Excellence in rural healthcare

United Lincolnshire Hospitals NHS Trust

UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 30 NOVEMBER 2017

Patient centred ▪ Excellence ▪ Respect ▪ Compassion ▪ Safety

To:	FSID
From:	Karen Brown, Director of Finance, Procurement & Corporate Affairs
Date:	16th January 2018
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for November 2017

Author/Responsible Director: Karen Brown, Director of Finance

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

The report is provided to the Board for:

	√		√
Decision	√	Discussion	√
Assurance	√	Information	

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

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

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

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

Resource implications (eg Financial, HR) None

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

Patient and Public Involvement (PPI) implications None

Equality impact

Information exempt from disclosure

Requirement for further review?

Executive Summary for period of 30th November 2017

- ☒ 4 hour waiting time target – performance of 79.37% in November 2017
- ☒ 5 of the 9 national cancer targets were achieved in October 2017
- ☒ 18wk RTT Incomplete Standard will not be submitted for October and November 2017
- ☒ 6wk Diagnostic Standard – November 2017performance was 96.58%

Successes:

Against a challenging background, the Trust achieved an increase in the 4 hr A&E target, raising its attainment by 1.9% against October.

A significant improvement was made in the Cancer targets with the target for 2ww breast symptomatic achieved in November, bringing the number of achieved targets up to 5 for the first time since December 2016. 2ww Suspect also moved from red to amber in the month, achieving 92.7% against the target of 93%. The improvement has been assisted by the funding of additional CT capacity and improvements in the delivery of the Pathlinks contract.

Improvement work has continued on the monthly Performance Review meetings with further financial metrics added to the reporting and a suite of financial KPIs to be developed for the report to accompany the Quality and Performance KPIs.

Learning compliance has improved continuously since recording began in 2014 and for the first time since achievement was over 90%

Challenges:

Medway upgrade took place on 20th October and has resulted in an inability to provide true reported figures for RTT incompletes for October and November.

Performance against the diagnostics standard, at 96.58%, failed for the fifth month in a row, having deteriorated by a further 0.8%. Significant staffing issues and increased inpatient demand in Echocardiography continuing to be the main issue. A recovery action plan is in place.

Whilst elective length of stays have showed a reduction month on month, non-elective length of stays have further worsened reflecting the challenging winter position in A&E and non-elective.

Staffing remains a challenge with the medical vacancy rate having risen, sickness absences continuing to exceed the target and agency spend continuing at high levels despite a reduction of over £140k on the previous month. However, nursing vacancies showed a slight and continuing improvement on the previous month and year to date but remained over target. Recruitment is progressing well but has been counterbalanced by further staff departures in some specialties. Overall the Trust vacancy rate has improved by comparison with the position in November 2016.

Looking forward:

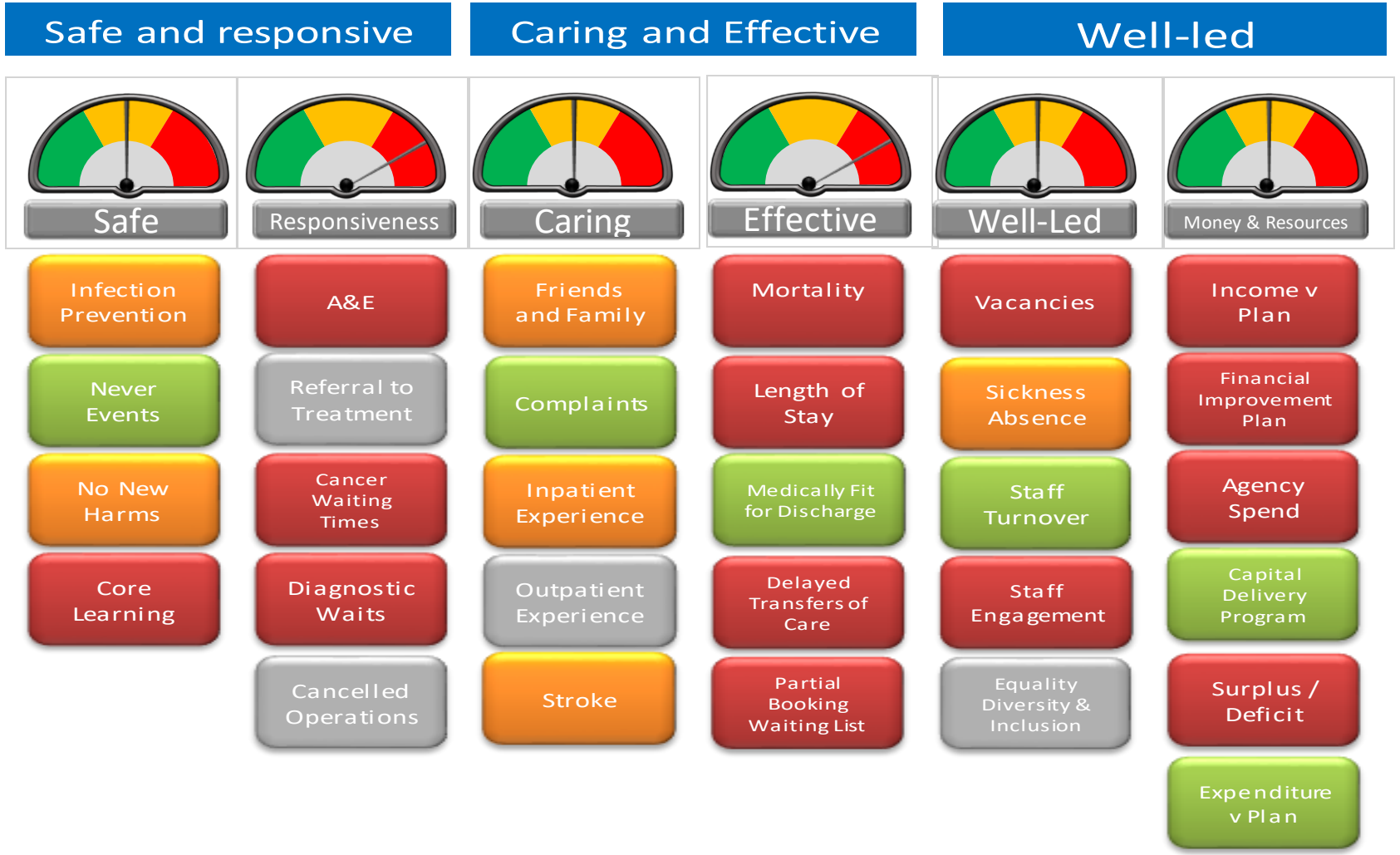
The Trust continues to focus on exception reports to identify future milestones to recovery, particularly or where there is a trending decline in performance, or where KPIs have been red or amber for three consecutive months.

The delivery of an improved financial run rate is a key priority for the Trust. A financial recovery plan to support this has been submitted to NHSI and the Trust is committed to its delivery.

Karen Brown
Director of Finance, Procurement & Corporate Affairs
January 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.



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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	46	4	6
MRSA bacteraemia (post 3 days)	Monthly	Datix	0	1	0	0
MSSA	Monthly	Datix	16	12	3	2
ECOLI	Monthly	Datix	64	28	3	2
Never Events	Monthly	Datix	0	1	0	0
No New Harms						
Serious Incidents reported (unvalidated)	Monthly	Datix	0	200	27	22
Harm Free Care %	Monthly		95%	91.75%	91.80%	90.80%
New Harm Free Care %	Monthly		98%	98.05%	98.10%	97.00%
Catheter & New UTIs	Monthly		1	1	1	2
Falls	Monthly	Datix	3.90	3.96	6.70	3.50
Medication errors	Monthly	Datix	0	1111	120	120
Medication errors (mod, severe or death)	Monthly	Datix	0	163	18	19
Pressure Ulcers (PUNT) 3/4	Monthly			54	8	9
VTE Risk Assessment	Monthly		95%	97.11%	97.86%	96.58%
Core Learning	Monthly	ESR	95%	90.46%	90.83%	89.17%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Caring						
Friends and Family Test						
Inpatient (Response Rate)	Monthly	Envoy Messenger	26%	23.38%	16.00%	24.00%
Inpatient (Recommend)	Monthly	Envoy Messenger	96%	91.25%	88.00%	90.00%
Emergency Care (Response Rate)	Monthly	Envoy Messenger	14%	19.25%	19.00%	20.00%
Emergency Care (Recommend)	Monthly	Envoy Messenger	87%	81.25%	83.00%	81.00%
Maternity (Reponse Rate)	Monthly	Envoy Messenger	23%	9.63%	14.00%	8.00%
Maternity (Recommend)	Monthly	Envoy Messenger	97%	96.00%	92.00%	97.00%
Outpatients (Reponse Rate)	Monthly	Envoy Messenger	14%	13.63%	10.00%	14.00%
Outpatients (Recommend)	Monthly	Envoy Messenger	94%	92.50%	93.00%	92.00%
Complaints						
No of Complaints received	Monthly	Datix	70	485	65	58
No of Complaints still Open	Monthly	Datix	0	2124	300	302
No of Complaints ongoing	Monthly	Datix	0	322	49	58
No of Pals	Monthly	Datix	0	0	380	378
No of pals converted to formal complaints	Monthly	Datix	0	0	0	0
Inpatient Experience						
Mixed Sex Accommodation	Monthly	Datix	0	7	2	2
eDD	Monthly	EDD	95%	83.91%	87.12%	83.27%
PPCI 90 hrs	Quarterly		100%	95.10%	97.33%	97.33%
PPCI 150 hr	Quarterly		100%	85.00%	85.33%	85.33%
#NOF 24	Monthly		70%	56.83%	50.62%	53.62%
#NOF 48 hrs	Monthly		95%	90.99%	85.19%	94.20%
Dementia Screening	1 month behind		90%	91.80%	94.50%	93.82%
Dementia risk assessment	1 month behind		90%	95.30%	95.21%	93.68%
Dementia referral for Specialist treatment	1 month behind		90%	85.82%	100.00%	88.57%
Stroke						
Patients with 90% of stay in Stroke Unit	1 month behind	SSNAP	80%	83.49%	83.10%	91.40%
Sallowing assessment < 4hrs	1 month behind	SSNAP	80%	71.13%	76.20%	73.50%
Scanned < 1 hrs	1 month behind	SSNAP	50%	57.63%	50.00%	52.10%
Scanned < 12 hrs	1 month behind	SSNAP	100%	97.83%	97.40%	99.00%
Admitted to Stroke < 4 hrs	1 month behind	SSNAP	90%	63.43%	56.40%	64.60%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Responsiveness						
A&E						
4hrs or less in A&E Dept	Monthly	Medway	90.0%	78.74%	79.37%	77.54%
12+ Trolley waits	Monthly	Medway	0	0	0	1
RTT						
52 Week Waiters	Monthly	Medway	0			
18 week incompletes	Monthly	Medway	92.0%			
Cancer - Other Targets						
62 day classic	1 month behind	Somerset	85%	69.61%	70.00%	66.30%
2 week wait suspect	1 month behind	Somerset	93%	89.53%	92.70%	90.10%
2 week wait breast symptomatic	1 month behind	Somerset	93%	84.56%	93.10%	87.90%
31 day first treatment	1 month behind	Somerset	96%	96.10%	97.20%	93.00%
31 day subsequent drug treatments	1 month behind	Somerset	98%	99.60%	100.00%	100.00%
31 day subsequent surgery treatments	1 month behind	Somerset	94%	92.06%	95.70%	92.70%
31 day subsequent radiotherapy treatments	1 month behind	Somerset	94%	95.70%	100.00%	95.60%
62 day screening	1 month behind	Somerset	90%	86.13%	83.10%	97.60%
62 day consultant upgrade	1 month behind	Somerset	85%	85.16%	75.30%	100.00%
104+ Day Waiters	1 month behind	Somerset		-	8	8
Diagnostic Waits						
diagnostics achieved	Monthly	Medway	99.1%	98.36%	96.58%	97.35%
diagnostics Failed	Monthly	Medway	0.9%	1.64%	3.42%	2.65%
Cancelled Operations						
Cancelled Operations on the day (non clinical)	Monthly	Medway	1.10%	3.96%	0.00%	4.57%
Not treated within 28 days. (Breach)	Monthly	Medway	0.00%		0.00%	8.97%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Effective						
Mortality						
SHMI	Quarterly		100	111.56	112.58	112.57
Hospital-level Mortality Indicator	Quarterly		100	103.00	103.06	102.34
Length of Stay						
Average LoS - Elective	Monthly	Medway / Slam	2.8	2.76	2.41	3.12
Average LoS - Non Elective	Monthly	Medway / Slam	3.8	4.37	4.42	4.37
Medically Fit for Discharge	Monthly	Bed managers	60	#N/A	#N/A	59.00
Delayed Transfers of Care	Monthly	Bed managers	3.5%		6.00%	4.12%
Partial Booking Waiting List	Monthly	Medway	0	5148	4436	3956

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Well Led						
Vacancies	Monthly	ESR	5.0%	10.46%	9.65%	9.85%
Sickness Absence	Monthly	ESR	4.5%	4.58%	4.89%	4.62%
Staff Turnover	Monthly	ESR	8.0%	5.59%	5.51%	5.37%
Staff Engagement						
Staff Appraisals	Monthly	ESR	95.0%	78.88%	79.00%	78.00%
Equality Diversity and Inclusion						

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Money & Resources						
Income	Monthly	Board Report Master	37963	283988	37299	35234
Expenditure	Monthly	Board Report Master	-41409	-330596	-42382	-41455
Efficiency Delivery	Monthly	FIMS report	1526	3746	0	0
Surplus / Deficit	Monthly	FPIC Finance Report	-3446	-56893	-6477	-7542

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Referral to Treatment

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	**Referral to Treatment (18 weeks)**	**Owner:**	Director of Operations
Domain:	**Responsive**	**Responsible Officer:**	Deputy Director of Operational Performance – Planned Care
Date:	16th January 2018	**Reporting Period:**	November 2017

Exception Details

The Trust did not submit RTT incompletes performance data for November 2017.

Following the Medway upgrade over the weekend of 20th 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 done to re-write the RTT scripts, firstly from a revised Periods table, then from Events directly, the latter being the current method of identifying incomplete pathways. Further work has been completed between Information Services and the 18 week team to narrow down the reported incomplete numbers through allocating pathway to exclusion or data quality cohorts, each with a specific rule for identifying pathways.

Initially 13 exclusion/data quality check cohorts were removed from the PTL data produced. Work between information support and the 18 weeks team has refined the reporting process further. Currently there are 6 exclusion cohorts which are being validated on a sample basis. The exclusion cohort are as follows:

- Exclusion 01 – No start event
- Exclusion 02 – 21 transferred
- Exclusion 03 – Status after start suggests stop has occurred
- Exclusion 04 – Pathway closed
- Exclusion 05 – Speciality
- Exclusion 99 – unconfirmed 52 weekers

The current findings relating to the patients reviewed are indicating that the reports are reliable, however further validation is required to complete this process for all cohorts. Where patients have been identified who have been incorrectly excluded from the PTL this has been the result of underlying data entry issues and further validation for affected groupings is being completed in order to ensure further review this risk. It is anticipated that the validation process will be complete by 10th January.

Once fully reviewed regular validation of exclusion cohorts will become a programmed activity, and Clinical Directorates will have access to daily self-service PTL reports.

It has been agreed that the Trust will not make RTT performance submissions for November 2017 as the PTL validation programme will still be ongoing.

The monthly cancelled Operations data hasn't been validated at the time of writing, unvalidated figures show 325 cancelled Operations on the day in November and 170 the day before.

There are long waiting times for first appointments in a number of specialities. There has been a significant reduction in the number of patients waiting over 12 weeks on the open referrals waiting list in the last 6 months, although the pace of improvement has reduced in recent weeks. The open referrals figures over 12 weeks have reduced from 2288 at the end of May to 1229 on 7th December, however Gastro and ENT still have patients waiting over 25 weeks on the open referrals waiting list.

As at the 7th December there were 4 patients (3xENT and 1x General Surgery) on incomplete pathways over 52 weeks.

Retrospective harm reviews continue to be completed for incomplete patients over 52 weeks. In addition, from December harm reviews will be completed in clinic for patients graded as urgent who remain on the open referrals waiting list without an appointment over 12 weeks and 6 days after referral and time critical follow-ups who are overdue their appointment. Harm reviews will be discussed at speciality Governance meetings, and Quality Safety Officers will include summaries relating to harm around long waits in the monthly Clinical Directorate reports to the Patient Safety Committee.

What action is being taken to recover performance?

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

The Endocrine/Diabetes Service have additional baseline capacity in place following recruitment related to the Pilgrim Hospital 4th Consultant Business Case.

The ENT Service continue to complete virtual clinics in order to assist with management of follow-ups. As at 28th November 160 ENT patients had been confirmed as transferred to a different provider as part of this year's outsourcing arrangements, however the speciality has experienced issues with delayed rejections back from private providers which has impacted upon the effectiveness of the outsourcing completed in this area. Further outsourcing and insourcing options are being explored by the Clinical Directorate, particularly relating to the backlog of paediatric cases.

An advice and guidance service is scheduled to commence within ENT by the end of mid-December, 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 scope of this new pathway has increased during November, as the age range of patients included has been widened.

Outsourcing has commenced within General Surgery, Ophthalmology and Urology. As at 28th November, a total of 78 General Surgery patients, 52 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.

The Cardiology Service has completed a process to standardise booking rules across the Service, which will provide a small increase in capacity. In the medium term once the valve registry is established this will release further capacity within the Cardiology Service, with the Lincoln Cardiology Devices Consultant due to start in Q4.

Two new Gastro Consultants have now commenced in post at Lincoln, which takes that service to a fully established position. In order to maximise the available capacity the Gastroenterology Service have completed a review of all of their rules in order to ensure optimal distribution of capacity.

The Clinical Directorates have been working with KPMG to increase efficiency of delivery within both Outpatient and Theatre settings. These work streams will be monitored by the Outpatient Improvement Committee and Theatre Optimisation Committee respectively.

What is the recovery date?

Forecast trajectory for the remainder of 2017/18:

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

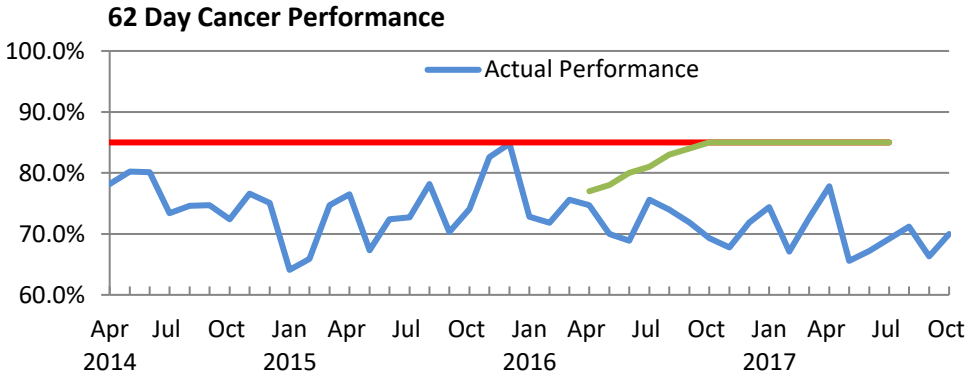
Cancer Waiting Times – 62 Day

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:	16th January 2018	Reporting Period:	October 2017

Exception Details

As at 4th January the Trust's performance position for November against the 62 day classic standard was 65.3%, with the final position to be confirmed on 11th January.



The Trust is forecast to achieve 5 out of the 9 cancer standards in November. This will be the first time in a year that 5 standards have been achieved in the same month for consecutive months.

As at 4th January 173 treatments were recorded in November against the 62-day classic standard, which is 42 treatments more than the same month in 2016.

Performance in Lower GI at 75% is on track to exceed 55% for the first time in seven months. Lung's performance is forecast to deteriorate below 50% for the first time in the last 5 months.

As at 4th January completion of RCAs for each breach in November found that the most frequent breach reasons were as follows (in order of occurrence):

- Pathology
- Patient choice and fitness
- OPA/clinic capacity
- Administrative delays
- CT capacity (including biopsies)
- Complexity of pathways
- Theatre capacity
- Oncology capacity

Pathology was identified 66% more frequently than any other individual factor as an issue associated with delays within breach pathways.

