# UNITED LINCOLNSHIRE HOSPITALS TRUST

# INTEGRATED PERFORMANCE REPORT

## PERIOD TO 30th APRIL 2017

| | |
|---|---|
| **To:** | Trust Board |
| **From:** | Amanda Brown, Assistant Director of Commissioning & Performance |
| **Date:** | 6th 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 30th April 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**<br>New risks that affect performance or performance that creates new risks to be inserted here. | **Performance KPIs year to date**<br>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 30th April 2017

## Safe

- There have been 0 cases of MRSA reported in April 2017
- There have been 7 cases of Clostrum Difficile in April 2017
- The effect of the Norovirus outbreak closed 155 beds at the peak of the virus, including those in MEAU
- Ward 3B has achieved 35 days without a fall
- The Trust has registered to take part in the National Falls Audit in May 2017
- Ward 3B and 6B are both achieving 100% compliance with lying and standing BP

## Caring

- Family and Friends Inpatient response rate is 29% (target 26%)
- Family and Friends A&E response rate is 22% (target 19%)

## Responsiveness

- 2 of the 9 National Cancer Targets were achieved in March 2017
- The Trust achieved 72.8% against the 62 day classic cancer standard in March, an improvement of 5.7% compared to February's performance
- 22 patients are on or over the 104 day pathway, 4 of which have confirmed cancer
- Revised ambulance handover processes at Pilgrim A&E have reduced turnaround times
- Capital building works in minors at Lincoln A&E is progressing well and is due for completion at the end of May giving four further minors cubicles

## Effective

- During April the number of patients overdue for a follow up appointment by 6 weeks or more reduced from 5,725 to 5,337. The cyber attack will lead to an increase in this position
- The first Lincolnshire Mortality Collaborative met on 3rd May 2017, looking at mortality cases within 48 hours of admission
- Charlson Comorbidity Audit has been completed and is a separate agenda item for the Patient Safety Committee

## Well-Led

- Vacancy rates for all specialties: medical, registered nurses and AHP remain above targets
- Rolling sickness rate of 4.70% against a target of 4%
- Core learning compliance is 91% in April 2017 compared to 81% in April 2016
- Agenda for Change/non medical appraisal compliance for April is 68.22% against a target of 85%
- Overall percentage of appraisals has increased by 3.32% from previous month end

## Money & Resources

- Possible impact of IR35 shows reduction of £857,368 Agency Cost and reduction of £499,700 since March 2017
- Trust delivered a deficit of £8.8m compared to the control total of £4.7m
- The Trust has an agreed control total deficit of £48.8m for 2017/18. The Trust requires a recovery plan for the deficit
- Awaiting resolution of contract disputes against the 2016/17 and 2017/18 contracts

**Successes:**

Overall Trust A&E performance for April 2017 is 82.21% which is 0.21% above the planned recovery trajectory.

The average number of patients discharged before midday is 49, which is well below the target of 60 patients. This is the first time this has been achieved, which is a clear reflection on the positive impact of the Red to Green and Pride and Joy initiatives.

Diagnostics is now sustaining the achievement of its 6 week standard, the standard has been met for five consecutive months.

There have been no mixed sex accommodation breaches during April 2017 (second consecutive month).

**Challenges:**

The cyber-attack will have a negative impact on May's performance as the Trust cancelled 1,876 outpatient appointments and 120 day cases and elective operations.

The impact of the cyber-attack also contributed to the loss of 5 days of validation capacity on the RTT standard. One week prior to the final submission for April the Trust's performance level was 86.6%, this was 0.4% behind the position at the same time last month.

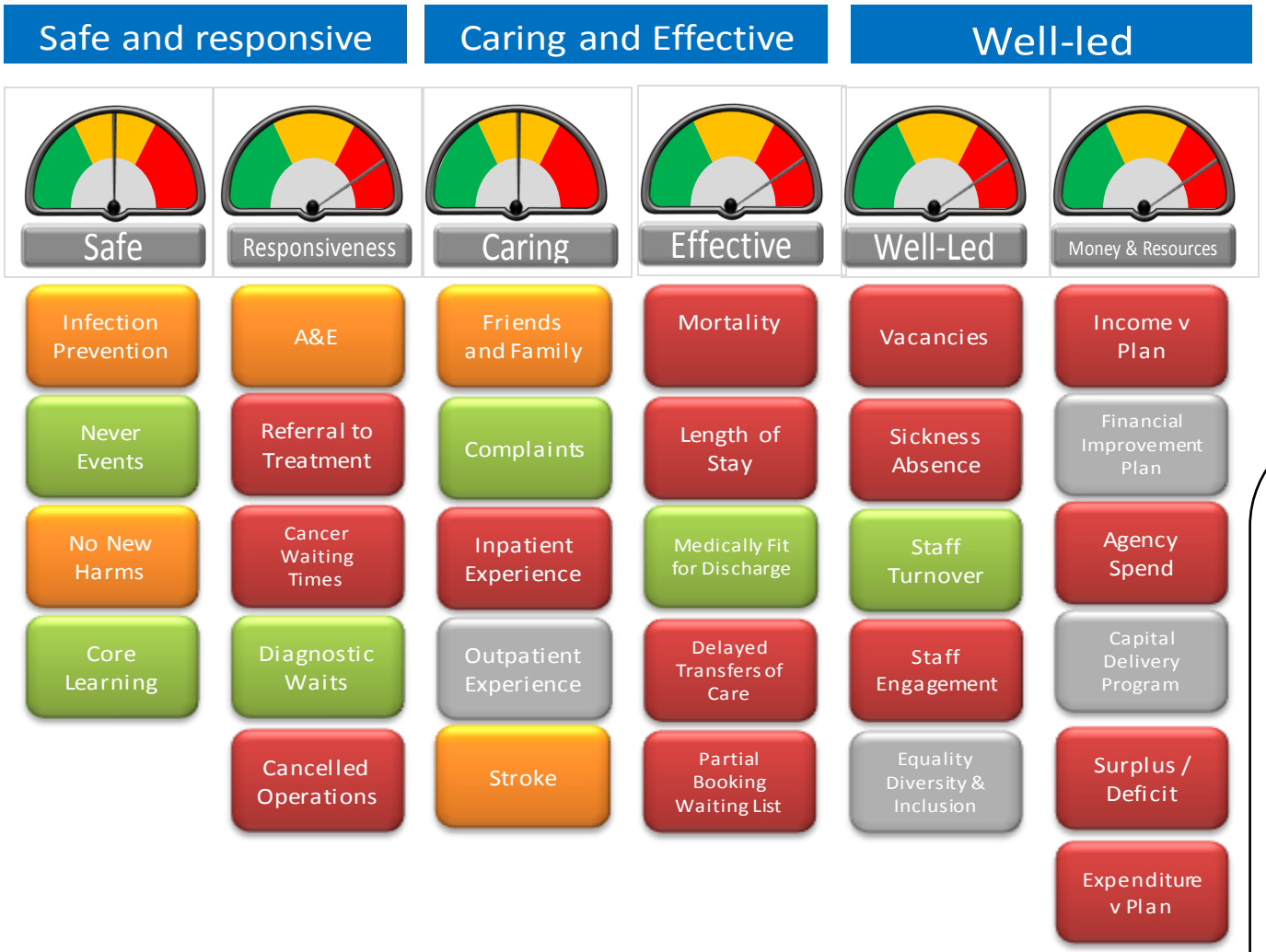
Pilgrim day case activity remains restricted whilst post fire estates works are carried out, this is likely to continue for a further 3-4 months.

Two out of the 9 national cancer targets have been met this month which is a deterioration from the previous month. Notably the 31 day subsequent drug treatment target continued to achieve 100%. The 7 Day Horizon (potentially cuts a week out the pathway by making the first appointment within 7 days of referral as opposed to 14 days) has now been successfully deployed in appropriate areas.

**Karen Brown**
**Interim Director of Finance & Corporate Affairs**
**May 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.




Single Oversight Framework Segmentation

3

CQC Compliance

Inadequate

| A&E | RTT | Diagnostics |
|---|---|---|
| 82.21% | 88.56% | 99.74% |

| 62 Day | Deficit | Agency |
|---|---|---|
| 72.6% | -8836k | -573k |

**Most deteriorated:**
**Domain:** Responsiveness
Cancer 2ww Breast Symptomatic has deteriorated by 37.9% in March 2017

**Domain:** Responsiveness
2 out of the 9 cancer standards were achieved in March 2017

**Most improved:**
**Domain:** Effective
An average of 49 patients Medically Fit were discharged before 12 noon compared to 68 last month

**Domain:** Caring
Family and Friends Inpatient response rate is 29% (target 26%) and A&E response rate is 22% (target 19%)

**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 | 7 | 7 | 10 | |
| MRSA bacteraemia (post 3 days) | Monthly | Datix | 0 | 0 | 0 | 0 | |
| MSSA | Monthly | Datix | 2 | 3 | 3 | 0 | |
| ECOLI | Monthly | Datix | 8 | 5 | 5 | 6 | |
| **Never Events** | Monthly | Datix | 0 | 0 | 0 | 0 | |
| **No New Harms** | | | | | | | |
| Serious Incidents reported (unvalidated) | Monthly | Datix | 0 | 23 | 23 | | |
| Harm Free Care % | Monthly | | 95% | 92.03% | 92.03% | 91.60% | |
| New Harm Free Care % | Monthly | | 98% | 97.98% | 97.98% | 97.90% | |
| Catheter & New UTIs | Monthly | | 1 | 1 | 2 | 1 | |
| Falls | Monthly | Datix | 3.90 | 3.66 | 3.66 | 3.42 | |
| Medication errors | Monthly | Datix | 0 | 144 | 144 | 108 | |
| Medication errors (mod, severe or death) | Monthly | Datix | 0 | 22 | 22 | 18 | |
| Pressure Ulcers (PUNT) 3/4 | Monthly | | | 8 | 8 | | |
| VTE Risk Assessment | Monthly | | 95% | 97.00% | 97.00% | 97.95% | |
| **Core Learning** | Monthly | ESR | 85% | 90.67% | 90.67% | 89.83% | |

| Metric | Reporting Frequency | Source | Target | YTD | Current Month | Last Month | Trend |
|---|---|---|---|---|---|---|---|
| **Caring** | | | | | | | |
| **Friends and Family Test** | | | | | | | |
| Inpatient (Response Rate) | Monthly | Envoy Messenger | 26% | 29.00% | 29.00% | 24.00% | |
| Inpatient (Recommend) | Monthly | Envoy Messenger | 96% | 91.00% | 91.00% | 92.00% | |
| A&E (Response Rate) | Monthly | Envoy Messenger | 14% | 22.00% | 22.00% | 19.00% | |
| A&E (Recommend) | Monthly | Envoy Messenger | 87% | 82.00% | 82.00% | 80.00% | |
| % of staff who would recommend care | | | | | | | |
| % of staff who would recommend work | | | | | | | |
| **Complaints** | | | | | | | |
| No of Complaints received | Monthly | Datix | 70 | 55 | 55 | 54 | |
| No of Complaints still Open | Monthly | Datix | 0 | 239 | 239 | 237 | |
| No of Complaints ongoing | Monthly | Datix | 0 | 39 | 39 | 35 | |
| **Inpatient Experience** | | | | | | | |
| Mixed Sex Accommodation | Monthly | Datix | 0 | 0 | 0 | 0 | |
| eDD | Monthly | EDD | 95% | 86.19% | 86.19% | 79.86% | |
| 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% | 56.72% | 56.72% | 57.69% | |
| #NOF 48 hrs | Monthly | | 95% | 95.52% | 95.52% | 83.33% | |
| Dementia Screening | 1 month behind | | 90% | 94.16% | 94.16% | 91.30% | |
| Dementia risk assessment | 1 month behind | | 90% | 98.69% | 98.69% | 96.89% | |
| Dementia referral for Specialist treatment | 1 month behind | | 90% | 85.37% | 85.37% | 88.89% | |
| **Stroke** | | | | | | | |
| Patients with 90% of stay in Stroke Unit | 1 month behind | SSNAP | 80% | 85.47% | 88.60% | 84.60% | |
| Sallowing assessment < 4hrs | 1 month behind | SSNAP | 80% | 69.83% | 69.10% | 69.10% | |
| Scanned < 1 hrs | 1 month behind | SSNAP | 50% | 63.53% | 61.50% | 54.50% | |
| Scanned < 12 hrs | 1 month behind | SSNAP | 100% | 95.98% | 96.90% | 97.00% | |
| Admitted to Stroke < 4 hrs | 1 month behind | SSNAP | 90% | 66.14% | 59.10% | 61.90% | |
| Patient death in Stroke | 1 month behind | SSNAP | 17% | 13.26% | 15.90% | 14.10% | |

| 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% | 82.21% | 82.21% | 79.12% | |
| 12+ Trolley waits | Monthly | Medway | 0 | 0 | 0 | 0 | |
| **RTT** | | | | | | | |
| 52 Week Waiters | Monthly | Medway | 1 | | | | |
| 18 week incompletes | Monthly | Medway | 92.4% | 88.56% | 88.56% | 88.36% | |
| **Cancer - Other Targets** | | | | | | | |
| 62 day classic | 1 month behind | Somerset | 85% | 71.52% | 72.60% | 67.10% | |
| 2 week wait suspect | 1 month behind | Somerset | 93% | 89.56% | 82.10% | 89.40% | |
| 2 week wait breast symptomatic | 1 month behind | Somerset | 93% | 69.91% | 18.90% | 56.80% | |
| 31 day first treatment | 1 month behind | Somerset | 96% | 96.53% | 96.30% | 94.30% | |
| 31 day subsequent drug treatments | 1 month behind | Somerset | 98% | 97.55% | 100.00% | 100.00% | |
| 31 day subsequent surgery treatments | 1 month behind | Somerset | 94% | 93.88% | 91.30% | 95.80% | |
| 31 day subsequent radiotherapy treatments | 1 month behind | Somerset | 94% | 92.63% | 93.40% | 95.10% | |
| 62 day screening | 1 month behind | Somerset | 90% | 86.75% | 87.50% | 94.10% | |
| 62 day consultant upgrade | 1 month behind | Somerset | 85% | 82.32% | 80.40% | 75.00% | |
| 104+ Day Waiters | 1 month behind | Somerset | | - | 22.00 | 23.00 | |
| **Diagnostic Waits** | | | | | | | |
| diagnostics achieved | Monthly | Medway | 99.1% | 99.74% | 99.74% | 99.74% | |
| diagnostics Failed | Monthly | Medway | 0.9% | 0.26% | 0.26% | 0.26% | |
| **Cancelled Operations** | | | | | | | |
| Cancelled Operations on the day (non clinical) | Monthly | Medway | 1.10% | 1.66% | 1.66% | 3.08% | |
| Not treated within 28 days. (Breach) | Monthly | Medway | 0.00% | 11.46% | 11.46% | 9.48% | |

| 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 | 103.84 | 103.84 | 103.60 | |
| **Length of Stay** | | | | | | | |
| Average LoS - Elective | Monthly | Medway / Slam | 2.8 | | | 2.75 | |
| Average LoS - Non Elective | Monthly | Medway / Slam | 3.8 | 4.42 | 4.42 | 4.86 | |
| **Medically Fit for Discharge** | Monthly | Bed managers | 60 | 49.00 | 49.00 | 68.00 | |
| **Delayed Transfers of Care** | Monthly | Bed managers | 3.5% | 4.57% | 4.57% | 5.38% | |
| **Partial Booking Waiting List** | Monthly | Medway | 0 | 6419 | 6419 | 5018 | |

| Metric | Reporting Frequency | Source | Target | YTD | Current Month | Last Month | Trend |
|---|---|---|---|---|---|---|---|
| **Well Led** | | | | | | | |
| **Vacancies** | Monthly | ESR | 5.0% | 11.14% | 11.14% | 10.46% | |
| **Sickness Absence** | Monthly | ESR | 4.0% | 4.48% | 4.48% | 5.20% | |
| **Staff Turnover** | Monthly | ESR | 8.0% | 5.80% | 5.80% | 9.77% | |
| **Staff Engagement** | | | | | | | |
| Staff Appraisals | Monthly | ESR | 95.0% | 68.00% | 68.00% | 65.00% | |
| **Equality Diversity and Inclusion** | | | | | | | |

| Metric | Reporting Frequency | Source | Target | YTD | Current Month | Last Month | Trend |
|---|---|---|---|---|---|---|---|
| **Money & Resources** | | | | | | | |
| **Income v Plan** | Monthly | Board Report Master | 35771 | 32493 | 32493 | 36566 | |
| **Expenditure v Plan** | Monthly | Board Report Master | -40469 | -48872 | -48872 | -42054 | |
| **Efficiency Plans** | Monthly | FIMS report | 1341 | 0 | | 0 | |
| **Surplus / Deficit** | Monthly | FPIC Finance Report | -4698 | -8836 | -8836 | -6946 | |
| **Capital Delivery Program** | Monthly | FPIC Finance Report | -375 | | | | |
| **Agency Spend** | Monthly | Agency Staff Analysis | -1790 | -2363 | -2363 | -3255 | |

# 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% | 82.21% | 82.21% | 79.12% | |
| 12+ Trolley waits | Monthly | Medway | 0 | 0 | 0 | 0 | |
| | | | | | | | |
| **RTT** | | | | | | | |
| 52 Week Waiters | Monthly | Medway | 1 | | | | |
| 18 week incompletes | Monthly | Medway | 92.4% | 88.56% | 88.56% | 88.36% | |
| | | | | | | | |
| **Cancer - Other Targets** | | | | | | | |
| 62 day classic | 1 month behind | Somerset | 85% | 71.52% | 72.60% | 67.10% | |
| 2 week wait suspect | 1 month behind | Somerset | 93% | 89.56% | 82.10% | 89.40% | |
| 2 week wait breast symptomatic | 1 month behind | Somerset | 93% | 69.91% | 18.90% | 56.80% | |
| 31 day first treatment | 1 month behind | Somerset | 96% | 96.53% | 96.30% | 94.30% | |
| 31 day subsequent drug treatments | 1 month behind | Somerset | 98% | 97.55% | 100.00% | 100.00% | |
| 31 day subsequent surgery treatments | 1 month behind | Somerset | 94% | 93.88% | 91.30% | 95.80% | |
| 31 day subsequent radiotherapy treatments | 1 month behind | Somerset | 94% | 92.63% | 93.40% | 95.10% | |
| 62 day screening | 1 month behind | Somerset | 90% | 86.75% | 87.50% | 94.10% | |
| 62 day consultant upgrade | 1 month behind | Somerset | 85% | 82.32% | 80.40% | 75.00% | |
| 104+ Day Waiters | 1 month behind | Somerset | | - | 22.00 | 23.00 | |
| | | | | | | | |
| **Diagnostic Waits** | | | | | | | |
| diagnostics achieved | Monthly | Medway | 99.1% | 99.74% | 99.74% | 99.74% | |
| diagnostics Failed | Monthly | Medway | 0.9% | 0.26% | 0.26% | 0.26% | |
| | | | | | | | |
| **Cancelled Operations** | | | | | | | |
| Cancelled Operations on the day (non clinical) | Monthly | Medway | | 1.66% | 1.66% | 3.08% | |
| Not treated within 28 days. (Breach) | Monthly | Medway | | 11.46% | 11.46% | 9.48% | |

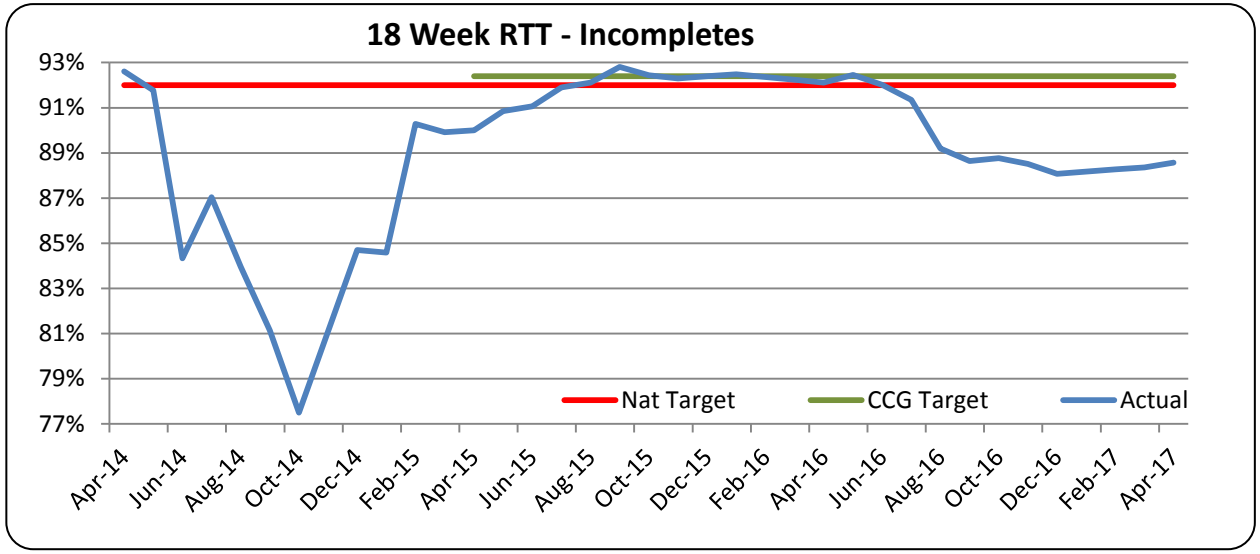
# Referral to Treatment

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: | 30th May 2017 | Reporting Period: | April 2017 |

**Exception Details**

In March the Trust reported performance of 88.7%, with the backlog of patients over 18 weeks dropping to the lowest levels since August 2016. At a national level the standard hasn't been achieved for 12 consecutive months, with an aggregated national performance in March of 90.3%.




The Trust's performance for April was 88.6%. This was a 0.1% deterioration on March's performance. Two key factors contributed to this deterioration. There was a significant impact from 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. Additionally, a cohort of patients were identified prior to the April submission which had been incorrectly excluded from the PTL report, and therefore hadn't been effectively tracked within their RTT pathways. The additions from this cohort of patients led to a c.0.1% deterioration in performance, but the validation of this cohort also reduced the validation capacity available for routine month-end validation. The cyber-attack will have a negative impact on May's performance. Between 12th-15th May the Trust cancelled 1876 outpatient appointments and 120 daycases and elective operations. Clinical Directorates are providing additional capacity over the coming weeks in order to ensure that patients are rebooked as quickly as possible, however it is unlikely that all will be rebooked by the end of May so this will have a negative impact on May's performance.

The increase in urgent care pressures during winter had a knock on impact onto RTT performance. In December and January, as part of the winter plan and to assist with the achievement of 85% bed occupancy by Christmas Eve and maintenance of urgent care flow, the Trust planned to complete a total of 130 less elective cases than standard (plus the impact of bank hols). In addition to this planned reduction, the Trust cancelled c.650 operations between December and March as a result of capacity issues such as lack of HDU and general beds.

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.( During April 142 patients were cancelled for non-clinical reasons.)

The Trust has an agreed trajectory which takes the performance to 92% by July. In addition to the risks related to the impact of the cyber-attack there is particular risk against speciality level trajectories within ENT, Orthopaedics and Cardiology, which due to their waiting list volumes create risk to the achievement of the overall Trust position in July.

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 Paed Dermatology.

During 2016/17 activity was above contracted levels in the following specialities:

- Neurology -27%
- Dermatology -16%
- Endocrine -22%
- Gastro -15%
- Rheum -16%
- Pain -11%

All of these areas have RTT incompletes performance below 92%.

The fire at Pilgrim at the end of March resulted in 16 cancelled operations. In addition to this capacity for daycases 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 daycases 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. Discussions are ongoing with LCHS regarding this situation however.

**What action is being taken to recover performance?**

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

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

The Trust have outsourced 92 patients between Orthopaedics and General Surgery during 2016/17. Levels of outsourcing have been less than expected as access to outsourcing capacity, particularly within the East of the county, has been limited. Agreement has now been reached that outsourcing can take place during 2017/18, and contracts with independent sector providers are now being finalised

The different sites are working together in order to equalise waits across the Trust within speciality areas, and to ensure that capacity is fully utilised.

Where activity levels are significantly above the contract level the CCGs are being asked to initiate actions to support the Trust by controlling referral rates into these specialities.

Internal theatre productivity and scheduling improvement programme is in place, in order to increase theatre productivity initially within Orthopaedics, but then to be expanded to include further specialities.

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. The CCGs have currently agreed to maintain this pause in referrals until the end of May, however the Trust have asked that this pause is extended until the end of August. In addition, the Trust have made a request to the CCGs for a pause in routine referrals into ENT, Cardiology, Community Paeds and Dermatology.

The Clinical Directorates have been requested to review and submit recovery action plans for submission by 31st May, which will deliver the following over the next 4 months:

- 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

**What is the recovery date?**

July 2017 with risk.

# 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: | 30th May 2017 | Reporting Period: | April 2017 |

**Exception Details**

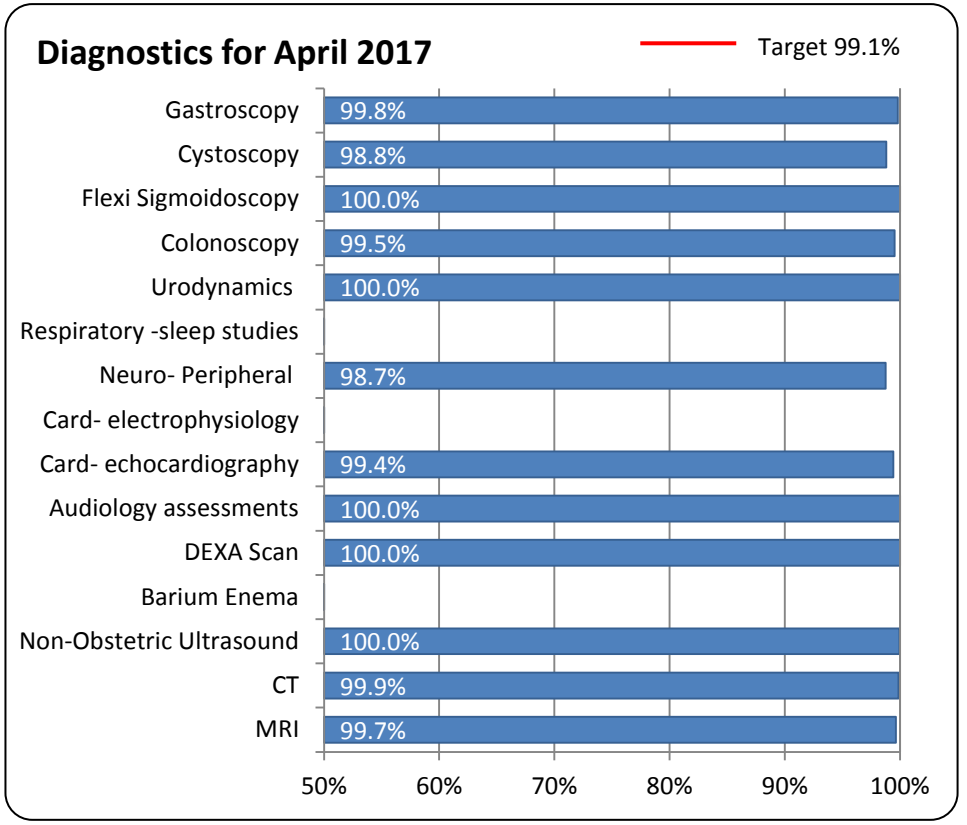
In April the Trust achieved the 6 week diagnostic standard for the fifth month in a row. The performance level was 0.26%.

