%	4.7%	1.2%	0%
Lincoln	456	92.3%	96.9%	4.6%	0.4%	1.5%	1.3%	0.9%	0.4%
Louth	2	100%	100%	0%	0%	0%	0%	0%	0%
Pilgrim	316	87.7%	95.3%	8.5%	2.2%	1.9%	1.6%	0%	0.6%
UHT Total	860	90.2%	96.4%	6.4%	1.2%	1.5%	1.7%	0.6%	0.5%

Current February Performance

6 new Pressure ulcers

7 harmful falls (5 before admission)

1 new CA-UTI

4 new VTE's

The new CA-UTI patient was transferred with their notes before validation of the harm could take place. 2 Falls before admission have been included in the return in error and adjustments will be made to reflect accurate data.

Action Plan

Lincolnshire East CCG have been served with formal notice that from March 2017 ULHT will no longer include Falls Before Admission in their data return bringing methodology in line with Sherwood Forest, Nottingham University and Peterborough Hospitals.

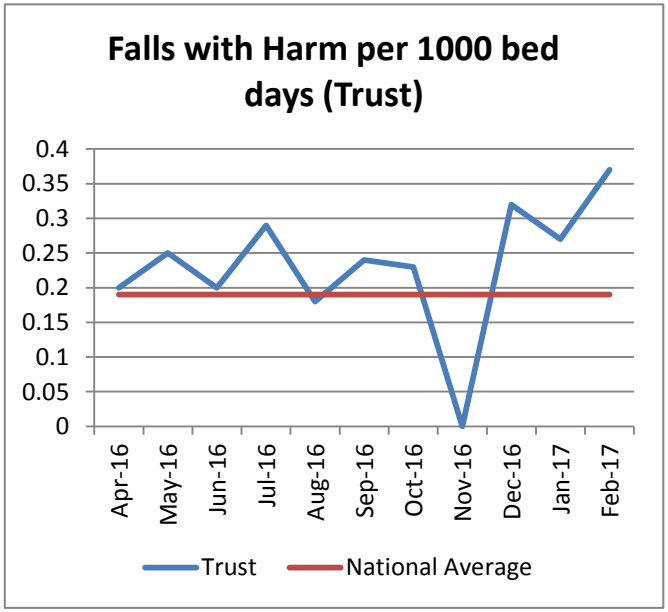
Reports are distributed detailing where all harms have occurred.

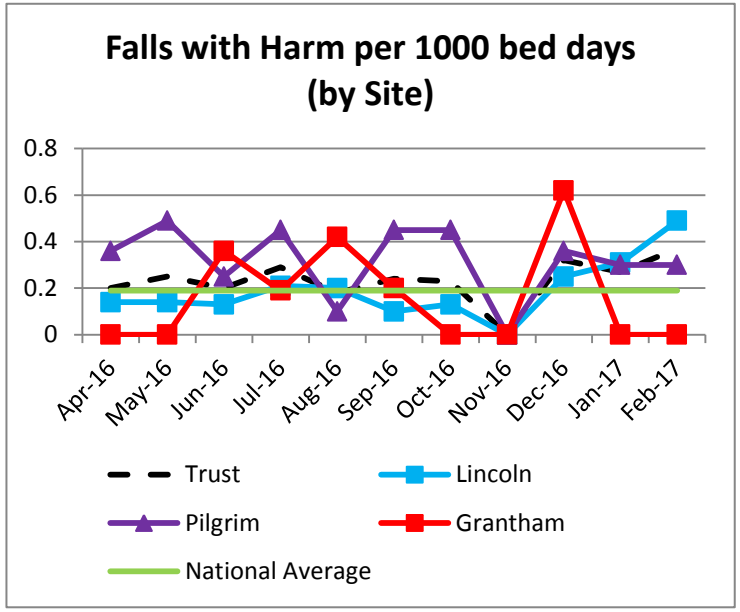
Nurse specialists review all CA-UTI/Pressure Ulcers and VTE.

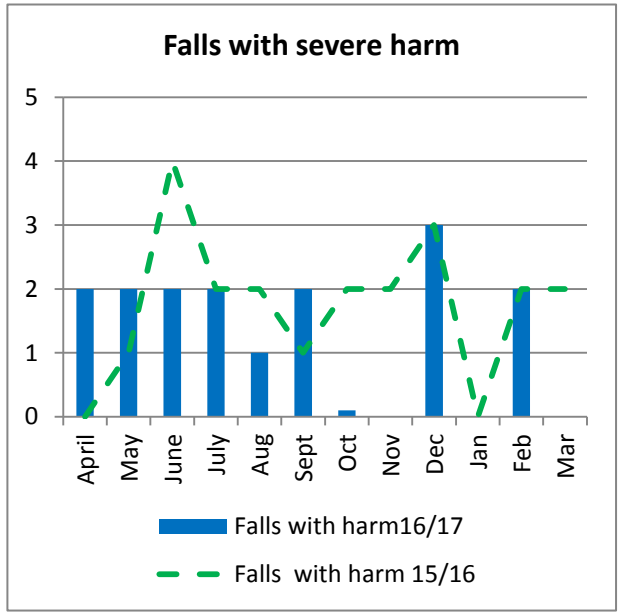
A work plan has been established for CA-UTI that includes more robust assurance around lessons learned from new CA-UTI. Additionally Old CA-UTI details will be shared with community colleagues from March 2017 to identify patterns of poor care in Nursing Homes and from within particular GP practices.

RCA'S are being completed when a patient has developed a hospital acquired thrombosis (HAT) and will be investigated in conjunction with ward leaders and Matrons.

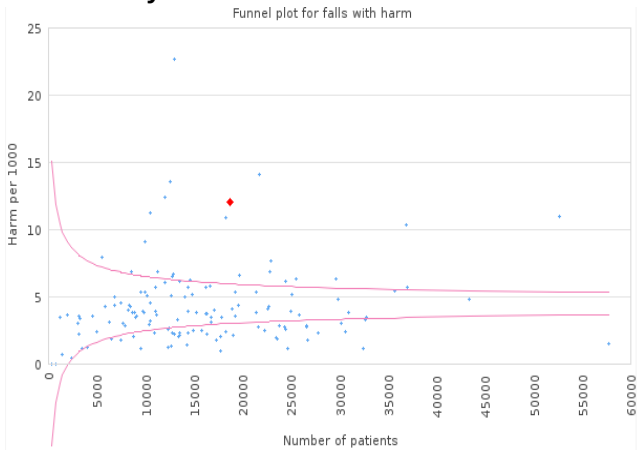
SAFE AMBITION 3 Reduction of Harm Associated with Falls







Safety Thermometer Dec 15 – 16



Safety Quality Dashbaord (SQD) for Trust Falls May 2016 – Feb 2017

Mtric Title	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	De 2016	Jan 2017	Feb 2017
Referred to OT	90.90%	89.80%	91.40%	80.40%	80.80%	90.00%	87.10%	85.50%	84.20%	-
Patient at risk of falls	349	360	344	336	338	344	318	284	325	333
Actions completed within 4 hours	91.40%	90.60%	93.00%	88.10%	87.40%	93.90%	90.50%	88.00%	87.70%	88%
Referred to physio	86.10%	87.10%	88.90%	90.10%	85.00%	90.50%	84.30%	84.20%	86.20%	-
Reviewed by physio	79.90%	81.40%	82.40%	78.50%	83.60%	84.40%	74.60%	79.50%	79.30%	-
Actions completed within 24 hours on admission	41.30%	42.40%	46.50%	42.20%	49.20%	45.30%	38.50%	48.50%	47.40%	-
Lying & standing BP completed	56.20%	55.60%	58.00%	62.60%	67.10%	63.10%	61.90%	61.00%	66.50%	62.8%
Actions completed within 24 hours of transfer	33.80%	32.10%	33.10%	39.30%	41.20%	35.40%	30.70%	34.30%	32.70%	42.7%
Medication review occurred	65.10%	67.10%	70.90%	66.50%	73.60%	70.10%	70.20%	71.50%	69.40%	68.9%
Care plan 7 activated	94.00%	95.50%	97.10%	96.40%	96.20%	93.80%	94.40%	93.60%	95.30%	95.4%

Performance Data Overview

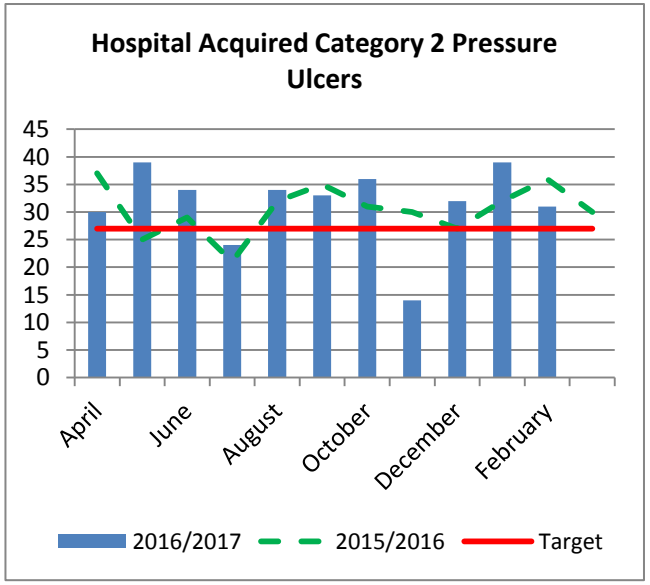
Data continues to demonstrate a higher proportion of falls across the sites for 2016/17 whilst maintaining overall a reduction in severe harm falls. April – February 2015/16 there were 1810 falls compared to 1872 in April – February 2016/17. In the same period in 2015/16 there were 24 falls resulting in

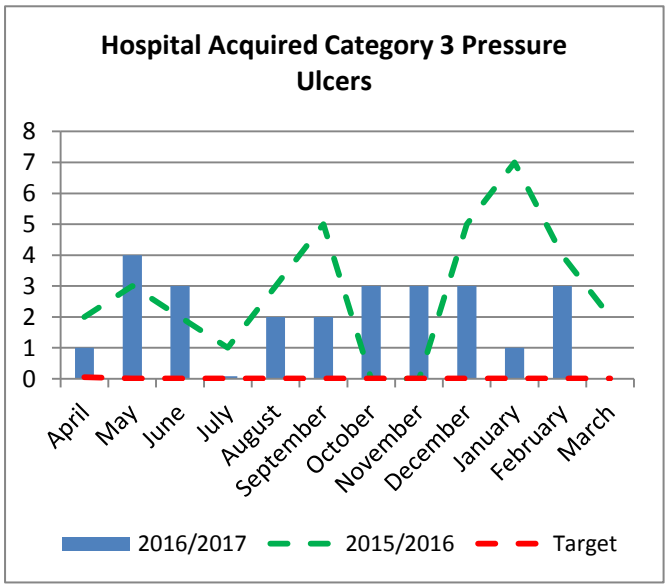
Action Plan

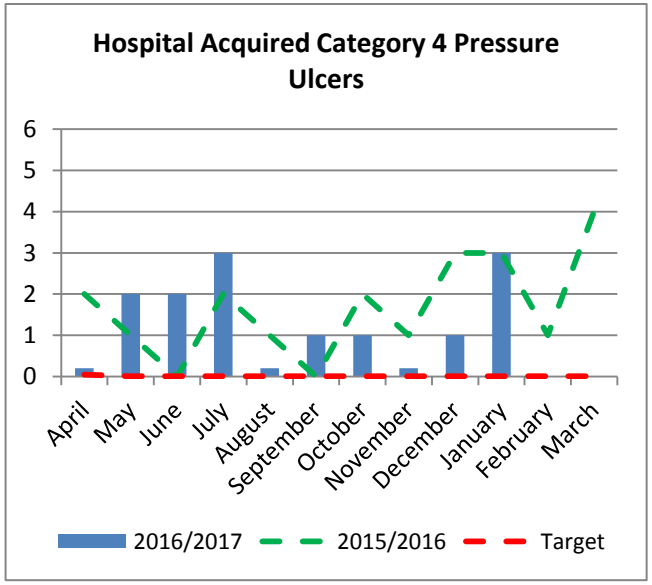
Lying & Standing BP training video due for launch in April 2017 to coincide with focus month.
Lying & Standing BP ward based training at Boston (March).
Falls webpages now live. Falls Metrics now amended on SQD
NHSi Falls work

severe harm or death compared with 16 in 2016/17.	

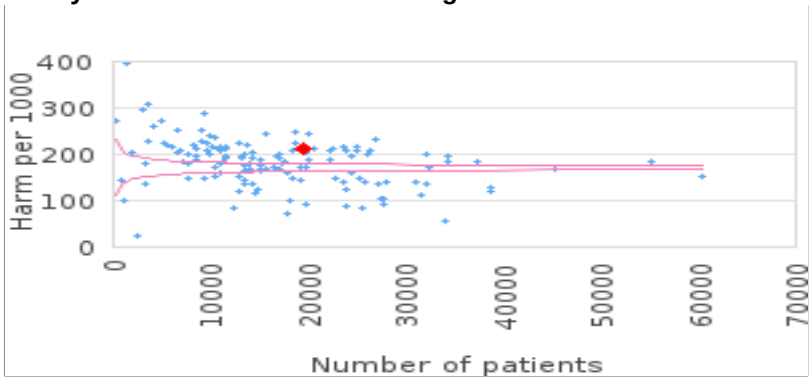
SAFE AMBITION 4 Reduction of Harm Associated with Pressure Ulcers







Safety thermometer national average



Safety Quality Dashboard (SQD) for Trust pressure area care May 2016- Feb 2017

Metric Title	May-2016	Jun-2016	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb-2017
Pressure area risk assessment completed within 24hrs	97.90%	98.10%	99.00%	98.80%	98.80%	99.30%	98.80%	98.30%	97.50%	-
Pressure area risk assessment updated weekly	85.50%	78.00%	75.30%	76.00%	78.90%	80.70%	78.40%	72.00%	71.60%	77.4%
Pressure-relieving equipment in situ if required	93.00%	92.30%	96.00%	93.50%	93.90%	96.60%	94.20%	95.50%	96.60%	93.4%
Repositioning chart commenced if required	95.90%	95.40%	96.10%	96.40%	98.20%	92.40%	95.90%	94.70%	92.80%	-
Pressure area care plan activated if required	91.40%	93.80%	95.10%	92.10%	94.30%	88.80%	94.40%	92.90%	93.50%	91.1%

Performance Data Overview

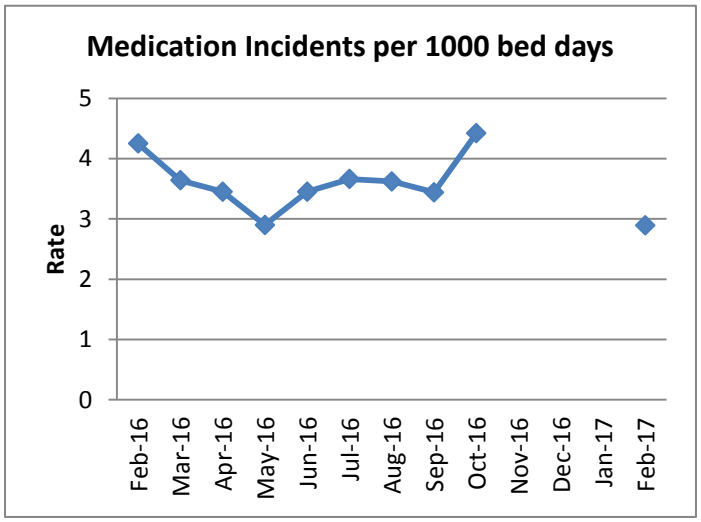
There were 31 new HA Grade 2 Pressure Ulcers, 3 Grade 3 and 0 Grade 4. Performance does not reflect assertion of avoidability. The data demonstrates a reduction overall in pressure damage for February but not in line with target. For the period April – February

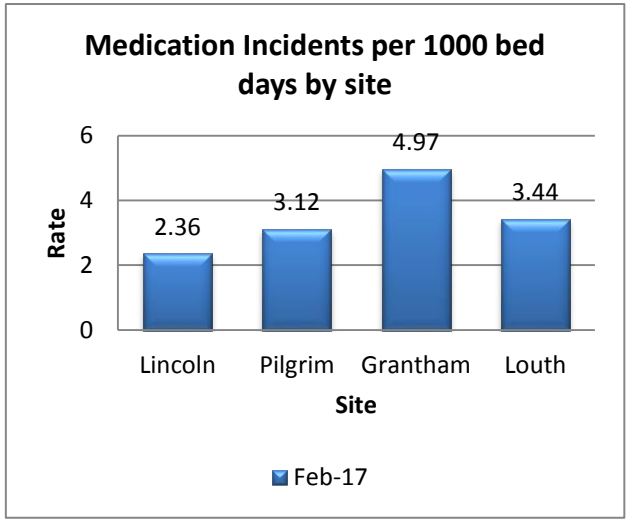
Action Plan

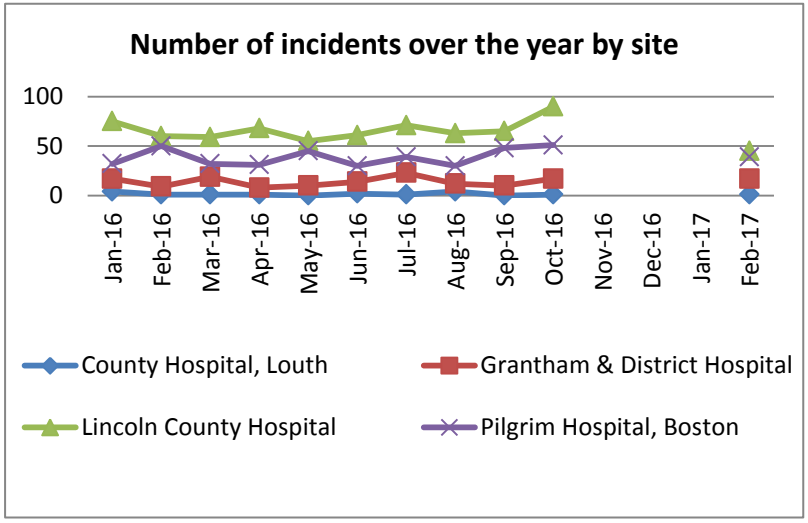
Scrutiny panels are ongoing. Assurance for pressure damage will be reviewed as part of ongoing work to establish ward accreditation. Further discussions are planned to explore shared learning from pressure damage. The Pressure Ulcer Committee have asked for

2015/16 there were 335 HA Grade 2 Pressure Ulcers compared to 346 in 2016/17.	legal advice on suitability of iPads as medical photography tool as these are in situ on all wards doing eCobs.

SAFE AMBITION 5 Reduction of Harm Medication Incidents







Trust Safety Quality Dashboard January 2016 – February 2017

Metric Group	Metric Title	Jan-2016	Feb-2016	May-2016	Jun-2016	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb-2017
Medication	Medicine chart demographics correct	68.30%	79.80%	73.80%	71.90%	75.00%	78.50%	78.40%	83.70%	78.10%	80.50%	78.80%	78.90%
Medication	Allergies documented	100.00%	98.70%	99.40%	95.50%	96.80%	98.10%	98.80%	98.20%	99.40%	98.40%	98.10%	99.40%
Medication	All medicines administered on time	86.00%	91.10%	88.80%	89.40%	87.90%	88.00%	91.90%	87.60%	88.60%	91.60%	89.10%	87.50%
Medication	Allergy nameband in place if required	90.40%	89.50%	91.20%	80.60%	91.00%	87.60%	91.80%	93.50%	86.20%	84.70%	92.90%	84.10%
Medication	Identification namebands in situ	98.50%	99.20%	97.90%	97.90%	98.80%	98.00%	99.50%	98.80%	99.80%	99.70%	98.50%	98.00%

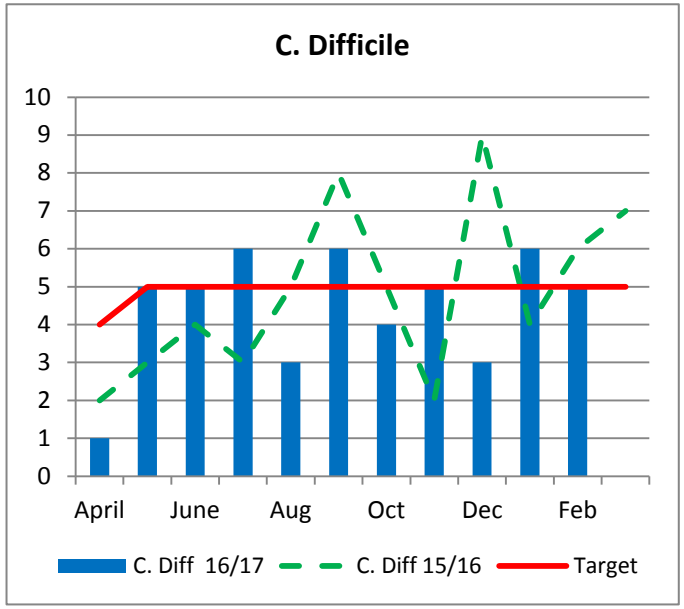
Performance Data Overview

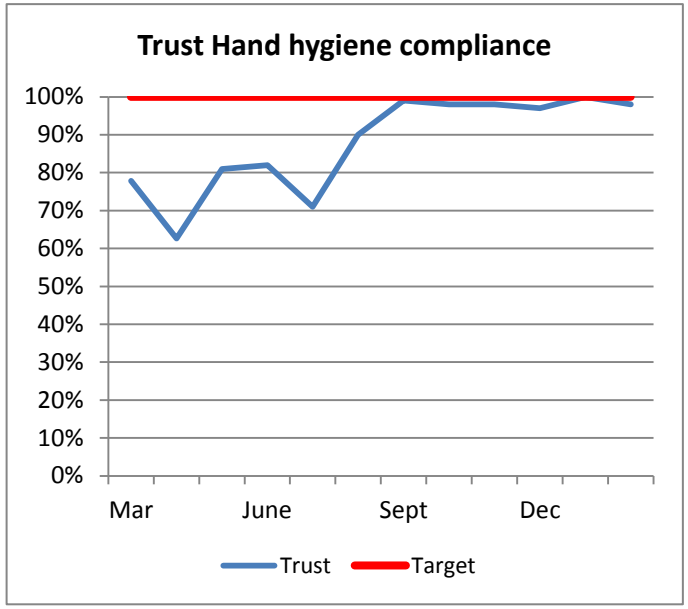
53 (52%) of all the incidents recorded were associated with priority/high risk drugs. The top 4 drug groups are; antimicrobials (26%), anticoagulants (25%), insulins and antidiabetics (17%), potassium (9%). The most common incident by type are omitted dose and wrong/unclear dose, these account for 56 % of all medication incidents in February (58/102). Severity of incidents; Severe 0.98 % Moderate 5.9 %, Low Harm 8.8 % and No Harm 84.3 %.