As of 4th January there are 13 pts on or over 104 days without an agreed treatment plan: 6 x Colorectal, 3 x Upper GI, 2 x Urology, 2 x Haem.
The Trust treated 14 patients at 104 days or over during November, completing RCAs for all 14 patients. Due to the length of these pathways these patients had multiple reasons for delays in their pathways, as follows:

- 10 cases included complexity or procedural factors
- 6 cases included pathology delays
- 6 cases included Outpatient capacity issues
- 5 cases included administrative delays
- 4 cases included patient fitness factors
- 4 cases included CT delays
- 4 cases included theatre capacity restrictions
- 3 cases included patient choice delays
- 3 cases included Oncology capacity delays
- 3 cases included other Radiology capacity delays
- 2 cases included delays linked to holistic needs
- 2 cases included delays as a result of pathway processes
- 1 case included delays linked to primary care
- 1 case included first OPA delays
- 1 case included tertiary diagnostic delays
- 1 cases included MRI capacity delays
- 1 case included chemo capacity delays
- 1 case included Radiotherapy delays
- 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 October, as at 5th January 7 had been completed, with 6 reporting no harm and 1 low harm.

What action is being taken to recover performance?

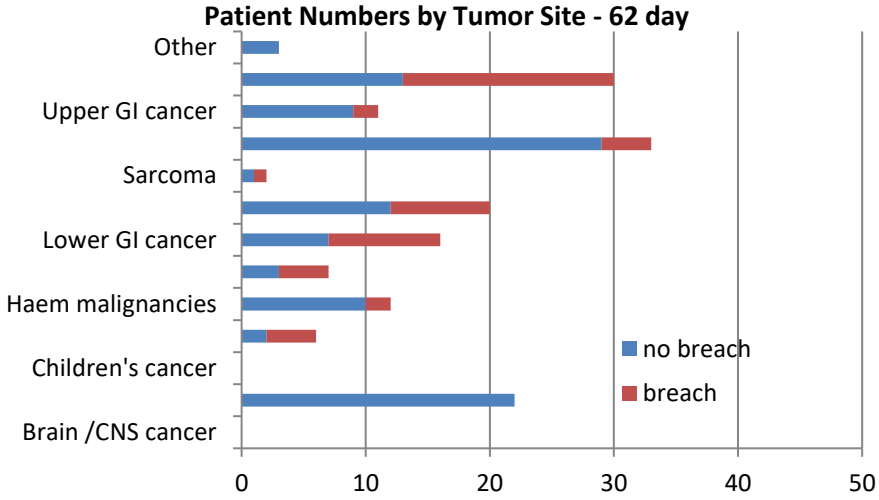
Representatives from ULHT and the Lincolnshire CCGs met with NHSI and NHSE representatives on 21st December in order to discuss actions required to improve cancer 62 day performance.

High impact actions which are to be undertaken and were identified by ULHT as likely to have a positive impact upon cancer performance:

- IST first OPA demand/capacity modelling to be refreshed against 7-day horizon for all specialities by end of January. To deliver 60% of First OPA's within 7 days of referral from mid-February.
- Radiology workflow review and maintenance of extension of scanning capacity to ensure delivery of referral to report within 7 days for 90% of patients by the end of March (compared to current position of c.50%).
- PathLinks to ensure Pathology workload allocation strategy in place by the end of February, in order to reduce turnaround times for samples on suspect cancer pathways down to 7-days by the end of March (compared to average of c.15 days currently).
- Redesign post MDT phase of Urology pathway by end of February in order to remove 4 days from a typical pathway.

Additionally, NHSI have written to the Trust since the above meeting and requested that the following actions are completed:

- Trust to investigate the opportunity to free up routine diagnostic capacity to support the cancer pathways by 26th January.
- The Trust to investigate the opportunities to improve Pathology reporting times by using other providers by 26th January.
- Trust to work with the lead CCG to commission the second phase of the demand and capacity work to ensure identified improvements are delivered.



Further actions which were discussed and agreed to be progressed included:

- Straight to Test CT for lung pathway to commence in January.
- Patient communication project to roll out in January in order to ensure that patients are aware that they have been referred on a suspect cancer pathway.
- Business cases for 7-day CT service and additional MRI capacity to be finalised.
- Implementation of the Endoscopy business case in order to increase internal capacity from April, as part of the plan to ensure 90% of patients on suspect cancer pathways undergo endoscopy within 10 days of referral into the service.
- Commence pilot of lung early diagnostic pathway changes on Lincoln site by end of March.
- Next available Oncology tumour site OPA to be allocated directly at MDT meeting by end of January.
- Ensure Trust-wide utilisation of lower GI theatre lists to ensure that TCIs available within 2 weeks (rolling period) by end of January.

What is the recovery date?

- 80% - March 2018
- 85% - June 2018

A&E 4 Hour Standard

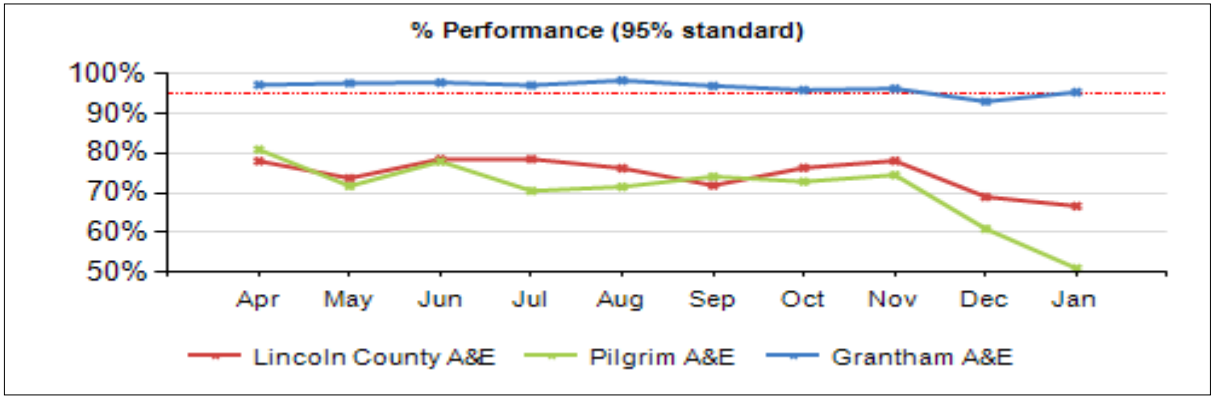
Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	**4 Hour Wait (A&E)**	**Owner:**	Chief Operating Officer
Domain:	**Responsive**	**Responsible Officer:**	Director of Operations / Deputy Director of Urgent Care
Date:	16th January 2018	**Reporting Period:**	November 2017

Exception Details

Pilgrim:

According to the A&E Dashboard December's overall performance was 60.90%, which is well below the planned trajectory of 89% by 28.1%. This is also down on November's performance of 74.49%. Currently January 2018 is worse still, and further off the 89% required at 50.04%. Triage performance within 15mins was also massively down for December at 57.14%, compared to 94.11% for November. Time to 1st assessment, was also down slightly from 46.21% in November to 40.94% in December against the national target of 50%, although I believe this is partly due to a lack of inputting rather than a failing to perform at this level.



Total attendances for December where above the planned level, and up on Novembers attendances of 4,751 by 158 patients at 4909, but October attendances of 5253 do still rate in the top 5 months for patient attendances over the past 5years.

Admission levels have remained high, but consistent throughout December with 1496 admissions, which equates to 30%, which is actually 2% lower than both October & November 1697 & 1501 admission respectively, still much higher for both months than the national average of 25-27%. January however is already sitting at 33%. Minor's performance in December has seen an increase from 91% in Nov to 93% in December, but slightly down on the 94% in October.

In-month key issues affecting performance were:

- Vacancies in ED Medical rotas with reliance on agency locums.
- Vacancies in Nursing rotas, and a particular issue with Sickness, as well as a variance in agency or bank fill rates.
- High patient attendances, with EMAS presentation numbers higher at times than other bigger hospitals nationally.
- Increased Acuity and co-morbidities.
- Poor hospital flow – admissions exceeded discharges. The AEC area as well as Ground Floor Theatres have been used on occasion as escalation bed capacity resulting in inefficient processing of ambulatory patients.
- Elective and Outpatient work was cancelled to facilitate medical patients, with 40+ in surgical beds at times.
- The MMFD numbers have increased with external delays awaiting packages of care & community beds.

Lincoln performance for November 2017 was 78.05% which is an increase of 1.76% but remains below the monthly trajectory of 89%.

Medical staffing fill rates continued to improve with very few gaps at any level. Nurse staffing slightly improved but remained challenging.

Activity levels during November rose again, seeing more days of attendances well above the 200 baseline level. There were many days where attendances reached the 220 mark with the department seeing the highest level of attendances ever record for the site last November (249 attendances). Acuity was again a major factor of poor performance along with flow and IPC issues. The site escalated to level 4 during the last week of November due to high ED attendances and poor outflow.

Discharge levels fell off mid-month but a deep dive approach to red to green and a renewed and more forward looking focus on patient pathways has helped to bring discharge levels back on track. Detailed pre and post weekend planning is in place.

GP Streaming continued to embed during November. There was a further improvement in the percentage of patients streamed but performance wasn't consistent. The site achieved the 20% target on 10 days during November with highs of 24% and a monthly average of 16.78%.

The building scheme completed 18th December and the rooms were handed over to LCHS who are now operating out of the new area.

What action is being taken to recover performance?

Pilgrim:

- GP Streaming commenced within the department with consistent figures being streamed into Primary Care.
- Additional streaming from ED into AEC and direct into specialty areas where applicable and possible due to a lack of capacity.
- GP referrals to be streamed directly into AEC also, where and when appropriate and safe to do so.
- Medical and Surgical General Managers to Chair daily Red2Green meetings.
- Late Matron rota to provide additional Site support later in the day.
- Late Snr Manager rota to provide additional Site support later in the day.
- Weekend Virtual Board rounds to Start with additional Weekend Medical Staffing being provided with winter funding.
- 7 Day working in AEC, when possible.
- AEC developing further patient pathways – Low Grade chest pain for example.
- Additional Medical MG cover at the front door to support Admission avoidance. Advert currently out (no takers as of yet).
- ED Orthopaedic & Surgical Specialty Support at the front door when elective work cancelled.
- Outpatient clinics reduced or cancelled to support ward discharges and front door.
- Continual recruitment/interviews for Middle grade Dr's – x6 Overseas MG Dr's offered clinical attachments to ascertain their English Language skills, and then positions within ED. X1 SHO also offered a provisional 3mth position to assess clinical skills to then progress onto MG rota – 1st Clinical attachment to now start on the 22nd Jan following Visa issues delayed the 8/1/18.
- Non-UK agency in discussion with Directorate to potentially supply ED MG Dr's initially, but scope could be expanded to other specialties and Nurses. Following procurement concerns details have been passed to a current agency to see if their Framework can support this agency and alleviate any Trust concerns.
- Breach Performance analysis being performed to identify any particular trends or patterns, as well as breach League table for the clinicians
- Embedding of SOPs for patient streaming away from the ED.
- Ongoing revision of ambulance handover process to Dr in RAIT that has reduced turnaround times

- LCH A&E Matron & Snr Sister brought in to try and embed process and stability across the department.
- Further focus on Red-Green and Pride & Joy to increase timely discharges and address delays to increase flow and improve performance.
- Increased usage and focus on the Discharge Lounge – Recent Staff comments/suggestions to be considered around staffing and process within the DCL.
- Continuation of Internal Jnr Dr contracts (NHS Locums) established to reduce impact of deanery gaps and subsequent agency spend.

The Lincoln Emergency Department medical rota has become more stable and international recruitment is progressing well. 8 middle grade doctors have been offered clinical attachments in the UK to enable sign off of an English assessment and registration with the GMC. Unfortunately we are struggling to see these doctors accept these offers and to date do not have any confirmed attachments arranged.

Focus has continued on achieving 10 empty admitting area beds by 10am in order to gain early flow on site and we have seen a slight improvement in pre-noon discharges because of this. This coupled with a drive to deliver agreed levels of ward discharges on a daily basis has been supporting an improvement on performance. Further work is required in order to improve weekend discharges and this will be one of 3 key areas of focus during November.

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:	16th January 2018	Reporting Period:	November 2017

Exception Details

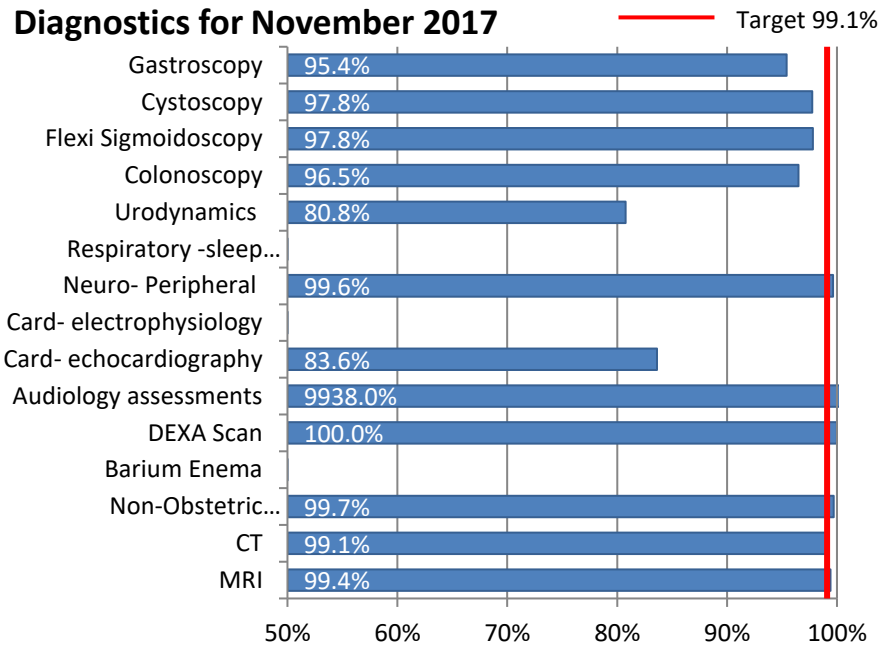
In November the Trust failed the 6 week diagnostic standard for the fifth time in the last year. The performance level was 96.58%.

There were 234 diagnostic patients which breached the 6-week standard in November, which was 58 more than at the end of October.

154 of the breaches were within Echocardiography. The poor performance in recent months in this area is 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

51 of the breaches were within Endoscopy. These breaches were primarily linked to reduced capacity as a result of mechanical failures during November and restricted capacity linked to water sample results.



What action is being taken to recover performance?

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

- Provision of addition capacity through internal resources
- 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
- 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 continued in December, but have improved at the beginning of January.

Quality Summary

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.

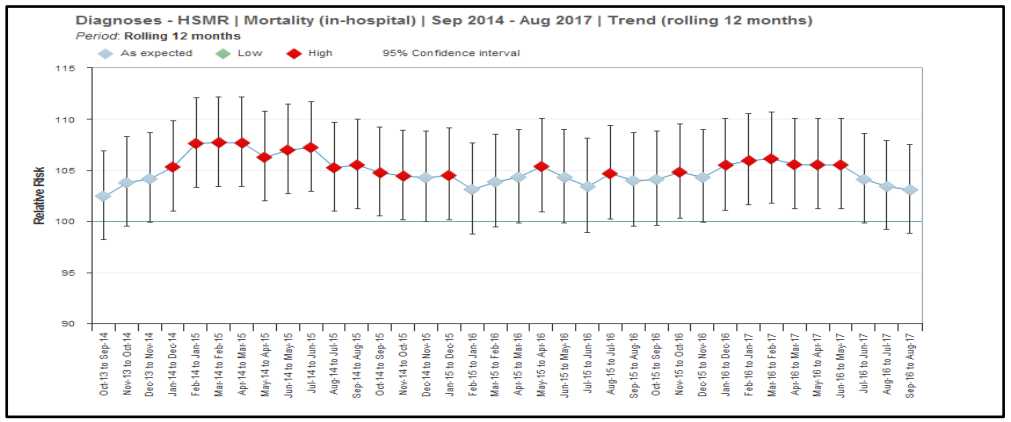
Per 1000 bed day data pre November 2017 is incorrect in respect of all harm measures. This is because previous information provided by Information Services had an incorrect formula that included count until the end of patient spell rather than the end of calendar month. The reduction in bed days is significant (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

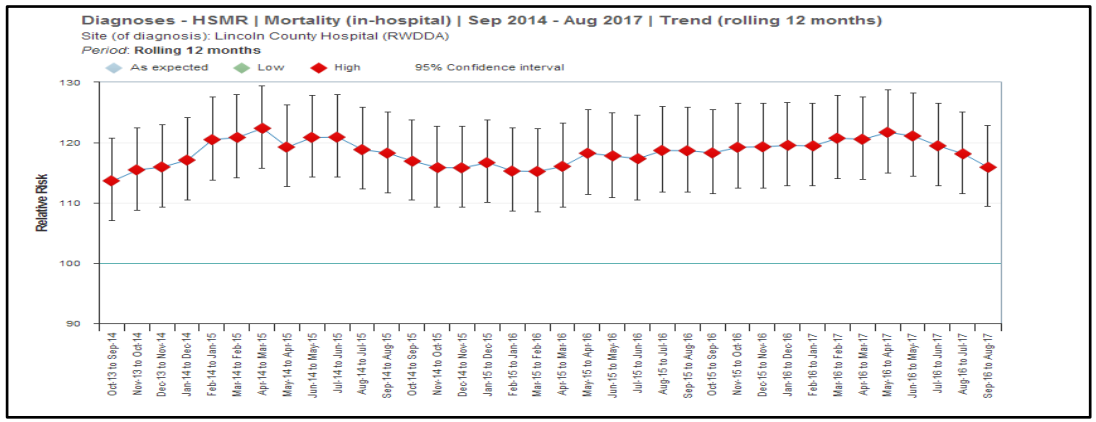
Executive Responsibility: Neil Hepburn – Medical Director

Trust/Site	ULHT HSMR Aug 16-Jul 17 12 month	ULHT HSMR Apr 17-Jul 17 YTD	ULHT HSMR Jul-17	ULHT SHMI Apr 16-Mar 17	Trust Crude Mortality YTD Internal source Nov 16-Oct 17
Trust	103.06	96.25	97.98	112.57	1.79%
LCH	115.94	1105.55	95.22	117.39	1.82%
PHB	95.52	91.57	97.81	111.14	1.99%
GDH	68.85	63.77	116.78	93.97	0.93%

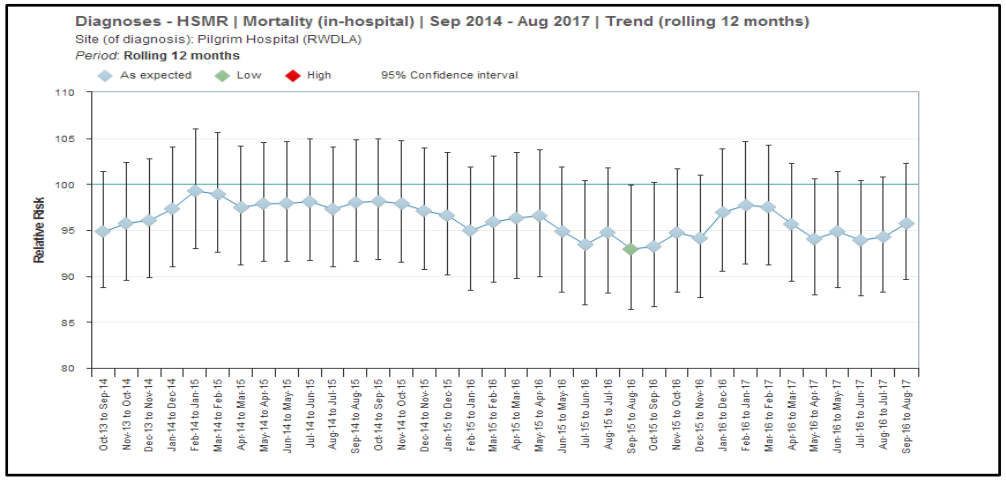
ULHT HSMR Rolling Year (36 Months)



