UNITED LINCOLNSHIRE HOSPITALS TRUST

INTEGRATED PERFORMANCE REPORT

PERIOD TO 31 OCTOBER 2017

To:	FSID
From:	Karen Brown, Director of Finance, Procurement & Corporate Affairs
Date:	28th November 2017
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for October 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 31st October 2017, provide analysis to support decisions, action or initiate change and set out proposed plans and trajectories for performance improvement.

The report is provided to the Board for:

	√		√
Decision	√	Discussion	√
Assurance	√	Information	

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

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

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

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

Resource implications (eg Financial, HR) None

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

Patient and Public Involvement (PPI) implications None

Equality impact

Information exempt from disclosure

Requirement for further review?

Executive Summary for period of 31st October 2017

- ☒ 4 hour waiting time target – performance of 77.5% in October 2017
- ☒ 4 of the 9 national cancer targets were achieved in September 2017
- ☒ 18wk RTT Incomplete Standard will not be submitted for October and November 2017
- ☒ 6wk Diagnostic Standard – October 2017performance was 97.4%

Successes:

Improvement in Sepsis KPI continues, with increase in performance for IP & A&E for screening for third month in a row and A&E maintaining 100% administration of antibiotics for the fourth month in a row.

The 6m vacancy trend for Nursing and AHP and voluntary turnover rates are positive.

GP streaming commenced in A&E on both main sites during September 2017 and is continuing to show improvement.

The Trust has worked extensively to review and I improve the performance management system to strengthen the ability to hold individual Clinical Directorates to account monthly for their performance from a quality, financial and contractual perspective: Challenging at a granular level, ensuring that performance and improvement trajectories are being delivered.

Challenges:

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

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

Performance against the Cancer 62 day standard was 66.3% for September 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 97.4%, failed for the fourth month in a row. Significant staffing issues and increased inpatient demand in Echocardiography being the main issue. Endoscopy also contributed to the poor performance this month. A recovery action plan is in place.

Looking forward:

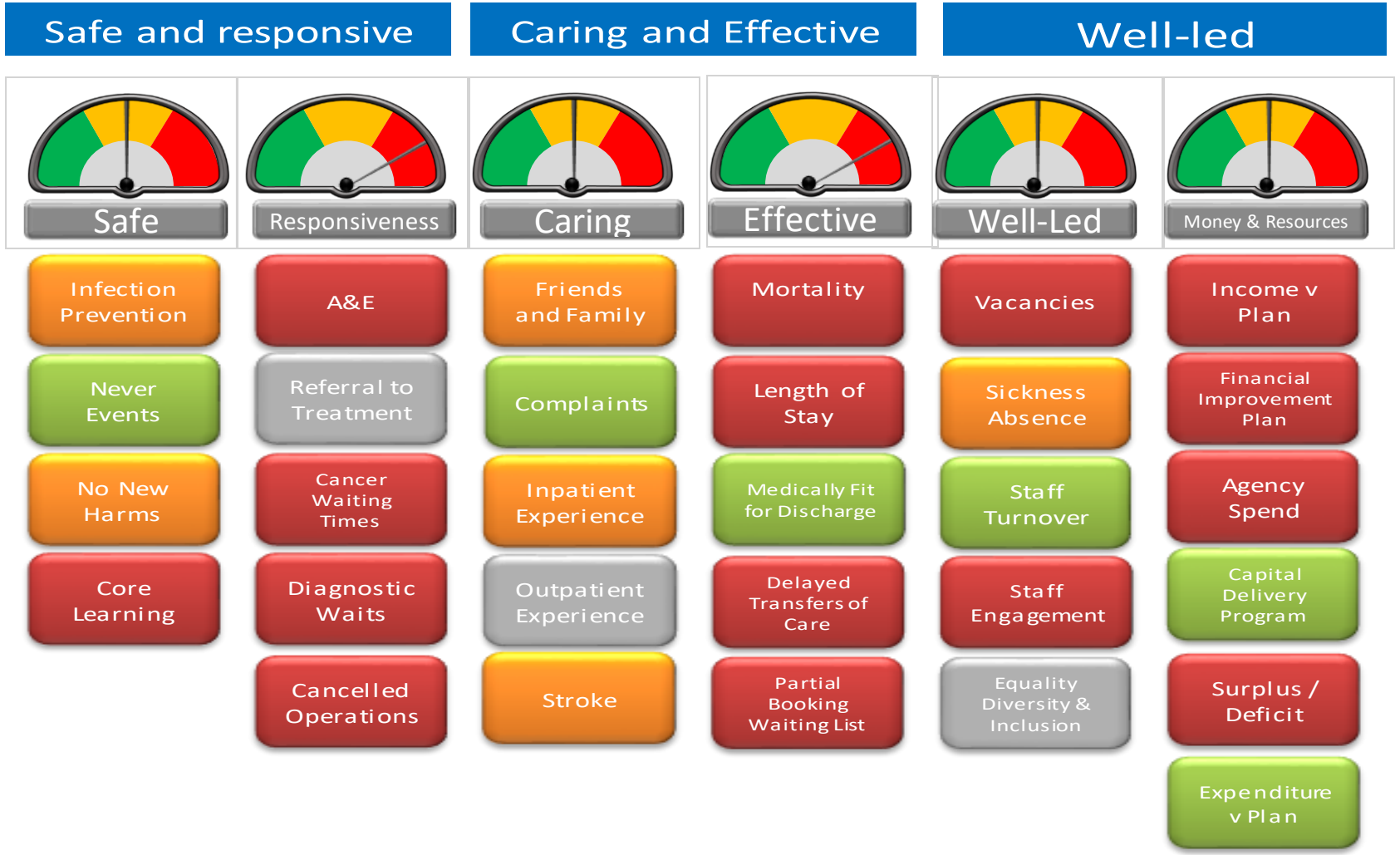
The Trust continues to focus on exception reports to identify future milestones to recovery, particularly or where there is a trending decline in performance, or where KPIs have been red or amber for three consecutive months.

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

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

Integrated Performance Report

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



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	42	6	8
MRSA bacteraemia (post 3 days)	Monthly	Datix	0	1	0	0
MSSA	Monthly	Datix	14	9	2	1
ECOLI	Monthly	Datix	56	25	2	3
Never Events	Monthly	Datix	0	1	0	1
No New Harms						
Serious Incidents reported (unvalidated)	Monthly	Datix	0	173	22	26
Harm Free Care %	Monthly		95%	91.74%	90.80%	91.90%
New Harm Free Care %	Monthly		98%	98.05%	97.00%	97.60%
Catheter & New UTIs	Monthly		1	1	2	1
Falls	Monthly	Datix	3.90	3.57	3.50	3.32
Medication errors	Monthly	Datix	0	991	120	138
Medication errors (mod, severe or death)	Monthly	Datix	0	145	19	19
Pressure Ulcers (PUNT) 3/4	Monthly			46	9	8
VTE Risk Assessment	Monthly		95%	97.00%	96.58%	96.49%
Core Learning	Monthly	ESR	95%	90.40%	89.17%	90.73%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Caring						
Friends and Family Test						
Inpatient (Response Rate)	Monthly	Envoy Messenger	26%	24.43%	24.00%	21.00%
Inpatient (Recommend)	Monthly	Envoy Messenger	96%	91.71%	90.00%	92.00%
Emergency Care (Response Rate)	Monthly	Envoy Messenger	14%	19.29%	20.00%	18.00%
Emergency Care (Recommend)	Monthly	Envoy Messenger	87%	81.00%	81.00%	82.00%
Maternity (Reponse Rate)	Monthly	Envoy Messenger	23%	9.00%	8.00%	9.00%
Maternity (Recommend)	Monthly	Envoy Messenger	97%	96.57%	97.00%	98.00%
Outpatients (Reponse Rate)	Monthly	Envoy Messenger	14%	14.14%	14.00%	13.00%
Outpatients (Recommend)	Monthly	Envoy Messenger	94%	92.43%	92.00%	92.00%
Complaints						
No of Complaints received	Monthly	Datix	70	420	58	74
No of Complaints still Open	Monthly	Datix	0	1824	302	276
No of Complaints ongoing	Monthly	Datix	0	273	58	42
No of Pals	Monthly	Datix	0	0	0	0
No of pals converted to formal complaints	Monthly	Datix	0	0	0	0
Inpatient Experience						
Mixed Sex Accommodation	Monthly	Datix	0	5	2	3
eDD	Monthly	EDD	95%	83.45%	83.27%	80.07%
PPCI 90 hrs	Quarterly		100%	95.10%	97.33%	97.33%
PPCI 150 hr	Quarterly		100%	85.00%	85.33%	85.33%
#NOF 24	Monthly		70%	57.72%	53.62%	53.33%
#NOF 48 hrs	Monthly		95%	91.82%	94.20%	92.00%
Dementia Screening	1 month behind		90%	91.35%	93.82%	93.52%
Dementia risk assessment	1 month behind		90%	95.32%	93.68%	92.72%
Dementia referral for Specialist treatment	1 month behind		90%	83.46%	88.57%	84.38%
Stroke						
Patients with 90% of stay in Stroke Unit	1 month behind	SSNAP	80%	83.55%	91.40%	90.30%
Sallowing assessment < 4hrs	1 month behind	SSNAP	80%	70.28%	73.50%	76.20%
Scanned < 1 hrs	1 month behind	SSNAP	50%	58.90%	52.10%	69.20%
Scanned < 12 hrs	1 month behind	SSNAP	100%	97.90%	99.00%	97.30%
Admitted to Stroke < 4 hrs	1 month behind	SSNAP	90%	64.60%	64.60%	67.10%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Responsiveness						
A&E						
4hrs or less in A&E Dept	Monthly	Medway	90.0%	78.65%	77.54%	76.68%
12+ Trolley waits	Monthly	Medway	0	0	1	0
RTT						
52 Week Waiters	Monthly	Medway	0	7	3	7
18 week incompletes	Monthly	Medway	92.0%			88.09%
Cancer - Other Targets						
62 day classic	1 month behind	Somerset	85%	69.55%	66.30%	71.20%
2 week wait suspect	1 month behind	Somerset	93%	89.00%	90.10%	85.30%
2 week wait breast symptomatic	1 month behind	Somerset	93%	83.13%	87.90%	91.70%
31 day first treatment	1 month behind	Somerset	96%	95.92%	93.00%	97.90%
31 day subsequent drug treatments	1 month behind	Somerset	98%	99.53%	100.00%	100.00%
31 day subsequent surgery treatments	1 month behind	Somerset	94%	91.45%	92.70%	97.60%
31 day subsequent radiotherapy treatments	1 month behind	Somerset	94%	94.98%	95.60%	100.00%
62 day screening	1 month behind	Somerset	90%	86.63%	97.60%	89.70%
62 day consultant upgrade	1 month behind	Somerset	85%	86.80%	100.00%	84.30%
104+ Day Waiters	1 month behind	Somerset		-	8	9
Diagnostic Waits						
diagnostics achieved	Monthly	Medway	99.1%	98.62%	97.35%	98.07%
diagnostics Failed	Monthly	Medway	0.9%	1.38%	2.65%	1.93%
Cancelled Operations						
Cancelled Operations on the day (non clinical)	Monthly	Medway	1.10%	3.96%	4.57%	4.06%
Not treated within 28 days. (Breach)	Monthly	Medway	0.00%		8.97%	4.71%

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Effective						
Mortality						
SHMI	Quarterly		100	111.42	112.57	112.57
Hospital-level Mortality Indicator	Quarterly		100	102.99	102.34	102.17
Length of Stay						
Average LoS - Elective	Monthly	Medway / Slam	2.8	2.81	3.12	2.73
Average LoS - Non Elective	Monthly	Medway / Slam	3.8	4.37	4.37	4.37
Medically Fit for Discharge	Monthly	Bed managers	60	56.14	53.00	62.00
Delayed Transfers of Care	Monthly	Bed managers	3.5%		4.12%	4.66%
Partial Booking Waiting List	Monthly	Medway	0	5249	3956	4762

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Well Led						
Vacancies	Monthly	ESR	5.0%	10.58%	9.85%	9.73%
Sickness Absence	Monthly	ESR	4.5%	4.53%	4.62%	4.62%
Staff Turnover	Monthly	ESR	8.0%	5.60%	5.37%	5.32%
Staff Engagement						
Staff Appraisals	Monthly	ESR	95.0%	78.86%	78.00%	80.00%
Equality Diversity and Inclusion						

Metric	Reporting Frequency	Source	Target	YTD	Current Month	Last Month
Money & Resources						
Income	Monthly	Board Report Master	37978	246689	35234	36249
Expenditure	Monthly	Board Report Master	-41646	-288214	-41455	-41306
Efficiency Delivery	Monthly	FIMS report	1526	3746	0	1523
Surplus / Deficit	Monthly	FPIC Finance Report	-3668	-50416	-7542	-6267

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:	28th November 2017	Reporting Period:	October 2017

Exception Details

In September the Trust reported performance of 88.1%, a deterioration of 0.6% compared with the position in August. The number of patients on incomplete pathways over 18 weeks increased by 254 during September, up to 3336 patients.

At a national level the standard hasn't been achieved for 18 consecutive months, with an aggregated national performance in September of 89.1%.

Five days prior to submission October's performance was in line with August's position, however the Trust was unable to run an updated performance position on the day of submission following the Medway upgrade. The impact of five days less validation than during a normal reporting cycle was spread across a range of speciality areas, with increases in 18 week backlogs in some areas and reduced rates of improvement in others (net increase of 254 patients).

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

- ENT – 18 week+ position deteriorated by 119 patients in September. The service accounts for c.29% of Trust's 18 week+ backlog of patients. It is considered that the speciality demonstrated a 'true' deterioration during September, but that this was exacerbated by the above validation issue. As described previously there have been significant clinical capacity reductions in recent months due to sickness and compassionate leave. The speciality has over 100 patients waiting over 40 weeks on the PTL, leading to Increasing numbers of 52 week breaches. Significant future risk relating to upcoming Consultant vacancies.
- Gastro – Accounted for c.10% of Trust's 18 week+ incompletes at the end of September. The Consultant capacity gaps from summer have now addressed. The Service had anticipated a greater improvement in performance during September, however the impact of the reduced validation time period offset this underlying improvement.
- General Surgery – Deterioration in 18 week+ position in September by 46 patients. This was exacerbated by an increased rate of cancelled operations and the validation issue.

The monthly Cancelled Operations had been partially validated at the time of writing, with 283 cancelled Operations on the day in October and 180 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 1255 on 20th November, 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 (14%)
- General Surgery (5%)
- ENT (4%)

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.

At the end of October there were 3 patients (all within ENT) on incomplete pathways over 52 weeks. Harm reviews were completed for these three patients by the lead Clinician responsible for their care, with 2 reporting low levels of harm and 1 reporting no harm as a result of the long waiting times.

What action is being taken to recover performance?

Following the Medway upgrade over the weekend of 20th October, post upgrade testing of RTT incomplete figures showed a drop in volumes. This was identified as a change to the underlying "Periods" RTT table which summarises records from the "Events" table to show current open pathways. However, it was soon identified that this was including some records that we would identify as incorrect. Work was done to re-write the RTT scripts, firstly from a revised Periods table, then from Events directly, the latter being the current method of identifying incomplete pathways. Further work has been done between Information Services and the 18 week team to narrow down the reported incomplete numbers through allocating pathway to exclusion or data quality cohorts, each with a specific rule for identifying pathways. These are currently being reviewed and validated on a sample basis by the 18 weeks team, and confirming or otherwise their continued exclusion. If they are identified as being true incompletes, the rule is removed so that they are included in incomplete numbers.

The PTL from the week before the upgrade was used to track pathways known at that time to the current position, and all but 95 of the c35,000 pathways were tracked. Further work is being undertaken on the 95 to understand where they are now (initial reviews suggest a combination of deleted and merged pathways will explain the bulk of the changes).

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

The Trust have submitted a request to NHSI for approval to not submit October or November month end RTT performance whilst the above data quality assurance actions are completed. The position at the end of November will be reviewed to inform the likelihood of reporting November month end in December, but it is currently anticipated that we won't be in a position to submit November's month end performance.

Speciality Actions

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

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

The ENT Service continue to complete virtual clinics in order to assist with management of follow-ups. As at 20th November 157 ENT patients had been confirmed as transferred to a different provider as part of this year's outsourcing arrangements, however the speciality has experienced issues with delayed rejections back from private providers which has impacted upon the effectiveness of the outsourcing completed in this area. Further outsourcing and insourcing options are being explored by the Clinical Directorate, particularly relating to the backlog of paediatric cases.

An advice and guidance service is scheduled to commence within ENT by the end of November, providing secondary care support to GP Practices prior to referrals being made into the Trust. A new Audiology pathway has commenced which will support the ENT backlog reduction, by streaming appropriate patients to Audiology assessment as part of a MDT clinic. The scope of this new pathway has increased during November, as the age range of patients included has been widened.

Outsourcing has commenced within General Surgery, Ophthalmology and Urology. As at 20th November, a total of 78 General Surgery patients, 49 Ophthalmology patients and 12 Urology patients have been accepted by independent sector providers, with plans for further patients to be identified within these speciality areas.

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

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

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

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. This period of referral divert has now come to an end. Lincs West CCG, South Lincs CCG and South-West CCG did not agreed to a service pause into the specialities requested in June. In ENT, Comm Paeds and Dermatology during the period of this referral divert, GP referrals into these specialities reduced by the following levels compared to the pre-divert period:

- ENT 15% reduction
- Dermatology 6% reduction
- Comm Paeds 43% reduction

Peer review of referrals has commenced in a small proportion of GP practices, and is expected to roll out to all practices in the coming months.

On 1st September the Neurology Service re-opened to headache patients, where the recently approved community headache pathway has been utilised. CCG representatives were unable to attend the scheduled meeting in early November to discuss the re-opening of the full Neurology Service, therefore this decision has been re-scheduled to be discussed on 27th November.

What is the recovery date?

