United Lincolnshire Hospitals NHS
NHS Trust

Quality Account 2014 - 15

Contents

Part 1

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Statement on quality from the Chief Executive

United Lincolnshire Hospitals NHS Trust is one of the largest trusts in the country. Across our four main hospitals, and four ancillary sites where some services are delivered, we provide a comprehensive range of hospital-based medical, surgical, paediatric, obstetric and gynaecological services to over 720,000 people of Lincolnshire. In an average year, we treat more than 145,000 accident and emergency patients, nearly half a million outpatients and almost 100,000 inpatients.

This past year was a challenging one for the Trust. We feel we have made big improvements across a number of areas to move us towards achieving our organisational vision but know there is still more work to do. The next 12 months is going to be increasingly challenging as we maintain quality, address our long-standing staffing challenges, improve access to our services for our patients, and manage with a forecast year-end deficit of £40 million . For us to manage these challenges all health, social care and voluntary organisations are going to need to work more closely together over the coming months and years. We are doing this as part of county-wide Lincolnshire Health and Care review programme.

Last year ended on a real high when it was announced we were being taken out of special measures. This was a real boost to staff and patients, and helped to build confidence in the services that we provide.

This decision reflects big strides in improving the safety and quality of our services and the patient experience over the previous 12 months. We recruited more nurses and doctors, and improved clinical practice, which together with the hard work of staff had the combined impact of better quality services. This was achieved through our 'Beyond Good' Quality Improvement Programme.

In addition, we invested into our hospitals to improve the services that we provide but also the environment in which they are delivered. This included the investment in new linear accelerator machines for radiotherapy, improvement to outpatients at Lincoln, new beds on our wards, and upgrade of boilers at Grantham to name just a few. Significant investment will continue into 2015/16 as we address many of our historical estate issues.

I would also like to highlight a number of areas where other institutions also recognised areas of good practice across our hospitals resulting in us either being nominated or winning a number of prestigious national awards. These included:

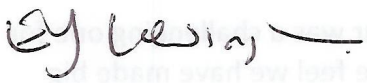
- Orthopaedic team at Pilgrim Hospital winning the clinical leadership and musculoskeletal care categories of the Patient Safety and Care Awards and the National Patient Safety Awards
- Heart centre at Lincoln was a runner-up in the Patient Safety and Care Awards
- Lincoln County's Macular Service team was named Macular Society's 'clinical service of the year' following praise from patients.

- One of our community midwifes, Karen Swan, won the title national midwife of the year.
- We, along with our partners, were finalists for HSJ Value in Healthcare Award. We all designed a new way of working to support health care professionals in the community to care for patients in their own home or closer to home to keep people out of hospital.

There are areas where we know we need to do better. During 2014/15, we did not meet the any of NHS constitutional standards. These include treating or discharging 95% of emergency patients within 4 hours; national cancer standards and referral to treatment times (18 weeks from referral to treatment). Our Trust HSMR also rose during the period of special measures, though other measures of mortality, and our actions to improve, have been maintained. Improving these are priorities for us as we head into 2015/16.

We won't sit on our laurels. We have significant challenges to deliver high quality services in a tight financial environment. We have clear quality objectives to move further towards achieving our vision

Jane Lewington
Chief Executive



Statement of directors' responsibilities in respect of the quality account

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year.
The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

Ron Buchanan
Chairman

Jane Lewington
Chief Executive Officer

- The Quality Account presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

Introduction – what is a Quality Account?

As well as the statement on quality from our Chief Executive (*Part 1*), our quality account describes our priorities and focused actions for future *(Part 2)* and also our progress over the past year *(Part 3)*.

Our achievements over the past year, which are more fully described in part three have included:

- Continuing to focus on reducing mortality by conducting mortality reviews in all specialties
- Implementing a new complaints policy with a renewed focus on listening and learning
- Reducing harmful adverse events including hospital acquired pressure ulcers
- Improving our identification and response to patients who contract septicemia
- Ensuring that an effective programme of governance takes place in all specialties and leads to change for patients
- Ensuring that patients are seen rapidly on admission by a senior doctor

During 2013, and following inspections by NHS England and the Care Quality Commission, ULHT was placed into Special Measures. The trust was inspected twice during the past financial year and on both occasions was able to demonstrate significant improvement in all areas. After the most recent inspection in early 2015, and in recognition of major improvements made, the trust was removed from Special Measures.

Areas for improvement in 2015/16

In 2015/16, we will continue to focus on quality. Across the trust, teams carry out work focusing on improvement in quality in their specific areas. Many of these integrated into the Trust's Listening into Action programme and are therefore deeply embedded in the work of all our professional groups. In addition, patient safety is driven by our commitment to the national Sign up to Safety campaign.

In 2015/16 we have selected, after consultation with our stakeholders and our staff, five key areas of quality improvement that we intend to focus upon as overarching goals supported by our culture of improvement throughout the trust.

These priority areas are as follows:

- Reducing hospital mortality
- Reducing harmful adverse events
- Improving our response to complaints
- Improving Outpatient Services
- Reducing delays in discharge
- Achieve our constitutional standards in cancer, referral to treatment and emergency access

A description of our aims and arrangements to check progress in each of these areas is provided in the following sections.

Priority 1 – Reducing Hospital Mortality

The issue explained

Hospital mortality is a key concern to all NHS acute trusts. It is measured by a number of statistics including Crude Mortality, Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Indicator (SHMI). Each of these measures provides insight into the number of patients who die and are a constant focus for both clinicians and managers at ULHT.

Unlike crude mortality, HSMR and SHMI try to highlight the expected number of deaths in a hospital based on the age, demographics, level of illness and other relevant factors of the patients. Each of these measures provides important information with regard to the quality of care. HSMR in particular is a helpful statistic because it can sometimes indicate specific clinical areas or diagnoses (such as septicaemia, or pneumonia) where the trust may wish to examine the quality of care provided in more detail by conducting further investigations into mortality. Importantly, none of these measures provides any indication of the level of "avoidable" death.

All three measures are reviewed every month at the trust Patient Safety/Clinical Effectiveness committee under the guidance of the Medical Director. Our key aim in all areas is to reduce mortality by identifying and acting upon improvements in the quality of care that our patients receive.

Current status

After a period of very high HSMR in previous years, ULHT made significant improvements in this area during 2013/14. During this period, HSMR fell to below the national average of 100.

In 2014/15, the trust once again experienced a rise in HSMR. Data to December 2014 (which is the latest available at this point) indicate that HSMR is estimated to have risen to 105 and is expected to rise further following the annual rebasing of data in September 2015. The most recent SHMI data indicate that trust mortality is within expectations at 1.07. During this same period, crude mortality at ULHT has remained at the lower levels achieved during the past three calendar years – indicating that though statistics will vary from year to year, the trust has been able to sustain the reduction in mortality which has been at chief goal in quality for three years.

The response to HSMR of any acute trust is always to examine clinical areas in more detail. A high HSMR in itself does not indicate poor quality but is used to highlight areas where further assurances needed. At ULHT, our aim is to review every patient death at a specialty governance meeting using an approved methodology and reporting openly throughout governance structures. These reviews of patient deaths lead to improvements and, in the case of two

areas, have been monitored by the Care Quality Commission who has expressed their satisfaction with trust progress and improvements.

Aims and goals for 2015/16

We wish to continue to reduce mortality levels. Many of our quality improvement programmes will contribute to achieving a lower HSMR. In particular, we will focus our efforts on:

- Ensuring that all patient deaths are independently reviewed in order to establish a coherent evidence base for change. In March 2015, the trust introduced a new mortality review system for all specialty governance meetings. In April 2015, the trust set up an independent mortality review group to assure the quality of reviews and identify key improvements.
- Continuing to build reliability in the care of patients who become septic with a special focus on the rapid delivery of intravenous antibiotics to patients at risk.
- Continuing to build reliability at ward level through monitoring and improving care processes.
- Monitoring the appropriateness of admissions for end-of-life care with a view to reducing admissions where hospital care is not best for the patient
- Ensuring that clinical records accurately reflect our provision of palliative care and the comorbidities of our patients
- Ensuring that critical care outreach provision supports patients who may deteriorate in our care

How we will assess our progress

Data are analysed in detail every month and assessed by the Patient Safety/Clinical Effectiveness Committee, chaired by the Trust Medical Director. This panel identifies any areas where further analysis is required and monitors progress in all key areas.

We will continue our programme of mortality reviews to develop understanding and action as to when and where untoward deaths take place with a view to changing practices and thereby reducing deaths which would be unexpected when compared to national statistics for similar Trusts.

Priority 2 - Reducing Harmful Adverse Events

The issue explained

Harmful adverse events are infrequent, but of major concern to all acute trusts. Many national campaigns in recent years have focused on the reduction of adverse events through developing interventions in the areas of pressure ulcer prevention, falls prevention, risk assessment and prophylaxis for venous thromboembolism and in medicines management and reconciliation.

ULHT, in common with other trusts, has seen a decline in the incidence of pressure ulcers acquired in hospitals as well as falls in harmful VTE. At this point, our chief concern is that harmful patient falls have risen. While this is in part associated with the level of dedicated care that may be provided to patients at risk, we believe that reducing harmful falls – as well as other adverse events – is possible through staff training and education and through developing more robust, evidence-based systems. Our aim, expressed simply, is to reduce harmful adverse events.

Current status

Patient harm is assessed through a monthly ward audit carried out nationally on all adult in-patients, known as the Safety Thermometer. Nationally, the target is that 95% of patients should be harm-free. The table below provides a comparison of ULHT performance in 2014/15 and National levels across all NHS Trusts.

Aims and goals for 2015/16

Our overarching aim is to use our local Sign up to Safety campaign, with its explicit focus on adverse events to develop a collective mindfulness with regard to patient safety. Our campaign is supported by dedicated groups of clinicians focusing on pressure ulcers, patient falls, infections associated with catheters, errors in medication and other adverse incidents. Each of these is reported through our trust governance systems and reviewed by our Patient Safety/Clinical Effectiveness Committee. Specifically, we aim to:

- Ensure best practice in falls risk assessment and management
- Reduce medication errors
- Improve infections through better hand hygiene and appropriate use of antibiotics
- Reduce hospital-acquired pressure ulcers and ensure caring and compassionate wound management
- Continue to assure that VTE risks are identified and managed

	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
NHS England	92.2%	92.4%	92.8%	92.8%	92.8%	93.1%	93.4%	93.5%	93.5%	94%	93.7%	94%
ULHT	91.4%	90.6%	90%	92.8%	90.3%	89.8%	90.6%	92.13 %	93.44 %	94.5%	93.17 %	92.1%

All adverse events are reported through the trusts risk management system as well as through detailed monthly audits of patient care. For the coming year we intend to ensure that reporting of adverse events becomes even more reliable through the development of better risk management, through education and training at ward level and through our detailed approach to the investigation of adverse events and the changes made as a result.

How we will assess our progress

Data are provided every month to the Patient Safety/Clinical Effectiveness Committee from our Risk Management and reporting system, from our monthly Safety Thermometer audit and our monthly audit of care reliability, the Safety and Quality Dashboard. At ward level, our detailed Ward Health Check includes all adverse events.

Priority 3 - Improving our response to complaints

The issue explained

Timely and compassionate response to feedback is vital to caring for our patients and their families and carers. Our overarching aims at ULHT are to both reduce complaints by providing better quality services and to respond quickly and effectively when things do go wrong for our patients

Current status

During 2013/14, the need for a review on the Trust's complaints system was highlighted and work has been underway to completely change the way in which we respond to concerns and complaints. The 'See it My Way' model has been designed by patients and staff and shaped by national best practice. We have developed the ways in which feedback can be provided and training packages are being delivered to ensure we deal with concerns in a proactive manner, achieving resolution and identifying learning points. Our new way of working has proved a success and as well as being positively received by our patients we were finalists for the Patient Experience National Awards.

See it My Way is being supported by site based PALS and complaints teams. The PALS service is proving successful with 3839 patients, relatives and carers accessing the team during 2014/15. Within complaints, we have seen an increase of the number of cases achieving resolution following a first response and the number of unresolved cases has reduced by 62% from 2013/14 to 2014/15.

Senior and clinical engagement is present throughout the process of complaints handling both through communication and liaison with the complainant/patient and regular performance monitoring. To assist with the cycle of improvement the learnings identified following complaint investigation is supported by the governance structure and discussed at speciality governance meetings.

We also obtain feedback from patients through national surveys, friends and family tests, counting compliments, patient opinion, and local surveys. We have tried to make ourselves accessible through a number of avenues including Trust held Twitter and Facebook accounts. This provides patients with another means of letting us know what they think about our services and a chance to put it right for them and future patients.

Aims and goals for 2015/16

During the coming year, our focus continues to be:

- Learning and change from patient feedback
- Reduction in the level of patient complaints
- Reduction in the level of reopened complaints
- Reduction in the level of outstanding complaints

How we will assess our progress

Key data on Patient Experience are provided by internal data on complaints performance, reported through the Patient Experience Committee, as well as by the national Friends and Family Test, which we will continue to monitor together with the number of complaints received and the number resolved after initial contact. We will continue to use the platforms of the Trust Patient Experience Committee and our Speciality Governance meetings to challenge our learning and improvements in response to patient feedback.

Priority 4 – Improving outpatient services

The issue explained

Efficient management of outpatient appointments and treatment is an essential element in caring and safety. Outpatient departments in Lincolnshire's hospitals provide a range of services to patients in Lincolnshire. The departments offer daytime first appointments, follow-up appointments and assessments across a range of specialties.

There are outpatient departments run by United Lincolnshire Hospitals NHS Trust at Lincoln County Hospital, Pilgrim Hospital, Boston, Grantham and District Hospital and County Hospital, Louth. During successive visits by the Care Quality Commission in 2014, Outpatient Departments were highlighted as key areas to improve.

Current status

Since the introduction of new computer systems for patient management, the Trust has been working hard to build efficient services with appropriate monitoring. The availability of patient notes for outpatient appointments is a key concern which impacts on efficiency and safety.

Aims and goals for 2015/16

Outpatient departments are a major focus for improvement in 2015/16, with a dedicated project team working hard to build safe, efficient and rapid treatment for our patients. This requires:

- Reliability in computer support for outpatient administration
- Availability of patient records at appointments
- Sensitivity to patient needs at all points of contact.

How we will assess our progress

As part of ULHT commitment to improving outpatients, we have developed a dashboard of key metrics with which we will measure our progress. This includes the following measures, which are reviewed every month through formal Trust processes and which form the daily measures used by our improvement team:

- Patients seen on time
- Patients report good experience (measured through Friends and Family scores)
- Health Records available
- Records fully prepared for clinic
- Clinics start on time
- Clinic cancellations within 6 weeks of appointment.
- Re-booking within 48 hrs.

Priority 5 – Reducing delays in discharge

The issue explained

Most people spend a very short period of their lives in hospital; their discharge follows a fairly predictable pattern and they usually return home. For those people already in the care system, or for those who will need ongoing support when they leave hospital, the discharge process should ensure continuity of the right care in the right place first time. Achieving safe and timely discharge from hospital is a complex activity. The pressure to discharge or transfer patients and release beds, together with a trend towards shorter lengths of stay, means there is less time for assessment and discharge or transfer planning.

Timely, safe discharge is essential for a good patient experience and for the efficient management of the hospital.

Current status

Delayed Transfers of Care and delayed discharges out of ULHT are one of the key factors building up system wide pressure and escalation points across the health community.

Lincolnshire County Council have been leading on the operational model of Integrated discharge for 18 months combining the hospital discharge teams and the adult social care functions, with 'plan for every patient' board round discussions being held regularly on wards. This has improved the decision-making and transfer of information. Nevertheless, the community teams only become involved at the latter end of the discharge planning when a patient is already deemed to be 'medically fit', thus building a delay into the discharge process and reducing the possibility of discharging the individual at an optimum time for their recovery.

Aims and goals for 2015/16

At both ward level and through a dedicated project team, we will aim to improve the discharge process. Through the creation and use of an innovative Integrated Discharge Hub, ULHT will:

- Work proactively with the wards in the early identification of patients who will require their support to facilitate the patient's discharge.
- Operate as the single point of referral / notification for all patients who require MDT support to facilitate a safe and timely discharge.
- Receive accurate and timely information from the wards.
- Be a multi-disciplinary team of practitioners and specialists who work collectively with the patient and family to identify the appropriate level of support required on discharge from hospital.
- Be the fact finders that centrally coordinate and pull together all appropriate clinical management plans and risk assessments to help identify the final decisions re: discharge.
- Be the key decision makers around the final discharge pathways and funding streams for patients.

- To ensure that patients have a smooth transition from LCH out to the appropriate community setting.
- Complete one 'Fact Finding' tool for each patient that identifies the patients clinical and social care needs and any key risk factors that will impact on a safe discharge back to their usual place of residence.
- Ensure, where appropriate, all patients have had a Mental Capacity and Deprivation of Liberty assessment.
- Consider the patients choice of discharge destination.
- Use key communication tools that identify a patient status, readiness for transfer and key clinical triggers. This will operate across the whole patient journey, giving the health community 'real time visibility' of the pressure, capacity and demand.

At ward level, our MDT approach will also aim to:

- Identify with the patient within 24 hrs of admission whether or not they may require support on discharge from hospital.
- Identify a key worker who will be the link between the patient and the Integrated Discharge Hub.
- The key worker inputs initial findings into the electronic white board system.
- At 72 hrs, the key worker will complete the appropriate documentation and attaches it to the patient's status record in the electronic white board system.

How we will assess our progress

Taken together, our plans to manage discharge are robust and will be assessed through key patient outcomes. Critical measures we will employ include the following:

- The number of discharges at a weekend.
- % of home support packages arranged within 48 hours of referral from Health
- Number of short and long term placements direct from ULHT sites
- The number of assessments commenced and completed at a weekend by the Integrated Discharge Teams.
- The number of patients who were assessed and ready for discharge at the weekend by the integrated discharge team who remained in a ULHT bed
- The number of patients discharged to their normal place of residence at a weekend by the Integrated Discharge Teams.
- The rate of readmissions per month across the three ULHT sites.

