AGENDA ITEM 10.1.1

United Lincolnshire Hospitals NHS
NHS Trust

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UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 31 OCTOBER 2016

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: 29th November 2016

Purpose of the Report:

To update the committee on the performance of the Trust for the period ended 31st October 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 October 2016

Contents:

1. Executive Summary for period of 31st October 2016

October headlines:

- ☒ 4 hour waiting time target – performance of 81.28% in October 2016
- ☒ 6 of the 9 national cancer targets were achieved in September 2016
- ☒ 18wk RTT Incomplete Standard – the current unvalidated performance for October 2016 is 87.74%
- ☒ 6wk Diagnostic Standard – October performance was 98.75%
- ☒ Agency Spend – Overspent in October
- ☒ Financial Improvement Plans below tolerances in October

Ongoing issues with validation not being completed in a timely fashion as well as technical problems with the files received have led to delays in getting the cancelled ops figures confirmed and signed off ahead of the Trust Board paper deadlines.
Weekly files are being sent and received for November, so this problem will not occur again next month.

Successes:
The Trust's performance is on a general upward trajectory with improved performance in A&E, diagnostics and 14 and 31 day cancer standard delivery. There is also a predicted improvement in RTT Incompletes from the September position. Finances also remain within tolerances.

Challenges:
While there is improvement in our delivery against core constitutional standards, these remain under STF trajectory and national access standard levels. In addition, there has been a deterioration in our 62 Day Cancer delivery and performance remains significantly under the STF trajectory. The service has however received substantial external non-recurrent funding to improve timely access to diagnostics which should be instrumental in reducing the patient pathway.

In RTT, the Trust is working on key actions to rapidly improve the position including a full review of patients on open referrals. The Neurology service is also planned to temporarily close to new referrals from 1st December 2016 to allow recovery in first and follow up backlogs.

In A&E, the Trust continues to highlight the challenges of the increased demand with commissioners. This has taken the form of a formal Activity Query Notice. To date, the Trust has not received any confirmation of the success of external community schemes and delayed transfers of care continue to cause issues in discharges.

Looking forward:
There is significant focus on our delivery against the 4 STF performance trajectories and supporting work-streams. The Trust will be submitting formal appeals and mitigations for performance in Quarter 2 against RTT and A&E.

Improvement in key standards is promising but continued improvement is challenged with workforce, increased demand and internal efficiency issues which could be amplified over the winter months.

John Barber
Interim Director of Finance & Corporate Affairs
November 2016

2. Integrated Performance Report
Integrated Performance Report - Headlines

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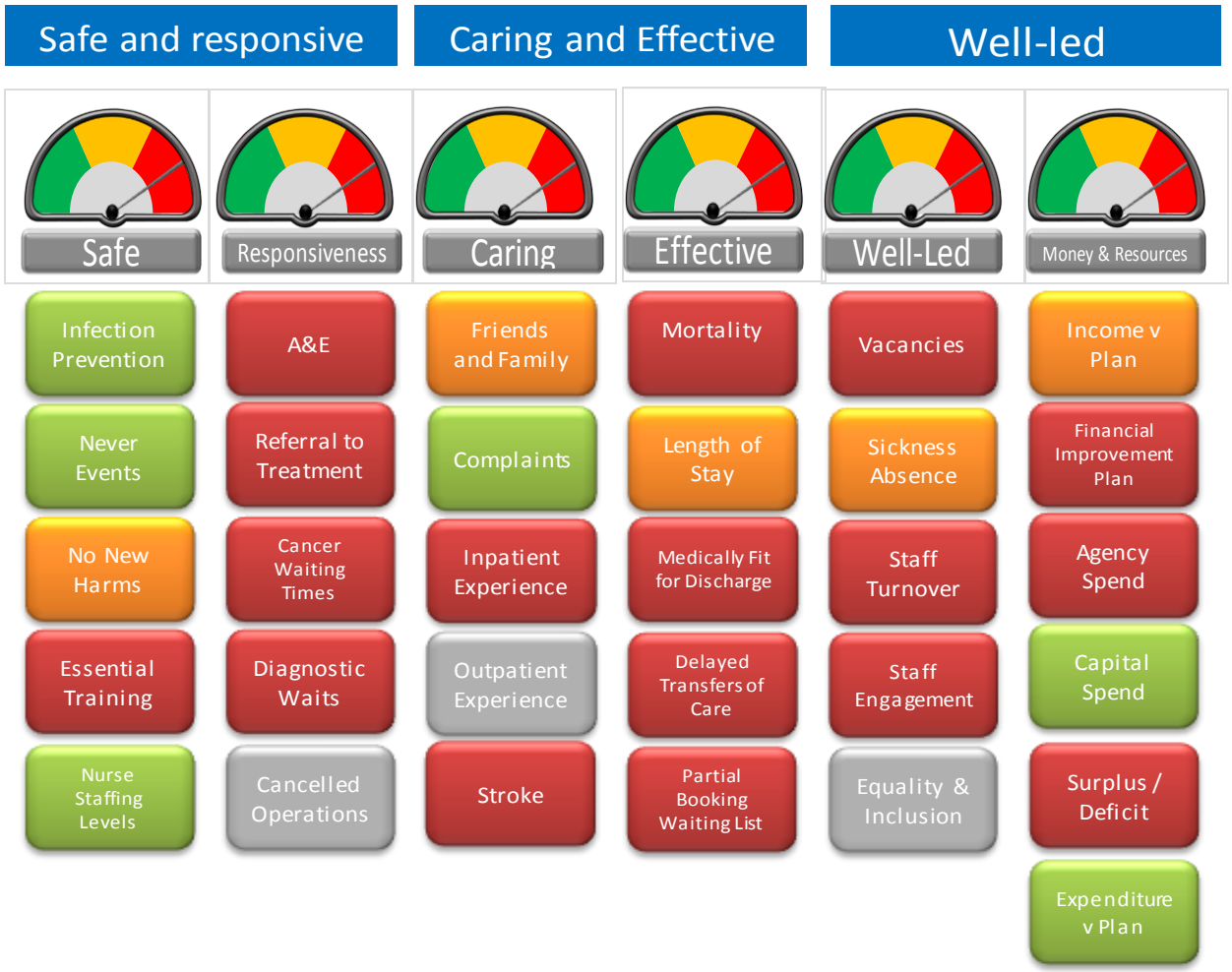
The dashboard shows the Trust's current performance against the chosen standards and indicators as a measure of overall Trust performance. The box to the right highlights key changes to performance during the period with priority actions. Further detail follows this summary at Business Unit and Speciality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



Monitor Risk Rating

5.0

CQC Compliance

Requires Improvement

A&E	RTT	Diagnostics
81.37%	88.77%	98.75%

62 Day	Deficit	Agency
71.9%	-4263k	+2073k

Most improved:

Domain: Money & Resources - Capital Spend (+532k above plan)

Domain: Effective – Cancer 14 day Breast Symptomatic (+62.5% against August) although this standard is not achieving national standard significant work has been undertaken to recover the positon.

Domain: Responsiveness – Cancer 31 Day Radiotherapy (+9.7% against August) this is the first time this standard has achieved since May 2016

Most deteriorated:

Domain: Responsiveness – Cancer 62 day (-2.1% compared August, -13.1% against national standard)

Domain: Money & Resources – Agency Spend

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

3. Trust Board Performance Dashboard

Integrated Performance Report - Detailed

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	Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Safe							
Infection Control							
Clostrum Difficile (post 3 days)	5	34	4	6			
MRSA bacteraemia (post 3 days)	0	0	0	0			
MSSA	2	13	1	2			
ECOLI	8	38	7	8			
Never Events	0	1	0	0			
No New Harms							
Serious Incidents reported (unvalidated)	TBC	27	5	2			
Harm Free Care %	95%	91.43%	91.25%	88.91%			
New Harm Free Care %	98%	97.09%	97.76%	96.77%			
Catheter & New UTIs	2.00	1	3	1			
Falls	3.9%	4.13%	4.01%	4.67%			
Medication errors	0	865	159	123			
Medication errors (mod, severe or death)	0	98	22	15			
Pressure Ulcers (PUNT) 3/4							
VTE Risk Assessment	95%	93.81%	96.95%	96.35%			
Overdue CAS alerts							
SQD %							
Essential training	85%	75.31%	63.98%	63.22%			
Nurse Staffing Levels							
Nurse to bed day ratio			2.04	1.93			

	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%	27.00%	28.00%	24.00%			
Inpatient (Recommend)	96%	88.00%	87.00%	86.00%			
A&E (Response Rate)	14%	21.00%	20.00%	23.00%			
A&E (Recommend)	87%	79.71%	82.00%	78.00%			
% of staff who would recommend care							
% of staff who would recommend work							
Complaints							
No of Complaints received	70	411	52	56			
No of Complaints still Open	0	2393	269	289			
No of Complaints ongoing	0	309	35	4			
Inpatient Experience							
Mixed Sex Accommodation	0	21	3	2			
eDD	95%	76.97%	76.93%	79.65%			
PPCI 90 hrs	100%	0.00%	97.33%	97.33%			
PPCI 150 hr	100%	0.00%	85.33%	85.33%			
#NOF 24	70%	60.70%	61.19%	59.70%			
#NOF 48 hrs	95%	92.35%	92.54%	91.04%			
Dementia Screening	90%	91.46%	96.46%	45.83%			
Dementia risk assessment	90%	83.47%	94.01%	96.08%			
Dementia referral for Specialist treatment	90%	45.69%	84.62%	66.67%			
Stroke							
Patients with 90% of stay in Stroke Unit	80%	85.58%	84.20%	79.40%			
Sallowing assessment < 4hrs	80%	71.84%	66.70%	71.40%			
Scanned < 1 hrs	50%	64.30%	61.30%	59.50%			
Scanned < 24 hrs	100%	96.18%	96.00%	98.80%			
Admitted to Stroke < 4 hrs	90%	69.26%	69.30%	65.50%			
Patient death in Stroke	17%	11.19%	8.80%	5.90%			
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	85.0%	80.05%	81.37%	78.40%			
12+ Trolley waits	0	0	0	0			
RTT							
52 Week Waiters	1						
18 week incompletes	92.4%	90.93%	88.77%	88.60%			
Cancer - Other Targets							
62 day classic	85%	72.53%	71.90%	74.00%			
2 week wait suspect	93%	87.31%	94.60%	81.10%			
2 week wait breast symptomatic	93%	67.18%	88.80%	26.30%			
31 day first treatment	96%	96.76%	98.00%	96.60%			
31 day subsequent drug treatments	98%	95.48%	98.40%	98.80%			
31 day subsequent surgery treatments	94%	91.96%	91.20%	97.80%			
31 day subsequent radiotherapy treatments	94%	89.26%	94.30%	84.60%			
62 day screening	90%	86.62%	92.90%	78.90%			
62 day consultant upgrade	85%	81.68%	90.50%	90.00%			
Diagnostic Waits							
diagnostics achieved	99.1%	98.85%	98.75%	98.42%			
diagnostics Failed	0.9%	1.15%	1.25%	1.58%			
Cancelled Operations							
Cancelled Operations on the day (non clinical)							
Not treated within 28 days. (Breach)							

	Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Effective							
Mortality							
SHMI	100	111.21		110.99			
Hospital-level Mortality Indicator	100	99.54		101.31			
Length of Stay							
Average LoS - Elective	2.8	2.85	2.58	2.74			
Average LoS - Non Elective	3.8	4.46	4.71	4.56			
Medically Fit for Discharge	60	893.29	931.00	731.00			
Delayed Transfers of Care	3.5%	4.65%	6.45%	3.61%			
Partial Booking Waiting List	0	4886	3727	4220			

	Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Well Led							
Vacancies	5.0%	10.06%	11.09%	10.54%			
Sickness Absence	4.0%	4.67%	4.38%	4.12%			
Staff Turnover	2.4%	2.20%	2.73%	2.73%			
Staff Engagement							
Staff Appraisals	95.0%	66.57%	70.00%	69.00%			
Equality and Inclusion							

	Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Money & Resources							
Income v Plan	38026	256269	37276	35446			
Expenditure v Plan	-40797	-273391	-40098	-35435			
Efficiency Plans	1968	8939	933	1796			
Surplus / Deficit	-3557	-29727	-4263	-4379			
Capital Program Spend	1281	7007	1813	520			
Agency Spend	1091	-15745	2073	2042			

