NHS
North Lincolnshire
Clinical Commissioning Group

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| **Date:** | 11th October 2018 |
| **Meeting:** | Governing Body |
| **Item Number:** | Item 9.1 |
| **Public/Private:** | Public ☒ Private ☐ |

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|---|---|
| **Author:** *(Name, Title)* | Chloe Nicholson, Quality Manager; Hazel Moore, Head of Nursing; Louise Tilley, Senior Finance Manager; and Emma Mundey, Performance & Information Manager |
| **GB Lead:** *(Name, Title)* | Clare E. Linley, Director of Nursing and Quality; Emma Sayner, Chief Finance Officer; |
| **Director approval** (Name) | Clare E. Linley, Director of Nursing and Quality |
| **Director Signature** **(MUST BE SIGNED)** | Clare E. Linley |

| **Report Title:** |
|---|
| Integrated Quality, Performance & Finance Committee Report |
| **Decisions to be made:** |
| Members are asked to review and note the content of this report. |

| | | |
|---|---|---|
| **Link to a Strategic Objective?** | ☒ | This paper contains information relevant to the following strategic priorities:<br>Acute care<br>Primary care |
| **Link to a Strategic Risk** | ☒ | This paper contains information relevant to the following strategic risks:<br>Acute commissioning<br>Primary care transformation |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Continue to improve the quality of services** | ☒ | **Improve patient experience** | | | | ☒ |
| **Reduced unwarranted variations in services** | ☒ | **Reduce the inequalities gap in North Lincolnshire** | | | | ☒ |
| **Deliver the best outcomes for every patient** | ☒ | **Statutory/Regulatory** | | | | ☒ |
| **Purpose (tick one only)** | Approval ☐ | Information ☐ | To note ☒ | Decision ☐ | Assurance ☐ | |

**Executive Summary (Question, Options, Recommendations):**

This report contains an overview of key points to note and items for escalation to the Governing Body Meeting, in relation to quality, performance and finance (using the latest data available to the CCG at the time of submission).

**Finance (as at 31st August 2018)**

YTD Performance

At Month 5 the CCG has reported a Year to Date overspend of £1.267m which is in line with plan. The main areas driving this overspend are Acute Services, offset by under spends in Prescribing and Running Costs.

The Year to Date QIPP achievement at Month 5 was £2,145k against a target of £2,499k.

Forecast Position

At Month 5 the CCG is forecasting a £3.6m over-spend by 31 March 2019 which is in line with plan.

Slippage on QIPP schemes at Month 5 is expected to be fully recovered by year end and therefore the CCG continues to forecast full achievement of its annual QIPP plan.

**Performance and Contracting (as at 31st July 2018)**

Referral to Treatment times at Northern Lincolnshire & Goole NHS Foundation Trust (NLaG) and Hull and East Yorkshire Hospitals NHS Trust (HEY) continued to fall below required standards in July 2018, and NLaG continues to report a significant number of breaches against the 52 weeks waiting time standard.

NLaG continues to progress the recovery plan to support improvements in referral to treatment performance during 2018/19, focusing on areas of priority including ENT, Colorectal Surgery, Gastroenterology and Ophthalmology.

Improvement actions include the reconfiguration of acute clinics, further development of primary care services, increased activity in community services and review of patient follow-up appointments. The 2018/2019 recovery plan is in place to ensure that the waiting list does not continue to grow and to reduce those waiting over 52 weeks by at least 50%, ideally to eliminate altogether.

The CCG did not achieve the Accident & Emergency (A&E) 4 Hour waiting time standard in July 2018, with further deterioration in performance reported at Scunthorpe Hospital (91.4% in June 18 to 85.6% in July 18).

Performance against the Cancer 2 week waiting time standard remains strong in NLaG and HEY, but there has been a reduction in performance against both the Cancer 31 Day and Cancer 62 Day waiting time pathways.

Work against the cancer improvement trajectory is progressing well, and the CCG continues to work closely with NLAG and HEY to improve this position via the contract management process, with on-going support provided by the Cancer Network.

**Quality**

The CQC published their outcome report on 12 September 2018 from their inspection of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) undertaken between 8 and 23 May 2018. The CQC awarded the Trust an overall rating of requires improvement; this is an improvement on the previous report where they were deemed inadequate. Further details on the findings from the

inspection are provided in the separate briefing report submitted to this meeting.

During the month of September the CCG was notified of six new serious incidents (SI's) relating to North Lincolnshire patients. Three of these were reported by Rotherham Doncaster and South Humber NHS Foundation Trust and three were reported by Northern Lincolnshire and Goole NHS Foundation Trust. These will follow the CCG's SI management process.

Key challenges identified since the August report include a further increase in waiting times for some outpatient appointments at NLaG, an increase in the number of patients waiting over 52 weeks for an appointment at NLaG (specifically in ENT and colorectal services) and remaining concern in relation to mortality rates at NLaG. In addition to these challenges there are also increasing concerns in relation to Crisis Mental Health services in North Lincolnshire provided by Rotherham Doncaster and South Humber NHS Trust (RDaSH). The Quality dashboard provides an overview of the latest position in relation to these areas and includes details of the latest performance trend and RAG rating.

Within NLaG, the medical & dental vacancy position has seen a positive improvement since the previous report identifying a decrease to 18.67% from 25.66% (as at August 2017). This is against the target of <15%. This improving positon is the result of targeted recruitment activity and improved fill rates of trainee doctor positions.

The CCG has identified improvements in emergency ambulance response times (Category 1 calls) provided by East Midlands Ambulance Service NHS Trust (EMAS) and improvements in the transfer of patients from ambulances to emergency services at Scunthorpe General Hospital.

The re-procurement of patient transport services in North Lincolnshire is now complete. The procurement assessment process incorporated all necessary quality, performance and governance standards. The new service will commence from April 2019.

**Summary**

The North Lincolnshire place continues to experience significant challenges in relation to long waiting times for some outpatient services and access to crisis mental health services. These challenges are further compounded by the on-going staffing pressures experienced across North Lincolnshire.

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|---|---|---|
| **Recommendations** | 1 - To receive and note the content of this report. | |
| **Report history** | This integrated report replaces the previous standalone Quality, Performance & Finance reports, as agreed at the Governing Body meeting on 14th December 2017. | |
| **Equality Impact** | Yes ☐ No ☒ | |
| **Sustainability** | Yes ☒ No ☐ | The report highlights areas of concern and pressure in relation to the sustainability of services across the CCG's main providers, and the CCG. |
| **Risk** | Yes ☒ No ☐ | The report supports the Quality & Performance section of the CCG Assurance Map, in particular Performance reporting – Finance and Quality. The report provides management level assurance to the Governing Body, to enable them to provide second line assurance to GP members.<br><br>The content of the report provides assurance in support of the NHS England Assurance Framework.<br><br>In addition, the report provides assurance against the CCG Board Assurance Framework (BAF) Risk FP1. Risk position |

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| | | monitored by the CCG Planning & Commissioning Committee and the CCG Governing Body. |
| **Legal** | Yes ☒ No ☐ | This report covers the NHS Constitution, and incorporates requirements in relation to the NHS Standard Contract across the CCG's providers. |
| **Finance** | Yes ☒ No ☐ | On-going financial sustainability impacted |

| ***Patient, Public, Clinical and Stakeholder Engagement to date*** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | ***N/A*** | ***Y*** | ***N*** | ***Date*** | | ***N/A*** | ***Y*** | ***N*** | ***Date*** |
| **Patient:** | ☐ | ☐ | ☒ | | **Clinical:** | ☐ | ☐ | ☒ | |
| **Public:** | ☐ | ☐ | ☒ | | **Other:** | ☐ | ☐ | ☒ | |

NHS
North Lincolnshire
Clinical Commissioning Group

# INTEGRATED QUALITY, PERFORMANCE & FINANCE REPORT

## OCTOBER 2018

## Contents

# Executive Summary

This section provides an overview of the key points to note in relation to finance, performance and quality within the CCG and across the CCG's main providers. The information contained within this report reflects the latest published data available to the CCG at the time of writing.

## Finance (as at 31st August 2018)

YTD Performance

At Month 5 the CCG has reported a Year to Date overspend of £1.267m which is in line with plan. The main areas driving this overspend are Acute Services, offset by under spends in Prescribing and Running Costs.

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## Summary

The North Lincolnshire place continues to experience significant challenges in relation to long waiting times for some outpatient services and access to crisis mental health services. These challenges are further compounded by the on-going staffing pressures experienced across North Lincolnshire.

## Financial Position (as at 31st August 2018)

### Achievement of Financial Duties

Based on information available up to 31 August 2018, achievement against the financial performance targets for 2018/19 are as follows:

| Financial Duties | Target | Outturn RAG | RAG Explanation |
|---|---|---|---|
| 1 Maintain expenditure within the agreed control total | Planned control total or better achieved | ✓ | At Month 5 the CCG is forecasting achievement of its in year control total |
| 2 Maintain expenditure within the allocated cash limit | Cash drawdown less than cash limit | ✓ | The CCG is forecasting to maintain expenditure within its Minimum Cash Drawdown (MCD) value |
| 4 Ensure running costs do not exceed our agreed admin allocation | Expenditure less than or equal to allocation | ✓ | At Month 3 running cost spend is less than allocation |
| 5 Provide 0.5% contingency | 0.5% | ✓ | 0.5% Contingency is provided and remains uncommitted |
| 6 Ensure compliance with the better payment practice code (BPPC) | Greater than or equal to 95% by Number/Value | ✓ | BPPC was achieved in month and YTD for both NHS and Non NHS suppliers, for both number and value of invoices |
| 7 Achievement of the Mental Health Investment Standard | Growth of 2.80% or greater | ✓ | At Month 5 the CCG is forecasting growth in Mental Health spend of 3.33% |

### Financial Performance

The CCG's summary financial position as at 31 August 2018 is:

| | Year to Date (£000's) | | | Full Year (£000's) | | |
|---|---|---|---|---|---|---|
| | Budget | Actual | Var | Budget | Actual | Var |
| Acute Services | 49,049 | 50,038 | (989) | 117,717 | 118,528 | (811) |
| Mental Health Services | 9,411 | 9,351 | 60 | 22,586 | 22,704 | (118) |
| Community Health services | 9,340 | 9,331 | 9 | 22,415 | 22,415 | 0 |
| Continuing Healthcare and Funded Nursing Care | 7,174 | 7,236 | (62) | 17,219 | 17,366 | (147) |
| Primary Care Services | 15,573 | 14,904 | 669 | 37,376 | 36,436 | 940 |
| Other Programme Services | 4,287 | 4,193 | 94 | 15,012 | 14,876 | 136 |
| Running Costs | 1,557 | 1,337 | 220 | 3,757 | 3,757 | 0 |
| Contingency | 0 | 0 | 0 | 1,150 | 1,150 | 0 |
| Planned In Year Deficit | (1,267) | 0 | (1,267) | (3,600) | 0 | (3,600) |
| **IN YEAR TOTAL** | **95,124** | **96,390** | **(1,267)** | **233,633** | **237,232** | **(3,600)** |
| Balance of Prior Year Deficit | (4,218) | 0 | (4,218) | (10,123) | 0 | (10,123) |
| **CUMULATIVE POSITION** | 90,906 | 96,390 | (5,485) | 223,510 | 237,232 | (13,723) |

*(Note - please note that the figures above exclude the impact of CSF)*

**Summary Financial Position**

At Month 5 the CCG is reporting a YTD overspend of £1.267m which is in line with plan. The forecast position remains as per plan at £3.6m which is after the receipt of £400k Commissioner Sustainability Fund (CSF) money for quarter 1 (received in July).

Acute Services

At Month 5 the CCG has reported a YTD overspend of £989k in Acute Services which is a deterioration of £178k from Month 4.

The over spend relates mainly to the CCG's smaller acute contracts with both NHS and Non NHS Providers, and in particular:

- Hull and East Yorkshire Hospitals NHS Trust £461k over spent – the over spend is driven predominantly by Non Elective and Critical Care activity, however all areas of the contract are over plan.
- Doncaster and Bassetlaw Hospitals NHS FT £130k over spent – this is due to higher than planned levels of elective activity for both inpatient and outpatient care.
- Sheffield Teaching Hospitals NHS FT £103k over spent. – due to higher than planned levels of activity in Critical Care.

High levels of coding and data inaccuracies in the data from Northern Lincolnshire and Goole Hospitals NHS FT (NLAG) means that the CCG is currently unable to ascertain an accurate trading position and forecast outturn. The CCG therefore continues to report in line with plan.

