UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 30th SEPTEMBER 2017

To:	Trust Board
From:	**Karen Brown, Director of Finance, Procurement & Corporate Affairs**
Date:	7th November 2017
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for September 2017

Author/Responsible Director: Karen Brown, Director of Finance

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

The report is provided to the Board for:

			√
Decision	√	Discussion	√
Assurance	√	Information	

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

Recommendations:
The Board is asked to note the current performance and future performance projections.
The Board is asked to approve action to be taken where performance is below the expected target.
This is an evolving report and the Board are invited to make suggestions as we continue to develop it

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

Resource implications (eg Financial, HR) None

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

Patient and Public Involvement (PPI) implications None

Equality impact

Information exempt from disclosure

Requirement for further review?

Executive Summary for period of 30th September 2017

☒ 4 hour waiting time target – performance of 76.9% in September 2017 (c.f. 77.6% in August 2017)
☒ 4 of the 9 national cancer targets were achieved in August 2017 (c.f. 3 in July 2017))
☒ 18wk RTT Incomplete Standard for September 2017 is currently at 88.09% (c.f. 88.73% in August)
☒ 6wk Diagnostic Standard – September 2017performance was 98.07% (c.f. 97.94% in August 2017)
☑ The Trust has now identified high level schemes to improve efficiency totalling £16m and these have been included within the updated financial recovery plan submitted to NHS Improvement

Successes:

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

A newly qualified intake of 60.90 wte nurses/midwife reduced the vacancy rate 15.5% in August 2017 to 12.87% in September 2017. AHP vacancy rates have reduced from 10.64% in August 2017 to 8.87% in September 2017 and are now within target.

Significant improvement in cancer targets performance, with 4 targets being achieved and a further 3 just being missed. There are now only 7 patients waiting over 104 days.

GP streaming commenced in A&E on both main sites during September 2017

Inpatient sepsis screening and administration of intravenous antibiotics within 1 hour were 100% for the third month running. Focus continues to gain similar improvement levels in A&E.

Challenges:

A&E performance has again been challenging with increased attendances and acuity and patient flow delays.

Medway upgrade is scheduled for 20th October and may affect the final 5 days of the RTT validation cycle resulting in a slight dip in RTT performance.

Performance against the Cancer 62 day standard was 71.20% for August 2017. However 13 patients who were waiting over 104 days were treated in month. The Trust is driving improvement in cancer pathways via the Cancer Action Plan which is reviewed fortnightly at the Cancer Recovery and Delivery Group. Also representatives from the Trust meet fortnightly with leads from CCGs, NHSI, NHSE and the Cancer Network to review support required from the health system as a whole.

Performance against the diagnostics standard, at 98.07%,failed for the third month in a row. Significant staffing issues in Echocardiography being the main issue. A recovery action plan is in place.

Looking forward:

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

The Trust continues to focus on delivery against the 4 STP performance trajectories and supporting work-streams. Fundamental to this is ensuring all actions attached to recovery plans are achieved with a view to noted improvement in October including recovery in Diagnostics.

The Trust is also focussed on the delivery of an improved financial run rate. A financial recovery plan to support this has been submitted to NHSI and the Trust is committed to its delivery.

Karen Brown
Director of Finance, Procurement & Corporate Affairs
October 2017

Integrated Performance Report

The dashboard shows the Trust's current performance against the chosen standards and indicators as a measure of overall Trust performance. More detail is shown in the detailed dashboard on the next page. This is followed by exception reports for specific areas.

Detailed Trust Board Performance

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Safe						
Infection Control						
Clostrum Difficile (post 3 days)	Monthly	Datix	59	36	8	4
MRSA bacteraemia (post 3 days)	Monthly	Datix	0	1	0	0
MSSA	Monthly	Datix	12	7	1	0
ECOLI	Monthly	Datix	48	23	3	2
Never Events	Monthly	Datix	0	1	1	0
No New Harms						
Serious Incidents reported (unvalidated)	Monthly	Datix	0	151	26	28
Harm Free Care %	Monthly		95%	91.90%	91.90%	93.70%
New Harm Free Care %	Monthly		98%	98.22%	97.60%	98.90%
Catheter & New UTIs	Monthly		1	1	1	2
Falls	Monthly	Datix	3.90	3.58	3.32	3.91
Medication errors	Monthly	Datix	0	871	138	112
Medication errors (mod, severe or death)	Monthly	Datix	0	126	19	14
Pressure Ulcers (PUNT) 3/4	Monthly			37	8	7
VTE Risk Assessment	Monthly		95%	97.08%	96.49%	97.10%
Core Learning	Monthly	ESR	95%	90.61%	90.73%	90.58%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Caring						
Friends and Family Test						
Inpatient (Response Rate)	Monthly	Envoy Messenger	26%	24.50%	21.00%	21.00%
Inpatient (Recommend)	Monthly	Envoy Messenger	96%	92.00%	92.00%	93.00%
Emergency Care (Response Rate)	Monthly	Envoy Messenger	14%	19.17%	18.00%	18.00%
Emergency Care (Recommend)	Monthly	Envoy Messenger	87%	81.00%	82.00%	81.00%
Maternity (Reponse Rate)	Monthly	Envoy Messenger	23%	9.17%	9.00%	10.00%
Maternity (Recommend)	Monthly	Envoy Messenger	97%	96.50%	98.00%	96.00%
Outpatients (Reponse Rate)	Monthly	Envoy Messenger	14%	14.17%	13.00%	14.00%
Outpatients (Recommend)	Monthly	Envoy Messenger	94%	92.50%	92.00%	93.00%
Complaints						
No of Complaints received	Monthly	Datix	70	362	74	68
No of Complaints still Open	Monthly	Datix	0	1522	276	276
No of Complaints ongoing	Monthly	Datix	0	215	42	41
No of Pals	Monthly	Datix	0	0	0	345
No of pals converted to formal complaints	Monthly	Datix	0	0	0	0
Inpatient Experience						
Mixed Sex Accommodation	Monthly	Datix	0	3	3	0
eDD	Monthly	EDD	95%	83.48%	80.07%	87.52%
PPCI 90 hrs	Quarterly		100%	95.15%	97.33%	97.33%
PPCI 150 hr	Quarterly		100%	86.85%	85.33%	85.33%
#NOF 24	Monthly		70%	58.40%	53.33%	46.99%
#NOF 48 hrs	Monthly		95%	91.42%	92.00%	85.54%
Dementia Screening	1 month behind		90%	90.85%	93.52%	83.75%
Dementia risk assessment	1 month behind		90%	95.65%	92.72%	95.93%
Dementia referral for Specialist treatment	1 month behind		90%	82.43%	84.38%	68.18%
Stroke						
Patients with 90% of stay in Stroke Unit	1 month behind	SSNAP	80%	81.98%	90.30%	73.70%
Sallowing assessment < 4hrs	1 month behind	SSNAP	80%	69.64%	76.20%	65.70%
Scanned < 1 hrs	1 month behind	SSNAP	50%	60.26%	69.20%	53.60%
Scanned < 12 hrs	1 month behind	SSNAP	100%	97.68%	97.30%	99.10%
Admitted to Stroke < 4 hrs	1 month behind	SSNAP	90%	64.60%	67.10%	55.40%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Responsiveness						
A&E						
4hrs or less in A&E Dept	Monthly	Medway	90.0%	78.84%	76.68%	77.64%
12+ Trolley waits	Monthly	Medway	0	0	0	0
RTT						
52 Week Waiters	Monthly	Medway	0	8	7	4
18 week incompletes	Monthly	Medway	91.0%	88.91%	88.09%	88.73%
Cancer - Other Targets						
62 day classic	1 month behind	Somerset	85%	70.20%	71.20%	69.20%
2 week wait suspect	1 month behind	Somerset	93%	88.78%	85.30%	87.50%
2 week wait breast symptomatic	1 month behind	Somerset	93%	82.18%	91.70%	92.00%
31 day first treatment	1 month behind	Somerset	96%	96.50%	97.90%	97.50%
31 day subsequent drug treatments	1 month behind	Somerset	98%	99.44%	100.00%	100.00%
31 day subsequent surgery treatments	1 month behind	Somerset	94%	91.20%	97.60%	85.00%
31 day subsequent radiotherapy treatments	1 month behind	Somerset	94%	94.86%	100.00%	94.80%
62 day screening	1 month behind	Somerset	90%	84.44%	89.70%	76.90%
62 day consultant upgrade	1 month behind	Somerset	85%	84.16%	84.30%	82.40%
104+ Day Waiters	1 month behind	Somerset		-	9	8
Diagnostic Waits						
diagnostics achieved	Monthly	Medway	99.1%	98.83%	98.07%	97.94%
diagnostics Failed	Monthly	Medway	0.9%	1.17%	1.93%	2.06%
Cancelled Operations						
Cancelled Operations on the day (non clinical)	Monthly	Medway	1.10%	3.86%	4.06%	3.40%
Not treated within 28 days. (Breach)	Monthly	Medway	0.00%		4.71%	2.73%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Effective						
Mortality						
SHMI	Quarterly		100	111.22	112.57	111.39
Hospital-level Mortality Indicator	Quarterly		100	103.10	102.17	102.02
Length of Stay						
Average LoS - Elective	Monthly	Medway / Slam	2.8	2.76	0.00	2.77
Average LoS - Non Elective	Monthly	Medway / Slam	3.8	4.37	4.37	4.15
Medically Fit for Discharge	Monthly	Bed managers	60	56.67	62.00	56.00
Delayed Transfers of Care	Monthly	Bed managers	3.5%			3.38%
Partial Booking Waiting List	Monthly	Medway	0	5458	4720	5085

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Well Led						
Vacancies	Monthly	ESR	5.0%	10.70%	9.73%	10.79%
Sickness Absence	Monthly	ESR	4.5%	4.52%	4.62%	4.82%
Staff Turnover	Monthly	ESR	8.0%	5.64%	5.32%	5.52%
Staff Engagement						
Staff Appraisals	Monthly	ESR	95.0%	79.00%	80.00%	82.00%
Equality Diversity and Inclusion						

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Money & Resources						
Income	Monthly	Board Report Master	36337	211455	36249	36370
Expenditure	Monthly	Board Report Master	-40761	-246759	-41306	-40992
Efficiency Delivery	Monthly	FIMS report	1343	3746	1523	525
Surplus / Deficit	Monthly	FPIC Finance Report	-4424	-42955	-6348	-5909

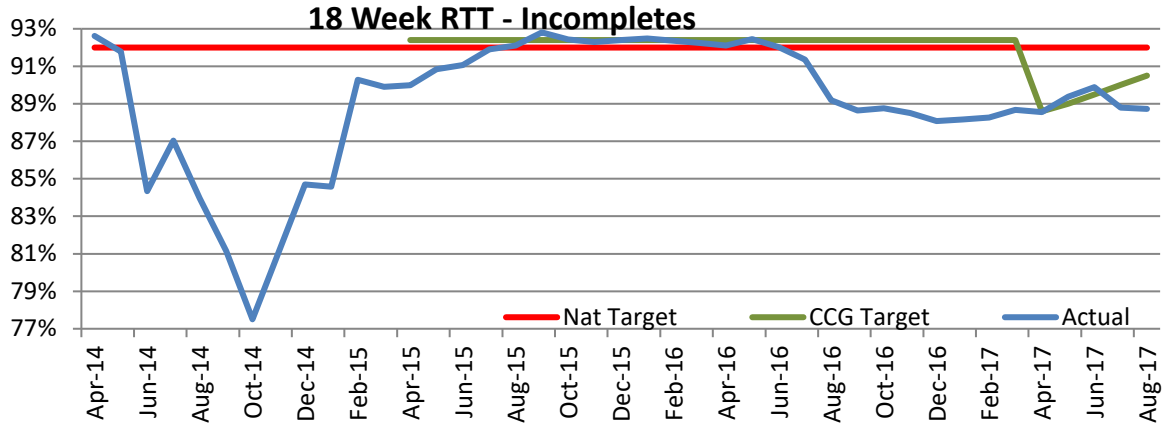
Referral to Treatment

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Referral to Treatment (18 weeks)	Owner:	Director of Operations
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance – Planned Care
Date:	20th October 2017	Reporting Period:	September 2017

Exception Details

In August the Trust reported performance of 88.7%, a deterioration of 0.07% compared with the position in June. The number of patients on incomplete pathways over 18 weeks increased by 7 during August, up to 3082 patients.



At a national level the standard hasn't been achieved for 17 consecutive months, with an aggregated national performance in July of 89.4%.

The final submission for September the Trust's performance level was 88.09%. The Medway upgrade took place on 20th October, the validation cycle was affected by system downtime during the upgrade. This has had a detrimental impact upon October's final performance position.

During July three specialities deteriorated by a total of 290 incomplete patients over 18 weeks – ENT, Ophthalmology, Gastro. During August these three speciality areas combined over 18 week position deteriorated by a further 148 patients. Deterioration in the incomplete position in these specialities was offset at a Trust level by improvements in General Surgery, T&O and Cardiology. Below is a brief summary of the challenges within ENT/Ophthalmology/Gastro which have impacted upon performance in recent months:

- ENT – The Service has experienced gaps in clinical capacity due to sickness and vacancies, and has also experienced significant managerial/administrative vacancies in the last 3 months which have severely restricted the capacity of the speciality team to drive performance improvement. The management team are now fully established, however there are significant risks relating to clinical capacity from January as a result of retirement and resignation of two Consultants. The Clinical Directorate is currently completing a rapid review in order to fully understand the implications of this reduction in clinical capacity, and the recommendations for the service provision going forwards.
- Ophthalmology – Between June and September the service had vacancies/maternity leave the equivalent of 4 Consultant posts. Recruitment has taken place, but there have been gaps between doctors leaving and new recruits starting which has reduced the capacity within the service. In addition theatre capacity issues have meant that some daycase lists have been suspended, leading to an increasing backlog of admitted patients.

- Gastro – A locum consultant left the Trust on 9th June. The Trust were unable to find a replacement before a substantive Consultant joined the Trust in August. This resulted in a reduction in capacity in this speciality for a two month period. The final Gastro vacancy at Lincoln was filled during September, meaning that from mid-September the service is now at full establishment for the first time in over a year.

The monthly cancelled Operations had been partially validated at the time of writing, with 252 cancelled Operations on the day in September and 173 the day before.

There are long waiting times for first appointments in a number of specialities. There has been a reduction in the number of patients waiting over 12 weeks on the open referrals waiting list, reducing from 2288 at the end of May to 1329 on 20th October, however Gastro and ENT still have patients waiting over 25 weeks on the open referrals waiting list.

In the first 5 months of 2017/18 The Trust's activity has been above contracted levels in the following specialities which are currently performing below 92%:

- Endocrine (18%)
- General Surgery (8%)
- ENT (5%)

Following the fire at Pilgrim, capacity for daycases has been restricted for the subsequent 7 month period due to the resultant ward moves, and reduced available bed spaces for these patients, which reduces daycases by c.30 patients per week.

Validation completed as at 20th October showed that there were 7 patients who were on incomplete pathways over 52 weeks at the end of September. Harm reviews had been completed for 5 out of 7 of these patients at this point, with 2 further harm review still pending. 3 of the 5 completed had no harm reported and 2 had low harm reported.

What action is being taken to recover performance?

Delivery of additional outpatient clinics over and above core capacity forms the basis of a significant proportion of the speciality level plans. The additional Clinical Directorate capacity is being delivered by existing staff working additional hours and also the use of agency locums in specialities such as Neurology, Cardiology and Respiratory. Two new Gastro Consultants have now commenced in post at Lincoln, which takes that service to a fully established position.

An advert for a substantive Neurology consultant closes on 25th October. The Endocrine/Diabetes Service have additional baseline capacity in place following recruitment related to the Pilgrim Hospital 4th Consultant Business Case.

The ENT Service have commenced completion of virtual clinics, with over 300 patients reviewed utilising this approach during September and early October. As at 18th October 145 ENT patients had been confirmed as transferred to a different provider as part of this year's outsourcing arrangements, and a further 44 patients are being contacted to determine whether they are willing to be seen by an alternative provider. Further outsourcing and insourcing options are being explored by the Clinical Directorate. A new Audiology pathway has been implemented which will support the ENT backlog reduction. The Clinical Directorate are currently completing a rapid review to determine the impact of clinical vacancies which will arise in January, and what further actions will be required to address this situation.

The Ophthalmology Service is reviewing cross-cover arrangements for theatre lists at Lincoln to ensure maximum utilisation. In addition, outsourcing has commenced within this speciality.

Outsourcing has commenced within Urology and General Surgery. As at 18th October, a total of 71 General Surgery patients and 12 Urology patient have been accepted by independent sector providers, with plans for further patients to be identified within these speciality areas.

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

Pathway improvements have been agreed within the Autism Service; Speech and Language Therapy capacity is being utilised to complete aspects of the assessment process which is releasing Consultant capacity to reduce the waiting list backlog.

There are key speciality areas (ENT, Cardiology, Community Paeds and Dermatology) where the Clinical Directorates believe that a significant reduction in referrals over a 3 month period into these areas is required in order to achieve the improvement in new and follow-up patient backlog reduction which is required. In June the Trust made a request to the CCGs for a pause in routine referrals into these four specialities. This request was discussed in a number of forums with the commissioners.

Lincs East CCG implemented a divert of routine referrals away from ULHT in ENT, Community Paeds and Dermatology from 4th August for a period of 3 months. Lincs West CCG, South Lincs CCG and South-West CCG have not agreed to a service pause into these specialities at this time. It has been agreed that the referral divert in Community Paeds would cease from the beginning of October due to the pathway changes which have been implemented. In ENT and Dermatology during the first two months of this period, GP referrals into these specialities have reduced by the following levels compared to the pre-divert period:

- ENT 13% reduction
- Dermatology 10% reduction

On 1st September the Neurology Service re-opened to headache patients, where the recently approved community headache pathway has been utilised. It is anticipated that agreement will be reached during November regarding the date when the service will fully re-open.

What is the recovery date?

November 2017

Cancer Waiting Times – 62 Day

Executive Responsibility: Mark Brassington – Chief Operating Officer

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

Exception Details

The Trust achieved a performance of 71.2% against the 62 day classic standard in August.

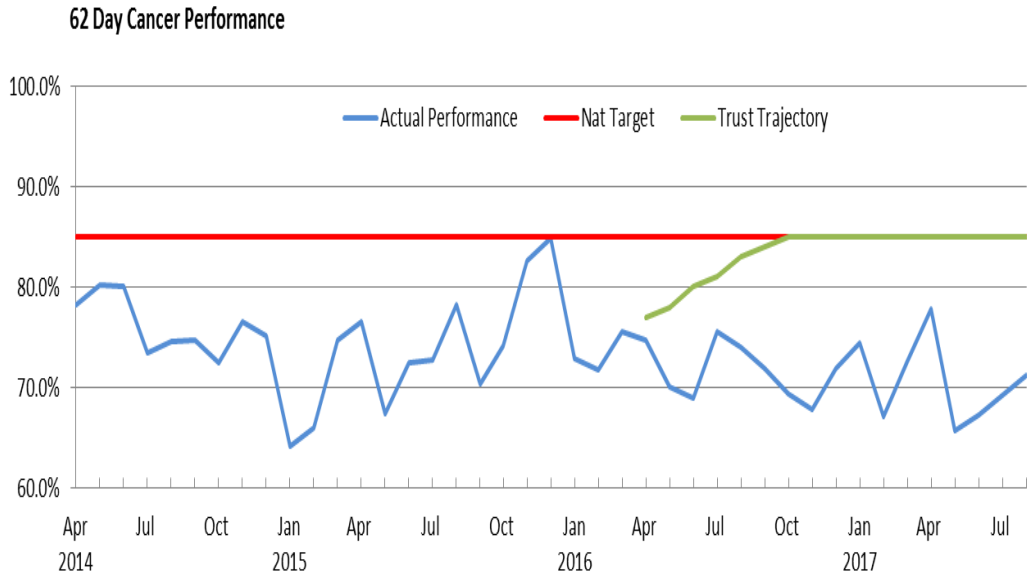
The Trust achieved 4 out of the 9 cancer standards.

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

Performance in Urology and Lower GI remained below 55% for the fourth month in a row. There was a significant improvement in haematology performance, which performed above 80% for only the third month in the last year. The overall Trust position was positively impacted by the high volume of non-breach Skin treatments recorded in August.