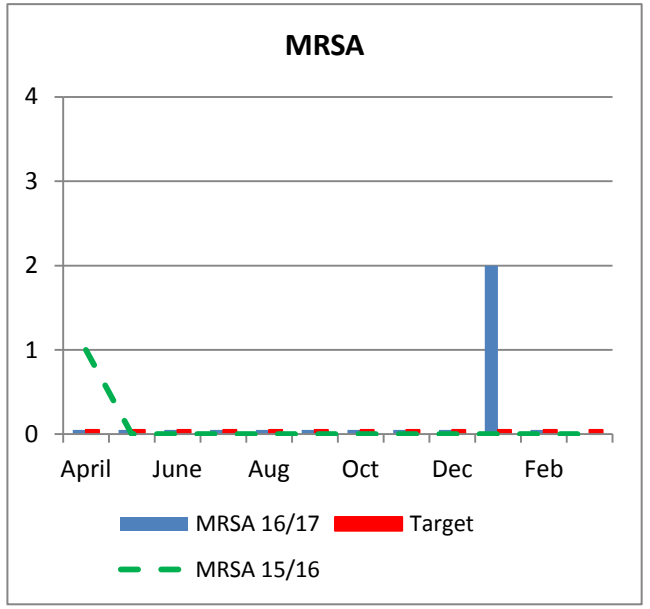
Action Plan

Data is reviewed at the Medicine Optimisation and Safety Committee and all incidents are reviewed on a monthly basis to identify trends. All Heads of Nursing receive the errors by ward area and disseminate to their matrons who in turn disseminate to their ward leaders. These all must be looked into regardless of the severity rating. Feedback reports from the Heads of Nursing are required to provide assurance that investigations and discuss have taken place.

SAFE AMBITION 6 Reduction of Harm Associated with Infection



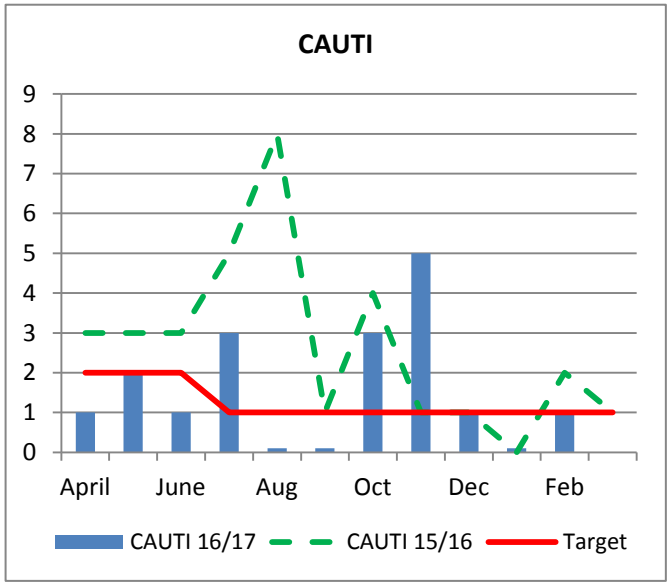




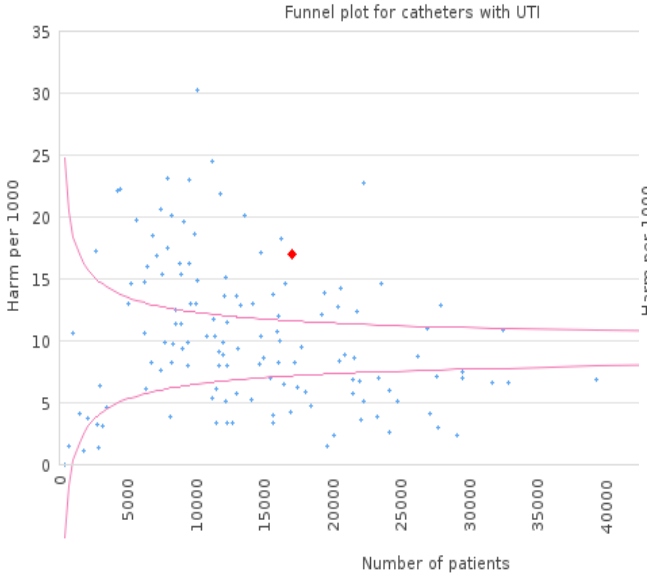
Performance Data Overview	**Action Plan**
There have been 5 cases of hospital acquired C.Diff (trajectory 5) for the month of February. For the year 2016/17 hospital C.Diff is therefore still within trajectory. There were no hospital attributable cases of MRSA reported in February however, cases previously reported in January take ULHT over trajectory for 2016/17. Hand Hygiene performance is 98 % for February 2017.	Monthly hand hygiene drop in sessions undertaken trust wide. Hand hygiene information published on intranet and circulated through Ward Health Check. Messages communicated via twitter Compliant assessment tool/review is undertaken for each patient with C.Diff. RCA is undertaken for each hospital acquired cases and an action place put into place which is overseen by the Infection Prevention Committee (IPC) .

SAFE AMBITION 6 Reduction of Harm Associated with Infection (CAUTI)

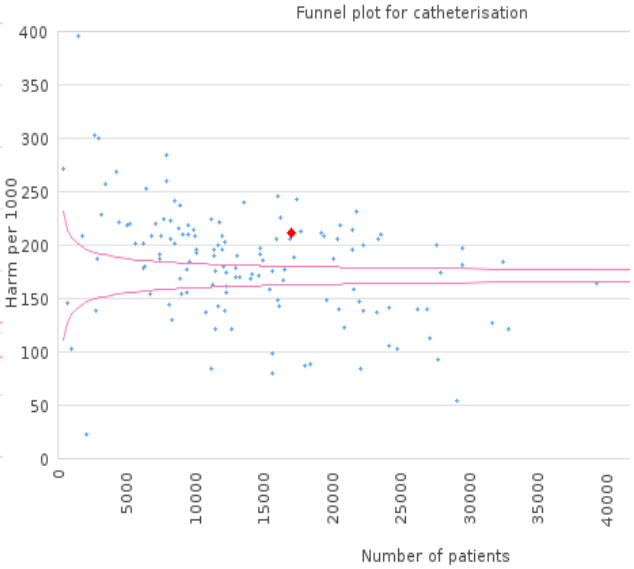
Number of CAUTIs at ULHT



Safety Thermometer catheters Dec 15 – Dec 16



Safety Thermometer



Safety Quality Dashboard (SQD) for Trust pressure area care May 2016- Feb 2017

Metric Title	May-2016	Jun-2016	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb-2017
Number of urinary catheters in-situ	72	74	75	81	63	72	81	53	67	84
Urinary catheter record demographics correct	90.1%	84.9%	90.4%	95.0%	96.8%	86.1%	98.8%	90.2%	94.0%	92.8%
Urinary catheter record completed &signed daily	72.2%	57.5%	57.5%	72.2%	65.1%	65.3%	72.2%	58.8%	68.2%	73.8%
TWOC occurred within 3 days for acute retention	100.0%	50.0%	36.4%	40.0%	50.0%	40.0%	58.3%	50.0%	66.7%	40%
Documented evidence why catheter needed	87.3%	87.3%	89.0%	91.1%	96.8%	86.1%	97.5%	92.2%	91.0%	91.7%
Urinary catheter bags secure	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	-
Urinary catheter care plan activated	83.3%	82.2%	87.5%	88.6%	90.5%	83.3%	90.1%	88.2%	88.1%	-

Performance Data Overview

There was 1 new CA-UTI in February 2017, however, it was not possible to validate this infection as the patient was transferred from the hospital post collection and transported with their medical notes. The trust position for new CA-UTI will require review post receipt of February GEM Arden report including revisions of inaccurate submission for January 2017. Until these revisions take effect a sound judgement cannot be made around national comparison however, crude data indicates significant reduction on 2015/16 figures.

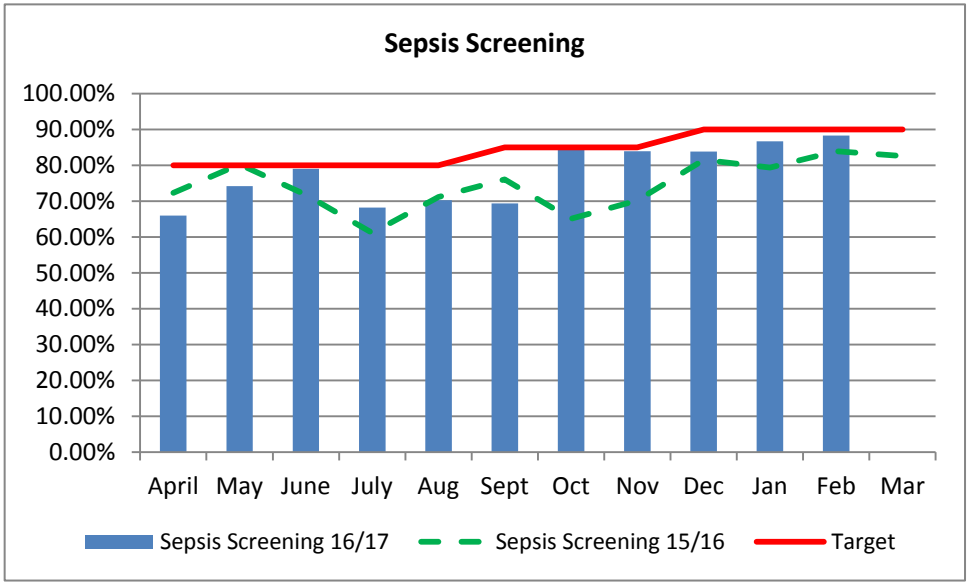
Action Plan

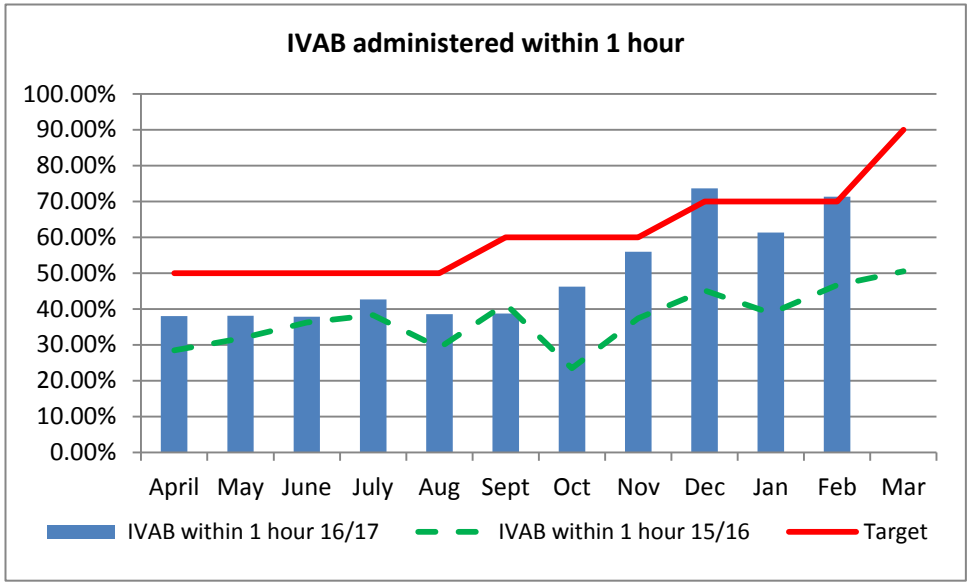
Nurse specialists review all CA-UTI/Pressure Ulcers and VTE.

A work plan has been established for CA-UTI that includes more robust assurance around lessons learned from new CA-UTI. Old CA-UTI details will be shared with community colleagues to identify patterns of poor care pre admission.

Ongoing review of internal webpages. Exploration of electronic training bundle supplied by manufacturer and mapped to appropriate clinicians ESR accounts. Ongoing training of FY1 & FY2.

SAFE AMBITION 7 Reduction of Harm Associated with Deterioration Sepsis





Safety Quality Dashboard (SQD) for Trust pressure area care May 2016- Feb 2017

Metric Title	May-2016	Jun-2016	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb - 2017
Patient demographics correct	98.1%	98.8%	99.5%	98.0%	98.8%	98.8%	99.8%	99.4%	99.0%	-
Patient observations on time and complete	79.2%	79.1%	80.0%	78.2%	80.5%	77.1%	77.1%	67.0%	61.8%	52.9%
NEWS score added correctly	97.1%	98.3%	98.1%	97.5%	98.3%	98.8%	98.8%	98.6%	98.7%	-
Evidence of escalation if required	91.2%	78.0%	78.3%	76.1%	71.4%	93.8%	86.0%	75.6%	82.9%	86.2%

Performance Data Overview

Site	Bundle Commenced –Feb 17	IVAB within 1 hour – Feb 17
Grantham	84.75%	70.37%
Lincoln	97.19%	83.72%
Pilgrim	82.76%	62.50%

There is week on week variability in site performance. Since January 2017 there has been notable improvement at Lincoln in respect of screening (January 88.37%) and deterioration at Grantham (January 94.74 %). Clinical engagement is variable across sites and Grantham and Boston have been asked to submit remedial action plans to the Sepsis Task & Finish Group

Action Plan

E-Bundle launched on two wards at Lincoln and milestone plan to introduce additional areas to be collated by Sepsis Nurses.
Compliance with e-learning remains at 71% however additional completed numbers are pending from postgraduate centre which will improve overall figures.
Sepsis Focus day held at Lincoln with various engagement strategies.
Launch of Sepsis boxes pending.
Sepsis literature to comply with NICE requirements pending purchase order but clinical and patient approval.
Sepsis PODCAST.
Sepsis performance data added to the front page of the intranet with dedicated pages for Site breakdown

4. Finance

Date of report:	07 March 2017
Lead Director:	Peter Hollinshead, Interim Director of Finance
Purpose of Report:	An update on the Trust's financial position as at the end of February 2017, and full year forecast
Strategic Objective	1) Efficient use of resources
	2) Ensure the Trust is in line with delivery of it's key financial duties

The Board of Directors are asked to note the above and the following main points:

- The likelihood that the Trust will deliver a deficit of £54.9m compared to the control total of £47.9m
- The significant operational pressures in January have continued in February resulting in continuing high levels of agency expenditure and reduced elective activity and income

High Level Financial Summary – February 2017 (Month 11)

Measure	Plan to date	Actual to date	Annual Plan	RAG
Income	411.9	400.7	450.7	
EBITDA (£'m)	-28.2	-35	-29.6	
Net surplus (£'m)	-44.9	-49.9	-47.9	
Efficiency	16.9	15.6	19	
Cash (£'m)	1.1	2.2	1	
Revenue Support Grant (£'m)	-102.8	-103	-103.4	
Capital Expenditure (£'m)	15.6	9.4	16.7	

Summary

The Trust has an agreed control total deficit of £47.9m for 2016/17.

The Month 11 position is a deficit of £7.0m, leading to a year to date deficit position of £49.9m. The performance to date has been impacted as a result of a high monthly spend on agency (£2.8m) to deal with the winter pressures and a resultant loss in elective income in month as beds are used to cope with the demands of winter.

The revised Income and Expenditure forecast (£54.9m) is based on the January performance to date with a projected run rate that shows an improvement in March from the February position.

As a consequence, the Trust will not be eligible for the Q4 STF funding of £3.9m.

The Trust is forecasting it will deliver its Capital Resource Limit (CRL) and its External Funding (EFL).

Performance

- Year to date deficit is £49.9m compared to plan of £44.9m
- Cash holdings at the end of February are £2.2m with RSG of £103.0m
- Year to date efficiency is £15.6m c.f. plan of £16.9m
- Capex is £9.4m c.f. plan of £15.6m

Forecast

The Trust is forecasting a deficit of £54.9m. This is a result of reduced elective income coupled with an increase in agency expenditure and reduced STF funding.

Category	Metric	Period of Measure	Plan	Actual	Variance	RAG	Month minus 1	Month minus 2	Month minus 3	Month minus 4	Month minus 5
			Feb-17				Jan-17	Dec-16	Nov-16	Oct-16	Sep-16
		In Month	-5.1	-7	-1.9		-5.1	-3.4	-4.5	-4.2	-4.4
	I&E Surplus/(Deficit) (£'m)	YTD	-44.9	-49.9	-5		-42.9	-37.8	-34.2	-29.7	-25.5
I&E and		Forecast	-47.9	-54.9	-7		-54.9	-47.9	-47.9	-47.9	-47.9
Profitability		In Month	-3.5	-5.6	-2.1		-3.9	-2	-3.3	-2.8	-3
	EBITDA (£'m)	YTD	-28.2	-34.9	-6.7		-29.3	-25.4	-23.4	-20.1	-17.3
		Forecast	-29.6	-31	-1.4		-30.9	-30.9	-30.9	-30.9	-30.9
		In Month	2.4	1.1	-1.3		1.8	2.5	1	0.9	1.8
FIP	Efficiency Achievement (£m)	YTD	16.9	15.6	-1.3		14.5	12.7	10.2	9.2	8
		Forecast	19	16.5	-2.5		19	19	19	19	19
	Cash (£m)	YTD	1.1	2.2	1.1		1.4	1.4	4	1.3	1.4
Liquidity		Forecast	1	1.2	0.2		1	1.2	1.2	1.2	1.2
	Revenue Support Loan (£m)	YTD	-102.8	-103	-0.2		-98.8	-94.2	-89.2	-85	-81.5
		Forecast	-103.4	-103.4	0		-103.4	-103.4	-103.4	-103.4	-103.4
	Capital Expenditure (£m)	YTD	15.6	9.4	-6.2		8.9	8	7.3	7.1	5.2
		Forecast	17.6	16.7	-0.9		16.7	16.7	16.7	16.7	16.7
	Substantive,bank and overtime(WTE	YTD	266.4	261.8	-4.6		237.9	214.2	190.3	166.3	142.2
Workforce	Agency & Locum Staff (WTE)	YTD	20.1	26.1	6		23.3	20.5	18.2	15.8	13.7
	Total	YTD	286.5	287.9	1.4		261.2	234.7	208.5	182.1	155.9

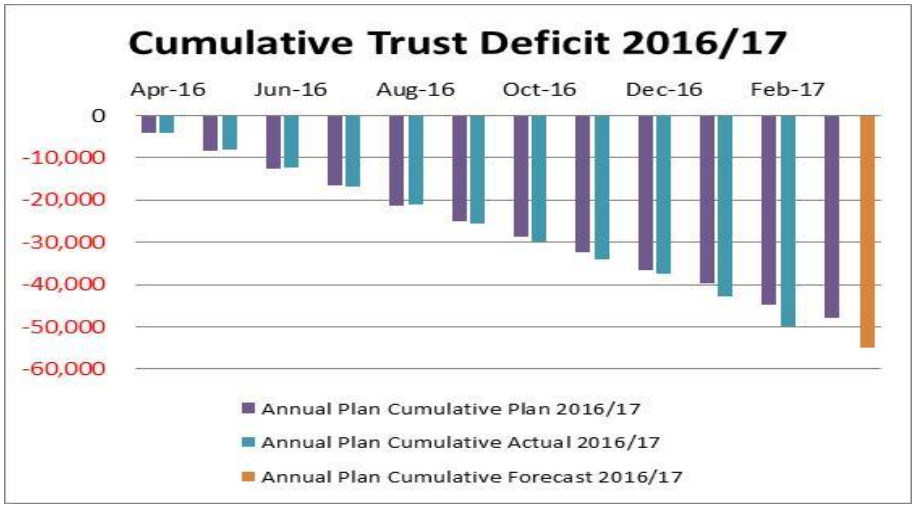
The Trust has a control deficit as follows:-

	£m
Trading deficit	64.0
Less STF funding	16.1
Planned deficit	47.9

The continued winter pressures resulting in increased agency to staff escalation areas and the reduction in elective activity and income has resulted in a revised forecast trading position of £66.1m deficit, which results in the loss of STF funding for Q4.

The main risks to the forecast:-

a) CCG activity challenges
b) Continued winter pressures
c) Delivery of CQUIN
d) Delivery of the efficiency programme
e) STF appeals



	Forecast Outturn		
	Best Case £k	Most Likely £k	Worst Case £k
Income Non STF	428,972	427,230	426,092
Income STF	11,169	11,169	11,169
Pay	-313,943	-314,443	-314,943
Non Pay	-165,164	-164,528	-164,525
Deprn, Dividend & IFRIC12	-17,129	-17,129	-17,129
Financial Flexibilities	2,709	2,709	2,709
	-53,385	**-54,991**	**-56,627**
Made up of:			
Trading Position	-64,555	-66,161	-67,797
Income STF	11,169	11,169	11,169
	-53,385	**-54,991**	**-56,627**

Financial Performance - February 2017

Trading Position

Period ending 28 February 2017

2015-16 Year end £k		2016-17 Annual FIMS Plan £k	2016-17 Annual Internal Plan £k	Year to Date Internal Plan £k	Year to Date Actual £k	Year to Date Surplus/ (Deficit) £k
	Income					
386,840	Revenue from Patient Care Activities	410,259	417,098	381,455	369,583	(11,872)
36,450	Other Operating Revenue	40,358	32,420	29,781	31,146	1,366
138	Receipt of govt granted /donated	120	120	53	28	(25)
423,428	**Total Income**	450,737	449,638	411,289	400,758	(10,531)
	Expenditure					
(305,876)	Pay	(312,134)	(316,751)	(290,165)	(287,881)	2,284
(157,204)	Non Pay	(168,112)	(164,201)	(150,927)	(147,842)	3,085
(463,080)	**Total Expenditure**	(480,246)	(480,952)	(441,092)	(435,723)	5,369
(39,652)	**Earnings before interest,tax,depreciation and**	(29,509)	(31,314)	(29,804)	(34,966)	(5,162)
(50)	Profit/Loss(-) on disposals	0	20	20	20	0
(11,448)	Depreciation	(12,870)	(11,700)	(10,522)	(10,630)	(108)
(8,557)	Impairment	0	0	0	0	0
(5,258)	PDC Dividend	(4,266)	(3,322)	(3,045)	(2,907)	139
70	Interest Receivable	42	64	58	45	(13)
(905)	Other interest payable	(1,627)	(1,981)	(1,857)	(1,851)	6
(65,800)	**Surplus / (Deficit) for period**	(48,230)	(48,233)	(45,150)	(50,288)	(5,138)
(15.5)%	**Net Margin**	**(10.7)%**	**(10.7)%**	**(11.0)%**	**(12.5)%**	**(1.6)%**
(56,917)	**Surplus / (Deficit) adjusted for impairment & impact of donated / govt granted assets**	**(47,927)**	**(47,930)**	**(44,814)**	**(49,946)**	**(5,132)**

