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United Lincolnshire Hospitals NHS
NHS Trust

UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 31st MARCH 2017

Document management

Title:	Integrated Performance Report
To:	Trust Board
Executive Lead:	Karen Brown, Interim Director of Finance
From:	Amanda Brown, Assistant Director of Commissioning & Performance
Author:	Katherine Etoria, Planning & Performance Manager
Date:	9th May 2017

Purpose of the Report:

To update the committee on the performance of the Trust for the period ended 31st March 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	Endorsement	

Recommendations:

The Board is asked to note the current performance and future performance projections. The Board is asked to approve action to be taken where performance is below the expected target.

This is an evolving report and the Board are invited to make suggestions as we continue to develop it.

Strategic Risk Register **New risks that affect performance or performance that creates new risks to be inserted here.**	**Performance KPIs year to date** **As detailed in the report.**

Resource Implications (e.g. Financial, HR) None
Assurance Implications: The report is a central element of the Performance Management Framework
Patient and Public Involvement (PPI) Implications None
Equality Impact None
Information exempt from Disclosure None
Requirement for further review? The Integrated performance dashboard will be updated on a monthly basis.

Integrated Performance Report for the Period to 31st March 2017

1. Executive Summary for period of 31st March 2017

March Headlines

Safe

- Lincoln site's HMSR to be reviewed and reported to the May Patient Safety Board.
- 10 cases of Clostridium Difficile (C.Diff) reported in March.
- Continued improvement in core learning, currently at 90%.

Caring

- EDD (raised by Commissioners), PPCI, Fractured NOF all require remedial action plans.
- Stroke performance continues below target, remedial action plans required.

Responsiveness

- A&E 4 hour waiting time – performance 78.83%.
- 18wk RTT Incomplete Standard – March unvalidated performance is currently at 86.96%.
- 6wk Diagnostic Standard – March performance was 99.74%.
- 4 of the 9 national cancer targets were achieved in February 2017.

Effective

- Mortality Review Compliance at Lincoln is below target and requires follow up
- Action plans to address the partial booking waiting list backlog have been agreed.

Well-Led

- Continued high level vacancies.
- Staff appraisal rates significantly off target, no improvement demonstrated.
- Increased sickness absence rate compared to rolling average.

Money and Resources

- Income v expenditure deficit is £56.9m against control total of £47.9m.
- Capital resource limit delivered.

Successes:

Four out of the 9 national cancer targets have been met this month which is an improved position from last month (January 2017). Notably the 31 day subsequent drug treatment target achieved 100%, against the national target of 98%.

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

The capital resource limit was delivered

There were no mixed sex accommodation breaches during March 2017.

Challenges:

Performance against the 2ww Breast target continues to be challenging. Demand against the breast 2ww referrals continues to be in the region of 144 referrals per week compared to a baseline service capacity of 100 slots per week. This is being escalated with Commissioners.

Ten cases of Clostridium Difficile (C.Diff) were reported in March compared to five cases reported in the previous month. Whilst this is disappointing the year to date figure is aligned to the annual target of 59 cases.

The Friends and Family Test performance against response rates continues to underperform although there was slight improvement on the inpatient response rate for March at 24%, just 2% behind the target of 26%. The CQC Inspection highlighted that the Trust's Friends and Family Test performance was generally worse than the England Average between October 2015 and September 2016.

RTT performance continues to be a performance issue. In February the Trust reported performance of 88.3%, with the backlog of patients over 18 weeks dropping below 3,000 for the first time since August 2016. At a national level the standard has not been achieved for twelve consecutive months, with an aggregated national performance in February of 90%. Two weeks prior to the final submission for March the Trust's performance level was 86.3%. It is expected that performance will improve prior to the final submission, with a forecast final position in the region of 88.2% - 88.7%.

A&E performance for March was 78.83% an improvement from February (75.22%). Medical rotas continue to be exceedingly difficult to staff particularly in the context of IR35 which has required new models of specialty working the impact of which will be reported in Aprils report.

Recruitment to continues to be the key focus for the Trust which is now being addressed through the People strategy and Executive focus on the medical and nursing shortfalls.

The Trust will be a reporting an Income and Expenditure deficit of £56.9m but has received CCG Agreement of Balances disputes of £3.1m in April. There is no provision for the disputes which will result in escalation to regulators

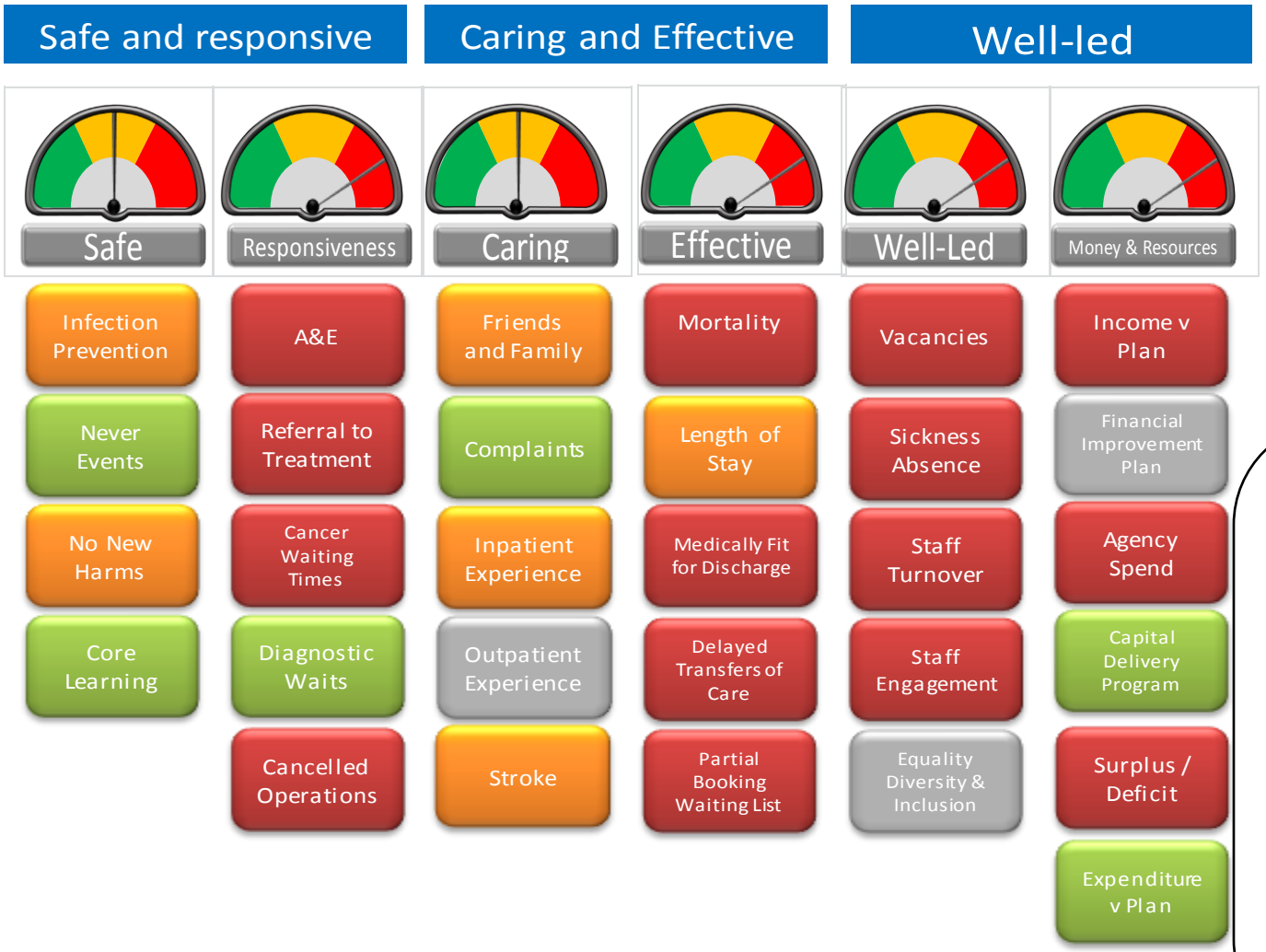
The publication of the CQC Report on Tuesday, 11th April recommended that overall the Trust be placed into special measures following the CQC Inspection during October 2016.
Site based publications found the Pilgrim Hospital to be “Inadequate” Lincoln County Hospital to “Require Improvement” and Grantham Hospital as “Good”.

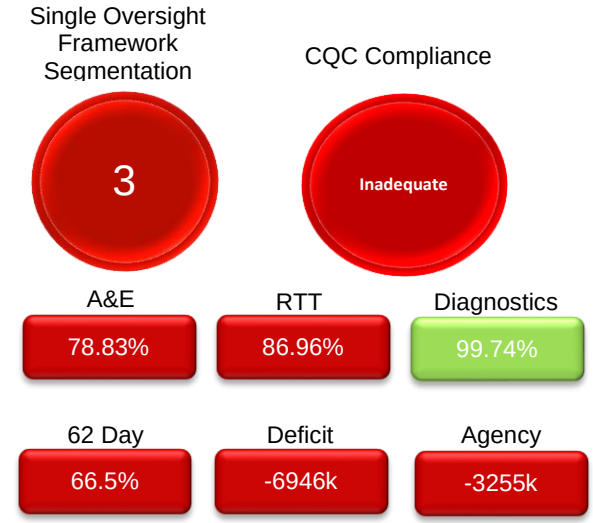
Karen Brown
Interim Director of Finance & Corporate Affairs
April 2017

2. Integrated Performance Report

Integrated Performance Report - Headlines

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





Most deteriorated:

Domain: Responsiveness
In February there was a 17.5% deterioration in the 2ww breast symptomatic cancer standard

Domain: Safe
In March there were 10 cases of Clostridium Difficile (C.Diff) reported compared to 5 in February

Most improved:

Domain: Caring
There were 0 Mixed Sex Accommodation breaches in March compared to 8 in February

Domain: Responsiveness
In March there were 11 less 104+ day cancer patients on the 62 day pathway compared to February

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

3. Detailed Trust Board Performance Dashboard

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Safe							
Infection Control							
Clostrum Difficile (post 3 days)	Monthly	Datix	59	59	10	5	
MRSA bacteraemia (post 3 days)	Monthly	Datix	0	2	0	0	
MSSA	Monthly	Datix	24	18	0	0	
ECOLI	Monthly	Datix	96	62	6	3	
Never Events	Monthly	Datix	0	1	0	0	
No New Harms							
Serious Incidents reported (unvalidated)	Monthly	Datix	TBC	48			
Harm Free Care %	Monthly		95%	90.97%	91.60%	90.08%	
New Harm Free Care %	Monthly		98%	97.07%	97.90%	98.04%	
Catheter & New UTIs	Monthly		2	1	1	1	
Falls	Monthly	Datix	0.19	0.25	0.23	0.37	
Medication errors	Monthly	Datix	0	1075	108	102	
Medication errors (mod, severe or death)	Monthly	Datix	0	132	18	16	
Pressure Ulcers (PUNT) 3/4	Monthly						
VTE Risk Assessment	Monthly		95%	94.34%	97.95%	97.86%	
Overdue CAS alerts	Monthly						
SQD %	Monthly	SQD					
Core Learning	Monthly	ESR	85%	84.02%	89.83%	87.92%	
			Target	YTD	Current Month	Last Month	Trend
Caring							
Friends and Family Test							
Inpatient (Response Rate)	Monthly	Envoy Messenger	26%	26.17%	24.00%	22.00%	
Inpatient (Recommend)	Monthly	Envoy Messenger	96%	89.08%	92.00%	93.00%	
A&E (Response Rate)	Monthly	Envoy Messenger	14%	21.00%	19.00%	18.00%	
A&E (Recommend)	Monthly	Envoy Messenger	87%	80.67%	80.00%	82.00%	
% of staff who would recommend care							
% of staff who would recommend work							
Complaints							
No of Complaints received	Monthly	Datix	70	700	54	53	
No of Complaints still Open	Monthly	Datix	0	3620	237	225	
No of Complaints ongoing	Monthly	Datix	0	481	35	39	
Inpatient Experience							
Mixed Sex Accommodation	Monthly	Datix	0	54	0	8	
eDD	Monthly	EDD	95%	77.60%	79.86%	79.85%	
PPCI 90 hrs	Quarterly		100%	96.10%	97.33%	97.33%	
PPCI 150 hr	Quarterly		100%	86.19%	85.33%	85.33%	
#NOF 24	Monthly		70%	62.00%	57.69%	52.40%	
#NOF 48 hrs	Monthly		95%	91.81%	83.33%	88.10%	
Dementia Screening	1 month behind		90%	87.80%	91.30%	91.06%	
Dementia risk assessment	1 month behind		90%	94.40%	96.89%	94.55%	
Dementia referral for Specialist treatment	1 month behind		90%	66.24%	88.89%	93.18%	
Stroke							
Patients with 90% of stay in Stroke Unit	1 month behind	SSNAP	80%	85.19%	84.60%	85.50%	
Sallowing assessment < 4hrs	1 month behind	SSNAP	80%	69.90%	69.10%	64.60%	
Scanned < 1 hrs	1 month behind	SSNAP	50%	63.71%	54.50%	53.70%	
Scanned < 12 hrs	1 month behind	SSNAP	100%	95.90%	97.00%	93.90%	
Admitted to Stroke < 4 hrs	1 month behind	SSNAP	90%	66.78%	61.90%	59.80%	
Patient death in Stroke	1 month behind	SSNAP	17%	13.02%	14.10%	21.00%	
Assesments within Deadline	1 month behind						
Thromb < 1hr	1 month behind						

			Nat. Target	YTD	Current Month	Last Month	Trend
Responsiveness							
A&E							
4hrs or less in A&E Dept	Monthly	Medway	89.0%	79.36%	78.83%	75.22%	
12+ Trolley waits	Monthly	Medway	0	0	0	0	
RTT							
52 Week Waiters	Monthly	Medway	1				
18 week incompletes	Monthly	Medway	92.4%	91.50%	86.96%	88.27%	
Cancer - Other Targets							
62 day classic	1 month behind	Somerset	85%	71.42%	67.10%	74.40%	
2 week wait suspect	1 month behind	Somerset	93%	90.24%	89.40%	89.50%	
2 week wait breast symptomatic	1 month behind	Somerset	93%	74.55%	56.80%	74.30%	
31 day first treatment	1 month behind	Somerset	96%	96.55%	94.30%	94.10%	
31 day subsequent drug treatments	1 month behind	Somerset	98%	97.33%	100.00%	99.00%	
31 day subsequent surgery treatments	1 month behind	Somerset	94%	94.11%	95.80%	100.00%	
31 day subsequent radiotherapy treatments	1 month behind	Somerset	94%	92.56%	95.10%	89.40%	
62 day screening	1 month behind	Somerset	90%	86.68%	94.10%	67.90%	
62 day consultant upgrade	1 month behind	Somerset	85%	82.49%	75.00%	85.70%	
104+ Day Waiters	1 month behind	Somerset		-	23.00	34.00	
Diagnostic Waits							
diagnostics achieved	Monthly	Medway	99.1%	99.00%	99.74%	99.72%	
diagnostics Failed	Monthly	Medway	0.9%	1.00%	0.26%	0.28%	
Cancelled Operations							
Cancelled Operations on the day (non clinical)	Monthly	Medway		2.36%	3.08%	3.23%	
Not treated within 28 days. (Breach)	Monthly	Medway		8.12%	10.58%	7.85%	
			Target	YTD	Current Month	Last Month	Trend
Effective							
Mortality							
SHMI	Quarterly		100	111.21	110.30	110.07	
Hospital-level Mortality Indicator	Quarterly		100	99.54	103.60	102.30	
Length of Stay							
Average LoS - Elective	Monthly	Medway / Slam	2.8	2.75		2.36	
Average LoS - Non Elective	Monthly	Medway / Slam	3.8	4.59	4.86	5.01	
Medically Fit for Discharge	Monthly	Bed managers	60	62.42	68.00	58.00	
Delayed Transfers of Care	Monthly	Bed managers	3.5%	5.10%	5.38%	5.77%	
Partial Booking Waiting List	Monthly	Medway	0	4766	5018	5059	
			Target	YTD	Current Month	Last Month	Trend
Well Led							
Vacancies	Monthly	ESR	5.0%	10.27%	10.46%	10.44%	
Sickness Absence	Monthly	ESR	4.0%	4.89%	5.20%	5.50%	
Staff Turnover	Monthly	ESR	8.0%	9.66%	9.77%	9.53%	
Staff Engagement							
Staff Appraisals	Monthly	ESR	95.0%	66.83%	65.00%	66.00%	
Equality Diversity and Inclusion							
			Target	YTD	Current Month	Last Month	Trend
Money & Resources							
Income v Plan	Monthly	Board Report Master	38713	437323	36566	33597	
Expenditure v Plan	Monthly	Board Report Master	-40526	-474776	-42054	-39313	
Efficiency Plans	Monthly	FIMS report	2171	15564		1060	
Surplus / Deficit	Monthly	FPIC Finance Report	-3052	-56892	-6946	-7058	
Capital Delivery Program	Monthly	FPIC Finance Report	1588	8855	0	0	
Agency Spend	Monthly	Agency Staff Analysis	875	-11540	-3255	-2804	

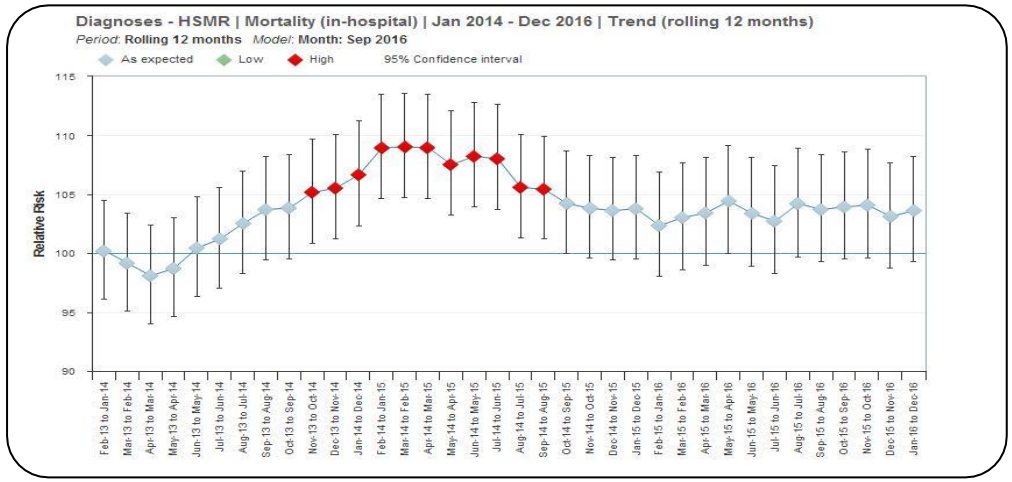
4. Quality – Safe Ambition 1: Reduction of Harm Associated with Mortality

Executive Responsibility:
Suneil Kapadia – Medical Director

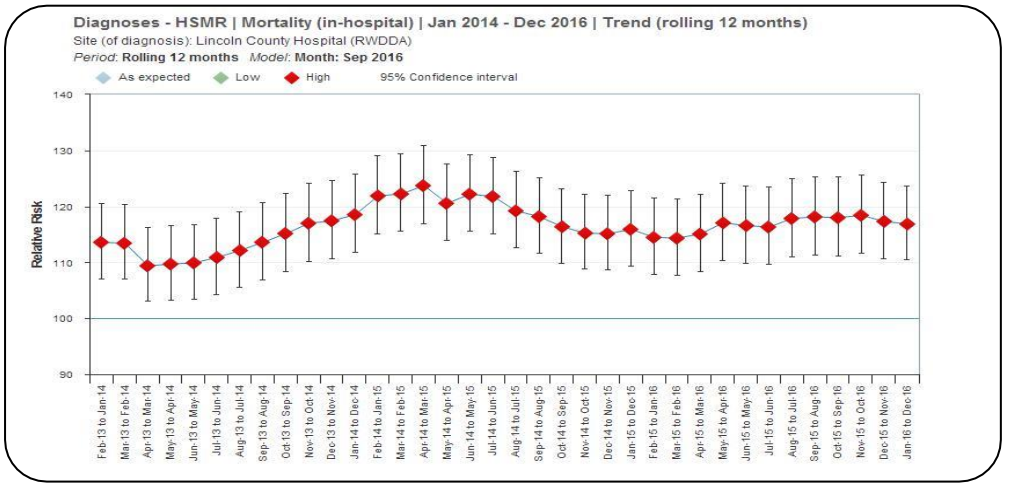
Trust/Site	ULHT HSMR Jan 16-Dec 16 12 month	ULHT HSMR Apr 16-Dec 16 YTD	ULHT HSMR Dec-16	ULHT SHMI Oct 15 – Sep 16	Trust Crude Mortality YTD Internal source Apr 16-Mar 17
Trust	**103.6**	**102.6**	**102.1**	**110.3**	1.81%
LCH	**116.8**	**116.1**	**120.9**	**112.91**	1.87%
PHB	**94.7**	**93.5**	**89.3**	**108.34**	1.93%
GDH	**71.0**	**68.6**	**29.8**	**97.82**	1.10%

Hospital Standardised Mortality Ratio (HSMR)

ULHT HSMR Rolling Year (36 Months)



Lincoln HSMR Rolling Year (36 Months)



Alerts

ULHT

The Trust diagnoses groups are:

Gastrointestinal Haemorrhage: Driven by an alert on the Lincoln Site; with 9.9 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 7.4 mortalities over the predicted Dr Foster data. This is the first alert for this time period.

SITE

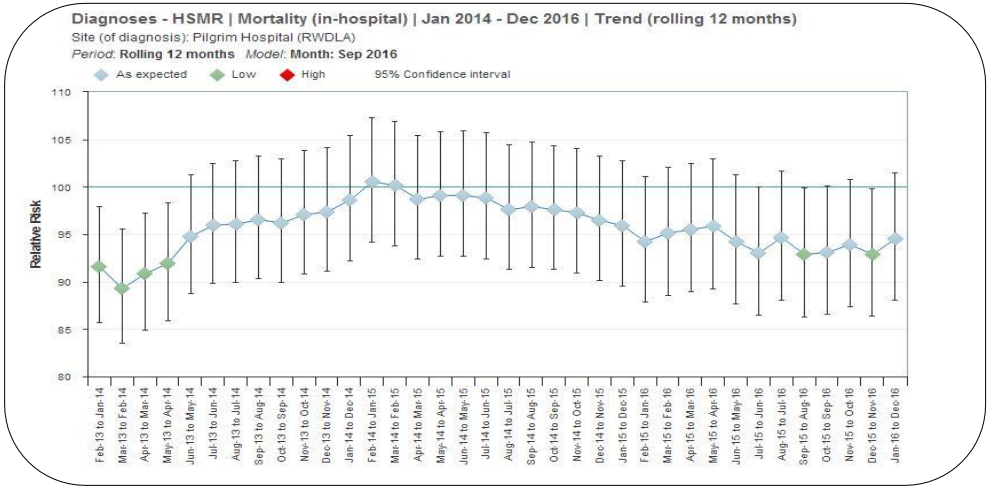
Lincoln County Hospital diagnoses groups are:

- **Biliary Tract Disease:** This is cumulative throughout the time period with 7.2 mortalities over the predicted Dr Foster data. This is the first alert for this time period. A comprehensive review was conducted in November 2015.
- **Gastrointestinal Haemorrhage:** 7.5 mortalities over the predicted Dr Foster data, no particular month is alerting this is cumulative over the time period. This is the first alert for this time period.
- **Intestinal Obstruction without hernia:** Due to a notification in October 16; Year to date there were 9.2 mortalities over the predicted within this diagnosis group. This is the third consecutive month of notification. A recommendation at Patient Safety Committee for an in-depth review of coding to be conducted.
- **Liver Disease, Alcohol-related:** This is a cumulative notification; there was a notification for the month of August 2016. Year to date there are 5.9 mortalities over the predicted. This is the second notification within this time period.