4. "Priority deliverables" – RTT Incompletes

United Lincolnshire Hospitals NHS Trust

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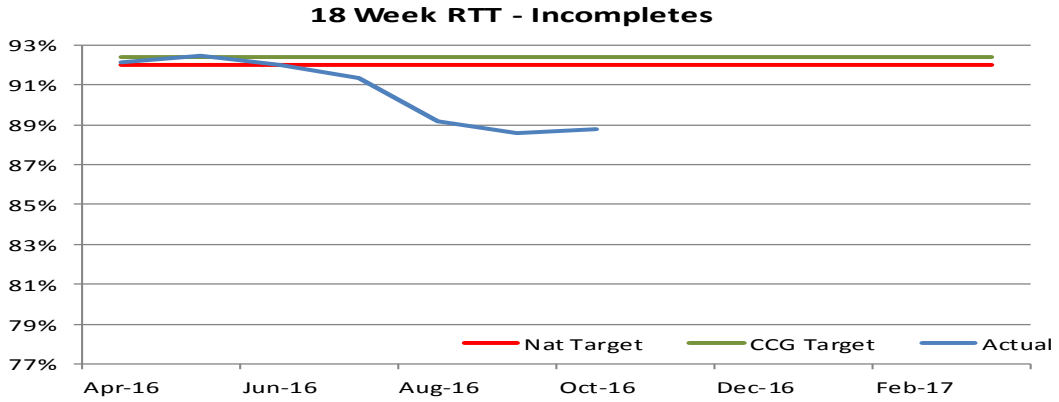
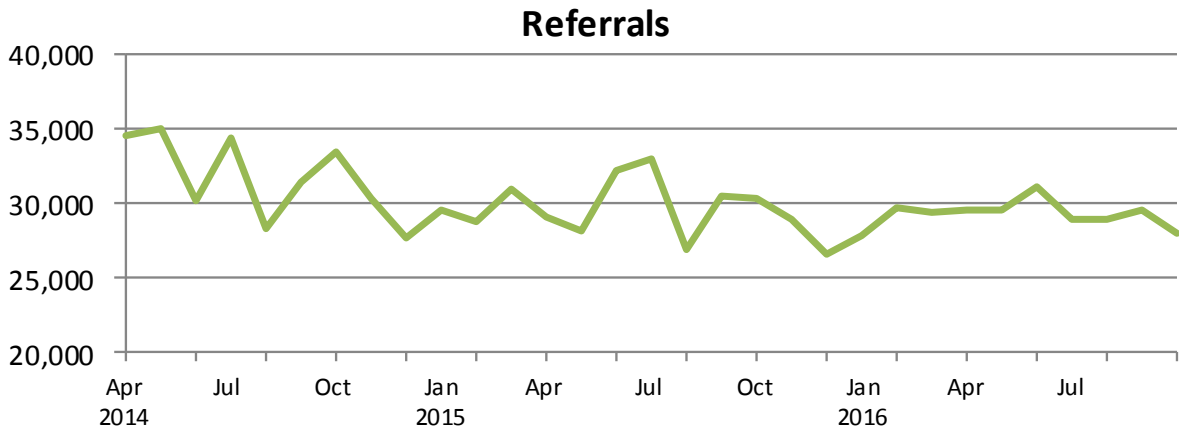
KPI:	**Referral to Treatment**	**Owner:**	Chief Operating Officer
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Operational Performance
Date:	**29th November 2016**	**Reporting Period:**	October 2016

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 3 months. In September the Trust reported performance of 88.77%. There are 3 significant factors which had an impact on performance across a range of specialities: • 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. 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.
Forward Trajectory	

	
Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	The following 8 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. 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. In October key specialities provided an extra 643 outpatient appointments and completed and additional 45 elective operations in order to assist the backlog reduction. In November an additional 646 outpatient appointments and 28 elective operation have been scheduled. The Orthopaedic and General Surgery Business Units have sub-contracting relationships in place with independent sector providers, although capacity and uptake rate is relatively low.

	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. The speciality action plans have been through an initial confirm and challenge process with the Chief Operating Officer, and have been shared with SET. Additional validation resource finished within the Trust on 18th November. Over the next 3 weeks the Business Units will complete 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.
What is the recovery date?	January 2017
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

United Lincolnshire Hospitals NHS
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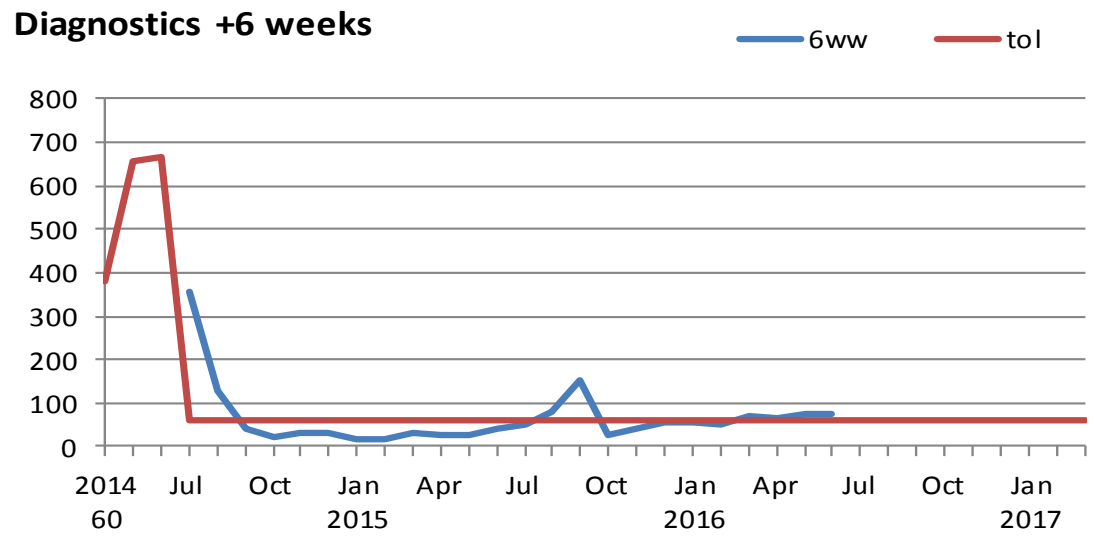
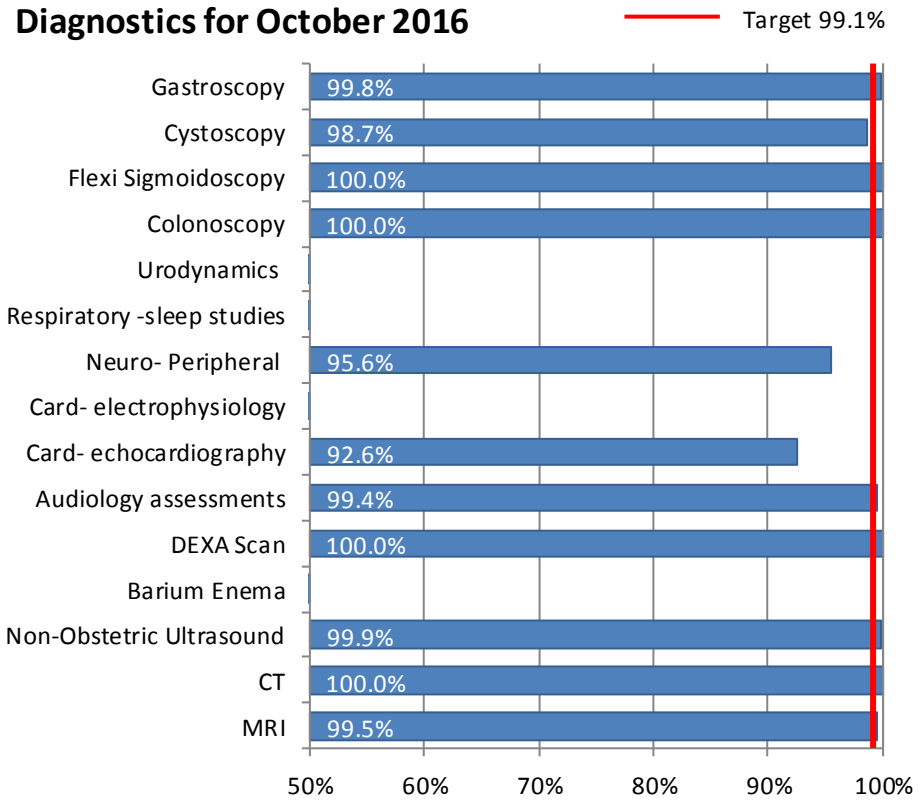
KPI:	**Diagnostic Waits**	**Owner:**	Chief Operating Officer
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Operational Performance
Date:	**29th November 2016**	**Reporting Period:**	October 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	The Trust did not achieve the 6 week diagnostic standard for October. The performance level was 1.25%. This is an improved position and is ahead of national aggregated position, however it is the third month in a row that the standard has not been achieved. At modality level performance of <1% was achieved in all modalities except for neurophysiology and Echocardiography. The level of breaches within Echocardiography was the most significant cause of the Trust's overall failure of this standard, contributing to 78 of the overall 99 breaches. The service have reported increased inpatient demand, as well as workforce capacity issues which have contributed to an increasing backlog of referrals over 6 weeks. TOEs make up the majority of the breaches reported within Echocardiography. However, there was also an increase in paediatric Echo breaches for October. The neurophysiology service relies on 2 external providers to cover a Consultant gap which has been present for over 2 years. Annual leave during the summer period led to a reduction in capacity within the service. The service returned to full capacity during September, but a backlog over 6 weeks had developed during the summer. The position at the end of October (5 breaches) was an improvement on the September performance (18 breaches). Radiological Services made significant progress during October against the 6-week standard, with MRI/CT/NOUS reporting a combined position of 10 breaches which is the lowest their combined position achieved during this financial year.

Forward Trajectory	
Variance Analysis (SPC Chart)	

What action is being taken to recover performance?	The neurophysiology service has been at full capacity during the majority of September and October, and it is expected that performance will be below 1% by the end of November in this modality. The Lincoln Medicine Business Unit have refreshed the Echo recovery plan. Additional sessions for TOEs and Stress Echos have been scheduled for November. Additionally the Women's and Children's Business Unit have scheduled additional paediatric Echo capacity during November. If all of the scheduled additional sessions are completed it is expected that the Echo performance will improve in November enabling the overall Trust position to be within 1% by the end of November.
What is the recovery date?	November 2016
Who is responsible for the action?	Neil Ellis – Deputy Director of Operational Performance

4. "Priority deliverables" – Cancer 62 Day Standard

United Lincolnshire Hospitals NHS Trust

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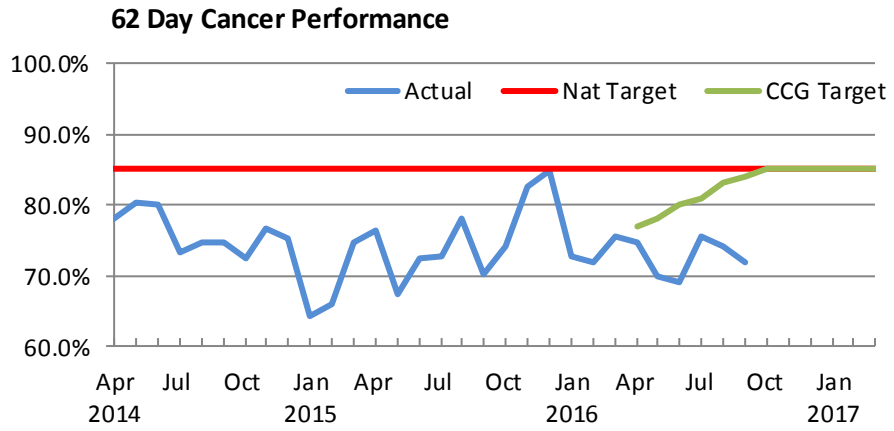
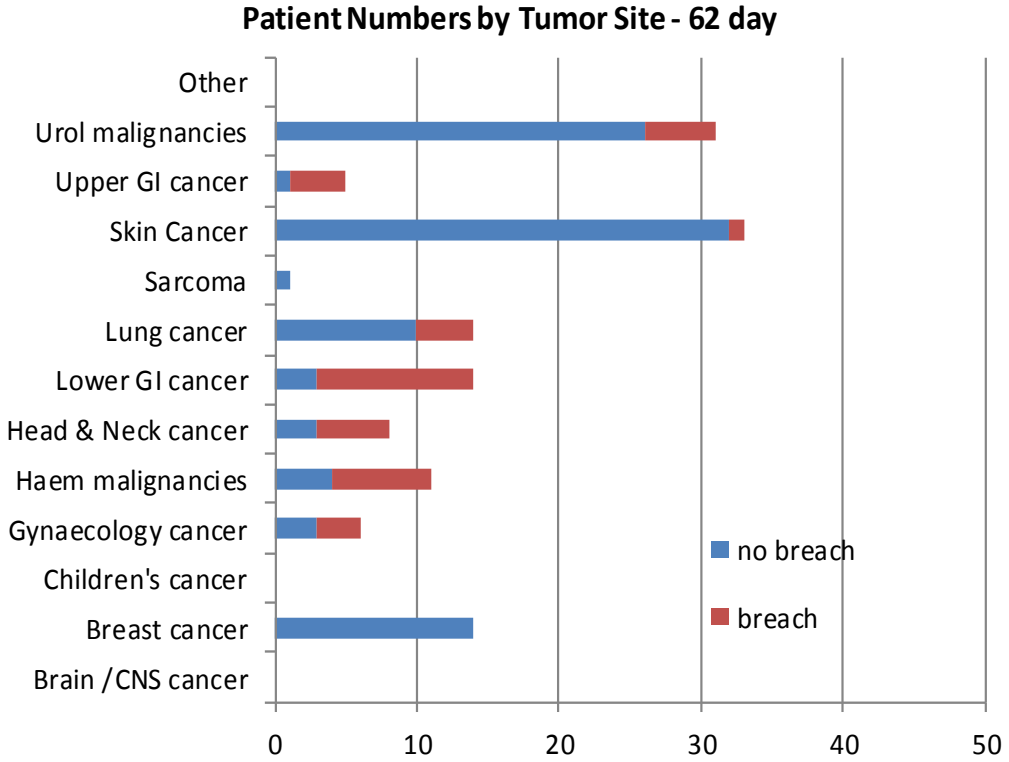
KPI:	**Cancer Waiting Times (62 Day)**	**Owner:**	Chief Operating Officer
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Operational Performance
Date:	**29th November 2016**	**Reporting Period:**	September 2016

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, national performance for September was 81.3%. Demand is continuing to rise with the number of referrals increasing by 52% YTD in 2016/17 compared to the same period in 2012/13 and the number of 2ww referrals converting into 62 day patients has increased by 7% compared to last year. This growth is impacting on the timeliness of diagnostic tests being carried out and is delaying diagnosis and causing additional pressures to treat patients within a smaller window before they breach. Though work is ongoing to improve performance on the 62 day standard, the impact has been minimal due to greater numbers of patients being referred in on a suspected cancer pathway. Radiotherapy performance has been impacted by the increase in the proportion of patients having IMRT requiring more complex planning. The Breast Services continues to be particularly vulnerable due to the level of vacancies within Breast Radiology staffing. Radiology services have also been affected by the significant challenges surrounding the transition to a new PACs system, as has been encountered across the region. The 62 day standard continues to remain the most challenged standard and work is ongoing to improve the quality of the patient journey and understand how improvements in this will work directly towards achievement of the standard. Additional projects have begun internally to focus on the Urology, Lower GI and Lung pathways as well as looking at what improvements can be made to the diagnostic phase of the patient journey. Work has also begun with tertiary colleagues to improve the pathways for patients going to other Trusts for diagnostic tests and/or treatments. The Trust holds a fortnightly 62 Day Trajectory meeting, chaired by the Deputy Director, for all tumour sites to report against agreed action plans, with attendance from the CCGs, East Midlands Clinical Network and the Trust's Planning & Performance team.

