Excellence in rural healthcare

United Lincolnshire Hospitals NHS Trust

UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 31 MARCH 2018

To:	Trust Board
From:	Karen Brown, Director of Finance, Procurement & Corporate Affairs
Date:	27th April 2018
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for March 2018

Author/Responsible Director: Karen Brown, Director of Finance

Purpose of the report:
To update the Board on the performance of the Trust for the period ended 31st March 2018, provide analysis to support decisions, action or initiate change and set out proposed plans and trajectories for performance improvement.

The report is provided to the Board for:

Decision	√	Discussion	√
Assurance	√	Information	

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

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

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

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

Resource implications (eg Financial, HR) None

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

Patient and Public Involvement (PPI) implications None

Equality impact

Information exempt from disclosure

Requirement for further review?

Integrated Performance Report for the Period to 31st March 2018

Executive Summary for period of 31st March 2018

☒ 4 hour waiting time target – performance of 65.21% in March 2018
☒ 5 of the 9 national cancer targets were achieved in February 2018
☒ 18wk RTT Incomplete performance in February 2018 was 86.84%, the current unvalidated position for March 2018 as at the 19th April is 84%. The final March performance will be submitted on 26th April and is forecast at 85-86%
☒ 6wk Diagnostic Standard – March 2018 performance was 93.53%

Challenges:

RTT performance held steady at 86.8% which is now the level agreed with the CCG to be maintained for the 18/19 contract year. ENT continues to be the most challenged specialty with T&O and General Surgery also having deteriorated due to higher than normal annual levels of elective cancellations during winter and weather pressure periods.

Diagnostic performance unfortunately deteriorated in March with only 95.5% of patients receiving their test within 6 weeks. Cancellation of scheduled endoscopy activity due to building works contributed to this performance decline.

A&E 4-hr performance continues to see large daily variability with overall March performance declining to its lowest point this year at 65.21%. Ambulance handovers improved at Lincoln but deteriorated significantly at Pilgrim following issues with process and staffing.

Provisional 62-day Cancer performance for February was 75.2%. If this is maintained the Trust will have achieved above 75% for 3 consecutive months for the first time since 2014. Additionally, all 4 31-day standards were achieved again – for the third time in the last 5 months.

Looking forward:

The Outpatient Improvement Programme and the Theatres Optimisation Committee are both delivering improvements in elective management processes and in patient throughput. The movement to electronic referral receipt begins in April with all specialties to move to electronic referrals by the end of July, offering improvements to referral processing. At the same time, the Trust continues to expand its programme of Advice and Guidance in line with the national CQUIN which should support a reduction in inappropriate referrals as this service takes effect.

Additional capacity for diagnostic performance improvement is being provided in the Echo service and in Endoscopies through outsourcing. New recruits starting in May will also assist.

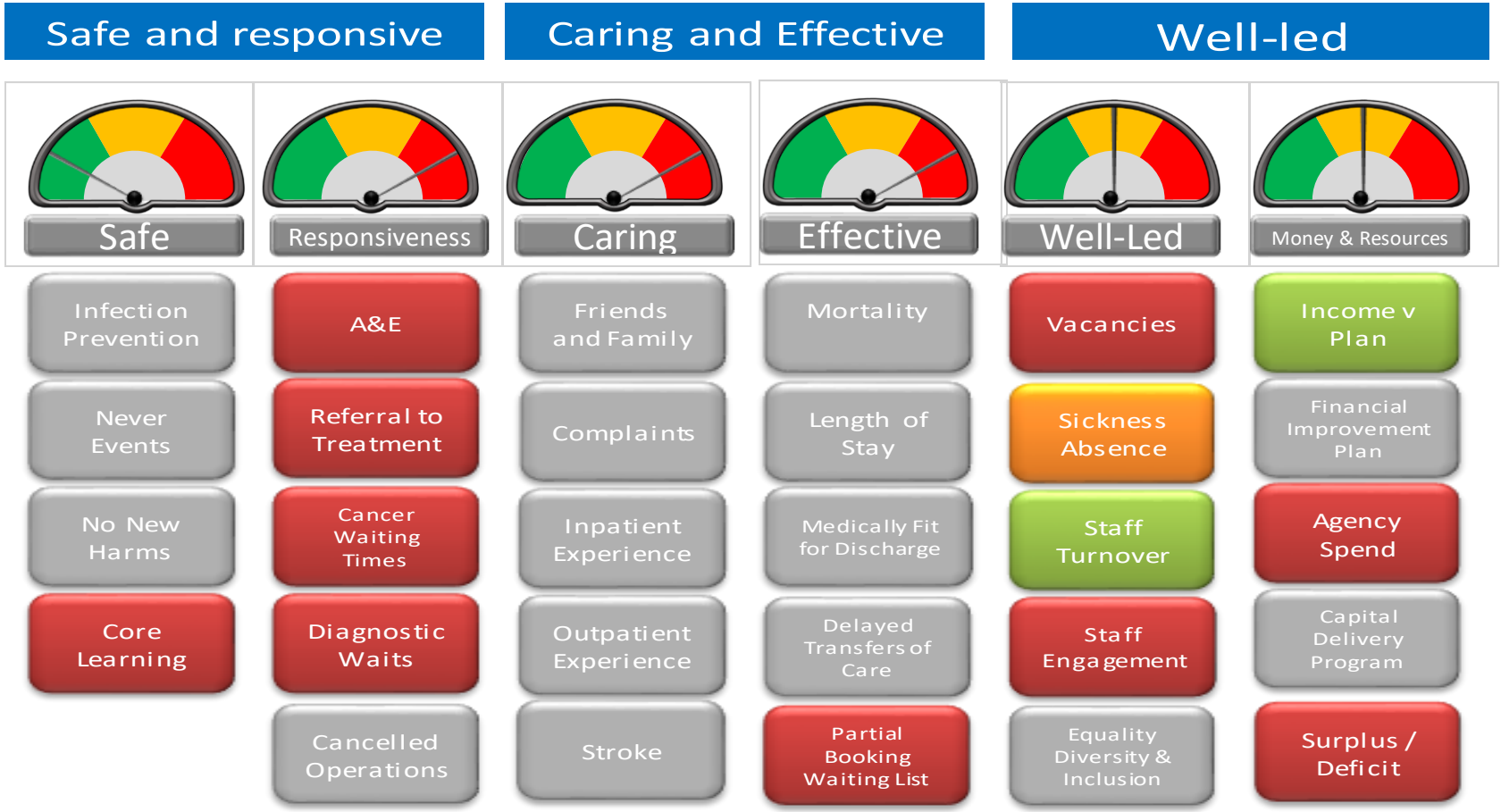
An 18/19 trajectory has been agreed for A&E 4hr standards and action plans are being finalised to align with these targets. Responsibility for Urgent Care streaming is being transferred to LCHS with increased targets for streaming at both sites.

The sustained improvement in cancer performance is at risk in March due to winter weather cancellations. Trajectories have been agreed to reduce the number of patients over 62 days and additional surgical lists and prioritisation of cancer cases should assist in the reduction of cancer delays going forward.

Karen Brown
Director of Finance, Procurement & Corporate Affairs
April 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. Further detail follows this summary at Clinical Directorate and Speciality level. Action plans should focus on resolving performance issues or delivering improved performance where required.



Detailed Trust Board Performance

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Safe						
Infection Control						
Clostrum Difficile (past 3 days)	Monthly	Datix	59	60		2
MRSA bacteraemia (past 3 days)	Monthly	Datix	0	2		0
MSSA	Monthly	Datix	24	15		2
EDOLI	Monthly	Datix	96	37		4
Never Events	Monthly	Datix	0	3		0
No New Harms						
Serious Incidents reported (unvalidated)	Monthly	Datix	0	262		28
Harm Free Care %	Monthly			92.05%		93.52%
New Harm Free Care %	Monthly			98.20%		98.66%
Catheter & New UTIs	Monthly			1		0
Falls	Monthly	Datix		5		6
Medication errors	Monthly	Datix		1483		131
Medication errors (mod, severe or death)	Monthly	Datix				10
Pressure Ulcers (PUNT) 3/4	Monthly			66		3
VTE Risk Assessment	Monthly		95%			97.54%
Core Learning	Monthly	ESR	95%		89.83%	90.83%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Caring						
Friends and Family Test						
Inpatient (Response Rate)	Monthly	Envoy Messenger	26%	22.45%	19.00%	28.00%
Inpatient (Recommend)	Monthly	Envoy Messenger	96%	90.45%	90.00%	89.00%
Emergency Care (Response Rate)	Monthly	Envoy Messenger	14%	20.09%	30.00%	20.00%
Emergency Care (Recommend)	Monthly	Envoy Messenger	87%	81.27%	82.00%	82.00%
Maternity (Reponse Rate)	Monthly	Envoy Messenger	23%	8.18%	6.00%	2.00%
Maternity (Recommend)	Monthly	Envoy Messenger	97%	94.64%	92.00%	93.00%
Outpatients (Reponse Rate)	Monthly	Envoy Messenger	14%	12.55%	6.00%	16.00%
Outpatients (Recommend)	Monthly	Envoy Messenger	94%	92.45%	92.00%	93.00%
Complaints						
No of Complaints received	Monthly	Datix	70	686		79
No of Complaints still Open	Monthly	Datix	0	2959		288
No of Complaints ongoing	Monthly	Datix	0	459		45
No of Pals	Monthly	Datix	0	0		347
No of pals converted to formal complaints	Monthly	Datix	0	0		0
Inpatient Experience						
Mixed Sex Accommodation	Monthly	Datix	0	11		1
eDD	Monthly	EDD	95%	84.34%		87.49%
PPCI 90 hrs	Quarterly		100%			97.33%
PPCI 150 hr	Quarterly		100%			85.33%
#NOF 24	Monthly		70%			51.61%
#NOF 48 hrs	Monthly		95%	83.16%		91.94%
Dementia Screening	1 month behind		90%			88.28%
Dementia risk assessment	1 month behind		90%			95.79%
Dementia referral for Specialist treatment	1 month behind		90%			90.91%
Stroke						
Patients with 90% of stay in Stroke Unit	1 month behind	SSNAP	80%	81.87%		67.00%
Swallowing assessment < 4hrs	1 month behind	SSNAP	80%	71.94%		73.50%
Scanned < 1 hrs	1 month behind	SSNAP	50%	56.42%		63.60%
Scanned < 12 hrs	1 month behind	SSNAP	100%	96.71%		96.20%
Admitted to Stroke < 4 hrs	1 month behind	SSNAP	90%	62.15%		47.20%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Responsiveness						
A&E						
4hrs or less in A&E Dept	Monthly	Medway	95.0%	75.07%	65.21%	69.26%
12+ Trolley waits	Monthly	Medway	0	0	0	1
RTT						
52 Week Waiters	Monthly	Medway	0			
18 week incompletes	Monthly	Medway	88.3%		84.00%	86.84%
Cancer - Other Targets						
62 day classic	1 month behind	Somerset	85%	71.09%	75.20%	76.87%
2 week wait suspect	1 month behind	Somerset	93%	89.13%	86.50%	86.00%
2 week wait breast symptomatic	1 month behind	Somerset	93%	82.54%	84.20%	84.21%
31 day first treatment	1 month behind	Somerset	96%	96.37%	96.90%	97.03%
31 day subsequent drug treatments	1 month behind	Somerset	98%	99.06%	100.00%	98.20%
31 day subsequent surgery treatments	1 month behind	Somerset	94%	92.98%	94.40%	91.18%
31 day subsequent radiotherapy treatments	1 month behind	Somerset	94%	96.80%	100.00%	97.20%
62 day screening	1 month behind	Somerset	90%	87.06%	83.30%	84.31%
62 day consultant upgrade	1 month behind	Somerset	85%	86.63%	91.70%	93.98%
104+ Day Waiters	1 month behind	Somerset		-	12	11
Diagnostic Waits						
diagnostics achieved	Monthly	Medway	99.1%	98.10%	93.53%	97.17%
diagnostics Failed	Monthly	Medway	0.9%	1.90%	6.47%	2.83%
Cancelled Operations						
Cancelled Operations on the day (non clinical)	Monthly	Medway	1.10%			5.69%
Not treated within 28 days. (Breach)	Monthly	Medway	0.00%			5.79%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Effective						
Mortality						
SHMI	Quarterly		100	111.77		112.22
Hospital-level Mortality Indicator	Quarterly		100	102.94		102.65
Length of Stay						
Average LoS - Elective	Monthly	Medway / Slam	2.5	2.67		2.38
Average LoS - Non Elective	Monthly	Medway / Slam	3.5			4.77
Medically Fit for Discharge	Monthly	Bed managers	60			44.00
Delayed Transfers of Care	Monthly	Bed managers	3.5%			4.90%
Partial Booking Waiting List	Monthly	Medway	0	5498	6970	6510

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Well Led						
Vacancies	Monthly	ESR	5.0%		12.03%	10.97%
Sickness Absence	Monthly	ESR	4.5%		4.54%	5.62%
Staff Turnover	Monthly	ESR	5.0%		5.80%	5.90%
Staff Engagement						
Staff Appraisals	Monthly	ESR	95.0%		80.00%	80.00%
Equality Diversity and Inclusion						

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Money & Resources						
Income	Monthly	Board Report Master	35950	429595	39141	34684
Expenditure	Monthly	Board Report Master	-41509	-497954	-43676	-41119
Efficiency Delivery	Monthly	FIMS report	1609	9079		0
Surplus / Deficit	Monthly	FPIC Finance Report	-2529		-23115	-7764

Patient centred ▪ Excellence ▪ Respect ▪ Compassion ▪ Safety

Quality Summary – latest data available is at 28th February 2018

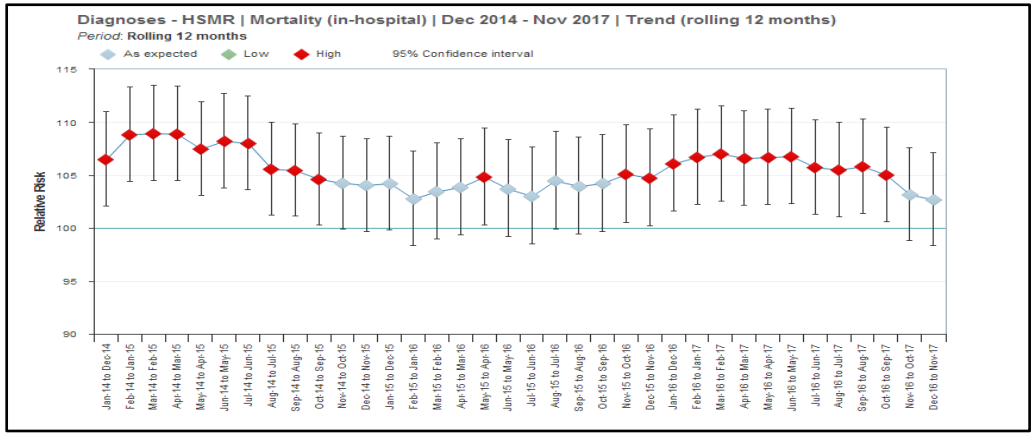
Following revision of the Quality Governance Committee and Trust Board dates the data within this paper has not yet been discussed at Patient Safety Committee. This will be a recurrent issue in 2018/19 with the revised schedule.

Safe Ambition: Reduction of Harm Associated with Mortality

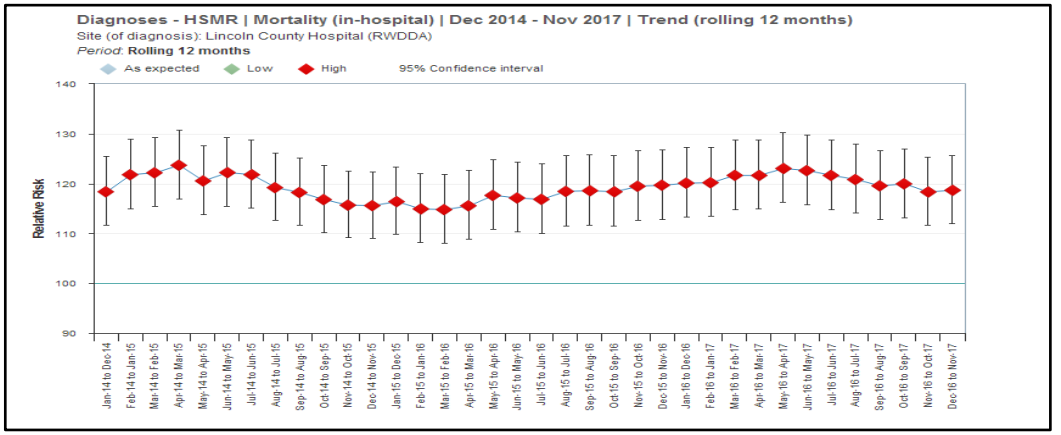
Executive Responsibility: Neil Hepburn – Medical Director

Trust/Site	ULHT HSMR Dec 16-Nov 17 12 month	ULHT HSMR Apr 17-Nov 17 YTD	ULHT HSMR Nov-17	ULHT SHMI Jul 16-Jun 17	Trust Crude Mortality Internal source Mar 17-Feb 18
Trust	102.65	98.73	95.03	112.22	1.82%
LCH	118.73	113.86	120.36	115.98	1.82%
PHB	91.96	89.01	75.42	110.60	2.03%
GDH	65.56	59.30	56.70	98.75	1.01%

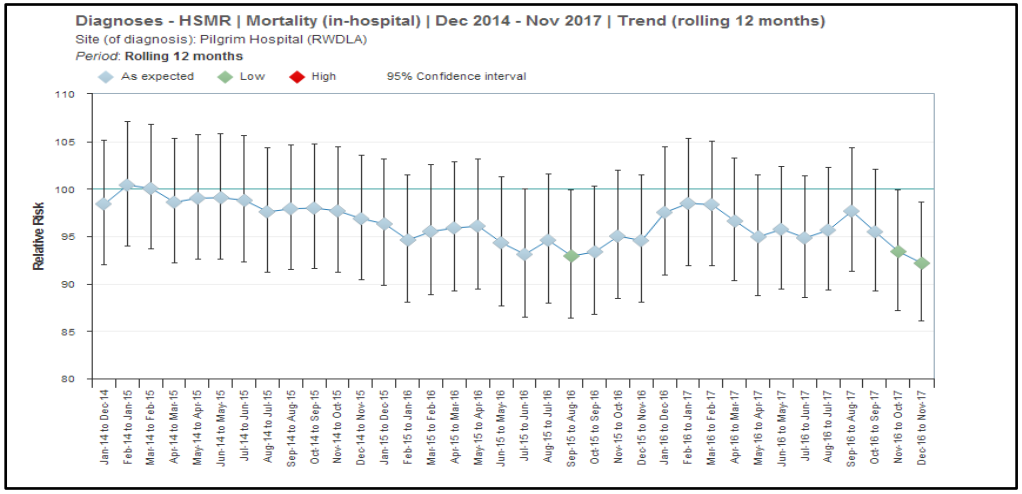
ULHT HSMR Rolling Year (36 Months)



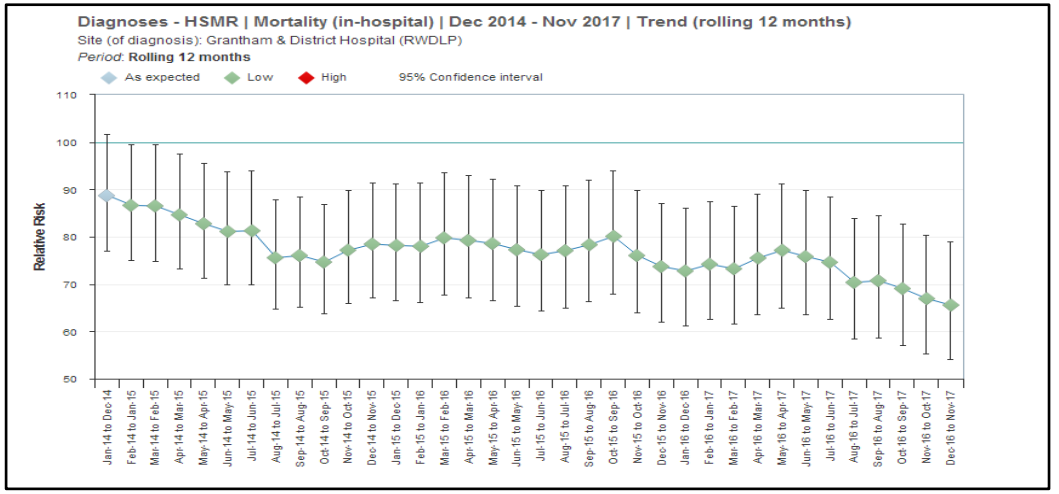
Lincoln HSMR Rolling Year (36 Months)



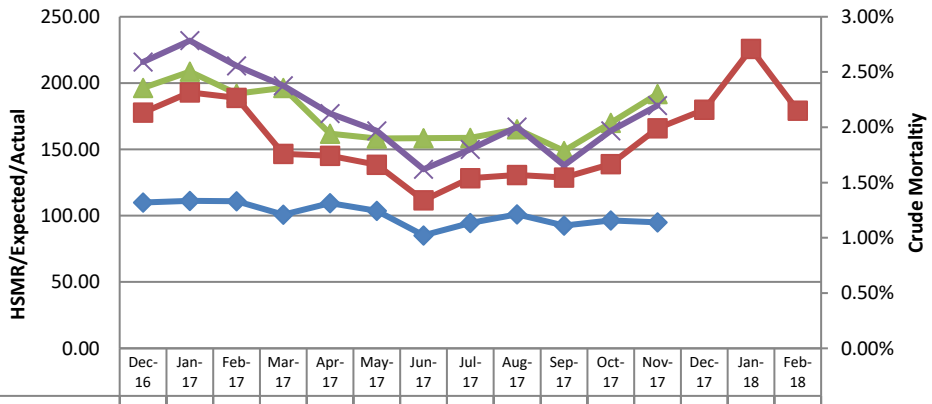
Pilgrim HSMR Rolling Year (36 Months)



Grantham HSMR Rolling Year (36 Months)