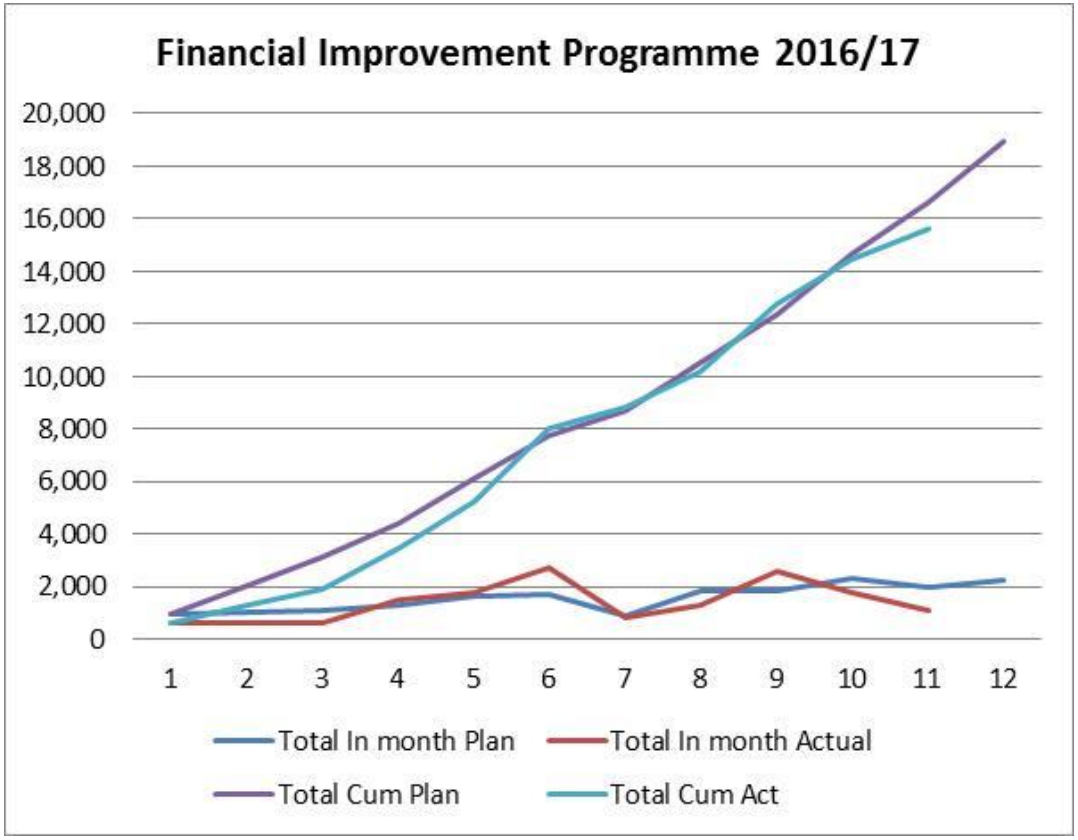
- Income below plan due to underperformance on patient activity.
- Expenditure budgets are £5.4m below plan due to underspends which partly offset increased agency
- The outcome of the STF appeals process in respect of performance is still pending

Statement of Financial Position

	March 2016	February 2017			Mar 2017 Forecast	
	Final Accounts	Plan	Actual	Variance	Actual	
	£000s	£000s	£000s	£000s	£000s	
NON-CURRENT ASSETS:						
Property, Plant and Equipment	215,768	246,338	214,824	(31,514)	219,310	+
Intangible Assets	5,607	4,087	5,386	1,299	5,253	
Trade and Other Receivables	1,477	1,250	1,076	(174)	1,477	+
Total Non-Current Assets	**222,852**	**251,675**	**221,286**	**(30,389)**	**226,040**	+
CURRENT ASSETS:						
Inventories	7,130	7,738	7,292	(446)	7,430	+
Trade and Other Receivables	21,127	27,041	25,727	(1,314)	21,741	+
Cash and cash equivalents	1,166	1,066	2,185	1,119	1,218	+
Subtotal	**29,423**	**35,845**	**35,203**	**(642)**	**30,389**	+
Non-Current Assets Held for Sale	1,075	0	1,075	1,075	1,075	+
Total Current Assets	**30,498**	**35,845**	**36,278**	**433**	**31,464**	+
Total Assets	**253,350**	**287,520**	**257,564**	**(29,956)**	**257,504**	+
CURRENT LIABILITIES:						
Trade & Other Payables	(42,020)	(46,899)	(46,288)	611	(41,595)	-
Other Liabilities	(503)	(503)	(503)	(0)	(503)	-
Provisions for Liabilities and Charges	(1,364)	(818)	(1,536)	(718)	(1,536)	-
Borrowings	(299)	(119)	(118)	1	(119)	-
Liabilities arising from PFIs / LIFT / Finance Leases	0	(15)	(16)	(1)	0	-
Total Current Liabilities	**(44,186)**	**(48,354)**	**(48,461)**	**(107)**	**(43,753)**	-
Net Current Assets /(Liabilities)	**(13,688)**	**(12,509)**	**(12,183)**	**326**	**(12,289)**	+/-
Total Assets less Current Liabilities	**209,164**	**239,166**	**209,103**	**(30,063)**	**213,751**	+/-
NON-CURRENT LIABILITIES						
Other Liabilities	(14,591)	(14,129)	(14,130)	(1)	(14,087)	-
Provisions for Liabilities and Charges	(2,484)	(2,446)	(2,974)	(528)	(2,926)	-
Borrowings	(178)	(118)	(118)	(0)	(58)	-
Working capital support facility	(18,382)	(19,282)	0	19,282	0	-
DH Revenue Support Loan	(35,618)	(83,518)	(102,997)	(19,479)	(110,547)	-
Total Non-Current Liabilities	**(71,253)**	**(119,493)**	**(120,219)**	**(726)**	**(127,618)**	-
Total Assets Employed	**137,911**	**119,673**	**88,884**	**(30,789)**	**86,133**	+
FINANCED BY: TAXPAYERS EQUITY						
Public dividend capital	251,746	254,990	253,006	(1,984)	255,663	+
Retained Earnings	(157,029)	(192,102)	(206,443)	(14,341)	(211,771)	+/-
Revaluation reserve	43,004	56,595	42,131	(14,464)	42,051	+
Other reserves	190	190	190	0	190	+/-
Total Taxpayers Equity	**137,911**	**119,673**	**88,884**	**(30,789)**	**86,133**	+

- Cash position slightly better than plan and still in line with the requirement of minimum £1m balance.
- Property value less than plan due to year end reduction in actuarial valuation, compensating reduction in revaluation reserve and retained earnings.
- The working capital support loan has been extending during the year which offsets the requirement for the Revenue Support Loan

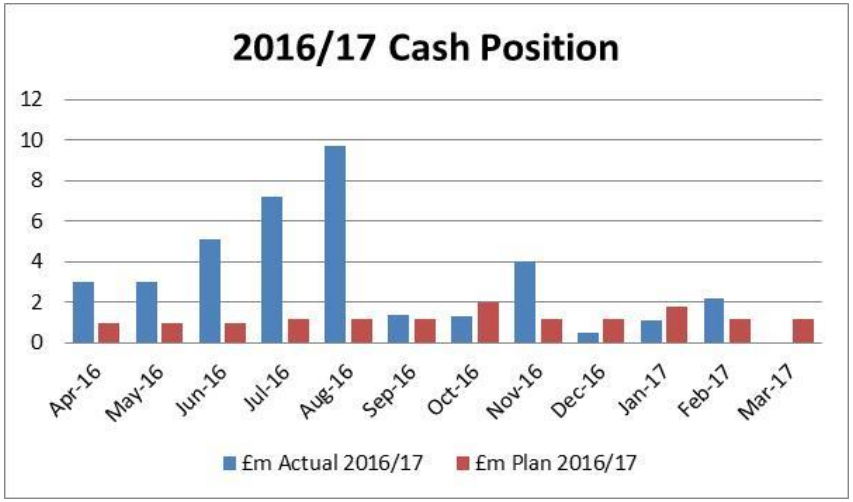
Financial Efficiency Programme – as at December 2016



- The FIP plan totals £19m for 2016/17
- Month 1 year to date delivery of £15.6m, of which £5.5m is non recurrent
- £6m estimated carry forward to 2017/18

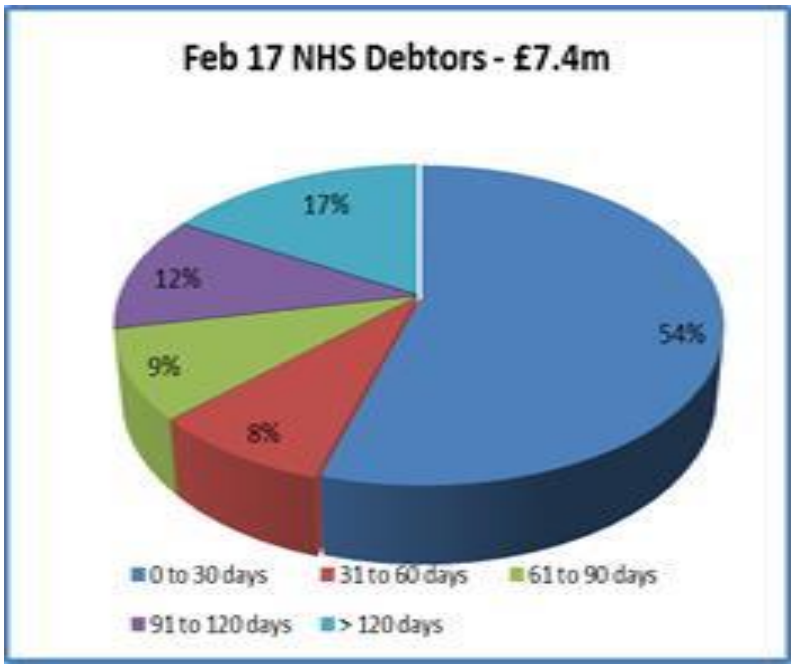
Cashflow

	February 2017			Mar 2017			
	Plan	Actual	Variance	Plan		Forecast Actual	Variance to Plan	
	£000s	£000s	£000s	£000s		£000s		
Operating Surplus / (Deficit)	**(39,817)**	**(45,595)**	**(5,778)**	**(42,379)**		**(50,597)**	(8,218)	+/-
Non Cash items to be excluded								
Depreciation / Amortisation	11,716	10,630	(1,086)	12,870		11,700	(1,170)	+
Impairments & Reversals	0	0	0	0		512	512	+
Receipt of Donated Assets	(110)	(28)	82	(120)		(142)	(22)	-
Earnings before Interest Tax & Dividends (EBITDA)	**(28,211)**	**(34,993)**	**(6,782)**	**(29,629)**		**(38,527)**	(8,898)	**+/-**
Interest paid	(677)	(1,286)	(609)	(1,590)		(1,898)	(308)	-
Dividends (Paid) / Refunded	(1,610)	(1,425)	185	(3,746)		(2,772)	974	-
(Increase)/decrease in inventories	0	(161)	(161)	0		(299)	(299)	+/-
(Increase)/decrease in trade & other receivables	(5,130)	(4,199)	931	62		(613)	(675)	+/-
Increase/(decrease) in trade & other payables	1,509	5,754	4,245	1,572		(2,041)	(3,613)	+/-
Increase/(decrease) in other current liabilities	(462)	(461)	1	(504)		(504)	(0)	+/-
Increase/(decrease) in provisions	(439)	624	1,063	(471)		576	1,047	+/-
NET CASH IN/(OUT)FLOW FROM OPERATING ACTIVITIES	**(35,020)**	**(36,147)**	**(1,127)**	**(34,306)**		**(46,078)**	**(11,772)**	+/-
CASHFLOWS FROM INVESTING ACTIVITIES								
Interest received	38	46	8	42		47	5	+
(Payments) to acquire property, plant & equipment	(18,772)	(11,922)	6,850	(21,774)		(13,091)	8,683	-
(Payments) for intangible assets	0	(1,015)	(1,015)	0		(1,014)	(1,014)	-
Receipts from disposal of property, plant & equipment	2,000	24	(1,976)	2,000		24	(1,976)	+
NET CASH IN/(OUT)FLOW FROM INVESTING ACTIVITIES	**(16,734)**	**(12,867)**	**3,867**	**(19,732)**		**(14,034)**	**5,698**	+/-
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(51,754)**	**(49,014)**	**2,740**	**(54,038)**		**(60,112)**	**(6,074)**	+/-
CASHFLOWS FROM FINANCING ACTIVITIES:								
Revolving Working Capital Support Facility Accessed	36,332	33,618	(2,714)	36,883		33,618	(3,265)	+
Revolving Working Capital Support Facility Repaid	(35,432)	(52,000)	(16,568)	(35,432)		(52,000)	(16,568)	
Public dividend capital received : Capital	3,244	1,260	(1,984)	5,000		3,917	(1,083)	+
Public dividend capital received: Revenue	0	2,818	2,818	0		2,818	2,818	+
Public dividend capital repaid: Revenue	0	(2,818)	(2,818)	0		(2,818)	(2,818)	-
Loans received from DH - Revenue Support Loans	47,900	67,379	19,479	47,900		74,929	27,029	+
Capital element of payments relating to PFI, LIFT and finance leases	(165)	(165)	(0)	(181)		(181)	0	-
Other loans repaid	(59)	(59)	(0)	(119)		(119)	0	
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**51,820**	**50,032**	**(1,788)**	**54,051**		**60,164**	**6,113**	+/-
INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	**66**	**1,018**	**952**	**13**		**52**	**39**	+/-
OPENING CASH BALANCE 1ST APRIL 2016	**1,000**	**1,166**	**166**	**1,000**		**1,166**	**166**	
CLOSING CASH BALANCE	**1,066**	**2,184**	**1,118**	**1,013**		**1,218**	**205**	



- Cash position slightly better than plan, due to STF drawn down based on achieving Q4 finance element.
- The Trust has drawn up to the maximum £52.0m RWCF limit.
- Cash is being managed to achieve a year end cash balance in line with plan.

Financial Performance – Working Capital



Non NHS debt over 90 days totals £0.2m, excluding those on payment plans.

NHS debt over 90 days totals £2.1m. This is split as follows:

	Over 90 Day Total
CCGs - Lincolnshire	884
CCGs - Other	362
Trusts - Lincolnshire	289
Trusts - Other	320
Other NHS	235
Total	**2,090**

2016/ 17 Year to date	**NHS**		**Non-NHS**	
	By volume Number	**By Value £000s**	**By volume Number**	**By Value £000s**
Total bills paid in the year	2,236	37,402	116,450	183,815
Total bills paid within target	1,630	28,993	96,725	151,162
% of bills paid within target YTD	**72.90%**	**77.52%**	**83.06%**	**82.24%**
% of bills paid within February 2017	**81.34%**	**76.82%**	**81.55%**	**80.12%**

Capital Expenditure – as at February 2017

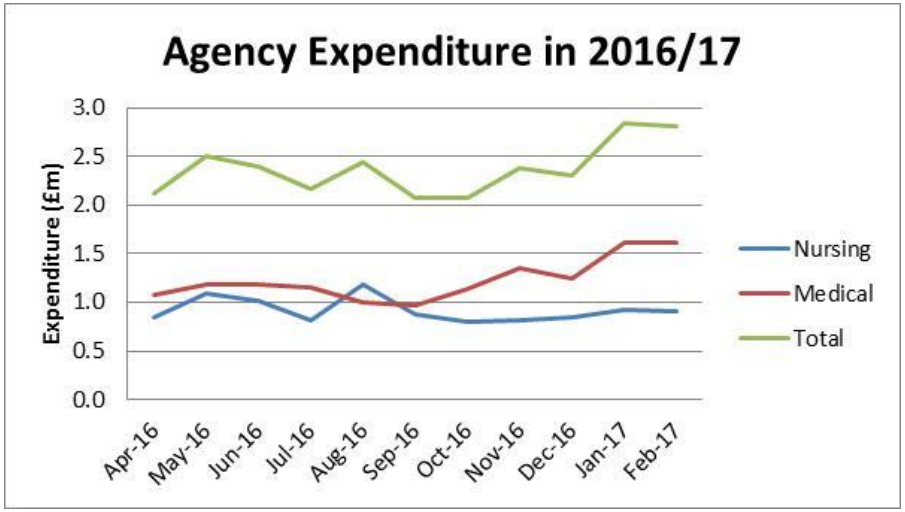
Programme	FIMS £000's	Plan to date £000's	Spend £000's	forecast
Facilities	6,126	5,907	2,005	5,027
Additional £12m	0	0	1	0
Medical Devices Group (Risk)	5,062	4,078	2,363	3,641
IM&T (Risk)	3,596	3,516	2,348	2,732
Service Development & Modernisation	2,998	2,998	2,730	3,863
Contingency/Other	1,768	1,584	0	0
Prior Year Schemes			7	0
Unallocated/(over allocated)				
	19,550	18,083	9,454	15,263

- The forecast has been revised down by £3.2m to mitigate the impacts of the reductions to the funding sources mainly the delay in the sale of Welland Hospital.
- The in month spend was £0.5m. The spend to date of £9.5m leaves £5.8m to be spend by the end of the year. All of this is committed, with delivery of the estates requirement (including the Neonates project) comprising the largest element. The medical equipment is all ordered for delivery by the end of March, the largest item being £0.4m for anesthetic machines.
- The forecast remains to deliver the CRL

Financial Performance – Pay and Workforce

WTE Analysis

Category	Feb	May	Aug	Nov	Feb	Movement Feb - Feb
Non Clinical	1,113	1,118	1,134	1,161	1,177	64
Nurses & Midwives	2,774	2,763	2,726	2,798	2,807	34
Other Support Staff	757	751	746	750	773	16
Consultants	310	306	309	319	313	4
Medical Staff	486	476	495	496	484	-2
Scientific, Therapeutic & Technical	923	916	908	905	909	-14
Total	6,361	6,330	6,319	6,429	6,464	103



Financial Performance – Year end Forecast and Risks

	Forecast Outturn		
	Best Case £k	Most Likely £k	Worst Case £k
Income Non STF	428,972	427,230	426,092
Income STF	11,169	11,169	11,169
Pay	-313,943	-314,443	-314,943
Non Pay	-165,164	-164,528	-164,525
Deprn, Dividend & IFRIC12	-17,129	-17,129	-17,129
Financial Flexibilities	2,709	2,709	2,709
	-53,385	**-54,991**	**-56,627**
Made up of:			
Trading Position	-64,555	-66,161	-67,797
Income STF	11,169	11,169	11,169
	-53,385	**-54,991**	**-56,627**

- Forecast is currently projecting a most likely case of £54.9m.
- The revised Income and Expenditure forecast (£54.9m) is based on performance to date with a projected run rate including the continuation of winter pressures (£3.7m).
- Key risks are as follows:

a) CCG activity challenges
b) Continued winter pressures
c) Delivery of CQUIN likely to be less than plan
d) Delivery of the efficiency programme
e) STF appeals

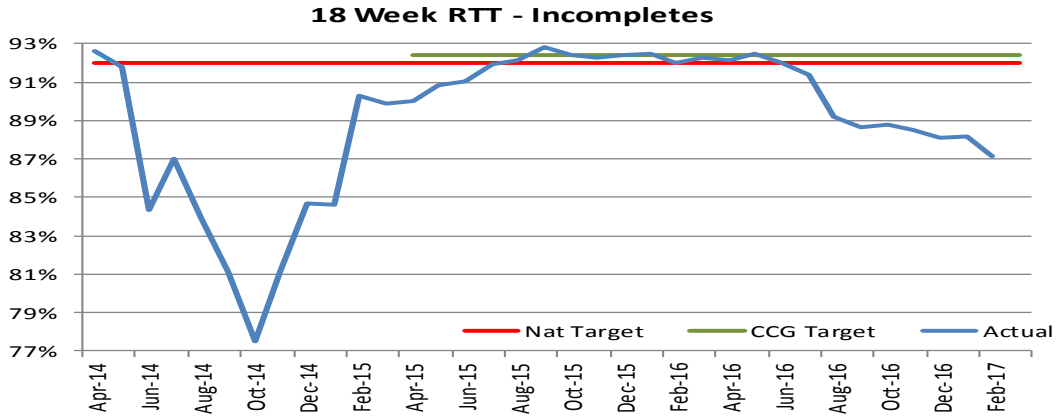
4. Workforce

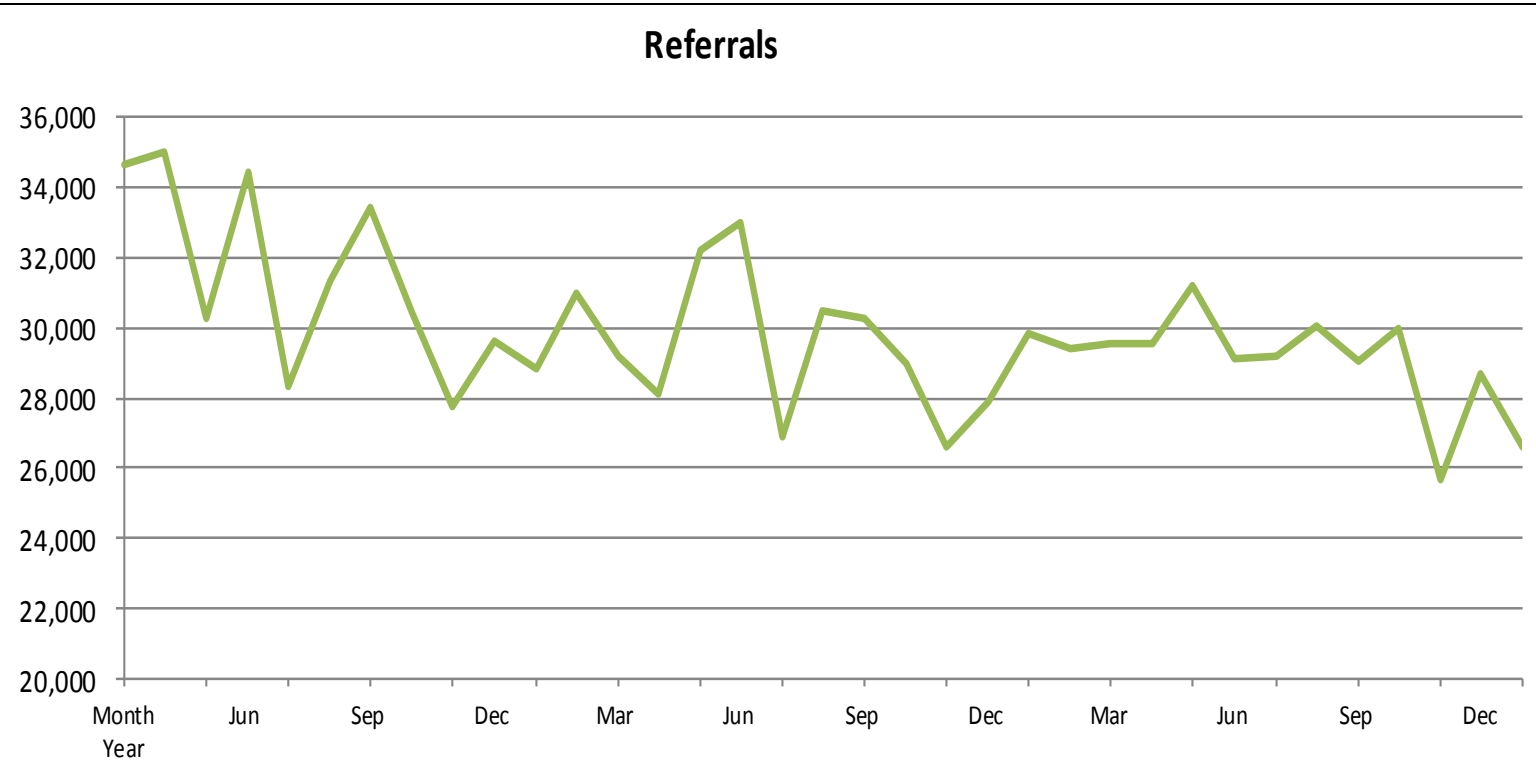
KPI	Current Target	Feb 17	Trend	
			Monthly	6 months
Staff Turnover Trust Wide	Under Mean of Acute Hospitals 11.61%	**9.35%**		
Vacancy Rate N&M	8%	**13.28%**		
Vacancy Rate Medical & Dental	7.5%	**13.86%**		
Agency & Bank Rate	<2%	**8.35%**		
Absence Rate (12 month rolling period)	4%	**4.73%**		
Appraisals	95%	**65.93%**		
Core learning	95%	**90%**	**No Change**	

