UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 31st MAY 2017

To:	Finance, Service Delivery and Improvement Assurance Committee
From:	Amanda Brown, Assistant Director of Commissioning & Performance
Date:	27th June 2017
Healthcare standard	

Title:	Integrated Performance Report

Author/Responsible Director: Karen Brown, Interim Director of Finance

Purpose of the report:
To update the committee on the performance of the Trust for the period ended 31st May 2017, provide analysis to support decisions, action or initiate change and set out proposed plans and trajectories for performance improvement.

The report is provided to the Board for:

Decision	x	Discussion	x
Assurance	x	Information	

Summary/key points:

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 (eg 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

Information exempt from disclosure

Requirement for further review?

Executive Summary for period of 31st May 2017

Safe

- Reduction of falls, 152 across ULHT in May 2017, compared to 166 in May 2016.
- There have been 0 cases of MRSA reported in May 2017, for the fourth consecutive month
- There have been 11 outbreaks of C.Diff in May 2017 compared to 7 in April 2017 (this is 6 more than May 2016). Root Cause Analyses are being undertaken

Caring

- No mixed sex accommodation breaches occured in May 2017
- eDD performance has deteriorated by 12.96% compared to April 2017, mainly due to unavailability of systems during the cyber-attack
- #NOF 24hrs performance has increased by 17.22% compared to April 2017

Responsiveness

- A&E performance against the 4 hour target for May was 76.49%, 5.51% below trajectory. First quarter performance at the end of May was 79.33%, 2.67% below trajectory
- 4 out of the 9 National Cancer Targets were achieved in April 2017
- The Trust achieved a performance of 77.8% against the 62 day classic standard in April, an improvement of 5% compared with March's performance
- A Root Cause Analysis (RCA) was completed for all 38 patients which breached 62 day cancer standard in April
- As at 16th June there are 23 cancer patients on or over 104 days without an agreed treatment plan

Effective

- The impact of the cyber-attack led to an increase in the number of patients waiting for a follow-up appointment, which having reduced to 5,337 from 5,725 rose back up to 5,943 (as at 31st May 2017). This position has stablised in the first two weeks of June. As at 21st June 2017 the position is 5,747

Well-Led

- Rolling sickness rate continues at 4.70%, however, in month position has reduced for three months in a row
- Completion of non-medical appraisals has increased by 10% in the last month, although this is still below target
- The original target set an Agency Spend of £21m which equates to £1.75m per month. Performance for May 2017 against this target was a spend of £2.748m which is an increase of £392,379 from the previous month

Money & Resources

- The overall month 2 financial reported position for May is an in-month deficit of £7.9m, which is £3.2m adverse to the planned in-month deficit of £4.6m and a year to date deficit of £16.7m, which is £7.4m adverse to the planned year to date deficit of £9.3m

Successes:

There have been no mixed sex accommodation breaches during May 2017, this is the third consecutive month.

8 Directorates have achieved the 85% compliance rate for appraisals.

The Trust is currently in a position to continue to achieve the Diagnostic standard in June, May achieved for the sixth consecutive month.

Challenges:

11 cases of C.Diff have proved challenging in May 2017 and root cause analyses are being undertaken with action plans for individual areas. 6 Cases occurred at Pilgrim, 4 at Lincoln, (3 of which occurred on the Stroke Unit) and 1 case at Grantham. The target for the year is 59.

The original Agency Spend target set a spend of £21m (equating to £1.75m per month), this would require a 28% reduction on 2016/17 levels, which is significantly challenging. Recruitment plans are being implemented but will take time for the full impact to be recognised. Additionally workforce planning arrangements continue to be reviewed.

The current Trust vacancy rate for May 2017 is 11.40%, which is an increase of 0.26% on April 2017. Overall vacancies have increased by 1.15% over the last 12 months (10.25% to 11.40%). At present 140.84 wte medical posts are vacant, out of a total of 937.73 wte established posts and 323.45 wte registered nursing and midwifery posts are vacant compared to a total establishment of 2272.84 wte posts. The equivalent figure for unregistered nurses is 133.60 wte vacancies compared to the establishment of 972.78 wte posts.

The sickness rate for May 2017 is over target at 4.70%, however, positive news to note is that this in month figure has reduced for three months in a row. Benchmarking data as at February 2017 from NHS Digital (previously Health & Social Care Information Centre - HSCIC) indicates that ULHT has the sixth highest sickness rate (lowest at 2.99% and highest 5.65%) against an average of 4.38%. The benchmarking is done across x38 Large Acute Trusts.

A & E performance continues to be challenging, Trustwide performance for the end of quarter one was 2.67% below trajectory, which means that in the remaining month collectively all Emergency Departments must operate at a minimum of 85% to recover the quarter trajectory.

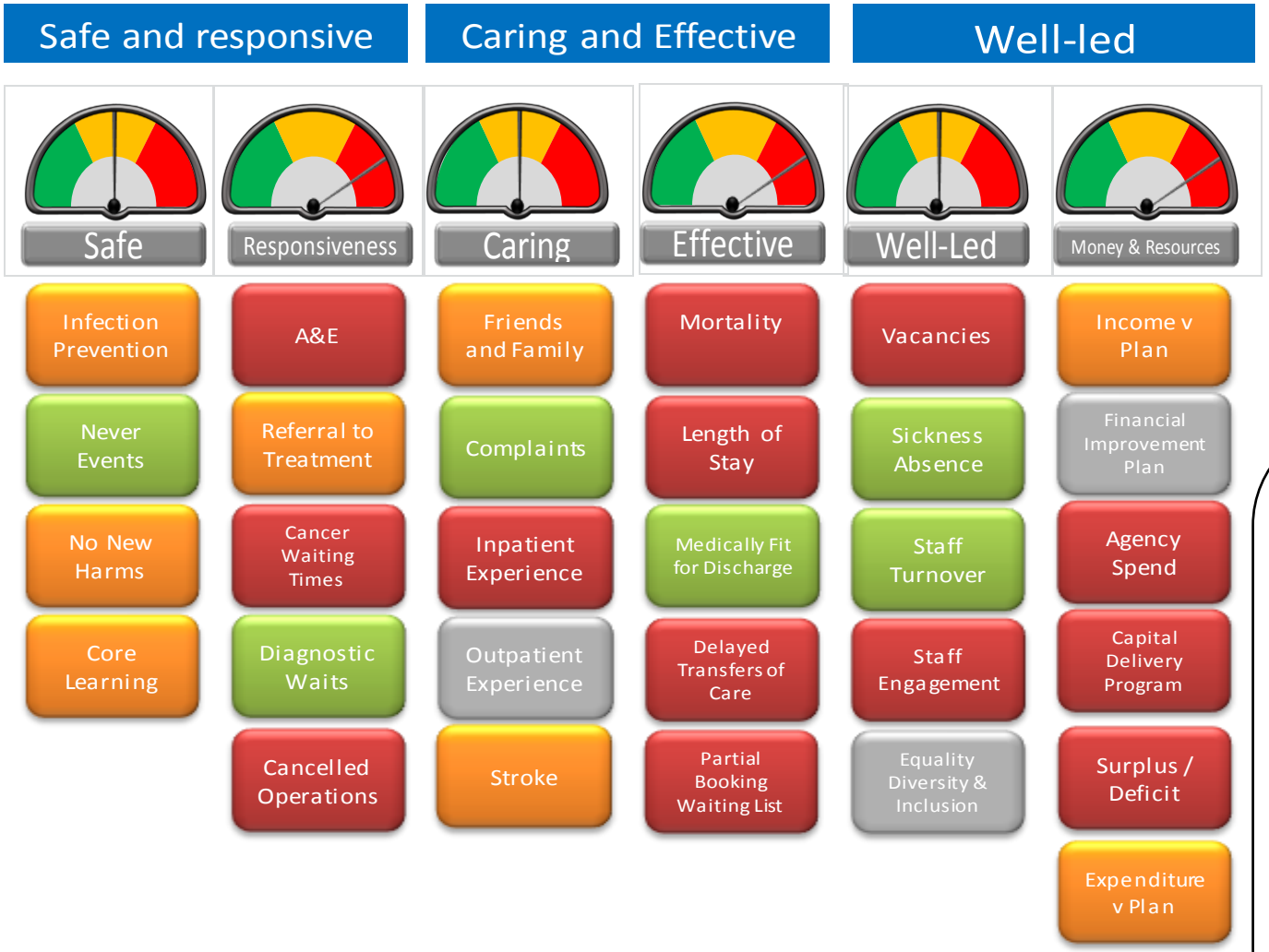
A prolonged Norovirus outbreak at Lincoln and Grantham led to the closure of over 150 beds at peak times. The international cyber-attack during this period added to difficulties in each of the Emergency Departments losing access to key systems for in some cases a number of days, however the departments did manage to stay open to patients where other units across the country did not.

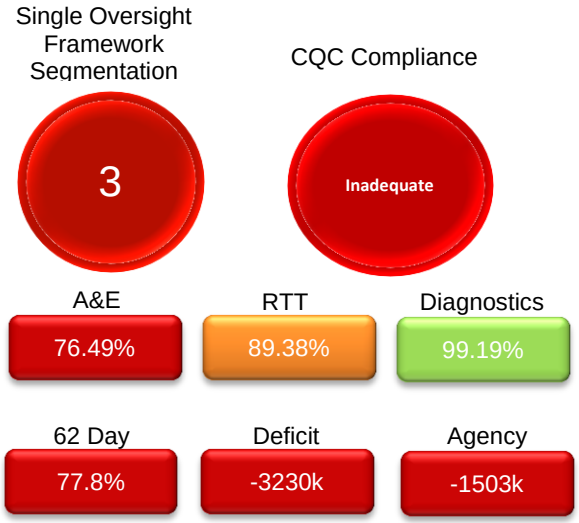
The Trust's performance against the 14 day suspect cancer target and the 14 day breast symptomatic target were both improved during April, but impact from the prolonged spike in referrals into the breast service was still evident, where referral rates from early January averaged over 140 referrals per week for a 10 week period compared to a baseline service capacity of 100 slots per week. The 62 Day Classic standard continues to remain the most challenging standard and work continues to improve the quality of the patient journey on the understanding that improvements in this will contribute directly towards achievement of the standard. Root Cause Analysis (RCAs) was completed for all 38 patients which breached 62 days in April. The Trust treated 8 patients at 104 days or over during April, completing RCAs for all 8 patients. As at 16th June there are 23 patients on or over 104 days without an agreed treatment plan

Karen Brown
Interim Director of Finance & Corporate Affairs
June 2017

Integrated Performance Report

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





Most deteriorated:
Domain: Caring
eDD performance has decreased by 12.96% compared to April's position, this is due to the cyber attack
Domain: Responsiveness
A&E performance has deteriorated by 5.72% in May due to the outbreak of Norovirus and staffing shortages
Domain: Safe
There have been 11 cases of C.Diff in May which is an increase of 6 compared to the same period in 2016

Most improved:
Domain: Responsiveness
2ww breast symptomatic performance has increased significantly in April 2017 (+53.7%)
Domain: Caring
#NOF 24hrs performance has increased by 17.22% compared to April

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

Detailed Trust Board Performance

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Safe							
Infection Control							
Clostrum Difficile (post 3 days)	Monthly	Datix	59	18	11	7	
MRSA bacteraemia (post 3 days)	Monthly	Datix	0	0	0	0	
MSSA	Monthly	Datix	4	4	1	3	
ECOLI	Monthly	Datix	16	12	7	5	
Never Events	Monthly	Datix	0	0	0	0	
No New Harms							
Serious Incidents reported (unvalidated)	Monthly	Datix	0	48	25	23	
Harm Free Care %	Monthly		95%	91.48%	90.93%	92.03%	
New Harm Free Care %	Monthly		98%	97.74%	97.49%	97.98%	
Catheter & New UTIs	Monthly		1	1	1	2	
Falls	Monthly	Datix	3.90	3.39	3.12	3.66	
Medication errors	Monthly	Datix	0	285	141	144	
Medication errors (mod, severe or death)	Monthly	Datix	0	45	23	22	
Pressure Ulcers (PUNT) 3/4	Monthly			7	5	8	
VTE Risk Assessment	Monthly		95%	97.08%	97.15%	97.00%	
Core Learning	Monthly	ESR	95%	90.54%	90.42%	90.67%	

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Caring							
Friends and Family Test							
Inpatient (Response Rate)	Monthly	Envoy Messenger	26%	29.50%	30.00%	29.00%	
Inpatient (Recommend)	Monthly	Envoy Messenger	96%	90.00%	89.00%	91.00%	
A&E (Response Rate)	Monthly	Envoy Messenger	14%	21.50%	21.00%	22.00%	
A&E (Recommend)	Monthly	Envoy Messenger	87%	81.50%	81.00%	82.00%	
% of staff who would recommend care							
% of staff who would recommend work							
Complaints							
No of Complaints received	Monthly	Datix	70	106	51	55	
No of Complaints still Open	Monthly	Datix	0	489	250	239	
No of Complaints ongoing	Monthly	Datix	0	74	35	39	
Inpatient Experience							
Mixed Sex Accommodation	Monthly	Datix	0	0	0	0	
eDD	Monthly	EDD	95%	79.71%	73.23%	86.19%	
PPCI 90 hrs	Quarterly		100%	96.30%	97.33%	97.33%	
PPCI 150 hr	Quarterly		100%	86.07%	85.33%	85.33%	
#NOF 24	Monthly		70%	65.66%	74.60%	56.72%	
#NOF 48 hrs	Monthly		95%	95.38%	95.24%	95.52%	
Dementia Screening	1 month behind		90%	93.56%	93.56%	94.16%	
Dementia risk assessment	1 month behind		90%	98.39%	98.39%	98.69%	
Dementia referral for Specialist treatment	1 month behind		90%	88.24%	88.24%	85.37%	
Stroke							
Patients with 90% of stay in Stroke Unit	1 month behind	SSNAP	80%	94.00%	94.00%	88.60%	
Sallowing assessment < 4hrs	1 month behind	SSNAP	80%	66.70%	66.70%	69.10%	
Scanned < 1 hrs	1 month behind	SSNAP	50%	61.70%	61.70%	61.50%	
Scanned < 12 hrs	1 month behind	SSNAP	100%	98.30%	98.30%	96.90%	
Admitted to Stroke < 4 hrs	1 month behind	SSNAP	90%	75.00%	75.00%	59.10%	
Patient death in Stroke	1 month behind	SSNAP	17%	18.00%	18.00%	15.90%	

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Responsiveness							
A&E							
4hrs or less in A&E Dept	Monthly	Medway	82.0%	79.35%	76.49%	82.21%	
12+ Trolley waits	Monthly	Medway	0	0	0	0	
AEC							
Number of patients seen in AEC (Lincoln only)	1 month behind	Medway		266		266	
% Readmissions within 7 days (Lincoln only)	1 month behind	Medway	0.00%	12.78%		12.78%	
% Patients discharged by LoS (Lincoln only)	1 month behind	Medway	0.00%	22.80%		22.80%	
% of G&A non-elective admissions to AEC	Monthly	Medway	25.00%	15.96%	16.96%	14.95%	
RTT							
52 Week Waiters	Monthly	Medway	0	13	9	16	
18 week incompletes	Monthly	Medway	89.0%	88.97%	89.38%	88.56%	
Cancer - Other Targets							
62 day classic	1 month behind	Somerset	85%	77.80%	77.80%	72.60%	
2 week wait suspect	1 month behind	Somerset	93%	89.20%	89.20%	82.10%	
2 week wait breast symptomatic	1 month behind	Somerset	93%	72.60%	72.60%	18.90%	
31 day first treatment	1 month behind	Somerset	96%	97.10%	97.10%	96.30%	
31 day subsequent drug treatments	1 month behind	Somerset	98%	100.00%	100.00%	100.00%	
31 day subsequent surgery treatments	1 month behind	Somerset	94%	89.50%	89.50%	91.30%	
31 day subsequent radiotherapy treatments	1 month behind	Somerset	94%	95.80%	95.80%	93.40%	
62 day screening	1 month behind	Somerset	90%	89.50%	89.50%	87.50%	
62 day consultant upgrade	1 month behind	Somerset	85%	87.00%	87.00%	80.40%	
104+ Day Waiters	1 month behind	Somerset		-	22.00	22.00	
Diagnostic Waits							
diagnostics achieved	Monthly	Medway	99.1%	99.47%	99.19%	99.74%	
diagnostics Failed	Monthly	Medway	0.9%	0.53%	0.81%	0.26%	
Cancelled Operations							
Cancelled Operations on the day (non clinical)	Monthly	Medway	1.10%	4.70%	7.74%	1.66%	
Not treated within 28 days. (Breach)	Monthly	Medway	0.00%	6.28%	1.11%	11.46%	

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Effective							
Mortality							
SHMI	Quarterly		100	110.30	110.30	110.30	
Hospital-level Mortality Indicator	Quarterly		100	104.22	104.60	103.84	
Length of Stay							
Average LoS - Elective	Monthly	Medway / Slam	2.8	2.54		2.54	
Average LoS - Non Elective	Monthly	Medway / Slam	3.8	4.44	4.45	4.42	
Medically Fit for Discharge	Monthly	Bed managers	60	54.50	60.00	49.00	
Delayed Transfers of Care	Monthly	Bed managers	3.5%	4.93%	5.29%	4.57%	
Partial Booking Waiting List	Monthly	Medway	0	6181	5943	6419	

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Well Led							
Vacancies	Monthly	ESR	5.0%	11.27%	11.40%	11.14%	
Sickness Absence	Monthly	ESR	4.5%	4.40%	4.32%	4.48%	
Staff Turnover	Monthly	ESR	8.0%	5.81%	5.82%	5.80%	
Staff Engagement							
Staff Appraisals	Monthly	ESR	95.0%	73.50%	79.00%	68.00%	
Equality Diversity and Inclusion							

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Money & Resources							
Income v Plan	Monthly	Board Report Master	35524	67238	34745	32493	
Expenditure v Plan	Monthly	Board Report Master	-40147	-90200	-41328	-48872	
Efficiency Plans	Monthly	FIMS report	1341	0		0	
Surplus / Deficit	Monthly	FPIC Finance Report	-4623	-16689	-7853	-8836	
Capital Delivery Program	Monthly	FPIC Finance Report	-412	-756	-756	0	
Agency Spend	Monthly	Agency Staff Analysis	-1790	-5083	-2720	-2363	

Responsiveness

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Responsiveness							
A&E							
4hrs or less in A&E Dept	Monthly	Medway	82.0%	79.35%	76.49%	82.21%	
12+ Trolley waits	Monthly	Medway	0	0	0	0	
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diagnostics Failed	Monthly	Medway	0.9%	0.53%	0.81%	0.26%	
Cancelled Operations							
Cancelled Operations on the day (non clinical)	Monthly	Medway	1.10%	4.70%	7.74%	1.66%	
Not treated within 28 days. (Breach)	Monthly	Medway	0.00%	6.28%	1.11%	11.46%	

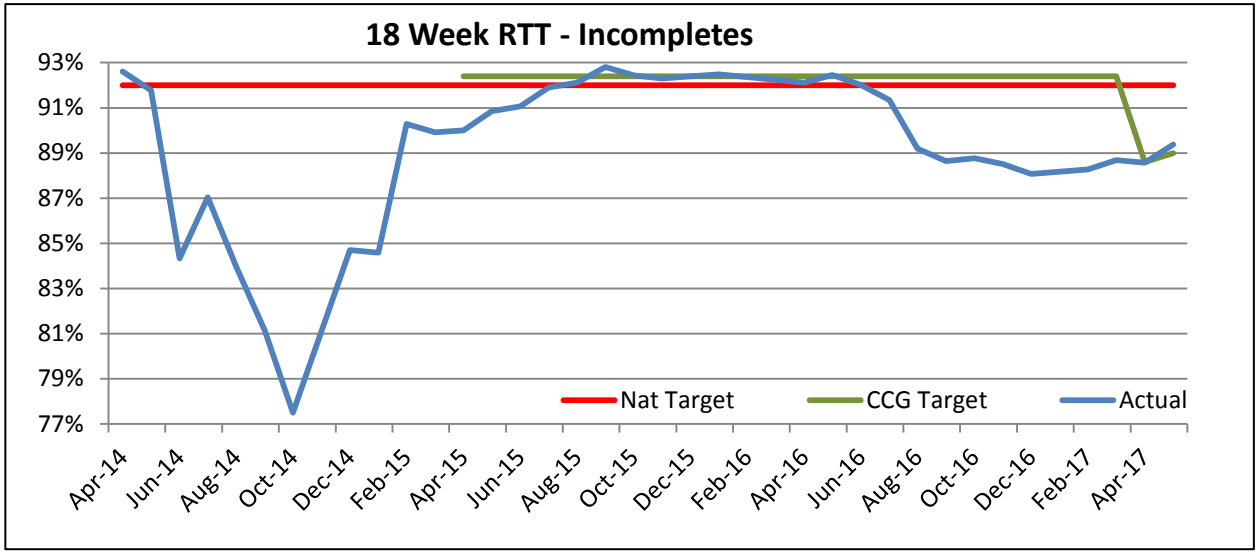
Referral to Treatment

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Referral to Treatment (18 weeks)	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance
Date:	27th June 2017	Reporting Period:	May 2017

Exception Details

In April the Trust reported performance of 88.6%, a deterioration of 0.1% compared with the position in March. The slight deterioration in the level of performance in April was directly related to the impact of the cyber-attack, which led to the loss of 5 days of validation capacity whilst systems were down and the process of rebooking the patients who were cancelled during the cyber-attack had a further knock on impact for validation capacity even once the IT systems were fully functioning. It is anticipated that April's performance would have continued the steady pattern of improvement if the disruption of the cyber-attack had not occurred. At a national level the standard hasn't been achieved for 13 consecutive months, with an aggregated national performance in April of 89.9%.



The Trust's validated final submission for May was 89.38%.

Between 12th-15th May the Trust cancelled 1876 outpatient appointments and 120 day cases and elective operations. Clinical Directorates re-provided additional capacity during May and June in order to rebook these patients, however during the week commencing 15th May there were c.450 less clock stops than anticipated which will negatively impact on May's performance.

The impact of urgent care pressures, and the requirement for Clinical Directorate management teams to be involved in assisting with operational management of the sites during times of increased pressure have resulted in reduced capacity to progress actions related to RTT recovery across a number of specialities. These pressures were particularly extreme during April as the impact of IR35 regulation changes took effect.

The Trust has an submitted a trajectory with achievement of 92% being reached in October 2017. This trajectory is based upon the following assumptions:

- CCG remain within activity plan across all specialties which includes delivery of STP assumptions
- Support from CCG to reduce routine referrals into 5 key specialties
- Primary care support to review all overdue follow ups
- Able to create sufficient internal or external capacity to meet the open new referral, follow up and ASI backlog within 15 weeks (end of Sept)

There are long waiting times for first appointments in a number of specialities. The longest waiting patients on the open referral waiting lists are over 30 weeks in ENT, Cardiology, Respiratory, Neurology and Paediatric Dermatology.

During 2016/17 activity was above contracted levels in the following specialities, which has continued into 2017/18:

Speciality	16/17 activity level above contract	Activity level above contract in month 1 of 17/18
Neurology	27%	8%
Endocrine	22%	20%
Gastro	15%	4%
Rheum	16%	8%

All of these areas have RTT incompletes performance below 92%. During month 1 of 2017/18 activity within Cardiology was 15% above contracted level, and 4% above contracted level in ENT and T&O.