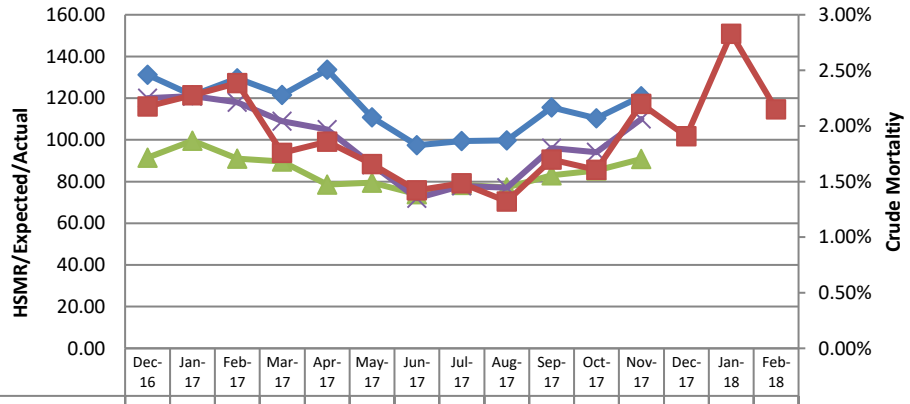


Trust Mortality Comparison Chart

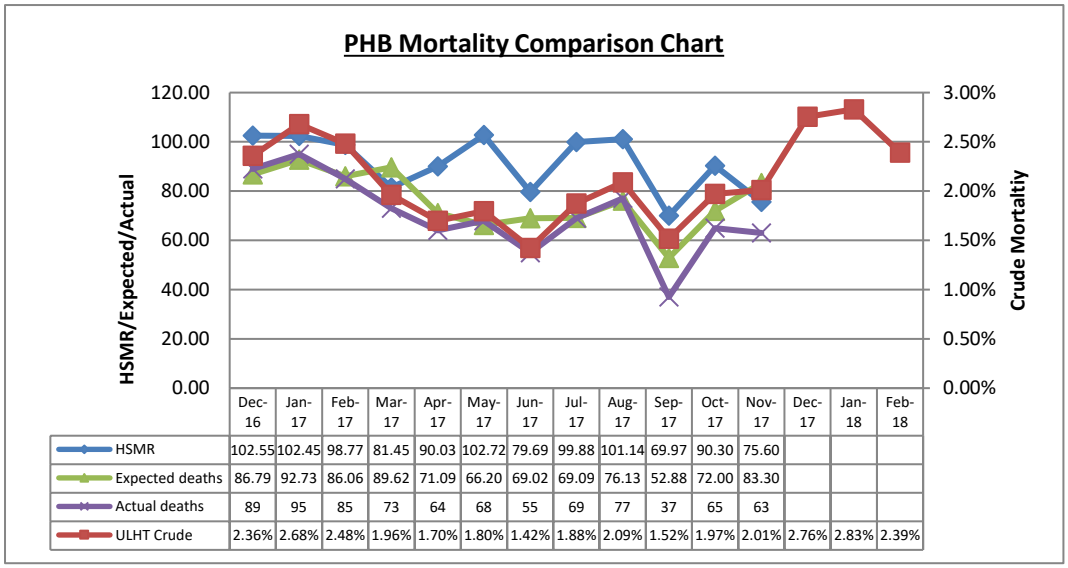


	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
HSMR	110.01	111.21	110.95	100.78	109.44	103.67	85.20	94.57	101.11	92.66	96.50	95.10			
Expected deaths	196.35	208.62	191.98	196.46	161.73	158.20	158.45	158.62	165.17	148.93	170.00	191.80			
Actual deaths	216	232	213	198	177	164	135	150	167	138	164	183			
ULHT Crude	2.13%	2.32%	2.27%	1.76%	1.74%	1.66%	1.34%	1.54%	1.57%	1.54%	1.67%	1.99%	2.16%	2.71%	2.15%

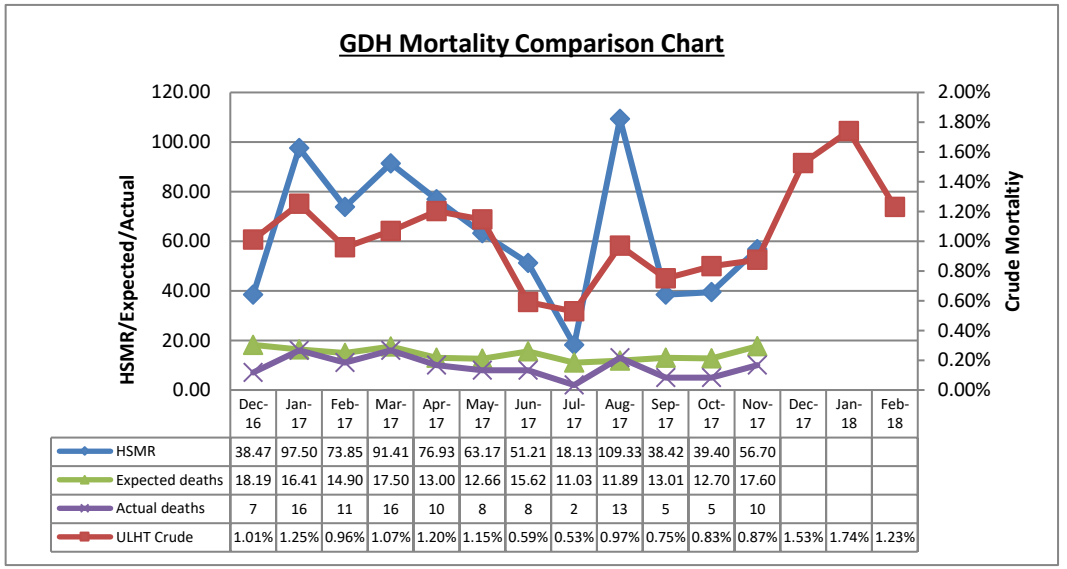
LCH Mortality Comparison Chart



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
HSMR	131.22	121.45	129.58	121.59	133.59	110.80	97.39	99.43	99.72	115.60	110.30	121.00			
Expected deaths	91.45	99.63	91.06	89.65	78.60	79.42	73.93	78.45	77.22	83.05	85.30	90.90			
Actual deaths	120	121	118	109	105	88	72	78	77	96	94	110			
ULHT Crude	2.18%	2.28%	2.38%	1.76%	1.86%	1.66%	1.42%	1.48%	1.32%	1.70%	1.60%	2.20%	1.91%	2.83%	2.15%



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
HSMR	102.55	102.45	98.77	81.45	90.03	102.72	79.69	99.88	101.14	69.97	90.30	75.60			
Expected deaths	86.79	92.73	86.06	89.62	71.09	66.20	69.02	69.09	76.13	52.88	72.00	83.30			
Actual deaths	89	95	85	73	64	68	55	69	77	37	65	63			
ULHT Crude	2.36%	2.68%	2.48%	1.96%	1.70%	1.80%	1.42%	1.88%	2.09%	1.52%	1.97%	2.01%	2.76%	2.83%	2.39%



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
HSMR	38.47	97.50	73.85	91.41	76.93	63.17	51.21	18.13	109.33	38.42	39.40	56.70			
Expected deaths	18.19	16.41	14.90	17.50	13.00	12.66	15.62	11.03	11.89	13.01	12.70	17.60			
Actual deaths	7	16	11	16	10	8	8	2	13	5	5	10			
ULHT Crude	1.01%	1.25%	0.96%	1.07%	1.20%	1.15%	0.59%	0.53%	0.97%	0.75%	0.83%	0.87%	1.53%	1.74%	1.23%

ULHT

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

Other Perinatal Conditions: Second month of alerting at Trust level, alerting on both PHB & LCH with 20 mortalities and 5.72 over the predicted Dr Foster data. 2 meetings have been held and the process reviewed; issues found with the well-baby coding and depth of coding in conjunction with the form not being sent to the coders. This process is being reinforced by the W&C Risk team. UPDATE: W&C have been contacted for evidence of actions for the improvement work.
Biliary Tract Disease: First month alerting at Trust level. 26 mortalities with 10 over the predicted Dr Foster data. An external Consultant has been contacted to so an external review as this has been sporadically alerting for Lincoln site and the Trust.
Aortic peripheral and visceral artery aneurysms: Third month of alerting; 25 mortalities with 11 over the predicted Dr Foster data.
Other lower respiratory disease: New alert; 23 mortalities with 9 over the predicted Dr Foster data.
Septicemia (except in Labor): New; 312 mortalities with 34 over the predicted Dr Foster data. This has been alerting on the Lincoln site since the coding rule change in April 17. This is the First time within 2 years for the Trust. Sepsis nurses completed a coding review and outputs were comorbidities not being documented which has now become part of the wider comorbidity work.

SITE

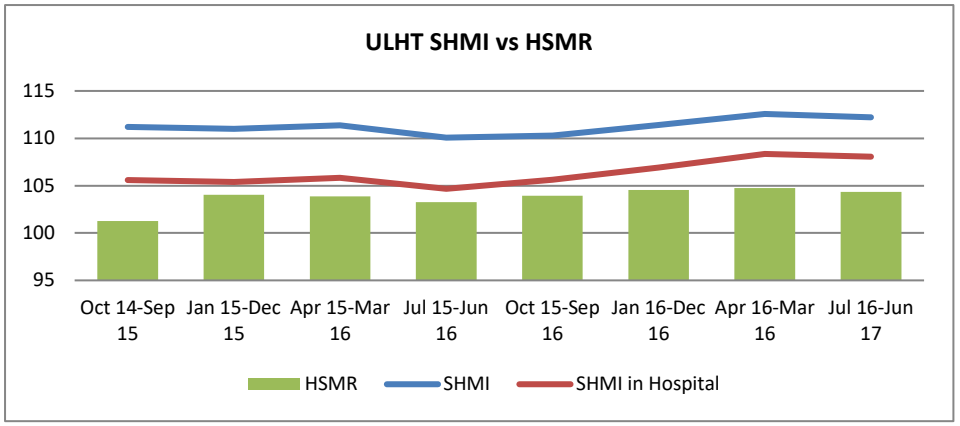
Lincoln County Hospital: primary diagnoses groups that are outside of the Dr Foster confidence intervals are:
Actions underway
Acute Cerebrovascular disease: This is the fifth month of alerting with 113 observed and 22 mortalities over the predicted Dr Foster data. Dr Foster Intelligence specialist and Quality Governance have met with the Stroke SSNAP audit Facilitator and QSO; The only notable difference between the data on the sites is the coding of patients been seen by the palliative care team-wider palliative care audit has been completed. Dr Foster still to meet with Clinician to discuss. SSNAP data has been correlated to Dr Foster data

as on SSNAP ULHT are not an outlier. The results showed that SSNAP focuses on 6 main comorbidities therefore the data was not comparable. The SSNAP data coordinators will also check for all co-morbidities.
Other Gastrointestinal disorders: Alerting at site level for the third month with 18 mortalities, 9 mortalities over the predicted Dr Foster data.
Senility and organic mental disorders: Second month of alerting with 20 moralities, 10 over the predicted Dr Foster data.
Fluid and electrolyte disorders: NEW- First month of alerting within 16 mortalities, 7 over the predicted Dr Foster data.

Pilgrim hospital: primary diagnoses groups that are outside of the Dr Foster confidence intervals are:
COPD and bronchiectasis: This is the third month on alerting with 47 mortalities, 14 over the predicted Dr Foster data.-Respiratory Consultants contacted for in-depth review.

Grantham Hospital
No notifications

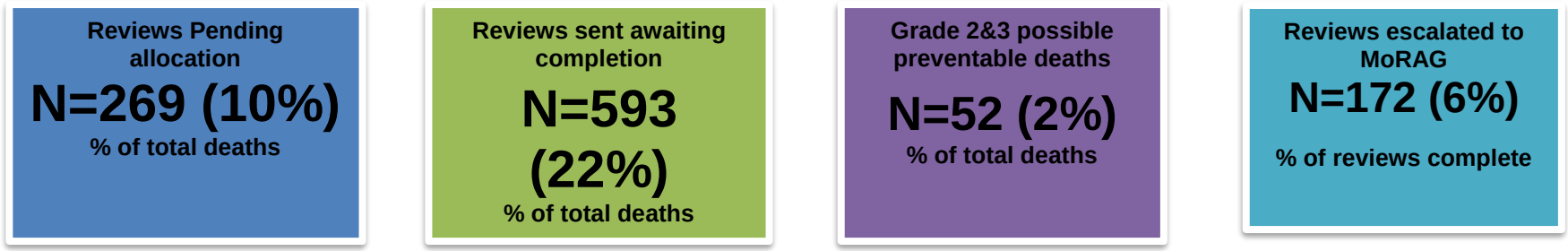
	Dec 16- Nov 17	
Metric	**National Acute (Non specialist)**	**ULHT**
HSMR	96.90	102.65
Elective Crude Rate %	0.20%	0.10%
Non elective Crude Rate %	6.30%	7.20%
% observed mortalities in hospital	3.45%	3.84%
% observed palliative coding	42.62%	31.80%
% Spells Palliative coding	2.37%	2.24%
Avg comorb 0 score per observed %	1.17%	1.39%
Avg comorb 0 score spells %	49.09%	49.63%
Weekend % of observed	5.90%	7.12%
Weekday % of observed	3.04%	3.30%
Crude rate %	3.50%	3.80%
Spells Readmissions 28 days %	0.00%	0.00%
Residual Coding % of spells (Signs & Symptoms)	0.85%	0.29%
LOS short stay 0-2 days Observed %	1.08%	1.24%
LOS 3+ Observed %	7.53%	8.06%



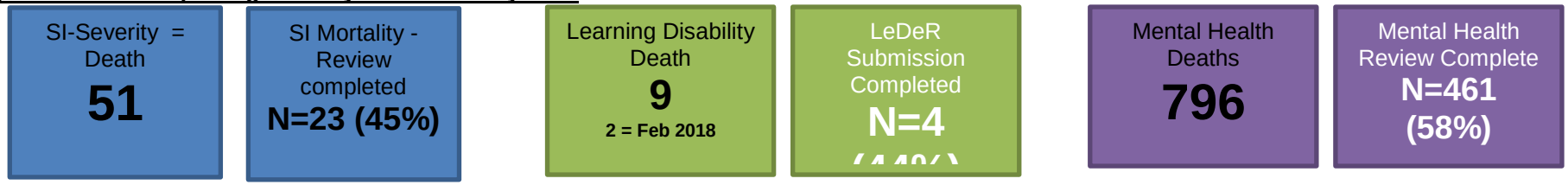
- Trust SHMI is currently outside of expected limits and is within Band 1 on the published NHS Digital data for July 2016 to June 2017.
- Lincoln and Pilgrim site are currently higher than expected.
- The Lincolnshire Mortality Collaborative continues to meet and are currently reviewing deaths within 30 days of transfer to community hospitals, deaths within 30 days and appropriate admissions to hospital. Working with GP's and Nursing homes.

Annual Total	3292	1660	744	81%	235	8%	52	172
Month of death	Total No. of Deaths	Reviews Completed	With Consultant	% of reviews completed	Excluded	% Excluded	Deaths Grade 2&3	MoRAG Escalation
Jan-17	290	221	40	90%	25	9%	3	21
Feb-17	273	210	26	86%	30	11%	7	19
Mar-17	252	189	30	87%	31	12%	5	20
Apr-17	216	146	26	80%	32	15%	3	12
May-17	204	141	27	82%	21	10%	5	13
Jun-17	181	119	31	83%	22	12%	2	7
Jul-17	205	132	39	83%	21	10%	6	15
Aug-17	202	104	56	79%	25	12%	1	6
Sep-17	193	123	38	83%	19	10%	6	14
Oct-17	223	102	71	78%	5	2%	2	8
Nov-17	244	93	81	71%	2	1%	1	12
Dec-17	256	62	128	74%	2	1%	2	4
Jan-18	350	18	123	40%		0%	2	2
Feb-18	203		28	14%		0%	7	19

Trust trajectory of 70% for completed reviews is being achieved.
Excluded cases are those cases that are not within our "MUST DO's" criteria, but where QG have been awaiting notes for review and not received within 3 months to ensure timely review.
NOTE: January and February 18 are not included within the reviews completed percentage as all reviews sent deadlines have not yet passed.



Learning from Deaths Reporting-January 2017-February 2018



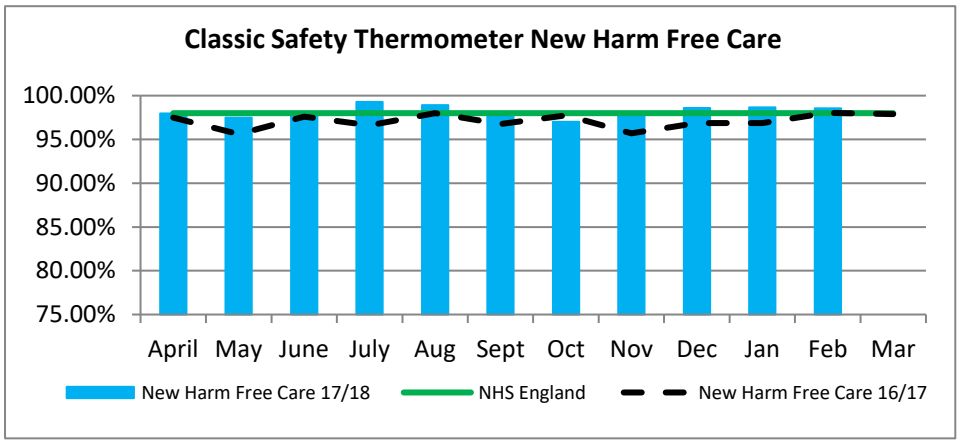
NOTE: LeDeR submissions are only from October 2017

Mortality Review	Source	Review Commenced	Site	Actions	Lead	Timescale	Progress	RAG
Clinical Coding Masterclass	On-going	Underway	All	To arrange the next Clinical Coding Masterclass. To incorporate Live Clinical Coding, Dr Foster Data, Finance and Mortality **NOW incorporating Commissioning and Information support**	Dr Andrews/ Karen Moon	On-going	**QG have asked both information and commissioning to become part of the masterclass and they have agreed. Dates to be booked and agreed for next year.**	
Junior Doctor Teaching	On-going	Underway	All	JD Teaching across each site	Quality Governance	On-going	All JD teaching has been completed, feedback was to get the training earlier and this is to become part of the induction.	
Audit of Palliative care coding not coded on Dr Foster	Mortality Report	Underway	Trust	Through analysis and in-depth reviews it has been highlighted the ULHT are below the national average of palliative care coding, which highly affects the HSMR	Karen Moon	On-going	Palliative Care Team have submitted figures of those that the team have seen. QG has correlated this with Dr Foster coded data. An audit is to be undertaken by Coding and Quality Governance to ascertain why there is a difference in coding -Particularly on the LCH site. **Palliative care coding audit completed:** action plan to be discussed at PSC in Jan 18-**An ongoing audit will be commencing correlating the data and driving improvement**	
Acute Cerebrovascular disease	Dr Foster	Underway	LCH	Meeting to be arranged to understand the underlying data. QG have produced an overview of the Dr Foster data in the October Mortality Report this has been shared with the QSO for Stroke.	Derek Smith, Quality Governance & Stroke Team	On-going	Meeting been held with Stroke audit coordinator and QSO She is looking at the Dr Foster data in comparison to SNNAP data. Data has been analysed but as SNNAP looks at different datasets this was deemed not comparable. **Dr Foster to meet to with stroke team to drive improvement and understanding. In depth review to be completed**	
Comorbidity Coding Quality Improvement	On-Going	Underway	All	Actions from Comorbidity Focus Month.	Bernie Gallen/Karen Moon	On-going	Meet with Shaun Caig and Mary Tomlinson for the quality Improvement action plan: meeting to be held 6th march 2018.	
Other Perinatal conditions	Dr Foster	Underway	Trust	Meeting to take place with W&C governance, QG governance, Dr Foster and coding to agree action plan	Karen Moon	Mar-18	Meeting held and actions allocated. Jude Cheesmond looking at coding process. Actions as per email attached. Another progress meeting arranged 18/12/17-Progress meeting held and issues found with the well-baby coding and depth of coding and the form reaching the coders for all well-babies that have not go to transitional or neonatal care. This process is being reinforced by the W&C Risk team. **UPDATE: KM chased action evidence and progress.**	
Respiratory Failure, insufficiency, arrest (adult)	Dr Foster	Underway	Trust	A meeting with Dr Pogson, to discuss alert and NIV mortality. **TO undertake an in-depth review at Pilgrim**	Karen Moon/ Bernie Gallen	May-18	Meeting was postponed awaiting date from Dr Pogson. Because of capacity within the respiratory team this has been extended	
Medical Examiner	Trust	Underway	Trust	Funding 11 PA's for a Medical Examiner	Bernadine Gallen/ Dr Andrews	Apr-18	Business Case and Job Description has been produced. And has been agreed in principle by ET. **UPDATE: This has now been approved and is going through the final stages before advertisement**	
Biliary Tract Disease	Trust	Underway	Trust	Biliary Tract has had several internal reviews. The Medical Director has expedited an external review	Leicester Trust/ULHT	Mar-18	Medical Director has asked Leicester for an external review-awaiting update.	

Safe Ambition: Harm Free Care (Safety Thermometer)

Executive Responsibility: Michelle Rhodes – Director of Nursing

The Safety Thermometer is a point prevalence audit undertaken on all acute adult wards. Scores are divided into Harm Free (inclusive of community harms) and New Harm Free (ULHT Harms).



The Harm Free score for February 2018 was 93.13% which is below the national target of 95%.

New Harm Free was 98.54% which is above the national target of 98%.

Information supplied by GEM Arden provides ULHT with national comparisons against each domain of the Safety Thermometer. The information below compares each domain in respect of **New** Harms only against national averages. National average consists of Acute Hospital Providers, Community Trusts, Mental Health Trusts and Independent Service Providers.

FALLS	A	M	J	J	A	S	O	N	D	J	F	M
National	*0.5*	*0.6*	*0.5*	*0.5*	*0.5*	*0.5*	*0.5*	*0.6*	*0.5*	*0.5*	*0.5*	
ULHT	0.6	1.3	0.6	0.1	0.1	0.6	0.7	0.6	0.4	0.2	0.3	
Lincoln	0.4	2.1	0.9	0.0	0.2	0.9	1.1	0.2	0.5	0.0	0.6	
Boston	0.3	0.3	0.3	0.3	0.0	0.3	0.3	1.3	0.3	0.6	0.0	
Grantham	2.4	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	

ULHT average of new falls with Harm for February 2018 is 0.3% and is below the national average of falls (0.5%)

PU	A	M	J	J	A	S	O	N	D	J	F	M
National	*0.9*	*0.9*	*0.9*	*1.0*	*0.9*	*0.8*	*0.9*	*0.9*	*0.9*	*0.9*	*1.0*	
ULHT	1.1	1.0	0.7	0.5	0.5	1.0	1.5	1.2	0.6	1.1	0.8	
Lincoln	1.1	1.1	0.5	0.5	0.0	0.5	1.3	0.4	0.7	1.1	0.6	
Boston	1.3	1.0	1.3	0.6	1.3	1.3	2.2	2.6	0.6	0.9	1.2	
Grantham	0.0	0.0	0.0	0.0	0.0	2.9	0.0	0.0	0.0	2.1	0.0	

ULHT average of new pressure ulcers for February 2018 is 0.8% and is below the national average (1.0%).

