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United Lincolnshire Hospitals NHS Trust

UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 31 JANUARY 2018

To:	FSID
From:	Karen Brown, Director of Finance, Procurement & Corporate Affairs
Date:	20th February 2018
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for January 2018

Author/Responsible Director: Karen Brown, Director of Finance

Purpose of the report:
To update the Board on the performance of the Trust for the period ended 31st January 2018, 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?

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Executive Summary for period of 31st January 2018

☒ 4 hour waiting time target – performance of 66.69% in January 2018
☒ 5 of the 9 national cancer targets were achieved in December 2017
☒ 18wk RTT Incomplete performance in December 2017 was 86.57%, the current unvalidated position for January 2018 as at the 12th February is 85.2%. The final January performance will be submitted on 26th February and is forecast at 86.5%-87%
☒ 6wk Diagnostic Standard – January 2018 performance was 98.05%

Challenges:

- The Medway upgrade is now embedded and RTT performance publication has resumed. The 18wk RTT Incomplete performance in December 2017 was 86.57% and the current unvalidated position for January 2018 as at the 12th February is 85.2%. The final January performance will be submitted on 26th February and is forecast at 86.5%-87%. The position has deteriorated form December due to winter pressures. In December the Trust cancelled 267 Operations on the day and 159 the day before for non-clinical reasons. This was over twice the cancellation rate that occurred in December 2016.
- Against a challenging position in A&E, further improvement was delivered with the achievement against the 4 hour target rising by a further 0.53% from December. This achievement, however, remains well below the 90% target
- The improvement in Cancer target achievement was sustained with 5 of the targets achieved again in December following November attainment. However, this represents a new achievement of the 62 day consultant upgrade target and a drop below target of the 31 day drug treatment target. Overall the position has worsened with 3 targets now on red against only 1 last month. Strong focus continues on managing the performance of the Pathlinks contract to support target achievement.
- Diagnostic waits improved from 97 to 98% but remains short of the 99% target.
- 2 of the 5 stroke targets were achieved this month following all being failed in December.
- There were significant improvements in patient experience both in Friends and Family test response rates and recommend rates in a number of areas and in dementia screening.
- In workforce measures, staff appraisal rate showed slight improvement but staffing remains a challenge with vacancy rates and sickness absence having deteriorated further in month.

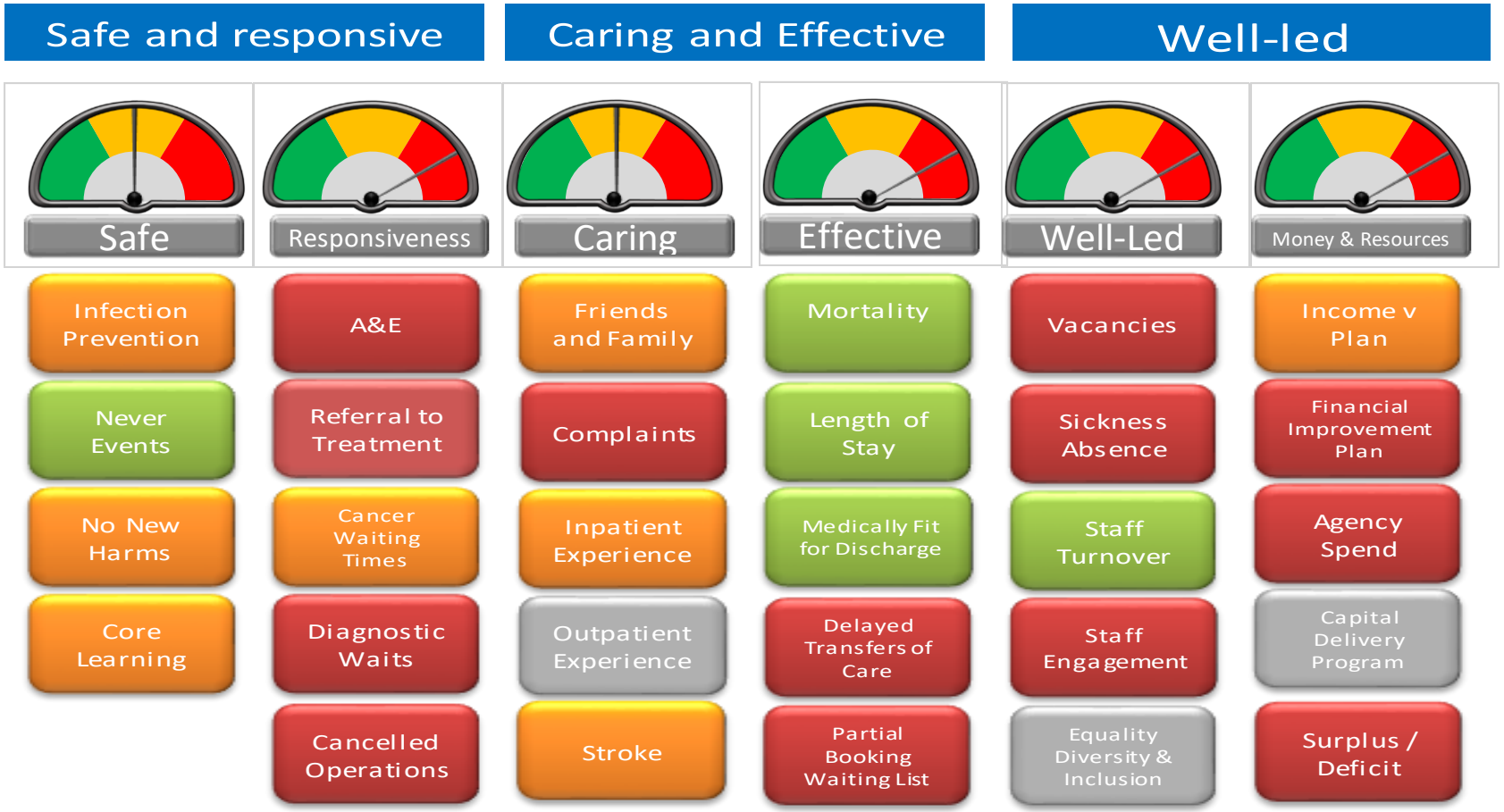
Looking forward:

- Work has been undertaken to validate the Medway reporting, ensuring that data is now being reported correctly with appropriate exclusions from the PTL. Current reporting is now run hourly, excluding the need for manual updates. Further validation testing will be carried out over the next month to ensure data accuracy.
- An Outpatient Improvement Programme and Theatre Optimisation Committee are expected to deliver improvements in productivity and capacity during the course of the next few months with an additional 400 outpatient slots already added to capacity. Outsourcing programmes continue to reduce waiting times and clear surgical backlogs and new suppliers are being brought into this programme.
- Cancer pathways will continue to be a focus with further improvements sought in Pathology turnaround times and sample identification, radiology action plans in place and pathway redesign underway in Urology and Oncology. Additionally, conversations are underway within the health system on ways of securing capacity to trial a visual management approach to proactive capacity management.
- Work continues on medical recruitment overseas with a number of appointments progressing well and proactive review of rota timings and plans for A&E front door staffing in place.
- Financial focus continues to be strong with a new initiative launched to improve clinical coding and income capture across the Trust.

Karen Brown
Director of Finance, Procurement & Corporate Affairs
February 2018

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.



Detailed Trust Board Performance

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Safe						
Infection Control						
Clostrum Difficile (post 3 days)	Monthly	Datix	59	58	4	8
MRSA bacteraemia (post 3 days)	Monthly	Datix	0	2	1	0
MSSA	Monthly	Datix	20	12	0	0
ECOLI	Monthly	Datix	80	28	0	0
Never Events	Monthly	Datix	0	2		1
No New Harms						
Serious Incidents reported (unvalidated)	Monthly	Datix	0	216		16
Harm Free Care %	Monthly			91.77%		91.90%
New Harm Free Care %	Monthly			98.11%		98.57%
Catheter & New UTIs	Monthly			1		1
Falls	Monthly	Datix		4		4
Medication errors	Monthly	Datix		1236		125
Medication errors (mod, severe or death)	Monthly	Datix				18
Pressure Ulcers (PUNT) 3/4	Monthly			64		10
VTE Risk Assessment	Monthly		95%			95.16%
Core Learning	Monthly	ESR	95%	90.49%	90.75%	90.50%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Caring						
Friends and Family Test						
Inpatient (Response Rate)	Monthly	Envoy Messenger	26%	22.80%	28.00%	13.00%
Inpatient (Recommend)	Monthly	Envoy Messenger	96%	91.10%	90.00%	91.00%
Emergency Care (Response Rate)	Monthly	Envoy Messenger	14%	19.10%	20.00%	17.00%
Emergency Care (Recommend)	Monthly	Envoy Messenger	87%	81.40%	84.00%	80.00%
Maternity (Reponse Rate)	Monthly	Envoy Messenger	23%	8.40%	2.00%	5.00%
Maternity (Recommend)	Monthly	Envoy Messenger	97%	96.30%	100.00%	95.00%
Outpatients (Reponse Rate)	Monthly	Envoy Messenger	14%	13.20%	16.00%	7.00%
Outpatients (Recommend)	Monthly	Envoy Messenger	94%	92.50%	93.00%	92.00%
Complaints						
No of Complaints received	Monthly	Datix	70	607	79	43
No of Complaints still Open	Monthly	Datix	0	2678	288	266
No of Complaints ongoing	Monthly	Datix	0	414	45	47
No of Pals	Monthly	Datix	0	0	0	294
No of pals converted to formal complaints	Monthly	Datix	0	0	0	0
Inpatient Experience						
Mixed Sex Accommodation	Monthly	Datix	0	9	1	1
eDD	Monthly	EDD	95%	83.83%	0.00%	83.19%
PPCI 90 hrs	Quarterly		100%		97.33%	97.33%
PPCI 150 hr	Quarterly		100%		85.33%	85.33%
#NOF 24	Monthly		70%			89.16%
#NOF 48 hrs	Monthly		95%	90.76%		88.89%
Dementia Screening	1 month behind		90%	88.52%	89.16%	64.90%
Dementia risk assessment	1 month behind		90%	95.75%	97.94%	96.72%
Dementia referral for Specialist treatment	1 month behind		90%	85.08%	85.00%	80.00%
Stroke						
Patients with 90% of stay in Stroke Unit	1 month behind	SSNAP	80%	83.52%	90.70%	76.60%
Sallowing assessment < 4hrs	1 month behind	SSNAP	80%	71.77%	79.20%	68.80%
Scanned < 1 hrs	1 month behind	SSNAP	50%	55.62%	52.10%	45.10%
Scanned < 12 hrs	1 month behind	SSNAP	100%	96.77%	93.80%	92.30%
Admitted to Stroke < 4 hrs	1 month behind	SSNAP	90%	63.81%	68.80%	61.50%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Responsiveness						
A&E						
4hrs or less in A&E Dept	Monthly	Medway	90.0%	76.64%	66.99%	69.46%
12+ Trolley waits	Monthly	Medway	0	0	1	0
RTT						
52 Week Waiters	Monthly	Medway	0			
18 week incompletes	Monthly	Medway	87.7%	88.15%	85.20%	86.57%
Cancer - Other Targets						
62 day classic	1 month behind	Somerset	85%	69.99%	77.20%	65.40%
2 week wait suspect	1 month behind	Somerset	93%	89.77%	88.70%	92.50%
2 week wait breast symptomatic	1 month behind	Somerset	93%	85.50%	85.40%	92.20%
31 day first treatment	1 month behind	Somerset	96%	96.23%	97.30%	96.10%
31 day subsequent drug treatments	1 month behind	Somerset	98%	99.06%	94.30%	100.00%
31 day subsequent surgery treatments	1 month behind	Somerset	94%	93.02%	98.80%	94.00%
31 day subsequent radiotherapy treatments	1 month behind	Somerset	94%	96.40%	100.00%	97.70%
62 day screening	1 month behind	Somerset	90%	87.79%	91.40%	95.80%
62 day consultant upgrade	1 month behind	Somerset	85%	85.24%	87.30%	83.80%
104+ Day Waiters	1 month behind	Somerset		-	13	14
Diagnostic Waits						
diagnostics achieved	Monthly	Medway	99.1%	98.19%	98.05%	97.00%
diagnostics Failed	Monthly	Medway	0.9%	1.81%	1.95%	3.00%
Cancelled Operations						
Cancelled Operations on the day (non clinical)	Monthly	Medway	1.10%	4.24%	5.55%	4.80%
Not treated within 28 days. (Breach)	Monthly	Medway	0.00%		14.77%	3.75%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Effective						
Mortality						
SHMI	Quarterly		100	111.67		112.57
Hospital-level Mortality Indicator	Quarterly		100	103.07		103.62
Length of Stay						
Average LoS - Elective	Monthly	Medway / Slam	2.8	2.72		2.44
Average LoS - Non Elective	Monthly	Medway / Slam	3.8			4.62
Medically Fit for Discharge	Monthly	Bed managers	60	58.10	60.00	57.00
Delayed Transfers of Care	Monthly	Bed managers	3.5%		4.02%	5.32%
Partial Booking Waiting List	Monthly	Medway	0	5250	5546	5772

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Well Led						
Vacancies	Monthly	ESR	5.0%	10.48%	10.71%	10.35%
Sickness Absence	Monthly	ESR	4.5%	4.67%	5.33%	4.78%
Staff Turnover	Monthly	ESR	8.0%	5.62%	5.77%	5.76%
Staff Engagement						
Staff Appraisals	Monthly	ESR	95.0%	79.10%	81.00%	79.00%
Equality Diversity and Inclusion						

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Money & Resources						
Income	Monthly	Board Report Master	38795	355770	37650	34133
Expenditure	Monthly	Board Report Master	-41632	-413159	-41824	-40739
Efficiency Delivery	Monthly	FIMS report	1750	9079		2100
Surplus / Deficit	Monthly	FPIC Finance Report	-2837	-69754	-5636	-7226

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Finance Headline Summary

Executive Responsibility: Karen Brown – Director of Finance, Procurement & Corporate Affairs

Key Financial Duties

Financial Duty	Initial Plan £m	Revised Plan £m	YTD Plan £m	YTD Actual £m	RAG
Delivering the Planned Deficit	(48.6)	(77.0)	(41.4)	(69.9)	R
Achieving the External Finance Limit (EFL)	76.3	86.6	-	-	G
Achieving the Capital Resource Limit (CRL)	17.7	22.8	-	-	G
Capital Programme	18.9	22.9	16.1	9.5	A

Key Issues

- The Trust plan for 2017/18 was a control total deficit of £48.6m, inclusive of £14.7m STF income (£63.4m before STF).
- Following the Trust's FSM progress meeting NHS Improvement have agreed a revised outturn deficit of £77.0m for the year exclusive of STF.
- The Month 10 position was an in-month deficit of £5.7m, which is £2.8m adverse to the planned in-month deficit of £2.8m.
- The financial recovery plan assumes delivery of £16.2m of efficiencies to achieve the £77m deficit.
- The deterioration in the income and expenditure position directly impacts on cash and the level of borrowing needed in 2017/18. The Trust will continue to require external cash support in line with the forecast outturn in 2017/18.

Month 10 Financial Position

Month 10 performance against the financial plan is summarised in the table below:

	January 2018			April 2017 to January 2018		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Operating income from patient care activities	33,925	34,774	849	324,683	327,780	3,097
Other operating income	4,870	2,875	-1,995	42,109	27,976	-14,133
Employee expenses	-25,883	-27,246	-1,363	-258,861	-270,332	-11,471
Operating expenses excluding employee expenses	-15,318	-15,679	-361	-145,410	-152,348	-6,938
OPERATING SURPLUS / (DEFICIT)	**-2,406**	**-5,276**	**-2,870**	**-37,479**	**-66,924**	**-29,445**
NET FINANCE COSTS	-431	-373	58	-4,055	-2,955	1,100
Other gains/(losses) including disposal of assets	0	13	13	0	124	124
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**-2,837**	**-5,636**	**-2,799**	**-41,534**	**-69,755**	**-28,221**
Add back all I&E impairments/(reversals)	0	0	0	0	-70	-70
Surplus/(deficit) before impairments and transfers	**-2,837**	**-5,636**	**-2,799**	**-41,534**	**-69,825**	**-28,291**
Remove capital donations/grants I&E impact	12	-57	-69	111	-81	-192
Adjusted financial performance surplus/(deficit)	**-2,825**	**-5,692**	**-2,867**	**-41,423**	**-69,906**	**-28,483**

The Trust is reporting:

- An in-month deficit in January of £5.7m, which is £2.8m adverse to the planned in-month deficit of £2.8m.
- A year to date deficit of £69.9m, which is £28.5m adverse to the planned year to date deficit of £41.4m.

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

- Non-achievement of STF income resulting in the loss of £11.3m STF income.
- Slower than planned delivery of efficiency savings, with delivery to date £3.4m below plan.
- Pilgrim fire, norovirus outbreak and cyberattack resulting to date in the loss of £3.6m of income.
- Non-achievement of £1.8m of CQUIN income.
- £0.7m in relation to the outcome of the hoist legal case.
- Contract challenges of £0.6m from 2016/17 re SUS to SLAM reconciliation.
- Higher than planned level of expenditure on agency staffing, with expenditure to date £7.2m higher than planned and only partially offset by a reduction in substantive and bank pay expenditure.

Financial Recovery

The current financial position highlighted above, coupled with the longer term financial issues necessitated the Trust being placed in Financial Special Measures on 1st September 2017 by NHS Improvement.

Efficiency

The financial plan for 2017/18 includes a FEP target of £18m, and adding to this the shortfall of £6m from 2016/17 gives a total requirement for 2017/18 of £24m.

The Trust identified high level schemes totaling £16.0m (and a full year effect of £18.3m) within the financial recovery plan submitted to NHS Improvement in October and a further update in November. The development of the detailed efficiency schemes is being led by the Trust's Executive Directors with support from the Trust's external partner, KPMG.

The Financial Efficiency Plan schemes have delivered £10.9m to date. There is risk of £1.4m associated with the remained £5.1m. A further set of schemes totaling £1.3m have been identified to mitigate the risk. The Trust originally planned to deliver £14.4m of savings by the end of January.

Capital
The spend to date of £9.5m is inclusive of

- £1.7m Pre-commitments; including £1.0m for Neonates and £0.5m Lincoln Specialist Rehab.
- £1.6m for Medical Equipment.
- £1.9m for IT development.
- £2.7m Fire and Facilities related costs.
- £1.6m CQC and Service Development & Modernisation

The spend to date is £6.6m lower than the revised £16.1m plan to date. The main drivers of the variance are as below:

- Fire related works; £5.0m behind the revised plan to date. The work has been slipped into the final quarter but contractors have been mobilised to deliver the programme of works and ensure compliance. Assurances in respect of delivery have been received from Estates leads and weekly monitoring is in place.
- CQC schemes; £1.2m lower than plan year to date mainly due to the slippage with the Trust wide Digital Dictation scheme, the Pilgrim emergency call bells, and enabling works to Lincoln 1st floor for 5th floor decant. All are still forecast to deliver.
- Medical Equipment; £0.1m behind plan to date. This is purely a timing issue and full delivery. The full programme will deliver.
- IT Development/IT Service Development & Modernisation; £0.2m lower than plan to date. Continued Development of the Secondary ICT Server Room at Pilgrim has been delayed as has the replacement of desktop PC's with the New Clinical Desktop Environment. The full IT programme will deliver in 2017/18 and this has been confirmed by the head of IT services.
- Other minor schemes of £0.1m, inclusive of the final bill of works for Primary Care Streaming that is complete as per the national timetable for roll out of the service at Lincoln and Pilgrim A&Es.

Total forecast capital schemes of £22.1m is on target to deliver the revised capital spend profile for 2017/18.

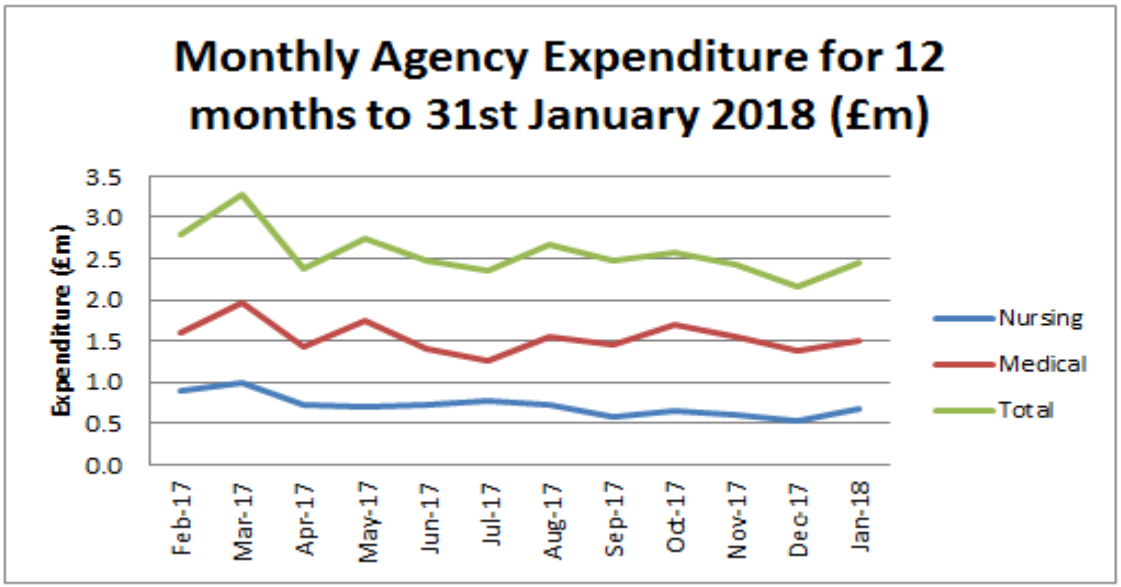
Cash
At the close of January 2018 the Trust held cash of £2.1m. This includes external revenue support loans of £69.5m.

The total 'repayable' borrowings through working capital loans, Salix loans and the uncommitted loan facility are currently £180.1m. The projected revenue borrowings required in 2017/18 are £78.3m, of which £1.3m relates to deficit support from 2016/17. This has been revised in line with the forecast revenue position.

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

Agency
The spend on agency has remained relatively flat throughout April 17 – Jan 18.

There was a drop in December spend partially attributable to availability with a return to previous levels in January that would have related to increased activity, winter pressures and improved availability.