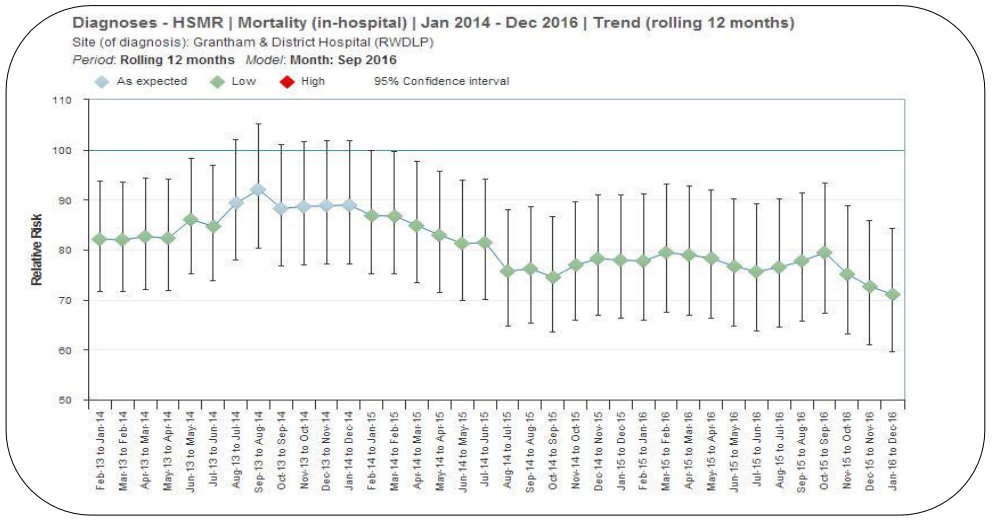
Pilgrim hospital/Grantham Hospital

No notifications

Pilgrim HSMR Rolling Year (36 Months)



Grantham HSMR Rolling Year (36 Months)

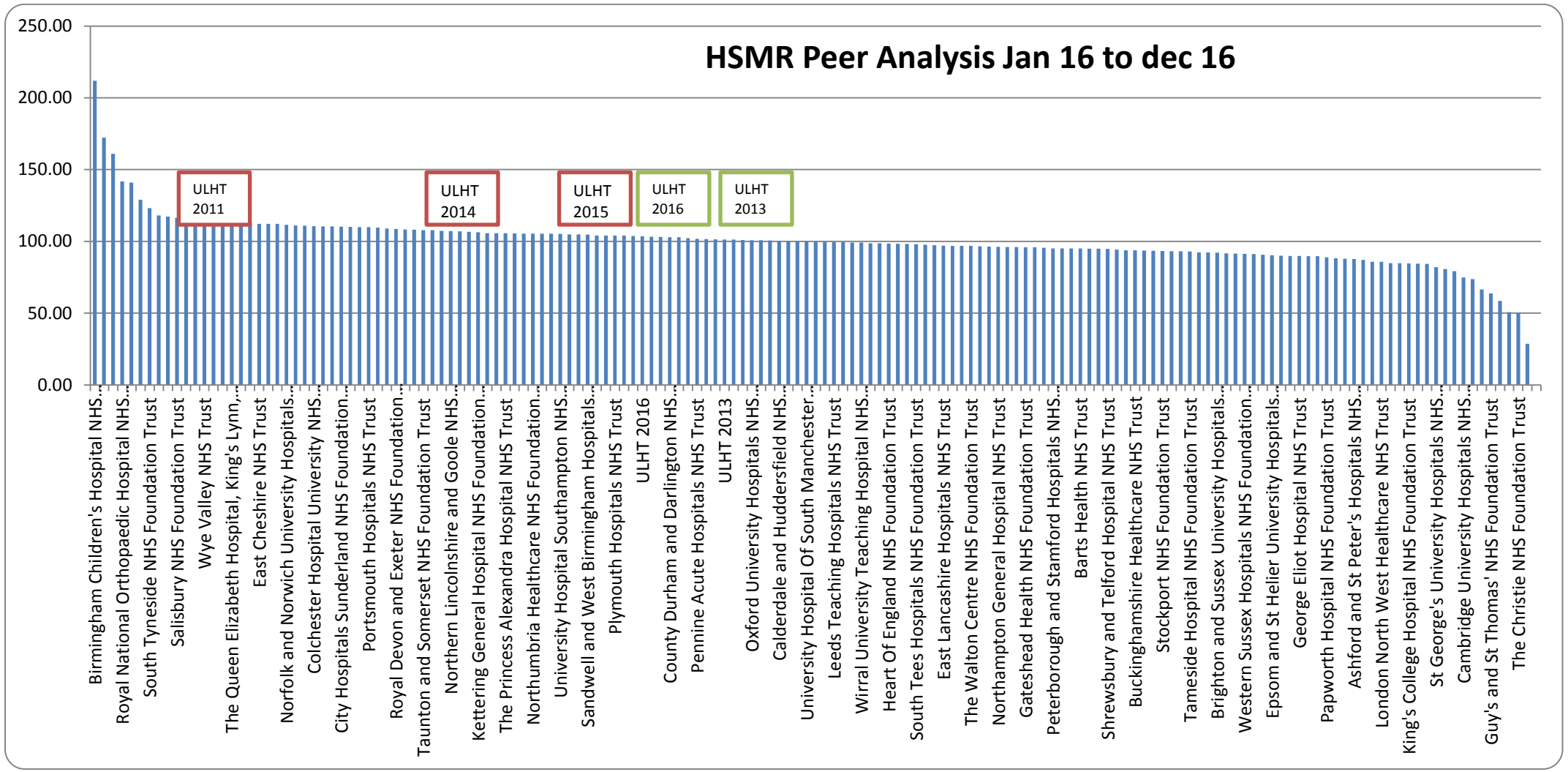


HSMR Top Observed Diagnosis Groups- April 2016 to December 2016

Rank	Diagnosis group	Spells	mortalities	% of all mortalities	Expected mortalities	Actual-Expected	Crude (%)	HSMR
1	Pneumonia	1797	315	20.19%	328.46	-13.46	17.57	95.90
2	Acute cerebrovascular disease	872	127	8.14%	126.59	0.41	14.67	100.32
3	Septicaemia (except in labour)	602	122	7.82%	114.19	7.81	20.30	106.84
4	Acute and unspecified renal failure	591	75	4.81%	74.52	0.48	12.78	100.64
5	Urinary tract infections	1769	68	4.36%	71.39	-3.39	3.85	95.26
6	Congestive heart failure, non-hypertensive	698	58	3.72%	76.78	-18.78	8.31	75.54
7	Chronic obstructive pulmonary disease and bronchiectasis	1097	57	3.65%	45.53	11.47	5.21	125.18
8	Acute myocardial infarction	681	53	3.40%	47.63	5.37	7.82	111.28
9	Secondary malignancies	1489	51	3.27%	43.46	7.54	3.44	117.34
10	Aspiration pneumonitis, food/vomitus	127	45	2.88%	37.13	7.87	35.43	121.21

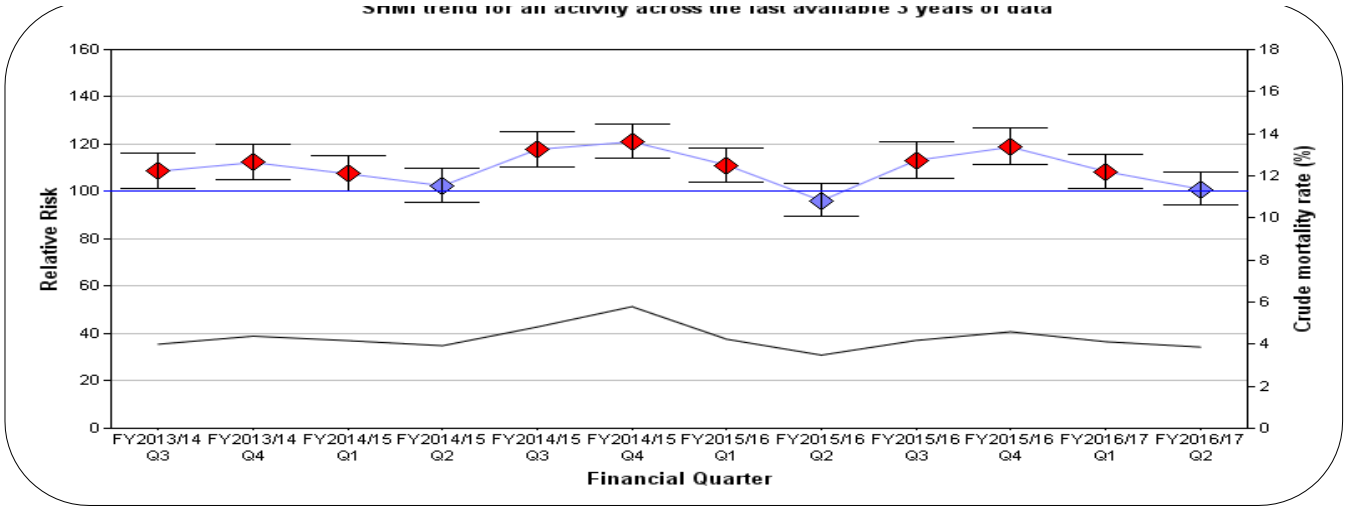
The above diagnosis groups show the top 60% of the alerting diagnosis within the Trust

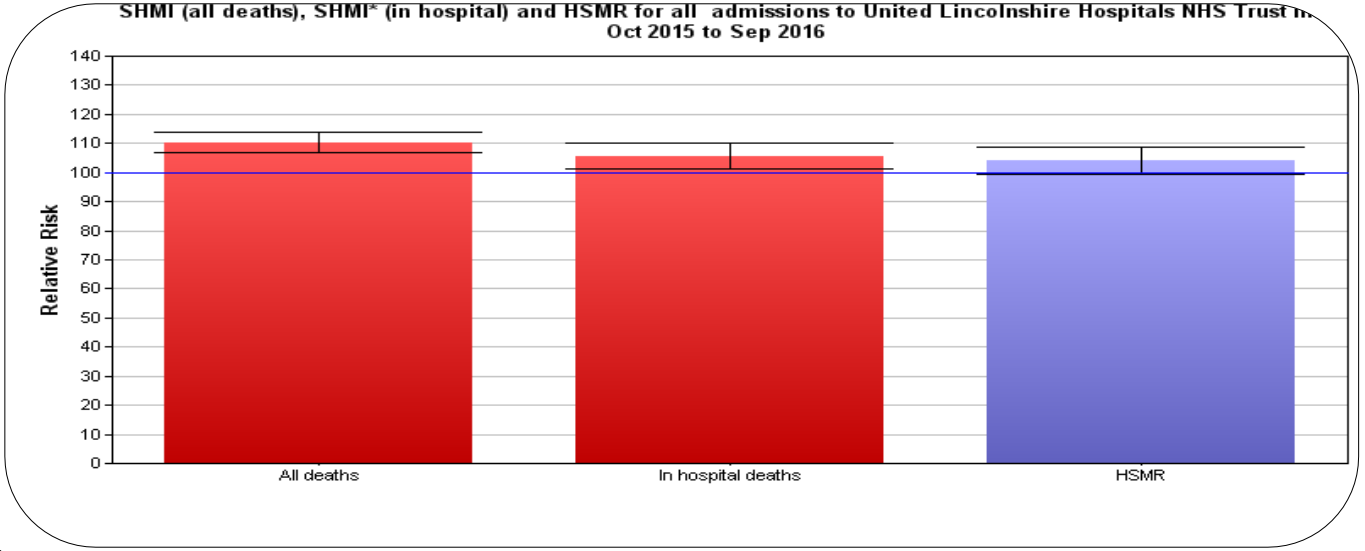
HSMR – Peer analysis



SHMI

The Trust is undertaking numerous strategies for Mortality Reduction:





- The first Lincolnshire Mortality Collaborative will take place at the Pilgrim Site on 21st April 2017; aligning ULHT CCG and GP. Reviewing both ULHT and community notes looking at mortalities within 30 days of discharge and mortalities within 48 hour of admissions.
- Quality Governance has received a proportion of the reviewed case notes and has initiated analysing the Charlson Comorbidity Audit for report production in May 2017.
- Dr Foster healthcare intelligence specialist attended the Pneumonia and Stroke Governance Meeting on the 13th April 2017 to go through the Dr Foster Data. A report will be generated for the May 2017 Patient Safety Committee on the actions discussed.
- 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. A report will be generated for July 2017.
- It has been agreed that two newsletters will be produced monthly; one newsletter will included a MoRAG case review and lessons learned; and the other will be a revival of the Mortality Matters Newsletter that will look at the specific effects of our mortality reviews; HSMR, SHMI, Review compliance. The first publication has been agreed will be end of April and bi-weekly.
- A process for non-compliance for completion of mortality reviews has been put into place. The Associate Medical Director has written to all consultants who have not completed their case note reviews within a timely manner and have 5 sets of case note reviews outstanding.
- 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.

Mortality Reviews

Reviews January 2016 – February 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	3667	898	2769	2011	73%	**75%**	55%
Lincoln Total	1999	386	1613	1077	67%	**75%**	54%
Pilgrim Total	1436	432	1004	792	79%	**75%**	55%
Grantham Total	232	80	152	142	93%	**75%**	61%

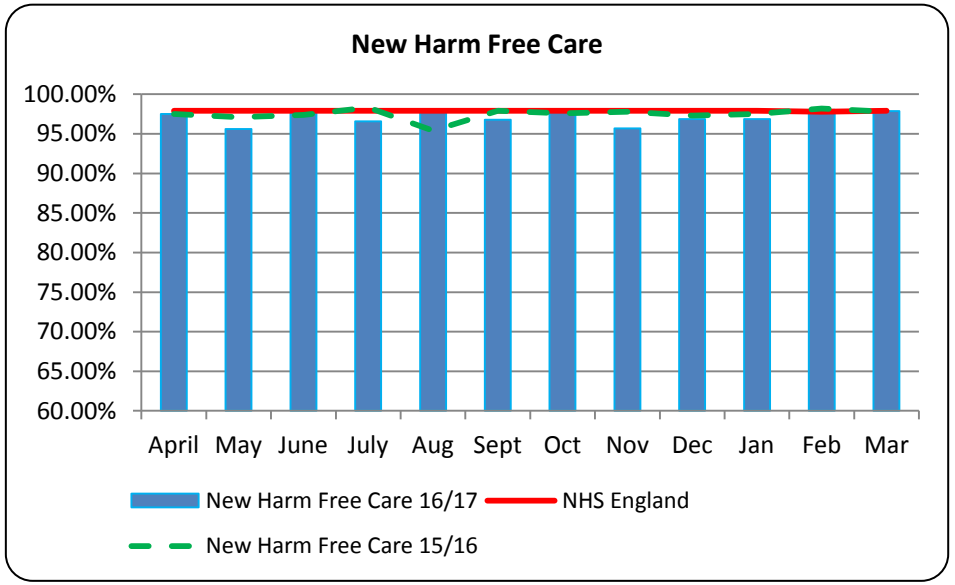
4. Quality – Safe Ambition 2: Reduction of Harm Associated with Harm Free Care

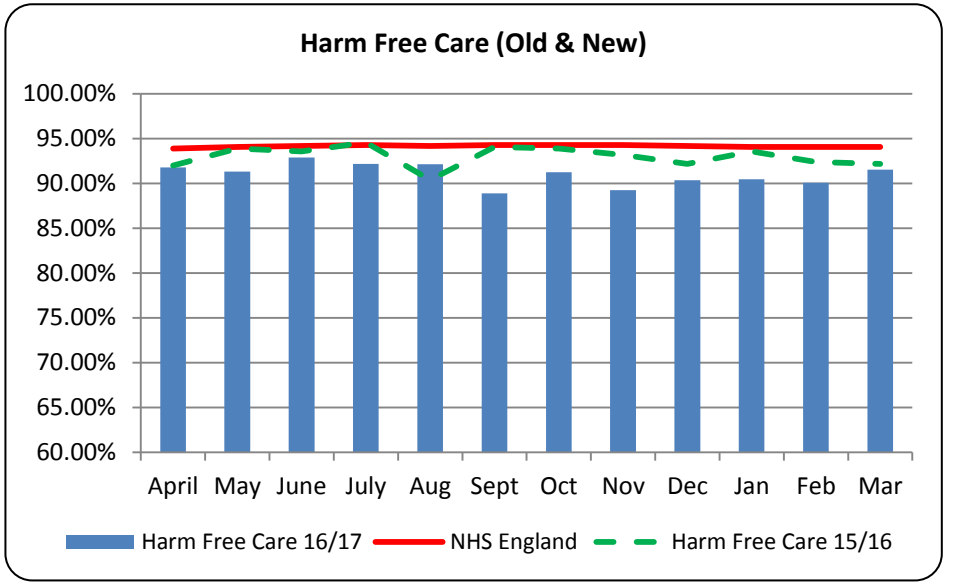
Executive Responsibility:
Michelle Rhodes – Director of Nursing

Performance Data Overview – February 2017 (March data not released by GEM Arden)

Current March Performance
5 Low Harm Falls (all after admission)
10 Pressure Ulcers (7 Cat2, 3 Cat3, 1 Cat4)
1 CA-UTI
2 PE

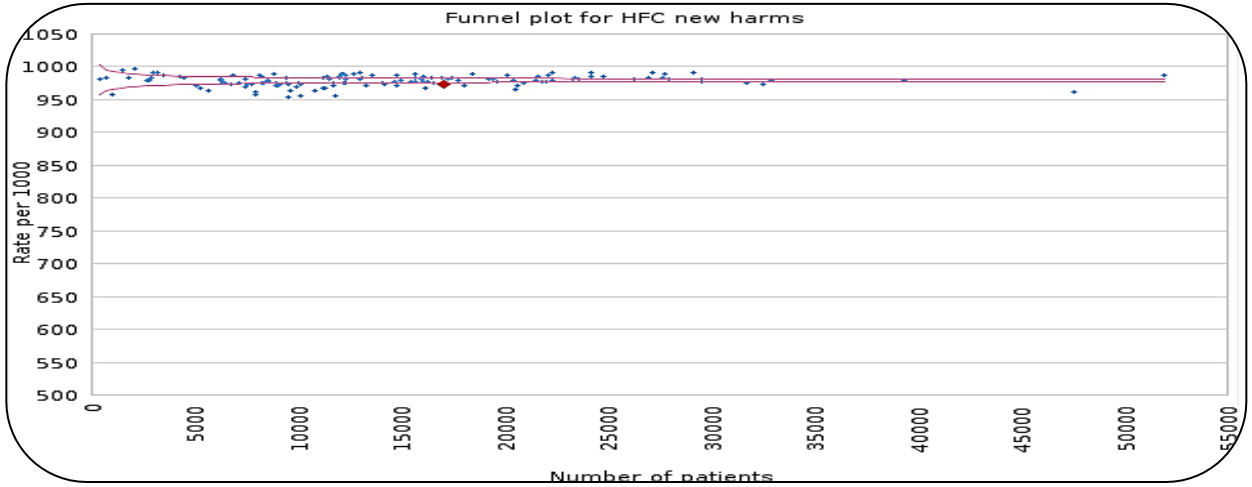
Site	No Patients	Harm Free	New Harm Free	PU- All	PU - New	Falls with harm	Cath & all UTI	Cath & New UTI	New VTEs
National Average		**94.0%**	**97.8%**	**4.5%**	**1.0%**	**0.5%**	**0.7%**	**0.3%**	**0.4%**
Grantham	**85**	**95.3%**	**98.8%**	**3.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**1.2%**
Lincoln	**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%**





Action Plan

Lincolnshire East CCG was served with formal notice that from March 2017 ULHT will no longer include fall before Admission in their data return.



Reports are distributed detailing where all harms have occurred. Dashboard is collated each month with trend analysis by Site.

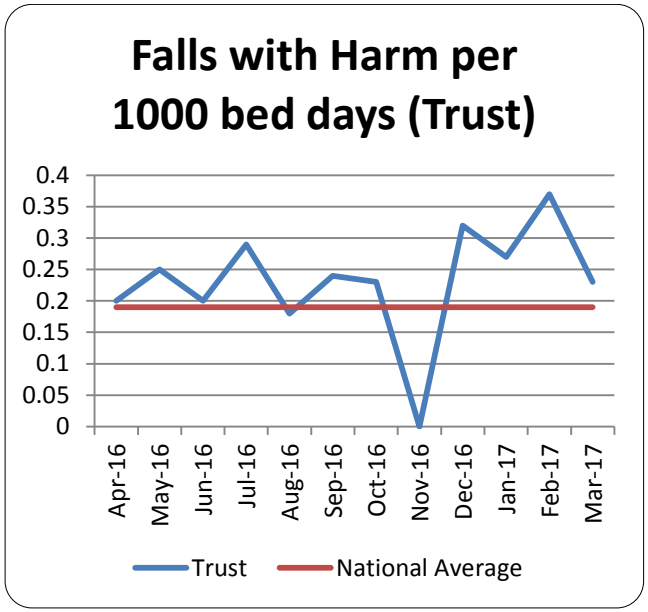
Nurse specialists review all CA-UTI/Pressure Ulcers and VTE.

A work plan has been established for CA-UTI that includes more robust assurance around lessons learned from new CA-UTI, further information available on page 11.

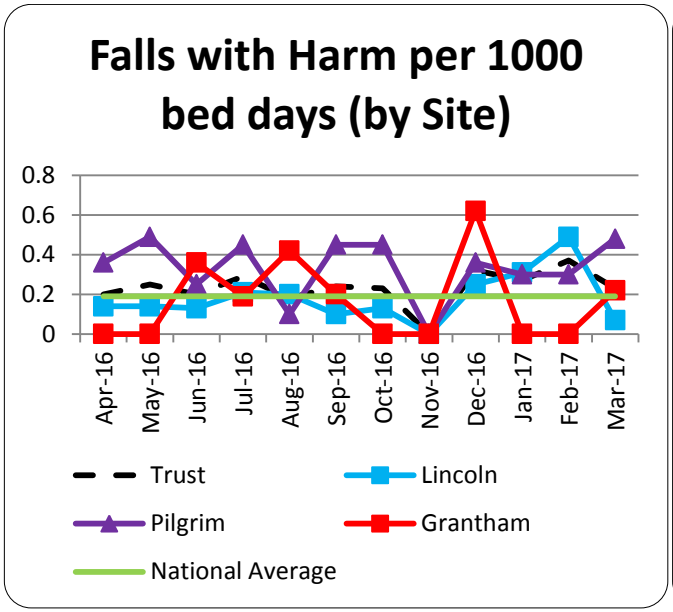
RCA'S are being completed when a patient has developed a hospital acquired thrombosis (HAT) and will be investigated in conjunction with ward leaders and Matrons.

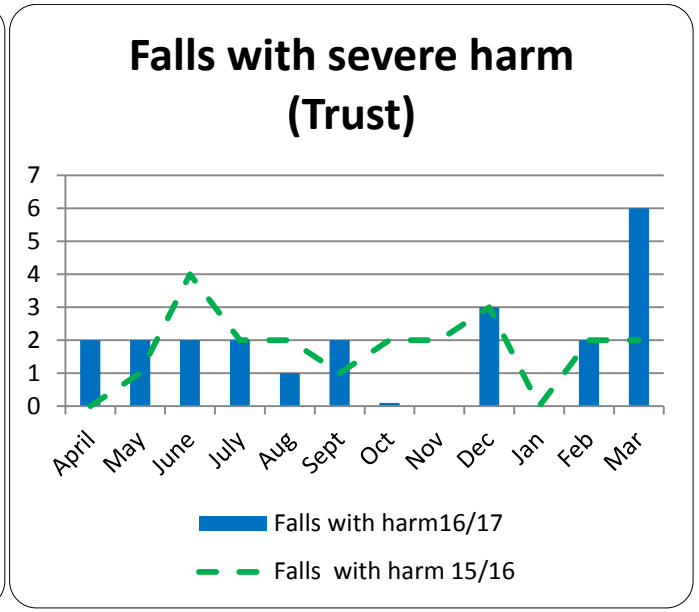
4. Quality – Safe Ambition 3: Reduction of Harm Associated with Falls

Executive Responsibility:
Michelle Rhodes – Director of Nursing



Safety Thermometer Feb 16- Feb 17





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

Performance Data Overview

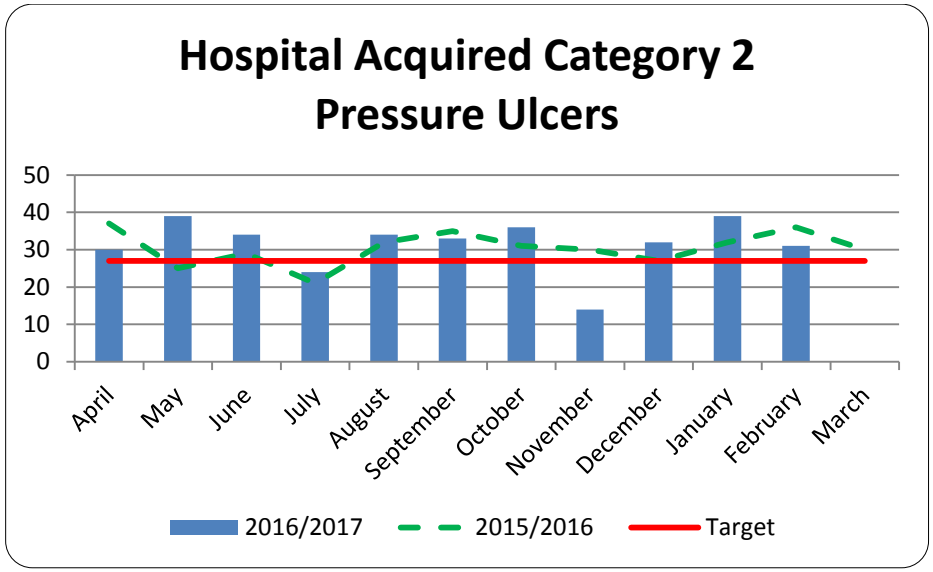
Data demonstrates a higher proportion of falls across the sites for 2016/17 whilst maintaining overall a reduction in severe harm falls. April – March 2015/16 there were 1998 falls compared to 2053 in April – March 2016/17. In the same period in 2015/16 there were 27 falls resulting in severe harm or death compared with 24 in 2016/17.

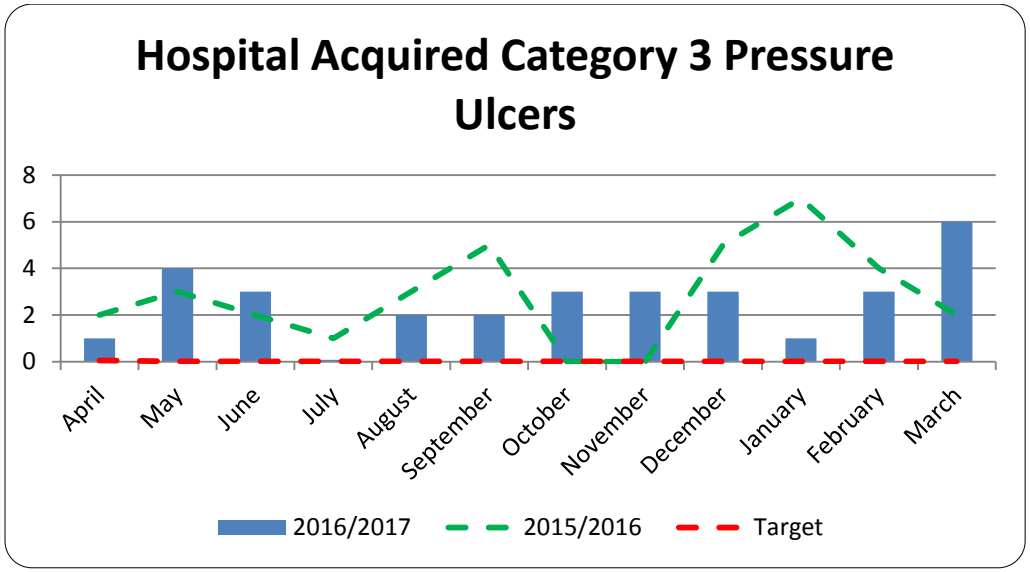
Action Plan

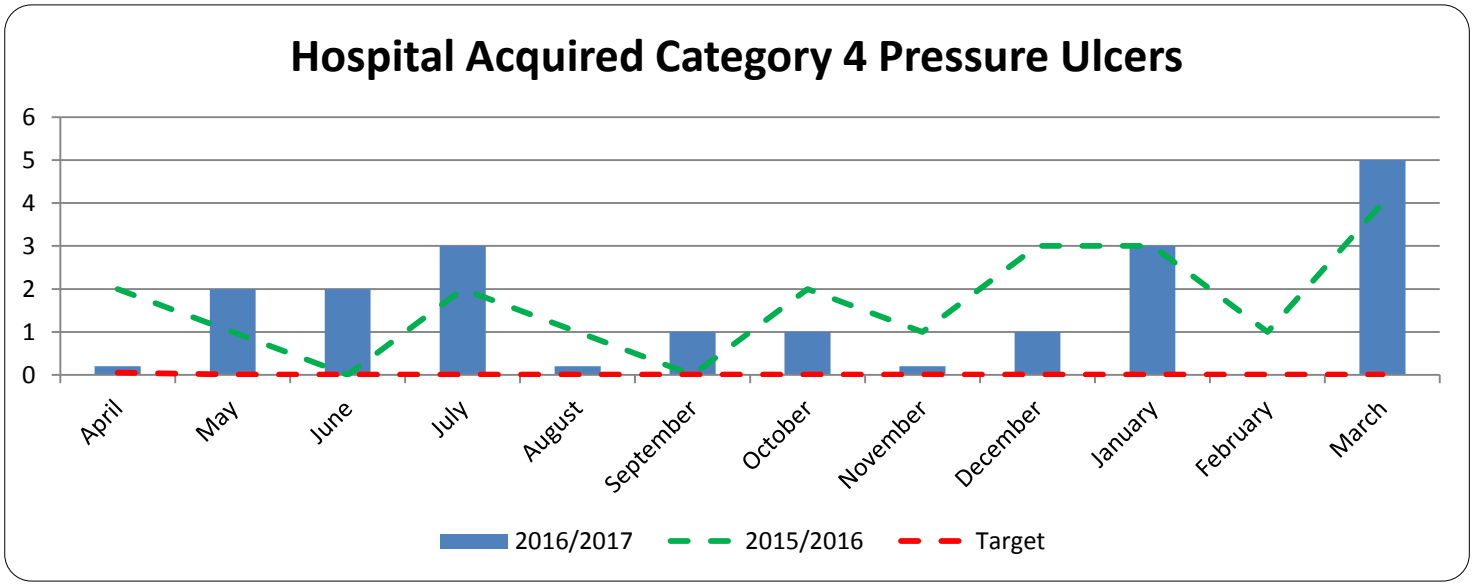
Lying & Standing BP training video due for launch in April 2017 to coincide with focus month. Lying & Standing BP ward based training at Boston – 223 staff trained. Session scheduled at Grantham on 18th May 2017
Falls webpages now live. Falls Metrics now amended on SQD
NHSi Falls work

4. Quality – Safe Ambition 4: Reduction of Harm Associated with Pressure Ulcers

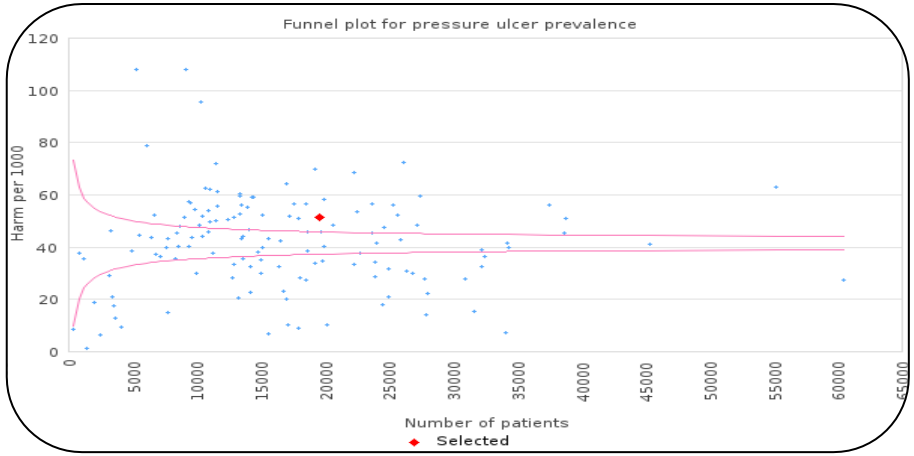
Executive Responsibility:
Michelle Rhodes – Director of Nursing







Safety Thermometer Feb 16- Feb 17
Safety Quality Dashboard (SQD) for Trust pressure area care June 2016- March 2017



Action Plan

Introduction of revised SQD metrics to assess completion of Scrutiny panels are ongoing. Assurance for pressure damage will be reviewed as part of ongoing work to establish ward accreditation. Further discussions are planned to explore shared learning from pressure damage. The Pressure Ulcer Committee have asked for legal advice on suitability of iPads as medical photography tool as these are in situ on all wards doing eCobs

Performance Data Overview

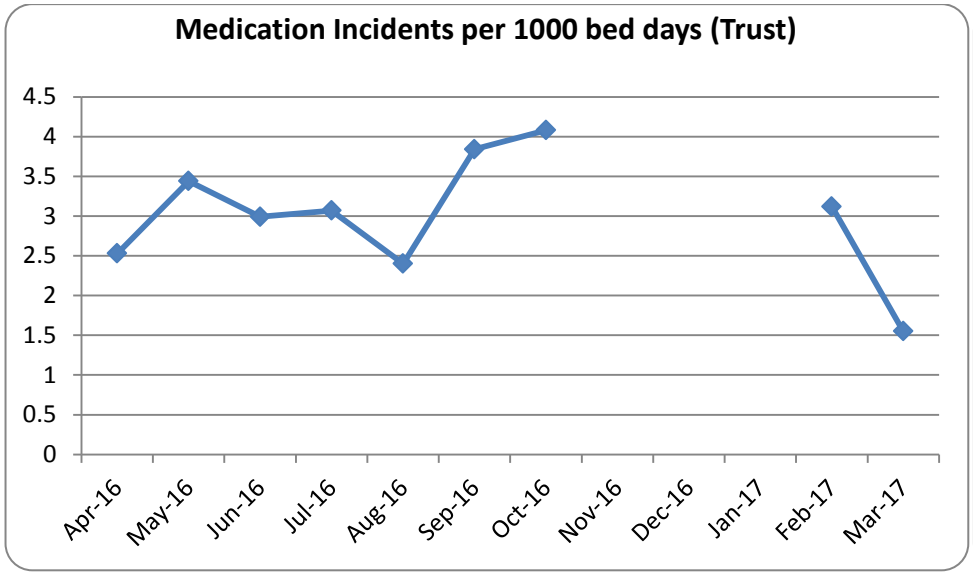
Grade 2 Pressure Damage unavailable for March 2017.