VTE	A	M	J	J	A	S	O	N	D	J	F	M
National	*0.4*	*0.4*	*0.4*	*0.4*	*0.4*	*0.4*	*0.4*	*0.4*	*0.5*	*0.4*	*0.4*	
ULHT	0.2	0.2	0.2	0.1	0.2	0.6	0.6	0.2	0.1	0.0	0.2	
Lincoln	0.0	0.0	0.2	0.2	0.0	0.5	1.1	0.2	0.2	0.0	0.2	
Boston	0.3	0.6	0.3	0.0	0.7	1.0	0.0	0.3	0.0	0.0	0.3	
Grantham	1.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	

ULHT average of new VTE for February 2018 is 0.2% and is below the national average (0.4%).

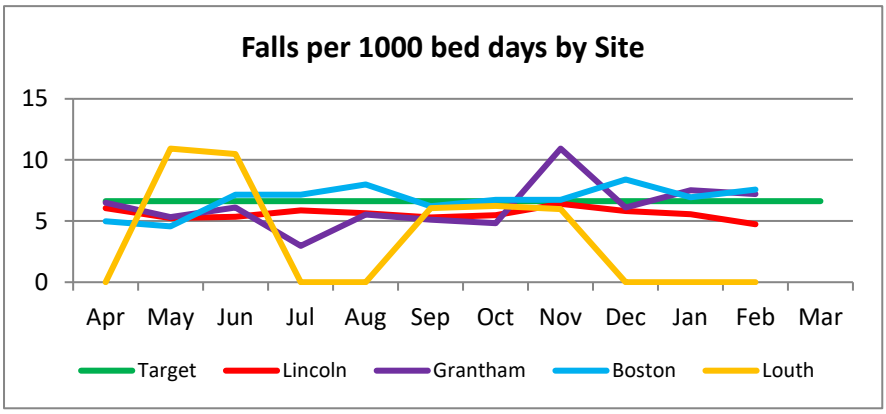
CAUTI	A	M	J	J	A	S	O	N	D	J	F	M
National	*0.3*	*0.3*	*0.3*	*0.3*	*0.3*	*0.4*	*0.3*	*0.3*	*0.3*	*0.3*	*0.3*	
ULHT	0.2	0.0	0.4	0.0	0.2	0.1	0.2	0.1	0.4	0.0	0.1	
Lincoln	0.0	0.0	0.5	0.0	0.2	0.0	0.4	0.2	0.2	0.0	0.2	
Boston	0.3	0.0	0.3	0.0	0.3	0.3	0.0	0.0	0.3	0.0	0.0	
Grantham	1.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	0.0	0.0	

ULHT average of Catheter with UTI (new) for February 2018 is 0.1% and is above the national average (0.3%). (Percentage is a measure of the proportion of patients with a catheter who are also being treated for a UTI)

Safe Ambition: Falls

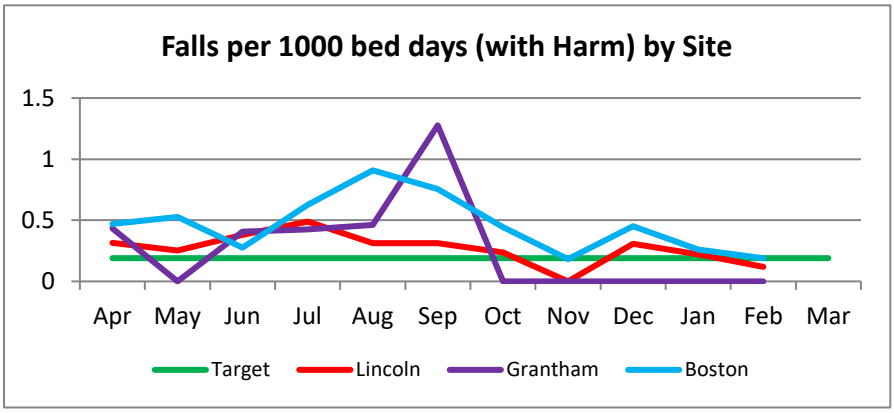
Executive Responsibility: Michelle Rhodes – Director of Nursing

Trust performance for falls is measured using per 1000 bed days formula. This is recognised as a measure of both reporting culture and reduction in harm and allows for national and regional comparison. Falls with harm include moderate, severe and death.



The Trust performance for all falls per 1000 OBDs is 5.95 in February 2018 which is below the national average of 6.63. The YTD Trust figure is 6.07. (National average is taken from the 2015 National Frailty and Falls Inpatient Audit)

ULHT is above the Trust's stretch trajectory of 3.9 falls per 1000 OBDs (Trust Sign Up to Safety campaign goal, 2014).



Falls with harm per 1000 bed days for the Trust is 0.14 in February 2018 which is below the national average of 0.19. The YTD Trust figure is 0.34. (National average is taken from the 2015 National Frailty and Falls Inpatient Audit)

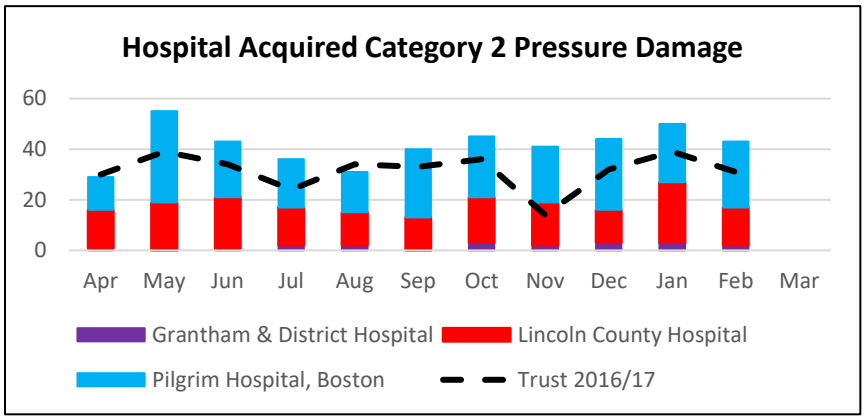
Assurance Summary

- Although falls with harm are showing a downward trend, all falls are showing an upward trend. The increased awareness and use of preventative measures and interventions are believed to be contributing to the reduction in falls with harm, however the ongoing focus on keeping patients mobile and the increased activity over recent months is resulting in an increased number of slips and controlled falls.
- The scrutiny panel process is being strengthened from April to improve accountability and assurance processes, and timely learning from incidents.
- Work ongoing to support wards with ward accreditation.
- Improvement work focusing on review of preventative measures and management plans following a fall to reduce the risk of subsequent falls.
- Detailed paper to be presented to Quality Governance Committee in April outlining improvement trajectory for Directorates, performance management strategy and quality improvement support.

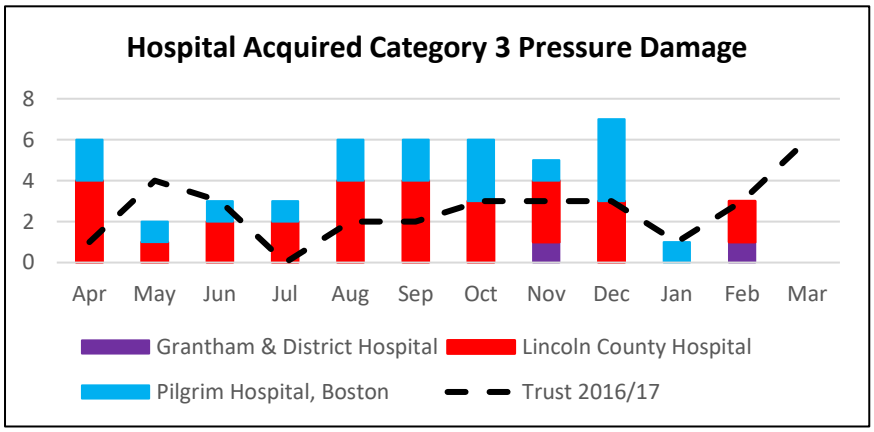
Safe Ambition: Pressure Damage

Executive Responsibility: Michelle Rhodes – Director of Nursing

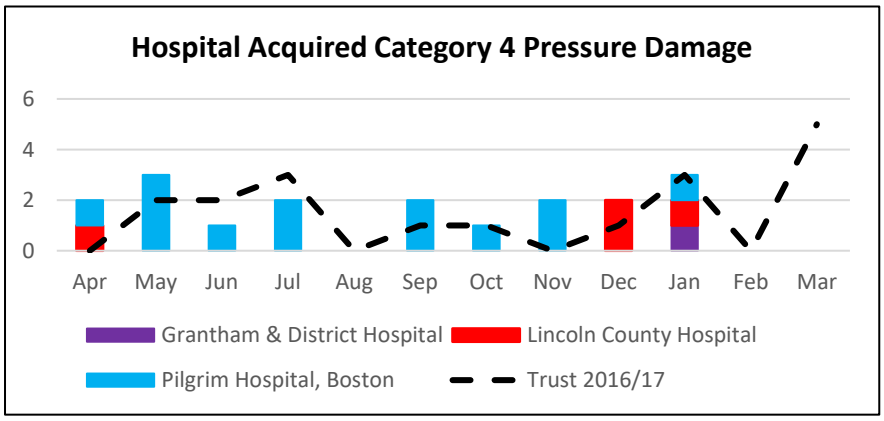
Trust performance for pressure damage is measured using crude numbers and avoidability. Avoidability is determined by Scrutiny Panel process for category 3 and 4 pressure damage. Category 1-4 pressure ulcers are all reported using Datix system. Figures for pressure ulcers are indicative and are subject to change pending outcome of Scrutiny Panels.



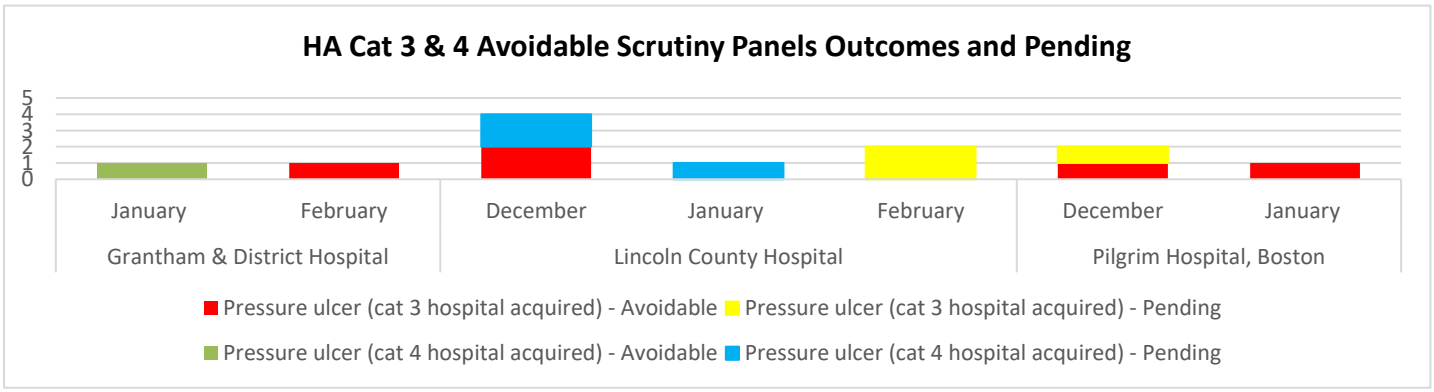
At February 2018 the Trust has reported 111 more Category 2 pressure ulcers than at the same point in 2017. A change in the reporting systems from Aug 2017 may account for this and the increase is being explored further.
Pilgrim Hospital report the highest number of Cat 2 pressure ulcers. Further work is currently being undertaken to explain this as crude figures do not identify whether this is indicative of increased harm or positive reporting culture.



At February 2018 the Trust has reported 23 more Category 3 pressure ulcers than at the same point in 2017.
At February 2018, 35 reported Category 3 Pressure ulcers were determined as avoidable and 10 unavoidable (remaining 3 pending Scrutiny Panel).



The Trust continues to report Category 4 pressure damage. At February 2018 the Trust has reported 5 more Category 4 pressure ulcers than at the same point in 2017. At February 2018, 9 reported Category 4 Pressure Ulcers were determined as avoidable and 5 unavoidable (remainder 4 pending Scrutiny Panel).

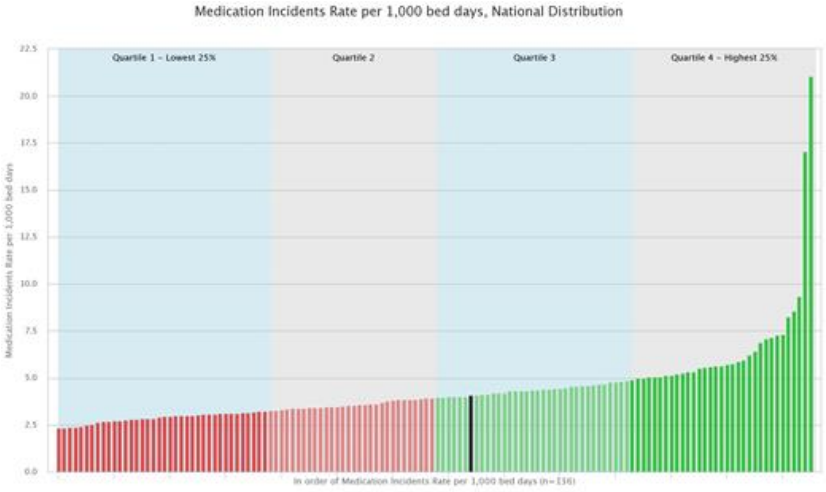


Assurance Summary

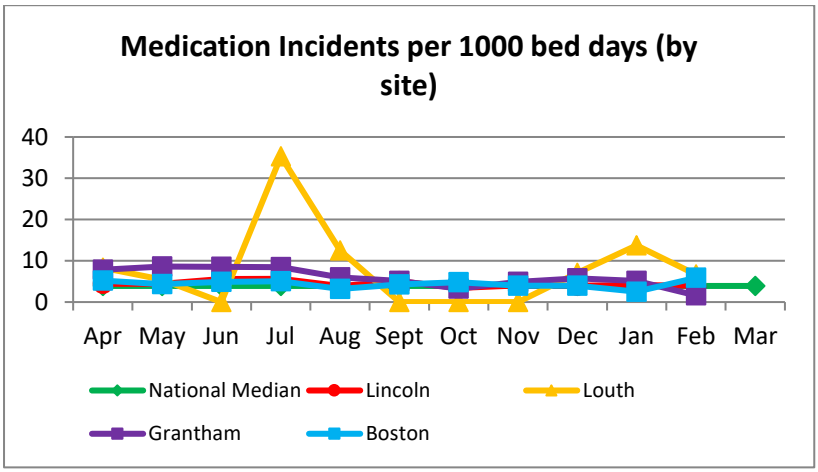
- The continued development of hospital acquired pressure damage remains a concern and is unacceptable.
- The Tissue Viability team are focusing on increasing the support they provide to clinical teams and providing targeted education. Priority is being given to wards with category 3 & 4 pressure ulcers.
- The team are supporting wards to progress on ward accreditation.
- The scrutiny panel process is being strengthened from April to improve accountability and assurance processes, and timely learning from incidents.
- Detailed paper to be presented to Quality Governance Committee in May outlining improvement trajectory for Directorates, performance management strategy and quality improvement support.

Safe Ambition: Medication Incidents

Executive Responsibility: Michelle Rhodes – Director of Nursing

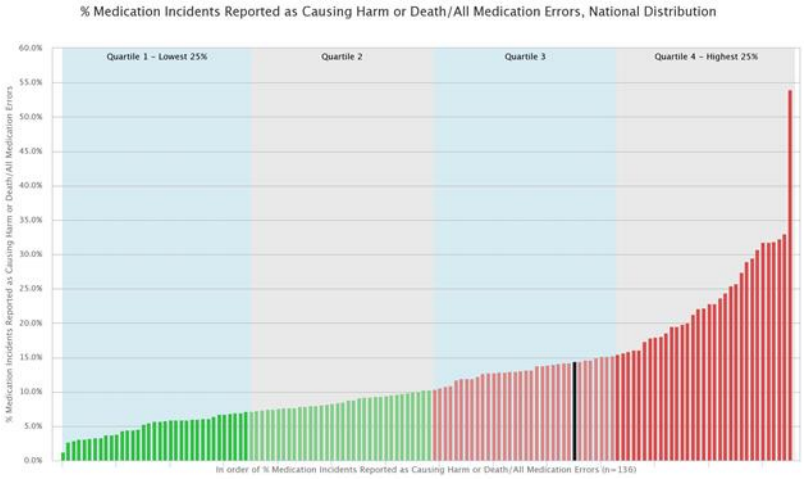


Medication Incidents per 1000 bed days is a measure of safety and governance. It is the total number of medication incidents reported to the National Reporting and Learning Service (NRLS) per 1,000 bed days. Reporting of Incidents is an essential indicator of safe & effective care. Whilst lower rates of incidents reporting can be seen as an issue this is linked to a range of other safety culture elements rather than as a direct correlation.

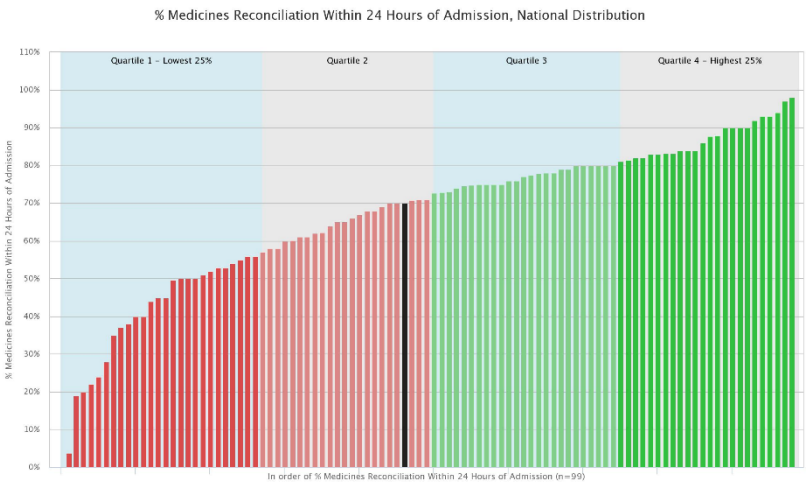


National Median (March 2017) for Medication Incidents is 3.9 per 1000 bed days. In February 2018 the Trust reported 4.48 Medication Incidents per 1000 Bed Days.

Medication Incidents per 1000 bed days should be interpreted with the same context as the Model Hospital data above.



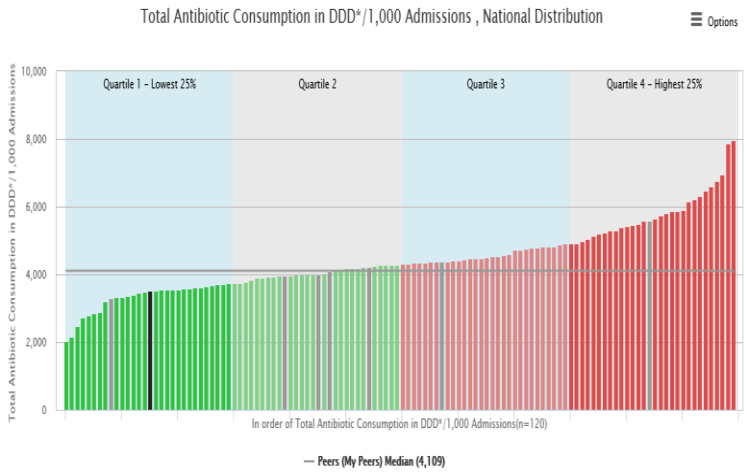
% of Medication Incidents causing harm is a measure of medicines safety and governance. It is the number of medication incidents causing harm or death reported to the National Reporting and Learning Service (NRLS). It is expressed as a percentage of all medication incidents reported. Under reporting of medication incidents will amplify the number with harm as a percentage of total incidents reported.



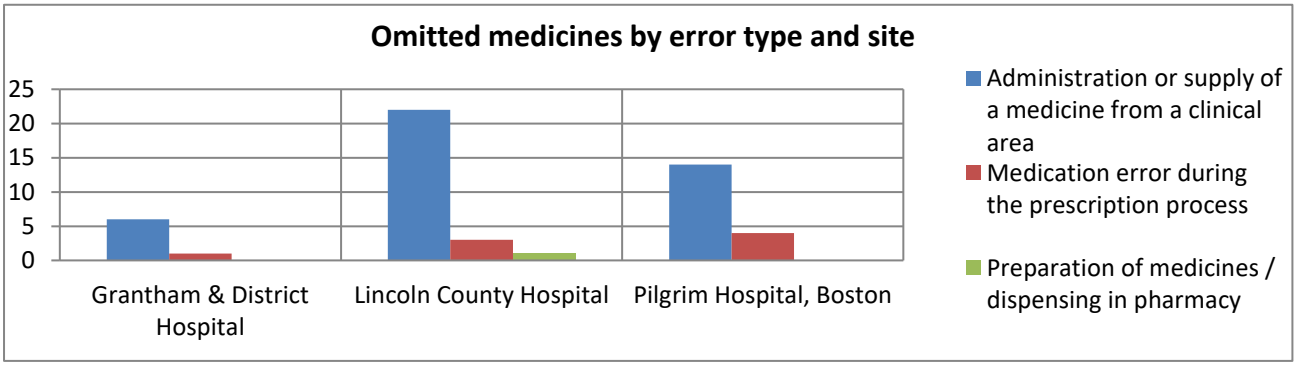
This metric represents the % of adult inpatients whose medicines are reconciled within 24 hours of the time of admission across a full 7-day working week. Higher values represent more effective medicines optimisation practices, which drive safety, efficiency and cost reduction.
Higher values indicate higher productivity and safer, more effective care (Benchmark value: 90%)

Controlled Drug Audit	Q1	Q2	Q3	Q4
Trust	67.5%	77%	66.88%	69%
Lincoln County Hospital	63%	69%	45.65%	52%
Pilgrim Hospital	56.50%	76%	82%	82%
Grantham Hospital	83.50%	93%	73%	73%

There has been a steady improvement however performance remains far below the benchmark of 100% compliance.



This metric is the high level antibiotic prescribing rate per 1,000 admissions. Inappropriate use of antibiotics is major driver for the development of antibiotic resistance. The rate shows how many antibiotic Defined Daily Doses have been prescribed per 1,000 admissions. This metric is calculated by Public Health England (PHE). Lower values are indicative of lower prescribing and safer, more effective care.