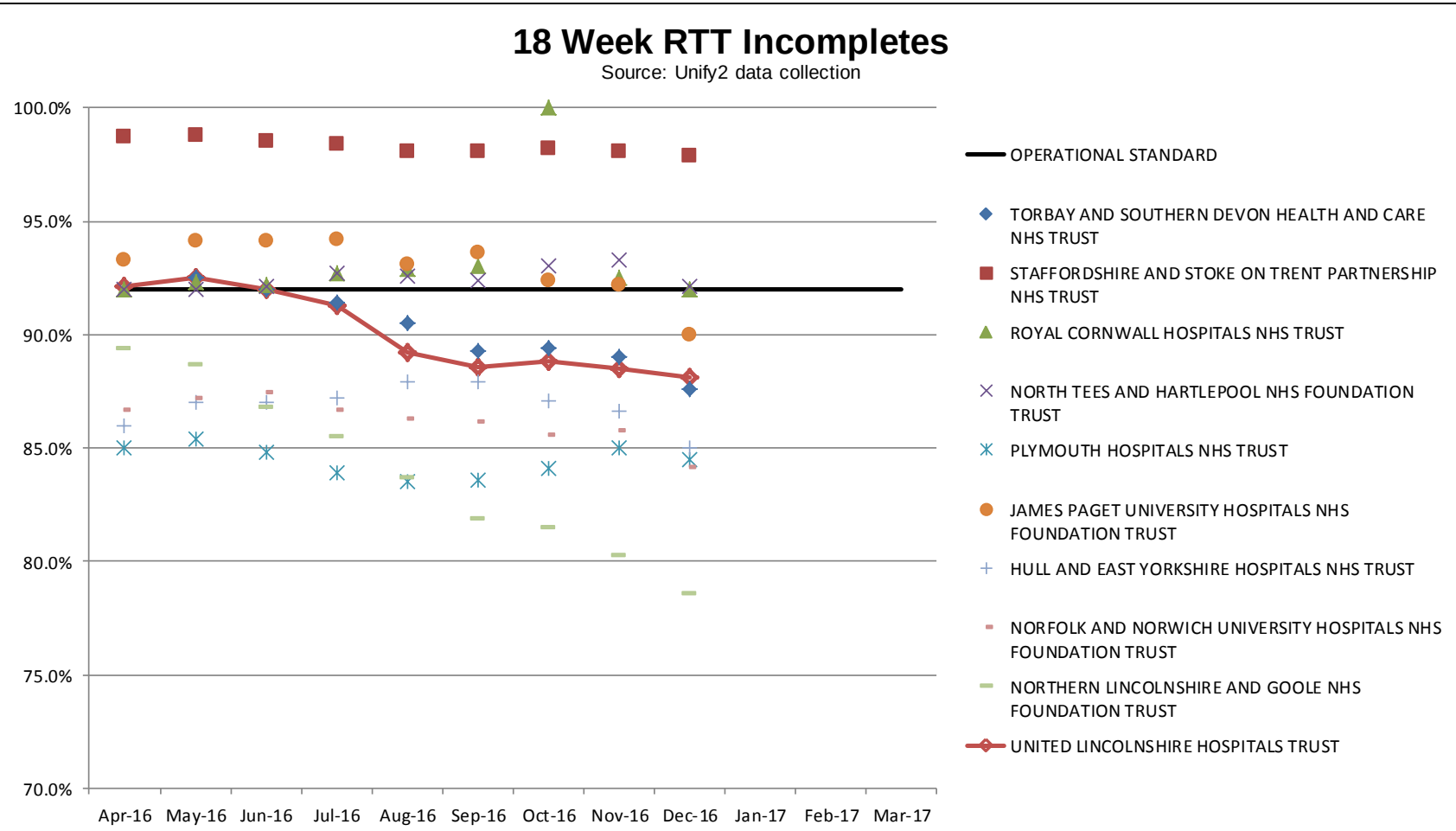
4. "Priority deliverables" – RTT Incompletes

KPI:	**Referral to Treatment**	**Owner:**	Chief Operating Officer
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Operational Performance
Date:	**28th March 2017**	**Reporting Period:**	February 2017

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	In February performance was 88.27%. There are 3 significant factors which had an impact on performance across a range of specialities in the early months of 2016/17, and led to growth in the RTT backlog: • Junior Doctor Industrial Action – During the two periods of industrial action in April alone there were 1335 outpatient appointments cancelled as a direct consequence of the Trust needing to maintain patient safety during this action. In addition there was a significant reduction in surgical activity during these periods. • Grantham Fire – As a result of the fire which occurred at Grantham in April there were c.300 outpatient cancellations and 25 elective cancellations. • Partial Booking Waiting List – The number of patients overdue over 6 weeks past their target date has reduced by c.1800 patients between the end of June and the end of September. This reduction in the size of the partial booking waiting list will have reduced the capacity available to treat patients on incomplete pathways. The above factors led to a reduction in capacity within the Trust, and by August 2017 the backlog of patients over 18 weeks had increased to c.3000. This backlog position has remained relatively stable since that time. The increase in urgent care pressures during winter have a knock on impact onto RTT performance. In December and January, as part of the winter plan and to assist with the achievement of 85% bed occupancy by Christmas Eve and maintenance of urgent care flow, the Trust planned to complete a total of 130 less elective cases than standard (plus the impact of bank hols). In addition to this planned reduction, the Trust cancelled over 300 operations during December and January as a result of capacity issues such as lack of HDU and general beds. In February the winter plan scheduled for a return to standard elective operating capacity. However, the Trust cancelled over 200 operations during February as a result of capacity issues such as lack of HDU and general beds. The impact of urgent care pressures, and the requirement for Business Unit management to be involved in assisting with operational management of the sites during times of increased pressure have resulted in reduced Business Unit capacity to

	progress actions related to RTT recovery across a number of specialities. The Trust has an agreed trajectory which takes the performance to 92% by June. There is particular risk against speciality level trajectories within ENT, Orthopaedics and Cardiology, which due to their waiting list volumes create risk to the achievement of the overall Trust position in June. As at month 10 Neurology is 25% above the contracted activity plan, Dermatology is 19%, Endocrine is 19%, Gastro is 15% and Pain is 12%. All of these areas have RTT incompletes performance below 90%.
Forward Trajectory	
Variance Analysis (SPC Chart)	


Referrals
36,000
34,000
32,000
30,000
28,000
26,000
24,000
22,000
20,000
Month
Year
Jun
Sep
Dec
Mar
Jun
Sep
Dec
Mar
Jun
Sep
Dec



The above graph shows the latest available national performance for 18week RTT Incomplete performance. The peer group that has been selected to benchmark ULHT against consists of Trust's which have a similar rural structure and patient demographics.

What action is being taken to recover performance?

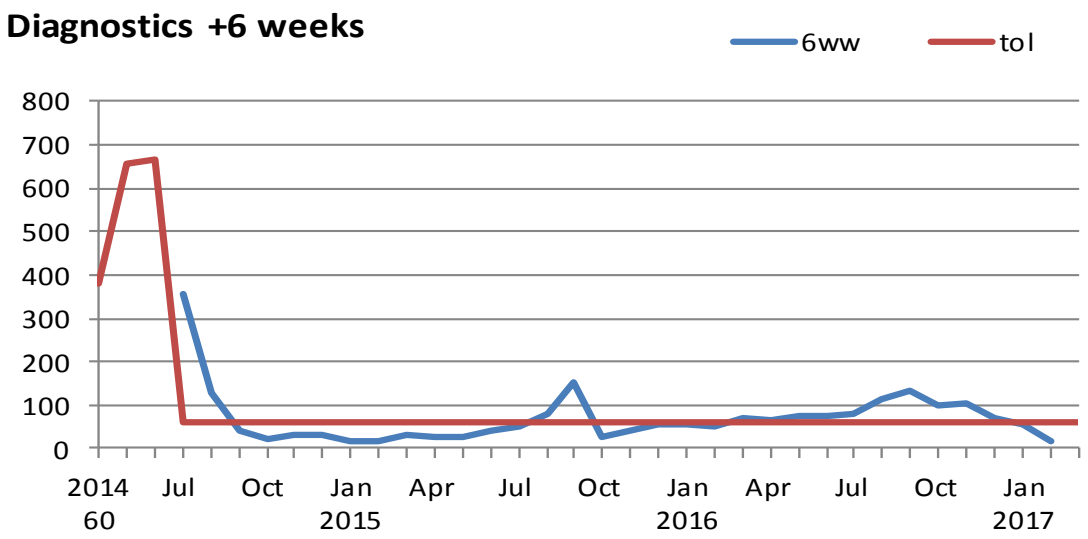
The following 11 specialities have each produced recovery action plans which set out short term actions to improve speciality level performance – General Surgery, Orthopaedics, ENT, Gastro, Respiratory, Dermatology, Cardiology, Neurology, Endocrine, Rheumatology, Vascular.

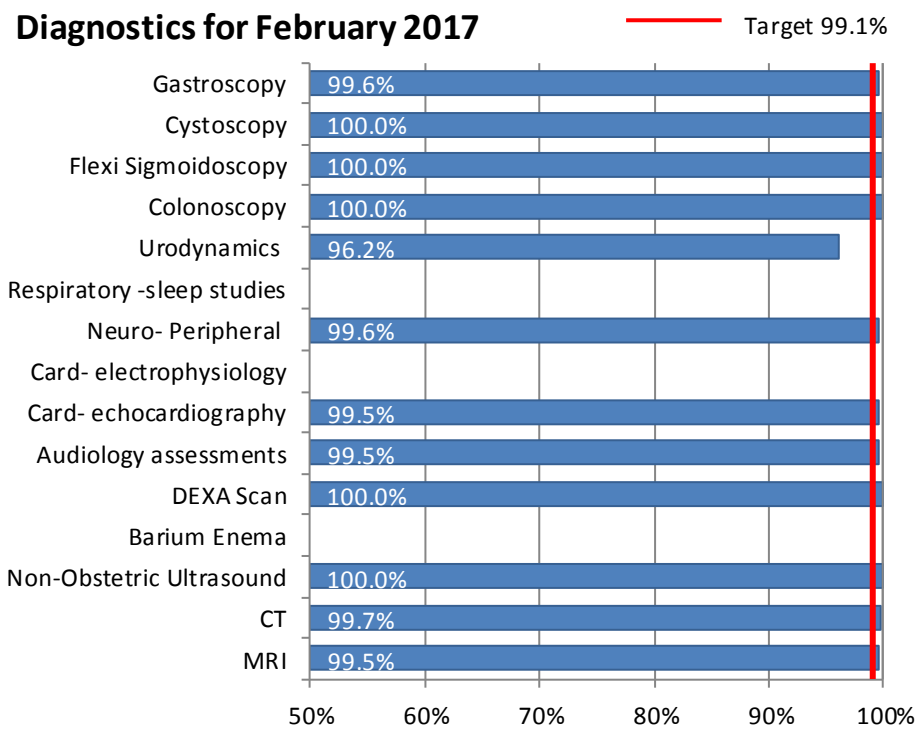
Key actions contained within these plans include increasing internal capacity through additional outpatient and theatre sessions from our existing workforce and utilisation of additional locum capacity. Plans were in place in February to deliver additional activity (primarily in outpatients) resulting in c.400 clock stops and c.300 in March, however some of this additional activity will be offset by the high volume of elective cancellations.

	The Clinical Directorates have plans to deliver over 300 additional clock stops above standard activity in April. The Trust has outsourced 71 patients between Orthopaedics and General Surgery this year. . Levels of outsourcing have been less than expected as access to outsourcing capacity, particularly within the East of the county, has been limited. The position regarding outsourcing during 2017/18 is yet to be confirmed. The different sites are working together in order to equalise waits across the Trust within speciality areas, and to ensure that capacity is fully utilised. Where activity levels are significantly above the contract level the CCGs are being asked to initiate actions to support the Trust by controlling referral rates into these specialities. An internal theatre productivity and scheduling improvement programme is in place and is anticipated to deliver an additional c.170 elective/day cases during Q4 above standard activity levels. In December the Business Units completed a clinical validation process relating to open referrals which have been waiting over 16 weeks from referral in order to ensure that they are appropriate for Consultant-led care. In January the Trust wrote to all patients awaiting a new appointment who were referred over 14 weeks ago, in order to ask them to confirm whether they still required an appointment. This process has now been completed.
What is the recovery date?	June 2017 – with risk
Who is responsible for the action? (Provide the role and name of the lead)	

4. “Priority deliverables” – Diagnostic 6wk Standard

KPI:	**Diagnostic Waits**	**Owner:**	Chief Operating Officer
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Operational Performance
Date:	**28th March 2017**	**Reporting Period:**	February 2017

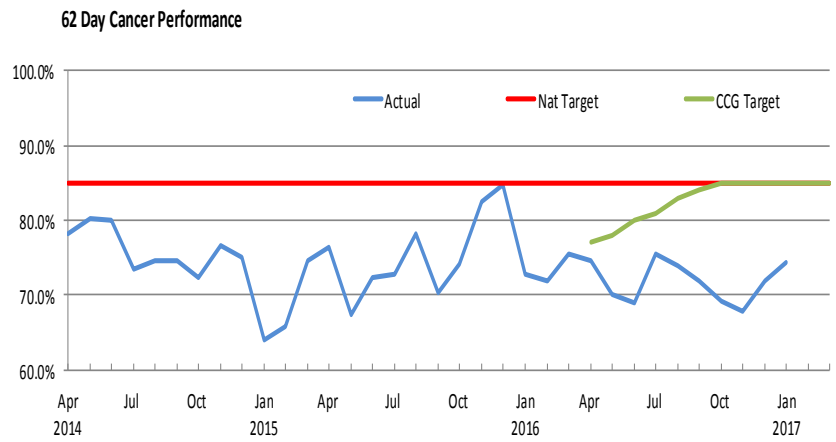
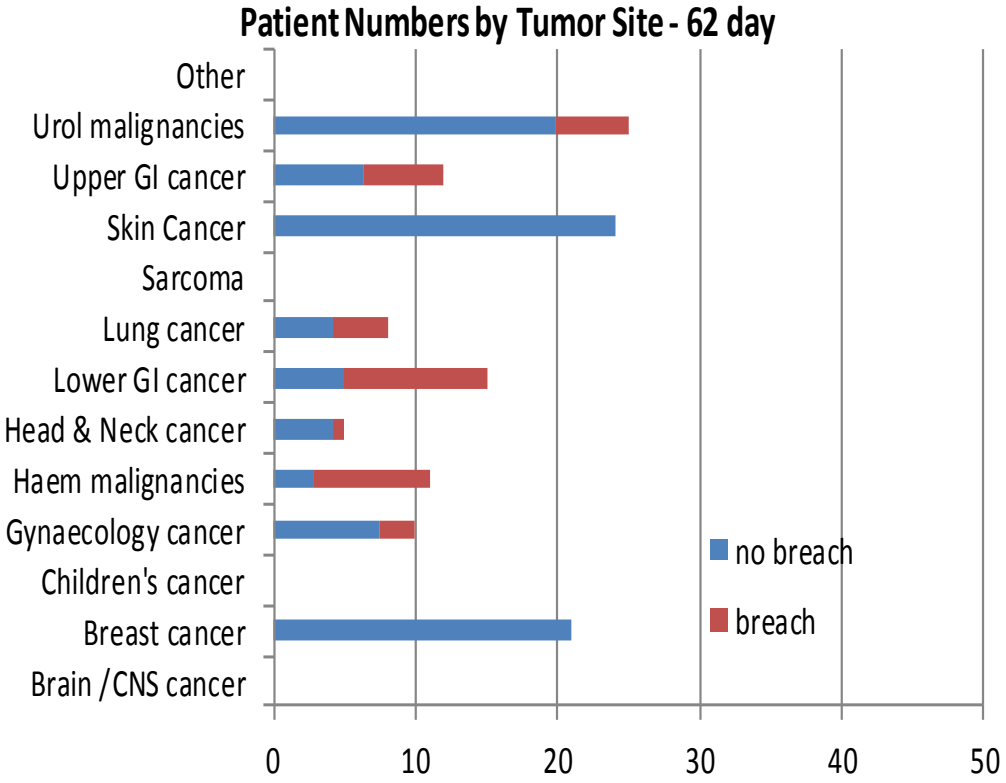
Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	In February the Trust achieved the 6 week diagnostic standard for the third month in a row. The performance level was 0.38%. The national average in January was 1.7%. The number of 6-week breaches reduced from 102 patients in November down to 18 patients in February. At modality level performance of <1% was achieved in all modalities except for Urodynamics (with this area only reporting 1 breach). The level of breaches within Echocardiography has been the most significant cause of the Trust’s overall failure of this standard in the second half of 2016. The service has put on additional capacity in recent months particularly within stress Echo and TOEs, and as a result the backlog of breaches has reduced significantly. In November Echo reported 86 breaches, but this has reduced to 64 in December, 30 in January and 4 in February.
Forward Trajectory	

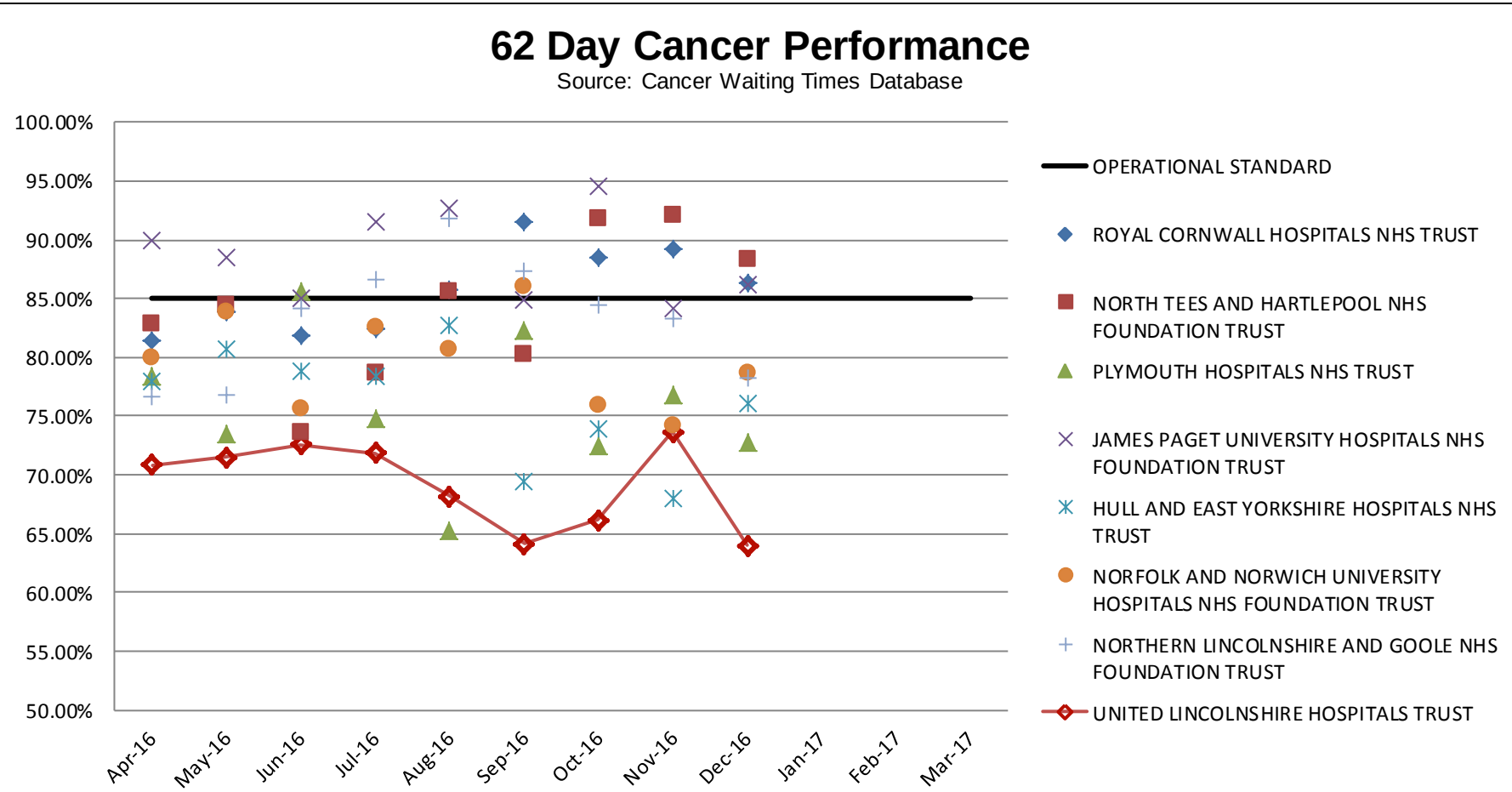
Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	It is forecast that the diagnostic 6-week standard will continue to be achieved in March.
What is the recovery date?	
Who is responsible for the action?	

4. "Priority deliverables" – Cancer 62 Day Standard

KPI:	**Cancer Waiting Times (62 Day)**	**Owner:**	Chief Operating Officer
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Operational Performance
Date:	**28th March 2017**	**Reporting Period:**	January 2017

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	The Trust achieved a performance of 74.4% against the 62 day classic standard in January, an improvement of 2.5% compared with December. At the same time the national average fell 3.4% from being 82.9% in December to 79.5% in January. The Trust achieved 3 out of the 9 cancer standards in January. Demand is continuing at unprecedented levels (highest recorded February 2ww referral rate, 5.5% higher than last year) and the increased number of referrals coming into the Trust, and hence demand on all diagnostics is delaying diagnosis and putting additional pressures to treat the patients within a smaller window before they breach. Though significant effort has been made in all areas on 62 Day performance improvement work, a lot of this effort has been absorbed by the higher levels of patients being referred in on a suspect cancer pathway. The 62 Day Classic standard continues to remain the most challenged standard and work continues to improve the quality of the patient journey on the understanding that improvements in this will work directly towards achievement of this standard. The RCAs for January 62 day breaches found a number of key themes in terms. Access to diagnostics within ULHT, particularly Radiology and Endoscopy, was slower than required for a significant proportion of patients on 62 day pathways. Since January Radiology turnaround times have improved for patients on suspected cancer pathways; however the impact of this on the 62 day performance is unlikely to be seen until March. In addition, delayed access to specialist tests (such as EBUS and EUS) and treatment at tertiary centres introduces further waiting periods into the 62 day pathways for our patients, deteriorating ULHT's performance. Small delays in access to the Oncology service and patient choice delays, particularly over the Christmas period, also contributed to the Trust's performance position. The impact of urgent care pressures on bed capacity and particularly HDU capacity is adversely effecting cancer performance, with increasing numbers of cancelled operations for cancer patients. The Trust's performance against the 14 day suspect cancer target and the 14 day breast symptomatic target were both adversely effected in January by a spike in referrals into the breast service, with referral rates in January of over 135 patients per week compared to a baseline service capacity of 100 slots per week.