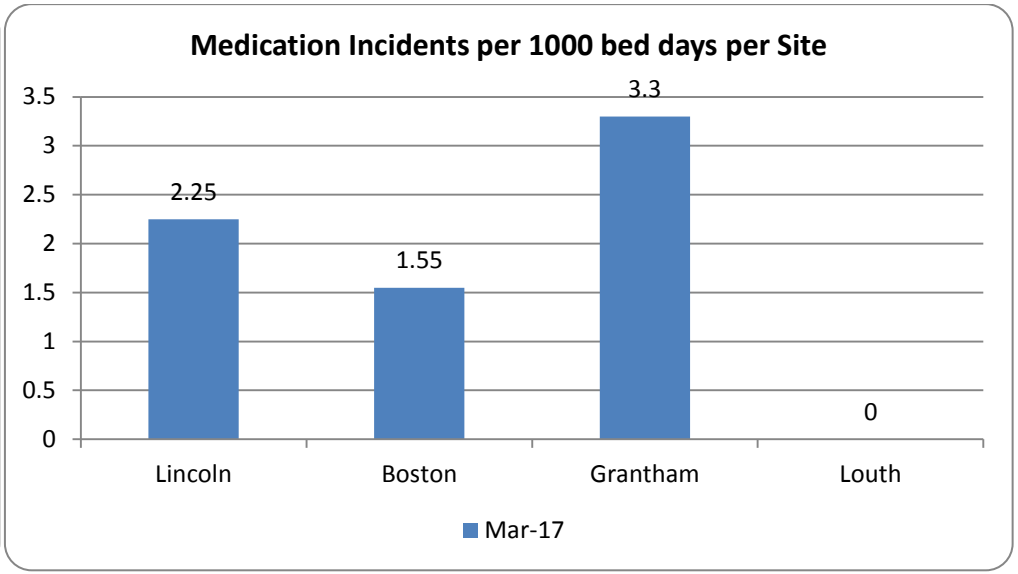
Metric Title	Jun-2016	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb-2017	Mar 2017
Pressure area risk assessment completed within 24hrs	98.10%	99.00%	98.80%	98.80%	99.30%	98.80%	98.30%	97.50%	-	97.0%
Pressure area risk assessment updated weekly	78.00%	75.30%	76.00%	78.90%	80.70%	78.40%	72.00%	71.60%	77.4%	76.7%
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%
Frequency of repositioning documented	-	-	-	-	-	-	-	-	-	60.8%
Prescribed frequency of turning has been followed for last 24 hours	-	-	-	-	-	-	-	-	-	59.5%
Pressure areas care wound dressing renewed	-	-	-	-	-	-	-	-	-	52.4%
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%

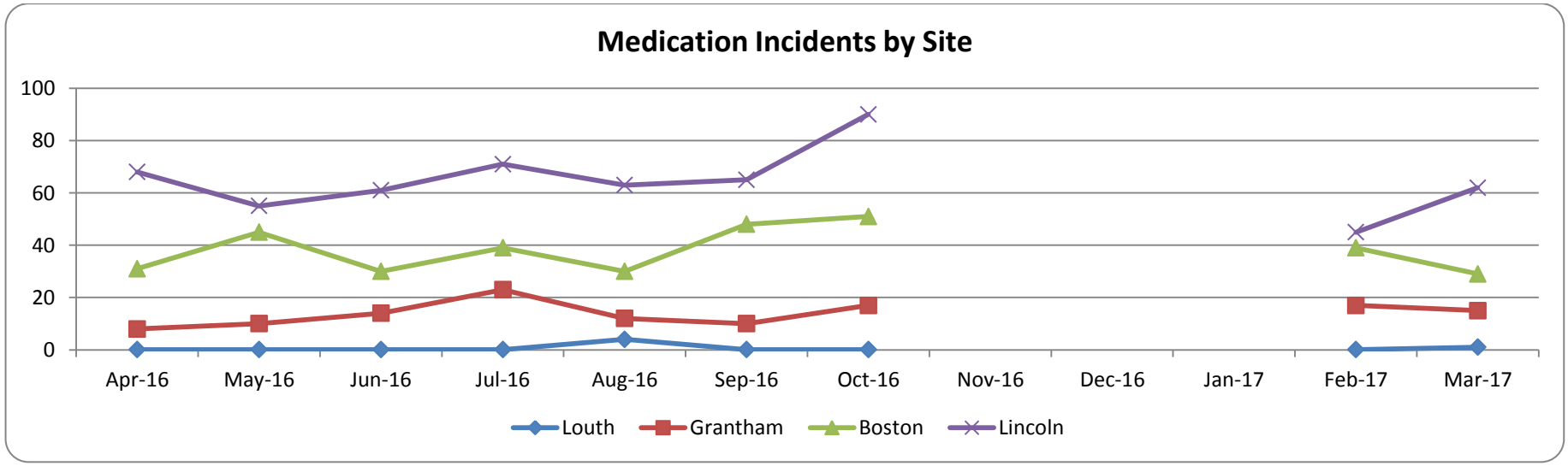
An RCA tracker has been introduced for all grade 3 and 4 Pressure Ulcers reported through DATIX. In March, 11 grade 3 and 4 pressure ulcers were reported of which 5 were grade 4 (4 at Pilgrim and 2 at LCH) Panel dates have been established and a work plan has been formulated for 2017/2018 to address the main lessons arising from the panels

4. Quality – Safe Ambition 5: Reduction of Harm Medication Incidents

Executive Responsibility:
Michelle Rhodes – Director of Nursing







Trust Safety Quality Dashboard June 2016 – March 2017

Metric Title	Jun-2016	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb-2017	Mar - 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%
Allergies documented	95.50%	96.80%	98.10%	98.80%	98.20%	99.40%	98.40%	98.10%	99.40%	99.4%
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%
Allergy name band in place if required	80.60%	91.00%	87.60%	91.80%	93.50%	86.20%	84.70%	92.90%	84.10%	92.3%
Identification name bands in situ	97.90%	98.80%	98.00%	99.50%	98.80%	99.80%	99.70%	98.50%	98.00%	98.5%

Performance Data Overview

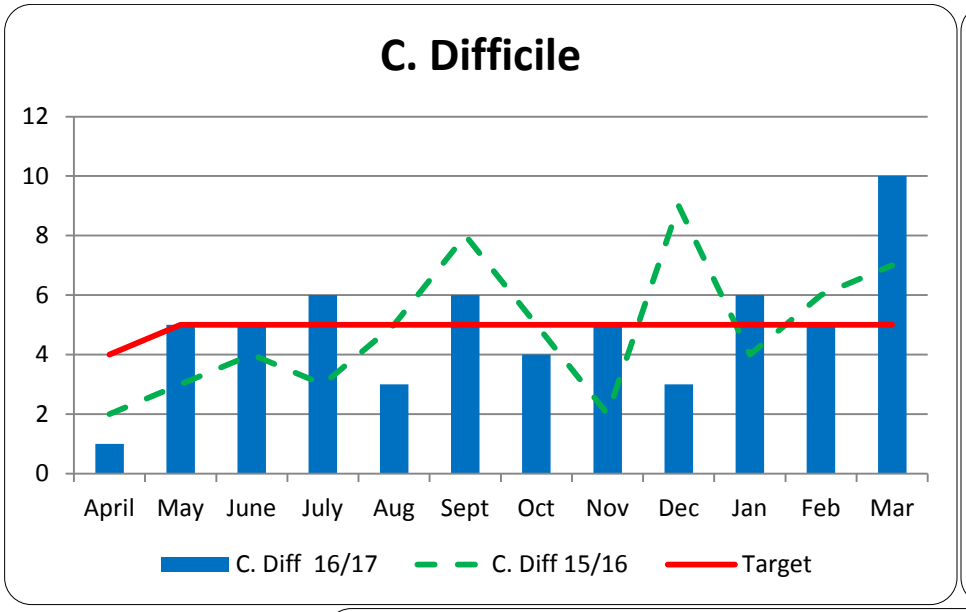
There has been a reduction in Trust Medication Incidents per 1000 bed days.

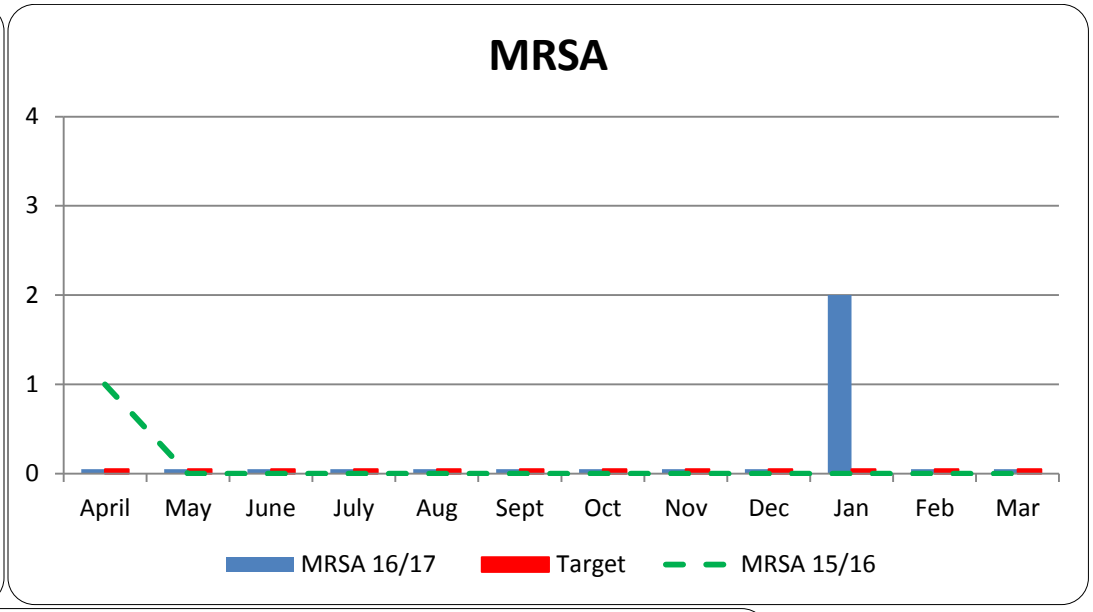
Action Plan

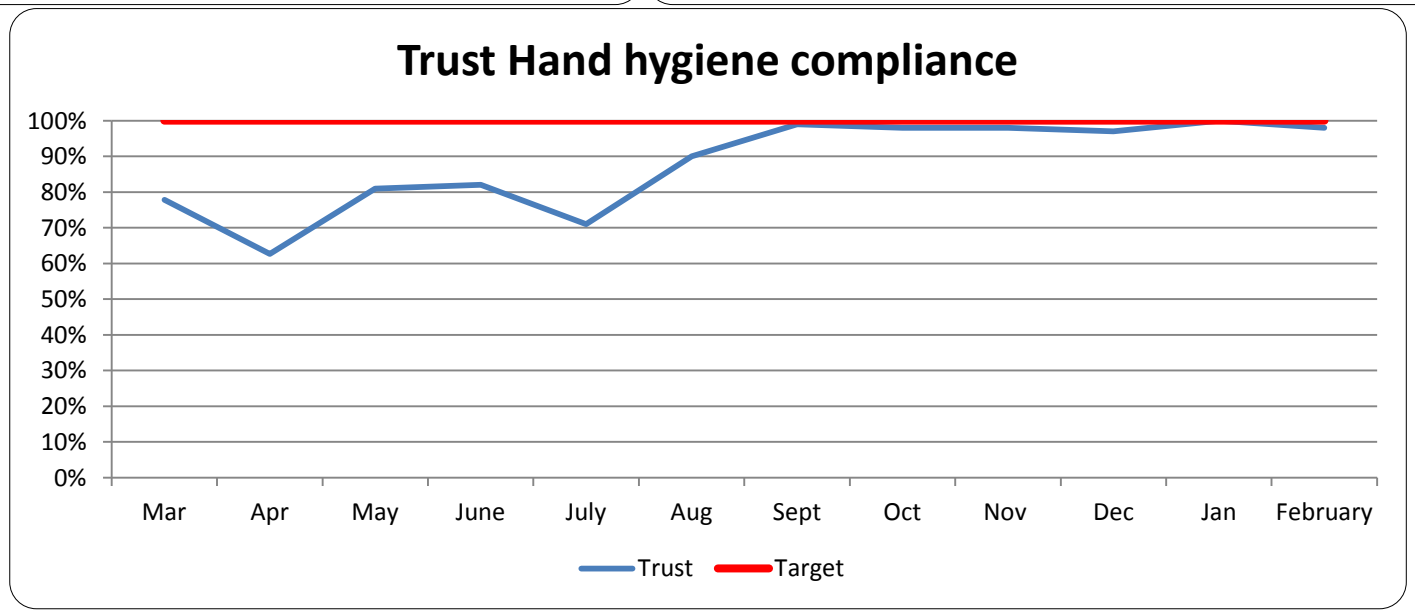
Data is reviewed at the Medicine Optimisation and Safety Committee and all incidents are reviewed on a monthly basis to identify trends. All Heads of Nursing receive the errors by ward area and disseminate to their matrons who in turn disseminate to their ward leaders. These all must be looked into regardless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

4. Quality – Safe Ambition 6: Reduction of Harm Associated with Infection

Executive Responsibility:
Michelle Rhodes – Director of Nursing







Performance Data Overview

There have been 10 cases of hospital acquired C.Diff (trajectory 5) for the month of March. For the year 2016/17 hospital C.Diff complied with trajectory reporting 59 cases (trajectory 59). There were no hospital attributable cases of MRSA reported in March however, cases previously reported in January take ULHT over trajectory for 2016/17.

Hand Hygiene performance is 98 % for March 2017.

Trajectory C.Diff for 2017/18 59
Trajectory MRSA for 2017/18 0

Action Plan

Monthly hand hygiene drop-in sessions undertaken trust wide.
Hand hygiene information published on intranet and circulated through Ward Health Check.
Messages communicated via twitter
Compliant assessment tool/review is undertaken for each patient with C.Diff. RCA is undertaken for each hospital acquired cases and an action place put into place which is overseen by the Infection Prevention Committee (IPC).

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%
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

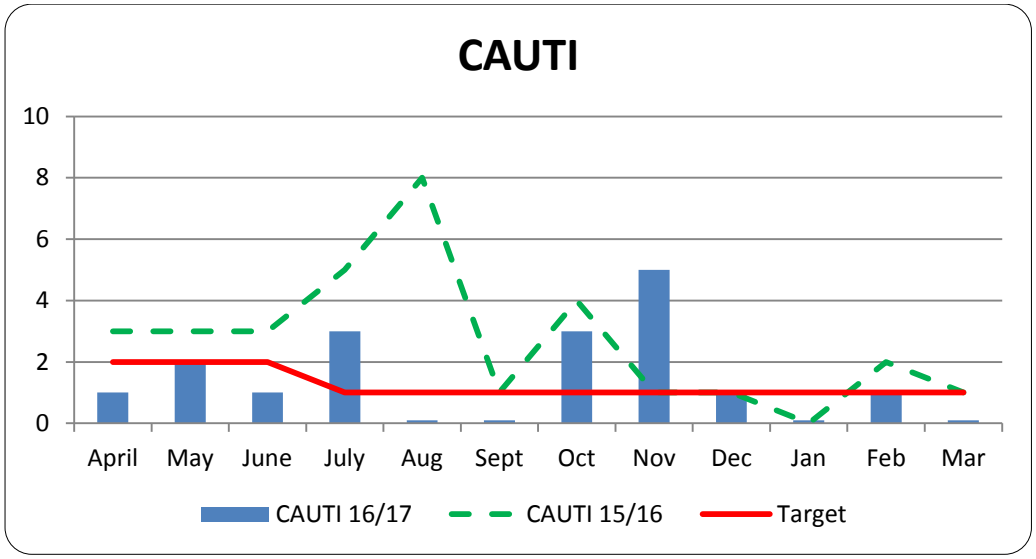
There was 1 new CA-UTI in March 2017.
The Trust have not delivered against 2016/17 trajectory (15), there have been 18 reported however, this is a significant reduction on 2015/16, 32.
ST data demonstrates that ULHT continue to insert higher than the national average number of catheters.
Performance of TWOC at Boston is still below an acceptable standard.

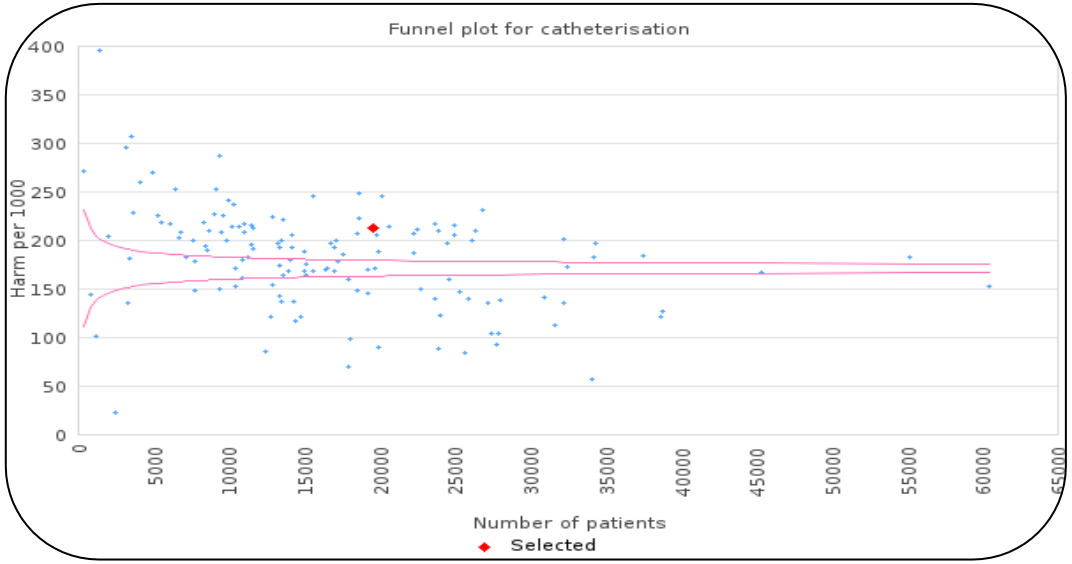
Action Plan

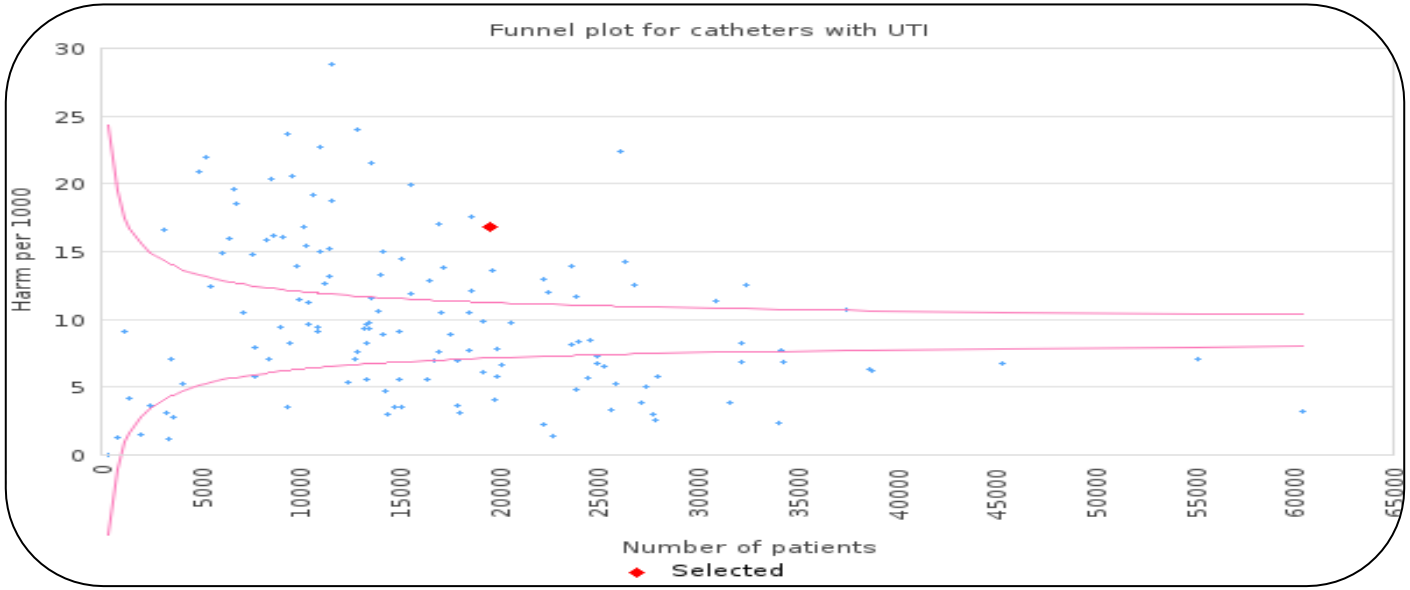
Nurse specialists review all CA-UTI/Pressure Ulcers and VTE.
Work plan established to provide more robust assurance around CA-UTI management and strategies. Catheter with old-UTI details have been shared with community colleagues to identify patterns of poor care pre admission.
Ongoing review of internal webpages. Application submitted to core learning panel to map Catheter Care as Core Module for Nursing/Medical and HCSW staff.

4. Quality – Safe Ambition 6: Reduction of Harm Associated with Infection (CAUTI)

Executive Responsibility:
Michelle Rhodes – Director of Nursing







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

Metric Title	Jun-2016	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb-2017	Mar – 2017
Number of urinary catheters in-situ	74	75	81	63	72	81	53	67	84	80
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%
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%
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%

Performance Data Overview

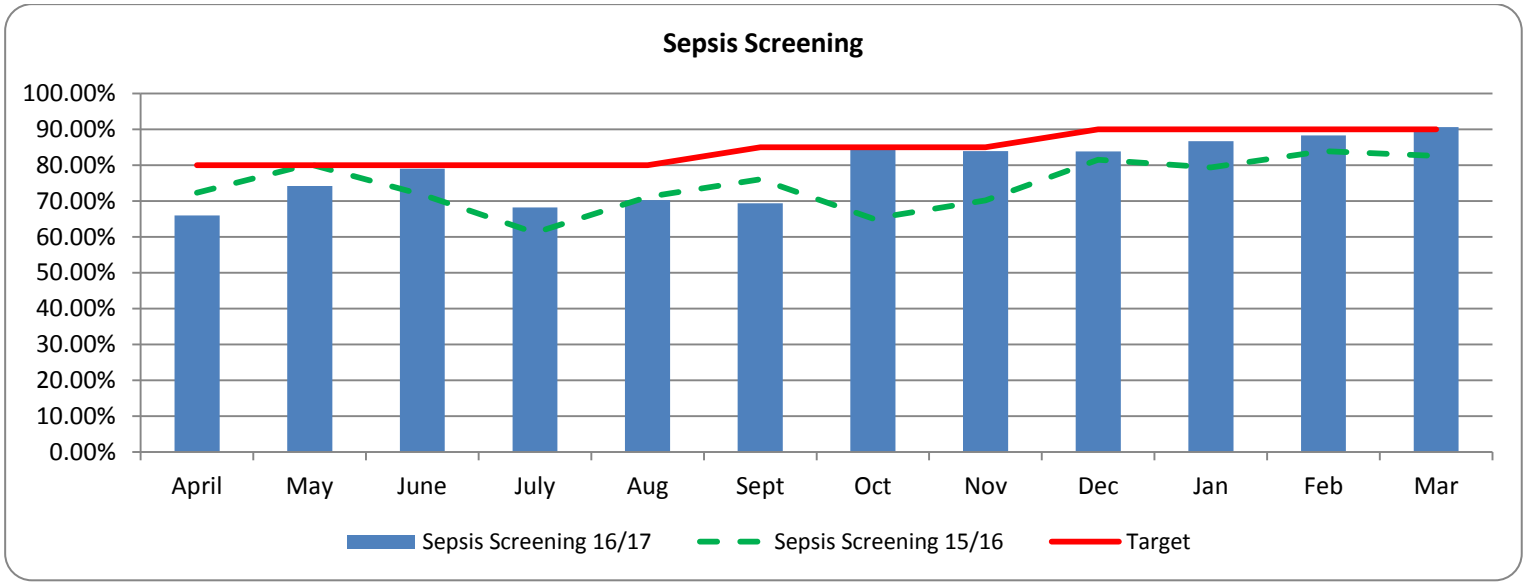
There was 1 new CA-UTI in March 2017.
The Trust have not delivered against 2016/17 trajectory (15), there have been 18 reported however, this is a significant reduction on 2015/16, 32.
ST data demonstrates that ULHT continue to insert higher than the national average number of catheters.
Performance of TWOC at Boston is still below an acceptable standard.