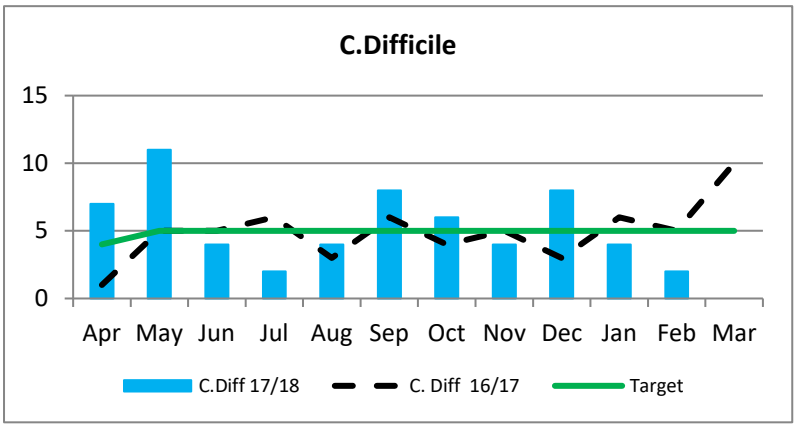
Assurance Summary

- Pharmacy had positive feedback from NHS Improvement deep-dive in our clinical service.
- Prescribing quality audit shows an average compliance of 80% of the standards; however some areas relating to the clarity and legibility of the prescriptions and amendments the compliance can be as low as 26%.
- Medicines Reconciliation within 24hr has fallen slightly below 80% during January 2018 probably due to the winter pressure and high turnover in some clinical areas.

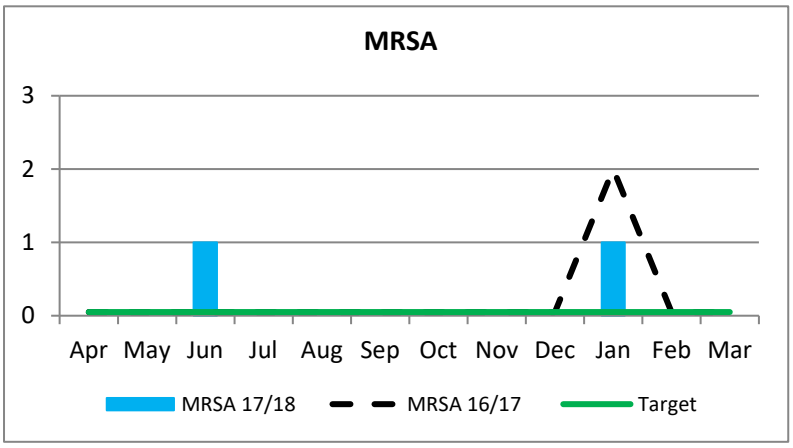
- Representation at MOPS in respect of nursing and medical should improve from February 2018.
- Controlled drugs audits show a slight improvement by actions targeted at specific area on each site to improve compliance.
- There were zero reported medication-related severe incidents in February 2018; however due to the low reporting rate, in general, those causing harm may appear higher proportionately.
- There is a need to increase reporting of near misses and non-serious incidents to promote learning across disciplines.
- Number of Prescription Charts sent to pharmacy has been reduced by 50% during February 2018.
- Omitted / delayed dose remains a concern and work is in progress to improve engagement with nursing and medical staff to minimise risk for the patient.

Safe Ambition: Infection Prevention

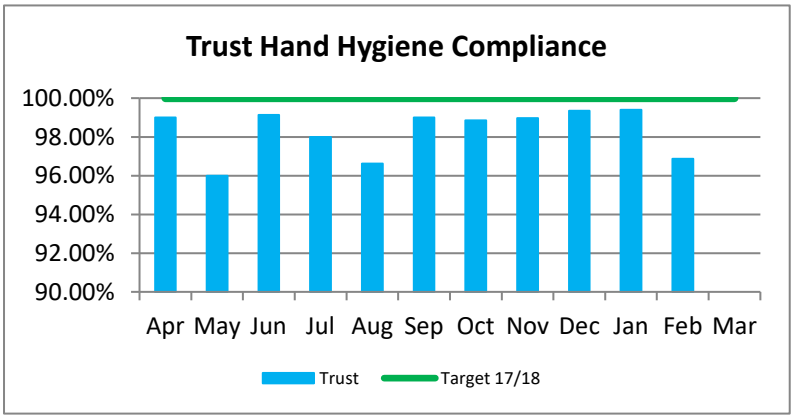
Executive Responsibility: Michelle Rhodes – Director of Nursing



The Trust current position for C.Difficile is 60 (end of Feb.) against a 2017/18 threshold of 59. This is against a national picture of increasing cases.
All cases have review and RCA completed.
The infection prevention and control team are refining the 'lapse in care' appeals process whereby cases can be removed from performance figures if it can be demonstrated that there was no lapse in the patients care. Currently 5 cases are being considered.



The trust has had 2 cases of MRSA year to date against a threshold of zero. MRSA is now considered a relatively rare event for the Trust. Full post infection reviews and root cause analysis investigations have been completed for both cases and actions taken. Both cases have been discussed at Infection Prevention Control Committee.



Hand hygiene compliance audits show a positive rate of compliance with hand hygiene across all Trust sites and areas. The audit detail and process is being further refined to support the infection prevention and control team to better focus their efforts.

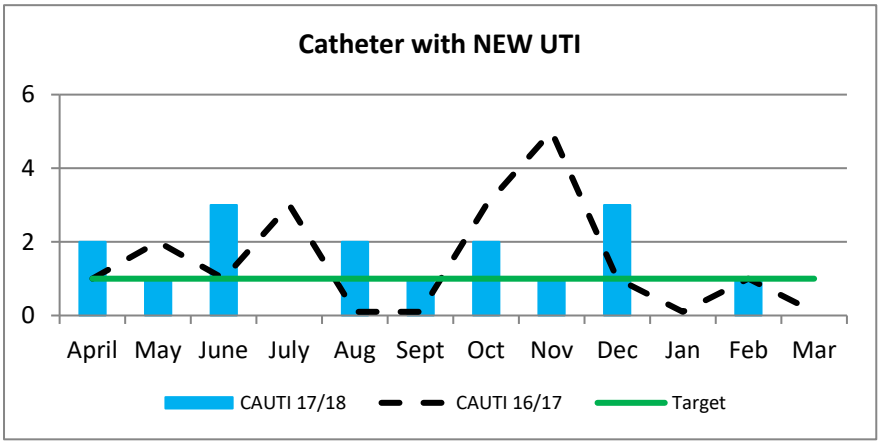
Assurance Summary

Overall performance with infection prevention and control appears to be improving supported through a greater understanding and alignment of issues captured within the risk register and an improvement in factors captured through the Hygiene Code gap analysis.
A further external visit from NHSI's Infection Prevention and Control lead is planned for 2nd May 2018.
The lead Nurse post has been redesigned and is being taken through the recruitment process.
The infection prevention and control team have changed their approach to better support clinical colleagues and improve patient safety, including: all clinical areas to have a specific IPC link, themed audits, focused incremental improvements.
The team are also supporting clinical areas to progress on ward accreditation.

Safe Ambition: CAUTI

Executive Responsibility: Michelle Rhodes – Director of Nursing

Trust performance for CAUTI is measured using Classic Safety Thermometer (see page 9). NEW UTI is defined as any UTI diagnosed or treated in acute care with catheter in-situ (exception Suprapubic Catheters). National average comparison by GEM Arden. National average consists of Acute Hospital Providers, Community Trusts, Mental Health Trusts and Independent Service Providers.



ULHT average of catheter with UTI (new) for February 2018 is 0.1% and is above the national average (0.3%).
ULHT are above local target for total Catheter with (new) UTI (16 cases/target 12). It is no longer possible to recover the position in 2017/18 and a trajectory for 2018/19 is being considered.

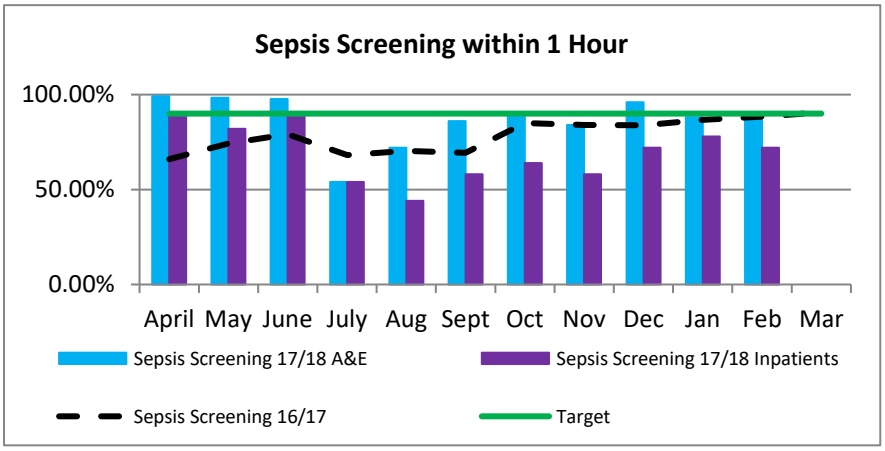
Assurance Summary

- First draft of E-Learning package is written with the support of Organisational Development, provisional launch date April 2018.
- Re-educate to highlight areas of non-concordance with the Catheter Care Bundle.
- Relaunch of Link Nurse/Ambassador Programme with representation from all clinical areas.
- Targeted improvement work to be undertaken with wards highlighted through the ward accreditation programme.
- Revised HOUDINI catheter care bundle launch planned for April to encourage both timely and nurse initiated removal of catheters.
- Collaborative work with South Lincolnshire Neighbourhood team to develop catheter and continence pathways to commence April 2018.
- Executive and senior leaders to attend NHS Improvement Urinary Tract Infection/Catheter Associated Urinary Tract Infection (CAUTI) masterclass on 1st May 2018.
- Participation in NHSI national improvement collaborative for system wide improvement focusing on interventions to reduce healthcare associated UTIs, including CAUTIs.
- Detailed improvement plan to be presented to Quality Governance meeting in June outlining new trajectories for Directorates, performance management strategy and national collaborative work.

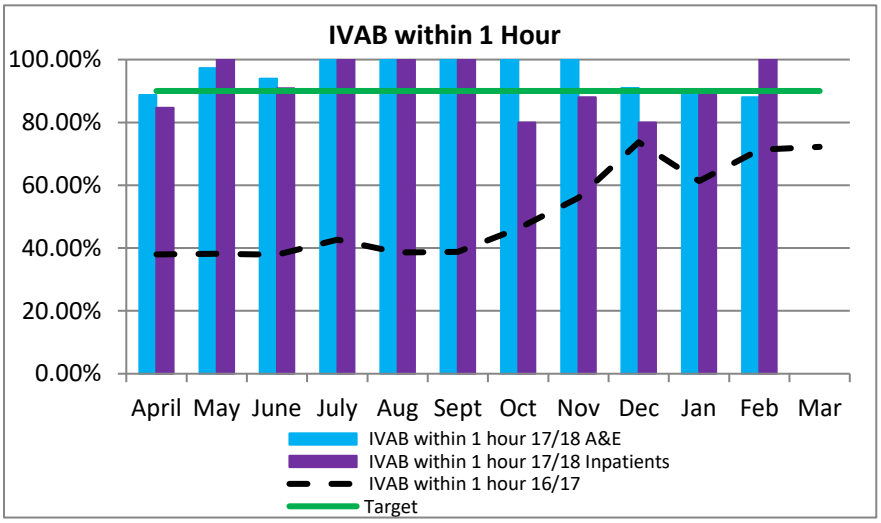
Safe Ambition: Sepsis

Executive Responsibility: Michelle Rhodes – Director of Nursing

The Trust measure Sepsis by first screen <60 minutes after NEWS 5 and Antibiotics given <60 minutes for Red Flag Sepsis. Data is collected on 50 patients each month from A&E and a further 50 patients from Inpatient areas. Patient results are validated and used for the National CQUIN submission each quarter.



January CQUIN data showed a deterioration in sepsis screening however performance has been maintained in February. This directly correlated with both an increase in the number of patients attending A&E and the acuity of patients (measured by the increased number of patients presenting with a news of 5 or more). The screening if inpatients has deteriorated in February; a safety brief has been released to clarify who should be screened and when. The data capture in screening process in 2016/17 was different and is not directly comparable.



The administration of IV antibiotics within 1 hour of sepsis diagnosis has deteriorated slightly for A&E which directly correlates with number of patients requiring care and admission within A&E for this period. We anticipate further improvement following permanent adoption of EMAS pilot to give first dose antibiotics to red flag sepsis patients prior to arrival.

Assurance Summary

- Robust process for monitoring and reporting performance to support continued and sustained patient safety: Trust wide CQUIN Audit and utilisation of trust wide electronic screening data to review any missed screens
- Use of the WebV electronic observations system has commenced in Lincoln A&E
- Monthly review templates of non-compliance with screening and sepsis six bundle delivery in place
- Harm Reviews undertaken as/when required
- There is a Sepsis Task and Finish Group who meet monthly
- Sepsis box/ trolley in all adult inpatient/admission areas
- Sepsis e-learning extended to include paediatric module with actions assigned to develop maternity.
- Increased Sepsis Link Nurse engagement across sites supported by Ward Accreditation domain
- Trust wide adoption of EMAS pilot to administer first dose ABX for red flag sepsis
- Adult Sepsis Bundle is not compliant with revised NICE guidance
- Sepsis Clinical Lead has engaged with at Trust Clinical Directors to request improved clinical engagement and medical representation at the Sepsis Task and Finish
- Sepsis e-learning compliance 86.52%, individual reminders circulated with reference to prohibition of gateway progression and study leave.

Workforce Headline Summary

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

Statistics

KPI	2017/18 Target	March 2018 Performance	Last Month Performance	Performance in March 2017	6th Month Trend
Vacancy Rate - Medical	Medical – 12%	**17.39%**	**16.36%**	**14.13%**	
Vacancy Rate – Registered Nurses	Registered Nursing 11.5%	**15.48%**	**14.59%**	**13.09%**	
Vacancy Rate – AHP's	10%	**12.01%**	**10.11%**	**12.08%**	
Voluntary Turnover	7%, with no group of staff more than 20% above the overall target	**5.80%**	**5.90%**	**n/a**	
Quarterly Engagement Index	10% improvement in average score during 2017/18	**3.3 (Sep'17)**	**3.4 (Jun'17)**	**n/a**	
Quality of Leadership/Management Index	10% improvement in average score during 2017/18	**2.6 (Sep'17)**	**2.8 (Jun'17)**	**n/a**	
Core Learning Completion	Overall target remains 95%.	**89.72%**	**90.60%**	**89.90%**	
Sickness Absence (12 month rolling average)	Overall target of 4.5% + no team over 25% above target	**4.76%**	**4.83%**	**4.70%**	
Appraisals - Medical	Medical – 95%	**97%**	**95%**	**92%**	
Appraisals – Non Medical	Non-medical – 85%	**80.19%**	**79.71%**	**64.90%**	
Agency Spend	£25.4m (£)	**£2.400m**	**£2.269m**	**£3.214m**	

Commentary

As we have reached the end of the financial year, it is possible to make comment on the extent of progress in the last 12 months against our key workforce risks in the Board Assurance Framework. The two risks relate to workforce numbers and engagement levels and it is evident that it has been a difficult year. Vacancy rates have risen, rather than fallen as intended. The actions planned have been taken. Some were delayed owing to resourcing challenges, but they have yet to have the impact we would have wished, although we do continue to recruit significant numbers.

We will have a continued focus on recruitment and new roles in 2018/19, but will review the establishment required (in the context of changes taking place through the STP, as it will not be possible, at the speed we need, to recruit to all the clinical vacancies we are carrying. We will also put as much emphasis on staff retention. Whilst our turnover rates are lower than most Trusts, we will continue to refine and promote our offer to staff ("what it is that would encourage people to join and stay at ULHT"). We are engaged in an NHSI project around nurse retention, to test our approach with best practice. One of the key factors in recruitment is staff engagement and we know, from our 2017 staff survey, that morale is poor in many places.

We will use the 2021 narrative to create greater hope in ULHT and a belief that ULHT will improve. We will use the staff charter in particular to promote our values and engagement around those values, demonstrating how the organisation lives by those values. We will focus on giving staff a strong voice and enabling them to raise their concerns, demonstrating that we listen and learn from their experiences. Key to all of this is leadership and we will invest heavily in new leadership programmes an holding leaders and others to account for what they deliver and how they do it.

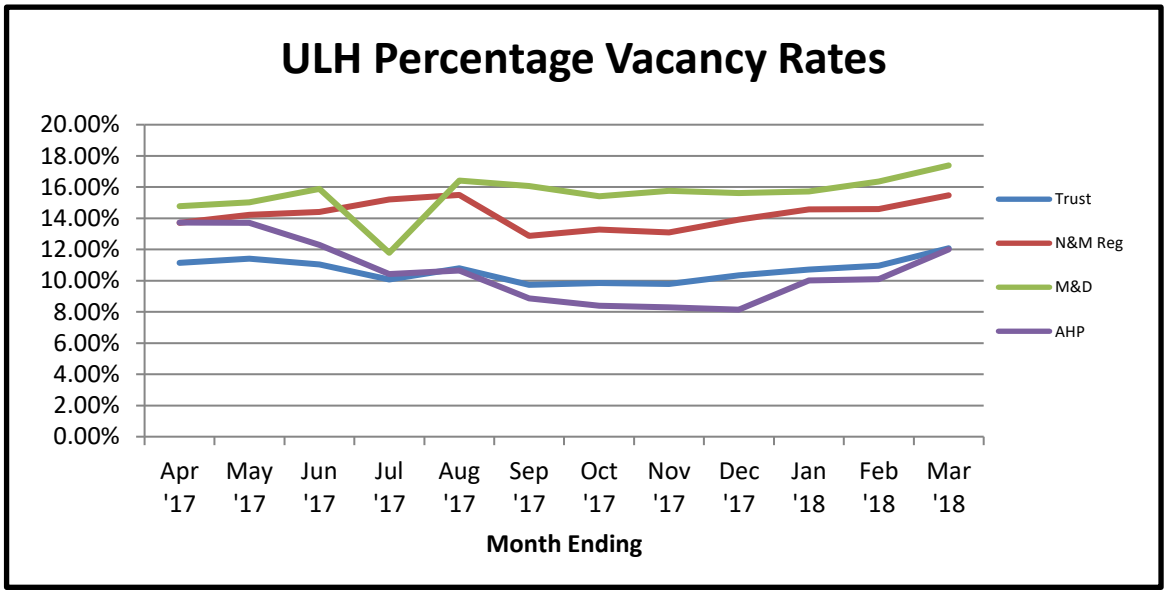
There have been successes in the year. Spend on agency has reduced significantly, albeit that we have not hit our targets and that reduction has been achieved whilst vacancy and sickness rates have gone up and the pressure on the system has increased. Appraisal rates, both medical and non-medical have increased by a large percentage. For the latter we did not hit our target and have become "stuck" at the 80% level. Core learning rates are stuck also and so we have to think about how we do something very different to make a further step change.

KPI:	**Vacancy rates**	**Owner:**	**Director of HR & OD**
Domain:		**Responsible Officer:**	**Deputy Director of HR & OD**
Date:	**11th April 2018**	**Reporting Period:**	**March 2018**
Target:	**Medical – 12%** **Registered Nursing – 11.5%** **AHPs – 10%**	**Tolerances:**	**Within 1% - Amber** **Above 1% - Red**
RAG Rating:	**Medical 17.39%**		
RAG Rating:	**N&M 15.48%**		
RAG Rating:	**AHP's 12.01%**		

Analysis

Vacancy rates for the three measured occupational groupings all increased compared to the previous month and are again above target. The overall Trust vacancy rate for March is 12.08% which is an increase compared to 10.46% rate in March 2017.

The graph below show vacancy rates by staff group and the tables establishment and numbers in post by staff group. The vacancy rate at middle grade level is of particular concern and the reduction now in the number of registered nurses in post compared to March 2017.



	Mar 17	Mar 18
Establishment (registered nurses and midwives)	2268.75	2279.46
Number in post (registered nurses and midwives)	**1971.67**	**1926.62**
% Vacancy Rate (registered nurses and midwives)	13.09%	15.48%
Establishment (non- registered nurses and midwives)	972.63	953.47
Number in post (non-registered nurses and midwives)	**833.19**	**848.43**
Vacancy rate (non-registered nurses and midwives)	14.34%	11.02%
Establishment (AHPs)	393.72	409.22
Number in post (AHPs)	**346.15**	**360.09**
Vacancy Rate (AHPs)	12.08%	12.01%
Establishment (consultants)	356.16	358.09
Number in post (consultants)	**315.03**	**313.38**
% Vacancy Rate (consultants)	11.55%	12.49%
Establishment (middle grades)	199.57	214.69
Number in post (middle grades)	**159.82**	**164.36**
Vacancy rate (middle Grades)	19.92%	23.44%

We have a particular medical engagement plan, with a focus on creating more development opportunities and therefore giving staff at this level a stake in the organisation. We have advertised a one-year post, funded through HEE, to look at structuring development pathways for medical and nursing staff in particular. This work has a degree of urgency and we will looking at alternative means of bringing in the capacity necessary to progress the work.

Action Taken	**Action Planned**
• Continued recruitment work – cohort recruiting, alongside some targeted activity • Contract signed with TRAC systems for improved recruitment processing (implementation date 23rd April).	• Recruitment agencies can now be used to help us find permanent Nurses; • Continue to deliver on the Recruitment Plan initiatives. • Recruitment team being brought together to enhance capacity. • Review of recruitment process by NHSI planned.

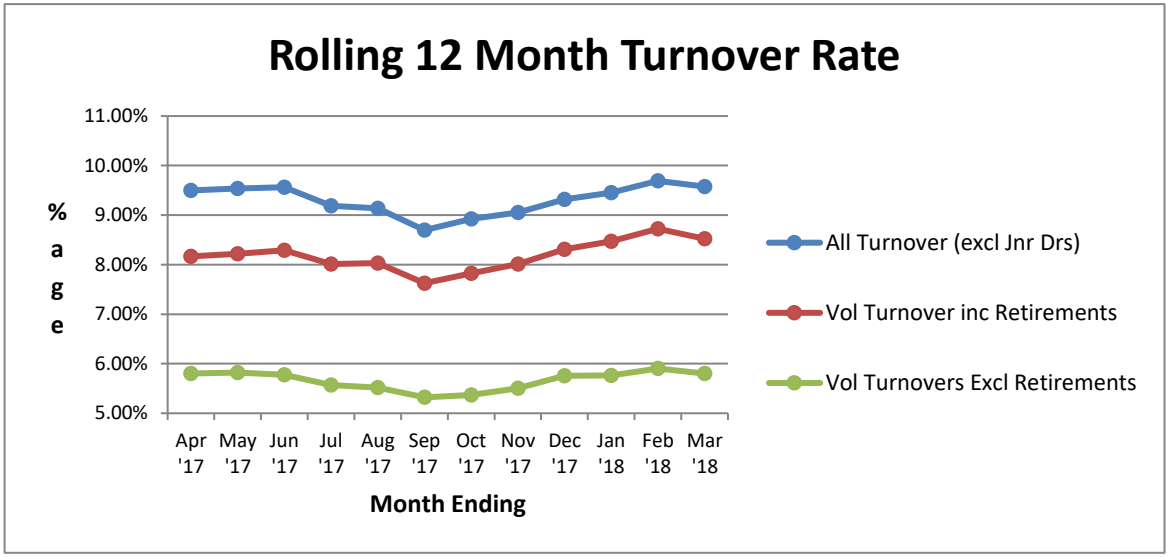
KPI:	Voluntary Turnover	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Deputy Director of HR
Date:	11th April 2018	Reporting Period:	March 2018
Target:	7% (excl. retirements) with no group of staff more than 20% above the overall target	Tolerances:	Within 1% - Amber Above 1% - Red
RAG Rating:	5.80%		

Analysis

The Trust remains within its target for voluntary staff turnover. However we recognise that rates have steadily risen since September 2017, although there was a drop in March.