Forward Trajectory	
Variance Analysis (SPC Chart)	



The above graph shows the latest available national performance for 62 Day Cancer performance. The peer group that has been selected to benchmark ULHT against consists of Trust's which have a similar rural structure and patient demographics. From this graph it can be seen that ULHT Is an outlier in the peer group.

What action is being taken to recover performance?

The Trust holds a fortnightly Cancer Recovery and Delivery meeting, chaired by a Deputy Director, in order to provide an oversight of the change programme set out in the Trust's Cancer Action Plan, holding Business Units to account for performance and delivery against the action plan.

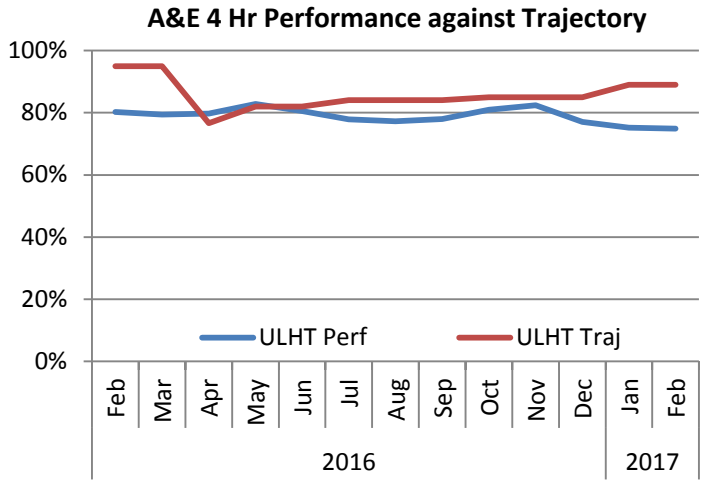
The 7 Day Horizon (potentially cuts a week out of pathway by making the First Appointment within 7 days of referral as opposed to 14 days) has now been successfully deployed in all areas that are appropriate. The areas that due to operational reasons will not be able to cross over (Brain, Breast, Sarcoma and Dermatology); will continue under the IST Capacity & Demand 85th percentile system.

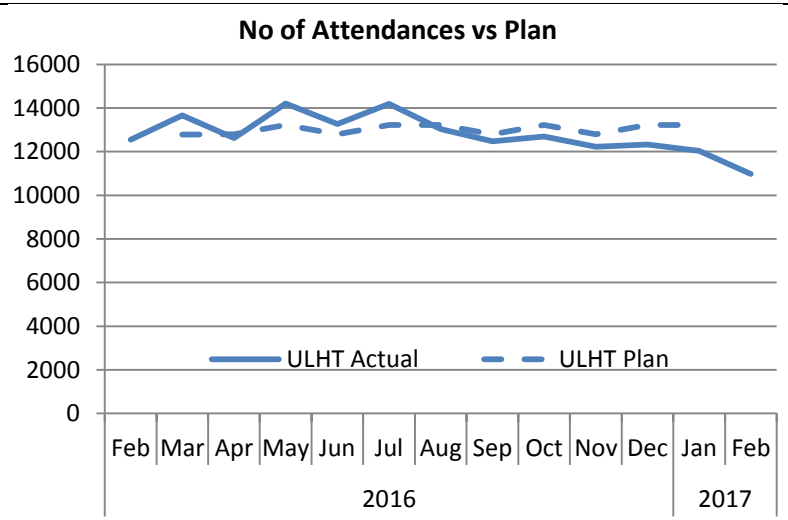
	There is now a weekly Radiotherapy PTL meeting held within the department so that they have visibility of all patients waiting for RT treatment and their target dates. The continued Subsequent RT performance reflects this work. The Upper GI Straight to Test pilot has proven to be successful and county-wide roll-out of the service will be from April 2017. Likewise plans are being developed to roll out the lower GI straight to test pathway to all sites by May 2017. The Somerset Cancer Register implementation continues at a fast pace. There are now 156 registered users (compared to 40 on Infoflex), including MDT Co-ordinators, Clinicians, Specialty Doctors, Business Unit teams, Bowel Screening Practitioners, Cancer Nurse Specialists, Radiology Booking Teams, Pathologists, Dietitians and Macmillan Cancer Information staff. A pilot of using it live in the MDT, sharing the information across two hospital sites, and the clinical outcome being recorded, printed and signed off within the meeting was successful and roll-out to the other MDTs continues. Radiology are currently piloting a new booking process, where appropriate patients are asked to go directly to Radiology reception, following their outpatient clinic appointment, in order to book their Radiology diagnostic appointment before they leave the Hospital. It is anticipated that this will reduce the time from referral to diagnostic test being completed. The Trust has utilized funding from the national diagnostic capacity fund in order to reduce CT waiting times, and the Radiology Dept. are currently exploring how additional capacity can be maintained after the end of March when this funding ceases. An Endoscopy stakeholder group met for the first time in March in order to plan how additional Endoscopy capacity could be provided in order to reduce waiting times within this area. Level 1 Beds are scheduled to open on the Lincoln site in April, with the expectation that this will reduce the number of cancelled operations linked to HDU capacity.
What is the recovery date?	
Who is responsible for the action? (Provide the role and name of the lead)	

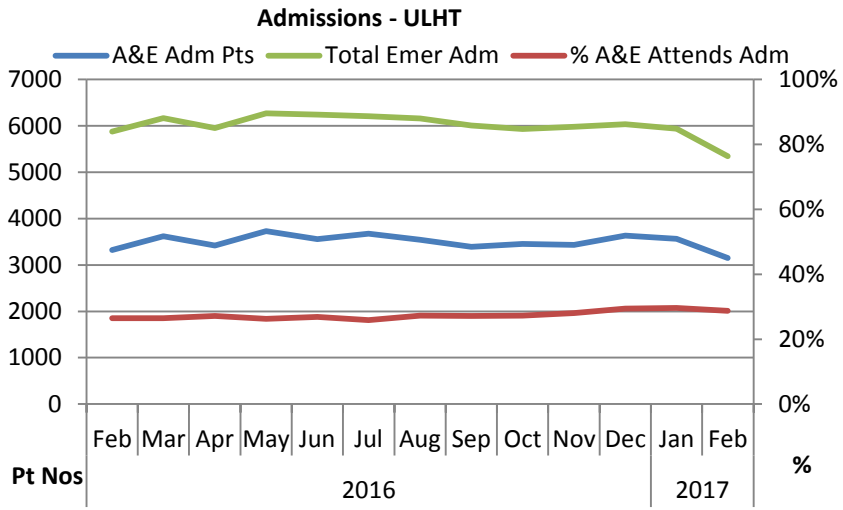
4. "Priority deliverables" – A&E 4hr Standard

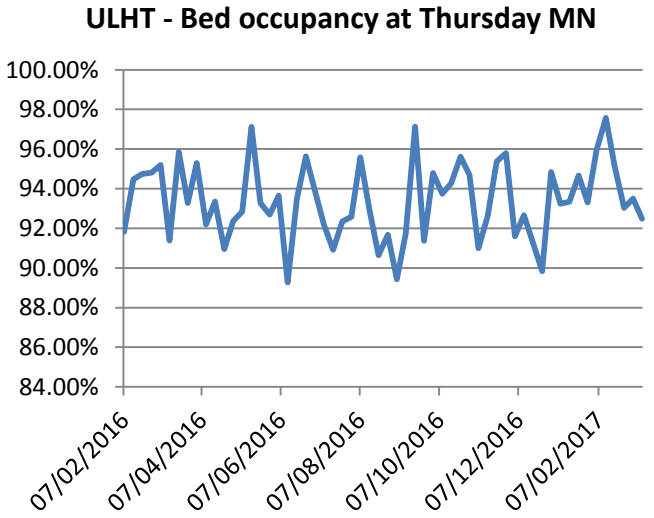
KPI:	**4 Hour Wait (A&E)**	**Owner:**	Chief Operating Officer
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Operations; Emergency Care Interim Head of Nursing; Grantham
Date:	**28th March 2017**	**Reporting Period:**	February 2017

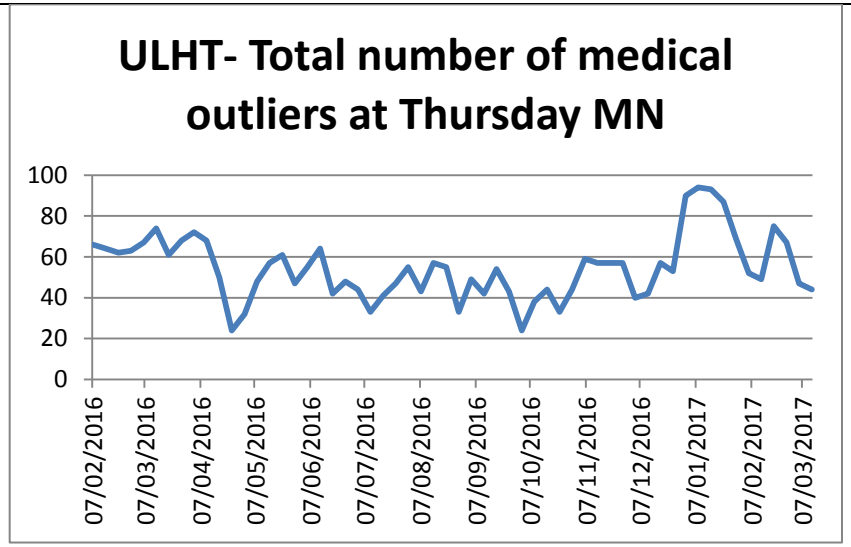
Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	**ULHT:** **Commentary:** Overall Trust performance is 74.87%.This is 14.13% lower than the planned recovery trajectory of 89%, and 5.33% less compared to February 2016. The February quality measures for: - triage are below the 15 minute standard at 8 minutes for the median (55 mins based on the 95th centile) - time to first 1st treatment at 76 mins for the median against a target of 60 mins (213mins at 95th centile). Attendances at ULHT level have reduced against plan since August last year, which is linked to the overnight closure of Grantham. During February attendances were 1055 less than during January with a corresponding reduction in total emergency admissions (593). The ULHT admission to attendance ratio is down by 1.11% compared to last February, with Lincoln (-1.55%), Pilgrim (-0.01%) and Grantham (+1.31%). Despite the reduction we saw a considerable increase in medical outliers which suggests that surgical specialities admissions reduced rather than medicine. Delays in Ambulance handover however remain at unacceptable levels. The ULHT overall bed occupancy for February was between 93.31 and 97.56% and DTOC remained c.5-6% of occupied acute beds. It must be noted that bed occupancy during February was the highest for the year to date. A snapshot view of "stranded" (over 7 day LOS) in February demonstrated that 50% of all patients in Grantham & Pilgrim were stranded and 40% at Lincoln. Key issues affecting performance for February were: • Workforce numbers remains insufficient to meet historical demand and planned contractual increase • Continued reliance on agency locums • Estate is not fit for purpose to manage ambulance handovers, minors and majors volumes • Bed occupancy levels are high, leading to inability to manage surges in demand • Internal and external delays for patients requiring discharge


A&E 4 Hr Performance against Trajectory
100%
80%
60%
40%
20%
0%
ULHT Perf
ULHT Traj
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
2016
2017


No of Attendances vs Plan
16000
14000
12000
10000
8000
6000
4000
2000
0
ULHT Actual
ULHT Plan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
2016
2017


Admissions - ULHT
A&E Adm Pts
Total Emer Adm
% A&E Attends Adm
7000
6000
5000
4000
3000
2000
1000
0
100%
80%
60%
40%
20%
0%
Pt Nos
%
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
2016
2017

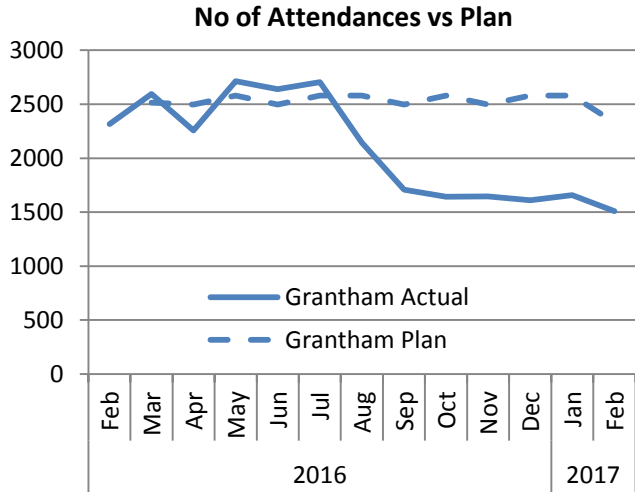

ULHT - Bed occupancy at Thursday MN
100.00%
98.00%
96.00%
94.00%
92.00%
90.00%
88.00%
86.00%
84.00%
07/02/2016
07/04/2016
07/06/2016
07/08/2016
07/10/2016
07/12/2016
07/02/2017

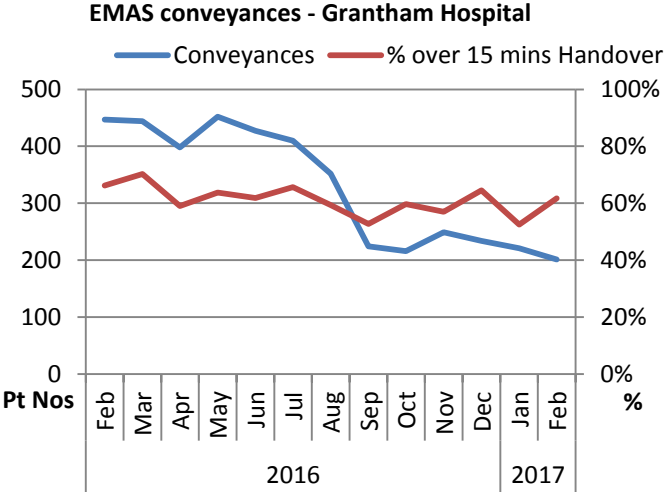


Each site is detailed below, including a commentary of the reasons for poor performance.

Grantham:

No exception report included as Grantham has exceeded the performance standard for the last two quarters and is on track to deliver the year end position, however the graphs below demonstrate the reduction in attendances (and Ambulance conveyances) since the overnight closure in August 2016.





Pilgrim:

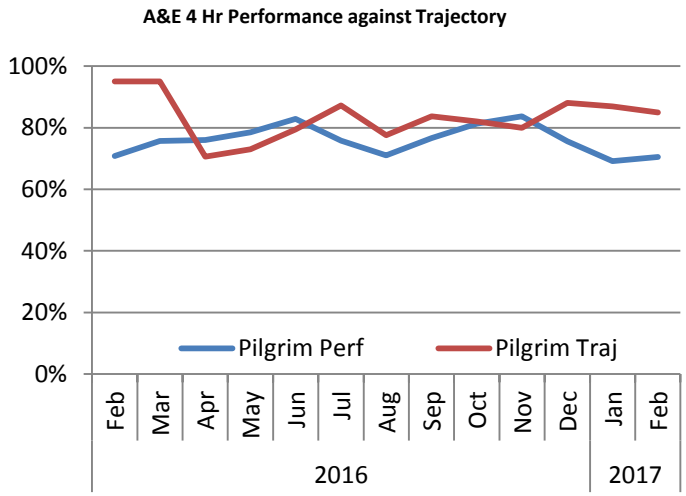
February's overall performance was 70.49%. This 14.51% below the planned recovery trajectory and 0.33% less compared to February 2016.

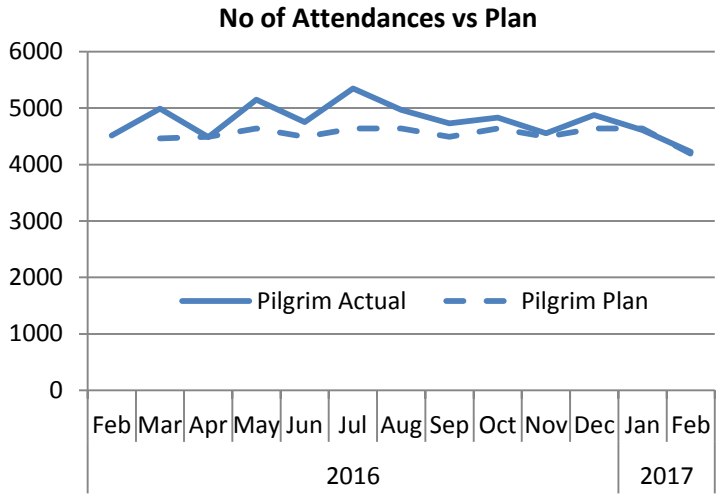
Total attendances are at the planned level for February. We have seen a reduction in conveyances by c. 8 per day in Feb '17 when compared to February 2016. Ambulance handover performance has improved in February compared to last month, but remains variable. The total emergency admissions are down by 241 compared to January, however bed occupancy rates remained in excess of 98% during February. DToC levels remain high (average at 5.6% for February).

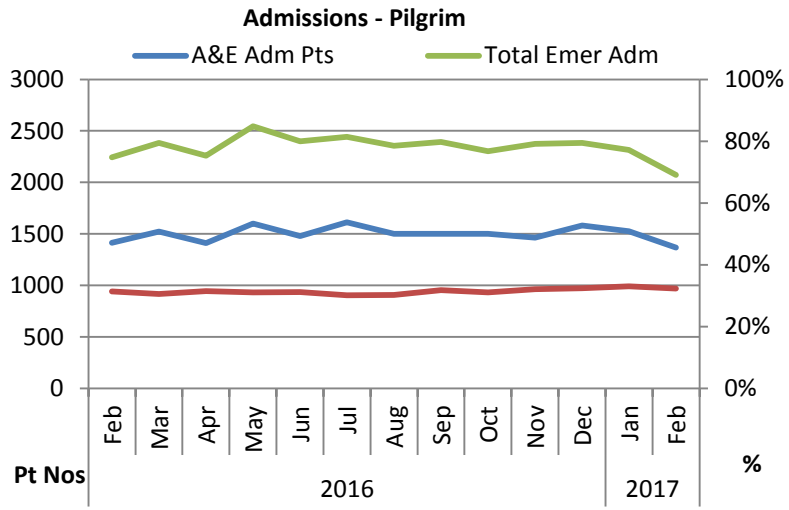
Arrival to triage median is at 10 minutes (62 mins at 95th centile) against the 15 minute standard and first treatment median time is 65 mins against 60 mins (218 mins at 95th centile).

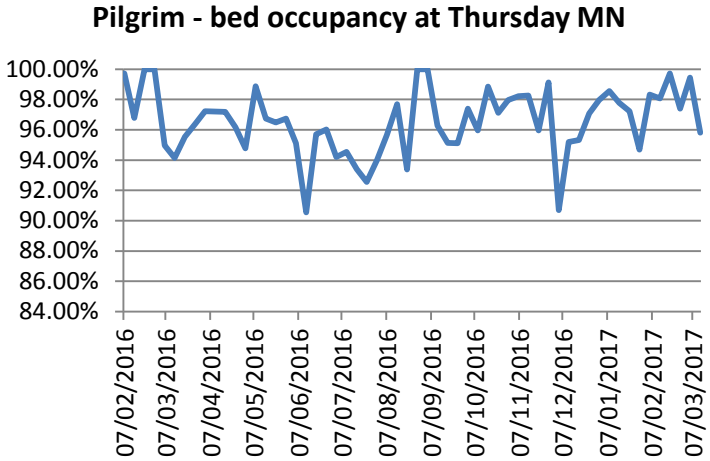
In-month key issues affecting performance in February were:

- Vacancies in ED Medical rota's with reliance on agency locums.
- Vacancies in Nursing rota's with a variance in agency or bank fill rates.
- Poor hospital flow – admissions exceeded discharges. The AEC area was frequently used as escalation bed capacity resulting in inefficient processing of ambulatory patients. The Ground floor theatre area was also used as escalation capacity when pressure became extreme. Elective work was cancelled to facilitate medical patients (up to 50) in surgical beds.
- The MMFD numbers have increased with external delays awaiting packages of care & community beds.









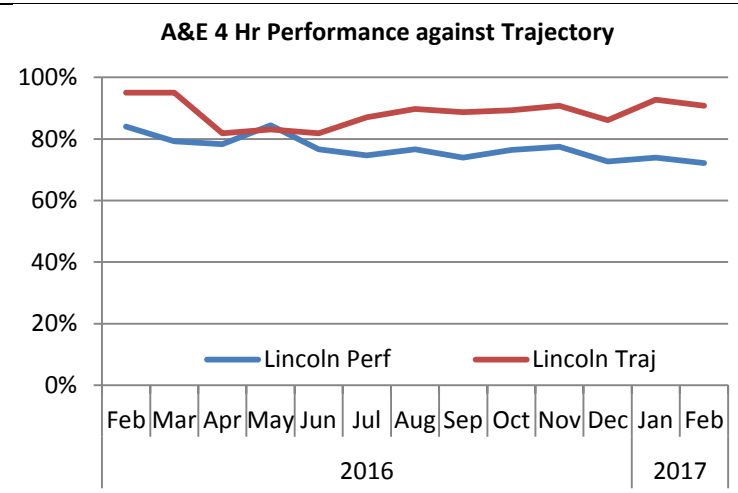
Lincoln:

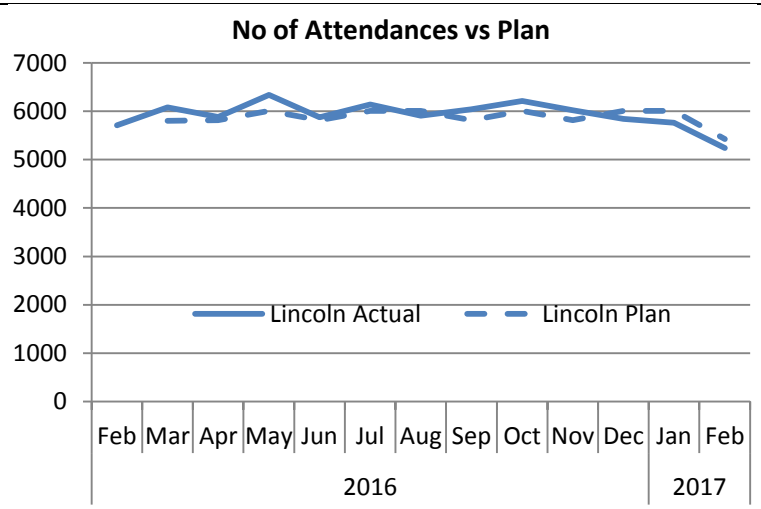
February's overall performance was 72.14%. This is 18.66% below the planned recovery trajectory and 7.03% less compared to February 2016.