The fire at Pilgrim at the end of March resulted in 16 cancelled operations. In addition to this capacity for day cases will be restricted for the subsequent 4 month period due to the resultant ward moves, and reduced available bed spaces for these patients, which reduces day cases by c.30 patients per week.

Out of hours medical cover at Louth remains an issue which resulted in 13 inpatient procedures being cancelled up to the end of April. Since that time short term arrangements have been in place in order to provide appropriate out of hours cover, and where not available adjust the case mix on the Louth site to reflect the level of cover overnight.

What action is being taken to recover performance?

All specialities received a request from the Executive Team in May to produce action plans which will deliver the following by the end of September:

- There will be no patients on the Trust's ASI list for more than 48hrs (national standard)
- All referrals will be graded within 2 working days of receipt
- The longest waiting time on the open referrals waiting list will be less than 12 weeks
- There will be no follow-up patients who are over 6 weeks overdue
- There will be no missing outcomes following an outpatient appointment over two weeks ago

All Clinical Directorates have produced plans and are currently going through a process of confirm and challenge, and synthesising the plans with capacity within support services such as outpatients and diagnostics in order to test deliverability.

Delivery of additional outpatient clinics over and above core capacity forms the basis of the majority of the plans. Confirmation of the final number of additional clinics to be completed before the end of September will be reached once outpatient room and nursing capacity is finalised, which is expected by 27th June. The additional Clinical Directorate capacity is proposed to be delivered by exiting staff working additional hours, and also the use of agency locums in specialities such as Cardiology, Neurology, Respiratory and Gastro.

The Trust will be outsourcing activity during 2017/18 in T&O and General Surgery, and have existing agreements in place with private sector providers to undertake such work. The Trust are also exploring potential options for outsourcing activity within ENT and Dermatology.

The Neurology Service is currently closed to routine referrals in order to enable the service to catch up on the backlog of new and follow-up appointment. In addition, the Trust have made a request to work with the CCGs in order to reduce demand into key service areas in the short term (including Cardiology, ENT, Dermatology and Community Paediatrics) in order to provide an opportunity for the Trust to progress waiting list reductions.

The Clinical Directorates are also planning to complete a range of further actions in order to achieve the rapid improvements in the key planned care metrics. These actions include:

- Review of polling ranges within ERS
- Review of clinic booking rules
- Strengthen referral grading processes
- Ongoing validation of open referral and partial booking waiting lists
- Expansion of nurse-led clinics
- Virtual clinics

What is the recovery date?

October 2017

Diagnostic 6wk Wait

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Diagnostic Waits	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance
Date:	27th June 2017	Reporting Period:	May 2017

Exception Details

In May the Trust achieved the 6 week diagnostic standard for the sixth month in a row. The performance level was 99.19%.

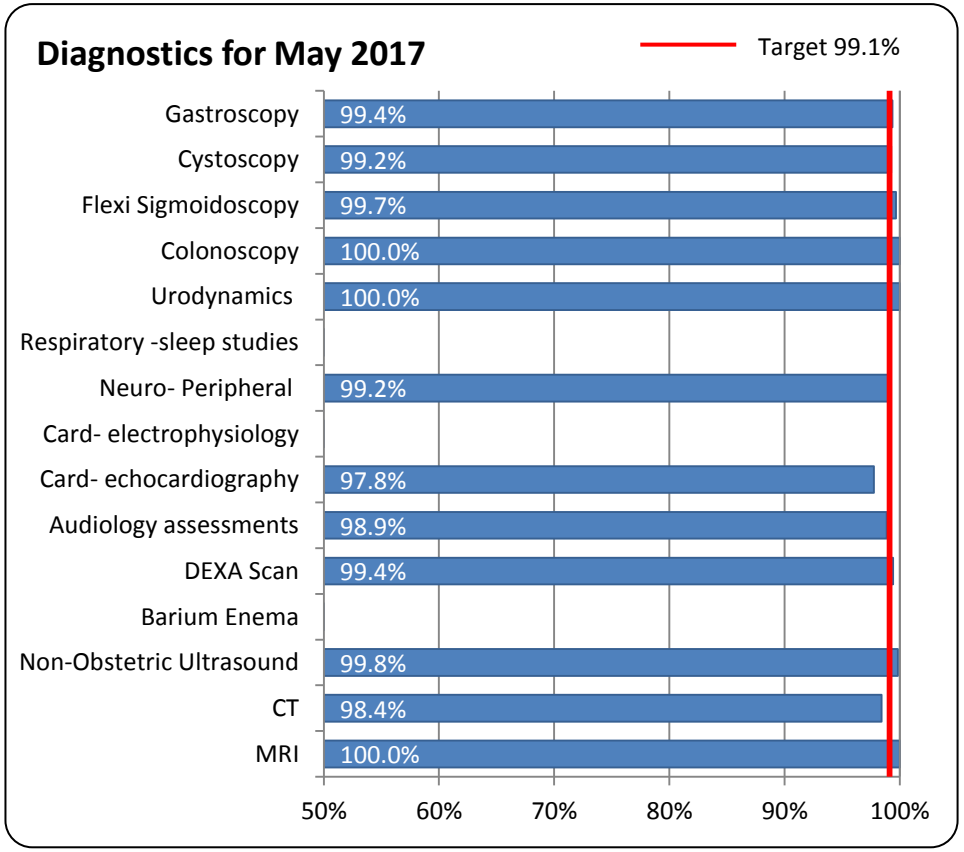
There were 56 diagnostic patients which breached the 6-week standard in May. At modality level performance of <1% was achieved in all modalities except for Echo, Audiology and CT.

The number of breaches reported in May, although within standard, increased compared with May. The two main factors contributing to this were:

- Impact of the cyber attack – cancellations across all modalities and system access challenges
- Workforce challenges within Cardiology as a result of sickness absence

What action is being taken to recover performance?

The Trust is currently in a position to continue to achieve the diagnostic standard in June. Endoscopy capacity remains a particular risk, however the Trust are currently utilising outsourcing capacity in the private sector and have commenced work on a tendering exercise in order to mitigate the medium term capacity issues within this service.



Cancer Waiting Times – 62 Day

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Cancer Waiting Times (62 Day)	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance – Planned Care
Date:	27th June 2017	Reporting Period:	April 2017

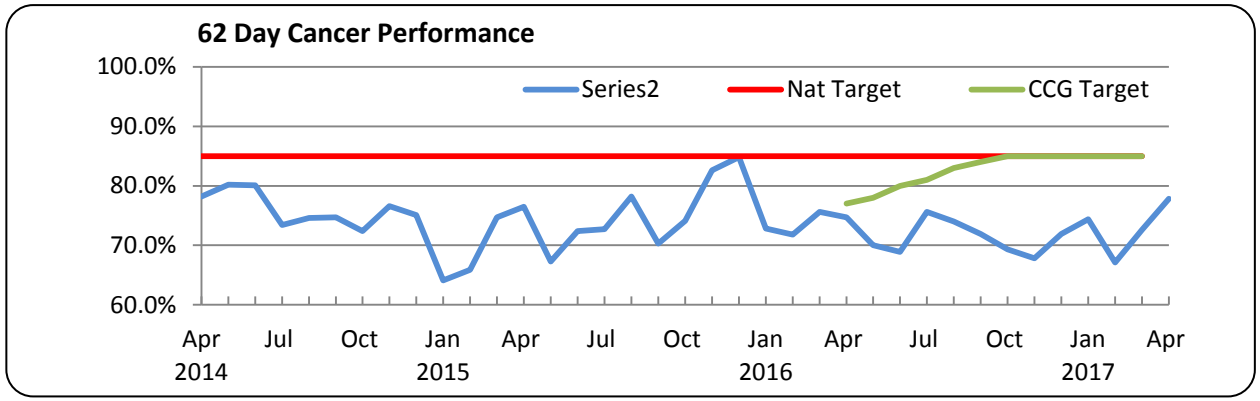
Exception Details

The Trust achieved a performance of 77.8% against the 62 day classic standard in April, an improvement of 5% compared with March's performance.

The Trust achieved 4 out of the 9 cancer standards.

The 62 Day Classic standard continues to remain the most challenging standard and work continues to improve the quality of the patient journey on the understanding that improvements in this will contribute directly towards achievement of the standard. Root Cause Analysis (RCAs) were completed for all 38 patients which breached 62 days in April and found a number of key themes:

- Complexity or procedural
- Patient choice and/or patient fitness
- Tertiary diagnostic delays
- Tertiary treatment delays
- MRI and CT capacity
- Theatre capacity



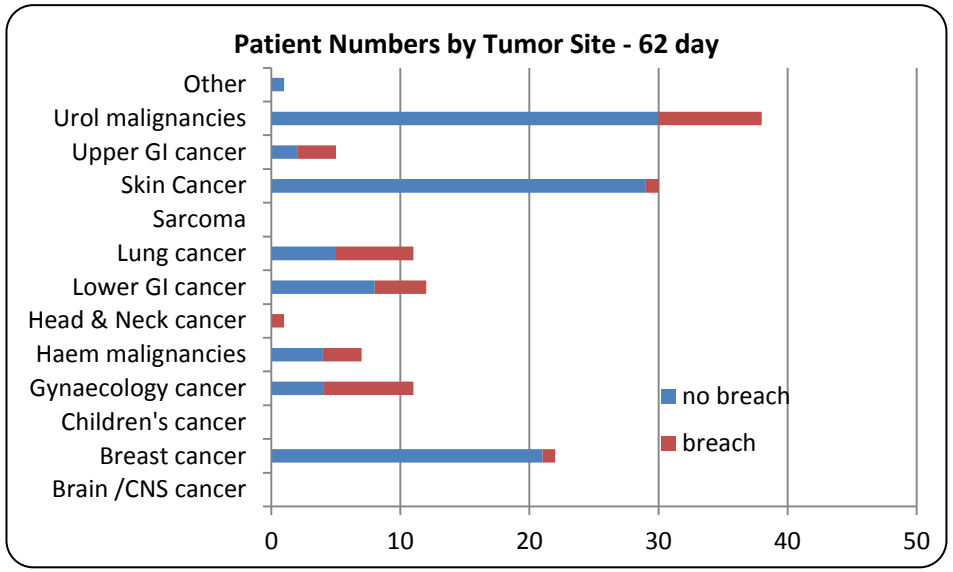
The Trust's performance against the 14 day suspect cancer target and the 14 day breast symptomatic target were both improved during April, but impact from the prolonged spike in referrals into the breast service was still evident, where referral rates from early January averaged over 140 referrals per week for a 10 week period compared to a baseline service capacity of 100 slots per week.

As of 16th June there are 23 pts on or over 104 days without an agreed treatment plan: 12 x Urology, 5 x Colorectal, 3 x lung, 1 x Upper GI, 1 x Skin, 1 x Gynaecology.
6 of the 23 have confirmed cancer diagnosis.

The Trust treated 8 patients at 104 days or over during April, completing RCAs for all 8 patients. Due to the length of these pathways these patients had multiple reasons for delays in their pathways, as follows:

- 4 cases included complexity or procedural factors
- 4 cases included tertiary diagnostic delays
- 3 cases included patient fitness factors
- 2 cases included CT delays
- 2 cases included theatre capacity restrictions
- 2 cases included patient choice delays

- 1 case included Outpatient capacity
- 1 case included Endoscopy capacity
- 1 case include HDU capacity constraints
- 1 case included aspects relating to holistic needs



The Trust is completing processes to review any potential harm related to excessive waits for cancer treatment, and will begin to report relating to this aspect of care from next month.

The performance position for 62-day Cancer in May and June is still subject to further treatments being recorded, and therefore will change prior to submission. However, early indications are that May and June's performance will deteriorate compared to April's position. There are a number of factors which have contributed to this position, including the impact of the cyber-attack which led to cancellations of outpatient appointments, surgery and diagnostic tests, all of which have added delays to cancer pathways. In addition the cyber-attack led to a significant number of delays within histology and Radiology reporting, both of which are crucial to the cancer 62-day pathway.

The ongoing impact of the fire at Pilgrim and the resultant reduction in day case activity onsite has caused delays within the Urology cancer pathway. The impact of HDU bed restrictions during May and June has also led to an increased level of Surgical cancellations affecting cancer patients. These factors, along with individual tumour site level issues, are likely to result in a deterioration in performance against the 62-day standard in May and June.

What action is being taken to recover performance?

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

Key actions being undertaken in the next weeks include:

- Embedding the roll out of CNS-led triage for upper GI at Grantham and Pilgrim
- Embedding the roll out of CNS-led triage for lower GI at Grantham and commence the service at Pilgrim
- Extend the number and remit of level 1 beds at Lincoln
- Pilot MRI prostate within Urology pathways
- Endoscopy backlog clearance through insourcing and provision of addition Endoscopy sessions within the Trust
- Continuation of extended CT capacity utilising additional central funding

The Chief Operating Officer wrote to all tumour site leads in May to request confirmation of further actions which will be taken to improve cancer performance rapidly. Responses received include the following actions to be taken forward:

- Introduce straight to test for lung CT
- Processes to introduce review of longest waiters by tumour site leads/CDs
- Deliver additional one-off first appointment capacity in order to move services within 7-day horizon
- Review MDT arrangements in order to ensure optimal
- Improve histology turnaround times
- Gynaecology pathway development following review

In June the Chief Operating Officer and the Medical Director wrote again to the tumour site leads requesting further enhancements of these plans and setting out the intention to meet with the tumour site leads as a group to review these plans in detail

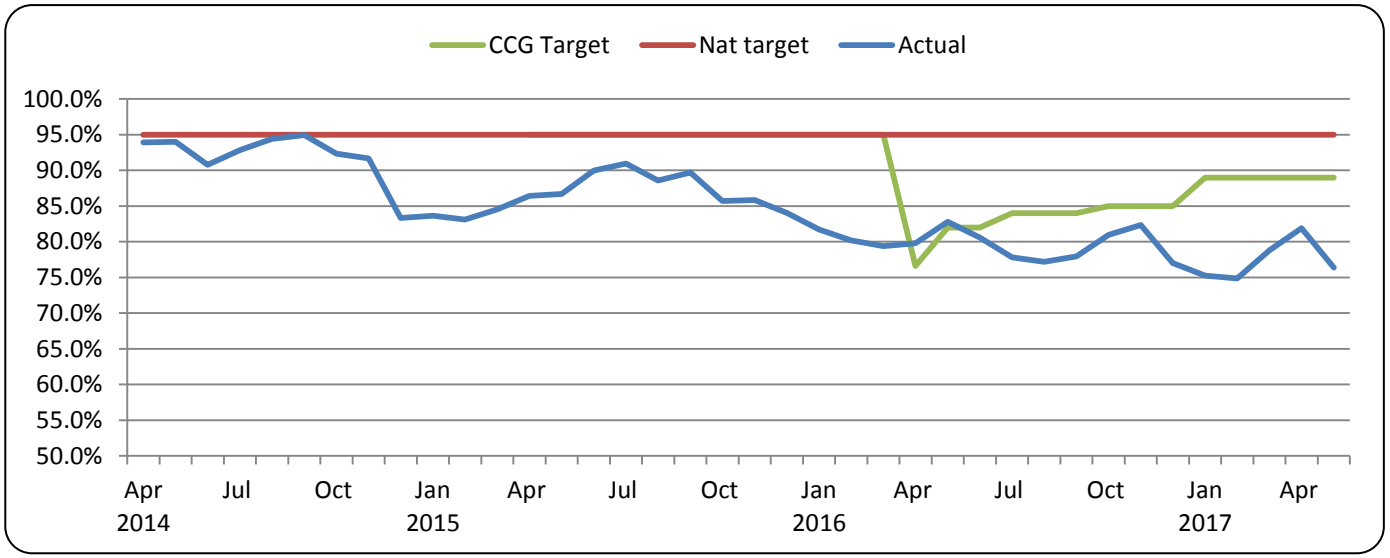
A&E 4 Hour Standard

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	**4 Hour Wait (A&E)**	**Owner:**	Chief Operating Officer
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Urgent Care
Date:	30th May 2017	**Reporting Period:**	April 2017

Exception Details

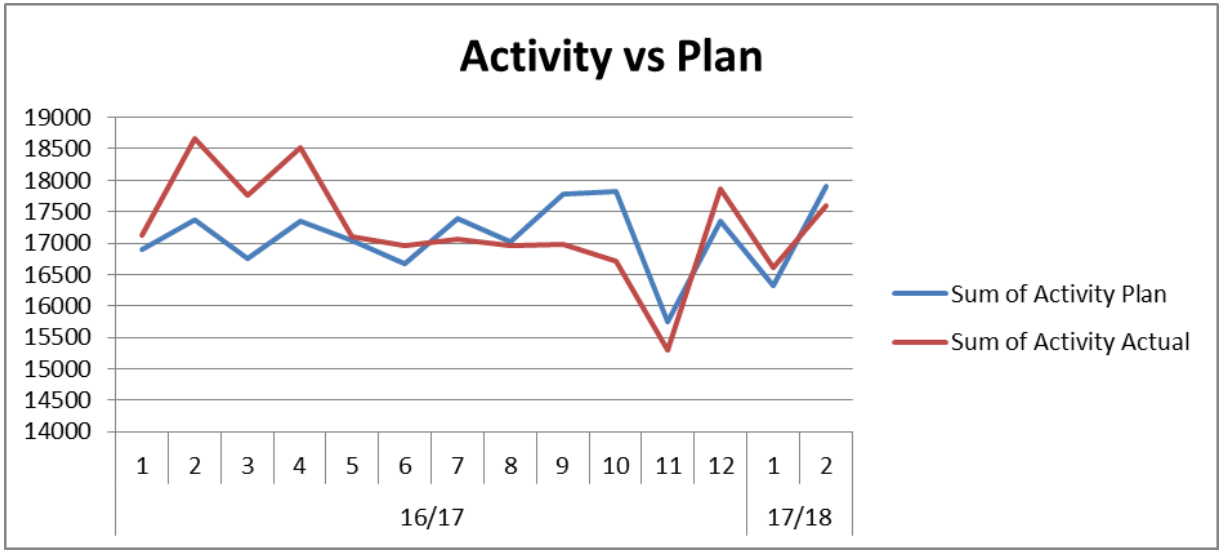
Overall Trust performance is 76.49%, which is 5.51% below the planned recovery trajectory of 82%. Lincoln County Hospital 73.94%, 5.06% below trajectory, Pilgrim Hospital 71.55%, 7.45% below trajectory, and Grantham Hospital 97.42%, 1.42% above trajectory. Performance for the 1st quarter at the end of May was 79.33%, 2.67% below trajectory hence for the remaining month the collective EDs must operate at a minimum of 85% to recover the quarter trajectory



Activity is close to plan for the Trust, despite the continuation of reduced hours at Grantham. Of all sites, Boston has seen the biggest increase in attendances and is significantly above plan.

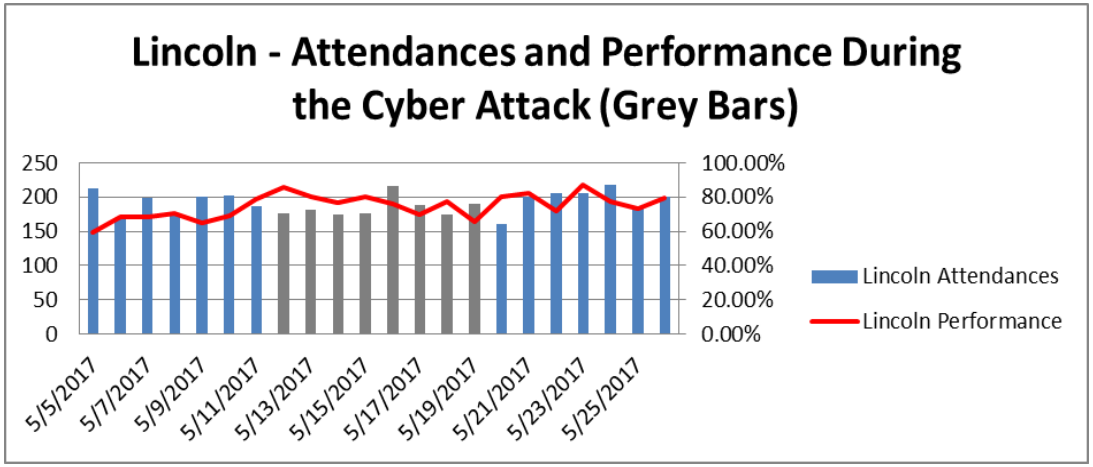
There were a number of significant events affecting performance over the month of May. The most significant of these events was the prolonged Norovirus outbreak at Lincoln and Grantham which led to the closure of over 150 beds closed at peak times. The international cyber-attack during this period added to difficulties in each of the Emergency Departments losing access to key systems for in some cases a number of days ,however the departments did manage to stay open to patients where other units across the country did not.

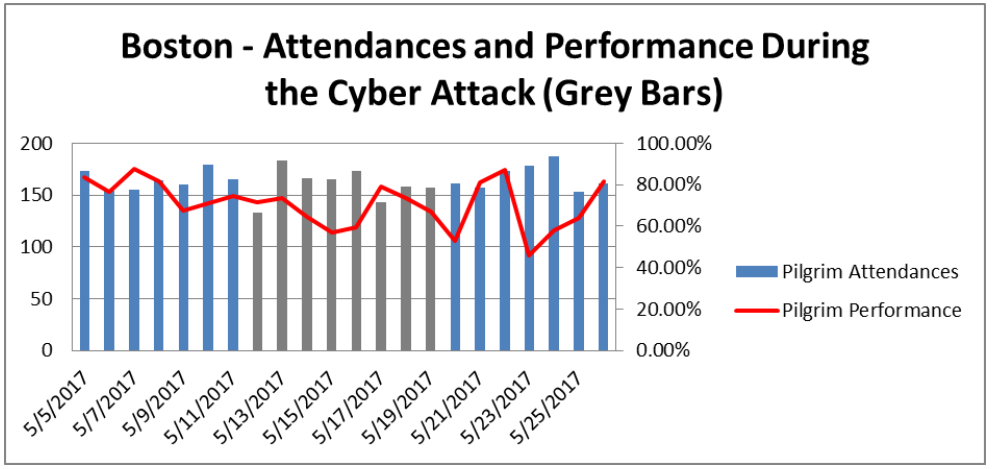
In addition to these unlikely, and out of the ordinary events staffing has remained the most significant challenge for the urgent care pathway. In particular this manifested itself through the increase in staff taking leave over the bank holidays whilst large reductions in agency fill rates across nursing and medical shifts.

