UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 30th JUNE 2017

To:	Trust Board
From:	Karen Brown, Director of Finance
Date:	1st August 2017
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for June 2017

Author/Responsible Director: Karen Brown, Director of Finance

Purpose of the report:
To update the Board on the performance of the Trust for the period ended 30th June 2017, provide analysis to support decisions, action or initiate change and set out proposed plans and trajectories for performance improvement.

The report is provided to the Board for:

Decision	√	Discussion	√
Assurance	√	Information	√

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

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

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

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

Resource implications (eg Financial, HR) None

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

Patient and Public Involvement (PPI) implications None

Equality impact

Information exempt from disclosure

Requirement for further review?

Executive Summary for period of 30th June 2017

Safe

- New Harm Free Care is stable at National benchmark.
- Early signs of significant improvement in June 2017 in falls reductions at Pilgrim following collaborative working with NHSi.
- Hospital acquired category 2 pressure ulcers are still above target and in particular the Trust had category 3 (10) & category 4 (7) pressure ulcers in quarter to end of June 2017.
- There were 22 C. Diff hospital acquired infections in quarter to end of June 2017 with an annual target of 59 and there was one MRSA hospital acquired infection in June 2017 with an annual target of zero.
- Improvement in sepsis care continues.

Caring

- All 3 dementia targets have been achieved in May 2017
- June 2017 eDD performance has restored back to 87% following the effects of the cyber-attack in May 2017

Responsiveness

- RTT incomplete performance for June 2017 was below target at 89.89% (target 92%).Improvement plans are in place to deliver the 92% target by October 2017
- ULHT only achieved 2 of the 9 cancer standards in May 2017. The 62 day performance was only 66%. The cyber-attack had an effect on a number of cancer pathways during May 2017 extending into June 2017
- There has been a significant focus during June 2017 with Clinical Directorates to drive rapid ownership and improvements in cancer performance.
- A&E performance has improved significantly on last month's performance at both the main sites (Lincoln by 4.8% and Pilgrim by 6.4%), however overall performance is still almost 1% below agreed trajectory

Effective

- Although there is continued focus and multiple actions underway HSMI and HSMR continue to alert on the Lincoln site.
- The plan to reduce the number of patients on the overdue PBWL was significantly impacted by the cyber-attack and has stabilised again during June 2017
- Delayed Transfers of Care (DTOC)

Well-Led

- Overall Trust vacancy rate remains an ongoing concern at 11.05% and in particular vacancy rates for Medical staffing,(15.89%) Registered Nursing (14.23%) and AHP's (12.29%). However staff turnover rates remain consistently within target.
- Agency spend for June 2017 was £2.48m against a target of £1.75m.
- Annual appraisal rates have significantly improved again this month . Boston site appraisal rates are as of June 2017 now all above target.
- Core learning compliance continues to improve month on month.

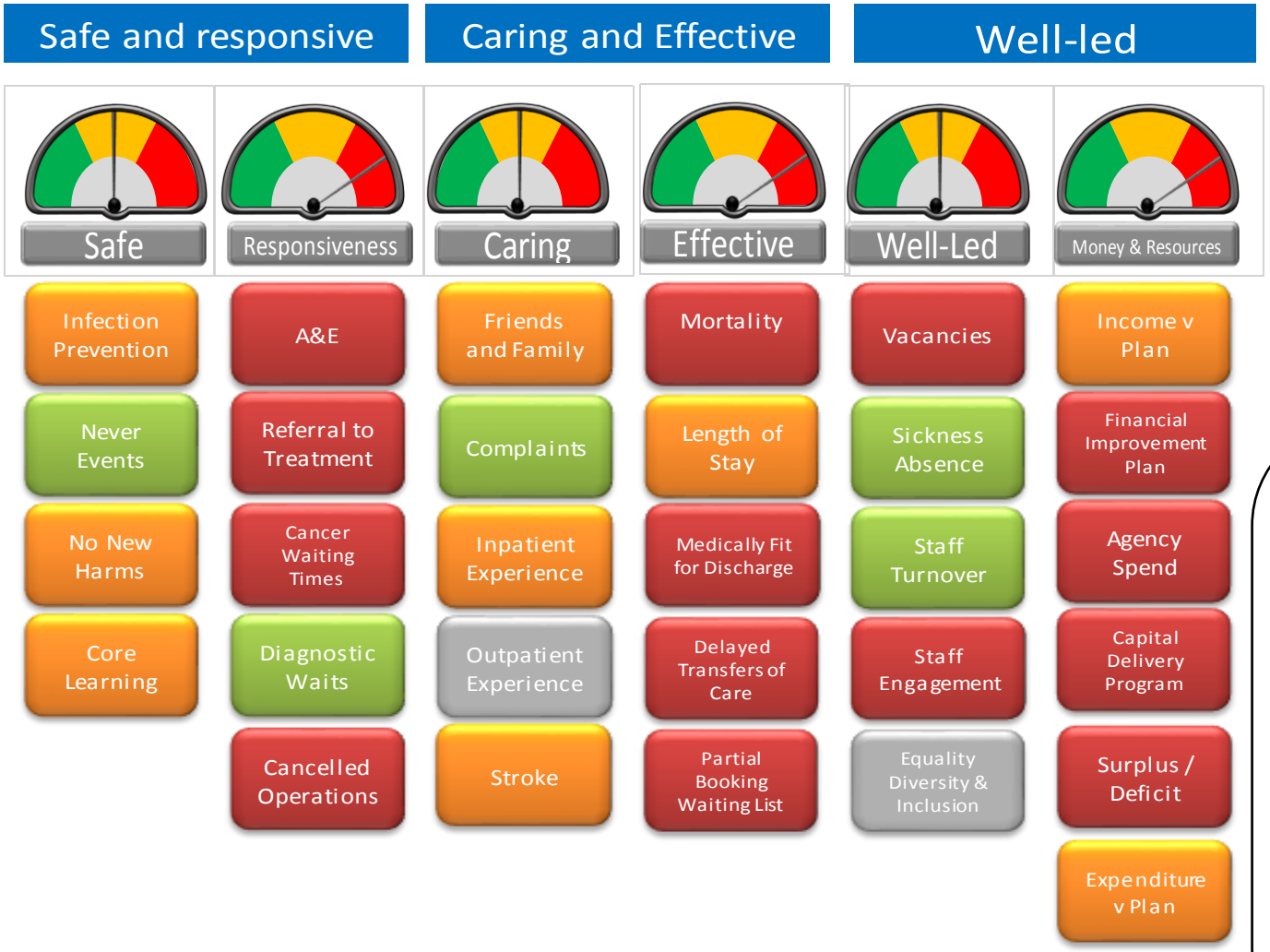
Money & Resources

- ULHT is delivering within the external finance Limit (EFL) and Capital Resource Limit (CRL)
- ULHT is not delivering the agreed planned deficit position and after Q1 has a deficit of £23.9m against a target of £14.0m
- ULHT not delivering the agreed Financial Efficiency Plan (FEP) and as at May 2017 has delivered £0.3 against a plan of £4m.
- 2017/18 CQUIN value is £4.5m

Karen Brown
Director of Finance & Corporate Affairs
July 2017

Integrated Performance Report

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



Single Oversight Framework Segmentation

3

CQC Compliance

Inadequate

A&E	RTT	Diagnostics
81.47%	89.89%	99.43%

62 Day	Deficit	Agency
71.7%	-2508k	-729k

Most deteriorated:
Domain: Safe
One case of MRSA reported on Carlton-Coleby Ward at Lincoln
Domain: Responsiveness
62 Day Classic Cancer performance has fallen to 65.6% against a national target of 85%
Domain: Money and Resources
£0.3m efficiency reported against a FEP plan of £4m

Most improved:
Domain: Caring
All 3 dementia targets have been achieved in May
Domain: Responsiveness
A&E 4hr wait has shown a 5% improvement for June
Domain: Safe
New Harm Free Care target has been achieved in June

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

Detailed Trust Board Performance

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Safe							
Infection Control							
Clostrum Difficile (post 3 days)	Monthly	Datix	59	22	4	11	
MRSA bacteraemia (post 3 days)	Monthly	Datix	0	1	1	0	
MSSA	Monthly	Datix	6	5	1	1	
ECOLI	Monthly	Datix	24	14	2	7	
Never Events	Monthly	Datix	0	0	0	0	
No New Harms							
Serious Incidents reported (unvalidated)	Monthly	Datix	0	67	19	25	
Harm Free Care %	Monthly		95%	91.20%	90.64%	90.93%	
New Harm Free Care %	Monthly		98%	97.84%	98.06%	97.49%	
Catheter & New UTIs	Monthly		1	1	3	1	
Falls	Monthly	Datix	3.90	3.49	3.69	3.12	
Medication errors	Monthly	Datix	0	447	162	141	
Medication errors (mod, severe or death)	Monthly	Datix	0	74	29	23	
Pressure Ulcers (PUNT) 3/4	Monthly			17	4	5	
VTE Risk Assessment	Monthly		95%	97.13%	97.25%	97.15%	
Core Learning	Monthly	ESR	95%	90.50%	90.42%	90.42%	

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Caring							
Friends and Family Test							
Inpatient (Response Rate)	Monthly	Envoy Messenger	26%	27.67%	24.00%	30.00%	
Inpatient (Recommend)	Monthly	Envoy Messenger	96%	91.33%	94.00%	89.00%	
A&E (Response Rate)	Monthly	Envoy Messenger	14%	20.33%	18.00%	21.00%	
A&E (Recommend)	Monthly	Envoy Messenger	87%	81.00%	80.00%	81.00%	
% of staff who would recommend care							
% of staff who would recommend work							
Complaints							
No of Complaints received	Monthly	Datix	70	165	56	51	
No of Complaints still Open	Monthly	Datix	0	723	234	250	
No of Complaints ongoing	Monthly	Datix	0	106	32	35	
Inpatient Experience							
Mixed Sex Accommodation	Monthly	Datix	0	0	0	0	
eDD	Monthly	EDD	95%	82.15%	87.03%	73.23%	
PPCI 90 hrs	Quarterly		100%	96.30%	97.33%	97.33%	
PPCI 150 hr	Quarterly		100%	86.07%	85.33%	85.33%	
#NOF 24	Monthly		70%	65.41%	64.91%	74.60%	
#NOF 48 hrs	Monthly		95%	93.41%	89.47%	95.24%	
Dementia Screening	1 month behind		90%	92.56%	91.56%	93.56%	
Dementia risk assessment	1 month behind		90%	96.91%	95.42%	98.39%	
Dementia referral for Specialist treatment	1 month behind		90%	89.28%	90.32%	88.24%	
Stroke							
Patients with 90% of stay in Stroke Unit	1 month behind	SSNAP	80%	87.50%	81.00%	94.00%	
Sallowing assessment < 4hrs	1 month behind	SSNAP	80%	68.65%	70.60%	66.70%	
Scanned < 1 hrs	1 month behind	SSNAP	50%	61.10%	60.50%	61.70%	
Scanned < 12 hrs	1 month behind	SSNAP	100%	98.50%	98.70%	98.30%	
Admitted to Stroke < 4 hrs	1 month behind	SSNAP	90%	70.85%	66.70%	75.00%	
Patient death in Stroke	1 month behind	SSNAP	17%	18.30%	18.60%	18.00%	

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Responsiveness							
A&E							
4hrs or less in A&E Dept	Monthly	Medway	82.0%	80.11%	81.47%	76.73%	
12+ Trolley waits	Monthly	Medway	0	0	0	0	
AEC							
Number of patients seen in AEC (Lincoln only)	1 month behind	Medway		251	263	238	
% Readmissions within 7 days (Lincoln only)	1 month behind	Medway	0.00%	12.55%	13.02%	12.08%	
% Patients discharged by LoS (Lincoln only)	1 month behind	Medway	0.00%	13.83%	2.08%	25.57%	
% of G&A non-elective admissions to AEC	Monthly	Medway	25.00%	16.12%	16.42%	16.99%	
RTT							
52 Week Waiters	Monthly	Medway	0	11	8	9	
18 week incompletes	Monthly	Medway	89.5%	89.28%	89.89%	89.38%	
Cancer - Other Targets							
62 day classic	1 month behind	Somerset	85%	71.70%	65.60%	77.80%	
2 week wait suspect	1 month behind	Somerset	93%	89.80%	90.40%	89.20%	
2 week wait breast symptomatic	1 month behind	Somerset	93%	76.30%	80.00%	72.60%	
31 day first treatment	1 month behind	Somerset	96%	95.35%	93.60%	97.10%	
31 day subsequent drug treatments	1 month behind	Somerset	98%	100.00%	100.00%	100.00%	
31 day subsequent surgery treatments	1 month behind	Somerset	94%	90.90%	92.30%	89.50%	
31 day subsequent radiotherapy treatments	1 month behind	Somerset	94%	93.90%	92.00%	95.80%	
62 day screening	1 month behind	Somerset	90%	86.40%	83.30%	89.50%	
62 day consultant upgrade	1 month behind	Somerset	85%	86.05%	85.10%	87.00%	
104+ Day Waiters	1 month behind	Somerset		-	25.00	22.00	
Diagnostic Waits							
diagnostics achieved	Monthly	Medway	99.1%	99.43%	99.37%	99.19%	
diagnostics Failed	Monthly	Medway	0.9%	0.57%	0.63%	0.81%	
Cancelled Operations							
Cancelled Operations on the day (non clinical)	Monthly	Medway	1.10%	4.14%	3.02%	7.74%	
Not treated within 28 days. (Breach)	Monthly	Medway	0.00%	11.35%	21.47%	1.11%	

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Effective							
Mortality							
SHMI	Quarterly		100	110.66	111.39	110.30	
Hospital-level Mortality Indicator	Quarterly		100	103.81	102.99	104.60	
Length of Stay							
Average LoS - Elective	Monthly	Medway / Slam	2.8	2.61	2.61	2.68	
Average LoS - Non Elective	Monthly	Medway / Slam	3.8	4.42	4.40	4.45	
Medically Fit for Discharge	Monthly	Bed managers	60	58.67	67.00	60.00	
Delayed Transfers of Care	Monthly	Bed managers	3.5%	4.67%	4.17%	5.29%	
Partial Booking Waiting List	Monthly	Medway	0	5903	5763	5528	

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Well Led							
Vacancies	Monthly	ESR	5.0%	11.20%	11.05%	11.40%	
Sickness Absence	Monthly	ESR	4.5%	4.38%	4.34%	4.32%	
Staff Turnover	Monthly	ESR	8.0%	5.80%	5.78%	5.82%	
Staff Engagement							
Staff Appraisals	Monthly	ESR	95.0%	76.33%	82.00%	79.00%	
Equality Diversity and Inclusion							

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Money & Resources							
Income v Plan	Monthly	Board Report Master	35660	102825	35587	34745	
Expenditure v Plan	Monthly	Board Report Master	-40396	-131825	-41625	-41328	
Efficiency Plans	Monthly	FIMS report	1342	300	300	0	
Surplus / Deficit	Monthly	FPIC Finance Report	-4736	-23932	-7243	-7853	
Capital Delivery Program	Monthly	FPIC Finance Report	-497	-1514	-758	-756	
Agency Spend	Monthly	Agency Staff Analysis	-1790	-7558	-2475	-2720	

Responsiveness

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Responsiveness							→
A&E							→
4hrs or less in A&E Dept	Monthly	Medway	82.0%	80.11%	81.47%	76.73%	↑
12+ Trolley waits	Monthly	Medway	0	0	0	0	→
AEC							→
Number of patients seen in AEC (Lincoln only)	1 month behind	Medway		251	263	238	↑
% Readmissions within 7 days (Lincoln only)	1 month behind	Medway	0.00%	12.55%	13.02%	12.08%	↓
% Patients discharged by LoS (Lincoln only)	1 month behind	Medway	0.00%	13.83%	2.08%	25.57%	↑
% of G&A non-elective admissions to AEC	Monthly	Medway	25.00%	16.12%	16.42%	16.99%	↓
RTT							→
52 Week Waiters	Monthly	Medway	0	11	8	9	↓
18 week incompletes	Monthly	Medway	89.5%	89.28%	89.89%	89.38%	→
Cancer - Other Targets							→
62 day classic	1 month behind	Somerset	85%	71.70%	65.60%	77.80%	↓
2 week wait suspect	1 month behind	Somerset	93%	89.80%	90.40%	89.20%	↑
2 week wait breast symptomatic	1 month behind	Somerset	93%	76.30%	80.00%	72.60%	↑
31 day first treatment	1 month behind	Somerset	96%	95.35%	93.60%	97.10%	↓
31 day subsequent drug treatments	1 month behind	Somerset	98%	100.00%	100.00%	100.00%	→
31 day subsequent surgery treatments	1 month behind	Somerset	94%	90.90%	92.30%	89.50%	↑
31 day subsequent radiotherapy treatments	1 month behind	Somerset	94%	93.90%	92.00%	95.80%	↓
62 day screening	1 month behind	Somerset	90%	86.40%	83.30%	89.50%	↓
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104+ Day Waiters	1 month behind	Somerset		-	25.00	22.00	↑
Diagnostic Waits							→
diagnostics achieved	Monthly	Medway	99.1%	99.43%	99.37%	99.19%	↑
diagnostics Failed	Monthly	Medway	0.9%	0.57%	0.63%	0.81%	↑
Cancelled Operations							→
Cancelled Operations on the day (non clinical)	Monthly	Medway	1.10%	4.14%	3.02%	7.74%	↓
Not treated within 28 days. (Breach)	Monthly	Medway	0.00%	11.35%	21.47%	1.11%	↑

Referral to Treatment

Executive Responsibility: Mark Brassington – Chief Operating Officer

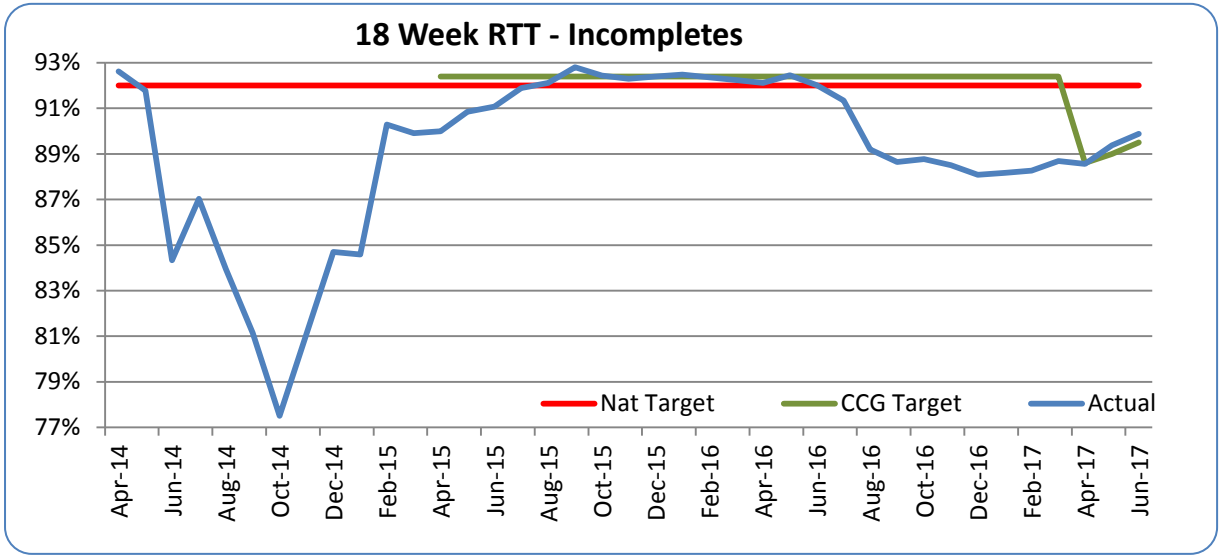
KPI:	Referral to Treatment (18 weeks)	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance
Date:	1st August 2017	Reporting Period:	June 2017

Exception Details

In May the Trust reported performance of 89.4%, an improvement of 0.8% compared with the position in April. The slight deterioration in the level of performance in April was directly related to the impact of the cyber-attack, which led to the loss of 5 days of validation capacity (during May) whilst systems were down. Performance bounced back strongly in May with a reduction of 270 patients over 18 weeks compared to April, reflecting the improving underlying position which was distorted by the impact of the cyber-attack.

At a national level the standard hasn't been achieved for 14 consecutive months, with an aggregated national performance in May of 90.4%.

The RTT incomplete performance for the end of June 2017 was 89.89%.



Between 12th-15th May the Trust cancelled 1876 outpatient appointments and 120 daycases and elective operations. Clinical Directorates re-provided additional capacity during May and June in order to rebook these patients, however during the week commencing 15th May there were c.450 less clockstops than anticipated which will negatively impact on June's performance.

