Excellence in rural healthcare

United Lincolnshire Hospitals NHS Trust

UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 28 FEBRUARY 2018

To:	Trust Board
From:	Karen Brown, Director of Finance, Procurement & Corporate Affairs
Date:	29th March 2018
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for February 2018

Author/Responsible Director: Karen Brown, Director of Finance

Purpose of the report:
To update the Board on the performance of the Trust for the period ended 28th February 2018, 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	√	Discussion	√
Assurance	√	Information	

Summary/key points:
Executive Summary for identifies highlighted performance with sections on key Successes and Challenges facing the Trust.

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 identified on the Risk Register.	**Performance KPIs year to date** As detailed in the report.

Resource implications (eg Financial, HR) None

Assurance implications The report is a central element of the Performance Management Framework

Patient and Public Involvement (PPI) implications None

Equality impact

Information exempt from disclosure

Requirement for further review?

Integrated Performance Report for the Period to 28th February 2018

Executive Summary for period of 28th February 2018

☒ 4 hour waiting time target – performance of 69.26% in February 2018
☒ 4 of the 9 national cancer targets were achieved in January 2018
☒ 18wk RTT Incomplete performance in January 2018 was 85.20%, the current unvalidated position for February 2018 as at the 14th March is 86%. The final February performance will be submitted on 26th March and is forecast at 86-86.5%
☒ 6wk Diagnostic Standard – February 2018 performance was 97.17%

Challenges:

A number of areas of quality performance remain unassured with issues occurring in Pressure Damage, Harm Free Care, CAUTI and Sepsis. Action plans are in place to address issues such as lack of multi-professional engagement and accountability. Medication Management was assured.

Workforce issues continue with vacancy rates still falling over the last 6 months but with rises occurring in all areas this month except for Allied Health Professionals. Voluntary Staff Departures and Sick Absences also increased this month but against this challenging background, agency spend fell again although targets were not yet achieved.

The results of the National Staff Survey were published and a significantly improved response rate of 45% was achieved, bringing us in line with national response rates. However, the results overall were disappointing with a deterioration across most indicators and many results falling well below the national average. An action plan is being developed in consultation with staff in order to address these issues.

Performance indicators improved despite seasonal challenges with our RTT position improving by 0.1%. 4 patients exceeded the 52 week target and a full harm review is under way with no or low harm being found for the first 2 reviews completed. Diagnostic targets improved to 98.05%.

A&E 4-hour issues continued with performance below national averages. The main cause of problems continued to be management of flow.

Cancer performance remained static with 4 of 9 targets achieved and all 31 day standards achieved. Urology performance improved for the second month in a row but UGI was still poor.

Looking forward:

A&E RAT (Rapid Access Team) has been increased to 24 hour at Lincoln and key SAFER flow actions have been put in place to improve performance.

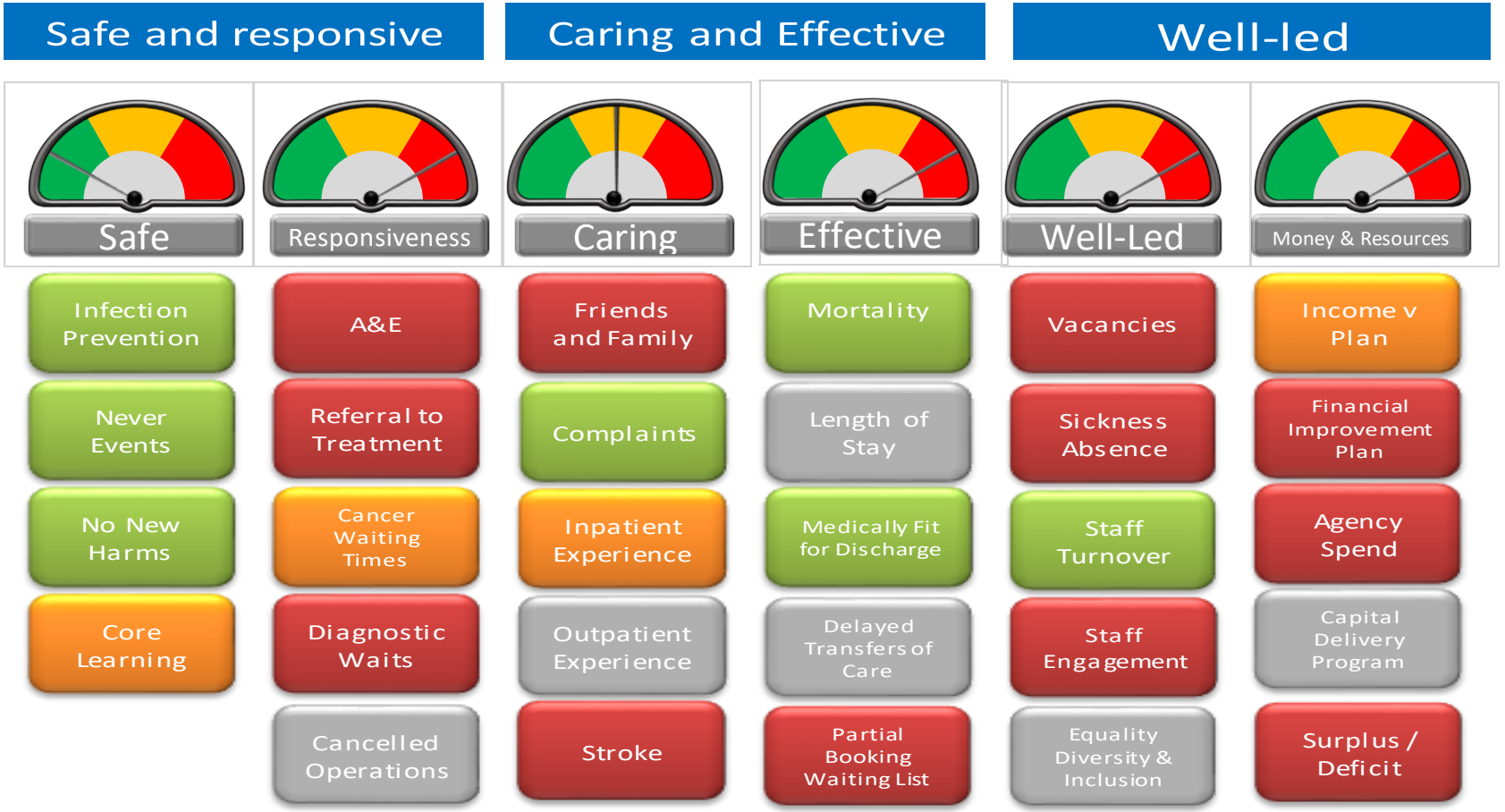
Weather pressures will have an impact on March performance with 157 operations and 2750 outpatient appointments having been cancelled in March. However, outsourcing is in place for ENT, General Surgery, Ophthalmology and Urology and will alleviate some of the pressures in these specialties.

Analysis of Cancer breaches has revealed the following key issues: pathology, patient choice and fitness, tertiary diagnosis and treatment, decision and process delays and theatres. Action plans are in place to work on these issues.

Karen Brown
Director of Finance, Procurement & Corporate Affairs
March 2018

Integrated Performance Report

The dashboard shows the Trust's current performance against the chosen standards and indicators as a measure of overall Trust performance. Further detail follows this summary at Clinical Directorate and Speciality level. Action plans should focus on resolving performance issues or delivering improved performance where required.



Detailed Trust Board Performance

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Safe						
Infection Control						
Clostrum Difficile (post 3 days)	Monthly	Datix	59	60	2	4
MRSA bacteraemia (post 3 days)	Monthly	Datix	0	2	0	1
MSSA	Monthly	Datix	22	15	2	1
ECOLI	Monthly	Datix	88	37	4	3
Never Events	Monthly	Datix	0	3	0	1
No New Harms						
Serious Incidents reported (unvalidated)	Monthly	Datix	0	242	26	16
Harm Free Care %	Monthly			91.94%	1	91.90%
New Harm Free Care %	Monthly			98.17%	1	98.57%
Catheter & New UTIs	Monthly			1	1	3
Falls	Monthly	Datix		5	6	7
Medication errors	Monthly	Datix		1357		121
Medication errors (mod, severe or death)	Monthly	Datix				14
Pressure Ulcers (PUNT) 3/4	Monthly			64	0	0
VTE Risk Assessment	Monthly		95%		1	95.16%
Core Learning	Monthly	ESR	95%	90.52%	90.83%	90.75%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Caring						
Friends and Family Test						
Inpatient (Response Rate)	Monthly	Envoy Messenger	26%	22.80%	28.00%	13.00%
Inpatient (Recommend)	Monthly	Envoy Messenger	96%	91.10%	90.00%	91.00%
Emergency Care (Response Rate)	Monthly	Envoy Messenger	14%	19.10%	20.00%	17.00%
Emergency Care (Recommend)	Monthly	Envoy Messenger	87%	81.40%	84.00%	80.00%
Maternity (Reponse Rate)	Monthly	Envoy Messenger	23%	8.40%	2.00%	5.00%
Maternity (Recommend)	Monthly	Envoy Messenger	97%	96.30%	100.00%	95.00%
Outpatients (Reponse Rate)	Monthly	Envoy Messenger	14%	13.20%	16.00%	7.00%
Outpatients (Recommend)	Monthly	Envoy Messenger	94%	92.50%	93.00%	92.00%
Complaints						
No of Complaints received	Monthly	Datix	70	607	79	43
No of Complaints still Open	Monthly	Datix	0	2678	288	266
No of Complaints ongoing	Monthly	Datix	0	414	45	47
No of Pals	Monthly	Datix	0	0	347	294
No of pals converted to formal complaints	Monthly	Datix	0	0	0	0
Inpatient Experience						
Mixed Sex Accommodation	Monthly	Datix	0	9		1
eDD	Monthly	EDD	95%	84.20%		83.19%
PPCI 90 hrs	Quarterly		100%		97.33%	97.33%
PPCI 150 hr	Quarterly		100%		85.33%	85.33%
#NOF 24	Monthly		70%		51.61%	47.30%
#NOF 48 hrs	Monthly		95%	90.72%	91.94%	89.19%
Dementia Screening	1 month behind		90%	88.49%	88.28%	89.16%
Dementia risk assessment	1 month behind		90%	95.76%	95.79%	97.94%
Dementia referral for Specialist treatment	1 month behind		90%	85.66%	90.91%	85.00%
Stroke						
Patients with 90% of stay in Stroke Unit	1 month behind	SSNAP	80%	81.87%	67.00%	90.70%
Sallowing assessment < 4hrs	1 month behind	SSNAP	80%	71.94%	73.50%	79.20%
Scanned < 1 hrs	1 month behind	SSNAP	50%	56.42%	63.60%	52.10%
Scanned < 12 hrs	1 month behind	SSNAP	100%	96.71%	96.20%	93.80%
Admitted to Stroke < 4 hrs	1 month behind	SSNAP	90%	62.15%	47.20%	68.80%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Responsiveness						
A&E						
4hrs or less in A&E Dept	Monthly	Medway	90.0%	75.97%	69.26%	66.99%
12+ Trolley waits	Monthly	Medway	0	0	1	1
RTT						
52 Week Waiters	Monthly	Medway	0			
18 week incompletes	Monthly	Medway	88.0%	87.83%	85.30%	85.20%
Cancer - Other Targets						
62 day classic	1 month behind	Somerset	85%	70.68%	76.90%	77.20%
2 week wait suspect	1 month behind	Somerset	93%	89.39%	86.00%	88.70%
2 week wait breast symptomatic	1 month behind	Somerset	93%	85.37%	84.20%	85.40%
31 day first treatment	1 month behind	Somerset	96%	96.31%	97.00%	97.30%
31 day subsequent drug treatments	1 month behind	Somerset	98%	98.97%	98.20%	94.30%
31 day subsequent surgery treatments	1 month behind	Somerset	94%	93.44%	97.20%	98.80%
31 day subsequent radiotherapy treatments	1 month behind	Somerset	94%	95.88%	91.20%	100.00%
62 day screening	1 month behind	Somerset	90%	87.44%	84.30%	91.40%
62 day consultant upgrade	1 month behind	Somerset	85%	86.12%	94.00%	87.30%
104+ Day Waiters	1 month behind	Somerset		-	-	13
Diagnostic Waits						
diagnostics achieved	Monthly	Medway	99.1%	98.10%	97.17%	98.05%
diagnostics Failed	Monthly	Medway	0.9%	1.90%	2.83%	1.95%
Cancelled Operations						
Cancelled Operations on the day (non clinical)	Monthly	Medway	1.10%	4.24%		5.55%
Not treated within 28 days. (Breach)	Monthly	Medway	0.00%			14.77%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Effective						
Mortality						
SHMI	Quarterly		100	111.73		112.57
Hospital-level Mortality Indicator	Quarterly		100	102.97		102.11
Length of Stay						
Average LoS - Elective	Monthly	Medway / Slam	2.8	2.72		2.68
Average LoS - Non Elective	Monthly	Medway / Slam	3.8			4.44
Medically Fit for Discharge	Monthly	Bed managers	60	56.82	44.00	60.00
Delayed Transfers of Care	Monthly	Bed managers	3.5%			4.02%
Partial Booking Waiting List	Monthly	Medway	0	5364	6510	5546

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Well Led						
Vacancies	Monthly	ESR	5.0%	10.52%	10.97%	10.71%
Sickness Absence	Monthly	ESR	4.5%	4.76%	5.62%	5.33%
Staff Turnover	Monthly	ESR	8.0%	5.65%	5.90%	5.77%
Staff Engagement						
Staff Appraisals	Monthly	ESR	95.0%	79.18%	80.00%	81.00%
Equality Diversity and Inclusion						

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Money & Resources						
Income	Monthly	Board Report Master	36074	390454	34684	37650
Expenditure	Monthly	Board Report Master	-40410	-454278	-41119	-41824
Efficiency Delivery	Monthly	FIMS report	1803	9079		0
Surplus / Deficit	Monthly	FPIC Finance Report	-4336	-77519	-7764	-5636

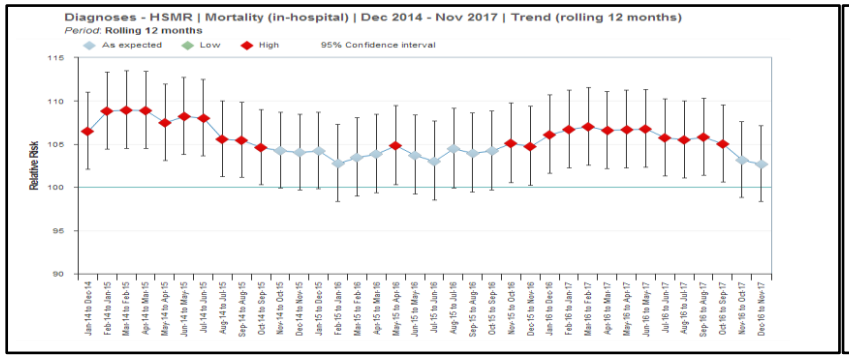
Patient centred . Excellence . Respect . Compassion . Safety

Safe Ambition: Reduction of Harm Associated with Mortality

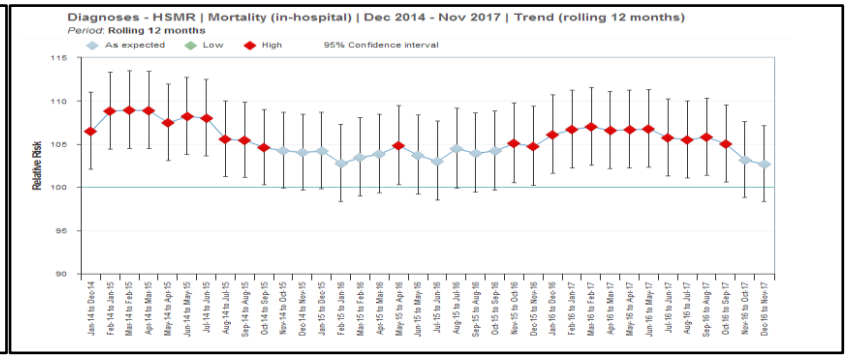
Executive Responsibility: Neil Hepburn – Medical Director

Trust/Site	ULHT HSMR Dec 16-Nov 17 12 month	ULHT HSMR Apr 17-Nov 17 YTD	ULHT HSMR Nov-17	ULHT SHMI Jul 16-Jun 17	Trust Crude Mortality Internal source Mar 17-Feb 18
Trust	102.65	98.73	95.03	112.22	1.82%
LCH	118.73	113.86	120.36	115.98	1.82%
PHB	91.96	89.01	75.42	110.60	2.03%
GDH	65.56	59.30	56.70	98.75	1.01%

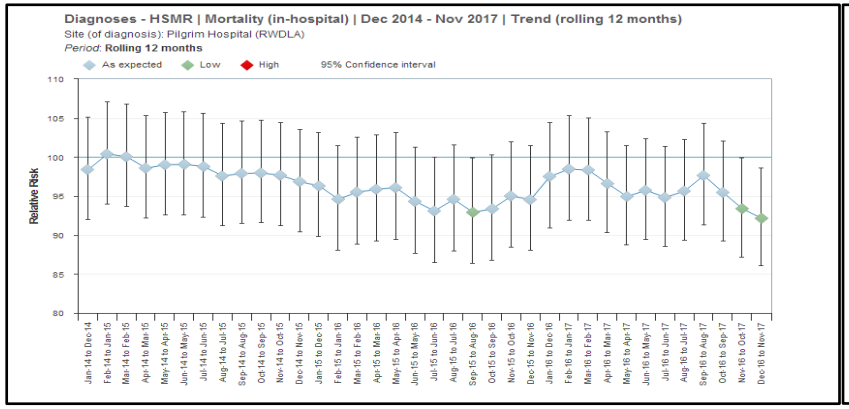
ULHT HSMR Rolling Year (36 Months)



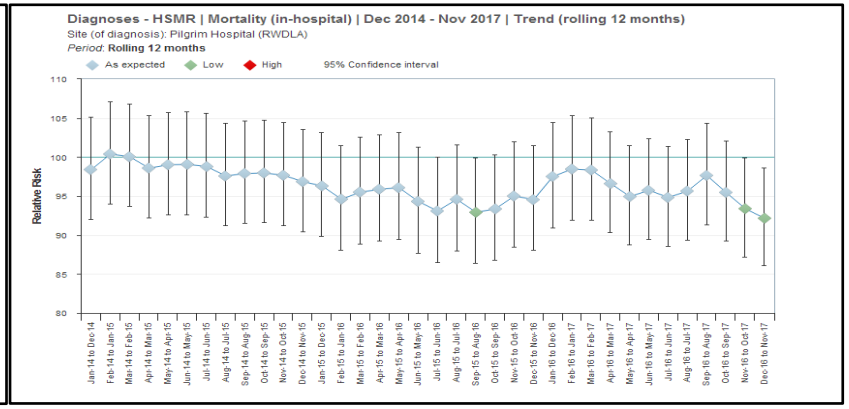
Lincoln HSMR Rolling Year (36 Months)



Pilgrim HSMR Rolling Year (36 Months)

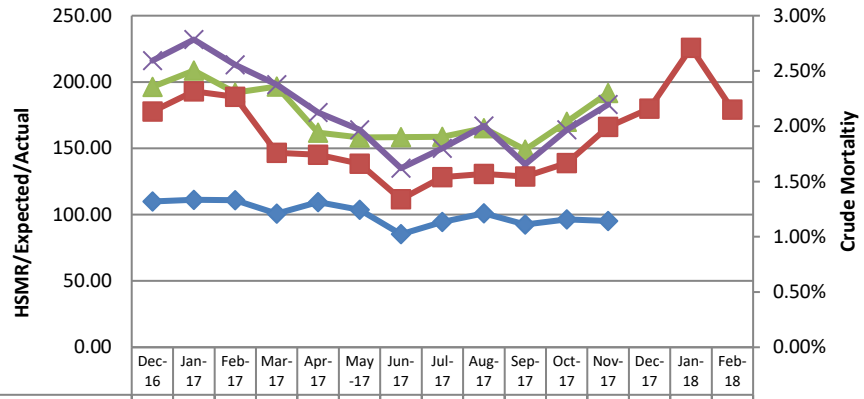


Grantham HSMR Rolling Year (36 Months)



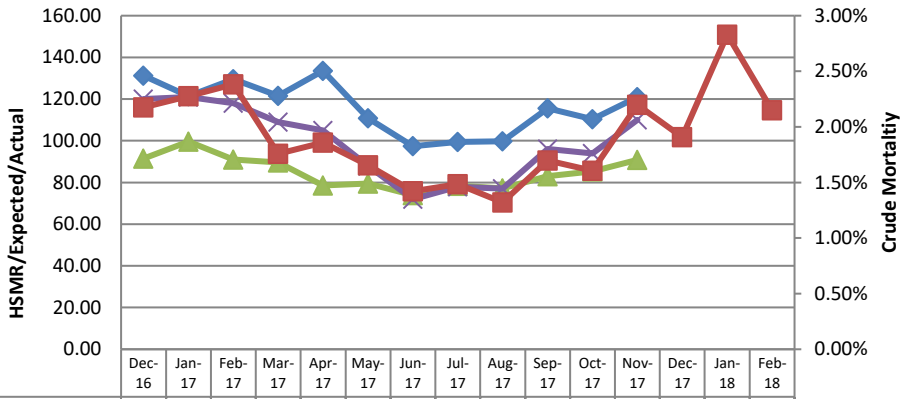
Monthly Mortality Comparison Trend Charts

