UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 31 JANUARY 2017

Document management

Title: Integrated Performance Report

To: Finance, Service Delivery and Improvement Assurance Committee

From: Rachel Harvey, Head of Planning & Performance

Author: Katherine Etoria, Planning & Performance Manager

Date: 28th February 2017

Purpose of the Report:

To update the committee on the performance of the Trust for the period ended 31st December 2016, 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 31st January 2017

1. Executive Summary for period of 31st January 2017

January headlines:

- ☒ 4 hour waiting time target – performance of 75.56%
- ☒ 5 of the 9 national cancer targets were achieved in January 2017
- ☒ 18wk RTT Incomplete Standard – the current validated performance for January 2017 is 88.17%
- ☒ 6wk Diagnostic Standard – January performance was 99.20%
- ☒ Agency Spend – £3,606k below plan
- ☒ Financial Improvement Plans -£306k below plan

Successes:

January Headlines

Diagnostics has achieved the standard for two months in row. This is sustainable if we continue to manage and reduce breaches; however, Endoscopy remains an area of risk in achieving the standard going forward. Issues in Qtr. 3 last year are still impacting on the performance of Cancer targets but it is believed that the actions taken to resolve these issues in diagnostics will help to improve Cancer performance in future months.

Friends and family response rates have improved overall suggesting better engagement in this area. This also helps provide more representative feedback for use in improving services and our responsiveness to patient needs. In particular our A&E response rates have risen from 19% to 28% with a slight improvement around stakeholders who would recommend our A&E department from 81% to 84%.

Whilst cancer remains a challenge to achieve performance standards and targets there has been a slight improvement in both 62 day classic (67.80% to 71.90%) and breast (82.40% to 88.10%) and the standard was met in December for 62 day screening (96.90% against a target of 90%).

Core learning rates are improving and at their highest levels since July 2014 with a steady upward trend since May 2015.

Challenges:

Risk of achieving the standards and associated targets and trajectories in future months are high in four of the six performance priority areas; A&E, RTT, Cancer and Deficit reduction (meeting our control total including agency spend).

Recovery action plans are in place for A&E, RTT and Cancer. Reviews of each of the plans has either taken place or is about to take place to provide assurance of impact on performance, including identifying tangible benefit achieved in relation to actions taken.

It is unlikely that we will recover to meet our control total by the end of Quarter 4 – see separate Finance Report.

Three of the four ‘active’ Well-led indicators are under performing. The annual cost of sickness (excluding any backfill costs) is £8,782,450; an increase of £212,706 in December 2016; and ULHT are the ninth highest across the 39 Large Acute Trusts in the country. Note: ‘active’ refers to indicators that have associated metrics developed and being reported on – Equality, Diversity and Inclusion is not yet fully developed but will be by the April 2017 reporting period.

Appraisal rates are still lower than expected with 396 staff having had no appraisals since joining the Trust prior to 2016. The lowest performing Directorate has a rate of 47.83%.

Looking forward:

Performance sustainability and recovery is increasingly challenging and risk levels of achieving this in all key performance areas are high based on the exception reports received to date as part of this report.

There remain significant recruitment issues and three examples would be cardiology, middle grade posts in A&E, and paediatric medicine.

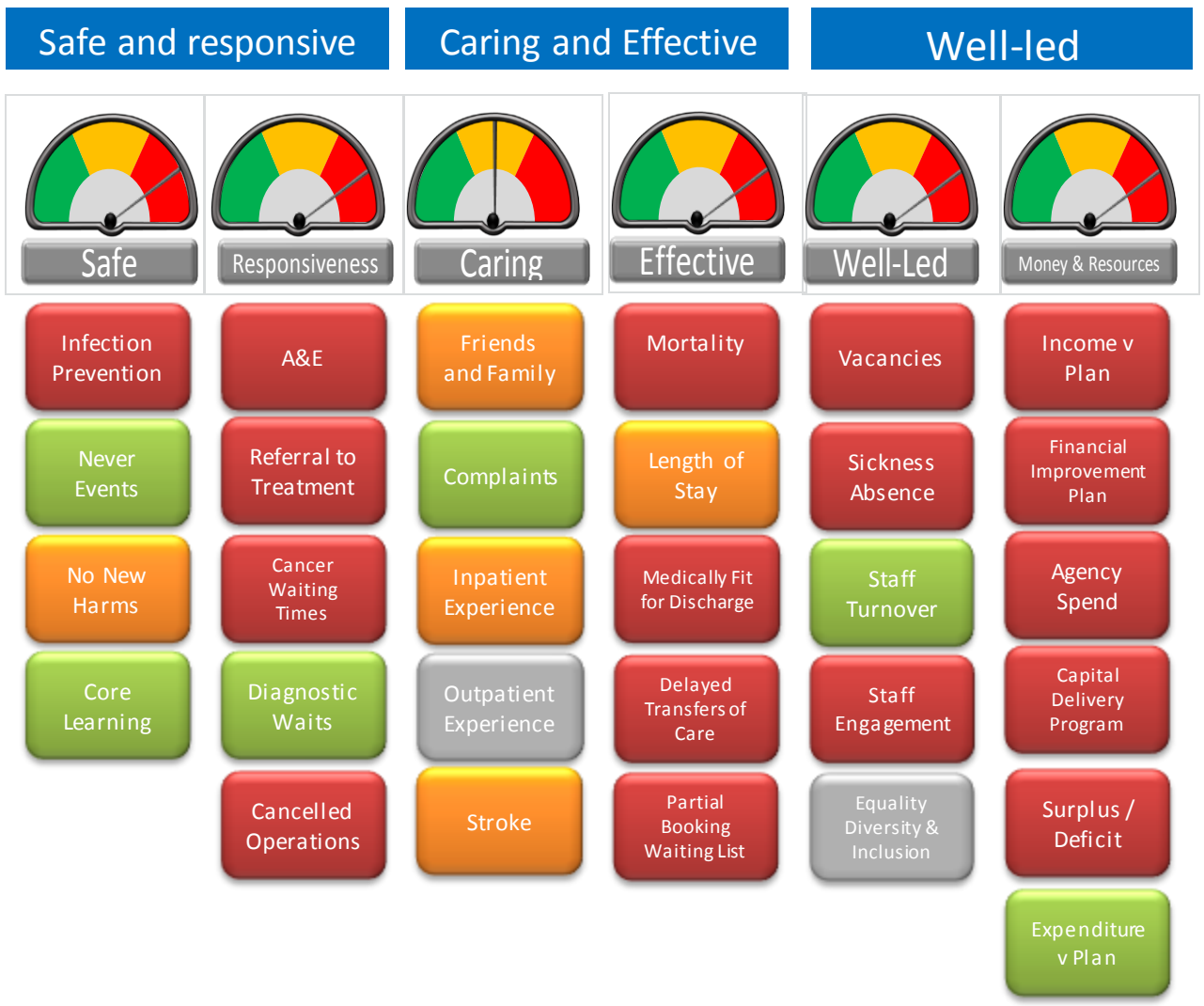
Whilst the increase in agency staffing levels is assisting with the safety and quality of patient care and delivery it is affecting on our ability to meet our control total which has an impact on drawing down significant levels of funding through the Sustainability and Transformation Fund.

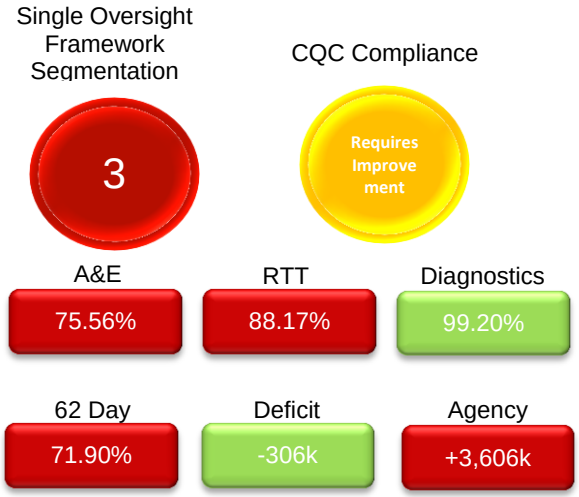
Peter Hollinshead
Interim Director of Finance & Corporate Affairs
February 2017

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 improved:

Domain: Responsiveness
Diagnostics achieved the standard for the second month in a row with an increase in performance of +0.17%

Domain: Caring
Friends & Family Test response rate for A&E has increased by 9% compared to last month

Most deteriorated:

Domain: Safe
MRSA – two cases where reported in January

Domain: Responsiveness
Cancelled Operations on the day has increased by 1.32% in 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	6	3			
MRSA bacteraemia (post 3 days)	0	2	2	0			
MSSA	2	18	2	2			
ECOLI	8	53	3	3			
Never Events	0	1	0	0			
No New Harms							
Serious Incidents reported (unvalidated)	TBC	35		8			
Harm Free Care %	95%	91.00%	90.35%	90.36%			
New Harm Free Care %	98%	96.89%	96.74%	96.86%			
Catheter & New UTIs	2.00	1	0	1			
Falls	95.0%						
Medication errors	1						
Medication errors (mod, severe or death)	1						
Pressure Ulcers (PUNT) 3/4							
VTE Risk Assessment	95%	93.66%	97.51%	95.90%			
Overdue CAS alerts							
SQD %							
Core Learning	85%	81.82%	85.62%	85.62%			
							#REF!

	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%	26.80%	28.00%	22.00%			
Inpatient (Recommend)	96%	88.40%	90.00%	89.00%			
A&E (Response Rate)	14%	21.50%	28.00%	19.00%			
A&E (Recommend)	87%	80.60%	84.00%	81.00%			
% of staff who would recommend care							
% of staff who would recommend work							
Complaints							
No of Complaints received	70	593	63	41			
No of Complaints still Open	0	3158	254	245			
No of Complaints ongoing	0	407	41	31			
Inpatient Experience							
Mixed Sex Accommodation	0	46	14	5			
eDD	95%	77.15%	77.90%	77.76%			
PPCI 90 hrs	100%	0.00%	97.33%	97.33%			
PPCI 150 hr	100%	0.00%	85.33%	85.33%			
#NOF 24	70%	63.68%	74.12%	70.49%			
#NOF 48 hrs	95%	93.25%	94.12%	96.72%			
Dementia Screening	90%	87.05%	95.98%	95.68%			
Dementia risk assessment	90%	94.11%	96.97%	93.75%			
Dementia referral for Specialist treatment	90%	60.73%	91.84%	87.18%			
Stroke							
Patients with 90% of stay in Stroke Unit	80%	85.22%	82.60%	85.30%			
Sallowing assessment < 4hrs	80%	70.58%	62.50%	69.80%			
Scanned < 1 hrs	50%	65.85%	55.00%	87.50%			
Scanned < 12 hrs	100%	96.00%	93.80%	96.90%			
Admitted to Stroke < 4 hrs	90%	68.10%	62.50%	65.60%			
Patient death in Stroke	17%	12.01%	13.80%	16.00%			
Assesments within Deadline							
Thromb < 1hr							
Outpatient Experience							
Standard							
Performance							

	Nat. Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Responsiveness							
A&E							
4hrs or less in A&E Dept	89.0%	80.18%	75.56%	77.47%			
12+ Trolley waits	0	0	0	0			
RTT							
52 Week Waiters	1						
18 week incompletes	92.4%	91.80%	88.17%	88.08%			
Cancer - Other Targets							
62 day classic	85%	71.57%	71.90%	67.80%			
2 week wait suspect	93%	90.41%	93.40%	94.10%			
2 week wait breast symptomatic	93%	76.54%	88.10%	82.40%			
31 day first treatment	96%	97.08%	98.40%	97.40%			
31 day subsequent drug treatments	98%	96.84%	96.40%	98.90%			
31 day subsequent surgery treatments	94%	93.27%	97.10%	100.00%			
31 day subsequent radiotherapy treatments	94%	92.63%	97.30%	98.90%			
62 day screening	90%	87.94%	96.90%	89.70%			
62 day consultant upgrade	85%	82.97%	82.60%	75.90%			
104+ Day Waiters		-	31.00	34.00			
Diagnostic Waits							
diagnostics achieved	99.1%	98.87%	99.20%	99.03%			
diagnostics Failed	0.9%	1.13%	0.80%	0.97%			
Cancelled Operations							
Cancelled Operations on the day (non clinical)		2.20%	3.15%	1.83%			
Not treated within 28 days. (Breach)		8.28%	1.76%	1.22%			

	Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Effective							
Mortality							
SHMI	100	111.21		110.07			
Hospital-level Mortality Indicator	100	99.54		102.60			
Length of Stay							
Average LoS - Elective	2.8	2.79	2.63	2.60			
Average LoS - Non Elective	3.8	4.53	4.89	4.45			
Medically Fit for Discharge	60	867.80	810.00	793.00			
Delayed Transfers of Care	3.5%	5.00%	5.14%	4.99%			
Partial Booking Waiting List	0	4711	4962	4213			