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

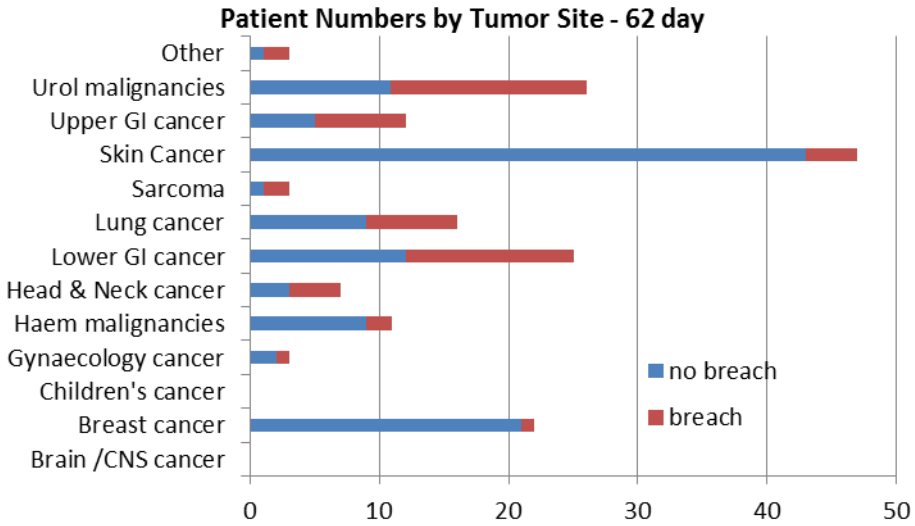
- Complexity or procedural
- Patient choice and/or patient fitness
- Tertiary diagnostic delays
- Pathology turnaround times
- CT capacity
- Interventional Radiology capacity
- Outpatient appointment delays
- Oncology capacity
- Administrative delays



As of 20th October there are 7 pts on or over 104 days without an agreed treatment plan: 2 x lung, 1 x Urology, 1 x Gynaecology, 1 x Head and Neck, 1 x colorectal, 1 x Haem. 2 of the 7 have confirmed cancer diagnosis, treatment for one of these patients being led by a tertiary centre and treatment for the other patient delayed until treatment has been completed relating to another condition.

The Trust treated 13 patients at 104 days or over during August, completing RCAs for all 13 p ns for delays in their pathways, as follows:

- 6 cases included patient choice delays
- 4 cases included complexity or procedural factors
- 3 case included pathology delays
- 3 cases included tertiary diagnostic delays
- 3 case included Outpatient capacity
- 2 cases included patient fitness factors
- 2 cases included admin delays
- 2 cases included theatre capacity restrictions
- 2 case included U/S capacity restrictions
- 1 case was linked to primary care delays
- 1 case included CT delays
- 1 case included IT related delays
- 1 case included Oncology capacity delays
- 1 case included Chemo capacity delays



The Trust completes a full review of any potential harm related to excessive waitsfor cancer treatment (104 + Day Waits). These are currently being completed by the Clinical Directorates, with the outcomes to be included within this report within the second version available for Trust Board.

What action is being taken to recover performance?

The Trust is driving improvement in cancer pathways via the Cancer Action Plan which is reviewed fortnightly at the Cancer Recovery and Delivery Group.

Key actions being undertaken/continuing in the coming weeks include:

- Revised Urology pathways – Clinical agreement has been reached relating to a revised pathway which will see 2ww clinics created which feed directly into MRI and TRUS biopsy slots. This new pathway went live on 1st October.
- Continuation of Endoscopy backlog clearance – Medinet continue to provide addition sessions at weekends. A procurement exercise for a longer term outsourcing arrangement has closed. An initial evaluation exercise has been completed, with the full process to be completed before the end of November and expectation of a start date before the end of the calendar year. Alongside this a business case for increased internal Endoscopy capacity has been completed. This was reviewed by IPB on 23rd August, where further clarifications were requested. This is scheduled to return to IPB in November.
- Continuation of extended CT capacity – External funding has enabled the Radiology Service to plan to continue the extended CT capacity until December 2017. An application has been made for additional central funding in order to continue this until the end of the financial year.
- Roll out of lower GI STT at Pilgrim – The specialist nursing post required to enable this development is at the recruitment stage.
- Oncology administrative optimisation – Chemo-scheduler business case has been approved. These posts have been appointed to, with individuals anticipated to commence in post by early November. This will improve co-ordination of chemotherapy capacity and enable full utilisation of the recently developed Oncology scheduling tool.
- Histology turnaround times – Performance meetings commenced with Path Links. Review of MDT arrangements for pathology to be completed in conjunction with MDT leads. Path Links have secured additional locum Consultant capacity and develop digital technology solutions. Raising awareness internally around utilization of 2ww priority stickers.

- Improve Radiology reporting times – Radiology Dept are piloting earlier utilization of outsourcing capacity within cancer pathways. Performance figures from mid-August show improvements in overall turnaround times, but this will continue to be reviewed with further options considered to improve performance as required.
- Radiology to reduce CT biopsy delays – Trust wide booking process in place since beginning of August.
- Straight to test for CT on lung pathway – Pathway agreed within the Trust. Work on-going with CCGs to roll-out by mid-November
- Communication with patients – The CCGs have agreed to resource a project manager to lead the development a standardized approach to communicating with patients on suspect cancer pathways from an administrative perspective, in order to ensure that patients are appropriately informed relating to the nature of the referral and the importance of timely access to appointments.
- Daily operational meetings to be established in order to unblock delays within individual cancer pathways.

Representatives from the Trust meet fortnightly with leads from CCGs, NHSI, NHSE and the cancer network to review support required from the health system as a whole. Key actions include:

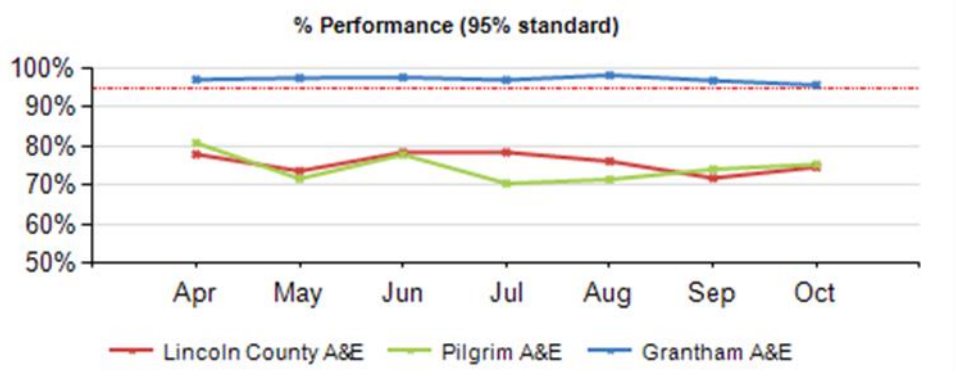
- SET funding of £250k for cancer pathway improvement has been agreed, schemes include:
  - Temporary additional cancer tracking capacity to increase tracking frequency – commenced during September
  - Project Lead post facilitating improvements within tracking processes, review of pathways, MDT support and tertiary communication – appointment made, with start date of beginning of December agreed
  - Urology/Lower GI Improvement/Operations Manager for Cancer – post out to advert
  - Radiology Cancer Co-ordinator – Advert has closed, with interviews scheduled for late October
  - External support to review whole pathway capacity/demand – commenced on site 30/8/17, producing revised PTL template and Radiology daily report tool. Tumour site capacity/demand tool in development.
- Review best practice PTL management from other organisations to inform ULHT systems – visits to other providers completed.
- External clinical support to review long waiting patient pathways – completed on 11th September.

A&E 4 Hour Standard

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	4 Hour Wait (A&E)	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Director of Operations / Deputy Director of Urgent Care
Date:	27th September 2017	Reporting Period:	August 2017

Exception Report



Lincoln performance for September 2017 was 71.86% which is a deterioration from last month of 4.84%. This remains below the monthly trajectory for September of 89%.

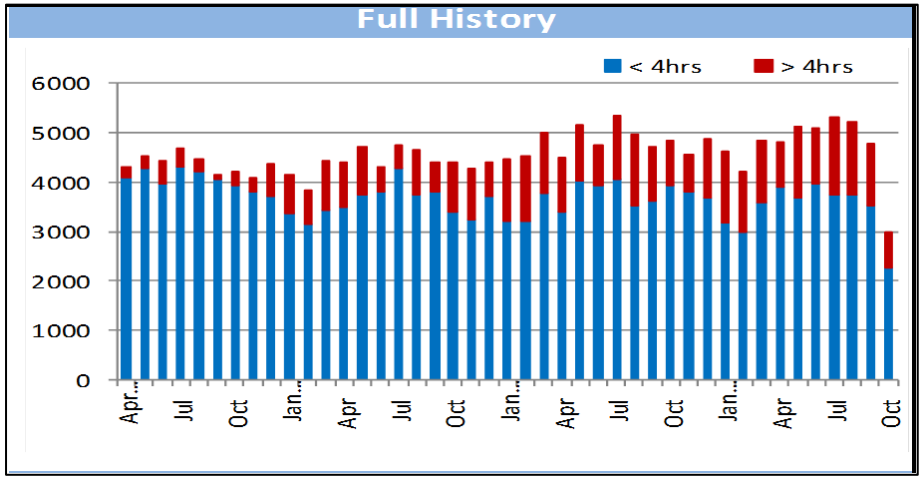
Medical staffing fill rates at Lincoln improved during September but nurse staffing levels both on site and in ED remained poor. This led to poor skill mix on shifts across the hospital with resultant delays in on site operational flow.

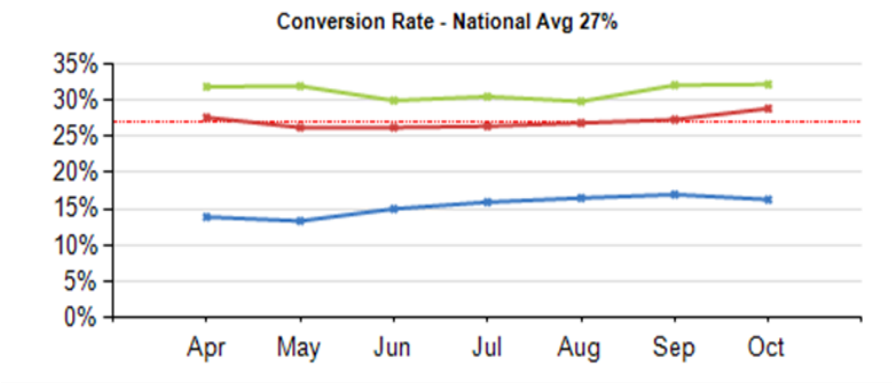
Middle Grade Doctors	04/09/2017	11/09/2017	18/09/2017	25/09/2017	Junior Doctors	04/09/2017	11/09/2017	18/09/2017	25/09/2017
Weekly hours required	534	534	534	534	Weekly hours required	399	399	399	399
Substantively filled	103	95	118.5	103	Substantively filled	357.5	318.5	365.5	301
Internal MG Extra	20	8	33	10	Internal Extra	8	8	8	24
Internal Con acting Down Extra	0	0	0	0					
Agency Filled	359	402.5	382.5	383.5	Agency Filled	0	64	25.5	66
Grantham Filled	0	0	0	0	Vacancies	0	1	1	1
Grantham extra hours	64	64	48	48					
Not Filled	**52**	**28.5**	**0**	**37.5**	Not Filled	**33.5**	**8.5**	**0**	**8**

From mid-September ED attendance numbers at Lincoln climbed to regularly being between 205 and 220 per day and peaked at 233. With this increase in attendance rates came an increased acuity. As a result LOS also increased causing problems with a lack of flow. Repeated problems with the Trust's non-urgent patient transport provider (TASL) added to the poor flow with increased delayed and failed discharges and prolonged patient stays in both our wards and the Emergency Department.

At Pilgrim, September's overall performance was 74.15%, which is 14.85% below the planned trajectory of 89%, but up slightly from the performance of 71.38% in Aug. Still some way off the 89% required for October (currently 75.27%). Triage performance within 15mins was up slightly to 59.97% for September compared to 58.96% in August but still a long way short of 100%, and time to 1st assessment was also slightly up from 39.31% in August to 44.1% in September against the national target of 50%.

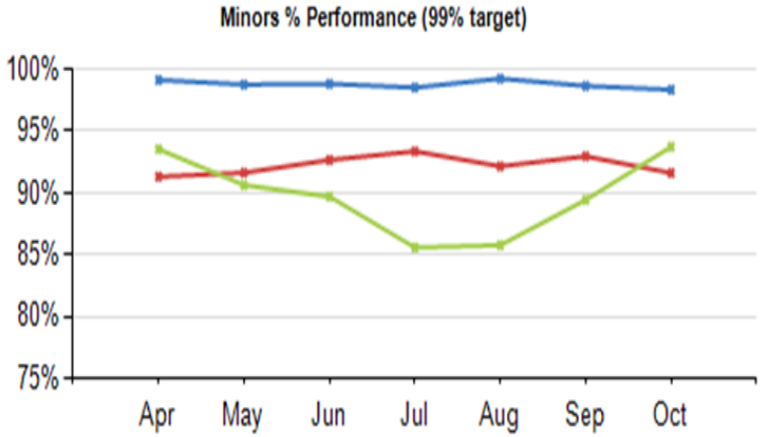
Pilgrim total attendances for Sept where at the planned level, slightly down on August attendances of 5,214 with 4,769 down by 445 patients, but Aug attendances do still rate in the top 5 months for patient attendances over the past 5yrs.





Pilgrim admission levels have remained high, but consistent throughout Sept with 1531admissions, which equates to 32%, this is a 2% increase from Aug's 30% with 1557 admission, some 26 more admission than in Sept, still much higher than the national average of 25-27%.

Pilgrim minors performance in September has seen another increase month on month, from 86% in Aug to 89% in Sept, with further increases to 93% in Oct so far.



At Pilgrim key in month key issues affecting performance in September were:

- Vacancies in ED Medical rota's with reliance on agency locums.
- Deanery Junior Doctor gaps proving to be a real issue with cover, with previous rotations resorting to Agency work, rather than progression or Bank work.
- Vacancies in Nursing rota's with a variance in agency or bank fill rates.
- High patient attendances and increased acuity.
- Poor hospital flow – admissions exceeded discharges. The AEC area was used on occasion as escalation bed capacity resulting in inefficient processing of ambulatory patients. Elective work was cancelled to facilitate medical patients (10-20+) in surgical beds.
- The MMFD numbers have increased with external delays awaiting packages of careand community beds

What action is being taken to recover performance?

AT Lincoln there is an on-going focus on recruitment to medical staff in the ED and the cohort recruitment nurses are now coming towards the end of their supernumerary period. The Emergency Department medical rota is more stable over the next month but will be monitored closely. The Trust has a stand at the BMJ Careers Fair and will be promoting working at ULH especially in our hard to fill specialties.

The new GP Streaming Service commended on 27th September 2017 on schedule and, at Lincoln, in the early weeks streamed numbers were in the region of the late teens. This figure is gradually increasing as the staff complete their training and gain confidence and is currently in the mid to late twenties per day. At Pilgrim GP Streaming has commenced within the department with consistent figures being streamed into Primary Care, with current average performance around 9% but increasing daily.

Other initiatives at Pilgrim site include :

- Additional streaming from ED into AEC and direct into specialty areas where applicable.
- GP referrals to be streamed directly into AEC also, where and when appropriate and safe to do so.
- Operational Matron chairs daily Red2Green meetings to provide further focus on Red to Green and Pride and Joy to increase timely discharges and address delays to increase flow and improve performance
- Late matron and senior manager rotas to provide additional site support later in the day.
- Weekend virtual board rounds are planned to commence in November
- 7 Day working in AEC.
- AEC developing further patient pathways – low grade chest pain for example.
- Continual recruitment/interviews for Middle grade Doctors
    - ED Surgical Specialty Doctor interviews have now been completed and 2 Dr's offered posts (18/10/17), awaiting responses.
    - ED Orthopaedic Specialty Doctor advert currently out.
    - Non-UK agency in discussion with Directorate to potentially supply ED Middle Grade doctors initially, but could be expanded to other specialties and nurses.
    - Internal Junior Doctor contracts (NHS Locums) established to reduce impact of deanery gaps and subsequent agency spend
- Review of rota's to try and ensure the best possible skills mix is present OOH/weekends – Recent rota redesign at LCH to be discussed at PHB.
- Breach performance analysis being performed to identify any particular trends or patterns, as well as breach league table for the clinicians
- Embedding of Standard Operating Procedures for patient streaming away from the ED.
- Established a new drug cupboard outside RAIT that has reduced RAIT times by approximately 4-5 minutes in an internal audit
- Revised ambulance handover process to doctor in RAIT that has reduced turnaround times
- Departmental weekly meeting 'time2talk' initiated to address any departmental issue's/quick wins..
- Increased usage and focus on the Discharge Lounge – Recent staff suggestions are being considered around staffing and process within the discharge lounge.

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Diagnostics

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Diagnostics	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Director of Operations / Deputy Director of Urgent Care
Date:	20th October 2017	Reporting Period:	September 2017

Exception Details

In September the Trust failed the 6 week diagnostic standard for the third time in the last ten months.

There were 123 diagnostic patients which breached the 6-week standard in September, which was 15 less than at the end of August.

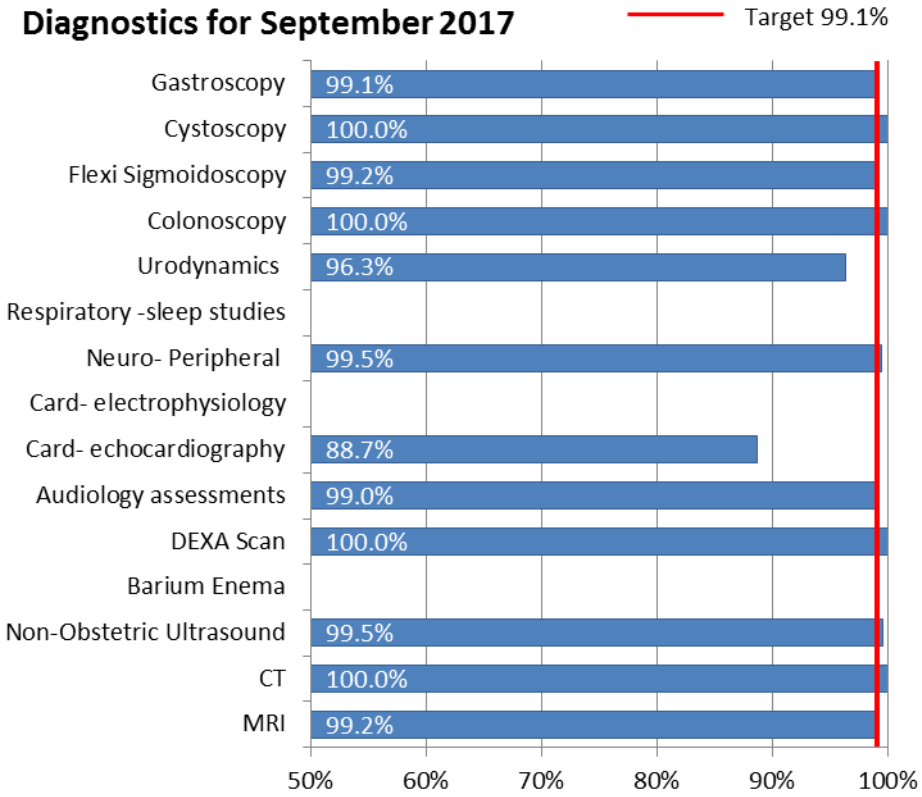
97 of the 123 breaches were within Echocardiography. This service has experienced significant capacity restrictions during the last 2 months with two members of staff commencing maternity leave, one member of staff taking paternity leave, alongside the impact of planned leave and existing sickness levels within the department. Additionally the service has experienced increasing inpatient demand during this period..

What action is being taken to recover performance?

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

- Provision of addition capacity through internal resources
- Working with external partners to increase capacity
- Taking action to improve data quality and visibility, with Cardiac Physiology (separate from Cardiology) now having a dedicated new and follow-up waiting list within Medway for the first time.

However, the service have had to cancel 33 Echo appointments during October in order to manage increased inpatient demand, which increases the risks relating to October's month-end position.