There were 20 diagnostic patients which breached the 6-week standard in April. At modality level performance of <1% was achieved in all modalities except for Cystoscopy and Neurophysiology (with 1 and 2 breaches respectively in these areas).

The level of breaches within Echocardiography has been the most significant cause of the Trust's overall failure of this standard in the second half of 2016. The service have put on additional capacity in recent months particularly within stress Echo and TOEs, and as a result the backlog of breaches has reduced significantly. In November Echo reported 86 breaches, but this has reduced to 64 in December, 30 in January, 4 in February and March, and 6 in April

**What action is being taken to recover performance?**

The Trust was in a position to continue to achieve the diagnostic standard in May, however the impact of the cyber-attack and the resulting cancelled appointments has increased the risk that this standard won't be achieved in May. A large number of diagnostic tests were cancelled across a range of modalities. As at 19th May the majority of modality areas have been able to rebook patients before their 6-week breach date. The two areas with the biggest risks following the cyber-attack are Neurophysiology and Endoscopy. There were 42 cancellations in Neurophysiology and 124 in endoscopy, as a result of these IT system issues. The diagnostic teams are in the process of attempting to secure further capacity before month end and rebooking these patients.



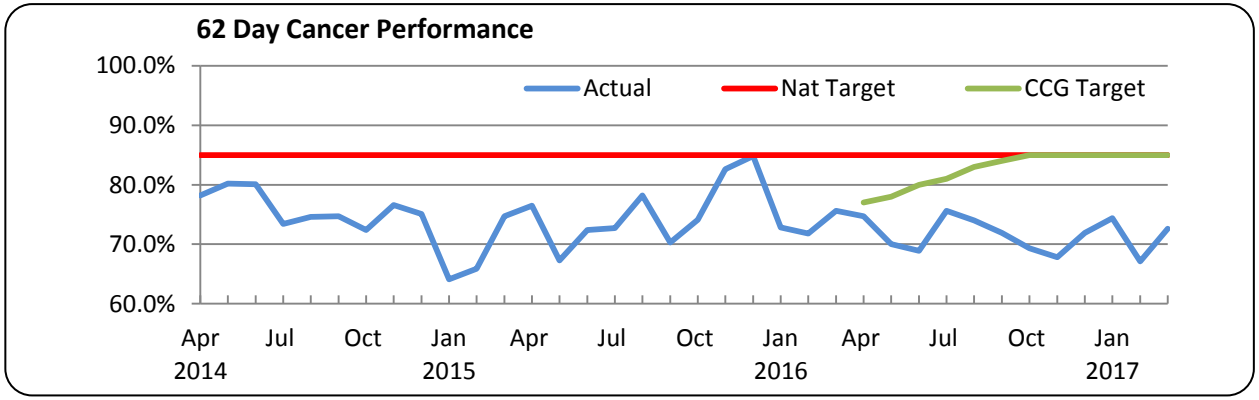
# Cancer Waiting Times – 62 Day

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: | 30th May 2017 | Reporting Period: | March 2017 |

**Exception Details**

The Trust achieved a performance of 72.8% against the 62 day classic standard in March, an improvement of 5.7% compared with February's performance.




The Trust achieved 2 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. The Route Cause Analysis (RCAs) for March 62 day breaches found a number of key themes in terms of access to diagnostics within ULHT, particularly CT, Ultrasound (especially biopsies) and Endoscopy. These were slower than required for a significant proportion of patients on 62 day pathways and there are ongoing restrictions relating to biopsies due to workforce constraints. In addition, delayed access to specialist tests (such as EBUS and EUS) and delays in local MDT decisions have introduced further waiting periods into the 62 day pathways for our patients. A significant number of patient choice and fitness delays also contributed to the Trust's performance position in March. Delays in admin processes were also found in a small but unacceptable number of patient pathways.

The Trust's performance against the 14 day suspect cancer target and the 14 day breast symptomatic target were both adversely effected in March by the prolonged spike in referrals into the breast service, with referral rates in from early January averaging over 140 referrals per week for a 10 week period compared to a baseline service capacity of 100 slots per week.

As of 23rd May there are 22 pts on or over 104 days without an agreed treatment plan: 12 x Urology, 7 x Colorectal, 1 x Haem, 1 x Upper GI, 1 x Skin. Two are very likely non-cancer (awaiting audit trail email confirmation from clinician)

4 of the 22 have confirmed cancer diagnosis.

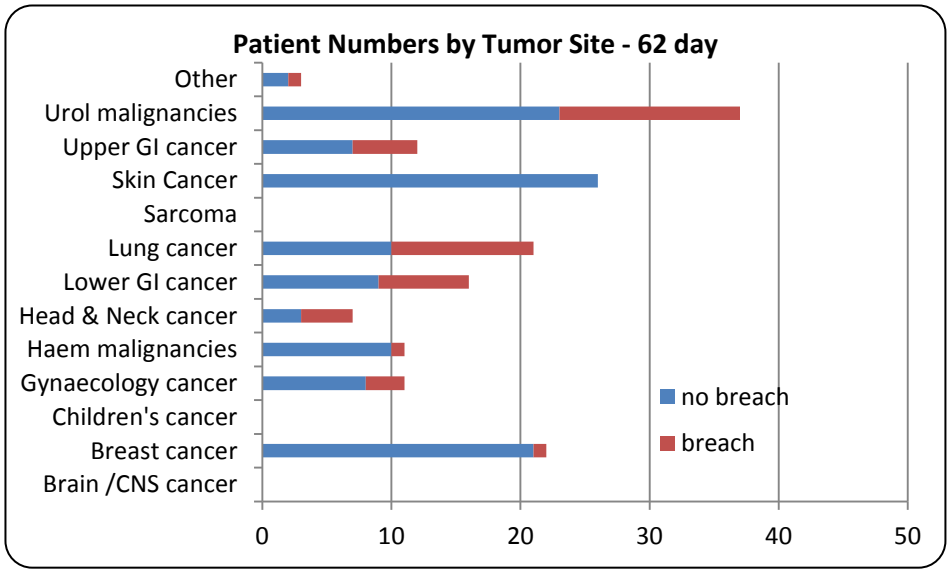
There are a number of factors involved in the delays: 9 x capacity, 7 x patient choice (cancelling appointments), 6 x procedural (clinical wait between tests), 6 x fitness, 5 x co-operation (DNAs or declining tests), 5 x admin, 4 x complex, 3 x tertiary delays (diagnostic or treatment)

**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.

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

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




The Upper GI Straight to Test pilot has proven to be successful and county-wide roll-out of the service commenced in May 2017. Likewise the roll out the lower GI straight to test pathway (piloted at Lincoln) started in May on the Grantham site, and a business case is being developed for the provision at Pilgrim.

The Somerset Cancer Register implementation continues at a fast pace. There are now over 180 registered users (compared to 40 on Infoflex), including MDT Co-ordinators, Clinicians, Specialty Doctors, Business Unit teams, Bowel Screening Practitioners, Cancer Nurse Specialists, Radiology & Endoscopy Booking Teams, Pathologists, Dietitians and Macmillan Cancer Information staff. A pilot of using it live in the MDT, sharing the information across two hospital sites, and the clinical outcome being recorded, printed and signed off within the meeting was successful and roll-out to the other MDTs continues.

The successful Radiology pilot of a new booking process has been extended, where appropriate patients are asked to go directly to Radiology reception, following their outpatient clinic appointment, in order to book their Radiology diagnostic appointment before they leave the Hospital. It is anticipated that this will reduce the time from referral to diagnostic test being completed.

The Trust utilised funding from the national diagnostic capacity fund in order to reduce CT waiting times between December and March. Approval has been given for non-recurrent funding to continue the extension of CT capacity until the end of September, whilst a Business Case goes through the Trust's IPB process. Further funding may be available via NHS England that may support further work with CT and Endoscopy capacity and the Lower GI Nurse Triage trial at Pilgrim.

The Endoscopy Service have developed an action plan to temporarily increase capacity, utilising additional locum Consultant capacity, re-scheduling Nurse Endoscopist rotas, reviewing in-list utilisation and are in discussions around utilising outsourcing capacity.

Level 1 Beds have been opened on the Lincoln site in April, with the expectation that this will reduce the number of cancelled operations linked to HDU capacity.

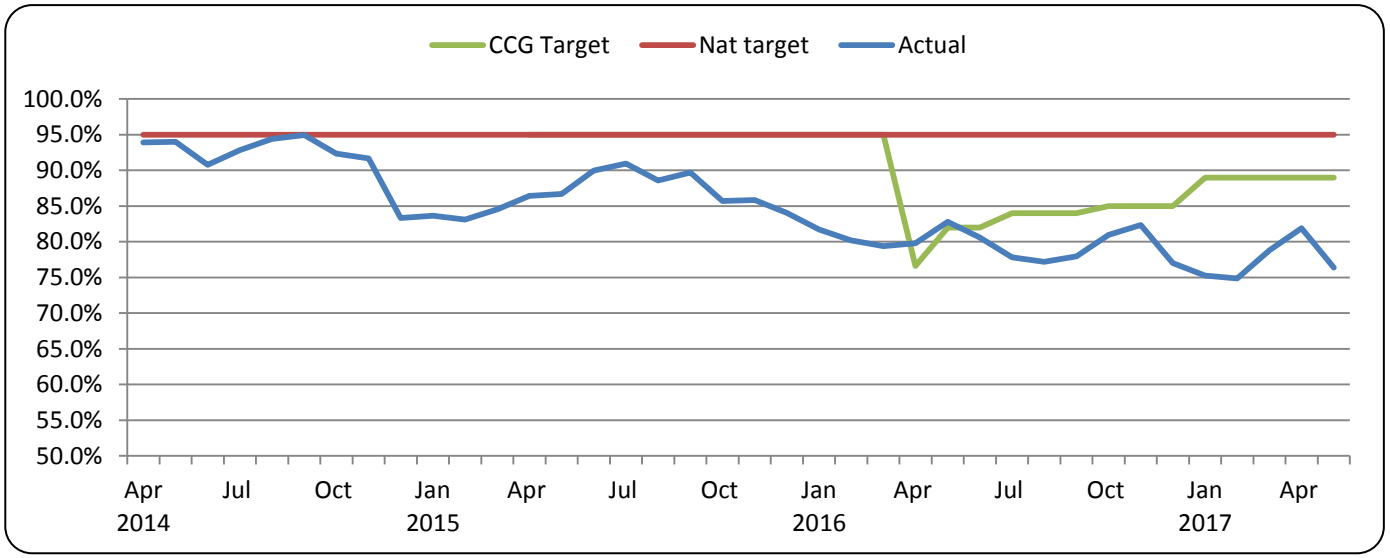
# A&E 4 Hour Standard

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 |

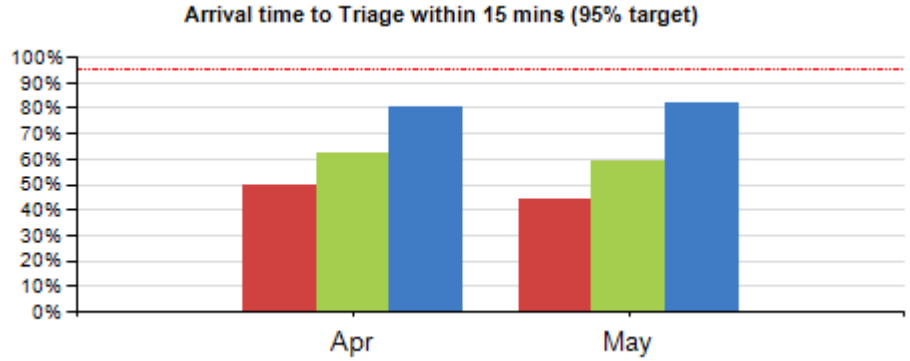
**Exception Details**

Overall Trust performance is 82.21%, which is 0.21% above the planned recovery trajectory of 82%. Lincoln County Hospital 78.53%, 3.47% below trajectory, Pilgrim Hospital 80.92%, 1.08% below trajectory, and Grantham Hospital 97.16%, 2.16% above trajectory.

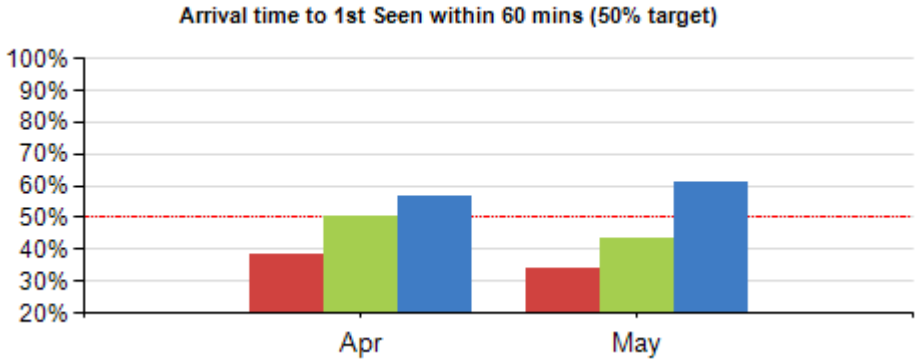



The April quality measures for:

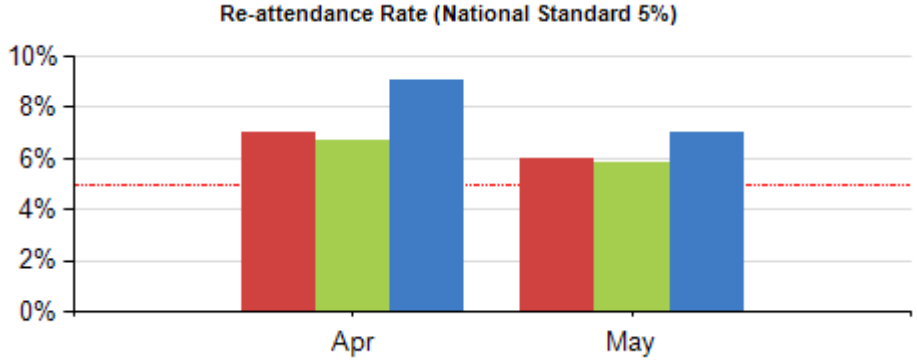
- Triage within 15mins is well below the expected standard of 95% across all 3 sites, with LCH at 50%, PHB 65%, and GK at 80%.



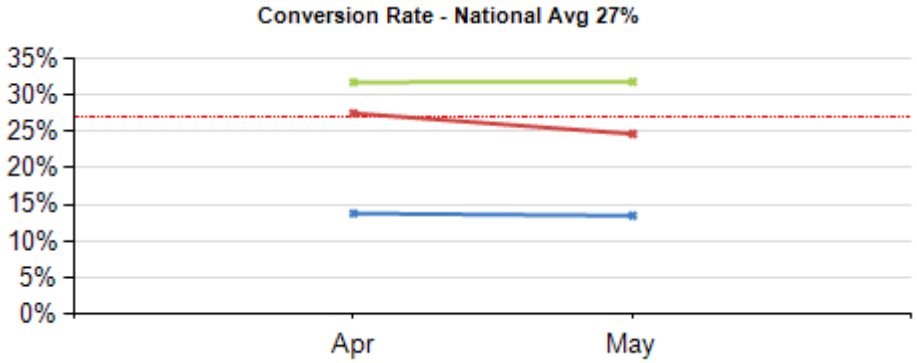
- Arrival time to first assessment within 60mins was close to the National target of 50%, with LCH at 39%, PHB at 50% and GK over the target at 58%.




- Re-attendance rates are above the national standard of 5% across all 3 sites, with LCH at 7%, PHB at 6.5% and GK at 9%

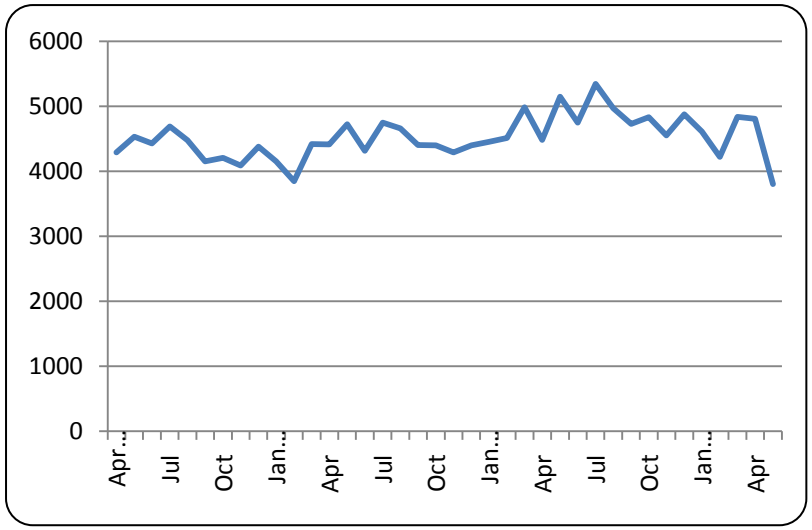



- Conversion rates across the Trust have remained constant across the Trust with PHB still above the national average of 27% at 32%, GK well below at 14% and LCH slightly above at 28% (Trust Overall at 27%).



Attendances at ULHT level have reduced against plan since April last year dropping from 13,130 in 2016 to 12,538 in 2017. LCH – 6102 in 2016 / down to 5859 in 2017, PHB – 4492 in 2016, up to 4816 in 2017, GK – 2536 in 2016, down to 1863 in 2017. Which would identify with the closure of Grantham A&E overnight.

**Full History - Total Attendances**

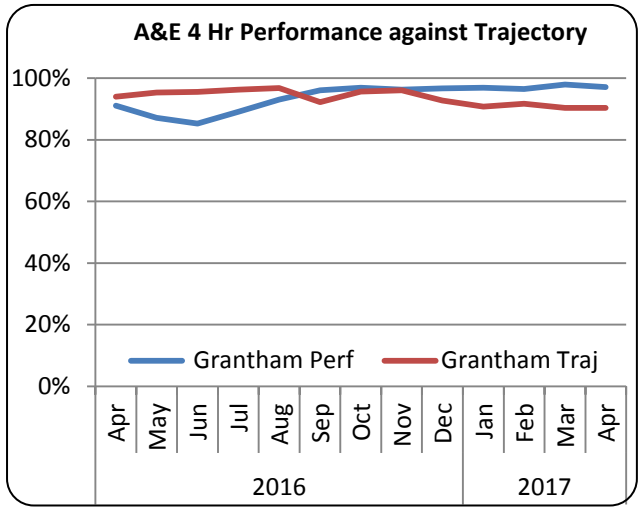


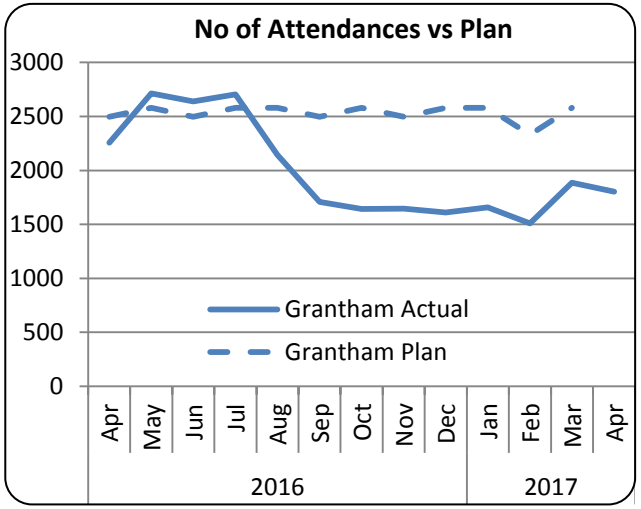

Key issues affecting performance for April were:

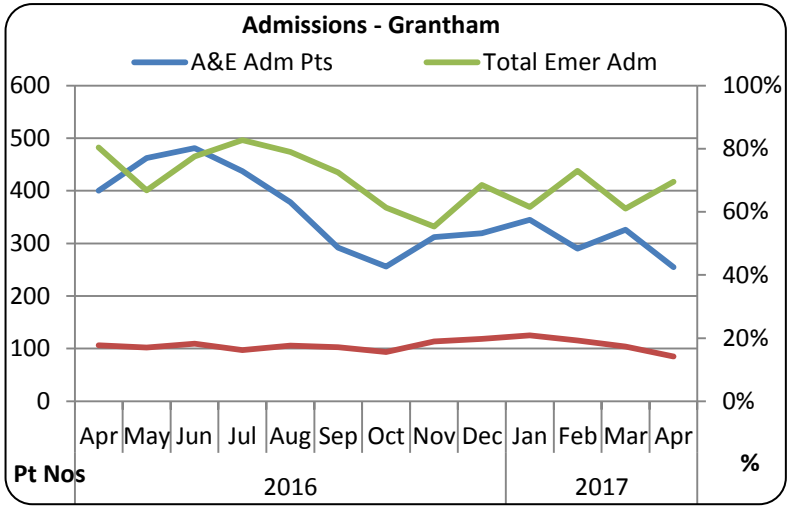
- Workforce numbers remains insufficient to meet historical demand and planned contractual increase
- IR35 and the National Average Caps have also meant a number of possible Dr's have been rejected due to increased rates which has affected both A&E & Medicine particularly at PHB.
- Continued reliance on agency locums
- Estate is not fit for purpose to manage ambulance handovers, minors and majors volumes
- Bed occupancy levels are high, leading to inability to manage surges in demand
- Internal and external delays for patients requiring discharge

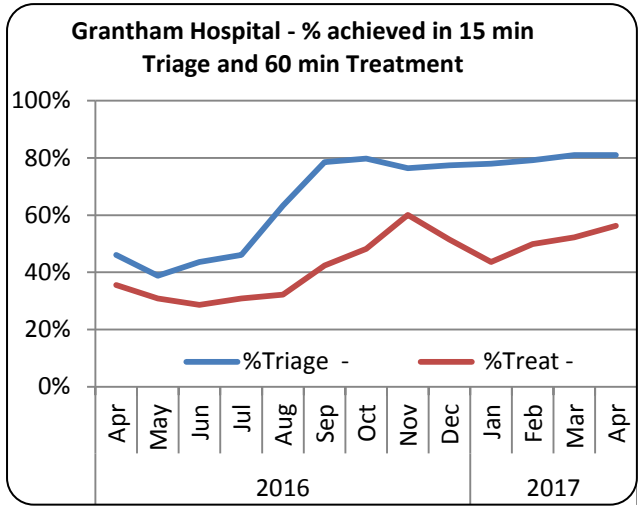
**Grantham**

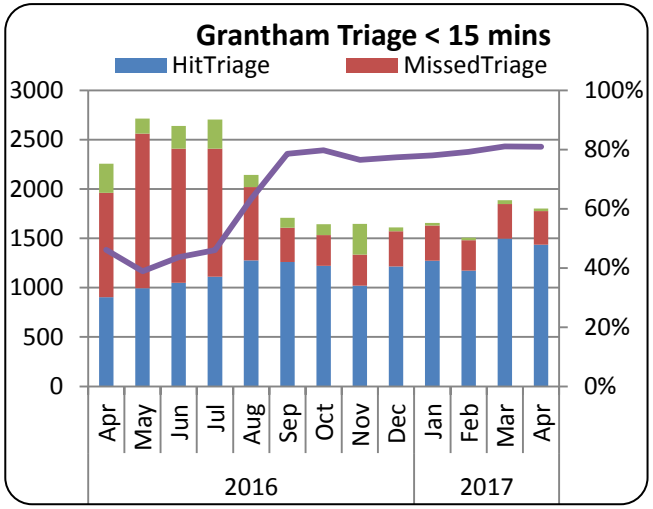
No exception report included as Grantham has exceeded the performance standard for the last two quarters and is on track to deliver the year end position, however the graphs below demonstrate the reduction in attendances (and Ambulance conveyances) since the overnight closure in August 2016.

