United Lincolnshire Hospitals NHS
NHS Trust

UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 30th SEPTEMBER 2012

Document management

Title: Integrated Performance Report

To: Trust Board (Private)

From: Jane Lewington, Director of Strategy and Performance

Author: Steve Hewitt, Deputy Director of Strategy and Performance

Date: 23rd October 2012

Purpose of the Report:

To update the Board on the performance of the Trust for the period ended 30th September 2012, and set out the plans and trajectories for performance improvement.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	x	Endorsement	

Recommendations:

The Trust Board is asked to note the current performance and future projections for improvement.

Strategic Risk Register	**Performance KPIs year to date** **As detailed in the report**

Resource Implications (e.g. Financial, HR) None
Assurance Implications: The report is a central element of the Board Assurance Framework
Patient and Public Involvement (PPI) Implications None
Equality Impact None
Information exempt from Disclosure None
Requirement for further review? The report will be updated in November 2012 reflecting performance to 31st October 2012.

Version: Integrated performance report September 2012 FINAL Issued 23rd October 2012

Content

Note that financial performance is part of this domain
but is reported separately to the Board

1. Key measures: performance at a glance

ULHT Performance at a Glance - September 2012

Indicator	Thresholds		Trust wide position				Lincoln			Pilgrim			Grantham		
	Achieve	Fail	Year to date	Current Month	Trend	Position as at	Year to date	Current Month	Trend	Year to date	Current Month	Trend	Year to date	Current Month	Trend
Total time in A&E: 4 hours or less	95%	94.99%	95.93%	96.69%	↑	Sep	96.63%	97.61%	↔	94.51%	95.03%	↑	96.89%	97.25%	↔
Referral to treatment times milestones - Admitted	90%	89.99%	90.92%	89.65%	↓	Sep	89.27%	88.80%	↓	92.22%	94.70%	↓	91.86%	93.10%	↑
Referral to treatment times milestones - Non-Admitted	95%	94.99%	94.89%	94.64%	↔	Sep	95.03%	95.08%	↔	93.92%	94.83%	↓	95.84%	94.05%	↑
Referral to treatment times milestones - Incompletes	92%	91.99%	92.38%	92.11%	↔	Sep	91.08%	90.90%	↔	91.60%	91.54%	↑	95.77%	95.37%	↓
Waiting times for diagnostic tests	1%	1.01%	0.95%	0.64%	↑	Sep	0.83%	0.83%	↑	0.56%	0.56%	↑	0.40%	0.40%	↑
Number of inpatients waiting longer than the 26 week standard	0.03%	0.15%	6 0.02%	4 0.07%	↓	Sep	5 0.03%	4 0.15%	↓	1 0.01%	0 0.00%	↔	0 0.00%	0 0.00%	↔
Number of outpatients waiting longer than the 13 week standard	0.03%	0.15%	339 0.46%	99 0.83%	↔	Sep	102 0.29%	38 0.66%	↓	143 0.71%	49 1.56%	↓	59 0.61%	2 0.12%	↑
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	93%	92.99%	94.10%	95.20%	↔	Aug	95.10%	95.93%	↑	93.34%	94.45%	↔	93.34%	93.26%	↓
2 week standard for non-suspected (symptomatic) breast referrals	93%	92.99%	90.06%	94.81%	↑	Aug	88.12%	94.00%	↑	91.08%	98.00%	↑	95.52%	88.00%	↓
Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments	96%	95.99%	97.80%	98.40%	↑	Aug	97.10%	97.69%	↓	98.28%	98.99%	↑	99.42%	100.00%	↑
31 day subsequent drug treatments	98%	97.99%	97.34%	98.67%	↔	Aug									
31 day subsequent surgery treatments	94%	93.99%	96.21%	98.55%	↑	Aug	94.24%	98.00%	↑	98.68%	100.00%	↔	100.00%	100.00%	↔
31 day subsequent radiotherapy treatments	94%	93.99%	91.40%	99.15%	↑	Aug									
Maximum waiting time of 62 days from all referrals to treatment for all cancers	85%	94.99%	84.24%	89.40%	↑	Aug	79.90%	87.88%	↑	90.06%	95.52%	↑	95.45%	87.50%	↓
62 day standard from screening programmes	90%	89.99%	92.00%	100.00%	↑	Aug	87.28%	100.00%	↑	96.77%	100.00%	↔	100.00%	100.00%	↔
62 day consultant upgrade	85%	84.99%	100.00%	-	↑	Aug									
(Cancelled ops) Number of patients whose operation was cancelled, by the hospital, for non clinical reasons, on the day of or after admission	0.80%	1.50%	400 1.07%	42 0.75%	↔	Sep	150 0.81%	9 0.33%	↔	230 1.80%	30 1.51%	↑	11 0.27%	3 0.47%	↔
(Cancelled ops) Not treated within 28 days. (Breach)	5%	15%	156 39.00%	16 38.10%	↑	Sep	24 16.00%	2 22.22%	↑	132 57.39%	14 46.67%	↑	0 0.00%	0 -	
Delayed transfers of care	3.50%	5.00%	2.90%	2.56%	↔	Sep	2.12%	1.34%	↑	3.53%	4.42%	↔	4.35%	2.16%	↓
MRSA Bacteraemia (Post 48 Hours)	6	7	3	0	↔	Sep	0	0	↔	2	0	↑	1	0	↑
Clostridium difficile (Post 72 Hours)	61	62	38	6	↑	Sep	13	1	↑	17	3	↔	8	2	↑
Thrombolysis - 60 minute call to needle time	68%	48%	58.82%	58.82%	↑	Apr-Jun 2012	54.55%	54.55%	↑	75.00%	75.00%	↓	50.00%	50.00%	↑
Waiting times for Rapid Access Chest Pain Clinic (2wk Wait)	98%	95%	100.00%	100%	↔	Jul	100.00%	100%	↔	100.00%	100%	↔	100.00%	100%	↔
Mixed Sex Accommodation (reported from December 2010)	0%	100%	0	0	↔	Sep	0	0	↔	0	0	↔	0	0	↔
VTE	90%	89.9%	90.42%	92.52%	↑	Aug	89.49%	92.57%	↑	91.63%	92.56%	↑	90.15%	90.53%	↔
eDD	90%	69.9%	67.6%	67.2%	↓	Sep	67.6%	69.1%	↓	63.9%	61.2%	↓	72.4%	72.4%	↓
No. Complaints Received			363	49		Sep	196			142			25		
Complaints completed within timescale	80%	59.9%		87%	↑	Sep		90%	↑		67%	↑		100%	↔
HSMR	89	101	107.3	107.3		Apr - Jun 12	105.8	105.8		117.5	117.5		80.1	80.1	
SHMI				109.3		Apr-11 - Mar-12									
Fractured neck of femur 24 Hours	70%	62.5%	73.3%	77.9%	↑	Sep	69.3%	80.8%	↑	85.6%	96.6%	↑	55.7%	30.8%	↓
Fractured neck of femur 48 Hours	95%	85%	91.2%	88.2%	↓		87.1%	88.5%	↓	99.4%	100.0%	↑	82.9%	64.5%	↓

Indicators highlighted have data older than current month

2. Performance domain 1: Service Quality

2.1 Hospital Standardised Mortality Ratio (HSMR)

Performance Indicator	Indicator type	Achieved	Under review	Under-performing	Currency	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Hospital Standardised Mortality Ratio																				
Hospital Standardised Mortality Ratio (quarterly)		<90	90-100	>100	RR			97.4			107									
Hospital Standardised Mortality Ratio (rolling 12m)		<90	90-100	>100		103.4	102.4	101.4	102	99.7	108	109								
Summary Hospital Mortality Indicator (April 2011 - March 2012)		<90	90-100	>100		110.8								109						

Please note: The HSMR figures for 2011/12 have now been retrospectively rebased to take into the national improvement in mortality rates.
The Trust's rolling 12 month HSMR for August 2011 to July 2012 (most up-to-date data available) is 108.7. This will means that the Trust is an outlier for HSMR. The rolling 12 month figures for HSMR at site-level are as follows: Lincoln County Hospital 111.2, Pilgrim Hospital 109.4, Grantham and District Hospital 98.2. The HSMR for Lincoln and Pilgrim sites is significantly higher than expected

2.2 Reducing Infection

Performance Indicator	Indicator type	Achieved	Under review	Under-performing	Currency	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
MRSA screening		100%		<100%	%	91	90	105	109.2	122	108	105	116	108						
Incidence of MSSA bacteraemia	NPF / QS	24 cases annually			No.	25	27	28	3	6	6	7	8	9						
Incidence of Clostridium difficile (cumulative)	NPF	maximum of 61 cases annually			No.	63	66	74	1	5	12	21	32	38						
Incidence of MRSA bacteraemia (cumulative)	NPF / QS	6 cases annually			No.	4	4	4	1	1	1	1	3	3						
Incidence of E Coli infections (cumulative)	NPF / QS	96 Cases annually			No.				7	20	30	36	42	53						

Still off trajectory for C Diff at the end of September 2012. An action group has been established by the Medical Director to meet fortnightly to recommend and monitor specific actions to reduce the incidence of hospital acquired infections.

2.3 Fractured Neck of Femur

DOMAIN 1 SERVICE QUALITY		THRESHOLDS			DATA	PERFORMANCE 2011/12			PERFORMANCE 2012/13											
Performance Indicator	Indicator type	Achieved	Under review	Under-performing	Currency	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Fractured NOF <24 hours of admission	QS	>70%		<62.5%	%	53.9	54.4	62.8	68.0	85.5	66.2	76.5	65.7	77.9						
Fractured NOF <48 hours of admission	QS	>95%		<85%	%	82.1	83.5	89.7	88.0	91.9	92.7	92.7	92.9	88.2						

Trust: The 24 and 48 hours target time is not always achieved as the patient's condition need to be stabilised prior to operation. Medical input is necessary to achieve appropriate stabilisation, which is required from orthogeriatricians, which the Trust are making progress to appoint and being able to achieve best practice tariff. We currently have a locum orthogeriatrician working at Lincoln, and medical input is being received at Pilgrim.

Lincoln Site: The use of ring fenced trauma beds continue, additionally the whole afternoon trauma list has been ring fenced for #NOF cases. Lincoln will be reviewing Pilgrim's plan for staffing and capacity/theatre scheduling to consider what can be adapted. There is a daily escalation process now in place if NOF's do not go to theatre on time.
Grantham Site: First theatre slot on every trauma list is reserved for #NOF patients. Performance however has steadily declined over the last 3 months. A review of all 24 hour breaches is underway with action plan from Grantham awaited.
Boston Site: First slot on trauma list is ring fenced for #NOF patients, additional improvements are planned in conjunction with vascular work as this will result in all day trauma lists. The continued work has resulted in 86% of patients to theatre in 24 hours and 99% of patients in 48 hours since April 2012.

