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UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 31 AUGUST 2017

CONTENTS

Report to:	Trust Board
Date of Meeting:	3rd October 2018
Section:	Performance
Report title:	Integrated Performance Report
Report written by:	Katherine Etoria
Job title:	Planning & Performance Manager
Lead officer:	Karen Brown – Director of Finance
Board Action Required:	Discussion, Decision
For Assurance (Yes or No)**:**	Yes

Purpose of the Report

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

Key Issues, Options and Risks

A review of performance against all key performance indicators is provided, based on complete data for month 05. The narrative below indicates the action that is being taken to address areas of concern or where performance is below the expected standard or target level.

Executive Analysis

There are four main sections to this report. Of the 74 indicators reported locally and nationally, 41 are off track and highlighted to the Board in this report. The Trust Scorecard provides an "at a glance" summary of the national and mandated indicators as well as those measured at a local level. The key areas are summarised below;

1. The **Performance Summary**
2. The **Quality and Safety Summary**
3. The **Financial**
4. The **Workforce**

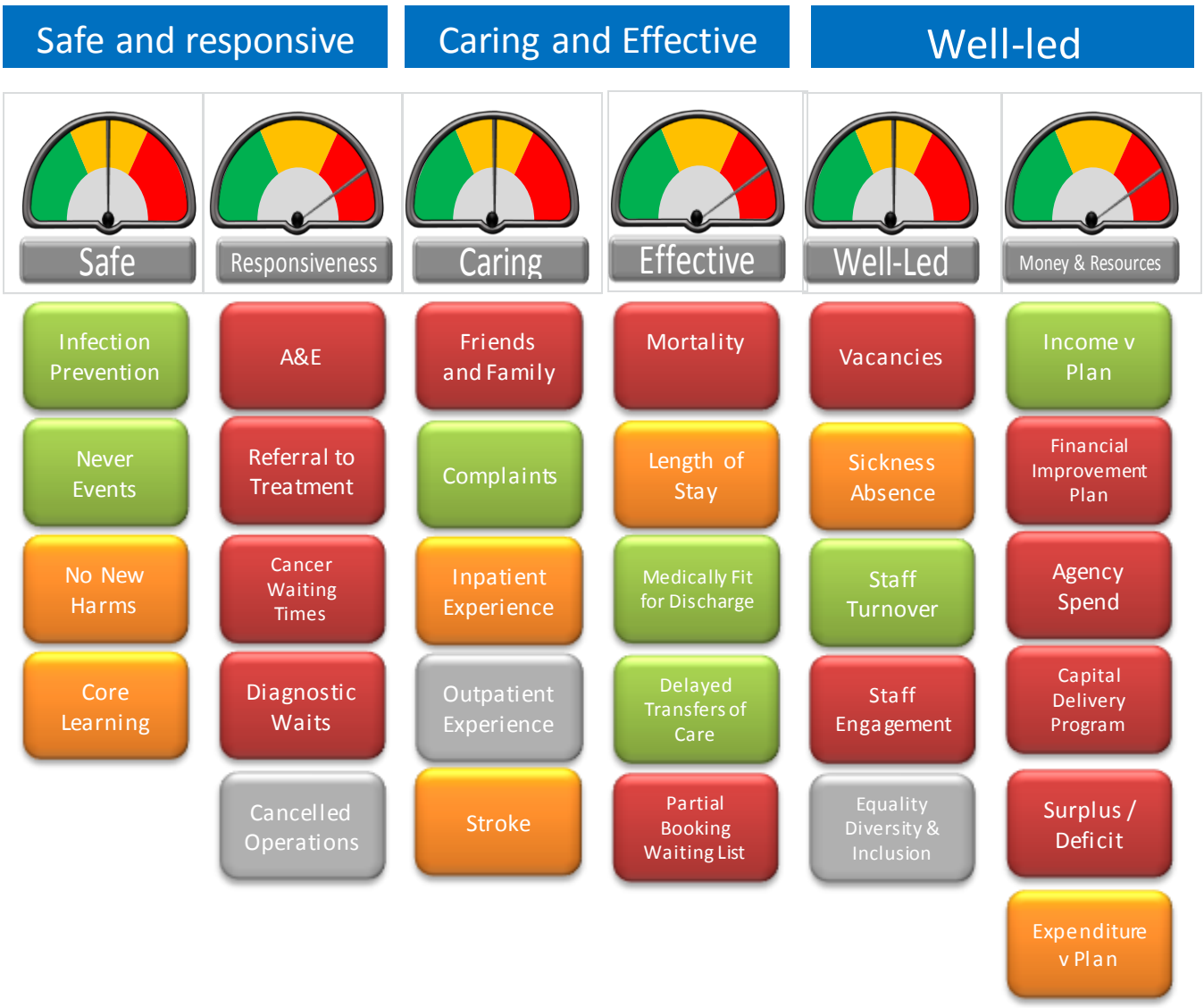
Recommendation (action required, by whom, by when)

The Board is to decide on the actions required arising from the discussions that take place, as a result of reviewing this report.

CQC Impact on Key Lines of Enquiry:	All.
Financial Implications:	Impact on financial standing if targets are not achieved.
Equality Analysis:	Not applicable.
Compliance Impact:	NHS Improvement, NHS England, Clinical Commissioning Groups and Care Quality Commission

	Completed below					
Risk Level >	**Avoid**	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
Key Elements v						
Financial / VFM:						
Compliance/Regulatory:						
Innovation/Quality:						
Reputation:						
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	
Explanation of variance from general (G) risk appetite	The level of risk has been assessed as meeting the Trust's general risk appetite. The Board will agree whether the risk appetite differs following the paper discussion					

The level of risk against each element should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.



Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Safe						
Infection Control						
Clostrum Difficile (post 3 days)	Monthly	Datix	59	28	4	2
MRSA bacteraemia (post 3 days)	Monthly	Datix	0	1	0	0
MSSA	Monthly	Datix	10	6	0	1
ECOLI	Monthly	Datix	40	20	2	4
Never Events	Monthly	Datix	0	0	0	0
No New Harms						
Serious Incidents reported (unvalidated)	Monthly	Datix	0	125	28	20
Harm Free Care %	Monthly		95%	91.90%	93.70%	92.20%
New Harm Free Care %	Monthly		98%	98.35%	98.90%	99.30%
Catheter & New UTIs	Monthly		1	1	2	0
Falls	Monthly	Datix	3.90	3.63	3.91	3.76
Medication errors	Monthly	Datix	0	733	112	174
Medication errors (mod, severe or death)	Monthly	Datix	0	107	14	19
Pressure Ulcers (PUNT) 3/4	Monthly			26	5	4
VTE Risk Assessment	Monthly		95%	97.19%	97.10%	97.46%
Core Learning	Monthly	ESR	95%	90.58%	90.58%	90.83%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Caring						
Friends and Family Test						
Inpatient (Response Rate)	Monthly	Envoy Messenger	26%	25.20%	21.00%	22.00%
Inpatient (Recommend)	Monthly	Envoy Messenger	96%	92.00%	93.00%	93.00%
A&E (Response Rate)	Monthly	Envoy Messenger	14%	19.40%	18.00%	18.00%
A&E (Recommend)	Monthly	Envoy Messenger	87%	80.80%	81.00%	80.00%
% of staff who would recommend care						
% of staff who would recommend work						
Complaints						
No of Complaints received	Monthly	Datix	70	288	68	55
No of Complaints still Open	Monthly	Datix	0	1246	276	247
No of Complaints ongoing	Monthly	Datix	0	173	41	26
Inpatient Experience						
Mixed Sex Accommodation	Monthly	Datix	0	0	0	0
eDD	Monthly	EDD	95%	84.17%	87.52%	86.86%
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%	59.41%	46.99%	53.85%
#NOF 48 hrs	Monthly		95%	91.31%	85.54%	90.77%
Dementia Screening	1 month behind		90%	90.19%	83.75%	91.88%
Dementia risk assessment	1 month behind		90%	96.38%	95.93%	95.77%
Dementia referral for Specialist treatment	1 month behind		90%	81.95%	68.18%	81.04%
Stroke						
Patients with 90% of stay in Stroke Unit	1 month behind	SSNAP	80%	79.90%	73.70%	70.90%
Sallowing assessment < 4hrs	1 month behind	SSNAP	80%	68.00%	65.70%	69.00%
Scanned < 1 hrs	1 month behind	SSNAP	50%	58.03%	53.60%	56.30%
Scanned < 12 hrs	1 month behind	SSNAP	100%	97.78%	99.10%	95.00%
Admitted to Stroke < 4 hrs	1 month behind	SSNAP	90%	63.98%	55.40%	58.80%
Patient death in Stroke	1 month behind	SSNAP	17%	14.88%	10.20%	12.70%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Responsiveness						
A&E						
4hrs or less in A&E Dept	Monthly	Medway	87.0%	79.27%	77.64%	78.37%
12+ Trolley waits	Monthly	Medway	0	0	0	0
AEC						
Number of patients seen in AEC (Lincoln only)	1 month behind	Medway		273	297	295
% Readmissions within 7 days (Lincoln only)	1 month behind	Medway	0.00%	13.33%	16.42%	11.79%
% Patients discharged by LoS (Lincoln only)	1 month behind	Medway	0.00%	7.79%	1.49%	2.03%
% of G&A non-elective admissions to AEC	Monthly	Medway	25.00%	16.26%	0.00%	16.62%
RTT						
52 Week Waiters	Monthly	Medway	0	8	4	2
18 week incompletes	Monthly	Medway	90.5%	89.07%	88.73%	88.79%
Cancer - Other Targets						
62 day classic	1 month behind	Somerset	85%	69.95%	69.20%	67.20%
2 week wait suspect	1 month behind	Somerset	93%	89.65%	87.50%	91.50%
2 week wait breast symptomatic	1 month behind	Somerset	93%	79.80%	92.00%	74.60%
31 day first treatment	1 month behind	Somerset	96%	96.15%	97.50%	96.40%
31 day subsequent drug treatments	1 month behind	Somerset	98%	99.30%	100.00%	97.20%
31 day subsequent surgery treatments	1 month behind	Somerset	94%	89.60%	85.00%	91.60%
31 day subsequent radiotherapy treatments	1 month behind	Somerset	94%	93.58%	94.80%	91.70%
62 day screening	1 month behind	Somerset	90%	83.13%	76.90%	82.80%
62 day consultant upgrade	1 month behind	Somerset	85%	84.13%	82.40%	82.00%
104+ Day Waiters	1 month behind	Somerset		-	8	23
Diagnostic Waits						
diagnostics achieved	Monthly	Medway	99.1%	98.98%	97.94%	98.64%
diagnostics Failed	Monthly	Medway	0.9%	1.02%	2.06%	1.36%
Cancelled Operations						
Cancelled Operations on the day (non clinical)	Monthly	Medway	1.10%	3.14%		3.28%
Not treated within 28 days. (Breach)	Monthly	Medway	0.00%			3.92%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Effective						
Mortality						
SHMI	Quarterly		100	110.95	111.39	111.39
Hospital-level Mortality Indicator	Quarterly		100	103.29	102.02	102.99
Length of Stay						
Average LoS - Elective	Monthly	Medway / Slam	2.8	2.76	2.77	2.98
Average LoS - Non Elective	Monthly	Medway / Slam	3.8	4.37	4.15	4.41
Medically Fit for Discharge	Monthly	Bed managers	60	55.60	56.00	52.00
Delayed Transfers of Care	Monthly	Bed managers	3.5%	4.33%	3.38%	4.23%
Partial Booking Waiting List	Monthly	Medway	0	5605	5085	5231

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Well Led						
Vacancies	Monthly	ESR	5.0%	10.89%	10.79%	10.08%
Sickness Absence	Monthly	ESR	4.5%	4.50%	4.82%	4.53%
Staff Turnover	Monthly	ESR	8.0%	5.70%	5.52%	5.57%
Staff Engagement						
Staff Appraisals	Monthly	ESR	95.0%	78.80%	82.00%	83.00%
Equality Diversity and Inclusion						

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Money & Resources						
Income	Monthly	Board Report Master	35518	175206	36370	36011
Expenditure	Monthly	Board Report Master	-40475	-205453	-40992	-41494
Efficiency Delivery	Monthly	FIMS report	1343	0	0	0
Surplus / Deficit	Monthly	FPIC Finance Report	-4957	-36607	-5909	-6752
Capital Delivery Program	Monthly	FPIC Finance Report	-708	-3383	-1583	-286
Agency Spend	Monthly	Agency Staff Analysis	-1790	-12400	-2593	-2248

Executive Summary for period to 31st August 2017

☒ 4 hour waiting time target – performance of 77.64% in July 2017 (slight fall from the July position)
☒ 3 of the 9 national cancer targets were achieved in July 2017 (1 months in arrears)
☒ 18wk RTT Incomplete Standard for July 2017 is at 88.73.%
☒ 6wk Diagnostic Standard – July performance was 97.94%
☑ 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:

New harm free care has been improving throughout the financial year and has been above national performance for the last 2 months.

DTOC and MFFD patient numbers are both within expected limits this month.

Staff turnover and sickness rates continue to improve slightly month on month.

3/9 Cancer targets have been achieved.

The numbers of open referrals has fallen to1680 in September 2017 (compared to 2288 in May 2017)

Challenges:

The Trust has seen challenged performance against RTT, A&E, Cancer and Diagnostics.

August 2017 Performance against the 4 hour A&E standard was 77.3%. GP streaming in A&E is set to commence by end of September 2017.

July 2017 RTT performance at 88.8% was below the agreed trajectory and August position at the mid-month point is 87.5% (this is not the final position an it is expected to improve. It is expected, with current plans that the agreed trajectory will be achieved by November 2017.

Performance against the Caner 62 day standard was 69.2% for July 2017. However 17 patients who had been waiting over 104 days were treated in month, with only 8 patients currently waiting over 104 days for treatment
The Trust is driving improvement in cancer pathways via the Cancer Action Plan which is reviewed fortnightly at the Cancer Recovery and Delivery Group. Also 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.

Performance against the diagnostics standard, at 97.84%,failed for the second month in a row. Significant staffing issues in Echocardiography being the main issue. A recovery action plan is in place.

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
September 2017

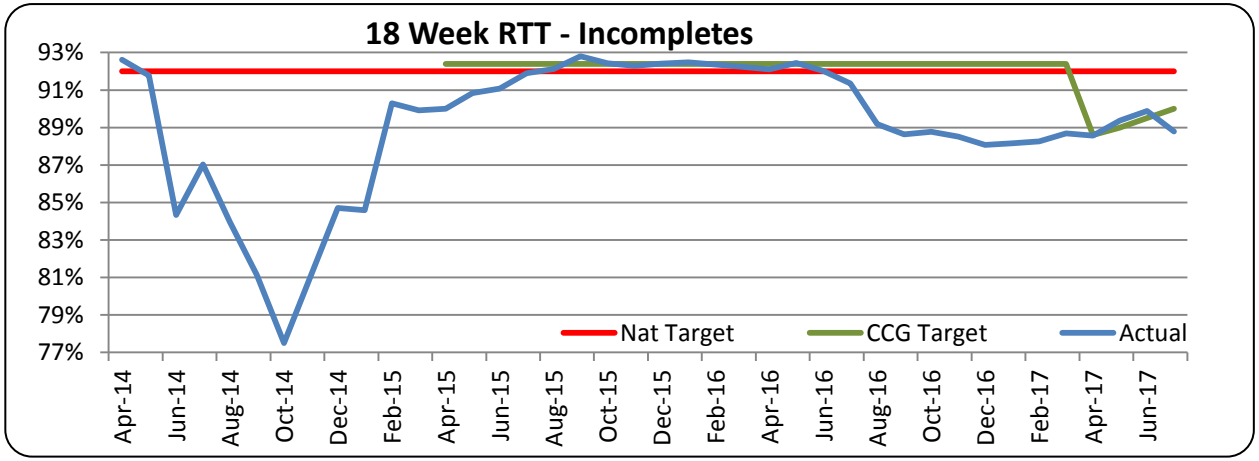
Trust Performance Report by Exception

Referral to Treatment

Executive Responsibility: Mark Brassington – Chief Operating Officer

Exception Details

In July the Trust reported performance of 88.8%, an deterioration of 1.1% compared with the position in June. The number of patients on incomplete pathways over 18 weeks increased by 275 during July, up to 3075 patients.
At a national level the standard has not been achieved for 16 consecutive months, with an aggregated national performance in July of 89.9%.
The final submission for August was 88.73%, with a deterioration of patients over 18 weeks by a total of 7 at Trust level. However, within that ENT deteriorated by 78 patents over 18 weeks.



Between June and July three specialities deteriorated by a total of 290 incomplete patients over 18 weeks – ENT, Ophthalmology, Gastro. The level of validation completed during August (for July's performance) was restricted by the impact of annual leave during the summer holidays and administrative gaps within the Clinical Directorates. However, these three speciality areas also have additional challenges which impacted upon performance in July:

- ENT – The Service has experienced gaps in clinical capacity due to sickness and vacancies, and has also experienced significant managerial/administrative vacancies in the last 2 months which have severely restricted the capacity of the speciality team to drive performance improvement.
- Ophthalmology – Over the last 3 months the service has had vacancies/maternity leave the equivalent of 4 Consultant posts. Recruitment has taken place, but there have been gaps between doctors leaving and new recruits starting which has reduced the capacity within the service. In addition theatre capacity issues have meant that some daycase lists have been suspended, leading to an increasing backlog of admitted patients.
- Gastro – A locum consultant left the Trust on 9th June. The Trust were unable to find a replacement before a substantive Consultant joined the Trust in August. This resulted in a reduction in capacity in this speciality for a two month period.

In July there were 204 cancelled operations on the day and 68 the day before.
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 1680 on 14th September, however Gastro and ENT still have patients waiting over 30 weeks on the open referrals waiting list.

In the first 4 months of 2017/18 The Trust's activity has been above contracted levels in the following specialities which are currently performing below 92%:

- Endocrine (24%)
- General Surgery (5%)
- ENT (2%)
- Resp Medicine (13%)

Following the fire at Pilgrim, capacity for daycases has been restricted for the subsequent 6 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.