Referral to Treatment

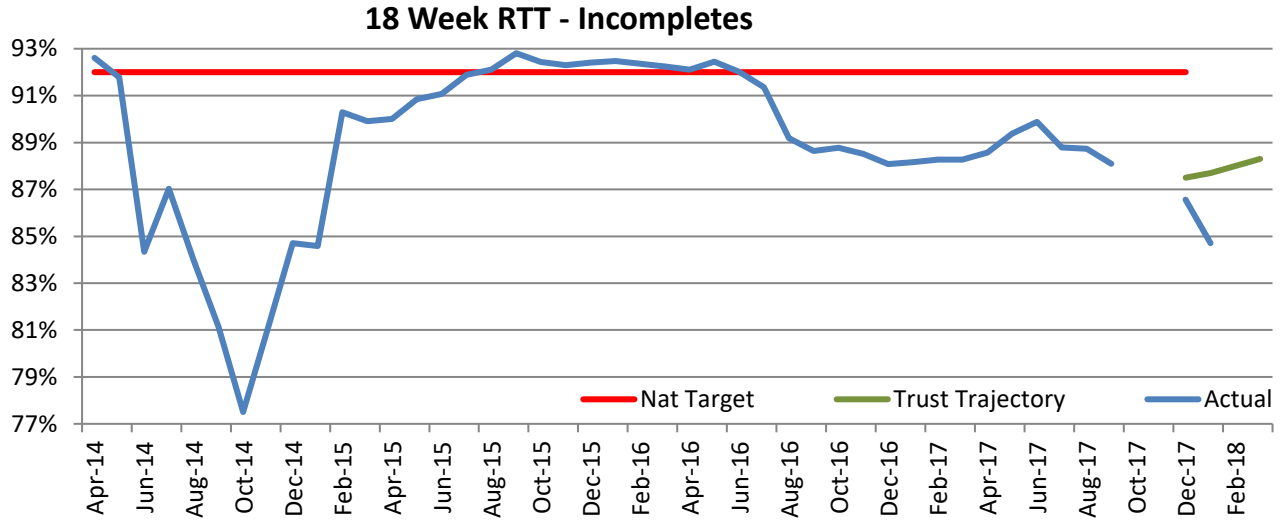
Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Referral to Treatment (18 weeks)	Owner:	Director of Operations
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance – Planned Care
Date:	20th February 2018	Reporting Period:	January 2018 – unvalidated position

Exception Details

The Trust submitted monthly performance of 86.6% in December, which was the first submission since the Medway upgrade in October. This is a deterioration of 1.5% compared with the position in September. This was driven by limited validation to release time to support flow, cancellations and reduced capacity during the festive period. There were 4,740 patients incomplete on a RTT pathway over 18 weeks at the end of December.

At a national level the standard hasn't been achieved for 21 consecutive months, with an aggregated national performance at the end of November of 89.5%.

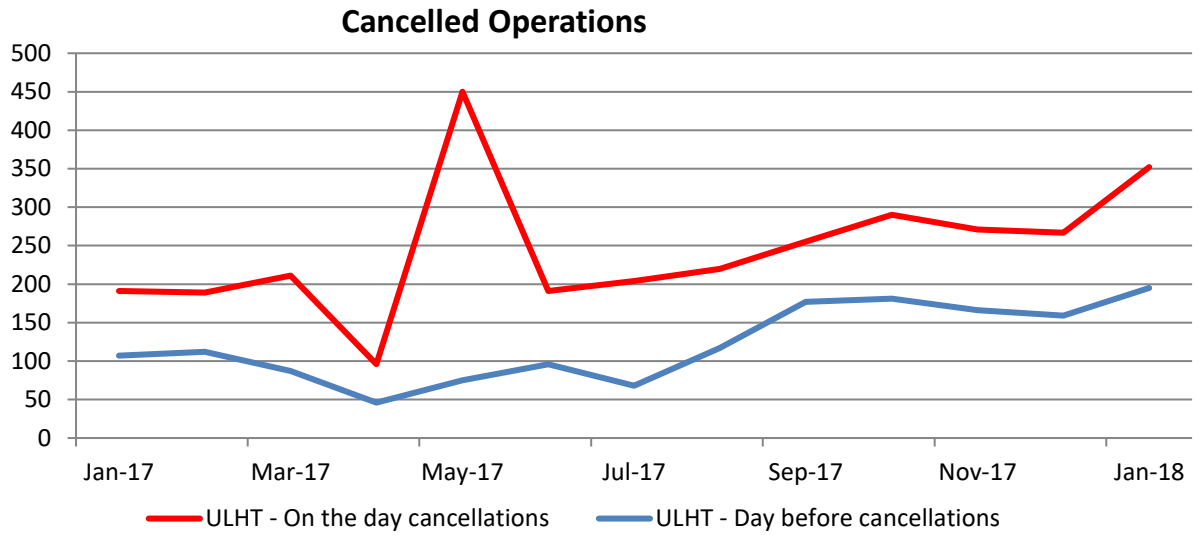


As at the 7th February the RTT incompletes position for January was 84.7%. There is still over 2 weeks from this point before the final position will be submitted 26th February 2018, therefore this performance level will improve prior to submission. Expected performance is expected to be c.86.5-87%

The three areas with highest 18 week+ incomplete numbers are as follows:

- ENT – 1149 patients over 18 weeks. The service accounts for c.29% of Trust's 18 week+ backlog of patients. This service experienced significant clinical capacity restrictions during 2017, and there were significant risks relating to Consultant vacancies at the end of the year. Short term mitigations are now in place to address these risks, and the monthly deterioration in performance has stabilised. However, the speciality has 164 patients waiting over 40 weeks on the PTL, leading to increasing numbers of 52 week breaches, particularly during winter months where electives are being cancelled as a result of urgent care pressures.
- Gastroenterology – Accounted for c.9% of Trust's 18 week+ incompletes at the end of December. The Consultant capacity gaps from summer were fully addressed by the beginning of Q3, however the service experienced reductions in capacity during December due to the impact unplanned leave and clinic cancellations due to inpatient pressures.

- General Surgery – Accounted for c.10% of Trust's 18 week+ incompletes at the end of December. Whilst the number of incompletes over 18 weeks on a non-admitted pathway has remained stable since September, there has been an increase of c.200 patients over 18 weeks on admitted General Surgery pathways. This is partly related to changes within the PTL reporting functionality, which has resulted in the patients awaiting pre-operative assessments being attributable to their originating speciality. However, the increased level of cancelled electives in recent months and the planned reduction of routine electives is also a significant contributory factor within this deterioration.



In December the Trust cancelled 267 Operations on the day and 159 the day before for non-clinical reasons. This was over twice the cancellation rate that occurred in December 2016.

There are long waiting times for first appointments in a number of specialities. During 2017 there was a reduction in the number of patients waiting over 12 weeks on the open referrals waiting list, reducing from 2820 at the beginning of January 2017 to 1485 on 7th February 2018, however Gastroenterology and ENT still have patients waiting over 25 weeks on the open referrals waiting list. Clinical Directorates are devising plans to resolve. Gastroenterology are now fully established at Lincoln and booking rules have been revised which will begin to reduce the new patient appointment backlog. Detailed actions for ENT are listed below.

At the end of December there were 2 patients (both within ENT) on incomplete pathways over 52 weeks. A harm review has been completed by the lead clinician for one of these cases, and no harm was found. In the other case the patient reported that their symptoms had resolved and therefore they didn't require the scheduled OPA and requested to be discharged.

What action is being taken to recover performance?

Following the Medway upgrade in October, post upgrade testing of RTT incomplete figures showed a drop in volumes. This was identified as a change to the underlying "Periods" RTT table which summarises records from the "Events" table to show current open pathways. However, it was soon identified that this was including some records that we would identify as incorrect. Work was undertaken to re-write the RTT scripts. A validation process was then completed where a sample 9704 patient records were validated in order to provide assurance that the exclusion rules within the new scripts were accurate.

This process was completed by mid-January, demonstrating that the scripts were excluding pathways appropriately based upon the information recorded within Medway, enabling the Trust to submit December's data at the end of January. Further sample validation is scheduled to be undertaken in order to periodically check the data accuracy within the exclusion cohorts within the new PTL report.

Current reporting is now run hourly, with snapshots being kept for review, and self-service SSRS reports have been built and share the reports with operational teams. This has removed the need for manual production of RTT reports to take place.

Speciality Actions

Delivery of additional outpatient clinics over and above core capacity formed the basis of a significant proportion of the speciality level plans during 2017. The additional Clinical Directorate capacity was being delivered by existing staff working additional hours and also the use of agency locums in specialities such as Neurology, Cardiology and Respiratory.

The standardisation of payments for additional hours for AFC staff in line with national agreements since January has led to increased difficulty providing ad-hoc additional clinics, this is having particular impacts within ENT, Endoscopy, Breast and Dermatology.

Since December the Outpatient Improvement Programme has focused on increasing productivity within baseline outpatient clinics. A workstream within this programme has co-ordinated the standardisation of outpatient clinic booking rules within the 12 largest specialities within the Trust, in order to reduce variation between clinicians, and has resulted in an additional 400 outpatient slots being added to core capacity per month from February.

Additionally, a SOP relating slot conversions has been implemented in order to ensure increased flexibility of clinic booking rules in order to reduce unbooked slots within clinics. A revised slot utilisation tool has also been developed for use within the Choice and Access Booking teams in order to assist the team to increase utilisation of outpatient capacity.

The Theatres Optimisation Committee is overseeing a programme of work relating to theatre scheduling, pre-operative assessment processes, peri-operative efficiency and short stay pathways in order to increase productivity within theatres.

Advice and guidance services are now available within ENT, Haem and Cardiology, providing secondary care support to GP Practices prior to referrals being made into the Trust.

A new Audiology pathway has commenced which will support the ENT backlog reduction, by streaming appropriate patients to Audiology assessment as part of a MDT clinic. The ENT service has recently secured 2 locum Consultants in order to provide cover for existing vacancies.

Outsourcing has been completed within General Surgery, Ophthalmology, ENT and Urology during 2017/18. As at 7th February, a total of 171 ENT patients, 78 General Surgery patients, 107 Ophthalmology patients and 12 Urology patients have been accepted by independent sector providers, with plans for further patients to be identified within these speciality areas.

In the last 2 months the Cardiology Service has recruited to a Consultant Echo Sonographer post and a substantive Consultant with a specialist interest in Cardiac Devices, and are advertising for a further substantive Consultant. Work is ongoing to establish the valve registry which is anticipated will release further capacity within the Cardiology Service by the end of Q1 of 18/19.

The Neurology Service is currently still closed to routine referrals. The Trust is working with the CCGs to develop further community pathways and to develop advice and guidance for Neurology, in order to enable the service to re-open to routine referrals.

What is the recovery date?

Forecast trajectory for the remainder of 2017/18:

- December – 87.5%
- January – 87.7%
- February – 88%
- March – 88.3%

Cancer Waiting Times – 62 Day

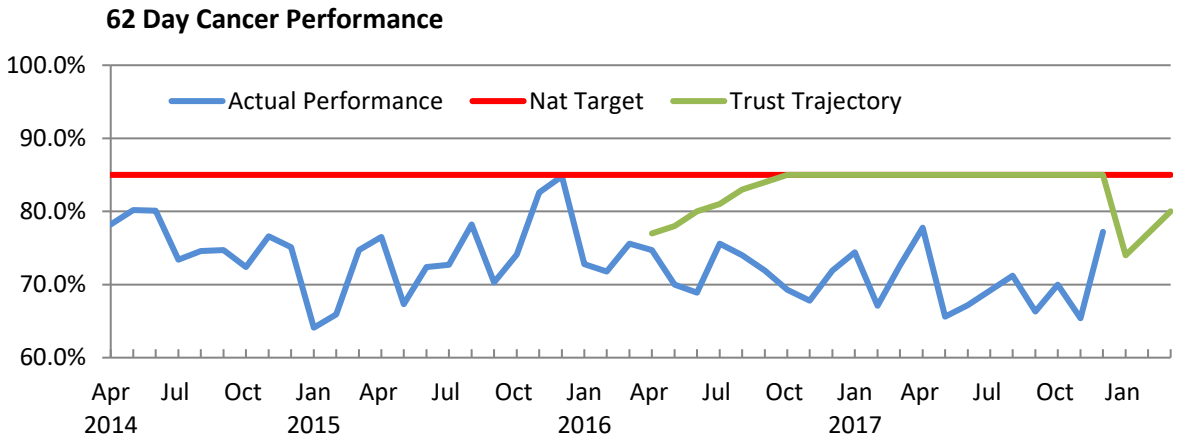
Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Cancer Waiting Times (62 Day)	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance – Planned Care
Date:	20th February 2018	Reporting Period:	December 2017

Exception Details

The Trust's submitted performance position for December against the 62 day classic standard was 77%. Final confirmation of performance pending final tertiary allocation/adjustments to be confirmed within one week, but is unlikely to change materially.

The Trust achieved 5 out of the 9 cancer standards in December. This is the first time in a year that 5 standards have been achieved in the same month for three consecutive months. The 31-day subsequent drug treatment standard was not achieved in December for the first time in six months, however the remaining 31-day standards and the 62-day screening and upgrade standard were all achieved.



Performance in Urology rose above 70% for the first time since April 2017. However Lower GI's performance deteriorated below 55% for the seventh time in the last eight months.

Completion of RCAs for each breach in December found that the most frequent breach reasons were as follows (in order of occurrence):

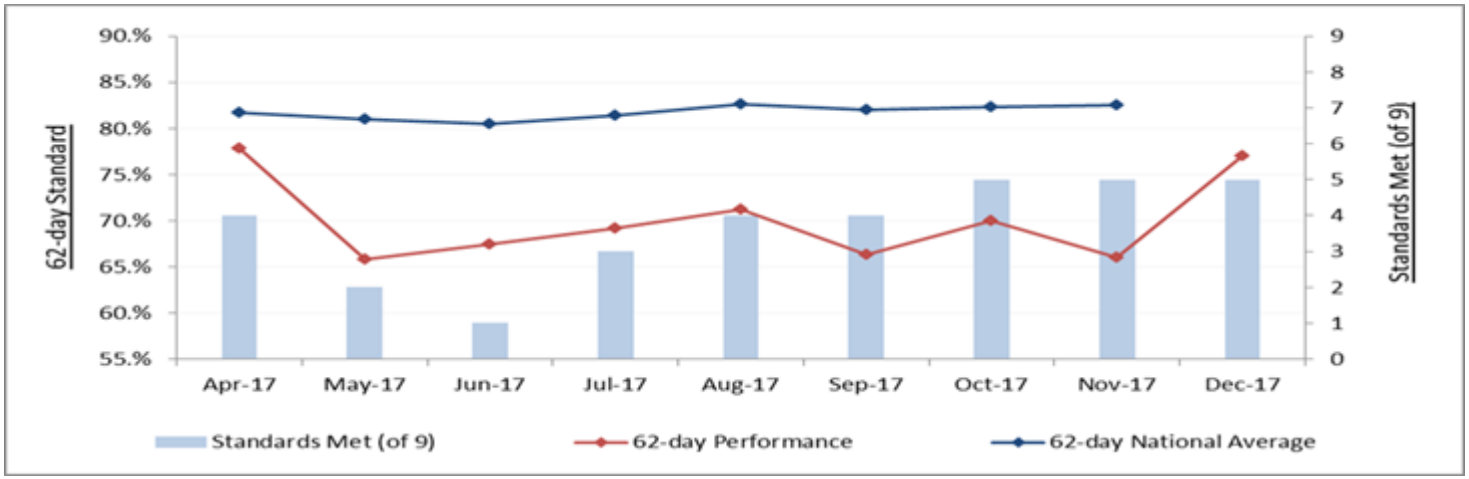
- Pathology
- Patient choice and fitness
- Theatre capacity
- CT capacity (including biopsies)
- Tertiary diagnostics/treatment

Pathology was identified 45% more frequently than any other individual factor as an issue associated with delays within breach pathways.

As of 6th February there are 11 pts on or over 104 days without an agreed treatment plan: 5 x Colorectal, 3 x Urology, 1 x Haem, 1 x Skin, 1 x Lung.

The Trust treated 9 patients at 104 days or over during December, completing RCAs for all 9 patients. Due to the length of these pathways these patients had multiple reasons for delays in their pathways, as follows:

- 6 cases included pathology delays
- 6 cases included theatre capacity restrictions
- 4 cases included Outpatient capacity issues
- 3 cases included administrative delays
- 3 cases included CT delays
- 3 cases included patient choice delays
- 3 cases included MRI capacity delays
- 2 cases included patient fitness factors
- 2 case included tertiary diagnostic delays
- 1 cases included complexity or procedural factors
- 1 cases included Oncology capacity delays
- 1 case included delays linked to IT issues
- 1 case included tertiary treatment delays



The Trust completes a full review of any potential harm related to excessive waits for cancer treatment (104 + Day Waits and patients who waited over 21 days for first appointment on a suspect cancer pathway who were subsequently diagnosed with cancer): 16 Harm Reviews have been issued for November, as at 6th February 9 had been completed, with all 9 reporting no harm.

As at 6th February, January's 62-day performance position was 73%, however further treatments are likely to be recorded over the next 3 weeks prior to submission of January's data and are likely to improve this position further

What action is being taken to recover performance?

Update on key improvement actions

- Intensive Support Team first OPA demand/capacity modelling has been refreshed, with implementation into booking rules on schedule to be completed by mid-February.
- Pathology workload allocation re-design commenced, with outsourcing of routine capacity from beginning of February and additional locum resource in place. At the beginning of February average pathology turnaround times for patients on suspect cancer pathways had reduced to less than 10 days, however routine waiting times remained high.
- Project Management time has been identified in February to deliver improvement work relating to the reliability of identifying pathology samples which should be processed on a suspect cancer pathway as opposed to a routine pathology pathway.
- STT for lung CT commenced at beginning of January on Lincoln and Pilgrim sites, and is due to commence at Grantham in early February. Remainder of lung optimal pathway (apart from EBUS) to be in place at Lincoln from April.
- Radiology action plan in place to deliver 90% turnaround within 7-days by the end of March. Latest performance 62% referral to report within 7-days for all modalities. CT remains the greatest challenge linked to scanning capacity.
- Redesign of post MDT phase of Urology pathway to completed by end of February.

- Oncology review of referral pathways underway, as part of a plan to achieve referral to first oncology appt within 7-days.
- Lower GI nurse led triage commenced on the Pilgrim site in January, following on from previous implementation on Lincoln and Grantham sites.
- Actions are being undertaken to implement extension of Endoscopy service from April following BC approval. There are risks relating to recruitment within these timescales. Discussions relating to mitigation plans are ongoing.
- Discussions taking place within Health System relating to securing capacity to trial a visual management approach to proactive capacity/demand management within cancer pathways.

What is the recovery date?

- 74% - January 2018
- 77% - February 2018
- 80% - March 2018
- 81% - April 2018
- 83% - May 2018
- 85% - June 2018

4 Hour Standard

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	4 Hour Wait (A&E)	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Director of Operations / Deputy Director of Urgent Care
Date:	20th February 2018	Reporting Period:	January 2018

Exception Details

PERFORMANCE

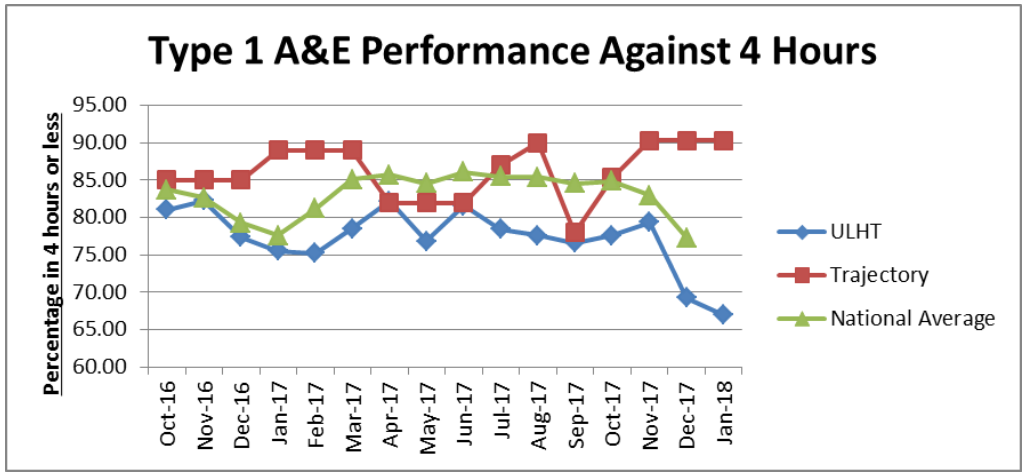
ULHT Type 1 plus streaming Performance for January was 66.95% against the 95% target for 4 hours.

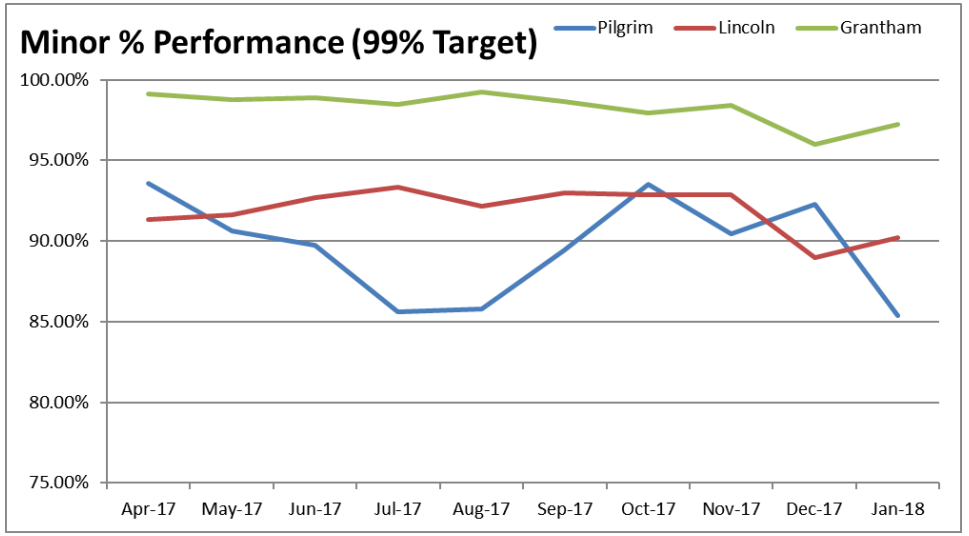
Month on month the trust remains below the national average.