March 2017

Cancer Waiting Times – 62 Day

Executive Responsibility: Mark Brassington – Chief Operating Officer

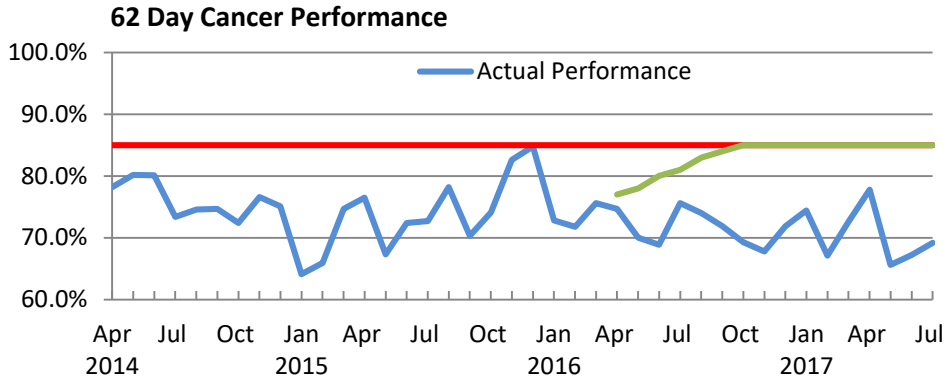
KPI:	Cancer Waiting Times (62 Day)	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Deputy Director of Operational Performance – Planned Care
Date:	28th November 2017	Reporting Period:	September 2017

Exception Details

The Trust achieved a performance of 66.3% against the 62 day classic standard in September.

The Trust achieved 4 out of the 9 cancer standards.

138 treatments were recorded in September against the 62-day classic standard, which is the lowest monthly treatment volume recorded since April (the previous 3 months had all been over 160 treatments each).



Performance in Lower GI remained below 55% for the fifth month in a row. Skin dropped below 90% for the first time in over a year, and the volume of treatments recorded in skin was 15 less than in August, which had a negative impact on the overall Trust position. There was a significant improvement in lung performance, which performed above 75% for the first time in the over 2 years.

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

- Theatre capacity
- Pathology
- Patient choice and fitness
- CT Capacity (including biopsies)
- Outpatient capacity
- Oncology capacity
- Administrative delays

The combined frequency of Pathology and theatre capacity issues identified has more than double compared with August

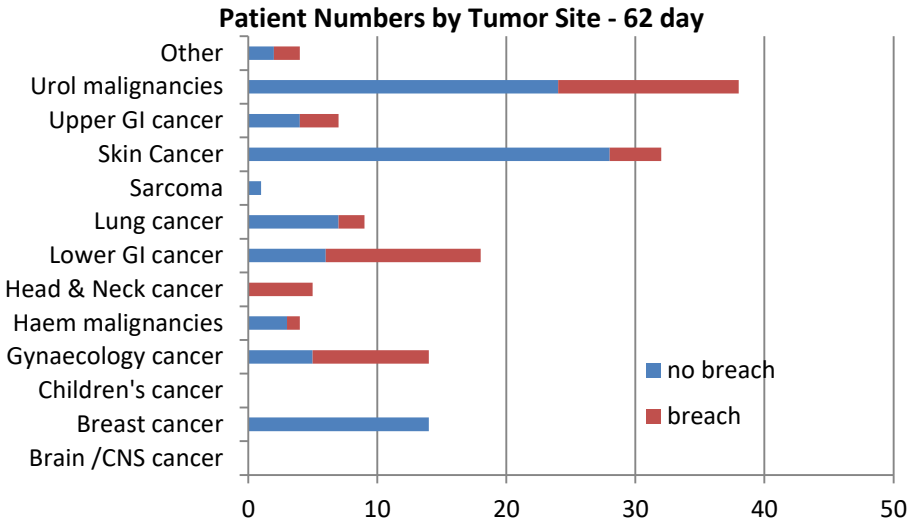
As of 17th November there are 13 pts on or over 104 days without an agreed treatment plan: 8 x Urology, 1 x colorectal, 1 x Head and Neck, 1 x Upper GI, 1 x Haem, 1 x lung. 3 of the 13 have confirmed cancer diagnosis. The management for five of these patients being led by a tertiary centre.

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

- 9 cases included patient choice delays
- 5 cases included theatre capacity restrictions
- 4 case included Outpatient capacity

- 4 case included pathology delays
- 4 cases included Oncology capacity delays
- 4 cases included complexity or procedural factors
- 3 cases included CT delays
- 3 cases included links to primary care delays
- 2 cases included patient fitness factors
- 1 case included U/S capacity restrictions
- 1 case included other Radiology restrictions
- 1 case included delays within the MDT
- 1 case included delays as a result of pathway processes

The Trust completes a full review of any potential harm related to excessive waits for cancer treatment (104 + Day Waits): 13 Harm Reviews issued for September. As at 20th November 7 have identified no harm, 3 have identified a low level of harm, 0 have identified a moderate level of harm. The remainder are awaiting clinical feedback. Moderate and severe levels of harm will be reviewed by the Medical Director for onward management.



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. The Trust is waiting for formal confirmation that additional central funding has been secured in order to continue this until the end of the financial year.
- Roll out of lower GI STT at Pilgrim – The Clinical Directorate and CCG are in agreement to ensure that this service will commence by the end of December.
- Oncology administrative optimisation – Chemo-scheduler business case has been approved. These posts have been appointed to and the individuals are now in post. This will improve co-ordination of chemotherapy capacity.
- Histology turnaround times – Performance meetings commenced with Path Links. Path Links have secured additional locum Consultant capacity and are pursuing options around outsourcing of reporting. 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 and have successfully recruited to longstanding vacancies. Performance figures from October show improvements in overall turnaround times, but this will continue to be reviewed with further options considered to improve performance as required.
- Straight to test for CT on lung pathway – Pathway agreed within the Trust. Details have been distributed to CCGs for communication with GP Practices, with a view to the service commencing in mid-December. Once the straight to test aspect of the pathway is established the lung team have plans to further develop the early stages of the pathway in line with national recommendations for service developments.
- Communication with patients – The CCGs have provided 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 have been established in order to unblock delays within individual cancer pathways, involving representation from all key areas within the Trust's cancer pathways.
- Chief Operating Officer has commenced weekly PTL review meetings with Clinical Directorates.

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 – interviews scheduled for mid-November
- Radiology Cancer Co-ordinator – Interviews completed, but no appointment made. Clinical Directorate reviewing alternative options for implementation.
- 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 has been developed in draft, with a plan to sign off this work by the end of November.

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:	28th November 2017	**Reporting Period:**	October 2017

Exception Details

ULHT performance against the 4 hour target for October was 77.54 %, showing a slight improvement compared to the previous month.

Lincoln performance for October 2017 was 76.15% which is an improvement from last month of 3.70%. This does however, remain below the monthly trajectory for October of 89%.

Medical staffing fill rates improved during October improved with nurse staffing levels remaining variable.

Middle Grade Fill Rates	02/10/2017	09/10/2017	16/10/2017	23/10/2017	30/10/2017
Weekly hours required	534	534	534	534	534
Substantively filled	125.5	101	120.5	139.5	120.5
Internal MG Extra	61	58.5	41	16	46
Internal Con acting Down Extra	0	0	0	0	24
Agency Filled	323.5	338	356.5	344	280
Grantham Filled	0	0	0	0	0
Grantham extra hours	48				
Not Filled	**24**	**36.5**	**16**	**34.5**	**63.5**
Vacancies	12	12	12	12	12

Activity levels during October have risen, seeing more days of attendances well above the 200 baseline level. There have been many days where attendances have been around 220 mark with the more significant spike being recorded as 240 attendances. Acuity has also been a notable feature of October with increasing respiratory illnesses and sepsis an issue. The attendance rise coupled with increasing acuity has required level 4 site management on an increasing number of days in order to return it to a state of normal working.

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

GP Streaming has been embedding throughout October with staff becoming more familiar and comfortable with the new process. Whilst streaming numbers were initially low, by the end of the month (5 weeks post commencement of streaming) they had increased to around 15% against the target of 20%.

A major cause of delays during October has been the poor performance of our non-emergency transport provider TASL who have struggled to step up to the required activity levels and have on occasions declared major incident status. This has necessitated the short-term engagement of a private transport provider to maintain flow on site.

What action is being taken to recover performance?

At Lincoln the newly qualified nurses completed their supernumery period in October. There is an on-going focus on recruitment to medical staff in the ED. The Emergency Department medical rota has become more stable and international recruitment is progressing well. 5 middle grade doctors have been offered clinical attachments in the UK to enable sign off of an English assessment and registration with the GMC.

The building scheme for the GP Streaming Service remains on track and is due to complete by 18th December 2017.

A key site focus is on achieving 10 empty admitting area beds by 10am in order to gain early flow on site in order to decompress the Emergency Department. This coupled with a drive to deliver agreed levels of ward discharges on a daily basis has been supporting an improvement on performance. Further work is required in order to improve weekend discharges and this will be one of 3 key areas of focus during November.

Diagnostics

Executive Responsibility: Mark Brassington – Chief Operating Officer

KPI:	Diagnostics	Owner:	Chief Operating Officer
Domain:	Responsive	Responsible Officer:	Director of Operations / Deputy Director of Urgent Care
Date:	28th October 2017	Reporting Period:	October 2017

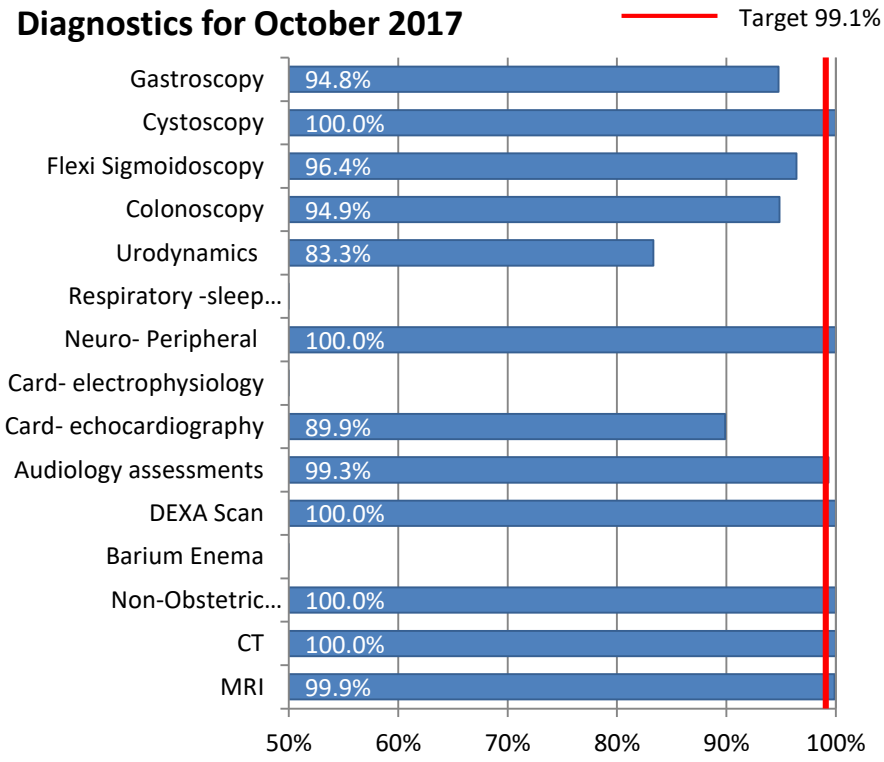
Exception Details

In October the Trust failed the 6 week diagnostic standard for the fourth time in the last eleven months. The performance level was 97.35%.

There were 176 diagnostic patients which breached the 6-week standard in October, which was 53 more than at the end of September.

109 of the breaches were within Echocardiography. This service has experienced significant capacity restrictions in recent months with two members of staff commencing maternity leave, one member of staff taking paternity leave and existing sickness levels within the department. Additionally the service has experienced increasing inpatient demand during this period. In October the service cancelled 59 outpatient slots due to the need to prioritise increased levels of inpatient demand.

57 of the breaches were within Endoscopy. The sudden increase in breach numbers within Endoscopy was primarily the result of a failure of escalation and administrative processes rather than clinical capacity restrictions.



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
- 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.
- Improved rota management and standardisation of booking rules
- The service will finalise a detailed capacity and demand review by December, with a view to formulating a Business Case to address capacity gaps.

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

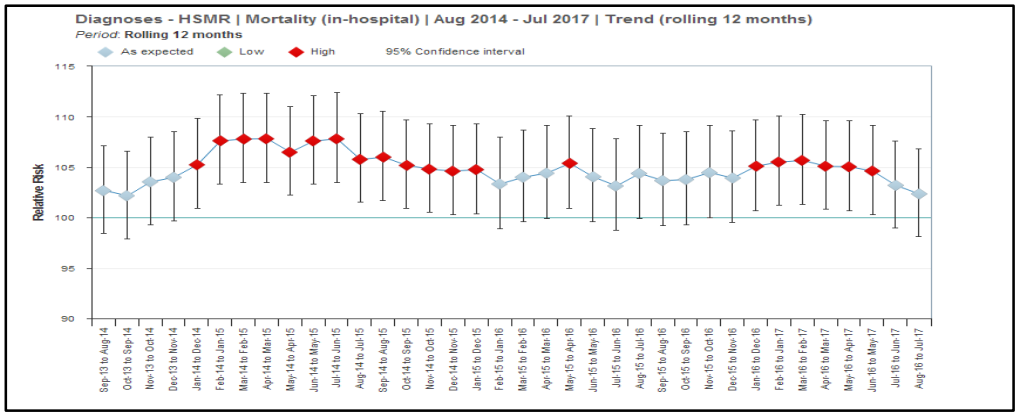
The Endoscopy Service have completed a RCA relating to the issues which led to the deterioration in performance in October. This has resulted in an action plan being devised with immediate actions to be undertaken to ensure booking and escalation processes are in place. There is increased risk relating to the November month end position for Endoscopy as a result of failures of sterilisation equipment on two sites in mid-November.

Safe Ambition 1: Reduction of Harm Associated with Mortality

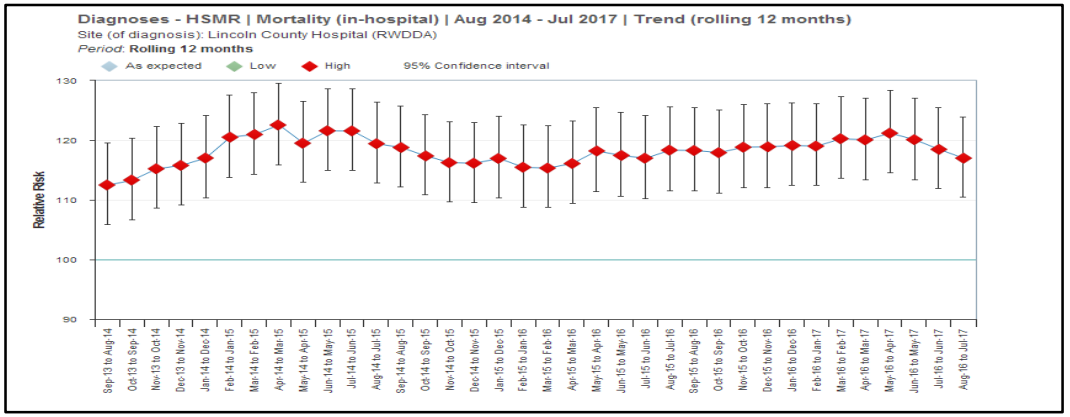
Executive Responsibility: Neil Hepburn – Medical Director

Trust/Site	ULHT HSMR Aug 16-Jul 17 12 month	ULHT HSMR Apr 17-Jul 17 YTD	ULHT HSMR Jul-17	ULHT SHMI Apr 16-Mar 17	Trust Crude Mortality YTD Internal source Nov 16-Oct 17
Trust	102.34	93.18	90.12	112.57	1.77%
LCH	116.98	1105.27	94.91	117.39	1.79%
PHB	93.28	87.64	96.60	111.14	1.97%
GDH	67.68	50.71	17.48	93.97	0.93%

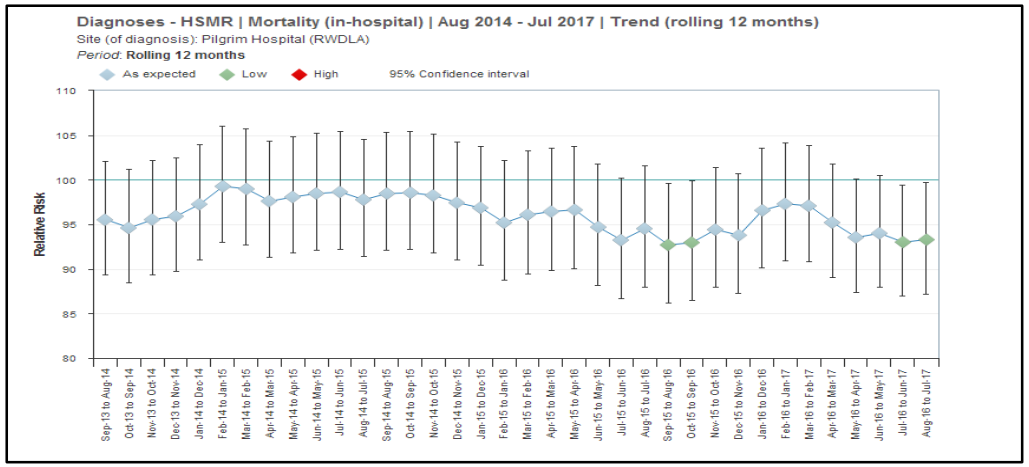
ULHT HSMR Rolling Year (36 Months)



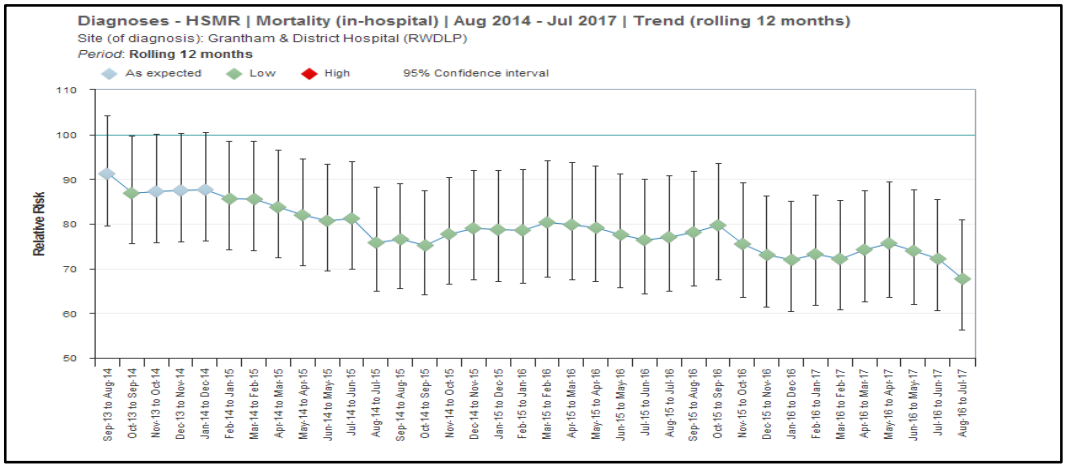
Lincoln HSMR Rolling Year (36 Months)



Pilgrim HSMR Rolling Year (36 Months)



Grantham HSMR Rolling Year (36 Months)



Alerts

ULHT

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

- Other Perinatal Conditions: Second month of alerting at Trust level, driven by the pilgrim site with 16 mortalities and 8.89 over the predicted Dr Foster data. A meeting is to be held with W&C governance, QG governance, coding and Dr Foster to agree action plan
- Respiratory Failure insufficiency arrest (adult): Second month alerting at Trust level. Driven by the Lincoln site; 42 mortalities with 13.88 over the predicted Dr Foster data. An in-depth review is currently underway due to the patient list sourced and notes requested.
- Aortic peripheral and visceral artery aneurysms: First month of alerting at Trust level. Not driven by any Site; 25 mortalities with 9.57 over the predicted Dr Foster data.