Validation completed as at 15th September showed that there were 4 patients who were on incomplete pathways over 52 weeks at the end of August. Harm reviews had been completed for 3 out of 4 of these patients, with the final harm review still pending. No harm had been reported amongst the 3 where the harm reviews had been completed.

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 existing staff working additional hours, and also the use of agency locums in specialities such as Neurology, Cardiology, Respiratory and Rheumatology.

Two new Gastro Consultants have now commenced in post at Lincoln, which takes that service to a fully established position. Additional capacity available during August was focused on reducing overdue follow-ups in this speciality, so improvements in RTT performance are not anticipated until the end of September.

An advert for a substantive Neurology consultant is currently open. The Endocrine/Diabetes Service plan to have additional baseline capacity in place by November following recruitment related to the Pilgrim Hospital 4th Consultant Business Case.

The ENT Service have commenced completion of virtual clinics, and are planning to significantly increase the volumes of virtual clinics completed during September. The service have secured temporary additional management capacity in order to help cover some of the vacancies within the Head and Neck Management team whilst recruitment processes are completed. As at 12th September 47 ENT patients had been confirmed as transferred to a different provider as part of this year's outsourcing arrangements, and a further 71 patients are being contacted to determine whether they are willing to be seen by an alternative provider. Once the outsourcing arrangements relating to this cohort of patients is completed a new cohort will be identified.

The Ophthalmology Service is reviewing cross-cover arrangements for theatre lists at Lincoln to ensure maximum utilisation. In addition, discussions are taking place regarding the potential utilisation of independent sector capacity within Ophthalmology.

Outsourcing has commenced within Urology and General Surgery. As at 14th September, a total of 47 General Surgery patients have been accepted by independent sector providers, with decisions awaited on 24 Urology patients and a further 29 General Surgery patients.

The Cardiology Service is completing a process to standardise booking rules across the Service, which will provide a small increase in capacity. In the medium term once the valve registry is established this will release further capacity within the Cardiology Service.

Pathway improvements have been agreed within the Autism Service; Speech and Language Therapy capacity will be utilised to complete aspects of the assessment process which will release Consultant capacity to reduce the waiting list backlog. This change will come into effect in early October.

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 pause in routine referrals into these four specialities. This request was been discussed in a number of forums with the commissioners. Lincs East CCG have agreed to a divert of routine referrals in these specialities away 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 pause into these specialities at this time. In the first five weeks of this period, GP referrals into these specialities have reduced by the following levels compared to the pre-divert period:

- ENT 17% reduction
- Cardiology 24% reduction
- Dermatology 7% reduction
- Community Paediatric 55% reduction

On 1st September the Neurology Service re-opened 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 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?

November 2017

Cancer Waiting Times – 62 Day

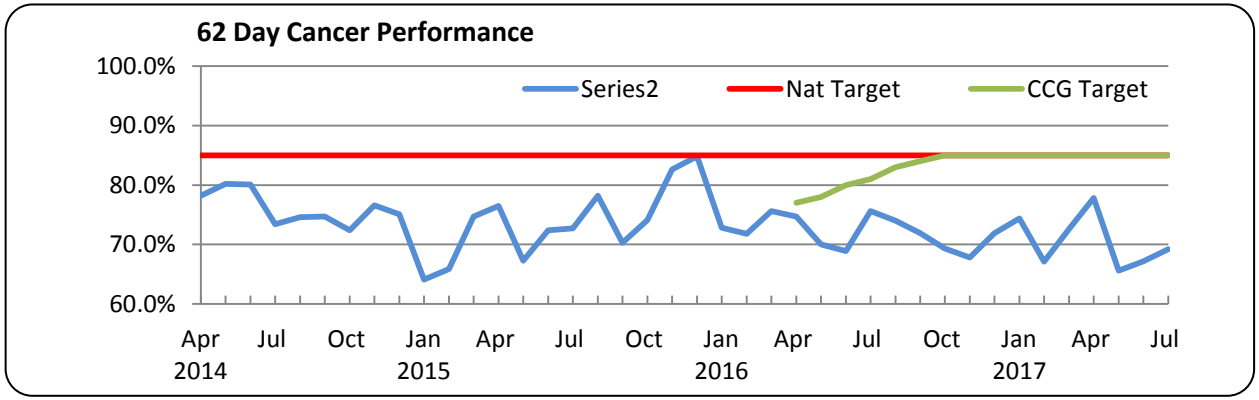
Executive Responsibility: Mark Brassington – Chief Operating Officer

Exception Details

The Trust achieved a performance of 69.2% against the 62 day classic standard in July.

The Trust achieved 3 out of the 9 cancer standards.

164 treatments were recorded in July against the 62-day classic standard, which is the third highest monthly treatment volume recorded in the last 12 months (with the highest level being recorded in June).



There were small improvements in performance in Urology and Lower GI, however performance in these two specialities remained below 55% for the third month in a row. There was a significant improvement in lung performance, which performed above 70% for only the second month in the last 2 years.

Completion of RCAs for each breach in July found that the most frequent breach reasons were as follows:

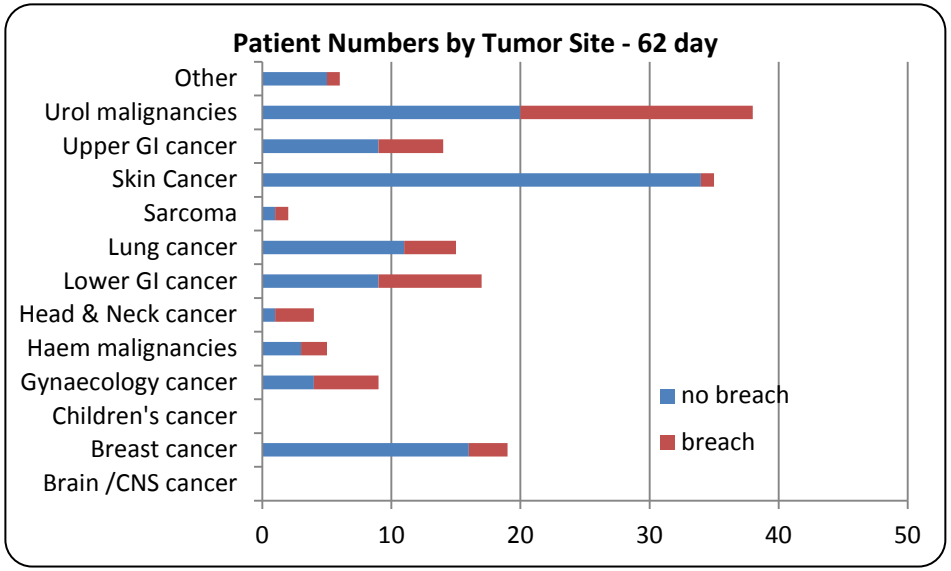
- Complexity or procedural
- Patient choice and/or patient fitness
- Tertiary diagnostic delays
- Pathology turnaround times
- CT capacity
- Theatre capacity
- MRI capacity
- Oncology capacity
- Administrative delays

As of 14th September there are 7 patients on or over 104 days without an agreed treatment plan: 2 x Urology, 1 x Lung, 2 x Gynaecology, 1 x Brain, 1 x Sarcoma. 2 of the 7 have confirmed cancer diagnosis, with treatment for both of these patients being led by tertiary centres.

The Trust treated 17 patients at 104 days or over during July, completing RCAs for all 17 patients. Due to the length of these pathways these patients had multiple reasons for delays in their pathways, as follows:

- 9 cases included complexity or procedural factors
- 6 cases included patient choice delays
- 6 cases included CT delays
- 5 cases included MRI capacity restrictions
- 5 cases included tertiary diagnostic delays

- 4 cases included theatre capacity restrictions
- 3 cases were linked to primary care delays
- 3 cases included admin delays
- 3 cases included Oncology capacity delays
- 3 cases included patient fitness factors
- 2 cases included Endoscopy capacity
- 1 case included tertiary treatment delays
- 1 case included Outpatient capacity
- 1 case included cyber-attack delays
- 1 case included U/S capacity restrictions
- 1 case included pathology delays



The Trust completes a full review of any potential harm related to excessive waits for cancer treatment (104 + Day Waits): 17 Harm Reviews issued for July. As at 14th September 5 have identified no harm, 1 has identified a low level of harm, 1 has identified a moderate level of harm. The remainder are awaiting clinical feedback. Moderate and severe levels of harm will be reviewed by the Medical Director for onward management.

The Trust made significant progress during June and July in reducing the size of the cancer PTL backlog of patients over 62 days and over 104 days, however there was a deterioration in this position in the later part of August:

w/c	12/6	19/6	26/6	3/7	10/7	17/7	24/7	31/7	7/8	14/8	21/8	28/8	2/9	9/9
62 day+	157	137	113	108	89	94	70	74	68	62	66	71	81	80
104 day+	34	32	26	21	14	15	9	7	8	5	9	7	9	9

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/continuing in the coming weeks include:

- Pilot utilisation of a Urology Cancer Business Manager role – This role was in place in July and August, during this period there was a reduction of greater than 50% in the volume of Urology patients waiting over 62 days on the Cancer PTL. This post will now be advertised to enable a longer term recruitment to be achieved and will be extended to included lower GI at Lincoln County Hospital.
- Full roll out of level 1 beds at Lincoln – in place from August. The site a still experiencing cancer cancellations and scheduling restrictions during August due to ITU/HDU capacity issues.
- Revised Urology pathways – Clinical agreement has been reached relating to a revised pathway which will see 2ww clinics created which feed directly into MRI and TRUS biopsy slots. This new pathway is due to commence on 1st October.
- Continuation of Endoscopy backlog clearance – Medinet continue to provide addition sessions at weekends. A procurement exercise for a longer term outsourcing arrangement closed on 1st September. The evaluation exercise will be completed by 4th October, with the expectation of a start date before the end of the calendar year. Alongside this a business case for increased internal Endoscopy capacity has been completed. This was reviewed by IPB on 23rd August, where further clarifications were requested.

- 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 – The specialist nursing post required to enable this development is at the recruitment stage.
- Oncology administrative optimisation – Chemo-scheduler business case has been approved. The interviews for these posts commenced in early September. 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 in conjunction with MDT leads. Path Links have secured 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. Performance figures from mid-August show improvements in overall turnaround times, but this will continue to be reviewed with further options considered to improve performance as required.
- Radiology to reduce CT biopsy delays – Trust wide booking process in place since beginning of August.
- Straight to test for CT on lung pathway – Pathway agreed within the Trust. Work on-going with CCGs to roll-out by the end of October

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 – scheduled to commence in mid-September
- Project Lead post facilitating improvements within tracking processes, review of pathways, MDT support and tertiary communication – advert closes on 15/9/17
- Urology/Lower GI Improvement/Operations Manager for Cancer – to be advertised w/c 11/9/17
- Radiology Cancer Co-ordinator – Job description awaiting job matching process
- External support to review whole pathway capacity/demand – commenced on site 30/8/17 for a six-week period
- Review best practice PTL management from other organisations to inform ULHT systems – visits to other providers completed.
- External clinical support to review long waiting patient pathways – completed on 11th September.

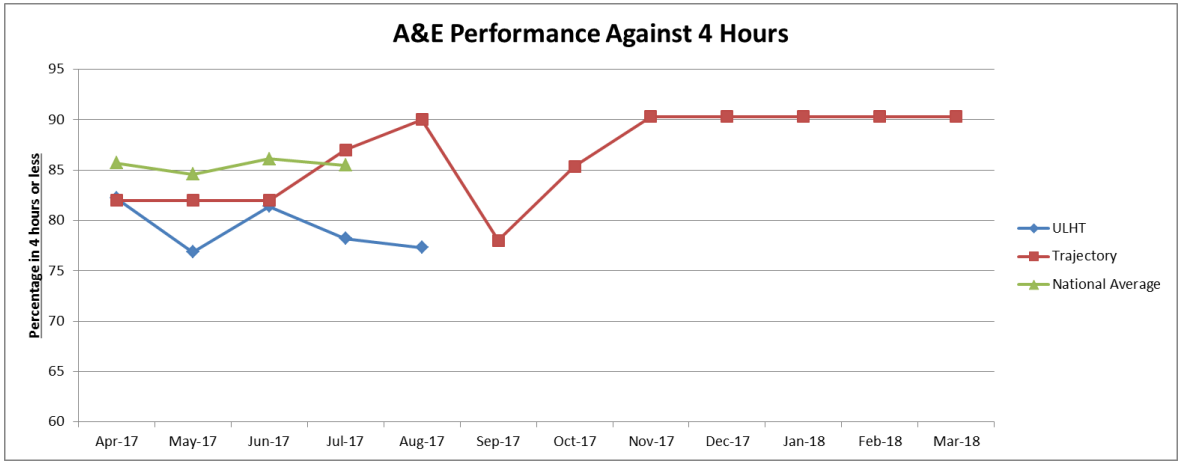
A&E 4 Hour Standard

Executive Responsibility: Mark Brassington – Chief Operating Officer

Exception Details

ULHT performance against the 4 hour target for August was 77.3 %, showing a deteriorating position for the last two months. The Trust has agreed a new improvement trajectory with NHSE that takes into account our current and future actions showing achievement of 90% from November to March:

September	October	November	December	January	February	March
78.00%	85.36 %	90.31%	90.31%	90.31 %	90.31%	90.31 %



Activity returned close to plan for August, however there were large variances with Grantham Hospital remaining under plan since its reduction in hours and Pilgrim Hospital significantly over plan.

Performance within month varied significantly with Lincoln County Hospital starting in a stronger position, deteriorating mid month and Pilgrim starting in a poor position making significant improvement mid month.

At Lincoln, during the first week of August medical staffing in ED became critical again. The medical staff rotation period coupled with agency locums tending to take August off, heightened the existing pressures with ED staffing. This necessitated increased support from colleagues in Medicine and Orthopaedics who did an excellent job supporting the department. During this time performance was reasonably good, and above 80% on most days. Bed flow on site at this time was also good and this supported performance. Throughout the month at Lincoln, nursing fill rates on site were extremely poor due to a diminished bank and agency shift uptake. This necessitated bed closures on site during the middle of the month in order to maintain safety on the wards. This had a marked impact on performance, despite the improvements in ED staffing, i.e. “exit block” resulting in reduced bed availability and increased outliers was the major cause of poor performance during the month. This was similar at Pilgrim where beds were scarce at the start of the month, but improved throughout the month as did the performance.

Middle Grade Fill Rates

	07/08/2017	14/08/2017	21/08/2017	28/08/2017
Weekly hours required	432	432	432	534
Substantively filled	60	54	80	106
Internal MG Extra	36	42	40	45
Internal Con acting Down Extra	0	10	0	10.5
Agency Filled	206	286	254	311.5
Grantham Filled	0	0	0	0
Grantham extra hours	64	56	48	48
Not Filled	**130**	**40**	**58**	**61**
Vacancies	7.4	7.4	7.4	7.4

Junior Grade Fill Rates

	07/08/2017	14/08/2017	21/08/2017	28/08/2017
Weekly hours required	399	399	399	399
Substantively filled	373.5	382.5	319	349
Internal Extra	0	0	32	8.5
Agency Filled	25.5	16.5	32	16
Not Filled	**0**	**0**	**16**	**25.5**
Vacancies	0	0	0	0

Throughout the month, nursing fill rates on site were extremely poor due to a diminished bank and agency shift uptake. This necessitated bed closures on site during the middle of the month in order to maintain safety on the wards. This had a marked impact on performance.

Nursing Fill Rate for August 2017

Day		Night	
Average Fill rate- Registered Nurses/ Midwives (%)	Average fill rate – care staff (%)	Average Fill rate- Registered Nurses/ Midwives (%)	Average fill rate – care staff (%)
86.95 (88.20)	99.20 (100.57)	90.15 (91.70)	103.02 (99.91)

What action is being taken to recover performance?

46% of the Trusts breaches have been demonstrated to be due to delays due to medical staff in the ED and delays to treatment. An earlier business case was approved by the Trusts board for 950k between the Lincoln and Pilgrim sites. This resulted in an increase in middle grade staffing, from 28th August, as shown above.
The business case was reviewed and resubmitted in light of Primary Care Streaming models being in place from the end of October 2017. This means that demand into the department, whilst still above current staffing models, would be significantly less. A recurrent cost of £2.6M has now been approved (FYE), which will see an end to expensive agency costs currently incurred.

The investment will ensure demand is met, extending current cover later in the day and across 7 days, support the team based approach ensuring cover remains in place in each of the areas of the ED (triage, RAT, minors, majors and resus), allow Pilgrim Hospitals AEC to move to a 7 day model and support the planned increase in resus capacity. There will be an added benefit of improving recruitment and retention and will allow the Trust to embed the CESR roles which improve training.

The department has been working with community colleagues to establish the GP Streaming Service which will commence on 27th September 2017. A number of pathways have been identified to be streamed away from ED either to GP's or specialties direct, to reduce the footfall and pressures in the department. The building work for the GP Streaming Service is on track and due to complete by 18th December 2017.

Recruitment is on-going. At Lincoln, in September two of the long-term agency consultants will be converting over to NHS locums which will provide some sustainability for the department and also financial savings. Recruitment to the middle grade posts is on-going and the department is working with some agency locums to offer them NHS contracts. A new substantive Consultant joined the team at the beginning of August and from September there will be no agency locum consultants in the department with the department being staffed by 7 Consultants. The new medical rota template is now fully in place and this offers improved coverage throughout the daytime to ensure the department can keep on top of the workload in the day without it carrying into the night. This will be reviewed at the end of September and if any minor tweaks are needed they will be made then.

A number of streaming schemes – to move patients away from the ED direct to other clinical areas – are being considered by the Trusts Clinical Directorates, or have commenced already. The Trust plans to stream 35% of patients away from its ED's by December. This will include the roll out of Primary Care Streaming described below.

Lincoln County commenced all GP referrals going direct to the Ambulatory Care Unit in July. Further schemes to relieve pressure on the ED include streaming and counting in Ophthalmology, Max-Fax, ENT, dentistry and paediatrics (patients who would attend ED if no direct access services were available). Further work has commenced looking at community hospitals, DVT pathways, low risk chest pains etc. The largest impact will be the commencement of Primary Care Streaming which will start working from within existing resources from the end of September with full roll out by 18th December at the completion of new facilities at Pilgrim Hospital and Lincoln County Hospital.