System Type 3 activity was 99.1% in January, bringing the system performance to 80.3%:

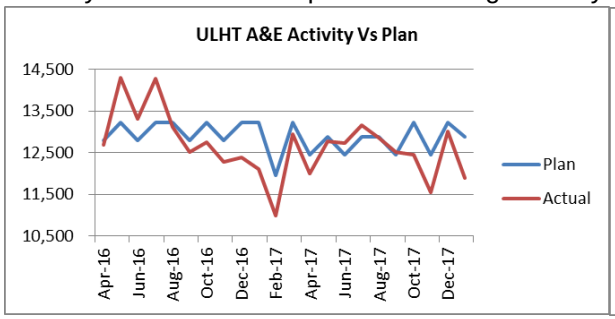
MONTH	ULHT TYPE 1	LCHS TYPE 3	SYSTEM %
December	69.6%	98.6%	81.6%
January	67.2%	99.1%	80.3%
February to 5th	67.4%	99.0%	80.7%

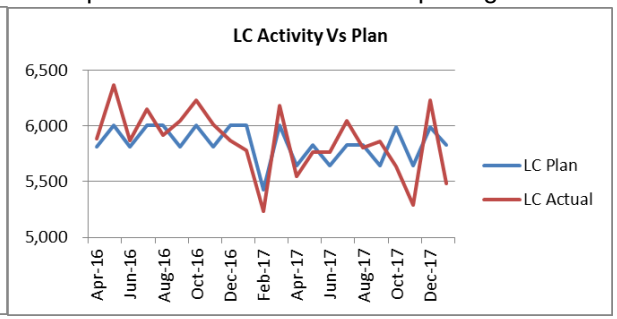
Minors performance at Pilgrim Hospital saw a decrease in performance to 87% from to 93% in December, partly due to the utilisation of the ACPs to support GP Streaming.

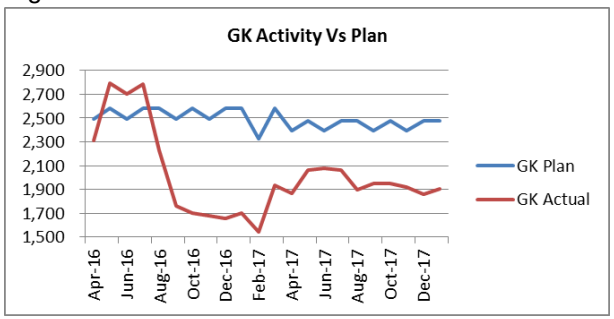




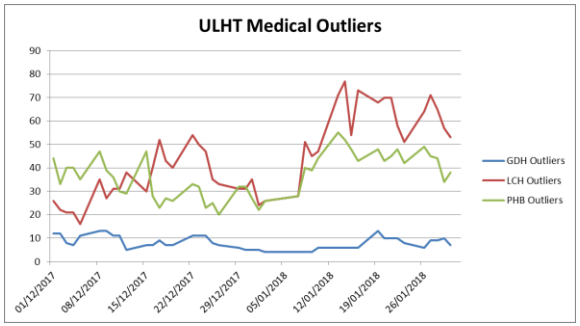
Activity for the month was below plan, most significantly at Lincoln County Hospital.
Activity at Grantham Hospital remains significantly below plan since the reduction in opening hours in August 16.

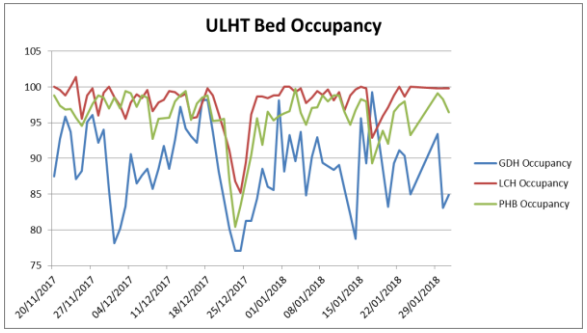


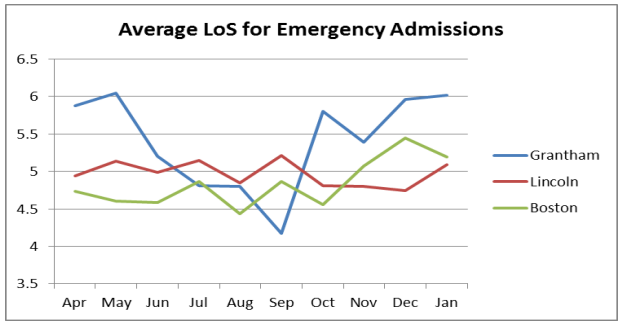




However, ED conversion rates to admission peaked at over 31%of attendances (typical conversion rates c.26%). The volume of discharges and timeliness has not matched the demand profile due to patient acuity and significant number of additional medical patients in ULHT bed stock which peaked at over 130. This resulted in increased outliers, use of escalation areas, longer LoS, bed occupancy levels that cannot sustain flow and overcrowded EDs.





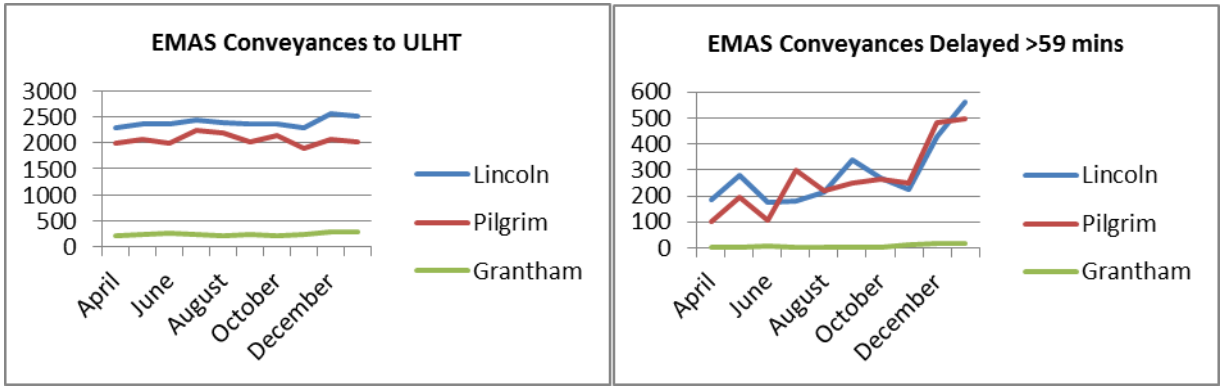


Key actions have been taken to ensure ongoing safety of the departments which include;

- Hourly Risk score of the department which is visible on all sites to drive actions
- Completion of the Bristol Safety Checklist to ensure all patients have received all tasks associated with their plan and ongoing care
- Escalation procedures for additional staff to support care rounding and patients awaiting ambulance handover
- Utilisation of the Full Capacity Protocol when triggered
- Review of the impact of outlying on our patients that shows an increased LoS but no impact upon mortality

EMAS conveyances at Lincoln and Grantham are elevated and Pilgrim within normal limits. Although proportionately Pilgrim Hospital still sees a higher conveyance rate for the size of the department.

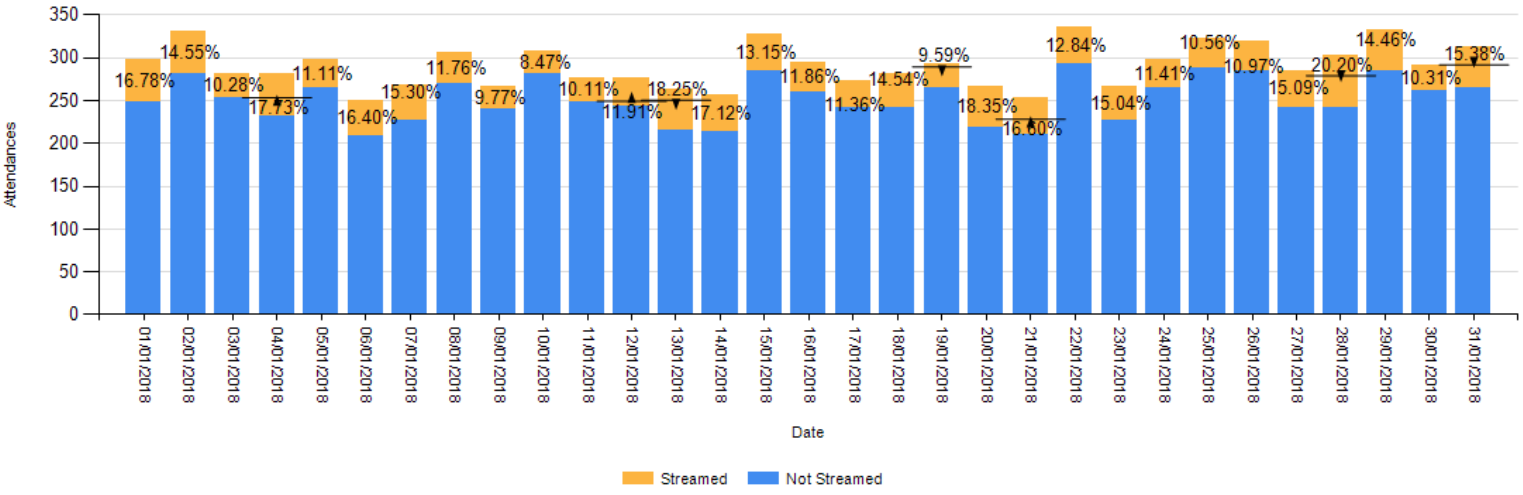
Pilgrim and Lincoln due to the aforementioned challenges have seen dramatic increases in handover delays. The teams are committed to timely handovers and have agreed protocols in place which include Rapid Assessment and Treatment, Fit2Sit and crew cohorting. Ambulance handover delays are a symptom of the acuity of patients and the available capacity within the system which creates a lack of patient flow.



To reduce EMAS delays the trust has reinforced the handover protocol and added this, with an escalation process to the Full Capacity Protocol. In addition the Lincoln RAT area is now open 24 hours with capacity to offload 6 crews. Pilgrim has increased its RAIT bays from 2 to 3 with a 4th available for cohorting and has gained help from "ADPRAC" – an ACP agency who work with organisations to improve handover times. Daily calls between the Director of Operations and the EMAS Divisional Manager are taking place to escalate any issues.

Primary care streaming numbers continue to be below the expected volumes. Performance in January was 13.52% against an expectation of 20% (stretch ambition of 25%).

To improve performance the trust is working closely with LCHS utilising LCHS staff to run the streaming triage. Future models with ALL patients going through the GP service if attending on foot are also being considered.



Medical and nursing staffing levels remain challenging during the month due to acute staff sickness in ED on top of variable shift fill rates. Sickness on the wards also compounded the situation with wards being unable to respond quickly to bed moves and the provision of EDD's.

The early part of January saw increasing cases of respiratory illness, influenza and winter vomiting present to the site causing a number of IPC issues across the wards, with areas restricted to admissions. Acuity on the sites was high and the sites operated at OPEL 4 on multiple days. The need for resus beds often exceeded the number available.

A Business Continuity Incident was declared w/c 15th January due to lack of flow on site. The site responded well with the following key actions:

- Deep dive approach to Red2Green, reviewing all patients in medical and surgical beds.
- Red Cross on site supporting with discharge.
- LCHS provided additional trained and untrained nursing support to the site.
- Additional Medical staffing, pharmacy and therapies staff were in place as part of the winter plan
- Additional escalation beds were opened to maintain flow and safety
- Increasing numbers of elective (non-urgent, non-cancer) cases were cancelled
- Senior management on-site presence was increased into the evening and weekends
- Increased frequency of teleconferences with social care partners to focus on increased discharges
- Focussed work with the Web V Electronic Bed Management Boards has been undertaken by the site operational teams. The teams are working closely with the wards to ensure their PDD's (predicted dates of discharge) are as accurate as possible to ensure we make comprehensive early plans to support patient's discharge from hospital.

The Medically Fit For Discharge (MFFD) numbers increased with external delays awaiting packages of care & community beds. Actions taken;

- LCHS took responsibility for 12 beds on Digby Ward Lincoln
- System spot purchasing additional 25 community beds
- Daily 3pm system discharge meeting in place (ULHT, LCHS, CCG, Social Care)
- Weekly escalation calls are in place with NHSi

What action is being taken to recover performance?

- Key SAFER Flow actions remain in place with priority being given to:
    - 10 by 10am
    - Focus on pre-noon discharges and ward level discharge volumes
    - PDD accuracy
    - Red2Green
- Extension of elective cancellations during January and extended into February
- Additional Winter Planned weekend Medical Teams now in place up to and including Easter.
- LPFT to open Rochford ward at Pilgrim during February to take MFFD patients
- Increased specialty support to ED
- Ongoing recruitment activity with 11 doctors offered clinical attachments (5 Lincoln and 6 Pilgrim)
- Planning for Multi Agency Discharge Event during February coordinated by CCGs
- Perfect Week / Breaking the Cycle event planned 5th March

Diagnostics

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Diagnostics	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Director of Operations / Deputy Director of Urgent Care
Date:	20th February 2018	Reporting Period:	January 2018

Exception Details

In December the Trust failed the 6 week diagnostic standard for the sixth time in the last year. The performance level was 97%, which was a 0.4% improvement on the previous month's performance.

There were 224 diagnostic patients which breached the 6-week standard in December (137 of which were in Echo and 53 in Endoscopy), which was 10 less than at the end of November.

In January the Trust's performance improved further, with 98.05% of patients receiving their diagnostic test within 6 weeks of referral. The number of breach patients reduced to 135 in January, with 26 of these being in Echo and 68 in Endoscopy.

The poor performance in Echocardiology in recent months has been due to a combination of factors:

- Vacancy levels
- Maternity leave
- Workforce skill mix (staff training and unable to sign off their own reports/ practice independently)
- Rota management challenges
- Lack of visibility with no waiting lists
- Sharp increase in demand for in-patient echo service.
- Equipment/Physical Capacity/Estate

Endoscopy breaches were primarily linked to reduced capacity as a result of mechanical failures and issues with water sample results during November and December, and reduced capacity over the Christmas period due to bank holidays and increased annual leave.

What action is being taken to recover performance?

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

- Provision of addition capacity through internal resources
- Action completed to improve data quality and visibility, with Cardiac Physiology (separate from Cardiology) now having a dedicated new and follow-up waiting list within Medway for the first time.
- Improved rota management and standardisation of booking rules completed

- Workforce review completed.
- The service has finalised a detailed capacity and demand review, with a view to formulating a Business Case to address capacity gaps.

Due to the current increased levels of demand there is significant risk relating to the performance position for Echo in Q4.

Issues within Endoscopy relating to mechanical failures and water samples have been resolved in January. The service continue to utilise Medinet to support additional capacity, as well as undertaking additional internal sessions, although uptake of additional sessions has been more limited since the standardisation of payments for AFC staff around these sessions was introduced in mid-January. An additional risk is the closure of the Grantham unit for 9 days in February for scheduled maintenance.

A business case has been approved to enable provision of extended working within the Endoscopy units from April, however delays relating to nurse recruitment pose risks to these timescales.

What is the recovery date?
March 2018

Quality Summary – latest data available is at 31st December 2017

Following revision of the Quality Governance Committee and Trust Board dates the data within this paper has not yet been discussed at Patient Safety Committee. This will be a recurrent issue in 2018/19 with the revised schedule.

Per 1000 bed day data pre November 2017 is incorrect in respect of all harm measures. This is because previous information provided by Information Services had an incorrect formula that included count until the end of patient spell rather than the end of calendar month. The reduction in bed days is significant (approx. 20,000 reduction) and if retrospectively applied would increase harm per 1000 bed days against all patient measures. Any further questions around this error should be discussed with Information Services. Data has been corrected for November 2017 and the correct formula will be applied in future.

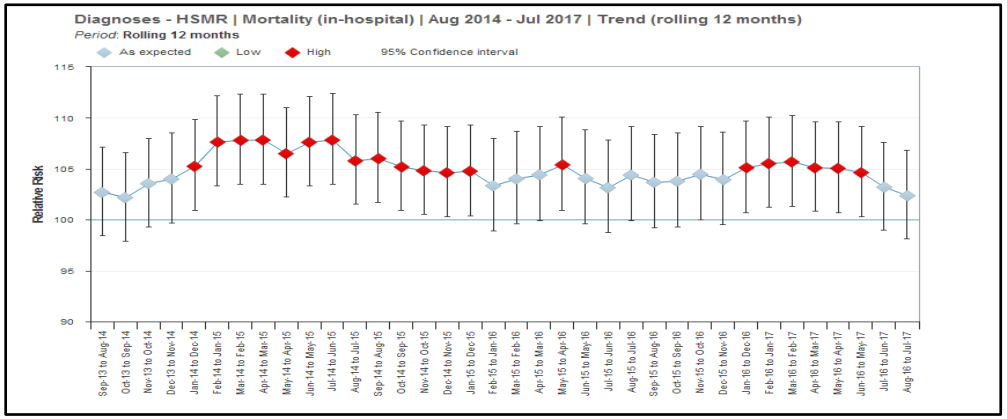
Safe Ambition 1: Reduction of Harm Associated with Mortality

Executive Responsibility: Neil Hepburn – Medical Director

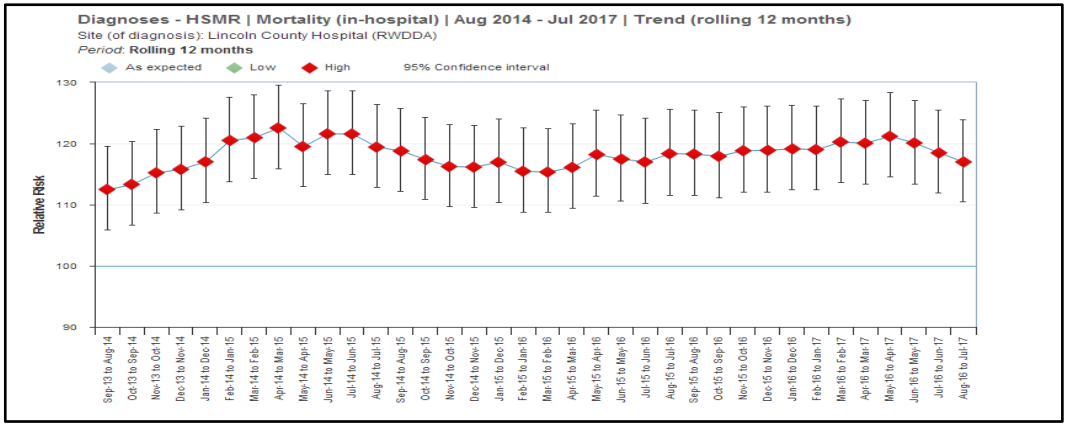
Trust/Site	ULHT HSMR Oct 16-Sep 17 12 month	ULHT HSMR Apr 17-Sep 17 YTD	ULHT HSMR Sep-17	ULHT SHMI Apr 16-Mar 17	Trust Crude Mortality YTD Internal source Jan 17-Dec 17
Trust	103.62	97.84	93.02	112.57	1.80%
LCH	117.71	1109.54	115.18	117.39	1.80%
PHB	94.91	91.32	71.62	111.14	2.02%
GDH	66.87	59.44	38.42	93.97	0.97%

Hospital Standardised Mortality Ration (HSMR)

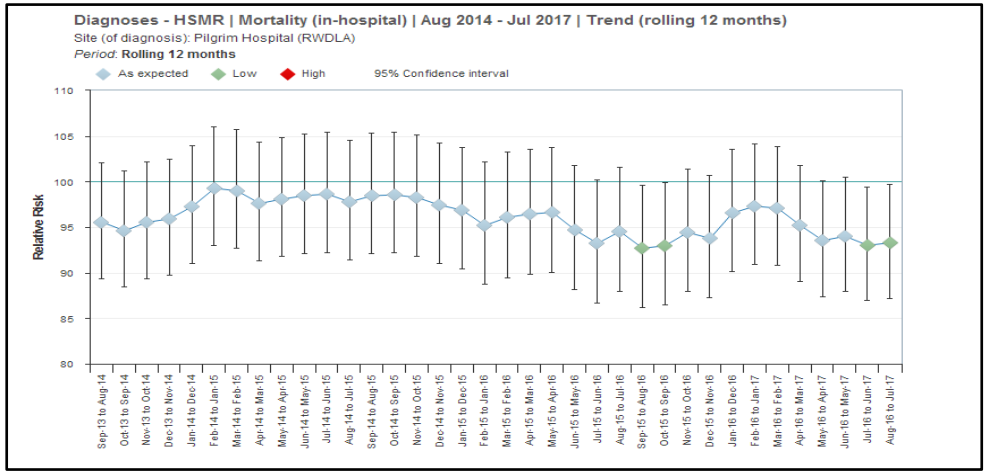
ULHT HSMR Rolling Year (36 Months)



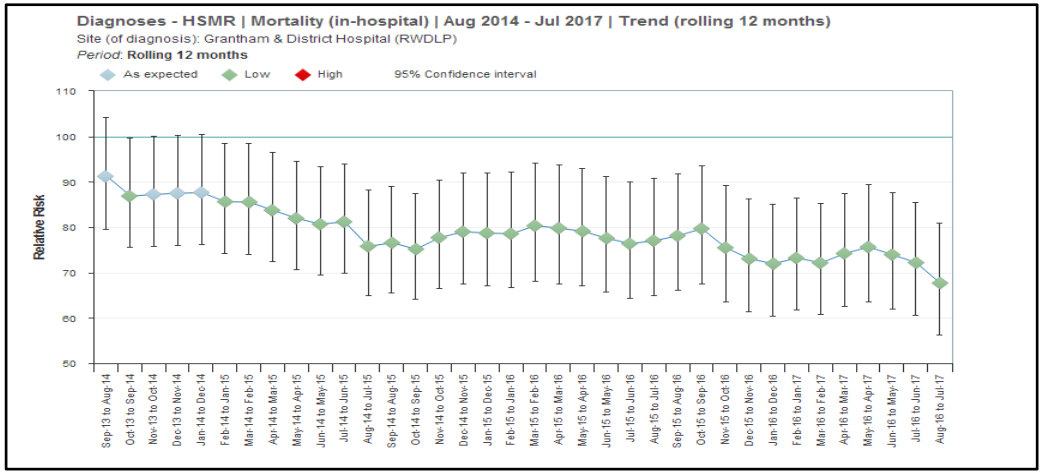
Lincoln HSMR Rolling Year (36 Months)



Pilgrim HSMR Rolling Year (36 Months)

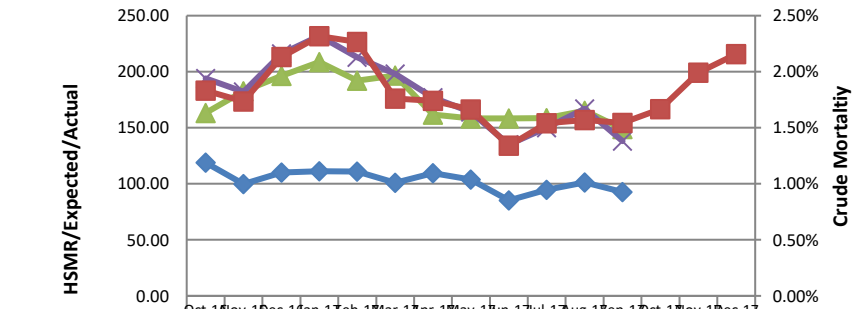


Grantham HSMR Rolling Year (36 Months)