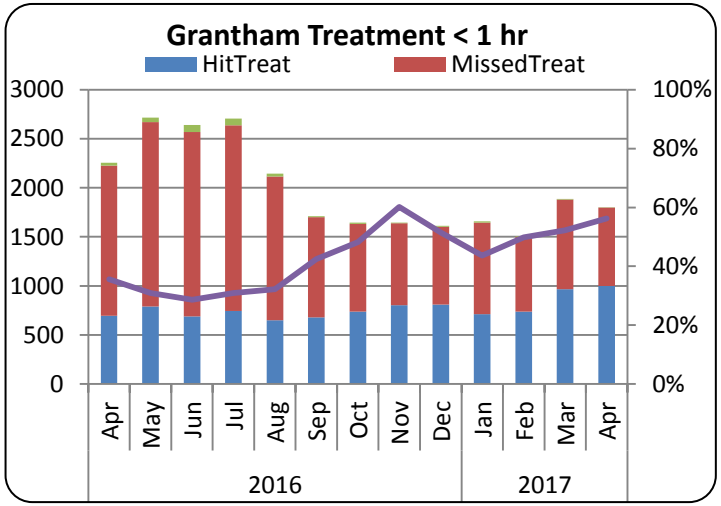


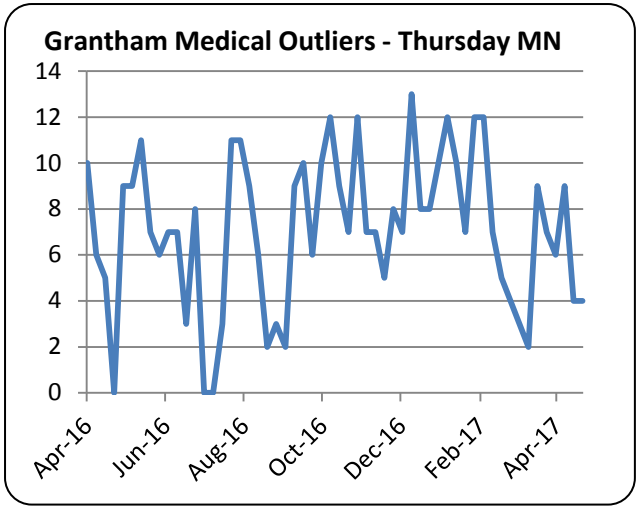



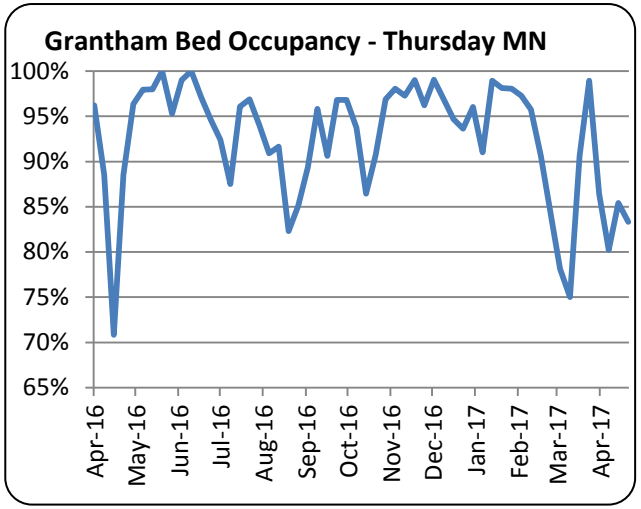



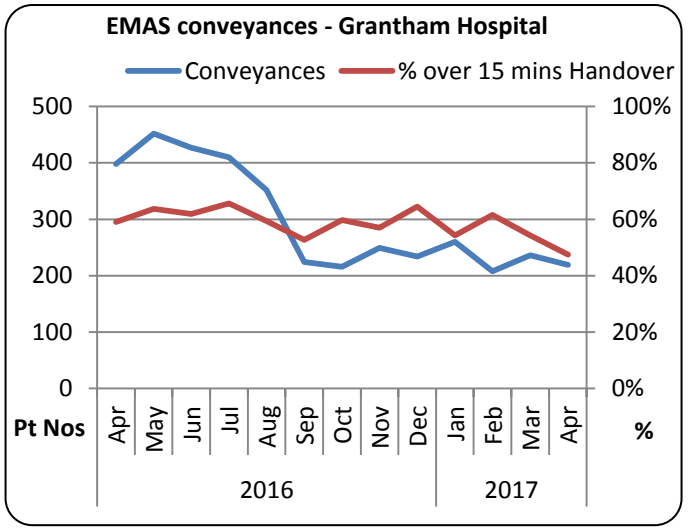



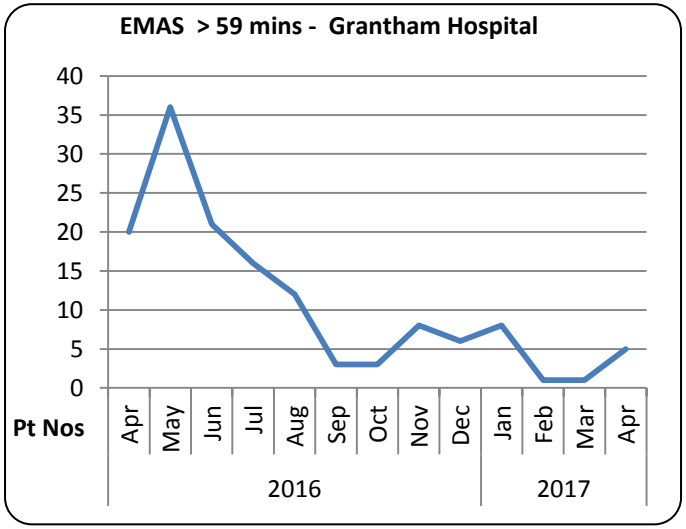




Grantham Medical Outliers - Thursday MN
14
12
10
8
6
4
2
0
Apr-16
Jun-16
Aug-16
Oct-16
Dec-16
Feb-17
Apr-17


Grantham Bed Occupancy - Thursday MN
100%
95%
90%
85%
80%
75%
70%
65%
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17


EMAS conveyances - Grantham Hospital
Conveyances
% over 15 mins Handover
500
400
300
200
100
0
100%
80%
60%
40%
20%
0%
Pt Nos
%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
2016
2017


EMAS > 59 mins - Grantham Hospital
40
35
30
25
20
15
10
5
0
Pt Nos
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
2016
2017

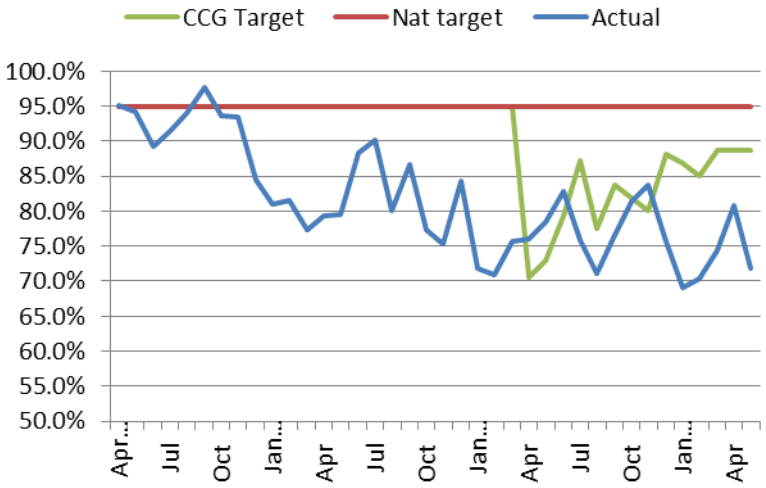
**Pilgrim**

April overall performance was 80.92%. Which is still 1.08% below the planned recovery trajectory of 82%, but up 6.52% compared to March 2017.
Total attendances are at the planned level for April but down some 28 patients compared to March, but still up 394 from 4492 to 4816. Admission levels have remained around the same at 32% compared to 31.51% in March, but still some 5% above the national average of 27%.
The total emergency admissions are up some 193 patients compared to April 2016 (1528 2017/1335 2016), but only 4 patients higher than March.
For the month of April Triage under 15mins was at 62% which is higher than the 57.2% for March, and 1st Assessment within 1hr for March 2017 was 50% 47.3% which was slightly higher than the 47.3% for March 2017.

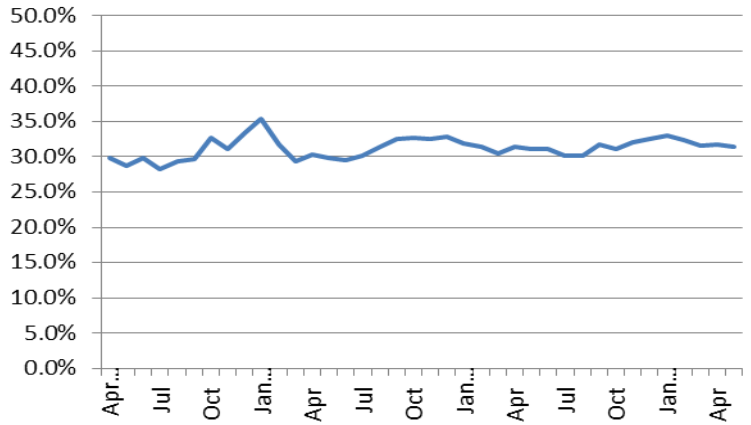
In-month key issues affecting performance in April were:

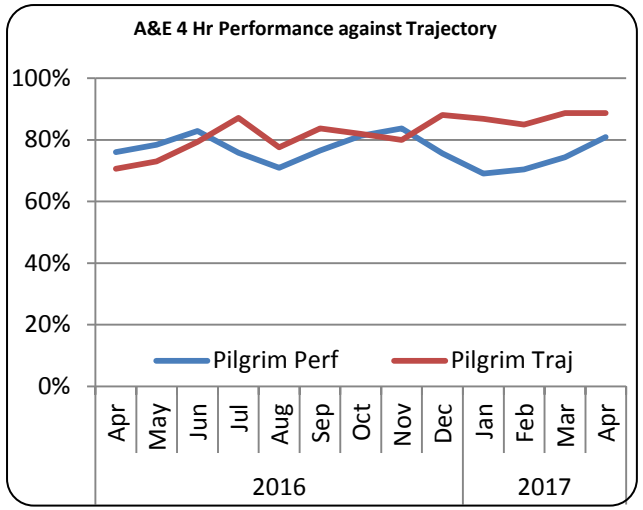
- Vacancies in ED Medical rota's with reliance on agency locums.
- Vacancies in Nursing rota's with a variance in agency or bank fill rates.
- Poor hospital flow – admissions exceeded discharges. The AEC area was frequently used as escalation bed capacity resulting in inefficient processing of ambulatory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

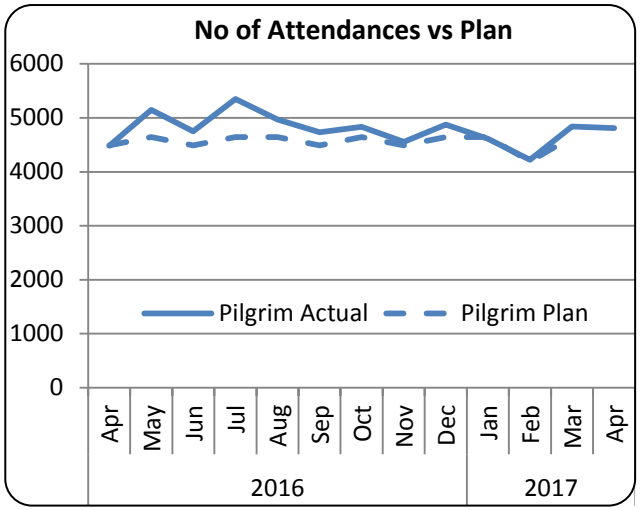
**Pilgrim Performance**

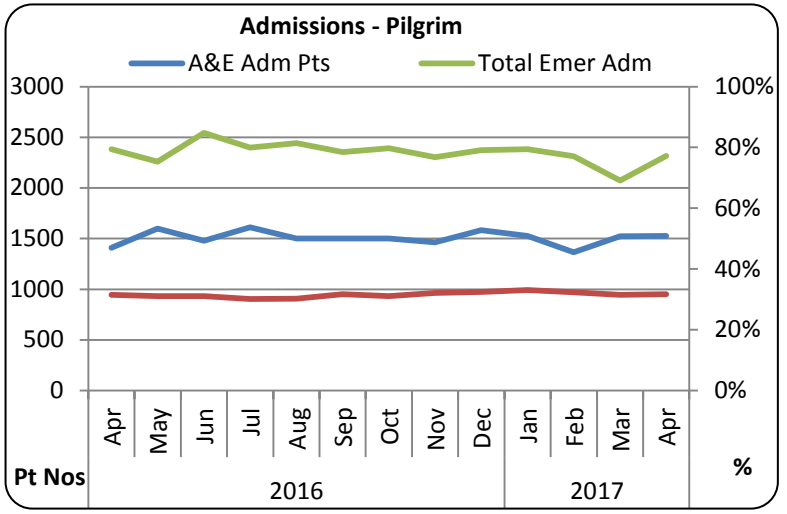


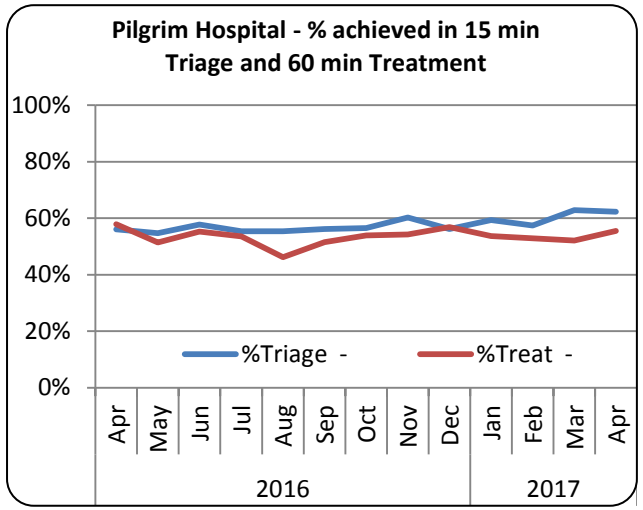

**Pilgrim Admissions**

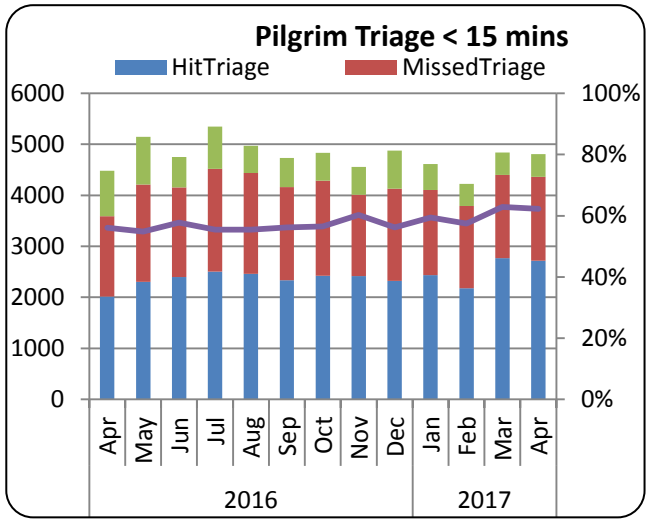


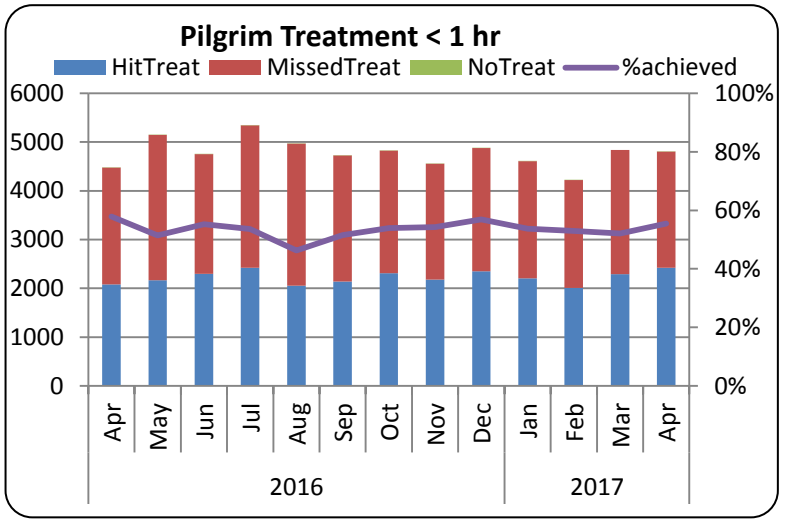

A&E 4 Hr Performance against Trajectory
100%
80%
60%
40%
20%
0%
Pilgrim Perf
Pilgrim Traj
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2016
2017

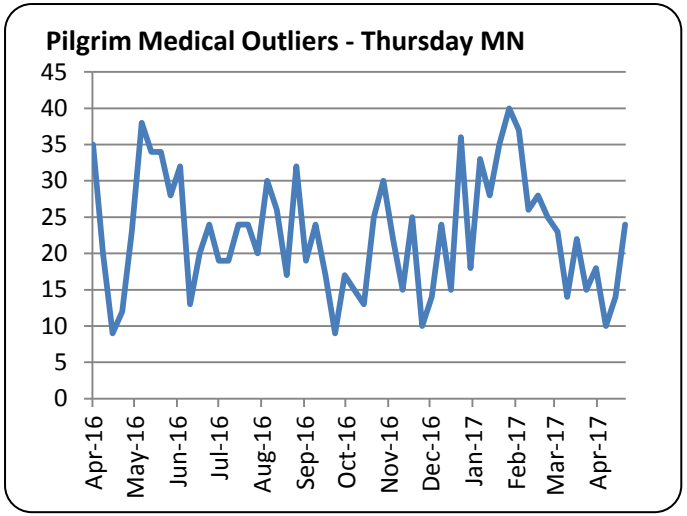

No of Attendances vs Plan
6000
5000
4000
3000
2000
1000
0
Pilgrim Actual
Pilgrim Plan
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2016
2017

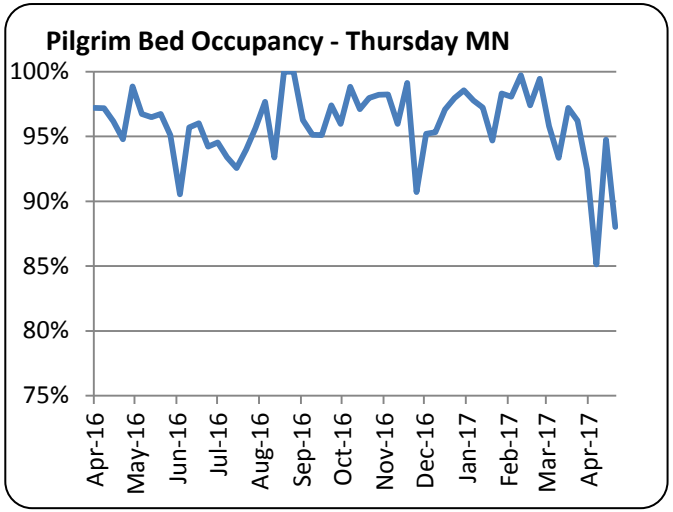

Admissions - Pilgrim
A&E Adm Pts
Total Emer Adm
3000
2500
2000
1500
1000
500
0
100%
80%
60%
40%
20%
0%
Pt Nos
%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2016
2017

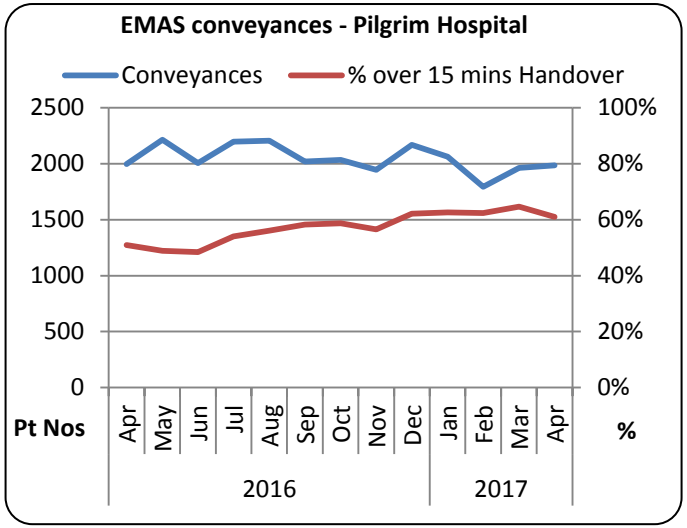

Pilgrim Hospital - % achieved in 15 min
Triage and 60 min Treatment
100%
80%
60%
40%
20%
0%
%Triage -
%Treat -
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2016
2017

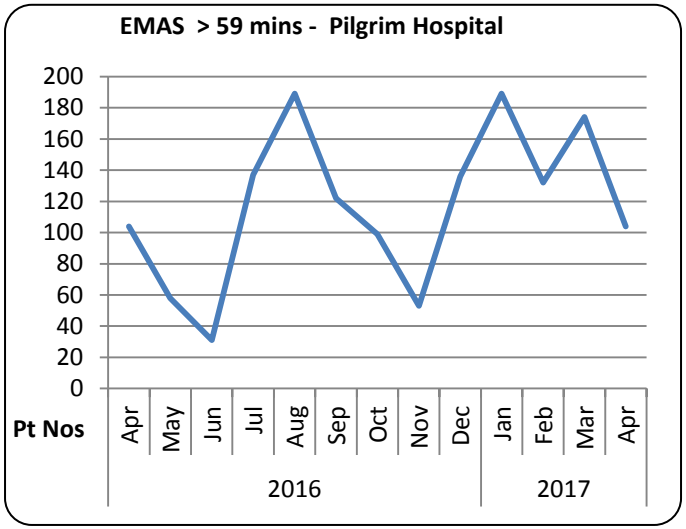

Pilgrim Triage < 15 mins
HitTriage
MissedTriage
6000
5000
4000
3000
2000
1000
0
100%
80%
60%
40%
20%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2016
2017


Pilgrim Treatment < 1 hr
HitTreat
MissedTreat
NoTreat
%achieved
6000
5000
4000
3000
2000
1000
0
100%
80%
60%
40%
20%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2016
2017


Pilgrim Medical Outliers - Thursday MN
45
40
35
30
25
20
15
10
5
0
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17


Pilgrim Bed Occupancy - Thursday MN
100%
95%
90%
85%
80%
75%
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17


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


EMAS > 59 mins - Pilgrim Hospital
200
180
160
140
120
100
80
60
40
20
0
Pt Nos
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
2016
2017

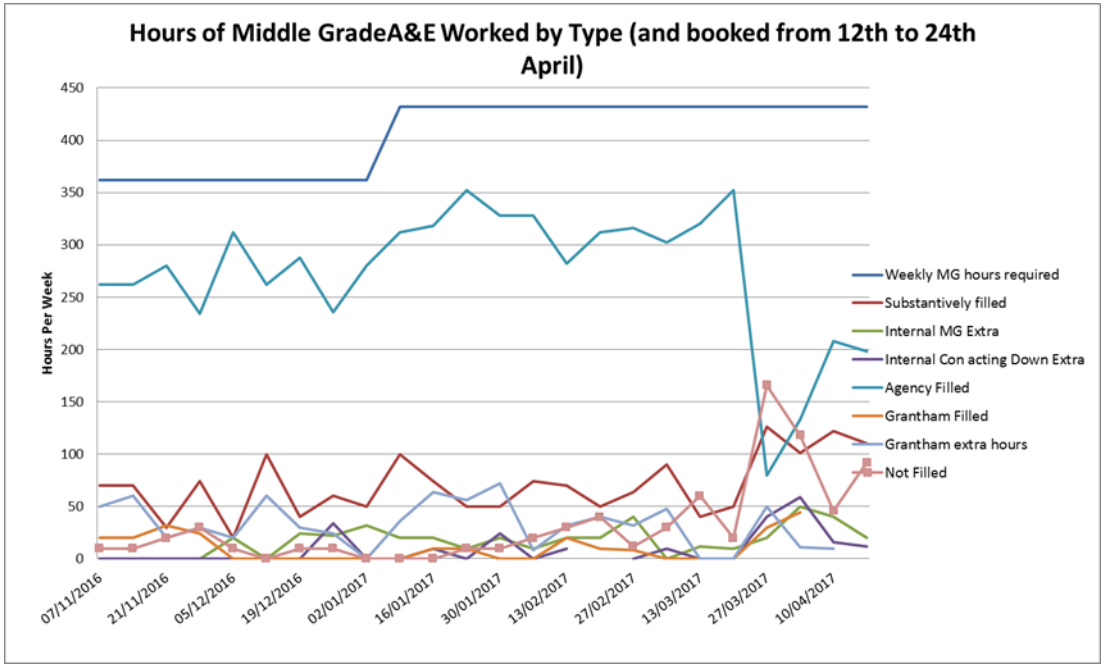
**Lincoln**

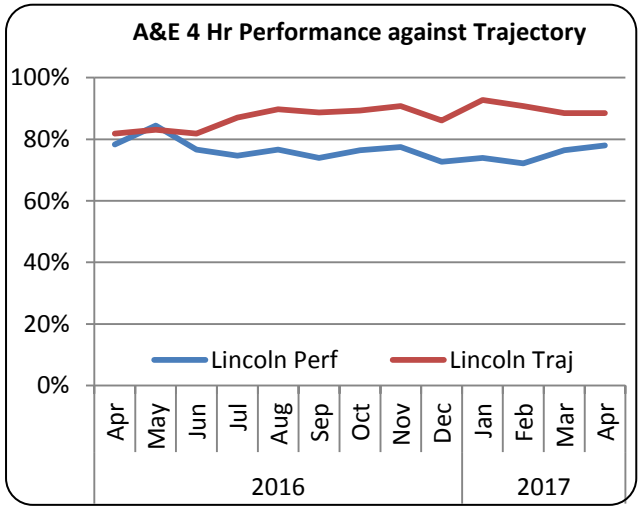
Lincoln performance for April 2017 was 78.53% which is an improvement of 1.55% from last month. This remains below the STF monthly trajectory of 82%.

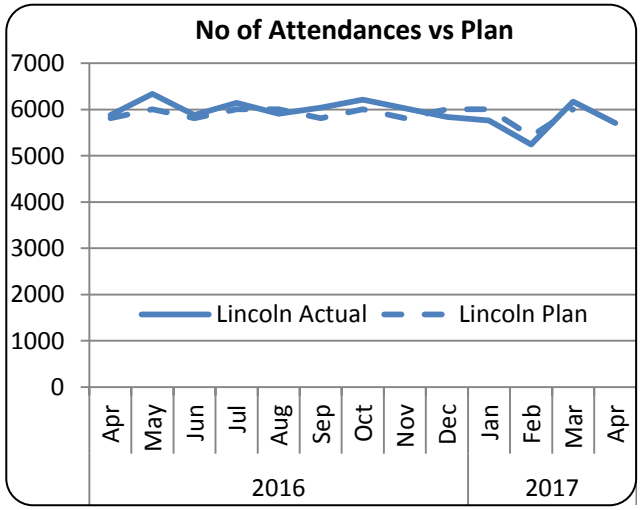
| | Q1 | Q2 | Q3 | Q4 | YTD |
|---|---|---|---|---|---|
| Trajectory | 82.00% | | | | |
| Performance | 77.96% | | | | |
| Variance | -4.04% | | | | |

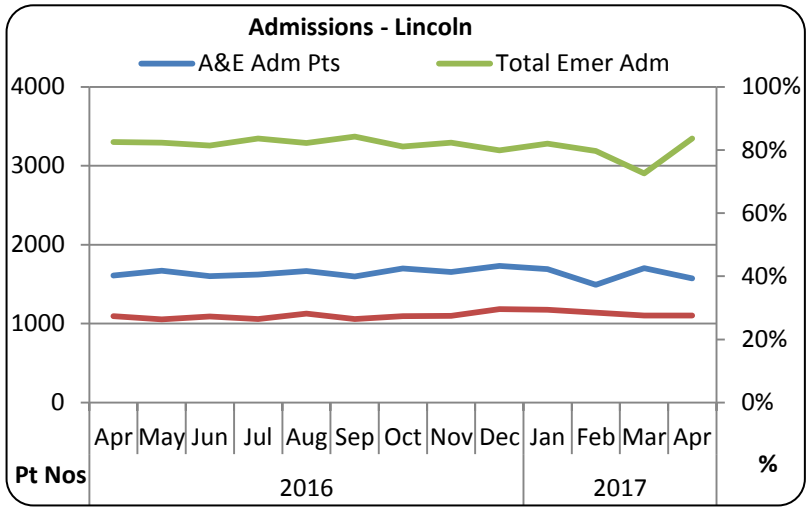
Key issues affecting performance in April predominantly related to ED Medical Staffing. The new IR35 taxation rules saw the locum market change overnight at the end of March. High volumes of locums cancelled bookings and withdrew their services citing "taking leave & family issues" as the reasons. This effectively resulted in a "silent strike" leaving the early April weekends and Easter bank holiday weekend with significant clinical risk.

