Agenda Item: 11.1.(1)

UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 31 DECEMBER 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:	31ST January 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 December 2016

1. Executive Summary for period of 31st December 2016

December headlines:

- ☒ 4 hour waiting time target – performance of 77.47%
- ☒ 5 of the 9 national cancer targets were achieved in November 2016
- ☒ 18wk RTT Incomplete Standard – the current unvalidated performance for December 2016 is 87.17%
- ☒ 6wk Diagnostic Standard – December performance was 99.03%
- ☒ Agency Spend – £1,249k above plan
- ✓ Financial Improvement Plans - +£554k above plan

Successes:

- ✓ Diagnostics performed to standard for the first time since June in December.
- ✓ Cancer 31 day first and 31 day subsequent achieved the standard (cancer is reported one month behind all other performance).
- ✓ 62 day cancer screening improved from 79.20% last month to 89.70% this month.
- ✓ Complaints reduced from the previous month from seventy eight to forty one in December.
- ✓ Staff turnover decreased in December to 1.73% from 2.73% in November.
- ✓ With the exception of Agency Spend all financial targets are either green or amber (four out of six of the metrics are green)

Challenges:

A&E

As of today this months current A&E performance is 74.31%. In December our 4 hour waits increased by 5.13%. In A&E the continuing picture shows a disconnect between our aims and efforts to meet our STF targets and work towards the constitutional standard and our capacity to deliver performance at this level of demand.

Proactive Winter planning was intended to help relieve bed pressures and our RTT position by cancelling electives and increasing day cases, however, the demand on our emergency departments at Pilgrim and Lincoln has put staffing levels under considerable pressure even with adjustments made at Grantham to opening times and their consistent positive performance levels.

Benchmarking against peers shows a mixed picture with most of the peer group falling well below the standard in November.

RTT

RTT recovery plans are in place with a focus on increasing outpatient and theatre sessions. Outsourcing is providing some support but external providers are also experiencing capacity issues. We are working with CCGs to manage referral rates into those specialities that are under particular pressure such as orthopaedics, ENT and gastro.

Cancer

62 day cancer is still of concern and although screening has improved it is unlikely that we will meet our target next month. Although diagnostics performance has improved this area is still having significant impact on improving 62 cancer performance.

Sickness absence

Sickness absence costs the Trust over £8 million per year (November 2015) and ULHT has the 13th highest rate for large acute trusts in the country. There has been an increase in sickness absence

during December and a review is taking place to understand how well sickness absence is managed and to consider the performance target relevance in current circumstances.

Staff Appraisals

Staff appraisal performance improved slightly during September, October and November. The target of 95% remains challenging and it was hoped that the progression policy would help support managers and staff with engaging with the process but the gap between the current position and the target is unlikely to be filled during the next few months.

Looking forward:

Performance improvement and sustainability is proving challenging for all areas of the Trust's domains. Our recovery picture shows a level of risk that needs careful management and monitoring.

A number of action plans have been reviewed and Trust Board may want to focus on key performance areas to understand the impact of these recovery plans on performance, bearing in mind the resourcing levels available in some specialities and the commitment being made to recover within the timescales required. This is particularly important for our STF trajectory targets in the coming few months with a significant reliance on drawing down this funding to meet our control totals.

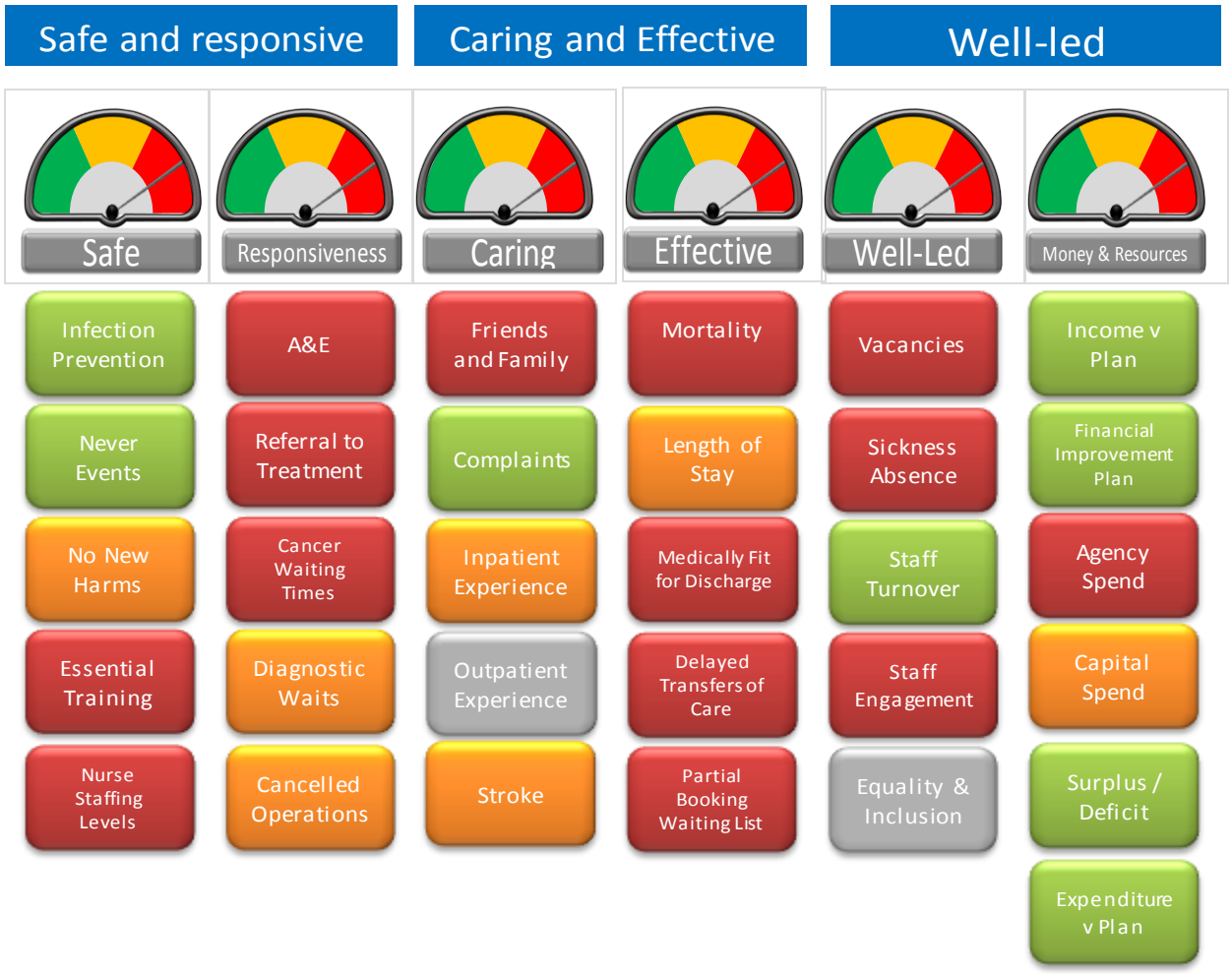
The production of our People Strategy and a review of all HR performance targets will help to ensure we are realistic about our performance expectations and changes to performance targets is likely from April 2017.

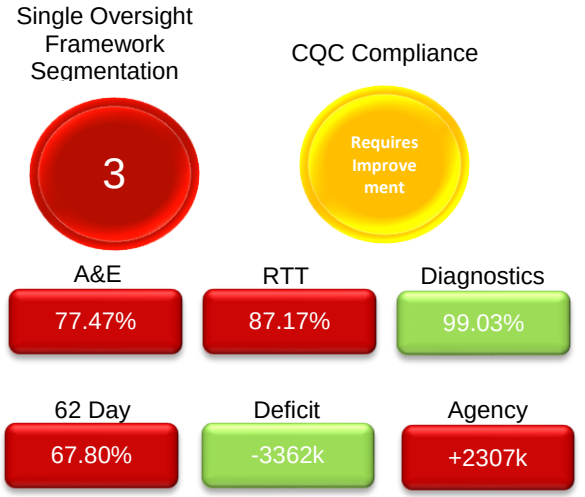
John Barber
Interim Director of Finance & Corporate Affairs
January 2017

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: Caring
Complaints received in December have reduced by 37 from November (78 to 41)

Domain: Responsiveness
Cancer 31 day first and 31 day subsequent all achieved standards in November

Domain: Responsiveness
Diagnostics achieved in December (99.03%) for the first time since June

Most deteriorated:

Domain: Responsiveness
Cancer 104+ day waiters has increased from 28 in November to 34 patients in December

Domain: Responsiveness
A&E 4 hour wait performance has decreased by 5.13% in December

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)	5	0	3	5			
MRSA bacteraemia (post 3 days)	0	0	0	0			
MSSA	2	16	2	1			
ECOLI	8	50	3	9			
Never Events	0	1	0	0			
No New Harms							
Serious Incidents reported (unvalidated)	TBC	35	8				
Harm Free Care %	95%	91.07%	90.36%	89.30%			
New Harm Free Care %	98%	96.91%	96.86%	95.70%			
Catheter & New UTIs	2.00	1	1	5			
Falls	95.0%						
Medication errors	1						
Medication errors (mod, severe or death)	1						
Pressure Ulcers (PUNT) 3/4							
VTE Risk Assessment	95%	96.18%	95.90%	96.94%			
Overdue CAS alerts							
SQD %							
Essential training	85%	114.41%	64.82%	64.63%			
Nurse Staffing Levels							
Nurse to bed day ratio			1.99	2.00			

	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%	26.67%	22.00%	29.00%			
Inpatient (Recommend)	96%	88.22%	89.00%	89.00%			
A&E (Response Rate)	14%	20.78%	19.00%	21.00%			
A&E (Recommend)	87%	80.22%	81.00%	83.00%			
% of staff who would recommend care							
% of staff who would recommend work							
Complaints							
No of Complaints received	70	530	41	78			
No of Complaints still Open	0	2904	245	266			
No of Complaints ongoing	0	366	31	26			
Inpatient Experience							
Mixed Sex Accommodation	0	32	5	6			
eDD	95%	77.06%	77.76%	77.05%			
PPCI 90 hrs	100%	0.00%	97.33%	97.33%			
PPCI 150 hr	100%	0.00%	85.33%	85.33%			
#NOF 24	70%	62.18%	70.49%	64.00%			
#NOF 48 hrs	95%	93.11%	96.72%	94.67%			
Dementia Screening	90%	85.93%	95.68%	96.10%			
Dementia risk assessment	90%	93.75%	93.75%	95.24%			
Dementia referral for Specialist treatment	90%	56.84%	87.18%	92.59%			
Stroke							
Patients with 90% of stay in Stroke Unit	80%	85.22%	85.30%	84.40%			
Sallowing assessment < 4hrs	80%	70.58%	69.80%	78.20%			
Scanned < 1 hrs	50%	65.85%	87.50%	68.30%			
Scanned < 12 hrs	100%	96.00%	96.90%	96.30%			
Admitted to Stroke < 4 hrs	90%	68.10%	65.60%	73.80%			
Patient death in Stroke	17%	12.01%	16.00%	9.40%			
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%	80.18%	77.47%	82.60%			
12+ Trolley waits	0	1	0	0			
RTT							
52 Week Waiters	1						
18 week incompletes	92.4%	91.81%	87.17%	88.51%			
Cancer - Other Targets							
62 day classic	85%	71.53%	67.80%	69.30%			
2 week wait suspect	93%	90.04%	94.10%	95.30%			
2 week wait breast symptomatic	93%	75.10%	82.40%	94.30%			
31 day first treatment	96%	96.91%	97.40%	96.20%			
31 day subsequent drug treatments	98%	96.90%	98.90%	98.80%			
31 day subsequent surgery treatments	94%	92.79%	100.00%	91.20%			
31 day subsequent radiotherapy treatments	94%	92.05%	98.90%	97.90%			
62 day screening	90%	86.83%	89.70%	79.20%			
62 day consultant upgrade	85%	83.01%	75.90%	87.50%			
104+ Day Waiters		-	34.00	28.00			
Diagnostic Waits							
diagnostics achieved	99.1%	98.85%	99.03%	98.57%			
diagnostics Failed	0.9%	1.15%	0.97%	1.43%			
Cancelled Operations							
Cancelled Operations on the day (non clinical)		1.90%		2.60%			
Not treated within 28 days. (Breach)		7.93%		9.52%			

	Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Effective							
Mortality							
SHMI	100	111.21		111.40			
Hospital-level Mortality Indicator	100	99.54		101.70			
Length of Stay							
Average LoS - Elective	2.8	2.80	2.60	2.67			
Average LoS - Non Elective	3.8	4.49	4.45	4.66			
Medically Fit for Discharge	60	874.22	793.00	822.00			
Delayed Transfers of Care	3.5%	4.98%	4.99%	5.46%			
Partial Booking Waiting List	0	4683	4213	3736			