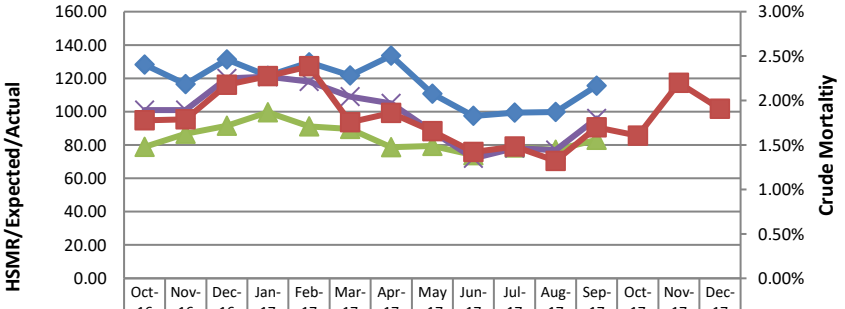
Monthly Mortality Comparison Trend Charts

Trust Mortality Comparison Chart

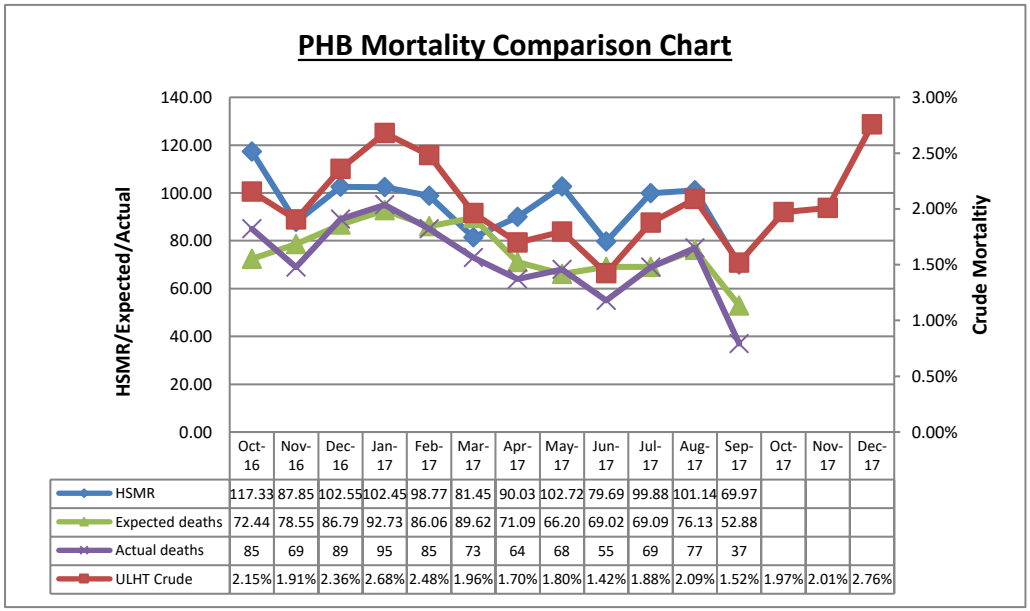


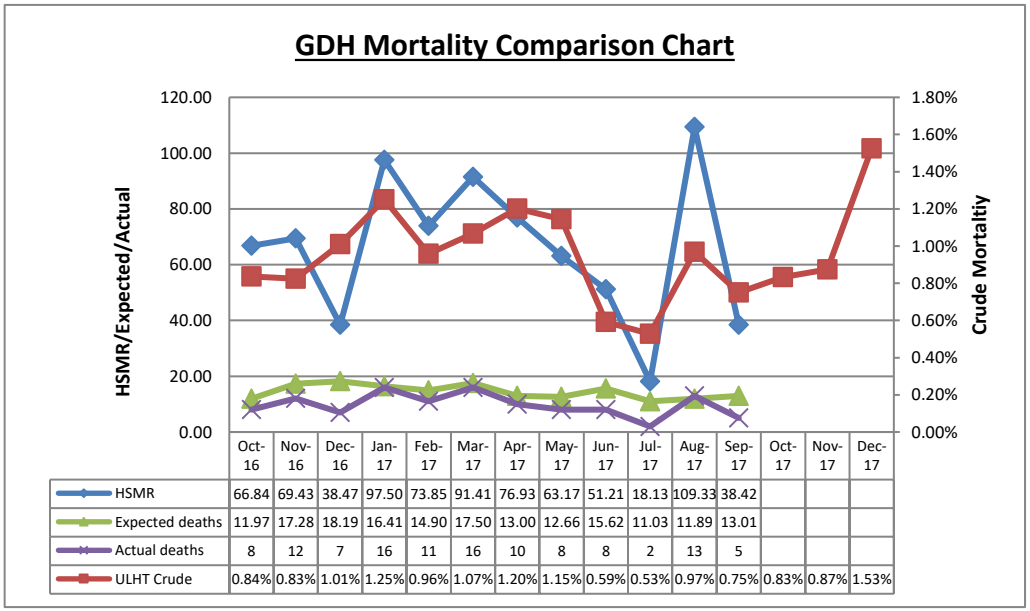
	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
HSMR	118.8	99.69	110.0	111.2	110.9	100.7	109.4	103.6	85.20	94.57	101.1	92.66			
Expected deaths	163.2	182.5	196.3	208.6	191.9	196.4	161.7	158.2	158.4	158.6	165.1	148.9			
Actual deaths	194	182	216	232	213	198	177	164	135	150	167	138			
ULHT Crude	1.83%	1.74%	2.13%	2.32%	2.27%	1.76%	1.74%	1.66%	1.34%	1.54%	1.57%	1.54%	1.67%	1.99%	2.16%

LCH Mortality Comparison Chart



	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
HSMR	128.1	116.4	131.2	121.4	129.5	121.5	133.5	110.8	97.39	99.43	99.72	115.6			
Expected deaths	78.79	86.73	91.45	99.63	91.06	89.65	78.60	79.42	73.93	78.45	77.22	83.05			
Actual deaths	101	101	120	121	118	109	105	88	72	78	77	96			
ULHT Crude	1.78%	1.79%	2.18%	2.28%	2.38%	1.76%	1.86%	1.66%	1.42%	1.48%	1.32%	1.70%	1.60%	2.20%	1.91%





Palliative Care Audit December 2017

Audit Results

Lincoln Register

- 132 cases had been identified between April 2017 and August 2017 was registered as being seen by Palliative care specialist team.
- 50/132 (38%) of these cases were not on Dr Foster patient list.
- 23/50 cases notes were not received for Audit; 11/23 not received were checked against Medway and had been coded as Palliative care in Dr Foster.
- 8/27 (30%) cases there was evidence of Palliative Care within the notes but was not coded in Medway- These have since been coded by Lincoln Coding team. 2 cases were handwritten and 6 cases there was evidence of the yellow sticker.
- 19/27 (70%) cases have been sent to information support to check the SUS submission, as these had been coded in Medway but not reflected within Dr Foster data.

Pilgrim Register

- 62 cases had been registered as seen by the Specialist care team at Pilgrim Hospital between April 2017 and May 2017 (Register from Palliative Care not up to date).
- 23/62 (37%) of these cases were not on Dr Foster patient list.
- 7/23 cases were not received for audit; 3/7 not received were checked against Medway and had been coded as Palliative Care in Dr Foster.
- 9/16 (56%) there was evidence of Palliative care within the notes but not coded on Medway-these have since been coded by pilgrim coding team. 5 were handwritten and 4 had yellow stickers.
- 6/16 (38%) have been sent to information support to check the SUS submission, as these had been coded in Medway but not reflected within Dr Foster data.

Grantham Register

- 60 cases had been registered as seen by the specialist care team between April 2017 and August 2017.
- 30/60 (50%) of these cases were not on Dr Foster patient list.
- 23/30 cases were not received for audit; 9/23 had been coded on Medway as palliative care.
- 2/7 (29%) there was evidence of palliative care within the notes but not coded on Medway- these have since been coded by the Grantham coding team. Both had yellow stickers within the notes.
- 5/7 (71%) have been sent to information support to check the SUS submission, as these had been coded in Medway but not reflected within Dr Foster data.

Action has been taken against those notes identified as Palliative care within the notes but not coded on Medway. This re-coding should be reflected within the next refresh of Dr Foster. The Quality Governance Team will continue to request the remaining notes outstanding for audit. Information support have looked into where the cases are coded in Medway but are not within the Dr Foster patient list. Information support have checked and some of the palliative care codes are within the second episode within the spell. Dr Foster has clarified that Palliative care coding is taken at any episode throughout the patients spell. Dr Foster's definition on the website it states:

"We currently adjust for the presence of palliative care episodes by including it in the risk adjustment model. If any episode in any of the spells in the super spell has treatment function code 315 or contains Z515 in any of the diagnosis fields, then it is defined as "Palliative", all others are termed "Non-palliative"

Alerts

ULHT

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

- **Other Perinatal Conditions:** Second month of alerting at Trust level, alerting on both PHB & LCH with 22 mortalities and 6.07 over the predicted Dr Foster data. 2 *meetings have been held and the process reviewed; issues found with the well-baby coding and depth of coding in conjunction with the form not being sent to the coders. This process is being reinforced by the W&C Risk team.*
- **Respiratory Failure insufficiency arrest (adult):** Second month alerting at Trust level. Driven by the Lincoln site; 40 mortalities with 25.19 over the predicted Dr Foster data. *A meeting has been arranged with the Respiratory Consultants to discuss mortality action on the 10th January 2018.*
- **Aortic peripheral and visceral artery aneurysms: S**econd month of alerting at Trust level. Driven by the Pilgrim site; 27 mortalities with 15.05 over the predicted Dr Foster data.
- **Biliary Tract Disease:** Alerting at Trust level, driven by the Lincoln Site with 32 mortalities over the expected 19.16. *And external review is being sourced by the Medical Director. Previously have had 2 in-depth investigations.*

SITE

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

Actions underway

- **Intestinal Obstruction without hernia:** This has been alerting for 8 months; to date there are 26 mortalities and 14.25 over the predicted within this diagnosis group. *An in-depth review has been completed with issues pertaining to the primary diagnosis coding and Palliative care coding. An action plan was agreed. The Associate Medical Director and Quality Governance have met with the palliative care team and work is underway to check coded data against Palliative care team log.*

- **Septicemia (except in labour):** This is a cumulative alert and not alerting in a particular month; year to date there are 133 mortalities and 104 over the predicted Dr Foster data. This is the fourth month alerting. There is a sepsis committee who meets monthly and has a detailed action plan to improve compliance of sepsis. Sepsis coding rule changed in April 2017. QG has completed an overview which was presented at July PSC. *Sepsis nurses completed a coding review and outputs were comorbidities not being documented which has now become part of the wider comorbidity work.*

- **Acute Cerebrovascular disease:** This is the fourth month of alerting with 109 observed and 85 mortalities over the predicted Dr Foster data. *Dr Foster Intelligence specialist and Quality Governance have met with the Stroke SSNAP audit Facilitator and QSO; The only notable difference between the data on the sites is the coding of patients been seen by the palliative care team-wider palliative care audit has been completed. Dr Foster still to meet with Clinician to discuss. SSNAP data has been correlated to Dr Foster data as on SSNAP ULHT are not an outlier. The results showed that SSNAP focuses on 6 main comorbidities therefore the data was not comparable. The SSNAP data coordinators will also check for all co-morbidities.*

- **Other Gastrointestinal disorders:** Alerting at site level for the second month with 20 mortalities over the predicted Dr Foster data of 8.46.

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

- **COPD and bronchiectasis:** This is the third month on alerting with 49 mortalities and 31.73 over the predicted Dr Foster data.-

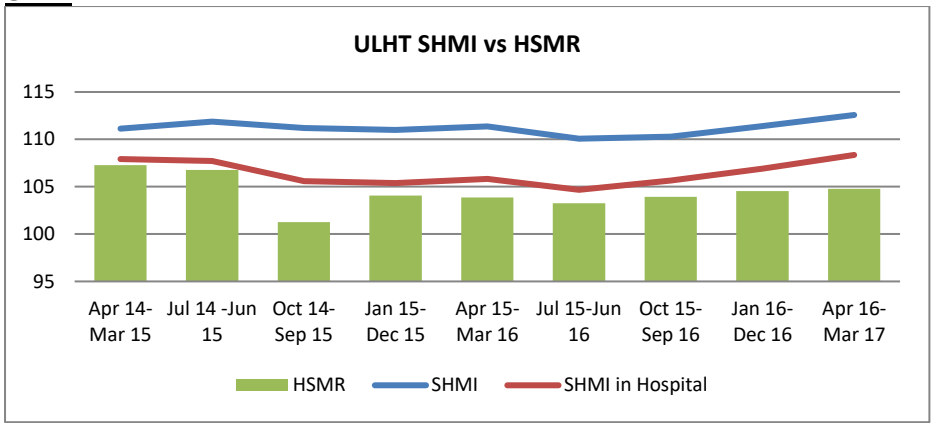
- **Peritonitis and intestinal abscess:** This is the third month of alerting with 7 mortalities and 2.59 over the predicted Dr Foster data.-

Grantham Hospital
No notifications

National Comparison

Metric	Oct 16-Sep 17	
	National Acute (Non specialist)	ULHT
HSMR	97.40	103.62
Elective Crude Rate %	0.10%	0.10%
Non elective Crude Rate %	6.40%	7.40%
% observed mortalities in hospital	3.53%	3.93%
% observed palliative coding	43.45%	31.45%
Avg comorb 0 score per observed %	1.19%	1.43%
Weekend % of observed	5.89%	7.08%
Weekday % of observed	3.09%	3.41%
Crude rate %	3.60%	3.90%
Spells Readmissions 28 days %	11.51%	10.66%
Residual Coding % of spells (Signs & Symptoms)	1.85%	1.55%
LOS short stay 0-2 days Observed %	1.01%	1.29%
LOS 3+ Observed %	7.69%	8.16%

SHMI



- Trust SHMI is Trust SHMI is currently outside of expected limits and is within Band 1 on the published NHS Digital data for April 2016 to May 2017.
- Lincoln and Pilgrim site are currently higher than expected.
- The Lincolnshire Mortality Collaborative continues to meet and are currently reviewing deaths within 30 days of transfer to community hospitals;
- April 17-October 17, there were 84 transfers to LCHS hospitals.
    - 5/84 were transfers form Lincoln

- 79/84 were transfers from Pilgrim. 11/79 from PHB passed away within 24 hours of transfer. All cases under 12 hours are being reviewed for appropriate discharge.

Annual Mortality Review Compliance

	Annual Total	2740	1378	660	73%	231	11%	35	123
	Month of Death	Total No. of Deaths	Reviews Completed	With Consultant	% of Reviews Completed	Excluded	% Excluded	Deaths grade 2&3	MoRAG Escalation
Quarter 1 2017	Jan-17	291	220	41	84%	26	9%	3	21
	Feb-17	273	207	28	88%	30	11%	7	19
	Mar-17	252	173	46	79%	31	12%	5	19
Quarter 2 2017	Apr-17	217	141	29	83%	32	15%	3	10
	May-17	208	136	30	82%	23	11%	4	10
	Jun-17	182	111	39	74%	21	12%	2	7
Quarter 3 2017	Jul-17	204	121	46	72%	21	10%	5	14
	Aug-17	204	90	65	58%	25	12%	1	5
	Sep-17	194	102	53	66%	19	10%	5	13
Quarter 4 2017	Oct-17	223	66	105	39%	2	1%	0	5
	Nov-17	245	11	119	8%	1	0%	0	0
	Dec-17	247		59	0%		0%	0	0

Trust trajectory of 70% for completed reviews is being achieved. However there are some Clinicians that have more than 5 reviews outstanding over the deadline date. An escalation process has been put into place from January 2018. Where each Clinician with 5 or more outstanding reviews will have an escalation letter from the Associate Medical Director.
Excluded cases are those cases that are not within our "MUST DO's" criteria, but where QG have been awaiting notes for review and not received within 3 months to ensure timely review.

NOTE: December 17 are not included within the reviews completed percentage as all reviews sent deadlines have not yet passed.

Reviews Pending allocation
N=169 (6%)
% of total deaths

Reviews sent awaiting completion
N=660 (24%)
% of total deaths

Grade 2&3 possible preventable deaths
N=35 (1.28%)
% of total deaths

Reviews escalated to MoRAG
N=123 (8.9%)
% of reviews complete

Learning from Deaths Reporting-January 2017-October 2017

SI-Severity = Death
42

SI Mortality - Review completed
N=20 (48%)

Learning Disability Death
3

LeDeR Submission Completed
N=2 (66%)

Mental Health Deaths
223

Mental Health Review Complete
N=142 (64%)

NOTE: LeDeR submissions are only from October 2017

Mortality reduction actions

Mortality Review	Source	Review Commenced	Site	Actions	Lead	Timescale	Progress	RAG
Clinical Coding Masterclass	On-going	Underway	All	To arrange the next Clinical Coding Masterclass. To incorporate Live Clinical Coding, Dr Foster Data, Finance and Mortality	Dr Andrews/ Karen Moon	On-going	**QG have asked both information and commissioning to become part of the masterclass and they have agreed. Dates to be booked and agreed for next year.**	
Junior Doctor Teaching	On-going	Underway	All	JD Teaching across each site	Quality Governance	On-going	All JD teaching has been completed, feedback was to get the training earlier and this is to become part of the induction.	
Audit of Palliative care coding not coded on Dr Foster	Mortality Report	Underway	Trust	Through analysis and in-depth reviews it has been highlighted the ULHT are below the national average of palliative care coding, which highly affects the HSMR	Karen Moon	On-going	Palliative Care Team have submitted figures of those that the team have seen. QG has correlated this with Dr Foster coded data. An audit is to be undertaken by Coding and Quality Governance to ascertain why there is a difference in coding -Particulary on the LCH site.	
Acute Cerebrovascular disease	Dr Foster	Underway	LCH	Meeting to be arranged to understand the underlying data. QG have produced an overview of the Dr Foster data in the October Mortality Report this has been shared with the QSO for Stroke.	Derek Smith, Quality Governance & Stroke Team	On-going	Meeting been held with Stroke audit coordinator and QSO She is looking at the Dr Foster data in comparison to SNNAP data. Data has been analysed but as SNNAP looks at different datasets this was deemed not comparable. **Dr Foster to meet to Dr Elmarimi to discuss further aciton plan.**	
Comorbidity Action Plan	Trust	Underway	Trust	Action plan to be agreed to raise awareness.	Karen Moon	On-going	Comorbidity Focus month and audit is underway and results to PSC in February 2018.	
Other Perinatal coditions	Dr Foster	Underway	Trust	Meeting to take place with W&C governance, QG governance, Dr Foster and coding to agree action plan	Karen Moon		Meeting held and actions allocated. Jude Cheesmond looking at coding process. Actions as per email attached. Another progress meeting arranged 18/12/17- **Progress meeting held and issues found with the well-baby coding and depth of coding and the form reaching the coders for all well-babies that have not go to transitional or neonatal care. This process is being reinforced by the W&C Risk team.**	
British Thorarcic Society	On-going	Underway	All	Respiratory diagnosis have been reporting on Dr Foster outside of the conifidence intervals. BTS audits are on the Trust Audit programme and findings of the audits to be reported to PSC	Respiratory/ Sharon Sinha	Jan-18	To report findings to PSC	
Respiratory Failure, insufficiency, arrest (adult)	Dr Foster	Underway	Trust	A meeting with Dr Pogson, to discuss alert and NIV mortality	Karen Moon	Jan-18	Meeting has been booked for 10th January	
Medical Examiner	Trust	Underway	Trust	Funding 11 PA's for a Medical Examiner	Bernadine Gallen/ Dr Andrews	Apr-18	Business Case and Job Description has been produced will be going to ET in January 2018	
Engaging families	Trust	Underway	Trust	From national guidance ensuring that families are involved in the mortality process-reduction in complaints	QG/ Bereavement / PALS	Jan-18	Communication flow chart of process has been written by QG. Awaiting feedback from Bereavement centre and PALS.	
Biliary Tract Disease	Trust	Underway	Trust	Biliary Tract has had several internal reviews. The Medical Director has expedited an external review	Leicester Trust/ULHT	Mar-18	Medical Director has asked leicester for an external review-awaiting update.	

MoRAG overview

The Trust Mortality Review Assurance Group (MoRAG) was formed in February 2016. A multidisciplinary team that peer review mortality reviews completed by Clinicians, Serious Incidents and incident Reports involving mortality. Meeting on a monthly basis to discuss the cases reviewed and agree any actions or lessons learned.

Members include; Physicians, Surgeons, Nursing, CCG, GP and Quality Governance.