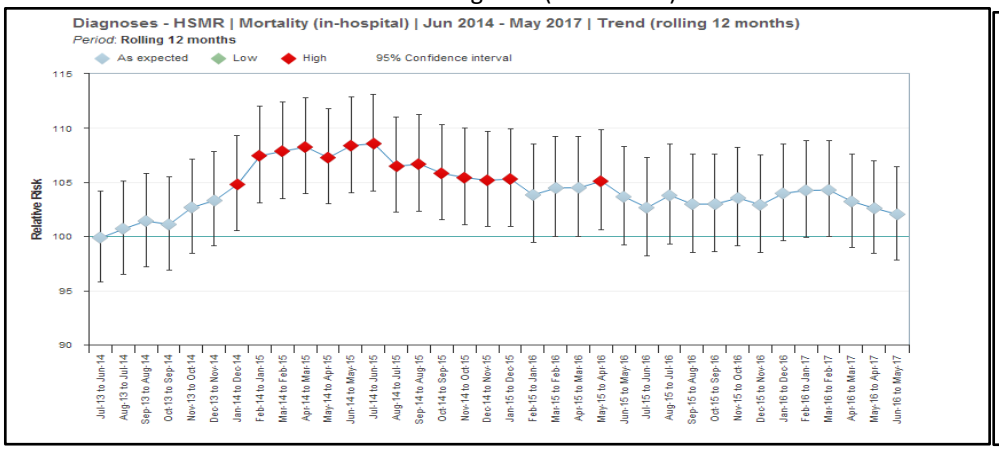
Safe Ambition 1: Reduction of Harm Associated with Mortality

Executive Responsibility: Neil Hepburn – Medical Director

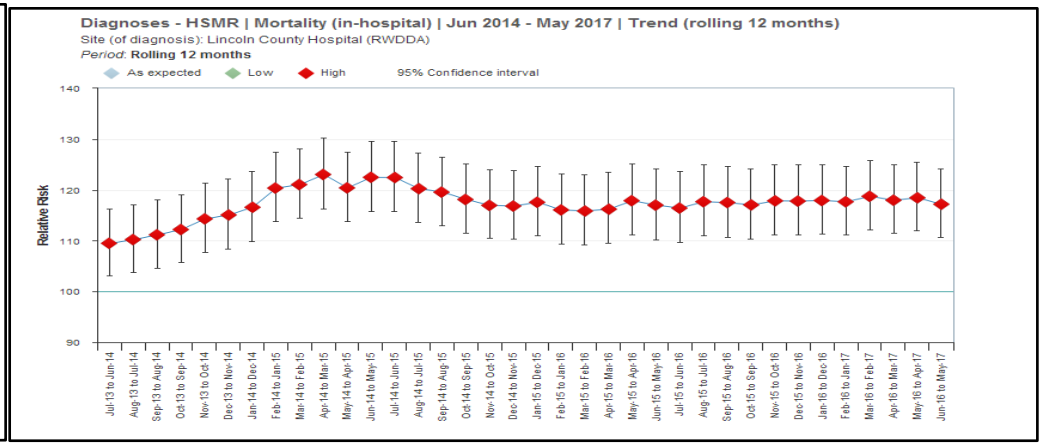
Trust/Site	ULHT HSMR Jun 16-May 17 12 month	ULHT HSMR Apr 17-May 17 YTD	ULHT HSMR May-17	ULHT SHMI Jan 16 – Dec 16	Trust Crude Mortality YTD Internal source Aug 16-Jul 17
Trust	102.02	95.01	92.0	111.39	1.80%
LCH	117.18	109.71	99.3	115.32	1.83%
PHB	91.58	84.14	69.6	109.01	1.96%
GDH	72.10	63.19	57.3	93.04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

Hospital Standardised Mortality Ratio (HSMR)

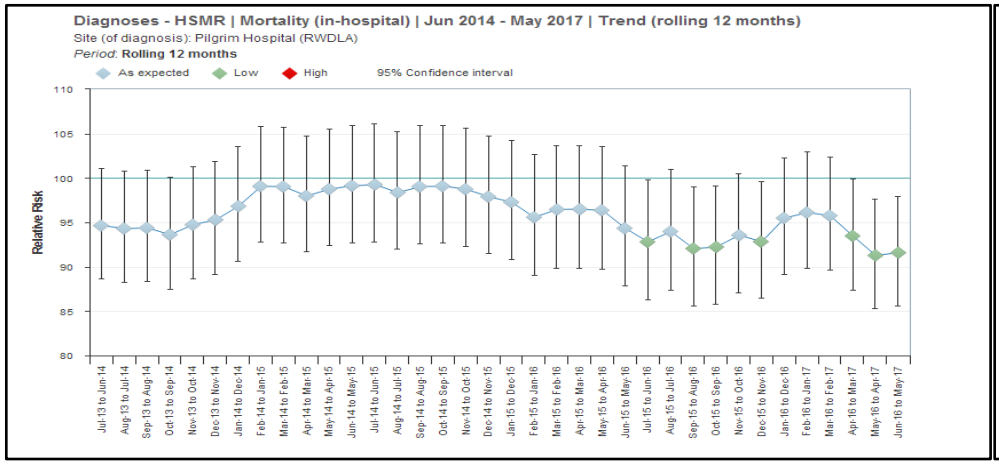
ULHT HSMR Rolling Year (36 Months)



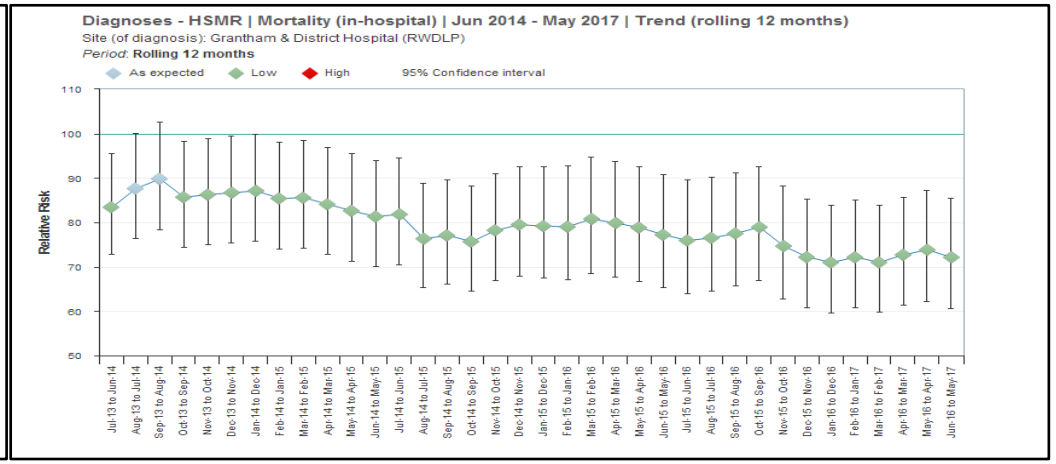
Lincoln HSMR Rolling Year (36 Months)



Pilgrim HSMR Rolling Year (36 Months)



Grantham HSMR Rolling Year (36 Months)



Alerts

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

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

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

- **Biliary Tract Disease:** This is cumulative throughout the time period with 13 mortalities over the predicted Dr Foster data. This has now been alerting for 5 months and is alerting at Trust level. A comprehensive review was conducted in November 2015. Quality Governance have contacted the Clinical Directors for this alert for volunteers to conduct and in-depth review, notes have now been received within Quality Governance.
- **Intestinal Obstruction without hernia:** Due to a notification in October 16; Year to date there were 9 mortalities over the predicted within this diagnosis group. This is the sixth consecutive month of notification. An in-depth review has been completed and will be discussed at the September PSC meeting.
- **Septicemia (except in labour):** This is a cumulative alert and not alerting in a particular month; year to date there are 20.6 mortalities over the predicted Dr Foster data. This is the third month alerting. There is a sepsis committee who meet monthly and have a detailed action plan to improve compliance of sepsis. Sepsis coding rule changed in April 2017. QG has completed an overview which was presented at July PSC. Sepsis nurses to complete a coding review to be presented at Sept PSC.
- **Acute Cerebrovascular disease:** This is the second month of alerting with 118 observed and 31 mortalities over the predicted Dr Foster data. Dr Foster Intelligence specialist and Quality Governance are meeting with Lincoln site stroke team to understand the data. The only notable difference between the data on the sites is the coding of patients been seen by the palliative care team.

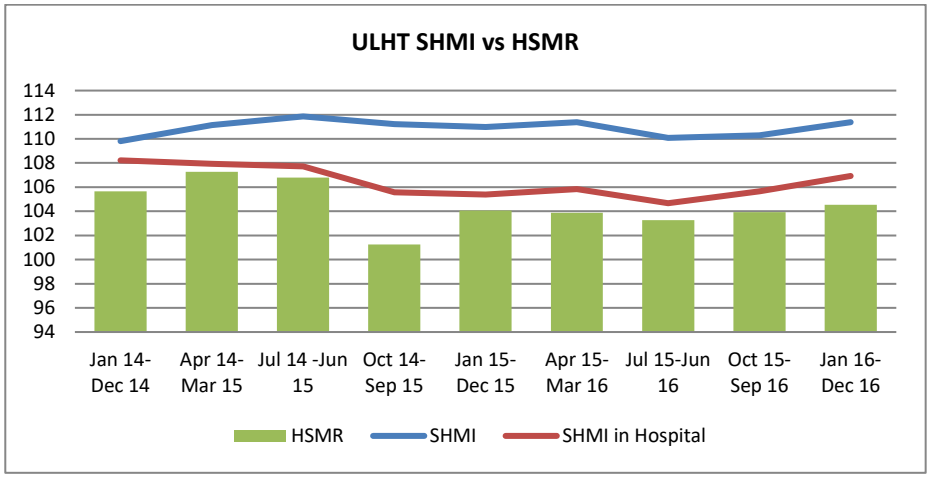
Pilgrim hospital primary diagnoses groups that are outside of the Dr Foster confidence intervals are:

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

Grantham Hospital

No notifications

SHMI



The Trust is undertaking numerous strategies for Mortality Reduction:

- Ward Clerk pilot for the Comorbidity chasing has been undertaken by Clayton and Burton Ward, this has now ceased and the Ward Clerks found that 58% of the new patients coming to the ward this part of the clerking proforma had not been completed. The wards found that putting the note in the notes did not work but adding it to the " New patient checklist" worked for Burton ward. Quality Governance have engaged the EAU's at Lincoln to try and increase the compliance of the completion of the clerking proforma.
- Intestinal hernia without obstruction is currently alerting diagnosis; an in-depth review has been undertaken; A report has been produced Quality Governance and has been sent to the lead to agree report and action plan. The main issues found were palliative care coding and missed comorbidities. Report being discussed at PSC in September 2017.
- Biliary Tract Disease alert, the committee agreed to undertake an in-depth review for this diagnosis group. This is now alerting for the Trust driven by the alert on the Lincoln site. Quality Governance have received the notes and are awaiting volunteers, a proforma has been created.
- National guidance on Learning from Deaths are currently being implemented by the Trust full implementation by September 2017. The policy has been updated for the committees approval in September 2017.
- Coding Masterclass being organised for October 2017 (these are run quarterly and we have previously orchestrated five masterclass).
- 6 weekly meetings of the Lincolnshire Mortality Collaborative with ULHT, CCG, LCHS and GP's to understand deaths within 48 hours of admission and within 30 days of discharge. An update for the committee will be submitted in October2017.
- Quality Governance has undertaken F2 training at Pilgrim and has dates for Grantham and Lincoln teaching programme of how the quality of notes affects our mortality, performance reports and income.
- Bereavement centre at Lincoln will be opening in October 2017.

Mortality Reviews

Reviews (Jan 2016-Aug 2017)

Site	Deaths	Awaiting notes/Notes in Quality Governance	Notes Sent for Review	Review Complete	Review completion Compliance	Review Completion Target	Total Death % Reviewed
ULHT Total	4624	406	4218	3263	**77%**	70%	71%
Lincoln Total	2529	218	2311	1715	**74%**	70%	68%
Pilgrim Total	1822	118	1704	1353	**79%**	70%	74%
Grantham Total	273	70	203	195	**96%**	70%	71%

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

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

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

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

Learning from Deaths National Template

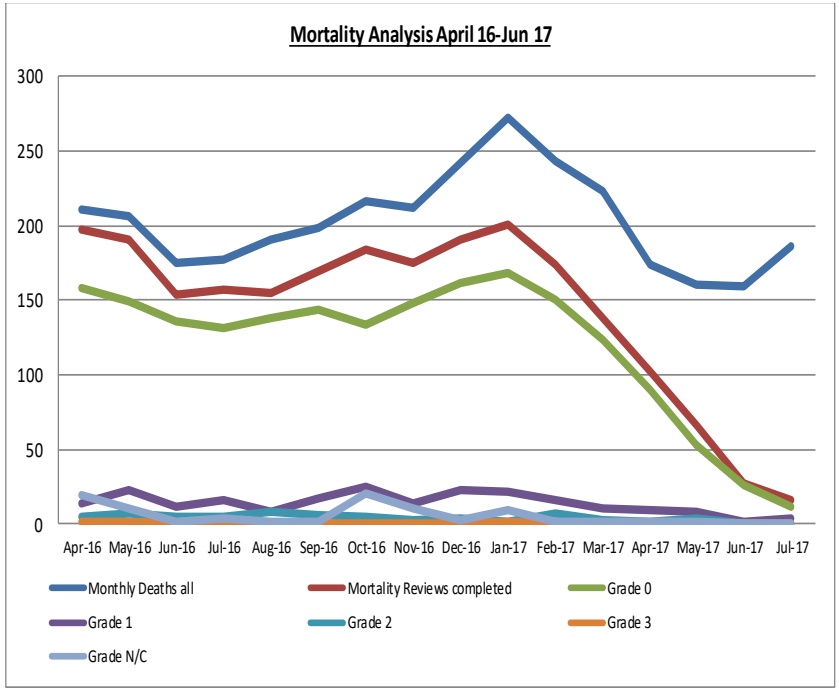
The below template was issued by NHS England and has been redesigned to for our grading. The dashboard will always be a quarter behind due to the timeliness of the reviews. This methodology is based upon the National Learning from Deaths paper published in March 2017. The methodology is based upon a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

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

Total Number of Deaths in Scope	
This Month-Jul 17	Last Month-Jun 17
186	159
This Quarter (QTD) (Apr 17-Jun 17)	Last Quarter (Jan 17-Mar 17)
493	738
This Year (YTD) (Apr 17-Jul 17)	Last Year (Apr 16-Mar 17)
679	2566

Total Deaths Reviewed	
This Month-Jul 17	Last Month-Jun 17
16	27
This Quarter (QTD) (Apr 17-Jun 17)	Last Quarter (Jan 17-Mar 17)
16	195
This Year (YTD) (Apr 17-Jul 17)	Last Year (Apr 16-Mar 17)
211	2086

Total Number of deaths considered to have been potentially avoidable Grade 2&3	
This Month-Jul 17	Last Month-Jun 17
0	0
This Quarter (QTD) (Apr 17-Jun 17)	Last Quarter (Jan 17-Mar 17)
6	12
This Year (YTD) (Apr 17-Jul 17)	Last Year (Apr 16-Mar 17)
6	64



Review Grading

Grade 0	
Unavoidable death, no suboptimal care	
This Month-Jun 17	96%
This Quarter (QTD) (Apr 17-Jun 17)	87%
This Year (YTD) (Apr 17-Jul 17)	86%

Grade 1	
Unavoidable death, suboptimal care but different management would NOT have affected outcome	
This Month-Jun 17	4%
This Quarter (QTD) (Apr 17-Jun 17)	9%
This Year (YTD) (Apr 17-Jun 17)	10%

Grade 2	
Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)	
This Month-Jun 17	0%
This Quarter (QTD) (Apr 17-Jun 17)	3%
This Year (YTD) (Apr 17-Jul 17)	3%

Grade 3	
Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)	
This Month-Jun 17	0%
This Quarter (QTD) (Apr 17-Jun 17)	0%
This Year (YTD) (Apr 17-Jul 17)	0%

Grading not completed	
Not completed in proforma by reviewer	
This Month-Jun 17	0%
This Quarter (QTD) (Apr 17-Jun 17)	1%
This Year (YTD) (Apr 17-Jul 17)	1%

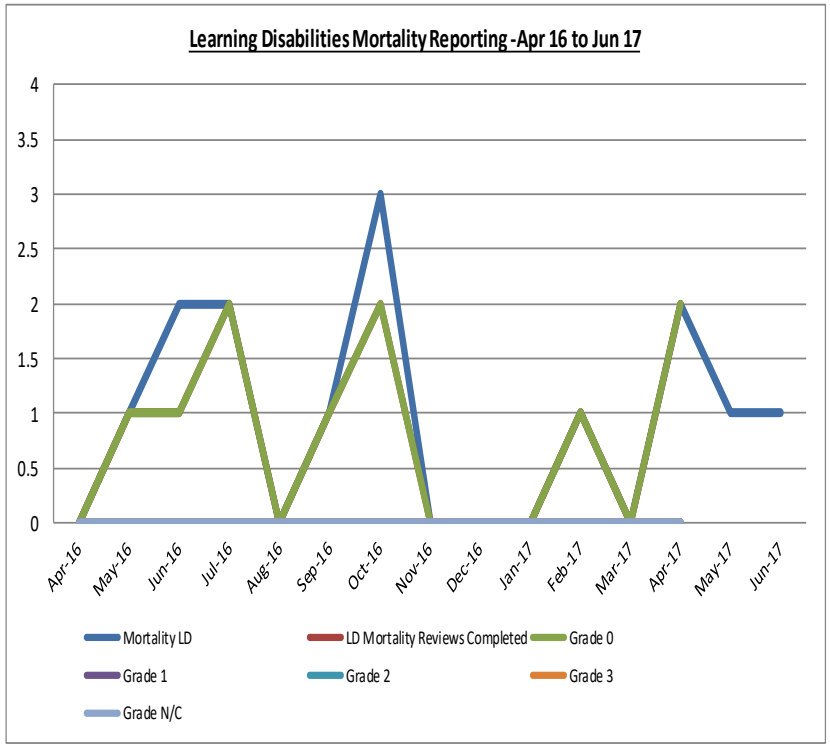
Learning Disability Template

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

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

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

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



Mental Health deaths

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

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

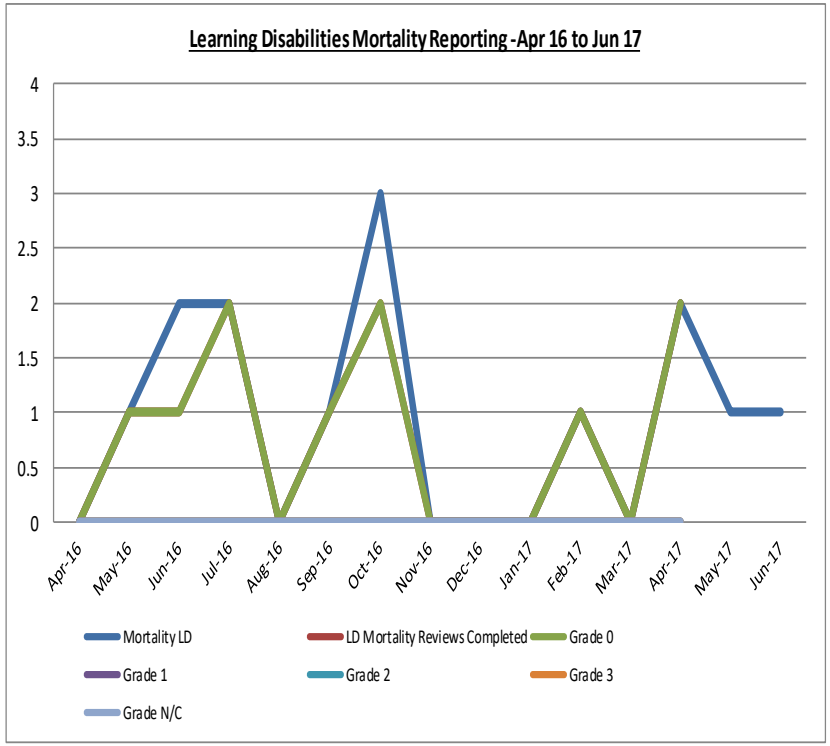
Learning Disability Template

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

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

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

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



Mental Health deaths

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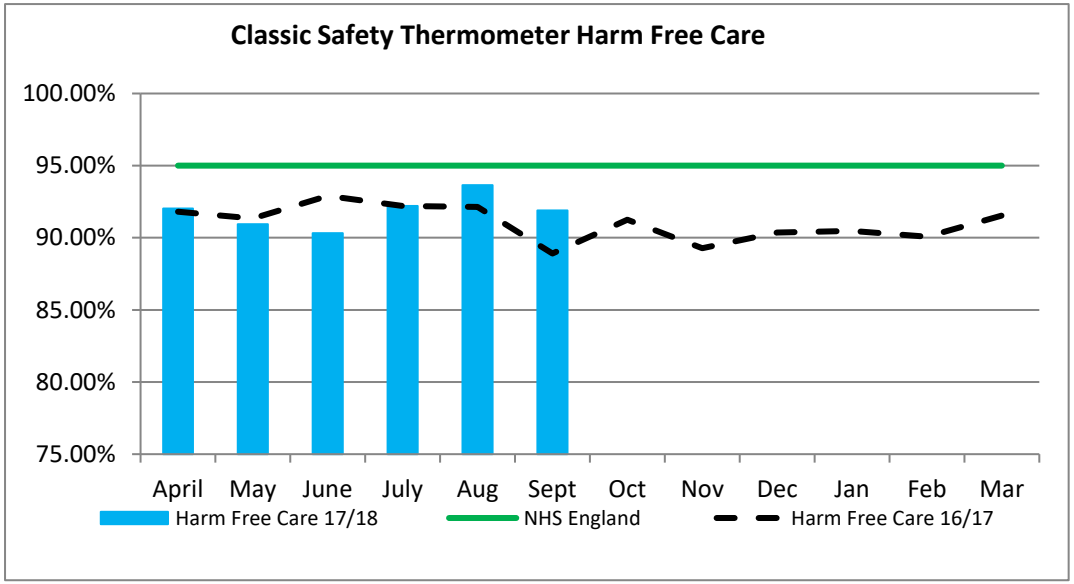
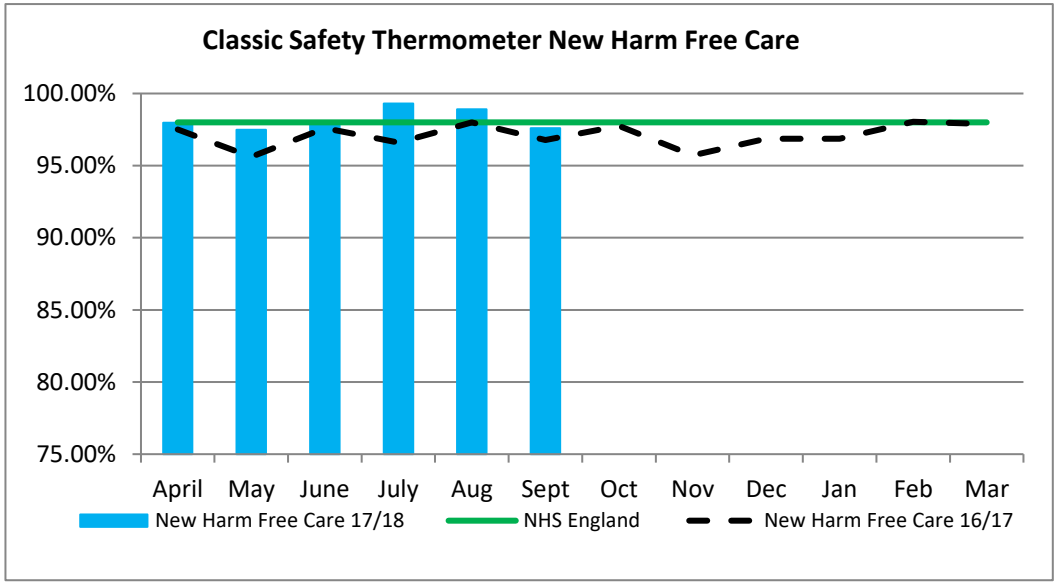
Safe Ambition 2: Reduction of Harm Associated with Harm Free Care