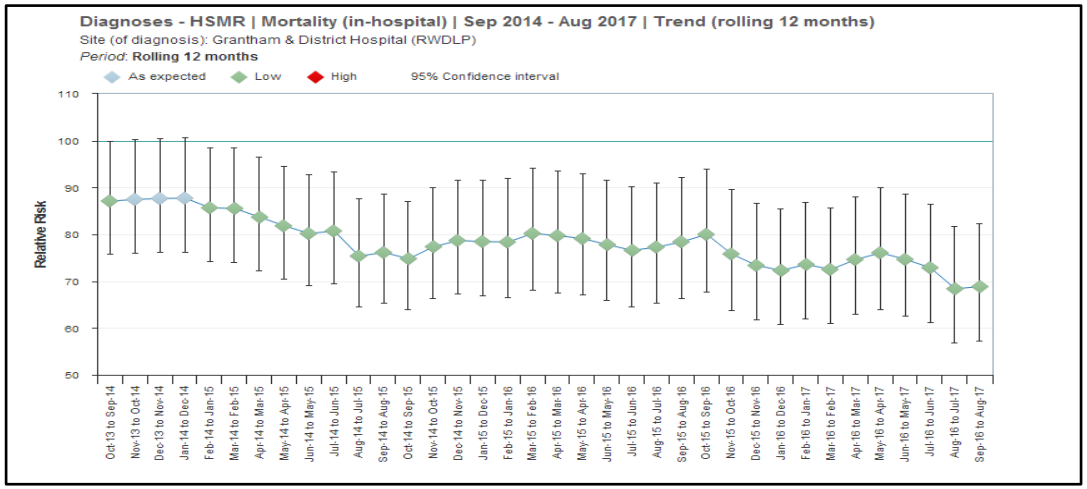
Lincoln HSMR Rolling Year (36 Months)



Pilgrim HSMR Rolling Year (36 Months)



Grantham HSMR Rolling Year (36 Months)



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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, with 21 mortalities and 14.03 over the predicted Dr Foster data. *Meeting has been held and an action plan is underway all coding has been checked. Work progression agreed. Both Pilgrim and Lincoln site are alerting for this LCH 9 mortalities with 4 over the predicted and PHB 11 mortalities with 8 over the predicted.*
- **Respiratory Failure insufficiency arrest (adult):** Third month alerting at Trust level. Driven by the Lincoln site; 41 mortalities with 14.12 over the predicted Dr Foster data. *LCH 23 mortalities with 8.4 over the predicted data.*
- **Aortic peripheral and visceral artery aneurysms:** Second month of alerting at Trust level. 29 mortalities with 12.13 over the predicted Dr Foster data. Alerting on the PHB site with 23 mortalities over a predicted 8.82.
- **Biliary tract Disease:** Driven by Lincoln site 34 mortalities with 13.87 over the predicted Dr Foster data. *An in-depth internal review has been completed. As this has been alerting for 8 months; to investigate an external review. Part of the wider Palliative care and comorbidity work.*

SITE

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

- **Intestinal Obstruction without hernia:** This has been alerting for 9 months; to date there are 25 mortalities and 11.04 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 and Associate Medical Director and Quality Governance have met with the palliative care team .As this has been alerting for 9 months; to investigate an external review. Part of the wider Palliative care and comorbidity work.*
- **Septicemia (except in labour):** This is a cumulative alert and not alerting in a particular month; year to date there are 126 mortalities and 21.62 over the predicted Dr Foster data. This is the fifth 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; when sepsis is coded throughout any part of the patient stay this overrides the main condition treated as the primary diagnosis. QG has completed an overview which was presented at July PSC. *Sepsis nurses completed a coding review and outputs were comorbidities not being documented. Part of the wider comorbidity quality work.*
- **Acute Cerebrovascular disease:** This is the fifth month of alerting with 106 observed and 21.62 mortalities over the predicted Dr Foster data. *Dr Foster Intelligence specialist and Quality Governance are met with Lincoln site stroke team to understand the data. The only notable difference between the data on the sites is the coding of patients been seen by the palliative care team. QG are looking at the Dr Foster data in comparison to the SNNAP audit data.*
- **Fluid and electrolyte disorders:** This is the fifth month of alerting with 15 observed and 7.33 mortalities over the predicted Dr Foster data.
- **Senility and organic mental disorders:** The second month of alerting with 20 mortalities with 8.62 over the Dr Foster predicted data.

Other gastrointestinal disorders: The second month of alerting with 18 mortalities and 9.73 over the Dr Foster predicted data.

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

Abdominal Pain: This is the fourth month of alerting with 5 observed and 3.70 mortalities over the predicted Dr Foster data.

COPD and bronchiectasis: This is the third month on alerting with 50 mortalities and 17.85 over the predicted Dr Foster data

Peritonitis and intestinal abscess: This is the third month of alerting with 7 mortalities and 4.59 over the predicted Dr Foster data.

Grantham Hospital
No notifications

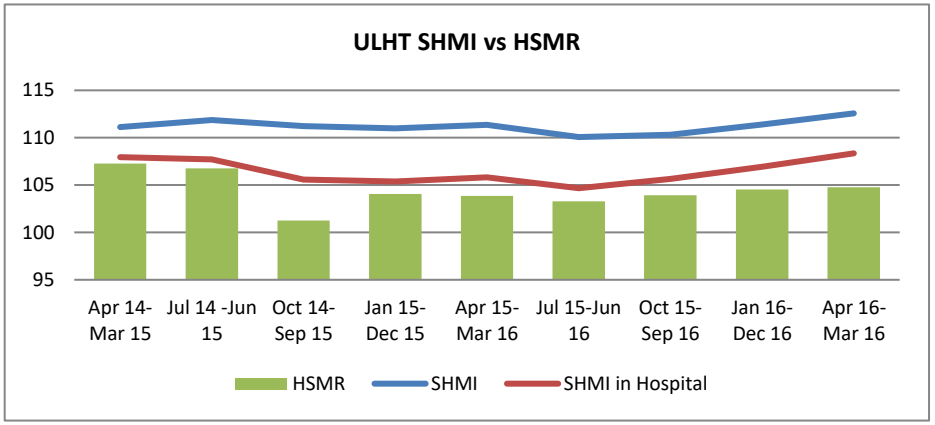
National Comparison

Metric	Sep 16-Aug 17	
	National Acute (Non specialist)	ULHT
HSMR	97.05	103.06
Elective Crude Rate %	0.07%	0.05%
Non elective Crude Rate %	2.75%	3.60%
% observed mortalities in hospital	1.40%	1.76%
% observed palliative coding	40.29%	30.99%
Avg comorb 0 score per observed %	0.41%	0.50%
Weekend % of observed	2.49%	3.10%
Weekday % of observed	1.23%	1.55%
Crude rate %	1.20%	1.50%
Spells Readmissions 28 days %	8.03%	7.43%
Residual Coding % of spells (Signs & Symptoms)	1.79%	1.46%
LOS short stay 0-2 days Observed %	0.34%	0.47%
LOS 3+ Observed %	4.38%	5.11%

SHMI

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 continue to meet; looking at cases that are mortalities within 48 hours of admission and mortalities within 30 days of hospital discharge the next meeting is on the 9th November. Which has identified areas for improvement with advanced care planning within the community for the GSF.
- From in-depth mortality reviews the depth of coding is being investigated by CHKS to improve coding with the Trust.



Mortality Reviews

Reviews (Jan 2016-Sep 2017)

Site	Deaths	Awaiting notes/Notes in Quality Governance	Notes Sent for Review	Review Complete	Review completion Compliance	Review Completion Target	Total Death % Reviewed
ULHT Total	5100	950	4150	3377	81%	70%	66%
Lincoln Total	2786	424	2362	1949	83%	70%	70%
Pilgrim Total	2014	449	1565	1229	79%	70%	61%
Grantham Total	300	77	223	199	89%	70%	66%

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

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

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

Review Complete total	**195**	**1353**	**1715**	**3263**
Grade	**GDH**	**PHB**	**LCH**	**ULHT**
0	181	959	1613	2753
1	11	126	196	333
2	2	40	52	94
3	0	3	7	10
Not completed	5	82	81	168

Mortality Reduction Actions

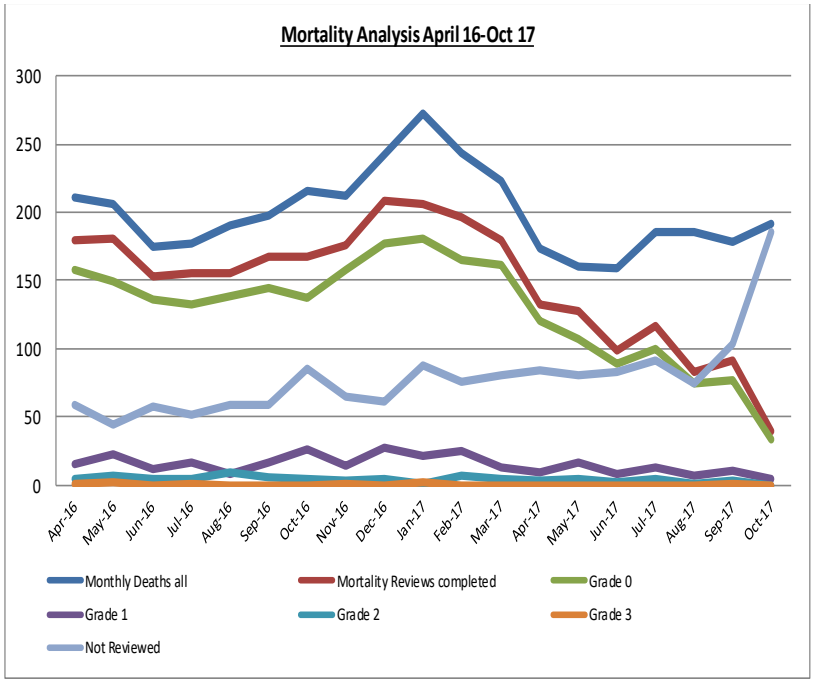
Mortality Review	Source	Review Commenced	Site	Actions	Lead	Timescale	Progress	RAG	Evidence Received
Lincolnshire Mortality Collaborative	On-going	Underway	All	To understand the SHMI data on an organisational level. Review cases of deaths within 30 days of discharge, appropriate admissions and within 48 hours of admission. To correlate with community services and general practitioners	Dr Andrews/ Karen Moon	On-going	6 weekly meetings established since May 2017 with a quarterly update to Patient Safety committee		
Mortality Shared Learning Breifings	On-going	Underway	All	Create 2 mortality brieifngs one for the MoRAG case note review learning and the other for Mortality Matters that covers various issues pertaining to Mortality	Dr Andrews/ Karen Moon	On-going	Monthly production and circulation for MoRAG case note breifings and Mortality Matters		
MoRAG	On-going	Underway	All	Mortality Surveillence Group to do in-depth reviews, where initial reviews have been Graded 1 or above.	Dr Andrews/ Karen Moon/ Kayleigh Pinner /Emma Wilson	On-going	Monthly meetings have been established since Feb 2016. With a Quarterly update to PSC		
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	This is booked for the 31st October 2017 and run qaurterly after that.		
Junior Doctor Teaching	On-going	Underway	All	JD Teaching across each site	Quality Governance	On-going	PHB & LCH have had teaching-GDH booked for the end of November. To get on every year after that.		
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.		
	Dr Foster		LCH	Now 3 months of alerting In-depth review to be undertaken	Karen Moon	Jan-17	Patient List sourced, notes requested		
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	Dec-17	To report findings to PSC		
Respiratory Failure, insufficiency, arrest (adult)	Dr Foster	Underway	Trust	Now 3 months of alerting In-depth review to be undertaken	Karen Moon	Jan-17	Patient List sourced, notes requested		
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	Jan-17	Meeting held and actions allocated. Jude Cheesmond looking at coding process. Actions as per email attached. Another progress meeting arranged 18/12/17		
Comorbidity Action Plan	Trust	Underway	Trust	Action plan to be agreed to raise awareness	Karen Moon	On-going	..\..\MORTALITY\Mortality work plan 17\Comorbidity\Comorbidity Action Plan.xls		
Community-LCHS hospitals	LCHS	Underway	Trust	Reviewing deaths within 24 hours of discharge to community hospital	Karen Moon/Kim Todd/ Richard Andrews	On-going	Received from LCHS deaths within 30 days of discharge. All under 24 hours to be reviewed by the mortality collaborative		

Learning from Deaths National Template

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable Grade 2&3	
This Month-Oct 17	Last Month-Sep 17	This Month-Oct 17	Last Month-Sep 17	This Month-Oct 17	Last Month-Sep 17
192	178	83	117	0	1
This Quarter (QTD) (August 17-Oct 17)	Last Quarter (Apr 17-Jul 17)	This Quarter (QTD) (August 17-Oct 17)	Last Quarter (Apr 17-Jul 17)	This Quarter (QTD) (August 17-Oct 17)	Last Quarter (Apr 17-Jul 17)
370	498	130	360	1	9
This Year (YTD) (Apr 17-Oct 17)	Last Year (Apr 16-Mar 17)	This Year (YTD) (Apr 17-Oct 17)	Last Year (Apr 16-Mar 17)	This Year (YTD) (Apr 17-Oct 17)	Last Year (Apr 16-Mar 17)
1234	2566	690	2127	18	69



Review Grading

Grade 0		Grade 1		Grade 2		Grade 3		Grading not completed	
Unavoidable death, no suboptimal care		Unavoidable death, suboptimal care but different management would NOT have affected outcome		Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)		Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)		Not completed in proforma by reviewer	
This Month-Oct 17	87%	This Month-Oct 17	13%	This Month-Oct 17	0%	This Month-Oct 17	0%	This Month-Oct 17	0%
This Quarter (QTD) (August 17-Oct 17)	87%	This Quarter (QTD) (August 17-Oct 17)	10%	This Quarter (QTD) (August 17-Oct 17)	2%	This Quarter (QTD) (August 17-Oct 17)	0%	This Quarter (QTD) (August 17-Oct 17)	1%
This Year (YTD) (Apr 17-Oct 17)	87%	This Year (YTD) (Apr 17-Oct 17)	10%	This Year (YTD) (Apr 17-Oct 17)	2%	This Year (YTD) (Apr 17-Oct 17)	0%	This Year (YTD) (Apr 17-Oct 17)	1%

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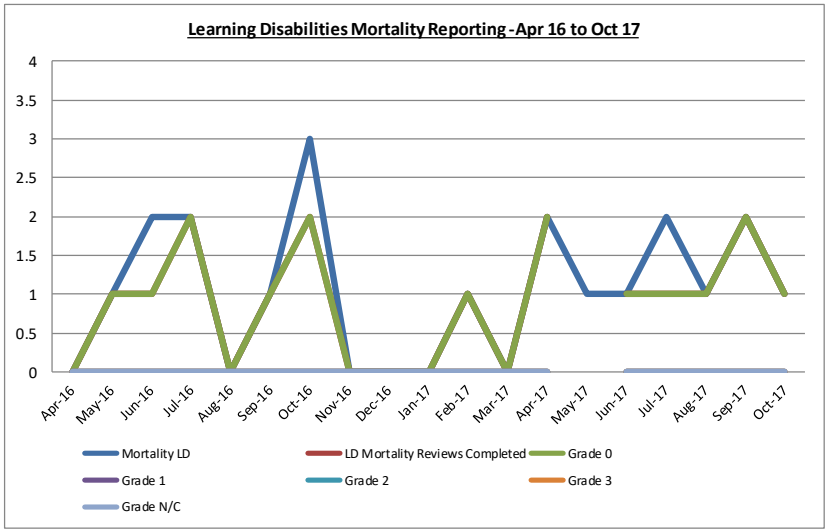
Learning Disability Deaths

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

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable Grade 2& 3	
This Month-Oct 17	Last Month-Sep 17	This Month-Oct 17	Last Month-Sep 17	This Month-Oct 17	Last Month-Sep 17
1	2	1	2	0	0
This Quarter (QTD) (August 17-Oct 17)	Last Quarter (Apr 17-Jul 17)	This Quarter (QTD) (August 17-Oct 17)	Last Quarter (Apr 17-Jul 17)	This Quarter (QTD) (August 17-Oct 17)	Last Quarter (Apr 17-Jul 17)
4	6	4	6	0	0
This Year (YTD) (Apr 17-Oct 17)	Last Year (Apr 16-Mar 17)	This Year (YTD) (Apr 17-Oct 17)	Last Year (Apr 16-Mar 17)	This Year (YTD) (Apr 17-Oct 17)	Last Year (Apr 16-Mar 17)
10	10	8	8	0	0



Mental Health deaths

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

			Reviews				
Qrtly Mortality	Month	Total Mortality	Grade 0	Grade 1	Grade 2	N/R	Review Compliance
16/17 QTR 1 MH	Apr-16	61	40	3	1	17	72%
169	May-16	59	34	11		14	76%
	Jun-16	49	35	3	2	9	82%
16/17 QTR 2 MH	Jul-16	64	43	6	2	13	80%
187	Aug-16	64	39	2	5	18	72%
	Sep-16	59	43	4	2	10	83%
16/17 QTR 3 MH	Oct-16	55	36	8	2	9	84%
220	Nov-16	73	45	6	1	21	71%
	Dec-16	92	62	9	1	20	78%
16/17 QTR 4 MH	Jan-17	71	44	6	1	20	72%
244	Feb-17	86	54	5	4	23	73%
	Mar-17	87	51	6	1	29	67%
17/18 QTR 1 MH	Apr-17	58	36	2	1	19	67%
162	May-17	51	28	4		19	63%
	Jun-17	53	25	4		24	55%
	Jul-17	42	25	5	2	10	76%
17/18 QTR 2 MH	Aug-17	62	23	2	1	36	42%
142	Sep-17	27	14			13	52%
	Oct 17	53	10	1		42	21%
	Grand Total	1166	687	87	26	366	69%

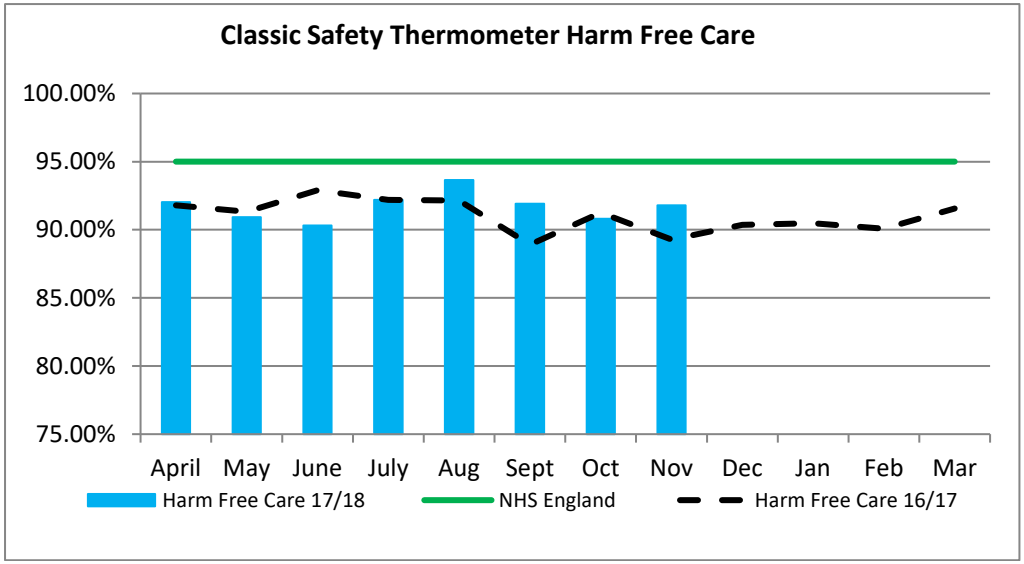
Serious Incidents

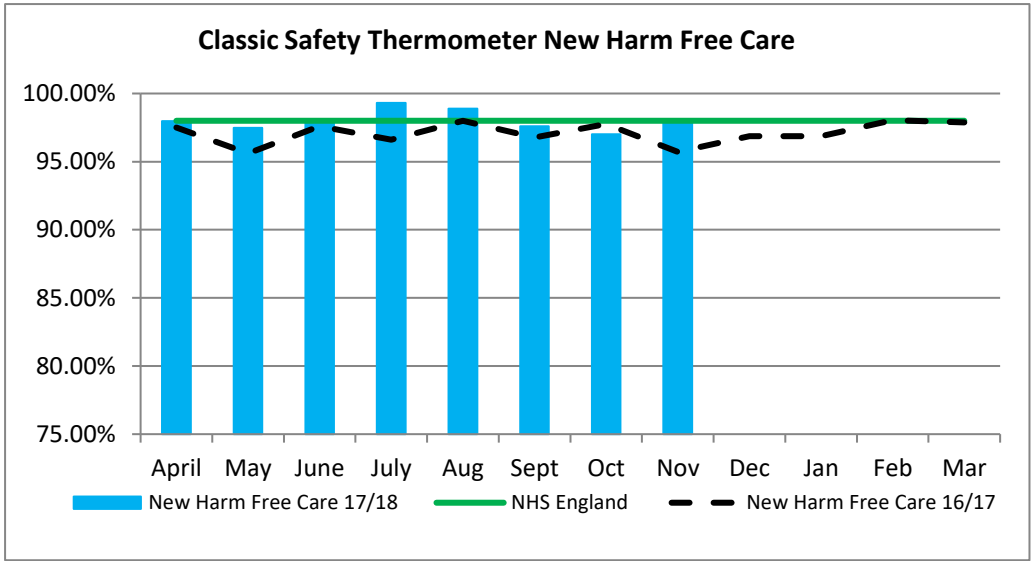
All Serious incidents form part of the “Must Do Reviews” within the Trust Methodology. Quality Governance pulls from datix the Serious Incidents with the severity of Death. Below are those SI’s correlated with the internal mortality process. Reviews are shared with the Risk Team to provide supplementary evidence to the Incident review to ensure a robust process;