Trust Mortality Comparison Chart



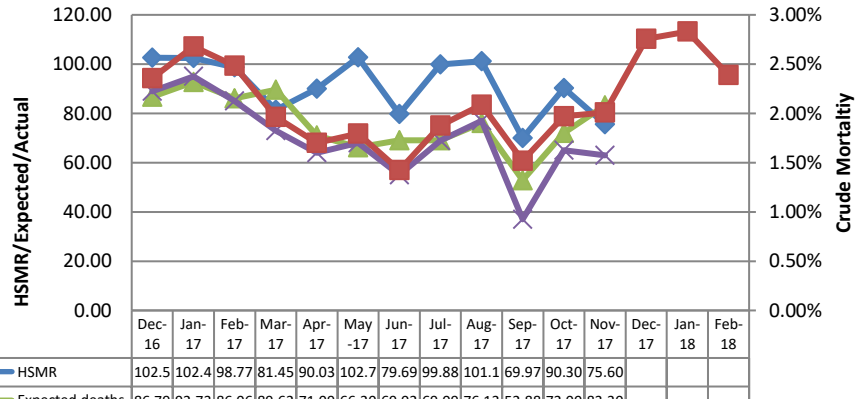
	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
HSMR	110.0	111.2	110.9	100.7	109.4	103.6	85.20	94.57	101.1	92.66	96.50	95.10			
Expected deaths	196.3	208.6	191.9	196.4	161.7	158.2	158.4	158.6	165.1	148.9	170.0	191.8			
Actual deaths	216	232	213	198	177	164	135	150	167	138	164	183			
ULHT Crude	2.13%	2.32%	2.27%	1.76%	1.74%	1.66%	1.34%	1.54%	1.57%	1.54%	1.67%	1.99%	2.16%	2.71%	2.15%

LCH Mortality Comparison Chart



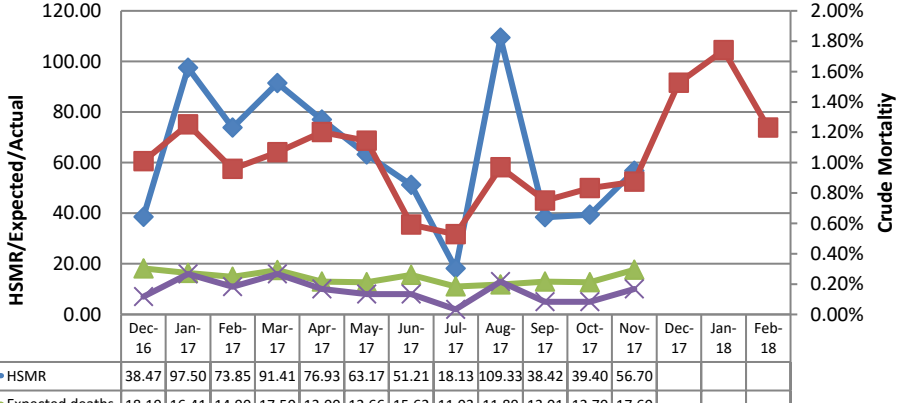
	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
HSMR	131.22	121.45	129.58	121.59	133.59	110.80	97.39	99.43	99.72	115.60	110.30	121.00			
Expected deaths	91.45	99.63	91.06	89.65	78.60	79.42	73.93	78.45	77.22	83.05	85.30	90.90			
Actual deaths	120	121	118	109	105	88	72	78	77	96	94	110			
ULHT Crude	2.18%	2.28%	2.38%	1.76%	1.86%	1.66%	1.42%	1.48%	1.32%	1.70%	1.60%	2.20%	1.91%	2.83%	2.15%

PHB Mortality Comparison Chart



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
HSMR	102.5	102.4	98.77	81.45	90.03	102.7	79.69	99.88	101.1	69.97	90.30	75.60			
Expected deaths	86.79	92.73	86.06	89.62	71.09	66.20	69.02	69.09	76.13	52.88	72.00	83.30			
Actual deaths	89	95	85	73	64	68	55	69	77	37	65	63			
ULHT Crude	2.36%	2.68%	2.48%	1.96%	1.70%	1.80%	1.42%	1.88%	2.09%	1.52%	1.97%	2.01%	2.76%	2.83%	2.39%

GDH Mortality Comparison Chart



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
HSMR	38.47	97.50	73.85	91.41	76.93	63.17	51.21	18.13	109.33	38.42	39.40	56.70			
Expected deaths	18.19	16.41	14.90	17.50	13.00	12.66	15.62	11.03	11.89	13.01	12.70	17.60			
Actual deaths	7	16	11	16	10	8	8	2	13	5	5	10			
ULHT Crude	1.01%	1.25%	0.96%	1.07%	1.20%	1.15%	0.59%	0.53%	0.97%	0.75%	0.83%	0.87%	1.53%	1.74%	1.23%

ULHT
The Trust primary diagnoses groups that are outside of the Dr Foster confidence intervals are:

Other Perinatal Conditions: Second month of alerting at Trust level, alerting on both PHB & LCH with 20 mortalities and 5.72 over the predicted Dr Foster data. 2 meetings have been held and the process reviewed; issues found with the well-baby coding and depth of coding in conjunction with the form not being sent to the coders. This process is being reinforced by the W&C Risk team.UPDATE: W&C have been contacted for evidence of actions for the improvement work.
Biliary Tract Disease: First month alerting at Trust level.; 26 mortalities with 10 over the predicted Dr Foster data. An external Consultant has been contacted to so an external review as this has been sporadically alerting for Lincoln site and the Trust.
Aortic peripheral and visceral artery aneurysms: Third month of alerting; 25 mortalities with 11 over the predicted Dr Foster data.
Other lower respiratory disease: New alert; 23 mortalities with 9 over the predicted Dr Foster data.
Septicemia (except in Labour): New ; 312 mortalities with 34 over the predicted Dr Foster data. This has been alerting on the Lincoln site since the coding rule change in April 17. This is the First time within 2 years for the Trust. Sepsis nurses completed a coding review and outputs were comorbidities not being documented which has now become part of the wider comorbidity work.

SITE

Lincoln County Hospital: primary diagnoses groups that are outside of the Dr Foster confidence intervals are:
Actions underway
Acute Cerebrovascular disease: This is the fifth month of alerting with 113 observed and 22 mortalities over the predicted Dr Foster data. Dr Foster Intelligence specialist and Quality Governance have met with the Stroke SSNAP audit Facilitator and QSO; The only notable difference between the data on the sites is the coding of patients been seen by the palliative care team-wider palliative care audit has been completed. Dr Foster still to meet with Clinician to discuss. SSNAP data has been correlated to Dr Foster data as on SSNAP ULHT are not an outlier. The results showed that SSNAP focuses on 6 main comorbidities therefore the data was not comparable. The SSNAP data coordinators will also check for all co-morbidities.
Other Gastrointestinal disorders: Alerting at site level for the third month with 18 mortalities, 9 mortalities over the predicted Dr Foster data.
Senility and organic mental disorders: Second month of alerting with 20 moralities, 10 over the predicted Dr Foster data.
Fluid and electrolyte disorders: NEW- First month of alerting within 16 mortalities, 7 over the predicted Dr Foster data.

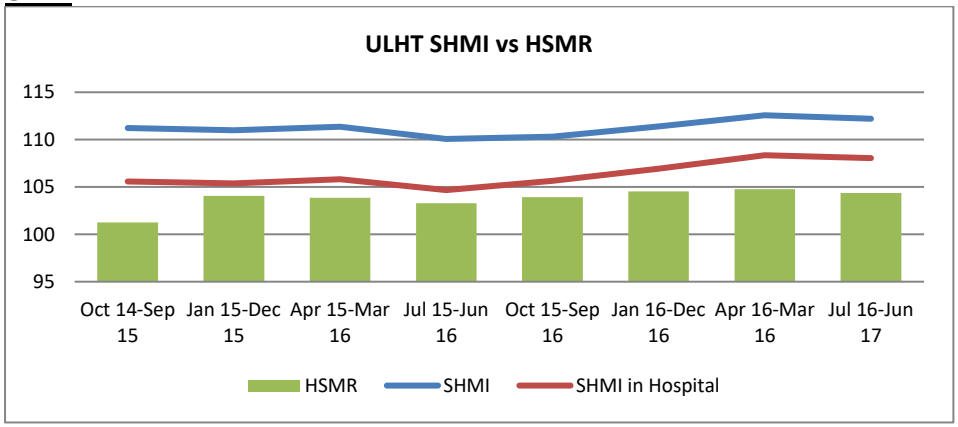
Pilgrim hospital: primary diagnoses groups that are outside of the Dr Foster confidence intervals are:
COPD and bronchiectasis: This is the third month on alerting with 47 mortalities, 14 over the predicted Dr Foster data.-Respiratory Consultants contacted for in-depth review.

Grantham Hospital
No notifications

National Comparison

Metric	Dec 16- Nov 17	
	National Acute (Non specialist)	ULHT
HSMR	96.90	102.65
Elective Crude Rate %	0.20%	0.10%
Non elective Crude Rate %	6.30%	7.20%
% observed mortalities in hospital	3.45%	3.84%
% observed palliative coding	42.62%	31.80%
% Spells Palliative coding	2.37%	2.24%
Avg comorb 0 score per observed %	1.17%	1.39%
Avg comorb 0 score spells %	49.09%	49.63%
Weekend % of observed	5.90%	7.12%
Weekday % of observed	3.04%	3.30%
Crude rate %	3.50%	3.80%
Spells Readmissions 28 days %	0.00%	0.00%
Residual Coding % of spells (Signs & Symptoms)	0.85%	0.29%
LOS short stay 0-2 days Observed %	1.08%	1.24%
LOS 3+ Observed %	7.53%	8.06%

SHMI



- Trust SHMI is currently outside of expected limits and is within Band 1 on the published NHS Digital data for July 2016 to June 2017.
- Lincoln and Pilgrim site are currently higher than expected.
- The Lincolnshire Mortality Collaborative continues to meet and are currently reviewing deaths within 30 days of transfer to community hospitals, deaths within 30 days and appropriate admissions to hospital. Working with GP's and Nursing homes

Reviews (Jan 2017-Dec 2017)

Annual Total	3292	1660	744	81%	235	8%	52	172
Month of death	Total No. of Deaths	Reviews Completed	With Consultant	% of reviews completed	Excluded	% Excluded	Deaths Grade 2&3	MoRAG Escalation
Jan-17	290	221	40	90%	25	9%	3	21
Feb-17	273	210	26	86%	30	11%	7	19
Mar-17	252	189	30	87%	31	12%	5	20
Apr-17	216	146	26	80%	32	15%	3	12
May-17	204	141	27	82%	21	10%	5	13
Jun-17	181	119	31	83%	22	12%	2	7
Jul-17	205	132	39	83%	21	10%	6	15
Aug-17	202	104	56	79%	25	12%	1	6
Sep-17	193	123	38	83%	19	10%	6	14
Oct-17	223	102	71	78%	5	2%	2	8
Nov-17	244	93	81	71%	2	1%	1	12
Dec-17	256	62	128	74%	2	1%	2	4
Jan-18	350	18	123	40%		0%	2	2
Feb-18	203		28	14%		0%	7	19

Trust trajectory of 70% for completed reviews is being achieved.

Excluded cases are those cases that are not within our "MUST DO's" criteria, but where QG have been awaiting notes for review and not received within 3 months to ensure timely review.

NOTE: January and February 18 are not included within the reviews completed percentage as all reviews sent deadlines have not yet passed.

Reviews Pending allocation
N=269 (10%)
% of total deaths

Reviews sent awaiting completion
N=593 (22%)
% of total deaths

Grade 2&3 possible preventable deaths
N=52 (2%)
% of total deaths

Reviews escalated to MoRAG
N=172 (6%)
% of reviews complete

Learning from Deaths Reporting-January 2017-December 2017 - NOTE: LeDeR submissions are only from October 2017

SI-Severity = Death
51

SI Mortality - Review completed
N=23 (45%)

Learning Disability Death
9
2 = Feb 2018

LeDeR Submission Completed
N=4 (44%)

Mental Health Deaths
796

Mental Health Review Complete
N=461 (58%)

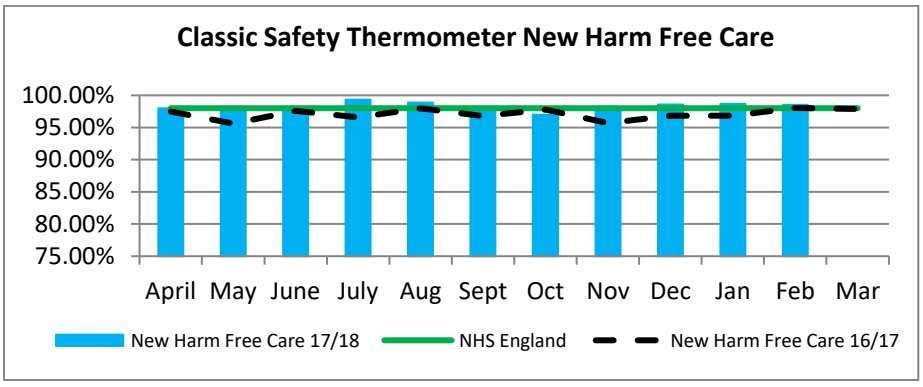
Mortality Reduction Actions

Mortality Review	Source	Review Commenced	Site	Actions	Lead	Timescale	Progress	RAG
Clinical Coding Masterclass	On-going	Underway	All	To arrange the next Clinical Coding Masterclass. To incorporate Live Clinical Coding, Dr Foster Data, Finance and Mortality **NOW incorporating Commissioning and Information support**	Dr Andrews/ Karen Moon	On-going	**QG have asked both information and commissioning to become part of the masterclass and they have agreed. Dates to be booked and agreed for next year.**	
Junior Doctor Teaching	On-going	Underway	All	JD Teaching across each site	Quality Governance	On-going	All JD teaching has been completed, feedback was to get the training earlier and this is to become part of the induction.	
Audit of Palliative care coding not coded on Dr Foster	Mortality Report	Underway	Trust	Through analysis and in-depth reviews it has been highlighted the ULHT are below the national average of palliative care coding, which highly affects the HSMR	Karen Moon	On-going	Palliative Care Team have submitted figures of those that the team have seen. QG has correlated this with Dr Foster coded data. An audit is to be undertaken by Coding and Quality Governance to ascertain why there is a difference in coding -Particularly on the LCH site. **Palliative care coding audit completed:** action plan to be discussed at PSC in Jan 18-**An ongoing audit will be commencing correlating the data and driving improvement**	
Acute Cerebrovascular disease	Dr Foster	Underway	LCH	Meeting to be arranged to understand the underlying data. QG have produced an overview of the Dr Foster data in the October Mortality Report this has been shared with the QSO for Stroke.	Derek Smith, Quality Governance & Stroke Team	On-going	Meeting been held with Stroke audit coordinator and QSO She is looking at the Dr Foster data in comparison to SNNAP data. Data has been analysed but as SNNAP looks at different datasets this was deemed not comparable. **Dr Foster to meet to with stroke team to drive improvement and understanding. In depth review to be completed**	
Comorbidity Coding Quality Improvement	On-Going	Underway	All	Actions from Comorbidity Focus Month.	Bernie Gallen/Karen Moon	On-going	Meet with Shaun Caig and Mary Tomlinson for the quality Improvement action plan: meeting to be held 6th march 2018.	
Other Perinatal conditions	Dr Foster	Underway	Trust	Meeting to take place with W&C governance, QG governance, Dr Foster and coding to agree action plan	Karen Moon	Mar-18	Meeting held and actions allocated. Jude Cheesmond looking at coding process. Actions as per email attached. Another progress meeting arranged 18/12/17-Progress meeting held and issues found with the well-baby coding and depth of coding and the form reaching the coders for all well-babies that have not go to transitional or neonatal care. This process is being reinforced by the W&C Risk team. **UPDATE: KM chased action evidence and progress.**	
Respiratory Failure, insufficiency, arrest (adult)	Dr Foster	Underway	Trust	A meeting with Dr Pogson, to discuss alert and NIV mortality. **TO undertake an in-depth review at Pilgrim**	Karen Moon/ Bernie Gallen	May-18	Meeting was postponed awaiting date from Dr Pogson. Because of capacity within the respiratory team this has been extended	
Medical Examiner	Trust	Underway	Trust	Funding 11 PA's for a Medical Examiner	Bernadine Gallen/ Dr Andrews	Apr-18	Business Case and Job Description has been produced. And has been agreed in principle by ET. **UPDATE: This has now been approved and is going through the final stages before advertisement**	
Biliary Tract Disease	Trust	Underway	Trust	Biliary Tract has had several internal reviews. The Medical Director has expedited an external review	Leicester Trust/ULHT	Mar-18	Medical Director has asked Leicester for an external review-awaiting update.	

Safe Ambition: Harm Free Care (Safety Thermometer)

Executive Responsibility: Michelle Rhodes – Director of Nursing

The Safety Thermometer is a point prevalence audit undertaken on all acute adult wards. Scores are divided into Harm Free (inclusive of community harms) and New Harm Free (ULHT Harms).



The Harm Free score for February 2018 was 93.13% which is below the national target of 95%.

New Harm Free was 98.54% which is above the national target of 98%.

Information supplied by GEM Arden provides ULHT with national comparisons against each domain of the Safety Thermometer. The information below compares each domain in respect of **New** Harms only against national averages.

FALLS	A	M	J	J	A	S	O	N	D	J	F	M
National	*0.5*	*0.6*	*0.5*	*0.5*	*0.5*	*0.5*	*0.5*	*0.6*	*0.5*	*0.5*	*0.5*	
ULHT	0.6	1.3	0.6	0.1	0.1	0.6	0.7	0.6	0.4	0.2	0.3	
Lincoln	0.4	2.1	0.9	0.0	0.2	0.9	1.1	0.2	0.5	0.0	0.6	
Boston	0.3	0.3	0.3	0.3	0.0	0.3	0.3	1.3	0.3	0.6	0.0	
Grantham	2.4	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	

ULHT average of new falls with Harm for February 2018 is 0.3% and is below the national average of falls (0.5%)

PU	A	M	J	J	A	S	O	N	D	J	F	M
National	*0.9*	*0.9*	*0.9*	*1.0*	*0.9*	*0.8*	*0.9*	*0.9*	*0.9*	*0.9*	*1.0*	
ULHT	1.1	1.0	0.7	0.5	0.5	1.0	1.5	1.2	0.6	1.1	0.8	
Lincoln	1.1	1.1	0.5	0.5	0.0	0.5	1.3	0.4	0.7	1.1	0.6	
Boston	1.3	1.0	1.3	0.6	1.3	1.3	2.2	2.6	0.6	0.9	1.2	
Grantham	0.0	0.0	0.0	0.0	0.0	2.9	0.0	0.0	0.0	2.1	0.0	

ULHT average of new pressure ulcers for February 2018 is 0.8% and is below the national average (1.0%).

PU	A	M	J	J	A	S	O	N	D	J	F	M
National	*0.9*	*0.9*	*0.9*	*1.0*	*0.9*	*0.8*	*0.9*	*0.9*	*0.9*	*0.9*	*1.0*	
ULHT	1.1	1.0	0.7	0.5	0.5	1.0	1.5	1.2	0.6	1.1	0.8	
Lincoln	1.1	1.1	0.5	0.5	0.0	0.5	1.3	0.4	0.7	1.1	0.6	
Boston	1.3	1.0	1.3	0.6	1.3	1.3	2.2	2.6	0.6	0.9	1.2	
Grantham	0.0	0.0	0.0	0.0	0.0	2.9	0.0	0.0	0.0	2.1	0.0	

ULHT average of new VTE for February 2018 is 0.2% and is below the national average (0.4%).

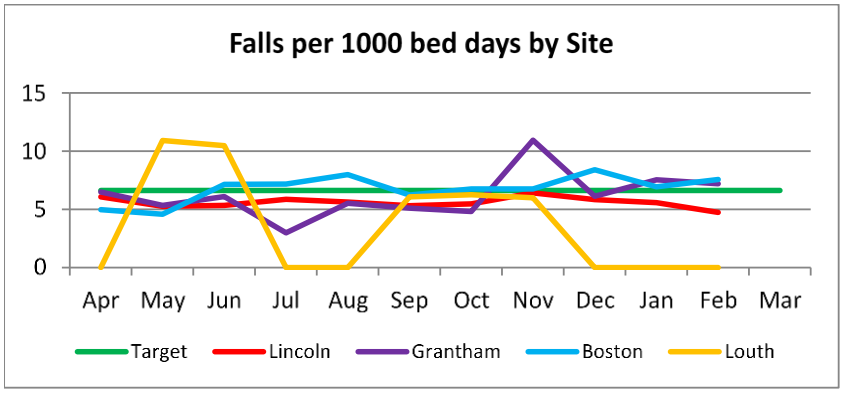
CAUTI	A	M	J	J	A	S	O	N	D	J	F	M
National	*0.3*	*0.3*	*0.3*	*0.3*	*0.3*	*0.4*	*0.3*	*0.3*	*0.3*	*0.3*	*0.3*	
ULHT	0.2	0.0	0.4	0.0	0.2	0.1	0.2	0.1	0.4	0.0	0.1	
Lincoln	0.0	0.0	0.5	0.0	0.2	0.0	0.4	0.2	0.2	0.0	0.2	
Boston	0.3	0.0	0.3	0.0	0.3	0.3	0.0	0.0	0.3	0.0	0.0	
Grantham	1.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	0.0	0.0	

ULHT average of Catheter with UTI (new) for February 2018 is 0.1% and is above the national average (0.3%). (Percentage is a measure of the proportion of patients with a catheter who are also being treated for a UTI)

Safe Ambition: Falls

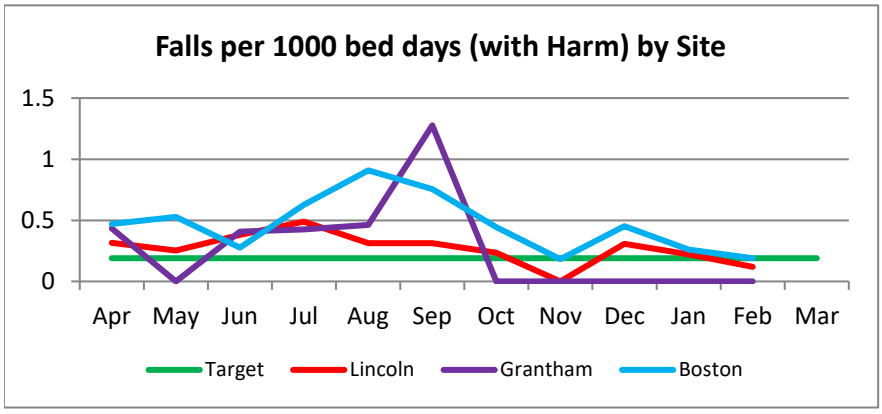
Executive Responsibility: Michelle Rhodes – Director of Nursing

Trust performance for falls is measured using per 1000 bed days formula. This is recognised as a measure of both reporting culture and reduction in harm and allows for national and regional comparison. Falls with harm include moderate, severe and death.



