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UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 31 JULY 2017

To:	Trust Board
From:	Karen Brown, Director of Finance
Date:	5th September 2017
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for July 2017

Author/Responsible Director: Karen Brown, Director of Finance

Purpose of the report:
To update the Board on the performance of the Trust for the period ended 31st July 2017, provide analysis to support decisions, action or initiate change and set out proposed plans and trajectories for performance improvement.

The report is provided to the Board for:

Decision	√	Discussion	√
Assurance	√	Information	√

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

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

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

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

Resource implications (eg Financial, HR) None

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

Patient and Public Involvement (PPI) implications None

Equality impact

Information exempt from disclosure

Requirement for further review?

Executive Summary for period of 31st July 2017

☒ 4 hour waiting time target – performance of 78.38% in July 2017 (a fall from the June position)
☒ 1 of the 9 national cancer targets were achieved in June 2017 (1 months in arrears)
☒ 18wk RTT Incomplete Standard for July 2017 is at 88.79%
☒ 6wk Diagnostic Standard – July performance was 98.64%
☑ Agency Spend – on target to improvement
☑ The Trust has now identified high level schemes to improve efficiency totalling £18.2m and these have been included within the financial recovery plan submitted to NHS Improvement

Successes:

The Trust's financial situation still reflects some positives including control over agency and our expenditure against plan. The Trust have also maintained a 3 month consecutive improvement regarding staff turnover.

DTOC at PHB has reduced significantly since the pilot of new leadership with Adult Social Care. Levels are now similar across the whole trust and have remained low.

Bed occupancy remains at approximately 95% on the Lincoln and Boston sites. The effects of Red to Green and the implementation of the Pride and Joy system at Pilgrim Hospital have been significant and can be evidenced from the drop in occupancy with the implementation on each site:

Challenges:
The Trust has seen challenged performance against RTT, A&E & Cancer.

In A&E, there has been continued demand pressures the largest increases in demand have been felt at Pilgrim Hospital with attendances over 10% above plan for June and July. Volumes through the A&E department have been at times been equal to LCH. Acuity has been high with significantly higher volumes of ambulance attendances coming into the Pilgrim site leading to delays and ambulances queuing:

RTT performance remains under the standard although the trend is moving in a positive direction towards the agreed improvement trajectory. There are key speciality areas (ENT, Cardiology, Community Paeds and Dermatology) where the Clinical Directorates believe that a significant reduction in referrals over a 3 month period into these areas is required in order to achieve the improvement in new and follow-up patient backlog reduction which is required commissioners have been made aware of this and discussions continue at various level and is being addressed contractually.

The 62 Day Classic standard continues to remain the most challenged standard and work continues to improve the quality of the patient journey on the understanding that improvements in this will work directly towards achievement of this standard. The Trust is driving improvement in cancer pathways via the Cancer Action Plan which is reviewed fortnightly at the Cancer Recovery and Delivery Group.
Representatives from the Trust meet fortnightly with leads from CCGs, NHSI, NHSE and the cancer network to review support required from the health system as a whole.

Looking forward:

The Trust continues to focus on exception Reports to identify future milestones to recovery, particularly or where there is a trending decline in performance, or where KPIs have been red or amber for three consecutive months.

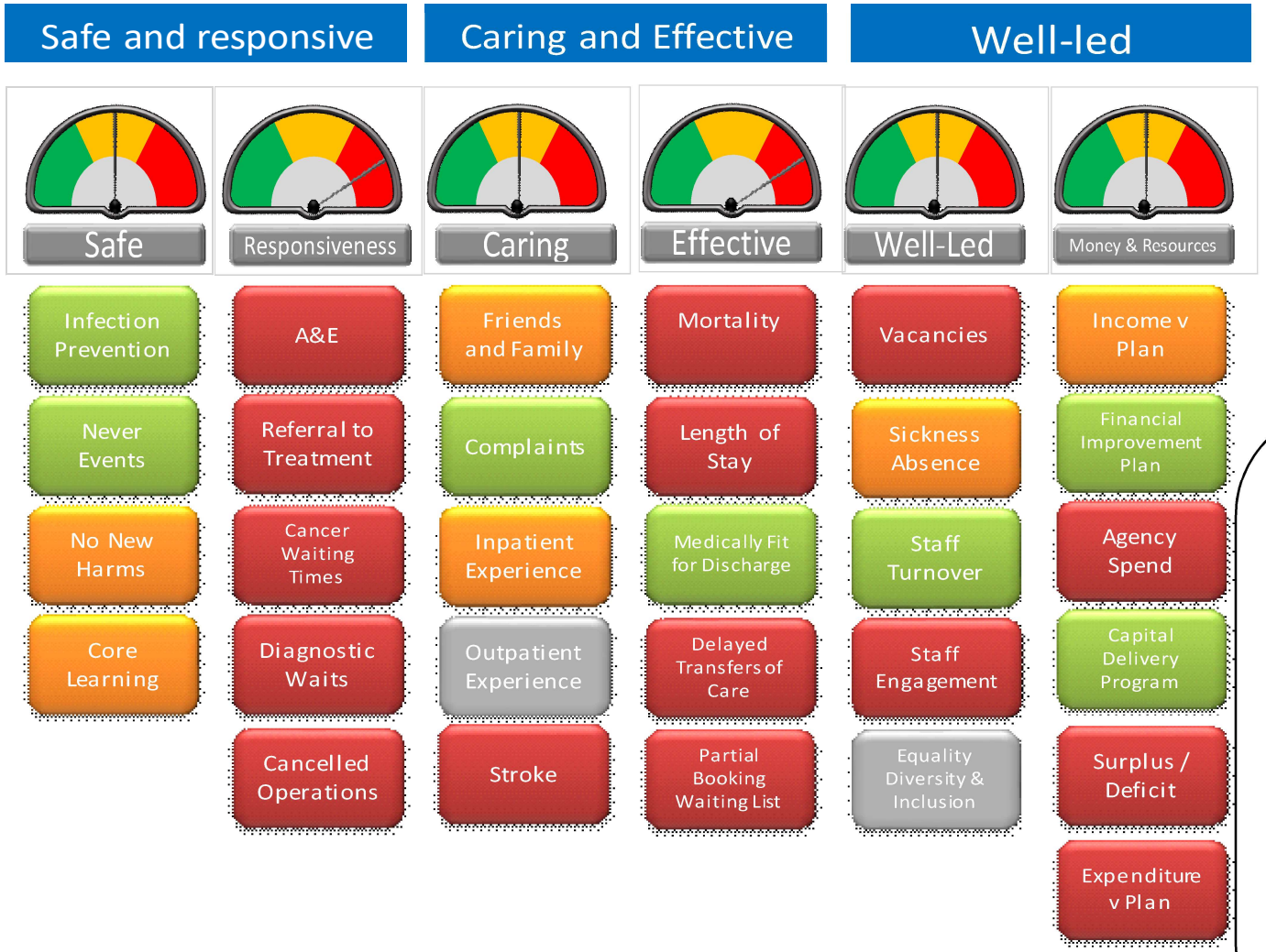
The Trust continues to focus on delivery against the 4 STP performance trajectories and supporting work-streams. Fundamental to this is ensuring all actions attached to recovery plans are achieved with a view to noted improvement in October including recovery in Diagnostics.

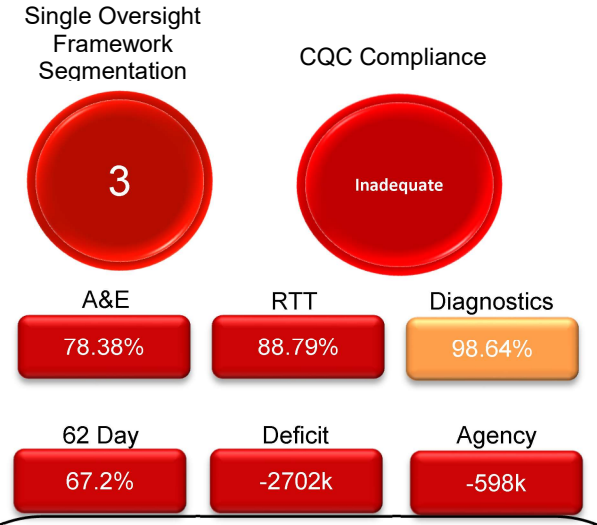
The Trust is also focussed on the delivery of an improved financial run rate. A financial recovery plan to support this has been submitted to NHSI and the Trust is committed to its delivery.

Karen Brown
Director of Finance & Corporate Affairs
August 2017

Integrated Performance Report

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





Deteriorated:
Domain: Responsiveness
A&E 4 hr wait has shown a deterioration for July
Domain: Responsiveness
18 weeks incompletes recorded a lower score than last month's 89.89%
Domain: Responsiveness
Diagnostics wait has dipped in performance at 98.64% compared to last month's 99.37%

Most improved:
Domain: Well Led
Staff turnover has maintained a good performance three months in a row
Domain: Safe
New Harm Free Care target has been achieved two months consecutively
Domain: Responsiveness
Cancer 62 Day Classic recorded an improvement to 67.2%

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

Detailed Trust Board Performance

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Safe						
Infection Control						
Clostrum Difficile (post 3 days)	Monthly	Datix	59	24	2	4
MRSA bacteraemia (post 3 days)	Monthly	Datix	0	1	0	1
MSSA	Monthly	Datix	8	6	1	1
ECOLI	Monthly	Datix	32	18	4	2
Never Events	Monthly	Datix	0	0	0	0
No New Harms						
Serious Incidents reported (unvalidated)	Monthly	Datix	0	97	20	29
Harm Free Care %	Monthly		95%	91.45%	92.20%	90.64%
New Harm Free Care %	Monthly		98%	98.21%	99.30%	98.06%
Catheter & New UTIs	Monthly		1	1	0	3
Falls	Monthly	Datix	3.90	3.56	3.76	3.69
Medication errors	Monthly	Datix	0	621	174	162
Medication errors (mod, severe or death)	Monthly	Datix	0	93	19	29
Pressure Ulcers (PUNT) 3/4	Monthly			21	4	4
VTE Risk Assessment	Monthly		95%	97.22%	97.46%	97.25%
Core Learning	Monthly	ESR	95%	90.58%	90.83%	90.42%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Caring						
Friends and Family Test						
Inpatient (Response Rate)	Monthly	Envoy Messenger	26%	28.25%	30.00%	24.00%
Inpatient (Recommend)	Monthly	Envoy Messenger	96%	91.00%	90.00%	94.00%
A&E (Response Rate)	Monthly	Envoy Messenger	14%	20.25%	20.00%	18.00%
A&E (Recommend)	Monthly	Envoy Messenger	87%	80.75%	80.00%	80.00%
% of staff who would recommend care						
% of staff who would recommend work						
Complaints						
No of Complaints received	Monthly	Datix	70	220	55	56
No of Complaints still Open	Monthly	Datix	0	970	247	234
No of Complaints ongoing	Monthly	Datix	0	132	26	32
Inpatient Experience						
Mixed Sex Accommodation	Monthly	Datix	0	0	0	0
eDD	Monthly	EDD	95%	83.33%	86.86%	87.03%
PPCI 90 hrs	Quarterly		100%	95.15%	97.33%	97.33%
PPCI 150 hr	Quarterly		100%	86.85%	85.33%	85.33%
#NOF 24	Monthly		70%	62.52%	53.85%	64.91%
#NOF 48 hrs	Monthly		95%	92.75%	90.77%	89.47%
Dementia Screening	1 month behind		90%	92.33%	91.88%	91.56%
Dementia risk assessment	1 month behind		90%	96.53%	95.77%	95.42%
Dementia referral for Specialist treatment	1 month behind		90%	86.53%	81.04%	90.32%
Stroke						
Patients with 90% of stay in Stroke Unit	1 month behind	SSNAP	80%	81.97%	70.90%	81.00%
Sallowing assessment < 4hrs	1 month behind	SSNAP	80%	68.77%	69.00%	70.60%
Scanned < 1 hrs	1 month behind	SSNAP	50%	59.50%	56.30%	60.50%
Scanned < 12 hrs	1 month behind	SSNAP	100%	97.33%	95.00%	98.70%
Admitted to Stroke < 4 hrs	1 month behind	SSNAP	90%	66.83%	58.80%	66.70%
Patient death in Stroke	1 month behind	SSNAP	17%	16.43%	12.70%	18.60%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Responsiveness						
A&E						
4hrs or less in A&E Dept	Monthly	Medway	87.0%	79.68%	78.37%	81.47%
12+ Trolley waits	Monthly	Medway	0	0	0	0
AEC						
Number of patients seen in AEC (Lincoln only)	1 month behind	Medway		265	295	263
% Readmissions within 7 days (Lincoln only)	1 month behind	Medway	0.00%	12.30%	11.79%	13.02%
% Patients discharged by LoS (Lincoln only)	1 month behind	Medway	0.00%	9.89%	2.03%	2.08%
% of G&A non-elective admissions to AEC	Monthly	Medway	25.00%	16.12%	0.00%	16.42%
RTT						
52 Week Waiters	Monthly	Medway	0	9	2	8
18 week incompletes	Monthly	Medway	90.0%	89.15%	88.79%	89.89%
Cancer - Other Targets						
62 day classic	1 month behind	Somerset	85%	70.20%	67.20%	65.60%
2 week wait suspect	1 month behind	Somerset	93%	90.37%	91.50%	90.40%
2 week wait breast symptomatic	1 month behind	Somerset	93%	75.73%	74.60%	80.00%
31 day first treatment	1 month behind	Somerset	96%	95.70%	96.40%	93.60%
31 day subsequent drug treatments	1 month behind	Somerset	98%	99.07%	97.20%	100.00%
31 day subsequent surgery treatments	1 month behind	Somerset	94%	91.13%	91.60%	92.30%
31 day subsequent radiotherapy treatments	1 month behind	Somerset	94%	93.17%	91.70%	92.00%
62 day screening	1 month behind	Somerset	90%	85.20%	82.80%	83.30%
62 day consultant upgrade	1 month behind	Somerset	85%	84.70%	82.00%	85.10%
104+ Day Waiters	1 month behind	Somerset		-	23	25
Diagnostic Waits						
diagnostics achieved	Monthly	Medway	99.1%	99.24%	98.64%	99.37%
diagnostics Failed	Monthly	Medway	0.9%	0.76%	1.36%	0.63%
Cancelled Operations						
Cancelled Operations on the day (non clinical)	Monthly	Medway	1.10%	3.93%	3.28%	3.02%
Not treated within 28 days. (Breach)	Monthly	Medway	0.00%	9.49%	3.92%	21.47%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Effective						
Mortality						
SHMI	Quarterly		100	110.85	111.39	111.39
Hospital-level Mortality Indicator	Quarterly		100	103.61	102.99	102.99
Length of Stay						
Average LoS - Elective	Monthly	Medway / Slam	2.8	2.75	2.98	2.79
Average LoS - Non Elective	Monthly	Medway / Slam	3.8	4.42	4.41	4.40
Medically Fit for Discharge	Monthly	Bed managers	60	58.50	58.00	67.00
Delayed Transfers of Care	Monthly	Bed managers	3.5%	4.56%	4.23%	4.17%
Partial Booking Waiting List	Monthly	Medway	0	5735	5231	5763

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Well Led						
Vacancies	Monthly	ESR	5.0%	10.92%	10.08%	11.05%
Sickness Absence	Monthly	ESR	4.5%	4.42%	4.53%	4.34%
Staff Turnover	Monthly	ESR	8.0%	5.74%	5.57%	5.78%
Staff Engagement						
Staff Appraisals	Monthly	ESR	95.0%	78.00%	83.00%	82.00%
Equality Diversity and Inclusion						

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Money & Resources						
Income	Monthly	Board Report Master	36415	138835	36010	35587
Expenditure	Monthly	Board Report Master	-40392	-169417	-42689	-42831
Efficiency Delivery	Monthly	FIMS report	1342	1698	1391	104
Surplus / Deficit	Monthly	FPIC Finance Report	-3977	-30582	-6679	-7244
Capital Delivery Program	Monthly	FPIC Finance Report	-615	-1662	-285	-769
Agency Spend	Monthly	Agency Staff Analysis	-1790	-9954	-2354	-2486

Responsiveness

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Responsiveness						
A&E						
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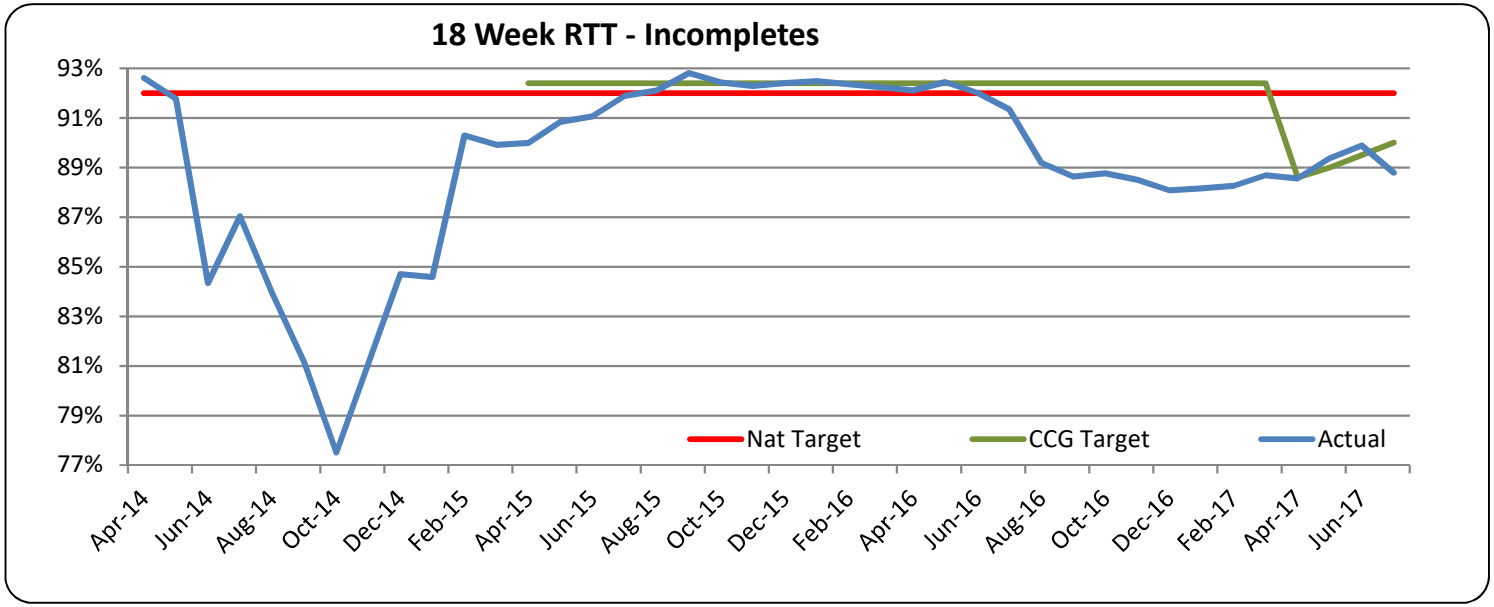
Referral to Treatment

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Referral to Treatment (18 weeks)	Owner:	Director of Operations
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance – Planned Care
Date:	5th September 2017	Reporting Period:	July 2017

Exception Details

In June the Trust reported performance of 89.9%, an improvement of 0.5% compared with the position in May. This was the Trust's highest performance since July 2016, with incomplete the number of incomplete patients over 18 weeks reducing to 2800.



At a national level the standard hasn't been achieved for 15 consecutive months, with an aggregated national performance in June of 90.3%.

The RTT incomplete performance for the end of July 2017 was 88.79%.

During the week immediately after the cyber-attack there were c.450 less clockstops than anticipated which negatively impacts on the Trust's 18 week+ backlog position.

In May the Trust cancelled 450 patients on the day (230 of the were between 13-15th May, therefore linked to the cyber-attack) and 75 before the day of their surgery. In June the Trust cancelled 191operations on the day and 91 before the day. In July the Trust cancelled 204 operations on the day and 68 before the day

June's performance was 0.4% ahead of the externally agreed trajectory for RTT performance.

There are long waiting times for first appointments in a number of specialities. There has been a reduction in the number of patients waiting over 12 weeks on the open referrals waiting list, reducing from 2288 at the end of May to 1848 on 11th August, however Gastro and ENT still have patients waiting over 30 weeks on the open referrals waiting list.

In the first 3 months of 2017/18 the Trust's activity has been above contracted levels in the following specialties, which are currently performing below 92%:

- Endocrine (24%)
- General Surgery (5%)

- ENT (2%)
- Gastroenterology (3%)

Following the fire at Pilgrim, capacity for daycases has been restricted for the subsequent 5 month period due to the resultant ward moves, and reduced available bed spaces for these patients, which reduces daycases by c.30 patients per week.

As at 18th August there were two confirmed patients waiting over 52 weeks on an incomplete pathway at the end of July. Harm reviews had been completed for these two patients and no harm was identified as being caused by the delays in their treatment.

178 patients waited over 12 weeks from referral for their first appointment. As at 18th August harm reviews had been completed for 85 of these patients by the lead clinician for the patients care. 80 reported no harm, 4 reported low harm and 1 reported moderate harm. The Trust's duty of candour policy will be followed relating to the case where a patient experienced moderate harm as a result of these delays.

What action is being taken to recover performance?

The Executive Team wrote to all Clinical Directorates in May requesting confirmation of the speciality level plans that they have developed in order to address the issues within planned care identified within this paper by the end of September. All Clinical Directorates have produced plans and performance against trajectories is being monitored and challenged on a daily basis.

Delivery of additional outpatient clinics over and above core capacity forms the basis of the majority of the plans. The additional Clinical Directorate capacity is proposed to be delivered by exiting staff working additional hours, and also the use of agency locums in specialities such as Cardiology, Respiratory and Rheumatology.

Adverts are being processed for new Consultant posts within Neurology and Endocrine following Business Case approval. Two new Gastro Consultants will be in post at Lincoln by September, which will make that service fully established.

The Clinical Directorates have completed a range of further actions to improve processes within speciality areas and increase capacity in order to achieve the rapid improvements in the key planned care metrics highlighted within this report. These actions have led to continued improvements in RTT incompletes performance, and reductions in open referrals and PBWL overdue backlogs. However, further actions are still ongoing including:

- Strengthening referral grading processes
- Ongoing validation of open referral and partial booking waiting lists
- Expansion of nurse-led clinics
- Work in collaboration with CCGs to introduce new pathways for the management of certain conditions within the community – for example Diabetes and Community Paeds
- Virtual clinics – recently commenced within ENT
- Reviewing pathways to adjust secondary care approach to follow-up provision
- Outsourcing activity – Commenced within General Surgery and ENT. Patients identified within Urology for outsourcing. Arrangements for Medinet to provide additional on-site capacity within Dermatology from early September..

There are key speciality areas (ENT, Cardiology, Community Paeds and Dermatology) where the Clinical Directorates believe that a significant reduction in referrals over a 3 month period into these areas is required in order to achieve the improvement in new and follow-up patient backlog reduction which is required. In June the Trust made a

request to the CCGs for a divert of routine referrals into these four specialities away from ULHT. This request has been discussed in a number of forums with the commissioners. Lincs East CCG have agreed to a divert in routine referrals in these specialities from ULHT from 4th August for a period of 3 months. Lincs West CCG, South Lincs CCG and South-West CCG have not agreed to a service divert into these specialities at this time.

The Neurology Service will open to headache patients, where the recently approved community headache pathway has been utilised, from September. The service remains closed to routine referrals for all other conditions at present as it works through the backlog partial booking overdues which remain within that service, and whilst further pathway work is led by the CCGs.

What is the recovery date?

October 2017

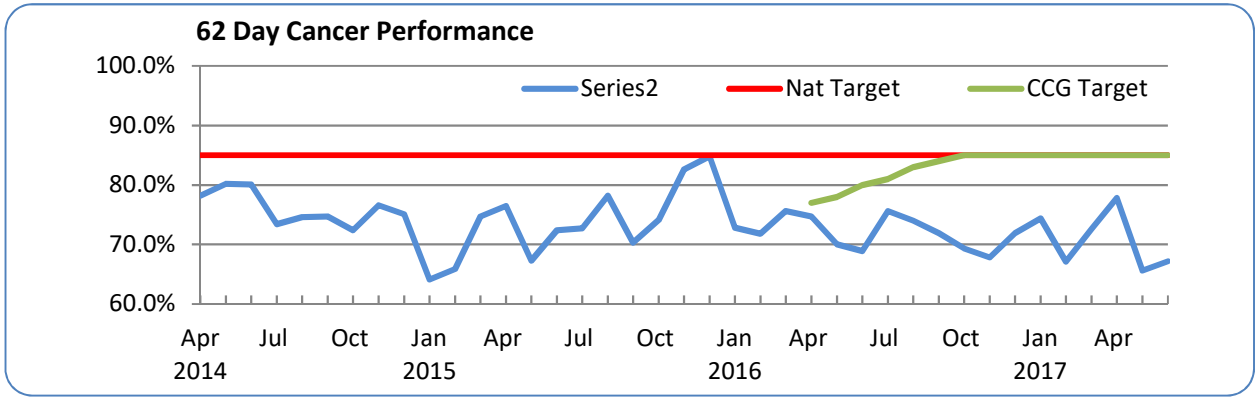
Cancer Waiting Times – 62 Day

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Cancer Waiting Times (62 Day)	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance – Planned Care
Date:	5th September 2017	Reporting Period:	June 2017

Exception Details

The Trust achieved a performance of 67.4% against the 62 day classic standard in June.