- 305 cases have been referred for review since February 2016.
- Referrals split by site are as follows:

Hospital at Discharge	Cases	% of Total cases referred
Grantham Hospital	3	0.98%
Lincoln County Hospital	181	59.34%
Pilgrim Hospital Boston	121	39.67%

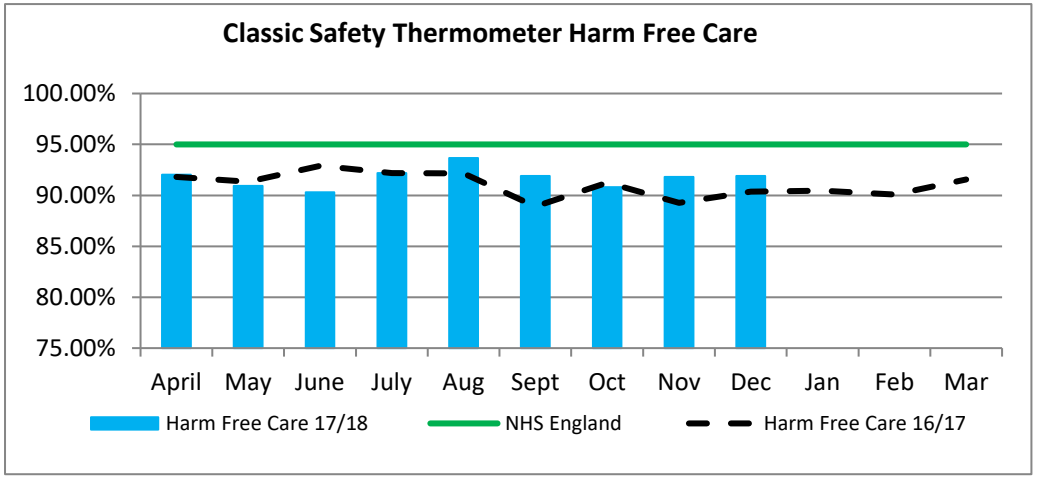
- 198/305 (65%) of cases have been completed.
- The group discuss and assess patients full care pathway and reassess initial grading. Since February 2016 89 grades have been changed this is as follows:

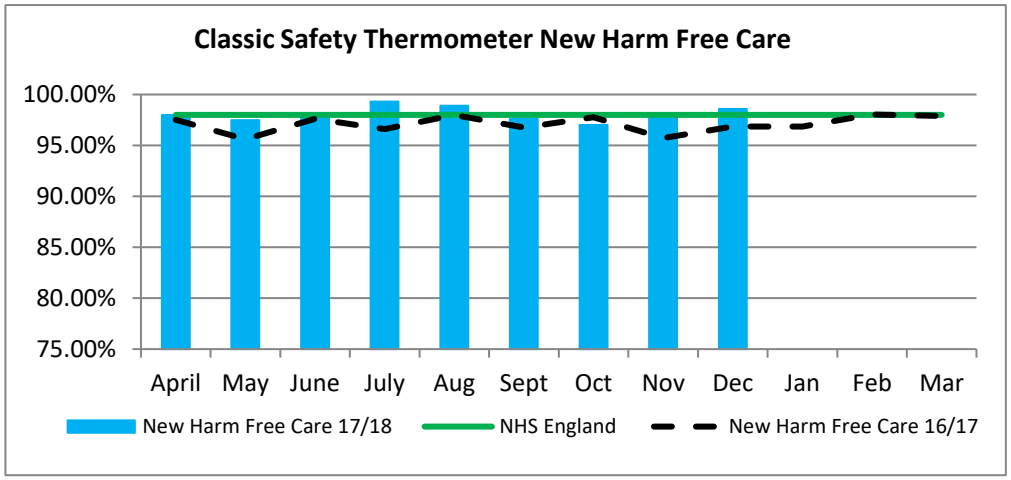
Reviews changed	Upgraded/downgraded	Grade from and to.
38	Downgraded	1-0
4	Downgraded	2-0
23	Downgraded	2-1
5	Downgraded	3-1
3	Downgraded	3-2
3	Upgraded	0-1
3	Upgraded	0-2
6	Upgraded	1-2
4	Upgraded	2-3

- 51 cases didn't have an original review grade or they were referred to MORAG via other means (SI/Complaints)
- 58 cases MoRAG agreed with the original grading.
- MoRAG through review have instigated 18 Incident review forms with 11 being identified as Serious Incidents.
- MoRAG case note briefings have been in circulation since July 2017-ideintifying cases of learning. These are sent through communications, to QSO's for speciality governance and to clinician's forums such as MAC. Areas of learning within the briefings are:
    - Respiratory failure and Oxygen prescribing.
    - Bleeding hazards of low molecular weight heparin.
    - Rhabdomyolysis caused by Statin/Macrolide interaction
    - SPONTANEOUS BACTERIAL PERITONITIS- EASILY MISSED
    - IMPORTANCE OF REPEAT SEPSIS SCREENING
    - THEMATIC CASES: Fluid Balance Management

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

Executive Responsibility: Michelle Rhodes – Director of Nursing





The Safety Thermometer is a point prevalence audit undertaken on all acute adult wards. Scores are divided into Harm Free (inclusive of community harms) and New Harm Free (ULHT Harms). The Harm Free score for December was 91.90% which is below the national target of 95%. New Harm Free was 98.57% which is above the national target of 98%

Performance Data Overview December 2017

	ULHT	GDH	LCH	PBH
Harm Free Care	**91.90%**	**88.42%**	**93.49%**	**90.79%**
New Harm Free Care	**98.57%**	**98.95%**	**98.37%**	**98.73%**
New Category 2	5	0	3	2
New Category 3	0	0	0	0
New Category 4	0	0	0	0
Low Harm	0	0	0	0
Moderate Harm	2	0	2	0
Severe Harm	1	0	0	1
Catheter & New UTI	3	1	1	1
New VTEs	1	0	1	0
Patients	840	95	430	315

Action Plan

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

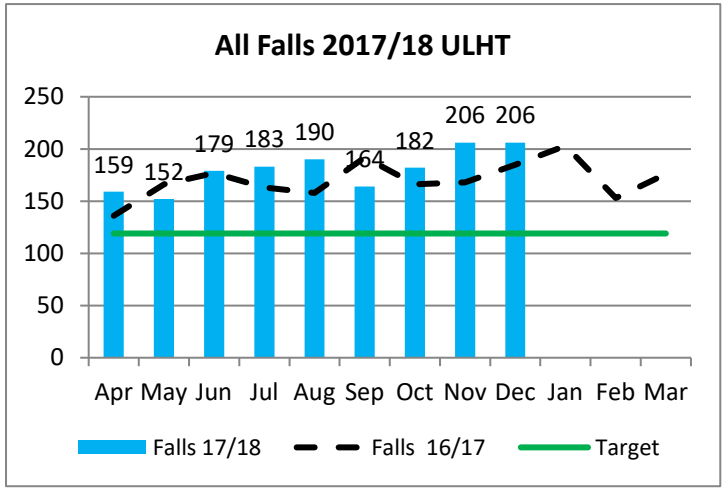
Fall actions outlined within Quality Report (see respective falls page). Results reported upwardly to Falls Reduction Group with delegated authority from Patient Safety Committee.

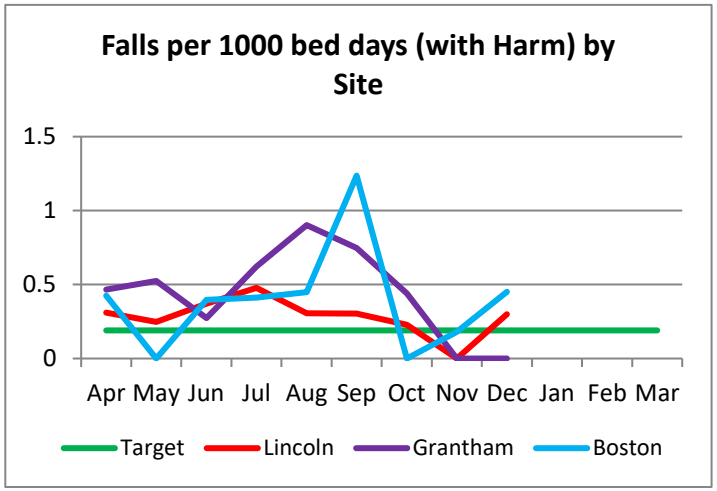
CA-UTI actions outlined within Quality Report (see respective CA-UTI page). . Results reported upwardly to Catheter Reduction Group with delegated authority from Patient Safety Committee.

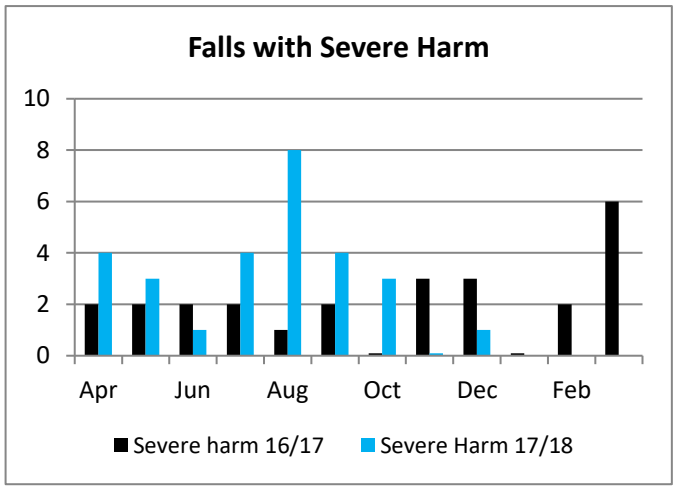
VTE investigated through Route Cause Analysis by VTE Nurse Manager and reported upwardly through Patient Safety Committee.

Safe Ambition 3: Reduction of Harm Associated with Falls

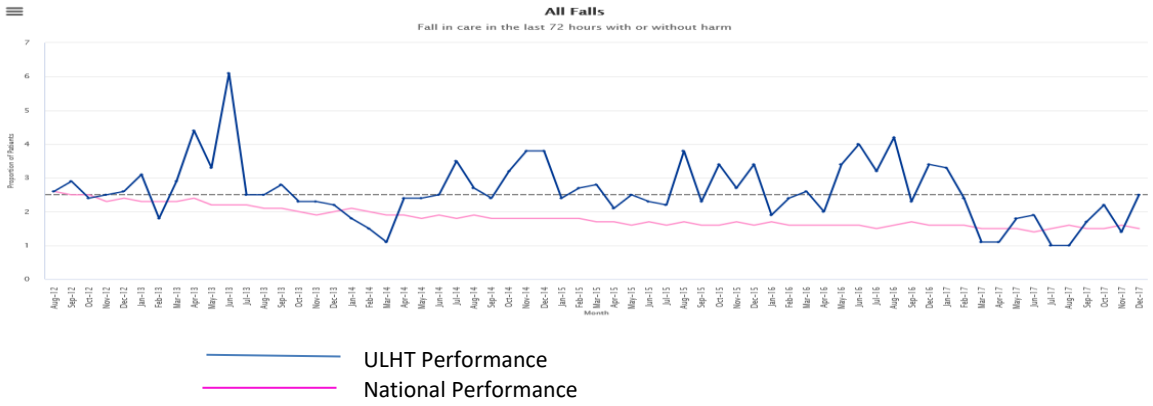
Executive Responsibility: Michelle Rhodes – Director of Nursing







Safety Thermometer 2017



Safety Quality Dashbaord (SQD) for Trust Falls Oct 2017- Dec 2017 (Grantham Only in December other sites participating in Comorbidity Audit)

Metric Title	Oct 2017	Nov 2017	Dec 2017
Number of patients at risk of falls	313	338	28
Medication review occurred	83.30%	100.00%	-
Actions completed within 4 hours	91.70%	94.10%	89.30%
Neuro Cognition assessed	97.80%	98.20%	100.00%
Actions completed within 24 hours on admission	65.00%	69.50%	71.40%
Patient vision assessed	97.40%	97.30%	100.00%
Bed rail assessment completed if required	99.40%	99.40%	100.00%
Continence/toilet regime documented care plan 4	84.20%	87.80%	100.00%
Care plan 7 activated	94.50%	96.10%	96.90%
Lying & Standing BP Completed	67.60%	74.20%	75.00%

Performance Data Overview December 2017

Safety Thermometer data shows ULHT average of falls (all falls) for December 2017 is 2.5% and is above the national average of falls which is 1.5%.

Dec-17	Trust	Lincoln	Pilgrim	Grantham
Ward Falls per 1000 bed days	6.68	5.65	8.33	5.98
Ward Falls with harm per 1000 bed days	0.32	0.30	0.45	0

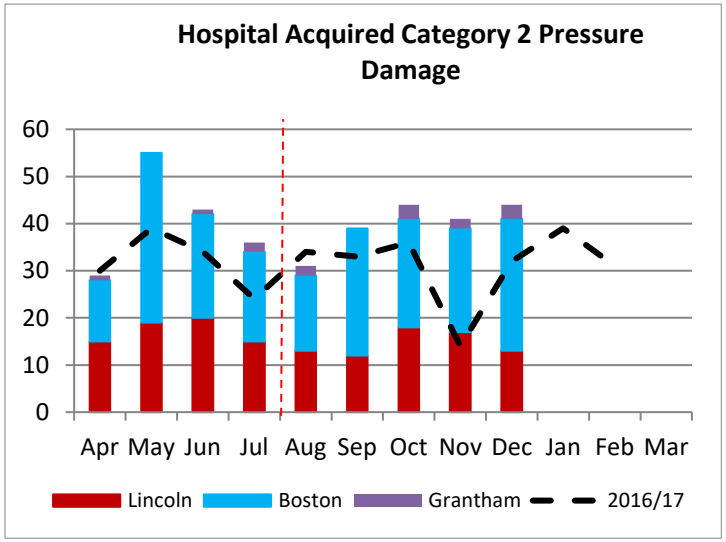
The Trust performance for all falls per 1000 OBDs is above the national average of 6.63 for the number of inpatient falls in acute hospital settings, ULHT is also above the Trust's stretch trajectory of 3.9 falls per 1000 OBDs. Falls with harm per 1000 bed days for the Trust is 0.32 which is above the national average of 0.19.

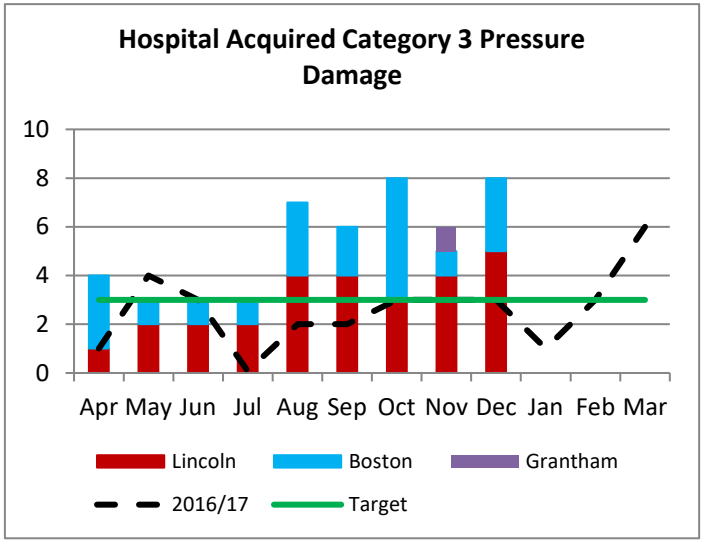
Action Plan

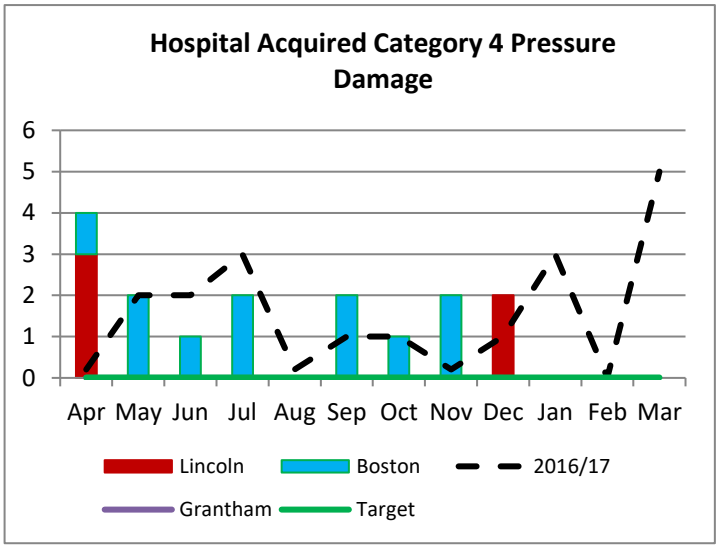
- Priority for all staff to complete the falls workbook and lying & standing BP training
- 'Call don't fall' posters awaiting print
- Falls prevention leaflet drafted
- Post fall rapid review template being developed to support post fall safety huddle
- Continued roll out of interventions from NHSi work
- Review how lessons learnt are shared and embedded into practice (link with Trust wide work)
- Identify Link Ambassadors in all clinical areas
- Development and publication of eLearning package to compliment falls workbook (content developed)
- Review of falls that have occurred in last 24 hours at 'ward huddles' and on Golden Hour visits
- Development of site based falls groups for Ward Ambassadors to feed into Trust Falls Group

Safe Ambition 4: Reduction of Harm Associated with Pressure Ulcers

Executive Responsibility: Michelle Rhodes – Director of Nursing

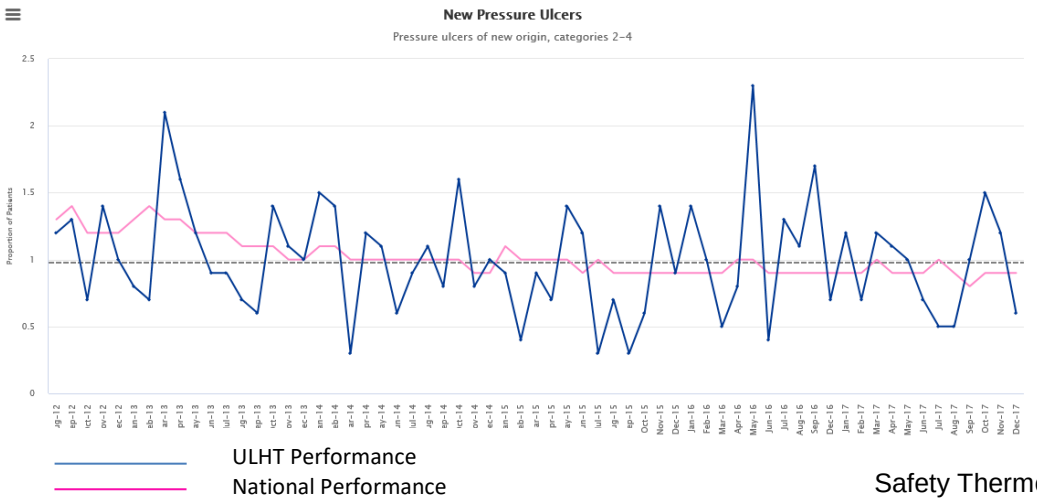






Reporting function changed to Datix August 2017

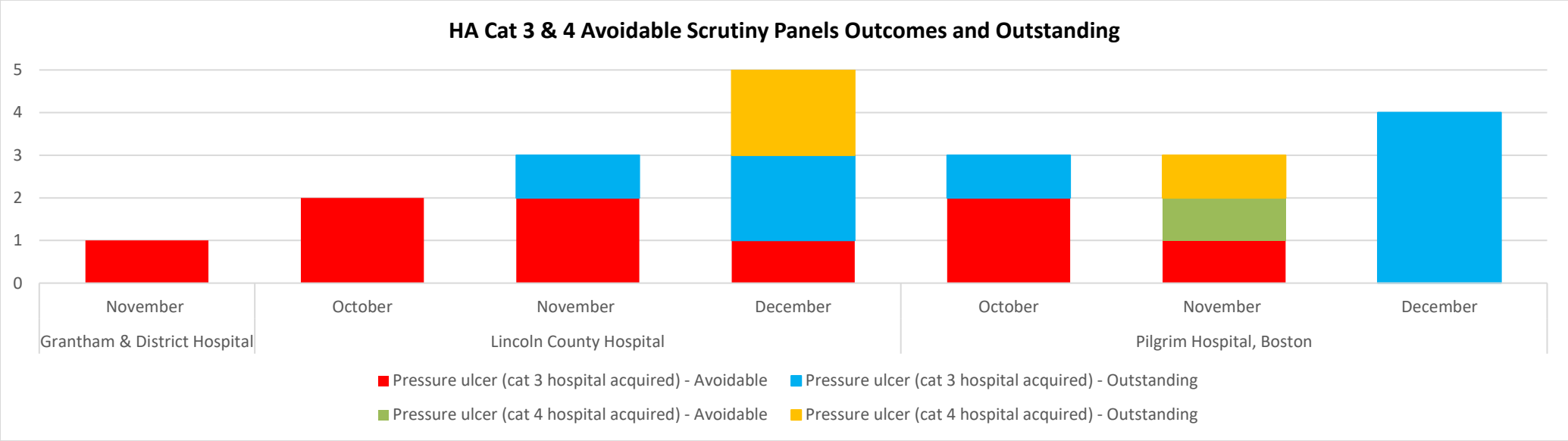
Safety Thermometer 2017



Safety Quality Dashbaord (SQD) for Trust Pressure Ulcers Oct 2017- Dec 2017 (Grantham only in December other sites participating in Comorbidity Audit)

Metric Title	Oct 2017	Nov 2017	Dec 2017
Pressure area risk assessment completed <4hrs	97.10%	99.30%	89.20%
Pressure area risk assessment updated weekly	78.90%	78.10%	87.00%
Pressure-relieving equipment in situ if required	95.60%	96.90%	100.00%
Frequency of repositioning documented	92.80%	91.60%	92.00%
Prescribed frequency of turning has been followed	87.70%	86.90%	95.80%
Pressure area care plan activated if required	91.40%	89.80%	96.00%

Safety Thermometer data shows ULHT average of pressure ulcers (new) for December 2017 is 0.6% and is below the national average of Pressure Ulcers (new) which is 0.9%.



Performance Data Overview December 2017

Site	Cat 1	Cat 2	Cat 3	Cat 4
Lincoln	2	13	5	2
Grantham	1	3	0	0
Boston	7	28	3	0
Louth	0	0	0	0

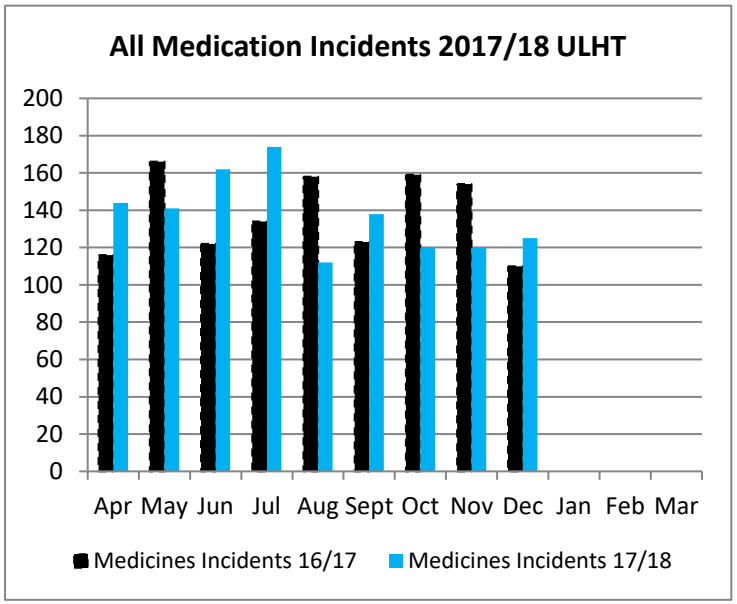
There was an increase in the total number of pressure ulcers reported in December (64) compared to November (60). 2 category 4 PUs and 8 category 3 PUs were reported in December compared to 2 cat 4 PU and 6 category 3 PUs in November. Scrutiny panels are pending to determine avoidability.
Lincoln has seen an increase in category 3 & 4 pressure ulcers in December (5 category 3 PUs reported compared to 4 in November and 2 category 4 PUs compared to 0 in November). Both Grantham and Pilgrim sites have seen a reduction in severity of harm in December.