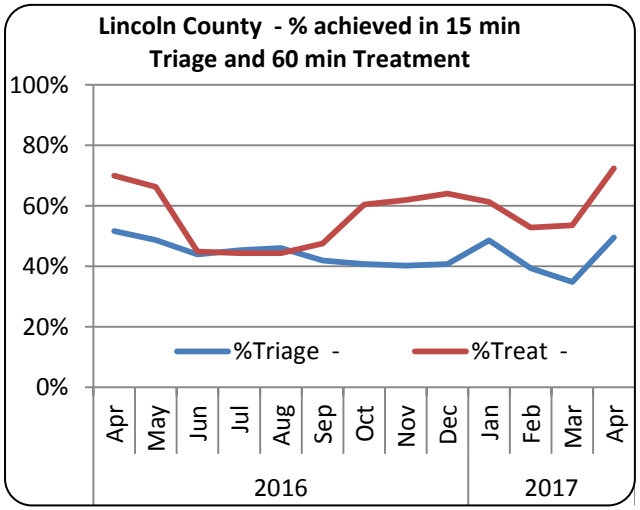
The impact of this was an increase in "unfilled rota hours" from 16 to 160 hours/week, a 1000% increase. On Sunday 2nd April the situation peaked resulting in a mutual aid request on risk of closure being initiated by ULHT. System-wide calls were triggered across the region with the support of NHSi The Medical Director requested support for ED from Clinical Directorates – all consultants / CDs. This request was met with an excellent response from colleagues in surgical, urological, paediatric, medical, and orthopaedic specialties. Performance during the weekend period of intensive support was at the early 90% level.

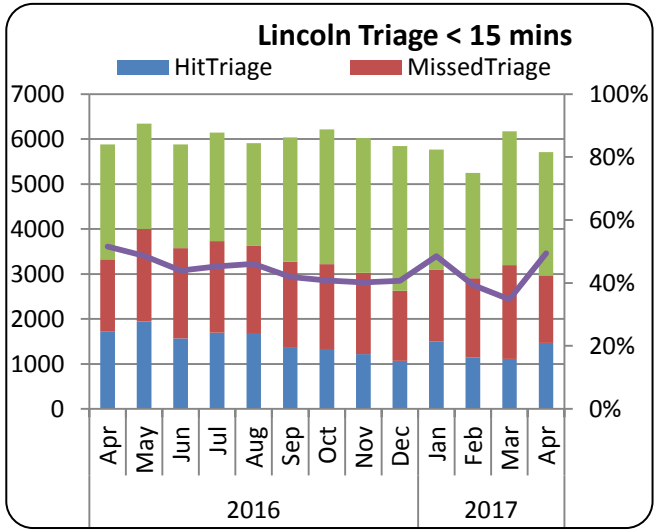


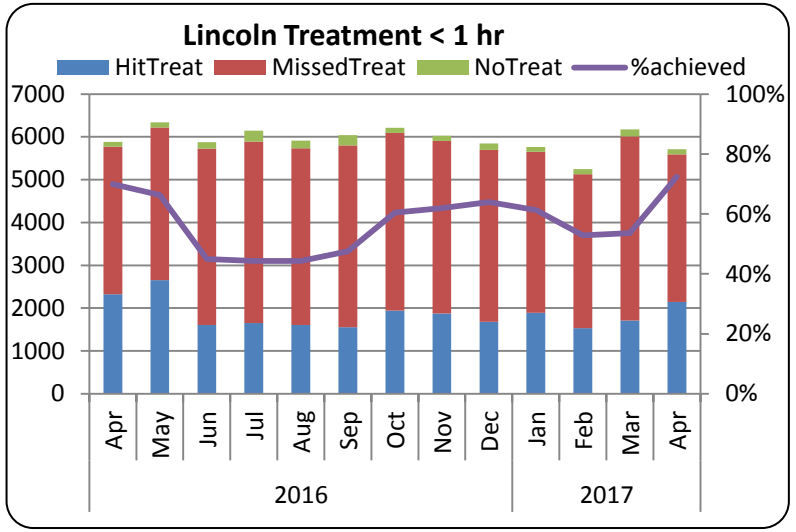

A&E 4 Hr Performance against Trajectory
100%
80%
60%
40%
20%
0%
Lincoln Perf
Lincoln Traj
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2016
2017

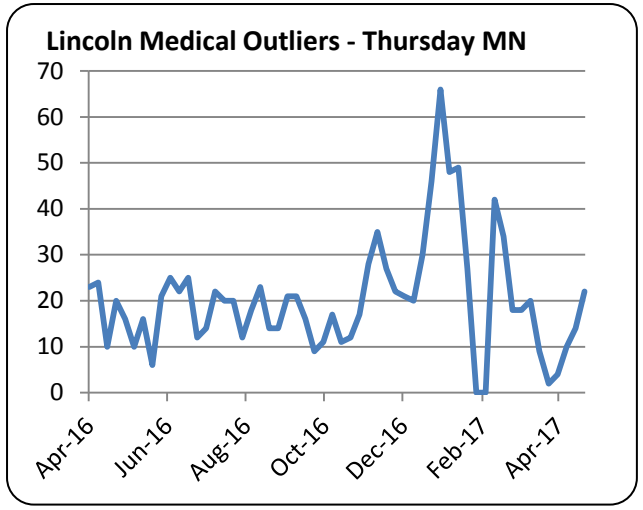

No of Attendances vs Plan
7000
6000
5000
4000
3000
2000
1000
0
Lincoln Actual
Lincoln Plan
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2016
2017

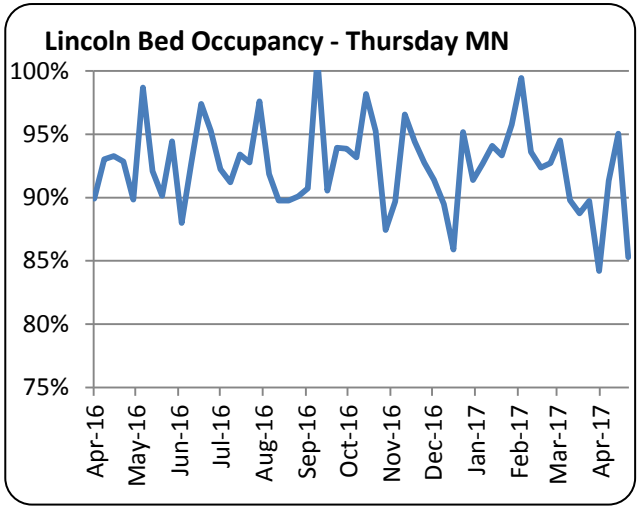

Admissions - Lincoln
A&E Adm Pts
Total Emer Adm
4000
3000
2000
1000
0
100%
80%
60%
40%
20%
0%
Pt Nos
%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2016
2017

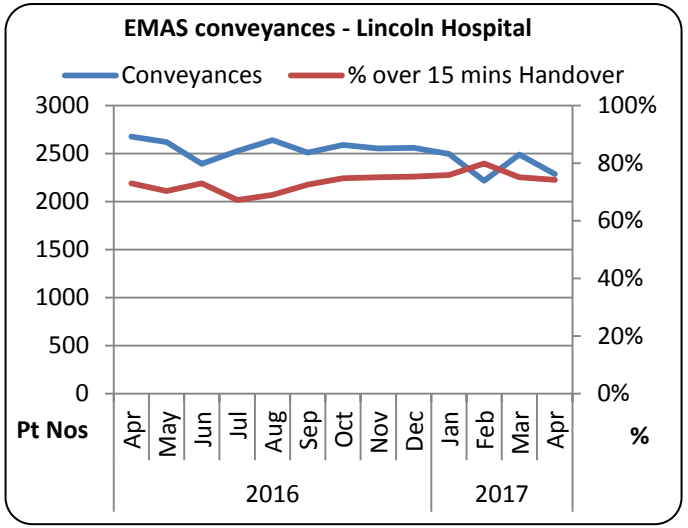

Lincoln County - % achieved in 15 min
Triage and 60 min Treatment
100%
80%
60%
40%
20%
0%
%Triage -
%Treat -
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2016
2017

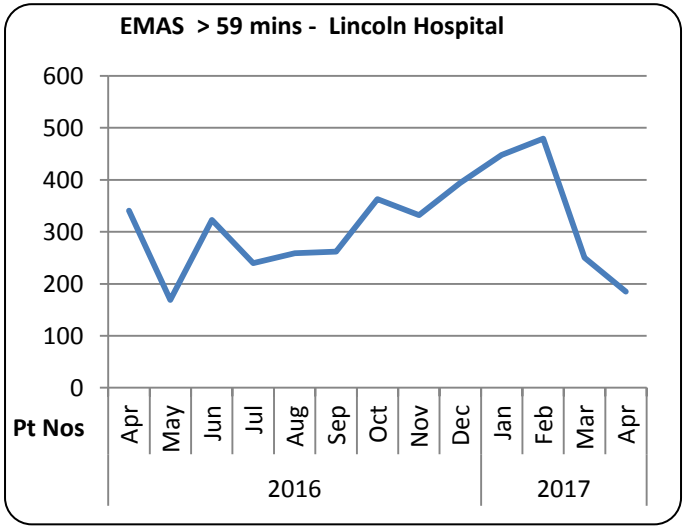

Lincoln Triage < 15 mins
HitTriage
MissedTriage
7000
6000
5000
4000
3000
2000
1000
0
100%
80%
60%
40%
20%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2016
2017


Lincoln Treatment < 1 hr
HitTreat
MissedTreat
NoTreat
%achieved
7000
6000
5000
4000
3000
2000
1000
0
100%
80%
60%
40%
20%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2016
2017


Lincoln Medical Outliers - Thursday MN
70
60
50
40
30
20
10
0
Apr-16
Jun-16
Aug-16
Oct-16
Dec-16
Feb-17
Apr-17


Lincoln Bed Occupancy - Thursday MN
100%
95%
90%
85%
80%
75%
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17


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


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

**What action is being taken to recover performance?**

Pilgrim:

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

Lincoln

A follow-up workshop has identified how specialties could be modelled into the core ED rotas and the Board has agreed investment of circa £900k to cover increased staffing at Lincoln and Boston Sites which will enable the first steps towards supporting the agreed new model of working.

Red2Green and implementation of SAFER continues with further sessions planned with ECIP to support work in respect of flow.

Capital building works in minors is progressing well and is due for completion at the end of May giving 4 further minors cubicles. The GP recruited to work in ED will commence in June 17 as planned.

A business case for the expansion of Resus will be completed by the end of May which will see the doubling of resus capacity from 4 beds to 8 beds.

**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 | 103.84 | 103.84 | 103.60 | ↑ |
| | | | | | | | |
| **Length of Stay** | | | | | | | ↓ |
| Average LoS - Elective | Monthly | Medway / Slam | 2.8 | | | 2.75 | ↓ |
| Average LoS - Non Elective | Monthly | Medway / Slam | 3.8 | 4.42 | 4.42 | 4.86 | ↓ |
| | | | | | | | |
| **Medically Fit for Discharge** | Monthly | Bed managers | 60 | 49.00 | 49.00 | 68.00 | ↓ |
| | | | | | | | |
| **Delayed Transfers of Care** | Monthly | Bed managers | 3.5% | 4.57% | 4.57% | 5.38% | ↓ |
| | | | | | | | |
| **Partial Booking Waiting List** | Monthly | Medway | 0 | 6419 | 6419 | 5018 | ↑ |

# Partial Booking Waiting List

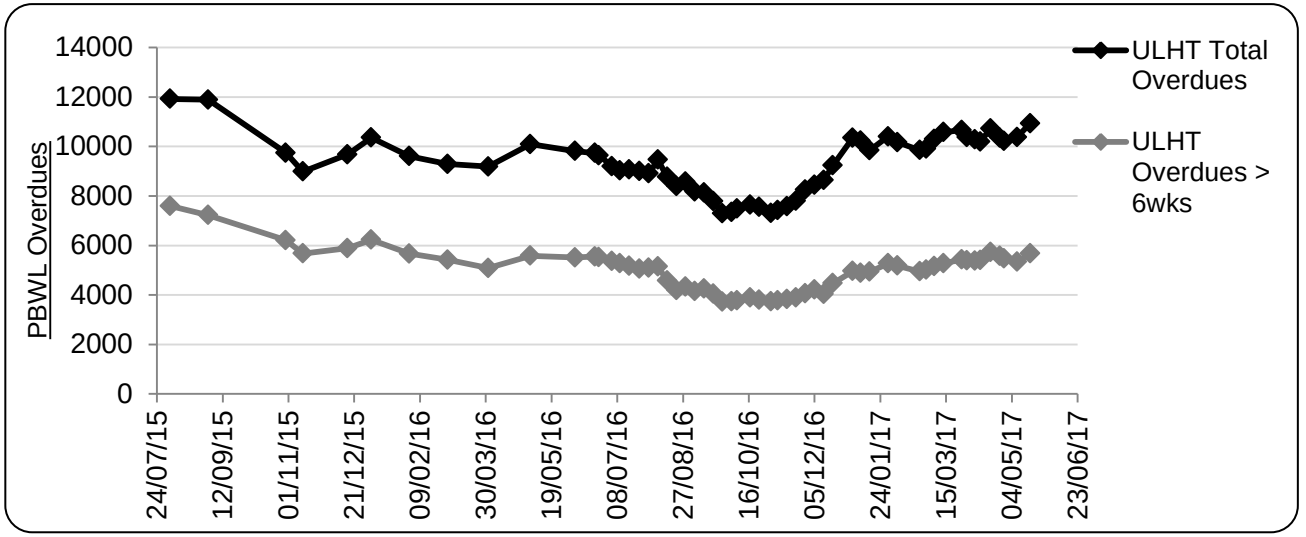
Executive Responsibility: Mark Brassington – Chief Operating Officer

| KPI: | Partial Booking Waiting List | Owner: | Chief Operating Officer |
|---|---|---|---|
| Domain: | Effective | Responsible Officer: | Deputy Director of Operational Performance |
| Date: | 30th May 2017 | Reporting Period: | April 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 has led to an increase in this position back up to 5673 as at 18th May.

Over 75% of the total Trust 6 week+ backlog relates to patients from just 7 speciality areas – ENT, Neurology, Rheumatology, Endocrine, Community Paeds, T&O and Cardiology.




**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:

- Community Paeds – Allocate additional telephone consultations to clinicians; Request additional clinics above job plan from Consultants; successful recruitment to NHS locum post. Forecast backlog resolved by October 17.
- Neurology – Service closed to routine referrals since December 2016, with request to CCG to remain closed until end of August to fully resolve backlog. Additional clinics being provided by Consultants in place. MS nurse specialists have commenced reviewing follow-ups. Business Case for 4th Consultant approved by IPB in April.
- Cardiology – Virtual clinics; locum Consultant now in post; additional ad hoc capacity. Request to CCGs to close to routine referrals for a period.
- Rheumatology – Substantive Consultant now in post, locum Consultant to remain in addition until backlog resolved. Forecast resolved by end of July.
- ENT – Additional clinics; additional audiology sessions; review discharge point for key pathways; review vacant slot processes. Request to CCGs to close to routine referrals for a period. Forecast recovery still to be confirmed.

# Safe

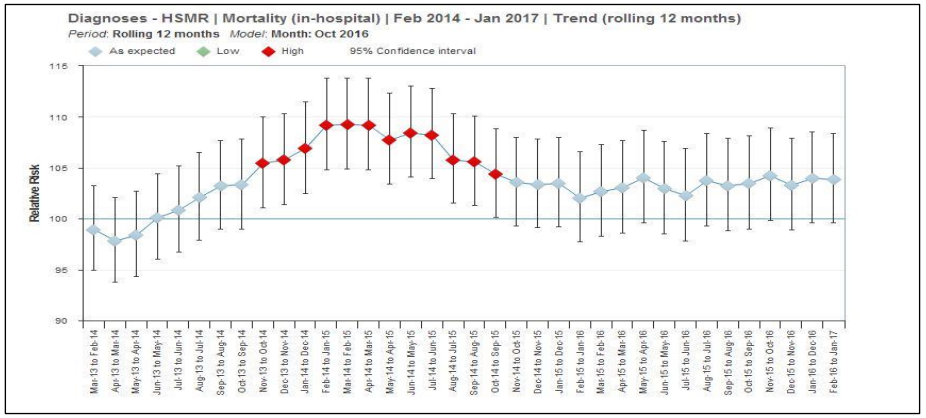
| Metric | Reporting Frequency | Source | Target | YTD | Current Month | Last Month | Trend |
|---|---|---|---|---|---|---|---|
| **Safe** | | | | | | | ↓ |
| **Infection Control** | | | | | | | → |
| Clostrum Difficile (post 3 days) | Monthly | Datix | 59 | 7 | 7 | 10 | ↓ |
| MRSA bacteraemia (post 3 days) | Monthly | Datix | 0 | 0 | 0 | 0 | ↓ |
| MSSA | Monthly | Datix | 2 | 3 | 3 | 0 | ↑ |
| ECOLI | Monthly | Datix | 8 | 5 | 5 | 6 | ↓ |
| **Never Events** | Monthly | Datix | 0 | 0 | 0 | 0 | ↓ |
| **No New Harms** | | | | | | | ↓ |
| Serious Incidents reported (unvalidated) | Monthly | Datix | 0 | 23 | 23 | | ↓ |
| Harm Free Care % | Monthly | | 95% | 92.03% | 92.03% | 91.60% | ↑ |
| New Harm Free Care % | Monthly | | 98% | 97.98% | 97.98% | 97.90% | ↑ |
| Catheter & New UTIs | Monthly | | 1 | 1 | 2 | 1 | ↑ |
| Falls | Monthly | Datix | 3.90 | 3.66 | 3.66 | 3.42 | ↑ |
| Medication errors | Monthly | Datix | 0 | 144 | 144 | 108 | ↑ |
| Medication errors (mod, severe or death) | Monthly | Datix | 0 | 22 | 22 | 18 | ↑ |
| Pressure Ulcers (PUNT) 3/4 | Monthly | | | 8 | 8 | | ↓ |
| VTE Risk Assessment | Monthly | | 95% | 97.00% | 97.00% | 97.95% | ↓ |
| **Core Learning** | Monthly | ESR | 85% | 90.67% | 90.67% | 89.83% | ↑ |

# Safe Ambition 1: Reduction of Harm Associated with Mortality

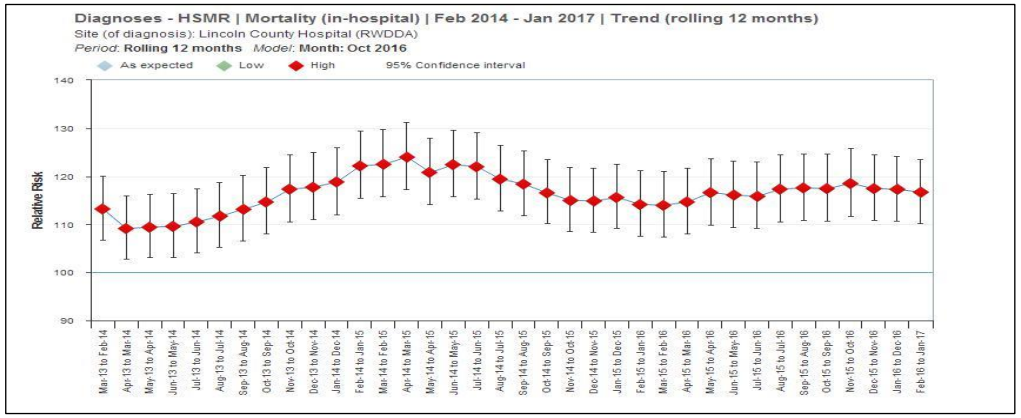
Executive Responsibility: Neil Hepburn – Interim Medical Director

| Trust/Site | ULHT HSMR Feb 16-Jan 17 12 month | ULHT HSMR Apr 16-Jan 17 YTD | ULHT HSMR Jan-17 | ULHT SHMI Oct 15 – Sep 16 | Trust Crude Mortality YTD Internal source May 16-Apr 17 |
|---|---|---|---|---|---|
| **Trust** | 103.84 | 103.4 | 104.4 | 110.30 | 1.81% |
| **LCH** | 116.6 | 116.6 | 114.7 | 112.91 | 1.88% |
| **PHB** | 95.9 | 95.1 | 98.1 | 108.34 | 1.91% |
| **GDH** | 71.0 | 70 | 78.1 | 97.82 | 1.08% |

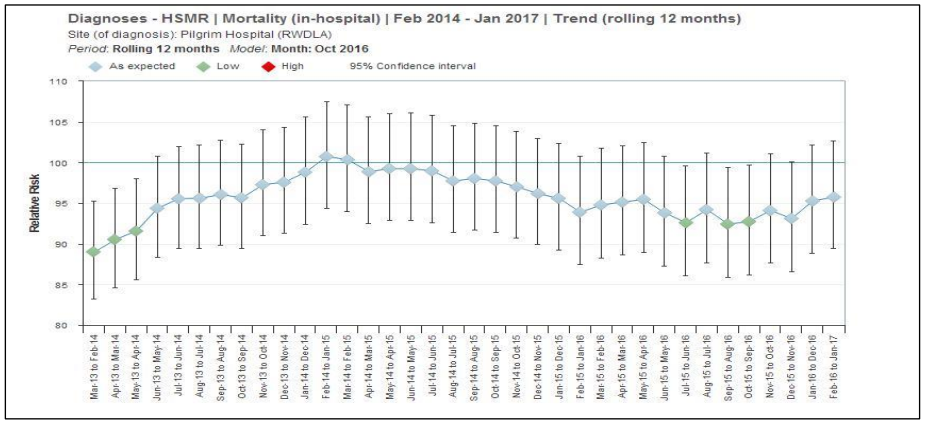
ULHT HSMR Rolling Year (36 Months)



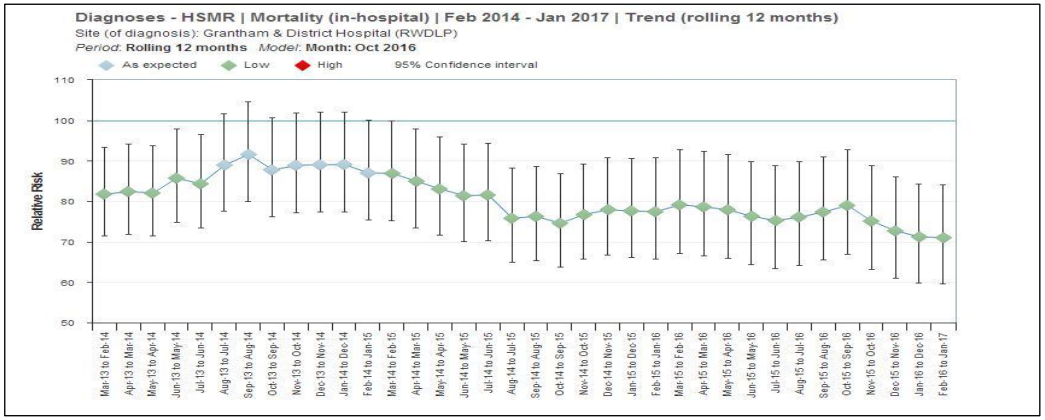

Lincoln HSMR Rolling Year (36 Months)




Pilgrim HSMR Rolling Year (36 Months)




Grantham HSMR Rolling Year (36 Months)



**Alerts**

**ULHT**
The Trust diagnoses groups are:
NEW COPD and bronchiectasis: Driven by an alert on the Pilgrim Site; with 18.17 mortalities over the predicted Dr Foster data with no particular month alerting as this is cumulative over the time period above. This is the first alert for this time period.
Other Liver Diseases: This alert is not driven by any particular site; but is cumulative over the sites for the time period above; with 8.3 mortalities over the predicted Dr Foster data. This has been alerting for 2 months.

**Lincoln County Hospital diagnoses groups are:**

- Biliary Tract Disease: This is cumulative throughout the time period with 9.7mortalities over the predicted Dr Foster data. This has now been alerting for 2 months. A comprehensive review was conducted in November 2015.
- 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 fourth consecutive month of notification. An in-depth review is underway; awaiting confirmation from the Clinical Leads for participants, Quality Governance have sourced the notes for circulation.

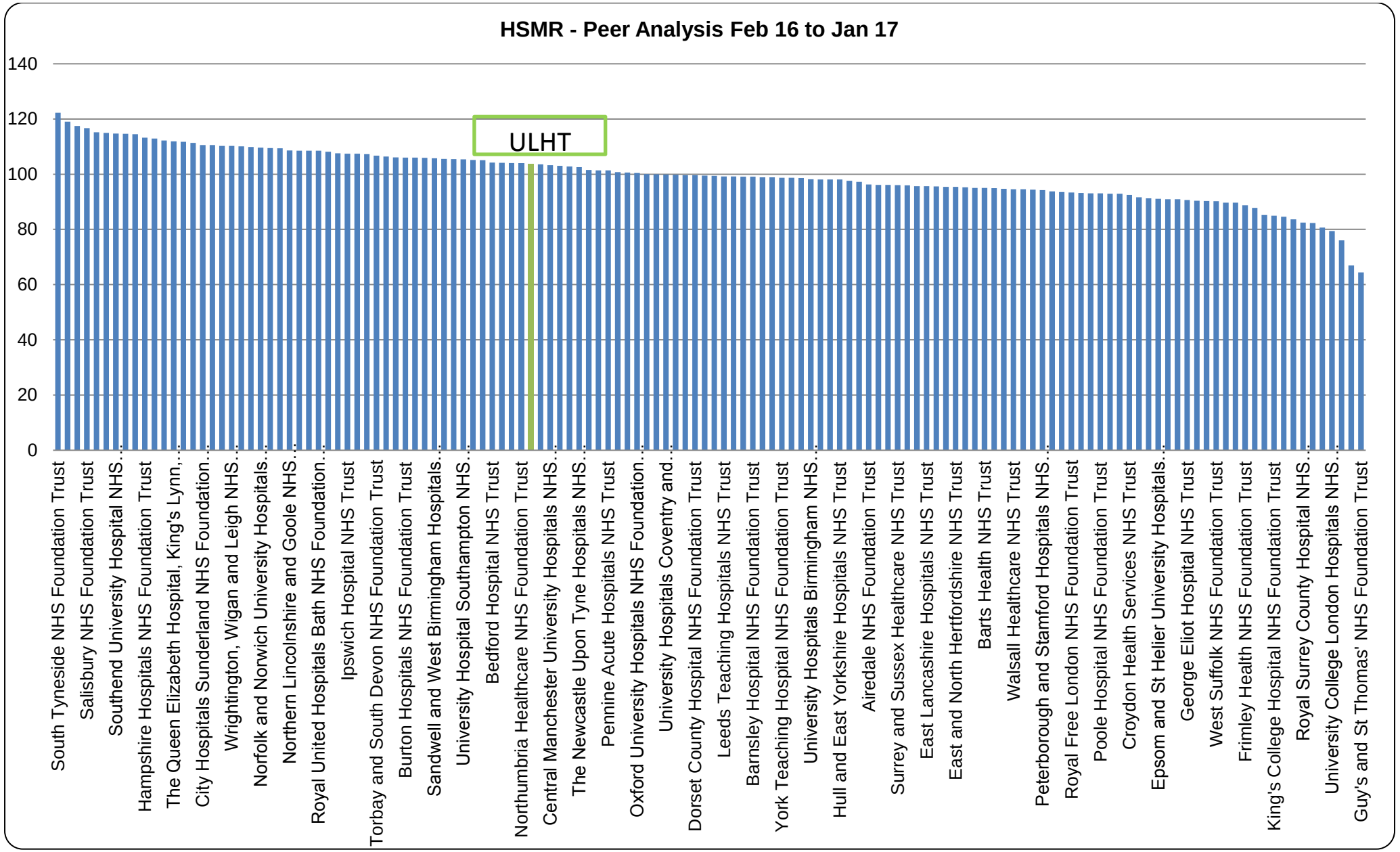
**Pilgrim Hospital**
NEW COPD and bronchiectasis: This alert is due to a notification in January 17, over the time period there has been 14.3 mortalities over the predicted Dr Foster data. This is the first month alerting.