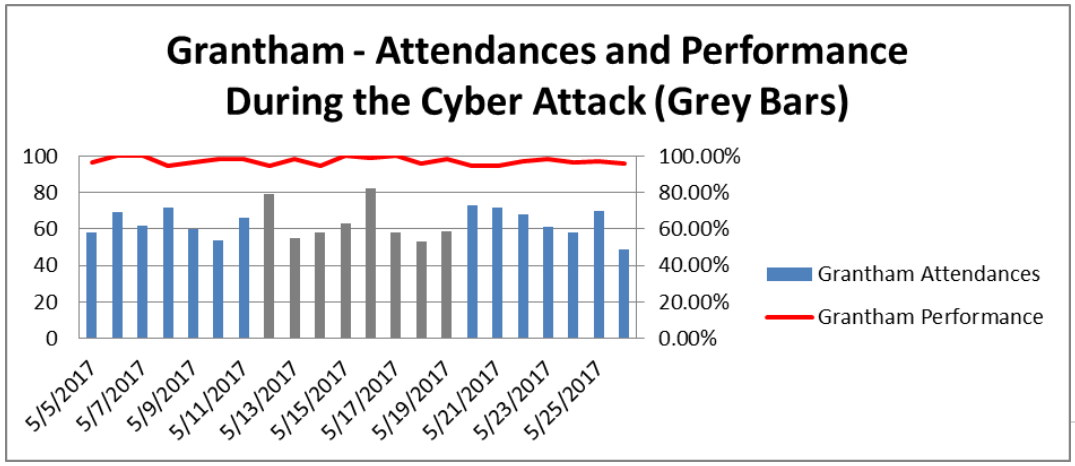


On Friday 12th May the trust was affected by the cyber-attack that impacted on many other NHS trusts and companies around the world. ULHT instigated command and control measures as per a major incident. Business continuity processes, mainly fallback to paper requesting and results, were implemented and additional staff were brought in to act as runners to ensure delays were minimised. As a result the sites coped well and no significant effect on Urgent Care performance was observed. Planned care and income suffered however, due to the need to cancel electives and OP's. Average performance for the 7 days prior, the 7 days of the attack and the 7 days after was:

	Performance (% against 4 hours)		
	7 day commencing:		
	05/05/2017	12/05/2017	20/05/2017
Lincoln	68.48	76.39	78.75
Boston	77.56	68.19	67.17
Grantham	97.76	97.66	96.28







Nationally messages were going out to the public regarding the situation and locally messages went out informing patients of possible delays and, for A&E, to avoid coming unless absolutely necessary. These messages had a minor effect on attendances at Lincoln and Boston, nil effect at Grantham:

	Average Attendances		
	7 day commencing:		
	05/05/2017	12/05/2017	20/05/2017
Lincoln	191.7	184.6	196.4
Boston	164.3	159.8	167.1
Grantham	63.0	63.4	64.4

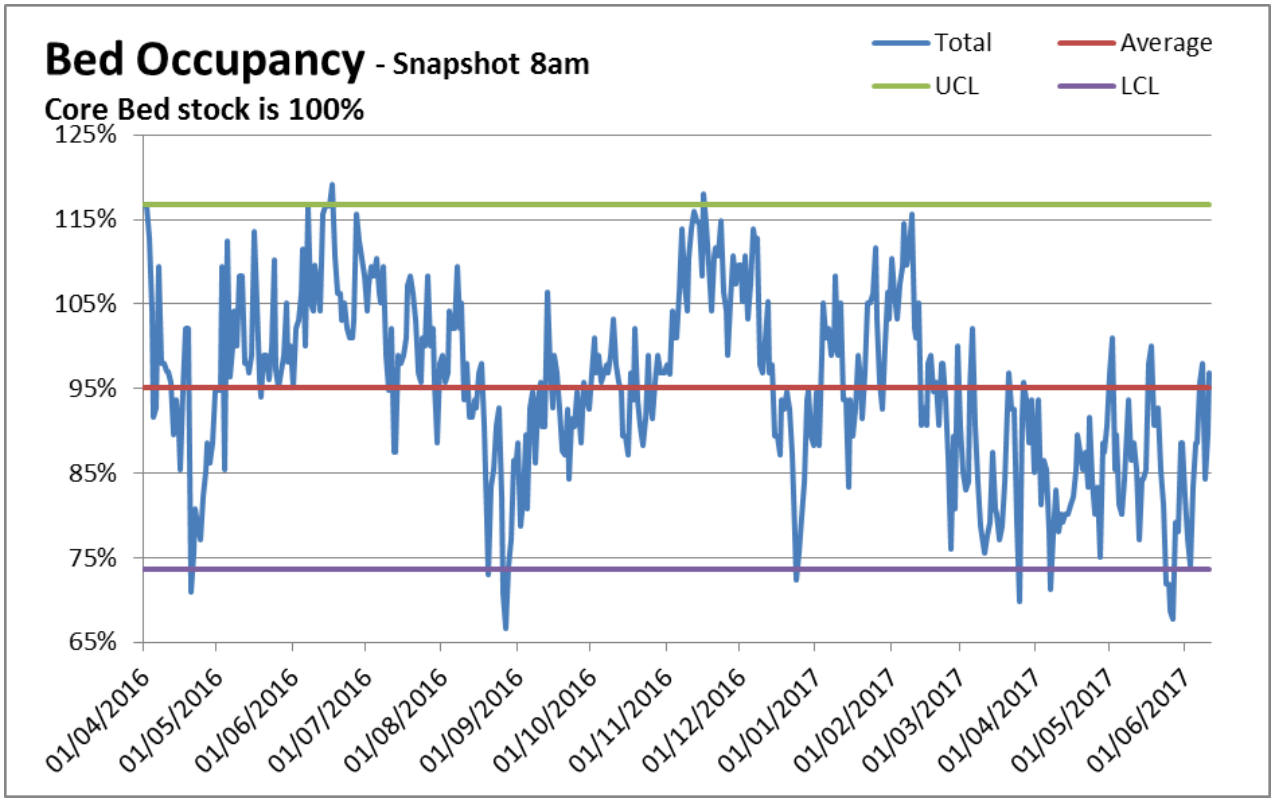
As a result of the Cyber-Attack the Ops Team had to prioritise which clinical systems were brought back on line. As Cayder – an old system that was used mainly by nursing teams – was likely to need quite a lot of data clearing off the system and there was a move to stop using it it was decided to leave Cayder turned off. Notice has now been served to the provider to terminate the contract.

Clinical teams in ED and assessment units have now moved to using Medway to manage the ED's. A lot of work was initially undertaken after the cyber-attack to get the system working properly in the departments. Although some teething problems persist all the departments are now fully using Medway. We have developed an ED whiteboard that pulls data from Medway and provides a view for the nursing teams similar to Cayder. The ED whiteboard also provides a map of the department to help locate patients and, as all teams are now using Medway, real time performance information has been possible.

As well as informing the management teams the performance has been included on the ED whiteboard as well as "Pulse" the Medway dashboard of ED. These systems are in view within the ED's and are focussing minds on performance.

Grantham

Grantham Hospital suffered an outbreak of norovirus, however this was contained. The site continued to perform well throughout the month. Red to Green meetings commenced at Grantham on 8th May, bed occupancy seems to have improved from this date

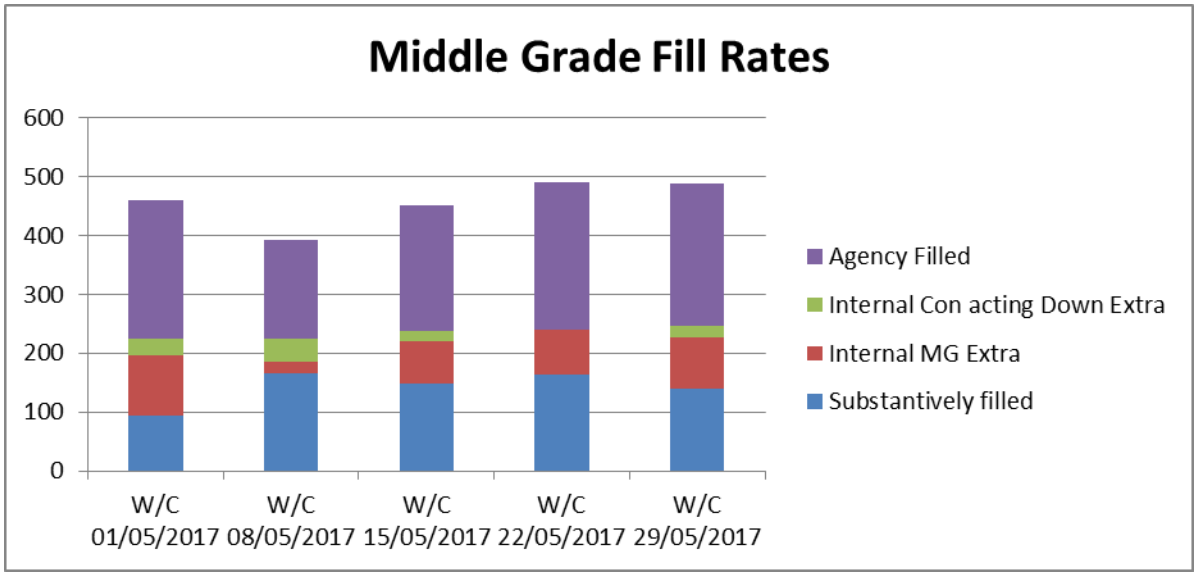


Pilgrim

Issues throughout the month were similar to Lincoln with poor flow and severe staffing issues. Bed occupancy throughout the month has remained high with admissions exceeding discharges on many days.

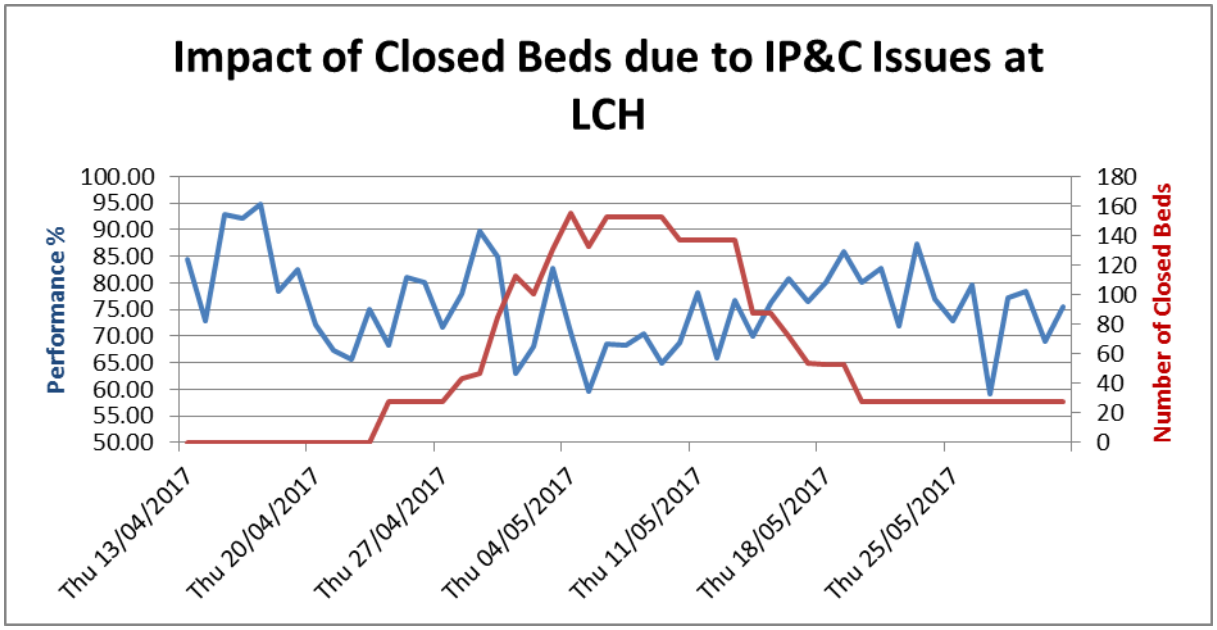
As an example, the 23rd of May saw performance at 46%. This was a legacy from the previous day when there were 20 breaches during the day going into the night with no available medical beds. The ED remained busy through the night with resus full (6 patients in the department requiring resus at 08:00 23rd May – there are only 4 resus cubicles). There were 35 breaches after midnight and 15 patients in ED waiting for beds on the morning of the 23rd. Although the site began to recover during the day the lack of capacity had already caused significant delays and poor performance.

Reliance on agency was high and fill rates were poor during the earlier part of the month



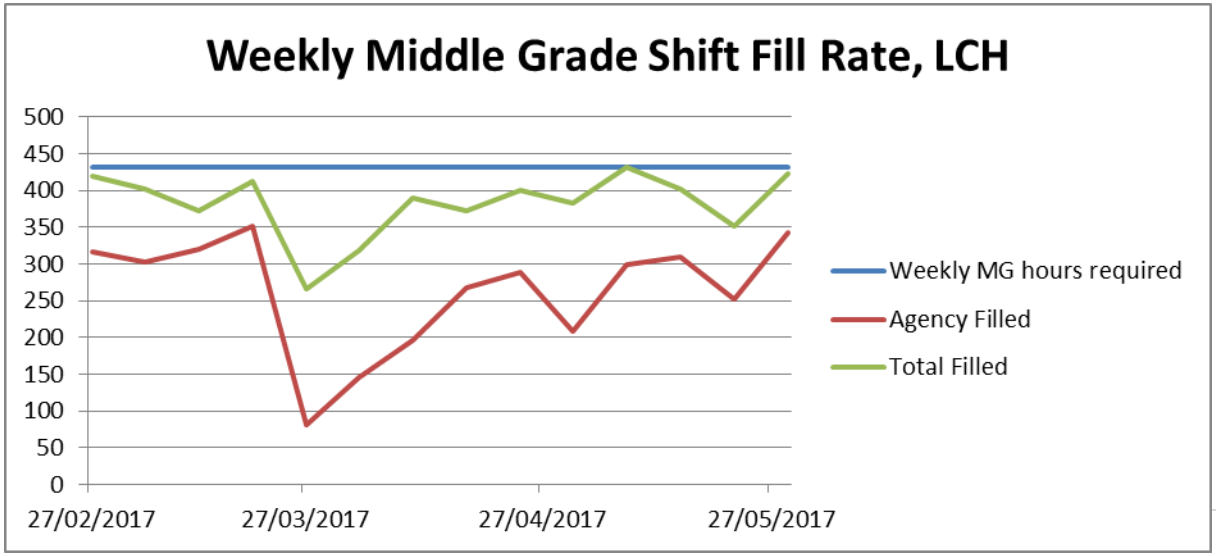
Lincoln

Performance has deteriorated in the month from an April position of 78.53% (-3.47% off trajectory) to 73.69% (-8.31% off trajectory). Performance dropped significantly at the beginning of the month in part due to the ongoing norovirus outbreak that started at the end of April. A further negative spike happened on Saturday 27th May when performance hit 59.26% over the bank holiday weekend when staffing was particularly challenged. Over the weekend of the 22nd and 23rd of April several wards reported patients with symptoms of norovirus. Infection Prevention and Control (PI&C) responded and relevant areas closed. In early May the site had 153 beds closed, many of which were empty but unusable. Daily performance dipped to an average below 70%. The outbreak continued for a further two weeks although Stroke Ward also had related cases of C. Difficile with the ward closed (28 beds) until Saturday 10th June.



In addition to the reduction in available bed stock from norovirus the bank holidays, in particular Monday 1st May showed a reduction in staffing. Performance on Monday 1st was 63% at Lincoln. Middle grade rota's were 50 hours below normal establishment in part from A/L of substantive staff but more significantly a drop in agency fill.

Performance in the month was also affected by nurse vacancies and poor agency nurse fill rates over the bank holidays. This impacts on the ED and wards in their ability to cope with high demand but also our ability to open escalation beds – vitally required during the norovirus outbreak. On Saturday 27th May, bank holiday weekend, although ED staffing was reasonable, the site was 10 qualified nurses short, affecting multiple wards. No escalation could be opened, despite 6 patients in ED waiting beds in the morning. Performance on the day for Lincoln was 59%. Later in the day escalation was opened as the risks in ED outweighed the risks for poor staffing on the wards.



What action is being taken to recover performance?

Pilgrim:

- Consultant covering RAIT from 08:00 to 12:00 will assist minors from 12:00
- EPIC to monitor minors stream and provide resource as required
- Clinical Directorate reviewing rota's to redesign with speciality support working shifts
- Additional support to nursing teams for Medway Training
- New Radiology Room within the ED operational from June will improve diagnostic turn around
- Finalising a new SOP for the Emergency Physician in Charge (EPIC) and looking at ways to improve leadership in the department
- Visit from the Head of Service and flow co-ordinator from Lincoln planned for Thursday 15th June to look at systems and processes in place between departments
- Commenced discussions to look at relocation of AEC and AMU to provide additional capacity within acute medicine
- Developing a plan to ring fence AEC and stop escalation

Lincoln:

- GP in ED starts June 17 to commence a "minor illness" stream
- Capital works to develop more minors cubicles in ED has been completed and rooms in operation from early June
- Dedicated ACP's as part of the Middle Grade Rota from July 2017
- New RAT cubicles now equipped and open
- New medical rota to start from July 17 will increase weekday cover from 10:00 to 22:00
- Plans to extend RAT to weekend cover are unable to progress due to business case only funded in part
- CESR candidate appointed to start September, 1 middle grade and 1 junior being interviewed in June with consultant interviews end of June. New NHS locum consultant to start July
- Increasing frailty input to pull patients direct from ED
- All GP admissions will go through AEC rather than being streamed to Medical Admissions Ward from early July, on return of the lead physician, in order to increase the number of patients seen in an ambulatory setting and reduce admissions

What is the recovery date?

Grantham:

Plan to achieve over the trajectory for quarter four to realise year-end trajectory.

Lincoln and Pilgrim:

Ongoing historical demand pressures and workforce challenges performance is expected to remain challenged in the near future. Q1 ambition is to achieve in excess of 82%. The National expectation is to deliver in excess of 90% in September 2017.

Effective

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Effective							↓
Mortality							→
SHMI	Quarterly		100	110.30	110.30	110.30	→
Hospital-level Mortality Indicator	Quarterly		100	104.22	104.60	103.84	↑
Length of Stay							↓
Average LoS - Elective	Monthly	Medway / Slam	2.8	2.54		2.54	↓
Average LoS - Non Elective	Monthly	Medway / Slam	3.8	4.44	4.45	4.42	↑
Medically Fit for Discharge	Monthly	Bed managers	60	54.50	60.00	49.00	↑
Delayed Transfers of Care	Monthly	Bed managers	3.5%	4.93%	5.29%	4.57%	↑
Partial Booking Waiting List	Monthly	Medway	0	6181	5943	6419	↓

Partial Booking Waiting List

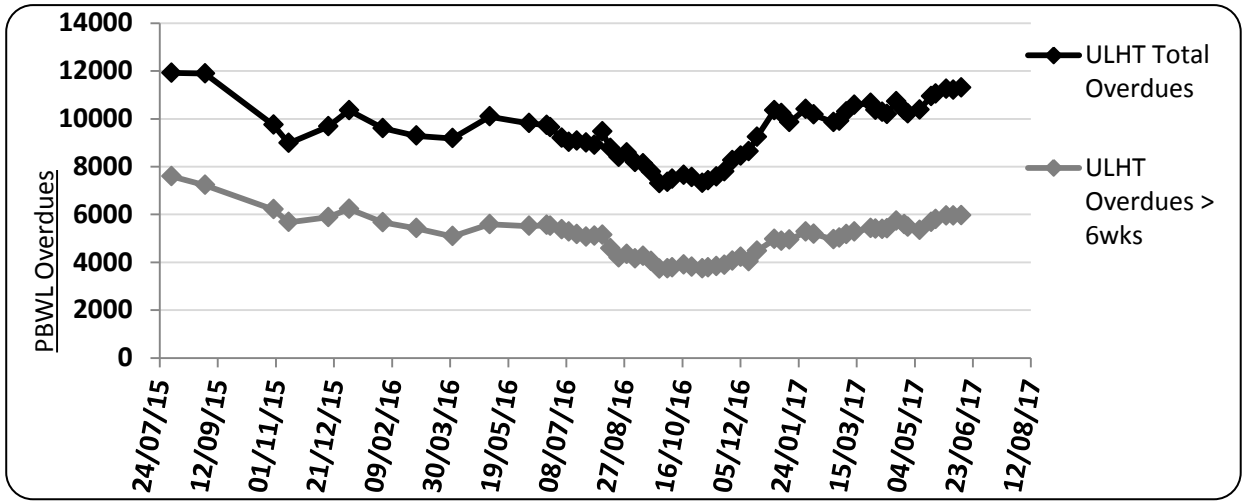
Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Partial Booking Waiting List	Owner:	Chief Operating Officer
Domain:	Effective	Responsible Officer:	Deputy Director of Operational Performance
Date:	27th June 2017	Reporting Period:	May 2017

Exception details

During the 3 weeks following the 18th April the number of patients which are overdue for a follow-up appointment by 6 weeks or more reduced from 5725 to 5337. However, the impact of the lost capacity and reduced booking activity during the cyber-attack, where 1099 follow-up appointments were cancelled, led to an increase in this position back up to 5943 by the 31st May. This position has stabilised in the first 2 weeks of June.

The number of patients overdue by over 6 weeks or more with 4 specialities (ENT, Neurology, Rheumatology, Endocrine) account for over 50% of the total patients overdue by over 6 weeks. The most significant increase in overdue follow-ups over 6 weeks has been within Lincoln ENT, which has seen an increase of 136 patients in the last month.



What action is being taken to recover performance?

Each speciality area with a partial booking backlog has an action plan to address the position. Below is a summary of the key speciality plans:

- Neurology – Service remains to routine referrals. Additional clinics being provided by Consultants in place. MS nurse specialists have commenced reviewing follow-ups. The job description for the 4th Neurology Consultant is currently with the Royal College for approval. The speciality continue to review CV's for locum Consultants. The Trust are working with CCGs relating to key community based pathways which are intended to reduce demand into secondary care.
- Rheumatology – Substantive Consultant now in post, locum Consultant to remain in addition until backlog resolved. Alternative models of working being reviewed within the speciality.
- ENT – Additional clinics; additional audiology sessions; review discharge point for key pathways; review vacant slot processes. Liaising with private providers around the potential options for utilising outsourcing capacity. Forecast recovery still to be confirmed.
- Endocrine – IPB has approved the business case for a 4th Consultant post at Pilgrim, which will be required for recovery within this area. Lincoln and Pilgrim are currently working together to review the spread of capacity across these sites.

Neurology, ENT, Cardiology and Community Paeds all have significant partial booking waiting list backlogs, and these are amongst a group of service areas where the Trust have requested support from the CCGs in order to manage referral rates into the Trust in the short term as part of the plan to address the backlogs.