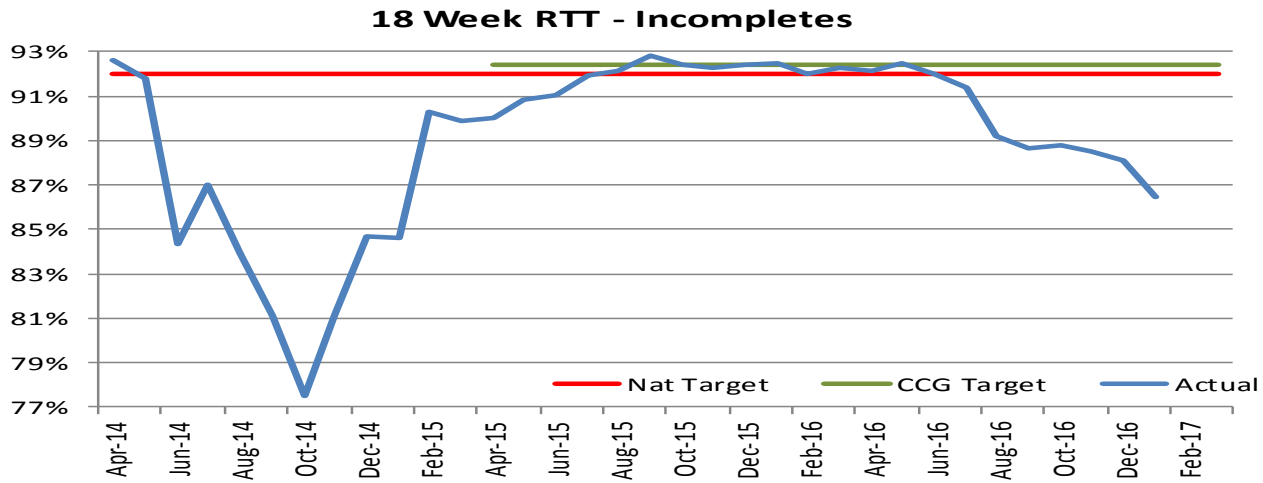
	Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Well Led							
Vacancies	5.0%	10.23%	10.48%	10.68%			
Sickness Absence	4.0%	4.80%	5.50%	5.08%			
Staff Turnover	2.4%	2.16%	1.73%	1.73%			
Staff Engagement							
Staff Appraisals	95.0%	67.10%	67.00%	68.00%			
Equality Diversity and Inclusion							

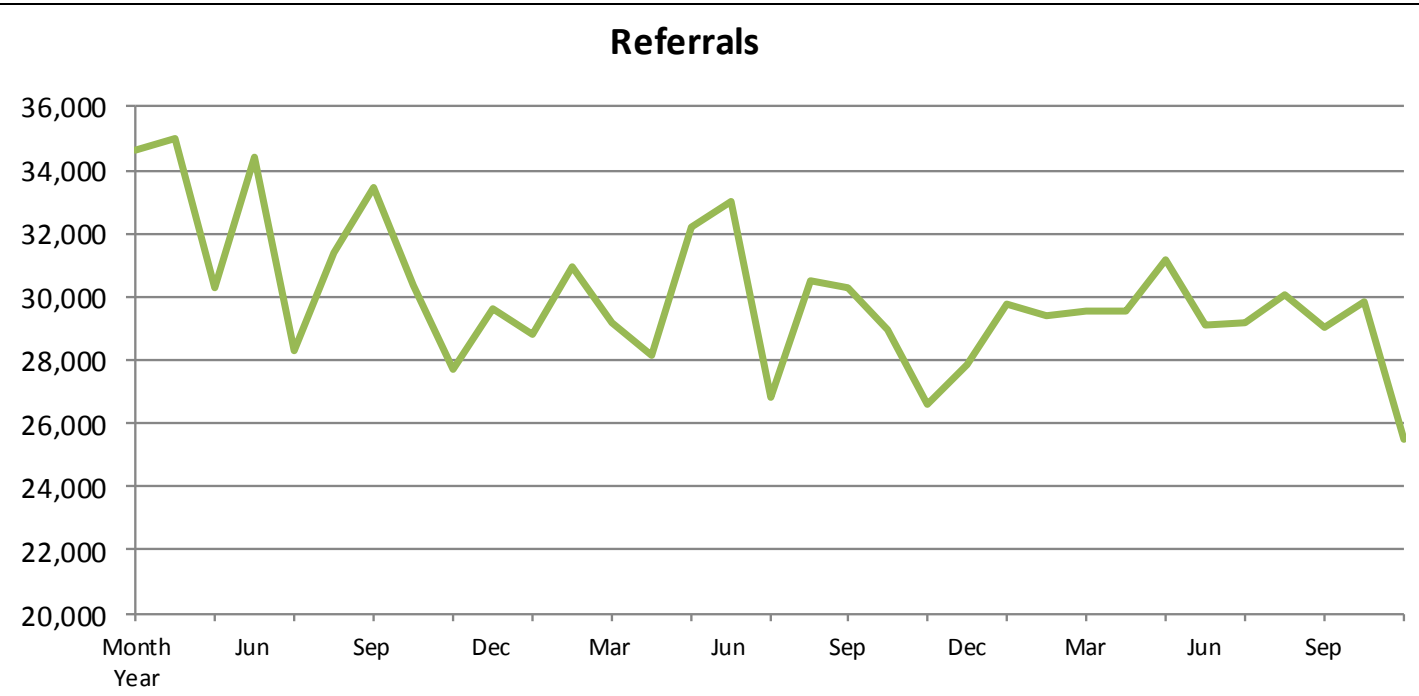
	Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Money & Resources							
Income v Plan	38503	367160	36318	36976			
Expenditure v Plan	-40236	-393409	-40221	-38948			
Efficiency Plans	2069	14504	1763	2550			
Surplus / Deficit	-3142	-42888	-5346	-3362			
Capital Delivery Program	1384	8855	858	701			
Agency Spend	772	-17599	-2834	2307			

4. "Priority deliverables" – RTT Incompletes

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

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	ULHT's performance has not achieved the 92% standard for the last 6 months. In December the Trust reported performance of 88.1%. At a national level the standard hasn't been achieved for 10 consecutive months, with an aggregated national performance in December of 89.7% (a 0.8% reduction from November's position. January performance was 88.17%. 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 has a knock on impact onto RTT performance. In December, as part of the winter plan and to assist with the achievement of 85% bed occupancy by Christmas Eve, the Trust planned to complete 108 less electives and 41 more day-cases than standard (plus the impact of bank hols). Therefore a planned reduction of 67 cases over and above bank holiday reductions. In addition to this planned reduction, the Trust cancelled 108 operations during December as a result of capacity issues such as lack of HDU and general beds. In January the net effect of the winter plan was a reduction in scheduled operations totalling 63 cases. In addition to this planned reduction, the Trust cancelled 195 operations during January 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.

	At a speciality level General Surgery, Neurology and Orthopaedics continue to be particularly challenged. In recent months performance within Cardiology, ENT and gastroenterology have all deteriorated as a result of consultant vacancies, which adds increased risk to the overall Trust position. In addition, unprecedented referral rates into Dermatology have caused significant performance issues within this speciality. At month 9 activity against contract shows an under-performance on electives (-1.5%, 128 cases), but offset by an over-performance within day cases (-0.2%, 102 cases). The result is 26 elective cases below contract as of M9. Outpatient first appointments are under plan (-3.1%, 5018), but follow-ups are over plan (+2.3%, 7640). In terms of activity we are 2622 above plan. Follow ups are over plan due to the need to reduce the number of overdue partial booking follow ups.
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
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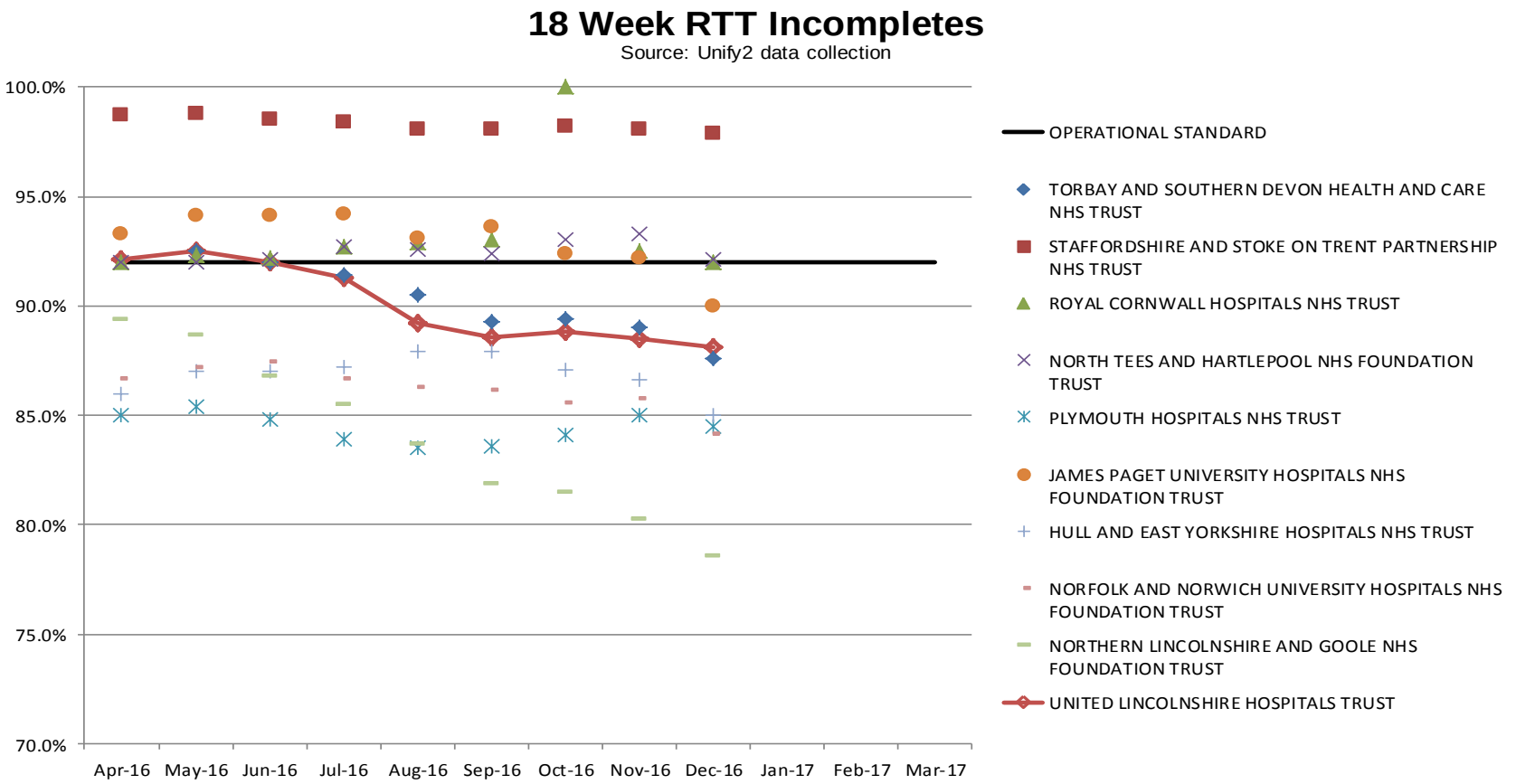
Jun
Sep



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, and Vascular.

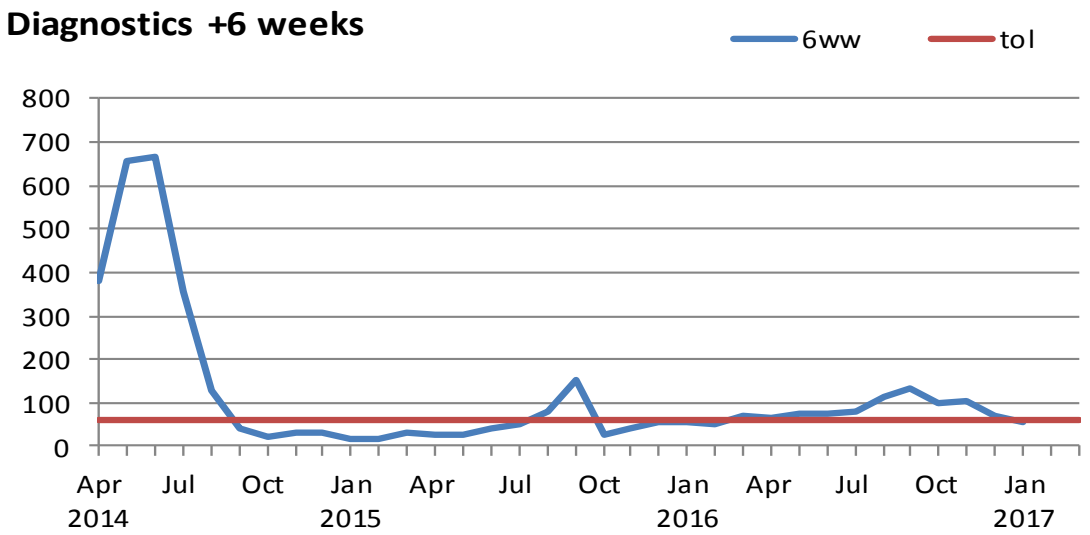
Key actions contained within these plans include increasing internal capacity through additional outpatient and theatre sessions from our existing workforce and utilisation of additional locum capacity. The Business Units scheduled c.700 additional outpatient appointments in January (above baseline capacity). Plans were in place in February to deliver additional activity resulting in c.400 clock stops, with plans to deliver an estimated 300 additional clock stops in March being finalised.