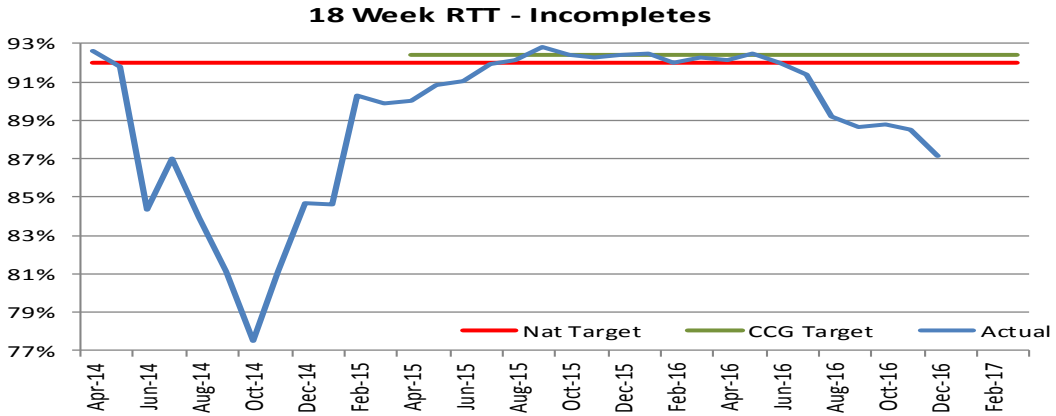
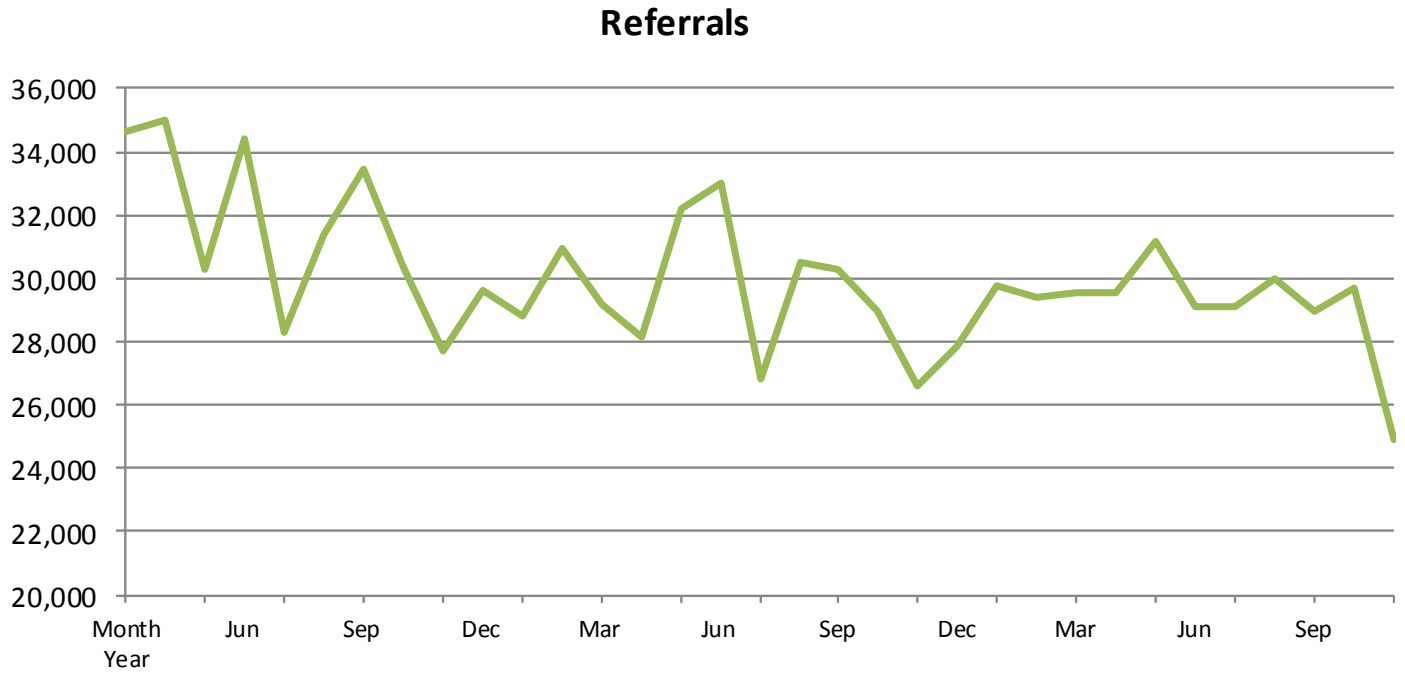
	Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Well Led							
Vacancies	5.0%	10.20%	10.68%	10.75%			
Sickness Absence	4.0%	4.72%	5.08%	4.73%			
Staff Turnover	2.4%	2.21%	1.73%	2.73%			
Staff Engagement							
Staff Appraisals	95.0%	67.11%	68.00%	70.00%			
Equality and Inclusion							

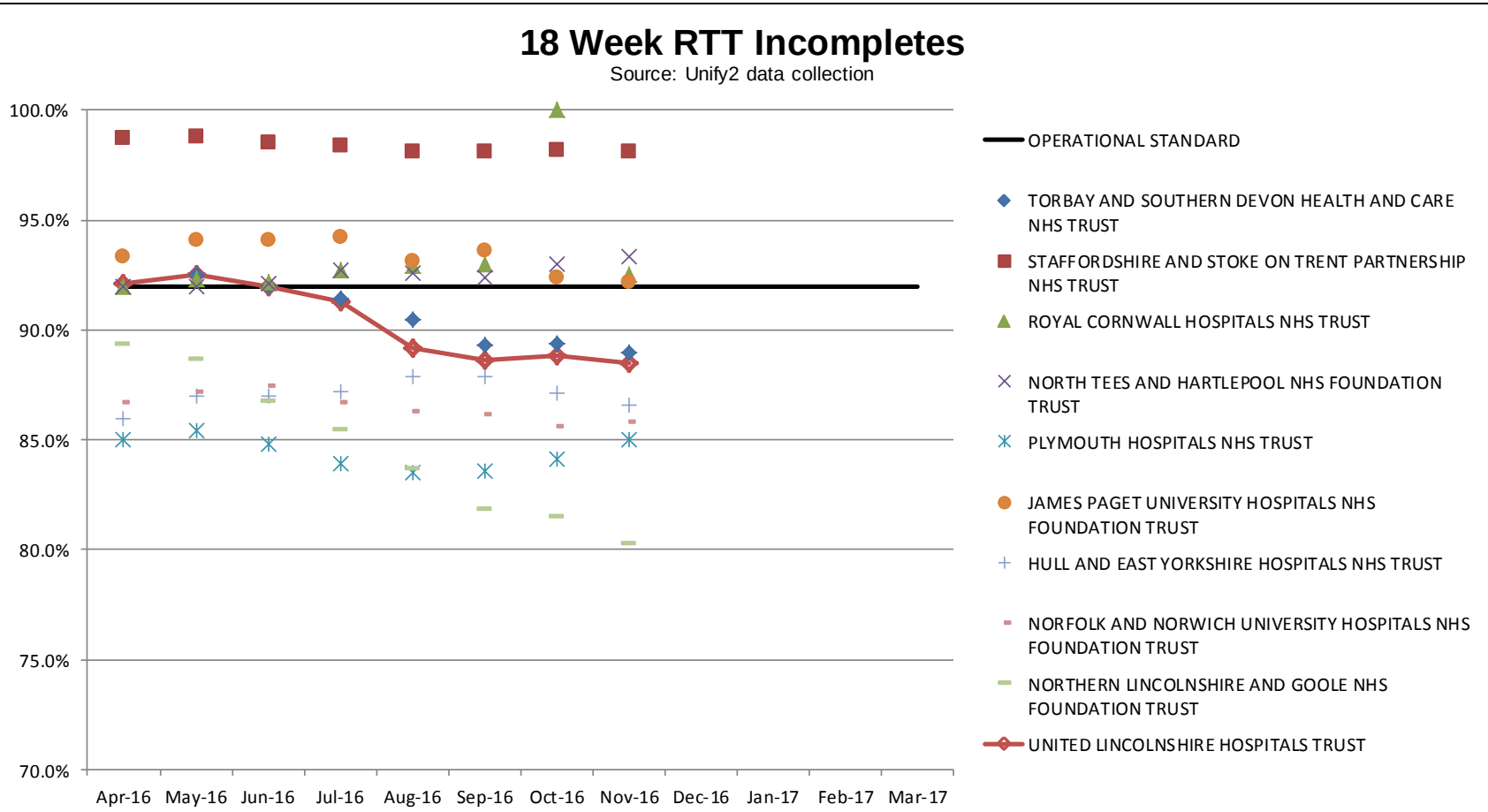
	Target	YTD	Current Month	Last Month	Expected performance for next month	Expected month of recovery	Trend
Money & Resources							
Income v Plan	36891	330842	36976	37597			
Expenditure v Plan	-39813	-353188	-38948	-40849			
Efficiency Plans	1996	12741	2550	1252			
Surplus / Deficit	-4381	-37542	-3362	-4453			
Capital Program Spend	777	7997	701	289			
Agency Spend	1058	-20433	2307	2381			

4. "Priority deliverables" – RTT Incompletes

KPI:	Referral to Treatment	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance
Date:	31st January 2017	Reporting Period:	December 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 5 months. In November the Trust reported performance of 88.5%. At a national level the standard has not been achieved for 9 consecutive months, with an aggregated national performance in November of 90.5%. One week prior to the final submission for December the performance level was 87.3%. It is expected that performance will improve prior to the final submission, with a forecast final position in the region of 88%. 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 increase in urgent care pressures during winter have 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 119 operations during December as a result of capacity issues such as lack of HDU and general beds (partially validated figures) 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)	



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

What action is being taken to recover performance?

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

Key actions contained within these plans include increasing internal capacity through additional outpatient and theatre sessions from our existing workforce and utilisation of additional locum capacity. In November key specialities provided an extra c.600 outpatient appointments. Plans are in place for c.700 additional outpatient appointments to be completed in January.

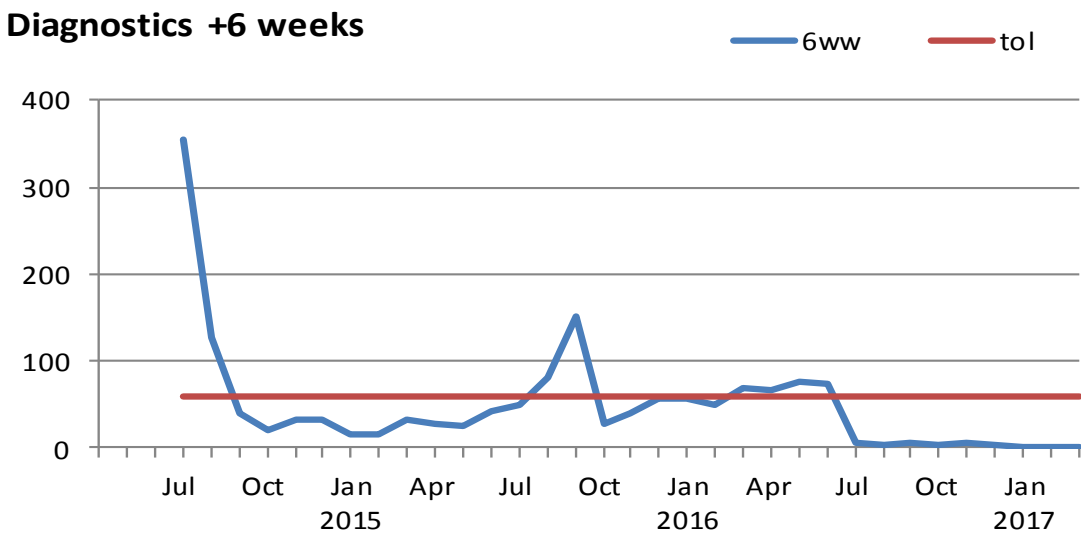
As part of the winter plan, in order to manage the anticipated surge in urgent care pressures, in January the Trust planned to complete 242 less electives and 179 more day cases than standard (plus the impact of bank holidays). Therefore a planned reduction of 63 cases.