Forward Trajectory	
Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	The 7 day horizon, which has the potential to reduce the patient pathway by one week by booking the first appointment within seven days of referral as opposed to 14 days, has been deployed in all areas that are appropriate (there is only one area this is not currently live in due to an unexpected staffing resource issue).

	Those areas where it has not been deemed operationally appropriate to carry out this method (Brain, Breast, Sarcoma and Dermatology), are continuing to use the IST Demand & Capacity 85th percentile system. For the latter system is must be noted that there is a potential effect on 18 week performance as a number of available appointments are sometimes needed to be reverted to Routine/Urgent at short notice when not required for 2ww patients. This is being monitored under a PDSA cycle to establish the most appropriate levels to satisfy both 2ww and 18 week patient needs. There is now a weekly Radiotherapy PTL meeting held within the department to ensure visibility of all patients waiting for Radiotherapy treatment so they are treated within target. The recent 31 day subsequent Radiotherapy performance (94.3% in September against 84.6% in August) reflects this work. The Somerset Cancer Registry implementation continues at a faster pace than anticipated with all Business Units having read, and in some instances write, access to the system and are able to see real-time information on their patients. Pilots with CNS' have begun and a training session is taking place in late November, a pilot has also begun with Dieticians with a view to rolling out further. A series of demonstration sessions have been organised for all MDTs prior to the system being fully integrated into their meetings, with the first of these scheduled to start in December. The Cancer action plan is being actively monitored and managed with the business units through fortnightly meetings and the business units to account for performance and delivery against the action plan. The following are considered to be high impact actions from within the overall action plan: • Standardisation of Radiology booking processes and cancer capacity modelling – November 2016 • Standardisation of Radiology cancer image reporting processes – January 2017 • Implementation of diagnostic schemes approved within the diagnostic capacity fund bid – December 2016 • Extension of the Lower GI pilot to Pilgrim – December 2016 • Capacity planning by tumour site for December and January – November 2016 **Key Achievements** During the first six months of 2016/17 ULHT have achieved the following developments within cancer services: • 7-day horizon has been implemented in all relevant tumour sites • Implementation of the Somerset Cancer Registry, which has replaced the Infoflex Cancer Management System (this was due to the increasing cost and complexity of the Infoflex software that in turn was limiting the options of making it a Trust-wide system) • Successful business case for increasing the establishment of the Cancer Centre team • Successful business cases for additional level 1 bed capacity and the Pilgrim and Lincoln sites • Successful pilot of the Lower GI CNS triage service • Commenced the Upper GI Straight to Test pilot • Restructured the Urology MDT pathway

	Key Challenges The following are key challenges facing cancer performance over the next six months: • Consultant vacancies in key specialty areas, particularly Radiology, Respiratory and Oncology • The impact of urgent case pressures over winter on cancer performance • Increased time period from referral to diagnostic scan being completed (84% of patients were booked and seen within 14 days during September) • Increased time period from diagnostic scan to report being completed (64% of patients had their scans reported on within 14 days during September) • Year on year increases in referrals into the Trust for patients on suspected cancer pathways (13% increase YTD in 2016 compared to YTD in 2015) • Delays in referral to tertiary centres for both diagnostic and treatment elements of cancer pathways
What is the recovery date?	There are fundamental issues, particularly within diagnostics, which need to be resolved prior to being in a position to achieve this standard.
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

United Lincolnshire Hospitals NHS Trust

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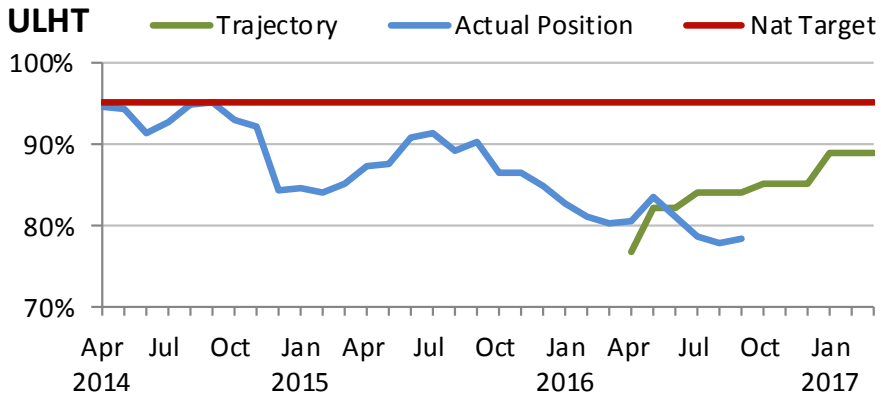
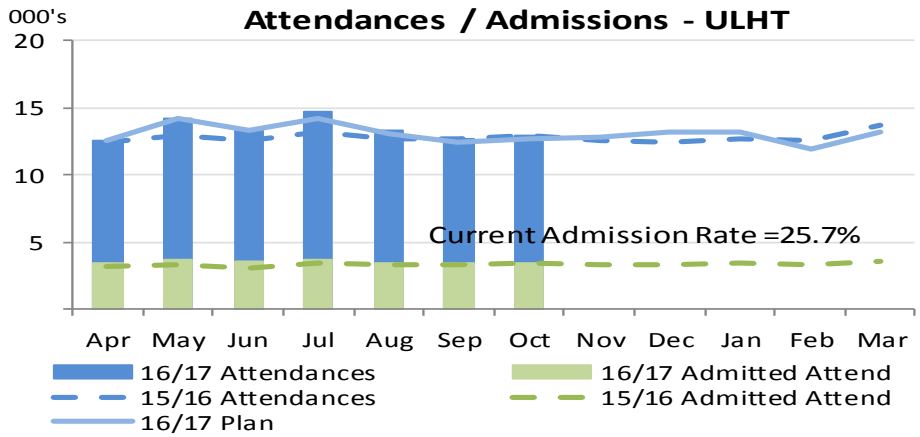
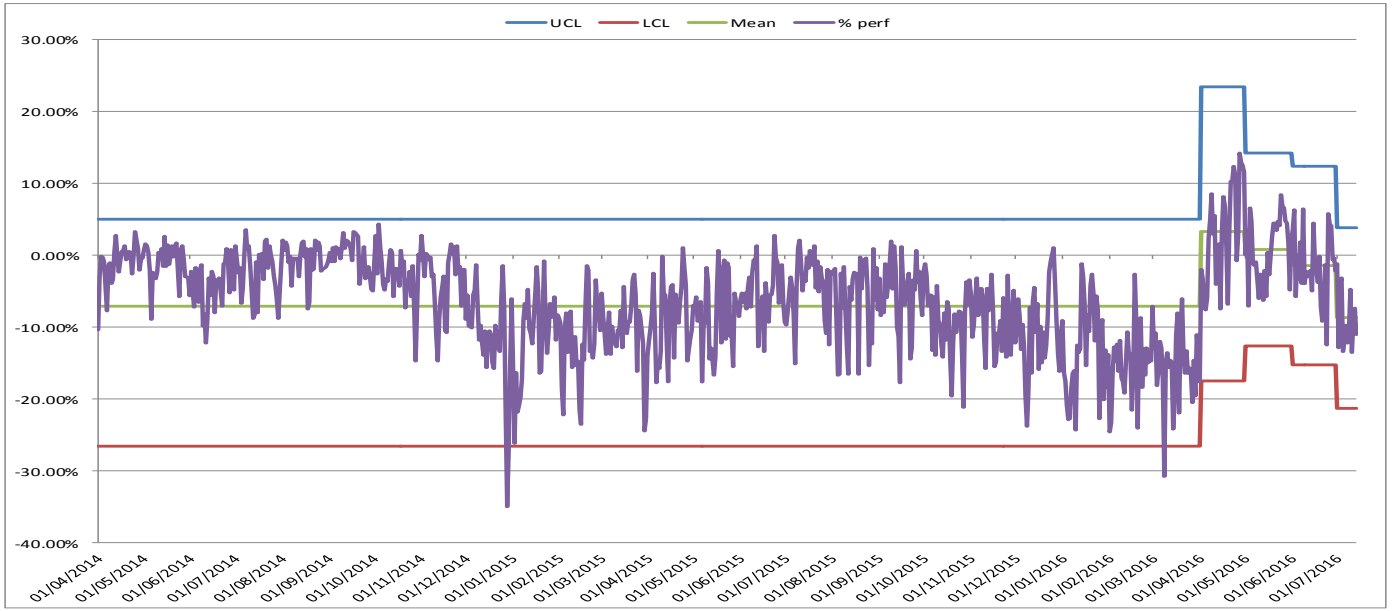
KPI:	**4 Hour Wait (A&E)**	**Owner:**	Chief Operating Officer
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Operations, Emergency Care Deputy Director of Operations, Pilgrim Interim Head of Nursing, Grantham
Date:	**29th November 2016**	**Reporting Period:**	October 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	Performance for Lincoln for October has improved from September (74.75%) with monthly site performance of 77.11%. This is however against a trajectory of 89.3% therefore the Lincoln site remains below where it needs to be. The site continues to rely on locum staffing, especially at night, which can lead to increased numbers of breaches and delays in first assessment. The position has improved since the temporary overnight closure of Grantham A&E with additional middle grade support to the Lincoln rota. As reported in September, there has been targeted A&E Risk Summits with clinical and business unit leadership to drive forward the actions – including stabilisation of "minor" stream performance, improving discharges including ward targets and further work on implementing SAFER (including a workshop held in November). Despite heightened demand pressures – which have been escalated through a formal Activity Query Notice to CCGs – there has been improvement in October. There have been continued pockets of transport issues which have hindered flow and discharge including with NSL and Thames (the new provider for North and North East Lincolnshire). Grantham October performance remained over trajectory for the second month in a row at 96.94% (1.24% over trajectory). Quarter three performance of site 96.91% (2.01% over trajectory). Poor performance in the first two quarters have left a deficit currently for total year of 2.73%. The change in opening hours has improved performance in the department as staffing is now focused on the core opening hours. This means that the nursing qualified deficit of 7 wte is not affecting performance however remains a risk. In the month of October Pilgrim underwent significant change to its senior management team with the replacement of both HoNs within the hospital together with a replacement to the Matron within the Emergency Department; Business Unit managers are also recent into post, including the appointment to Integrated Medicine. This change in personnel has had positive impact upon performance, despite the embedding period required for new staff. • New senior leadership has had a positive effect on recovery, improving performance in month by 11.7% • Further nursing staff have been recruited to within month for A&E • Doctor rotas have been further reviewed to assure senior leadership presence from a substantive

	member of staff, particularly at night. There is now a named shift lead (Middle-grade Doctor) in the absence of a Consultant at night, the consequences being that responsibility and accountability has been heightened. • Shift leads have been briefed regarding their responsibility and accountability for A&E performance per shift; league tables are circulated. • Bed occupancy has remained >95%; the majority of patients continuing to breach between 00.00hrs and 08.00hrs; as a consequence beds are unavailable for admissions and patients have had to remain within A&E for long periods. • Increase in local population (East Coast residency) has led to increased attendances within month (average daily attendance is now 163 patients, compared to 149 a year ago), resulting in increased admissions to the hospital. • Admissions have increased within month by 10% and now run at 35% compared to national average of 25%. As a consequence, operational flow has impeded and breaches have occurred. • After 5pm all Minor Injuries presenting at Skegness Urgent Care centre are re-directed to Pilgrim A&E as non-admitted patients for diagnostics. The consequence resulting in increased attendances and poor patient experience. This could be remedied via resourcing an additional Radiographer at Skegness Urgent Care Centre until at least 10pm, via LCHS.
Forward Trajectory	

Variance Analysis (SPC Chart)	  This graph shows the variance against Target in an SPC Chart, using daily performance from 1st Apr 2014 to current date. Control limits are based on mean ± 3 standard deviation with a maximum on the Upper Control Limit of 100% The current year has been stepped up as we are unable to compare like for like, due to the target movements.
What action is being taken to recover performance?	At Lincoln targeted work on further embedding of SAFER including a workshop in November; In terms of staffing – as reported last month, there is improvement in quality of consultant locum staffing allowed option of moving 2 associate specialists who were acting up back to middle grade rota to support Grantham middle grades now supporting the rota; Furthermore, the site continues to place an additional middle grade being put on in evenings / nights on