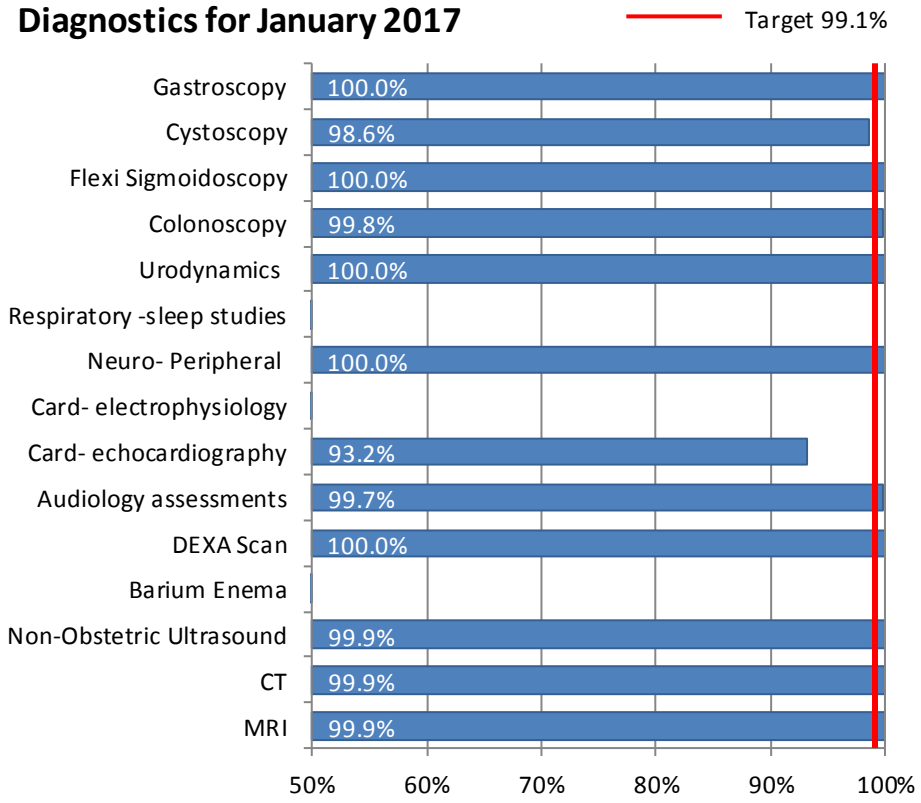
The Trust has commenced outsourcing, primarily related to Orthopaedics. The Executive Team have agreed an initial volume of outsourcing levels. There is the potential to send out a further c.70 elective cases before this initial maximum volume is reached. However, access to outsourcing capacity is currently limited particularly within the East of the county. Contracts are in place with 2 independent providers and are being explored with 2 further providers.

	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 will be completed by the end of February 2017.
What is the recovery date?	April 2017 – with risk
Who is responsible for the action? (Provide the role and name of the lead)	Neil Ellis – Deputy Director of Operational Performance

4. "Priority deliverables" – Diagnostic 6wk Standard

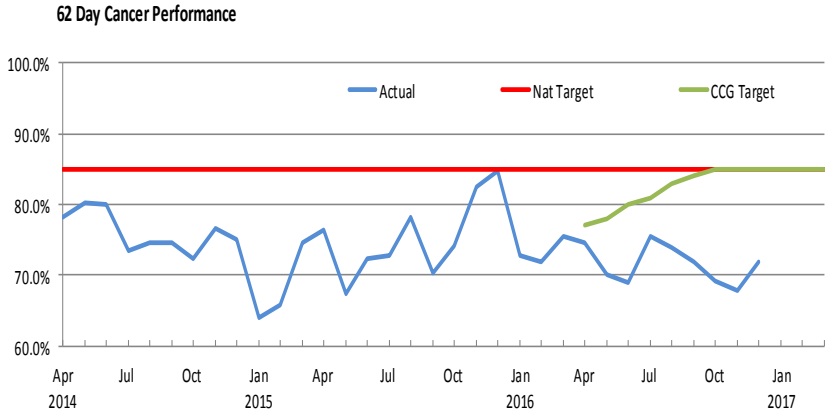
KPI:	Diagnostic Waits	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance
Date:	28th February 2017	Reporting Period:	January 2017

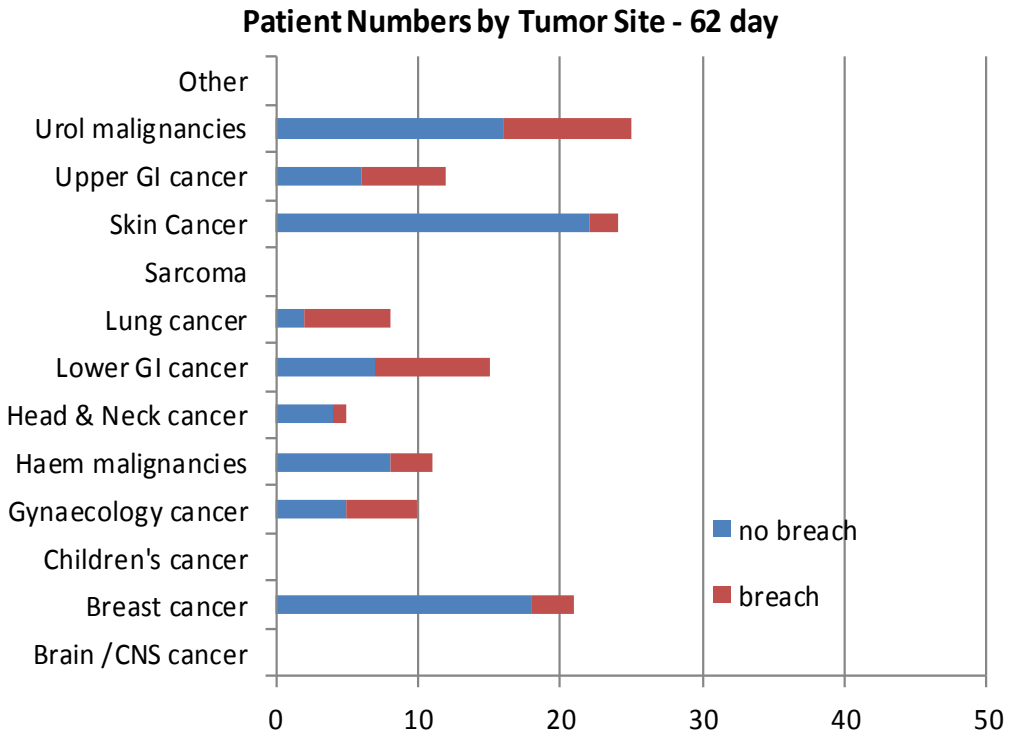
Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	In January the Trust achieved the 6 week diagnostic standard for the second month in a row. The performance level was 0.8%. The national average in December was 1.7%. The number of 6-week breaches reduced from 102 patients in November down to 54 patients in January. At modality level performance of <1% was achieved in all modalities except for Echocardiography and Endoscopy. 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 is beginning to reduce. In November Echo reported 86 breaches, but this has reduced to 64 in December and 30 in January. The Endoscopy Service reported 21 breaches in January, due to a combination of capacity constraints and administrative process issues. These administrative issues have been resolved, and therefore won't impact upon February's performance; however capacity within Endoscopy still remains a risk.
Forward Trajectory	

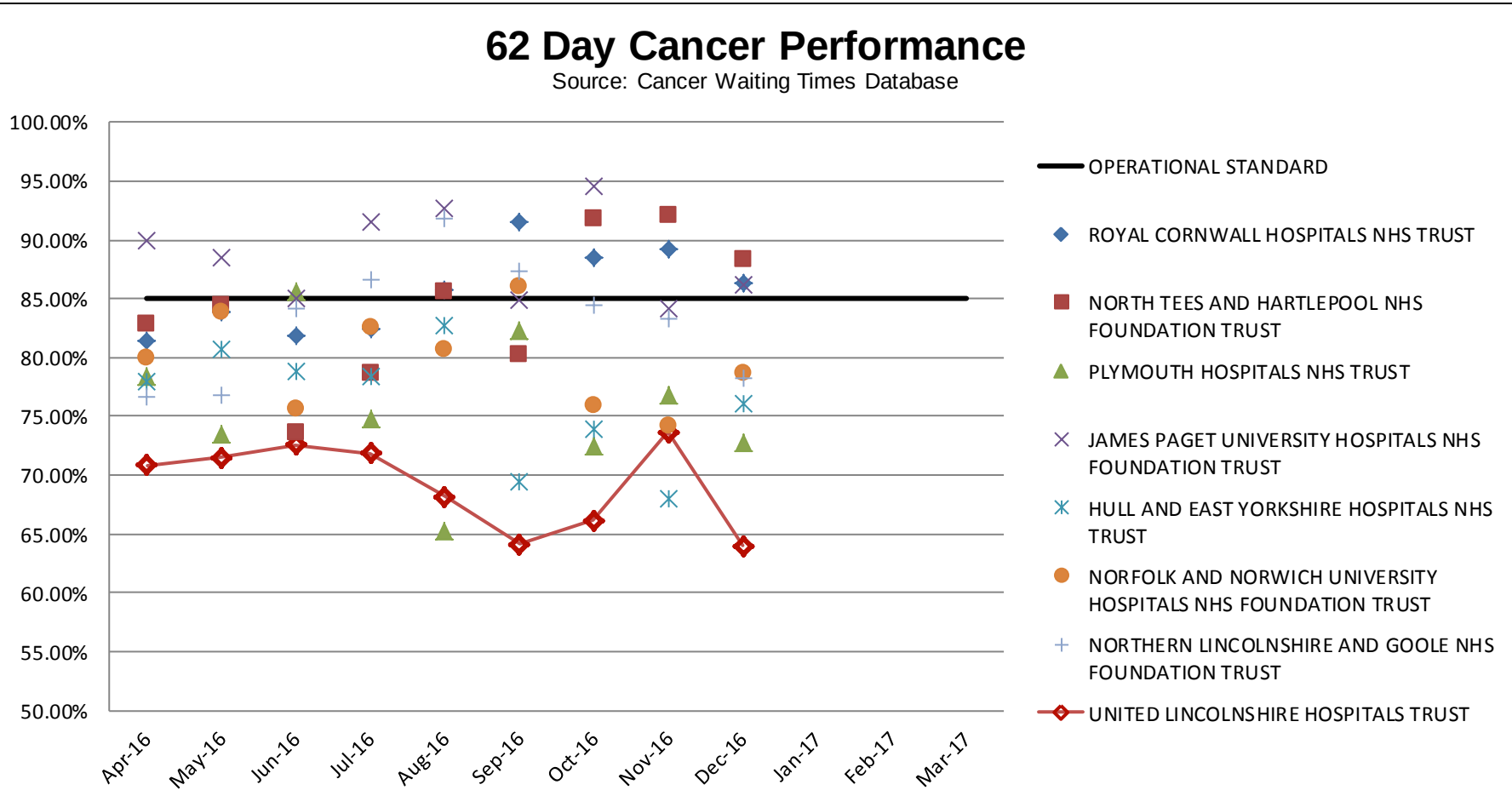
Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	Further additional Echo capacity is scheduled for February in order to achieve further improvements in performance in this area, and therefore assist the overall Trust position, ensuring continued achievement of the standard in February.
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 February	**Reporting Period:**	December 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	The Trust achieved a performance of 71.9% against the 62 day classic standard in December, an improvement of 4.1% compared with November. The Trust achieved 5 out of the 9 cancer standards in December. Demand is continuing at unprecedented levels (highest recorded January 2ww referral rate, 11% 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. Access to diagnostics within ULHT, particularly Radiology and Endoscopy, is slower than required for a significant proportion of patients on 62 day pathways. In addition, delayed access to specialist tests (such as EBUS and EUS) at tertiary centres introduces further waiting periods into the 62 day pathways for our patients. Work has begun with tertiary colleagues to improve the pathways for patients going to other Trusts for diagnostic tests and/or treatments. The Trust also holds a fortnightly 62 Day Trajectory meeting, chaired by a Deputy Director, for all tumour sites to report against agreed Action Plan, with attendance from the CCGs, East Midlands Clinical Network and the Trust's Planning & Performance Directorate. 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.
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 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.