The Trust performance for all falls per 1000 OBDs is 5.95 in February 2018 which is below the national average of 6.63. The YTD Trust figure is 6.07. (National average is taken from the 2015 National Frailty and Falls Inpatient Audit)

ULHT is above the Trust's stretch trajectory of 3.9 falls per 1000 OBDs (Trust Sign Up to Safety campaign goal, 2014).



Falls with harm per 1000 bed days for the Trust is 0.14 in February 2018 which is below the national average of 0.19. The YTD Trust figure is 0.34. (National average is taken from the 2015 National Frailty and Falls Inpatient Audit)

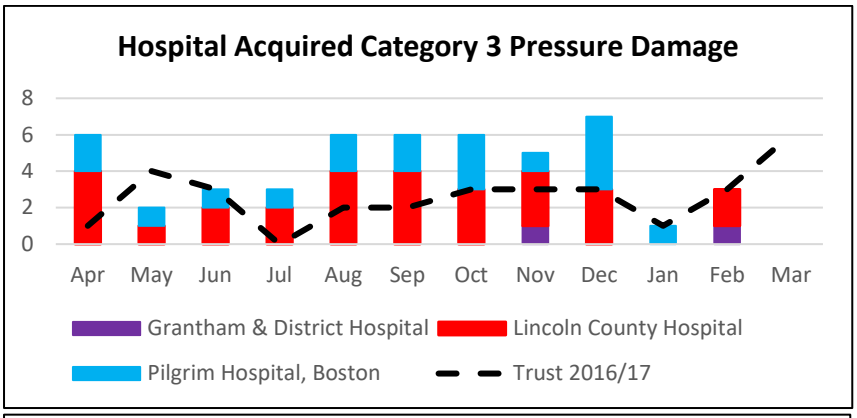
Assurance Summary

- Although falls with harm are showing a downward trend, all falls are showing an upward trend. The increased awareness and use of preventative measures and interventions are believed to be contributing to the reduction in falls with harm, however the ongoing focus on keeping patients mobile and the increased activity over recent months is resulting in an increased number of slips and controlled falls.
- The scrutiny panel process is being strengthened from April to improve accountability and assurance processes, and timely learning from incidents.
- Work ongoing to support wards with ward accreditation.
- Improvement work focusing on review of preventative measures and management plans following a fall to reduce the risk of subsequent falls.
- Detailed paper to be presented to Quality Governance Committee in April outlining improvement trajectory for Directorates, performance management strategy and quality improvement support.

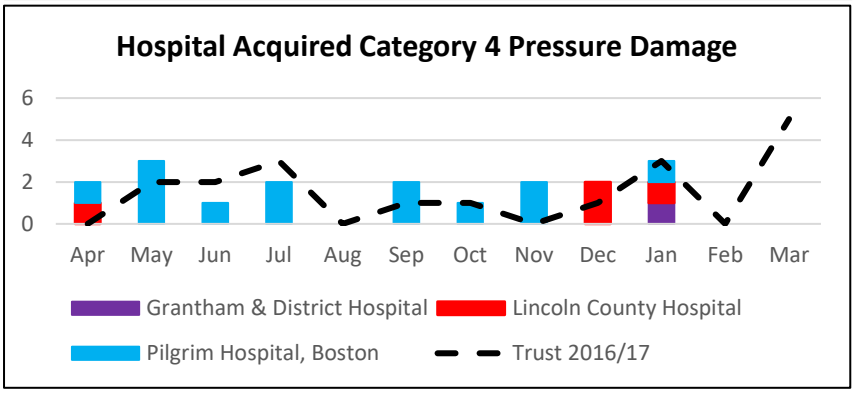
Safe Ambition: Pressure Damage

Executive Responsibility: Michelle Rhodes – Director of Nursing

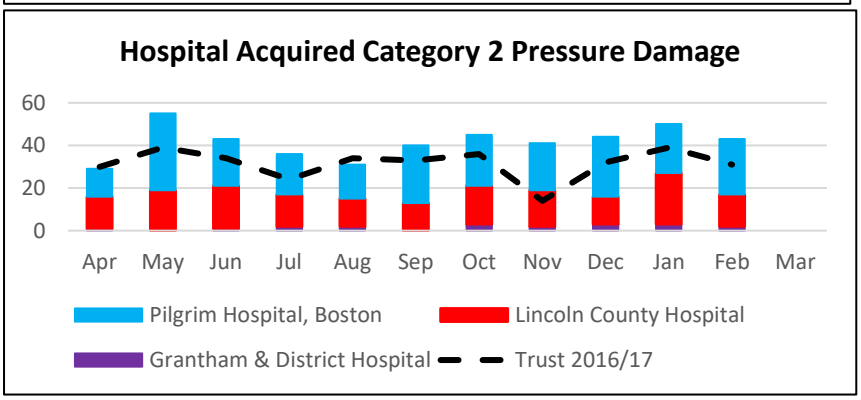
Trust performance for pressure damage is measured using crude numbers and avoidability. Avoidability is determined by Scrutiny Panel process for category 3 and 4 pressure damage. Category 1-4 pressure ulcers are all reported using Datix system. Figures for pressure ulcers are indicative and are subject to change pending outcome of Scrutiny Panels.



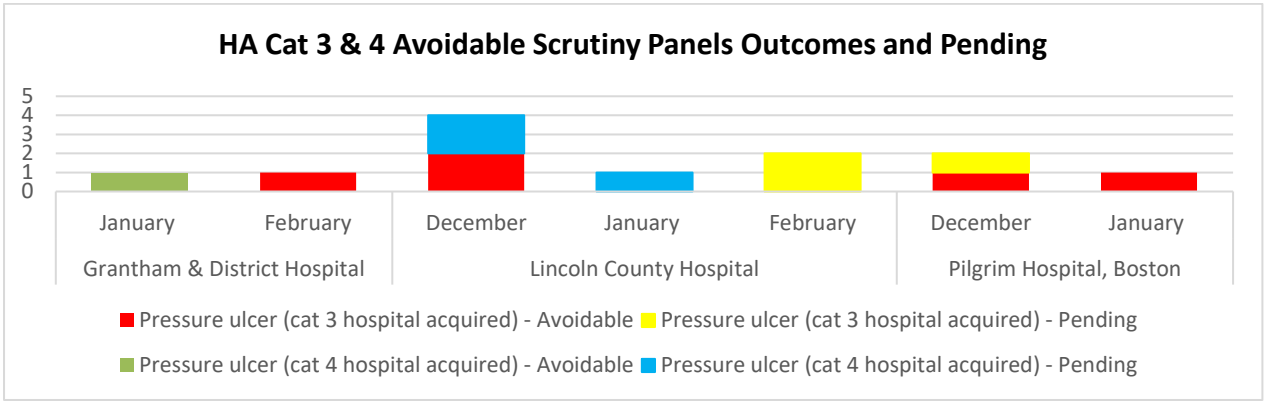
At February 2018 the Trust has reported 111 more Category 2 pressure ulcers than at the same point in 2017. A change in the reporting systems from Aug 2017 may account for this and the increase is being explored further. Pilgrim Hospital report the highest number of Cat 2 pressure ulcers. Further work is currently being undertaken to explain this as crude figures do not identify whether this is indicative of increased harm or positive reporting culture.



At February 2018 the Trust has reported 23 more Category 3 pressure ulcers than at the same point in 2017.
At February 2018, 35 reported Category 3 Pressure ulcers were determined as avoidable and 10 unavoidable (remaining 3 pending Scrutiny Panel).



The Trust continues to report Category 4 pressure damage. At February 2018 the Trust has reported 5 more Category 4 pressure ulcers than at the same point in 2017. At February 2018, 9 reported Category 4 Pressure Ulcers were determined as avoidable and 5 unavoidable (remainder 4 pending Scrutiny Panel).

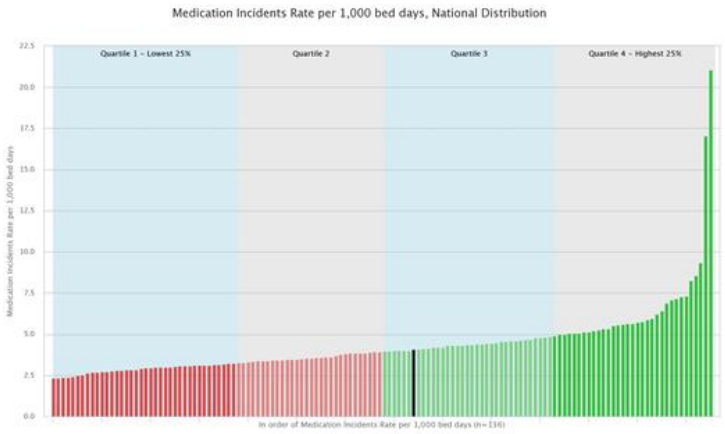


Assurance Summary

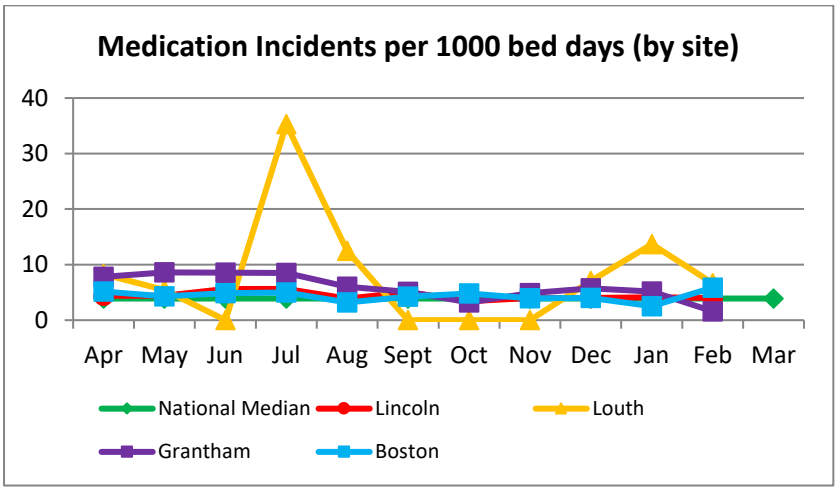
- The continued development of hospital acquired pressure damage remains a concern and is unacceptable.
- The Tissue Viability team are focusing on increasing the support they provide to clinical teams and providing targeted education. Priority is being given to wards with category 3 & 4 pressure ulcers.
- The team are supporting wards to progress on ward accreditation.
- The scrutiny panel process is being strengthened from April to improve accountability and assurance processes, and timely learning from incidents.
- Detailed paper to be presented to Quality Governance Committee in May outlining improvement trajectory for Directorates, performance management strategy and quality improvement support.

Safe Ambition: Medication Incidents

Executive Responsibility: Michelle Rhodes – Director of Nursing

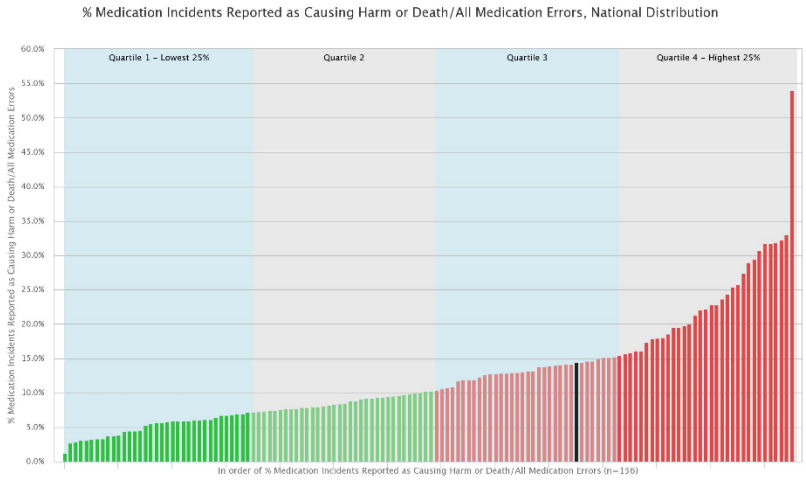


Medication Incidents per 1000 bed days is a measure of safety and governance. It is the total number of medication incidents reported to the National Reporting and Learning Service (NRLS) per 1,000 bed days. Reporting of Incidents is an essential indicator of safe & effective care. Whilst lower rates of incidents reporting can be seen as an issue this is linked to a range of other safety culture elements rather than as a direct correlation.

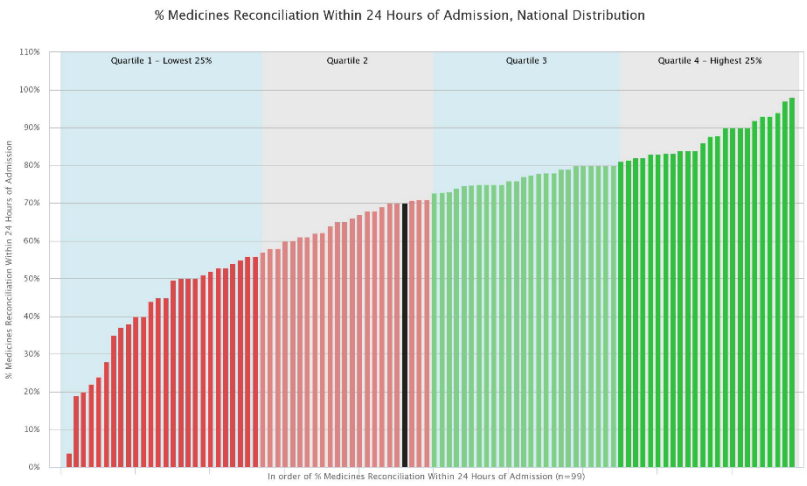


National Median (March 2017) for Medication Incidents is 3.9 per 1000 bed days. In February 2018 the Trust reported 4.48 Medication Incidents per 1000 Bed Days.

Medication Incidents per 1000 bed days should be interpreted with the same context as the Model Hospital data above.



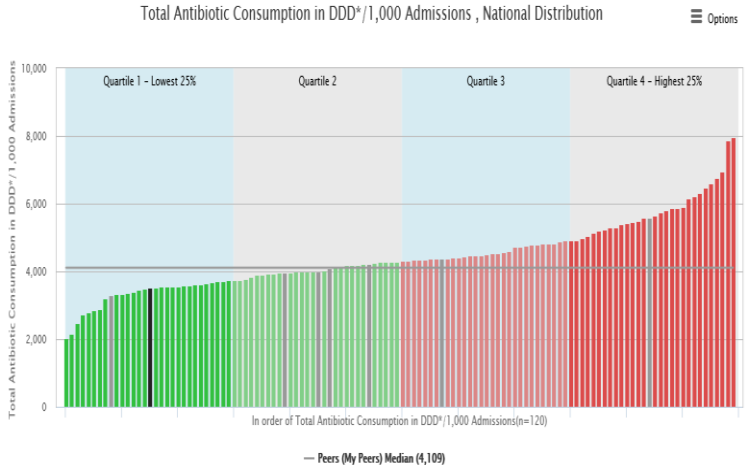
% of Medication Incidents causing harm is a measure of medicines safety and governance. It is the number of medication incidents causing harm or death reported to the National Reporting and Learning Service (NRLS). It is expressed as a percentage of all medication incidents reported. Under reporting of medication incidents will amplify the number with harm as a percentage of total incidents reported.



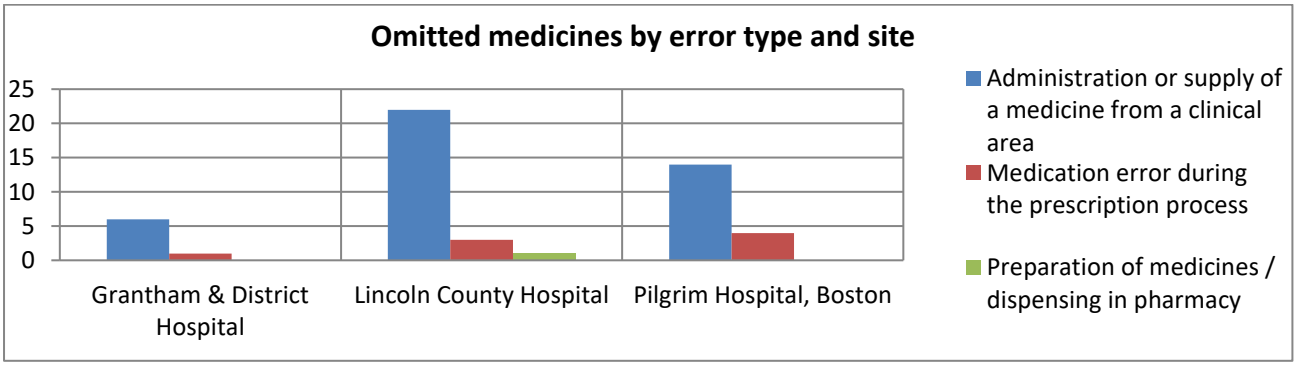
This metric represents the % of adult inpatients whose medicines are reconciled within 24 hours of the time of admission across a full 7-day working week. Higher values represent more effective medicines optimisation practices, which drive safety, efficiency and cost reduction.
Higher values indicate higher productivity and safer, more effective care (Benchmark value: 90%)

Controlled Drug Audit	Q1	Q2	Q3	Q4
Trust	67.5%	77%	66.88%	69%
Lincoln County Hospital	63%	69%	45.65%	52%
Pilgrim Hospital	56.50%	76%	82%	82%
Grantham Hospital	83.50%	93%	73%	73%

There has been a steady improvement in respect of CD Audit however the Trust remains far below the benchmark of 100% compliance.



This metric is the high level antibiotic prescribing rate per 1,000 admissions. Inappropriate use of antibiotics is major driver for the development of antibiotic resistance. The rate shows how many antibiotic Defined Daily Doses have been prescribed per 1,000 admissions. This metric is calculated by Public Health England (PHE). Lower values are indicative of lower prescribing and safer, more effective care.

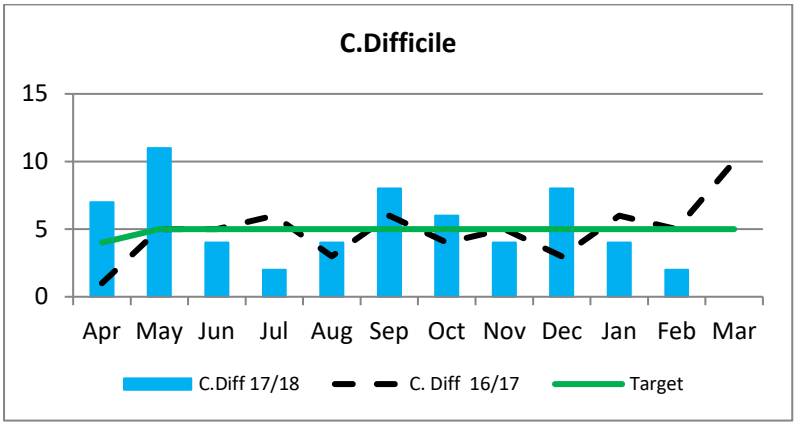


Assurance Summary

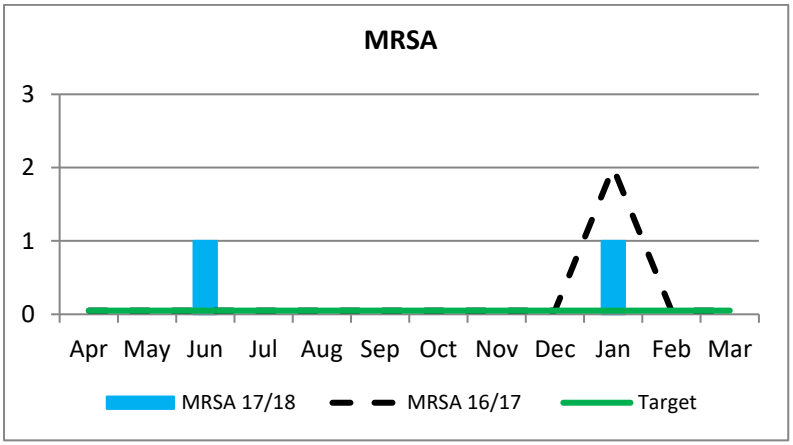
- Pharmacy had positive feedback from NHS Improvement deep-dive in our clinical service.
- Prescribing quality audit shows an average compliance of 80% of the standards; however some areas relating to the clarity and legibility of the prescriptions and amendments the compliance can be as low as 26%.
- Medicines Reconciliation within 24hr has fallen slightly below 80% during January 2018 probably due to the winter pressure and high turnover in some clinical areas.
- Representation at MOPS in respect of nursing and medical should improve from February 2018.
- Controlled drugs audits show a slight improvement by actions targeted at specific area on each site to improve compliance.
- There were zero reported medication-related severe incidents in February 2018; however due to the low reporting rate, in general, those causing harm may appear higher proportionately.
- There is a need to increase reporting of near misses and non-serious incidents to promote learning across disciplines.
- Number of Prescription Charts sent to pharmacy has been reduced by 50% during February 2018.
- Omitted / delayed dose remains a concern and work is in progress to improve engagement with nursing and medical staff to minimise risk for the patient.