Executive Responsibility: Michelle Rhodes – Director of Nursing





Performance Data Overview September 2017

	ULHT	GDH	LCH	PBH
Harm Free Care	91.9%	91.2%	93.1%	90.3%
New Harm Free Care	97.6%	97.1%	98.1%	97.1%
New Category 2	7	2	1	4
New Category 3	1	0	1	0
New Category 4	1	0	0	0
Low Harm	5	0	0	1
Moderate Harm	0	0	0	0
Severe Harm	0	0	0	0
Catheter & New UTI	1	0	0	1
New VTEs	5	0	2	3
Patients	799	68	421	310

Action Plan

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

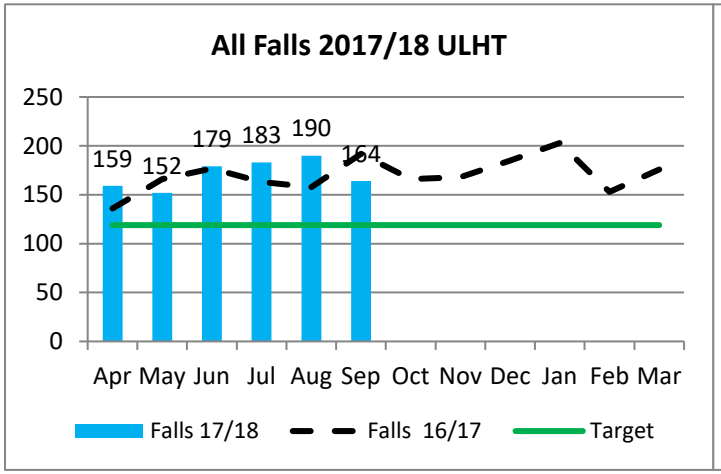
Fall actions outlined within Quality Report (see respective falls page). Results reported upwardly to Falls Reduction Group with delegated authority from Patient Safety Committee.

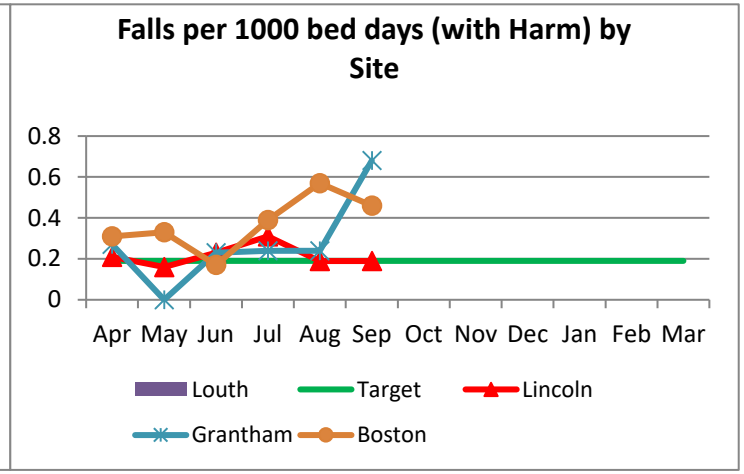
CA-UTI actions outlined within Quality Report (see respective CA-UTI page). . Results reported upwardly to Catheter Reduction Group with delegated authority from Patient Safety Committee.

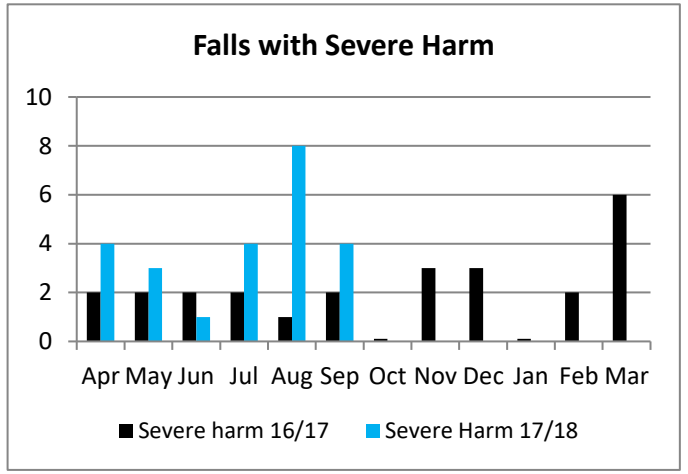
VTE investigated through Route Cause Analysis by VTE Nurse Manager and reported upwardly through Patient Safety Committee.

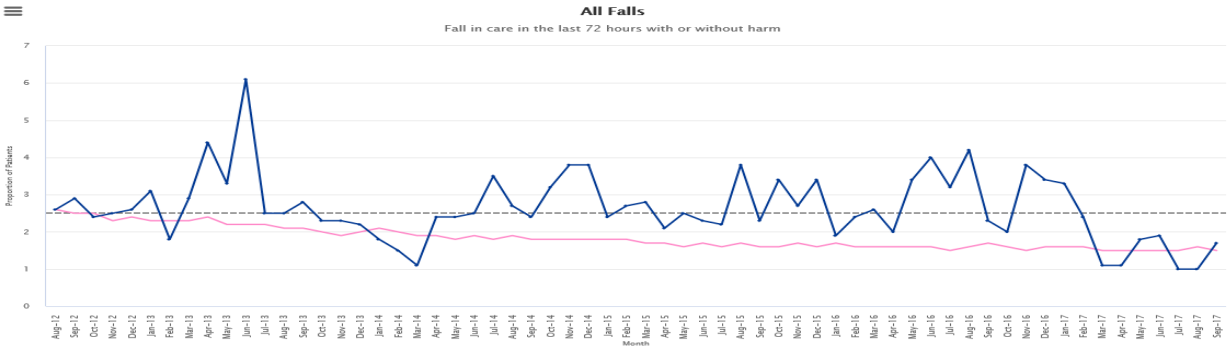
Safe Ambition 3: Reduction of Harm Associated with Falls

Executive Responsibility: Michelle Rhodes – Director of Nursing









Metric Title	Jul 2017	Aug 2017	Sep 2017
Patient at risk of falls	315	320	322
Actions completed within 4 hours	93.4%	93.5%	100.0%
Actions completed within 24 hours of admission	57.8%	63.60%	86.0%
Lying & standing BP completed	71.7%	77.30%	95.7%
Care plan 7 activated	97.5%	96.50%	66.3%
Neuro Cognition Assessed	97.1%	98.70%	94.1%
Vision Assessed	97.5%	98.40%	99.4%
Bed Rails Assessment	99.1%	99.70%	88.3%
Continence/toilet regime documented	91.9%	95%	95.9%

Performance Data Overview September 2017

Falls per 1000 bed days have increased from 3.15 for 2016/17 to 3.33 for April-September 2017, falls with harm have increased from 0.25 to 0.26 for the same periods. When the data is reviewed at site level, Lincoln and Pilgrim have seen a deterioration in falls per 1000 bed days from April-September 2017, however Grantham has seen improvement. Pilgrim has seen a reduction in falls with harm.

Trust and site incident of falls Sept 2017

Sep-17	Trust	Lincoln	Pilgrim	Grantham
Ward Falls per 1000 bed days	3.32↓	3.16↓	3.77↓	2.73↓
rm p		↑	0.46↓	0.68↑

ULHT Performance

National Performance

ith s N/Welton, 7A and Stroke Unit Pilgrim.

RCA investigations will be completed and reviewed at scrutiny panel.

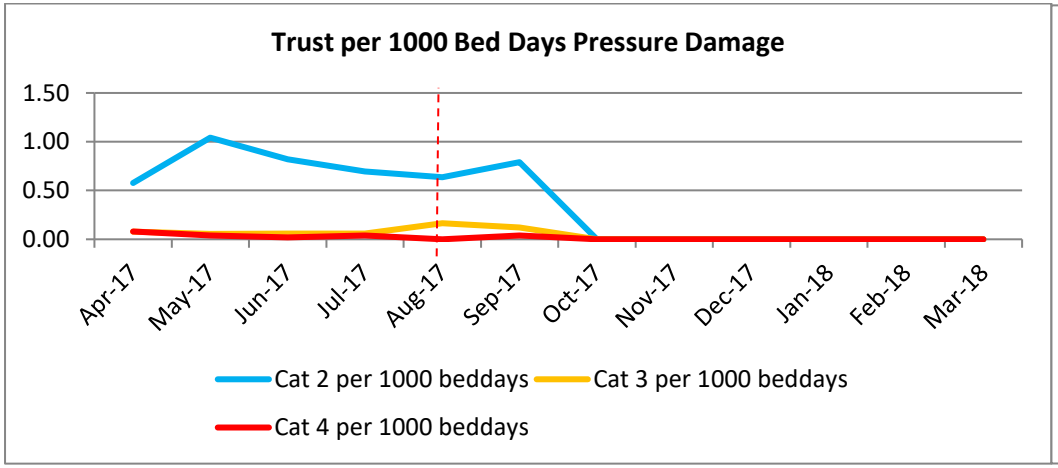
Action Plan

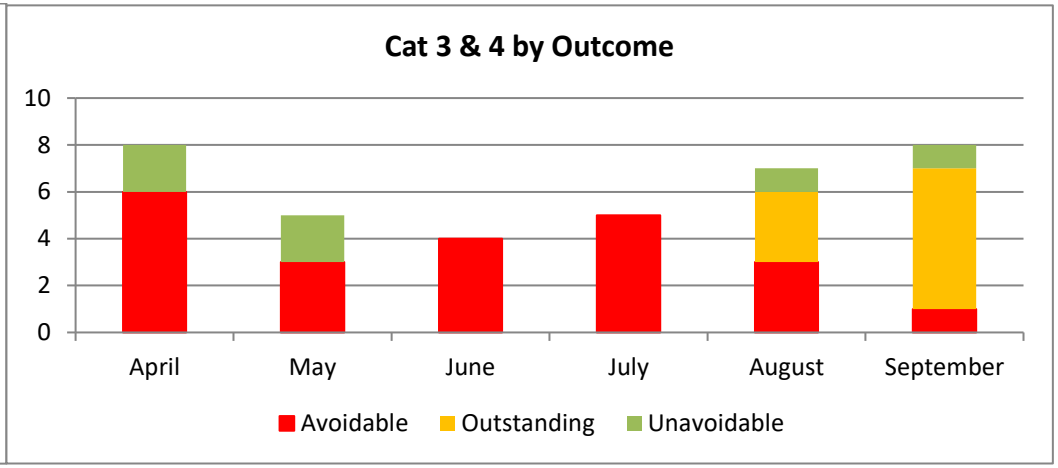
- Introduction of scrutiny process for patients who have 3 or more falls being planned
- Rollout of NHSi falls prevention collaborative work – prioritising completion of workbook and completion of lying and standing BP
- Develop ward trajectories for completion of lying and standing BP and for completion of actions within 24 hours of admission
- Patient safety brief to share lessons learnt with all professions
- E-learning programme being developed to compliment workbook
- Call don't fall posters being developed
- Ward accreditation standard for falls developed – WA launched September

ULHT Performance National Performance	• Collaborative working with CAUTI group to ensure falls risk considered when TWOC undertaken

Safe Ambition 4: Reduction of Harm Associated with Pressure Ulcers

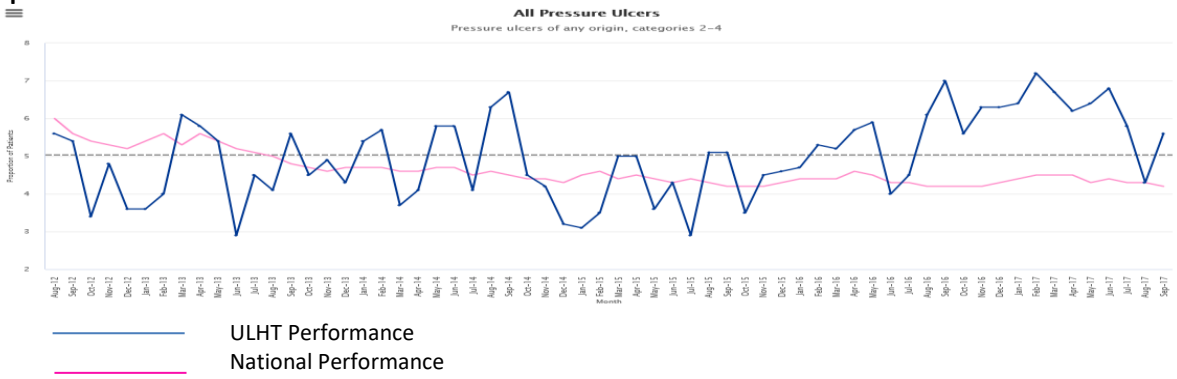
Executive Responsibility: Michelle Rhodes – Director of Nursing





Reporting function changed to Datix August 2017

Safety Thermometer 2017 Sept 2017



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

Metric Title	Jul 2017	Aug 2017	Sep 2017
Pressure area risk assessment completed within 4hrs	95.9%	97.70%	96.6%
Pressure area risk assessment updated weekly	83.5%	84.10%	79.9%
Pressure-relieving equipment in situ if required	96.8%	95.80%	94.8%
Frequency of repositioning documented	83.4%	85.60%	93.8%
Prescribed frequency of turning has been followed for last 24 hours	85.7%	76.90%	91.8%
Pressure area care plan activated if required	93.6%	94.70%	93.2%

Performance Data Overview September 2017

Site	Cat 1	Cat 2	Cat 3	Cat 4
Lincoln	6	12	4	0
Boston	11	27	2	2
Grantham	1	0	0	0

Data suggests continued underreporting of cat 1 PUs since Datix became the sole reporting system from August however time required for the system to be embedded. 2 cat 4 PUs were reported in Sept (5B &

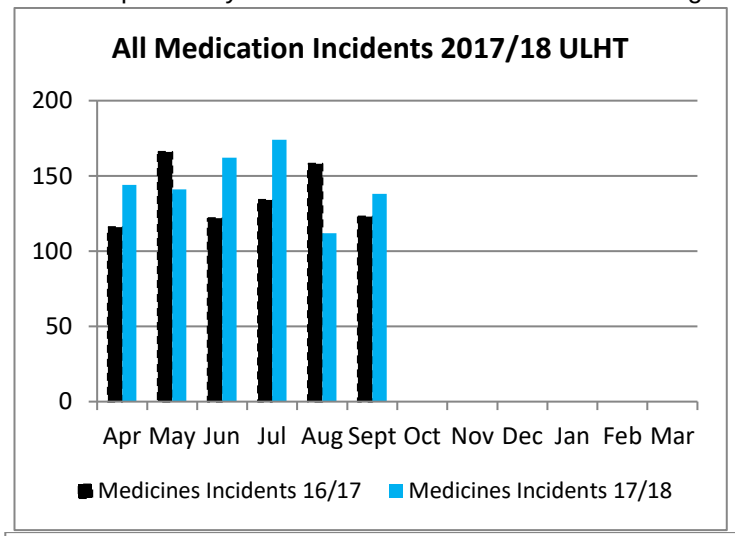
Action Plan

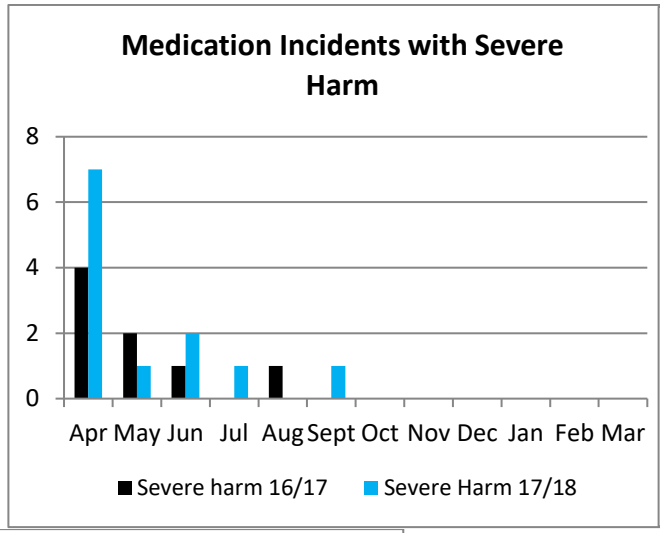
- Targeted work to be undertaken with Shuttleworth and 8A staff, and with ward teams where cat 3&4 PUs continue to be reported
- Investigation tool for cat 2 PUs launched October 2017
- Patient safety brief October 2017 to remind staff to complete Datix for all PUs
- Pressure ulcer prevention meetings re-established on the Lincoln & Pilgrim sites

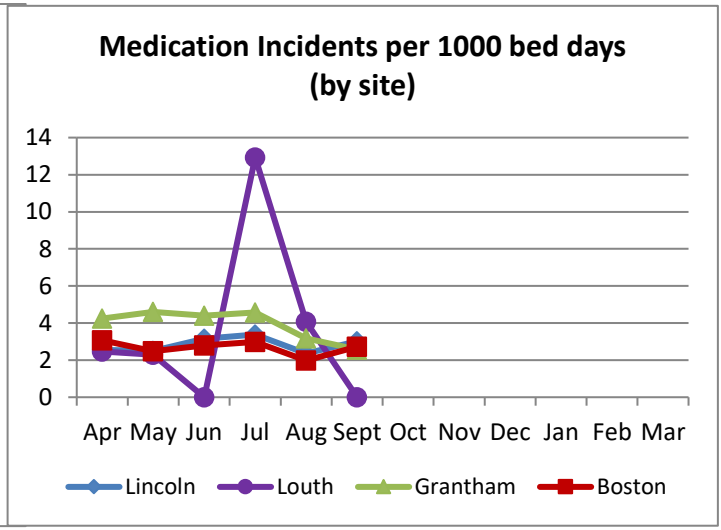
6B) compared to nil in August. 6 cat 3 PUs were reported in September (Dixon x2, Hatton, Greetwell, 7A and ITU) compared to 5 in August. Scrutiny panels are being held to determine availability. Highest incidence of avoidable cat 3 & 4 pressure damage since April has been reported on Shuttleworth who have reported 4 avoidable cat 3 PUs, and 8A who have reported 3 avoidable cat 4 PUs with an additional cat 3 PU scrutiny panel outcome pending. GDH have reported no cat 3 or 4 PUs since and Jan 2017.	• PDSA PU prevention project to commence on the Pilgrim site and poster competition planned by HoN • Additional training provided for HCSWs • Newsletter produced and circulated to share lessons learnt from scrutiny panels • Additional education to be undertaken in A&E & emergency assessment units • Stop the pressure awareness campaign being planned for Nov