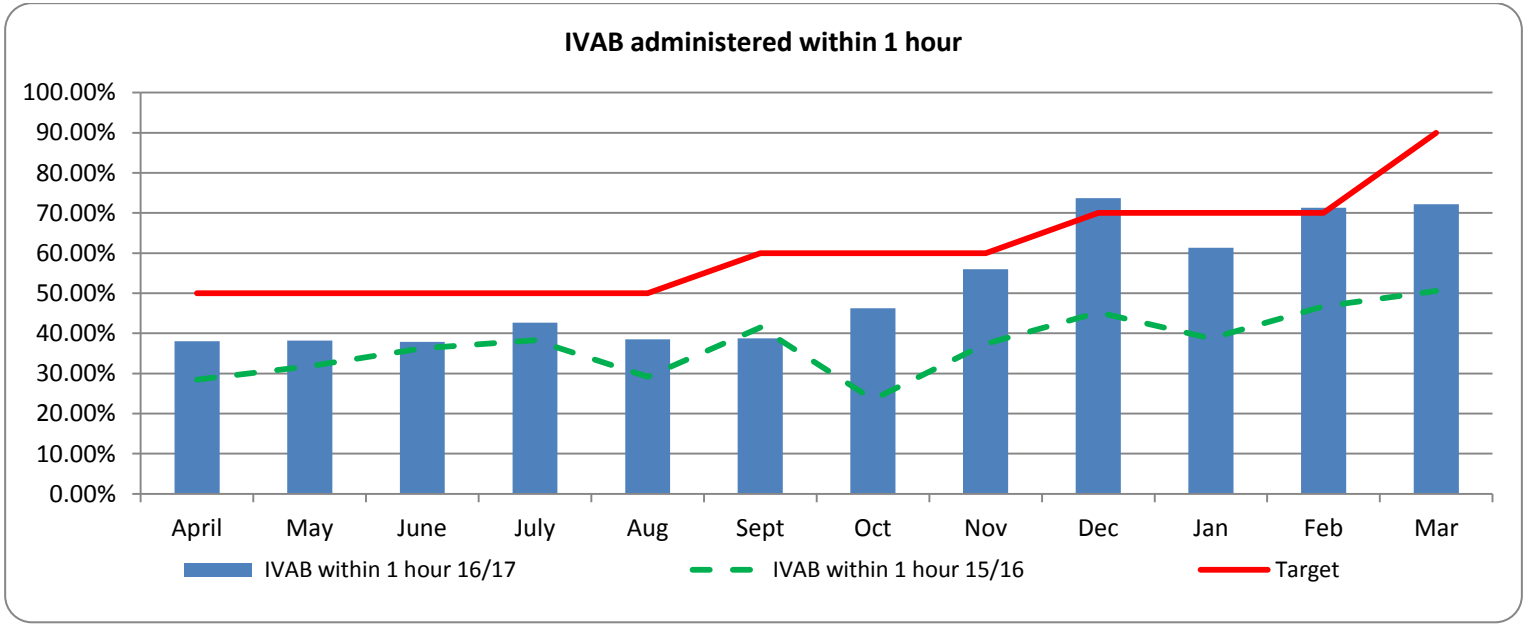
Action Plan

Nurse specialists review all CA-UTI/Pressure Ulcers and VTE.
Work plan established to provide more robust assurance around CA-UTI management and strategies. Catheter with old-UTI details have been shared with community colleagues to identify patterns of poor care pre admission.
Ongoing review of internal webpages. Application submitted to core learning panel to map Catheter Care as Core Module for Nursing/Medical and HCSW staff.

4. Quality – 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- March 2017

Metric Title	Jun-2016	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb - 2017	Mar – 2017
Patient observations on time and complete	-	-	-	-	-	-	-	-	-	43.8%
Patient pain score complete	98.3%	98.1%	97.5%	98.3%	98.8%	98.8%	98.6%	98.7%	-	16.2%
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%
Patient observation frequency document on PfER	-	-	-	-	-	-	-	-	-	75.7%

Performance Data Overview

Site	Bundle Commenced –Mar 17	IVAB within 1 hour – Mar 17
Grantham	92.59%	71.43%
Lincoln	97.01%	87.84%
Pilgrim	81.25%	56.76%

Remedial action plan received from Boston. Compliance on all sites continues to improve week on week with pace of improvement notably slower on Boston Site. Appointment of Sepsis Nurse delayed at Boston will significantly impact upon continuity of education. Audit data will continue to be collected by Quality Governance Team.

Action Plan

Trust Milestone Plan established for launch of Sepsis E Bundle. Grantham site scheduled for "go live" on 18th April. Compliance with e-learning has increased to 80%.

Patient posters for negative screen (to comply with NICE requirement) have been ordered and will be available by all adult inpatient bedsides.

Revised SBAR tool designed and ordered for use as visual aid by ward telephones when handing over/escalating patients. Use is not exclusively for Sepsis.

Sepsis PODCAST.

Sepsis performance data has been added to the front page of the intranet with dedicated pages for Site breakdown.

Patients with absence of screen or failure to provide bundle <60 minutes are recorded via IR1 to assess harm

5. Finance

Executive Responsibility:
Peter Hollinshead – Director of Finance

KPI:	**Finance**	**Owner:**	Interim Director of Finance; Peter Hollinshead
Domain:	**Well-led**	**Responsible Officer:**	Deputy Director of Finance; Neil Morton
Date:	25th April 2017	**Reporting Period:**	March 2017

The Committee are asked to note the above and the following main points:

The Trust delivered a deficit of £56.9m compared to the control total of £47.9m and a most likely forecast of £54.9m
The main movement from the forecast most likely outcome was that the Trust did not receive £1.5m STF funding that it was planning to receive through the appeals process.
The Trust have received formal disputes totalling £3.1m from the Lincolnshire CCGs which have not been provided for in the accounts. This is likely to be raised by External Audit and is likely to result in formal arbitration.

Measure	Plan to date	Actual to date	Annual Plan	RAG
Income	450.7	437.3	450.7	
EBITDA (£'m)	-29.6	-40.5	-29.6	
Net surplus (£'m)	-47.9	-56.9	-47.9	
Efficiency	19	17.1	19	
Cash (£'m)	1	1.7	1	
Revenue Support Grant (£'m)	-103.4	-110.5	-103.4	
Capital Expenditure (£'m)	15.3	15.3	15.3	

Performance

- Year to date deficit is £56.9m compared to plan of £47.9m
- Cash holdings at the end of March are £1.7m
- Capex is £15.3m c.f. plan of £15.3m

Summary

The Trust has an agreed control total deficit of £47.9m for 2016/17.
The Month 12 position is a deficit of £6.9m, leading to a year end deficit position of £56.9m. The performance has been impacted as a result of a high monthly spend on agency (£3.3m) to deal with the demands of winter.
As a consequence, the Trust will not be eligible for the Q4 STF funding of £3.9m.
The Trust has also not received £1.5m of STF relating to appeals for Q2-4 that were included in the most likely forecast. This accounts for £1.5m of the £2m variance from the most likely forecast of £54.9.
The Trust has received formal challenges totaling £3.1m from the Lincolnshire CCGs, which have not been provided for in the accounts.
The Trust delivered its Capital Resource Limit (CRL) and its External Funding (EFL).

- Income below plan due to underperformance on patient activity.
- Expenditure budgets are £3.8m below plan due to underspends which partly offset increased agency
- The outcome of the STF appeals process resulted in no further allocation of STF so the Trust did not receive £6.4m of the planned STF.
- No provision has been made for CCG agreement of balances dispute (£3.1m)

Category	Metric	Period of Measure	Plan	Actual	Variance	RAG	Month minus 1	Month minus 2	Month minus 3	Month minus 4	Month minus 5
			Mar-17				Feb-17	Jan-17	Dec-16	Nov-16	Oct-16
I&E and Profitability	I&E Surplus/(Deficit) (£'m)	In Month	-3.1	-6.1	-3		-5.1	-5.1	-3.4	-4.5	-4.2
		YTD	-47.9	-56.9	-9		-42.9	-42.9	-37.8	-34.2	-29.7
	EBITDA (£'m)	In Month	-1.5	-5.5	-4		-3.9	-3.9	-2	-3.3	-2.8
		YTD	-31.3	-40.5	-9.2		-29.3	-29.3	-25.4	-23.4	-20.1
FIP	Efficiency Achievement (£m)	In Month	2.7	1.5	-1.2		1.8	1.8	2.5	1	0.9
		YTD	19	17.1	-1.9		15.6	14.5	12.7	10.2	9.2
Liquidity	Cash (£m)	YTD	1	1.7	0.7		1.4	1.4	1.4	4	1.3
	Revenue Support Loan (£m)	YTD	-103.4	-110.5	-7.1		-98.8	-98.8	-94.2	-89.2	-85
	Capital Expenditure (£m)	YTD	15.3	15.3	0		8.9	8.9	8	7.3	7.1
Workforce	Substantive,bank and overtime(WTE	YTD	291.1	285.7	-5.4		261.8	237.9	214.2	190.3	166.3
	Agency & Locum Staff (WTE)	YTD	21	29.4	8.4		26.1	23.3	20.5	18.2	15.8
	Total	YTD	312.1	315.1	3		287.9	261.2	234.7	208.5	182.1

Financial Performance - March 2017

Trading Position

Period ending 31 March 2017

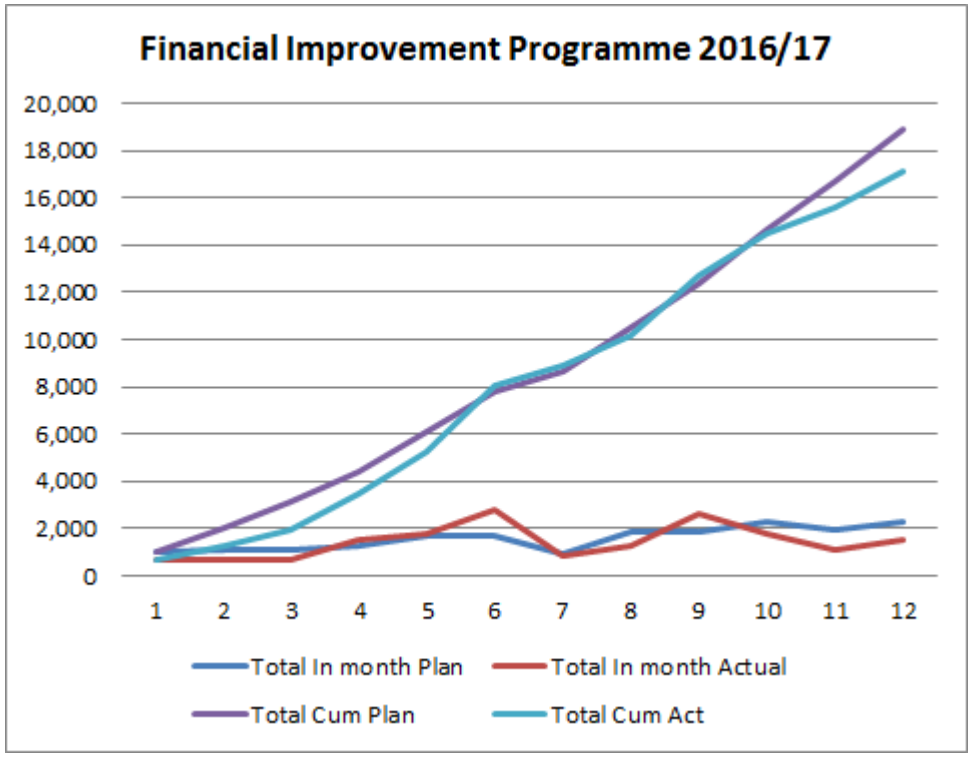
2015-16 Year end £k		2016-17 Annual FIMS Plan £k	2016-17 Annual Internal Plan £k	Year to Date Internal Plan £k	Year to Date Actual £k	Year to Date Surplus/ (Deficit) £k
	Income					
386,840	Revenue from Patient Care Activities	410,259	417,056	417,056	402,087	(14,969)
36,450	Other Operating Revenue	40,358	33,128	33,128	35,202	2,074
138	Receipt of govt granted /donated	120	120	120	35	(85)
423,428	**Total Income**	450,737	450,304	450,304	437,324	(12,981)
	Expenditure					
(305,876)	Pay	(312,134)	(316,819)	(316,819)	(315,131)	1,688
(157,204)	Non Pay	(168,112)	(164,799)	(164,799)	(162,647)	2,153
(463,080)	**Total Expenditure**	(480,246)	(481,618)	(481,618)	(477,778)	3,841
(39,652)	**Earnings before interest,tax,depreciation and**	(29,509)	(31,314)	(31,314)	(40,454)	(9,140)
(50)	Profit/Loss(-) on disposals	0	20	20	(51)	(71)
(11,448)	Depreciation	(12,870)	(11,700)	(11,700)	(11,733)	(33)
(8,557)	Impairment	0	0	0	509	509
(5,258)	PDC Dividend	(4,266)	(3,322)	(3,322)	(3,154)	168
70	Interest Receivable	42	64	64	47	(17)
(905)	Other interest payable	(1,627)	(1,981)	(1,981)	(1,962)	19
(65,800)	**Surplus / (Deficit) for period**	(48,230)	(48,233)	(48,233)	(56,798)	(8,565)
(15.5)%	**Net Margin**	**(10.7)%**	**(10.7)%**	**(10.7)%**	**(13.0)%**	**(2.3)%**
(56,917)	**Surplus / (Deficit) adjusted for impairment & impact of donated / govt granted assets**	**(47,927)**	**(47,930)**	**(47,930)**	**(56,892)**	**(8,962)**

Financial Performance - March 2017

Statement of Financial Position

	March 2016		March 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	215,768	246,865	221,161	(25,704)	+
Intangible Assets	5,124	5,607	3,994	6,052	2,058	
Trade and Other Receivables	1,250	1,477	1,250	1,211	(39)	+
Total Non-Current Assets	**245,659**	**222,852**	**252,109**	**228,424**	**(23,685)**	+
CURRENT ASSETS:						
Inventories	7,738	7,130	7,738	7,769	31	+
Trade and Other Receivables	21,914	21,127	21,849	24,692	2,843	+
Cash and cash equivalents	1,000	1,166	1,013	1,675	662	+
Subtotal	**30,652**	**29,423**	**30,600**	**34,136**	**3,536**	+
Non-Current Assets Held for Sale	0	1,075	0	1,251	1,251	+
Total Current Assets	**30,652**	**30,498**	**30,600**	**35,386**	**4,786**	+
Total Assets	**276,311**	**253,350**	**282,709**	**263,810**	**(18,899)**	+
CURRENT LIABILITIES:						
Trade & Other Payables	(43,099)	(42,020)	(43,007)	(46,752)	(3,745)	-
Other Liabilities	(503)	(503)	(503)	(503)	(0)	-
Provisions for Liabilities and Charges	(1,218)	(1,364)	(834)	(1,516)	(682)	-
Borrowings	(118)	(299)	(119)	(118)	1	-
Liabilities arising from PFIs / LIFT / Finance Leases	(182)	0	0	(166)	(166)	-
Total Current Liabilities	**(45,120)**	**(44,186)**	**(44,463)**	**(49,055)**	**(4,592)**	-
Net Current Assets /(Liabilities)	**(14,468)**	**(13,688)**	**(13,863)**	**(13,668)**	**195**	+/-
Total Assets less Current Liabilities	**231,191**	**209,164**	**238,246**	**214,755**	**(23,491)**	+/-
NON-CURRENT LIABILITIES						
Other Liabilities	(14,591)	(14,591)	(14,087)	(14,088)	(1)	-
Provisions for Liabilities and Charges	(2,485)	(2,484)	(2,398)	(2,926)	(528)	-
Borrowings	(178)	(178)	(58)	(60)	(2)	-
Working capital support facility	(18,382)	(18,382)	(19,833)	0	19,833	-
DH Revenue Support Loan	(35,618)	(35,618)	(83,518)	(110,548)	(27,030)	-
Total Non-Current Liabilities	**(71,254)**	**(71,253)**	**(119,894)**	**(127,774)**	**(7,880)**	-
Total Assets Employed	**159,937**	**137,911**	**118,352**	**86,982**	**(31,370)**	+
FINANCED BY: TAXPAYERS EQUITY						
Public dividend capital	251,746	251,746	256,746	255,663	(1,083)	+
Retained Earnings	(148,225)	(157,029)	(195,063)	(212,874)	(17,811)	+/-
Revaluation reserve	56,226	43,004	56,479	44,003	(12,476)	+
Other reserves	190	190	190	190	0	+/-
Total Taxpayers Equity	**159,937**	**137,911**	**118,352**	**86,982**	**(31,370)**	+

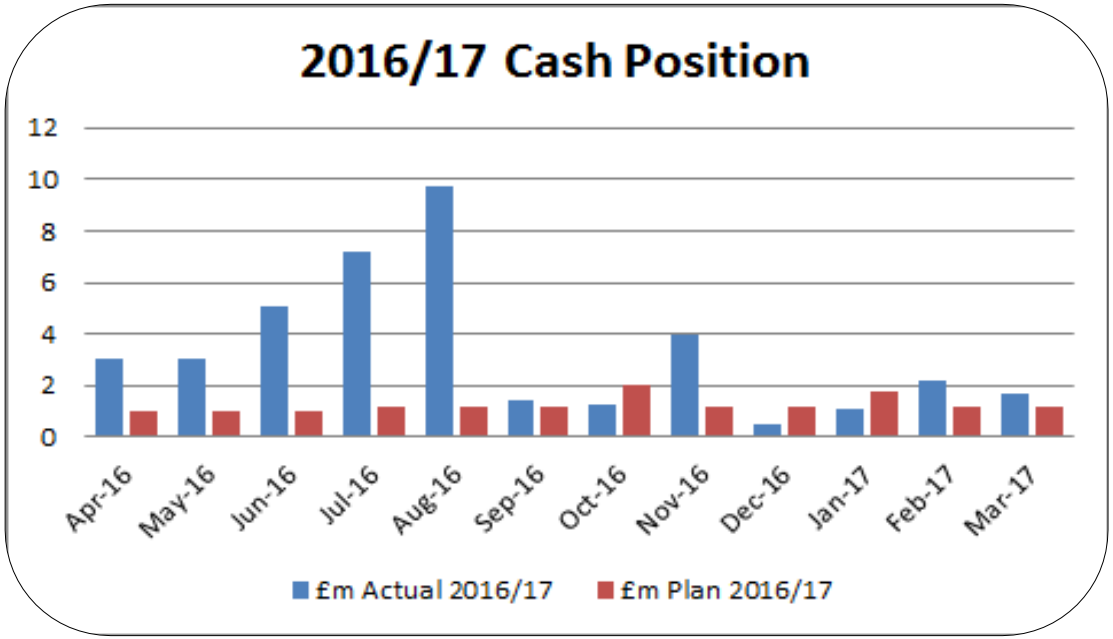
- Cash position slightly better than plan at £1.7m so the Trust achieved the minimum £1m cash balance.
- Property value less than plan due to year end reduction in actuarial valuation, compensating reduction in revaluation reserve and retained earnings.
- The working capital support loan has been extending during the year which offsets the requirement for the Revenue Support Loan



- The FIP plan totals £19.0m for 2016/17
- The year end delivery is £17.1m, of which £6.0m is non recurrent
- £6.0m estimated carry forward to 2017/18

Cashflow

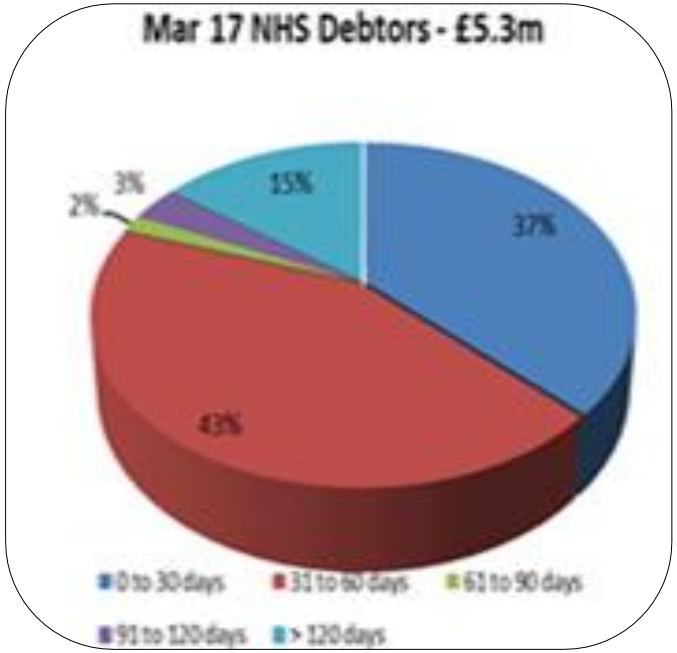
	March 2017			
	Plan £000s	Actual £000s	Variance £000s	
Operating Surplus / (Deficit)	**(42,379)**	**(51,677)**	**(9,298)**	+/-
Non Cash items to be excluded				
Depreciation / Amortisation	12,870	11,733	(1,137)	+
Impairments & Reversals	0	(509)	(509)	+
Receipt of Donated Assets	(120)	(35)	85	-
Earnings before Interest Tax & Dividends (EBITDA)	**(29,629)**	**(40,488)**	**(10,859)**	+/-
Interest paid	(1,590)	(1,424)	166	-
Dividends (Paid) / Refunded	(3,746)	(2,920)	826	-
(Increase)/decrease in inventories	0	(638)	(638)	+/-
(Increase)/decrease in trade & other receivables	62	(3,298)	(3,360)	+/-
Increase/(decrease) in trade & other payables	1,572	3,660	2,088	+/-
Increase/(decrease) in other current liabilities	(504)	(503)	1	+/-
Increase/(decrease) in provisions	(471)	241	712	+/-
NET CASH IN/(OUT)FLOW FROM OPERATING ACTIVITIES	**(34,306)**	**(45,371)**	**(11,065)**	+/-
CASHFLOWS FROM INVESTING ACTIVITIES				
Interest received	42	47	5	+
(Payments) to acquire property, plant & equipment	(21,774)	(13,215)	8,559	-
(Payments) for intangible assets	0	(1,460)	(1,460)	-
Receipts from disposal of property, plant & equipment	2,000	24	(1,976)	+
NET CASH IN/(OUT)FLOW FROM INVESTING ACTIVITIES	**(19,732)**	**(14,605)**	**5,127**	+/-
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(54,038)**	**(59,975)**	**(5,937)**	+/-
CASHFLOWS FROM FINANCING ACTIVITIES:				
Revolving Working Capital Support Facility Accessed	36,883	35,407	(1,476)	+
Revolving Working Capital Support Facility Repaid	(35,432)	(53,789)	(18,357)	
Public dividend capital received : Capital	5,000	3,917	(1,083)	+
Public dividend capital received: Revenue	0	2,818	2,818	+
Public dividend capital repaid: Revenue	0	(2,818)	(2,818)	-
Loans received from DH - Revenue Support Loans	47,900	74,930	27,030	+
Capital element of payments relating to PFI, LIFT and finance leases	(181)	137	318	-
Other loans repaid	(119)	(118)	1	
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**54,051**	**60,484**	**6,433**	+/-
INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	**13**	**509**	**496**	+/-
OPENING CASH BALANCE 1ST APRIL 2016	**1,000**	**1,166**	**166**	
CLOSING CASH BALANCE	**1,013**	**1,675**	**662**	



- Cash position slightly better than plan, due to STF drawn down based on achieving Q4 finance element.
- The Trust has borrowings totaling £110.7m as at 31 March 2017.

Non NHS debt over 90 days totals £0.07m, excluding those on payment plans.
NHS debt over 90 days totals £1.0m. This is split as follows:

2016/ 17 Year to date	NHS		Non-NHS	
	By volume Number	By Value £000s	By volume Number	By Value £000s
Total bills paid in the year	2,455	39,147	116,450	213,109
Total bills paid within target	1,768	29,462	96,725	174,942
% of bills paid within target YTD	**72.02%**	**75.26%**	**82.32%**	**82.09%**
% of bills paid within March 2017	**63.01%**	**26.88%**	**78.04%**	**81.18%**



Scheme Summary	Reported Position March 2017 £000s
Medical Equipment	3,667
IT Development	1,219
IT Service Development and Modernisation	1,437
Backlog Maintenance	5,050
Service Development & Modernisation	3,954
Contingency and Developments In Progress	0
Total	**15,327**
Revised CRL	**15,334**
Over / (Under) shoot against CRL target	**-7**

- The in month spend was £5.8m. The main areas of expenditure in March were as follows: £3m backlog maintenance (mainly Neonates and Pilgrim Level 1 facility), £1.3m medical equipment (largest item being an anesthetics machine £0.4m), £1.3m service development (largest item being an X-ray machine £0.4m)
- The CRL has been achieved for the year.

6. Workforce

Executive Responsibility:
Martin Rayson – Director of HR & OD

This page is currently being developed by the Director of Human Resources and Organisational Development. A revised template will be available for 2017 / 2018

7. Exception Report: Well-led

Executive Responsibility:
Martin Rayson – Director of HR & OD

KPI:	**Sickness Absence**	**Owner:**	Director of Human Resources and Organisational Development
Domain:	**Well-led**	**Responsible Officer:**	Assistant Director of Human Resources
Date:	25th April 2017	**Reporting Period:**	March 2017

Exception Details

The Trust has a target of 4% for staff absence. The Trust annual rolling sickness rate of 4.75% as at February 2017 has increased by 0.28% in comparison to the February 2016 figure (4.47%).

Sickness Comparison:

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	4.75% (12 months ending February 2017)

Monthly sickness rate for February 2017 is 5.20%. 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.

The annual cost of sickness (excluding any backfill costs) has increased by £643,905 (from £8,426,095 as at Feb'16 to £9,070,001) compared to 12 months ago.