The Trust achieved 1 out of the 9 cancer standards.

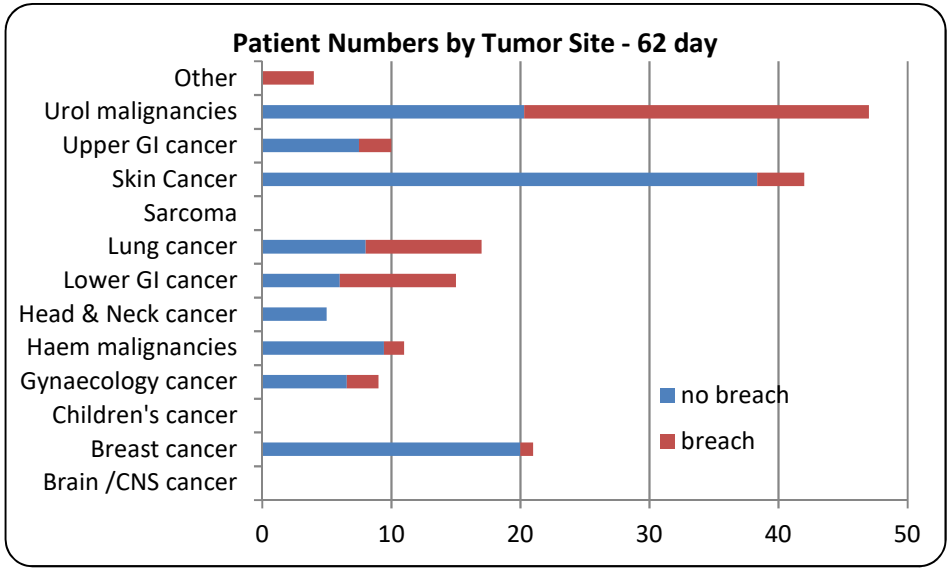
The 62 Day Classic standard continues to remain the most challenged standard and work continues to improve the quality of the patient journey on the understanding that improvements in this will work directly towards achievement of this standard. The Trust recorded 176.5 treatments during June on this pathway, which is the highest number of treatments for over 18 months. The RCAs for the 62 patients in June who were 62 day breaches found a number of key themes in terms of access to diagnostics within ULHT, particularly Endoscopy and CT guided biopsies were slower than required for a significant proportion of patients on 62 day pathways. In addition, delayed access to specialist tests at tertiary centres (such as EBUS and EUS) as well as outpatient and theatre capacity introduced further waiting periods into the 62 day pathways for our patients, deteriorating ULHT's performance. A significant number of patient choice and fitness delays also contributed to the Trust's performance position in June. Delays in admin processes were also found in an unacceptable number of patient pathways.

The impact of the cyber-attack effected June's performance, particularly relating to diagnostic and pathology turnaround times.

As of 15th August there are 7 pts on or over 104 days without an agreed treatment plan: 3 x Urology, 1 x Colorectal, 1 x Lung, 1 x Gynaecology, 1 x Brain. 3 of the 7 have confirmed cancer diagnosis.

The Trust treated 22 patients at 104 days or over during June, completing RCAs for all 22 patients. Due to the length of these pathways these patients had multiple reasons for delays in their pathways, as follows:

- 13 cases included complexity or procedural factors
- 8 cases included patient choice delays
- 7 cases included patient fitness factors
- 7 cases included Outpatient capacity
- 5 cases included tertiary diagnostic delays
- 5 cases included theatre capacity restrictions



- 5 cases included Endoscopy capacity
- 5 cases included cyber-attack delays
- 3 cases included admin delays
- 2 cases included CT delays
- 2 cases included tertiary treatment delays
- 1 case included Oncology capacity delays
- 1 case included MRI capacity restrictions
- 1 case included U/S capacity restrictions
- 1 case included pathology delays
- 1 case included First Appointment delays
- 1 case included delays within the MDT
- 1 case included chemo delays

The Trust has completed the first month's full review of any potential harm related to excessive waits for cancer treatment (104 + Day Waits): 22 Harm Reviews issued. 7 have identified no harm, 1 has identified a low level of harm, 1 has identified a severe level of harm, 2 clinicians were unable to identify if any harm was caused or not. The remainder are awaiting clinical feedback. Moderate and severe levels of harm will be reviewed by the Medical Director for onward management.

The Trust has made significant progress over the last 2 months in reducing the size of the cancer PTL backlog of patients over 62 days and over 104 days, as demonstrated below, however as the Trust has treated an increased number of long waiters this has had a negative impact on the reported performance figures.

w/c	12/6	19/6	26/6	3/7	10/7	17/7	24/7	31/7	7/8	14/8
62 day+	157	137	113	108	89	94	70	74	68	62
104 day+	34	32	26	21	14	15	9	7	8	5

What action is being taken to recover performance?

The Trust is driving improvement in cancer pathways via the Cancer Action Plan which is reviewed fortnightly at the Cancer Recovery and Delivery Group.

Key actions being undertaken in the coming weeks include:

- Pilot utilisation of a Urology Cancer Business Manager role – This role has been in place for the last 5 weeks, and will continue until the end of August in its current form. In the last 5 weeks the number of patients over 62 days on the Urology PTL has reduced from 50 down to 18 patients.
- Full roll out of level 1 beds at Lincoln – Direct admissions into the 6 level 1 beds from 7th August, with a plan in place for the number of level 1 beds to increase to 8 from 14th August.
- Pilot MRI prostate within Urology pathways – Clinical agreement reached relating to revised pathway which will see 2ww clinics created which feed directly into MRI and TRUS biopsy slots. Sign off of these shared pathways with UHL as part of the Urology Alliance is required prior to the service commencing. This is expected to be achieved in September.
- Continuation of Endoscopy backlog clearance – Medinet continue to provide addition sessions at weekends. A procurement exercise for a longer term outsourcing arrangement commenced on 7th July, with a closing date of 1st September. Evaluations will be completed in early September, with the expectation of a start date in November. Alongside this a business case for increased internal Endoscopy capacity has been completed.
- Continuation of extended CT capacity – External funding has enabled the Radiology Service to plan to continue the extended CT capacity until December 2017. An application has been made for additional central funding in order to continue this until the end of the financial year.
- Roll out of lower GI STT at Pilgrim – Delays with job matching currently being addressed in order to enable advert to be published.
- Oncology administrative optimisation – Chemo-scheduler business case has been approved, and the posts are out to advert. This will improve co-ordination of chemotherapy capacity and enable full utilisation of the recently developed Oncology scheduling tool.

- Histology turnaround times – Performance meetings commenced with Path Links. Review of MDT arrangements for pathology to be completed. Path Links to seek additional locum Consultant capacity and develop digital technology solutions. Raising awareness internally around utilization of 2ww priority stickers.
- Improve Radiology reporting times – Radiology Dept are piloting earlier utilization of outsourcing capacity within cancer pathways.
- Radiology to reduce CT biopsy delays – Trust wide booking process in place since beginning of August.

Representatives from the Trust meet fortnightly with leads from CCGs, NHSI, NHSE and the cancer network to review support required from the health system as a whole. Key actions include:

- SET funding of £250k for cancer pathway improvement has been agreed, schemes include:
    - Temporary additional cancer tracking capacity to increase tracking frequency
    - Project Lead post facilitating improvements within tracking processes, review of pathways, MDT support and tertiary communication
    - Urology/Lower GI Operations Manager for Cancer
    - Radiology Cancer Co-ordinator
    - External support to review whole pathway capacity/demand
- Review best practice PTL management from other organisations to inform ULHT systems – visits to other providers commenced.
- External clinical support to review long waiting patient pathways – arranged for 11th September.

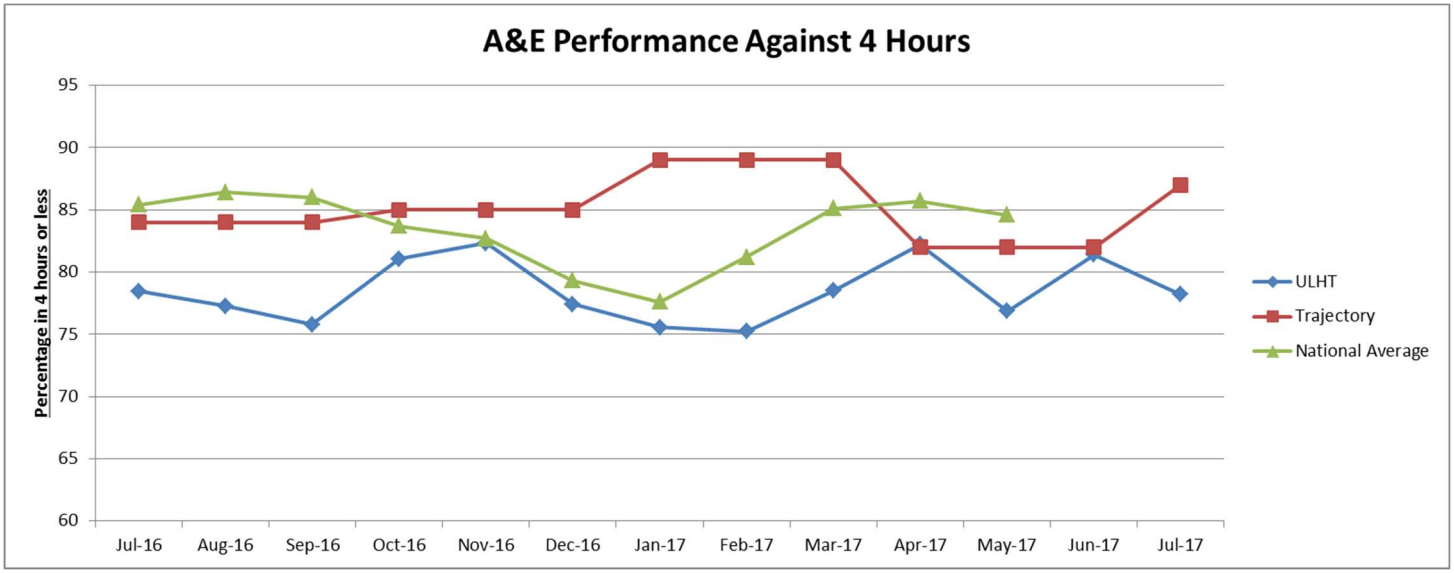
A&E 4 Hour Standard

Executive Responsibility: Mark Brassington – Chief Operating Officer

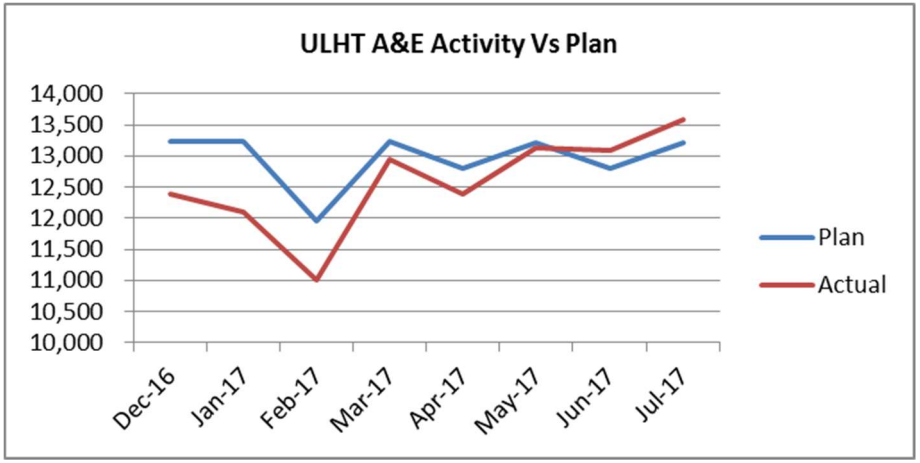
KPI:	**4 Hour Wait (A&E)**	**Owner:**	Chief Operating Officer
Domain:	**Responsive**	**Responsible Officer:**	Director of Operations / Deputy Director of Urgent Care
Date:	5th September 2017	**Reporting Period:**	July 2017

Exception Details

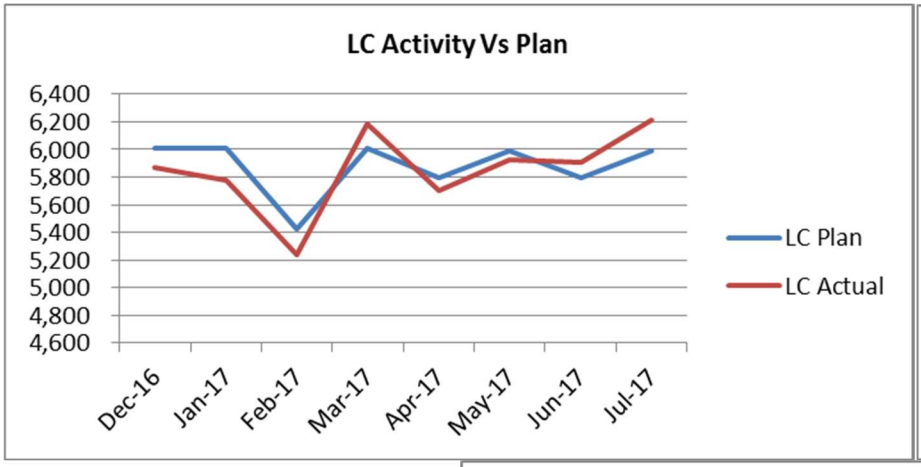
ULHT performance against the 4 hour target for July was 78.22%, deteriorating from 81.38% in June. The Trust's trajectory for July increased from 82% to 87%, meaning the Trust was 8.78% behind trajectory.

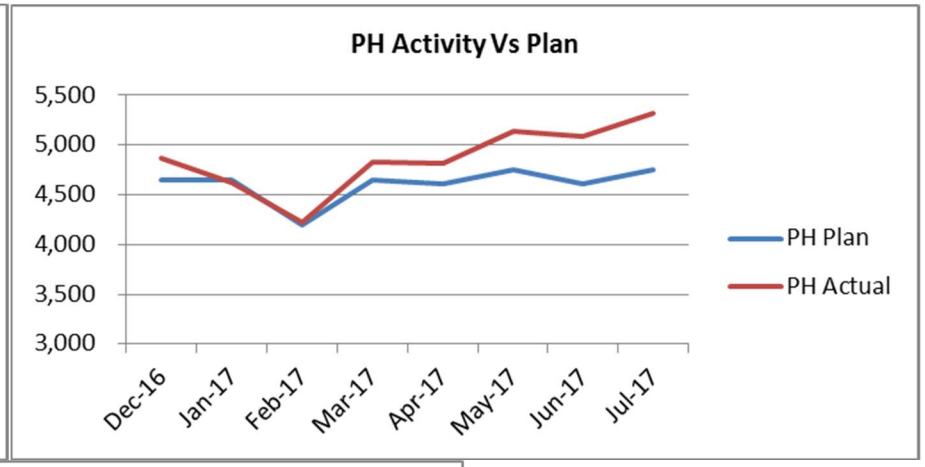


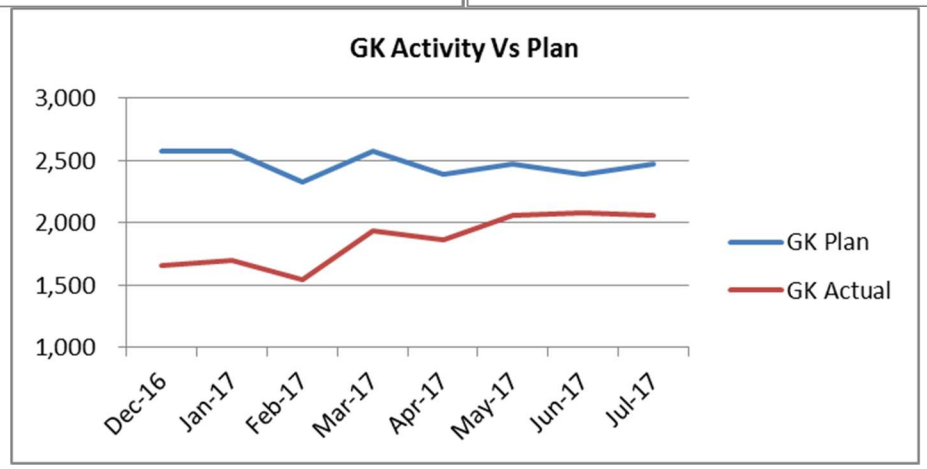
Activity was 2.7% above plan for the trust in July:



Lincoln County Hospital was above plan by 3.5%, whilst Pilgrim Hospital, Boston continues to see attendances significantly above plan (10% above plan in June, 10/5% in July). The activity at Grantham, whilst remaining below plan due to the reduced hours, remains consistently higher than after the hours were originally restricted (July 19% below plan):



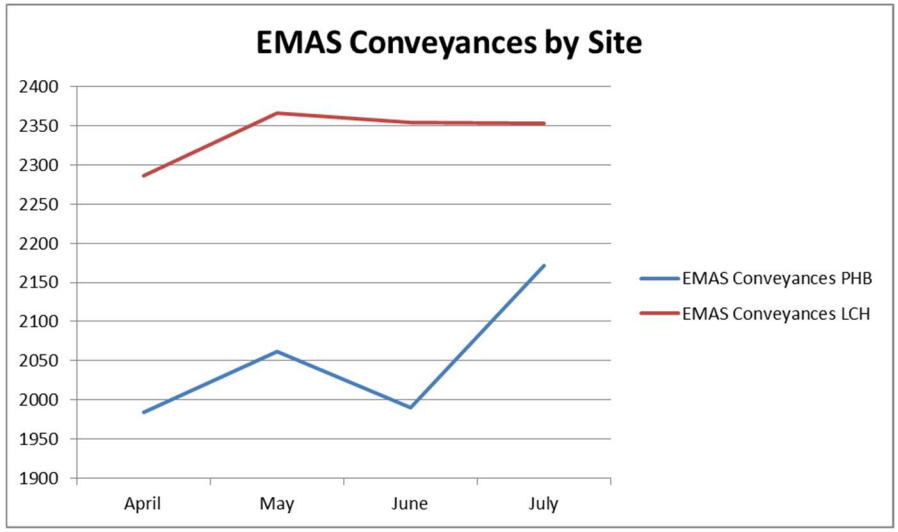




2 Issues Affecting Performance

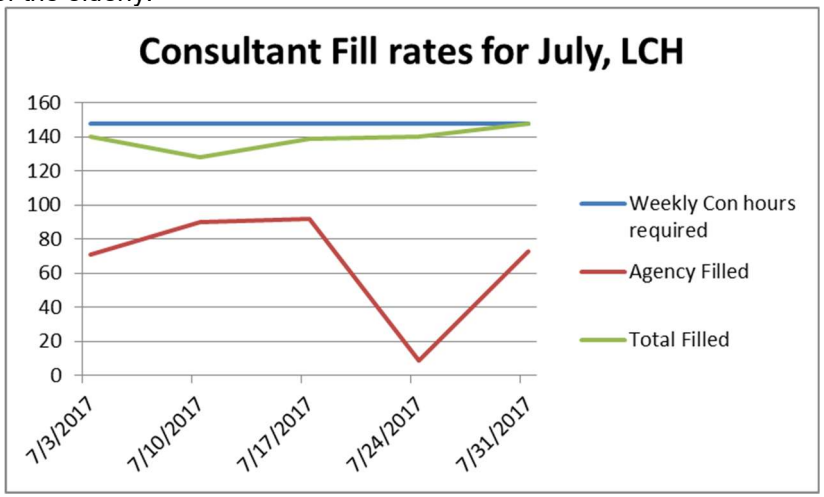
2.1 Demand

The largest increases in demand have been felt at Pilgrim Hospital with attendances over 10% above plan for June and July. Volumes through the A&E department have been at times been equal to LCH. Acuity has been high with significantly higher volumes of ambulance attendances coming into the Pilgrim site leading to delays and ambulances queuing:

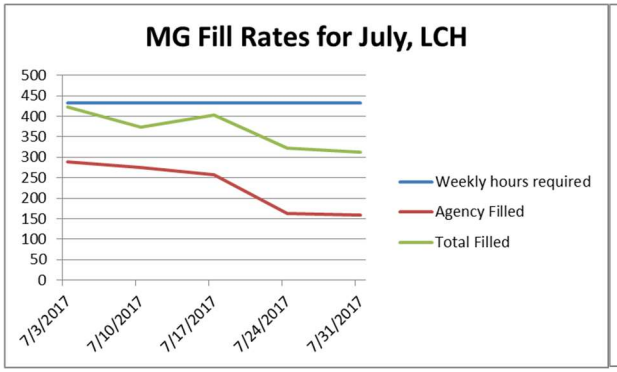


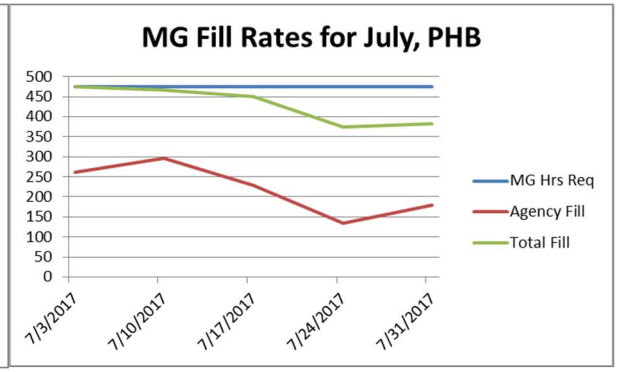
2.2 Staffing

Significant agency gaps have prevailed on both the Lincoln and Boston sites since mid-July with the onset of the school holidays. This has particularly affected the middle grade rotas. At Lincoln the agency gaps on the consultant rota became a serious issue during w/c 24th July but this was covered to a safe level with input from specialities such as oncology, trauma & orthopaedics and care of the elderly:



Neither site was able to backfill the gaps in middle grade doctor rotas however, minimum safe levels of staffing were achieved although performance was affected as a result. Throughout July deanery junior doctor posts were operating at 50% vacancy and combined with unplanned leave increased the demands on agency doctors. For two weeks during July Boston nursing teams had a significant gap in senior nursing capacity that could only be partially mitigated with nurses from other departments.





All of the above vacancies and gaps in rotas were forecast to improve from August, when agency rates showed some improvement, as well as a greatly improved fill from deanery junior doctor rotation.

3 Actions Taken to Address Performance

3.1 Immediate Response to the Poor Performance

In view of the issues around staffing at the onset of the summer holidays the Trust undertook specific immediate actions to try to secure safe services, including:

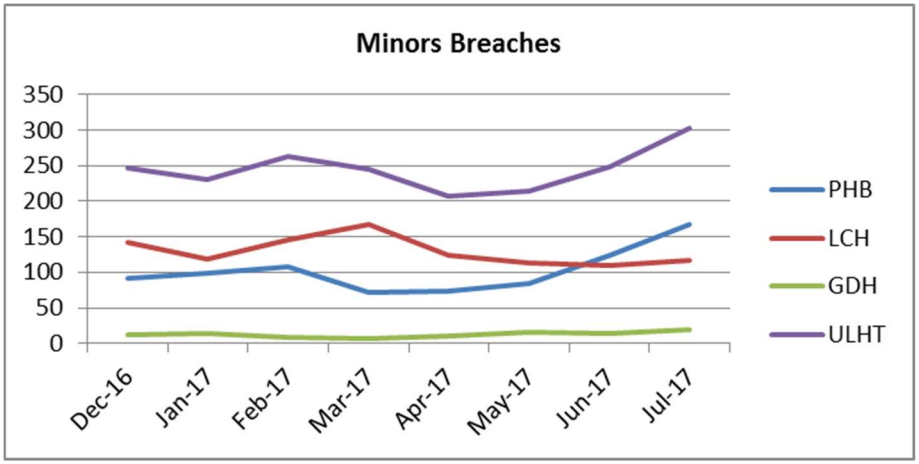
- On-call medical workforce converted to resident for Orthopaedics specialties (in addition to existing specialty input);
- 24 hour consultant rotas put in place at Lincoln where most effected, and increased consultant presence at Boston;
- Additional specialties support to ED (Acute Oncology, Anaesthesia/Intensivists, Urology amongst others) to cover junior gaps;
- Increased off framework usage agency.

3.2 7 Key Actions

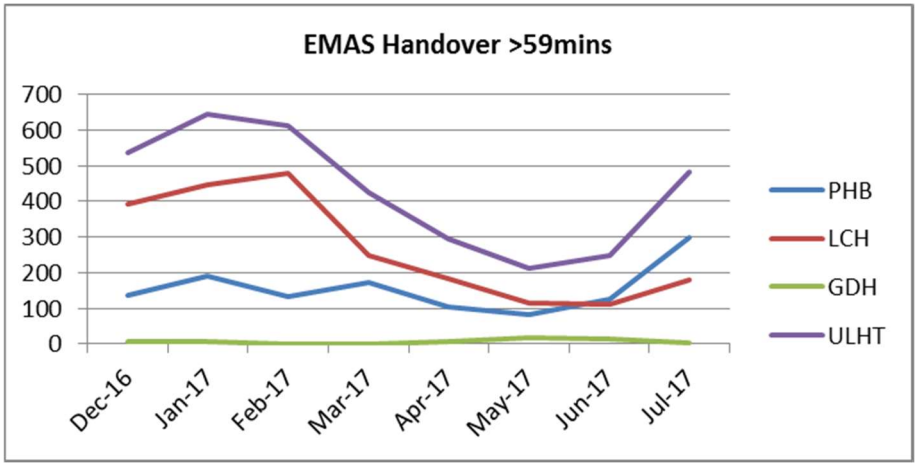
The performance of the clinical directorates continues to be monitored through the 7 key actions, despite issues with staffing, acuity and attendances.

i) Zero Tolerance of Minors Breaches

The trust saw a continued increase in minors breaches despite new middle grade rotas being put in place, ring fencing staff to areas such as minors. The significant shortfall in agency fill rates has impacted the ability to deliver this plan. Lincoln remains stable with a small decrease in minors since April.