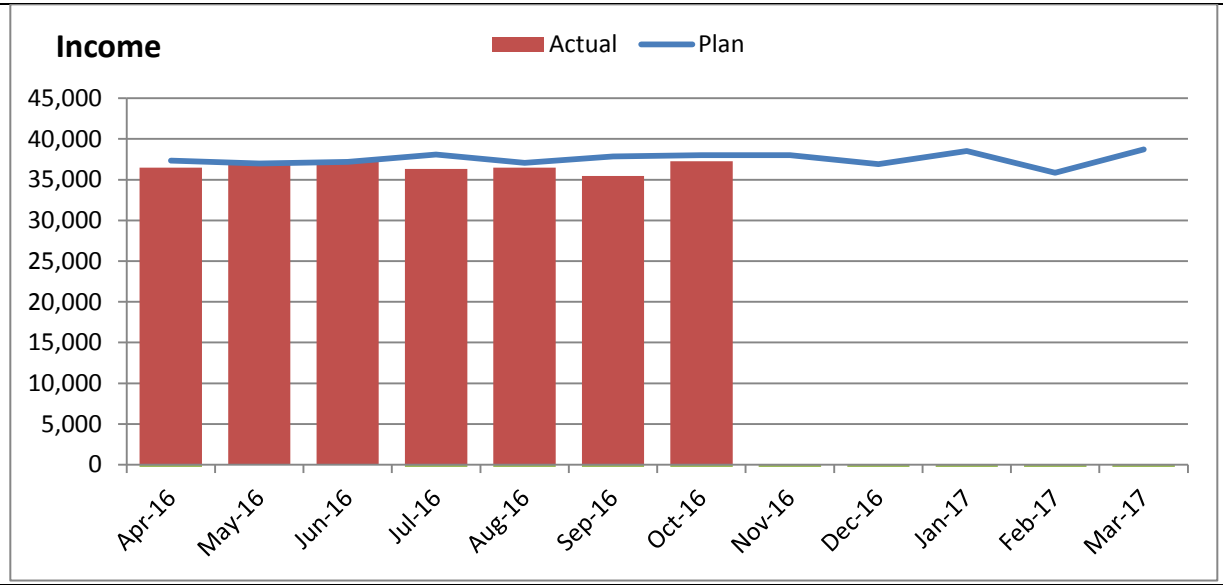
	busy days (Fri – Tuesday) where possible; A&E Risk tool is now live and Operations Centre are monitoring and sourcing additional doctors from wards to support A&E when required; MEAU consultants reviewing medical patients remaining in A&E first thing in the mornings; Close working with EMAS to implement actions to reduce handover delays. Grantham performance improved due to changes in working practices. Team working now fully embedded and providing continuity, triage within 15 minutes and first assessment due to creation of dedicated see and treat room next to triage room have shown an improvement with triage rates as high as 98%. Weekly team meeting to review performance and progress of actions improving team leadership and responsibility continue. The embedding of the new Emergency 10 principles now a key focus. Speciality teams met with by CD and expectations on non A&E medical teams performance shared. At Pilgrim, the rate and amount of patient breaches per day has continued to decline and the department has demonstrated a significant improvement within month by 11.7%. The key actions taken to recover performance are: • Continued senior leadership presence within the department to work with A&E clinical leads to prevent breaching (External Consultant deployed for 9 weeks) • Embedding the ongoing A&E recovery programme • Assuring Doctors/ Nursing rotas on a daily basis, exercising scrutiny to ensure that there is senior Doctor / Senior Nurse leadership presence within the department on all shifts, particularly at night • Discussion organised with LCHS / CCG for the 9th November regarding increased Radiology cover at Skegness Urgent Care Centre • Continue to progress the deployment of "*Pride and Joy*" to improve operational bed flow and reduce LOS. • Resurrected Stranded patient meeting; this is now back on track and delivering outcomes
What is the recovery date?	Pilgrim is expected to recover in November 2016. At Lincoln some success with recent adverts to fill middle grade roles will mean a more sustainable rota and the trajectory presented as part of the STP – based mainly on improving flow – will be back in place. With current improvements the performance should be sustained and a return to the STP trajectory is achievable for November. At the time of writing this exception report (15th November), the monthly position for Lincoln was in excess of 81%. Grantham plan to achieve over trajectory for quarter three and four.
Who is responsible for the action? (Provide the role and name of the lead)	Andrew Prydderch – Deputy Director of Operations, Emergency Care Tina White – Deputy Director of Operations, Pilgrim Hospital John Boulton – Interim Head of Nursing, Grantham Hospital

4. "Priority deliverables" – Money & Resources

United Lincolnshire Hospitals NHS
NHS Trust

CARING FOR YOU

KPI:	**Income v Plan**	**Owner:**	Director of Finance
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Finance
Date:	**29th November 2016**	**Reporting Period:**	October 2016

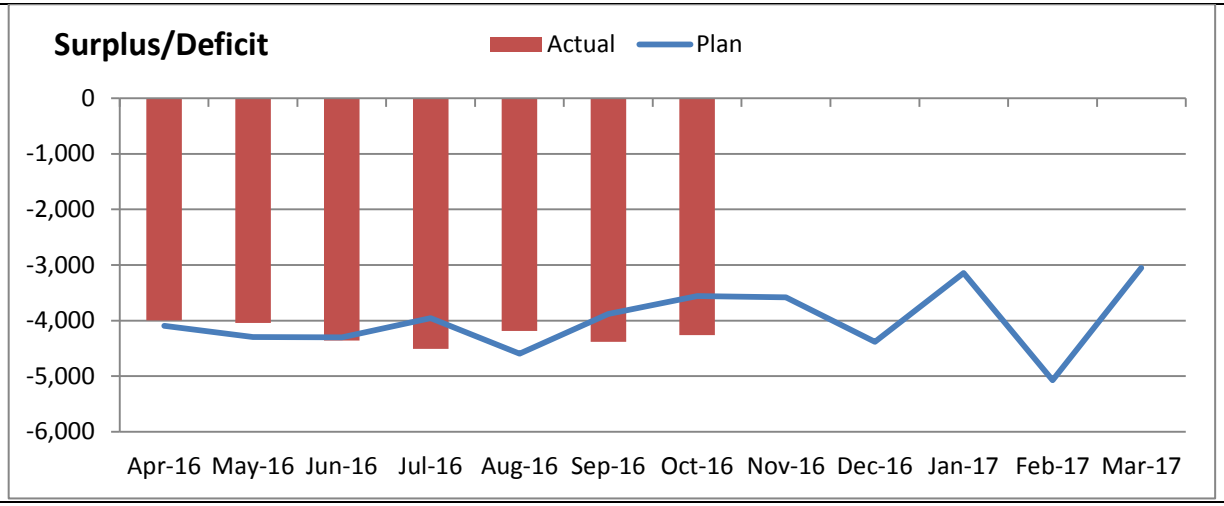
Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	As at the end of October (Month 7) the Trust income is £6.5m behind plan. The adverse variance is driven by a significant deterioration in inpatient activity, particularly in Trauma & Orthopaedics, together with a £3.1m 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. Plans are being developed to ensure we can reduce the run rate to achieve the year end control total.
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?	All Clinical Directors

4. "Priority deliverables" – Money & Resources

United Lincolnshire Hospitals NHS
NHS Trust

CARING FOR YOU

KPI:	**Surplus/Deficit**	**Owner:**	Director of Finance
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Finance
Date:	**29th November 2016**	**Reporting Period:**	October 2016

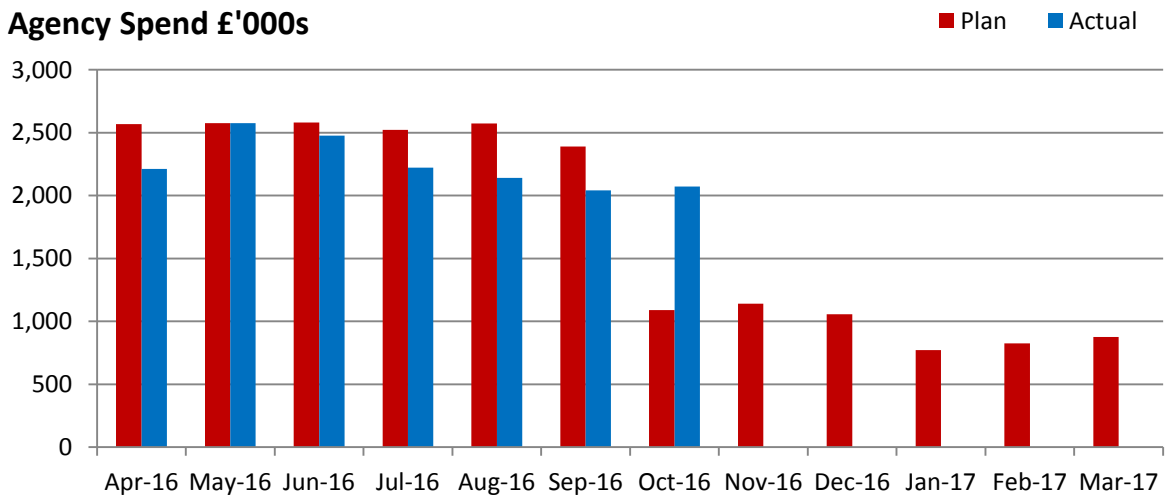
Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	As at the end of October (Month 7) the Trust financial performance is £1.0m behind plan. The adverse variance is driven by income performance to date, with a recognition that the Trust is failing on the other performance measures so will not receive the Sustainability and Transformation Funding for quarter 2 of £1.6m.
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 all the target being offset by additional efficiency/underspends across the Trust. Plans are being developed to ensure we can reduce the run rate to achieve the year end control total.
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

4. "Priority deliverables" – Money & Resources

United Lincolnshire Hospitals NHS Trust

CARING FOR YOU

KPI:	**Agency Spend**	**Owner:**	Director of Finance
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Finance
Date:	**29th November 2016**	**Reporting Period:**	October 2016

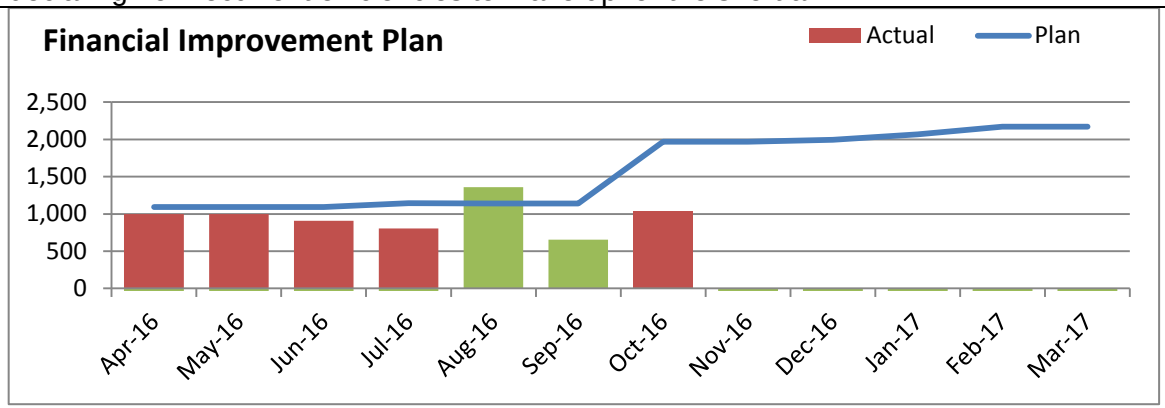
Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	As at the end of October (Month 7) the in month spend on agency is £1.0m worse than the in month plan. However, the year to date position is still within target. Project teams are in place to lead on nursing (and shortly on medical) agency spend reduction.
Forward Trajectory	Year end forecast is expenditure of £23.8m on all agency.
Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	Project teams are working on nursing and medical agency spend reduction and executive Team are considering various measures to reduce run rate overall, some of which will reduce agency expenditure.
What is the recovery date?	
Who is responsible for the action? (Provide the role and name of the lead)	All Clinical Directors

4. "Priority deliverables" – Money & Resources

United Lincolnshire Hospitals NHS Trust

CARING FOR YOU

KPI:	**Financial Improvement Programmes**	**Owner:**	Director of Finance
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Finance
Date:	**29th November 2016**	**Reporting Period:**	October 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	As at the end of October (Month 7) the in month efficiency is reported as £1.2m against a plan of £2.0m. The plan has assumed a significant ramp up in efficiencies that has not materialised as yet.
Forward Trajectory	Year end forecast is efficiencies of £19m in line with plan, based on an overall detailed plan of £21.7m. This will be achieved by support from RSM and business units reviewing the level of underspends and declaring non recurrent efficiencies to make up for the shortfall.
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. A recovery plan is also being developed to ensure we make all the required savings, through further controls on various levels of expenditure, and deliver the year end control total.
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

United Lincolnshire Hospitals NHS Trust

CARING FOR YOU

KPI:	Sickness Absence	Owner:	Director of Human Resources
Domain:	Well-led	Responsible Officer:	Assistant Director of Human Resources
Date:	29th November 2016	Reporting Period:	October 2016

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

Monthly sickness rate for September 2016 is 4.38%. The August 2016 monthly sickness rate has now decreased from 4.12% to 4.03%.