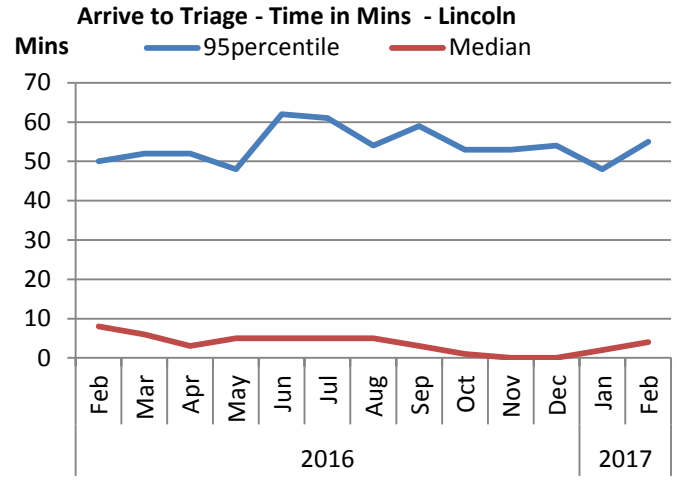
Total attendances are slightly below plan during February. Ambulance handover performance has steadily deteriorated and had 459 crews delayed over 1 hour. The total emergency admissions are down by 281 compared to January, however bed occupancy rates peaked at 99.45% during February. They have subsequently reduced following the launch of Red 2 Green. DTOC levels remain high (average at 5% for February).

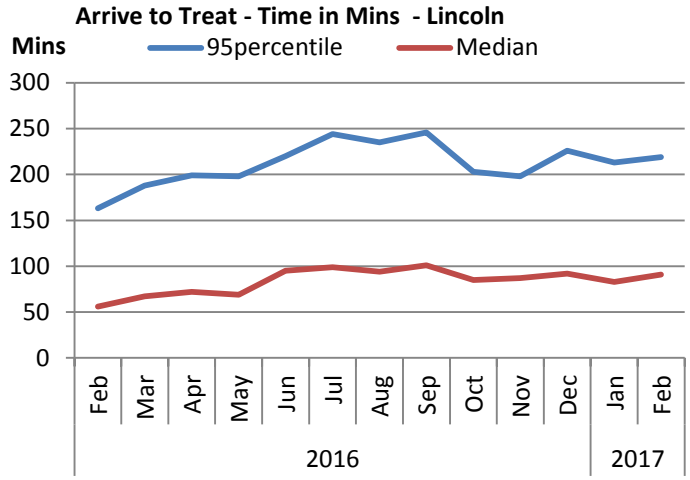
In-month key issues affecting performance in February were:

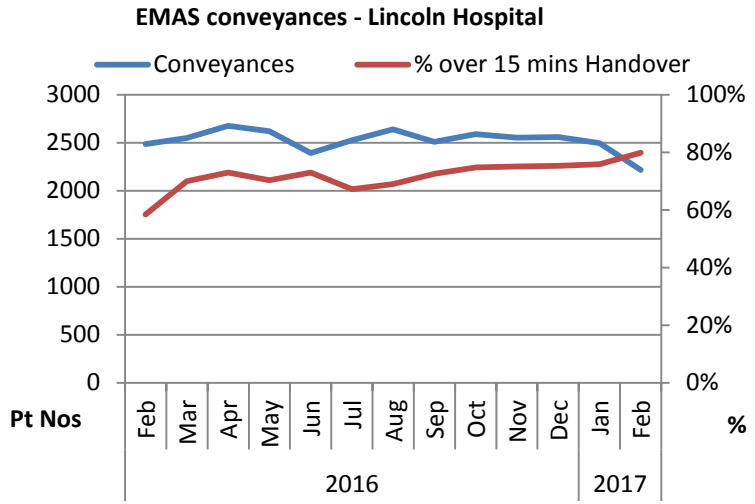
- Vacancies in ED medical rota's with reliance on agency locums. Increasingly variable shift cover in ED with many new locums doing single shifts.
- Vulnerability in medical staffing due to medical locum sickness or last minute cancellation.
- Acuity on site during February remained extremely high with demand outstripping capacity for resus capacity, ICU beds and NIV beds.
- Poor hospital flow – admissions exceeded discharges up until the 20th February with the launch of Red 2 Green. Additional escalation beds were opened on site to support flow. Elective work was cancelled to facilitate the use of Surgical Admissions Lounge as escalation and medical patients (up to 60) were placed in surgical beds
- MFFD and reported external delays had remained static until the launch of Red 2 Green, whereby numbers increased.
- Despite increased flow, reduced outliers, and reduced usage of escalation areas the ED performance did not improve (with one exception, Friday 24th, 93.64%). Reasons for this were attributed to delays in 1st assessment by the ED medical staff, which is linked to point one above.

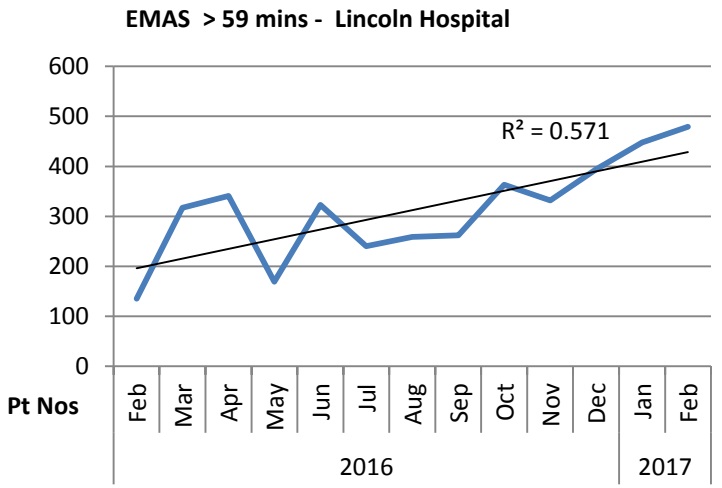

A&E 4 Hr Performance against Trajectory
100%
80%
60%
40%
20%
0%
Lincoln Perf
Lincoln Traj
Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2016
2017

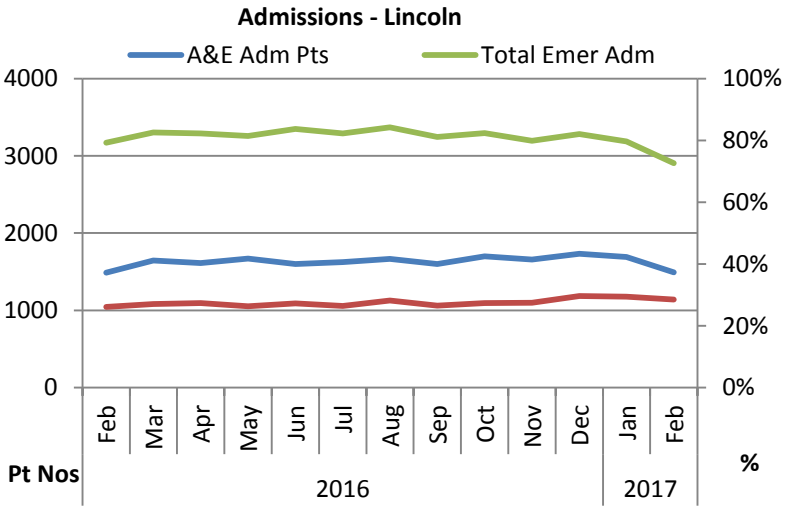

No of Attendances vs Plan
7000
6000
5000
4000
3000
2000
1000
0
Lincoln Actual
Lincoln Plan
Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2016
2017

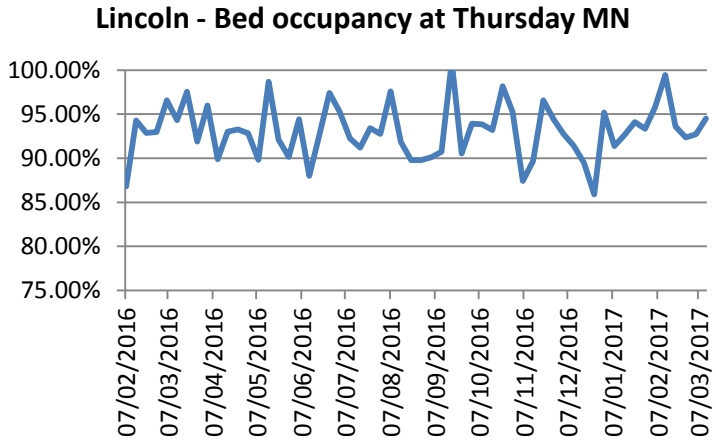

Arrive to Triage - Time in Mins - Lincoln
Mins
95percentile
Median
70
60
50
40
30
20
10
0
Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2016
2017

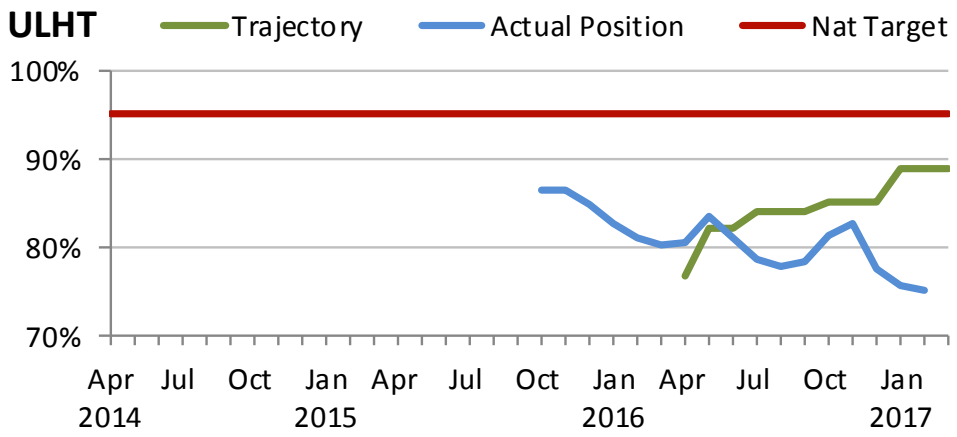
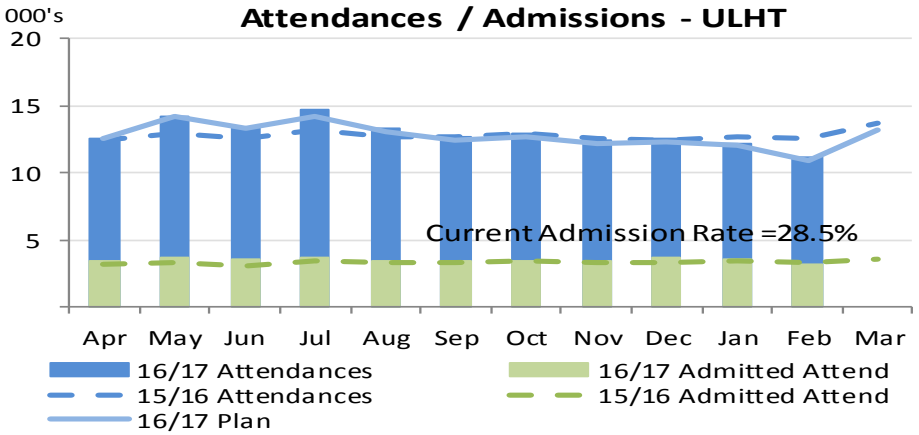

Arrive to Treat - Time in Mins - Lincoln
Mins
95percentile
Median
300
250
200
150
100
50
0
Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2016
2017

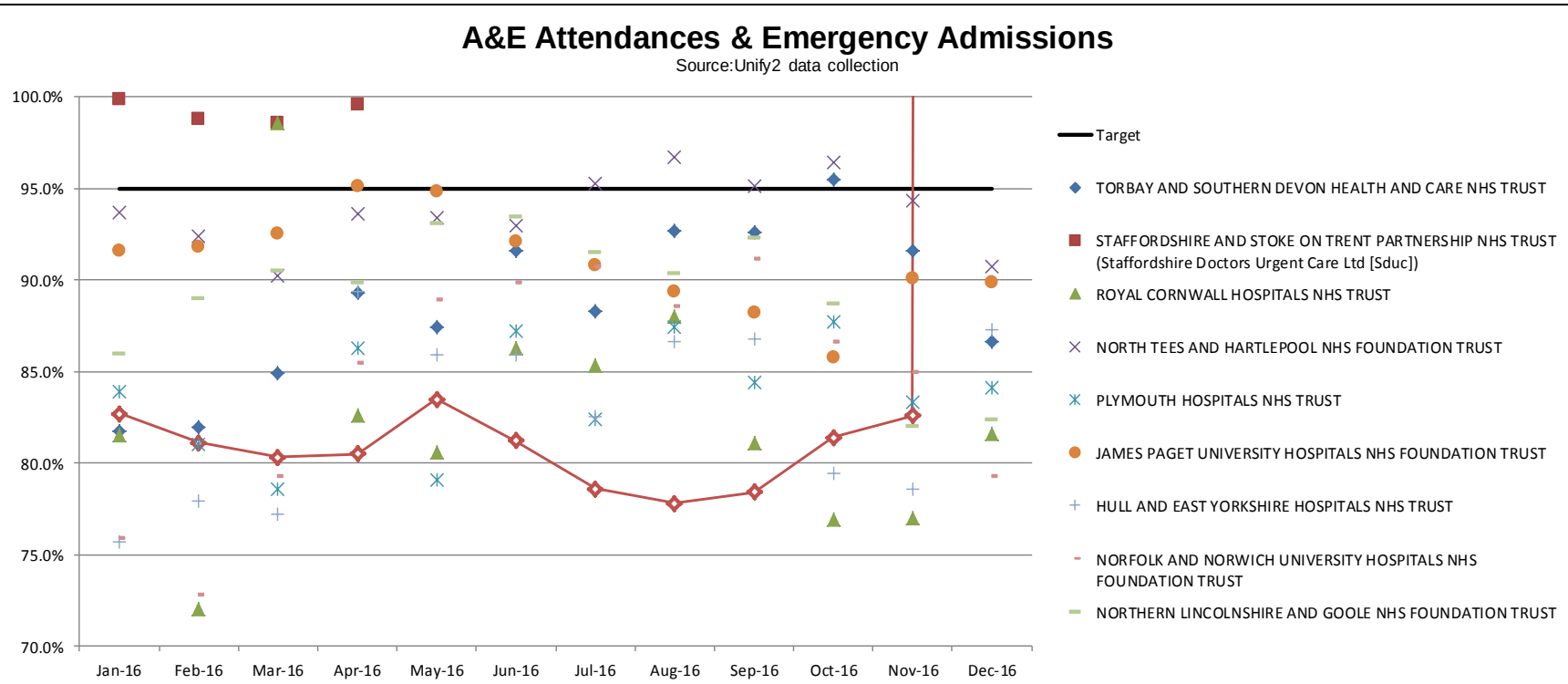

EMAS conveyances - Lincoln Hospital
Conveyances
% over 15 mins Handover
3000
2500
2000
1500
1000
500
0
100%
80%
60%
40%
20%
0%
Pt Nos
%
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
2016
2017


EMAS > 59 mins - Lincoln Hospital
600
500
400
300
200
100
0
R² = 0.571
Pt Nos
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
2016
2017


Admissions - Lincoln
A&E Adm Pts
Total Emer Adm
4000
3000
2000
1000
0
100%
80%
60%
40%
20%
0%
Pt Nos
%
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
2016
2017


Lincoln - Bed occupancy at Thursday MN
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
07/02/2016
07/03/2016
07/04/2016
07/05/2016
07/06/2016
07/07/2016
07/08/2016
07/09/2016
07/10/2016
07/11/2016
07/12/2016
07/01/2017
07/02/2017
07/03/2017

Forward Trajectory	
Variance Analysis (SPC Chart)	



The above graph shows the latest available national performance for A&E attendances and emergency admissions. The peer group that has been selected to benchmark ULHT against consists of Trust's which have a similar rural structure and patient demographics.

What action is being taken to recover performance?

Pilgrim:

- Additional medical staffing is still being funded as a cost pressure (x1 Day Middle Grade / x2 Night Middle Grade)
- A&E Specific SDM Support extended to end of April
- Continual recruitment/interviews for Middle grade Dr's
- Review of Rota's to try and ensure the best possible skills mix is present OOH/Weekends
- Breach Performance analysis being performed to identify any particular trends or patterns, as well as breach League table for the clinicians
- Embedding of SOPs for the nursing staff working in the different areas to improve communication with the nurse in charge
- The Paediatric business unit are developing a new structure which will work similar to the STRAP protocol that is used in other specialities to improve flow during times of high pressure
- Established a new drug cupboard outside RAIT that has reduced RAIT times by approx 4-5 mins in an internal audit
- Meetings ongoing with orthopaedic speciality to address the delays with reviews
- Revised ambulance handover process to Dr in RAIT that has reduced turnaround times
- Ongoing process to embed Pride and Joy with adjunct of Red2Green launching on 24th April
-

	Lincoln: • The re-launch of Red2Green on 20th February improved hospital flow, reduced outliers, reduced the usage of escalation areas and reduced cancellations of electives. This process is now being embedded with twice daily meetings. • With the continued rollout of SAFER we have seen discharge lounge use improve month on month since December (from 330 patients per month to 434 patients in February). The Urgent Care Delivery Manager is undertaking a focussed piece of work to embed SOP's for new ways of working in the lounge and with the wards. • Evaluation of the impact of the Ambulatory Care Service shows that prior to their relocation from the ED footprint they saw an average of 6.5 patients daily (7 day week), totalling 195 patients a month. In February this rose to 12 patients seen daily (5 day week) with 245 patients seen in month. Based on the first week of March the activity estimate for March looks like reaching 17 patients daily and circa 340 patients in the month. Work will continue to expand the types of patient that the Ambulatory Care Service can accommodate. • Recruitment continues to secure staff on a permanent basis for RAT to make this service more robust and less reliant on agency medical and nursing staff. Feedback from EMAS is positive. • There has been some success in medical recruitment and 1.0 wte further junior doctor resource has been recruited in month (start date awaited) and 1.0wte GP for ED has been recruited (start date awaited). There is also a potential candidate for Consultant interview. • The other additional medical staffing measures that have been in place during winter on site continue to be covered although coverage has been variable with locum fill rates. Substantive funding has been confirmed and the focus is now on recruitment to these posts on a permanent basis to reduce risk to safety and performance.
What is the recovery date?	N.B. Further focussed work is planned to commence in early March (See separate paper: Urgent care – Short term actions to improve performance) **Grantham:** Plan to achieve over the trajectory for quarter four to realise year-end trajectory. **Lincoln and Pilgrim**: Ongoing historical demand pressures and workforce challenges performance is expected to remain challenged in the near future. Q1 ambition is to achieve in excess of 82%. The National expectation is to deliver in excess of 90% in September 2017.
Who is responsible for the action? (Provide the role and name of the lead)	Maxine Hughes Head of Operations and Clinical Services Grantham Site Paul Hogg, Senior Business Manager, Pilgrim Hospital Lisa Vickers, Senior Business Manager, Lincoln County Hospital

4. Exception Report: Well-led

KPI:	Sickness Absence	Owner:	Director of Human Resources
Domain:	Well-led	Responsible Officer:	Assistant Director of Human Resources
Date:	28th March 2017	Reporting Period:	February 2017

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)

The Trust has a target of 4% for staff absence. The Trust annual rolling sickness rate of 4.73% as at January 2017 has increased by 0.22% in comparison to the January 2016 figure (4.51%).

Sickness Comparison:

Year	Year End Sickness Absence rate
2011/12	4.95%
2012/13	5.12%
2013/14	4.66%
2014/15	4.79%
2015/16	4.54%
2016/17	4.73% (12 months ending January 2017)

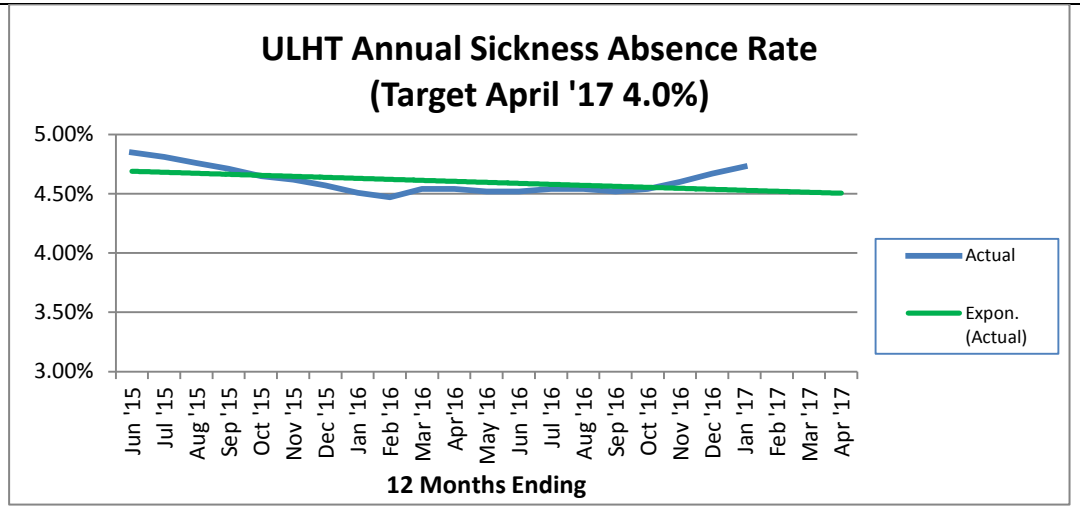
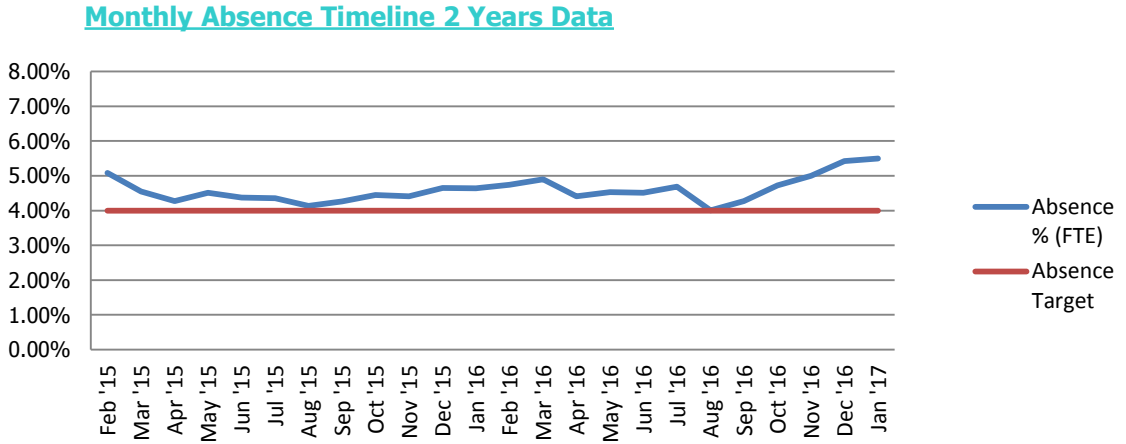
Monthly sickness rate for January 2017 is 5.50%. Sickness absence data is reported two months in 'arrears'.