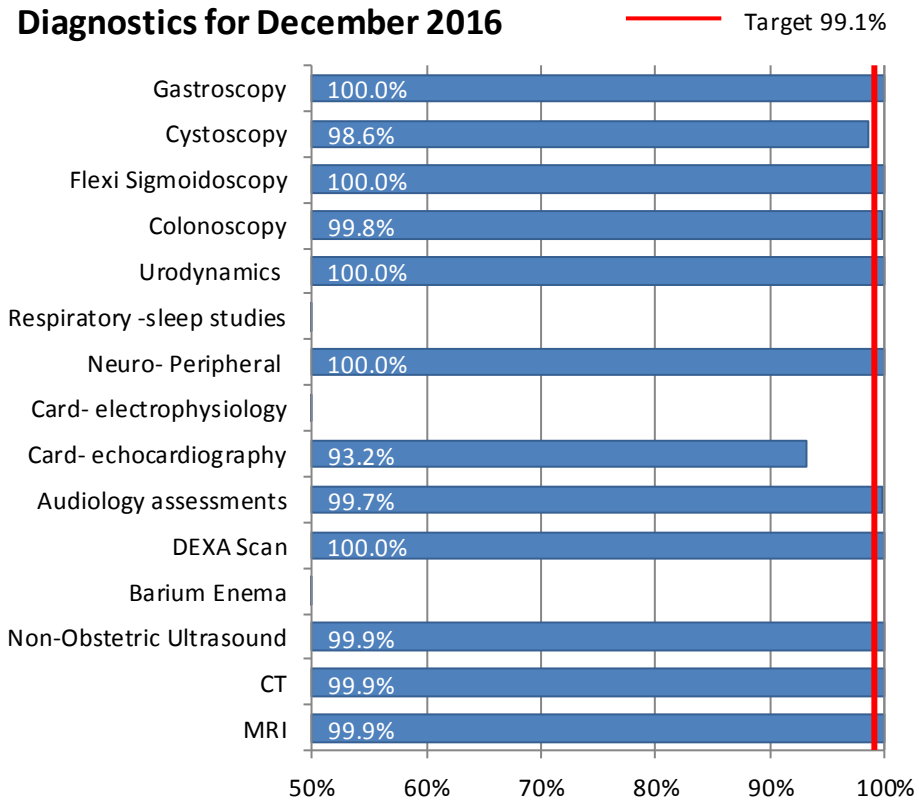
The Trust have commenced outsourcing, primarily related to Orthopaedics. The Executive Team have agreed an initial volume of outsourcing levels. There is the potential to send out a further c.70 elective cases before this initial maximum volume is reached. However, access to outsourcing capacity is currently 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 early 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

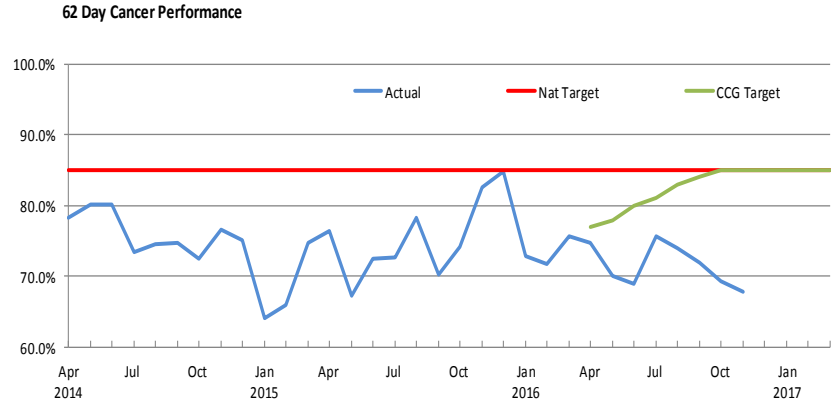
KPI:	**Diagnostic Waits**	**Owner:**	Chief Operating Officer
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Operational Performance
Date:	**31st January 2017**	**Reporting Period:**	December 2016

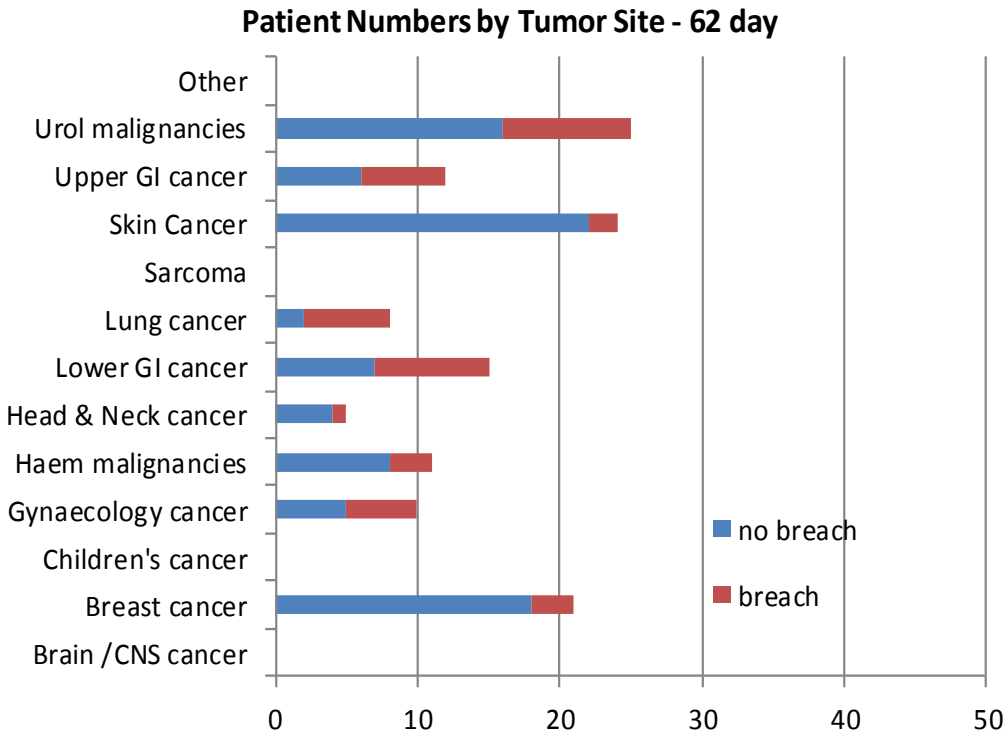
Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	In December the Trust achieved the 6 week diagnostic standard for the first time in six months. The performance level was 0.97%. The number of 6-week breaches reduced from 102 patients in November down to 70 patients in December. At modality level performance of <1% was achieved in all modalities except for Echocardiography. The level of breaches within Echocardiography has been the most significant cause of the Trust's overall failure of this standard over the last 6 months. The service have 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.
Forward Trajectory	

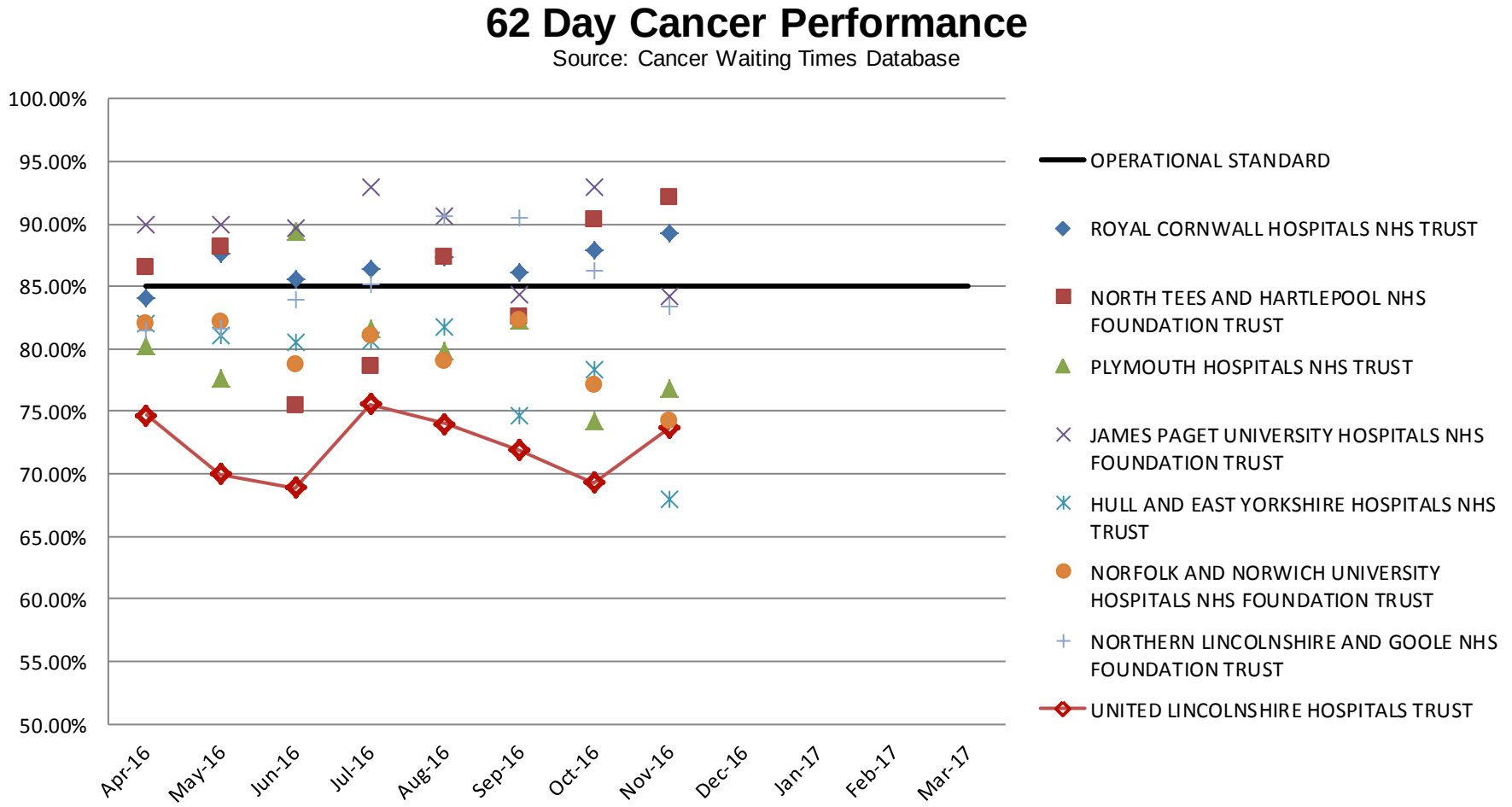
Variance Analysis (SPC Chart)	
What action is being taken to recover performance?	Further additional Echo capacity is scheduled for January in order to achieve further improvements in performance in this area, and therefore assist the overall Trust position, ensuring continued achievement of the standard in January.
What is the recovery date?	
Who is responsible for the action?	Neil Ellis – Deputy Director of Operational Performance

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:	**31st January 2017**	**Reporting Period:**	November 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	The Trust achieved a performance of 67.8% against the 62 day classic standard. The Trust achieved 5 out of the 9 cancer standards in November, missing achievement of a sixth standard (62 day screening) by only 0.3%. The Trust have now achieved the 14 day suspect cancer standard for 3 months in a row, and have achieved at least three out of the four 31 day standards for six months in a row. Demand is continuing at unprecedented levels (highest recorded December 2ww referral rate) 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.
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.

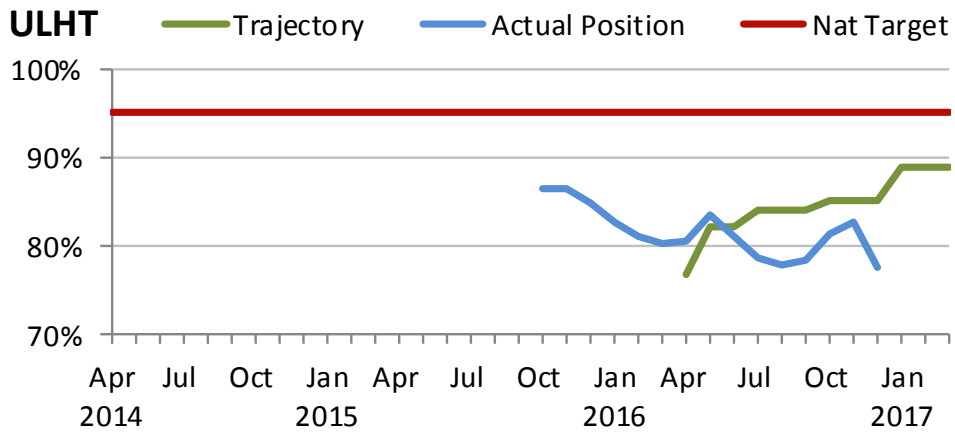
There is now a weekly Radiotherapy PTL meeting held within the department so that they have visibility of all patients waiting for RT treatment and their target dates. The continued Subsequent RT performance reflects this work.

Early indications from the Upper GI Straight to Test pilot is that there is a reduction in mean time to diagnosis from 30 days to 23 days but more work needs to be completed to validate the results and confirm the benefits of the process.