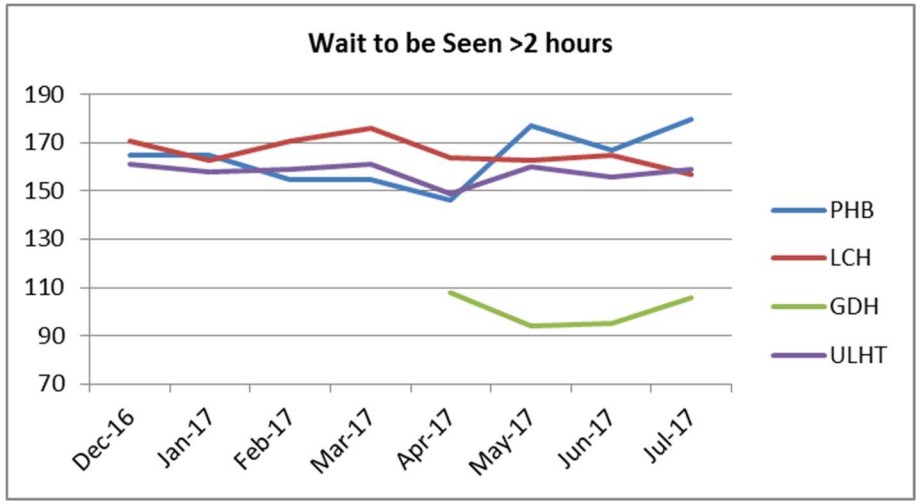
ii) Reduction in Ambulance handover waits to zero tolerance of over 1 hour



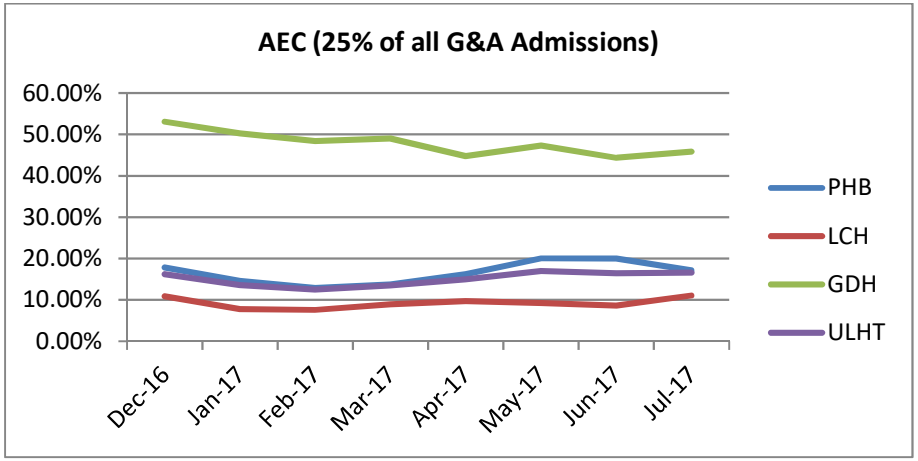
Increases in delayed handovers have been prevalent throughout the month due to the issues described above.

iii) Ensure Wait to be Seen is <2 hours @ 85th Centile

Small increases in waits noted at Boston, otherwise Lincoln continues to see a slow downward trend despite the staffing problems.



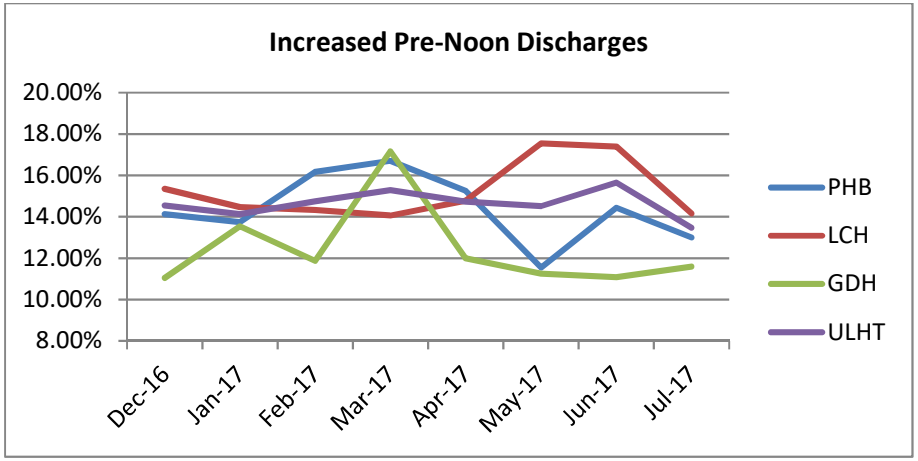
iv) Increased % proportion of patients through Ambulatory Emergency Care



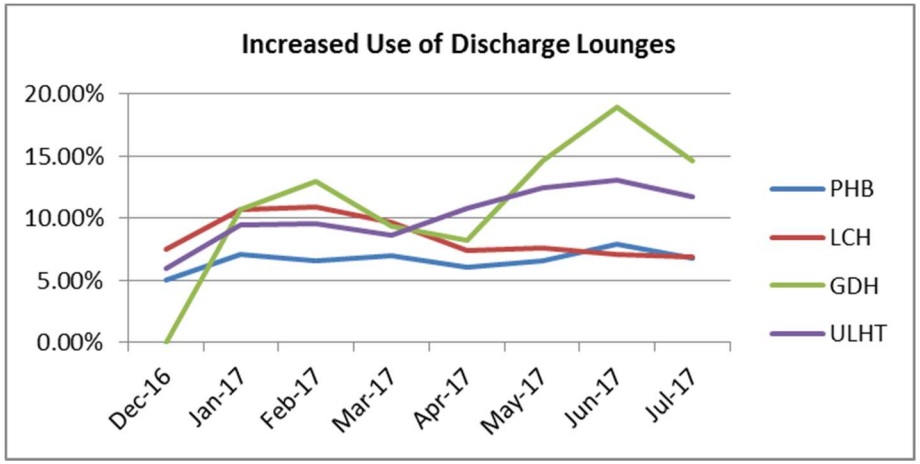
The small increase at LCH is likely to be part month effect of the new protocol for all GP admissions to go through A&E. This should increase further in August.

v) Increase number of discharges before midday

Significant challenges at Boston in particular with the increase in attendances, EMAS conveyances and issues with staffing. The site continues to struggle to find adequate discharges, outliers have increased as a result.



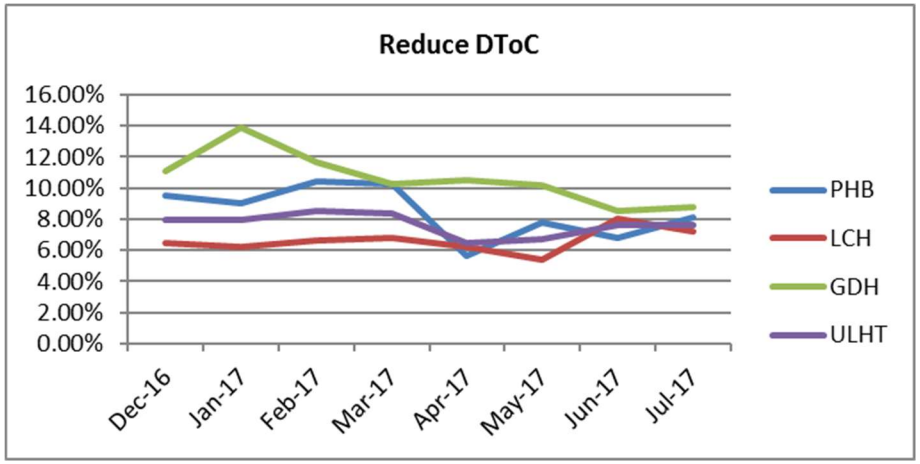
vi) Increased usage of discharge lounge



There has been little improvement in the use of discharge lounges to create early flow, other than at GDH.

vii) Reduce DToC

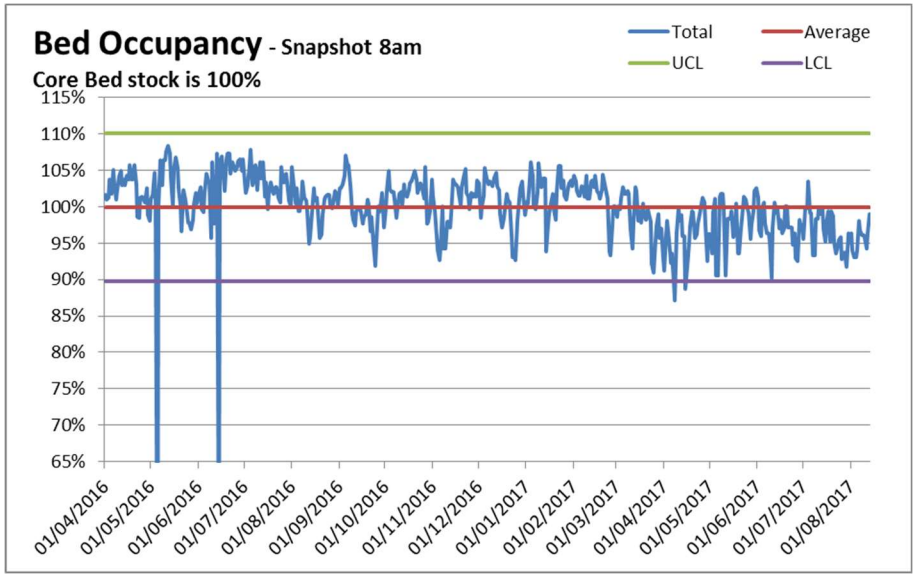
DTOC at PHB has reduced significantly since the pilot of new leadership with Adult Social Care. Levels are now similar across the whole trust and have remained low.



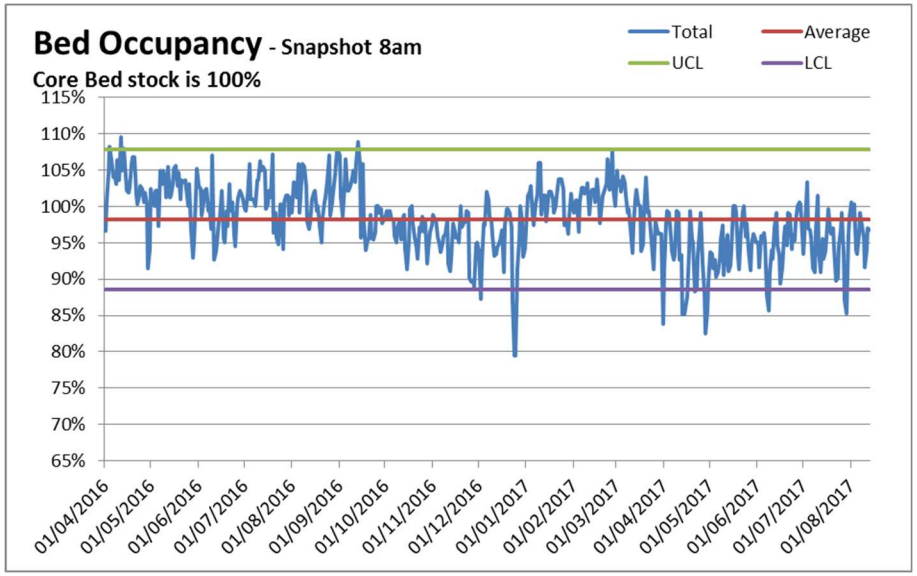
3.3 Red to Green and Bed Occupancy

Bed occupancy remains at approximately 95% on the Lincoln and Boston sites with Grantham significantly lower. The effects of Red to Green and the implementation of the Pride and Joy system at Pilgrim Hospital have been significant and can be evidenced from the drop in occupancy with the implementation on each site:

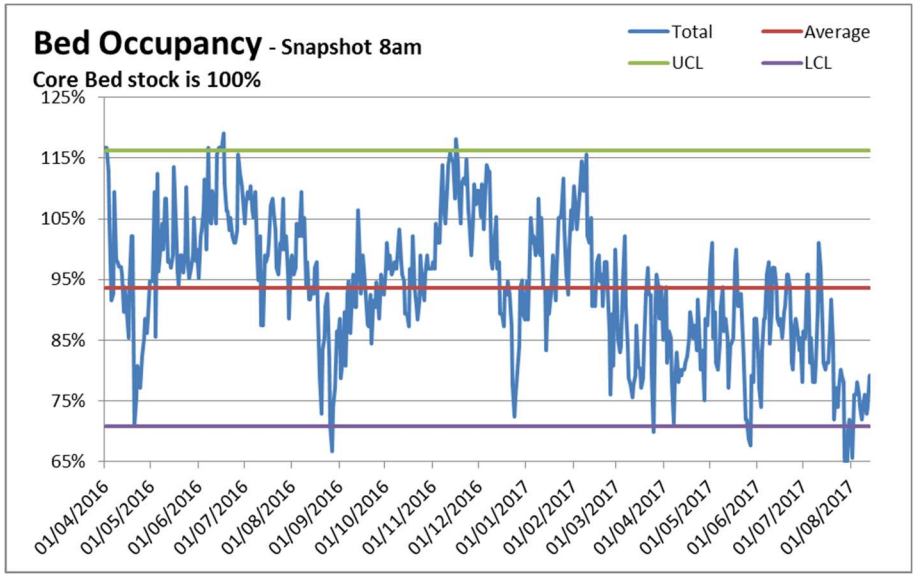
Lincoln:



Boston:



Grantham:



ULHT is an outlier for “Stranded Patients” (those with lengths of stay of 7 days and above) – see 3.5 below. In order to improve our position a full Stranded Review has been undertaken in early August. Results from this will be shared. However, some common issues that arose from both sites include:

- Data Quality – due to the number of IT systems in use the ward staff do not always discharge patients in a timely manner, meaning patients appear to have a longer length of stay;
- Plans were in place for patients but only for the current day and, in some cases, the next. Ward round forms were poorly completed for this section and clinicians were often not providing plans up to discharge;
- Patient Expectations – many patients refuse onward care. The trust provides leaflets that are meant to manage expectations and inform patients when they will expect to be discharged and to where this may be, however, these are not widely read;
- Few patients appeared up and dressed. The visiting teams suggested that expectations would be better managed if the trust adopted the “End PJ Paralysis” campaign;
- Mobility aids are not transported by ambulance services – often cited as no space available. Patients then are without familiar aids and therapists have to start getting them used to new equipment.

3.4 Site Plans

The Director of Operations has pulled together a Trust wide action plan which will be followed to ensure key actions are enabled.

3.5 SAFER

The Deputy Director of Operations – Urgent Care has updated the A&E Delivery Board on the SAFER Patient Flow Bundle. 100% of applicable wards are using the SAFER Patient Flow Bundle. Current compliance for every element of the bundle is 57%.

3.6 Primary Care Streaming

Architect plans have been shared with the clinical teams and approved. Plans to complete the building work are on track with a new facility based opposite the front of A&E at Lincoln and a corridor from the front of A&E to the back of the department at Pilgrim to allow access to primary care (which is to be based in and around existing Out of Hours facilities) without patients entering the A&E Department.

Plans to establish the streaming pathway are in place with nurses employed by ULHT. Protocols for streaming are being agreed with LCHS. The LCHS model is currently to provide Nurse Practitioners within the Primary Care Service, which ULHT has challenged as the trust feels it more appropriate to have GP’s within this service as per the Luton and Dunstable Model. Lincolnshire’s staffing constraints make this difficult however.

ULHT continues to engage in all meetings with commissioners and LCHS to ensure the best model is agreed and delivered on time.

Effective

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Effective						
Mortality						
SHMI	Quarterly		100	110.85	111.39	111.39
Hospital-level Mortality Indicator	Quarterly		100	103.61	102.99	102.99
Length of Stay						
Average LoS - Elective	Monthly	Medway / Slam	2.8	2.75	2.98	2.79
Average LoS - Non Elective	Monthly	Medway / Slam	3.8	4.42	4.41	4.40
Medically Fit for Discharge	Monthly	Bed managers	60	58.50	58.00	67.00
Delayed Transfers of Care	Monthly	Bed managers	3.5%	4.56%	4.23%	4.17%
Partial Booking Waiting List	Monthly	Medway	0	5735	5231	5763

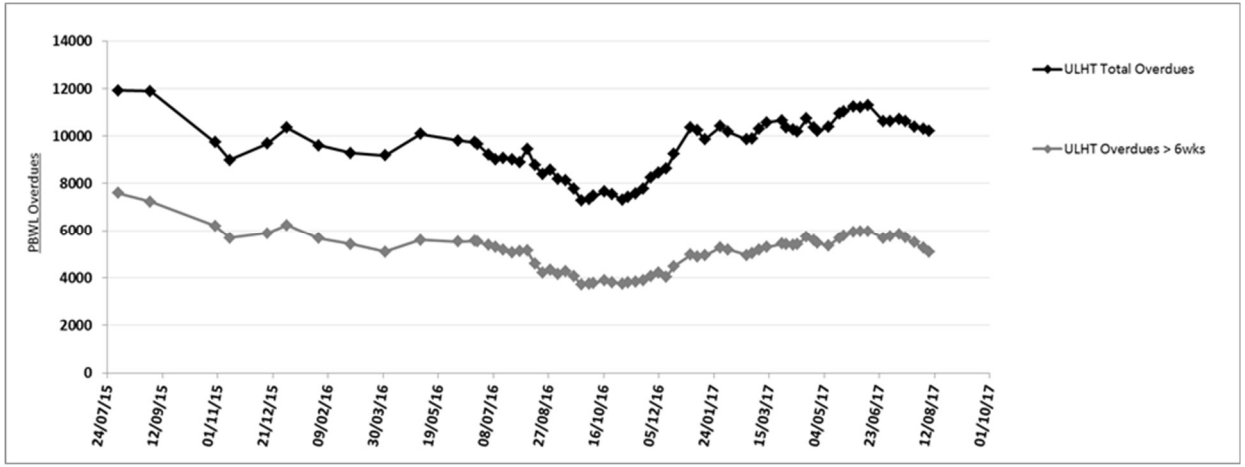
Partial Booking Waiting List

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Partial Booking Waiting List	Owner:	Director of Operations
Domain:	Effective	Responsible Officer:	Deputy Director of Operational Performance
Date:	5th September 2017	Reporting Period:	July 2017

Exception details

The impact of the lost capacity and reduced booking activity during the cyber-attack led to an increase in this partial booking over 6 week overdue position during May, climbing up to 5943 by the 31st May. This position remained stable during June, however the impact of the recent Clinical Directorate actions have started to make an impact, with reductions in the overdue backlog during July and early August taking the position as at 10th August to 5013, which is the lowest position since February.



Four specialities (ENT, Neurology, Rheumatology, Endocrine / Diabetes) account for over 60% of the patients. ENT on its own accounts for over 20% of the 6 week overdue follow-ups. All four of these areas have plans in place to reduce their PBWL backlogs, however due to capacity restrictions there is high risk that these service won't achieve the target level of reduction by the end of September.

What action is being taken to recover performance?

Each speciality area with a partial booking backlog has an action plan to address the position. Below is a summary of the key speciality plans:

- Neurology – From September the Neurology Service will open to headache patients, where the recently approved community headache pathway has been utilised. The service remains closed to routine referrals for all other conditions at present. Additional clinics being provided by Consultants in place. MS nurse specialists have commenced reviewing follow-ups. The job description for the 4th Neurology Consultant is out to advert. The speciality continue to review CV's for locum Consultants. The Lincolnshire CCGs have been asked to expedite pathway work relating to other high volume Neurological conditions.
- Rheumatology – Substantive Consultant now in post, an additional locum Consultant is in post until the end of September. Discussions have taken place relating to alternative models of working related to follow-ups within the speciality. The clinical leads meet on 22nd August for the Speciality Governance Meeting and are scheduled to confirm how they wish to implement a patient initiated follow-up service model.
- ENT – Additional clinics; additional audiology sessions; review discharge point for key pathways; review vacant slot processes. Since the beginning of August ENT have commenced weekly virtual clinics to review a greater volume of follow-ups. Lincs East CCG have agreed to a divert of routine referrals away from ULHT for 3 months. This period will be utilised to re-distribute capacity to improve the ENT PBWL overdue backlog.
- Endocrine – IPB has approved the business case for a 4th Consultant post at Pilgrim. The job description is now being finalised prior to advertising. Lincoln and Pilgrim are currently working together to review the spread of capacity across these sites. Discussions taking place internally and with commissioners re alternative models of managing follow-up patients in this speciality.

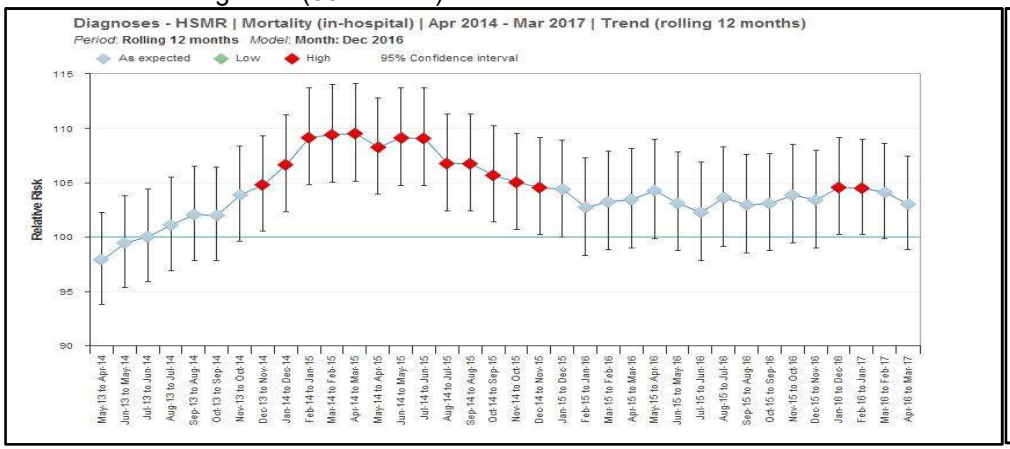
Safe

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Safe						
Infection Control						
Clostrum Difficile (post 3 days)	Monthly	Datix	59	24	2	4
MRSA bacteraemia (post 3 days)	Monthly	Datix	0	1	0	1
MSSA	Monthly	Datix	8	6	1	1
ECOLI	Monthly	Datix	32	18	4	2
Never Events	Monthly	Datix	0	0	0	0
No New Harms						
Serious Incidents reported (unvalidated)	Monthly	Datix	0	97	20	29
Harm Free Care %	Monthly		95%	91.45%	92.20%	90.64%
New Harm Free Care %	Monthly		98%	98.21%	99.30%	98.06%
Catheter & New UTIs	Monthly		1	1	0	3
Falls	Monthly	Datix	3.90	3.56	3.76	3.69
Medication errors	Monthly	Datix	0	621	174	162
Medication errors (mod, severe or death)	Monthly	Datix	0	93	19	29
Pressure Ulcers (PUNT) 3/4	Monthly			21	4	4
VTE Risk Assessment	Monthly		95%	97.22%	97.46%	97.25%
Core Learning	Monthly	ESR	95%	90.58%	90.83%	90.42%

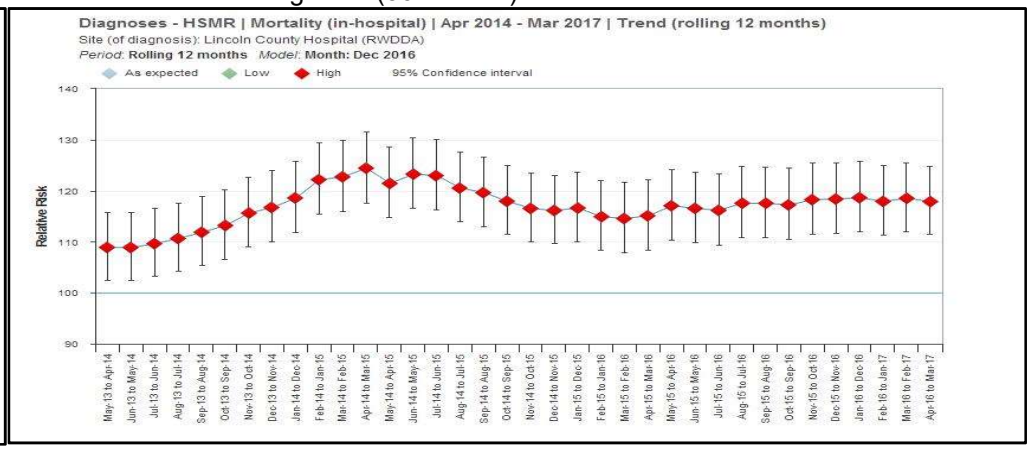
Safe Ambition 1: Reduction of Harm Associated with Mortality

Executive Responsibility: Neil Hepburn – Medical Director

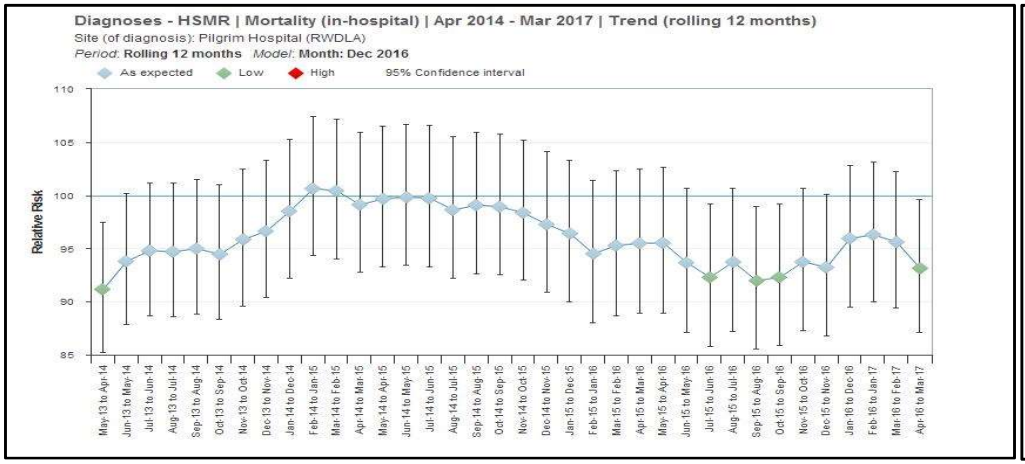
ULHT HSMR Rolling Year (36 Months)



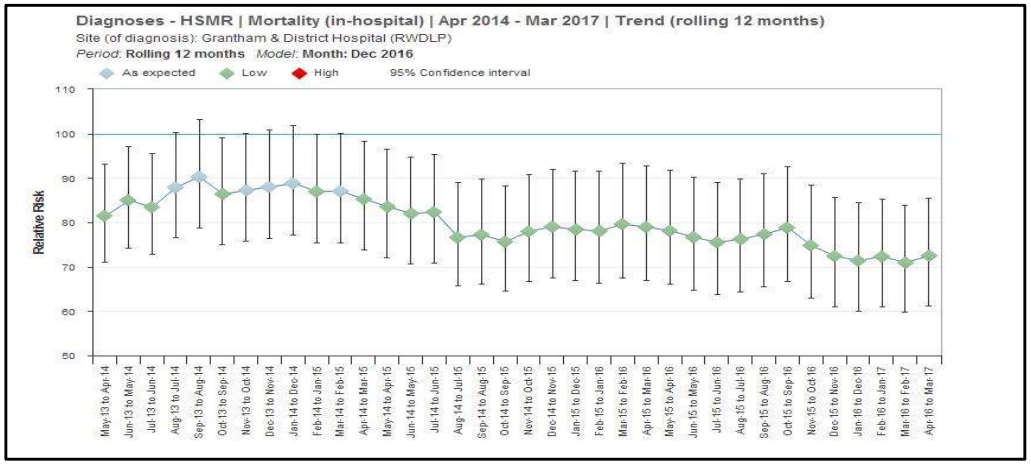
Lincoln HSMR Rolling Year (36 Months)



Pilgrim HSMR Rolling Year (36 Months)



Grantham HSMR Rolling Year (36 Months)



Alerts

ULHT

The Trust diagnoses groups are:

- **Biliary Tract Disease:** Driven by an alert on the Lincoln Site, with 34 mortalities (25 attributed to LCH) and 12 over the predicted Dr Foster data.
- **Other liver disease:** Driven by an alert on the Lincoln site, with 22 mortalities (13 attributed to LCH) and 8.7 over the predicted Dr Foster data.