Based on the latest (January 2018) benchmarking data available (x37 Trusts) from NHS Digital for other Large Acute (Non-Teaching) Hospitals.

- The current Trust turnover rate (excl. junior doctors) of 9.58% is below the average of 10.20%
- The current Trust Nursing & Midwifery (Registered) turnover rate of 8.06% is below the average of 10.67%,
- The current Trust AHP turnover rate of 9.40% is below the average of 11.40%.



Whilst turnover rates remain below the average for acute trusts, we are putting particular emphasis on retention projects, to seek to ensure they do not rise further. We have used HEE money invested in the Trust to bring in additional temporary staff to focus on the following:

- Defining more clearly what the ULHT brand and offer is (this will help with recruitment also)
- Creating a plan to market the offer more effectively to staff
- Defining development pathways for clinical staff in particular, so they can see how they can build their careers with ULHT
- Understanding what we can do to encourage staff who could potentially retire to stay at the Trust and putting in place the necessary measures to enable them to do so
- Taking part in an NHSI project on nurse retention, so we can reflect best practice in our approach.

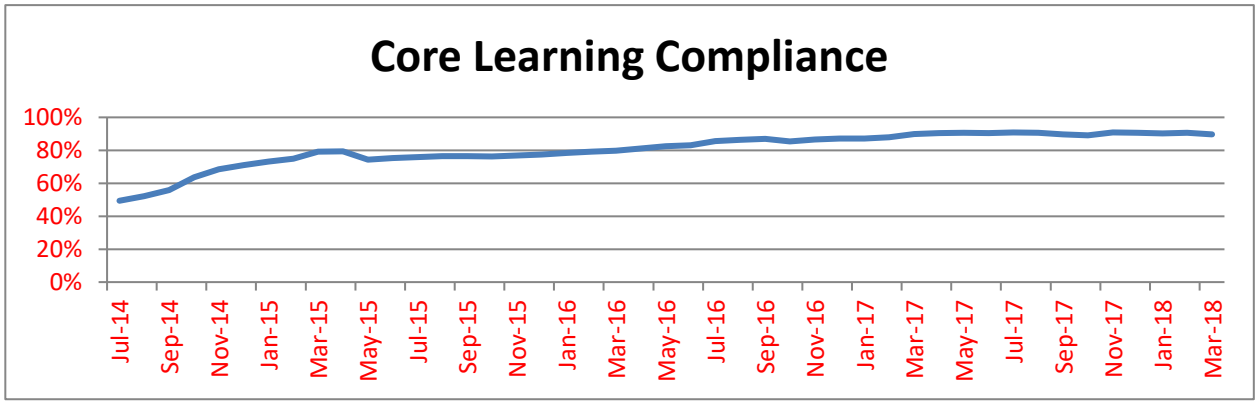
Action Taken	**Action Planned**
• New exit interview process in place – results available • Work underway around the development offer for both nursing and medical staff • Review of benefits underway – focus on extending benefits offer, reflecting on it from an age differentiation perspective and how we promote our offer;	• Survey of nursing staff who have stayed and left the Trust; • All potential retirees to be contacted and asked about their intentions and what the Trust could do to help them stay; • Intention to introduce an “itchy feet” interview process, whereby we can intervene where people are thinking about leaving; • Focus on junior doctor experience (partly in response to the findings of the Guardians of Safe Working Practice and the GMC survey) – project with project manager underway involving key stakeholders.

KPI:	Core Learning Completion	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Head of OD
Date:	11th April 2018	Reporting Period:	March 2018
Target:	Revised targets have been set and will form the basis of the performance report in 2018/19	Tolerances:	
RAG Rating:	89.72%		

Analysis

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

We struggle now though to get beyond the figure of 90%. We are in future going to set differentiated targets for the different elements of core learning. 8 of the 13 topics have compliance over 90% achieving the new individual targets set in November 2017 and the remaining 5 are over 80%.



Trust	Fire	Infection Prevention	Equality & Diversity	Information Governance	Safeguarding Children L1	Safeguarding Children L2	Health & Safety	Slips, Trips & Falls	Inanimate Load Handling	Risk Awareness	Fraud	Basic Life Support	Major Incident Awareness
Target	100%	95%	90%	95%	90%	90%	90%	90%	90%	90%	95%	90%	90%
Mar-18	88.17%	83.61%	96.80%	82.32%	90.25%	90.19%	93.13%	92.73%	90.95%	90.32%	96.76%	82.72%	88.38%

This month the focus is on Infection Prevention & Control which is currently 83.61%, the 3rd lowest compliance rate and 3.05% lower than March 2017. Following the recruitment of the new Infection Prevention lead, this topic is being reinstated onto Day 2 of Trust Induction from April 2018 capturing new starters early.

Directorate Compliance – Infection Prevention & Control:

Directorate	Mar-18
Chief Executive	100.00%
Director of Fin & Corp Affair	95.80%
Deputy Chief Executive	95.38%
Medical Director	92.93%
Clinical Support Services	87.82%
TACC Boston	87.36%
Women & Childrens Pan Trust	86.59%
Director of Nursing	86.21%
Director of HR & Org Dev	84.42%
Grantham	84.27%
Acute Medicine Lincoln	83.43%
Trustwide Cardiology Services	83.26%
Gen Surg Linc & Urology Trust	82.64%
Chief Operating Officer	82.19%
Orthopaedics Boston	82.08%
Acute Medicine Boston	80.66%
Haem & Onc Trustwide	80.47%
TACC Lincoln	80.00%
Director of Estates & Facil	78.87%
Head & Neck Trustwide	77.40%
Orthopaedics Lincoln	75.00%
General Surgery Boston	74.14%
A&E Lincoln	61.76%

Directorate Performance – Infection Prevention & Control:

Directorate Top Improvers	Mar-18	Feb-17	Variance
Orthopaedics Boston	82.08%	76.15%	5.93%
TACC Boston	87.36%	83.51%	3.85%
Medical Director	92.93%	91.09%	1.84%
Trustwide Cardiology Services	83.26%	81.65%	1.60%
Acute Medicine Lincoln	83.43%	82.47%	0.96%
Director of Fin & Corp Affair	95.80%	94.96%	0.84%
Grantham	84.27%	83.88%	0.39%

Staff Group Performance – Infection Prevention & Control:

Staff Group	Mar-18	Feb-17	Variance
Add Prof Scientific and Technic	85.39%	83.26%	2.13%
Additional Clinical Services	82.70%	85.16%	-2.45%
Administrative and Clerical	86.91%	89.70%	-2.79%
Allied Health Professionals	88.37%	91.00%	-2.63%
Estates and Ancillary	78.81%	78.79%	0.02%
Healthcare Scientists	84.68%	86.49%	-1.80%
Medical and Dental	72.87%	74.01%	-1.15%
Nursing and Midwifery Registered	85.24%	86.30%	-1.06%
Students	75.00%	75.00%	0.00%

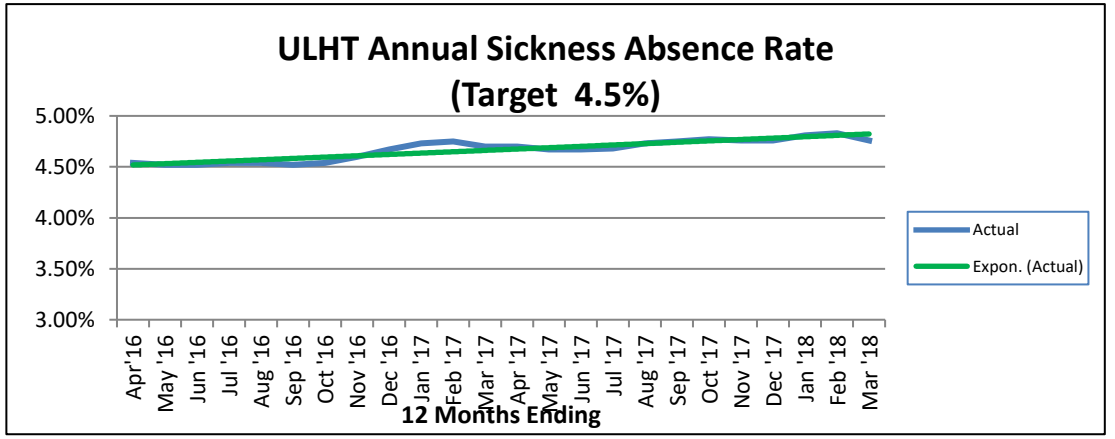
Action Taken	**Action Planned**
• 'Hotspots' are any areas in the red i.e. with less than 70% compliance with any number of staff. Following work by the Core Learning Lead, 14 areas have come off the hotspot list this month. However a further 12 have become new hotspots making a total of 19. • Infection Prevention returned to Trust Induction as of April 2018 to capture this core topic for new starters and new presentation implemented for core classroom sessions.	• The Trust's Core Learning Lead will continue to work with poorly performing areas to identify and implement any support required • Infection Prevention e-learning to be updated and topic to be advertised to improve compliance.

KPI:	Sickness Absence	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Assistant Director of HR
Date:	11th April 2018	Reporting Period:	March 2018
Target:	Overall target of 4.5% + no team over 25% above target	Tolerances:	Within 0.5% - Amber Above 0.5% - Red
RAG Rating:	4.76%		

Analysis

The Trust annual rolling 12 month sickness rate is 4.76%, above our target of 4.50%. Sickness has increased slightly from 4.70% at the same period 12 months ago. The rate however has reduced from February 2018. The average across 37 acute trusts is 4.27%.

Our ability to interrogate the reasons for sickness data continues to be hampered by the signifcant amount of sickness being coded to 'other'. There are 25 categories sickness can be coded to so it is highly unlikely that such a large amount of sickness is genuinely for a reason 'other'. Recent investigations have shown that approximately 90% of sickness recorded as 'other' were entered via the Healthroster system. help address this problem, the Healthroster team have recently sent communication to managers informing them where possible use a specific reason for absence.



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In order to make a significant difference to this absence rate, we need to tackle the underlying causes of sickness. Given a very large proportion of sickness is attributed to stress and pressure, we must seek to deal with those things that cause stress.

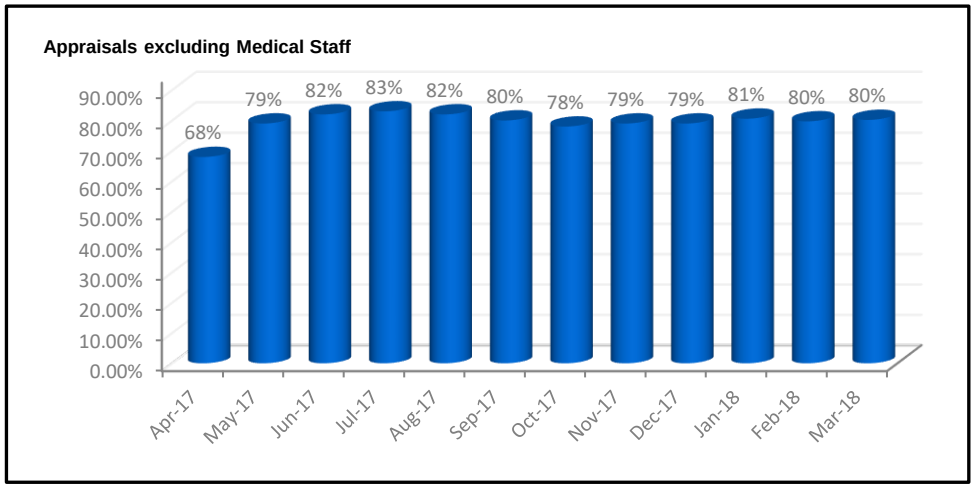
Action Taken	Action Planned
• There is a reduction in the longest LTS i.e. 9-12+ following a high number of capability hearings taking place. • Continuation of the monthly meetings with OH has increased in accountability to the ER Managers to support the case management of cases. • The new HR structure will allow more time to focus on the reduction of sickness rates and more analysis on trends. • Absence training is being developed as part of the new training packages for all levels of staff across the Trust this includes referrals and OH support	• ER Staff have been tasked to meet with managers on a regular basis to discuss the absence information • ER managers going forward will manage complex absence cases and those with absence history alongside those with long term conditions • A communications has been drafted to address the issue of managers to ensure that 'other reason' is not used • ER team will email managers to address with those currently recording in this way • Review of health and well-being activity, relating to both mental and physical health, is underway

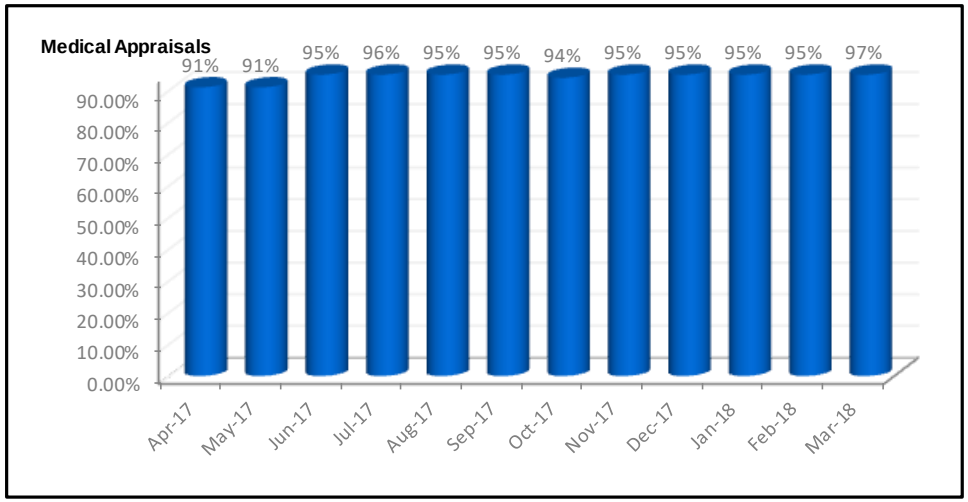
KPI:	Appraisal Rates	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Head of OD
Date:	10th April 2018	Reporting Period:	March 2018
Target:	Medical – 95% Non-Medical – 85%		Within 5% below - Amber More than 5% below – Red
RAG Rating:	Medical – 97%		
RAG Rating:	Non-Medical – 80.19%		

Analysis

The graph below shows that the Agenda for Change Staff/Non-Medical Appraisal compliance rate for March is 80.19%. This is a slight increase of 0.48% from the previous month. This is a significantly better position than last year, but below the target (which was 85% this year, stepping up to 90% in 18/19).

The Medical Workforce appraisal rate for the month ending March 2018 has increased to 97%. Only once in the last ten months has the Trust target of 95% not been achieved. We do not have an update report on medical appraisal owing to staff sickness.





Action Taken	**Action Planned**

Non-Medical
• Monthly reports will continue to be provided to Executives naming individuals whose appraisals remain outstanding.
• HR Business Partners will continue to:
  ○ Hold regular monthly meetings with Matrons/equivalent managers to identify those staff that haven't been captured
  ○ Help to managers when they are unsure about completing the reporting process, guidance docs shared as appropriate
  ○ Highlight completion rates on monthly scorecards which are discussed at monthly Performance Reviews.
  ○ Provide bespoke training offered where appropriate
  ○ List of non-compliant staff sent to managers monthly
  ○ Data cleansing carried out where info is incorrect
  ○ Latest format of Performance Review requires CDs to account for compliance rates.
  ○ Emails for example as below and reposts to identify the areas of non-compliance.
• Launch of new individual Performance Review process
	Non-medical
	We need to review the legitimacy of the target and the high proportion of managers who say they have completed the appraisals but this is not shown in the system.

KPI:	Agency Spend	Owner:	Director of HR/OD
Domain:		Responsible Officer:	Various leads on different aspects of agency spend
Date:	11th April 2018	Reporting Period:	March 2018
RAG Rating:	Actual spend of £2.400m, against target of £1.75m		

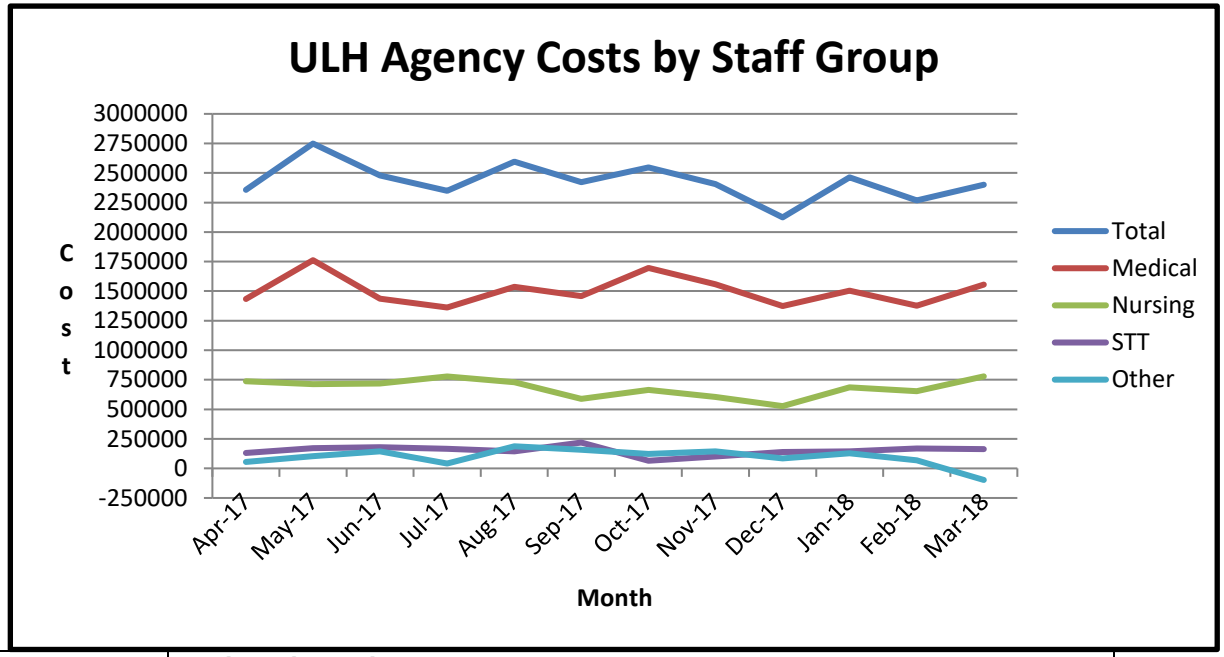
Analysis

The table below shows agency spend in the last 12 months. Spend continues to be above target and increased by £131,110 compared to the previous month. However It is £813,906 lower than March 2017 which was £3.214m. The increase in spend has been the result of the significant pressures on the system and the growth in vacancy rate. The reduction in "other" agency spend is noteworthy and evidence of the impact of action taken.

The final 2017/18outturn figures are still being finalised, but we expect an outturn spend on Agency of £29.4m. This is made up of the following:

- £17.9m on agency medical staff
- £8.2m on agency nursing staff
- £3.3m on other agency staff

This compares to a cap of c£21m.



Action Taken	Action Planned
• Medical bank via Holt starts May 2018 • Review of "other" agency posts • Review of establishment/workforce planning exercise underway for the 18/19 year • Review of long-standing medical agency staff and extent to which we are actively seeking to recruit to those roles	• Review of nursing agency rates • Review of workforce model in key areas where use of agency and overtime remains high.

KPI:	Quarterly engagement index	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Head of OD
Date:	16th April 2018	Reporting Period:	March 2018
Target:	10% improvement in average score during 2017/18		
RAG Rating:	3.3 The score is out of five and comprises six questions from the pulse survey		

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

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

Action Taken	Action Planned
• Staff Survey Directorate level reports shared with CDs and Executive Directors with a requirement for them to take action and to be held to account through CMB • Big conversations held themed around health and wellbeing. 127 staff attended over all four sites • Significant work undertaken to define employment brand and make it much easier for staff to locate staff benefits and to identify what benefits we may be missing. • ULHT invited to be part of cohort 3 of NHSI 90 day Nursing Retention programme. Debrah Bates and Helen Nicholson attended launch event in Birmingham. Key to developing plans is staff engagement.	• The data and feedback received at the Big Conversations will shared with the health and wellbeing team, executive team and staff engagement group. The outcomes will be published on the 2021 intranet pages along with the presentation. • Finalising the employment brand campaign and ensuring alignment with 2021 • Staff Charter workshops commence May.Workshops are being held on all of our sites to ensure staff are familiar with the charter, as well as giving the opportunity to think what this means to them as individuals and their departments/wards and explore how this relates to the patient experience. Workshops last for 90 minutes and are open to all members of staff.

KPI:	Quality of leadership and management index	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Head of OD
Date:	16th April 2018	Reporting Period:	March 2018
Target:	10% improvement in average score during 2017/18		
RAG Rating:	2.6 (The score is out of five and comprises two questions from the pulse survey		

Analysis

There is no pulse check this quarter due to the National Staff Survey taking place. Alongside expected behaviours for all staff, our PRF sets out specific responsibilities for leaders at all levels. Significant work is being undertaken to completely review the Trust's approach to management and leadership development moving away from the traditional programmes and sheep dip approach to one based on organisational and job role need. The approach will use a variety of media including workshops, videos, action learning sets and so on. This was launched in April 2018.

Action Taken	Action Planned
• Work on leadership and management modules continues, with the core behaviours modules complete and being rolled out starting in April. • Costings for Development Centres (HEE funded) have been completed, and orders have started to be placed – revised DC paper circulated to ET for comment • Execs will make decision on which leaders will be sponsored to apply for national leadership programmes • One-off three day programme for aspiring managers funded via EMLA delivered and evaluated very well. • Selections made for 8 HEE sponsored places on Elizabeth Garrett Anderson and one place on Nye Bevan programme	• Dates now advertised for Core behaviours modules, and bookings are being taken. First finance leadership workshop is due for delivery on 16/5 • Nominations for participants for a first 'proof of concept' development centre are being sought, with the first centre scheduled for WC 21/5 • Staff charter workshops have been designed and have been scheduled in throughout the year. A detailed comms plan has been developed to keep the charter and the personal responsibility framework in focus. • More work to be done on how wider we offer the charter workshops • Online resources and packages in support of the leadership programme being developed and loaded onto the knowledge hub of the OD intranet site.