The forecast position for Acute Services includes £1.182m of balance sheet flexibilities.

Mental Health Services

In Month 5 the reported position for Mental Health Services has worsened as a result of changes to the high cost specialist packages of care. The figures for this service are reported based on Broadcare data which is updated by the Rotherham Doncaster and South Humber NHS FT Case Management Team. The accuracy of this data remains a concern for the CCG and we continue to work with the Provider to validate the records via a recently formed Placement Funding Panel.
The reported position also includes £230k of prior year benefit.

Primary Care Services

The YTD underspend relates mainly to Prescribing which was £723k under spent at Month 5. This comprises a YTD underspend on PMD prescribing costs of £407k based on Month 3 PMD data and a benefit from prior year of £316k.

Running Costs

The CCG is reporting a YTD underspend of £220k on running costs, mainly as a result of vacant posts within the establishment. The figures reported at Month 5 include the full impact of the pay award. It is envisaged that the running cost budget will be fully spent by year end as vacant posts are filled and non-staff related costs are realised.

Risks

1. Managing activity within Acute Services remains a risk to the CCG's financial position. Work continues with NLAG to address data, quality and performance concerns, alongside the continued work to support their most fragile services by diverting new referrals to alternative providers.

2. The values reported for Specialist Mental Health and Learning Disability packages are based on current live packages. We are aware, particularly through our work with the Transforming Care Partnership, of some planned NHS England Step Down patients who would become the commissioning responsibility of the CCG which would result in a cost pressure for the CCG.

3. The impact of the category M price review for PMD prescribing will not be known until the second half of the year.

Revenue Resource Limit

The annual Revenue Resource Limit for the CCG was £233,633k for both 'Programme' and 'Running' costs. This has increased by £2,302k in August, £3,009k transferred from Lincolnshire West CCG for the Hawthorn and Scotter Practice Merger, £38k uplift for the Agenda for Change pay award and (£745k) returned to NHS England to correct a Month 3 allocation which was made in error.

**Working Balance Management**

Cash:

The closing cash for July was £47k which was below the 1.25% target of £203k.

Better Payment Practice Code

North Lincolnshire CCG achieved the Better Payment Practice Code target of 95%.

a. Non NHS

The Non NHS performance for August was 100% on the value and number of invoices, whilst the YTD position is 99.97% achievement on the value and 99.86% on number.

b. NHS

The NHS performance for August was 100% on the value and number of invoices, whilst the YTD position is 99.99% achievement on the value and 99.89% on number.

**QIPP**

The CCG has an annual QIPP plan of £5,997k.

At Month 5 the CCG has reported at YTD achievement of £2,145k (85.8%) of QIPP savings against the year to date plan of £2,499k. Scheme slippage at Month 5 is expected to be fully recovered by year end and therefore the CCG continues to forecast full achievement of its annual QIPP plan.

The CCG continues to proactively consider future QIPP schemes. The Financial Recovery Plan highlights the CCG's Pipeline schemes for 2018/19, leading in to 2019/20 and beyond.

| Savings Area | Scheme | Realisation of Savings |
|---|---|---|
| Acute | Implementation of an MSK Triage Service to manage referrals and ensure the patient receives treatment in the most appropriate care setting | As evidenced in other areas, MSK Triage Services help to reduce demand in Secondary Care by managing patients in the Community / Primary Care. The CCG will need to consider the level of care commissioned "Out of Hospital" but evidence suggests that the savings from the reduction in secondary care appointments will outweigh any required investment. |
| Prescribing | Phase 2 Prescribing | An extension of the current work plan to continue the review of medicines optimisation within North Lincolnshire. |
| Acute | Roll out of ERS and Advice and Guidance | The full roll out of ERS and Advice and Guidance by NLAG, focussed on key specialties, will reduce inappropriate referrals in to secondary care and provide an alternative to face to face contacts at a lower cost to the CCG. |
| Primary Care | New Primary Care Offer | The CCG has begun work to review the current Local Enhanced Service offer to Primary Care. Through monthly internal meetings (including GP input) a new offering will be developed for 2019/20 which will optimise system opportunities. |

The CCG is also progressing work on schemes that were identified by the QIPP 4 programme which was facilitated by Deloitte. This programme worked across the 4 Humber CCG's to identify areas of learning and best practice by highlighting the most successful QIPP schemes in recent years.

From this work 2 priority areas were identified:

1. Advice and Guidance
   Following the success of referral management initiatives on the North Bank, the QIPP 4 work has identified likely savings should the South Bank align practices with that of the North Bank for Advice and Guidance linked to referral management. Indicative savings for North Lincolnshire CCG are £387k in year 1 and £884k in year 2.

2. IFR Reconciliation Process
   East Riding CCG has a well-established contract challenge process for IFR procedures and a robust IFR policy which through clinical negotiation includes access thresholds for BMI and Smoking. Should the contract challenge process be adopted in North Lincolnshire CCG it is estimated that this would save £446k per annum.

## CCG Performance Summary (as at 31 July 18)

### A&E/Urgent Care

| Indicator | | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A&E waiting time - total time in the A&E department, SitRep data | Actual | 85.2% | 88.1% | 88.0% | 83.8% | | | | | | | | |
| | Improv Traj. | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| 12 hour trolley waits in A&E - NL CCG | Actual | 0 | 0 | 0 | 0 | | | | | | | | |
| | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| A&E performance - local performance (NLAG Performance) | Actual | 85.3% | 88.3% | 88.1% | 84.0% | | | | | | | | |
| | Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |

The CCG level A&E 4 Hour waiting time position deteriorated further in July 18, and the number of breaches increased to 2048 (1462 breaches in June 18).

Performance at Scunthorpe General Hospital deteriorated from 91.4% to 85.6% in July 18, and performance at Diana Princes of Wales Hospital deteriorated to 82.5%.

NLaG has reported that the recent decline in A&E performance has been attributed to increased activity to the Emergency Departments, specifically in relation to elderly patients and medical admissions, due to recent hot weather. The on-going staffing issues in A&E and reduced number of available beds at Scunthorpe Hospital and Diana Princess of Wales sites (also due to staffing pressures) contributed to reduced performance.

The table below provides site level performance of the NLAG Trust performance.

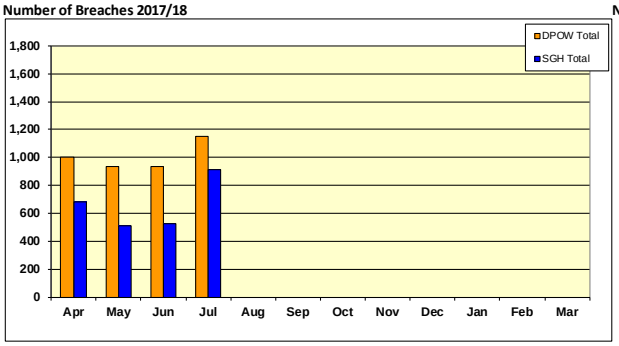
Northern Lincolnshire and Goole Foundation Trust - Activity Dashboard as at July (Month 04)

**A&E Performance - 2018/19**

**Full Year 2018/19**

| | DPoW | | | SGH | | | NLaG Combined |
|---|---|---|---|---|---|---|---|
| | Attendances | Over 4 hrs | % seen within 4 hrs | Attendances | Over 4 hrs | % seen within 4 hrs | % |
| APRIL | 5,649 | 1,000 | 82.3% | 5,769 | 680 | 88.2% | 85.3% |
| MAY | 6,115 | 936 | 84.7% | 6,208 | 511 | 91.8% | 88.3% |
| JUNE | 6,081 | 934 | 84.6% | 6,158 | 528 | 91.4% | 88.1% |
| JULY | 6,519 | 1,148 | 82.4% | 6,320 | 912 | 85.6% | 84.0% |
| AUGUST | | | | | | | |
| SEPTEMBER | | | | | | | |
| OCTOBER | | | | | | | |
| NOVEMBER | | | | | | | |
| DECEMBER | | | | | | | |
| JANUARY | | | | | | | |
| FEBRUARY | | | | | | | |
| MARCH | | | | | | | |
| | 24,364 | 4,018 | 83.5% | 24,455 | 2,631 | 89.2% | 86.4% |

Number of Breaches 2017/18

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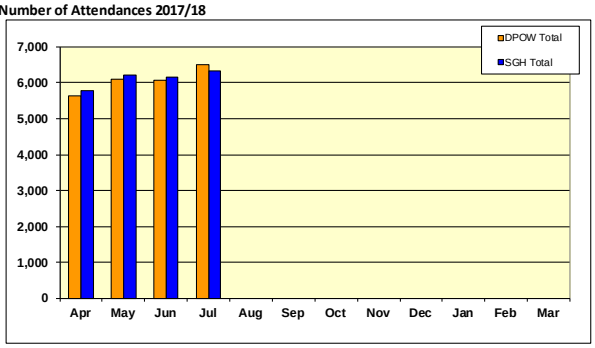

## Referral to Treatment Times (RTT)

| Indicator | | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referral to Treatment pathways: incomplete | Actual | 72.26% | 73.68% | 74.19% | 74.21% | | | | | | | | |
| | Target | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% |
| | Imp Traj. | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% |
| | Num. | 11,120 | 11,654 | 11,980 | 11,880 | | | | | | | | |
| | Den. | 15,389 | 15,816 | 16,147 | 16,009 | | | | | | | | |
| Number of >52 week Referral to Treatment in Incomplete Pathways | Actual | 183 | 171 | 171 | 155 | | | | | | | | |
| | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Performance against the CCG level RTT waiting time target improved slightly in July 2018 and the number of patients waiting over 52 weeks decreased from 171 to 155. The majority of these breaches took place at Northern Lincolnshire and Goole NHS Foundation Trust (NLaG).

The table below provides a breakdown of these breaches at NLaG by speciality for July 18, and the specialties current RTT % performance for North Lincolnshire patients at NLaG:

| Specialty | 52 week Breaches | 18 week Performance |
|---|---|---|
| ENT | 17 | 54.90% |
| Cardiology | 1 | 74.97% |
| General Surgery | 61 | 61.35% |
| Ophthalmology | 7 | 76.12% |
| Orthopaedics | 26 | 65.20% |
| Other (inc Pain) | 43 | 65.72% |

NLaG continues to undertake root cause analyses for all 52 week breaches, and lessons continue to be identified as part of the NLaG weekly performance meetings and the divisional governance meetings.

## Cancer Waiting Times

## 2 Week Waits

| Indicator | | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| All Cancer 2 week waits | Actual | 95.5% | 95.1% | 93.6% | 95.8% | | | | | | | | |
| | Target | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% |
| | Num. | 551 | 540 | 615 | 544 | | | | | | | | |
| | Den. | 577 | 568 | 657 | 568 | | | | | | | | |
| Breast Cancer 2 week waits | Actual | 89.2% | 86.2% | 72.2% | 81.8% | | | | | | | | |
| | Target | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% |
| | Num. | 33 | 25 | 26 | 36 | | | | | | | | |
| | Den. | 37 | 29 | 36 | 44 | | | | | | | | |

Performance against the Cancer 2 Week Wait standard remained strong in July 2018, with CCG performance against the Breast Cancer 2 week waiting time standard improving, although remaining below target with 8 breaches of the standard, the majority of these breaches related to patient choice.

## 31 Day Diagnosis to Treatment Waits

| Indicator | | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer 31 day waits: first definitive treatment | Actual | 97.8% | 96.8% | 97.1% | 97.2% | | | | | | | | |
| | Target | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% |
| | Num. | 87 | 92 | 102 | 104 | | | | | | | | |
| | Den. | 89 | 95 | 105 | 107 | | | | | | | | |
| Cancer 31 day waits: subsequent cancer treatments-surgery | Actual | 95.2% | 100.0% | 92.9% | 91.7% | | | | | | | | |
| | Target | 94% | 94% | 94% | 94% | 94% | 94% | 94% | 94% | 94% | 94% | 94% | 94% |
| | Num. | 20 | 11 | 13 | 22 | | | | | | | | |
| | Den. | 21 | 11 | 14 | 24 | | | | | | | | |
| Cancer 31 day waits: subsequent cancer treatments-anti cancer drug regimens | Actual | 100% | 100% | 100% | 100% | | | | | | | | |
| | Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| | Num. | 21 | 24 | 17 | 27 | | | | | | | | |
| | Den. | 21 | 24 | 17 | 27 | | | | | | | | |
| Cancer 31 day waits: subsequent cancer treatments-radiotherapy | Actual | 93.1% | 100.0% | 95% | 100% | | | | | | | | |
| | Target | 94% | 94% | 94% | 94% | 94% | 94% | 94% | 94% | 94% | 94% | 94% | 94% |
| | Num. | 27 | 24 | 18 | 13 | | | | | | | | |
| | Den. | 29 | 24 | 19 | 13 | | | | | | | | |

There have been 2 breaches of the 31 day subsequent treatment waiting time standard in July 18, both breaches related to capacity issues at HEYHT.