Safe Ambition: Infection Prevention

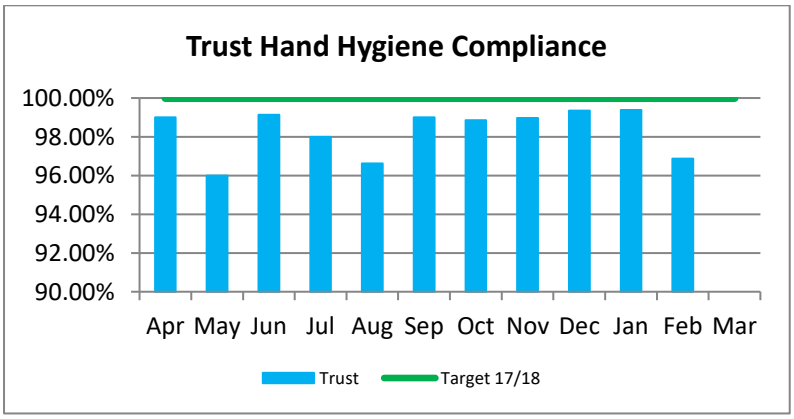
Executive Responsibility: Michelle Rhodes – Director of Nursing



The Trust current position for C.Difficile is 60 (end of Feb.) against a 2017/18 threshold of 59. This is against a national picture of increasing cases.
All cases have review and RCA completed.
The infection prevention and control team are refining the 'lapse in care' appeals process whereby cases can be removed from performance figures if it can be demonstrated that there was no lapse in the patients care. Currently 5 cases are being considered.



The trust has had 2 cases of MRSA year to date against a threshold of zero. MRSA is now considered a relatively rare event for the Trust. Full post infection reviews and root cause analysis investigations have been completed for both cases and actions taken. Both cases have been discussed at Infection Prevention Control Committee.



Hand hygiene compliance audits show a positive rate of compliance with hand hygiene across all Trust sites and areas. The audit detail and process is being further refined to support the infection prevention and control team to better focus their efforts.

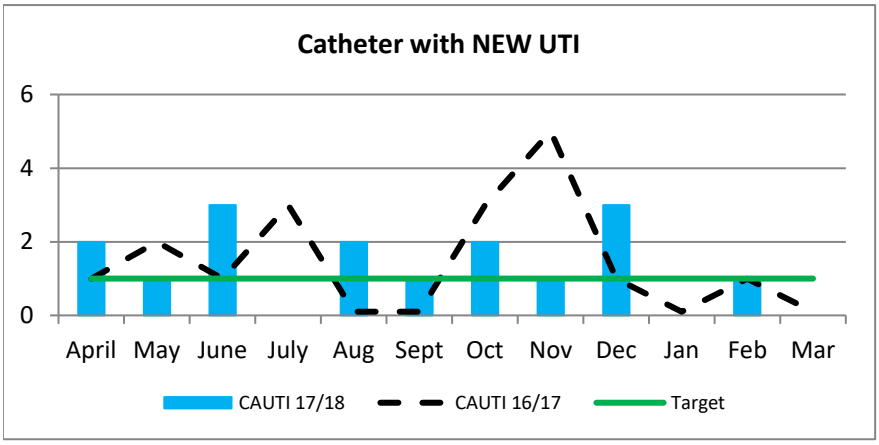
Assurance Summary

- Overall performance with infection prevention and control appears to be improving supported through a greater understanding and alignment of issues captured within the risk register and an improvement in factors captured through the Hygiene Code gap analysis.
- A further external visit from NHSI's Infection Prevention and Control lead is planned for 2nd May 2018.
- The lead Nurse post has been redesigned and is being taken through the recruitment process.
- The infection prevention and control team have changed their approach to better support clinical colleagues and improve patient safety, including: all clinical areas to have a specific IPC link, themed audits, focused incremental improvements.
- The team are also supporting clinical areas to progress on ward accreditation.

Safe Ambition: CAUTI

Executive Responsibility: Michelle Rhodes – Director of Nursing

Trust performance for CAUTI is measured using Classic Safety Thermometer (see page 9). NEW UTI is defined as any UTI diagnosed or treated in acute care with catheter in-situ (exception Suprapubic Catheters). National average comparison by GEM Arden. National average consists of Acute Hospital Providers, Community Trusts, Mental Health Trusts and Independent Service Providers.



ULHT average of catheter with UTI (new) for February 2018 is 0.1% and is above the national average (0.3%). ULHT are above local target for total Catheter with (new) UTI (16 cases/target 12). It is no longer possible to recover the position in 2017/18 and a trajectory for 2018/19 is being considered.

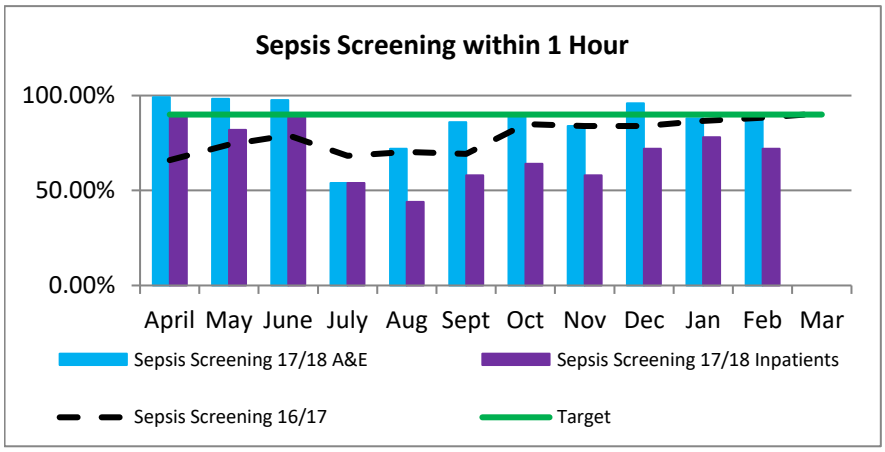
Assurance Summary

- First draft of E-Learning package is written with the support of Organisational Development, provisional launch date April 2018.
- Re-educate to highlight areas of non-concordance with the Catheter Care Bundle.
- Relaunch of Link Nurse/Ambassador Programme with representation from all clinical areas.
- Targeted improvement work to be undertaken with wards highlighted through the ward accreditation programme.
- Revised HOUDINI catheter care bundle launch planned for April to encourage both timely and nurse initiated removal of catheters.
- Collaborative work with South Lincolnshire Neighbourhood team to develop catheter and continence pathways to commence April 2018.
- Executive and senior leaders to attend NHS Improvement Urinary Tract Infection/Catheter Associated Urinary Tract Infection (CAUTI) masterclass on 1st May 2018.
- Participation in NHSI national improvement collaborative for system wide improvement focusing on interventions to reduce healthcare associated UTIs, including CAUTIs.

Safe Ambition: Sepsis

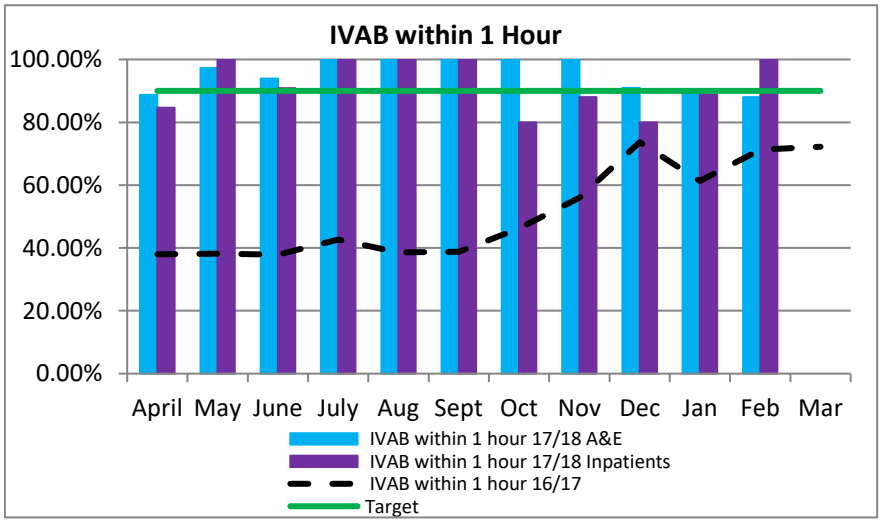
Executive Responsibility: Michelle Rhodes – Director of Nursing

The Trust measure Sepsis by first screen <60 minutes after NEWS 5 and Antibiotics given <60 minutes for Red Flag Sepsis. Data is collected on 50 patients each month from A&E and a further 50 patients from Inpatient areas. Patient results are validated and used for the National CQUIN submission each quarter.



January CQUIN data showed a deterioration in sepsis screening however performance has been maintained in February. This directly correlated with both an increase in the number of patients attending A&E and the acuity of patients (measured by the increased number of patients presenting with a news of 5 or more). The screening if inpatients has deteriorated in February; a safety brief has been released to clarify who should be screened and when.

The data capture in screening process in 2016/17 was different and is not directly comparable.



The administration of IV antibiotics within 1 hour of sepsis diagnosis has deteriorated slightly for A&E which directly correlates with number of patients requiring care and admission within A&E for this period. We anticipate further improvement following permanent adoption of EMAS pilot to give first dose antibiotics to red flag sepsis patients prior to arrival.

Assurance Summary

- Robust process for monitoring and reporting performance to support continued and sustained patient safety: Trust wide CQUIN Audit and utilisation of trust wide electronic screening data to review any missed screens
- Use of the WebV electronic observations system has commenced in Lincoln A&E
- Monthly review templates of non-compliance with screening and sepsis six bundle delivery in place
- Harm Reviews undertaken as/when required
- There is a Sepsis Task and Finish Group who meet monthly
- Sepsis box/ trolley in all adult inpatient/admission areas
- Sepsis e-learning extended to include paediatric module with actions assigned to develop maternity.
- Increased Sepsis Link Nurse engagement across sites supported by Ward Accreditation domain
- Trust wide adoption of EMAS pilot to administer first dose ABX for red flag sepsis
- Adult Sepsis Bundle is not compliant with revised NICE guidance
- Sepsis Clinical Lead has engaged with at Trust Clinical Directors to request improved clinical engagement and medical representation at the Sepsis Task and Finish
- Sepsis e-learning compliance 86.52%, individual reminders circulated with reference to prohibition of gateway progression and study leave.

Workforce Headline Summary –

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

Statistics

KPI	2017/18 Target	February 2018 Performance	Last Month Performance	Performance in February 2017	6th Month Trend
Vacancy Rate - Medical	Medical – 12%	16.36%	15.71%	13.86%	↓
Vacancy Rate – Registered Nurses	Registered Nursing 11.5%	14.59%	14.58%	13.28%	↓
Vacancy Rate – AHP's	10%	10.11%	10.01%	10.35%	↓
Voluntary Turnover	7%, with no group of staff more than 20% above the overall target	5.90%	5.77%	n/a	↑
Quarterly Engagement Index	10% improvement in average score during 2017/18	3.3 (Sep'17)	3.4 (Jun'17)	n/a	↓
Quality of Leadership/Management Index	10% improvement in average score during 2017/18	2.6 (Sep'17)	2.8 (Jun'17)	n/a	↓
Core Learning Completion	Overall target remains 95%.	90.60%	90.17%	88.99%	↑
Sickness Absence (12 month rolling average)	Overall target of 4.5% + no team over 25% above target	4.83%	4.81%	4.75%	↑
Appraisals - Medical	Medical – 95%	95%	95%	88%	↔
Appraisals – Non Medical	Non-medical – 85%	79.71%	80.59%	65.93%	↓
Agency Spend	£25.4m (£)	£2.269m	£2.462m	£2.766m	↓

Commentary

Overall the performance figures for February are disappointing, with vacancy rates and turnover increasing. Scores around engagement and quality of management have declined and sickness rates have increased. The 2017 national staff survey indicated that morale in the organisation was poor and these indicators reinforce that fact.

Agency spend is down on the equivalent figure in 2017. This is despite the fact that vacancy and sickness rates are up. This demonstrates that our efforts to control both usage of agency staff and manage down rates is proving successful.

The core learning compliance rate has increased by 0.43% to 90.60% bringing it back in line with compliance at the end of December 2017 prior to the inclusion of Major Incident Awareness into overall compliance rates. Again this shows a positive improvement despite continued staffing pressures.

Non-Medical appraisal has reduced slightly by 0.88% from the previous month. We continue to press managers on a monthly basis to complete appraisals due. The rate though hovers around 80% and we are struggling to achieve the target of 85%. Whilst we are in a much better position than in February 2017, to be in a position where 1 in 5 staff have not had an appraisal is not acceptable.

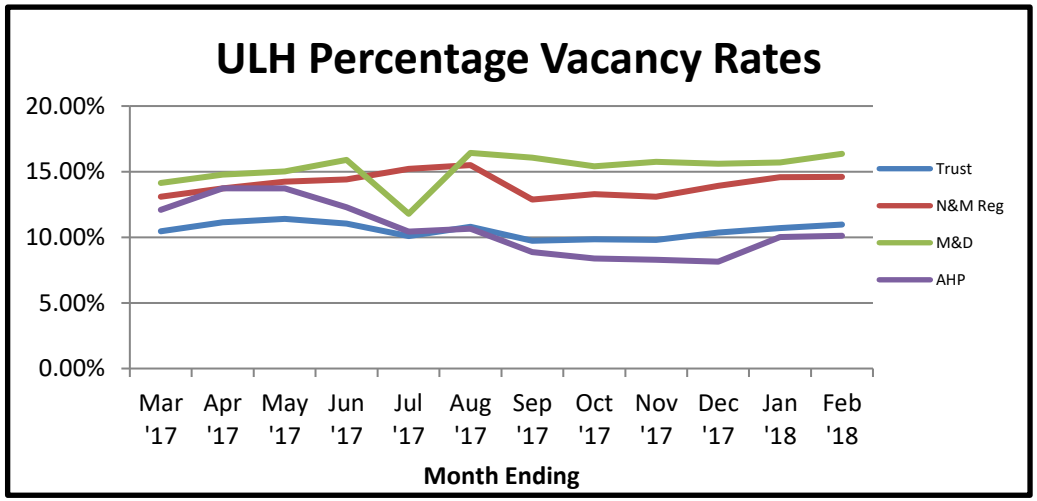
The National Staff Survey is now complete. The response rate is 45% which is significantly higher than last year (39%) and in line with the national average. Scores across the 88 questions in the survey have gone down. Overall across the country, scores have reduced, but the drop in positive scores is much steeper in ULHT. The response to the question “would you recommend ULHT as a place to work” sums up the results. This has gone down by 10 points between 2016 and 2017 and we are in the bottom 20% of acute trusts. Given the Trust has gone into special measures for finance and quality and some difficult decisions have been taken which impact on staff, the results are not surprising. The Workforce and OD Committee received a full report at its meeting on 26th March, detailing how we intend to continue a dialogue with staff about the results and how we have already responded on the issues raised.

KPI:	Vacancy rates	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Deputy Director of HR & OD
Date:	9th March 2018	Reporting Period:	February 2018
Target:	Medical – 12% Registered Nursing – 11.5% AHPs – 10%	Tolerances:	Within 1% - Amber Above 1% - Red
RAG Rating:	Medical 16.36%		
RAG Rating:	N&M 14.59%		
RAG Rating:	AHP's 10.11%		

Analysis

Vacancy rates for the three measured occupational groupings are again above target. The overall Trust vacancy rate for February is 10.97% which is an increase compared to 10.44% rate in February 2017.

The graph shows vacancy rates by staff group and the table's establishment and numbers in post by staff group. The vacancy rate at middle grade level is of particular concern.



	Feb 17	Feb 18
Establishment (registered nurses and midwives)	2268.75	2275.72
Number in post (registered nurses and midwives)	**1967.49**	**1943.63**
% Vacancy Rate (registered nurses and midwives)	13.28%	14.59%
Establishment (non- registered nurses and midwives)	972.63	950.87
Number in post (non-registered nurses and midwives)	**830.01**	**853.64**
Vacancy rate (non-registered nurses and midwives)	14.66%	10.23%
Establishment (AHPs)	394.25	405.92
Number in post (AHPs)	**353.46**	**364.90**
Vacancy Rate (AHPs)	10.35%	10.11%

Establishment (consultants)	356.16	357.09
Number in post (consultants)	**313.42**	**315.77**
% Vacancy Rate (consultants)	12.00%	11.57%
Establishment (middle grades)	199.57	213.37
Number in post (middle grades)	**163.82**	**170.23**
Vacancy rate (middle Grades)	17.91%	20.22%

At the time of writing, the Trust has made offers to 6 Consultants, 42 middle grade doctors, 16.8 doctors to cover training posts, 28.92 registered Nurses, 13 AHPs and 4.82 non-registered nurses, and we are hopeful these will join the Trust over the coming months. The use of agencies for recruiting registered nurses is now in place and the first interviews were held on 9th March.

At its meeting on 26th March, the Workforce & OD Committee will review the current approach to recruitment, to ensure we are taking all steps possible to bring staff into the organisation. The exercise by KPMG to "right-size the establishment based around activity, is important in determining how many of our vacancies need to be filled and could have a significant impact on the vacancy rates shown, for medical staff in particular.

We are focused on ensuring our processes around recruitment are as efficient as possible. We do have staffing gaps in the medical recruitment team at present, which we are striving to cover. We are consulting on bringing the medical and non-medical recruitment teams together, to ensure we can maximise the impact of the resources we have. The new TRAC system will be introduced in May. An NHSI workforce lead visited the Trust on 20/21 March to review our processes.

We have also held a workshop on junior doctor rotation to ensure that through that process that group get a good experience of the Trust.

Action Taken	**Action Planned**
• Continued recruitment work. • Contract signed with TRAC systems for improved recruitment processing (implementation date 23rd April).	• Recruitment agencies can now be used to help us find permanent Nurses; • Continue to deliver on the Recruitment Plan initiatives.

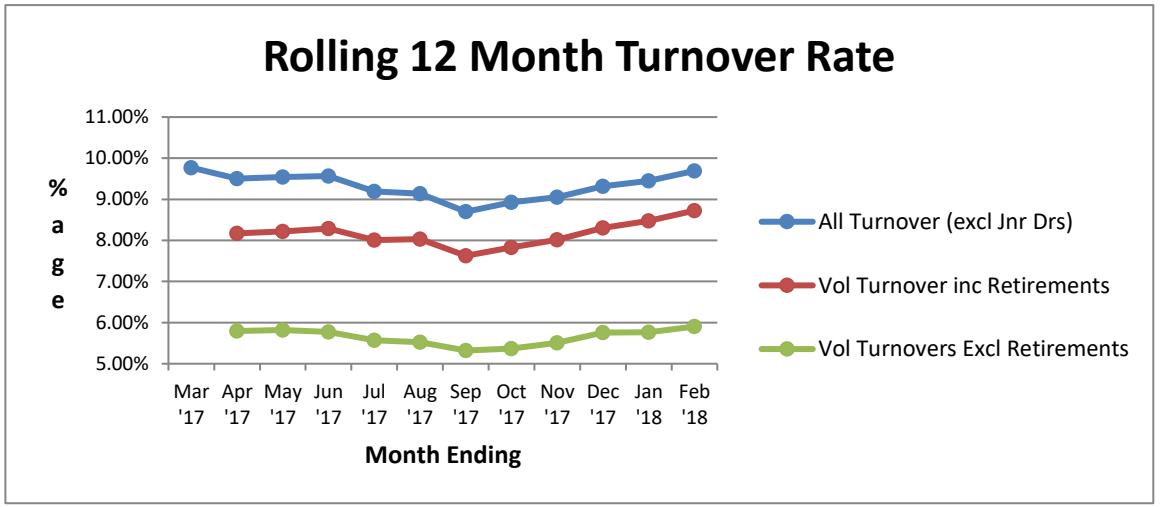
KPI:	Voluntary Turnover	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Deputy Director of HR
Date:	9th March 2018	Reporting Period:	February 2018
Target:	7% (excl. retirements) with no group of staff more than 20% above the overall target	Tolerances:	Within 1% - Amber Above 1% - Red
RAG Rating:	5.90%		

Analysis

The Trust remains within its target for voluntary staff turnover. However we recognise that rates have steadily risen since September 2017.

Based on the latest (December 2017) benchmarking data available (x37 Trusts) from NHS Digital for other Large Acute (Non-Teaching) Hospitals.

- The current Trust turnover rate (excl. junior doctors) of 9.69% is below the average of 10.16%
- The current Trust Nursing & Midwifery (Registered) turnover rate of 8.10% is below the average of 10.75%,
- The current Trust AHP turnover rate of 11.27% is below the average of 11.44%.