As per guidance set out by NHSE, all acute Trusts will have primary care streaming in place this year. ULHT was successful in bidding for 1M capital to establish new facilities to provide the service. The service is commissioned by the CCG and a draft specification has been completed. Meetings are ongoing to refine this, and the streaming protocols that will be in place to divert patients inappropriately attending the ED over to a primary care facility, staffed mainly by Lincolnshire Community Health Services. Governance systems are now drafted to ensure patients incorrectly streamed are identified, systems for Primary Care to direct back deteriorating patients are in place and mechanisms to work closer with GP practises are in place. Although work on new facilities will not be complete until mid-December streaming will commence in September (following pilots of the streaming pathway within the existing ULHT staffing) and full implementation from 31st October. The Trust is currently out to tender for construction of the Primary Care Streaming facilities – stand-alone unit at Lincoln County Hospital and extension of existing facilities at Pilgrim Hospital, Boston. Tenders close at the end of September with building commencing soon after. Projects will complete by the 18th December when full mobilisation of Primary Care Streaming will commence.

19% of the Trusts breaches of the 4 hour target are attributable to hospital flow. Increased bed occupancy results in increased medical outliers (who's length of stay increases, compounding the problem) and inability to move patients out of the ED. This not only causes those patients waiting for beds to breach but other patients breach due to a lack of cubicle space to assess them.
Although Pilgrim Hospitals occupancy reduced in August it remained at around the 98% level, too high to maintain adequate flow around the site and small increases will causes the system to grind to a halt.
Forecast demand has been modelled based on anticipated adult bed requirement throughout 2017/18. At a Trust-level the model forecasts a bed shortfall of circa 106 beds. Whilst at an aggregated level the pressure is seasonal, the model is forecasting the bed-base to be insufficient throughout 2017/18.

The system-led changes and investment to enable hospital capacity to reduce include:

- Admissions avoidance; community beds will be used as an alternative to acute
- Effective streaming to divert patients from the acute setting
- Expediting transfer from hospital of medically safe patients (Discharge to Assess, investment in community and home care capacity via the BCF)
- Elective care pathway redesign

Within the Trust work done during the year with schemes such as the SAFER patient flow bundle, Red to Green days and Stranded Patients has reduced our bed occupancy. For non-elective length of stay this is below our expected position, now 4.7 days during August. The impact of Red to Green has had the most significant effect with a demonstrable reduction since commencement during April.

Other actions to improve flow include a programme to reconfigure wards at Pilgrim Hospital. This will allocate correct beds to each speciality and allow for an improved capacity for urgent care. The programme has commenced and has an ambitious timescale with completion within 7 months and the Urgent Care and Assessment and Admissions areas to be completed by the end of December

The Trust will implement an electronic bed management system utilising current software platforms available in the organisation. This will commence with a pilot on limited wards but roll out to all wards by the end of October. This will give more responsive turnaround times for available beds and allow the "bed manager" role to be developed to support the wards more in improving discharge and flow.

Improvements to weekend ward rounds, moving to consultant hot week models and finalising job planning with appropriate time given to focus on in patient care will all improve occupancy and create the capacity required to remove exit block from the ED's.

Diagnostics

Executive Responsibility: Mark Brassington – Chief Operating Officer

Exception Details

In August the Trust failed the 6 week diagnostic standard for the second month in a row. The performance level was 97.94%.

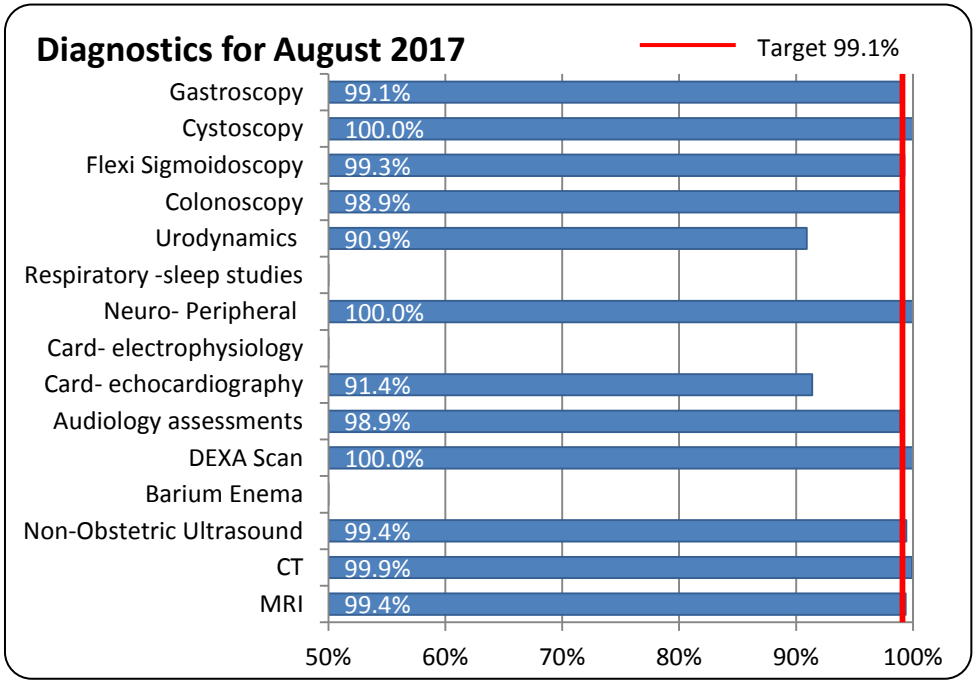
There were 138 diagnostic patients which breached the 6-week standard in August.

108 of the 138 breaches were within Echocardiography. This service has experienced significant capacity restrictions during the last 6 weeks with two members of staff commencing maternity leave, one member of staff taking paternity leave, alongside the impact of planned leave and existing sickness levels within the department. Additionally the service has experienced increasing inpatient demand during this period.

What action is being taken to recover performance?

The Cardiology Team have produced a recovery action plan in order to address this position. The plan includes:

- Provision of addition capacity through internal resources
- Working with external partners to increase capacity
- Taking action to improve data quality and visibility



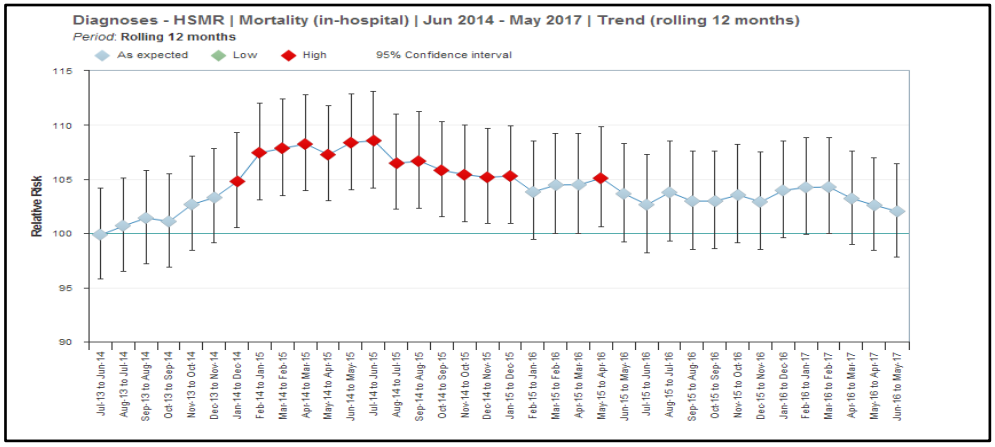
Quality and Patient Safety Summary

Safe Ambition 1: Reduction of Harm Associated with Mortality

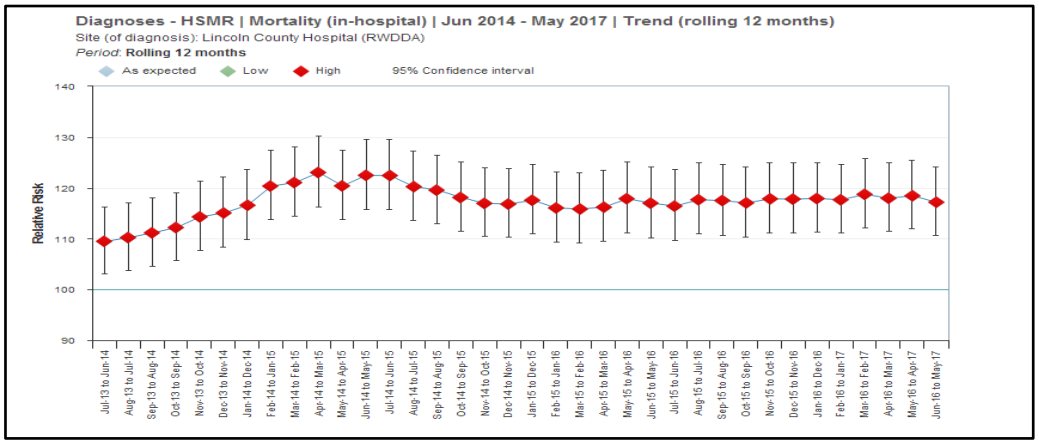
Executive Responsibility: Neil Hepburn – Medical Director

Trust/Site	ULHT HSMR Jun 16-May 17 12 month	ULHT HSMR Apr 17-May 17 YTD	ULHT HSMR May-17	ULHT SHMI Jan 16 – Dec 16	Trust Crude Mortality YTD Internal source Aug 16-Jul 17
Trust	**102.02**	**95.01**	**92.0**	**111.39**	1.80%
LCH	**117.18**	**109.71**	**99.3**	**115.32**	1.83%
PHB	**91.58**	**84.14**	**69.6**	**109.01**	1.96%
GDH	**72.10**	**63.19**	**57.3**	**93.04**	0.97%

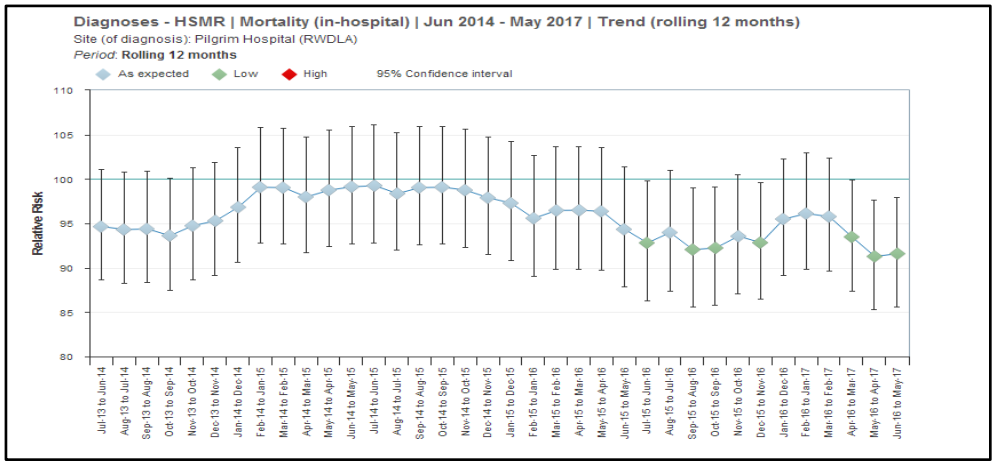
ULHT HSMR Rolling Year (36 Months)



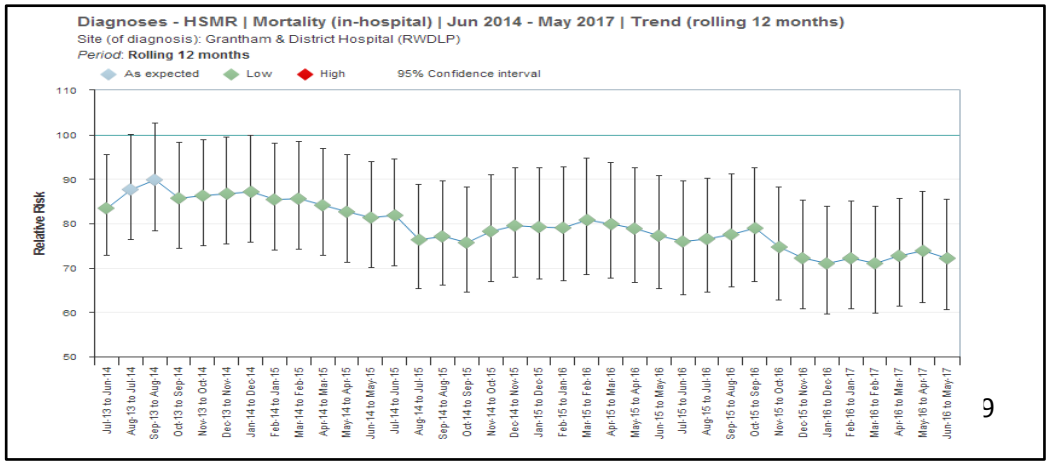
Lincoln HSMR Rolling Year (36 Months)



Pilgrim HSMR Rolling Year (36 Months)



Grantham HSMR Rolling Year (36 Months)



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

- Other lower respiratory disease: Not driven by a particular site with 25 mortalities and 9.54 over the predicted Dr Foster data. This is the first month.
- Other Perinatal Conditions: Not driven by a particular site with 15 mortalities and 7.4 over the predicted Dr Foster data. Report to be presented to PSC in October 2017.

Lincoln County Hospital primary diagnoses groups that are outside of the Dr Foster confidence intervals are:
Actions underway

- Biliary Tract Disease: This is cumulative throughout the time period with 13 mortalities over the predicted Dr Foster data. This has now been alerting for 5 months and is alerting at Trust level. 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, notes have now been received within Quality Governance.
- Intestinal Obstruction without hernia: Due to a notification in October 16; Year to date there were 9 mortalities over the predicted within this diagnosis group. This is the sixth consecutive month of notification. An in-depth review has been completed and will be discussed at the September PSC meeting.
- Septicemia (except in labour): This is a cumulative alert and not alerting in a particular month; year to date there are 20.6 mortalities over the predicted Dr Foster data. This is the third month alerting. There is a sepsis committee who meet monthly and have a detailed action plan to improve compliance of sepsis. Sepsis coding rule changed in April 2017. QG has completed an overview which was presented at July PSC. Sepsis nurses to complete a coding review to be presented at Sept PSC.
- Acute Cerebrovascular disease: This is the second month of alerting with 118 observed and 31 mortalities over the predicted Dr Foster data. Dr Foster Intelligence specialist and Quality Governance are meeting with Lincoln site stroke team to understand the data. The only notable difference between the data on the sites is the coding of patients been seen by the palliative care team.

Pilgrim Hospital primary diagnoses groups that are outside of the Dr Foster confidence intervals are:

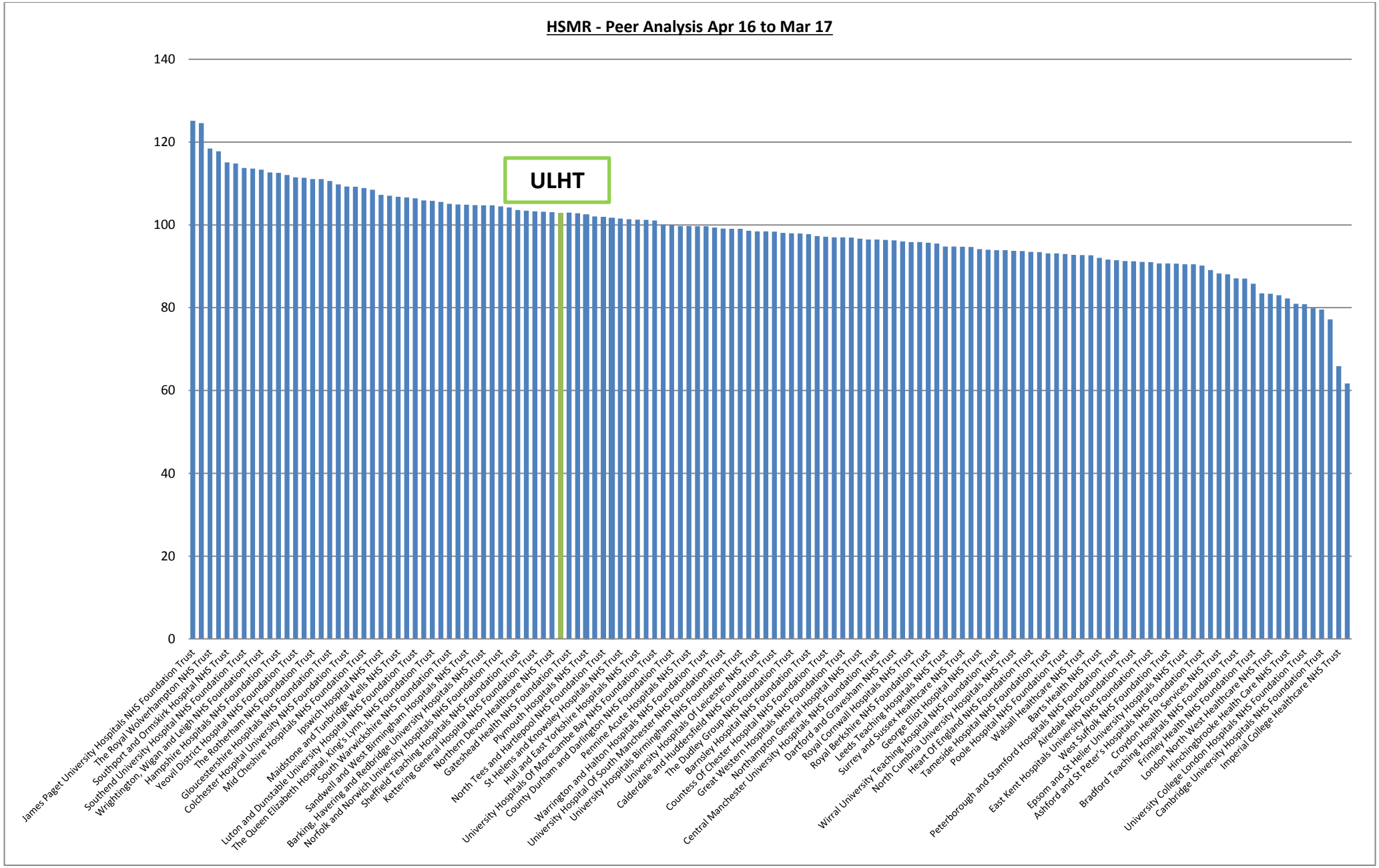
- Abdominal Pain: The first month of alerting with 5 observed and 3.62 mortalities over the predicted Dr Foster data.