Safe

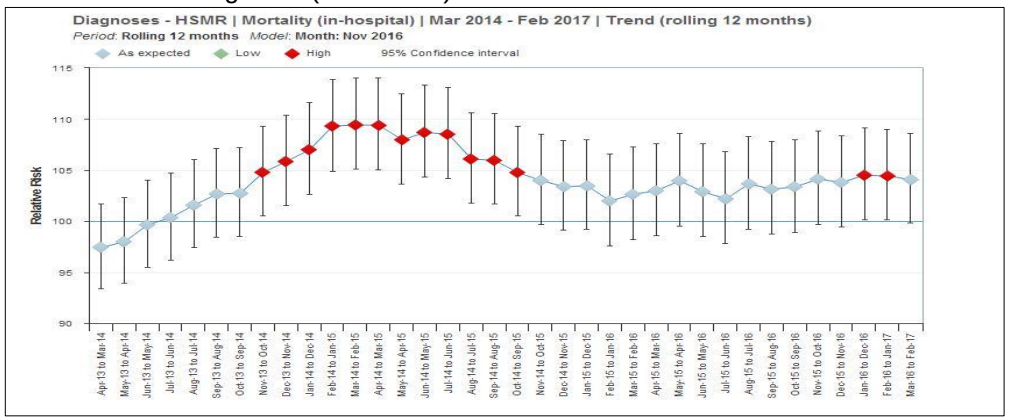
Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Safe							→
Infection Control							→
Clostrum Difficile (post 3 days)	Monthly	Datix	59	18	11	7	↑
MRSA bacteraemia (post 3 days)	Monthly	Datix	0	0	0	0	→
MSSA	Monthly	Datix	4	4	1	3	↓
ECOLI	Monthly	Datix	16	12	7	5	↑
Never Events	Monthly	Datix	0	0	0	0	→
No New Harms							→
Serious Incidents reported (unvalidated)	Monthly	Datix	0	48	25	23	↑
Harm Free Care %	Monthly		95%	91.48%	90.93%	92.03%	↓
New Harm Free Care %	Monthly		98%	97.74%	97.49%	97.98%	↓
Catheter & New UTIs	Monthly		1	1	1	2	↓
Falls	Monthly	Datix	3.90	3.39	3.12	3.66	↓
Medication errors	Monthly	Datix	0	285	141	144	↓
Medication errors (mod, severe or death)	Monthly	Datix	0	45	23	22	↑
Pressure Ulcers (PUNT) 3/4	Monthly			7	5	8	↓
VTE Risk Assessment	Monthly		95%	97.08%	97.15%	97.00%	↑
Core Learning	Monthly	ESR	95%	90.54%	90.42%	90.67%	↓

Safe Ambition 1: Reduction of Harm Associated with Mortality

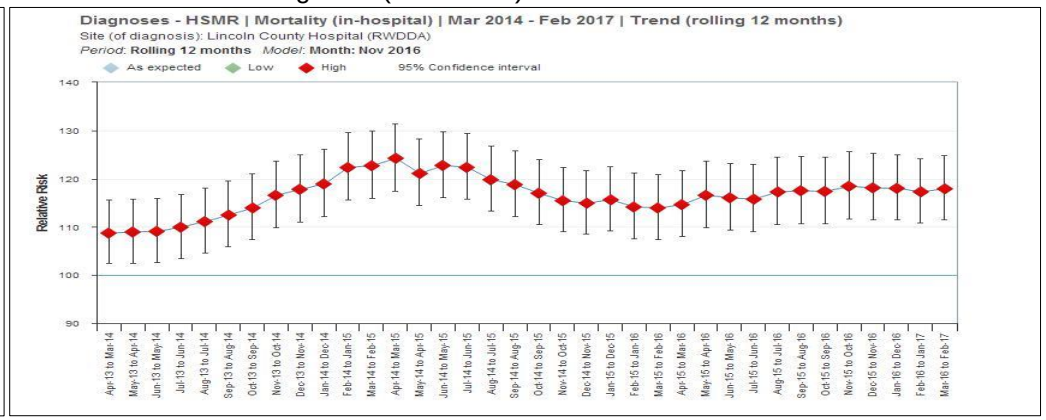
Executive Responsibility: Neil Hepburn – Interim Medical Director

Trust/Site	ULHT HSMR Mar 16-Feb 17 12 month	ULHT HSMR Apr 16-Feb 17 YTD	ULHT HSMR Feb-17	ULHT SHMI Oct 15 – Sep 16	Trust Crude Mortality YTD Internal source Jun 16-May 17
Trust	104.6	104.0	103.2	110.30	1.80%
LCH	117.8	117.6	120.4	112.91	1.86%
PHB	95.4	95.1	90.9	108.34	1.93%
GDH	71.2	71.6	69.8	97.82	1.06%

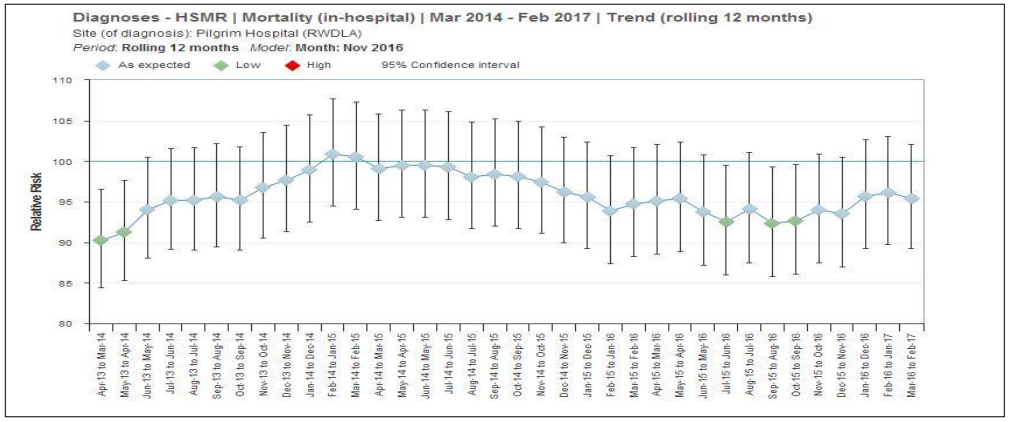
ULHT HSMR Rolling Year (36 Months)



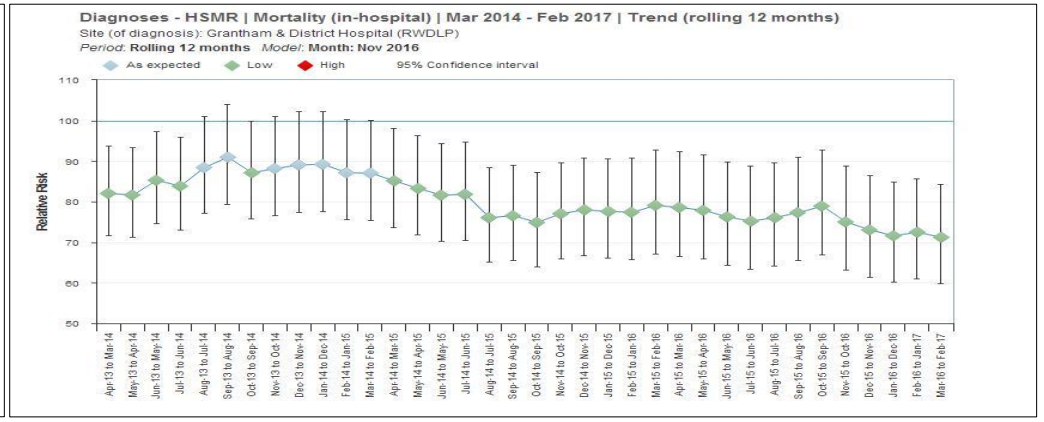
Lincoln HSMR Rolling Year (36 Months)



Pilgrim HSMR Rolling Year (36 Months)



Grantham HSMR Rolling Year (36 Months)



Alerts

ULHT

The Trust diagnoses groups are:

- **COPD and bronchiectasis:** Driven by an alert on the Pilgrim Site; with 20.13 mortalities over the predicted Dr Foster data with no particular month alerting as this is cumulative over the time period above. This has been alerting for 2 consecutive months. Dr Foster Healthcare specialist is working with the Respiratory Team on understanding their data.
- **NEW Other lower respiratory disease:** Not driven by an alert on an individual site; with 8.38 mortalities over the predicted Dr Foster data.

Lincoln County Hospital diagnoses groups are:

- **Biliary Tract Disease:** This is cumulative throughout the time period with 10.65 mortalities over the predicted Dr Foster data. This has now been alerting for 3 months. A comprehensive review was conducted in November 2015 the attached report is below.

Biliary Tract Disease Mortality Review Nov

- **Intestinal Obstruction without hernia:** Due to a notification in October 16; Year to date there were 11.3 mortalities over the predicted within this diagnosis group. This is the fifth consecutive month of notification. An in-depth review is underway; Notes and proforma have been sent to Consultant Colorectal Surgeon for review.
- **Liver Disease, alcohol related:** This is a cumulative alert and not alerting in a particular month; year to date there are 9.84 mortalities over the predicted Dr Foster data. This is the first month alerting.
- **Other gastrointestinal disorders:** This is a cumulative alert and not alerting in a particular month; year to date there are 9.07 mortalities over the predicted Dr Foster data. This is the first month alerting.
- **Septicaemia (except in labour):** This is a cumulative alert and not alerting in a particular month; year to date there are 16.61 mortalities over the predicted Dr Foster data. This is the first month alerting. There is a sepsis committee who meet monthly and have a detailed action plan to improve compliance of sepsis.

Pilgrim hospital diagnoses groups are:

- **COPD and bronchiectasis:** For this alert there has been 15.98 mortalities over the predicted Dr Foster data. This is the second month of alerting.
- **Abdominal pain:** This is a cumulative alert and not alerting in a particular month; year to date there are 2.5 mortalities over the predicted Dr Foster data. This is the first month alerting.

Grantham Hospital

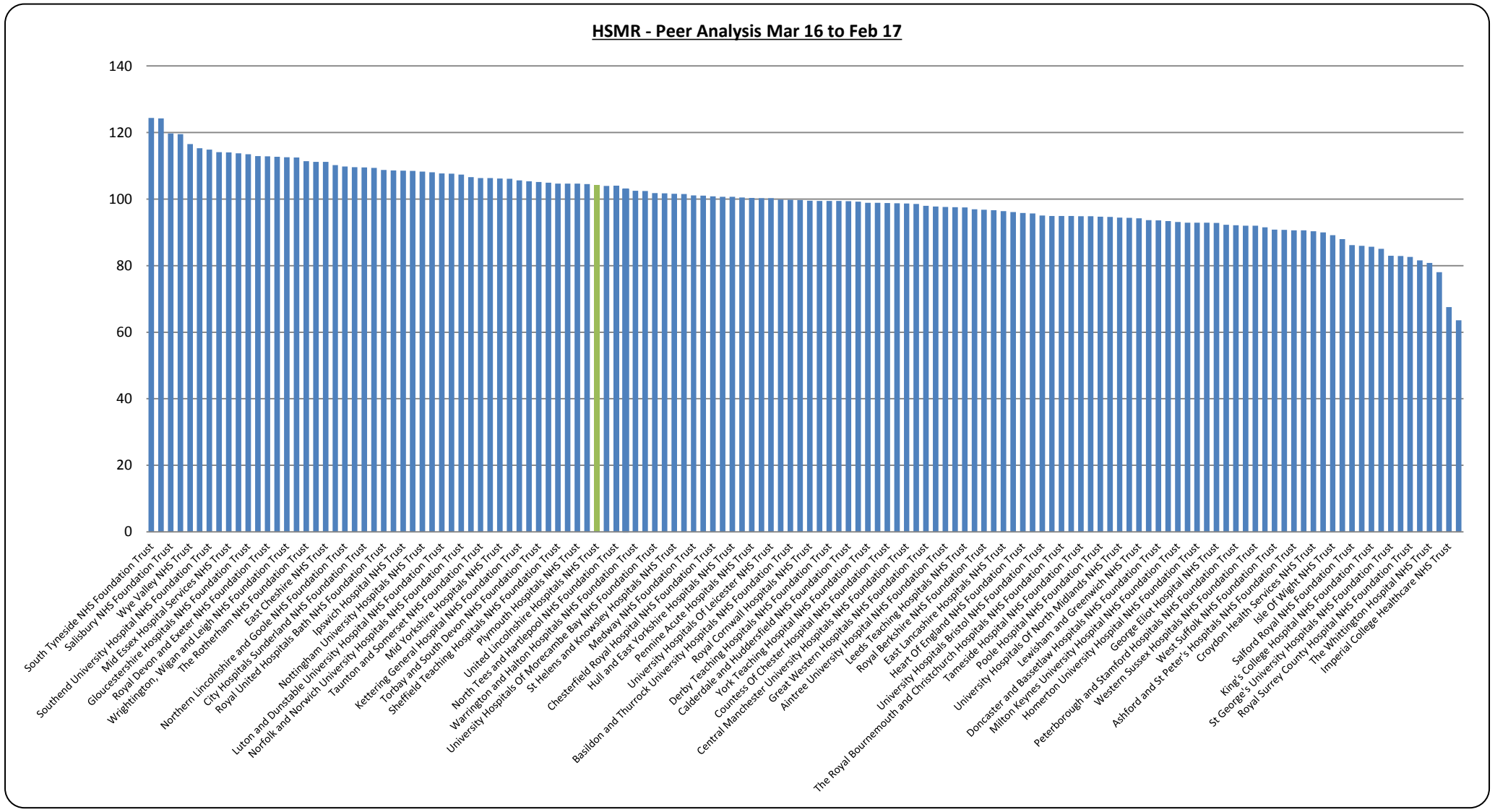
No notifications

HSMR Top Observed Diagnosis Groups April 2016- February 2017

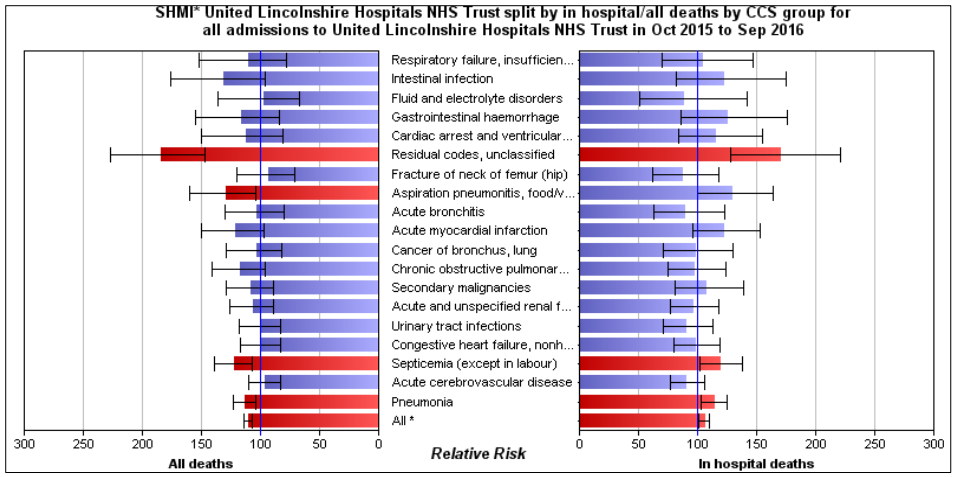
Rank	Diagnosis group	Spells	mortalities	% of all mortalities	Expected mortalities	Actual-Expected	Crude (%)	HSMR
1	Pneumonia	2620.00	484.00	22.04%	482.64	1.36	18.52	100.28
2	Septicemia (except in labour)	823.00	182.00	8.29%	160.59	21.41	22.14	113.33
3	Acute cerebrovascular disease	1156.00	169.00	7.70%	176.05	-7.05	14.71	96.00
4	Acute and unspecified renal failure	756.00	105.00	4.78%	95.37	9.63	13.98	110.10
5	Urinary tract infections	960.00	94.00	4.28%	108.50	-14.50	9.79	86.63
6	Chronic obstructive pulmonary disease and bronchiectasis	1603.00	91.00	4.14%	70.87	20.13	5.68	128.41
7	Congestive heart failure, non-hypertensive	2331.00	90.00	4.10%	95.53	-5.53	3.86	94.21
8	Acute myocardial infarction	896.00	69.00	3.14%	61.22	7.78	7.72	112.72
9	Secondary malignancies	183.00	65.00	2.96%	54.69	10.31	35.71	118.86
10	Aspiration pneumonitis, food/vomitus	2024.00	63.00	2.87%	58.14	4.86	3.12	108.36

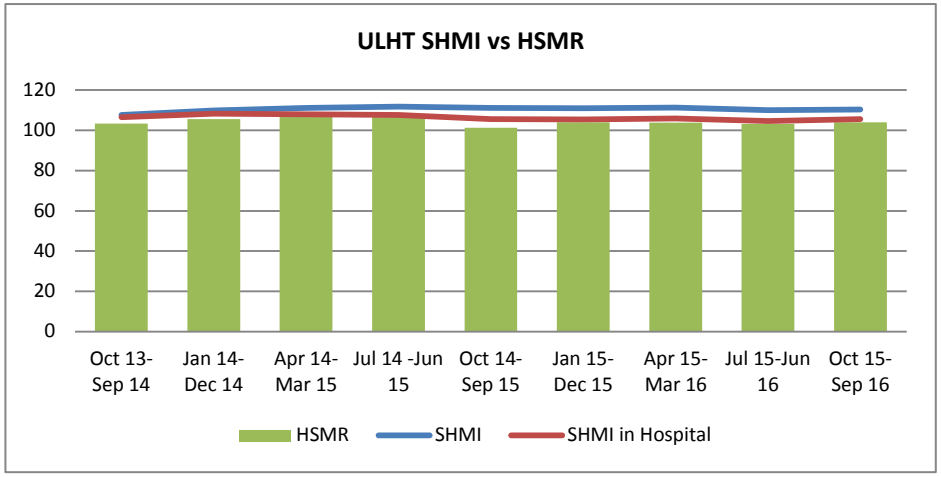
The above diagnosis groups show the top 60% of the alerting diagnosis within the Trust

HSMR Peer Analysis



SHMI





The Trust is undertaking numerous strategies for Mortality Reduction:

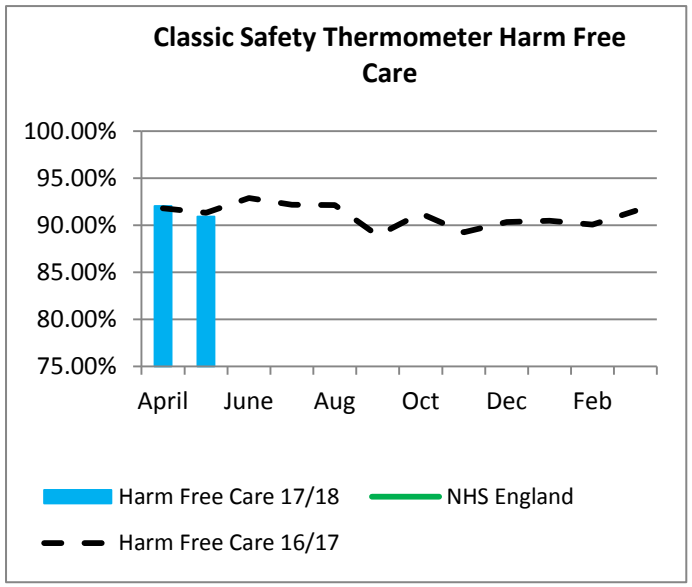
- The first MoRAG briefing has been circulated at the end of May; sharing lessons on Oxygen prescribing case. The second case will for lessons learned will be circulated at the end of June.
- An update on Lincolnshire Mortality Collaborative will be included in the July Mortality matters Newsletter and an update to the committee in July 2017 on the progression of cases identified with issues.
- Following the Comorbidity Audit presented at PSC in May. An action plan has been created to circulate a Mortality Matters briefing disseminating the learning (June 17), and to have a coding masterclass for Junior Doctors.
- PHB have been piloting a Ward Clerk checking the clerking proforma for completion of the comorbidities please see depth of Dr Foster intelligence page 14.
- Dr Foster healthcare intelligence specialist attended the Pneumonia and Stroke Governance Meeting on the 13th April 2017 to review the Dr Foster Data. A report will be generated for Patient Safety Committee.
- Intestinal hernia without obstruction is currently alerting diagnosis; an in-depth review is currently being undertaken; a proforma has been agreed by Consultant Colorectal Surgeon and the notes have been sent for review.
- Mortality Alert overview will be completed on all alerts going forward.
- National guidance on Learning from Deaths are currently being implemented by the Trust.
- Coding Masterclass being organised for October 2017 (these are run quarterly and we have previously orchestrated five masterclass

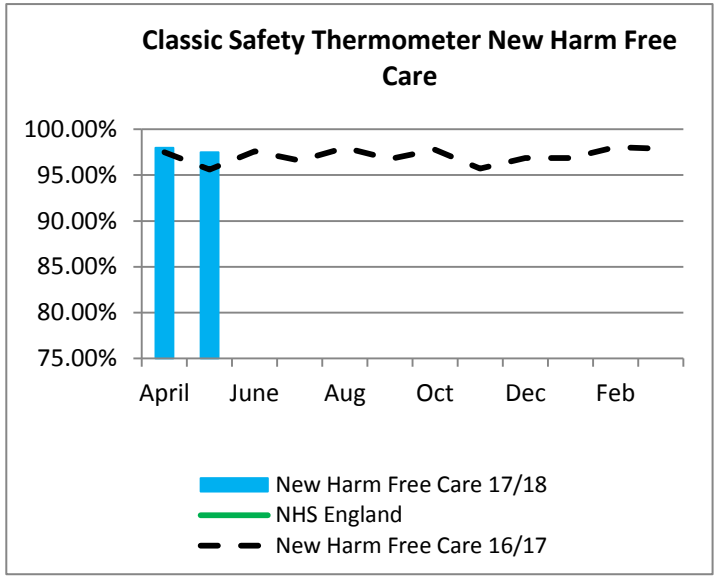
Reviews (Jan 2016-May 2017)

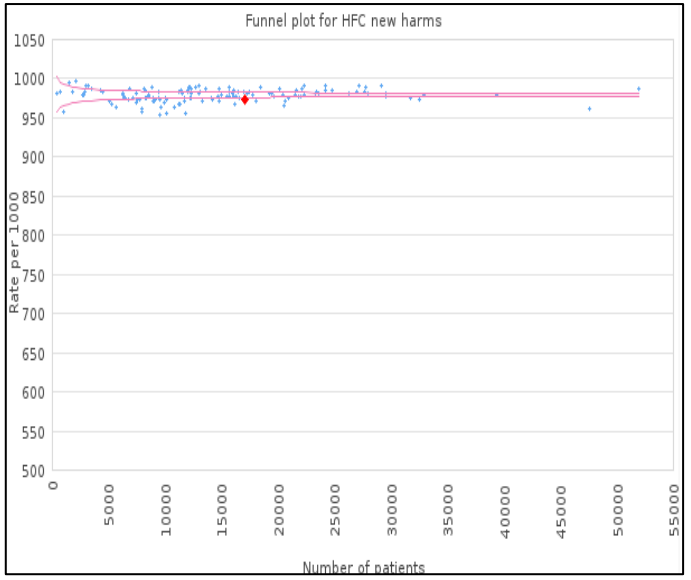
Site	Deaths	Awaiting notes/Notes in Quality Governance	Notes Sent for Review	Review Complete	Review completion Compliance	Review Completion Target	Total Death % Reviewed
ULHT Total	4104	753	3340	2431	73%	75%	59%
Lincoln Total	2250	351	1899	1335	70%	75%	59%
Pilgrim Total	1600	338	1251	945	76%	75%	59%
Grantham Total	254	64	190	151	79%	75%	59%

Safe Ambition 2: Reduction of Harm Associated with Harm Free Care

Executive Responsibility: Michelle Rhodes – Director of Nursing







Performance Data Overview – April 2017

Site	No Patients	Harm Free	New Harm Free	PU- All	PU - New	Falls with harm	Cath & all UTI	Cath & New UTI	New VTEs
National Average	-	94.1%	97.9%	4.5%	0.9%	0.5%	0.4%	0.3%	0.4%
Grantham	82	92.7%	96.3%	3.7%	0.0%	2.4%	1.2%	1.2%	1.2%
Lincoln	449	93.8%	98.4%	5.1%	1.1%	0.4%	0.9%	0.0%	0.0%
Louth	0	n/r	n/r	n/r	n/r	n/r	n/r	n/r	n/r
Pilgrim	310	89.4%	97.7%	8.4%	1.3%	0.3%	1.6%	0.3%	0.3%
UHT Total	841	92.0%	98.0%	6.2%	1.1%	0.6%	1.2%	0.2%	0.2%

May

Harm Free Care = 90.93 % New Harm Free Care = 97.49 %
8 New Pressure Ulcers (6x Cat2 2 x Cat3)
11 Falls with Harm (9 Low 2 Moderate)
1 New CA-UTI
2 New VTE

Action Plan

Pressure damage actions outlined in the report. Results reported upwardly to Pressure Ulcer Reduction Committee with delegate authority from Patient Safety Committee.

Fall actions outlined in the report. Results reported upwardly to Falls Reduction Group with delegated authority from Patient Safety Committee.