2.4 Clinical Quality Indicators (CQUIN): Quarterly Report

			Quarterly Compliance							
No.	Indicator	Lead Director / CQUIN Lead	Quarter 1 Target	Quarter 1 Actual	Quarter 2 Target	Quarter 2 Actual	Quarter 3 Target	Quarter 3 Actual	Quarter 4 Target	Quarter 4 Actual
National Targets										
1a	VTE Risk Assessment	David Levy / Clinical Directors	90%	MONTHLY REPORTING						
1b	VTE prophylaxis where clinically appropriate	David Levy / Sharon Sinha	Qtr 1 Baseline audit Qtr 4 Final Audit		N/A		N/A		Final Audit	
2	Patient Experience: Improve responsiveness to personal needs of patients.	Eiri Jones / Deputy Directors	Improvement on 2 standardised score from 11/12 national survey		N/A		N/A		Improvement on 2 standardised score from 11/12 survey	
3a	Dementia Screening: Patients aged 75 and over Screened within 72 hours	Eiri Jones / Gill Garden & Alex Afifi	90%		90%		90%		90%	
3b	Dementia Screening: All those at risk have had a dementia risk assessment within 72 hours		90%		90%		90%		90%	
3c	Dementia Screening: All those at risk are referred for a specialist diagnosis		90%		90%		90%		90%	
4	NHS Safety Thermometer: Collect data on pressure ulcers, falls, UTI and VTE	Eiri Jones / Steve Cross	100% of data collected		100% completed survey for all relevant patients		100% completed survey for all relevant patients		100% completed survey for all relevant patients	
Regional Targets										
5	Net Promoter: To demonstrate improvements in patient experience using the Net Promoter score	Eiri Jones / Jenny Negus	Report continuous Board to Ward breakdown in board papers and provide evidence of ward feedback mechanisms		Qtr 2 target: Development of action plan for implementing additional mechanisms for obtaining real time patient experience feedback.		Evidence of changes made to services based on the net Promoter Score or top quartile performance evidenced		10% improvement or top quartile performance evidenced	

Local Targets										
6	Cancer: Reporting outcome of 2 week wait referral to GPs	Michelle Rhodes / Julie Pipes	Pilots completed. Pilots will include the electronic generation of the communication, exchange of communication, and detail content of communication confirmed with the GP's		Qtr 2 Target: 90% of total number of referrals notified back to GP for the breast specialty		90% of total number of referrals notified back to GP for the Gynaecology, Paediatric, Lung and Dermatology specialties		90% of total number of referrals notified back to GP for the Colorectal Upper GI, Urology, Haematology, Head & Neck, Brain/CNS, Sarcoma, and Thyroid specialties	
7a	Reduce number of patient ward moves	Eiri Jones / Linda Higginbottom	provide baseline from Q4 11/12 data and agree % improvement target		N/A		N/A		reduction in % of patient moves based on Q1 data	
7b	Daily ward all board round by senior decision maker	Jane Lewington / David Furley	Implementation		Progress Assessment		75%		90%	
7c	Reduction in the number of hospital cancelled outpatient appointments	Michelle Rhodes / Sue Cooper	For paediatrics, ENT and ophthalmology there should be a 3% improvement against Q1 11/12 figures.		For paediatrics, ENT and ophthalmology there should be a 3% improvement against Q1 11/12 figures.		For paediatrics, ENT and ophthalmology there should be a 3% improvement against Q1 11/12 figures.		For paediatrics, ENT and ophthalmology there should be a 3% improvement against Q1 11/12 figures.	
			cancellations should not exceed 13% of the total outpatients seen in any other specialties		cancellations should not exceed 13% of the total outpatients seen in any other specialties		cancellations should not exceed 13% of the total outpatients seen in any other specialties		cancellations should not exceed 13% of the total outpatients seen in any other specialties	
8	Visual Planning Tool	Jane Lewington / David Furley	N/A		60%		75%		100%	
9	Compliance with clinical trials in ARMD	Michelle Rhodes / Jo Fawcus & Dr Tesha / Tanweer Ahmed	TBC		TBC		TBC		TBC	
10	Roll out of Ambulance ECS technology to allow the e- patient record	Jane Lewington / Anne Symon	Implementation plan by 29 June 12 ready to start roll out		Boston - 6 weeks implementation 2 July to 10 August Lincoln - 13 August to 21 September		Grantham - 24 September to 2 November		N/A	
11	Robust data validation through audit and E learning master classes	Kevin Turner / Shaun Caig	Audit and delivery of e-learning master class training (annual total 400 people)		Audit and delivery of e-learning master class training (annual total 400 people)		Audit and delivery of e-learning master class training (annual total 400 people)		Audit and delivery of e-learning master class training (annual total 400 people)	
13	Laparoscopic Cholecystectomy	Michelle Rhodes / Paul Hogg & Clinical Leads	Evidence of medical staff training and training plans where necessary to increase capacity to achieve an improved day case rate up to 25%		Evidence of medical staff training and training plans where necessary to increase capacity to achieve an improved day case rate up to 25%		N/A		above 16% day case rate with suitably trained clinicians	
14	Reduce ratio of outpatient follow ups (The aim is to improve from Lower quartile to median performance or where above lower quartile to improve to 25th percentile performance.)	Michelle Rhodes / Steve Hewitt & Business Managers	Cardiology: 1.27		Cardiology: 1.27		Cardiology: 1.27		Cardiology: 1.27	
			General Surgery: 1.02		General Surgery: 1.02		General Surgery: 1.02		General Surgery: 1.02	
			Respiratory Medicine: 1.61		Respiratory Medicine: 1.61		Respiratory Medicine: 1.61		Respiratory Medicine: 1.61	
			Clinical Oncology: 4.43		Clinical Oncology: 4.43		Clinical Oncology: 4.43		Clinical Oncology: 4.43	
			Breast: ??		To be confirmed					
15	Making Every Contact Count: To raise healthy lifestyle issues and offer advice	Eiri Jones / Jenny Negus & Deputy Directors	% increase		% increase		% increase		% increase	

EMSCG Targets										
1	Specialist services clinical dashboards	David Levy / Clinical Directors	1.Identify and provide contact details of the following: * An overall dashboards lead for the Provider * a dashboard lead in each clinical area for which a dashboard is required in 12/13 2. Provide a summary setting out the plans for implementation of the dashboards within the required timescale (half of quarterly value)		1. Demonstrate implementation of routine reporting against quality dashboard requirements for all relavant services and, 2.Provide a brief update for each clinical area detailing any specific comments or issues		1. Continued routine reporting on all relevant dashboards and, 2. Provision of a brief update for each clinical area detailing any specific comments or issues. This may include feedback on the quality dashboards/measures (for example comments on other measures that may be considered, measures where case-mix adjustments might be considered prior to publication more broadly etc)		1. Continued routine reporting on all relvant dashboards and, evidence that all relevant dashboards have been considered by front line clinical staff with documented evidence of consideration of current performance and identification of plans for improvement, where appropriate	
2	Increased access to Intensity Modulated Radiotherapy	Michelle Rhodes / Elaine Graves	25% across a number of tumour sites		17%		%		%	
3	Intravenous Chemotherapy and performance Status measurements	Michelle Rhodes / Elaine Graves	1) 90% compliance on performance status, 2) evidence regarding appropriate continuation of treatment, 3) data on total IV doses given		90%		90%		90%	
4	Optimising Hepatitis C Treatment	Michelle Rhodes / Karen Murray	To increase compliance and improve outcomes associated with Hepatitis C treatment		%		%		%	
5	Neonatal Infection Control	Eiri Jones / Yvonne Truepenny	Reduction of catheter-related CONS infections in low birth weight neonates		% reduction		% reduction		% reduction	
6	Managing complications of chemotherapy	Michelle Rhodes / Elaine Graves	Project and baseline setting		Targets agreed		Audit		Audit	

2.4 Clinical Quality Indicators (CQUIN): Monthly Report

No.	Indicator	Lead Director / CQUIN Lead	Target	Reporting Frequency	Monthly Performance											
					Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
National Targets																
1a	VTE Risk Assessment	David Levy / Clinical Directors	90%	Monthly	87.20%	90.83%	91.63%	90.01%	92.52%	Month Behind						
1b	VTE prophylaxis where clinically appropriate	David Levy / Sharon Sinha	Qtr 1 Baseline audit Qtr 4 Final Audit	Quarterly												
2	Patient Experience: Improve responsiveness to personal needs of patients.	Eiri Jones / Deputy Directors	Improvement on 2 standardised score from 11/12 national survey	Annually			N/A									
3a	Dementia Screening: Patients aged 75 and over Screened within 72 hours	Eiri Jones / Gill Garden / Alex Afifi / Jennie Negus	90%	Monthly				14.52	6.67%	Month Behind						
3b	Dementia Screening: All those at risk have had a dementia risk assessment within 72 hours		90%	Monthly				50.94	29.63%	Month Behind						
3c	Dementia Screening: All those at risk are referred for a specialist diagnosis		90%	Monthly				7.41	12.50%	Month Behind						
4	NHS Safety Thermometer: Collect data on pressure ulcers, falls, UTI and VTE	Eiri Jones / Steve Cross	100% of data collected	Monthly												
Regional Targets																
5	Net Promoter: To demonstrate improvements in patient experience using the Net Promoter score	Eiri Jones / Jennie Negus	Qtr 2 Target: Development of action plan for implementing additional mechanisms for obtaining real time patient experience feedback.	Quarterly												

Local Targets																
6	Cancer: Reporting outcome of 2 week wait referral to GPs	Michelle Rhodes / Julie Pipes	Qtr 2 Target: 90% of total number of referrals notified back to GP for the breast specialty	Quarterly												
7a	Reduce number of patient ward moves	Eiri Jones / Linda Higginbottom	provide baseline from Q4 11/12 data and agree % improvement target	Quarterly												
7b	Daily ward all board round by senior decision maker	Jane Lewington / David Furley	Progress Assessment	Quarterly												
7c	Reduction in the number of hospital cancelled outpatient appointments (3% reduction for Paediatrics, ENT and Ophthalmology, no higher than 13% for all other services)	Michelle Rhodes / Sue Cooper	Paediatrics: 19.2%	Monthly	17.9%	21.2%	25.9%	19.4	26.8	21.9						
			ENT: 16.8%	Monthly	24.7%	19.0%	18.4%	18.9	21.1	16.2						
			Ophthalmology: 16.2%	Monthly	21.3%	18.1%	18.7%	17.4	16.8	18.7						
			Others: 13%	Monthly	14.8%	13.8%	15.1%	14.4	16.8	14.9						
8	Visual Planning Tool: Implementation of Plan For Every Patient on all medical wards	Jane Lewington / David Furley	Sept 12: 60%, Nov 12: 90% Dec 12: 100%	Quarterly						70%						
9	Compliance with clinical trials in ARMD	Michelle Rhodes / Jo Fawcus & Dr Tesha / Tanweer Ahmed	TBC	Quarterly												
10	Roll out of Ambulance ECS technology to allow the e- patient record to be populated, capturing the NHS number of patients	Jane Lewington / Anne Symon	Boston - implementation 2 Jul to 10 Aug Lincoln - 13 Aug to 21 Sept Grantham - 24 Sept to 2 Nov	Quarterly												
11	Robust data validation through audit and E learning master classes	Kevin Turner / Shaun Caig	Audit and delivery of e-learning master class training (annual total 400 people)	Annually												
13	Laparoscopic Cholecystectomy	Michelle Rhodes / Paul Hogg & Clinical Leads	Evidence of medical staff training and training plans where necessary to increase capacity to achieve an improved day case rate up to 25%	Quarterly			13%			19%						
14	Reduce ratio of outpatient follow ups. (The aim is to improve from Lower quartile to median performance or where above lower quartile to improve to 25th percentile performance.)	Michelle Rhodes / Steve Hewitt & Business Managers	Cardiology: 1.10	Monthly	0.91	0.97	0.97	0.96	0.9	1.13						
			General Surgery: 1.02	Monthly	1.45	1.4	1.31	1.44	1.51	1.45						
			Respiratory Medicine: 1.61	Monthly	2.03	1.98	2.62	2.23	2.41	2.28						
			Clinical Oncology: 6.25	Monthly	11.59	11.98	12.6	10.29	11.61	13.44						
			Breast Surgery: 1.27	Monthly	2.01	1.84	1.86	1.71	2.04	1.79						
15	Making Every Contact Count: To raise healthy lifestyle issues and offer advice	Eiri Jones / Jenny Negus & Deputy Directors	To measure the increase in the number of contacts by trained staff to raise healthy lifestyle issues	Quarterly												