## 62 Day Referral to Treatment Waits

| Indicator | | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer (inc 31 day Rare cancers) | Actual | 70.7% | 67.8% | 73.2% | 61.8% | | | | | | | | |
| | Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| | Num. | 29 | 40 | 41 | 34 | | | | | | | | |
| | Den. | 41 | 59 | 56 | 55 | | | | | | | | |
| Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service. | Actual | 100.0% | 50.0% | 100.0% | 50.0% | | | | | | | | |
| | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | Num. | 1 | 1 | 6 | 3 | | | | | | | | |
| | Den. | 1 | 2 | 6 | 6 | | | | | | | | |
| Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status. | Actual | 66.7% | Nil Return | 100.0% | Nil Return | | | | | | | | |
| | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | Num. | 2 | 0 | 2 | 0 | | | | | | | | |
| | Den. | 3 | 0 | 2 | 0 | | | | | | | | |

The CCG failed to achieve the required level of performance against the 62 Day Cancer GP Referral standard in July 18 achieving 61.8% against a target of 85%..

The CCG also failed to meet required standards against the 62 day screening standard in July 2018 achieving 50% against a target of 90%.

## Diagnostic Waiting Times

| Indicator | | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Diagnostic test waiting times | Actual | 14.95% | 19.64% | 13.22% | 10.62% | | | | | | | | |
| | Target | 1% | 1% | 1% | 1% | 1% | 1% | 1% | 1% | 1% | 1% | 1% | 1% |
| | Num. | 896 | 1161 | 755 | 579 | | | | | | | | |
| | Den. | 5994 | 5911 | 5712 | 5451 | | | | | | | | |

Diagnostic performance continued to fall below the required levels in July 18, although there has been some improvement since the previous month with fewer breaches of the 6 week waiting time standard.

The majority of diagnostic pressures relate to MRI services, which accounts for over 72% of the breaches, and Endoscopy services. Plans are being developed to improve cancer performance and recover the 6 week diagnostic target.

Out of the 579 diagnostic breaches reported in July 18, 554 related to NLaG, 24 related to Hull and East Yorkshire NHS Hospitals Trust (HEY) and 1 breaches related to provider organisations in other areas.

Ambulance Response Programme (ARP) Standards

The tables below provide an overview of latest East Midlands Ambulance Service NHS Trust (EMAS) performance against the ARP performance standards at Trust level and at CCG level. Each table is separated into the four ARP response time categories (1 – 4) and reflects performance against the mean target and the 90% centile target.

*Table 1 – Trust level performance*

| Indicator EMAS TRUST POSITION | | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ambulance clinical quality: **Category 1** - 7 Minute Mean; 15 minute 90th centile response time (EMAS) - | Actual | 00:08:38 | 00:08:06 | 00:07:15 | 00:07:41 | | | | | | | | |
| | Target | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 |
| | Actual | 00:15:42 | 00:14:36 | 00:12:58 | 00:13:53 | | | | | | | | |
| | Target | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 |
| Ambulance clinical quality: **Category 2** - 18 Minute Mean; 40 minute 90th centile response time (EMAS) - | Actual | 00:31:57 | 00:30:45 | 00:31:10 | 00:33:17 | | | | | | | | |
| | Target | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 |
| | Actual | 01:08:06 | 01:04:35 | 01:05:49 | 01:10:26 | | | | | | | | |
| | Target | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 |
| Ambulance clinical quality: **Category 3** - 120 minute response time (EMAS) | Actual | 02:41:18 | 02:53:55 | 02:51:48 | 03:13:58 | | | | | | | | |
| | Target | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 |
| Ambulance clinical quality: **Category 4** - 180 minute response time (EMAS) | Actual | 02:01:15 | 02:42:50 | 02:09:08 | 02:29:24 | | | | | | | | |
| | Target | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 |

*Table 2 – CCG level performance*

| Indicator NLCCG POSITION | | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ambulance clinical quality: **Category 1** - 7 Minute Mean; 15 minute 90th centile response time (NL CCG) - | Actual | 00:08:28 | 00:08:39 | 00:06:59 | 00:07:49 | | | | | | | | |
| | Target | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 | 00:07:00 |
| | Actual | 00:16:56 | 00:16:39 | 00:13:07 | 00:14:46 | | | | | | | | |
| | Target | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 | 00:15:00 |
| Ambulance clinical quality: **Category 2** - 18 Minute Mean; 40 minute 90th centile response time (NL CCG) - | Actual | 00:29:47 | 00:28:16 | 00:32:14 | 00:32:04 | | | | | | | | |
| | Target | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 | 00:18:00 |
| | Actual | 01:03:23 | 00:59:59 | 01:07:34 | 01:06:06 | | | | | | | | |
| | Target | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 | 00:40:00 |
| Ambulance clinical quality: **Category 3** - 120 minute response time (NL CCG) | Actual | 02:16:29 | 02:20:09 | 02:55:00 | 03:34:52 | | | | | | | | |
| | Target | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 | 02:00:00 |
| Ambulance clinical quality: **Category 4** - 180 minute response time (NL CCG) | Actual | 01:15:03 | 02:50:33 | 01:16:07 | 01:39:00 | | | | | | | | |
| | Target | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 | 03:00:00 |

In July 18, EMAS achieved the 90$^{th}$ centile target response time for Category 1 calls (calls from people with life-threatening illnesses or injuries) in North Lincolnshire, but failed to meet the mean performance target or the 90% centile target for Category 2 and Category 3 calls during 2018/19 (as at 31 July 2018).

Ambulance activity data for North Lincolnshire states that approximately 2,000 Category 2 calls and 700 Category 3 calls were made to EMAS by North Lincolnshire residents in July 18. Approximately 50 patients were waiting over 40 minutes for a Category 2 call, and approximately 420 patients were waiting over 2 hours for a Category 3 call.

During quarter 1 2018/19, 8 incidents were reported to the CCG (via the incident reporting app) by primary care colleagues in relation to delayed ambulance response times. To date in quarter 2 18/19 (as at 26 Sep 18), 3 incidents have been reported to the CCG in relation to delayed ambulance response times.

EMAS did achieve the mean performance target and the 90% centile target for Category 4 calls. EMAS performance in North Lincolnshire remains relatively strong.

## Mental Health

| Indicator | | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of people who have depression and/or anxiety disorders who receive psychological therapies | Actual | 1.4% | 1.7% | 2.0% | 1.8% | | | | | | | | |
| | Target | 1.6% | 1.6% | 1.6% | 1.4% | 1.4% | 1.4% | 1.4% | 1.4% | 1.4% | 1.4% | 1.4% | 1.4% |
| | Num. | 195 | 235 | 270 | 248 | | | | | | | | |
| | Den. | 13460 | 13460 | 13460 | 13460 | | | | | | | | |
| % of people who are moving to recovery | Actual | 60.0% | 63.1% | 49.2% | 49.4% | | | | | | | | |
| | Target | 50% | 50% | 50% | 50% | 50% | 50% | 50% | 50% | 50% | 50% | 50% | 50% |
| | Num. | 81 | 101 | 60 | 87 | | | | | | | | |
| | Den. | 135 | 160 | 122 | 176 | | | | | | | | |
| % of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days | Actual | | | 100.00% | | | | | | | | | |
| | Target | | | 95% | | | 95% | | | 95% | | | 95% |
| | Num. | | | 43 | | | | | | | | | |
| | Den. | | | 43 | | | | | | | | | |
| Early Intervention in Psychosis (EIP First Episode Pyschosis) | Actual | NIL Return | 100.00% | 100.00% | 100.00% | | | | | | | | |
| | Target | 50% | 50% | 50% | 50% | 50% | 50% | 50% | 50% | 50% | 50% | 50% | 50% |
| | Num. | 0 | 2 | 4 | 1 | | | | | | | | |
| | Den. | 0 | 2 | 4 | 1 | | | | | | | | |
| The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period. | Actual | 100.00% | 100.00% | 100.00% | 100.00% | | | | | | | | |
| | Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| | Num. | 135 | 160 | 122 | 176 | | | | | | | | |
| | Den. | 135 | 160 | 122 | 176 | | | | | | | | |
| The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period. | Actual | 96.30% | 96.25% | 96.72% | 94.89% | | | | | | | | |
| | Target | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% |
| | Num. | 130 | 154 | 118 | 167 | | | | | | | | |
| | Den. | 135 | 160 | 122 | 176 | | | | | | | | |

Local data from Rotherham Doncaster and South Humber NHSFT (RDaSH) confirms that performance for the Improving Access to Psychological Therapies (IAPT) Entering Treatment, 6 and 18 week waiting time positions were all achieved in July 18, but RDaSH performance in relation to patients moving on to recovery failed to meet the required standards in July 18.

RDaSH achieved the required levels of performance for the early Intervention 2 week waiting time standard in July 2018.

## Healthcare Associated Infections

| Indicator | | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Incidence of healthcare associated infection (HCAI): MRSA | Actual | 0 | 0 | 0 | 0 | 0 | | | | | | | |
| | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Incidence of healthcare associated infection (HCAI): Clostridium difficile (C.difficile). | Actual | 7 | 3 | 1 | 3 | 1 | | | | | | | |
| | Target | 3 | 2 | 3 | 3 | 2 | | | | | | | |

There have been no cases of meticillin-resistant Staphylococcus aureus (MRSA) reported during 2018/19, against a zero tolerance approach.

There have been 15 cases of clostridium difficile reported to date in 2018/19 against the year to date target of 13, the CCG is currently off trajectory in relation to clostridium difficile performance.
A clostridium difficile reduction action plan is in place to monitor case numbers and identify themes and trends from cases which have deemed to be attributed to the community.

Mixed Sex Accommodation (MSA)

| Indicator | | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of MSA breaches for the reporting month in question | Actual | 16 | 6 | 6 | 5 | | | | | | | | |
| | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

The CCG has breached the MSA zero tolerance standard in each month (up to 30 July 18) in 2018/19. All breaches took place at NLaG. There were 5 MSA breaches reported by NLaG, affecting NLCCG patients, 2 at Diana Princess of Wales Hospital (DPoW) and 3 at Scunthorpe General Hospital in July 2018.

NLaG has confirmed, via the contract meeting process, that the majority of these breaches took place on Ward 22 at Scunthorpe Hospital, and in the Coronary Care Unit (CCU) at Scunthorpe hospital and DPoW hospital, as these environments are not considered to be conducive to single sex bays.

In response to these pressures, NLaG has submitted a capital bid to NHS Improvement to relocate the modular CCU facility and develop an integrated cardiology unit with single sex monitored bays. The Trust will undertake an audit in the CCU before October 18 to look at the process for admitting the patient to the CCU.

Senior staff within the Medical Division are currently reviewing bed and staffing models for Ward 22 at Scunthorpe Hospital to address the mixed sex issue. A definitive plan will be ratified at the Medicine Divisional Performance Meeting in September 18.

NLaG continues to review individual breaches as they occur to mitigate any risk to patients, in line with the Trust's MSA policy.

The Director of Nursing and Quality has undertaken a clinical site visit of the CCU at DPoW and is currently reviewing the Trust MSA Policy against the national guidance with the Trust.

## Overview of the CCG's Main Providers

### Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)

Care Quality Commission (CQC)

Within the final outcome report, the CQC identified several areas which had shown improvement. Significant improvements were identified within Maternity, Childrens and A&E. Improvement was also see in the identification of patients at risk of sepsis; compliance with the WHO surgical checklist in theatres and staff morale where staff felt supported by leaders.

The CQC also identified several areas that require improvement; including the Trust's approach to leadership, organisational vision and strategy, increased waiting times, senior accountability for managing risk and staffing levels for doctors and nurses.

Long waiting times

*Referral to Treatment (RTT) Incomplete Pathways*

NLaG achieved 70.97% against the RTT incomplete pathway waiting time standard in July 18, against the national target of 92%. This is an improvement on the previous position (70.66% in June 18) but performance continues to fall below the national RTT standard and below the local improvement trajectory.