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

The Trust has an submitted a trajectory with achievement of 92% being reached in October 2017. This trajectory is based upon the following assumptions:

- CCG remain within activity plan across all specialties which includes delivery of STP assumptions
- Support from CCG to reduce routine referrals into 5 key specialties
- Primary care support to review all overdue follow ups
- Able to create sufficient internal or external capacity to meet the open new referral, follow up and ASI backlog within 15 weeks (end of Sept)

There are long waiting times for first appointments in a number of specialities. There has been a slight 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 1969 on 12th July, however Gastro and ENT still have patients waiting over 30 weeks on the open referrals waiting list.

During 2016/17 activity was above contracted levels in the following specialities, which has continued into 2017/18:

Speciality	16/17 activity level above contract	Activity level above contract in month 1 of 17/18
Endocrine	22%	20%
Gastro	15%	6%
Rheum	16%	13%

All of these areas have RTT incompletes performance below 92%. During first 2 months of 2017/18 activity within Cardiology was 3% above contracted level, and 4% above contracted level in ENT.

The fire at Pilgrim at the end of March resulted in 16 cancelled operations. In addition to this capacity for daycases will be restricted for the subsequent 4 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..

Out of hours medical cover at Louth remains an issue which resulted in 13 inpatient procedures being cancelled up to the end of April. Since that time short term arrangements have been in place in order to provide appropriate out of hours cover, and where not available adjust the case mix on the Louth site to reflect the level of cover overnight.

What action is being taken to recover performance?

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

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

In addition to the delivery of additional capacity the Clinical Directorates are planning to complete a range of further actions in order to achieve the rapid improvements in the key planned care metrics highlighted within this report. These actions include:

- Review of polling ranges within ERS
- Review of clinic booking rules
- Strengthen referral grading processes
- Ongoing validation of open referral and partial booking waiting lists
- Expansion of nurse-led clinics
- Work in collaboration with CCGs to introduce new pathways for the management of certain conditions within the community
- Virtual clinics
- Outsourcing activity in T&O, General Surgery and ENT, and exploring potential to outsource in Dermatology.

There are key speciality areas (ENT, Cardiology, Community Paeds and Dermatology) where the Clinical Directorates believe that a significant reduction in referrals over a 3-6 month period into these areas is required in order to achieve the improvement in new and follow-up patient backlog reduction which is required. Discussions have taken place with the CCGs regarding how these reductions in referrals can be achieved. The CCGs have taken these proposals to their Governing Bodies and have shared their current position, with partial support being indicated relating to this request. NHSI are co-ordinating a meeting with key stakeholders on 21st July in order to attempt to finalise plans and agree timescales/implementation plans/metrics to monitor.

The Neurology Service remains closed to routine referrals at present as it works through the backlog of open referrals and partial booking overdues which built up within that service.

What is the recovery date?
October 2017

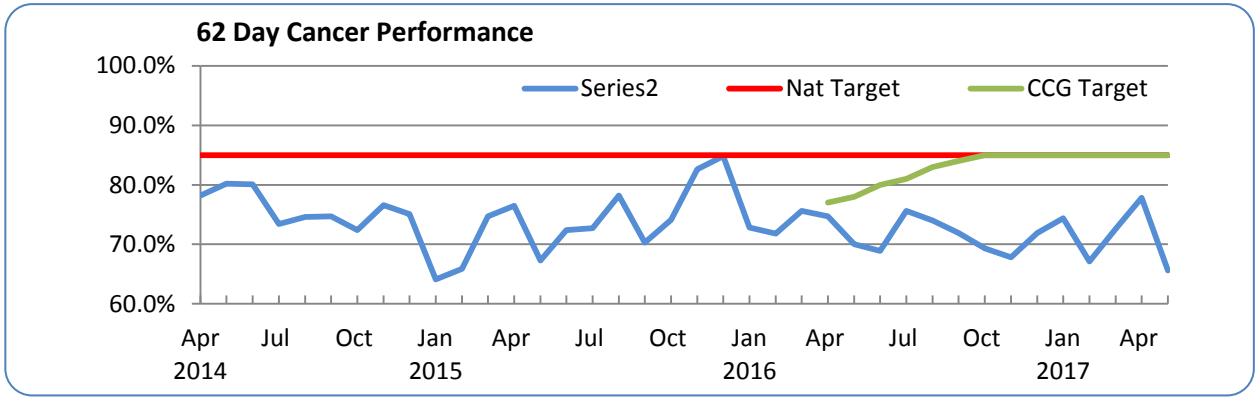
Cancer Waiting Times – 62 Day

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Cancer Waiting Times (62 Day)	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance – Planned Care
Date:	1st August 2017	Reporting Period:	May 2017

Exception Details

The Trust achieved a performance of 65.9% against the 62 day classic standard in May.



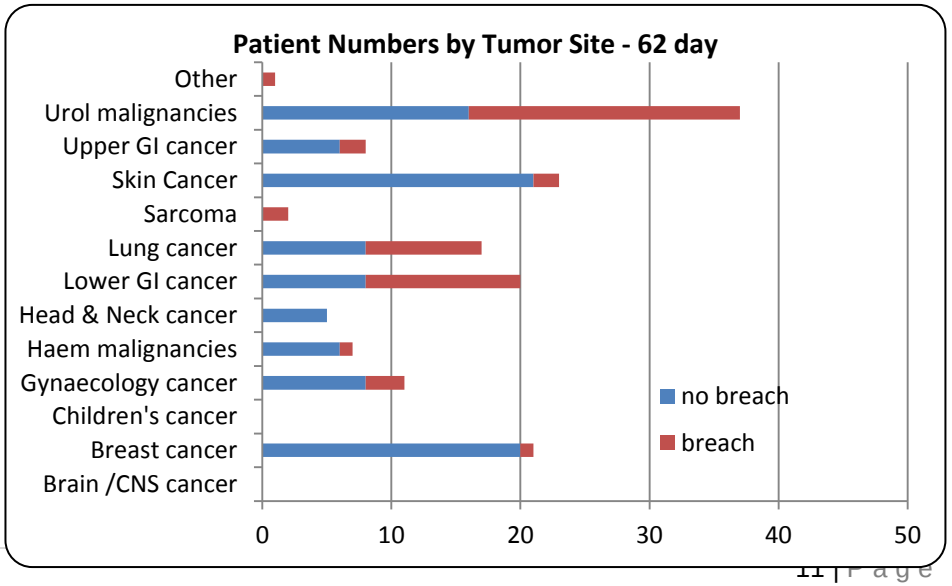
The Trust achieved 2 out of the 9 cancer standards.

The 62 Day Classic standard continues to remain the most challenged standard and work continues to improve the quality of the patient journey on the understanding that improvements in this will work directly towards achievement of this standard. The RCAs for the 59 patient in May who were 62 day breaches found a number of key themes in terms of access to diagnostics within ULHT, particularly Endoscopy and CT guided biopsies were slower than required for a significant proportion of patients on 62 day pathways. In addition, delayed access to specialist tests (such as EBUS and EUS) as well as outpatient and theatre capacity introduced further waiting periods into the 62 day pathways for our patients, deteriorating ULHT's performance. A significant number of patient choice and fitness delays also contributed to the Trust's performance position in May. Delays in admin processes were also found in an unacceptable number of patient pathways.

The Trust's performance against the 14 day suspect cancer target and the 14 day breast symptomatic target were both adversely effected in May by another growing spike in referrals and the impact of the cyber-attack.

The cyber-attack had a significant impact upon cancer pathways:

- 2 confirmed cancer patients had their surgery cancelled
- There were 180 operations and Endoscopy procedures cancelled in total
- 92 first outpatient appointments were cancelled for patients on suspect cancer pathways
- At least 28 outpatient follow-up appointments were cancelled for patients on suspect cancer pathways
- It is estimated that pathology turnaround times increased by c.7 days for a two week period.
- Radiology – Cancellation of all scans on Monday 15th, however the bigger impact from a cancer perspective was that the Trust were off of the EMRAD network for 1 week causing significant issues with reporting images and the Trust couldn't outsource any images during this time
- Radiotherapy – 26 patients missed 2 treatment days, and 70 patients missed 1 treatment day.



As of 14th July there are 15 pts on or over 104 days without an agreed treatment plan: 10 x Urology, 1 x Colorectal, 2 x Upper GI, 2 x Gynae.

4 of the 15 have confirmed cancer diagnosis.

The Trust treated 13 patients at 104 days or over during May, completing RCAs for all 13 patients. Due to the length of these pathways these patients had multiple reasons for delays in their pathways, as follows:

- 7 cases included complexity or procedural factors
- 4 cases included patient choice delays
- 3 cases included CT delays
- 3 cases included theatre capacity restrictions
- 3 cases included Outpatient capacity
- 3 cases included Oncology capacity delays
- 2 cases included MRI capacity restrictions
- 2 cases included primary care delays
- 2 cases included tertiary treatment delays
- 2 cases included tertiary diagnostic delays
- 2 cases included patient fitness factors
- 2 cases included Endoscopy capacity
- 2 cases include HDU capacity constraints
- 2 cases included admin delays
- 2 cases included delays within the MDT
- 1 case included aspects relating to holistic needs
- 1 case included chemo delays

The responsible clinicians for all patients treated over 104 days during May have been requested to complete a harm review in line with the Trust's 104 day waiter process. At the time of writing 11 harm reviews had been completed, with 1 patient identified as potentially having experienced moderate/severe harm as a result of the delay within the cancer pathway. For this patient the clinicians have been asked to complete a further assessment to determine whether their treatment outcome and prognosis has been negatively affected by the pathway delays. This assessment has not been concluded at the time of writing this report. The Trust's duty of candour process will be followed relating to this patient.

What action is being taken to recover performance?

The Trust holds a fortnightly Cancer Recovery and Delivery meeting, chaired by a Deputy Director, in order to provide an oversight of the change programme set out in the Trust's Cancer Action Plan, holding Business Units to account for performance and delivery against the action plan.

Key actions being undertaken in the coming weeks include:

- Pilot utilisation of a Urology Cancer Business Manager role
- Full roll out of level 1 beds at Lincoln
- Pilot MRI STT for Prostate pathways
- Continuation of Endoscopy backlog clearance
- Continuation of extended CT capacity
- Roll out of lower GI STT at Pilgrim – in recruitment phase currently
- Lung STT for CT
- Oncology administrative optimisation

The Chief Operating Officer and Medical Director met with all tumour site leads in June to discuss the current issues within each area and request confirmation of further actions which will be taken to improve cancer performance rapidly. Actions which were agreed include:

- All Clinical Directorate Teams (management and clinical, with appropriate input from cancer trackers) to meet weekly to track, update and progress management of all patients over 62 days on cancer pathways.
- Ensure MDT co-ordinator cover arrangements in place
- Investigate histology turnaround times, and work with Path Links to ensure improvement achieved.
- Review options to improve Radiology reporting times
- Radiology to reduce CT biopsy delays

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:

- Proposal to utilise non-recurrent system funding to increase cancer tracking capacity and facilitate improvements within tracking processes.
- Review whole pathway capacity/demand
- Review best practice PTL management from other organisations to inform ULHT systems
- External clinical support to review long waiting patient pathways

A&E 4 Hour Standard

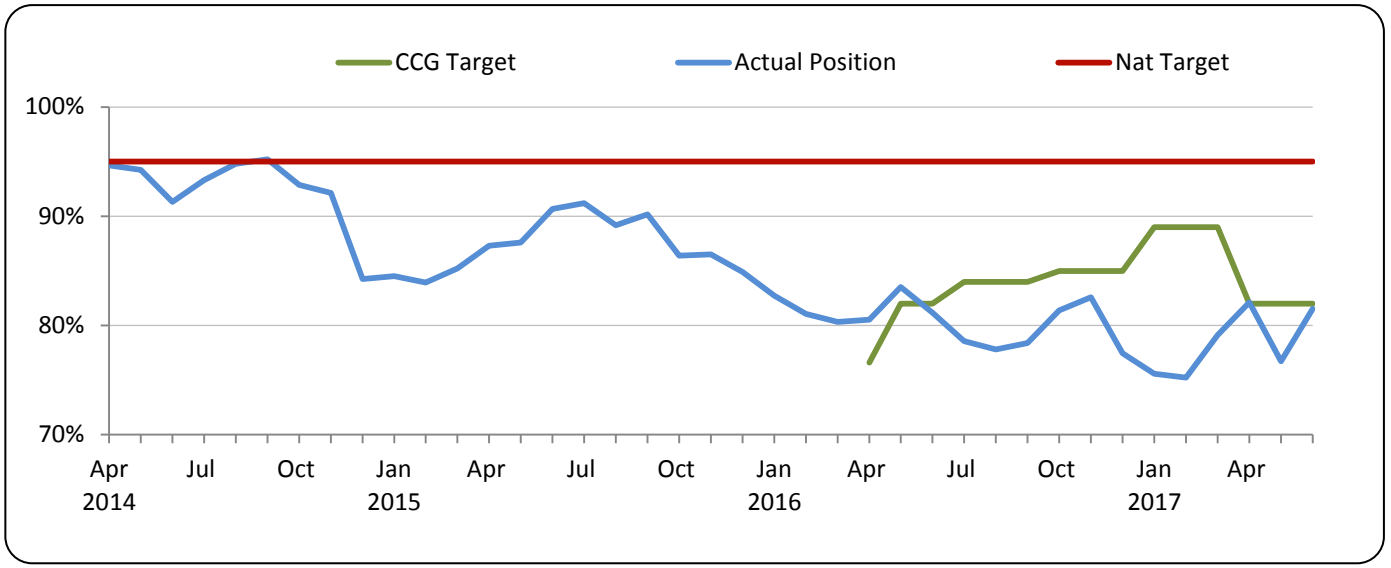
Executive Responsibility: Mark Brassington – Chief Operating Officer

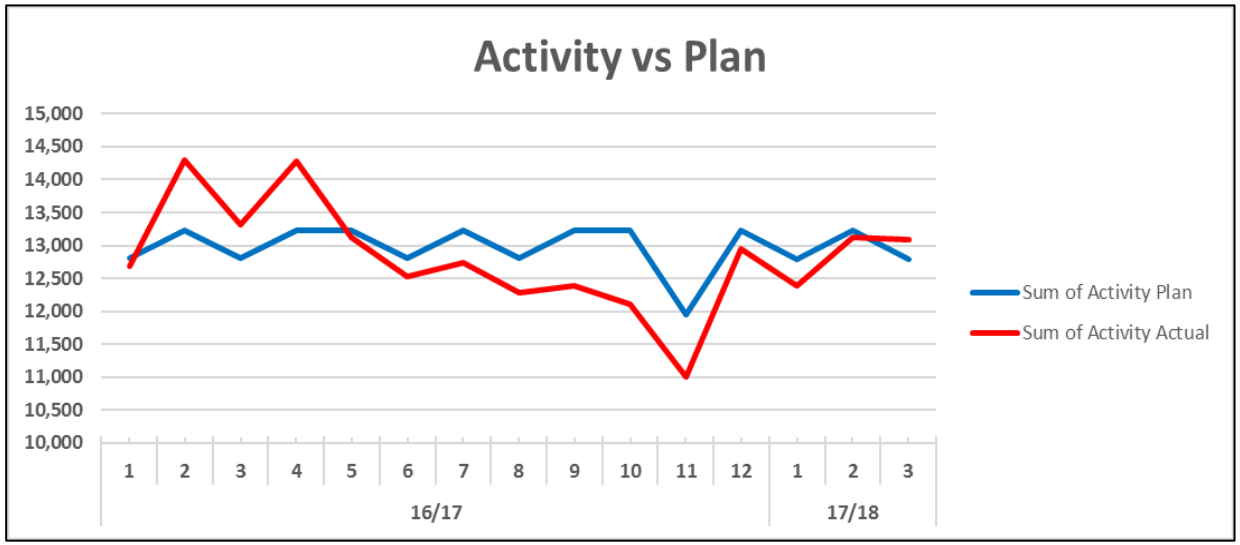
KPI:	**4 Hour Wait (A&E)**	**Owner:**	Chief Operating Officer
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Urgent Care
Date:	1st August 2017	**Reporting Period:**	June 2017

Exception Details

Overall Trust performance is 81.47%, which is 0.53% below the planned recovery trajectory of 82%. Lincoln County Hospital 78.47%, 0.53% below trajectory, Pilgrim Hospital 78.07%, 0.93% below trajectory, and Grantham Hospital 97.74%, 1.74% above trajectory. Performance for the 1st quarter at the end of June was 81.38% (subject to final validation), 0.62% below trajectory.

Activity is close to plan for the Trust, despite the continuation of reduced hours at Grantham. Of all sites, Boston has seen the biggest increase in attendances and is significantly above plan.





Pilgrim

June's overall performance was 78.07%, which is an improvement of 6.4% from last month. This remains marginally below the STF monthly trajectory for June of 79%.

Triage performance within 15mins was improved to 62.3% compared with 56.36% last month

Time to 1st assessment was slightly down from 40.28% last month to 39.49% against the national target of 50%

Total attendances for June 2017 was 5092 compared to 5142 in May 2017

Admission levels have remained high, but consistent throughout June with 1528 at 30%, but this is a 2% drop from May's 1643 at 32%, still much higher than the national average of 25-27%.

In-month key issues affecting performance in June were:

- Vacancies in ED Medical rota's with reliance on agency locums.
- Deanery junior doctor gaps and nursing vacancies cover with consequent agency increase.
- High patient attendances and increased acuity of those attending: High temperatures contributed to the increase in attendances and acuity.
- Poor hospital flow – admissions exceeded discharges. The AEC area was frequently used as escalation bed capacity resulting in inefficient processing of ambulatory patients.
- Elective work was cancelled to facilitate medical patients (30-40+) in surgical beds.
- The MMFD numbers have increased with external delays awaiting packages of care & community beds

Lincoln

Performance for June 2017 was 78.47% which is an improvement in performance of 4.78% from last month. This remains marginally below the STF monthly trajectory for June of 79%.

During the first 2 weeks in June the daily attendance levels exceeded 200 on most days and this was coupled with increasing acuity and requirement for 4+ resus beds. Discharge levels reduced as LOS increased with the higher acuity resulting in significant difficulty in maintaining adequate on site flow. Attendances were in excess of 200 patients on 18 out of the 30 days peaking at 228.

Rota gaps peaked during the 2nd week of June with fill rates dropping and hours remaining uncovered (see table below). Medical staffing again became critical with significant rota gaps due to non-attendance of booked doctors during the weekend of 23/24/25th June. This caused both safety risks and delays in patients being seen. All doctors (agency or substantive) have been written to by the Director of Operations. Many nights during the month, the department only just met minimum staffing template.

	05/06/2017	12/06/2017	19/06/2017	26/06/2017
Weekly MG hours required	432	432	432	432
Substantively filled	60	94	40	96
Internal MG Extra	10	0	50	10
Internal Con acting Down Extra	12	0	0	0
Agency Filled	318	268	342	306
Grantham Filled	0	0		0
Not Filled	**32**	**70**	**0**	**20**
MG Vacancies	7.4	7.4	7.4	7.4

What action is being taken to recover performance?

Pilgrim:

- Continual recruitment/interviews for Middle grade Dr's
- Review of rotas to try and ensure the best possible skills mix is present.
- Breach Performance analysis being performed to identify any particular trends or patterns, as well as breach League table for the clinicians
- Embedding of SOPs for patient streaming away from the ED.
- Established a new drug cupboard outside RAIT that has reduced RAIT times by approx 4-5 mins in an internal audit
- Meetings ongoing with orthopaedic speciality to address the delays with reviews – July MG rota to have specialty (T&O) input/cover.
- Revised ambulance handover process to Dr in RAIT that has reduced turnaround times
- Departmental weekly meeting 'time2talk' initiated to address any departmental issue's/quick wins.
- Further focus on Red-Green and Pride & Joy to increase timely discharges and address delays to increase flow and improve performance.
- Increased usage and focus on the Discharge Lounge
- Internal junior doctor contracts (NHS Locums) established to reduce impact of deanery gaps and subsequent agency spend.

Lincoln:

- Recruitment is yielding some successes and the new GP in A&E commenced in post on 7th June. A new CESR middle grade joined the department late June and a new substantive Consultant will join the team on 4th August 2017. There are currently 3 middle grade level agency locums who have expressed an interest in working in Lincoln and we are working with them on an offer currently. Two of the agency consultants have also expressed a wish to join the department as NHS Locums.
- The new medical rota template will be in place from 24th July 2017 which begins to address some of the staffing capacity shortfall during the daytime.
- The GP "take" will change from arriving directly to MEAU to being run through AEC from 17th July. Patients will be treated as ambulant until proven otherwise.
- Red2Green processes have been refined and more robust processed put in place regarding review of stranded patients.
- Plans are being put in place for the development of a GP streaming service which will commence by end of September 2017. This will involve mainly workforce development in partnership with CCG and community colleagues and a small capital build which will be completed in line with the national timescale of mid-December.