EMSCG Targets																	
1	Specialist services clinical dashboards in: Radiotherapy, Haemaphilia, Neonatal, Cardiology & specialised immunology	David Levy / Clinical Directors	1. Demonstrate implementation of routine reporting against quality dashboard requirements for all relavant services and, 2.Provide a brief update for each clinical area detailing any specific comments or issues	Quarterly													
2	Increased access to Intensity Modulated Radiotherapy	Michelle Rhodes / Elaine Graves	25% across a number of tumour sites	Quarterly						17%							
3	Intravenous Chemotherapy and performance Status measurements	Michelle Rhodes / Elaine Graves	1) 90% compliance on performance status, 2) evidence regarding appropriate continuation of treatment, 3) data on total IV doses given	Quarterly						91.90%							
4	Optimising Hepatitis C Treatment	Michelle Rhodes / Karen Murray	To increase compliance and improve outcomes associated with Hepatitis C treatment	Quarterly													
5	Neonatal Infection Control	Eiri Jones / Yvonne Truepenny	Reduction of catheter-related CONS infections in low birth weight neonates	Quarterly													
6	Managing complications of chemotherapy in cancer patients admitted via A&E	Michelle Rhodes / Elaine Graves	Target to be agreed	Quarterly													

Key:	Achieved Target / On Trajectory	Partially Achieved	Did Not Achieve Target / Not on Trajectory

2.4 Clinical Quality Indicators (CQUIN)

Dementia Screening (National target & EMSCG target)
The CQUIN work was initially commenced at Pilgrim. Nurse training has taken place on each site. Some medical staff training has taken place at Pilgrim and Grantham. More medical and managerial engagement is required on each site to achieve this target. A paper is being taken to the Trust Executive Group on 4 November 2012

Reduction in the number of hospital cancelled outpatient appointments
Ongoing monitoring and management through the performance framework process

Compliance with ARMD clinical trial
We have been recruiting patients for the TANDEM study since August 2012. The target recruitment of eligible patients has yet to be agreed with the PCT.

Laparoscopic Cholecystectomy
The business units have advised this procedure is only carried out by surgeons who have been formally trained in accordance with Royal College guidelines. Evidence is being gathered. The overall Trust day case is still below the target at 19% although it is being achieved at Louth(60%) and Grantham (50%). The business units are reviewing their plans to meet this target

New to follow up ratio
Ongoing monitoring and management through performance framework process. Project Manager to commence in post in November to lead on this area.

2.5 MINAP standards (Access to thrombolysis)

DOMAIN 1 SERVICE QUALITY		THRESHOLDS			DATA	PERFORMANCE 2011/12			PERFORMANCE 2012/13											
Performance Indicator	Indicator type	Achieved	Under review	Under-performing	Currency	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
MINAP standards																				
Call to needle time within 60 mins (quarterly)		68%		<68%	%			50			58.8									
Door to needle time within 30 mins (quarterly)		75%		<75%	%			79.1			76.4									
PPCI Call to Balloon in <150 mins					%			92.3			76									
PPCI Door to Balloon in <90 mins					%			83			100									

Primary Percutaneous Coronary Intervention has been implemented; this is recognised nationally as best practice and provides an improved service for the Trusts patients.

Collaborative working with EMAS continues to improve call to needle time

2.6 Patient Reported Outcome Measures (PROMS)

DOMAIN 1 SERVICE QUALITY		THRESHOLDS			DATA	PERFORMANCE 2011/12			PERFORMANCE 2012/13											
Performance Indicator	Indicator type	Achieved	Under review	Under-performing	Currency	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Listening to feedback and responding to concerns																				
Patient Reported Outcome Measure -% Patients reporting an improvement following hip replacement (April 2011 - September 2011)		>78.6%		<78.6%	%		96.9													
Patient Reported Outcome Measure -% Patients reporting an improvement following knee replacement (April 2011 - September 2011)		>76.6%		<76.6%	%		92.9													
Patient Reported Outcome Measure -% Patients reporting an improvement following varicose vien surgery (April 2011 - September 2011)		>47.2%		<47.2%	%		83.9													
Patient Reported Outcome Measure - % patients reporting improved general health following Groin Hernias (April 2011 - September 2011)EQ-5D index score		>57.1%		<57.1%	%		52.3													

2.7 Managing complaints

DOMAIN 1 SERVICE QUALITY		THRESHOLDS			DATA	PERFORMANCE 2011/12			PERFORMANCE 2012/13											
Performance Indicator	Indicator type	Achieved	Under review	Under-performing	Currency	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Total number of formal complaints received (accumulative)		less than 505 annually			No.	589	671	756	65	135	189	255	313	364						
Proportion of complaints responded to within agreed timescale		<=80%	60-80%	>=60%	%	71	75	77	71	64	74	72	80	87						
Total number of backlog complaints still open (prior to Oct 11)										12	20	14	21	16						
Total number of complaints reopened									17	23	18	19	14	15						

All sites have achieved 80% or more for September, with 87% overall.
Complaints teams have been formed to provide screening and coordination functions, the latter directly provide more support to operational management teams on all sites.
Learning is being identified following investigation and actions planned when relevant.
Tracking reports are being provided to operational management teams to highlight performance reliability issues.
Escalation processes are being implemented for points in the investigation and response process where delays occur (comments from relevant staff, draft letter completion and final reply compliance within timescale.)
Audit process implemented to monitor reasons for delays and the quality of responses.

2.8 Serious untoward incidents (SUI)

DOMAIN 1 SERVICE QUALITY		THRESHOLDS			DATA	PERFORMANCE 2011/12			PERFORMANCE 2012/13											
Performance Indicator	Indicator type	Achieved	Under review	Under-performing	Currency	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
SUI investigations not completed within timescale	Contract	0	1	>1	No.	0	0	0	0	0	0	0	0	0						
Number of SUIs reported in month					No.				8	12	6	8	11	16						
Number of SUIs that are recognised as external investigations					No.							8	8	9						
Number of open SUIs requiring investigation					No.				34	31	34	32	27	23						
Risk register overdue reviews	Local	0		>0	No.	52	44	88	68	70	69	47	50	45						
Never Events		0		>0	No.	0	0	1	0	2	0	0	1	1						

2.9 Access to services

Referral to Treatment (Admitted): Current position

This performance area covers the referral to treatment standards (RTT) and cancelled operations standards. Our performance was **89.65**% which is **below** the standard of 90%. All specialties are delivering against the target with the exception of **General Surgery** (**88.37**%), **Urology** (**84.40**%), **Ophthalmology** (**89.67**%), **Cardiology** (**75.00**%), **Paediatrics** (**25.00**%), **Interventional Radiology** (**63.64**%) and **Diagnostic Imaging** (**75.00**%

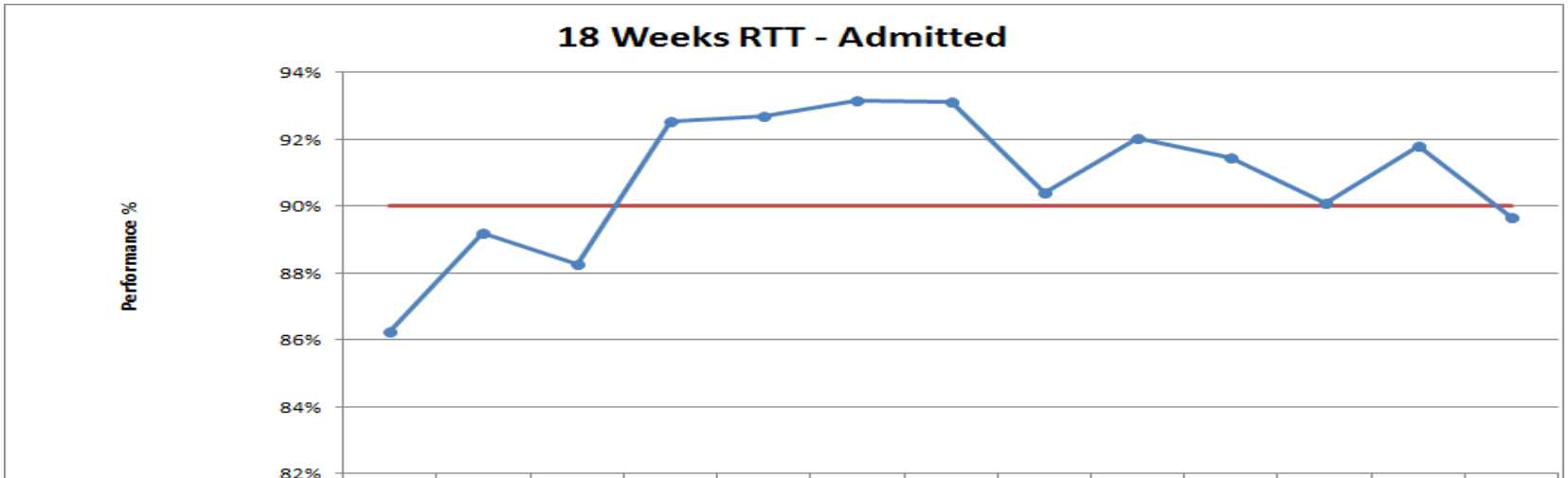
Key Issues:

- Pressures relating to capacity remain in Ophthalmology, Cardiology, General Surgery, Urology and Gastroenterology.
- Bed pressures still remain an issue at times, resulting in lack of bed availability when the site is particularly busy
- The Cardiology Service is now managing patients to the NICE 94 Guidelines for the management of Unstable Angina and NSTEMI (non-ST elevation myocardial infarction). This has seen many patients who were previously not investigated invasively now being listed for a diagnostic angiogram (cardiac catheter procedure). These patients are added to the Lincoln Site Waiting List for their procedure.

  Despite increasing the capacity for the Cardiac Catheter Laboratory, the waiting list still remains static. The demand for cardiology out-patients has risen which has provided a consequent increase in demand for diagnostic interventions.