SITE

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

Actions underway

- Biliary Tract Disease: This is cumulative throughout the time period with 23 mortalities and 12.39 over the predicted Dr Foster data. This has now been alerting for 7 months and is alerting at Trust level. An in-depth review is currently underway Quality Governance have produced a report for November PSC – action plan to be agreed.
- Intestinal Obstruction without hernia: This has been alerting for 8 months; to date there are 24 mortalities and 11.37 over the predicted within this diagnosis group. An in-depth review has been completed with issues pertaining to the primary diagnosis coding and Palliative care coding. An action plan was agreed and Associate Medical Director and Quality Governance have met with the palliative care team and work is underway to check coded data against Palliative care team log.
- Septicemia (except in labour): This is a cumulative alert and not alerting in a particular month; year to date there are 113 mortalities and 21.29 over the predicted Dr Foster data. This is the fourth month alerting. There is a sepsis committee who meets monthly and has a detailed action plan to improve compliance of sepsis. Sepsis coding rule changed in April 2017. QG has completed an overview which was presented at July PSC. Sepsis nurses completed a coding review and outputs were comorbidities not being documented.
- Acute Cerebrovascular disease: This is the fourth month of alerting with 114 observed and 27.65 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. An in-depth review is underway patient list sourced and notes requested.
- Fluid and electrolyte disorders: This is the fourth month of alerting with 17 observed and 9.28 mortalities over the predicted Dr Foster data. An in-depth review is underway patient list sourced and notes requested.

New

- Senility and organic mental disorders: The first month of alerting with 19 mortalities with 7.88 over the Dr Foster predicted data.
- Other gastrointestinal disorders: The first month of alerting with 16 mortalities and 7.93 over the Dr Foster predicted data.

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

- Abdominal Pain: The is the third month of alerting with 5 observed and 3.62 mortalities over the predicted Dr Foster data.
- COPD and bronchiectasis: This is the second month on alerting with 48 mortalities and 15.10 over the predicted Dr Foster data.
- Peritonitis and intestinal abscess: This is the second month of alerting with 6 mortalities and 3.83 over the predicted Dr Foster data.

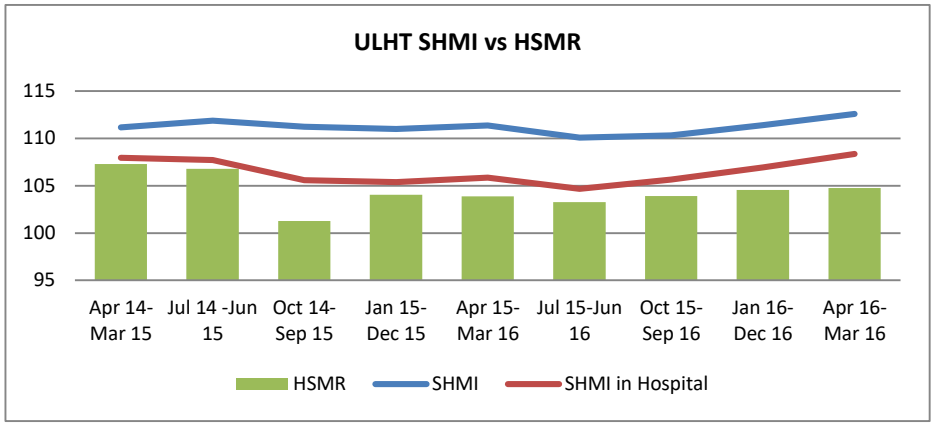
Grantham Hospital

No notifications

	Aug 16-Jul 17	
Metric	**National Acute (Non specialist)**	**ULHT**
HSMR	97.08	102.34
Elective Crude Rate %	0.20%	0.10%
Non elective Crude Rate %	6.40%	7.40%
% observed mortalities in hospital	3.50%	3.96%
% observed palliative coding	42.72%	31.67%
Avg comorb 0 score per observed %	1.20%	1.40%
Weekend HSMR	101.60	103.30
Weekday HSMR	95.50	101.90
Crude rate %	3.60%	4.00%
Spells Readmissions 28 days %	11.46%	10.74%
Residual coding % of spells	5.48%	3.46%
LOS short stay 0-2 days Observed %	1.02%	1.30%
LOS 3+ Observed %	7.69%	8.15%

SHMI

- Trust SHMI is currently outside of expected limits and is within Band 1 on the published NHS Digital data for April 2016 to May 2017.
- Lincoln and Pilgrim site are currently higher than expected.
- The Lincolnshire Mortality Collaborative continue to meet; looking at cases that are mortalities within 48 hours of admission and mortalities within 30 days of hospital discharge the next meeting is on the 9th November. Which has identified areas for improvement with Advanced care planning within the community for the GSF.
- From in-depth mortality reviews the depth of coding is being investigated by CHKS to improve coding with the Trust



Palliative Coding

- ULHT have been reporting below national average depth of coding for palliative care and also as a result of In-depth review within Intestinal Obstruction without Hernia which identified 50% of palliative care seen were not coded. A Work Programme has begun to understand this and increase palliative care coding which affects the Trust's HSMR.
- Associate Medical Director and Quality governance met with the palliative care team. Palliative care team have been logging patients seen by site.
- This was shared with Quality Governance whom have correlated this with data coded within Dr Foster:
- Time period April 2016-March 2017 1909 patients were seen by the Palliative Care Team
- For the same period 1467 patients were coded as under Palliative Care in Dr Foster.
  - 23% (442) Palliative Care was not documented/coded.
  - 35% (347) of cases were not coded on Lincoln Site.
  - 53% (89) of cases were not coded on Grantham Site.
  - 1% (6) of cases were not coded on Pilgrim Site.
  - SHMI does not take palliative care in account within the algorithm
- From this data Quality Governance have asked Palliative Care team for the most current data with patient identifiable data; so an audit can be undertaken for those from April 2017 to July 2017 (the current Dr Foster reporting period). Clinical Coding Manager has agreed to audit alongside Quality Governance for those not coded within this time period. Changing these could affect the HSMR algorithm for expected mortality.

Mortality Reviews

Reviews (Jan 2016-Sep 2017)

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

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

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

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

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

Mortality Reduction Actions

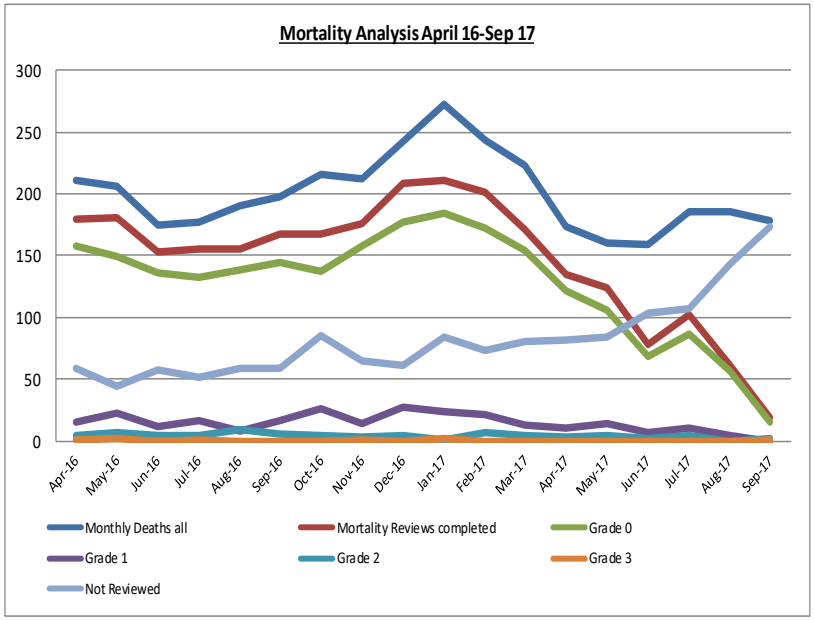
Mortality Review	Source	Review Commenced	Site	Actions	Lead	Timescale	Progress	RAG
Lincolnshire Mortality Collaborative	On-going	Underway	All	To understand the SHMI data on an organisational level. Review cases of deaths within 30 days of discharge, appropriate admissions and within 48 hours of admission. To correlate with community services and general practitioners	Dr Andrews/ Karen Moon	On-going	6 weekly meetings established since May 2017 with a quarterly update to Patient Safety committee	
Mortality Shared Learning Breifings	On-going	Underway	All	Create 2 mortality brieifngs one for the MoRAG case note review learning and the other for Mortality Matters that covers various issues pertaining to Mortality	Dr Andrews/ Karen Moon	On-going	Monthly production and circulation for MoRAG case note breifings and Mortality Matters	
MoRAG	On-going	Underway	All	Mortality Survellience Group to do in-depth reviews, where initial reviews have been Graded 1 or above.	Dr Andrews/ Karen Moon/ Kayleigh Pinner /Emma Wilson	On-going	Monthly meetings have been established since Feb 2016. With a Quarterly update to PSC	
Clinical Coding Masterclass	On-going	Underway	All	To arrange the next Clinical Coding Masterclass. To incorporate Live Clinical Coding, Dr Foster Data, Finance and Mortality	Dr Andrews/ Karen Moon	On-going	This is booked for the 31st October 2017 and run qaurterly after that.	
Junior Doctor Teaching	On-going	Underway	All	JD Teaching across each site	Quality Governance	On-going	PHB & LCH have had teaching-GDH booked for the end of November. To get on every year after that.	
Audit of Palliative care coding not coded on Dr Foster	Mortality Report	Underway	Trust	Through analysis and in-depth reviews it has been highlighted the ULHT are below the national average of palliative care coding, which highly affects the HSMR	Karen Moon	On-going	Palliative Care Team have submitted figures of those that the team have seen. QG has correlated this with Dr Foster coded data. An audit is to be undertaken by Coding and Quality Governance to ascertain why there is a difference in coding -Particulary on the LCH site.	
Acute Cerebrovascular disease	Dr Foster	Underway	LCH	Meeting to be arranged to understand the underlying data. QG have produced an overview of the Dr Foster data in the October Mortality Report this has been shared with the QSO for Stroke.	Derek Smith, Quality Governance & Stroke Team	Nov-17	Awaiting confirmation from Dr Foster to be able to progress the meeting. Both Stroke and QG have chased.	
	Dr Foster		LCH	Now 3 months of alerting In-depth review to be undertaken	Karen Moon	Jan-17	Patient List sourced, notes requested	
Depth of coding	Dr Foster In-depth Reviews	Underway	All	A need was identifed for an audit of the depth of coding for charlson comorbidity score against the notes and whats has been coded	Dr Andrews/ Karen Moon	Nov-17	Notes have been sent out for review. Awaiting return of completed proforma before producing a report for PSC.	
				The Trust has outsourced CHKS to investigate the depth of coding within the Trust. Pertaining to Mortality and Financial Performance	CHKS	On-going	QG have contacted CHKS for a meeting to discuss	
British Thorarcic Society	On-going	Underway	All	Respiratory diagnosis have been reporting on Dr Foster outside of the conifidence intervals. BTS audits are on the Trust Audit programme and findings of the audits to be reported to PSC	Respiratory/ Sharon Sinha	Dec-17	To report findings to PSC	
Biliary Tract Disease	Dr Foster	Underway	LCH	Conduct in-depth review and collate findings to produce report for PSC	Karen Moon	Dec-17	Awaiting completion of proformas to be able to produce report	
Fluid and electrolyte disorders	Dr Foster	Underway	LCH	Now 3 months of alerting In-depth review to be undertaken	Karen Moon	Jan-17	Patient List sourced, notes requested	
Respiratory Failure, insufficiency, arrest (adult)	Dr Foster	Underway	Trust	Now 3 months of alerting In-depth review to be undertaken	Karen Moon	Jan-17	Patient List sourced, notes requested	
Other Perinatal coditions	Dr Foster	Underway	Trust	Meeting to take place with W&C governance, QG governance, Dr Foster and coding to agree action plan	Karen Moon	Jan-17	Meeting to be arranged.	

Learning from Deaths National Template

The below template was issued by NHS England and has been redesigned to for our grading. The dashboard will always be a quarter behind due to the timeliness of the reviews. This methodology is based upon the National Learning from Deaths paper published in March 2017. The methodology is based upon an initial review within 7 days of the death of a patient.

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable Grade 2&3	
This Month-Sep17	Last Month-Aug 17	This Month-Sep17	Last Month-Aug 17	This Month-Sep17	Last Month-Aug 17
178	185	61	102	0	1
This Quarter (QTD) (Apr 17-Jul 17)	Last Quarter (Jan 17-Mar 17)	This Quarter (QTD) (Apr 17-Jul 17)	Last Quarter (Jan 17-Mar 17)	This Quarter (QTD) (Apr 17-Jul 17)	Last Quarter (Jan 17-Mar 17)
493	738	182	337	9	14
This Year (YTD) (Apr 17-Sep 17)	Last Year (Apr 16-Mar 17)	This Year (YTD) (Apr 17-Sep 17)	Last Year (Apr 16-Mar 17)	This Year (YTD) (Apr 17-Sep 17)	Last Year (Apr 16-Mar 17)
1042	2566	527	2128	16	68



Review Grading

Grade 0		Grade 1		Grade 2		Grade 3		Grading not completed	
Unavoidable death, no suboptimal care		Unavoidable death, suboptimal care but different management would NOT have affected outcome		Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)		Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)		Not completed in proforma by reviewer	
This Month-Sep17	84%	This Month-Sep17	0%	This Month-Sep17	11%	This Month-Sep17	5%	This Month-Sep17	0%
This Quarter (QTD) (Apr 17-Jul 17)	87%	This Quarter (QTD) (Apr 17-Jul 17)	10%	This Quarter (QTD) (Apr 17-Jul 17)	3%	This Quarter (QTD) (Apr 17-Jul 17)	0%	This Quarter (QTD) (Apr 17-Jul 17)	1%
This Year (YTD) (Apr 17-Sep 17)	88%	This Year (YTD) (Apr 17-Sep 17)	9%	This Year (YTD) (Apr 17-Sep 17)	3%	This Year (YTD) (Apr 17-Sep 17)	0%	This Year (YTD) (Apr 17-Sep 17)	1%

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.

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.

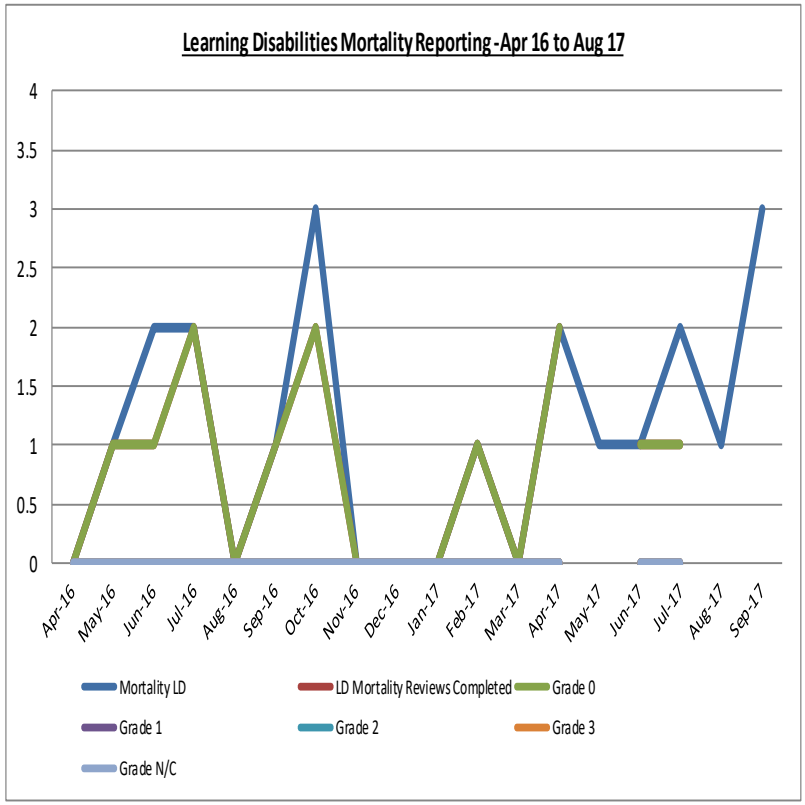
Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

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

Total Number of Deaths in scope	
This Month-Sep17	Last Month-Aug 17
3	2
This Quarter (QTD) (Apr 17-Jul 17)	Last Quarter (Jan 17-Mar 17)
6	1
This Year (YTD) (Apr 17-Aug 17)	Last Year (Apr 16-Mar 17)
10	10

Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)	
This Month-Sep17	Last Month-Aug 17
3	0
This Quarter (QTD) (Apr 17-Jul 17)	Last Quarter (Jan 17-Mar 17)
4	1
This Year (YTD) (Apr 17-Aug 17)	Last Year (Apr 16-Mar 17)
4	8