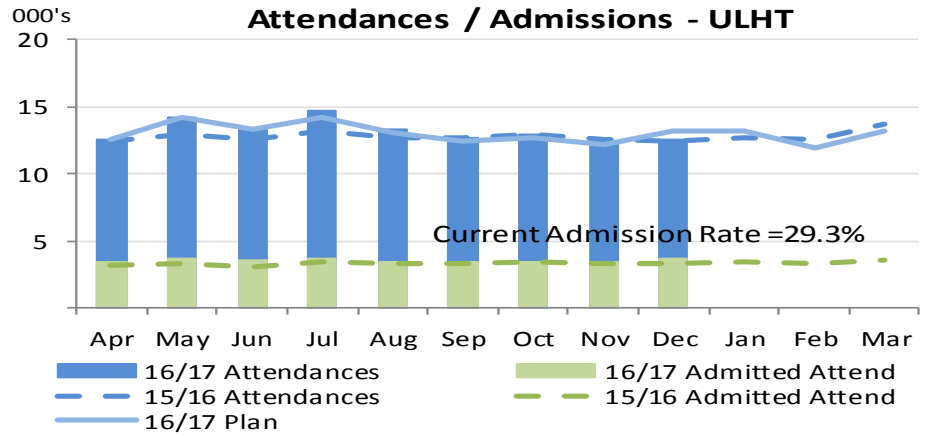
	The Somerset Cancer Register implementation continues at a fast pace. There are now 126 registered users (compared to 40 on Infoflex), including MDT Co-ordinators, Clinicians, Specialty Doctors, Business Unit teams, Bowel Screening Practitioners, Cancer Nurse Specialists, Radiology Booking Teams, Dietitians 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 other MDTs has begun. For patients referred from October onwards an RCA process has commenced for every 62 day cancer breach. This will give clear visibility of the factors contributing to the breaches and the Business Unit and corporate teams will use this information to identify trends in causes of delays, and therefore actions required to address these. 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.
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

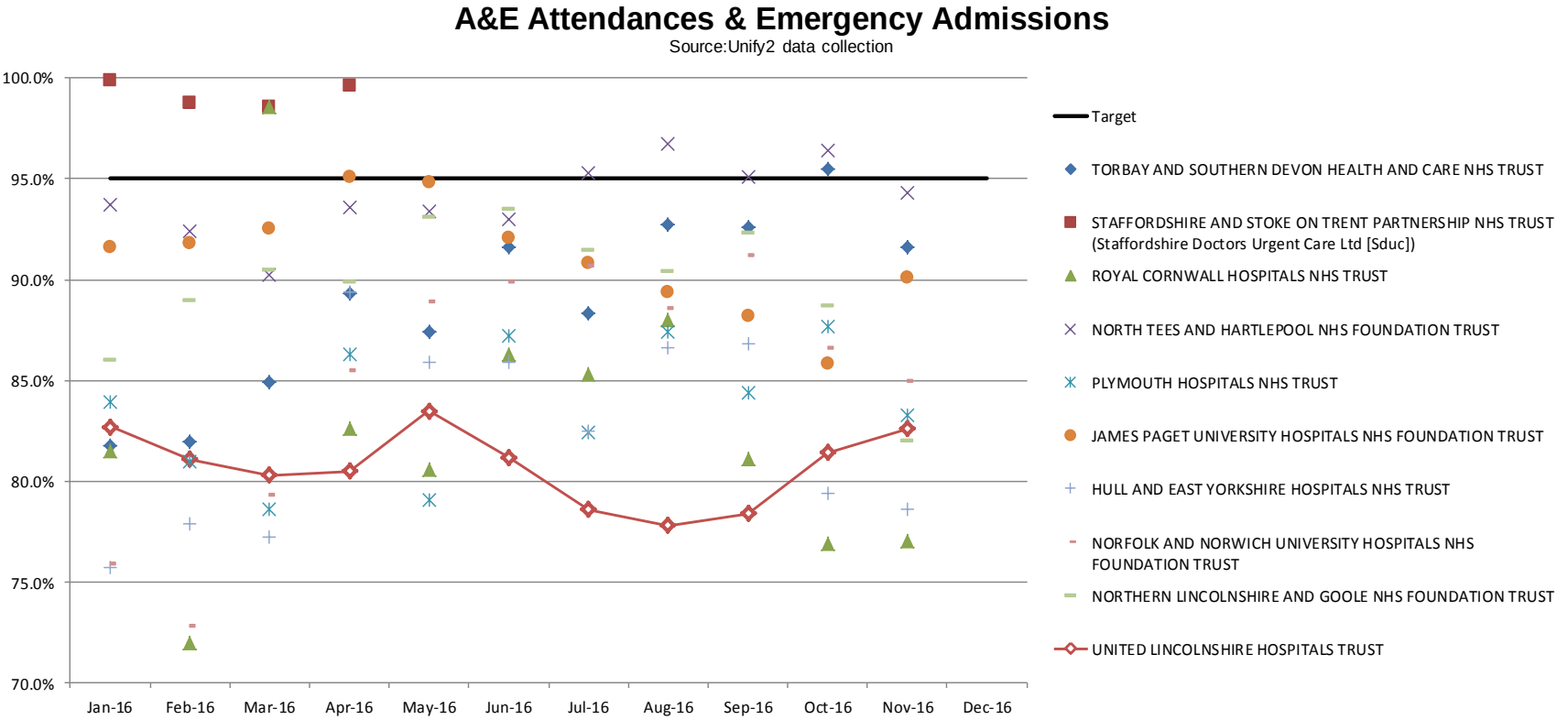
4. "Priority deliverables" – A&E 4hr Standard

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:	**31st January 2017**	**Reporting Period:**	December 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	Grantham December performance went above trajectory for this month. December performance was 96.78% (3.98% over trajectory). Quarter three performance for the site was 96.68% (1.78% over trajectory). Poor performance in the first two quarters have left a deficit currently of 1.87% 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 focused on the core opening hours. The nursing qualified deficit of 6 WTE is not affecting performance however remains a risk. The site has been fully escalated with additional 18 beds open due to increases in admissions and poor flow out due to waits for packages of care and placement. External delays have been up to 23 per day. At Lincoln, performance for December showed 73.78%, but this still fell below the STF monthly trajectory of 86.10%. Key issues affecting performance in December were poor medical and nursing agency fill rates coupled with increased staff sickness. Acuity during the immediate pre and post-Christmas period was much higher than earlier in the month and resulted in a steadily increasing number of medical outliers. Of particular note were the challenges that Paediatrics faced with their capacity and the difficulties that resulted for both the Paediatric Service and ED with them having little scope to pull their patients from the ED in a timely manner.
Forward Trajectory	

Variance Analysis (SPC Chart)



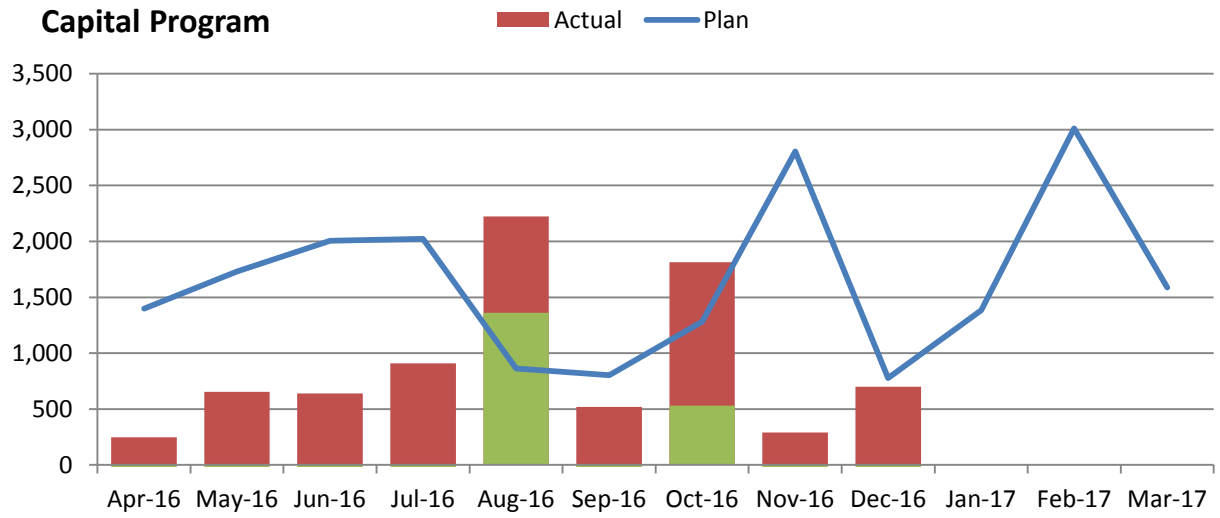


The above graph shows the latest available national performance for A&E attendances and emergency admissions. The peer group that has been selected to benchmark ULHT against consists of Trust's which have a similar rural structure and patient demographics.

What action is being taken to recover performance?	At Grantham an internal review of the triage and first assessment processes continue as a focus to prevent unnecessary breaches. Currently triage is at 100% for minors. Review of team working introduced in August is under way to ensure that the processes implemented are not causing delays in referral. Majors triage has been reorganised to ensure triage rates as a whole for the site achieve the 15 minute standard. An agreement on site of speciality review within 30 minutes has been implemented. At Lincoln the Frailty Service has been and continues to be successful and is turning round up to 10 patients a day. A new triage system was trialled in ED with a view to adjusting the workforce in the future to support earlier streaming of patients thus reducing delays and also improving patient safety. Additional medical support was planned into the site with additional acute medicine consultant time at weekends, plus twilight medical registrars based in ED and weekend EDD doctors. The discharge lounge also opened at weekend and the focused work on EDD's and the lounge together greatly improved the number of weekend discharges. Daily ward round feedback meetings have occurred with Ward Leads at lunchtime every day in Medicine with a focus on planning discharges for tomorrow and identification of medical outliers. A new Medical Outlier policy launched the week prior to Christmas which facilitates a much more even spread of outliers across the medical teams and has improved ownership of outliers with a consequent improvement in safety with more robust access to daily senior reviews.
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

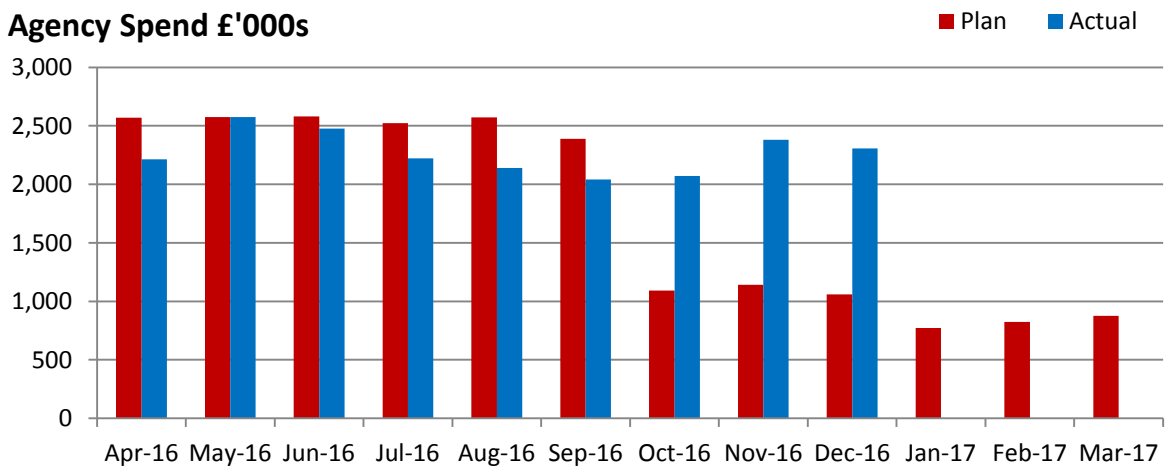
4. "Priority deliverables" – Money & Resources

KPI:	Capital	Owner:	Director of Finance
Domain:	Responsive	Responsible Officer:	Deputy Director of Finance
Date:	31st January 2017	Reporting Period:	December 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	There is currently underperformance across a couple of schemes and the 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 Capital Resource Limit for the year, which is £16.3m
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. The plan will be delivered this year as actions are in place to spend against the slipped schemes.
What is the recovery date?	March 2017
Who is responsible for the action?	Chris Farrah, Assistant Director of Estates and Capital Plans

4. "Priority deliverables" – Money & Resources

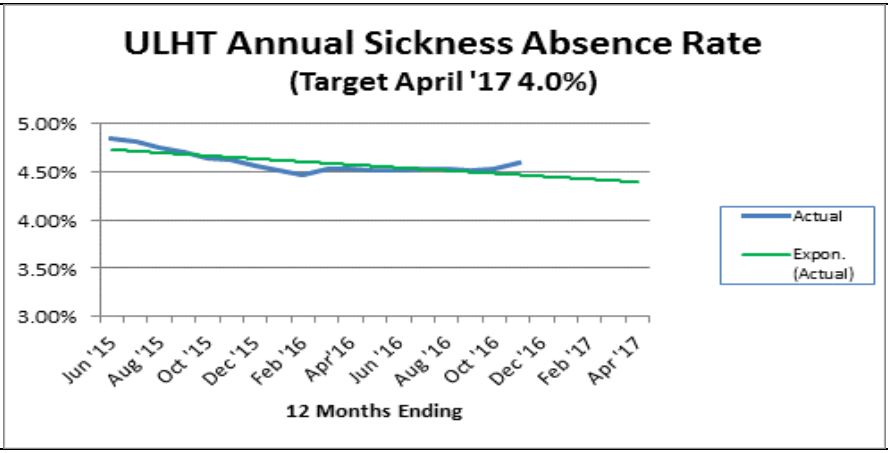
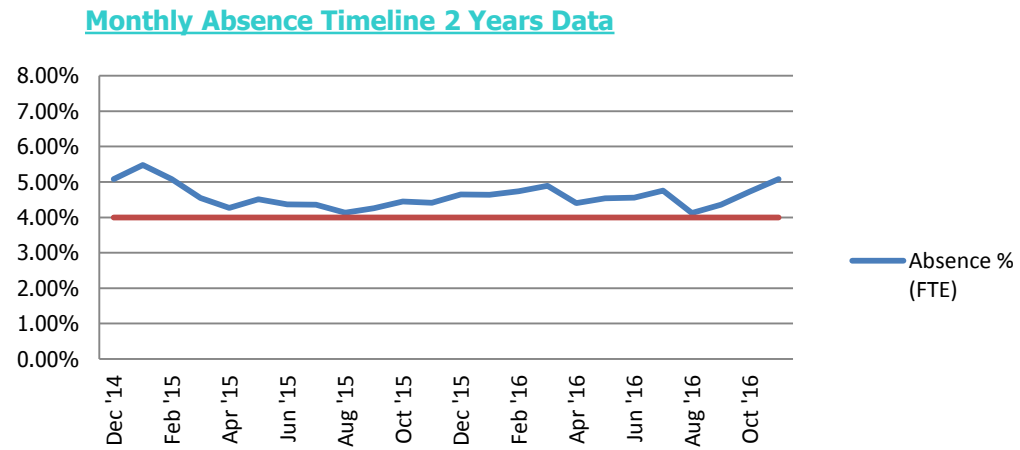
KPI:	Agency Spend	Owner:	Director of Finance
Domain:	Responsive	Responsible Officer:	Deputy Director of Finance
Date:	31st January 2017	Reporting Period:	December 2016