Grantham Hospital
No notifications

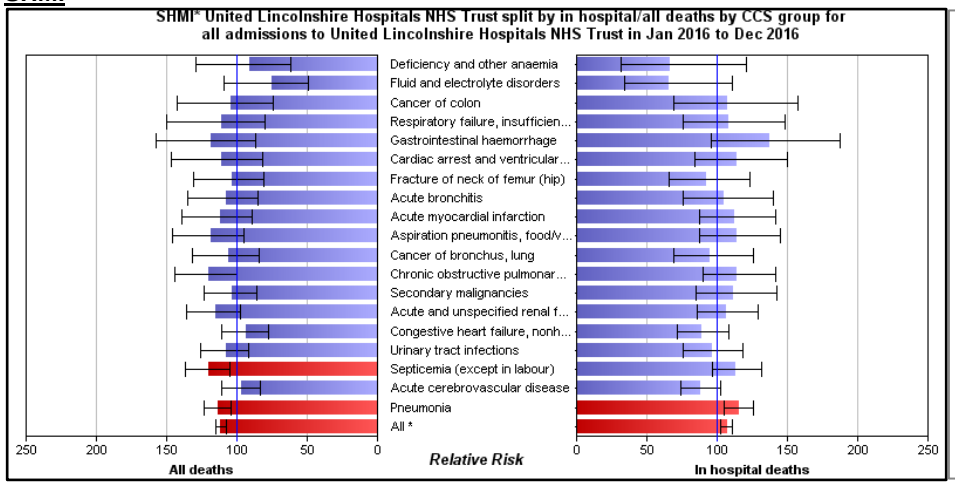
HSMR Top Observed Diagnosis Groups – June 2016- May 2017

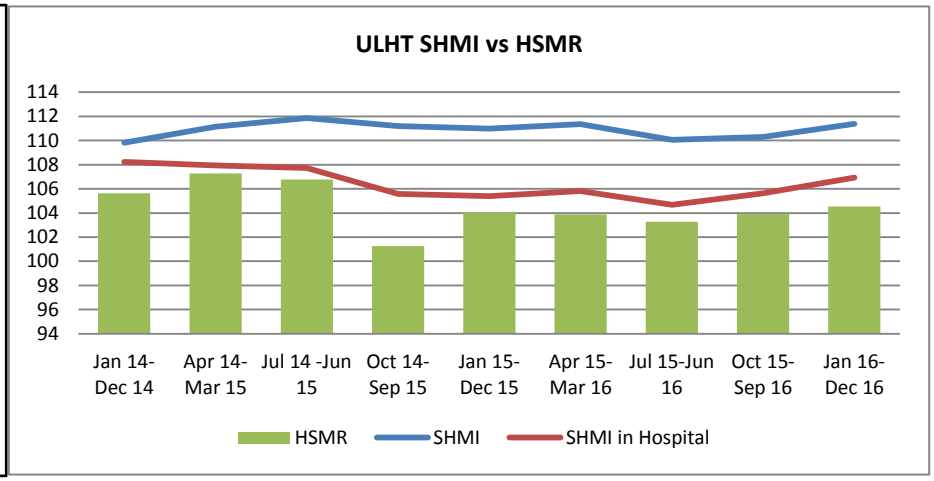
Rank	Diagnosis group	Spells	mortalities	% of all mortalities	Expected mortalities	Actual-Expected	Crude (%)	HSMR
1	Pneumonia	2537	446	20.32%	455.33	-9.33	17.64	97.95
2	Septicemia (except in labour)	1000	210	9.57%	191.87	18.13	21.11	109.45
3	Acute cerebrovascular disease	1145	178	8.11%	176.72	1.28	15.67	100.73
4	Acute and unspecified renal failure	752	97	4.42%	95.69	1.31	12.97	101.37
5	Urinary tract infections	2248	94	4.28%	93.03	0.97	4.19	101.04
6	Congestive heart failure nonhypertensive	933	94	4.28%	105.95	-11.95	10.10	88.72
7	Chronic obstructive pulmonary disease and bronchiectasis	1590	86	3.92%	74.95	11.05	5.41	114.74
8	Aspiration pneumonitis food/vomitus	203	69	3.14%	61.96	7.04	34.16	111.37
9	Secondary malignancies	2110	62	2.82%	59.28	2.72	2.94	104.58
10	Acute myocardial infarction	877	60	2.73%	60.69	-0.69	6.86	98.86

The above table demonstrates the top 60% of the observed diagnoses groups. Those diagnoses highlighted in red are alerting diagnosis at site level.



SHMI





The Trust is undertaking numerous strategies for Mortality Reduction:

- Ward Clerk pilot for the Comorbidity chasing has been undertaken by Clayton and Burton Ward, this has now ceased and the Ward Clerks found that 58% of the new patients coming to the ward this part of the clerking proforma had not been completed. The wards found that putting the note in the notes did not work but adding it to the " New patient checklist" worked for Burton ward. Quality Governance have engaged the EAU's at Lincoln to try and increase the compliance of the completion of the clerking proforma.
- Intestinal hernia without obstruction is currently alerting diagnosis; an in-depth review has been undertaken; A report has been produced Quality Governance and has been sent to the lead to agree report and action plan. The main issues found were palliative care coding and missed comorbidities. Report being discussed at PSC in 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 have received the notes and are awaiting volunteers, a proforma has been created.
- National guidance on Learning from Deaths are currently being implemented by the Trust full implementation by September 2017. The policy has been updated for the committees approval in September 2017.
- Coding Masterclass being organised for October 2017 (these are run quarterly and we have previously orchestrated five masterclass).
- 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 October2017.
- Quality Governance has undertaken F2 training at Pilgrim and has dates for Grantham and Lincoln teaching programme of how the quality of notes affects our mortality, performance reports and income.
- Bereavement centre at Lincoln will be opening in October 2017.

Mortality Reviews

Reviews (Jan 2016-Aug 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	4624	406	4218	3263	77%	70%	71%
Lincoln Total	2529	218	2311	1715	74%	70%	68%
Pilgrim Total	1822	118	1704	1353	79%	70%	74%
Grantham Total	273	70	203	195	96%	70%	71%

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

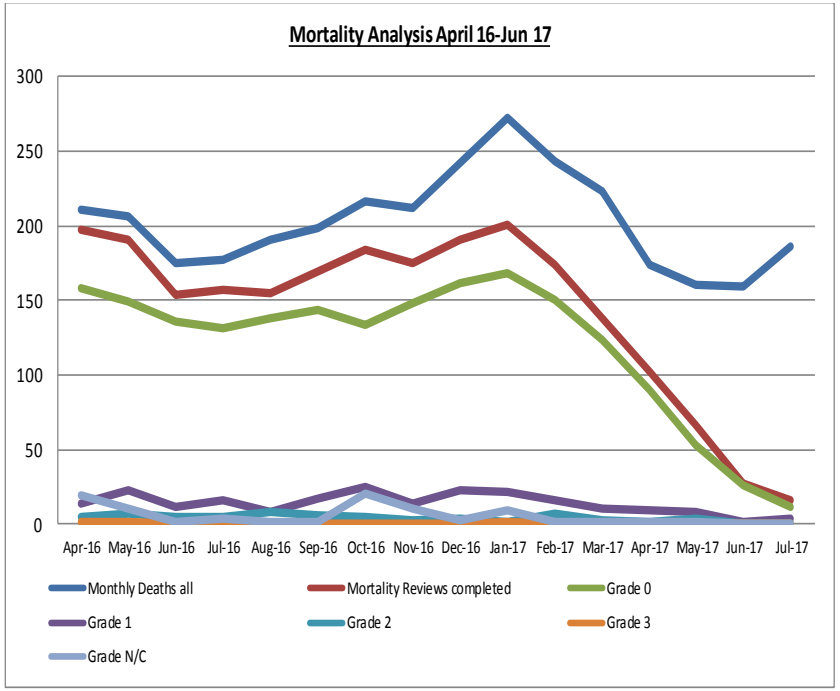
Review Complete total	195	1353	1715	3263
Grade	GDH	PHB	LCH	ULHT
0	178	878	1312	2368
1	11	114	164	289
2	2	37	43	82
3	0	3	4	7
Not completed	4	321	192	517

Learning from Death National Template

The below template was issued by NHS England and has been redesigned to for our grading. The dashboard will always be a quarter behind due to the timeliness of the reviews. This methodology is based upon the National Learning from Deaths paper published in March 2017. The methodology is based upon a initial review within 7 days of the death of a patient. Within the Trust methodology we give the clinicians 4 weeks to do a mortality review, therefore our monthly review compliance is low for the current months. **Patient Safety Committee to agree on reporting methodology.**

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable Grade 2&3	
This Month-Jul 17	Last Month-Jun 17	This Month-Jul 17	Last Month-Jun 17	This Month-Jul 17	Last Month-Jun 17
186	159	16	27	0	0
This Quarter (QTD) (Apr 17-Jun 17)	Last Quarter (Jan 17-Mar 17)	This Quarter (QTD) (Apr 17-Jun 17)	Last Quarter (Jan 17-Mar 17)	This Quarter (QTD) (Apr 17-Jun 17)	Last Quarter (Jan 17-Mar 17)
493	738	16	195	6	12
This Year (YTD) (Apr 17-Jul 17)	Last Year (Apr 16-Mar 17)	This Year (YTD) (Apr 17-Jul 17)	Last Year (Apr 16-Mar 17)	This Year (YTD) (Apr 17-Jul 17)	Last Year (Apr 16-Mar 17)
679	2566	211	2086	6	64



Review Grading

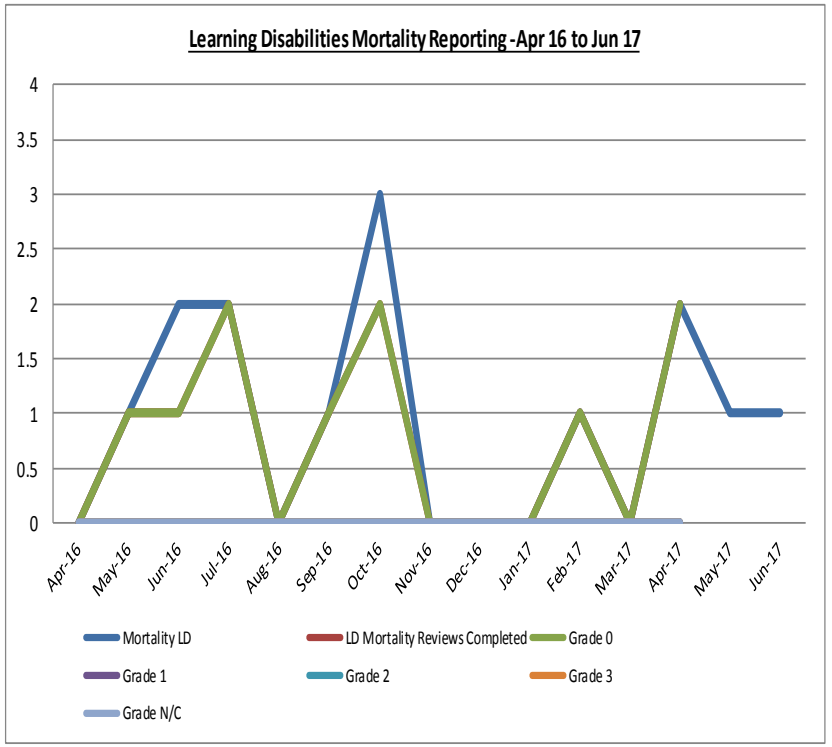
Grade 0		Grade 1		Grade 2		Grade 3		Grading not completed	
Unavoidable death, no suboptimal care		Unavoidable death, suboptimal care but different management would NOT have affected outcome		Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)		Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)		Not completed in proforma by reviewer	
This Month-Jun 17	96%	This Month-Jun 17	4%	This Month-Jun 17	0%	This Month-Jun 17	0%	This Month-Jun 17	0%
This Quarter (QTD) (Apr 17-Jun 17)	87%	This Quarter (QTD) (Apr 17-Jun 17)	9%	This Quarter (QTD) (Apr 17-Jun 17)	3%	This Quarter (QTD) (Apr 17-Jun 17)	0%	This Quarter (QTD) (Apr 17-Jun 17)	1%
This Year (YTD) (Apr 17-Jul 17)	86%	This Year (YTD) (Apr 17-Jun 17)	10%	This Year (YTD) (Apr 17-Jul 17)	3%	This Year (YTD) (Apr 17-Jul 17)	0%	This Year (YTD) (Apr 17-Jul 17)	1%

Learning Disability Template

From April 2017 from the new National Learning from Deaths paper issued in March 2017. All patients that die within hospital that are coded with F819: Developmental disorder of scholastic skills, unspecified are to be reported externally to the LeDeR programme. The LeDeR programme will contact us if there is a selection of deaths that they want to do a multi-agency review with.

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities					
Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable Grade 2& 3	
This Month-Jun 17	Last Month-May 17	This Month-Jun 17	Last Month-May 17	This Month-Jun 17	Last Month-May 17
1	1	0	0	0	0
This Quarter (QTD) (Apr 17-Jun 17)	Last Quarter (Jan 17-Mar 17)	This Quarter (QTD) (Apr 17-Jun 17)	Last Quarter (Jan 17-Mar 17)	This Quarter (QTD) (Apr 17-Jun 17)	Last Quarter (Jan 17-Mar 17)
4	1	2	1	0	0
This Year (YTD) (Apr 17-Jul 17)	Last Year (Apr 16-Mar 17)	This Year (YTD) (Apr 17-Jul 17)	Last Year (Apr 16-Mar 17)	This Year (YTD) (Apr 17-Jul 17)	Last Year (Apr 16-Mar 17)
6	10	2	8	0	0



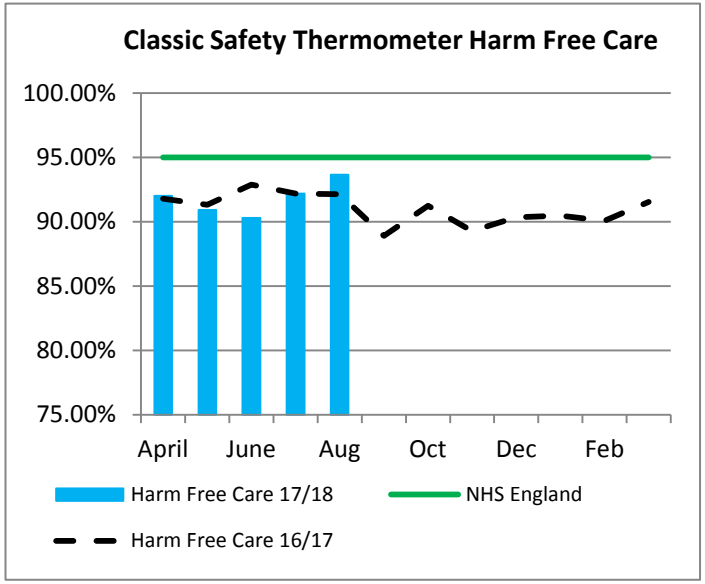
Mental Health deaths

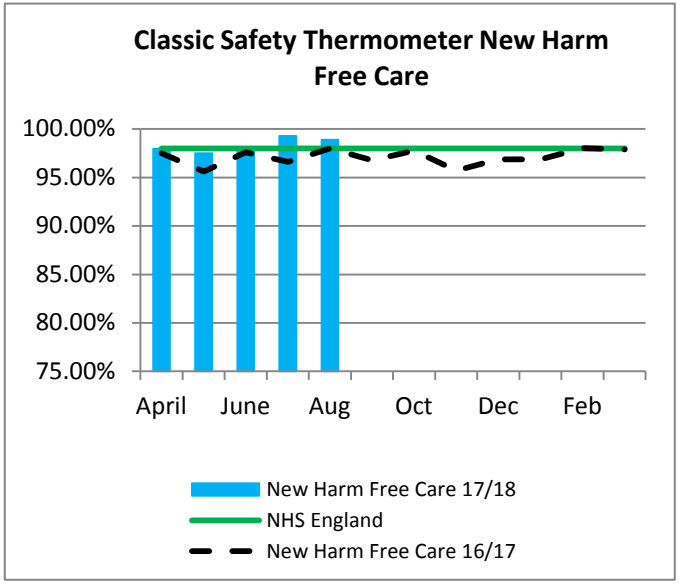
All mental health deaths are part of the "Must Do Reviews" within the Trusts Methodology. The National Learning on Deaths focus on the Mental Health deaths the review proforma has been changed to include mental health pathway questions. Mental Health review overview is as follows:

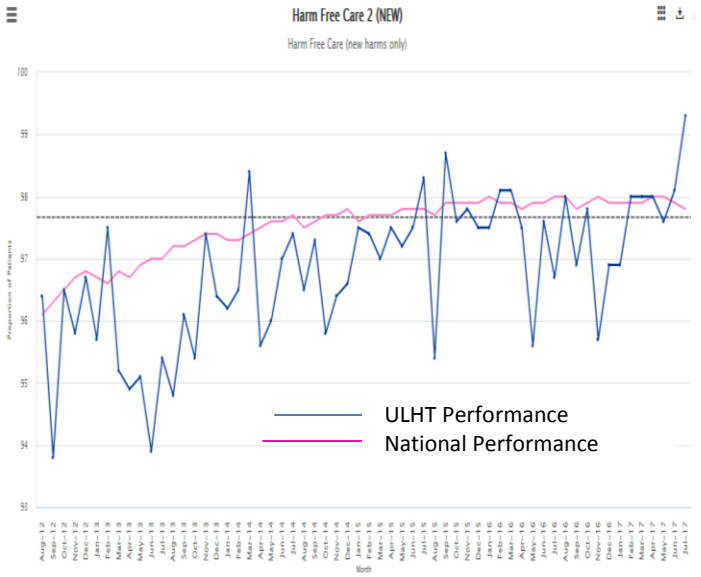
			Reviews				
Qrtly Mortality	Month	Total Mortality	Grade 0	Grade 1	Grade 2	N/R	Review Compliance
16/17 QTR 1 MH	Apr-16	61	42	2	1	16	74%
169	May-16	59	36	11	1	11	81%
	Jun-16	49	35	4	2	8	84%
16/17 QTR 2 MH	Jul-16	64	42	6	2	14	78%
187	Aug-16	64	42	2	4	16	75%
	Sep-16	59	39	4	2	14	76%
16/17 QTR 3 MH	Oct-16	55	34	8	2	11	80%
220	Nov-16	73	45	6	1	21	71%
	Dec-16	92	62	9	1	20	78%
16/17 QTR 4 MH	Jan-17	71	44	6	1	20	72%
244	Feb-17	86	51	3	4	28	67%
	Mar-17	87	42	6	1	38	56%
17/18 QTR 1 MH	Apr-17	58	28	2	1	27	53%
162	May-17	51	17	2		32	37%
	Jun-17	53	9	1		43	19%
	Jul-17	42	3	1		38	10%
	Grand Total	1024	571	73	23	357	65%

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

Executive Responsibility: Michelle Rhodes – Director of Nursing







Performance Data Overview August 2017

	ULHT	GDH	LCH	PBH
Harm Free Care	**93.7%**	**93.4%**	**96.2%**	**90.1%**
New Harm Free Care	**98.9%**	**100%**	**99.6%**	**97.7%**
New Category 2	3	0	0	3
New Category 3	1	0	0	1
New Category 4	0	0	0	0
Low Harm	1	0	1	0
Moderate Harm	0	0	0	0
Severe Harm	0	0	0	0
Catheter & New UTI	2	0	1	1
New VTEs	2	0	0	2
Patients	819	76	441	302

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.