Month Reported	Initial rev compl	Initial Grade	MoRAG Completed	MoRAG Grade	No. of SI's
Jan-17	No	N/R	N/R	N/R	1
	Yes	Grade 2	Yes	Grade 2	1
	W&C	W&C	W&C	W&C	1
Feb-17	No	N/R	N/R	N/R	1
	Yes	Grade 2	Yes	Grade 3	1
Mar-17	No	N/R	N/R	N/R	1
	Yes	Grade 0	N/A	N/A	1
		Grade 2	Yes	Grade 2	1
Apr-17	N/A	N/A	N/R	N/R	1
	No	N/R	N/R	N/R	1
	Yes	Grade 0	N/A	N/A	1
May-17	No	N/R	N/R	N/R	2
	Yes	Grade 2	Yes	Grade 3	1
				Grade 1	1
	W&C	W&C	W&C	W&C	1
Jun-17	No	N/R	N/R	N/R	4
	Straight to MoRAG	N/A	No	N/C	1
	Yes	Grade 0	N/A	N/A	1
		Grade 1	Yes	Grade 2	1
Jul-17	No	N/R	N/R	N/R	1
		Straight to MoRAG	No	(blank)	1
	Yes	Grade 0	N/A	N/A	1
		Grade 2	Yes	Grade 2	1
Aug-17	No	N/R	N/R	N/R	3
	Yes	Grade 1	Yes	Grade 2	1
Sep-17	No	No-Complaint also	N/R	N/R	1
		N/R	N/R	N/R	2
		30 day death	N/A	N/A	1
Oct-17	No	N/A	N/A	N/A	1
	Yes	Grade 2	Yes	Grade 2	1
	Not deceased on our system	Awaiting Risk	Awaiting Risk	Awaiting Risk	1
Grand Total					38

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

Executive Responsibility: Michelle Rhodes – Director of Nursing





Performance Data Overview November 2017

	ULHT	GDH	LCH	PBH
Harm Free Care	91.8%	94.3%	93.4%	89.0%
New Harm Free Care	98.1%	100.0%	98.9%	96.4%
New Category 2	6	0	1	5
New Category 3	3	0	1	2
New Category 4	1	0	0	1
Low Harm	5	0	1	0
Moderate Harm	0	0	0	0
Severe Harm	0	0	0	0
Catheter & New UTI	1	0	1	0
New VTEs	2	0	1	1
Patients	819	66	411	309

Action Plan

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

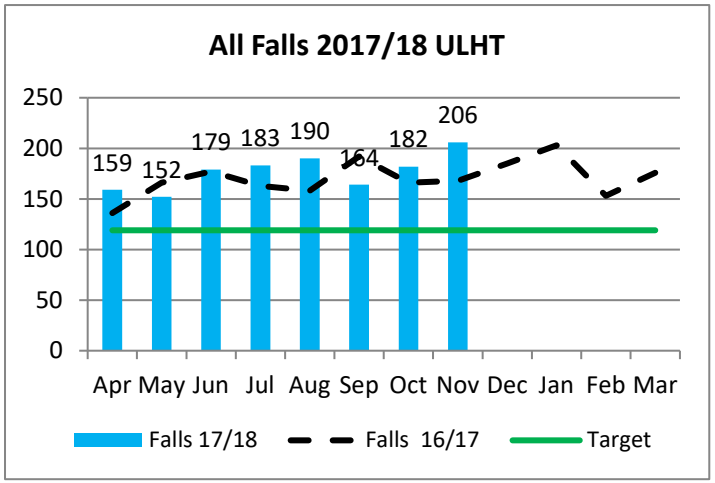
Fall actions outlined within Quality Report (see respective falls page). Results reported upwardly to Falls Reduction Group with delegated authority from Patient Safety Committee.

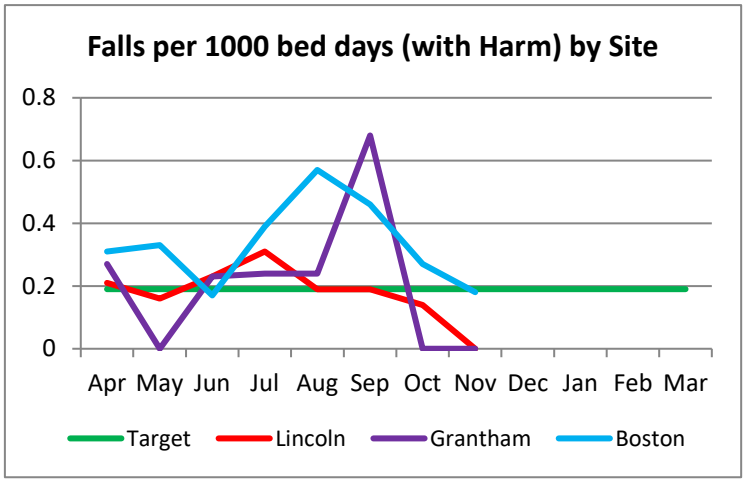
CA-UTI actions outlined within Quality Report (see respective CA-UTI page). Results reported upwardly to Catheter Reduction Group with delegated authority from Patient Safety Committee.

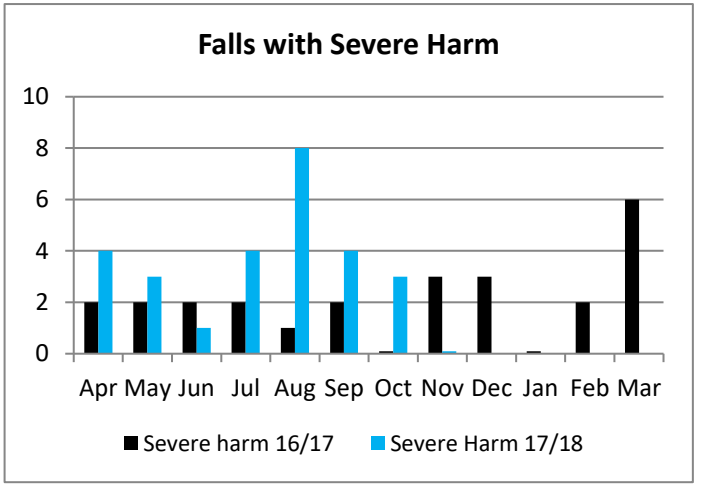
VTE investigated through Route Cause Analysis by VTE Nurse Manager and reported upwardly through Patient Safety Committee.

Safe Ambition 3: Reduction of Harm Associated with Falls

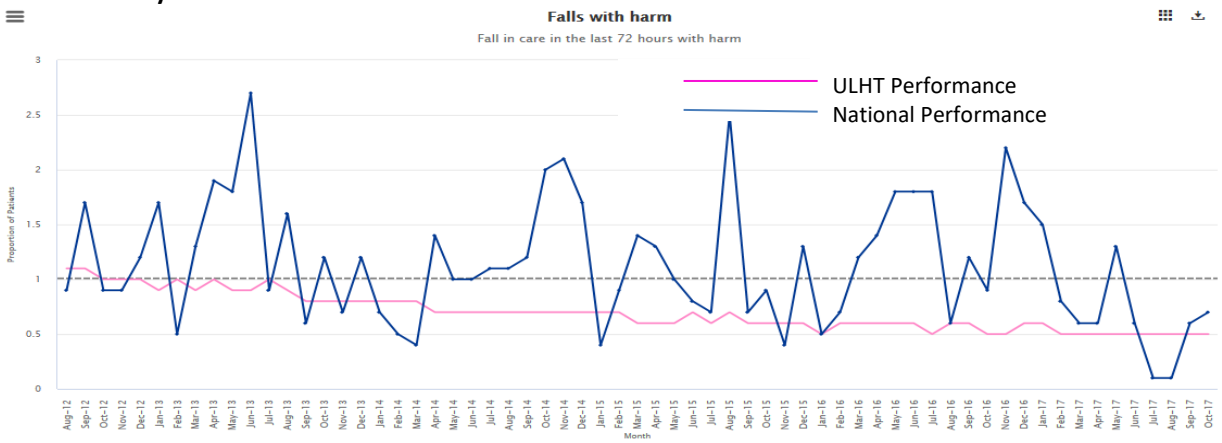
Executive Responsibility: Michelle Rhodes – Director of Nursing







Safety Thermometer 2017



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

Metric Title	Sep 2017	Oct 2017	Nov 2017
Number of patients at risk of falls	322	313	338
Medication review occurred	100.00%	83.30%	100.00%
Actions completed within 4 hours	86.00%	91.70%	94.10%
Neuro Cognition assessed	95.70%	97.80%	98.20%
Actions completed within 24 hours on admission	66.30%	65.00%	69.50%
Patient vision assessed	94.10%	97.40%	97.30%
Bed rail assessment completed if required	99.40%	99.40%	99.40%
Continence/toilet regime documented care plan 4	88.30%	84.20%	87.80%
Care plan 7 activated	95.90%	94.50%	96.10%
Lying & Standing BP Completed	75.00%	67.60%	74.20%

Performance Data Overview November 2017

Nov-17	Target	Lincoln	Pilgrim	Grantham
Ward Falls per 1000 bed days	3.9	6.2	6.67	10.64
Ward Falls with harm per 1000 bed days	0.19	0	0.18	0

The total number of falls has increased in November to 206 compared to 182 in October. The number of falls increased at LCH & GDH, with EAU at GDH &

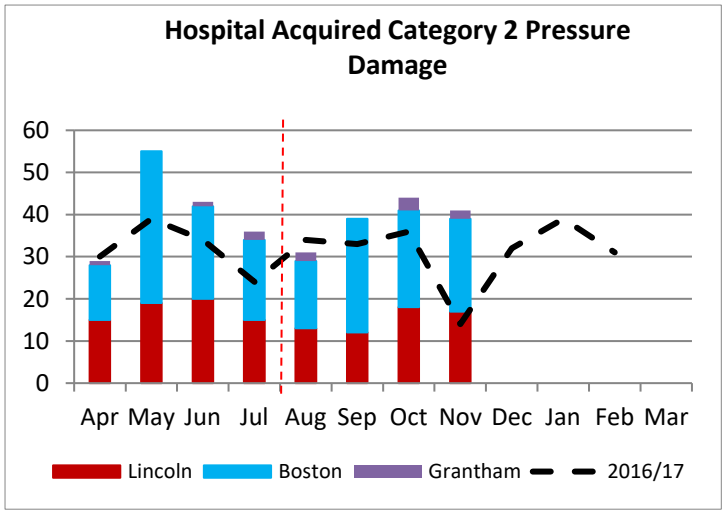
Action Plan

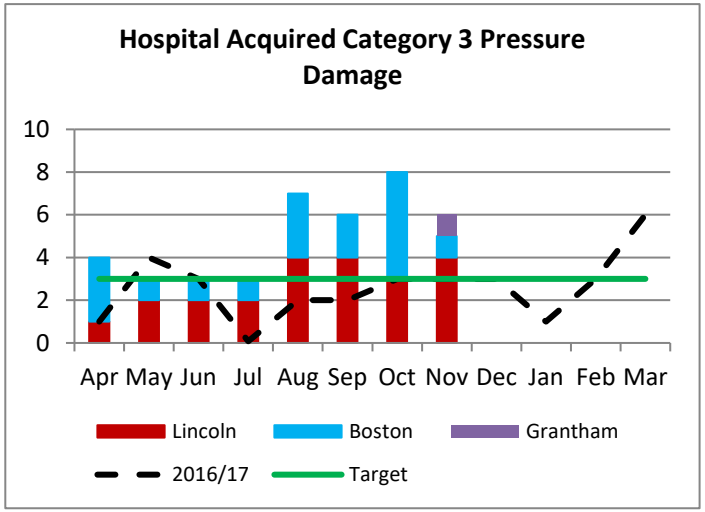
- Detailed analysis of falls incidents being prepared for January PSC & QGC (to include scrutiny of quality metrics on wards with the highest number of falls in Quarter 3: EAU (GDH), FAU, Lancaster, Navenby, MEAU (LCH), 8A, AMU (PHB), 6B, 5B)

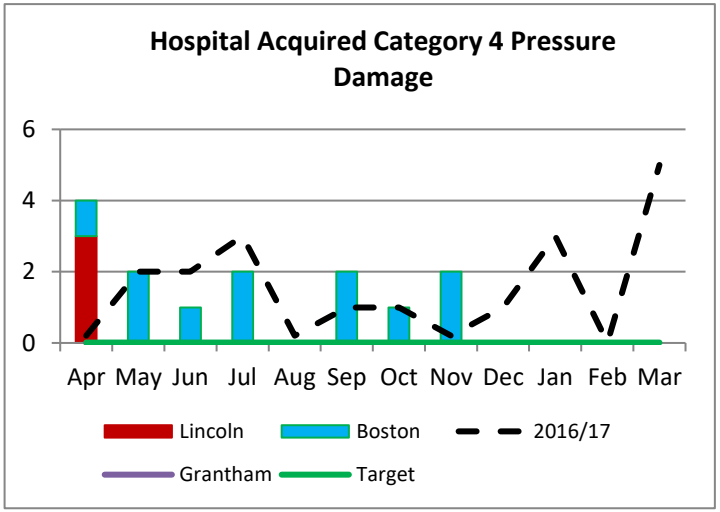
MEAU at LCH both reporting 14 falls with no or low harm. When the incidence of falls is recalculated using the corrected bed days, all sites are above the target of 3.9 falls per 1000 bed days. Falls with harm per 1000 bed days for the Trust is 0.07 which is below the target of 0.19 for the first time since April. Both LCH & GDH had no falls with harm, at PHB ward 6B & 7B each had a fall with moderate harm.	• Post fall rapid review checklist being explored to ensure preventative actions are taken to reduce multiple falls • Rollout of NHSi falls prevention collaborative work – prioritising completion of workbook and completion of lying and standing BP • Development of site based falls prevention groups with Ward Ambassadors • Falls prevention literature being developed to support NICE Guidance recommendations • Exploration of Falls Bundle to accompany Risk Assessment

Safe Ambition 4: Reduction of Harm Associated with Pressure Ulcers

Executive Responsibility: Michelle Rhodes – Director of Nursing

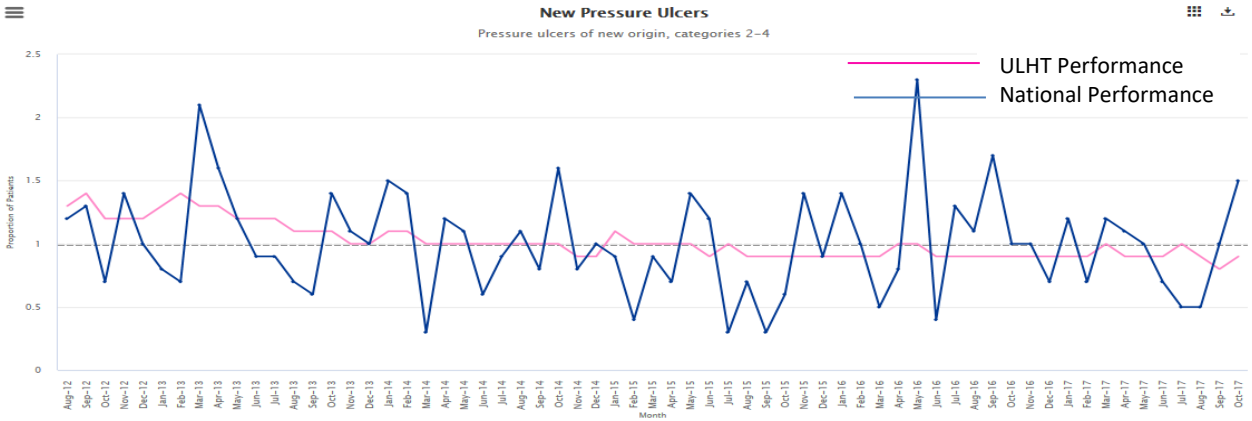






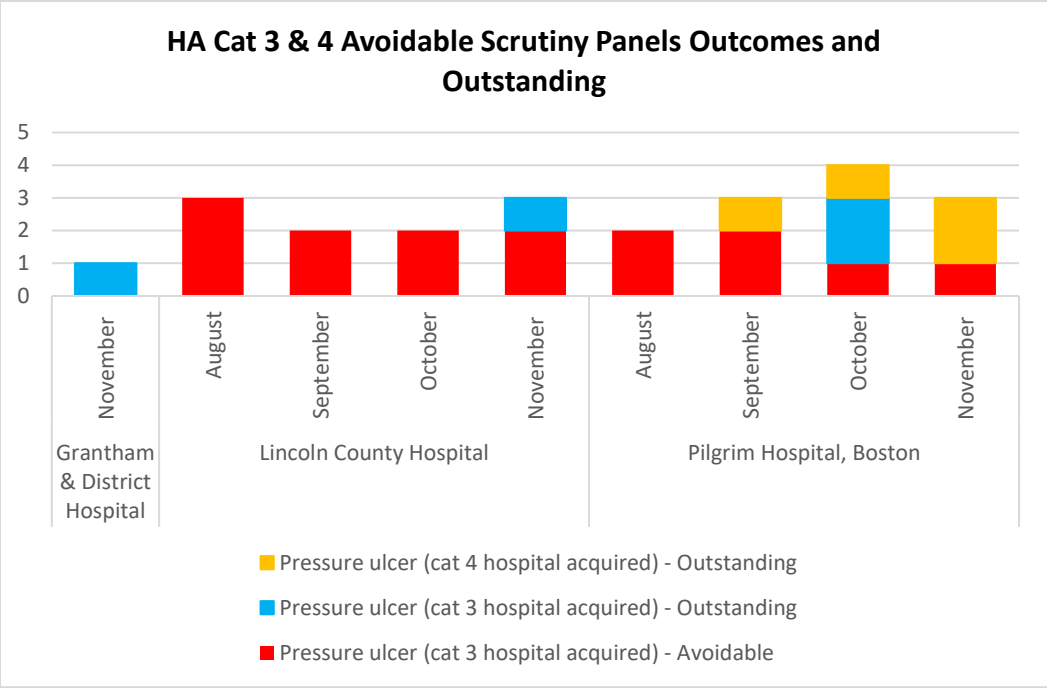
Reporting function changed to Datix August 2017