Total Number of deaths considered to have been potentially avoidable Grade 2& 3	
This Month-Sep17	Last Month-Aug 17
0	0
This Quarter (QTD) (Apr 17-Jul 17)	Last Quarter (Jan 17-Mar 17)
0	0
This Year (YTD) (Apr 17-Aug 17)	Last Year (Apr 16-Mar 17)
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	41	2	1	17	72%
169	May-16	59	36	11	1	11	81%
	Jun-16	49	34	3	2	10	80%
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	35	8	2	10	82%
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	45	6	1	19	73%
244	Feb-17	86	53	3	4	26	70%
	Mar-17	87	47	6	1	33	62%
17/18 QTR 1 MH	Apr-17	58	34	2	1	21	64%
162	May-17	51	23	5		23	55%
	Jun-17	53	19	2		32	40%
	Jul-17	42	15	3		24	43%
17/18 QTR 2 MH	Aug-17	62	6			56	10%
62	**Grand Total**	**1024**	**571**	**73**	**23**	**357**	**65%**

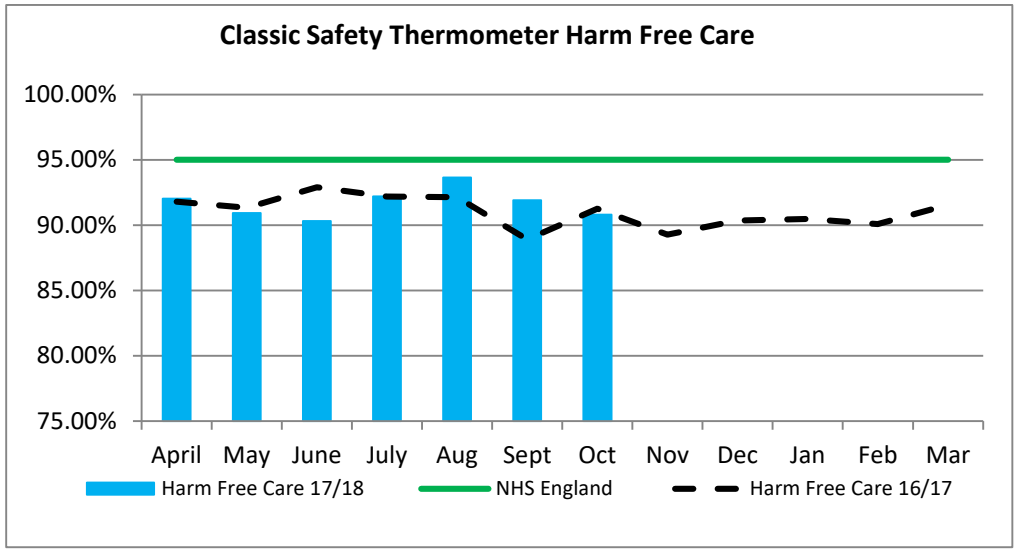
Serious Incidents

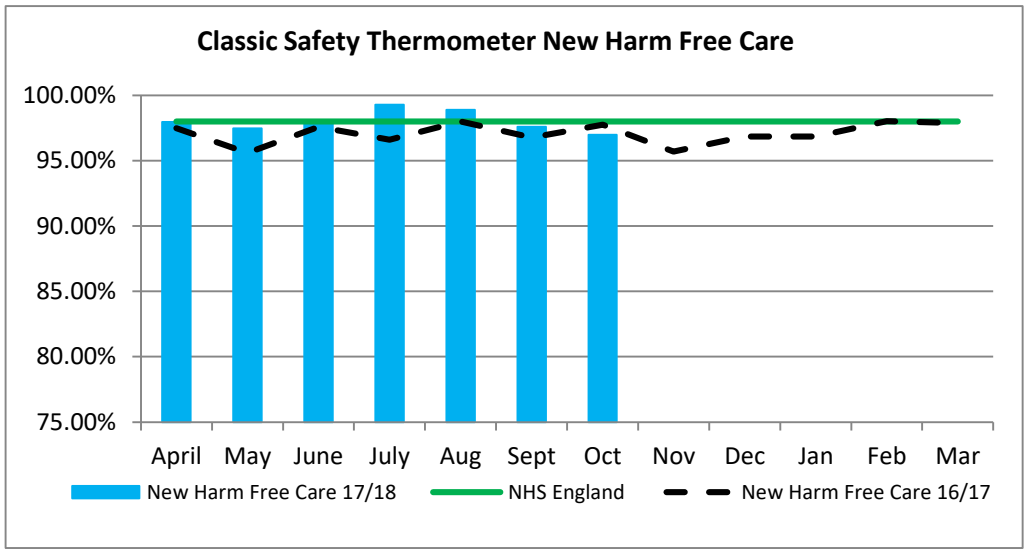
All Serious incidents form part of the “Must Do Reviews” within the Trust Methodology. Quality Governance pulls from datix the Serious Incidents with the severity of Death. Below are those SI’s correlated with the internal mortality process. Reviews are shared with the Risk Team to provide supplementary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

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

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

Executive Responsibility: Michelle Rhodes – Director of Nursin





Performance Data Overview October 2017

	ULHT	GDH	LCH	PBH
Harm Free Care	90.8%	86.8%	91.4%	91.0%
New Harm Free Care	97.0%	100.0%	96.1%	97.5%
New Category 2	9	0	3	6
New Category 3	3	0	3	0
New Category 4	1	0	0	1
Low Harm	2	0	2	0
Moderate Harm	3	0	2	1
Severe Harm	1	0	1	0
Catheter & New UTI	2	0	2	0
New VTEs	5	0	5	0
Patients	870	68	465	322

Action Plan

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

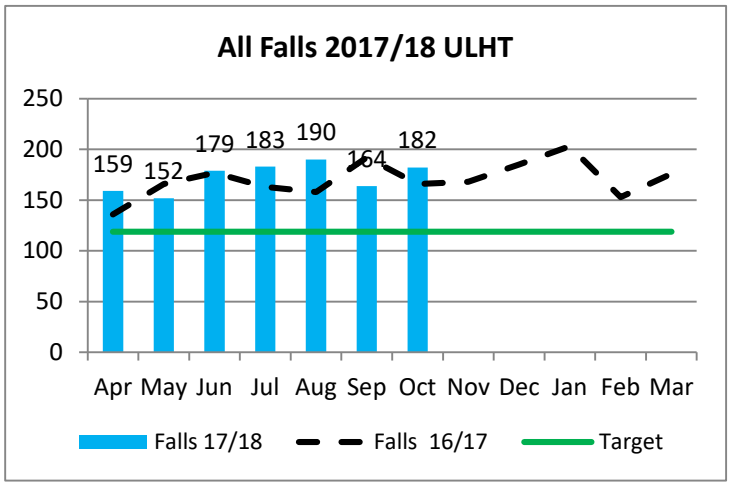
Fall actions outlined within Quality Report (see respective falls page). Results reported upwardly to Falls Reduction Group with delegated authority from Patient Safety Committee.

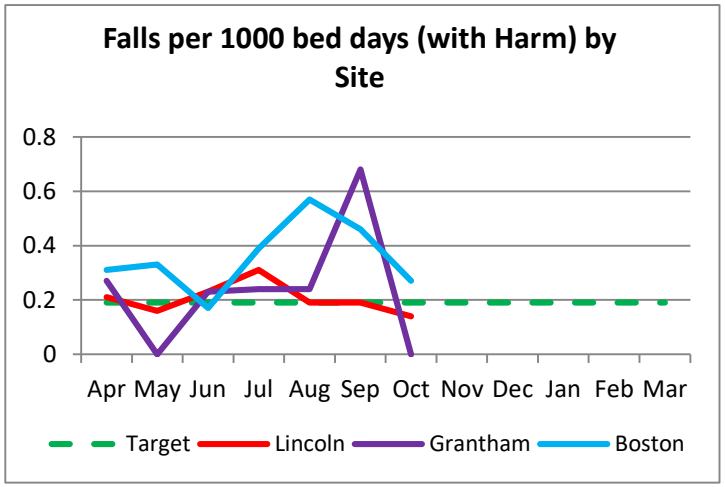
CA-UTI actions outlined within Quality Report (see respective CA-UTI page). . Results reported upwardly to Catheter Reduction Group with delegated authority from Patient Safety Committee.

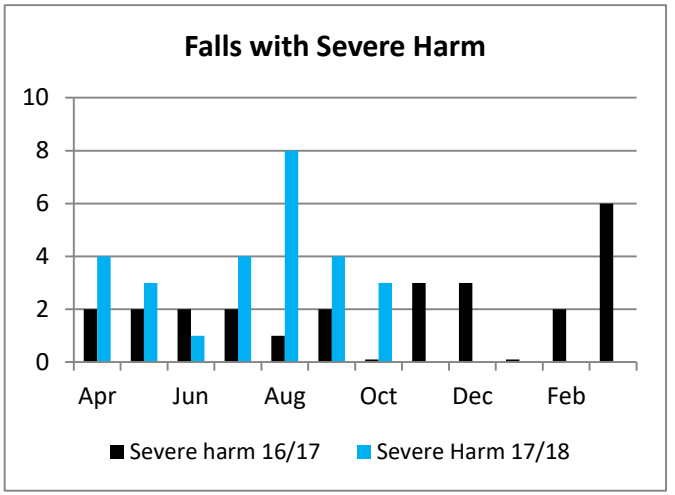
VTE investigated through Route Cause Analysis by VTE Nurse Manager and reported upwardly through Patient Safety Committee.

Safe Ambition 3: Reduction of Harm Associated with Falls

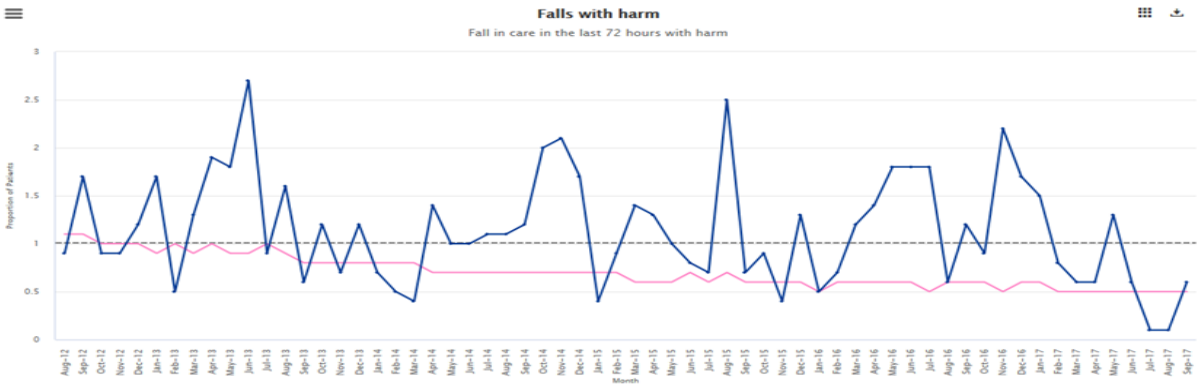
Executive Responsibility: Michelle Rhodes – Director of Nursing







Safety Thermometer 2017



Safety Quality Dashbaord (SQD) for Trust Falls Aug 2017- Oct 2017

Metric Title	Aug 2017	Sep 2017	Oct 2017
Number of patients at risk of falls	320	322	313
Medication review occurred	100.00%	100.00%	83.30%
Actions completed within 4 hours	93.50%	86.00%	91.70%
Neuro Cognition assessed	98.70%	95.70%	97.80%
Actions completed within 24 hours on admission	63.60%	66.30%	65.00%
Patient vision assessed	98.40%	94.10%	97.40%
Bed rail assessment completed if required	99.70%	99.40%	99.40%
Continence/toilet regime documented care plan 4	95.00%	88.30%	84.20%
Care plan 7 activated	96.50%	95.90%	94.50%

Performance Data Overview October 2017

Oct-17	Target	Lincoln	Pilgrim	Grantham
Ward Falls per 1000 bed days	3.9	3.26	4.12	2.67
Ward Falls with harm per 1000 bed days	0.19	0.14	0.27	0

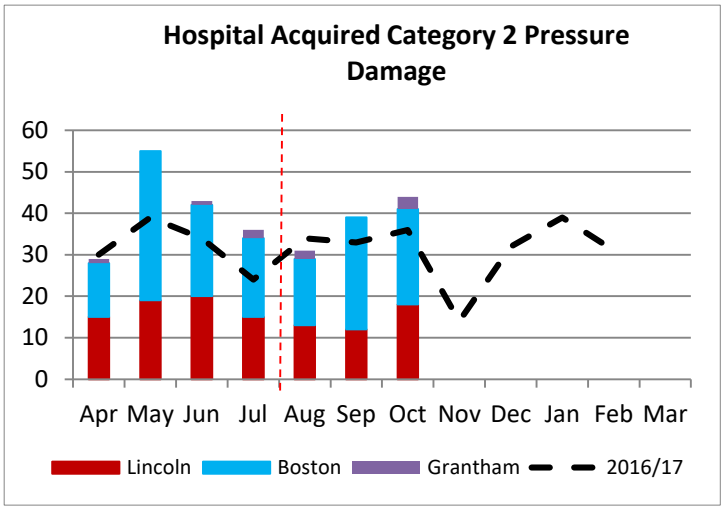
There were 3 falls with severe harm in October – Carlton Coleby (Lincoln) Navenby (Lincoln) and 6B (Boston) – compared to 4 in September. RCA investigations will be completed and reviewed at scrutiny panel. Increased severity of harm is noted in comparison to 2016/17 and further analysis is being undertaken into low completion of actions within 24 hours of admission.

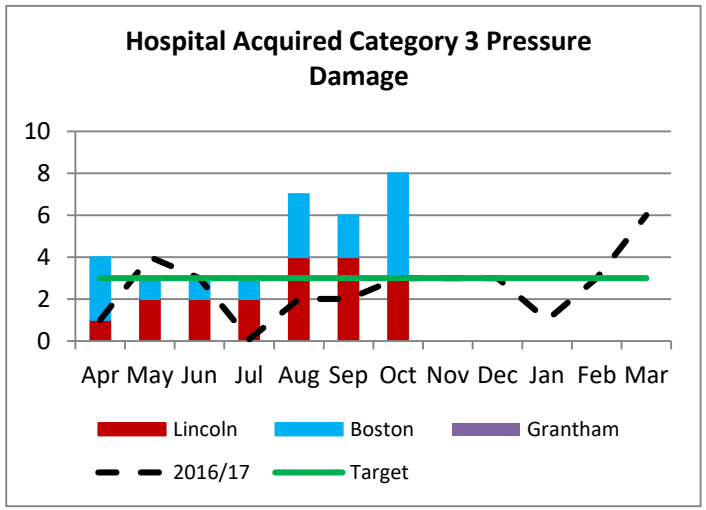
Action Plan

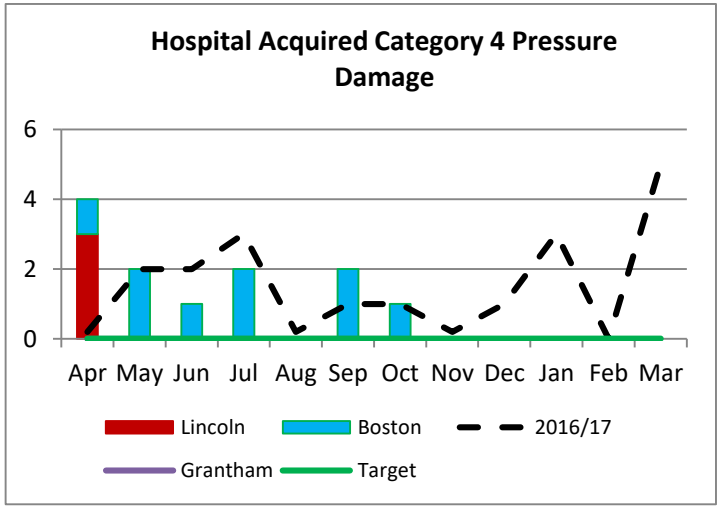
- Introduction of scrutiny process for patients who have 3 or more falls being planned
- Rollout of NHSi falls prevention collaborative work – prioritising completion of workbook and completion of lying and standing BP
- Develop ward trajectories for completion of lying and standing BP and for completion of actions within 24 hours of admission
- Revision of Falls Work Plan to identify priorities and trajectories for 2018/19
- E-learning programme being developed to compliment workbook
- Review of literature requirements from NICE Guidance
- Exploration of Falls Bundle to accompany Risk Assessment

Safe Ambition 4: Reduction of Harm Associated with Pressure Ulcers

Executive Responsibility: Michelle Rhodes – Director of Nursing

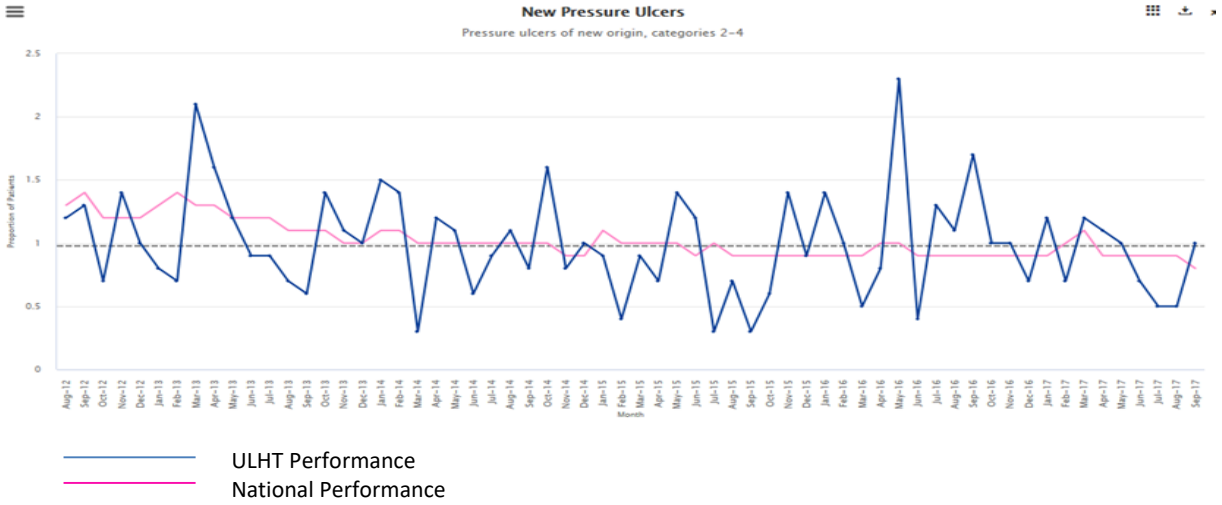






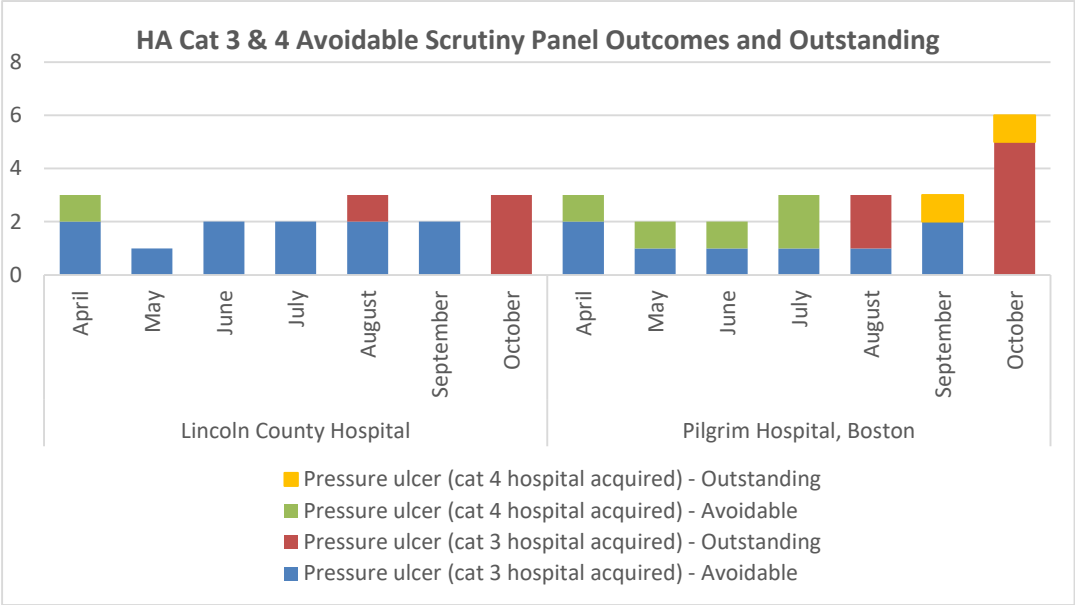
Reporting function changed to Datix August 2017