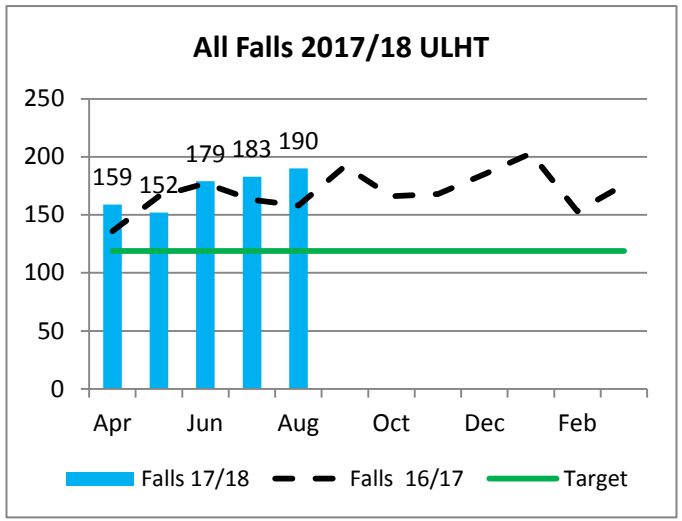
Fall actions outlined within Quality Report (see respective falls page). Results reported upwardly to Falls Reduction Group with delegated authority from Patient Safety Committee.

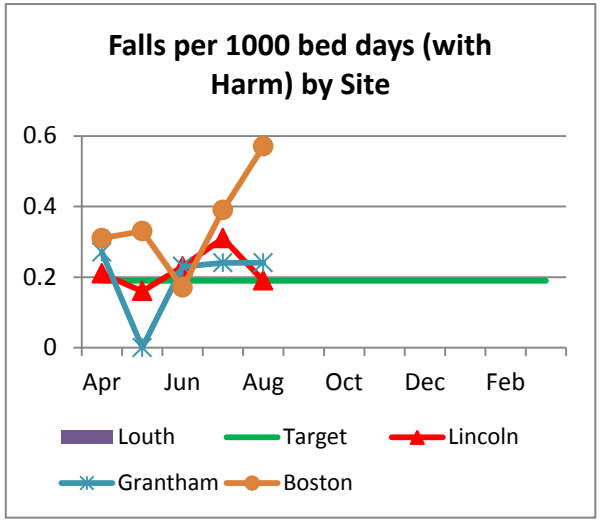
CA-UTI actions outlined within Quality Report (see respective CA-UTI page). . Results reported upwardly to Catheter Reduction Group with delegated authority from Patient Safety Committee.

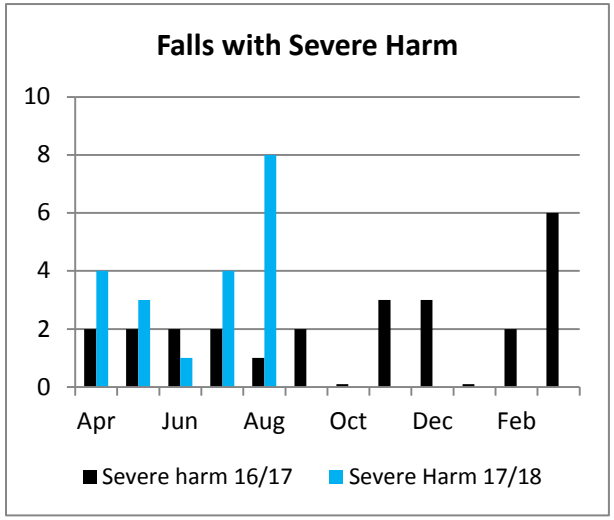
VTE investigated through Route Cause Analysis by VTE Nurse Manager and reported upwardly through Patient Safety Committee.

Safe Ambition 3: Reduction of Harm Associated with Falls

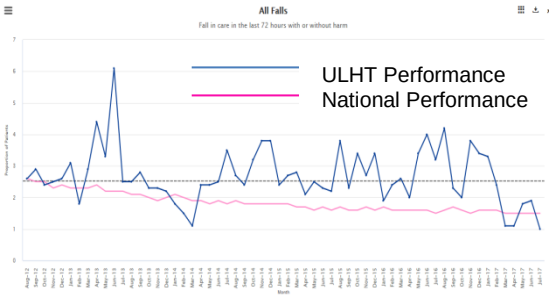
Executive Responsibility: Michelle Rhodes – Director of Nursing







Safety Thermometer 2017



Safety Quality Dashbaord (SQD) for Trust Falls Sep 2016- Aug 2017

Metric Title	Sep 2016	Oct 2016	Nov 2016	De 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017
Patient at risk of falls	338	344	318	284	325	333	344	312	296	332	315	320
Actions completed within 4 hours	87.40%	93.90%	90.50%	88.00%	87.70%	88%	88.1%	91.0%	90.60%	92.8%	93.4%	93.5%
Actions completed within 24 hours of admission	49.20%	45.30%	38.50%	48.50%	47.40%	-	46.7%	57.7%	57.40$	62.0%	57.8%	63.60%
Lying & standing BP completed	67.10%	63.10%	61.90%	61.00%	66.50%	62.8%	68.3%	78.0%	81.80%	78.7%	71.7%	77.30%
Care plan 7 activated	96.20%	93.80%	94.40%	93.60%	95.30%	95.4%	91.4%	97.7%	97.60%	96.1%	97.5%	96.50%
Neuro Cognition Assessed	-	-	-	-	-	-	96.2%	97.1%	98.00%	99.1%	97.1%	98.70%
Vision Assessed	-	-	-	-	-	-	95.3%	97.8%	96.60%	97.6%	97.5%	98.40%
Bed Rails Assessment	-	-	-	-	-	-	98.6%	99.7%	99.30%	100%	99.1%	99.70%
Continence/toilet regime documented	-	-	-	-	-	-	76.4%	92.9%	87.50%	94.1%	91.9%	95%

Performance Data Overview August 2017

ST data shows ULHT average of falls with harm is 1.0% for July which is below the national average of 1.5%. Falls per 1000 bed days has increased from 3.13 for 2016/17 to 3.39 for April-August 2017, falls with harm remains at 0.25.

Incidence of falls by site per 1000 bed days by hospital site

Site	2015/2016 All Falls	2016/2017 All Falls	Apr-Aug 2017 All Falls	2015/2016 All Falls with Harm	2016/2017 All Falls with Harm	Apr-Aug 2017 All Falls with Harm

Action Plan

- Audit of patients who have fallen multiple time being undertaken Sept 17 to identify learning (consider introduction of scrutiny process for patients who have multiple falls)
- Rollout of NHSi falls prevention collaborative work – prioritising completion of workbook and completion of lying and standing BP
- Develop ward trajectories for completion of lying and standing BP and for completion of actions within 24 hours of admission

Grantham	5.32	4.05 ↓	2.81 ↓	0.26	0.18 ↓	0.18 ↔
Lincoln	2.91	2.82 ↓	3.26 ↑	0.22	0.19 ↓	0.20 ↑
Pilgrim	3.49	3.48 ↓	3.76 ↑	0.29	0.36 ↑	0.33 ↓

When the data is reviewed at site level, Lincoln and Pilgrim have seen a deterioration in falls from April – August 2017, however Grantham has seen improvement. Pilgrim has seen a reduction in falls with harm, Grantham falls with harm remains at 0.18 which is below trajectory (0.19).

Trust and site incident of falls Aug 2017

Aug-17	Trust	Lincoln	Pilgrim	Grantham
Ward Falls per 1000 bed days	3.91↑	3.42↓	4.98↑	2.93↑
Ward Falls with harm per 1000 bed days	0.33↑	0.19↓	0.57↑	0.24↑

Falls & falls with harm have increased on both the PHB and GDH sites in August. 3 falls were reported to have resulted in death at PHB, however on initial review it appears that all 3 patients had a sudden cardiac event and collapse that resulted in the fall. 5 severe harms were reported at PHB on wards 5A, 5B, Bostonian, AMU and ENT clinic. RCA investigations will be completed and reviewed at scrutiny panel.

Patients who fall repeatedly remains an issue with 54 repeat falls reported and 2 patients falling 5 times. An audit of patients who have fallen multiple times is being undertaken to identify learning, and consideration is being given to the introduction of a scrutiny process for patients who have multiple falls regardless of the level of harm.

Wards 6B & 3B (NHSi falls collaborative work wards): 6B reporting an increase in the number of falls (14 in August), however severity remains low (no moderate harms since April), 3B reporting low number of falls (5 in August – 2 no and 3 low harm) however reported 2 moderate harms in July. Completion of lying and standing blood pressure training is believed to have contributed to the downward trajectory of falls on these wards. Following the training across the Trust there was a demonstrable improvement in completion of lying and standing blood pressure, however a reduction in compliance is now being seen therefore ward trajectories for improved performance against completion of lying and standing BP will be set.

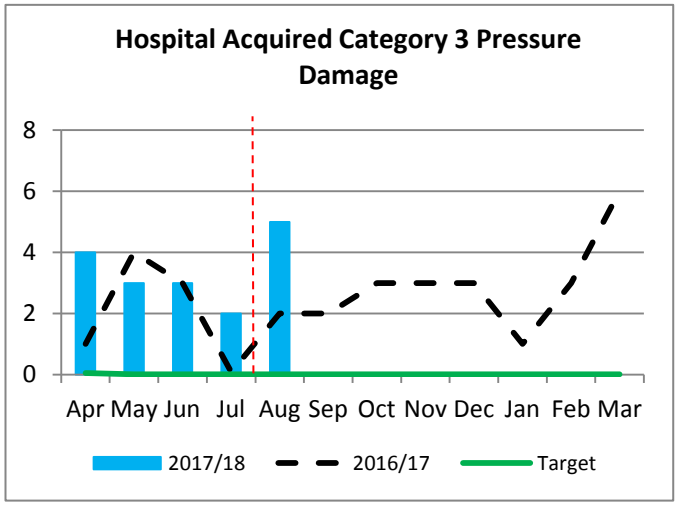
Falls scrutiny panels continue and the following learning has occurred from investigations:

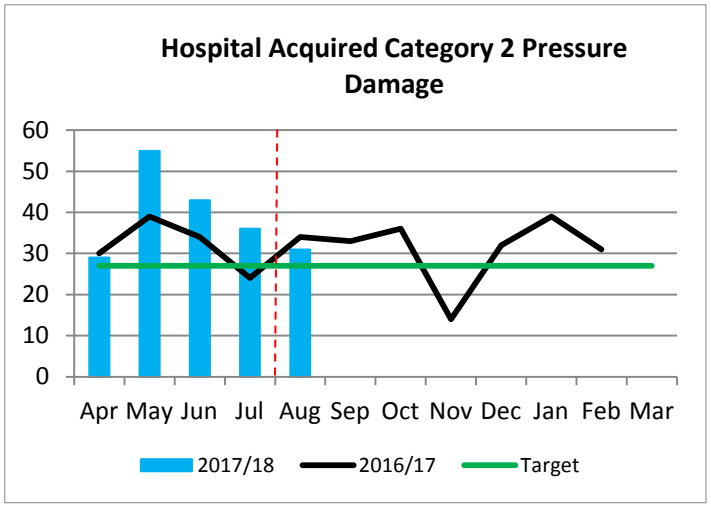
- Lying and standing BP to be recorded as soon as possible following admission and repeated as clinically indicated
- Risk assessments to be reviewed following ward transfers
- Minimise bed moves for patients with cognitive impairment
- Cognitive assessment to be undertaken when indicated by clinical history
- Lifestyle advice not sufficient in patients with delirium/ confusion
- Falls medication review to be undertaken by medical staff
- Prompt therapy review required following referral, particularly when admitted with a history of falls
- Proactive discharge planning and escalation to reduce missed opportunities to discharge patient once medically fit and have reached rehab potential
- Pathway to be followed after an unwitnessed fall, particularly monitoring of GCS
- TWOC - close observation and regular toileting of patients at risk of falls required

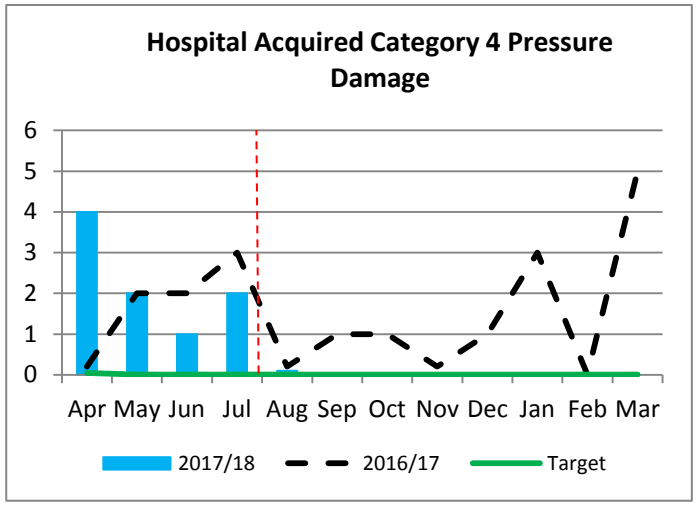
- Patient safety brief to share lessons learnt with all professions
- E-learning programme being developed to compliment workbook
- Call don't fall posters being developed
- Ward accreditation standard for falls developed – WA being launched September
- Collaborative working with CAUTI group to ensure falls risk considered when TWOC undertaken

Safe Ambition 4: Reduction of Harm Associated with Pressure Ulcers

Executive Responsibility: Michelle Rhodes – Director of Nursing

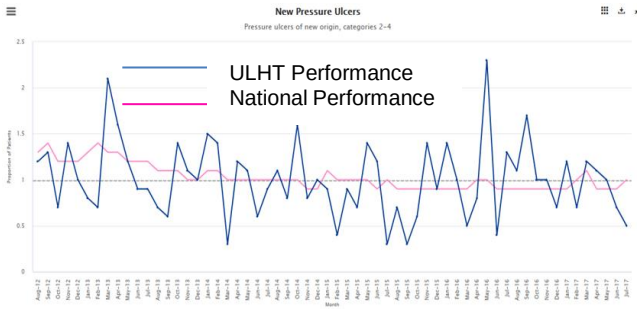






Reporting function changed to Datix August 2017

Safety Thermometer 2017



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

Metric Title	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun-2017	Jul 2017	Aug 2017
Pressure area risk assessment completed within 4hrs	98.80%	99.30%	98.80%	98.30%	97.50%	-	97.0%	98.7%	98.60%	95.5%	95.9%	97.70%
Pressure area risk assessment updated weekly	78.90%	80.70%	78.40%	72.00%	71.60%	77.4%	76.7%	80.5%	81.50%	81.3%	83.5%	84.10%
Pressure-relieving equipment in situ if required	93.90%	96.60%	94.20%	95.50%	96.60%	93.4%	94.0%	96.2%	95.20%	96.8%	96.8%	95.80%
Frequency of repositioning documented	-	-	-	-	-	-	60.8%	62.4%	79.50%	83.4%	83.4%	85.60%
Prescribed frequency of turning has been followed for last 24 hours	-	-	-	-	-	-	59.5%	61.7%	79.00%	85.7%	85.7%	76.90%
Pressure area care plan activated if required	94.30%	88.80%	94.40%	92.90%	93.50%	91.1%	91.5%	94.7%	93.80%	93.6%	93.6%	94.70%

Performance Data Overview August 2017

	Cat 1	Cat 2	Cat 3	Cat 4
Lincoln	0	13	3	0
Boston	4	16	2	0
Grantham	0	2	0	0

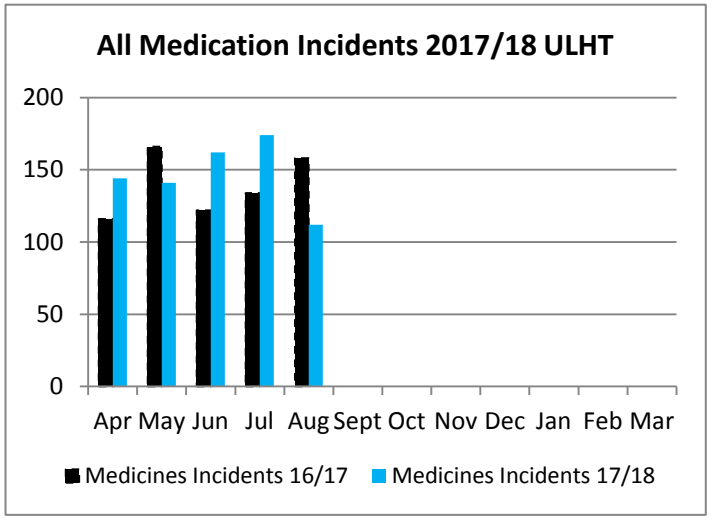
ST data for new PUs in July shows ULHT average is 0.5% compared to the national average of 1.0%. Use of PUNT to report PUs was suspended from 01.08.17 with Datix now the reporting system for all PUs. Data suggests underreporting of cat 1 PUs – anticipated whilst Datix is embedded (previously reported on PUNT only). An improving position is seen in respect of eliminating avoidable cat 4 PUs with no cat 4 PUs reported in August. 5 cat 3 PUs were reported in August (5B, 8A, N/Welton and 2 on S/worth), scrutiny panels are being held to determine availability. GDH have reported no cat 3 or 4 PUs since Jan 2017.