Priority 6 – • Achieve our constitutional standards in cancer, referral to treatment and emergency access

The issue explained

National NHS constitutional standards apply to all Trust and focus on the key areas of rapid Emergency Access for patients within 4 hours, an 18 week standard for referral to Treatment and National cancel waiting times. The Trust is committed to ensuring that we deliver high quality services against these important standards.

Current status

Our compliance with these standards during 2014/15 has been a significant challenge to the organisation. Our performance in 2014/15 is shown below.

Indicators			Standard	Current Month	Month Actual	YTD	Site Achievement (month)	Forecast Next Month	Expected Delivery Date
MEETING THE HIGHEST EXPECTATIONS OF OUR PATIENTS	A&E	Total time in A&E: 4 hours or less	95%	March	85.18%	90.67%		✗	n/a
	REFERRAL TO TREATMENT	RTT: Admitted	90%	March	79.11%	82.37%		✗	
		RTT: Non-Admitted	95%	March	89.42%	91.13%		✗	
		RTT: Incompletes	92%	March	89.91%	85.43%		✗	
		Waiting times for diagnostic tests	1%	March	0.45%	2.83%		✓	
		52 week waiters	0	March	1	14		✗	
		13 week waiting standard	0.03%	March	not avail	not avail		✗	n/a
		Appointment Slot issues (ASIs)		(Snapshot at month end) March	543			n/a	n/a
		Cancelled Operations on the day of the operation	0.80%	March	1.87%	1.81%		n/a	n/a
		(Cancelled ops) Not treated within 28 days. (Breach)	5.00%	March	18.50%	8.73%		n/a	n/a
		Delayed transfers of care	3.50%	March	5.34%	4.82%		✗	
	CANCER TARGETS	2 week wait suspect cancer	93%	February	87.90%	87.70%		n/a	n/a
		2 week wait breast symptomatic	93%	February	69.10%	70.22%		n/a	n/a
		31 day first treatment	96%	February	98.10%	95.95%		n/a	n/a
		31 day subsequent drug treatments	98%	February	99.10%	98.54%		n/a	n/a
		31 day subsequent surgery treatments	94%	February	97.00%	92.39%		n/a	n/a
		31 day subsequent radiotherapy treatments	94%	February	96.50%	88.60%		n/a	n/a
		62 day Classic	85%	February	66.20%	74.36%		n/a	n/a
		62 day screening	90%	February	77.80%	94.17%		n/a	n/a
		62 day consultant upgrade	85%	February	100.0%	80%		n/a	n/a

Aims and goals for 2013/14

We aim to build on our achievements by being an integral member of the System Resilience Group (SRG). The SRG has a membership of representatives from all of the Health and Social Care organisations in Lincolnshire, who work together to review the system wide pathways for delivering safe and effective care in the local area. Our performance is reliant on the whole systems ability in Lincolnshire to manage patient flow. This includes managing the need for Urgent Care as well as ensuring medically fit patients are discharged to the appropriate community setting when they become ready. A further development in 2015/16 is the re-launch of the Planned Care Board, which will take strategic ownership of the delivery and improvement of services linked to 18 week Referral to Treatment (RTT) and Cancer waiting time standards. ULHT are a core member.

The Trust is also committed to ensure we deliver services that are of high quality, efficient and safe; therefore, the following improvements will be made:

4 hour emergency access standard:

- Embedding the ambulatory care model
- Ensuring good senior medical and nursing staff availability
- Establishing out of hours streams at the front door including the frailty unit at Lincoln
- Revised early escalation procedures
- Increase focus on internal discharge process and external delays to transition of care.

18 week Referral to Treatment standard:

- Speciality recovery plans in place to meet expected levels of demand
- Service redesign in specialities where problems have been identified with meeting the expected levels of demand
- Extensive activity modelling and monitoring throughout the year to ensure capacity and demand levels are managed and are transparent
- Increase levels of support for the operational business units to provide realistic and achievable trajectories and remedial action plans
- Increase levels of support for clinicians and business managers in identifying issues outside of their control, and facilitating the dialogue with commissioners to rectify issues in a proactive manner
- Ongoing data quality improvement, training and validation.

National cancer waiting times

- Urology, lower GI and breast pressures impacting on 2 week wait %
- contracted levels of activity for breast surgery have reduced for 2015/16 to ensure the quality of the service provided meets national standards
- Breast redesign programme underway
- Capacity refresh of urology and lower GI

- 62 day pathway focus on Lower GI, Lung, Urology
- Demand and capacity pathway review
- Increase radiology staffing and multi-disciplinary team support
- Increase level 1 / high dependency unit access.

How we will assess our progress

The constitutional standards form part of our monthly integrated performance report and are reviewed in full Board meetings in public session.

Statements of assurance

Review of services

During 2014/15, United Lincolnshire Hospitals NHS Trust (ULHT) provided and/or subcontracted 48 NHS services. We have reviewed all the data available to us on the quality of care in all of these 48 NHS services.

The income generated by the NHS services reviewed in 2012/13 represents 88.4% of the total income generated from the provision of NHS services by the Trust for 2014/15.

Participation in clinical audits

Clinical audit is a key element of clinical effectiveness – one of our four strategic quality goals. The Trust has a continuing record of strong participation on national audits and also in ensuring that local audits are relevant to clinical improvement. We encourage this through our quality governance systems and also through an annual competition and prize. The data below summarises our audit performance in 2013/14.

Between 1st April 2014 and 31st March 2015, ULHT took part in 32/36 national clinical audits. In addition, we participated in four national confidential enquiries covering NHS services that United Lincolnshire NHS Trust provides. This means that United Lincolnshire Hospitals Trust participated in 88.8% of possible national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate.

Details of these audits and enquiries are provided below, together with the number of cases submitted to each audit or enquiry as a % of the number of registered cases required by the terms of that audit or enquiry.

National Audits	ULHT Participation	Reporting Period	Number and % required
Peri- and Neonatal			
Perinatal Mortality (MBRRACE-UK)	Yes	2009-2012	No case ascertainment reported by MBRRACE-UK
Neonatal Intensive and Special care (NNAP)	Yes	1st January – 31st December 2013 (report published August 2014)	894 (episodes of care) (100%)
Children			
Fitting Child (College Emergency Medicine)	Yes	1st August 2014 – 31st January 2015	51 (100% of the expected minimum)

National Audits	**ULHT Participation**	**Reporting Period**	**Number and % required**
Childhood Epilepsy (RCPH National Childhood Epilepsy Audit) Round 2	Yes	Round 2 of this audit commenced 1st March 2013 (report published November 2014)	29 eligible cases submitted PREM 3 cases submitted 2 service questionnaires Case ascertainment is not reported
Paediatric Intensive Care (PICANet)	N/A	This audit is only applicable to specialist centres	N/A
Paediatric Cardiac Surgery (NICOR Congenital Heart Disease Audit)	N/A	This audit is only applicable to specialist centres	N/A
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	1st April 2012 – 31st March 2013 (report published December 2014)	254 cases submitted. (case ascertainment is not reported)
Acute Care			
Emergency Laparotomy (3 year project)	Yes	Commenced October 2013 (organisation of service report to be published May 2014) Year 1 January 2014 – November 2014	Cases submitted so far 127/305 (42%)
Cardiac Arrest (National Cardiac Arrest Audit) ICNARC	Yes	1st April 2013- 31st March 2014	366 (case ascertainment is not reported)
Mental Health (CEM)	Yes	1st January 2014- 31st December 2014	122/150 (81.3%)
Older People (CEM)	Yes	1st August 2014 – 31st January 2015	240/300 (80%)
National Audits	**ULHT Participation**	**Reporting Period**	**Number and % required**
Adult Community Acquired Pneumonia (British Thoracic Society	Yes	Data currently being submitted	Not yet available
Pleural Procedures (British Thoracic Society)	No	N/A	N/A
Chronic Obstructive Pulmonary Disease (COPD) Royal College Physicians	Yes	1st February – 30th April 2014	93 (case ascertainment is not reported)

National Care of the Dying	Yes	1st May – 31st May 2013 Report Published May 2014	121/150 (80.6%)
Adult Critical Care (Case Mix Programme) ICNARC	Yes	2013-2014	1482 (100%)
Long Term Conditions			
Diabetes (National Adult Diabetes Audit)	No	-	N/A
Diabetes (National Adult Diabetes Inpatient /Survey/ Audit)	N/A	Audit did not take place during 2014	N/A
National Audit of Seizure Management (NASH)	Yes	12th June 2013-September 2013	30 cases submitted (case ascertainment is not reported)
Ulcerative Colitis & Chron's Disease (National IBD Audit) biologics Audit	No	Patients newly started on biologics therapy 12th September 2011-28th February 2014	Insufficient data submitted
Parkinson's Disease (National Parkinson's Audit)	Yes	2011 Report published May 2012 Next audit to commence April 2015	Number submitted and case ascertainment is not reported

National Audits	**ULHT Participation**	**Reporting Period**	**Number and % required**
Elective Procedures			
Hip, Knee and Ankle Replacements (National Joint Registry)	Yes	1st January 2014-31st December 2014	1216 submitted records (case ascertainment is not reported)
National Elective Surgery Patient Reported Outcome Measures (National PROMs Programme) (4 operations) Overall patient participation rate (patients who completed a pre-operative questionnaire) Participation by each PROM 1.Varicose Veins 2.Groin Hernia 3.Hip Replacement 4.Knee Replacement	Yes	PROMs April 2012 – March 2013 PROMs April 2013 – March 2014	1378/1911 (72%) 1359/1923 (70.6%) 12/13 13/14 1. 57, 41.9%, 69, 48.2% 2. 279, 57.%, 286, 54% 3.493, 76.8%, 476, 79.6% 4. 549, 85%, 528, 80.9%

Cardiothoracic Transplantation (NHSBT UK Transplant Registry)	N/A	Applicable to specialist centres only	N/A
Liver Transplantation (NHSBT UK Transplant Registry)	N/A	Applicable to specialist centres only	N/A
Cardiac Arrhythmia (NICOR)	Yes	April 2013 – March 2014 Report published December 2014	388 (case ascertainment is not reported)
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Yes	January 2013- December 2013	1107 (100%) eligible cases
National Vascular Registry including NVD -Carotid Interventions (Carotid Interventions Audit)	Yes	1st October 2011- 30th December 2014 (patients operated on during this period)	107 AAA, 136 CEA (case ascertainment is not reported)
National Audits	**ULHT Participation**	**Reporting Period**	**Number and % required**
Coronary Artery Bypass Graft (CABG) and Valvular Surgery (Adult Cardiac Surgery Audit)	N/A	Applicable to specialist centres only	N/A
Cardiovascular Disease			
Stroke Care (National Sentinel Audit of Stroke) SSNAP	Yes	July – December 2014 75% case submission expected	395/533 (74.1%)
Acute Myocardial Infarction & Other Acute Coronary Syndrome (MINAP)	Yes	1st April 2013 – 31st March 2014 Report published 2014	1524 eligible cases (100%)
Heart Failure	Yes	April 2012- March 2013 2013-2014 data submitted report has not been published as planned in 2014	305/888 (34.3%) for this period only required to submit 20 cases per month (240)as a Trust 100% compliance with submission
Pulmonary Hypertension	N/A	Applicable to specialist centres only	N/A
Renal Disease			
Renal Registry and Transplant	Yes	2014 - Data is not specific to ULHT	Data is submitted via Leicester Renal Unit
Cancer			
Prostate Cancer	Yes	1st April 2013 – Five year project	Data is not specific to the Trust in the first report
Lung Cancer (LUCADA)	Yes	Patients diagnosed with	348/349 (99.7%) of

		lung cancer first seen in 2013	the expected
Bowel Cancer (NBCA)	Yes	Patients diagnosed between 1st April 2012 and 31st March 2013	347/404 (86%)
National Audits	ULHT Participation	Reporting Period	Number and % required
Head & Neck Cancer (DAHNO)	Yes	Patients first seen between 1st November 2012 and 31st October 2013	>80% case ascertainment reported by East Midlands Cancer Network – no site data reported
Oesophago-Gastric Cancer (National O-G Cancer Audit)	Yes	Patients diagnosed between 1st April 2011 and 31st March 2012 and followed up for treatment until September 2013	85 (20-40%) case ascertainment
Trauma			
Hip Fracture (National Hip Fracture Database) Includes Falls & Fragility Fractures Audit (FFFAP)	Yes	1st April 2013 – 31st March 2014	761 case ascertainment is not reported
Trauma Audit Research Network (TARN) Trauma	Yes	2014	375 (45%)
Psychological Conditions			
Prescribing in Mental Health Services (POMH)	N/A	Not applicable to acute trusts	N/A
Blood Transfusion			
Audit of the Use of Anti-D	Yes	2013	6/6 (100%)
Audit of Patient Information and Consent	No	2014	N/A

Confidential Enquiries			
NCEPOD Gastrointestinal Haemorrhage	Yes	April 2013- March 2014 Clinical questionnaire Case note Organisational questionnaire completed	 9/9 (100%) 9/9 (100%) 3 /4 (75%)
NCEPOD Sepsis	Yes	April 2013- March 2014 Clinical questionnaire Case note Organisational questionnaire completed Still submitting data	 9/15 (60%) 8/9 (89%) 2/3 (66.6%)
Lower Limb Amputation	Yes	April 2013 – March 2014 Clinical questionnaire Case note Organisational questionnaire completed	 7/7 (100%) 6/7 (85.7%) 1/1 (100%)
Tracheostomy Care	Yes	April 2013 – March 2014 Clinical questionnaire Insertion questionnaire Case note Organisational questionnaire completed	 ITU 18 (100%) Ward 12 (66.6%) ITU 15/18 (83.3%) 4/12 (33.3%) 2/2 (100%)

The benefit of participating in clinical audit is to provide some assurance that the services delivered are safe and effective and that outcomes for patients are as good as they possibly can be based on evidenced based practice and standards of care. The percentage required by the terms of the audit could be a specific number (for example 50 mental health) or it may be compared to Hospital Episode Statistics (HES). This has been noted where available.

The participation is based on reports published during 2014/15 the data period covered may cover previous years.

Glossary:
HQIP – Health Quality Improvement Partnership
SSNAP – Sentinel Stroke National Audit Project
EMAS - East Midlands Ambulance Service
NVD- National Vascular Database
NICOR - National Institute for Cardiovascular Outcomes Research
PREM – Patient Reported Experience Measure
AAA – Abdominal Aortic Aneurysm
CEA - Carotid Endarterectomy
CEM – College Emergency Medicine
MDT – Multidisciplinary Team

The reports of 24/32 national clinical audits were reviewed by United Lincolnshire Hospitals NHS Trust between 1st April 2014 and 31st March 2015. The remaining audits are still active and will be reviewed over the coming months when the audit reports are published.

Descriptions of actions from a sample of the national audits:

National Audit	Headline results and actions taken
MINAP (heart attack and Ischaemic heart disease)	• Lincolnshire Heart Attack Centre 24/7 continues to provide good quality care and improve on last year's results • Procedure to open up blocked heart vessels quickly to restore coronary blood flow 98.5% of patients met the door to balloon time of 90 minutes • Collaborative work with EMAS continuing to ensure eligible patients are taken directly to the Heart Attack Centre 87.9% of patients met the time of call for help to balloon time of 150 minutes • Secondary prevention prescribing above the national average • Training for Acute Cardiac Practitioners who are specialised cardiology nurses
TARN (Trauma)	• Trauma Unit – Peer Review January 2015 • Trauma meetings held to discuss findings and share learning • Transfer to Trauma Centre reviewed to ensure patients are transferred for specialist care • Trauma Board review of standards and protocols to ensure safe and best practice care for Trauma patients is ongoing
Hip Fracture	• Improved time to theatre achieving best practice • Reduction in length of stay • Improved outcomes • Sharing best practice across the trust to improve the patient pathway • National and regional award for providing best practice at Pilgrim Hospital
Stroke	• Improving compliance with NICE standards • Ongoing improvement programme and sharing of good practice with monthly monitoring • Regular meetings to review patient pathway • Review of data collection processes to improve case

	ascertainment and data submissions
Vascular	• Case reviews discussed at regular meetings with MDT • Consultant outcome publication within expected range
Cardiac Arrest	• Updated proforma and policy • Ongoing monitoring
Chronic Obstructive Airways Disease (COPD)	• Care Bundle Implemented • Compliance with standards improving • Oxygen policy implemented
Bowel cancer data	• Data submission for the 2014 report has improved to 88.6%. • Clinical leads with MDT oversee compliance with standards • Consultants outcome publication within expected range
PROMs	• Ongoing recruiting of patients via pre-assessment clinics to complete the questionnaire before surgery • Ensuring patient leaflets are available in other languages explaining the purpose of PROMs • Data reported every four months to monitor progress with participation rates and outcome measures • PROMs multidisciplinary workshop held to discuss findings and review where improvements can be made • Discuss all options with patients prior to surgery • Discuss what to expect post-surgery
Hip, Knee and Ankle Replacements (National Joint Registry NJR)	• Consultant access to data to review own outcomes improved access to web based data • Consultant outcome publication within expected range • On-going review of NJR process to improve quality of data submission to the national database • Regional Coordinator support to ensure robust data collection and reporting system in place with staff training

The reports of 119/230 local clinical audits were reviewed by United Lincolnshire Hospitals NHS Trust between 1st April 2014 and 31st March 2015. The remaining audits are still active and will be reviewed over the next few months.