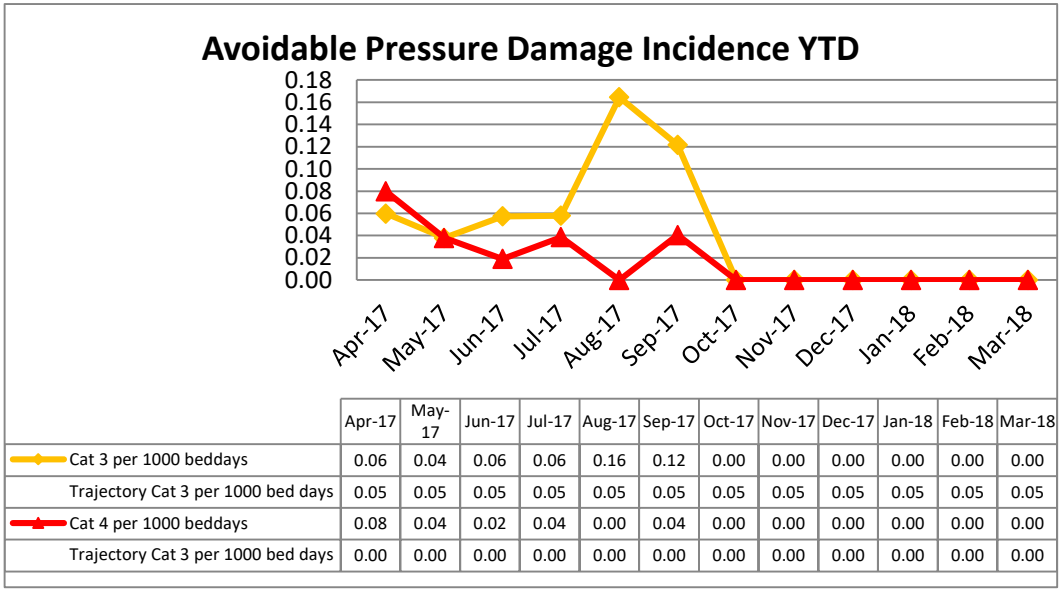
Safety Thermometer 2017 Oct 2017



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

Metric Title	Aug 2017	Sep 2017	Oct 2017
Pressure area risk assessment completed <4hrs	97.70%	96.60%	97.10%
Pressure area risk assessment updated weekly	84.10%	79.90%	78.90%
Pressure-relieving equipment in situ if required	95.80%	94.80%	95.60%
Frequency of repositioning documented	85.60%	93.80%	92.80%
Prescribed frequency of turning has been followed	76.90%	91.80%	87.70%
Pressure area care plan activated if required	94.70%	93.20%	91.40%





	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Cat 3 per 1000 beddays	0.06	0.04	0.06	0.06	0.16	0.12	0.00	0.00	0.00	0.00	0.00	0.00
Trajectory Cat 3 per 1000 bed days	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05
Cat 4 per 1000 beddays	0.08	0.04	0.02	0.04	0.00	0.04	0.00	0.00	0.00	0.00	0.00	0.00
Trajectory Cat 3 per 1000 bed days	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Performance Data Overview October 2017

Site	Cat 1	Cat 2	Cat 3	Cat 4
Lincoln	6	18	3 (Scampton, Burton, C/Coleby)	0
Grantham	1	3	0	0
Boston	9	23	5 (1B, 5B, 6B, 7a, Stroke)	1 (5B)
Louth	0	0	0	0

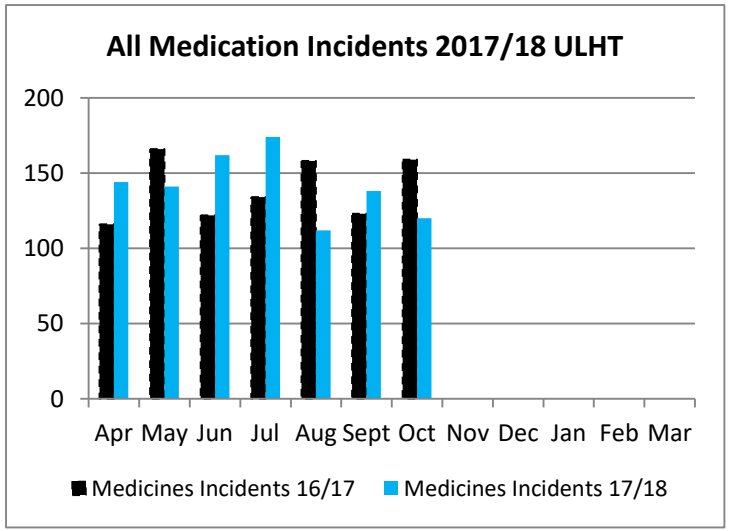
1 cat 4 PU and 8 category 3 pressure ulcers were reported in October which is an increase from recent months, however the scrutiny panels have not yet taken place to determine if these are avoidable and attributable to ULHT or not. Data suggests improved reporting of cat 1 and 2 PUs as Datix is embedded for reporting PU incidents.
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 July 2016.

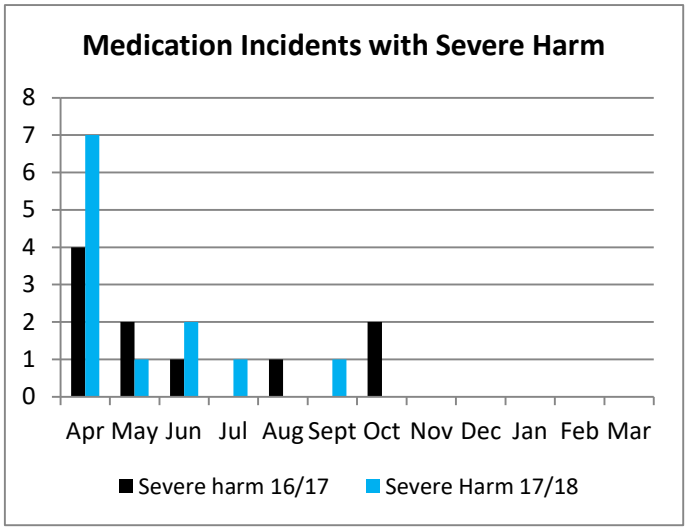
Action Plan

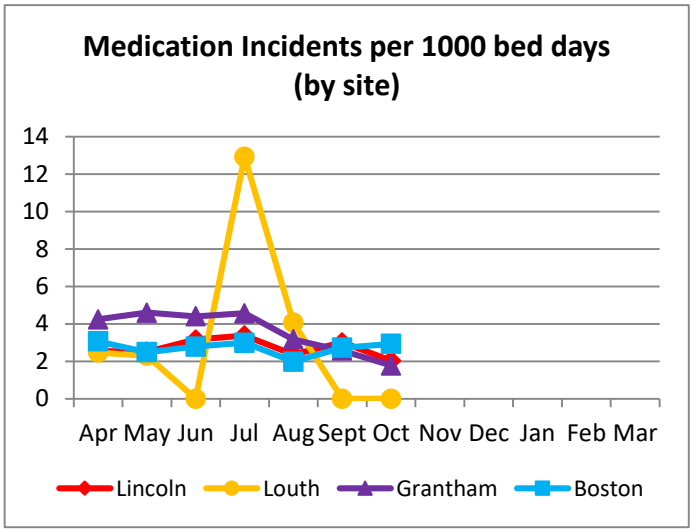
- Deep dive into Shuttleworth and 8A performance underway by Matrons, report to be presented to QGC
- Target work by TVNs with ward teams where cat 3&4 PUs continue to be reported
- Pressure ulcer prevention meetings re-established on the Lincoln & Pilgrim sites
- Revision of monitoring tracker
- Launch of Head of Nursing reports
- Commence reporting of pressure damage incidence per 1000 bed days (including trajectory Cat 3/4)
- PDSA PU prevention project to commence on the Pilgrim site
- International Sop the Pressure Day awareness campaign & poster competition - 16.11.17
- Additional training provided for HCSWs
- Newsletter produced and circulated to share lessons learnt from scrutiny panels
- Care plan developed & launched for use in A&E & emergency assessment units Nov 2017

Safe Ambition 5: Reduction of Harm Medication Incidents

Executive Responsibility: Michelle Rhodes – Director of Nursing







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

May 2017 - November 2017

WARD/DEPARTMENT	NO.
Ward 7B	4
A&E Department - Lincoln	3
Breast Screening Unit - Lincoln	3
Ward 5A	3
A&E Department - Pilgrim	2
AMU	2
Out Patient Department - Lincoln	2
Ward 5B	2
Ward 6B	2

Safety Quality Dashboard (SQD) Dashboard for Medications Aug 2017- Oct 2017

Metric Title	Aug-2017	Sep-2017	Oct-2017
Medicine chart demographics correct	96.60%	97.80%	98.90%
Allergies documented	98.10%	100.00%	99.40%
All medicines administered on time	85.70%	83.90%	84.90%
Allergy nameband in place if required	85.30%	84.30%	92.10%
Identification namebands in situ	97.90%	98.70%	99.50%

Performance Data Overview October 2017

There have been no deaths or severe rated events reported this month. There were 5 moderate rated events. The most common medication error types were:-

Adverse Event	Number
Omitted medicine/ingredient	50
Wrong/unclear dose or strength	15
Other	14
Wrong frequency	12

59% (71/120) of all the events recorded were associated with high risk drugs. The top 4 drug groups are; antimicrobials (30%), insulin and antidiabetics (21%), opiates (21%) and anticoagulant (16%).

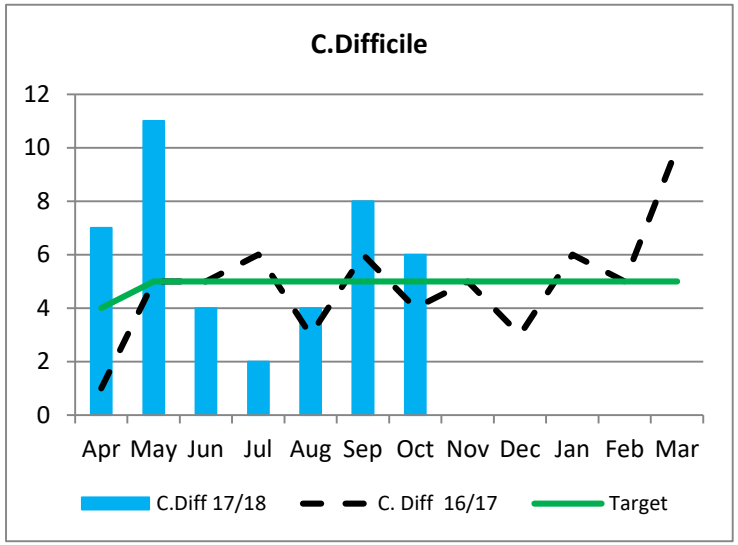
Action Plan

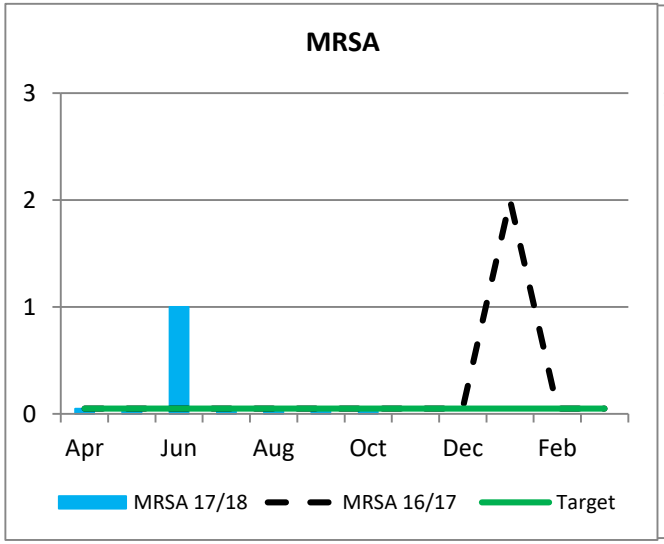
This report is reviewed at the Medicine Optimisation and Safety Committee (MOPS) and all incidents are reviewed on a monthly basis to identify trends. All Heads of Nursing receive the errors by ward area and disseminate to their matrons who in turn disseminate to their ward leaders. These all must be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

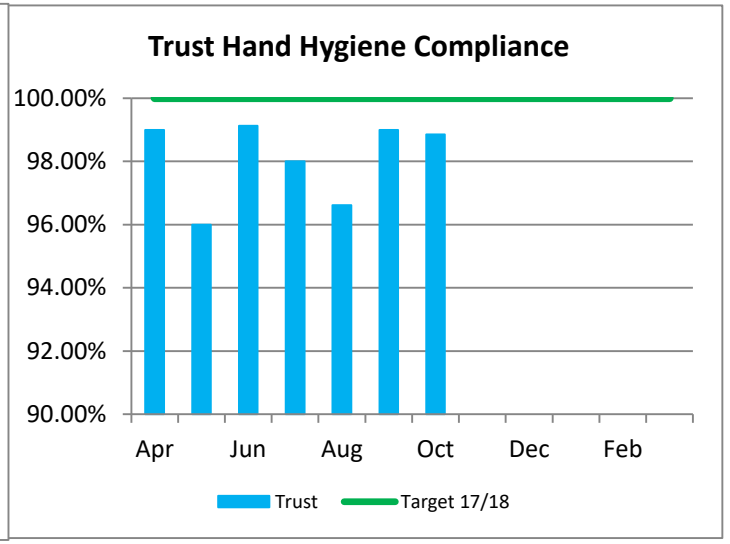
Representation at MOPS in respect of nursing and medical should improve from January 2018.

Safe Ambition 6: Reduction of Harm Associated with Infection

Executive Responsibility: Michelle Rhodes – Director of Nursing







Performance Data Overview October 2017

Hand Hygiene	
Target	99.00%
Grantham	100.00%
Lincoln	98.66%
Louth	100.00%
Pilgrim	98.33%

C.Diff

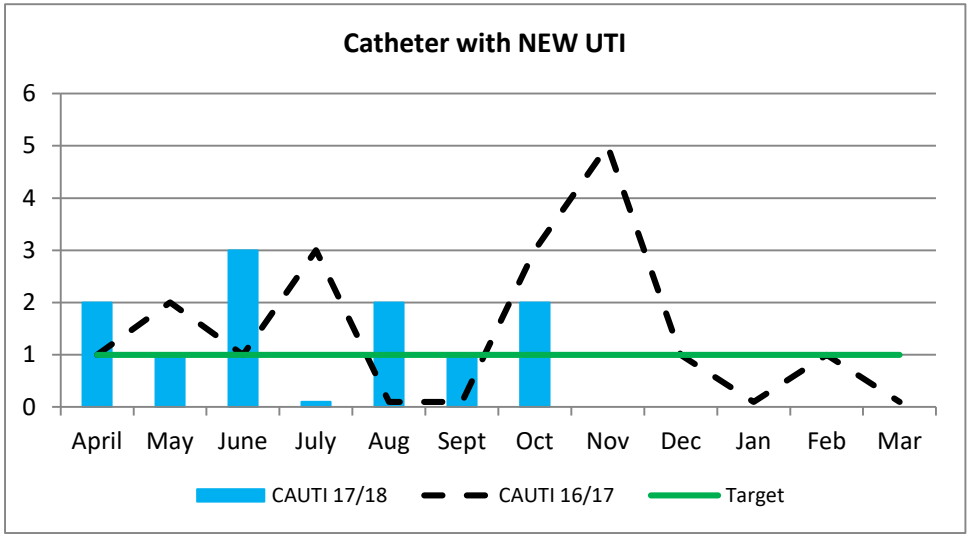
- Ward 1 Grantham – 2 Cases
- 6A Boston 1 Case (5 in 2017)
- 7B Boston 1 Case (4 in 2017)
- Bostonian Boston 1 Case
- 5B Boston 1 Case

Action Plan

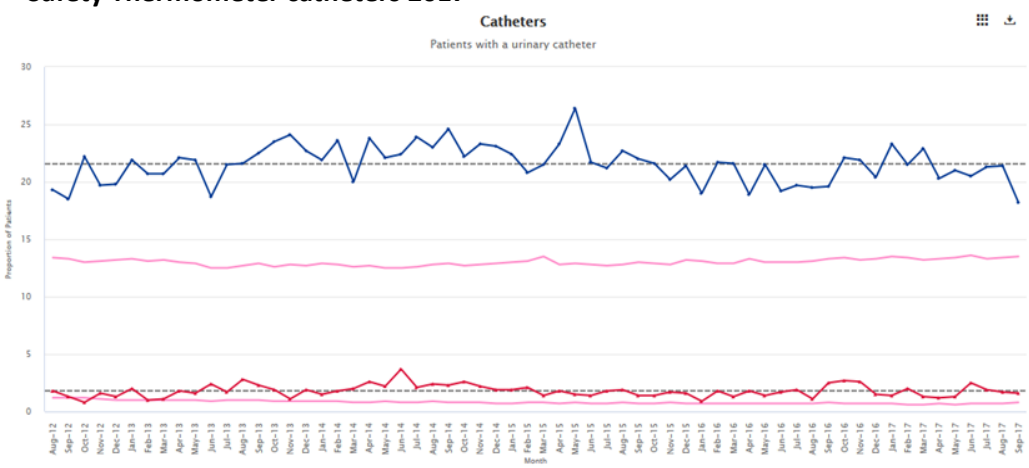
- Fortnightly Clostridium difficile Infection (CDI) review meetings continue to monitor rates and plan specific actions: plans are in place for Consultant Gastroenterologist representation at the meeting from November onwards.
- Frequent Infection Prevention Nurse visits to areas deemed to be high risk
- Saving Lives High Impact Intervention number 7 carried out on all areas where there is a confirmed case of CDI. Additional actions are put in place when a period of increased incidence (PII) is declared for a ward area.
- Enhanced cleaning regime in place on areas where there are symptomatic patients with known CDI or GDH.
- Additional chlorine cleaning of sluices is being rolled out.
- The focus of communications during Infection Prevention Week in October was around individual and team responsibilities for IP practice.
- Trust-wide messages about CDI prevention went out to all medical and nursing staff from the Medical Director and Deputy DIPC during October 2017.