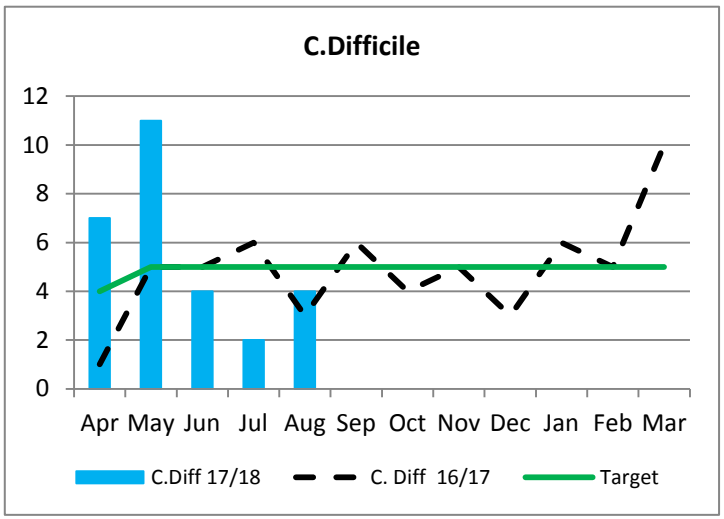
Action Plan

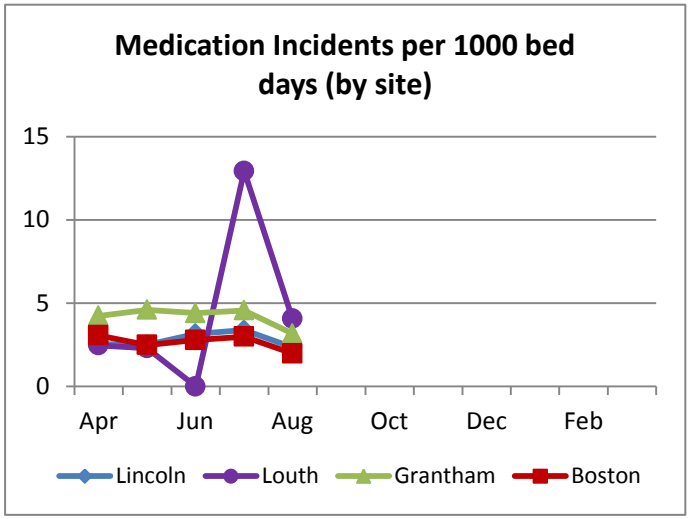
- PU reduction drop in days facilitated on the PHB site in June & August and further sessions planned
- Pressure ulcer prevention meetings re-established on the Lincoln & Pilgrim sites
- PDSA PU prevention project to commence on the Pilgrim site and poster competition planned by HoN
- Additional training provided for HCSWs
- Newsletter produced and circulated to share lessons learnt from scrutiny panels
- Increased visibility of TV team on the wards and targeted work with wards that continue to report category 3 PUs
- Develop ward trajectories for weekly completion of pressure area risk assessments
- Additional education undertaken in A&E departments
- Stop the pressure awareness campaign being planned for Nov

Safe Ambition 5: Reduction of Harm Medication Incidents

Executive Responsibility: Michelle Rhodes – Director of Nursing







Datix Moderate/Severe (Mar – Aug 2017)

Ward/Department	No.
Ward 6B	4
Ward 7B	4
AMU	3
Breast Screening Unit - Lincoln	3
MEAU	3
Ward 5A	3
A&E Department - Lincoln	2
Dixon Ward	2
Greetwell Ward	2
Out Patient Department - Lincoln	2
Ward 5B	2

SQD Dashboard for Medications Sep 2016 – Aug 2017

Metric Title	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017
Medicine chart demographics correct	78.40%	83.70%	78.10%	80.50%	78.80%	78.90%	97.2%	98.2%	98.40%	98.00%	98.2%	96.60%
Allergies documented	98.80%	98.20%	99.40%	98.40%	98.10%	99.40%	99.4%	98.7%	97.20%	97.00%	100%	98.10%
All medicines administered on time	91.90%	87.60%	88.60%	91.60%	89.10%	87.50%	76.8%	83%	81.40%	86.20%	84.7%	85.70%
Allergy nameband in place if required	91.80%	93.50%	86.20%	84.70%	92.90%	84.10%	92.3%	82.8%	86.80%	88.90%	76.7%	85.30%
Identification namebands in situ	99.50%	98.80%	99.80%	99.70%	98.50%	98.00%	98.5%	98.1%	99.70%	98.50%	96.7%	97.90%

Site	Number Reported	Rate per 1000 bed days
	13	3.17
	62	2.36
	2	4.07
	35	1.98

Performance Data Overview August 2017

There were no incidents with death or severe harm. There were 5 moderate rated incidents. Of the 112 incidents reported 88% (98/112) were classed as resulting in no harm. The most common medication incidents by event type were:-

Omitted medicine/ingredient	45
Wrong/unclear dose or strength	18
Other	10
Contra-indication or conditions	9
Wrong frequency	8
Patient allergic to treatment	4

Action Plan

Safety culture survey circulated within Staff Pulse Check September 2017, results available for October Quality Report.

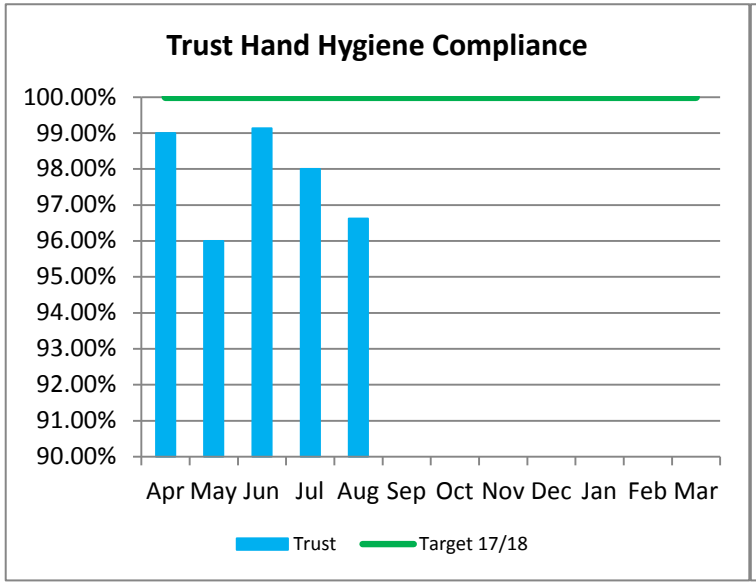
Patient Safety Briefing to be drafted on Penicillin allergy/sensitivity to be circulated by end of September 2017.

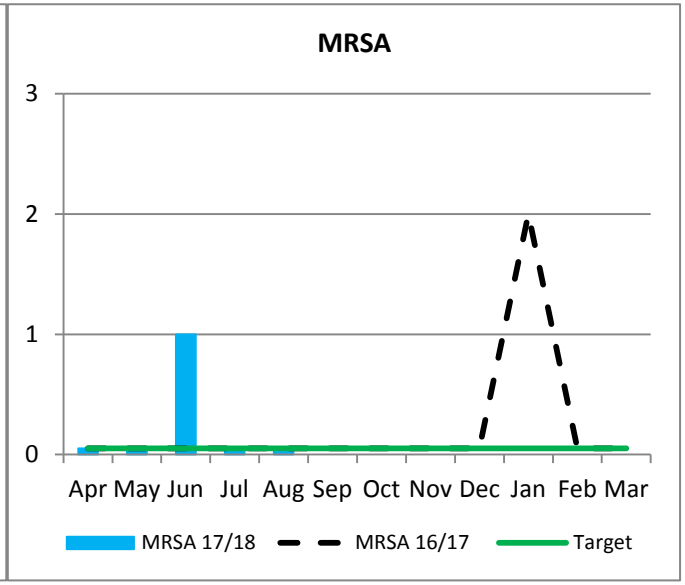
Conclusions of pathway review exercise outstanding (CQC action plan).

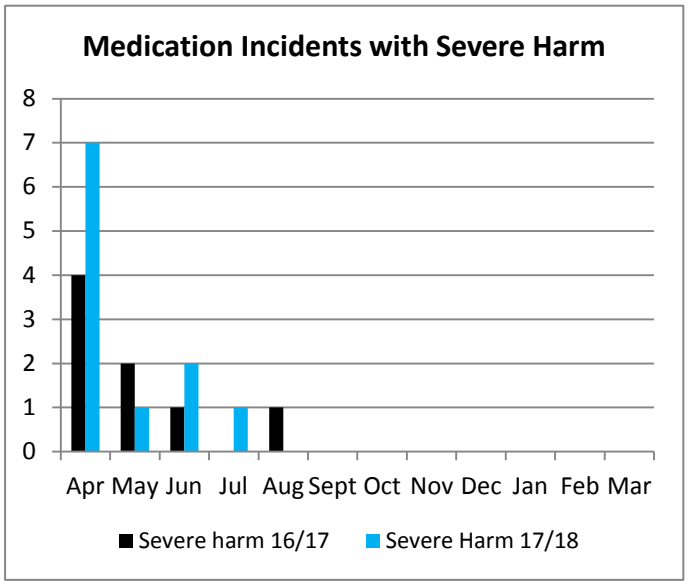
Ward accreditation launches in September 2017 with focused domain for Safer Medicines.

Safe Ambition 6: Reduction of Harm Associated with Infection

Executive Responsibility: Michelle Rhodes – Director of Nursing







Performance Data Overview August 2017

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

In August 2017 there were four reported cases of Trust attributed Clostridium difficile: three at Lincoln County Hospital and one at Pilgrim Hospital.
There were no Trust-attributed cases of MRSA bacteraemia during August.
Two TB incidents were identified during August: one where a patient with suspected TB was admitted to an open bay, and a second when an inappropriate transfer of a patient with suspected TB took place. A patient safety briefing to inform staff on the learning from these incidents is being planned.

Action Plan

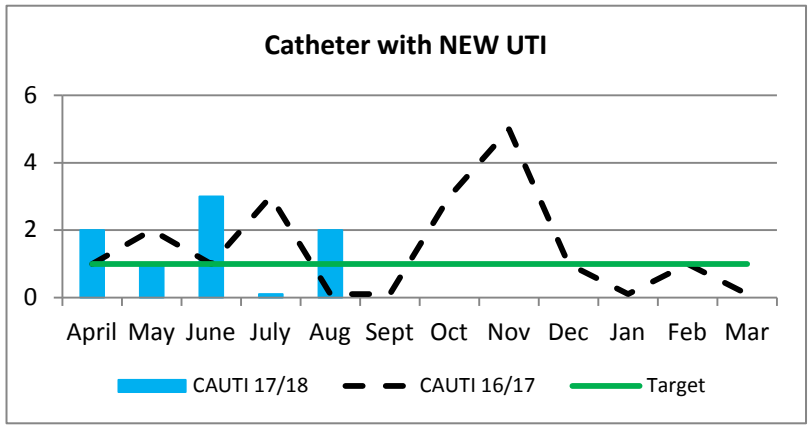
An initial draft of the gap analysis of Trust compliance with the ten criterion outlined in the Health and Social Care Act (2008) Code of practice for the prevention and control of infections and related guidance has been completed. The actions identified through the gap analysis are being incorporated into the infection prevention and control plan for 2017-18.

Weekly Clostridium difficile review meetings are continuing, and actions to reduce Clostridium difficile rates are currently focusing on timely isolation of patients with suspected infectious diarrhoea, and education of staff. Antimicrobial ward rounds are taking place at Lincoln County Hospital and Pilgrim Hospital.

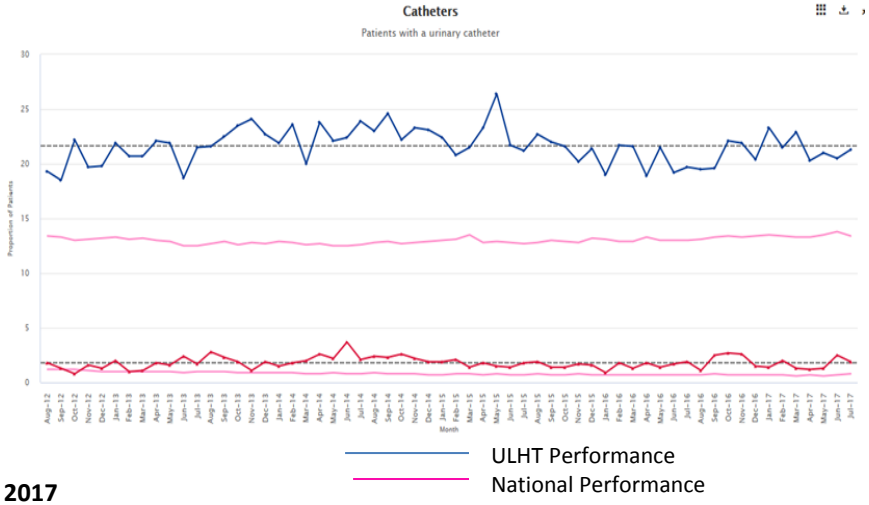
Infection Control Nurses are carrying out frequent ward visits, including daily visits to areas currently deemed to be high risk.

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 catheter care Sep 2016- Aug 2017

Metric Title	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb-2017	Mar – 2017	Apr – 2017	May – 2017	Jun-2017	Jul 2017	Aug 2017
Number of urinary catheters in-situ	63	72	81	53	67	84	80	85	72	88	89	89
Urinary catheter record demographics correct	96.8%	86.1%	98.8%	90.2%	94.0%	92.8%	96.1%	97.6%	97.20%	97.70%	93.3%	93.30%
Urinary catheter record completed &signed daily	65.1%	65.3%	72.2%	58.8%	68.2%	73.8%	54.5%	67.5%	70.00%	66.30%	69.7%	62.10%
TWOC occurred within 3 days for acute retention	50.0%	40.0%	58.3%	50.0%	66.7%	40%	25.0%	36.4%	40.00%	44.40%	50%	27.30%
Documented evidence why catheter needed	96.8%	86.1%	97.5%	92.2%	91.0%	91.7%	89.6%	94.0%	94.40%	93.10%	93.3%	89.90%

Performance Data Overview

Metric	ULHT Average	National Average
Catheter Insertion Rate JULY	21.3%	13.4%
Catheter and UTI Rate JUNE	1.9%	0.8%

The Trust is currently over trajectory for CA-UTI for 2017/18. Average catheter insertion rates for ULHT (according to Safety Thermometer) are 21.2 % (Jan – Aug 2017). Crude Safety Thermometer data suggests that ULHT inserts more catheters and has more NEW UTI's than Acute Trusts of similar size.

Action Plan

First draft of E-Learning package to be developed with Organisational Development (Trust launch December 2017).

The Urology Consultant Nurse will attend Band 7 meetings on all sites to provide education and support, and to highlight areas of non-concordance with the Catheter Care Bundle with the aim of promoting local ownership.

Review Catheter Care Bundle to identify opportunities for emphasis of Nurse Led Protocol for Removal.

Launch of Ward Accreditation 18th September 2017 with specific focus metrics on continence promotion and inclusive of relaunch of Link Nurse/Ambassador Programme (October 2017) with representation from all clinical areas

Catheter Focus Sessions (October 2017) led by Continence Specialist Nurses with focus on appropriate insertion and TWOC.

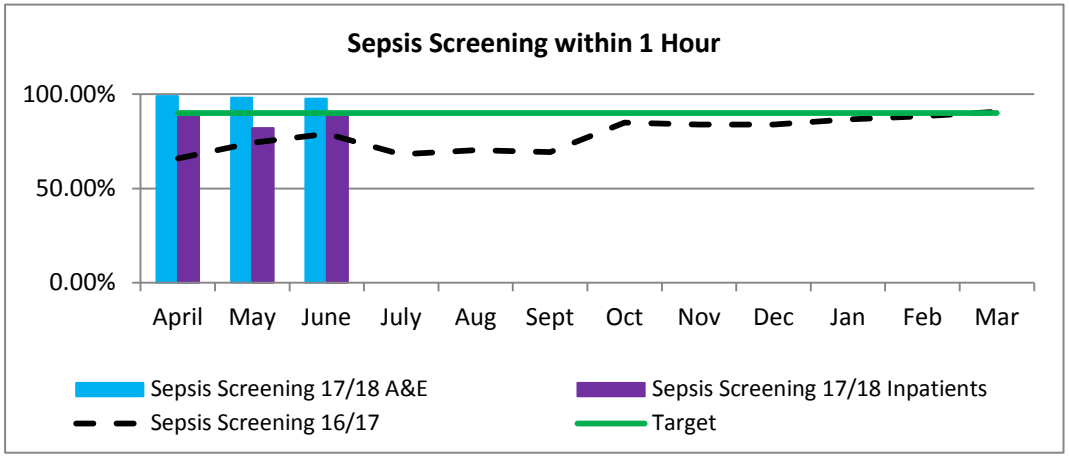
Catheter insertion performance data from SQD and Safety Thermometer to be circulated to Matrons and Heads of Nursing each month for discussion at Specialty Governance.