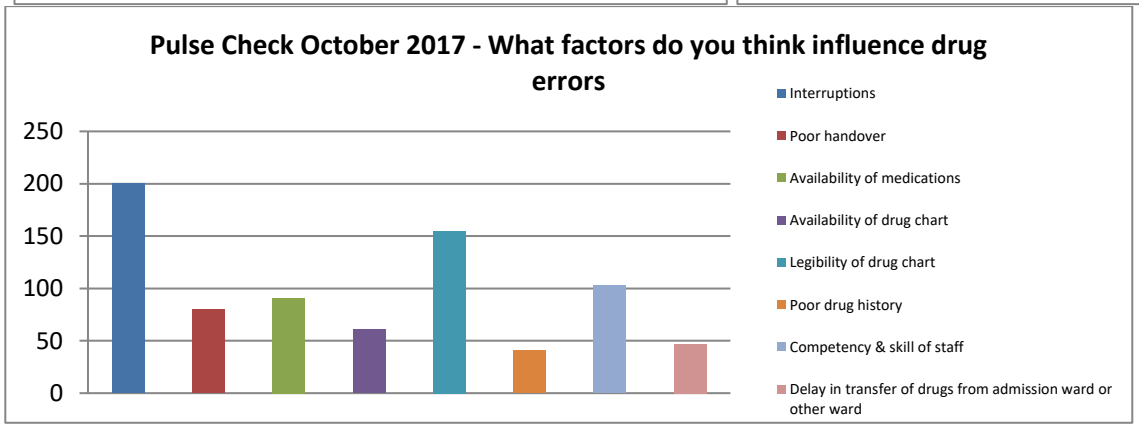
Safe Ambition 5: Reduction of Harm Medication Incidents

Executive Responsibility: Michelle Rhodes – Director of Nursing









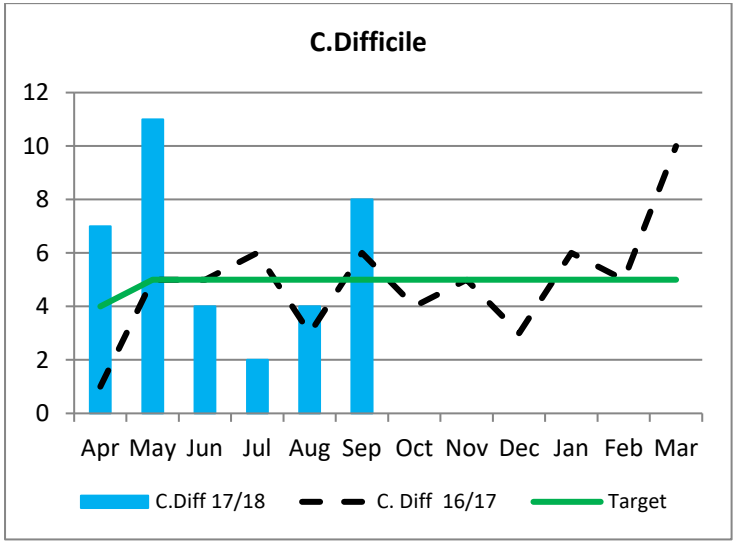
Safety Quality Dashboard (SQD) Dashboard for Medications Jul 2017- Sept 2017

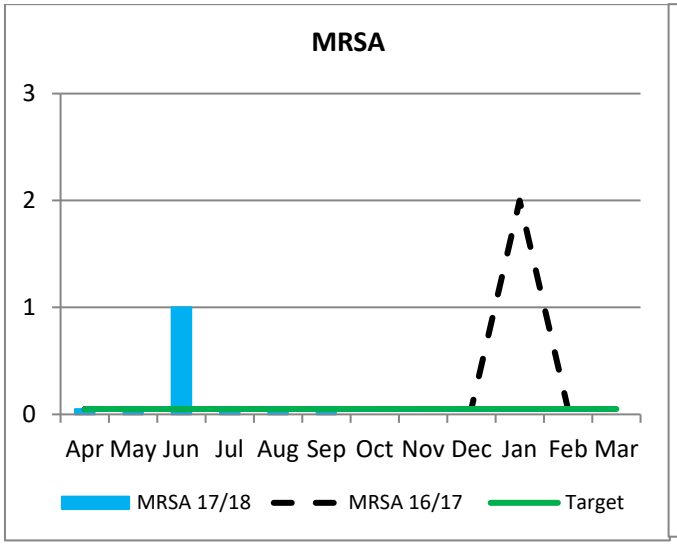
Metric Title	Jul 2017	Aug 2017	Sep 2017
Medicine chart demographics correct	98.2%	96.60%	97.8%
Allergies documented	100%	98.10%	100.0%
All medicines administered on time	84.7%	85.70%	83.9%
Allergy nameband in place if required	76.7%	85.30%	84.3%
Identification namebands in situ	96.7%	97.90%	98.7%

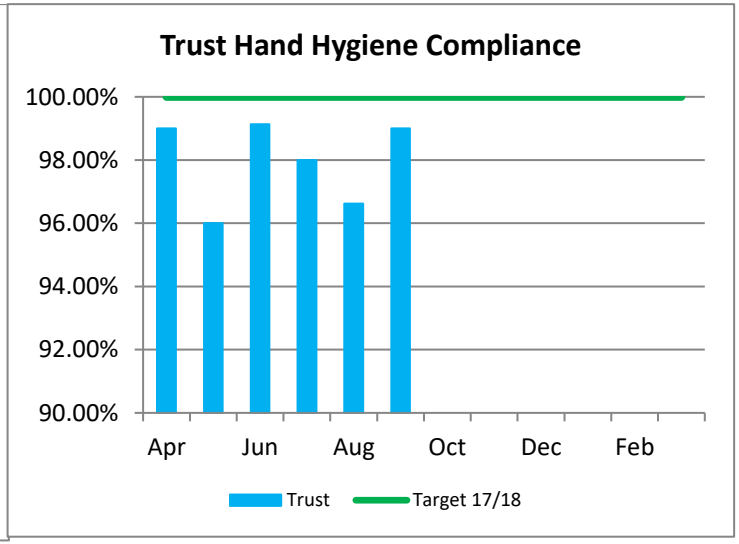
Performance Data Overview September 2017	Action Plan
Of the 138 incidents reported 86% (119/138) were classed as resulting in no harm. 58% (80/138) of all the events recorded were associated with high risk drugs. The top 4 drug groups are; anticoagulants (24%), opiate (22%), antimicrobials (14%) and insulin and antidiabetics (14%). 30% (42/138) of all incidents reported were due to medicines being omitted. Omissions of medicines are reported for several reasons. 17% (7/42) resulted in some level of harm to the patient.	This report is reviewed at the Medicine Optimisation and Safety Committee and all incidents are reviewed on a monthly basis to identify trends. All Heads of Nursing receive the errors by ward area and disseminate to their matrons who in turn disseminate to their ward leaders. These all must be looked into regardless of the severity rating. Feedback reports from the Heads of Nursing are required to provide assurance that investigations and discuss have taken place.

Safe Ambition 6: Reduction of Harm Associated with Infection

Executive Responsibility: Michelle Rhodes – Director of Nursing







Performance Data Overview September 2017

Hand Hygiene	
Target	99.00%
Grantham	100.00%
Lincoln	99.75%
Louth	98.62%
Pilgrim	100.00%

8 reported cases of C.Diff >72 hours in September. The cases were reported on ACU, Grantham (1), Navenby Ward Lincoln (2), Greetwell Ward Lincoln (1), 7B Boston (2), ICU Boston (1) and 5A Boston (1).

2 patients (1 Boston/1 Grantham) with suspected Tuberculosis, subsequent investigations have identified areas for improvement in respect of prompt isolation and appropriate ward placement. Where highly pathogenic conditions are suspected teams have been reminded to liaise with Infection Prevention and Control for specialist input.

Action Plan

C.Diff rates have increased. This is being addressed through the C.Diff recovery meeting. Discussion with Public Health England indicate that although C.Diff rates are organisationally in excess of agreed trajectory ULHT performance is favourable against other acute trusts in the East Midlands and nationally.

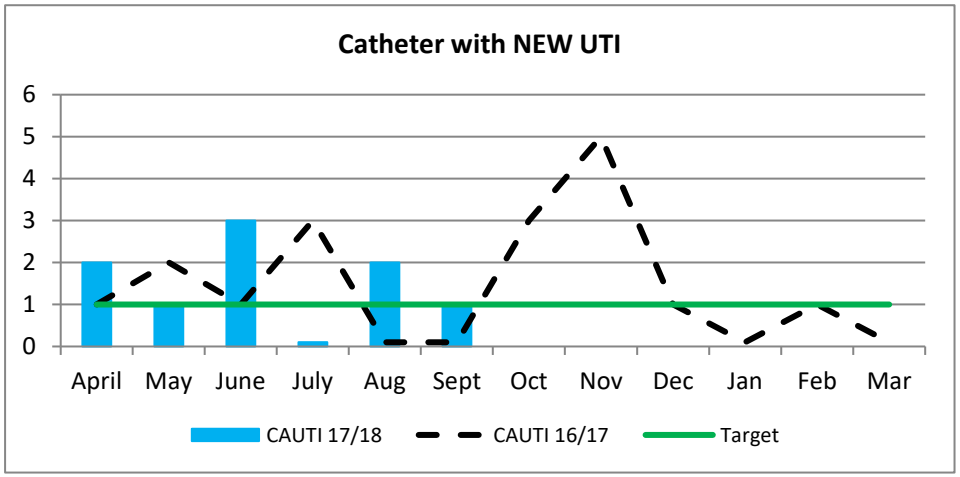
Infection Prevention and Control focus week will commence on 16th October with prepared key messages for each day.

New uniform policy to be launched on 17th November 2017 as part of above focus week.

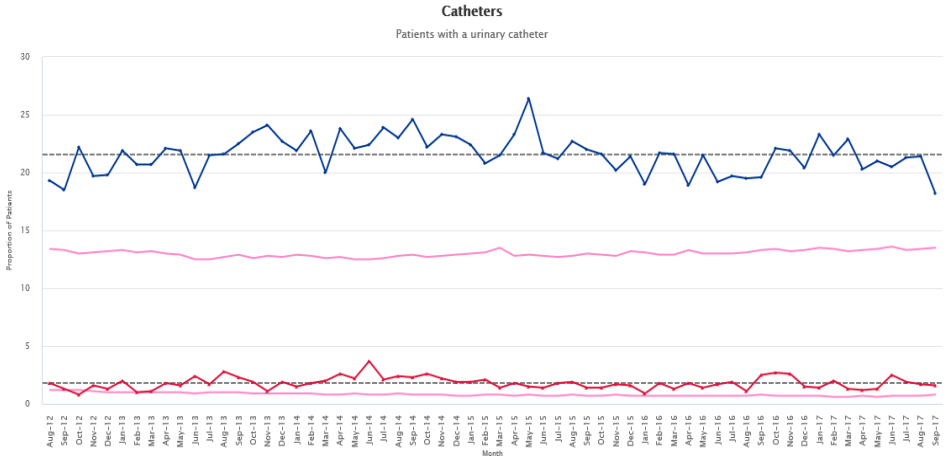
Patient Safety Briefing to be circulated in relation to appropriate placement and isolation of Tuberculosis patients. The Infection Prevention and Control team are revisiting organisational policies and procedures in respect of barrier nursing and actively contributing to the development of countywide guidance on management and treatment of Tuberculosis

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

Executive Responsibility: Michelle Rhodes – Director of Nursing



Safety Thermometer catheters 2017



Safety Quality Dashboard (SQD) for Trust catheter care Jul 2017- Sept 2017

Metric Title	Jul	Aug	Sep

	2017	2017	2017
Number of urinary catheters in-situ	89	89	82
Urinary catheter record demographics correct	93.3%	93.30%	92.6%
Urinary catheter record completed &signed daily	69.7%	62.10%	68.8%
TWOC occurred within 3 days for acute retention	50%	27.30%	30.0%
Documented evidence why catheter needed	93.3%	89.90%	93.8%

Performance Data Overview September 2017

	Metric Title	Jul 2017	Aug 2017	Sep 2017
Boston	Catheter record completed & signed daily	51.4%	53.1%	56.7%
Grantham		90.9%	87.5%	100.0%
Lincoln		79.1%	63.8%	73.3%
Boston	TWOC within 3 days for acute retention	33.3%	0.0%	0.0%
Grantham		-	-	100%
Lincoln		80.0%	42.9%	50.0%

The data indicates ULHT inserts more catheters and has more NEW UTIs than the national average. Trust performance for September 2017 remains consistently below Trust aspiration of 90% against all urinary catheter metrics. Areas of particular concern are inconsistent daily completion of catheter care bundle and trial without catheter (TWOC) at Lincoln and Boston.

Action Plan

Implementation of Datix form for CAUTI with an investigation outcome (1st September 2017) to determine avoidability and lessons learned. This applies to all patients with a catheter in situ where they are either symptomatic of, or are receiving treatment for, a UTI.

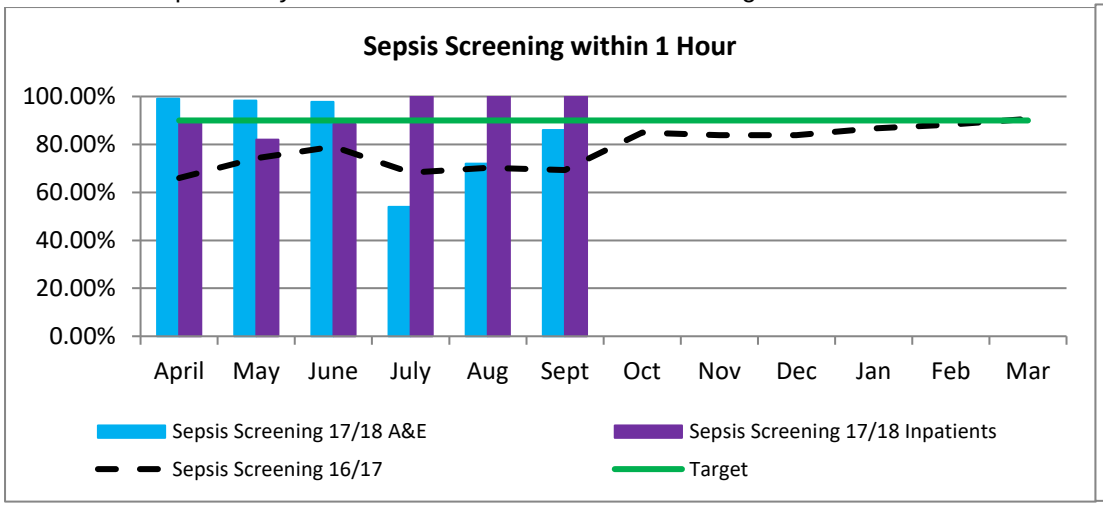
Develop a culture of accountability when providing catheter care by establishing achievable catheter insertion parameters for specific areas in our trust and disseminate in appropriate leaders forums.

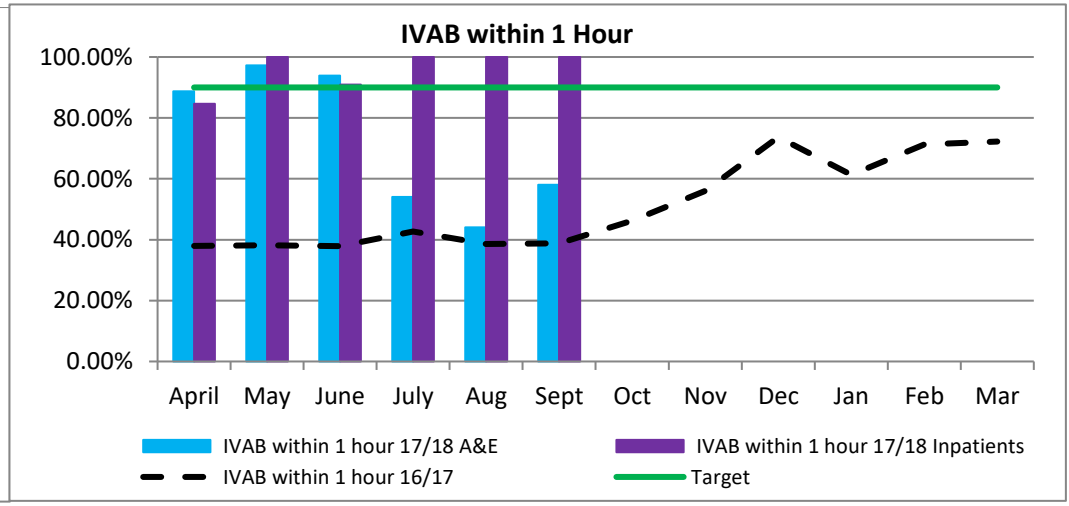
Relaunch of Link Nurse/Ambassador Programme (October 2017) in conjunction with Ward Accreditation event (18th September 2017) to highlight specific metrics on continence promotion and increase awareness regarding catheter care.

Teaching regarding catheter care will be delivered through Catheter Focus Sessions (October 2017) led by Continence Specialist Nurses with focus on appropriate insertion and TWOC for all health care professionals, and development of E-Learning recommended by Core Learning Panel as Essential Skill training for those undertaking catheter care.

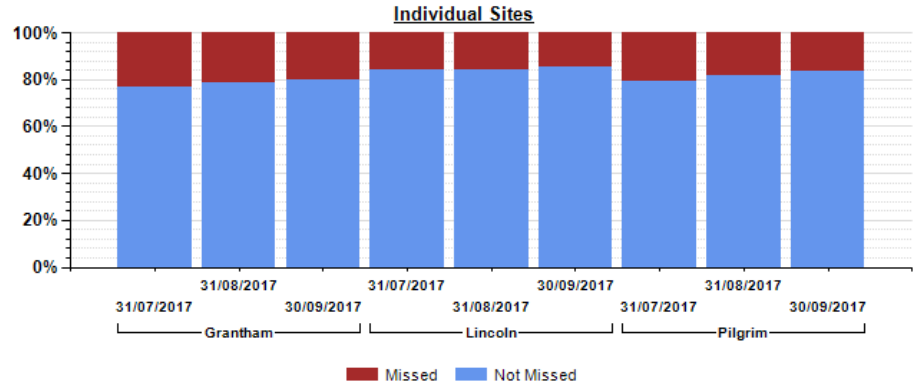
Safe Ambition 7: Reduction of Harm Associated with Deterioration Sepsis

Executive Responsibility: Michelle Rhodes – Director of Nursing

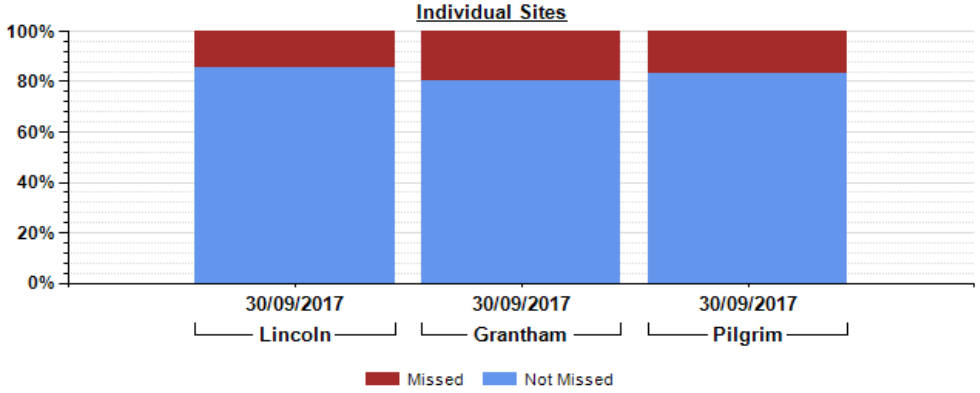




Patient Electronic Observations (Trust) Jul-Sep 2017



Patient Electronic Observations (Site) September 2017



Performance Data Overview September 2017

A&E Target 90%	**Screening –September 17**	**IVAB within 1 hour – September 17**
Trust	86%	100%
Inpatients Target 90%	**Screening – September 17**	**IVAB within 1 hour – September 17**
Trust	58%	100%

Sepsis E-Learning 90.12%

Action Plan

Safety Brief clarifying and outlining approach to sepsis screening due to go out this week – ALL PATIENTS WITH NEWS ≥ 5 SHOULD BE SCREENED – DRs CANNOT OVERULE THE NEED TO COMPLETE A SEPSIS SCREEN.

Review Template disseminated to all Ward Managers to ensure themes can be identified and acted upon when screens are missed or bundles not completed – these are to be completed on a monthly basis

Improvement Plans in place to combat issues within A&E's, in relation to patients being allocated to web-v in a timely manner.