In response to these concerns, NLaG has implemented recovery plans and improvement trajectories in each specialty and these plans continue to progress. NLaG has confirmed significant pressures in Pain services and ENT services due to on-going staffing issues in these areas; the Trust is working with an alternative provider to support these services. The Trust continues to report significant challenges in colorectal, urology and outpatient services; these issues largely relate to insufficient capacity due to low staffing levels.

Progress with the RTT recovery plan continues to be reviewed via the Planned Care Board, the contract management meeting process and via the System Improvement Board.

*52 Week Breaches*

NLaG continue to report a significant number of patients waiting in excess of 52 weeks for an appointment, although the number decreased slightly to 294 breaches in July 18 compared to 312 in June.

Of the 294 breaches reported in July 18, 155 related to North Lincolnshire patients. The majority of breaches relating to North Lincolnshire patients took place in Pain management services, ENT, General Surgery and Orthopaedic services.

NLaG does not currently provide the CCG with details of patients waiting in excess of 52 weeks for an appointment. The CCG has formally requested this information from the Trust and further detail on the NLaG waiting list will be provided to this meeting in due course.

*Clinical Harm Reviews*

During their latest inspection, the CQC identified concerns regarding the Trust's waiting list position and requested further assurances on action taken to manage the situation. In response to this, the Trust provided the CQC and commissioners with the following update:

- All patients identified in the 2015 waiting list cohort have now been seen.
- All patients identified in the 2016 waiting list cohort will be seen by end of Sep 18. Some of these patients will be seen via virtual clinic, this approach is already in place for patients on the colorectal waiting list.
- Some of the patients that were identified in the August 2017 cohort, many of which were on colorectal waiting list, have not yet been seen due to increasing capacity and staffing issues within this service. A recovery plan is now in place to support improvements.
- The Trust continues to work with GP's to review the records of those patients that have died whilst on a waiting list.

The outcome from the clinical review process continues to be monitored via the Patient Safety Group and via the System Improvement Board (SIB).

Mortality rates

The Trust's official Summary Hospital-level Mortality Indicator (SHMI) rate remains high at 119 and the Hospital Standardised Mortality Ratio (HSMR) rate also remains high at 115. SHMI and HSMR data reflects the period January to December 17 and was published June 2018.

The Trust remains within the higher than expected category for mortality. The updated mortality position will be published in the near future and further details will be provided in this report following publication.

In response to the latest mortality position the Trust has undertaken a deep dive review of its processes for reviewing mortality, resulting in the successful appointment of two clinical leads to lead on mortality across the Trust, and the development of a new Mortality strategy. The strategy has been developed with NHS Improvement oversight and is structured into three priority work streams, these are

- Deteriorating patient and sepsis
- Learning from deaths
- Review of the Trust's medical model

Commissioners continue to support the Trust in delivering the strategy through the Mortality Group.

Staffing

The Trust wide vacancy position increased slightly in August 18 to 9.24% against the target of <7%, this is an increase of 0.06%. Whilst the vacancy position remains above target levels, the overall vacancy position is improving.

The Medical & Dental vacancy position decreased significantly in August 2018 to 18.67% against the target of <15%, this is a decrease of 2.44% since the previous month. The vacancy position has been gradually improving over the last 5 months; this is the result of targeted recruitment activity and improved fill rates of trainee doctor positions.

The Trust has successfully recruited 78 newly qualified Nurses, these individuals will commence in their role in September 18.

The Trust continues to lead a number of recruitment initiatives to promote the Trust as an employer, these initiatives include

- development of a 'New Deal for Nursing' initiative which looks to look at workforce, recruitment, retention and new roles across nursing
- implementation of the Ward Excellence Programme. This is a new initiative aimed at celebrating the achievement of safe, effective and high quality care on inpatient wards and has been introduced across the Trust. The Programme has been devised to identify and showcase excellent practice, to help to reduce variation and provide a framework to support continuous quality improvement
- implementation of workforce strategies within the priority specialties

Fractured Neck of Femur Outlier

Following analysis of mortality data for the calendar year 2017, the Royal College of Physicians identified that Scunthorpe General Hospital reported a mortality rate above the 95% control limit. Commissioners are working closely with the Trust to review this position and consider any remedial actions, via the quality contract meeting process.

NLaG Waiting List Dashboard

The information provided in the table below has been extracted from the latest NLaG Waiting List Summary Report (as at 16/09/18) and includes an overview of RTT incomplete pathway performance, outpatient waiting list position, inpatient waiting list position and diagnostic waiting list position.

*Summary of Key Points from the waiting list dashboard:*

Performance against the Referral to Treatment (RTT) Incomplete Pathway standards improved in July 18 to 70.97%; this is an improving position.

NLaG reported a slight reduction in the number of patients waiting over 52 weeks for treatment in July 18 at 294 breaches.

The number of patients waiting 18 weeks and over for a new outpatient appointment continues to grow. NLaG has also reported an increase in the number of patients that are overdue a follow-up appointment in outpatient services, with 33,529 patients overdue a follow-up appointment as at 16/09/18.

The number of patients on the diagnostic waiting list continues to grow, with an increasing number of patients waiting between 6 to 12 weeks for an appointment. This exceeds the national diagnostic waiting time tolerance of <6 weeks wait.

The overall number of patients on the diagnostics waiting list has decreased by 3.2% compared to this period in 2017, but these patients are waiting longer for their appointment. The percentage of patients waiting less than 5 weeks for an appointment has reduced by 8.5%.

In response to these growing pressures, NLaG reported three serious incidents relating to delayed diagnostic processes in quarter 4 17/18 (latest published data available). Commissioners continue to work with the Trust to identify organisational learning via the NLaG Collaborative Serious Incident meeting.

**Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)**

Serious incidents (SI's)

In September 18, RDaSH reported three SI's relating to North Lincolnshire patients.

Crisis Mental Health Services

In response to increasing concerns raised by RDaSH in relation to capacity within its crisis mental health services, the Trust undertook a comprehensive capacity and demand review to further understand recent changes in demand for local mental health services, review current staffing levels and consider whether current provision is sufficient to meet increasing demand.

In addition to this work, the CCG is working closely with RDaSH to undertake a Quality Risk Profile (QRP) of emergency mental health services provided in the local area. The QRP will support the CCG and RDaSH in identifying areas of improvement and potential areas of risk in relation to crisis services. The learning from this profiling work will be used to inform the development of crisis service specifications.

The outcome from the review and the Quality Risk Profile will be considered by the CCG and RDaSH via the contract management process. Further detail on the impact of these areas of work will be provided in due course.

**Hull and East Yorkshire Hospitals NHS Trust (HEY)**

Pressures in Urology services

HEY has identified a significant increase in the number of referrals made to its Urology services. The specific reason for this increase is unclear, however HEY has identified a potential issue with the Urology pathway at NLaG as patients are required to have a follow-up appointment where they have a catheter in place, and this appears to be contributing to the rise in referrals.

In response to this, the HEY Urology Meeting is undertaking an end to end review of the Urology pathway to identify any issues and concerns and to support the development of improvement plans. The outcome from this review will be shared with partner organisations once finalised.

Referral to treatment 18 week incomplete pathway

HEY reported further deterioration in RTT performance in June 18 achieving 81.98% against a target of 92%. The Trust has robust recovery plans in place across all health groups to improve the RTT position; these plans incorporate improvement trajectories and commenced in July 2018.

Progress with these plans is monitored on a weekly basis via the Trust's Performance and Activity Meeting and is reviewed in detail via the HEY Contract Management Board.

Learning from never events

Following the six never events reported by HEY in 2017/18, the Trust undertook a thematic review of each incident to identify themes and trends. The review identified that all six incidents related to wrong site surgery, and several incidents were caused by human error due to distraction.

In response to this review, the Trust has developed a training package to support staff to focus on delivering good practice whilst in theatre. This initiative is based on the 'Sterile Cockpit' approach that has been adopted in the aviation industry, and requires a noise and distraction free environment during surgery. Good progress continues to be made with the training package and the Trust has identified that lessons have been learned across the organistion as a result of this training.

Infection Prevention

HEY reported a significant increase in Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia cases in June 18 (latest data available). A root cause analysis has been undertaken on each case; all cases were identified on one ward and these cases may be linked to the recent norovirus outbreak in the hospital and hot weather.

HEY has implemented an action plan to support improvements and to identify organisational learning, and the position is being closely reviewed by NHS Hull CCG as the lead commissioner for the HEY contract.

**East Midlands Ambulance Service NHS Trust (EMAS)**

*Conveyance rates*

Ambulance conveyance rates remain high; latest ambulance conveyance data reflects that 66.06% of North Lincolnshire patients that contacted EMAS were conveyed to A&E at Scunthorpe Hospital, 33.94% of patients were not conveyed to A&E. High conveyance rates by EMAS could lead to increased pressure in emergency services at NLaG.

EMAS continues to work with commissioners to reduce the number of patients that are conveyed to A&E by EMAS through the development of the EMAS telephone triage process, which takes place at the point the caller makes contact with EMAS through telephone call. The aim of this work is to convert calls from see and convey activity to see and treat or hear and treat activity where appropriate.

*Clinical handover of patients*

EMAS continues to exceed the national tolerance of <15 minutes for the clinical handover of patients between ambulance and Scunthorpe hospital, achieving average 18 minutes 46 seconds. Although performance does not meet the national standard, this is an improving position and clinical handover performance at Scunthorpe hospital is the best in the Lincolnshire division.

Staffing

In response to current staffing pressures across the Trust, EMAS continues to recruit frontline staff and utilise voluntary ambulance services and private ambulance services to meet demand.

In addition to this, EMAS has developed workforce improvement plans at divisional and regional levels. These plans will be implemented as part of the Locality Development Plan for each Division and will be reviewed by commissioners via the Contract Management structure.

Incidents

Since the previous report, the CCG has identified a reduction in the number of incidents and concerns raised in relation to emergency ambulance response times.

The CCG's Accountable Officer is liaising with the EMAS Chief Executive Officer to review actions undertaken by EMAS to improve performance and the quality of EMAS services provided in North Lincolnshire, and the position continues to be reviewed via the EMAS County Commissioning Meeting and the EMAS Clinical Assurance Group.

**Thames Ambulance Service Limited (TASL) - Patient Transport Services**

Re-procurement of Patient Transport Services

In light of the recent concerns identified in relation to local patient transport services provided by TASL, the CCG served notice to TASL in March 2018 with a 12 month notice period.

The re-procurement of patient transport services in North Lincolnshire is now complete, and the new service will commence from April 2019.

Quality improvements

The CCG has identified several improvements in the quality and performance of patient transport services provided in North Lincolnshire. These improvements include a reduction in the number of complaints and concerns raised with the CCG and with TASL regarding patient transport services in North Lincolnshire; additional training provided to staff within with TASL call centre; appointment of several new Senior Manager and Project Support roles within the TASL Patient Experience Team; development of a Complaints Management Policy and a Complaints Operating Process;

improvements to the TASL complaints management database and implementation of a new quality performance reporting process.

The quality of TASL services continues to be overseen and reviewed by the Director of Quality & Clinical Governance at TASL and the position is reviewed with commissioners via the TASL contract meeting process.

**St Hugh's Hospital**

Staff competency framework

St Hugh's Hospital has implemented a new clinical competency framework across the hospital. The framework will support the hospital's clinical staff in maintaining their clinical competencies in a range of areas including administration of medication, operating medical devices, undertaking an ECG and venepuncture.
The hospital has developed an action plan and several clinical policies to support implementation of the competency framework, and all clinical roles have been mapped to the framework. Progress against the action plan is reviewed via the St Hugh's Quality Contract Meeting.

Waiting times

Demand for services provided by St Hugh's Hospital continues to rise; this increase is largely due to long waiting times at NLaG. To support this increase in demand, St Hugh's Hospital is reviewing options to create additional capacity in some areas such as minor surgery; the hospital has also recruited a Theatre Manager to oversee the co-ordination and management of theatre lists and support the admin team in managing the increase in demand.

## NLCCG Quality Dashboard

The NLCCG quality dashboard contains an overview of performance against national and local quality indicators across the CCG's main providers, using latest data available. Quality indicators are categorised into three section; these are safety, effectiveness and experience. Each provider is RAG rated according to their performance.

Supplementary information/narrative is provided for indicators that are rated red.

# Primary Care Update

North Lincolnshire Primary Care Scorecard – Quarter 1 (April – June 2018)

The aim of the North Lincolnshire Primary Care Scorecard is to flag trends and themes in relation to GP Practice performance against a range of indicators, and to aid commissioners in deciding if there is a need to meet with a GP practice to discuss performance and agree actions that can be put in place to improve the overall position.

The scorecard is in place to facilitate discussion and is not used as a contract monitoring tool.