Our plans for improvement:

- Additional capacity is being scheduled in for all areas in order to increase throughput and theatre utilisation is being monitored closely, with introductions of Pilots around improving theatre efficiency General Surgery planned for November.
- Weekly meetings with all Business Units will be taking place to review their waiting lists and patient pathways in detail, to improve patient flow and wait times.
- The PPCI Building Scheme remains on track. The service will reduce down to just the modular cath lab for a 6 week period commencing on 5th November 2012. Activity plans have been revised during this time with a consequential impact on activity. Once the 2nd cardiac catheter lab opens in mid-December the service will then begin a recovery plan to pick up the lost activity



	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
% Treated within 18 Wks	86.24%	89.19%	88.28%	92.53%	92.69%	93.18%	93.11%	90.40%	92.03%	91.46%	90.09%	91.81%	89.65%

Referral to Treatment (Non-Admitted): Current position

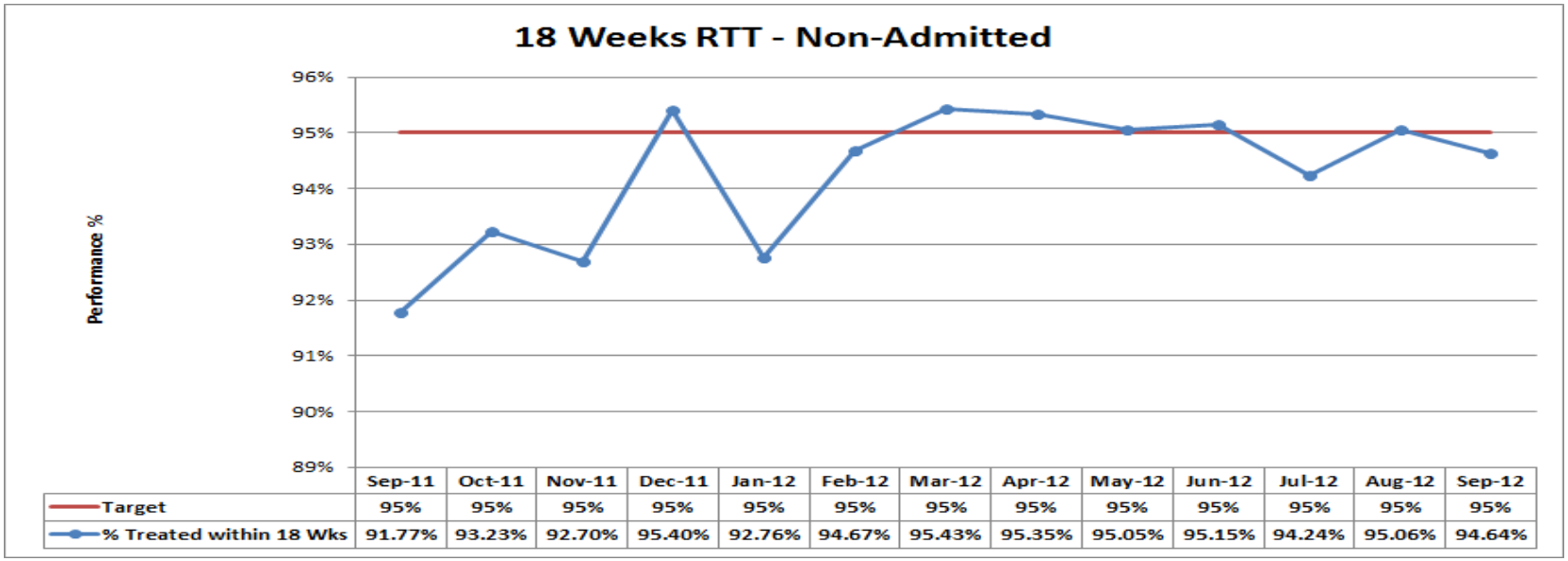
Our performance was **94.64**% which is **below** the standard of 95%. All specialties are delivering against the target with the exception of **General Surgery** (**86.13**%), **Urology** (**88.31**%), **Colorectal Surgery** (**78.79**%), **Vascular Surgery** (**86.57**%), **Trauma & Orthopaedics** (**89.78**%), **Anaesthetics** (**77.94**%), **Community Paediatrics** (**94.87**%), **Gastroenterology** (**86.46**%), **Cardiology** (**84.28**%), **Respiratory Physiology** (**79.25**%), **Nephrology** (**94.23**%), **Medical Oncology** (**90.00**%), **Nuclear Medicine** (**50.00**%), **Gynaecology** (**94.98**%) and **Interventional Radiology** (**80.00**%).

Key Issues:

- Areas that have failed to achieve the non-admitted target for September are General Surgery, Urology, Orthopaedics, Gastroenterology, Cardiology
- .Key reasons for General Surgery continue to be lack of adequate out- patient capacity and increase in endoscopy diagnostic waiting times.
- The waiting list volume of diagnostic angiograms for cardiology continues to be the main cause of the current failure to deliver this target..Orthopaedics continues to have a backlog of follow ups in the system, due to lack of sufficient outpatient capacity,
- Some services are over performing on Follow Ups because of inefficiencies in clinics and consequently definitive decisions about treatments are not being arrived at soon enough in the pathway. A dedicated Project Manager, focusing specifically on reducing Follow Ups will start in post from 1st Nov, with the remit to work closely with the Business Units and associated Clinicians to agree specific actions to reduce follow ups.

Our plans for improvement:

- Areas not achieving non-admitted performance continue to have on-going actions plans in place to address and achieve the target, along with specific trajectories for each area, detailing timelines. These action plans are now refreshed and reviewed weekly to enable closer monitoring of improvement against the trajectory for each specialty.
- Weekly meetings with all Business Units will be taking place to review their waiting lists and patient pathways in detail, to improve patient flow and wait times.
- General Surgery & Urology are increasing outpatient capacity and additional endoscopy sessions are also being provided to reduce the wait time.
- Work continues within Orthopaedics to reduce the 13 week wait position across all sites Work is on-going to review the capacity and demand relating to this issue.



	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
% Treated within 18 Wks	91.77%	93.23%	92.70%	95.40%	92.76%	94.67%	95.43%	95.35%	95.05%	95.15%	94.24%	95.06%	94.64%

Incompletes: Current position

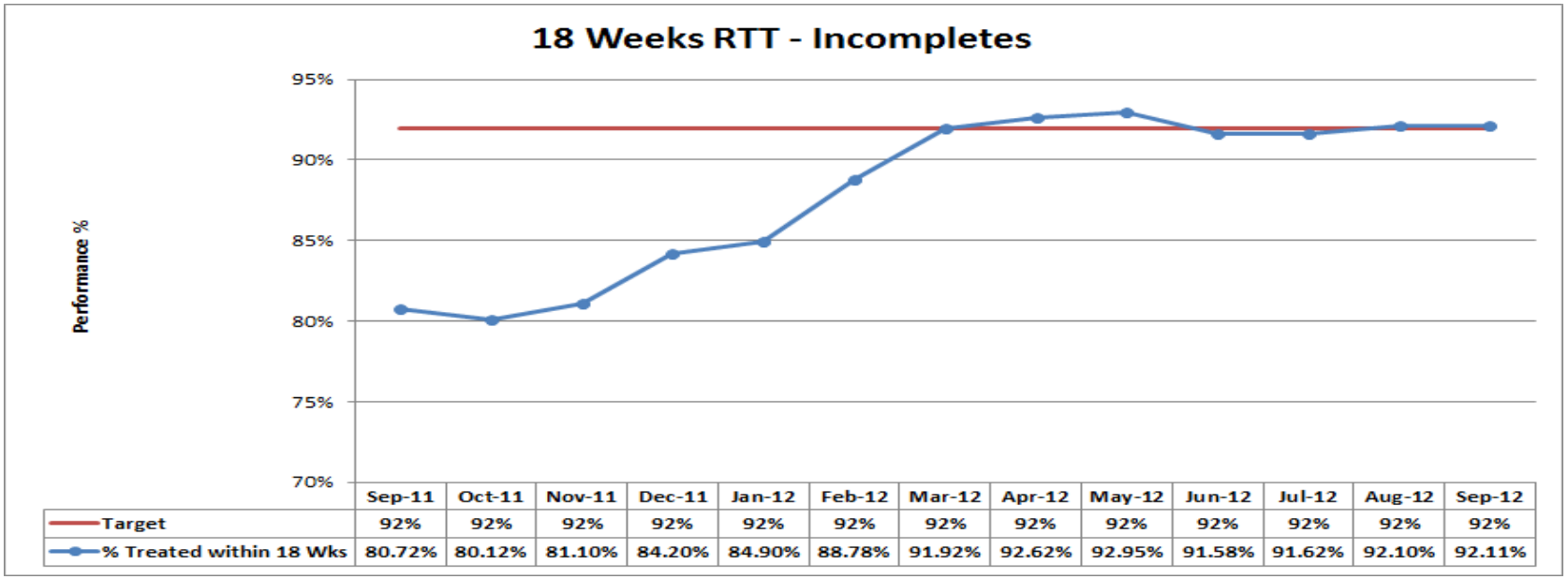
Our performance was **92.11**% which is **above** the standard of 92%. All specialties are delivering against the target with the exception of **General Surgery** (8**7.55**%), **Urology** (**90.51**%), **Breast Surgery** (**91.87**%), **Colorectal Surgery** (**89.91**%), **Vascular Surgery** (**87.15**%), **Cardiothoracic Surgery** (**00.00**%), **Paediatric Surgery** (**90.91**%), **Community Paediatrics** (**59.76**%), **General Medicine** (**86.96**%), **Gastroenterology** (**91.88**%), **Cardiology** (**85.07**%), **Respiratory Physiology** (**81.85**%), **Nuclear Medicine** (**69.28**%), **Clinical Oncology** (**91.74**%) and **Interventional Radiology** (**80.00**%).

Key Issues:

- Lack of prompt outcomes relating to Incompletes data from some Business Units has resulted in a delay occurring in relation to the overall validation process

Our plans for improvement:

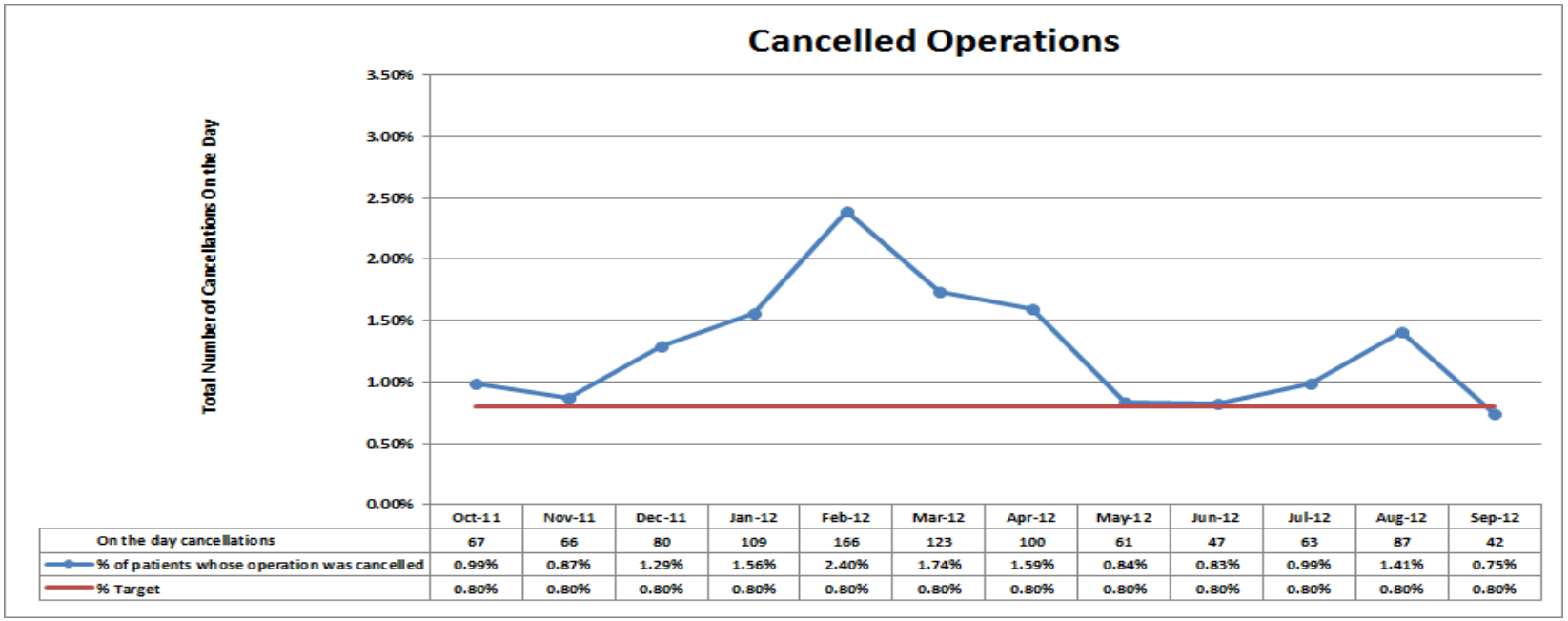
- The information and data relating to Incompletes continues to be monitored closely with each Business Unit, to ensure that all information is outcomed accurately and in a timely manner to enable all validation to be completed promptly.
- The 18 week training programme continues to be rolled out across all four sites.
- The 18 week team is also now being recruited to, which will provide a dedicated infrastructure and additional resource for the monitoring, auditing and support around the 18 weeks process for the Trust.



	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
% Treated within 18 Wks	80.72%	80.12%	81.10%	84.20%	84.90%	88.78%	91.92%	92.62%	92.95%	91.58%	91.62%	92.10%	92.11%

Cancelled operations

The total number of cancelled operations on the day for non-clinical reasons was **42** (**0.75%**) with **16** patients not admitted within 28 days of their cancellation. The national standard is less than 0.8%



	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
On the day cancellations	67	66	80	109	166	123	100	61	47	63	87	42
% of patients whose operation was cancelled	0.99%	0.87%	1.29%	1.56%	2.40%	1.74%	1.59%	0.84%	0.83%	0.99%	1.41%	0.75%
% Target	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%

Diagnostic waiting times

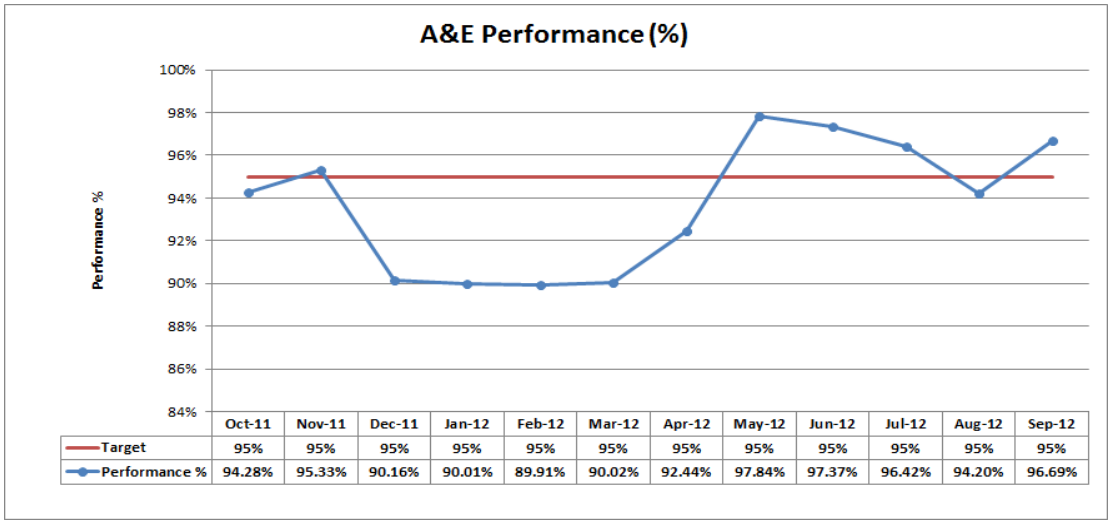
At the end of September there were 34 patients (0.64%) confirmed as waiting over 6 weeks for the 15 key diagnostic tests.

Modality	**Breaches**	**Issue**	**Action**
MRI	**3**	**Temporary lack of capacity for Radiologist led procedures**	**Interventional radiologists AAC panel – 31st Oct 2012. 3 applicants. 1 locum starting end of October**
CT	**1**	**Late Referral**	**Referrer made aware**
Dexa	**1**	**Late Referral**	**Referrer made aware**
Non Obs U/S	**7**	**Consultant availability**	**As above**
Audiology	**9**	**Increase in Paediatric referrals. No demand management in Primary Care**	**Demand issue raised with LCHS commissioners. No positive response**
Echo	**1**	**Increase in demand and insufficient physiologist capacity**	**Demand & Capacity planning underway in conjunction with Cardiology Business Units**
Neurophysiology	**2**	**Temporary lack of capacity**	
Urodynamics	**3**	**Insufficient referrals to hold no more than 1 clinic per month**	
Endoscopy	**7**	**Clerical errors**	**Increased supervision in place**
Total	**34**		

3. Performance domain 2: Service performance

3.1 A&E performance

In September the Trust recorded 439 breaches of the 4 hour standard for total time in A&E out of 13279 attendances (96.69%) against a standard of 95%.



	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Performance %	94.28%	95.33%	90.16%	90.01%	89.91%	90.02%	92.44%	97.84%	97.37%	96.42%	94.20%	96.69%

September issues

Pilgrim:

During September there were peaks in emergency activity with both emergency admissions and A&E attendances significantly up against plan over the month.

Lincoln

Good performance with the 4 hour standard being achieved.

Still experiencing peaks in activity affecting performance, but recovery from high attendance levels is quick.

Focus on A&E: Pilgrim Hospital performance improvement plan and trajectory

A&E

- Accountability framework introduced for Nursing and Medical staff in A&E with focused support for staff continuing.
- Trust approval for substantive 4th A&E Consultant with interviews to take place in November.
- A&E Nurse Consultant appointed and commenced 16th July 2012
- Model for sustained delivery of A&E streams/workforce currently under development with business case being presented to IPB in November

Patient Flow through hospital

- Existing and additional 4 Medical Consultant posts (Respiratory, Stroke, Diabetes, Orthogeriatrician) to support new Physician model of care, filled with substantive and/or Trust locum appointments. Trust locum appointments commencing June to October'12. Substantive appointments commencing October'12 to February'13.
- Active nursing recruitment program progressing well
- Primary Care, LCHS and Community Nursing advised of any delays on daily basis and more often under periods of extreme pressure
- Modernisation of Physician Provision of Care Model:
  - Phase 1 implemented: Daily senior review of all medical patients Monday to Friday with doubling up of physicians at weekends
  - Phase 2: Consultant of days (e.g. week or fortnight) model being rolled out across medicine to be complete end October
- Trust approval to join National Cohort II of Ambulatory Emergency Care 12 month Programme commencing in November 2012. Participation and support from local CCG.
- Supportive visit from Professor David Oliver (National leader in elderly care provision) took place 21 September

3.2 Cancer waiting standards

Due to data processing and checking, the reported position on cancer waits is for the month of August.

In August the Trust successfully achieved all the cancer targets

Validated position – August

- 2 week waits for all urgent suspect cancer referrals was **95.20%** - above the 93% operational standard
- 2WW Breast Symptomatic – **94.81%** - above the 93% operational standard
- 31 Day 1st – **98.40%** - above the 96% operational standard
- 31 Day 2nd – Drug – **98.67%** - above the 98% operational standard
- 31 Day 2nd – Surgery – **98.55%** - above the 94% operational standard
- 31 Day 2nd– RT – **99.15%** - above the 94% operational standard
- 62 Day – **89.40%** - above the 85% operational standard
- 62 Day Screening – **100%** - above the 90% operational standard
- 62 Day Consultant upgrade – n/a.

Action Plan

	Cancer Target	Issue	Consequence	Recovery/Action Plan	Timescale
1	14 Day Suspect Cancer	Significant increase in referrals (approx. 185 extra per month)	Demand has far exceeded capacity planning based on previous years' figures	Patients unable to be appointed due to lack of capacity are escalated to Deputy Director level within one working day of referral received	Implemented
2				Full review of all Colorectal capacity from 1st Appt through to Theatres with Transformation Team	End Dec 2012
3		High number of patient choice delays taking on average a third of total pathway (20 days)	Difficulties to keep to agreed clinical pathway timescales	Draft Action Plan issued, NHSL to lead discussions with GP's on C&B usage	End Sept 2012

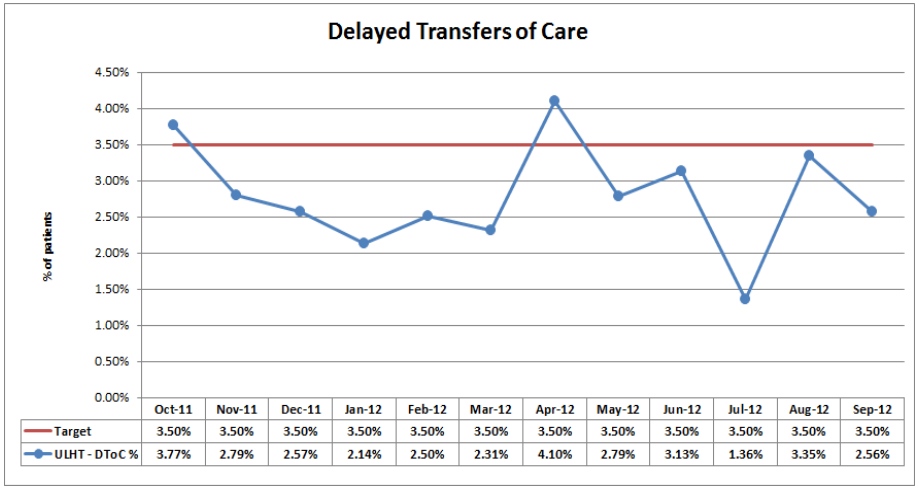
	Cancer Target	Issue	Consequence	Recovery/Action Plan	Timescale
4	14 Day Breast Symptomatic	Lack of patient understanding in 'choice' delays taking on average a third of total pathway (22 days)	Difficulties to keep to agreed clinical pathway timescales and delays treatment date	Draft Action Plan issued, NHSL to lead discussions with GP's on C&B usage	End Sept 2012
5	31 Day First	Lack of appropriate clinic capacity to see patient post MDT	Delays treatment planning	Issue addressed as part of the review of the Urology Service by Royal College and Project Manager due to be recruited	End Oct 2012
6	31 Day Subsequent – Drug	Worldwide shortage of BCG drug	Unable to commence patients on appropriate drug treatment	Limited supplies are now available, allocation of Trust stock is being managed by Urology MDT Lead Clinician	Implemented
7		Insufficient capacity to meet the current increasing demand	Unable to date patients within target	Business Case for extended working hours being completed, to go to Technical Group and the Investment Program Board	Investment Program Board Oct 2012
8		Staff shortages in Chemo Suite due to vacancies and specialised chemotherapy skills (ie PICC Line insertion)	Unable to date patients within target	Ward now recruited to establishment	Implemented
9	31 Day Subsequent – RT	Ageing Radiotherapy equipment prone to breakdown and requiring more frequent servicing	Reduced capacity during service periods (breakdowns reduce this further)	Replacement equipment program to commence pending final SHA approval (Continuity Plan in place)	Sept 2014 - Oct 2015
10				Mitigation of current capacity issues is to extend working hours to maximise capacity – consultation in progress	End of Nov 2012
11		Insufficient capacity to meet the current increasing demand	Unable to date patients within target	Recruitment plan in progress	End Sept 2012
12	62 Day Classic	Insufficient capacity to meet the current increasing demand	Delay in the patient treatment	Endoscopy Business Plan agreed, recruitment in process (split appointing to posts)	End Oct 2012