Workforce Headline Summary

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

Statistics

KPI	2017/18 Target	September 2017 Performance	Last Month Performance	Performance in September 2016	6th Month Trend
Vacancy Rate - Medical	Medical – 12%	**16.08%**	**16.43%**	**13.57%**	
Vacancy Rate – Registered Nurses	Reg Nursing 11.5%	**12.87%**	**15.50%**	**11.87%**	
Vacancy Rate – AHP's	10%	**8.87%**	**10.64%**	**10.79%**	
Voluntary Turnover	7%, with no group of staff more than 20% above the overall target	**5.32%**	**5.52%**	**n/a**	**n/a**
Quarterly Engagement Index	10% improvement in average score during 2017/18	**3.3**	**3.4 (last pulse check)**	**n/a**	
Quality of Leadership/Management Index	10% improvement in average score during 2017/18	**2.6**	**2.8 (last pulse check)**	**n/a**	
Core Learning Completion	Overall target remains 95%.	**89.63%**	**90.58%**	**86%**	
Sickness Absence (12 month rolling average)	Overall target of 4.5% + no team over 25% above target	**4.73%**	**4.68%**	**4.52%**	
Appraisals - Medical	Medical – 95%	**95%**	**96%**	**91%**	
Appraisals – Non Medical	Non-medical	**80.10%**	**82.24%**	**68.66%**	
Agency Spend	£25.4m (£2.005m in September)	**£2.423m**	**£2.597m**	**£2.172m**	

Commentary

Vacancy rates have reduced in the last month. The most significant reduction is in AHP recruitment. We indicated at the start of the year that this was an area to focus on as it was relatively easy to recruit to these posts. The recent cohort recruitment exercise for AHP posts resulted in 22 appointments and these are yet to show in the above figures.

The improvement in the Registered Nursing rate reflects the fact that 83 newly-qualifies nurses started with us in September.

The in-month agency spend was considerably higher than the target. There was a reduction in spend on medical and nursing agency. The incentivisation of bank has had an impact on nursing agency spend and seven medical staff will transfer onto permanent contracts on 1st October. The spend on "other" agency grew in September, but all spend in that area will have been challenged by the end of October and a reduction in overall spend should result.

Although the 12 monthly rolling average sickness rate increased this month the winter of 2016/17 had a significantly higher absence rate than previous years. If sickness this coming winter returns to previous levels we should see a reduction in the 12 month rolling average by the end of the financial year. It should though be noted that flu was not a significant factor last year and it was a mild winter.

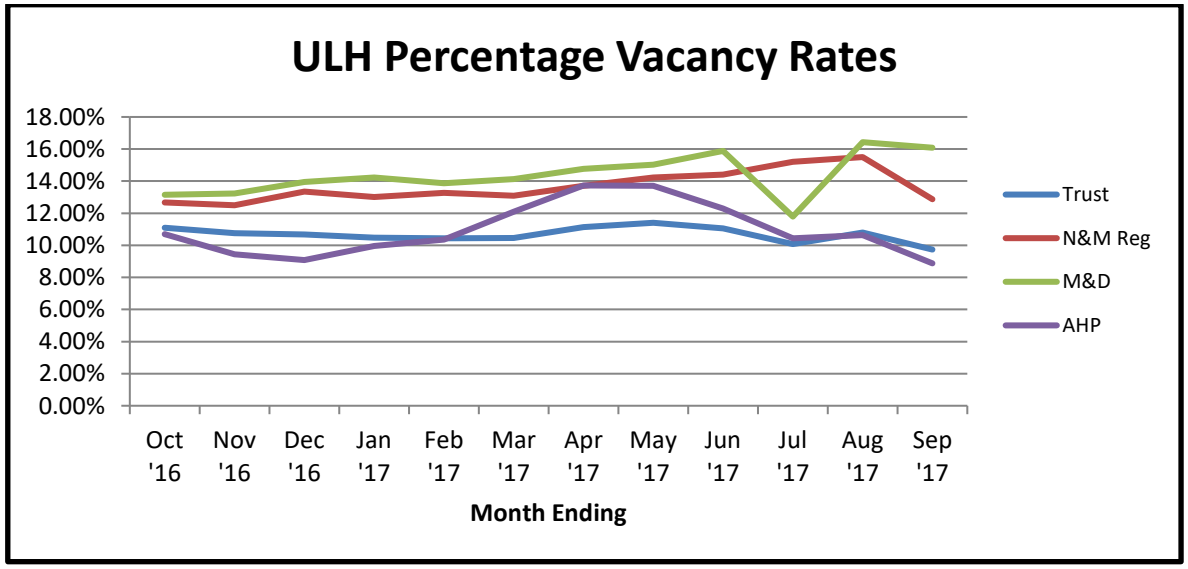
The dip in core learning and appraisal rates continued in September and it is evident that we need to renew our focus in these areas if we are to continue the upward trend in compliance rates previously seen.

Vacancy Rates

KPI:	Vacancy rates	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Deputy Director of HR & OD
Date:	11th October 2017	Reporting Period:	September 2017
Target:	Medical – 12% Registered Nursing – 11.5% AHPs – 10%	Tolerances:	Within 1% - Amber Above 1% - Red
RAG Rating:	Medical 16.08%		
RAG Rating:	N&M 12.87%		
RAG Rating:	AHP's 8.87%		

Analysis

The current overall Trust vacancy rate (September) is 9.73%, which is a reduction of 1.07% on September. Much of this can be accredited to the new intake of newly qualified nurses which has seen a net increase of 60.90 wte Nurses and Midwives in-post. This has had the impact of reducing the vacancy rate for the N&M Reg staff group from 15.50% to 12.87%. The Allied Health Professional staff group has also seen a reduction in the vacancy rate, down from 10.64% in August to 8.87% in September, and is now below target.



Vacancy rate Comparison

	Sept '17	Aug '17	Sept '16
Trust	9.73%	10.80%	10.54%
Medical & Dental	16.08%	16.43%	13.57%
Registered Nursing	12.87%	15.50%	11.87%
AHP's	8.87%	10.64%	10.79%

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

- more registered Nurses working for us than we did in September 2016;
- more Consultants working for us than in September 2016;
- more unregistered Nurses working for us than in September 2016.

In addition the Trust has 368.01 wte AHPs, compared to 346.15 at the start of the financial year.
The table below shows the current recruitment pipeline:

Hard to fill roles	WTE Vacancies @w/e 29/9	WTE under offer of employment but not yet started - INTERNAL	WTE under offer of employment but not yet started - EXTERNAL	WTE roles at either advert / shortlisting / interview stage	WTE roles resourcing team engaging with agency providers (as instructed by Business Units)	WTE roles not being actively recruited to
Consultants	46.85	1	15.5	11.65	5	13.7
Middle Grade Doctors	42.75	0	21	19	4	-1.25
Doctors in Training	60.45	0	10	9	0	41.45
Registered Nurses	294.93	13.61	29.77	89.03	0	162.52
AHPs (registered)	42.97	3.2	7	3	0	29.77
Non- registered Nurses	72.43	8.48	27.62	10.31	0	26.02
Totals	**560.38**	**25.29**	**110.89**	**141.99**	**9**	**272.21**

It shows a significant number of people in that pipeline, which, if they translated into starters would make a significant impact on our position. As an example if we do not include any of the medical roles which were not ‘actively recruiting’ to, this would reduce the medical vacancy rate to just above 10%. We are also exploring why there are a number of roles where no active recruitment is underway.

Action Taken	Action Planned
• New approach to employment references implemented to speed up the recruitment process; • Review of East of England Procurement Hub suppliers for permanent Recruitment for doctors and nurses completed (Total of 150+ agencies included in process across EoE region). Renegotiated fees and charges across 12 agencies identified as first tier providers; • 80 CVs provided for roles identified as hard to fill.	• Deliver the actions identified in the 2017/18 Trust Recruitment Plan (reported into Workforce and OD Committee); • Nursing to take a business case to fund agency costs to help recruit Nurses. • Attending BMJ Recruitment Fair (20th/21st October) • Explore reason/s why a number of posts are not actively being recruited to

Nursing Workforce report

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

Day		Night	
Average Fill rate- Registered Nurses/ Midwives (%)	Average fill rate – care staff (%)	Average Fill rate- Registered Nurses/ Midwives (%)	Average fill rate – care staff (%)
86.54 (86.95)	99.77 (99.20)	92.73 (90.15)	99.78 (103.02)

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

Table Two:

Site	Day		Night	
	Average Fill rate- Registered Nurses/ Midwives (%)	Average fill rate – care staff (%)	Average Fill rate- Registered Nurses/ Midwives (%)	Average fill rate – care staff (%)
GDH	88.67 (89.92)	104.74 (100.22)	91.20 (87.64)	95.00 (91.81)
LCH	88.46 (89.20)	99.30 (99.80)	92.70 (90.61)	98.01 (103.31)
PHB	83.68 (83.55)	99.27 (98.28)	93.14 (90.05)	103.48 (105.61)

NQB Average Fill Rates for Registered and Unregistered Staff July 2017 by Nursing/Children & Midwifery

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

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals
Grantham	88.67%	104.74%	91.20%	95.00%	94.00%
Lincoln	88.00%	99.89%	94.23%	96.71%	93.37%
Pilgrim	83.59%	103.67%	93.57%	107.95%	94.04%
Trust	86.37%	101.94%	93.71%	100.69%	93.68%

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

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals
Grantham	n/a	n/a	n/a	n/a	n/a
Lincoln	91.35%	94.67%	76.84%	130.30%	90.57%
Pilgrim	81.60%	62.95%	87.26%	68.69%	76.92%
Trust	86.09%	77.85%	81.32%	93.26%	83.56%

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

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals
Grantham	n/a	n/a	n/a	n/a	n/a
Lincoln	94.03%	96.86%	94.31%	94.66%	95.05%
Pilgrim	88.74%	97.86%	96.12%	83.74%	91.99%
Trust	91.03%	97.06%	95.44%	92.48%	93.69%

Table Three: September 2017 vacancy position

VACANCY POSITION						
	Jul-17		Aug-17		Sep-17	
	Data from Payroll		Data from Payroll		Data from Payroll	
	R	UR	R	UR	R	UR
Lincoln	94.22	27.71	89.61	21.22	60.99	23.27
Pilgrim	99.07	9.60	103.04	10.60	86.50	6.51
Grantham	20.90	-0.21	23.14	0.35	19.51	-0.34
Main Site Nursing & Midwifery Sub-total	**214.19**	**37.10**	**215.79**	**32.17**	**167.00**	**29.44**
Paediatrics & Neonatal	21.36	1.04	23.85	0.04	23.26	-1.09
Obs & Gynae	5.83	3.55	6.82	2.55	4.82	1.16
Total	**241.38**	**41.69**	**246.46**	**34.76**	**195.08**	**29.51**
Nursing & Midwifery In Post	832.80	525.07	822.46	526.74	873.84	531.99

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

Staff Group	Week Commencing →	04/09/2017	11/09/2017	18/09/2017	25/09/2017
Nursing, Midwifery & Health Visiting	Framework only	0	0	0	0
Nursing, Midwifery & Health Visiting	Price cap only	361	376	360	394
Nursing, Midwifery & Health Visiting	Both framework & price cap	0	0	0	1
Healthcare assistant and other support	Framework only	0	0	0	0
Healthcare assistant and other support	Price cap only	0	0	0	0
Healthcare assistant and other support	Both framework & price cap	0	0	0	0

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

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

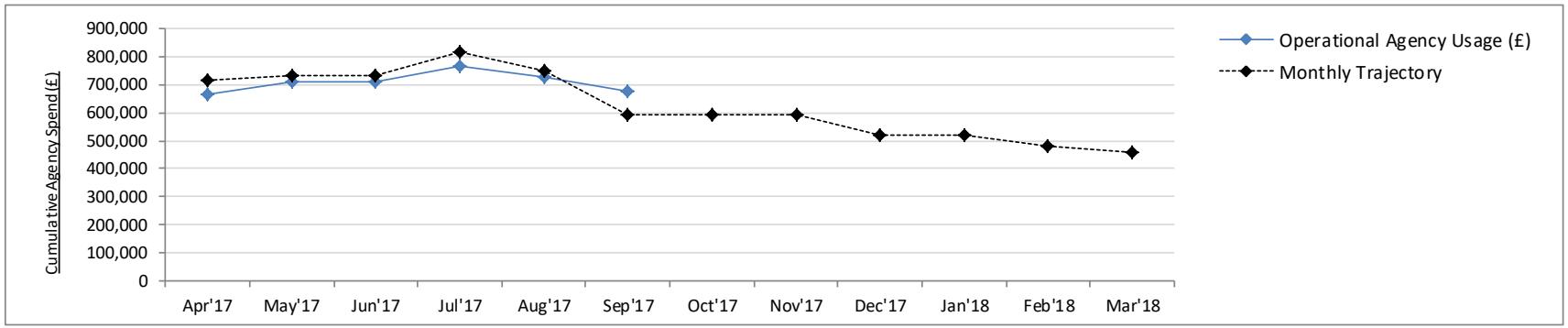
A	DZ	EA	EB	EC	ED	EE	EF	EG	EH	EI	EJ	EK	EL	EM	EN	EO	EP	EQ
Date	13/09/2017	14/09/2017	15/09/2017	16/09/2017	17/09/2017	18/09/2017	19/09/2017	20/09/2017	21/09/2017	22/09/2017	23/09/2017	24/09/2017	25/09/2017	26/09/2017	27/09/2017	28/09/2017	29/09/2017	30/09/2017
Day	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Site	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln
Unfilled Bank requests	148	117	213	329.5	279.5	162.5	199.15	235	205	302.5	342	309	241.75	114.5	124	143.25	202	267
Filled temp staffing	384	475.5	433.5	385.8	438	402.5	441	388.5	372	424.5	399.25	508	328.5	427	520.5	463.45	391	445
Agency	222.5	351	332	246	272.5	197.5	293.5	258.5	260	283	240.5	283	204.5	279	316.5	340	276	233.5
Total registered hours	2039	2089	2004	1794	1886	1883	1970	1953	1970	1929	1830	1863	1926	2089	2105	2060	1953	1952
Planned staffing on template	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195
Required staffing	2186.5	2206	2216.5	2123.3	2165.66	2045.98	2168.65	2187.5	2175	2231.05	2171.75	2172	2167.75	2203.5	2228.5	2203.7	2155	2218.5
Contracted hours	1654.5	1613.5	1570.0	1408.0	1448.2	1481.0	1528.5	1564.0	1598.0	1504.1	1430.5	1355.0	1597.5	1662.0	1584.0	1597.0	1562.0	1506.5
Contracted staff Percentage	76%	73%	71%	66%	67%	72%	70%	71%	73%	67%	66%	62%	74%	75%	71%	72%	72%	68%
Total temp percentage	19%	23%	22%	22%	23%	21%	22%	20%	19%	22%	22%	27%	17%	20%	25%	22%	20%	23%
Bank percentage	8%	6%	5%	8%	9%	11%	7%	7%	6%	7%	9%	12%	6%	7%	10%	6%	6%	11%
Agency percentage	11%	17%	17%	14%	14%	10%	15%	13%	13%	15%	13%	15%	11%	13%	15%	17%	14%	12%
Total bank requests	532	592.5	646.5	715.3	717.5	565	640.15	623.5	577	727	741.25	817	570.25	541.5	644.5	606.7	593	712
Percentage bank fill	72%	80%	67%	54%	61%	71%	69%	62%	64%	58%	54%	62%	58%	79%	81%	76%	66%	63%
Total percentage staffing against required	95%	96%	92%	88%	90%	94%	93%	91%	92%	89%	88%	90%	91%	96%	96%	95%	93%	91%
Total substantive and bank	1816	1738	1671.5	1547.8	1613.66	1685.98	1676	1694	1710	1645.55	1589.25	1580	1721.5	1810	1788	1720.45	1677	1718
Total percentage staffing without agency	84%	79%	76%	74%	76%	83%	78%	78%	79%	75%	75%	74%	80%	83%	81%	78%	78%	79%
Date	13/09/2017	14/09/2017	15/09/2017	16/09/2017	17/09/2017	18/09/2017	19/09/2017	20/09/2017	21/09/2017	22/09/2017	23/09/2017	24/09/2017	25/09/2017	26/09/2017	27/09/2017	28/09/2017	29/09/2017	30/09/2017
Day	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Site	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston
Unfilled Bank requests	89.5	54	115	159	153.5	115	81	152.5	71	195	229	143.5	222	95.3	123	84	225.5	191
Filled temp staffing	292.5	335.5	333	343	347	298.5	348	303.5	433	281	162	236.5	287.2	336.7	316.16	386	294.16	304.5
Agency	213.5	213.5	259.5	243	183.5	190.5	239.5	215.5	280	194	91	137.5	204.5	236.5	205.5	269.5	227	149.5
Total registered hours	1292.75	1338.75	1365	1294	1320.25	1334	1444.25	1359.5	1412	1306	1218	1293	1240	1387	1381.5	1419	1288.15	1253
Planned staffing on template	1553.5	1553.5	1553.5	1553.5	1553.5	1553.5	1553.5	1553.5	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0
Required staffing	1382.25	1392.75	1480	1453	1473.75	1449	1525.25	1512	1483	1501	1447	1436.5	1462	1482.3	1504.5	1503	1513.65	1444
Contracted Hours	1000.3	1003.3	1032.0	951.0	973.3	1035.5	1096.3	1056.0	979.0	1025.0	1056.0	1056.5	952.8	1050.3	1065.3	1033.0	994.0	948.5
Contracted staff percentage	72%	72%	70%	65%	66%	71%	72%	70%	66%	68%	73%	74%	65%	71%	71%	69%	66%	66%
Total temp percentage	23%	25%	24%	27%	26%	22%	24%	22%	31%	22%	13%	18%	23%	24%	23%	27%	23%	24%
Bank percentage	6%	9%	5%	8%	12%	8%	8%	6%	11%	7%	6%	8%	7%	7%	8%	8%	5%	12%
Agency percentage	17%	16%	19%	19%	14%	14%	17%	16%	20%	15%	7%	11%	16%	17%	15%	19%	18%	12%
Total bank requests	382	389.5	448	502	500.5	413.5	429	456	504	476	391	380	509.2	432	439.16	470	519.66	495.5
Percentage bank fill	77%	86%	74%	68%	69%	72%	81%	67%	86%	59%	41%	62%	56%	78%	72%	82%	57%	61%
Total percentage staffing against required	95%	97%	94%	92%	92%	94%	96%	92%	97%	90%	86%	92%	88%	95%	94%	96%	89%	90%
Total substantive and bank	1079.25	1125.25	1105.5	1051	1136.75	1143.5	1204.75	1144	1132	1112	1127	1155.5	1035.5	1150.5	1176	1149.5	1061.15	1103.5

In-Month Nursing Agency Ceiling

Target:	
Trajectory Start Month:	Apr '17
Trajectory End Month:	Mar '18

Objective: Actual £ spent to be BELOW the trajectory

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 (£)	665,349	712,398	710,214	767,717	726,020	677,826						
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	-48,233	-18,487	-21,296	-50,492	-22,526	84,181	-593,645	-593,645	-518,790	-518,790	-481,363	-457,390



Return to Summary Table

Key:

BAD NEWS!
GOOD NEWS!

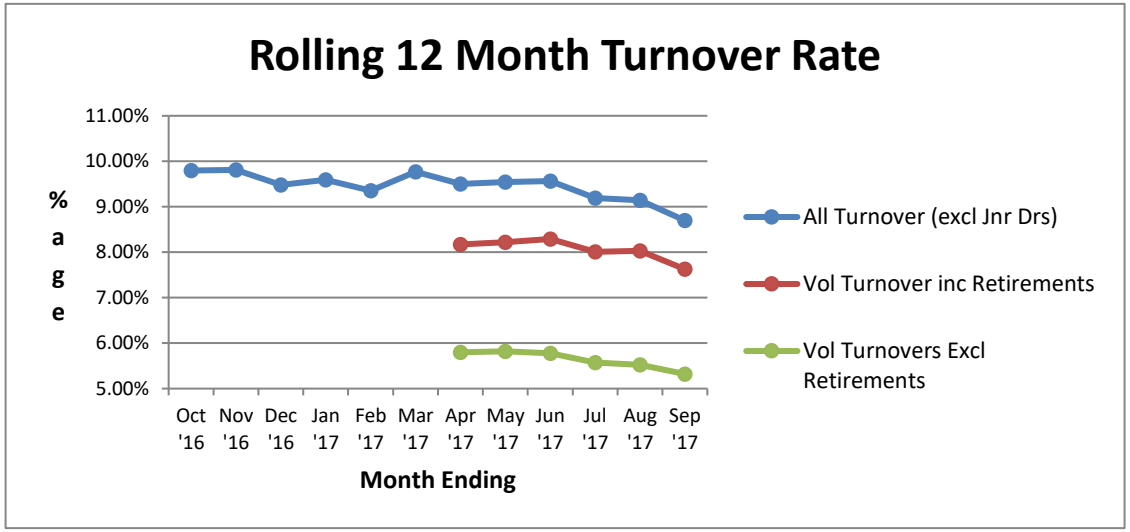
Turnover

KPI:	Voluntary Turnover	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Deputy Director of HR
Date:	11th October 2017	Reporting Period:	September 2017
Target:	7% (excl. retirements) with no group of staff more than 20% above the overall target	Tolerances:	Within 1% - Amber Above 1% - Red
RAG Rating:	5.32%		

Analysis

The current 12 month rolling average as at September 2017 is 7.63% including retirements and 5.32% excluding retirements. Of the leavers 27.41% was due to retirement and 65.73% was due to voluntary resignations. The remaining 6.86% of leavers were for other reported reasons e.g. dismissal.