The Somerset Cancer Register implementation continues at a fast pace. There are now 156 registered users (compared to 40 on Infoflex),

	including MDT Co-coordinators, 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. The Trust continues to hold its fortnightly cancer improvement meetings to monitor and progress the Cancer Improvement Action Plan, holding Business Units to account for performance and delivery against the action plan. The action planning is currently being reviewed, in order to ensure that the actions will deliver tumour site level improvements in performance which is demonstrable. The following are considered to be high impact actions from within the overall action plan: • Pilot new Radiology booking process, to reduce time from request to scan. • Standardisation of Radiology cancer image reporting processes • Implementation of diagnostic schemes approved within diagnostic capacity fund bid – Ongoing since December 2016, and planning for capacity from April 2017. • Establish Endoscopy working group. • Extension of Lower GI pilot to Pilgrim and Grantham – April 2017 **<u>Key Achievements</u>** During the first three quarters of 2016/17 ULHT have achieved the following developments within cancer services: • 7-day horizon has been implemented for all relevant tumour sites • Successful implementation of the Somerset Cancer Register • Successful business case for increasing establishment of Cancer Centre Team • Successful business cases for additional level 1 bed capacity at the Pilgrim and Lincoln sites • Successful pilot of lower GI CNS triage service • Commenced upper GI straight to test pilot • Restructured the Urology MDT pathway
What is the recovery date?	
Who is responsible for the action? (Provide the role and name of the lead)	Neil Ellis – Deputy Director of Operational Performance

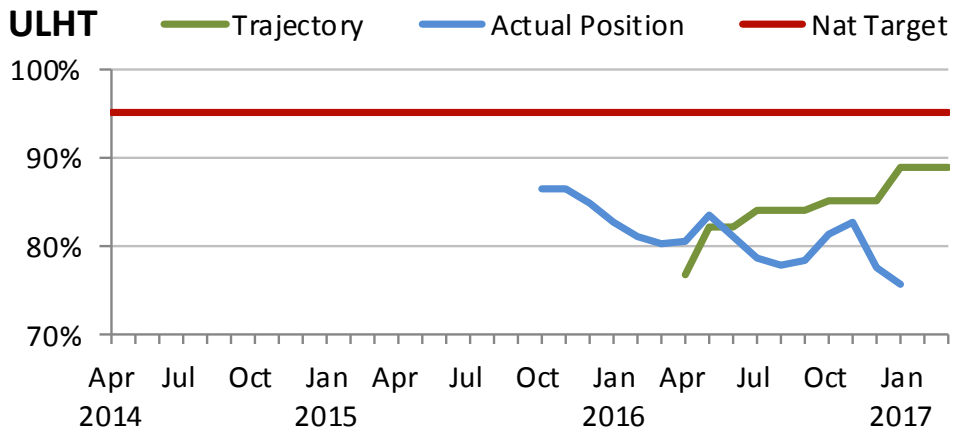
4. "Priority deliverables" – A&E 4hr Standard

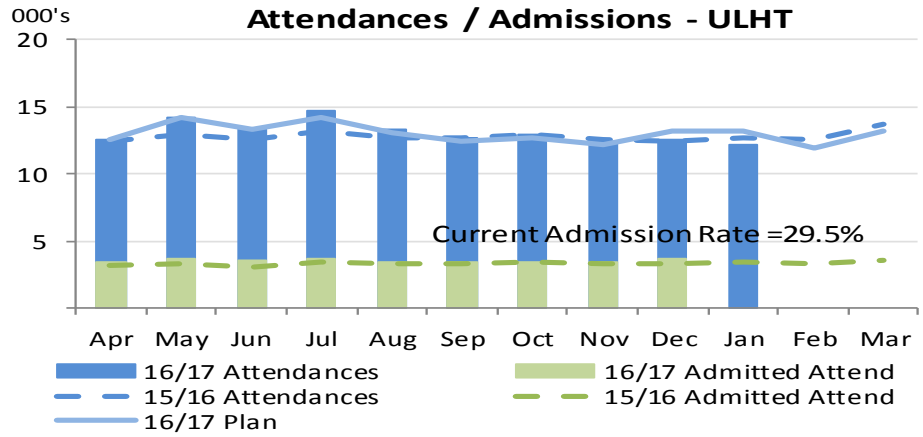
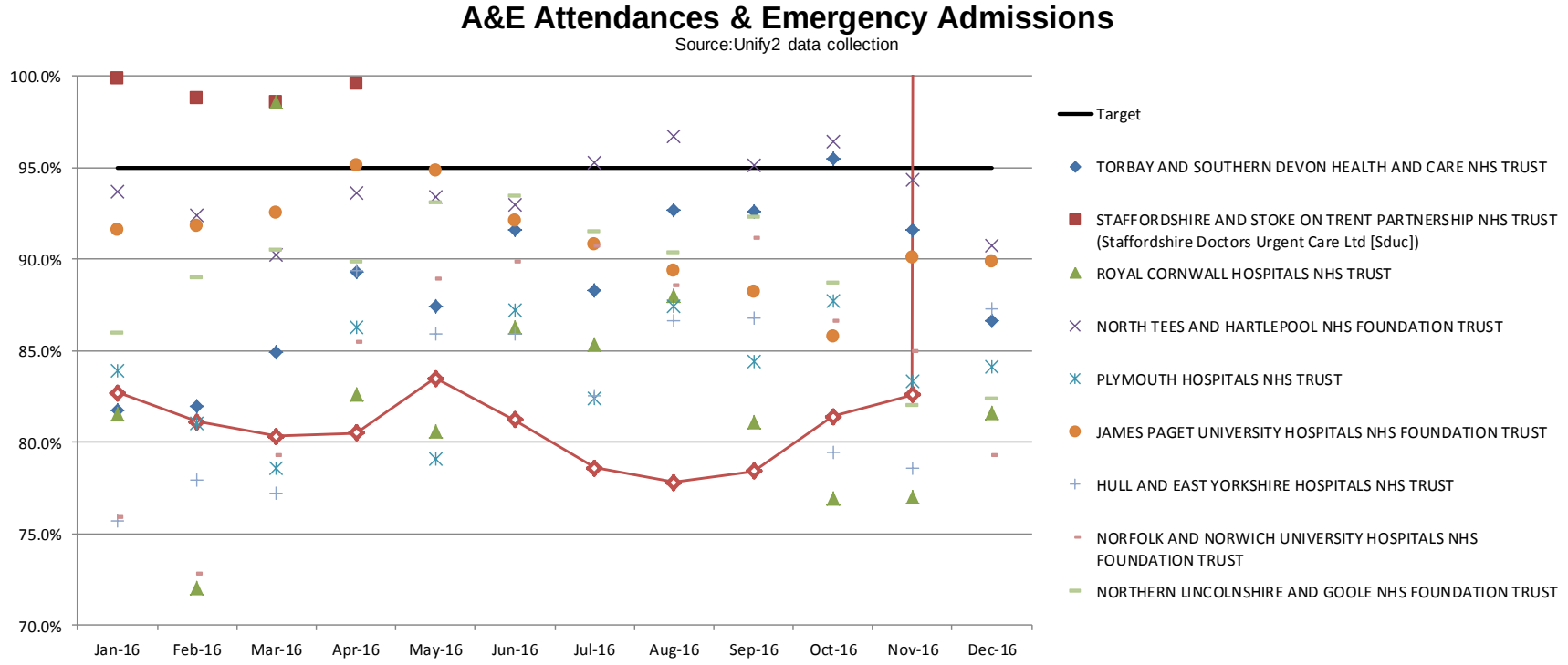
KPI:	4 Hour Wait (A&E)	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Deputy Director of Operations; Emergency Care Interim Head of Nursing; Grantham
Date:	28th February 2017	Reporting Period:	January 2017

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	**Lincoln** performance for January 2017 was 74.46% which is an increase of 0.68% from last month. However, this remains below the STF monthly trajectory of 92.80%. Key issues affecting performance in January continued to be variable medical and nursing agency fill rates/staff sickness. Acuity during January was at the highest levels experienced for many months. This manifested in a rise in the average length of stay for patients on site, and demand beyond capacity for both NIV beds and ICU beds on site. Across the network there were days with no ICU beds availability within the regional network. Further escalation was opened to support flow, with Digby Ward being utilised on a small number of occasions when pressure became extreme. This resulted in increased cancellations of elective work, above the levels planned. Lincoln Site was reporting an internal Level 4 on multiple days during January at a time when our neighbouring trusts were also on high levels of alert and often diverting work across the borders into Lincolnshire. **Grantham** January performance went above trajectory for this month. January performance 97.13% (trajectory 90.80%). Quarter three performance for the site was 96.68% (1.78% over trajectory). Poor performance in the first two quarters has left a deficit currently of 1.54% for the year. The temporary change in opening hours implemented in August has continued to positively impact on the performance of the department as staffing is now focussed on the core opening hours. The nursing qualified deficit of 6 wte is not affecting performance however remains a risk and recruitment is ongoing. The site has been escalated with additional 16 beds opened due to increases in admissions and poor flow out due to waits for packages of care and placement. External delays have been up to 18 per day. **Pilgrim** Performance for January 2017 was 69.39%, which is down 6.21% from Decembers total of 75.60%. In both instances these are well below the STF monthly trajectory of 88.10% for December and 86.90% for January. Key issues affecting performance in January continued to be gaps in current establishment from both a Medical and Nursing perspective, accompanied by a variance in agency or bank fill rates for both. Acuity and attendance numbers were also a major issue with numbers up around 10% on last January (4156 – 2016 / 4613 – 2017), which translated into an increase in Admissions from 1422 in Jan 2016 to 1525 in Jan 2017. Bed pressures and a lack of discharges also contributed to the issues around A&E performance. With a lack of escalation beds available onsite, AEC was required to be open 24/7 on a number of occasions, with Elective work also being cancelled due to the lack of available surgical beds and a large number of medical outliers, which reached +50 on numerous occasions. The site reached level 4 status on a number of occasions and at times when other sites within the Trust and those on the peripherals where in a similar situation. External delays have also contributed to the lack of available beds which in-turn affects the sites ability to admit patients from A&E/AMU or AEC, again affecting A&E performance.

		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Grantham Hospital	Trajectory	94.00%	95.40%	95.60%	96.30%	96.80%	92.30%	95.70%	96.10%	92.80%	90.80%	91.70%	90.40%
	Performance	92.07%	88.02%	86.49%	90.07%	93.46%	97.14%	96.94%	96.04%	96.78%	97.13%	96.17%	
	variance	*-1.93%*	*-7.38%*	*-9.11%*	*-6.23%*	*-3.34%*	*4.84%*	*1.24%*	*-0.06%*	*3.98%*	*6.33%*	*4.47%*	
Lincoln County	Trajectory	81.80%	83.10%	81.80%	87.00%	89.70%	88.70%	89.30%	90.80%	86.10%	92.80%	90.80%	88.50%
	Performance	79.06%	85.10%	77.26%	75.22%	76.50%	74.75%	76.50%	77.47%	72.78%	73.95%	67.89%	
	variance	*-2.74%*	*2.00%*	*-4.54%*	*-11.78%*	*-13.20%*	*-13.95%*	*-12.80%*	*-13.33%*	*-13.32%*	*-18.85%*	*-22.91%*	
Pilgrim Hospital Boston	Trajectory	70.60%	73.00%	79.40%	87.20%	77.60%	83.70%	82.00%	80.00%	88.10%	86.90%	85.00%	88.70%
	Performance	76.05%	78.87%	82.93%	75.76%	70.88%	69.67%	81.37%	83.69%	76.44%	69.24%	70.01%	
	variance	*5.45%*	*5.87%*	*3.53%*	*-11.44%*	*-6.72%*	*-14.03%*	*-0.63%*	*3.69%*	*-11.66%*	*-17.66%*	*-14.99%*	
ULHT Total	Trajectory	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%	78.45%	77.27%	75.77%	81.07%	82.31%	77.42%	75.36%	72.72%	
	variance	*3.94%*	*1.52%*	*-0.82%*	*-5.55%*	*-6.73%*	*-8.23%*	*-3.93%*	*-2.69%*	*-7.58%*	*-13.64%*	*-16.28%*	