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. Exception Report: Well-led

KPI:	**Sickness Absence**	**Owner:**	Director of Human Resources
Domain:	**Well-led**	**Responsible Officer:**	Assistant Director of Human Resources
Date:	**31st January 2017**	**Reporting Period:**	December 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 4.60% as at November 2016 has reduced by 0.02% in comparison to the November 2015 figure (4.62%). Monthly sickness rate for November 2016 is 5.08%. Sickness absence data is reported two months in 'arrear'. The annual cost of sickness (excluding any backfill costs) has decreased by £31,184 (from £8,663,496 as at Nov '15 to £8,632,312) compared to 12 months ago. During the 12 months ending November 2016, Anxiety/Stress/Depression and other Psychological illness was the top reason for time lost due to sickness at 19.98% of all absence. • Work related: 1.47% • Non Work related: 18.51% The 'entries' on ESR for 'work related' absence for anxiety/depression is reliant on Managers 'ticking' the relevant 'box' in ESR. If not selected, the absence will be default show this as 'not-work' related absence. As such the actual sickness rate for work related stress may be higher as reported at present. Additional Clinical Services had the highest sickness rate during the 12 months at 6.88% (Unregistered Nurses 7.59%) followed by Estates & Ancillary at 6.36% and Nursing & Midwifery Registered at 4.90%. Benchmarking data from NHS Digital (previously Health & Social Care Information Centre - HSCIC) indicate that ULHT has the thirteenth highest sickness rate (lowest at 3.13% and highest 5.48%) against an average of 4.70%. The benchmarking is done across x39 Large Acute Trusts. Comparison data with other Lincolnshire Trusts: LCHS – 6.1% LPFT – 4.76%

Forward Trajectory	
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. • Further analysis on sickness by 'Department/Ward' are planned to support 'League' table to identify 'hot spot' areas and at same time identify 'good practice' which could be applied trust wide. • 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. A 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:	**31st January 2017**	**Reporting Period:**	December 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 (December) is 10.68%, which is a decrease of 0.07% on November. Previous month's performance was:

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	9.80%
August 2016	11.75%
September 2016	10.54%
October 2016	11.09%
November 2016	10.75%

Vacancies have increased by 3.24% over the last 12 months (7.44% to 10.68%)

13.94% of medical roles are vacant. There has been an increase of 16.24 FTE Medical Staff in post over past 12 months.

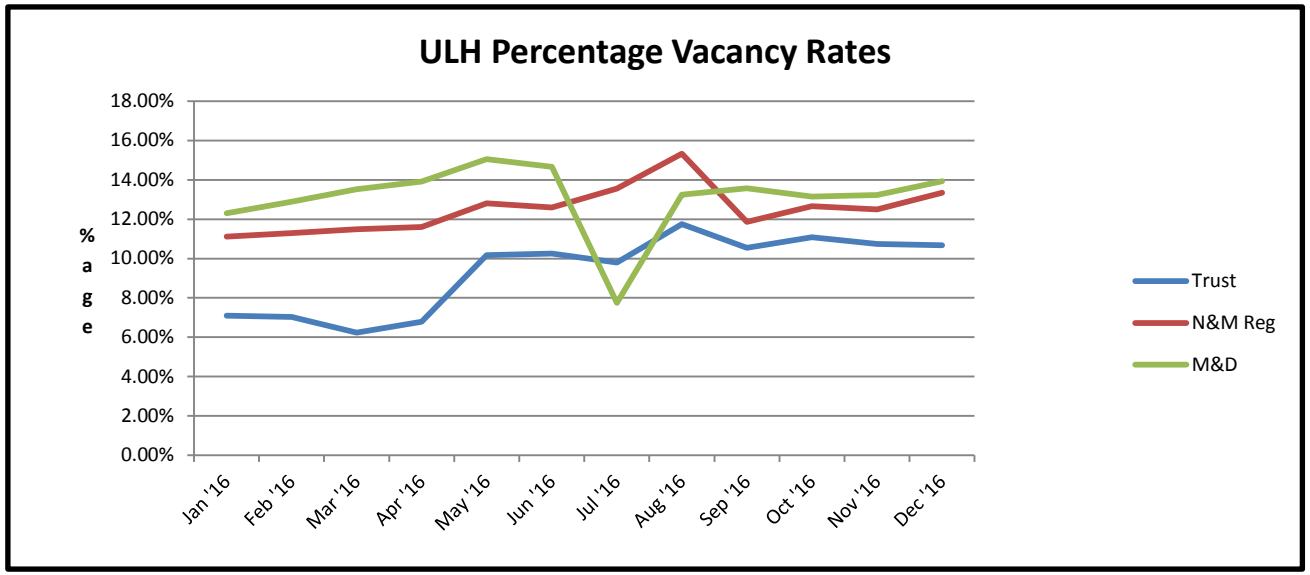
13.35% of all Registered Nursing & Midwifery roles are vacant. The number of band 5 nurses in post has increased over the last 12 months by 18.66 FTES to 1108.08 FTEs.

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

International Nurse Recruitment: A further three (3) International nurses will join the Trust during February, with a further five (5) awaiting decisions from the NMC.

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?	• We need to ensure we are engaged with the Lincolnshire Healthcare Attraction Strategy • A 'Nurse Recruitment' Workshop took place with the Nursing & Medical to discuss recruitment approached and requirements going forward and an Action Plan will be signed off shortly. • A similar 'Medical Recruitment' Workshop will be held during February. • Through the Business Unit Workforce Plans, specific Recruitment Action Plans will be identified when/how staff will be recruited, with emphasis on Business Unit accountability and ownership of plans • We continue to explore options around the introduction of an applicant tracking system (Q3 - 2017/18). • Work continues as part of the Apprentices Programme as well as the STP Workforce Transformation Programme to explore 'new roles' e.g. ACP's, NP's, Nurse Associates and Apprenticeship roles • All non-clinical 'recruitment' is signed-off by the Executive Team. • Vacancy Reports are shared with Clinical Directors and Corporate Directors, which highlight 'risk' areas and enable 'ownership' of recruitment at BU/Directorate level. • An HR Recruitment Recovery Plan has been identified with key actions to improve/enhance our internal processes • All Wards/Departments with vacancies of x1 WTE or more for Band 2's have been identified and information have been shared with the relevant stakeholders for further action. • Finance is working with Ward Managers to compare 'In-Post' and 'Establishment' data held at Ward/Departmental level with Finance/Ledger information and to 'agree' establishments going forward. This will support more accurate reporting of vacancies
What is the recovery date?	It is unlikely that we will recover to target by March 2017. The medical and nursing recruitment reviews/workshops taking place will identify a new trajectory of improvement. Subsequently we will set a new target for the year ahead.
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 Clinical Directors 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:	31st January 2016	Reporting Period:	December 2016

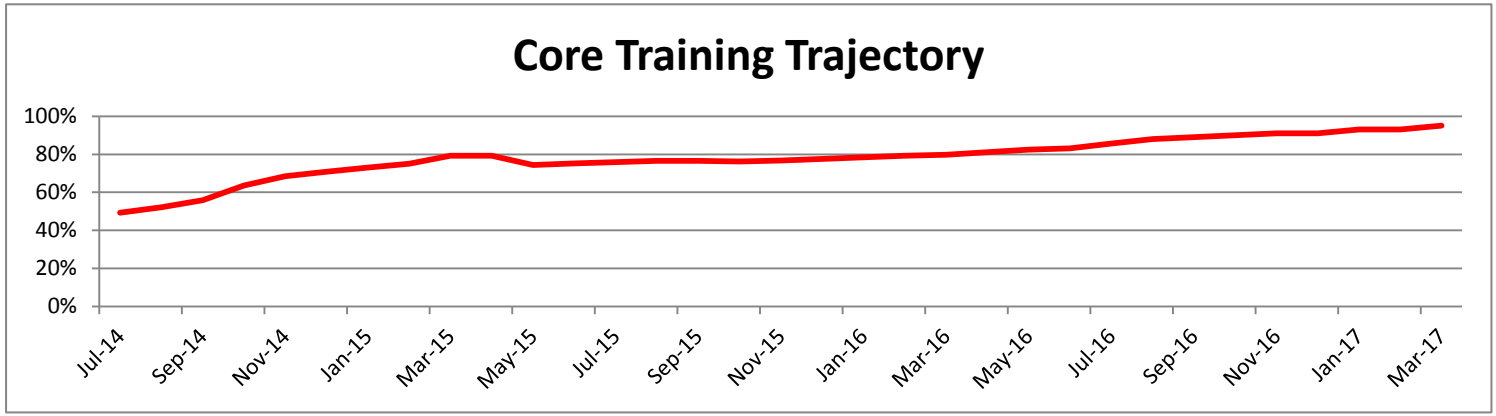
Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)

The Trust has a target of having 95% for Core Learning. This month sees another increase of 1% to 87%. Although the 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:
December 2014 – 71%
December 2015 – 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%*
Nov-16	*86%*
Dec-16	*87%*

- From October 2016 BLS compliance has been included in overall compliance following the 6 month introduction period. Compliance for BLS has increased by 4% this month to 70% having increased from April's 24%.
- Compliance for Fire increased by another 2% this month following the introduction of the new e-learning package. Infection Prevention increased by 2% and Information Governance by 1%. All 3 are between 11%-14% higher than this time last year.
- The DNA 'No Show' rate remains unchanged at 24% this month.
- Comparative data from East Midlands Benchmarking Group (x8 Trusts) shows none of the Trusts have reached a 95% compliance rate at this point (lowest 74.70% and highest 93.24%)

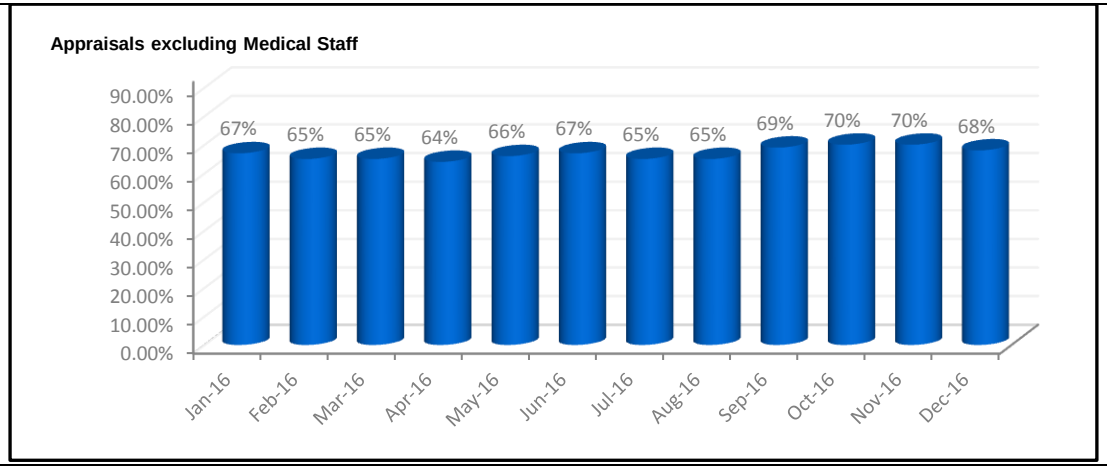
	• Concerns continue in that 13% of our staff remain non-compliant for core learning and potential risks associated.
Forward Trajectory	We have seen a gradual improvement/increase in compliance rate, however it's unlikely that we will achieve our compliance by March 2017. 
Variance Analysis (SPC Chart)	<table><tr><th>Trust</th><th>Fire</th><th>IPC</th><th>E&D</th><th>IG</th><th>SGC1</th><th>SGA1</th><th>H&S</th><th>Slips</th><th>M&H IL</th><th>Risk</th><th>Fraud</th><th>BLS</th><th>Average</th></tr><tr><td>Oct-16</td><td>75%</td><td>79%</td><td>97%</td><td>82%</td><td>90%</td><td>90%</td><td>90%</td><td>92%</td><td>91%</td><td>89%</td><td>90%</td><td>61%</td><td>85%</td></tr><tr><td>Nov-16</td><td>77%</td><td>79%</td><td>97%</td><td>82%</td><td>91%</td><td>91%</td><td>91%</td><td>93%</td><td>91%</td><td>89%</td><td>91%</td><td>66%</td><td>86%</td></tr><tr><td>*Dec-16</td><td>79%</td><td>81%</td><td>97%</td><td>83%</td><td>91%</td><td>90%</td><td>90%</td><td>92%</td><td>91%</td><td>89%</td><td>92%</td><td>70%</td><td>87%</td></tr><tr><td>**Dec-16</td><td>74%</td><td>79%</td><td>91%</td><td>80%</td><td>83%</td><td>82%</td><td>87%</td><td>87%</td><td>84%</td><td>86%</td><td>89%</td><td>59%</td><td>82%</td></tr></table> *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 onwards will be made available later in January. • 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. • 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. • We continue to encourage employees to complete core learning, which also include comments on 'Blogs' and regular updates from on Chief Executive Officer. • We are liaising with the Trust (mentioned earlier), achieving 93.24% compliance to learn from their 'good practice' and 'actions' to further increase our compliance rate. • 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?	We are unlikely to achieve the target by March 2017. A new target will be set 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:	**31st January 2017**	**Reporting Period:**	December 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 December is 67.58%. *Appraisal Compliance rate (Year-on-Year) comparison:* December 2015 - 67% December 2014 - 69% The overall percentage for appraisals has reduced by 2.82% 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. X2 Directorates have a compliance rate less than 50% X6 Directorates have a compliance rate below 65% The remaining x10 Directorates have a compliance rate between 65% and 88.89% Appraisal rates reduced at all four sites with Lincoln and Pilgrim seeing a reduction of over 2%, Grantham over 4% and Louth more than 8%. It is not in the HR Directorates 'gift' to deliver on appraisals/improve appraisal rate, until we are culturally in a better place and have greater commitment and accountability from Clinical Directors and Managers to deliver on this. Benchmarking with other Lincolnshire Trusts: LCHS – 76.70% LPFT – 89.58%
Forward Trajectory	We have consistently not achieved a compliance rate above 70% (highest to date) and it is therefore unlikely that we will achieve the target of 95% at year end.