Nursing Workforce

Executive Responsibility: Michelle Rhodes – Director of Nursing

Safer Staffing: Summary by Site — Mar-18

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals	CHPPD (Care Hours Per Patient Day)		
						Registered	Unregistered	Total
Grantham	93.37%	101.58%	93.55%	97.37%	95.94%	4.2	2.7	6.9
Lincoln	90.93%	94.90%	97.29%	103.44%	95.13%	4.3	2.5	6.8
Pilgrim	81.18%	91.21%	95.16%	103.89%	89.79%	4.4	3.0	7.4
Trust	87.25%	93.91%	96.22%	103.04%	93.11%	4.3	2.7	7.0

Safer Staffing: Summary by Site - General Nursing — Mar-18

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals	CHPPD (Care Hours Per Patient Day)		
						Registered	Unregistered	Total
Grantham	93.37%	101.58%	93.55%	97.37%	95.94%	4.2	2.7	6.9
Lincoln	90.82%	95.73%	98.81%	102.83%	95.55%	4.5	2.5	7.0
Pilgrim	81.64%	93.40%	97.02%	107.76%	91.55%	3.9	2.9	6.8
Trust	87.59%	95.31%	97.70%	104.12%	94.08%	4.2	2.7	6.9

Safer Staffing: Summary by Site - Children — Mar-18

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals	CHPPD (Care Hours Per Patient Day)		
						Registered	Unregistered	Total
Grantham	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Lincoln	89.50%	82.70%	82.98%	114.81%	87.89%	6.0	3.0	9.0
Pilgrim	69.30%	72.04%	78.32%	67.30%	71.81%	12.3	9.3	21.6
Trust	78.64%	77.13%	80.99%	86.30%	79.69%	7.8	4.8	12.6

Safer Staffing: Summary by Site - Midwifery — Mar-18

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals	CHPPD (Care Hours Per Patient Day)		
						Registered	Unregistered	Total
Grantham	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Lincoln	96.67%	97.88%	94.87%	103.72%	98.43%	1.7	2.1	3.9
Pilgrim	96.68%	83.27%	97.90%	101.86%	96.36%	20.3	4.1	24.4
Trust	96.68%	95.00%	96.76%	103.35%	97.51%	3.8	2.3	6.2

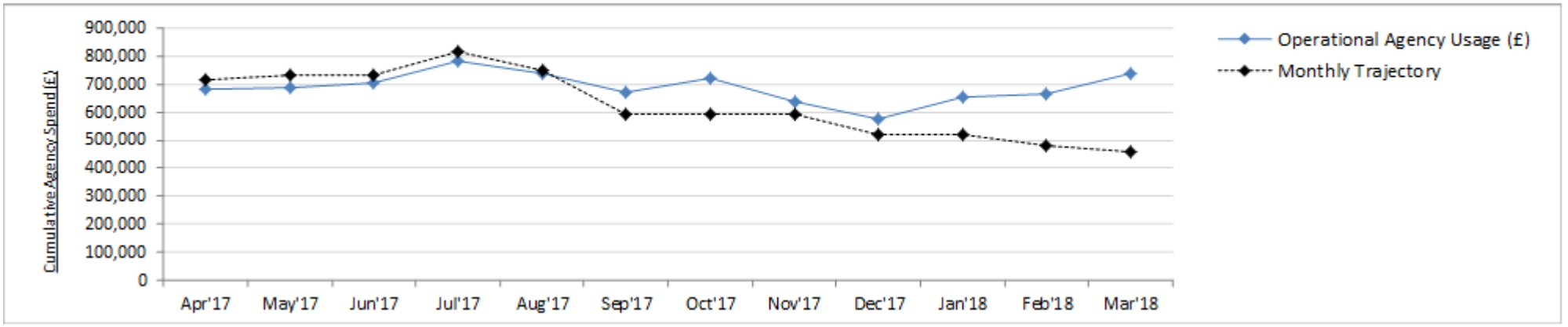
VACANCY POSITION

	Jan-18 Data from Payroll		Feb-18 Data from Payroll		Mar-18 Data from Payroll	
	R	UR	R	UR	R	UR
Lincoln	111.21	57.24	126.74	56.55	135.87	59.41
Pilgrim	128.53	20.40	133.48	25.43	127.28	32.63
Grantham	33.56	7.43	34.78	7.13	35.35	7.55
Main Site Nursing & Midwifery Sub-total	**273.30**	**85.07**	**295.00**	**89.11**	**298.50**	**99.59**
Louth	4.45	1.12	4.45	0.32	2.02	0.32
Paediatrics & Neonatal	31.83	4.78	32.52	5.31	31.31	6.01
Obs & Gynae	16.26	6.27	16.93	7.58	22.61	9.08
Diagnostics	8.79	2.22	9.10	2.62	8.55	2.62
Corporate Nursing – All Sites	16.50	4.36	16.71	4.36	13.51	4.07
Specialist Nursing – All Sites	4.13	0.56	4.41	0.56	2.99	-0.04
Nursing & Midwifery Sub-total	**355.26**	**104.38**	**379.12**	**109.86**	**379.49**	**121.65**
Physiotherapy	10.11	1.38	13.24	1.98	14.44	3.88
Occupational Therapy	5.80	2.23	4.66	4.66	5.86	4.46
Dietetics	3.97	0.00	3.17	0.00	4.07	0.65
Total	**375.14**	**107.99**	**400.19**	**116.50**	**403.86**	**130.64**
Nursing & Midwifery In Post	1,953.76	853.66	1,930.38	845.89	1,935.30	836.37
Nursing & Midwifery Vacancy Changes	5.98%	34.86%	8.93%	24.60%	0.10%	10.73%

VACANCY POSITION

	Jan-18		Feb-18		Mar-18	
	Data from Payroll		Data from Payroll		Data from Payroll	
	R	UR	R	UR	R	UR
Lincoln	80.68	35.16	87.42	36.78	93.26	37.32
Pilgrim	102.17	4.36	106.25	8.39	103.07	14.95
Grantham	27.18	0.81	28.35	0.61	28.17	1.17
Main Site Nursing & Midwifery Sub-total	**210.03**	**40.33**	**222.02**	**45.78**	**224.50**	**53.44**
Paediatrics & Neonatal	28.04	2.08	28.04	2.61	25.83	3.41
Obs & Gynae	3.17	3.66	5.27	3.66	7.47	4.26
Total	**241.24**	**46.07**	**255.33**	**52.05**	**257.80**	**61.11**
Nursing & Midwifery In Post	837.31	519.67	823.22	513.69	824.67	507.37

Summary	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Operational Agency Usage (£)	681,212	689,236	706,666	779,708	736,571	673,297	723,139	635,978	576,512	655,809	665,112	735,519
Monthly Trajectory	713,582	730,885	731,510	818,209	748,546	593,645	593,645	593,645	518,790	518,790	481,363	457,390
Difference from Trajectory	-32,370	-41,649	-24,844	-38,501	-11,975	79,652	129,494	42,333	57,722	137,019	183,749	278,129



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
Delivering the Planned Deficit	(48.6)	(77.0)	(77.0)	(84.8)
Capital Programme	18.9	23.0	23.0	23.0

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 position in March was a deficit of £7.2m, which is £4.3m adverse to the planned in-month deficit of £2.9m.
- The financial recovery plan assumed delivery of £16.2m of efficiencies and this has been delivered.
- The deterioration in the income and expenditure position has increased the levels of external borrowing necessary to maintain day to day operations in 2017/18.
- The Trust has drawn £81.0m of revenue loans in 2017/18. Cumulative revenue borrowings are now £191.5m.

Month 12 Financial Position

Month 12 performance against the financial plan is summarised in the table below:

	March 2018			April 2017 to March 2018		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	34,096	34,813	717	390,014	394,512	4,498
Other operating income	4,884	4,327	-557	51,832	35,069	-16,763
Employee expenses	-25,933	-25,664	269	-310,652	-322,737	-12,085
Operating expenses excluding employee expenses	-15,447	-36,790	-21,343	-174,978	-204,437	-29,459
OPERATING SURPLUS / (DEFICIT)	**-2,400**	**-23,314**	**-20,914**	**-43,784**	**-97,593**	**-53,809**
NET FINANCE COSTS	-429	218	647	-4,915	-3,150	1,765
Other gains/(losses) including disposal of assets	0	-19	-19	0	109	109
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**-2,829**	**-23,115**	**-20,286**	**-48,699**	**-100,634**	**-51,935**
Add back all I&E impairments/(reversals)	0	17,597	17,597	0	17,527	17,527
Surplus/(deficit) before impairments and transfers	**-2,829**	**-5,518**	**-2,689**	**-48,699**	**-83,107**	**-34,408**
Remove capital donations/grants I&E impact	11	-224	-235	135	-288	-423
CQUIN Risk Reserve - 1617 CT non achievement adj	0	-1,411	-1,411	0	-1,411	-1,411
Adjusted financial performance surplus/(deficit)	**-2,818**	**-7,153**	**-4,335**	**-48,564**	**-84,806**	**-36,242**

The Trust is reporting:

- The in-month position in March was a deficit of £7.2m, which is £4.3m adverse to the planned in-month deficit of £2.9m.
- The year to date position in March was a deficit of £84.8m, which is £36.2m adverse to the planned YTD deficit of £48.6m.

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

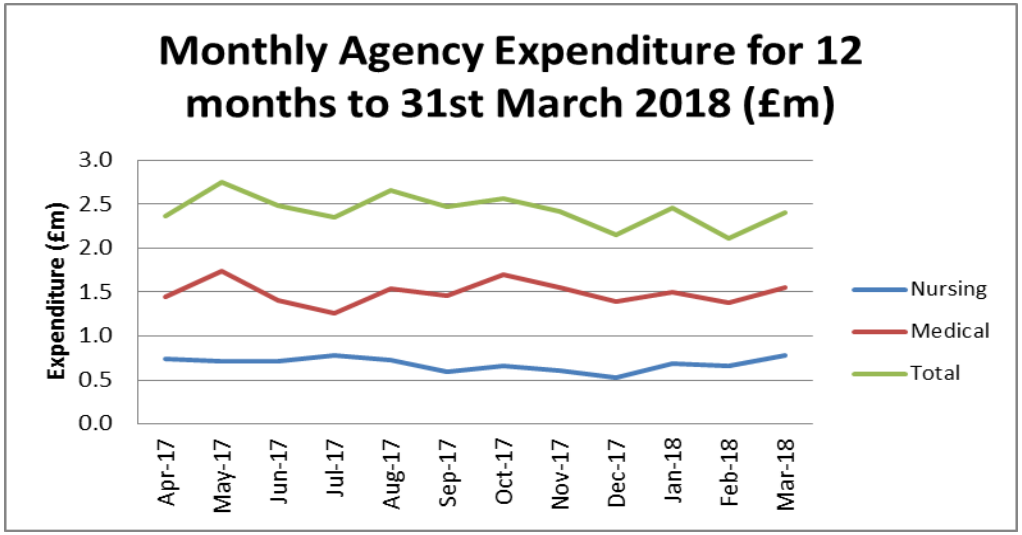
- Non-achievement of STF income resulting in the loss of £14.7m STF income.
- Slower than planned delivery of efficiency savings, with delivery £1.8m below plan.
- Pilgrim fire, norovirus outbreak and cyberattack resulting in the loss of £3.6m of income.
- Non-achievement of £1.5m of CQUIN income.
- £0.7m in relation to the outcome of the hoist legal case.
- Contract challenges of £3.7m.
- Higher than planned level of expenditure on agency staffing, with expenditure to date £8.9m higher than planned and only partially offset by a reduction in substantive and bank pay expenditure.

Efficiency

The financial recovery plan for 2017/18 includes assumed delivery of £16.2m of efficiencies to achieve the £77m deficit, and savings of £16.2m have been delivered.

Agency

The Trust has an Agency ceiling of £21m but spent £29.4m, or £8.4m more than ceiling. Although agency expenditure in 2017/18 is overall unchanged compared to 2016/17, expenditure in March 2018 is £0.9m less than it was in March 2017.



Capital

Total capital works as at the end of 2017/18 are £23.0m this is in line with revised plan and accounts for fully spending the internal resources, the external monies in relation to Fire, Cyber Security and GP Primary Care Streaming.

The main areas of expenditure are included in the table below:

Scheme	2017/18 £m
Medical Equipment	2.5
IM&T	3.9
Estates Includes CQC Service improvements	1.6
Fire Compliance	10.7
Service Developments	4.3
Grand Total	**23.0**

Cash

At the close of March 2018 the Trust held cash of £10.5m. This includes external revenue support loans in 2017/18 of £81.0m.

At 31 March 2018 total 'repayable' borrowings are £201.1m (£191.5m revenue, £9.5m capital and £0.2m Salix / finance lease).

Total borrowing costs for 2017/18 will be £2.7m after taking into account the additional £0.4m charge resulting from the punitive financial special measures 6% interest rate charge levied on new loans from October.

The Trust application for borrowing to address the first phase of works to address the Fire Enforcement Notice was approved with £9.5m awarded and drawn in 2017/18.

The Trust was also awarded £1.9m PDC cash to support Cybersecurity and GP Streaming.

Referral to Treatment

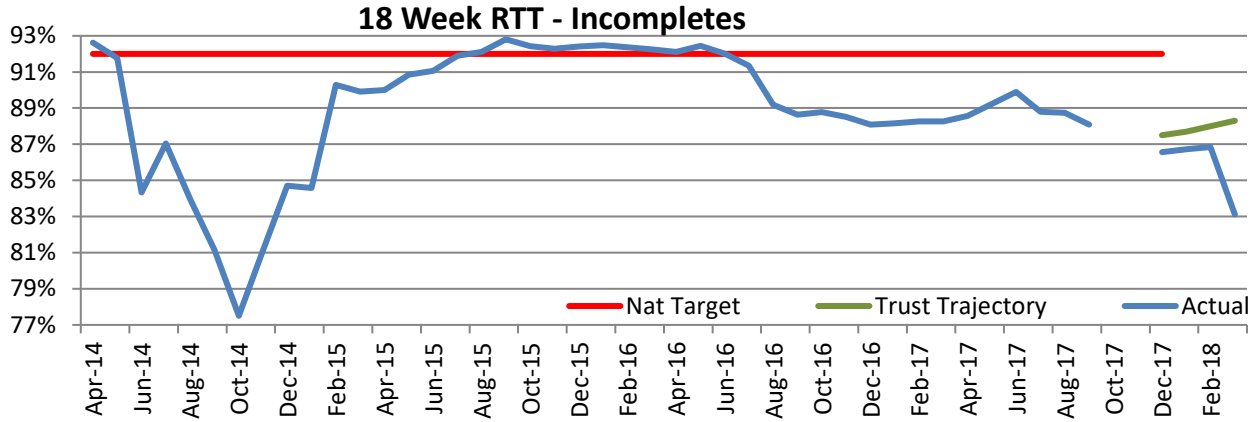
Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Referral to Treatment (18 weeks)	Owner:	Director of Operations
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance – Planned Care
Date:	17th April 2018	Reporting Period:	March 2018 – unvalidated position

Exception Details

The Trust reported performance at the end of February of 86.8%, an improvement of 0.1% compared with the position in January. There were 4,860 patients incomplete on a RTT pathway over 18 weeks at the end of February.

At a national level the standard hasn't been achieved for 23 consecutive months, with an aggregated national performance at the end of January of 88.2%.



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

- ENT – 1098 patients over 18 weeks, which was an increase compared to January of 9 patients. ENT had a negative impact on the overall Trust performance to the value of c.1.5%. Therefore if ENT performance was in line with the average of all other specialities the Trust performance level would be above the national average level. This service experienced significant clinical capacity restrictions during 2017, and there were significant risks relating to Consultant vacancies at the end of the year. Short term mitigations are now in place to address these risks, and the Trust is in discussions with an external organisation relating to insourcing to assist with backlog reduction. The speciality performance position has improved for the last 2 months. However, the speciality has 164 patients waiting over 40 weeks on the PTL, leading to increasing numbers of 52 week breaches, particularly during winter month where electives have been cancelled as a result of urgent care pressures and adverse weather conditions.
- Gen Surg – Accounted for c.12% of Trust's 18 week+ incompletes at the end of February. There was an increase of 109 patients within the admitted backlog in this speciality between December and February, due to a combination of the planned reduction in electives during January and the high level of cancelled operations as a result of urgent care pressures.
- T&O – Deteriorated by 2.5% during January, primarily as a result of reduced electives increasing the admitted backlog by 82 patients. During February the decline was significantly lower, at 0.15%.

The Trust cancelled 157 operations and c.2750 outpatient appointments as a result of the adverse weather conditions which affected the UK at the end of February/beginning of March. This resulted in c.1000 less treatments being started (clockstops) during w/c 26th Feb than expected, and an increased number of patients becoming overdue for a follow-up (as at 3rd April there were 6970 patients over 6 weeks overdue for a follow-up). It is anticipated that this unplanned loss of capacity will have a significant detrimental impact upon the Trust's RTT performance in March.

As at the 19th April the RTT incompletes position for March was 84.0%. The Trust's final performance for March will be submitted on 26th April, therefore this performance level will improve prior to submission. It is expected to reach a performance level of 85-86%.

In February, primarily due to a combination of urgent care pressures and the impact of the adverse weather conditions at the beginning of the month, the Trust cancelled 311 Operations on the day and 230 the day before for non-clinical reasons. This cancellation rate is 80% higher than that which occurred in February 2017.

There are long waiting times for first appointments in a number of specialities. During 2017 there was a reduction in the number of patients waiting over 12 weeks on the open referrals waiting list, reducing from 2820 at the beginning of January 2017 to 1434 at the beginning of January 2018. However, in the last 3 months this position has deteriorated as a result of the reduction in additional clinic provision following the withdrawal of the demand/capacity payment for agenda for change staff, urgent care pressures have led to the cancellation of clinics and the adverse weather conditions at the end of February had a significant impact. As at 3rd April there were 2276 patients on the open referrals waiting list over 12 weeks awaiting their first appointment.

At the end of February there were 13 patients (8xENT, 3xGen Surg, 1xT&O, 1xUrology) on incomplete pathways over 52 weeks. As at 3rd April harm reviews had been completed by the lead clinician for nine of these cases, with no harm found in seven cases, low harm in one case and moderate harm in the other case. In the case where moderate harm was assessed to have been caused the patient required an increase in the level of intervention in order to treat the condition. The Trust's Duty of Candour process will be followed relating to this case. Of the remaining four cases, one was awaiting for the histology report to be returned before the harm review was completed and the remaining cases were with the lead clinician to complete.

What action is being taken to recover performance?

The Outpatient Improvement Programme initially focused on increasing productivity within baseline outpatient clinics. Booking rules have been reviewed resulting in an additional 400 outpatient slots being added to core capacity per month from February. Additionally, a SOP relating to slot conversions has been implemented in order to ensure increased flexibility of clinic booking rules in order to reduce unbooked slots within clinics.

A revised slot utilisation tool is now in use within the Choice and Access Booking teams in order to assist the team to increase utilisation of outpatient capacity. The C&A teams hold daily huddles in order to maintain oversight of slot utilisation on a daily basis. The Trust-wide Outpatient 6-4-2 meeting commenced in February in order to co-ordinate and maximise the utilisation of outpatient facilities and staffing across the Trust. Outpatient slot utilisation increased by 5% between December 2017 and March 2018.

The Trust's slot utilisation guidance document will be updated by early April. Analysis is being completed relating to reasons for under-utilisation of certain clinics, with feedback to Clinical Directorates where the construction of the clinic is contributing to low utilisation rates. Additionally, the C&A team are exploring the potential benefits which could be gained from a small investment in additional booking staff.

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

A pilot commenced at Louth at the end of February, increasing weekday operating capacity and extending theatre scheduling into Saturday's. The first 3 weeks of this pilot saw an additional 26 operation completed compared with the previous operating model.

The Theatres Optimisation Committee is overseeing a programme of work relating to theatre scheduling so that theatres are fully booked; pre-operative assessment processes in order to reduce short notice cancellations and improve availability for listing; peri-operative efficiency in order to optimise the number of patients listed per session; short stay pathways in order to ensure that patients are treated in the most appropriate setting; implementation of enhanced recovery. A theatres dashboard is now in use in order to track and proactively manage the key theatres metrics. Activity analysis shows that in December 2017 the average number of cases per list run signifciantly inreased through better theatre list scheduling. Additional retrospective reviews showed that if the level of cancellations during January and February had been the same as last winter and if the Trust hadn't needed to reduce electives in January due to extensive urgent care pressures, then the level of theatre activity during January and February would have been higher than the average for the first nine months of the year.

Advice and guidance services are available within ENT, Haem and Cardiology, providing secondary care support to GP Practices prior to referrals being made into the Trust. In addition, since late February, advice and guidance has been available within Gynaecology, Dermatology and Gastro. The Neurology service will offer advice and guidance to GPs from April.

The Trust goes live with the national paper switch off programme on 16th April. The first cohort of specialities which will move to receiving referrals via eRS only from this date are Neurology, Dermatology, Haematology, Vascular, Diabetes, Nephrology and Gynaecology. It is intended that all specialities will complete the eRS switch-over process by the end of July 2018.

Outsourcing has been completed within General Surgery, Ophthalmology, ENT and Urology during 2017/18. As at 27th March, a total of 170 ENT patients, 141 General Surgery patients, 107 Ophthalmology patients and 12 Urology patients have been accepted by independent sector providers, with plans for further patients to be identified within these speciality areas. Additionally, ENT are in discussions with an independent sector organisation relating to insourcing of capacity.

The Neurology Service is currently still closed to routine referrals. The Trust is working with the CCGs to develop further community pathways and to develop advice and guidance for Neurology, in order to enable the service to re-open to routine referrals. The Trust are targeting re-opening the service to routine referrals on 16th April.

The Gastro Service has secured additional clinic capacity at the Grantham site in order to reduce the waits for first appointments on that site. Additionally, patients are being asked to consider moving their referral from Lincoln to Pilgrim where waiting times are lower, and the model of clinic reductions whilst the Consultant is providing inpatient cover is being reviewed in order to ensure that the impact is spread across sites.

What is the recovery date?

In line with national planning guidance the Trust is planning to maintain performance at March 2018 levels through to March 2019.