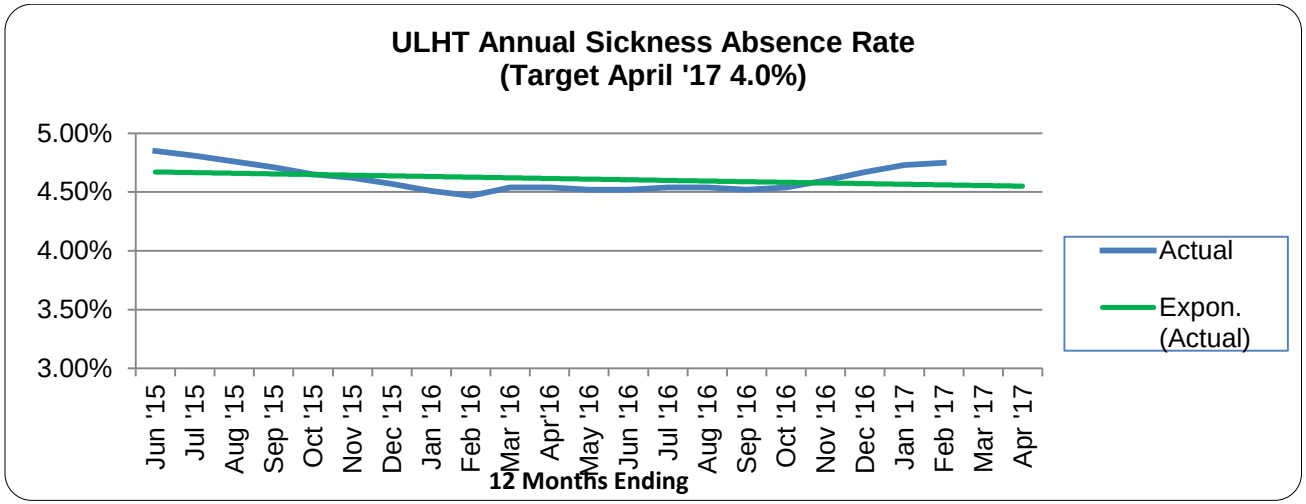
During the 12 months ending February '17, Anxiety/Stress/Depression and other Psychological illness was the top reason for time lost due to sickness at 19.87% of all absence. These 'mirror' patterns across the NHS nationally, incl. MSK

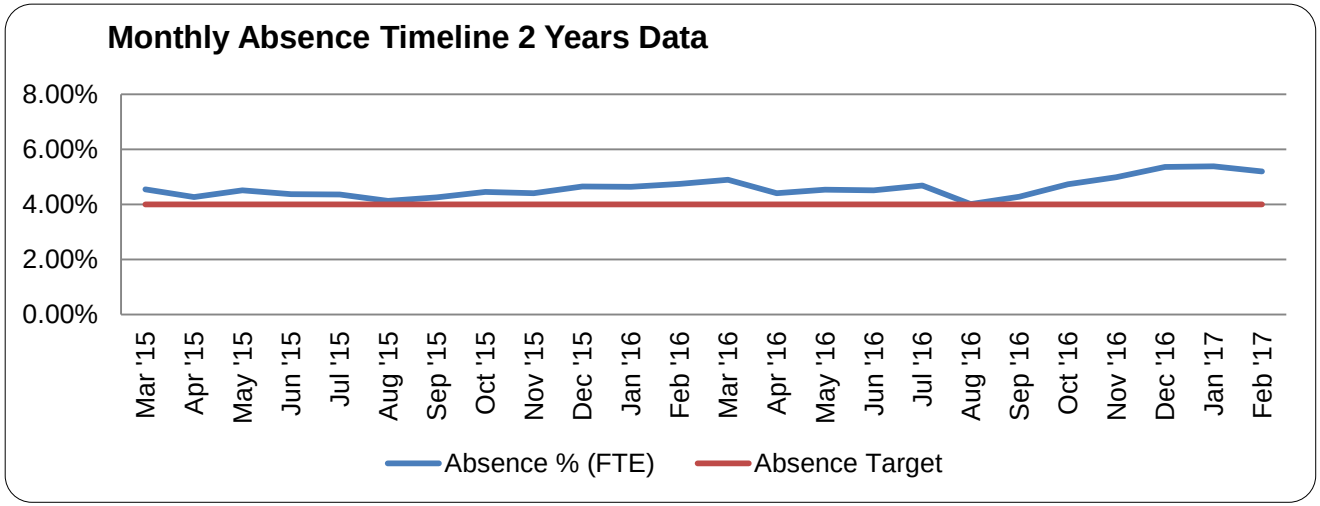
Additional Clinical Services had the highest sickness rate during the 12 months at 7.27% (Unregistered Nurses 8.06%) followed by Estates & Ancillary at 6.49% and Nursing & Midwifery Registered at 4.92%.

Comparison data with some other Large Acute Trusts:

IView Jan 16 - Dec 16 Large Acute Trusts	Absence Rate
Cwm Taf University LHB	5.59%
Aneurin Bevan University LHB	5.22%
Mid Yorkshire	5.22%
Hywel Dda University LHB	5.21%
East Lancs Hosp	4.88%
Betsi Cadwaladr Uni LHB	4.82%
Lincolnshire Utd	4.77%
North Lincolnshire & Goole F	4.76%
Portsmouth Hosp	3.85%
Western Sussex F	3.84%
Barking Hav & R'bridge Uni	3.77%
Gloucestershire Hosp F	3.69%
Hampshire Hosp F	3.65%
London North West Healthcare	3.50%
Royal Berkshire F	3.46%
Frimley Health F	2.94%
Average	**4.37%**

The latest Benchmarking data as at December 2016 from NHS Digital (previously Health & Social Care Information Centre - HSCIC) indicates that ULHT has the seventh highest sickness rate (lowest at 2.94% and highest 5.59%) against an average of 4.37%. The benchmarking is done across x39 Large Acute Trusts.





Action taken to recover performance?

- A recent 'deep dive' of sickness was conducted, and a report was presented to the WF & OF Assurance Committee at the end of March. The report was well received and we agreed to provide and update on progress at a future meeting.
- The 'Management Essentials for ULH' course is available to managers and the programme include how to manage absence as a Leader. This also includes how to conduct challenging conversations.
- 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

What is the recovery date?

We have not met the 4% target in 2016/17. A new target for the KPI has been set for 2017/18, as follows
Overall target of 4.5% + no team over 25% above target

WORKFORCE SCORECARD

Directorate	Sickness Rate (Month)	Sickness Rate (Rolling 12 Months)
Bostonian	9.17%	5.59%
Chief Executive	*10.09%*	*5.47%*
Chief Operating Officer	6.37%	6.03%
Clinical Support Services	4.47%	4.23%
Diagnostics	*4.61%*	*4.25%*
Therapies	*4.48%*	*3.91%*
Outpatient Management	*4.33%*	*4.95%*
Director of Estates & Facilities	*6.21%*	*5.64%*
Director of Finance & Corporate Affairs	*2.30%*	*2.50%*
Director of HR & Organisational Development	*1.31%*	*2.15%*
Director of Nursing	*4.81%*	*5.30%*
Director of Performance Improvement	*1.92%*	*3.42%*
Grantham	6.63%	5.23%
Integrated Medicine Boston	5.46%	5.99%
Integrated Medicine Lincoln	5.83%	5.03%
Medical Director	*3.47%*	*3.29%*
Surgical Services Boston	4.25%	4.12%
Surgical Services Lincoln	5.02%	4.30%
TACC Boston	5.78%	5.27%
TACC Lincoln	5.81%	4.52%
Women & Children's Pan Trust	4.98%	4.76%
ULHT	**5.20%**	**4.75%**

8. Exception Report: Well-led

Executive Responsibility:
Martin Rayson – Director of HR & OD

KPI:	**Vacancies**	**Owner:**	Director of Human Resources and Organisational Development
Domain:	**Well-led**	**Responsible Officer:**	Head of Workforce Intelligence
Date:	25th April 2017	**Reporting Period:**	March 2017

Exception Details

The Trust has a target of having 8% or fewer vacancies across its staffing establishment. The current rate (March) is 10.46%, which is an increase of 0.02% on February. Previous month's performance was:

May 2016	10.17%
June 2016	10.25%
July 2016	9.80%
August 2016	11.75%
September 2016	10.54%
October 2016	11.09%
November 2016	10.75%
December 2016	10.68%
January 2017	10.48%
February 2017	10.44%

Vacancies have increased by 0.29% over the last 11 months (10.17% to 10.46%). However, vacancy levels have reduced since their peak in August 2016.

The Medical vacancy rate remains above 13% at 14.13% which is an increase of 0.27% from the previous month.

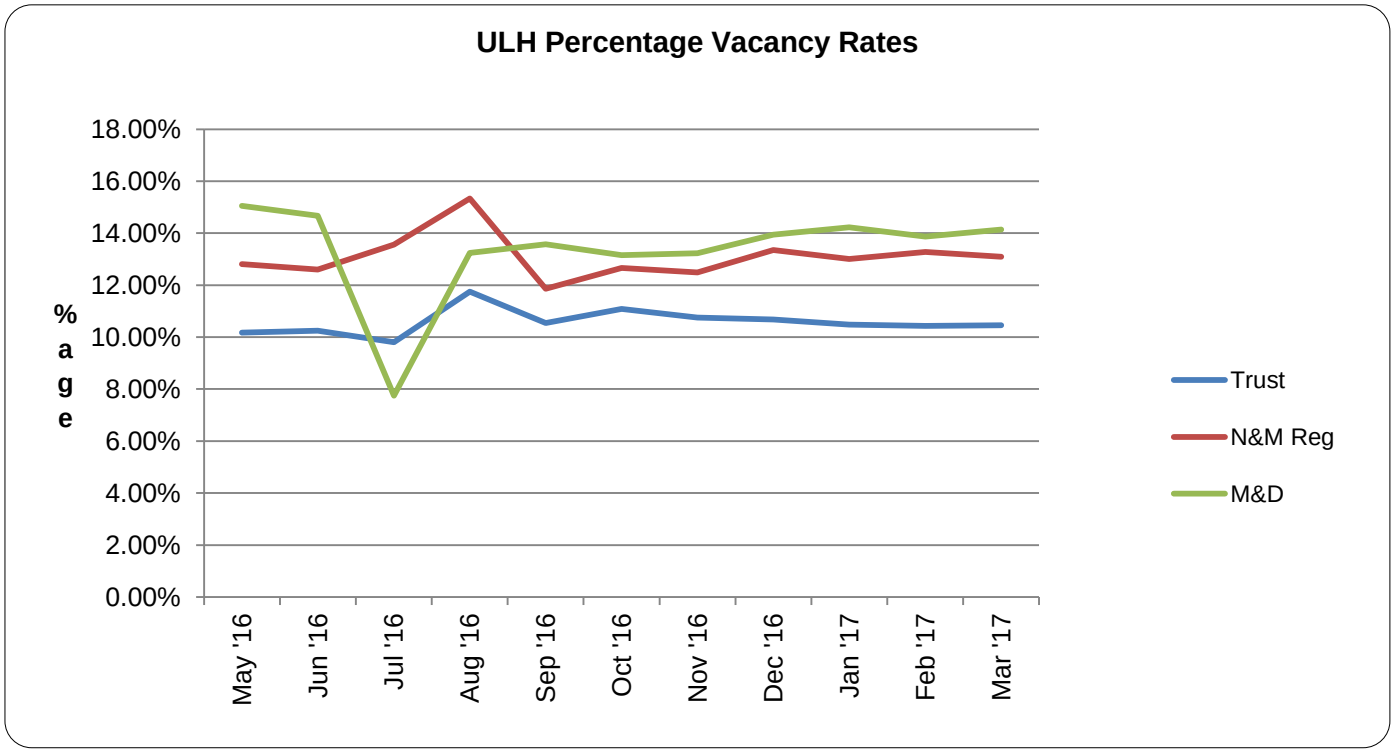
The number of Band 5 Nurses in post has increased over the last 12 months by 22.34 FTES to 1092.07 FTEs. This aside, the vacancy rate for all Registered Nursing & Midwifery staff remains above 13% at 13.09%.

The Unregistered Nursing/HCSW vacancy rate for March is 14.34% which is a decrease of 0.32% from the previous month.

Although we have continued to see a downward trend month on month since peaking in August and October 2016, but we have not met the annual target. Revised targets will be set for 2017/18.

What action is being taken to recover performance?

- The Nursing Recruitment Plan was shared at the WF & OD Assurance Committee during March and subsequently signed off
- The Medical Recruitment Plan will be discussed at the WF & OD Assurance Committee during May.
- An update will be provided at WF & OD Committee in the coming months on the progress with regards to the Recruitment Plans.
- As part of the ESR Work Programme, a business case is being drafted to support a project to update/amend hierarchies in ESR to reflect the Clinical Directorate Structures. By using correct work structure/hierarchy functionality in ESR it will provide an opportunity to work with Finance colleagues to create and record individual uniquely/appropriately coded posts for all funded establishment. This will enable us to performance unique tracking of individual posts and allows for enhances vacancy control. This can be supported by 'real-time' reports on WTE establishments



What is the recovery date?

New targets have been set for 2017/18, as follows:
Medical – 12%
Reg Nursing – 11.5%
AHPs – 10%

8. Exception Report: Well-led

Executive Responsibility:
Martin Rayson – Director of HR & OD

KPI:	**Staff Turnover**	**Owner:**	Director of Human Resources and Organisational Development
Domain:	**Well-led**	**Responsible Officer:**	Head of Workforce Intelligence
Date:	25th April 2017	**Reporting Period:**	March 2017

Exception Details

The Trust has a target of 8% staff turnover. The current 12 month rolling average as at March is 9.77%, which is an increase of 0.42% on February. Previous month's performance was:

April '16	10.06%
May '16	9.81%
June '16	9.78%
July '16	10.02%
August '16	9.76%
September '16	9.45%
October '16	9.80%
November '16	9.81%
December '16	9.48%
January '17	9.59%
February '17	9.35%

Records show that the Trust has not had a turnover rate at 8% or lower since 2010/11. Turnover rate is the lowest it has been all year, down from 10.06% to 9.35%

Turnover rate excluding retirements: The turnover rate for the 12 months' ending 31st March '17 is 7.30% in comparison with the previous month of 7.05%.

We've had 70.48 WTE leavers during March. Of the leavers 33.76% was due to retirement and 60.59% was due to voluntary resignations. The majority of leavers (voluntary resignations) for this period are linked to AHPs in particular, Physiotherapist (3 WTE) & Radiographers (5 WTE) and Band 5 Registered Nurse (9.95 WTE).

Staff Turnover – Year on Year comparison

Mar '16	10.02%
Mar '15	10.99%
Mar '14	10.06%

Comparison data indicate that the annual turnover rate/trend has been at the average of 10% over the past 4 years.

Number of Permanent Employees Leaving with 12 Months or less employment

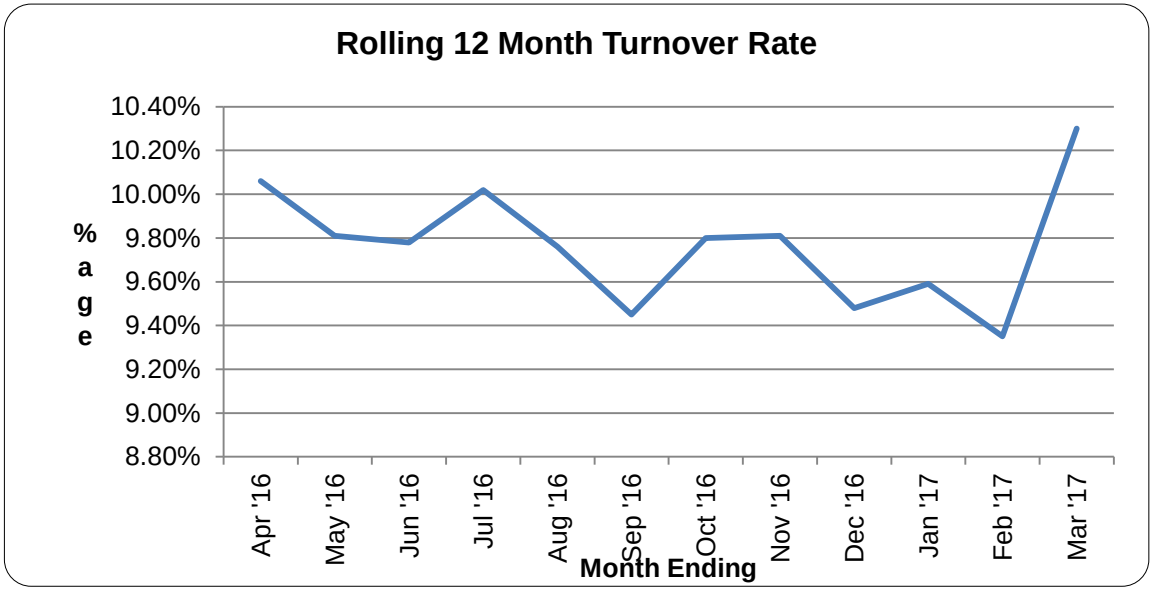
	Year				
Staff Group	13/14	14/15	15/16	16/17	**Total**
Add Prof Scientific and Technic	4	3	4	5	**16**
Additional Clinical Services	10	15	11	14	**50**
Administrative and Clerical	14	16	25	26	**81**
Allied Health Professionals	7	9	8	8	**32**
Estates and Ancillary	14	8	7	7	**36**
Healthcare Scientists	1		3	2	**6**
Medical and Dental	6	4	8	1	**19**
Nursing and Midwifery Registered	43	73	44	29	**187**
Students		2	1		**3**
Total	**99**	**130**	**111**	**90**	**430**

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.

Nursing and Midwifery turnover rate has increased in month to 8.42% (slightly up from 8.14%). Medical and Dental Staff turnover rate has increased in month to 14.42% (up from 14.09%).

Based on the latest (January 2017) benchmarking data available (x39 Trusts) from NHS Digital (previously Health and Social Care Information Centre) for other Large Acute (Non-Teaching) Hospitals:

- The current Trust turnover rate of 10.30% is below the average of 10.49%
- The current Trust Nursing & Midwifery (Registered) turnover rate of 9.27% is below the average of 11.06%,
- AHP's 14.36% is above the average of 12.90%.



What action is being taken to recover performance?

- 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.
- Workforce Scorecard comparative data has been shared with the Directors/Clinical Directors, which shows compliance against key workforce indicators
- The STP 'models' a different workforce and the use of vacancies/turnover will be a factor to 'facilitate' the shift in the workforce across services/organisations and work streams.
- We will link closely with the Lincolnshire Attraction Strategy to identify 'methods' to increase staff numbers (next working group meeting taking place at end of April)

What is the recovery date? We did not achieve the target of 8% at the end of March. A new target will be set as part of the development of the People Strategy

Trust Turnover

Staff Group	Establishment as at 31.03.17	SIP as at 1.04.16	SIP as at 31.03.17	Average SIP	Leavers 1.04.16 - 31.03.17	Turnover SIP	Turnover Leavers against establishment
Nursing & Midwifery	2268.75	1935.96	1971.67	1953.82	164.48	8.42%	7.24%
Medical (excluding juniors)	555.73	464.67	476.85	470.76	67.57	14.35%	12.15%

Directorate	Rolling 12 Month %age Turnover rate
Bostonian	1.10%
Chief Executive	14.80%
Chief Operating Officer	9.59%
Clinical Support Services	14.85%
Diagnostics	*13.16%*
Therapies	*20.96%*
Outpatient Management	*10.18%*
Director of Estates & Facilities	8.06%
Director of Finance & Corporate Affairs	10.81%
Director of HR & Organisational Development	17.50%
Director of Nursing	14.29%
Director of Performance Improvement	6.64%
Grantham	11.02%
Integrated Medicine Boston	9.06%
Integrated Medicine Lincoln	9.27%
Medical Director	8.59%
Surgical Services Boston	8.57%
Surgical Services Lincoln	6.12%
TACC Boston	6.43%
TACC Lincoln	7.31%
Women & Children's Pan Trust	9.02%

8. Exception Report: Well-led

Executive Responsibility:
Martin Rayson – Director of HR & OD

KPI:	**Medical Staff Engagement (Medical Appraisals)**	**Owner:**	Medical Director
Domain:	**Well led**	**Responsible Officer:**	Head of Medical Revalidation
Date:	25th April 2017	**Reporting Period:**	March 2017

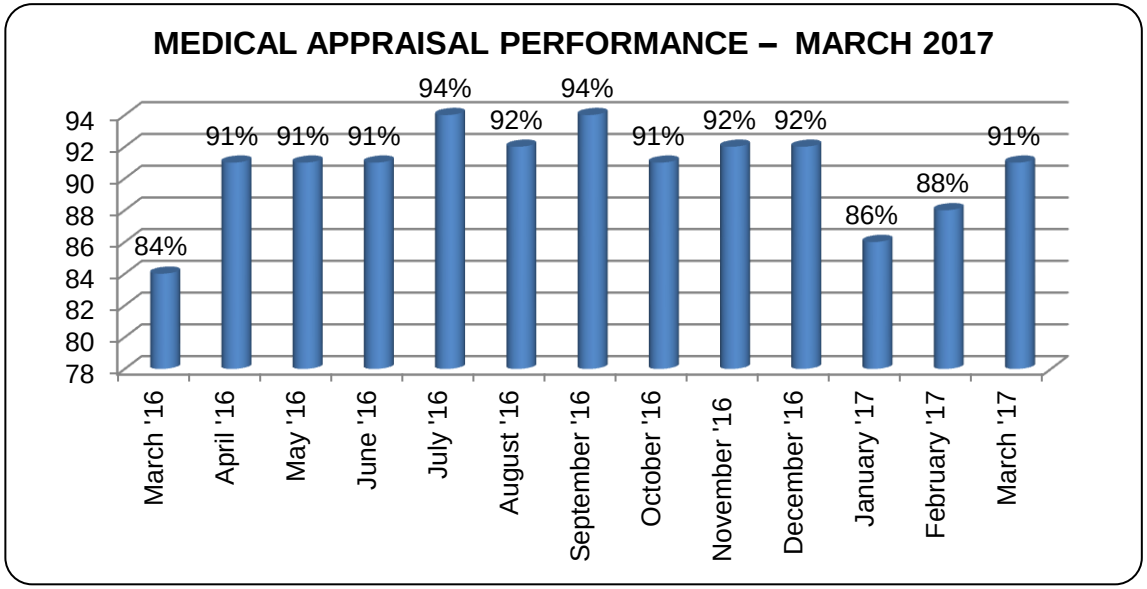
Exception Details

Medical Staff appraisal compliance rate for Appraisal year ending March 2017 is 91% - 4% below the 95% year-end target. The figure includes Consultants, SAS Doctors and includes Trust Locums.

High turnover of doctors, in particular short term locums covering gaps in junior doctor rotas, continues to present a challenge as a low % of new starters have previously been appraised. The Trust allocates an appraisal month for this group of doctors usually within six months of commencement.

The current appraisal rate of 91% is improved compared to the end of March 2016 position of 84% and the 86% February 2017 figure.

Meetings with Doctors whose appraisals had not been completed took place throughout March in order to establish the support needed to enable completion and to remind them of the contractual and professional requirement to participate in annual appraisal.



Outstanding appraisals are at various stages of completion ranging from incomplete documentation; documentation complete awaiting appraisal meeting or awaiting final sign-off. Only 4 doctors will have a recorded missed appraisal for 2016/2017. These doctors are now being managed in accordance with the Trust Medical Appraisal escalation process.

There is now much improved communication with doctors who in the past have failed to respond to email requests and letters to make contact with the Revalidation Office. The use of mobile and telephone contact to establish the position with appraisal arrangements has been successful and medical secretaries continue to be really helpful.

Only one doctor has submitted a formal request in March to postpone their appraisal. Delay in final sign off of appraisal documentation has again improved for a third month. The Revalidation Office will continue to closely monitor progress to ensure timely sign off meets the GMC requirements of 28 days following the appraisal meeting.

The appraisal rate for locum doctors employed to cover gaps in junior doctor rotas has increased from to 31% to 54% at the end of March position. A total of 22 doctors have not worked in the UK previously and have therefore not yet participated in the appraisal process.

Although short term locum turnover is high, Doctors in this group are encouraged to engage in medical appraisal during their contract period which ranges from one month to 12 months.

What Action is being taken to Recover Performance?

- There is a plan in place for each doctor whose appraisal has not taken place before the end of March 2017. Clinical Directors will be notified of the names of Doctors who have failed to have an appraisal in the 2016-2017 appraisal years. There is a plan to provide a quarterly report to CD's in the 2017/2018 appraisal year.
- Proposal to increase the admin support to the Revalidation Office (0.53 of Band 2) to ensure improved governance to Revalidation processes. Awaiting decision from the Interim Director of Finance.
- The Revalidation Office will continue to closely monitor and take prompt action when appraisals are not undertaken as planned. The new Allocate e-appraisal system allows the Administrator to track progress with timely completion of appraisal documentation. This enables early intervention and support to both appraisee and appraiser.
- Notification of '*Appraisal Due'* sent to Doctors 4 months prior to their appraisal month. Strict adherence to the escalation processes set out in the Medical Appraisal Policy, with particular focus on the allocation of appraiser to appraisee 6 weeks prior to the appraisal due date if the doctor has not confirmed appraisal details.
- Continued close monitoring of appraisal progress on the e-allocate appraisal system. Reminders sent to Appraisers to complete Appraisal Output documentation and *sign off* appraisal documentation within 28 days of the appraisal meeting in order to meet the GMC requirements.
- Ensuring new and existing doctors receive continued support to use the new Allocate system.

What is the recovery date?

31st October 2017

8. Exception Report: Well Led

Executive Responsibility:
Martin Rayson – Director of HR & OD

KPI:	**Staff Engagement (Staff Appraisals)**	**Owner:**	Director of Human Resources and Organisational Development
Domain:	**Safe**	**Responsible Officer:**	Head of Workforce Intelligence
Date:	25th April 2017	**Reporting Period:**	March 2017

Exception Details

The Trust has a target of 95% for Appraisals. Agenda for Change Staff Appraisal compliance rate for March is 64.90%.

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

The overall percentage for appraisals has reduced by 1.03% from the previous month and 5.50% since the end of November 2016.

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 64% - 70% range.

Appraisal compliance rate is calculated based on a percentage of appraisals completed over a 12-months' rolling period. The 'target' of 95% is based on the expectation that every member of staff should have an appraisal and it should take place on or before the employment 'anniversary' date or within 12 months from previous appraisal. The other 5% is provision for absence, maternity leave etc.

X1 Directorate has a compliance rate less than 50%
X8 Directorates have a compliance rate between 50% and 65%
The remaining x9 Directorates have a compliance rate between 65% and 80.00%

Appraisal rates reduced at Lincoln (-2.83%) but increased on all other sites Louth (6.14%), Grantham (2.13%) and Pilgrim (0.09%) compared to the previous month end.

Directorate	Appraisal Rate (Excludes Medical Staff)
Director of Nursing	44.44%
CSS Outpatient Management	*51.76%*
TACC Lincoln	52.43%
Director of Finance & Corporate Affairs	54.26%
Integrated Medicine Boston	56.28%
Director of Estates & Facilities	57.65%
Medical Director	61.76%
Director of Performance Improvement	61.95%
Clinical Support Services	64.03%
Chief Operating Officer	64.79%
CSS Diagnostics	*64.97%*
Integrated Medicine Lincoln	65.73%
Surgical Services Boston	66.17%
Surgical Services Lincoln	66.67%
Women & Childrens Pan Trust	69.05%
Bostonian	70.21%
CSS Therapies	*72.44%*
TACC Boston	77.82%
Chief Executive	80.00%
Grantham	82.19%
Director of HR & Organisational Development	82.81%

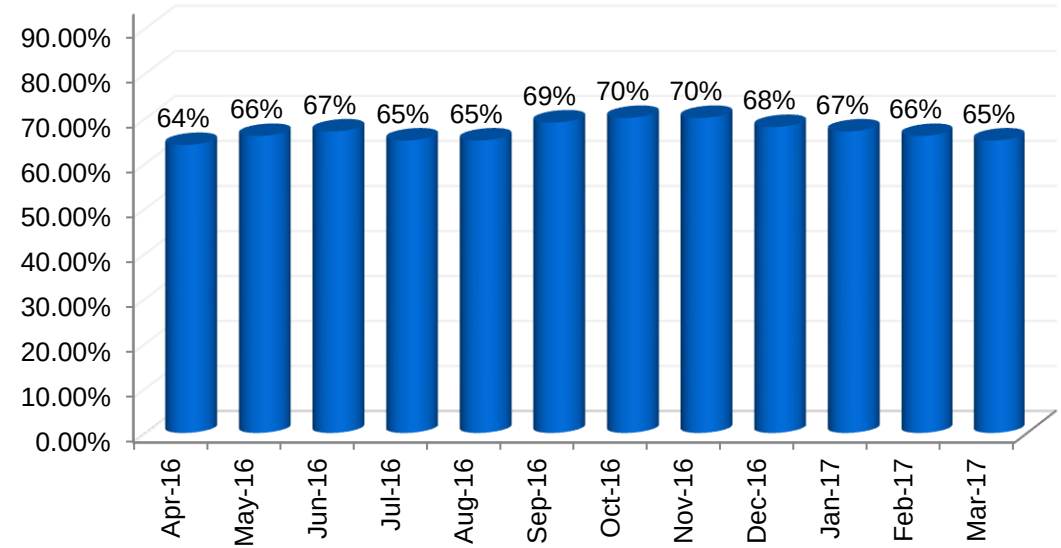
We have consistently not achieved a compliance rate above 70% (highest to date) and we must therefore look for a concerted effort from leadership to achieve the target during 2017/18.

What action is being taken to recover performance?