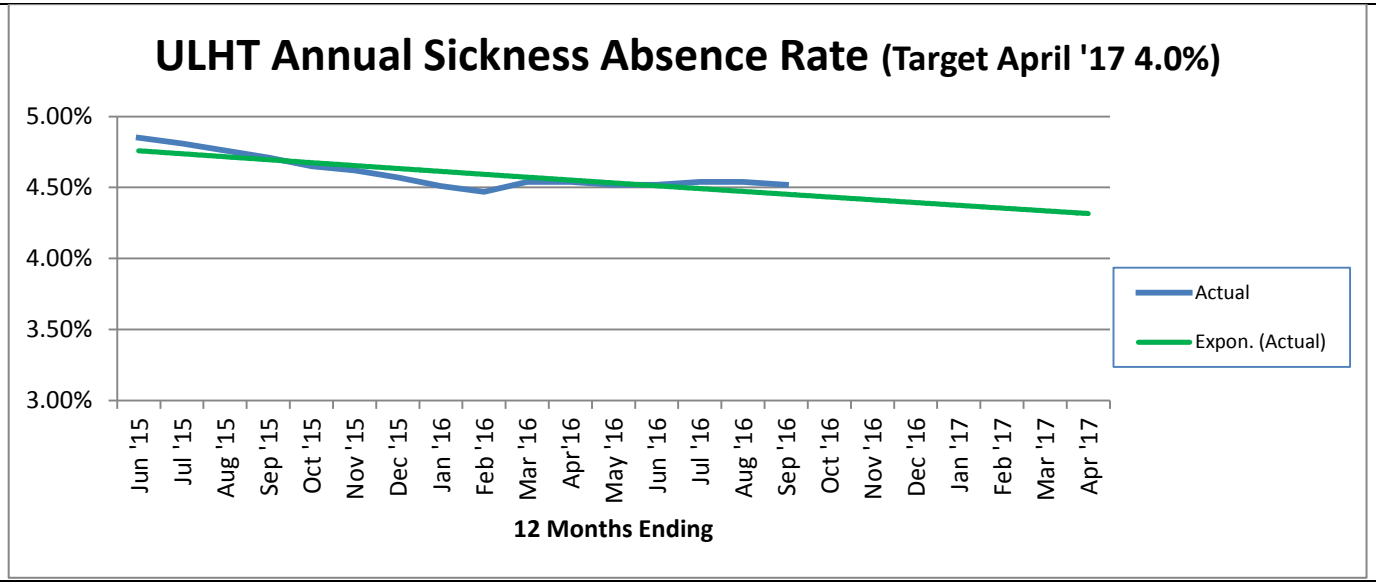
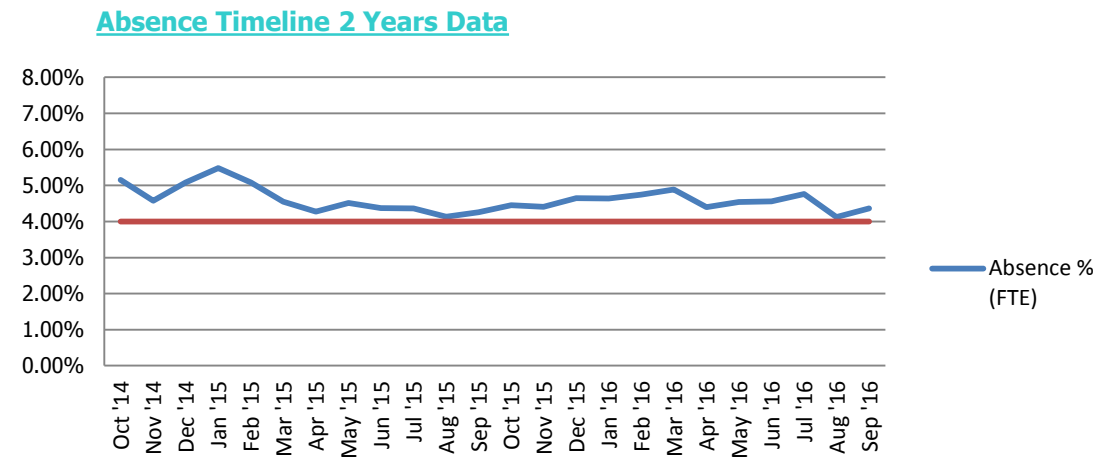
Annual sickness rate has decreased by 0.19% in comparison to September 2015 figures.

The annual cost of sickness (excluding any backfill costs) has decreased by £297,723 compared to 12 months ago.

During the 12 months ending September '16, Anxiety/Stress/Depression and other Psychological illness was the top reason for time lost due to sickness at 20.60% of all absence. Of this figure 1.61% was work related and 18.99% non-work related.

Additional Clinical Services had the highest sickness rate during the 12 months at 6.46% (Unregistered Nurses 7.13%) followed by Estates & Ancillary at 6.31% and Nursing & Midwifery Registered at 4.97%.

Absence Reason	Episodes	No. of FTE Days Lost	% of Total FTE Days Lost
Anxiety/stress/depression/other psychiatric illnesses	770	21,656.00	20.6
Other known causes - not elsewhere classified	1,102	14,881.24	14.2
Other musculoskeletal problems	638	11,430.08	10.9
Back Problems	564	9,034.47	8.6
Gastrointestinal problems	2,774	8,997.68	8.6
Cold, Cough, Flu - Influenza	2,143	7,425.76	7.1

Forward Trajectory	
Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	• Confirm and challenge meetings are supported by the HR Team in order to ensure that any trends, hotspots etc are being recognised and proactive action plans are put in place to support the deduction in the absence rate. • Monthly meetings also continue to be held with Occupational Health to support the absence management process by ensuring that this service is being fully utilised by both managers and staff. • Appointment of interim staff to support and increase the proactive work in decreasing the absence figure

	• Case conference meetings within HR to ensure that all cases are being addressed and also to provide further support at a higher level if necessary and appropriate. • HR Team continue to work closely with both Matrons, Sisters and Team Leads to ensure that the absence management process is being adhered to as per policy for both long term and short term cases. • HR Team are working closely with mangers to ensure that the Stress Risk Assessment is being completed where appropriate and to ensure that any stress triggers highlighted are then managed by implementing an action plan to remove these triggers. • HR Team increasing the use of the counselling services within Occupational Health to provide the staff with further support where appropriate. • HR Team work with managers to ensure that all core learning is being completed to limit the absence rates in relation to MSK and back problems by ensuring all staff are up to date with their moving and handling training. • Hand hygiene training is being monitored in relation to the gastrointestinal problems. This is further being supported through the introduction of the Pay Progression policy relating completion of core learning to having a direct impact as to whether you receive your incremental pay increase. • Staff are also being encouraged to have the flu vaccination to help maintain their own health and wellbeing and also of their patients and family. HR Team are addressing the use of "other known causes" being used as a reason to ensure that the usage of this is eradicated.
What is the recovery date?	April 2017
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

United Lincolnshire Hospitals NHS Trust

CARING FOR YOU

KPI:	**Vacancies**	**Owner:**	Director of HR
Domain:	**Well-led**	**Responsible Officer:**	Elaine Stasiak, Workforce Intelligence (reports completed by Karen Taylor, Asst Director HR)
Date:	**29th November 2016**	**Reporting Period:**	October 2016

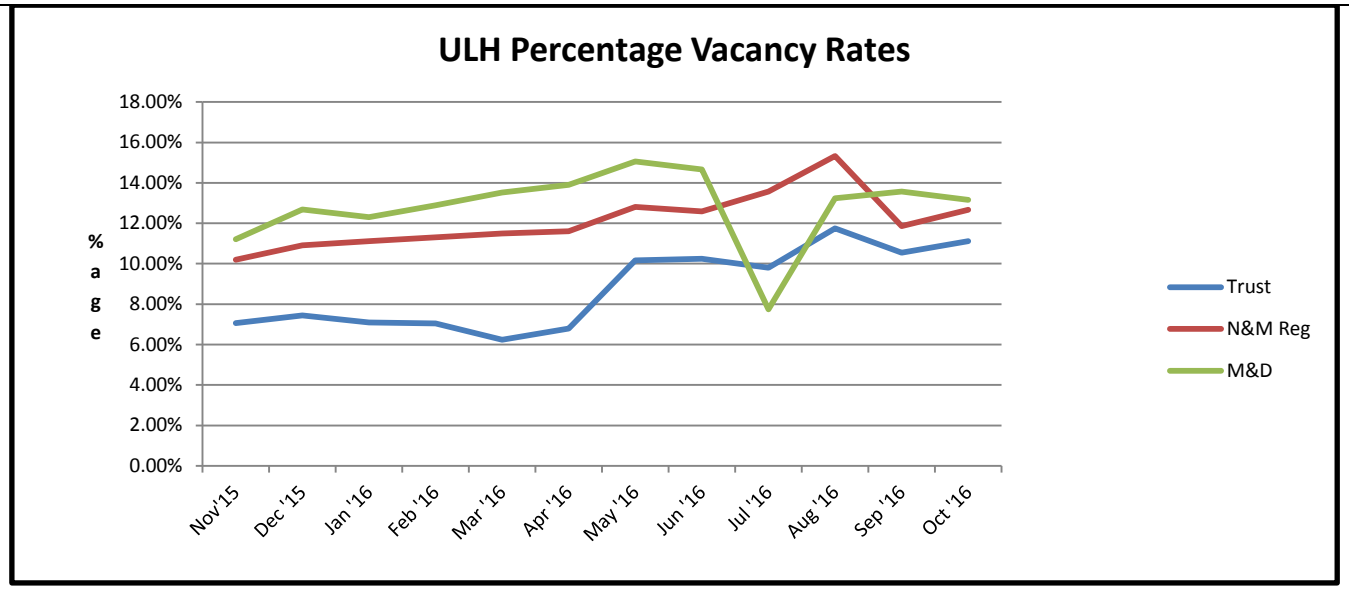
Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	The Trust has a target of having 8% or fewer vacancies across its staffing establishment. The current rate (October) is 11.09%, which is an increase of 0.55% on September. Previous month's performance was:

October 2015	6.72%
November 2015	7.05%
December 2015	7.44%
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	9.8%
August 2016	11.75%
September 2016	10.54%

13.16% of medical roles are vacant. There has been an increase of 10.17FTE Medical Staff in post over past 12 months.

12.66% of Nursing roles are vacant. Numbers remain static compared to 12 months ago (increasing by 2.59 FTEs to 1111.99 FTEs).

Forward Trajectory	Clearly we are not achieving our target and the trajectory is generally upwards rather than downwards.

Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	• The Trust is currently working through 2 year plans and the associated workforce planning. At the culmination of this, it is the intent to have a clear understanding of need with regards to numbers, locations and timescales. We will then review our approach to medical and nurse recruitment and retention, building on our successes to date and identifying new approaches to filling vacancies. This review will be completed by end-January. • We continue to work to improve the efficiency of our recruitment process, so that we can fill vacancies more quickly and reduce drop-out rates through the system. We are looking at current blockages in the process (e.g. job banding) and exploring options around the introduction of an applicant tracking system. • The Trust has entered into a contractual relationship with Manpower 'Experis' to help find medical candidates for hard to fill roles across the Trust. It is anticipated that the International Nurse recruitment will soon start to deliver Nurses into the Trust (7 candidates at NMC stage waiting decision and hoping to arrive early January 2017, 33 nurses waiting for IELTS results, 43 nurses with confirmed IELTS bookings and 12 retracted applications).
What is the recovery date?	It is unlikely that we will recover to target by March 2017. The review taking place will identify a new trajectory of improvement.
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

United Lincolnshire Hospitals NHS Trust

CARING FOR YOU

KPI:	**Core Learning**	**Owner:**	Director of HR
Domain:	**Safe**	**Responsible Officer:**	Elaine Stasiak, Workforce Intelligence (reports completed by Karen Taylor, Asst Director HR)
Date:	**29th November 2016**	**Reporting Period:**	October 2016

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. The Trust's compliance/performance this month dropped by 2% due to the introduction of Basic Life Support (BLS) compliance into overall compliance rates. Excluding BLS compliance would have increased by another 1% to 88%.

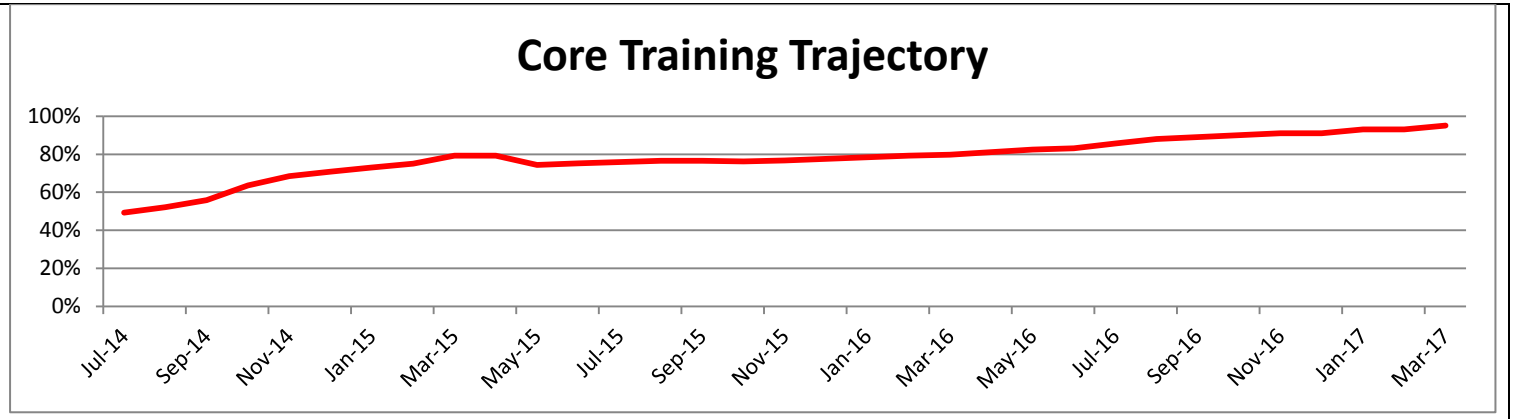
Nov-15	77%
Dec-15	78%
Jan-16	78%
Feb-16	79%
Mar-16	80%
Apr-16	81%
May-16	82%
Jun-16	83%
Jul-16	86%
Aug-16	86%
Sep-16	87%
Oct-16	85%

- BLS compliance is now included in overall compliance following the 6 month introduction period. Compliance for BLS has increased from 24% in April to 61% in October.
- Compliance for annual topics - Fire, Infection Prevention and Information Governance either stay the same or increase by up to 2%. They are also between 8 and 9% higher than this time last year.
- 3 yearly topics either remain the same or show another increase of 1%. Rates are much higher than this time last year.

The DNA 'No Show' rate for October decreases by 3%.

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*
Aug-16	74%	76%	97%	80%	89%	88%	90%	92%	90%	87%	87%		*86%*
Sep-16	75%	77%	97%	81%	90%	89%	91%	92%	90%	88%	89%		*87%*
*Oct-16	75%	79%	97%	82%	90%	90%	90%	92%	91%	89%	90%	61%	*85%*
**Oct-16	68%	75%	90%	77%	81%	80%	86%	86%	84%	86%	87%	48%	*79%*

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

What action is being taken to recover performance?

- New Fire e-learning package introduced on 1st November 2016 to help fire compliance. This can be used every alternate year, alternating with classroom to maintain annual compliance.
- Continued promotion of the pre-prepared '5 Click' Core Learning Compliance report available through ESR Supervisor Self-Service. This provides Managers/Supervisors/Clinical Educators up to date compliance for their areas automatically in 5 clicks. This will help simplify and improve compliance monitoring.
- DNA '5 Click Report' continues to be promoted. This 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 Pay Progression Policy was launched on 1.10.16. Non-compliance with core learning may act as a bar to incremental pay progression.