Local Audit Speciality	Clinical Audits Registered on the Trust Clinical Audit Database (number =230)
Accident & Emergency	21
Acute medicine	1
Anaesthetics	16
Breast surgery	2
Colorectal Surgery	1
Cardiology	6
Corporate	2
Dermatology	7
Diabetes/Endocrinology	3
Dietetics	5
Elderly Care	4
Endoscopy	3
ENT	5
Gastroenterology	5
General Medicine	13
General Surgery	18
Gynaecology	1
Haematology	1
Intensive Care	1
Maxillo-facial Surgery	4
Neonatal	3
Neurophysiology	1
Obstetrics & Gynaecology	12
Ophthalmology	13
Orthopaedics	17
Occupational Therapy	5
Paediatrics	19
Paediatrics Community	4
Pain Management	2
Pharmacy	3
Physiotherapy	4
Radiology	8
Rehabilitation	2
Renal	1
Respiratory	2
Rheumatology	2
Urology	9
Vascular	4
Total	230

Examples of actions taken locally:

Local Audit	Actions - Improvements
Clinical Record Keeping	• Improved staff knowledge • Improved compliance scores • Trust guideline updated • Updated admission proforma • Educational presentation update on responsibilities
Efficacy of Common Injection Procedures for Chronic Low Back Pain	• Patients having repeat procedures on were asked to complete a form to indicate the duration and efficacy of procedures carried out for their chronic low back pain • Use of an assessment form to screen benefits of procedures before offering repeat procedure, have in the past shown that patient selection is good, with good duration and benefit obtained for several months. • Even those who still have some pain report significant reduction in pain levels, and improved quality of life This re-audit has affirmed that patient selection remains good, and that. procedures are effective.
Compliance With Atrial Fibrillation Guidelines	• Partial compliance • Junior medical staff education sessions
Compliance with NICE Glaucoma Guidelines	• Improved compliance with NICE standards on previous audits • To improve information given to patients document discussions

The reports of 158/260 local clinical audits were reviewed by United Lincolnshire Hospitals NHS Trust between 1st April 2013 and 31st March 2014.

Participation in Clinical Research

Clinical research is an essential part of maintaining a vibrant culture of improvement. Our research and development department has a strong record in recruiting patients and collaborative working with local networks to ensure that high quality research in a part of the culture at ULHT.

The number of patients receiving NHS services provided or sub-contracted by United Lincolnshire Hospitals NHS Trust in 2014/15 who were recruited during that period to participate in research approved by the National Health Research Authority were 1230. Total number of patients/participants recruited for portfolio and non-portfolio studies was 1398.

These patients/participants were recruited from a range of specialities and included patients with cancer, stroke, diabetes, Dementia & Neurodegenerative diseases, paediatrics and a number of other areas. The Trust is supporting trials from more specialities as compared to 2013/14. In addition, the Trust is also supporting significantly more commercial NIHR portfolio studies. This increasing level of participation in clinical research demonstrates the United Lincolnshire Hospitals NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. In addition, by participating in NIHR portfolio trials and recruiting patients, the Trust is playing an important role in improving patient care and in developing new and innovative drugs, treatment and services. Due to the increased number of commercial and non-commercial trials, Lincolnshire patients are benefitting and receiving latest drugs/treatment free of charge as drugs are supplied by study sponsors. The Trust has implemented findings of trials which has helped the Trust in improving patient care and cost saving.

The Trust is involved in conducting over 200 clinical research studies including studies in follow up. By the end of March 2015, for stroke Lincoln we recruited 28 patients and for Stroke Pilgrim we recruited 87 patients. In case of cancer Randomised Controlled Trials (RCT), the Trust recruited 140 patients. In case of Cancer non-RCT, we recruited 267 patients. Since the establishment of the NIHR, the Trust has used the national system for approving all studies (portfolio and non-portfolio) and carry out risk assessments. Of the 40 NIHR portfolio studies given permission to start, all studies were approved within 30 days except one which took 32days.

In last three years, over 50 publications have resulted from our involvement in clinical research, helping to improve

patient outcomes and experience across the NHS.

The Lincolnshire Clinical Research Facility (LCRF) was short-listed as finalist in national highly prestigious Health Service Journal Award for Workforce Development category in November 2013. In addition, the Lincolnshire Clinical Research Facility (LCRF) two entries, one for “Strengthening the Foundation” and second for “Partnership working to improve the experience” for the Patient Experience Network (PEN) national award were short-listed as finalist in 2014.

The LCRF and The Research and Development Department is committed and will continue to play an important role in follow following areas:

- To promote research and innovation
- To develop a culture in which research is seen as integral to clinical practice
- To support Clinical Business Units in developing specialist clinical services
- To support all healthcare staff undertaking research
- To support research activity by developing an infrastructure, which ensures all
- research is carried out in accordance with the ‘NHS Research Governance Framework’ and regulations.
- To increase the number of staff within the Trust with skills in research
- To work closely with R & D Departments within the other Lincolnshire health providers to incrementally increase patients recruitment over the next five years period.

Commissioning for Quality and Innovation (CQUIN)

A proportion of United Lincolnshire Hospitals NHS Trust's income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between ULHT and NHS Lincolnshire and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The CQUIN framework was introduced in April 2009 as a National Framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of Healthcare provider's income to the achievement of local quality improvement goals. The Framework aims to embed quality within commissioner-provider discussions and to create a culture of continuous quality improvement, with stretching goals agreed in contracts on an annual basis.

The Trust fully achieved eight schemes. The table below demonstrates the achievement of our national and local CQUINs.

2014/15 CQUIN Compliance

No.	Goal name	Q1 RAG	Q2 RAG	Q3 RAG	Q4 potential RAG rating
NATIONAL CQUINs					
1a	Friends and Family Test – Implementation of staff FFT				
1b	Friends and Family test - early implementation				
1.2	FFT response rate				
1.3	FFT response rate				
2	Safety Thermometer				
3.1	Dementia - Find, Assess, Investigate and Refer				
3.2	Dementia - clinical leadership				
3.3	Dementia support				
LOCAL CQUINs					
4	Medication safety				
5a	Care reliability at ULHT - sepsis bundle				
5b	Care reliability at ULHT - Catheters and UTIs				
6	Falls prevention				
7	7 day consultant review in emergency admissions within 12 hours				
8	Staff Friends and Family Test Improvement				
9	Holistic Care Needs Assessment utilised for patients with a diagnosis of cancer				
10	Specialised commissioning dashboards				

RAG Green = Fully Achieved /Amber = Partially Achieved / Red = Not Achieved

Care Quality Commission (CQC) Statements

United Lincolnshire Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is full registration. Inspections during the year have evaluated the Trust and its sites. Overall CQC ratings for the five overarching domains of CQC evaluations (dated February 2015) are shown below for the Trust.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

Detailed rating for each hospital are as follows:

Lincoln County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Good	Not rated	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical care	Good	Good	Good	☆ Outstanding	Good	Good
Maternity & Family planning	Requires improvement	Good	Good	Good	Good	Good
Children & young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Good	Good	Good	Good	Good
Outpatients	Requires improvement	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

Pilgrim Hospital Boston

	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Good	Not rated	Good	Good	Good	Good
Medical care	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity & Family planning	Good	Good	Good	Good	Good	Good
Children & young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

Grantham District Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Good	Not rated	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

County Hospital Louth

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

The CQC has asked the Trust to take compliance actions with regard to the following regulations:

- Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records
- Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing - *People who use services and others were not protected against the risks associated with insufficient numbers of suitably qualified, skilled and experienced staff in a number of areas across the trust.*
- Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers - *People who use services and others were not protected against the risks associated with inappropriate or unsafe care by means of effective operating systems to ensure that the quality of the service is regularly monitored in that Governance systems at County Louth Hospital were not embedded into the trusts governance systems.*
- Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers - *The provider had failed at times to assess the needs of patients*

receiving outpatient care to ensure their welfare and safety needs were met in a timely manner in that: Patients receiving outpatient care did not always have their appointments for assessment and treatment made in a timely manner.

Data quality

Data quality is an important element of safe, quality care at acute sites and is a continuing focus for improvement. United Lincolnshire Hospitals NHS Trust will be taking the following actions to improve data quality:

- Following the introduction of Medway (Patient Administration System), process maps are being reviewed for patient flow through hospital (outpatients, day cases, inpatients) and data quality reports identified at key stages to ensure any data input errors are flagged earlier and highlighted to relevant teams for correction and any training needs identified
- Continuation of implementing actions identified by the 2013 Payment by Results Assurance Audit (mainly around clinical coding, produced by the Audit Commission on behalf of Lincolnshire CCGs)
- Data Quality function reviewed to ensure the team supports the needs of the Business through a restructure of the department. Additional resource has been introduced in 2014/15 and this will be further reviewed in 2015/16.
- Further develop the data warehouse which will enable more timely reporting of information and assist with data quality reporting throughout the Business Units in the Trust

NHS Number and General Medical Practice Code validity

United Lincolnshire Hospitals Trust submitted records during April to January 2014/15 at the Month 10 inclusion date to the Secondary Uses service for inclusion in the Hospital Episode Statistics (HES), which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS number was: 99.5% for admitted patient care (National performance 99.2%); 99.7% for outpatient care (National 99.3%); and 97.6% for accident and emergency care (National 95.2%).
- Which included the patient's valid General Medical Practice Code was: 100.0% for admitted patient care (National performance 99.9%); 99.9% for outpatient care (National 99.9%); and 99.9% for accident and emergency care (National 99.2%).

Clinical coding error rate

United Lincolnshire Hospitals NHS Trust was not subject to the Payment by Results Clinical Coding audit by the Audit Commission during the 2014/15 reporting period, but is being audited in April 2015. Based on the 2013/14 audit, which were based on one clinical area that was the focus of audits nationally, with a couple of supporting areas for individual Trusts, the focus was on co-morbidities and complications with digestive systems nationally, supported by Paediatrics and General Medicine locally. The performance of the Trust, measured using the error rate of the number of spells affecting price, was 6.9% for admitted patient care (last year's comparably

number was 7.6% error rate). As mentioned above, the Data Quality strategy will include accurate and comprehensive capture of information within the clinical notes, which is then translated into clinical codes by the Coders.

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records.

Please note: these are technical errors of coding within patient records, not clinical errors in terms of actual diagnosis.

Information Governance Toolkit attainment levels

The information quality and records management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

United Lincolnshire Hospitals NHS Trust score for April 2014 to March 2015 for information quality and records management, assessed using the Information Governance toolkit, is 78%. The Trust has achieved compliance with all 45 standards and has maintained full compliance with the Information Governance Statement of Compliance.

Reporting of harm to patients

Reporting of harm to patients and other significant incidents forms the basis for some organisational learning and improvement initiatives. These data reflect Trust organisational learning culture and are reported formally for the first time. It is subject to reliance on staff reporting all incidents and includes an element of local clinical judgement in the reported figure. Data are forwarded from the Trust to the National Reporting and Learning Service (NRLS) as appropriate.

Data provided by the Health and Social Care Information Centre

The following data relating to national reporting requirements in the Quality Account are provided by the Health and Social Care Information Centre.

Prescribed Information							
Related NHS Outcomes Framework Domain & who will report on them	**Indicator**	**Indicator detail**	**Period**	**ULHT data obtained from Health and Social Care Information Centre (HSCIC)**	**National average (where available)**	**Ranges: Best / Worse national performance**	**Commentary and Other Information**
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to— (a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and (b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. *The palliative care indicator is a contextual indicator.							
1: Preventing People from dying prematurely Acute trusts	"SHMI"	The SHMI is a ratio of the observed deaths in a trust over a period of time divided by the expected number given the characteristics of patients treated by that trust.	Jul 13-Jun 14 Value OD Banding	107.302	Not available	54.10 / 119.823 / 1	Both SHMI and HSMR have shown increases. Further information is provided in the Mortality section of this report.
			Apr 13-Mar14 Value OD Banding	104.002	NA	53.90 / 119.703 / 1	
		Palliative care coding by diagnosis	Apr 13-Mar14	23.31%	NA		These data provide context for mortality indicators, though SHMI is itself unaffected by

							palliative care coding.
		Palliative care coding by diagnosis	Jul 13-Jun 14	24.87%	NA		
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's patient reported outcome measures scores, National Outcomes Framework – Indicator 3.1 for— **(i) groin hernia surgery** **(ii) varicose vein surgery** **(iii) hip replacement surgery** **(iv) knee replacement surgery**							
3: Helping people to recover from episodes of ill health or following injury All acute trusts	The trust's patient reported outcome measures scores – Average Health Gain for— (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery.	Patient Reported Outcome Measures (PROMs) are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves.	Apr 12 – Mar 13	Hernia – 0.074 V Vein – 0.138 Hip – 0.390 Knee – 0.289	Hernia – 0.085 V Vein – 0.093 Hip – 0.425 Knee – 0.315	Hernia: 0.169 / 0.000 V Vein: 0.264 / -0.106 Hip: 0.534 / 0.019 Knee: 0.388 / 0.000	The Trust continues to strive for improvement and increase performance as reported through the Patient Reported Outcome Measures.
			Apr 11 – Mar 12	Hernia – 0.069 V Vein – 0.106 Hip – 0.389 Knee – 0.275	Hernia – 0.087 V Vein – 0.095 Hip – 0.416 Knee – 0.302	Hernia: 0.156 / -0.002 V Vein: 0.167 / -0.029 Hip: 0.499 / 0.306 Knee: 0.385 / 0.181	
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged— **(i) 0 to 15; and** **(ii) 16 or over,** **Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.**							

3: Helping people to recover from episodes of ill health or following injury All trusts	The percentage of patients aged— (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital	The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period-	Apr 11 – Mar 12	(i) 7.97 (ii) 9.74	(i) 4.21 (ii) 6.03	(i) 14.94/0 (ii) 41.65/0	The trusts indicators are within National Expectations.
			Apr 10 – Mar 11	(i) 8.37 (ii) 9.47	(i) 4.19 (ii) 11.04	(i) 16.05/0 (ii) 22.76/0	NOTE: The HCSIS data Remains unchanged from the prior year's report, Data available Dec-13 Therefore remains the same.
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's responsiveness to the personal needs of its patients during the reporting period.							
4: Ensuring that people have a positive experience of care All acute trusts	The trust's responsiveness to the personal needs of its patients	Average weighted score of 5 questions relating to responsiveness to inpatients' personal needs (Score out of 100)	Apr 13 – Mar 14	63.9	68.7	84.2 / 54.4	The Trust continues to apply its detailed patient experience strategy. Further information is provided in this report.
			Apr 12 – Mar 13	64.3	68.1	84.4/57.4	
			Apr 11 – Mar 12	64.2	67.4	85.0/56.5	NOTE: This element remains unchanged from the prior year's report. Therefore the data remains unchanged. The next version will be made available in May 15.
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.							
5: Treating and caring for people in a safe environment and protecting them from avoidable harm All acute trusts	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism	Number of admissions vs number of completed risk assessments	Oct 14 – Dec 14	No Data Available	96.00%	100% / 81.00%	In comparison to our Quality Account last year. The trust improved in Quarter 1 by 0.5% from Mar 14 for the
			Jul 14 – Dec 14	No Data Available	96.00%	100% / 86.4%	

			Apr 14 – Jun 14	96.5%	96.00%	100% / 87.2%	performance of risk assessments and provision of prophylaxis for VTE. NOTE: Since the Trusts' implementation of Medway. HSCIC has been unable to report on VTE.
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.							
5: Treating and caring for people in a safe environment and protecting them from avoidable harm All acute trusts	The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over		Apr 13 – Mar 14	17.5	14.7	0 / 37.1	The trust continues to decrease the number of cases of C.Difficile. The Trusts performance in infection control is described within the Quality Account Report.
			Apr 12 – Mar 13	19.7	17.3	0 / 30.8	
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.							
5: Treating and caring for people in a safe environment and protecting them from avoidable harm All trusts	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	Patient safety incidents reported to the National Reporting and Learning Service (NRLS) by provider organisations	Oct 13-Mar 14	4892 (reported) 6.4 (rate per 100 admissions) Severe harm or death = 68/4,892= 1.39%	NA NA	LARGE ACUTE TRUSTS ONLY 1.7/12.5 N/A	The Trusts outlined performance in reporting Incidents indicates strong reporting values with outcome rates mid-range against similar Large Acute Trusts.
			Apr 13-Sep 14	5119 (reported) 6.7 (rate per 100 admissions) Severe harm or death = 76/5,119= 1.48%	NA NA	LARGE ACUTE TRUSTS ONLY 3.8/11.1 N/A	

Friends and Family Test - Question Number 12d – Staff – The data made available by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation' for each acute & acute specialist trust who took part in the staff survey.							
4: Ensuring that people have a positive experience of care **All acute trusts**	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends	Percentages who agreed and who strongly agreed with the statement from the "b. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust" columns.	Staff Survey - 2014	45% (Agreed = 38% + Strongly agreed = 7%)	67% (Agreed = 47% + Strongly agreed = 20%)	Agreed = 80% + Strongly agreed = 54% / Agreed = 17% + Strongly agreed = 0%	The Trust staff survey for 2014 showed a total increase in employees that Agreed and Strongly Agreed to recommend a friend or relative to our Trust. Portraying the Trusts actions and achievements positively improving.
Friends and Family Test – Patient. The data made available by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2)							
4: Ensuring that people have a positive experience of care **This indicator is not a statutory requirement.** **All acute trusts**	The trust's score from a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.	Patient FFT based on Recommend % and Response Rate %	Feb 15	**Recommends:** 82.5% - A&E 89% - Inpatient **Response:** 20.7% - A&E 32.6% - Inpatient	**Recommends:** 88% - A&E 95% - Inpatient **Response:** 21.2% - A&E 39.8%- Inpatient	**Recommends:** 98% / 53%-A&E 100% / 82%-Inpatient **Response:** 47.3% / 1.6% - A&E 100% / 4.19% - Inpatient	The Reporting of the FFT from 2013/14 has now changed from singularly response rates to include Recommends % and Response Rate %. Therefore is not comparable to prior years. However compared against National performance the Trust is in line with National comparable Trusts. The Trust actions and achievements show positive improvements.