- Director of HR/OD is writing direct to all managers responsible where appraisals are not shown to be completed (coped to the relevant Director). Responses suggest many appraisals have been completed, but have not been recorded on the system.
- We are having a 'fresh' look at the system for reporting appraisals (completion dates and reporting 'outcomes) and agree way forward. Recent 'audit' shows that 1491 appraisals have been input directly into ESR via Supervisor self-service and 1264 have been manually entered by HR using reports from the intranet.
- Refresh publication of the availability of the ½ day Appraisal Workshop for managers, to support managers in conducting effective staff appraisals.

What is the recovery date?

- We did not achieve the annual target by the end of March 2017. A new target has been set for 2017/18 as follows:
    - Medical – 95%
    - Non-Medical – 85%



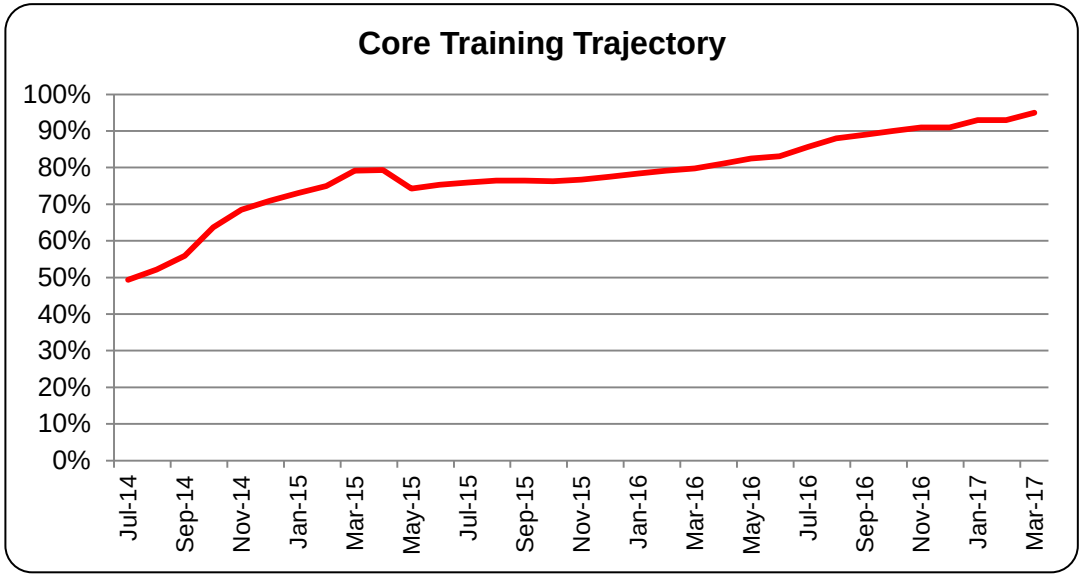
8. Exception Report: Safe

Executive Responsibility:
Martin Rayson – Director of HR & OD

KPI:	**Core Learning**	**Owner:**	Director of Human Resources and Organisational Development
Domain:	**Safe**	**Responsible Officer:**	Head of Workforce Intelligence
Date:	25th April 2017	**Reporting Period:**	March 2017

Exception Details

The Trust has a target of having 95% for Core Learning. This month compliance increases by 2% to 90%. Although previous month on month increase in compliance is 'marginal', the compliance rate is at its highest since July 2014.



Apr-16	*81%*
May-16	*82%*
Jun-16	*83%*
Jul-16	*86%*
Aug-16	*86%*
Sep-16	*87%*
Oct-16	*85%*
Nov-16	*86%*
Dec-16	*87%*
Jan-17	*87%*
Feb-17	*88%*
Mar-17	*90%*

Core Learning Compliance rate (Year-on-Year) comparison:
July 2014 - 49% (first recording of average compliance as combined figure of all modules)
March 2015 – 79%
March 2016 – 80%

- Although we have seen a significant increase in the core learning compliance rate since 2014, and further improvement since 2016, the data shows a consistent compliance rate over the last eight months between 86% and 88%. There has been an increase this month by 2% reaching 90% for the first time. The month's compliance is the highest since we started recorded average rate in 2014.
- From October 2016 BLS compliance has been included in overall compliance following the 6 month introduction period. Compliance for BLS has increased by another 2% this month to 75% having increased from April's 24%.
- Annual topics increase at a higher rate this month. Compliance for Fire increased by 4%, Infection Prevention by 5% and Information Governance by 6%. All core topics, apart from the newly introduced BLS, are now 80% or above. And all 3 annual topics are between 18%-20% higher than this time last year.
- Fire compliance is now 85% compared to 65% at the end of March 2016.
- The DNA rate went up 1% to 24% this month although is 2% less than this time last year. Proactive in 'chasing' non attendees with Line Managers which have yielded some improvement.

We have seen a gradual improvement/increase in compliance rate, however it's unlikely that we will achieve our compliance by March 2017.

Trust	Fire	IPC	E&D	IG	SGC1	SGA1	H&S	Slips	M&H IL	Risk	Fraud	BLS	*Average*
Jan-17	80%	81%	97%	82%	91%	90%	90%	92%	91%	89%	92%	71%	87%
Feb-17	81%	81%	98%	84%	92%	91%	90%	92%	91%	89%	93%	73%	88%
* Mar-17	85%	86%	98%	90%	92%	92%	90%	93%	92%	91%	94%	75%	90%
** Mar-17	80%	84%	94%	90%	85%	84%	89%	91%	87%	90%	92%	67%	86%

**Core Learning compliance for AfC Staff*

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

What action is being taken to recover performance?

- The new Core Learning programme allows more flexibility to mix classroom and e-learning with the topics previously available within Core Module 1, bookable as individual sessions on the same date or independently.
- The improvements to the '5 Click' Core Learning reports provide automatic compliance % by Ward/Dept. helping senior managers review compliance for areas within their ESR hierarchy.
- DNA '5 Click Report' provides quick and easy access for managers to all DNA information. This replaces the individual e-mail notifications to senior managers which proved to have no noticeable impact on DNA rates.

What is the recovery date?

The new target for 2017/18 will be set shortly, following a workshop to review core learning content.

Directorate	**March 2017 Average**
Bostonian	88%
Chief Executive	86%
Chief Operating Officer	88%
Clinical Support Services	91%
Director of Estates & Facil	87%
Director of Fin & Corp Affair	96%
Director of HR & Org Dev	95%
Director of Nursing	94%
Director of Perf Improvement	99%
Grantham	92%
Integrated Medicine Boston	84%
Integrated Medicine Lincoln	88%
Medical Director	96%
Surgical Services Boston	89%
Surgical Services Lincoln	88%
TACC Boston	91%
TACC Lincoln	93%
Women & Children's Pan Trust	92%

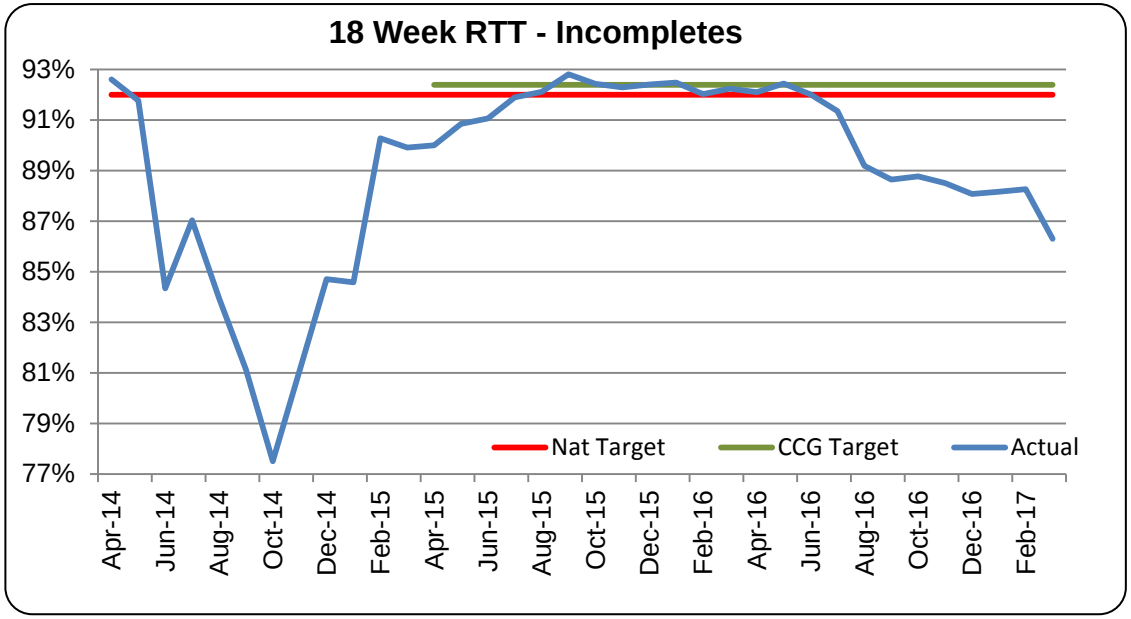
9. "Priority deliverables" – Referral to Treatment

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:	25th April 2017	**Reporting Period:**	March 2017

Exception Details

In February the Trust reported performance of 88.3%, with the backlog of patients over 18 weeks dropping below 3000 for the first time since August 2016. At a national level the standard hasn't been achieved for 12 consecutive months, with an aggregated national performance in February of 90%. One week prior to the final submission for March the Trust's performance level was 86.96%. It is expected that performance will improve prior to the final submission, with a forecast final position in the region of 88.2-88.7%.



There are 3 significant factors which had an impact on performance across a range of specialities in the early months of 2016/17, and led to growth in the RTT backlog:

- Junior Doctor Industrial Action – During the two periods of industrial action in April alone there were 1335 outpatient appointments cancelled as a direct consequence of the Trust needing to maintain patient safety during this action. In addition there was a significant reduction in surgical activity during these periods.
- Grantham Fire – As a result of the fire which occurred at Grantham in April there were c.300 outpatient cancellations and 25 elective cancellations.
- Partial Booking Waiting List – The number of patients overdue over 6 weeks past their target date has reduced by c.1800 patients between the end of June and the end of September. This reduction in the size of the partial booking waiting list will have reduced the capacity available to treat patients on incomplete pathways.

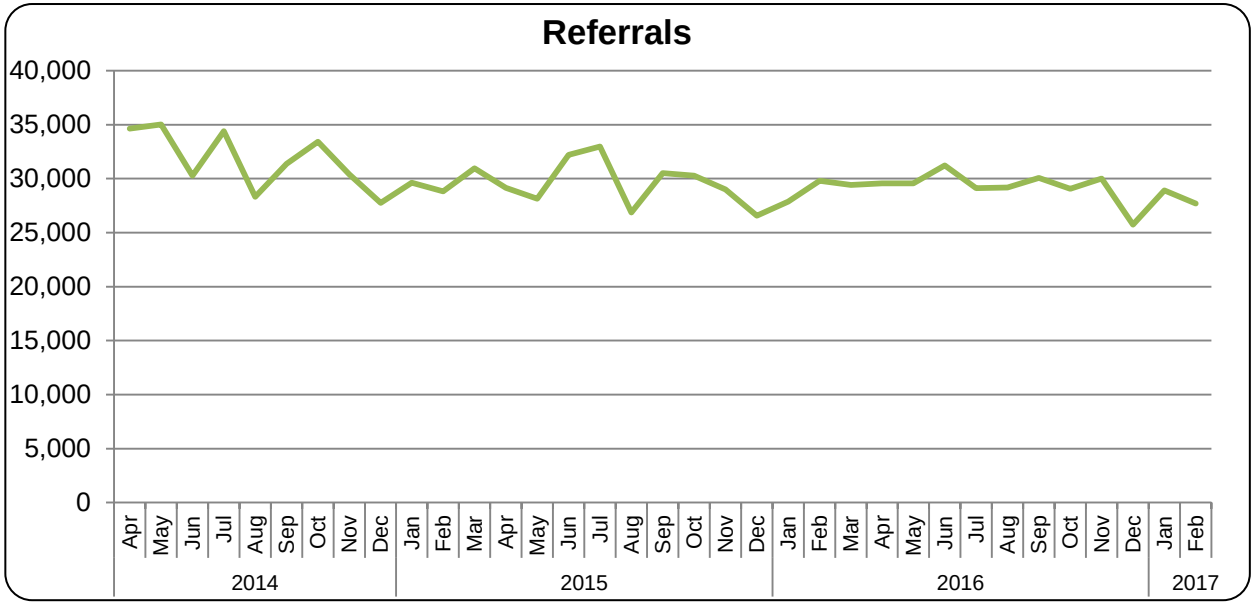
The above factors led to a reduction in capacity within the Trust, and by August 2016 the backlog of patients over 18 weeks had increased to c.3000. This backlog position has been reducing gradually in recent months.

The increase in urgent care pressures during winter has 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 over 300 operations during December and January as a result of capacity issues such as lack of HDU and general beds.

In February and March the winter plan scheduled for a return to standard elective operating capacity. However, the Trust cancelled over 350 operations during February 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 Business Unit management to be involved in assisting with operational management of the sites during times of increased pressure have resulted in reduced Business Unit capacity to progress actions related to RTT recovery across a number of specialities.

The Trust has an agreed trajectory which takes the performance to 92% by July. 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 Cardiology, Respiratory, Neurology and Paediatric Dermatology.

As at month 10 Neurology is 25% above the contracted activity plan, Dermatology is 19%, Endocrine is 19%, Gastro is 15% and Pain is 12%. All of these areas have RTT incompletes performance below 90%.

The fire at Pilgrim at the end of March resulted in 16 cancelled operations. In addition to this capacity for day cases will be restricted for the subsequent 6 week period due to the resultant ward moves, and reduced available bed spaces for these patients.

Out of hours medical cover at Louth is an issue which resulted in 8 inpatient procedures being cancelled in March. Discussions are ongoing with LCHS regarding this situation, however further cancellations have occurred during April as a result of this issue.

What action is being taken to recover performance?

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

Key actions contained within these plans include increasing internal capacity through additional outpatient and theatre sessions from our existing workforce and utilisation of additional locum capacity. Plans were in place in February to deliver additional activity (primarily in outpatients) resulting in c.400 clock stops and c.300 in March, however some of this additional activity will be offset by the high volume of elective cancellations.

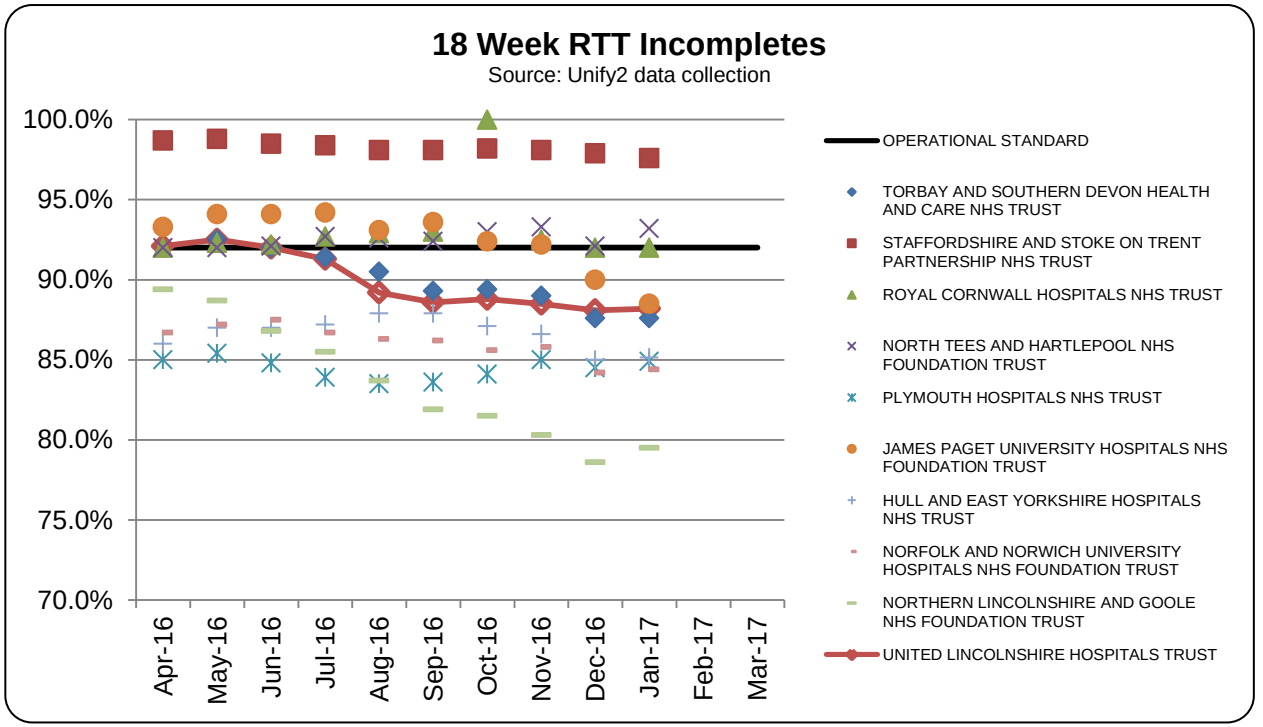
The Clinical Directorates have plans to deliver over 300 additional clock stops above standard activity in April.

The Trust has outsourced 86 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. The position regarding outsourcing during 2017/18 is yet to be confirmed.

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.



In December the Business Units completed a clinical validation process relating to open referrals which have been waiting over 16 weeks from referral in order to ensure that they are appropriate for Consultant-led care. In January the Trust wrote to all patients awaiting a new appointment who were referred over 14 weeks ago, in order to ask them to confirm whether they still required an appointment. This process has now been completed.

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.

What is the recovery date?

June 2017 – with risk

9. "Priority deliverables" – Diagnostic 6wk Standard

Executive Responsibility:
Mark Brassington – Chief Operating Officer

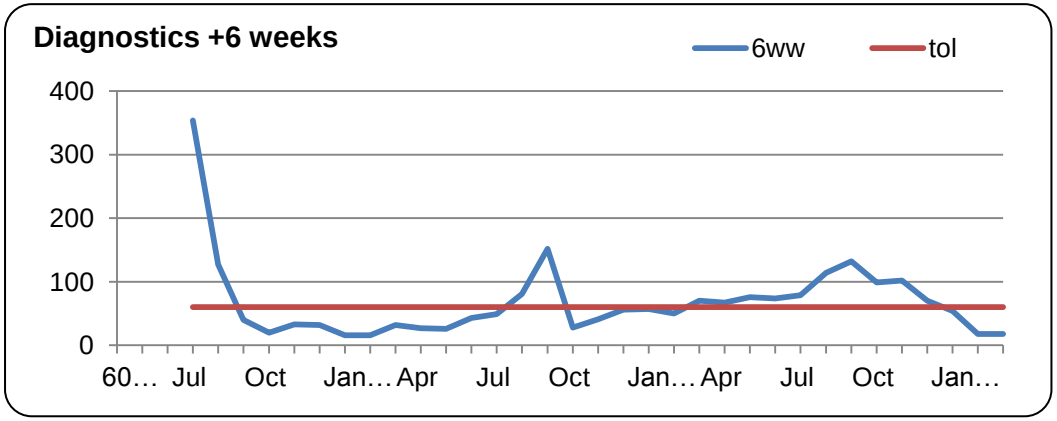
KPI:	**Diagnostic Waits**	**Owner:**	Chief Operating Officer
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Operational Performance
Date:	25th April 2017	**Reporting Period:**	March 2017

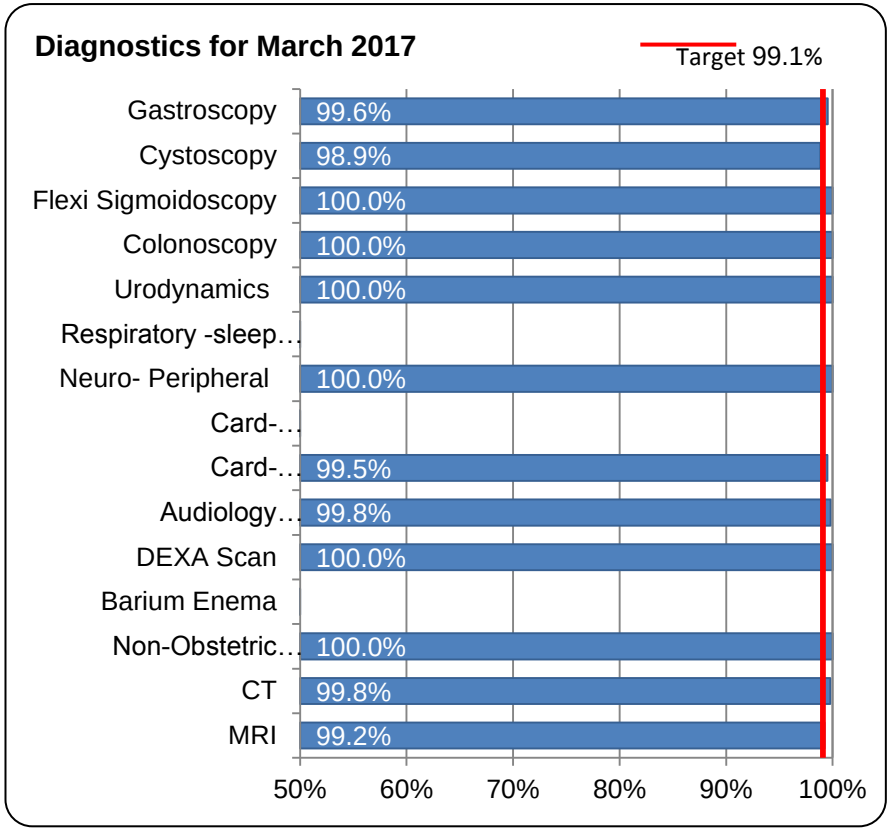
Exception Details

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

The number of 6-week breaches reduced from 102 patients in November down to 18 patients in February and March. At modality level performance of <1% was achieved in all modalities except for Cystoscopy (with this area only reporting 1 breach).

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





9. "Priority deliverables" – Cancer 62 Day Standard

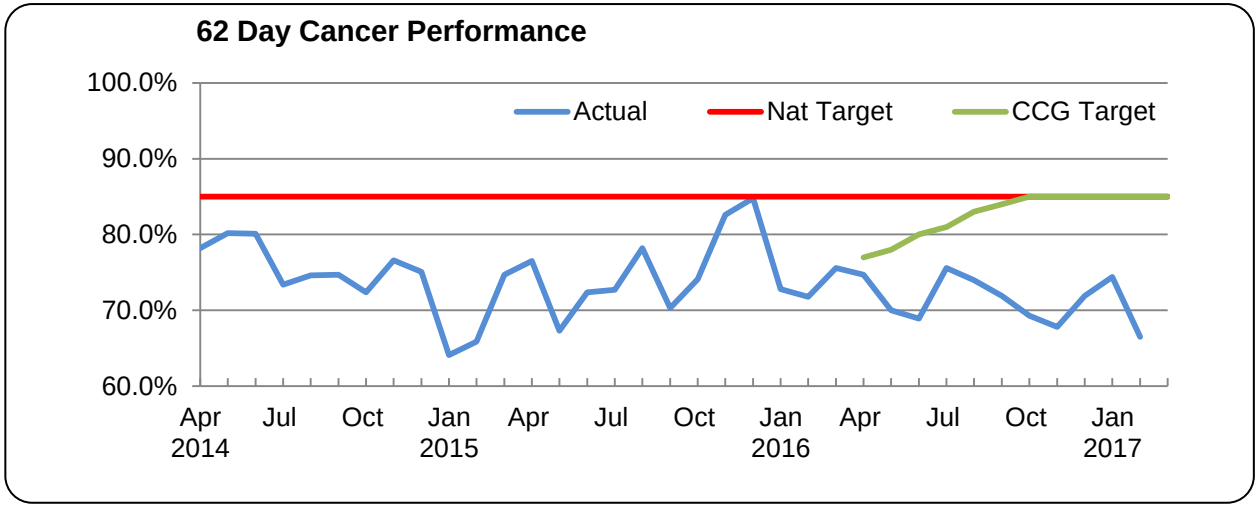
Executive Responsibility:
Mark Brassington – Chief Operating Officer

KPI:	**Cancer Waiting Times (62 Day)**	**Owner:**	Chief Operating Officer
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Operational Performance – Planned Care
Date:	25th April 2017	**Reporting Period:**	February 2017

Exception Details

The Trust achieved a performance of 67.1% against the 62 day classic standard in February. The Trust achieved 4 out of the 9 cancer standards.

Demand is continuing at unprecedented levels (March has the highest recorded 2ww referral rate, 18% higher than same period last year) and the increased number of referrals coming into the Trust, and hence demand on all diagnostics is delaying diagnosis and putting additional pressures to treat the patients within a smaller window before they breach. Though significant effort has been made in all areas on 62 Day performance improvement work, a lot of this effort has been absorbed by the higher levels of patients being referred in on a suspect cancer pathway.



The 62 Day Classic standard continues to remain the most challenged standard and work continues to improve the quality of the patient journey on the understanding that improvements in this will work directly towards achievement of this standard. The RCAs for February 62 day breaches found a number of key themes in terms of access to diagnostics within ULHT, particularly CT biopsies and Endoscopy, was slower than required for a significant proportion of patients on 62 day pathways. Since January Radiology turnaround times have improved for patients on suspected cancer pathways, however the impact of this on the 62 day performance is unlikely to be seen until March and there are still restrictions relating to biopsies due to workforce constraints. In addition, delayed access to specialist tests (such as EBUS and EUS) and treatment at tertiary centres introduces further waiting periods into the 62 day pathways for our patients, deteriorating ULHT's performance. A significant number of patient choice delays, particularly over the Christmas period, also contributed to the Trust's performance position in February. 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 February by a further spike in referrals into the breast service, with referral rates in February of over 144 patients per week compared to a baseline service capacity of 100 slots per week.

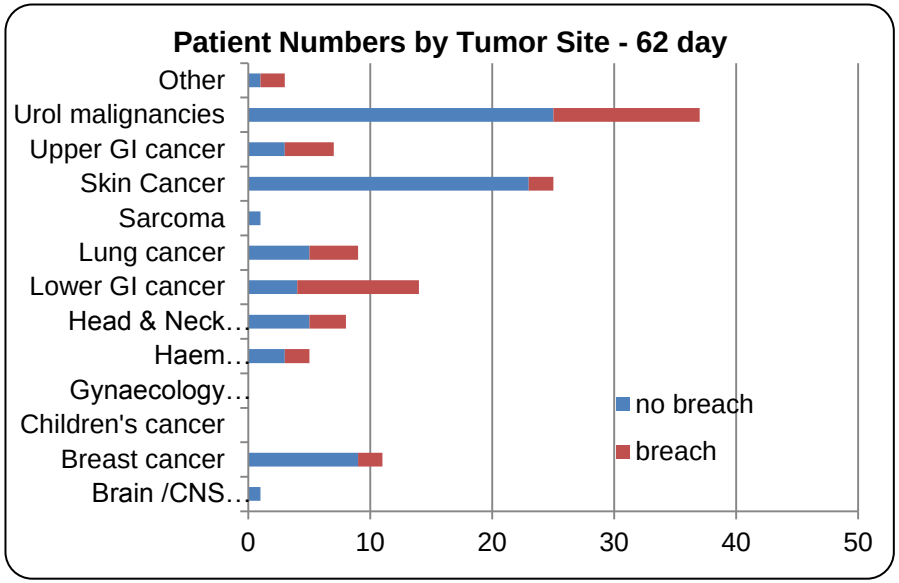
What action is being taken to recover performance?

The Trust holds a fortnightly Cancer Recovery and Delivery meeting, chaired by a Deputy Director, in order to provide an oversight of the change programme set out in the Trust's Cancer Action Plan, holding Business Units 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. The areas that due to operational reasons will not be able to cross over (Brain, Breast, Sarcoma and Dermatology), will continue under the IST Capacity & Demand 85th percentile system.

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

The Upper GI Straight to Test pilot has proven to be successful and county-wide roll-out of the service will be from May 2017. Likewise plans are being developed to roll out the lower GI straight to test pathway to all sites.