Variance Analysis (SPC Chart)	
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. • We continue to identify 'hot spot' areas with low appraisal rates and encourage managers to action accordingly • 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) Head of Medical Revalidation, Sue Powley supported by the Revalidation Administrator.

4. Exception Report: Safe

KPI:	Staff Turnover	Owner:	Director of HR
Domain:	Safe	Responsible Officer:	Elaine Stasiak, Workforce Intelligence
Date:	31st January 2017	Reporting Period:	December 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 12 month rolling average as at December is 9.48%, which is a decrease of 0.33% on November. 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%

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 Dec '16 is 6.84%

We've had 34.66 leavers during December. Of the leavers 46.13% was due to retirement and 52.63% was due to voluntary resignations.

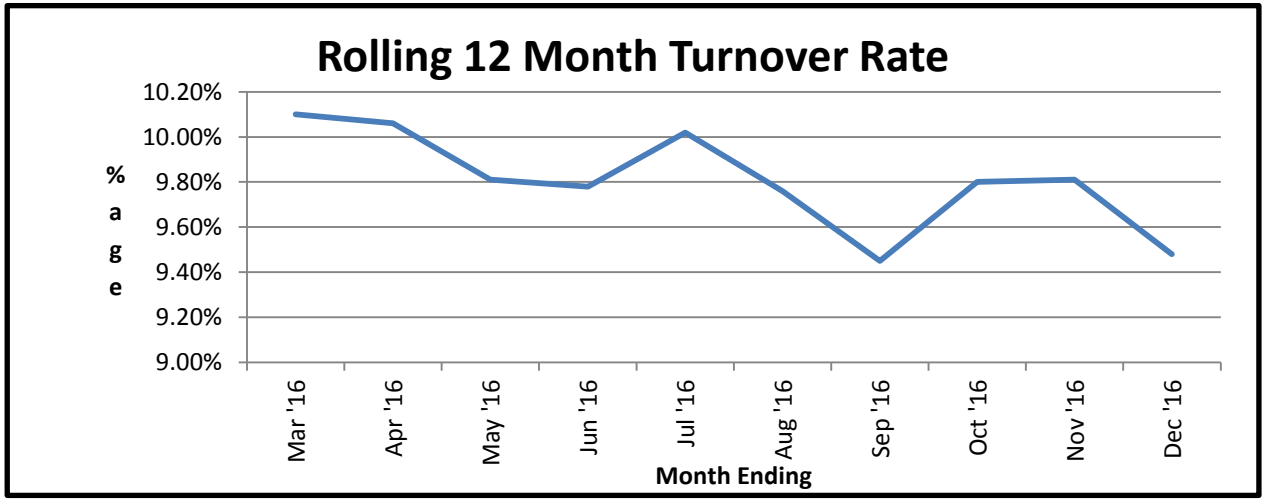
Comparative November data from the East Midlands 'Benchmarking Group' (x10 Trusts) indicate that ULHT has the second lowest rate (lowest at 9.68% and highest 14.24%).

Nursing and Midwifery turnover rate has slightly decreased in month to 9.06% (down from 9.28%). Medical and Dental Staff turnover rate has increased in month to 15.33% (up from 14.48%).

Based on the latest (October 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 9.48% is below the average of 10.49%
- The current Trust Nursing & Midwifery (Registered) turnover rate of 9.06% is below the average of 11.35%,
- Other Non-Medical Clinical Services (usually unregistered) 12.33% is below the average of 14.48%.
- AHP's 12.10% is below the average of 12.87%.

Although the overall turnover rate is below the 'average' (benchmark), the concerns remain that we continue to 'lose' staff in the

	areas/specialities we can't afford to do so.
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 four months.
Variance Analysis (SPC Chart)	 **Trust Turnover** **Leavers by Month January 16 – December 16**

Staff Group	Establishment as at 31.12.16	SIP as at 1.01.16	SIP as at 31.12.16	Average SIP	Leavers 1.01.16 - 31.12.16	Turnover SIP	Turnover Leavers against establishment
Nursing & Midwifery	2265.04	1944.20	1962.71	1953.45	177.05	9.06%	7.82%
Medical (excluding juniors)	552.73	460.74	478.87	469.81	72.04	15.33%	13.03%

What action is being taken to recover performance?	• Review of the exit interview process is underway to ensure 'higher return rate and capture of wider staff groups' • Exploring options to enhance the format of the exit 'report' to enable reporting at Business Unit level to identify 'hot spot' areas/topics. • Age/Retirement Profile and 'projected exit dates' will form part of broader Workforce Planning 'Agenda' to identify pro-active plans . • More flexible 'retirement' options will also be explored as part of the overall 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:	Sepsis	Owner:	Medical Kapadia
Domain:	Safe	Responsible Officer:	Quality & Safety Manager
Date:	31st January 2017	Reporting Period:	December 2016

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

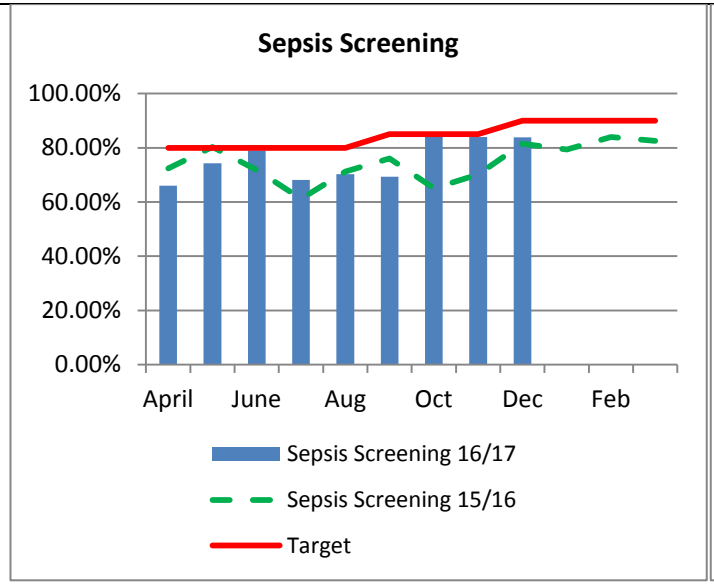
Site	Bundle Commenced –Dec 16	IVAB within 1 hour – Dec 16
Grantham	87.5%	80%
Lincoln	94.44%	66.67%
Pilgrim	72.73%	75%

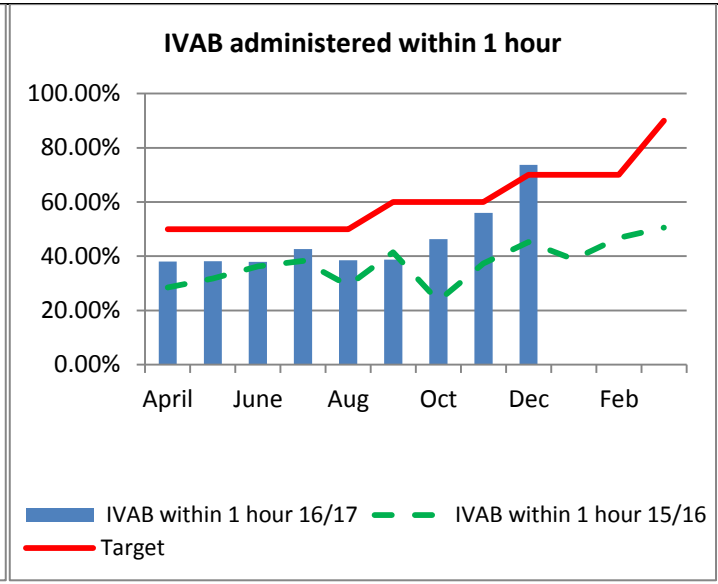
The data is demonstrating an improvement at Lincoln and Grantham however Pilgrim have had a deterioration for screening. For IVAB administered within 1 hour Lincoln site has slightly deteriorated (Nov 73.91%).

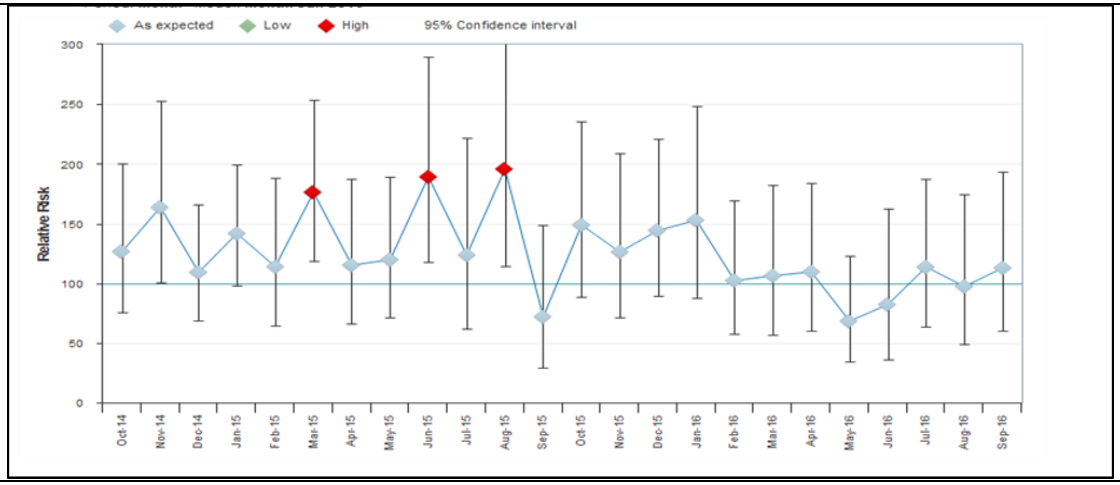
Forward Trajectory

To achieve our CQUIN target for Q3 the Trust needs to achieve 90% for screening and 90% for administration of IVAB within 1 hour. To maintain a HSMR of 100 or less.