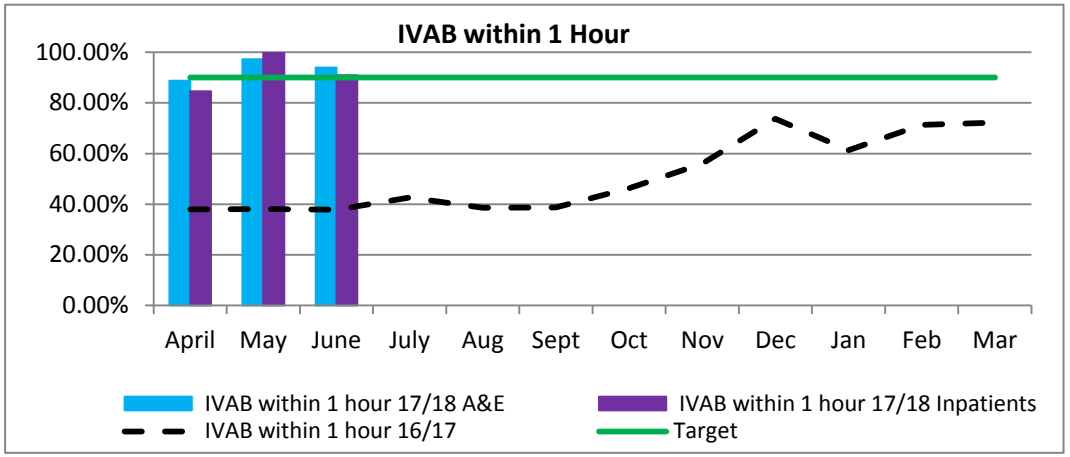
Collaborative Community Meeting 15th September 2017 to review pathway and management of catheters across Lincolnshire.

Trajectory for insertion rates to be set for ward areas – October 2017

Safe Ambition 7: Reduction of Harm Associated with Deterioration Sepsis

Executive Responsibility: Michelle Rhodes – Director of Nursing





Performance Data Overview August 2017

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

Sepsis e-learning at 88 %. Decrease considered to be attributable to expired training completed August 2016 now due for renewal.

The Trust is demonstrating improvements in the timely completion of the Sepsis 6 once Sepsis has been identified but still has work to do on the initial screening to ensure all cases are identified.

The Trust has rolled out the sepsis eBundle and is working on the development of eBundles for Paediatrics and Maternity areas. Electronic auditing is now live and issues are being identified and addressed. There is an ongoing CQC action plan.

Action Plan – July/August data is inaccurate at present and undergoing a period of validation by the Sepsis Practitioners. Developers currently reviewing the data collection system to ensure the most accurate representation possible and reduce the risk of skewed/erroneous results.

Pain Score Compliance significantly improved in August 2017 following reassignment of Pain as a mandatory field in the electronic observations system.

Sepsis Practitioners are improving awareness and compliance through education and continual monitoring. Safety Briefings circulated on IR1 reporting for Sepsis breaches with guidance on harm reviews. Prospective harm defined as those patients admitted to ICU or died during the same episode. Failure to screen to be investigated by nurse lead and failure to treat to be shared with Consultant for investigation and notification to educational lead.

Development of Maternity and Paediatric e-bundles underway.

EMAS will commence Sepsis Screening in 2017, they will be screening and administering Abx, Fluids and Oxygen to those identified as Red Flag Sepsis. SOP to support is in development.

Workforce Headline Summary

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

Statistics

KPI	2017/18 Target	August 2017 Performance	Last Month Performance	Performance in August 2016	6th Month Trend
Vacancy Rate - Medical	Medical – 12%	16.43%	11.79%	13.24%	
Vacancy Rate – Registered Nurses	Reg Nursing 11.5%	15.50%	15.21%	15.33%	
Vacancy Rate – AHP's	10%	10.64%	10.43%	11.75%	
Voluntary Turnover	7%, with no group of staff more than 20% above the overall target	5.52%	5.57%	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	Overall target remains 95%. Revised targets to be set for each topic.	90.58%	90.81%	86%	
Sickness Absence (12 month rolling average)	Overall target of 4.5% + no team over 25% above target	4.68%	4.67%	4.54%	
Appraisals - Medical	Medical – 95%	95%	96%	91%	
Appraisals – Non Medical	Non-medical	82.24%	82.64%	64.70%	
Agency Spend	£25.4m (£2.090m per in August)	£2.597m	£2.348m	£2.380m	

Commentary

Agency spend increased in the month, although there is some evidence that initiatives we have taken e.g. to increase nurse bank shifts, is having an impact. Although we have more medical and clinical staff in post at the same time in 2016, the rise in medical and registered nurse vacancies is a concern. The drop in the medical vacancy rate last month due to the intake of juniors has been reversed, as predicted.

We continue to take action to both improve recruitment rates through a structured approach to using agencies who will source from both the UK and overseas and

There continues to be some positive news about sickness levels, as the rate for the last five months is 4.46% compared to 4.61% 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 trend continues we should see a reduction in the 12 month rolling average by the end of the financial year.

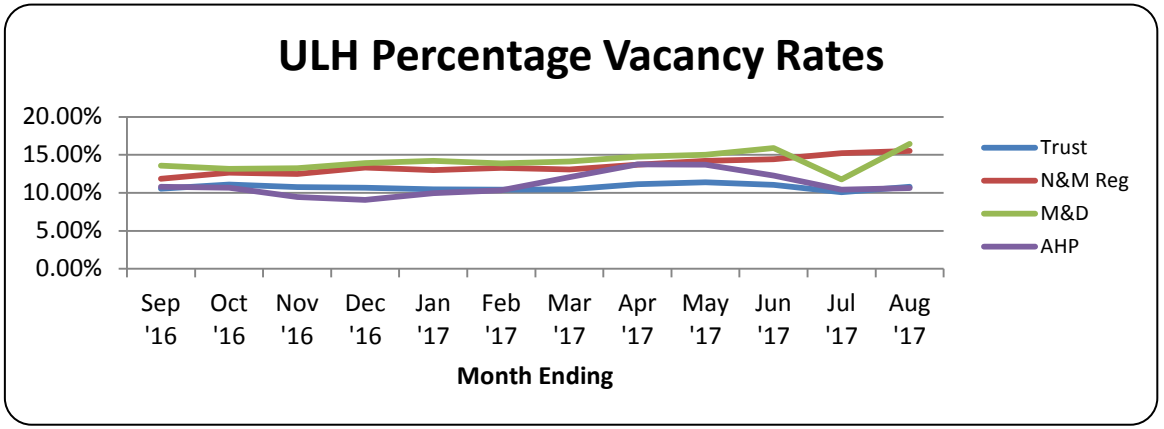
Sickness Between November and February in 2016/17 was 0.59% higher than in the previous winter and 0.15% higher than in 2014/15. We have plans in place to protect our staff from winter flu, although it should be noted that flu was not a significant factor last year and it was a mild winter.

The dip in core learning and appraisal rates is potentially the result of levels of leave in August and we will watch for the upward trend we have had for the last few months to continue.

KPI:	**Vacancy rates**	**Owner:**	Director of HR & OD
Domain:	**Well Led**	**Responsible Officer:**	Deputy Director of HR & OD
Date:	27th September 2017	**Reporting Period:**	August 2017
Target:	Medical – 12% Registered Nursing – 11.5% AHPs – 10%	**Tolerances:**	Within 1% - Amber Above 1% - Red
RAG Rating:	Medical 16.43%		
RAG Rating:	N&M 15.50%		
RAG Rating:	AHP's 10.64%		

Analysis

The current overall Trust vacancy rate (August) is 10.80%, which is an increase of 0.72% on July. M&D Trainee Grade vacancies have increased since last month by 9.44%, however this is mainly due to the one week overlap of Foundation Year 1 Doctors in post at the end of July / beginning of August no longer occurring.



Whilst still outside the percentage targets the Trust has set, it is worth noting that, for every month this financial year the Trust has had:-

- more registered Nurses working for us than we did in the corresponding period 12 months previously;
- more Consultants working for us than the corresponding period 12 months previously;
- more unregistered Nurses working for us than the corresponding period 12 months previously;

For three of the five months of this financial year and including the last two, the Trust has had:

- more middle grade doctors working for us than the corresponding period 12 months previously.

In addition the Trust has 360.78 wte AHPs, compared to 346.15 at the start of the financial year.

Action Taken	Action Planned
• Detailed recruitment plan in place; • BMJ recruitment campaign commenced; • New approach to employment references implemented to speed up the recruitment process; • All jobs now advertised via EURES Job board across the EU; • All jobs now advertised via Career Global Job Board; • Dedicated Twitter Feed in place, Linkedin Company Page constructed in August with a review of job advertising currently being assessed. Selected jobs being published to the ULHT corporate Facebook Account by Comms	• Deliver the actions identified in the 2017/18 Trust Recruitment Plan (reported into Workforce and OD Committee); • Nursing to take a business case to fund agency costs to help recruit Nurses.

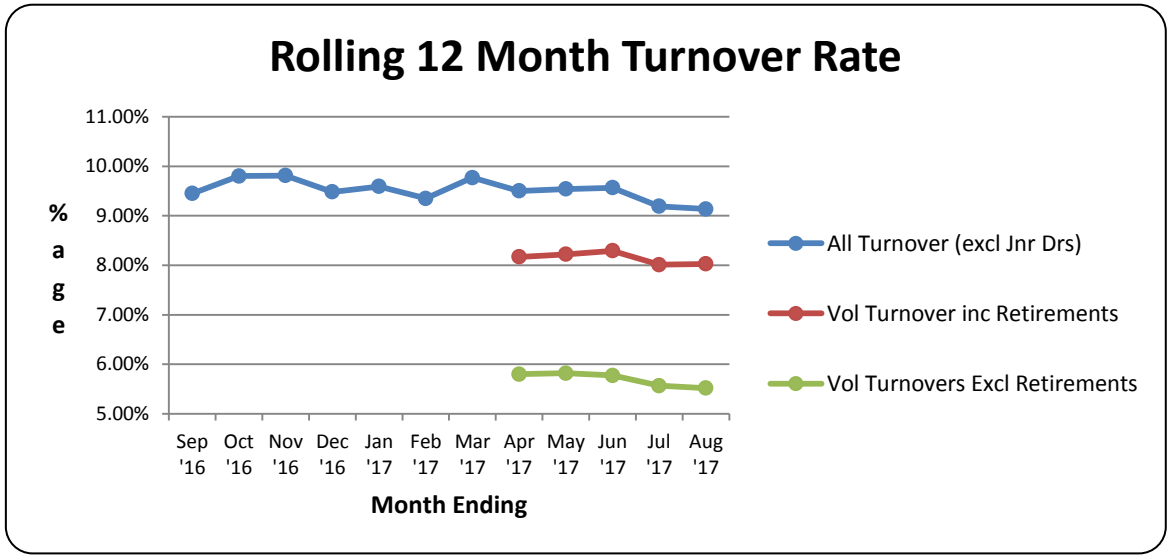
Team on an ad-hoc basis; • Review of East of England Procurement Hub suppliers for permanent Recruitment for doctors and nurses completed (Total of 150+ agencies included in process across EoE region). Renegotiated fees and charges across 12 agencies identified as first tier providers; • 80 CVs provided for roles identified as hard to fill.	

KPI:	**Voluntary Turnover**	**Owner:**	Director of HR & OD
Domain:	**Well Led**	**Responsible Officer:**	Deputy Director of HR
Date:	27th September 2017	**Reporting Period:**	August 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:	5.52%		

Analysis

The current 12 month rolling average as at August 2017 is 8.03% including retirements and 5.52% excluding retirements. Of the leavers 28.55% was due to retirement and 64.80% was due to voluntary resignations. The remaining 6.65% of leavers were for other reported reasons e.g. dismissal.

Voluntary turnover excluding retirements has reduced from 5.57% at the end of July to 5.52% at the end of August. No comparison with the end of August '16 is currently available as turnover was not calculated in this format last year.



Based on the latest (June 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 9.14% is below the average of 10.23%
- The current Trust Nursing & Midwifery (Registered) turnover rate of 7.60% is below the average of 10.75%,
- The current Trust AHP turnover rate of 14.30% is above the average of 12.02%.

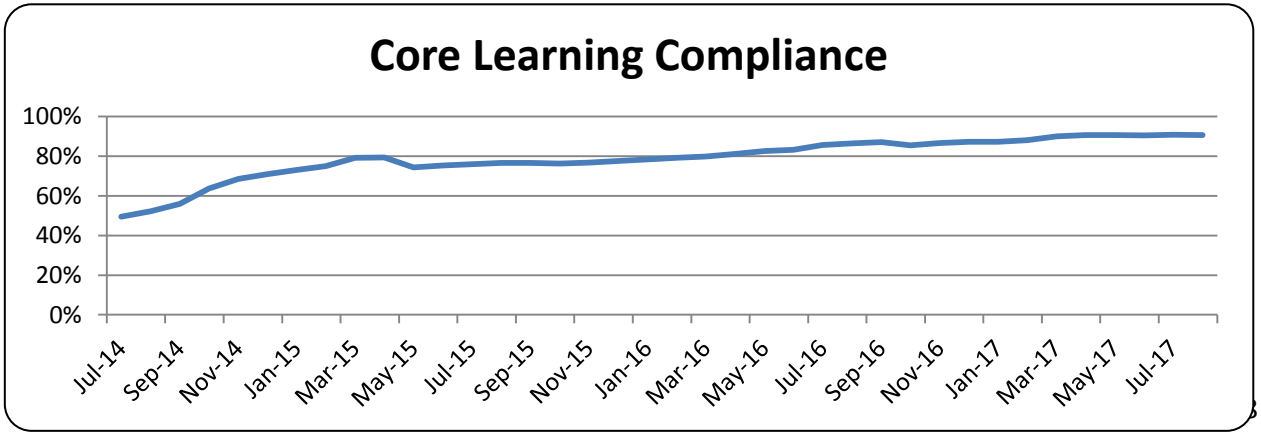
Action Taken	Action Planned
• Workforce & OD Committee received a “deep-dive” report into turnover in Allied Health Professionals. The report looked at each team in detail. There were several teams where turnover statistics were high in 2016/17. However in nearly every case the statistics could be explained by either an increased number of retirements, TUPE transfers out of ULHT or where an area had a small number of staff and as a consequence, any turnover would automatically appear as a higher percentage. In one area (Pilgrim Physiotherapy) a pattern of turnover was evident, but action has been taken in that area to address the issues which were evidently driving the level of turnover. • 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. Event to be organised to bring together key stakeholders to consider how to implement the recommendations of the retention report and develop the ULHT brand and consider how we can keep our best people as well as support attraction and recruitment

KPI:	**Core Learning Completion**	**Owner:**	Director of HR & OD
Domain:	**Well Led**	**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	27th September 2017	**Reporting Period:**	August 2017
Target:	Project to set revised targets delayed. Will be completed asap	**Tolerances:**	
RAG Rating:	90.58%		

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 August shows a slight fall from 90.81% last month to 90.58%. We now report on a combined figure (including medical) for core learning compliance. We do not have any Directorate with a compliance rate below 85% at this point, with two Directorates achieving the 95% compliance target.



Compliance for 4 of the core learning topics is increasing slowly. The others have fallen slightly with Information Governance falling by more than 1%. We must focus on achieving 100% compliance with fire safety training however, so we will be working with facilities to dramatically increase this rate. Fire has increased by 0.77% this month.

There has been a steady improvement in core learning rates which is welcomed. However, we are still not meeting our 95% target.

Action Taken	Action Planned
• Core Learning forms part of the WF Balanced 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. • 'ESR Tip 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 read and learn from a short tip. • All staff reminded through corporate communications of their core learning and how to access it	• QSIP work programme to introduce competency and skill matrices for key roles. • Core Learning Panel, chaired by Deputy Chief Nurse (Workforce), meets monthly CLP to review compliance % target by topic at September meeting • Managers will be reminded that non-compliance with Core Learning is a barrier to incremental Pay Progression

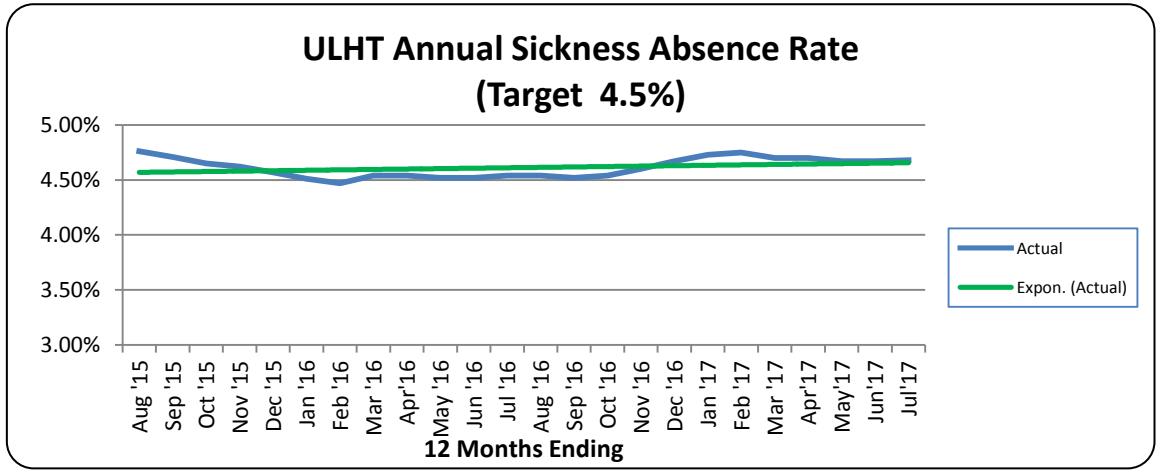
KPI:	**Sickness Absence**	**Owner:**	Director of HR & OD
Domain:	**Well Led**	**Responsible Officer:**	Assistant Director of HR
Date:	27th September 2017	**Reporting Period:**	July 2017
Target:	Overall target of 4.5% + no team over 25% above target	**Tolerances:**	Within 0.5% - Amber Above 0.5% - Red
RAG Rating:	4.68%		

Analysis

The Trust annual rolling sickness rate of 4.68% (against 2017/18 target of 4.50%) has increased by 0.01% from the previous month. The 12 month rolling sickness as at the end of July 2017 has increased by 0.14% in comparison to the July 2016 figure (4.54%).