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:	17th April 2018	Reporting Period:	March 2018

Exception Details

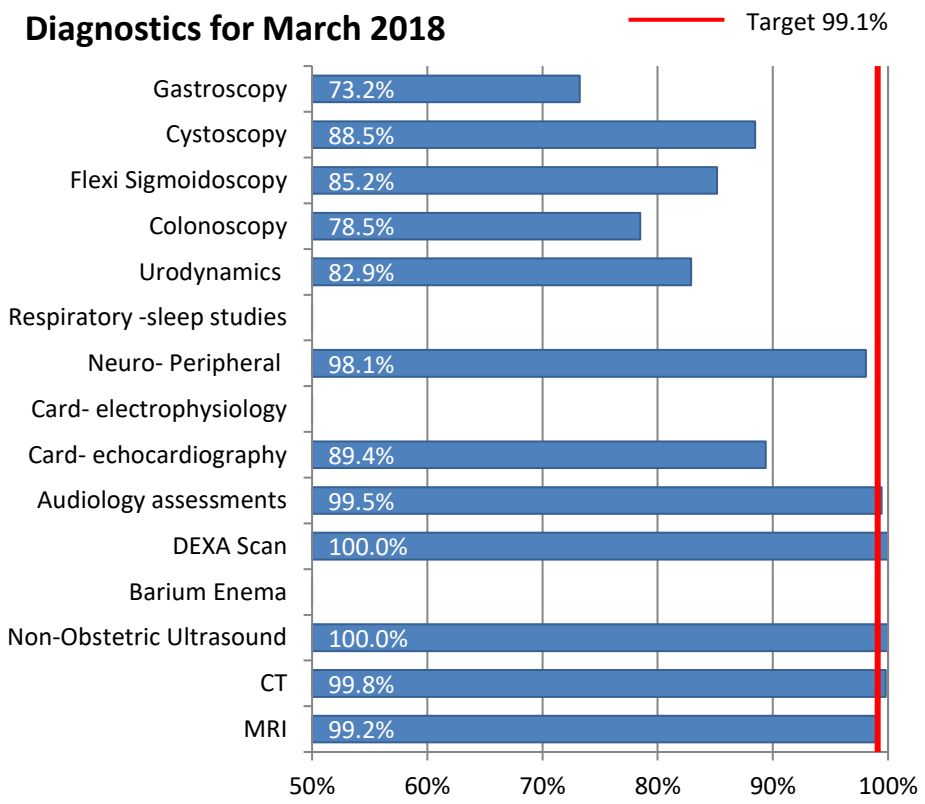
In March the Trust's performance deteriorated, with 93.53% of patients receiving their diagnostic test within 6 weeks of referral. The number of breach patients increased to 443 in March.

The three service areas where the 99% target was not achieved were Endoscopy (333 breaches), Echo (73 breaches) and Urodynamics (20 breaches).

The performance within Urodynamics improved slightly during March, with plans in place for performance in this area to continue to improve.

There were 30 more breaches in Echo at the end of March than at the end of February. This primarily related to the lost capacity at the beginning of the month relating to the adverse weather conditions which affected the region – which resulted in 45 cancelled investigations.

The area which reported the most significant deterioration in March was the Endoscopy Service, with an increase of 197 breaches. The Endoscopy Service on the Grantham site had long standing maintenance work scheduled for late February and early March. During this time activity was planned to continue, but at a reduced level. However, once the building work commenced a decision was taken by IP&C that the level of dust within the unit was too great to allow any clinical activity to continue on the unit whilst the works were being undertaken. Therefore 252 procedures at Grantham was cancelled from 23rd February until 15th March (the adverse weather conditions also delayed the completion of the scheduled works). In addition, the adverse weather resulted in 128 cancelled Endoscopy procedures across the remaining sites between 28th Feb and 3rd March.



What action is being taken to recover performance?

The Echo Service are providing additional capacity during April in order to reduce the backlog position which developed as a result of the adverse weather.

During early March the Endoscopy Service utilised Medinet capacity in-week, and from mid-March this was extended into weekend lists as well. At the Pilgrim site a model of prospective cover has been implemented in order to ensure capacity isn't lost when Consultant's on-calls clash with Endoscopy sessions. This is to be taken forward at the other sites.

Recruitment to nursing and administrative posts is underway following the approval of the Endoscopy BC. The majority of administrative posts have now been recruited to, and the first nursing recruits are expected to commence in post from late May.

Additional short-term support has been agreed for the administrative teams, and inpatient and outpatient referral and preparation processes are being reviewed in order to optimise list utilisation.

What is the recovery date?

June 2018

Diagnostic Waiting Times (key 15 tests)	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Total waiting list	7500	7300	7100	7000	6900	6900	6900	6900	6900	6900	6900	6900
Number of patients waiting > 6 weeks	250	150	70	69	68	68	68	68	68	68	68	68
Percentage patients waiting > 6 weeks	3%	2%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%

4 Hour Standard

Executive Responsibility: Mark Brassington – Chief Operating Officer

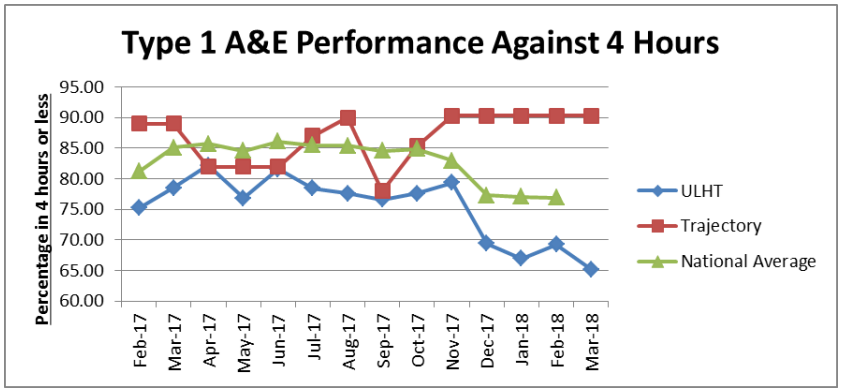
KPI:	4 Hour Wait (A&E)	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Director of Operations / Deputy Director of Urgent Care
Date:	17th April 2018	Reporting Period:	March 2018

Exception Details

PERFORMANCE

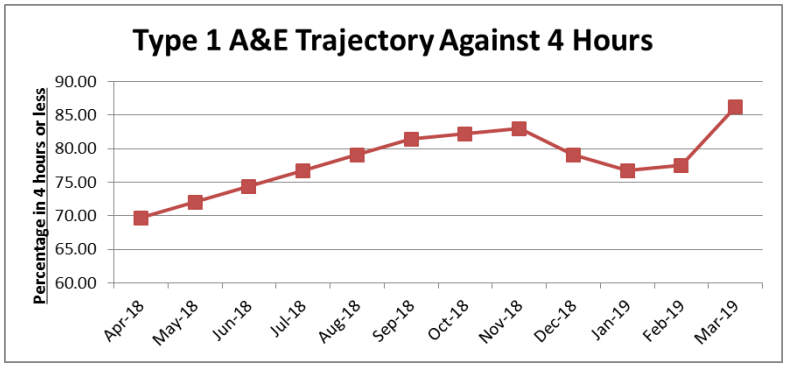
ULHT Type 1 plus streaming Performance for March was 65.21% against the 95% target for 4 hours. Month on month the trust remains below the national average which for February was 76.9%. System Type 3 activity was 97.33%, bringing the whole system performance to 76.33%.

Month	December	January	February	March
Trajectory	90.31%	90.31%	90.31%	90.31%
Type 1 (ULHT)	66.37%	64.28%	66.82%	62.35%
Type 1 (ULHT) Numbers	11827	11874	10780	12485
Type 1 (ULHT) Breaches	3977	4241	3577	4700
ULHT Submission	69.46%	66.99%	69.26%	65.21%
TOTAL (ULHT+Streaming) Numbers	13023	12849	11635	13511
TOTAL (ULHT+Streaming) Breaches	3977	4241	3577	4700
LCHS/SMG only Streaming performance	98.63%	99.07%	98.43%	97.33%
LCHS/SMG only Streaming Numbers	9268	9064	7057	7151
LCHS/SMG only Streaming Breaches	127	84	111	191
All	81.59%	80.26%	80.27%	76.33%

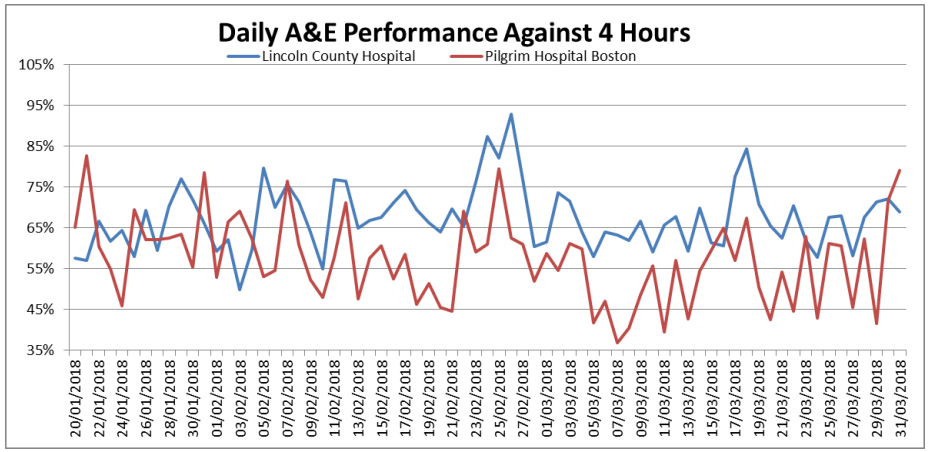


A trajectory for 2018/19 has been agreed for the trusts type 1 activity, type 1 plus streaming and type 1, streaming and type 3 (system) performance:

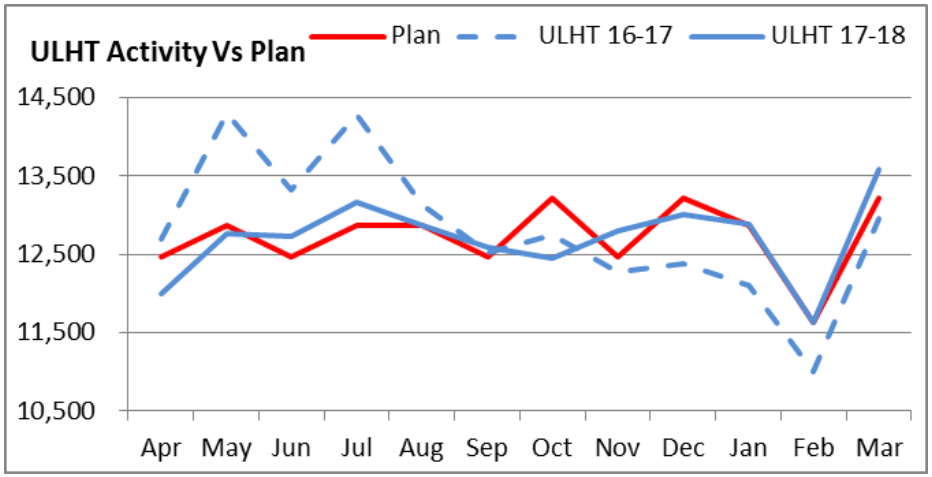
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
ULHT Type I	69.69%	72.03%	74.38%	76.72%	79.07%	81.41%	82.22%	83.02%	79.07%	76.72%	77.53%	86.24%
ULHT + Streaming	72.04%	74.33%	76.63%	78.92%	81.22%	83.51%	84.39%	85.26%	81.22%	78.92%	79.79%	88.74%
ULHT + Streaming & Type 3	82.07%	83.68%	85.30%	86.91%	88.52%	90.13%	90.94%	91.75%	88.52%	86.91%	87.72%	95.00%



The trajectory for 18/19 is realistic and clinical directorates are finalising their action plans to align with this performance. Daily performance is still far too variable, with poor achievement particularly following weekends. There were two periods of heavy snowfall – at the end of February and mid-March. These two



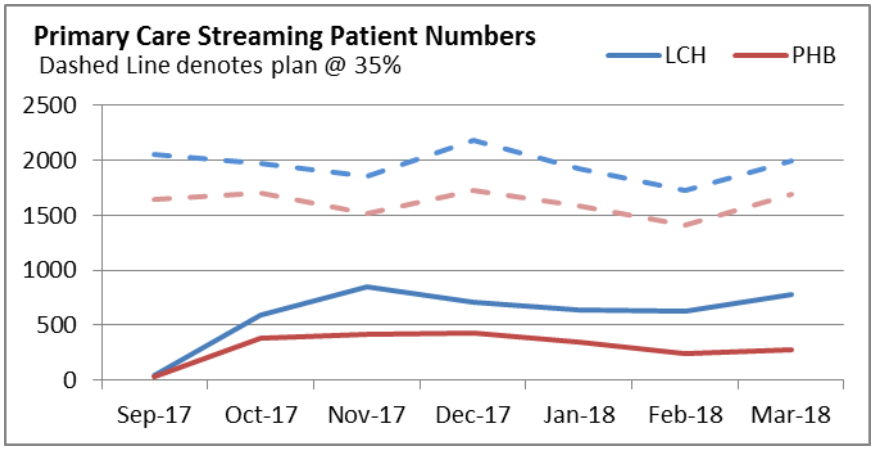
In general, attendances to the A&E departments are above plan, despite the significant reduction in attendances due to the reduced opening hours at Grantham. Some of the highest attendance numbers on record have been reported in Lincoln A&E since the closure of the walk in centre.



ULHT and Site Activity Vs Plan for Type 1 A&E Attendances

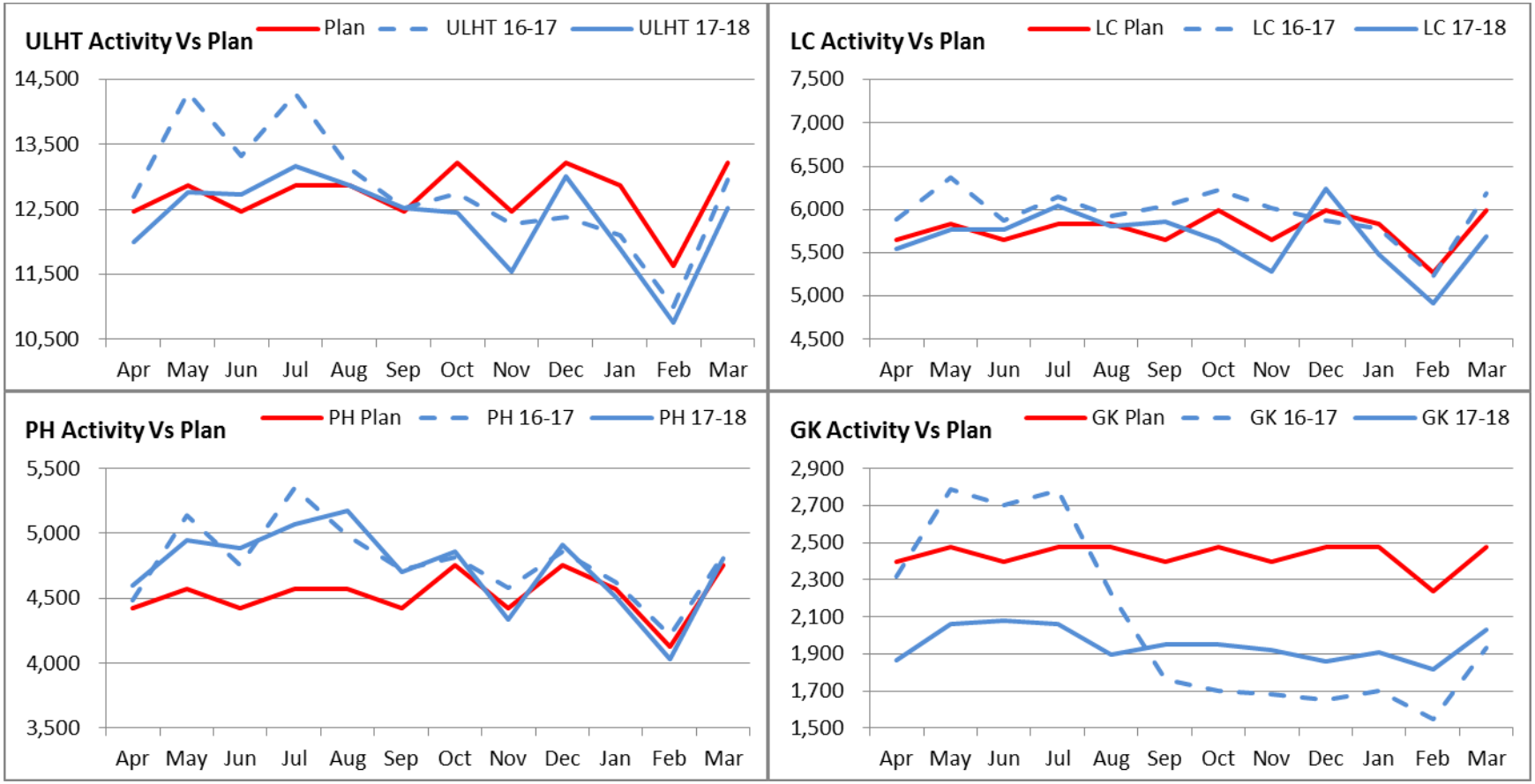
periods saw a significant fall in attendances and despite the pressures on staffing the trust saw an improvement in performance due to the reduced attendances particularly within Lincoln ED.

Primary care streaming performance remained below the target of 25% despite changes to the protocol, including LCHS staff at reception providing the streaming function.



However, these figures are for the total number of patients arriving at A&E include both the Type 1 activity that goes in to the A&E and the patients who are streamed into the LCHS Primary Care areas. The trust reports only type 1 activity to NHSE each month. Therefore despite record attendances to the front door the trust is below plan for type 1 activity in each department.

For March, type 1 activity plan was 13,222 for the trust. The actual type 1 activity was 12,526. The charts elow show the type 1 activity for 16/17, 17/18 (amended to remove streaming attendances) and 17/18 planned activity.


ULHT Activity Vs Plan
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LC Activity Vs Plan
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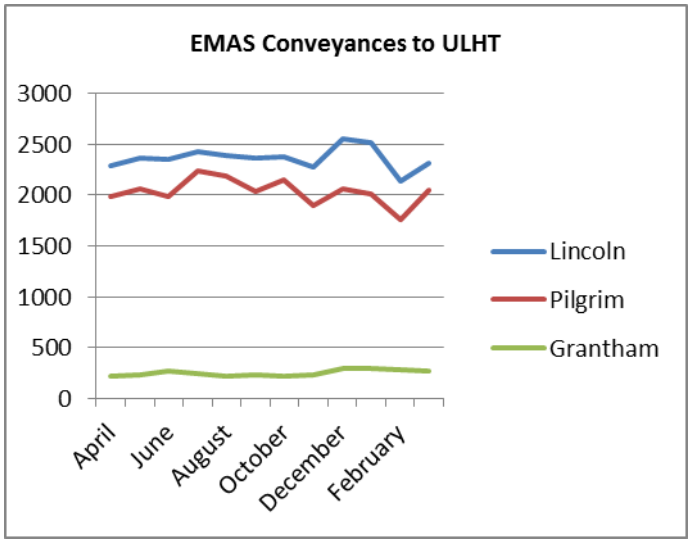
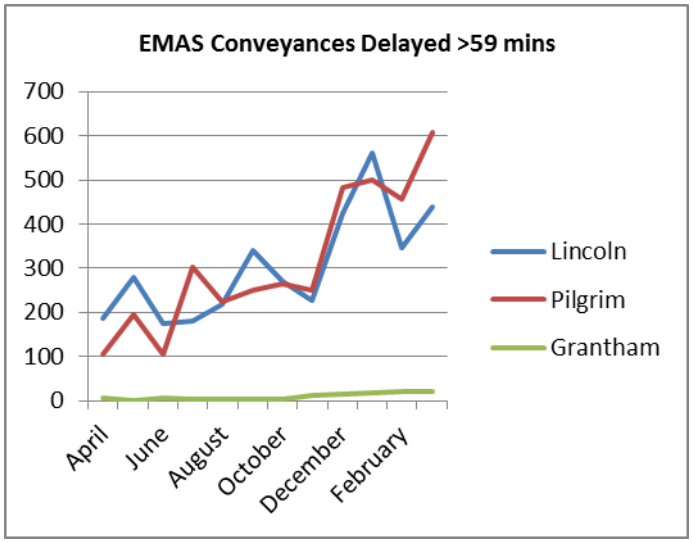
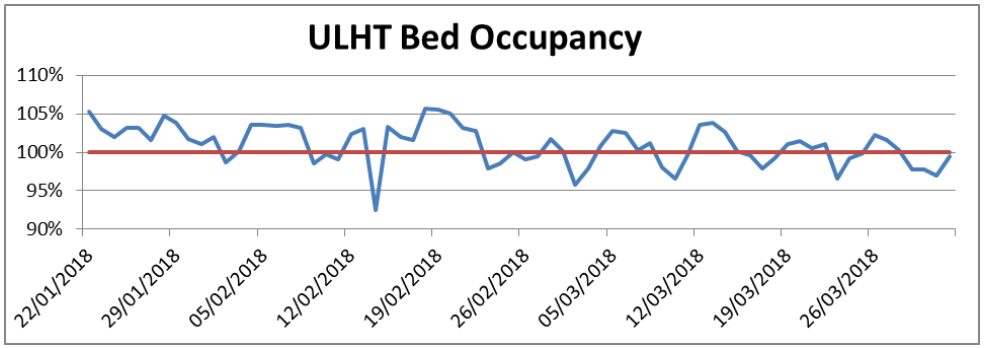
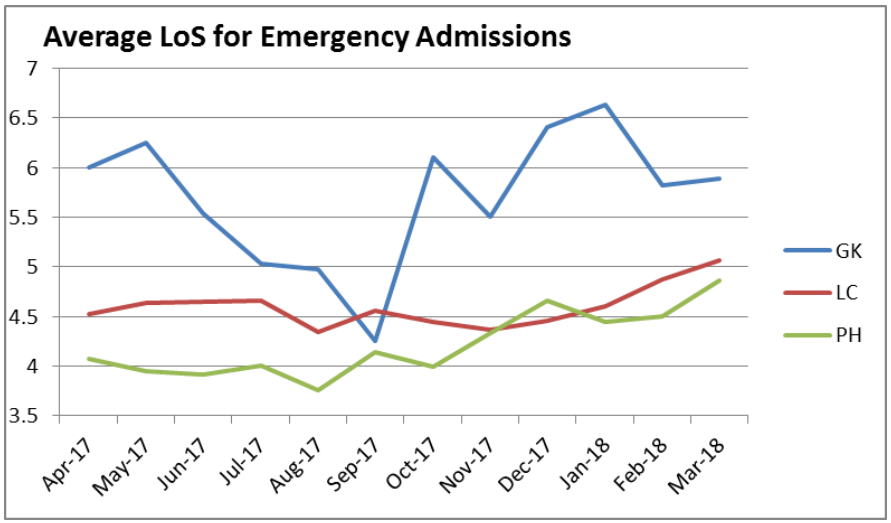


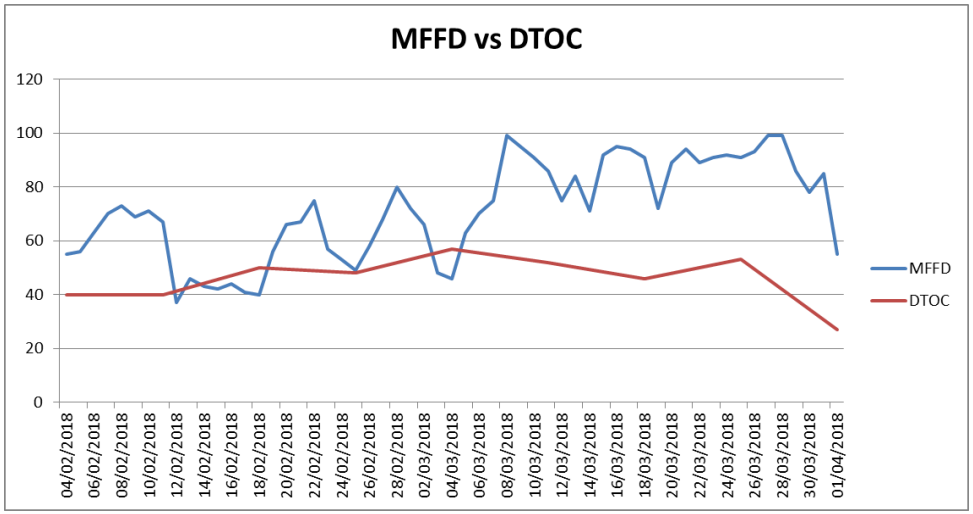


Ambulance conveyances on all sites remained consistent during March. Handover delays improved slightly at LCH in February and March but deteriorated significantly at PHB. The new RAT area at Lincoln has had a positive impact whilst at Pilgrim hospital there have been issues with process and staffing, picked up by the CQC and forming part of the Section 31 notice. Handovers are now a key focus area for improvement with external help from NHSI and the trust has brought in SSG to assist with an improvement programme across the trust with "ADPRAC" to help in ACP training at PHB. Early indications for April are positive.