Historically we've seen sickness go up during the summer period, followed by a decrease, the weighted increase since September is higher than previous years, which is cause for concern. This could be attributed to seasonal influences e.g. flu.

The annual cost of sickness (excluding any backfill costs) has increased by £500,065 (from £8,483,817 as at Jan '16 to £8,983,882) compared to 12 months ago.

During the 12 months ending January '17, Anxiety/Stress/Depression and other Psychological illness was the top reason for time lost due to sickness at 19.87% of all absence. These 'mirror' patterns across the NHS nationally, incl. MSK

Additional Clinical Services had the highest sickness rate during the 12 months at 7.19% (Unregistered Nurses 7.59%) followed by Estates & Ancillary at 6.46% and Nursing & Midwifery Registered at 4.90%.

	The latest Benchmarking data as at October 2016 from NHS Digital (previously Health & Social Care Information Centre - HSCIC) indicates that ULHT has the ninth highest sickness rate (lowest at 2.90% and highest 5.54%) against an average of 4.34%. The benchmarking is done across x39 Large Acute Trusts. Comparison data with other Lincolnshire Trusts: LCHS – 4.78% (unplanned sickness) LPFT – 4.60%
Forward Trajectory	
Variance Analysis (SPC Chart)	 **JANUARY 2017 WORKFORCE SCORECARD**

Directorate	Sickness Rate (Month)	Sickness Rate (Rolling 12 Months)
Bostonian	6.07%	5.02%
Chief Executive	7.34%	5.15%
Chief Operating Officer	5.33%	6.24%
Clinical Support Services	4.99%	4.15%
Diagnostics	*5.55%*	*4.11%*
Therapies	*3.67%*	*3.97%*
Director of Estates & Facilities	5.49%	5.70%
Director of Finance & Corporate Affairs	1.65%	2.86%
Director of HR & Organisational Development	2.56%	2.68%
Director of Nursing	4.25%	5.23%
Director of Performance Improvement	3.34%	3.35%
Grantham	6.43%	5.04%
Integrated Medicine Boston	7.23%	6.02%
Integrated Medicine Lincoln	6.41%	4.85%
Medical Director	4.81%	3.34%
Surgical Services Boston	3.60%	4.08%
Surgical Services Lincoln	5.58%	4.21%
TACC Boston	6.04%	5.24%
TACC Lincoln	4.69%	4.15%
Women & Children's Pan Trust	5.66%	4.69%
ULHT	**5.50%**	**4.67%**

What action is being taken to recover performance?

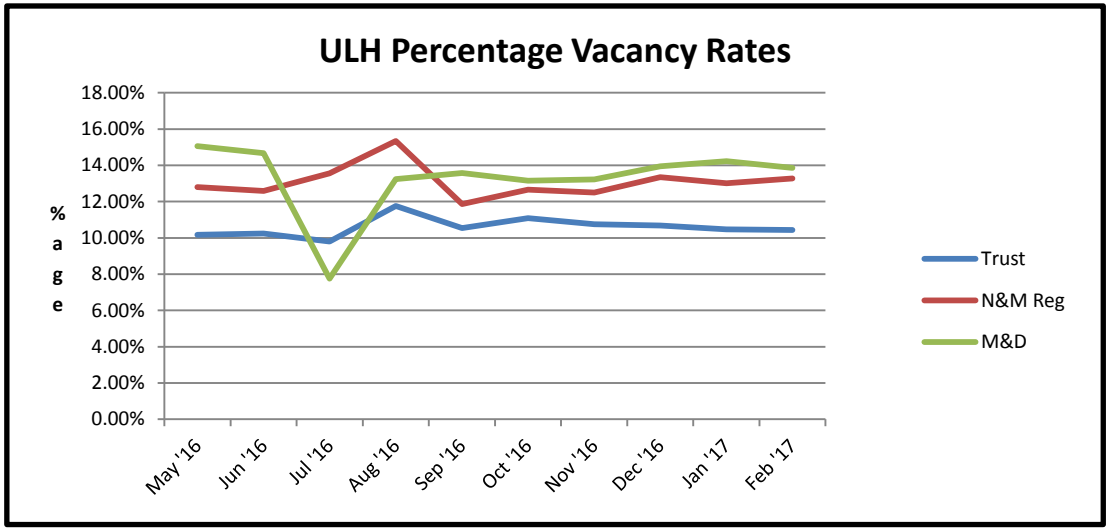
- Monthly meetings with Occupational Health continue to support process and to ensure that the service is being fully utilised by both managers and staff.
- Workforce Scorecard has been shared with Directors/Clinical Directors, which shows compliance against key workforce indicators
- A recent 'deep dive' of sickness was conducted, with a report being presented to the WF & OF Assurance Committee at the end of March. Recommendations and next steps will be discussed and taken forward
- We considered the physical demanding roles in Estates & Facilities and the potential of the 'aspect' having an impact on the sickness rate for this Directorate against other services. As such we have done some benchmarking against other Large Acute Trusts and the data confirmed that the average absence rate ranges from 4.00% to 8.19%.
- Further analysis and benchmarking will be carried out for HCSW and other clinical support staff by

	Directorate to identify if there are common occurrences at speciality level. Results will be communicated at WF & OD Assurance Committee.
What is the recovery date?	The 'forward' trajectory of sickness indicates that it is unlikely that we will achieve the sickness target of 4% at year end. New target will be set as part of the development of the People Strategy
Who is responsible for the action? (Provide the role and name of the lead)	Line managers with support from HR

4. Exception Report: Well-led

KPI:	**Vacancies**	**Owner:**	Director of HR
Domain:	**Well-led**	**Responsible Officer:**	Head of Workforce Intelligence
Date:	**28th March 2017**	**Reporting Period:**	February 2017

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	The Trust has a target of having 8% or fewer vacancies across its staffing establishment. The current rate (February) is 10.44%, which is a decrease of 0.04% on January. Previous month's performance was: May 2016 – 10.17% June 2016 – 10.25% July 2016 – 9.80% August 2016 – 11.75% September 2016 – 10.54% October 2016 – 11.09% November 2016 – 10.75% December 2016 – 10.68% January 2017 – 10.48% We have seen a downward trend for the fourth month in successions, despite the increase in vacancies by 0.270% over the last 9 months (10.17% to 10.44%) Although there has been an increase of 5.25 FTE Medical Staff in post over past 12 months the medical vacancy rate remain above 13% at 13.86%. The number of Band 5 Nurses in post has increased over the last 12 months by 13.70 FTES to 1092.15 FTEs. This aside, the vacancy rate for all Registered Nursing & Midwifery staff remain above 13% at 13.28%. We currently have 50 wte Unregistered Nursing/HCSW vacancies.
Forward Trajectory	Although we have continued to see a downward trend month on month since October 2016, it's is not anticipated that we will meet our target of 8% at the end of March.

Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	• The Nursing Recruitment Plan will be shared at the WF & OD Assurance Committee during March. • The Medical Recruitment Plan will be discussed at the WF & OD Assurance Committee during May. • Both plans will indicate a number of actions and initiatives aimed at reducing the number of vacancies • We are working closely with LWAB and HEE colleagues to explore new roles/workforce models to identify career development opportunities for current staff as well as recruitment into new roles e.g. Physician Associates, ACPs. • Through the development of BU Operational Plans, 'targeted' recruitment will be identified e.g. when/how staff will be recruited, with emphasis on BU accountability and ownership of plans • Workforce Scorecards (which include vacancies) have been shared with Clinical Directors and Corporate Directors, which highlight 'risk' areas and enable 'ownership' of recruitment at BU/Directorate level.
What is the recovery date?	It is unlikely that we will recover to target by March 2017. We are reviewing the Workforce KPIs for 2017/18, which will include a definition for each indicator for ease of reference.
Who is responsible for the action? (Provide the role and name of the lead)	Clinical Directors and Heads of Department are responsible for having clear workforce plans, which identify need. HR is responsible for helping CDs and Heads of Department's develop their workforce plans, and putting in place and executing the recruitment plans.

4. Exception Report: Well-led

KPI:	Staff Turnover	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Head of Workforce Intelligence
Date:	28th March 2017	Reporting Period:	February 2017

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)

The Trust has a target of 8% staff turnover. The current 12 month rolling average as at February is 9.35%, which is a reduction of 0.24% on January. Previous months performance was:

April '16	10.06%
May '16	9.81%
June '16	9.78%
July '16	10.02%
August '16	9.76%
September '16	9.45%
October '16	9.80%
November '16	9.81%
December '16	9.48%
January '17	9.59%

Records show that the Trust has not had a turnover rate at 8% or lower since 2010/11.

Turnover rate excluding retirements: The turnover rate for the 12 months' ending 28th Feb '17 is 7.05% in comparison with the previous month of 7.21%, which indicate that we have managed to retain more staff.

We've had 20.80 leavers during February. Of the leavers 15.63% was due to retirement and 75.82% was due to voluntary resignations.

Staff Turnover – Year on Year comparison

Mar '16	10.02%
Mar '15	10.99%
Mar '14	10.06%

Comparison data indicate that the turnover rate/trend has been at the average of 10% over the past 4 years. However, we have seen a slight improvement/downward trend in the rate since March 2016.

Number of Permanent Employees Leaving with 12 Months of employment

	Year				
Staff Group	13/14	14/15	15/16	16/17	**Total**
Add Prof Scientific and Technic	4	3	4	5	**16**
Additional Clinical Services	10	15	11	12	**48**
Administrative and Clerical	14	16	25	26	**81**
Allied Health Professionals	7	9	8	5	**29**
Estates and Ancillary	14	8	7	5	**34**
Healthcare Scientists	1		3	2	**6**
Medical and Dental	6	4	8	1	**19**
Nursing and Midwifery Registered	43	73	44	25	**185**
Students		2	1		**3**
Total	**99**	**130**	**111**	**81**	**421**

Note: 16/17 data is for the 11 months ending 28th Feb '17 only

Historically data indicate/confirm that we have managed to retain more staff with less than 12 months' service/employment with ULHT over the past 12 months.

Comparative December data from the East Midlands 'Benchmarking Group' (x10 Trusts) indicate that ULHT has the second lowest turnover rate (lowest at 9.27% and highest 14.37%).

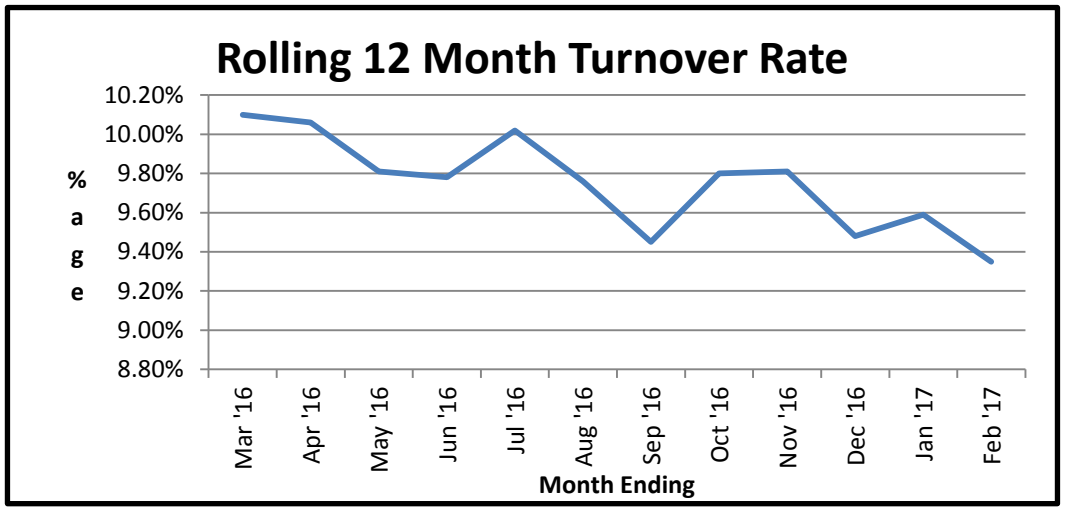
Nursing and Midwifery turnover rate has decreased in month to 8.14% (down from 8.50%). Medical and Dental Staff turnover rate has decreased in month to 14.09% (down from 15.02%).

Based on the latest (December 2016) benchmarking data available (x39 Trusts) from NHS Digital (previously Health and Social Care Information Centre) for other Large Acute (Non-Teaching) Hospitals:

- The current Trust turnover rate of 9.35% is below the average of 10.43%
- The current Trust Nursing & Midwifery (Registered) turnover rate of 8.14% is below the average of 11.12%,
- Other Additional Clinical Services (usually unregistered) 11.96% is below the average of 13.94%.
- AHP's 13.10% is above the average of 12.76%.

High level of turnover in Clinical Support Services, HR & OD and Nursing will impact on the function and the ability to provide the service/s the Trust need.

Although the overall turnover rate is below the 'average' (benchmark), the concerns remain that we continue to 'lose' staff in the areas/specialities we cannot afford to do so. We need going forward, to focus upon any hot-spot areas

Forward Trajectory	It is unlikely that the target of 8% will be achieved by March 2017. The turnover rate has remained below 10% over the past six months.
Variance Analysis (SPC Chart)	 **Trust Turnover**

Staff Group	Establishment as at 28.02.17	SIP as at 1.03.16	SIP as at 28.02.17	Average SIP	Leavers 1.03.16 - 28.02.17	Turnover SIP	Turnover Leavers against establishment
Nursing & Midwifery	2268.75	1942.84	1967.49	1955.17	159.22	8.14%	7.02%
Medical (excluding juniors)	555.73	462.09	477.24	469.67	66.17	14.09%	11.91%

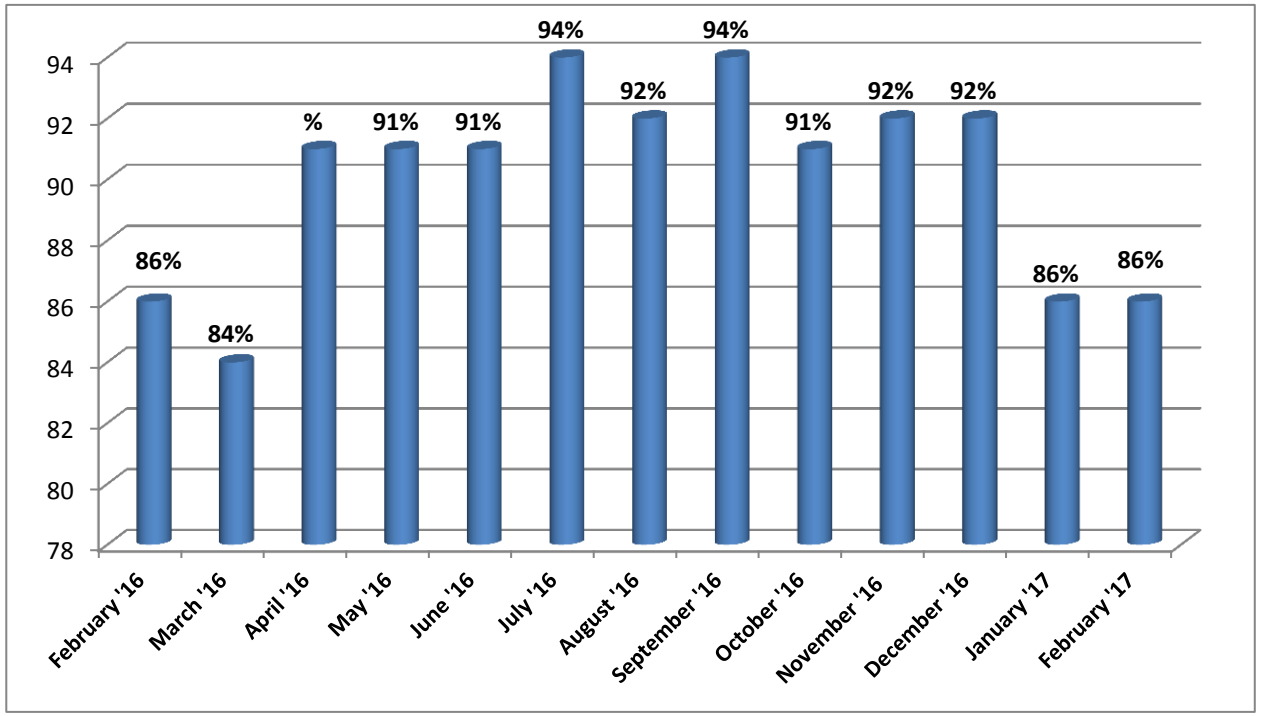
Directorate	Rolling 12 Month %age Turnover rate
Bostonian	3.07%
Chief Executive	15.37%
Chief Operating Officer	10.08%
Clinical Support Services	13.94%

		Diagnostics	*12.54%*
		Therapies	*18.30%*
		Outpatient Management	*11.19%*
		Director of Estates & Facilities	7.95%
		Director of Finance & Corporate Affairs	10.80%
		Director of HR & Organisational Development	17.16%
		Director of Nursing	14.53%
		Director of Performance Improvement	8.02%
		Grantham	10.72%
		Integrated Medicine Boston	8.96%
		Integrated Medicine Lincoln	8.41%
		Medical Director	9.13%
		Surgical Services Boston	8.23%
		Surgical Services Lincoln	6.12%
		TACC Boston	4.80%
		TACC Lincoln	6.75%
		Women & Children's Pan Trust	8.84%
What action is being taken to recover performance?	• We will utilise the data from the revised exit interview process to explore in more detail the reasons why employees are leaving the Trust, in particular areas such as Clinical Support Services, HR & OD and Nursing. • Workforce Scorecard comparative data has been shared with the Directors/Clinical Directors, which shows compliance against key workforce indicators • The STP 'models' a different workforce and the use of vacancies/turnover will be a factor to 'facilitate' the shift in the workforce across services/organisations and work streams. • We will link closely with the Lincolnshire Retention Strategy to identify methods to improve staff retention.		
What is the recovery date?	We are unlikely to achieve the target by March. A new target will be set as part of the development of the People Strategy		
Who is responsible for the action? (Provide the role and name of the lead)	Clinical Directors and Heads of Department are responsible for leading and managing their service areas, including understanding why people leave; addressing areas of concern, and having plans to replace them. HR is responsible for identifying trends and/or areas of concern regarding why people are leaving and helping the Trust address any such issues. HR will work with the business to understand what we can do within the employee lifecycle to tackle the reasons why people leave.		

4. Exception Report: Well-led

KPI:	Medical Staff Engagement (Medical Appraisals)	Owner:	Dr Kapadia - Medical Director
Domain:	Well led	Responsible Officer:	Sue Powley - Head of Medical Revalidation
Date:	17th March 2017	Reporting Period:	February 2017

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	Medical Staff appraisal compliance rate for month ending February 2017 is 86%. The year-end target is 95%. This figure includes Consultants, SAS Doctors including Locums. High turnover of doctors, in particular short term locums covering gaps in junior doctor rotas, continues to present a challenge as a low % of new starters have previously been appraised. The current appraisal rate of 86% is unchanged compared to the end of February 2016 position and the January 2017 figure. An increased number of doctors are failing to have an appraisal within their designated appraisal month despite efforts by the Revalidation Office. Meetings with Doctors who have not yet completed their appraisal are taking place in order to establish the support they need and to remind them of the contractual and professional requirement to participate in annual appraisal. 35 (6%) of the 540 doctors currently employed by the Trust are scheduled to have their appraisals before end of March 2017 an improved position in comparison with end of January 2017 - 51 (9%). Outstanding appraisals are at various stages of completion including documentation complete awaiting appraisal meeting or awaiting final sign-off. Only 2 doctors do not have an agreed date for their appraisal meeting before the end of the Appraisal year (31-03-17). These doctors are now being managed in accordance with the Trust Medical Appraisal escalation process. There is improved communication with doctors who in the past have failed to respond to email requests and letters to make contact with the Revalidation Office. The use of mobile and telephone contact to establish the position with appraisal arrangements has been quite successful and medical secretaries have been really helpful. No doctors have submitted formal requests in February to postpone their appraisals. The appraisal rate for locum doctors employed to cover gaps in junior doctor rotas has dropped significantly to 31% compared to the 64% January position. This is due to the high turnover of staff in

	February 2017. A total of 16 doctors have not worked in the UK previously and have therefore not participated in the appraisal process. Although short term locum turnover is high (35% in Feb 2017), Doctors in this group are encouraged to engage in medical appraisal during their contract period which ranges from one month to 12 months. Delay in final sign off of appraisal documentation has again improved this month. The Revalidation Office will continue to closely monitor progress to ensure timely sign off meets the GMC requirements of 28 days following the appraisal meeting. The Revalidation Team have a plan in place for every doctor whose appraisal is due to take place before the end of March 2017.
Forward Trajectory	
Variance Analysis	**MEDICAL APPRAISAL PERFORMANCE – FEBRUARY 2017** 
What action is being taken to recover performance?	• There is a plan in place for each doctor whose appraisal is due before the end of March 2017. • Proposal to increase the admin support to the Revalidation Office 0.53 of Band 2 to ensure improved governance to Revalidation processes. Awaiting decision from Medical Director.

	• Close monitoring and prompt action by the Revalidation Office when appraisals are not undertaken as planned. The new Allocate e-appraisal system allows the Administrator to track progress with timely completion of appraisal documentation. This enables early intervention and support to both appraisee and appraiser. • Notification of '*Appraisal Due'* sent to Doctors 4 months prior to their appraisal month. Strict adherence to the escalation processes set out in the Medical Appraisal Policy, with particular focus on the allocation of appraiser to appraisee 6 weeks prior to the appraisal due date if the doctor has not confirmed appraisal details. • Closer monitoring of appraisal progress on the e-allocate appraisal system. Reminders sent to Appraisers to complete Appraisal Output documentation and *sign off* appraisal documentation within 28 days of the appraisal meeting. • Reminders sent to Appraisees to complete sign off the appraisal documentation within 28 days of the appraisal meeting in accordance with GMC guidance. • Ensuring doctors receive continuing support to use the new Allocate system.
What is the recovery date?	31st March 2017
Who is responsible for the action? (Provide the role and name of the lead)	Head of Medical Revalidation, Sue Powley supported by the Revalidation Administrator.