Effective

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Effective							↓
Mortality							→
SHMI	Quarterly		100	110.66	111.39	110.30	↑
Hospital-level Mortality Indicator	Quarterly		100	103.81	102.99	104.60	↓
Length of Stay							→
Average LoS - Elective	Monthly	Medway / Slam	2.8	2.61	2.61	2.68	↓
Average LoS - Non Elective	Monthly	Medway / Slam	3.8	4.42	4.40	4.45	↓
Medically Fit for Discharge	Monthly	Bed managers	60	58.67	67.00	60.00	↑
Delayed Transfers of Care	Monthly	Bed managers	3.5%	4.67%	4.17%	5.29%	↓
Partial Booking Waiting List	Monthly	Medway	0	5903	5763	5528	↑

Partial Booking Waiting List

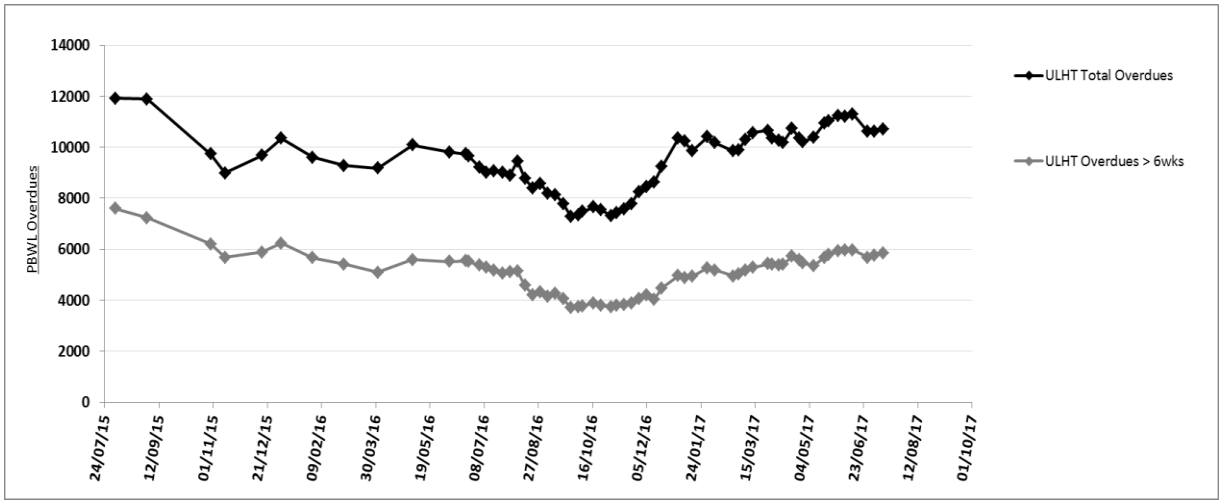
Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Partial Booking Waiting List	Owner:	Chief Operating Officer
Domain:	Effective	Responsible Officer:	Deputy Director of Operational Performance
Date:	1st August 2017	Reporting Period:	June 2017

Exception details

The impact of the lost capacity and reduced booking activity during the cyber-attack led to an increase in this partial booking over 6 week overdue position during May, climbing up to 5943 by the 31st May. This position has remained stable over the last 4 weeks, with 5832 patients 6 weeks or more overdue on 11th July.

The number of patients overdue by over 6 weeks or more with 4 specialities (ENT, Neurology, Rheumatology, Endocrine) account for 49% of the total patients overdue by over 6 weeks. ENT on its own accounts for over 20% over the 6 week overdue follow-ups.



What action is being taken to recover performance?

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

- Neurology – Service remains closed to routine referrals. Additional clinics being provided by Consultants in place. MS nurse specialists have commenced reviewing follow-ups. The job description for the 4th Neurology Consultant has been approved by the Royal College, and will go out to advert imminently. The speciality continue to review CV's for locum Consultants. The Lincolnshire CCGs have approved a Headache pathway which is expected to reduce referrals for headaches into secondary care once the service re-opens.
- Rheumatology – Substantive Consultant now in post, locum Consultant to remain in addition until backlog resolved. Alternative models of working being reviewed within the speciality. The service are investigating the potential of utilising a patient initiated follow-up service model.
- ENT – Additional clinics; additional audiology sessions; review discharge point for key pathways; review vacant slot processes. Liaising with private providers around the potential options for utilising outsourcing capacity. Forecast recovery still to be confirmed.
- Endocrine – IPB has approved the business case for a 4th Consultant post at Pilgrim. The job description is now being finalised prior to advertising. Lincoln and Pilgrim are currently working together to review the spread of capacity across these sites.

Neurology, ENT, Cardiology and Community Paeds all have significant partial booking waiting list backlogs, and these are amongst a group of service areas where the Trust have requested support from the CCGs in order to manage referral rates into the Trust in the short term as part of the plan to address the backlogs.

Safe

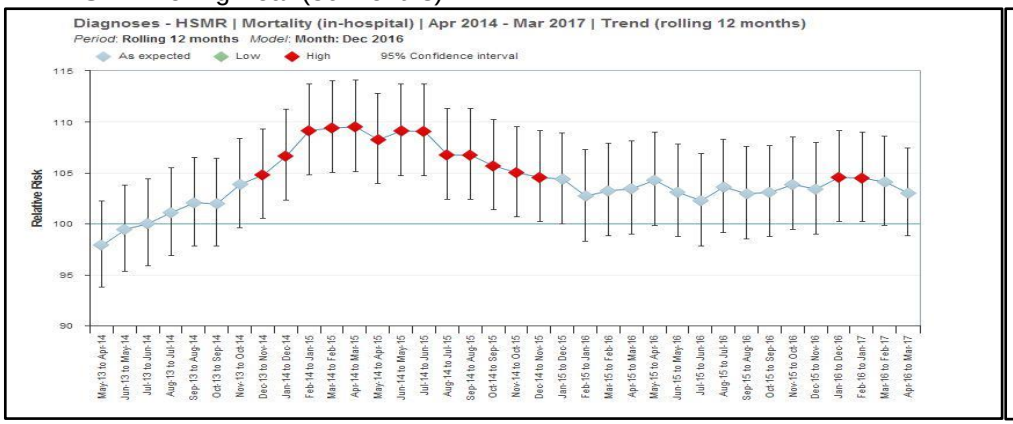
Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Safe							→
Infection Control							→
Clostrum Difficile (post 3 days)	Monthly	Datix	59	22	4	11	↓
MRSA bacteraemia (post 3 days)	Monthly	Datix	0	1	1	0	↓
MSSA	Monthly	Datix	6	5	1	1	→
ECOLI	Monthly	Datix	24	14	2	7	↓
Never Events	Monthly	Datix	0	0	0	0	→
No New Harms							→
Serious Incidents reported (unvalidated)	Monthly	Datix	0	67	19	25	↓
Harm Free Care %	Monthly		95%	91.20%	90.64%	90.93%	↓
New Harm Free Care %	Monthly		98%	97.84%	98.06%	97.49%	↑
Catheter & New UTIs	Monthly		1	1	3	1	↑
Falls	Monthly	Datix	3.90	3.49	3.69	3.12	↑
Medication errors	Monthly	Datix	0	447	162	141	↑
Medication errors (mod, severe or death)	Monthly	Datix	0	74	29	23	↑
Pressure Ulcers (PUNT) 3/4	Monthly			17	4	5	→
VTE Risk Assessment	Monthly		95%	97.13%	97.25%	97.15%	↑
Core Learning	Monthly	ESR	95%	90.50%	90.42%	90.42%	→

Safe Ambition 1: Reduction of Harm Associated with Mortality

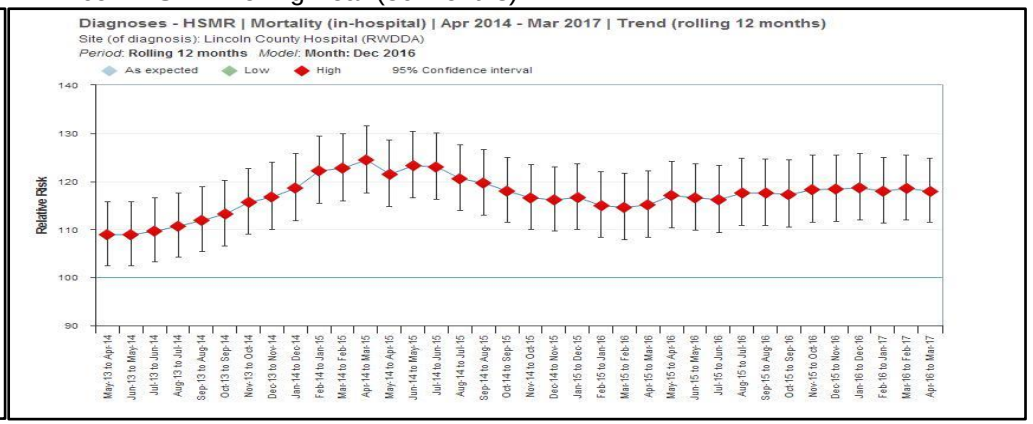
Executive Responsibility: Neil Hepburn – Interim Medical Director

Trust/Site	ULHT HSMR Apr 16-Mar 17 12 month	ULHT HSMR Apr 16-Mar 17 YTD	ULHT HSMR Mar-17	ULHT SHMI Jan 16 – Dec 16	Trust Crude Mortality YTD Internal source Jul 16-Jun 17
Trust	102.99	102.99	92.3	111.39	1.80%
LCH	118.0	118.0	113.4	115.32	1.84%
PHB	93.0	93.0	73.1	109.01	1.94%
GDH	72.5	72.5	82.7	93.04	1.01%

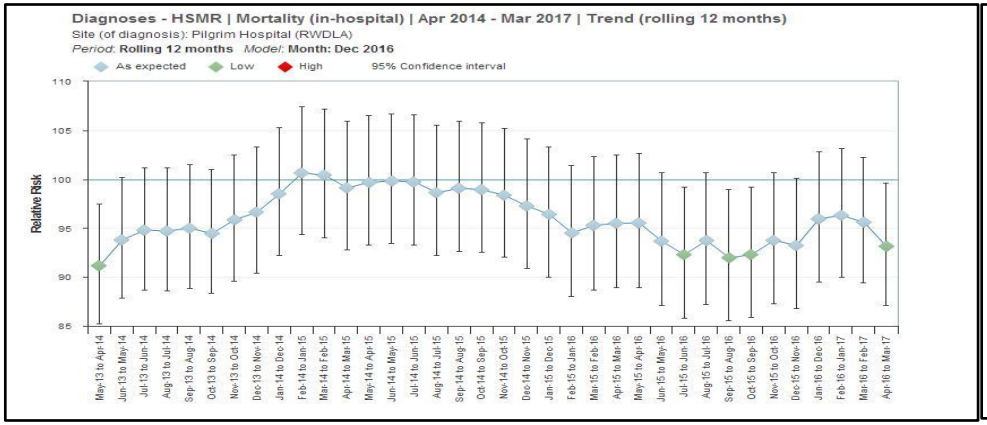
ULHT HSMR Rolling Year (36 Months)



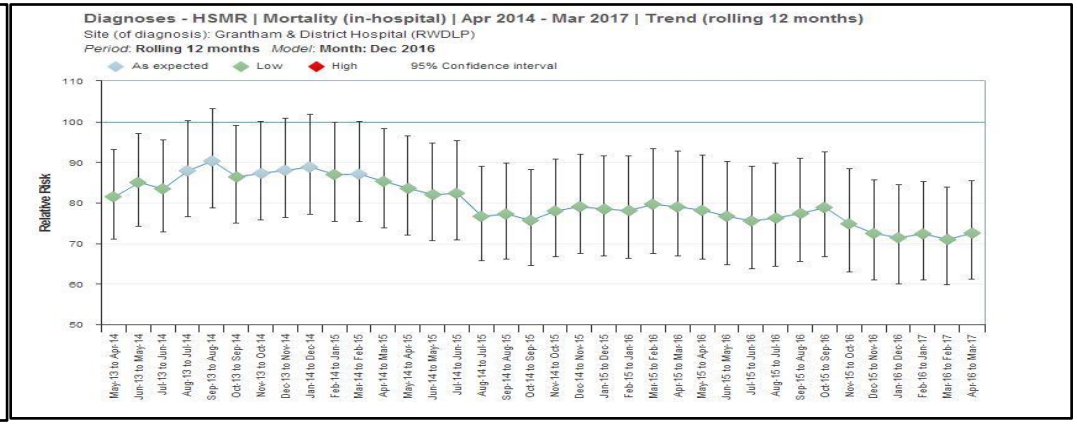
Lincoln HSMR Rolling Year (36 Months)



Pilgrim HSMR Rolling Year (36 Months)



Grantham HSMR Rolling Year (36 Months)



Alerts

ULHT

The Trust diagnoses groups are:

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

Lincoln County Hospital diagnoses groups are:

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

Pilgrim hospital diagnoses groups are:

- **COPD and bronchiectasis:** For this alert there has been 15.98 mortalities over the predicted Dr Foster data. This is the third month of alerting.
- **Abdominal pain:** This is a cumulative alert and not alerting in a particular month; year to date there are 2.5 mortalities over the predicted Dr Foster data. This is the first month alerting.
- **NEW Other perinatal conditions:** This is the first month of alerting with 8 observed and 4.9 mortalities over the predicted Dr Foster data. As the Trust has had in-depth reviews and changed processes a Mortality alert overview has been produced**.**

Grantham Hospital

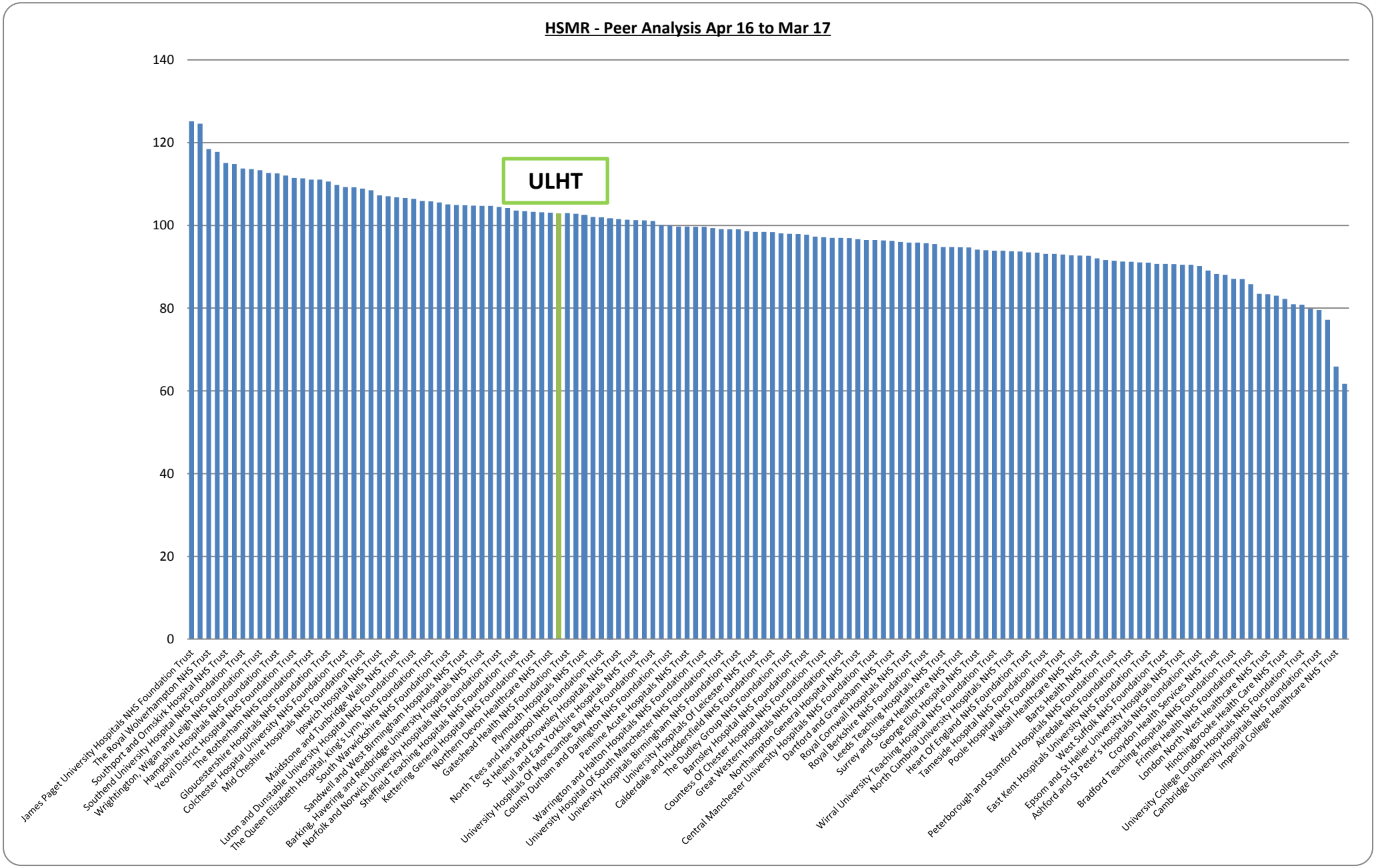
No notifications

HSMR Top Observed Diagnosis Groups April 2016- March 2017

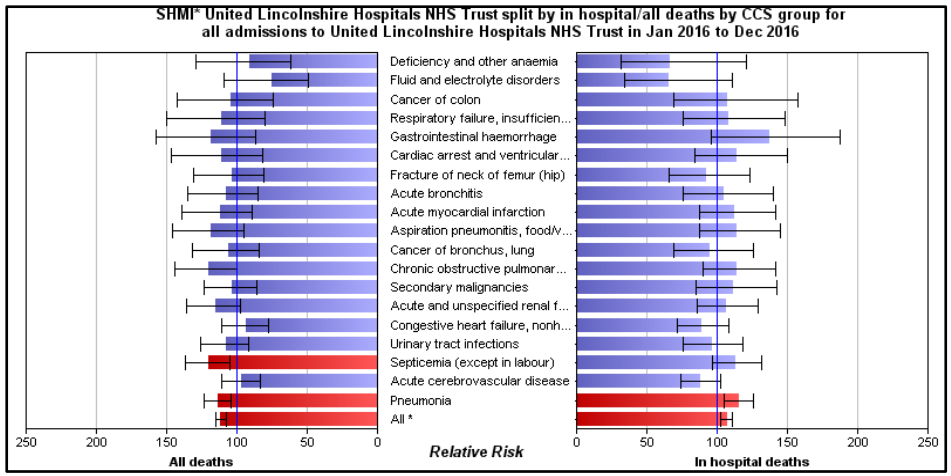
Rank	Diagnosis group	Spells	mortalities	% of all mortalities	Expected mortalities	Actual-Expected	Crude (%)	HSMR
1	Pneumonia	2590.00	469.00	21%	477.50	-8.50	18.11	98.22
2	Septicemia (except in labour)	853.00	189.00	9%	167.25	21.75	22.16	113.00
3	Acute cerebrovascular disease	1164.00	176.00	8%	180.52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

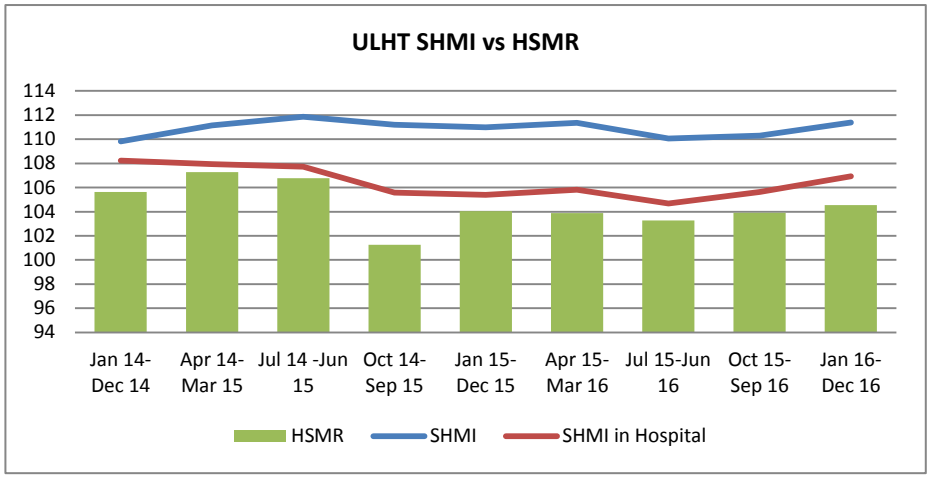
The above diagnosis groups show the top 60% of the alerting diagnosis within the Trust. Those diagnoses highlighted in red are alerting diagnosis at site level.