Forward Trajectory

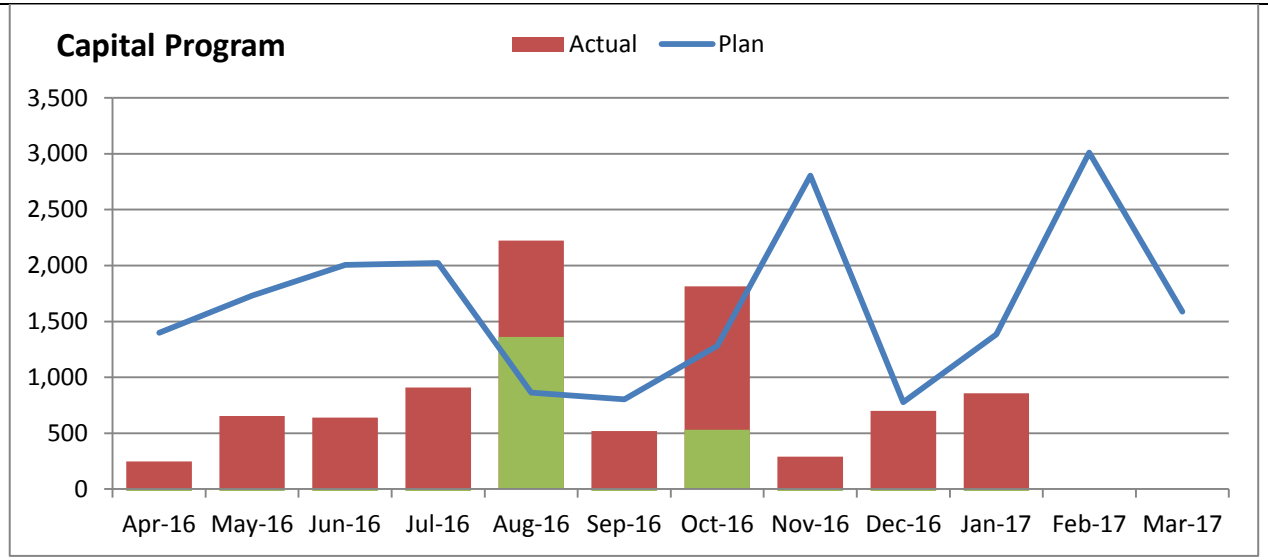


Variance Analysis (SPC Chart)	  The above graph shows the latest available national performance for A&E attendances and emergency admissions. The peer group that has been selected to benchmark ULHT against consists of Trust's which have a similar rural structure and patient demographics.
What action is	**Lincoln**: At Grantham an internal review of the triage and first assessment processes continue as a focus to prevent unnecessary

being taken to recover performance?	breaches. Currently triage at 100% for minors. Review of team working introduced in August under way to ensure that the processes implemented are not causing delays in referral. Major's triage reorganised to ensure triage rates as a whole for site achieve the 15 mins standard. Five out of seven days saw over 85% of majors triaged within 15 minutes. Agreement on site of speciality review within 30 mins implemented. **Grantham**: Daily Senior Reviews by Consultants on the wards were supplemented by the operational teams (matrons & business teams) working closely with the wards to pick up and action any delays. This has been done informally during January and from 20th February 2017 this will be formalised via the Red2Green Programme. Additional medical support continues in place with further additional medical staff added to the weekends. The Ambulatory Care Unit moved from its location in ED to Alex Ward on 17th January 2017 and is now taking all GP stream patients direct as well as pulling from the ED. The 8 CDU/short-stay beds on Alex Ward opened on 23rd January with additional Consultant Acute Physician cover. This area is increasing discharges for short-stay acute patients. The Acute Medicine Physicians have increased their presence in ED in order to provide early review of wardable patients first thing in the morning. The discharge lounge has been putting through up to 90-100 patients per week which has supported flow on site and is a large step-change increase from previous usage. Daily ward round feedback meetings have continued to ensure a focussed push on both discharge planning and identification of appropriate outliers. The pressures on site during January were extreme and well over and above any previously anticipated levels with all areas reporting high numbers of frail, sick patients. NEWS score across very many wards were much higher than average. Safety during this period was paramount and careful attention continues to be paid to ensure all patients are being reviewed despite not always being in their optimal location.
What is the recovery date?	
Who is responsible for the action? (Provide the role and name of the lead)	Andrew Prydderch – Deputy Director of Operations, Emergency Care John Boulton – Interim Head of Nursing, Grantham Hospital

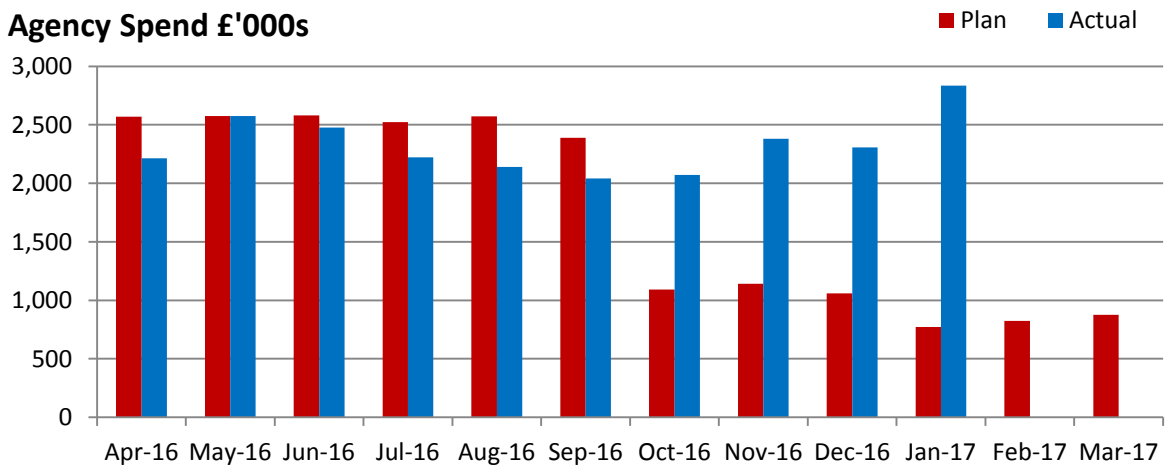
4. "Priority deliverables" – Money & Resources

KPI:	Capital	Owner:	Director of Finance
Domain:	Responsive	Responsible Officer:	Deputy Director of Finance
Date:	28th February 2017	Reporting Period:	January 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	Underperformance across a couple of schemes. Neonates and Specialist Rehabs schemes will be phased later in the year while the Trust undertakes value for money tests.
Forward Trajectory	Forecast is still to deliver the reduced Capital Resource Limit for the year, which is £15.0m
Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	Projects have slipped due to positive actions taken to delay expenditure to ensure value for money. Plan will be delivered this year as actions are in place to spend against the slipped schemes.
What is the recovery date?	
Who is responsible for the action?	Chris Farrah, Ass Director of Estates and Capital Plans

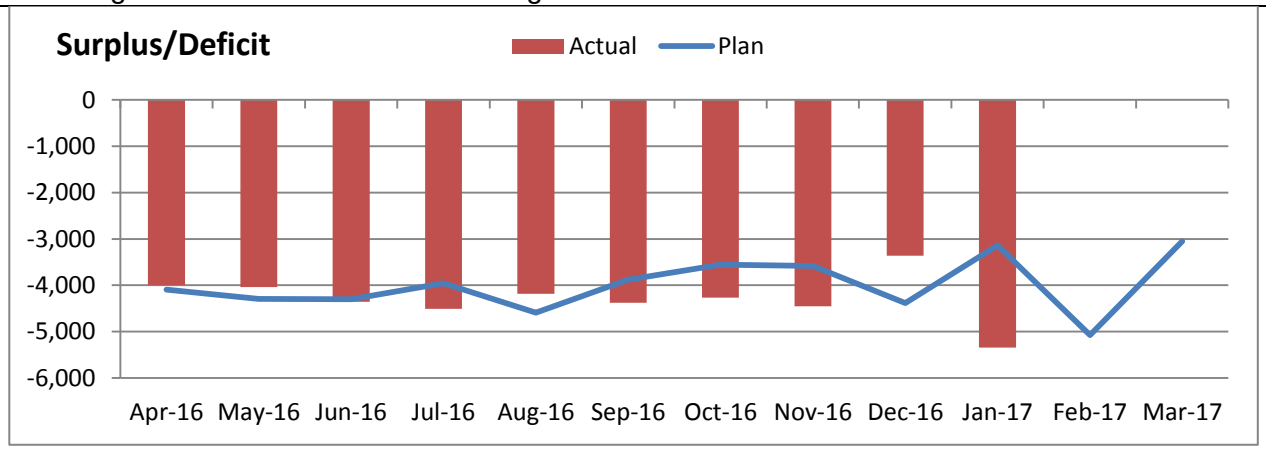
4. "Priority deliverables" – Money & Resources

KPI:	Agency Spend	Owner:	Director of Finance
Domain:	Responsive	Responsible Officer:	Deputy Director of Finance
Date:	28th February 2017	Reporting Period:	January 2017

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	The agency expenditure is above budget levels year to date. The original budget planned for a reduction in agency use from September onwards. However, the Trust still has a high level of reliance on agency expenditure. The forecast is for agency expenditure to be approx. £25m.
Forward Trajectory	The forecast is for agency expenditure to be approx. £25m, which is higher than the annual target of £21m but lower than last year's expenditure which was in excess of £30m.
Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	Medical and nursing workforce groups, led by Executives, are working through the ideas to reduce the reliance on agency.
What is the recovery date?	
Who is responsible for the action? (Provide the role and name of the lead)	Chief Operating Office and Head of Nursing

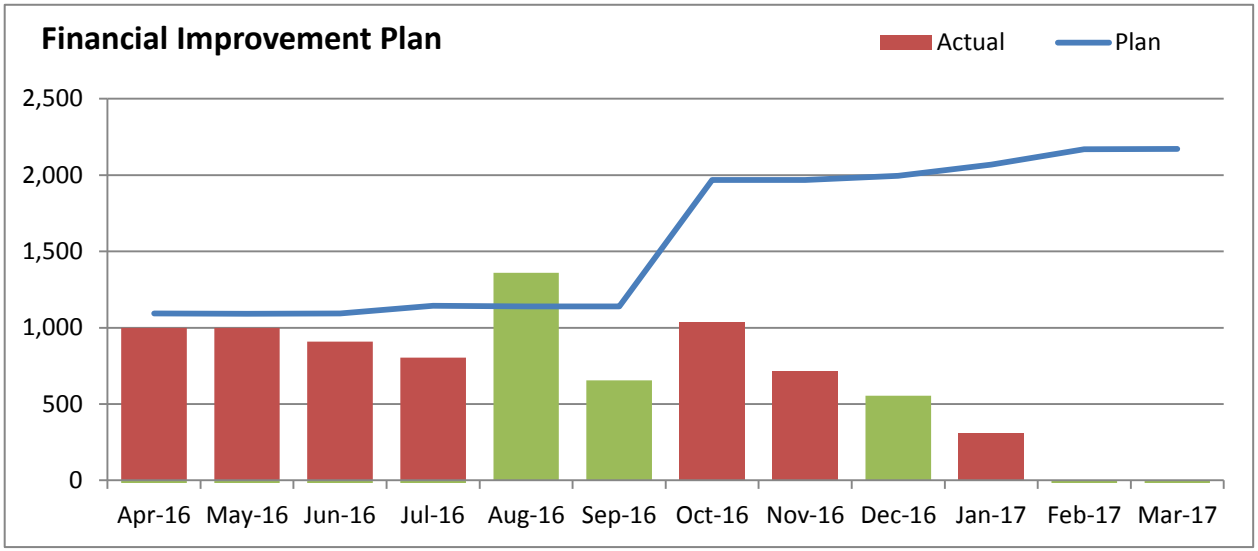
4. "Priority deliverables" – Money & Resources

KPI:	Surplus/Deficit	Owner:	Director of Finance
Domain:	Money & finances	Responsible Officer:	Director of Finance
Date:	28th February 2017	Reporting Period:	January 2017

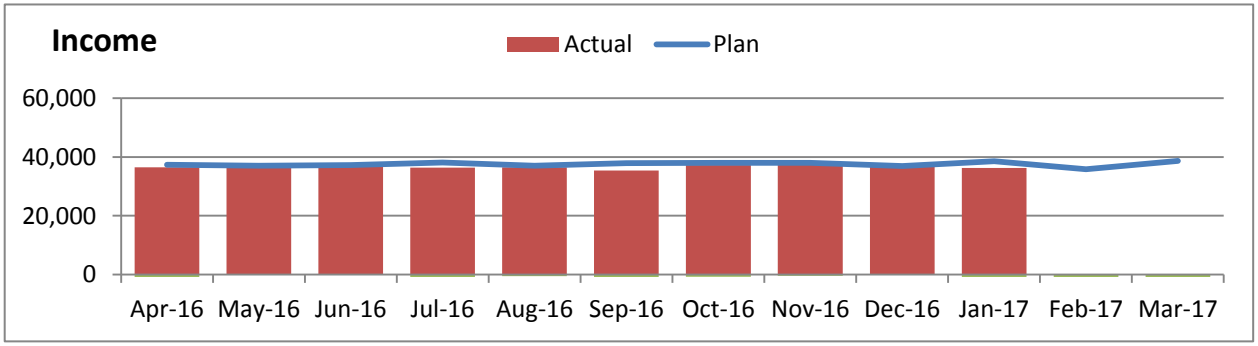
Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	As at the end of January (Month 10) the Trust financial performance is £3.1m behind plan at £42.9m deficit. The adverse variance is driven by income performance to date, with recognition that the Trust is failing on finance and the other performance measures so will not receive the Sustainability and Transformation Funding for the first 10 months of £2.8m. £0.9m of this is due to the financial performance being £0.4m worse than plan, and £1.9m is due to missing performance targets.
Forward Trajectory	Forecast is to deliver the budget deficit of £47.9m; with a reduction of £2.1m in the STF funding that relates to underperformance against the entire target being offset by additional efficiency/underspends across the Trust and receiving £1.0m or STF incentive funding.
Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	Income and activity delivery paper being discussed at Executive Team and activity performance to be challenged at Business Unit performance meetings
What is the recovery date?	