The Somerset Cancer Register implementation continues at a fast pace. There are now 172 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.

Radiology are currently piloting a new booking process, 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 utilized 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 May, whilst a Business Case goes through the Trust's IPB process.

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

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

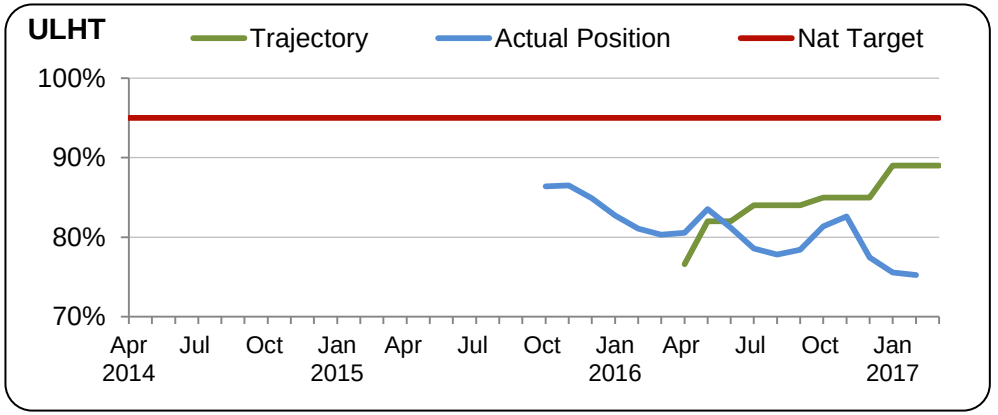
9. "Priority deliverables" – A&E 4hr Standard

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:	25th April 2017	**Reporting Period:**	March 2017

Exception Details

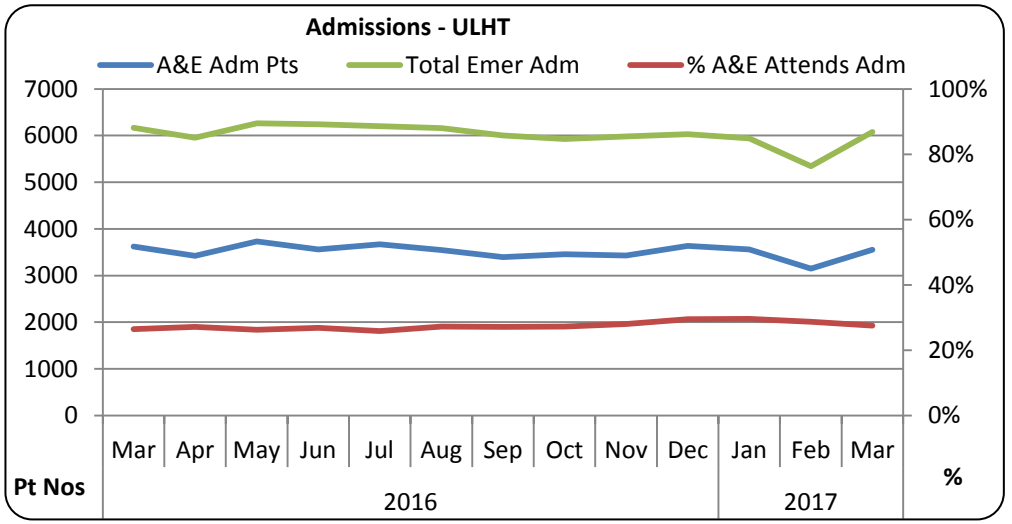
Overall performance for March 17 was 78.78%. This is a 3.91% improvement on last month, 0.62% less than 1 year ago and 9.92% below the 88.7% trajectory. We are currently 82.18% for Q1, which is above the required 82.01% for Q1 2017/18.
Overall attendances have increased by 1917 compared to February, however are 774 less than March 2016. As previously discussed this is associated to the reduced hours at Grantham since August 2016. Against the plan, Lincoln (+163) & Pilgrim (+196) are above plan, whilst Grantham (-693),remain below. Attendances have increased at both Lincoln (4.93%) & Pilgrim (7.87%) compared to March 2016.
The quality measures for March:



- Triage remains below the 15 minute standard at 7 minutes for the median (30 mins based on the 95th centile)
- Time to first 1st treatment has deteriorated slightly at 78 mins for the median against a target of 60 mins (217mins at 95th centile).

EMAS handovers over 1 hour have started to reduce and are 187 less than February.
Following the introduction of Red 2 Green at Lincoln from the 20th February we have seen:

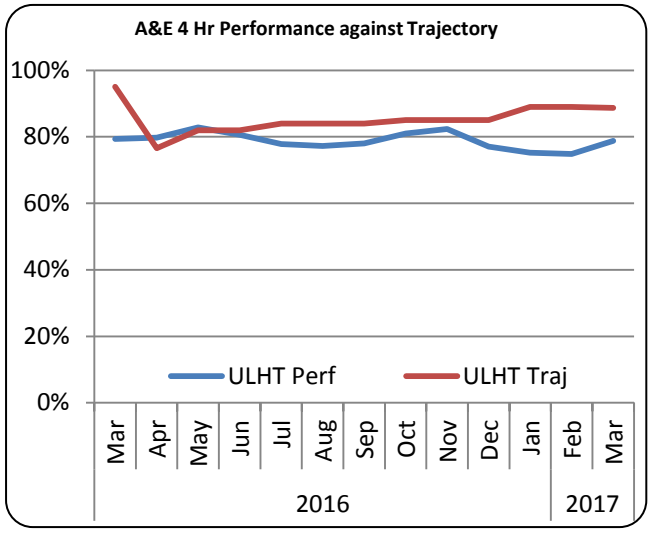
- A continued level of discharge
- Sustained reduction in medical outliers
- Lack of requirement to use 'escalation beds
- Overall decrease in bed occupancy levels
- Significant number of beds available to manage demand overnight
- Reduction in elective cancellations

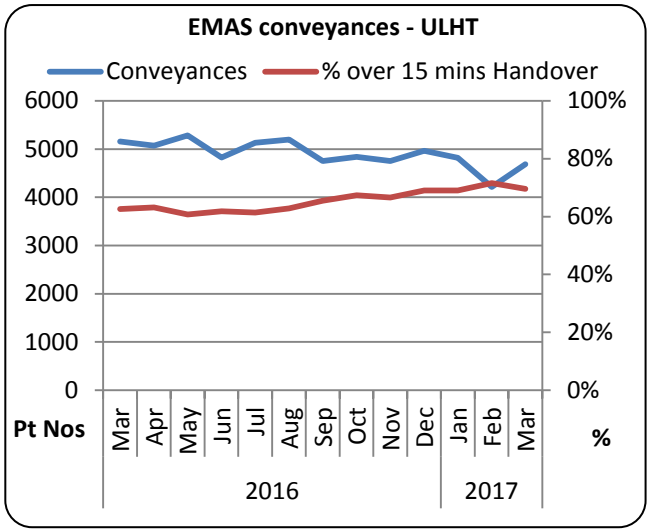


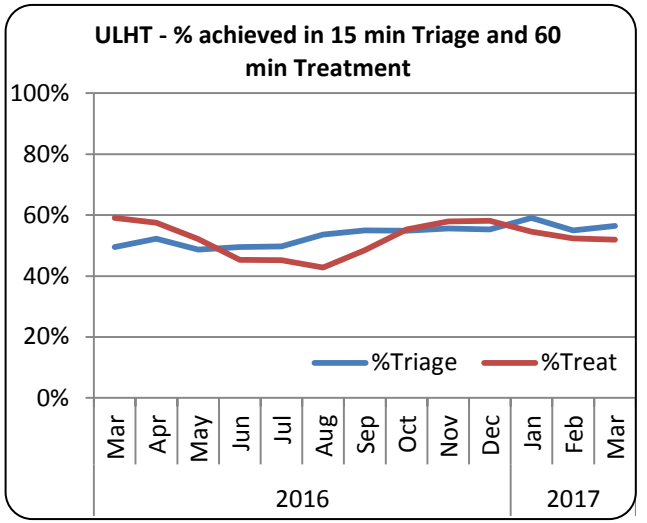
Key issues affecting performance for February were:

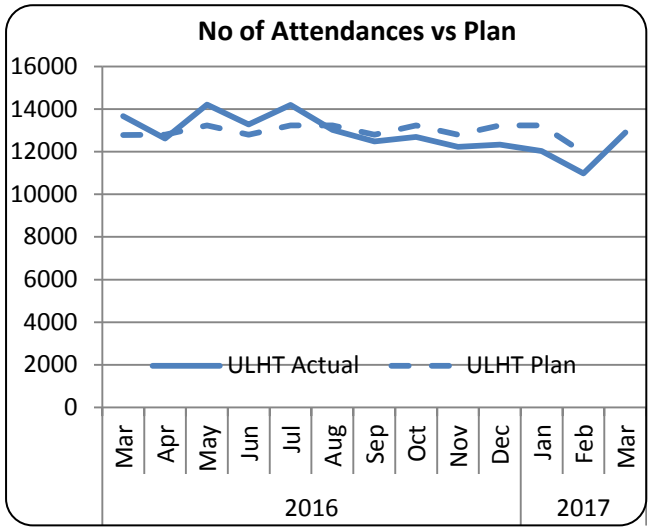
- Workforce numbers remains insufficient to meet historical demand and planned contractual increase
- Continued reliance on agency locums (variable productivity)
- Inability to provide consistent leadership within Emergency departments
- Estate is not fit for purpose to manage ambulance handovers, minors and majors volumes

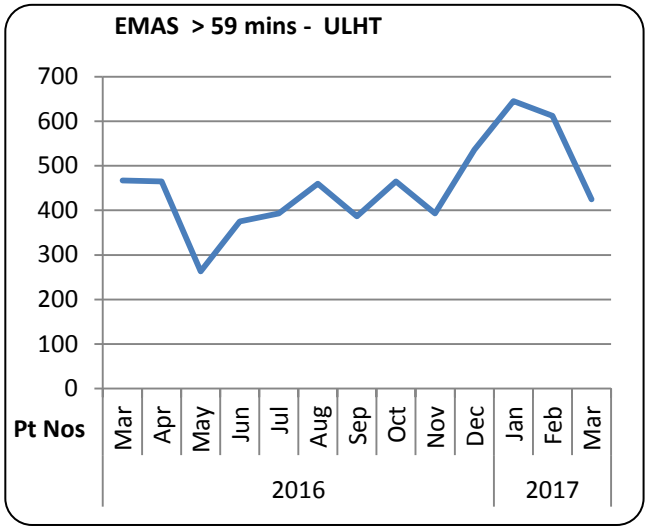
- Bed occupancy levels at Pilgrim remain high, leading to inability to manage surges in demand
- Internal and external delays for patients requiring discharge

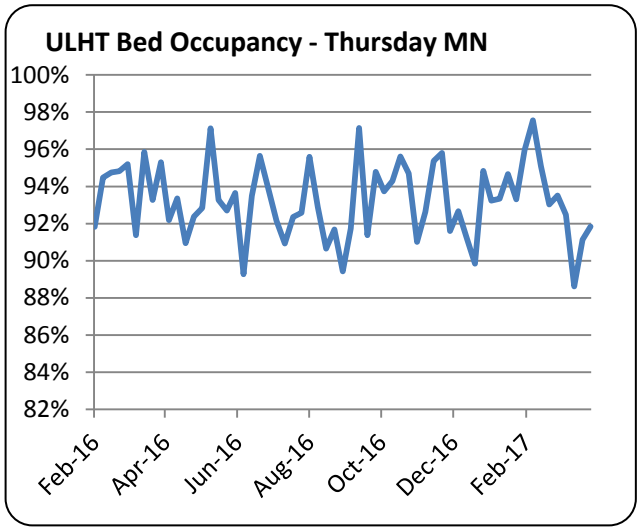




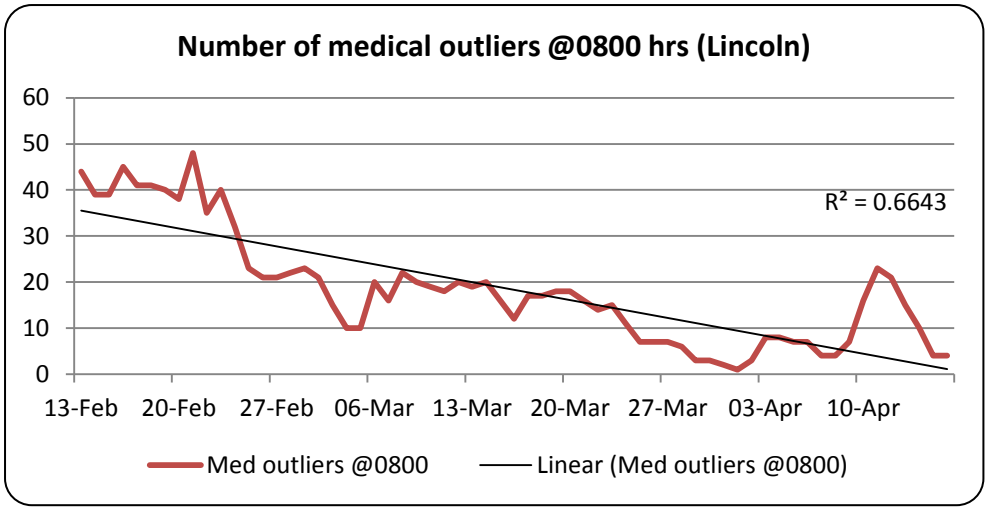


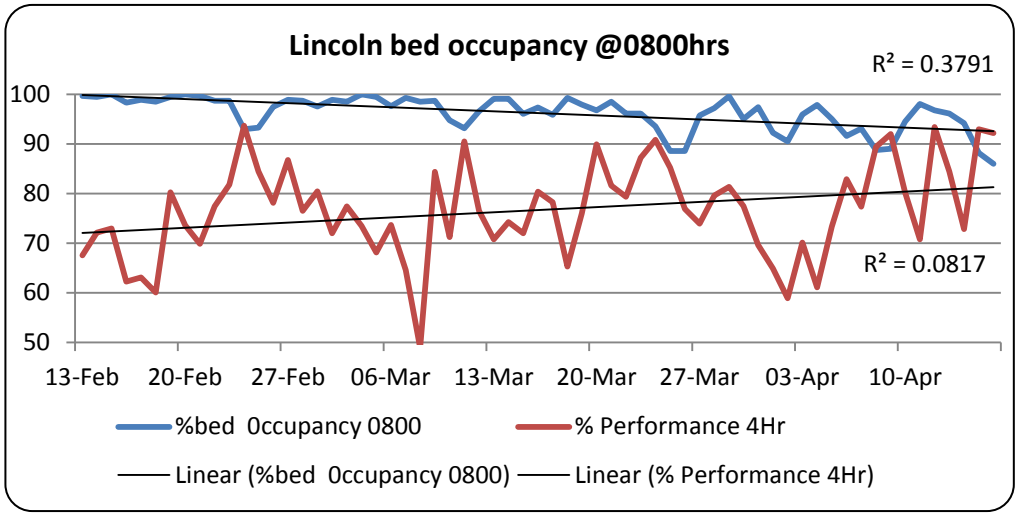


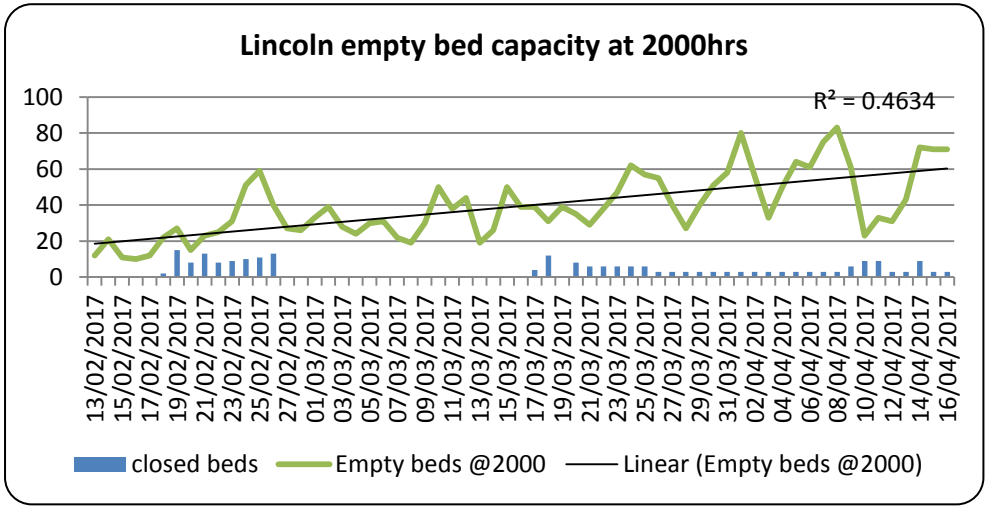


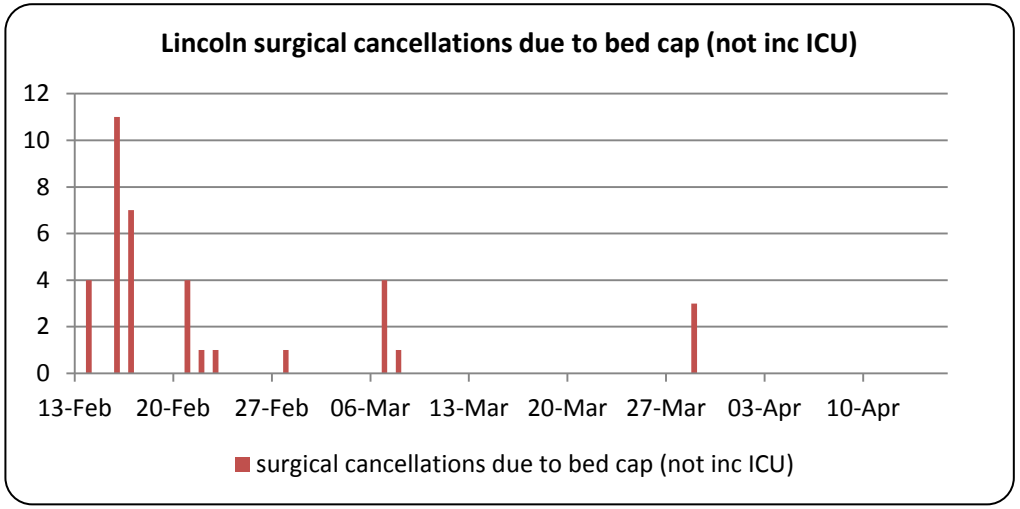


Red 2 Green graphs



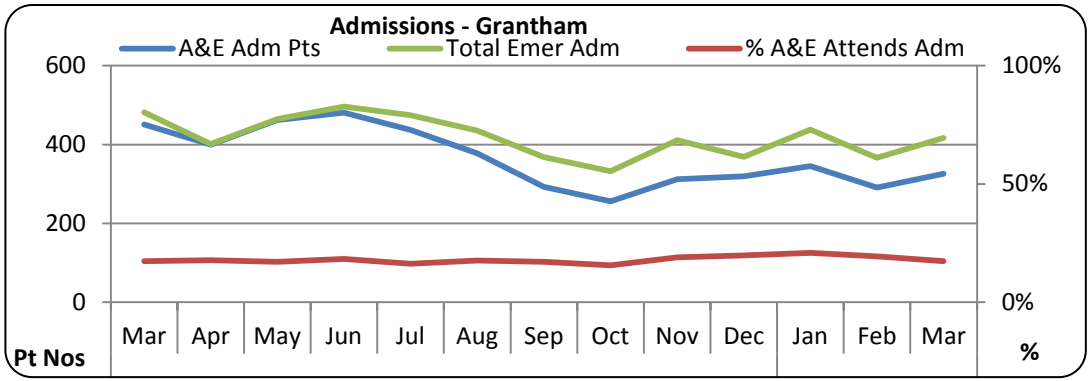


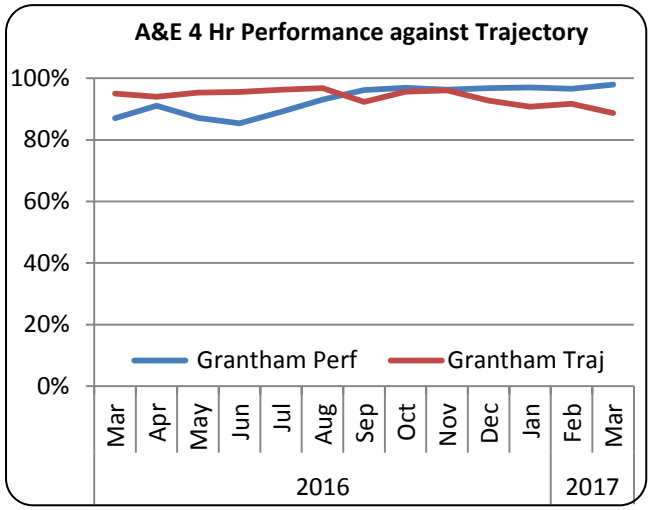


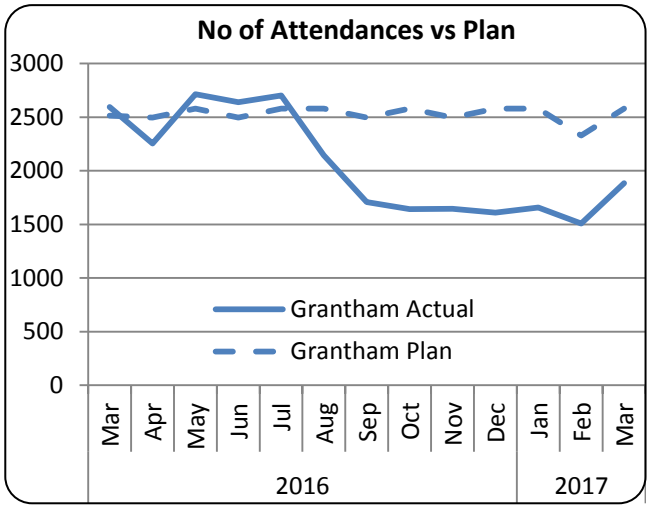


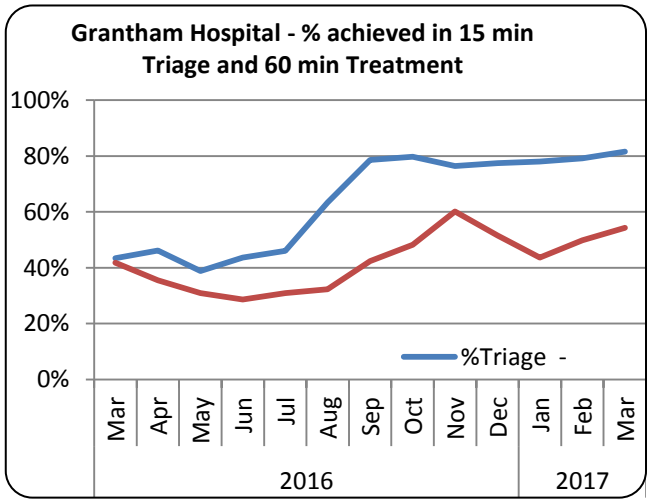
Grantham

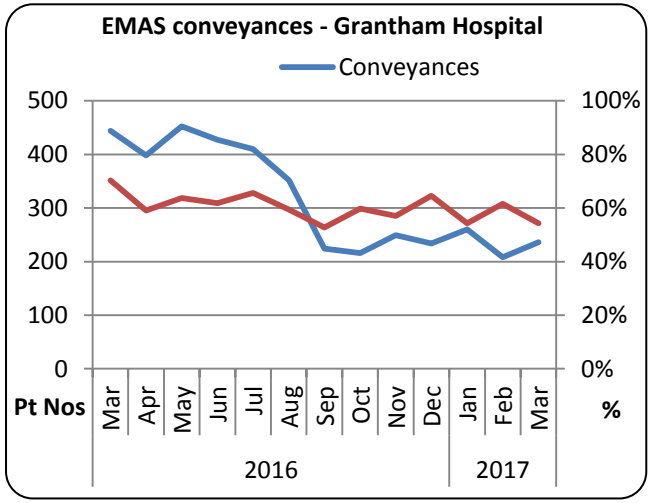
No exception report included as Grantham has exceeded the performance standard for the last two quarters and is on track to deliver the year end position, however the graphs below demonstrate the reduction in attendances (and Ambulance conveyances) since the overnight closure in August 2016.

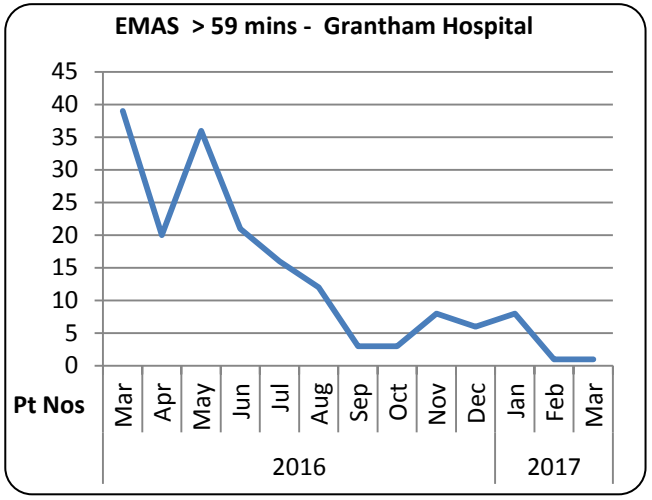












Pilgrim

March's overall performance was 74.36%. This 14.1% below the planned recovery trajectory and 1.31% less compared to March 2016.

Total attendances are above the planned level by 7.87%. Ambulance handover performance for over 1 hour waits deteriorated again in March.

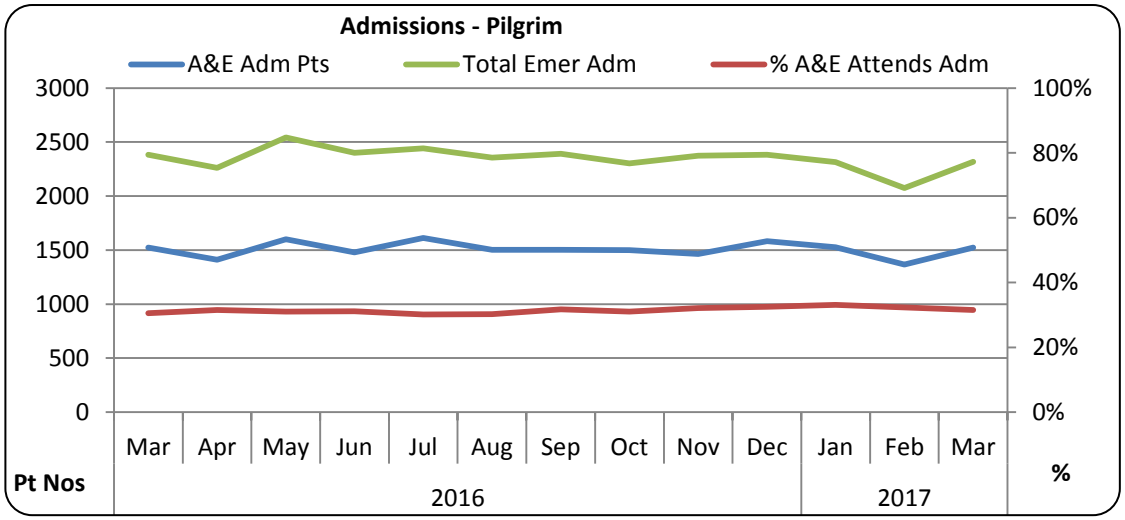
The total emergency admissions are 244 more compared to February (2 days less) and 57 up on March 2016. Bed occupancy rates remained in excess of 95% during March.