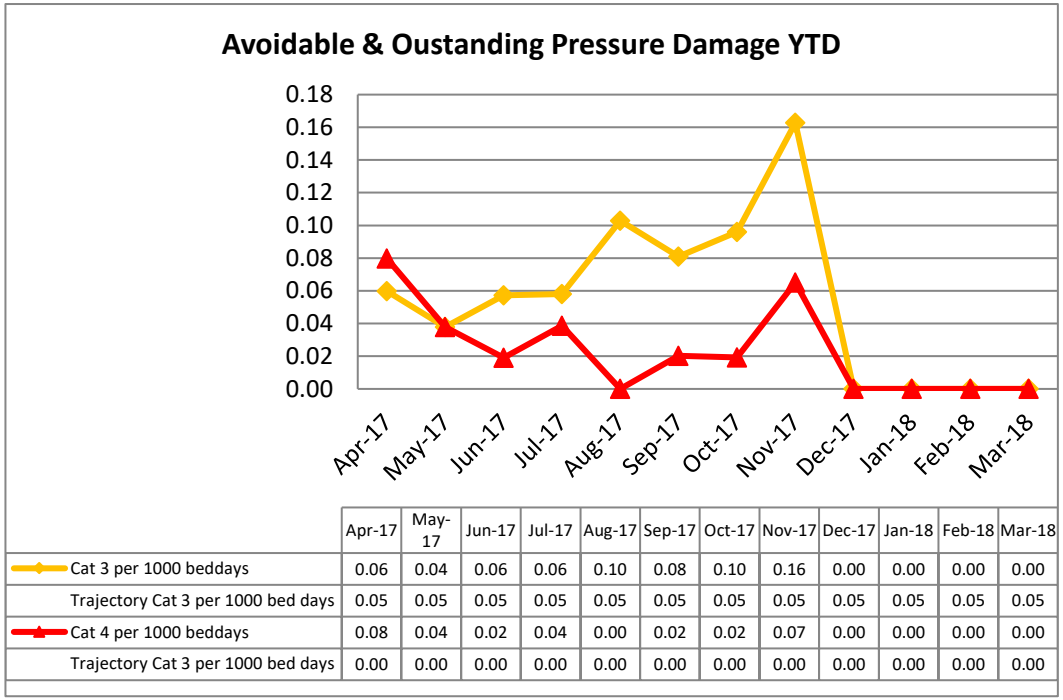
Safety Thermometer 2017



Safety Quality Dashboard (SQD) for Trust Pressure Damage Sep 2017- Nov 2017

Metric Title	Sep 2017	Oct 2017	Nov 2017
Pressure area risk assessment completed <4hrs	96.60%	97.10%	99.30%
Pressure area risk assessment updated weekly	79.90%	78.90%	78.10%
Pressure-relieving equipment in situ if required	94.80%	95.60%	96.90%
Frequency of repositioning documented	93.80%	92.80%	91.60%
Prescribed frequency of turning has been followed	91.80%	87.70%	86.90%
Pressure area care plan activated if required	93.20%	91.40%	89.80%





	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Cat 3 per 1000 beddays	0.06	0.04	0.06	0.06	0.10	0.08	0.10	0.16	0.00	0.00	0.00	0.00
Trajectory Cat 3 per 1000 bed days	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05
Cat 4 per 1000 beddays	0.08	0.04	0.02	0.04	0.00	0.02	0.02	0.07	0.00	0.00	0.00	0.00
Trajectory Cat 3 per 1000 bed days	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Performance Data Overview November 2017

Site	Cat 1	Cat 2	Cat 3	Cat 4
Lincoln	4	17	4 (Greetwell, C/Coleby, Dixon x2)	0
Grantham	0	2	1 (Ward 2)	0
Boston	7	22	1 (8A)	2 (5B, 8A)
Louth	0	0	0	0

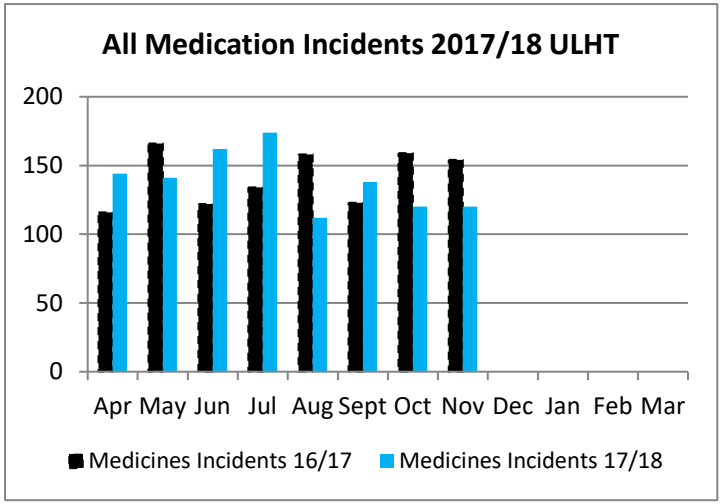
There was a reduction in the total number of pressure ulcers reported in November (60) compared to October (69). 2 category 4 PUs and 6 category 3 pressure ulcers were reported in November compared to 1 cat 4 PU and 8 category 3 pressure ulcers in October.
Not all of the scrutiny panels have taken place to determine avoidability, however the PU on Greetwell was determined to be unavoidable, and the cat 3 PUs on Dixon ward and 8A were found to have been avoidable.
Ward 5B have reported a cat 4 PU monthly for the last 3 months. Scrutiny panels are booked for early Jan 2018 due to delays in retrieving notes to complete the investigations.

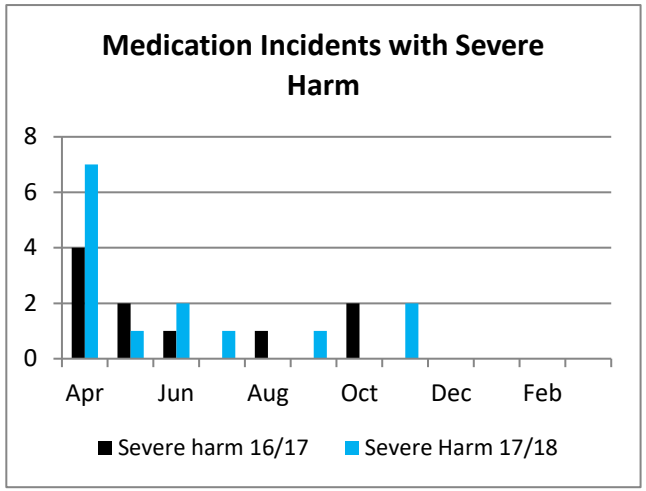
Action Plan

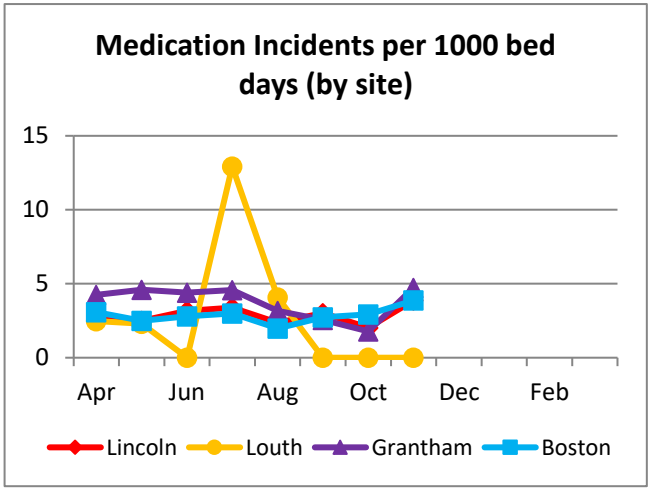
- Deep dive into Shuttleworth and 8A undertaken by Matrons and presented to QSG Nov 2017. Focus now on individual accountability
- Deep dive into performance on 5B to be considered if scrutiny panel outcomes avoidable and lapses in care are identified
- Targeted work by TVNs continues with ward teams where cat 3&4 PUs continue to be reported, with a particular focus on ward 8A, and where the Ward Accreditation inspection outcome for the Tissue Viability standard is 'red' (Navenby, Dixon, 7A)
- 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
- Additional training for HCSWs ongoing

Safe Ambition 5: Reduction of Harm Medication Incidents

Executive Responsibility: Michelle Rhodes – Director of Nursing







Number of moderate, severe and death rated incidents by ward location over the last 6 months June 2017 - November 2017

WARD/DEPARTMENT	NO.
A&E Department - Lincoln	3
Breast Screening Unit - Lincoln	3
Ward 5A	3
Ward 6B	3
Ward 7B	3
A&E Department - Pilgrim	2
Ward 5B	2

Safety Quality Dashboard (SQD) Dashboard for Medications Sep 2017- Nov 2017

Metric Title	Sep-2017	Oct-2017	Nov 2017
Medicine chart demographics correct	97.80%	98.90%	98.10%
Allergies documented	100.00%	99.40%	98.90%
All medicines administered on time	83.90%	84.90%	83.60%
Allergy name band in place if required	84.30%	92.10%	88.10%
Identification name bands in situ	98.70%	99.50%	96.60%

Performance Data Overview November 2017

There was 1 severe incident in November 2017. This related to the management of a hypo episode. The most common medication error types were:-

Adverse Event Type	Number
Omitted medicine/ingredient	51
Wrong/unclear dose or strength	13
Mismatching between patient and medicine	12
Wrong frequency	11
Wrong drug/medicine	9

60% (72/120) of all the events recorded were associated with high risk drugs. The top 4 drug groups are; antimicrobials (32%), insulin and antidiabetics (28%), opiates (19%) and anticoagulants (11%).

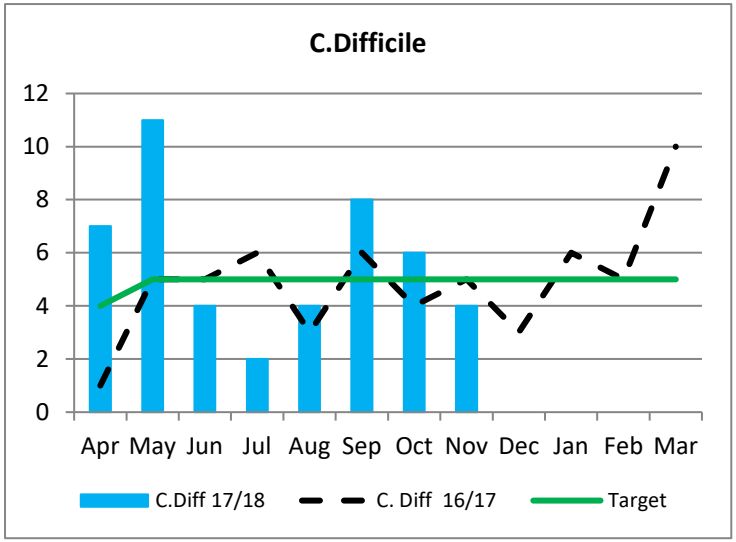
Action Plan

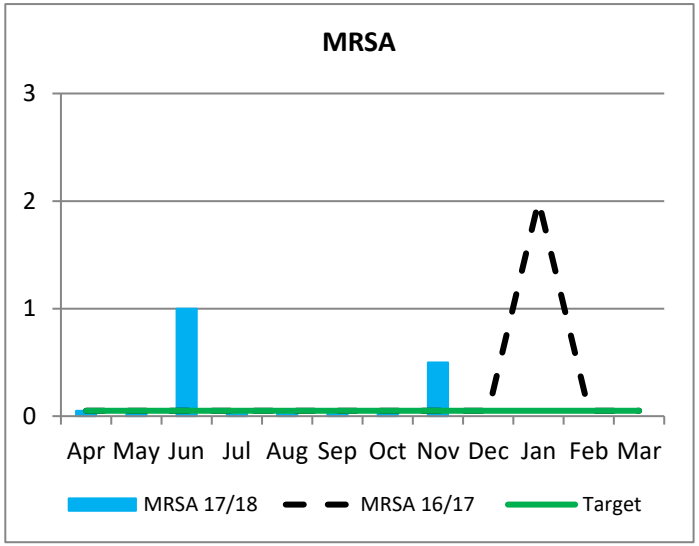
This report is reviewed at the Medicine Optimisation and Safety Committee (MOPS) and all incidents are reviewed on a monthly basis to identify trends. All Heads of Nursing receive the errors by ward area and disseminate to their matrons who in turn disseminate to their ward leaders. These all must be 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.

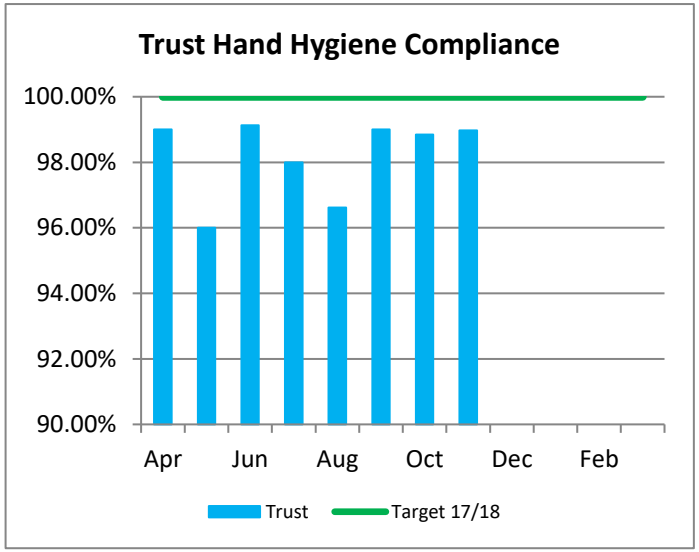
Representation at MOPS in respect of nursing and medical should improve from January 2018.

Safe Ambition 6: Reduction of Harm Associated with Infection

Executive Responsibility: Michelle Rhodes – Director of Nursing







Performance Data Overview November 2017

Hand Hygiene	
Trust	98.97%
Grantham	99.75%
Lincoln	98.90%
Louth	100%
Pilgrim	98.51%

C-Diff episodes were reported as follows:-
2 X Burton Ward Lincoln
1 X 7B Boston
1 X 5A Boston

Action Plan

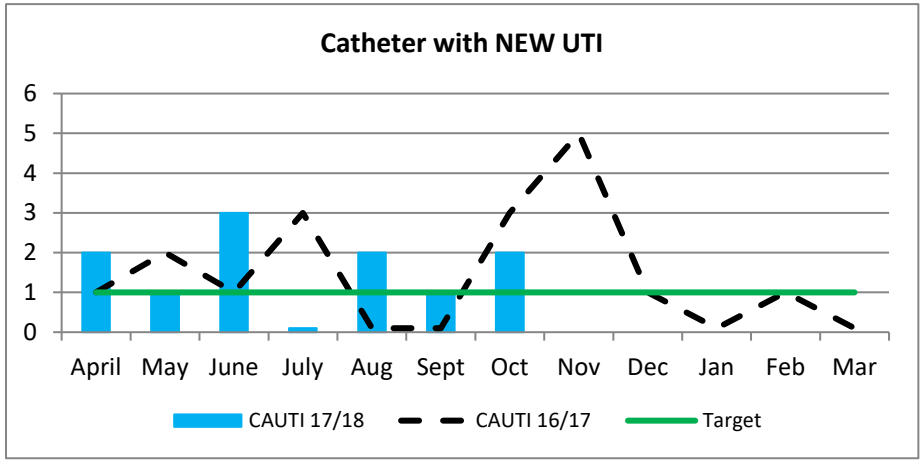
CDI reduction:

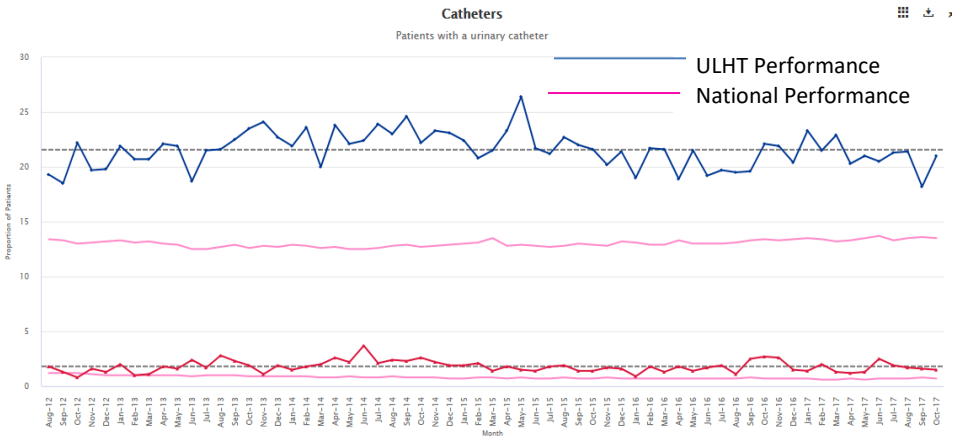
- A meeting took place on 30.11.2017 to review the five cases of CDI reported on Ward 7B at Pilgrim Hospital during this financial year. Focused actions concerning antimicrobial stewardship are being implemented on the ward.
- Continued focus trust-wide on rapid isolation and testing of patients with suspected symptoms of CDI
- Frequent IPCN visits to areas deemed to be high risk
- Enhanced cleaning regime in place on areas where there are symptomatic patients with known CDI or GDH
- All toilets and sluices trust-wide are being routinely disinfected with a chlorine-based disinfectant
- HPV business case has been submitted: outcome awaited

Gram-negative bloodstream infection (GNBSI) reduction work is being co-ordinated by the CCG Health Protection Team for the Lincolnshire Whole Health Economy (WHE). ULHT are contributing to this via regular attendance at the WHE Infection Prevention Group. The trust IP team will contribute a GNBSI reduction plan in January 2018 which will be incorporated into the economy-wide plan.

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

Executive Responsibility: Michelle Rhodes – Director of Nursing





Safety Quality Dashboard (SQD) for Trust catheter care Sep 2017- Nov 2017

Metric Title	Sep 2017	Oct 2017	Nov 2017
Number of urinary catheters in-situ	82	87	86
Urinary catheter record demographics correct	92.60%	90.70%	91.70%
Urinary catheter record completed & signed daily	68.80%	64.30%	59.80%
TWOC occurred within 3 days for acute retention	30.00%	60.00%	30.00%
Documented evidence why catheter needed	93.80%	94.10%	88.00%

Performance Data Overview November 2017

	Metric Title	Sep 2017	Oct 2017	Nov 2017
Boston	Catheter record completed & signed daily	56.7%	45.5%	37.5%
Grantham		100.0%	100%	100%
Lincoln		73.3%	72.7%	64.7%
Boston	TWOC within 3 days for acute retention	0.0%	40%	28.6%
Grantham		100%	100%	-
Lincoln		50.0%	66.7%	33.3%

Action Plan

Request and arrange meetings with heads of nursing to identify successful ways to engage nursing and medical staff in CAUTI reduction programme.

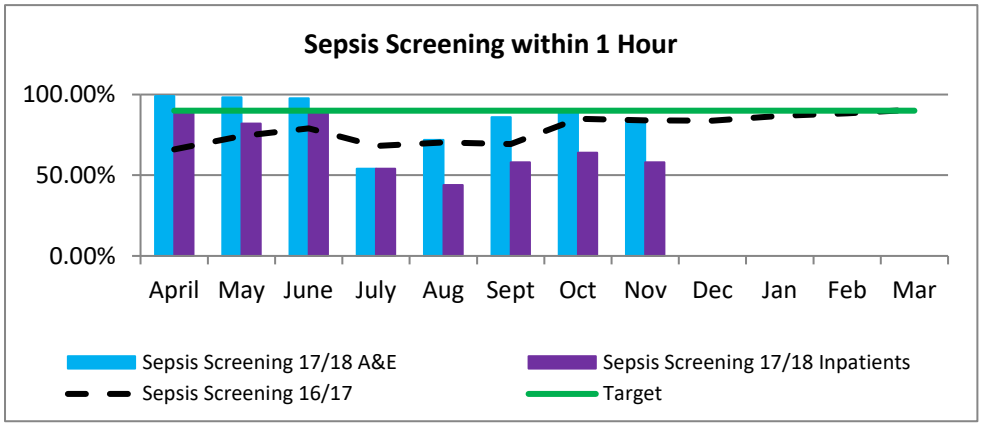
Reorganize attendance at Band 7 meetings on all sites to provide education and support, and to highlight areas of non-concordance with the Catheter Care Bundle with the aim of promoting local ownership.