Lincoln County Hospital diagnoses groups are:

- **Biliary Tract Disease:** This is cumulative throughout the time period with 14.3 mortalities over the predicted Dr Foster data. This has now been alerting for 4 months. A comprehensive review was conducted in November 2015. Quality Governance have contacted the Clinical Directors for this alert for volunteers to conduct and in-depth review.
- **Intestinal Obstruction without hernia:** Due to a notification in October 16; Year to date there were 11.3 mortalities over the predicted within this diagnosis group. This is the sixth consecutive month of notification. An in-depth review is underway; Notes and proforma have been sent to Consultant Colorectal Surgeon for review to be completed by September 2017.
- **Liver Disease, alcohol related:** This is a cumulative alert and not alerting in a particular month; year to date there are 6.9 mortalities over the predicted Dr Foster data. This is the second month alerting.
- **Other gastrointestinal disorders:** This is a cumulative alert and not alerting in a particular month; year to date there are 7.4 mortalities over the predicted Dr Foster data. This is the second month alerting.
- **Septicemia (except in labour):** This is a cumulative alert and not alerting in a particular month; year to date there are 19.5 mortalities over the predicted Dr Foster data. This is the second month alerting. There is a sepsis committee who meet monthly and have a detailed action plan to improve compliance of sepsis.
- **Acute Cerebrovascular disease:** This is the first month of alerting with 113 observed and 24.8 mortalities over the predicted Dr Foster data.
- **Fluid and electrolyte disorders:** This is the first month of alerting with 14 observed and 6.7 mortalities over the predicted Dr Foster data.
- **Other liver diseases:** This is the first month of alerting with 13 observed and 6.6 mortalities over the predicted Dr Foster data.
- **Respiratory failure, insufficiency, arrest (adult):** This is the first month of alerting with 29 observed and 6.9 mortalities over the predicted Dr Foster data.

Pilgrim hospital diagnoses groups are:

- **COPD and bronchiectasis:** For this alert there has been 15.98 mortalities over the predicted Dr Foster data.
- **Other perinatal conditions:** This is the first month of alerting with 8 observed and 4.9 mortalities over the predicted Dr Foster data. Data has been sent to Risk Lead for Womens and Children.

Grantham Hospital

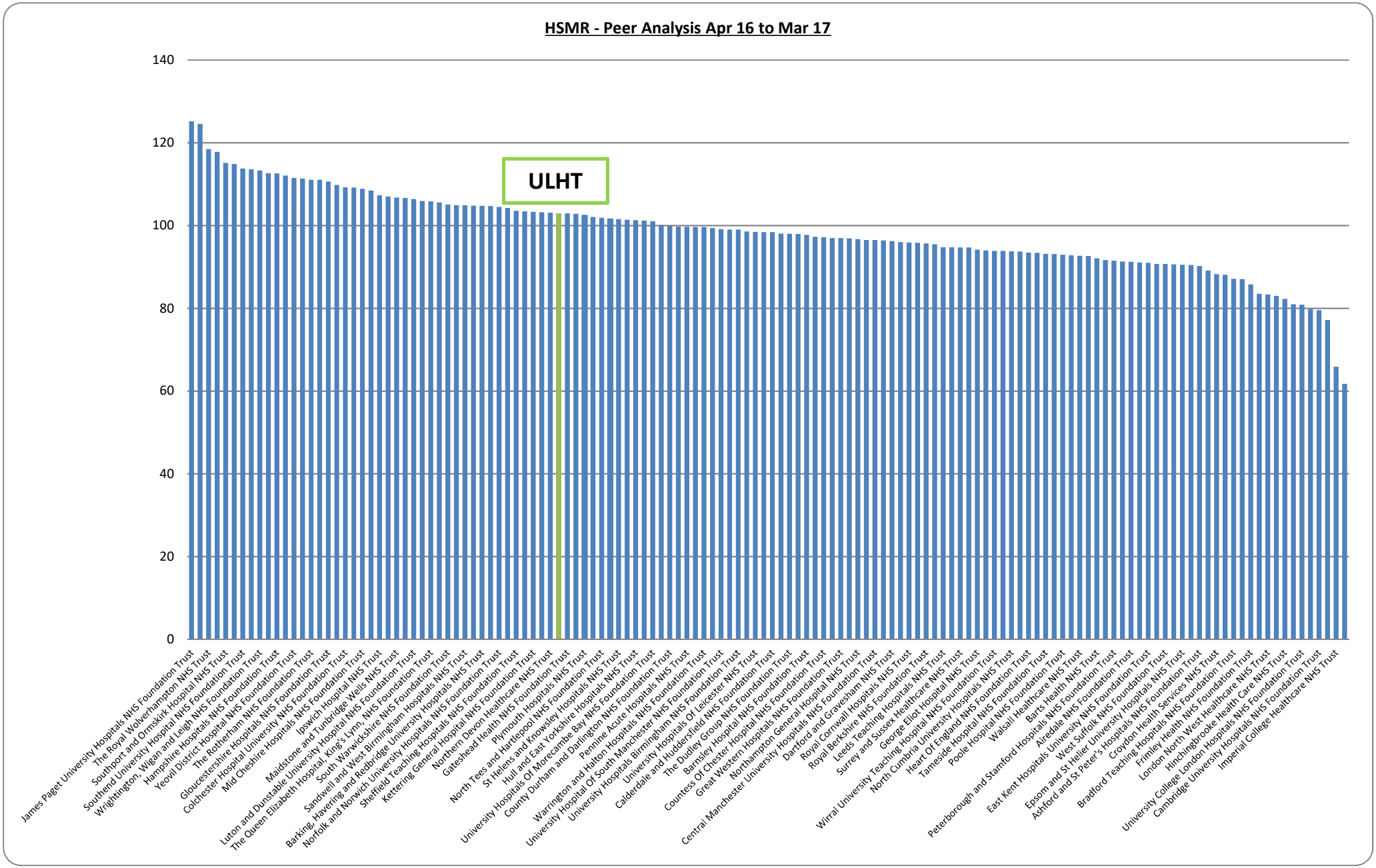
No notifications

HSMR Top Observed Diagnosis Groups April 2016- March 2017

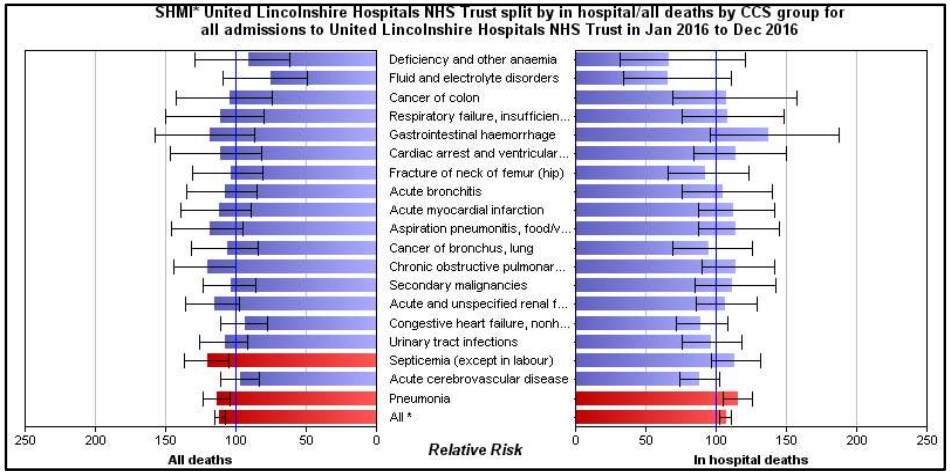
Rank	Diagnosis group	Spells	mortalities	% of all mortalities	Expected mortalities	Actual-Expected	Crude (%)	HSMR
1	Pneumonia	2590.00	469.00	21%	477.50	-8.50	18.11	98.22
2	Septicemia (except in labour)	853.00	189.00	9%	167.25	21.75	22.16	113.00
3	Acute cerebrovascular disease	1164.00	176.00	8%	180.52	-4.52	15.12	97.50
4	Acute and unspecified renal failure	756.00	108.00	5%	98.27	9.73	14.29	109.90
5	Urinary tract infections	2332.00	96.00	4%	98.78	-2.78	4.12	97.18
6	Congestive heart failure, nonhypertensive	941.00	90.00	4%	107.44	-17.44	9.56	83.77
7	Chronic obstructive pulmonary disease and bronchiectasis	1585.00	89.00	4%	71.62	17.38	5.62	124.26
8	Secondary malignancies	2086.00	65.00	3%	58.74	6.26	3.12	110.66
9	Aspiration pneumonitis, food/vomitus	193.00	64.00	3%	58.68	5.32	33.16	109.07
10	Acute myocardial infarction	889.00	63.00	3%	61.19	1.81	7.09	102.96

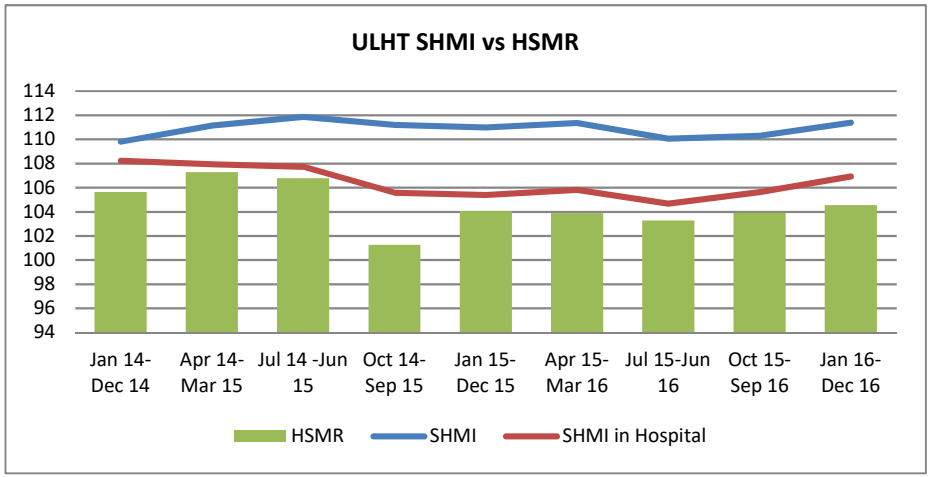
The above diagnosis groups show the top 60% of the alerting diagnosis within the Trust. Those diagnoses highlighted in red are alerting diagnosis at site level.

HSMR Peer Analysis



SHMI





The Trust is undertaking numerous strategies for Mortality Reduction:

- Mortality Matters and MoRAG case review for lessons learned remain to be distributed monthly via communications and to MAC and the Senior Leaders forum. August Mortality matters will focus on the themes pulled from Mortality Reviews.
- Ward Clerk pilot for the Comorbidity chasing has been undertaken by Clayton and Burton Ward, the trial deadline is 21st August 2017.
- Intestinal hernia without obstruction is currently alerting diagnosis; an in-depth review is currently being undertaken; a proforma has been agreed by Consultant Colorectal Surgeon and the notes have been sent for review. A report will be produced for the committee upon completion of the audit and incorporate an action plan September 2017.
- Biliary Tract Disease alert, the committee agreed to undertake an in-depth review for this diagnosis group. This is now alerting for the Trust driven by the alert on the Lincoln site. Quality Governance are still awaiting notes for this review to disseminate, a proforma has been created.
- National guidance on Learning from Deaths are currently being implemented by the Trust full implementation by September 2017.
- A new process has been built in with the Bereavement Service where the service escalates concerning cases that are “Must do” reviews.
- Coding Masterclass being organised for October 2017 (these are run quarterly and we have previously orchestrated five masterclass).
- Monthly MoRAG reviews for assurance and escalate lessons. Quarterly report submitted to the board next report is due in September 2017.
- 6 weekly meetings of the Lincolnshire Mortality Collaborative with ULHT, CCG, LCHS and GP’s to understand deaths within 48 hours of admission and within 30 days of discharge. An update for the committee will be submitted in September 2017.
- Quality Governance has undertaken F2 training at Pilgrim and has dates for Grantham Pilgrim teaching programme of how the quality of notes affects our mortality, performance reports and income.
- Quality Governance are engaging the EAU’s through the Trust on the importance of the quality of notes undertaken and how these affect the Trust

Reviews (Jan 2016-Jul 2017)

Site	Deaths	Awaiting notes/Notes in Quality Governance	Notes Sent for Review	Review Complete	Review completion Compliance	Review Completion Target	Total Death % Reviewed
ULHT Total	4436	754	3692	2765	**75%**	70%	62%
Lincoln Total	2429	323	2116	1526	**72%**	70%	63%
Pilgrim Total	1742	356	1386	1059	**76%**	70%	61%
Grantham Total	265	75	190	180	**95%**	70%	68%

NOTE: The review compliance target has changed to 70% due to the New National Learning from Deaths guidance.

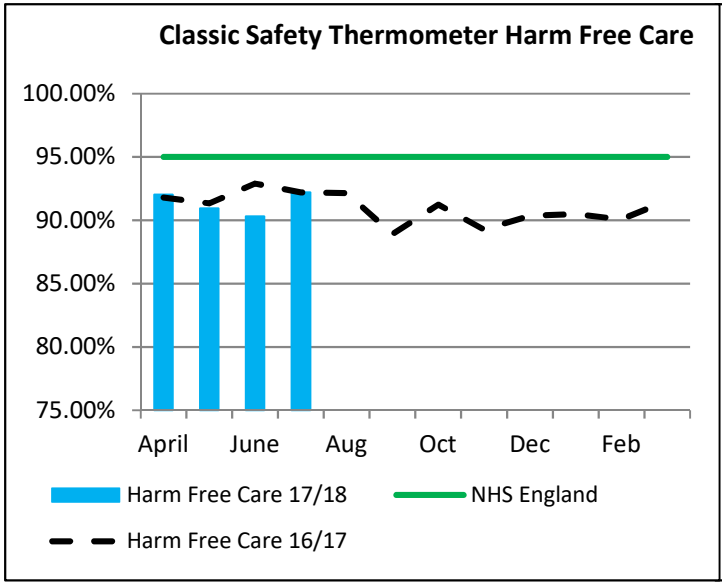
ULHT Review Grading:
From the completed reviews the following grading's were applied by the reviewing consultants:

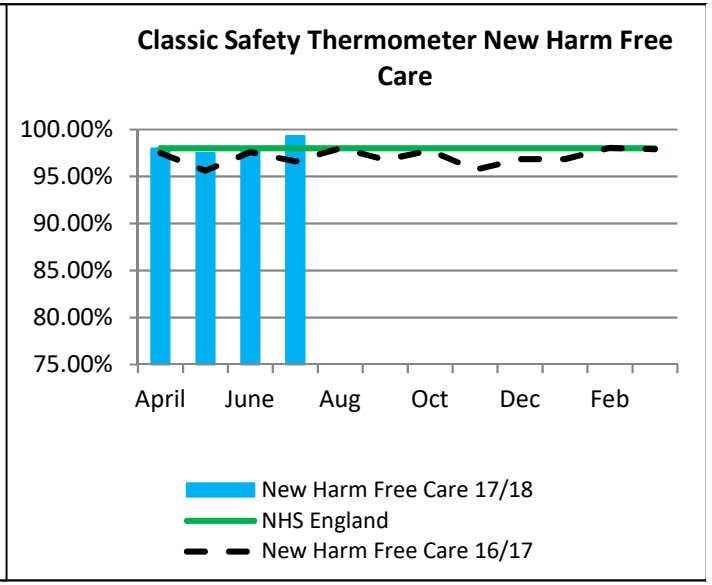
Grading
Grade 0-Unavoidable death, no suboptimal care
Grade 1-Unavoidable death, suboptimal care but different management would NOT have affected outcome
Grade 2- Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
Grade 3- Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death).
Grading not completed by reviewer

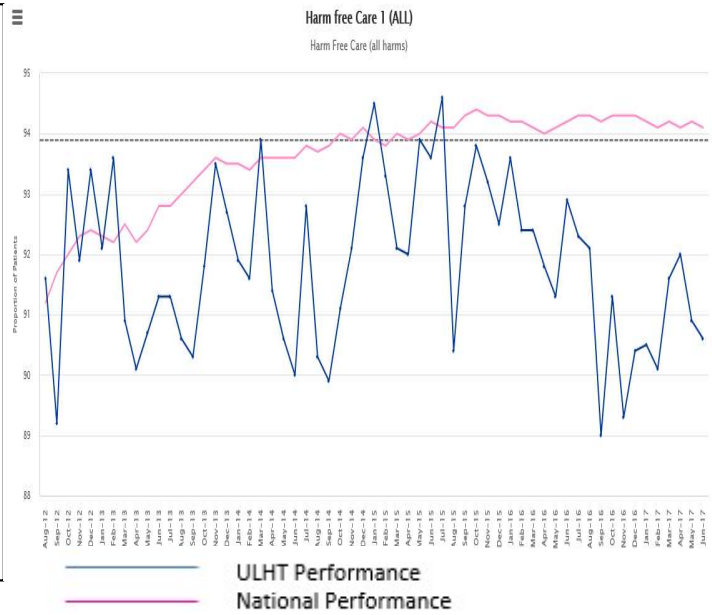
Review Complete total	180	1059	1526	2765
Grade	GDH	PHB	LCH	ULHT
0	164	842	1244	2250
1	11	106	156	273
2	2	35	40	77
3	0	3	3	6
Not completed	3	73	83	159

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

Executive Responsibility: Michelle Rhodes – Director of Nursing







Performance Data Overview July 2017

	ULHT	GDH	LCH	PBH
Harm Free Care	92.2%	97.4%	92.7%	90.1%
New Harm Free Care	99.3%	100%	99.3%	99.0%
PU New Category 2	2	0	2	0
PU New Category 3	0	0	0	0
PU New Category 4	2	0	0	2
Fall Low Harm	1	0	0	1
Fall Moderate Harm	0	0	0	0
Fall Severe Harm	0	0	0	0
Catheter & New UTI	0	0	0	0
New VTEs	1	0	1	1
Patients	830	76	441	313

Action Plan

Pressure damage actions outlined within Quality Report (see respective pressure damage page). Results reported upwardly to Pressure Ulcer Reduction Committee with delegate authority from Patient Safety Committee.

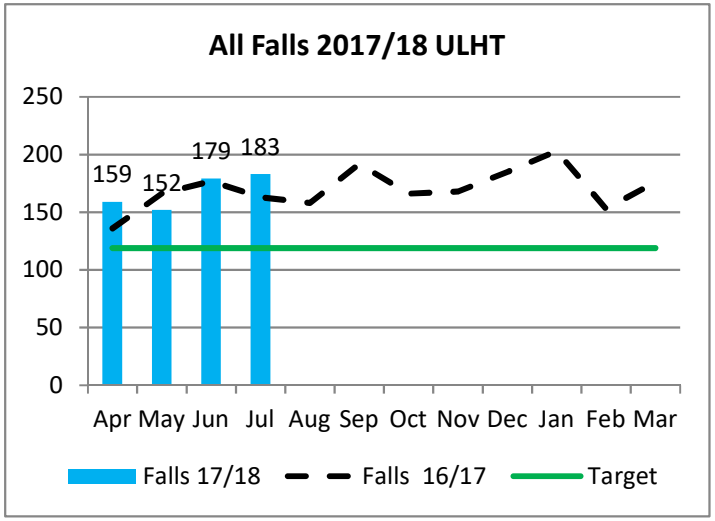
Fall actions outlined within Quality Report (see respective falls page). Results reported upwardly to Falls Reduction Group with delegated authority from Patient Safety Committee.

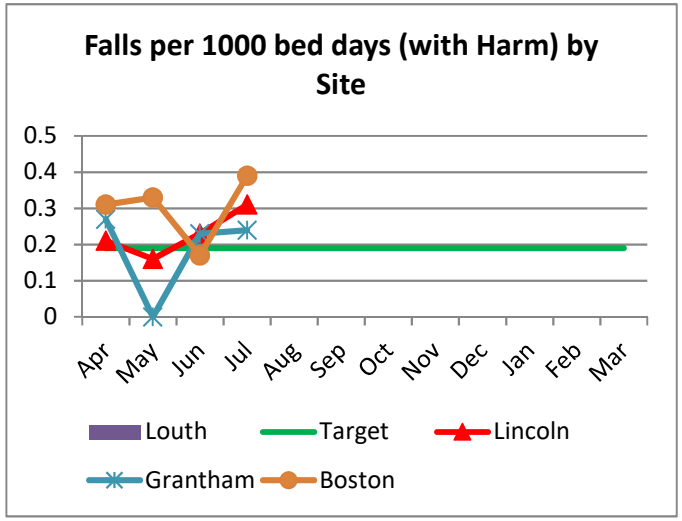
CA-UTI actions outlined within Quality Report (see respective CA-UTI page). Results reported upwardly to Catheter Reduction Group with delegated authority from Patient Safety Committee.

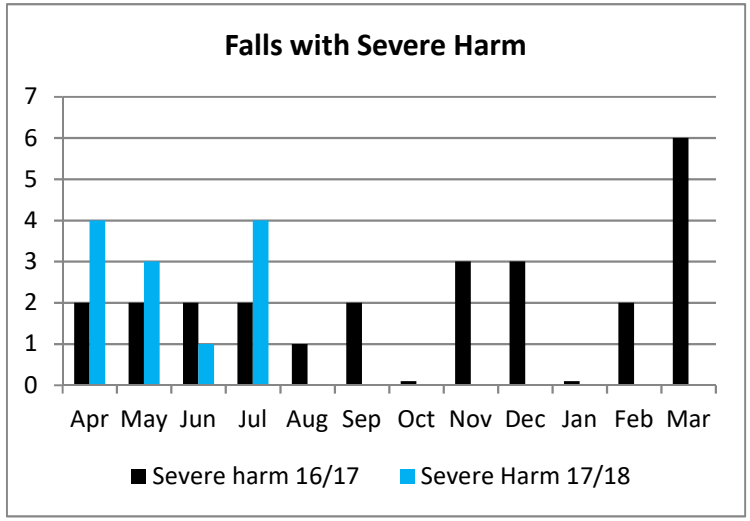
VTE investigated through Route Cause Analysis by VTE Nurse Manager and reported upwardly through Patient Safety Committee.