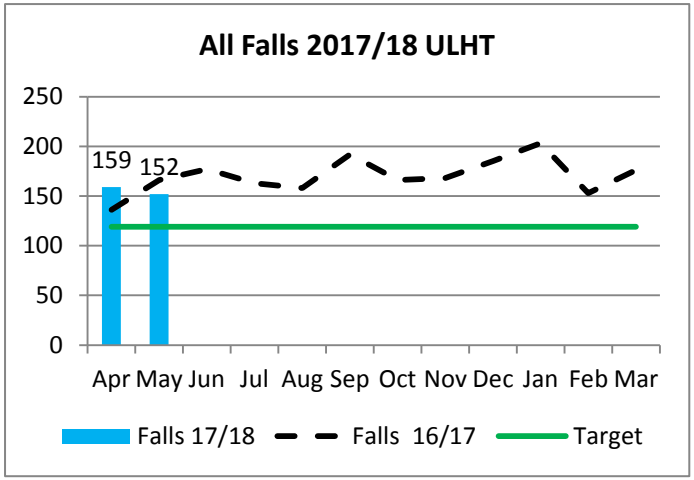
CA-UTI actions outlined in the report. Results reported upwardly to Catheter Reduction Group with delegated authority from Patient Safety Committee.

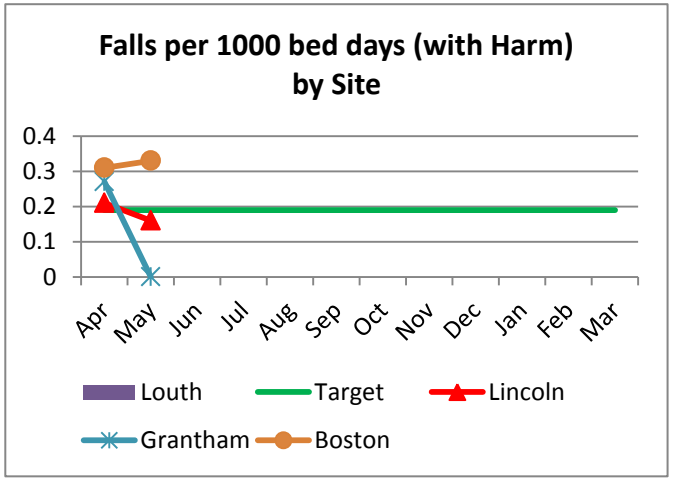
VTE investigated through Route Cause Analysis by VTE Nurse Manager and reported upwardly through Patient Safety Committee.

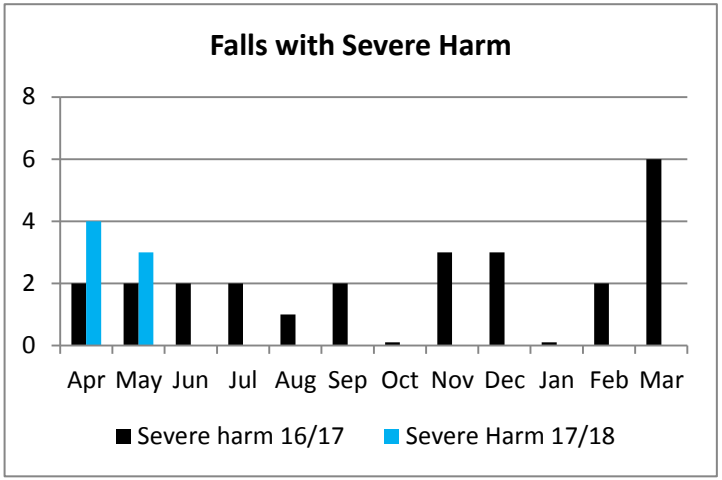
There are educational issues in respect of ST parameters for Pressure Damage and VTE.

Safe Ambition 3: Reduction of Harm Associated with Falls

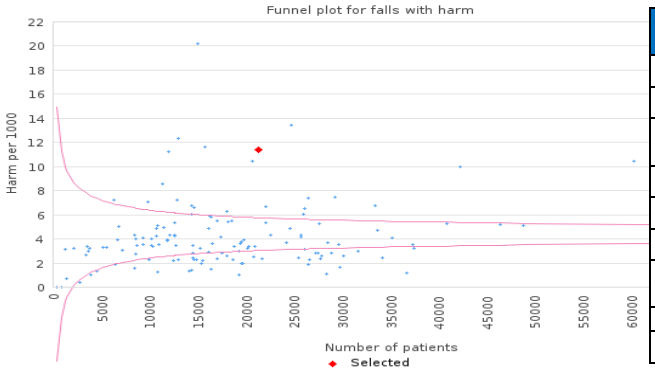
Executive Responsibility: Michelle Rhodes – Director of Nursing







Safety Thermometer Apr 16 – Apr 17



Safety Quality Dashbaord (SQD) for Trust Falls July 2016- May 2017

Metric Title	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	De 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017
Patient at risk of falls	344	336	338	344	318	284	325	333	344	312	296
Actions completed within 4 hours	93.00%	88.10%	87.40%	93.90%	90.50%	88.00%	87.70%	88%	88.1%	91.0%	90.60%
Actions completed within 24 hours of admission	46.50%	42.20%	49.20%	45.30%	38.50%	48.50%	47.40%	-	46.7%	57.7%	57.40$
Lying & standing BP completed	58.00%	62.60%	67.10%	63.10%	61.90%	61.00%	66.50%	62.8%	68.3%	78.0%	81.80%
Care plan 7 activated	97.10%	96.40%	96.20%	93.80%	94.40%	93.60%	95.30%	95.4%	91.4%	97.7%	97.60%
Neuro Cognition Assessed	-	-	-	-	-	-	-	-	96.2%	97.1%	98.00%
Vision Assessed	-	-	-	-	-	-	-	-	95.3%	97.8%	96.60%
Bed Rails Assessment	-	-	-	-	-	-	-	-	98.6%	99.7%	99.30%
Continence/toilet regime documented	-	-	-	-	-	-	-	-	76.4%	92.9%	87.50%

Performance Data Overview- There have been 152 falls across ULHT in May 2017 (comparable to 166 in May 2016). There were 3 falls with Severe Harm (1 LCH and 2 PHB –separate wards). Falls per 1000 bed days is within trajectory on all sites however falls with harm remains above trajectory at Boston. Sustained improvements in number and severity of falls seen on 6B with NHSi collaborative work (18 falls March, 11 falls April, 9 falls May). Of the 152 Falls 41 falls were repeat falls. 17 Falls were recorded as near misses. There were 54 falls with some level of harm. Of these falls the majority were classified as slips (16) or unwitnessed falls (17). This is a change from April when accumulative primary source of falls with harm was classified as "From Height bed or chair" (24).

Action Plan

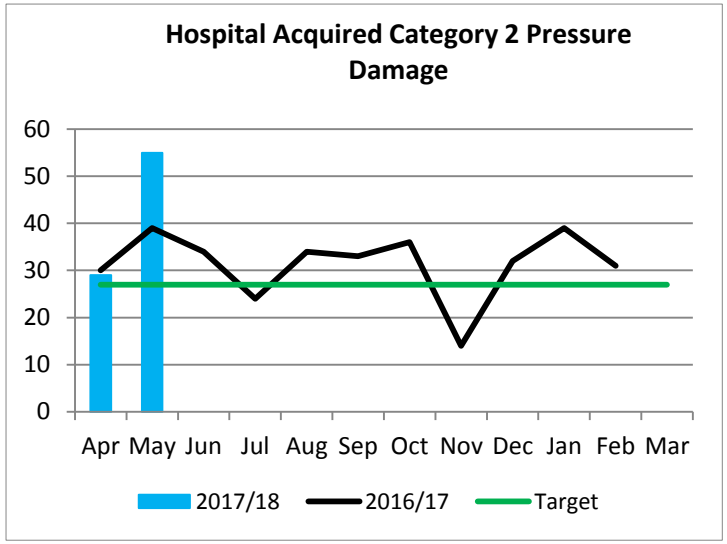
Since launch of dedicated training and educational video (March 2017) there has been demonstrable improvement in completion of Lying and Standing Blood Pressure. Session undertaken at Grantham on 12th June and scheduled for Lincoln on 29th June.

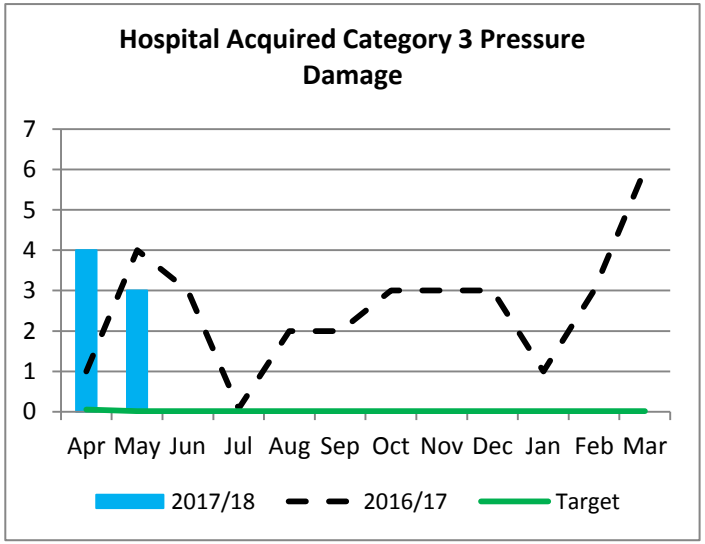
Jan-2017	Feb-2017	Mar-2017	Apr-2017	May-2017	Jun-2017
66.5%	62.8%	68.3%	78.0%	81.8%	76.4%

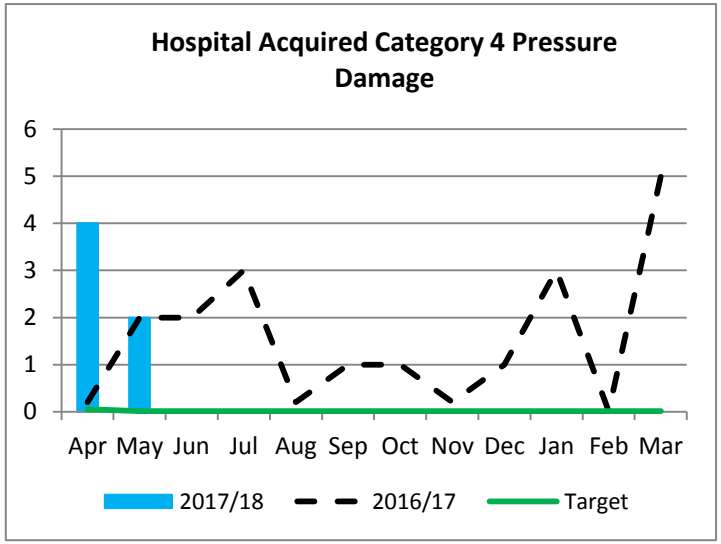
Milestone plan revised to reflect 2017/18 ambitions with cross reference to Ward Accreditation and KLOE. Falls Workbook translated into prospective e-learning package and awaiting consideration by Core Learning Panel. NHSi collaborative initiatives being rolled out.

Safe Ambition 4: Reduction of Harm Associated with Pressure Ulcers

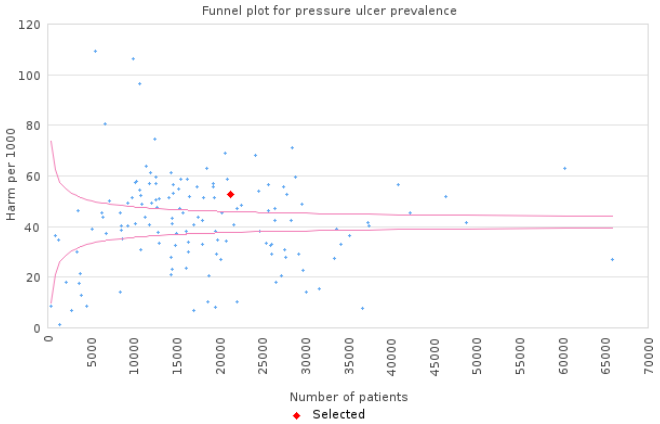
Executive Responsibility: Michelle Rhodes – Director of Nursing







Safety Thermometer Apr 16 – Apr 17



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

Metric Title	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb-2017	Mar 2017	Apr 2017	May 2017
Pressure area risk assessment completed within 24hrs	99.00%	98.80%	98.80%	99.30%	98.80%	98.30%	97.50%	-	97.0%	98.7%	98.60%
Pressure area risk assessment updated weekly	75.30%	76.00%	78.90%	80.70%	78.40%	72.00%	71.60%	77.4%	76.7%	80.5%	81.50%
Pressure-relieving equipment in situ if required	96.00%	93.50%	93.90%	96.60%	94.20%	95.50%	96.60%	93.4%	94.0%	96.2%	95.20%
Frequency of repositioning documented	-	-	-	-	-	-	-	-	60.8%	62.4%	79.50%
Prescribed frequency of turning has been followed for last 24 hours	-	-	-	-	-	-	-	-	59.5%	61.7%	79.00%
Pressure areas care wound dressing renewed	-	-	-	-	-	-	-	-	52.4%	59.7%	76.40%
Pressure area care plan activated if required	95.10%	92.10%	94.30%	88.80%	94.40%	92.90%	93.50%	91.1%	91.5%	94.7%	93.80%

Performance Data Overview

Analysis of PUNT and Datix has identified inconsistencies in incident reporting. PUNT data indicates an increase in the number of Category 2 PUs from 30 in April to 55 in May, 36 of which occurred on the Pilgrim site and 19 at Lincoln. There were 2 Category 4 PUs (deteriorations), both occurred at Pilgrim (6A & 6B). There were 3 Category 3 PUs, 2 at Lincoln (Scampton & Johnson) and 1 at Pilgrim (3B). Grantham had no HA Category 2-4 PUs in May.

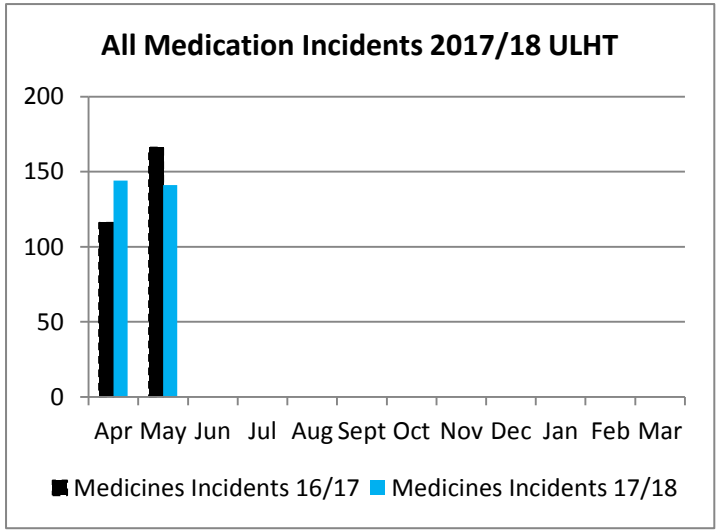
Action Plan

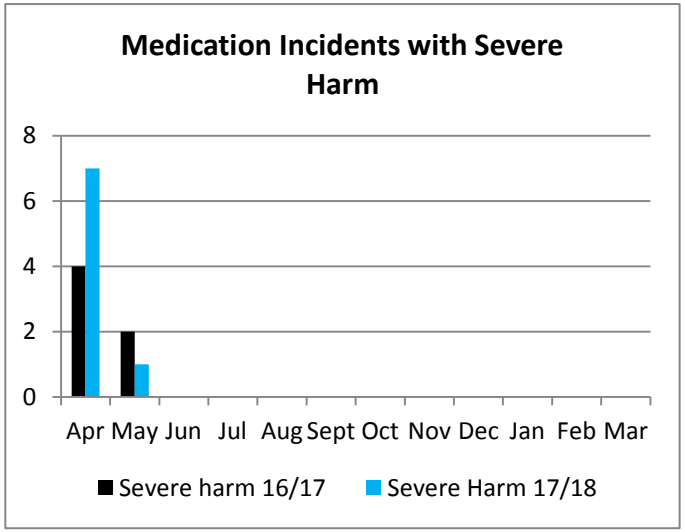
Use one reporting system from July 2017 (Datix) for 3-6 months whilst further review of PUNT undertaken. Focused work at Pilgrim to include facilitation of PU drop in days in June and August, poster competition, PDSA cycle improvement work, increased visibility of Nurse Consultant & TVNs on the wards, and further updates/teaching in A&E/assessment units regarding the use of the Anderson Tool/initial PU Assessments.

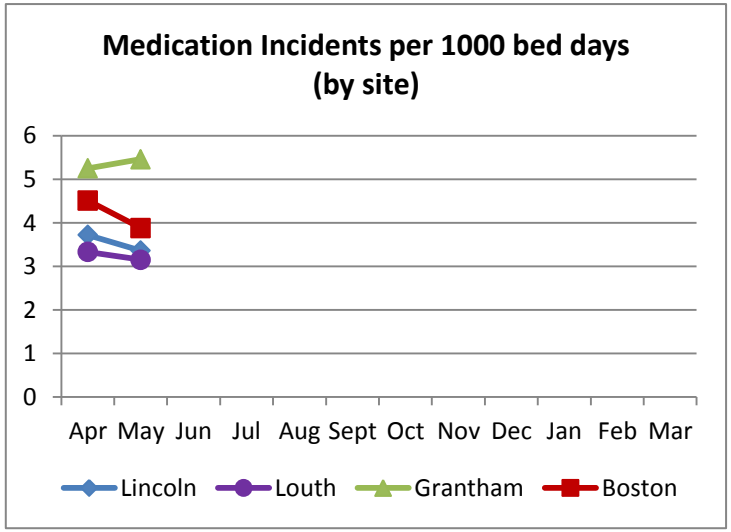
Ongoing investigations and scrutiny panels for Cat 3 & 4 PUs.

Safe Ambition 5: Reduction of Harm Medication Incidents

Executive Responsibility: Michelle Rhodes – Director of Nursing







Trust Safety Quality Dashboard July 2016 – May 2017

Metric Title	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb-2017	Mar -2017	Apr-2017	May- 2017
Medicine chart demographics correct	75.00%	78.50%	78.40%	83.70%	78.10%	80.50%	78.80%	78.90%	97.2%	98.2%	98.40%
Allergies documented	96.80%	98.10%	98.80%	98.20%	99.40%	98.40%	98.10%	99.40%	99.4%	98.7%	97.20%
All medicines administered on time	87.90%	88.00%	91.90%	87.60%	88.60%	91.60%	89.10%	87.50%	76.8%	83%	81.40%
Allergy nameband in place if required	91.00%	87.60%	91.80%	93.50%	86.20%	84.70%	92.90%	84.10%	92.3%	82.8%	86.80%
Identification namebands in situ	98.80%	98.00%	99.50%	98.80%	99.80%	99.70%	98.50%	98.00%	98.5%	98.1%	99.70%

Performance Data Overview

Of the 141 incidents reported the majority (83.7%) were classed as resulting in no harm. 79 (56%) of all the events recorded were associated with priority/high risk drugs. This is an increase on April (51%). 58 (41%) of all incidents reported were due to medicines being omitted. This is an increase from April (28%).

Over the last 6 months AMU Boston have had the highest number of Trust moderate, severe and death medication related incidents (comparative to 4 LCH MEAU).

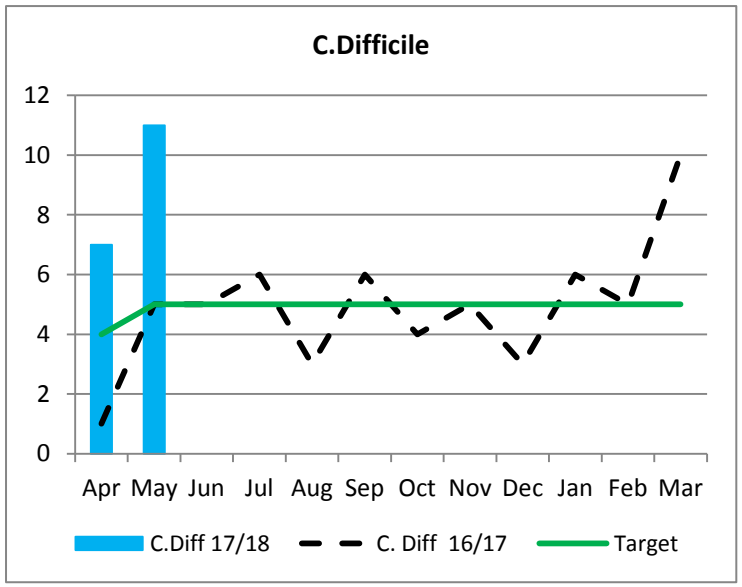
There were 10 incidents reported in May that involved errors made by the Pharmacy department. Pharmacy issued 62021 items in May making the error rate 0.01612%

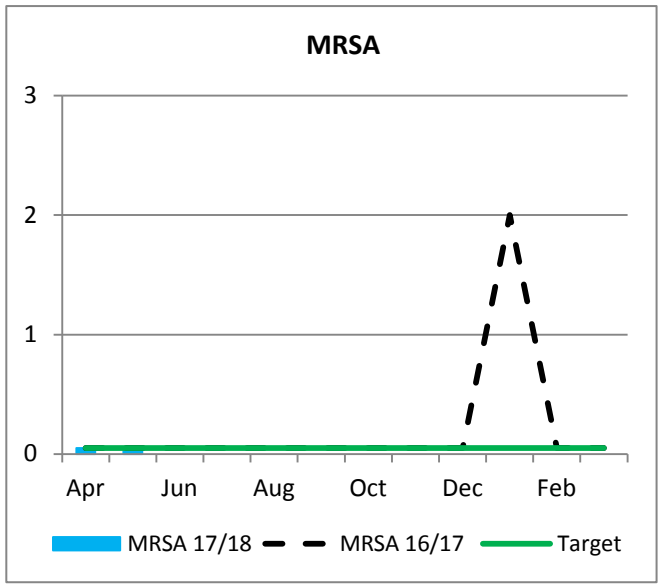
Action Plan

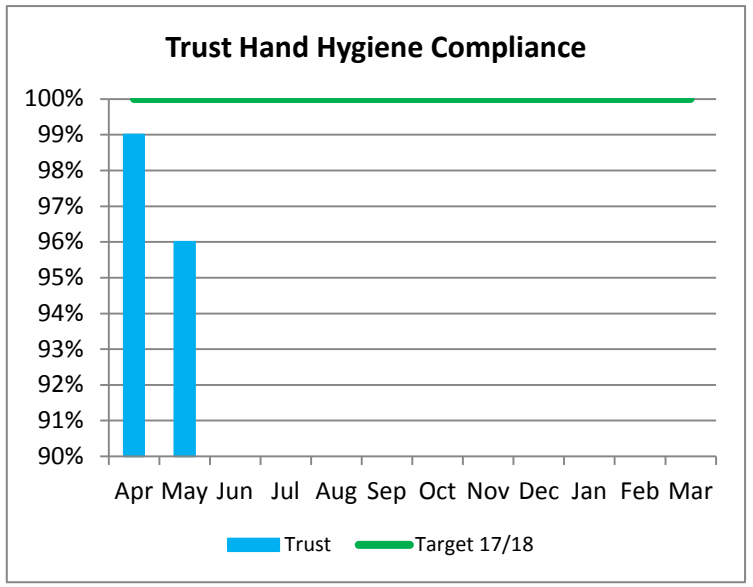
This medications error report is reviewed at the Medicine Optimisation and Safety Committee and all incidents are reviewed on a monthly basis to identify trends. All Heads of Nursing receive the errors by ward area and disseminate to their matrons who in turn disseminate to their ward leaders. These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

Safe Ambition 6: Reduction of Harm Associated with Infection

Executive Responsibility: Michelle Rhodes – Director of Nursing







Performance Data Overview

In May 2017 there were 11 confirmed hospital acquired C.Diff cases. 6 at Boston 3 on Ward 6A, 4 at Lincoln 3 on Stroke Unit and 1 at Grantham.