	Cancer Target	Issue	Consequence	Recovery/Action Plan	Timescale
13		Delays in Urology patient pathway relating to MDT decision	Delay in the patient treatment	Urology Service by Royal College took place 15 July, awaiting recommendations. Recommendations will be managed by the Cancer Operational Board	Cancer Operational Board agenda Sept 2012
14		Lack of ICU bed availability for complex patients	Delay in the patient treatment	New electronic bed booking template in place	Implemented 1st Aug, review end Sept 2012

3.3 Delayed transfers of care

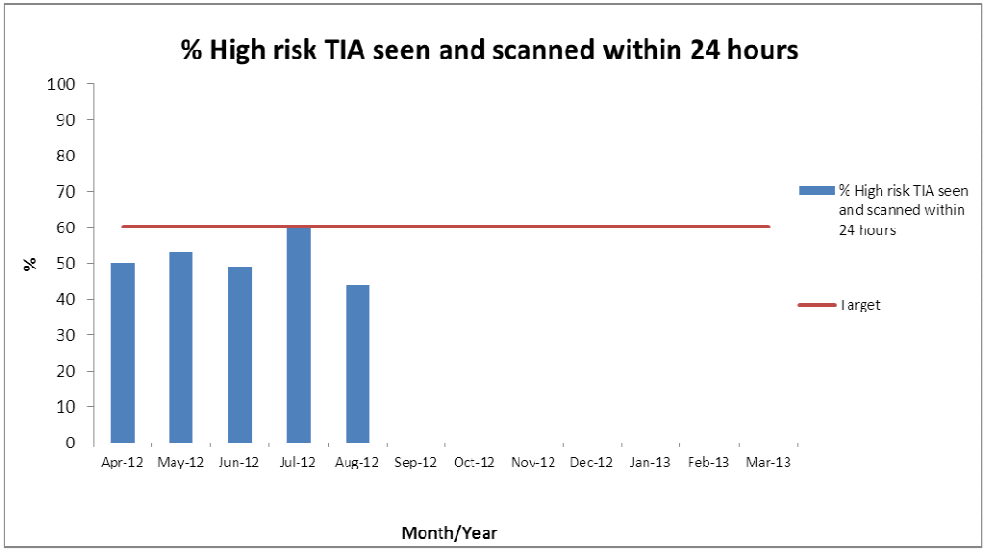
In September 2.56% of discharges were classified as delayed.

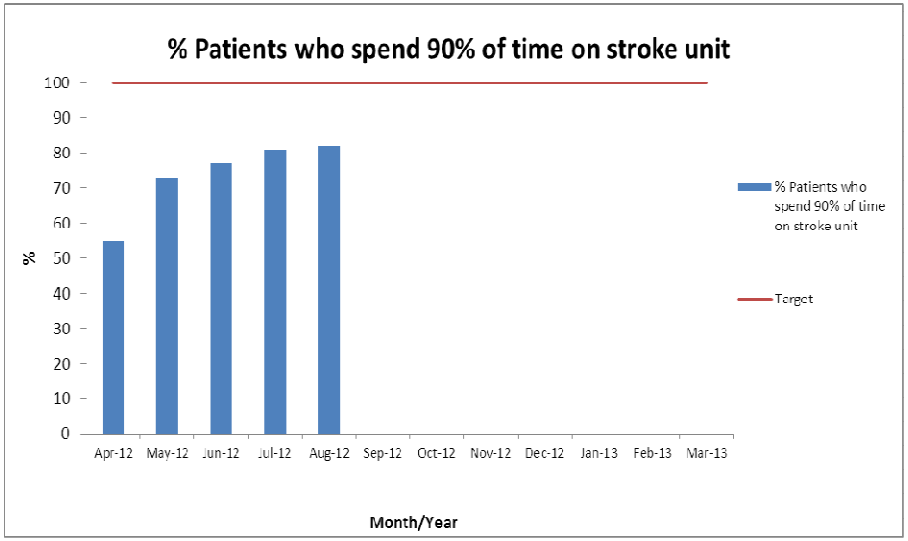
This is below the standard of 3.5%

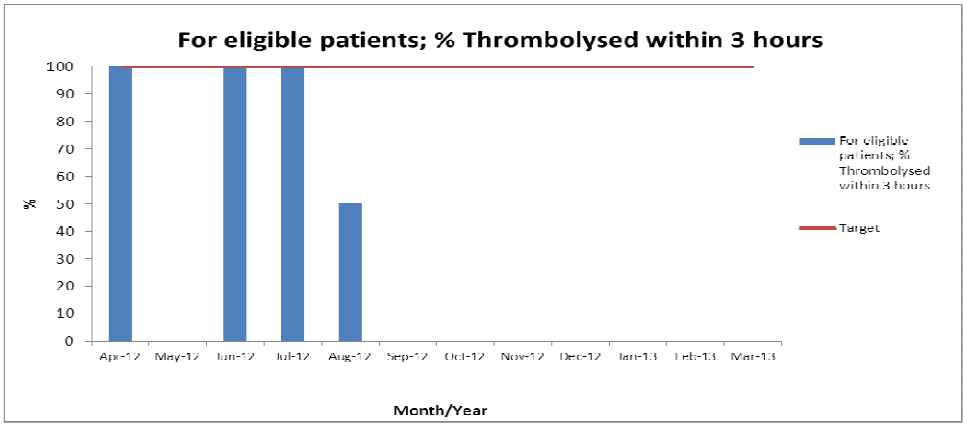


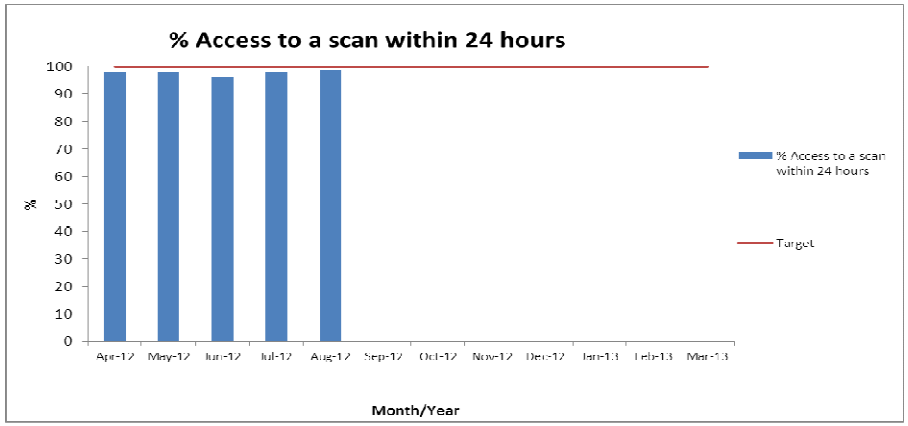
3.4 Stroke indicators

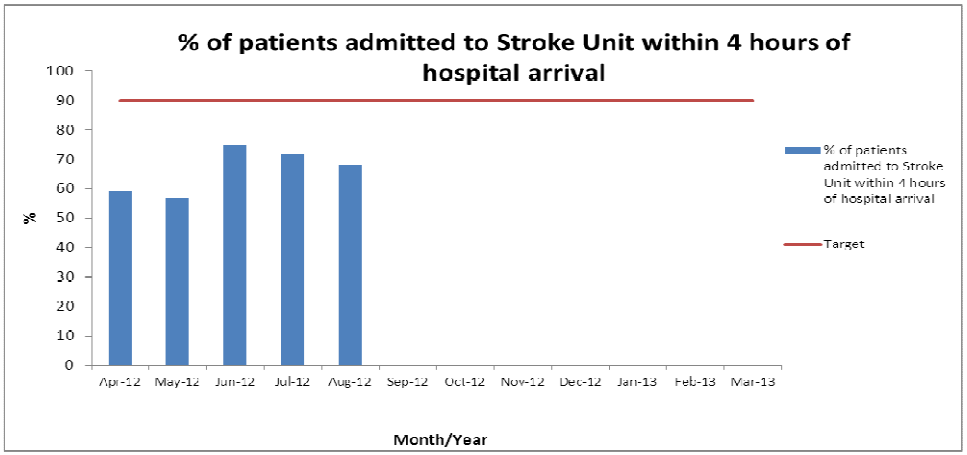
	Target	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% High risk TIA seen and scanned within 24 hours	60%	39	68	60	52	50	53	49	61	44							
% Patients who spend 90% of time on stroke unit	80%	42	35	34	39	55	73	77	81	82							
% Access to a scan within 24 hours	100%	95	97	95	91	98	98	96	98	99							
% Access to a scan within 60 mins	50%	27	36	24	34	34	51	53	53	57							
For eligible patients; % Thrombolysed within 3 hours	100%	n/a	n/a	n/a	100	100	n/a	100	100	50							
% of Stroke Patients treated on the Stroke unit during their stay	No Target	79	67	75	80	91	86	95	94	93							
Outcome of death from stroke inpatient stay (%)	No Target	27	17	15	30	15	31	26	25	18							
% of patients admitted to Stroke Unit within 4 hours of hospital arrival	90%	23	21	24	22	59	57	75	72	68							
Patients with acute stroke have their swallowing screened by a specially trained healthcare professional within 4 hours of admission to hospital, before being given any oral food, fluid or medication, and they have an ongoing management plan for the provision of adequate nutrition.	No Target	31	31	31	45	51	80	88	91	90							
Patients with stroke are assessed and managed by (a) stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital,	No Target	19	23	31	55	70	93	92	78	91							
and (b) by all relevant members of the specialist rehabilitation team within 72 hours,	No Target	35	30	52	88	78	83	87	75	95							
(c) with documented multidisciplinary goals agreed within 5 days.	No Target	31	29	27	72	63	57	31	86	80							