HSMR Peer Analysis



SHMI





The Trust is undertaking numerous strategies for Mortality Reduction:

- Mortality Matters and MoRAG case review for lessons learned remain to be distributed monthly via communications and to MAC and the Senior Leaders forum.
- PHB have been piloting a Ward Clerk checking the clerking proforma for completion of the comorbidities-**The committee to agree pilot in Lincoln for this process.**
- Intestinal hernia without obstruction is currently alerting diagnosis; an in-depth review is currently being undertaken; a proforma has been agreed by Consultant Colorectal Surgeon and the notes have been sent for review. A report will be produced for the committee upon completion of the audit and incorporate an action plan.
- 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 contacted the Clinical Directors for volunteers to undertake the in-depth review.
- National guidance on Learning from Deaths are currently being implemented by the Trust full implementation by September 2017.
- Coding Masterclass being organised for October 2017 (these are run quarterly and we have previously orchestrated five masterclass).
- Monthly MoRAG reviews for assurance and escalate lessons. Quarterly report submitted to the board next report is due in September 2017.
- 6 weekly meetings of the Lincolnshire Mortality Collaborative with ULHT, CCG, LCHS and GP's to understand deaths within 48 hours of admission and within 30 days of discharge. An update for the committee will be submitted in August 2017. A GP mortality proforma is to be ratified at the collaboratives' next meeting 18th July 2017, to enable the GP to input to the meeting where we are discussing a patient under their care.
- Teaching sessions to be arranged to incorporate comorbidity training for Junior Doctors.

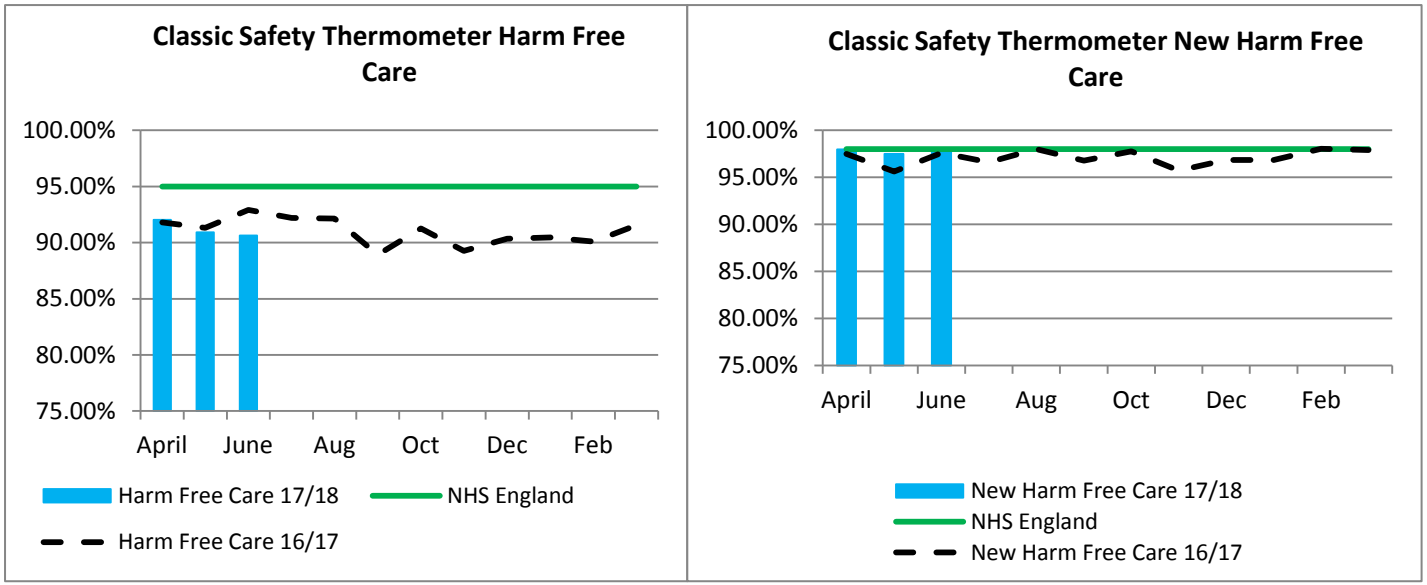
Reviews (Jan 2016-Jun 2017)

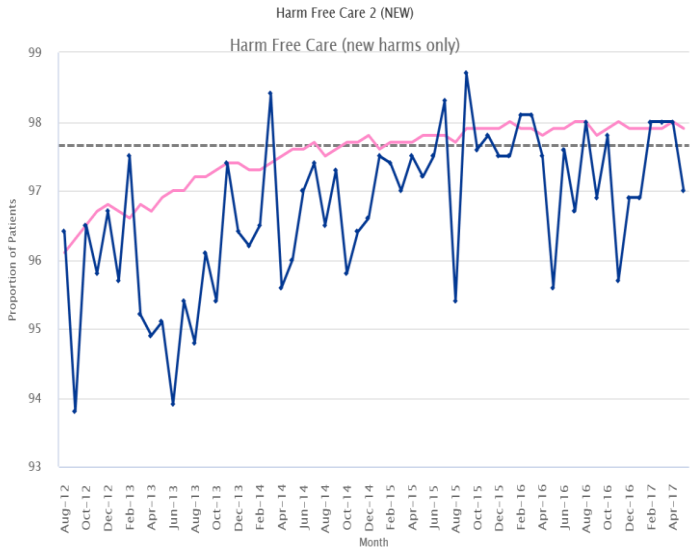
Site	Deaths	Awaiting notes/Notes in Quality Governance	Notes Sent for Review	Review Complete	Review completion Compliance	Review Completion Target	Total Death % Reviewed
ULHT Total	4245	750	3495	2591	**74%**	70%	61%
Lincoln Total	2319	331	1988	1423	**72%**	70%	61%
Pilgrim Total	1668	351	1317	992	**75%**	70%	59%
Grantham Total	258	68	190	176	**93%**	70%	68%

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

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

Executive Responsibility: Michelle Rhodes – Director of Nursing





Performance Data Overview – April 2017

June 2017	ULHT #	GDH #	LCH #	PBH #
New Category 2	4	0	2	2
New Category 3	0	0	0	0
New Category 4	2	0	0	2
Falls No Harm	11	1	3	7
Falls Low Harm	2	0	1	1
Falls Moderate Harm	3	0	3	0
Falls Severe Harm	0	0	0	0
Catheter & New UTI	3	0	2	1
New VTEs	2	0	1	1

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.

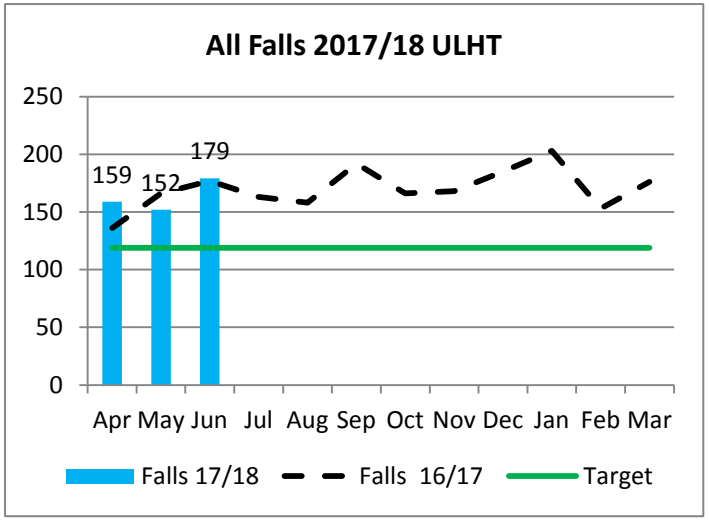
Fall actions outlined within Quality Report (see respective falls page). Results reported upwardly to Falls Reduction Group with delegated authority from Patient Safety Committee.

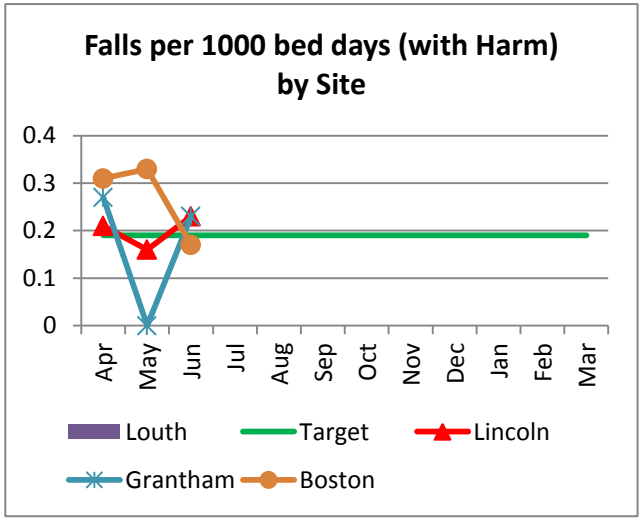
CA-UTI actions outlined within Quality Report (see respective CA-UTI page). . Results reported upwardly to Catheter Reduction Group with delegated authority from Patient Safety Committee.

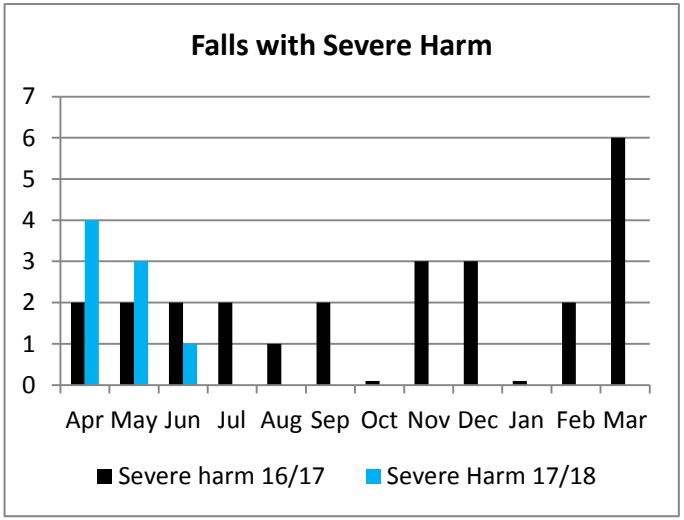
VTE investigated through Route Cause Analysis by VTE Nurse Manager and reported upwardly through Patient Safety Committee.

Safe Ambition 3: Reduction of Harm Associated with Falls

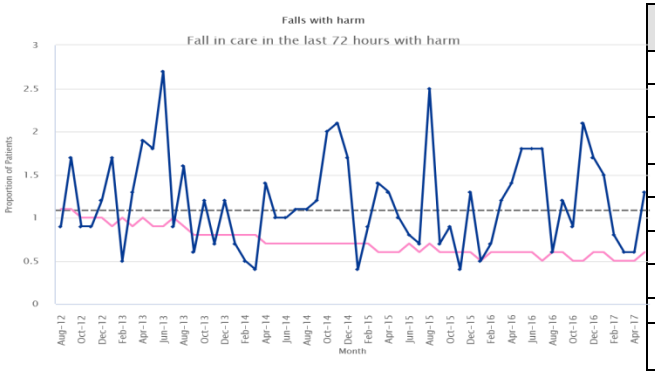
Executive Responsibility: Michelle Rhodes – Director of Nursing







Safety Thermometer May 16 – May 17



Safety Quality Dashbaord (SQD) for Trust Falls July 2016- June 2017

Metric Title	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	De 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017
Patient at risk of falls	344	336	338	344	318	284	325	333	344	312	296	332
Actions completed within 4 hours	93.00%	88.10%	87.40%	93.90%	90.50%	88.00%	87.70%	88%	88.1%	91.0%	90.60%	92.8%
Actions completed within 24 hours of admission	46.50%	42.20%	49.20%	45.30%	38.50%	48.50%	47.40%	-	46.7%	57.7%	57.40$	62.0%
Lying & standing BP completed	58.00%	62.60%	67.10%	63.10%	61.90%	61.00%	66.50%	62.8%	68.3%	78.0%	81.80%	78.7%
Care plan 7 activated	97.10%	96.40%	96.20%	93.80%	94.40%	93.60%	95.30%	95.4%	91.4%	97.7%	97.60%	96.1%
Neuro Cognition Assessed	-	-	-	-	-	-	-	-	96.2%	97.1%	98.00%	99.1%
Vision Assessed	-	-	-	-	-	-	-	-	95.3%	97.8%	96.60%	97.6%
Bed Rails Assessment	-	-	-	-	-	-	-	-	98.6%	99.7%	99.30%	100%
Continence/toilet regime documented	-	-	-	-	-	-	-	-	76.4%	92.9%	87.50%	94.1%

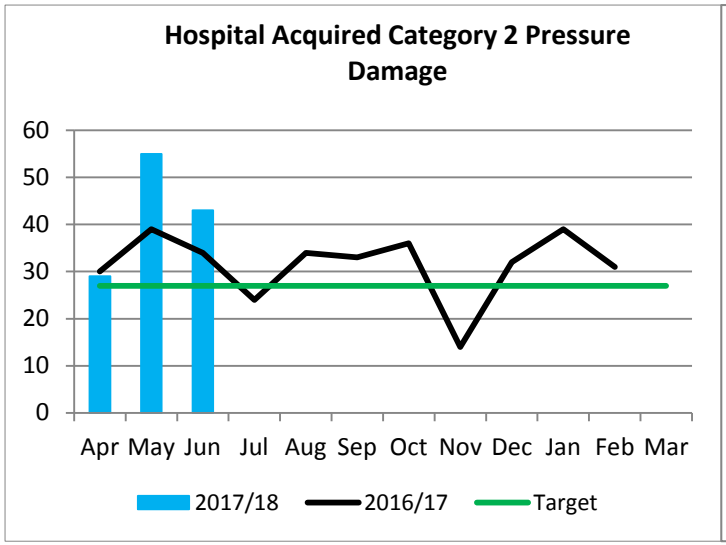
Performance Data Overview- There have been 179 falls across ULHT in June 2017 compared to 177 in June 2016. Of the 179 falls, 46 were repeat falls. 62 falls resulted in some level of harm of which 52 were low harm and 8 were moderate harm. There was 1 fall that was recorded as resulting in a death on Navenby Ward, however it has been confirmed that it was a significant medical event that resulted in the fall. 1 fall resulted in severe harm on EAU at Grantham. Falls per 1000 bed days has increased across all hospital sites. Falls with harm per 1000 bed days on the Pilgrim site is now below trajectory.

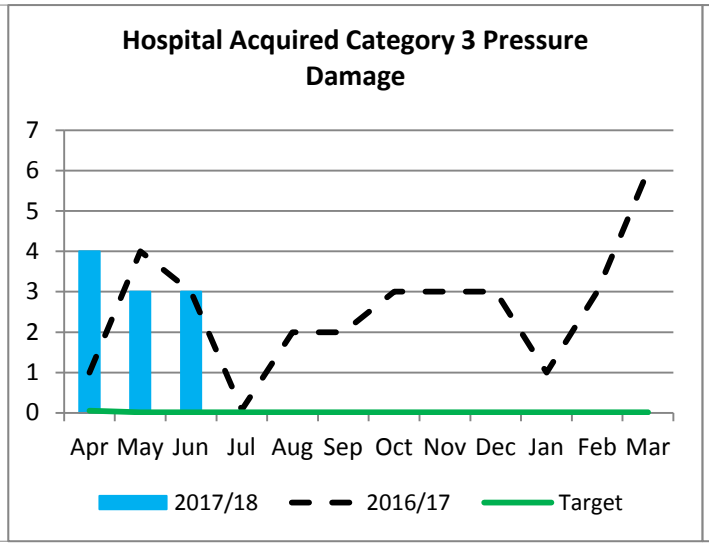
Action Plan

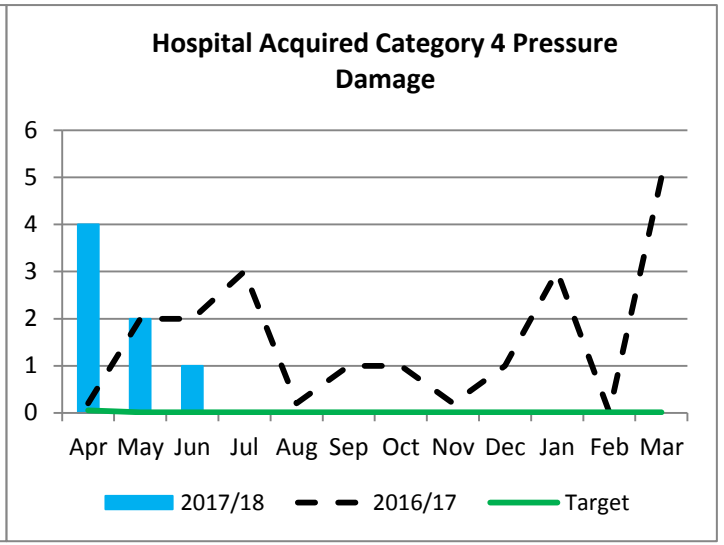
Scrutiny panels continue for falls. The falls policy is being reviewed and 'Call don't fall' posters are being developed. Interventions from the NHSi improvement work undertaken on the Pilgrim site are being rolled out across the Trust. As a result of learning and recommendations from scrutiny panels, the Falls Group will be reviewing use of night sedation late at night (including links to the use of chemical restraint), and reviewing the requirement for neuro observation training.

Safe Ambition 4: Reduction of Harm Associated with Pressure Ulcers

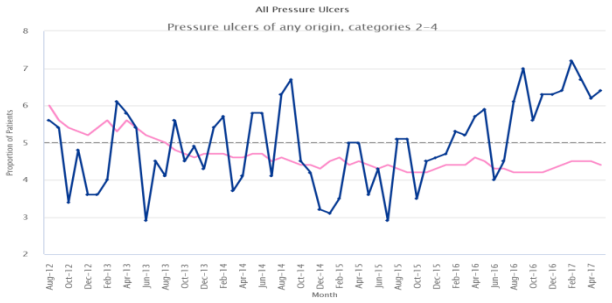
Executive Responsibility: Michelle Rhodes – Director of Nursing







Safety Thermometer May 16 – May 17



Safety Quality Dashboard (SQD) for Trust pressure area care July 2016- June 2017

Metric Title	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun-2017
Pressure area risk assessment completed within 4hrs	99.00%	98.80%	98.80%	99.30%	98.80%	98.30%	97.50%	-	97.0%	98.7%	98.60%	95.5%
Pressure area risk assessment updated weekly	75.30%	76.00%	78.90%	80.70%	78.40%	72.00%	71.60%	77.4%	76.7%	80.5%	81.50%	81.3%
Pressure-relieving equipment in situ if required	96.00%	93.50%	93.90%	96.60%	94.20%	95.50%	96.60%	93.4%	94.0%	96.2%	95.20%	96.8%
Frequency of repositioning documented	-	-	-	-	-	-	-	-	60.8%	62.4%	79.50%	83.4%
Prescribed frequency of turning has been followed for last 24 hours	-	-	-	-	-	-	-	-	59.5%	61.7%	79.00%	85.7%
Pressure areas care wound dressing renewed	-	-	-	-	-	-	-	-	52.4%	59.7%	76.40%	100%
Pressure area care plan activated if required	95.10%	92.10%	94.30%	88.80%	94.40%	92.90%	93.50%	91.1%	91.5%	94.7%	93.80%	93.6%

Performance Data Overview

	Cat 2	Cat 3	Cat 4
Lincoln	20	2	0
Boston	22	1	1
Grantham	1	0	0

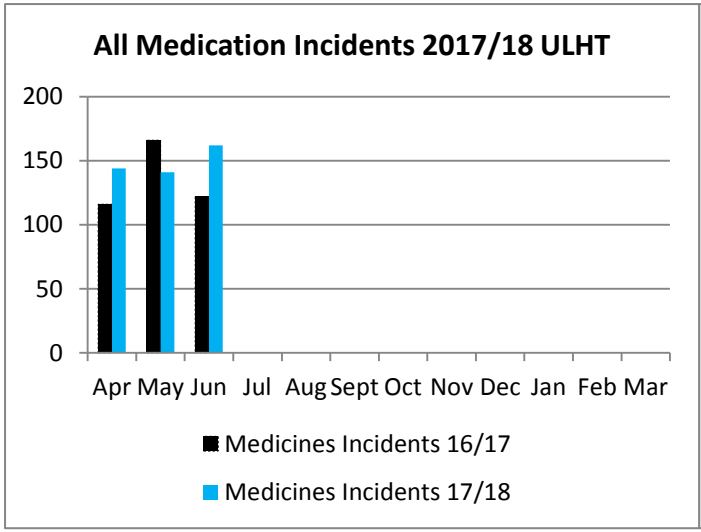
There were 43 hospital acquired (HA) category 2 PUs reported in June compared to 55 in May (PUNT data). This is primarily due to a reduction in the number reported at Pilgrim from 36 in May to 22 in June. There were 3 HA category 3 PUs reported in June (Stroke unit PHB, Greetwell & Shuttleworth) compared to 2 in May, and 1 HA category 4 PU reported in June (ward 8A) compared to 3 in May (SI Tracker). Avoidability will be determined at scrutiny panels.