Safe Ambition 3: Reduction of Harm Associated with Falls

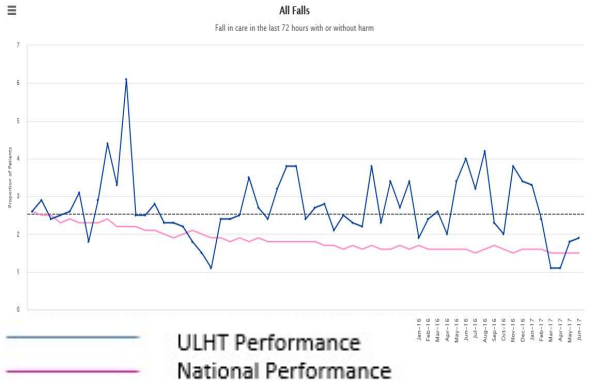
Executive Responsibility: Michelle Rhodes – Director of Nursing







Safety Thermometer 2017



Safety Quality Dashboard (SQD) for Trust Falls Aug 2016- Jul 2017

Metric Title	Aug 2016	Sep 2016	Oct 2016	Nov 2016	De 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017
Patient at risk of falls	336	338	344	318	284	325	333	344	312	296	332	315
Actions completed within 4 hours	88.10%	87.40%	93.90%	90.50%	88.00%	87.70%	88%	88.1%	91.0%	90.60%	92.8%	93.4%
Actions completed within 24 hours of admission	42.20%	49.20%	45.30%	38.50%	48.50%	47.40%	-	46.7%	57.7%	57.40$	62.0%	57.8%
Lying & standing BP completed	62.60%	67.10%	63.10%	61.90%	61.00%	66.50%	62.8%	68.3%	78.0%	81.80%	78.7%	71.7%
Care plan 7 activated	96.40%	96.20%	93.80%	94.40%	93.60%	95.30%	95.4%	91.4%	97.7%	97.60%	96.1%	97.5%
Neuro Cognition Assessed	-	-	-	-	-	-	-	96.2%	97.1%	98.00%	99.1%	97.1%
Vision Assessed	-	-	-	-	-	-	-	95.3%	97.8%	96.60%	97.6%	97.5%
Bed Rails Assessment	-	-	-	-	-	-	-	98.6%	99.7%	99.30%	100%	99.1%
Continence/toilet regime documented	-	-	-	-	-	-	-	76.4%	92.9%	87.50%	94.1%	91.9%

Performance Data Overview July 2017

There have been 183 falls at ULHT in July 2017 compared to 163 in July 2016. Of the 183, 46 falls were repeat falls. 76 falls resulted in some degree of harm with 12 moderate harm and 4 severe harm. Severe harm falls were reported on 8A, Greetwell and 7A (2).

Falls with harm per 1000 bed days has increased on the three main sites now reporting above the national average (0.19).

The most prominent adverse events types are slip (48), fall from bed (34), fall unwitnessed (34), fall from chair (25), fall from height (13), other types (29).

Action Plan

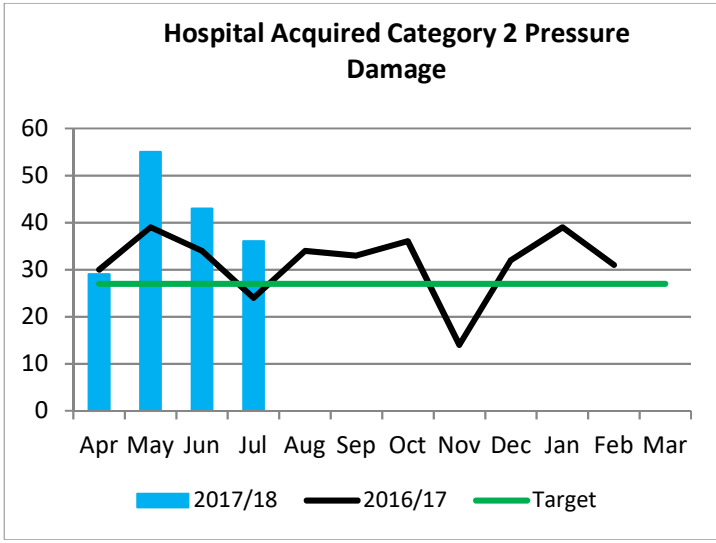
Scrutiny panels continue for falls. "Call don't fall" poster has been agreed for use in bed spaces and in bathrooms. A review of multiple falls is scheduled for September 2017 and notes have been requested in anticipation. The review will examine all patients with 3+ falls in the period April – June 2017 (17 patients in total accounting for over 60 falls).

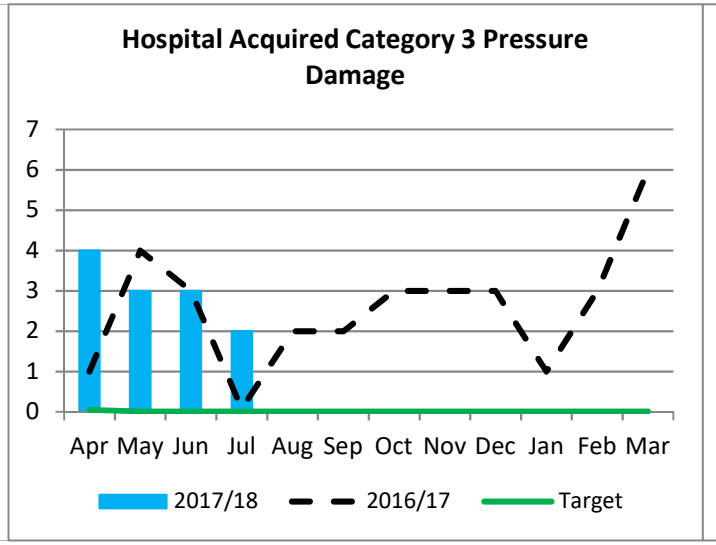
Focus L&S BP training will present an evaluation paper in September 2017, findings suggested that initial site improvements have not been sustained.

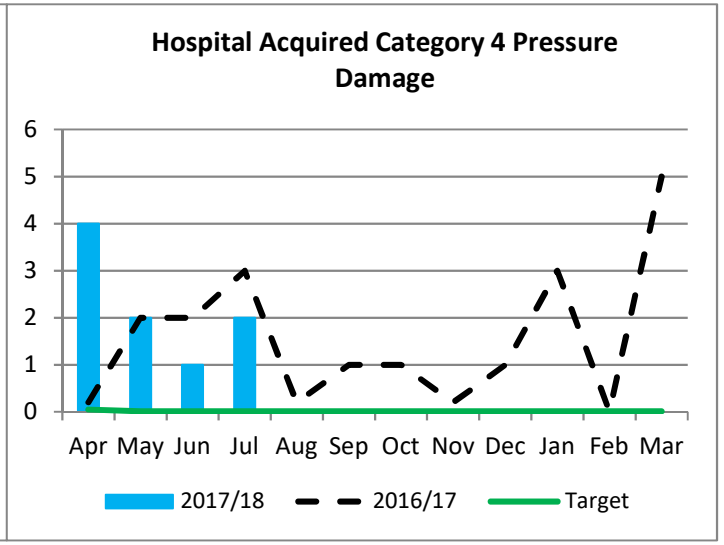
Ward accreditation launches in September 2017 with focused domain for Falls Prevention. E-learning awaiting consideration by core learning panel.

Safe Ambition 4: Reduction of Harm Associated with Pressure Ulcers

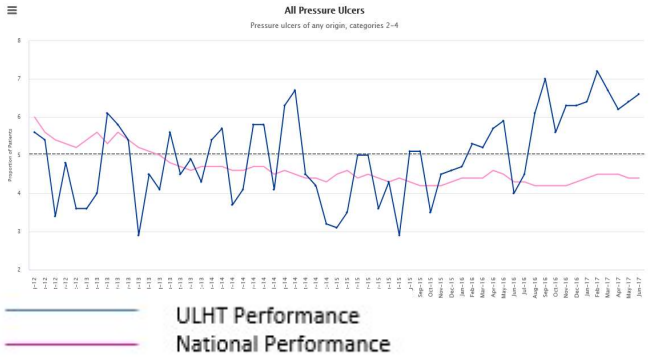
Executive Responsibility: Michelle Rhodes – Director of Nursing







Safety Thermometer 2017



Safety Quality Dashboard (SQD) for Trust pressure area care Aug 2016- Jul 2017

Metric Title	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun-2017	Jul 2017
Pressure area risk assessment completed within 4hrs	98.80%	98.80%	99.30%	98.80%	98.30%	97.50%	-	97.0%	98.7%	98.60%	95.5%	95.9%
Pressure area risk assessment updated weekly	76.00%	78.90%	80.70%	78.40%	72.00%	71.60%	77.4%	76.7%	80.5%	81.50%	81.3%	83.5%
Pressure-relieving equipment in situ if required	93.50%	93.90%	96.60%	94.20%	95.50%	96.60%	93.4%	94.0%	96.2%	95.20%	96.8%	96.8%
Frequency of repositioning documented	-	-	-	-	-	-	-	60.8%	62.4%	79.50%	83.4%	83.4%
Prescribed frequency of turning has been followed for last 24 hours	-	-	-	-	-	-	-	59.5%	61.7%	79.00%	85.7%	85.7%
Pressure areas care wound dressing renewed	-	-	-	-	-	-	-	52.4%	59.7%	76.40%	100%	100%
Pressure area care plan activated if required	92.10%	94.30%	88.80%	94.40%	92.90%	93.50%	91.1%	91.5%	94.7%	93.80%	93.6%	93.6%

Performance Data Overview July 2017

	Cat 2	Cat 3	Cat 4
Lincoln	15	2	0
Boston	19	0	2
Grantham	2	0	0

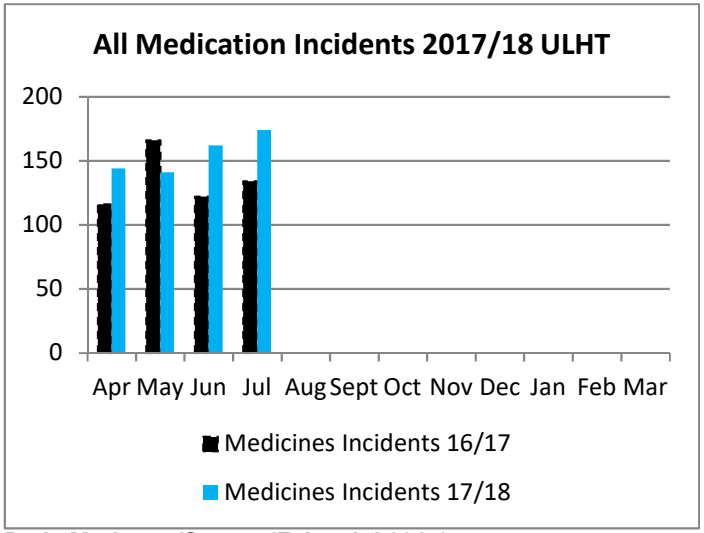
There were 36 reported cat 2 pressure ulcers. This is a reduction from June 2017 (43) but an increase on July 2016 (24). There were 2 Hospital Acquired cat 3 pressure ulcers (Dixon /Neustadt Welton) and 2 Hospital Acquired cat 4 pressure ulcers (5B/8A). Avoidability of cat 3 and 4 will be determined at scrutiny panels.

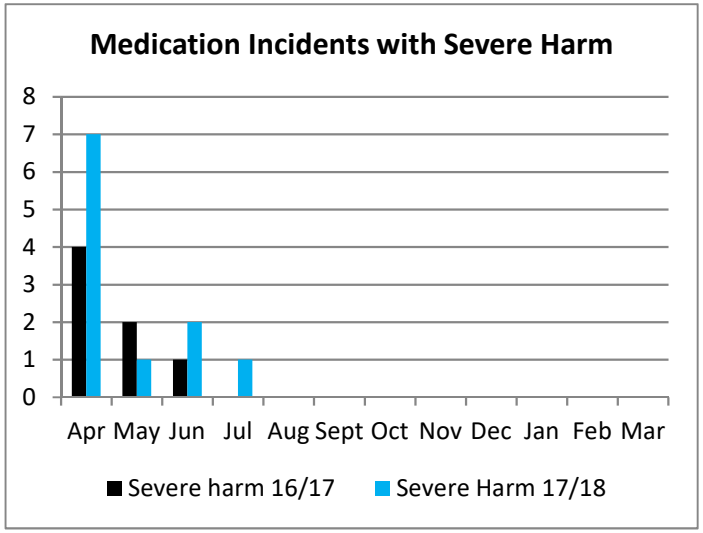
Action Plan

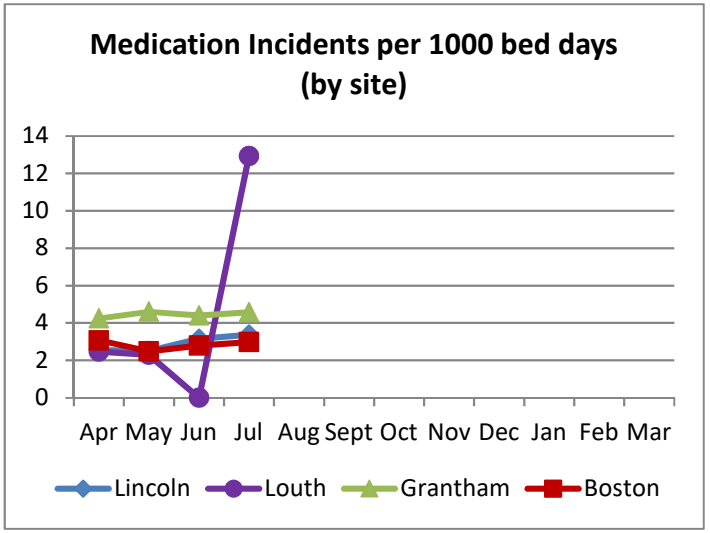
Pressure ulcer prevention meetings have been re-established at LCH and PHB.
Additional pressure ulcer prevention session has been scheduled for Boston in August 2017.
Temporary suspension of PUNT effective from 01.08.2017 whilst integration of PUNT and Datix is explored. Information on new reporting arrangements shared with the ward by Patient Safety Briefing and printed SOP.
Ward accreditation launches in September 2017 with focused domain for Pressure Ulcer Prevention.

Safe Ambition 5: Reduction of Harm Medication Incidents

Executive Responsibility: Michelle Rhodes – Director of Nursing







Datix Moderate/Severe (Feb – Jul 2017)

Ward/Department	No.
AMU PHB	4
6B PHB	4
7B PHB	4
Breast LCH	3
MEAU LCH	3
5A PHB	3
A&E PHB	2
Greetwell LCH	2
OPD LCH	2
Ward 1 GDH	2
Ward 2 GDH	2
5B PHB	2

SQD Dashboard for Medications Aug 2016 – Jul 2017

Metric Title	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb-2017	Mar – 2017	Apr-2017	May-2017	Jun-2017	Jul 2017
Medicine chart demographics correct	78.50%	78.40%	83.70%	78.10%	80.50%	78.80%	78.90%	97.2%	98.2%	98.40%	98.00%	98.2%
Allergies documented	98.10%	98.80%	98.20%	99.40%	98.40%	98.10%	99.40%	99.4%	98.7%	97.20%	97.00%	100%
All medicines administered on time	88.00%	91.90%	87.60%	88.60%	91.60%	89.10%	87.50%	76.8%	83%	81.40%	86.20%	84.7%
Allergy nameband in place if required	87.60%	91.80%	93.50%	86.20%	84.70%	92.90%	84.10%	92.3%	82.8%	86.80%	88.90%	76.7%
Identification namebands in situ	98.00%	99.50%	98.80%	99.80%	99.70%	98.50%	98.00%	98.5%	98.1%	99.70%	98.50%	96.7%

Performance Data Overview July 2017

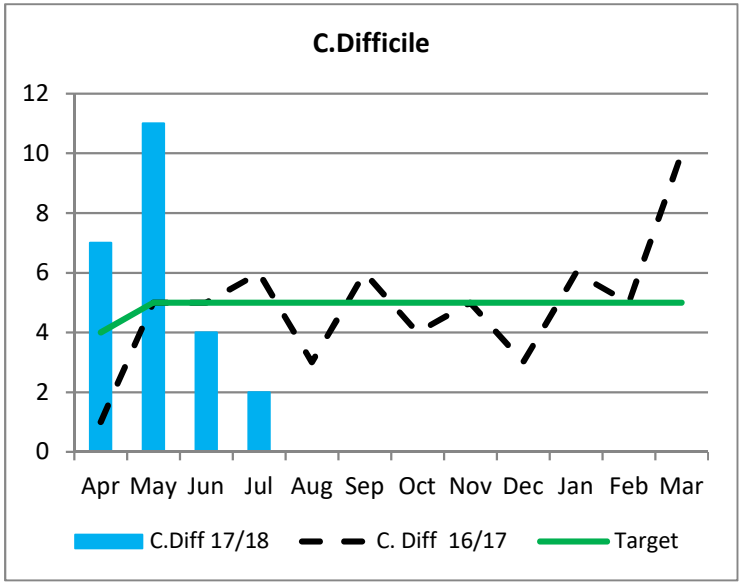
Data issues for Medication incidents per 1000 bed days identified and remedied in July. Amendments reflect reduction in per 1000 bed day harm on all sites. Louth highlighted as outlier (July) per 1000 bed days equivalent to 6 incidents. There were 174 medication incidents in July. This is an increase in year and against 2016/17. The most common medication error type was omitted medications 45/174. The most prominent areas for this were 6A/Hatton, Ward 1, A&E PHB, SEAU and 7A.

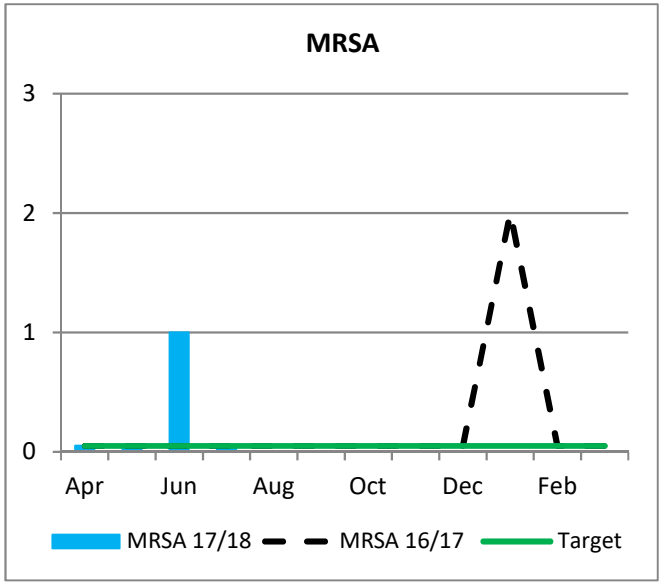
Action Plan

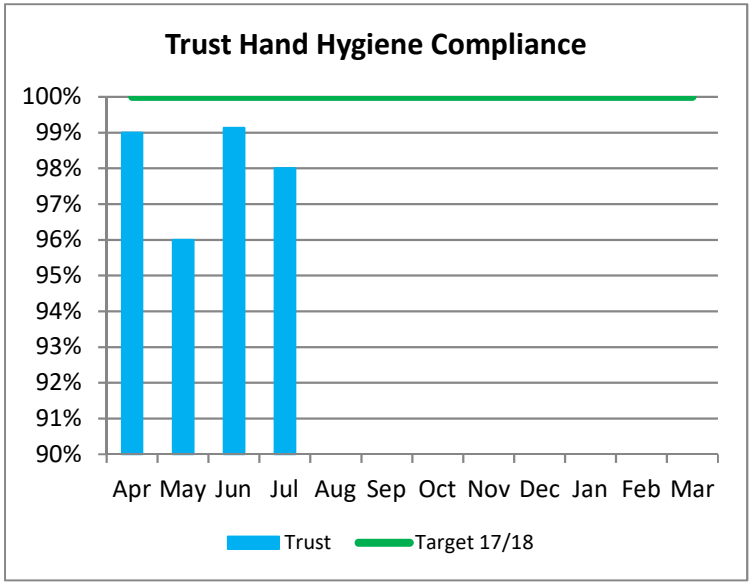
Deep dive review of omitted medications and allergy incidents is underway.
Review of prescription chart with omitted medications flowchart out for consultation.
Planned safety culture survey within Staff Pulse Check September 2017.
Patient Safety Briefings to be drafted to reiterate process for over labelled packs and omitted medications.
Ward accreditation launches in September 2017 with focused domain for Safer Medicines.

Safe Ambition 6: Reduction of Harm Associated with Infection

Executive Responsibility: Michelle Rhodes – Director of Nursing







Performance Data Overview July 2017

Hand Hygiene	
Target	100%
Grantham	99.88%
Lincoln	98.23%
Louth	100%
Pilgrim	96.53%

C.Diff cases reported on Navenby and ICU PHB.

Action Plan

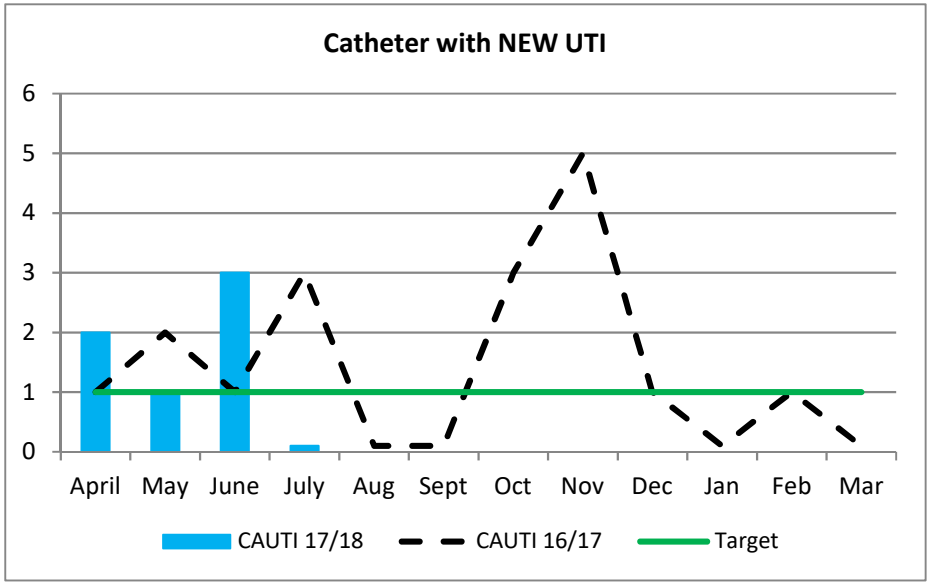
Ward accreditation launches in September 2017 with focused domain for Infection Prevention Control. IPC will be a mandatory domain to progress through accreditation.

Weekly Clostridium difficile review meetings continue and actions are being implemented with regard to the key areas of antimicrobial prescribing, hand hygiene, effective isolation, and cleaning and disinfection of patient equipment and the environment.

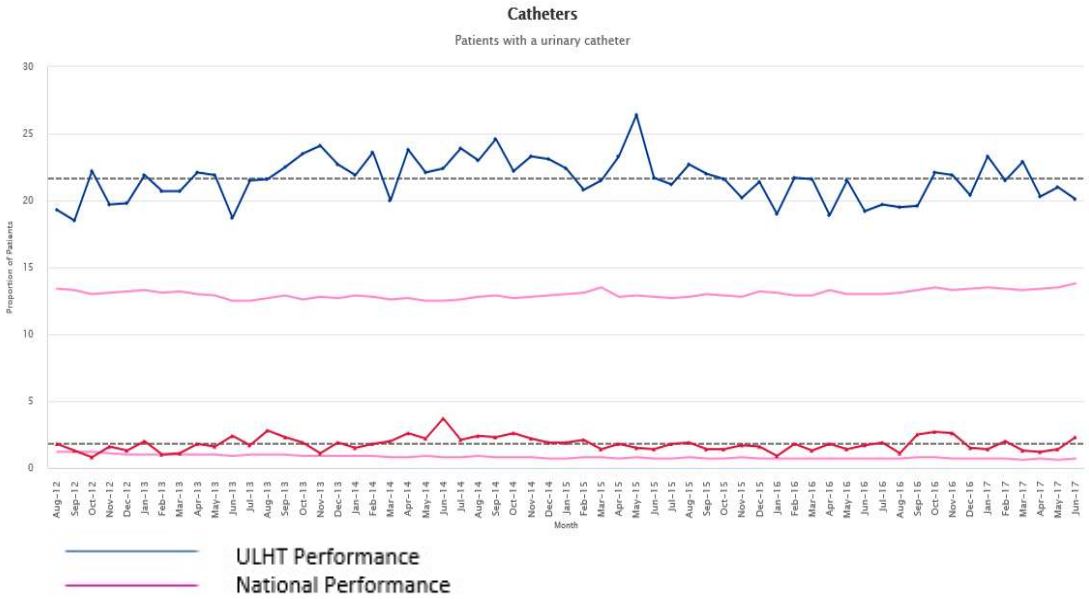
The IPC team are carrying out frequent ward visits to review IPC practice, and are providing verbal and written feedback to sisters and matrons.