Whilst turnover rates remain below the average for acute trusts, we are putting particular emphasis on retention projects, to seek to ensure they do not rise further. We have used HEE money invested in the Trust to bring in additional temporary staff to focus on the following:

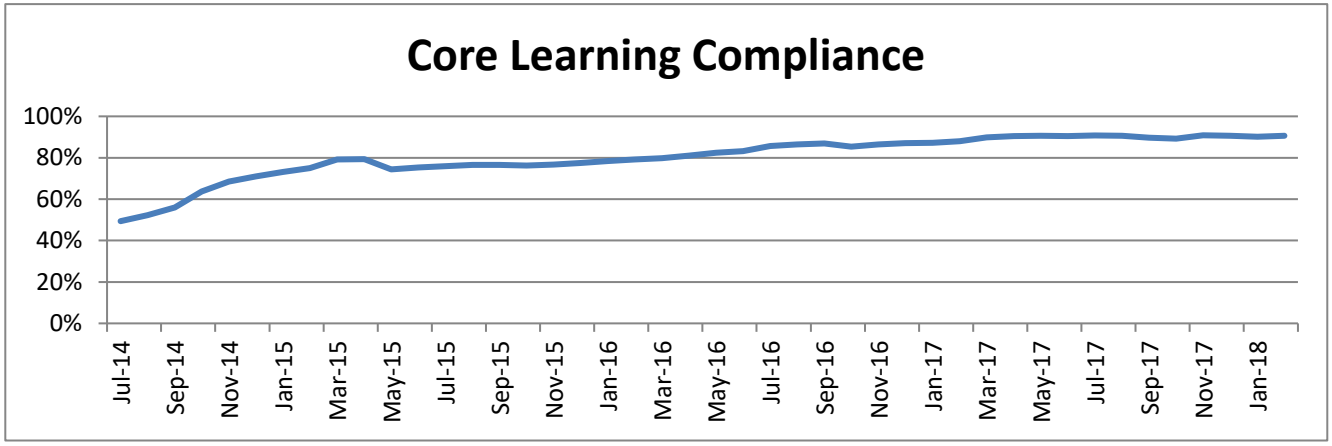
- Defining more clearly what the ULHT brand and offer is (this will help with recruitment also)
- Creating a plan to market the offer more effectively to staff
- Defining development pathways for clinical staff in particular, so they can see how they can build their careers with ULHT
- Understanding what we can do to encourage staff who could potentially retire to stay at the Trust and putting in place the necessary measures to enable them to do so.

Action Taken	Action Planned
• New exit interview process in place – results available	• Work underway around the development offer for both nursing and medical staff • Review of benefits underway – focus on extending benefits offer, reflecting on it from an age differentiation perspective and how we promote our offer; • Survey of nursing staff who have stayed and left the Trust; • All potential retirees to be contacted and asked about their intentions and what the Trust could do to help them stay;

KPI:	Core Learning Completion	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Head of OD
Date:	7 March 2018	Reporting Period:	February 2018
Target:	Revised targets have been set and will form the basis of the performance report in 2018/19	Tolerances:	
RAG Rating:	90.60%		

Analysis

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



The core learning compliance rate has increased by 0.43% to 90.60% bringing it back in line with compliance at the end of December 2017 prior to the inclusion of Major Incident Awareness into overall compliance rates. As the graph shows we have seen a gradual improvement in rates of compliance. The 95% compliance rate is unrealistic and we will set a more sophisticated target for 2018/19.

This month the focus is on Information Governance which is currently at 86.49% with a target of 95%. Although this is 2% better than the same time last year, compliance did rise to 90% by the end of March 2017 so there is some improvement to be made to reach the same level this year. Learning & Development have been supporting the Information Goveranance team in providing compliance information and chaser e-mails targeted at individuals and managers are being sent out monthly.

Directorate Compliance – Information Governance:

Directorate	Feb-18
Deputy Chief Executive	96.92%
Medical Director	94.06%
Director of HR & Org Dev	93.59%
Director of Fin & Corp Affair	93.28%
Clinical Support Services	92.91%
Chief Executive	92.86%
Head & Neck Trustwide	91.61%
Women & Childrens Pan Trust	90.80%
Director of Nursing	90.59%
TACC Lincoln	89.28%
Chief Operating Officer	89.19%
Grantham	86.92%
Trustwide Cardiology Services	86.24%
TACC Boston	83.87%
Haem & Onc Trustwide	83.72%
Orthopaedics Boston	82.57%
Director of Estates & Facil	81.10%
Acute Medicine Boston	80.77%
Acute Medicine Lincoln	79.58%
Orthopaedics Lincoln	78.57%
General Surgery Boston	78.08%
Gen Surg Linc & Urology Trust	77.78%
A&E Lincoln	74.82%

Directorate Performance – Information Governance:

Directorate Top Improvers	Feb-18	Jan-18	Variance
Director of Estates & Facil	81.10%	78.30%	2.80%
Acute Medicine Boston	80.77%	78.42%	2.35%
Director of HR & Org Dev	93.59%	91.36%	2.23%
Gen Surg Linc & Urology Trust	77.78%	75.72%	2.06%
TACC Boston	83.87%	81.91%	1.96%
A&E Lincoln	74.82%	73.05%	1.77%
Head & Neck Trustwide	91.61%	89.86%	1.75%
Grantham	86.92%	85.61%	1.30%
Haem & Onc Trustwide	83.72%	82.49%	1.23%
TACC Lincoln	89.28%	88.19%	1.09%

Staff Group Performance – Inforamtion Governance:

Staff Group	Feb-18	Jan-18	Variance
Healthcare Scientists	96.40%	90.18%	6.22%
Allied Health Professionals	93.83%	91.79%	2.04%
Administrative and Clerical	91.49%	92.36%	-0.87%
Nursing and Midwifery Registered	87.72%	87.71%	0.01%
Add Prof Scientific and Technic	87.33%	88.34%	-1.01%
Additional Clinical Services	84.14%	83.97%	0.17%
Medical and Dental	80.98%	77.94%	3.04%
Estates and Ancillary	76.77%	75.22%	1.54%
Students	75.00%	75.00%	0.00%

Action Taken	**Action Planned**
• 'Hotspots' are any areas in the red i.e. with less than 70% compliance with any number of staff. Following work by the Core Learning Lead, 13 areas have come off the hotspot list this month. However a further 5 have become new hotspots. • To help managers plan ahead, core learning classroom dates have now been organised and published for April 2018-19. • The Information Governance Team have been targeting individuals and managers using data provided by the Learning & Development Team to try and improve compliance towards the 95% target.	• The Trust's Core Learning Lead will continue to work with poorly performing areas to identify and implement any support required

KPI:	Sickness Absence	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Assistant Director of HR
Date:	9th March 2018	Reporting Period:	February 2018
Target:	Overall target of 4.5% + no team over 25% above target	Tolerances:	Within 0.5% - Amber Above 0.5% - Red
RAG Rating:	4.83%		

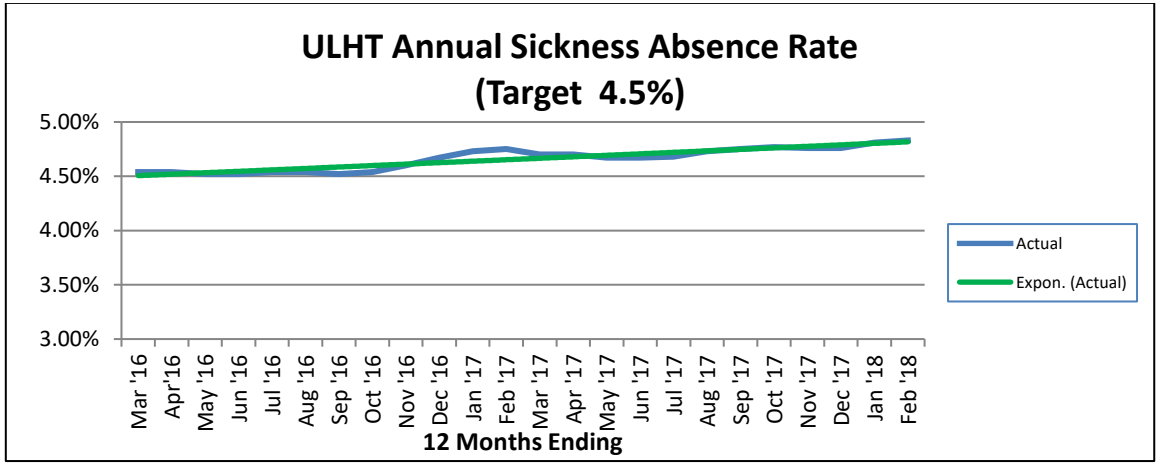
Analysis

The Trust annual rolling 12 month sickness rate is 4.83%, above our target of 4.50%. Sickness has increased from 4.75% at the same period 12 months ago. The top reason for sickness in the month of February was anxiety/stress/depression/other psychiatric illness, however the largest increase of FTE days lost from the previous year was colds, coughs and flu (797.54 fte increase). Given the general level of sickness in the community (as evidenced by attendances at A and E), our efforts to manage sickness effectively are, I would suggest, helping to keep sickness under control.

Our ability to interrogate the reasons for sickness data continues to be hampered by the signifcant amount of sickness being coded to 'other'. There are 25 categories sickness can be coded to so it is highly unlikely that such a large amount of sickness is genuinely for a reason of 'other'. Recent investigations have shown that during February 2018, of the 164 periods of sickness recorded as 'other', 143 were entered via the Healthroster system, 19 by managers using ESR Supervisor Self Service and 2 entered by Payroll. The Healthroster team have been asked to send a communication to managers to where possible use a specific reason for absence which will hopefully address this problem.

The latest Benchmarking data as at November 2017 from NHS Digital (previously Health & Social Care Information Centre - HSCIC) indicates that ULHT has the 6th highest sickness rate (rolling 12 month average - lowest at 3.08% and highest 5.50%) against an average of 4.26%. Of the eight staff groups the Trust again has only one with a sickness rate below the average, this being Healthcare Scientists. The benchmarking is done across x37 Large Acute Trusts.

Rolling 12 Months and Monthly Sickness Rates												
	Mar '16	Apr '16	May '16	Jun '16	Jul '16	Aug '16	Sep '16	Oct'16	Nov '16	Dec '16	Jan '17	Feb '17
Rolling 12 months	4.54%	4.54%	4.52%	4.52%	4.54%	4.54%	4.52%	4.54%	4.60%	4.67%	4.73%	4.75%
Monthly Rate	5.38%	4.73%	4.68%	4.65%	4.77%	4.12%	4.38%	4.73%	5.08%	5.50%	5.50%	5.20%
	Mar '17	Apr '17	May '17	Jun '17	Jul '17	Aug '17	Sep '17	Oct'17	Nov '17	Dec '17	Jan '18	Feb '18
Rolling 12 months	4.70%	4.70%	4.67%	4.67%	4.68%	4.73%	4.75%	4.77%	4.76%	4.76%	4.81%	4.83%
Monthly Rate	4.48%	4.32%	4.34%	4.53%	4.82%	4.62%	4.62%	4.89%	4.78%	5.33%	5.96%	5.62%



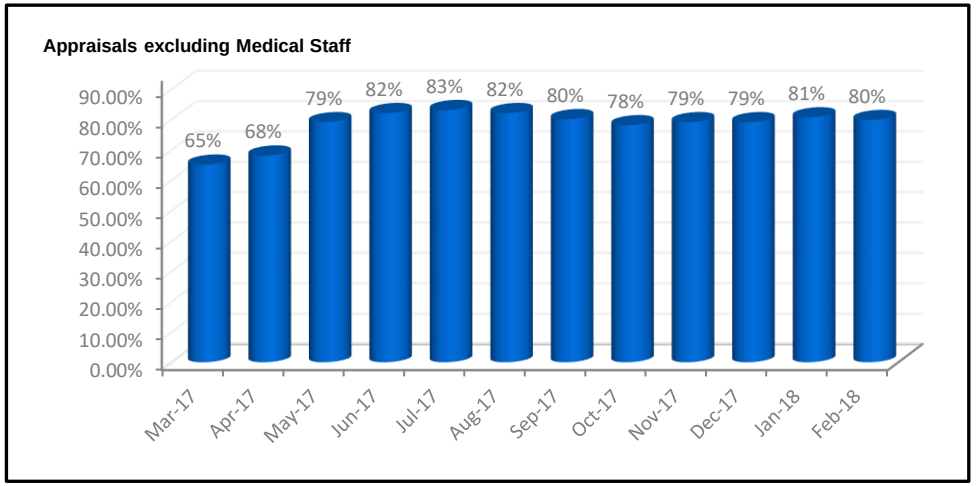
Action Taken	Action Planned
• Communication to focus on the increase in LTS cases. • Further Increase in ER support in managing absence cases and supporting managers on the pilgrim site with their complexities. • Absence training as part of the leadership and management training programme continues to be positively received • Monthly meetings with OH widened to allow wider remit of attendance, OH meetings increased to ensure more time to focus on cases, OH lead has asked for further support to ensure that these are supported at the correct level	• A new training programme has been devised to be rolled out to all levels of staff this will include OH support and how to make a referral • ER Staff have been asked to liaise timely with managers to ensure they are aware of all of their outstanding absences • ER managers to manage complex absence cases and those with absence history alongside those with long term conditions • ER Teams to liaise with managers to ensure that 'other reason is not used' • A number of training sessions for absence management has been arranged for band 6 over the upcoming weeks in pilgrim • Difficult conversation training that includes managing sickness has been rolled out to all of the pilgrim site • Well-being programme being reviewed • Business case for first day reporting to OH being considered

KPI:	**Appraisal Rates**	**Owner:**	**Director of HR & OD**
Domain:		**Responsible Officer:**	**Head of OD**
Date:	**9th March 2018**	**Reporting Period:**	**February 2018**
Target:	**Medical – 95%** **Non-Medical – 85%**		**Within 5% below - Amber** **More than 5% below – Red**
RAG Rating:	**Medical – 95%**		
RAG Rating:	**Non-Medical – 79.71%**		

Analysis

The graph below shows that the Agenda for Change Staff/Non-Medical Appraisal compliance rate for February is 79.71%. This is a slight decrease of 0.88% from the previous month. We are struggling to raise the completion rate above 80%. This is a significantly better position than last year, but below the target (which was 85% this year, stepping up to 90% in 18/19).

The Medical Workforce appraisal rate for the month ending February 2018 remained for the fourth consecutive month at 95%. Only once in the last nine months has the Trust target of 95% not been achieved. We do not have an update report on medical appraisal owing to staff sickness.



Directorate Non- Medical Appraisal Rate

Directorate		Appraisal Rate February '18 (Excludes Medical Staff)	Appraisal Rate January '18 (Excludes Medical Staff)	% Change
Chief Executive	⇨	100.00%	100.00%	0.00%
CSS Blood & Pathlinks	⇨	100.00%	100.00%	0.00%
Director of Fin & Corp Affair	⇨	95.19%	95.19%	0.00%
CSS Therapies	⇩	*93.50%*	*95.32%*	-1.82%
Deputy Chief Executive	⇩	92.50%	95.83%	-3.33%
Women & Children's Pan Trust	⇧	89.31%	88.71%	0.60%
Orthopaedics Boston	⇩	86.25%	89.02%	-2.77%
CSS Diagnostics	⇩	*85.63%*	*89.41%*	-3.78%
Clinical Support Services	⇩	85.54%	87.94%	-2.40%
CSS Outpatient Management	⇩	*84.58%*	*86.46%*	-1.88%
TACC Boston	⇩	84.19%	88.24%	-4.05%
Orthopaedics Lincoln	⇧	80.65%	70.21%	10.44%
Grantham	⇧	78.77%	78.55%	0.22%
Medical Director	⇧	78.57%	67.01%	11.56%
Chief Operating Officer	⇩	78.38%	84.72%	-6.34%
Trustwide Cardiology Services	⇩	76.32%	77.37%	-1.05%
Director of Estates & Facil	⇩	75.08%	76.17%	-1.09%
Medicine Boston	⇩	74.94%	80.69%	-5.75%
Gen Surg Linc & Urology Trust	⇩	74.13%	75.38%	-1.25%
Director of HR & Org Dev	⇩	73.44%	88.52%	-15.08%
CSS Pharmacy	⇧	*73.28%*	*73.02%*	0.26%
General Medicine Lincoln	⇧	73.01%	70.82%	2.19%
TACC Lincoln	⇩	72.94%	74.03%	-1.09%
Haem & Onc Trustwide	⇩	72.22%	75.41%	-3.19%
General Surgery Boston	⇧	72.09%	69.86%	2.23%
A&E Lincoln	⇧	71.96%	70.09%	1.87%
Head & Neck Trustwide	⇧	66.67%	55.29%	11.38%
Director of Nursing	⇧	56.96%	55.13%	1.83%

Action Taken	**Action Planned**
Non-Medical • Managers have been reminded of the need to and how to record completed appraisals through ESR • League table by Directorate was shared at ET and Executive Directors requested to take action by the Chief Executive to address shortfalls	Non-medical • Monthly reports will continue to be provided to Executives naming individuals whose appraisals remain outstanding. • HR Business Partners will continue to: o Hold regular monthly meetings with Matrons/equivalent managers to identify those staff that haven't been captured o Help to managers when they are unsure about completing the reporting process, guidance docs shared as appropriate o Highlight completion rates on monthly scorecards which are discussed at monthly Performance Reviews. o Provide bespoke training offered where appropriate o List of non-compliant staff sent to managers monthly o Data cleansing carried out where info is incorrect o Latest format of Performance Review requires CDs to account for compliance rates. o Emails for example as below and reposts to identify the areas of non-compliance. • Launch of new individual Performance Review process

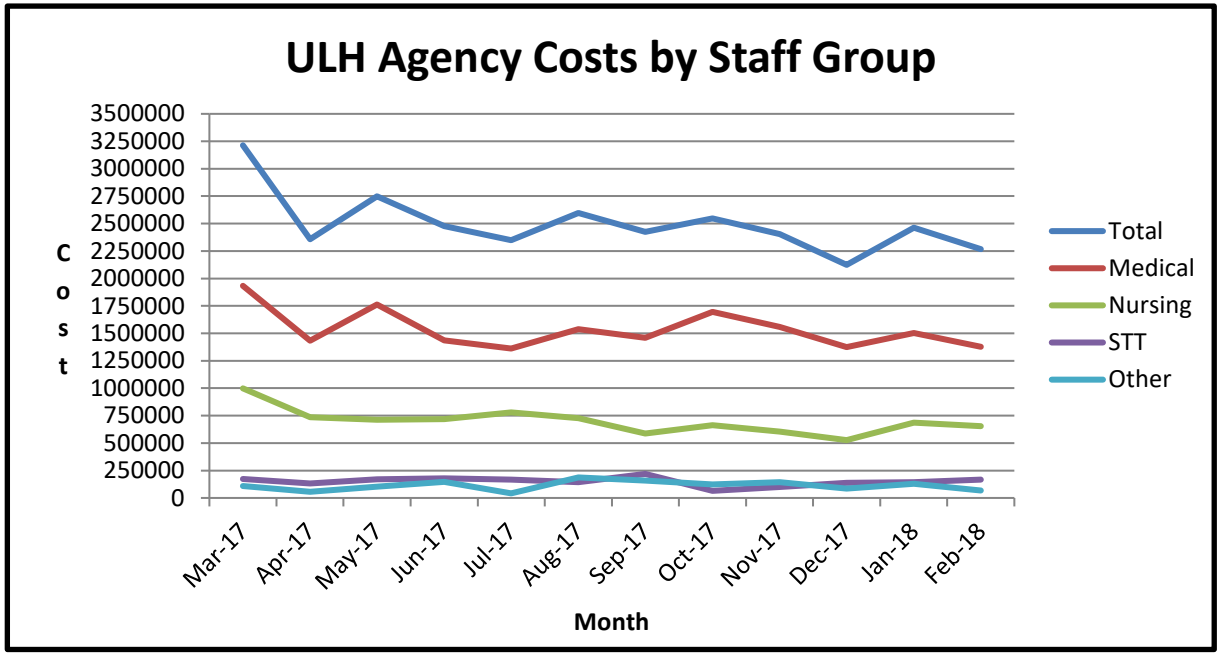
KPI:	Agency Spend	Owner:	Director of HR/OD
Domain:		Responsible Officer:	Various leads on different aspects of agency spend
Date:	9th March 2018	Reporting Period:	February 2018
RAG Rating:	Actual spend of £2.269m, against target of £1.75m		

Analysis

The table below shows agency spend in the last 12 months.

Spend is still above target however it is £193,564 lower than the previous month and £497,655 lower than February 2018 which was £2.766m. Whilst targets have not been achieved, this is a considerable success, if growing vacancy and sickness rates are taken into consideration.

ULHT Monthly Agency Costs					
Month	Total	Medical	Nursing	STT	Other
Feb-17	**2766237**	1605861	908261	172351	79764
Mar-17	**3213598**	1932958	998546	172766	109328
Apr-17	**2356230**	1433258	736176	131342	55454
May-17	**2748610**	1761876	713080	170800	102854
Jun-17	**2478528**	1436862	717214	179061	145391
Jul-17	**2348079**	1361565	778485	166176	41853
Aug-17	**2596696**	1537633	728052	143957	187054
Sep-17	**2423365**	1458234	587363	218845	158923
Oct-17	**2546990**	1695873	664225	64714	122178
Nov-17	**2405537**	1557614	603705	101218	143000
Dec-17	**2124047**	1373919	526962	138704	84462
Jan-18	**2462146**	1502649	685902	144429	129166
Feb-18	**2268582**	1376918	654656	168450	68558



Of the £2,268,582 spent on Agency staff in February £1,376,918 was spent on Medical and Dental staff, £654,656 was spent on Nursing staff (including HCSW's), £168,450 was spent on STT staff and £68,558 was spent on Other staff (including Admin & Clerical staff).