Who is responsible for the action? (Provide the role and name of the lead)	All Clinical Directors

KPI:	**Financial Improvement Programmes**	**Owner:**	Director of Finance
Domain:	**Money & finances**	**Responsible Officer:**	Director of Finance
Date:	**28th February 2017**	**Reporting Period:**	January 2017

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	As at the end of January (Month 10) the month efficiency is reported as £1.8m against a plan of £2.0m. The plan has assumed a significant ramp up in efficiencies that has not materialised as yet.
Forward Trajectory	Yearend forecast is efficiencies of £19m in line with plan, however a number of these will be non-recurrent or pure underspends against budget. The forecast underperformance of recurrent efficiency ideas is approx. £6m and this will be added to the efficiency target for 2017/18.
Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	Efficiencies are managed through performance meetings and through regular reviews with business units to ensure milestones are met.
What is the recovery date?	
Who is responsible for the action? (Provide the role and name of the lead)	All Clinical Directors

KPI:	**Income**	**Owner:**	Director of Finance
Domain:	**Money & finances**	**Responsible Officer:**	Director of Finance
Date:	28th February 2017	**Reporting Period:**	January 2017

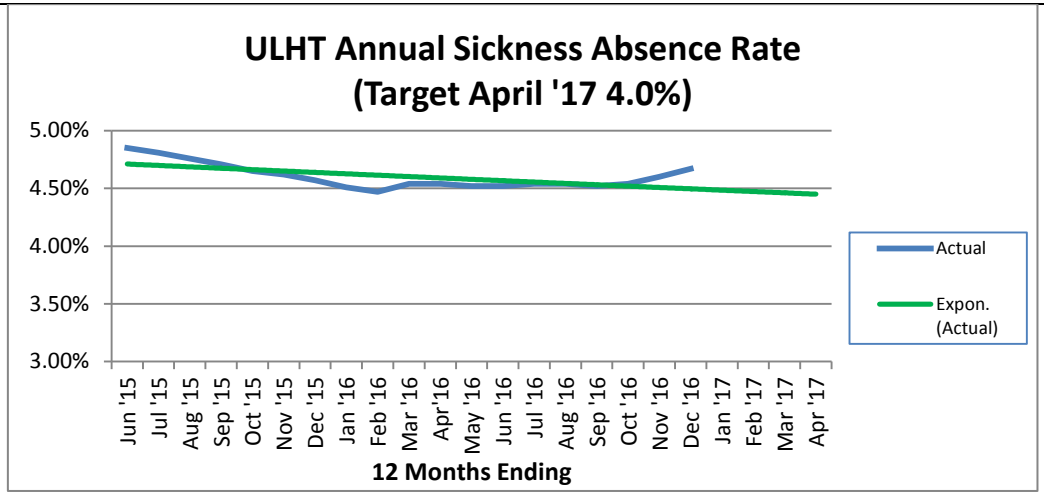
Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	As at the end of January (Month 10) the Trust income is £8.0m behind plan. The adverse variance is driven by a significant deterioration in inpatient activity, particularly in Trauma & Orthopaedics, together with a non-delivery of income related efficiency schemes.
Forward Trajectory	Forecast is to deliver the budget deficit of £47.9m, with a reduction of £3.1m in the STF funding that relates to underperformance against the performance target being offset by additional efficiency/underspends across the Trust and obtaining STF Incentive funds.
Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	Income and activity performance to be challenged at Business Unit performance meetings. NHSI checklist being reviewed to ascertain what steps can be taken to control costs.
What is the recovery date?	
Who is responsible for the action? (Provide the role and name of the lead)	All Clinical Directors

4. Exception Report: Well-led

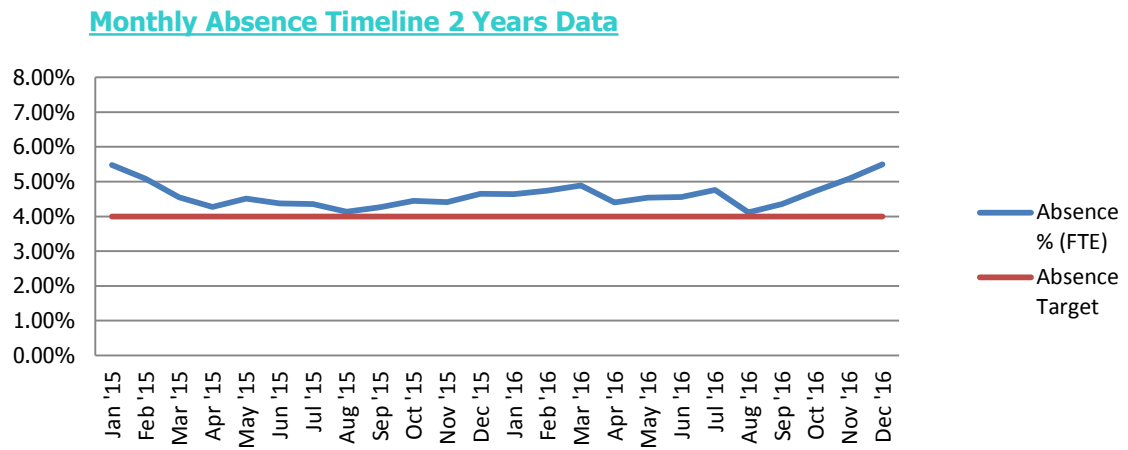
KPI:	**Sickness Absence**	**Owner:**	Director of Human Resources
Domain:	**Well-led**	**Responsible Officer:**	Assistant Director of Human Resources
Date:	28th February 2017	**Reporting Period:**	January 2016

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 4.67% as at December 2016 has increased by 0.10% in comparison to the November 2015 figure (4.57%). Monthly sickness rate for December 2016 is 5.50%. Sickness absence data is reported two months in 'arrears'. Based on 'trend' analysis we've historically seen an increase in sickness absence over the period October to January, with a 'drop' in sickness absence during the Summer months each year. The annual cost of sickness (excluding any backfill costs) has increased by £212,706 (from £8,569,743 as at Dec '15 to £8,782,450) compared to 12 months ago. During the 12 months ending December '16, Anxiety/Stress/Depression and other Psychological illness was the top reason for time lost due to sickness at 19.96% of all absence. Additional Clinical Services had the highest sickness rate during the 12 months at 7.06% (Unregistered Nurses 7.59%) followed by Estates & Ancillary at 6.41% 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 – 4.90% LPFT – 4.86%

Forward Trajectory



Directorate	Sickness Rate (Rolling 12 Months)
Bostonian	5.02%
Chief Executive	5.15%
Chief Operating Officer	6.24%
Clinical Support Services	4.15%
Diagnostics	*4.11%*
Therapies	*3.97%*
Director of Estates & Facilities	5.70%
Director of Finance & Corporate Affairs	2.86%
Director of HR & Organisational Development	2.68%
Director of Nursing	5.23%
Director of Performance Improvement	3.35%
Grantham	5.04%
Integrated Medicine Boston	6.02%
Integrated Medicine Lincoln	4.85%
Medical Director	3.34%
Surgical Services Boston	4.08%

		Surgical Services Lincoln	4.21%	
		TACC Boston	5.24%	
		TACC Lincoln	4.15%	
		Women & Children's Pan Trust	4.69%	
Variance Analysis (SPC Chart)				
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. • There is a focus on building resilience in the organisation, through the new management development programme (creating resilient workplaces), mindfulness and mental health first aid • Workforce Scorecard comparative data will go out to Directors/Clinical Directors from February onwards, which shows compliance against key workforce indicators • The HR Team continue to support managers to ensure they take action to manage sickness according to policy.			
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 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 February	Reporting Period:	January 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 (January) is 10.48%, which is a decrease of 0.20% on December. Previous month's performance was:

January 2016	7.09%
February 2016	7.04%
March 2016	6.23%
April 2016	6.79%
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%

Vacancies have increased by 3.39% over the last 12 months (7.09% to 10.48%)

14.23% of medical roles are vacant. There has been an increase of 3.61 FTE Medical Staff in post over past 12 months.

13.01% of all Registered Nursing & Midwifery roles are vacant. The number of band 5 nurses in post has increased over the last 12 months by 13.14 FTES to 1101.20 FTEs.

Unregistered Nursing vacancies are at 14.59% down from 14.81% in December and 16.54% in November.

Forward Trajectory	Although we have seen a slight 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)	

Directorate	Rolling 12 Month %age Turnover rate	Funded Establishment (FTE)	%age of Establishment Filled	%age of Funded Establishment Vacant
Bostonian	3.05%	46.11	91.93%	8.07%
Chief Executive	14.81%	14.51	106.89%	-6.89%
Chief Operating Officer	9.86%	74.75	96.84%	3.16%
Clinical Support Services	13.98%	1169.71	91.44%	8.56%
Diagnostics	*12.25%*	*687.96*	*91.58%*	*8.42%*
Therapies	*19.61%*	*298.95*	*92.62%*	*7.38%*
Director of Estates & Facilities	8.91%	518.29	92.41%	7.59%
Director of Finance & Corporate Affairs	10.95%	114.00	89.28%	10.72%
Director of HR & Organisational Development	15.68%	63.45	99.62%	0.38%
Director of Nursing	12.66%	129.66	58.88%	41.12%
Director of Performance Improvement	8.20%	105.87	110.79%	-10.79%
Grantham	10.75%	486.05	85.91%	14.09%
Integrated Medicine Boston	9.17%	633.77	82.93%	17.07%
Integrated Medicine Lincoln	8.84%	1222.47	87.20%	12.80%
Medical Director	6.47%	125.26	98.37%	1.63%
Surgical Services Boston	8.44%	462.45	87.00%	13.00%
Surgical Services Lincoln	6.28%	616.11	91.31%	8.69%
TACC Boston	4.86%	293.83	91.60%	8.40%
TACC Lincoln	8.19%	396.30	91.31%	8.69%
Women & Children's Pan Trust	9.21%	774.58	93.25%	6.75%

The Director of Nursing figures stand out and reflect the challenges regarding the ratios of agency to permanent staff. We must collectively get greater momentum on our work on nursing recruitment and retention in order to reduce costs and improve safety

What action is being taken to recover performance?	• As part of the Workforce Planning exercise the Deputy Director of Nursing (Workforce Lead) will be identifying recruitment initiatives to include in the Recruitment Plan for 2017/18 • The Medical Recruitment Workshop is re-scheduled for early March. • 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) will be shared with Clinical Directors and Corporate Directors from February, which will highlight 'risk' areas and enable 'ownership' of recruitment at BU/Directorate level. • An HR Recruitment Improvement Plan has been identified with key actions to improve/enhance our internal processes
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: 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 February 2017	Reporting Period:	January 2017

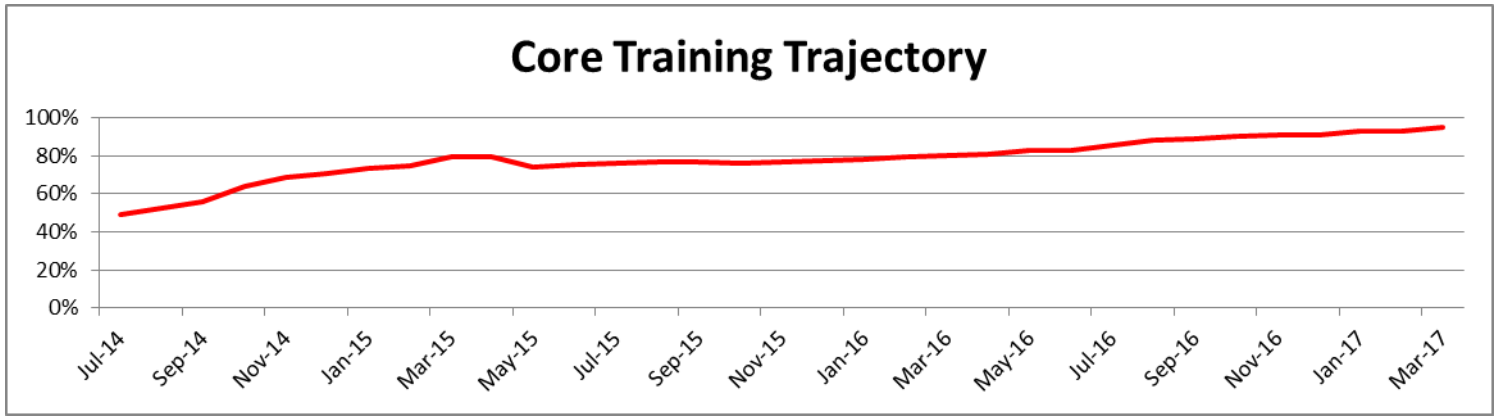
Exception Details
(provide an overview explanation / cause of the variance to performance and the consequences)

The Trust has a target of having 95% for Core Learning. This month compliance remains at 87%. 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:
January 2015 – 73%
January 2016 – 78%

Feb-16	*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%*

- From October 2016 BLS compliance has been included in overall compliance following the 6 month introduction period. Compliance for BLS has increased by 1% this month to 71% 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 dropped by 1%.