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

Executive Responsibility: Michelle Rhodes – Director of Nursing



Safety Thermometer catheters 2017



Safety Quality Dashboard (SQD) for Trust pressure area care Aug 2016- Jul 2017

Metric Title	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb-2017	Mar – 2017	Apr – 2017	May – 2017	Jun-2017	Jul 2017
Number of urinary catheters in-situ	81	63	72	81	53	67	84	80	85	72	88	89
Urinary catheter record demographics correct	95.0%	96.8%	86.1%	98.8%	90.2%	94.0%	92.8%	96.1%	97.6%	97.20%	97.70%	93.3%
Urinary catheter record completed &signed daily	72.2%	65.1%	65.3%	72.2%	58.8%	68.2%	73.8%	54.5%	67.5%	70.00%	66.30%	69.7%
TWOC occurred within 3 days for acute retention	40.0%	50.0%	40.0%	58.3%	50.0%	66.7%	40%	25.0%	36.4%	40.00%	44.40%	50%
Documented evidence why catheter needed	91.1%	96.8%	86.1%	97.5%	92.2%	91.0%	91.7%	89.6%	94.0%	94.40%	93.10%	93.3%
Urinary catheter bags secure	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	-	-	-	-	-	-
Urinary catheter care plan activated	88.6%	90.5%	83.3%	90.1%	88.2%	88.1%	-	-	-	-	-	-

Performance Data Overview June 2017

Metric	ULHT Average	National Average
Catheter Insertion Rate	20.1%	13.8%
Catheter and UTI Rate	2.3%	0.7%

Retrospective validation of outstanding alleged CA-UTI from June 2017 did not identify any further CAUTI. There are 4 alleged CA-UTI for July outstanding for validation. These will be included in August return once harm has been established by Continence leads.

Action Plan

E-learning to be considered by Core Learning Panel – dates pending.

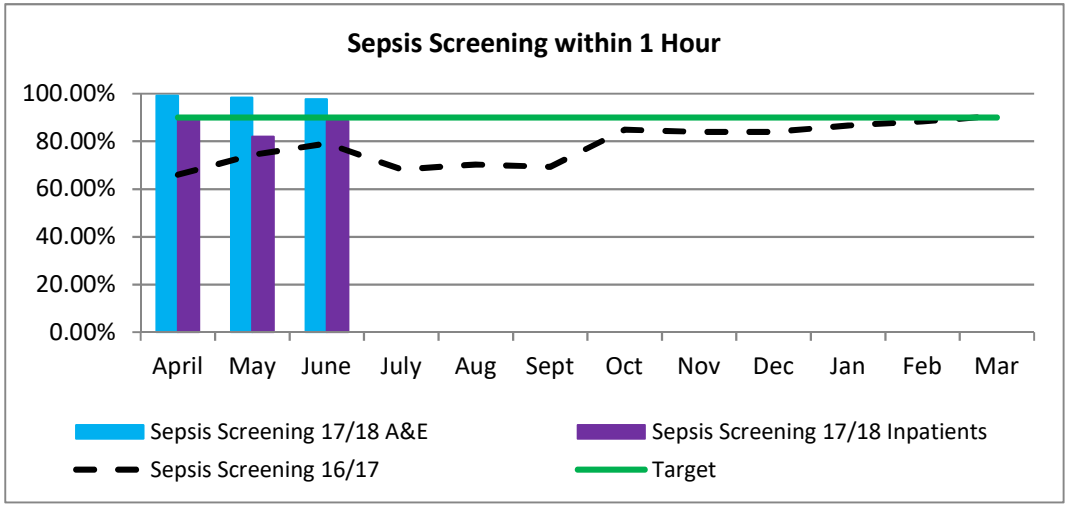
Focus catheter education to be delivered on all sites in October 2017 led by continence nurses with focus on appropriate insertion and TWOC.

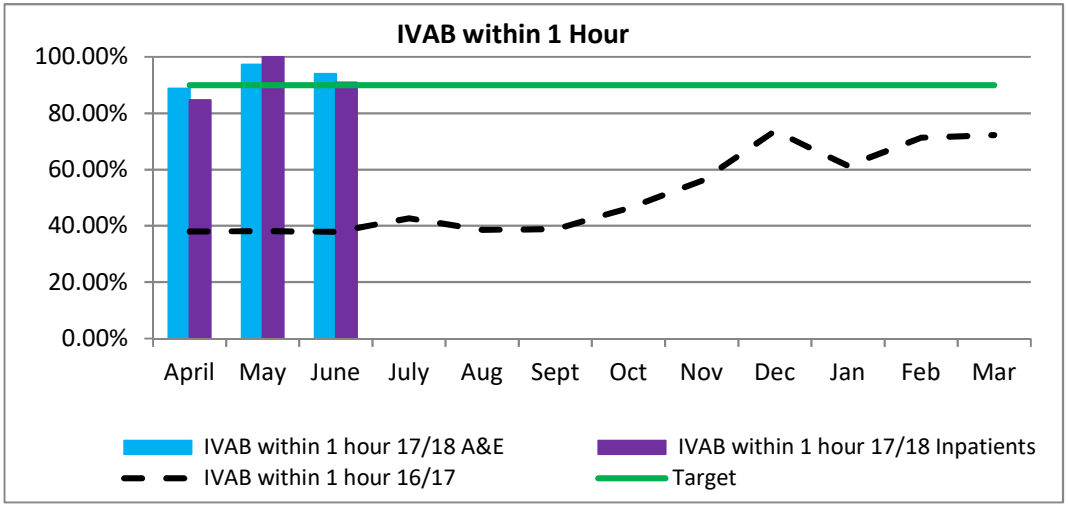
From 01.09.2017 all CAUTI to be recorded on Datix – Patient Safety Briefing communicated to this effect.

ToR revised to reflect co-oped members and identify medical representation. Ward accreditation launches in September 2017 with focused domain for Continence Care.

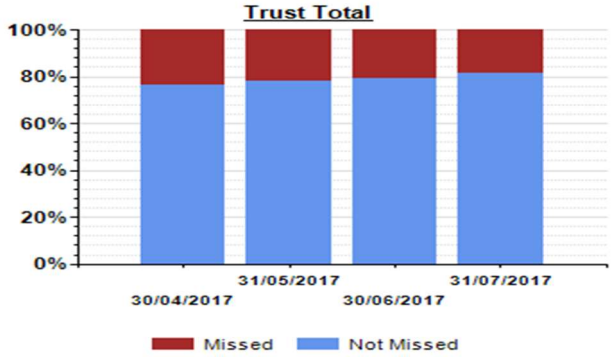
Safe Ambition 7: Reduction of Harm Associated with Deterioration Sepsis

Executive Responsibility: Michelle Rhodes – Director of Nursing

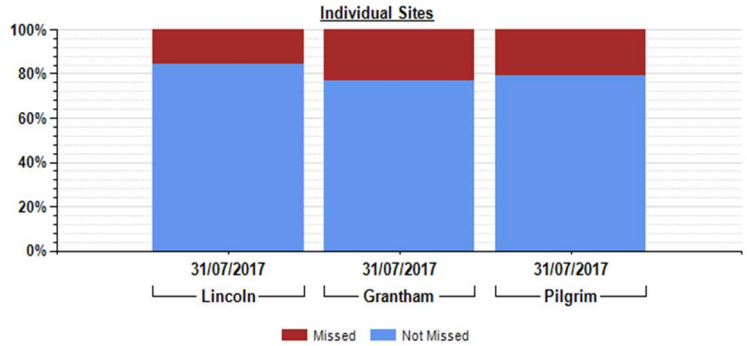




Patient Electronic Observations (Trust) Apr-Jul 2017



Patient Electronic Observations (Site) July 2017



SQD Pain Score Mar – Jul 2017

Metric Title	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017
Pain Score complete	16.2%	19%	29.20%	28.80%	33.6%

Performance Data Overview July 2017

A&E Target 90%	Screening –July 17	IVAB within 1 hour – July 17
Trust	*Unavailable*	*Unavailable*
Inpatients Target 90%	**Screening –July 17**	**IVAB within 1 hour – July 17**
Trust	*Unavailable*	*Unavailable*

Sepsis e-learning at 90.95 % (31st July 2017)

Action Plan - July data is inaccurate and so at present will effect CQUIN attainment. This is to be discussed with CCG whilst the process is streamlined by developers and analysts. Developers currently reviewing the data collection system to ensure the most accurate representation possible and reduce the risk of skewed/erroneous results. Sepsis Practitioners to send monthly ward breakdown of compliance and screening data to allow for targeted ongoing education and training, as well as the identification of trends.
Safety Briefings composed in relation to IR1 completion if opportunity to screen is missed and also in relation to only Registered Staff completing the screening process, clearly outlining responsibility.

Caring

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Caring						
Friends and Family Test						
Inpatient (Response Rate)	Monthly	Envoy Messenger	26%	28.25%	30.00%	24.00%
Inpatient (Recommend)	Monthly	Envoy Messenger	96%	91.00%	90.00%	94.00%
A&E (Response Rate)	Monthly	Envoy Messenger	14%	20.25%	20.00%	18.00%
A&E (Recommend)	Monthly	Envoy Messenger	87%	80.75%	80.00%	80.00%
% of staff who would recommend care						
% of staff who would recommend work						
Complaints						
No of Complaints received	Monthly	Datix	70	220	55	56
No of Complaints still Open	Monthly	Datix	0	970	247	234
No of Complaints ongoing	Monthly	Datix	0	132	26	32
Inpatient Experience						
Mixed Sex Accommodation	Monthly	Datix	0	0	0	0
eDD	Monthly	EDD	95%	83.33%	86.86%	87.03%
PPCI 90 hrs	Quarterly		100%	95.15%	97.33%	97.33%
PPCI 150 hr	Quarterly		100%	86.85%	85.33%	85.33%
#NOF 24	Monthly		70%	62.52%	53.85%	64.91%
#NOF 48 hrs	Monthly		95%	92.75%	90.77%	89.47%
Dementia Screening	1 month behind		90%	92.33%	91.88%	91.56%
Dementia risk assessment	1 month behind		90%	96.53%	95.77%	95.42%
Dementia referral for Specialist treatment	1 month behind		90%	86.53%	81.04%	90.32%
Stroke						
Patients with 90% of stay in Stroke Unit	1 month behind	SSNAP	80%	81.97%	70.90%	81.00%
Sallowing assessment < 4hrs	1 month behind	SSNAP	80%	68.77%	69.00%	70.60%
Scanned < 1 hrs	1 month behind	SSNAP	50%	59.50%	56.30%	60.50%
Scanned < 12 hrs	1 month behind	SSNAP	100%	97.33%	95.00%	98.70%
Admitted to Stroke < 4 hrs	1 month behind	SSNAP	90%	66.83%	58.80%	66.70%
Patient death in Stroke	1 month behind	SSNAP	17%	16.43%	12.70%	18.60%

Well-Led

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Well Led						
Vacancies	Monthly	ESR	5.0%	10.92%	10.08%	11.05%
Sickness Absence	Monthly	ESR	4.5%	4.42%	4.53%	4.34%
Staff Turnover	Monthly	ESR	8.0%	5.74%	5.57%	5.78%
Staff Engagement Staff Appraisals	Monthly	ESR	95.0%	78.00%	83.00%	82.00%
Equality Diversity and Inclusion						

Workforce Headline Summary

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

KPI	2017/18 Target	July 2017 Performance	Last Month Performance	Performance in July 2016	6th Month Trend
Vacancy Rate For Specialties: - Medical - Registered Nurses - AHPs	Medical – 12% Reg Nursing – 11.5% AHPs – 10%	**Medical 11.79%** **N&M Reg 15.21%** **AHP'S 10.43%**	**15.89%** **14.41%** **12.29%**	**7.74%** **13.57%** **10.44%**	
Voluntary Turnover	7%, with no group of staff more than 20% above the overall target	**5.57%**	**5.78%**	**n/a**	**n/a**
Quarterly Engagement Index	10% improvement in average score during 2017/18	**3.35**	**n/a**	**n/a**	**n/a**
Quality of Leadership/Management Index	10% improvement in average score during 2017/18	**2.8**	**n/a**	**n/a**	**n/a**
Core Learning Completion	Revised target to be set asap following review that is underway	**90.81%**	**90.47%**	**86%**	
Sickness Absence (12 month rolling average)	Overall target of 4.5% + no team over 25% above target	**4.67%**	**4.67%**	**4.52%**	
Appraisals: - Medical - Non-Medical	Medical – 95% Non-Medical – 85%	**96%** **82.67%**	**95%** **81.97%**	**91%** **65.00%**	
Agency Spend	£21m (equates to £1.75m per month)	**£2.348m**	**£2.479m**	**£2.200m**	

In order to reduce both overall workforce costs and agency spend we have to focus on recruitment and reducing vacancy rates, but also changing the skill mix and the establishment, so that we can recruit to roles we can fill at a lower cost. Our KPI for vacancy rates is now amber, as have seen a reduction in the medical vacancy rate following the latest junior doctor rotation. This is artificial owing to overlaps and it will increase again next month. AHP vacancy rates have also significantly reduced following a recent recruitment campaign. However, the rise in the Nursing and Midwifery rate is a concern, as are the problems in specific services, demonstrating how vulnerable our services are to the loss of staff.

We continue to look at alternative ways to fill roles. The launch of ULHTs Nursing Cadet programme resulted in editorial features in both the local media and also the Nursing Times. Alongside this, turnover rates continue to be lower than the national average. Although there are concerns about Nursing & Midwifery staff vacancies, the voluntary turnover rate for this staff group (including retirements) at 7.44%, is still below the Trust average of 8.01%.

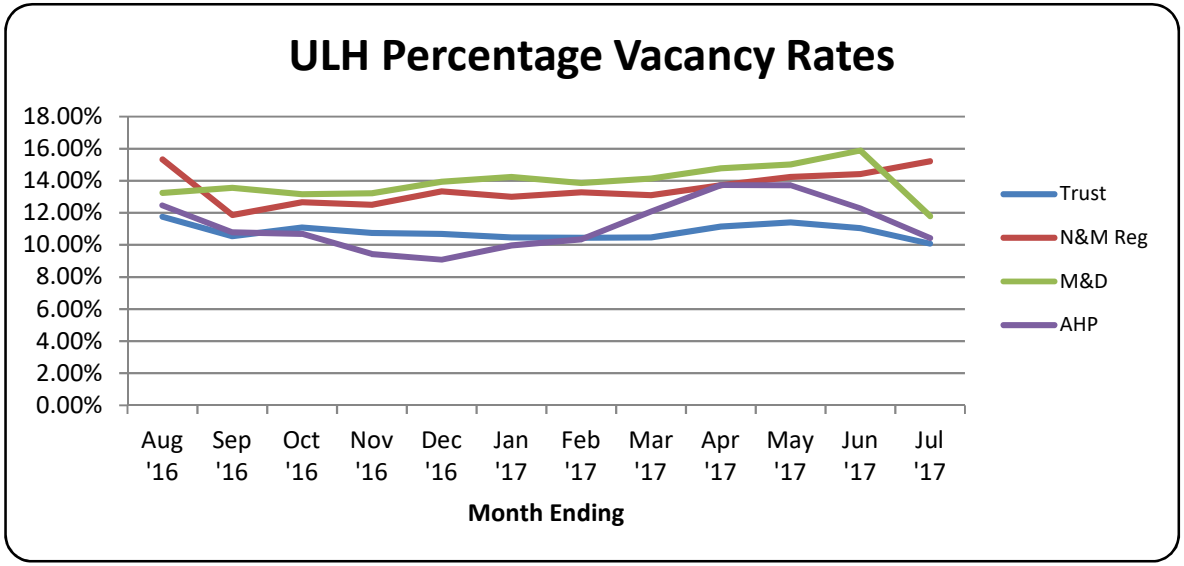
There is again positive news about sickness levels, as the rate for the last four months is 4.37% compared to 4.59% in the corresponding period last year. However this has yet to translate into a change in the 12 month rolling average as the winter of 2016/17 had a significantly higher sickness rate than in the same period during the previous year. If the current trend continues we should see a sizable reduction in the 12 month rolling average by the end of the financial year.

The completion rate for non-Medical appraisals has gone up by a further 0.70% in the last month and 17.77% since the end of March 2017. The current compliance rate this month has been the highest since 2014.

KPI:	Vacancy rates	**Owner:**	Director of HR & OD
Domain:		**Responsible Officer:**	Deputy Director of HR & OD
Date:	5th September 2017	**Reporting Period:**	July 2017
Target:	Medical – 12% Registered Nursing – 11.5% AHPs – 10%	**Tolerances:**	Within 1% - Amber Above 1% - Red
RAG Rating:	**Medical 11.79%** **N&M Reg 15.21%** **AHP'S 10.43%**		

Analysis

The current overall Trust vacancy rate (July) is 10.08%, which is a decrease of 0.97% on June. However the reduction can be explained by the one week overlap of Foundation Year 1 Doctors at the end of July / beginning of August, and the omission from July onwards of the Consortia Nurses funded establishment (included in Unregistered numbers) reducing the number of vacancies calculated for this staff group. Nursing & Midwifery vacancies have increased since last month, with a reduction in AHP vacancies by 1.86%. It is one of our objectives to reduce vacancies by 16.66% in 2017/18.



The Trust had at the end of July:-

- 828.65 wte doctors and consultants compared to 800.90 at the start of the financial year. However much of the increase was due to the new intake of Foundation Year 1 doctors starting at the end of July, with the 2016 year's intake not leaving until the first week of August (one week overlap);
- 1925.58 registered nurses and midwives, compared to 1971.67 at the start of the financial year;
- 847.71 unregistered nurse and midwives, compared to 833.19 at the start of the financial year;
- 361.82 wte AHPs, compared to 346.15 at the start of the financial year.

The increase in the nursing vacancy rate is recognised as a concern. Further discussions will take place with nursing management to consider what further action we might take.

There have been some different 'views' regarding the number of unregistered nursing vacancies in the Trust. To help resolve this a meeting was held between the Deputy Chief Nurse, Finance and Human Resources at the end of July, and following the meeting Band 2 Consortia nurses who are funded by the Education Levy are now excluded from the vacancy figure for Unregistered Nursing & Midwifery staff and the overall Trust vacancy rate.

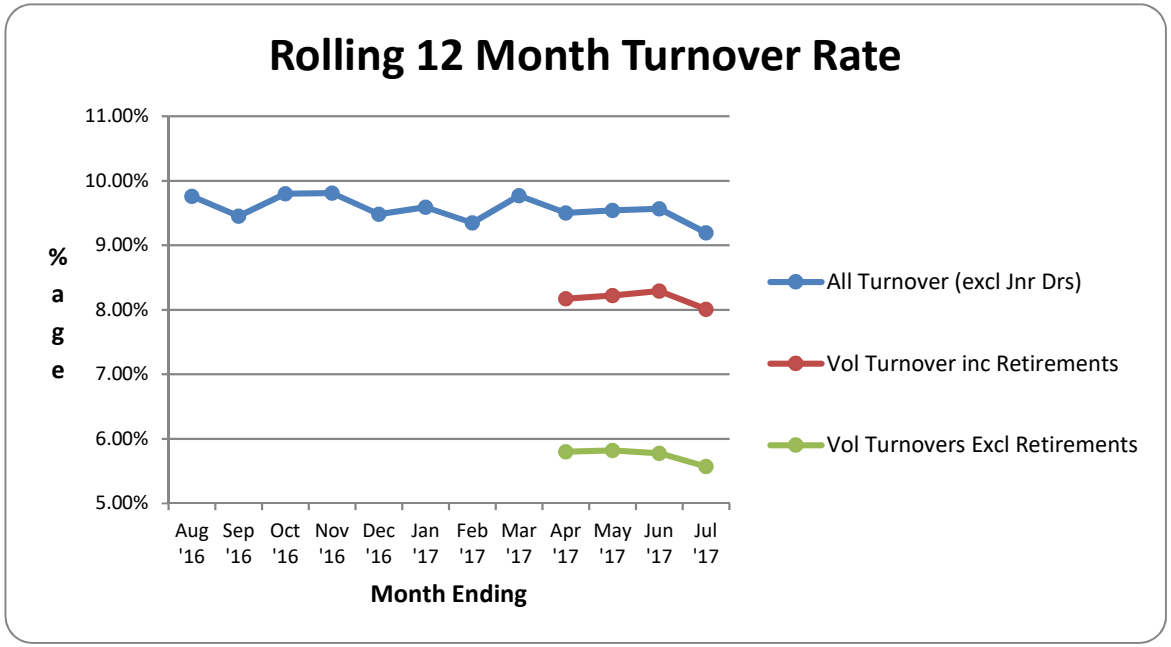
Action Taken	**Action Planned**
• The 'plan for every medical role' reintroduced so that clinical directorates can articulate what they plan to do to fill their vacancies; • Two pieces of work have been commissioned, to better understand why people are leaving and ULHT's reputation in the prospective workforce. • Meeting took place on 27th July between HR, Finance and DD of Nursing to review the 'source' and 'calculation' used for Nursing staff vacancies. It was found that nursing dashboards include ITTC areas only, whereas the Workforce Integrated Performance report includes all nursing vacancies. Although the two reports are using different measures, it was agreed HR would exclude consortia establishments as they are funded by Health Education East Midlands as salary replacement for Nurses on OU courses. This action has reduced the Unregistered N&M vacancy rate. • TMP have reported back on the views of potential medical candidates about ULHT and we will be assessing how we can utilise this information to enhance our offer. • Our work to recruit to nurse "cadet" roles has been well-received and publicised.	• 'Petaurum Solutions' will be working with the Trust to understand better from the 350 Registered Nurses and 50 Midwives that have left in the last two years the reasons why they left, what we could have done to keep them, and what we could do to entice them back. • Deliver the actions identified in the Medical and Nursing Recruitment Plans.

KPI:	Voluntary Turnover	**Owner:**	Director of HR & OD
Domain:		**Responsible Officer:**	Deputy Director of HR
Date:	5th September 2017	**Reporting Period:**	July 2017
Target:	7% (excl. retirements) with no group of staff more than 20% above the overall target	**Tolerances:**	Within 1% - Amber Above 1% - Red
RAG Rating:	5.57%		

Analysis

The current 12 month rolling average as at July '17 is 8.01% including retirements and 5.57% excluding retirements. This is a reduction on the previous month when the rate including retirements was 8.29% and excluding retirements 5.78%. Of the leavers 27.85% was due to retirement and 65.72% was due to voluntary resignations. The remaining 6.43% of leavers were for other reported reasons e.g. dismissal. Over the last 12 months 109 staff have returned post 'retirement', most to the bank.

The return rate of exit interview questionnaires remains below 30%. We are currently undertaking an analysis of the results and will report back shortly.



The table below shows the percentage voluntary turnover by Staff Group over a rolling 12 month period, with AHP and Additional Professional Scientific and Technical Services (Pharmacist, Technicians, ACPs, Advanced Practitioners, Physician Associate, etc.) having a turnover of more than 20% above the target of 8.4% (when we exclude retirements). If we take retirements into account Health Scientists, AHPs and Additional Professional Scientific and Technical Staff Groups will exceed the target.

There is clearly variation between groups and we need to specifically understand the 'issues/challenges' in Professional, Scientific and Technical and Allied Health Professionals to determine if there are particular issues to address. It is noteworthy that 27% of leavers are retiring, reflecting the known issue about the age of the workforce.

It's important to note that a number of AHP staff (in particular Therapies) have TUPE'd out of ULHT which contributes to the increase in the rolling turnover rate, and should not, therefore be considered as legitimate turnover. In addition the number of retirements in this service increased over the last 12 months as well. During 2016/17 the service had 67 leavers (8 who retired) and recruited/replaced 46 new staff (resulting in shortfall of 21 wte staff)

	Voluntary Turnover including Retirements Jul '17	Voluntary Turnover excluding Retirements Jul' 17	Voluntary Leavers including Retirements Jun '17	Voluntary Leavers including Retirements Jul '17	Increase / Decrease compared to previous month
Staff Group	**%age**	**%age**	**WTE**	**WTE**	**WTE**
Allied Health Professionals	14.82%	12.63%	1.80	2.00	0.20
Add Prof Scientific and Technic	13.97%	11.86%	0.00	3.00	3.00
Healthcare Scientists	10.89%	6.58%	1.67	2.00	0.33
Medical and Dental	8.80%	6.07%	3.00	0.00	-3.00
Nursing & Midwifery Reg	7.44%	4.76%	10.86	12.68	1.82
Administrative & Clerical	7.27%	5.17%	5.99	5.03	-0.96
Additional Clinical Services	7.03%	4.98%	3.60	3.80	0.20
Estates and Ancillary	6.30%	3.48%	3.89	5.12	1.23
Students	0.00%	0.00%	0.00	0.00	0.00
Total	**8.01%**	**5.57%**	**30.81**	**33.63**	**2.82**

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

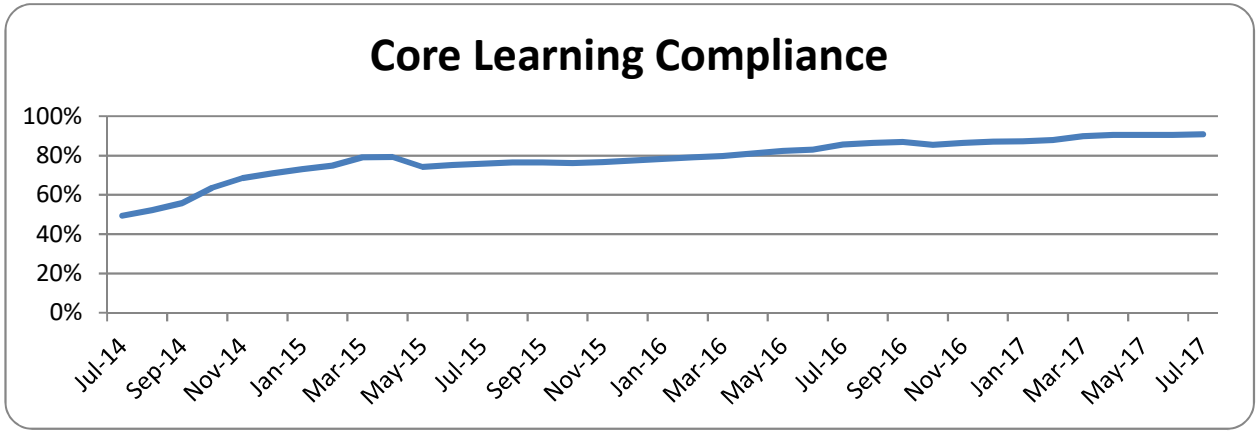
- The current Trust turnover rate (excl. junior doctors) of 9.19% is below the average of 10.14%
- The current Trust Nursing & Midwifery (Registered) turnover rate of 7.81% is below the average of 10.64%,
- The current Trust AHP turnover rate of 14.90% is above the average of 11.99%.