There were no hospital acquired cases of MRSA reported in May 2017.

Hand Hygiene Trust Average has dropped to 96 %. Trust average has not been <97% since August 2016.

Grantham	95%
Lincoln	99%
Louth	100%
Pilgrim	92%

The overall May 2017 Trust percentage for undertaking and submitting hand hygiene returns is 96.85%.
Unfortunately the Trust did not receive returns from the following areas:
Grantham: Pre-Assessment
Pilgrim: Fracture Clinic, OPD and Ward 7A

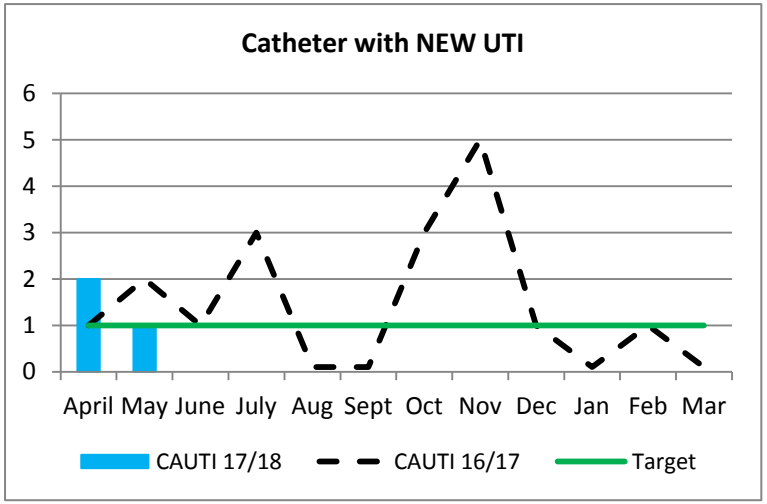
Action Plan

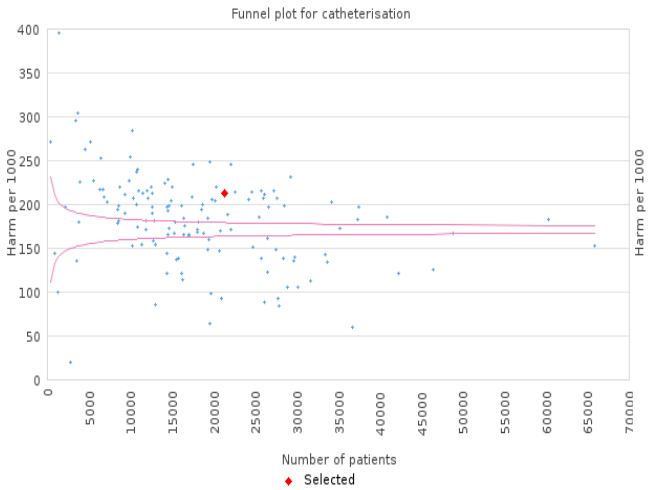
An increase in the number Clostridium difficile cases has been noted across the trust. Root cause analyses are being carried out for each individual case and action plans formulated for individual areas. Following the June Infection Prevention Committee meeting an extraordinary meeting was held to discuss the general increase in C diff rates. A trust-wide action plan to address this increase is being implemented, and weekly Clostridium difficile review meetings will be held to monitor progress against this plan. This work is being supported by the CCG.

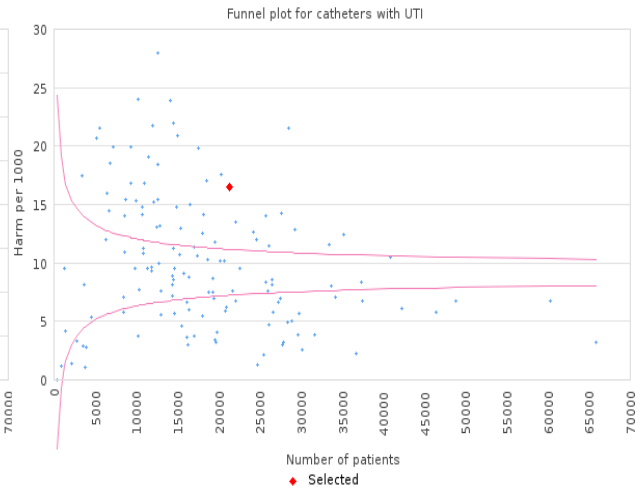
Reduction in EColi bacteremia to be included as recurrent agenda item at Catheter Reduction Group to align with ongoing work of IPC . Catheter Reduction Committee requested to report upwardly to IPC.

Safe Ambition 6: Reduction of Harm Associated with Infection (CAUTI)

Executive Responsibility: Michelle Rhodes – Director of Nursing







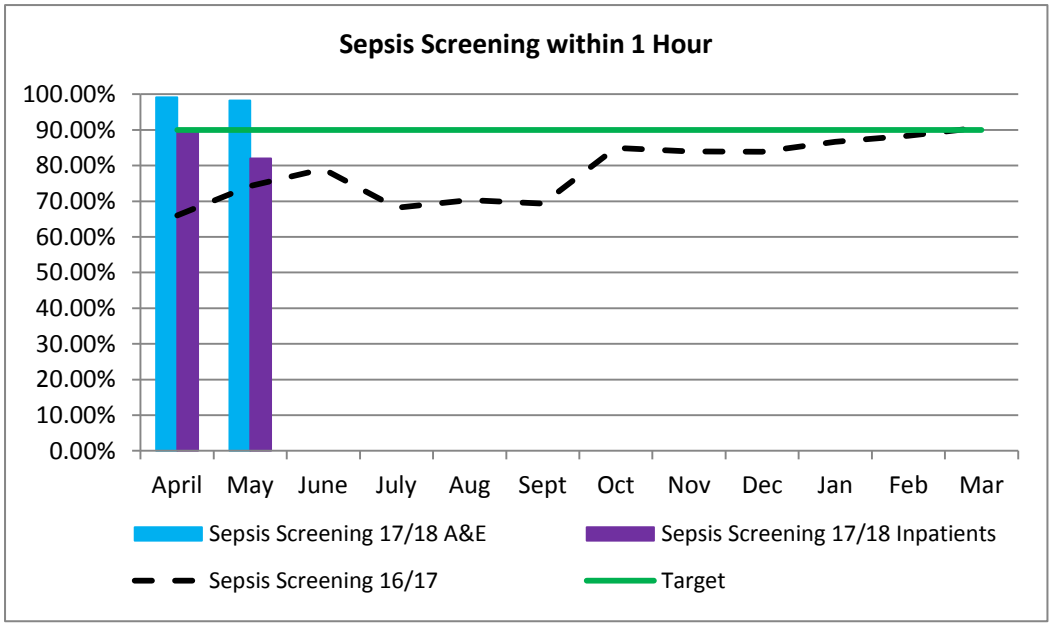
Safety Quality Dashboard (SQD) for Trust pressure area care July 2016- May 2017

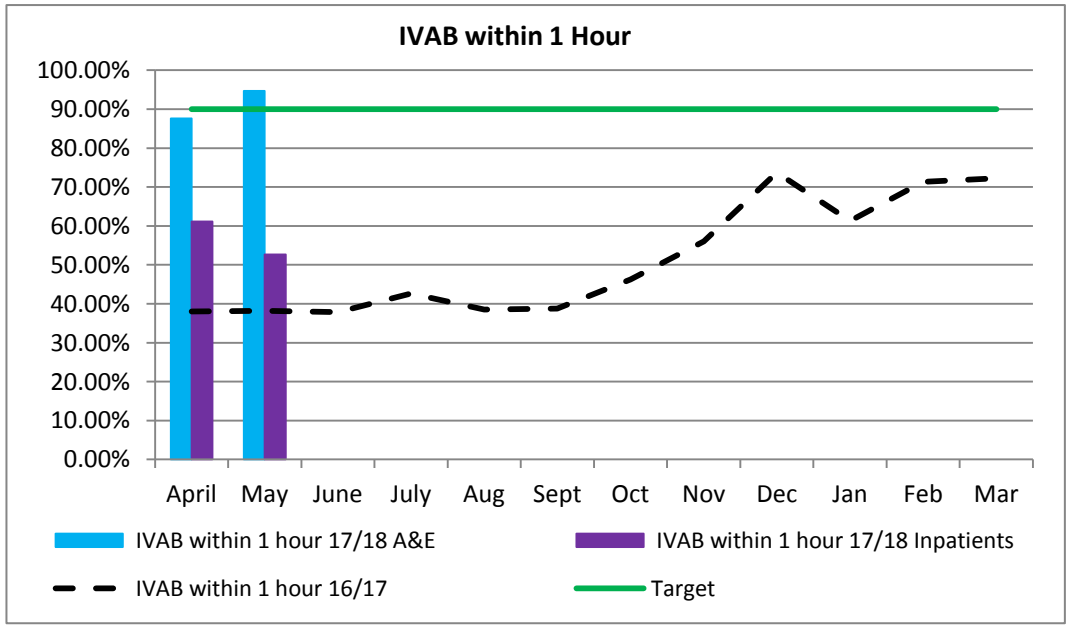
Metric Title	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb- 2017	Mar – 2017	Apr – 2017	May – 2017
Number of urinary catheters in-situ	75	81	63	72	81	53	67	84	80	85	72
Urinary catheter record demographics correct	90.4%	95.0%	96.8%	86.1%	98.8%	90.2%	94.0%	92.8%	96.1%	97.6%	97.20%
Urinary catheter record completed &signed daily	57.5%	72.2%	65.1%	65.3%	72.2%	58.8%	68.2%	73.8%	54.5%	67.5%	70.00%
TWOC occurred within 3 days for acute retention	36.4%	40.0%	50.0%	40.0%	58.3%	50.0%	66.7%	40%	25.0%	36.4%	40.00%
Documented evidence why catheter needed	89.0%	91.1%	96.8%	86.1%	97.5%	92.2%	91.0%	91.7%	89.6%	94.0%	94.40%
Urinary catheter bags secure	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	-	-		
Urinary catheter care plan activated	87.5%	88.6%	90.5%	83.3%	90.1%	88.2%	88.1%	-	-		

Performance Data Overview	**Action Plan**
The Trust is over trajectory for CA-UTI in May 2017. Average catheter insertion rates for ULHT (according to Safety Thermometer) are 21.2 % (Jan – May 2017). Safety Thermometer data suggests that ULHT inserts more catheters and has more NEW UTI's than Acute Trusts of similar size. Further interrogation of the data is required to identify outlying wards and implement improvement strategies.	Review of all Intranet guidelines and literature to ensure current Launch webpages for Catheter care Finalise training package, map e-learning to staff profiles on ESR and launch Deep dive catheter audit to understand differential between specialty/site insertion rates Use audit intelligence and regional comparison of Safety Thermometer to establish baseline and insertion trajectory Report all UTIs in patients with a catheter on Datix Use Datix investigation outcomes to determine avoidability and lessons learned

Safe Ambition 7: Reduction of Harm Associated with Deterioration Sepsis

Executive Responsibility: Michelle Rhodes – Director of Nursing





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

Metric Title	Jun-2016	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb - 2017	Mar – 2017	Apr-2017	May – 2017
Patient observations on time and complete	-	-	-	-	-	-	-	-	-	43.8%	57.1%	62.30%
Patient pain score complete	98.3%	98.1%	97.5%	98.3%	98.8%	98.8%	98.6%	98.7%	-	16.2%	19%	29.20%
Evidence of escalation if required	78.0%	78.3%	76.1%	71.4%	93.8%	86.0%	75.6%	82.9%	86.2%	78.3%	88.9%	82.10%
Patient observation frequency document on PfER	-	-	-	-	-	-	-	-	-	75.7%	84.2%	87.00%

Performance Data Overview

A&E Target 90%	**Screening –May 17**	**IVAB within 1 hour – May 17**
Grantham	88.88%	75%
Lincoln	100%	100%
Pilgrim	97.56%	90.90%
Inpatients Target 90%	**Screening –May 17**	**IVAB within 1 hour – May 17**
Grantham	73.33%	20%
Lincoln	100%`	100%
Pilgrim	75%	44.44%

Action Plan

E Bundle launched across all adult inpatient areas (excluding maternity) and A&E departments on 5th June 2017. CQUIN data to be collected via manual audit until 30th June 2017. Reporting function from E-Bundle tested and clinical comments incorporated ahead of launch.

Sepsis performance circulated by site weekly with numeric and percentage values. Performance to be separated into inpatients and A&E departments from 1st July 2017.

Non-compliance reported through IR1 process, includes failure to screen and failure to give IVABX within 60 minutes.

Caring

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Caring							→
Friends and Family Test							→
Inpatient (Response Rate)	Monthly	Envoy Messenger	26%	29.50%	30.00%	29.00%	↑
Inpatient (Recommend)	Monthly	Envoy Messenger	96%	90.00%	89.00%	91.00%	↓
A&E (Response Rate)	Monthly	Envoy Messenger	14%	21.50%	21.00%	22.00%	↓
A&E (Recommend)	Monthly	Envoy Messenger	87%	81.50%	81.00%	82.00%	↓
% of staff who would recommend care							
% of staff who would recommend work							
Complaints							→
No of Complaints received	Monthly	Datix	70	106	51	55	↓
No of Complaints still Open	Monthly	Datix	0	489	250	239	
No of Complaints ongoing	Monthly	Datix	0	74	35	39	
Inpatient Experience							↑
Mixed Sex Accommodation	Monthly	Datix	0	0	0	0	→
eDD	Monthly	EDD	95%	79.71%	73.23%	86.19%	↓
PPCI 90 hrs	Quarterly		100%	96.30%	97.33%	97.33%	→
PPCI 150 hr	Quarterly		100%	86.07%	85.33%	85.33%	→
#NOF 24	Monthly		70%	65.66%	74.60%	56.72%	↑
#NOF 48 hrs	Monthly		95%	95.38%	95.24%	95.52%	↓
Dementia Screening	1 month behind		90%	93.56%	93.56%	94.16%	↓
Dementia risk assessment	1 month behind		90%	98.39%	98.39%	98.69%	↓
Dementia referral for Specialist treatment	1 month behind		90%	88.24%	88.24%	85.37%	↑
Stroke							→
Patients with 90% of stay in Stroke Unit	1 month behind	SSNAP	80%	94.00%	94.00%	88.60%	↑
Sallowing assessment < 4hrs	1 month behind	SSNAP	80%	66.70%	66.70%	69.10%	↓
Scanned < 1 hrs	1 month behind	SSNAP	50%	61.70%	61.70%	61.50%	↑
Scanned < 12 hrs	1 month behind	SSNAP	100%	98.30%	98.30%	96.90%	↑
Admitted to Stroke < 4 hrs	1 month behind	SSNAP	90%	75.00%	75.00%	59.10%	↑
Patient death in Stroke	1 month behind	SSNAP	17%	18.00%	18.00%	15.90%	↑

Well-Led

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Well Led							→
Vacancies	Monthly	ESR	5.0%	11.27%	11.40%	11.14%	↑
Sickness Absence	Monthly	ESR	4.5%	4.40%	4.32%	4.48%	↓
Staff Turnover	Monthly	ESR	8.0%	5.81%	5.82%	5.80%	↑
Staff Engagement							→
Staff Appraisals	Monthly	ESR	95.0%	73.50%	79.00%	68.00%	↑
Equality Diversity and Inclusion							

Workforce Headline Summary

Executive Responsibility: Martin Rayson –Director of Human Resources & Organisational Development

KPI	2017/18 Target	May 2017 Performance	Last Month Performance	Performance in May 2016	6th Month Trend
Vacancy Rate For Specialties: - Medical - Registered Nurses - AHPs	Medical – 12% Reg Nursing – 11.5% AHPs – 10%	**Medical 15.02% N&M Reg 14.23% AHP'S 13.72%**	**14.77% 13.71% 13.73%**	**Available from next month**	↑
Voluntary Turnover	7%, with no group of staff more than 20% above the overall target	**5.82%**	**5.80%**	**N/A**	**N/A**
Quarterly Engagement Index	10% improvement in average score during 2017/18	**Pulse survey to be run in June**			
Quality of Leadership/Management Index	10% improvement in average score during 2017/18	**Pulse survey to be run in June**			
Core Learning Completion	Revised target to be set asap following review that is underway	**90.25%**	**91%**	**82%**	↑
Sickness Absence (12 month rolling average)	Overall target of 4.5% + no team over 25% above target	**4.70%**	**4.70%**	**4.54%**	↑
Appraisals: - Medical - Non-Medical	Medical – 95% Non-Medical – 85%	**N/A 79.18%**	**68.22%**	**65.81%**	↑
Agency Spend	£21m (equates to £1.75m per month)	**£2.748m**	**£2.356m**	**£2.357**	↑

The key issue highlighted by this report is the high level of agency spend. The original target set of a spend of £21m would require a 28% reduction on 2016/17 levels, which is significantly challenging. However, we have seen spend levels higher than in the equivalent months in the last financial year and this is an area where we have to get more control. Plans and reporting arrangements are being reviewed in order to address the challenge.

As we have discussed previously, reducing vacancy rates is one of the key mechanisms by which we will reduce agency spend. Recruitment plans are being implemented, but will take time to have an impact. There is a need to implement new workforce planning arrangements to ensure there is a review of roles required to deliver services, with a focus on areas where it is hard to recruit medical staff.

There is positive new about sickness levels, as the in-month rate has reduced for three months in a row. However, this has yet to translate into a change in the 12 month rolling average, as same downward trend was seen in the spring of 2016. The additional actions we have taken over sickness should see the downward trend continue, thereby impacting on the rolling 12 month average in future months.

Finally, on a positive note, the completion rate for non-Medical appraisals has gone up by 10% in the last month. However, it still remains below target and there was a significant amount of cajoling required to push the rate up. We need to get to a position where appraisal is valued as part of an overall performance management framework and this is the purpose of the review proposed.

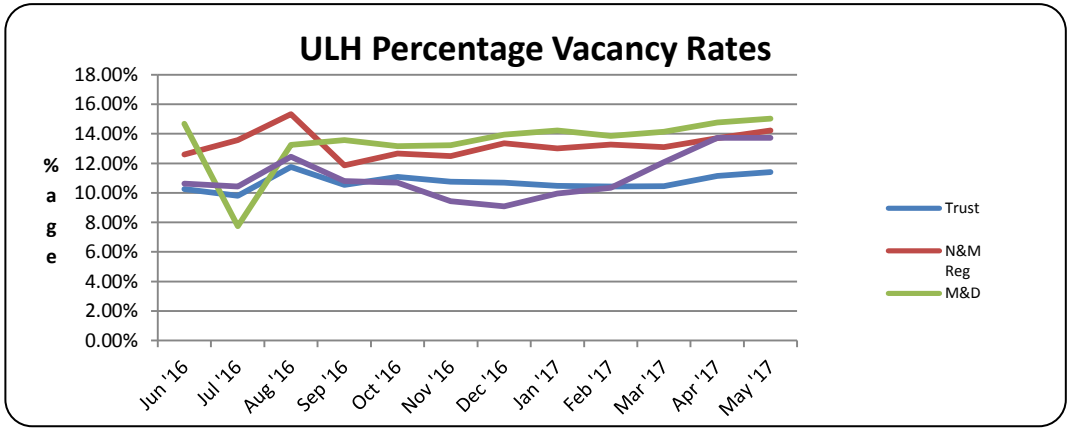
KPI:	Vacancy rates	**Owner:**	Director of HR & OD
Domain:		**Responsible Officer:**	Deputy Director of HR & OD
Date:	27th June 2017	**Reporting Period:**	May 2017
Target:	Medical – 12% Registered Nursing – 11.5% AHPs – 10%	**Tolerances:**	Within 1% - Amber Above 1% - Red
RAG Rating:	**Medical 15.02%** **N&M Reg 14.23%** **AHP'S 13.72%**		

Analysis

The current overall Trust vacancy rate (May) is 11.40%, which is an increase of 0.26% on April. The graph below shows that overall vacancies have increased by 1.15% over the last 12 months (10.25% to 11.40%).

The Trust had at the end of May:-

- 796.89 wte doctors and consultants compared to 800.90 at the start of the financial year;
- 1949.39 registered nurse and midwives, compared to 1971.67 at the start of the financial year;
- 839.18 unregistered nurse and midwives, compared to 837.47 at the start of the financial year;
- 350.48 wte AHPs, compared to 346.15 at the start of the financial year.



However during April and May, 11 doctors and consultants, 25 registered nurses and midwives, 25 unregistered nurses and 13 AHPs started with us. Unfortunately, the number of leavers outnumbered new starters in two of these occupational groupings.

At present 140.84 wte medical posts are vacant, out of a total of 937.73 wte established posts, and 323.45 wte registered nursing and midwifery posts are vacant compared to a total establishment of 2272.84 wte posts. The equivalent figure for unregistered nurses is 133.60 wte vacancies compared to the establishment of 972.78 wte posts.

The Trust has in place plans to get within its target for vacancies for these occupational groups. As well as recruiting, this will rely on retaining staff and transforming the way we work so we only need to recruit to difficult to fill roles if we cannot deliver the service in any other way.

Action Taken	**Action Planned**
• Additional resources provided into HR to help speed up the process of recruitment and to focus on the plans to increase recruitment to medical and nursing roles; • Recruitment Plans drawn up for the Medical and Nursing workforce and discussed and agreed at the Workforce & OD Committee • Work commissioned to better understand how we are perceived as an employer by those outside of the Trust but within the groups we are looking to recruit to; • Work commenced on better understanding the reasons why we have had the number of nurse and midwife leavers over the past two years; • The 'plan for every medical role' reintroduced so that clinical directorates can articulate what they plan to do to fill their vacancies; • All ULHT jobs now advertised on careers.global website.	• For roles that we have failed to recruit to via NHS jobs, engage with framework agency providers to help them find us suitable candidates; • Launch of a Lincolnshire wide recruitment campaign in the BMJ; • Revised approach to workforce planning developed. To be discussed at Strategic Planning Group and a clear timetable for implementation agreed; • Complete the 'plan for every medical role' work; • Deliver the actions identified in the Medical and Nursing Recruitment Plans.