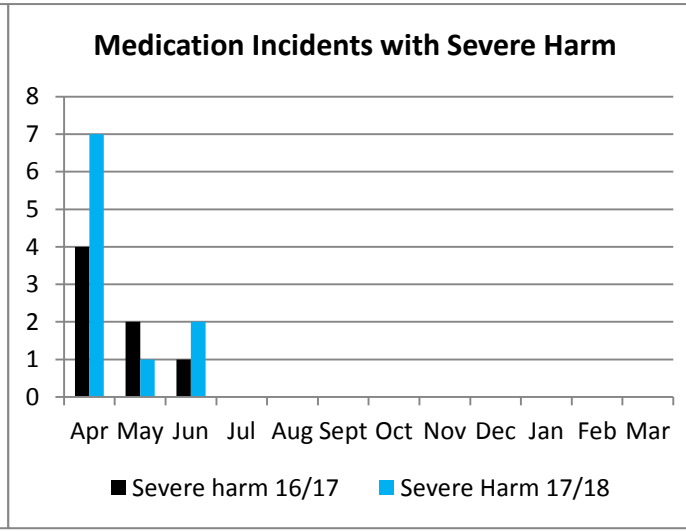
Action Plan

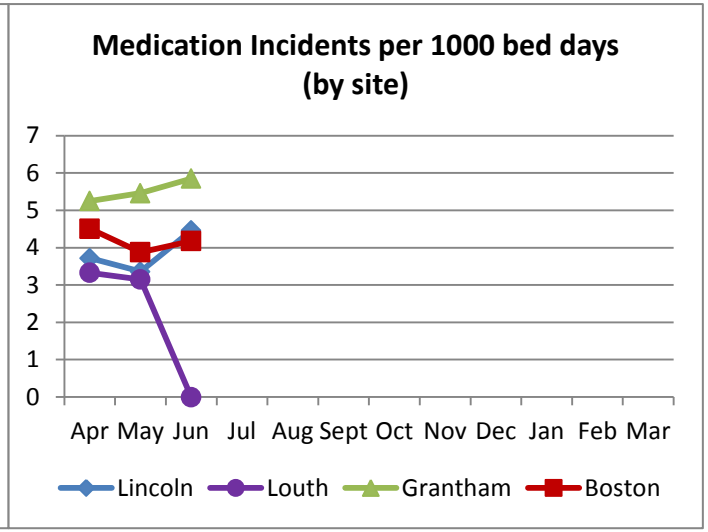
- Pressure ulcer prevention meetings re-established on the Pilgrim and Lincoln sites
- PU prevention drop in days at Pilgrim in July and August
- Further focused work with A&E and EAUs
- Additional training for support workers
- Review of training methods and resources with offer of ward based training in support of current operational pressures
- Development of a system wide approach to pressure damage through the countywide frailty group

Safe Ambition 5: Reduction of Harm Medication Incidents

Executive Responsibility: Michelle Rhodes – Director of Nursing







Datix Moderate/Severe (Jan – Jun 2017)

Ward/Department	No.
A&E Department - Pilgrim	2
AMU	6
Cardiac Short Stay Unit - Lincoln	2
Dixon Ward	2
Greetwell Ward	2
MEAU	4
Out Patient Department - Lincoln	2
Ward 1	3
Ward 6B	2
Ward 7B	4
Ward 8A	2

SQD Dashboard for Medications July 2016 – June 2017

Metric Title	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb-2017	Mar – 2017	Apr-2017	May-2017	Jun-2017
Medicine chart demographics correct	75.00%	78.50%	78.40%	83.70%	78.10%	80.50%	78.80%	78.90%	97.2%	98.2%	98.40%	98.00%
Allergies documented	96.80%	98.10%	98.80%	98.20%	99.40%	98.40%	98.10%	99.40%	99.4%	98.7%	97.20%	97.00%
All medicines administered on time	87.90%	88.00%	91.90%	87.60%	88.60%	91.60%	89.10%	87.50%	76.8%	83%	81.40%	86.20%
Allergy nameband in place if required	91.00%	87.60%	91.80%	93.50%	86.20%	84.70%	92.90%	84.10%	92.3%	82.8%	86.80%	88.90%
Identification namebands in situ	98.80%	98.00%	99.50%	98.80%	99.80%	99.70%	98.50%	98.00%	98.5%	98.1%	99.70%	98.50%

Performance Data Overview

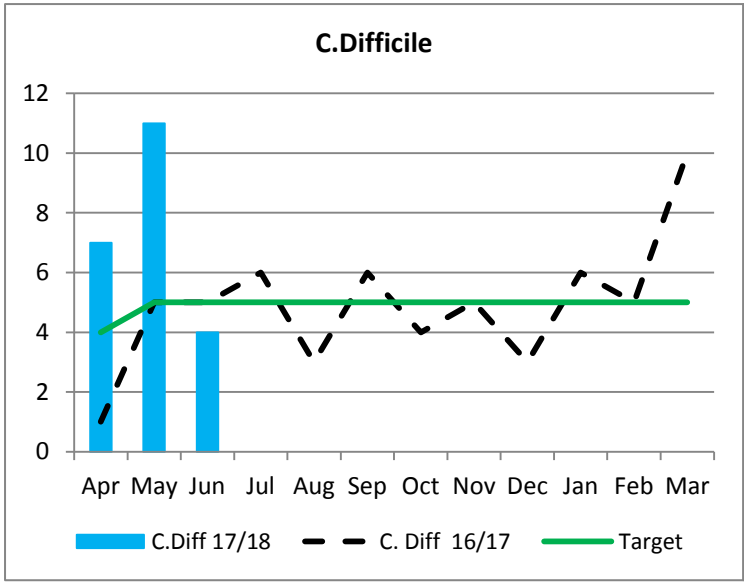
Of the 162 incidents reported the majority (82%) were classed as resulting in no harm. 97 (60%) of all the events recorded were associated with priority/high risk drugs. This is an increase on May (56%). 54 (33%) of all incidents reported were due to medicines being omitted. This is an increase from May (41%).
There were 8 incidents reported in June that involved errors made by the Pharmacy department. Pharmacy issued 61463 items in June making the error rate 0.01301%

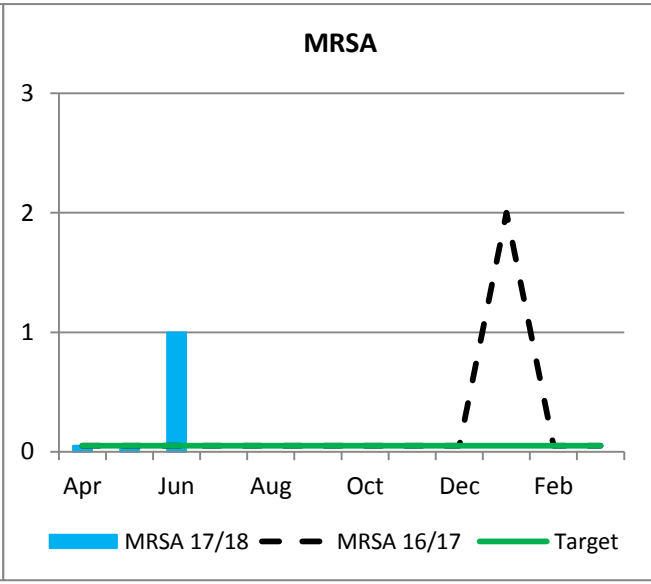
Action Plan

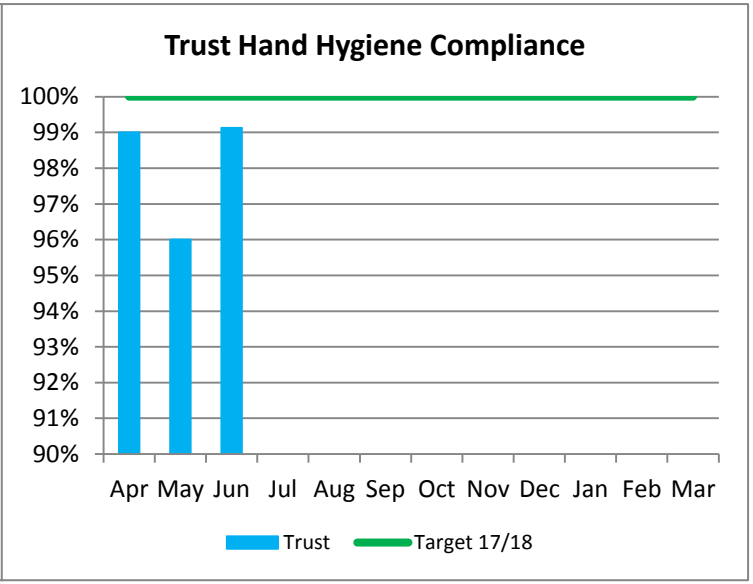
This medications error report is reviewed at the Medicine Optimisation and Safety Committee and all incidents are reviewed on a monthly basis to identify trends. All Heads of Nursing receive the errors by ward area and disseminate to their matrons who in turn disseminate. Deep dive analysis of medication incidents with planned focus on High Risk Medications specifically omitted medications and known patient allergy incidents will be undertaken.

Safe Ambition 6: Reduction of Harm Associated with Infection

Executive Responsibility: Michelle Rhodes – Director of Nursing







Performance Data Overview

Hand Hygiene	
Target	100%
Grantham	99.75%
Lincoln	98.79%
Louth	100%
Pilgrim	99.13%

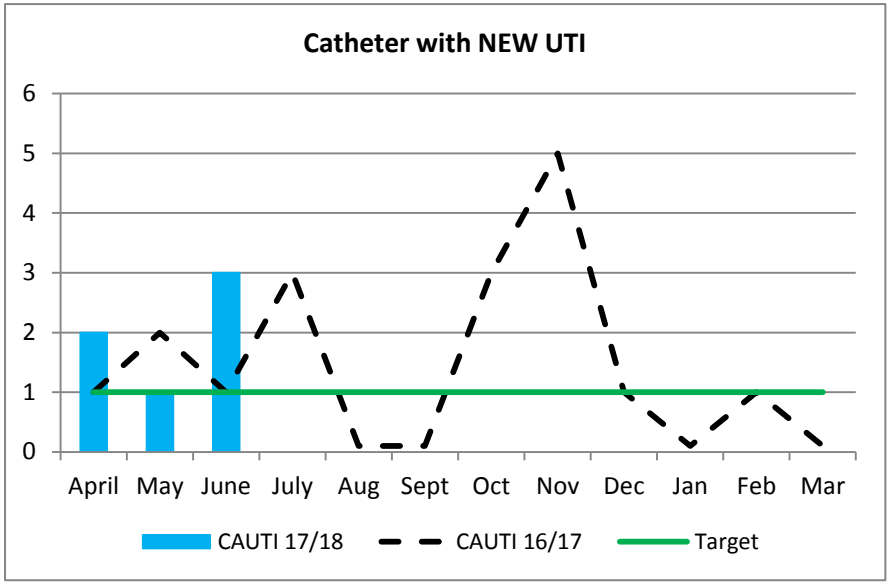
The 4 C.Difficile were on Stroke Unit Lincoln
The 1 MRSA was on Carlton Coleby Lincoln

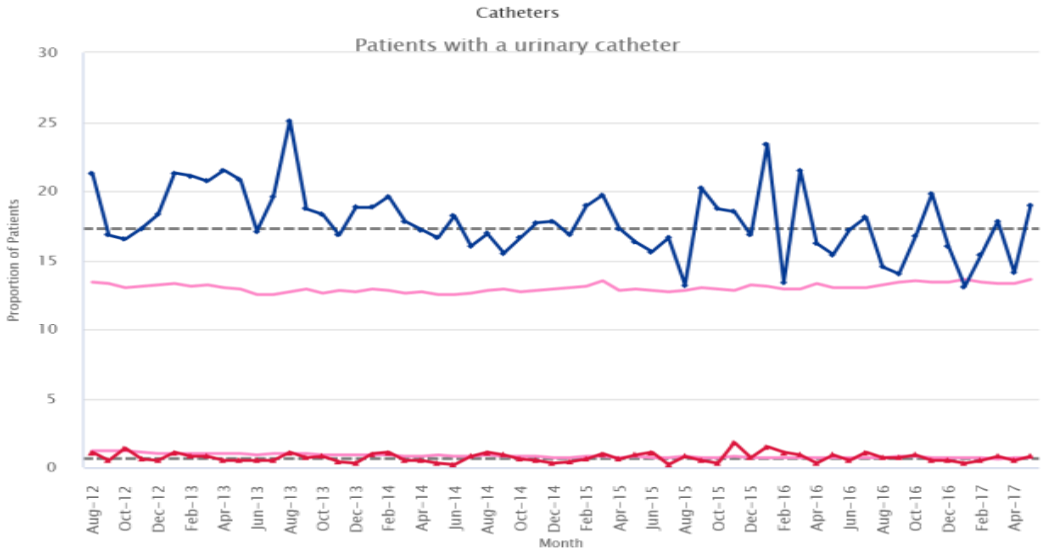
Action Plan

An NHS Improvement visit to the trust took place during June to review infection prevention and control practice in light of the currently increased C difficile rates and the hospital-attributable MRSA bacteraemia reported in June. An action plan is being developed in line with the recommendations made in the report.
An external Clostridium difficile review took place in July 2017 on the recommendation of NHSI. A report is awaited.
Weekly Clostridium difficile review meeting are continuing. An immediate action log has been implemented and a trustwide Clostridium difficile recovery plan is being developed.
Targeted Clostridium difficile training has been delivered to housekeepers, deep clean teams and porters across the Boston, Lincoln and Grantham sites. 301 staff were trained between 14.06.2017 and 12.07.2017.
The IPC have focused on ward visits during June and provided both verbal and written feedback to ward leads and matrons.

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

Executive Responsibility: Michelle Rhodes – Director of Nursing





Safety Quality Dashboard (SQD) for Trust pressure area care July 2016- June 2017

Metric Title	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb-2017	Mar – 2017	Apr – 2017	May – 2017	Jun-2017
Number of urinary catheters in-situ	75	81	63	72	81	53	67	84	80	85	72	88
Urinary catheter record demographics correct	90.4%	95.0%	96.8%	86.1%	98.8%	90.2%	94.0%	92.8%	96.1%	97.6%	97.20%	97.70%
Urinary catheter record completed &signed daily	57.5%	72.2%	65.1%	65.3%	72.2%	58.8%	68.2%	73.8%	54.5%	67.5%	70.00%	66.30%
TWOC occurred within 3 days for acute retention	36.4%	40.0%	50.0%	40.0%	58.3%	50.0%	66.7%	40%	25.0%	36.4%	40.00%	44.40%
Documented evidence why catheter needed	89.0%	91.1%	96.8%	86.1%	97.5%	92.2%	91.0%	91.7%	89.6%	94.0%	94.40%	93.10%
Urinary catheter bags secure	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	-	-	-	-	-
Urinary catheter care plan activated	87.5%	88.6%	90.5%	83.3%	90.1%	88.2%	88.1%	-	-	-	-	-

Performance Data Overview

Safety Thermometer May 2017

Metric	ULHT Average	National Average
Catheter Insertion Rate	21%	13.6%
Catheter and UTI Rate	1.4%	0.7%

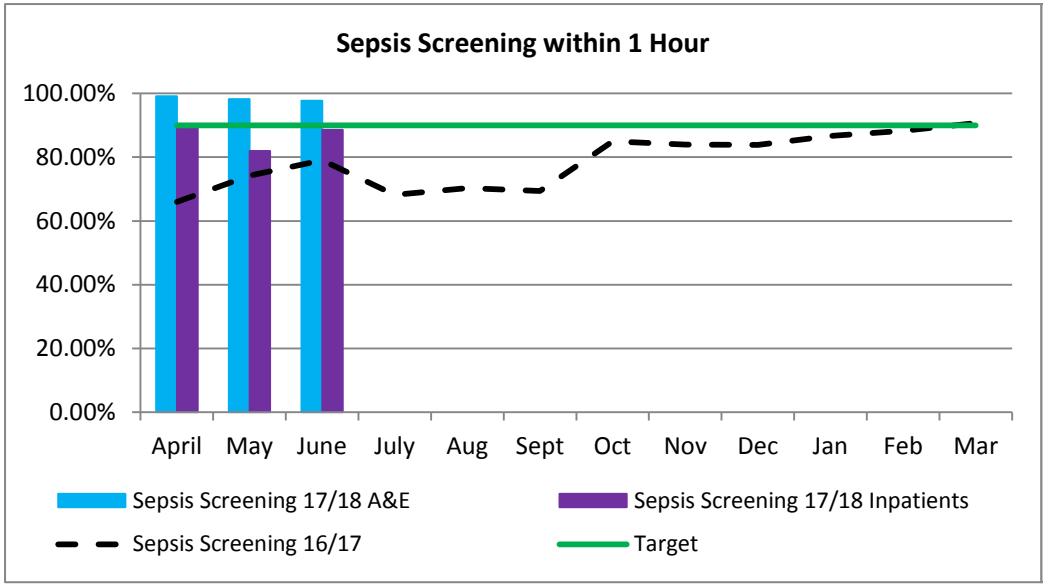
Performance data from safety thermometer has been interrogated to understand the difference between specialty splits and shared with Heads of Nursing for further discussion. Safety Thermometer have been approached for comparative Acute Trust data.

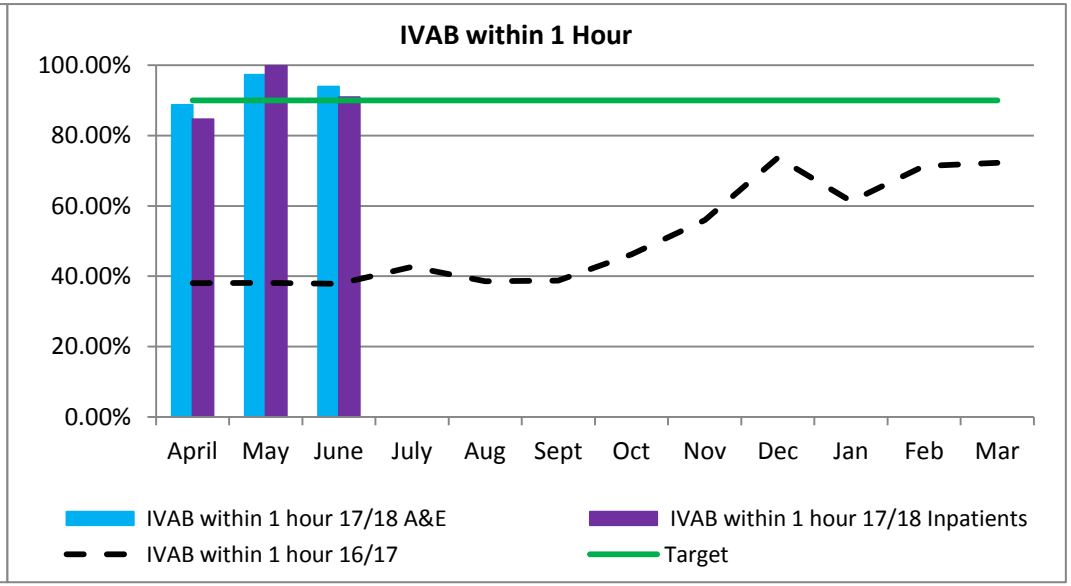
Action Plan

Internal work is focusing on reducing catheter insertion rates and ensuring timely TWOCs. Collaborative work is planned with Lincolnshire Community Health Services to develop a countywide pathway for continence and catheter management which will focus on management of continence issues to reduce catheter insertion rates, management of patients with short term catheters and review of TWOC process and clinics within primary and secondary care, and management of patients with long term catheters.

Safe Ambition 7: Reduction of Harm Associated with Deterioration Sepsis

Executive Responsibility: Michelle Rhodes – Director of Nursing





Safety Quality Dashboard (SQD) for Trust pressure area care July 2016- June 2017

Metric Title	Jun-2016	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb - 2017	Mar – 2017	Apr-2017	May – 2017	June – 2017
Patient observations on time and complete	-	-	-	-	-	-	-	-	-	43.8%	57.1%	62.30%	54.90%
Patient pain score complete	98.3%	98.1%	97.5%	98.3%	98.8%	98.8%	98.6%	98.7%	-	16.2%	19%	29.20%	28.80%
Evidence of escalation if required	78.0%	78.3%	76.1%	71.4%	93.8%	86.0%	75.6%	82.9%	86.2%	78.3%	88.9%	82.10%	88.90%
Patient observation frequency document on PfER	-	-	-	-	-	-	-	-	-	75.7%	84.2%	87.00%	86.20%

Performance Data Overview

A&E Target 90%	Screening –June 17	IVAB within 1 hour – June 17
Grantham	100%	92.85%
Lincoln	100%	93.75%
Pilgrim	93.33%	95%

Inpatients Target 90%	Screening –June 17	IVAB within 1 hour – June 17
Grantham	75%	100%
Lincoln	96%	83.33%
Pilgrim	86.48%	100%

Sepsis e-learning at 89.63%.