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 Aug 2017- Oct 2017

Metric Title	Aug 2017	Sep 2017	Oct 2017
Number of urinary catheters in-situ	89	82	87
Urinary catheter record demographics correct	93.30%	92.60%	90.70%
Urinary catheter record completed & signed daily	62.10%	68.80%	64.30%
TWOC occurred within 3 days for acute retention	27.30%	30.00%	60.00%
Documented evidence why catheter needed	89.90%	93.80%	94.10%

Performance Data Overview October 2017

	Metric Title	Aug 2017	Sep 2017	Oct 2017
Boston	Catheter record completed & signed daily	53.1%	56.7%	45.5%
Grantham		87.5%	100.0%	100%
Lincoln		63.8%	73.3%	72.7%
Boston	TWOC within 3 days for acute retention	0.0%	0.0%	40%
Grantham		-	100%	100%
Lincoln		42.9%	50.0%	66.7%

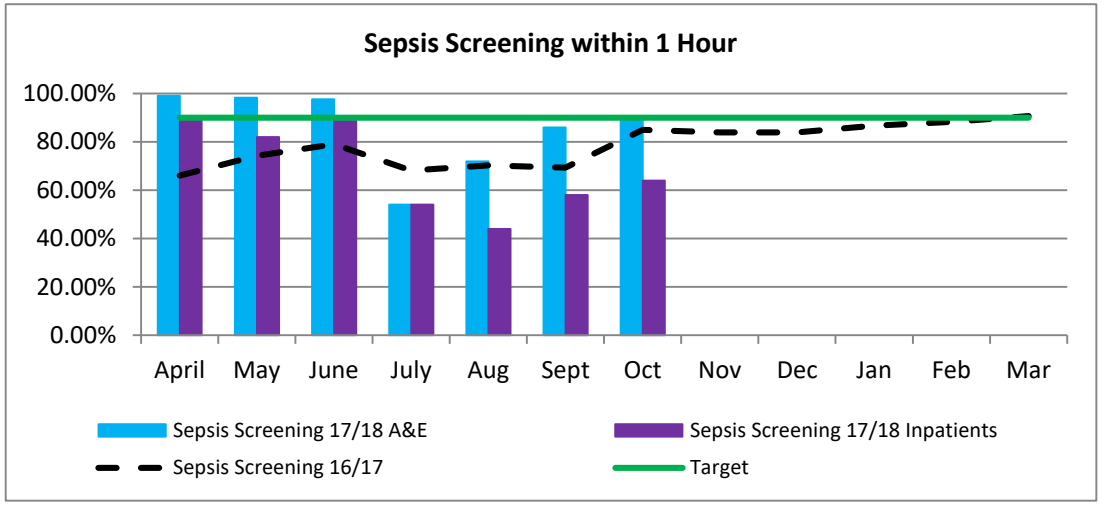
Data indicates ULHT inserts more catheters and has more NEW UTIs than the national average. Performance for October 2017 remains consistently below Trust aspiration of 90%, areas of particular concern are inconsistent daily completion of catheter care bundle and trial without catheter (TWOC) at Lincoln and Boston though there is some evidence of improvement.

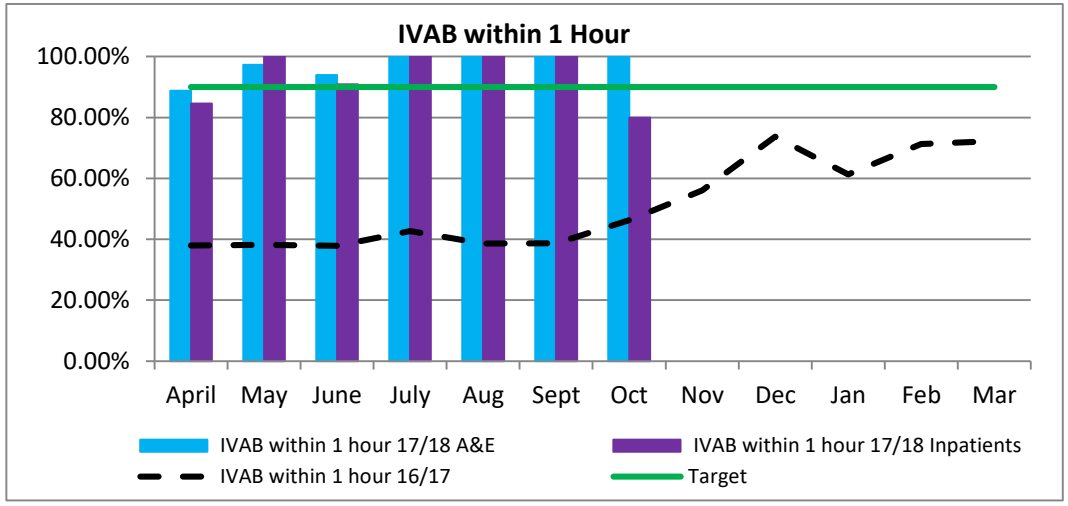
Action Plan

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.
Revision of Catheter Reduction Work Plan
Review of catheter insertion bundle
Collaborative work with Lincolnshire Community Health Services
E-learning training for catheter care to be introduced as essential skills

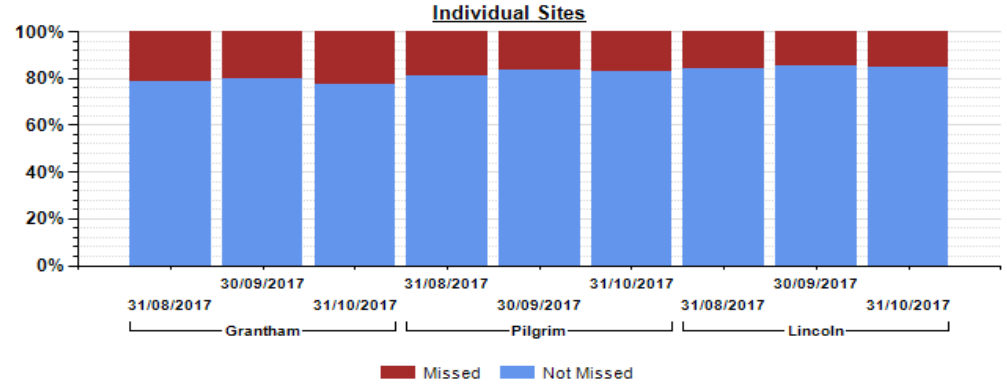
Safe Ambition 7: Reduction of Harm Associated with Deterioration Sepsis

Executive Responsibility: Michelle Rhodes – Director of Nursing

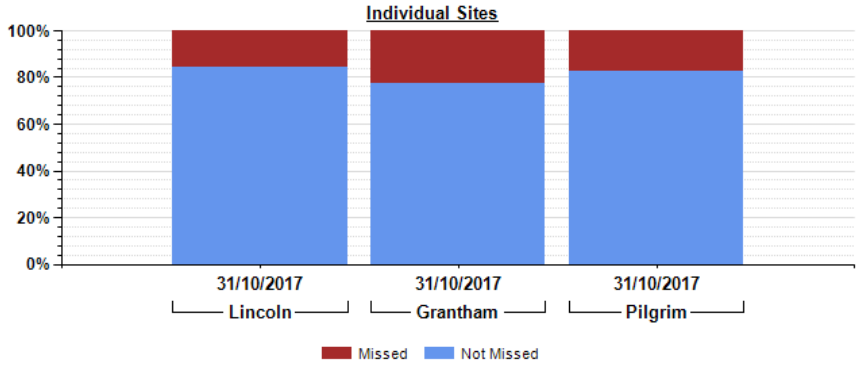




Patient Electronic Observations (Trust) Aug-Oct 2017



Patient Electronic Observations (Site) October 2017



Performance Data Overview October 2017

A&E Target 90%	Screening – October 2017	IVAB within 1 hour – October 2017
Trust	90% (up from 86%)	100% (remains the same)
Inpatients Target 90%	**Screening – October 2017**	**IVAB within 1 hour – October 2017**
Trust	64% (up from 58%)	80% (down from 100% *)

*whilst this does show a drop this is due to 1 of 3 patients not receiving abx)

Sepsis E-Learning 91.73%

Action Plan

- Safety Brief and updated screening flow chart disseminated outlining approach to sepsis screening.
- Sepsis Policy providing clear outline of guidance currently under construction and will be incorporated under a wider "Deteriorating Patient" umbrella.
- Work underway to embed the process of review via the designated Review Templates.
- A&E Web-v allocation issue being closely monitored and regularly reviewed to track progress.

Workforce Headline Summary

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

Statistics

KPI	2017/18 Target	October 2017 Performance	Last Month Performance	Performance in October 2016	6th Month Trend
Vacancy Rate - Medical	Medical – 12%	**15.42%**	**16.08%**	**13.16%**	
Vacancy Rate – Registered Nurses	Reg Nursing 11.5%	**13.28%**	**12.87%**	**12.66%**	
Vacancy Rate – AHP's	10%	**8.39%**	**8.87%**	**10.69%**	
Voluntary Turnover	7%, with no group of staff more than 20% above the overall target	**5.37%**	**5.32%**	**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%.	**89.17%**	**89.63%**	**85%**	
Sickness Absence (12 month rolling average)	Overall target of 4.5% + no team over 25% above target	**4.75%**	**4.73%**	**4.52%**	
Appraisals - Medical	Medical – 95%	**94%**	**95%**	**91%**	
Appraisals – Non Medical	Non-medical	**78.11%**	**80.10%**	**70.24%**	
Agency Spend	£25.4m (£1.75m in September)	**£2.601m**	**£2.472m**	**£2.073m**	

Commentary

The overall vacancy rate reduced again in October. There have been improvements in the medical and AHP vacancy rate, reflecting the successful recruitment exercises we have recently undertaken. The registered nursing rate unfortunately has risen. We have started cohort recruitment for band 5s. Our strategy is to use agencies to support registered nurse recruitment. This is held up by the difficulty of authorising up-front investment at a time of financial constraint.

In order to achieve target vacancy rates and given the number of vacancies where there is no active recruitment, we do need to undertake a robust workforce planning exercise and review the establishment. This is a priority for the remaining months of 2017/18. This is also crucial because our agency spend (notably on medical staff) is not reducing. Additional actions are being taken to drive down agency spend and these must start to impact in November and December.

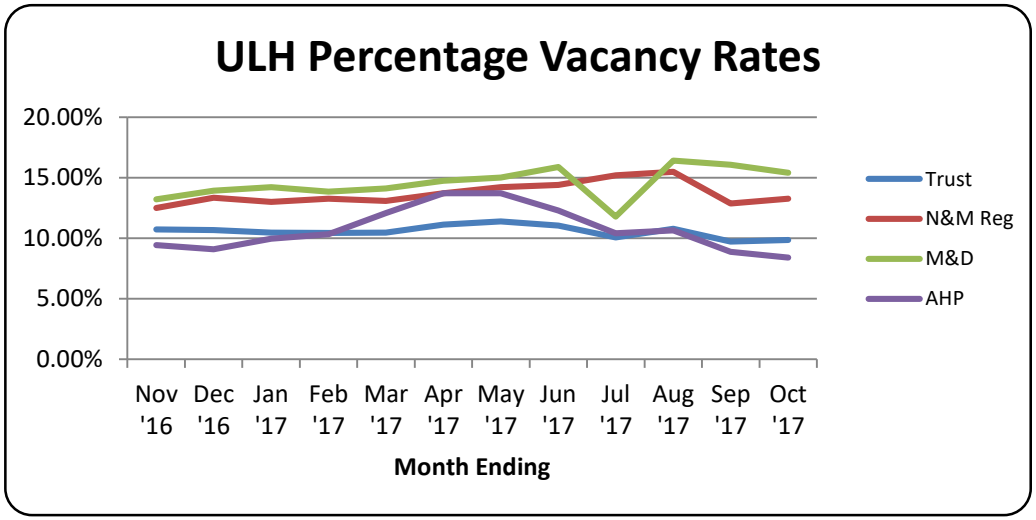
Although the 12 monthly rolling average sickness rate slightly increased again this month the winter of 2016/17 had a significantly higher absence rate than previous years. If sickness this coming winter returns to previous levels we should see a reduction in the 12 month rolling average by the end of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

Both core learning compliance rates and non-medical appraisal now have a downward trend for the last three to four months. This is very disappointing and we are seeking to hold managers accountable through the monthly performance meetings. We have longer term plans to review our approach to individual performance management and to set new core learning targets and this work is underway. There are of course time pressures on managers and staff, but we must find a way to increase participation rates in these key people management practices.

KPI:	**Vacancy rates**	**Owner:**	Director of HR & OD
Domain:	**Well Led**	**Responsible Officer:**	Deputy Director of HR & OD
Date:	28th November 2017	**Reporting Period:**	October 2017
Target:	Medical – 12% Registered Nursing – 11.5% AHPs – 10%	**Tolerances:**	**Within 1% - Amber** **Above 1% - Red**
RAG Rating:	Medical 15.42%		
RAG Rating:	N&M 13.28%		
RAG Rating:	AHP's 8.39%		

Analysis

Whilst the vacancy rates overall are above target, in October the Trust had more Consultants, more middle grade doctors, more Allied Health Professionals and more non- registered Nurses working than in the previous period twelve months ago. Indeed, vacancies for Consultants (11.01%), AHPs (8.39%) and non-registered Nurses (6.8%) are within Trust target. The overall Trust vacancy rate for October is 9.85%, which compares favourably to the 11.09% rate in October 2016.



The Registered Nursing & Midwifery vacancy rate increased from 12.87% in September to 13.28% in October. The tough financial times the Trust finds itself in has affected the ability to recruit Registered Nurses via initiatives that involve the upfront spending of money. As such, the Trust continues to try to recruit using traditional means, this is a difficult challenge in the current labour market.

Whilst we make good progress in recruiting consultant and middle grade doctors, the number of vacancies the Trust carries in the doctor in training grade (57.45) as a result of us not getting the placements we require, puts added pressure on us as we try and fill these roles on a temporary basis to cover these gaps. We are exploring opportunities to pilot alternative roles, such as Physician Associates, to cover these gaps in the longer term.

The Allied Health Professional staff group has again seen a reduction in the vacancy rate, down from 13.73% in April to 8.39% in October.