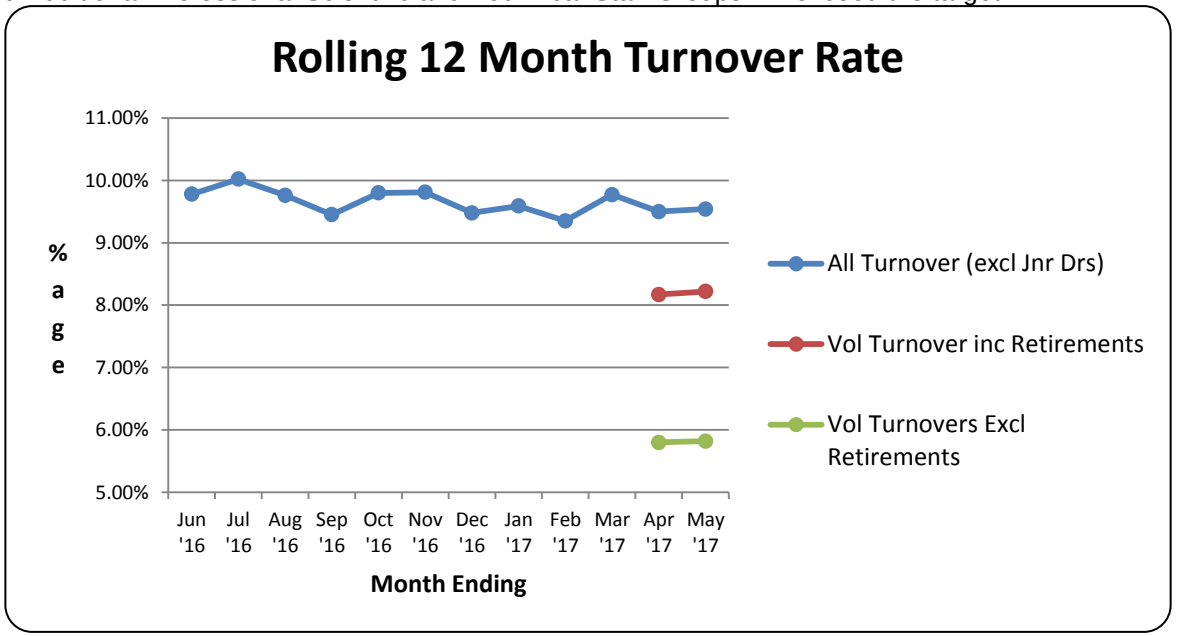
KPI:	Voluntary Turnover	**Owner:**	Director of HR & OD
Domain:		**Responsible Officer:**	Deputy Director of HR
Date:	27th June 2017	**Reporting Period:**	May 2017
Target:	7% (excl. retirements) with no group of staff more than 20% above the overall target	**Tolerances:**	Within 1% - Amber Above 1% - Red
RAG Rating:	5.82%		

Analysis

The current 12 month rolling average as at May 2017 is 8.22% including retirements and 5.82% excluding retirements. This is a slight increase on the previous month when voluntary turnover was 8.17% including retirements and 5.80% with retirements excluded. Of the leavers 26.55% was due to retirement and 65.66% was due to voluntary resignations.

The table below shows the percentage voluntary turnover by Staff Group over a rolling 12 month period, with AHP and Additional Professional Scientific and Technical Services (Pharmacist, Technicians, ACPs, Advances Practitioners, Physician Associate, etc.) having a turnover of more than 20% above the target (when we exclude retirements). If we take retirements into account Health Scientists, AHPs and Additional Professional Scientific and Technical Staff Groups will exceed the target.

	Voluntary Turnover including Retirements	Voluntary Turnover excluding Retirements
Staff Group	%age	%age
Add Prof Scientific and Technic	14.51%	12.54%
Additional Clinical Services	7.38%	5.03%
Administrative and Clerical	7.58%	5.45%
Allied Health Professionals	15.21%	13.55%
Estates and Ancillary	6.59%	3.65%
Healthcare Scientists	8.98%	4.66%
Medical and Dental	8.40%	5.89%
Nursing and Midwifery Reg	7.61%	5.14%
Students	8.28%	8.28%
Total	**8.22%**	**5.82%**



There is clearly variation between groups and we need specifically to understand the issues in Professional, Scientific and Technical and Allied Health Professionals to understand if there are particular issues to address. It is noteworthy that 25% of leavers in some areas are retiring, reflecting the known issue about the age of the workforce.

The Trust also benchmarks itself against other Trusts using the NHS Digital (previously Health and Social Care Information Centre) iView system. However this data is only available based on all staff (permanent, locums and fixed term etc. and all reasons for leaving) but excluding Junior Doctor Grades. Calculated this way the Trust had a turnover rate of 9.54% at the end of May, which is an increase of 0.04% on April.

Based on the latest (March 2017) benchmarking data available (x38 Trusts) from NHS Digital for other Large Acute (Non-Teaching) Hospitals:

- The current Trust turnover rate of 9.54% is below the average of 10.52%
- The current Trust Nursing & Midwifery (Registered) turnover rate of 8.06% is below the average of 11.06%,
- The current Trust AHP turnover rate of 16.56% is above the average of 12.89%.

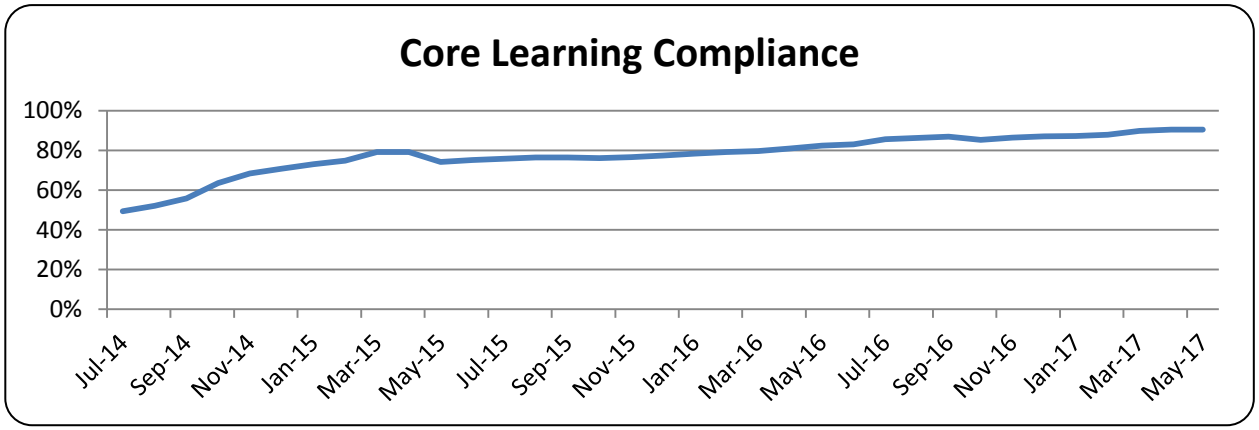
Historical data indicate/confirm that we have managed to retain more staff with less than 12 months' service/employment with ULHT over the past 12 months. A Month on month voluntary turnover comparison by staff group will be available from next month.

Action Taken	**Action Planned**
• Workforce Scorecard comparative data has been shared with the Directors/Clinical Directors, which shows compliance against key workforce indicators • There has been a number of planned visits to other Trusts in the East Midlands who have better vacancy rates that as enabled discussions around 'best practice' and explore/identify option to improve our vacancy and turnover rates	• 'Deep dives' will continue to be undertaken in the areas identified with more than 20% above target of 7%, to identify and analyse the underlying reasons for staff leaving the Directorates and feedback provided to relevant parties/committees. • We are exploring how we can bring greater flexibility to the workplace and thereby encourage potential retirees to remain with the Trust

KPI:	Core Learning Completion	**Owner:**	Director of HR & OD
Domain:		**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	27th June 2017	**Reporting Period:**	May 2017
Target:	Project to set revised targets delayed. Will be completed asap	**Tolerances:**	
RAG Rating:	90.25%		

Analysis

The graph below shows a significant increase in the core learning compliance rate since 2014, and further improvement since 2016.



Compliance for May and moving forward combines medical and non-medical compliance rates giving one combined figure. As at the end of May this is 90.25%. This is the reason for a slight decrease in reporting of approximately 0.35%. The Board performance figures was 90.42% as at 9th June 2017.

The information below shows how this is broken down by topic, directorate and staff group The RAG rating shows compliance with the over 95% rating. The current review will revise the scope of core learning and review targets as 95% is over ambitious.

Topic	Average
Fire Safety - 1 Year	85.74%
Infection Control - 1 Year	84.81%
Equality, Diversity and Human Rights - 3 Years	98.25%
Information Governance - 1 Year	88.01%
Safeguarding Children Level 1 - 3 Years	92.97%
Safeguarding Adults Level 1 - 3 Years	92.94%
Health and Safety - 3 Years	91.89%
Slips, Trips & Falls - 3 year	93.32%
Moving & Handling for Inanimate Load Handlers - 3 Years	92.42%
Risk Awareness - 3 Years	91.80%
Fraud Awareness - 3 years	94.52%
Resuscitation [BLS] - 1 Year	76.31%

Directorate	Average
Bostonian	90.28%
Chief Executive	90.28%
Chief Operating Officer	89.00%
Clinical Support Services	91.53%
Director of Estates & Facil	88.08%
Director of Fin & Corp Affair	97.44%
Director of HR & Org Dev	96.18%
Director of Nursing	93.53%
Director of Perf Improvement	96.68%
Grantham	90.46%
Integrated Medicine Boston	85.20%
Integrated Medicine Lincoln	88.59%
Medical Director	93.59%
Surgical Services Boston	90.56%
Surgical Services Lincoln	87.86%
TACC Boston	92.98%
TACC Lincoln	92.72%
Women & Childrens Pan Trust	92.05%

Staff Group	Average
Add Prof Scientific and Technic	91.07%
Additional Clinical Services	89.52%
Administrative and Clerical	91.83%
Allied Health Professionals	92.30%
Estates and Ancillary	85.62%
Healthcare Scientists	92.43%
Medical and Dental	84.82%
Nursing and Midwifery Registered	92.04%
Students	95.83%

Although true comparative data is not currently available, it has to be noted that the percentages by topic under the previous reporting criteria are not dissimilar to the above compliance. Fire has remained the same whereas Infection Prevention and Information Governance has seen its first fall since 2016 down 2%. However, these topics are still between 11%-15% higher than the same time last year.

Core learning DNA 'no-show' rates to classroom training have gone up another 1% to 25%. A DNA 'no-show' is someone who does not turn up to training on the day without providing an apology resulting in large numbers of lost places.

Action Taken	**Action Planned**
• The introduction of the '5 click' compliance reports has provided Ward/Dept managers access to automatic compliance % and breakdowns for their teams to assist in their compliance monitoring. These reports have been developed further to provide senior managers with automatic % rates by Ward/Dept within their ESR hierarchy giving them an overview of compliance. • Continued support provided to managers to access the '5 click' reports. • 1 to 1 support provided remotely on request to staff struggling to use ESR learning and complete e-learning • '5 click' DNA report available to managers to monitor which of their staff have DNA'd.	• The roll-out of the New 'ESR' Portal at ULHT as part of the national programme will enable supervisors/managers to receive a range of 'dashboards' through ESR Self Service, incl. core learning. • Review of core learning underway. • Longer-term plan to introduce competency and skill matrices for key roles. • Reminder about the cost and impact of "no-shows" to be sent

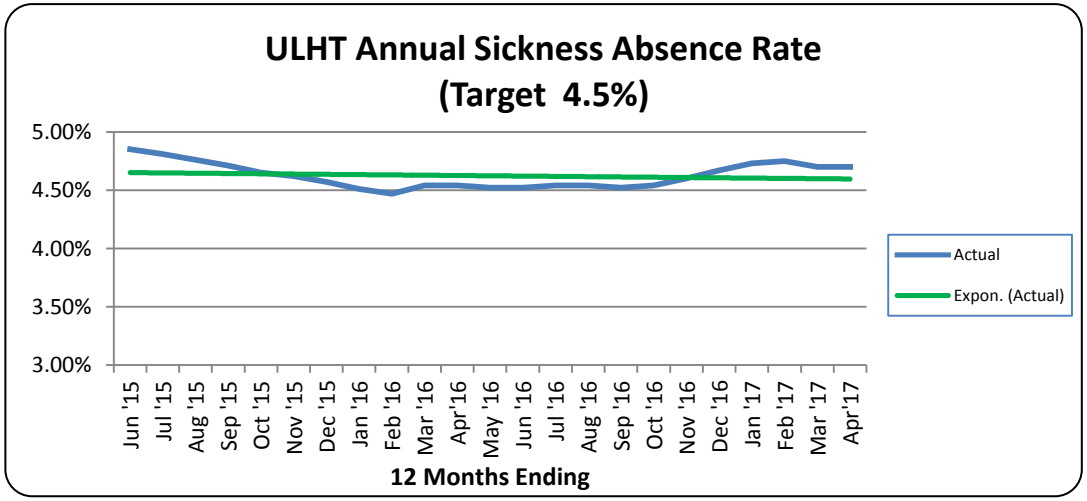
KPI:	Sickness Absence	**Owner:**	Director of HR & OD
Domain:		**Responsible Officer:**	Deputy Director of HR
Date:	27th June 2017	**Reporting Period:**	April 2017
Target:	Overall target of 4.5% + no team over 25% above target	**Tolerances:**	Within 0.5% - Amber Above 0.5% - Red
RAG Rating:	4.70%		

Analysis

The Trust annual rolling sickness rate of 4.70% (against 2017/18 target of 4.5%) as at the end of April 2017 has increased by 0.16% in comparison to the April 2016 figure (4.54%).

The table below shows that the Trust did not achieve the present 4.50% sickness target in any of the last 6 financial years.

Year	Year End Sickness Absence rate
2011/12	4.95%
2012/13	5.12%
2013/14	4.66%
2014/15	4.79%
2015/16	4.54%
2016/17	4.70%



Monthly sickness rate for April 2017 is 4.32% down from 4.48% in the previous month. Sickness absence data is reported two months in 'arrears'. Comparative data with previous years indicate that the Trust has not achieved a 4.5% compliance rate over the past 6 years.

During the 12 months ending April 2017, Anxiety/Stress/Depression and other Psychological illness was the top reason for time lost due to sickness at 20.16% of all absence. These 'mirror' patterns across the NHS nationally, incl. MSK
Additional Clinical Services had the highest sickness rate during the 12 months at 7.13% (Unregistered Nurses 7.91%) followed by Estates & Ancillary at 6.67%, Additional Professional Scientific and Technical at 5.15% and Nursing & Midwifery Registered at 4.79%.

The latest Benchmarking data as at February 2017 from NHS Digital (previously Health & Social Care Information Centre - HSCIC) indicates that ULHT has the sixth highest sickness rate (lowest at 2.99% and highest 5.65%) against an average of 4.38%. The benchmarking is done across x38 Large Acute Trusts.

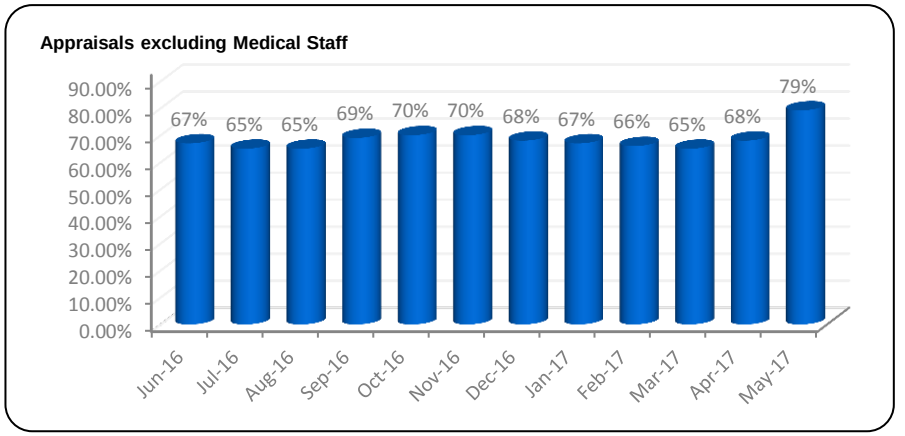
Action Taken	**Action Planned**
• Workforce Scorecard containing sickness data is shared on a monthly basis with Directorates for consideration/action. • New report for managers on staff that hit trigger points including RTW interviews are sent to managers for action on a monthly basis. This identifies consistent underperformance of line managers managing their teams sickness rates.	• Sickness management forms part of the Trusts leadership programme this aims at supporting managers to manage their teams sickness episodes. This also include how to conduct challenging conversations.

KPI:	Appraisal Rates	**Owner:**	Director of HR & OD
Domain:		**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	27th June 2017	**Reporting Period:**	May 2017
Target:	Medical – 95% Non-Medical – 85%		Within 5% below - Amber More than 5% below – Red
RAG Rating:	Non-Medical – 79.18%		

Analysis

The focus at present is on the non-Medical appraisal rate. Data on the Medical appraisal rate will follow from next month.

The graph shows that the Agenda for Change Staff/Non-Medical Appraisal compliance rate for May is 79.18%. The overall percentage for appraisals has increased by 10.96% from the previous month end, which is very positive, although we remain below target.



The table below shows Non-Medical compliance rates for the 12 month rolling periods ending both April 2017 and May 2017. The data indicates the following as at the end of May:

- 2 Directorates have a compliance rate between 50% and 65%
- 5 Directorates have a compliance rate between 65% and 80%
- The remaining 11 Directorates have a compliance rate above 80.00%

There are now 8 Directorates who have achieved the 85% appraisal compliance rate.

Directorate	Appraisal Rate Apr'17 (Excludes Medical Staff)	Appraisal Rate May'17 (Excludes Medical Staff)
Director of Nursing	50.62%	50.00%
CSS Outpatient Management	*51.15%*	*53.11%*
Director of Estates & Facilities	54.93%	59.33%
CSS Diagnostics	*65.06%*	*70.51%*
Clinical Support Services	66.17%	73.13%
Medical Director	67.33%	73.27%
Director of Finance & Corporate Affairs	48.42%	77.08%
Surgical Services Lincoln	65.90%	77.66%
Chief Operating Officer	69.57%	78.26%
Integrated Medicine Lincoln	68.16%	81.33%
Women & Childrens' Pan Trust	73.14%	82.17%
TACC Lincoln	59.53%	82.72%
Grantham	83.46%	85.71%
Director of Performance Improvement	77.59%	86.32%

Chief Executive	81.82%	88.89%
Integrated Medicine Boston	64.52%	89.44%
Surgical Services Boston	77.71%	89.53%
TACC Boston	82.83%	93.07%
CSS Therapies	*81.18%*	*95.22%*
Director of HR & Organisational Development	87.30%	96.92%
Bostonian	74.47%	97.87%

The table below shows that both the Additional Clinical Services and Nursing and Midwifery Registered staff groups are currently achieving the Trust 85% target appraisal rate.

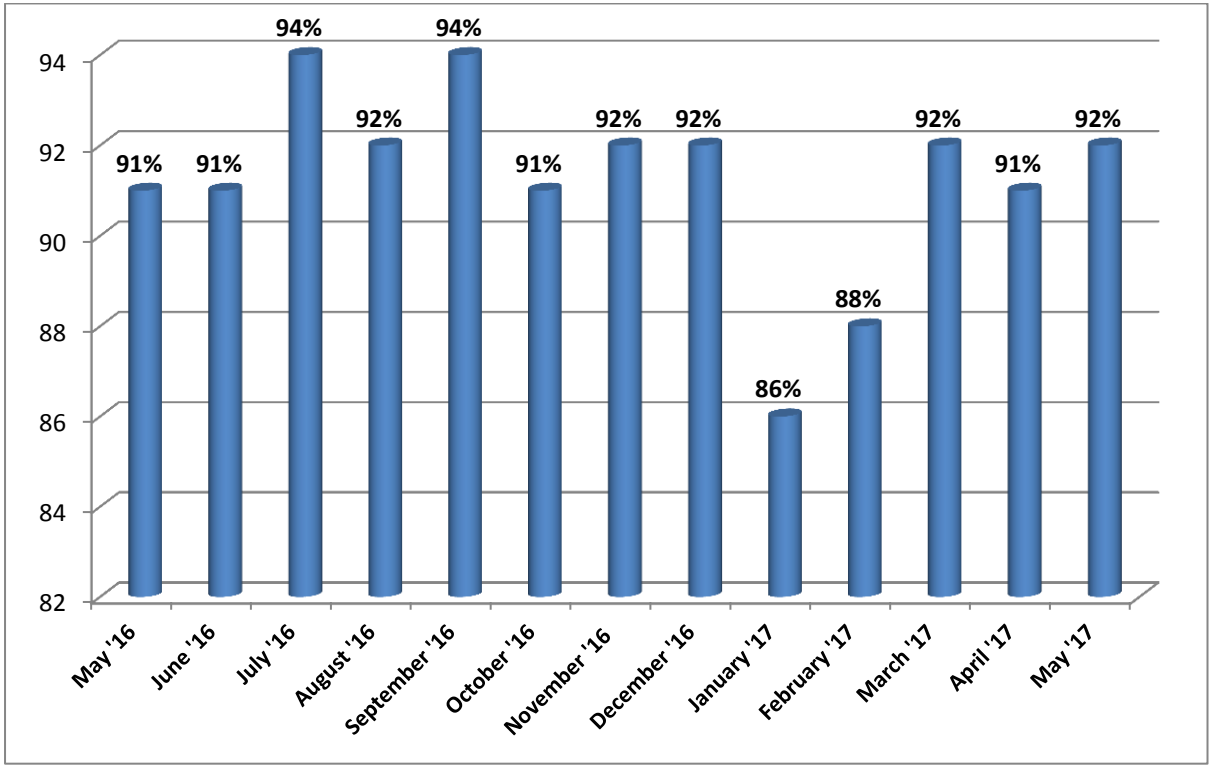
Staff Group	Appraisal Rate May 2017
Additional Clinical Services	90.70%
Nursing and Midwifery Registered	85.61%
Allied Health Professionals	81.42%
Add Prof Scientific and Technic	72.14%
Estates and Ancillary	70.72%
Healthcare Scientists	67.31%
Administrative and Clerical	67.11%
Total	**79.18%**

Appraisal Compliance rate (Year-on-Year) comparison:
May 2014 – 45.21%
May 2015 – 76.84%
May 2016 – 65.81%
May 2017 – 79.18%

The 'target' of 85% 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.

Action Taken	**Action Planned**
• Workforce Scorecards continue to contain appraisal data which is shared on a monthly basis with Directorates for consideration/action this is also reported into clinical directorate performance meetings.	• The HR Team will continue to contact Supervisors/Managers via phone and/or e-mail to establish whether appraisals have been completed and ESR will be updated accordingly. • We will focus in particular on those areas where rates are still very low • Review of appraisal/individual performance management will commence once resource is in place to take this forward

The table below shows the position for Medical appraisal rates. It shows an improving picture, but we remain below the 95% target.



High turnover of short term locums covering gaps in junior doctor rotas, continues to present a challenge as a low % of new starters have previously been appraised. The Trust allocates an appraisal month for this group of doctors usually within six months of commencement. Currently 63% of the 40 doctors in post have had an appraisal within the last 12 months. The figure for the end of March was 54%.

The following actions are planned to ensure the target is met:

- The Revalidation Office will continue to closely monitor and take prompt action when appraisals are not undertaken as planned. The new Allocate e-appraisal system allows the Administrator to track progress with timely completion of appraisal documentation. This enables early intervention and support to both appraisee and appraiser.
- There is a plan in place for each doctor for whom this is their first post in the UK to participate in appraisal within six months of their start date with the Trust.
- Clinical Directors will receive quarterly reports of appraisal performance. The first report will be sent to CD's mid-July 2017.
- Proposal to increase the admin support to the Revalidation Office (0.53 of Band 2) to ensure improved governance to Revalidation processes. Awaiting decision from the Director of Finance.
- Notification of 'Appraisal Due' sent to Doctors 4 months prior to their appraisal month. Strict adherence to the escalation processes set out in the Medical Appraisal Policy, with particular focus on the allocation of appraiser to appraisee 6 weeks prior to the appraisal due date if the doctor has not confirmed appraisal details.
- Continued close monitoring of appraisal progress on the e-allocate appraisal system. Reminders sent to Appraisers to complete Appraisal Output documentation and sign off appraisal documentation within 28 days of the appraisal meeting in order to meet the GMC requirements.