The Trust considers the data supplied and the performance reported is as described for the reasons set out in table above.

The table below sets out commentary on the indicators presented in the HSCIC data (previous table). In this table we outline key contextual factors and actions we are taking as a Trust in response to data.

Indicator	Key factors and actions
SHMI	ULHT has carried out a detailed review of mortality and actioned a comprehensive Mortality Reduction Plan. Although we have seen a slight increase in SHMI reported for the year, the final reporting period Apr 14-Jun 14 shows improvement with a result of 105.7. The Trust strives to continue to improve processes for the mortality reviews.
Staff Survey	The results of the 2014 Staff Survey were shared at the March Trust Board. This paper identifies what actions have been taken and will be taken to respond to the issues raised by staff. The response rate was 40% with the average for acute Trusts being 43%. Our response rate last year was 45% but the lower response rate was mirrored across all Trusts and our provider has indicated that this is to do with the implementation of the Staff Friends and Family Test. The results have been shared with staff-side at Executive Partnership Forum and to staff through staff briefings and Team Lincoln, Pilgrim etc. **Actions** 1. Particular focus will be given to the Lincoln Site and Team Lincoln will be used as a vehicle to engage staff and to drive change, learning from what has worked well for Team Pilgrim. Volunteers be will be sought from all staff to form a small team to shape Team Lincoln. 2. An Improving Time to Care LiA event is being held at the end of April, with seven events in total on all four sites which will take account of staff views in the way we roster staff 3. Staff engagement LiA events are being held at the end of April to understand from staff what is important to them in how they are involved and engaged 4. There is a pan Trust conference on 1st May to consider how we can reduce paperwork on wards. This includes a listening event 5. There is a listening event for Lincoln admin and clerical staff on how we can improve the health records service 6. Cohort 2 of the Stepping into Management programme for supervisors at Bands 3 and 4 starts in April 2015 with 17 staff enrolled. 7. Cohort 8 of the Leadership in Practice programme for bands 6 and 7 starts in April 2015 8. Cohort 1 of the ULHT Senior Leadership Development programme starts on 17th April 2015 with 20 medics enrolled 9. We will be learning from other Trusts who have a higher response rate to understand what we can do differently.

	10. A specific piece of work will be considered for the Facilities team at Lincoln to support managers and listen to staff 11. Focus will be given to the quality of appraisals and ensuring that they are a positive, meaningful exercise for staff. This will be audited on a quarterly basis from April 2015. 12. We will use regular Pulse Check surveys to measure impact of the above actions.
Patients who were admitted to hospital and who were risk assessed for venous thromboembolism	ULHT performance in this area has shown a marked improvement and is now within acceptable limits. We continue to work hard to ensure that each patient is appropriately risk-assessed and that prophylaxis is provided accordingly.
The rate per 100,000 bed days of cases of *C.difficile* infection reported within the trust amongst patients aged 2 or over	ULHT considers that this data is as described for the following reasons: strong performance in infection control and prevention. IPC team have implemented this year; the Hand Hygiene campaign on twitter #inyourhands. All of the Executive Team promoted a zero tolerance in Bare below the elbows/Hand Hygiene. Key actions going forward; improvement in the data collection for Hand Hygiene Audits. Anti-microbial stewardship is a CQUIN for 15/16. There is going to be a re-launch of a more robust RCA process for each case of C.Diff.
Patient Safety Incidents	ULHT continues to enjoy good reporting behaviour from staff and has a focus on learning from events and translating this into changes in safety and clinical effectiveness.
Patient Reported Outcome Measures (PROMs)	ULHT continues to promoted the Patient Reported Outcome Measures. The Trust has held a PROMs workshop to review the data and in doing so this has improved the Trust's compliance.
Patient FFT and Patient Responsiveness	The Friends and Family test measures Trust performance in patient care as perceived by patients through a prescribed sampling regime. Performance is influenced by many factors and this measure is only one of our many approaches to improving the patient experience. Patient Experience is a key quality domain governed through our Trust Patient Safety Committee. Patient Responsiveness is similarly a key work programme of this committee
Patient Readmission within the Trust 28 days of being discharged	The Trust works closely with commissioners with regards to patients readmitted to a hospital within 30 days of discharge. Monthly data is provided and reviewed. Furthermore, the Trust and commissioners jointly commissioned an independent audit which established the percentage of readmissions which were deemed as "avoidable". The audit found that 26% were deemed avoidable which was within the norm for the region. Under the NHS Contract, commissioners do not pay for emergency readmissions that occur within 30 days of discharge from an acute hospital following an initial planned stay. This funding is pooled by both CCGs and Specialised commissioners to be reinvested in areas that will prevent readmissions. The Trust therefore works closely with commissioners to establish where this is best utilised. In 2014/15, this included funding for a therapies outreach team that were proven to effectively reduce the number of readmissions. The intention is to continue this scheme into 2015/16 and look at a potential admission avoidance scheme in Oncology.

Review of quality performance

This section is where we set out information relating to the quality of services that we provide. It includes details of how we organise to manage quality and safety, a review of last years' priority areas, external review and assurance of our quality and an overview of performance against selected metrics, national targets and indicators.

Organisational arrangements and initiatives to embed quality

To address our goals in quality, we have continued our focus on our four areas:

- Patient safety
- Clinical effectiveness
- Patient experience
- Continuous improvement and cultural change

Our goals and strategy have been developed to take into account the needs of the Trust and its stakeholders including service users, commissioners, partners and our valued staff. The principal areas of quality shown above are therefore drawn from national guidance and also from patient feedback. A summary of our plans and key initiatives is provided below; if you would like further information in any area, please contact communications@ulh.nhs.uk.

During the past year ULHT has continued to focus on quality. As part of this process, the Trust has established a number of key committees with the responsibility of managing work streams in the areas of Patient Safety and Clinical Effectiveness, Patient Experience and continuous Improvement. Each of these committees is chaired by an executive director and takes an operational responsibility for improvement; all committees have a work programme, will take input from other committees or working parties across the trust and keeps a detailed action log. These operational committees, in turn, report to the Quality Governance Committee, which is one of four key assurance committees reporting directly to the board, all of which are chaired by non-executive directors who provide robust challenge. In this way, the board is directly sighted on the most important activities in maintaining and improving the quality of the care we deliver to our patients.

During 2014/15 every medical and surgical speciality has had regular meetings supported by newly appointed Quality and Safety Officers. These meetings cover mortality reviews where patients have passed away, essential aspects of patient safety and clinical effectiveness and other important elements of health and safety, information governance and lessons to be learned from incidents and events.

In this section, we present some of the arrangements for quality and safety which

are overseen by our governance structures.

Patient Safety

The Safety and Quality Dashboard (SQD)

The Safety & Quality Dashboard (SQD) is a dashboard developed to provide staff with relevant and timely information to inform daily decisions to improve the safety & quality of patient care. The SQD has been rolled out across ULHT since January 2012. New metrics have been added since the introduction of the SQD to reflect our achievements and any changes in priority, but in essence, the dashboard retains its emphasis on assessing the very basics of care process reliability.

The SQD has now expanded to the paediatric wards and A&E departments pan trust. The primary objective of the SQD is to ensure continuous improvement in clinical care with a clearly defined mechanism and named individuals on each ward responsible to drive up the standards. Data coordinators at the respective sites collect information on KPIs on 50% of all adult inpatients monthly.

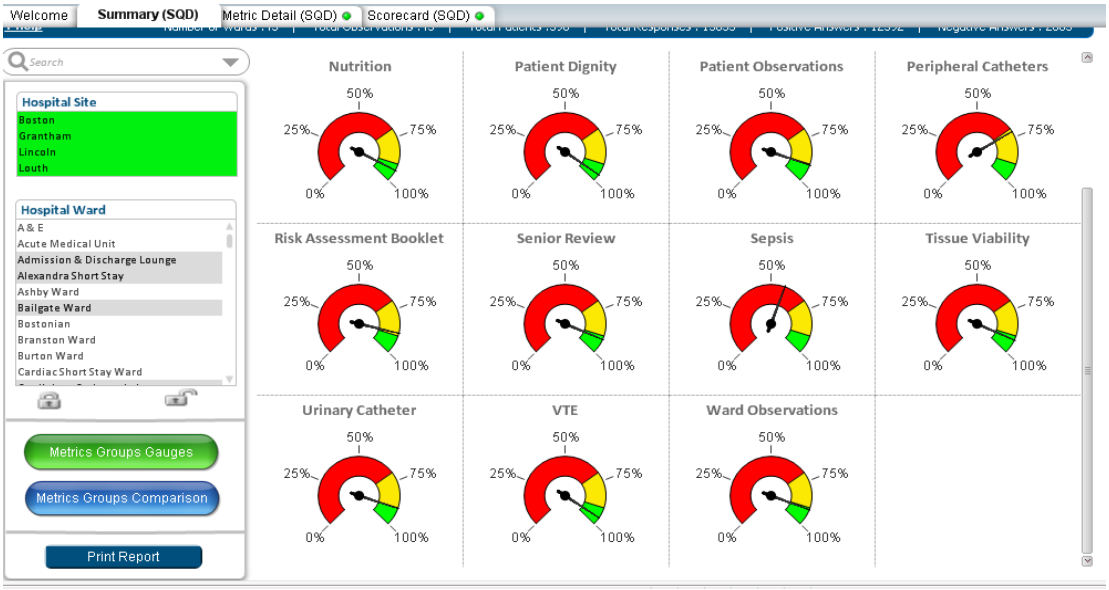
SQD Metrics

Metrics are divided into key groupings as shown in the table below. In all, over 60 essential quality metrics are included for display at ward level.

Ward Observations	VTE
Physiological Observations	Catheter Management
Sepsis	Peripheral Catheter
Nutrition	DNACPR
Tissue Viability	Senior Review
Falls	CQUIN Confusion Assessment
Medicine Management	Patient Dignity

Example of SQD display

The illustration below shows how data are displayed for patients to view on each ward.



Ward Health Check

Following on from the development of the Trust Safety and Quality Dashboard and the recommendations of the Keogh review team, the Trust developed the Ward Health Check which brought together the key sources of data onto one report for each ward/department.

Access to and use of good quality information is a key component of performance measurement and improvement for high quality, safe and reliable healthcare. Performance improvement involves monitoring the current level of performance and instituting changes where performance is not at the desired level. The Ward Health Check supports the Trust to improve the safety and quality of care by providing information about the current level of performance and identifying where there are opportunities for improvement.

There are a number of key sources of information available at ULHT which we use to assemble the Ward Health Check.

These include:

- Safety Quality Dashboard (SQD) – measure process reliability on 13 metrics
- Safety Thermometer – measures 4 key harms as a point prevalence
- DATIX – recording of incidents and complaints
- Staff Experience – recording of mandatory training, appraisal, staff sickness, vacancy rates
- Patient Experience – recording of friends and family scores and response rates
- Servicetrac – Ward / department cleanliness
- Fill rates – staffing levels
- Hand hygiene – monthly compliance with hand hygiene

Ward Health Check Dashboard – an illustration

To reset report always click Main Menu Button	Pan Trust Total																											
		21	1	63%	178	90%	53	92%	97%	82%	93%	97%	2	29%	90%	160	89%	60	85%	22%	74%	6%	75%	88%	101%	93%	111%
		IF YOU FILTER ON ANY OF THESE CELLS ENSURE YOU TAKE OFF BEFORE CLICKING THE MAIN MENU BUTTON																										
					Safety & Incidents														Environment	Patient Experience			Staff Experience				Day		Night	
Site	Business Unit	Dept	Cost Centre	Serious Incidents		Falls		Pressure Ulcers		VTE		Patient OBS on Time & Complete	Harm Free Care (New & Old)	New Harm Free Care	Clostrum Difficile (Post 72 Hours)	Hand Hygiene MAR - 15	Medication		Servicetrac	Formal Complaints Received	Friends & Family Recommends %	Friends & Family Response Rate %	Appraisal Rates	Sickness / Absence - JAN-14	Care Training	Average fill rate - registered nurses/mid wives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/mid wives (%)	Average fill rate - care staff (%)
				Datix	Never Events	SCD	Datix	SCD	PUNT	Assessed SCD	Prophylaxis SCD	SCD	ST	ST	Datix	IPC	SCD	Datix	Facilities	Datix	FFT	FFT	HR	HR	HR	E-Roster	E-Roster	E-Roster	E-Roster
Lincoln	AE Lincoln	A&E	L3734	1	0	N/R	0	100%	0	N/R	N/R	100%	N/R	N/R	0	88%	100%	8	81%	4	83%	20%	80%	5%	65%	N/R	N/R	N/R	N/R
Lincoln	Medicine Lincoln	Ambulatory Care	L1037	0	0	N/R	3	N/R	0	N/R	N/R	N/R	N/R	N/R	0	0%	N/R	1	91%	0	82%	26%	44%	3%	80%	N/R	N/R	N/R	N/R
Lincoln	Women & Childrens	Antenatal Clinic	L4520	0	0	N/R	0	N/R	0	N/R	N/R	N/R	N/R	N/R	0	0%	N/R	0	N/R	0	N/R	N/R	76%	4%	73%	N/R	N/R	N/R	N/R
Lincoln	Therapies	Ashby Ward	L1038	0	0	89%	1	100%	1	100%	100%	100%	100%	100%	0	0%	100%	1	89%	0	100%	100%	96%	1%	50%	97%	144%	96%	199%
Lincoln	Women & Childrens	Bardney Ward	L4535	0	0	N/R	0	N/R	0	N/R	N/R	N/R	100%	100%	0	0%	N/R	0	86%	0	92%	14%	76%	6%	69%	106%	105%	100%	101%

Sign up to Safety

The Secretary of State for Health set out the ambition of halving avoidable harm in the NHS over the next three years, and saving 6,000 lives as a result. This is supported by a campaign that aims to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patient's safety helping to ensure patients get harm free care every time, everywhere. So far, over 200 organisations have pledged support and are committed to improve the safety of healthcare through personalised Safety Improvement Plans. ULHT has committed to this plan and has used it to bring together all the safety initiative already in place across the Trust.

The five overarching Sign up to Safety pledges are; **Put safety first, Continually learn, Be Honest, Collaborate, Be Supportive.**

Our Safety Improvement Plan focuses on specific areas where local data shows that improvements can be made across the organisation. Areas included, but are not restricted too, are; Falls, Medication, Pressure Ulcers, Infections, Care Bundles and Senior Review.

Patient Experience

As part of national policy, ULHT fulfils an expectation that all organisations will report on the Friends and Family Test in their Quality Accounts for 2014/15 (both staff and patient elements). The following section provides key data and commentary.

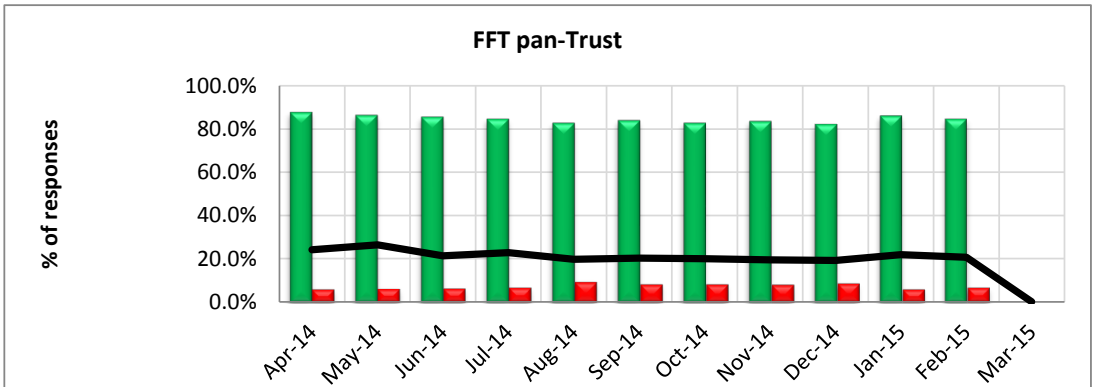
Friends & Family Test (FFT)

FFT aims to provide a simple headline metric which when combined with follow-up questions is a tool to ensure transparency, celebrate success and galvanise improvements to patient experience. The question asked is:

'How likely are you to recommend our (ward / A&E / maternity service) to friends and family if they needed similar care or treatment?'

The most recent data for the current year is shown below.

Within these global data, individual ward and department approval rating and response rates are reviewed by the Trust Patient Experience Committee and appropriate actions agreed. The current focus of the Trust includes the following:



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
% Recommend	88.1%	86.7%	85.9%	85.0%	83.1%	84.2%	83.1%	83.8%	82.5%	86.5%	84.9%	0.0%
% Not recommend	5.9%	6.3%	6.4%	6.7%	9.4%	8.3%	8.3%	8.1%	8.6%	6.0%	6.8%	0.0%
Response rate	24.1%	26.5%	21.3%	22.8%	19.7%	20.2%	19.9%	19.4%	19.1%	21.8%	20.6%	0.0%

- Work continues to encourage responses and ensure data quality for contacting patients.
- Wards and services receiving their reports and new reporting dashboards will enable local display of results and 'You said - We did' actions on new ward information boards..
- Outpatient developments as an early implementer continue with national roll out from April 1st including day case and paediatrics.
- National discussions being held with regard to maternity FFT as mothers and professionals report survey fatigue with being asked FFT question 4 times.