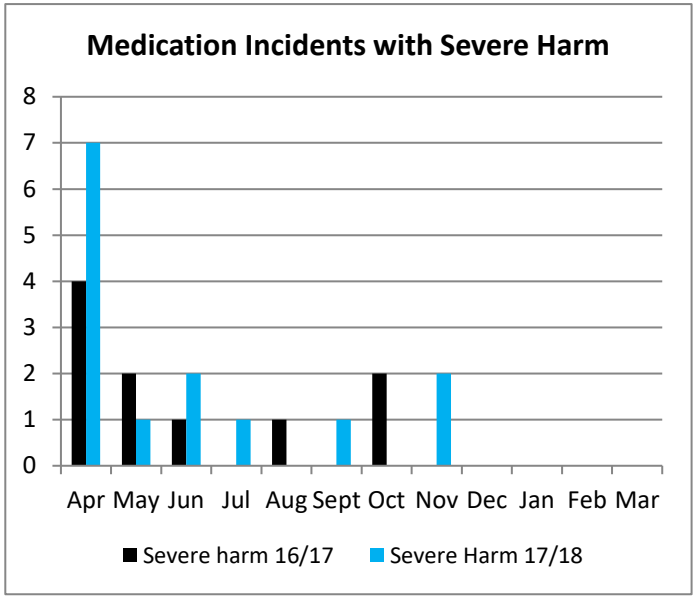
Action Plan

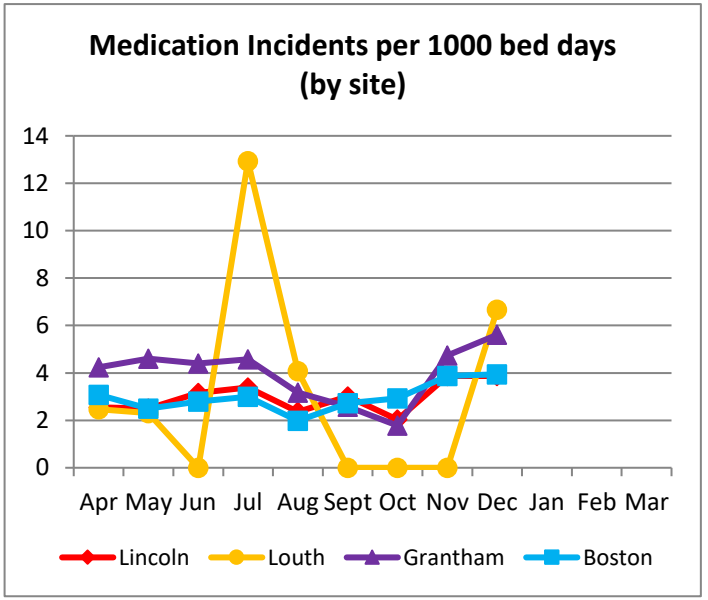
- The TVN team will be spending more time in the clinical areas to support staff and promote pressure ulcer prevention
- Targeted work by TVNs continues with ward teams where cat 3&4 PUs continue to be reported
- Pressure ulcer prevention meetings re-established on the Lincoln & Pilgrim sites
- Category 2 PU investigations to be reviewed at site meetings
- PDSA PU prevention project to commence on the Pilgrim site
- TVNs working with Quality Matrons to develop ward ambassador roles and responsibilities

Safe Ambition 5: Reduction of Harm Medication Incidents

Executive Responsibility: Michelle Rhodes – Director of Nursing







Incident reporting is indicative of reporting culture and not patient harm contrary to other per 1000 bed day measures

Safety Quality Dashbaord (SQD) for Trust Medications Oct 2017- Dec 2017 (Grantham only in December other sites participating in Comorbidity Audit)

Metric Title	Oct-2017	Nov 2017	Dec 2017
Medicine chart demographics correct	98.90%	98.10%	100.00%
Allergies documented	99.40%	98.90%	100.00%
All medicines administered on time	84.90%	83.60%	88.20%
Allergy nameband in place if required	92.10%	88.10%	94.10%
Identification namebands in situ	99.50%	96.60%	100.00%

Controlled Drugs Audit for Trust by Quarter

Metric Title	Q1	Q2	Q3
Trust	67.5%	77%	66.88%
Lincoln County Hospital	63%	69%	45.65%
Pilgrim Hospital	56.50%	76%	82%
Grantham Hospital	83.50%	93%	73%

Benchmark 100%

Performance Data Overview December 2017

There were zero reported severe incidents in December 2017.

Controlled drugs audits show a reduced compliance at LCH and GDH.

Adverse Event Type	Number	Percentage
Missed dose	46	33%
Prescribing error	12	9%
IV medication	10	7%
Controlled Drugs	7	5%
IV fluids	7	5%
Duplicated dose	7	5%

The 41% (58/140) of all the events recorded were associated with high risk drugs. The top 4 drug groups are;

Antimicrobials	35%
Anticoagulant	26%
Opiate	24%
Insulin	6%

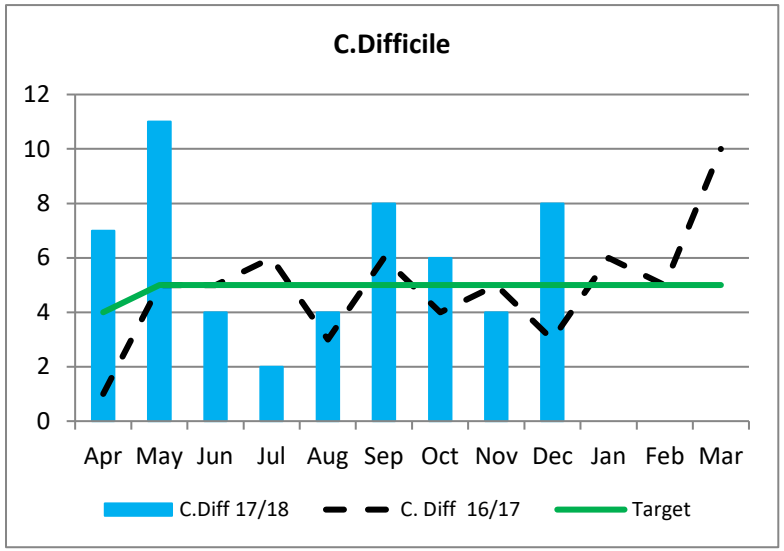
Action Plan

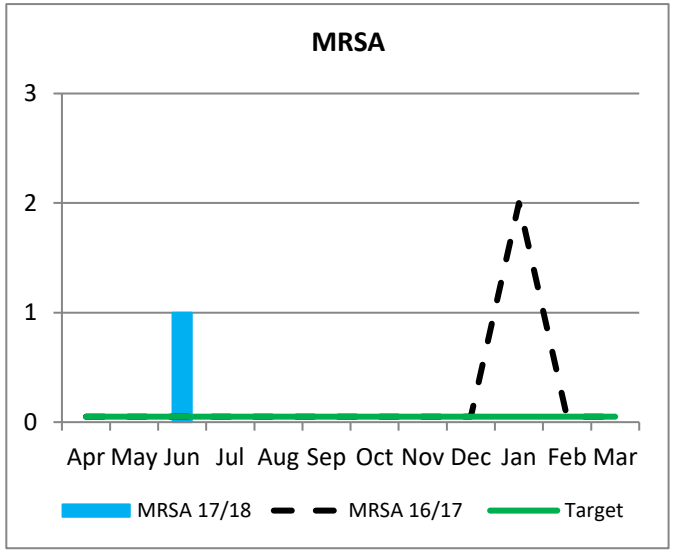
This report is reviewed at the Medicine Optimisation and Safety Committee (MOPS) and all incidents are reviewed on a monthly basis to identify trends. All Heads of Nursing receive the errors by ward area and disseminate to their matrons who in turn disseminate to their ward leaders. These all must be looked into regardless of the severity rating. Feedback reports from the Heads of Nursing are required to provide assurance that investigations and discussions have taken place.

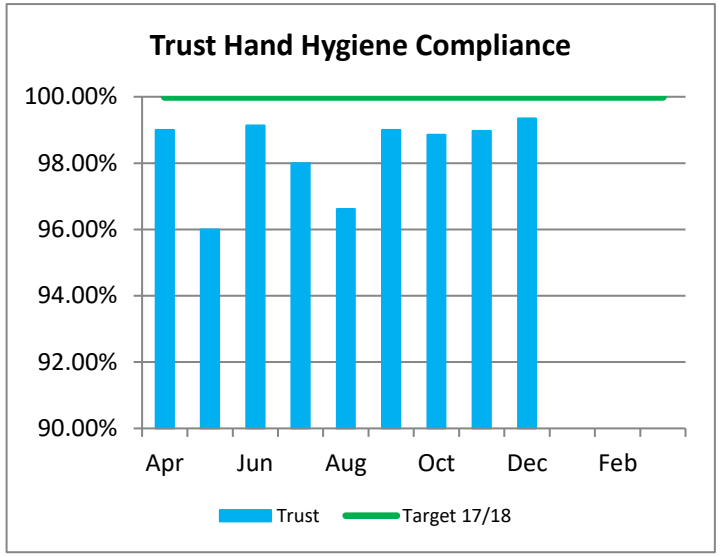
Representation at MOPS in respect of nursing and medical should improve from January 2018. For controlled drugs audits, action will be targeted at specific wards on each site to improve compliance.

Safe Ambition 6: Reduction of Harm Associated with Infection

Executive Responsibility: Michelle Rhodes – Director of Nursing







Performance Data Overview December 2017

Hand Hygiene	
Trust	99.35%
Grantham	99.88%
Lincoln	99.15%
Louth	100.00%
Pilgrim	99.24%

C-Diff Performance December 2017

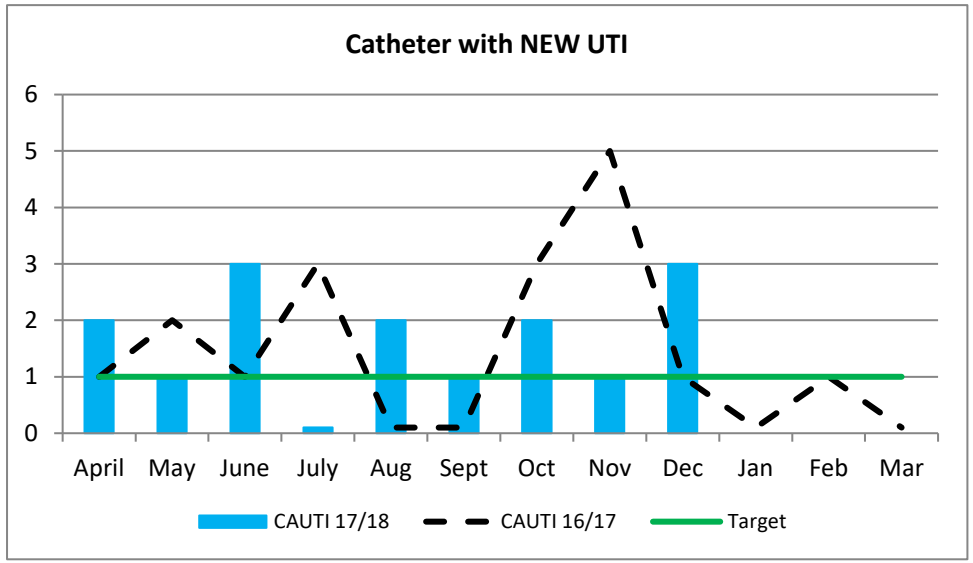
Acute Care Unit Grantham
Ward 2 Grantham
Burton Ward Lincoln
ICU Lincoln
Johnson Ward Lincoln
Stroke Unit Lincoln
Neustadt Welton Ward Lincoln
Ward 7B Boston (Ward 7B have had 6 confirmed C-Diff episodes in 2017/18)

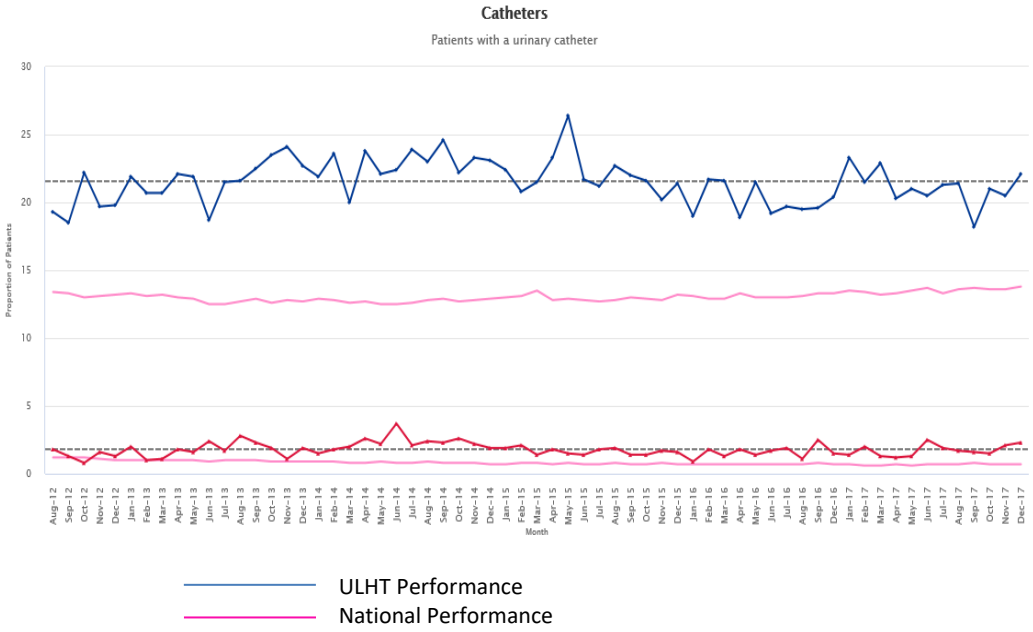
Action Plan

- *C.difficile* infection numbers remain over trajectory with current performance at 54/44 cases.
- As a trust we are working to support better cleanliness through both housekeeping and clinical staff to ensure that decontamination of hands, care equipment and environment are sufficient to prevent cross-contamination although hand hygiene performance is already very good.
- The IP&C team will be increasing time spent in clinical areas to further support colleagues and to promote hygiene initiatives for staff, patients and visitors.
- The IP&C team, IP&C Doctor and the Consultant Antimicrobial Pharmacist will continue to check appropriate antibiotic prescribing is taking place to further reduce the risks of both *C.difficile* and antibiotic resistance.
- The IP&C team is developing an IP&C service plan for 2018/19 that meets the needs of the trust both strategically and operationally. This plan will have prevention of avoidable healthcare associated infection as the core priority.

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

Executive Responsibility: Michelle Rhodes – Director of Nursing





Safety Quality Dashbaord (SQD) for Trust CAUTI Oct 2017- Dec 2017 (Grantham only in December other sites participating in Comorbidity Audit)

Metric Title	Oct 2017	Nov 2017	Dec 2017
Number of urinary catheters in-situ	87	86	8
Urinary catheter record demographics correct	90.70%	91.70%	100.00%
Urinary catheter record completed & signed daily	64.30%	59.80%	75.00%
TWOC occurred within 3 days for acute retention	60.00%	30.00%	-
Documented evidence why catheter needed	94.10%	88.00%	100.00%

Safety Thermometer data shows ULHT average of Catheters inserted for December 2017 is 22.1% and is above the national average which is 13.8%. Safety Thermometer data also shows ULHT average of Catheter with UTI (new) for November 2017 is 2.3% and is above the national average of which is 0.7%.

Performance Data Overview December 2017

	Metric Title	Oct 2017	Nov 2017	Dec 2017
Boston	Catheter record completed & signed daily	45.5%	37.5%	-
Grantham		100%	100%	75%
Lincoln		72.7%	64.7%	-
Boston	TWOC within 3 days for acute retention	40%	28.6%	-
Grantham		100%	-	-
Lincoln		66.7%	33.3%	-

Action Plan

Improving medical and nursing staff knowledge and raising awareness regarding CAUTI by reorganising Catheter Focus Sessions led by Continence Specialist Nurses with emphasis on appropriate insertion and TWOC and re-launching of Link Nurse/Ambassador Programme with representation from all clinical areas.

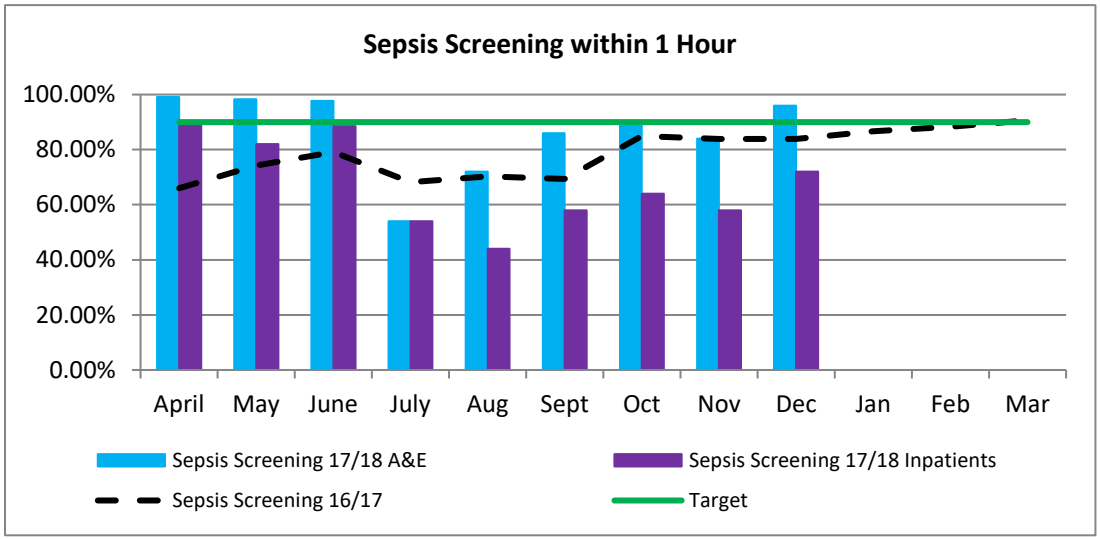
Development of e learning programme as a part of CAUTI educational programme.

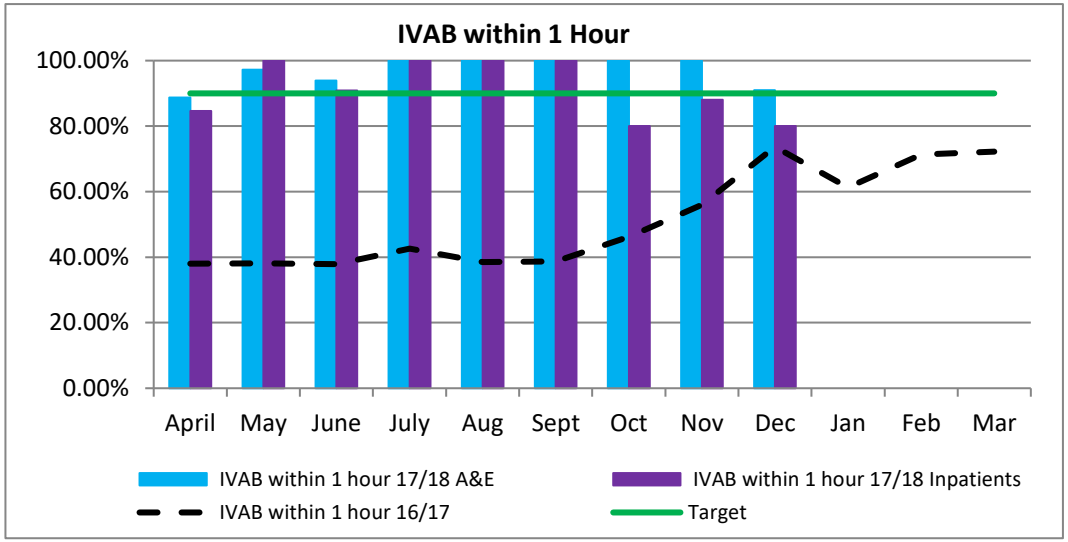
Catheter Performance data from SQD and Safety Thermometer to be presented each month at IPC meetings in order to identify areas with persistent low performance against the TRUST target of 90% achievement on the main elements of catheter care bundle.

Review of catheter care bundle to reiterate timely removal of catheters.

Safe Ambition 7: Reduction of Harm Associated with Deterioration Sepsis

Executive Responsibility: Michelle Rhodes – Director of Nursing





The above data represents the CQUIN submission. Sepsis data is collated from 150 patient records each month and validation is undertaken by the Sepsis Nurses.

Performance Data Overview December 2017

A&E Target 90%	Screening – Dec 2017	IVAB within 1 hour – Dec 2017
Trust	96% (84%)	91% (100%)
Inpts Target 90%	**Screening – Dec 2017**	**IVAB within 1 hour – Dec 2017**
Trust	72% (58%)	80% (88%)

E-Learning Sepsis 84.57% at 31st December 2017.

Action Plan

- All adult inpatient areas have either a Sepsis box or Sepsis Trolley – these will be audited from February
- Weekly missed Sepsis Screen reviews have commenced – individual accountability letters to be introduced (3 tier escalation system) to improve initial screening.
- Thematic review for non-compliance to be undertaken for all Sites
- Site Sepsis leads to be identified
- Staff non-compliant with Core Learning to be reminded of correlation between training requirement and progression through pay increments.
- Paediatric e-bundle to go live end of January 2018
- A&E Lincoln electronic observations and e-bundle predicted to go live by end of January 2018

Workforce Headline Summary – January 2018 data will not be available until 14th February 2018

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

Statistics

KPI	2017/18 Target	January 2018 Performance	Last Month Performance	Performance in January 2017	6th Month Trend
Vacancy Rate - Medical	Medical – 12%	**15.71%**	**15.61%**	**14.23%**	↑
Vacancy Rate – Registered Nurses	Registered Nursing 11.5%	**14.58%**	**13.91%**	**13.01%**	↓
Vacancy Rate – AHP's	10%	**10.01%**	**8.14%**	**9.96%**	↓
Voluntary Turnover	7%, with no group of staff more than 20% above the overall target	**5.77%**	**5.76%**	**n/a**	↑
Quarterly Engagement Index	10% improvement in average score during 2017/18	**3.3 (Sep'17)**	**3.4 (Jun'17)**	**n/a**	↓
Quality of Leadership/Management Index	10% improvement in average score during 2017/18	**2.6 (Sep'17**	**2.8 (Jun'17)**	**n/a**	↓
Core Learning Completion	Overall target remains 95%.	**90.17%**	**90.63%**	**87.23%**	↓
Sickness Absence (12 month rolling average)	Overall target of 4.5% + no team over 25% above target	**4.81%**	**4.76%**	**4.73%**	↑
Appraisals - Medical	Medical – 95%	**95%**	**95%**	**86%**	↓
Appraisals – Non Medical	Non-medical – 85%	**80.59%**	**79.10%**	**67.20%**	↓
Agency Spend	£25.4m (£)	**£2.462m**	**£2.124m**	**£2.784m**	↑

Commentary

The Medical Workforce appraisal rate for the month ending January 2018 again remains at 95%. Only once in the in the last eight months has the Trust target not been achieved.

The core learning compliance rate has fallen by 0.46% this month owing to the inclusion of Major Incident Awareness into overall compliance rates at the end of its 6 month introductory period. This shows a positive achievement as compliance still remains over 90%. Excluding Major Incident Awareness, compliance would have risen to 90.77% despite continued winter pressures.