Action Plan

EMAS will commence first dose IVABX from September 2017. This follows the successful pilot of a project across the East Midlands.

CQUIN data for Quarter 1

Inpatients Screening	134/150 = **89.33%**
Inpatients IVABX	25/28 = **89.28%**
A&E Screening	149/150 = **99.33%**
A&E IVABX	90/97 = **92.78 %**

Data to be extracted from e-bundle from 1st July 2017. Audit methodology will change to exclude those patients with failure to screen from IVABX/6 actions questions. Amendment to collection methodology applied retrospectively to April 2017. Continued scrutiny of e-bundle data with circulation by Sepsis Nurses to department leads.

Caring

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Caring							→
Friends and Family Test							→
Inpatient (Response Rate)	Monthly	Envoy Messenger	26%	27.67%	24.00%	30.00%	↓
Inpatient (Recommend)	Monthly	Envoy Messenger	96%	91.33%	94.00%	89.00%	↑
A&E (Response Rate)	Monthly	Envoy Messenger	14%	20.33%	18.00%	21.00%	↓
A&E (Recommend)	Monthly	Envoy Messenger	87%	81.00%	80.00%	81.00%	↓
% of staff who would recommend care							
% of staff who would recommend work							
Complaints							→
No of Complaints received	Monthly	Datix	70	165	56	51	↑
No of Complaints still Open	Monthly	Datix	0	723	234	250	
No of Complaints ongoing	Monthly	Datix	0	106	32	35	
Inpatient Experience							↓
Mixed Sex Accommodation	Monthly	Datix	0	0	0	0	→
eDD	Monthly	EDD	95%	82.15%	87.03%	73.23%	↑
PPCI 90 hrs	Quarterly		100%	96.30%	97.33%	97.33%	→
PPCI 150 hr	Quarterly		100%	86.07%	85.33%	85.33%	→
#NOF 24	Monthly		70%	65.41%	64.91%	74.60%	↓
#NOF 48 hrs	Monthly		95%	93.41%	89.47%	95.24%	↓
Dementia Screening	1 month behind		90%	92.56%	91.56%	93.56%	↓
Dementia risk assessment	1 month behind		90%	96.91%	95.42%	98.39%	↓
Dementia referral for Specialist treatment	1 month behind		90%	89.28%	90.32%	88.24%	↑
Stroke							→
Patients with 90% of stay in Stroke Unit	1 month behind	SSNAP	80%	87.50%	81.00%	94.00%	↓
Sallowing assessment < 4hrs	1 month behind	SSNAP	80%	68.65%	70.60%	66.70%	↑
Scanned < 1 hrs	1 month behind	SSNAP	50%	61.10%	60.50%	61.70%	↓
Scanned < 12 hrs	1 month behind	SSNAP	100%	98.50%	98.70%	98.30%	↑
Admitted to Stroke < 4 hrs	1 month behind	SSNAP	90%	70.85%	66.70%	75.00%	↓
Patient death in Stroke	1 month behind	SSNAP	17%	18.30%	18.60%	18.00%	↑

Well-Led

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Well Led							→
Vacancies	Monthly	ESR	5.0%	11.20%	11.05%	11.40%	↓
Sickness Absence	Monthly	ESR	4.5%	4.38%	4.34%	4.32%	↑
Staff Turnover	Monthly	ESR	8.0%	5.80%	5.78%	5.82%	↓
Staff Engagement							→
Staff Appraisals	Monthly	ESR	95.0%	76.33%	82.00%	79.00%	↑
Equality Diversity and Inclusion							

Workforce Headline Summary

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

KPI	2017/18 Target	June 2017 Performance	Last Month Performance	Performance in June 2016	6th Month Trend
Vacancy Rate For Specialties: - Medical - Registered Nurses - AHPs	Medical – 12% Reg Nursing – 11.5% AHPs – 10%	**Medical 15.89%** **N&M Reg 14.41%** **AHP'S 12.29%**	**15.02%** **14.23%** **13.72%**	**14.67%** **12.60%** **10.64%**	↑
Voluntary Turnover	7%, with no group of staff more than 20% above the overall target	**5.78%**	**5.82%**	**N/A**	**N/A**
Quarterly Engagement Index	10% improvement in average score during 2017/18	**Pulse survey report will be available by the end of July**			
Quality of Leadership/Management Index	10% improvement in average score during 2017/18	**Pulse survey report will be available by the end of July**			
Core Learning Completion	Revised target to be set asap following review that is underway	**90.47%**	**90.25%**	**83%**	↑
Sickness Absence (12 month rolling average)	Overall target of 4.5% + no team over 25% above target	**4.67%**	**4.70%**	**4.52%**	↑
Appraisals: - Medical - Non-Medical	Medical – 95% Non-Medical – 85%	**92%** **81.93%**	**91%** **79.18%**	**91%** **66.83%**	↑
Agency Spend	£21m (equates to £1.75m per month)	**£2.479m**	**£2.748m**	**£2.403**	↑

One of our drivers is to reduce overall vacancies by 16.66%, which could reduce overall spend by approx. £1.968m. Although there are growing concerns with regards to Nursing & Midwifery staff vacancies, the turnover rate at 8.00% for this staff group is still below the Trust average of 8.4%.

As we have discussed previously, reducing vacancy rates is one of the key mechanisms by which we will reduce agency spend. Recruitment plans are being implemented, but will take time to have an impact. There is a need to implement new workforce planning arrangements to ensure there is a review of roles required to deliver services, with a focus on areas where it is hard to recruit medical staff. The continuing high level of agency spend demonstrates this, although further actions are planned to drive down agency spend levels.

There is positive news about sickness levels, as the rate for the last quarter is 4.38% compared to 5.04% in the corresponding quarter last year. However this has yet to translate into a change in the 12 month rolling average as December '16 to March '17 had a significantly higher sickness rate than in the same period during the previous year. If the current trend continues we should see a sizable reduction in the 12 month rolling average by the end of the financial year.

Our Core Learning compliance rates (incl. Medical & Dental Staff) are above 90%. A review of core learning content has been concluded. The next step is to agree target completion rates for the key elements.

Finally, on a positive note, the completion rate for non-Medical appraisals has gone up by a further 2.75% in the last month. The current compliance rate this month has been the highest since 2014. We need to get to a position where appraisal is valued as part of an overall performance management framework and this is the purpose of the review proposed.

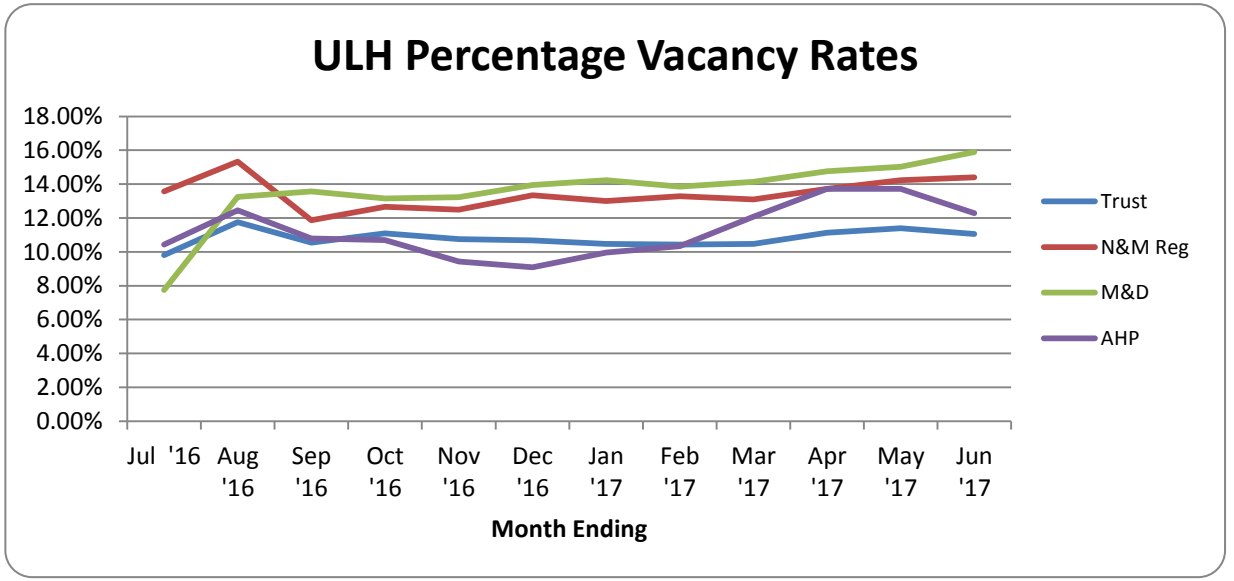
KPI:	Vacancy rates	**Owner:**	Director of HR & OD
Domain:		**Responsible Officer:**	Deputy Director of HR & OD
Date:	1st August 2017	**Reporting Period:**	June 2017
Target:	Medical – 12% Registered Nursing – 11.5% AHPs – 10%	**Tolerances:**	Within 1% - Amber Above 1% - Red
RAG Rating:	**Medical 15.89%** **N&M Reg 14.41%** **AHP'S 12.29%**		

Analysis

The current overall Trust vacancy rate (June) is 11.05%, which is a decrease of 0.35% on May. The graph below shows that overall vacancies have increased by 1.25% over the last 12 months (9.80% to 11.05%). Both Nursing & Medical vacancies have increased since last month, with a reduction in AHP vacancies by 1.43%. It is one of our objectives to reduce vacancies by 16.66%

The Trust had at the end of June:-

- 790.07 wte doctors and consultants compared to 800.90 at the start of the financial year;
- 1943.80 registered nurse and midwives, compared to 1971.67 at the start of the financial year;
- 851.75 unregistered nurse and midwives, compared to 833.19 at the start of the financial year;
- 356.62 wte AHPs, compared to 346.15 at the start of the financial year.



At present 149.22 wte medical posts are vacant, out of a total of 939.29 wte established posts, and 327.26 wte registered nursing and midwifery posts are vacant compared to a total establishment of 2271.06 wte posts. The equivalent figure for unregistered nurses is 125.58 wte vacancies compared to the establishment of 977.33 wte posts.

Establishment & In-Post Figures (Selected Staff Groups) 30th June 2017 compared to 30th June 2016

Staff Group	30.06.16				30.06.17			
	Estab	In-Post	Difference	Vacancy Rate	Estab	In-Post	Difference	Vacancy Rate
Medical & Dental	928.11	791.96	136.15	14.67%	939.29	790.07	149.22	15.89%
Reg Nursing & Midwifery	2209.99	1931.64	278.35	12.60%	2271.06	1943.8	327.26	14.41%
Unreg Nursing & Midwifery	917.35	804.43	112.92	12.31%	977.33	851.75	125.58	12.85%
Allied Health Professionals	396.41	354.25	42.16	10.64%	406.59	356.62	49.97	12.29%

As can be seen above although we have seen an increase in the vacancy rate for all four staff groups, this can be contributed mainly to an increase in funded establishments in comparison with last year, rather than less staff employed. Indeed the number of Registered Nurses & Midwives, Unregistered Nursing & Midwifery Staff (In-Post) and Allied Health Professionals has increased with a very slight reduction in the number of Medical & Dental Staff In-Post (1.89 wte).

There has been some different 'views' regarding the number of unregistered nursing vacancies in the Trust. A meeting has been arranged between the Deputy Chief Nurse, Finance and Human Resources for the 20th July to ascertain how figures are calculated and ensure consistent reporting. One area where discrepancies may occur is regarding Band 2 Consortia nurses who are funded by the Education Levy and whether they should be included as vacancies or not.

The Trust has in place plans to get within its target for vacancies for these occupational groups. As well as recruiting, this will rely on retaining staff and transforming the way we work so we only need to recruit too difficult to fill roles if we cannot deliver the service in any other way.

Although the format of the Exit Questionnaire/Interview process has been reviewed, only 22.13% of forms have been returned during Q1.

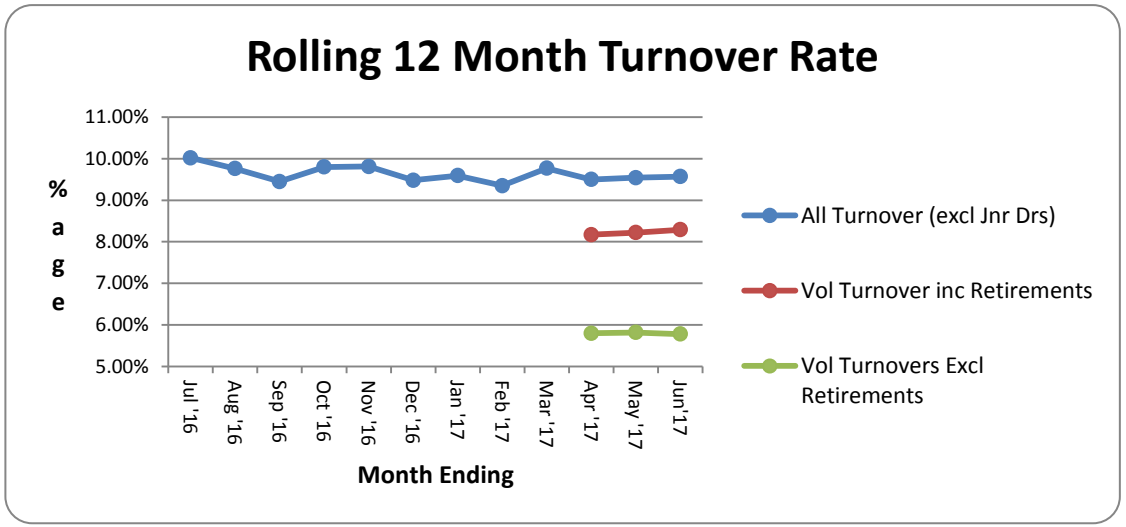
Action Taken	**Action Planned**
• The 'plan for every medical role' reintroduced so that clinical directorates can articulate what they plan to do to fill their vacancies; • Two pieces of work have been commissioned, to better understand why people are leaving and ULHT's reputation in the prospective workforce; • Number of offers made: ➢ 69 consultants and doctors; ➢ 158 registered nurses; ➢ 50 HCSWs • Exit questionnaire process was received and new format implemented	• TMP are working with the Trust to approach 450 potential future candidates, a mixture of other NHS employees and also private consultants, to get their views on ULHT and what would need to be different, if anything, for them to work here. Information will also be collated about six private hospitals and five NHS hospitals all within the surrounding areas. • 'Petaurum Solutions' will be working with the Trust to understand better from the 350 Registered Nurses and 50 Midwives that have left in the last two years the reasons why they left, what we could have done to keep them, and what we could do to entice them back. • Deliver the actions identified in the Medical and Nursing Recruitment Plans. • Meeting scheduled for 20th July, between HR, Finance and DD of Nursing to review 'source' and 'formula' used for Unregistered Nursing staff vacancies to ensure consistency in reporting going forward • Consider what other actions can be taken to improve exit questionnaire return rate.

KPI:	Voluntary Turnover	**Owner:**	Director of HR & OD
Domain:		**Responsible Officer:**	Deputy Director of HR
Date:	1st August 2017	**Reporting Period:**	June 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:	5.78%		

Analysis

The current 12 month rolling average as at June '17 is 8.29% including retirements and 5.78% excluding retirements. This is a slight increase on the previous month when including retirements (was 8.22%) but a reduction if excluding retirements (was 5.82%). Of the leavers 27.87% was due to retirement and 64.66% was due to voluntary resignations. The remaining 7.47% of leavers were for other reported reasons e.g. dismissal

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



	Voluntary Turnover including Retirements Jun '17	Voluntary Turnover excluding Retirements Jun' 17	Voluntary Leavers including Retirements Jun '17	Voluntary Leavers including Retirements May '17	Increase / Decrease compared to previous month
Staff Group	**%age**	**%age**	**WTE**	**WTE**	**WTE**
Allied Health Professionals	14.99%	13.12%	1.40	2.45	-1.05
Add Prof Scientific and Technic	12.82%	10.84%	0.00	3.74	-3.74
Healthcare Scientists	9.96%	4.66%	1.67	0.00	1.67
Medical and Dental	9.38%	6.63%	3.00	2.00	1.00
Students	8.28%	8.28%	0.00	0.00	0.00
Nursing and Midwifery Reg	8.00%	5.33%	10.14	14.64	-4.50
Administrative and Clerical	7.67%	5.52%	5.99	9.80	-3.81
Additional Clinical Services	7.36%	4.97%	3.60	5.81	-2.21
Estates and Ancillary	5.86%	2.95%	3.89	2.68	1.21
Total	**8.29%**	**5.78%**	**29.69**	**41.12**	**-11.43**

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

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

Although there are growing concerns with regards to

Nursing & Midwifery staff vacancies, the turnover rate at 8.00% for this staff group is still below the Trust average of 8.4%.

The Trust also benchmarks itself against other Trusts using the NHS Digital (previously Health and Social Care Information Centre) iView system. However this data is only available based on all staff (permanent, locums and fixed term etc. and all reasons for leaving) but excluding Junior Doctor Grades. Calculated this way the Trust had a turnover rate of 9.57% at the end of May, which is an increase of 0.03% on May.

Based on the latest (April 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 9.57% is below the average of 10.35%
- The current Trust Nursing & Midwifery (Registered) turnover rate of 8.35% is below the average of 11.01%,
- The current Trust AHP turnover rate of 16.29% is above the average of 12.27%.

Action Taken	**Action Planned**
• Workforce Scorecard comparative data has been shared with the Directors/Clinical Directors, which shows compliance against key workforce indicators • A 'deep dive' into turnover and sickness in Therapies was carried out and a report presented at the WF & OD Assurance Committee	• An Action Plan is being drafted by the Head of the Service to address the 'findings' from the Therapies 'Deep Dive' and will be tabled at the WF & OD Assurance Committee on the 28th July. • A second 'Deep Dive' has been carried out this month into Additional Clinical Service on turnover and sickness and will be tabled at the WF &OD Assurance Committee as well. • 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. • We will 'review' the potential number of 'retirees' in each staff groups for the remainder of 2017/18 and reflect this in our recruitment plans.

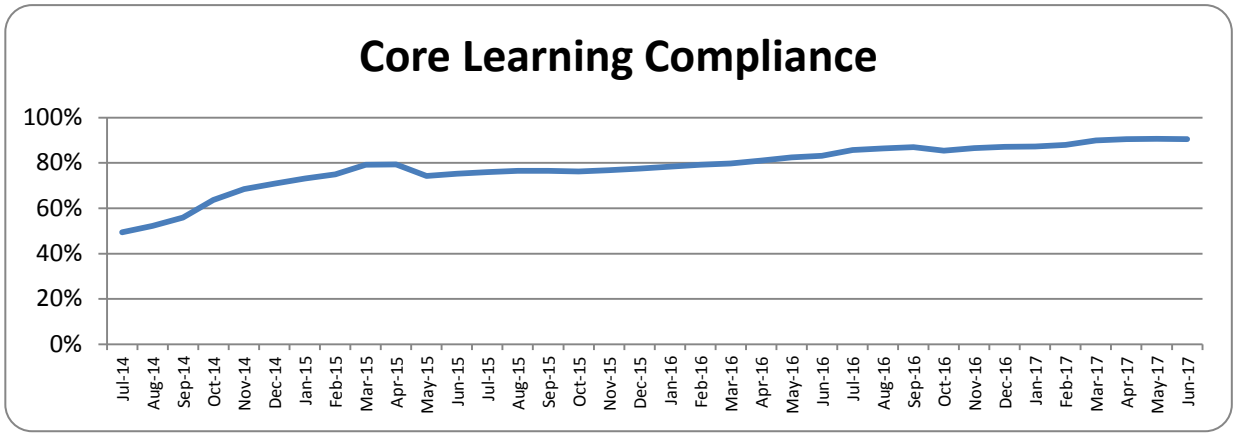
KPI:	Core Learning Completion	**Owner:**	Director of HR & OD
Domain:		**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	1st August 2017	**Reporting Period:**	June 2017
Target:	Project to set revised targets delayed. Will be completed asap	**Tolerances:**	
RAG Rating:	90.47%		

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 June shows a slight decrease from 91% last month to 90.47%. We now report on a combined figure (including medical) for core learning compliance. We do not have any Directorate with a compliance rate below 78% at this point, with two Directorates achieving the 95% compliance target.