Voluntary turnover excluding retirements has reduced from 5.52% at the end of August to 5.32% at the end of September. No comparison with the end of September '16 is currently available as turnover was not calculated in this format last year.



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

	Voluntary Turnover including Retirements Sep '17	Voluntary Turnover excluding Retirements Sep '17	Voluntary Leavers including Retirements in Aug '17	Voluntary Leavers including Retirements in Sep '17	Increase / Decrease compared to previous month
Staff Group	%age	%age	WTE	WTE	WTE
Allied Health Professionals	13.75%	11.86%	3.00	2.00	-1.00
Add Prof Scientific and Technic	12.60%	10.55%	2.60	1.00	-1.60
Medical and Dental	10.20%	7.20%	4.30	4.00	-0.30
Healthcare Scientists	12.99%	6.54%	4.00	0.80	-3.20
Administrative and Clerical	7.51%	5.60%	7.41	10.80	3.39
Nursing and Midwifery Reg	6.64%	4.23%	8.87	11.32	2.45
Additional Clinical Services	6.06%	4.07%	3.88	5.79	1.91
Estates and Ancillary	6.16%	3.67%	6.12	1.61	-4.51
Students	0.00%	0.00%	0.00	0.00	0.00
Total	**7.63%**	**5.32%**	**40.18**	**37.32**	**-2.86**

It is noteworthy that 27% of leavers are retiring, reflecting the known issue about the age of the workforce.

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

- The current Trust turnover rate (excl. junior doctors) of 8.70% is below the average of 10.31%
- The current Trust Nursing & Midwifery (Registered) turnover rate of 6.90% is below the average of 10.87%,
- The current Trust AHP turnover rate of 13.83% is above the average of 11.98%.

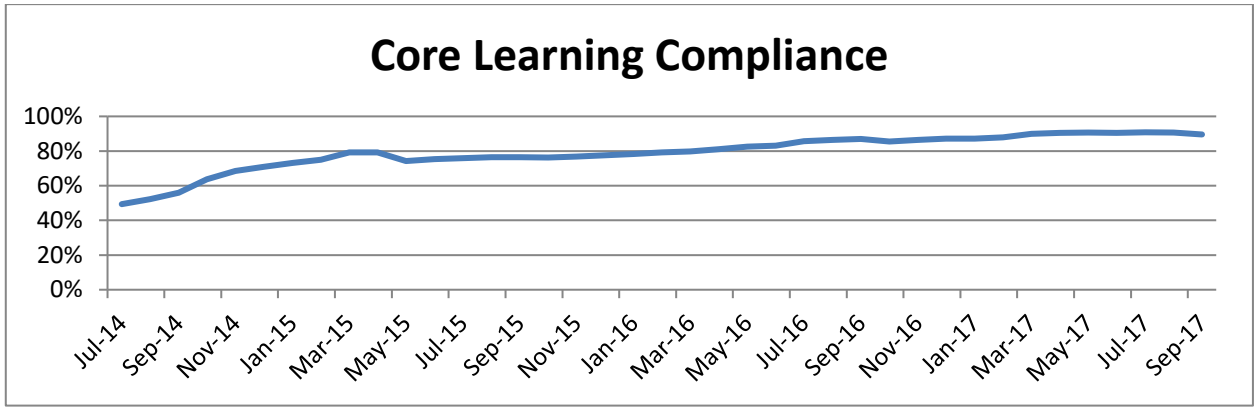
Action Taken	**Action Planned**
• Completion of report on staff retention and consideration at Staff Engagement Group	• Event to be organised to bring together key stakeholders to consider how to implement the recommendations of the retention report and develop the ULHT brand and consider how we can keep our best people as well as support attraction and recruitment

Core Learning Completion

KPI:	Core Learning Completion	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Head of Transformational Change and Engagement
Date:	9 October 2017	Reporting Period:	Sept 2017
Target:	Project to set revised targets delayed. Will be completed asap	Tolerances:	
RAG Rating:	89.63%		

Analysis

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



Compliance as of the end of September shows a slight fall from 90.58% last month to 89.63%. The table below shows the top 10 and bottom 10 performing wards/departments.

Ward/Dept	Directorate	Fire Safety - 1 Year	Infection Control - 1 Year	Equality, Diversity and Human Rights - 3 Years	Information Governance - 1 Year	Safeguarding Children Level 1 - 3 Years	Safeguarding Adults Level 1 - 3 Years	Health and Safety - 3 Years	Slips, Trips & Falls - 3 year	Moving & Handling for Inanimate Load Handlers - 3 Years	Risk Awareness - 3 Years	Fraud Awareness - 3 years	Resuscitation [BLS] - 1 Year	Overall Compliance %	Major Incidents - 1 Year (currently excluded from overall compliance)
L3420 Oral Surgery	Clinical Support Services	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
L3520 Orthopaedic Clinic	Clinical Support Services	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	88.24%
A0203 Financial Management	Director of Fin & Corp Affair	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	95.24%	100.00%	100.00%	99.60%	100.00%
P6711 Pilgrim CPU	Director of Estates & Facil	98.44%	100.00%	100.00%	98.44%	100.00%	100.00%	100.00%	98.44%	100.00%	98.44%	100.00%	100.00%	99.48%	18.75%
G2537 Day Ward	Grantham	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	88.24%	99.02%	100.00%
P4536 Ward M1 Maternity	Women & Childrens Pan Trust	100.00%	95.65%	100.00%	95.65%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	95.65%	98.91%	91.30%
A0211 Information Dept	Deputy Chief Executive	100.00%	100.00%	100.00%	100.00%	93.75%	93.75%	100.00%	100.00%	100.00%	100.00%	100.00%	93.75%	98.44%	87.50%
P4521 Antenatal Clinic	Women & Childrens Pan Trust	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	93.75%	100.00%	93.75%	100.00%	100.00%	93.75%	98.44%	87.50%
G3906 Anaesthetics	TACC Lincoln	100.00%	93.33%	100.00%	86.67%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.33%	73.33%
P6112 Pilgrim Ultrasound	Clinical Support Services	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	90.00%	90.00%	100.00%	100.00%	98.33%	100.00%

Ward/Dept	Directorate	Fire Safety - 1 Year	Infection Control - 1 Year	Equality, Diversity and Human Rights - 3 Years	Information Governance - 1 Year	Safeguarding Children Level 1 - 3 Years	Safeguarding Adults Level 1 - 3 Years	Health and Safety - 3 Years	Slips, Trips & Falls - 3 year	Moving & Handling for Inanimate Load Handlers - 3 Years	Risk Awareness - 3 Years	Fraud Awareness - 3 years	Resuscitation [BLS] - 1 Year	Overall Compliance %	Major Incidents - 1 Year (currently excluded from overall compliance)
L1125 Lincoln Dermatology OP	Grantham	55.56%	38.89%	77.78%	50.00%	61.11%	55.56%	61.11%	72.22%	61.11%	55.56%	50.00%	33.33%	56.02%	22.22%
G3725 Grantham AE Attenders	Grantham	70.00%	60.00%	90.00%	60.00%	70.00%	70.00%	70.00%	70.00%	70.00%	50.00%	90.00%	70.00%	70.00%	40.00%
L1029 Navenby Ward	Acute Medicine Lincoln	74.07%	59.26%	81.48%	59.26%	70.37%	70.37%	77.78%	77.78%	70.37%	74.07%	81.48%	62.96%	71.60%	18.52%
P3206 Pilgrim Urology IP	Gen Surg Linc & Urology Trust	70.00%	50.00%	80.00%	80.00%	100.00%	90.00%	60.00%	70.00%	70.00%	70.00%	90.00%	40.00%	72.50%	20.00%
L3725 Lincoln AE Attenders	A&E Lincoln	85.71%	42.86%	100.00%	50.00%	71.43%	71.43%	92.86%	92.86%	92.86%	57.14%	64.29%	50.00%	72.62%	28.57%
P1038 Ward 7B Respiratory	Acute Medicine Boston	75.00%	67.50%	82.50%	70.00%	82.50%	82.50%	70.00%	72.50%	72.50%	70.00%	75.00%	52.50%	72.71%	20.00%
A4057 Endoscopy Management	Clinical Support Services	67.86%	53.57%	92.86%	57.14%	82.14%	82.14%	71.43%	75.00%	75.00%	85.71%	96.43%	39.29%	73.21%	32.14%
P2506 Pilgrim General Surgery IP	General Surgery Boston	75.00%	60.00%	95.00%	65.00%	65.00%	65.00%	95.00%	95.00%	100.00%	75.00%	70.00%	45.00%	75.42%	15.00%
P6720 Pilgrim Portering	Director of Estates & Facil	79.31%	55.17%	96.55%	48.28%	100.00%	100.00%	79.31%	82.76%	68.97%	93.10%	89.66%	17.24%	75.86%	3.45%
M1003 Louth Choice & Access	Clinical Support Services	54.55%	54.55%	45.45%	54.55%	81.82%	81.82%	90.91%	90.91%	90.91%	90.91%	90.91%	90.91%	76.52%	72.73%

Action Taken	**Action Planned**
• Core Learning forms part of the WF Balanced Score Card and highlighted as part of the performance review meetings. • All staff reminded through corporate communications of their core learning and how to access it	• Managers will be reminded that non-compliance with Core Learning is a barrier to incremental Pay Progression • Focus at performance meetings, particularly around fire safety compliance.

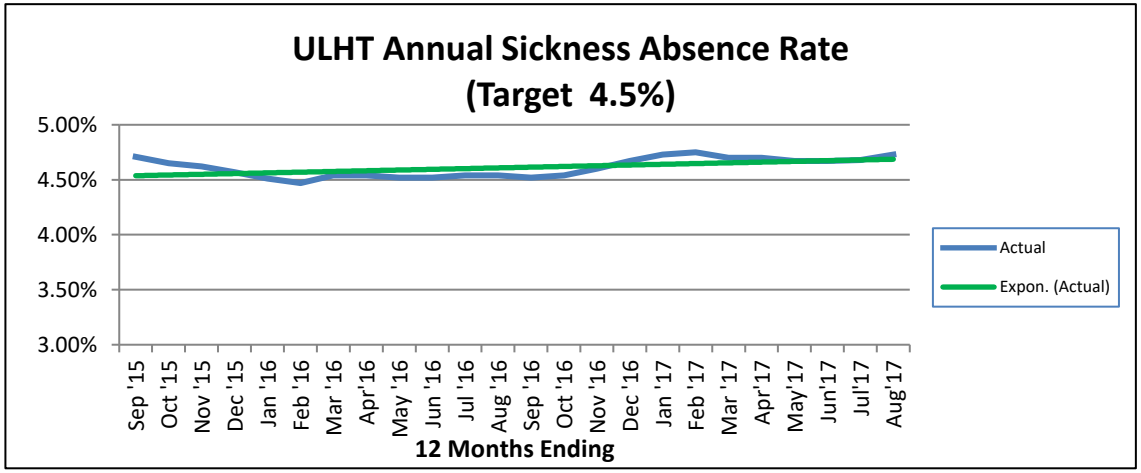
Sickness Absence

KPI:	Sickness Absence	Owner:	Director of HR & OD
Domain:		Responsible Officer:	Assistant Director of HR
Date:	10th October 2017	Reporting Period:	August 2017
Target:	Overall target of 4.5% + no team over 25% above target	Tolerances:	Within 0.5% - Amber Above 0.5% - Red
RAG Rating:	4.73%		

Analysis

The Trust annual rolling sickness rate of 4.73% (against 2017/18 target of 4.50%) has increased by 0.05% from the previous month. The 12 month rolling sickness rate as at the end of August 2017 has increased by 0.19% in comparison to the August 2016 figure (4.54%).

The latest Benchmarking data as at June 2017 from NHS Digital (previously Health & Social Care Information Centre - HSCIC) indicates that ULHT has the 8th highest sickness rate (lowest at 3.01% and highest 5.60%) against an average of 4.30%. Of the eight staff groups the Trust has two with sickness rates lower than the average, these being Administrative & Clerical and Healthcare Scientists. The benchmarking is done across x38 Large Acute Trusts.



Action Taken	Action Planned
• Review of sickness data shows evidence a reduction in MSK conditions • Better than target for 'FLU Jab' campaign	• The 360 Sickness Absence Management Audit actions have been requested by the 31st October • HRBPs have a trajectory of sickness rates planned to the end of the financial year • Extension of OH Meeting with HRBPs at Pilgrim to include staff that are having difficulties managing certain absence situations • Review of ESR delivery to see if any actions can be taken to deliver more timely reporting • Absence letter drafted for staff with 100% attendance • Commencement of the role out of electronic occupational health referrals and management

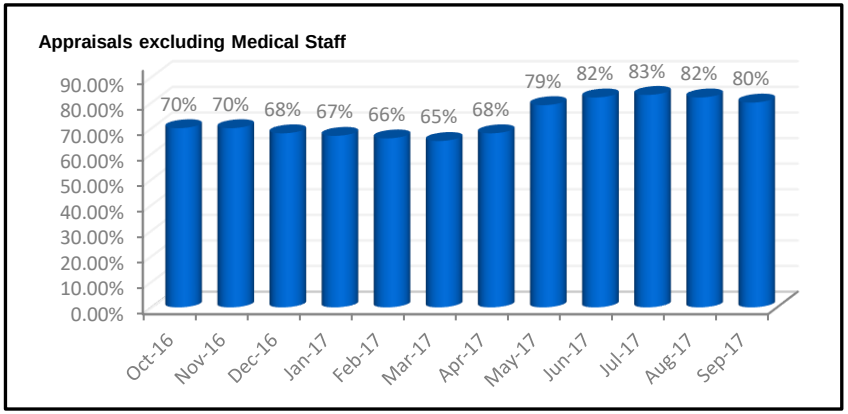
Appraisals

KPI:	**Appraisal Rates**	**Owner:**	**Director of HR & OD**
Domain:		**Responsible Officer:**	**Head of Transformational Change and Engagement**
Date:	**9th October 2017**	**Reporting Period:**	**September 2017**
Target:	**Medical – 95%** **Non-Medical – 85%**		**Within 5% below - Amber** **More than 5% below – Red**
RAG Rating:	**Medical – 96%**		
RAG Rating:	**Non-Medical – 80.10%**		

Analysis

The graph shows that the Agenda for Change Staff/Non-Medical Appraisal compliance rate for September is 80.10%. This is a reduction from the previous month by 2.14% and is the second successive month that the rate has reduced.

Our focus is on reversing the downward trend on appraisals. We will be focusing in particular on the Directorates with the lowest completion rates. There is clearly pressure on the time managers' have available, but an appraisal rate where 1 in 5 staff have not had an appraisal in the last year is clearly unacceptable. We will be looking to enforce the policy where incremental progression cannot take place if an appraisal has not been held and ensuring there are consequences where managers have failed to complete appraisals.



The Medical Workforce appraisal rate for the month ending September 2017 is 95%. The Trust target rate of 95% has been achieved for the past four successive months. The appraisal performance figure includes Consultants, SAS Doctors and all Trust Locums who all now have access to the Allocate e-appraisal system for appraisal.

Action Taken	**Action Planned**
Non-Medical • Workforce Scorecards continue to contain appraisal data which is shared on a monthly basis with Directorates for consideration/action this is also reported into clinical directorate performance meetings. • Appraisal compliance is reported into the Quality and Safety Improvement Plan as part of this work stream • Managing Performance (incl. appraisals) was presented at the recent Senior Leadership Forum (SLF) and senior leader were asked for the	Non-medical • A number of action/next steps on performance management have been identified at People Forum • A 'league table' for appraisals will be prepared to identify Directorates with very low compliance rates • The HBPs will pick this up with Directorates as part of their end of year 'trajectory' action plan (which covers three critical areas, such as appraisals, sickness and core learning)

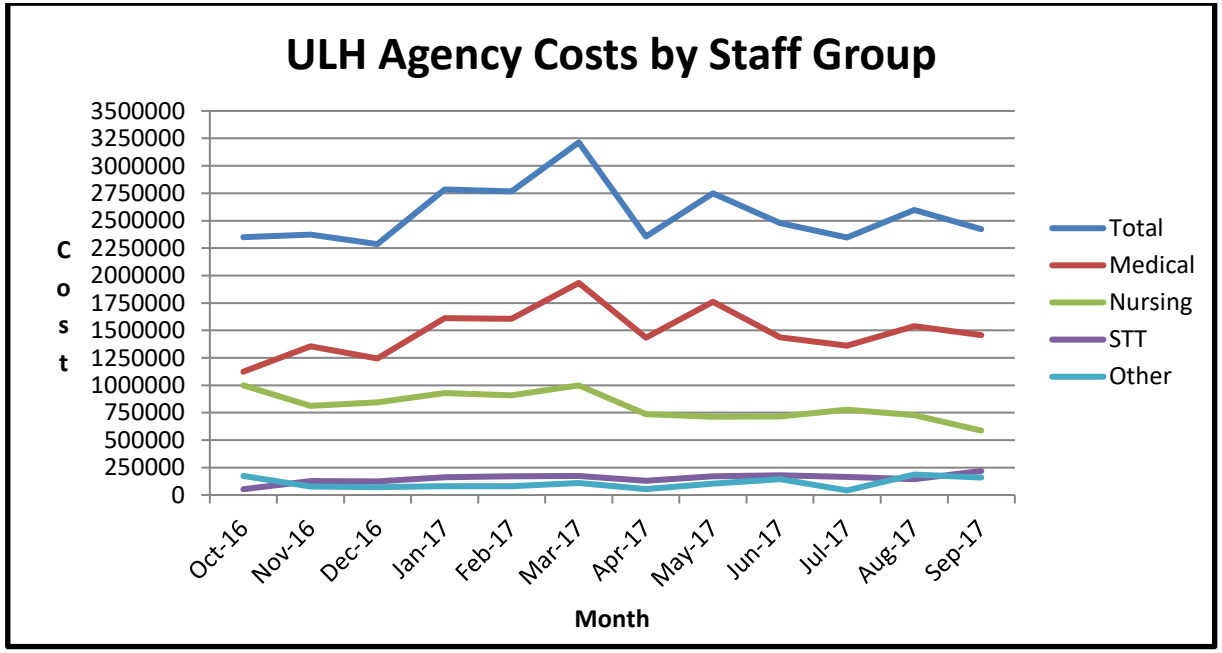
thoughts/views on how the Trust should approach performance management going forward. • Feedback from SLF was collated and discussed at the People Forum • The schedule for appraisal has been brought forward from 6 months to 3 months to ensure doctors who are employed on short term contracts have the opportunity to participate in appraisal during their employment with ULHT. <u>Medical</u> • The schedule for appraisal has been brought forward from 6 months to 3 months to ensure doctors who are employed on short term contracts have the opportunity to participate in appraisal during their employment with ULHT. • Reminders sent to Appraisers to complete Appraisal Output documentation and sign off appraisal documentation within 28 days of the appraisal meeting in order to meet the GMC requirements. • Notification of 'Appraisal Due' sent to Doctors 4 months prior to their appraisal month. Strict adherence to the escalation processes set out in the Medical Appraisal Policy, with particular focus on the allocation of appraiser to appraisee 6 weeks prior to the appraisal due date if the doctor has not confirmed appraisal details.	• A formal letter will be sent to Manager and/or Clinical Directors that show a very low or zero appraisal compliance. <u>Medical</u> • Proposal to meet newly appointed Doctors at Trust Induction in order to introduce ourselves and highlight processes in respect of Medical Revalidation and Appraisal. There is a plan in place for each doctor, for whom this is their first post in the UK, to participate in appraisal within 3 months of their start date with the Trust. • The Revalidation Office continues to closely monitor and take prompt action when appraisals are not undertaken as planned. The e-appraisal system allows the Administrator to track progress with timely completion of appraisal documentation. This enables early intervention and support to both appraisee and appraiser. • Proposal to increase the administration support to the Revalidation Office (0.53 of Band 2) to ensure improved governance to Revalidation processes. Awaiting decision from the Director of Finance. • Provide Clinical Directors with monthly reports of appraisal performance within their areas of responsibility. • Continue to closely monitor appraisal progress on the e-allocate appraisal system. • Ensuring new and existing doctors receive continued support to use the new Allocate system.

Agency Spend

KPI:	Agency Spend	Owner:	Director of HR/OD
Domain:		Responsible Officer:	Various leads on different aspects of agency spend
Date:	11th October 2017	Reporting Period:	September 2017
RAG Rating:	Actual spend of £2.423m, against target of £1.75m		

Analysis

The table below shows agency spend in the last 12 months. In September there has been a reduction of £173,331 from the previous month, spend is significantly above target and £251,515 higher than the level of spend in September 2016.