Action Taken	**Action Planned**
• Decision taken to implement a medical bank via Holt • Agreement to extend nursing bank to cover "other" roles	• Review of establishment/workforce planning exercise underway for the 18/19 year • Review of long-standing medical agency staff and extent to which we are actively seeking to recruit to those roles • Review of nursing agency rates • Introduction of standard East Midlands rate caps after Easter

KPI:	Quarterly engagement index	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Head of OD
Date:	13 February 2018	Reporting Period:	January 2018
Target:	10% improvement in average score during 2017/18		
RAG Rating:	3.3 The score is out of five and comprises six questions from the pulse survey		

Analysis
The National Staff Survey is now complete. The response rate is 45% which is significantly higher than last year (39%) and in line with the national average. Results are embargoed for external release until 6th March 2018. We intend to build the response through discussion with stakeholders, staff in particular, through the planned big conversation, but also at Directorate level.

Our approach to engagement is driven around the four known enablers of engagement:

Strategic narrative – we are using our 2021 brand to create a sense of hope for the future
Compassionate and effective leaders and managers – we will be setting out our expectations of managers and supporting them through training
Employee voice – we are listening to our staff through pulse surveys, 2021 Executive walk rounds, Staff Engagement Group, Big 2021 conversations
Organisational integrity – living the values – Our Staff Charter sets out "the deal " for staff and our Personal Responsibility Framework (PRF) clearly articulates the behaviours we expect of ourselves to live those values

Action Taken	Action Planned
• National staff survey results being reviewed internally to identify high level themes • Executives carrying out 2021 walk rounds • Communications timetable for National Staff Survey results developed	• Presentations to CMB and ET on high level outcomes of Staff Survey and CDs and Execs provided with Directorate level reports to enable them to provide local response • Plans being developed for discussions with Directorates which Execs will attend alongside big conversations • Meeting with LPFT to learn from their experience of improving their staff engagement score

KPI:	Quality of leadership and management index	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Head of OD
Date:	13 February 2018	Reporting Period:	January 2018
Target:	10% improvement in average score during 2017/18		
RAG Rating:	2.6 (The score is out of five and comprises two questions from the pulse survey		

Analysis
There is no pulse check this quarter due to the National Staff Survey taking place.

Alongside expected behaviours for all staff, our PRF sets out specific responsibilities for leaders at all levels.

Significant work is being undertaken to completely review the Trust's approach to management and leadership development moving away from the traditional programmes and sheep dip approach to one based on organisational and job role need. The approach will use a variety of media including workshops, videos, action learning sets and so on. There will be a significant focus on the role of managers in supporting the transfer of learning into practice. This will be launched in April 2018.

Action Taken	Action Planned
• New approach to leadership and management development shared at January Senior Leadership Forum • One-off three day programme for aspiring managers funded via EMLA advertised • First STP Mary Seacole leadership programme celebration event took place. 6 ULHT managers graduated from programme. A further nine are on the programme alongside colleagues from a very wide range of Lincolnshire health and care bodies HEE funding being used to sponsor 8 places on National Leadership Academy Masters in Health Care Leadership (Elizabeth Garrett Anderson) and one place on Nye Bevan programme.	• Detailed work on leadership and management modules underway • New brochure being developed • Work on costings for Development Centres (HEE funded) being finalised Execs will make decision on which leaders will be sponsored to apply for national leadership programmes

Nursing Workforce

Executive Responsibility: Michelle Rhodes – Director of Nursing

Safer Staffing: Summary by Site

Feb-18

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals
Grantham	88.64%	98.23%	92.39%	95.04%	92.75%
Lincoln	91.39%	94.77%	97.54%	102.60%	95.24%
Pilgrim	80.83%	88.75%	96.90%	99.08%	88.77%
Trust	86.93%	92.48%	96.87%	100.56%	92.48%

Safer Staffing: Summary by Site - General Nursing

Feb-18

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals
Grantham	88.64%	98.23%	92.39%	95.04%	92.75%
Lincoln	91.03%	96.55%	98.73%	102.39%	95.74%
Pilgrim	82.21%	91.66%	98.26%	102.57%	90.89%
Trust	87.48%	94.62%	97.95%	101.70%	93.62%

Safer Staffing: Summary by Site - Children

Feb-18

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals
Grantham	n/a	n/a	n/a	n/a	n/a
Lincoln	92.84%	76.73%	84.81%	108.93%	87.93%
Pilgrim	63.19%	60.91%	83.27%	64.39%	67.13%
Trust	76.15%	68.09%	84.15%	82.21%	76.97%

Safer Staffing: Summary by Site - Midwifery

Feb-18

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals
Grantham	n/a	n/a	n/a	n/a	n/a
Lincoln	97.76%	91.08%	99.43%	101.48%	97.10%
Pilgrim	96.45%	102.03%	100.40%	102.25%	98.89%
Trust	97.00%	93.37%	100.04%	101.63%	97.91%

Finance Headline Summary

Executive Responsibility: Karen Brown – Director of Finance, Procurement & Corporate Affairs

Key Financial Duties

Financial Duty	Initial Plan £m	Revised Plan £m	YTD Plan £m	YTD Actual £m	RAG
Delivering the Planned Deficit	(48.6)	(77.0)		(77.7)	R
Capital Programme	18.9	22.9	11.7	5.6	A

Key Issues

- The Trust plan for 2017/18 was a control total deficit of £48.6m, inclusive of £14.7m STF income (£63.4m before STF).
- Following the Trust's FSM progress meeting NHS Improvement have agreed a revised outturn deficit of £77.0m for the year exclusive of STF.
- The position in February was a deficit of £7.7m, which is £3.4m adverse to the planned in-month deficit of £4.3m.
- The financial recovery plan assumes delivery of £16.2m of efficiencies to achieve the £77m deficit.
- The deterioration in the income and expenditure position directly impacts on cash and the level of borrowing needed in 2017/18. The Trust will continue to require external cash support in line with the forecast outturn in 2017/18.

Month 11 Financial Position

Month 11 performance against the financial plan is summarised in the table below:

	February 2018			April 2017 to February 2018		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	31,235	31,919	684	355,918	359,699	3,781
Other operating income	4,839	2,766	-2,073	46,948	30,742	-16,206
Employee expenses	-25,858	-26,741	-883	-284,719	-297,073	-12,354
Operating expenses excluding employee expenses	-14,121	-15,299	-1,178	-159,531	-167,647	-8,116
OPERATING SURPLUS / (DEFICIT)	**-3,905**	**-7,355**	**-3,450**	**-41,384**	**-74,279**	**-32,895**
NET FINANCE COSTS	-431	-413	18	-4,486	-3,368	1,118
Other gains/(losses) including disposal of assets	0	4	4	0	128	128
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**-4,336**	**-7,764**	**-3,428**	**-45,870**	**-77,519**	**-31,649**
Add back all I&E impairments/(reversals)	0	0	0	0	-70	-70
Surplus/(deficit) before impairments and transfers	**-4,336**	**-7,764**	**-3,428**	**-45,870**	**-77,589**	**-31,719**
Remove capital donations/grants I&E impact	13	17	4	124	-64	-188
Adjusted financial performance surplus/(deficit)	**-4,323**	**-7,746**	**-3,423**	**-45,746**	**-77,653**	**-31,907**

The Trust is reporting:

- The in-month position in February was a deficit of £7.7m, which is £3.4m adverse to the planned in-month deficit of £4.3m.
- The year to date position in February was a deficit of £77.7m, which is £31.9m adverse to the planned YTD deficit of £45.7m.

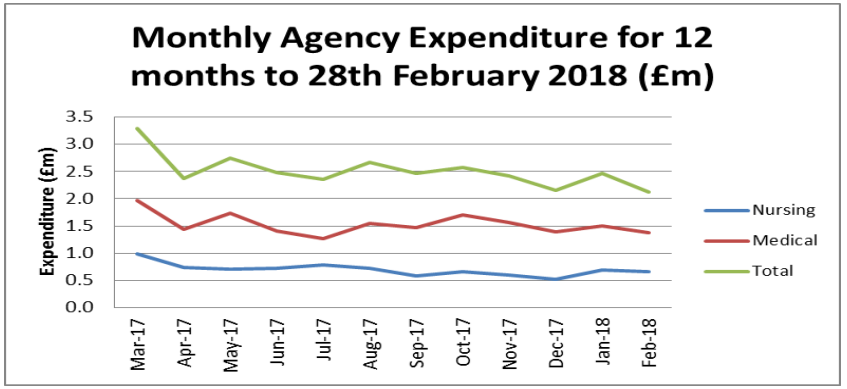
The main reasons for the adverse variance to plan are as follows:

- Non-achievement of STF income resulting in the loss of £13.0m STF income.
- Slower than planned delivery of efficiency savings, with delivery to date £3.4m below plan.
- Pilgrim fire, norovirus outbreak and cyberattack resulting to date in the loss of £3.6m of income.

- Non-achievement of £2.0m of CQUIN income.
- £0.7m in relation to the outcome of the hoist legal case.
- Contract challenges of £1.6m.
- Higher than planned level of expenditure on agency staffing, with expenditure to date £8.1m higher than planned and only partially offset by a reduction in substantive and bank pay expenditure.

Efficiency
The financial recovery plan for 2017/18 includes assumes delivery of £16.2m of efficiencies to achieve the £77m deficit, and savings of £12.9m have been delivered to date.

Agency
The Trust has an Agency ceiling of £21m but has spent £26.96m year to date. Although agency expenditure to date is £0.7m higher than it was at this point last financial year, it is £0.4m lower this month than last month and is £0.7m less in February 2018 than it was in February 2017.



Capital
Total capital works spend to date is £11.7m is inclusive of; £4.0m for Fire and Estates backlog £2.3m Pre-commitments including £1.0m for Neonates, £0.4m Lincoln Specialist Rehab and £0.8m Endoscopy Grantham. £1.7m for Medical Equipment and £1.9m for IT development. The remainder for CQC and Service Development & Modernisation, including Primary Care Streaming of £1.0m.

This is £7.6m lower than the revised £19.3m plan. The main drivers of the variance are as below:

- Fire related works; £6.4m behind the revised plan to date. The work has been slipped into the final quarter but contractors have been mobilised to deliver the programme of works and ensure compliance. Assurances in respect of delivery have been received from Estates leads and weekly monitoring is in place.
- CQC schemes; £1.3m lower than plan year to date mainly due to the slippage with the Trust wide Digital Dictation scheme, and Medical records environment scheme. All are still forecast to deliver.
- Medical Equipment; £0.3m behind plan to date. This is purely a timing issue and full delivery. The full programme will deliver.
- Pre-commitments; £0.4m over the plan to date. This is due to significant spend in February for the Grantham Endoscopy (JAG) scheme.
- IT Development/IT Service Development & Modernisation; £0.2m lower than plan to date. The full IT programme inclusive of an additional PDC loan of £0.9m awarded from NHSI ring-fenced for Cyber Security will deliver in 2017/18.
- Other minor schemes of £0.1m over plan to date.

Total forecast capital schemes of £22.3m is on target to deliver the revised capital envelope and profile for 2017/18.

Cash
At the close of February 2018 the Trust held cash of £8.2m. This includes external revenue support loans of £75.5m.

The total ‘repayable’ borrowings through working capital loans, Salix loans and the uncommitted loan facility are currently £186.1m. The projected revenue borrowings required in 2017/18 are £80.1m, of which £1.3m relates to deficit support from 2016/17. This has been revised in line with the forecast revenue position.

The Trust application for borrowing to address the Fire Enforcement Notice has been approved with £9.5m awarded in 2017/18, £5.1m of which was drawn in February 2018.

The Trust has also been awarded £1.9m PDC for Cybersecurity and GP Streaming, the latter of which has been drawn in full.

Referral to Treatment

Executive Responsibility: Mark Brassington – Chief Operating Officer

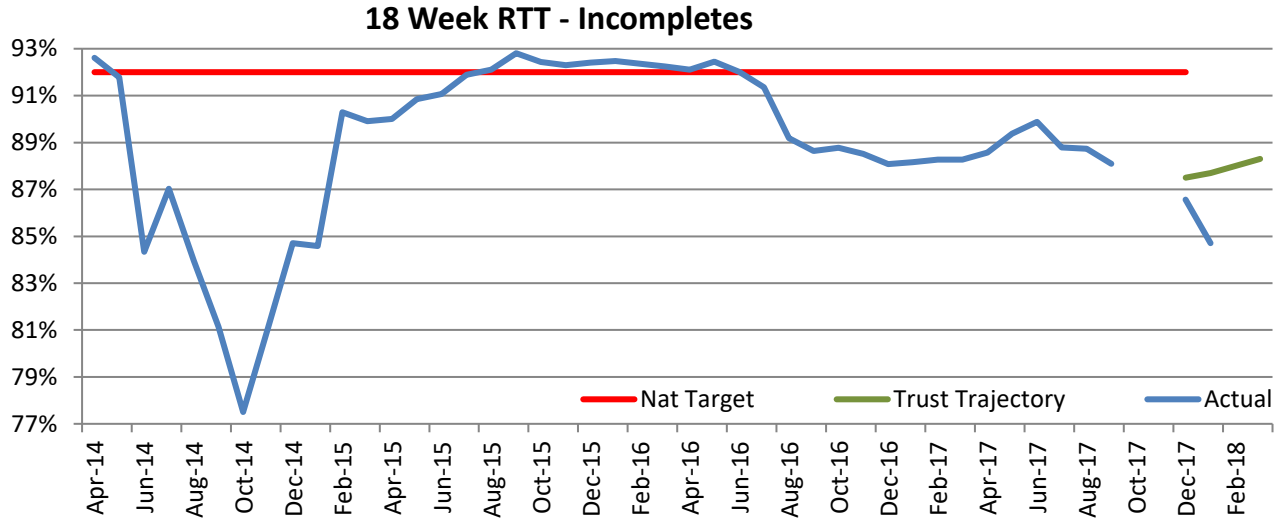
KPI:	Referral to Treatment (18 weeks)	Owner:	Director of Operations
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance – Planned Care
Date:	20th March 2018	Reporting Period:	February 2018 – unvalidated position

Exception Details

The Trust reported performance at the end of December of 86.7%, an improvement of 0.1% compared with the position in December. There were 4,760 patients incomplete on a RTT pathway over 18 weeks at the end of January.

At a national level the standard hasn't been achieved for 22 consecutive months, with an aggregated national performance at the end of December of 88.2%.

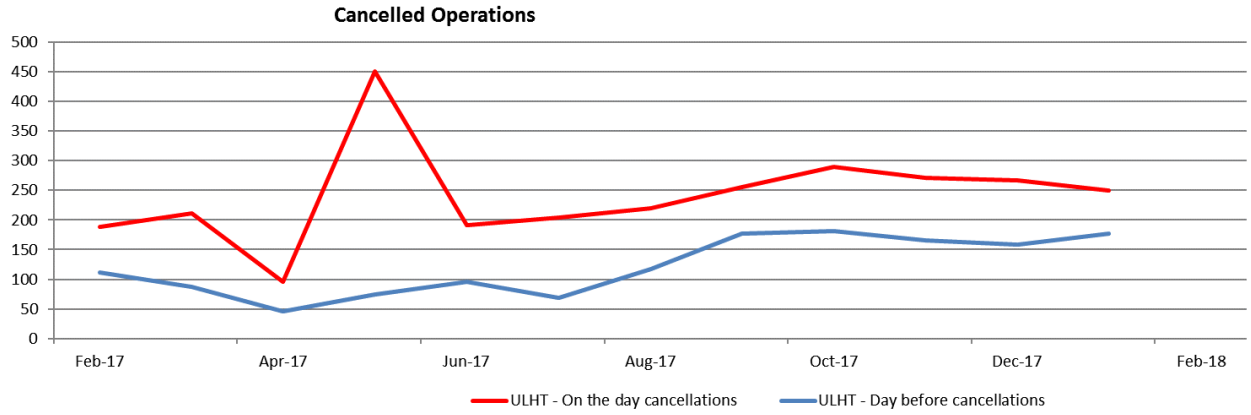
As at the 7th March the RTT incompletes position for February was 84%. The Trust's final performance for February will be submitted on 26th March, therefore this performance level will improve prior to submission. It is expected to reach a performance level of 86-86.5%



The three areas with highest 18 week+ incomplete numbers are as follows:

- ENT – 1089 patients over 18 weeks, which was a reduction compared to December of 54 patients, however ENT still had a negative impact on the overall Trust performance to the value of c.1.6%. Therefore if ENT performance was in line with all other specialities the Trust performance level would be at the national average level. This service experienced significant clinical capacity restrictions during 2017, and there were significant risks relating to Consultant vacancies at the end of the year. Short term mitigations are now in place to address these risks. However, the speciality has 173 patients waiting over 40 weeks on the PTL, leading to increasing numbers of 52 week breaches, particularly during winter month where electives are being cancelled as a result of urgent care pressures and the recent adverse weather conditions.

- General Surgery – Accounted for c.12% of Trust's 18 week+ incompletes at the end of January. There was an increase of 75 patients within the admitted backlog in this speciality between December and January, due to a combination of the planned reduction in electives during January and the high level of cancelled operations as a result of urgent care pressures.
- T&O – Deteriorated by 2.5% during January, primarily as a result of reduced electives increasing the admitted backlog by 82 patients



In January, the Trust scheduled fewer routine operations, however due to urgent care pressures the Trust still cancelled 249 Operations on the day and 177 the day before for non-clinical reasons. This cancellation rate is 60% higher than that which occurred in January 2017.

There are long waiting times for first appointments in a number of specialities. During 2017 there was a reduction in the number of patients waiting over 12 weeks on the open referrals waiting list, reducing from 2820 at the beginning of January 2017 to 1434 at the beginning of January 2018. However, in the last 2 months this position has deteriorated as a result of the reduction in additional clinic provision following the withdrawal of the demand/capacity payment for agenda for change staff, urgent care pressures have led to the cancellation of clinics and the adverse weather conditions at the end of February had a significant impact. As at 6th March there were 2082 patients on the open referrals waiting list over 12 weeks awaiting their first appointment.

At the end of January there were 4 patients (2xENT, 1xGen Surg, 1xGastro) on incomplete pathways over 52 weeks. A harm review has been completed by the lead clinician for two of these cases, with no harm found in one case and low harm in the other. Of the remaining two cases, one of the patients has a TCI on 9th March and the Clinician will complete the harm review after the surgery, with the final harm review still outstanding.

What action is being taken to recover performance?

Delivery of additional outpatient clinics over and above core capacity formed the basis of a significant proportion of the speciality level plans during 2017. The additional Clinical Directorate capacity was being delivered by existing staff working additional hours and also the use of agency locums in specialities such as Neurology, Cardiology and Respiratory.

The standardisation of payments for additional hours for AFC staff in line with national agreements since January has led to increased difficulty providing ad-hoc additional clinics, this is having particular impacts within ENT, Endoscopy, Breast and Dermatology.
The Outpatient Improvement Programme has focused on increasing productivity within baseline outpatient clinics. Booking rules have been reviewed resulting in an additional 400 outpatient slots being added to core capacity per month from February. Additionally, a SOP relating to slot conversions has been implemented in order to

ensure increased flexibility of clinic booking rules in order to reduce unbooked slots within clinics. A revised slot utilisation tool is now in use within the Choice and Access Booking teams in order to assist the team to increase utilisation of outpatient capacity. The C&A teams hold daily huddles in order to maintain oversight of slot utilisation on a daily basis. Slot utilisation increased by 2% between December and February.

The Trust-wide Outpatient 6-4-2 meeting commenced in February in order to co-ordinate and maximise the utilisation of outpatient facilities and staffing across the Trust.

The Theatres Optimisation Committee is overseeing a programme of work relating to theatre scheduling, pre-operative assessment processes, peri-operative efficiency and short stay pathways in order to increase productivity within theatres. Consultant job plans have been reviewed in order to ensure that theatre time is optimised. A theatres dashboard has been created in order to track and proactively manage the key theatres metrics. Work is ongoing to pilot the 'perfect theatre session' within gynaecology and to standardise pre-operative assessments across the Trust. Between January and February there was a 0.5 case increase in the average cases per list, although the proportion of day cases compared to electives remains high as part of the trust's approach to managing the risks relating to winter pressures.

Advice and guidance services are available within ENT, Haem and Cardiology, providing secondary care support to GP Practices prior to referrals being made into the Trust. In addition, since late February, advice and guidance has been available within Gynaecology, Dermatology and Gastro.

Outsourcing has been completed within General Surgery, Ophthalmology, ENT and Urology during 2017/18. As at 7th March, a total of 171 ENT patients, 91 General Surgery patients, 106 Ophthalmology patients and 12 Urology patients have been accepted by independent sector providers, with plans for further patients to be identified within these speciality areas.

The Neurology Service is currently still closed to routine referrals. The Trust is working with the CCGs to develop further community pathways and to develop advice and guidance for Neurology, in order to enable the service to re-open to routine referrals. The Trust are targeting re-opening the service to routine referrals in mid-April.

Impact of adverse weather conditions between 28th February and 3rd March
The Trust cancelled 157 operations and c.2750 outpatient appointments as a result of the adverse weather conditions which affect the UK at the end of February. This resulted in c.1000 less treatments being started (clockstops) during w/c 26th Feb than expected, and an increased number of patients becoming overdue for a follow-up (as at 5th March there were 6917 patients over 6 weeks overdue for a follow-up).

The Clinical Directorates are constructing plans to provide additional capacity in the coming weeks in order to recover as much of the lost capacity as possible.