Action Taken	**Action Planned**
• Workforce Scorecard comparative data has been shared with the Directors/Clinical Directors, which shows compliance against key workforce indicators • As a positive response to the incremental increases in state and NHS retirement ages, as well as to our local staff survey data, we have embarked on a thoroughgoing review of our flexible working options. Utilising nationally recognised resources from NHS Employers and benchmarking with other NHS Trusts, this work is initially focussing on the nursing establishment. It is anticipated that the output of this work stream will be a robust and structured portfolio of flexible working options for nurses. If successful, the Trust would look at rolling this approach out to other professional groups.	• We will continue to undertake reviews in the areas identified with more than 20% above target of 7%, to identify and analyse the underlying reasons for staff leaving the Directorates and feedback provided to relevant parties/committees. A second 'Deep Dive' has been carried out this month into Additional Clinical Service on turnover and sickness and will be tabled at the WF &OD Assurance Committee as well. • As part of the wider People Strategy and QSIP plans, a piece of work on staff retention is underway looking specifically at 'Making ULHT a Great Place to Work – Retaining You' and feedback from specific areas/categories from Exit Interviews questionnaires will form part of this e.g. My Wellbeing, My Manager, My Team, Fair Deal, personal growth etc.

KPI:	Core Learning Completion	**Owner:**	Director of HR & OD
Domain:		**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	5th September 2017	**Reporting Period:**	July 2017
Target:	Project to set revised targets delayed. Will be completed asap	**Tolerances:**	
RAG Rating:	90.81%		

Analysis

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



Compliance as of the end of July shows a slight increase from 90.47% last month to 90.81%. We now report on a combined figure (including medical) for core learning compliance. We do not have any Directorate with a compliance rate below 84% at this point, with two Directorates achieving the 95% compliance target.

The information below shows how this is broken down by topic, directorate and staff group. The RAG rating shows compliance with the present target of 95%.

Compliance for all core learning topics apart from Fraud are increasing slowly with Fire showing the biggest increase of 1.24%. We must focus on achieving 100% compliance with fire safety training however, so we will be working with facilities to dramatically increase this rate.

Topic		Jul-17	Jun-17
Equality, Diversity and Human Rights - 3 Years	↑	98.11%	97.90%
Fraud Awareness - 3 years	↓	94.86%	94.90%
Slips, Trips & Falls - 3 year	↑	93.53%	93.44%
Safeguarding Children Level 1 - 3 Years	↑	93.06%	92.79%
Safeguarding Adults Level 1 - 3 Years	↑	92.94%	92.73%
Health and Safety - 3 Years	↑	92.85%	92.27%
Moving & Handling for Inanimate Load Handlers - 3 Years	↑	92.62%	92.47%
Risk Awareness - 3 Years	↑	92.52%	92.50%
Information Governance - 1 Year	↑	88.49%	87.80%
Fire Safety - 1 Year	↑	87.38%	86.15%
Infection Control - 1 Year	↑	85.33%	85.10%
Resuscitation [BLS] - 1 Year	↑	78.08%	77.57%

Directorate		Jul-17	Jun-17
Director of Fin & Corp Affair	↑	98.12%	96.74%
Deputy Chief Executive	↓	97.39%	97.44%
Director of HR & Org Dev	↑	94.93%	93.44%
Integrated Medicine Lincoln	↓	93.75%	94.35%
Women & Childrens Pan Trust	↓	93.07%	93.09%
Director of Nursing	↑	92.98%	92.69%
Chief Executive	↑	92.95%	78.21%
TACC Lincoln	↓	92.90%	93.13%
Medical Director	↓	92.88%	93.06%
Clinical Support Services	↑	92.25%	92.14%
TACC Boston	↓	91.96%	93.23%
Chief Operating Officer	↑	91.44%	89.08%
Director of Estates & Facil	↑	91.43%	89.32%
Head & Neck Trustwide	↑	90.78%	89.39%
General Surgery Boston	↓	90.53%	91.12%
Surgical Services Lincoln	↑	90.00%	89.29%
Grantham	↓	89.81%	89.82%
Acute Medicine Lincoln	↓	89.80%	89.88%
Surgical Services Boston	↓	89.47%	94.12%
Haem & Onc Trustwide	↓	89.29%	89.88%
Trustwide Cardiology Services	↑	88.21%	87.36%
Orthopaedics Lincoln	↑	87.20%	86.40%
Gen Surg Linc & Urology Trust	↑	86.75%	86.39%
Orthopaedics Boston	↑	86.21%	84.51%
Acute Medicine Boston	↓	84.71%	84.93%
A&E Lincoln	↑	84.70%	81.12%

Staff Group		Jul-17	Jun-17
Healthcare Scientists	↓	92.52%	92.97%
Allied Health Professionals	↓	92.28%	92.32%
Nursing and Midwifery Registered	↓	92.16%	92.21%
Administrative and Clerical	↑	91.98%	91.52%
Add Prof Scientific and Technic	↑	91.89%	91.44%
Students	↓	91.67%	97.92%
Additional Clinical Services	↑	90.14%	89.53%
Estates and Ancillary	↑	89.13%	87.50%
Medical and Dental	↓	84.46%	85.11%

Action Taken	**Action Planned**
• Core Learning forms part of the WF Balances Score Card and highlighted as part of the performance review meetings. • An additional tab has been developed within the ESR '5 click' compliance report providing an automatic overall percentage for core learning. This is particularly useful for senior managers to gain an overview of compliance for their teams	• Longer-term plan to introduce competency and skill matrices for key roles. • Core Learning Panel will meet monthly moving forward. There have been several submissions received for consideration as Core and Core Plus. The panel has also been asked to review the compliance % target. • Focus on fire in the next month

• 'ESR Top of the Week!' has been introduced which provides short tips to help staff use ESR Learning Management. A new tip is provided weekly in the Weekly Roundup and also on the core learning area of the intranet. The intention is that staff who do not access the user guide will rea and learn from a short tip. • Core Learning Panel met on 11 August where it was decided that Fraud Awareness should remain core learning. • New Core Topic – Major Incident Awareness went live on 1st August. Compliance will not be included in the overall compliance figures for the first six months to allow for local completion.	

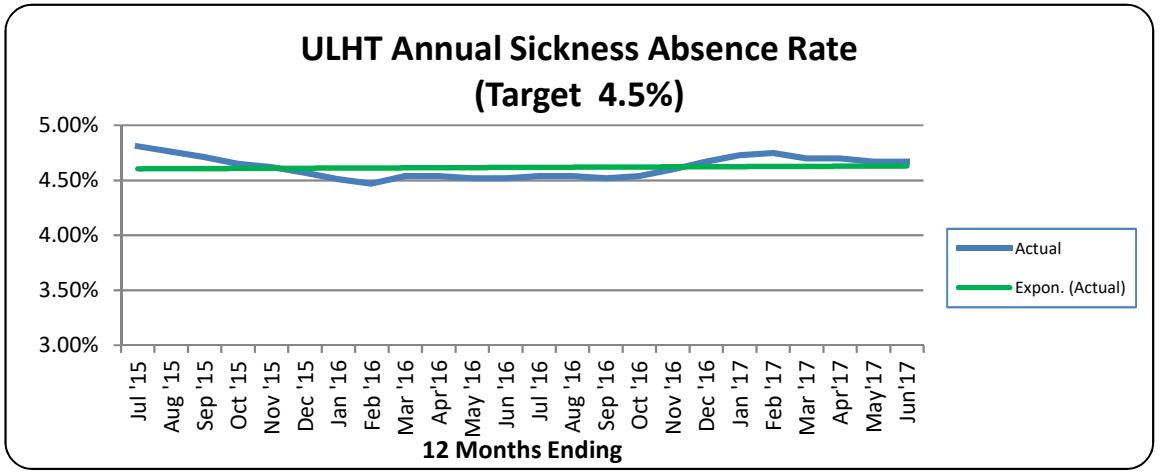
KPI:	Sickness Absence	**Owner:**	Director of HR & OD
Domain:		**Responsible Officer:**	Deputy Director of HR
Date:	5th September 2017	**Reporting Period:**	June 2017
Target:	Overall target of 4.5% + no team over 25% above target	**Tolerances:**	Within 0.5% - Amber Above 0.5% - Red
RAG Rating:	**4.67%**		

Analysis

The Trust annual rolling sickness rate of 4.67% (against 2017/18 target of 4.5%) remains unchanged from the previous month. Although our last four month sickness rate has improved year-on-year, the 12 month rolling sickness as at the end of June 2017 has increased by 0.15% in comparison to the June 2016 figure (4.52%).

The CCG's have confirmed that the Trust has achieved our 2016/17 CQUIN, which has a value to the Trust of £800.000

During the 12 months ending Jun '17, Anxiety/Stress/Depression and other Psychological illness was the top reason for time lost due to sickness at 20.16% of all absence. These 'mirror' patterns across the NHS nationally, incl. MSK



Additional Clinical Services had the highest sickness rate during the 12 months at 7.04% (Unregistered Nurses 7.82%) followed by Estates & Ancillary at 6.71%, Additional Professional Scientific and Technical at 5.01% and Nursing & Midwifery Registered at 4.66%.

The latest Benchmarking data as at April 2017 from NHS Digital (previously Health & Social Care Information Centre - HSCIC) indicates that ULHT has the 7th highest sickness rate (lowest at 2.96% and highest 5.62%) against an average of 4.32%. The benchmarking is done across x38 Large Acute Trusts.

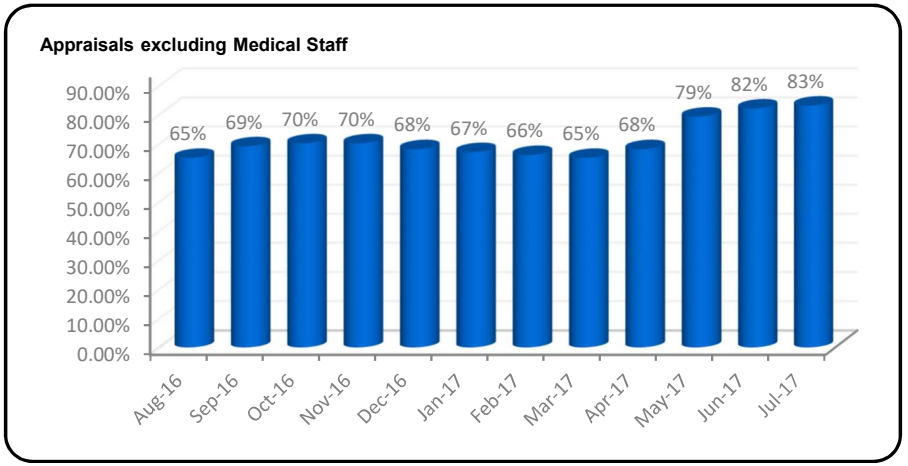
Action Taken	**Action Planned**

• A number of O/H 'interventions' have been put in place to support health and wellbeing:
  o Provision of Mental Health First Aid and Mindfulness Training (for 2017, 140 staff have attended these courses)
  o Trust provide a Level 2 accredited Counselling Course for Band 6 and above and 22 staff have been trained to date
  o All member of ULHT staff have direct access to Physiotherapy for MSK or back pain and staff can self-refer to O/H for support (for 2016/17 689 referrals were made)
• Continuation on a monthly basis a MDT with HR colleagues and Occupational Health to assess actions and accountability take place. This month it was 171 long term sickness cases across the organisation
• Notifications of staff that are hitting triggers are being sent to line managers.
• A 360 Sickness Absence Management Audit was conducted and resulted in a 'significant assurance' rating.
	• A review of the Sickness Policy is scheduled for later in the year.
	• HRBPs and ER Team will continue to support Managers with managing their staff attendance, flagging up trigger points
	• Continuation of Regular/Monthly sickness review meetings with Occupational Health continue with the aim to return staff back to work and/or support managers with 'alternative' and supportive actions were appropriate.
	• Training is being delivered to staff around having difficult conversations through absence management.
	• Feedback being arranged with the Director of E&F following complaint in managing sickess case with over 50 participants attending
	• Work being carried out on reviewing Junior doctors sickness with communication to Clinical Directorates to ensure the Trust manages these episodes

KPI:	Appraisal Rates	**Owner:**	Director of HR & OD
Domain:		**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	5th September 2017	**Reporting Period:**	July 2017
Target:	Medical – 95% Non-Medical – 85%		Within 5% below - Amber More than 5% below – Red
RAG Rating:	Non-Medical – 82.67%		

Analysis

Action taken to date has clearly had an impact on the overall level of non-medical appraisals. However, 82.67% is still well below where the organisation should be in terms of appraisal compliance. HR Business Partners will continue to press managers on appraisal completion. The graph below shows that the Agenda for Change Staff/Non-Medical Appraisal compliance rate for July is 82.67%. This has been the highest compliance rate since 2014. The overall percentage for appraisals has increased by 0.70% from the previous month and an improvement of 14.45% in the last two months, which is very positive, although we remain below target.



The table below shows the year on year rate and the graph the month on month improvement in the last 12 months:

Appraisal Compliance rate (Year-on-Year) comparison:

- July 2014 – 44.00%
- July 2015 – 78.88%
- July 2016 – 65.00%
- July 2017 – 82.67%

A month on month appraisal comparison by Directorate is now available. This follows the development of additional Clinical Directorates reports in ESR to mirror Finance budget reporting.

Note: Surgical Services Boston, Surgical Services Lincoln and Integrated Medicine Lincoln contain management staff responsible for several clinical directorates so can't be allocated to specific directorates. They include General Managers and Heads of Nursing etc

Directorate		Appraisal Rate July '17 (Excludes Medical Staff)	Appraisal Rate June '17 (Excludes Medical Staff)
Chief Executive	↑	100.00%	55.56%
Surgical Services Boston (see note below)	↑	95.00%	89.47%
Director of Fin & Corp Affair	↑	94.90%	89.80%
TACC Boston	↓	94.17%	94.92%
CSS Therapies	↓	*93.70%*	*96.02%*
Director of HR & Org Dev	↓	93.55%	96.88%
Orthopaedics Boston	↓	93.33%	94.81%
Medicine Boston	↓	91.55%	92.05%
TACC Lincoln	↑	89.97%	87.88%
General Surgery Boston	↓	89.32%	94.69%
Women & Children's Pan Trust	↑	88.89%	87.15%
Haem & Onc Trustwide	↑	87.08%	84.36%
Grantham	↑	86.93%	86.12%
Gen Surg Linc & Urology Trust	↑	86.70%	85.59%
CSS Pharmacy	↑	*83.33%*	*81.75%*
CSS Diagnostics	↑	*82.80%*	*75.30%*
Trustwide Cardiology Services	↑	82.56%	81.91%
Clinical Support Services	↑	81.80%	79.50%
A&E/Acute Lincoln	↓	81.73%	83.17%
General Medicine Lincoln	↓	80.84%	84.51%
Chief Operating Officer	↓	79.10%	81.82%
Orthopaedics Lincoln	↓	78.65%	78.72%
Medical Director	↑	74.75%	72.73%
Deputy Chief Executive	↑	74.38%	73.50%
Integrated Medicine Lincoln (see note below)	↑	74.07%	73.08%
CSS Outpatient Management	↓	*73.35%*	*74.41%*
Head & Neck Trustwide	↓	68.29%	69.88%
Director of Estates & Facil	↑	63.12%	61.87%
Director of Nursing	→	57.32%	57.32%
Surgical Services Lincoln (see note below)	↑	36.84%	30.00%

The Medical Workforce appraisal rate has achieved the required 95% target for two successive months. Medical Staff appraisal compliance rate for Appraisal month ending July 2017 is 96%. This figure includes Consultants, SAS Doctors and all Trust Locums who all now have access to the Allocate e-appraisal system.

The appraisal rate currently stands at 96% compliant. The 4% who did not achieve appraisal consist of:

- 8 doctors with late appraisals not agreed – Escalation process in place
- 7 doctors with agreed postponement – 6 of these doctors have been in post less than 8 months.
- 4 doctors on career break / Sabbatical / Secondment.
- 2 doctors on sick leave.
- 2 doctors on Maternity leave.

Action Taken	**Action Planned**
• Workforce Scorecards continue to contain appraisal data which is shared on a monthly basis with Directorates for consideration/action this is also reported into clinical directorate performance meetings. • Appraisal compliance is reported into the Quality and Safety Improvement Plan as part of this work stream	• HRBPs will continue with the actions being taken to date as this is clearly having an impact • There is a plan in place for each doctor, for whom this is their first post in the UK, to participate in appraisal within 3 months of their start date with the Trust. The schedule for appraisal has been brought forward from 6 months to 3 months to ensure doctors who are employed on short term contracts have the opportunity to participate in appraisal during their employment. • The Revalidation Office will continue to closely monitor and take prompt action when appraisals are not undertaken as planned. The new Allocate e-appraisal system allows the Administrator to track progress with timely completion of appraisal documentation. This enables early intervention and support to both appraisee and appraiser. • Clinical Directors receive monthly reports of appraisal performance. • Proposal to increase the admin support to the Revalidation Office (0.53 of Band 2) to ensure improved governance to Revalidation processes. Awaiting decision from the Director of Finance. • Notification of 'Appraisal Due' sent to Doctors 4 months prior to their appraisal month. Strict adherence to the escalation processes set out in the Medical Appraisal Policy, with particular focus on the allocation of appraiser to appraisee 6 weeks prior to the appraisal due date if the doctor has not confirmed appraisal details. • Continued close monitoring of appraisal progress on the e-allocate appraisal system. Reminders sent to Appraisers to complete Appraisal Output documentation and sign off appraisal documentation within 28 days of the appraisal meeting in order to meet the GMC requirements. • Ensuring new and existing doctors receive continued support to use the new Allocate system.

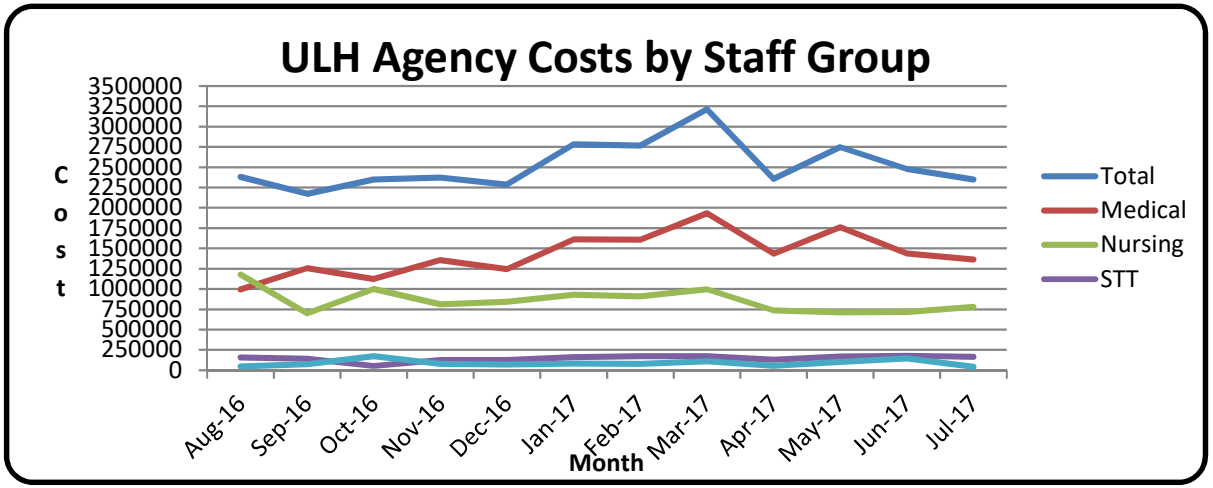
KPI:	Agency Spend	**Owner:**	Director of HR/OD
Domain:		**Responsible Officer:**	Various leads on different aspects of agency spend
Date:	5th September 2017	**Reporting Period:**	July 2017
RAG Rating:	Actual spend of £2.348m, against target of £1.75m		

Analysis

The table below shows agency spend in the last 12 months. For the second consecutive month there has been a reduction, however spend is still significantly above target and £147,768 higher than the level of spend in July 2016.

The total Agency cost in July was £2,348,079 which is a reduction of £130,449 from the previous month. Agency pay expenditure on Medical Staffing in July was £1,361,565 a decrease of £75,297 from June and £400,311 less than May.

This is a top priority for the Trust, but should be viewed also in the context of reducing overall workforce costs. It is now managed through the Financial Recovery Group. The Agency Cost Reduction Plan submitted to NHSI was not considered to be adequate and more work is being undertaken to review plans and demonstrate how actions taken will enable target spend levels to be achieved.



Action Taken	Action Planned
• Plans are in place and are monitored for Nursing and Medical agency spend. • Actions taken include incentivisation of bank for nursing and conversion of locums to permanent medical contracts.	• Action plan to cover spend on non-medical/nursing agency spend being developed. • Implementation of weekly pay for nursing staff on bank in November.

KPI:	Quarterly engagement index	**Owner:**	Director of HR/OD
Domain:		**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	5th September 2017	**Reporting Period:**	July 2017
Target:	10% improvement in average score during 2017/18		
RAG Rating:	3.35 (The score is out of five and comprises six questions from the pulse survey)		

Analysis

The score has not been RAG rated this month as this is the first time that the figure has been available. And as this is a local measure, there is no comparator.

Over the past few months, the Trust has invested in a number of staff engagement and listening events. These are:

- Pulse Survey
- Staff Charter development
- Management training course Executive listening session
- Listening and responding to staff exercise with staff-side

The main themes emerging from these interventions can broadly be categorised as follows:

1. Resources
   - Staffing
   - Environment
   - Equipment

2. Management/leadership
   - Communication
   - Feedback
   - Appreciation
   - Challenging poor behaviours and attitudes

The themes have been discussed with the Staff Engagement Group and the Director of HR and OD will be sharing themes and proposed responses from the management course with the Executive Team.

Action Taken	**Action Planned**
• Feedback from all four interventions discussed at Staff Engagement Group • Discussion at SEG about best practice in increasing response rates for 2017 NHS Staff Survey • Significant work undertaken on Staff Charter including presentations to ET and Executive Partnership Forum	• HRD to present themes and proposed actions with ET • Head of OD to feedback responses and actions to staff through wide range of communications media • Preparation taking place to communicate with staff about 2017 Staff Survey • Staff Charter to be completed end August 2017 • Planning to take place to embed Staff Charter across whole staff journey

KPI:	Quality of leadership and management index	**Owner:**	Director of HR/OD
Domain:		**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	5th September 2017	**Reporting Period:**	July 2017
Target:	10% improvement in average score during 2017/18		
RAG Rating:	2.8 (The score is out of five and comprises two questions from the pulse survey)		

Analysis

The score has not been RAG rated this month as this is the first time that the figure has been available. And as this is a local measure, there is no comparator. However, we are disappointed with the score of 2.8 but recognise the importance of leadership on our improvement journey and this is one of the priorities in the People Strategy. (actions from the Strategy included below)

Following a paper to ET in April 2017, work has been undertaken on a wholesale review of ULHT's internal and external leadership and management development offers to ensure that this is fit for purpose to support the delivery of the Trust's objectives and develop inclusive, compassionate leaders. This included a SWOT analysis which has been used to inform the revised offer.

Action Taken	**Action Planned**
• Continuation of 2 day Supporting You to Manage and Deliver our Values and Behaviours. Target group is all CDs, Heads of Service, Heads of Nursing, Matrons, senior AHPs, Ward Managers, General Managers. 146 managers have now attended. Programme includes requirement to complete 360 feedback using the NHS Healthcare Leadership Model • Regular RAG rated reports of booking and attendance sent to CDs and Executives • 3 cohorts of Lincolnshire's Mary Seacole programme running. Participants drawn from all health providers, adult social care and CCGs. • ULHT continues to support staff to participate in East Midlands Leadership Academy programmes – the Trust is in discussion with EMLA	• Revised leadership offer to be presented to ET end August 2017 • Proposed STP Lincolnshire Health and Care leadership programme being progressed • Senior Leadership Forum being planned for October 2017 with revised targeted list of attendees • Staff Charter will incorporate current Leadership Charter

Money & Resources

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Money & Resources						
Income	Monthly	Board Report Master	36415	138835	36010	35587
Expenditure	Monthly	Board Report Master	-40392	-169417	-42689	-42831
Efficiency Delivery	Monthly	FIMS report	1342	1698	1391	104
Surplus / Deficit	Monthly	FPIC Finance Report	-3977	-30582	-6679	-7244
Capital Delivery Program	Monthly	FPIC Finance Report	-615	-1662	-285	-769
Agency Spend	Monthly	Agency Staff Analysis	-1790	-9954	-2354	-2486

Finance Headline Summary

Executive Responsibility: Karen Brown – Director of Finance

Trust Financial Performance

Key Financial Duties

Financial Duty	Annual Plan / Target £m	YTD Plan £m	YTD Actual £m	RAG
Delivering the Planned Deficit	-48.564	-17.992	-30.698	R
Achieving the External Finance Limit (EFL)	76.316	-	-	G
Achieving the Capital Resource Limit (CRL)	18.912	1.899	1.811	G

Key Issues

- The Trust plan for 2017/18 is a control total deficit of £48.6m, inclusive of £14.7m STF income.
- The Month 4 position was an in-month deficit of £6.8m, which is £2.8m adverse to the planned in-month deficit of £4.0m
- The Trust will not deliver its control deficit of £48.6m and a financial recovery plan that was submitted to NHSI identified a most likely deficit of £75.2m.
- The £75.2m forecast plan assumes delivery of £18.2m of efficiency savings.
- The deterioration in the income and expenditure position directly impacts on cash and the level of borrowings needed in 2017/18. The Trust will require external cash support in line with the forecast outturn in 2017/18.