**Grantham Hospital**
No notifications

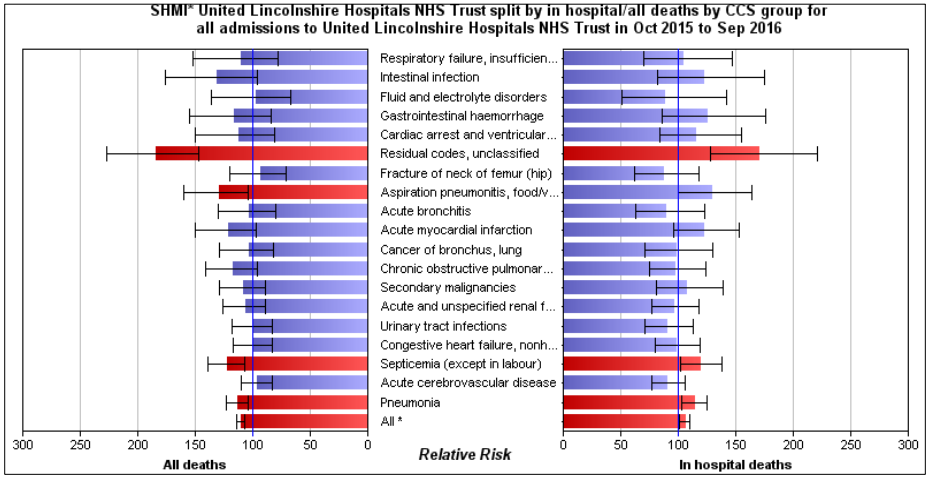
**HSMR Top Observed Diagnosis Groups – April 2016 to January 2017**

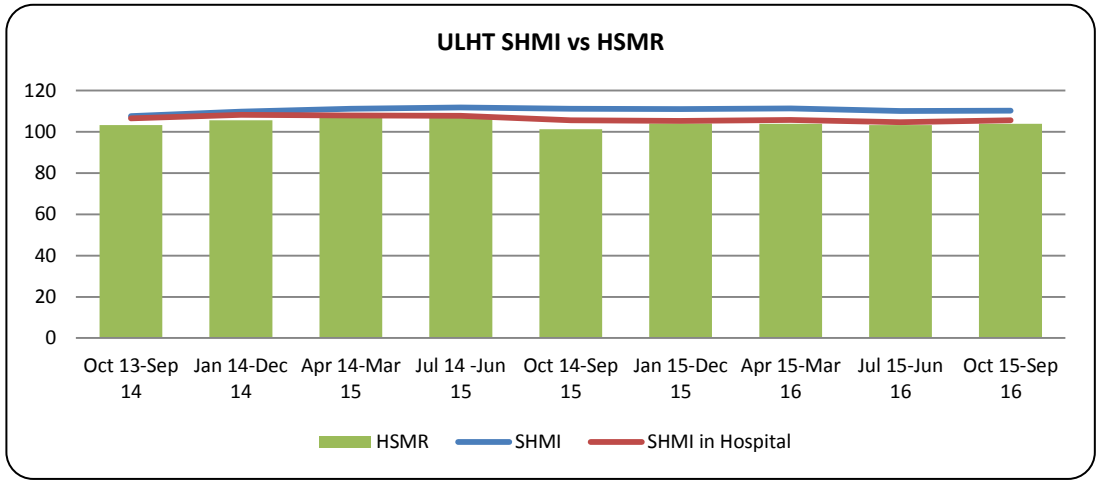
| Rank | Diagnosis group | Spells | mortalities | % of all mortalities | Expected mortalities | Actual-Expected | Crude (%) | HSMR |
|---|---|---|---|---|---|---|---|---|
| 1 | Pneumonia | 2088 | 372.00 | 20.72% | 382.11 | -10.11 | 17.85 | 97.35 |
| 2 | Septicemia (except in labour) | 686 | 143.00 | 7.97% | 133.00 | 10.00 | 20.88 | 107.52 |
| 3 | Acute cerebrovascular disease | 956 | 140.00 | 7.80% | 141.03 | -1.03 | 14.75 | 99.27 |
| 4 | Acute and unspecified renal failure | 648 | 85.00 | 4.74% | 80.97 | 4.03 | 13.22 | 104.98 |
| 5 | Urinary tract infections | 1969 | 76.00 | 4.23% | 83.41 | -7.41 | 3.86 | 91.12 |
| 6 | Chronic obstructive pulmonary disease and bronchiectasis | 1281 | 75.00 | 4.18% | 56.83 | 18.17 | 5.86 | 131.97 |
| 7 | Congestive heart failure, non hypertensive | 781 | 70.00 | 3.90% | 87.36 | -17.36 | 8.96 | 80.13 |
| 8 | Acute myocardial infarction | 747 | 59.00 | 3.29% | 51.67 | 7.33 | 7.92 | 114.19 |
| 9 | Secondary malignancies | 1699 | 58.00 | 3.23% | 50.17 | 7.83 | 3.43 | 115.61 |
| 10 | Aspiration pneumonitis, food/vomitus | 146 | 49.00 | 2.73% | 43.75 | 5.25 | 33.56 | 112.01 |

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


HSMR - Peer Analysis Feb 16 to Jan 17
140
120
100
80
60
40
20
0
ULHT
South Tyneside NHS Foundation Trust
Salisbury NHS Foundation Trust
Southend University Hospital NHS...
Hampshire Hospitals NHS Foundation Trust
The Queen Elizabeth Hospital, King's Lynn,...
City Hospitals Sunderland NHS Foundation...
Wrightington, Wigan and Leigh NHS...
Norfolk and Norwich University Hospitals...
Northern Lincolnshire and Goole NHS...
Royal United Hospitals Bath NHS Foundation...
Ipswich Hospital NHS Trust
Torbay and South Devon NHS Foundation Trust
Burton Hospitals NHS Foundation Trust
Sandwell and West Birmingham Hospitals...
University Hospital Southampton NHS...
Bedford Hospital NHS Trust
Northumbria Healthcare NHS Foundation Trust
Central Manchester University Hospitals NHS...
The Newcastle Upon Tyne Hospitals NHS...
Pennine Acute Hospitals NHS Trust
Oxford University Hospitals NHS Foundation...
University Hospitals Coventry and...
Dorset County Hospital NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust
Barnsley Hospital NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust
University Hospitals Birmingham NHS...
Hull and East Yorkshire Hospitals NHS Trust
Airedale NHS Foundation Trust
Surrey and Sussex Healthcare NHS Trust
East Lancashire Hospitals NHS Trust
East and North Hertfordshire NHS Trust
Barts Health NHS Trust
Walsall Healthcare NHS Trust
Peterborough and Stamford Hospitals NHS...
Royal Free London NHS Foundation Trust
Poole Hospital NHS Foundation Trust
Croydon Health Services NHS Trust
Epsom and St Helier University Hospitals...
George Eliot Hospital NHS Trust
West Suffolk NHS Foundation Trust
Frimley Health NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Royal Surrey County Hospital NHS...
University College London Hospitals NHS...
Guy's and St Thomas' NHS Foundation Trust

## SHMI




The Trust is undertaking numerous strategies for Mortality Reduction:

- The first Lincolnshire Mortality Collaborative met on the 3rd May 2017; looking at cases with ULHT, CCG and GP that are mortalities within 48 hours of admission. From the first meetings actions are underway corroborating with Nursing homes and the community on appropriate admissions and delayed discharges. The format of the meetings have been agreed. An update on lessons will be included in the July Mortality matters Newsletter and an update to the committee in July 2017.
- Charlson Comorbidity Audit has been completed and being discussed as a separate item on the Patient Safety Committee Agenda for May 17. This will also be the first Lesson learned shared for the Mortality Matters Newsletter.
- 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 in May 2017.
- Governance in correlation with Information Support, Dr Foster and Coding are reviewing mortalities that have occurred from 2014 to ensure all comorbidities from prior admissions have been pulled through to the final admission and coded appropriately. This has been analysed and included within the Charlson Comorbidity Audit paper being presented in May 2017.
- The first MoRAG lessons learned Newsletter has been approved and is due for Publication. New software is being sourced by Quality Governance to be able to ensure that the information governance rules are adhered too and this requires a new version of Adobe. To allow the presentations to be readable within the Newsletter. The first Publication should be by the end of May 2017.
- Quality Governance are working with Dr Foster to understand Lincoln Site's HSMR, a report will be presented to Patient Safety Committee in May 2017.
- Intestinal hernia without obstruction has been an alerting diagnosis February to April 2017; an in-depth review is currently being undertaken; Quality Governance have sourced the notes and are meeting with Mr Pillai to facilitate the Audit.

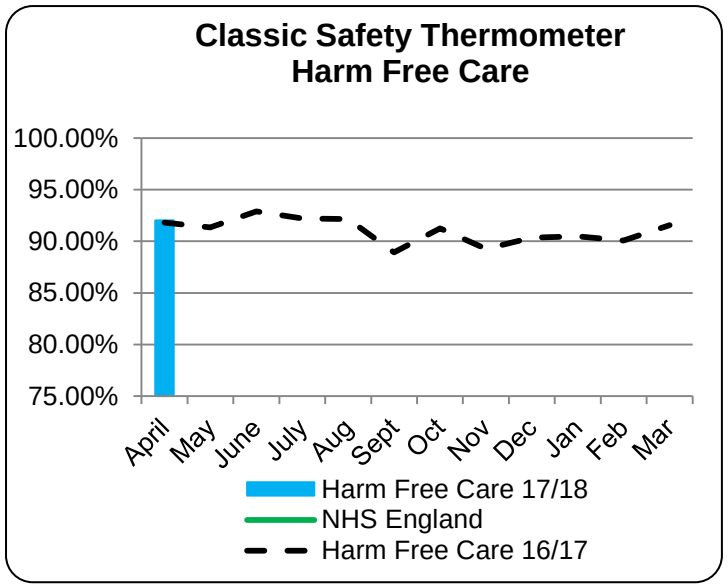
## Mortality Reviews

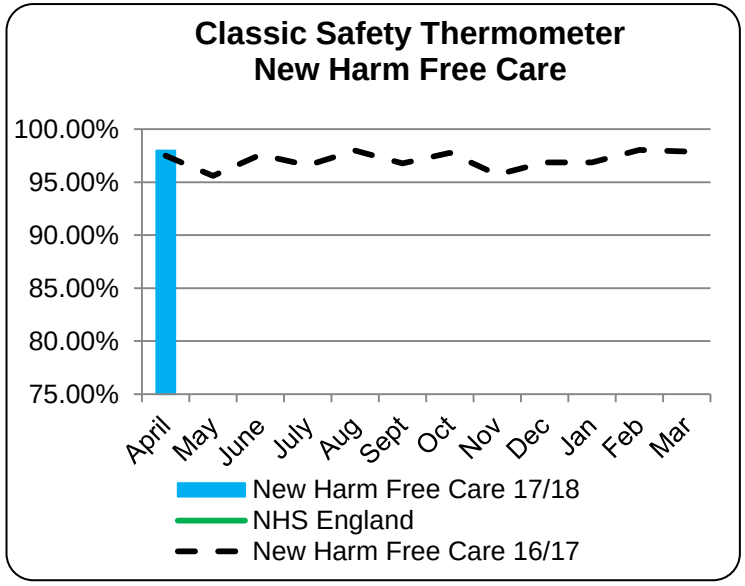
Reviews (Jan 2016-Apr 2017)

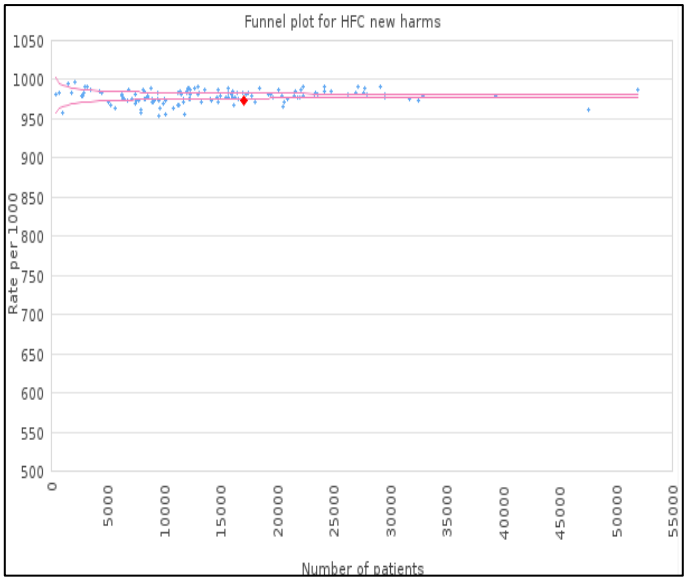
| Site | Deaths | Awaiting notes/Notes in Quality Governance | Notes Sent for Review | Review Complete | Review completion Compliance | Review Completion Target | Total Death % Reviewed |
|---|---|---|---|---|---|---|---|
| ULHT Total | 3872 | 748 | 3106 | 2224 | **72%** | **75%** | 57% |
| Lincoln Total | 2126 | 363 | 1756 | 1233 | **70%** | **75%** | 58% |
| Pilgrim Total | 1507 | 318 | 1178 | 840 | **71%** | **75%** | 56% |
| Grantham Total | 239 | 67 | 172 | 151 | **88%** | **75%** | 63% |

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

Executive Responsibility: Michelle Rhodes – Director of Nursing




**Performance Data Overview – February 2017 (March/April data unavailable from NHS Digital)**

| 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** | | **94.0%** | **97.8%** | **4.5%** | **1.0%** | **0.5%** | **0.7%** | **0.3%** | **0.4%** |
| Grantham | **85** | **95.3%** | **98.8%** | **3.5%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **1.2%** |
| Lincoln | **452** | **90.9%** | **97.8%** | **5.3%** | **0.4%** | **1.1%** | **2.2%** | **0.2%** | **0.7%** |
| Louth | **3** | **100.0%** | **100.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** |
| Pilgrim | **327** | **87.5%** | **98.2%** | **10.7%** | **1.2%** | **0.6%** | **2.1%** | **0.0%** | **0.0%** |
| **UHT Total** | **867** | **90.1%** | **98.0%** | **7.2%** | **0.7%** | **0.8%** | **2.0%** | **0.1%** | **0.5%** |

**April New Harms**

There were 9 NEW pressure ulcers
5 Falls with harm (all following admission)
2 Catheters with NEW UTI
2 NEW VTE

**Action Plan**

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

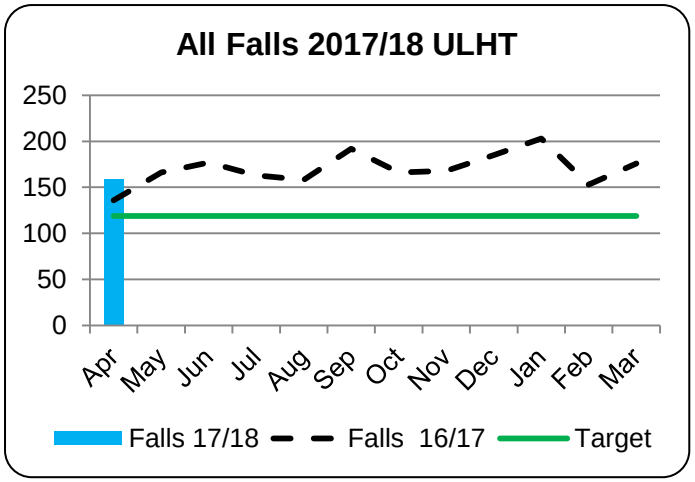
Fall actions outlined further in the report. Results reported upwardly to Falls Reduction Group with delegated authority from Patient Safety Committee.

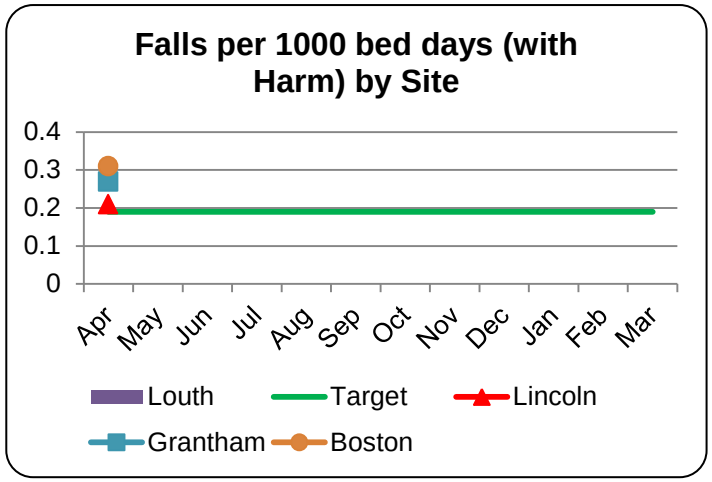
CA-UTI actions outlined further in the report. Results reported upwardly to Catheter Reduction Group with delegated authority from Patient Safety Committee.

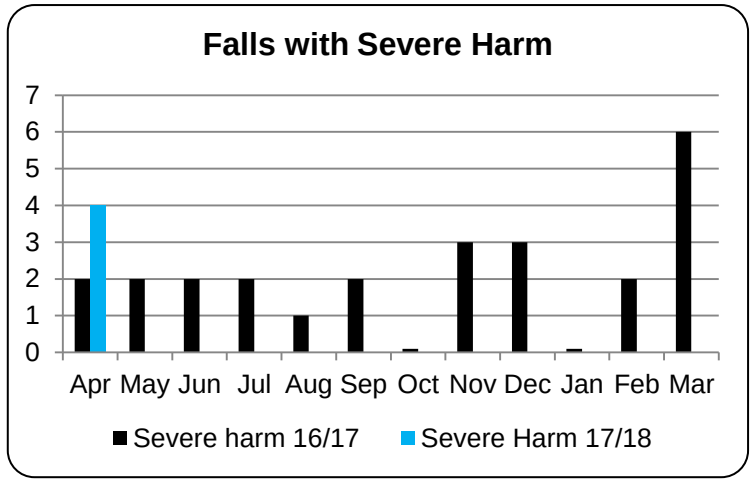
VTE investigated through Route Cause Analysis by VTE Nurse Manager and reported upwardly through Patient Safety Committee.

# Safe Ambition 3: Reduction of Harm Associated with Falls

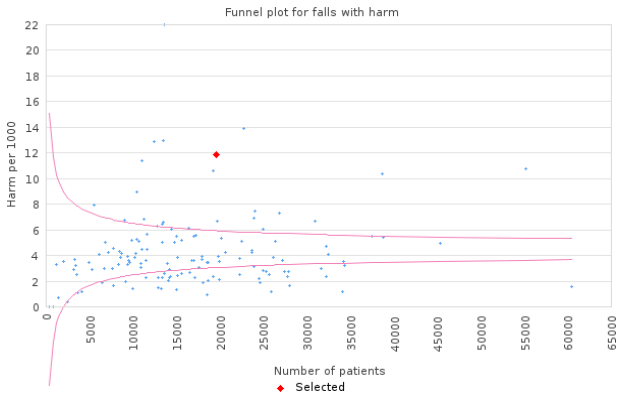
Executive Responsibility: Michelle Rhodes – Director of Nursing




**Safety Thermometer Feb 16- Feb 17**




**Safety Quality Dashbaord (SQD) for Trust Falls June 2016 – April 2017**

| Metric Title | Jun 2016 | Jul 2016 | Aug 2016 | Sep 2016 | Oct 2016 | Nov 2016 | De 2016 | Jan 2017 | Feb 2017 | Mar 2017 | Apr 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient at risk of falls | 360 | 344 | 336 | 338 | 344 | 318 | 284 | 325 | 333 | 344 | 312 |
| Actions completed within 4 hours | 90.60% | 93.00 % | 88.10 % | 87.40 % | 93.90 % | 90.50% | 88.00 % | 87.70% | 88% | 88.1% | 91.0% |
| Actions completed within 24 hours of admission | 42.40% | 46.50 % | 42.20 % | 49.20 % | 45.30 % | 38.50% | 48.50 % | 47.40% | - | 46.7% | 57.7% |
| Lying & standing BP completed | 55.60% | 58.00 % | 62.60 % | 67.10 % | 63.10 % | 61.90% | 61.00 % | 66.50% | 62.8% | 68.3% | 78.0% |
| Care plan 7 activated | 95.50% | 97.10 % | 96.40 % | 96.20 % | 93.80 % | 94.40% | 93.60 % | 95.30% | 95.4% | 91.4% | 97.7% |
| Neuro Cognition Assessed | - | - | - | - | - | - | - | - | - | 96.2% | 97.1% |
| Vision Assessed | - | - | - | - | - | - | - | - | - | 95.3% | 97.8% |
| Bed Rails Assessment | - | - | - | - | - | - | - | - | - | 98.6% | 99.7% |
| Continence/toilet regime documented | - | - | - | - | - | - | - | - | - | 76.4% | 92.9% |

**Performance Data Overview**

There have been 159 falls across ULHT in April 2017 (comparable to 136 in April 2016). There were 4 falls with Severe Harm (1 GDH, 1 LCH and 2 PHB). Falls per 1000 bed days and falls per 1000 bed days **with harm** has increased at LCH and GDH since March 2017.

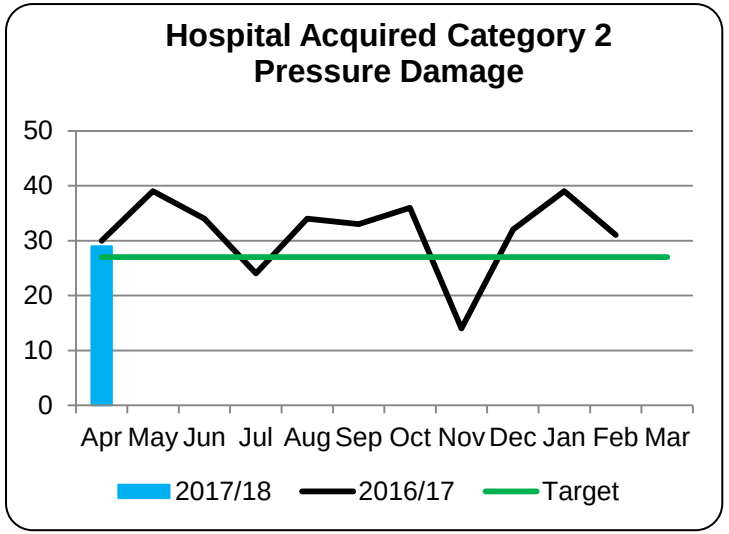
Of the 159 Falls 30 falls were repeat fallers. 15 Falls were recorded as near misses. The majority of actual falls (24) were classified as “From Height bed or chair”. There were 10 Falls on Stroke Unit LCH and 11 on Ward 6B PHB in April 2017.

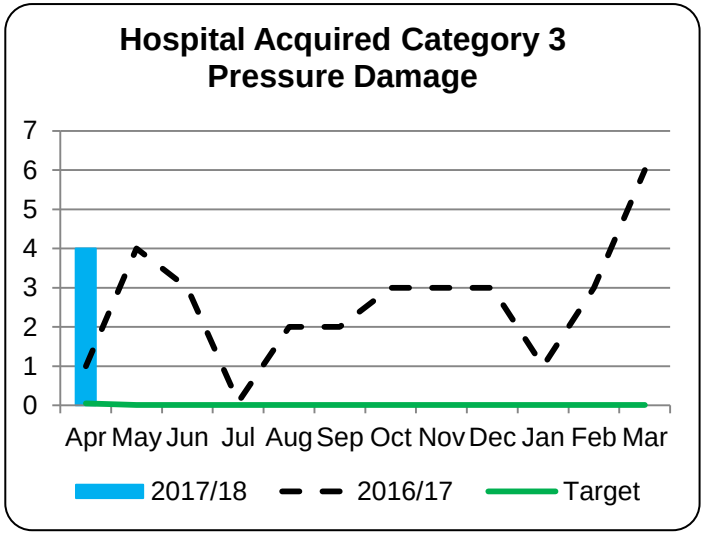
**Action Plan**

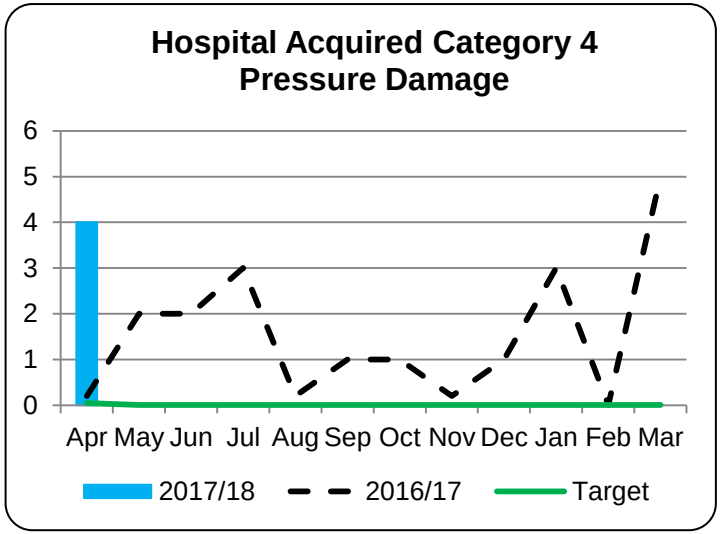
NHSi Collaborative work continues to implement PDSA cycles on Ward 3B and 6B at Boston to reduce Falls. PDSA cycles include the introduction of L&S BP stickers, automatic urine analysis, weekly falls reviews, patient wrist bands for those with history of falls and dedicated L&S BP training (>200 staff). Ward 3B has gone 35 days without a fall and both Ward 3B and 6B are achieving 100% compliance with the recording of lying and standing BP. These strategies are under evaluation and pilots are planned for wards at LCH and GSH. The Trust has registered to take part in the National Falls Audit in May 2017.