What is the recovery date?
Forecast trajectory for the remainder of 2017/18:

- December – 87.5%
- January – 87.7%
- February – 88%
- March – 88.3%

Diagnostics

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Diagnostics	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Director of Operations / Deputy Director of Urgent Care
Date:	20th March 2018	Reporting Period:	February 2018

Exception Details

In January the Trust's performance improved, with 98.05% of patients receiving their diagnostic test within 6 weeks of referral. The number of breach patients reduced to 135 in January, with 26 of these being in Echo and 68 in Endoscopy. This level of performance was ahead of the national average for January which was 97.7%.

In February the Trust's performance deteriorated, with 7718 of patients receiving their diagnostic test within 6 weeks of referral. The number of breach patients increased to 225 in February. There were increases in the breaches within Urodynamics (22 breaches) and Echo (43 breaches), both do to short-term capacity issues related to unexpected staffing sickness, which are expected to improve during March.

The area which reported the most significant deterioration in February was the Endoscopy Service (130 breaches). The Endoscopy Service on the Grantham site had long standing maintenance work scheduled for late February and early March, during this time activity was planned to continue, but at a reduced level. However, once the building work commenced a decision was taken by IP&C that the level of dust within the unit was too great to allow any clinical activity to continue on the unit whilst the works were being undertaken. Therefore the remaining scheduled activity at Grantham in the last week of February was cancelled. Where possible additional activity was put on at other sites, but this issue resulted in the significant deterioration in the Endoscopy performance level at the end of February.

What action is being taken to recover performance?

The Grantham Endoscopy Unit is scheduled to remain closed until 14th March, with deep cleaning teams in place from 11th March and an inspection to be completed by the IP&C team on 15th March in order to determine whether the Unit is able to open on that date. The unexpected full closure of this unit poses risks to March's performance.

The Endoscopy Service have utilised Medinet capacity in-week since the changes in demand and capacity payments were introduced in January, however following consultation with staff the Endoscopy nursing team will move to a 7-day rota during March which will enable weekend Medinet lists to commence again from mid-March.

A business case has been approved to enable provision of extended working within the Endoscopy units from Q1 of 2018/19. The majority of administrative posts have now been recruited to, and recruitment for the nursing staff is now underway.

What is the recovery date?

March 2018

4 Hour Standard

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	4 Hour Wait (A&E)	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Director of Operations / Deputy Director of Urgent Care
Date:	20th March 2018	Reporting Period:	February 2018

Exception Details

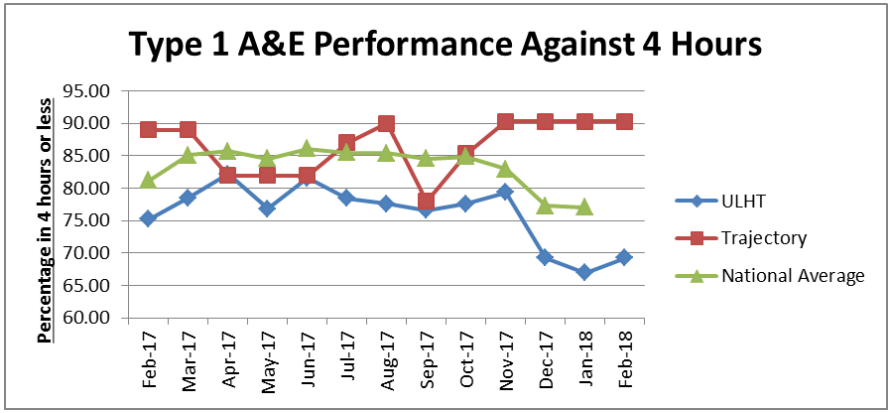
PERFORMANCE

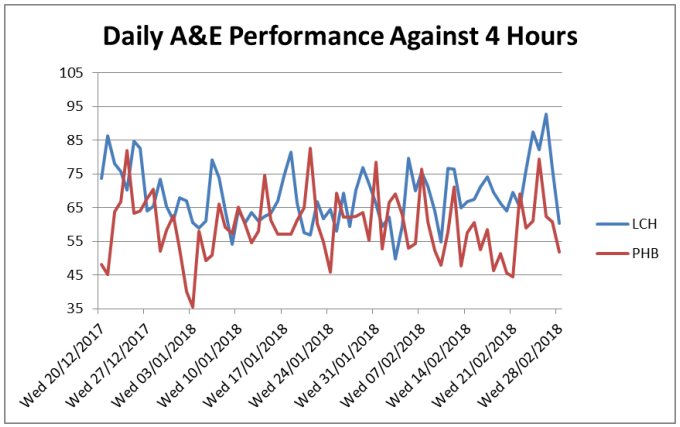
ULHT Type 1 plus streaming Performance for February was 69.26% against the 95% target for 4 hours.

Month on month the trust remains below the national average.

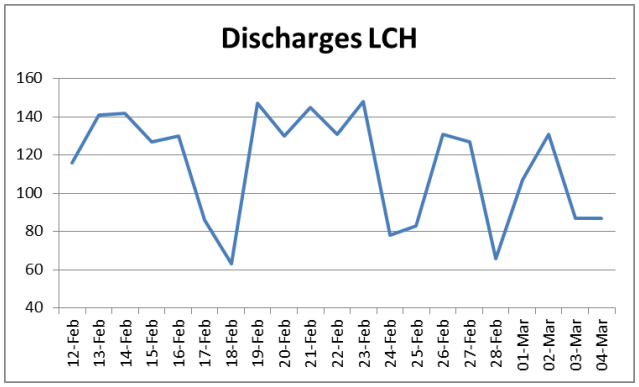
System Type 3 activity was 98.4% in February, bringing the system performance to 80.5%:

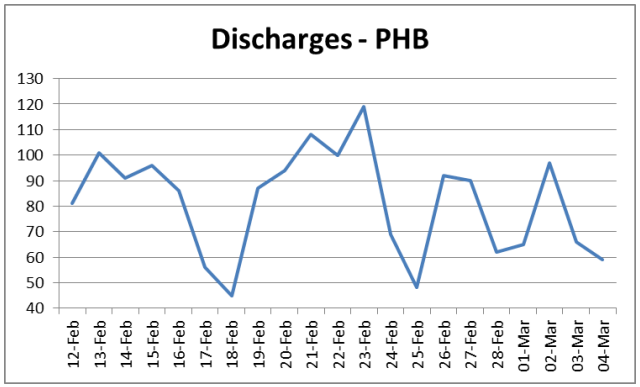
Month	ULHT Type 1 + Streaming	LCHS Type 3	System %
December	69.6%	98.6%	81.6%
January	67.2%	99.1%	80.3%
February	67.7%	98.4%	80.5%

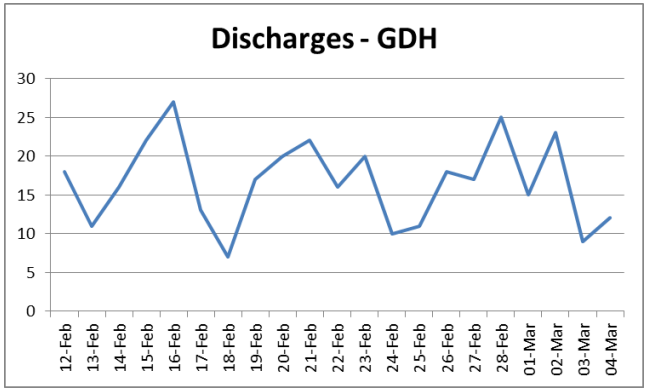




Significant improvements in performance were evident towards the end of the month coinciding with the system discharge "surge" event, run in conjunction with CCG's, LCHS, LPFT and third sector organisations, from week commencing 19th February. An improvement in discharges was evident at Pilgrim Hospital towards the end of the week and a smaller improvement at Lincoln County Hospital for 2 days, although this coincided with larger impact from reduced admissions. There is no analysis to evidence the cause of the reduction in admissions although it is suggested that a combination of system admission avoidance and change in risk approach given the additional system support in ED may have caused this.

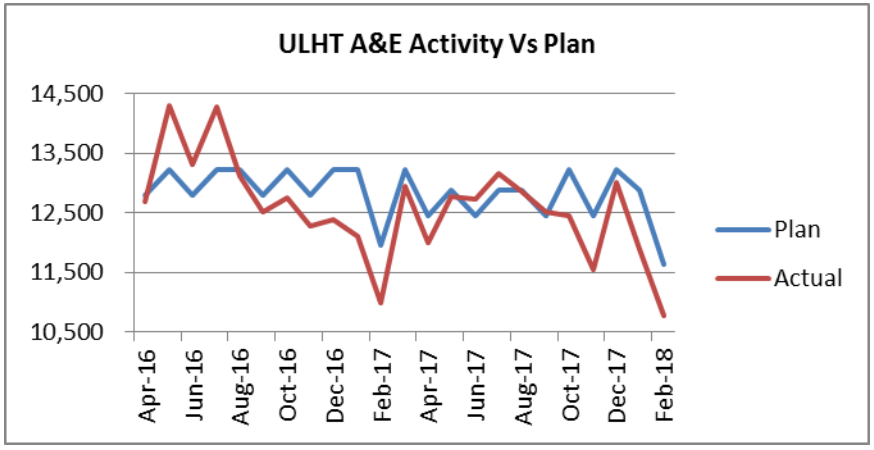


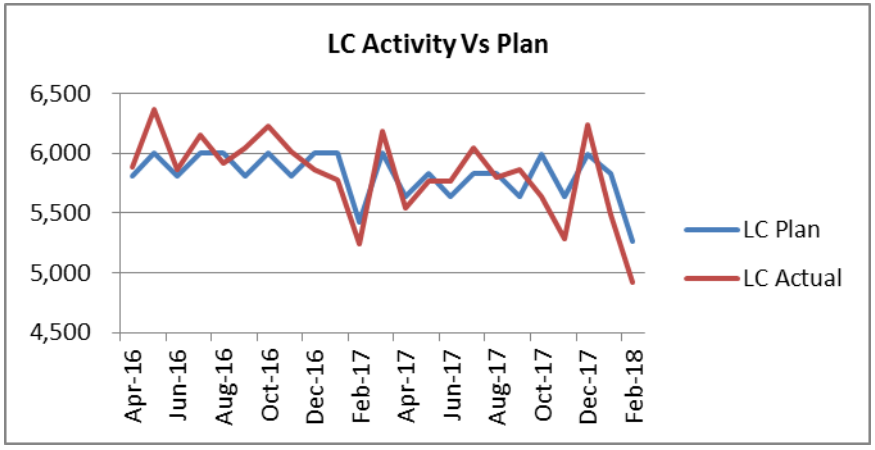


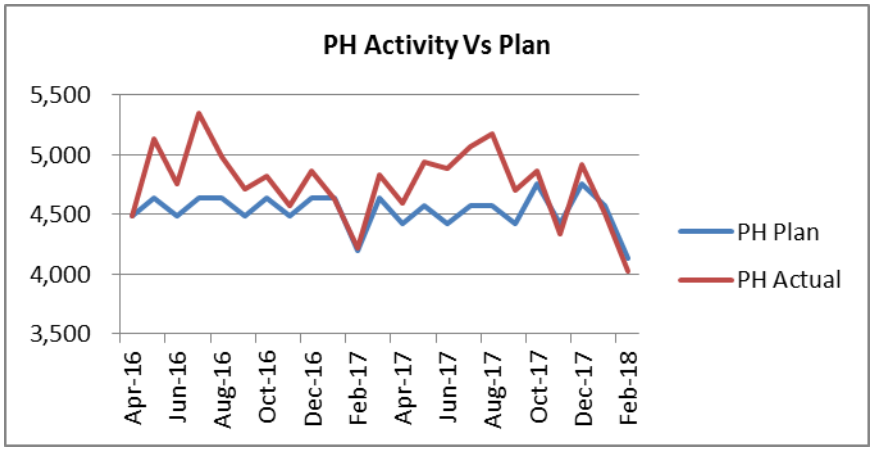


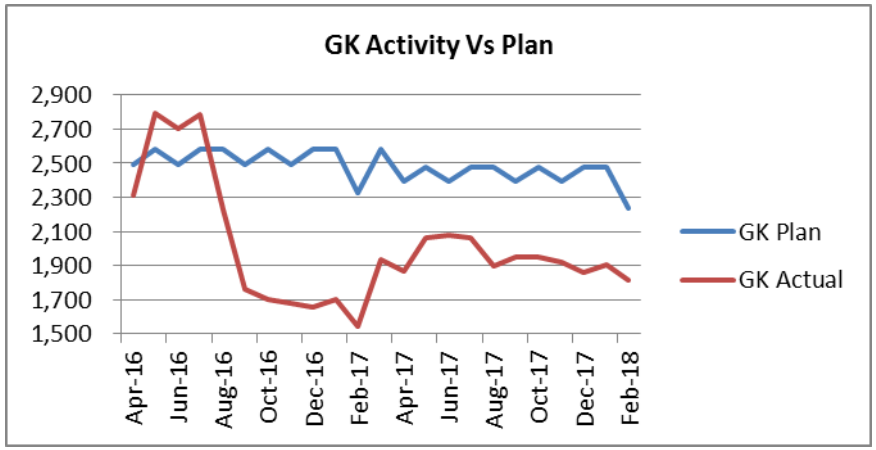
ACTIVITY

Activity for the month was below plan for the trust mainly due to the reduced opening hours at Grantham and District Hospital however unlike previous months Pilgrim and Lincoln hospitals also experienced reduced demand was also slightly below plan at Lincoln and Pilgrim hospitals. February 27th and 28th activity was at times 50% lower than normal reflecting the extreme adverse weather conditions and deterioration in transport networks:

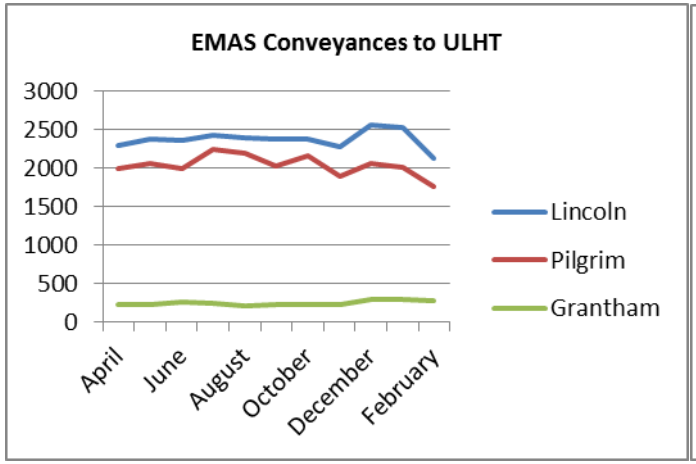


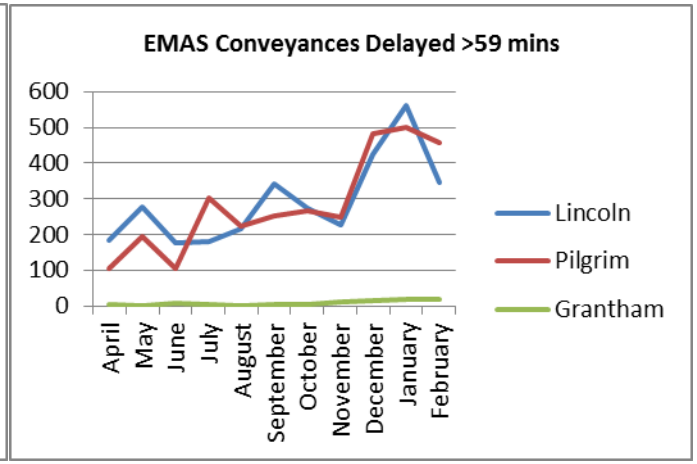






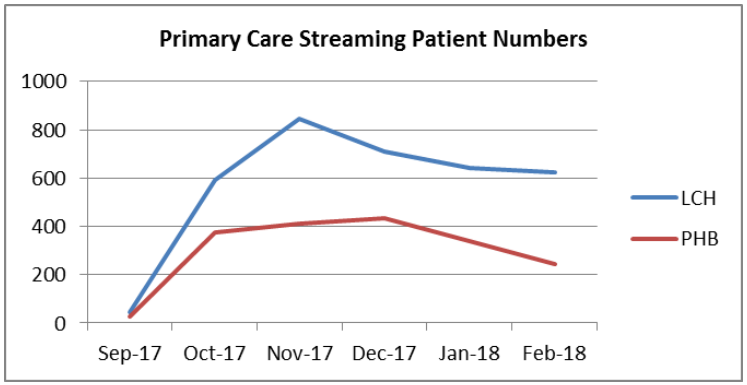
EMAS demand remains consistent with previous months and disproportionally high at PHB in view of the size and total attendances to the department. Handover delays remain a significant problem although have reduced slightly at Lincoln County. The predominant issue remains the high acuity of patients and the available capacity within the system creating a lack of patient flow.





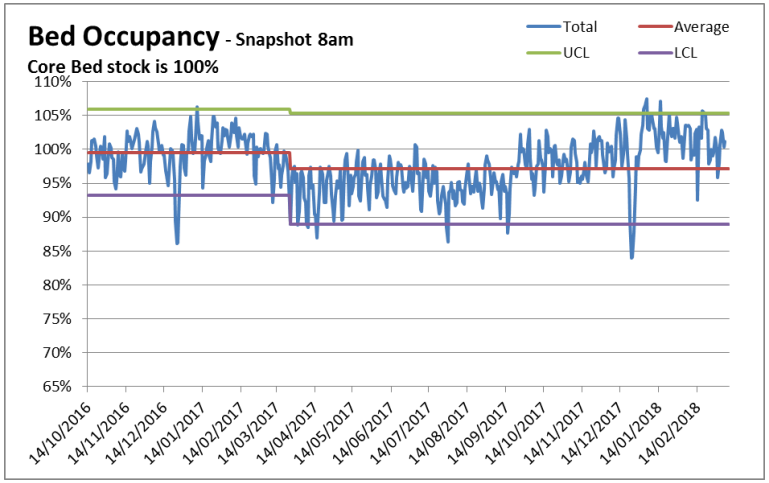
Lincoln Hospitals ambulance handover time improvements have been helped by increasing the Rapid Assessment and Triage (RAT) process to 24 hours. At Pilgrim Hospital the team continue to embed the new Pre Handover Practitioner Role assisted by increased use of agency paramedic staff working for the Trust. Improvement plans developed will lead to these staff taking handover and cohorting crews if several ambulances are waiting and thus reduce the time to ambulance handover. SSGHealth, specialist consultants in process redesign, who have a proven track record of ambulance handover improvements have been procured by NHSi to support the improvement plan developed in collaboration with EMAS.

Primary Care Streaming numbers fell in February again at Pilgrim Hospital. Streaming is now being undertaken by staff from LCHS and the two trusts are engaging regularly in conversations about performance and how we can help each other to develop the skills of streaming staff. Future planning continues to look at all self-presenting patients being considered for the streaming service.



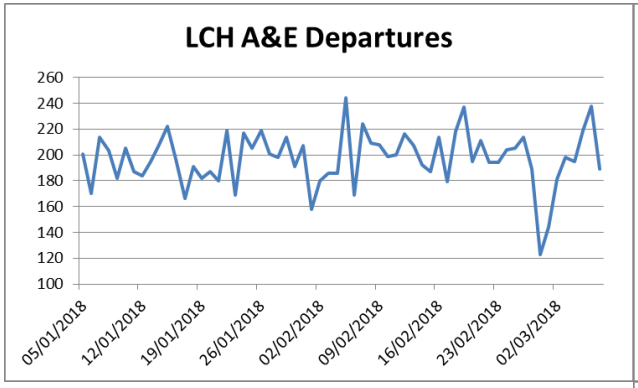
ISSUES AFFECTING PERFORMANCE

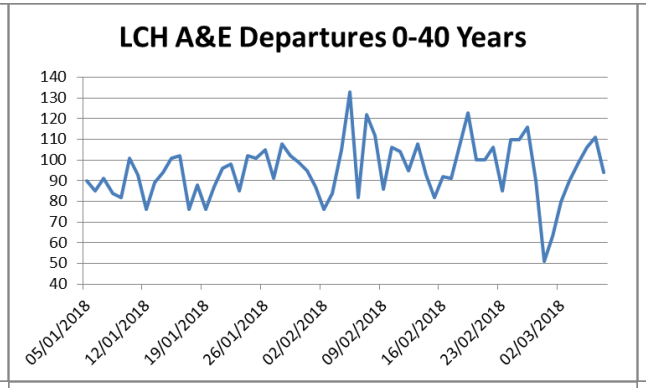
The single greatest issue impacting on performance in February was bed capacity and overall inpatient occupancy at PHB and LCH sites. Throughout the month there were extreme fluctuations, both positively as a result of the surge week, improvements in discharges and reduction in admissions, but also because of the adverse weather in the last part of the month. The chart below shows this at Trust level, having not returned to pre-winter levels and with continuing peaks above 100% occupancy.