The CCGs 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 Jul '17, Anxiety/Stress/Depression and other Psychological illness was the top reason for time lost due to sickness at 20.64% 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 7.02% (Unregistered Nurses 7.80%) followed by Estates & Ancillary at 6.73%, Additional Professional Scientific and Technical at 5.02% and Nursing & Midwifery Registered at 4.66%.

The latest Benchmarking data as at May 2017 from NHS Digital (previously Health & Social Care Information Centre - HSCIC) indicates that ULHT has the 8th highest sickness rate (lowest at 2.99% and highest 5.61%) against an average of 4.31%. 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:
  ○ Provision of Mental Health First Aid and Mindfulness Training (for 2017, 140 staff have attended these courses)
  ○ Trust provide a Level 2 accredited Counselling Course for Band 6 and above and 22 staff have been trained to date
  ○ 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
• 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.
	• A trajectory of sickness rates planned over the next 12 months with monthly monitoring of HRBP's service Trajectories
	• Formal Feedback to HRBP's on their monthly management of sickness cases will take place
	• HRBP's to take ownership of sickness figures for their area to ensure assurance.
	• 2 HRBPs and ER Team will continue to support Managers with managing their staff attendance, flagging up trigger points.
	• Support meetings for managers having difficulties in managing staff situation have been arranged with OH to take place over the next 4 months on the pilgrim site
	• Training is being delivered to staff around having difficult conversations through absence management with more planned
	• Feedback date arranged with the Director of E&F. following complaint in manging sickness case with over 50 participants attending.
	• Commencement of the role out of Electronic Occupational Health Referrals and Management

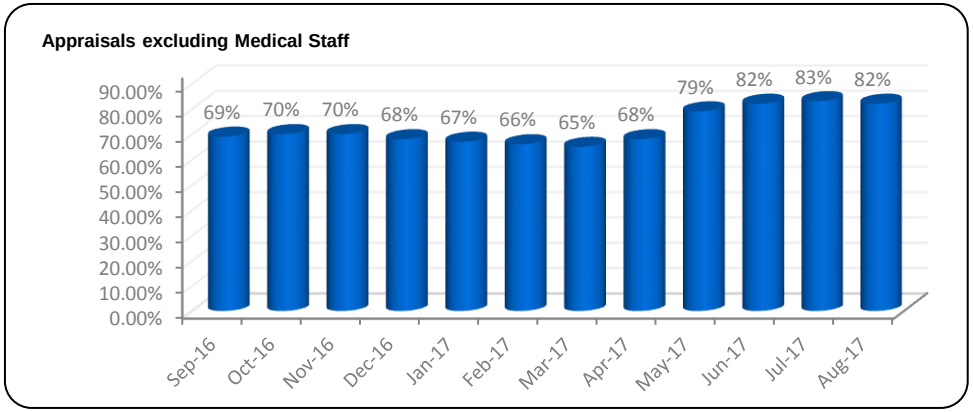
KPI:	**Appraisal Rates**	**Owner:**	Director of HR & OD
Domain:	**Well Led**	**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	27th September 2017	**Reporting Period:**	August 2017
Target:	Medical – 95% Non-Medical – 85%		Within 5% below - Amber More than 5% below – Red
RAG Rating:	Medical – 96%		
RAG Rating:	Non-Medical – 82.24%		

Analysis – Non Medical

Action taken to date has clearly had an impact on the overall level of non-medical appraisals. However, 82.24% is still well below where the organisation should be in terms of appraisal compliance. The graph below shows that the Agenda for Change Staff/Non-Medical Appraisal compliance rate for August is 82.24%. This is a reduction from the previous month by 0.40% but is still the highest figure recorded for August in the last four years.

Appraisal rates for the previous 3 years show that historically rates do not increase in August. This could be due to both employees and managers taking annual leave during this period. The table below shows the year on year rate and the graph the month on month rate in the last 12 months:

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.



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	A full review of the Trust's approach to individual performance management forms part of the QSIP and Workforce programmes and will take place during October. Senior leaders will be asked for their thoughts on how the Trust should approach performance management at the October Senior Leadership Forum

KPI:	**Agency Spend**	**Owner:**	Director of HR/OD
Domain:	**Money & Resources**	**Responsible Officer:**	Various leads on different aspects of agency spend
Date:	27th September 2017	**Reporting Period:**	August 2017
RAG Rating:	Actual spend of £2.597m, against target of £2.090m		

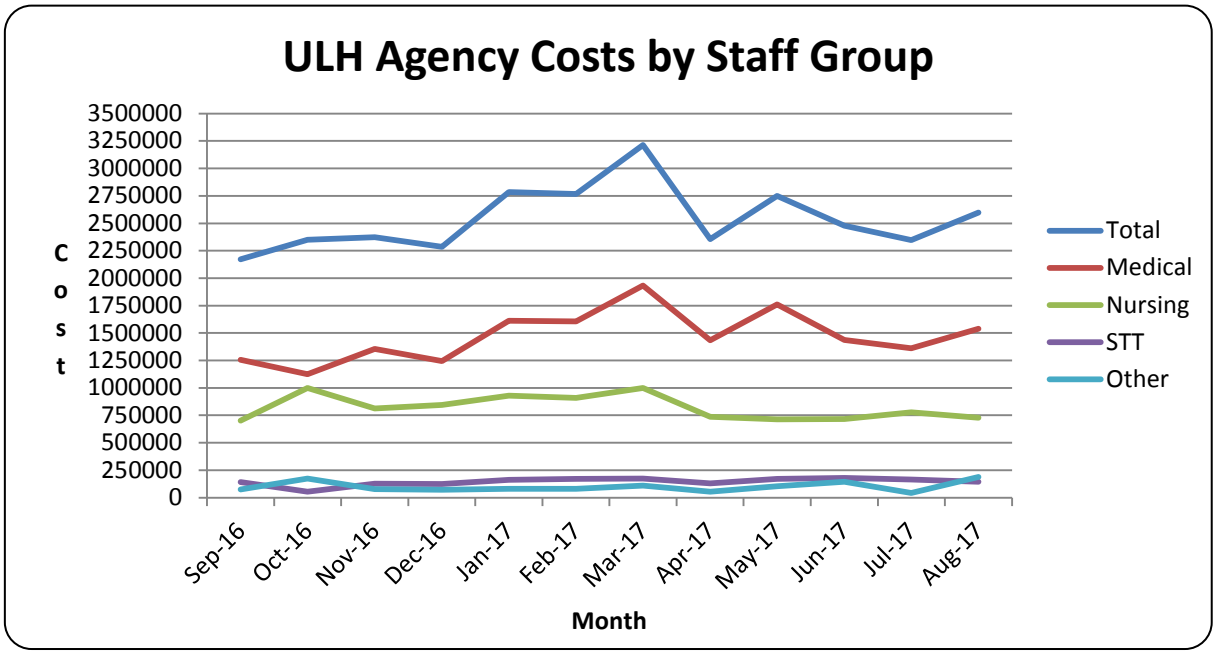
Analysis

NHSI have set an agency spend ceiling of £21m for the Trust. We have submitted an Agency Reduction Plan to NHSI which sets what we believe to be a more realistic £25.4m target spend for 2017/18. This is one element of the overall plan to reduce pay costs within the Financial Recovery Plan. At present though our expectation of the actions in the Plan submitted will only deliver £2.6m savings. The target spend in August is based on the monthly profile of spend submitted as part of our plan and it is clear that actual spend has significantly exceeded the in-month target. There has been an increase in spend of £248,617 compared to the previous month..

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

It is of concern that the level of spend in August 2017 is higher than 12 months previously. The trend through May to July was downwards, so the increase in August is of particular concern.

Of the £2,596,696 spent on Agency staff in August, £1,537,633 was spent on Medical and Dental staff, £728,052 was spent on Nursing staff (including HCSW's), £143,957 was spent on STT staff and £187,054 was spent on Other staff (including Admin & Clerical staff).



The revised Agency Cost Reduction Plan that we have developed and submitted to NHSI includes actions to manage down spend in each of the categories above. We are developing plans to cover the gap and achieve the £25.4m overall spend target and we will report on these in more detail at the next Board meeting. Regular reporting to the Financial Recovery Group is in place. We are developing some lead indicators (e.g. nurse shifts filled by agency) to enable better and earlier management of the key drivers of agency spend.

There is early evidence that there is a shift in the number of nursing shifts filled by bank rather than agency staff, but we need to see that trend sustained and translated into a reduction in spend levels. Actions to reduce medical agency spend have been taken (move from locum to substantive positions), but the cost has not reduced. We plan to review the reasons for agency staff being appointed and stop spend where we believe it cannot be justified.

Action Taken	Action Planned
• Plans are now in place to reduce all agency spend and are monitored thro ugh the Financial Recovery Group.	• Implementation of weekly pay for nursing staff on bank in November. • Implementation of "banks" for other staff groups (including medical staff) • Identify additional actions which will ensure the target of £25.4m agency spend in 2017/18 is met. •

KPI:	**Quarterly engagement index**	Owner:	Director of HR & OD
Domain:	**Well Led**	Responsible Officer:	Head of Transformational Change and Engagement
Date:	27th September 2017	Reporting Period:	August 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

We gather this data from our quarterly staff survey, but it will not be updated until after our September survey

Action Taken	Action Planned
• Staff Charter/Personal Responsibility Framework signed off by Trust Board • Comms plan for National Staff Survey agreed with Staff Engagement Group • Themes, feedback and action from Executive listening event on management training programme fed back to all participants following review at Executive Team with covering letter by Chief Executive • Introduced Team Briefing cascade	• National Staff Survey issued end September supported by comms campaign • Comms messages around actions as a result of surveys to be issued to encourage staff to complete NSS • Pulse check ends 22.9.17. Results and trends will be analysed • Feedback to staff on all 2021 ideas raised • Staff Engagement events taking place on all four sites during October • Hold site-based meeting with “influencers” who attended the 2021 Big Conversation, plus a buddy, in addition to other identified individuals to re-inforce key messages about 2021 and ask how they want to be engaged • Continue to use Pulse Checks to monitor awareness and understanding of 2021 strategy and how it affects staff

KPI:	**Quality of leadership and management index**	**Owner:**	Director of HR & OD
Domain:	**Well Led**	**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	27th September 2017	**Reporting Period:**	August 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

We gather this data from our quarterly staff survey, but it will not be updated until after our September survey

Action Taken	Action Planned
• All those on senior leaders list reminded to attend the Supporting You to Manager and Deliver our Values and Behaviours. This is KPI for QSIP • Regular RAG rated reports of booking and attendance sent to CDs and Executives • Cohort 4 of Mary Seacole Local programme recruited to • Revised management and leadership development offer approved by ET • SLF Terms of Reference and October programme being finalised by ET • Working with EMLA on new model of provision for 18/19	• Finalise list of senior leaders • Senior Leadership Forum to be held 9.10.17 • Staff Charter/Personal Responsibility Framework to be launched as part of 2021 Launch in October • New management and leadership paper to be shared with Workforce and OD Committee 29.10.17 • New management and leadership offer being designed including clearer remit for line managers in their responsibility for identifying talent and supporting transfer of learning into the workplace • Updated proposal and programme specification for Lincolnshire Health and Care leadership programme to be discussed with SET

Finance Headline Summary

Executive Responsibility: Karen Brown – Director of Finance

Key Financial Duties

Financial Duty	Annual Plan / Target £m	Current Target	YTD Plan £m	YTD Actual £m	RAG
Delivering the Planned Deficit	-48.564	-48.564	-22.938	-36.607	R
Achieving the External Finance Limit (EFL)	76.316	86.636	-	-	G
Achieving the Capital Resource Limit (CRL)	18.912	22.806	3.810	3.383	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 5 position was an in-month deficit of £5.9m, which is £1.0m adverse to the planned in-month deficit of £4.9m.
- 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 £75m.
- The £75m forecast plan assumes delivery of £18.2m of efficiencies.
- 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

	August 2017			April 2017 to August 2017		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Operating income from patient care activities	31,484	33,554	2,070	159,424	161,640	2,216
Other operating income	4,034	2,816	-1,218	19,464	13,566	-5,898
Employee expenses	-25,896	-27,122	-1,226	-129,405	-134,920	-5,515
Operating expenses excluding employee expenses	-14,182	-14,902	-720	-70,516	-75,615	-5,099
OPERATING SURPLUS / (DEFICIT)	**-4,560**	**-5,654**	**-1,094**	**-21,033**	**-35,330**	**-14,297**
NET FINANCE COSTS	-397	-284	113	-1,958	-1,288	670
Other gains/(losses) including disposal of assets	0	5	5	0	103	103
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**-4,957**	**-5,933**	**-976**	**-22,991**	**-36,515**	**-13,524**
Adjusted financial performance surplus/(deficit)	**-4,946**	**-5,909**	**-963**	**-22,938**	**-36,607**	**-13,669**

The Trust is reporting:

- An in-month deficit in August of £5.9m, which is £1.0m adverse to the planned in-month deficit of £4.9m.
- A year to date deficit of £36.6m, which is £13.7m adverse to the planned year to date deficit of £22.9m.

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

- Slower than planned delivery of efficiency savings, with delivery to date £4.5m below plan.
- Non-achievement of STF income resulting in the loss of £4.2m STF income.
- Pilgrim fire, norovirus outbreak and cyberattack resulting to date in the loss of £2.2m of income.
- Non-achievement of £0.9m 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 £3.9m higher than planned and not fully offset by a reduction in substantive and bank pay expenditure.

Efficiency

The financial plan for 2016/17 included a financial efficiency programme (FEP) target of £19m, and recurrent schemes were only identified for a total of c£13m full year effect, such that c£6m of the 2016/17 FEP target remains to be identified on a recurrent basis.

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 efficiency 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 5 is £2.2m, which is £4.5m short of the level of savings the Trust originally planned to deliver by the end of August 2017. The £2.2m is now below the recovery plan submitted to NHSi at the end of August but has been compensated by increased activity so the financial position overall is still on track. A summary of the themes is shown below.

Theme	Plan £m fye	Plan £m pye	Mth 5 Plan YTD £m	Mth 5 Act YTD £m	Mth 5 YTD Var £m	Mth 5 Recurrent FEP
Agency	6.9	2.3	0	0	0	0
Theatre efficiency	2	1	0	0	0	0
GIRFT	4	2	0	0	0	0
FEP	3.7	5.3	2.8	2.2	-0.6	1.3
Model Hospital	4	2	0	0	0	0
Grip & Control	2	1	0	0	0	0
Staff engagement	1	0.5	0	0	0	0
External Partner	8.2	4.1	0	0	0	0
Total	31.8	18.2	2.8	2.2	-0.6	1.3

Capital

The spend to date is inclusive of £0.6m on IT infrastructure, £1.0m on replacement medical devices, £0.5m on Estates compliance including fire and £1.3m on major developments including those that have spanned the 2016/17 and 2017/18 financial year-end – primarily Neonates.

The Trust application for additional capital resources to support compliance with the fire enforcement notices received from the Fire Service has been approved by NHSI in part and £9.5m has been allocated by Department of Health. The Trust is in continuous dialogue with NHSI regarding the additional Capital resources identified in the application.

Cash

At the close of August 2017 the Trust held cash of £3.3m. This includes external revenue support loans of £35.5m drawn over the first five months.

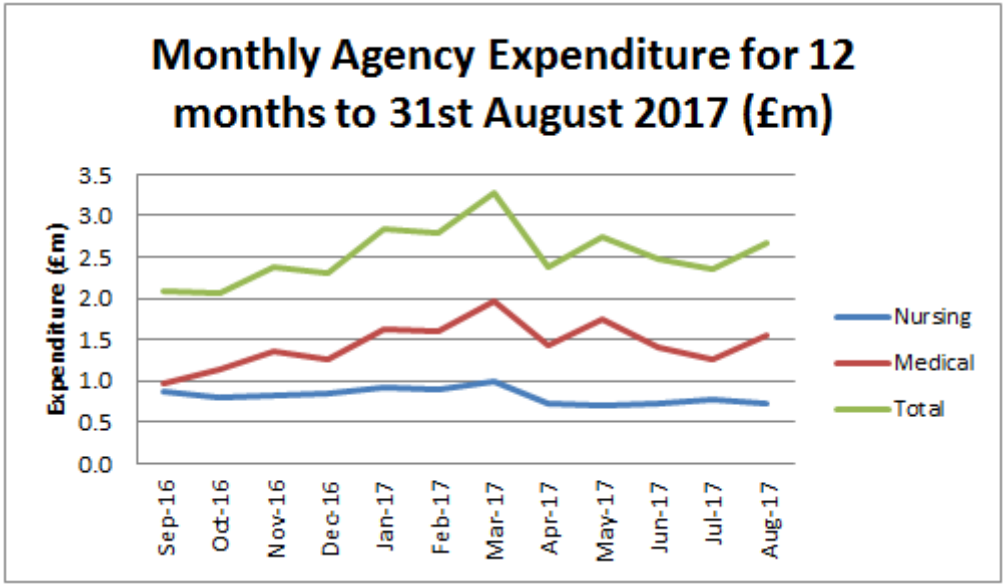
The total 'repayable' borrowings through working capital loans, Salix loans and the uncommitted loan facility are currently £146.2m. The projected revenue borrowings required in 2017/18 are £76.3m, of which £1.3m relates to deficit support from 2016/17. This has been revised in line with the forecast revenue position.

The Trust application for borrowing to address the Fire Enforcement Notice has been approved with £9.5m awarded in 2017/18.

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

Agency

The table below shows that the upward trend on agency pay expenditure has been driven by an increase in agency expenditure in Medical staffing. Over the last six months, despite rising to £2.0m in March and falling to £1.3m in July, agency expenditure on Medical staffing has averaged £1.4m per month over the past 12 months.



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	**QI** • 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.