KPI:	Agency Spend	**Owner:**	Director of HR/OD
Domain:		**Responsible Officer:**	Various leads on different aspects of agency spend
Date:	27th June 2017	**Reporting Period:**	May 2017
RAG Rating:	Actual spend of £2.748m, against target of £1.75m		

Analysis

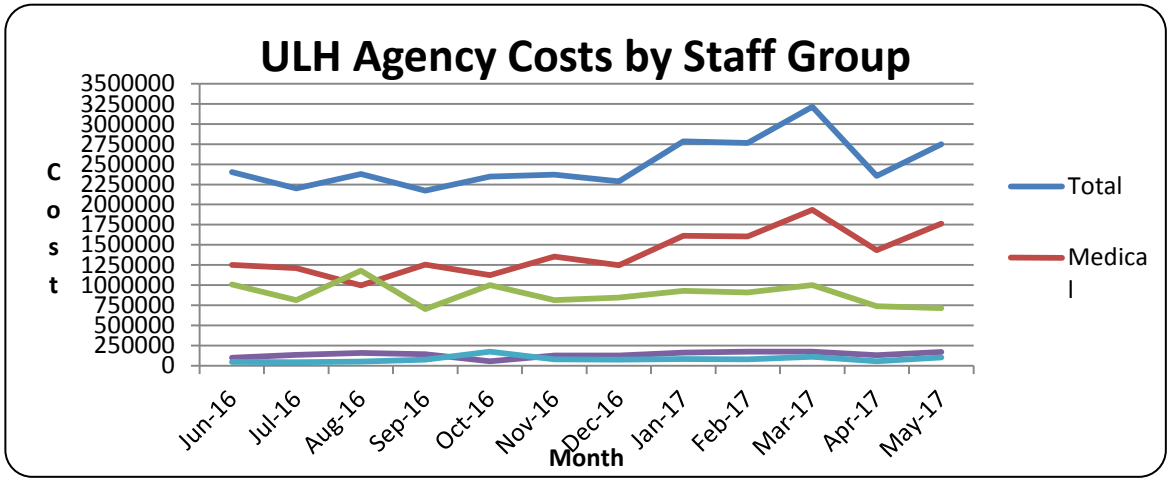
The table below shows spend on agency in the last 12 months. There has been an increase in spend in May compared to April. It remains significantly above target and the level of spend in May 2016.

The total Agency cost in May was £2,748,609 which is an increase of £392,379 from the previous month.

Agency pay expenditure on Medical Staffing in May was £1,761,876 an increase of £328,618 from April.

The directorates with the highest Agency spend in May were Integrated Medicine Lincoln at £951,593 (April £805,391) and Integrated Medicine Pilgrim at £509,920 (April £559,801).

This is the top priority owing to the impact on the financial position of the Trust.



Action Taken	Action Planned
• An overall Agency Cost Reduction Plan has been developed and submitted to NHSI. Within that plan there is a waterfall graph showing the expected reduction in spend as a consequence of the various actions planned, under the headings: Control Price Demand Governance • Quality of information regularly available and discussed each week at ET improved • Challenge and control actions in place for both medical and nursing agency spend	• Nursing and Medical Agency Reduction Plans are being reviewed • Taking part in NHSE programme to assist in reducing medical agency spend

Money & Resources

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Money & Resources							→
Income v Plan	Monthly	Board Report Master	35524	67238	34745	32493	↓
Expenditure v Plan	Monthly	Board Report Master	-40147	-90200	-41328	-48872	↑
Efficiency Plans	Monthly	FIMS report	1341	0		0	→
Surplus / Deficit	Monthly	FPIC Finance Report	-4623	-16689	-7853	-8836	↓
Capital Delivery Program	Monthly	FPIC Finance Report	-412	-756	-756	0	
Agency Spend	Monthly	Agency Staff Analysis	-1790	-5083	-2720	-2363	↓

Finance Headline Summary

Executive Responsibility: Karen Brown – Interim Director of Finance

Trust Financial Performance

Key Financial Duties

Financial Duty	Annual Plan / Target £m	YTD Plan £m	YTD Actual £m	RAG
Delivering the Planned Deficit	-48.564	-9.300	-16.687	R
Achieving the External Finance Limit (EFL)	76.316	-	-	G
Achieving the Capital Resource Limit (CRL)	18.912	0.787	0.757	G

Key Issues

- The Trust plan for 2017/18 is a control total deficit of £48.5m, inclusive of £14.7m STF income.
- The Month 2 position was an in-month deficit of £7.9m, which is £3.2m adverse to the planned in-month deficit of £4.6m including non-delivery of £1.2m of STF income.
- The phasing of the income plan is under review.
- The Trust will not deliver its' control deficit of £47.9m with a current forecast deficit of £75.0m, based on current performance.
- The deterioration in the income and expenditure position directly impacts on cash and the level of borrowings needed in 2017/18. The Trust is likely to require external cash support of £75.0m in 2017/18.

Financial Performance

The Trust is reporting:

- An in-month deficit in May of £7.9m, which is £3.2m adverse to the planned in-month deficit of £4.6m.
- A year to date deficit of £16.7m, which is £7.4m adverse to the planned year to date deficit of £9.3m.

The main reasons for the adverse variance to plan are as follows:

- £6.9m shortfall in income from patient care activities and other operating income, including a shortfall of £2.5m in STF income.
- £0.8m over spend on expenditure budgets.

	May 2017			April 2017 to May 2017		
	Plan	Actual	Surplus (Deficit)	Plan	Actual	Surplus (Deficit)
	£m	**£m**	£m	£m	**£m**	£m
Income	38.2	34.7	(3.5)	74.2	67.2	(6.9)
Expenditure	(41.4)	(41.3)	0.1	(80.6)	(81.3)	(0.8)
EBITA	**(3.2)**	**(6.6)**	**(3.4)**	**(6.4)**	**(14.1)**	**(7.7)**
Net Interest	(0.2)	(0.1)	0.1	(0.3)	(0.2)	0.1
Depreciation	(1.0)	(1.0)	(0.0)	(2.0)	(2.1)	(0.1)
PDC Dividend Payable	(0.3)	(0.1)	0.2	(0.6)	(0.3)	0.3
Net Deficit	**(4.6)**	**(7.8)**	**(3.2)**	**(9.3)**	**(16.7)**	**(7.3)**
Net Deficit adjusted for impairment & impact of donated / govt granted assets	**(4.6)**	**(7.9)**	**(3.2)**	**(9.3)**	**(16.7)**	**(7.4)**

The in-month financial position includes £2.7m of expenditure on agency staffing, which is an increase of £0.3m compared to expenditure in April, and is £1.0m higher than the average monthly spend of £1.748m required to stay within the agreed agency ceiling of £20.98m for 2017/18.

Efficiency

The financial plan for 2017/18 includes a FEP target of £18m, to which the shortfall of £6m from 2016/17 has to be added, giving a total FEP requirement for 2017/18 of £24m.

The actual delivery to date at Month 2 is £0.2m, as detailed in the table below, which is short of the plan by £2.48m.

	Financial Efficiency Programme (FEP)						Identified				
	2016/17 Shortfall FEP target	2017/18 Directorate FEP target (2%)	2017/18 Central FEP target (2%)	2017/18 Total FEP target	Identified	Unidentified	R	A	G	Total	Actuals m1-2
Sub-Total - Corporate	1,040,500	1,994,200	0	3,034,700	1,389,600	1,645,100	169,000	275,000	945,600	1,389,600	76,868
Sub-Total - Operations	4,928,800	8,389,200	0	13,318,000	5,330,700	7,987,300	2,924,800	1,498,600	907,300	5,330,700	126,104
Total	5,969,300	10,383,400	0	16,352,700	6,720,300	9,632,400	3,093,800	1,773,600	1,852,900	6,720,300	202,972
Total - Investments					250,000	-250,000	0	250,000	0	250,000	0
Total - Corporate schemes			10,200,000	10,200,000	5,250,000	4,950,000	1,000,000	4,250,000	0	5,250,000	0
Grand Total	5,969,300	10,383,400	10,200,000	26,552,700	12,220,300	14,332,400	4,093,800	6,273,600	1,852,900	12,220,300	202,972

Delivery is slow as schemes for the year are still being worked up. The current forecast is that the Trust will deliver £12m of savings this year.

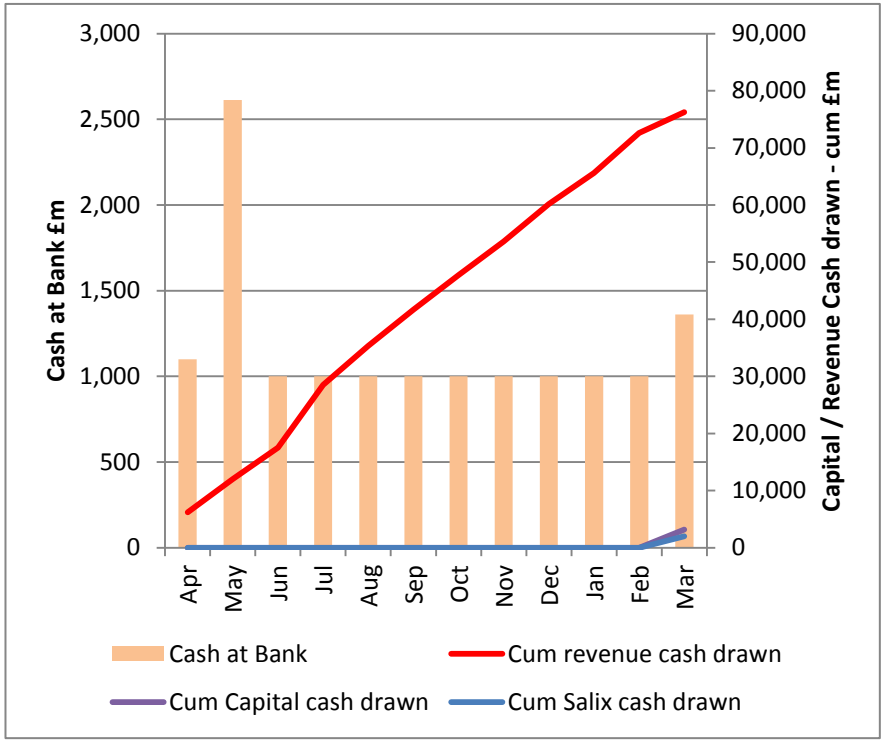
Capital

The spend to date is £0.8m year to date which is in line with plan. The expenditure includes £0.2m on IT infrastructure, £0.2m on replacement medical devices and £0.4m on major developments that were started during 2016/17, primarily Neonates.

Cash

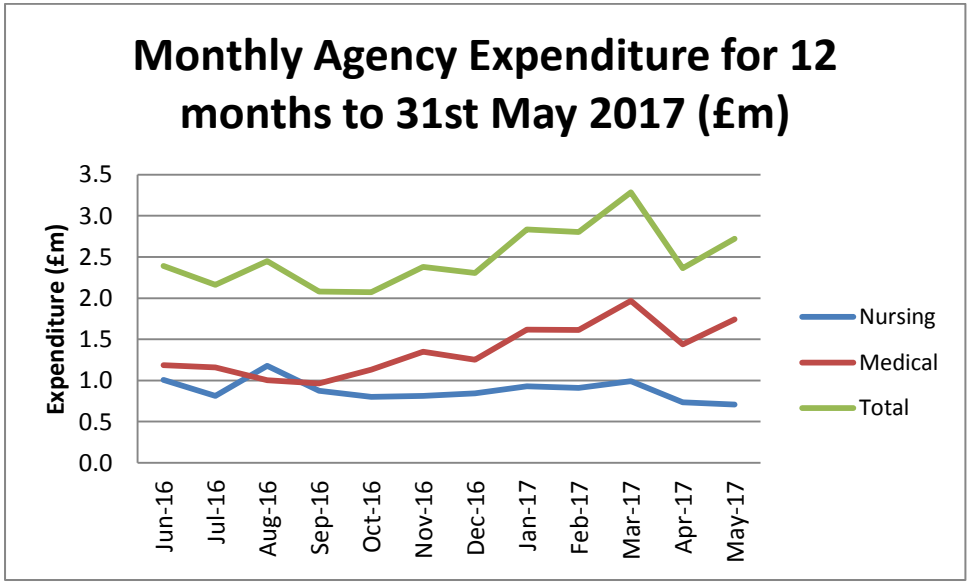
As at the end of May, the Trust held cash of £2.6m, including external revenue support loans of £12m drawn down over the first two months. The total repayable borrowings through working capital loans, Salix loans and uncommitted loan facilities were £122.8m.

The revenue cash draw down to support the forecast Income and expenditure during the year is shown below and highlights that the trust borrowings will increase in line with the forecasted deficit for the year.



Agency

The table below shows the moving monthly agency expenditure, which increased from £2.4m to £2.7m. The increase in agency is driven by medical staffing and reflects the fact that there were more working days in the month, which is consistent with the income growth experienced in month.



CQUINs 2016/17

No.	Goal name	Lead Director / CQUIN Lead	Description of indicator /target	Reporting Frequency	Latest updates and Delivery plan	Q1 RAG rating from CCG	Q2 RAG Rating from CCG	Q3 RAG Rating from CCG	Q4 Potential RAG Rating
National CQUINs									
1a	Introduction of staff health & wellbeing initiatives	Stephen Kelly	**Q1: Providers should have developed a plan to introduce a range of physical activity schemes, access to physiotherapy services and introducing a range of mental health initiatives for staff.** **Q2:N/A** **Q3:N/A** **Q4: Providers should have implemented their initiatives as above**	Monthly collection, Quarterly reporting	Q1 - Achieved Cuirrently impementing their initiatives for Q4				
1b	Development of an implementation plan and implementation of a healthy food and drink offer	Paul Boocock/Clive Marriott	**Q1: The collection of the 11 data points and submission via UNIFY.** **Q2: N/A** **Q3: N/A** **Q4: Providers will be expected achieve a step-change in the health of the food offered on their premises in 2016/17.**	Monthly collection, Quarterly reporting	Q1 achieved. Currenlty impelementing their initiatives for Q4				
1c	Improving the uptake of flu vaccinations for frontline clinical staff	Stephen Kelly	**Q1: N/A** **Q2: N/A** **Q3: Achieving an uptake of flu vaccinations by frontline clinical staff of 75%.** **Providers to submit cumulative data monthly over four months on the ImmForm website** **Q4: N/A**	Monthly collection, Quarterly reporting	Q3 - Achieved 70%			**PARTIAL PAYMENT**	
2a	Sepsis: Timely Identification and treatment for sepsis in emergency department	Dr Adam Wolverson	**Q1: Audit of at least 50 patients per month to see if screening took place. Quarterly trajectories set at the end of Q1.** **Q2: Achievement of Q2 target, to be set by CCG.** **Q3: Achievement of Q3 target, to be set by CCG.** **Q4: Achievement of Q4 target, to be set by CCG.**	Monthly collection, Quarterly reporting	Q1 - Partial Q2 - Partial Q3 - Partial Q4 need to be achieving 90%.	**PARTIAL PAYMENT**	**PARTIAL PAYMENT**	**PARTIAL PAYMENT**	**PARTIAL PAYMENT**
2b	Sepsis: Timely Identification and treatment for sepsis in inpatient settings.	Dr Adam Wolverson	**Q1: Audit of at least 30 patients per month of patients with sepsis to see IV antibiotics were prescribed within the appropriate timeframe and had an empiric review within three days of the prescribing of antibiotics. Quarterly trajectories set at the end of Q1.** **Q2: Achievement of Q2 target, to be set by CCG.** **Q3: Achievement of Q3 target, to be set by CCG.** **Q4: Achievement of Q4 target, to be set by CCG.**	Monthly collection, Quarterly reporting	Q1 - Not achieved Q2 - Not achieved Q3 - Not achieved Q4 need to be achieving 90%.				**PARTIAL PAYMENT**
4a	Reduction in antibiotic consumption per 1,000 admissions	Balwinder Bolla	**Q1: Antibiotic consumption data to be available for commissioners to review via a dedicated website. Antibiotic review data to be submutted from the provider to the commissioners directly to monitor progress. Data to be collected quarterly.** **Q2: As quarter 1** **Q3: As quarter 1** **Q4: As quarter 1**	Monthly collection, Quarterly reporting	Q1 - Achieved Q2 - Achieved Q3 - Achieved				
4b	Empiric review of antibiotic	Balwinder Bolla	**Q1:Undertake local audit of a minimum of 50 antibiotic prescriptions per month, taken from a representative sample across sites and wards. Perform an empiric review for at least 25% of cases in the sample.** **Q2: Perform an empiric review for at least 50% of cases in the sample.** **Q3: Perform an empiric review for at least 75% of cases in the sample.** **Q4: Perform an empiric review for at least 90% of cases in the sample**	Monthly collection, Quarterly reporting	Q1 - Achieved Q2 - Achieved Q3 - Achieved				

No.	Goal name	Lead Director / CQUIN Lead	Description of indicator /target	Reporting Frequency	Latest updates and Delivery plan	Q1 RAG rating from CCG	Q2 RAG Rating from CCG	Q3 RAG Rating from CCG	Q4 Potential RAG Rating
Local CQUINs									
5	Safeguarding Training	Penny Snowden/Elaine Todd/Lisa Newboult	**Cohort :** **- Consultants, Registrars, Band 7s and Band 6s within Paediatric and A&E Level 3** **- Consultants, Registrars, Band 7s and band 6s within Elderly Care Level 2** **Q1: Baseline for previous year against group above. Provide a training plan for 16/17 Trajectories for the year to be set at the end of Q1.** **Q2: N/A** **Q3: N/A** **Q4: Achieve 85% compliance by end Q4**	Quarterly	Q1 - Achieved Q2 - N/A Q3 - N/A				
6	Maternity	Ailsa McGiveron	**Q1: Provide draft strategy and training needs analysis. Trajectories for the year to be set at the end of Q1.** **Q2: Trajectory to be set at Q1.** **Q3: Trajectory to be set at Q1.** **Q4: Trajectory to be set at Q1.**	Quarterly	Q1 - Awaiting outcome of appeal Q2 - Achieved Q3 - Achieved	**Awaiting oucome of appeal**			
7	Antimicrobial Stewardship (Year 2)	Bal Bolla	**Q1: Agree & achieve Q1 trajectories for phase 1&2 wards. Establish baseline for phase 3 wards Trustwide. Commence rollout of audit activities to further high risk wards.** **Q2: Agree & achieve Q1 trajectories for phase 1 - 3 wards.** **Establish baseline for phase 4 wards. Commence rollout of audit activities to further high risk wards.** **Q3: Agree & achieve quarter 1 trajectories for phase 1 - 4 wards . Establish baseline for phase 5 wards. Commence rollout of audit activities to further high risk wards.** **Q4: Agree & achieve quarter 1 trajectories for phase 1 - 5 wards.**	Quarterly	Q1 - Achieved Q2 - Achieved Q3 - Achieved				
8a	End of Life: e-Learning	Dr Adam Brown	**Q1: Communicate to staff as per e-learning training plan.** **Achieve trajectory set for Q1: . Set trajectory at the end of Q4 2015/16** **Q2: As for Q1.** **Q3: As for Q2** **Q4: Achieve overall trajectory set in Q1**	Quarterly	Q1 - did not achieve target Q2 - Did not achieve target - mapping completed Q3 - Achieved				
8b	End of Life: Staff Education	Dr Adam Brown	**Q1: Completion of ward based training programme on at least 1 ward on each site (LCH, Pilgrim and Grantham) as per ward based training plan.** **Development of audit tool to demonstrate the impact of the training on the care given to patients dying on the ward.** **Q2: Completion of ward based training programme on at least 3 wards at LCH/PBH and 2 wards at GDH.** **Q3: Completion of ward based training programme on at least 4 wards at LCH/PBH and 3 wards at GDH.** **Q4: Completion of ward based training programme on at least 6 wards at LCH/PBH.** **Completion of audit tool and a summary report.**	Quarterly	Q1 - Achieved Q2 - Achieved Q3 - Achieved				
8c	End of Life: Link Practitioner	Dr Adam Brown	**Q1: Continue quarterly Link Practitioner meetings on all 3 sites.** **Deliver Palliative Care training day for Link Practitioners.** **Q2: As for Q1. Develop new resource folder for hospital wards.** **Q3: As for Q1. Develop new resource folder for hospital wards.** **Q4: As for Q1. Continue quarterly LP meetings on all sites.**	Quarterly	Q1 - Achieved Q2 - Achieved Q3 - Achieved				
9	Cancer: Release of CNS capacity to provide increased patient facing support to cancer patient pathways for Breast/Gastro/Lung/ Urology	Sarah Ward	**Q1:One session per week of CNS time identified on Breast pathway. Structured process for "end of treatment" and "end of follow up" established through risk stratification. Revised job plan for Breast CNS activity established. Collect data / monthly report for clinic documentation. Agree baseline of improvement for Q2.** **Q2: Same as above for Gastro.** **Q3: Same as above for Lung.** **Q4: Same as above for Urology.. Provide quarterly activity reports and breast patient survey for 2016/17 and commence urology clinic acitiving Q1 17/18.**	Quarterly	Q1 - Not achieved Q2 - Achieved Q3 - Achieved				

No.	Goal name	Lead Director / CQUIN Lead	Description of indicator /target	Reporting Frequency	Latest updates and Delivery plan	Q1 RAG rating from CCG	Q2 RAG Rating from CCG	Q3 RAG Rating from CCG	Q4 Potential RAG Rating
EMSCG CQUINs									
1	Adult Critical Care Timely Discharge	Dr Adam Wolverson	**Q1-Q3 Reduction in the number of Critical Care bed days occupied by patients who are clinically ready for discharge for more than 4 hours. Reduction in the number of Critical Care by patients who are ready for discharge for more than 24 hours.** **Q4: Achievement of a 30% reduction in the number of Critical Care bed days by patients who are ready for discharge for more than 24 hours compared to the 2014/15 base.**	Quarterly	Q1 - Not fully achieved Q2 - Achieved Q3 - Not fully achieved	**PARTIAL PAYMENT**		**PARTIAL PAYMENT**	**PARTIAL PAYMENT**
2	Dose Banding Adult Intravenous Systemic Anticancer Therapy	Colin Costello/ Simon Priestley/Francisca Martinez	**Q1: Collection of base-line data for a range of dose banded drugs as agreed with Hub. Agreement with hub of stretch target for improvement during course of the year.** **Q2: Achievement of Q2 target.** **Q3: Achievement of Q3 target.** **Q4: Achievement of Q4 target.**	Quarterly	Q1 - Achieved Q2 - Achieved Q3 - Achieved				
3	Severe Haemophilia Haemtrack Patient Home Reporting System	Bethan Mysers/ Claire Lovett	**Q1: Q3 2015/16 confirmed 10 patients recruited with 40% compliance. Recruitment on Haemtrack in excess of 50% of eligible patients, quarter by quarter. Increase in compliant recruitment (number of patients) on Haemtrack up to 70%** **Q2: As above** **Q3: As above** **Q4: Compliant recruitment on Haemtrack from 70% to 95% (number of patients) as a proportion of targeted compliant recruitment.**	Quarterly	Q1 - Achieved Q2 - Achieved Q3 -				
4	Antimicrobial Stewardship (Year 2)	Bal Bolla	**As above**	Quarterly	As above				
5	Cancer: Release of CNS capacity to provide increased patient facing support to cancer patient pathways for Breast/Gastro/Lung/ Urology	Sarah Ward	**As above**	Quarterly	As above				

Risks

This section is being developed and will be available and revised by 2017 / 2018

Equality Analysis Statement

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

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

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

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

Appendix 1. 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 2. 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 3. Detailed thresholds for Red, Amber, Green ratings

Metric	Red	Amber	Green
C.diff 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
E.coli	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