Vacancy rate Comparison

	Oct '17	Sept '17	Oct '16
Trust	9.85%	9.73%	11.09%
Medical & Dental	15.42%	16.08%	13.16%
Registered Nursing	13.28%	12.87%	12.66%
AHP's	8.39%	8.87%	10.69%

Action Taken	Action Planned
• ULHT represented at the BMJ fair in London – with 65 doctors expressing interest in working for us; • Continued recruitment work – currently 45 doctors are under offer to start work with us, as well as 51.4 registered Nurses, 7.4 AHPs and 27.78 Non-registered Nurses; • Cohort recruit for Band 5 Nurses started – the first round resulted in us making 13 offers of employment; • The Preferred Supplier List of medical agencies that are working for us have provided 230 CVs for Clinical Directors to consider. As a result, during the last 8 weeks, 63 interviews have been arranged, and 34 offers have been made. • Continued to develop out LinkedIn presence – we now have 1585 followers of our page; • Had the business case for the TRAC recruitment system agreed – this will significant speed up the time to recruit and improve our processes and accessibility;	• Continue to deliver on the Recruitment Plan initiatives;

Nursing Workforce report

Table One: NQB Average Fill Rates for Registered and Unregistered Staff October 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 (%)
89.00 (86.54)	97.93 (99.77)	95.51 (92.73)	98.85 (99.78)

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

Site	Day		Night	
	Average Fill rate- Registered Nurses/ Midwives (%)	Average fill rate – care staff (%)	Average Fill rate- Registered Nurses/ Midwives (%)	Average fill rate – care staff (%)
GDH	92.08 (88.67)	100.43 (104.74)	90.12 (91.20)	95.56 (95.00)
LCH	92.37 (88.46)	98.37 (99.30)	97.61 (92.71)	97.03 (98.01)
PHB	84.08 (83.68)	96.86 (99.27)	93.49 (93.14)	102.32 (103.48)

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

Hospital	Total % Registered Day	Total % Unregistered Day	Total % Registered Night	Total % Unregistered Night	Totals
Grantham	92.08%	100.43%	90.12%	95.56%	94.06%
Lincoln	92.15%	98.52%	99.22%	95.48%	95.85%
Pilgrim	85.94%	102.46%	94.47%	106.76%	94.75%
Trust	89.78%	100.33%	96.74%	99.62%	95.27%

Safer Staffing: Summary by Site - Children **Oct-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	92.65%	95.82%	79.94%	123.39%	91.74%
Pilgrim	68.57%	54.06%	83.21%	66.14%	67.92%
Trust	79.26%	72.89%	81.34%	89.09%	79.25%

Safer Staffing: Summary by Site - Midwifery **Oct-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	97.16%	99.40%	101.60%	99.40%	99.18%
Pilgrim	88.36%	88.86%	96.65%	87.18%	91.48%
Trust	92.15%	97.33%	98.51%	96.98%	95.73%

Table Three: October 2017 vacancy position

VACANCY POSITION

	Aug-17		Sep-17		Oct-17	
	Data from Payroll		Data from Payroll		Data from Payroll	
	R	UR	R	UR	R	UR
Lincoln	133.92	37.52	99.08	40.70	99.50	45.83
Pilgrim	128.70	24.40	111.19	16.53	121.55	19.36
Grantham	34.99	4.59	27.21	4.90	29.21	2.19
Main Site Nursing & Midwifery Sub-total	**297.61**	**66.51**	**237.48**	**62.13**	**250.26**	**67.38**
Louth	3.79	2.72	5.17	1.37	4.02	1.37
Paediatrics & Neonatal	29.48	1.40	28.59	0.41	28.36	0.94
Obs & Gynae	25.73	10.32	23.76	6.13	23.83	5.53
Diagnostics	9.74	0.63	9.34	0.23	11.05	0.43
Corporate Nursing – All Sites	12.96	3.36	12.11	3.36	14.75	3.36
Specialist Nursing – All Sites	3.06	-0.04	3.23	-0.04	2.08	0.56
Nursing & Midwifery Sub-total	**382.37**	**84.90**	**319.68**	**73.59**	**334.35**	**79.57**
Physiotherapy	9.71	-0.51	6.11	0.29	6.43	1.12
Occupational Therapy	3.82	6.56	1.36	3.25	1.76	4.25
Dietetics	4.87	0.00	4.87	0.00	4.97	0.00
Total	**400.77**	**90.95**	**332.02**	**77.13**	**347.51**	**84.94**
Nursing & Midwifery In Post	1,915.78	856.32	1,980.27	869.66	1,969.91	866.11
Nursing & Midwifery Vacancy Changes	7.94%	-13.52%	-14.49%	-20.05%	4.59%	8.13%

Safe Staffing

VACANCY POSITION

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

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

Staff Group	Week Commencing	02/10/2017	09/10/2017	16/10/2017	23/10/2017	30/10/2017
Nursing, Midwifery & Health Visiting	Framework only	0	0	0	0	0
Nursing, Midwifery & Health Visiting	Price cap only	407	394	362	384	352
Nursing, Midwifery & Health Visiting	Both framework & price cap	0	0	0	0	0
Healthcare assistant and other support	Framework only	0	0	0	0	0
Healthcare assistant and other support	Price cap only	0	0	0	0	0
Healthcare assistant and other support	Both framework & price cap	0	0	0	0	0

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

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

Date	11/10/2017	12/10/2017	13/10/2017	14/10/2017	15/10/2017	16/10/2017	17/10/2017	18/10/2017	19/10/2017	20/10/2017	21/10/2017	22/10/2017	23/10/2017	24/10/2017	25/10/2017	26/10/2017	27/10/2017	28/10/2017	29/10/2017	30/10/2017	31/10/2017
Day	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday
Site	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln	Lincoln
Unfilled Bank requests	102.5	58.5	86.5	77	95.5	61.5	26.5	11.5	67	58.5	45.5	46.5	174	122.5	96.15	138.5	144	188.5	97	146.5	76.5
Filled temp staffing	456.25	415.5	402.5	510	497.5	399.5	392.5	515.5	338.8	342	393.5	500.5	369	373.5	431.25	413.5	445	397	498.3	314	362
Agency	314.5	247	339.25	297.5	328	214	239	292	214	289	263	260	243	171	230	301.5	308.5	244	302.5	172.5	214.5
Total registered hours	2135	2211	2095	2105	2087	2146	2183	2162	2097	2125	2092	2140	2044	2099	2092	2081	2055	2021	2095	2037	2108
Planned staffing on template	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195	2195
Required staffing	2237.5	2269	2181.5	2182	2182.16	2207.25	2209.5	2173.25	2164	2183.5	2137	2186.16	2217.5	2221.7	2188.15	2219.5	2199	2209.5	2192	2183.5	2184.66
Contracted hours	1678.8	1795.0	1692.5	1595.0	1589.2	1746.3	1790.5	1646.3	1758.2	1783.0	1698.0	1639.2	1674.5	1725.7	1660.8	1667.5	1610.0	1624.0	1596.7	1723.0	1746.2
Contracted staff Percentage	75%	79%	78%	73%	73%	79%	81%	76%	81%	82%	79%	75%	76%	78%	76%	75%	73%	74%	73%	79%	80%
Total temp percentage	21%	19%	19%	24%	24%	19%	18%	24%	16%	16%	19%	23%	18%	18%	21%	20%	22%	20%	24%	15%	17%
Bank percentage	7%	8%	3%	10%	8%	9%	7%	10%	6%	2%	6%	11%	6%	10%	10%	5%	7%	8%	9%	7%	7%
Agency percentage	15%	11%	16%	14%	16%	10%	11%	14%	10%	14%	13%	12%	12%	8%	11%	14%	15%	12%	14%	8%	10%
Total bank requests	558.75	474	489	587	593	461	419	527	405.8	400.5	439	547	543	496	527.4	552	589	585.5	595.3	460.5	438.5
Percentage bank fill	82%	88%	82%	87%	84%	87%	94%	98%	83%	85%	90%	91%	68%	75%	82%	75%	76%	68%	84%	68%	83%
Total percentage staffing against required	96%	98%	97%	97%	97%	98%	99%	100%	97%	98%	98%	98%	94%	95%	97%	95%	95%	93%	97%	94%	97%
Total substantive and bank	1820.5	1963.5	1755.75	1807.5	1758.66	1931.75	1944	1869.75	1883	1836	1828.5	1879.66	1800.5	1928.2	1862	1779.5	1746.5	1777	1792.5	1864.5	1893.66
Total percentage staffing without agency	82%	87%	81%	83%	81%	88%	88%	86%	87%	84%	86%	86%	82%	87%	86%	81%	80%	81%	82%	86%	87%

Date	11/10/2017	12/10/2017	13/10/2017	14/10/2017	15/10/2017	16/10/2017	17/10/2017	18/10/2017	19/10/2017	20/10/2017	21/10/2017	22/10/2017	23/10/2017	24/10/2017	25/10/2017	26/10/2017	27/10/2017	28/10/2017	29/10/2017	30/10/2017	31/10/2017
Day	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday
Site	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston	Boston
Unfilled Bank requests	32	42.5	86.5	180	92	35	11.5	26	91	116	147	165	191	109.5	78.5	106.5	167.5	181	202.5	141.5	81
Filled temp staffing	268	330.5	283	244.5	402	340	353	305.5	390	232.5	263.5	281.5	242	417.75	354.5	314.5	288	297.5	303	356.5	411
Agency	227	250.5	200.5	149.5	188.5	189	228.5	209.5	231	123.5	116	133	122	234	242	218	171.5	127.5	145.5	131.5	262.5
Total registered hours	1432.33	1399	1346.5	1280.5	1339.5	1390	1502.25	1404.5	1430.33	1283	1244	1225	1206	1342	1324	1282.5	1270	1191	1160.5	1320.33	1390.5
Planned staffing on template	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0	1554.0
Required staffing	1464.33	1441.5	1433	1460.5	1431.5	1425	1513.75	1430.5	1521.33	1399	1391	1390	1397	1451.5	1402.5	1389	1437.5	1372	1363	1461.83	1471.5
Contracted Hours	1164.3	1068.5	1063.5	1036.0	937.5	1050.0	1149.3	1099.0	1040.3	1050.5	980.5	943.5	964.0	924.3	969.5	968.0	982.0	893.5	857.5	963.8	979.5
Contracted staff percentage	80%	74%	74%	71%	65%	74%	76%	77%	68%	75%	70%	68%	69%	64%	69%	70%	68%	65%	63%	66%	67%
Total temp percentage	19%	24%	21%	19%	30%	24%	23%	22%	27%	18%	21%	23%	20%	31%	27%	25%	23%	25%	26%	27%	30%
Bank percentage	3%	6%	6%	7%	16%	11%	8%	7%	11%	8%	12%	12%	10%	14%	8%	8%	9%	14%	14%	17%	11%
Agency percentage	16%	18%	15%	12%	14%	14%	15%	15%	16%	10%	9%	11%	10%	17%	18%	17%	14%	11%	13%	10%	19%
Total bank requests	300	373	369.5	424.5	494	375	364.5	331.5	481	348.5	410.5	446.5	433	527.25	433	421	455.5	478.5	505.5	498	492
Percentage bank fill	89%	89%	77%	58%	81%	91%	97%	92%	81%	67%	64%	63%	56%	79%	82%	75%	63%	62%	60%	72%	84%
Total percentage staffing against required	98%	98%	95%	90%	96%	98%	99%	99%	96%	93%	92%	91%	89%	95%	96%	94%	91%	90%	89%	93%	96%
Total substantive and bank	1205.33	1148.5	1146	1131	1151	1201	1273.75	1195	1199.33	1159.5	1128	1092	1084	1108	1082	1064.5	1098.5	1063.5	1015	1188.83	1128
Total percentage staffing without agency	82%	80%	80%	78%	81%	85%	84%	84%	79%	84%	82%	80%	79%	77%	78%	77%	77%	79%	76%	83%	77%

Trajectories:
The trajectory data is below.

Summary	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Operational Agency Usage (£)	675,143	685,820	724,245	779,661	737,049	674,879	746,111
Monthly Trajectory	713,582	730,885	731,510	818,209	748,546	593,645	593,645
Difference from Trajectory	-38,439	-45,065	-7,265	-38,548	-11,497	81,234	152,466

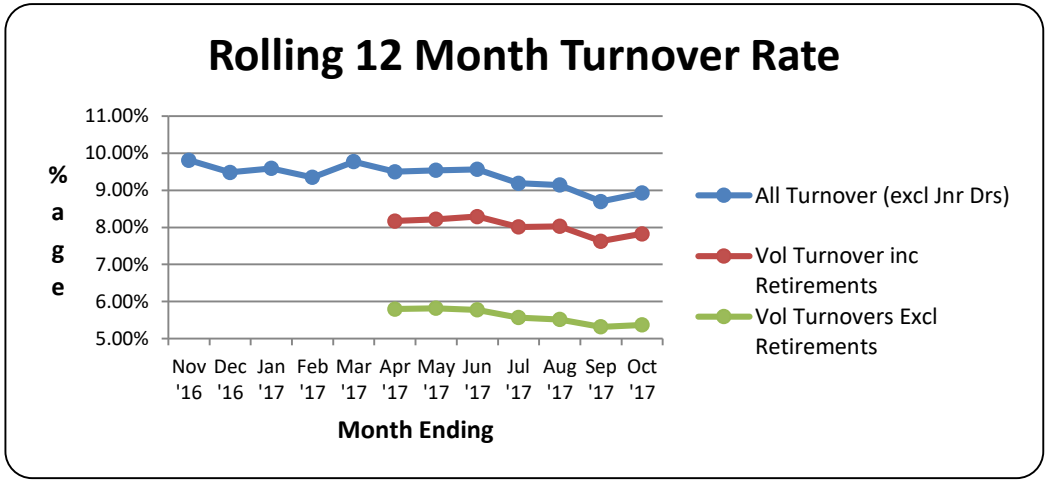
Cumulatively

Summary	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Cumulative Agency Usage (£)	675,143	1,360,962	2,085,207	2,864,868	3,601,918	4,276,797	5,022,908
Cumulative Trajectory	713,582	1,444,467	2,175,977	2,994,186	3,742,732	4,336,377	4,930,022
Difference from Trajectory	-38,439	-83,505	-90,770	-129,318	-140,814	-59,580	92,886

KPI:	Voluntary Turnover	Owner:	Director of HR & OD
Domain:	Well Led	Responsible Officer:	Deputy Director of HR
Date:	28th November 2017	Reporting Period:	October 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:	5.37%		

Analysis

Based on permanent employees only the current 12 month rolling average as at October 2017 is 7.83% including retirements and 5.37% excluding retirements. Of the leavers 28.66% was due to retirement and 64.79% was due to voluntary resignations. The remaining 6.55% of leavers were for other reported reasons e.g. dismissal.



Voluntary turnover excluding retirements has increased from 5.32% at the end of September to 5.37% at the end of October. No comparison with the end of September '16 is currently available as turnover was not calculated in this format last year. There has been anecdotal evidence of higher turnover amongst registered nurses, but the statistics do not support this – see below:

31st Oct '16 = 9.65%
30th Apr '17 = 7.69%
31st Oct '17 = 6.72%

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

It is noteworthy that 29% of leavers are retiring, reflecting the known issue about the age of the workforce.

Based on the latest (August 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 8.93% is below the average of 10.41%
- The current Trust Nursing & Midwifery (Registered) turnover rate of 6.96% is below the average of 10.89%,
- The current Trust AHP turnover rate of 12.69% is above the average of 12.17%.

It should be noted that to allow comparison with NHS Digital the above figures are calculated based on permanent, fixed-term and locum staff (excluding Junior Doctors) not just permanent staff.

Action Taken	Action Planned
• Focus on flexible working – policy being reviewed to support flexible working for people potentially retiring but who wish to remain at work	• Work underway around the development offer for both nursing and medical staff • Review of benefits underway – focus on extending benefits offer, reflecting on it from an age differentiation perspective and how we promote our offer • Survey of nursing staff who have stayed and left the Trust

KPI:	Core Learning Completion	Owner:	Director of HR & OD
Domain:	Well Led	Responsible Officer:	Head of Transformational Change and Engagement
Date:	28th November 2017	Reporting Period:	October 2018
Target:	Project to set revised targets delayed. Will be completed asap	Tolerances:	
RAG Rating:	89.17%		

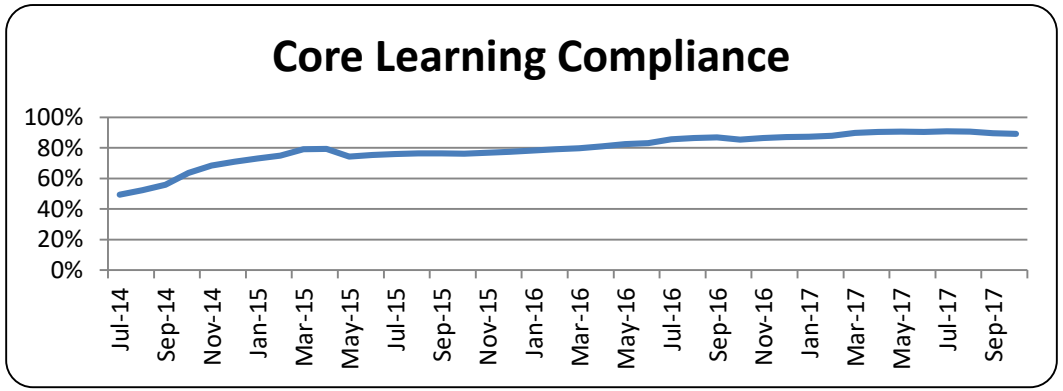
Analysis

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 October shows a slight fall from 89.63% last month to 89.17%. We have seen a slow improvement over the last 3 months and rates of compliance have 'dipped'. This is a concern for us and recognised as such by way of inclusion during discussions of key topics at performance reviews and November's Clinical Management Board..

We will continue to manage compliance strongly and setting aside a period of time during which we would expect all staff to be compliant.

Our currently model is a mix of class room based and e-learning modules. The approach has been based on employee choice as staff do not have to attend class room training as e-learning could be done in short 20/30 minutes 'sessions'. We have considered alternatives to the current practice, however taking into account operational challenges our current approach remains the best 'way'



We recognise that one of the issues may be staff 'impressions' of when/how they can complete core learning. Now that almost 100% of shifts are being filled the 'pressure' may potentially ease to enable managers to free up time for staff.

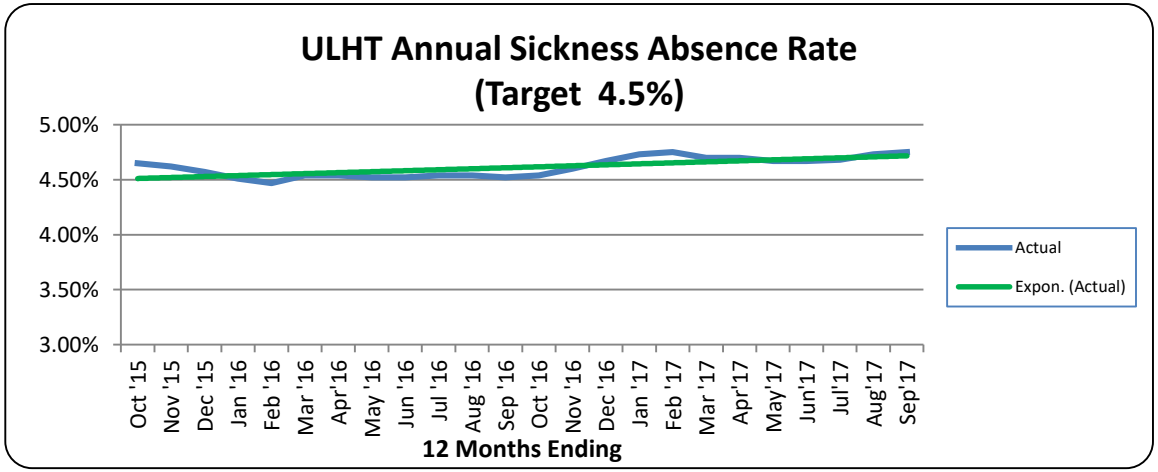
Action Taken	Action Planned
• Revised targets have been agreed for each of the core learning topics • All senior managers have been reminded of their responsibilities under the Pay Progression Policy and that non-completion of Core Learning can lead to (a) deferral of incremental pay progression or (b) disciplinary action.	• The OD Core Learning Lead will be released to look at the available compliance data and work with the top performing areas to understand areas of 'best practice' and to identify how this can be share across the Trust to 'drive' improvement. • A planned 'communication' to Managers to emphasise the importance to 'releasing staff to complete their training and by planning this as part of their weekly schedule will enable them to do so (good management practice). • We need to reflect on best practice where Leaders are finding ways to enable staff to do their core learning and to spread into other areas.