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



Topic		Jun-17	May-17
Equality, Diversity and Human Rights - 3 Years	↓	97.90%	98.25%
Fraud Awareness - 3 years	↑	94.90%	94.52%
Slips, Trips & Falls - 3 year	↑	93.44%	93.32%
Safeguarding Children Level 1 - 3 Years	↓	92.79%	92.97%
Safeguarding Adults Level 1 - 3 Years	↓	92.73%	92.94%
Risk Awareness - 3 Years	↑	92.50%	91.80%
Moving & Handling for Inanimate Load Handlers - 3 Years	↑	92.47%	92.42%
Health and Safety - 3 Years	↑	92.27%	91.89%
Information Governance - 1 Year	↓	87.80%	88.01%
Fire Safety - 1 Year	↑	86.15%	85.74%
Infection Control - 1 Year	↑	85.10%	84.81%
Resuscitation [BLS] - 1 Year	↑	77.57%	76.31%

Directorate	Jun-17
Deputy Chief Executive	97.44%
Director of Fin & Corp Affair	96.74%
Integrated Medicine Lincoln	94.35%
Surgical Services Boston	94.12%
Director of HR & Org Dev	93.44%
TACC Boston	93.23%
TACC Lincoln	93.13%
Women & Children's Pan Trust	93.09%
Medical Director	93.06%
Director of Nursing	92.69%
Clinical Support Services	92.14%
General Surgery Boston	91.12%
General Medicine Lincoln	89.88%
Haem & Onc Trustwide	89.88%
Grantham	89.82%
Head & Neck Trustwide	89.39%
Director of Estates & Facil	89.32%

Staff Group		Jun-17	May-17
Students	↑	97.92%	95.83%
Healthcare Scientists	↑	92.97%	92.43%
Allied Health Professionals	↑	92.32%	92.30%
Nursing and Midwifery Registered	↑	92.21%	92.04%
Administrative and Clerical	↓	91.52%	91.83%
Add Prof Scientific and Technic	↑	91.44%	91.07%
Additional Clinical Services	↑	89.53%	89.52%
Estates and Ancillary	↑	87.50%	85.62%
Medical and Dental	↑	85.11%	84.82%

Surgical Services Lincoln	89.29%
Chief Operating Officer	89.08%
Trustwide Cardiology Services	87.36%
Orthopaedics Lincoln	86.40%
Gen Surg Linc & Urology Trust	86.39%
Medicine Boston	84.93%
Orthopaedics Boston	84.51%
A&E Lincoln	81.12%
Chief Executive	78.21%

Compliance for the majority of core learning topics is increasing slowly, 4 topics show a slight fall of up to 0.35% this month. This can be linked to the fall within the Admin and Clerical staff group. However, all topics are between 3% and 14% higher than the same time last year. A comparison by directorate is not available this month due to the recent structure updates within ESR.

Core learning DNA 'no-show' rates to classroom training have reduced by 2% however are still a high 23%. A DNA 'no-show' is someone who does not turn up to training on the day without providing an apology resulting in large numbers of lost places.

Action Taken	**Action Planned**
• Core Learning forms part of the WF Balances Score Card and highlighted as part of the performance review meetings. • The introduction of the '5 click' compliance reports has provided Ward/Department Managers access to automatic compliance % and breakdowns for their teams to assist in their compliance monitoring. These reports have been developed further to provide senior managers with automatic % rates by Ward/Department within their ESR hierarchy giving them an overview of compliance and manager support continues • 1 to 1 support provided remotely and face to face for staff struggling to use ESR learning • Review of Core Learning took place on 29/06/17 by Head of Transformational Change & Engagement, Paediatric Consultant, Deputy Chief Nurse & Core Learning Lead. All current Core Topics were agreed with the exception of Fraud to establish as to whether this needs to remain. It was agreed that Major Incident Awareness would become a new Core Topic.	• Longer-term plan to introduce competency and skill matrices for key roles. • Establish evidence as to whether Fraud needs to remain as Core • Major Incident Awareness e-learning will become Core for all staff as of 1st August. Compliance will not be included in the overall compliance figures for the first six months to allow for local completion. • Core Learning Panel to reconvene as of August with Deputy Chief Nurse as agreed chair to monitor Core, Core Plus, and Essential Skills topics going forward

KPI:	Sickness Absence	**Owner:**	Director of HR & OD
Domain:		**Responsible Officer:**	Deputy Director of HR
Date:	1st August 2017	**Reporting Period:**	May 2017
Target:	Overall target of 4.5% + no team over 25% above target	**Tolerances:**	Within 0.5% - Amber Above 0.5% - Red
RAG Rating:	**4.67%**		

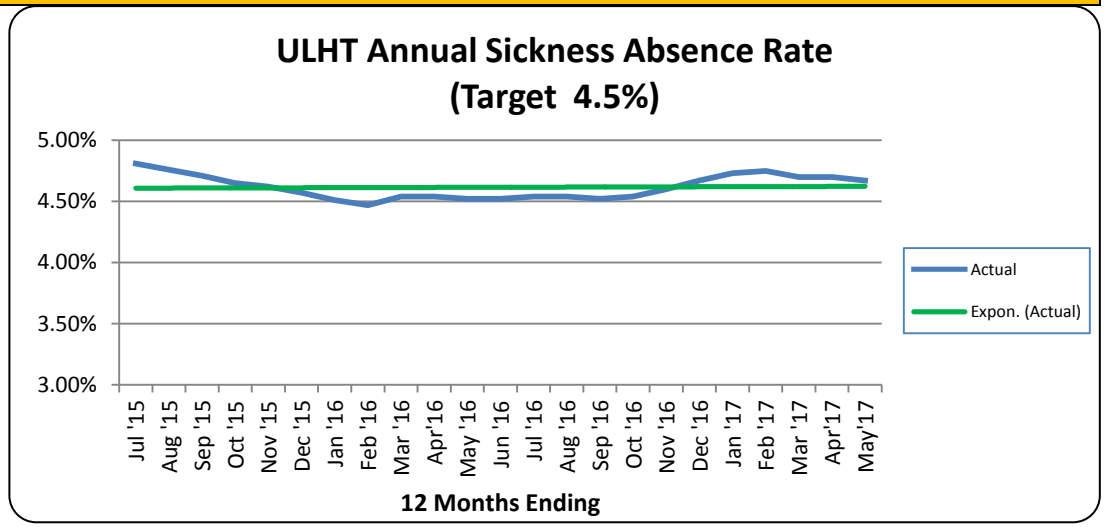
Analysis

The Trust annual rolling sickness rate of 4.67% (against 2017/18 target of 4.5%) marginally improved by 0.03% since last month. Although our quarterly sickness rate has improved year-on-year, the 12 month rolling sickness as at the end of May 2017 has increased by 0.15% in comparison to the May 2016 figure (4.52%).

The CCG's have confirmed that the Trust has achieved our 2016/17 CQUIN, which has a value to the Trust of £800,000.

The table below shows that the Trust did not achieve the present 4.50% sickness target in any of the last 6 financial years.

Year	Year End Sickness Absence rate
2011/12	4.95%
2012/13	5.12%
2013/14	4.66%
2014/15	4.79%
2015/16	4.54%
2016/17	4.70%



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

Additional Clinical Services had the highest sickness rate during the 12 months at 7.05% (Unregistered Nurses 7.82%) followed by Estates & Ancillary at 6.73%, Additional Professional Scientific and Technical at 5.08% and Nursing & Midwifery Registered at 4.72%.

The latest Benchmarking data as at March 2017 from NHS Digital (previously Health & Social Care Information Centre - HSCIC) indicates that ULHT has the 7th highest sickness rate (lowest at 2.83% and highest 5.00%) against an average of 4.08%. The benchmarking is done across x38 Large Acute Trusts.

Local Sickness Absence Benchmarking:

Trust	Sickness Absence Rate
LCHS	5.43%
LPFT	4.68%
NLAG	4.57%
ULHT	4.52%

Local benchmarking indicates that ULHT has the lowest sickness rate compared to other Trust in the Lincolnshire region.

Sickness by Directorate 12 months ending 31st May 2017

Directorate	12 Month Rolling Ave
Head & Neck Trustwide	1.41%
Director of Finance & Corporate Affairs	1.88%
Director of HR & Organisational Development	1.96%
Surgical Services Boston (see note below)	2.09%
Surgical Services Lincoln (see note below)	2.09%
Integrated Medicine Lincoln (see note below)	2.76%
Deputy Chief Executive	3.05%
Medical Director	3.20%
Pharmacy (part of Clinical Support Services)	*3.41%*
Therapies (part of Clinical Support Services)	*3.50%*
Orthopaedics Boston	4.06%
Haematology & Oncology Trustwide	4.26%
General Surgery Lincoln & Urology Trustwide	4.37%
Clinical Support Services	4.38%
Diagnostics (part of Clinical Support Services)	*4.48%*
Women & Children's Pan Trust	4.51%
Trustwide Cardiology Services	4.53%
General Surgery Boston	4.56%
TACC Lincoln	4.71%
Director of Nursing	4.78%
Grantham	4.93%
TACC Boston	4.95%
Chief Operating Officer	5.23%

Outpatient Management (part of Clinical Support Services)	*5.46%*
Chief Executive	5.47%
Director of Estates & Facilities	5.62%
Integrated Medicine Boston	5.69%
Orthopaedics Lincoln	5.73%
General Medicine Lincoln	5.85%
A&E Lincoln	7.12%

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

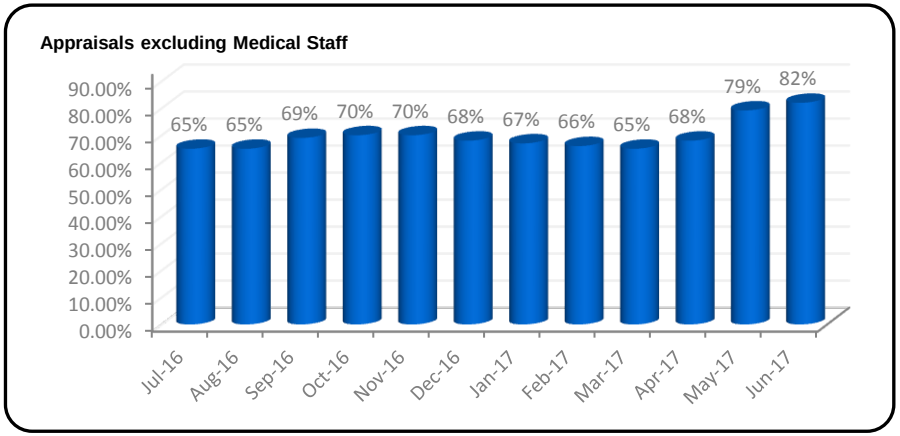
Action Taken	**Action Planned**
• New report for managers on staff that hit trigger points including RTW interviews are sent to managers for action on a monthly basis. This identifies consistent underperformance of line managers managing their team's sickness rates. • A number of O/H 'interventions' have been put in place to support health and wellbeing: o Provision of Mental Health First Aid and Mindfulness Training (for 2017, 140 staff have attended these courses) o Trust provide a Level 2 accredited Counselling Course for Band 6 and above and 22 staff have been trained to date o All member of ULHT staff have direct access to Physiotherapy for MSK or back pain and staff can self-refer to O/H for support (for 2016/17 689 referrals were made) o Global Challenge introduced to encourage physical activity to improve sleep, emotional and physical wellbeing (to date 322 staff have taken part) • The HR team has supporter and attended 136 sickness management meetings and hearings throughout the month of June. • On a monthly basis a MDT with HR colleagues and Occupational Health to assess actions and accountability take place. This month it was 146 long term sickness cases across the organisation • Notifications of staff that are hitting triggers are being sent to line managers. • A 360 Sickness Absence Management Audit was conducted and resulted in a 'significant assurance' rating. • Absence Training, absence management and referral training is being increased across sites • The 'Management Essentials for ULH' course is available to managers and the programme includes how to manage absence as a Leader.	• A review of the Sickness Policy is scheduled for later in the year. • Review of 'closed' RTW incidents where date occurs before the actual return to work date in line with action from Sickness Audit. • A communication is being made to inform managers that RTW's do not migrate to ESR from E rostering if they take place after the episode of sickness is closed. • Review of findings in Audit Report (Significant Assurance) to agree identified actions. • HRBPs and ER Team will continue to support Managers with managing their staff attendance. • Continuation of Regular/Monthly sickness review meetings with Occupational Health continue with the aim to return staff back to work and/or support managers with 'alternative' and supportive actions were appropriate. • A 'Deep Dive' on sickness absence for Additional Clinical Services has been carried out and the report will be tabled at the WF & OD Assurance Committee on the 28th July. • Training is being delivered to staff around having difficult conversations through absence management.

KPI:	Appraisal Rates	**Owner:**	Director of HR & OD
Domain:		**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	1st August 2017	**Reporting Period:**	June 2017
Target:	Medical – 95% Non-Medical – 85%		Within 5% below - Amber More than 5% below – Red
RAG Rating:	Medical – TBC Non-Medical – 81.97%		

Analysis

The focus at present is on non-Medical appraisal rate.

The graph below shows that the Agenda for Change Staff/Non-Medical Appraisal compliance rate for June is 81.97%. This has been the highest compliance rate since 2014. The overall percentage for appraisals has increased by 2.79% from the previous month and an improvement of 13.75% in the last two months, which is very positive, although we remain below target.



The table below shows Non-Medical compliance rates for the 12 month rolling periods ending June 2017:

- 4 Directorates have a compliance rate below 65%
- 6 Directorates have a compliance rate between 65% and 80%
- The remaining Directorates have a compliance rate above 80.00% with 11 Directorates who have achieved the 85% appraisal compliance rate

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

Directorate	Appraisal Rate June '17 (Excludes Medical Staff)
Director of HR & Org Dev	96.88%
CSS Therapies	*96.02%*
TACC Boston	94.92%
Orthopaedics Boston	94.81%
General Surgery Boston	94.69%
Medicine Boston	92.05%
Director of Fin & Corp Affair	89.80%
Surgical Services Boston (see note below)	89.47%
TACC Lincoln	87.88%
Women & Children's Pan Trust	87.15%

Grantham	86.12%
Gen Surg Linc & Urology Trust	85.59%
General Medicine Lincoln	84.51%
Haem & Onc Trustwide	84.36%
A&E/Acute Lincoln	83.17%
Trustwide Cardiology Services	81.91%
Chief Operating Officer	81.82%
CSS Pharmacy	*81.75%*
Clinical Support Services	79.50%
Orthopaedics Lincoln	78.72%
CSS Diagnostics	*75.30%*
CSS Outpatient Management	*74.41%*
Deputy Chief Executive	73.50%
Integrated Medicine Lincoln (see note below)	73.08%
Medical Director	72.73%
Head & Neck Trustwide	69.88%
Director of Estates & Facil	61.87%
Director of Nursing	57.32%
Chief Executive	55.56%
Surgical Services Lincoln (see note below)	30.00%

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

The table below shows that both the Additional Clinical Services and Nursing and Midwifery Registered and Allied Health Professionals staff groups are currently achieving the Trust 85% target appraisal rate.

Staff Group	Appraisal Rate June '17
Additional Clinical Services	90.31%
Nursing and Midwifery Registered	88.23%
Allied Health Professionals	86.73%
Add Prof Scientific and Technic	84.24%
Healthcare Scientists	73.79%
Estates & Ancillary	73.64%
Administrative and Clerical	70.38%
Total	**81.97%**

Appraisal Compliance rate (Year-on-Year) comparison:
June 2014 – 43.08%
June 2015 – 77.88%
June 2016 – 66.83%
June 2017 – 81.97%

The ‘target’ of 85% is based on the expectation that every member of staff should have an appraisal and it should take place on or before the employment ‘anniversary’ date or within 12 months from previous appraisal. The other 5% is provision for absence, maternity leave etc.

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	• The HR Team will continue to contact Supervisors/Managers via phone and/or e-mail to establish whether appraisals have been completed and ESR will be updated accordingly. • We will focus in particular on those areas where rates are still very low • The SHRPs provide further reports to CD’s on areas with low compliance rates. These will be reviewed as part of the performance review meetings. • Review of appraisal/individual performance management will commence once resource is in place to take this forward • Teams/Directorates with a compliance rate below 70% will be contacted to ascertain their action plan/s to improve appraisal rates and to address non-compliance. •

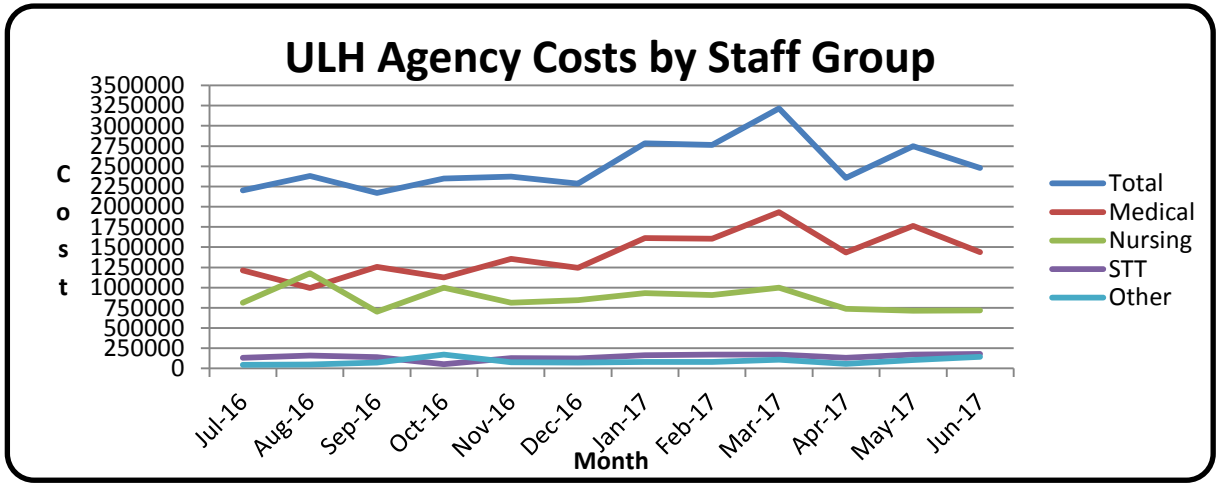
KPI:	Agency Spend	**Owner:**	Director of HR/OD
Domain:		**Responsible Officer:**	Various leads on different aspects of agency spend
Date:	1st August 2017	**Reporting Period:**	June 2017
RAG Rating:	Actual spend of £2.479m, against target of £1.75m		

Analysis

The table below shows spend on agency in the last 12 months. There has been a reduction in spend in June compared to May, however spend is still significantly above target and £162,372 higher than the level of spend in June 2016.

The total Agency cost in June was £2,478,528 which is a reduction of £270,081 from the previous month. Agency pay expenditure on Medical Staffing in June was £1,436,862 a decrease of £325,014 from May. Overspend on overall pay budget for medical staff is significantly less.

The directorates with the highest Agency spend in June were Medicine Pilgrim at £434,192 and General Medicine Lincoln at £356,438. Regular challenge meetings are held to explore ways in which that spend can be reduced.



This is the top priority owing to the impact on the financial position of the Trust.

Action Taken	Action Planned
• An overall Agency Cost Reduction Plan has been developed and submitted to NHSI. Within that plan there is a waterfall graph showing the expected reduction in spend as a consequence of the various actions planned.	• Nursing and Medical Agency Reduction Plans have been reviewed – Nursing is focusing on the introduction of weekly pay and the incentivisation of bank over overtime and agency • On medical spend • Taking part in NHSE programme to assist in reducing medical agency spend, so that we can identify and apply best practice • Link to proposed workforce planning exercise to review number of vacancies which we need to cover with agency

Money & Resources

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month	Trend
Money & Resources							→
Income v Plan	Monthly	Board Report Master	35660	102825	35587	34745	↓
Expenditure v Plan	Monthly	Board Report Master	-40396	-131825	-41625	-41328	↓
Efficiency Plans	Monthly	FIMS report	1342	300	300	0	↓
Surplus / Deficit	Monthly	FPIC Finance Report	-4736	-23932	-7243	-7853	↓
Capital Delivery Program	Monthly	FPIC Finance Report	-497	-1514	-758	-756	
Agency Spend	Monthly	Agency Staff Analysis	-1790	-7558	-2475	-2720	↑

Finance Headline Summary

Executive Responsibility: Karen Brown – Director of Finance

Trust Financial Performance

Key Financial Duties

Financial Duty	Annual Plan / Target £m	YTD Plan £m	YTD Actual £m	RAG
Delivering the Planned Deficit	-48.564	-14.025	-23.946	R
Achieving the External Finance Limit (EFL)	76.316	-	-	G
Achieving the Capital Resource Limit (CRL)	18.912	1.314	1.526	G

Key Issues

- The Trust plan for 2017/18 is a control total deficit of £48.5m, inclusive of £14.7m STF income.
- The Month 3 position was an in-month deficit of £7.3m, which is £2.5m adverse to the planned in-month deficit of £4.7m
- The Trust will not deliver its' control deficit of £47.9m with a most likely forecast deficit of £75m, although the Trust is working though the impact of Quarter 1 results on the year end position. Based on current performance and still a high level of risk regarding delivery of efficiency required to achieve this forecast.
- The deterioration in the income and expenditure position directly impacts on cash and the level of borrowings needed in 2017/18. The Trust is likely to require external cash support in line with the forecast outturn in 2017/18.