	However all core topics, apart from the newly introduced BLS, are now 80% or above for the first time. And all 3 annual topics are between 10%-15% higher than this time last year. • The DNA 'No Show' rate increases to 28% this month.
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. 
Variance Analysis (SPC Chart)	

Trust	Fire	IPC	E&D	IG	SGC1	SGA1	H&S	Slips	M&H IL	Risk	Fraud	BLS	*Average*
Nov-16	77%	79%	97%	82%	91%	91%	91%	93%	91%	89%	91%	66%	*86%*
Dec-16	79%	81%	97%	83%	91%	90%	90%	92%	91%	89%	92%	70%	*87%*
*Jan-17	80%	81%	97%	82%	91%	90%	90%	92%	91%	89%	92%	71%	*87%*
**Jan-17	75%	80%	91%	80%	83%	82%	87%	88%	85%	87%	89%	65%	*83%*

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

What action is being taken to recover performance?	• The new Fire e-learning package was introduced on 1st November 2016 to help fire compliance. This can be used every alternate year, alternating with classroom to maintain annual compliance. • Classroom dates for April 2017 are now available. • Continued encouragement and support provided to managers to use the pre-prepared '5 Click' Core Learning. This is helping to simplify and improve compliance monitoring especially in areas with large numbers of staff. • 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.

	• We are currently exploring a common approach to Core Learning across the 3 Trusts (LCHS, LPFT and ULHT) to aid 'transferable' learning/compliance.
What is the recovery date?	Without further action, we are unlikely to 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

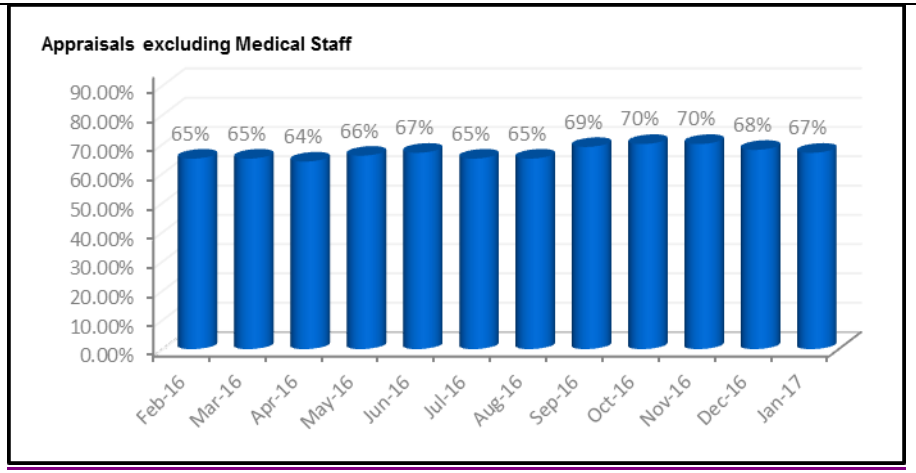
4. Exception Report: Safe

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 February 2017	Reporting Period:	January 2016

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 January is 67.20%. *Appraisal Compliance rate (Year-on-Year) comparison:* January 2016 - 67% January 2015 - 72% The overall percentage for appraisals has reduced by 0.38% from the previous month. 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% X7 Directorates have a compliance rate between 50% and 65% The remaining x10 Directorates have a compliance rate between 65% and 80.34% Further analysis of non-compliance (13%) has identified the following: • 396 staff has no appraisal date recorded and as such we are not able to determine whether they have had any appraisal since joining the Trust prior to 2016. • 1592 staff has no appraisal data recorded either via ESR SSS or 'On-Line' Reporting system and as such we are also not able to establish whether they have had any appraisal completed prior to 1st January 2016. Appraisal rates reduced at Lincoln (-1.18%) and Louth (-3.94%) and increased at Grantham (+0.55%) and Pilgrim (+0.66%) 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	47.83%
Bostonian	54.35%
Integrated Medicine Boston	54.78%
Director of Nursing	56.25%
Chief Operating Officer	58.57%
Medical Director	59.62%
Director of HR & Organisational Development	62.30%
TACC Lincoln	63.76%
Director of Estates & Facilities	65.14%
Surgical Services Boston	65.37%
Integrated Medicine Lincoln	66.91%
Director of Performance Improvement	69.37%
CSS Diagnostics	*69.76%*
Clinical Support Services	70.05%
Women & Children's Pan Trust	70.22%
Surgical Services Lincoln	70.46%
CSS Therapies	*74.90%*
Grantham	76.61%
Chief Executive	80.00%
TACC Boston	80.34%

	 **Appraisals (excluding Medical Staff)**
What action is being taken to recover performance?	• We will, as part of the People Strategy, review our approach to performance management and within that the annual appraisal, understanding as part of that review, why we achieve relatively low levels of compliance incl. when appraisals take place, process and reporting. • Workforce Scorecard comparative data will go out to Directors/Clinical Directors from February onwards, which shows compliance against key workforce indicators • The Pay Progression Policy was launched on 1.10.16. Non-compliance with appraisals may act as a bar to incremental pay progression.
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?	Line managers/Clinical Directors (Medical Revalidation)

4. Exception Report: Safe

KPI:	Staff Turnover	Owner:	Director of HR
Domain:	Safe	Responsible Officer:	Elaine Stasiak, Workforce Intelligence
Date:	28th February 2017	Reporting Period:	January 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 January is 9.59%, which is an increase of 0.11% on December. Previous months performance was:

April	10.06%
May	9.81%
June	9.78%
July	10.02%
August	9.76%
September	9.45%
October	9.80%
November	9.81%
December	9.48%

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 31st Jan '17 is 7.21%

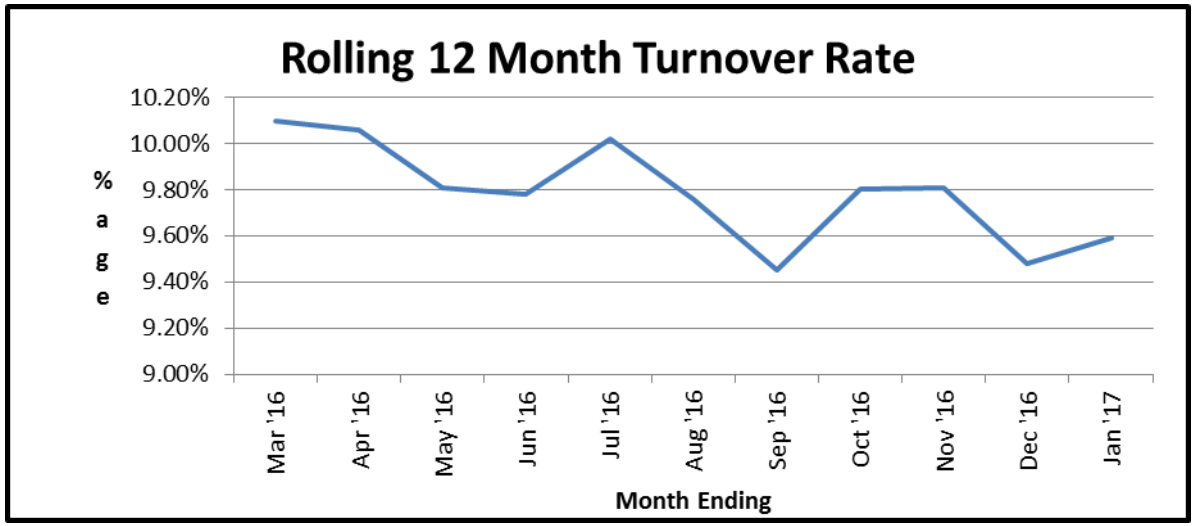
We've had 32.53 leavers during January. Of the leavers 9.25% was due to retirement and 79.40% was due to voluntary resignations.

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

Nursing and Midwifery turnover rate has decreased in month to 8.50% (down from 9.06%). Medical and Dental Staff turnover rate has decreased in month to 15.02% (down from 15.33%).

Based on the latest (November 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 9.59% is below the average of 10.39%
- The current Trust Nursing & Midwifery (Registered) turnover rate of 8.50% is below the average of 11.09%,
- Other Non-Medical Clinical Services (usually unregistered) 12.31% is below the average of 14.11%.

	• AHP's 12.58% is below the average of 12.70%. 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 31.01.17	SIP as at 1.02.16	SIP as at 31.01.17	Average SIP	Leavers 1.02.16 - 31.01.17	Turnover SIP	Turnover Leavers against establishment
Nursing & Midwifery	2266.80	1947.88	1971.96	1959.92	166.56	8.50%	7.35%
Medical (excluding juniors)	554.73	467.89	477.09	472.49	70.99	15.02%	12.80%

Leavers by Month February 16 – January 17

Directorate	Rolling 12 Month %age Turnover rate
Bostonian	3.05%
Chief Executive	14.81%
Chief Operating Officer	9.86%
Clinical Support Services	13.98%
Diagnostics	*12.25%*
Therapies	*19.61%*
Director of Estates & Facilities	8.91%
Director of Finance & Corporate Affairs	10.95%
Director of HR & Organisational Development	15.68%
Director of Nursing	12.66%
Director of Performance Improvement	8.20%
Grantham	10.75%
Integrated Medicine Boston	9.17%
Integrated Medicine Lincoln	8.84%
Medical Director	6.47%
Surgical Services Boston	8.44%
Surgical Services Lincoln	6.28%
TACC Boston	4.86%
TACC Lincoln	8.19%
Women & Children's Pan Trust	9.21%

What action is being taken to recover performance?

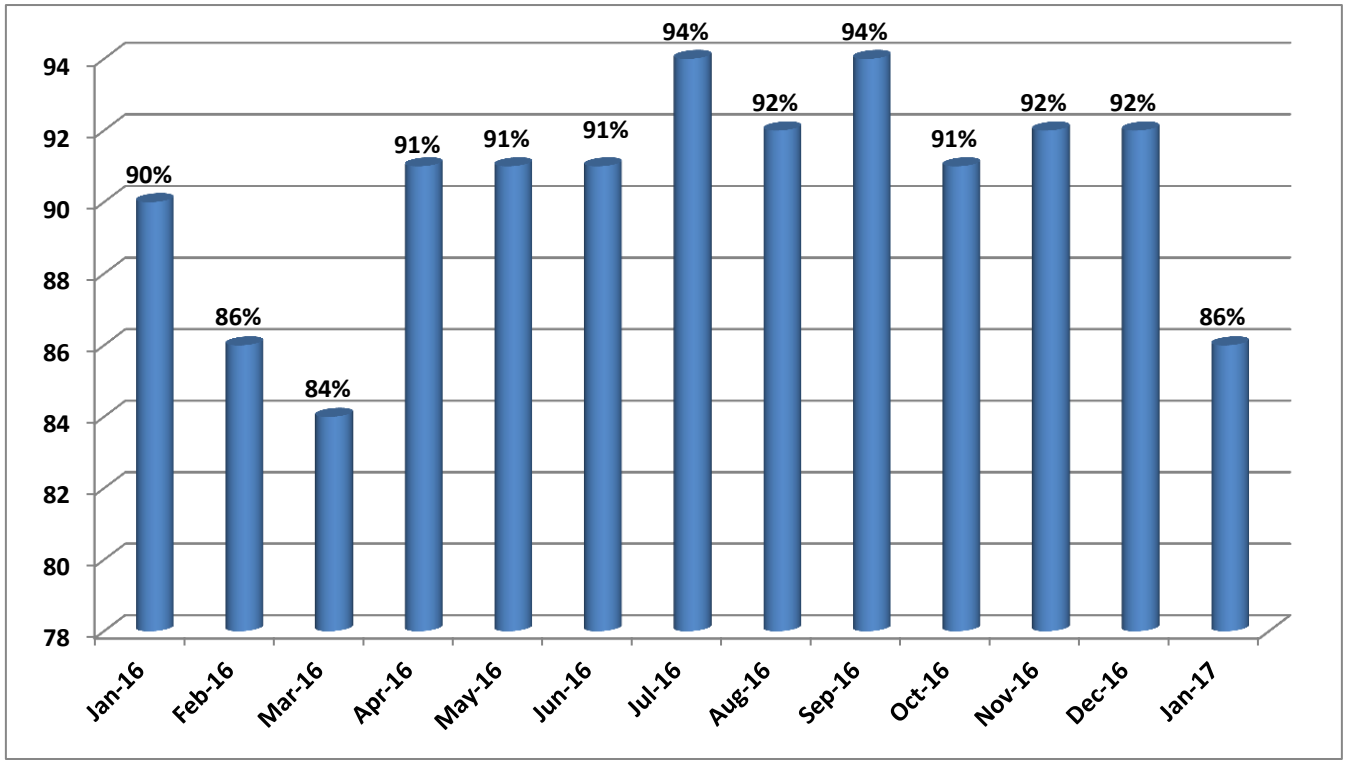
- A reviewed and revised exit process will be in place from February 2017
- The current potential retirement profile has been compared against a 'predicted' retirement in 2021 as part of the Workforce Planning process and actions will be identified as part of People Strategy to target this area.
- Workforce Scorecard comparative data will go out to Directors/Clinical Directors from February onwards, which shows compliance against key workforce indicators
- More flexible 'retirement' options will also be explored as part of the overall People Strategy
- 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.