Innovation and improvement – Listening into Action

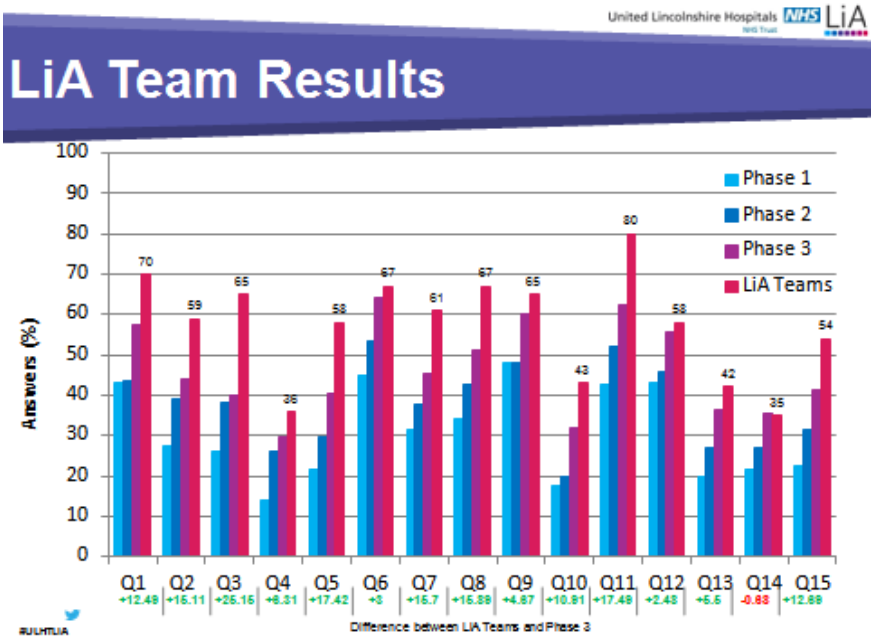
Listening into Action (LiA) is a way of working that has been proven to increase staff engagement. There is evidence that engaging staff increases morale, but more importantly leads to higher quality of care, more satisfied patients, lower patient mortality and significant financial savings.

LiA is one of the main ways in which the trust listens to and engages staff. Over 50 NHS trusts have used Listening into Action and ULHT has been using it since May 2013 with a mission to fundamentally shift the way in which staff, who know the most, are put at the centre of change. LiA enables staff to cut through all of the usual bureaucracy to deliver outstanding outcomes to improve their service.

Our results show that LiA is helping to improve staff engagement. Our Pulse Check survey, a set of 15 questions

focused on staff engagement, showed 8% improvement in how engaged staff were feeling, from July 2013 to March 2014. Positive changes in staff attitudes are illustrated below.

To engage staff using LiA, one of the first things to happen, is that we listen. Our listening events have been attended by over 2000 staff and as a result we have a clear idea of their priorities for change. Recent listening events include senior doctors and our junior staff. 68 senior doctors told us what needed to change to make it easier for them to provide a quality service and we have held listening events on each of our hospital sites for our junior staff (our pay bands 1-4) to let us know what frustrates them at work every day. We have set up LiA masterclasses at each hospital at which the site leaders discuss the action they can take to address the issues raised by staff and agree how to embed LiA as the way they make change.



Listening events are usually followed by setting up LiA teams to tackle the agreed priorities. Typically each LiA team is made up of 3 staff (usually a doctor, nurse or therapist and a manager) who are passionate about making a difference and who have 20 weeks to achieve their agreed mission. Since we started LiA we have launched 60 LiA teams who have achieved some great things. These include teams to focus on the priorities from listening to our senior doctors. Our latest phase of 15 LiA teams have been focused on supporting the trusts quality improvement journey to move Beyond Good, including supporting achievement of the trusts Care Quality Commission (CQC) actions which helped the organisation move out of special measures.

The teams will celebrate their achievements at the LiA Pass it On Event in May. The teams have been focused on:

1. Radiology – Pilgrim
2. Medicines management - Lincoln
3. Information for Eastern Europeans - Pilgrim
4. Cleanliness is everyones responsibility – Pilgrim
5. Outpatients – Lincoln
6. Frailty service for older people – Lincoln
7. Equipment – Lincoln
8. Reducing paperwork – Lincoln
9. Customer care – Lincoln
10. Endoscopy – Grantham
11. Discharge – Grantham
12. Care bundles – Grantham
13. Core learning for staff – Louth
14. Medical management – Pilgrim
15. Special observations - Pilgrim

Supporting our workforce to deliver high quality care

The Workforce & OD Strategy is an integral part of the business plan and has been developed in consideration of both the ULHT Clinical Strategy, and the Lincolnshire Health and Care Programme (LHAC); and is underpinned by a number of aims to ensure we support and develop our workforce and to drive forward change. The aims are:

- Effective workforce plans, which are clearly defined at both and operational and strategic level.
- An employment proposition, which is innovative and fulfilling enabling us to recruit and retain at the highest level, ensure that professionals have the opportunity to develop.
- A culture of high performance and continuous improvement in every aspect of our service.
- Every member of our workforce having a clear understanding of their role and objectives, working effectively in teams.
- Promotion and celebration of equality and diversity throughout the Trust.
- Leaders across the Trust openly demonstrate the values of our people management approach through their behaviours and interactions with others.
- Learning and development opportunities are made available to all, enabling staff to gain and improve skills and competencies that contribute to delivering the organisational goals and excellent patient care.
- A culture which values, encourages and recognises engagement, openness, achievement, candour and contribution.
- A learning culture which creates and nurtures, supporting highly motivated and skilled staff who are empowered to challenge constructively, and find solutions to problems.

The next few years will see transformational change across the Health Services, both nationally and locally, and the strategy will support the delivery of a high performing organisation, which maximises both the delivery of patient care and the opportunities to develop and utilize knowledge and skills across boundaries, during a period of major change. This will require a clear focus upon the culture of the organization and the need to develop our staff to consider how the future requirements of patients will call upon us to think differently, as we

consider what ULHT will need deliver in the future.

The illustration below shows the work streams for 2015/16 which support priorities and objectives which underpin the Workforce & OD Strategy.

Review of 2014/15 improvement priorities

For 2014/15, we selected five priorities for improvement, each linked to one of the key quality domains of safety, effectiveness or patient experience. As with the priorities identified for 2015/16, these were identified through consultation, review of performance in key areas of national focus, staff feedback and patient feedback. In the following sections we review our progress during the year for:

- Learning from patient feedback and complaints
- Reducing hospital mortality
- Reducing errors in medication
- Preventing harmful falls
- Ensuring that all patients are seen quickly by a consultant grade doctor

Priority 1 – Learning from patient feedback and complaints

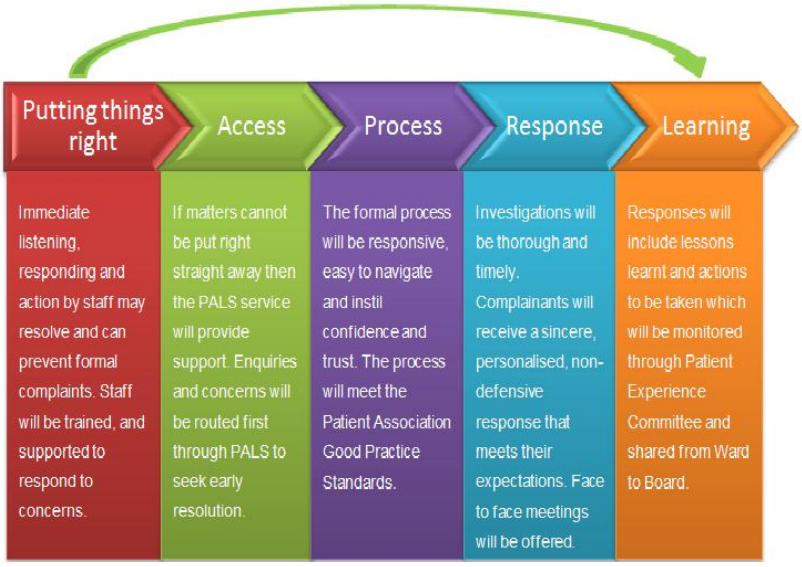
Providing a caring and responsive service is central to our continuing quality strategy. Following the Keogh Review of 2013, an integrated service model relating to patient complaints and enquiry was designed, taking into account the patient perspective, national best practice and input from the executive team. The principles within are of empathy and compassion and the pathway is called 'See it My Way'. The model looks at access and contact points and from these points creates a pathway that is responsive and patient-centred.

To design this model, staff and patients were consulted to define expectations alongside national best practice standards and the new process and systems follows the steps at each key point of contact and clear expectations of outcomes. Our objective was to ensure that concerns and complaints, whether formal or informal, and from whichever access point, are handled with compassion, expertise and in a timely fashion.

What have we achieved?

See it my Way

Implementing the new processes in listening and responding to feedback represents a major transformation in Trust culture and one that will continue into the future. In developing and implementing this vision, patient involvement has been central. Illustrated below are the key elements of *See it my Way.*



In developing this approach, the key was to ensure genuine consultation and involvement of our patients and staff at every step. The introduction of the Patient Advice and Liaison Service, a confidential, on-the-spot support service for patients, relatives and carers, has helped many patients through answering questions, offering advice when things go wrong, listening to suggestions and providing advice on formal NHS complaints procedures. Designing this service and other elements of *See it my Way* included:

- Setting up the PALS service - 15 patient representatives helped us to design the service model and recruit the staff.
- The Patient Association facilitated a listening event where 25 ex-

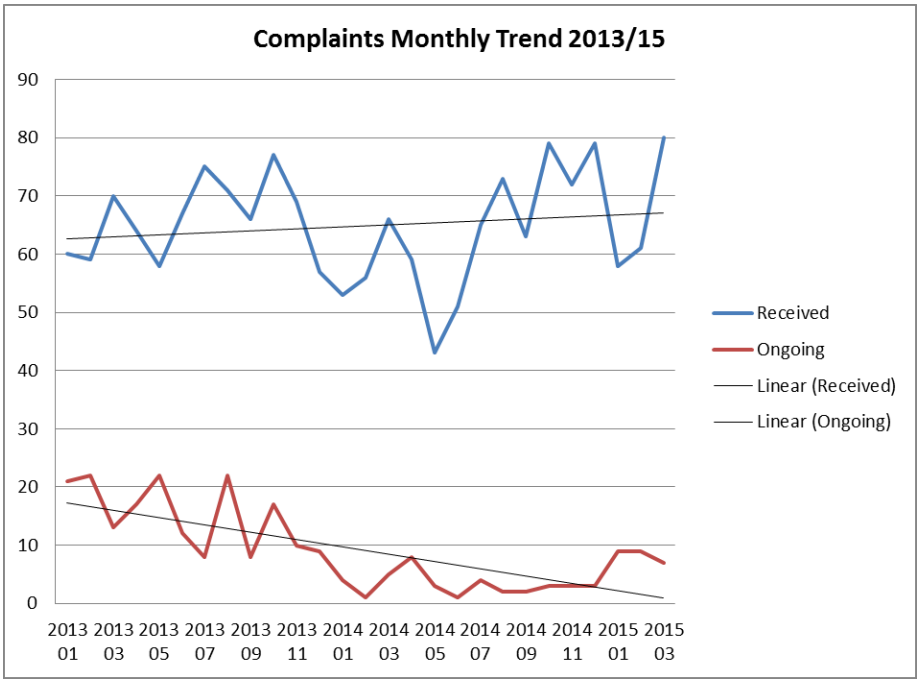
complainants worked through their experience of the complaints process.
- Staff workshops exploring their involvement with and handling of complaints.
- Postal survey of 300 Trust members (26% response rate).
- Review of national reports and best practice.

Key outcomes

- The near elimination of complainants returning dissatisfied
- Monthly increases in PALS enquiries, corresponding fall in formal complaints and extremely positive feedback from complainants on evaluation
- The development of 3 site based complaints from a central customer care service that was viewed as remote
- Immediate response to a complaint by a deputy director to acknowledge, apologise and explain next steps
- Development of quality metrics within business performance dashboards
- Development of innovative new documentation templates that demand transparency
- Development of a change register and process for sharing lessons learned with the explicit aim of identifying, learning and sharing lessons
- Development of a prospective survey of complainants to understand their experience and enable continuous improvement
- Development of a patient peer review process
- Completion of a training blueprint and comprehensive training programme

Key data

Complaints will always occur in complex systems. The task of the organisation is to ensure that improvements in our service to patients and carers result in fewer complaints and, further, to ensure that complaints have been dealt with appropriately and to the satisfaction of the complainant. Key measures for these are shown below.



Identifying learning and improvement actions

The new investigation template for complaints demands staff consider what learning or actions can be taken forward as a result of either the complaint as a whole or elements therein. We collate this information, which is then used and reviewed by:

- Quality & Safety Officers – to use within specialty governance meetings
- Heads of Nursing
- Clinical Directors
- Deputy Directors
- Matrons
- Business Managers

A monthly report from the change register is provided to Patient Experience Committee.

Priority 2 – Reducing hospital mortality

Mortality indicators are used to try to establish whether hospital mortality is higher or lower than average. They cannot and do not claim to establish whether any particular death or group of deaths was avoidable – that can only be established through detailed individual case note review. There are two statistics in common use: Hospital Standardised Mortality Rate (HSMR) and Standardised Hospital Mortality Indicator (SHMI).

A further key statistic, and one that drives both HSMR and SHMI, is "crude mortality" – the percentage of patients who die while in hospital. This itself will vary, depending on case mix, the age of the population, the provision of palliative or

end-of-life care in the community and other factors.

None of these measures are indicative of "avoidable deaths". At the Francis Inquiry, Professor Jarman of Imperial College made it clear that it is not possible to calculate the exact number of deaths that would have been avoidable, nor to identify avoidable incidents because those tasks would require expert review of all the relevant case notes. The statistics can only be signposts to areas for further inquiry. Mortality indicators therefore serve as pointers for clinicians to examine particular sites, diagnostic groups or specialities in order to determine – through further analysis – whether there are issues with the quality and safety of care. These analyses are routinely carried out when our data indicate higher than expected levels of mortality.

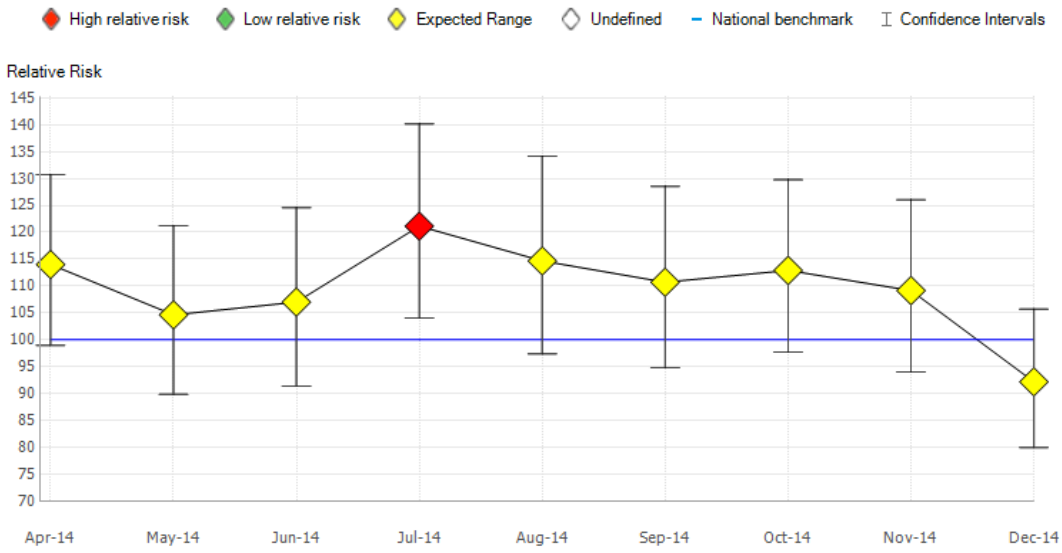
What have we achieved?

The Trust Mortality Reduction plan continues to focus on the following objectives:

- Introduction of key care bundles
- Safe and timely medicines management
- Management of the deteriorating patient
- Timely review by senior medical staff
- Reviews and learning from patient deaths.

Delivering this plan involves a robust Trust-wide communication plan including podcasts from key clinicians, newsletters and news blogs and the introduction of a suite of tools for mortality reviews and root cause analyses. Reliability levels for key care processes such as patient observations, use of track and trigger scores, medication and timely review of patients by consultants are monitored and displayed publicly on adult wards.

Hospital mortality, as measured by the comparative index "HSMR" has shown an increase during 2014/15, though due to data issues resulting from system changes at both ULHT and our data analysts, Dr Foster International, full data for the year are not yet available. The illustration below provides the HSMR for the 2014/15 YTD (April 2014 to Dec 2014).

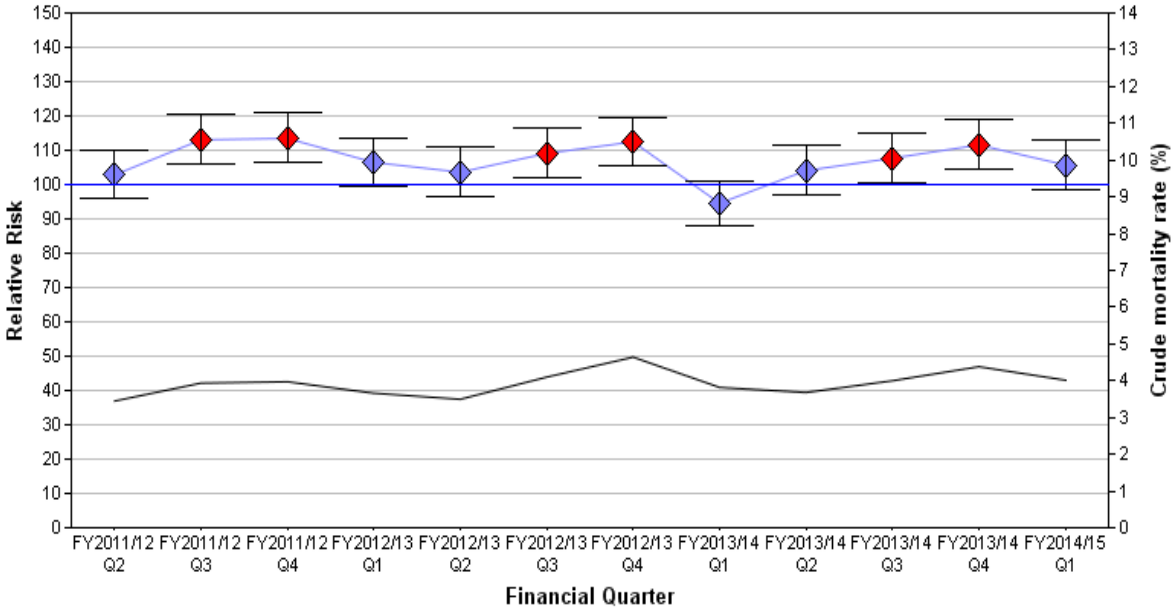


Past years' data are illustrated in the table below.