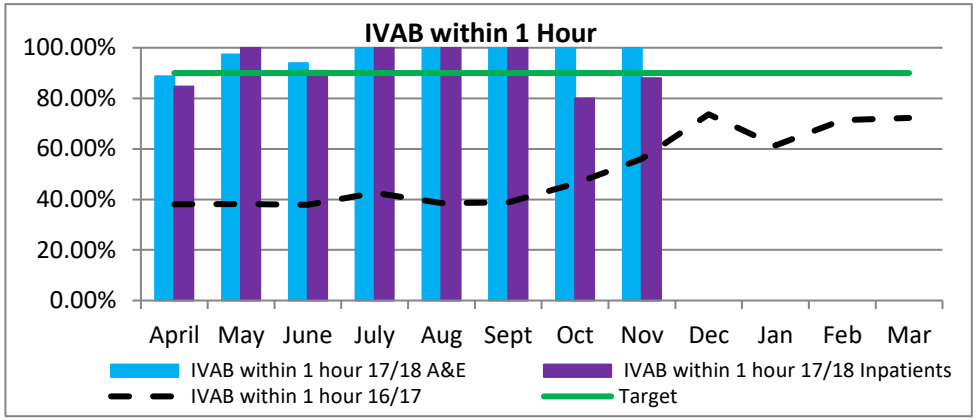
Reorganize Catheter Focus Sessions led by Continence Specialist Nurses with focus on appropriate insertion and TWOC

Reorganize launch of Link Nurse/Ambassador Programme with representation from all clinical areas.

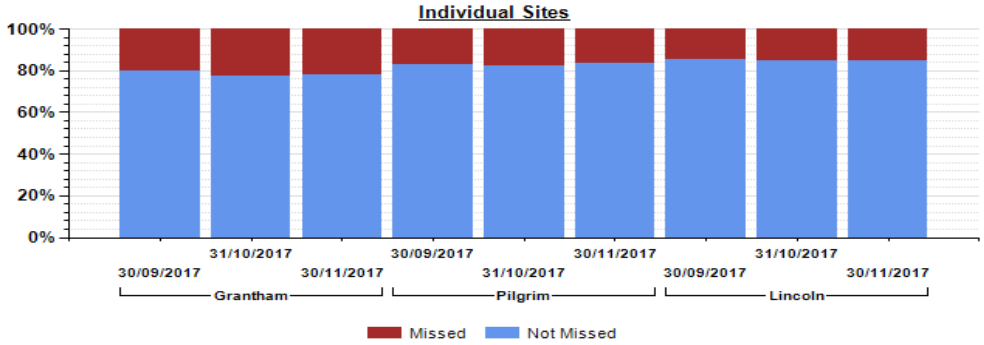
Safe Ambition 7: Reduction of Harm Associated with Deterioration Sepsis

Executive Responsibility: Michelle Rhodes – Director of Nursing

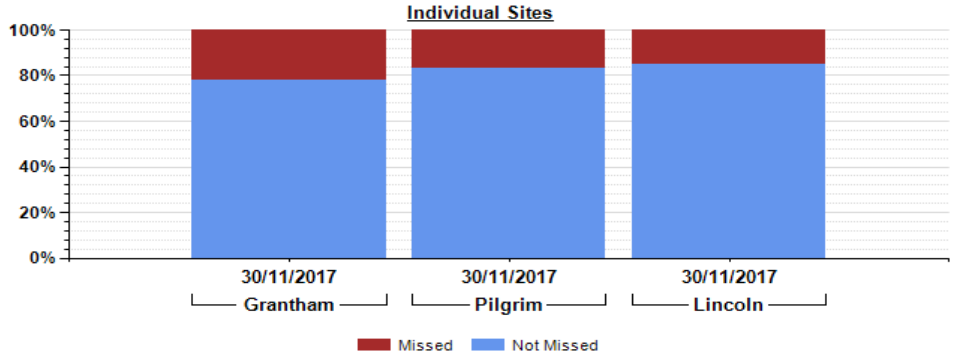




Patient Electronic Observations (Site) November 2017



Patient Electronic Observations (Trust) Sep-Nov 2017



Performance Data Overview November 2017

A&E Target 90%	Screening – Nov 2017	IVAB within 1 hour – Nov 2017
Trust	84% (down from 90%)	100% (same as previous month)
Inpatients Target 90%	**Screening – Nov 2017**	**IVAB within 1 hour – Nov 2017**
Trust	58% (down from 64%)	88% (up from 80%)

E-Learning Sepsis 89.41% at 30th November 2017.

Action Plan

- Revised Sepsis boxes containing required equipment for completion of Sepsis 6 in 60 (excluding actual Abx and IVI) being rolled out to all inpatient areas this week.
- Simplified Screening Flow Chart, Reference Guide on how to complete the Sepsis 6 in 60, reiteration of screening protocol and questionnaire regarding perceived training shortfalls already disseminated. For collection and consolidation after Christmas Bank Holiday to allow for targeted training.
- Weekly missed screens to be escalated to ward managers for review, commencing ASAP.

Workforce Headline Summary

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

Statistics

KPI	2017/18 Target	November 2017 Performance	Last Month Performance	Performance in November 2016	6th Month Trend
Vacancy Rate - Medical	Medical – 12%	**15.76%**	**15.42%**	**13.23%**	
Vacancy Rate – Registered Nurses	Registered Nursing 11.5%	**13.09%**	**13.28%**	**12.50%**	
Vacancy Rate – AHP's	10%	**8.29%**	**8.39%**	**9.44%**	
Voluntary Turnover	7%, with no group of staff more than 20% above the overall target	**5.51%**	**5.37%**	**n/a**	
Quarterly Engagement Index	10% improvement in average score during 2017/18	**3.3**	**3.4 (last pulse check)**	**n/a**	
Quality of Leadership/Management Index	10% improvement in average score during 2017/18	**2.6**	**2.8 (last pulse check)**	**n/a**	
Core Learning Completion	Overall target remains 95%.	**90.85%**	**89.17%**	**85%**	
Sickness Absence (12 month rolling average)	Overall target of 4.5% + no team over 25% above target	**4.77%**	**4.75%**	**4.54%**	
Appraisals - Medical	Medical – 95%	**95%**	**94%**	**92%**	
Appraisals – Non Medical	Non-medical – 85%	**78.70%**	**78.11%**	**70.40%**	
Agency Spend	£25.4m (£)	**£2.406m**	**£2.547m**	**£2.372m**	

Patient centred ▪ Excellence ▪ Respect ▪ Compassion ▪ Safety

Commentary

The overall vacancy rate reduced again in November. There have been slight improvements in the Registered Nursing and AHP vacancy rate, reflecting the successful recruitment exercises we have recently undertaken. The Medical and Dental vacancy rate has increased by 0.34% from the previous month. The successful appointment of new medical staff is being counter-balanced by staff leaving. We have a number of candidates in the pipeline, some of whom are undertaking assessment for their quality of English and will not fully join the establishment until February.

The N&M vacancy rate continues to improve month on month. The vacancy rate for Registered Nurses has reduced from 13.28% to 13.09%. This is due to a net increase in registered nurses in November of 9.58 wte. AHP vacancies at the end of November stand at 33.63 wte. This is down from 55.71 wte vacancies 6 months ago (end of May).

The Medical Workforce appraisal rate for the month ending November 2017 is 95%. This figure achieves the Trust target for the fifth time in six months.

The core learning compliance rate has taken an upward turn to the highest rate we've seen since we started reporting compliance in 2014. Non-Medical appraisals is once again moving in an upward trend, more work needs to be done to get it back on track (4% 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.

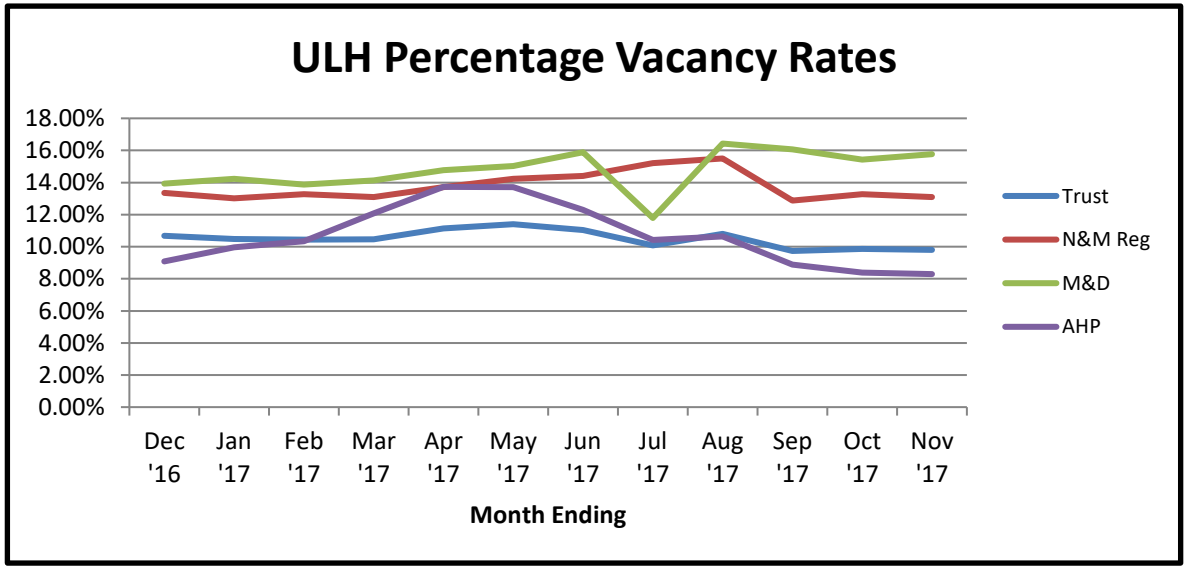
The National Staff Survey is now complete. The response rate is 45% which is significantly higher than last year (39%) and in line with the national average.

KPI:	**Vacancy rates**	**Owner:**	Director of HR & OD
Domain:	**Well Led**	**Responsible Officer:**	Deputy Director of HR & OD
Date:	16th January 2018	**Reporting Period:**	November 2017
Target:	Medical – 12% Registered Nursing – 11.5% AHPs – 10%	**Tolerances:**	**Within 1% - Amber** **Above 1% - Red**
RAG Rating:	Medical 15.76%		
RAG Rating:	N&M 13.09%		
RAG Rating:	AHP's 8.29%		

Analysis

Whilst vacancy rates overall are above target, in November the Trust employed approximately the same number of Consultants and more middle grade doctors, Allied Health Professionals, Registered Nurses & Midwives and non-registered Nurses than twelve months ago. Indeed, vacancies for Consultants (11.90%), AHPs (8.29%) and non-registered Nurses (6.83%) are within Trust target. The overall Trust vacancy rate for November is 9.80%, which compares favourably to the 10.75% rate in November 2016.

The Registered Nursing & Midwifery vacancy rate decreased from 13.28% in October to 13.09% in November.



The table below shows the number of staff in post against establishment for the period April 17 to Nov 17. Where the number is higher than the period 12 months ago, the shading is green, where it is lower, the shading is red. This shows the progress being made, rapid in some areas (e.g. unregistered nurses) and slower in other areas (e.g. medics). Changes in definitions and the TUPE of GP trainee's makes comparison of the doctors in training figures with previous years difficult. However the fewer placement we have had at ULHT has added to our shortages.

	April 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17
Establishment (registered nurses and midwives)	2274.16	2272.84	2271.06	2270.94	2268.49	2270.04	2271.10	2277.33
Number in post (registered nurses and midwives)	**1962.30**	**1949.39**	**1943.80**	**1925.58**	**1916.91**	**1977.81**	**1969.60**	**1979.18**
% Vacancy Rate (registered nurses and midwives)	13.71%	14.23%	14.41%	15.21%	15.50%	12.87%	13.28%	13.09%
Establishment (non- registered nurses and midwives)	971.62	972.78	977.33	930.34	925.96	928.59	944.46	947.89
Number in post (non-registered nurses and midwives)	**837.47**	**839.18**	**851.75**	**847.71**	**853.53**	**863.23**	**880.22**	**883.19**
Vacancy rate (non-registered nurses and midwives)	13.81%	13.73%	12.85%	8.88%	7.82%	7.04%	6.80%	6.83%
Establishment (AHPs)	405.20	406.19	406.59	403.95	403.75	403.85	403.85	405.58
Number in post (AHPs)	**349.57**	**350.48**	**356.62**	**361.82**	**360.78**	**368.01**	**369.95**	**371.95**
Vacancy Rate (AHPs)	13.73%	13.72%	12.29%	10.43%	10.64%	8.87%	8.39%	8.29%
Establishment (consultants)	358.16	358.16	357.96	358.96	358.96	358.96	358.96	359.96
Number in post (consultants)	**317.41**	**314.81**	**311.29**	**311.87**	**312.11**	**315.43**	**319.43**	**317.13**
% Vacancy Rate (consultants)	11.38%	12.10%	13.04%	13.12%	13.05%	12.13%	11.01%	11.90%
Establishment (middle grades)	201.33	201.33	200.30	200.27	210.27	210.27	210.27	210.27
Number in post (middle grades)	**158.82**	**159.82**	**161.28**	**167.48**	**167.52**	**167.42**	**166.42**	**166.22**
Vacancy rate (middle Grades)	21.11%	20.60%	19.48%	16.37%	20.33%	20.38%	20.85%	20.95%
Establishment (Doctors In Training)	378.24	378.24	381.03	380.16	344.16	344.16	344.16	344.16
Number in post (Doctors In Training)	**325.56**	**322.25**	**317.50**	**349.30**	**283.71**	**283.71**	**286.71**	**286.93**
Vacancy Rate (Doctors In Training)	14.61%	14.80%	16.67%	8.12%	17.56%	17.56%	16.69%	16.63%

Action Taken	**Action Planned**
• Continued recruitment work – currently 62 doctors are under offer to start work with us, as well as 27 registered Nurses, 7.4 AHPs and 15 Non-registered Nurses;	• Continue to deliver on the Recruitment Plan initiatives

Nursing Workforce report

Table One: NQB Average Fill Rates for Registered and Unregistered Staff November 2017

Day		Night	
Average Fill rate- Registered Nurses/ Midwives (%)	Average fill rate – care staff (%)	Average Fill rate- Registered Nurses/ Midwives (%)	Average fill rate – care staff (%)
92.39 (89.00)	99.16 (97.93)	97.43 (95.51)	102.41 (98.85)

Table Two: NQB Average Fill Rates for Registered and Unregistered Staff November 2017 by Hospital Site

Site	Day		Night	
	Average Fill rate- Registered Nurses/ Midwives (%)	Average fill rate – care staff (%)	Average Fill rate- Registered Nurses/ Midwives (%)	Average fill rate – care staff (%)
GDH	94.57 (92.08)	99.77 (100.43)	97.51 (90.12)	95.98 (95.56)
LCH	97.29 (92.37)	97.41 (98.37)	98.23 (97.61)	101.99 (97.03)
PHB	85.72 (84.08)	101.15 (96.86)	96.14 (93.49)	104.62 (102.32)

Safer Staffing: Summary by Site - General Nursing **Nov-17**

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals
Grantham	94.57%	99.77%	97.51%	95.98%	96.74%
Lincoln	97.20%	98.14%	99.35%	102.20%	98.63%
Pilgrim	87.67%	106.88%	96.70%	109.81%	97.45%
Trust	93.32%	101.87%	98.28%	104.35%	98.01%

Safer Staffing: Summary by Site - Children **Nov-17**

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	96.04%	87.93%	85.61%	107.05%	91.74%
Pilgrim	69.35%	60.23%	87.50%	62.35%	70.13%
Trust	81.03%	72.49%	86.42%	79.43%	80.26%

Safer Staffing: Summary by Site - Midwifery **Nov-17**

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	102.23%	98.71%	102.26%	97.39%	100.03%
Pilgrim	91.49%	83.77%	101.34%	97.08%	95.03%
Trust	96.16%	95.71%	101.69%	97.33%	97.79%

Table Three: November 2017 vacancy position

VACANCY POSITION

	Aug-17		Sep-17		Oct-17		Nov-17	
	Data from Payroll		Data from Payroll		Data from Payroll		Data from Payroll	
	R	UR	R	UR	R	UR	R	UR
Lincoln	133.92	37.52	99.08	40.70	99.50	45.83	107.16	46.78
Pilgrim	128.70	24.40	111.19	16.53	121.55	19.36	117.63	15.80
Grantham	34.99	4.59	27.21	4.90	29.21	2.19	28.42	1.72
Main Site Nursing & Midwifery Sub-total	**297.61**	**66.51**	**237.48**	**62.13**	**250.26**	**67.38**	**253.21**	**64.30**
Louth	3.79	2.72	5.17	1.37	4.02	1.37	3.85	1.58
Paediatrics & Neonatal	29.48	1.40	28.59	0.41	28.36	0.94	28.93	2.54
Obs & Gynae	25.73	10.32	23.76	6.13	23.83	5.53	18.94	3.63
Diagnostics	9.74	0.63	9.34	0.23	11.05	0.43	11.70	1.43
Corporate Nursing – All Sites	12.96	3.36	12.11	3.36	14.75	3.36	13.83	3.36
Specialist Nursing – All Sites	3.06	-0.04	3.23	-0.04	2.08	0.56	4.76	0.56
Nursing & Midwifery Sub-total	**382.37**	**84.90**	**319.68**	**73.59**	**334.35**	**79.57**	**335.22**	**77.40**
Physiotherapy	9.71	-0.51	6.11	0.29	6.43	1.12	7.83	2.27
Occupational Therapy	3.82	6.56	1.36	3.25	1.76	4.25	2.56	1.96
Dietetics	4.87	0.00	4.87	0.00	4.97	0.00	4.97	0.00
Total	**400.77**	**90.95**	**332.02**	**77.13**	**347.51**	**84.94**	**350.58**	**81.63**
Nursing & Midwifery In Post	1,915.78	856.32	1,980.27	869.66	1,969.91	866.11	1,975.56	871.71

Safe Staffing

VACANCY POSITION

	Aug-17		Sep-17		Oct-17		Nov-17	
	Data from Payroll		Data from Payroll		Data from Payroll		Data from Payroll	
	R	UR	R	UR	R	UR	R	UR
Lincoln	89.61	21.22	60.99	23.27	64.75	24.60	75.43	25.26
Pilgrim	103.04	10.60	86.50	6.51	92.92	7.60	95.61	2.53
Grantham	23.14	0.35	19.51	-0.34	20.71	-3.54	22.12	-4.01
Main Site Nursing & Midwifery Sub-total	**215.79**	**32.17**	**167.00**	**29.44**	**178.38**	**28.66**	**193.16**	**23.78**
Paediatrics & Neonatal	23.85	0.04	23.26	-1.09	23.70	-1.16	24.42	0.44
Obs & Gynae	6.82	2.55	4.82	1.16	9.06	0.52	8.62	1.82
Total	**246.46**	**34.76**	**195.08**	**29.51**	**211.14**	**28.02**	**226.20**	**26.04**
Nursing & Midwifery In Post	822.46	526.74	873.84	531.99	858.38	533.48	850.70	538.09

Table Four: Summary of November 2017 figures against Agency (framework and cap)

Staff Group	Week Ending	05/11/2017	12/11/2017	19/11/2017	26/11/2017
Nursing, Midwifery & Health Visiting	Framework only	0	0	0	2
Nursing, Midwifery & Health Visiting	Price cap only	352	344	355	394
Nursing, Midwifery & Health Visiting	Both framework & price cap	0	0	0	2
Healthcare assistant and other support	Framework only	0	0	0	0
Healthcare assistant and other support	Price cap only	0	0	0	0
Healthcare assistant and other support	Both framework & price cap	0	0	0	0

Table Five: Agency/bank/substantive skill mix by site.