# Safe Ambition 4: Reduction of Harm Associated with Pressure Ulcers

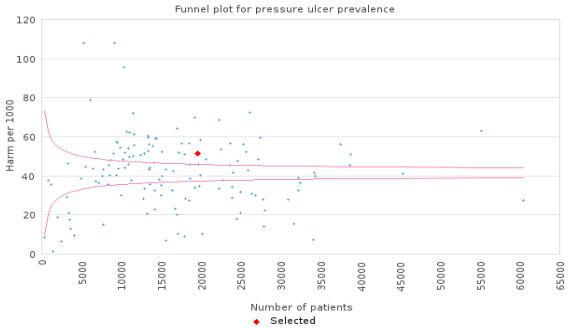
Executive Responsibility: Michelle Rhodes – Director of Nursing




### Safety Thermometer Feb 16- Feb 17




### Safety Quality Dashboard (SQD) for Trust pressure area care June 2016- April 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Pressure area risk assessment completed within 24hrs | 98.10 % | 99.00 % | 98.80 % | 98.80 % | 99.30 % | 98.80 % | 98.30 % | 97.50 % | - | 97.0% | 98.7 % |
| Pressure area risk assessment updated weekly | 78.00 % | 75.30 % | 76.00 % | 78.90 % | 80.70 % | 78.40 % | 72.00 % | 71.60 % | 77.4% | 76.7% | 80.5 % |
| Pressure-relieving equipment in situ if required | 92.30 % | 96.00 % | 93.50 % | 93.90 % | 96.60 % | 94.20 % | 95.50 % | 96.60 % | 93.4% | 94.0% | 96.2 % |
| Frequency of repositioning documented | - | - | - | - | - | - | - | - | - | 60.8% | 62.4 % |
| Prescribed frequency of turning has been followed for last 24 hours | - | - | - | - | - | - | - | - | - | 59.5% | 61.7 % |
| Pressure areas care wound dressing renewed | - | - | - | - | - | - | - | - | - | 52.4% | 59.7 % |
| Pressure area care plan activated if required | 93.80 % | 95.10 % | 92.10 % | 94.30 % | 88.80 % | 94.40 % | 92.90 % | 93.50 % | 91.1% | 91.5% | 94.7 % |

**Performance Data Overview**

In April there were the following grades of Hospital Acquired Pressure Damage:-
29 Grade 2
4 Grade 3
4 Grade 4
These figures represent a significant increase on performance in April 2016. Site breakdown to Grade 3/4 damage is:-

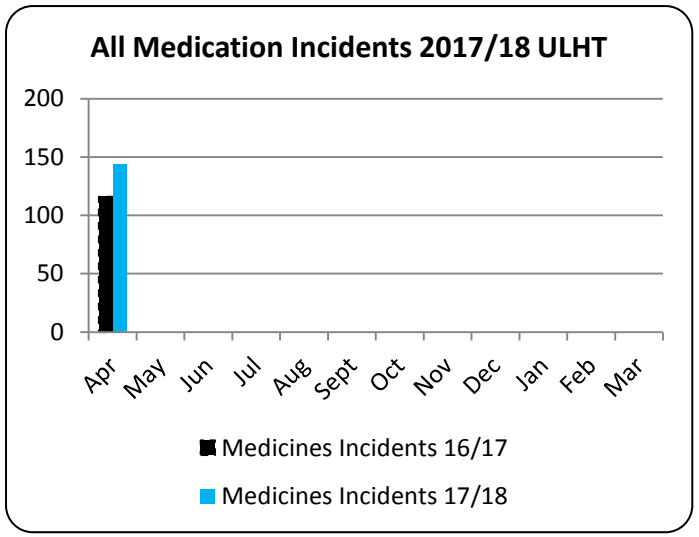
| | LCH | PHB |
|---|---|---|
| **Grade 3** | 1 | 3 |
| **Grade 4** | 3 | 1 |

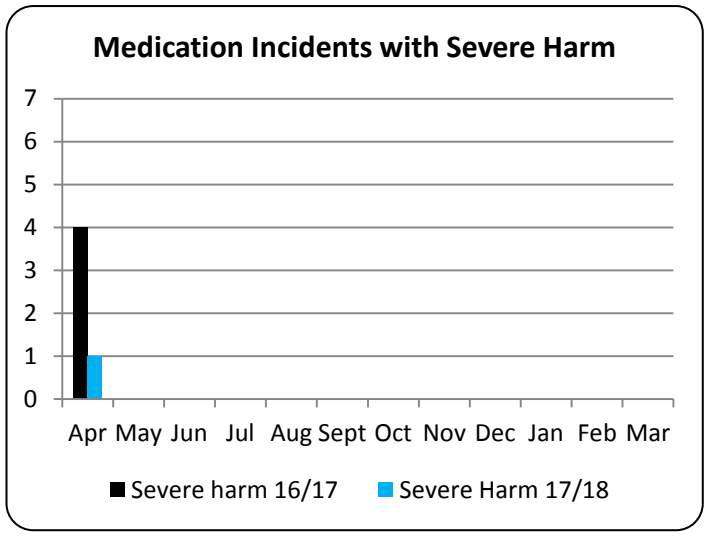
**Action Plan**

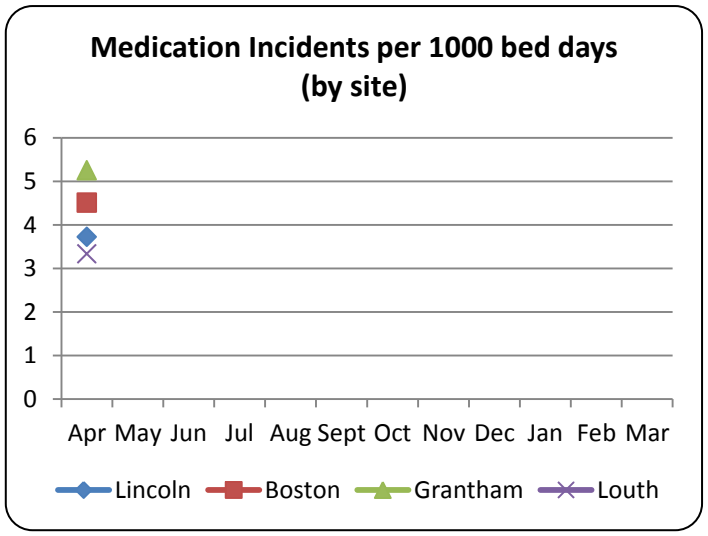
A full thematic review of 2016 Pressure Damage at Boston has been undertaken. Actions resulting from this thematic review are incorporated into the Trust Pressure Ulcer Improvement Plan which will be monitored through the ULHT Pressure Ulcer Prevention/Reduction Committee. Actions include additional bespoke ward education and updating HCSW. Review of pathway for patient non-concordance to ensure that risks are clearly outlined to patients and documented in full within patient notes. Reporting capabilities of Datix and PUNT are under review to ensure accuracy and assurance.
All pressure ulcers have diarised scrutiny panels planned.

# Safe Ambition 5: Reduction of Harm Medication Incidents

Executive Responsibility: Michelle Rhodes – Director of Nursing




**Trust Safety Quality Dashboard June 2016 – April 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicine chart demographics correct | 71.90% | 75.00% | 78.50% | 78.40% | 83.70% | 78.10% | 80.50% | 78.80% | 78.90% | 97.2% | 98.2% |
| Allergies documented | 95.50% | 96.80% | 98.10% | 98.80% | 98.20% | 99.40% | 98.40% | 98.10% | 99.40% | 99.4% | 98.7% |
| All medicines administered on time | 89.40% | 87.90% | 88.00% | 91.90% | 87.60% | 88.60% | 91.60% | 89.10% | 87.50% | 76.8% | 83% |
| Allergy nameband in place if required | 80.60% | 91.00% | 87.60% | 91.80% | 93.50% | 86.20% | 84.70% | 92.90% | 84.10% | 92.3% | 82.8% |
| Identification namebands in situ | 97.90% | 98.80% | 98.00% | 99.50% | 98.80% | 99.80% | 99.70% | 98.50% | 98.00% | 98.5% | 98.1% |

**Performance Data Overview**

Of the 144 incidents reported the majority (84.7%) were classed as resulting in no harm.

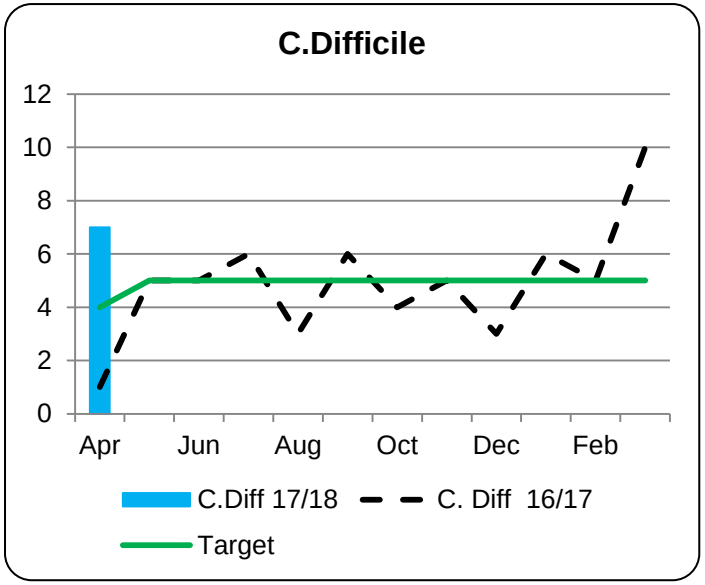
- 26% of the no harm incidents were due to omitted medicines. This is not to say that the potential for harm isn't there.
- 73 (51%) of all the events recorded were associated with priority/high risk drugs.
- 40 (28%) of all incidents reported were due to medicines being omitted.
- 20 (13.9%) incidents reported were due to prescriptions having wrong/unclear drug doses or strengths.

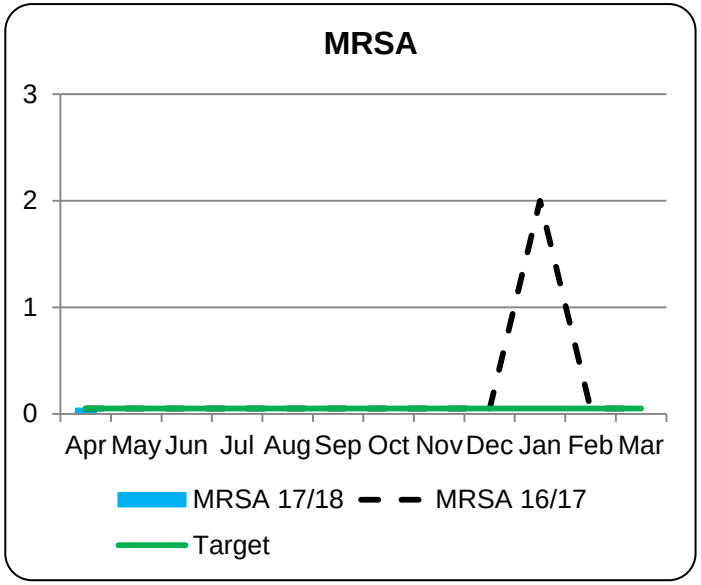
**Action Plan**

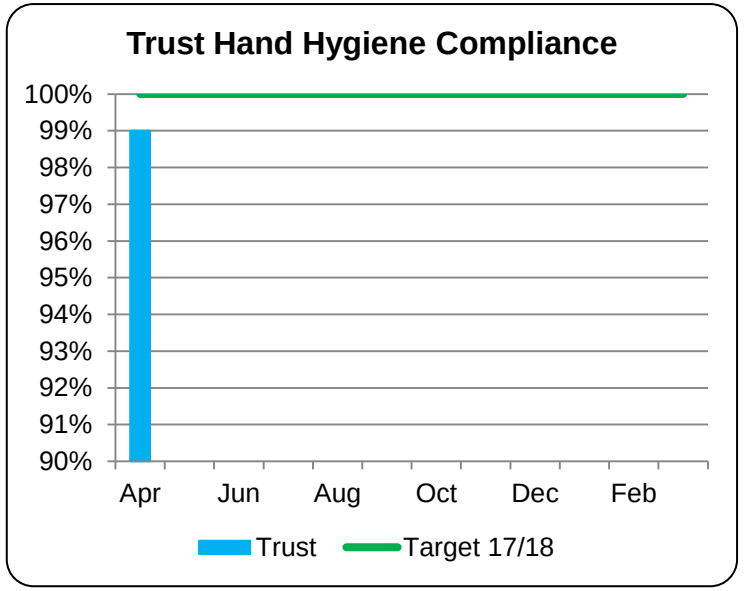
This medications error report is reviewed at the Medicine Optimisation and Safety Committee and all incidents are reviewed on a monthly basis to identify trends. All Heads of Nursing receive the errors by ward area and disseminate to their matrons who in turn disseminate to their ward leaders. These 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 April 2017 there were 7 confirmed C-Difficile. They were reported as follows:

| LCH | GDH | PHB |
|---|---|---|
| Stroke | Ward 6 | AMU |
| Neustadt Welton | | 8A |
| Navenby | | 5A |

0 MRSA cases were reported in April 2017.

Norovirus outbreak identified in April 2017 with several wards affected on all sites.

Hand hygiene for April 2017 by site is:-

| | |
|---|---|
| **Grantham** | 100% |
| **Lincoln** | 99% |
| **Louth** | 100% |
| **Pilgrim** | 98% |

**Action Plan**

Compliant assessment tool/review is undertaken for each patient with C-Difficile.

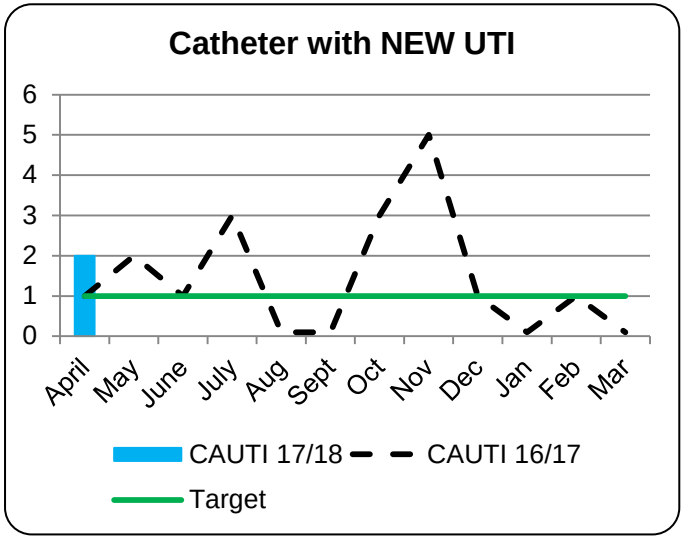
Route Cause Analysis is undertaken for each hospital acquired cases and an action plan put into place which is overseen by the Infection Prevention Committee.

Sampling has been inappropriate at times and IPC have requested staff speak with co-ordinator prior to sending so that it is not a repeat and complex cases are discussed with Consultant Microbiologist to ensure antibiotic prescribing is appropriate.

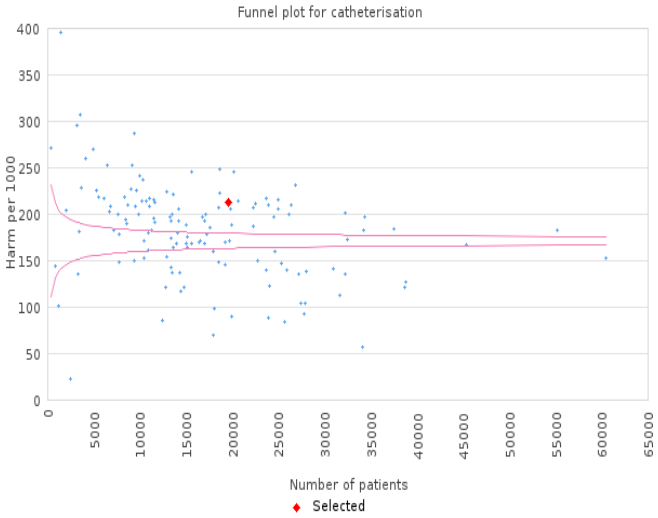
Documentation to be improved and IPC are requesting accurate stool charts to be completed to reflect patient patterns.

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

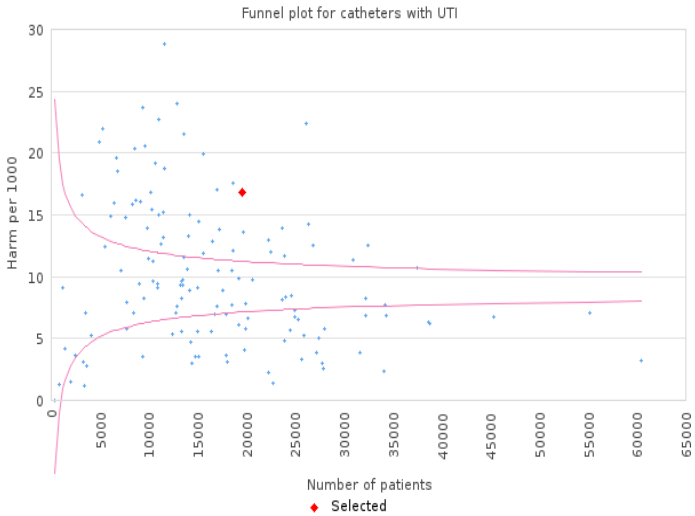
Executive Responsibility: Michelle Rhodes – Director of Nursing




Safety Thermometer catheters Feb 16 – Feb 17




Safety Thermometer CAUTI Feb 16 – Feb 17



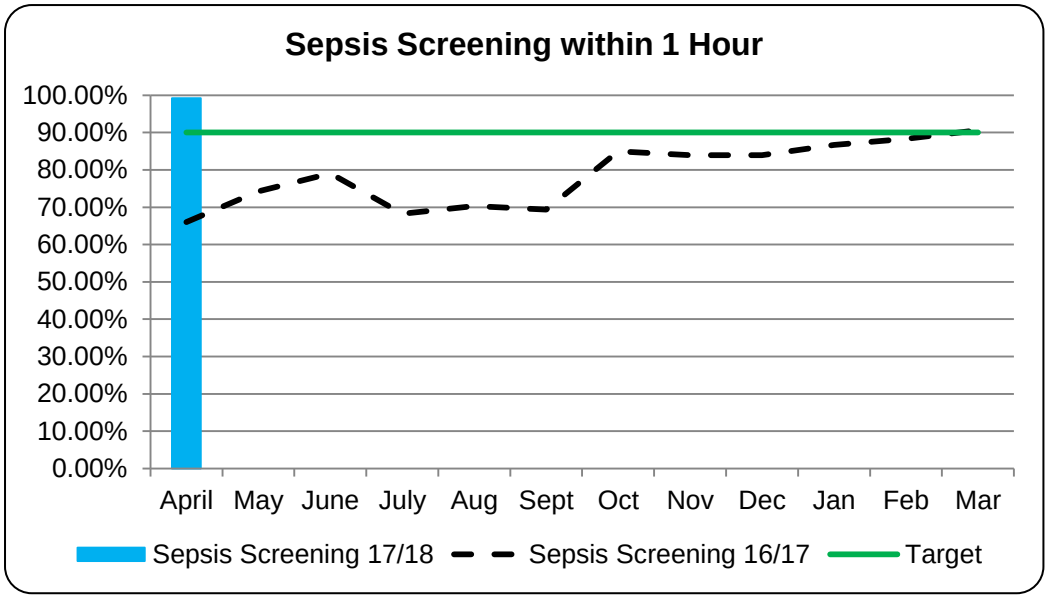

**Safety Quality Dashboard (SQD) for Trust pressure area care June 2016- April 2017**

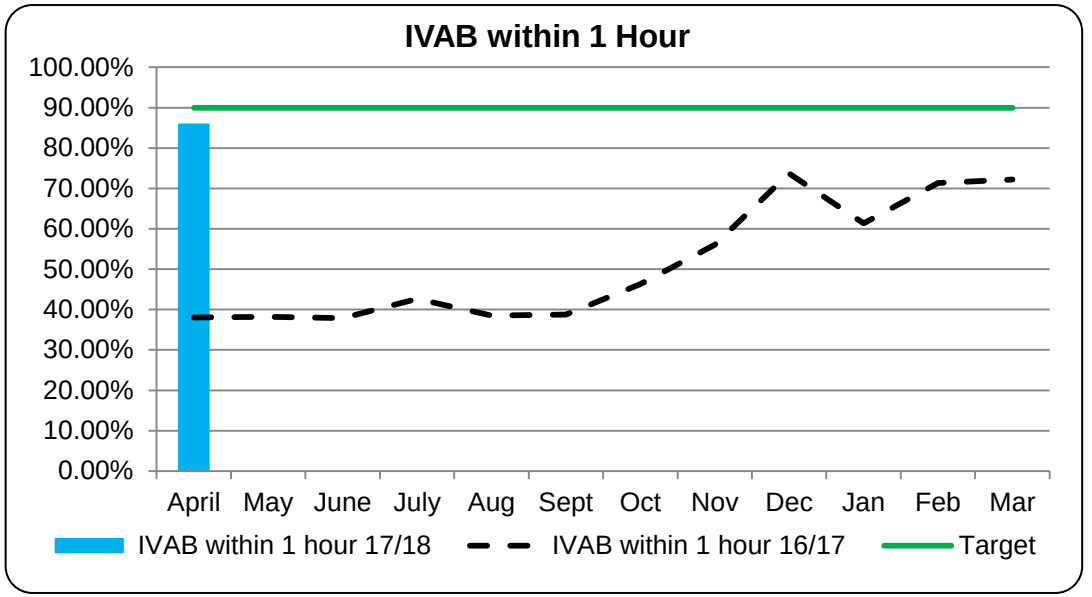
| Metric Title | Jun-2016 | Jul-2016 | Aug-2016 | Sep-2016 | Oct-2016 | Nov-2016 | Dec-2016 | Jan-2017 | Feb-2017 | Mar – 2017 | Apr – 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of urinary catheters in-situ | 74 | 75 | 81 | 63 | 72 | 81 | 53 | 67 | 84 | 80 | 85 |
| Urinary catheter record demographics correct | 84.9% | 90.4% | 95.0% | 96.8% | 86.1% | 98.8% | 90.2% | 94.0% | 92.8% | 96.1% | 97.6% |
| Urinary catheter record completed &signed daily | 57.5% | 57.5% | 72.2% | 65.1% | 65.3% | 72.2% | 58.8% | 68.2% | 73.8% | 54.5% | 67.5% |
| TWOC occurred within 3 days for acute retention | 50.0% | 36.4% | 40.0% | 50.0% | 40.0% | 58.3% | 50.0% | 66.7% | 40% | 25.0% | 36.4% |
| Documented evidence why catheter needed | 87.3% | 89.0% | 91.1% | 96.8% | 86.1% | 97.5% | 92.2% | 91.0% | 91.7% | 89.6% | 94.0% |
| Urinary catheter bags secure | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.5% | - | - | |
| Urinary catheter care plan activated | 82.2% | 87.5% | 88.6% | 90.5% | 83.3% | 90.1% | 88.2% | 88.1% | - | - | |

| **Performance Data Overview** | **Action Plan** |
|---|---|
| There were 2 catheters with NEW UTI in April 2017. These were on Wards 3B PHB and Ward 6 GDH. The patient on Ward 6 was not reviewed using the approved investigation tool as the patient had been discharged however, this will be undertaken retrospectively. Any amendment will be captured in future submission for recognition by GEM Arden and NHS England. | Nurse specialists continue to review all suspected catheters with NEW UTI as identified by the Safety Thermometer. Application submitted to the core learning panel for introduction of catheter care as mandatory module. E-Learning package to be adopted from BARD. Consideration being given to recording Catheter with NEW UTI on Datix. Average number of catheters in situ at PHB continues to parallel those at LCH despite differential in beds. Broader catheter audit undertaken by Patient Safety Lead to explore whether cause is attributed to rate of insertion or insitu duration, results to be fed back to Catheter Reduction Group. Catheter Reduction Group to be introduced as formal upward report to Patient Safety Committee. |

# 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 June 2016- April 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient observations on time and complete | - | - | - | - | - | - | - | - | - | 43.8% | 57.1% |
| Patient pain score complete | 98.3% | 98.1% | 97.5% | 98.3% | 98.8% | 98.8% | 98.6% | 98.7% | - | 16.2% | 19% |
| 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% |
| Patient observation frequency document on PfER | - | - | - | - | - | - | - | - | - | 75.7% | 84.2% |

**Performance Data Overview**

| Site | Bundle Commenced –Apr 17 | IVAB within 1 hour – Apr 17 |
|---|---|---|
| Grantham | 100% | 100% |
| Lincoln | 100% | 91.11% |
| Pilgrim | 97.78% | 75% |

Remedial plan at Boston evaluated to identify clear workstream leads and milestone dates. Non-compliance for all sites continues to be monitored and investigated through Trust Incident Reporting System.
Sepsis recorded on Risk Register ID3498 score 25.
Quarter 4 CQUIN Milestone results are:-
Inpatient Sepsis – partially achieved
A&E Sepsis – partially achieved

**Action Plan**

Continuous launch of Sepsis e-bundle in accordance with milestone plan. Training delivered by WebV ICT team and Sepsis Nurses.
Sepsis Patient Information leaflets launched on all adult inpatient wards and rebrand of SBAR disseminated to all clinical areas to improve quality and standardise handover.
Sepsis performance circulated by site weekly with numeric and percentage values.
Sepsis PODCAST.
Additional funding confirmed for temporary increase in Sepsis nurses

# Caring

| Metric | Reporting Frequency | Source | Target | YTD | Current Month | Last Month | Trend |
|---|---|---|---|---|---|---|---|
| **Caring** | | | | | | | → |
| | | | | | | | |
| **Friends and Family Test** | | | | | | | → |
| Inpatient (Response Rate) | Monthly | Envoy Messenger | 26% | 29.00% | 29.00% | 24.00% | ↑ |
| Inpatient (Recommend) | Monthly | Envoy Messenger | 96% | 91.00% | 91.00% | 92.00% | ↓ |
| A&E (Response Rate) | Monthly | Envoy Messenger | 14% | 22.00% | 22.00% | 19.00% | ↑ |
| A&E (Recommend) | Monthly | Envoy Messenger | 87% | 82.00% | 82.00% | 80.00% | ↑ |
| % of staff who would recommend care | | | | | | | |
| % of staff who would recommend work | | | | | | | |
| | | | | | | | |
| **Complaints** | | | | | | | → |
| No of Complaints received | Monthly | Datix | 70 | 55 | 55 | 54 | ↑ |
| No of Complaints still Open | Monthly | Datix | 0 | 239 | 239 | 237 | |
| No of Complaints ongoing | Monthly | Datix | 0 | 39 | 39 | 35 | |
| | | | | | | | |
| **Inpatient Experience** | | | | | | | → |
| Mixed Sex Accommodation | Monthly | Datix | 0 | 0 | 0 | 0 | → |
| eDD | Monthly | EDD | 95% | 86.19% | 86.19% | 79.86% | ↑ |
| 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% | 56.72% | 56.72% | 57.69% | ↓ |
| #NOF 48 hrs | Monthly | | 95% | 95.52% | 95.52% | 83.33% | ↑ |
| Dementia Screening | 1 month behind | | 90% | 94.16% | 94.16% | 91.30% | ↑ |
| Dementia risk assessment | 1 month behind | | 90% | 98.69% | 98.69% | 96.89% | ↑ |
| Dementia referral for Specialist treatment | 1 month behind | | 90% | 85.37% | 85.37% | 88.89% | ↓ |
| | | | | | | | |
| **Stroke** | | | | | | | → |
| Patients with 90% of stay in Stroke Unit | 1 month behind | SSNAP | 80% | 85.47% | 88.60% | 84.60% | ↑ |
| Sallowing assessment < 4hrs | 1 month behind | SSNAP | 80% | 69.83% | 69.10% | 69.10% | → |
| Scanned < 1 hrs | 1 month behind | SSNAP | 50% | 63.53% | 61.50% | 54.50% | ↑ |
| Scanned < 12 hrs | 1 month behind | SSNAP | 100% | 95.98% | 96.90% | 97.00% | ↓ |
| Admitted to Stroke < 4 hrs | 1 month behind | SSNAP | 90% | 66.14% | 59.10% | 61.90% | ↓ |
| Patient death in Stroke | 1 month behind | SSNAP | 17% | 13.26% | 15.90% | 14.10% | ↑ |

## Well-Led

| Metric | Reporting Frequency | Source | Target | YTD | Current Month | Last Month | Trend |
|---|---|---|---|---|---|---|---|
| **Well Led** | | | | | | | → |
| **Vacancies** | Monthly | ESR | 5.0% | 11.14% | 11.14% | 10.46% | ↑ |
| **Sickness Absence** | Monthly | ESR | 4.0% | 4.48% | 4.48% | 5.20% | ↓ |
| **Staff Turnover** | Monthly | ESR | 8.0% | 5.80% | 5.80% | 9.77% | ↓ |
| **Staff Engagement** | | | | | | | → |
| Staff Appraisals | Monthly | ESR | 95.0% | 68.00% | 68.00% | 65.00% | ↑ |
| **Equality Diversity and Inclusion** | | | | | | | |

# Workforce Headline Summary

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

## Statistics

| KPI | 2017/18 Target | April 2017 Performance | Last Month Performance | Performance in April 2016 | 6th Month Trend |
|---|---|---|---|---|---|
| Vacancy Rate For Specialties:<br>- Medical<br>- Registered Nurses<br>- AHPs | Medical – 12%<br>Reg Nursing – 11.5%<br>AHPs – 10% | **Medical 14.77%**<br>**N&M Reg 13.71%**<br>**AHP'S 13.73%** | **14.13%**<br>**13.09%**<br>**12.08%** | **N/A**<br>**N/A**<br>**N/A** |  |
| Voluntary Turnover | 7%, with no group of staff more than 20% above the overall target | **5.80%** | **N/A** | **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 by May following review that is underway | **91%** | **90%** | **81%** |  |
| Sickness Absence (12 month rolling average) | Overall target of 4.5% + no team over 25% above target | **4.70%** | **4.75%** | **4.54%** |  |
| Appraisals:<br>- Medical<br>- Non-Medical | Medical – 95%<br>Non-Medical – 85% | **N/A**<br>**68.22%** | **64.90%** | **64.23%** |  |
| Agency Spend | £21m | | | | |

**Commentary**

The key issue for April is our level of non-Medical appraisal. Given the focus on improving the appraisal rate, it is extremely disappointing that the rate is below that recorded when the CQC visited in October 2016. We have been following up with all managers where appraisals appear to be outstanding and have changed the way in which they are recorded to overcome a barrier that seemed to be in place. There is anecdotal evidence that in May the backlog of appraisals is being helped with, helped by the absence of systems for a few days.