Variance Analysis (SPC Chart)

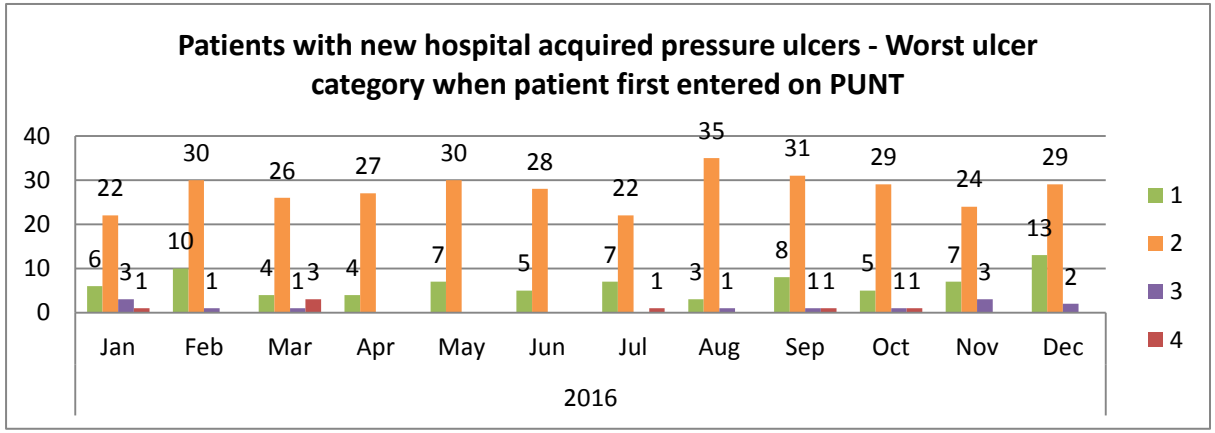


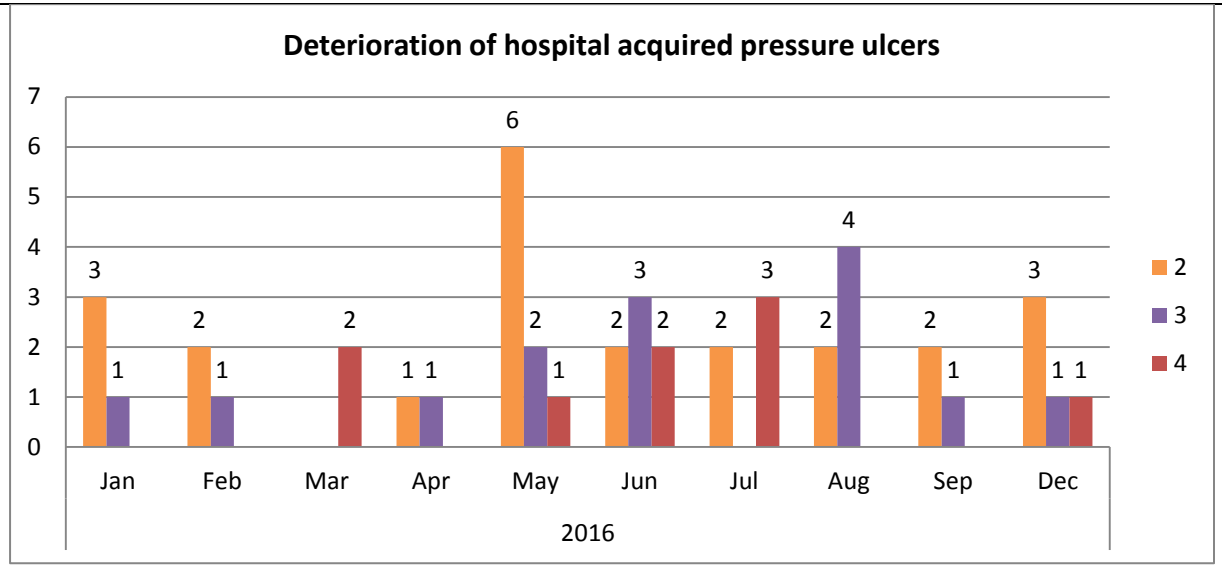


	
What action is being taken to recover performance?	There are 2.0 WTE seconded as sepsis nurses – 1.0 WTE at Pilgrim and 1.0 WTE at Lincoln. They will alternate and visit Grantham 1 day a week. The job description was approved and substantive post is currently being advertised. eBundle being piloted to ensure no bugs are present Clinical education team have trained 183 nurses to be Silver and Gold level Guardians. Compliance with eLearning has improved since mapping was completed in November for frontline staff has occurred; 01-Nov-16 = 18% 30-Nov-16 = 35% 08-Dec-16 = 43% 11- Jan-17 = 61%
What is the recovery date?	As soon as possible
Who is responsible for the action? (Provide the role and name of the lead)	Trust Sepsis Lead

4. Exception Report: Safe

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:	31st January 2017	**Reporting Period:**	December 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 Pressure ulcers (including detriorations from previously reported Category 2 damage - 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 Trust cumulative incidence for December was = 7% (Cat 2), 0.7%* (Cat 3) and 0.35%* (Cat 4) as calculated per 1000 in-patient bed days. *(*PHB bed days only used to calculate).* *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. 2 to a 3 and a 3 to a 4).
Forward Trajectory	All ULHT staff are being supported to try to ensure that the achievement of this KPI is as soon as possible. The aim is to eliminate category 3 / 4 pressure ulcers.
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 recently delivered by the Nurse Consultant – Tissue Viability. Further dates being planned! 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. Completed RAD's have been completed and signed off by finance. It is hope to have these posts by end of April/early May 2017.
What is the recovery date?	ASAP or by the end of March 2017.
Who is responsible for the action? (Provide the role and name of the lead)	Mark Collier, Nurse Consultant – Tissue Viability (ULHT).

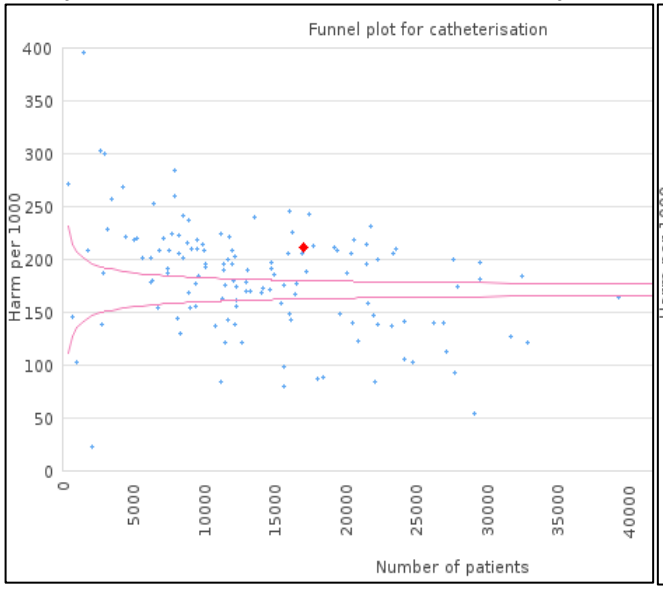
4. Exception Report: Safe

KPI:	Catheter Associated Urine Tract Infection (CAUTI)	Owner:	Medical Director
Domain:	Safe	Responsible Officer:	Quality & Safety Manager
Date:	31st January 2017	Reporting Period:	December 2016

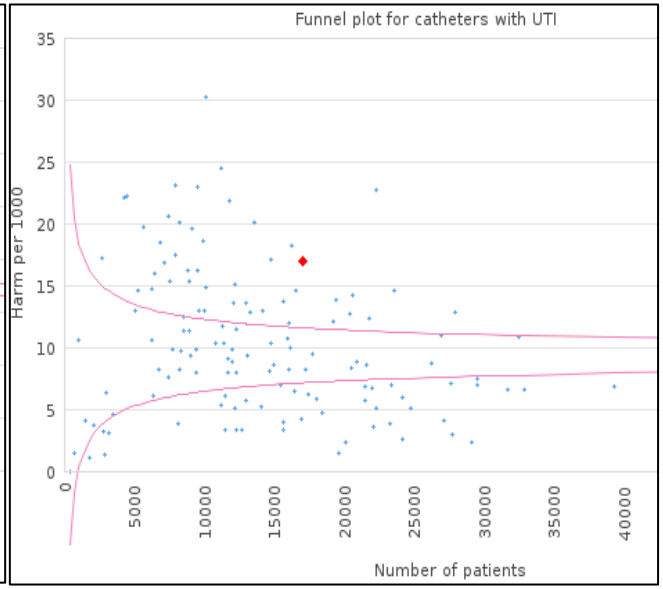
Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	It is acknowledged that in ULHT the catheter insertion rate and subsequently CAUTI are higher than the national average rate. Data is collected through the safety thermometer and SQD. The main reason for the high number of catheters inserted is patient being acutely ill and for urinary retention. Another reason for this phenomena could be the way different organisation report their safety thermometer data. Therefore the Patient Safety committee decided to explore the methodology employed by other organisations in the midlands used to collect ST data, as this could explain the discrepancy in the catheter insertion rates.
Forward Trajectory	To not exceed 1 catheter and UTI each month
Variance Analysis (SPC Chart)	Safety Quality Dashboard Jan 16- Dec 16

Metric Title	Jan-2016	Feb-2016	May-2016	Jun-2016	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016
Number of urinary catheters in-situ	65	73	72	74	75	81	63	72	81	53
Urinary catheter record demographics correct	90.90 %	87.70 %	90.10 %	84.90 %	90.40 %	95.00 %	96.80 %	86.10 %	98.80 %	90.20 %
Urinary catheter record completed &signed daily	54.50 %	64.40 %	72.20 %	57.50 %	57.50 %	72.20 %	65.10 %	65.30 %	72.20 %	58.80 %
TWOC occurred within 3 days for acute retention	14.30 %	25.00 %	100.00 %	50.00 %	36.40 %	40.00 %	50.00 %	40.00 %	58.30 %	50.00 %
Documented evidence why catheter needed	83.30 %	83.60 %	87.30 %	87.30 %	89.00 %	91.10 %	96.80 %	86.10 %	97.50 %	92.20 %
Urinary catheter bags secure	100.00%	100.00 %	100.00 %	100.00%	100.00%	100.00 %	100.00 %	100.00%	100.00 %	100.00 %
Urinary catheter care plan activated	74.20 %	78.10 %	83.30 %	82.20 %	87.50 %	88.60 %	90.50 %	83.30 %	90.10 %	88.20 %