To further inform the staffing position, we calculate the percentage of registered temporary staffing deployed within Nursing along with the % of Registered Agency staff deployed at the Lincoln and Pilgrim sites.

Date	01/11/2017	02/11/2017	03/11/2017	04/11/2017	05/11/2017	06/11/2017	07/11/2017	08/11/2017	09/11/2017	10/11/2017	11/11/2017	12/11/2017	13/11/2017	14/11/2017	15/11/2017	16/11/2017	17/11/2017	18/11/2017	19/11/2017	20/11/2017	21/11/2017	22/11/2017	23/11/2017	24/11/2017	25/11/2017	26/11/2017	27/11/2017	28/11/2017	29/11/2017	30/11/2017
Day	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday
Site	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln
Unfilled Bank requests	33	64.5	54.75	46	35	132	119	61.5	34.5	37	34.5	28	19	62	35	57.5	11.5	23	34.5	71.5	67	34.5	42	46.1	0	16.5	119.75	21.25	34.5	34
Filled temp staffing	379.5	394.75	465.25	474	494.5	238	281.5	366.91	417.5	404.5	397.5	393.5	385.5	393	449	402.25	434	414	486	415	390	443.25	448	447.5	512	515	459.5	449.25	507.7	382.5
Agency	228.5	248	300.5	269.5	254	135	129.5	172	311	241.5	230.5	133.5	175	209	251.5	264.25	228	273	155	202.5	227	246.5	289	260.5	261	229.5	222	241.5	324	219.2
Total registered hours	2159	2117	2156	2128	2145	2061	2085	2102	2168	2139	2182	2157	2129	2159	2182	2144	2176	2192	2179	2123	2145	2189	2120	2118	2170	2149	2149	2168	2190	2148
Planned staffing on template	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195
Required staffing	2192	2181.75	2211	2174	2179.66	2192.5	2204	2163.41	2202.66	2175.83	2216.5	2185	2148	2221	2217	2201.75	2187	2215	2213.5	2194	2212	2223.25	2161.5	2163.6	2170	2165.5	2268.75	2189	2224.7	2181.75
Contracted hours	1779.5	1722.5	1691.0	1654.0	1650.2	1822.5	1803.5	1735.0	1750.7	1734.3	1784.5	1763.5	1743.5	1766.0	1733.0	1742.0	1741.5	1778.0	1693.0	1707.5	1755.0	1745.5	1671.5	1670.0	1658.0	1634.0	1689.5	1718.5	1682.5	1765.3
Contracted staff Percentage	81%	79%	76%	76%	76%	83%	82%	80%	79%	80%	81%	81%	81%	81%	80%	78%	79%	80%	80%	76%	78%	79%	79%	77%	77%	76%	75%	74%	79%	76%	81%
Total temp percentage	18%	19%	22%	22%	23%	12%	14%	17%	19%	19%	18%	18%	18%	18%	21%	19%	20%	19%	22%	20%	18%	20%	21%	21%	24%	24%	21%	21%	23%	18%
Bank percentage	7%	7%	8%	10%	11%	5%	7%	9%	5%	8%	8%	12%	10%	9%	9%	6%	9%	6%	15%	10%	8%	9%	8%	9%	12%	13%	11%	10%	8%	8%
Agency percentage	11%	12%	14%	13%	12%	7%	6%	8%	14%	11%	11%	6%	8%	10%	12%	12%	10%	12%	7%	10%	11%	11%	14%	12%	12%	11%	10%	11%	15%	10%
Total bank requests	412.5	459.25	520	520	529.5	370	400.5	428.41	452	441.5	432	421.5	404.5	455	484	459.75	445.5	437	520.5	486.5	457	477.75	490	493.6	512	531.5	579.25	470.5	542.2	416.5
Percentage bank fill	92%	86%	89%	91%	93%	64%	70%	86%	92%	92%	92%	93%	95%	86%	93%	87%	97%	95%	93%	85%	85%	93%	91%	91%	100%	97%	79%	95%	94%	92%
Total percentage staffing against required	99%	98%	98%	98%	99%	95%	95%	98%	99%	99%	99%	99%	99%	98%	99%	98%	100%	99%	99%	97%	98%	99%	98%	98%	100%	99%	96%	99%	99%	99%
Total substantive and bank	1930.5	1869.25	1855.75	1858.5	1890.66	1925.5	1955.5	1929.91	1857.16	1897.33	1951.5	2023.5	1954	1950	1930.5	1880	1947.5	1919	2024	1920	1918	1942.25	1830.5	1857	1909	1919.5	1927	1926.25	1866.2	1928.55
Total percentage staffing without agency	88%	86%	84%	86%	87%	88%	89%	89%	84%	87%	88%	93%	91%	88%	87%	86%	89%	87%	92%	88%	87%	88%	85%	86%	88%	89%	86%	88%	84%	89%

Date	01/11/2017	02/11/2017	03/11/2017	04/11/2017	05/11/2017	06/11/2017	07/11/2017	08/11/2017	09/11/2017	10/11/2017	11/11/2017	12/11/2017	13/11/2017	14/11/2017	15/11/2017	16/11/2017	17/11/2017	18/11/2017	19/11/2017	20/11/2017	21/11/2017	22/11/2017	23/11/2017	24/11/2017	25/11/2017	26/11/2017	27/11/2017	28/11/2017	29/11/2017	30/11/2017
Day	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday
Site	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston
Unfilled Bank requests	53	33	31.5	25.5	22	130.5	26.5	7.5	17.5	47.5	44.3	7	20.5	53	37	38.5	14	87	28	56	56.5	34	18	100	73	19	67.5	59.5	24	18
Filled temp staffing	354	307	521.5	579	645	260.5	263.5	307.5	340	395.5	350	351	343.5	345	331.5	321	368.5	367.5	427	319	359	323	370.5	306.7	345.5	425	374	320.5	357.5	345.5
Agency	148	201	245	195.5	181.5	145	128.5	102	186	287.5	126	150	197	140	170	169	203.5	142	11.5	193.5	196.5	198	229	203	222	211.5	147	172	157.5	173.5
Total registered hours	1399.25	1337.25	1421.5	1380.5	1398.75	1356	1434.5	1420.5	1437.5	1396	1362	1395.75	1429.33	1411	1427.75	1393.25	1410.33	1325.5	1409	1349.33	1380.5	1412	1372.5	1372.2	1345.5	1391	1431.5	1404.75	1445	1411.5
Planned staffing on template	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0	1516.0
Required staffing	1452.25	1370.25	1453	1406	1420.75	1486.5	1461	1428	1455	1443.5	1406.3	1402.75	1449.83	1464	1464.75	1431.75	1424.33	1412.5	1437	1405.33	1437	1446	1390.5	1472.2	1418.5	1410	1499	1464.25	1469	1429.5
Contracted Hours	1045.3	1030.3	900.0	801.5	753.8	1095.5	1171.0	1113.0	1097.5	1000.5	1012.0	1044.8	1085.8	1066.0	1096.3	1072.3	1041.8	958.0	982.0	1030.3	1021.5	1089.0	1002.0	1065.5	1000.0	966.0	1057.5	1084.3	1087.5	1066.0
Contracted staff percentage	72%	75%	62%	57%	53%	74%	80%	78%	75%	69%	72%	74%	75%	73%	75%	75%	73%	68%	68%	73%	71%	75%	72%	72%	70%	69%	71%	74%	74%	75%
Total temp percentage	25%	23%	37%	42%	46%	19%	18%	22%	24%	28%	26%	25%	24%	24%	23%	23%	26%	28%	30%	24%	26%	23%	27%	22%	26%	31%	26%	23%	25%	24%
Bank percentage	15%	8%	19%	28%	33%	9%	9%	14%	11%	8%	16%	14%	10%	15%	11%	11%	12%	17%	29%	9%	12%	9%	10%	8%	9%	15%	16%	11%	14%	12%
Agency percentage	11%	15%	17%	14%	13%	11%	9%	7%	13%	21%	9%	11%	14%	10%	12%	12%	14%	11%	1%	14%	14%	14%	17%	15%	16%	15%	10%	12%	11%	12%
Total bank requests	407	340	553	604.5	667	391	290	315	357.5	443	394.3	358	364	398	368.5	359.5	382.5	454.5	455	375	415.5	357	388.5	406.7	418.5	444	441.5	380	381.5	363.5
Percentage bank fill	87%	90%	94%	96%	97%	67%	91%	98%	95%	89%	89%	98%	94%	87%	90%	89%	96%	81%	94%	85%	86%	90%	95%	75%	83%	96%	85%	84%	94%	95%
Total percentage staffing against required	97%	98%	99%	99%	99%	93%	99%	100%	99%	98%	98%	100%	99%	97%	98%	98%	99%	96%	99%	97%	97%	98%	99%	95%	96%	99%	97%	97%	99%	99%
Total substantive and bank	1251.25	1136.25	1176.5	1185	1217.25	1211	1306	1318.5	1251.5	1108.5	1236	1245.75	1232.33	1271	1257.75	1224.25	1206.83	1183.5	1397.5	1155.83	1184	1214	1143.5	1169.2	1123.5	1179.5	1284.5	1232.75	1287.5	1238
Total percentage staffing without agency	87%	83%	81%	85%	86%	82%	90%	92%	86%	77%	88%	89%	85%	87%	86%	86%	85%	85%	98%	83%	83%	84%	82%	80%	80%	84%	86%	85%	88%	87%

Patient centred . Excellence . Respect . Compassion . Safety

Trajectories:

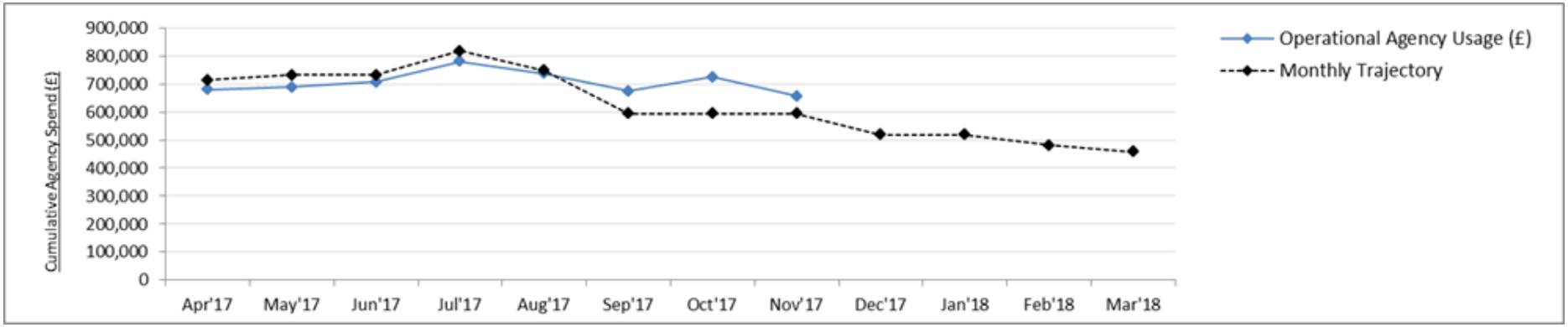
The trajectory data is below.

Agency

Summary	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Operational Agency Usage (£)	680,065	688,566	705,982	779,818	736,866	673,961	725,174	657,392
Monthly Trajectory	713,582	730,885	731,510	818,209	748,546	593,645	593,645	593,645
Difference from Trajectory	-33,517	-42,319	-25,528	-38,391	-11,680	80,316	131,529	63,747

Cumulative

Summary	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Cumulative Agency Usage (£)	680,065	1,368,632	2,074,614	2,854,431	3,591,297	4,265,258	4,990,433	5,647,825
Cumulative Trajectory	713,582	1,444,467	2,175,977	2,994,186	3,742,732	4,336,377	4,930,022	5,523,667
Difference from Trajectory	-33,517	-75,835	-101,363	-139,755	-151,435	-71,119	60,411	124,158



KPI:	**Voluntary Turnover**	**Owner:**	Director of HR & OD
Domain:	**Well Led**	**Responsible Officer:**	Deputy Director of HR
Date:	16th January 2018	**Reporting Period:**	November 2017
Target:	7% (excl. retirements) with no group of staff more than 20% above the overall target	**Tolerances:**	Within 1% - Amber Above 1% - Red
RAG Rating:	5.51%		

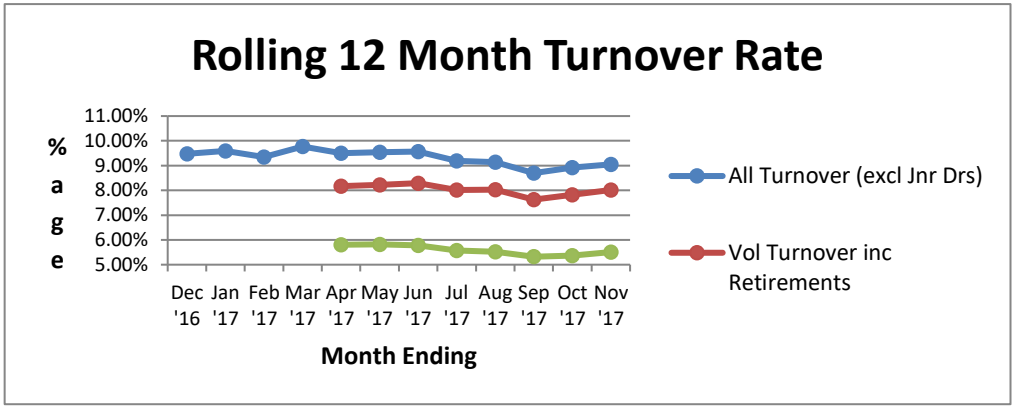
Analysis

The Trust remains within its target for Turnover.

Of the permanent staff who left 31.60% was due to retirement and 65.38% was due to voluntary resignations. The remaining 3.03% of leavers were for other reported reasons e.g. dismissal.

The table below shows voluntary turnover by Staff Group over a rolling 12 month period.

Only AHPs have a turnover of more than 20% above the target of 8.4% (when we exclude retirements).



	Voluntary Turnover including Retirements Nov '17	Voluntary Turnover excluding Retirements Nov '17	Voluntary Leavers including Retirements in Oct '17	Voluntary Leavers including Retirements in Nov '17	Increase / Decrease compared to previous month
Staff Group	%age	%age	WTE	WTE	WTE
Healthcare Scientists	12.77%	6.42%	1.00	0.00	-1.00
Add Prof Scientific and Technic	11.48%	9.37%	2.00	2.00	0.00
Allied Health Professionals	11.48%	10.42%	2.00	1.60	-0.40
Medical and Dental	11.26%	7.90%	4.00	2.00	-2.00
Administrative and Clerical	8.37%	6.10%	7.89	12.46	4.57
Additional Clinical Services	7.03%	4.94%	6.20	8.95	2.75
Nursing and Midwifery Reg	6.94%	4.22%	9.33	6.69	-2.64
Estates and Ancillary	6.61%	3.76%	6.55	1.11	-5.44
Students	0.00%	0.00%	0.00	0.00	0.00
Total	**8.01%**	**5.51%**	**38.97**	**34.81**	**-4.16**

Based on the latest (September 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 9.05% is below the average of 10.15%
- The current Trust Nursing & Midwifery (Registered) turnover rate of 7.25% is below the average of 10.69%,
- The current Trust AHP turnover rate of 11.54% is below the average of 11.56%.

We are doing work around retention. We have an exit interview process in place. We recognise that the overall turnover rate (which in comparison with others is positive) hides problems in terms of the loss of experienced staff through retirement, other losses of key experienced individuals in stressed areas and issues within particular staff groups.

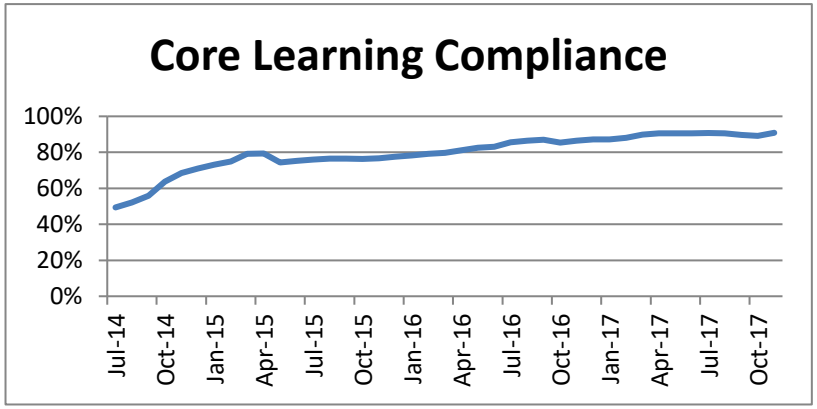
Action Taken	**Action Planned**
• Focus on flexible working – policy being reviewed to support flexible working for people potentially retiring but who wish to remain at work	• Work underway around the development offer for both nursing and medical staff • Review of benefits underway – focus on extending 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

KPI:	**Core Learning Completion**	**Owner:**	Director of HR & OD
Domain:	**Well Led**	**Responsible Officer:**	Deputy Director of HR
Date:	16th January 2018	**Reporting Period:**	November 2017
Target:	Revised targets have been set and will form the basis of the performance report in 2018/19	**Tolerances:**	
RAG Rating:	90.85%		

Analysis

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

Compliance as at the end of November shows an increase of 1.67% which is the biggest increase we have had since March 2017. This also takes us over 90% to 90.85% which is the highest rate it has been since we started to record in 2014. We will continue to manage compliance strongly and setting aside a period of time duirng which we would expect all staff to be compliant. W 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 improvement compliance



We have agreed new targets for each module and these will become the measure for this KPI in 2018/19. The table on the left shows compliance against thse individual targets. The table on the right those Directorates that have improved most in the month and those that have slipped back. We do press the need to improve compliance at all Directorate monthly performance meetings.

Topic Compliance Against New Targets:

Topic	Nov	New Targets
Fire Safety - 1 Year	90.90%	100%
Infection Control - 1 Year	85.83%	95%
Equality, Diversity and Human Rights - 3 Years	97.43%	90%
Information Governance - 1 Year	86.54%	95%
Safeguarding Children Level 1 - 3 Years	92.23%	90%
Safeguarding Adults Level 1 - 3 Years	92.32%	90%
Health and Safety - 3 Years	93.43%	90%
Slips, Trips & Falls - 3 year	93.07%	90%
Moving & Handling for Inanimate Load Handlers - 3 Years	92.21%	90%

Directorate Performance:

Directorate Top 10 improvers	Nov	Oct	Variance
Chief Executive	98.21%	92.86%	5.36%
Director of HR & Org Dev	92.25%	88.29%	3.95%
Trustwide Cardiology Services	88.39%	85.26%	3.13%
Acute Medicine Boston	86.62%	83.60%	3.02%
Orthopaedics Boston	88.32%	85.36%	2.96%
Head & Neck Trustwide	90.26%	87.38%	2.88%
Clinical Support Services	94.09%	91.26%	2.84%
Director of Estates & Facil	91.16%	88.97%	2.19%
General Surgery Boston	88.94%	87.22%	1.72%
Deputy Chief Executive	97.49%	95.92%	1.56%

Risk Awareness - 3 Years	90.50%	90%
Fraud Awareness - 3 years	94.82%	95%
Resuscitation [BLS] - 1 Year	80.89%	90%
Major Incidents - 1 Year *(currently excluded from overall %)*	76.08%	90%

Directorate back-sliders	Nov	Oct	Variance
Medical Director	92.90%	93.08%	-0.18%
Orthopaedics Lincoln	85.24%	85.73%	-0.49%
TACC Boston	89.59%	90.77%	-1.18%
A&E Lincoln	82.45%	84.84%	-2.40%

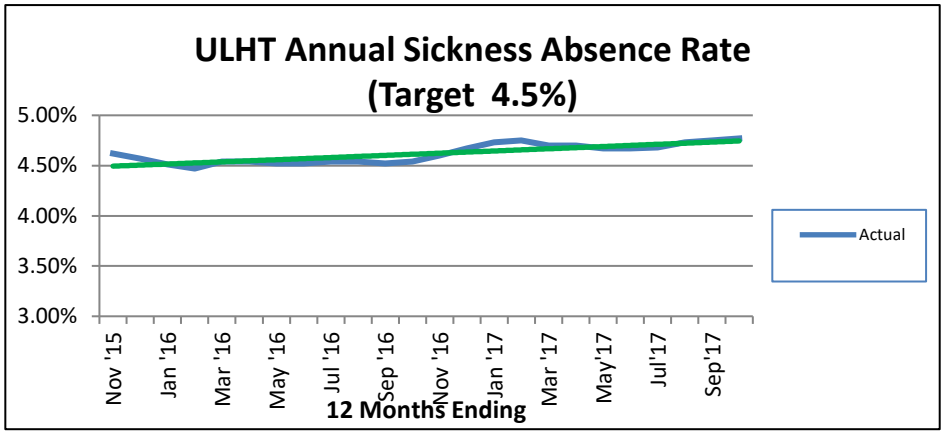
Action Taken	**Action Planned**
• 'Hotspots' were previously identified as areas in the red with 10 or more staff. As hotspots decreased to just one area, the range was extended last month to include all areas in the red regardless of the number of staff. Following work by the Core Learning Lead, 11 areas have come off the hotspot list this month. • 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:	**Well Led**	**Responsible Officer:**	Assistant Director of HR
Date:	16th January 2018	**Reporting Period:**	October 2017
Target:	Overall target of 4.5% + no team over 25% above target	**Tolerances:**	Within 0.5% - Amber Above 0.5% - Red
RAG Rating:	4.77%		

Analysis

The Trust annual rolling sickness rate of 4.77% (against 2017/18 target of 4.50%) has increased by a further 0.02% from the previous month. The 12 month rolling sickness rate as at the end of October 2017 has increased by 0.23% in comparison to the October 2016 figure (4.54%).