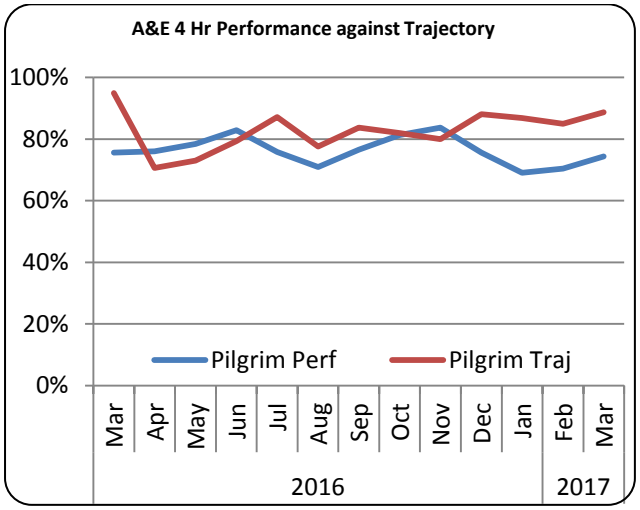
Quality indicators for March:

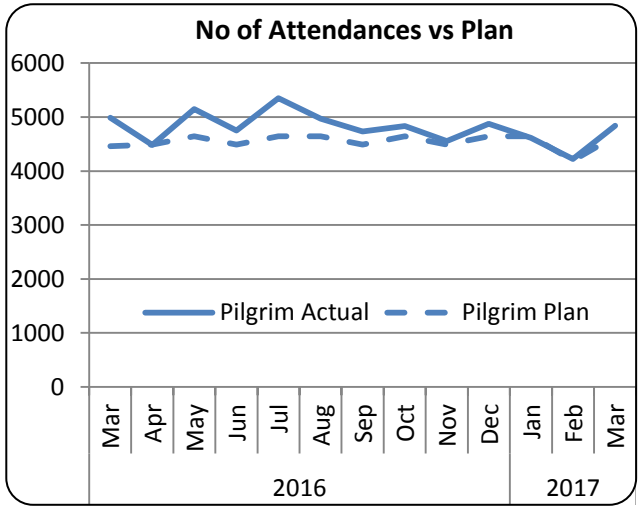
- Arrival to triage median is at 10 minutes (53 mins at 95th centile) against the 15 minute standard
- first treatment median time is 65 mins against 60 mins (220 mins at 95th centile).

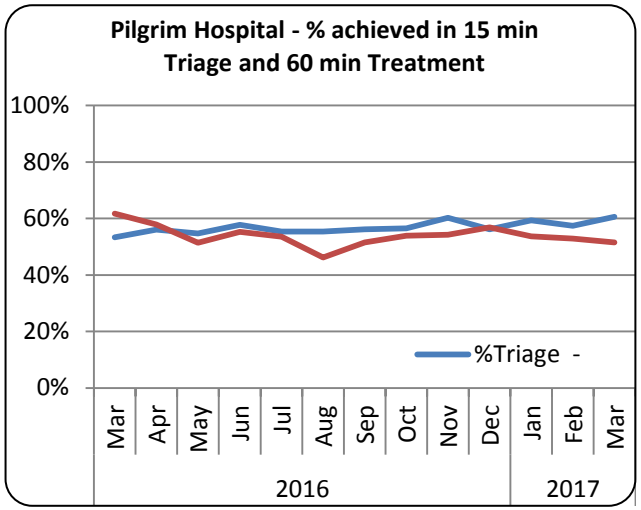
In-month key issues affecting performance in March were:

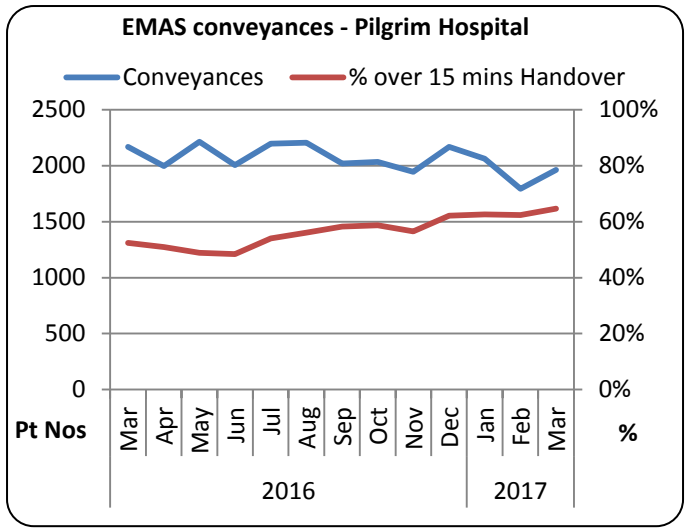
- Vacancies in ED Medical rota's with reliance on agency locums.
- Vacancies in Nursing rota's with a variance in agency or bank fill rates.
- Poor hospital flow – admissions exceeded discharges. The AEC area was frequently used as escalation bed capacity resulting in inefficient processing of ambulatory 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 beds.

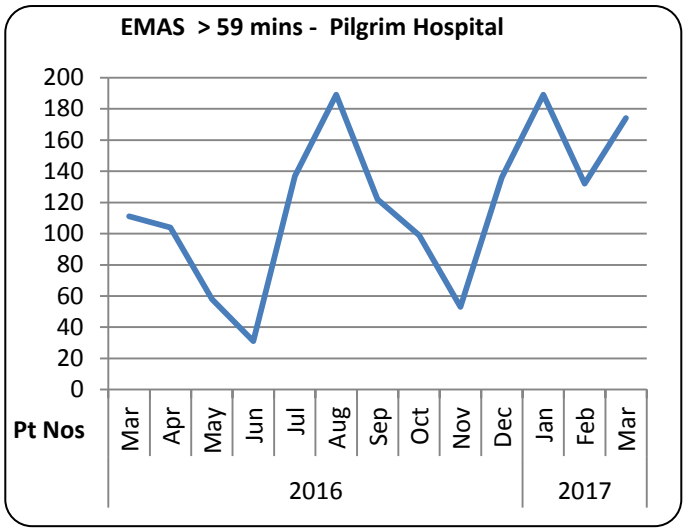


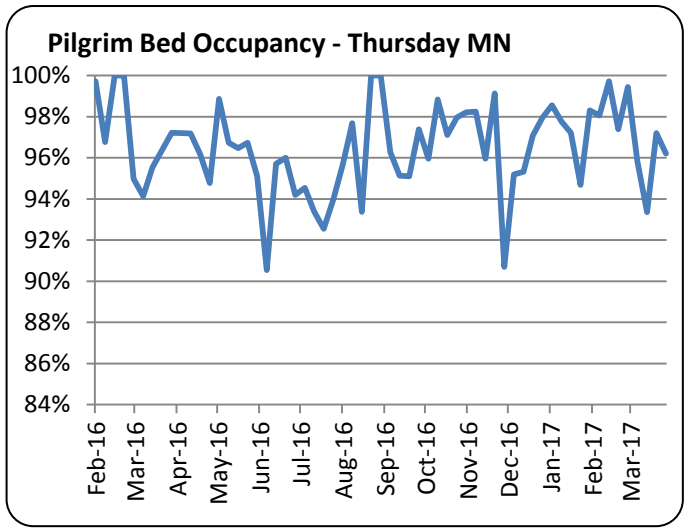






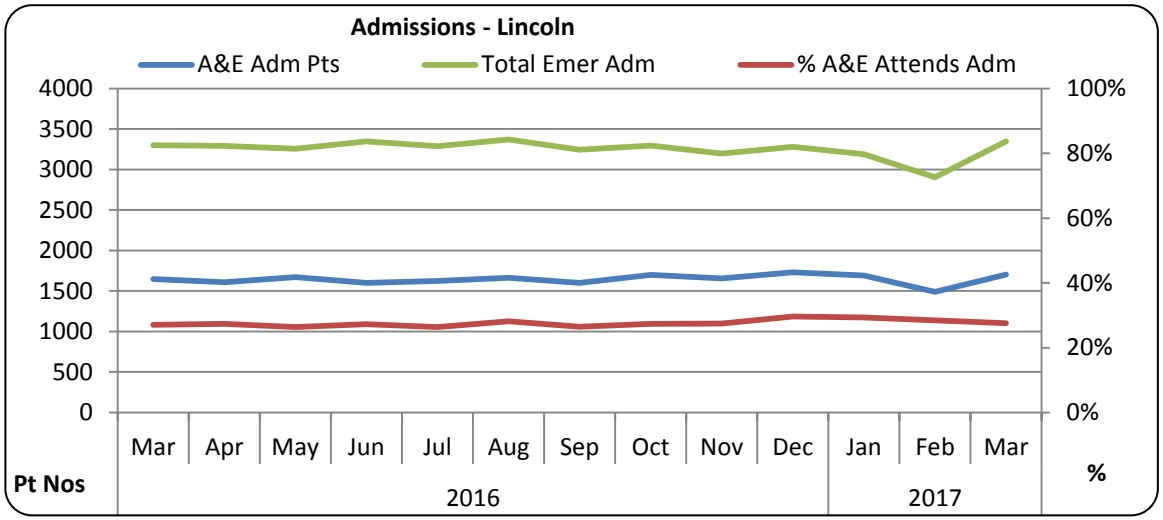




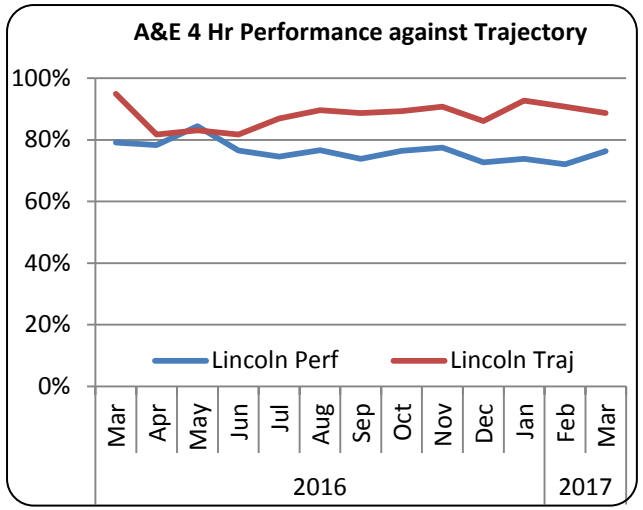


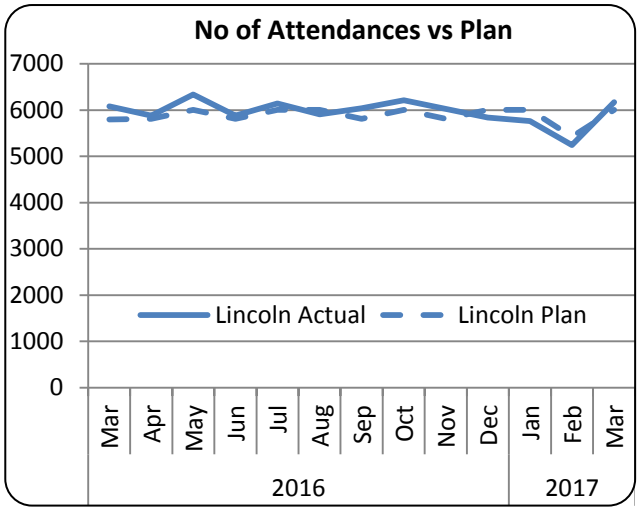
Lincoln

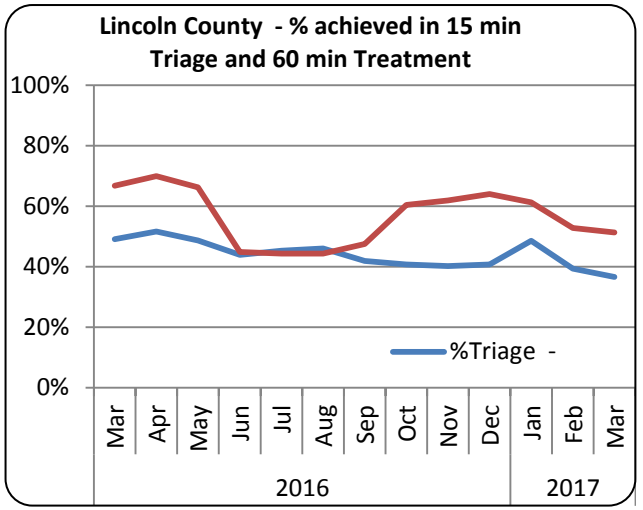
March's overall performance was 76.39%. This is 12.31% below the planned recovery trajectory and 2.8% less compared to March 2016.
Total attendances are 4.93% above plan during March.
Ambulance handover performance has improved from 459 crews delayed over 1 hour for February to 250 in March.
The total emergency admissions are 340 up compared to February (2 days less) , however bed occupancy rates have reduced gradually as seen in the Red 2 green graph to a low of 85.9% following the launch of Red 2 Green.
In-month key issues affecting performance in March were:

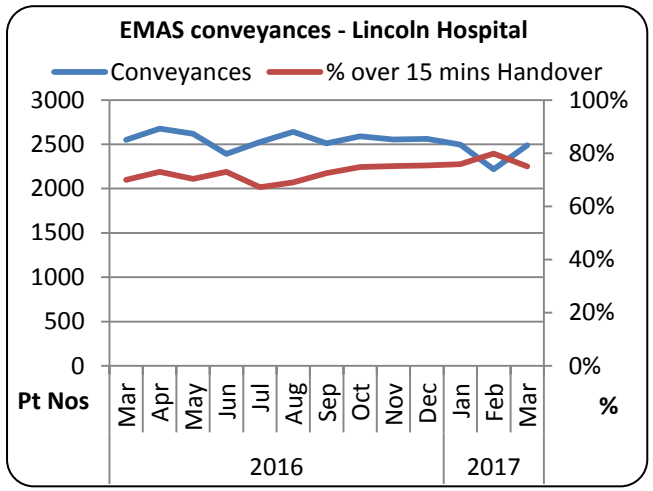


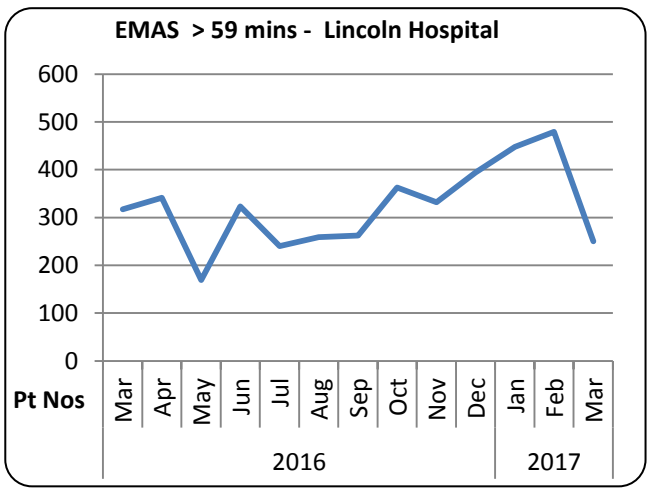
- Vacancies in ED medical rota's with reliance on agency locums. Increasingly variable shift cover in ED with many new locums doing single shifts.
- Vulnerability in medical staffing due to medical locum sickness or last minute cancellation.
- Despite increased flow, reduced outliers, and reduced usage of escalation areas the ED performance did not improve. Reasons for this were attributed to delays in 1st assessment by the ED medical staff, which is linked to point one above.

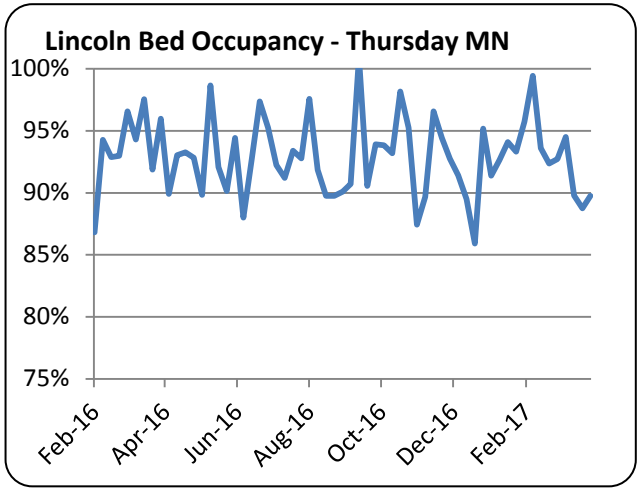












What action is being taken to recover performance?

Pilgrim:

- Launch of Red 2 Green at Pilgrim on 24th April, linking ongoing work with the Pride and Joy system.
- Full time senior managerial leadership on site from 24th April.
- Focussed work related to specific short term actions
- Continual recruitment/interviews for Middle grade Dr's
- Review of Rotas' to try and ensure the best possible skills mix is present OOH/Weekend
- Revised ambulance handover process to Dr in RAIT that has reduced turnaround times
- Evaluation of the impact of the Ambulatory Care Service

Lincoln:

- Boost of Red2Green process on 18th April to further embed and push the process.
- Support from ECIP to further help with the continued rollout of SAFER bundle across the wards.
- Focussed work related to specific short term actions
- Continued evaluation of RAT area & changed process in Ambulatory
- Recruitment process ongoing

What is the recovery date?

Continued focussed work to deliver short term actions to improve performance. These have been overshadowed by more recent issues related to IR35 and a severe shortage of ED doctors. Q1 ambition is to achieve in excess of 82%. The National expectation is to deliver in excess of 90% in September 2017.

10. Exception Report - Effective

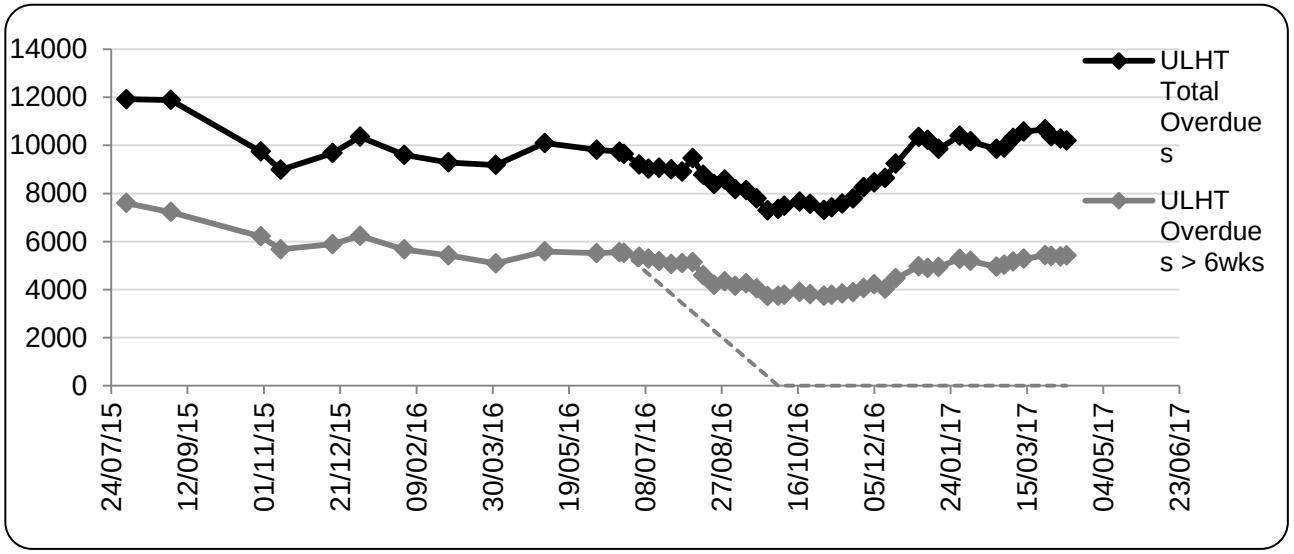
Executive Responsibility:
Mark Brassington – Chief Operating Officer

KPI:	**Partial Booking Waiting List**	**Owner:**	Chief Operating Officer
Domain:	**Effective**	**Responsible Officer:**	Deputy Director of Operational Performance
Date:	25th April 2017	**Reporting Period:**	March 2017

Exception details

On 10th April there were 5412 patient 6 weeks or more overdue for a follow-up appointment on the partial booking waiting list. At the end of September there were 3721 patients 6 weeks or more overdue, but this backlog increased Q3 and has been above 5000 for the majority of Q4.

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



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 Paediatrics – Allocate additional telephone consultations to clinicians; Request additional clinics above job plan from Consultants; recruit agency locums to cover sickness and vacancies. 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 and locum Consultant in place. MS nurse specialists have commenced reviewing follow-ups. Business Case for 4th Consultant to IPB in April.
- Cardiology – Virtual clinics; locum Consultant now in post; additional ad hoc capacity.
- Rheumatology – Substantive Consultant now in post, locum Consultant to remain in addition until backlog resolved. Forecast resolved by end of June.
- ENT – Additional clinics; additional audiology sessions; review discharge point for key pathways; review vacant slot processes. Forecast recovery still to be confirmed.

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

The dashboard shows the Trust's current performance against the non-negotiables as set out in the Sustainability and Transformation Fund. Trajectories and performance are based on what has been agreed within the 2016/17 Contract with Lincolnshire Clinical Commissioning Groups and therefore not necessarily to deliver performance at the national constitutional standard (for example A&E).

Further information and remedial actions in relation to the four access standards are illustrated over the following pages. Further information with regards to the agency spends and financial run rate are captured within the Trust Board Finance Report.

		Standard	Change in Month	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
RTT Incompletes	Trajectory	92%		92.40%	92.40%	92.40%	92.40%	92.40%	92.40%	92.40%	92.40%	92.40%	92.40%	92.40%	92.40%
	Performance		↓	92.11%	92.45%	92.02%	91.35%	89.19%	88.64%	88.77%	88.51%	88.08%	88.17%	88.27%	86.96%
Diagnostics 6wk Access	Trajectory	99.0%		99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%
	Performance		↓	99.11%	99.06%	99.08%	98.92%	98.67%	98.42%	98.75%	98.57%	99.03%	99.20%	99.72%	99.74%
Cancer 62 Day	Trajectory	85%		77.00%	78.00%	80.00%	81.00%	83.00%	84.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
	Performance		↓	74.70%	70.00%	68.90%	75.60%	74.00%	71.90%	69.30%	67.80%	71.90%	74.40%	67.10%	
A&E 4hr Access	Trajectory	95%		76.60%	82.00%	82.00%	84.00%	84.00%	84.00%	85.00%	85.00%	85.00%	89.00%	89.00%	89.00%
	Performance		↑	80.54%	83.52%	81.18%	78.56%	77.80%	78.40%	81.37%	82.60%	77.47%	75.56%	75.22%	78.83%
Agency Spend £'000s	Plan			2569	2575	2582	2523	2573	2390	1091	1142	1058	772	824	875
	Actual		↑	2213	2576	2477	2223	2141	2042	2073	2381	2307	-2834	-2804	-3255
Financial Surplus / Deficit	Plan			-4093	-4294	-4299	-3957	-4594	-3881	-3557	-3580	-4381	-3142	-5073	-3052
£'000s	Actual		↑	-3995	-4040	-4358	-4506	-4186	-4379	-4263	-4453	-3362	-5346	-7058	-6946

12. 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
EMSCG CQUINs									
1	Adult Critical Care Timely Discharge	Dr Adam Wolverson	**Q1-Q3 Reduction in the number of Critical Care bed days occupied by patients who are clinically ready for discharge for more than 4 hours. Reduction in the number of Critical Care by patients who are ready for discharge for more than 24 hours.** **Q4: Achievement of a 30% reduction in the number of Critical Care bed days by patients who are ready for discharge for more than 24 hours compared to the 2014/15 base.**	Quarterly	Q1 - Not fully achieved Q2 - Achieved Q3 - Not fully achieved	**PARTIAL PAYMENT**		**PARTIAL PAYMENT**	**PARTIAL PAYMENT**
2	Dose Banding Adult Intravenous Systemic Anticancer Therapy	Colin Costello/ Simon Priestley/Francisca Martinez	**Q1: Collection of base-line data for a range of dose banded drugs as agreed with Hub. Agreement with hub of stretch target for improvement during course of the year.** **Q2: Achievement of Q2 target.** **Q3: Achievement of Q3 target.** **Q4: Achievement of Q4 target.**	Quarterly	Q1 - Achieved Q2 - Achieved Q3 - Achieved				
3	Severe Haemophilia Haemtrack Patient Home Reporting System	Bethan Mysers/ Claire Lovett	**Q1: Q3 2015/16 confirmed 10 patients recruited with 40% compliance. Recruitment on Haemtrack in excess of 50% of eligible patients, quarter by quarter. Increase in compliant recruitment (number of patients) on Haemtrack up to 70% Q2: As above** **Q3: As above** **Q4: Compliant recruitment on Haemtrack from 70% to 95% (number of patients) as a proportion of targeted compliant recruitment.**	Quarterly	Q1 - Achieved Q2 - Achieved Q3 -				
4	Antimicrobial Stewardship (Year 2)	Bal Bolla	**As above**	Quarterly	As above				
5	Cancer: Release of CNS capacity to provide increased patient facing support to cancer patient pathways for Breast/Gastro/Lung/ Urology	Sarah Ward	**As above**	Quarterly	As above				

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

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

13. Risks

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

14. 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. Monitor Risk Rating

Area	Indicator	Threshold	Monitoring Period	Monitor Weighting score	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
1	Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway	92%	Quarterly	1	92.11%	92.45%	92.02%	91.35%	89.19%	88.64%	88.77%	88.51%	88.08%	88.17%	88.27%	86.30%
2	A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	Quarterly	1	80.54%	83.52%	81.18%	78.56%	77.80%	78.40%	81.37%	82.60%	77.47%	75.56%	75.22%	78.83%
3	All cancers: 62 day wait for first treatment from: Urgent GP referral for suspected cancer*	85%	Quarterly	1	75.60%	74.70%	70.00%	68.90%	75.60%	74.00%	71.90%	69.30%	67.80%	71.90%	74.40%	67.10%
	NHS Cancer Screening Service referral*	90%			92.10%	80.60%	86.20%	96.20%	90.90%	78.90%	92.90%	79.20%	89.70%	96.90%	67.90%	94.10%
4	All cancers: 31 day wait for second or subsequent treatement comprising: Surgery*	94%	Quarterly	1	92.10%	80.40%	90.90%	95.00%	95.80%	97.80%	91.20%	91.20%	100.00%	97.10%	100.00%	95.80%
	Anti-cancer drug treatments*	98%			91.60%	84.60%	97.70%	100.00%	98.00%	98.80%	98.40%	98.80%	98.90%	96.40%	99.00%	100.00%
	Radiotherapy*	94%			90.70%	80.40%	90.90%	95.00%	95.80%	97.80%	91.20%	91.20%	100.00%	97.10%	100.00%	95.80%
5	All cancers: 31 day wait from diagnosis to first treatment*	96%	Quarterly	1	96.70%	95.80%	95.00%	98.70%	97.60%	96.60%	98.00%	96.20%	97.40%	98.40%	94.10%	94.30%
6	Cancer: two week wait from referral to date first seen, comprising: all urgent referrals (cancer suspected)*	93%	Quarterly	1	92.50%	87.80%	92.60%	92.10%	82.70%	81.10%	94.60%	95.30%	94.10%	93.40%	89.50%	89.40%
	for symptomatic breast patients (cancer not initially suspected)*	93%			90.60%	94.60%	96.60%	93.00%	24.80%	26.30%	88.80%	94.30%	82.40%	88.10%	74.30%	56.80%
14	Meeting the C.difficile objective (cumulative)	59	Quarterly	1	1	5	5	6	3	6	4	5	3	6	5	10
15	meeting the MRSA objective (cumulative)	0	Quarterly	1	0	0	0	0	0	0	0	0	0	2	0	0
19	Certification against compliance with requirements regarding access to health care for people with a learning disability	n/a	Quarterly	1	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
				Risk rating	4	5	5	5	5	5	5	4	4	5	4	4

Trust Internal Compliance Rating	
	Target Met
	Target Not Met

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

GOVERNANCE RISK RATING

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

Appendix 2. Glossary

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

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

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

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

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

Metric	Red	Amber	Green
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