The latest version of the scorecard uses a RAG rating system to highlight areas that might warrant further investigation with the GP practice. If performance is more than 2 standard deviations away from the CCG average, they will be rated as red in the scorecard.

An amber rating is applied where the indicator is 1 standard deviation above or below the CCG average.

Deviation from the CCG average could represent better than average performance as well as below average performance, depending on the indicator being considered.

The CCG continues to capture soft intelligence around local primary care services to further support and inform development of the scorecard. The scorecard is shared with the Primary Care Quality and Performance Meeting for consideration.

The latest Primary Care Key Indicator Scorecard and the Secondary Care Utilisation Scorecard are provided below, for information.

# Scorecard 1 - Primary Care Key Indicators and Scorecard 2 - Secondary Care Utilisation

NHS North Lincolnshire CCG - Primary Care Reporting Key Indicators

South
West
East

NHS North Lincolnshire Clinical Commissioning Group

| Practice No. | Practice Name | Practice List Size June 18 | List size increase / decrease (from previous month) | Friends & Family % Patients would reccommend Jun 18 | Friends and Family % Patients would not recommend Jun 18 | Overall Patient Experience Very Good/Good (GP Survey 2018 | Patient OnLine - Patients enabled to electronically book or cancel an appointment - May 18 | Patient OnLine - Patients enabled to electronically order repeat prescriptions - May 18 | QOF - Practice Overall Achievement | CQC | Quality Issue reporting - Overview of inddents reported from GP Practices either rinte mally or against another Provider & from a provider against the GP Practice during 2017-2018 | | Quality Issue reporting - Overview of inddents reported from GP Practices either rinte mally or against another Provider & from a provider against the GP Practice during Q1 18/19 | | PALS/Concerns* | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | Occurring at the practice | Occurring outside the practice | Occurring at the practice | Occurring outside the practice | Q1 2017/18 | Q2 2017/18 | Q3 2017/18 | Q4 2017/18 | Q1 2018/19 |
| B81045 | Ashby Turn PC Partners | 12618 | -0.01% | No Data | No Data | 86% | 17.15% | 17.16% | 532.5 | May 2016 - Good | | 5 | | | | | 1 | 1 | |
| B81118 | West Common Lane Teaching Practice | 7912 | 0.24% | 88.80% | 9.60% | 86% | 15.50% | 15.39% | 540.4 | Feb 2016 - Good | | 106 | | 22 | | | 1 | 1 | |
| B81113 | Cedar Medical Practice | 7101 | 0.89% | 95.31% | 3.65% | 93% | 11.63% | 11.63% | 553.2 | Feb 2016 - Good | | 3 | | | 1 | 1 | | | |
| B81026 | Ancora Medical Practice | 19052 | 0.91% | 92.14% | 4.90% | 92% | 29.13% | 29.13% | 534.4 | November 2015 - Good | | 12 | | 9 | | | | 1 | |
| B81022 | Cambridge Avenue Medical Centre | 14173 | -0.18% | 91.02% | 6.64% | 81% | 28.34% | 28.21% | 543.9 | June 2016 - Good | | 12 | | 4 | | | | 1 | |
| B81099 | Kirton Lindsey Surgery | 10138 | 0.00% | No Data | No Data | 92% | 19.09% | 19.08% | 555.2 | May 2016 - Good | | 7 | | 2 | | | | 3 | 1 |
| B81648 | The Killingholme Surgery | 1395 | 1.15% | 100.00% | 0.00% | 91% | 13.86% | 13.93% | 527.0 | Oct 2017 - Good | 1 | 14 | | | | | | | |
| B81109 | Riverside Surgery (Brigg) | 12756 | 0.23% | No Data | No Data | 84% | 23.88% | 22.10% | 539.5 | March 2016 - Good | 1 | 7 | | | | | | | 1 |
| B81647 | West Town Surgery (Barton on Humber) | 3080 | 0.10% | No Data | No Data | 86% | 17.48% | 17.58% | 559.0 | August 2016 - Good | | 5 | | 1 | | | | | |
| B81628 | The Medical Centre (Barnetby) | 2989 | -0.33% | No Data | No Data | 96% | 14.34% | 14.21% | 557.2 | Jan 2017 - Good | 3 | 2 | | | | | | | |
| B81007 | Winterton Medical Practice | 9771 | -0.24% | No Data | No Data | 90% | 12.11% | 12.11% | 546.5 | April 2015 - Good | | 41 | | 8 | | | | | |
| B81005 | Central Surgery (Barton on Humber) | 16783 | -0.02% | No Data | No Data | 68% | 21.67% | 21.67% | 554.8 | Nov 2017 - Good | | 5 | | | 1 | | | | |
| B81063 | Bridge Street Surgery (Brigg) | 6369 | -0.11% | No Data | No Data | 95% | 48.63% | 48.47% | 558.6 | Jan 2017 - Good | | 17 | | 1 | | | 1 | | |
| B81617 | The Birches Medical Practice | 8892 | -0.07% | 82.93% | 10.57% | 72% | 6.00% | 5.99% | 538.5 | April 2016 - Good | | 13 | 1 | 2 | 2 | | | 3 | 1 |
| Y02787 | Market Hill | 5878 | 0.87% | No Data | No Data | 79% | 21.06% | 21.06% | 489.9 | April 2018 - Requires Improvement | | 11 | | 1 | | 2 | 1 | | |
| B81064 | Church Lane Medical Centre | 8949 | -0.15% | 97.34% | 1.14% | 88% | 22.07% | 22.04% | 527.7 | May 2015 - Good | | 22 | | 4 | | | | | |
| B81090 | The Oswald Road Medical Centre | 4529 | -0.15% | 97.67% | 0.00% | 89% | 14.47% | 14.43% | 543.0 | June 2015 - Good | | 16 | | 2 | | | | | |
| B81043 | South Axholme Practice | 14862 | 0.12% | 93.95% | 3.78% | 87% | 13.73% | 13.72% | 525.9 | May 2018 - Good | 1 | 9 | | | | | | | |
| B81065 | Trent View Medical Practice | 11614 | -0.16% | 84.21% | 9.47% | 73% | 11.30% | 11.28% | 548.0 | March 2015 - Good | | 20 | | 2 | 1 | | 1 | 2 | |

F&F Test - extremely low numbers of responses - needs promotion?

Patient OnLine - the GMS/PMS regulations 2017/18 and APMS regulations, the BMA and NHS England have made a joint commitment to encourage practices to register a minimum of 20 per cent of their patients for at least one online service by 31 March 2018.

Practices are also required to support patients to use apps to access Patient Online services. [Technical support for the apps will be provided by the app supplier.] Finally, practices should continue to provide patients who request it, with online access to clinical correspondence.

| Practice No. | Practice Name | Imms & Vaccs - % Uptake | | | | | | | Childhood Vaccs | Screening | | | | | Workforce Issues |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Flu 65 & Over Feb 18 | Flu Under 65 at Risk Feb 18 | Flu Pregnant Women at Risk Feb 18 | Flu Pregnant Women NOT at Risk Feb 18 | Flu - HCW Feb 18 | Pneumo 65s & Overs at 31/03/2018 | MenACWY 18-20 yr olds Mar 18 | | Cervical QOF Dec 2016 | Breast Round 8 2011-2014 | Breast Round 9 2014-2017 | Bowel | Retinal | |
| B81045 | Ashby Turn PC Partners | 74.3% | 48.5% | 60% | 32.7% | 65.60% | 51% | 41% | | 74% | 67% | 68% | | | |
| B81118 | West Common Lane Teaching Practice | 76.8% | 62.0% | 100% | 53.7% | 69.60% | 75% | 28% | | 72% | 67% | 70% | | | |
| B81113 | Cedar Medical Practice | 68.9% | 47.2% | 36.40% | 30.6% | 80% | 74% | 40% | | 73% | 69% | 59% | | | |
| B81026 | Ancora Medical Practice | 71.7% | 56.6% | 48% | 31.8% | 70% | 70% | 37% | | 73% | 69% | 67% | | | |
| B81022 | Cambridge Avenue Medical Centre | 69.8% | 44.2% | 72.70% | 38.9% | 68.40% | 61% | 45% | | 81% | 62% | 79% | | | |
| B81099 | Kirton Lindsey Surgery | 68.2% | 47.0% | 50% | 43.9% | 0% | 66% | 34% | | 80% | 70% | 78% | | | |
| B81648 | The Killingholme Surgery | 69.8% | 48.7% | 0% | 33.3% | 75% | 75% | 31% | | 78% | 63% | 62% | | | |
| B81109 | Riverside Surgery (Brigg) | 70.6% | 42.4% | 57.10% | 46.3% | 85.70% | 67% | 27% | | 80% | 77% | 78% | | | |
| B81647 | West Town Surgery (Barton on Humber) | 67.2% | 54.6% | 100% | 34.2% | 0% | 69% | 51% | | 80% | 73% | 74% | | | |
| B81628 | The Medical Centre (Barnetby) | 71.7% | 55.0% | 100% | 65.0% | 0% | 64% | 20% | | 88% | 71% | 77% | | | |
| B81007 | Winterton Medical Practice | 76.4% | 56.0% | 83.30% | 32.9% | 49% | 74% | 53% | | 77% | 73% | 78% | | | |
| B81005 | Central Surgery (Barton on Humber) | 72.0% | 46.0% | 60.90% | 33.0% | 0% | 65% | 43% | | 78% | 77% | 75% | | | |
| B81063 | Bridge Street Surgery (Brigg) | 68.0% | 46.3% | 0% | 52.0% | 100% | 37% | 41% | | 78% | 75% | 74% | | | |
| B81617 | The Birches Medical Practice | 73.9% | 56.3% | 100% | 36.2% | 0% | 78% | 8% | | 70% | 59% | 60% | | | |
| Y02787 | Market Hill | 60.7% | 46.4% | 14.30% | 26.5% | 0% | 38% | 10% | | 59% | 37% | 50% | | | |
| B81064 | Church Lane Medical Centre | 72.4% | 48.1% | 66.70% | 30.2% | 64% | 67% | 38% | | 75% | 74% | 77% | | | |
| B81090 | The Oswald Road Medical Centre | 75.6% | 56.9% | 57.10% | 46.5% | 30.80% | 71% | 44% | | 73% | 72% | 72% | | | |
| B81043 | South Axholme Practice | 73.7% | 54.9% | 50% | 65.9% | 48.30% | 64% | 57% | | 82% | 74% | 76% | | | |
| B81065 | Trent View Medical Practice | 70.7% | 44.3% | 43.80% | 25.8% | 91.70% | 54% | 39% | | 75% | 70% | 74% | | | |