The latest Benchmarking data as at August 2017 from NHS Digital (previously Health & Social Care Information Centre - HSCIC) indicates that ULHT has the 7th highest sickness rate (lowest at 3.03% and highest 5.55%) against an average of 4.27%. 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. It is a concern that sickness continues to drift upwards, but is a reflection of morale within the Trust, which is challenged and all actions are being taken to manage sickness with managers.

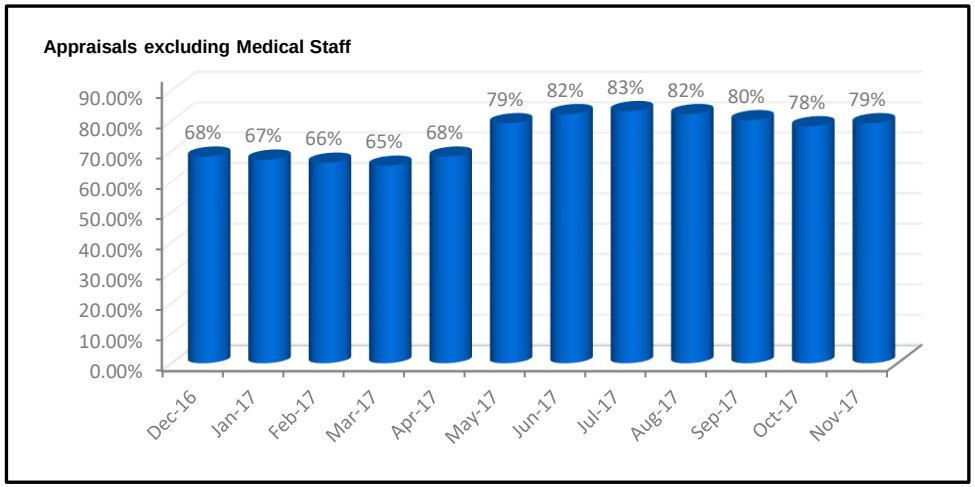


Action Taken	**Action Planned**
• Focus on the reduction of LTS cases by early intervention • Continuation of absence training as part of the leadership and management training this is being delivered solely in-house • Staff have been trained in mediation to support staff relationships and support retaining at work and this work has commenced.	• Timeline being agreed for the implementation of a pilot for the streaming of reporting absences and triaging absences • 70% of front-line staff have had a flu vaccination which has reached our target tis work will continue to increase the figure. • focus over Xmas periods will be around trends and analysis of absences over the Christmas period that are unsupported and whereby there are potential historic patterns • Monthly meetings with OH widened to allow matrons to attend. • Difficult conversation/ situation widened to all staff on Pilgrim site in which OH attend with HR and HON • There are 6 case reviews planned for medical/surgery for the after Christmas in the new year

KPI:	**Appraisal Rates**	**Owner:**	Director of HR & OD
Domain:	**Well Led**	**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	16th January 2018	**Reporting Period:**	November 2017
Target:	Medical – 95% Non-Medical – 85%		Within 5% below - Amber More than 5% below – Red
RAG Rating:	Medical – 95%		
RAG Rating:	Non-Medical – 78.70%		

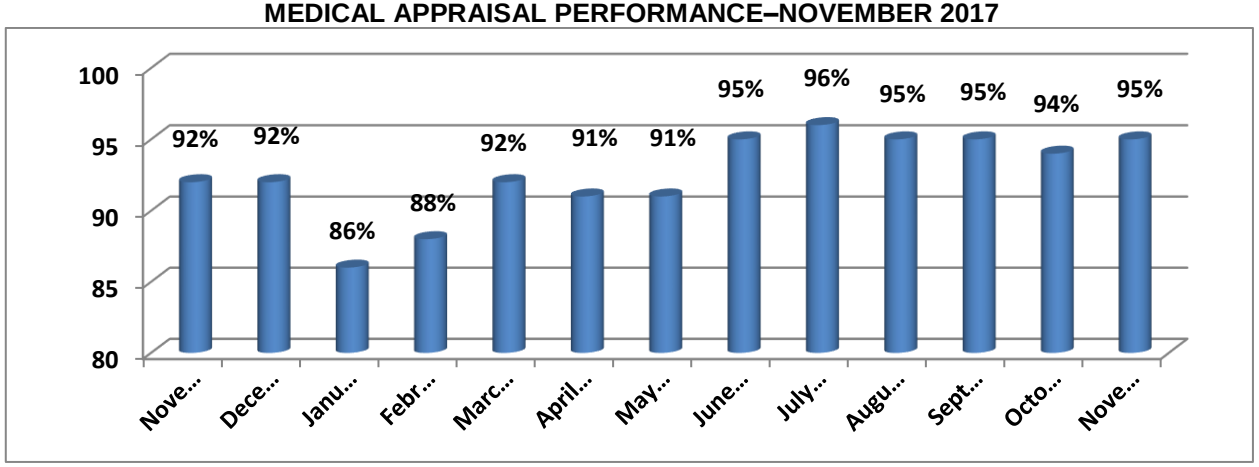
Analysis

The graph below shows that the Agenda for Change Staff/Non-Medical Appraisal compliance rate for November is 78.70%. This is a slight increase of 0.59% from the previous month. Feedback from information being sent to senior managers suggest 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.



The Medical Workforce appraisal rate for the month ending November 2017 is 95%. This figure achieves the Trust target for the fifth time in six 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.



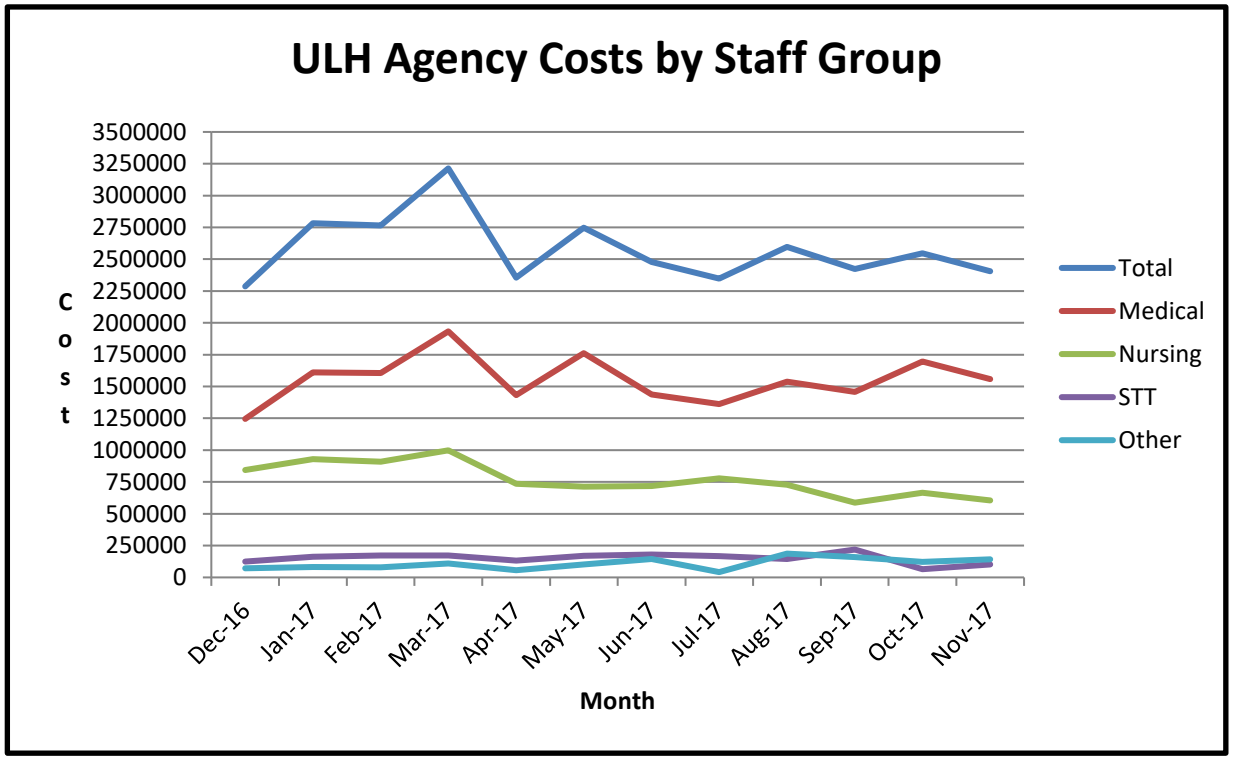
Action Taken	**Action Planned**
Non-Medical • For October and November Executive Directors have been advised of named individuals in their teams who are non-compliant with appraisals and advised which had been actioned since the previous month • Managers have been reminded of the need to and how to record completed appraisals through ESR 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 continue to closely monitor and take prompt action when appraisals are not undertaken as planned.	Non-medical • Monthly reports will continue to be provided to Executives naming individuals whose appraisals remain outstanding. • HR Business Partners will continue to: o Hold regular monthly meetings with Matrons/equivalent managers to identify those staff that haven't been captured o Help to managers when they are unsure about completing the reporting process, guidance docs shared as appropriate o Highlight completion rates on monthly scorecards which are discussed at monthly Performance Reviews. o Provide bespoke training offered where appropriate o List of non-compliant staff sent to managers monthly o Data cleansing carried out where info is incorrect o Latest format of Performance Review requires CDs to account for compliance rates. o Emails for example as below and reposts to identify the areas of non-compliance. 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:	Money & Resources	Responsible Officer:	Various leads on different aspects of agency spend
Date:	16th January 2018	Reporting Period:	November 2017
RAG Rating:	Actual spend of £2.406m, against target of £1.75m		

Analysis

The table below shows agency spend in the last 12 months. In November there has been a decrease of £141,453 from the previous month, spend is still significantly above target and £33,568 higher than the level of spend in November 2016. 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. The controls we have in place also means that we would not expect to see the dramatic increases in agency spend seen through the winter of 2016/17.

Of the £2,405,537 spent on Agency staff in November, £1,557,614 was spent on Medical and Dental staff, £603,705 was spent on Nursing staff (including HCSW's), £101,218 was spent on STT staff and £143,000 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:	**Well Led**	**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	16th January 2018	**Reporting Period:**	November 2017
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.

Action Taken	**Action Planned**
• Staff Charter launched at Senior Leadership Forum with active support of staff-side. Favourable feedback and commitment from attendees to implement this with teams • 2021 and Staff Charter launch site events took place. Over four sites, 238 people attended, 57 signed up to be ambassadors and 141 made pledges. The majority of staff who attended gave positive feedback that the length and method of the events were appropriate and informative. • Executives have started their 2021 walk rounds	• The feedback from the 2021 launch events received will help to shape our future communications around the 2021 strategy. Some of the points are already in action. • Executive walk rounds will continue across the Trust. • Future events are currently being planned to share in the New Year. • A list of ambassadors has been created from staff who have volunteered and a meeting will be held with those staff in the New Year to discuss the role of the ambassadors.

KPI:	**Quality of leadership and management index**	**Owner:**	Director of HR & OD
Domain:	**Well Led**	**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	16th January 2018	**Reporting Period:**	November 2017
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 annual National Staff Survey taking place.

Action Taken	**Action Planned**
• Recruitment completed for Cohort 6 of Mary Seacole Local programme • Process underway for procurement of Lincolnshire Health and Care senior leadership programme • Critical review of all STP Leadership and OD activity to date commenced to help shape 18/19 OD plans • Senior Leadership Forum took place 29.11.17. 113 attendees. Very positive feedback. • 201 managers have completed the mandatory 2 day "Supporting You to Deliver and Manage our Values and Behaviours" programme. Senior managers have been notified which staff have still not booked on	• STP Lincolnshire Health and Care leadership programme procurement will conclude • Next Senior Leadership Forum takes place January 2017 • Review of 'Well Led' key lines of inquiry underway (part of CQC domains) • Working with National Leadership Academy to ensure new leadership offer can show impact using current research • Message to go out from Chief Executive to those who have not booked onto the 2 day programme informing them that this is not acceptable and requiring that if they are not able or willing to, that he would like an explanation

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)	(34.4)	(57.0)	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	11.7	5.6	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 8 position was an in-month deficit of £6.5m, which is £3.1m adverse to the planned in-month deficit of £3.4m.
- 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 8 Financial Position

Month 8 performance against the financial plan is summarised in the table:

The Trust is reporting:

- An in-month deficit in November of £6.5m, which is £3.1m adverse to the planned in-month deficit of £3.4m.
- A year to date deficit of £57.0m, which is £22.6m adverse to the planned year to date deficit of £34.4m.

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

- Non-achievement of STF income resulting in the loss of £8.1m STF income.

	November 2017			April 2017 to November 2017		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	33,382	34,024	642	258,493	261,506	3,013
Other operating income	4,581	3,275	-1,306	32,673	22,468	-10,205
Employee expenses	-25,880	-27,197	-1,317	-207,061	-216,385	-9,324
Operating expenses excluding employee expenses	-15,111	-16,243	-1,132	-115,436	-122,368	-6,932
OPERATING SURPLUS / (DEFICIT)	**-3,028**	**-6,141**	**-3,113**	**-31,331**	**-54,779**	**-23,448**
NET FINANCE COSTS	-418	-337	81	-3,198	-2,225	973
Other gains/(losses) including disposal of assets	0	1	1	0	111	111
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**-3,446**	**-6,477**	**-3,031**	**-34,529**	**-56,893**	**-22,364**
Add back all I&E impairments/(reversals)	0	0	0	0	-70	-70
Surplus/(deficit) before impairments and transfers	**-3,446**	**-6,477**	**-3,031**	**-34,529**	**-56,963**	**-22,434**
Remove capital donations/grants I&E impact	12	-66	-78	86	-44	-130
Adjusted financial performance surplus/(deficit)	**-3,434**	**-6,543**	**-3,109**	**-34,443**	**-57,007**	**-22,564**

- Slower than planned delivery of efficiency savings, with delivery to date £4.1m below plan.
- Pilgrim fire, norovirus outbreak and cyberattack resulting to date in the loss of £3.3m of income.
- Non-achievement of £1.4m 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 £4.4m higher than planned and only partially offset by a reduction in substantive and bank pay expenditure.

Financial Recovery Plan

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 totalling £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 on 13 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 been RAG rated and contains £7.0m of delivered schemes and £9.0m of Green rated schemes. A further set of schemes totalling £1.1m have been identified to mitigate any risk and they are currently being worked up for delivery.

The Trust originally planned to deliver £11.1m of savings by the end of November. Actual delivery to date at the end of November is as follows:

Savings of £7.0m have been delivered to date, which is £4.1m lower than the £11.1m of savings planned to date.

The savings delivered to date comprises of £4.2m of non-recurrent savings and £2.8m of recurrent savings.

Capital

The spend to date of £5.6m is inclusive of £1.3m Pre-commitments including £0.7m for Neonates and £0.4m Lincoln Specialist Rehab. £1.2m for Medical Equipment and £1.0m for IT development. The remainder for Backlog Maintenance, CQC and Service Development & Modernisation total £2.1m. The spend to date of £5.6m is £6.1m lower than plan.

The main drivers of the variance are as below:

- CQC schemes are £1.0m 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.

- Backlog Maintenance including fire enforcement notice related expenditure is £3.9m behind the plan to date. Work is on-going at pace to ensure compliance within the pre-determined timeframes. Contractors are on-site and phased plans to deliver the full allocation for fire are in place.
- IT Development/IT Service Development & Modernisation are £0.6m 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.
- Other minor schemes of £0.6m

Cash

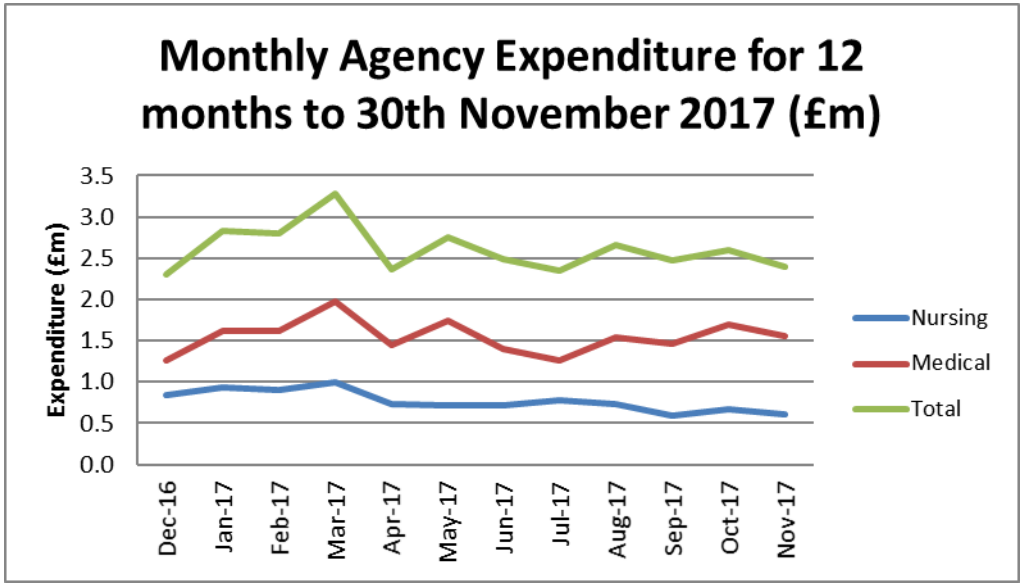
At the close of November 2017 the Trust held cash of £1.0m. This includes external revenue support loans of £57.5m.

The total 'repayable' borrowings through working capital loans, Salix loans and the uncommitted loan facility are currently £168.2m. 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 remains flat at an average of £2.5m per month since April. Medical staffing has increased from a low point of £1.3m in July and Nursing continues to show a slow decrease.



CQUINs 2017/18

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

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

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

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

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

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

Equality Analysis Statement

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

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

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

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

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

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

The nine protected characteristics are:

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

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

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

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

Appendix 1. Glossary

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

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

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

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

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

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

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

Elective LOS	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Non-Elective LOS	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
MFFD	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
DTOC	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Vacancies	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Sickness Absence	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Staff Turnover	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Staff Appraisals	Failed Target by more than 2%	Failed Target but by less than 2%	Achieved Target
Equality and Diversity	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Income v Plan	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Expenditure v Plan	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Efficiency Plans	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Surplus / Deficit	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Capital Program Spend	Failed Target by more than 10%	Failed Target but by less than 10%	Achieved Target
Agency Spend	Failed Target by more than 5%	Failed Target but by less than 5%	Achieved Target
Partial Booking Waiting List	Failed Target		Achieved Target