Year	HSMR
2010/11	112.34
2011/12	110.18
2012/13	110.08
2013/14	97.5
2014/15 YTD	108.83

SHMI

SHMI for the 12 month period to June 2014 is 1.07 – The Trust is within expected limits for this indicator.



While these data indicate a rise in hospital mortality as measured by HSMR and SHMI, crude mortality (as measured by Dr Foster) for this period has shown a reduction.

Year	Crude mortality
2011/12	4.34%
2012/13	4.26%
2013/14	4.04%
2014/15 YTD	4.07%

(Note: the above data reflect mortality for the diagnoses in the set used in calculating HSMR – not Trust Mortality overall. Crude (total percentage) mortality fell from 1.82% in 2012 to 1.73% in the following two years)

The rise in HSMR is a key concern for the Trust and a number of actions are in place to manage this. We outline these below.

Mortality reviews

Measures of relative mortality, especially HSMR, provide indications of where quality of care should be reviewed –either by location, or, more frequently, by diagnosis. Where a diagnosis alerts as having a higher relative risk than expected, it is the responsibility of the Trust to ensure that detailed case note reviews are conducted by clinical staff and that a balanced view of the quality of care in the cases is arrived at, reported appropriately and necessary changes implemented.

In most Trusts, case note reviews will be formally requested by the Care Quality Commission. At ULHT, we have had two alerting diagnoses from the CQC during 2014/15, for the diagnoses Septicaemia and Aortic and Peripheral Aneurysms. In both cases, detailed reviews were conducted and submitted to the CQC, who subsequently judged quality of care and review as appropriate and removed these items as risks.

In addition to those reviews requested by the regulator, we have conducted detailed case note reviews into diagnostic groups not alerting as higher than expected but where mortality was seen to have risen. These have included reviews into Atheroscheloris, Urinary Tract Infection and Gastro-intestinal Haemorrhage.

Governance

All case-note reviews for alerting diagnoses are commissioned by the Medical Director through the Patient Safety/Clinical Effectiveness Committee. This committee also receives a monthly mortality report.

Patient deaths are reviewed as part of speciality governance meetings at all sites and reported through Business Unit governance meetings. A single business unit will review a great many deaths during the year as part of its programme of work, using the mortality toolkit provided by Clinical Governance to ensure consistency in approach. At Lincoln County Hospital, for example, more than 750 mortality reviews in the Integrated Medicine business unit were conducted during 2014.

Coding

HSMR and SHMI are measures which are affected by a number of factors. Chief among these are the admitting diagnosis of the patient, the extent of other conditions (co-morbidities) and the application of palliative care for a patient. Each of these affects the expected mortality of the patient and therefore the relative risk. During 2014/15, the Trust has experienced a fall in the reliability of coding of the admitting diagnosis and the depth of coding of co-morbidities, both of which can be expected to influence HSMR adversely. The reasons for these changes include technical (non-clinical) issues relating to the point at which a firm diagnosis is recorded and also the accurate recording of all data in patient notes. Both of these issues are under review by the Patient Safety Committee.

Priority 3 – Reducing errors in medication

Reducing errors in medication is a key element of patient safety and is the subject of national work. During 2014/15 the Trust has focused on this area through detailed work carried out by the Pharmacy staff and through an ongoing analysis by external Human Factors consultants, funded by the Health Foundation.

What have we achieved?

During 2014/15 we implemented a number of strategies to improve medication safety and reduce errors around medication. Our main focus was directed at high risk areas where the closest management of medicines was required. To identify these areas we looked at several factors, including the speciality of the ward, the types of medicines they regularly used and the error rates for that area.

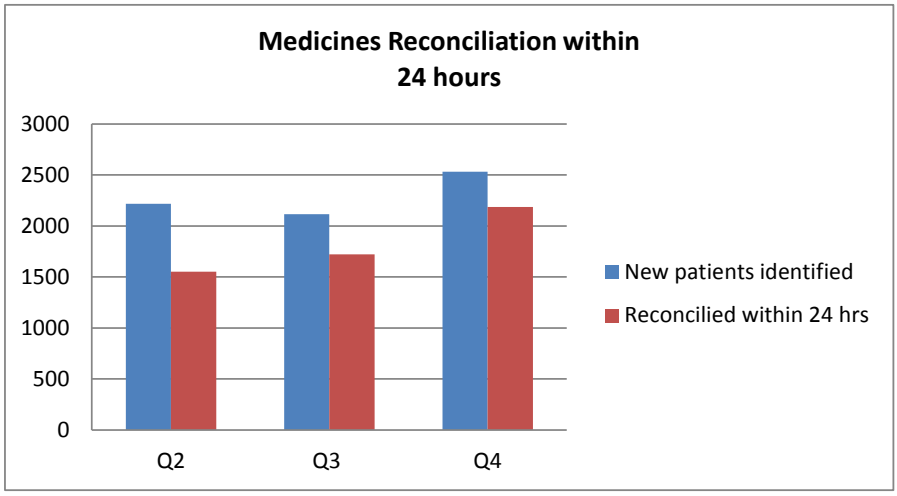
In these high risk areas we collected data on reliable medicines reconciliation, accurate and safe prescribing by doctors and reliable administration of drugs on wards. The Medication Safety CQUIN required us to make a 5% improvement over baseline in all three of these metrics in quarter 3 and in quarter 4.

Medicines Reconciliation

The aim of medicines reconciliation on hospital admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking prior to admission. Details to be recorded include the name of the medicine, dosage, frequency and route of administration. Establishing these details may involve discussion with the patient and/or carers and the use of records from primary care.

National Prescribing Centre defines medicines reconciliation as:

- collecting information on medication history (prior to admission) using the most recent and accurate sources of information to create a full and current list of medicines (for example, GP repeat prescribing record supplemented by information from the patient and/or carer)
- checking or verifying this list against the current prescription chart in the hospital, ensuring any discrepancies are accounted for and actioned appropriately
- communicating through appropriate documentation, any changes, omissions and discrepancies



In accordance with NICE/NPSA guidance our aim is to complete accurate medicines reconciliations within 24hours of a patient being admitted into hospital. The figure below illustrates our achievements.

What this means for patients

Seeing an increased number of new patients within 24 hours will help to ensure that more patients receive the right medicines at the right dose and frequency. This means that a patient's treatment prior to admission will be continued correctly. There will be a reduction in risk of medication errors and adverse drug events achieved through an increase in the availability and timeliness of accurate information about a patient's medicines.

Accurate and safe prescribing by doctors

To assess the quality of prescribing by doctors we recorded the clinical interventions made by a pharmacist and a pharmacy technician. A clinical intervention is a professional activity undertaken by a registered pharmacist or pharmacy technician directed towards improving quality use of medicines and resulting in a recommendation for a change in the patient's medication therapy, means of administration or how to take their medication. Making these interventions can aid in the reduction of risks, preventing issues such as drug interactions and possible overdosing and under dosing.

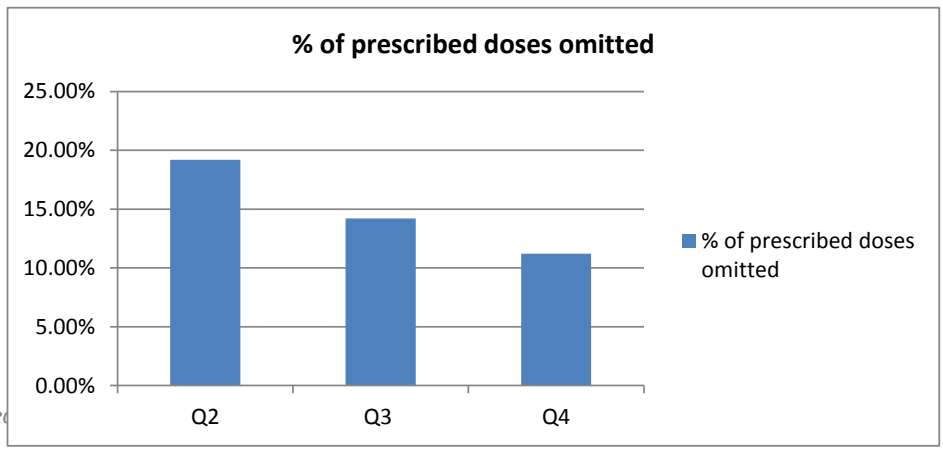
- During Quarter 2 we recorded 1861 interventions for 1717 patients seen.
- During Quarter 3 we recorded 2032 interventions for 1615 patients seen which meant a 9.2% increase in absolute intervention numbers meaning a 16% relative increase per patient compared to quarter 2.
- During Quarter 4 we recorded 1945 interventions for 1601 patients seen which meant a 4.5% increase in absolute intervention numbers and the same relative intervention rate per patient compared to quarter 3.

What this means for patients

When the clinical pharmacy team members make clinical interventions this ensures reduced risks and safer outcomes for the patient. By feeding the information back to the prescriber we can ensure lessons are learned leading to safer prescribing and a reduction in errors in the future.

Reliable administration of drugs on wards

To report on the accurate administration of drugs on wards we looked at the timeliness and completeness of administration, i.e. omitted and delayed doses of medicines. Omitted doses can be broadly split into two groups. The first group relates to physical unavailability of a medicine and the second group relates to failures to follow existing medicines management policies. Our data collection captured both of these groups.



- In Quarter 2 we identified 19.2% of all prescribed doses were omitted.
- In Quarter 3 we identified 14.2% of all prescribed doses were omitted. This meant omitted doses had been reduced by 26% from quarter 2 to quarter 3.
- In Quarter 4 we identified 11.2% of all prescribed doses were omitted. This meant omitted doses had been reduced by 21% from quarter 3 to quarter 4.
- Overall we have dramatically improved on this metric and omitted doses have been reduced by 41.7%

What this means for patients?

Clinical outcomes are improved for patients as the incidence of missed doses of medication is reduced. The patient experience is improved as a result of uninterrupted drug therapy, reducing the risk of associated treatment failure.

Priority 4 – Preventing harmful falls

Patient falls in hospitals are a significant risk, especially to our most vulnerable and elderly patients. Harmful falls can lead to extended stays in hospital, and sometimes additional surgery with all of the risks entailed in extended care. The Trust measures falls every month through a national survey called the *Safety Thermometer*. In-patient falls continue to be a key issue for our staff and patients.

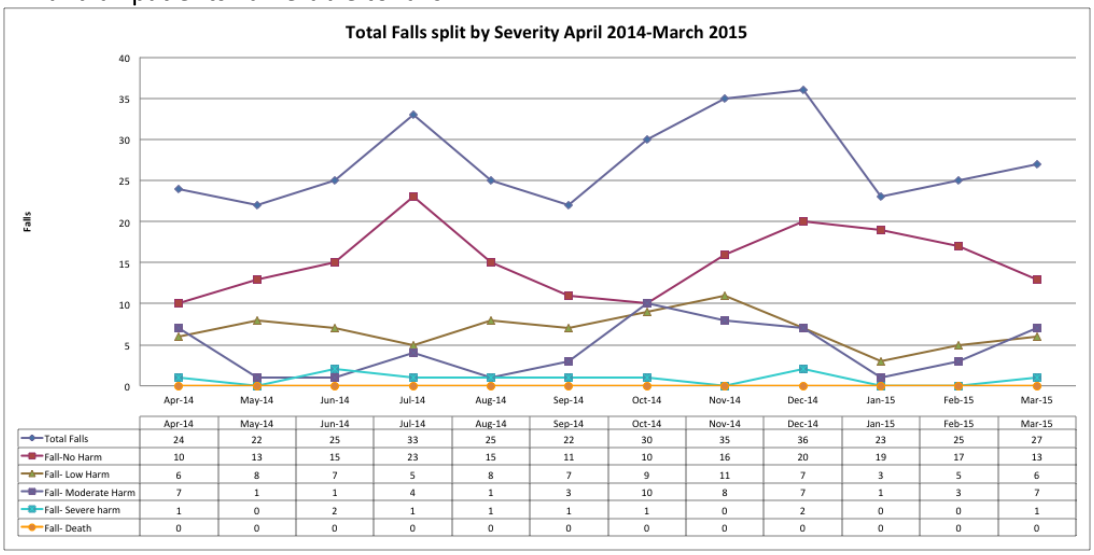
What we have achieved

During 2014/15, we initiated a Falls group as part of our overall development of better care for older people. Our chief objectives in this area were:

- To reduce harmful falls in ULHT
- To focus on those most at risk, including all patients over the age of 65
- To ensure that full risk assessments are carried out for patients over 65 and all patients vulnerable to falls
- To take into account the influence of medication on falls risk and identify possible proactive changes.

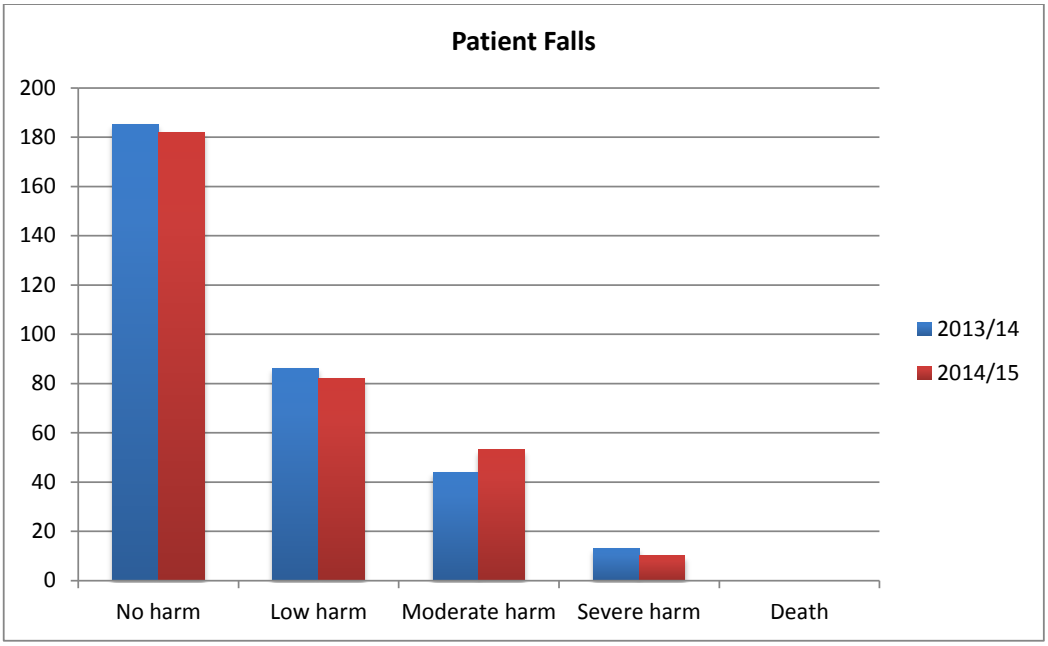
As part of ULHT commitment to reduce falls with harm we also developed and agreed a CQUIN related to this area. This work was being led pan trust by an experienced Matron who reports to the Older People's Board.

The figure below shows falls across ULHT during 2014/15, as measured by the Safety Thermometer. These data measure patient falls which have occurred within 72 hours of the national audit and therefore include a number of falls occurring in the community, prior to admission. This Trust has recently introduced systems to segregate these data, since our chief interventions will be to target in-patient falls.



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Total Falls	24	22	25	33	25	22	30	35	36	23	25	27
Fall-No Harm	10	13	15	23	15	11	10	16	20	19	17	13
Fall- Low Harm	6	8	7	5	8	7	9	11	7	3	5	6
Fall- Moderate Harm	7	1	1	4	1	3	10	8	7	1	3	7
Fall- Severe harm	1	0	2	1	1	1	1	0	2	0	0	1
Fall- Death	0	0	0	0	0	0	0	0	0	0	0	0

Comparing falls as identified by the Safety Thermometer with the previous year, a slight reduction in severe falls is present but the overall levels are very similar, indicating a continuing need to focus on the critical area of patient care:



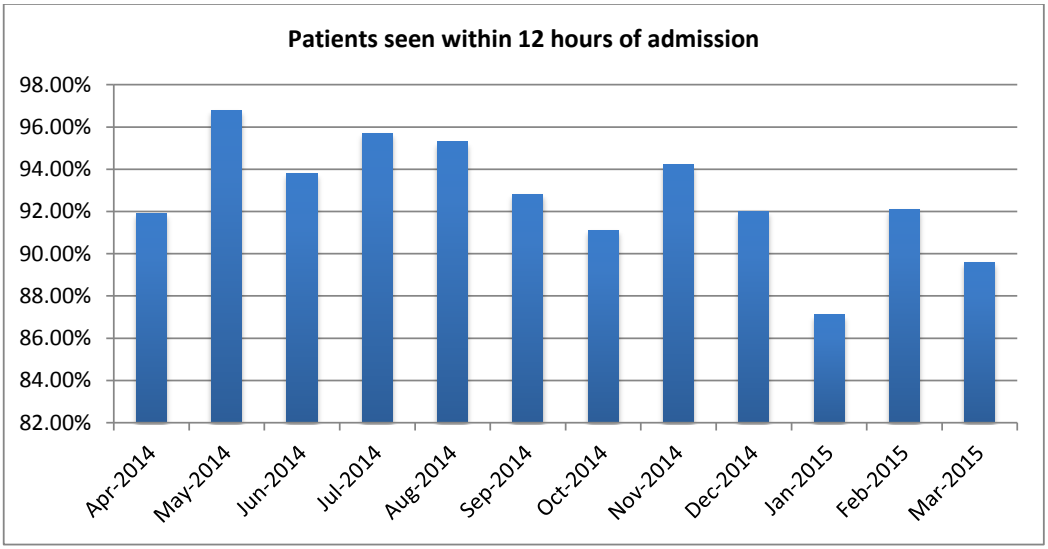
Priority 5 – Ensuring that all patients are seen quickly by a consultant grade doctor

What have we achieved?