**NHS North Lincolnshire CCG - Primary Care Reporting**
**Secondary Care Utilisation Scorecard - Q1**

NHS North Lincolnshire Clinical Commissioning Group

| | Crude rate per 1000 registered practice population (as at 1st June 2018) * | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | GP Referrals (All Specialties) | Other Referrals (All Specialties) | e-Referral Utilisation % (Jun '18) ** | Outpatient First Appointments | Outpatient Follow-up Appointments | Outpatient Procedure Appointments | Outpatient First Appointments Discharged % *** | A&E (Arrival Mode Ambulance) | A&E (Arrival Mode Other) | Non-Elective Emergency Discharges (Admission Method A&E) | Non-Elective Emergency Discharges (Admission Method Other) | Elective Discharges |
| Ashby Turn PC Partners | 48.7 | 50.5 | 36.3% | 73.9 | 141.1 | 59.8 | 34.1% | 24.8 | 76.3 | 22.8 | 4.5 | 42.6 |
| West Common Lane Teaching Practice | 32.2 | 51.6 | 25.3% | 54.5 | 114.4 | 41.8 | 38.3% | 22.6 | 79.1 | 21.6 | 5.9 | 39.4 |
| The Killingholme Surgery | 42.3 | 48.7 | 59.1% | 69.5 | 166.3 | 39.4 | 35.1% | 20.8 | 58.1 | 19.4 | 2.9 | 67.4 |
| The Birches Medical Practice | 45.0 | 50.2 | 38.4% | 67.8 | 114.5 | 48.5 | 37.3% | 23.1 | 89.0 | 21.3 | 5.2 | 31.4 |
| Riverside Surgery (Brigg) | 48.3 | 45.1 | 49.8% | 59.7 | 128.0 | 53.1 | 36.4% | 24.0 | 64.8 | 20.5 | 4.8 | 44.6 |
| Cedar Medical Practice | 49.6 | 61.3 | 46.7% | 76.5 | 140.1 | 55.6 | 35.9% | 29.4 | 85.5 | 26.1 | 9.6 | 39.4 |
| Ancora Medical Practice | 43.9 | 52.2 | 29.4% | 70.9 | 124.1 | 54.0 | 35.0% | 25.6 | 87.4 | 25.9 | 6.4 | 41.2 |
| Cambridge Avenue Medical Centre | 54.2 | 52.9 | 50.2% | 75.3 | 154.8 | 65.9 | 36.3% | 21.2 | 80.1 | 23.7 | 5.5 | 46.3 |
| Market Hill | 30.1 | 46.4 | 47.6% | 51.0 | 66.2 | 43.2 | 36.7% | 24.5 | 109.9 | 15.5 | 3.4 | 18.0 |
| Church Lane Medical Centre | 44.9 | 43.1 | 49.6% | 67.8 | 135.4 | 65.6 | 34.1% | 22.2 | 75.3 | 21.5 | 3.9 | 39.9 |
| West Town Surgery (Barton on Humber) | 55.8 | 39.6 | 68.5% | 54.5 | 135.1 | 51.9 | 42.3% | 20.8 | 60.7 | 18.2 | 4.2 | 35.1 |
| Kirton Lindsey Surgery | 36.8 | 58.1 | 80.0% | 71.5 | 139.6 | 51.5 | 36.7% | 18.0 | 72.3 | 18.0 | 4.3 | 37.7 |
| The Oswald Road Medical Centre | 67.3 | 51.7 | 51.5% | 85.2 | 151.5 | 60.7 | 39.6% | 20.8 | 92.1 | 23.0 | 8.4 | 44.4 |
| South Axholme Practice | 59.1 | 40.0 | 57.1% | 72.3 | 143.9 | 60.4 | 31.3% | 16.6 | 55.6 | 17.9 | 5.8 | 39.6 |
| Trent View Medical Practice | 58.4 | 49.8 | 27.3% | 76.2 | 144.2 | 68.0 | 32.9% | 20.0 | 76.4 | 22.0 | 5.9 | 50.4 |
| The Medical Centre (Barnetby) | 46.5 | 45.8 | 68.6% | 68.9 | 146.2 | 44.5 | 37.9% | 14.1 | 58.2 | 15.7 | 6.7 | 35.1 |
| Winterton Medical Practice | 49.8 | 49.4 | 36.7% | 69.2 | 149.1 | 67.9 | 34.0% | 19.4 | 69.5 | 18.6 | 5.1 | 49.6 |
| Central Surgery (Barton on Humber) | 49.8 | 42.7 | 61.7% | 60.7 | 136.5 | 54.0 | 38.9% | 23.2 | 51.5 | 18.4 | 5.5 | 37.5 |
| Bridge Street Surgery (Brigg) | 65.2 | 49.9 | 50.4% | 78.2 | 148.2 | 55.3 | 31.5% | 18.8 | 64.7 | 21.7 | 5.7 | 49.3 |
| South Network | 45.0 | 53.7 | 43.3% | 71.1 | 136.0 | 55.8 | 35.7% | 23.5 | 80.7 | 23.3 | 5.9 | 41.6 |
| East Network | 51.3 | 45.5 | 53.8% | 64.4 | 139.4 | 55.4 | 36.3% | 21.5 | 60.6 | 19.2 | 5.2 | 43.4 |
| West Network | 51.9 | 45.9 | 45.2% | 70.5 | 130.1 | 59.1 | 34.3% | 20.5 | 77.5 | 20.1 | 5.4 | 38.7 |
| CCG Average | 48.8 | 48.9 | - | 68.6 | 135.7 | 54.8 | 35.44% | 21.6 | 74.0 | 20.6 | 5.5 | 41.5 |

***Notes / Caveats***

**Method of RAG Rating currently set based on deviation from the CCG average (above or below) based on the rate not the underlying data**

** Kirton Lindsey practice population size now includes Scotter patients. Activity levels will not yet include these patients and, therefore, this practice will currently be misrepresented when benchmarking.*

*** e-Referral utilisation will be the latest available month position and expressed as a percentage*

**** Outpatient First Appointments Discharged will be based on rolling 12 months and expressed as a percentage*

***Key***

| Care Network |
|---|
| South Network |
| East Network |
| West Network |

| RAG | Red | Amber | Green |
|---|---|---|---|
| E-Referral Utilisation | < 80% | - | >= 80% |
| GP Referrals<br>Other Referrals<br>Outpatient First Appointments<br>Outpatient Follow-up Appointments<br>Outpatient Procedure Appointments<br>Outpatient First Appointments Discharged<br>A&E Arrival Mode Ambulance<br>A&E Arrival Mode Other<br>Non-Elective Emergency Admission Method A&E<br>Non-Elective Emergency Admission Method Other<br>Elective Admissions | 2 standard deviations above /below average | 1 standard deviations above /below average | Within average range |

## Glossary of Abbreviations

| | |
|---|---|
| NHS | National Health Service |
| NLCCG | North Lincolnshire Clinical Commissioning Group |
| NLaG | Northern Lincolnshire and Goole NHS Foundation Trust |
| HEY | Hull and East Yorkshire NHS Hospitals Trust |
| RDASH | Rotherham Doncaster & South Humber NHS Mental Health Trust |
| EMAS | East Midlands Ambulance Service NHS Trust |
| TASL | Thames Ambulance Service Limited |
| Spire | Hull & East Riding Spire Hospital |
| St Hugh's | HMT St Hugh's Hospital (Grimsby) |
| ULHT | United Lincolnshire Hospitals NHS Trust |
| NHS | NHS England |
| YTD | Year To Date |
| A&E | Accident & Emergency |
| MRI | Magnetic Resonance Imaging |
| CT | Computerised Tomography scan |
| HDU | High Dependency Unit |
| CHC | Continuing Healthcare |
| FNC | Funded Nursing Care |
| QIPP | Quality, Innovation, Productivity and Prevention programme |
| MH | Mental Health |
| LD | Learning Disability |
| IP&C | Infection Prevention & Control |
| MRSA | Methicillin-resistant Staphylococcus aureus |
| MSSA | Methicillin-sensitive Staphylococcus aureus |
| E-Coli | Escherichia coli |
| SHMI | Summary Hospital-level Mortality Indicator |
| ARP | Ambulance Response Programme |
| IAPT | Improving Access to Psychological Therapies |
| CPA | Care Programme Approach |
| RTT | Referral to Treatment waiting times |

| CQC domain | Provider | Latest CQC rating | Quality indicator | Latest Reporting Period | Target/ Tolerance | Actual | Direction of travel | Current RAG rating | Themes & Trends | Exception Link/Supp File |
|---|---|---|---|---|---|---|---|---|---|---|
| Safe | NLaG | Requires improvement | No. of C.Difficile cases | Aug-18 | 21 lapse in care | 10 (3 lapse in care) | Deterioration | | | |
| | | | No. of MRSA cases | Aug-18 | Nil | 0 | Remains the same | | | |
| | | | Patient Safety Thermometer | Aug-18 | 95% | All: 90.2%; New: 95% | Deterioration | | Increase in % of patients with new VTE | |
| | | | Staffing - Vacancy rate (Medical) | Sep-18 | <15% | 18.67% | Improvement | | | StaffNLaG!A1 |
| | | | Staffing - Vacancy rate (Reg) | Sep-18 | <6% | 12.05% | Deterioration | | | StaffNLaG!A1 |
| | | | Staffing - Vacancy rates (Unreg) | Sep-18 | <2% | 7.95% | Deterioration | | | StaffNLaG!A1 |
| | | | Duty of Candour incidents | Aug-18 | Nil | Nil | Improvement | | | |
| | | | Safer Surgery checklists | Jul-18 | 100% | 97.30% | Deterioration | | | |
| | HEY | Requires improvement | No. of C.Difficile cases | Jun-18 | 53 | 3 | Improvement | | | |
| | | | No. of MRSA cases | Jun-18 | Nil | Nil | Remains the same | | | |
| | | | Patient Safety Thermometer | Aug-18 | 95.00% | New 93.5% All: 94.1% | Deterioration | | | |
| | | | Staffing | Jul-18 | 100% | See text | Improvement | | RN: Day - 84.8%; Night - 94.10% | |
| | | | Incident management | Jun-18 | No concerns | No concerns | Improvement | | | |
| | | | Safer Surgery checklists | Q1 18/19 | 100% | 100% | Remains the same | | | |
| | RDASH | Good | No. of C.Difficile cases | May-18 | | Nil | Remains same | | | |
| | | | No. of MRSA cases | May-18 | | Nil | Remains same | | | |
| | | | Patient Safety Thermometer | Aug-18 | 95 | New: 92.3% All: 97.1% | Deterioration | | | |
| | | | Staffing | Aug-18 | Nil concerns | Concerns identified | Deterioration | | Concerns identified via Capacity & Demand Review | |
| | | | Duty of Candour incidents | May-18 | Nil | 1 | Deterioration | | RDASH has reported 3 incidents to date in 2018/19. | |
| | | | Reducing Restrictive Interventions | May-18 | Not defined | 15 | Improvement | | RDASH reported 15 incidents of restraint in May 18. Adult Mental Health Services has reported more restraints than any other clinical service during the past 12 months. | |

| CQC domain | Provider | Latest CQC rating | Quality indicator | Latest Reporting Period | Target/ Tolerance | Actual | Direction of travel | Current RAG rating | Themes & Trends | Exception Link/Supp File |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Incident management | May-18 | Not defined | 105 | Deterioration | | 105 incidents reported by RDASH in relation to North Lincs care group. in May 18, 64% of these incidents were categorised as 'no harm'. Increase in incidents. | |
| | EMAS | Requires improvement | IP&C Station Audit | Jul-18 | 100% | 58% | Deterioration | | | |
| | | | Deep Clean | Jul-18 | 100% | 100% | Improvement | | | |
| | | | Staffing | Jul-18 | No concerns | Concerns identified | Deterioration | | Concerns identified in relation to staff sickness rates and staff abstractions. | |
| | | | Incident management | Aug-18 | No concerns | Some concerns | Improvement | | Concerns identified in relation to timeliness of response to NL incidents. | |
| | St Hugh's hospital | Requires Improvement | No. of C.Difficile cases | Jul-18 | Not defined | Nil | Remains the same | | | |
| | | | No. of MRSA cases | Jul-18 | Not defined | Nil | Remains the same | | | |
| | | | Patient Safety Thermometer | Aug-18 | 94% | All: 93.9% New: 97.9% | Deterioration | | | |
| | | | National Early Warning Score (NEWS) | Jul-18 | >95% | 94% | Deterioration | | | |
| | | | Staffing | Jul-18 | No concerns | No concerns identified | Remains the same | | | |
| | | | Incident management | Jun-18 | No concerns | Concerns identified | Deterioration | | Increasing number of incidents in the holding area, awaiting review | |
| | | | Safer Surgery checklists | Jul-18 | 100% | 99% | Deterioration | | | |
| | Spire hospital | Requires improvement | No. of C.Difficile cases | Jun-18 | Nil | Nil | Remains the same | | | |
| | | | No. of MRSA cases | Jun-18 | Nil | Nil | Remains the same | | | |
| | | | Patient Safety Thermometer | Jun-18 | 97% | All & New: 100% | Improvement | | | |
| | | | National Early Warning Score (NEWS) | Jun-18 | 100% | 100% | Remains the same | | | |
| | | | Staffing | Jun-18 | No concerns | No concerns | Improvement | | | |
| | | | Incident management | Jun-18 | No concerns | No concerns | Remains the same | | | |
| | | | Safer Surgery checklists | Jun-18 | 100% | 99% | Deterioration | | | |
| | | | Audit | Aug-18 | No concerns | No Concerns | Remains the same | | | |
| | | | NICE compliance | Aug-18 | 95% | 95.9% | Improvement | | | |