Financial Performance

The Trust is reporting:

- An in-month deficit in June of £7.3m, which is £2.5m adverse to the planned in-month deficit of £4.7m.
- A year to date deficit of £23.9m, which is £9.9m adverse to the planned year to date deficit of £14.0m.

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

- Slower than planned delivery of efficiency savings, with delivery to date £3.7m below plan.
- Non-achievement of STF income resulting in the loss of £2.2m STF income.
- Pilgrim fire, norovirus outbreak and cyberattack resulting to date in the loss of £1.8m of income.
- Non-achievement of £0.6m of CQUIN income.
- 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 £2.4m higher than planned and not fully offset by a reduction in substantive and bank pay expenditure.

Table 1: Financial position

	June 2017			April 2017 to June 2017		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	31,866	32,860	994	95,572	94,657	(915)
Other operating income	3,794	2,727	(1,067)	11,383	8,168	(3,215)
Employee expenses	(25,881)	(27,063)	(1,182)	(77,613)	(81,154)	(3,541)
Operating expenses excluding employee expenses	(14,129)	(15,593)	(1,464)	(42,229)	(44,836)	(2,607)
OPERATING SURPLUS / (DEFICIT)	**(4,350)**	**(7,069)**	**(2,719)**	**(12,887)**	**(23,165)**	**(10,278)**
NET FINANCE COSTS	**(386)**	**(172)**	**214**	**(1,170)**	**(738)**	**432**
Other gains/(losses) including disposal of assets	0	(3)	(3)	0	0	0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(4,736)**	**(7,244)**	**(2,508)**	**(14,057)**	**(23,903)**	**(9,846)**
Adjusted financial performance surplus/(deficit)	**(4,725)**	**(7,259)**	**(2,534)**	**(14,025)**	**(23,946)**	**(9,921)**
Adjusted financial performance surplus/(deficit) excluding STF	**(5,461)**	**(7,259)**	**(1,798)**	**(16,235)**	**(23,946)**	**(7,711)**

Efficiency

The financial plan for 2017/18 includes a FEP target of £18m, to which the shortfall of £6m from 2016/17 has to be added, giving a total FEP requirement for 2017/18 of £24m.

The actual delivery to date at Month 3 is £0.3m, as detailed in the table to the right, which is short of the plan by £3.7m.

	Financial Efficiency Programme (FEP)			Identified					
	2017/18 Total FEP target	Identified	Unidentified	R	A	G	Total	Actuals m1-2	Actuals m3
Sub-Total - Corporate	**3,034,700**	**1,440,300**	**1,594,400**	**169,000**	**275,000**	**945,600**	**1,389,600**	**76,868**	**62,929**
Sub-Total - Operations	**13,318,000**	**5,330,700**	**7,987,300**	**2,924,800**	**1,498,600**	**907,300**	**5,330,700**	**126,104**	**41,158**
Total	**16,352,700**	**6,771,000**	**9,581,700**	**3,093,800**	**1,773,600**	**1,852,900**	**6,720,300**	**202,972**	**104,087**
Total - Investments		**250,000**	**-250,000**	**250,000**	**0**	**0**	**250,000**	**0**	**0**
Total - Corporate schemes	**10,200,000**	**5,250,000**	**4,950,000**	**1,000,000**	**4,250,000**	**0**	**5,250,000**	**0**	**0**
Grand Total	**26,552,700**	**12,271,000**	**14,281,700**	**4,343,800**	**6,023,600**	**1,852,900**	**12,220,300**	**202,972**	**104,087**
Financial Recovery Plan									
Corporate	0	1,614,324	-1,614,324	1,614,324			1,614,324		
Medical	0	1,162,300	-1,162,300	1,162,300			1,162,300		
Nursing	0	3,559,733	-3,559,733	3,559,733			3,559,733		
Service Change	0	456,900	-456,900	456,900			456,900		
Total - FRP schemes	**0**	**6,793,257**	**-6,793,257**	**6,793,257**	**0**	**0**	**6,793,257**		

Delivery is slow as schemes for the year are still being worked up. The current forecast is that the Trust will deliver £12m of savings this year but the Trust is compiling a recovery plan, with plans highlighted to date of £6.8m to increase the delivery from September.

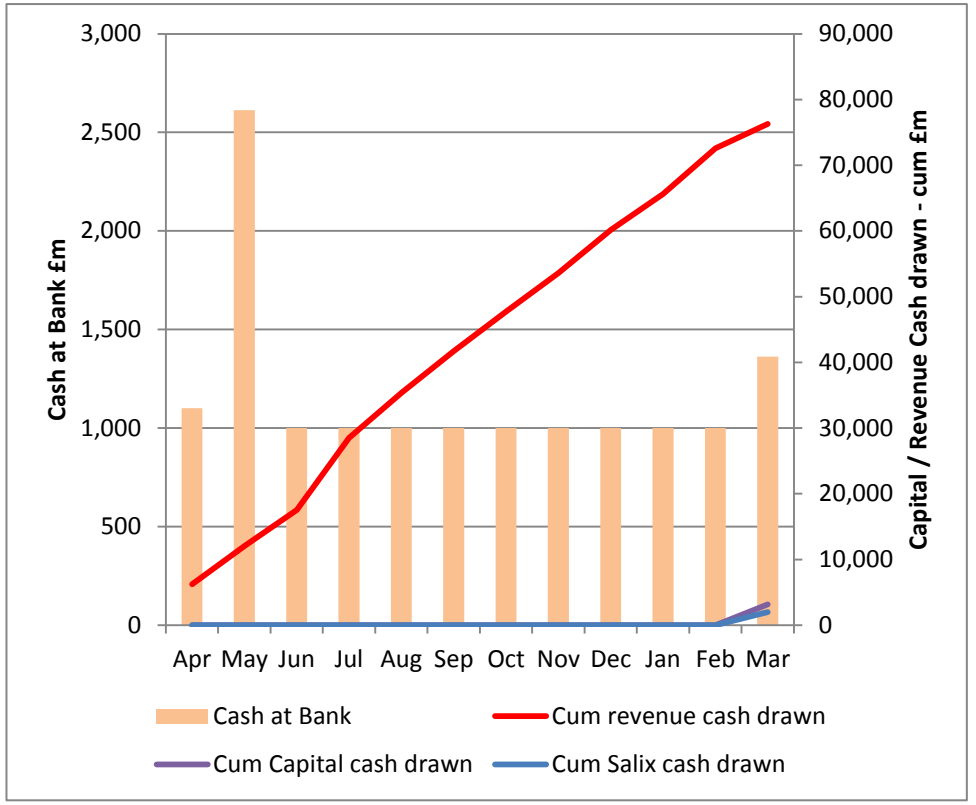
Capital

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

Cash

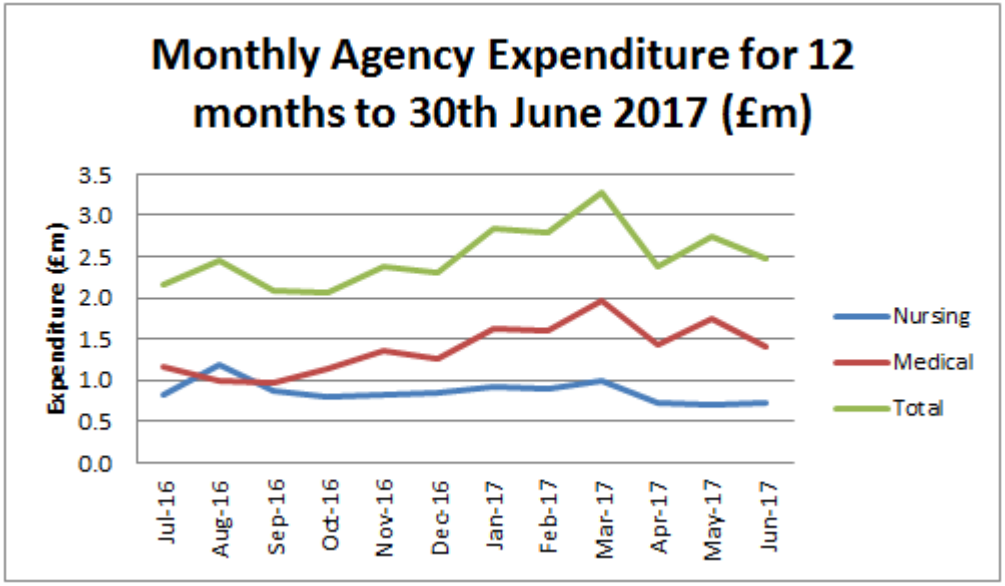
As at the end of June, the Trust held cash of £1.0m, including external revenue support loans of £17.5m drawn down over the first three months. The total repayable borrowings through working capital loans, Salix loans and uncommitted loan facilities were £128.2m.

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 agency expenditure over the last twelve months, and it fell from £2.7m in May to £2.5m in June. Agency spend reflects the fact that there are significant numbers of vacancies and overall spend is driven by the movement in medical agency spend. Part of the agency cost is covered by an underspend on substantive staff but there is still an overall overspend on employee costs of £1.2m in month.



CQUINs 2016/17

No.	Goal name	Lead Director / CQUIN Lead	Description of indicator /target	Reporting Frequency	Latest updates and Delivery plan	Q1 RAG rating from CCG	Q2 RAG Rating from CCG	Q3 RAG Rating from the CCG	Q4 RAG Rating from the CCG
National CQUINs									
1a	Introduction of staff health & wellbeing initiatives	Stephen Kelly	**Q1: Providers should have developed a plan to introduce a range of physical activity schemes, access to physiotherapy services and introducing a range of mental health initiatives for staff.** **Q2:N/A** **Q3:N/A** **Q4: Providers should have implemented their initiatives as above.**	Monthly collection, Quarterly reporting	Q1 - Achieved Currently impementing their initiatives for Q4				
1b	Development of an implementation plan and implementation of a healthy food and drink offer	Paul Boocock/Clive Marriott	**Q1: The collection of the 11 data points and submission via UNIFY.** **Q2: N/A** **Q3: N/A** **Q4: Providers will be expected achieve a step-change in the health of the food offered on their premises in 2016/17.**	Monthly collection, Quarterly reporting	Q1 achieved. Currenlty impelementing their initiatives for Q4				
1c	Improving the uptake of flu vaccinations for frontline clinical staff	Stephen Kelly	**Q1: N/A** **Q2: N/A** **Q3: Achieving an uptake of flu vaccinations by frontline clinical staff of 75%.** **Providers to submit cumulative data monthly over four months on the ImmForm website** **Q4: N/A**	Monthly collection, Quarterly reporting	Q3 - Achieved 70%			PARTIAL PAYMENT	
2a	Sepsis: Timely Identification and treatment for sepsis in emergency department	Dr Adam Wolverson	**Q1: Audit of at least 50 patients per month to see if screening took place. Quarterly trajectories set at the end of Q1.** **Q2: Achievement of Q2 target, to be set by CCG.** **Q3: Achievement of Q3 target, to be set by CCG.** **Q4: Achievement of Q4 target, to be set by CCG.**	Monthly collection, Quarterly reporting	Q1 - Partial Q2 - Partial Q3 - Partial Q4 need to be achieving 90%.	PARTIAL PAYMENT	PARTIAL PAYMENT	PARTIAL PAYMENT	PARTIAL PAYMENT
2b	Sepsis: Timely Identification and treatment for sepsis in inpatient settings.	Dr Adam Wolverson	**Q1: Audit of at least 30 patients per month of patients with sepsis to see IV antibiotics were prescribed within the appropriate timeframe and had an empiric review within three days of the prescribing of antibiotics. Quarterly trajectories set at the end of Q1.** **Q2: Achievement of Q2 target, to be set by CCG.** **Q3: Achievement of Q3 target, to be set by CCG.** **Q4: Achievement of Q4 target, to be set by CCG.**	Monthly collection, Quarterly reporting	Q1 - Not achieved Q2 - Not achieved Q3 - Not achieved Q4 need to be achieving 90%.				
4a	Reduction in antibiotic consumption per 1,000 admissions	Balwinder Bolla	**Q1: Antibiotic consumption data to be available for commissioners to review via a dedicated website. Antibiotic review data to be submutted from the provider to the commissioners directly to monitor progress. Data to be collected quarterly.** **Q2: As quarter 1** **Q3: As quarter 1** **Q4: As quarter 1**	Monthly collection, Quarterly reporting	Q1 - Achieved Q2 - Achieved Q3 - Achieved				Awaiting PHE publication
4b	Empiric review of antibiotic	Balwinder Bolla	**Q1:Undertake local audit of a minimum of 50 antibiotic prescriptions per month, taken from a representative sample across sites and wards. Perform an empiric review for at least 25% of cases in the sample.** **Q2: Perform an empiric review for at least 50% of cases in the sample.** **Q3: Perform an empiric review for at least 75% of cases in the sample.** **Q4: Perform an empiric review for at least 90% of cases in the sample**	Monthly collection, Quarterly reporting	Q1 - Achieved Q2 - Achieved Q3 - Achieved				

No.	Goal name	Lead Director / CQUIN Lead	Description of indicator /target	Reporting Frequency	Latest updates and Delivery plan	Q1 RAG rating from CCG	Q2 RAG Rating from CCG	Q3 RAG Rating from the CCG	Q4 RAG Rating from the CCG
Local CQUINs									
5	Safeguarding Training	Penny Snowden/Elaine Todd/Lisa Newboult	**Cohort :** **- Consultants, Registrars, Band 7s and Band 6s within Paediatric and A&E Level 3** **- Consultants, Registrars, Band 7s and band 6s within Elderly Care Level 2** **Q1: Baseline for previous year against group above. Provide a training plan for 16/17 Trajectories for the year to be set at the end of Q1.** **Q2: N/A** **Q3: N/A** **Q4: Achieve 85% compliance by end Q4**	Quarterly	Q1 - Achieved Q2 - N/A Q3 - N/A				
6	Maternity	Ailsa McGiveron	**Q1: Provide draft strategy and training needs analysis. Trajectories for the year to be set at the end of Q1.** **Q2: Trajectory to be set at Q1.** **Q3: Trajectory to be set at Q1.** **Q4: Trajectory to be set at Q1.**	Quarterly	Q1 - Awaiting outcome of appeal Q2 - Achieved Q3 - Achieved	**Awaiting oucome of appeal**			
7	Antimicrobial Stewardship (Year 2)	Bal Bolla	**Q1: Agree & achieve Q1 trajectories for phase 1&2 wards. Establish baseline for phase 3 wards Trustwide. Commence rollout of audit activities to further high risk wards.** **Q2: Agree & achieve Q1 trajectories for phase 1 - 3 wards.** **Establish baseline for phase 4 wards. Commence rollout of audit activities to further high risk wards.** **Q3: Agree & achieve quarter 1 trajectories for phase 1 - 4 wards . Establish baseline for phase 5 wards. Commence rollout of audit activities to further high risk wards.** **Q4: Agree & achieve quarter 1 trajectories for phase 1 - 5 wards.**	Quarterly	Q1 - Achieved Q2 - Achieved Q3 - Achieved				
8a	End of Life: e-Learning	Dr Adam Brown	**Q1: Communicate to staff as per e-learning training plan.** **Achieve trajectory set for Q1: . Set trajectory at the end of Q4 2015/16** **Q2: As for Q1.** **Q3: As for Q2** **Q4: Achieve overall trajectory set in Q1**	Quarterly	Q1 - did not achieve target Q2 - Did not achieve target - mapping completed Q3 - Achieved				
8b	End of Life: Staff Education	Dr Adam Brown	**Q1: Completion of ward based training programme on at least 1 ward on each site (LCH, Pilgrim and Grantham) as per ward based training plan.** **Development of audit tool to demonstrate the impact of the training on the care given to patients dying on the ward.** **Q2: Completion of ward based training programme on at least 3 wards at LCH/PBH and 2 wards at GDH.** **Q3: Completion of ward based training programme on at least 4 wards at LCH/PBH and 3 wards at GDH.** **Q4: Completion of ward based training programme on at least 6 wards at LCH/PBH.** **Completion of audit tool and a summary report.**	Quarterly	Q1 - Achieved Q2 - Achieved Q3 - Achieved				

No.	Goal name	Lead Director / CQUIN Lead	Description of indicator /target	Reporting Frequency	Latest updates and Delivery plan	Q1 RAG rating from CCG	Q2 RAG Rating from CCG	Q3 RAG Rating from the CCG	Q4 RAG Rating from the CCG
8c	End of Life: Link Practitioner	Dr Adam Brown	**Q1: Continue quarterly Link Practitioner meetings on all 3 sites. Deliver Palliative Care training day for Link Practitioners. Q2: As for Q1. Develop new resource folder for hospital wards. Q3: As for Q1. Develop new resource folder for hospital wards. Q4: As for Q1. Continue quarterly LP meetings on all sites.**	Quarterly	Q1 - Achieved Q2 - Achieved Q3 - Achieved				
9	Cancer: Release of CNS capacity to provide increased patient facing support to cancer patient pathways for Breast/Gastro/Lung/ Urology	Sarah Ward	**Q1:One session per week of CNS time identified on Breast pathway. Structured process for "end of treatment" and "end of follow up" established through risk stratification. Revised job plan for Breast CNS activity established. Collect data / monthly report for clinic documentation. Agree baseline of improvement for Q2. Q2: Same as above for Gastro. Q3: Same as above for Lung. Q4: Same as above for Urology.. Provide quarterly activity reports and breast patient survey for 2016/17 and commence urology clinic acitiving Q1 17/18.**	Quarterly	Q1 - Not achieved Q2 - Achieved Q3 - Achieved				
EMSCG CQUINs									
1	Adult Critical Care Timely Discharge	Dr Adam Wolverson	**Q1-Q3 Reduction in the number of Critical Care bed days occupied by patients who are clinically ready for discharge for more than 4 hours. Reduction in the number of Critical Care by patients who are ready for discharge for more than 24 hours. Q4: Achievement of a 30% reduction in the number of Critical Care bed days by patients who are ready for discharge for more than 24 hours compared to the 2014/15 base.**	Quarterly	Q1 - Not fully achieved Q2 - Achieved Q3 - Not fully achieved	**PARTIAL PAYMENT**		**PARTIAL PAYMENT**	**PARTIAL PAYMENT**
2	Dose Banding Adult Intravenous Systemic Anticancer Therapy	Colin Costello/ Simon Priestley/Franci sca Martinez	**Q1: Collection of base-line data for a range of dose banded drugs as agreed with Hub. Agreement with hub of stretch target for improvement during course of the year. Q2: Achievement of Q2 target. Q3: Achievement of Q3 target. Q4: Achievement of Q4 target.**	Quarterly	Q1 - Achieved Q2 - Achieved Q3 - Achieved				
3	Severe Haemophilia Haemtrack Patient Home Reporting System	Bethan Mysers/ Claire Lovett	**Q1: Q3 2015/16 confirmed 10 patients recruited with 40% compliance. Recruitment on Haemtrack in excess of 50% of eligible patients, quarter by quarter. Increase in compliant recruitment (number of patients) on Haemtrack up to 70% Q2: As above Q3: As above Q4: Compliant recruitment on Haemtrack from 70% to 95% (number of patients) as a proportion of targeted compliant recruitment.**	Quarterly	Q1 - Achieved Q2 - Achieved Q3 -				
4	Antimicrobial Stewardship (Year 2)	Bal Bolla	**As above**	Quarterly	As above				

No.	Goal name	Lead Director / CQUIN Lead	Description of indicator /target	Reporting Frequency	Latest updates and Delivery plan	Q1 RAG rating from CCG	Q2 RAG Rating from CCG	Q3 RAG Rating from the CCG	Q4 RAG Rating from the CCG
5	Cancer: Release of CNS capacity to provide increased patient facing support to cancer patient pathways for Breast/Gastro/Lung/ Urology	Sarah Ward	**As above**	Quarterly	As above				

CQUINs 2017/18

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

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

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

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

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

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

Risks

This section is being developed and will be available and revised by 2017 / 2018

Equality Analysis Statement

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

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

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

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

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

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

The nine protected characteristics are:

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

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

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

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

Appendix 1. Glossary

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

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

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

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

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

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

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

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