Of the £2,423,365 spent on Agency staff in September, £1,458,234 was spent on Medical and Dental staff, £587,363 was spent on Nursing staff (including HCSW's), £218,845 was spent on STT staff and £158,923 was spent on Other staff (including Admin & Clerical staff). There were small reductions in both medical and nursing spend, evidence that the actions in the two action plans are having an impact and we expect that trend to continue as the conversion of agency to permanent medical staff impacts and the introduction of weekly pay encourages more staff to join the nursing bank. There has been a significant increase in numbers on bank already and the balance of shifts filled by bank and agency is now positively in favour of bank.

"Other" agency spend has increased, notably in August on AHPs. A process has been established whereby all "other" agency spend will be challenged by the Vacancy Control Panel in October, with the expectation of a significant reduction to achieve the agreed target.

Action Taken	**Action Planned**
• Plans are in place and are monitored for Nursing and Medical agency spends. • Actions taken include incentivisation of bank for nursing and conversion of locums to permanent medical contracts.	• See text above on actions proposed on other agency spend • Enhanced controls are being explored with regards to agency spend and payment processes

Engagement

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

Analysis

We gather this data through the Pulse Survey which took place from Friday 1 September 2017 to Friday 22 September inclusive.
The score is the average of seven questions included within the survey

- I am aware of the 2021 strategy
- I understand how the 2021 strategy affects me
- Communication between senior management (such as executive directors, clinical directors, heads of service) and me is effective
- I am encouraged by the Trust to contribute to changes that affect my team or service
- I am encouraged by my manager to contribute to changes that affect my team or service
- I feel that the quality and safety of patient care is ULHT's top priority
- I am aware of how the Trust's values impact on me

The score has decreased by 0.1 since the last Pulse Check in June 2017.

Action Taken	Action Planned
• Staff Charter/Personal Responsibility Framework signed off by Trust Board • Design work being undertaken to tie in with 2021 branding • National Staff Survey launched • Regular updates on NSS response rates provided to Execs • Staff Charter launch being planned as part of 2021 launch in November – project plan in place • Pulse check report analysed – to be presented to Staff Engagement Group 20.10.17	• 2021 launch planning continues: • Four site-based meetings in November with "influencers" who attended the 2021 Big Conversation, plus a buddy. • All visual materials across the Trust to be updated overnight • Executive team will walk the sites to share the 2021 messages • Video clips to be available • Social media campaign planned • An activity is underway to review induction of our temporary workforce and the 'link' with the Trust Values and Staff Charter.

Leadership and Management

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

Analysis

We gather this data through the Pulse Survey which took place from Friday 1 September 2017 to Friday 22 September inclusive

Action Taken	Action Planned
• Senor leaders list completed • All members invited to 2 day management programme • Attendance monitored through Quality and Safety programme • Cohort 5 of Mary Seacole Local programme recruited to • Revised Senior Leadership Forum held with 133 attendees and new Terms of Reference • Clear message from CEO that attendance is mandatory • Positive evaluation of SLF • Future dates for SLF planned and shared • Leadership Charter incorporated into Staff Charter and Personal Responsibility Framework	• Updated proposal and programme specification for Lincolnshire Health and Care leadership programme to be discussed with SET • Further design work on new leadership and management programme to be shared with ET • Work underway on new performance management approach within ULHT

Finance Headline Summary

Executive Responsibility: Karen Brown – Director of Finance

Trust Financial Performance

Key Financial Duties

Financial Duty	Annual Plan / Target £m	Current Target	YTD Plan £m	YTD Actual £m	RAG
Delivering the Planned Deficit	-48.564	-48.564	-27.352	-42.955	R
Achieving the External Finance Limit (EFL)	76.316	86.636	-	-	G
Achieving the Capital Resource Limit (CRL)	17.663	22.806			G
Capital Programme	18.912	22.994	5.405	4.304	G

Key Issues

- The Trust plan for 2017/18 is a control total deficit of £48.6m, inclusive of £14.7m STF income (£63.4m before STF).
- The Month 6 position was an in-month deficit of £6.3m, which is £1.9m adverse to the planned in-month deficit of £4.4m.
- The Trust will not deliver its' control deficit of £48.6m and a financial recovery plan submitted to NHSi on October 23rd identified a stretch target deficit of £77m. Further details are included below.
- The £77m financial recovery plan assumes delivery of £16m of efficiencies.
- The deterioration in the income and expenditure position directly impacts on cash and the level of borrowings needed in 2017/18. The Trust will require external cash support in line with the forecast outturn in 2017/18.

Month 6 Financial Position

Month 6 performance against the financial plan is summarised in the table below:

	September 2017			April 2017 to September 2017		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Operating income from patient care activities	32,290	33,430	1,140	191,714	195,070	3,356
Operating income from patient care activities STF	983	0	-983	5,157	0	-5,157
Other operating income	3,064	2,818	-246	18,354	16,384	-1,970
Employee expenses	-25,896	-26,984	-1,088	-155,301	-161,904	-6,603
Operating expenses excluding employee expenses	-14,457	-15,354	-897	-84,973	-90,970	-5,997
OPERATING SURPLUS / (DEFICIT)	**-4,016**	**-6,090**	**-2,074**	**-25,049**	**-41,420**	**-16,371**
NET FINANCE COSTS	**-408**	**-283**	**125**	**-2,366**	**-1,571**	**795**
Other gains/(losses) including disposal of assets	0	0	0	0	103	103
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**-4,424**	**-6,373**	**-1,949**	**-27,415**	**-42,888**	**-15,473**
Adjusted financial performance surplus/(deficit)	**-4,414**	**-6,348**	**-1,934**	**-27,352**	**-42,955**	**-15,603**

The Trust is reporting:

- An in-month deficit in September of £6.3m, which is £1.9m adverse to the planned in-month deficit of £4.4m.
- A year to date deficit of £43.0m, which is £15.6m adverse to the planned year to date deficit of £27.4m.

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

- Non-achievement of STF income resulting in the loss of £5.2m STF income.
- Slower than planned delivery of efficiency savings, with delivery to date £4.3m below plan.
- Pilgrim fire, norovirus outbreak and cyberattack resulting to date in the loss of £2.5m of income.
- Non-achievement of £1.1m of CQUIN income.
- £0.7m in relation to the outcome of the hoist legal case.
- Contract challenges of £0.6m from 2016/17 re SUS to SLAM reconciliation.

Higher than planned level of expenditure on agency staffing, with expenditure to date £4.6m higher than planned and only partially offset by a reduction in substantive and bank pay expenditure.

Financial Recovery Plan

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

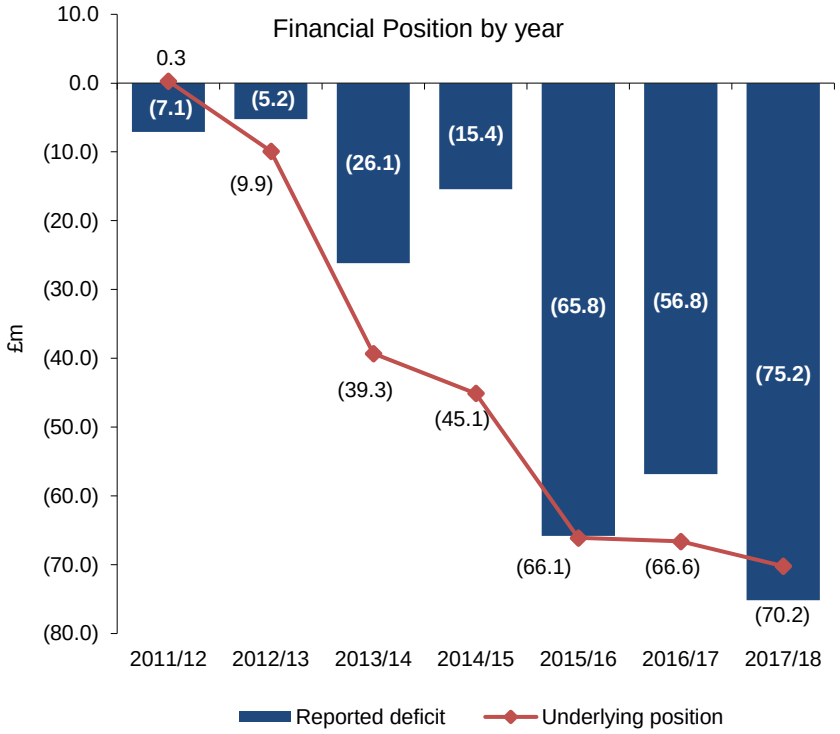
Long Term Financial Issues

The Trust has not achieved a breakeven position since 2011/12 and the graph below identifies that the underlying financial position has been deteriorating since that point. The significant changes in the underlying run rate occurred in 2013/14 and 2015/16.

In 2013/14 this was driven by increases in staff costs, £11.5m, agency costs, £5.4m and clinical non pay costs, £5.9m. In 2015/16 this was driven by increases in agency staff, £10.2m and Clinical Negligence Schemes for Trusts payments, £6.1m, clinical non-pay costs, £9.9m.

The issues have arisen by the cost of delivering and investing in services over three main sites and a large rural geography whilst struggling to deliver the national efficiency agenda. This has resulted in a significant structural deficit that the Trust is working with the Lincolnshire health economy to address.

The position in recent years has been exacerbated by the need to rely on higher than national average levels of agency staff in order to deliver the services in a safe environment due to a large number of clinical vacancies. This has placed a financial burden on the Trust as the agency bill is currently around £30m per year.



The table below describes the drivers of the deficit and how the underlying deficit can be broken down.

Reason	Cost
Duplication of services across multiple hospitals	£30m
Use of agency staff	£13m
Loss of elective (planned) work	£13m
ULHT inefficiencies	£14m
Total	£70m

Impact of Financial Special Measures

Financial Special Measures has various elements to it, many of which have already been put in place. These are detailed below.

- NHS Improvement appoints an executive director sponsor
- An improvement director is appointed by NHS Improvement for each financial special measures provider
- Board vacancies to be filled on the direction of NHS Improvement
- Regular progress reviews are held with NHSI
- Provider is required to publish on its website home page that it is in financial special measures, and the reasons for this
- Potential removal of provider's autonomy over key spending decisions
- NHSI control over applications for Department of Health financing
- A financial improvement notice issued for a time-limited period
- Rapid (by end of week 1) articulation of key issues
- Recovery plan (with milestones) - including accelerated proposals on service consolidation or closure, Lord Carter Review and organisational form and workforce review - with buy-in from key stakeholders
- Provider and NHS Improvement agree the recovery plan (by end of month 1)
- Appointment of turnaround /recovery support (full time), possibly including peer support

Exiting Special Measures

The exiting of financial special measures requires three elements to be completed, as follows:

1) Robust recovery plan setting out the key changes required to remedy the financial position
2) Plan to be approved by ULHT Board and NHSI within 1 month
3) Having a detailed delivery plan and evidence of significant wins within a further 2 months

NHSI may require evidence of delivery over a further 3 month window and if these elements are not met, NHSI may consider any, or a combination of the following:

1) extend special measures by 3-6 months,
2) make changes to the Board
3) initiate an org form change if issues are due to org capability or capacity
4) initiate a wider local health economy process,

External Support

As highlighted in 3.1 above, there are a number of support arrangements that are put in place to support the organisation and a number of these are in place already.

The Trust has already undertaken the following, in terms of obtaining support:

- appointing a Turnaround Director who will support the Board in progress to exiting financial special measures
- appointing an external partner to support the development and delivery of the recovery plan.
- Receiving support from the national NHSI team through a senior financial colleague within the Trust

6. Turnaround Plans

6.1 The Trust has produced a high level turnaround plan this is summarised in the table below.

Impact on services/engagement with staff and public

6.3 The key themes of the turnaround plan are to reduce the costs of delivering services through initiatives such as recruiting more substantive clinical staff to reduce agency costs and using current resources in a more productive way. The underlying aim is not to cut or reduce the level of service delivered to the patients but how to use our money more effectively to deliver a more efficient service without reducing the quality. The Trust is progressing it's plans with regard to quality special measures and the two recovery plans will dovetail together so that neither finance or quality are compromised.

6.4 The Trust has engaged with over 2,000 people including staff and the public for their ideas on how we can reduce waste and develop our services in the future. The Trust has received over 1,200 finance ideas which are all being considered and will be included in our plans for how the services will be shaped over the forthcoming years, as part of our 2021 vision.

6.5 The draft turnaround plan does not include any planned reduction to service provision at any of the Trust sites. However, the Trust is awaiting a formal response from NHSI, and achievement of financial sustainability may affect the future range and scope of services. All schemes are subject to a full quality impact assessment (QIA) signed by the Medical Director and Director of Nursing and to ensure patient quality is not reduced. The QIA has not been completed yet and may affect the final plan. This is to ensure that decisions made to get a grip on our finances don't affect the quality of the care we provide. In fact, the more money we save the more care we can deliver.

High Level Financial Turnaround Programme

Theme	Full Year Effect Plan £m
Directorates	2.5
Efficient management of resources	2.9
Theatre Efficiency	1.8
Agency	3.0
Clinical services Review	0.2
Procurement	0.8
Estates	0.7
Outpatients	1.7
Workforce	4.7
Total	18.3

Description of the Themes
Directorates – Maximising savings within the current services through ongoing efficiency work
Efficient Management of Resources – Management of non-clinical discretionary expenditure
Theatre Efficiency – Working at improving the use of theatres so we can treat more patients within a set timeframe
Agency – Reducing the demand for agency staff by improving the recruitment of our own staff
Clinical Services Review – Developing and delivering plans for Trauma and Orthopaedics and General Surgery to streamline the current working practices of those services
Procurement – Delivering the same quality of products at a cheaper price
Estates – Making more effective use of the portfolio of properties
Outpatients – Improving the efficiency of the current outpatient services, reducing the unutilised outpatient appointments and making best use of current clinics.
Workforce – Undertaking reviews of workforce requirements across the Trust to ensure the models are fit for purpose and deliver the right outcomes for patients.

Progress made to date

The Trust has made steady progress against the financial turnaround targets to date. The current delivery as at month 6, September 2017 is £3.7m against the year to date plan of £3.2m on the heading Financial Efficiency Plan.

There has been no delivery to date on the other themes. The majority of the financial turnaround programme is phased into the second half of the financial year.

This increased requirement will be supported by the aforementioned Turnaround Director, External Partner, NHSI experts and the Trust's own newly established programme management office (known as the PMO) and governance structure set out in section 8.

Governance arrangements

Tracking delivery of overall financial recovery plan will be undertaken and monitored as follows:

- Progress against the Finance recovery plan to be presented to Executive Team twice a month
- Finance is one of five key priorities for each Board meeting (the others being quality, fire compliance, A&E performance and Cancer performance)
- Performance meetings with Clinical Directorates will include a focus on finances to raise concerns around slippage and ensuring delivery is on track
- 2021 Finance strategy group already developed and approved an efficiency framework and to lead on developing a long term financial model
- All Efficiency ideas to be documented and to go through a QIA sign off process before being adopted
- Executive or Clinical lead sponsor for each efficiency scheme
- Capacity and capability to deliver to be addressed, in part by recruiting to 2021 PMO

Key Delivery Meetings

Financial Turnaround Group (FTG) reports to 2021 Programme Board and provides assurance to Finance, Service Improvement and Delivery Committee (FSID) and Trust Board

- Fortnightly meetings chaired by the Chief Executive
- Terms of Reference and Membership agreed
- PMO supports the meeting and records actions

Financial Turnaround Implementation Group report to Financial Turnaround Group

- Fortnightly meetings chaired by Director of Finance
- Terms of Reference and Membership under review – this is the group responsible for delivery using the Financial Efficiency Programme (FEP) framework and escalation to Financial Turnaround Group
- PMO supports the meetings and records action

PMO Support Overall

- Programme Delivery Manager to be allocated to manage the day-to-day running of the finance programme
- Co-ordinate delivery of the programme / projects, pro-actively monitoring its overall progress against plans, highlighting issues to the delivery group and co-ordinating corrective action
- Manage the programme control process, including monitoring dependencies, escalating to Financial Turnaround Group as agreed and maintain a risk register
- Support the implementation of a project tracking system and work within the agreed framework as this develops
- Compile and maintain a programme evidence library and provide highlight / escalation reports to FTG
- Provide Project Support Officer for meetings to maintain action logs
- Project Managers to be allocated as agreed by 2021 Programme Board

Efficiency

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

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

The Financial Efficiency Plan schemes have been RAG rated and the £16m most likely outcome contains £4.8m of Green, £9.1m of Amber and £2.1m of Red RAG rated schemes

The Trust originally planned to deliver £8.1m of savings by the end of September. Actual delivery to date at the end of September is as follows:

Savings of £3.7m have been delivered to date, which is £4.3m lower than the £8.1m of savings planned to date.

The savings delivered to date comprises of £2.1m of non-recurrent savings and £1.6m of recurrent savings. The non-recurrent savings delivery includes £0.3m of technical efficiency savings released in August and a further £0.7m released in September [including £0.4m of deferred income] i.e. £1.0m of technical efficiency savings to date.

Despite the release of £1.0m of technical efficiency savings, delivery to date is still £1.2m lower than expected within the original high level financial recovery plan.

Capital

The spend to date is inclusive of £ inclusive of £1.2m Pre-commitments including £0.7m for Neonates and £0.5m Lincoln Specialist Rehab. £1.1m for Medical Equipment and £0.8m for IT development. The remainder for Backlog Maintenance, CQC and Service Development & Modernisation total £1.2m.

The 2017/18 capital resources of £18.9m submitted in December 2016 was inclusive of internally generated funds of £12.6m and additional funding of £6.3m; Invest to save (financed by capital PDC / loans) £5.1m and £1.2m land sales. The planned external financing has not proceeded as planned while the major land sale (Welland Hospital site) will not be completed until 2018/19.

The Trust has had written confirmation from the Department of Health that its Primary Care Streaming application for £986k has been approved as PDC. Funding will be drawn down and matched to capital spend throughout the project.

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

Taking account of these changes the resources available and planned capital spend in 2017/18 (excluding donated assets) is now £23.0m.
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Cash

At the close of September 2017 the Trust held cash of £2.2m. This includes external revenue support loans of £44.5m drawn over the first six months.

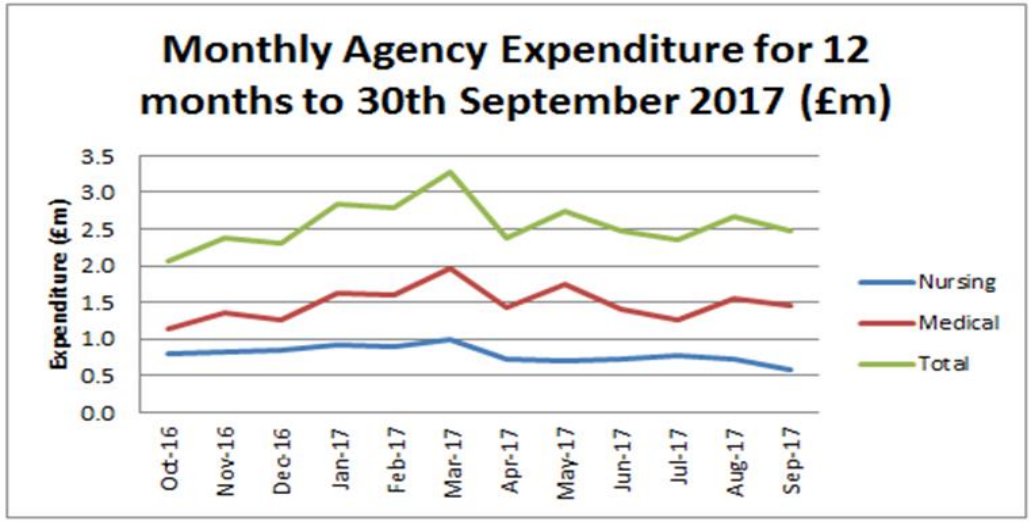
The total 'repayable' borrowings through working capital loans, Salix loans and the uncommitted loan facility are currently £155.4m. The projected revenue borrowings required in 2017/18 are £76.3m, of which £1.3m relates to deficit support from 2016/17. This has been revised in line with the forecast revenue position.

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

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

Agency

The table below shows that the upward trend on agency pay expenditure has been driven by an increase in agency expenditure in Medical staffing. Over the last six months, despite rising to £2.0m in March and falling to £1.3m in July, agency expenditure on Medical staffing has averaged £1.5m per month in 2017/18.



CQUINs 2017/18

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

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

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

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

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

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

Equality Analysis Statement

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

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

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

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

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

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

The nine protected characteristics are:

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

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

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

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

Appendix 1. Glossary

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

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

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

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

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

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

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

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