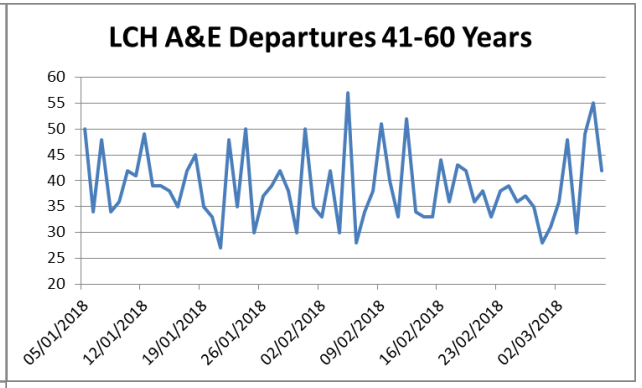


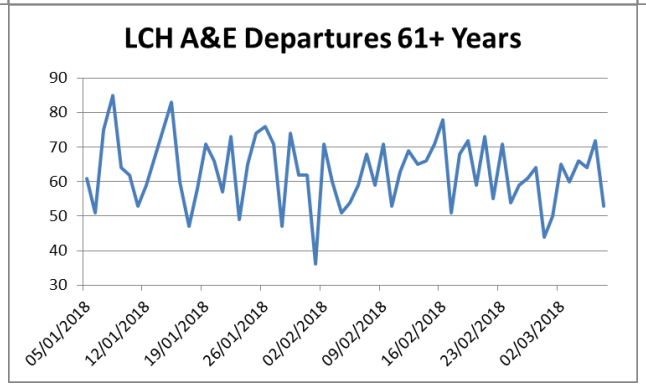
The Lincoln walk in centre closed during weekdays from the beginning of February and closed fully from the end of February. It is therefore still too early to draw conclusions but this will continue to be closely monitored to ensure plans in place prevent walk in patients from defaulting to A&E. The impact of the adverse weather incident on 27th

February – 1st March is significant and can be seen in the charts below. Whilst reducing the number of attendances, which would in normal circumstances lead to an improvement in 4 hour waits, the adverse weather also created significant staffing challenges as well as exit-block from the A&E as patients were delayed in discharge into the community and in some cases to their homes.

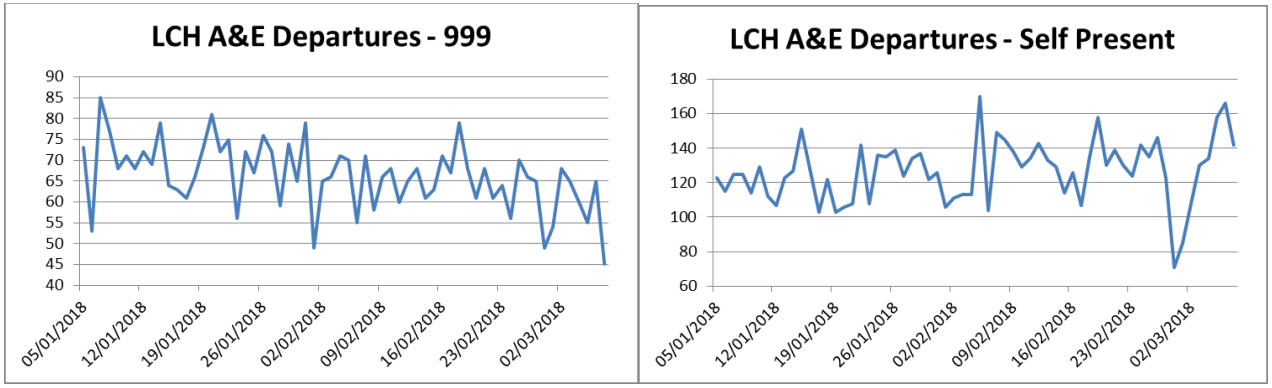








Self-presenting attendances have also shown an increase since the beginning of February, whilst 999 attendances decreased slightly in February and were impacted by the snowfall.



Business continuity incidents were declared when the trust hit level 4 due to bed capacity 1st February (LCH), 11th February (PHB), 13th – 14th February (LCH & PHB), 19th – 21st February (LCH and PHB). On each occasion the sites recovered well putting in place additional actions such as:

- Additional flow meetings every 2 hours with key actions to support the wards and ED
- Additional medical, surgical and orthopaedic doctors into ED
- Deep dive approached to Red to Green meetings, looking at every patient in the hospital
- Support for community teams
- Cancellation of non-urgent / cancer elective procedures
- Senior management present on site in evenings and weekends

Staffing issues persist on all sites. Changes around the rules for clinical attachments to sign doctors off for language competency have meant the trust has rescinded offers to several oversees candidates. Staffing due to sickness and half terms school holidays also caused difficulties during the month.

What action is being taken to recover performance?

Key SAFER flow actions remain in place with priority given to:

- 10 x 10 (10 discharges and 10 patients to be moved into base wards by 10am): This scheme is underway and will improve flow earlier in the day.
- Pre noon discharges and level discharge volumes (performance management of discharges across all wards) as above.
- Accurate setting of predicted discharge dates, confirmed by Bed Managers and Matrons: This scheme is underway and will improve overall discharges and improve LOS.
- Red2Green (Review, escalation and reduction of delays in patient discharge process and reduction) this scheme is underway and will improve earlier discharges and reduce LOS.

Unfortunately due to the adverse weather at the end of February and into early March the “Perfect Week” event had to be cancelled. The trust continued to take part in an additional surge event working with community partners to increase complex discharges.

An enhanced Escalation Operating Procedure was reviewed and added to the Full Capacity Protocol to manage long waiters in ED and any potential 12 hour trolley wait, after recent breaches of this standard. In addition to this the Bristol Safety Checklist is being embedded to ensure all patients are receiving planned tasks and ongoing care, especially when A&Es are overcrowded.

Plans to open the Rochford Ward at Pilgrim Hospital have not been successful due to staffing constraints within LPFT, however the Digby ward at LCH continues to be run by LCHS and support patients who otherwise do not require acute hospital care.

Cancer Waiting Times – 62 Day

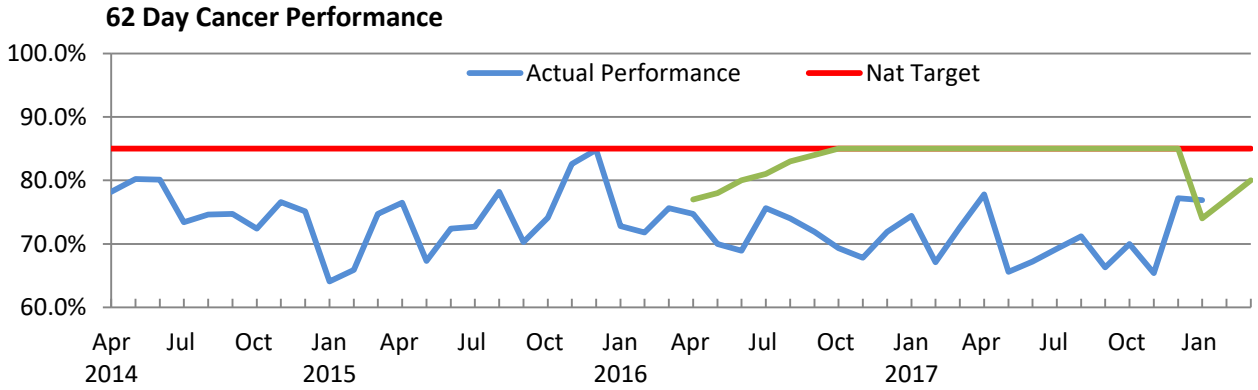
Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Cancer Waiting Times (62 Day)	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance – Planned Care
Date:	20th March 2018	Reporting Period:	January 2018

Exception Details

The Trust's submitted performance position for January against the 62 day classic standard was 76.9%.

The Trust achieved 4 out of the 9 cancer standards in January. The 31-day subsequent drug treatment standard was achieved for the sixth month out of the last seven, the 31-day first standard was achieved for the fourth month in a row and the 31 day Radiotherapy standard was achieved for the seventh month in a row. The 62-day upgrade standard was also achieved.



Performance in Urology remained above 70% for the two consecutive months for the first time in 16 months. However Lower GI's performance remained below 55% for the eighth time in the last nine months.

Completion of RCAs for each breach in December found that the most frequent breach reasons were as follows (in order of occurrence):

- Pathology
- Patient choice and fitness
- Tertiary diagnostics/treatment
- Decision/process delays
- Theatre capacity

As of 6th March there are 9 pts on or over 104 days without an agreed treatment plan: 4 x Colorectal, 2 x Urology, 2 x Lung, 2 x H&N.

The Trust treated 11 patients at 104 days or over during January, completing RCAs for all 11 patients. Due to the length of these pathways these patients had multiple reasons for delays in their pathways, as follows:

- 7 cases included patient choice delays

- 5 cases included patient fitness factors
- 4 cases included complexity or procedural factors
- 3 cases included Outpatient capacity issues
- 2 cases included HDU capacity issues
- 2 cases included ultrasound capacity restrictions
- 2 cases included administrative delays
- 1 case included pathology delays
- 1 case included theatre capacity restrictions
- 1 case included CT delays
- 1 case included MRI capacity delays
- 1 case included MDT process delays
- 1 case included other Radiology capacity delays
- 1 case included first OPA delays
- 1 case included tertiary treatment delays

The Trust completes a full review of any potential harm related to excessive waits for cancer treatment (104 + Day Waits and patients who waited over 21 days for first appointment on a suspect cancer pathway who were subsequently diagnosed with cancer): 13 Harm Reviews have been issued for December, as at 6th March 7 had been completed, with 6 reporting no harm and 1 reporting low harm.

As at 6th March, February's 62-day performance position was 68%, however further treatments are likely to be recorded over the next 3 weeks prior to submission of February's data and are likely to improve this position further.

There is risk to February, March and April's performance levels due to the impact of winter. In January 11 operations for cancer patients were cancelled as a result of unavailability of HDU capacity due to urgent care pressures. In addition, between 28th February – 2nd March 18 operations for cancer patients were cancelled due to adverse weather conditions that affected the UK.
Performance against the Breast 2-week-wait target during February and March isn't yet confirmed, but has been significantly impacted by an increase in referral levels during January and restrictions in service capacity, which have been magnified since the withdrawal of the demand and capacity mechanism of payment for additional hours.

What action is being taken to recover performance?
Update on key improvement actions

- Intensive Support Team first OPA demand/capacity modelling has been refreshed, and was implemented by late February.
- Pathology workload allocation re-design commenced and additional locum resource is in place. During the majority of February average pathology turnaround times for patients on suspect cancer pathways were less than 10 days, however routine waiting times remained high.

- A project has commenced to deliver improvement work relating to the reliability of identifying pathology samples which should be processed on a suspect cancer pathway as opposed to a routine pathology pathway, including the production of a standardised SOP, communications with Clinical teams and processes to identify patients who have been incorrectly categorised as routine who are on cancer pathways.
- STT for lung CT commenced at beginning of January on Lincoln and Pilgrim sites, and at Grantham in February. Recruitment processes have commenced relating to a lung pathway co-ordinator post which will assist in the delivery of the lung optimal pathway changes.
- Radiology action plan being delivered with the ambition to achieve 90% of turnaround within 7-days by the end of March. Latest performance 51% referral to report within 7-days for all modalities. CT remains the greatest challenge linked to scanning capacity. Discussions taking place to utilise central cancer resources in order to fund a mobile CT scanner for the last 3 weeks of March in order to address this. CT 7-day business case to be reviewed by Financial Turnaround Group in March.
- Redesign of post MDT phase of Urology pathway to completed, with changes to post MDT booking rules actioned.
- A new process for identifying Oncology capacity directly from MDT is currently being trialled within Urology.
- Actions are being undertaken to implement extension of Endoscopy service following BC approval. The majority of administrative posts linked to this business case have been successfully recruited to. The nursing posts are currently out to advert.
- Discussions are at an advanced stage with an external organisation in order to secure capacity to trial a visual management approach to proactive capacity/demand management within cancer pathways.
- A case management approach is to be utilised during March for patients waiting over 62 days on a cancer pathway
- A pilot is due to commence in March relating to nurse led triage within Urology

What is the recovery date?

- 74% - January 2018
- 77% - February 2018
- 80% - March 2018
- 81% - April 2018
- 83% - May 2018
- 85% - June 2018

CQUINs 2017/18

No.	Goal name	CQUIN Lead	Financial Value	Q1	Q2 forecast
National					
1a	Improving Staff Health and Wellbeing (achieve improvement scores on 2/3 questions on the staff survey)	Stephen Kelly	£245,326		
1b	Healthy food for NHS staff, visitors and patients	John Spencer	£245,327		
1C	Improving the uptake of flu vaccinations for frontline clinical staff	Stephen Kelly	£245,327		
2a	Timely identification for sepsis in emergency departments & Inpatient	Adam Wolverson	£183,996		Partial (10% instead of 25%)
2b	Timely treatment for sepsis in emergency departments & Inpatient settings	Adam Wolverson	£183,996		
2c	Empiric review of antibiotic prescriptions	Sue Leo	£183,996		
2d	Reduction in antibiotic consumption	Sue Leo	£183,996		
4	Improving services for people with mental health needs who present to A&E	Dr Roberts / Dr Sant (joint CQUIN with LPFT)	£735,980		
6	Set up and operate A&G services for non-urgent GP referrals	Lee Parkin	£735,980		
7	All providers to publish ALL of their services and make ALL of their First Outpatient Appointment slots available on eRS by 31 March 2018	Lee Parkin	£735,980		
8	Supporting Proactive and Safe Discharge (split between increasing discharges(£588,785) and ECDS (£147,196))	Kate Sayles	£735,980		
Specialised					
B12	Severe Haemophilia Haemtrack Patient Home Reporting	Bethan Myers / Alison Dawson Meadows	£69,917		
GE3	Hospital Medicines Optimisation	Sue Leo	£188355 (£269000 being paid)		Awaiting confirmation
AF1	Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community	Tim Couchman	£34,018		
1	NHS Dental Services	Dr Kotyla	£122,152		

RAG

Grey - no milestone due for this quarter
Green - fully achieved milestone & full payment
Amber - partially achieved milestones & received a partial payment

Equality Analysis Statement

United Lincolnshire Hospitals NHS Trust is fully committed to caring for all patients, service users, their families and carers, and staff in a manner which embraces, respects, promotes and celebrates equality and cultural diversity.

The Equality Act 2010 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, and for public sector bodies to take proactive steps to:

- eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act;

- advance equality of opportunity between people who share a protected characteristic and people who do not share it; and

- foster good relations between people who share a protected characteristic and people who do not share it.

These are referred to as the three aims of the General Equality Duty.

The nine protected characteristics are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

As a public sector body the Trust has a statutory duty to ensure all aspects of Trust business and functions are compliant with, and evidence due regard to, the Equality Act 2010.

As this performance paper is derived from a range of individual directorate reports, each report from respective directorates must be underpinned by equality analysis.

Trust Board is advised that whilst gaps in equality analysis currently exist, directorates should be held to account in respect of provision of structured and robust equality analysis to support their business.

Appendix 1. Glossary

Indicator	Definition
C.Diff – Acute acquired (>72hrs)	The number of Clostridium Difficile in a calendar month
MRSA Bacteraemia – Acute acquired (>72hrs)	The number of MRSA Bacteraemia in a calendar month
MSSA Bacteraemia – Acute acquired (>48hrs)	The number of MSSA Bacteraemia in a calendar month
ECOLI Bacteraemia – Acute acquired (>48hrs)	The number of ECOLI Bacteraemia in a calendar month
Never Events	Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
Serious Incidents	Acts and/or omissions occurring as part of NH-funded healthcare that result in: - Unexpected or avoidable death of one or more people - Unexpected or avoidable injury to one of more people that has resulted in serious harm - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional - Actual or alleged abuse
Harm Free Care %	The proportion of patients without any documented evidence of pressure ulcer, harm from a fall in care in the last 72 hours, a urinary infection or a new VTE
New Harm Free Care %	The proportion of patients without any documented evidence of a new pressure ulcer, harm from a fall in care in the last 72 hours, a new urinary infection in patients with urinary catheter has developed since admission or a new VTE
Catheter & New UTIs (Safety Thermometer)	The proportion of patients with an indwelling urethral urinary catheter present on the day of the survey or removed in the last 72 hours
Falls	The proportion of patients with evidence of a fall in a care setting in the last 72 hours
Medication Errors	An unintended failure in the drug treatment process that leads to, or has the potential to lead to, harm to the patient
Pressure Ulcers 3/4	Number of incidences of grade 3 and 4 avoidable pressure ulcers acquired by inpatients in the care of the organisation in the calendar month
VTE Risk Assessment	The proportion of patients with a documented VTE risk assessment
eDD	Proportion of patients with a completed electronic discharge document
PPCI 90 mins	Acute myocardial infection (AMI) patients with ST-segment elevation on the ECG closest to arrival time receiving primary PCI during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less
PPCI 150 mins	Acute myocardial infection (AMI) patients with ST-segment elevation on the ECG closest to arrival time receiving primary PCI during the hospital stay with a time from hospital to arrival to PCI of 150 minutes or less

Indicator	Definition
#NOF 24hrs	Fracture neck of femur time to theatre within 24 hours
#NOF 48hrs	Fracture neck of femur time to theatre within 48 hours
A&E 4 hour wait	Percentage of all A&E attendances where the patient spends four hours of less in A&E from arrival to transfer, admission or discharge
A&E 12 hour trolley wait	Total number of patients who have waited over 12 hours in A&E from decision to admit to admission
52 Week Wait	The number of incomplete pathways greater than 52 weeks for patients on incomplete pathways at the end of the period
RTT - 18 week referral to treatment	The percentage of patients on incomplete pathways within 18 weeks against the total number of patients on an incomplete pathway as at the end of the calendar month
Cancer 2ww	Two weeks from urgent GP referral for suspected cancer to first appointment.
Cancer 2ww Breast Symptomatic	Two weeks from referral for breast symptoms to first appointment.
Cancer 62 Day classic	62 days from urgent GP referral for suspected cancer to first treatment.
Cancer 62 day screening	62 days from urgent referral from NHS Cancer Screening Programme to first treatment.
Cancer 62 day upgrade	62 days from a consultant's decision to upgrade the urgency of a patient due to a suspicion of cancer to first treatment.
Cancer 31 day first	31 days from diagnosis to first treatment for all cancers.
Cancer 31 day subsequent treatment (drug)	31 days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (drug).
Cancer 31 day subsequent treatment (surgery)	31 days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (surgery).
Cancer 31 day subsequent treatment (radiotherapy)	31 days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (radiotherapy).
Cancer 104+ day waiters	Number of patients on a 62 day pathway who have been waiting 104+ days for first definitive treatment
Diagnostics 6weeks	The percentage of patients waiting 6 weeks or more for a diagnostic test
SHMI – Summary Hospital level Mortality Indicator	The ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there
HSMR – Hospital Standardised Mortality Ratio	The ratio of the observed to expected deaths, multiplied by 100, with expected deaths derived from statistical models that adjust for available case mix factors such as age and comorbidity
MFFD - Medically fit for discharge	Average number of patients discharged before 12 noon who have been declared as medically fit for 72hours
DTOC - Delayed transfers of care	Total number of delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both)

Appendix 2. Overview of thresholds for Red, Amber, Green ratings

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

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

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

Metric	Red	Amber	Green
C.diff Actual	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
C-diff Accum	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
MRSA	More than 0 instances		0 instances
MSSA	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
E.coli	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Never Events	More than 0 instances		0 instances
Serious Incidents	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Harm Free Care	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
New Harm Free Care	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Catheter & UTIs	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Falls	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Medication Errors (Datix)	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Medication errors (mod, severe or death) (DATIX)	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Pressure Ulcers (PUNT) 3/4	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
VTE Risk Assessment	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Core Learning	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Nurse to Bed Ratio	Deteriorated from last month		Improved from last month
A&E 4 Hr	Missed both National and CCG Targets	Missed National Target but achieved CCG Target	Achieved National Target
A&E 12hr Trolley Wait	More than 0 instances		0 Instances
RTT 52 week wait	More than 0 instances		0 Instances
RTT 18 Week Incompletes	Missed both National and CCG Targets	Achieved National Target but failed CCG Target	Achieved National Target
62 Day Classic	Missed both National and CCG Targets	Missed National Target but achieved CCG Target	Achieved National Target
2 Week Wait	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
2 Week Wait Breast	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
31 day first treatment	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
31 day subsequent drug treatments	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
31 day subsequent surgery treatments	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target

31 day subsequent radiotherapy treatments	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
62 day screening	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
62 day consultant upgrade	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Diagnostics achieved	Failed Target by more than 1%	Failed Target but by less than 1%	Achieved Target
Diagnostics Failed	Failed Target by more than 1%	Failed Target but by less than 1%	Achieved Target
Cancelled Operations –on the day	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Cancelled Operations -Not treated within 28 days	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
FFT: IP (Response Rate)	Deteriorated from last month	Same as last month	Improved from last month
FFT: IP (Recommend)	Failed Target by more than 3%	Failed Target but by less than 3%	Achieved Target
FFT: A&E (Response Rate)	Deteriorated from last month	Same as last month	Improved from last month
FFT: A&E (Recommend)	Failed Target by more than 3%	Failed Target but by less than 3%	Achieved Target
Complaints	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Mixed Sex Accommodation	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
EDD	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
PPCI 90 hrs	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
PPCI 150 hrs	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
NOF 24	Failed Target by more than 4%	Failed Target but by less than 4%	Achieved Target
NOF 48	Failed Target by more than 4%	Failed Target but by less than 4%	Achieved Target
Dementia Screening	Failed Target by more than 4%	Failed Target but by less than 4%	Achieved Target
Dementia Risk Assessment	Failed Target by more than 4%	Failed Target but by less than 4%	Achieved Target
Dementia Specialist Referral	Failed Target by more than 4%	Failed Target but by less than 4%	Achieved Target
Stroke 90% attendance	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Swallowing <4hrs	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Scan <60mins	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Scan <24hrs	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Stroke Admitted < 4hrs	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Stroke IP dying in dept.	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
SHMI	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Hospital Level Mortality Indicator	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Elective LOS	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target

Non-Elective LOS	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
MFFD	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
DTOC	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Vacancies	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Sickness Absence	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Staff Turnover	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Staff Appraisals	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Equality and Diversity	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Income v Plan	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Expenditure v Plan	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Efficiency Plans	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Surplus / Deficit	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Capital Program Spend	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Agency Spend	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Partial Booking Waiting List	Failed Target		Achieved Target