| CQC domain | Provider | Latest CQC rating | Quality indicator | Latest Reporting Period | Target/ Tolerance | Actual | Direction of travel | Current RAG rating | Themes & Trends | Exception Link/Supp File |
|---|---|---|---|---|---|---|---|---|---|---|
| Effective | NLAG | Requires improvement | Mortality position | Dec-17 | 100 | SHMI: 119; HED SHMI: 117 | Remains the same | | See exception report. | MortalityNL&G'!A1 |
| | | | Accreditation | Aug-18 | Fully compliant | Non-compliant with JAG at SGH | Remains the same | | NLaG accreditation achieved at DPoW in April 18. NLaG in process of applying for re-accreditation at SGH. | |
| | | | Nutrition & Hydration | Mar-18 | 95% | Food: 93.3%; Fluid: 87.9% | Deterioration | | Await updated information from NL&G. Update due to be published end Sep 18 | |
| | HEY | Requires improvement | Audit | Jun-18 | 75% | 89.87% | Improvement | | Improvements identified in relation to compliance with the Accelarating Stroke Programme. SSNAP rated B (80-89%) | |
| | | | NICE Guidance compliance | Q1 18/19 | Not defined | 61 TBD | Improvement | | | |
| | | | CAS | Jun-18 | 100% | 100% | Remains the same | | | |
| | | | Mortality position | Dec-17 | 95 | HSMR 93 (SHMI: 95.8) | Improvement | | | |
| | | | Accreditation | Jun-18 | No concerns | No concerns | Remains the same | | | |
| | | | Nutrition & Hydration | Jun-18 | No concerns | No concerns | Remains the same | | | |
| | RDASH | Good | Audit | Aug-18 | Fully compliant | No concerns identified | Remains the same | | Audit undertaken in Laurels ward. Outcome: Outstanding. RDaSH wokring with HC&V STP on peer review of HTT. | |
| | | | NICE compliance | May-18 | Fully compliant | No concerns identified | Remains the same | | | |
| | | | CAS | May-18 | Not defined | 1 x in progress | Remains the same | | | |
| | | | Accreditation | Aug-18 | | No concerns | Remains the same | | | |
| | | | Nutrition & Hydration | Not recorded | Not recorded | Not recorded | N/A | N/A | Escalated to CMB for action | |
| | EMAS | Requires improvement | Audit | Q1 18/19 | No concerns | No concerns | Improvement | | | |
| | | | CAS | Jun-08 | 100% | 100% | Remains the same | | | |
| | | | Accreditation / Standards | Jun-18 | No concerns | No concerns | Remains the same | | | |
| | St Hugh's hospital | Requires Improvement | Audit | Jul-18 | 100% | 80% | Deterioration | | Deterioration in compliance with Record Keeping standards in Theatre. Reviewed by NELCCG as Lead Commissioner | |
| | | | NICE compliance | Jul-18 | Fully compliant | Partially compliant | Remains the same | | Concerns re compliance with NICE CG 65 Hypothermia. Action plan is in place, position to be re-audited in September 18. | |
| | | | CAS | Jul-18 | 100% | 100% | Remains the same | | | |
| | | | Accreditation | Jul-18 | 100% | 100% | Remains the same | | | |

| CQC domain | Provider | Latest CQC rating | Quality indicator | Latest Reporting Period | Target/ Tolerance | Actual | Direction of travel | Current RAG rating | Themes & Trends | Exception Link/Supp File |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Nutrition & Hydration | Jul-18 | No concerns | No concerns | Remains the same | | | |
| | Spire hospital | Requires improvement | Audit | Jun-18 | No concerns | No concerns | Improvement | | | |
| | | | NICE compliance | Jul-18 | 100% | 100% | Remains the same | | | |
| | | | CAS | Jun-18 | 100% | 100% | Remains the same | | | |
| | | | Accreditation | Jun-18 | 100% | 100% | Remains the same | | | |
| Caring | NLAG | Good | Pressure ulcers | Jul-18 | Not defined | See text | Deterioration | | 36 x grade 2 pressure ulcers; 11 x grade 3 pressure ulcers, nil x grade 4 | |
| | | | Falls | Aug-18 | 20% | 69.50% | Improvement | | Reduction in the number of falls resulting in harm (36.4% patients harmed) | |
| | HEY | Good | Pressure ulcers | Jun-18 | Not defined | 14 (4 lapses in care) | Deterioration | | | |
| | | | Falls | Jun-18 | Reduction on 17/18 | 0.18 | Improvement | | | |
| | | | Care of the deteriorating patient | Jun-18 | Not defined | Concerns identified | Deterioration | | Deteriorating patients identified as a theme in SI's. | |
| | RDASH | Good | Falls | May-18 | Not defined | 3 | Improvement | | | |
| | | | Pressure ulcers | May-18 | Nil | Nil | Remains the same | | | |
| | EMAS | Good | Regulator feedback | Jul-18 | No concerns | No sig concerns | Improvement | | | |
| | Spire hospital | Good | Falls | Jun-18 | <2.0% | 1 (0.19%) | Improvement | | | |
| | | | Pressure ulcers | Jun-18 | Nil | Nil | Improvement | | | |
| | St Hugh's hospital | Good | Falls | Jul-18 | Not confirmed | 1 | Improvement | | No harm caused to the patient | |
| | | | Pressure ulcers | Jul-18 | Nil | Nil | Remains the same | | | |
| | NLAG | Inadequate | Culture | Aug-18 | No concerns | Concerns identified | Remains the same | | The Trust has identified a risk that organisational culture could adversely effect the Trust's ability to continuously focus on quality improvement. Rated as high risk (20) on NL&G BAF. | |
| | | | Staff training | Aug-18 | 85% | 83% | Improvement | | | |
| | | | Governance | Aug-18 | No concerns | Concerns identified | Improvement | | The Trust has identified a risk in relation to Information Governance Breaches, Cyber Security, non-compliance with Digital 2020 Strategy and non-compliance with NHS Information Standard. | |
| | | | Equality & diversity | Aug-18 | Fully assured | Assured | Improvement | | | |

| CQC domain | Provider | Latest CQC rating | Quality indicator | Latest Reporting Period | Target/ Tolerance | Actual | Direction of travel | Current RAG rating | Themes & Trends | Exception Link/Supp File |
|---|---|---|---|---|---|---|---|---|---|---|
| Well-led | HEY | Requires improvement | Risk Management | Jul-18 | No concerns | No sig concerns | Improvement | | No sig concerns regarding the risk management process, however HEYHT reported 6 x Never Events in 2017/18, none of these related to NLCCG. | |
| | | | Culture | Jul-18 | No concerns | No concerns | Improvement | | | |
| | | | Staff training | Juy 18 | 90% | 86.1% Moving & Handling | Remains the same | | | |
| | | | Governance | Jul-18 | No concerns | No significant concerns | Remains the same | | | |
| | | | Equality & diversity | Jul-18 | Not defined | No significant concerns | Remains the same | | | |
| | RDASH | Good | Risk Management | Jul-18 | No concerns | No significant concerns | Improvement | | | |
| | | | Culture | Jul-18 | Not recorded | No concerns identified | Remains the same | | Improved staffing levels on inpatient ward areas, leading to improved morale. Staffing challenges remain in Crisis Team. | |
| | | | Staff training | Jul-18 | No concerns | Some concerns | Remains the same | | Concerns identified in relation to compliance with Safeguarding training level 2 and 3. | |
| | | | Governance | Jul-18 | No concerns | No concerns | Remains the same | | | |
| | | | Equality & diversity | Jul-18 | No concerns | Some concerns | Deterioration | | Gaps identified in recording of E&D data in the patients record. Lack of assurance provided to the CCG in relation to RDASH compliance with E&D duties. | |
| | EMAS | Requires improvement | Risk Management | Aug-18 | Nil concerns | No concerns | Improvement | | | RiskEMAS!A1 |
| | | | Culture | Jun-18 | Nil concerns | No concerns | Improvement | | | |
| | | | Staffing | Jun-18 | Nil concerns | Concerns identified | Improvement | | | StaffEMAS!A1 |
| | | | Governance | Jun-18 | 32w | No concerns identified | Remains the same | | | |
| | | | Equality & diversity | Jun-18 | Nil concerns | Concerns identified | Deterioration | | Decline in percentage of E&D data recorded accurately in patient records. The CQC identified concerns in relation to compliance with E&D training. | |
| | St Hugh's hospital | Requires Improvement | Risk Management | Jul-18 | Nil concerns | Concerns | Remains the same | | Delays in processing incidents. | |
| | | | Culture | Jul-18 | Nil concerns | No concerns | Remains the same | | | |
| | | | Staff training | Jul-18 | Not recorded | Concerns identified | Remains the same | | Prevent and WRAP training at 71% | |
| | | | Governance | Jul-18 | Nil concerns | No sig concerns | Improvement | | See exception report | GovStHughs!A1 |
| | | | Equality & diversity | Jul-18 | Nil concerns | No concerns identified | Remains the same | | | |

| CQC domain | Provider | Latest CQC rating | Quality indicator | Latest Reporting Period | Target/ Tolerance | Actual | Direction of travel | Current RAG rating | Themes & Trends | Exception Link/Supp File |
|---|---|---|---|---|---|---|---|---|---|---|
| | Spire hospital | Requires Improvement | Risk Management | Jun-18 | Nil concerns | No concerns identified | Remains the same | | | |
| | | | Culture | Jun-18 | Nil concerns | No concerns identified | Remains the same | | | |
| | | | Staff training | Jun-18 | 80% | 53% | Deterioration | | Low compliance with IG. Concerns have been escalated to Spire CMB. | |
| | | | Governance | Jun-18 | No concerns | No concerns identified | Improvement | | New monthly Quality Group established to review quality and governance at Spire. Positive assurance received to date. | |
| | | | Equality & diversity | Jun-18 | Nil concerns | No concerns identified | Remains the same | | | |
| Responsive | NL&G | Requires improvement | Friends & Family Test - Response Rate | Jul-18 | Not defined | A&E: 7.1%; Inpatients: 8.8% | Improvement | | | |
| | | | Friends & Family Test - Positive response | Jul-18 | Not defined | A&E: 75%; Inpatients: 97% | Remains the same | | Positive response to inpatient services. Reduction in positive response rate in A&E. | |
| | | | Complaints (New) | Jul-18 | Not defined | 50 | Deterioration | | | |
| | | | Mixed Sex Accommodation | Aug-18 | Nil | 75 | Deterioration | | See exception report | MSANL&G'!A1 |
| | | | Access & Flow | Aug-18 | 92% | 18 week (incomplete) - 69.8% | Deterioration | | The Trust continues to miss delivery of a number of key operational performance standards, falling someway short of delivering best practice. | NLAGRTT!A1 |
| | HEY | Requires improvement | Friends & Family Test - Response rate | Jul-18 | Not defined | A&E: 17.6%; Inpatient: 15.7% | Deterioration | | | |
| | | | Friends & Family Test - Positive response | Jul-18 | Not defined | A&E - 82%; Inpatient: 99% | Deterioration | | Positive response to inpatient and A&E services. | |
| | | | Complaints | Jun-18 | Not defined | 62 | Deterioration | | | |
| | | | Mixed Sex Accommodation | Jul-18 | Nil | Nil | Remains the same | | | |
| | | | Access & Flow | Jun-18 | No concerns | RTT 81.98%; A&E 84.31% | Deterioration | | Deterioration in RTT and diagnostic performance. Improvement in A&E performance. | RTTHEY!A1 |
| | RDASH | Good | Friends & Family Test - Response rate | Jul-18 | Not defined | <1% | Remains the same | | Low response rate | |
| | | | Friends & Family Test - Positive response | Jul-18 | Not defined | 90% | Deterioration | | | |
| | | | Complaints | May-18 | 3 per month | 1 | Improvement | | | |
| | | | Mixed Sex Accommodation | May-18 | Nil | Nil | Remains the same | | | |
| | | | Access & Flow | Aug-18 | No concerns | Concerns identified | Deterioration | | Concerns identified in relation to timeliness and accesds to Crisis services. | |

| CQC domain | Provider | Latest CQC rating | Quality indicator | Latest Reporting Period | Target/ Tolerance | Actual | Direction of travel | Current RAG rating | Themes & Trends | Exception Link/Supp File |
|---|---|---|---|---|---|---|---|---|---|---|
| | EMAS | Good | Friends & Family Test - Response rate | Jul-18 | Not defined | Nil | Deterioration | | Nil response rate | |
| | | | Friends & Family Test - Positive response | Jul-18 | Not defined | Nil | Deterioration | | Nil response rate | |
| | | | Complaints | Jul-18 | Not defined | 14 | Deterioration | | None of these relate to NLCCG | |
| | | | Access & Flow | Jun-18 | CAT1 - 7min; CAT2 - 18 min | See exception report | Improvement | | See exception report for details | Access&FlowEMAS'!A1 |
| | St Hugh's hospital | Good | FFT response (inpatients) | Jun-18 | 90% | 9% positive | Deterioration | | | |
| | | | FFT response (Outpatients) | Jun-18 | 90% | 77% positive | Deterioration | | | |
| | | | Complaints | Jul-18 | Not defined | 3 | Improvement | | | |
| | | | Mixed Sex Accommodation | Jul-18 | Not defined | Nil | Remains the same | | | |
| | | | Access & Flow | Jul-18 | Nil concerns | No concerns | Improvement | | | |
| | Spire hospital | Good | Friends & Family Test | Jun-18 | Not recorded | 29.7% response & 99% recommend | Improvement | | | |
| | | | Complaints | Jun-18 | Not defined | 2 | Remains the same | | No themes or trends identified. Currently reviewed by NHS Hull CCG as Lead CCG. | |
| | | | Mixed Sex Accommodation | Jun-18 | Nil | Nil | Remains the same | | | |
| | | | Access & Flow | Jun-18 | No concerns | No concerns | Remains the same | | Increase in activity from NLCCG | |

Yorkshire and Humber Commissioning Support

## North Lincolnshire Quality Exception Summary

| Indicator Reference |
|---|
| Access&FlowEMAS |
| **Report Area:** |
| Access & Flow |
| **Provider** |
| EMAS |
| **Lead Officer: Chloe Nicholson** |

| Period | Tolerance | Actual | YTD | Status |
|---|---|---|---|---|
| Jun-18 | | | | |

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**Underlying Cause/Supporting Narrative**

Since the previous report, improvements have been identified in ambulance response times and time taken to transfer patients from ambulances to emergency services at Scunthorpe General Hospital. The CCG has also identified a reduction in the number of incidents and concerns raised in relation to emergency ambulance response times.