Meetings are held with HR and managers on all sites to discuss core learning.

What is the recovery date?

We are unlikely to achieve the target by March 2017

Who is responsible for the action?

Clinical Directorates
Service Leads
Line Managers

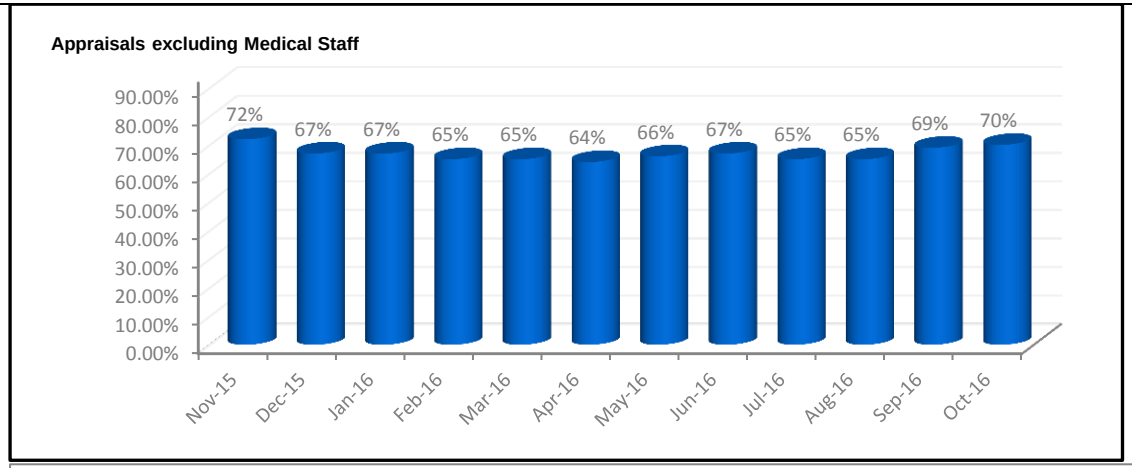
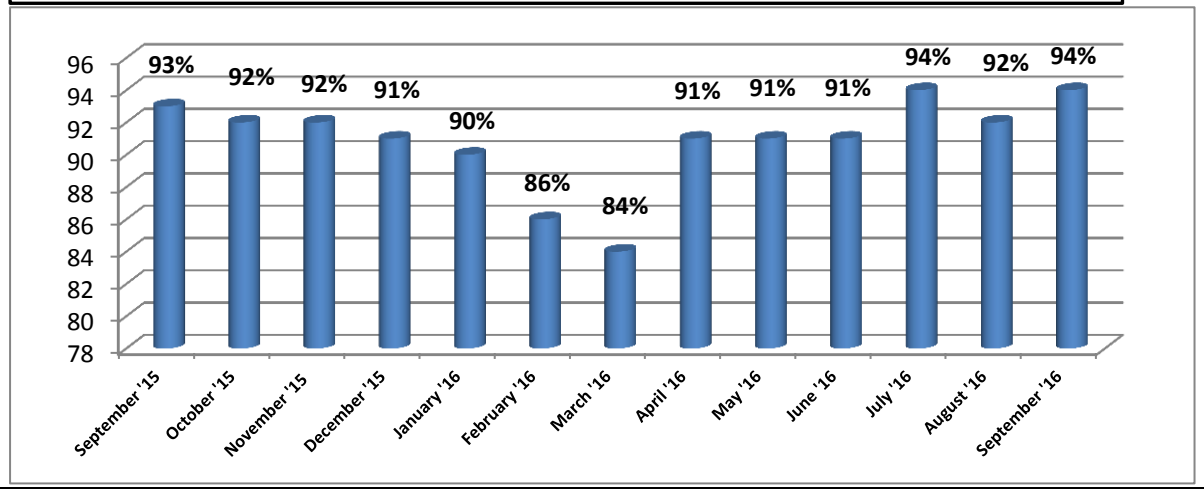
4. Exception Report: Safe

United Lincolnshire Hospitals NHS Trust

CARING FOR YOU

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:	**29th November 2016**	**Reporting Period:**	October 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	Agenda for Change Staff Appraisal compliance rate for October is 70.24%. Appraisal Compliance rate (Year-on-Year) comparison: October 2015 - 74% October 2014 - 60% The overall percentage for appraisals has increased by 1.58% from the previous month. Appraisal rates increased on all 4 sites with the highest rates at Louth with 76.74% and Grantham at 76.15%. Pilgrim has the highest increase in appraisal rate from 64.17% in the previous month to 66.40% in October. Lincoln appraisal rate increased by 1.33% from the previous month to 71.16%. Appraisals are a key focus and proxy for staff engagement so it is encouraging to note the improvement over the last two months.
Forward Trajectory	It is unlikely that the target of 95% will be achieved by March 2017. The trend has changed from downward to upward for the last two months which could be assumed to be as a result in the change in the method of reporting and the implementation of the Pay Progression Policy.

Variance Analysis (SPC Chart)	 
What action is being taken to recover performance?	• Following feedback from managers, it was agreed that appraisal reporting could revert to the previous system of using the intranet rather than ESR Supervisor Self Service which managers were reporting was time consuming and cumbersome. • "Hot spot' reports continue to be provided to managers monthly • Monthly Confirm and Challenge Meetings held to ensure any areas of concern have clear actions set to address these concerns which are then challenged at the next meeting to ensure full compliance and that completion targets rates are met. • Further meetings are held with managers to help support addressing these issues in between the Confirm and Challenge meetings. • Pay Progression Policy launched 1.10.16 put a very clear spotlight on appraisals and managers' responsibility for doing them. Managers need to ensure that they fully implement the Pay Progression Policy which requires them to ensure that those that they manage have completed appraisals for all their staff and that incremental pay progression could be withheld if this is not in place.

What is the recovery date?	It is unlikely that we will recover to target by March 2017. As a Trust we have not managed to achieve a compliance rate of 80% for Non-Medical Appraisals.
Who is responsible for the action?	Line managers/Clinical Directors (Medical Revalidation)

4. Exception Report: Safe

United Lincolnshire Hospitals NHS Trust

CARING FOR YOU

KPI:	**Staff Turnover**	**Owner:**	Director of HR
Domain:	**Safe**	**Responsible Officer:**	Elaine Stasiak, Workforce Intelligence
Date:	**29th November 2016**	**Reporting Period:**	October 2016

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 rate (October) is 9.80%, which is an increase of 0.35% on September. Previous months performance was:

March	10.10%
April	10.06%
May	9.81%
June	9.78%
July	10.02%
August	9.76%
September	9.45%

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

Nursing and Midwifery turnover rate has slightly decreased in month to 9.65% (down from 9.88%). Medical and Dental Staff turnover rate has decreased in month to 13.55% (down from 14.92%).

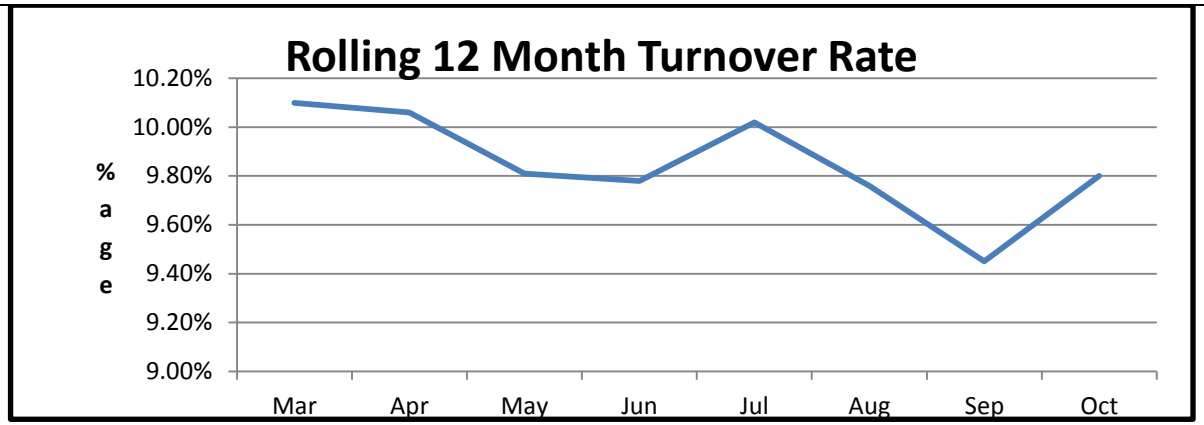
Based on the August 2016 data from HSCIC (Health and Social Care Information Centre) for other Large Acute (Non-Teaching) Hospitals:-

- The current Trust turnover rate of 9.80% is below the average of 10.71%
- Nursing & Midwifery (Registered) 10.12% is below the average of 11.48%,
- Other Non-Medical Clinical Services (usually unregistered) 11.97% is below the average of 14.10%.
- AHP's 11.96% is below the average of 13.37%.

Forward Trajectory

We have consistently seen a reduction in the turnover rate during the year. It is unlikely that the target of 8% will be achieved by March 2017

Variance Analysis (SPC Chart)



Trust Turnover

Staff Group	Establishment as at 31.10.16	SIP as at 1.11.15	SIP as at 31.10.16	Average SIP	Leavers 1.11.15 - 31.10.16	Turnover SIP	Turnover Leavers against establishment
Nursing & Midwifery	2256.01	1963.18	1970.29	1966.74	189.73	9.65%	8.41%
All Medical	933.73	800.69	810.87	805.78	445.14	55.24%	47.67%
Medical excluding juniors	552.73	457.69	477.66	467.67	63.39	13.55%	11.47%

Leavers by Month November 15 – October 16

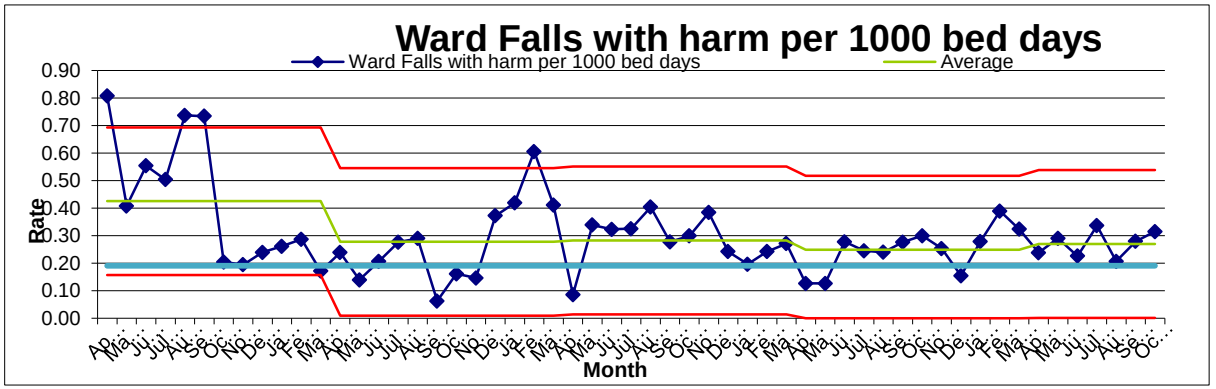
What action is being taken to recover performance?	We need a better understanding of the reasons why people leave the Trust. Work to enhance the exit interview process has been commissioned by the new Director of HR and OD. We need to understand whether there are common issues across the Trust and if there are any "hot-spot" areas and target these to understand any specific reasons why people may be leaving. As part of the programmes of work around medical and nurse recruitment and retention, we will using the data we have to consider areas within the employee lifecycle that we might address to enhance retention e.g. access to development opportunities or reward and recognition issues.
What is the recovery date?	If the current downward trend continues then we might expect to hit the target by August 2017. We are unlikely to achieve the target by March.
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

United Lincolnshire Hospitals NHS Trust

CARING FOR YOU

KPI:	**Falls**	**Owner:**	Medical Director
Domain:	**Safe**	**Responsible Officer:**	Deputy Chief Nurse
Date:	**29th November 2016**	**Reporting Period:**	October 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	Since April 2016, the number of falls both with harm for the Trust has remained fairly static with a rate of 0.31 per 1000OBD reported in October 2016 against a national average of 0.19 The static position is due to the increase of falls with harm on the Pilgrim site which has increased to 0.43 YTD compared to 0.29 for 2015/16. An improvement plan for Pilgrim has been formulated in partnership with the Heads of Nursing. Reduction in falls at Grantham has been achieved and Lincoln is currently reporting less falls with harm though there is no reduction in the overall figure.
Forward Trajectory	Target is to reach 0.19
Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	• An improvement plan for Pilgrim has been developed • Multi-professional scrutiny panels are in place for all falls resulting in death or severe harm and are due to be extended to moderate harm for hot spot areas • Lying and standing blood pressure video formulated • Falls Competency Booklet developed

	• Falls Summit held on the 10th November 2016 • Falls intranet site drafted and waiting for IT to upload
What is the recovery date?	Progress is being monitored through the Falls Group which is due to meet on the 23rd November
Who is responsible for the action? (Provide the role and name of the lead)	Penny Snowden, Deputy Chief Nurse