Non-Medical appraisal again moves in an upward trend, however more work needs to be done to get it back on track (2% down from performance in July). Further communication has taken place with Team Leaders to ensure timely recording of appraisals on ESR. We have longer term plans to review our approach to individual performance management and to set new core learning targets and this work is underway.

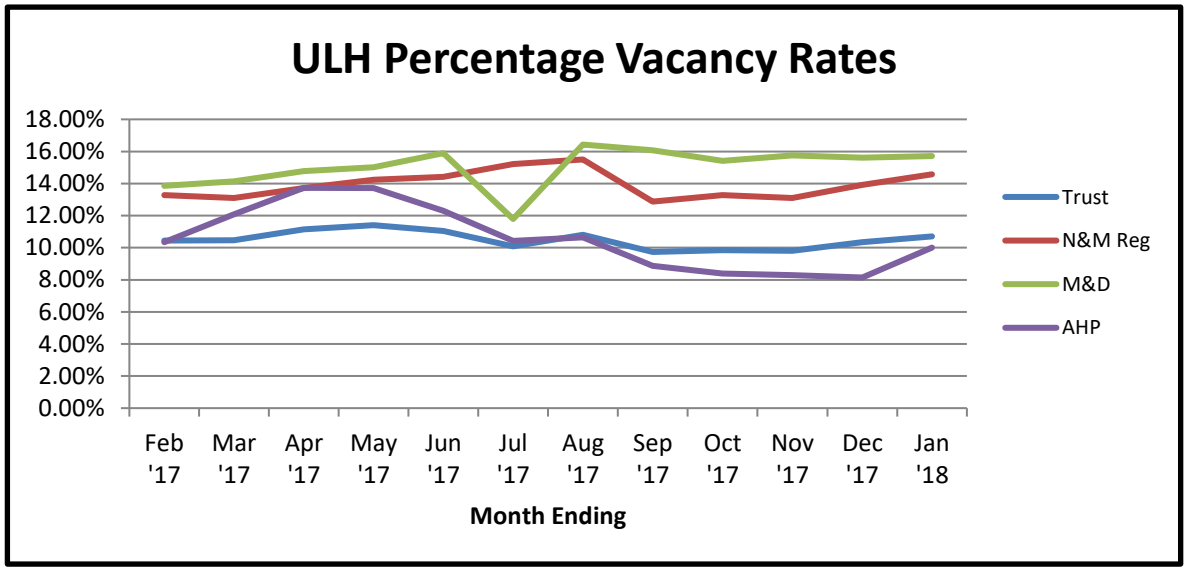
The National Staff Survey is now complete. The response rate is 45% which is significantly higher than last year (39%) and in line with the national average. Results are now embargoed for external release until 6th March 2018.

The overall vacancy rate increased slightly in January by 0.36%. Medical and Dental vacancy rate has increased slightly by 0.10%, AHP vacancy rate has increase by 1.87% and Registered Nursing & Midwifery vacancy has increased by 0.67%.

KPI:	Vacancy rates	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Deputy Director of HR & OD
Date:	9th February 2018	Reporting Period:	January 2018
Target:	Medical – 12% Registered Nursing – 11.5% AHPs – 10%	Tolerances:	Within 1% - Amber Above 1% - Red
RAG Rating:	Medical 15.71%		
RAG Rating:	N&M 14.58%		
RAG Rating:	AHP's 10.01%		

Analysis

Vacancy rates for the three measured occupational groupings are above target as at the end of January. However, the Trust employs more Consultants, Middle Grade doctors, Allied Health Professionals and Non-Registered Nurses than it did at the corresponding time 12 months ago. Registered Nurses & Midwives have reduced by 27.76 wtes in the 12 months and 34.98 wtes in the two months since November 2017. This is now the third time in four months that the Trust has had less Nurses than the corresponding period 12 months ago. This is largely down to the decision to pause using recruitment agencies to help to find registered Nurses to come and work for the Trust, a decision taken in an effort to control in year spending. Happily this decision has now been relaxed and this should have a positive effective on the number of Nurses coming into the Trust over the next six to nine months.



A further breakdown of data shows that vacancies for Consultants (11.67%) and non-registered Nurses (9.37%) are within the Trust target. The overall Trust vacancy rate for January is 10.71% which is a slight increase compared to 10.48% rate in January 2017.

At the time of writing, the Trust has made offers to 6 Consultants, 42 middle grade doctors, 16.8 doctors to cover training posts, 28.92 registered Nurses, 13 AHPs and 4.82 non-registered nurses, and we are hopeful these will join the Trust over the coming months.

Establishment Nursing, Medical and AHPs

	Jan 17	Jan 18
Establishment (registered nurses and midwives)	2266.80	2276.00
Number in post (registered nurses and midwives)	**1971.96**	**1944.20**
% Vacancy Rate (registered nurses and midwives)	13.01%	14.58%
Establishment (non- registered nurses and midwives)	971.30	950.97
Number in post (non-registered nurses and midwives)	**829.56**	**861.91**
Vacancy rate (non-registered nurses and midwives)	14.59%	9.37%
Establishment (AHPs)	394.25	405.93
Number in post (AHPs)	**354.98**	**365.30**
Vacancy Rate (AHPs)	9.96%	10.01%
Establishment (consultants)	355.16	357.09
Number in post (consultants)	**313.27**	**315.43**
% Vacancy Rate (consultants)	11.79%	11.67%
Establishment (middle grades)	199.57	212.37
Number in post (middle grades)	**161.80**	**172.98**
Vacancy rate (middle Grades)	18.92%	18.55%

Action Taken	**Action Planned**
• Continued recruitment work. • Contract signed with TRAC systems for improved recruitment processing (implementation date 23rd April).	• Recruitment agencies can now be used to help us find permanent Nurses; • Continue to deliver on the Recruitment Plan initiatives.

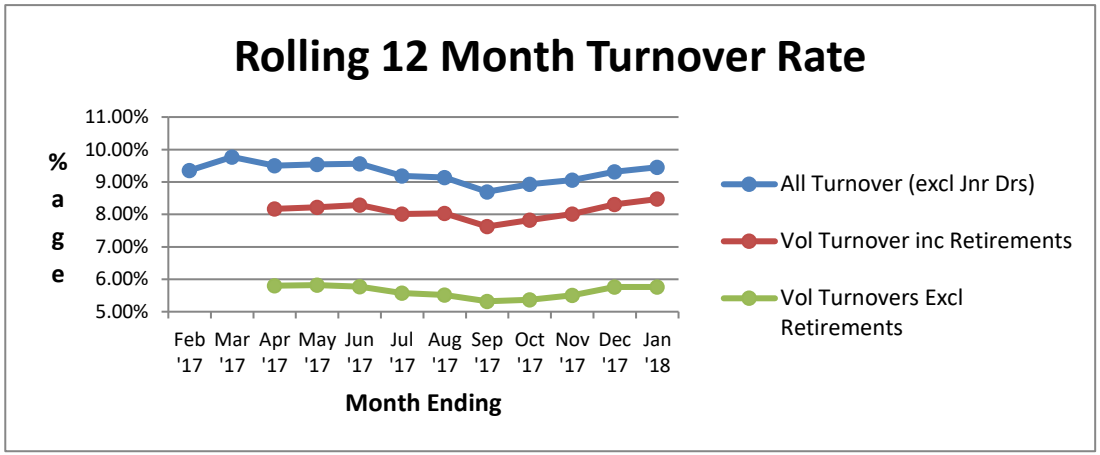
KPI:	Voluntary Turnover	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Deputy Director of HR
Date:	9th February 2018	Reporting Period:	January 2018
Target:	7% (excl. retirements) with no group of staff more than 20% above the overall target	Tolerances:	Within 1% - Amber Above 1% - Red
RAG Rating:	5.77%		

Analysis

The Trust remains within its target for voluntary staff turnover.

The table below shows voluntary turnover by Staff Group over a rolling 12 months and compared to the same period 12 months previously. Turnover including retirements has remained fairly constant, however turnover excluding retirements has slightly reduced to 5.77% from 5.93%

Additional Professional Scientific & Technical and AHPs have turnover exceeding our locally set target of not being more than 20% above the target of 7% when we exclude retirements (10.31% and 10.41% accordingly). However both occupational groups have turnover less than 12 months ago, so the trend is moving in a positive direction.



	Voluntary Turnover including Retirements Jan '18	Voluntary Turnover excluding Retirements Jan '18	Voluntary Turnover including Retirements Jan '17	Voluntary Turnover excluding Retirements Jan '17	Increase / Decrease Voluntary Turnover Including Retirements compared to previous Year
Staff Group	%age	%age	%age	%age	%age
Add Prof Scientific and Technic	12.55%	10.31%	13.96%	11.65%	-1.41%
Additional Clinical Services	7.03%	5.07%	5.98%	4.07%	1.05%
Administrative and Clerical	8.44%	6.19%	8.28%	6.02%	0.15%
Allied Health Professionals	11.48%	10.41%	14.36%	12.41%	-2.88%
Estates and Ancillary	7.87%	4.51%	7.41%	4.18%	0.45%
Healthcare Scientists	13.50%	7.27%	7.37%	2.86%	6.13%
Medical and Dental	11.84%	8.19%	10.95%	6.53%	0.89%
Nursing and Midwifery Reg	7.62%	4.44%	8.14%	5.72%	-0.52%
Students	0.00%	0.00%	7.01%	7.01%	-7.01%
Total	**8.47%**	**5.77%**	**8.45%**	**5.93%**	**0.02%**

Based on the latest (November 2017) benchmarking data available (x37 Trusts) from NHS Digital for other Large Acute (Non-Teaching) Hospitals.

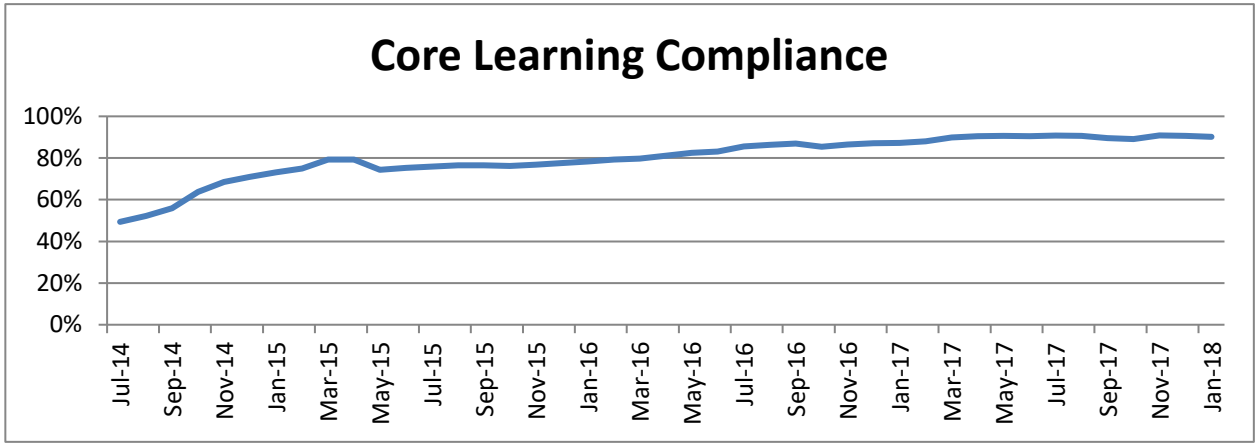
- The current Trust turnover rate (excl. junior doctors) of 9.45% is below the average of 10.12%
- The current Trust Nursing & Midwifery (Registered) turnover rate of 7.97% is below the average of 10.65%,
- The current Trust AHP turnover rate of 11.57% is below the average of 11.29%.

Action Taken	**Action Planned**
• Focus on flexible working – policy being reviewed to support flexible working for people potentially retiring but who wish to remain at work	• Work underway around the development offer for both nursing and medical staff • Review of benefits underway – focus on extending benefits offer, reflecting on it from an age differentiation perspective and how we promote our offer; • Survey of nursing staff who have stayed and left the Trust; • All potential retirees to be contacted and asked about their intentions and what the Trust could do to help them stay;

KPI:	Core Learning Completion	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Head of OD
Date:	12 February 2018	Reporting Period:	January 2018
Target:	Revised targets have been set and will form the basis of the performance report in 2018/19	Tolerances:	
RAG Rating:	90.17%		

Analysis

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



The core learning compliance rate has fallen by 0.46% owing to the inclusion of Major Incident Awareness into overall compliance rates at the end of its 6 month introductory period. This shows a positive achievement as compliance still remains over 90%. Excluding Major Incident Awareness, compliance would have risen to 90.77% despite continued winter pressures.

We will continue to manage compliance strongly and setting aside a period of time duirng which we would expect all staff to be compliant. We are also in the process of reviewing the components of core learning and how we can present both core learning and core learning plus in a more coherent way to improve compliance.

We have agreed new targets for each module and these will become the measure for this KPI in 2018/19.

This month the focus is on Major Incident Awareness which has just been introduced in to overall compliance rates. It became a core learning topic on 1st August 2017 with an intoductory period of 6 months to allow departments time to gain compliance before intoducing into their figures. The uptake has been good from gaining 38% compliance at the end of the first month to 82.93% at the end of January. However there is still a little way to go before reaching the 90% target.

Managers have been reminded of their responsibilities to fully implement the Pay Progression Policy in relation to ensuring that all staff have completed their core learning as a condition of achieving their incrementatal pay progression.

Directorate Compliance – Major Incident Awareness:

Directorate	Jan-18
Deputy Chief Executive	99.23%
Director of Fin & Corp Affair	94.92%
Chief Executive	92.86%
Clinical Support Services	92.03%
TACC Lincoln	90.29%
Grantham	88.40%
Women & Childrens Pan Trust	87.80%
Medical Director	87.13%
Director of HR & Org Dev	85.19%
Director of Nursing	84.34%
Chief Operating Officer	83.78%
Head & Neck Trustwide	83.33%
Haem & Onc Trustwide	82.49%
TACC Boston	80.50%
Orthopaedics Boston	80.36%
Acute Medicine Lincoln	78.39%
Trustwide Cardiology Services	75.46%
Director of Estates & Facil	73.15%
Gen Surg Linc & Urology Trust	72.84%
Orthopaedics Lincoln	71.88%
Acute Medicine Boston	71.87%
General Surgery Boston	70.83%
A&E Lincoln	63.12%

Directorate Performance – Major Incident Awareness:

Directorate Top Improvers	Jan-18	Dec-17	Variance
Orthopaedics Boston	80.36%	70.80%	9.56%
Director of Nursing	84.34%	75.29%	9.04%
Chief Operating Officer	83.78%	76.32%	7.47%
Chief Executive	92.86%	85.71%	7.14%
TACC Boston	80.50%	74.91%	5.59%
Gen Surg Linc & Urology Trust	72.84%	67.41%	5.44%
Haem & Onc Trustwide	82.49%	77.52%	4.97%
Director of HR & Org Dev	85.19%	80.25%	4.94%
Head & Neck Trustwide	83.33%	78.52%	4.81%
Orthopaedics Lincoln	71.88%	67.69%	4.18%

Staff Group Performance – Major Incident Awareness:

Staff Group	Jan-18	Dec-17	Variance
Allied Health Professionals	93.85%	90.63%	3.21%
Add Prof Scientific and Technic	88.79%	87.56%	1.23%
Nursing and Midwifery Registered	86.61%	83.73%	2.88%
Healthcare Scientists	86.61%	85.45%	1.15%
Administrative and Clerical	85.49%	82.64%	2.85%
Additional Clinical Services	82.73%	78.22%	4.51%
Students	75.00%	75.00%	0.00%
Medical and Dental	71.78%	66.05%	5.73%
Estates and Ancillary	69.75%	67.04%	2.72%

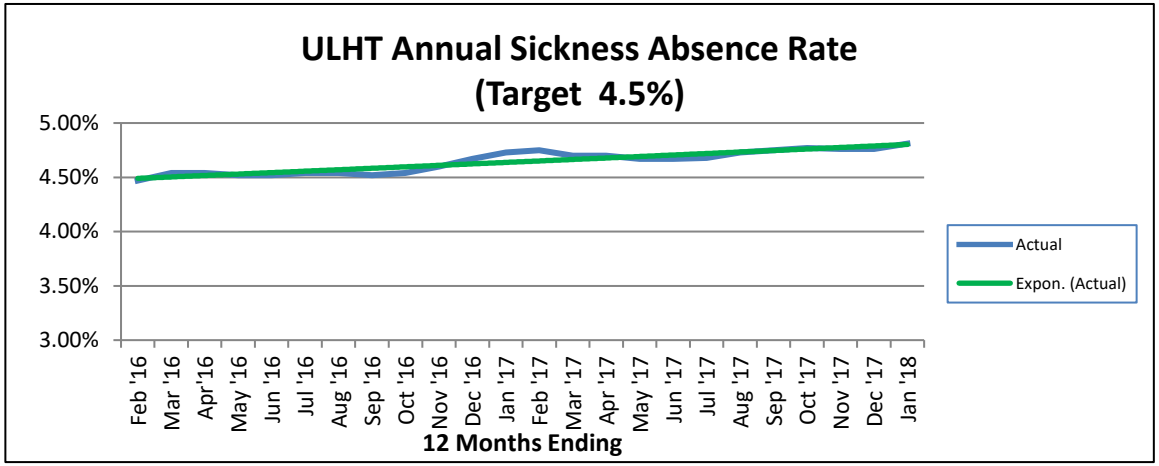
Action Taken	**Action Planned**
• 'Hotspots' are any areas in the red i.e. with less than 70% compliance with any number of staff. Following work by the Core Learning Lead, 8 areas have come off the hotspot list this month. However a further 14 have become new hotspots. • To help managers plan ahead, core learning classroom dates have now been organised and published for April 2018-19.	• The Trust's Core Learning Lead will continue to work with poorly performing areas to identify and implement any support required

KPI:	Sickness Absence	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Assistant Director of HR
Date:	12th February 2018	Reporting Period:	January 2018
Target:	Overall target of 4.5% + no team over 25% above target	Tolerances:	Within 0.5% - Amber Above 0.5% - Red
RAG Rating:	4.81%		

Analysis

The Trust annual rolling 12 month sickness rate is 4.81%, above our target of 4.50%. Sickness has increased from 4.73% at the same period 12 months ago. The trend over the past 12 months is for sickness to have worsened each month compared to the corresponding period 12 months ago. January 2018 saw the worst sickness figures in the past 2 years, however it also saw significantly more days lost to colds, coughs and flu (80% increase), this despite the Trust having excellent performance for the flu jab take up.

Our ability to interigate the reasons for sickness data is hampered by the signifcant amount of sickness being coded to 'other'. There are 25 categories sickness can be coded to so it is highly unlikely that such a large amount of sickness is genuinely for a reason 'other' than the 24 categories. This will be investigated and improvments made.



The latest Benchmarking data as at October 2017 from NHS Digital (previously Health & Social Care Information Centre - HSCIC) indicates that ULHT has the 5th highest sickness rate (lowest at 3.07% and highest 5.52%) against an average of 4.26%. Of the eight staff groups the Trust has only one with a sickness rate below the average, this being Healthcare Scientists. The benchmarking is done across x37 Large Acute Trusts.

Rolling 12 Months and Monthly Sickness Rates												
	Feb '16	Mar '16	Apr '16	May '16	Jun '16	Jul '16	Aug '16	Sep '16	Oct'16	Nov '16	Dec '16	Jan '17
Rolling 12 months	4.47%	4.54%	4.54%	4.52%	4.52%	4.54%	4.54%	4.52%	4.54%	4.60%	4.67%	4.73%
Monthly Rate	5.01%	5.38%	4.73%	4.68%	4.65%	4.77%	4.12%	4.38%	4.73%	5.08%	5.50%	5.50%
	Feb '17	Mar '17	Apr '17	May '17	Jun '17	Jul '17	Aug '17	Sep '17	Oct'17	Nov '17	Dec '17	Jan '18
Rolling 12 months	4.75%	4.70%	4.70%	4.67%	4.67%	4.68%	4.73%	4.75%	4.77%	4.76%	4.76%	4.81%
Monthly Rate	5.20%	4.48%	4.32%	4.34%	4.53%	4.82%	4.62%	4.62%	4.89%	4.78%	5.33%	5.96%

Top 5 Absence Reasons by FTE Days Lost Comparison	Jan-18		Jan-17	
Absence Reason	FTE Days Lost	% of all sickness	FTE Days Lost	% of all sickness
Cold, Cough, Flu - Influenza	2,453.15	20.43	1,359.49	12.67
Anxiety/stress/depression/other psychiatric illnesses	1,951.09	16.25	2,096.27	19.53
Other known causes - not elsewhere classified	1,765.93	14.71	1,715.09	15.98
Gastrointestinal problems	1,050.55	8.75	946.58	8.82
Other musculoskeletal problems	900.51	7.50	954.37	8.89

A rolling 12 month comparsion on whether sickness is long or short term, shows that it is broadly similar now to the rolling 12 months at the same time last year, with long term sickness (28 days or more) accounting for for 64% of the Trusts total sickness.

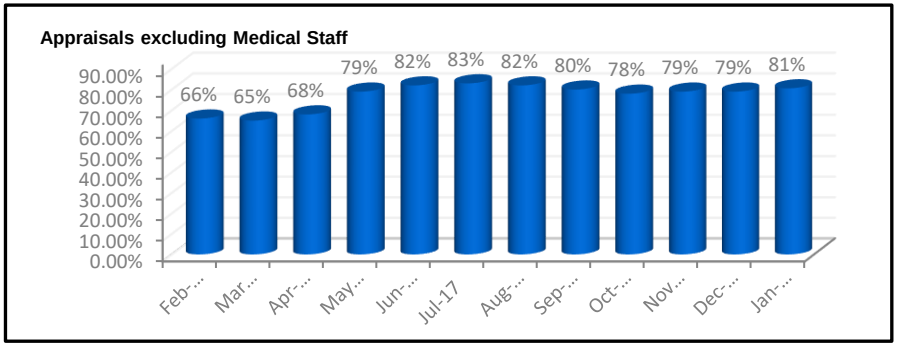
	Jan '18			Jan '17		
	Longterm	Shortterm	Total	Longterm	Shortterm	Total
Fte Days Lost	73,122	40,777	113,899	70,321	39,836	110,157
%age Sickness Rate	3.09%	1.72%	4.81%	3.02%	1.71%	4.73%

Action Taken	Action Planned
• Communication to focus on the increase in LTS cases. • Increase in HR support in manging absences cases and supporting managers on the pilgrim site. • Absence training as part of the leadership and management training has been positively received following changes to deliver the training internally. • Monthly meetings with OH widened to allow wider remit of attendance, OH meetings increased to ensure more time to focus on cases.	• OH plan to organise OH meetings over the next year on a monthly basis. • Investigate reasons for 'other' coding;

KPI:	Appraisal Rates	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Head of OD
Date:	9th February 2018	Reporting Period:	January 2018
Target:	Medical – 95% Non-Medical – 85%		Within 5% below - Amber More than 5% below – Red
RAG Rating:	Medical – 95%		
RAG Rating:	Non-Medical – 80.59%		

Analysis

The graph below shows that the Agenda for Change Staff/Non-Medical Appraisal compliance rate for January is 80.59%. This is an increase of 1.49% from the previous month. Feedback from information being sent to senior managers suggests that some appraisals have been completed but not recorded on ESR. This has been addressed (see below). We remain concerned however about the level of appraisal compliance, given the key part it plays in performance management, accountability and determining learning and development needs.