During 2014/15, the Trust has continued to invest where possible in additional staffing to support the rapid senior review of patients following admission.

We have focused on the reliability of our 12-hour target for review of emergency patients by a consultant-grade doctor and also on how reliable our review processes are at weekends. For adult in-patients, our data displayed on each ward include the percentage of patients receiving such a review within 12 hours. These data are gathered by independent audit of patient notes every month as part of the Trust Safety and Quality Dashboard and are displayed at ward level.

During 2014/15, our achievements are shown in the figure below.



What this means for patients

Review by a senior doctor is an essential part of both patient safety and clinical effectiveness. Patients at ULHT are reliably reviewed on most occasions and our performance here continues to be a priority area for the coming year.

External regulation and assurance

Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission and its current registration status is full registration with concerns.

Clinical Negligence Scheme for Trusts ULHT Maternity Services

The Clinical Negligence Scheme for Trusts (CNST) standards and assessment process are designed to provide a framework to focus effective risk management activities in order to deliver quality improvements in organisational governance, patient care and the safety of patients.

ULHT continue to focus on compliance with the best practice guidelines from CNST.

Quality Overview

RESPONSIVE DOMAIN															
SEE INTEGRATED PERFORMANCE REPORT															
SAFE DOMAIN															
METRIC	**STANDARD**	**YTD**	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**MOVEMENT**
Hospital Standardised Mortality Ratio (DFI)	100			87.27				91.07	93.31			no data	no data	no data	
Summary Hospital-level Mortality Indicator (Latest data July 13 - June 14)	100	107.31		103.45					104.01			no data	no data	107.31	↑
Clostrium Difficile (post 3 days)	62	65	7	8	7	6	5	10	5	5	2	3	1	6	↑
MRSA bactaraemias (post 3 days)	0	1	0	0	0	0	0	0	0	0	1	0	0	0	↔
MSSA	24	28	0	4	2	2	0	2	6	3	0	4	2	3	↑
ECOLI	96	60	5	6	4	5	6	5	4	7	3	8	3	4	↑
Never Events (may change when reviewed)	0	5	0	1	1	0	0	0	1	0	0	0	1	1	↔
Serious Incidents reported (may change when reviewed)		136	9	9	11	10	4	8	9	20	13	17	9	17	↑
Harm Free Care % (Safety Thermometer)	95%	91.94%	93.92%	90.62%	89.97%	92.84%	90.06%	89.92%	90.61%	92.13%	93.44%	94.46%	93.17%	92.10%	↓
New Harm Free Care % (Safety Thermometer)		96.70%	95.58%	96.01%	96.96%	97.44%	96.54%	97.26%	95.68%	96.44%	96.57%	97.54%	97.33%	97.00%	↑
CAUTI (Safety Thermometer)		0.83%	1.21%	1.19%	1.22%	0.53%	0.86%	0.77%	0.53%	0.86%	0.94%	0.82%	0.64%	0.41%	↓
Falls (DATIX)		2212	190	186	169	193	201	190	173	210	170	187	178	165	↓
Medication errors (DATIX)	0	1398	119	97	109	111	101	84	133	122	131	113	160	118	↓
Medication errors (mod, severe or death) (DATIX)	0	94	4	7	13	7	8	8	10	11	4	6	8	8	↔
Pressure Ulcers (PUNT) 3/4	0	47		3	1	8	5	6	1	4	2	3	6	8	↑
VTE Risk Assessment	95%		96.41	96.54%	no data	no data	no data	no data	no data	no data	no data	no data	no data	no data	
Overdue CAS alerts (PD = past deadline) (NC = not completed)	0	11	2(PD)	2(PD)	1 (NC)	3 (PD)	0	1(pd)	2(pd)	0	0	0	0	0	↔
SQD %	90%	87.44%	88.93%	90.20%	90.21%	89.53%	88.90%	91.62%	86.05%	86.71%	86.08%	83.61%	83.99%	83.43%	↓

EFFECTIVENESS DOMAIN															
METRIC	**STANDARD**	**YTD**	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**MOVEMENT**
#NOF 24 hrs	70%	79.30%	85.0%	75.32%	73.85%	89.10%	74.60%	78.57%	81.00%	82.46%	70.65%	83.53%	85.00%	71.95%	↓
#NOF 48 hrs	95%	95.43%	97.50%	97.40%	96.92%	96.90%	95.20%	94.29%	95.20%	94.74%	93.48%	94.12%	96.67%	92.68%	↓
PPCI - 90 minute door to balloon Q3		96.95%			97.26%			94.80%				98.80%			↑
PPCI - 150 minute call to balloon Q3		90.08%			91.55%			88.50%				90.20%			↑
Dementia Screening (Awaiting data validation)	90%	81.57%	88.60%	83.60%	78.40%	77.70%	80.30%	79%	77.38%	80.81%	78.82%	78.08%	94.61%	MB	↑
Dementia Risk Assessment (Awaiting data validation)	90%	78.94%	79.20%	78.10%	76.20%	70.50%	75.40%	80%	77.00%	77.69%	83.03%	82.10%	89.07%	MB	↑
Dementia Referral for Specialist Treatment	90%	100.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	MB	↔
High Risk TIAs seen within 24 hours	60%	55%	41%	51%	40%	40%	57%	68%	59%	63%	54%	63%	68%	MB	↑
Inpatient stay on a stroke unit	80%	76%	72%	77%	67%	73%	84%	80%	74%	78%	81%	78%	75%	MB	↓
Scanned within 1 hour	50%	58%	58%	52%	59%	63%	53%	60%	67%	57%	58%	51%	56%	MB	↑
Scanned within 24 hours	100%	98%	96%	93%	99%	100%	100%	100%	95%	99%	99%	98%	100%	MB	↑
Thrombolysed within 4½ hours of symptom onset	12%	97%	93%	100%	87%	96%	89%	100%	100%	100%	100%	100%	100%	MB	↔
Treated on the stroke unit during their inpatient stay		89%	91%	88%	90%	87%	93%	87%	78%	86%	96%	91%	93%	MB	↑
Death following stroke inpatients stay		17%	21%	17%	18%	17%	12%	12%	16%	14%	19%	18%	12%	MB	↓
Admitted to a stroke unit within 4 hours	90%	63.00%	53%	60%	57%	59%	64%	61%	59%	75%	60%	52%	54%	MB	↑
eDD	98%	68.96%	67.90%	63.72%	65.51%	69.12%	75%	72.50%	70.20%	72.16%	70.95%	70.72%	70.56%	71.02%	↑

*MB = Month Behind

WELL - LED DOMAIN															
METRIC	**STANDARD**	**YTD**	**Apr**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**MOVEMENT**
IP response rate from FFT	>30%	31.55%	35.80%	37.70%	34%	37%	25%	27%	25%	26%	27%	33%	33%	41%	↑
A&E response rate from FFT	>20%	22.87%	19.40%	28.70%	19%	36%	22%	22%	21%	20%	21%	22%	21%	19.60%	↓
Staff FFT: % of staff who would recommend the trust if they needed care (extremely & extremely likely) Q3				63%				54%				45%			
Staff FFT: % of staff who would recommend the trust to friends & family as a place to work (extremely & extremely likely) Q3				56%				62%				44%			

METRIC	**STANDARD**	**YTD**	**Apr**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**MOVEMENT**
Inpatient scores from FFT	60		68	68.8	63	63	51	54	82%	90%	87%	88%	89%	86%	↓
A&E scores from FFT	46		47.1	45.7	35	36	41	41	82%	81%	81%	85%	82%	82%	↔
Complaints Received		783	57	60	50	64	66	64	74	73	78	57	60	80	↑
Complaints open												524	543	552	↑
Complaints on-going												9	9	7	↓
Mixed sex accommodation breaches (To be confirmed, investigation pending)	0	60	0	0	0	0	0	0	0	2 (TBC)	8 (TBC)	16 TBC	15(TBC)	19 (TBC)	↑

Stakeholder comments

NHS Lincolnshire West Clinical Commissioning Group (Lead Commissioner)

NHS Lincolnshire West Clinical Commissioning Group welcomes the opportunity to review and comment on the United Lincolnshire Hospitals NHS Trust Annual Quality Accounts 2014/15.

The Account commences with a clear and candid account by the Chief Executive of the headline quality achievements and challenges for the Trust. The quality priorities that the United Lincolnshire Hospitals NHS Trust has focussed on in 2014 – 15 are clearly articulated with supporting data & narrative including the two priorities which are carried over into the 2015/16 year.

As a whole the Quality Account provides a well-balanced, thorough overview of the initiatives undertaken by the trust to deliver improved quality of care and patient experience.

There are a few areas which would have been improved with further elaboration as below:

- As commissioners we would have also been keen to see more clearly defined the work undertaken over the past year on a number of other key national strategies pivotal to quality improvement i.e the Nursing 6 C's strategy, the Safer Staffing Initiative and the work being undertaken to prepare for Nurse Revalidation.
- While the continued development of systems and processes during 2014 – 15 to support quality improvement are clearly articulated, the commissioners would have liked to see more detail of outcome information, for example:
- The outcomes of the complaints process including time to respond to a complaint, themes of complaints and actions taken to prevent reoccurrence;
- The learning from patient safety incidents including Serious Incidents and Never Events

The Commissioning Group does however receive regular progress on the above areas from ULHT through 1 to 1 and group meetings and through formal Quality and Patient Safety Review Meetings, so are satisfied these areas are being addressed and reported both internally and externally to relevant stakeholders.

For the second year the Quality Account does not detail the robust consultation process undertaken with key stakeholders by the trust in the identification of quality priorities for the coming year. This is a concern for the commissioners which was also raised during the 2013/14 Quality Account Review. A robust consultation process is crucial to ensure the full breadth of views from patients, commissioners and other stakeholders informs service

development and improvement to meet the needs of the local population. The Clinical Commissioning Group is aware this consultation has taken place, so it would have been good to have seen more detail within the Account of the process of consultation undertaken. We note the quality priorities chosen align well with commissioner and regulator requirements for improvement.

Once again the Commissioning Group is pleased to read of the focus and support for innovation and research, evidenced by increasing participation in clinical research projects. Other areas worthy of specific note are the improvements made to ward/team governance processes including more robust mortality review processes and development of the full Ward Health Check system. These initiatives and the Listening into Action programme are truly supporting quality improvement and ownership at the very frontline of care delivery.

The commissioner can confirm that to the best of our knowledge the report is a true and accurate reflection of the quality of care delivered by United Lincolnshire Hospitals NHS Trust and the information contained in the report is accurate. NHS Lincolnshire West Clinical looks forward to continuing to work with the trust to improve the quality of services available for the patients of Lincolnshire in order to improve patient outcomes.

Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire

This statement has been jointly prepared by the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire.

Review of Progress on Priorities for 2014-15

We note that progress on the five priorities for last year has been mixed, with progress in many areas, and as a result three of the priorities have been carried forward into 2015-16.

One of the most notable achievements has been the re-introduction of the Patient Advice and Liaison Service (PALS), which has led to improvements in the handling of patient concerns and fewer complaints. We also note that ULHT is one of the few trusts to measure the number of inpatients seen by a consultant-grade clinician within twelve hours of admission, and we are pleased that this has been achieved in over 90% of cases during the last year, but would like further improvement in the coming year.

We accept the impact of palliative care and other coding issues on the Trust's Hospital Standardised Mortality Rate (HSMR), which may increase to 108 and may make the Trust a statistical 'outlier', and we also accept that this does not necessarily mean that there has been an increase in avoidable deaths at the Trust's hospitals. However, we support the Trust's emphasis on responding to this increase and continuing to work to reduce the HSMR, together with the other two measures of mortality.

Although not listed as a specific priority, we would like to acknowledge the high standards provided by Lincoln County Hospital's Cardiology Centre.

Priorities for 2015-16

The Health Scrutiny Committee for Lincolnshire and Lincolnshire Healthwatch support the Trust's six priorities for 2015-16 and accept the rationale for their selection. We also do not believe that there should be any other priorities included in the Quality Account for the coming year.

In particular we would like to make the following comments: -

- Priority 1 (Reducing Mortality) – As stated above, it is important for the Trust to continue to reduce the levels of mortality, in particular the HSMR.
- Priority 2 (Reducing Harmful Adverse Events) – This priority includes five elements, all of which will improve patient care. It is important that these five elements are appropriately measured and reported.
- Priority 3 (Improving the Response to Complaints) – We support the emphasis in this priority to learning from previous complaints and developing services accordingly.

- Priority 4 (Improving Outpatient Services) – We recognise that this priority is included because of the Care Quality Commission's rankings for Outpatient Services.
- Priority 5 (Reducing Delays in Discharge) – Healthwatch Lincolnshire has reported on this topic in the last year, but we suggest that the Quality Account acknowledges that improvements cannot be delivered in isolation, but as part of a partnership involving Community Health Nurses, Primary Care, Social Care, patients and carers.
- Priority 6 (Achieving Standards in Cancer, Referral to Treatment and Emergency Access) - A particular concern for the residents of Lincolnshire has been the Trust's performance on its cancer standards and we hope to see significant improvements in this area, once plans for improving cancer care have been published.

As always, we would like any targets for these priorities to refer to actual numbers and percentages rather than to percentages alone.

Recruitment and Retention

A recurring theme for the NHS is attracting and retaining staff across all the areas of health care activity. These national challenges are magnified in Lincolnshire and we would like to support the Trust in any initiatives that lead to improving the quality of service to patients, by seeking to recruit and retain permanent staff rather than rely excessively on agency and locum staffing.

Engagement with the Health Scrutiny Committee and Healthwatch Lincolnshire

During 2014-15, representatives from the Trust attended the Health Scrutiny Committee for Lincolnshire on four occasions. These attendances included instances where the Committee was seeking assurance in relation to the Trust's response to the Care Quality Commission report published in July 2015.

Healthwatch Lincolnshire produced a report in January 2015, entitled Care Planning for Discharge, which made a total of 18 recommendations for improvements. Healthwatch Lincolnshire would like to see the Trust publish a response to these recommendations and, where appropriate, a plan for their implementation.

Involvement of the Public and Stakeholders

There is a reference to the stakeholders being involved in the development of the Trust's six priorities for 2015/16. For future years, we suggest that the Quality Account includes further detail on how stakeholders were engaged in the development of the priorities, for example by referring to the outcomes of specific events or consultations, although we have been assured that sufficient engagement took place in the development of the six priorities.

Care Quality Commission

The Quality Account refers to the CQC inspections of the Trust, and the fact that by March 2015, the Trust was no longer in Special Measures. We would like to commend the work by

all members of staff in seeking to raise the standards at the hospital of quality in order to satisfy the Care Quality Commission, but we note that the Outpatients Department at Lincoln County Hospital was rated as inadequate overall. As stated above, we fully support the priority aimed at improving Outpatients Services at all hospital sites and look forward to the Trust reporting on improvements in such services during the coming year. We commend the Trust for being rated as outstanding for responsiveness in Critical Care at Lincoln County Hospital.

Lincolnshire Health and Care

The Lincolnshire Health and Care programme is going to change the approach to many services in Lincolnshire and a key element in the year to come for the Trust is maintaining high quality care for its patients, while planning for and implementing changes in services.

Conclusion

The Health Scrutiny Committee for Lincolnshire and Lincolnshire Healthwatch are pleased to have had an opportunity to make a statement on the Quality Account, and accept that it has been a challenging year for the Trust in seeking to respond to the Special Measures regime. We hope to see the Trust building on these improvements in the coming year.

Appendix: Governance Statement 2014/15

United Lincolnshire Hospitals NHS Trust
Annual Governance Statement 2014/15

Scope of responsibility

As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives whilst safeguarding public funds and the organisation's assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the organisation is administered prudently and economically and that resources are applied efficiently and effectively. I acknowledge my responsibilities as set out in the Accountable Officer Memorandum which sets out my responsibilities of propriety and regulation of expenditure, and for putting in place effective management systems which safeguard public funds and allow for the keeping of proper accounts.

The governance framework of the organisation

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk. It therefore provides reasonable rather than absolute assurance of effectiveness. The governance and system of internal control of the organisations is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in United Lincolnshire Hospitals NHS Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

Trust Board and Committee Structure

The Trust Board meets on a monthly basis and consists of a Chairman, 5 voting Executive Directors, including the Chief Executive and 6 Non-Executive Directors. The Director of Operations, Director of Estates and Facilities, Acting Director of Performance Improvement and the Director of Human Resources and Organisational Development also attend the Board meetings. The Board focusses on strategic issues, whilst also receiving assurances in relation to the Trust performance on quality, the NHS constitutional commitments and finance. The Board membership has been stable for the last 12 month period.