The position continues to be reviewed by the CCG via the EMAS County Commissioning Meeting.

**Ambulance response times**

EMAS achieved the national response time performance targets in North Lincolnshire in June 18 (latest data available) and met the mean response time for all performance categories. This is an improving position and reflects further improvement on the previous performance position.

**Conveyance**

Ambulance conveyance rates remain high; latest ambulance conveyance data (June 18) reflects that 66.06% of North Lincolnshire patients that contacted EMAS in June 18 were conveyed to A&E at Scunthorpe Hospital, 33.94% of patients were not conveyed to A&E. High conveyance rates by EMAS could lead to increased pressure in emergency services at NLaG.

EMAS continues to work with commissioners to reduce the number of patients that are conveyed to A&E by EMAS through the development of the EMAS telephone triage process, which takes place at the point the caller makes contact with EMAS through telephone call. The aim of this work is to convert calls from see and convey activity to see and treat or hear and treat activity where appropriate.

**Patient handover**

EMAS continues to exceed the national tolerance of <15 minutes for the clinical handover of patients between ambulance and Scunthorpe hospital, achieving average 18 minutes 46 seconds. Although performance does not meet the national standard, this is an improving position and clinical handover performance at Scunthorpe hospital is the best in the Lincolnshire division.

Yorkshire and Humber Commissioning Support

## North Lincolnshire Quality Exception Summary

| Indicator Reference |
|---|
| MortalityNL&G |
| **Report Area:** |
| Mortality |
| **Provider** |
| NL&G |
| **Lead Officer: Chloe Nicholson** |

| Period | Tolerance | Actual | YTD | Status |
|---|---|---|---|---|
| Dec-17 | | 116 | | |

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**Underlying Cause/Supporting Narrative**

Crude Mortality (all & non-elective) rates remain higher than national and peer averages. Crude Mortality displays a progressive declining trend which can be seen across both sites.

Crude mortality is 1.51% (all deaths) with non-elective rate of 3.32%, the 8th consecutive month this has reduced, demonstrating a statistically significant reduction.

There is a gap between the Trust's non-elective (MAT) mortality (3.32%) and peer (2.92%). Since Jun-18, DPOW has slightly increased in nonelective mortality specifically increased deaths occurring on AMU, Stroke Unit and HDU.

SGH (MAT) crude mortality is higher than DPOW noticeably since Jan18 mainly driven by increase in deaths on Ward 16, CDU and Ward 23. This has been decreasing since April-18. See Mortality Briefing Report embedded below for details of action taken by the Trust to mnage the mortality position.

C:\Users\NicholsonC\Desktop\QP&F Oct

Yorkshire and Humber Commissioning Support

| Indicator Reference |
|---|
| MSA NL&G |
| **Report Area:** |
| Mixed Sex Accommodation |
| **Provider** |
| NL&G |
| **Lead Officer: Chloe Nicholson** |

| Period | Tolerance | Actual | YTD | Status |
|---|---|---|---|---|
| Jul-18 | | | 275 | |

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**Underlying Cause/Supporting Narrative**

During 2018/19, NL&G reported 275 breaches of the MSA criterion; the majority of these breaches took place on ward 22 at Scunthorpe Hospital and the Coronary Care Unit (CCU) at Diana Princess of Wales hospital. A summary position for each of these ward areas is provided below,

**Ward 22, SGH –** in order to maintain patient safety, those patients requiring NIV intervention are cared for in a mixed sex respiratory high observation bay. This approach enables safe use of the staffing resource and centralises the patients within one area of the ward, giving greater visibility of these higher risk patients. NL&G has identified an option to revise the bed/staffing model; this review will be completed by the end of April 2018.

**CCU, DPoW** – some of the patients meet Level 2 Critical Care standards an d this would deem them exempt from being reporting as mixed sex breaches under the national guidance. However there are other patients on the unit that need cardiology oversight and monitoring but no longer meet the Level 2 criteria. When these patients are present, NL&G must declare mixed sex breaches for all patients on the unit.

In response to these pressures, NL&G has submitted a capital bid has been submitted to NHS Improvement to relocate the modular CCU facility and develop an integrated cardiology unit with single sex monitored bays.

NL&G recently published its annual declaration of compliance with the Eliminating Mixed Sex Accommodation guidance, with the exemption of ward 22 at Scunthorpe Hospital and the Coronary Care Unit at Diana Princess of Wales hospital.

Yorkshire and Humber Commissioning Support

## North Lincolnshire Quality Exception Summary

| Indicator Reference |
|---|
| GovStHugh's |
| **Report Area:** |
| Governance |
| **Provider** |
| St Hugh's |
| **Lead Officer: Chloe Nicholson** |

| Period | Tolerance | Actual | YTD | Status |
|---|---|---|---|---|
| Jun-18 | | | | |

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| Underlying Cause/Supporting Narrative |
|---|
| CQC (section 29 notice) - Good progress has been made by St Hugh's against the action plan, no further action taken by CQC. Improving position. |

Yorkshire and Humber Commissioning Support

## North Lincolnshire Quality Exception Summary

| Indicator Reference |
|---|
| NL&GRTT |
| **Report Area:** |
| RTT Incomplete Pathways |
| **Provider** |
| NL&G |
| **Lead Officer: Chloe Nicholson** |

| Period | Tolerance | Actual | YTD | Status |
|---|---|---|---|---|
| Jul-18 | 1 | 1 | | |

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**Underlying Cause/Supporting Narrative**

Work streams are being developed to support the delivery of all aspects of planned care. Specific work is underway in outpatients to identify operational inefficiencies, a theatre work stream has been established focussing on improved booking processes and theatre utilisation. All of this work is part of the Improving Together Programme of work, the outcome of which will be discussed in detail at the Planned Care Board.
RTT performance dipped to the lowest level in March-18 at 66.2%. This has began to rise to a validated position in July-18 of 70.97%.
Performance is lowest within the SGH site, with DPOW greatly increasing their performance from 65.8% to 72.9% in July-18. The Trust also has a requirement to ensure the overall incomplete waiting list size does not grow from the March 2018 position. The number was 29396 in March and is 29366 at the end of July.

**Actions been taken**

The governance processes highlighted in the S31 response are in place. A weekly RTT PTL meeting is held with all specialties every week chaired by the Operational Improvement Director or the Chief Operating Officer. This is underpinned by the mobilisation of the specialty plans for the 8 most at risk specialties which is starting to be delivered. This will slow down in August due to high amounts of annual leave , increasing sickness rates and difficulties in staffing with bank and agency. In addition the next phase of Capacity and demand is underway with 2 additional confirm and challenge meetings with the specialties in August and September. The transfer of work to Goole will be dependant on the capital works required and nurse recruitment. Plans are being explored to transfer work for pain services and ENT to St Hughes in agreement with the CCG's.

Yorkshire and Humber Commissioning Support

## North Lincolnshire Quality Exception Summary

| Indicator Reference |
|---|
| RTTHEY |
| **Report Area:** |
| RTT Incomplete Pathways |
| **Provider** |
| HEY |
| **Lead Officer: Chloe Nicholson** |

| Period | Tolerance | Actual | YTD | Status |
|---|---|---|---|---|
| Jul-18 | 1 | 1 | | |

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**Underlying Cause/Supporting Narrative**

Further reduction in RTT perf but recovery plans are in place across all health groups. Recovery plans commenced July 18, monitored via Performance and Activity meetings. The Trust is reviewing outpatient appointments, all plans include improvement trajectory.

Yorkshire and Humber Commissioning Support

## North Lincolnshire Quality Exception Summary

| Indicator Reference |
|---|
| StaffEMAS |
| **Report Area:** |
| Staffing |
| **Provider** |
| EMAS |
| **Lead Officer: Chloe Nicholson** |

| Period | Tolerance | Actual | YTD | Status |
|---|---|---|---|---|
| Jun-18 | | | | |

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**Underlying Cause/Supporting Narrative**

Staff abstraction through sickness higher than expected, a comprehensive sickness improvement plan has been developed and is being implemented. EMAS continues to recruit frontline staff and utilise voluntary ambulance services and private ambulance services to meet demand. In addition to this, EMAS has developed workforce improvement plans at divisional and regional levels. These plans will be implemented as part of the Locality Development Plan for each Division and will be reviewed by commissioners via the Contract Management structure.

Yorkshire and Humber Commissioning Support

## North Lincolnshire Quality Exception Summary

| Indicator Reference |
|---|
| RiskEMAS |
| **Report Area:** |
| Risk Management |
| **Provider** |
| EMAS |
| **Lead Officer: Chloe Nicholson** |

| Period | Tolerance | Actual | YTD | Status |
|---|---|---|---|---|
| | | | | |

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**Underlying Cause/Supporting Narrative**

The CCG has identified a reduction in the number of incidents and concerns raised in relation to emergency ambulance response times. These improvements appear to be linked to improved ambulance response times.

The CCG's Accountable Officer is liaising with the EMAS Chief Executive Officer to review actions undertaken by EMAS to improve performance and the quality of EMAS services provided in North Lincolnshire, and the position continues to be reviewed via the EMAS County Commissioning Meeting and the EMAS Clinical Assurance Group.

Yorkshire and Humber Commissioning Support

## North Lincolnshire Quality Exception Summary

| Indicator Reference |
|---|
| StaffNLaG |
| **Report Area:** |
| Staffing |
| **Provider** |
| NLaG |
| **Lead Officer: Chloe Nicholson** |

| Period | Tolerance | Actual | YTD | Status |
|---|---|---|---|---|
| Sep-18 | | | | |

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**Underlying Cause/Supporting Narrative**

The **Medical & Dental vacancy position** has decreased significantly to 18.67% against the target of <15% which is an in month decrease of 2.44%. This decreasing position is positive as the vacancy position has been gradually improving over the last 5 months due to targeted recruitment activity and the August rotation fill resulting in a significant reduction. This time last year the vacancy rate stood at 25.66% therefore the Trust is in a much improved position. Ongoing activity has created a substantial pipeline of doctors that the Trust is working to convert into starters; this pipeline currently stands at 81 doctors awaiting a start date. The vacancy position is equivalent to 115.17 whole time equivalent vacancies left unfilled. The **Registered Nursing vacancy position** remains outside of target resulting in an increased vacancy factor of 12.05%, against the target of 6% which is an in month increase of 0.89%. The vacancy position dropped in October 2017 but has been steadily increasing month on month. This is the highest it has been in the last year. Despite this, when compared to this time last year the Registered Nursing vacancy position remains largely unchanged, standing at 12.10% in August 2017. It is predicted that the vacancy rate for Registered Nursing will
decrease in the next 2 months due to the Newly Qualified Nurse intake over the next few months. If the Nursing vacancy position follows the same pattern as last year, it will start to increase again during the winter months.
Despite the noticeable reduction last month, the **Unregistered Nursing vacancy rate** has increased slightly in month to 7.95%, an increase of 0.4%. Alongside the high vacancy rate there is a high number of Healthcare Assistant agency and bank shifts being requested. The vacancy rate is significantly outside the target of <2%. The high vacancy rate is due to Band 2 and 3 Healthcare Assistant vacancies which are highest within Surgery and Critical Care and Communities and Therapies.