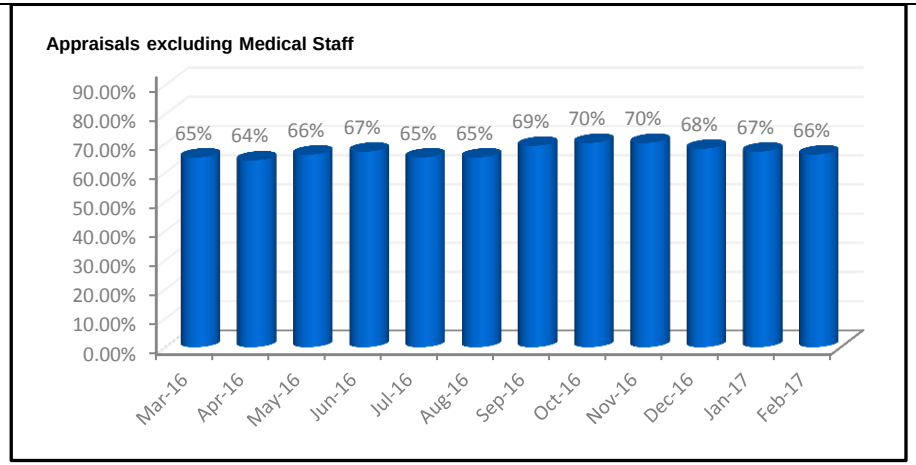
4. Exception Report: Well Led

KPI:	**Staff Engagement (Staff Appraisals)**	**Owner:**	Director of HR
Domain:	**Safe**	**Responsible Officer:**	Elaine Stasiak, Workforce Intelligence (reports completed by Karen Taylor, Asst Director HR)
Date:	**28th March 2017**	**Reporting Period:**	February 2017

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	The Trust has a target of 95% for Appraisals. Agenda for Change Staff Appraisal compliance rate for February is 65.93%. *Appraisal Compliance rate (Year-on-Year) comparison:* March 2014 – 47.13% February 2016 – 65.44% February 2015 – 74.02% The overall percentage for appraisals has reduced by 1.27% from the previous month and 4.47% since the end of November 2016. Although we've seen a significant increase in the appraisal rate since 2014, the data shows a consistent compliance rate at the same period each year and the compliance rate over the last 12 months has remained in the 64% - 70% range. Appraisal compliance rate is calculated based on a percentage of appraisals completed over a 12-months' rolling period. The 'target' of 95% is based on the expectation that every member of staff should have an appraisal and it should take place on or before the employment 'anniversary' date or within 12 months from previous appraisal. The other 5% is provision for absence, maternity leave etc. X1 Directorate has a compliance rate less than 50% X8 Directorates have a compliance rate between 50% and 65% The remaining x9 Directorates have a compliance rate between 65% and 80.00% Appraisal rates reduced at Lincoln (-1.54%), Louth (-5.34%), Grantham (-1.87%) and Pilgrim (-0.42%) compared to the previous month end. CQC have identified the need to achieve higher appraisal completion rates. We will work with leaders across the organisation to increase rates in the short-term, but explore also why completion rates are low and how we need to change our performance management arrangements or the underlying culture to enhance compliance (ensuring people want to (participate in appraisal)

Forward Trajectory	We have consistently not achieved a compliance rate above 70% (highest to date) and we must therefore look for a concerted effort from leadership to achieve the target of 95% at year end.
Variance Analysis (SPC Chart)	

Directorate	Appraisal Rate (Excludes Medical Staff)
Director of Finance & Corporate Affairs	47.31%
Director of Nursing	51.90%
Bostonian	53.19%
Medical Director	54.90%
Integrated Medicine Boston	55.97%
TACC Lincoln	56.81%
Director of Estates & Facilities	62.69%
Surgical Services Boston	64.20%
Chief Operating Officer	64.43%
Director of Performance Improvement	65.49%
CSS Outpatient Management	*66.08%*
Integrated Medicine Lincoln	66.32%
CSS Diagnostics	*67.47%*
Clinical Support Services	67.85%
Surgical Services Lincoln	68.61%
Women & Children's Pan Trust	70.49%
CSS Therapies	*72.83%*
Grantham	76.08%
TACC Boston	78.24%
Director of HR & Organisational Development	78.46%
Chief Executive	80.00%

	 **Appraisals (excluding Medical Staff)**
What action is being taken to recover performance?	• We have recently conducted a 'deep dive' into appraisal and the data has shown additional information we are exploring in certain areas within Trust. The HRD will be writing to the CDs/Leads in this regard and part of this would be highlighting their accountability to ensure compliance. • A 'reminder' communique will be shared Trust would with all Lead to confirm where appraisal reports for Directorates and Teams could be located on the Staff Intranet site. This functionality enables Managers to review/monitor their teams' compliance rate. • The Leadership Charter will be explicit on the expectations of Managers and their accountability in this regard and being held to account. • The Workforce Scorecard has been shared with Directorate and performance management reviews/discussions will include compliance on appraisal
What is the recovery date?	It is unlikely that we will recover to target by end of March 2017. A new target will be set as part of the development of the People Strategy.
Who is responsible for the action? (Provide the role and name of the lead)	Line managers/Clinical Directors (Medical Revalidation)

4. Exception Report: Safe

KPI:	**Core Learning**	**Owner:**	Director of HR
Domain:	**Safe**	**Responsible Officer:**	Elaine Stasiak, Workforce Intelligence (reports completed by Karen Taylor, Asst Director HR)
Date:	**28th March 2017**	**Reporting Period:**	February 2017

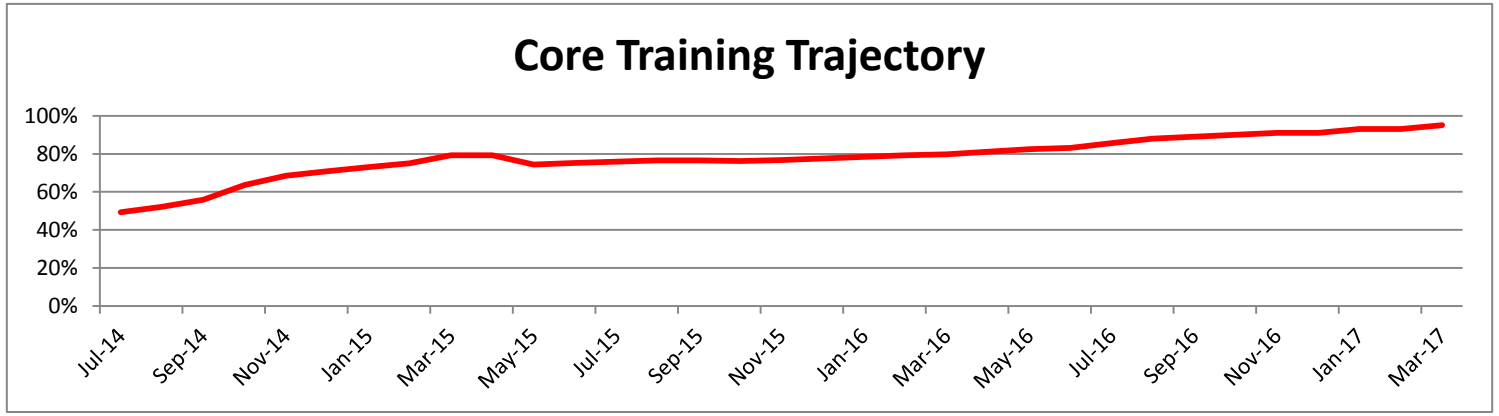
Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)

The Trust has a target of having 95% for Core Learning. This month compliance increases to 88%. Although previous month on month increase in compliance is 'marginal', the compliance rate is at its highest since July 2014.

Core Learning Compliance rate (Year-on-Year) comparison:
July 2014 - 49% (first recording of average compliance as combined figure of all modules)
February 2015 – 75%
February 2016 – 79%

Mar-16	*80%*
Apr-16	*81%*
May-16	*82%*
Jun-16	*83%*
Jul-16	*86%*
Aug-16	*86%*
Sep-16	*87%*
Oct-16	*85%*
Nov-16	*86%*
Dec-16	*87%*
Jan-17	*87%*
Feb-17	*88%*

- Although we have seen a significant increase in the core learning compliance rate since 2014, and further improvement since 2016, the data shows a consistent compliance rate over the last eight months between 86% and 88%. The month's compliance is the highest since we started recorded average rate in 2014.
- From October 2016 BLS compliance has been included in overall compliance following the 6 month introduction period. Compliance for BLS has increased by 2% this month to 73% having increased from April's 24%.
- Compliance for Fire increased by another 1% this month following the introduction of the new e-learning package. Infection Prevention remained the same this month and Information Governance has increased 2%. All core topics, apart from the newly introduced BLS, are now 80% or above. And all 3 annual topics are

	between 10%-15% higher than this time last year. • Fire compliance is now 81% compared to 66% at the end of February 2016. • There is an improvement in the DNA 'No Show' rate down 5% to 23% this month. Porac in 'chasing' non attendees with Line Managers which have yielded - improve
Forward Trajectory	We have seen a gradual improvement/increase in compliance rate, however it's unlikely that we will achieve our compliance by March 2017. 

Directorate	Average
Bostonian	80%
Chief Executive	85%
Chief Operating Officer	84%
Clinical Support Services	90%
Director of Estates & Facil	86%
Director of Fin & Corp Affair	93%
Director of HR & Org Dev	91%
Director of Nursing	92%
Director of Perf Improvement	98%
Grantham	91%
Integrated Medicine Boston	83%
Integrated Medicine Lincoln	85%
Medical Director	94%
Surgical Services Boston	87%
Surgical Services Lincoln	85%
TACC Boston	90%
TACC Lincoln	91%
Women & Children's Pan Trust	90%

	Average Compliance per Directorate
Variance Analysis (SPC Chart)	

Trust	Fire	IPC	E&D	IG	SGC1	SGA1
Dec-16	79%	81%	97%	83%	91%	
Jan-17	80%	81%	97%	82%	91%	
* Feb-17	81%	81%	98%	84%	92%	
** Feb-17	77%	80%	93%	81%	84%	

**Core Learning compliance for AfC Staff*
***Core Learning compliance for Medical & Dental Staff*

What action is being taken to recover performance?	• Classroom dates for April 2017 are now available. • Further improvement this month to the '5 Click' Core Learning report providing automatic compliance % by Ward/Dept. helping senior managers review compliance for areas within their ESR hierarchy. • DNA '5 Click Report' provides quick and easy access for managers to all DNA information. This replaces the individual e-mail notifications to senior managers which proved to have no noticeable impact on DNA rates. • The Streamlining project of Core Learning across east Midlands will allow 'portability/transferability' of core compliance across Trusts in the East Midlands.
What is the recovery date?	Although we have made steady progress, it is unlikely that we will achieve the target by March 2017. We need to review what we consider to be mandatory training and will set a new target, as part of developing the People Strategy
Who is responsible for the action?	Clinical Directorates Service Leads Line Managers

5. Summary of "Priority deliverables" – Performance against STF Trajectories

The dashboard shows the Trust's current performance against the non-negotiables as set out in the Sustainability and Transformation Fund. Trajectories and performance are based on what has been agreed within the 2016/17 Contract with Lincolnshire Clinical Commissioning Groups and therefore not necessarily to deliver performance at the national constitutional standard (for example A&E).

Further information and remedial actions in relation to the four access standards are illustrated over the following pages. Further information with regards to the agency spends and financial run rate are captured within the Trust Board Finance Report.

		Standard	Change in Month	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
RTT Incompletes	Trajectory	92%		92.40%	92.40%	92.40%	92.40%	92.40%	92.40%	92.40%	92.40%	92.40%	92.40%	92.40%	92.40%
	Performance		↑	92.11%	92.45%	92.02%	91.35%	89.19%	88.64%	88.77%	88.51%	88.08%	88.17%	88.27%	
Diagnostics 6wk Access	Trajectory	99.0%		99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%
	Performance		↓	99.11%	99.06%	99.08%	98.92%	98.67%	98.42%	98.75%	98.57%	99.03%	99.20%	99.72%	
Cancer 62 Day	Trajectory	85%		77.00%	78.00%	80.00%	81.00%	83.00%	84.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
	Performance		↑	74.70%	70.00%	68.90%	75.60%	74.00%	71.90%	69.30%	67.80%	71.90%	74.40%		
A&E 4hr Access	Trajectory	95%		76.60%	82.00%	82.00%	84.00%	84.00%	84.00%	85.00%	85.00%	85.00%	89.00%	89.00%	89.00%
	Performance		↓	80.54%	83.52%	81.18%	78.56%	77.80%	78.40%	81.37%	82.60%	77.47%	75.56%	75.22%	
Agency Spend £'000s	Plan			2569	2575	2582	2523	2573	2390	1091	1142	1058	772	824	875
	Actual		↓	2213	2576	2477	2223	2141	2042	2073	2381	2307	-2834	-2804	
Financial Surplus / Deficit	Plan			-4093	-4294	-4299	-3957	-4594	-3881	-3557	-3580	-4381	-3142	-5073	-3052
£'000s	Actual		↓	-3995	-4040	-4358	-4506	-4186	-4379	-4263	-4453	-3362	-5346	-7058	

6. Risks and Recommendations

Risks

RTT – The Trust expected to meet the constitutional standard by May 2017 when it forecasted performance in the submitted Trust Two Year Integrated Operational Plan. From the exception report there is increased risk from last month of achieving this target.

There has been a review of the Cancer Recovery Action Plan with a focus on 62 Day Waiters. The plan has been shared with external partners and was received positively, however, there is still some concern that we are not articulating our intent to reach the standard in year even though achieving 81% from July 2017 is still the intention even though this target is below the national average.

Expenditure and deficit recovery - see Finance Section and separate report.

Recommendations

RTT performance is at high risk of not achieving the proposed trajectory and although ongoing discussions with NHSI and CCGs are taking place each month the improvement date keeps shifting forward. Validation still remains a key focus to achieve the level of performance we are reaching which is unsustainable. Trust Board is advised to seek further assurance for the purpose patient experience, safety and achievement of STF trajectories to consider increased recovery action to achieve the standard.

Committee is advised to maintain a focussed interest in the challenge to deliver the Cancer Recovery Action Plan, on a quarterly basis as a minimum, to assure themselves of continuous improvement as a result of the actions being taken.

Committee is asked to feedback on the highlighted successes, challenges and risks and to follow up on the recommended two actions from this month's report.

The report this month has included a number of more detailed sections for Committee to consider. As a result the document has increased in size and content. Committee is asked to consider whether it would like to focus on a small number of areas of performance (priority performance areas) each month with more detailed analysis and benchmarking being provided to assure our position.

7. Equality Analysis Statement

The Trust is committed to carrying out effective equality analysis and to assure Trust Board of compliance with the Public Sector Equality Duty (Equality Act 2010). The Act requires specific provision is made to consider the impact of services and functions for people who identify with one or more of the nine protected characteristics. The Integrated Performance Report recommends decisions, action and change which may have an impact on services and functions. The actions and recommendations identified in Directorate Plans, Exception Reports in this document and any related Recovery Action Plans which support performance improvement should be subject to effective equality analysis as described in The Equality Act and our revised documentation.

In producing this report we have carried out an initial assessment and identified gaps in three areas where activity is identified that may have an impact on services and functions and therefore on people who identify with one or more of the nine protected characteristics. These are:

- Directorate Plans: Clinical and Corporate Directorate operational plans that identify actions to be taken to achieve the strategic objectives of the Trust, for example, service delivery and meeting constitutional standards (A&E, RTT, Cancer).
- Performance Recovery Plans (RAPs): Actions either recommended or already ongoing in addition to the above that are required to recover performance within a given period.
- Decisions/Actions/Change initiated by approval by Trust Board to progress the actions required to recover performance. Decisions/Actions/Change approved by Trust Board in order to ensure performance improvement within a given period.

Trust Board is advised that gaps in effective equality analysis currently exist in all three areas of the above activity. It is recommended that this analysis should be carried out by producers of the plans to ensure compliance and to provide assurance to Trust Board that we are effectively considering the impact of our actions.

Appendix 1. Monitor Risk Rating

Area	Indicator	Threshold	Monitoring Period	Monitor Weighting score	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
1	Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway	92%	Quarterly	1	92.11%	92.45%	92.02%	91.35%	89.19%	88.64%	88.77%	88.51%	88.08%	88.17%	87.16%	
2	A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	Quarterly	1	80.54%	83.52%	81.18%	78.56%	77.80%	78.40%	81.37%	82.60%	77.47%	75.56%	75.22%	
3	All cancers: 62 day wait for first treatment from: Urgent GP referral for suspected cancer*	85%	Quarterly	1	75.60%	74.70%	70.00%	68.90%	75.60%	74.00%	71.90%	69.30%	67.80%	71.90%	74.40%	
	NHS Cancer Screening Service referral*	90%			92.10%	80.60%	86.20%	96.20%	90.90%	78.90%	92.90%	79.20%	89.70%	96.90%	67.90%	
4	All cancers: 31 day wait for second or subsequent treatement comprising: Surgery*	94%	Quarterly	1	92.10%	80.40%	90.90%	95.00%	95.80%	97.80%	91.20%	91.20%	100.00%	97.10%	100.00%	
	Anti-cancer drug treatments*	98%			91.60%	84.60%	97.70%	100.00%	98.00%	98.80%	98.40%	98.80%	98.90%	96.40%	99.00%	
	Radiotherapy*	94%			90.70%	80.40%	90.90%	95.00%	95.80%	97.80%	91.20%	91.20%	100.00%	97.10%	100.00%	
5	All cancers: 31 day wait from diagnosis to first treatment*	96%	Quarterly	1	96.70%	95.80%	95.00%	98.70%	97.60%	96.60%	98.00%	96.20%	97.40%	98.40%	94.10%	
6	Cancer: two week wait from referral to date first seen, comprising: all urgent referrals (cancer suspected)*	93%	Quarterly	1	92.50%	87.80%	92.60%	92.10%	82.70%	81.10%	94.60%	95.30%	94.10%	93.40%	89.50%	
	for symptomatic breast patients (cancer not initially suspected)*	93%			90.60%	94.60%	96.60%	93.00%	24.80%	26.30%	88.80%	94.30%	82.40%	88.10%	74.30%	
14	Meeting the C.difficile objective (cumulative)	62%	Quarterly	1	2	5	5	0	3	6	4	5	3	6	5	
15	meeting the MRSA objective (cumulative)	0%	Quarterly	1	0	0	0	0	0	0	0	0	0	2	0	
19	Certification against compliance with requirements regarding access to health care for people with a learning disability	n/a	Quarterly	1	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	
				Risk rating	4	5	5	5	5	5	5	4	4	5	4	

Trust Internal Compliance Rating	
	Target Met
	Target Not Met

Monitor Governance Risk Rating Calculation	
<1.0	Green
≥1.0	Amber/Green
<2.0	
≥2.0	Amber/Red
<4.0	
≥4.0	Red

GOVERNANCE RISK RATING

Monitor assign a Governance Risk Rating to reflect quality of services at a Trust. Higher levels of governance risk may serve to trigger greater regulatory action.
The Risk Rating is calculated from performance against service indicators.
Each of these indicators is given a weighting and compliance with all indicators would achieve a Risk Rating of 0.
For each non-compliant indicator the weighted score is applied and the total of these formulate the Risk Rating.
The numerical score is RAG rated using the table to the left.
Monitor may apply a red Governance Risk Rating where any indicator with a rating of 1.0 is breached for three successive quarters.
For each of the non-compliant indicators a failure in one month is considered to be a quarterly failure.

Appendix 2. Glossary

MRSA bacteraemia	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin Sensitive Staphylococcus aureus
ECOLI	Escherichia coli
UTIs	Urinary tract infection
VTE Risk Assessment	Venous thromboembolism
Overdue CAS alerts	Central alerting system
SQD %	Safety and Quality dashboard
eDD	Electronic discharge document
PPCI	Primary percutaneous coronary intervention
#NOF	Fractured neck of femur
A&E	Accident & Emergency
RTT	Referral to Treatment
SHMI	Summary Hospital level Mortality Indicator
LoS	Length of Stay

Appendix 3. Overview of thresholds for Red, Amber, Green ratings

Below is an explanation of how the RAG rating for each measure, KPI and Trust Value is calculated.

	Red	**Amber**	**Green**
Section 2 – KPIs	The majority of measures in section 3 that make up the KPI fail the target by more than 10% tolerance	The majority of measures in section 3 that make up the KPI fail the target but within the 10% tolerance	All measures in section 3 that make up the KPI achieve the target
Section 2 – Trust Values	Any zero tolerance measures fail the target (e.g. never events) or any priority deliverables fail the target or the majority of KPIs that contribute to the Trust Value fail the target by more than 10% tolerance	The majority of KPIs that fail the target but within the 10% tolerance	All KPIs achieve the target
Section 3 - Measures	Fail the target by more than 10% tolerance	Fail the target but within the 10% tolerance	Achieve the target

Appendix 4. Detailed thresholds for Red, Amber, Green ratings

Metric	Red	Amber	Green
Cdiff Actual	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
C-diff Accum	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
MRSA	More than 0 instances		0 instances
MSSA	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Ecoli	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Never Events	More than 0 instances		0 instances
Serious Incidents	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Harm Free Care	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
New Harm Free Care	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Catheter & UTIs	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Falls	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Medication Errors (Datix)	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Medication errors (mod, severe or death) (DATIX)	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Pressure Ulcers (PUNT) 3/4	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
VTE Risk Assessment	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Core Learning	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Nurse to Bed Ratio	Deteriorated from last month		Improved from last month
A&E 4 Hr	Missed both National and CCG Targets	Missed National Target but achieved CCG Target	Achieved National Target
A&E 12hr Trolley Wait	More than 0 instances		0 Instances
RTT 52 week wait	More than 0 instances		0 Instances
RTT 18 Week Incompletes	Missed both National and CCG Targets	Achieved National Target but failed CCG Target	Achieved National Target
62 Day Classic	Missed both National and CCG Targets	Missed National Target but achieved CCG Target	Achieved National Target
2 Week Wait	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
2 Week Wait Breast	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
31 day first treatment	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
31 day subsequent drug treatments	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
31 day subsequent surgery treatments	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
31 day subsequent radiotherapy treatments	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
62 day screening	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
62 day consultant upgrade	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Diagnostics achieved	Failed Target by more than 1%	Failed Target but by less than 1%	Achieved Target
Diagnostics Failed	Failed Target by more than 1%	Failed Target but by less than 1%	Achieved Target
Cancelled Operations –on the day	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Cancelled Operations -Not treated within 28 days	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
FFT: IP (Response Rate)	Deteriorated from last month	Same as last month	Improved from last month
FFT: IP (Recommend)	Failed Target by more than 3%	Failed Target but by less than 3%	Achieved Target
FFT: A&E (Response Rate)	Deteriorated from last month	Same as last month	Improved from last month
FFT: A&E (Recommend)	Failed Target by more than 3%	Failed Target but by less than 3%	Achieved Target
Complaints	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Mixed Sex Accommodation	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target

EDD	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
PPCI 90 hrs	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
PPCI 150 hrs	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
NOF 24	Failed Target by more than 4%	Failed Target but by less than 4%	Achieved Target
NOF 48	Failed Target by more than 4%	Failed Target but by less than 4%	Achieved Target
Dementia Screening	Failed Target by more than 4%	Failed Target but by less than 4%	Achieved Target
Dementia Risk Assessment	Failed Target by more than 4%	Failed Target but by less than 4%	Achieved Target
Dementia Specialist Referral	Failed Target by more than 4%	Failed Target but by less than 4%	Achieved Target
Stroke 90% attendance	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Swallowing <4hrs	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Scan <60mins	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Scan <24hrs	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Stroke Admitted < 4hrs	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Stroke IP dying in dept	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
SHMI	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Hospital Level Mortality Indicator	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Elective LOS	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Non-Elective LOS	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
MFFD	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
DTOC	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Vacancies	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Sickness Absence	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Staff Turnover	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Staff Appraisals	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Equality and Diversity	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Income v Plan	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Expenditure v Plan	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Efficiency Plans	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Surplus / Deficit	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Capital Program Spend	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Agency Spend	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Partial Booking Waiting List	Failed Target		Achieved Target