KPI:	Sickness Absence	Owner:	Director of HR & OD
Domain:	Well Led	Responsible Officer:	Assistant Director of HR
Date:	28th November 2017	Reporting Period:	September 2017
Target:	Overall target of 4.5% + no team over 25% above target	Tolerances:	Within 0.5% - Amber Above 0.5% - Red
RAG Rating:	4.75%		

Analysis

The Trust annual rolling sickness rate of 4.75% (against 2017/18 target of 4.50%) has increased by 0.02% from the previous month. The 12 month rolling sickness rate as at the end of September 2017 has increased by 0.23% in comparison to the September 2016 figure (4.52%).

The latest Benchmarking data as at July 2017 from NHS Digital (previously Health & Social Care Information Centre - HSCIC) indicates that ULHT has the 7th highest sickness rate (lowest at 3.03% and highest 5.57%) against an average of 4.28%. Of the eight staff groups the Trust has only two with sickness rates at or below the average, these being Administrative & Clerical and Healthcare Scientists. The benchmarking is done across x37 Large Acute Trusts.



Action Taken	Action Planned
• Focus on the reduction of LTS cases by early intervention • Continuation of absence training as part of the leadership and management training, supporting having difficult conversations • Grantham hospital has reduced its sickness rate to 3.93% and a reduction in long term sickness cases by 65% since march 17 • In March 2017 Estates and Facilities had 30 Active LTS cases and by the end of October 17 it has reduced to 10 • October has seen a significant drop in LTS sickness cases in comparison to the previous months • 8 further staff have been trained in mediation to support staff relationships and support retaining at work	• To implement a pilot for the streaming of reporting absences and triaging absences, based on outcomes this will be rolled out to the remaining sites • 58% of front-line staff have had a flu vaccination. We need to vaccinate another 674 frontline staff by the end of Feb to reach the 70% target. • Current focus and comms to be delivered on carrying out RTW's as a campaign in increasing the completion of them • To commence feedback to HON on LTS cases following the monthly review • Based on trajectories and management of cases it is expected that this month's figure showed evidence a reduction in the sickness rate

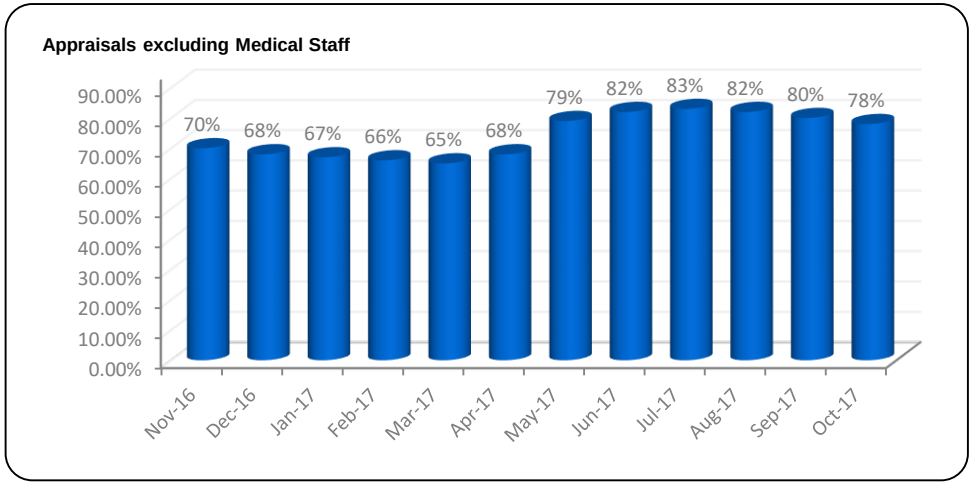
KPI:	**Appraisal Rates**	**Owner:**	Director of HR & OD
Domain:	**Well Led**	**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	28th November 2017	**Reporting Period:**	October 2017
Target:	Medical – 95% Non-Medical – 85%		Within 5% below - Amber More than 5% below – Red
RAG Rating:	Medical – 94%		
RAG Rating:	Non-Medical – 78.11%		

Analysis

The graph below shows that the Agenda for Change Staff/Non-Medical Appraisal compliance rate for October is 78.11%. This is a reduction from the previous month by 1.99% and is the third successive month that the rate has reduced.

The Medical Workforce appraisal rate for the month ending October 2017 is 94%. This figure is 1% lower compared to the Trust target rate of 95% which had been achieved for the past four successive months.

We continue to see a 'dip' in the month on month compliance after a period of 4 months where we saw good improvement. This raise concerns and we are looking at best practice elsewhere, such as Morecambe NHS Trust to understand their approach to appraisals as well as learning from other available research. This will be reflected in our new performance management approach and policy.

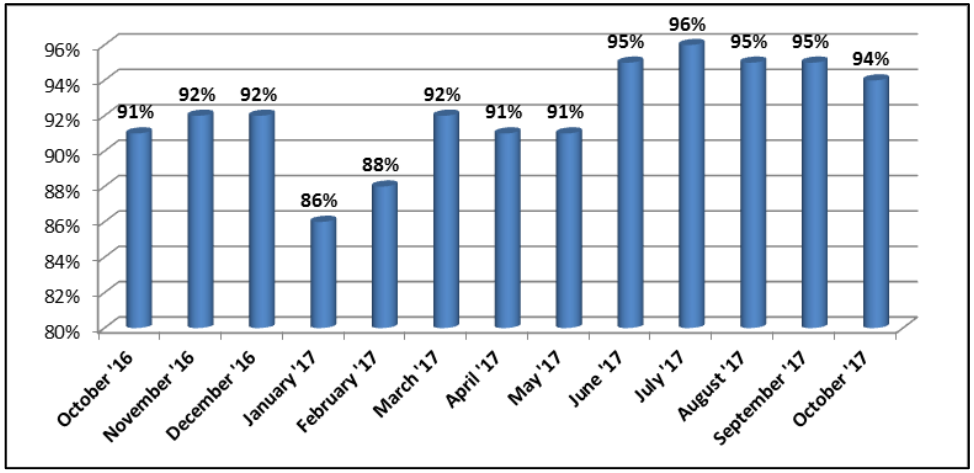


MEDICAL APPRAISAL PERFORMANCE–OCTOBER 2017

Turnover* and doctors postponing their appraisals due to workload has contributed to the reduction in performance.

The appraisal performance figure includes Consultants, SAS Doctors and all Trust Locums who now have access to the Allocate e-appraisal system for appraisal.

*A high percentage of new doctors are new to the UK and therefore have not been appraised previously.



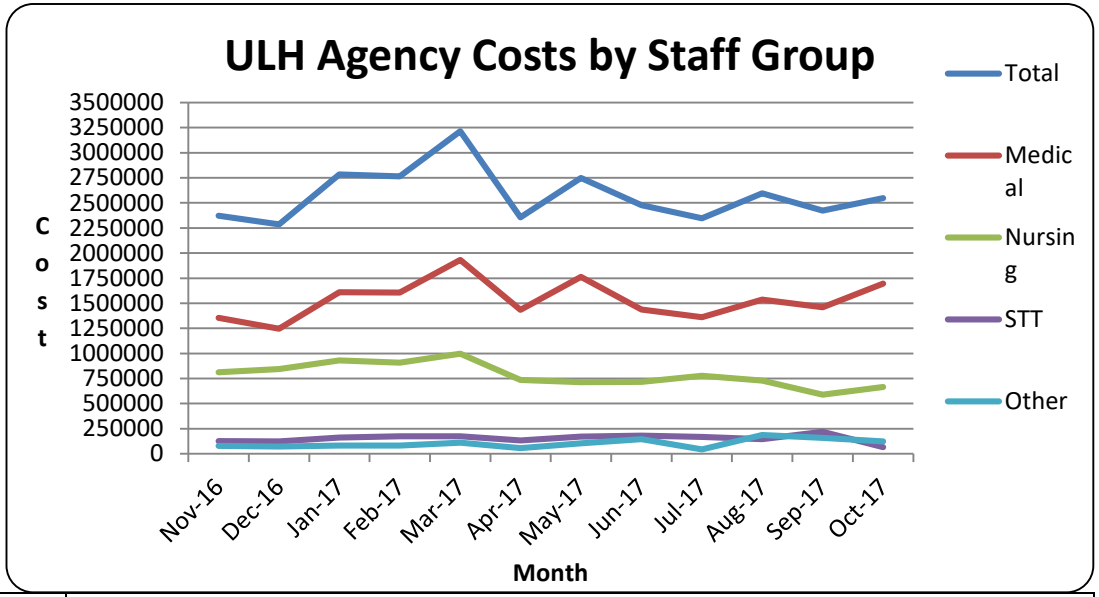
Action Taken	**Action Planned**
Non-Medical • A new approach to Individual Performance Management has been drafted and feedback is being collated • League table of appraisals has been circulated • Senior managers have been notified of specific staff in their Directorates with outstanding appraisals • All senior managers were reminded of their responsibilities under the Pay Progression Policy to conduct annual appraisals and that not doing so could affect their incremental pay progression Medical • Closer liaison with HR regarding notification of start dates for new doctors. • 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. • Closer monitoring of sign off of appraisals. Reminders sent to Appraisers to complete Appraisal Output documentation and sign off appraisal documentation within 28 days of the appraisal meeting in order to meet the GMC requirements. • Notification of 'Appraisal Due' sent to Doctors 4 months prior to their appraisal month. Strict adherence to the escalation processes set out in the Medical Appraisal Policy, with particular focus on the allocation of appraiser to appraisee 6 weeks prior to the appraisal due date if the doctor has not confirmed appraisal details.	Non-Medical • Areas which were targeted with specific senior managers will be followed up to identify if there have been any improvements • The draft Performance Management approach will be revised to take account of feedback and wider consultation will take place Medical • 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. Initial proposal not supported. • 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.

KPI:	Agency Spend	Owner:	Director of HR/OD
Domain:	Money & Resources	Responsible Officer:	Various leads on different aspects of agency spend
Date:	28th November 2017	Reporting Period:	October 2017
RAG Rating:	Actual spend of £2.601m, against target of £1.75m		

Analysis

The table below shows agency spend in the last 12 months. In October there has been an increase of £129,214, from the previous month, spend is significantly above target and £527,870 higher than the level of spend in October 2016.

Of the £2,600,784 spent on Agency staff in October, £1,695,873 was spent on Medical and Dental staff, £664,225 was spent on Nursing staff (including HCSW's), £64,714 was spent on STT staff and £175,972 was spent on Other staff (including Admin & Clerical staff).



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

KPI:	**Quarterly engagement index**	**Owner:**	Director of HR & OD
Domain:	**Well Led**	**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	28th November 2017	**Reporting Period:**	October 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

There is no pulse check this quarter as the annual National Staff Survey is underway.

Action Taken	**Action Planned**
• Staff Charter design work finalised and launch planned as part of 2021 launch • Regular updates on NSS response rates provided to Executives – more communication to follow to target areas of poor response • Current NSS response rate 36% which is higher than this time last year • Members of the OD Team are spending time on the Wards and having laptops available with them to encourage staff to complete the staff survey during these visits.	• Four 2021 site-based meetings will take place – open to all staff to launch 2021 and staff charter • All visual materials across the Trust to be updated overnight • Executive team walk the sites and attend existing meetings to share the 2021 messages • Social media campaign planned • Work being undertaken to explore new staff "thank you" scheme based on successful initiative in another NHS trust which will support existing departmental schemes • In the 'run-up' to the closure of the Staff Survey a focussed communication campaign will take place to encourage staff to complete the survey. • Results of the national survey will be reported during Jan 2018.

KPI:	**Quality of leadership and management index**	**Owner:**	Director of HR & OD
Domain:	**Well Led**	**Responsible Officer:**	Head of Transformational Change and Engagement
Date:	28th November 2017	**Reporting Period:**	October 2017
Target:	10% improvement in average score during 2017/18		
RAG Rating:	2.6 (The score is out of five and comprises two questions from the pulse survey		

Analysis

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

Action Taken	**Action Planned**
• Cohort 5 of Mary Seacole Local programme commenced • Cohort 1 and 2 Mary Seacole Local successfully completed with graduates from all local Trusts and organisations • Proposal for Lincolnshire Health and Care leadership programme agreed with SET • £38k funding approved by LWAB to critically review all STP Leadership and OD activity to date to help shape 18/19 OD plans • Fundamental review of ULHT's approach to Leadership and Management is progressing well and report due at ET during December.	• Lincolnshire Health and Care leadership programme procurement will commence • Next Senior Leadership Forum takes place 29.11.17 • 3 day introduction to management programme being procured via EMLA (free of charge) • Review of 'Well Led' key lines of inquiry underway (part of CQC domains)

Finance Headline Summary

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

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	-31.009	-50.464	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	8.445	4.884	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 7 position was an in-month deficit of £7.5m, which is £3.9m adverse to the planned in-month deficit of £3.7m.
- The Trust will not deliver its' control deficit of £48.6m and a financial recovery plan submitted to NHSi on November 13th identified a stretch target deficit of £76.6m. Further details are included elsewhere on the agenda.
- The £76.6m financial recovery plan assumes delivery of £16.2m 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 7 Financial Position

Month 7 performance against the financial plan is summarised in the table below:

	October 2017			April 2017 to October 2017		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	33,397	32,403	-994	225,111	227,427	2,316
Other operating income	4,581	2,818	-1,763	28,092	19,248	-8,844
Employee expenses	-25,880	-27,285	-1,405	-181,181	-189,189	-8,008
Operating expenses excluding employee expenses	-15,352	-15,155	197	-100,325	-106,125	-5,800
OPERATING SURPLUS / (DEFICIT)	**-3,254**	**-7,219**	**-3,965**	**-28,303**	**-48,638**	**-20,335**
NET FINANCE COSTS	-414	-318	96	-2,780	-1,888	892
Other gains/(losses) including disposal of assets	0	8	8	0	110	110
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**-3,668**	**-7,529**	**-3,861**	**-31,083**	**-50,416**	**-19,333**
Adjusted financial performance surplus/(deficit)	**-3,657**	**-7,509**	**-3,852**	**-31,009**	**-50,464**	**-19,455**

The Trust is reporting:

- An in-month deficit in October of £7.5m, which is £3.9m adverse to the planned in-month deficit of £3.7m.
- A year to date deficit of £50.5m, which is £19.5m adverse to the planned year to date deficit of £31.0m.

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

- Non-achievement of STF income resulting in the loss of £6.6m STF income.
- Slower than planned delivery of efficiency savings, with delivery to date £4.1m below plan.
- Pilgrim fire, norovirus outbreak and cyberattack resulting to date in the loss of £2.9m of income.
- Non-achievement of £1.3m 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 £5.5m 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. A further update on the FRP is reported separately on the agenda.

Efficiency

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

The Trust identified high level schemes totalling £16.0m (and a full year effect of £18.3m) within the financial recovery plan submitted to NHS Improvement in October and a further update on 13 November. The development of the detailed efficiency schemes is being led by the Trust's Executive Directors with support from September from the Trust's external partner, KPMG.

The Financial Efficiency Plan schemes have been RAG rated and the £16m most likely outcome contains £8.6m of Green, £4.4m of Amber and £2.9m of Red RAG rated schemes

The Trust originally planned to deliver £9.6m of savings by the end of October. Actual delivery to date at the end of October is as follows:

Savings of £5.5m have been delivered to date, which is £4.1m lower than the £9.6m of savings planned to date.

The savings delivered to date comprises of £3.5m of non-recurrent savings and £2.0m of recurrent savings. The non-recurrent savings delivery includes £1.0m of technical efficiency savings to date.

Capital

The spend to date of £4.9m inclusive of £1.3m Pre-commitments including £0.7m for Neonates and £0.4m Lincoln Specialist Rehab. £1.1m for Medical Equipment and £0.9m for IT development. The remainder for Backlog Maintenance, CQC and Service Development & Modernisation total £1.6m. The spend to date of £34.9m is £3.5m lower than plan.

The main drivers of the variance are as below:

- CQC schemes are £0.9m lower than plan year to date mainly due to the slippage in the Pilgrim emergency call bells, Trust wide Digital Dictation and enabling works to Lincoln 1st floor for 5th floor decant.
- Backlog Maintenance including fire enforcement notice related expenditure are £1.7m behind the plan to date. Work is on-going at pace to ensure compliance within the pre-determined timeframes.
- IT Development/IT Service Development & Modernisation are £0.5m lower than plan to date. Continued Development of the Secondary ICT Server Room at Pilgrim has been delayed as has the replacement of desktop PC's with the New Clinical Desktop Environment.
- Other minor schemes of £0.4m

Cash

At the close of October 2017 the Trust held cash of £2.1m. This includes external revenue support loans of £51.3m drawn over the first seven months.

The total 'repayable' borrowings through working capital loans, Salix loans and the uncommitted loan facility are currently £161.9m. 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 Otober 2017)** • 80% of Referrals to 1st O/P Services to be received through e-RS. • Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals in line with trajectory **Q3** **(to get to commissioners by 1st January 2018)** • 90% of Referrals to 1st O/P Services received through e-RS. • Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals in line with trajectory **Q4** **(to get to commissioners by 9th April 2018)** • 100% of Referrals to 1st O/P Services received through e-RS. • Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals in line with trajectory	
8	Supporting Proactive and Safe Discharge	Kathyrn Sayles (joint CQUIN with community)	Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories and undertake clinical audit as set out in the milestones section. Increasing proportion of patients discharged to their usual place of residence within 7 days of admission to 70%	**(Baseline data Q3 & Q4 2016/17 to be submitted by 8th May 2017)** **Q1** **(IT plan for update of ECDS to Commissioners by 26th Jun 2017)** • Emergency Care Data Set (ECDS) can be collected and returned from 1st October 2017 - plan **Q2** **(Discharge pathways, rollout protocols, baseline and trajectories yrs 1 and 2 to Commissioners by 2nd Oct 2017)** • Map and streamline existing discharge pathways across acute, community and NHS-care home providers, and roll-out protocols in partnership across local whole-systems. •Develop and agree with commissioner a plan, baseline and trajectories for ECDS. Achievement will require collaboration between acute and community providers. **Q3** **(Q3 Report HES data to Commissioners by 1st Jan 2018)** • Return data at least weekly AND 95% of patients have both a valid Chief Complaint and Diagnosis **Q4** **(Q3 Report HES data to Commissioners by 9th April 2018)** • 2.5% point increase from baseline in number of patients discharged to usual place of residence **OR** 47.5% in % of patients discharged to usual place of residence	

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

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

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