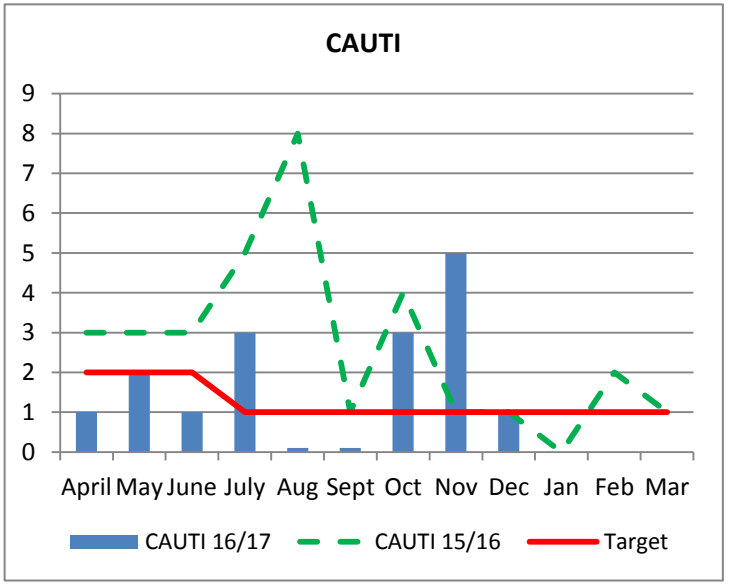
Safety Thermometer data – Catheters



Safety Thermometer data – Catheters and UTI



Number of Catheters and UTI

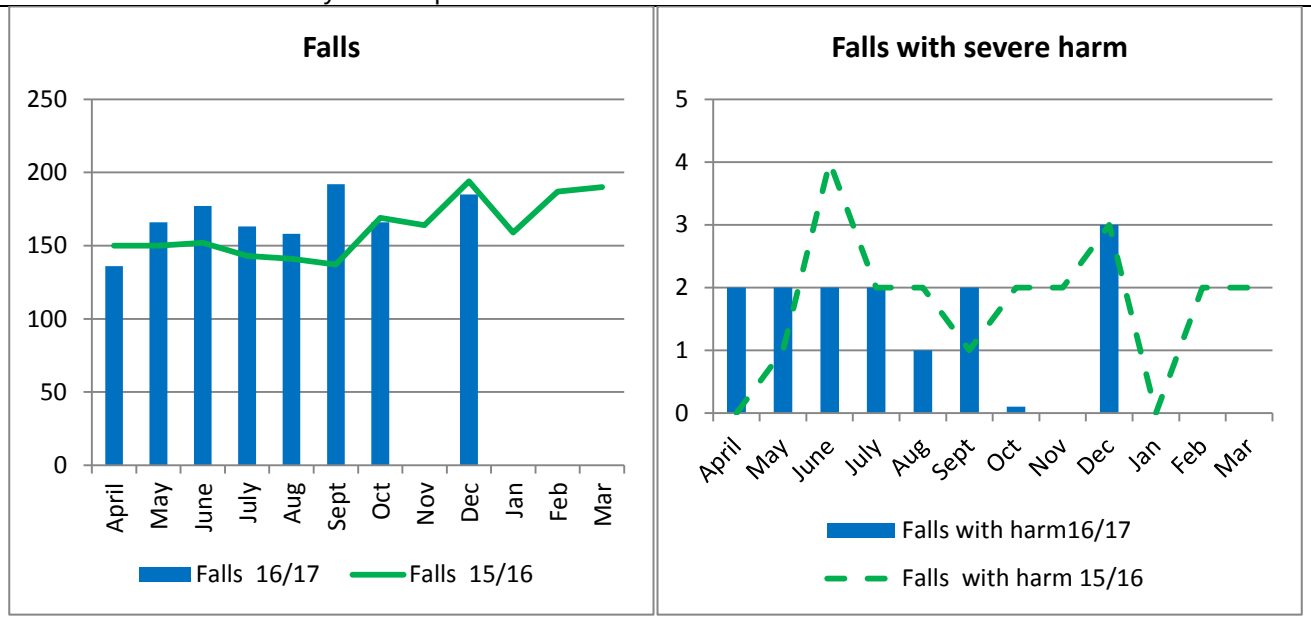


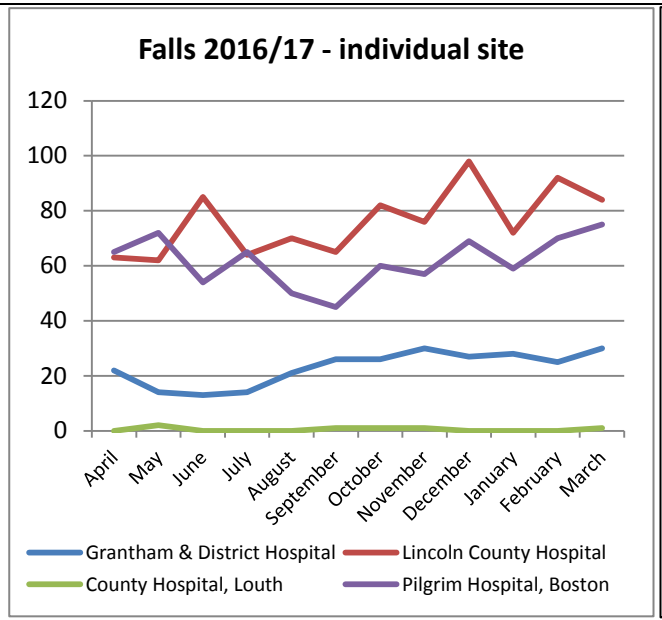
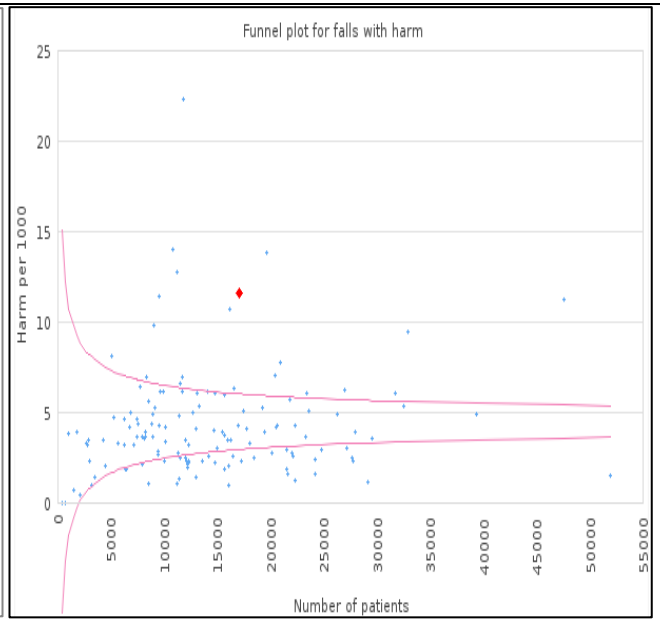
What action is being taken to recover performance?	• Development of a new catheter care bundle to decrease inappropriate catheter insertion. The new bundle does incorporate four interventions related to reducing urinary catheter-associated infection recommend by The EPIC Project guidelines. • Development of a nurse led catheter removal protocol incorporated within the catheter care bundle to minimize the

	incidence of hospital-acquired CAUTI, actively supported across the Trust by all Urology CNS. • CAUTI reported through Safety thermometer are regularly reviewed by the Urology CNS and a root cause analysis undertaken. The lessons learned from these episodes are shared at the monthly CAUTI meetings and an action plan is taken upon these incidents. • Introduction of an 'All in one Catheterisation Pack' from Bard. The unique feature of this pack is that the urinary catheter is pre-connected to the drainage bag and sealed with a plastic seal. The evidence showed that it reduced the incidence of CAUTI's by 41% compared to open-systems. Launching date pan trust is 30st of January 2017 • Ongoing clinically based education is being provided Urology CNS on all sites within all clinical areas. • Reintroduction of Continence link nurse into wards practice • Education programme developed in conjunction with clinical educators to teach nursing staff the principles of male Catheter insertion technique and ongoing catheter care to help reduce the CAUTI rate. Our target will be to have 65% ward based compliance within the first year (from February 2017) eventually resulting as near 85% compliance within 2 years.
What is the recovery date?	ASAP or by the end of March 2017.
Who is responsible for the action? (Provide the role and name of the lead)	Zina Bojin, Nurse Consultant – Urology (ULHT).

4. Exception Report: Safe

KPI:	**Falls**	**Owner:**	Medical Director
Domain:	**Safe**	**Responsible Officer:**	Deputy Chief Nurse
Date:	**31st January 2017**	**Reporting Period:**	December 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	The static position is due to the increase of falls with harm on the Pilgrim site which has increased 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. The safety Thermometer data is demonstrating ULHT as an outlier for falls however this data encompasses falls in the community and it has been highlighted that all Trusts are not utilising the same methodology to collect this data. The Trust is reviewing the methodology at other Trusts.
Forward Trajectory	Target is to reach 0.19. Unable to produce SPC charts comparing falls with 1000 bed days for January 2017 but this will be rectified for February 2017 report. Due to technical issues with Datix the data for November 2016 is unavailable.
Variance Analysis (SPC Chart)	 Safety Thermometer – Nov 15 - 16

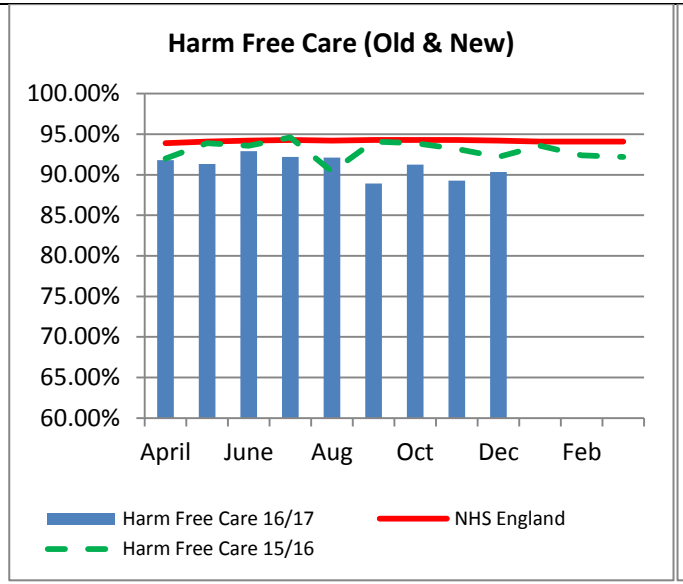
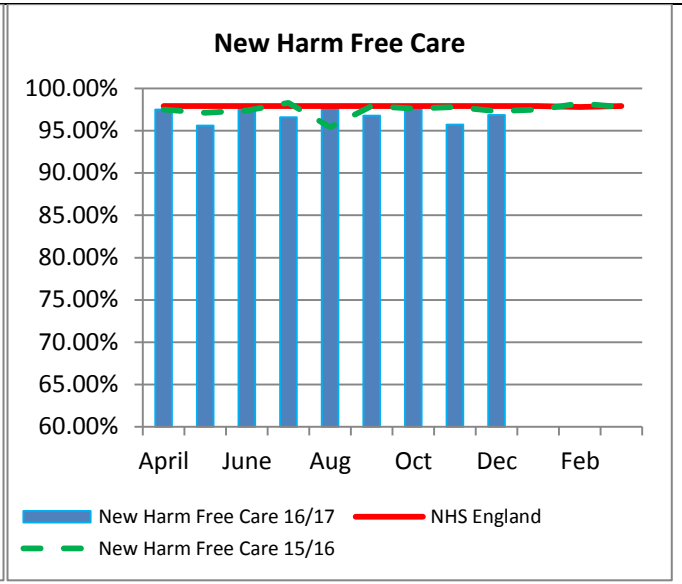
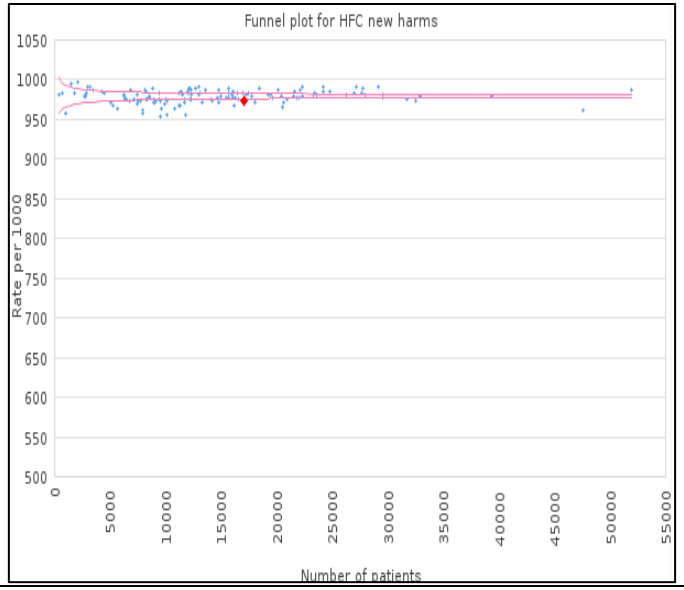
	 
What action is being taken to recover performance?	• An improvement plan for Pilgrim has been developed • Multi-professional scrutiny panels are in place for all falls resulting in death or severe harm and are due to be extended to moderate harm for hot spot areas • Lying and standing blood pressure 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
Who is responsible for the action? (Provide the role and name of the lead)	Penny Snowden, Deputy Chief Nurse

4. Exception Report: Safe

KPI:	**Safety**	**Owner:**	Medical Director
Domain:	**Harm Free Care**	**Responsible Officer:**	Quality & Safety Manager
Date:	23rd January 2017	**Reporting Period:**	December 2016

Exception Details (provide an overview explanation / cause of the variance to performance and the consequences)	The NHS Safety Thermometer is the measurement tool for a programme of work to support patient safety improvement. It is used to record patient harms at the frontline, and to provide immediate information and analyses for frontline teams to monitor their performance in delivering harm free care. It is a point prevalence audit one day a month. There have been discussions with other Trust as it has become clear we are not all using the same methodology when we collect the data. The NHS Safety Thermometer records the presence or absence of four harms: • Pressure ulcers (Old and New) • Falls (Falls in hospital and falls in the community if from a care setting within 72 hours) • Urinary tract infections (UTIs) in patients with a catheter (Old & New) • New venous thromboembolisms (Old & New) **Harm free care** Harm free care encompasses old and new harms; Old harms = harms occurred prior to admission New harms = harms occurred post admission
Forward Trajectory	Harm Free care - to achieve 95% New Harm Free Care – to achieve 98%

Site	No Patients	Harm Free	New Harm Free	PU- All	PU - New	Falls with harm	Cath & all UTI	Cath & New UTI	New VTEs
National Average		94.30%	97.90%	4.30%	0.90%	0.50%	0.70%	0.30%	0.40%
Grantham	**90**	**88.90%**	**94.40%**	**5.60%**	**0%**	**4.40%**	**2.20%**	**1.10%**	**0%**
Lincoln	**432**	**93.80%**	**97.00%**	**3.50%**	**0.20%**	**2.30%**	**0.50%**	**0%**	**0.50%**
Louth	**1**	**100%**	**100%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**
Pilgrim	**314**	**86.30%**	**97.80%**	**10.50%**	**1.30%**	**0.30%**	**2.50%**	**0%**	**0.60%**
UHT Total	**837**	**90.40%**	**97.00%**	**6.30%**	**0.60%**	**1.80%**	**1.40%**	**0.10%**	**0.50%**

Variance Analysis (SPC Chart)	  
What action is being taken to recover performance?	Reports are distributed detailing where all of the harms have occurred. Nurse specialists review the harms before being uploaded Analysis of how other organisations are collecting their data is being investigated. RCAs are being completed when patient has developed a Hospital Acquired Thrombosis (HAT) Discussion with CCG to develop a health community to discuss harms A work plan has been developed for CAUTIs

What is the recovery date?	April 2017
Who is responsible for the action? (Provide the role and name of the lead)	Quality & Safety Manager

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 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%	88.64%	88.77%	88.51%	87.17%			
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%			
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%				
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%			
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			
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			

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%	87.17%			
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%			
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%			
	NHS Cancer Screening Service referral*	90%			92.10%	80.60%	86.20%	96.20%	90.90%	78.90%	92.90%	79.20%	89.70%			
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%			
	Anti-cancer drug treatments*	98%			91.60%	84.60%	97.70%	100.00%	98.00%	98.80%	98.40%	98.80%	98.90%			
	Radiotherapy*	94%			90.70%	80.40%	90.90%	95.00%	95.80%	97.80%	91.20%	91.20%	100.00%			
5	All cancers: 31 day wait from diagnosis to first treatment*	96%	Quarterly	1	96.70%	95.80%	95.00%	98.70%	97.60%	96.60%	98.00%	96.20%	97.40%			
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%			
	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%			
14	Meeting the C.difficile objective (cumulative)	62%	Quarterly	1	2	5	5	0	3	6	4	5	3			
15	meeting the MRSA objective (cumulative)	0%	Quarterly	1	0	0	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	1	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant			
				Risk rating	4	5	5	5	5	5	5	4	4			

Trust Internal Compliance Rating	
	Target Met
	Target Not Met

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

GOVERNANCE RISK RATING

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

Appendix 2. Glossary

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

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

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

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

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

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

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