The Board completed a self-assessment against the criteria in the Board Governance Assurance Framework in 2014. The purpose of this was to provide assurance of the effectiveness of Board governance. This was done by measuring current status and practice against various leading indicators of effective board governance. The framework was divided in to four sections, Board composition and commitment, Board evaluation, development and learning, Board insight and foresight and Board engagement and involvement. An independent review was then completed in late 2014 which included assessment of Board members and how the board operates. A plan was formulated based on the output of these reviews. The plan includes:

- A board development schedule which has been put in place to engage the Board in strategic and future facing issues for the Trust as well to undertake detailed reviews into key aspects of the Trust's annual plan
- A succession planning process to provide a more consistent flow of Board and senior management talent
- Establishing locality forums to engage our Trust members and local stakeholders. The Locality Forums are chaired by a Non -Executive member of the Board
- Patient listening clinics which the Non-Executive Directors hold and all Board members participate in a programme of Board visits to front line areas.

The Trust can confirm that the arrangements in place for the discharge of statutory functions have been checked for any irregularities and that they are legally compliant.

In managing the affairs of the Trust, the Trust Board is committed to the highest standards of integrity, ethics and professionalism in all areas. As part of this commitment the Board supports the highest standards of corporate governance within the statutory framework. The Trust has in place a corporate governance framework which includes standing orders and standing financial instructions and a scheme of delegation.

The Trust Board subscribes to the NHS Code of Conduct and Code of Accountability and has adopted the Nolan Principles.

Supporting Committee Structures

To support the Trust Board in carrying out its duties effectively, committees reporting to the Board are formally established. A fundamental review of the committee structure was completed in 2013/14 to deliver robust governance and assurance and this has continued to be embedded during 2014/15. Each Assurance Committee of the Board has its own agreed sub structures and the Assurance Committees receive reports as outlined within their terms of reference and work programme, Each Committee provides an Assurance and Exception report to each meeting of the Trust Board. The Assurance Committee structure reflects the key strategic themes within the Trust's Annual Plan.

The key committees for governance and assurance are as follows:

Audit Committee - delegated to approve the annual accounts on behalf of the Board and

provide assurance in relation to internal and external audit, counter fraud and security management, statutory financial reporting, integrated governance, risk management and internal control, and the annual governance statement.

Quality Governance Assurance Committee –provides assurance to the Trust Board that appropriate and effective governance mechanisms are in place for all aspects of Quality Governance and risk, In particular ensuring the strategic objectives and trust ambitions are being delivered ie:

- Ensure Our Patients are Safe
- Ensure that our Patients have the Best Possible Experience
- Ensure that our Treatment is Effective and Compliant
- Be A High Reliability Organisation

Finance, Performance and Investment Assurance Committee – responsible for monitoring delivery of performance and financial plans, providing appropriate assurances and/or raising concerns to the Board. Coverage includes but is not limited to the financial plan agreed with the NHS Trust Development Authority (NTDA), performance standards within the NHS Constitution and the Trust's capital programme and estate management function. The key related strategic objectives are:

- Ensure that services are Financially Viable, ie delivery of agreed CIPs
- Ensure a Fit for Purpose estate
- Be A Well Governed Organisation.

Service Transformation Assurance Committee - responsible for overseeing progress against Service Transformation objectives and providing appropriate assurances to the Board. In particular ensuring the strategic objectives and trust ambitions are being delivered ie:

- Ensure that our services are clinically and financially sustainable; ensuring access to services locally within Lincolnshire where we can

Workforce and Organisational Development Assurance Committee - provides the Board with assurance concerning all aspects of workforce and organisational development relating In particular ensuring the strategic objectives and trust ambitions are being delivered ie:

- Ensure an engaged, empowered and healthy workforce
- Ensure that staff are appropriately developed and skilled
- Ensure that services are well led
- To assure the Board, that the structures, systems and processes are in place and functioning to support the workforce in the provision and delivery of excellent quality health and social care services
- To assure the Board that strategic workforce and OD risks and issues that may jeopardise the Trust's ability to deliver its objectives are being managed in a controlled and timely way.

Clinical Executive Committee - leads the clinical and operational service delivery across the Trust and advises the Board on clinical and organisational strategy.

The Assurance Committee reports to the Board include those areas where assurance has been sought, received, and where further action to gain assurance was required and what that action is.

Capacity to handle risk

Overall responsibility for risk management rests with all members of the Board. The Director of Human Resources and Organisational Development has overall Executive level responsibility for the risk management strategy and processes within the organisation. The Director of Finance has specific responsibility for financial risks within the Trust, whilst the Medical Director holds specific responsibility for the management of clinical risks. There is a defined structure for the management and ownership of governance, through the risk register and assurance framework which is regularly monitored in the Board committees and at Trust Board level. The Trust operates and maintains an approved Risk Management Strategy and policies and procedures that identify the levels of accountability and responsibility for all staff within the organisation.

The Trusts Risk Management Strategy and Policy and Procedures define the types of risks that may impact the Trust and the overall Trust approach to risk assessment. The strategic risks are captured in the Board Assurance Framework and form the basis of the Board's risk management agenda, supported by the Business Unit Risk Registers. Operational risks are captured within the Business Unit; Specialty and Committee structures as appropriate to the level of risk identified.

Risks are identified in the Trust by managers and the management of those risks is determined by the risk rating. The risk rating, defined in the Trust's Risk Management Policy and Procedures, is derived from evaluating the likelihood and severity of an occurrence that may impact on the Trusts objectives.

A review of the risks recorded in the Trust's Risk Register over the last year saw the number of extant risks reduced considerably and the risk rating of the remaining risks holds a lower aggregated value. This review has seen certain categories of risk reduced eg health and safety; though the reputational risk arising from ongoing Health and Safety Executive prosecutions and notices remains high. The risk profile shows high risk ratings in the Women's and Children's Business Unit.

The major corporate risks to the Trust relate to its finances, ongoing relationships with regulatory bodies, namely Health and Safety Executive and staffing levels (the appropriate levels of competency and experience). The major clinical risks relate to the management of care relating to the incident of falls; infections and medicine administration errors.

This is in addition to targeted improvement work during the year arising from successive reviews by the Keogh Review team and the Care Quality Commission to mitigate individual risks identified in 2013/2014 and the CQC revisit in March 2014.

Emergent risks are identified from a variety of sources within ULHT: learning from adverse

events; the Quality Performance Improvement Committee; the Integrated Performance Report, various Dashboards; Quality Impact Assessments and Internal Review Audits. During 2014/2015 these emergent risks relate to the shortage of sufficient trained staff particularly in nursing and some therapy services. Horizon scanning for emerging risks in the short to medium term (1-5 years) is carried out by the relevant Directors and the Risk Manager. A core element of this will be risk emerging from the transformation in health and social care and its impact upon the Trust's risk profile and strategic objectives.

The Trust reported two data security breaches to the Information Commissioner's Office (ICO) in 2014/2015; one related to patient records being left unsecured in a car park whilst another related to the transfer of personal and sensitive date to a personal computer via a data stick. The latter was also reported to the police. The ICO was content with our investigations into these breaches and the Trust remains compliant with the IG toolkit.

Quality Governance is managed through the monthly Quality Governance Committee, chaired by a non-executive director . This committee takes reports from all supporting key quality committees, including Patient Safety/Clinical Effectiveness, Patient Experience and Quality Performance and Improvement Committee. A detailed annual programme of work and reporting supports this committee, which itself reports directly to Trust Board. The committee also supervises the production of the annual Quality Account and manages, through the Patient Safety and Clinical Effectiveness Committee, Serious Incidents and resulting actions, Never Events and related actions. Further committees, including Information Governance, CQC Compliance Assurance and Health and Safety address regulatory compliance and operational management, and form part of the annual work programme.

The risk and control framework

Managing risk is the responsibility of all employees and not just the role of specialists, managers or the Trust Board. All employees are responsible for identifying, reducing and eliminating risk where possible. A key element of the Trust's Risk Management strategy is the integration of risk management into both the strategic and routine operational decision making processes within the Trust. The strategy is designed for prevention and deterrence of risks, and the Board are committed to minimising risk through the use of the Risk Register and Board Assurance Framework.

The Trust's Risk Management Policy and Procedures are in place and encourage staff to report adverse incidents and near misses in order to minimise risk and take action to prevent recurrence. The Trust's Incident Reporting system has been upgraded to facilitate easier reporting. The policy and procedures underpin the Trust's Risk Management Strategy.

The structure of the Trust's Risk Register has recently been upgraded to capture strategic, operational and local risks. This gives managers at all levels the facility to identify, manage and escalate (where necessary) the main risks in their area of work. Risk assessments

contribute to the Trust's risk register and encompass both clinical and non-clinical risks.

Increased reporting of incidents and a culture of learning lessons from adverse incidents helps mitigate against their re-occurrence and acts as a deterrent. Robust reviews of adverse incidents, near misses and recorded risks through the governance committees and specialty governance meetings provides visibility of on-going concerns at all levels.

For all risks recorded on the risk registers the controls currently in place to manage the risk are described, as are the gaps in those controls to reduce the risk to as low as reasonably practicable. An action plan with a nominated "risk lead" is developed for every action to address those mitigation measures required and a review date for each action. The timeliness for the completion of actions is linked to the level of the risk score.

Risk Management training commences at induction with further training in risk management provided through the Trust's mandatory training programme. That training reinforces individuals' accountabilities with respect to incident reporting and risk management and enables staff to assess and manage risks within their sphere of responsibility.

Specialised risk management training is provided to staff who have been identified as 'Risk Handlers' to enable them to aggregate risks across their Business Unit or Specialty and consider the impact upon the Trust's strategic objectives.

The Board is responsible for setting the organisation's aims and objectives and ensuring that an Assurance Framework identifies the principal risks to the organisation meeting these aims and objectives, as well as confirming the key controls in place to manage these risks.

The Board Assurance Framework identifies the source of independent assurance in relation to each objective and risk. The framework is dynamic to reflect changes in priorities and developments in the external environment. It is a strategic management tool to support the annual governance statement, not designed to show every risk, but to focus attention on those which are most significant.

The Audit Committee assess the overall adequacy of the Assurance Framework on behalf of the Accountable Officer and the Board and advises the Board in relation to the systems, processes and controls in place for co-ordinated and effective risk mitigation in achieving the Trust's objectives. This enables the Board to discharge its responsibilities for governance and understand the balance of clinical, operational and financial risk.

Throughout 2014/15, the Board has identified and monitored against key objectives within its Board Assurance Framework. The controls and assurances in relation to the objectives' risks were received by the Board during the year. In addition, each Assurance Committee reviews at every meeting the parts of the Board Assurance Framework relevant to their terms of reference and then reports to the following Trust Board meeting in an Assurance Report. The framework identified gaps in control for some financial, operational and clinical measures and the Trust has taken and continues to take remedial action to address them.

The Trust continues to put in place an adequately resourced plan of work for the Local Counter Fraud Specialist which includes proactive deterrence and prevention of fraud work.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the organisation that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report and other performance information available to me. I have been advised on my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Assurance Committees and plans to address weaknesses and ensure continuous improvement of the system are in place.

The Assurance Framework and the Risk report provide me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives has been reviewed.

The Audit Committee receives and monitors the Assurance Framework and relevant internal audit reports. It monitors and performance manages the action plans to address the recommendations from audits which have identified weaknesses in internal control. It reviews the annual report and accounts including the Trust wide governance arrangements as described. The Chair of the Audit Committee has recent and relevant financial experience and members provide rigorous challenge on reports received by the committee and ensure the application of sound accounting policies and practices.

The preparation of the Quality Account has been informed by scrutiny of guidance. All data incorporated in to the Quality Account is from established sources subject to routine and regular audit of data quality. The comments from Healthwatch, the Lincolnshire Health Overview and Scrutiny Committee and the Clinical Commissioning Groups provide external assurance of the effectiveness of internal controls.

The Trust has engaged its External Auditor to provide an external assurance audit of the quality report which will be reported to the Audit Committee and Quality Governance Assurance Committee.

The Trust is committed to continuous improvement of its risk management and assurance systems and processes to ensure improved effectiveness and efficiency.

My review is also informed by:

- Opinion and reports from Internal Audit (TIAA) based on a risk based audit plan approved by the Audit Committee
- Opinion and reports from External Audit (KPMG)
- Compliance with CQC essential standards of safety and quality and CQC reports on visits and inspections
- An Information Governance Toolkit Assessment

- Results of national patient and staff surveys
- Monitoring of patient experience and complaints
- External visits and inspections
- Clinical audit reports.

Significant Issues

During the year the Trust identified the following issues.

Following a CQC re-visit in February 2015 a recommendation was made that the Trust was removed from special measures and the CQC recognised that significant improvement had been made since their previous inspection in 2014. However the visit identified that there were still some essential standards of quality and care that were not being met and required improvement. Out of a possible 113 ratings the Trust achieved 95 'good' or 'outstanding' ratings, 16 'requires improvement' and 2 'inadequate ratings'. The areas where the Trust still needs to take action are recruiting staff to vacancies in some services, managing and monitoring governance systems at Louth and reviewing the Trust wide system for patient appointments.

Improvement plans to take account of the CQC findings have been put in place.

The Trust reported a financial deficit of £15.2m for the 2014/15 year. Whilst this was a significant improvement on the £25.4m deficit in 2013/14 and the Trust's cost improvement target was exceeded in year, the duty to break event was not met. The Trust is reviewing its financial strategy and aims to return to financial balance at the earliest realistic point.

The Trust failed to deliver the key NHS constitutional standards for:

- A&E 4 hour wait - internally efforts have focussed on:
  - ensuring good senior medical and nursing staff availability
  - establishing out of hours streams at the front door including the frailty unit at Lincoln
  - revised early escalation procedures.

- Planned care and referral to treatment (RTT) - we have carried out a significant programme of validation, data cleansing and capacity planning to improve the current position and reduce waiting times. The Trust assures itself of the quality and accuracy of elective waiting time data through specific training for staff, the use of electronic solutions to improve accuracy, validation processes linked to the new systems and inclusion in the internal and external audit work programmes. The risks associated with elective waiting times and specifically those attached to the new Patient Administration System (PAS) have been reviewed and assurance sought at the Finance Performance and Investment Assurance Committee throughout the year.

- Cancer pathways - the national NHS Intensive Support Team demand and capacity tool is being utilised to identify the required capacity as part of an approach to improvement in this area.

- Infection control - in common with many trusts, we continue to have isolated incidents of Clostridium difficile. In 2014/15 the Trust's final number was 64 against a ceiling of 62. Work continues to embed and enhance infection prevention and control practice across the organisation with performance improving significantly in the last six months of the year.

- Cancelled operations – these have been in excess of the threshold throughout the year. Action plans are in place for all specialties where improvement is required.

The Trust is working with the TDA to agree an improvement trajectory to achieve compliance with the national priorities set out in the NHS TDA Accountability Framework 2014/15.

During the year 2013/14, HSMR showed a significant reduction when compared to previous years. Early indications during the year 2014/15 have shown a rise of overall trust HSMR. It is important to bear in mind that HSMR is affected by many factors not directly related to clinical care. Despite monthly and seasonal variation, crude mortality does not show a significant increase. A number of actions are being undertaken to ensure we remain focused on reducing mortality as well as reviewing the factors that influence HSMR data.

With the exception of the issues that I have outlined in this statement, my review confirms that United Lincolnshire Hospitals NHS Trust has a system of internal controls that supports the achievement of its policies, aims and objectives and that those issues highlighted have been or are being addressed.

Accountable Officer : Mrs Jane Lewington, Chief Executive

Organisation: United Lincolnshire Hospitals NHS Trust

Signature

Date

Board Members Voting	Trust Board Max 11	Audit Committee Voting Max 5	Quality Governance Committee Max 11
Ron Buchanan Chairman	11		
Steve Barnett Non Executive Director	11	4	
Paul Grassby	7		8

Non Executive Director			
Geoffrey Hayward Non Executive Director	10	5	
Penny Owston Non Executive Director	10		11
Tim Staniland Non Executive Director	10		10
Kate Truscott Non Executive Director	10	3	
Jane Lewington Chief Executive	10		
Kevin Turner Deputy Chief Executive	11		
Suneil Kapadia Medical Director	7		6 Deputy attended for further 3 meetings
David Pratt Director of Finance and Corporate Affairs	11	5	
Pauleen Pratt Acting Chief Nurse	Max 10 8		8 Deputy attended for further 2 meetings
Board Members Non Voting			
Paul Boocock Director of Estates and Facilities	11		
Mark Brassington Acting Director of Performance Improvement	Max 3 3		
Michelle Rhodes Director of Operations	9		5 Deputy attended for further 3 meetings
Ian Warren Director of Human Resources and OD	8		0 Deputy attended for 4 meetings
Keith Darwin Associate Non Executive Director	8		

Appendix 2: Independent Auditor's Limited Assurance Report To The Directors Of United Lincolnshire Hospitals NHS Trust On The Annual Quality Account

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF UNITED LINCOLNSHIRE HOSPITALS NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of United Lincolnshire Hospitals NHS Trust's Quality Account for the year ended 31 March 2015 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following indicators:

- Rate of Clostridium difficile infections per 100,000 bed days for patients aged two or more on the date the specimen was taken during the reporting period, as set out on page 44 of the quality account.
- Percentage of reported patient safety incidents resulting in severe harm or death during the reporting period, as set out on page 44 of the quality account.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the Directors and the auditor

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2014 to June 2015;
- papers relating to quality reported to the Board over the period April 2014 to June 2015;
- feedback from the Commissioners dated June 2015;
- feedback from Local Healthwatch dated June 2015;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated June 2015;
- the latest national patient survey 2014;
- the latest national staff survey 2014;
- the Head of Internal Audit's 2014/15 annual opinion over the trust's control environment dated May 2015;
- the 2014/15 Annual Governance Statement dated June 2015; and
- Care Quality Commission Intelligent Monitoring Reports, dated December 2014 and May 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of United Lincolnshire Hospitals NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and [Name of Trust] for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the

measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by United Lincolnshire Hospitals NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Neil Bellamy, Director

for and on behalf of KPMG LLP, Chartered Accountants

Chartered Accountants
1 Waterloo Way
Leicester
LE1 6LP
KPMG LLP

24 June 2015