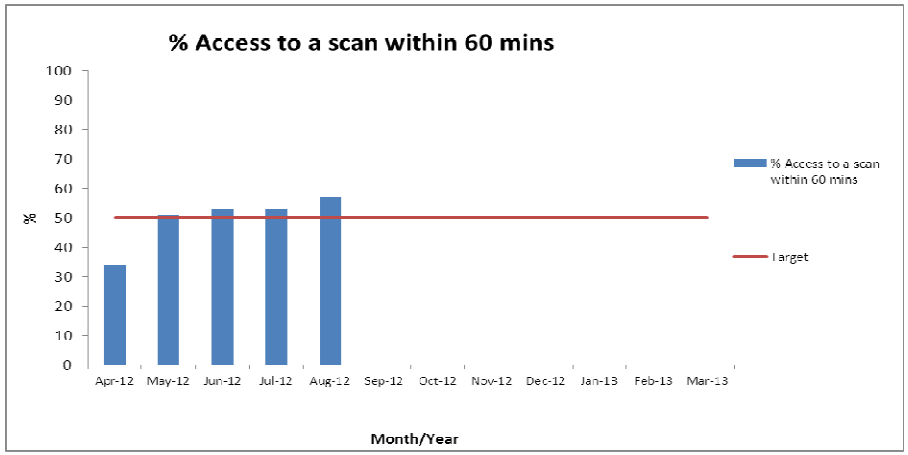

% High risk TIA seen and scanned within 24 hours
100
90
80
70
60
50
40
30
20
10
0
%
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Month/Year
% High risk TIA seen and scanned within 24 hours
Target


% Patients who spend 90% of time on stroke unit
100
90
80
70
60
50
40
30
20
10
0
%
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Month/Year
% Patients who spend 90% of time on stroke unit
Target


For eligible patients; % Thrombolysed within 3 hours
100
90
80
70
60
50
40
30
20
10
0
%
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Month/Year
For eligible patients; % Thrombolysed within 3 hours
Target


% Access to a scan within 24 hours
100
90
80
70
60
50
40
30
20
10
0
%
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Month/Year
% Access to a scan within 24 hours
Target


% of patients admitted to Stroke Unit within 4 hours of hospital arrival
100
90
80
70
60
50
40
30
20
10
0
%
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Month/Year
% of patients admitted to Stroke Unit within 4 hours of hospital arrival
Target


% Access to a scan within 60 mins
100
90
80
70
60
50
40
30
20
10
0
%
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Month/Year
% Access to a scan within 60 mins
Target

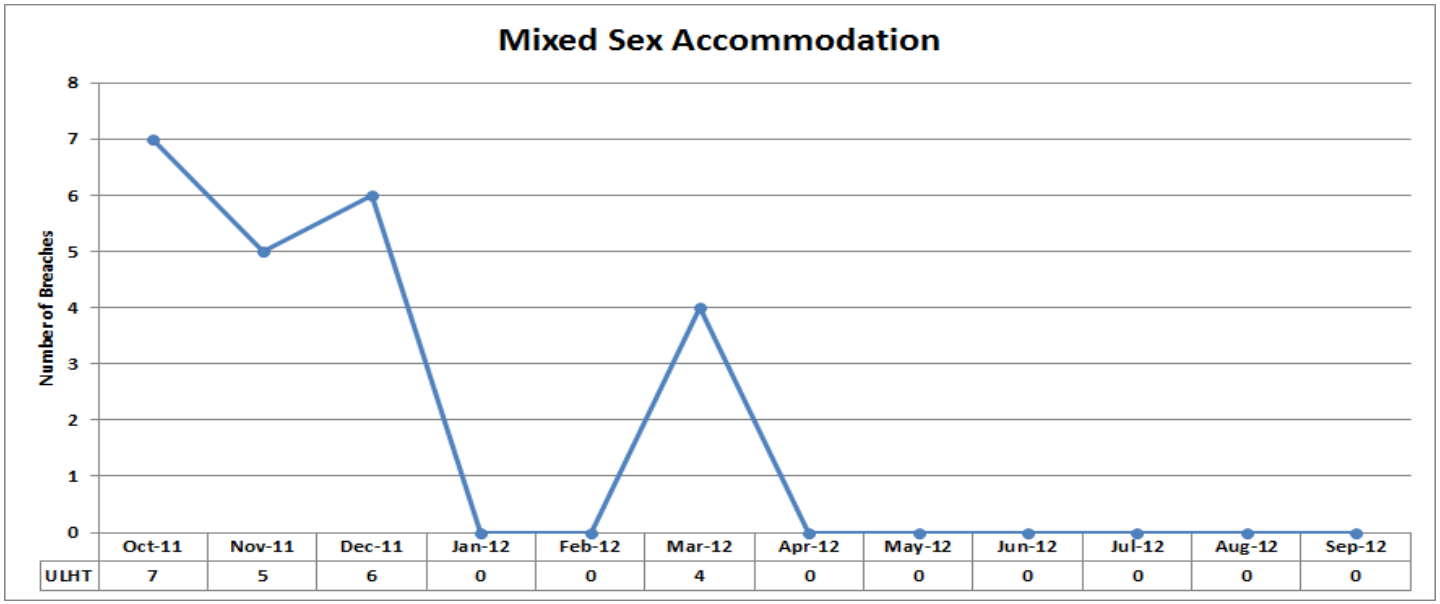
Stroke Indicators – Commentary

Implementation of the stroke and TIA pathway continues and improvement in performance has been sustained. The Stroke Board and site implementation groups continue to progress the Stroke action plans for Lincoln, Grantham and Boston.

Data on all stroke patients continues to be analysed at a weekly stroke breach meeting and key themes are reported to the weekly Trust stroke Decision Panel. The main focus is still on getting patients to the stroke unit within 4 hours of arrival and current performance against the 4hr standard.
The trust is currently focussing on completing the East Midlands Stroke Review

3.5 Compliance with same sex regulations

At the end of September there were 0 occurrences of patients receiving care that is in breach of the sleeping accommodation guidelines, where there is no clinical justification for the breach.



	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
ULHT	7	5	6	0	0	4	0	0	0	0	0	0

4. Performance domain 3: Use of resources

4.1 Human Resources management

Summary/Key Points

The key points from the scorecard are highlighted in this report.

Labour turnover
Labour turnover for the Trust is recorded quarterly, with the most recent quarterly figure for quarter two being 2.18%. This has increased by 0.40% from quarter one. The annual turnover rate for the Trust as at end of September was 7.37%, an increase of 0.47% when compared to the annual rate of 6.90% in 2011/12.

Recruitment
The overall vacancy rate for the Trust at the end of September was 96.71%, meaning that the Trust has 3.29% of posts currently unfilled. Within the Nursing areas, we have completed a Health Care Support Worker cohort for Pilgrim Hospital, interviews took place on Friday 7th September and 26th September and 26 offers have been made. In addition to support the Pilgrim site, a site advert has recently closed for Band 5 Staff Nurses.

- Medicine and A&E Campaign at Pilgrim

Progress continues to be made within the Medicine and A&E Business Unit at Pilgrim with a clear action plan in place to address their outstanding medical vacancies. Work is well underway for the Consultants posts and a review meeting is scheduled for the 23rd October 2012.

- Radiology Campaign

This continues to be robustly managed with weekly updates being provided to the Business Unit. An AAC Consultant interview panel has been arranged for the 31st October 2012. Executive panel members and Royal College representative have already been secured for this date and shortlisting has been completed and 2 candidates have been invited to attend the AAC interviews.

- A&E Campaign – Lincoln

This international campaign continues to be robustly managed, 2 offers have been made and accepted for new Consultants within anticipated start dates of November and January 2013. An AAC has been arranged and to suit the candidates annual leave commitments has been planned in for the 22nd November 2012, the advert is currently live with a closing date of the 18th October 2012.

- Other International Interest

Following conversations with the Business Unit, there is interest to explore international recruitment for Oncology, Dermatology and Haematology and this will be progressed in the coming weeks.

Updates on Medical Recruitment are sent to Dr Levy and Michelle Rhodes on a weekly basis now and these are used to provide updates through to MAC groups across the Trust. Recruitment activity levels are rising and to support establishment control, monthly VAF/activity reports are to be produced and sent to ET for their information.

Workforce Planning
The 13/14 workforce planning cycle was launched at the end of September 12. Meetings are taking place with individuals and teams to raise awareness of the process and the timetable.
This years return requires business units and patient services colleagues to work together to produce a joint narrative workforce plan. This will reflect the joint planning of services and the workforce required over the next 5 years in terms of numbers and the resulting education and training. Support has been offered to teams to support this approach.
To meet the Trust workforce information requirements the numbers element of the return will be in two stages. A first cut 2 year return at the end of November and then a more detailed 5 year return at the end of January 13 accompanied by the narrative.
The governance arrangements to support the workforce plans are in place with Site Deputy Directors having the responsibility for the overview of plans for each site.

Establishment Control
A pilot commenced at Pilgrim site in July to agree, enter and maintain funded establishments on the ESR system. By holding establishments on ESR the Trust will be better able to identify and control vacancies and provide detailed reports to support management processes. This was completed in September. The actions arising from the sessions will be followed up on site. Where there were issues raised which sit outside ESR they will be actioned outside the pilot project.

Absence
The validated Trust sickness absence percentage figure for a 12 month rolling period at the end of August 2012 stands at 5.04%.
The monthly sickness absence percentage was 4.87% this is a decrease of 0.21% in month

- 1.84% being Short term absence
- 3.03% being form long term absence

There were 717 reported episodes of short term absence and 271 episode of long term absence. Anxiety/stress /depression/ other psychiatric illness continues to be the top reason for absence and accounts for 18.98% of absence.
The decrease in absence rate was encouraging, the slight increase in the long term absence rate was disappointing but the average length of long term absence has decreased .
The Attendance Management group is currently developing the attendance management strategy and this will link closely with the Health and Wellbeing strategy.

WTE worked v plan (establishment)
In September 2012, wte worked against plan equated to 100.75%, a slight increase of 0.22% compared to the previous month. Establishments figures used are in line with the Trusts financial plan and to reflect CIP savings.

Average number of PAs per Consultant
The figure for September 2012 is 11.50PAs, a slight increase from August, the negligible variance from month to month suggests that whilst job planning is not being universally completed its application is not bringing about large reductions in PA's. Work is ongoing to develop individual level data behind the job plan to identify productivity and capacity from an individual level upwards to demonstrate productivity being delivered within those PA's.

Agency Usage
Agency usage in September has marginally decreased to 2.26% of wte establishment, most sites and staff groups did have a reduction in use during September, however this was offset by increases in medical agency at Grantham and increases in scientific and technical staff across all sites

Appraisals
There has been improvement in some of the nursing appraisals. We are continuing to provide appraisal reports to site teams for them to encourage completion of appraisals in their hot spot areas. During October we will be chasing areas with low appraisal completions. Managers will be advised of the appraisal report on the website and asked to check that their details are correct.

Annual Mandatory Training
Updated Mandatory Matrix has now been published on the intranet. Mandatory passport to be aligned. Reporting to be developed in line with the matrix. Differentiation needed between mandatory and essential training leading to a clear mandatory package. Overall percentage has remained constant.

Staff Survey

2012 surveys have been circulated and reminders will be distributed week commencing 15 October 2012. We have a response rate of 22%. Display boards outlining some of the actions from 2011 survey and details for 2012 survey have been displayed on all sites. Display boards will also be available at the Chief Executive roadshows that are taking place during November.