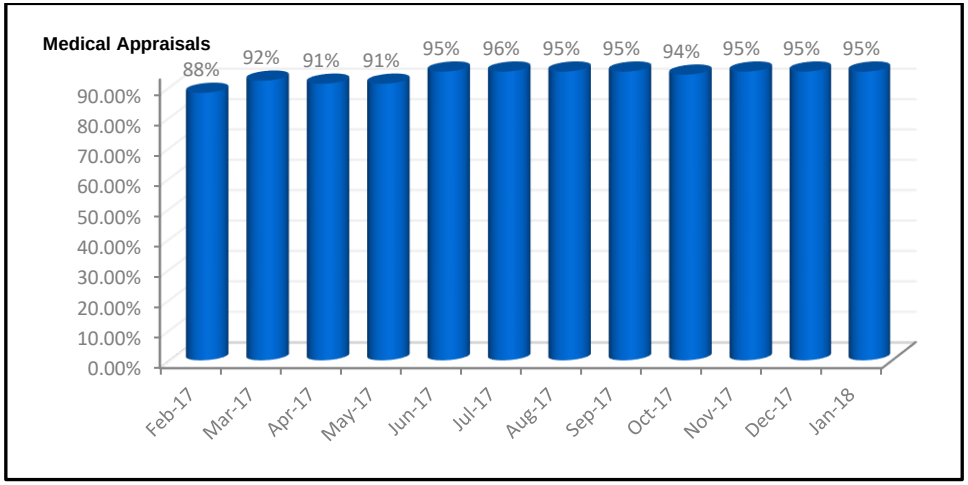
Directorate Non- Medical Appraisal Rates

Directorate		Appraisal Rate January '18 (Excludes Medical Staff)	Appraisal Rate December '17 (Excludes Medical Staff)	% Change
Chief Executive	⇨	100.00%	100.00%	0.00%
Deputy Chief Executive	⇧	95.83%	95.08%	0.75%
CSS Therapies	⇧	*95.32%*	*95.31%*	*0.01%*
Director of Fin & Corp Affair	⇧	95.19%	93.33%	1.86%
CSS Diagnostics	⇩	*89.41%*	*89.94%*	*-0.53%*
Orthopaedics Boston	⇩	89.02%	90.12%	-1.10%
Women & Children's Pan Trust	⇧	88.71%	87.03%	1.68%
Director of HR & Org Dev	⇩	88.52%	88.71%	-0.19%
TACC Boston	⇧	88.24%	84.94%	3.30%
Clinical Support Services	⇧	87.94%	87.70%	0.24%
CSS Outpatient Management	⇧	*86.46%*	*85.52%*	*0.94%*
Chief Operating Officer	⇧	84.72%	73.97%	10.75%
Medicine Boston	⇧	80.69%	79.17%	1.52%
Grantham	⇩	78.55%	79.49%	-0.94%
Trustwide Cardiology Services	⇧	77.37%	75.52%	1.85%
Director of Estates & Facil	⇧	76.17%	69.62%	6.55%
Haem & Onc Trustwide	⇩	75.41%	75.96%	-0.55%
Gen Surg Linc & Urology Trust	⇧	75.38%	68.46%	6.92%
TACC Lincoln	⇧	74.03%	72.88%	1.15%
CSS Pharmacy	⇧	*73.02%*	*72.44%*	*0.58%*
General Medicine Lincoln	⇧	70.82%	69.52%	1.30%
Orthopaedics Lincoln	⇩	70.21%	74.19%	-3.98%
A&E Lincoln	⇧	70.09%	68.18%	1.91%
General Surgery Boston	⇩	69.86%	76.26%	-6.40%
Medical Director	⇧	67.01%	66.67%	0.34%
Head & Neck Trustwide	⇧	55.29%	50.62%	4.67%
Director of Nursing	⇩	55.13%	55.56%	-0.43%

The Medical Workforce appraisal rate for the month ending January 2018 has remained at 95%. This figure achieves the Trust target for the seventh time in eight months.

The numbers of Doctors postponing their appraisals, due to workload, has significantly contributed to the increased requests for postponement of appraisals due in November and December. The appraisal performance figure includes Consultants, SAS Doctors and all Trust Locums who now have access to the Allocate e-appraisal system for appraisal.

MEDICAL APPRAISAL PERFORMANCE–JANUARY 2018



Action Taken	**Action Planned**
Non-Medical • Managers have been reminded of the need to and how to record completed appraisals through ESR • League table by Directorate was shared at ET and Executive Directors requested to take action by the Chief Executive to address shortfalls	Non-medical • Monthly reports will continue to be provided to Executives naming individuals whose appraisals remain outstanding. • HR Business Partners will continue to: ○ Hold regular monthly meetings with Matrons/equivalent managers to identify those staff that haven't been captured ○ Help to managers when they are unsure about completing the reporting process, guidance docs shared as appropriate ○ Highlight completion rates on monthly scorecards which are discussed at monthly Performance Reviews. ○ Provide bespoke training offered where appropriate ○ List of non-compliant staff sent to managers monthly

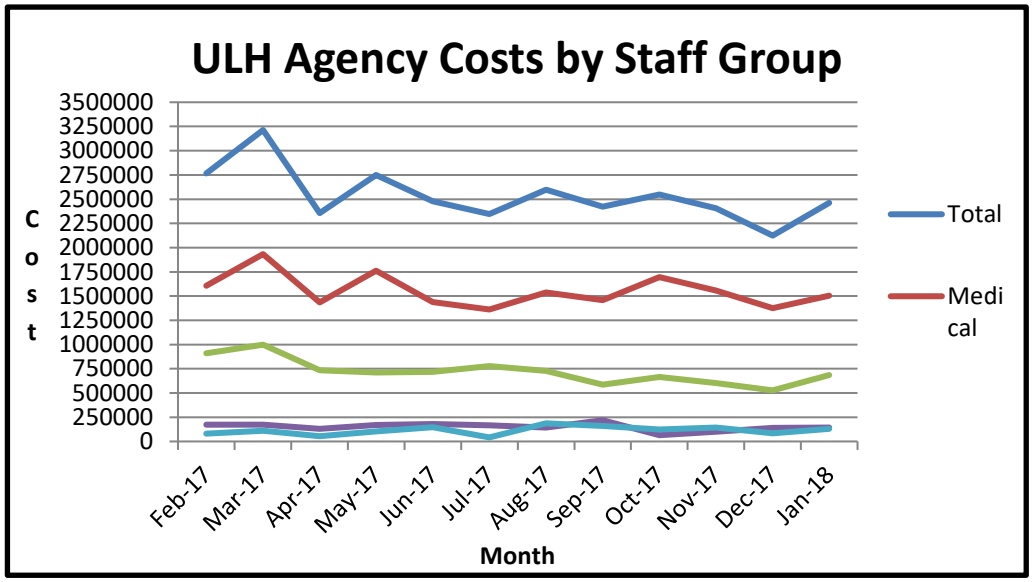
Medical • Continue to work closer with HR regarding notification of start dates for new doctors. • Continue with the 'a plan in place' for each doctor, for whom this is their first post in the UK, to participate in appraisal within 3 months of their start date with the Trust. Despite initial concerns from Trust Appraisers the schedule for appraisal brought forward from 6 months to 3 months is working well. This ensures doctors who are employed on short term contracts have the opportunity to participate in appraisal during their employment with ULHT. • Closer monitoring of sign off of appraisals. Reminders sent to Appraisers to complete Appraisal Output documentation and *sign off* appraisal documentation within 28 days of the appraisal meeting in order to meet the GMC requirements. • Notification of 'Appraisal Due' sent to Doctors 4 months prior to their appraisal month. Strict adherence to the escalation processes set out in the Medical Appraisal Policy, with particular focus on the allocation of appraiser to appraisee 6 weeks prior to the appraisal due date if the doctor has not confirmed appraisal details. • Continue to provide Clinical Directors with monthly reports of appraisal performance within their areas of responsibility. • The Revalidation Office continues to closely monitor and take prompt action when appraisals are not undertaken as planned.	○ Data cleansing carried out where info is incorrect ○ Latest format of Performance Review requires CDs to account for compliance rates. ○ Emails for example as below and reposts to identify the areas of non-compliance. • Launch of new individual Performance Review process Medical • Plan to meet newly appointed Doctors at Trust Induction or individually in order to introduce ourselves and our processes in respect of Medical Revalidation and Appraisal. • Proposal to increase the administration support to the Revalidation Office (0.53 of Band 2) to ensure improved governance to Revalidation processes. Initial proposal not supported. • Ensuring new and existing doctors receive continued support to use the new Allocate system.

KPI:	Agency Spend	Owner:	Director of HR/OD
Domain:		Responsible Officer:	Various leads on different aspects of agency spend
Date:	9th February 2018	Reporting Period:	January 2018
RAG Rating:	Actual spend of £2.462m, against target of £1.75m		

Analysis

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

Spend is still above target however it is £321,866 lower than the level of spend in January 2017 which was £2.784m. Successful actions have been taken to reduce agency spend across all staff groups. New medical vacancies and decisions based around maintaining quality and safety means that the benefit of those actions has been counter-acted by new areas of spend.



ULHT Monthly Agency Costs					
Month	Total	Medical	Nursing	STT	Other
Jan-17	**2,784,012**	1,611,118	929,881	162,231	80,782
Feb-17	**2,766,237**	1,605,861	908,261	172,351	79,764
Mar-17	**3,213,598**	1,932,958	998,546	172,766	109,328
Apr-17	**2,356,230**	1,433,258	736,176	131,342	55,454
May-17	**2,748,610**	1,761,876	713,080	170,800	102,854
Jun-17	**2,478,528**	1,436,862	717,214	179,061	145,391
Jul-17	**2,348,079**	1,361,565	778,485	166,176	41,853
Aug-17	**2,596,696**	1,537,633	728,052	143,957	187,054
Sep-17	**2,423,365**	1,458,234	587,363	218,845	158,923
Oct-17	**2,546,990**	1,695,873	664,225	64,714	122,178
Nov-17	**2,405,537**	1,557,614	603,705	101,218	143,000
Dec-17	**2,124,047**	1,373,919	526,962	138,704	84,462
Jan-18	**2,462,146**	1,502,649	685,902	144,429	129,166

Of the £2,462,146 spent on Agency staff in December, £1,502,649 was spent on Medical and Dental staff, £685,902 was spent on Nursing staff (including HCSW's), £144,429 was spent on STT staff and £129,166 was spent on Other staff (including Admin & Clerical staff).

Action Taken	**Action Planned**
• Weekly pay introduced for nursing staff • All “other” agency spend been through a review process and spend reductions should flow through shortly • Continued action to reduce vacancy rates	• Medical agency spend review process revamped • Medical bank planned • Review of nursing agency rates underway • Review of establishment/workforce planning exercise underway for the 18/19 year

KPI:	Quarterly engagement index	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Head of OD
Date:	13 February 2018	Reporting Period:	January 2018
Target:	10% improvement in average score during 2017/18		
RAG Rating:	3.3 The score is out of five and comprises six questions from the pulse survey		

Analysis
The National Staff Survey is now complete. The response rate is 45% which is significantly higher than last year (39%) and in line with the national average. Results are embargoed for external release until 6th March 2018. We intend to build the response through discussion with stakeholders, staff in particular, through the planned big conversation, but also at Directorate level.

Our approach to engagement is driven around the four known enablers of engagement:

Strategic narrative – we are using our 2021 brand to create a sense of hope for the future
Compassionate and effective leaders and managers – we will be setting out our expectations of managers and supporting them through training
Employee voice – we are listening to our staff through pulse surveys, 2021 Executive walk rounds, Staff Engagement Group, Big 2021 conversations
Organisational integrity – living the values – Our Staff Charter sets out "the deal " for staff and our Personal Responsibility Framework (PRF) clearly articulates the behaviours we expect of ourselves to live those values

Action Taken	Action Planned
• National staff survey results being reviewed internally to identify high level themes • Executives carrying out 2021 walk rounds • Communications timetable for National Staff Survey results developed	• Presentations to CMB and ET on high level outcomes of Staff Survey and CDs and Execs provided with Directorate level reports to enable them to provide local response • Plans being developed for discussions with Directorates which Execs will attend alongside big conversations • Meeting with LPFT to learn from their experience of improving their staff engagement score

KPI:	Quality of leadership and management index	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Head of OD
Date:	13 February 2018	Reporting Period:	January 2018
Target:	10% improvement in average score during 2017/18		
RAG Rating:	2.6 (The score is out of five and comprises two questions from the pulse survey		

Analysis

There is no pulse check this quarter due to the National Staff Survey taking place.

Alongside expected behaviours for all staff, our PRF sets out specific responsibilities for leaders at all levels.

Significant work is being undertaken to completely review the Trust's approach to management and leadership development moving away from the traditional programmes and sheep dip approach to one based on organisational and job role need. The approach will use a variety of media including workshops, videos, action learning sets and so on. There will be a significant focus on the role of managers in supporting the transfer of learning into practice. This will be launched in April 2018.

Action Taken	Action Planned
• New approach to leadership and management development shared at January Senior Leadership Forum • One-off three day programme for aspiring managers funded via EMLA advertised • First STP Mary Seacole leadership programme celebration event took place. 6 ULHT managers graduated from programme. A further nine are on the programme alongside colleagues from a very wide range of Lincolnshire health and care bodies HEE funding being used to sponsor 8 places on National Leadership Academy Masters in Health Care Leadership (Elizabeth Garrett Anderson) and one place on Nye Bevan programme.	• Detailed work on leadership and management modules underway • New brochure being developed • Work on costings for Development Centres (HEE funded) being finalised Execs will make decision on which leaders will be sponsored to apply for national leadership programmes

Nursing Workforce

Executive Responsibility: Michelle Rhodes – Director of Nursing

Safer Staffing: Summary by Site

Jan-18

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals
Grantham	91.23%	101.09%	100.39%	95.37%	96.45%
Lincoln	94.10%	94.00%	98.15%	104.31%	96.49%
Pilgrim	82.42%	90.21%	96.90%	101.54%	90.05%
Trust	89.17%	92.98%	97.90%	102.42%	93.95%

Safer Staffing: Summary by Site - General Nursing

Jan-18

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals
Grantham	91.23%	101.09%	100.39%	95.37%	96.45%
Lincoln	93.62%	94.52%	99.45%	104.71%	96.79%
Pilgrim	83.61%	93.67%	98.14%	105.54%	92.30%
Trust	89.61%	94.79%	99.10%	104.04%	95.06%

Safer Staffing: Summary by Site - Children

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals
Grantham	n/a	n/a	n/a	n/a	n/a
Lincoln	97.86%	85.71%	83.12%	117.08%	91.92%
Pilgrim	67.27%	60.27%	83.87%	67.55%	69.13%
Trust	80.54%	71.69%	83.44%	87.36%	79.86%

Safer Staffing: Summary by Site - Midwifery

Jan-18

Hospital	% Total Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals
Grantham	n/a	n/a	n/a	n/a	n/a
Lincoln	98.93%	96.63%	103.40%	94.02%	97.88%
Pilgrim	96.02%	94.46%	100.93%	88.17%	97.14%
Trust	97.25%	96.19%	101.85%	92.85%	97.55%

Trust Position

VACANCY POSITION

	Oct-17		Nov-17		Dec-17		Jan-18	
	Data from Payroll		Data from Payroll		Data from Payroll		Data from Payroll	
	R	UR	R	UR	R	UR	R	UR
Lincoln	99.50	45.83	107.16	46.78	107.68	51.83	111.21	57.24
Pilgrim	121.55	19.36	117.63	15.80	129.07	15.52	128.53	20.40
Grantham	29.21	2.19	28.42	1.72	31.97	5.05	33.56	7.43
Main Site Nursing & Midwifery Sub-total	**250.26**	**67.38**	**253.21**	**64.30**	**268.72**	**72.40**	**273.30**	**85.07**
Louth	4.02	1.37	3.85	1.58	3.85	1.12	4.45	1.12
Paediatrics & Neonatal	28.36	0.94	28.93	2.54	30.93	2.14	31.83	4.78
Obs & Gynae	23.83	5.53	18.94	3.63	14.78	5.87	16.26	6.27
Diagnostics	11.05	0.43	11.70	1.43	9.51	2.72	8.79	2.22
Corporate Nursing – All Sites	14.75	3.36	13.83	3.36	16.53	3.36	16.50	4.36
Specialist Nursing – All Sites	2.08	0.56	4.76	0.56	3.73	0.56	4.13	0.56
Nursing & Midwifery Sub-total	**334.35**	**79.57**	**335.22**	**77.40**	**348.05**	**88.17**	**355.26**	**104.38**
Physiotherapy	6.43	1.12	7.83	2.27	8.07	0.98	10.11	1.38
Occupational Therapy	1.76	4.25	2.56	1.96	3.16	1.66	5.80	2.23
Dietetics	4.97	0.00	4.97	0.00	4.97	0.00	3.97	0.00
Total	**347.51**	**84.94**	**350.58**	**81.63**	**364.25**	**90.81**	**375.14**	**107.99**
Nursing & Midwifery In Post	1,969.91	866.11	1,975.56	871.71	1,967.70	865.83	1,953.76	853.66
Nursing & Midwifery Vacancy Changes	-12.56%	-6.28%	4.86%	5.18%	4.10%	10.81%	2.07%	18.38%

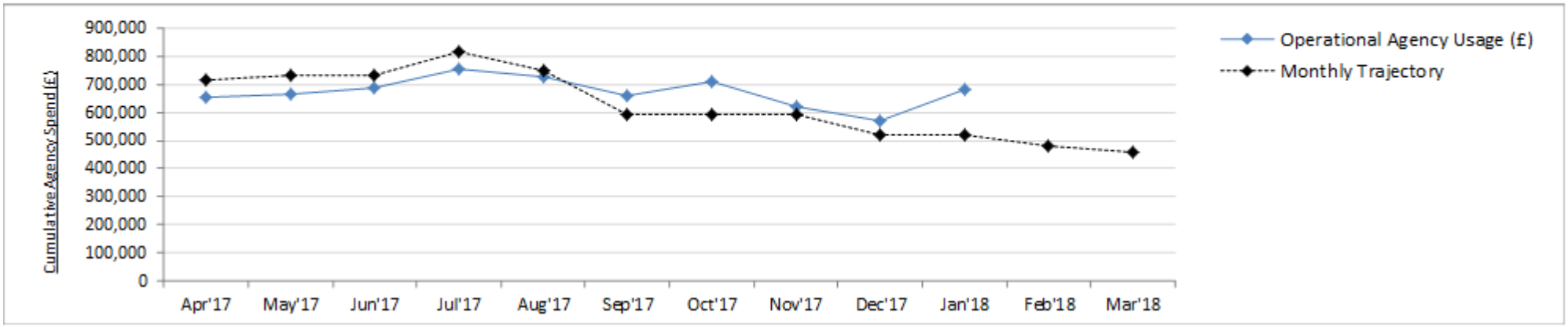
Safe Staffing Position

VACANCY POSITION

	Oct-17		Nov-17		Dec-17		Jan-18	
	Data from Payroll		Data from Payroll		Data from Payroll		Data from Payroll	
	R	UR	R	UR	R	UR	R	UR
Lincoln	64.75	24.60	75.43	25.26	79.46	30.63	80.68	35.16
Pilgrim	92.92	7.60	95.61	2.53	102.59	1.20	102.17	4.36
Grantham	20.71	-3.54	22.12	-4.01	23.79	-1.48	27.18	0.81
Main Site Nursing & Midwifery Sub-total	**178.38**	**28.66**	**193.16**	**23.78**	**205.84**	**30.35**	**210.03**	**40.33**
Paediatrics & Neonatal	23.70	-1.16	24.42	0.44	26.42	-0.56	28.04	2.08
Obs & Gynae	9.06	0.52	8.62	1.82	6.09	3.06	3.17	3.66
Total	**211.14**	**28.02**	**226.20**	**26.04**	**238.35**	**32.85**	**241.24**	**46.07**
Nursing & Midwifery In Post	858.38	533.48	850.70	538.09	842.72	532.89	837.31	519.67

Nursing Agency Ceiling

Summary	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Operational Agency Usage (£)	651,275	662,403	684,990	755,830	725,335	660,485	709,286	621,173	569,924	682,244		
Monthly Trajectory	713,582	730,885	731,510	818,209	748,546	593,645	593,645	593,645	518,790	518,790	481,363	457,390
Difference from Trajectory	-62,307	-68,482	-46,520	-62,379	-23,211	66,840	115,641	27,528	51,134	163,454	-481,363	-457,390



CQUINs 2017/18

No.	Goal name	CQUIN Lead	Financial Value	Q1	Q2 forecast
National					
1a	Improving Staff Health and Wellbeing (achieve improvement scores on 2/3 questions on the staff survey)	Stephen Kelly	£245,326		
1b	Healthy food for NHS staff, visitors and patients	John Spencer	£245,327		
1C	Improving the uptake of flu vaccinations for frontline clinical staff	Stephen Kelly	£245,327		
2a	Timely identification for sepsis in emergency departments & Inpatient	Adam Wolverson	£183,996		Partial (10% instead of 25%)
2b	Timely treatment for sepsis in emergency departments & Inpatient settings	Adam Wolverson	£183,996		
2c	Empiric review of antibiotic prescriptions	Sue Leo	£183,996		
2d	Reduction in antibiotic consumption	Sue Leo	£183,996		
4	Improving services for people with mental health needs who present to A&E	Dr Roberts / Dr Sant (joint CQUIN with LPFT)	£735,980		
6	Set up and operate A&G services for non-urgent GP referrals	Lee Parkin	£735,980		
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	£735,980		
8	Supporting Proactive and Safe Discharge (split between increasing discharges(£588,785) and ECDS (£147,196))	Kate Sayles	£735,980		
Specialised					
B12	Severe Haemophilia Haemtrack Patient Home Reporting	Bethan Myers / Alison Dawson Meadows	£69,917		
GE3	Hospital Medicines Optimisation	Sue Leo	£188355 (£269000 being paid)		Awaiting confirmation
AF1	Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community	Tim Couchman	£34,018		
1	NHS Dental Services	Dr Kotyla	£122,152		

RAG

Grey - no milestone due for this quarter
Green - fully achieved milestone & full payment
Amber - partially achieved milestones & received a partial payment

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