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?	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: Safe

KPI:	Medical Staff Engagement (Medical Appraisals)	Owner:	Dr Kapadia - Medical Director
Domain:	Appraisals	Responsible Officer:	Sue Powley - Head of Medical Revalidation
Date:	28th February 2017	Reporting Period:	January 2017

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	Medical Staff (All Consultants and SAS Doctors including Locums) appraisal compliance rate for month ending January 2017 is 86%. The Target is 95%. High turnover of doctors, in particular short term locums, continues to present a challenge as a low % of new starters have previously been appraised. The current appraisal rate is 5% lower than the end of January 2016 position and 6% lower than the December 2016 figure. There has been an increase in the number of doctors failing to have an appraisal within their designated appraisal month despite efforts by the Revalidation Office. 174 (32%) of the 540 doctors currently employed by the Trust are scheduled to have their appraisals before end of March 2017. To date 67 are at various stages of completion including documentation complete awaiting appraisal meeting or awaiting final sign-off. 16 do not have an agreed date for their appraisal meeting. These doctors are now being managed in accordance with the Trust Medical Appraisal escalation process. In an attempt to improve communication with doctors who fail to respond to email requests and letters to make contact with the Revalidation Office, it has been necessary to use mobile and telephone contact to establish the position with appraisal arrangements. Five doctors submitted requests in January to postpone their appraisals citing department workload and appraiser unavailability as the main reasons. The appraisal rate for locum doctors employed to cover gaps in junior doctor rotas is 57%. This figure excludes 22 doctors in this category with less than 3 months service who have not worked in the UK previously. Doctors in this group are encouraged to engage in medical appraisal during their short term contract period which ranges from one month to 12 months. The 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.

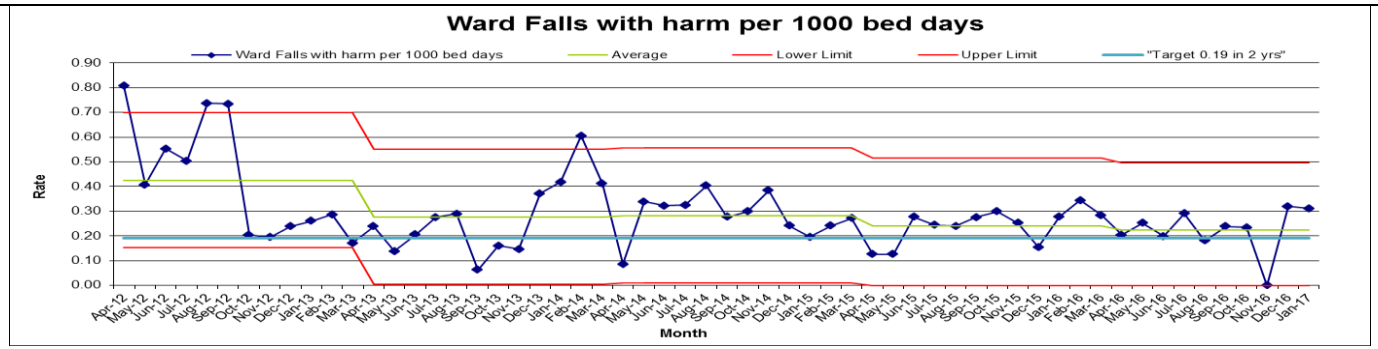
	The Revalidation Team focus currently is to ensure there is a plan in place for every doctor whose appraisal is due to take place before the end of March 2017.
Forward Trajectory	
Variance Analysis	**MEDICAL APPRAISAL PERFORMANCE – JANUARY 2017** 
What action is being taken to recover performance?	• 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.

	• 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?	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.

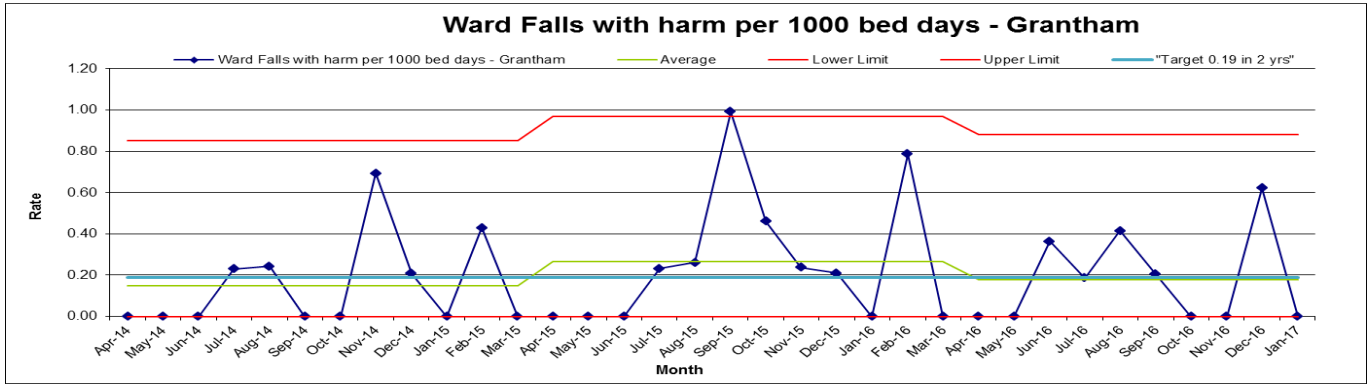
4. Exception Report: Safe

KPI:	**Falls**	**Owner:**	Medical Director
Domain:	**Safe**	**Responsible Officer:**	Deputy Chief Nurse
Date:	28th February 2017	**Reporting Period:**	January 2016

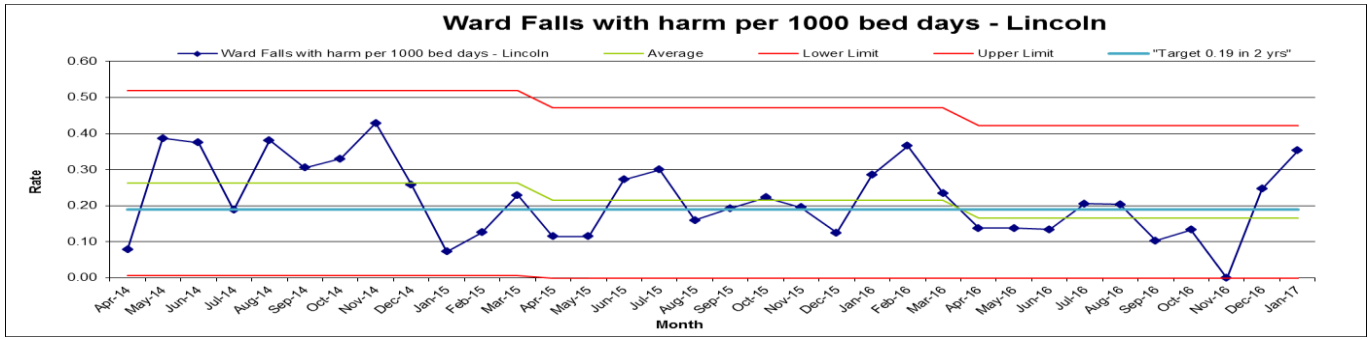
Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	Year to date, the rate of all harms across the Trust is 3.22 per 1000OBD compared to 3.32 for the last fiscal year which is an improvement. However, the rate of falls with harm has remained fairly static at 0.25 per 1000OBD compared to 0.24 for the previous fiscal year. Whilst Lincoln County and Grantham District Hospital are reporting reductions in the rate of all falls and those falls with harm; Pilgrim Hospital is reporting an increase in both falls and those with harm leading to a static overall Trust position for falls with harm. However, month on month improvement has been noted since September 2016 where the falls with harm rate was 0.45 and in January a rate of 0.34 was reported Of note is that falls during December and January have increased which is pattern observed annually as sites face increasing operational pressure To address this variance, Pilgrim Hospital has commenced a 90 day quality improvement project as part of the NHSi's programme on falls prevention. Two wards that are part of that project are Ward 3b (trauma and orthopaedics) and Ward 6b (male older adults). The Trust has also registered for the National Audit of Inpatient Falls which will provide more up to date benchmarking with other acute providers
Forward Trajectory	Target is to reach 0.19 per 1000 OBD for falls with harm
Variance Analysis (SPC Chart)	Overall Trust Position for falls with Harm (SPC)



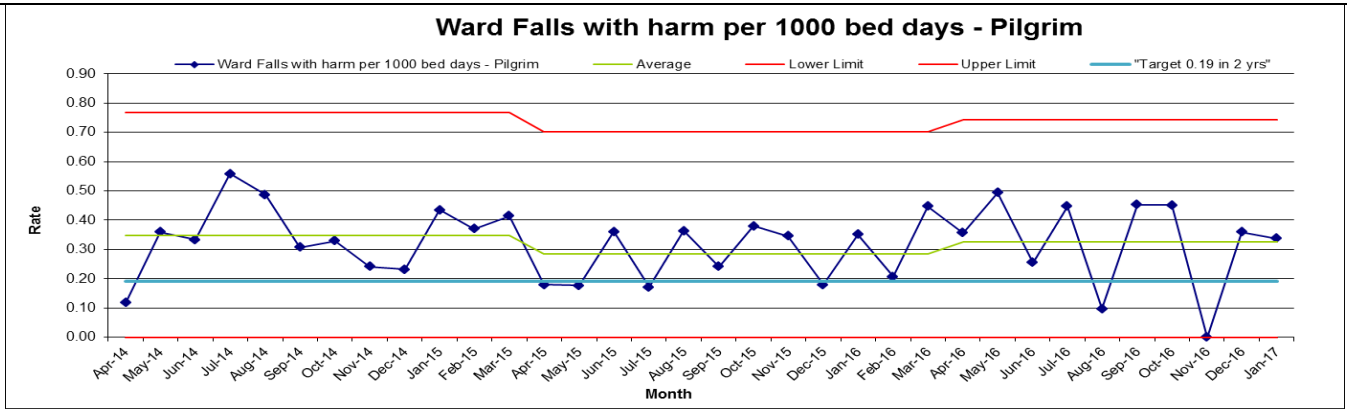
Grantham SPC for Falls with Harm



Lincoln SPC for Falls with Harm



Pilgrim SPC for Falls with Harm

	
What action is being taken to recover performance?	• An improvement plan for Pilgrim has been developed • NHSi falls collaborative in progress for Pilgrim Hospital • Multi-professional scrutiny panels are in place for all falls resulting in death or severe harm and has been extended to moderate harm for hot spot areas • Lying and standing blood pressure video being edited prior to release • Falls Competency Booklet being piloted • Falls Newsletter
What is the recovery date?	Progress is being monitored through the Falls Group
Who is responsible for the action? (Provide the role and name of the lead)	Penny Snowden, Deputy Director of Nursing

KPI:	**Infection Prevention and Control**	**Owner:**	Michelle Rhodes
Domain:	**Safe**	**Responsible Officer:**	Penny Snowden
Date:	28th February 2017	**Reporting Period:**	January 2017

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	Six cases of clostridium difficile were detected in January and the RCA's reported that there were lapses in care in each of those cases. Themes included isolation of patient was not in a timely manner, missed doses of treatment, lack of side rooms, and incomplete documentation. The detail of this is presented to the Trust IPCC and to QGC through the upward report. There were 2 cases of MRSA bacteraemia and the PIR reported that: processes required improvement for reviewing medical patients when outlied to another area, potential transmission of MRSA to other susceptible patients- importance of hand hygiene and general cleanliness of ward, need to continue with implementation of project on improving antimicrobial prescribing standards. Importance of pharmacy clinical checking of prescriptions for appropriateness / highlighting risks and prescriber awareness of need to document decisions. Invasive lines documentation required improvement and possible weekly screening for MRSA for high risk patients. Second case -no wound swab taken on admission or throughout the admission, poor documentation both nursing and medical. Large gaps noted in documentation, no dates and times put against some entries, unsure of who has documented some entries due to poor hand writing unclear signatures. Medical plan not always documented or clear plan in place. Medications omitted prior to surgery, even though documentation on prescription chart states not given as patient nil by mouth and there is a clear protocol in place for administration of medication pre operatively. Inappropriate antibiotics initially given. Consideration of previous MRSA was not taken into account.
Forward Trajectory	
Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	Learning outcomes shared at site meetings on all sites, IPCC, QGC and doctors grand round meetings.
What is the recovery date?	Progress monitored monthly through the IPC committee.
Who is responsible for the action? (Provide the role and name of the lead)	Michelle Rhodes, Director of Nursing/ Director of Infection Prevention and Control Penny Snowden Deputy Chief Nurse/ Deputy Director of Infection Prevention and Control

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%		
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%		
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%			
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%		
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		
Financial Surplus / Deficit £'000s	Plan			-4093	-4294	-4299	-3957	-4594	-3881	-3557	-3580	-4381	-3142	-5073	-3052
	Actual		↓	-3995	-4040	-4358	-4506	-4186	-4379	-4263	-4453	-3362	-5346		

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%		
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%		
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%		
	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%		
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%		
	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%		
	Radiotherapy*	94%			90.70%	80.40%	90.90%	95.00%	95.80%	97.80%	91.20%	91.20%	100.00%	97.10%		
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%		
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%		
	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%		
14	Meeting the C.difficile objective (cumulative)	62%	Quarterly	1	2	5	5	0	3	6	4	5	3	6		
15	meeting the MRSA objective (cumulative)	0%	Quarterly	1	0	0	0	0	0	0	0	0	0	2		
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		
				Risk rating	4	5	5	5	5	5	5	4	4	5		

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