4. Exception Report: Safe

United Lincolnshire Hospitals NHS Trust

CARING FOR YOU

KPI:	**Safeguarding**	**Owner:**	Director of Nursing
Domain:	**Safe**	**Responsible Officer:**	Deputy Chief Nurse
Date:	**29th November 2016**	**Reporting Period:**	October 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	• Safeguarding Training whilst improving remains below 90% for all levels • Training compliance for CQUIN cohorts requires improving across the three accident and emergency departments particularly amongst medical staff to achieve 100% compliance • External Report highlighted deficits in safeguarding governance arrangements and made 21 recommendations. Action plan being monitored through Integrated Safeguarding Committee • Joint CQC/OFSTED inspection undertaken week commencing 17th October 2016.Overall positive report with 2 main recommendations regarding the use of separate cas-cards for paediatrics in accident and emergency which include safeguarding prompts and about maternity sharing their safeguarding database with A&E • Lack of Restraint Training provision in the Trust
What action is being taken to recover performance?	• Adequate number of training sessions have been arranged • Training compliance has now been added to the Ward Health Check • Training compliance is monitored through the Integrated Safeguarding Committee which upwardly reports the Quality Governance Committee • A review of training provision is proposed for quarter 4 • Action plan in place in response to the external peer review of safeguarding • Monthly reporting through QGC of safeguarding performance • Lack of restraint training is on the risk register. Included in the mental health workstream
What is the recovery date?	18th November for Children Safeguarding Training and the 19th December for Adult Safeguarding training
Who is responsible for the action? (Provide the role and name of the lead)	Penny Snowden, Deputy Chief Nurse

4. Exception Report: Safe

United Lincolnshire Hospitals NHS Trust

CARING FOR YOU

KPI:	Infection Prevention and Control	Owner:	Director of Nursing
Domain:	Safe	Responsible Officer:	Deputy Chief Nurse
Date:	29th November 2016	Reporting Period:	October 2016

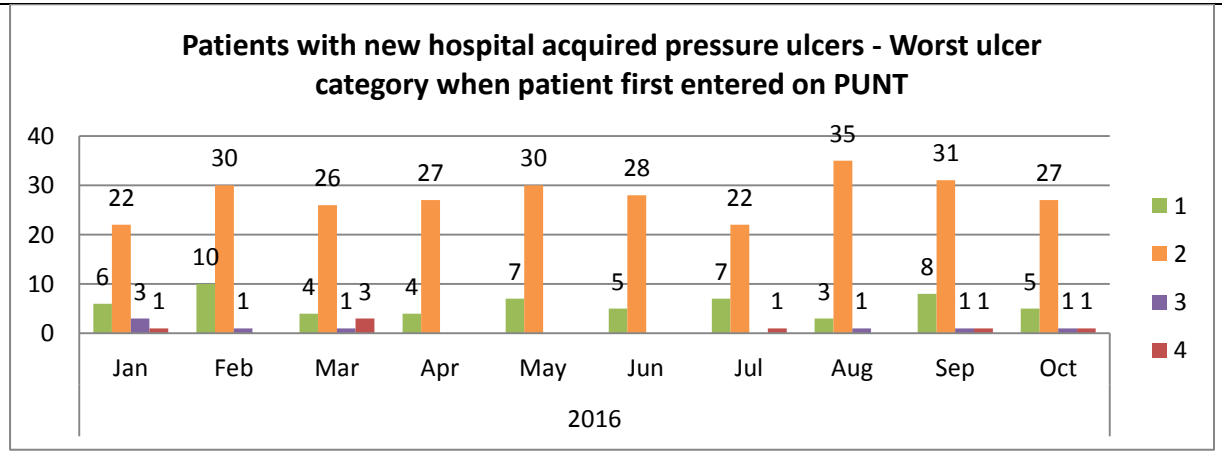
Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	Four cases of clostridium difficile were detected in October and the RCA's reported that there were lapses in care in each of those cases. Themes included isolation of patient was not in a timely manner, in appropriate sampling and incomplete documentation. The detail of this is presented to the Trust IPCC and to QGC through the upward report. MRSA screening is now required to be a 1:1 patient match and 100% compliance is required. Data collection methodology has been changed to report patient match and the latest compliance level is 60.5%. The IPT are meeting with information support to ensure appropriate wards and departments are included in the data as per the MRSA policy in the first instance. This will also form part of the matrons report and actions plans made for those areas not screening to be discussed at site meetings and escalated to IPCC. The Trust reported a blood culture contamination rate of 5.11% for October 2016 compared against a national recommended level of below 3%. Pilgrim reports the highest contamination rates amongst the four sites and they are trialling blood culture packs/teaching to support them. Sharing good practice from the other sites to be put into place which includes the clinical educator undertaking blood culture collection competency with staff and sharing results at monthly team meetings.
What action is being taken to recover performance?	The site IPC leads have been tasked to develop an improvement plan regarding contaminated blood cultures.
What is the recovery date?	Progress monitored monthly through the IPC committee and progress to be reported at next meeting on 14th December 2016.
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

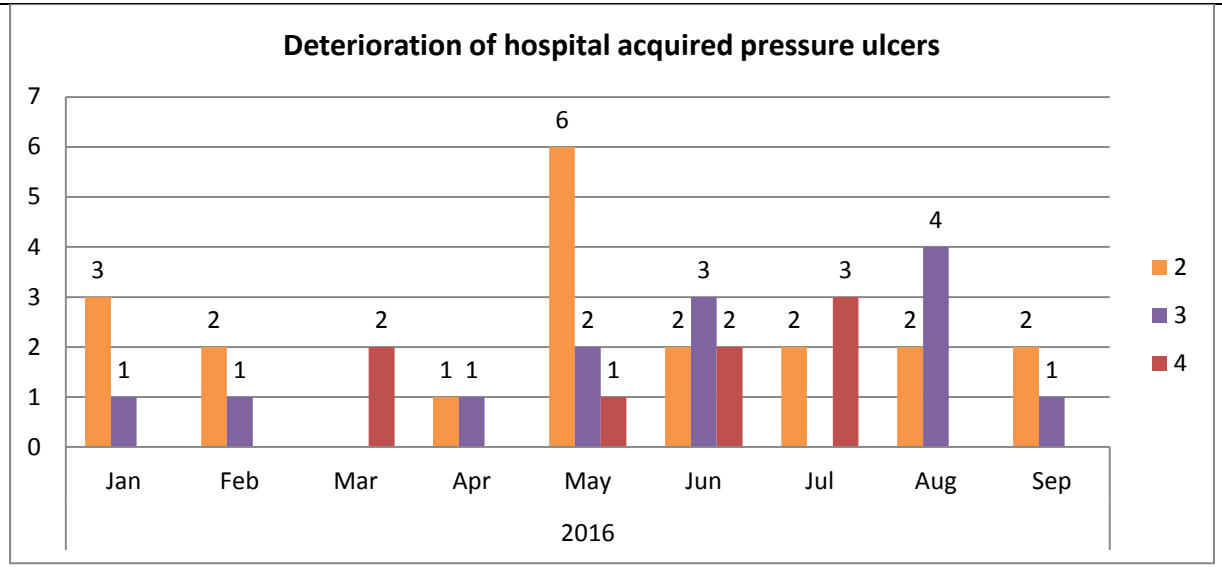
4. Exception Report: Safe

United Lincolnshire Hospitals NHS Trust

CARING FOR YOU

KPI:	The Elimination of all Avoidable Hospital Acquired (HA) Category 3 and 4 Pressure Ulcers across ULHT	**Owner:**	Nurse Consultant – Tissue Viability
Domain:	Safe	**Responsible Officer:**	Deputy Director of Nursing
Date:	29th November 2016	**Reporting Period:**	October 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	It is acknowledged that a number of new HA Cat 3 and 4 Pressure ulcers (within all ULHT sites) are reported on a monthly basis (see variance charts below) however it should also be noted that these are prior to the ULHT intrenal RCA process being completed to ascertain avoidability/unavoidability. The current trust cumulative incidence for October is = 8% (Cat 2), 0.6% (Cat 3) and 0.25% (Cat 4) as calculated per 1000 in-patient bed days. (National average all categories combined – between 4 and 6% min). *For information:* the PUNT reported patients with deteriorations of previously reported Pressure Damage, e.g. category two and three Pressure Ulceration (see variance charts), represent patients pressure damage that has deteriorated during the last reported period (e.g. 1 to a 2, 2 to a 3).
Forward Trajectory	All ULHT staff are being supported to try to ensure that the achievement of this KPI is as soon as possible.
Variance Analysis (SPC Chart)	

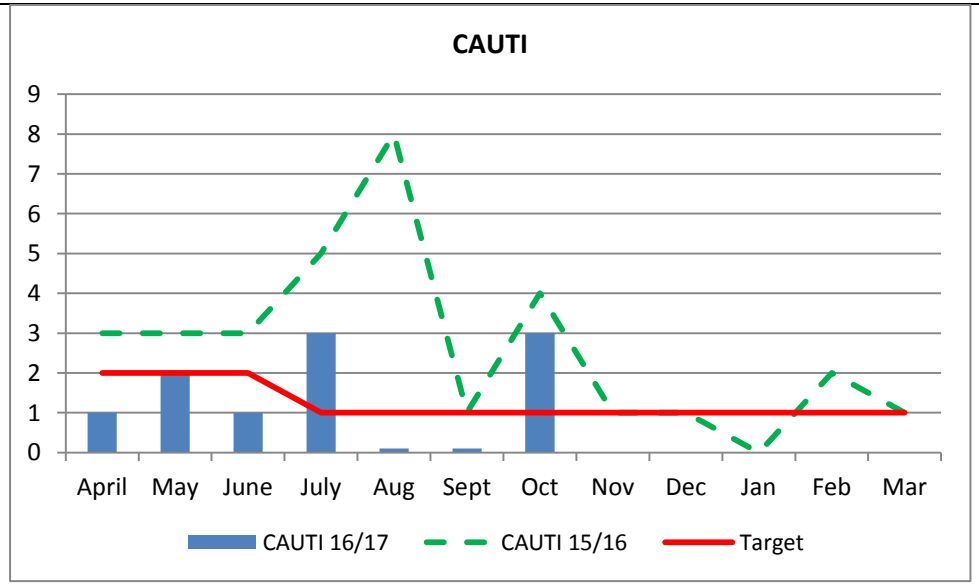
	
What action is being taken to recover performance?	1. Ward staff are advised as a minimum on a weekly basis about their current PUNT status and supported with the same. 2. Ongoing clinically based education is being provided by members of the Tissue Viability (TV) team on all sites within all clinical areas. 3. Specifically requested support/education of the A&E/staff in admission areas re: the use of the Andersen Screening Tool and Classification of Damage has been arranged with the Nurse Consultant – Tissue Viability. 4. Wards that are identified (through regular analysis of PUNT data) to have a higher than average incidence of pressure damage for their clinical speciality are offered further support from members of the ULHT TV team. 5. Relevant protocols/flowcharts/care pathways i.e. The Minimisation of Heel Pressure Ulcers flowchart is being actively supported across the Trust by all TV team members and the clinically based TV Link Nurses. 6. Two 0.5wte posts are being created for Pressure Ulcer Prevention Nurses to further support staff with the assessment and admission process (and documentation) of patients in particular with or 'at risk' of pressure ulceration. It is hoped that these posts – one for LCH and the other for PHB – will be advertised early in December 2016.
What is the recovery date?	March 2017
Who is responsible for the action? (Provide the role and name of the lead)	Nurse Consultant – Tissue Viability (ULHT).

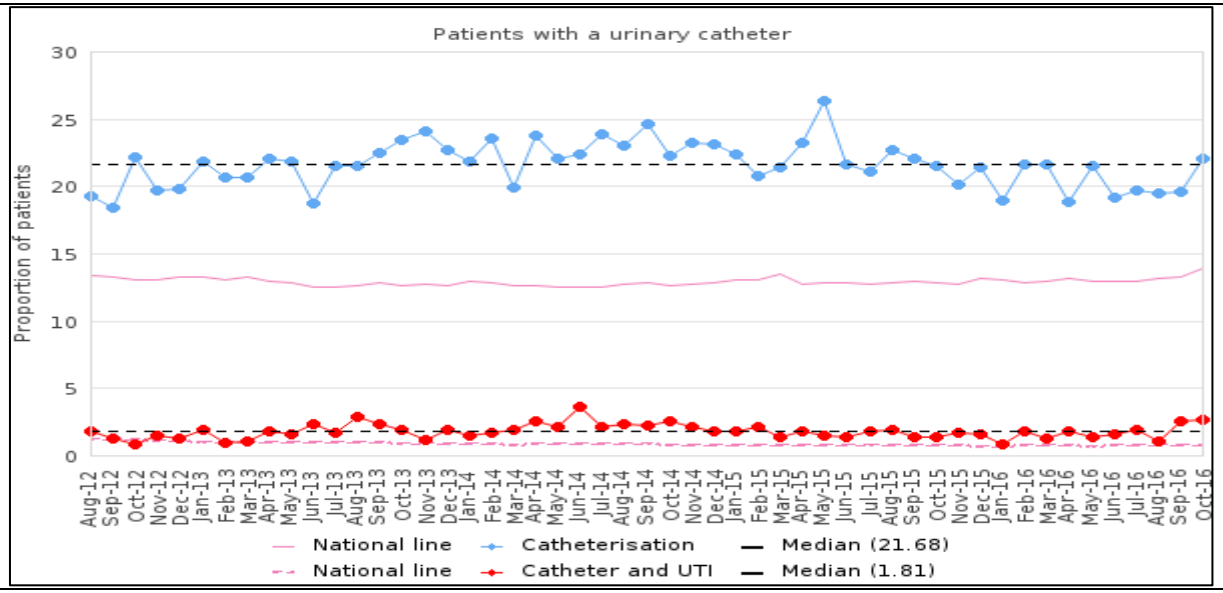
4. Exception Report: Safe

United Lincolnshire Hospitals NHS Trust

CARING FOR YOU

KPI:	Catheter Associated Urine Tract Infection (CAUTI)	**Owner:**	Medical Director
Domain:	Safe	**Responsible Officer:**	Quality & Safety Manager
Date:	29th November 2016	**Reporting Period:**	October 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	The data is collected as part of the national data set of the Safety Thermometer which is a point prevalence audit which demonstrates ULHT as an outlier for CAUTI. The Trust is also an outlier for the number of catheters inserted. If the Trust reduced the number of catheters inserted, patients would not be at risk of developing a CAUTI.
Forward Trajectory	

Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	Monthly CAUTI meetings Urology nurses validate all CAUTIs prior to being reported on the Safety Thermometer Trial of intermittent self-catheterisation is still an ongoing project, as awaiting feedback from the surgical doctors. Nurse led twoc protocol pathway is complete and audits to assess compliance are being implemented. Urology / continence nurses to provide regular ward teachings on Catheter care, TWOC's and completion of documentation. Bard catheter Trays has received good feedback and will now be trialled in clinics.
What is the recovery date?	March 2017
Who is responsible for the action? (Provide the role and name of the lead)	Urology Nurse Consultant

4. Exception Report: Safe

United Lincolnshire Hospitals NHS Trust

CARING FOR YOU

KPI:	**Sepsis**	**Owner:**	Medical Director
Domain:	**Safe**	**Responsible Officer:**	Quality & Safety Manager
Date:	**29th November 2016**	**Reporting Period:**	October 2016

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

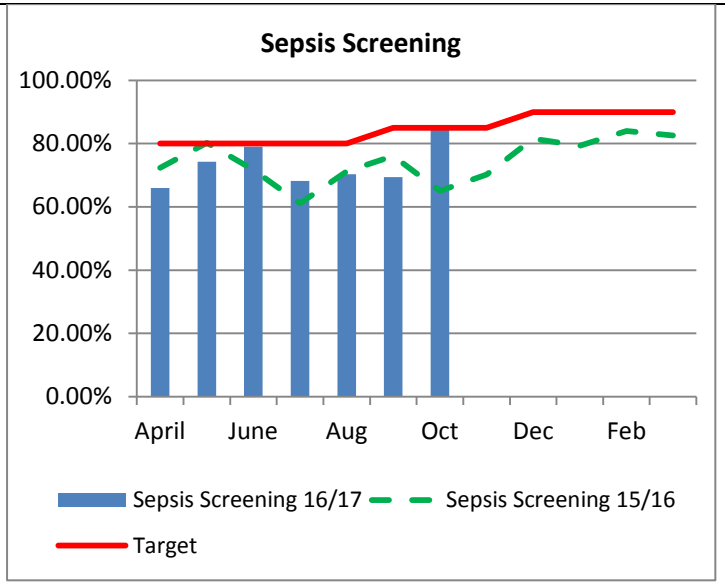
Site	**Bundle Commenced –Oct 2016**	**IVAB within 1 hour – Oct 2016**
Grantham	88.24%	57.14%
Lincoln	91.89%	47.83%
Pilgrim	77.14%	40%

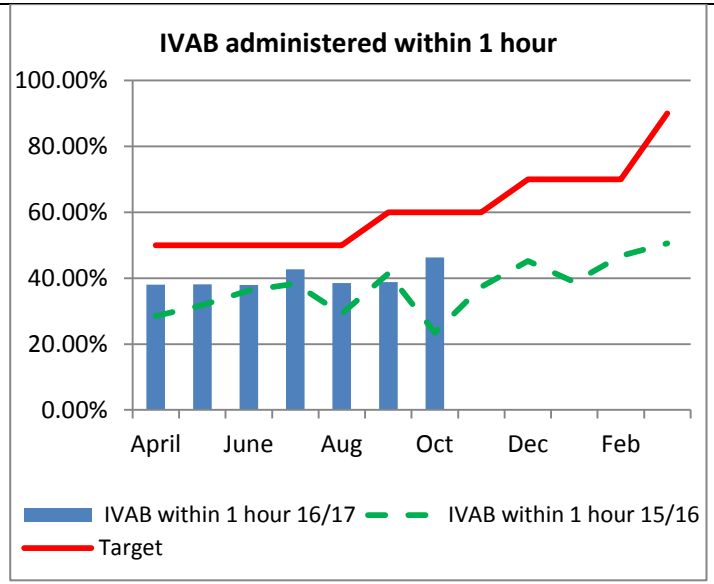
Lincoln achieved the target for screening, Grantham has nearly achieved the target and Pilgrim has improved considerably from previous month. The administration of IVAB within 1 hour still requires improvement however with the secondment of 2 nurses to A&E this will improve the compliance. The processes and policies are in place however staff are not adhering to the policy.

Forward Trajectory

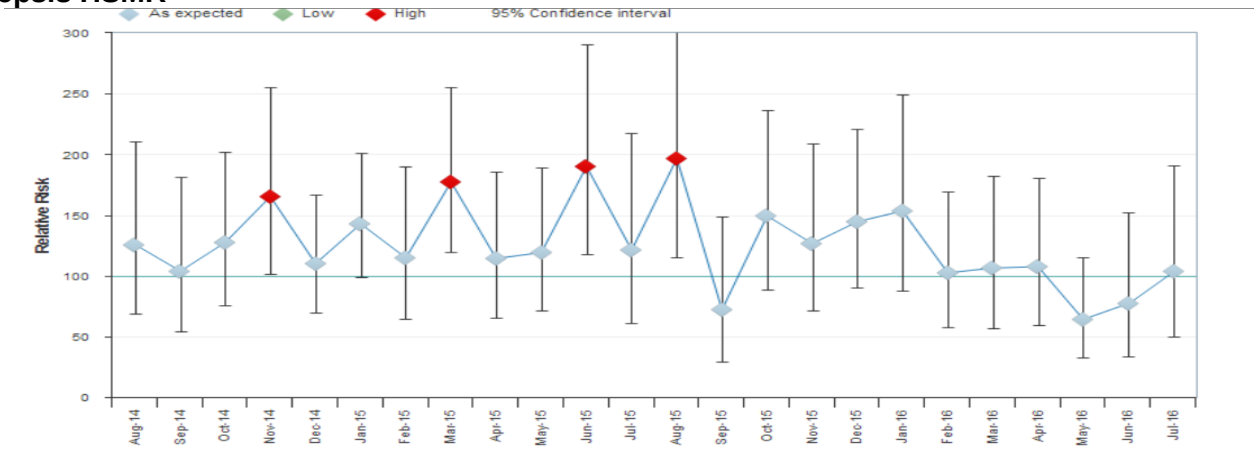
To achieve our CQUIN target for Q2 the Trust needs to achieve 90% for screening and 90% for administration of IVAB within 1 hour. The HSMR for sepsis is showing an improvement since February 2016.

Variance Analysis (SPC Chart)





Sepsis HSMR



Metric Title	Jan-2016	Feb-2016	May-2016	Jun-2016	Jul-2016	Aug-2016	Sep-2016	Oct-2016
Patient demographics correct	99.00%	98.00%	98.10%	98.80%	99.50%	98.00%	98.80%	98.80%
Patient observations on time and complete	72.90%	77.60%	79.20%	79.10%	80.00%	78.20%	80.50%	77.10%
NEWS score added correctly	95.80%	96.20%	97.10%	98.30%	98.10%	97.50%	98.30%	98.80%
Evidence of escalation if required	92.00%	81.50%	91.20%	78.00%	78.30%	76.10%	71.40%	93.80%
Evidence of reset baseline	85.00%	96.60%	100.00%	75.00%	-	100.00%	100.00%	-

What action is being

1. Due to the time to appoint substantive sepsis nurses, 2 nurses will be seconded commencing in November

taken to recover performance?	2016. 2. eBundle will be trialled on ward 3B and Johnson ward 3. Training for staff by the Clinical Education Team will commence on the 1st December 2016 4. eLearning will be on staff matrix within the coming weeks as mapping has been completed. 5. Daily audits will commence in A&E and emergency admission wards and weekly audits on wards – proformas have been developed. 6. eCOBs is being rolled out to improve processes with physiological observations.
What is the recovery date?	Pilgrim and Grantham need to achieve 90% for screening by December 2016 and Lincoln needs to sustain 90% or greater. For IVAB within 1 hour we have given we originally gave target of 90% by March 2017 however we need to review this target as we have the sepsis nurses in place.
Who is responsible for the action? (Provide the role and name of the lead)	Adam Wolverson – Trust Sepsis Lead Sepsis Nurses at Lincoln & Pilgrim

4. Exception Report: Safe

United Lincolnshire Hospitals NHS Trust

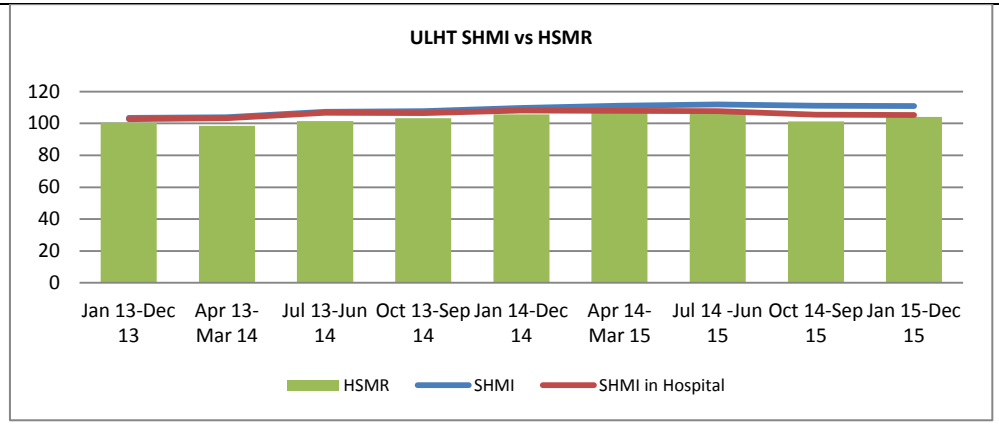
CARING FOR YOU

KPI:	Mortality (SHMI)	**Owner:**	Medical Director
Domain:	Safe	**Responsible Officer:**	Quality & Safety Manager
Date:	29th November 2016	**Reporting Period:**	October 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	HSMR Year to date position ULHT is within expected limits. Current SHMI reporting period (Jan 15-Dec 15) demonstrate that ULHT has decreased to 110.99 . In hospital deaths are in line with HSMR at this time period. Septicemia alert was driven by the Lincoln and Pilgrim sites. Residual codes (signs and symptoms) were not alerting on any particular site. At this time period within the HSMR basket; Septicemia replicates the SHMI alert. Pneumonia is not alerting at this time. All alerting diagnosis mirror in hospital apart from COPD; suggesting that post 30 day discharge mortality have initiated the alert. Diagnosis within this time period alerting in HSMR have had reviews and action plans. Pneumonia although not alerting in this time period have had subsequent reviews.
Forward Trajectory	

Death I/O Hospital Jan 15-Dec15	SHMI Spells	SHMI/ HSMR	Actual Deaths	Expected Deaths
SHMI All deaths	82545	110.99	3591	3235.3
SHMI In hospital deaths	82545	105.38	2436	2311.71
HSMR	51873	104.05	2131	2048.06

Trust/Site	ULHT SHMI Jan 15-Dec 15 (Current)
ULHT	110.99
LCH	112.11
PHB	110.8
GDH	106.07

Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	Alerting Diagnosis for SHMI; due to the time lapse in SHMI reviews were carried out for these alerts when these diagnosis alerted in HSMR. SHMI in hospital mirrors ULHT's HSMR, therefore with our reducing HSMR ULHT's SHMI should decrease ULHT are working with the CCG's to assess the out of hospital mortality.
What is the recovery date?	March 2017
Who is responsible for the action? (Provide the role and name of the lead)	Dr Kapadia, Medical Director

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

United Lincolnshire Hospitals NHS Trust

CARING FOR YOU

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 spend 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%	88.60%	88.77%					
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%					
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%						
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%					
Agency Spend £'000s	Plan			2569	2575	2582	2523	2573	2390	1091	1142	1058	772	824	875
	Actual		↓	2213	2576	2477	2223	2141	2042	2073					
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					

Appendix 1. Monitor Risk Rating

United Lincolnshire Hospitals NHS Trust

CARING FOR YOU

Area		Indicator	Threshold	Monitoring Period	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep -16	Oct -16
Access	1	maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway	92%	Quarterly	92.11%	92.45%	92.02%	91.35%	89.19%	88.24%	88.77%
	2	A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	Quarterly	80.54%	83.52%	81.12%	78.56%	77.80%	78.40%	81.37%
	3	All cancers: 62 day wait for first treatment from: Urgent GP referral for suspected cancer *	85%	Quarterly	75.6%	74.7%	70%	68.9%	75.6%	74.0%	71.9%
		NHS Cancer Screening Service referral *	90%		92.1%	80.6%	86.2%	96.2%	90.9%	78.9%	81.3%
	4	All cancers: 31 day wait for second or subsequent treatment comprising: Surgery *	94%	Quarterly	92.1%	80.4%	90.9%	95.0%	95.8%	97.8%	91.2%
		anti-cancer drug treatments *	98%		91.6%	84.6%	97.7%	100%	98%	98.8%	98.4%
		radiotherapy *	94%		90.7%	84.0%	94%	92.8%	90.9%	84.6%	94.3%
	5	All cancers: 31 day wait from diagnosis to first treatment *	96%	Quarterly	96.7%	95.8%	95%	98.7%	97.6%	96.6%	98.0%
	6	cancer: two week wait from referral to date first seen, comprising: all urgent referrals (cancer suspected) *	93%	Quarterly	92.5%	87.8%	92.6%	92.1%	82.7%	81.1%	94.6%
		for symptomatic breast patients (cancer not initially suspected) *	93%		90.6%	94.6%	96.6%	93.0%	24.8%	26.3%	88.8
Outcomes	14	Meeting the C.difficile objective (cumulative)	62	Quarterly	2	5	5	6	3	6	4
	15	Meeting the MRSA objective (cumulative)	0	Quarterly	0	0	0	0	0	0	0
	19	Certification against compliance with requirements regarding access to health care for people with a learning disability	n/a	Quarterly	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
				Risk Rating	4	5	5	5	5	5	5

*** Information is reported a month behind**

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

United Lincolnshire Hospitals NHS
NHS Trust

CARING FOR YOU

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

United Lincolnshire Hospitals NHS
NHS Trust

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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