Financial Performance

The Trust is reporting:

- An in-month deficit in July of £6.8m, which is £2.8m adverse to the planned in-month deficit of £4.0m.
- A year to date deficit of £30.7m, which is £12.7m adverse to the planned year to date deficit of £18.0m.

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

- Slower than planned delivery of efficiency savings, with delivery to date £3.7m below plan.
- Non-achievement of STF income resulting in the loss of £3.2m STF income.
- Pilgrim fire, norovirus outbreak and cyberattack resulting to date in the loss of £2.0m of income.
- Non-achievement of £0.7m of CQUIN income.
- £0.7m in relation to the outcome of the hoist legal case.
- Contract challenges of £0.6m from 2016/17 re SUS to SLAM reconciliation.
- Higher than planned level of expenditure on agency staffing, with expenditure to date £3.0m higher than planned and not fully offset by a reduction in substantive and bank pay expenditure.

Table 1: Financial Position

	July 2017			April 2017 to July 2017		
	Plan	Actual	Variance	YTD	YTD	YTD
	£'000	£'000	£'000	£'000	£'000	£'000
Operating income from patient care activities	32,368	33,429	1,061	127,940	128,086	146
Other operating income	4,047	2,581	-1,466	15,430	10,749	-4,681
Employee expenses	-25,896	-26,645	-749	-103,509	-107,799	-4,290
Operating expenses excluding employee expenses	-14,105	-15,876	-1,771	-56,334	-60,712	-4,378
OPERATING SURPLUS / (DEFICIT)	**-3,586**	**-6,511**	**-2,925**	**-16,473**	**-29,676**	**-13,203**
NET FINANCE COSTS	**-391**	**-266**	**125**	**-1,561**	**-1,004**	**557**
Other gains/(losses) including disposal of assets	0	98	98	0	98	98
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**-3,977**	**-6,679**	**-2,702**	**-18,034**	**-30,582**	**-12,548**
Adjusted financial performance surplus/(deficit)	**-3,967**	**-6,752**	**-2,785**	**-17,992**	**-30,698**	**-12,706**
Adjusted financial performance surplus/(deficit) excluding STF	**-4,949**	**-6,752**	**-1,803**	**-21,184**	**-30,698**	**-9,514**

Efficiency

- The financial plan for 2017/18 includes a FEP target of £18m, to which the shortfall of £6m from 2016/17 has to be added, giving a total FEP requirement for 2017/18 of £24m.
- The Trust has now identified high level schemes totalling £18.2m and these have been included within the financial recovery plan submitted to NHS Improvement. The development of the detailed schemes is being led by the Trust's Executive Directors and will be supported by the appointment of an external partner.
- The actual delivery to date at Month 4 is £1.7m, which is £3.7m short of the level of savings the Trust originally planned to deliver by the end of July 2017.

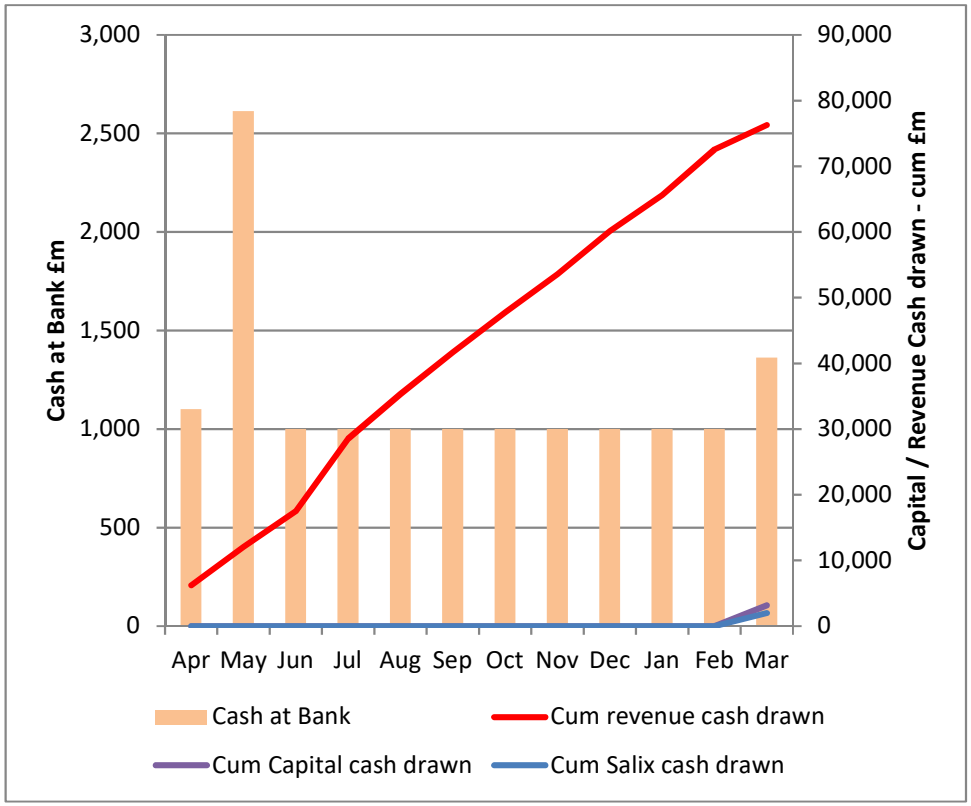
Capital

The spend to date of £1.6m is inclusive of £0.4m on IT infrastructure, £0.4m on replacement medical devices, £0.3m on Estates compliance including fire and £0.7m on major developments that have spanned the 2016/17 and 2017/18 financial year-end – primarily Neonates

Cash

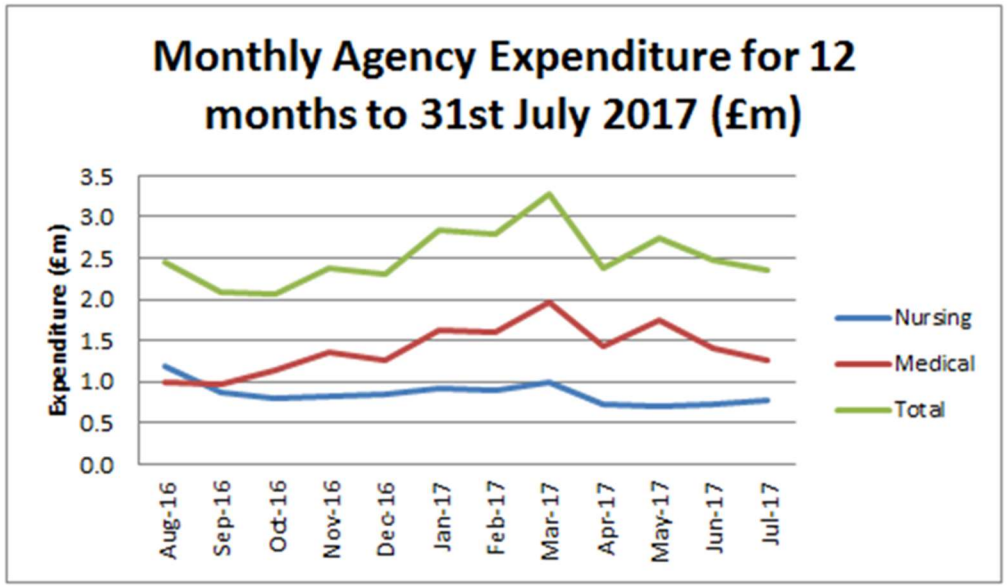
As at the end of July, the Trust held cash of £1.33m, including external revenue support loans of £28.5m drawn down over the first four months. The total repayable borrowings through working capital loans, Salix loans and uncommitted loan facilities were £139.2m.

The revenue cash draw down to support the forecast Income and expenditure during the year is shown to the right and highlights that the trust borrowings will increase in line with the forecast deficit for the year.



Agency

The table below shows agency expenditure over the last twelve months, and that agency expenditure fell in-month from £2.5m in June to £2.4m in July. The spend on agency staffing reflects the fact that there are significant levels of vacancies in the Trust. While part of the agency cost is covered by an underspend on substantive staffing, pay expenditure remains £0.7m higher in-month than planned, and this reflects both the higher than planned spend on agency staffing and under delivery of efficiency savings.



CQUINs 2017/18

No.	Goal name	Lead Director / CQUIN Lead	Description of indicator /target	Reporting Frequency	Q1 potential achievement
National CQUINs					
1a	Improving Staff Health and Wellbeing	Stephen Kelly	Achieving an improvement in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress. 1. Question 9a: Does your organisation take positive action on health and well-being? Achieve an improvement of 5% points in the answer "yes, definitely" compared to 2016 staff survey results or achieve 45% of staff surveyed answering "yes, definitely" 2. Question 9b: In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Achieve an improvement of 5% points in the answer "no" compared to 2016 staff survey results or achieve 85% of staff surveyed answering "no" 3. Question 9c: During the last 12 months have you felt unwell as a result of work related stress? Achieve an improvement of 5% points in the answer "no" compared to 2016 staff survey results or achieve 75% of staff surveyed answering "no"	**March 2017** (Submit survey to commissioners by 5th March 2018) • 2016 staff survey - Individual trust performance against each staff survey question 9a = 21% 9b = 73% 9c = 65% **Q4 - February 2018** • Achievement of the 5% improvement in 2 of the 3 questions in the staff survey results	
1b	Healthy food for NHS staff, visitors and patients	Paul Boocock	We are expected to build on the four changes required in the 2016/17 CQUIN by: **1**. Maintaining the four changes that were required in the 2016/17 CQUIN: a. The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS)1. b. The banning of advertisement on NHS premises of sugary drinks and foods high in fat, sugar or salt (HFSS); c. The banning of sugary drinks and foods high in fat, sugar or salt (HFSS) from checkouts; and d. Ensuring that healthy options are available at any point including for those staff working night shifts. **2**. Introducing three new changes to food and drink provision: a) 70% of drinks lines stocked must be sugar free b) 60% of confectionery and sweets do not exceed 250 kcal c) At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g	**Q4** (Submit signed agreements by 2nd April 2018) • Maintained the changes in 2016/17 • Introduced the 2017/18 changes by providing : - A signed document between the NHS Trust and any external food supplier committing to keeping the changes - Evidence for improvements provided to a public facing board	
1C	Improving the uptake of flu vaccinations for frontline clinical staff	Stephen Kelly	Achieving an uptake of flu vaccinations by frontline clinical staff of 70%	**Q4 - March 2018** (Submit to Commissioners & ImmForm by 26th March 2018) Achieve 70% uptake of flu vaccinations	
2a	Timely identification for sepsis in emergency departments	Adam Wolverson	The percentage of patients who met the criteria for sepsis screening and were screened for sepsis The indicator applies to adults and child patients arriving in hospital as emergency admissions. 50 sets of notes monthly to be audited..	**Q1** = 90% screened (Q1 sepsis identification data to Commissioners by 31st July 2017) **Q2** = 90% screened (Q2 sepsis identification data to Commissioners by 30th Oct 2017) **Q3** = 90% screened (Q3 sepsis identification data to Commissioners by 29th Jan 2018) **Q4** = 90% screened (Q4 sepsis identification data to Commissioners by 7th May 2018)	

No.	Goal name	Lead Director / CQUIN Lead	Description of indicator /target	Reporting Frequency	Q1 potential achievement
2a	Timely identification for sepsis in acute inpatient settings	Adam Wolverson	The percentage of patients who met the criteria for sepsis screening and were screened for sepsis The indicator applies to adults and child patients on acute in-patient wards. 50 sets of notes monthly to be audited.	**Q1** = 90% screened **(Q1 sepsis identification data to Commissioners by 31st July 2017)** **Q2** = 90% screened **(Q2 sepsis identification data to Commissioners by 30th Oct 2017)** **Q3** = 90% screened **(Q3 sepsis identification data to Commissioners by 29th Jan 2018)** **Q4** = 90% screened **(Q4 sepsis identification data to Commissioners by 7th May 2018)**	
2b	Timely treatment for sepsis in emergency departments	Adam Wolverson	The percentage of patients who present with severe sepsis, Red Flag Sepsis or septic shock and were administered intravenous antibiotics within the appropriate timeframe and had an empiric review within three days of the prescribing of antibiotics. Use the same sets of notes as in 2a.	**Q1** = 90% received IVAB within 1 hour **(Q1 sepsis treatment data to Commissioners by 31st Jul 2017)** **Q2** = 90% received IVAB within 1 hour **(Q2 sepsis treatment data to Commissioners by 30th Oct 2017)** **Q3** = 90% received IVAB within 1 hour **(Q3 sepsis treatment data to Commissioners by 29th Jan 2018)** **Q4** = 90% received IVAB within 1 hour **(Q4 sepsis treatment data to Commissioners by 7th May 2018)**	
2b	Timely treatment for sepsis in acute inpatient settings	Adam Wolverson	The percentage of patients who present with severe sepsis, Red Flag Sepsis or septic shock and were administered intravenous antibiotics within the appropriate timeframe and had an empiric review within three days of the prescribing of antibiotics. Use the same sets of notes as in 2a.	**Q1** = 90% received IVAB within 1 hour **(Q1 sepsis treatment data to Commissioners by w/c 31st Jul 2017)** **Q2** = 90% received IVAB within 1 hour **(Q2 sepsis treatment data to Commissioners by w/c 30th Oct 2017)** **Q3** = 90% received IVAB within 1 hour **(Q3 sepsis treatment data to Commissioners by w/c 29th Jan 2018)** **Q4** = 90% received IVAB within 1 hour **(Q4 sepsis treatment data to Commissioners by w/c 7th May 2018)**	
2c	Empiric review of antibiotic prescriptions	Simon Priestley	Audit a minimum of 30 notes for a clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.	**Q1** = Perform an empiric review for at least 25% of cases **(Q1 antibiotic review data to Commissioners & PHE by 31st Jul 2017)** **Q2** = Perform an empiric review for at least 50% of cases **(Q2 antibiotic review data to Commissioners & PHE by 30th Oct 2017)** **Q3** = Perform an empiric review for at least 75% of cases **(Q3 antibiotic review data to Commissioners & PHE by 29th Jan 2018)** **Q4** = Perform an empiric review for at least 90% of cases **(Q4 antibiotic review data to Commissioners & PHE by 7th May 2018)**	
2d	Reduction in antibiotic consumption	Simon Priestley / Sue Leo	Reduction of 1% or more in total antibiotic consumption against the baseline Reduction of 1% or more in carbapenem against the baseline Reduction of 1% or more in piperacillin-tazobactam against the baseline	**Q1** = submit antibiotic consumption data to PHE **Q2** = submit antibiotic consumption data to PHE **Q3** = submit antibiotic consumption data to PHE **Q4 (Q4 antibiotic consumption data to be submitted to Commissioners & PHE by 26th March 2018)** • Submit antibiotic consumption data to PHE • Reduction of 1% antibiotic consumption against baseline • Reduction of 1% in carbapenem against baseline • Reduction of 1% in piperacillin-tazobactam against baseline	

No.	Goal name	Lead Director / CQUIN Lead	Description of indicator /target	Reporting Frequency	Q1 potential achievement
4	Improving services for people with mental health needs who present to A&E	Dr Robers / Dr Sant (joint CQUIN with LPFT)	20% reduction in A&E attendances of the cohort of top 0.25% most frequent attenders to A&E in 2016/17	Q1 • Baseline of 2016/17 attendances is recorded (baseline/subset data to Commissioners & HES by 8th May 2017) (Q1 activity report to Commissioners & HES by 3rd July 2017) • Clinical review meetings between A&E and MH Liason • Opportunistic assessment by MH Liaison Clinicians • Reiew of case notes • Assure commissioners work with other partners (111, ambulance, police etc) Q2 (Q2 evidence and plans to Commissioners & HES by 28th August 2017) • MH Trust, Acute Trust to identify cohort were coded appropriately in A&E HES dataset. • Internal audit of A&E MH coding - agree joint data quality improvement plan and arrangements of regular sharing of data • MH Trust & Acute Trust to establish joint governance • Care plans for each of the identified cohort • system to identify new frequent attenders • Care plans shared with other key system partners • Work with local partners to support sustained reduction Q3 (Q3 assurance report to Comissioners & HES by 27th Nov 2017) •Repeat internal audit of A&E MH coding to ensure accurate data quality Q4 (Q4 evidence to Comissioners & HES by 19th Mar 2018) • 20% reduction in A&E attendances within the cohort with a primary or secondary mental health diagnosis	
6	Set up and operate A&G services for non-urgent GP referrals	Lee Parkin	95% of GP referrals are made to elective outpatient specialties which provide access to A&G services.	Q1 (to get to commissioners by 1st June 2017) • Agree specialties with highest volume of GP referrals for A&G implementation • Agree plan / trajectory / timetable for the specialities responsible for 35% for introduction of A&G to these specialties during the remainder of 2017/18 • Agree local quality standard for provision of A&G, including 80% of responses within 2 working days Q2 (to get to commissioners by 30th October 2017) • A&G services in line with implementation plan • Local quality standard for provision of A&G finalised • Baseline data for main indicatorsprovided Q3 - (to get to commissioners by 29th January 2018) • A&G services operational for first agreed tranche • Quality standards for provision of A&G met • Data for main indictors provided • Timetable, implementation plan and trajectory for rollout of A&G to 75% of specialties by Q4 2018/19 agreed Q4 (to get to commissioners by 23rd April 2018) • A&G services operational for specialties covering at least 35% of total GP referrals by start of Q4 and sustained across the quarter • Quality standards for provision of A&G met • Data for main indictors provided	

No.	Goal name	Lead Director / CQUIN Lead	Description of indicator /target	Reporting Frequency	Q1 potential achievement
7	All providers to publish ALL of their services and make ALL of their First Outpatient Appointment slots available on eRS by 31 March 2018	Lee Parkin	To assess that all services are published on the NHS e-Referral Service and evidence a definitive list of all services/clinics accepting 1st O/P referrals and details of the NHS e-Referral Services they are mapped to.	**Q1** **(Slot polling to get to commissioners by 8th May 2017)** **(Remainder to get to commissioners by 3rd July 2017)** • Providers supply a plan to deliver Q2, Q3 and Q4 targets • Providers supply a definitive list of all services/clinics accepting 1st O/P referrals • Trajectory to reduce Appointment Slot Issues to a level of 4%, or less, over Q2, Q3 and Q4. **Q2** **(to get to commissioners by 2nd Otober 2017)** • 80% of Referrals to 1st O/P Services to be received through e-RS. • Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals in line with trajectory **Q3** **(to get to commissioners by 1st January 2018)** • 90% of Referrals to 1st O/P Services received through e-RS. • Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals in line with trajectory **Q4** **(to get to commissioners by 9th April 2018)** • 100% of Referrals to 1st O/P Services received through e-RS. • Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals in line with trajectory	
8	Supporting Proactive and Safe Discharge	Kathyrn Sayles (joint CQUIN with community)	Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories and undertake clinical audit as set out in the milestones section. Increasing proportion of patients discharged to their usual place of residence within 7 days of admission to 70%	**(Baseline data Q3 & Q4 2016/17 to be submitted by 8th May 2017)** **Q1** **(IT plan for update of ECDS to Commissioners by 26th Jun 2017)** • Emergency Care Data Set (ECDS) can be collected and returned from 1st October 2017 - plan **Q2** **(Discharge pathways, rollout protocols, baseline and trajectories yrs 1 and 2 to Commissioners by 2nd Oct 2017)** • Map and streamline existing discharge pathways across acute, community and NHS-care home providers, and roll-out protocols in partnership across local whole-systems. •Develop and agree with commissioner a plan, baseline and trajectories for ECDS. Achievement will require collaboration between acute and community providers. **Q3** **(Q3 Report HES data to Commissioners by 1st Jan 2018)** • Return data at least weekly AND 95% of patients have both a valid Chief Complaint and Diagnosis **Q4** **(Q3 Report HES data to Commissioners by 9th April 2018)** • 2.5% point increase from baseline in number of patients discharged to usual place of residence **OR** 47.5% in % of patients discharged to usual place of residence	

Specialised CQUINs - Detail for each Quarter to be discussed					
B12	Severe Haemophilia Haemtrack Patient Home Reporting	Bethan Myers / Alison Dawson Meadows	Improving adherence, timeliness, and accuracy of patient data submissions to the Haemtrack patient reporting system.	**Q1** (to get to commissioners by 31st July 2017) **Q2** (to get to commissioners by 13th November 2017) **Q3** (to get to commissioners by 19th February 2018) **Q4** (to get to commissioners by 14th May 2018) • Proportion of patients providing regular Haemtrack data as a proportion of all relevant patients. ...If baseline is 66% or less to achieve minimum 80%. If baseline is 67% to 84% to achieve minimum of 90%. If baseline is 85% or more to halve number of non-users • Proportion of all Haemtrackusers who provide an update once per week in period Q1-Q3 (39 weeks) to exceed 67% • To assess the accuracy of records made by patients and provide a baseline.	
GE3	Hospital Medicines Optimisation	Colin Costello / Simon Priestley	Support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services.The following priority areas for implementation have been identified nationally : **1** Faster adoption of best value medicines with a particular focus on the uptake of best value generics, biologics and CMU frameworks **2** Significantly improved drugs data quality to include dm+d code and all other mandatory fields in the drugs MDS and outcome registries such as SACT, as well as to meet the requirements of the ePharmacy and Define agendas **3** The consistent application of lowest cost dispensing channels **4** Compliance with policy/ consensus guidelines to reduce variation and waste.	**Q1** (to get to commissioners by 31st July 2017) **Q2** (to get to commissioners by 13th November 2017) **Q3** (to get to commissioners by 19th February 2018) **Q4** (to get to commissioners by 14th May 2018) • Adoption of best value generic/ biologic products in 90% of new patients within one quarter of guidance available. • Adoption of best value generic/ biologic products in 80% of applicable existing patients within one year of being made available • Improving drugs MDS data quality to include dm+d as drug code in line with ISB 0052 by June 2017 Submit HCD data in agreed MDS format • Increase use of cost effective dispensing routes for outpatient medicines • Transition to agreed cost per item reimbursement approach Improving data quality associated with outcome databases (SACT and IVIg) • Implementation of agreed transition plan for increasing data quality.	

No.	Goal name	Lead Director / CQUIN Lead	Description of indicator /target	Reporting Frequency	Q1 potential achievement
AF1	Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community	Tim Couchman	Defining and empowering the role of the Trust Board Armed Forces Champion(s) in embedding the Armed Forces Covenant across all operational functions to support improved health outcomes for the Armed Forces Community	**Q1** **(to get to commissioners by 31st July 2017)** 1. Identify a Trust Board member as Armed Forces Covenant lead 2. Provider will commit to share evidence of: • Policies within the organisationto ensure processes are embedded in line with the Armed Forces Covenant • Organisational sign-up to the Armed Forces Covenant via inclusion in local Covenant agreements; • Linkages with NHS organisations for subject matter expertise • Proposed engagement methods with local Armed Forces Third Sector/Charity Providers; • Access to national (and local) training course resources **Q2** **(to get to commissioners by 13th November 2017)** • The Provider will share their progress against actions in Q1 to assure the substance of the plan and to ensure all actions can be realistically delivered **Q3** **(to get to commissioners by 19th February 2018)** • Update of progress of delivery against plan **Q4** **(to get to commissioners by 14th May 2018)** To provide a report on the delivery against the agreed evidence as per Q1	
1	NHS Dental Services		Active involvement of clinicians in clinical engagement to create a culture of care, where primary care and secondary care clinicians view collaboration as valuable and an essential approach to further improve NHS dental services so as to achieve the change and developments required to produce a modernised NHS.	**Q1** **(to get to commissioners by 31st July 2017)** • Identify clinicans and NCCGs who should be members of the Managed Clinicla Network (MCN) • Job plans to be amended to reflect the delivery of the MCN objectives **Q2** **(to get to commissioners by 13th November 2017)** Engage with the development of the MCN objectives **Q3** **(to get to commissioners by 19th February 2018)** Engage with the development of the MCN objectives **Q4** **(to get to commissioners by 14th May 2018)** Evidence of contribution of delivery of the MCN objectives	

Equality Analysis Statement

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

The Equality Act 2010 requires specific provision is made to consider the impact of services and functions for people who identify with one or more of the nine protected characteristics, and for public sector bodies to take proactive steps to:

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

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

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

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

The nine protected characteristics are:

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

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

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

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

Appendix 1. Glossary

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

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

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

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

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

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

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

Staff Appraisals	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Equality and Diversity	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Income v Plan	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Expenditure v Plan	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Efficiency Plans	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Surplus / Deficit	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Capital Program Spend	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Agency Spend	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Partial Booking Waiting List	Failed Target		Achieved Target