The increase in the rate of sickness has been reversed in the last month, which is positive. The AHP vacancy rate has reduced, which is also positive, as this has been our initial focus on recruitment. Completion rates for core learning continue to rise (a trend over the course of the last year), which demonstrates the on-going drive to promote core learning, rather than any specific action (around scope of core learning, for example), as these have yet to be completed.

Our new pulse surveys will give us snap-shot data around leadership and engagement and that will be reported in August.

## Vacancy Rates

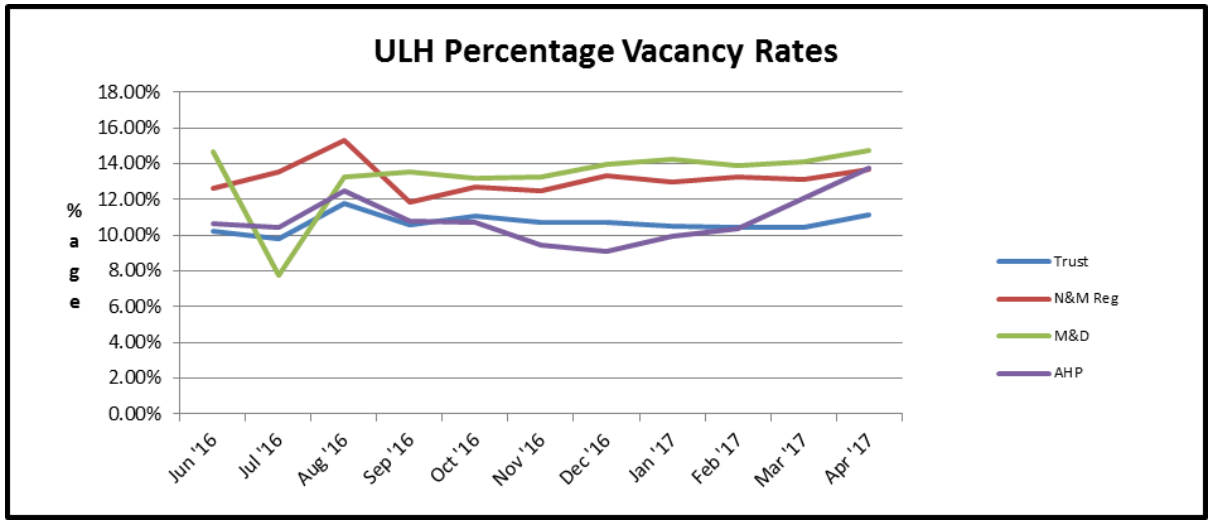
| | | | |
|---|---|---|---|
| **KPI:** | Vacancy rates | **Owner:** | Director of HR & OD |
| **Domain:** | | **Responsible Officer:** | Deputy Director of HR & OD |
| **Date:** | 30 May 2017 | **Reporting Period:** | April 2017 |
| **Target:** | Medical – 12%<br>Registered Nursing – 11.5%<br>AHPs – 10% | **Tolerances:** | Within 1% - Amber<br>Above 1% - Red |
| **RAG Rating:** | Medical 14.77%<br>N&M Reg 13.71%<br>AHP'S 13.73% | | |

**Analysis**

The current overall Trust rate (April) is 11.14%, which is an increase of 0.68% on March. The graph below shows that overall vacancies have increased by 0.97% over the last 11 months (10.17% to 11.14%).

Vacancy rates remain above the target and have increased since March for Medical staff and Registered Nurses. The rate for AHPs has declined, reflecting the efforts being made to recruit into roles where we have traditionally found recruitment to be easier.

At present 138.94 wte medical posts are vacant, out of a total of 940.73 wte established posts, and 311.86 wte registered nursing and midwifery posts are vacant compared to a total establishment of 2274.16 wte posts. The equivalent figure for unregistered nurses is 134.15 wte vacancies compared to the establishment of 971.62 wte posts. What we do know is that for a certain percentage of posts, recruitment will be underway (the figure for unregistered nurses is 50%).




It is worth noting that we have more doctors and registered nurses in post than we did 12 months ago, but the number of posts has also increased, leaving the vacancy rate unchanged. We have now recruited to the new recruitment strategy role in HR and have agreed at Workforce and OD Committee the recruitment plan for medical staff. It will take some time before this work starts to have a significant impact, but we would expect significant improvement in vacancy rates in the third quarter of the year. Based on this plan an "action taken/action planned" section will be added to the next performance report.

## Turnover

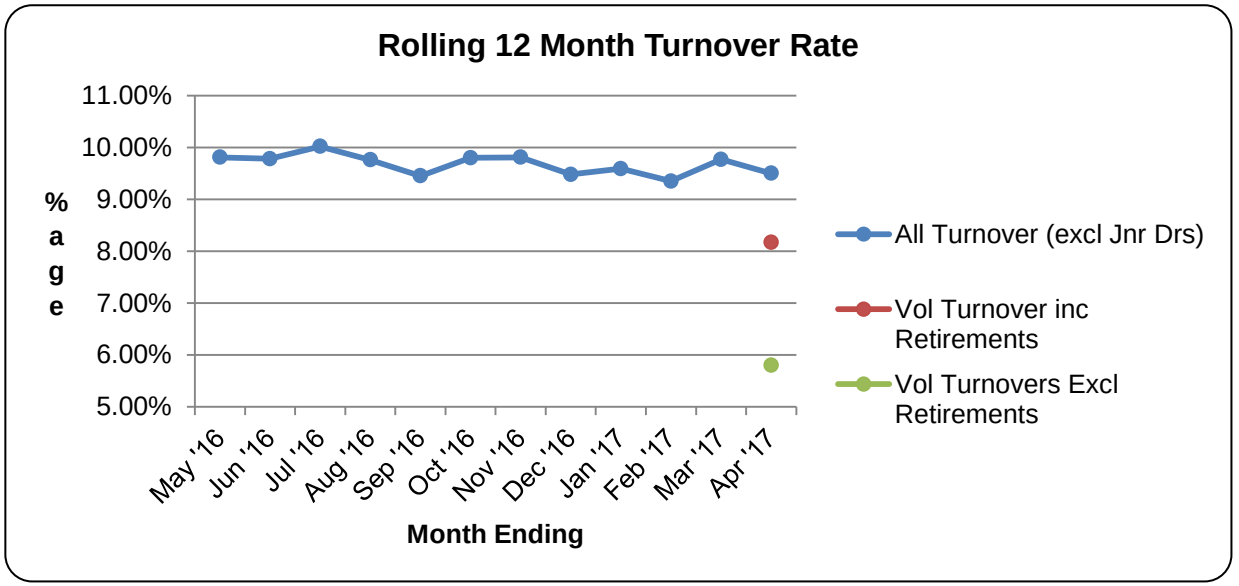
| | | | |
|---|---|---|---|
| **KPI:** | Voluntary Turnover | **Owner:** | Director of HR & OD |
| **Domain:** | | **Responsible Officer:** | Deputy Director of HR |
| **Date:** | 30 May 2017 | **Reporting Period:** | April 2017 |
| **Target:** | 7% (excl. retirements) with no group of staff more than 20% above the overall target | **Tolerances:** | Within 1% - Amber<br>Above 1% - Red |
| **RAG Rating:** | 5.80% | | |

**Analysis**

The current 12 month rolling average as at April '17 is 8.17% including retirements and 5.80% excluding retirements. This is the first month that turnover has been calculated in this way so comparison with previous months is not yet available. Of the leavers 26.43% was due to retirement and 63.32% 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 Medical & Dental, 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 | 13.43% | 11.21% |
| Additional Clinical Services | 6.77% | 4.75% |
| Administrative and Clerical | 7.56% | 5.48% |
| Allied Health Professionals | 15.87% | 13.90% |
| Estates and Ancillary | 6.57% | 3.43% |
| Healthcare Scientists | 10.78% | 5.49% |
| Medical and Dental | 8.45% | 5.93% |
| Nursing and Midwifery Reg | 7.69% | 5.29% |
| Students | 8.76% | 8.76% |
| **Total** | **8.17%** | **5.80%** |




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 9.50% at the end of April, which is a reduction of 0.27% on March.

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

- The current Trust turnover rate of 9.50% is below the average of 10.49%
- The current Trust Nursing & Midwifery (Registered) turnover rate of 8.12% is below the average of 11.08%,

- The current Trust AHP turnover rate of 17.46% 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.

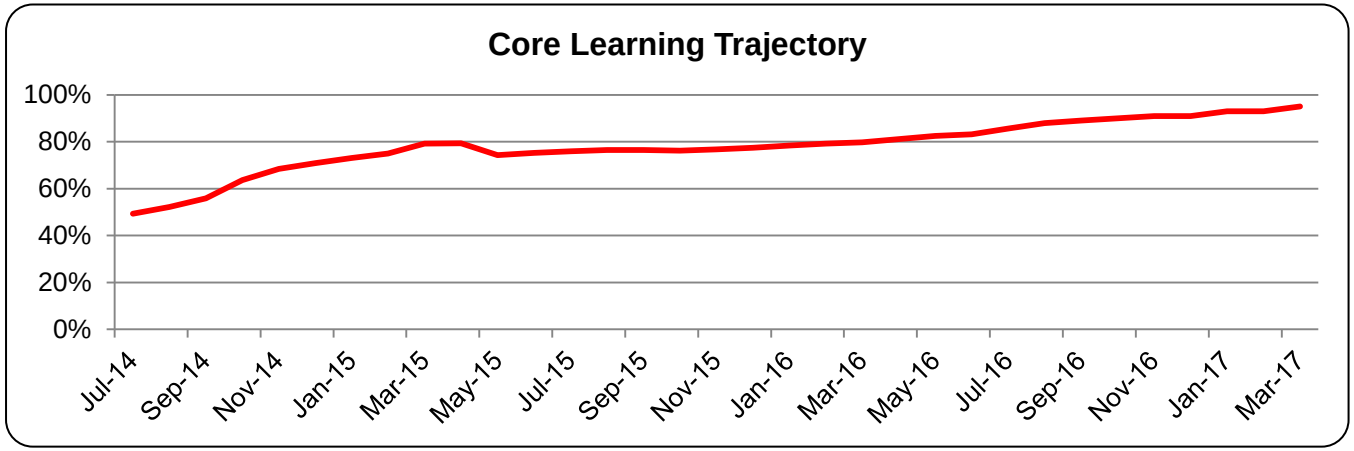
| **Action Taken** | **Action Planned** |
|---|---|
| • Workforce Scorecard comparative data has been shared with the Directors/Clinical Directors, which shows compliance against key workforce indicators | • We will utilise the data from the revised exit interview process to explore in more detail the reasons why employees are leaving the Trust, in particular areas such as Clinical Support Services, HR & OD and Nursing.<br><br>• We will be arranging meetings with Trusts in the East Midlands with better vacancy rates to identify 'best practice' and explore/identify option to improve our vacancy and turnover rates.<br><br>• 'Deep dives' will 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. |

## Core Learning Completion

| | | | |
|---|---|---|---|
| **KPI:** | Core Learning Completion | **Owner:** | Director of HR & OD |
| **Domain:** | | **Responsible Officer:** | Head of Transformational Change and Engagement |
| **Date:** | 30 May 2017 | **Reporting Period:** | April 2017 |
| **Target:** | Revised target to be set by May following review that is underway | **Tolerances:** | |
| **RAG Rating:** | 91% | | |

**Analysis**

The graph below shows a significant increase in the core learning compliance rate since 2014, and further improvement since 2016. The data shows a gradual increase with another 1% this month to 91%. The month's compliance is the highest since we started recording an average rate in 2014




| Directorate | March 2017 Average |
|---|---|
| Bostonian | 90% |
| Chief Executive | 85% |
| Chief Operating Officer | 88% |
| Clinical Support Services | 92% |
| Director of Estates & Facil | 89% |
| Director of Fin & Corp Affair | 96% |
| Director of HR & Org Dev | 96% |
| Director of Nursing | 95% |
| Director of Perf Improvement | 99% |
| Grantham | 93% |
| Integrated Medicine Boston | 85% |
| Integrated Medicine Lincoln | 88% |
| Medical Director | 94% |
| Surgical Services Boston | 89% |
| Surgical Services Lincoln | 89% |
| TACC Boston | 92% |
| TACC Lincoln | 93% |
| Women & Childrens Pan Trust | 92% |

Compliance for BLS has remained at 75% this month however this shows a big increase from 24% this time last year when it became core learning.

Annual topics for Fire and Infection Prevention increase by 1% this month. All core topics, apart from the newly introduced BLS, are now above 85%. And all 3 annual topics are between 15%-18% higher than this time last year.

Fire compliance is now 86% compared to 68% at the end of April 2016.

| Action Taken | Action Planned |
|---|---|
| • Introduction of a '5 click' DNA reports, which provide automatic compliance % by Ward/Department helping senior managers review DNA for areas within their ESR hierarchy | • 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.<br>• Review of core learning underway.<br>• Longer-term plan to introduce competency and skill matrices for key roles. |

## Sickness Absence

| | | | |
|---|---|---|---|
| **KPI:** | Sickness Absence | **Owner:** | Director of HR & OD |
| **Domain:** | | **Responsible Officer:** | Deputy Director of HR |
| **Date:** | 30 May 2017 | **Reporting Period:** | March 2017 |
| **Target:** | Overall target of 4.5% + no team over 25% above target | **Tolerances:** | Within 0.5% - Amber<br>Above 0.5% - Red |
| **RAG Rating:** | 4.70% | | |

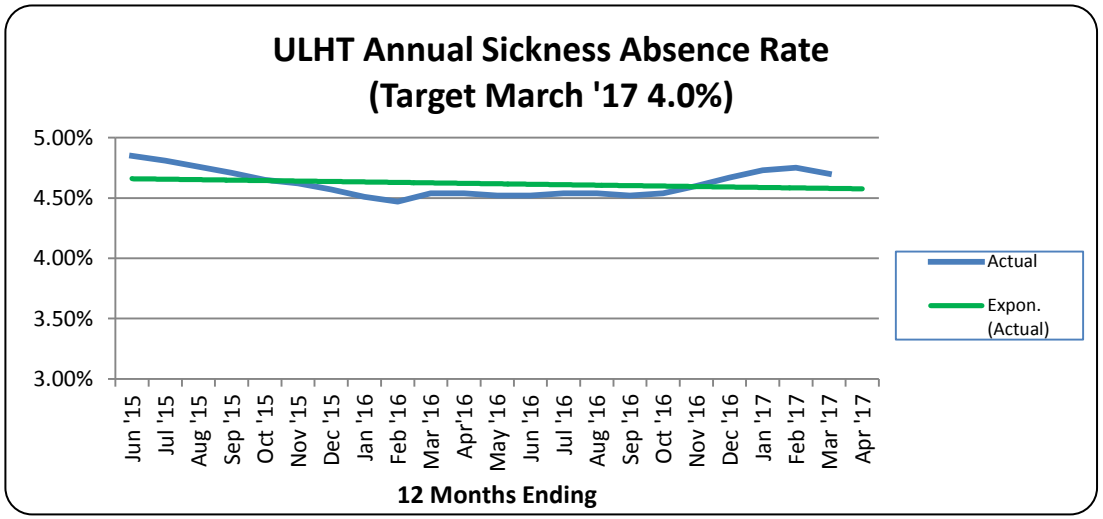
**Analysis**

The graph below shows that we had a slight increase in sickness over a 3 month period (Nov to Jan), however we are starting to see a downward trend in this regard.

The Trust annual rolling sickness rate of 4.70% (against 2016/17 target of 4%) as at the end of March 2017 has increased by 0.16% in comparison to the March 2016 figure (4.54%).

The table below shows that we did not end the financial year in the position we wanted to be and that sickness increased duirng 2016/17 in comparison with the previous year.

| 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 March 2017 is 4.48% down from 5.20% 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% compliance rate over the past 6 years.

During the 12 months ending March '17, Anxiety/Stress/Depression and other Psychological illness was the top reason for time lost due to sickness at 20.34% 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 7.21% (Unregistered Nurses 8.00%) followed by Estates & Ancillary at 6.59%, Additional Professional Scientific and Technical at 5.00% and Nursing & Midwifery Registered at 4.81%.

The latest Benchmarking data as at January 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 5.63%) against an average of 4.39%. 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. | • The 'Management Essentials for ULH' course is available to managers and the programme include how to manage absence as a Leader. This also include how to conduct challenging conversations.<br><br>• As part of the Annual Business Unit Operational Plans, Directorate and Team KPIs and targets are being identified/agreed, which will include sickness absence targets |

## Appraisals

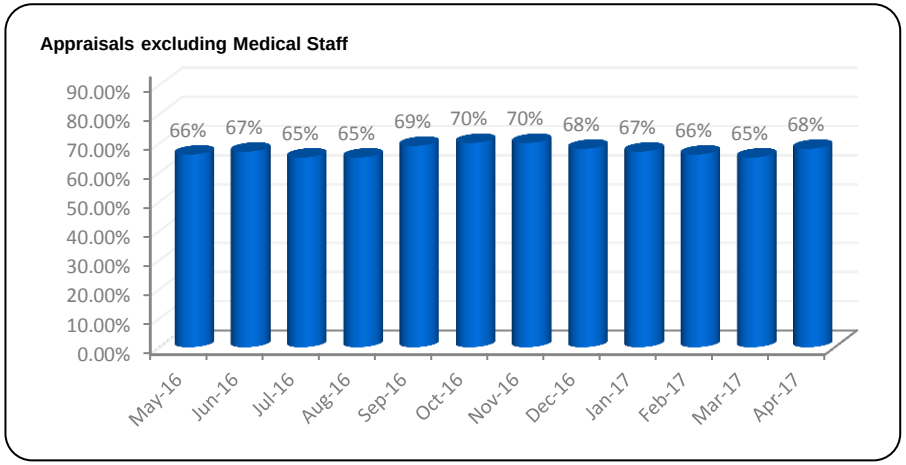
| | | | |
|---|---|---|---|
| **KPI:** | Appraisal Rates | **Owner:** | Director of HR & OD |
| **Domain:** | | **Responsible Officer:** | Head of Transformational Change and Engagement |
| **Date:** | 30 May 2017 | **Reporting Period:** | April 2017 |
| **Target:** | Medical – 95%<br>Non-Medical – 85% | | Within 5% below - Amber<br>More than 5% below - Red |
| **RAG Rating:** | Non-Medical - 68.22% | | |

**Analysis**

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

The graph below shows that the Agenda for Change Staff/Non-Medical Appraisal compliance rate for April is 68.22%. The overall percentage for appraisals has increased by 3.32% from the previous month end, however this is still 2.18% below the November 2016 figure of 70.40%.

Although we've seen a significant increase in the appraisal rate since 2014, the compliance rate over the last 12 months has remained in the 65% - 70% range. This is extremely disappointing and is a priority for improvement in the next two months.




The table below shows the compliance rate for the 12 month rolling period as at end of April. The data indicate the following:

- X1 Directorate has a compliance rate less than 50%
- X4 Directorates have a compliance rate between 50% and 65%
- X9 Directorates have a compliance rate between 65% and 80%
- The remaining X4 Directorates have a compliance rate above 80.00%

HR & OD is the only Directorate who has achieved the 85% appraisal compliance rate.

| Directorate | Appraisal Rate (Excludes Medical Staff) |
|---|---|
| *Director of Finance & Corporate Affairs* | 48.42% |
| *Director of Nursing* | 50.62% |
| *CSS Outpatient Management* | *51.15%* |
| Director of Estates & Facilities | 54.93% |
| TACC Lincoln | 59.53% |
| Integrated Medicine Boston | 64.52% |
| *CSS Diagnostics* | *65.06%* |
| Surgical Services Lincoln | 65.90% |
| Clinical Support Services | 66.17% |
| Medical Director | 67.33% |
| Integrated Medicine Lincoln | 68.16% |
| Chief Operating Officer | 69.57% |
| Women & Childrens' Pan Trust | 73.14% |
| Bostonian | 74.47% |
| Director of Performance Improvement | 77.59% |
| Surgical Services Boston | 77.71% |
| *CSS Therapies* | *81.18%* |
| Chief Executive | 81.82% |
| TACC Boston | 82.83% |
| Grantham | 83.46% |
| Director of HR & Organisational Development | 87.30% |

Appraisal Compliance rate (Year-on-Year) comparison:
March 2014 – 47.13%
March 2015 – 75.82%
March 2016 – 65.26%
March 2017 – 64.90%

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** |
|---|---|
| • We have reviewed our reporting template and processes to date, benchmarked against other Trusts with good practices and good appraisal compliance rates. As a result we have 'revamped' and simplified the ESR reporting template.<br><br>• Supervisor/Managers were contacted on behalf of the HRD on in all areas where staff have not had an appraisal in the last 13 months. Data /feedback received was uploaded onto ESR which has showed some improvement in the compliance figures.<br><br>• A new 'user guide' has been created to support the new reporting process on ESR.<br><br>• Workforce Scorecard containing appraisal data is shared on a monthly basis with Directorates for consideration/action. | • 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. |

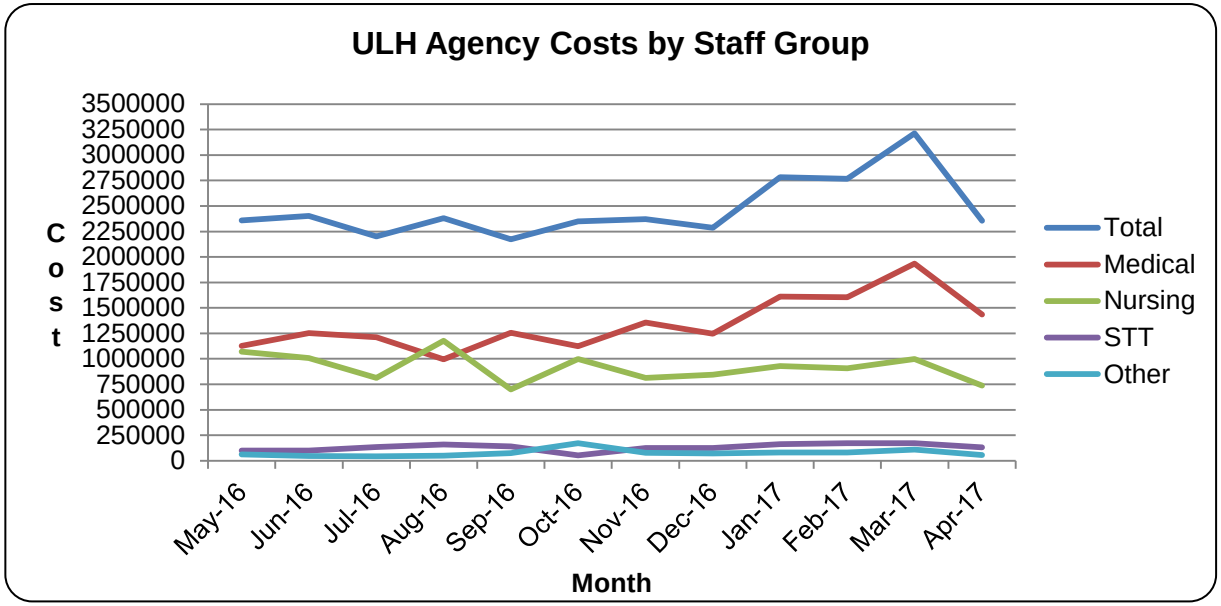
## Agency Spend

### Analysis

The table below shows spend on agency in the last 12 months. There has been a significant reduction in spend in April, across both medical and nursing. This is in part a consequence of the impact of the IR35 changes, but also the increased controls being exercised through the Nursing and Medical Utilisation Groups and the challenge sessions run by the COO and Director of Nursing. However this does follow a surge in agency spend in the final quarter of 2016/17 and spend in April 2017 is broadly the same as in April 2016, when our target through 2016/17 was to reduce spend significantly. There is no cause at this stage for celebration.