Workforce Indicators

HUMAN RESOURCES MANAGEMENT	MAR '12	APR '12	MAY '12	JUN '12	JUL '12	AUG '12	SEPT '12	OCT '12	NOV '12	DEC '12	JAN '13	FEB '13	MAR '13
Turnover	1.67%	1.67%	1.67%	1.78%	1.78%	1.78%	2.18%						
Vacancy rate	93.41%	97.93%	97.62%	96.62%	98.17%	96.64%	96.71%						
WTE worked v plan (establishment)	96.49%	103.18%	99.66%	100.59%	100.17%	100.53%	100.75%						
Use of agency staff	2.24%	1.79%	1.80%	1.62%	1.77%	2.30%	2.26%						
Annual Sickness absence rate	4.95%	4.95%	4.98%	5.03%	5.01%	5.04%	5.04%						
Monthly Sickness absence rate	5.42%	4.91%	4.94%	5.22%	4.68%	5.08%	4.87%						
Average number of Pas paid per consultant	11.50	11.48	11.49	11.52	11.50	11.48	11.50						
Appraisals completed	N/A	N/A	51%	50%	54%	48%	47%						
Staff completed annual Mandatory training	N/A	N/A	60%	59%	57%	53%	53%						

4.2 Productivity and throughput: Activity to 30th September 2012 with variances to plan: all PCTs

Specialty	Daycase Target	Daycase Actual	Daycase Var	Daycase Var %	Elective Target	Elective Actual	Elective Var	Elective Var %	Non-Elective Target	Non-Elective Actual	Non-Elective Var	Non-Elective Var %	OP First Target	OP First Actual	OP First Var	OP First Var %	OP F Up Target	OP F Up Actual	OP F Up Var	OP F Up Var %	NF2F Target	NF2F Actual	NF2F Var	NF2F Var %
100 General Surgery	3058	4186	1128	37%	1333	1276	-57.3	-4%	4378	4343	-34.8	-1%	4810	4400	-410	-9%	6893	6412	-481	-7%	51.12	42	-9.12	-18%
101 Urology	2073	2534	461.3	22%	767.2	740	-27.2	-4%	679.2	710	30.78	5%	5109	4025	-1084	-21%	8908	9454	545.9	6%	188.4	74	-114	-61%
103 Breast Surgery	99.81	170	70.19	70%	100.1	164	63.92	64%	1.998	2	0.002	0%	3142	2759	-383	-12%	4565	5192	627	14%	47.08	26	-21.1	-45%
104 Colorectal Surgery			0				0				0		509.4	897	387.6	76%	688	934	246	36%	3.363	2	-1.36	-41%
105 Hepatobiliary And Pancreatic Surgery			0				0				0		2.276	18	15.72	691%	139.1	125	-14.1	-10%			0	
107 Vascular Surgery	8.565	12	3.435	40%	30.78	49	18.22	59%	29.48	102	72.52	246%	431.9	488	56.06	13%	477	567	90.02	19%	0.673	4	3.327	495%
110 Trauma & Orthopaedics	1223	1475	252.2	21%	1443	1424	-18.7	-1%	2701	2519	-182	-7%	12799	12177	-622	-5%	24998	24482	-516	-2%	68.98	49	-20	-29%
120 ENT	439.9	556	116.1	26%	671.3	535	-136	-20%	361.6	366	4.351	1%	7092	5281	-1811	-26%	8071	8090	19.23	0%	102.4	86	-16.4	-16%
130 Ophthalmology	3018	3123	105.1	3%	66.49	37	-29.5	-44%	32.14	20	-12.1	-38%	10767	11267	500.2	5%	29013	28947	-65.8	0%	1746	1811	65.36	4%
140 Oral Surgery	11.38		-11.4	-100%			0				0			1	1		10.6		-10.6	-100%			0	
143 Orthodontics			0				0				0		895.8	752	-144	-16%	7030	7195	165.4	2%	7.991	5	-2.99	-37%
144 Maxillo-Facial Surgery	1444	1290	-154	-11%	117.1	107	-10.1	-9%	103.6	100	-3.63	-4%	3368	3455	87.07	3%	4296	4304	8.076	0%	112.5	35	-77.5	-69%
150 Neurosurgery			0				0				0		0.757		-0.76	-100%	0.757		-0.76	-100%			0	
160 Plastic Surgery		14	14				0				0			1	1				0				0	
170 Cardiothoracic Surgery			0				0				0			51	51			85	85				0	
171 Paediatric Surgery			0				0				0			65	65			21	21				0	
173 Thoracic Surgery			0				0				0			5	5			33	33				0	
180 Accident & Emergency			0				0		1792	2484	691.5	39%	1450	893	-557	-38%	208.8	201	-7.8	-4%			0	
190 Anaesthetics			0				0				0		328.1	101	-227	-69%	10549	10736	187	2%	372.9	359	-13.9	-4%
191 Pain Management	1009	1397	388.1	38%	4.873	12	7.127	146%	0.525		-0.53	-100%	1214	1422	208.3	17%	3819	4151	331.9	9%	146.6	142	-4.58	-3%
192 Critical Care Medicine		1	1				0		99.06	71	-28.1	-28%	1.002		-1	-100%	3.005	26	23	765%			0	
252 Paediatric Endocrinology			0				0				0		0.504	2	1.496	297%	13.77	15	1.229	9%			0	
259 Paediatric Nephrology			0				0				0		1.511	6	4.489	297%	2.003	18	16	799%			0	
263 Paediatric Diabetic Medicine			0				0				0		2.504	1	-1.5	-60%	283.9	274	-9.93	-3%			0	
264 Paediatric Cystic Fibrosis			0				0				0				0			21	21				0	
290 Community Paediatrics			0				0				0		743.7	594	-150	-20%	2109	1709	-400	-19%	35.22		-35.2	-100%
300 General Medicine	1498	1416	-82.3	-5%	167.7	158	-9.72	-6%	12524	13391	867.1	7%	4024	4118	94.03	2%	2312	3814	1502	65%	15.32	14	-1.32	-9%
301 Gastroenterology	2236	2255	19.4	1%	63.26	73	9.736	15%	17.12	33	15.88	93%	2930	2644	-286	-10%	4154	4430	275.8	7%	636.6	652	15.39	2%
302 Endocrinology	99.71	134	34.29	34%	2.565	2	-0.56	-22%	0.525	3	2.475	471%	505.8	535	29.17	6%	1394	1604	210.1	15%	11.99	5	-6.99	-58%
303 Haematology (Clinical)	2141	2757	616.1	29%	152.7	127	-25.7	-17%	157.4	187	29.59	19%	720.4	791	70.64	10%	7006	7442	436.3	6%	433.5	496	62.49	14%
307 Diabetic Medicine			0				0				0		1419	809	-610	-43%	4361	5126	764.6	18%	2774	2591	-183	-7%
313 Clinical Immunology and Allergy		208	208			1	1				0				0				0			1	1	
314 Rehabilitation			0				0		1.576	1	-0.58	-37%	191.6	195	3.445	2%	597	738	141	24%		1	1	
317 Allergy			0				0				0			1	1				0				0	
320 Cardiology	836.7	835	-1.67	0%	341	250	-91	-27%	710.7	640	-70.7	-10%	13704	11180	-2524	-18%	10346	11004	658	6%	34.64	21	-13.6	-39%
321 Paediatric Cardiology			0				0				0			34	34			45	45				0	
329 Transient Ischaemic Attack			0				0				0			209	209			337	337				0	
330 Dermatology	388.2	376	-12.2	-3%	1.539	1	-0.54	-35%	0.525		-0.53	-100%	5119	4719	-400	-8%	10978	12081	1103	10%	27.97	19	-8.97	-32%
340 Respiratory Medicine	265.1	319	53.88	20%	25.2	27	1.795	7%	62.03	49	-13	-21%	1948	2015	66.99	3%	3929	4315	386.2	10%	32.63	73	40.37	124%
341 Respiratory Physiology			0		357.6	440	82.42	23%			0		453.2	405	-48.2	-11%	2014	2128	113.6	6%	37.96	97	59.04	156%
361 Nephrology	356.5	346	-10.5	-3%	2.471	3	0.529	21%	22.16	10	-12.2	-55%	493.1	292	-201	-41%	1957	1991	33.82	2%	4.661	2	-2.66	-57%
370 Medical Oncology	2106	1930	-176	-8%	65.86	41	-24.9	-38%	133.2	112	-21.2	-16%	459.5	416	-43.5	-9%	2354	2303	-51.4	-2%	403.5	346	-57.5	-14%
371 Nuclear Medicine			0				0				0			151	151			1	1				0	
400 Neurology	234	272	37.96	16%			0			1	1		1526	1567	40.81	3%	1693	1979	285.5	17%	5.327	2	-3.33	-62%
401 Clinical Neurophysiology			0				0				0		1549	1636	87.02	6%		93	93				0	
410 Rheumatology	650.4	518	-132	-20%	4.36	19	14.64	336%		1	1		1055	1012	-42.9	-4%	4486	4499	12.54	0%	50.61	23	-27.6	-55%
420 Paediatrics	67.36	83	15.64	23%	43.6	36	-7.6	-17%	2685	3225	540.3	20%	3047	3011	-35.5	-1%	5003	4287	-716	-14%	108.6	47	-61.6	-57%
421 Paediatric Neurology			0				0				0		1.502	1	-0.5	-33%	4.006	3	-1.01	-25%			0	
422 Neonatology			0		1.539	2	0.461	30%	234.2	558	323.8	138%	1.332	7	5.668	426%		96	96		8.657	245	236.3	#####
424 Well Babies			0				0		-1.58		1.576	-100%			0				0				0	
430 Geriatric Medicine	1.341	1	-0.34	-25%			0		31.94	135	103.1	323%	1175	830	-345	-29%	1947	1414	-533	-27%	22.64	21	-1.64	-7%
501 Obstetrics			0		2.957	3	0.043	1%	5528	6801	1273	23%	3575	3233	-342	-10%	10386	11421	1035	10%	1834	2554	719.6	39%
502 Gynaecology	1440	1279	-161	-11%	780.5	744	-36.5	-5%	919.8	922	2.219	0%	7914	8219	304.6	4%	6359	6985	626.4	10%	56.73	80	23.27	41%
560 Midw ife Episode			0				0		244.6	274	29.35	12%	700.3	732	31.67	5%	2149	3043	894.2	42%	1.319		-1.32	-100%
650 Physiotherapy			0				0				0				0				0		187.6		-188	-100%
651 Occupational Therapy			0				0				0				0				0		2510		-2510	-100%
654 Dietetics			0				0				0				0				0		1797		-1797	-100%
800 Clinical Oncology	2822	2982	160.1	6%	315.5	267	-48.5	-15%	148.7	142	-6.7	-5%	964.6	845	-120	-12%	10639	10603	-35.6	0%	410.9	555	144.1	35%
811 Interventional Radiology	129	136	7.008	5%	184.7	220	35.33	19%			0		142.7	215	72.28	51%	29.56	13	-16.6	-56%			0	
812 Diagnostic Imaging	37.45	36	-1.45	-4%	4.104	4	-0.1	-3%			0				0				0				0	
Grand Total	27693	30641	2948	11%	7051	6762	-289	-4%	33598	37202	3604	11%	1E+05	98483	-7803	-7%	2E+05	2E+05	8610	4%	14289	10480	-3809	-27%