Length of stay for emergency admissions has been increasing steadily since October 2017. Grantham continues to have the highest non elective LoS but Lincoln and Pilgrim Hospitals have seen their highest average for the year in March. Despite A&E attendances reducing due to the impact of the streaming service the same volume of higher acuity patients will continue within the departments and admission rates are unchanged. With an increasing LoS bed occupancy has remained high and "exit block" persists as one of the key breach reasons during March. Occupancy across the trust has been consistently at or in excess of 100% throughout winter with highest occupancy on Mondays, slowly reducing through the week as a regular pattern:







Daily totals of patients Medically Fit for Discharge increased during March with a smaller associated increase in Delayed Transfers of Care.

The proportionally smaller number of DTOC patients indicates that community organisations were working well to support the trust during the month.

The higher number of MFFD patients is reflective of the occupancy situation and the trust saw a high number of "outlier" patients during March. Outliers being associated with an increased LoS due to the problems getting timely reviews.

What action is being taken to recover performance?

The proposed schemes are grouped into the areas of:

- Ambulance Handovers and Conveyance
- Streaming to services co-locating or outside of the Emergency Department
- Pilgrim and Lincoln Emergency Department Staffing and Emergency Department Processes
- Admissions areas and flow management
- Large Scale Trust Bed Re-configuration

Ambulance Handovers and Conveyance

- Fully implement Straight to Community Hospital Pathways (CCG)
- Reduce care home conveyance with better care planning for patients (CCG)
- Fully implement the falls pathway and associated community service, reducing the number of conveyances for falls with no significant injury (CCG)
- Implement the catheter service to reduce the number of conveyances for issues with catheters (CCG)
- With support from SSG Health refine the handover processes to improve to upper quartile of 60 min handover with 0% 2 hour handovers (ULHT)

SSG are now working within the ED's to look at improving handover delays. There will be fortnightly improvement cycles. The first cycle commenced in March and was focussed on ensuring staff follow existing protocols to embed consistent ways of working.

The trust is now in the first cycle, which commenced Wednesday 2nd April and includes "Pre-Handover Practitioners" taking handover and cohorting crews.

Streaming to services co-locating or outside of the Emergency Department

- Switch streaming nurses to LCHS and increase PHB streaming to 16% by end of April. 25% by end of August 2018. (CCG & LCHS)
- Switch streaming nurses to LCHS and increase LCH streaming to 20% by end of April and 25% by 1st August 2018 (CCG & LCHS)
- All other specialties to define GP referral accepting areas alternative to ED where patients are stable to remove overcrowding in EDs (ULHT)
- Dear Doctor referral pathways to be banned with a new SOP and system for reporting primary care breaches to be implemented (CCG & ULHT)

Pilgrim and Lincoln Emergency Department Staffing and Emergency Department Processes

The trust had some success in March in improving the medical rota's appointing 2 consultants and 2 middle grade doctors to Lincoln County Hospital.

- Implement the 19-man middle grade rota at PHB and LC with no significant increase in agency (through recruitment and bank - ULHT)
- Use the most recent analysis to revise rota patterns to match demand of all grades at both LCH and PHB from the 1st June 2018. Where rotations require further notice 1st August 2018 (ULHT).
- Complete a team-based nursing rota and overlay shift patterns against demand and occupancy to improve shift and coverage and safe staffing levels. Identify requirements and develop redeployment where necessary by 1st June 2018 (ULHT).
- Improve the RAIT process at PHB in line with recommendations, reducing turnaround time and assessment times – by end of April 2018 (ULHT)
- Introduce safe handover and cohort nursing processes at LCH and PHB utilising appropriate staffing of nurses/paramedics/technicians – by end of April 2018 (ULHT)
- Develop ACPs at LCH and PHB, recognising the likely loss of 3 ACPs at PHB with increases in banding to more senior 8a level of some. Utilising the ADPRAC expert ACP team procured for 2018-19. Programme to be fully defined by end of April 2018, and majority complete by March 31st 2019 (ULHT)
- Complete the inter-professional standards document for all specialties and services that support Emergency Departments. Sign off by all CDs, all doctors and put in place a rotational induction system that has all new doctors signing off on each rotation. By the end of April 2018 (ULHT).

In view of the Section 31 Notice from the CQC risk summits have been held regarding the risks presented to PHB ED. The key risks have been identified and some key actions identified. These risk summits are planned weekly with senior leadership support until the risks are reduced.

Admissions areas and flow management

- Introduce specialty delay monitoring (specialty labelling) on admission wards (MEAU AMU SEAU) to drive improvement in flow from admissions to wards to base wards by end of April 2018 (ULHT).
- Complete job planning to ensure all ward rounds start at 08:00 – Complete by October 2018 (ULHT)
- Update 7-day medical services review and identify gaps for medical discharge capabilities at weekend. – Complete review by the end of April (ULHT)
- Extend the Red 2 Green process and performance management process to all diagnostic and referring services. Fully implement with senior operational leads for Red 2 Green by end of May 2018 (ULHT)
- Implement the Medically Fit for Discharge SOP – June 2018 (CCG, LCHS&ULHT)
- Discharge all "hyper stranded" patients >50day LOS by 1st June 2018 utilising complex discharge hub and MDTs where necessary (CCG, LCHS&ULHT)
- Drive the 10x10 discharges and pull from admissions ward each day, with clear planning each day to secure early movement on admissions wards. To be delivered each weekday by June 2018, weekends included by 1st September 2018

Large Scale Trust Bed Re-configuration

In order to ensure a reduced bed occupancy position going into next winter it will be essential for the trust to reconfigure services and bed provision. Much of this work will require significant investment, still to be agreed.

- Recruit a programme manager and then deliver the reconfiguration plan at PHB, increasing admissions beds and reallocating beds to the correct specialty to deliver predicted requirements. – Complete by 1st October 2018
- Reconfigure the Orthopaedic Services to hot and cold sites reallocating and transferring beds to specialties and across sites to deliver GiRFT recommendations – Complete by the 1st August 2018
- Develop AEC and SEAU (Note financial impact - £200k net FYE revenue and £40k capital. Proposed breakeven 7 months)
- Develop a plan to safely open and manage Digby ward in winter 2018/19 as either escalation beds or an expected Medical daycase unit to deliver increase capacity and increased admission avoidance through ambulatory schemes. To be in place by October 2018
- Large scale re-profile of the remaining elective operations at LCH, Louth, Grantham and PHB to reduce demand on PHB and LCH over winter 2018-19.

Cancer Waiting Times – 62 Day

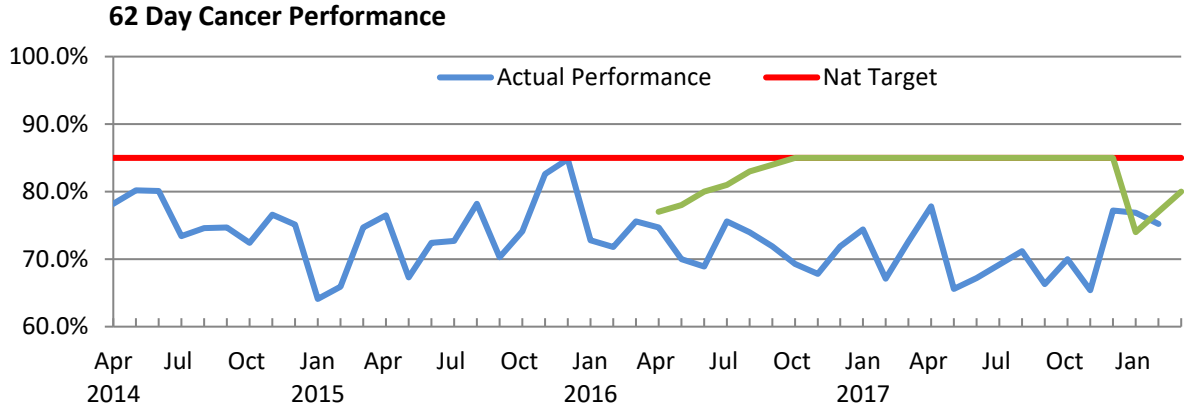
Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Cancer Waiting Times (62 Day)	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance – Planned Care
Date:	17th April 2018	Reporting Period:	February 2018

Exception Details

The Trust's submitted performance position for February against the 62 day classic standard was 75.2%. Official performance pending final tertiary allocation/adjustments to be confirmed on 12th April, but is unlikely to change materially. If the current level of performance is maintained then the Trust will achieve three consecutive months above 75% for the first time since 2014.

The Trust achieved 5 out of the 9 cancer standards in February. All four 31-day standards were achieved during February. This is the third month in the last five that all four of these standards have been met. The 62-day upgrade standard was achieved for the third month in a row.



The Trust's 14 day Breast Symptomatic performance in February was 54%, due to a combination of increased referrals into the service (an average of 132 referrals per week between 8th January and the end of February, against a baseline capacity of 110 triple assessment slots) and a reduction in Radiology capacity and a reduction in the ability to provide additional ad hoc sessions at weekends. The performance level within the Breast tumour site had a significant impact upon the 14 day suspect cancer performance for February, where the Trust recorded 86.5%.

Improved performance at a Trust level during December, January and February has coincided with Urology performance being above 64% for three months in a row for the first time in a year. Lower GI performance has only exceeded 60% once in the last 10 months, and remains the lowest performing tumour site.

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

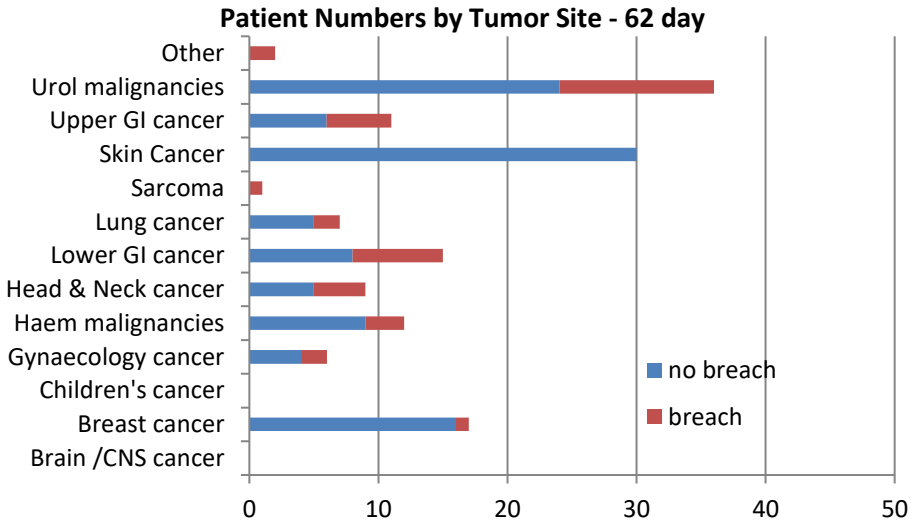
- Pathology (relative numbers have reduced in last two months, but remains highest individual factor particularly where samples were processed before end of January)
- Patient choice and fitness, especially over the Christmas period
- Tertiary diagnostics/treatment
- Theatre/HDU capacity

- MRI capacity
- Endoscopy capacity
- Oncology and Outpatient procedure waiting times

As of 4th April there are 9 pts on or over 104 days without an agreed treatment plan: 4 x colorectal, 3 x lung, 1 x Urology, 1 x Upper GI.

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

- 4 cases included tertiary diagnostic delays
- 3 cases included tertiary treatment delays
- 3 cases included patient choice delays
- 3 cases included Outpatient capacity issues
- 2 cases included complexity or procedural factors
- 2 cases included pathology delays
- 1 case included administrative delays
- 1 case included CT delays
- 1 case included other Radiology capacity delays
- 1 case included HDU capacity issues
- 1 case included theatre capacity restrictions
- 1 case included patient fitness factors
- 1 case included MDT process delays
- 1 case included delays related to the patients holistic needs
- 1 case included delays relating to Endoscopy capacity
- 1 case included delays relating to Oncology capacity



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): 13 Harm Reviews have been issued for January. As at 4th April, eight have had been returned, with 4 reporting no harm, 2 reporting low harm and 2 requesting further input from colleagues. The remaining 5 harm reviews are with the relevant lead clinician for completion.

As at 4th April, March's 62-day performance position was 69%, however further treatments are likely to be recorded over the next 4 weeks prior to submission of March's data and are likely to improve this position further.

Risks

- There is risk to March and April's performance levels due to the impact of winter. Between 28th February – 2nd March, 18 operations for cancer patients were cancelled due to adverse weather conditions that affected the UK. In addition, 6 further cancer operations were cancelled during March as a result of HDU bed unavailability.
- As at 3rd April the Breast Service was polling at 22 days for triple assessment appointments, however there was the risk that this would increase further during April if additional capacity can't be provided. The service has baseline capacity for c.105 triple assessments per week, however during the 12 weeks from 8th January the Trust received an average of 134 referrals per week. In addition, the service has struggled to staff additional clinics since the standardisation of overtime payment mechanisms for AFC staff was introduced in January.

Breast 62-day performance for April is currently forecast to be in excess of 85%. During 2016/17 when polling ranges for Breast 2WW rose to 20 days the Service was still able to maintain performance against the 62-day standard. Data analysis suggests that the risk of deterioration against the 62-day standard increases once polling reaches 22 days, however the Service will attempt to mitigate this risk through optimisation of capacity within the treatment phase for patients with a confirmed cancer diagnosis.

The Service Leads are in discussions with staff groups around new models of working, and are pursuing locum capacity within Radiology. Additionally, the CCGs have produced communication messages to make GP practices aware of this issue, and to take this into account when patient choice discussions are undertaken.

- From April the national cancer waiting times allocation rules will change in order to reflect day 38 as the target date by which handover to the treating Trust should occur. It is anticipated that this change will have a small negative impact upon ULHT's monthly 62-day performance. Over the last 12 months, if these rules were applied retrospectively, there would have been on average a 0.25% reduction in the Trust's reported 62-day performance.

What action is being taken to recover performance?

The Trust have agreed a trajectory to reduce the number of patients over 62 days on the cancer PTL down to 40 patients by 6th May. In order to achieve this backlog reduction the tumour sites are planning to deliver further actions, in addition to the existing cancer action plan schedule, over the next five weeks. These include:

- Urology 2WW referral triage pilot taking place from March - May. In conjunction with this the allocation of the cancer new patient slots has been optimised within the Urology tumour site, with implementation from April.
- Additional TRUS Biopsy capacity to be provided.
- Additional Surgical lists identified on the Grantham site for Cancer patients from other sites.
- Gynae Cancer Leads to displace routine and non-clinical activity during April in order to increase capacity for Cancer patients.
- Routine General Surgical Outpatients and Electives to be displaced on all sites in order to reduced Cancer delays.
- Additional lung and upper GI outpatient capacity in place on Pilgrim site in order to reduce delays in pathways.
- General Manager review of all patients down to day 38 at least once per week.
- Continuation of Daily Cancer Operational Meeting.
- Recruitment to Pathway facilitator roles within Lincoln Lung and Lincoln Surgery.
- Additional colo-rectal Oncology capacity planned during April.

- Additional MDT capacity identified in order to reduce the impact of capacity lost on the Friday/Monday of the Easter weekend.
- Endoscopy commitment to deliver 90% request to scope within 10 days by the end of April.
- Radiology commitment to deliver 80% request to report within 7 days by the end of April.

What is the recovery date?

The following recovery trajectory for 2018/19 has been submitted to NHSI:

Cancer 62 Day	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Percentage pathways completed <= 62 Days	76%	78%	80%	82%	83%	85%	85%	85%	85%	80%	80%	82%

CQUINs 2017/18

No.	Goal name	CQUIN Lead	Financial Value	Q1	Q2 forecast
National					
1a	Improving Staff Health and Wellbeing (achieve improvement scores on 2/3 questions on the staff survey)	Stephen Kelly	£245,326		
1b	Healthy food for NHS staff, visitors and patients	John Spencer	£245,327		
1C	Improving the uptake of flu vaccinations for frontline clinical staff	Stephen Kelly	£245,327		
2a	Timely identification for sepsis in emergency departments & Inpatient	Adam Wolverson	£183,996		Partial (10% instead of 25%)
2b	Timely treatment for sepsis in emergency departments & Inpatient settings	Adam Wolverson	£183,996		
2c	Empiric review of antibiotic prescriptions	Sue Leo	£183,996		
2d	Reduction in antibiotic consumption	Sue Leo	£183,996		
4	Improving services for people with mental health needs who present to A&E	Dr Roberts / Dr Sant (joint CQUIN with LPFT)	£735,980		
6	Set up and operate A&G services for non-urgent GP referrals	Lee Parkin	£735,980		
7	All providers to publish ALL of their services and make ALL of their First Outpatient Appointment slots available on eRS by 31 March 2018	Lee Parkin	£735,980		
8	Supporting Proactive and Safe Discharge (split between increasing discharges(£588,785) and ECDS (£147,196))	Kate Sayles	£735,980		
Specialised					
B12	Severe Haemophilia Haemtrack Patient Home Reporting	Bethan Myers / Alison Dawson Meadows	£69,917		
GE3	Hospital Medicines Optimisation	Sue Leo	£188355 (£269000 being paid)		Awaiting confirmation
AF1	Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community	Tim Couchman	£34,018		
1	NHS Dental Services	Dr Kotyla	£122,152		

RAG

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

Equality Analysis Statement

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

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

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

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

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

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

The nine protected characteristics are:

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

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

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

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

Appendix 1. Glossary

Indicator	Definition
C.Diff – Acute acquired (>72hrs)	The number of Clostridium Difficile in a calendar month
MRSA Bacteraemia – Acute acquired (>72hrs)	The number of MRSA Bacteraemia in a calendar month
MSSA Bacteraemia – Acute acquired (>48hrs)	The number of MSSA Bacteraemia in a calendar month
ECOLI Bacteraemia – Acute acquired (>48hrs)	The number of ECOLI Bacteraemia in a calendar month
Never Events	Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
Serious Incidents	Acts and/or omissions occurring as part of NH-funded healthcare that result in: - Unexpected or avoidable death of one or more people - Unexpected or avoidable injury to one of more people that has resulted in serious harm - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional - Actual or alleged abuse
Harm Free Care %	The proportion of patients without any documented evidence of pressure ulcer, harm from a fall in care in the last 72 hours, a urinary infection or a new VTE
New Harm Free Care %	The proportion of patients without any documented evidence of a new pressure ulcer, harm from a fall in care in the last 72 hours, a new urinary infection in patients with urinary catheter has developed since admission or a new VTE
Catheter & New UTIs (Safety Thermometer)	The proportion of patients with an indwelling urethral urinary catheter present on the day of the survey or removed in the last 72 hours
Falls	The proportion of patients with evidence of a fall in a care setting in the last 72 hours
Medication Errors	An unintended failure in the drug treatment process that leads to, or has the potential to lead to, harm to the patient
Pressure Ulcers 3/4	Number of incidences of grade 3 and 4 avoidable pressure ulcers acquired by inpatients in the care of the organisation in the calendar month
VTE Risk Assessment	The proportion of patients with a documented VTE risk assessment
eDD	Proportion of patients with a completed electronic discharge document
PPCI 90 mins	Acute myocardial infection (AMI) patients with ST-segment elevation on the ECG closest to arrival time receiving primary PCI during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less
PPCI 150 mins	Acute myocardial infection (AMI) patients with ST-segment elevation on the ECG closest to arrival time receiving primary PCI during the hospital stay with a time from hospital to arrival to PCI of 150 minutes or less

Indicator	Definition
#NOF 24hrs	Fracture neck of femur time to theatre within 24 hours
#NOF 48hrs	Fracture neck of femur time to theatre within 48 hours
A&E 4 hour wait	Percentage of all A&E attendances where the patient spends four hours of less in A&E from arrival to transfer, admission or discharge
A&E 12 hour trolley wait	Total number of patients who have waited over 12 hours in A&E from decision to admit to admission
52 Week Wait	The number of incomplete pathways greater than 52 weeks for patients on incomplete pathways at the end of the period
RTT - 18 week referral to treatment	The percentage of patients on incomplete pathways within 18 weeks against the total number of patients on an incomplete pathway as at the end of the calendar month
Cancer 2ww	Two weeks from urgent GP referral for suspected cancer to first appointment.
Cancer 2ww Breast Symptomatic	Two weeks from referral for breast symptoms to first appointment.
Cancer 62 Day classic	62 days from urgent GP referral for suspected cancer to first treatment.
Cancer 62 day screening	62 days from urgent referral from NHS Cancer Screening Programme to first treatment.
Cancer 62 day upgrade	62 days from a consultant's decision to upgrade the urgency of a patient due to a suspicion of cancer to first treatment.
Cancer 31 day first	31 days from diagnosis to first treatment for all cancers.
Cancer 31 day subsequent treatment (drug)	31 days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (drug).
Cancer 31 day subsequent treatment (surgery)	31 days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (surgery).
Cancer 31 day subsequent treatment (radiotherapy)	31 days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (radiotherapy).
Cancer 104+ day waiters	Number of patients on a 62 day pathway who have been waiting 104+ days for first definitive treatment
Diagnostics 6weeks	The percentage of patients waiting 6 weeks or more for a diagnostic test
SHMI – Summary Hospital level Mortality Indicator	The ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there
HSMR – Hospital Standardised Mortality Ratio	The ratio of the observed to expected deaths, multiplied by 100, with expected deaths derived from statistical models that adjust for available case mix factors such as age and comorbidity
MFFD - Medically fit for discharge	Average number of patients discharged before 12 noon who have been declared as medically fit for 72hours
DTOC - Delayed transfers of care	Total number of delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both)

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