The total Agency cost in April was £2,356,230 which is a reduction of £857,368 from the previous month.

Agency pay expenditure on Medical Staffing in April was £1,433,258 a reduction of £499,700 from March.




The directorates with the highest Agency spend in April were Integrated Medicine Lincoln at £805,391 (March £962,732) and Integrated Medicine Pilgrim at £559,801 (March £736,609).

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

What will be particularly challenging is delivery of the £21m target (hence the Amber RAG rating) as this would require a 28% reduction in spend across all categories.

| Action Taken | Action Planned |
|---|---|
| • Plans developed for the reduction of nursing and medical agency spend, overseen by the Nursing and Medical Groups<br><br>• Weekly confirm & challenge meetings are held between Chief Operating Officer and Clinical Directors to discuss Agency Spend. | • CDs have been given 5 'areas' to adhere to, in order to bring down agency spend<br><br>• Actions around recruitment will impact on levels of agency spend, but potentially not until the second half of the year.<br><br>• The Agency Spend Reduction Plan will be considered by the Workforce and OD Committee in July |

# Money & Resources

| Metric | Reporting Frequency | Source | Target | YTD | Current Month | Last Month | Trend |
|---|---|---|---|---|---|---|---|
| **Money & Resources** | | | | | | | → |
| **Income v Plan** | Monthly | Board Report Master | 35771 | 32493 | 32493 | 36566 | ↑ |
| **Expenditure v Plan** | Monthly | Board Report Master | -40469 | -48872 | -48872 | -42054 | ↓ |
| **Efficiency Plans** | Monthly | FIMS report | 1341 | 0 | | 0 | → |
| **Surplus / Deficit** | Monthly | FPIC Finance Report | -4698 | -8836 | -8836 | -6946 | ↑ |
| **Capital Delivery Program** | Monthly | FPIC Finance Report | -375 | | | | |
| **Agency Spend** | Monthly | Agency Staff Analysis | -1790 | -2363 | -2363 | -3255 | ↑ |

# Finance Headline Summary

Executive Responsibility: Karen Brown – Interim Director of Finance

The Committee are asked to note the following main points:

- The Trust delivered a deficit of £8.8m compared to the control total of £4.7m
- The main movement from the plan is due to a shortfall on income of £2.1m on patient activities and £1.2m lost STF funding
- £0.8m overspend on expenditure due mainly to agency costs. The agency spend has reduced from March levels by £0.9m to £2.4m but this is still above plan levels.

| Measure | Plan to date | Actual to date | Annual Plan | RAG |
|---|---|---|---|---|
| Income | 35.8 | 32.5 | 441.8 | |
| EBITDA (£'m) | -3.4 | -7.5 | -29.6 | |
| Net surplus (£'m) | -4.7 | -8.8 | -48.6 | |
| Cash (£'m) | 1 | 2.1 | 1 | |
| Revenue Support Grant (£'m) | -116.8 | -116.8 | -152.1 | |
| Capital Expenditure (£'m) | 0.3 | 0.2 | 12.6 | |

The Trust has an agreed control total deficit of £48.6m for 2017/18.
The Month 1 position is a deficit of £8.8m against a plan of £4.7m. The performance has been impacted as a result of a low level of income linked to the lower than plan number of working days.

Despite a reduction in agency spend of £0.9m from March levels to an actual in April of £2.4m, this is still higher than plan leading to an overspend of £0.9m on pay.
As a consequence, the Trust will not be eligible for the M1 STF funding of £1.2m.
The Trust has delivered £0.2m of capital expenditure relating to projects that were near completion from last year.

**Performance**

- Year to date deficit is £8.8m compared to plan of £4.7m
- Cash holdings at the end of March are £2.1m
- Capex is £0.2m c.f. plan of £0.3m.

| Category | Metric | Period of Measure | Plan | Actual | Variance | RAG | Month minus 1 | Month minus 2 | Month minus 3 | Month minus 4 | Month minus 5 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Apr-17 | | | | Mar-17 | Feb-17 | Jan-17 | Dec-16 | Nov-16 |
| | | In Month | -4.7 | -8.8 | -4.1 | | -6.1 | -5.1 | -5.1 | -3.4 | -4.5 |
| I&E and | I&E Surplus/(Deficit) (£'m) | YTD | -4.7 | -8.8 | -4.1 | | -56.9 | -42.9 | -42.9 | -37.8 | -34.2 |
| Profitability | | In Month | -3.4 | -7.5 | -4.1 | | -5.5 | -3.9 | -3.9 | -2 | -3.3 |
| | EBITDA (£'m) | YTD | -3.4 | -7.5 | -4.1 | | -40.5 | -29.3 | -29.3 | -25.4 | -23.4 |
| | Cash (£m) | YTD | 1 | 2.1 | 1.1 | | 1.7 | 1.4 | 1.4 | 1.4 | 4 |
| Liquidity | Revenue Support Loan (£m) | YTD | -116.8 | -116.8 | 0 | | -116.8 | -98.8 | -98.8 | -94.2 | -89.2 |
| | Capital Expenditure (£m) | YTD | 0.3 | 0.2 | -0.1 | | | 8.9 | 8.9 | 8 | 7.3 |
| | Substantive,bank and overtime(WTE | YTD | 24.2 | 24.3 | 0.1 | | 285.7 | 261.8 | 237.9 | 214.2 | 190.3 |
| Workforce | Agency & Locum Staff (WTE) | YTD | 1.7 | 2.4 | 0.7 | | 29.4 | 26.1 | 23.3 | 20.5 | 18.2 |
| | Total | YTD | 25.9 | 26.7 | 0.8 | | 315.1 | 287.9 | 261.2 | 234.7 | 208.5 |

**Income & Expenditure**

- Patient level Income below plan due to underperformance on patient activity of £2.2m against the plan. The plan was built on an average number of working days from prior years. However, the actual number of working days was a lot lower.
- STF income of £1.2m not achieved due to underlying performance.
- Expenditure budgets are £0.9m over plan due to overspends against budget on agency.

**Financial Performance - April 2017**

**Trading Position**

**Month ending 30 April 2017**

| 2016-17 Year end £k | | 2017-18 Annual FIMS Plan £k | 2017-18 Annual Internal Plan £k | Year to Date | | |
|---|---|---|---|---|---|---|
| | | | | Internal Plan £k | Actual £k | Surplus/ (Deficit) £k |
| | **Income** | | | | | |
| 402,087 | Revenue from Patient Care Activities | | 405,307 | 33,268 | 29,812 | (3,456) |
| 35,202 | Other Operating Revenue | | 31,878 | 2,660 | 2,682 | 21 |
| 35 | Receipt of govt granted /donated | | 120 | 10 | 0 | (10) |
| **437,324** | **Total Income** | 0 | 437,305 | 35,938 | 32,493 | (3,445) |
| | **Expenditure** | | | | | |
| (315,131) | Pay | | (317,441) | (26,589) | (26,743) | (155) |
| (162,647) | Non Pay | | (151,032) | (12,587) | (13,271) | (685) |
| **(477,778)** | **Total Expenditure** | 0 | (468,473) | (39,175) | (40,015) | (839) |
| **(40,454)** | **Earnings before interest,tax,depreciation and** | | (31,168) | (3,237) | (7,522) | (4,285) |
| (51) | Profit/Loss(-) on disposals | | 0 | 0 | 0 | 0 |
| (11,733) | Depreciation | | (12,034) | (1,003) | (1,033) | (30) |
| 509 | Impairment | | 0 | 0 | 0 | 0 |
| (3,154) | PDC Dividend | | (3,681) | (307) | (154) | 153 |
| 47 | Interest Receivable | | 42 | 4 | 2 | (1) |
| (1,962) | Other interest payable | | (1,858) | (155) | (151) | 4 |
| (56,798) | **Surplus / (Deficit) for period** | 0 | (48,699) | (4,698) | (8,857) | (4,159) |
| **(13.0)%** | **Net Margin** | **#DIV/0!** | **(11.1)%** | **(13.1)%** | **(27.3)%** | **(14.2)%** |
| **(56,892)** | **Surplus / (Deficit) adjusted for impairment & impact of donated / govt granted assets** | **213** | **(48,486)** | **(4,680)** | **(8,836)** | **(4,156)** |

**Summary Statement of Financial Position**

- Cash position slightly better than plan at £0.9m so the Trust achieved the minimum £1m cash balance.
- The borrowings are £7m greater than plan due to the impact of missing the control total for 2016/17.

**Financial Performance - April 2017**

**Statement of Financial Position**

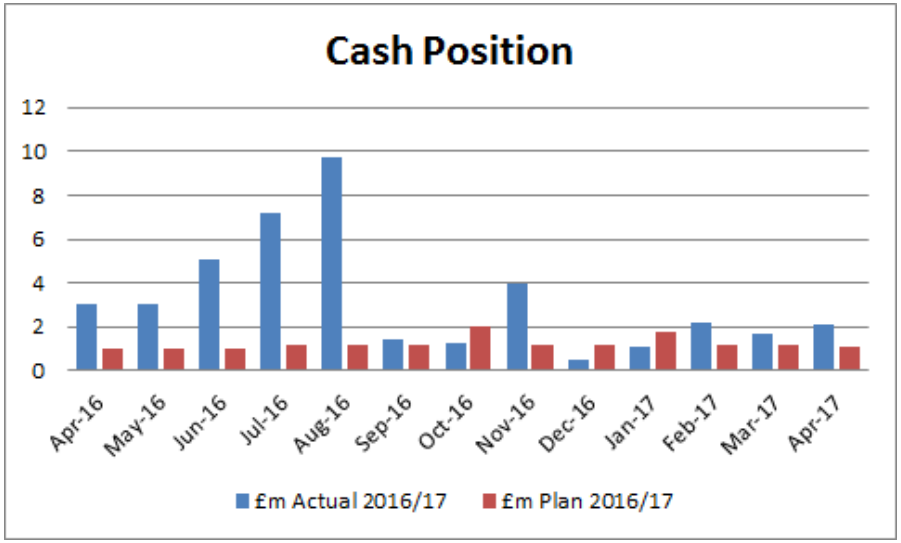
| | March 2017 | | April 2017 | | | |
|---|---|---|---|---|---|---|
| | Financial Plan submission April 16 £000s | Final Accounts £000s | Plan £000s | Actual £000s | Variance £000s | |
| **NON-CURRENT ASSETS:** | | | | | | |
| Property, Plant and Equipment | 239,285 | 221,161 | 220,176 | 220,447 | 271 | + |
| Intangible Assets | 5,124 | 6,052 | 4,811 | 5,937 | 1,126 | |
| Investment Property | 0 | 0 | 0 | | 0 | |
| Other Financial Assets | 0 | 0 | 0 | | 0 | |
| Trade and Other Receivables | 1,250 | 1,211 | 1,477 | 1,170 | (307) | + |
| **Total Non-Current Assets** | **245,659** | **228,424** | **226,464** | **227,554** | **1,090** | + |
| **CURRENT ASSETS:** | | | | | | |
| Inventories | 7,738 | 7,769 | 7,430 | 7,806 | 376 | + |
| Trade and Other Receivables | 21,914 | 24,280 | 22,422 | 23,598 | 1,176 | + |
| Other Financial Assets | 0 | 0 | 0 | | 0 | |
| Other Current Assets | 0 | 0 | 0 | 0 | 0 | + |
| Cash and cash equivalents | 1,000 | 1,675 | 1,100 | 2,074 | 974 | + |
| Subtotal | **30,652** | **33,724** | **30,952** | **33,477** | **2,525** | + |
| Non-Current Assets Held for Sale | 0 | 1,251 | 1,075 | 1,251 | 176 | + |
| **Total Current Assets** | **30,652** | **34,975** | **32,027** | **34,728** | **2,701** | + |
| **Total Assets** | **276,311** | **263,399** | **258,491** | **262,282** | **3,791** | + |
| **CURRENT LIABILITIES:** | | | | | | |
| Trade & Other Payables | (43,099) | (46,340) | (39,481) | (47,834) | (8,353) | - |
| Other Liabilities | (503) | (503) | (503) | (503) | (0) | - |
| Provisions for Liabilities and Charges | (1,218) | (1,516) | (1,433) | (1,410) | 23 | - |
| Borrowings | (118) | (284) | (119) | (118) | 1 | - |
| Liabilities arising from PFIs / LIFT / Finance Leases | (182) | 0 | 0 | (153) | (153) | - |
| **Total Current Liabilities** | **(45,120)** | **(48,643)** | **(41,536)** | **(50,018)** | **(8,482)** | - |
| **Net Current Assets /(Liabilities)** | **(14,468)** | **(13,668)** | **(9,509)** | **(15,291)** | **(5,782)** | +/- |
| **Total Assets less Current Liabilities** | **231,191** | **214,756** | **216,955** | **212,264** | **(4,691)** | +/- |
| **NON-CURRENT LIABILITIES** | | | | | | |
| Trade and Other Payables | **0** | 0 | 0 | | **0** | |
| Other Liabilities | (14,591) | (14,088) | (14,045) | (14,046) | (1) | - |
| Provisions for Liabilities and Charges | (2,485) | (2,926) | (2,610) | (3,102) | (492) | - |
| Borrowings | (178) | (212) | (110,809) | (59) | 110,750 | - |
| Other Financial Liabilities | 0 | 0 | 0 | | 0 | |
| Liabilities arising from PFIs / LIFT / Finance Leases | 0 | 0 | 0 | (152) | (152) | - |
| DH Working Capital Loan - FT Liquidity Loan | 0 | 0 | 0 | | 0 | |
| Working capital support facility | (18,382) | 0 | 0 | 0 | 0 | - |
| DH Revenue Support Loan | (35,618) | (110,548) | 0 | (116,768) | (116,768) | - |
| DH Capital Loan | 0 | 0 | 0 | | | |
| **Total Non-Current Liabilities** | **(71,254)** | **(127,774)** | **(127,464)** | **(134,127)** | **(6,663)** | - |
| **Total Assets Employed** | **159,937** | **86,982** | **89,491** | **78,137** | **(11,354)** | + |
| **FINANCED BY: TAXPAYERS EQUITY** | | | | | | |
| Public dividend capital | 251,746 | 255,663 | 256,746 | 255,662 | (1,084) | + |
| Retained Earnings | (148,225) | (212,874) | (209,893) | (221,625) | (11,732) | +/- |
| Revaluation reserve | 56,226 | 44,003 | 42,448 | 43,910 | 1,462 | + |
| Other reserves | 190 | 190 | 190 | 190 | 0 | +/- |
| **Total Taxpayers Equity** | **159,937** | **86,982** | **89,491** | **78,137** | **(11,354)** | + |

## Summary Statement of Cash Flow

- Cash position slightly better than plan, due to STF drawn down based on achieving Q4 finance element.
- The Trust has borrowings totalling £117m as at 30 April 2017.

**Cashflow**

| | April 2017 | | | |
|---|---|---|---|---|
| | Plan £000s | Actual £000s | Variance £000s | |
| **Operating Surplus / (Deficit)** | **(4,293)** | **(8,553)** | **(4,260)** | +/- |
| **Non Cash items to be excluded** | | | | |
| Depreciation / Amortisation | **1,023** | 1,032 | 9 | + |
| Impairments & Reversals | **0** | 0 | 0 | + |
| Receipt of Donated Assets | **(10)** | 0 | 10 | - |
| **Earnings before Interest Tax & Dividends (EBITDA)** | **(3,280)** | **(7,521)** | **(4,241)** | +/- |
| Interest paid | **0** | 185 | 185 | - |
| Dividends (Paid) / Refunded | **0** | 234 | 234 | - |
| Release of PFI/deferred credit | **0** | | 0 | |
| (Increase)/decrease in inventories | **0** | (37) | (37) | +/- |
| (Increase)/decrease in trade & other receivables | **(1,703)** | 723 | 2,426 | +/- |
| Increase / decrease in other current assets | **0** | 0 | 0 | +/- |
| Increase/(decrease) in trade & other payables | **(4)** | 3,321 | 3,325 | +/- |
| Increase/(decrease) in other current liabilities | **(42)** | (42) | 0 | +/- |
| Increase/(decrease) in provisions | **108** | 63 | (45) | +/- |
| **NET CASH IN/(OUT)FLOW FROM OPERATING ACTIVITIES** | **(4,921)** | **(3,073)** | **1,848** | +/- |
| **CASHFLOWS FROM INVESTING ACTIVITIES** | | | | |
| Interest received | **5** | 2 | (3) | + |
| (Payments) to acquire property, plant & equipment | **(2,624)** | (2,748) | (124) | - |
| (Payments) for intangible assets | **0** | 0 | 0 | - |
| (Payments) for Investments with DH | **0** | | 0 | |
| (Payments) for Other Financial Assets | **0** | | 0 | |
| (Payments) for Financial Assets (LIFT) | **0** | | 0 | |
| Receipts from disposal of property, plant & equipment | **0** | 0 | 0 | + |
| **NET CASH IN/(OUT)FLOW FROM INVESTING ACTIVITIES** | **(2,619)** | **(2,746)** | **(127)** | +/- |
| **NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING** | **(7,540)** | **(5,819)** | **1,721** | +/- |
| **CASHFLOWS FROM FINANCING ACTIVITIES:** | | | | |
| Revolving Working Capital Support Facility Accessed | **7,400** | 53,789 | 46,389 | + |
| Revolving Working Capital Support Facility Repaid | **0** | (53,789) | (53,789) | |
| Public dividend capital received : Capital | **0** | 3,917 | 3,917 | + |
| Public dividend capital received: Revenue | **0** | (1,099) | (1,099) | + |
| Public dividend capital repaid : Capital | **0** | 0 | 0 | - |
| Public dividend capital repaid: Revenue | **0** | (2,818) | (2,818) | - |
| Loans received from DH - New Capital Investment Loans | **0** | 0 | 0 | + |
| Loans received from DH - FT Liquidity Loans | **0** | | 0 | |
| Loans received from DH - Revenue Support Loans | **0** | 6,220 | 6,220 | + |
| Other Loans Received | **0** | | | |
| Loans repaid to DH - Capital Investment Loans Repayment of Principal | **0** | 0 | 0 | - |
| Loans repaid to DH - FT Liquidity Loans Repayment of Principal | **0** | | 0 | |
| Loans repaid to DH - Revenue Support Loans Repayment of Principal | **0** | 0 | 0 | - |
| Capital element of payments relating to PFI, LIFT and finance leases | **0** | (13) | (13) | - |
| Other loans repaid | **0** | 0 | 0 | |
| **NET CASH INFLOW/(OUTFLOW) FROM FINANCING** | **7,400** | **6,207** | **(1,193)** | +/- |
| **INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS** | **(140)** | **388** | **528** | +/- |
| **OPENING CASH BALANCE 1ST APRIL 2017** | **1,240** | **1,675** | **435** | |
| **CLOSING CASH BALANCE** | **1,100** | **2,063** | **963** | |

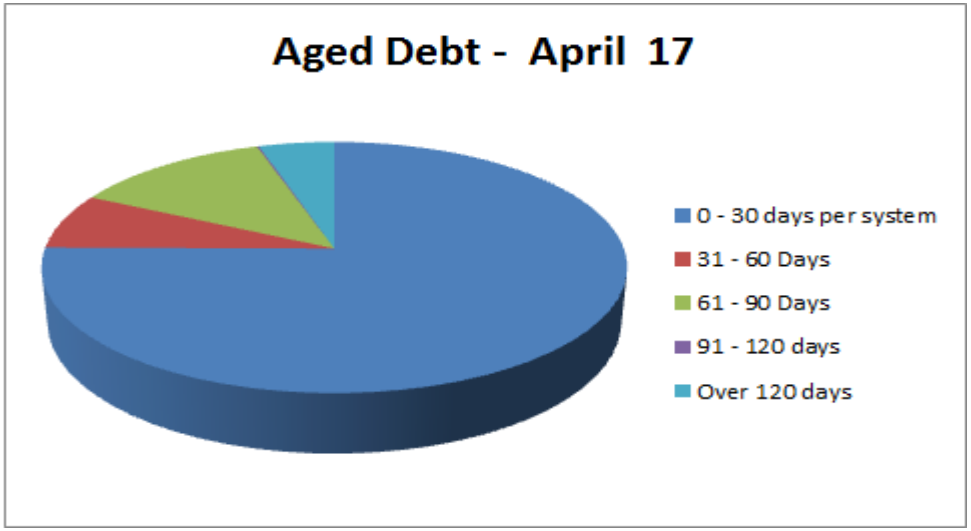


**Working Capital & Capital**

Capital – Expenditure of £0.2m relates mainly to the maternity project that had started last year.

Non NHS debt over 90 days totals £0.07m excluding those on payment plans. NHS debt over 90 days totals £0.5m. This is split as follows:

| | Over 90 days |
|---|---|
| CCGs - Lincolnshire | 33 |
| CCGs - Other | 288 |
| Trusts - Lincolnshire | 69 |
| Trusts - Other | 125 |
| **Total** | **515** |




| 2017/18 PERFORMANCE Against 30 Day Target for all suppliers compliance | Year to date 17/18 YTD Number | YTD Value £000s |
|---|---|---|
| **Non-NHS Creditors** | | |
| Total bills paid in the year | 7,505 | 12,668 |
| Total bills paid within target | 6,422 | 9,085 |
| Percentage of bills paid within target | 85.57 | 71.72 |
| **NHS Creditors** | | |
| Total bills paid in the year | 237 | 4,496 |
| Total bills paid within target | 201 | 3,735 |
| Percentage of bills paid within target | 84.81 | 83.07 |
| **Combined NHS & Non NHS** | | |
| Total bills paid in the year | 7,742 | 17,164 |
| Total bills paid within target | 6,623 | 12,820 |
| Percentage of bills paid within target | 85.55 | 74.69 |

# 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.**<br>**Q2:N/A**<br>**Q3:N/A**<br>**Q4: Providers should have implemented their initiatives as above** | Monthly collection, Quarterly reporting | Q1 - Achieved<br>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.**<br>**Q2: N/A**<br>**Q3: N/A**<br>**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.<br>Currenlty impelementing their initiatives for Q4 | | | | |
| 1c | Improving the uptake of flu vaccinations for frontline clinical staff | Stephen Kelly | **Q1: N/A**<br>**Q2: N/A**<br>**Q3: Achieving an uptake of flu vaccinations by frontline clinical staff of 75%.**<br>**Providers to submit cumulative data monthly over four months on the ImmForm website**<br>**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.**<br>**Q2: Achievement of Q2 target, to be set by CCG.**<br>**Q3: Achievement of Q3 target, to be set by CCG.**<br>**Q4: Achievement of Q4 target, to be set by CCG.** | Monthly collection, Quarterly reporting | Q1 - Partial<br>Q2 - Partial<br>Q3 - Partial<br>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.**<br>**Q2: Achievement of Q2 target, to be set by CCG.**<br>**Q3: Achievement of Q3 target, to be set by CCG.**<br>**Q4: Achievement of Q4 target, to be set by CCG.** | Monthly collection, Quarterly reporting | Q1 - Not achieved<br>Q2 - Not achieved<br>Q3 - Not achieved<br>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.**<br>**Q2: As quarter 1**<br>**Q3: As quarter 1**<br>**Q4: As quarter 1** | Monthly collection, Quarterly reporting | Q1 - Achieved<br>Q2 - Achieved<br>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.**<br>**Q2: Perform an empiric review for at least 50% of cases in the sample.**<br>**Q3: Perform an empiric review for at least 75% of cases in the sample.**<br>**Q4: Perform an empiric review for at least 90% of cases in the sample** | Monthly collection, Quarterly reporting | Q1 - Achieved<br>Q2 - Achieved<br>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 :**<br>**- Consultants, Registrars, Band 7s and Band 6s within Paediatric and A&E Level 3**<br>**- Consultants, Registrars, Band 7s and band 6s within Elderly Care Level 2**<br>**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.**<br>**Q2: N/A**<br>**Q3: N/A**<br>**Q4: Achieve 85% compliance by end Q4** | Quarterly | Q1 - Achieved<br>Q2 - N/A<br>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.**<br>**Q2: Trajectory to be set at Q1.**<br>**Q3: Trajectory to be set at Q1.**<br>**Q4: Trajectory to be set at Q1.** | Quarterly | Q1 - Awaiting outcome of appeal<br>Q2 - Achieved<br>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.**<br>**Q2: Agree & achieve Q1 trajectories for phase 1 - 3 wards.**<br>**Establish baseline for phase 4 wards. Commence rollout of audit activities to further high risk wards.**<br>**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.**<br>**Q4: Agree & achieve quarter 1 trajectories for phase 1 - 5 wards.** | Quarterly | Q1 - Achieved<br>Q2 - Achieved<br>Q3 - Achieved | | | | |
| 8a | End of Life: e-Learning | Dr Adam Brown | **Q1: Communicate to staff as per e-learning training plan.**<br>**Achieve trajectory set for Q1: . Set trajectory at the end of Q4 2015/16**<br>**Q2: As for Q1.**<br>**Q3: As for Q2**<br>**Q4: Achieve overall trajectory set in Q1** | Quarterly | Q1 - did not achieve target<br>Q2 - Did not achieve target - mapping completed<br>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.**<br>**Development of audit tool to demonstrate the impact of the training on the care given to patients dying on the ward.**<br>**Q2: Completion of ward based training programme on at least 3 wards at LCH/PBH and 2 wards at GDH.**<br>**Q3: Completion of ward based training programme on at least 4 wards at LCH/PBH and 3 wards at GDH.**<br>**Q4: Completion of ward based training programme on at least 6 wards at LCH/PBH.**<br>**Completion of audit tool and a summary report.** | Quarterly | Q1 - Achieved<br>Q2 - Achieved<br>Q3 - Achieved | | | | |
| 8c | End of Life: Link Practitioner | Dr Adam Brown | **Q1: Continue quarterly Link Practitioner meetings on all 3 sites.**<br>**Deliver Palliative Care training day for Link Practitioners.**<br>**Q2: As for Q1. Develop new resource folder for hospital wards.**<br>**Q3: As for Q1. Develop new resource folder for hospital wards.**<br>**Q4: As for Q1. Continue quarterly LP meetings on all sites.** | Quarterly | Q1 - Achieved<br>Q2 - Achieved<br>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.**<br>**Q2: Same as above for Gastro.**<br>**Q3: Same as above for Lung.**<br>**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<br>Q2 - Achieved<br>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.**<br>**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<br>Q2 - Achieved<br>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.**<br>**Q2: Achievement of Q2 target.**<br>**Q3: Achievement of Q3 target.**<br>**Q4: Achievement of Q4 target.** | Quarterly | Q1 - Achieved<br>Q2 - Achieved<br>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%**<br>**Q2: As above**<br>**Q3: As above**<br>**Q4: Compliant recruitment on Haemtrack from 70% to 95% (number of patients) as a proportion of targeted compliant recruitment.** | Quarterly | Q1 - Achieved<br>Q2 - Achieved<br>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 |